NHS
Bolton
NHS Foundation Trust

BOARD OF DIRECTORS' MEETING
AGENDA - MEETING HELD IN PUBLIC

To be held at 1300 on 30 March 2023
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref Nᵒ·	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB028/23	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm meeting quoracy*	*Verbal*	Chair	13:00
TB029/23	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	13:05
TB030/23	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*Report + Verbal*	Chair	
TB031/23	**Minutes of the previous meeting held on 26 January 2023** *Purpose: To **approve** the minutes of the previous meeting*	*Report*	Chair	13:20
TB032/23	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB033/23	**Chair's Update** *Purpose: To **note** the update from the Chair.*	*Verbal*	Chair	13:25
OPERATIONAL PERFORMANCE				
TB034/23	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	13:30

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TB035/23	**Operational Update**	*Presentation*	COO	13:40
	*Purpose: To **receive** the Operational Update*			
TB036/23	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance	*Report*	DCEO	13:50
	*Purpose: To **receive** the Integrated Performance Report*			

STRATEGY AND PERFORMANCE				
TB037/23	**2023/24 Operational and Financial Plan**	*Report*	DoSDT CFO	*14:15*
	*Purpose: To **approve** the Operational and Financial Plan*			
TB038/23	**Greater Manchester Integrated Care Partnership (ICP) Strategy Update**	*Report*	DoSDT	14:30
	*Purpose: To **receive** the GM ICS Strategy Update*			
TB039/23	**Strategy and Operations Committee Chair's Report**	*Report*	SoC Chair	*14:40*
	*Purpose: To **receive** assurance on work delegated to the Committee*			
COMFORT BREAK				14:50

QUALITY AND SAFETY				
TB040/23	**Quality Account Arrangements**	*Report*	Medical Director	15:00
	*Purpose: To **receive** the Quality Account Objectives*			
TB041/23	**Care Quality Commission (CQC) Inspection and Improvement Plan**	*Report*	Chief Nurse	15:10
	*Purpose: To **receive** the CQC Update*			

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TB042/23	**Quality Assurance Committee Chair's Reports**	*Report*	QAC Chair	15:25
	*Purpose: To **receive** assurance on work delegated to the Committee*			
FINANCE				
TB043/23	**Finance and Investment Committee Chair's Report**	*Report*	F&I Chair	15:35
	*Purpose: To **receive** assurance on work delegated to the Committee*			
TB044/23	**Audit Committee Chair's Report**	*Report*	AC Chair	15:45
	*Purpose: To **receive** assurance on work delegated to the Committee*			
TB045/23	**Charitable Funds Committee Chair's Report**	*Report*	CFC Chair	15:50
	*Purpose: To **receive** assurance on work delegated to the Committee*			
WORKFORCE				
TB046/23	**People Committee Chair Reports**	*Report*	PC Chair	15:55
	*Purpose: To **receive** assurance on work delegated to the Committee*			
RISK AND GOVERNANCE				
TB047/23	**Board Assurance Framework**	*Report*	DCG	16:00
	*Purpose: To **receive** the Board Assurance Framework*			
TB048/23	**Feedback from Board Walkabouts**	*Verbal*	NEDs	16:10
	*Purpose: to **note** the feedback following the Non-Executive Walkabouts*			
CONCLUDING BUSINESS				
TB049/23	**Questions to the Board**	*Verbal*	*Chair*	*16:20*

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Purpose: To discuss and respond to any questions received from the members of the public

TB050/23   **Messages from the Board**

Verbal   *Chair*

Purpose: To agree messages from the Board to be shared with all staff

TB051/23   **Any Other Business**

Report   *Chair*

*Purpose: To **receive** any urgent business not included on the agenda*

Date and time of next meeting: *16:30*
- 09.00 on Thursday 25 May 2023   *close*

Chair: Jackie Njoroge

Name:	Position:	Interest Declared	Type of Interest
Prof. Donna Hall	Chair	Honorary Professor University of Manchester	Non-Financial Professional Interest
		Donna Hall Consulting Ltd	Financial Interest
		Chair New Local (not remunerated position)	Non-Financial Professional Interest
		System Advisor NHS England	Financial Interest
		Board Member Carnall Farrarr (from 1st April 2020)	Financial Interest
		Chair PossAbilities learning disability social enterprise	Financial Interest
		CIPFA C Co Ltd (previously CIPFA NEWCO Limited	Financial Interest
		Family member employed by the Trust	Non-Financial Personal 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
		ED&I Grant Advisor Lord Shuttleworth Benevolent Fund	Financial Interest
		Associate Hospital Manager LSCF NHS Trust	Financial Interest
		EDI Football Advisor Lancashire Football Club	Non-Financial Professional Interest
		National Board Advisor for race discrimination for (Independent Office of Police Conduct(IOPC)	Non-Financial Professional Interest
		Coaching Bank for Academic Health and Social Care Network hosted by Liverpool Heart and Chest Hospital	Financial Interest
Francis Andrews	Medical Director	Holt Doctors (locum agency) payments for appraisals	Financial Interest
		Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of Interest
Malcolm Brown	Non-Executive Director	Family member employed by Trust	Non-Financial Personal Interest
Lynn Donkin	*Partnership Member	Director of Public Health, Bolton City Council	Financial 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/shareholder of Bornite Legal Limited and Bornite Holdings Limited	Financial Interest
		Director of Azurite Holdings Limited	Financial Interest
		Governor Bolton Sixth Form College	Non-Financial Personal Interest
Sharon Katema	*Director of Corporate Governance	Nothing to declare	
Naomi Ledwith	*Partnership Member	Delivery Director, NHS GM ICS Bolton Locality	Financial Interest
		Trustee at The Counselling and Family Centre	Non-Financial Professional Interest
		Family member employed by Aqua (until 31/03/23)	Non-Financial Personal Interest
James Mawrey	Chief People Officer and Deputy CEO	Trustee at Stammer	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
Jackie Njoroge	Non-Executive Director	Director – Salford University	Financial Interest
		Deputy Chair HESPA (non-remunerated position)	Non-Financial Professional Interest

Name:	Position:	Interest Declared	Type of Interest
Martin North	Non-Executive Director	Director MIRL Group Ltd	Financial Interest
		Company Secretary Aspire POD Ltd	Financial Interest
Niruban Ratnarajah	*Partnership Member	GP Partner: Stonehill Medical Centre	Financial Interest
		Associate Medical Director: NHS GMIC	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
Tyrone Roberts	Chief Nurse	Nothing to declare	
Alan Stuttard	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
		NED Blackpool Operating Company Ltd (Blackpool Sandcastle Waterpark)	Financial Interest
		Non-Executive Director - Blackpool Waste Services Ltd (trading as Enveco)	Financial Interest
Rachel Tanner	*Partnership Member	Director of Adult Social Care, Bolton City Council	Financial Interest
		Managing Director, Integrated Care Partnership	Financial Interest
Annette Walker	Chief Finance Officer	Joint Chief Finance Officer for Bolton NHS FT and NHS GM ICS Bolton Locality	Financial 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

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Name:	Position:	Interest Declared	Type of Interest
Rae Wheatcroft	Chief Operating Officer	Nothing to declare	
Sharon White	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

**Indicates non-voting member*

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

Draft **Board of Directors Minutes of the Meeting**
Held on Microsoft Teams
Thursday 26 January 2023
(Subject to the approval of the Board of Directors on 30 March 2023

Present

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

In Attendance

Name	Initials	Title
Lynn Donkin	LD	Director of Public Health
Naomi Ledwith	NL	Delivery Director (Bolton), NHS Greater Manchester Integrated Care
Nicola Caffrey	NC	Corporate Business Manager to Medical Director (item 2 only)
Niruban Ratnarajah	NR	Interim Locality Clinical Director, NHS Greater Manchester
Rachel Carter	RC	Associate Director of Communications and Engagement
Rachel Tanner	RT	Managing Director – Bolton Integrated Care Partnership
Sharon Katema	SK	Director of Corporate Governance
Tracey Joynson	TJ	Patient Experience Manager (item 2 only)
Victoria Crompton	VC	Corporate Governance Manager

There were also three observers who attended this meeting.

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB001/23	**Chair's Welcome and Note of Apologies**	
	DH welcomed all to the meeting. There were no apologies for absence.	
TB002/23	**Patient and Staff Story**	
	The patient story was relayed by Lee and Shirley Hawarden, and concerned Lee's 80-year-old father Brian, who died on 24 April 2020 at the Royal Bolton Hospital. Brian was admitted following a fall, but caught Covid whilst in hospital, became very unwell and sadly passed away. Lee explained that whilst initially he had felt	

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| | responsible for the decision to end treatment taken when his father's health had deteriorated, the discussion with the Covid Review Team had been a huge comfort as it assuaged any guilt he had. He highlighted that he sincerely wished this had been done earlier as the meeting took place after 12 months.

The Board also heard the staff story of Nicola Caffrey, who worked alongside the Medical Director, Dr Harni Bharaj, Deputy Medical Director and Dr Kevin Jones, Consultant Physician undertaking the Nosocomial Covid Duty of Candour Project. NC advised that Bolton was the second Trust in the UK to undertake this work meaning many other organisations were now approaching the Trust for advice and guidance. She outlined that Lee and Shirley were one of 537 families that the team contacted as part of this work which was completed in stages.

Initially the families and next of kin of the 214 people who died due to, or with nosocomial Covid were written to. This letter was followed up by a telephone call to find out if there were any further questions, along with the offer to meet the Nosocomial Review Team to discuss anything further. 13 families took the offer to meet, and although some of the discussions were difficult, they were beneficial with the learning from each meeting used to create the "Our Commitment to Learning" document. In addition, a cohort of patients who caught Covid in hospital and were subsequently discharged, were also contacted to fulfil the organisational Duty of Candour requirements. NC commented the work undertaken was some of the most impactful of her career and publicly credited all of the families involved.

FA thanked NC for her fantastic work adding it was remarkable how she managed to rebuild confidence with the affected families. He added that a bi-product of the work has been a lost property project which NC was working on alongside ward staff which resulted in there being no complaints for the previous six months' in relation to lost property. The Trust has also received a £30,000 grant for the "Call 4 Concern" patient safety innovation which was also being led by NC.

DH queried whether there were any other areas of learning. NC advised that flexibility when communicating with bereaved families is important and should be treated as an individual preference with some families wanting to interact immediately whereas some prefer to wait.

JN commented the project reemphasises the need for listening, and it was confirmed there are other areas the learning can be transferred to such as in complaints management. It was agreed to take a future paper on the complaints process and lessons learned through Quality Assurance Committee | |
| | **ACTION:** Paper on complaints process and lessons learned to go through Quality Assurance Committee | **FT/23/01 TR** |

	FN thanked the Medical Director and his team, and in particular NC for their work on the Nosocomial Covid Duty of Candour Project. **RESOLVED:** The Board of Directors **received** the patient and staff story.	
TB003/23	**Declarations of Interest**	
	There were no declarations of interests in relation to the agenda items.	
TB004/23	**Minutes of the previous meetings**	
	The Board of Directors reviewed the minutes of the meeting held on 24 November 2022 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board of Directors **approved** the minutes from the meeting held 24 November 2022.	
TB005/23	**Matters Arising and Action Logs**	
	The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. **RESOLVED:** The Board **approved** the action log	
CORE BUSINESS		
TB006/23	**Chair's Update**	
	The Chair thanked all staff for their hard work during, what was, an incredibly busy period for the Trust.	
TB007/23	**Chief Executive Report**	
	FN highlighted the following key points from the Chief Executive Report: • Staff continued to do everything possible to look after patients during, what was, a period of intense pressure. . • All patients, who are smokers that are admitted to Royal Bolton Hospital will be offered support from a team of specialist nurses. The CURE project is supported by Greater Manchester Integrated Care Partnership as part of a whole system approach, which aims to reduce smoking rates in Greater Manchester. • We were successful with the bid for £19.6 million funding to increase theatre capacity. The funding will build four modular theatres, as well as the creation of a bespoke day case paediatrics theatre hub, by refurbishing the existing day case theatres.	

	• A Garden of Reflection has been created to remember those who have given the gift of life through organ donation. RG queried whether staff had been accessing the cost of living support provided. JM confirmed additional OD support has been made available alongside a variety of other initiatives which included signposting financial support services and counselling. The breakfast packs were well received by a small number of staff, and there is further work to do to promote the services further. RG asked whether there had been feedback following the Hewitt Review. DH commented a number of workstreams had been established which both herself and FN were involved with. Work is progressing quickly, and recommendations are expected shortly. **RESOLVED:** The Board of Directors **received** the Chief Executive Report.	
TB008/23	**Strategy and Operations Committee Chair Report**	
	RG presented the Strategy and Operations Committee Chair Reports and drew attention to the following key points: • Month 9 Operational IPM was received noting December was particularly challenging in Emergency Care. The Strategy and Operations Committee commended the improvements despite the significant winter pressures. • No criteria to reside (NCTR) pressures continue, but the average number of patients with NCTR is reducing, although it remains above the target. The committee will receive quarterly updates. • The Strategy and Operations Committee completed a successful focus on major quarterly priorities to aid transformation approach. • A three-month extension was approved for the delivery of the Clinical Strategy. BI queried whether there had been an increase in the number of GPs who had signed up to the early discharge initiative. RW advised this is a collaborative piece of work which is in its infancy and will be closely monitored. With regards to a query regarding plans to develop Urgent Treatment Centers away from the hospital site, RW confirmed that an evaluation of the entirety of the urgent care provision was underway which will include the identification of services provided with a view to shape these to the requirements of the public. **RESOLVED:** The Board of Directors **received** the Strategy and Operations Committee Chair Reports.	
TB009/23	**Operational Update**	

		RW presented the Operational Update which provided an overview of operational performance during December and January. Key points included:	
		- In addition to usual winter pressures the organisation had to contend with industrial action, increased flu and Covid, Strep A, and an NWAS critical incident; all of which culminated in declaring OPEL 4 ourselves. - Increased paediatric attendances in A&E with similar pressures felt in primary care, likely caused by the high profile cases of Strep A. - A&E attendances increased by 8% compared to similar period in 2021 - There were no adverse clinical incidents as a result of the impact of industrial action. However, there was a peak in pressures due to a huge spike in flu admissions alongside a small increase in COVID. This resulted in an overcrowded A&E, all escalation areas open including additional beds in our same day emergency care area, as well as in the ambulatory care unit. - Primary care colleagues have provided additional capacity through Bardoc, a Respiratory hub and an extra surge hub aimed at relieving pressure across the system. Social care focussed on enabling as many people as possible to be discharged commissioning additional discharge to assess residential beds. - Performance against no reason to reside has steadily improved since September. - The Trust restarted the elective orthopaedic programme a week earlier than the previous year. - The Trust remained on track to deliver zero 78week wait in March, despite the slight rise in 78 week waits, due to patients moving under Bolton as part of the organisation providing mutual aid to organisations in G,. - Cancer performance remained a challenge, but treatments were not cancelled due to any bed pressures. We remain on track to deliver our backlog back to pre-pandemic levels in line with the national planning guidance. MN queried whether there were any medical reasons for the increase in flu cases this winter and whether there are any lessons to learn for next year. TR stated the Trust held a vaccine hub this winter allowing staff to receive their Covid and flu vaccines simultaneously, but this reduced uptake of the flu vaccination, and the Trust will revert to a hybrid vaccination model next year. There was a general resistance to vaccinations with both national and local vaccine rates being much lower than in previous years. JM added the management of the industrial action was extremely well managed, but there are further difficulties ahead with Junior Doctors currently balloting to take strike action and teachers striking will have a massive impact on the Trust. **RESOLVED:** The Board of Directors **received** the Operational Update.	
TB010/23	**Bolton Locality Plan Update**		
		NL presented the Bolton Locality Plan update advising that following the successful passing of legislation through parliament, Integrated Care Systems (ICS) were established in England from 1st July 2022, and have four aims: - - Improve outcomes in population health and healthcare; - Tackle inequalities in outcomes, experience and access;	

	• Enhance productivity and value for money; • Help the NHS support broader social and economic development. JN queried what the plan will mean to the people of Bolton and how success can be measured. SW commented the Strategic Planning and Delivery Group will report into Strategy and Operations Committee to provide oversight to the Trust. The neighborhood matrix will provide visibility on the maturity of the neighborhoods, and NR added that longer term measures will be evident by improvements in smoking, drinking and mortality rates. Shorter term measures will include improved access to services and patients accessing services on need rather than want. Measures were outlined within the Locality Plan, but it is important when this is refreshed these remain the same rather than introducing new ones.	
	It was agreed as part of Non-Executive Director walkabouts to include multi-working locations.	**FT/23/02** **SK**
	RESOLVED: The Board of Directors **received** the Bolton Locality Plan Update.	
TB011/23	**2023/24 Operational Planning Guidance**	
	SW presented the Operational Planning Guidance for 2023/24 advising this was released on 23 December 2022, by NHS England (NHSE) and outlines three priority areas: • Prioritise recovering core services and productivity • Return to delivering key ambitions in the NHS Long Term Plan (LTP) • Continue transforming the NHS for the future Against the first two priories, the year's guidance includes 12 national priority areas and 31 objectives. They will form the basis for how NHSE assess the performance of the NHS alongside the local priorities set by systems. It was noted that technical guidance was subsequently released on 13 January 2023 and details the formal planning targets (KPIs); these will form the basis of our actual planning return. MB queried the objective around reducing corporate costs, and SW advised this is mainly in relation to reducing agency spend and managing corporate vacancies. There will be one financial plan for GM, and SW added that managing the financial position will be one of the biggest challenges next year SW responded to a query from AS regarding how the Operational Plan will support the winter plans for 2023/24 advising that the Chief Operating Officer and their team will be working on lessons learnt from last winter and how these are taken forward for next year. **RESOLVED:** The Board of Directors **received** the 2023/24 Operational Planning Guidance.	
TB012/23	**Integrated Performance Report**	

		Executive Directors presented the Integrated Performance Report for December 2022, and the following key points were highlighted:	
		• Pressure Ulcer Collaborative – A learning session took place in October with a further learning session scheduled to take place in March.	
		• Notable improvements were recorded for C.Diff infections, although not statistically relevant yet and still above the monthly objective.	
		• Complaints response rates continue to indicate a special cause variation concern with 45.5% of complaints responded to within timescales against a target of 95%. December 2022 response rates fell despite an improvement in previous months	
		• Clinical correspondence figures remain below target and FA explained divisions are encountering issues whilst trying to improve figures and mitigation plans are in place.	
		• Despite operational pressures in A&E the department continued to perform well in relation to Sepsis screening. Screening for inpatients remained below target and a deep dive highlighted that patient scores may indicate screening is required hourly, whereas in reality only one screening test is required. The data team were looking into this issue.	
		• Staff sickness rates were high in December particularly for colds/flu and this was mirrored across GM. It was noted the early indication for January was that the figure had improved.	
		• Agency spend continued to reduce which was in line with the NHSI projection.	
		BI queried whether the pressure ulcer collaborative training had led to an increase in pressure ulcers. TR advised the Quality Assurance Committee had discussed the increase seen in December and felt it was realistic that there may be further increases which is usually the case following collaborative events.	
		RG queried what proportion of complaints were in relation to A&E. FN stated there was an increase in complaints in October, but due to good communications and media coverage this had now led to a reduction in complaints and an increase in compliments for the department.	
		RESOLVED:	
		The Board of Directors received the Integrated Performance Report.	
TB013/23		**Quality Assurance Committee Chair Report**	
		MB presented the December Quality Assurance Committee Chair Report highlighting the following key points:	
		• A report was received on Quality Account Priority One – Antibiotic Prescribing Standards indicating that standards one, two and four are on track for completion. Standard three is off track, but there is still an opportunity for this to be recovered.	
		• Since the BoSCA programme was refreshed in June 2021 there have been 33 areas assessed. B2 had been an escalation ward since February 2022 and had been identified as a 'white' ward. There is a need to determine the next	

	steps if the ward remains 'white' at the next assessment as regardless of this being an escalation ward there still needs to be the same standard of care. • The Annual Complaints report was received and noted. JN presented the chair report from the Quality Assurance Committee held on 18 January 2023, and highlighted the following key points: • A report was received on Quality Account Priority 3 Improving Information to Patients. Maternity have shown some improvement from Q1, but remain around 70%. The next set of questionnaires are aimed at more ethnic minorities with a use of different languages. • A report was received on Quality Account Priority 5 Q2 Accessible Information Standards highlighting the division had incorporated the fundamental Accessible Information Standards (AIS) in relation to text reminders and digital letters for outpatient and Elective Care appointments. Multiple written and audio translation options have been implemented via the digital letter service and the division work closely with translation services. **RESOLVED:** The Board of Directors **received** the Quality Assurance Committee Chair Report.	
TB014/23	**Mortality Report**	
	FA presented the Mortality Report which provided an update on mortality metrics and details of key actions and priorities for improving these metrics. The SHMI showed Bolton in month figure was above target and the average for the time period, but had remained 'in control' for the previous two years. The HSMR ratio was 111.72 for the 12 months to September 2022; this had just tipped over into a 'Red' alert. However, the in-month figure was within control limits but above average for the time frame. In hospital crude mortality in month is slightly above Trust target and average for the period. The rate has remained 'in control' for the previous two years. RG commended the clinical Coding Team who continued to achieve the >98% coding completeness and asked how the team could be further supported to maintain this. FA advised there was not currently a requirement from the Board of Directors to support the team. In response to AS's query on whether the November/December 2022 period might impact the Trust figures considering the flu and Covid rates for this period, FA advised that whilst the Trust would not be an outlier for Covid rates, but flu would be dependent on flu vaccination rates and population demographics. **RESOLVED:** The Board of Directors **received** the Mortality Report.	
TB015/23	**CNST Maternity Update**	

	JC presented the CNST Maternity update advising the Trust had met the required standard of three of the safety actions within the CNST year 4 scheme and had not met the required standard for seven of the safety actions. There were 141 evidential sub-requirements to be attained within the ten safety actions. The service can evidence compliance with 118 of the 141 requirements of the year 4 scheme (83.6%).	
	The cycle of business for maternity specific reports to be presented to the Board of Directors was revised in anticipation of future CNST schemes. In addition, internal auditors were commissioned to undertake a review of the governance arrangements relating to management of the year 4 scheme in order to identify areas of future improvement prior to commencement of the year 5 scheme.	
	Evidence is available to substantiate compliance with three of the maternity safety actions during the year 4 period. Action plans for the remaining seven safety actions were being compiled in preparation for presentation to Board prior to formal submission to NHS Resolution on 02 February 2023.	
	The Board of Directors discussed the funds requested for the summary actions and TR confirmed the division had been in receipt of additional financial support and risks have been mitigated. The benefits of the additional resource should be evident going forward.	
	RG queried when the division expected to compliant and the expected compliance rate. JC advised the position will next be assessed at the end of year five so January 2024. The division will report quarterly to the Board of Directors which will provide assurance and oversight to members.	
	RESOLVED: The Board of Directors **received** the CNST Maternity update.	
TB016/23	**Finance and Investment Committee Chair Report**	
	JN provided a brief summary from the Finance and Investment Committee that had taken place the previous day. The committee had received the month 9 finance update and there were no additional items to bring to the Board's attention.	
	RESOLVED: The Board of Directors **received** the Finance and Investment Committee update.	
TB017/23	**Charitable Funds Committee Chair Report**	
	MN presented the Charitable Funds Committee Chair Report from the meeting held on 05 December 2022 where committee members received updates on the charity strategy and implementation plan, Amazon wish lists, NHS Charities Together and a financial update. There were no items for escalation to the Board of Directors.	

	RESOLVED: The Board of Directors **received** the Charitable Funds Committee Chair Report.	
TB018/23	**Audit Committee Chair Report**	
	AS presented the Audit Committee Chair Report from the meeting held on 07 December 2022. The following key points were highlighted: • The Adult Safeguarding review which had been specifically requested by the Trust, highlighted two high risk findings and two medium risk findings with some areas of good practice. The Chief Nurse had developed an action plan which would be taken forward by the Quality Assurance Committee. • A report was received outlining the options for the tendering of Internal and External Audit Services. It was agreed Internal Audit would be put out to full tender process with a timescale to be completed by the 31 March 2023. External Audit is a responsibility of the Council of Governors and an options paper will be presented at the February 2023 Council of Governors meeting. **RESOLVED:** The Board of Directors **received** the Audit Committee Chair Report.	
TB019/23	**Our Bolton NHS Charity Annual Report and Accounts**	
	MN presented the Our Bolton NHS Charity Annual Report and Accounts which would be submitted to the Charity Commission by the deadline of 31 January 2023. RG queried whether there were difficulties around spending restricted funds. AW advised the difference between restricted and unrestricted funds is the way they are receipted. There are increased difficulties when spending restricted funds but the Charity Manager was working with division to develop plans to spend these monies. **RESOLVED:** The Board of Directors **received** the Our Bolton NHS Charity Annual Report and Accounts.	
TB020/23	**People Committee Chair Report**	
	BI presented the People Committee Chair Reports from the meetings held on 20 December 2022 and 17 January 2023 and passed thanks to the Head of Resourcing and his team for their continued work on recruitment within the Trust, which remains in a strong position when compared to the regional and national position and the plethora of actions being taken to sustain the recruitment position. In January, the People Committee also received an update on Freedom to Speak Up and noted that Tracey Guard, Freedom to Speak Up Guardian had been appointed as Deputy Chair for the Freedom to Speak Up North West Network. **RESOLVED:**	

	The Board of Directors **received** the People Committee Chair Report.	
TB021/23	**Board Annual Workplan**	
	SK presented the Board Annual Workplan which detailed items to be presented throughout the calendar year to ensure that the Trust meets all its regulatory, statutory duties. The Workplan would be used to inform the work plans of the committees. **RESOLVED:** The Board of Directors **approved** the Board Annual Workplan.	
TB022/23	**Feedback from Board Walkabouts**	
	AS provided feedback from a recent visit with SW to the Coronary Care Unit and C1. The patients in both areas praised the care they had received, and the commitment of staff was evident. AS also spoke with a Locum Consultant who commented the health of patients attending was worse than he had previously seen in other areas with some patients delaying accessing treatment despite their health concerns. **RESOLVED:** The Board of Directors **received** the feedback from Board Walkabouts.	
TB023/23	**Board Anti-Slavery Statement**	
	SK presented Board Anti-Slavery Statement which would be included in the Annual Report and would be published on the Trust website. The Board of Directors were asked to confirm that every member has considered and approves the statement and will continue to support the requirements of the legislation. **RESOLVED:** The Board of Directors **approved** the Board Anti-Slavery Statement.	
TB024/23	**NHS Charities Together: 'Two Years' On' Impact Report**	
	The Director of Strategy, Digital and Transformation presented the report which provided the Board of Directors with a copy of the NHS Charities Together Stage One Grant Funding: Impact Report, which was submitted in September 2022, in line with the grant terms and conditions. **RESOLVED:** The Board of Directors **noted** the NHS Charities Together: 'Two Years' On' Impact Report.	
CONCLUDING BUSINESS		

TB025/23	Questions to the Board	
	None.	
TB026/23	Messages from the Board	
	The following key messages from the Board were agreed: • Congratulate staff on hard work during organisational pressures • Bolton Locality Plan • Our Bolton Charity • Learning from Covid document to be published on website	
TB027/23	Any Other Business	
	There being no other business, the chair thanked all for attending and brought the meeting to a close at 12.30 The next Board of Directors meeting will be held on **Thursday 30 March 2023**.	

Meeting Attendance 2022/23						
Members	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**
Donna Hall	✔	✔	✔	✔	✔	
Fiona Noden	✔	✔	✔	✔	✔	
Francis Andrews	✔	✔	✔	✔	✔	
James Mawrey	✔	A	✔	A	✔	
Tyrone Roberts	✔	✔	A	✔	✔	
Annette Walker	✔	✔	✔	✔	✔	
Rae Wheatcroft	✔	✔	✔	✔	✔	
Sharon White	✔	✔	✔	✔	✔	
Malcolm Brown	✔	✔	✔	✔	✔	
Rebecca Ganz	✔	✔	✔	✔	✔	
Bilkis Ismail	✔	✔	✔	✔	✔	
Jackie Njoroge	✔	✔	✔	✔	✔	
Martin North	✔	✔	✔	✔	✔	
Zada Shah	A	✔	✔	-	✔	
Alan Stuttard	✔	✔	✔	✔	✔	
In Attendance	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**
Sharon Katema	✔	✔	✔	✔	✔	
Helen Lowey	✔	✔				
Rachel Tanner	✔	A	✔	✔	✔	
Niruban Ratnarajah	A	✔	✔	✔	✔	
Lynn Donkin			✔	✔	✔	
✔ = In attendance A = Apologies						

January 2022 actions

Code	Date	Context	Action	Who	Due	Comments
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	Lauren Searle invited to attend March 2023 Board meeting. Unable to attend to invited to May 2023 meeting instead.
FT/22/22	24/11/2022	Midwifery Staffing Report	Forward view on maternity staffing to be provided through People Committee	CS	May-23	
FT/22/21	29/09/2022	Any other business	Chief Finance Officer to present the Estates Plan at a future Board Development Session.	AW	Apr-23	
FT/22/20	29/09/2022	WRES/WDES	Updates from the BAME and Disability and Health Conditions Forums back in six months.	SK	May-23	
FT/23/01	26/01/2023	Staff Story	Paper on complaints process and lessons learned to go through Quality Assurance Committee	TR	May-23	
FT/23/02	26/01/2023	Bolton Locality Update	It was agreed as part of Non-Executive Director walkabouts to include multi-working locations.	SK	May-23	

Key

complete	agenda item	due	overdue	not due

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Purpose	To provide an outline of key activity since the last meeting.

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

Previously considered by:
N/A

Proposed Resolution	The Board is asked to receive and note the Report of the Chief Executive.

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 there has been a 72-hour period of industrial action, following an announcement from the British Medical Association that a significant majority (98%) of their Junior Doctor members voted in favour of industrial action. A significant amount of planning took place to minimise the impact for our patients, and to ensure safe care continued to be provided to those who needed it.

As always, there were incredible efforts from our teams to keep our patients safe and support each other, to enable us to continue to provide 24-hour care for our patients. This saw many staff assume different roles outside of their normal day jobs. We also appealed to the public throughout, to choose the right service and help us protect our urgent resources for those most in need.

This month we received the report following the recent CQC inspection of our maternity services. As part of the national maternity inspection programme we were assessed on of the five key lines of enquiry; safety and well-led. Both domains for the maternity service were rated by the CQC as 'required improvement' which also brings the overall rating for our maternity services to 'requires improvement'.

As a result of both our Urgent and Emergency Services and Maternity Services ratings for safety changing to 'requires improvement', the trust's overall rating for safety is also now 'requires improvement'.

We feel that the outcome is fair, balanced and proportionate to the scale of the challenges we are currently facing, but it also reflects that the CQC saw numerous evidence of improved systems, processes and also culture. We are confident that we have correctly prioritised the areas of focus to continue to make improvements in the service. Further detail including the full report can be found here.

Following a recent bid to the NHSE Acute Deterioration Team, we were one of only seven successful organisations to be awarded a financial grant of £30,000 and the opportunity to work collaboratively with NHSE to develop a "Worry and Concern" pilot. This allows us to focus on the management of the deteriorating patient by further incorporating the patient, family and carers voice relating to concerns for the patient.

The grant will help us to develop innovation and improved patient safety practices, in the recording and raising of concerns or alerts in patient records. Our first national meeting is in London on the 23rd April and we will continue to build our local multi disciplinary team to develop and pilot our ideas.

Ambition 2
To be a great place to work

The national NHS Staff Survey results have now been published. As expected, there are some key areas where we know we need to make changes, but also some areas where our staff tell us we are doing really well. This is reflective of the ongoing pressures of treatment backlogs, long waits in our emergency department, industrial action and fatigue and burnout following two years of the pandemic.

For the fifth year running, we have been placed highest of all acute and acute and community Trusts in Greater Manchester in several of the key areas. We are so proud to be in this position, but know that the hard work does not stop here. Further detail about the results will be shared with the Board of Directors by James Mawrey, our Director of People.

To mark this year's International Women's Day on 8th March, we celebrated the huge contributions of our female staff and patients. The majority of Bolton's staff are female, much like the NHS throughout the country, at approximately 85%. Bolton provides a wide range of services to women in Bolton and beyond, including maternity, breast and gynaecology, and this month is once again running cervical smear clinics for staff to allow more women to be able to have this potentially life-saving test in their workplace at a time convenient to them.

Building on the success of our existing networks; LGBTQ+, BAME and disabilities and health conditions, we are really pleased that we will be launching three new staff networks in the coming weeks. The names are still to be determined, and they will cover the themes of gender, generational differences and social and economic influences and the impact they may have on staff. All of the networks now have an executive sponsor to support with key priorities and make sure we are doing everything we can to deliver on the things that are important.

Our maternity services signed up to the Royal College of Midwives' Caring for You charter which aims to improve the health, safety and wellbeing of midwives at work so that they are able to provide safe and high-quality maternity care for women, babies and their families. The charter encourages teams to create a positive working environment for our dedicated midwives and maternity support workers by focusing on principles such as creating an inclusive culture, safe learning environments, and flexible and innovative working patterns to support effective working within our teams.

Our new intranet is now live for staff across the organisation. The system has been built and developed in house on SharePoint, which integrates with other Microsoft 365 programmes including Teams. Staff voted to keep the name BOB (Bolton's Online Buddy) and have shaped the content through focus groups and targeted engagement sessions.

Finally, the interviews for our new Chair took place last week. I am delighted that we will be welcoming a new to Chair to join the Board of Directors. I would like to thank Professor Donna Hall for 4 years of service to this organisation, for all she has supported us to achieve, and to wish her all the best in the future.

Ambition 3
To use our resources wisely

Our Bolton NHS Charity continues to support the organisation by raising funds to support our work. In the last quarter they have funded; support for our professional nurse advocates to facilitate restorative supervision for colleagues, improvements to the cardiac pacing unit, and bespoke baby-loss counselling for 30 families.

The iFM Catering Department has received a five-star rating following a recent unannounced food hygiene audit of the services on our hospital site. The scheme helps members of the public choose where to eat out or shop for food by giving clear information about the

businesses' hygiene standards. The Foods Standard Agency run the scheme in partnership with local authorities in England, Wales and Northern Ireland.

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

This week we celebrated the official opening of the new faith facilities on the hospital site. The facilities have been relocated to a much larger space, in the former doctor's mess, in the Sports and Social Club building behind the main hospital. The facilities include a new Mosque and Temple, and community room available for staff and patient use. The project has been charitably funded by Our Bolton NHS Charity, and an NHS Charities Together grant, in addition to our local community sponsors, to support patients and staff with their spiritual wellbeing at work, or during their time in hospital.

Work will shortly begin on our new Community Diagnostic Centre (CDC), which will be housed in J Block, in what is currently the outpatients' department. The new centre will increase our ability to provide thousands of tests and scans every year, and support our elective recovery work by helping to continue the reduction in our patient backlogs and vastly improving patient pathways. Whilst the centre will generate lots of great benefits for staff and patients for years to come, in the short-term the development will mean changes to where teams work and we have recently been in touch with those teams to set out what it means for them. Building work is scheduled to start imminently so that it's ready to use by spring 2024.

Ambition 5
To integrate care

We have been busy rolling out WiFi across many of our community sites, improving quality and speed of access for our staff working across different health centres and locations in Bolton. We expect the roll-out to be complete at all our community locations by the end of April.

Towards the end of last year, NHS England released its 2023/24 priorities and operational planning guidance, which outlined three priority areas; to recover core services and productivity, revisit and deliver the key ambitions of the NHS Long Term Plan, and continue to transform the NHS for the future.

We have responded with our own operation plan, working very closely with GM and their overall oversight so that we are aligned with organisations across the system. The submission date for this was earlier this month.

As well as the clear priority areas, digital, workforce, system working and health inequalities are key drivers in how we will support this recovery. Specific work is expected to improve core services including urgent and emergency care, community health services, cancer, diagnostics, elective care, maternity and neonatal services and primary care.

Ambition 6
To develop partnerships

As a result of growing areas of concern across the Greater Manchester system, including around elective recovery and cancer performance, delays in urgent care and ambulance handovers, and our financial position, NHS England will be providing additional support to the GM system. In-line with this, NHS Greater Manchester has now been formally moved from Segment 2 to Segment 3 of the System Oversight Framework, and will receive the associated support and scrutiny to agree an improvement plan going into 23/24.

We continue to be grateful for the support we receive from patients and their relatives. The family of a young mum from Bolton who donated her organs and tissue after dying from a brain tumour are setting themselves a series of fundraising challenges throughout 2023 to honour her legacy, and raise money for Our Bolton NHS Charity. The money will be used to invest in specialist organ donation training for our staff and has the potential to save and transform other people's lives.

The Bolton College of Medical Sciences build continues at pace, with the project moving quickly onto the installation of flooring. Whilst some additional disruption is expected as a result of this, the project remains on track to welcome its first learners next September.

We held the Bolton Locality Strategy, Planning and Delivery Group, coming together with partners to discuss our priorities and moving forward in our key areas of focus; children and young people including mental health, neighbourhoods and community, and workforce and digital.

We have continued to adapt and evolve the way we are working across the Bolton locality to make sure our focus is on the health and well-being of our local communities. Making sure the voices of the public are heard will be of huge importance to getting this right and a framework has been developed to enable this, and support how we work as a system to deliver.

A big focus for the system will be refreshing our work with children and young people, ensuring that they get the best start in life and the chance to be successful and happy.

NHS
Bolton
NHS Foundation Trust

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	30/03/2023		Discussion	X
Exec Sponsor	James Mawrey		Decision	

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

Previously considered by:	Divisional IPMs

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

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

Prepared by:	Emma Cunliffe	Presented by:	James Mawrey

NHS

Bolton NHS Foundation Trust

Integrated Performance Report

February 2023

Guide to Statistical Process Control

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

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

One or more points outside either the upper or lower control limits.

7 or more consecutive points above or below the mean.

Common cause variation only.

6 or more consecutive points either ascending or descending in value.

Upper/ Lower Control Limits — Mean — Actual — Target

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
	(common cause)	H↑	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	2	2	1	0	1	2	14
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	6	1	0	0	0	0	0	3
Patient Experience	13	2	0	0	1	2	0	14
Maternity	9	0	0	0	0	1	0	8
Operational Performance								
Access	4	0	1	4	2	0	8	3
Productivity	8	0	1	4	2	2	3	7
Cancer	4	0	0	0	3	0	1	6
Community	0	0	0	1	1	0	0	2
Workforce								
Sickness, Vacancy and Turnover	3	0	0	1	0	0	1	2
Organisational Development	1	1	0	0	2	1	2	1
Agency	1	0	0	2	0	2	0	1
Finance								
Finance	1	1	0	0	1	0	0	3
Appendices								
Heat Maps								

Variation

- (common cause icon) Common cause variation.
- **H** (orange) Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
- **L** (orange) Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
- **H** (blue) Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
- **L** (blue) Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.

Assurance

- **P** We can be confident in consistantly meeting the required level of performance for this KPI.
- **F** Indicates that we should not expect to achieve the required level of performance for this KPI.
- **?** We cannot be confident in consistantly achieving the required level of performance as the target is within the range of common cause variation.

Performance

- **6/6** Indicates how many times we have achieved the required level of performance across the last 6 data points.

Quality and Safety

Harm Free Care

Report to patient/family within 60 working days of incident declaration
In February 2023 there were three SI investigation reports approved however were overdue being sent to the patients/families by the 60-day deadline.
The three reports did not meet the submission deadline for the sign off panel in January and therefore were rescheduled for sign off in February where they were all approved.
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.

Pressure Ulcers
Hospital
Twelve pressure Ulcers were reported in February 2023, eight of these were categorised as category 2; this demonstrated common cause variation. Four un-stageable pressure ulcers were also reported. As reported at Quality assurance committee in March, there is a national proposal to record un-stageable pressure ulcers as minimum category 3.
Quality assurance committee received a focussed review highlighting that pressure ulcers have been increasing since 2019 at Bolton FT, and it was further highlighted that this is a trend not illustrated across other organisations. A review of model hospital shows Bolton FT in quartile 4 (lowest performance) for prevalence of pressure ulcers.
The Quality improvement collaborative has recently had its second learning session with in excess of 24 teams presenting their tests of change. The collaborative is scheduled to collude in July 2024. It is expected that reductions in pressure ulcer prevalence will be observed 23/24, and specifically Q2 onwards following the collaborative timeline and previous experience with improvement methodology outcomes.
Additionally, the Divisional nurse directors are implementing focussed interventions with clear expectations on objectives.

Community
A review into community pressure ulcer reporting across Greater Manchester reveals large variation in reporting. From April 2023, Bolton FT will be providing data that demonstrates where community pressure ulcers have demonstrated omissions in care. The Chief Nurse has also proposed to lead a GM group on reviewing pressure ulcer reporting to ensure equity across Greater Manchester ICB.

Pressure Ulcer Collaborative
Pressure ulcers are a system wide issue and there are a number of interventions which have been proven to reduce pressure ulcers within health and care home settings – a pressure ulcer collaborative has been set up to help us test and implement these changes; the outcome aims being:
• "To reduce hospital acquired category 2 pressure ulcers by 50% by July 2024"
• "To reduce community caseload acquired pressure ulcers by 30% by July 2024
• "To eradicate category 3 and 4 pressure ulcers by July 2023" **this is under review following the national direction to include un-stageable pressure ulcers at minimum category 3
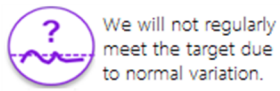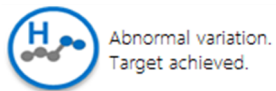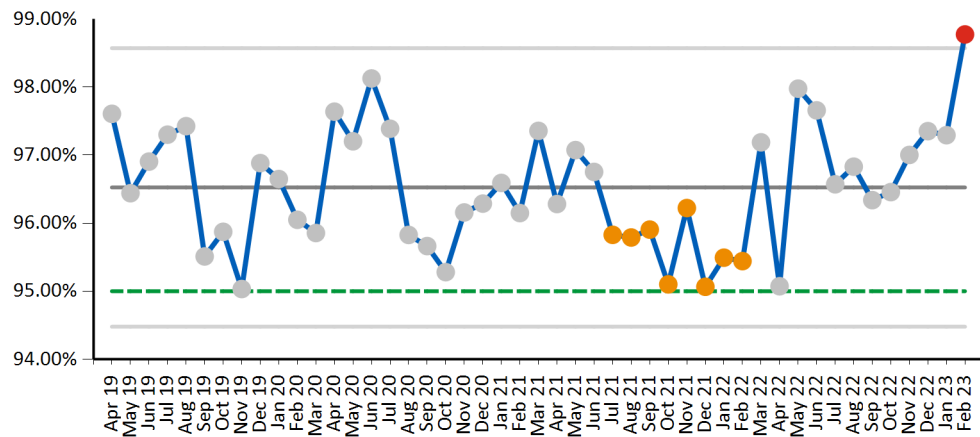
Falls
Our YTD performance is currently at 4.85 falls per 1000 bed days. This means we continue to remain under our local target, which is 5.3 falls per 1000 bed days. Falls continue to demonstrate normal variation
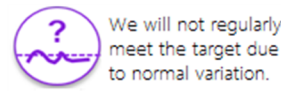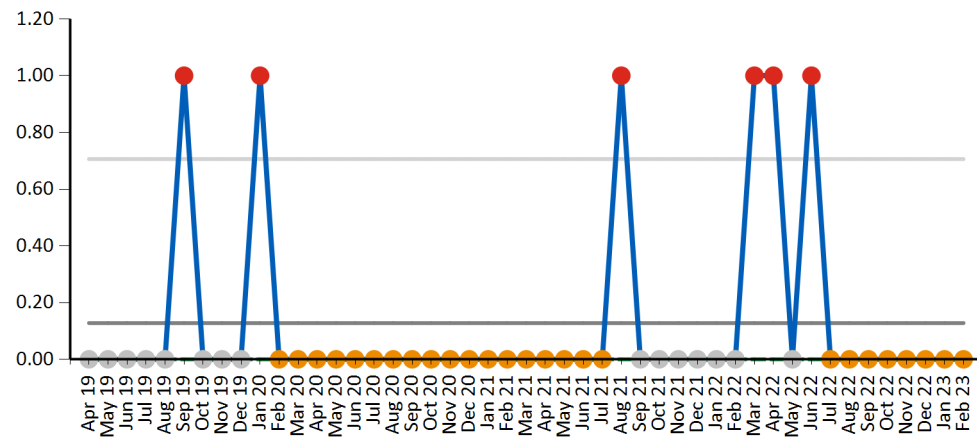
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	98.8%	Feb-23	(H)	>= 95%	97.3%	Jan-23	>= 95%	97.0%	(?)
9 - Never Events	= 0	0	Feb-23	(L)	= 0	0	Jan-23	= 0	2	(?)
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	6.17	Feb-23	(~)	<= 5.30	4.58	Jan-23	<= 5.30	4.85	(?)
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	3	Feb-23	(~)	<= 1.6	6	Jan-23	<= 17.6	28	(?)
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	8.0	Feb-23	(H)	<= 6.0	14.0	Jan-23	<= 66.0	128.0	(?)
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Feb-23	(~)	<= 0.5	0.0	Jan-23	<= 5.5	7.0	(?)
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Feb-23	(~)	= 0.0	0.0	Jan-23	= 0.0	1.0	(?)
515 - Acute Inpatients acquiring pressure damage (unstagable)		4	Feb-23			9	Jan-23		59	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	14.0	Feb-23	(~)	<= 7.0	10.0	Jan-23	<= 77.0	147.0	(?)
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Feb-23	(L)	<= 4.0	2.0	Jan-23	<= 44.0	8.0	(?)
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Feb-23	(~)	<= 1.0	1.0	Jan-23	<= 11.0	7.0	(?)
516 - Community patients acquiring pressure damage (unstagable)		7	Feb-23			10	Jan-23		64	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	95.0%	Q3 2022/23	(~)	>= 90%	76.4%	Q2 2022/23	>= 90%	86.8%	(?)
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q3 2022/23	(~)	>= 90%		Q2 2022/23	>= 90%	100.0%	(?)
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	24.0%	Q3 2022/23		>= 90%	22.0%	Q2 2022/23	>= 90%	28.0%	
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q3 2022/23		>= 90%	100.0%	Q2 2022/23	>= 90%	100.0%	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	75.4%	Feb-23	(variation)	>= 95%	74.3%	Jan-23	>= 95%	75.5%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	81.7%	Feb-23	H	>= 95.0%	71.9%	Jan-23	>= 95.0%	66.5%	F
86 - Patient Safety Alerts	= 100%	100.0%	Feb-23	(variation)	= 100%	100.0%	Jan-23	= 100%	63.7%	?
88 - Nursing KPI Audits	>= 85%	94.6%	Feb-23	(variation)	>= 85%	91.6%	Jan-23	>= 85%	93.3%	P
91 - Report to patient/family within 60 working days of incident declaration	= 100%	0.0%	Feb-23	(variation)	= 100%	0.0%	Jan-23	= 100%	19.0%	?

6 - Compliance with preventative measure for VTE

H — Abnormal variation. Target achieved.

? — We will not regularly meet the target due to normal variation.

6/6

9 - Never Events

L — Abnormal variation. Target achieved.

? — We will not regularly meet the target due to normal variation.

6/6

13 - All Inpatient Falls (Safeguard Per 1000 bed days)
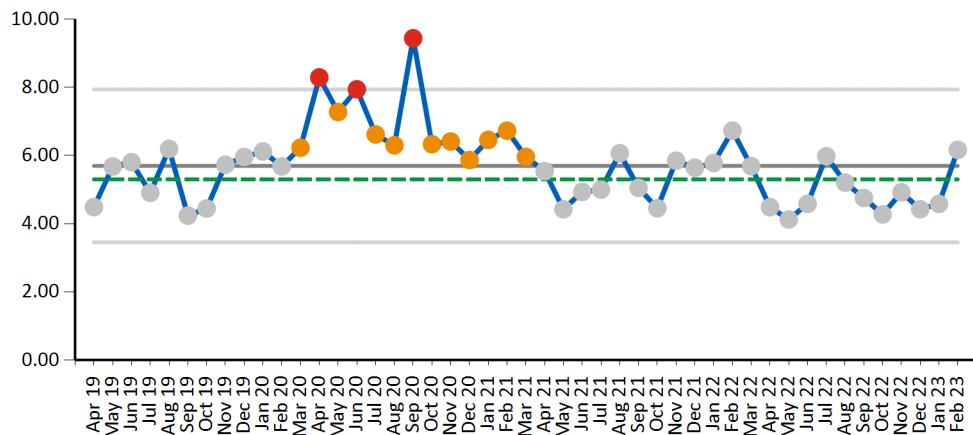
Normal Variation | We will not regularly meet the target due to normal variation. | 5/6

14 - Inpatient falls resulting in Harm (Moderate +)
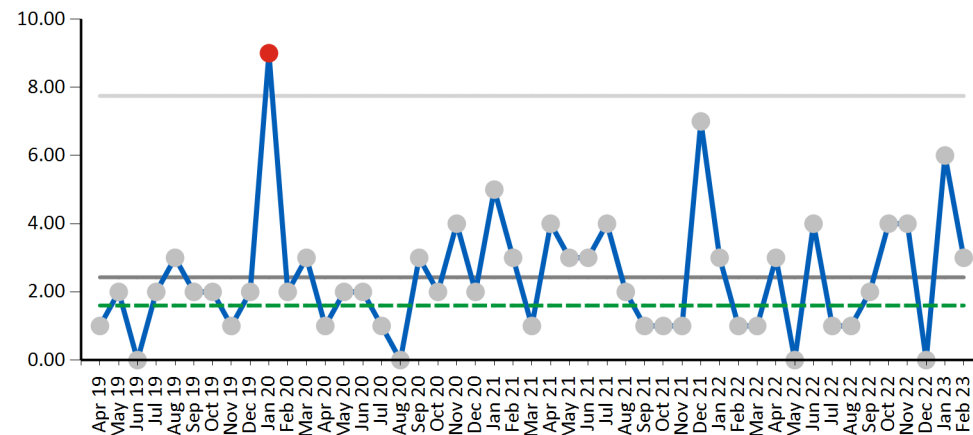
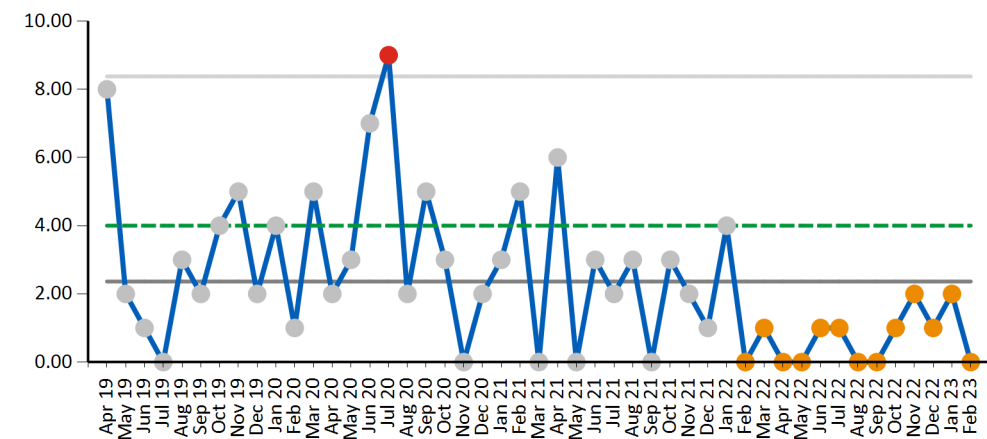
Normal Variation | We will not regularly meet the target due to normal variation. | 1/6

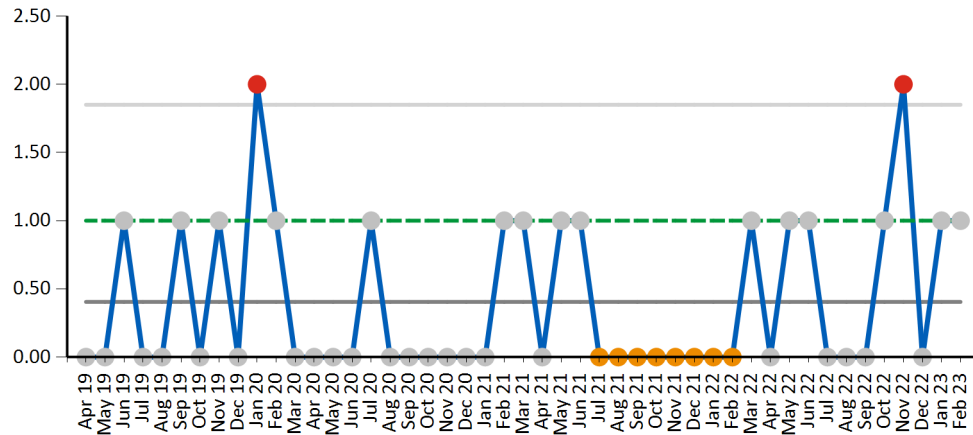## 15 - Acute Inpatients acquiring pressure damage (category 2)
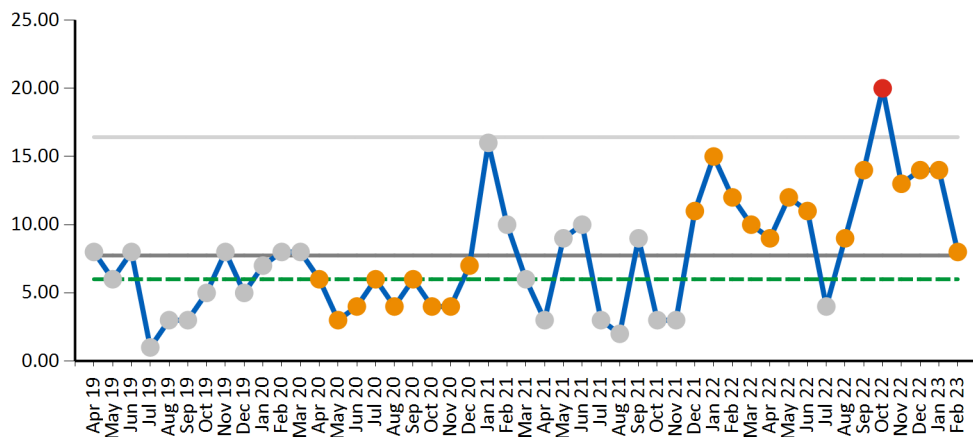
H Abnormal variation. Target not achieved. | We will not regularly meet the target due to normal variation. | 0/6

16 - Acute Inpatients acquiring pressure damage (category 3)
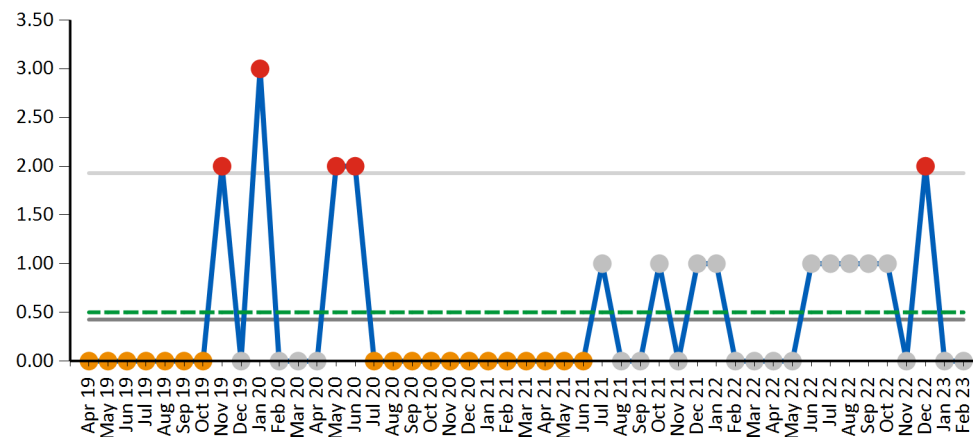
Normal Variation | We will not regularly meet the target due to normal variation. | 3/6

17 - Acute Inpatients acquiring pressure damage (category 4)
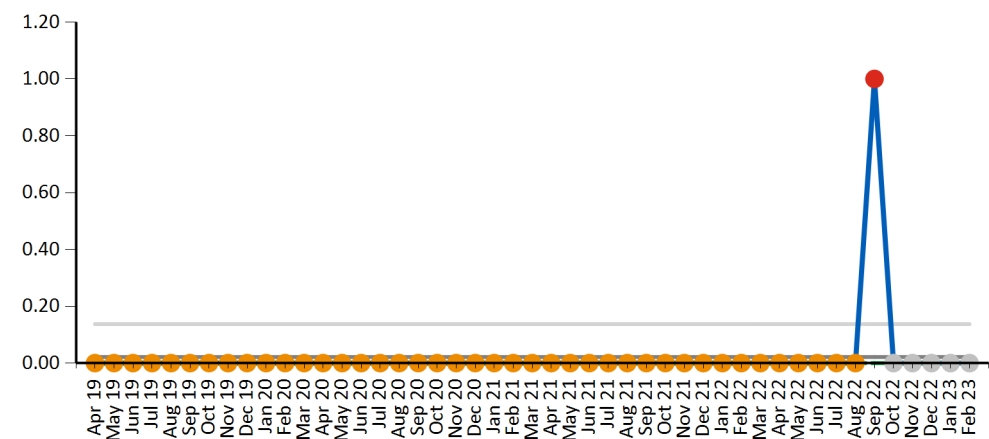
Normal Variation

We will not regularly meet the target due to normal variation.

5/6

515 - Acute Inpatients acquiring pressure damage (unstagable) - SPC data available after 20 data points
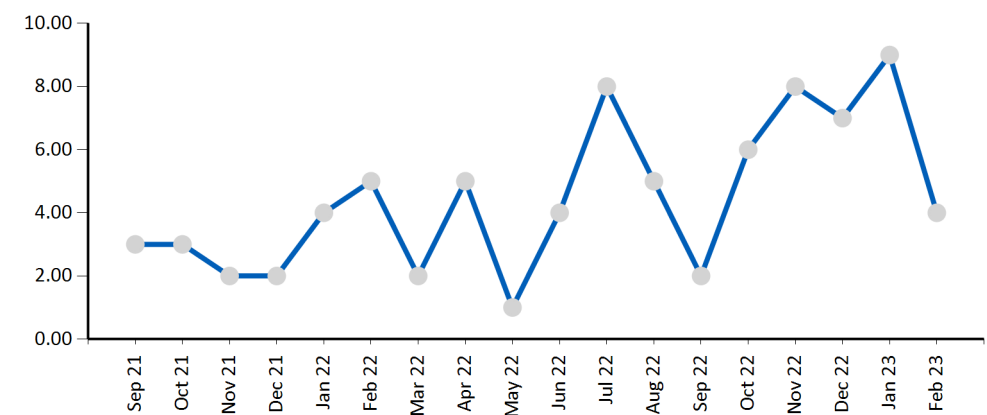
18 - Community patients acquiring pressure damage (category 2)
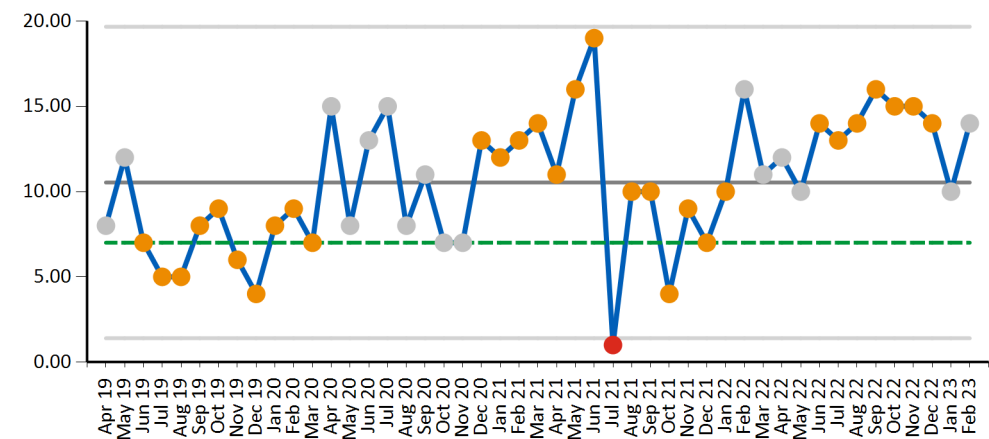
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

19 - Community patients acquiring pressure damage (category 3)

Abnormal variation. Target achieved.

We will not regularly meet the target due to normal variation.

6/6

9/54

20 - Community patients acquiring pressure damage (category 4)

Normal Variation

? We will not regularly meet the target due to normal variation.

5/6

516 - Community patients acquiring pressure damage (unstagable) - SPC data available after 20 data points
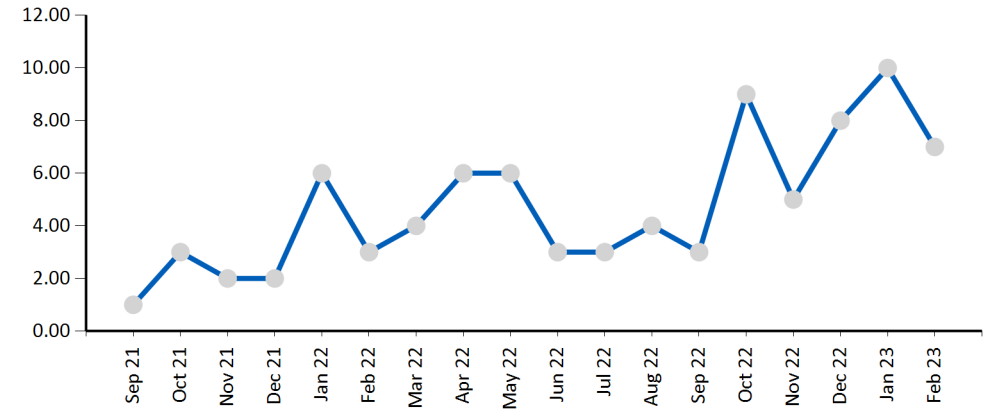
28 - Emergency patients - screened for Sepsis (quarterly)
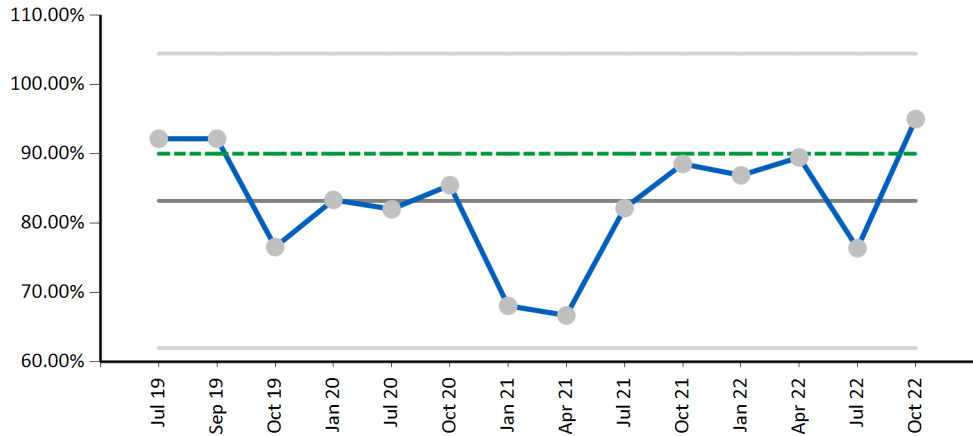
Normal Variation

? We will not regularly meet the target due to normal variation.

1/6

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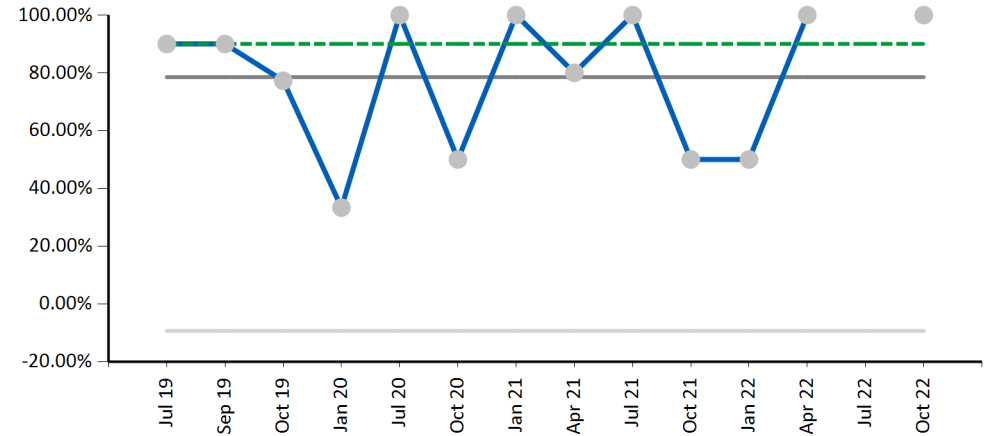
Normal Variation

? We will not regularly meet the target due to normal variation.

3/6

513 - Inpatients - screened for Sepsis (quarterly) - SPC data available after 20 data points
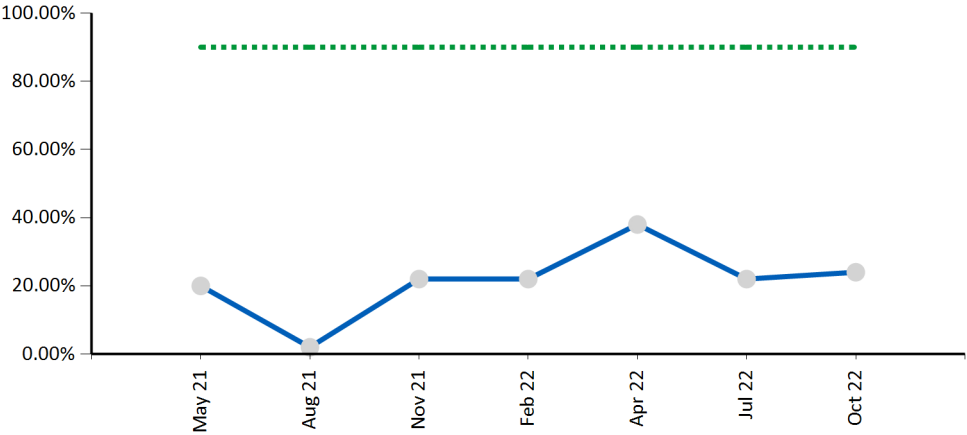
0/6

514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points
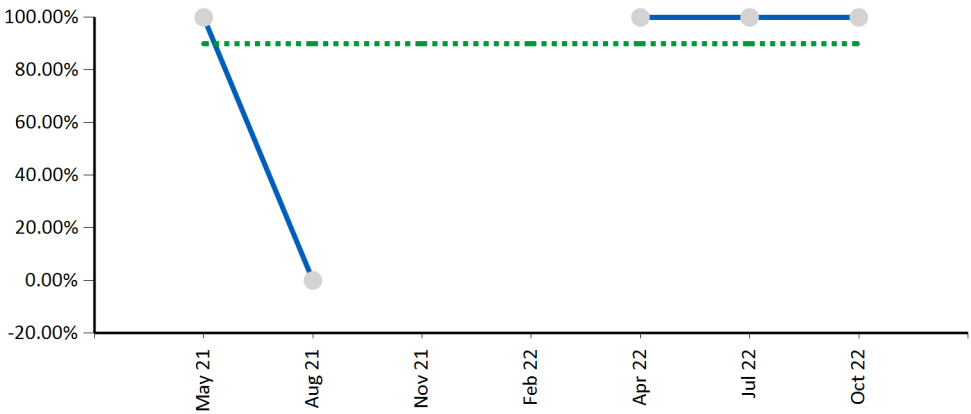
3/6

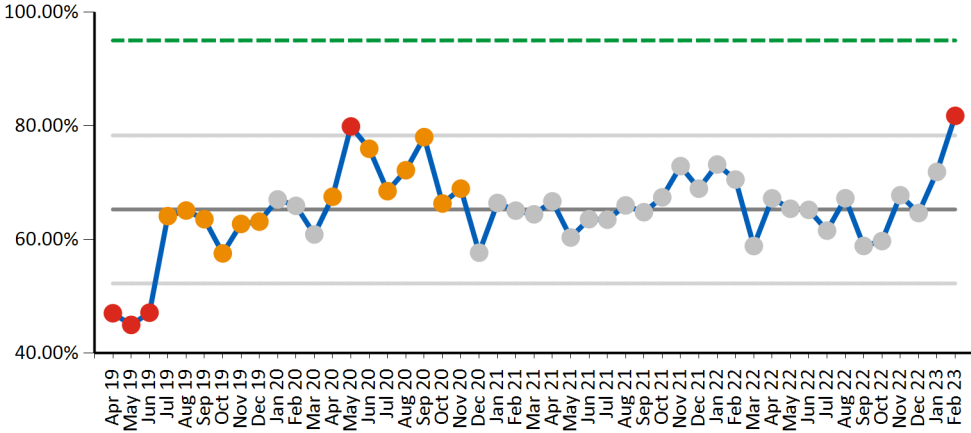**30 - Clinical Correspondence - Inpatients %<1 working day**
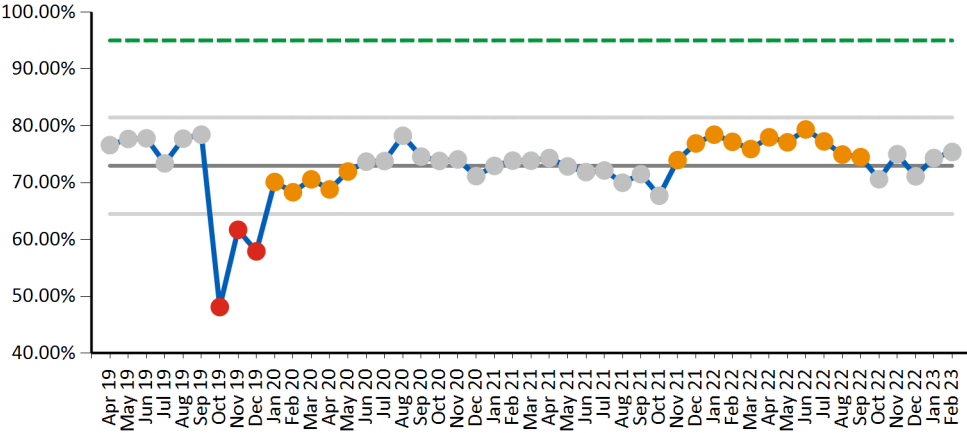
Normal Variation

F We will regularly fail to meet the target.

0/6

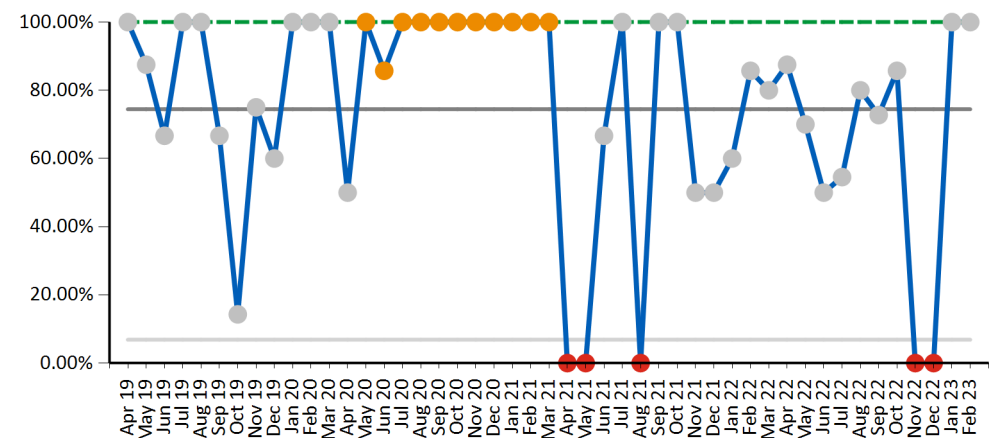**31 - Clinical Correspondence - Outpatients %<5 working days**

H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

11/54

86 - Patient Safety Alerts

Normal Variation

? We will not regularly meet the target due to normal variation.
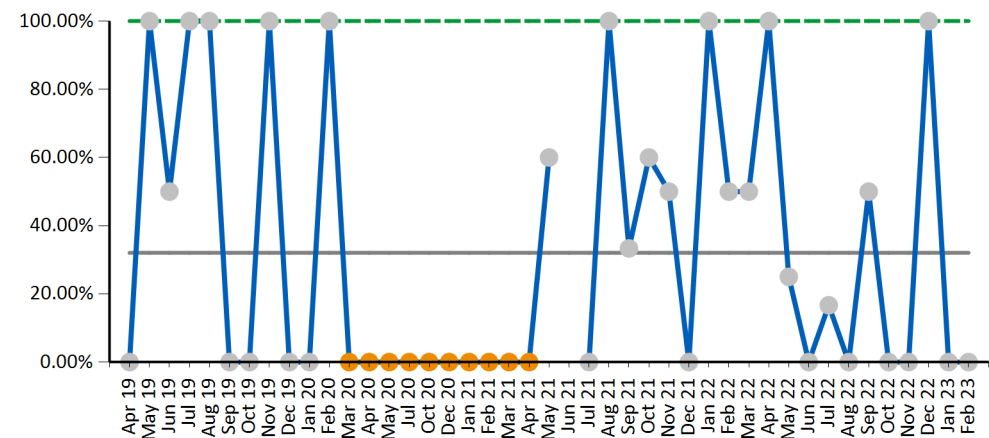
2/6

88 - Nursing KPI Audits
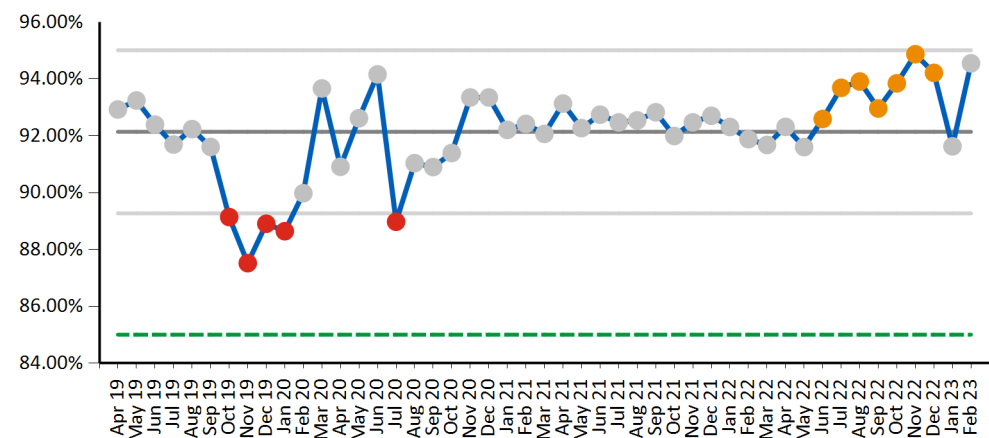
Normal Variation

P Target will be regularly met.

6/6

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

Normal Variation

? We will not regularly meet the target due to normal variation.

1/6

Infection Prevention and Control

The incidence of nosocomial COVID-19 cases reflect a general trend across the region of the impact of more COVID-19 cases in February which has been out of sync with the impact of influenza infections.

The total number of healthcare associated Clostridium difficile infections (CDI) has reduced and for the second time in 2022/23 is below the objective rate. However, there is no evidence that this is sustained or sustainable and there has been no statistical improvement and as a consequence a Quality Improvement Collaborative will be initiated supported by the Trust QI specialists to drive sustained and sustainable improvements related to the factors influencing the likelihood of CDI.

The healthcare associated infections (HCAIs) with external objectives – CDI, E. coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections have now been exceeded for 2022/23. The improvements that are generated by the CDI collaborative will impact positively on other HCAIs: focus on cleanliness, hand hygiene, suitable personal protective equipment (PPE) use and improved communication between members of the care teams.

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.
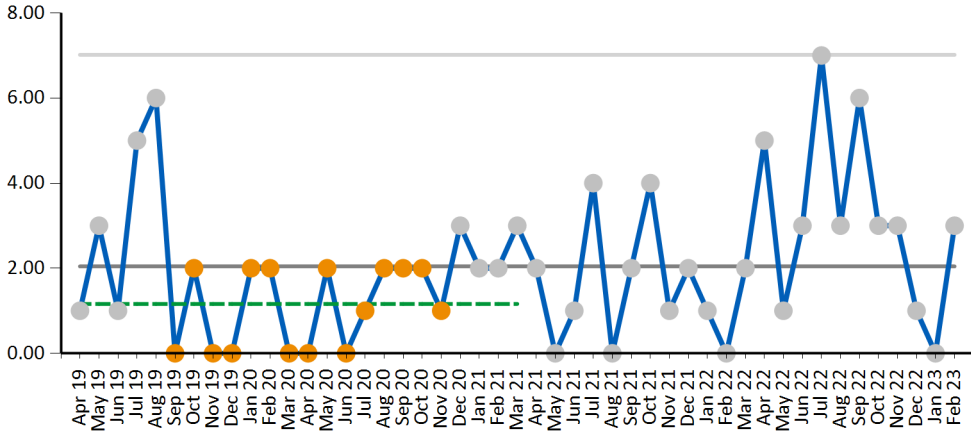
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		2	Feb-23	(variation)		8	Jan-23		88	
346 - Total Community Onset Hospital Associated C.diff infections		3	Feb-23	(variation)		0	Jan-23		35	
347 - Total C.diff infections contributing to objective	<= 7	5	Feb-23	(variation)	<= 7	8	Jan-23	<= 73	110	(?)
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Feb-23	(variation)	= 0	0	Jan-23	= 0	21	(?)
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	8	Feb-23	(variation)	<= 2	2	Jan-23	<= 20	57	(?)
219 - Blood Culture Contaminants (rate)	<= 3%	2.8%	Feb-23	(variation)	<= 3%	2.5%	Jan-23	<= 3%	3.1%	(?)
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	1.0	Feb-23	(variation)	<= 1.0	1.0	Jan-23	<= 11.0	26.0	(?)
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	3	Feb-23	(variation)	<= 1	0	Jan-23	<= 6	23	(?)

13/54

39/230

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Feb-23		= 0	1	Jan-23	= 0	7	
491 - Nosocomial COVID-19 cases		85	Feb-23			28	Jan-23		522	

215 - Total Hospital Onset C.diff infections
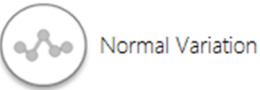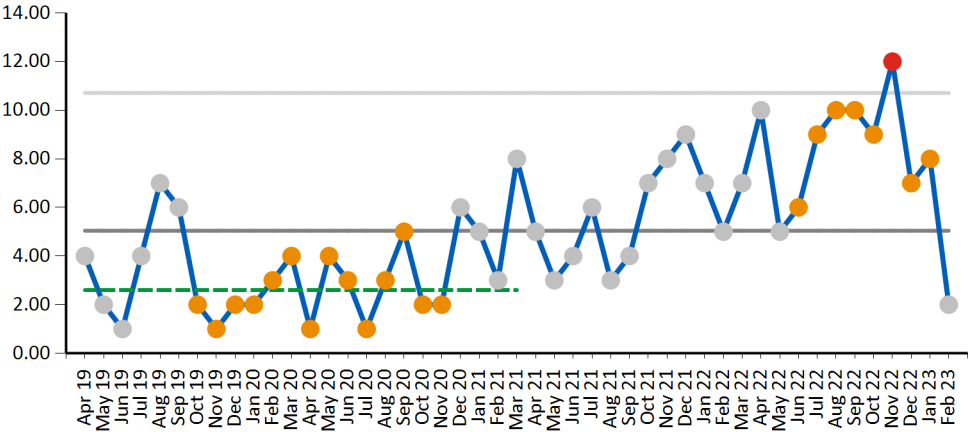
Normal Variation

346 - Total Community Onset Hospital Associated C.diff infections

Normal Variation

347 - Total C.diff infections contributing to objective

Normal Variation

We will not regularly meet the target due to normal variation.

1/6
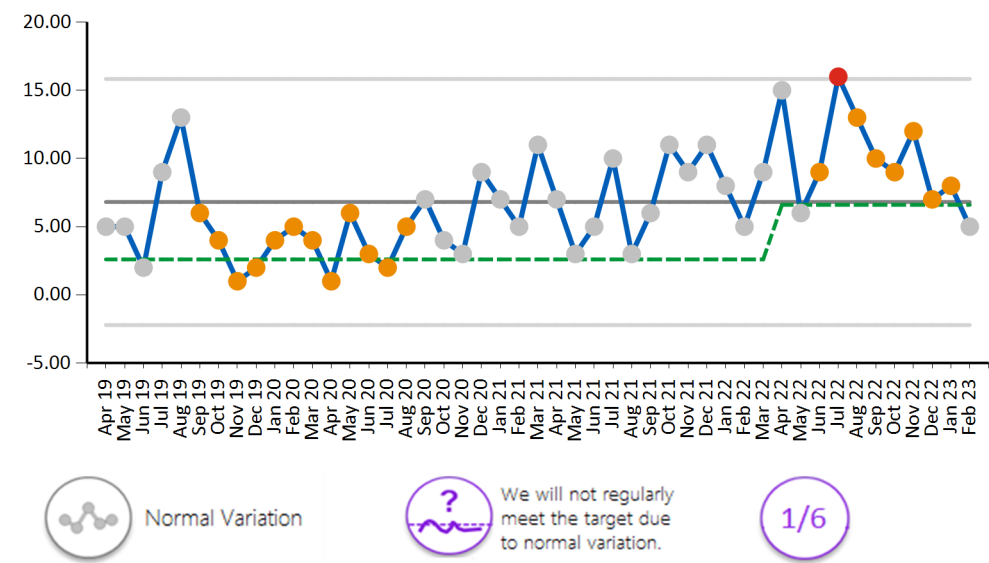
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)
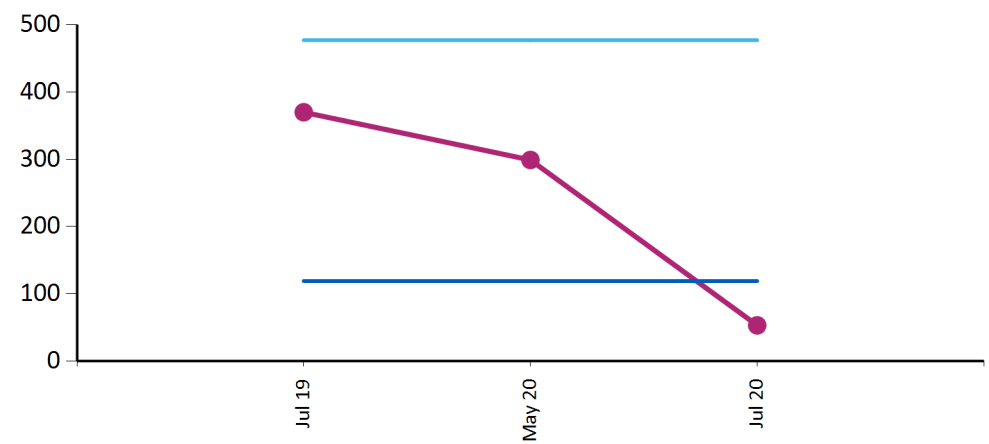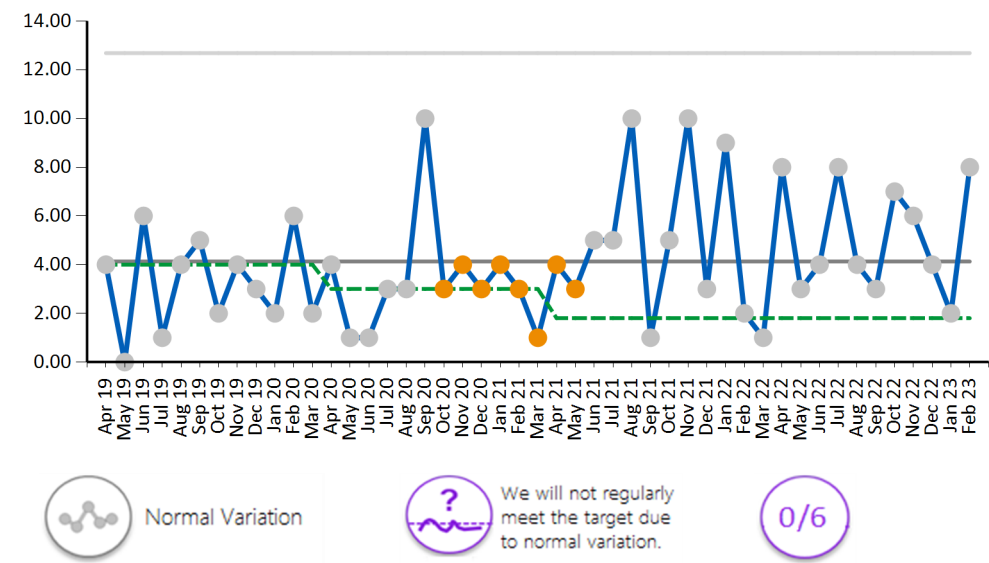
Jul 19   May 20   Jul 20

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

Normal Variation

We will not regularly meet the target due to normal variation.

0/6

219 - Blood Culture Contaminants (rate)

Normal Variation

We will not regularly meet the target due to normal variation.
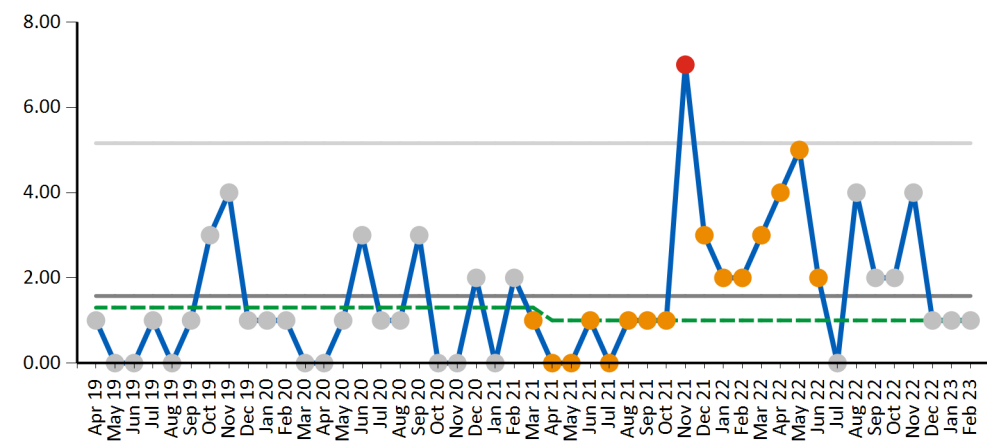
3/6

15/54
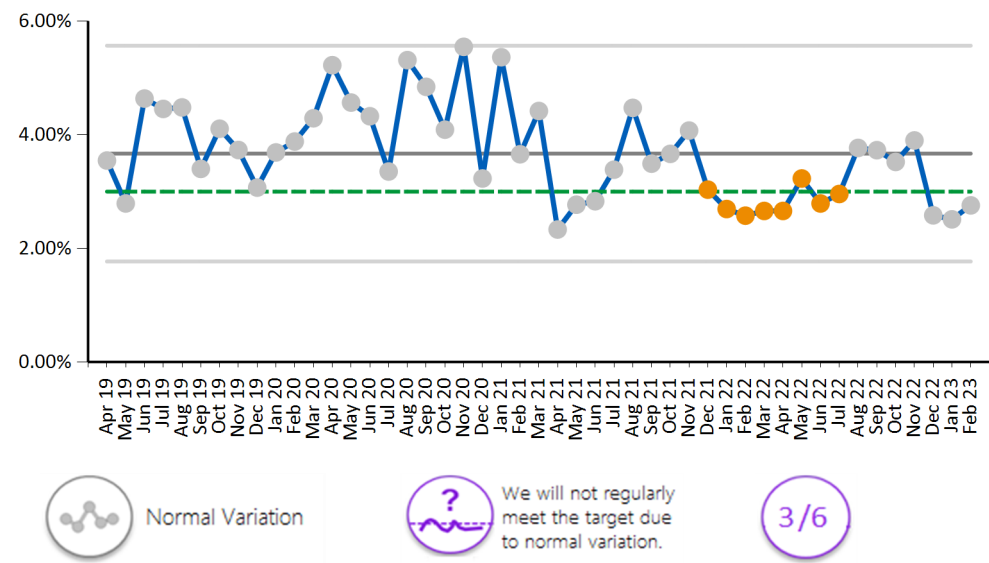
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data point
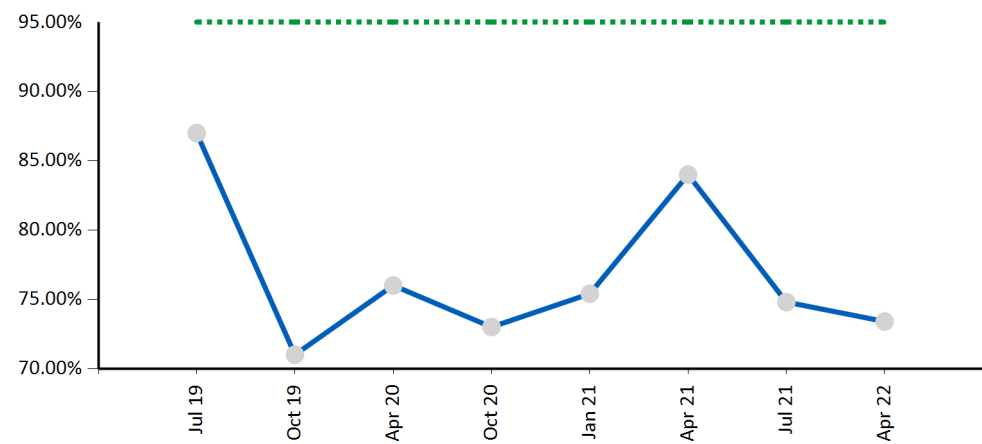
0/6

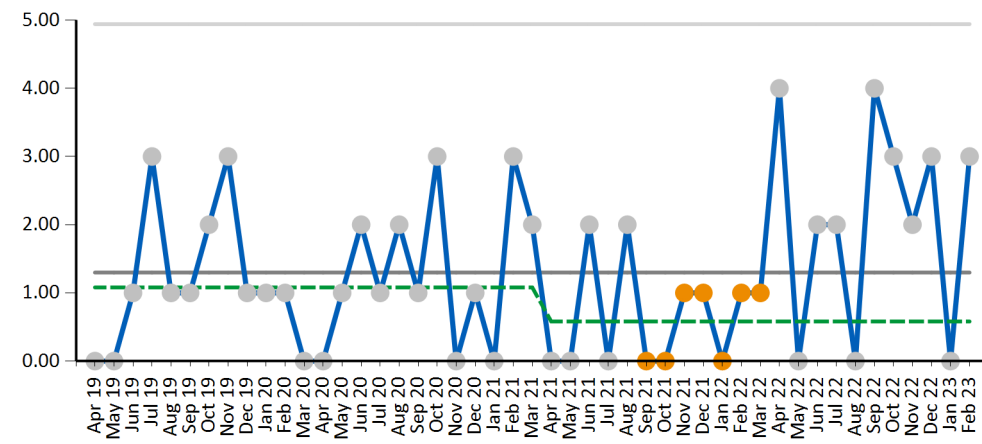## 304 - Total Trust apportioned MSSA BSIs

Normal Variation

We will not regularly meet the target due to normal variation.

3/6

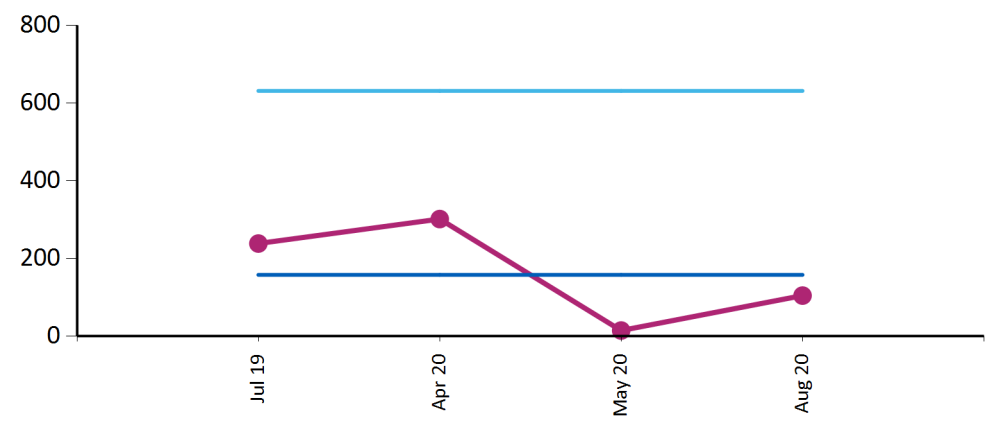## 305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)
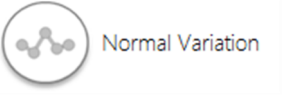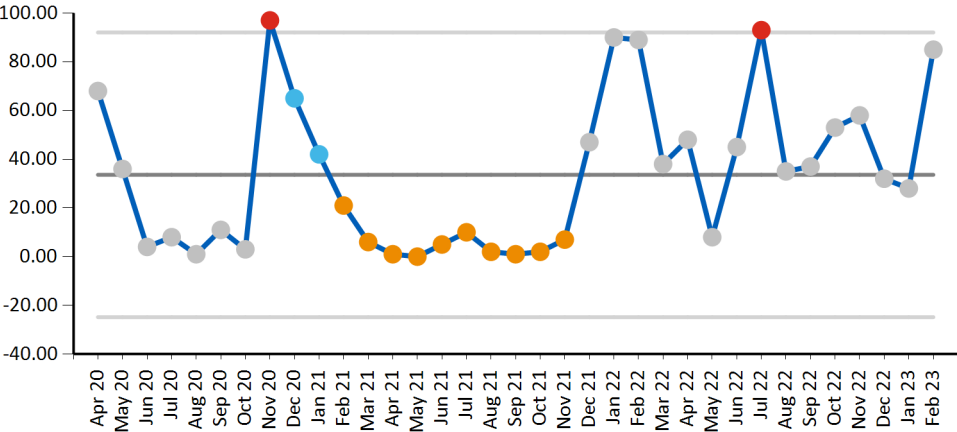

Normal Variation

We will not regularly meet the target due to normal variation.

1/6

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

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491 - Nosocomial COVID-19 cases

Normal Variation

Mortality

Crude – in month rate is below Trust target and average for the period. The crude rate has remained in control and has been for more than two years.

HSMR – in month figure is within control limits and below average for the time frame. The 12 month average to November 2022 is 113.32, this is a 'Red' alert.

SHMI – In month figure is above the average for the time period but has remained 'in control' for more than two years. The published rolling average for the period November 2021 to October 2022 is 106.96 'as expected'.

The proportion of Charlson comorbidities and the Depth of Recording remain in control and have done for the previous seven months. However, both are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot download is above the target and average for the time frame. There has been a sustained period of 11 points above the mean since February 2022 indicating sustained improvement.

	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%	80.7%	Feb-23		>= 85%	100.0%	Jan-23	>= 85%	97.6%	
495 - HSMR		109.22	Nov-22			108.22	Oct-22		109.22	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	116.53	Sep-22		<= 100.00	110.30	Aug-22	<= 100.00	116.53	
12 - Crude Mortality %	<= 2.9%	2.3%	Feb-23		<= 2.9%	3.4%	Jan-23	<= 2.9%	2.5%	
519 - Average Charlson comorbidity Score (First episode of care)		3	Nov-22			4	Oct-22		29	
520 - Depth of recording (First episode of care)		6	Nov-22			6	Oct-22		49	
521 - Proportion of fully coded records (Inpatients)		98.2%	Dec-22			98.9%	Nov-22		98.1%	

3 - National Early Warning Scores to Gold standard
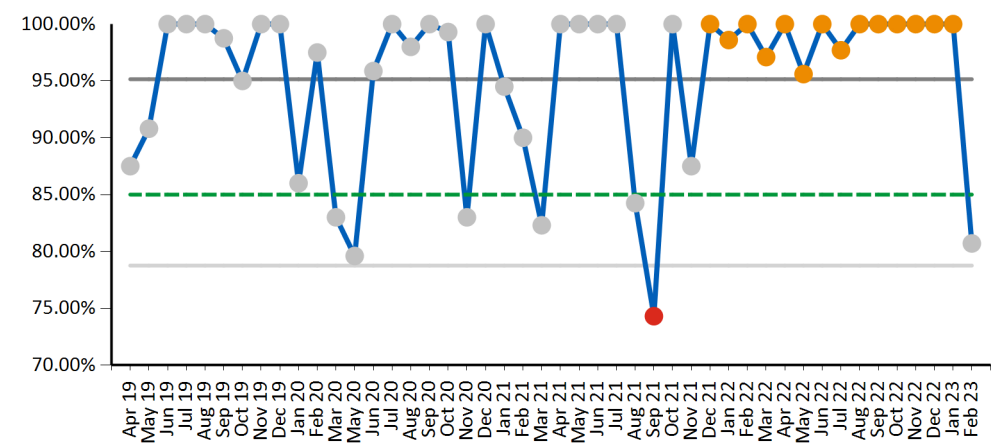
Normal Variation

We will not regularly meet the target due to normal variation.

5/6

495 - HSMR
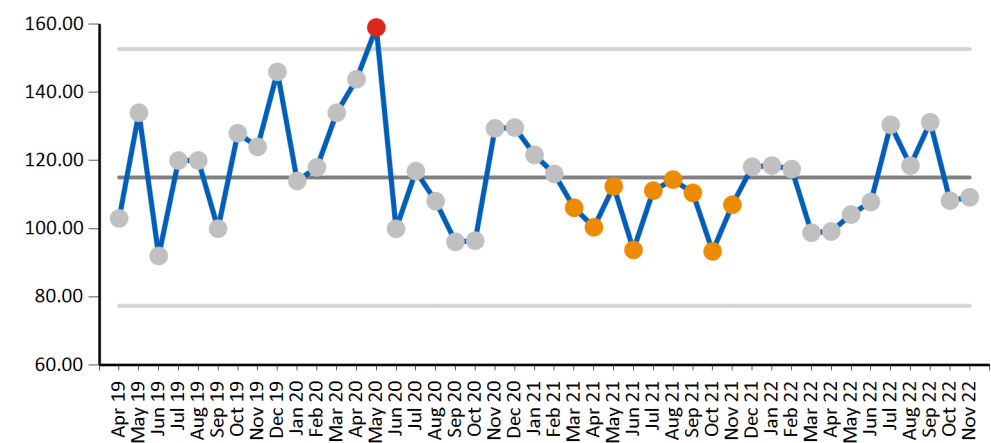
Normal Variation

11 - Summary Hospital-level Mortality Indicator (SHMI)
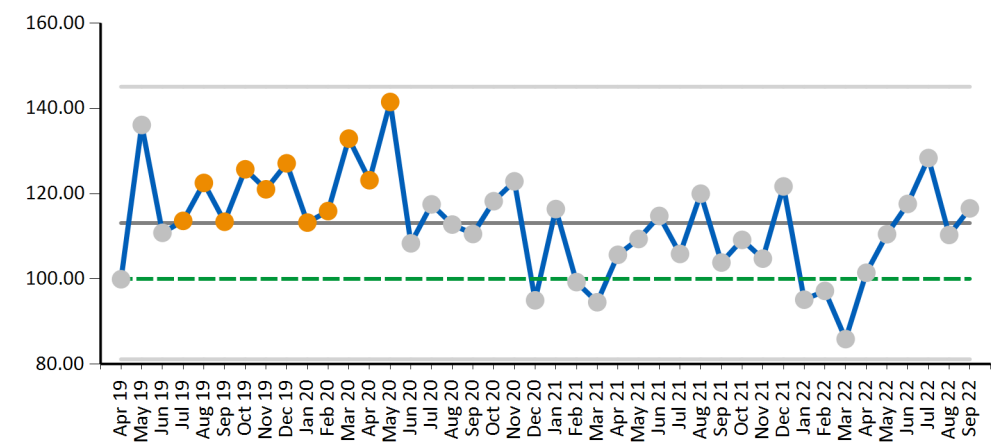
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

12 - Crude Mortality %
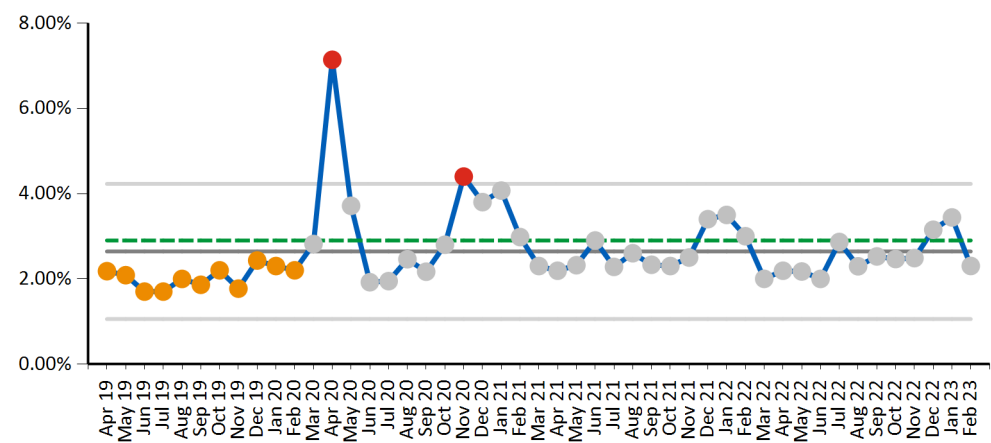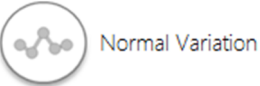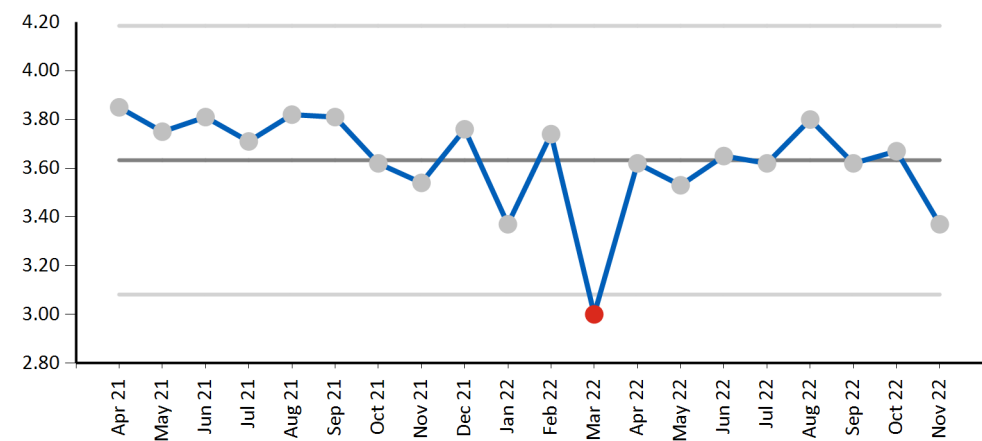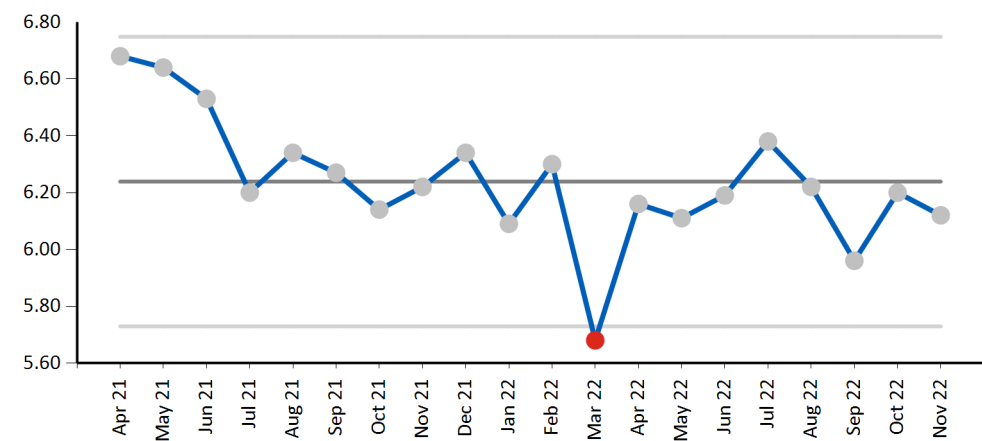

Normal Variation

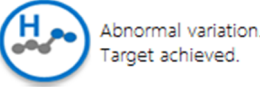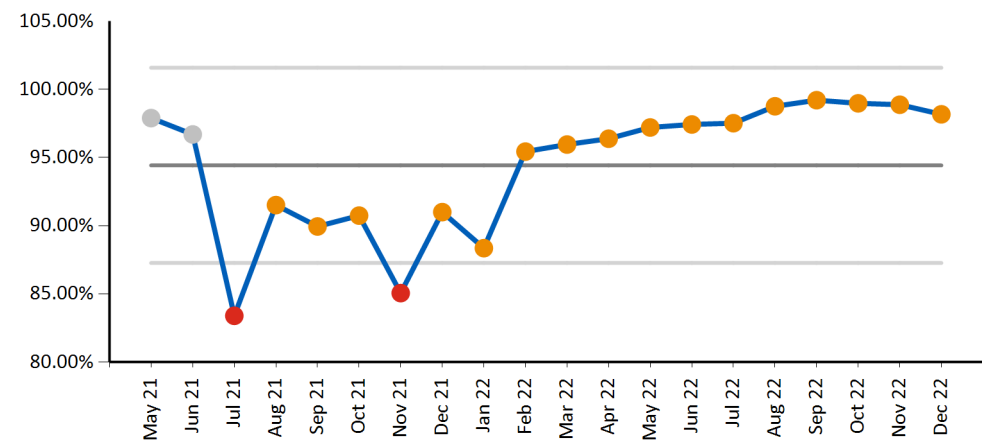We will not regularly meet the target due to normal variation.

4/6

519 - Average Charlson comorbidity Score (First episode of care)

Normal Variation

520 - Depth of recording (First episode of care)

Normal Variation

521 - Proportion of fully coded records (Inpatients)

Abnormal variation.
Target achieved.

Patient Experience

COMPLAINTS
Complaints response rates continue to indicate a special cause variation concern with 53.3% of complaints responded to within timescales against a target of 95%. February 2023 responses showed a decline on the previous month, this remains within standard variation in the lower limit.

Focused work continues to be undertaken to reduce the overall number of open complaints. From March 2023, complainants are supported from the outset to agree a list of specific questions to aid in a more focussed investigation and response. A change to the point in the process where DDO approval has been provided commenced also on 20th March 2023. The objective of these changes is to improve the quality check process, make this more timely and ensure DDO have sight of the final complaint responses in their respective divisions.

FFT
Response rate for community postnatal is indicating a special cause variation concern however remains with process limits. Antenatal satisfaction is indicating a special cause variation concern and has fallen outside of the lower process limit.

The Patient Experience Team continue to work with all areas to encourage staff to seek feedback and identify alternative means for patients to provide feedback. Where recommendation rates fell below 90%, Divisional Nurse Directors and Governance Leads are working on the narrative provided with the feedback to identify learning outcomes. All ward managers and matrons have access to the database to enable real time monitoring of response and recommendation rates and to act on the narrative feedback provided. Access is being widened to DNDs and other Senior Managers. In some areas, administrative staff have been identified to support collection and inputting to ensure this is in as close to real time as possible.

| Outcome Measure | Latest | | | | Previous | | | Year to Date | | Target |
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	22.4%	Feb-23		>= 20%	15.8%	Jan-23	>= 20%	14.8%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	87.1%	Feb-23		>= 90%	87.9%	Jan-23	>= 90%	81.8%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	27.3%	Feb-23		>= 30%	19.9%	Jan-23	>= 30%	23.5%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.4%	Feb-23		>= 90%	95.7%	Jan-23	>= 90%	96.6%	P
81 - Maternity Friends and Family Response Rate	>= 15%	24.6%	Feb-23		>= 15%	17.0%	Jan-23	>= 15%	17.9%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	93.3%	Feb-23		>= 90%	86.6%	Jan-23	>= 90%	86.6%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	20.9%	Feb-23	H	>= 15%	0.9%	Jan-23	>= 15%	8.7%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	99.0%	Feb-23		>= 90%	80.0%	Jan-23	>= 90%	87.8%	?

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
83 - Birth - Friends and Family Response Rate	>= 15%	34.9%	Feb-23	(Normal Variation)	>= 15%	29.6%	Jan-23	>= 15%	31.1%	(P)
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	92.5%	Feb-23	(Normal Variation)	>= 90%	87.7%	Jan-23	>= 90%	87.7%	(?)
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	25.2%	Feb-23	(Normal Variation)	>= 15%	28.9%	Jan-23	>= 15%	17.7%	(?)
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	86.6%	Feb-23	(Normal Variation)	>= 90%	84.0%	Jan-23	>= 90%	81.9%	(?)
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	17.2%	Feb-23	(L)	>= 15%	13.0%	Jan-23	>= 15%	14.3%	(?)
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	92.9%	Feb-23	(Normal Variation)	>= 90%	89.6%	Jan-23	>= 90%	88.5%	(?)
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Feb-23	(H)	= 100%	100.0%	Jan-23	= 100%	99.6%	(?)
90 - Complaints responded to within the period	>= 95%	53.3%	Feb-23	(Normal Variation)	>= 95%	80.0%	Jan-23	>= 95%	39.6%	(?)

200 - A&E Friends and Family Response Rate
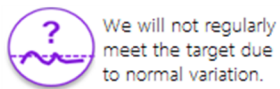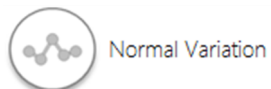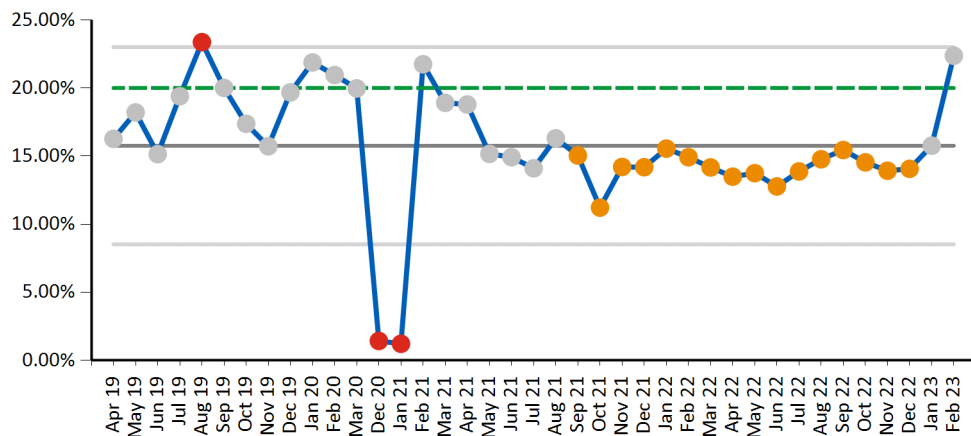
294 - A&E Friends and Family Satisfaction Rates %
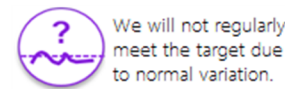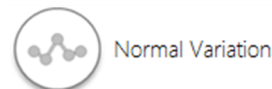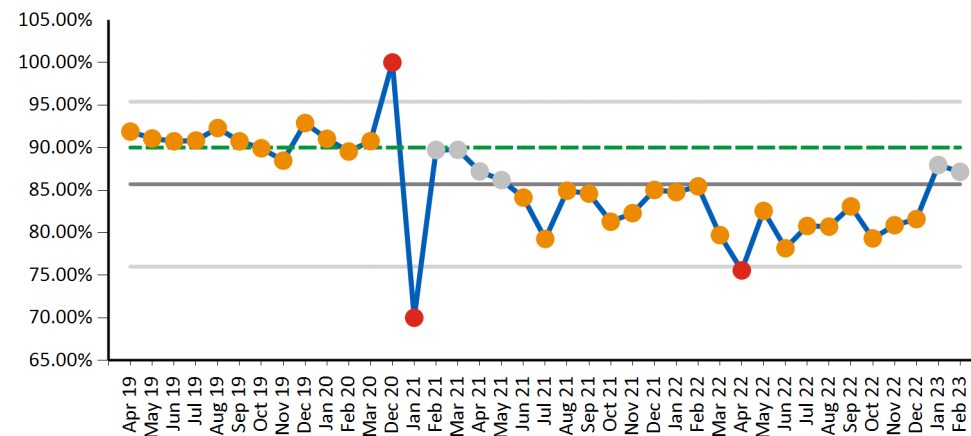
Normal Variation | We will not regularly meet the target due to normal variation. | 1/6

Normal Variation | We will not regularly meet the target due to normal variation. | 0/6

80 - Inpatient Friends and Family Response Rate
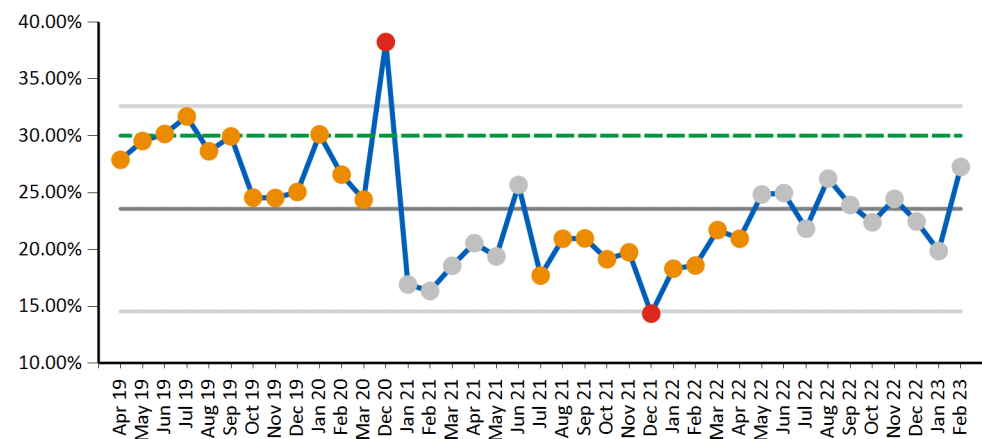
Normal Variation — We will not regularly meet the target due to normal variation. — 0/6

240 - Friends and Family Test (Inpatients) - Satisfaction %
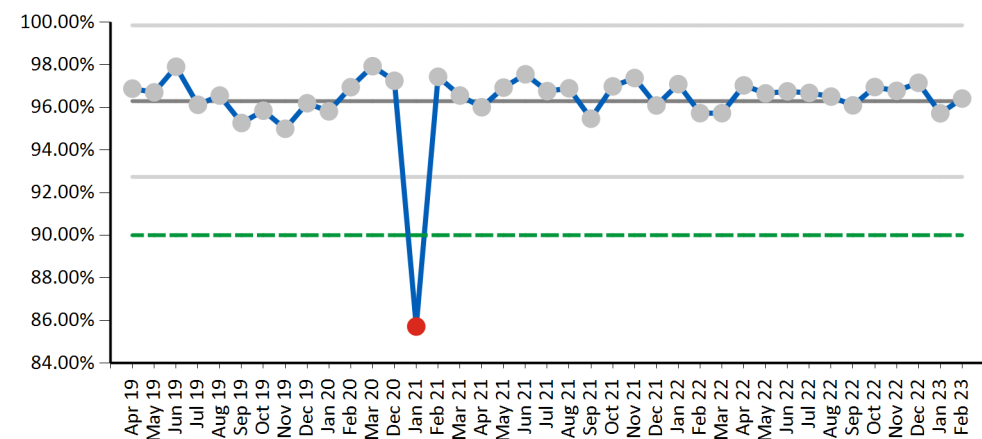
Normal Variation — Target will be regularly met. — 6/6

81 - Maternity Friends and Family Response Rate
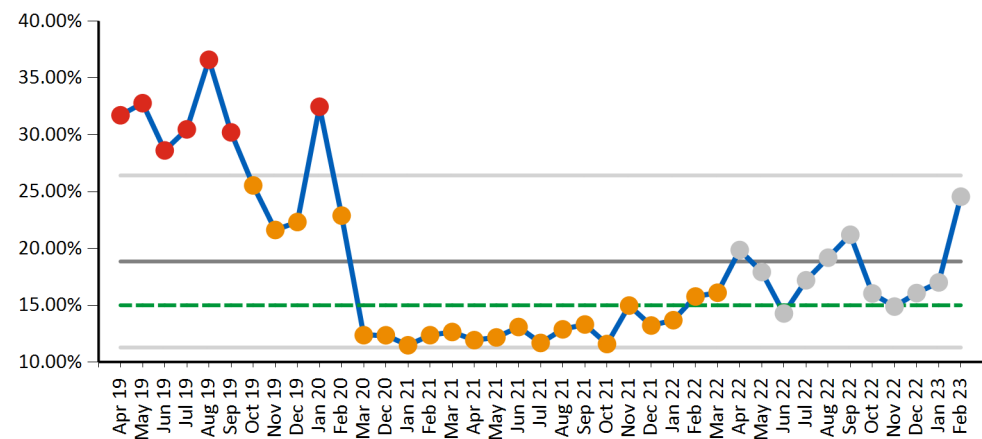
Normal Variation — We will not regularly meet the target due to normal variation. — 5/6

241 - Maternity Friends and Family Test - Satisfaction %
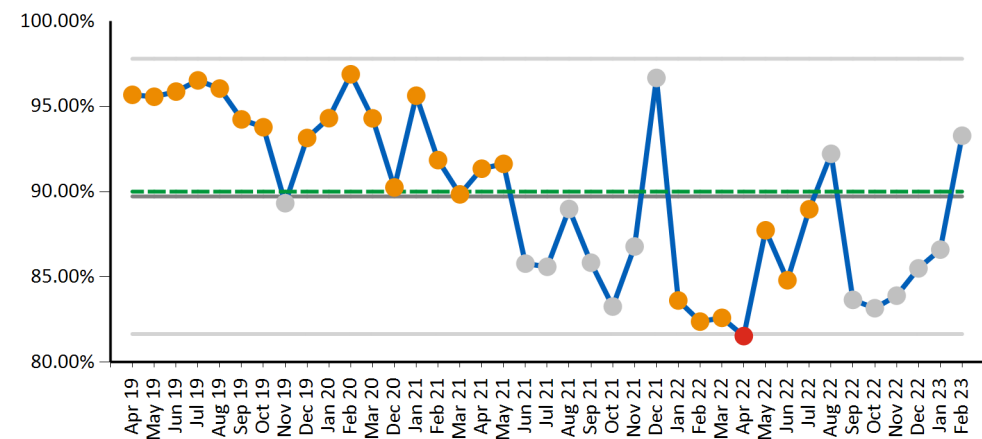
Normal Variation — We will not regularly meet the target due to normal variation. — 1/6

82 - Antenatal - Friends and Family Response Rate
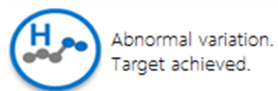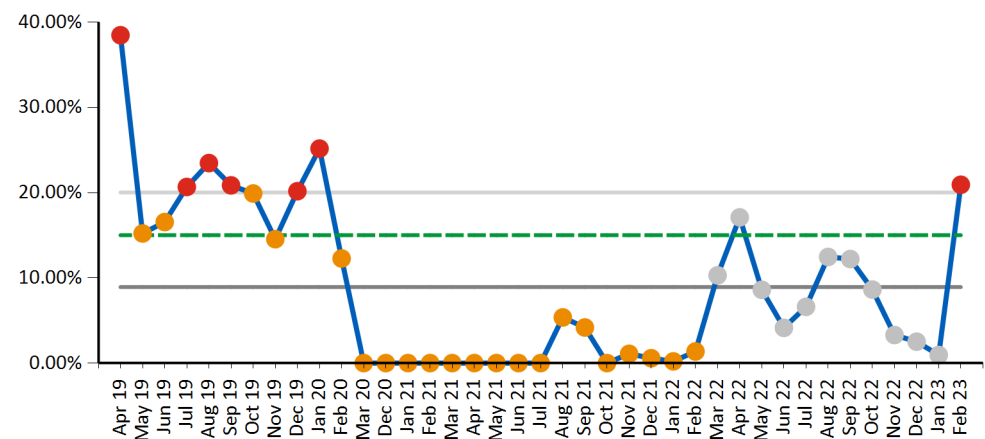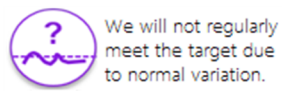
Abnormal variation. Target achieved.

We will not regularly meet the target due to normal variation.

1/6

242 - Antenatal Friends and Family Test - Satisfaction %

Normal Variation

We will not regularly meet the target due to normal variation.

3/6

83 - Birth - Friends and Family Response Rate
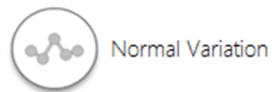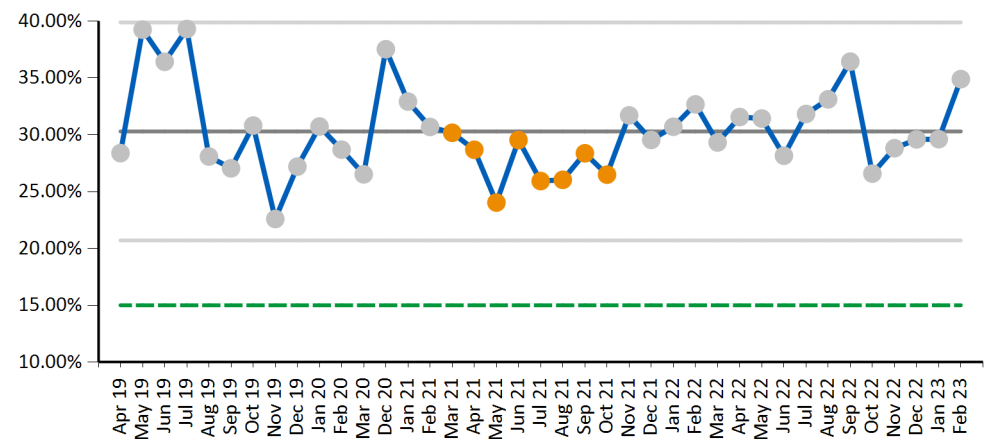
Normal Variation

Target will be regularly met.
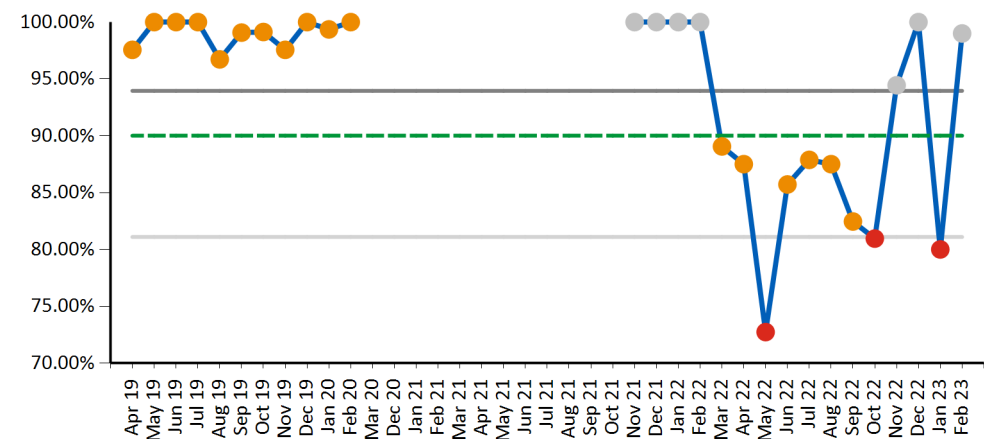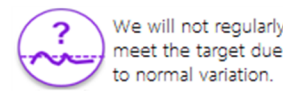
6/6

243 - Birth Friends and Family Test - Satisfaction %
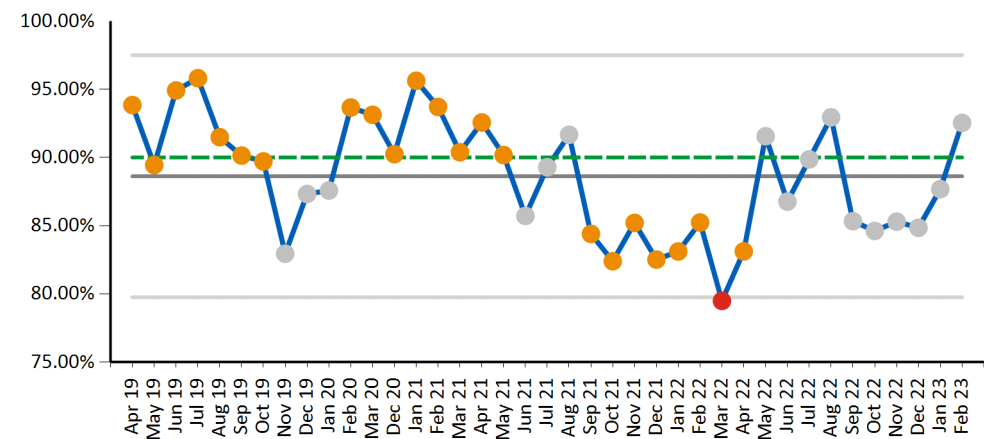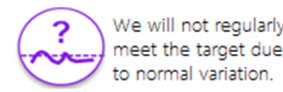
Normal Variation

We will not regularly meet the target due to normal variation.

1/6

84 - Hospital Postnatal - Friends and Family Response Rate
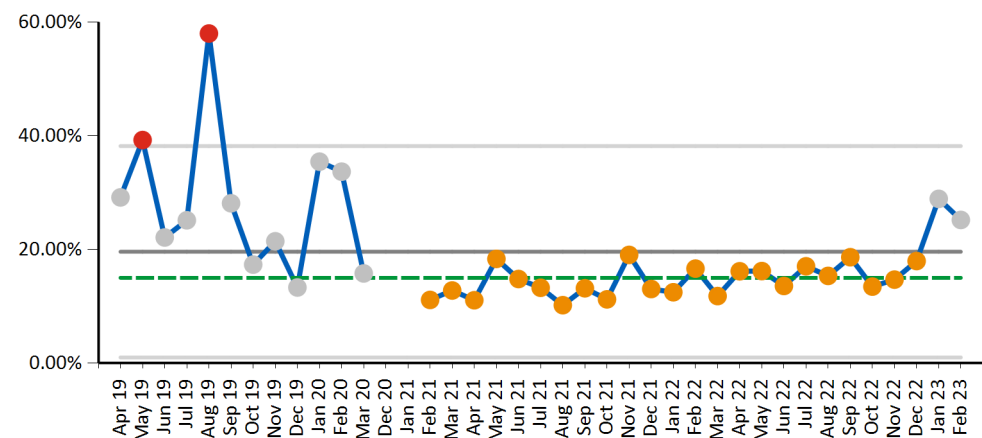
Normal Variation

We will not regularly meet the target due to normal variation.

4/6

244 - Hospital Postnatal Friends and Family Test - Satisfaction %
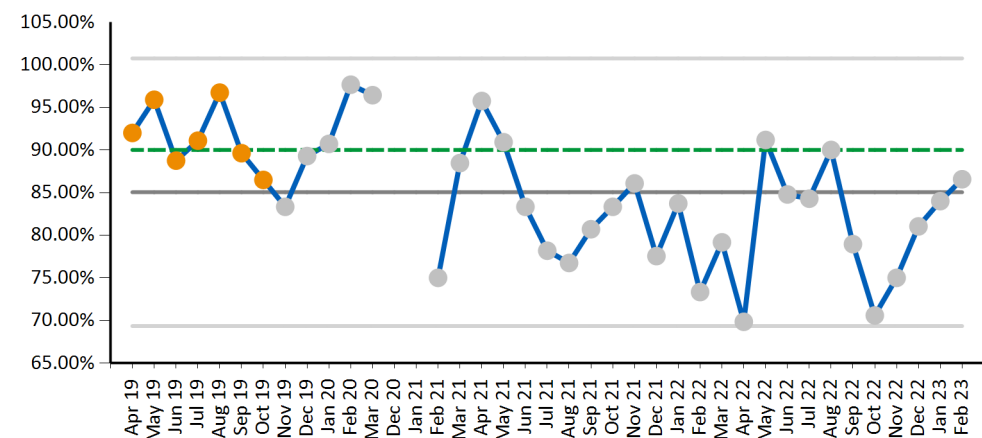
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

85 - Community Postnatal - Friend and Family Response Rate
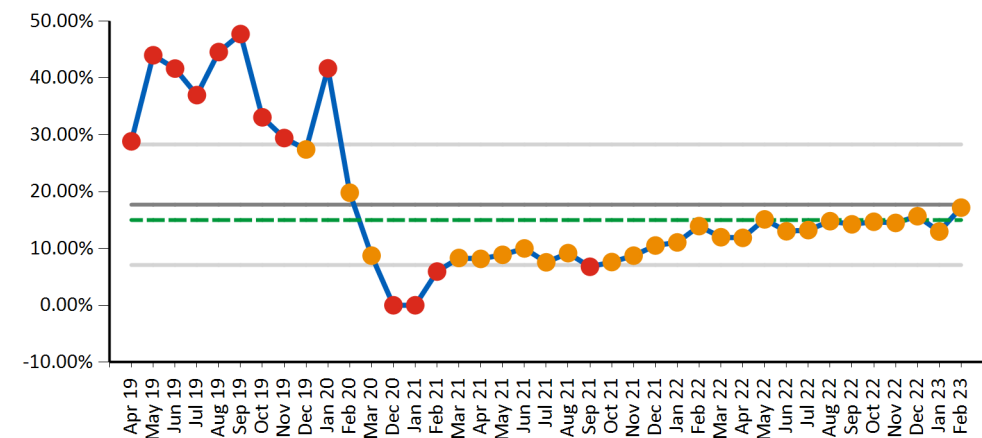
Abnormal variation. Target not achieved.

We will not regularly meet the target due to normal variation.

2/6

245 - Community Postnatal Friends and Family Test - Satisfaction %
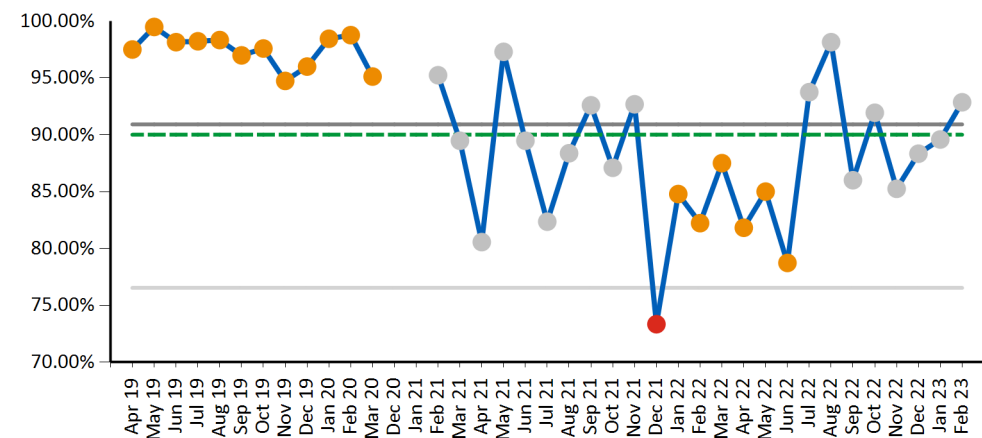
Normal Variation

We will not regularly meet the target due to normal variation.

2/6

89 - Formal complaints acknowledged within 3 working days
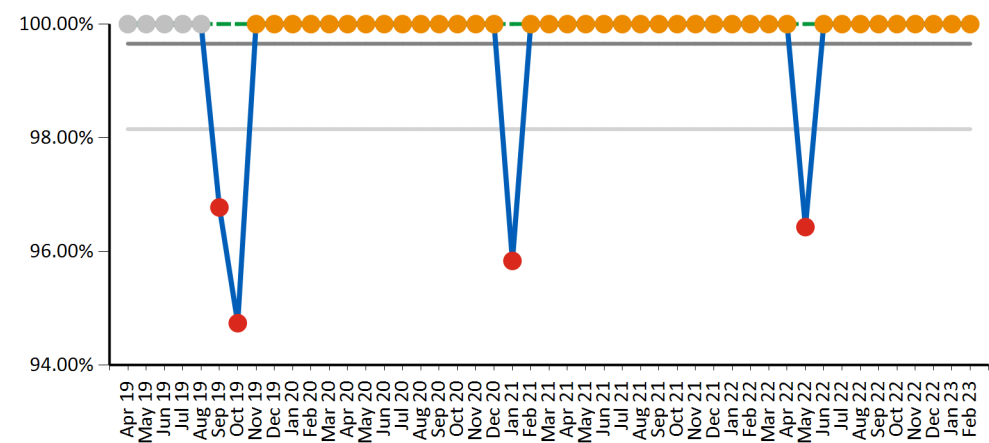
Abnormal variation. Target achieved.

We will not regularly meet the target due to normal variation.

6/6

90 - Complaints responded to within the period
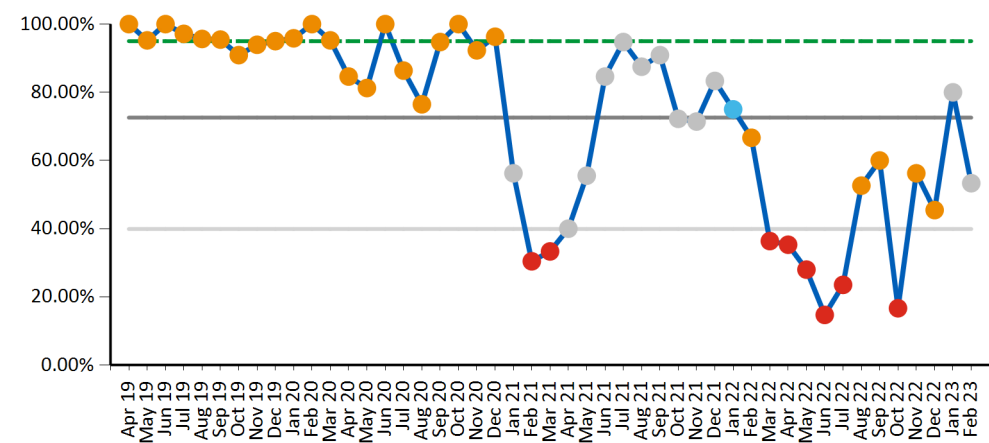
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

Maternity

Friends and Family Response Rate – Trend increased slightly in month in response rate in all areas except hospital postnatal. Satisfaction rates increased in all areas in month. Significant improvement in Antenatal response and satisfaction rate noted in month due to reintroduction of paper feedback forms temporarily replacing QR codes. Support awaited with alternative methods of data collection such as electronic fixed devices in clinic areas. KPI being added as a performance KPI to Team Leaders appraisal and progress continues to be monitored.

1:1 care in labour. Mean Trust year to date 2022 (89.76%) is lower than the Greater Manchester and East Cheshire (GMEC) mean (96.10%) and peer average mean in similar sized providers (ie Oldham). GMEC mean data only available until Dec 2022 for comparison. Delivery Suite Co-ordinator establishment increased and appointed to provide additional resilience for CNST Year 5 scheme, enabling 2 Co-ordinators to be rostered 24/7 each day.

Obstetric Anal Sphincter Injury (OASI) 3rd and 4th Degree Tears- Trend Reduced in Month (n=3), 2 associated with forceps following failed vacuum, 1 spontaneous vertex. Review of peak in the number of OASI in January completed. No clinical trends noted however sharpening of episcissors undertaken which may have led to increased rate of OASI. Greater Manchester and East Cheshire (GMEC) dashboard data for November and December 2022 shows Trust higher than median rates of % episiotomies for all vaginal births and % of episcissors used. Trust mean for 2022 (3.32%), higher than GMEC mean (2.74%), and comparative sized providers (Ie Oldham). MDT Task and Finish Group re-established to review use of episcissors and focus on local training and support for Midwives and Obstetricians

Booked by 12+6 – Inconsistent performance continues with a slight increase in trend from previous month. Community midwifery staffing remains challenging with Registered Midwife vacancy of 13.60wte within the five teams. Deficit impacting upon the team's ability to flex availability and offer weekend/evening clinics for booking that positively influence the 12+6 compliance. Late community midwifery shift removed from staffing template to optimise ability to cover community activity and plan made to merge community rosters to enable flex of cover between teams. Trust mean for 12+6 (87.60%) slightly higher than GMEC median (85.55% Dec 2022 data). Midwifery led recruitment campaign in progress.

Breastfeeding initiation – Infant feeding team have had reduced capacity as team members have been working clinically to maintain safe staffing levels in service. Tongue tie clinics have been restricted to two per week to increase support that can be provided. Staff training cancelled due to midwifery staffing challenges. Authorisation given for additional infant feeding support workers to be recruited to increase support being provided on the wards and focus on staff training. Trust mean (65.95%) slightly higher than GMEC mean (58.70%) for 2022.

Maternity Stillbirth Rate –Review of perinatal mortality tool process ongoing to strengthen governance and oversight. Trust 2022 mean 3.46/1000 rate lower than GMEC 2022 mean of 4.38/1000 and comparative sized providers (ie Oldham)

Additional Information – Total caesarean section rate – No confirmation received regarding introduction of Robson score as yet. GMEC dashboard highlights that rate of caesarean section higher in Tier 3 units ie Manchester Foundation Trust, Bolton and Oldham due to higher acuity casemix. Bolton total caesarean section number comparable with similar sized provider approx. 2000 per year.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	2.67	Feb-23	⚬⚬⚬	<= 3.50	8.99	Jan-23	<= 3.50	4.46	?
23 - Maternity -3rd/4th degree tears	<= 3.5%	1.4%	Feb-23	⚬⚬⚬	<= 3.5%	6.4%	Jan-23	<= 3.5%	3.4%	?
202 - 1:1 Midwifery care in labour	>= 95.0%	98.5%	Feb-23	⚬⚬⚬	>= 95.0%	98.6%	Jan-23	>= 95.0%	98.2%	P

| Outcome Measure | Latest | | | | Previous | | | Year to Date | | Target |
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
203 - Booked 12+6	>= 90.0%	87.7%	Feb-23	⌀	>= 90.0%	82.7%	Jan-23	>= 90.0%	86.8%	?
204 - Inductions of labour	<= 40%	36.8%	Feb-23	⌀	<= 40%	38.8%	Jan-23	<= 40%	36.1%	?
210 - Initiation breast feeding	>= 65%	66.94%	Feb-23	⌀	>= 65%	67.73%	Jan-23	>= 65%	65.11%	?
213 - Maternity complaints	<= 5	2	Feb-23	⌀	<= 5	3	Jan-23	<= 55	38	?
319 - Maternal deaths (direct)	= 0	0	Jan-23	⌀	= 0	0	Dec-22	= 0	0	?
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.6%	Feb-23	⌀	<= 6%	10.3%	Jan-23	<= 6%	9.5%	?

322 - Maternity - Stillbirths per 1000 births
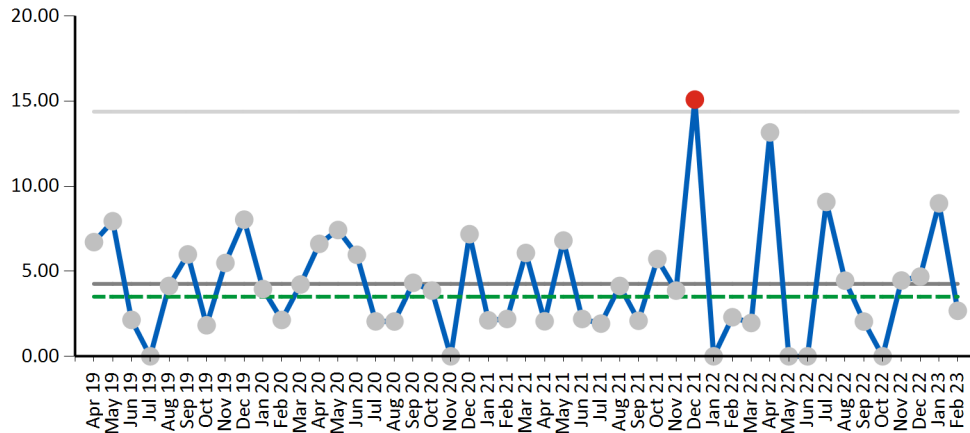
23 - Maternity -3rd/4th degree tears

Normal Variation

We will not regularly meet the target due to normal variation.

3/6
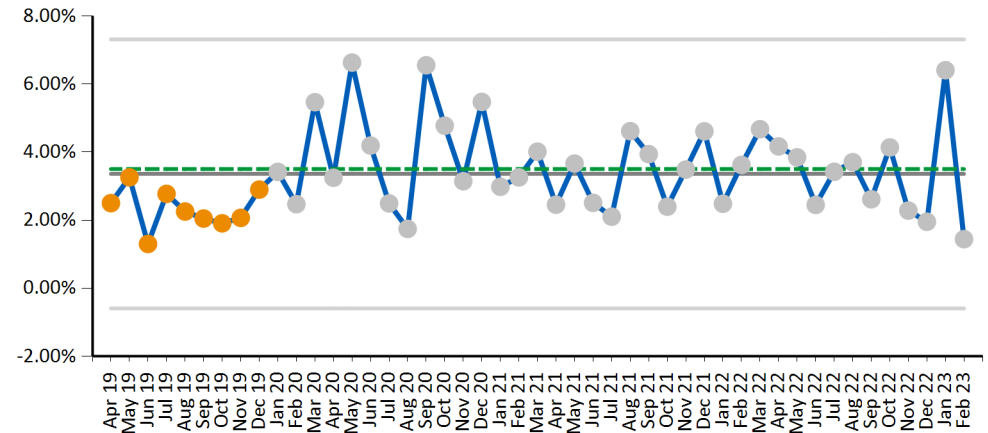
Normal Variation

We will not regularly meet the target due to normal variation.

4/6

202 - 1:1 Midwifery care in labour
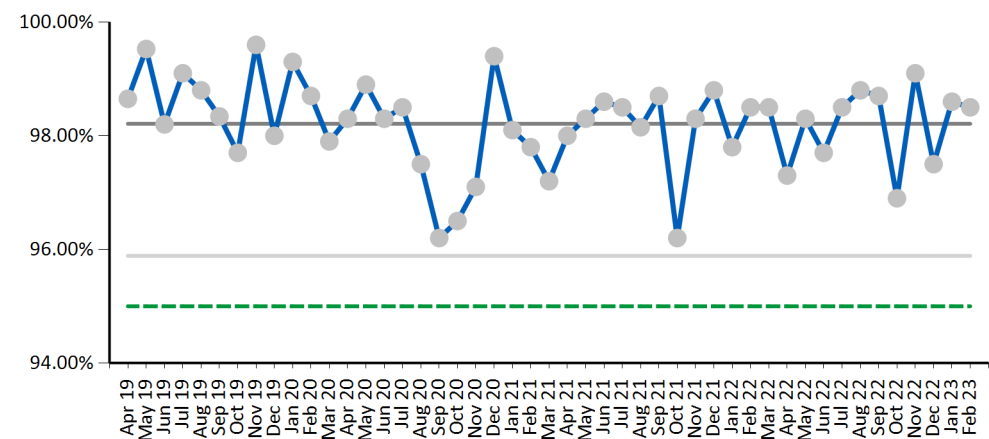
Normal Variation — (P) Target will be regularly met. — 6/6

203 - Booked 12+6
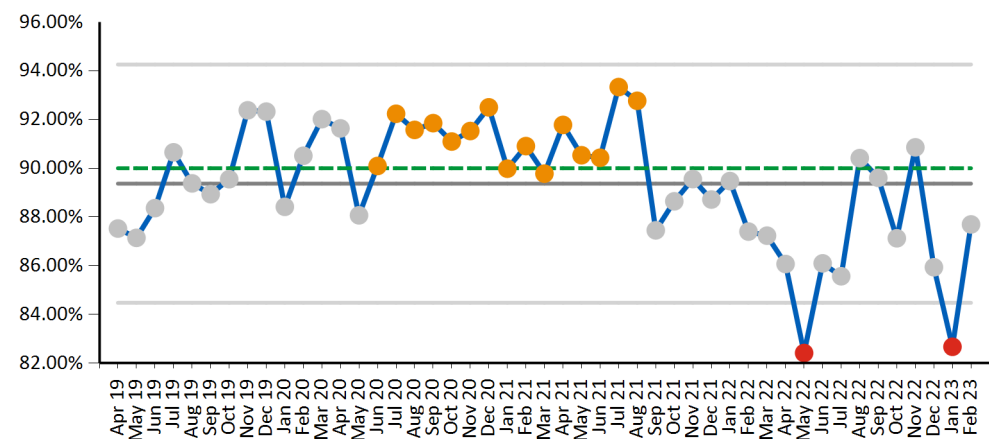
Normal Variation — (?) We will not regularly meet the target due to normal variation. — 1/6

204 - Inductions of labour
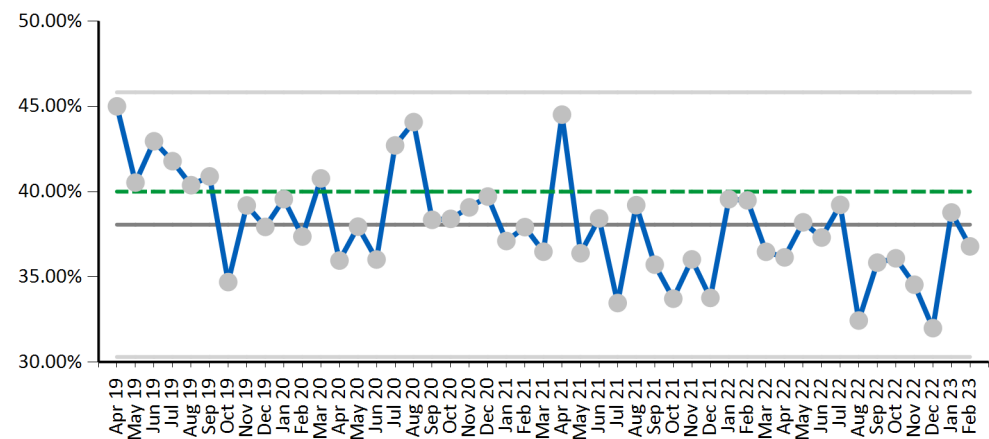
Normal Variation — (?) We will not regularly meet the target due to normal variation. — 6/6

210 - Initiation breast feeding
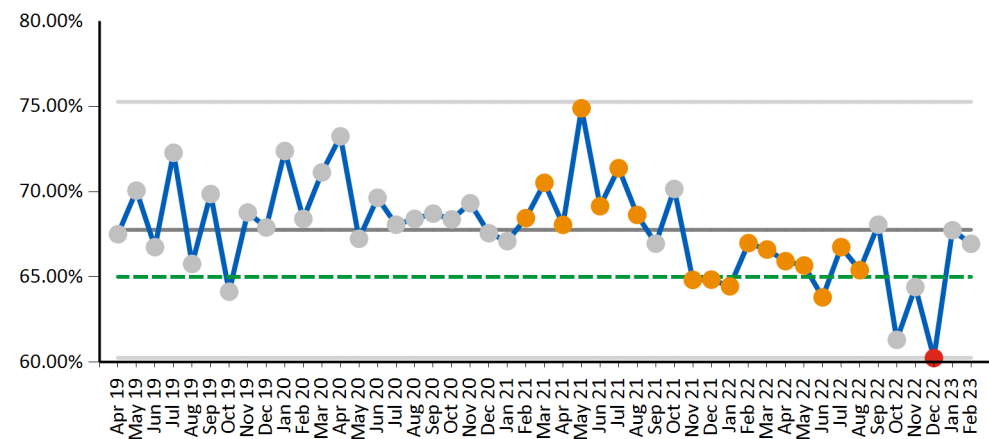
Normal Variation — (?) We will not regularly meet the target due to normal variation. — 3/6

213 - Maternity complaints
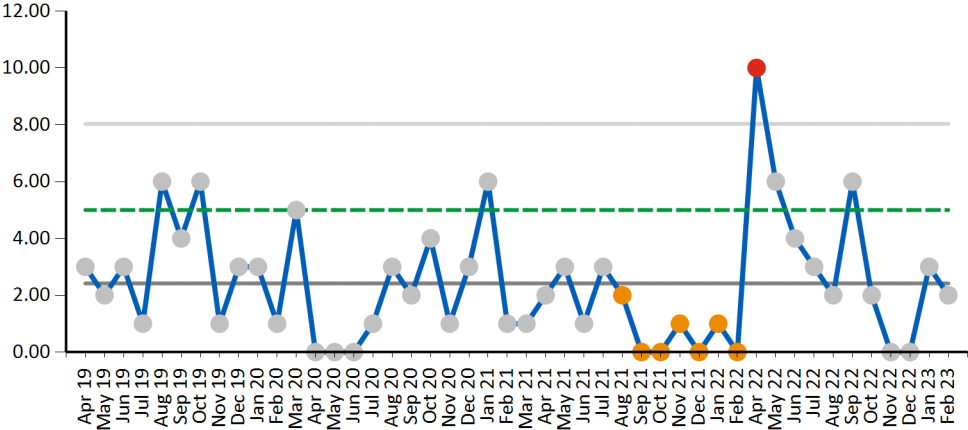
Normal Variation

We will not regularly meet the target due to normal variation.

5/6

319 - Maternal deaths (direct)
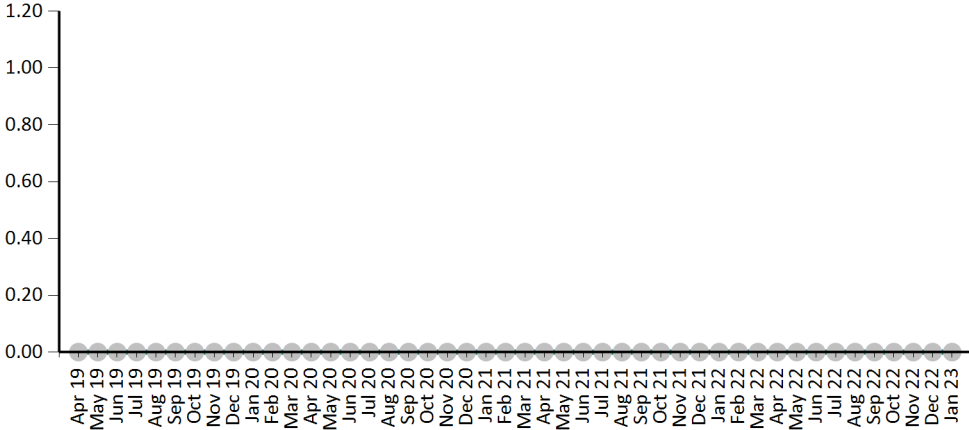
Normal Variation

We will not regularly meet the target due to normal variation.

6/6

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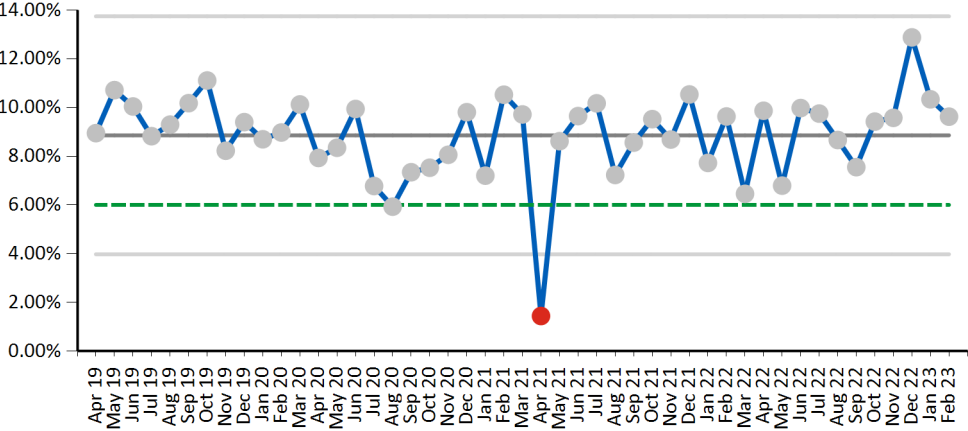
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

30/54

Operational Performance

Access

A&E
Ambulance handovers over 60 mins continued to show a slight improvement in February with a series of rapid improvement events leading on from the externally supported Quality Improvement (QI) programme.

We have aligned our ED recovery plan with the recently published 'Delivery plan for recovering urgent and emergency care services' to ensure that all aspects of the patient pathway are encompassed in one overarching improvement plan. This is a 2 year recovery plan which focuses on:

    Increasing capacity to deal with increased hospital pressures
    Growing the workforce
    Improved timely discharge
    Expand community services
    Supporting patients to access the right care first time

The early focus of ED improvement has seen an increase in performance to 64.2% against an improvement trajectory of 60%.

Diagnostics
The DM01 position for the Trust improved by a further 6.87% with the final position at 12.5%. The number of breached patients decreased by 184 (399 breaches in total).
• Endoscopy total 16.9%
• Majority of breaches occurred with cystoscopy referrals. Continued increase in 2ww referrals has had an impact on routine capacity in month. Additional weekend lists have been scheduled to facilitate additional capacity to recover position and this is ongoing.
• Imaging total 0.0%
• Maintained consistent performance in line with national targets since September 22.
• Physiological Measurements total 20.69% (reduction of 20.3% on previous month)
• Continued improvements in Cardiology with Echo now at 16.4% (reduction of 5.6% on previous month)
• Improvement in overall audiology by 39%- Paediatric Audiological services are still on track for full recovery by March 23 with a reduction in breach percentage from January by 39.8% to a performance of 29.7% in month (146 breaches vs 342 breaches previous month).
• Improvement in Urodynamics by 5.6%

RTT
78 week waiting patients continue to reduce and we are on target to achieve zero 78 week waiting patients after 1st April except for patients within the exclusion criteria who are not clinically suitable to be treated yet.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	81	Feb-23	(variation)	<= 30	91	Jan-23	<= 330	1,001	(?)
8 - Same sex accommodation breaches	= 0	14	Feb-23	(variation)	= 0	21	Jan-23	= 0	170	(F)
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	74.4%	Jan-23	(variation)	>= 75%	38.8%	Dec-22	>= 75%	50.0%	(?)

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	59.7%	Feb-23	L	>= 92%	59.5%	Jan-23	>= 92%	61.8%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	1,798	Feb-23	H	= 0	1,924	Jan-23	= 0	21,485	F
314 - RTT 18 week waiting list	<= 25,530	38,270	Feb-23	H	<= 25,530	37,798	Jan-23	<= 25,530	38,270	F
53 - A&E 4 hour target	>= 95%	64.2%	Feb-23	L	>= 95%	62.8%	Jan-23	>= 95%	58.7%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	11.9%	Feb-23	H	= 0.0%	14.9%	Jan-23	= 0.0%	15.7%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	8.20%	Feb-23	H	= 0.00%	9.53%	Jan-23	= 0.00%	14.50%	F
72 - Diagnostic Waits >6 weeks %	<= 1%	12.5%	Feb-23	L	<= 1%	19.4%	Jan-23	<= 1%	30.1%	F
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	66.7%	Feb-23		= 100%	100.0%	Jan-23	= 100%	84.0%	?

7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)
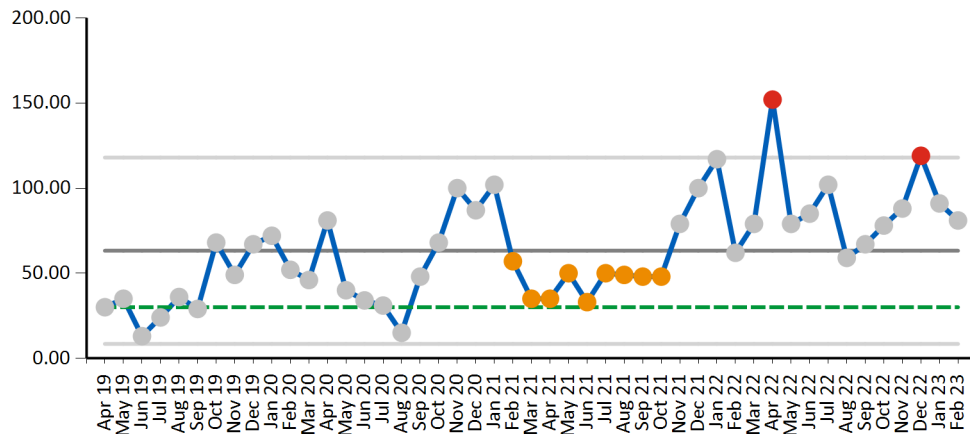
8 - Same sex accommodation breaches

Normal Variation

We will not regularly meet the target due to normal variation.

0/6
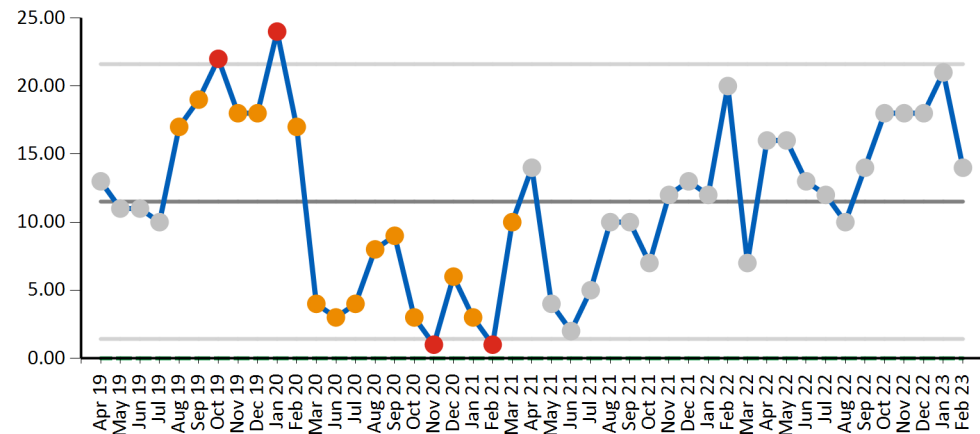
Normal Variation

We will regularly fail to meet the target.

0/6

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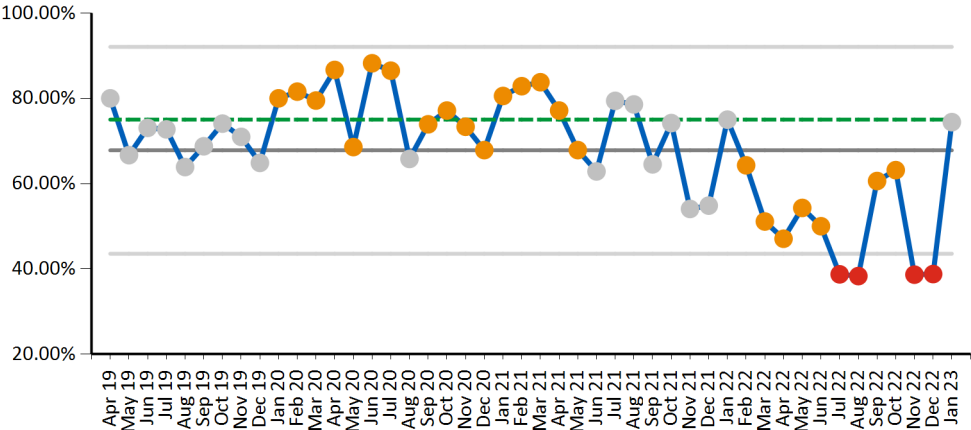
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

41 - RTT Incomplete pathways within 18 weeks %
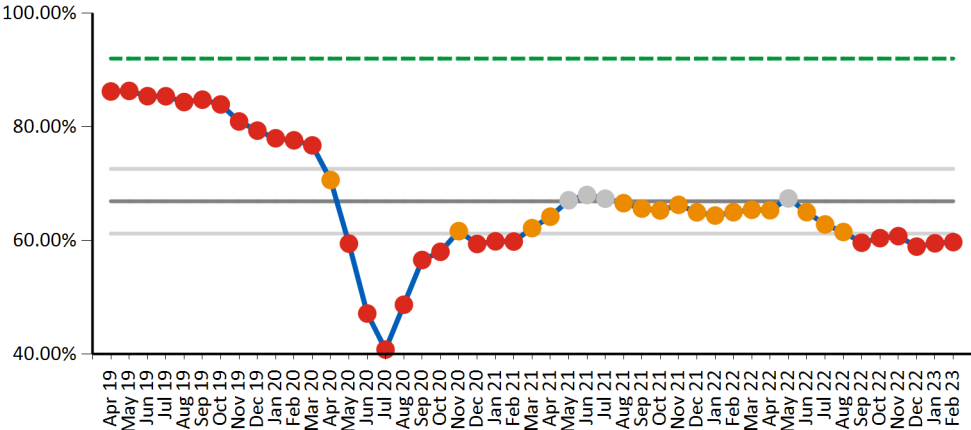
Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

42 - RTT 52 week waits (incomplete pathways)
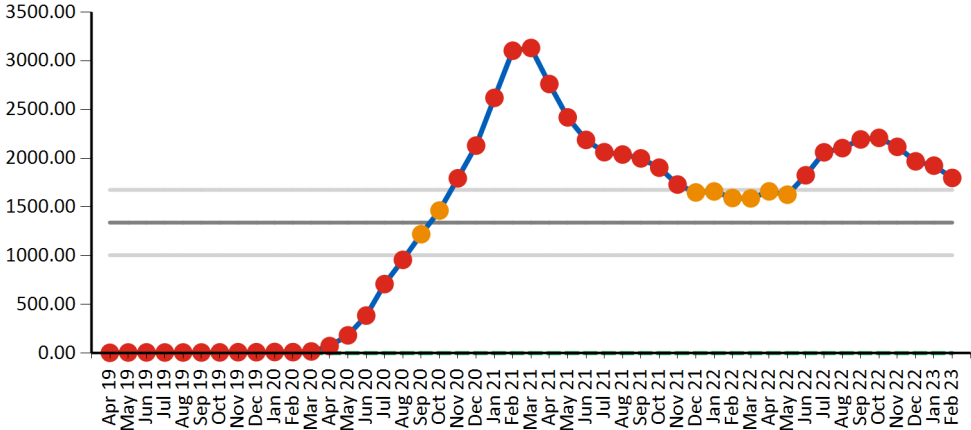
Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

314 - RTT 18 week waiting list
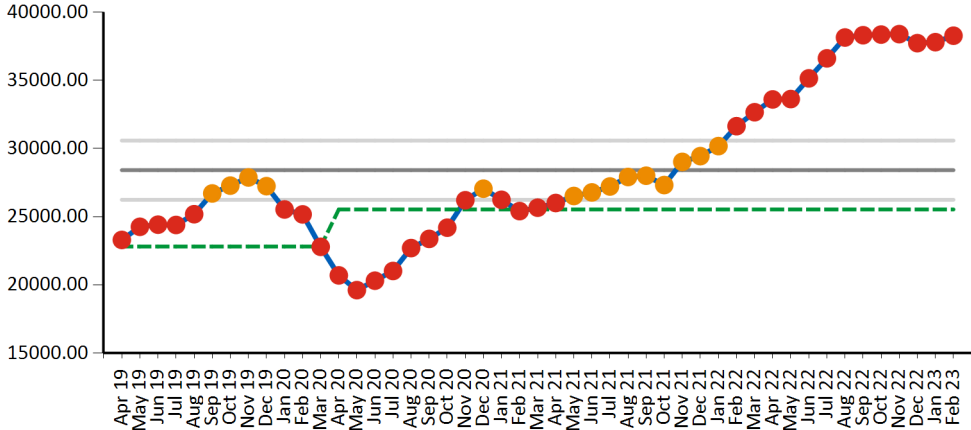
Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

53 - A&E 4 hour target
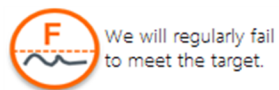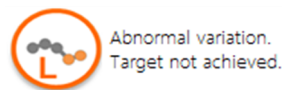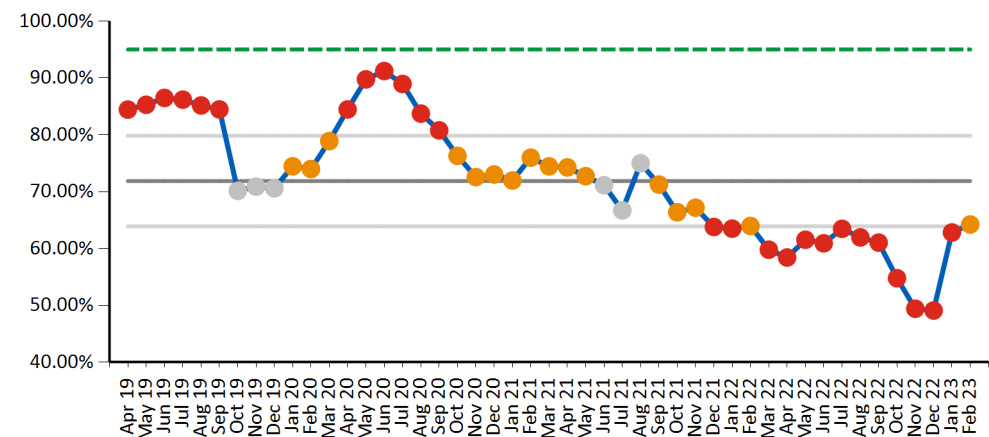
| | Abnormal variation. Target not achieved. | | We will regularly fail to meet the target. | 0/6 |

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

| | Abnormal variation. Target not achieved. | | We will regularly fail to meet the target. | 0/6 |

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

| | Abnormal variation. Target not achieved. | | We will regularly fail to meet the target. | 0/6 |

72 - Diagnostic Waits >6 weeks %

| | Abnormal variation. Target achieved. | | We will regularly fail to meet the target. | 0/6 |

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

Normal Variation

We will not regularly meet the target due to normal variation.

3/6
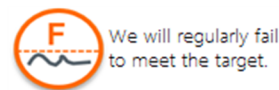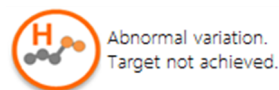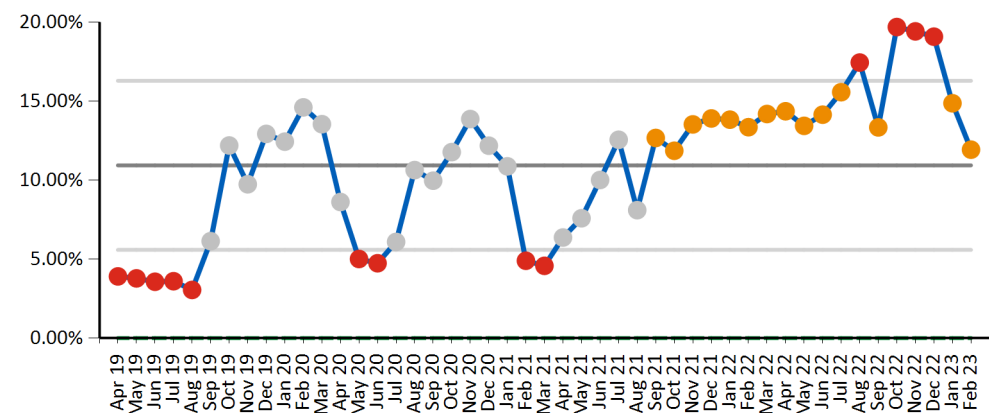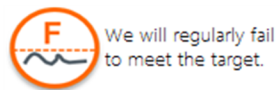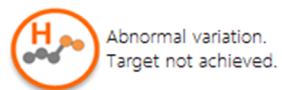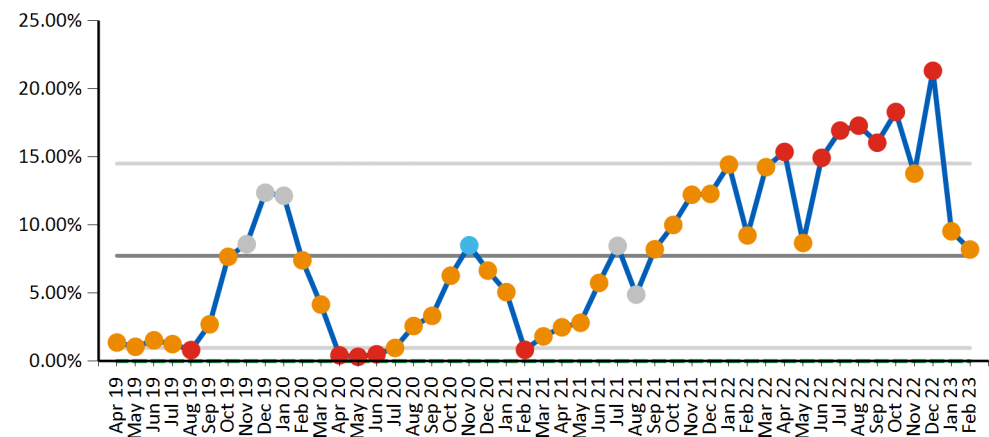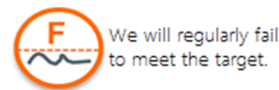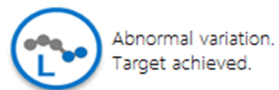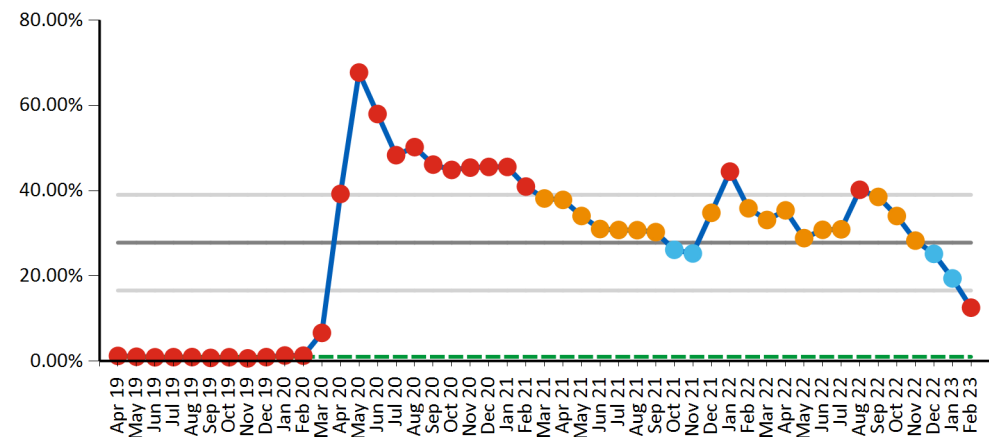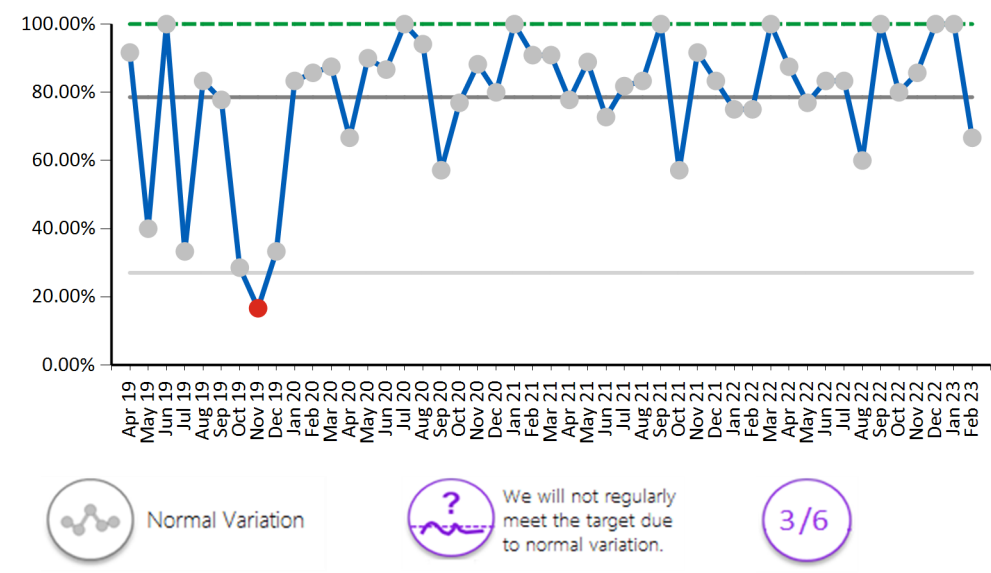
Productivity

TIA - There has been a reduction in performance due to Consultant leave and an increase in weekend referrals. We are working with SRFT to improve weekend access to TIA services with a central hub based at SRFT

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 M11 NCTR has remained static in M11 following 6 months continuous reduction. There has been a continued decrease in occupied bed days (63.8% reduction based on the same time period last year). 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 7 days.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	295	Feb-23	H	<= 200	276	Jan-23	<= 200	295	?
307 - Stranded Patients - LOS 21 days and over	<= 69	120	Feb-23	H	<= 69	107	Jan-23	<= 69	120	?
57 - Discharges by Midday	>= 30%	21.5%	Feb-23		>= 30%	20.9%	Jan-23	>= 30%	21.0%	F
58 - Discharges by 4pm	>= 70%	58.5%	Feb-23	L	>= 70%	53.2%	Jan-23	>= 70%	54.8%	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.9%	Jan-23	L	<= 13.5%	8.5%	Dec-22	<= 13.5%	9.2%	P
489 - Daycase Rates	>= 80%	91.5%	Feb-23		>= 80%	91.9%	Jan-23	>= 80%	89.6%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.4%	Feb-23		<= 1%	1.0%	Jan-23	<= 1%	1.9%	?
62 - Cancelled operations re-booked within 28 days	= 100%	16.1%	Feb-23	L	= 100%	16.0%	Jan-23	= 100%	17.6%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.76	Feb-23	H	<= 2.00	2.93	Jan-23	<= 2.00	2.97	?
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.12	Feb-23		<= 3.70	4.61	Jan-23	<= 3.70	4.33	?
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	73.3%	Jan-23		>= 80%	74.1%	Dec-22	>= 80%	72.6%	?
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision	= 0	25	Feb-23		= 0	28	Jan-23	= 0	430	F

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
493 - Average Number of Patients: with no Criteria to Reside		96	Feb-23	H		96	Jan-23	<= 405	1,203	
494 - Average Occupied Days - for no Criteria to Reside		488	Feb-23			571	Jan-23		9,644	
496 - Average bed days since patients with LOS >14 days moved onto NCTR list		384	Feb-23			482	Jan-23	>= 1,380	8,891	

56 - Stranded patients
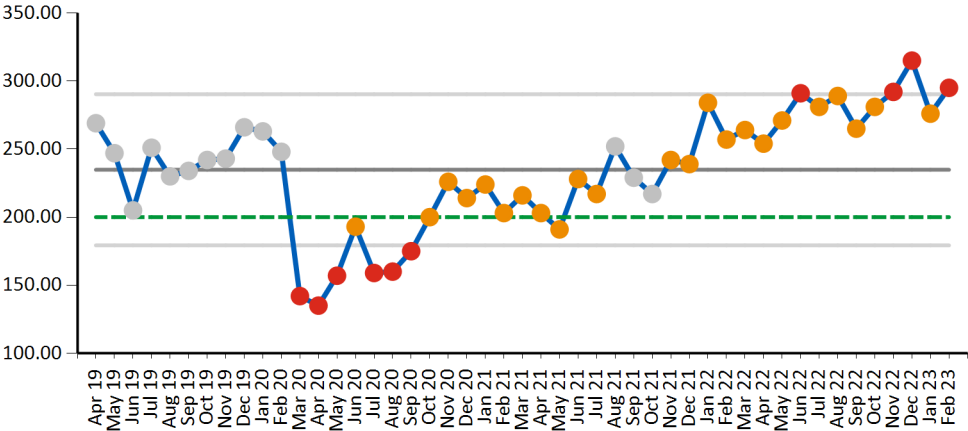
307 - Stranded Patients - LOS 21 days and over

H Abnormal variation. Target not achieved.

? We will not regularly meet the target due to normal variation.

0/6
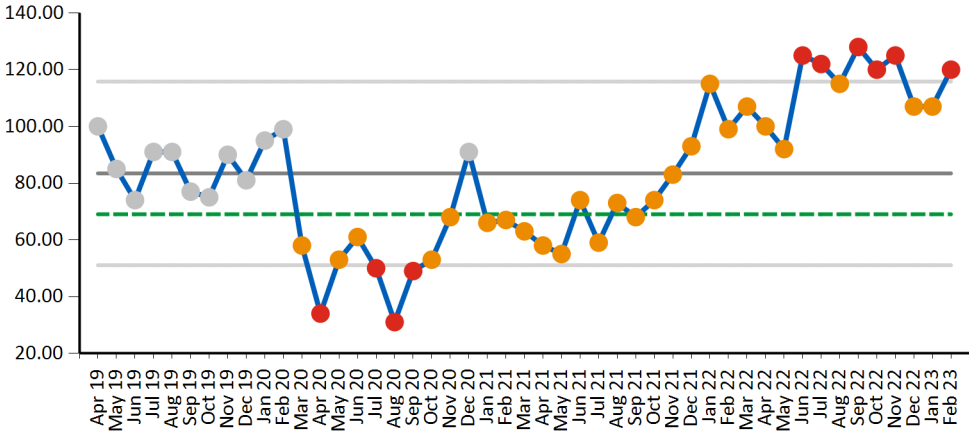
H Abnormal variation. Target not achieved.

? We will not regularly meet the target due to normal variation.

0/6

57 - Discharges by Midday
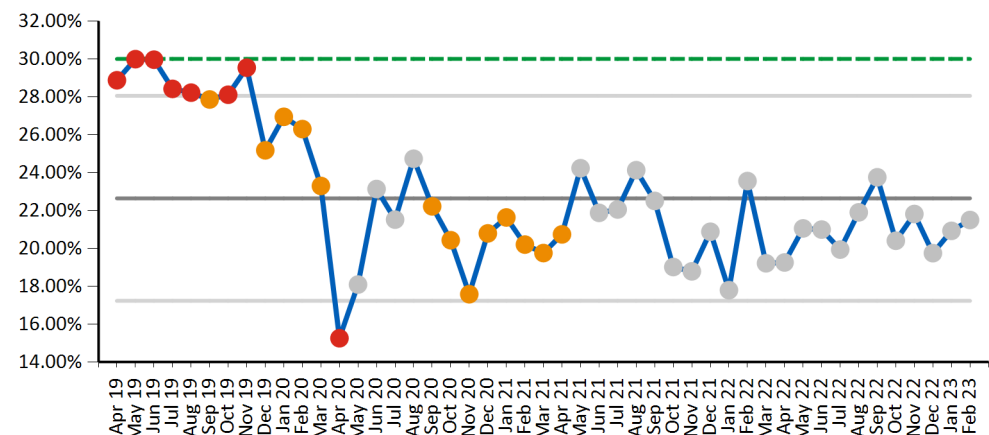
Normal Variation

F — We will regularly fail to meet the target.

0/6
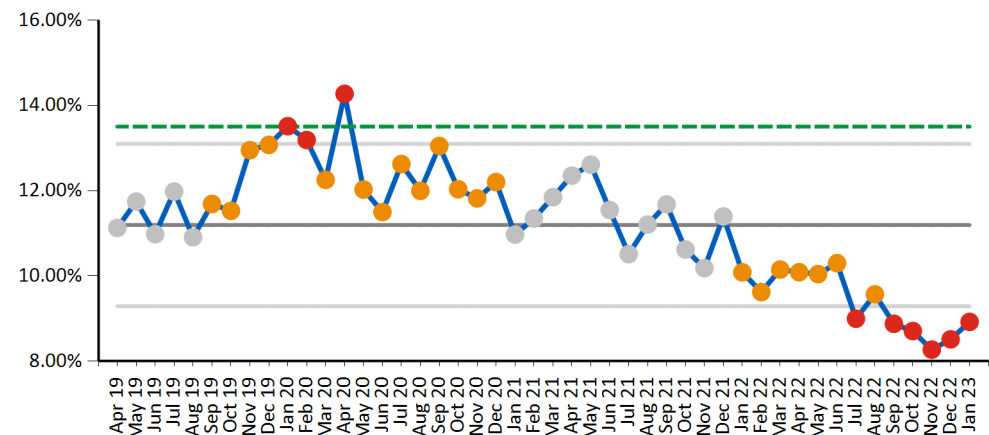
58 - Discharges by 4pm

Abnormal variation. Target not achieved.

F — We will regularly fail to meet the target.

0/6

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

Abnormal variation. Target achieved.

P — Target will be regularly met.

6/6
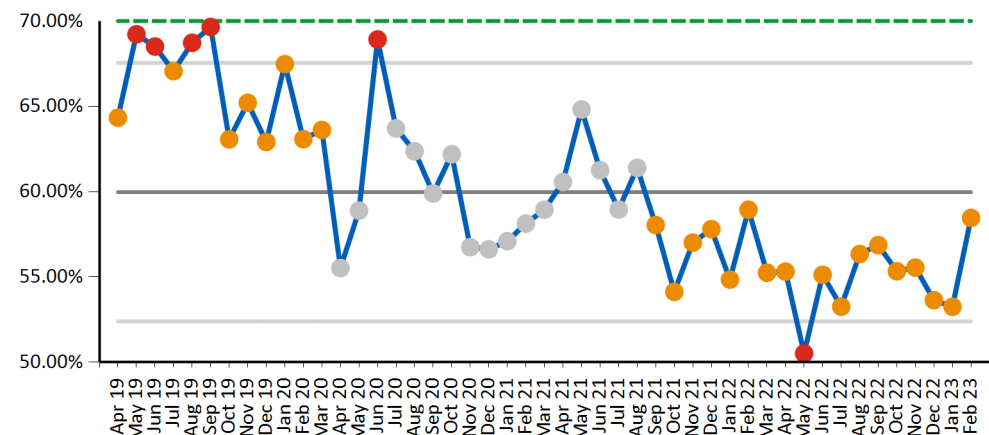
489 - Daycase Rates

Normal Variation

P — Target will be regularly met.

6/6
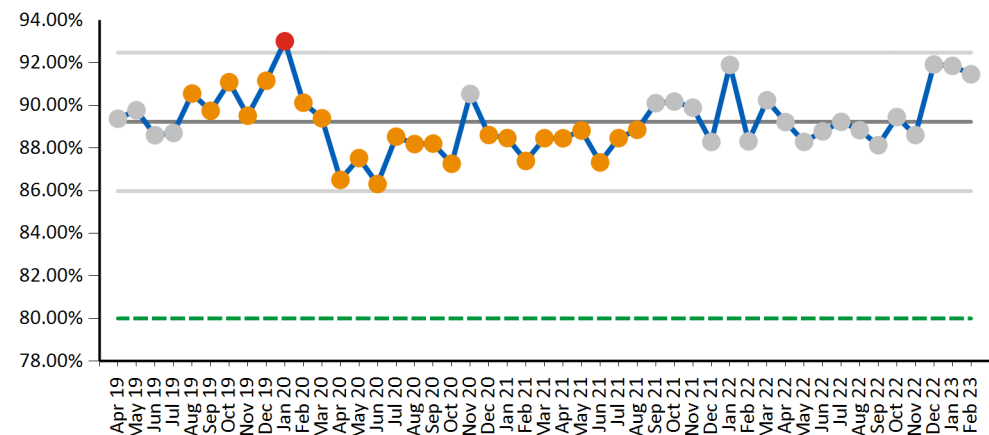
61 - Operations cancelled on the day for non-clinical reasons

Normal Variation | We will not regularly meet the target due to normal variation. | 0/6

62 - Cancelled operations re-booked within 28 days
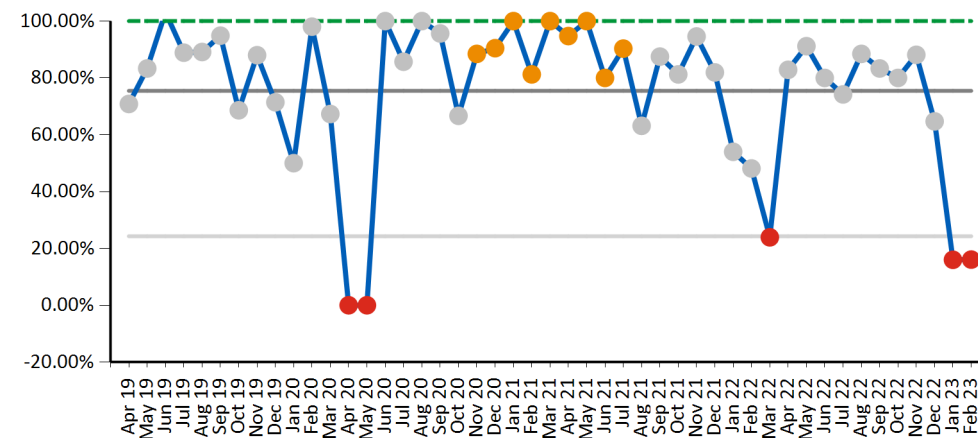
L - Abnormal variation. Target not achieved. | We will not regularly meet the target due to normal variation. | 0/6

65 - Elective Length of Stay (Discharges in month)
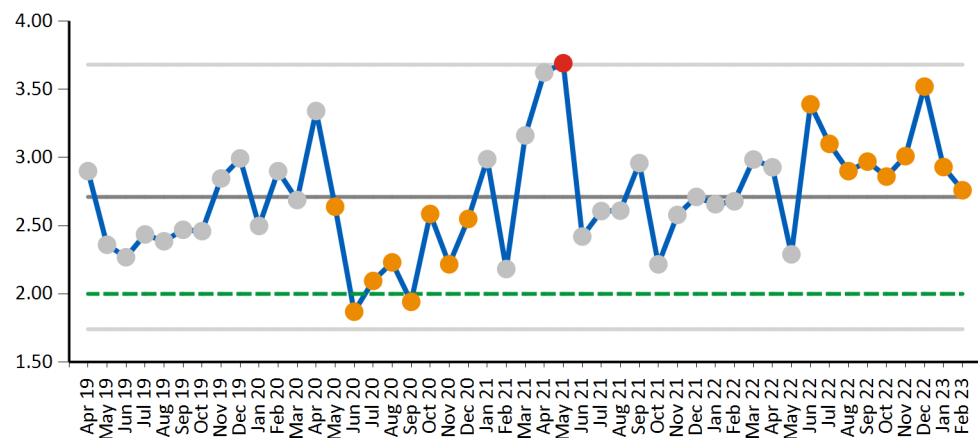
H - Abnormal variation. Target not achieved. | We will not regularly meet the target due to normal variation. | 0/6

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

Normal Variation | We will not regularly meet the target due to normal variation. | 0/6

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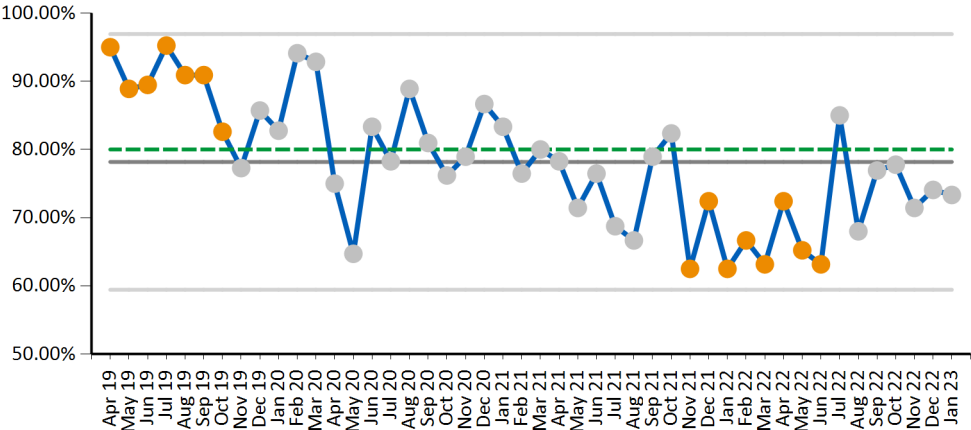
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

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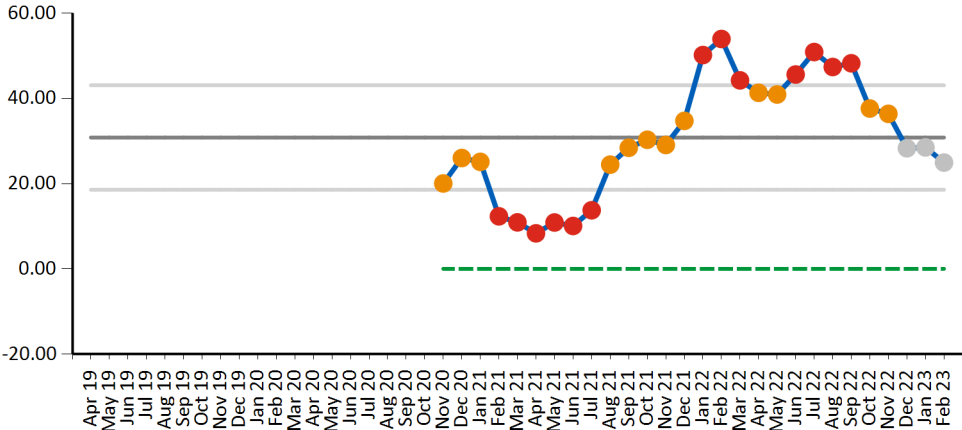
Normal Variation

We will regularly fail to meet the target.

0/6

493 - Average Number of Patients: with no Criteria to Reside
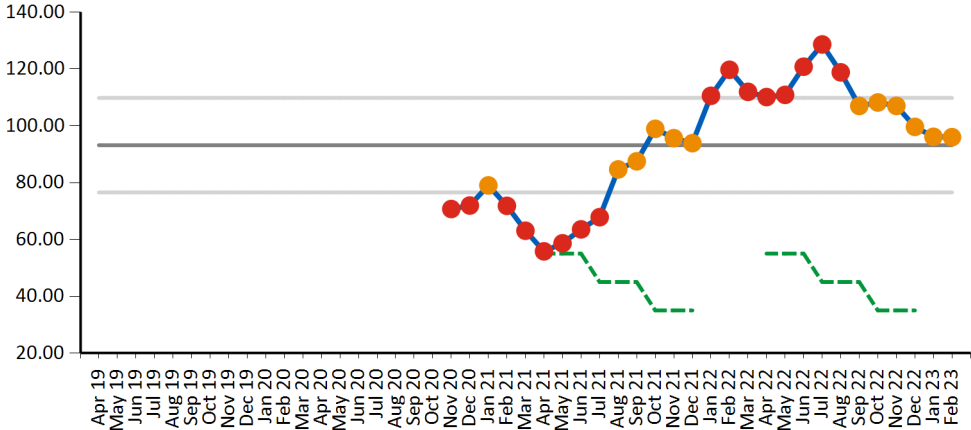
Abnormal variation. Target not achieved.

0/6

494 - Average Occupied Days - for no Criteria to Reside
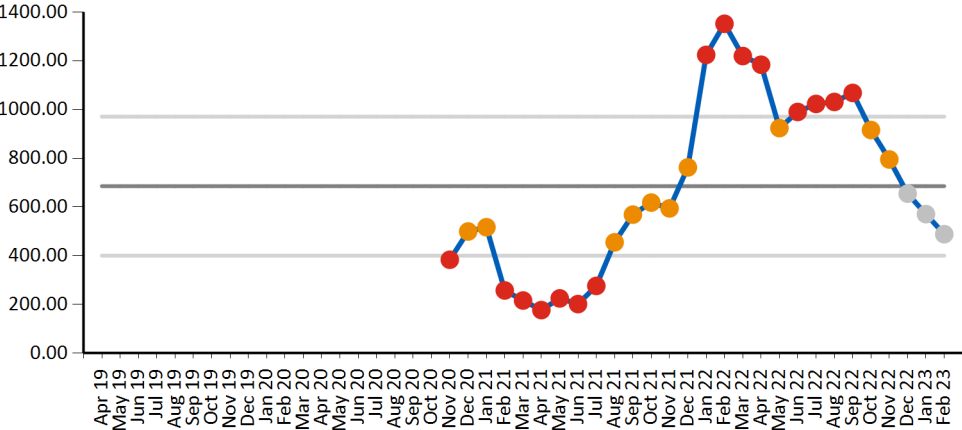
Normal Variation

496 - Average bed days since patients with LOS >14 days moved onto NCTR list
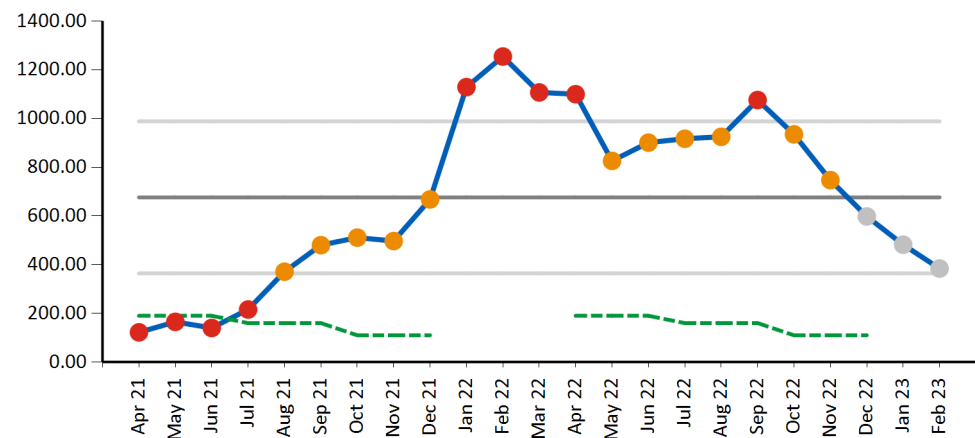
Cancer

Our 2 week wait performance for January was below target at 82.4%, this is due to Radiology capacity in Breast services. We are continuing to work to increase Breast Radiology capacity through recruitment although it is expected that the 2 week wait position will continue to be impacted in the medium-term until this is resolved.
We failed the 62 day standard for January with performance at 84.2%, the deterioration in the 2 week wait standard for Breast services is now starting to impact delivery of the 62 day standard. We are continuing to focus on improving the position through our Trust-wide cancer recovery plan although the position for February 2023 is predicted to deteriorate.
We failed the 62 day screening standard in January with breaches in Breast services and Colorectal. It is anticipated that Breast performance will continue to impact delivery of the standard for the remainder of the quarter.
We failed the 31 day standard (first treatment), performance in Breast services has also contributed to this. There were also a number of skin 31 day breaches although on validation, most of these are recording issues.
We failed the 31 day standard (subsequent surgery), the breaches were all for Breast services.
We achieved the Faster Diagnosis standard in January with performance at 77.6%.
We were slightly behind in our 62 day backlog trajectory for January with 29 patients against a trajectory of 26, this has recovered in February reducing to 22 patients.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	84.2%	Jan-23		>= 85%	81.6%	Dec-22	>= 85%	82.5%	?
47 - 62 day screening % (1 mth in arrears)	>= 90%	75.0%	Jan-23		>= 90%	91.8%	Dec-22	>= 90%	82.4%	?
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	90.3%	Jan-23	L	>= 96%	97.4%	Dec-22	>= 96%	98.1%	?
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	72.7%	Jan-23	L	>= 94%	100.0%	Dec-22	>= 94%	80.8%	?
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Jan-23		>= 98%		Dec-22	>= 98%	100.0%	?
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	82.4%	Jan-23	L	>= 93%	79.3%	Dec-22	>= 93%	88.9%	?
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	21.4%	Jan-23		>= 93%	41.7%	Dec-22	>= 93%	35.1%	F

46 - 62 day standard % (1 mth in arrears)
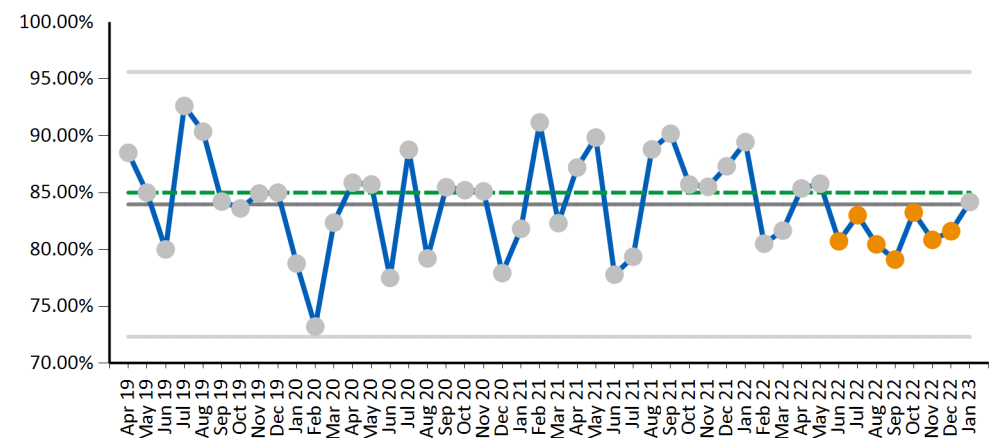
Normal Variation — We will not regularly meet the target due to normal variation. — 0/6

47 - 62 day screening % (1 mth in arrears)
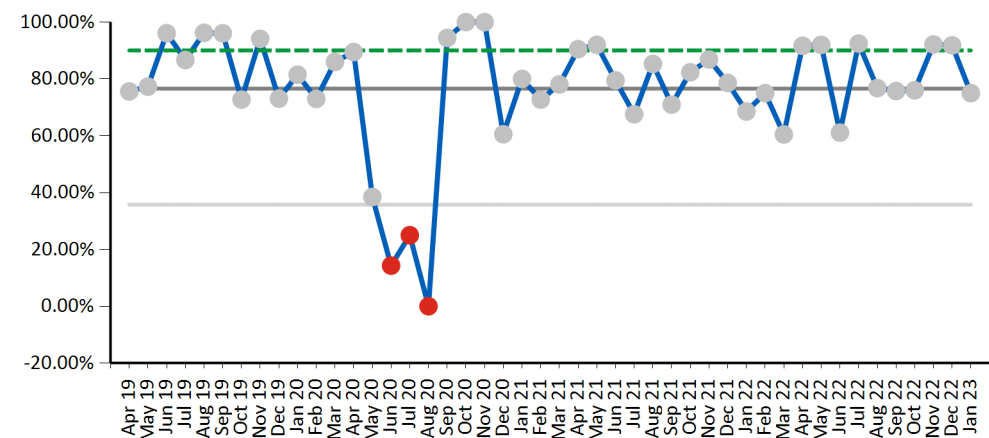
Normal Variation — We will not regularly meet the target due to normal variation. — 2/6

48 - 31 days to first treatment % (1 mth in arrears)
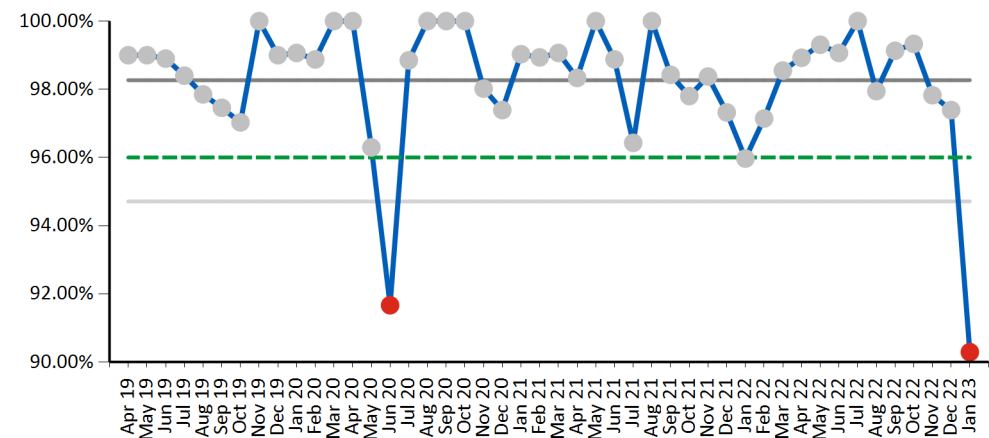
Abnormal variation. Target not achieved. — We will not regularly meet the target due to normal variation. — 5/6

49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)
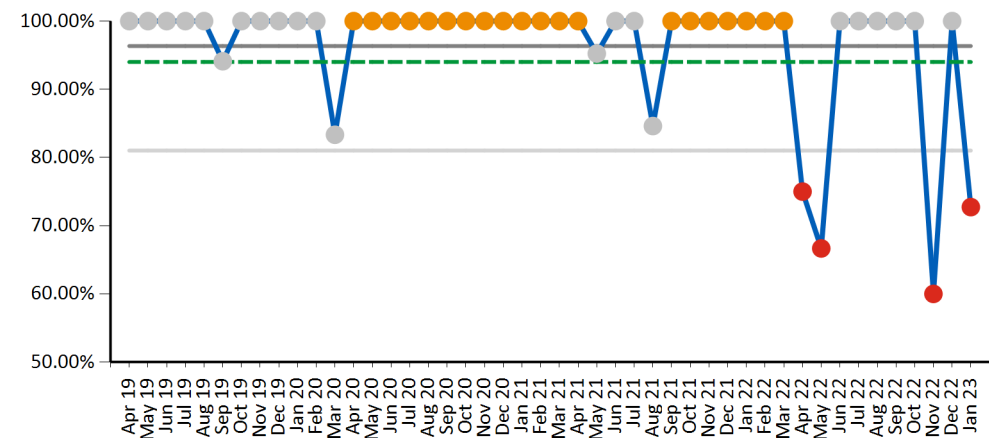
Abnormal variation. Target not achieved. — We will not regularly meet the target due to normal variation. — 4/6

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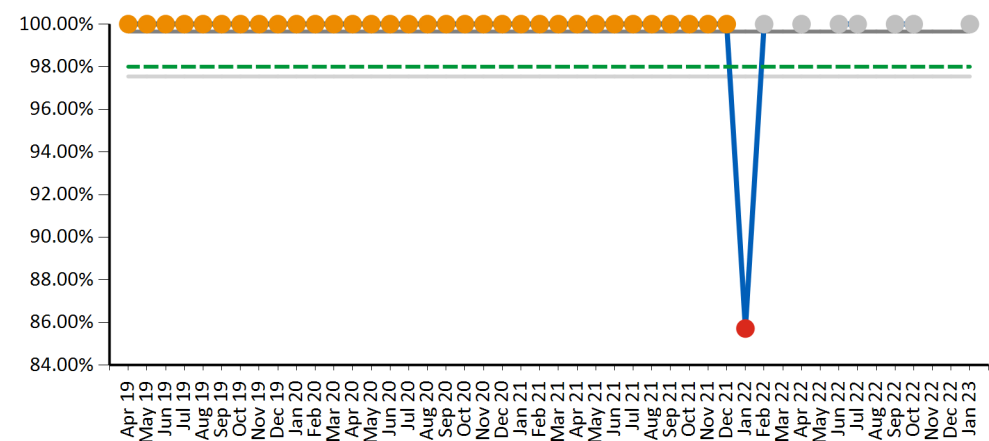
Normal Variation

We will not regularly meet the target due to normal variation.

3/6

51 - Patients 2 week wait (all cancers) % (1 mth in arrears)
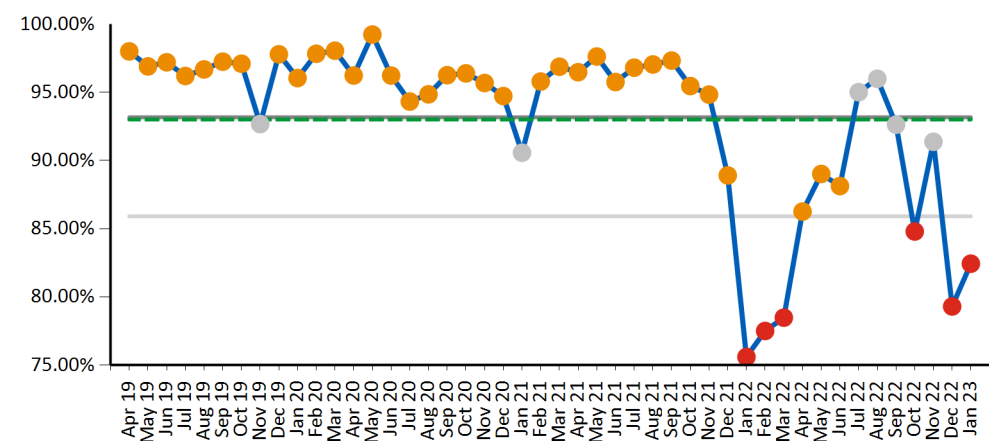
Abnormal variation. Target not achieved.

We will not regularly meet the target due to normal variation.

1/6

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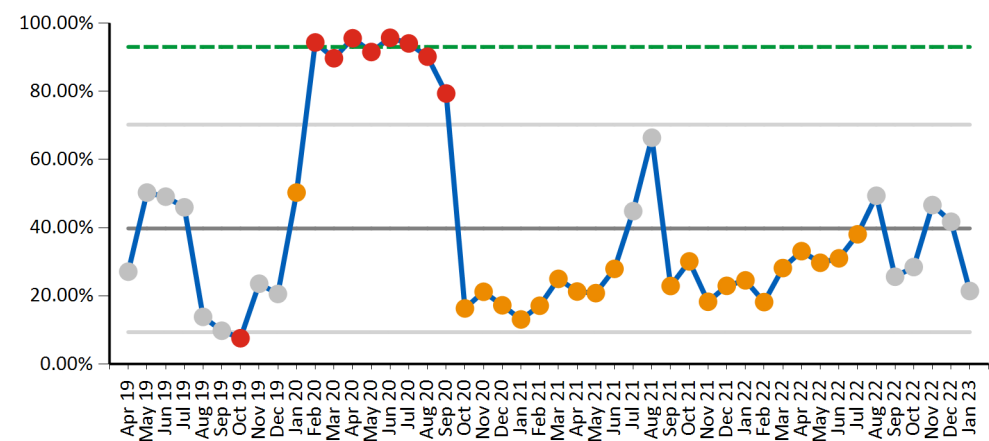
Normal Variation

We will regularly fail to meet the target.

0/6

Community

We continue to work with system partners to prevent avoidable admissions to hospital and deflect patients away from ED.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	428	Feb-23	(L)	>= 400	490	Jan-23	>= 4,400	5,489	(?)
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	6.30	Jan-23	(H)	<= 6.00	5.89	Dec-22	<= 6.00	6.30	(?)

334 - Total Deflections from ED
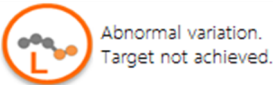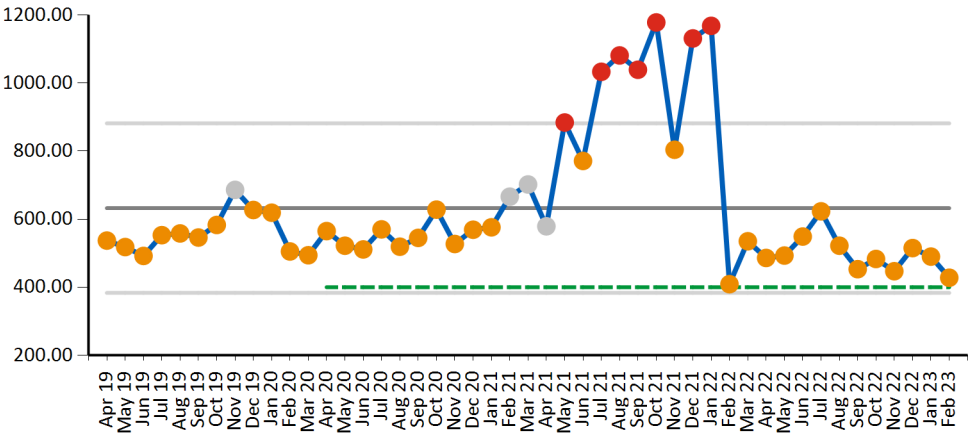
335 - Total Intermediate Tier LOS (weeks)

(L) Abnormal variation. Target not achieved.

(?) We will not regularly meet the target due to normal variation.

6/6

(H) Abnormal variation. Target not achieved.

(?) We will not regularly meet the target due to normal variation.

3/6

Workforce
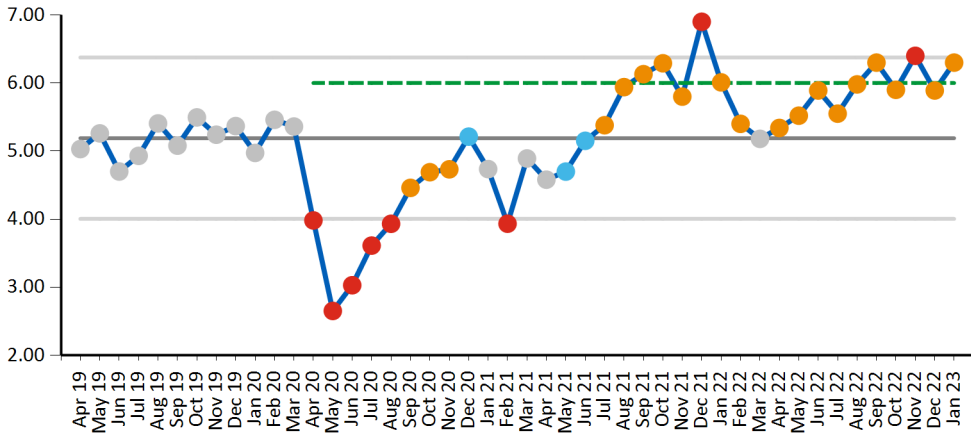
Sickness, Vacancy and Turnover

Sickness has fallen further in February 2023 to 4.72% from 5.38% in January 2023. The Trust has seen a reduction in the rate of sickness across the majority of the Divisions and this is largely due to a significant reduction in absences related to Coughs, colds and also a reduction in longer term absences. Rates of Covid related absence continues to reduce and now stands at 0.57%.

Turnover has reduced slightly in February at 13.54% from 13.99% in January 23, and the lowest level of turnover in the last 12 months. Focused work continues in conjunction with the Divisions and the OD team on exit interviews and retention and will be supported by the Trust's revised People Plan commitment due later this year.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.72%	Feb-23	(Normal Variation)	<= 4.20%	5.38%	Jan-23	<= 4.20%	5.40%	(?)
120 - Vacancy level - Trust	<= 6%	6.32%	Feb-23	(Normal Variation)	<= 6%	6.88%	Jan-23	<= 6%	6.79%	(?)
121 - Turnover	<= 9.90%	13.54%	Feb-23	(H)	<= 9.90%	13.99%	Jan-23	<= 9.90%	14.15%	(F)
366 - Ongoing formal investigation cases over 8 weeks		0	Jan-23	(Normal Variation)		0	Dec-22		15	

117 - Sickness absence level - Trust
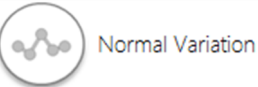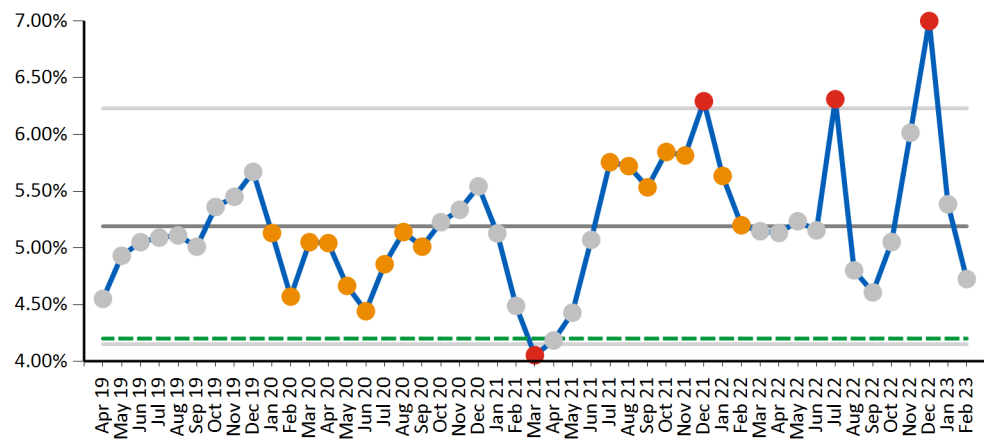
120 - Vacancy level - Trust

Normal Variation | We will not regularly meet the target due to normal variation. | 0/6
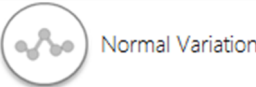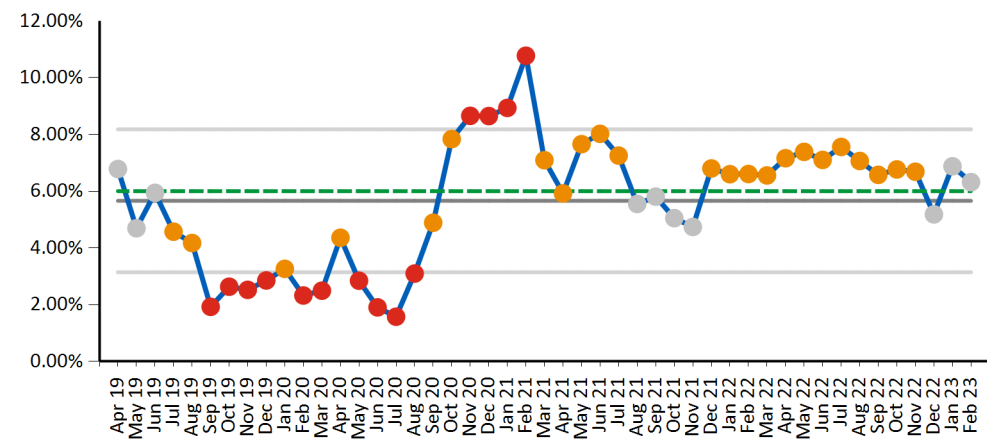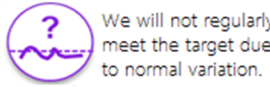
Normal Variation | We will not regularly meet the target due to normal variation. | 1/6

121 - Turnover
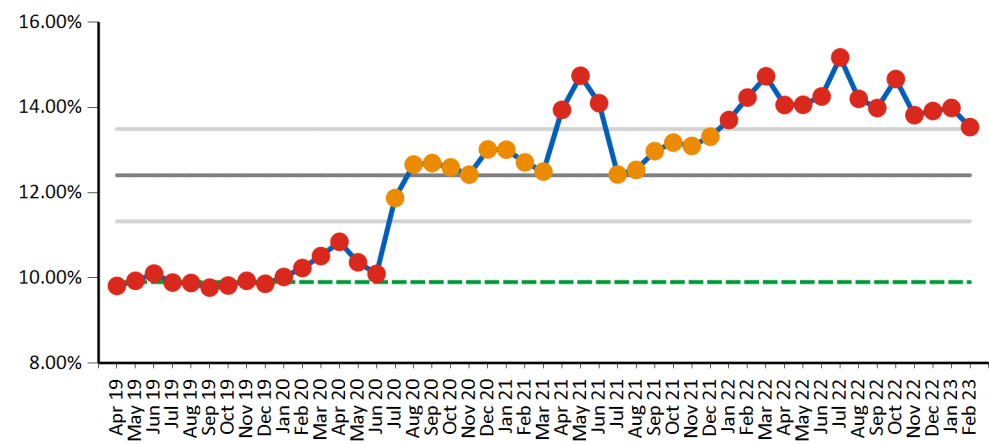
| H | Abnormal variation. Target not achieved. | F | We will regularly fail to meet the target. | 0/6 |

366 - Ongoing formal investigation cases over 8 weeks
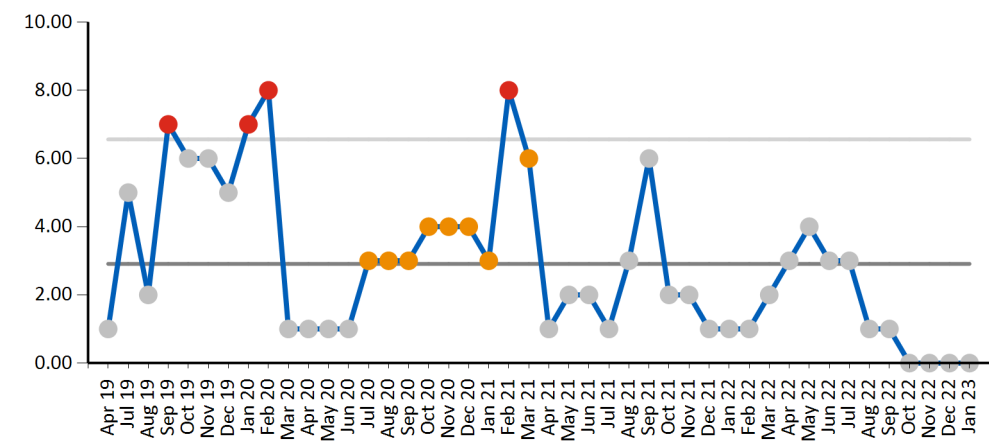
Normal Variation

Organisational Development

The Trust's overall compliance level for mandatory training was 86.7% (a 2.1% increase since last month and above our corporate target of 85%) and statutory training was 91.4% (a 2.3% increase from last month and below our corporate target of 95%). We continue to place great focus on completion and there are agreed targets in place per division; with an update paper going to People Committee in April. Appraisal compliance has seen a minor decrease this month.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	91.4%	Feb-23	(L)	>= 95%	89.1%	Jan-23	>= 95%	89.1%	(F)
38 - Staff completing Mandatory Training	>= 85%	86.7%	Feb-23	(L)	>= 85%	84.6%	Jan-23	>= 85%	86.8%	(P)
39 - Staff completing Safeguarding Training	>= 95%	94.37%	Feb-23	(●)	>= 95%	90.62%	Jan-23	>= 95%	90.51%	(?)
101 - Increased numbers of staff undertaking an appraisal	>= 85%	82.1%	Feb-23	(H)	>= 85%	83.6%	Jan-23	>= 85%	81.0%	(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
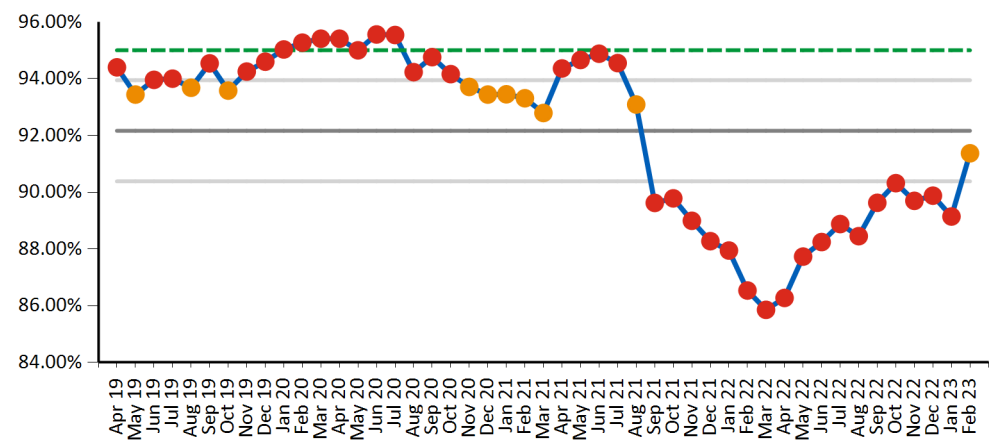
38 - Staff completing Mandatory Training
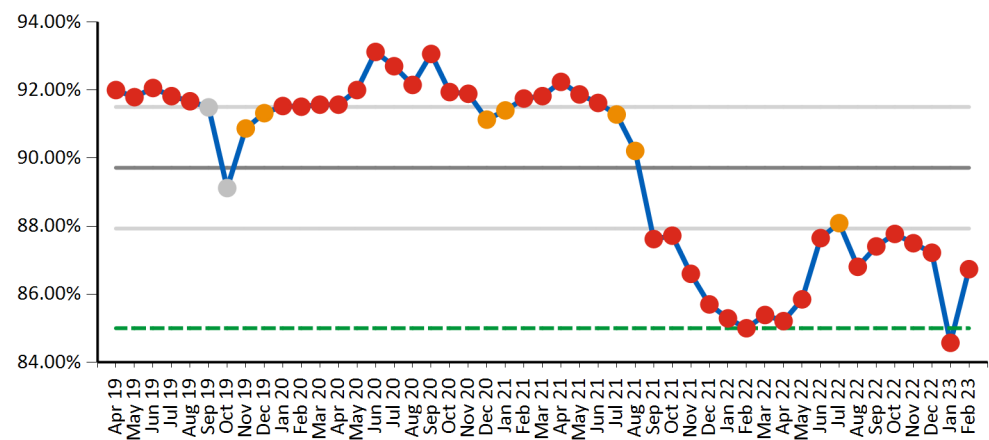
(L) Abnormal variation. Target not achieved. (F) We will regularly fail to meet the target. 0/6

(L) Abnormal variation. Target not achieved. (P) Target will be regularly met. 5/6

39 - Staff completing Safeguarding Training
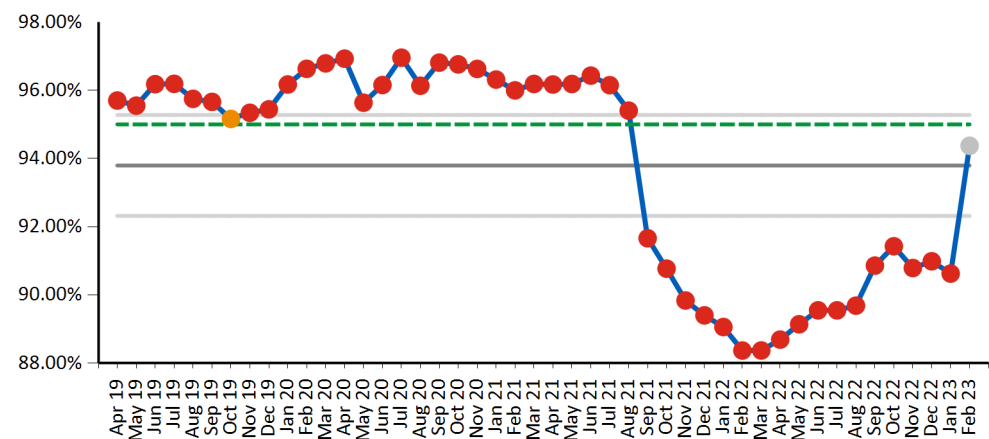
Normal Variation

We will not regularly meet the target due to normal variation.

0/6

101 - Increased numbers of staff undertaking an appraisal


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

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

5/6

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

0/6

49/54
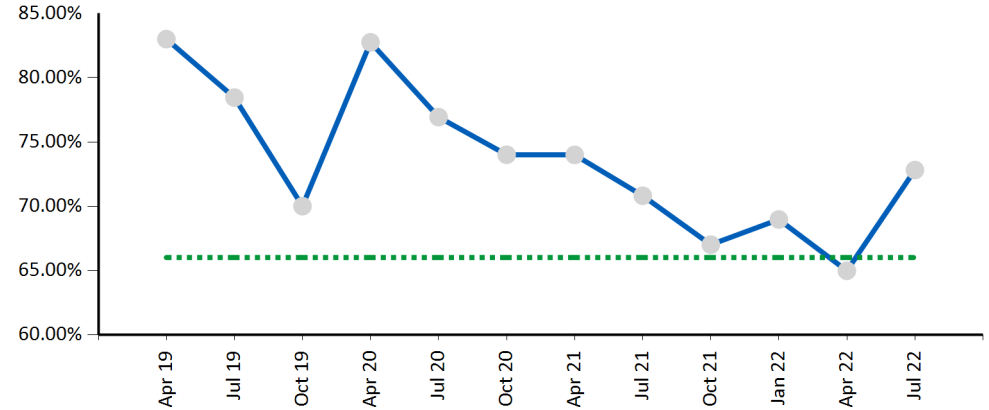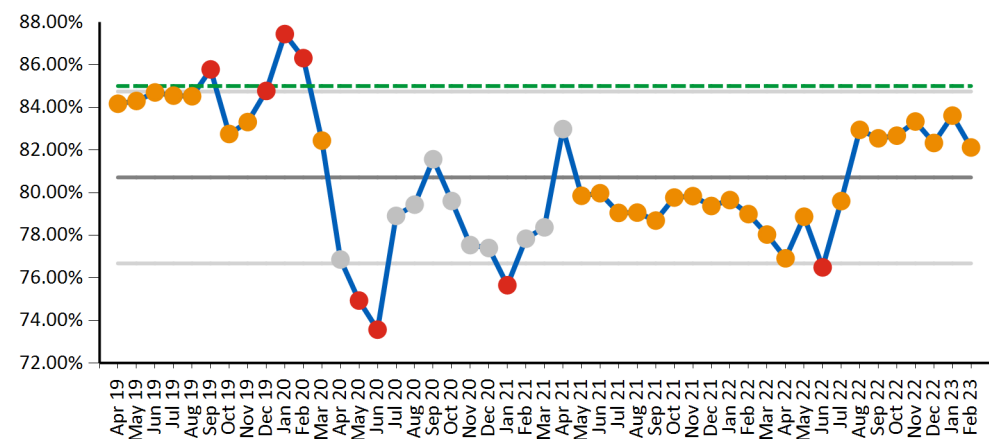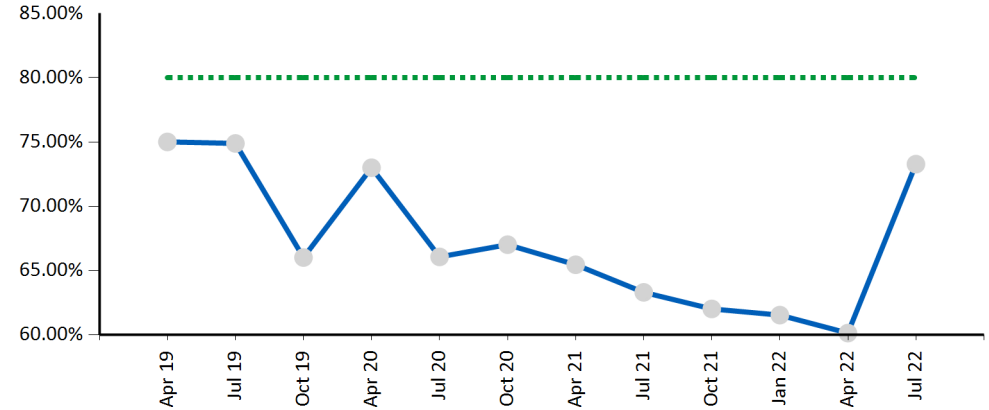
Agency

It is pleasing to note that agency analysis for February 2023 shows that, despite significant clinical pressures, the Trust maintained agency expenditure levels in-month at broadly the same (small increase of £3.5k in-month) levels as January 2023. January 2023 expenditure had been the lowest recorded 'normal month' (i.e. no accrual adjustments were made) for the entire financial year.

In February 2023 nursing agency spend showed a small decrease in-month (£13k); medical agency showed an increase (of £40k in-month); Admin & Clerical continued a downwards spend trend and reduced by £6k in-month; Estates & Facilities also continued a downward trend and reduced by £7k in-month; Allied Health Professions & Professional & Technical staffing groups showed a small increase in spend in month of £6k.

This means that we now expect to deliver a better year-end spend position than we forecasted to NHSEI at the start of the financial year (tracking to beat that forecast by £1.3m); albeit that we are tracking to be above our internally set stretch target by £2.06m at current spending levels.

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 1.38	1.36	Feb-23	(H)	<= 1.38	1.34	Jan-23	<= 15.15	17.17	(P)
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.68	0.64	Feb-23	(H)	<= 0.68	0.65	Jan-23	<= 7.51	8.41	(P)
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.56	Feb-23	(~)	<= 0.62	0.52	Jan-23	<= 6.78	6.52	(?)

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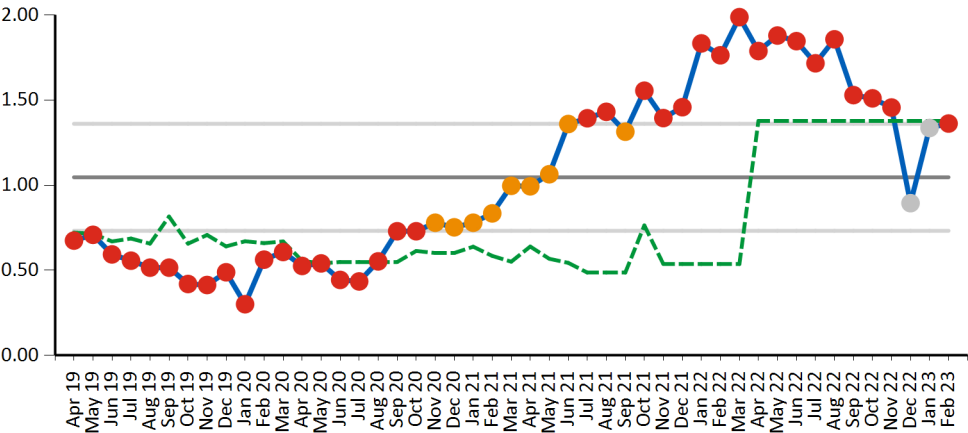
111 - Annual ceiling for Nursing Staff agency spend (£m)

(H) Abnormal variation. Target not achieved.

(P) Target will be regularly met.

3/6
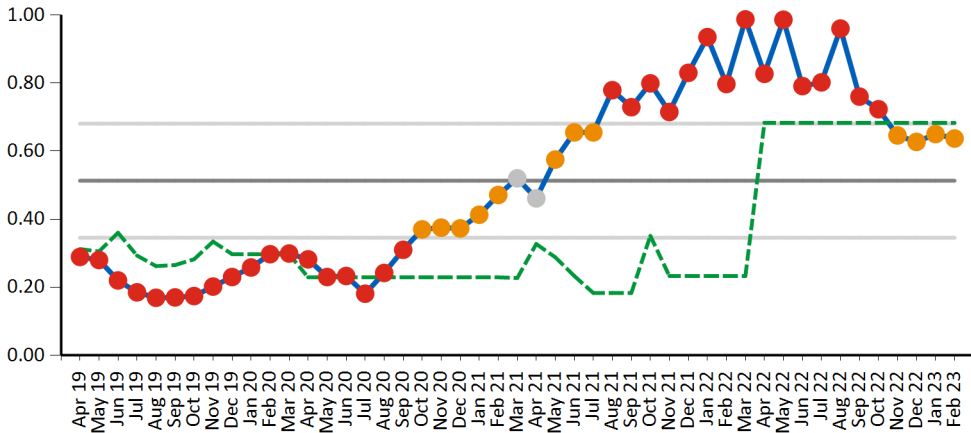
(H) Abnormal variation. Target not achieved.

(P) Target will be regularly met.

4/6

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

Normal Variation

? We will not regularly meet the target due to normal variation.

6/6
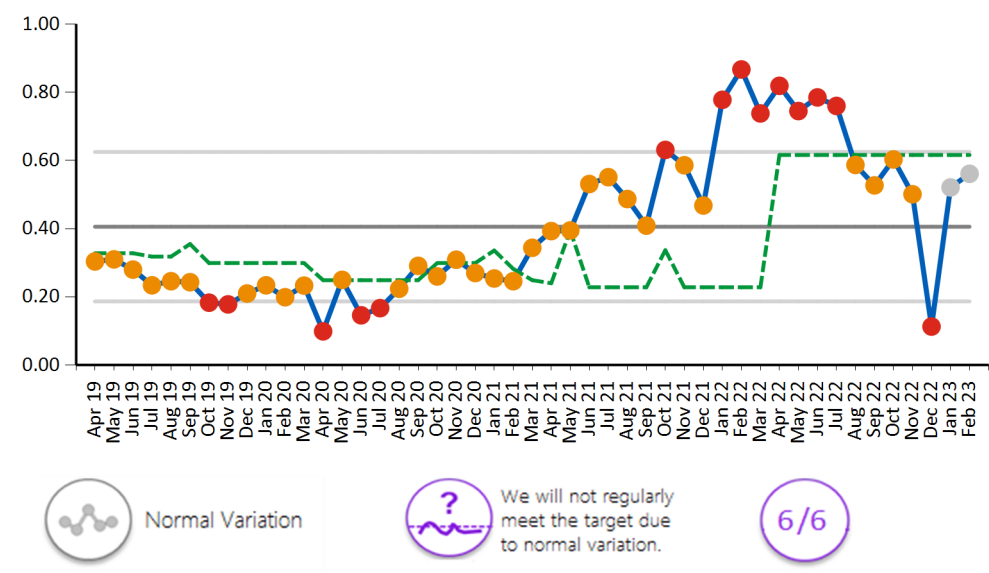
Finance

Finance

Revenue Performance Year to Date
- We have a year to date deficit of £3.5m compared with a planned deficit of £6.2m. The in-month position was a £5.7m surplus
- Financial Recovery actions including a weekly pay and discretionary non pay review panel have been implemented

Revenue Forecast Outturn
- The likely forecast outturn for 2022/23 is a £1.5m deficit.
- Forecast Outturn is currently rated amber.

Cost Improvement
- The current trackers indicate that £17.7m of savings have been delivered against a target of £17.7m.
- £4.9m of recurrent full year effect savings have been delivered against a target of £12.4m
- CIP is rated amber due to the reliance on non recurrent savings

Variable Pay
- We spent £3.1m on variable pay in month 11 and have now spent £43.3 YTD.

Capital Spend
- Year to date spend is £18.3m; of which £7m relates to Theatres and £4m to CDC
- NHSE have approved the CDC business case and BFT has received £11.8m of funding from a total of £14.9m, with the remainder to be received in financial year 2023/24
- An additional £3.1m of funding for CDC preliminary works has been funded
- FLD funding of £1.3m has been agreed and awarded to the Trust for digital Capital schemes such as EPR
- Theatres TIF has been approved for the full £19.6m business case, with £14.5m received in current year
- Further discussions continue with NHSI and GM around the 22/23 plan
- Capital is rated amber for the risk associated with delivering plan.

Cash Position
- We had cash of £21.7m at the end of the month, which is an increase of £1.2m from month 10
- Cash is lower than planned. The finance team are reviewing all aged debt and introducing more regular cash flow monitoring.
- Outstanding funding for PDC for capital schemes will be received March 2023.

Better Payment Practices Code
- Year to date we have paid 90.5% of our invoices within 30 days.
- Non-NHS performance is 93.2% YTD with 96.0% in month.
- Action to improve performance is underway and showing results

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 1.0	-5.7	Feb-23	(L)	>= 0.8	-1.0	Jan-23	>= 6.2	3.5	(?)

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
222 - Capital (£ millions)	>= 3.9	5.5	Feb-23	(H)	>= 4.5	2.1	Jan-23	>= 29.2	18.5	(?)
223 - Cash (£ millions)	>= 21.7	38.3	Feb-23	(~)	>= 38.3	20.5	Jan-23	>= 21.7	38.3	(?)

220 - Control Total (£ millions)
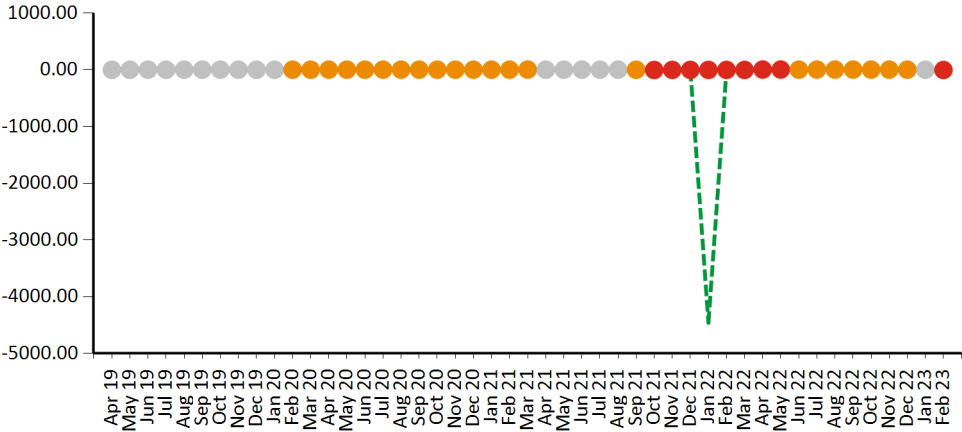
(L) Abnormal variation. Target not achieved.

(?) We will not regularly meet the target due to normal variation.

2/6

222 - Capital (£ millions)
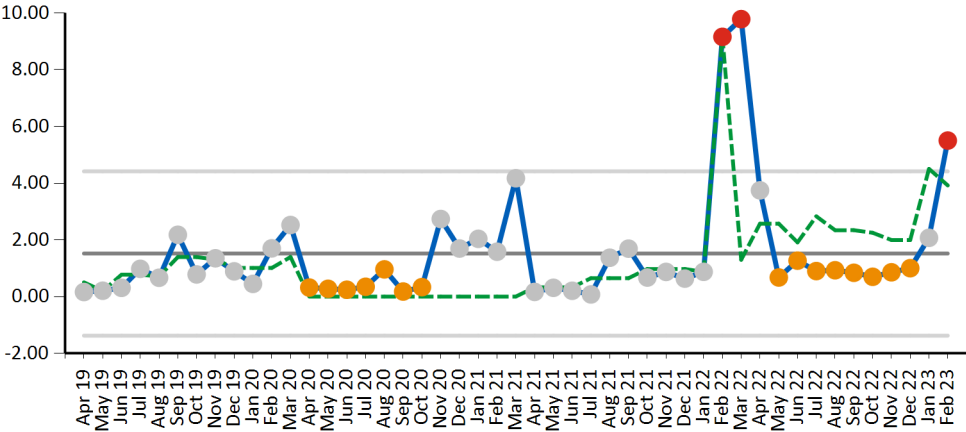
(H) Abnormal variation. Target achieved.

(?) We will not regularly meet the target due to normal variation.

1/6

223 - Cash (£ millions)
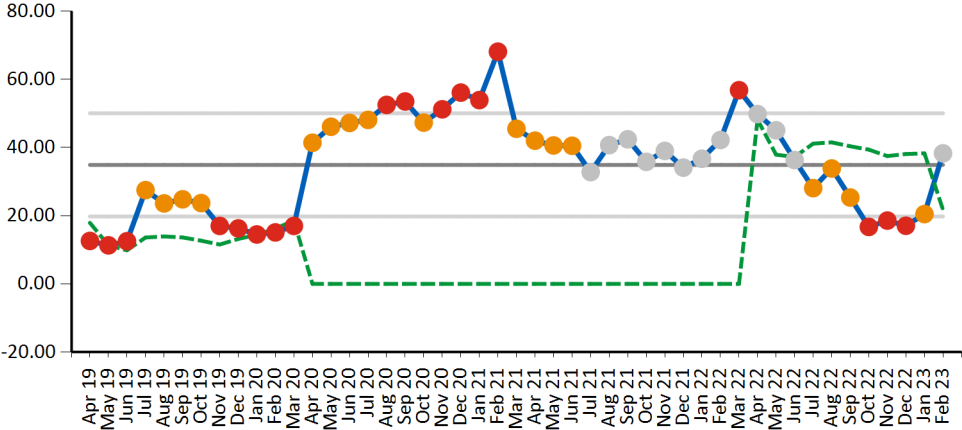
Normal Variation

We will not regularly meet the target due to normal variation.   1/6

Report Title:	Operational Planning Return 2023/24			

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Sharon White		Decision	✓

Purpose	The purpose of this report, and associated presentation, is to inform Board of the detail surrounding our 2023/24 operational planning return.

Summary:	The operational planning round is broken down into 3 distinct segments and submissions; - Activity - Finance - Workforce. Due to disparate submission dates to GM, this paper provides a detailed view of our activity return, and summary views of our finance and workforce returns. A detailed, triangulated view of our finance and workforce submissions will be shared with the Board in a supplementary presentation. Our activity plan is a pragmatic and realistic view of performance for the forthcoming year, with Bolton projecting not to meet 4 key activity targets: • Deliver 30% more elective activity (than before the pandemic) • Eliminate 65 week waits • Reduce no criteria to reside (NCTR) to 60 • Reduce outpatient follow ups by 25% The rationale for this is detailed within this report and was communicated to GM throughout the planning round; we do not anticipate being an outlier in GM. This plan has been worked up with Divisions, BI, Workforce and Finance; and signed off by the Trust Executive Team. This is an assumed positon only, based on a bottom-up approach to planning, and we will strive to improve the position over the course of the year. The target to 'deliver 30% more elective activity by 2024/25 (than before the pandemic) has a finance impact due to the interdependency with the value-weighted activity target and re-introduction of PBR. Achievement and improvement against this target also has an impact on overall performance of other targets; such as 65 week waits and cancer, The Trust has not seen a financial link to delivery in this way since pre-covid, so there will be a resumption of active monitoring through the Board sub-committees, with input from the Trust's new Finance and Intelligence Group. As in previous rounds, GM will submit a system operational planning return, of which Bolton's return is a component part, and the North West region of NHS England will monitor the GM system's performance against operational planning targets. If GM does not achieve their targets, but Bolton do, we could still be

	negatively impacted in order to support the wider system. This therefore adds another layer of complexity, scrutiny and risk for the Trust. As GM are already seen as underperforming against the plan, when compared nationally, this position puts significant pressure on all providers in GM and indicates a challenging year ahead.

Previously considered by:
✓ The Finance & Investment Committee reviewed and endorsed approval by the Board, at the meeting held on 22 March 2023.   ✓ Approved by the Executive Directors Group

Proposed Resolution	The Board is asked to • **Approve** the final operational activity template described in this paper; and associated presentation • **Accept** the risk of underperformance against the 4 highlighted targets

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:	Francesca Dean	**Presented by:**	Sharon White Annette Walker James Mawrey

1. Introduction

This report will focus on a detailed overview of our activity position, with high level summaries on our known workforce and finance positions.

The associated, supplementary presentation, which will be circulated at a later date prior to Board, will summarise the activity positon and provide final workforce and finance positions. It will also include any known positioning of the Trust in Greater Manchester.

Board is asked to review the final activity position within this report and to note the current status of the final workforce and finance positions, prior to circulation of the presentation prior to Board.

2. Assurance and Delivery

2.1 2023/24 Planning approach and process

This year the Trust has undertaken an extensive, bottom up, approach to planning. The phases of this approach can be seen in Diagram 1.

Diagram 1

FT Planning round phases

November - March

Specialty pod reviews (Nov-Dec)	Technical guidance and assumptions response (Jan-Mar)	Confirm and challenge (Feb-Mar)
Guidance and Targets Review (Dec-Jan)	Early Triangulation and 1st DRAFT activity submission (Jan-Feb)	Final Submission (Mar)
Finance Workforce Activity (Jan)	Planning guidance narrative response (Jan-Mar)	Monitoring and Delivery (Apr)

Triangulation
Confirm and challenge
Links with locality

This process started in Nov/Dec-22 with speciality level reviews and by the end of January ensured we had an accurate current activity positon, with an early forecast plan which supported the first draft submission on 17/02/2023. As these reviews included representatives from clinical teams, Workforce, Business Intelligence and Finance, it supported Divisions to understand their plans in much more detail than previous years.

Following first draft submission of the Operating Plan the finance, workforce and activity returns were triangulated to ensure cohesion across each submission and this was repeated at frequent points throughout the process.

The detailed process described above and the ongoing approach to triangulation provides confidence and assurance that the plan Bolton FT is submitting is our best position; pragmatic but stretched.

The Operational Plan submission to NHS England is completed at a Greater Manchester level. The Bolton FT activity, finance and workforce returns have been developed in partnership with Greater Manchester Integrated Care Team (Bolton) to ensure local system oversight. A shared narrative plan will be developed for the Bolton Locality, which will include the actions required to deliver the Bolton FT activity, finance and workforce Operating Plan requirements.

To support the development of the activity, finance and workforce returns a Greater Manchester check and confirm session was held with Stockport NHS FT on 08/03/2023. This did not identify any unexpected areas of challenge or opportunities to improve our projected position. This session is a key part of the GM Integrated Care Board assurance and scrutiny process.

A lessons learned document and Standard Operating Procedure are being developed and will be taken through Strategic Operations Committee. These will be used to inform the 2024/25 planning; reflecting the new approach and process taken this year.

2.Activity

2.1 Activity Headlines

The table below shows Bolton FTs final submission against key activity targets. Despite ongoing work to improve the position we are not projecting to meet four targets. It should be noted that we do not anticipate being an outlier in Greater Manchester against any of the targets.

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual:Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement
Elective - Activity 'Deliver 30% more elective activity by 2024/25 (than before the pandemic)'. – *GM target is 120%*	28,834	28,834	29,916	3.8%	Increase to 130%	**103.8%**
Referral To Treatment Eliminate 65 week waits by Mar 24			722	0		**722**
Outpatients Reduce outpatient follow-ups by 25% by March 2024 (against the 2019/20 baseline)	245,068	246,298	261,922	6%	Reduce by 25%	**14.6%**
No Criteria To Reside GM 650 Bolton 22/23 – 60 Bolton 23/24 - 58			90	60		**90**
A&E Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024; with further improvement in 2024/25.	79%	79%	76.0%		No less than 76%	**76%**
Beds Reduce adult general and acute (G&A) bed occupancy to 92% or below.			94%		92%	**92%**
Diagnostics 95% having a diagnostic test within 6 weeks					95%	**95%**
Cancer Reduce 62 day waits – by end March 2024			18		**18	**18**

2.2 Activity Targets

This section details our final position against each target and associated Trust level risks and challenges to improve for unmet targets.

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
Elective - Activity 'Deliver 30% more elective activity by 2024/25 (than before the pandemic)' - *National target 130%* - *GM target is 120%*	28,834	28,834	29,916	3.8%	Increase to 130%	**103.8%**	**Bolton are showing a final position of 103.8%.** Specialty reviews in Dec/Jan ensured an accurate baseline position of 98% for first draft submission and an internal check and challenge process followed to improve the position. This included specialty level breakdown analysis and regular reviews with the Theatre lead, OBMs and DDO/Deputy. In addition, the check and challenge session with Stockport did not result in an expectation to increase further. Main challenges to improving the position include: - Aging estates and layout (new theatres) - Hard to recruit posts - national shortage of ODPs and Anesthetists - Legacy demand - Backlog pre Covid was significant - Industrial action - Ongoing and future action has significant impact on elective delivery - Covid/flu impact - Bad flu season again results in cancelled electives - Inflation - Cost to run a theatre is higher than last year **Risk** If we do not deliver at least 103.8%, then we will have an increased financial risk. – ***Please see section 3 for further information***

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
Referral To Treatment Eliminate 65 week waits by Mar 24			722		0	**722**	**Bolton are showing a final position of 722; which is a significant improvement of our first draft plan of 1465.** Positively, the number of 52 week waiters has dropped slightly since the 1st draft (currently 2,137 was 2,698) and we are not expecting to see much growth in the overall PTL size. Specialty reviews in Dec/Jan ensured an accurate baseline position for first draft submission and an internal check and challenge process followed to improve the position. This included specialty level breakdown analysis and regular reviews with the Theatre lead, OBMs and DDO/Deputy. In addition, the check and challenge session with Stockport did not result in an expectation to increase this further. <u>The main challenges to improving the position include:</u> - Existing back log means our starting point to reduce was very high - We have several high risk areas to delivery such as Urology, General Surgery, ENT, Plastics, Gynae and Paeds T&O. Workforce, capacity and existing back logs are the main issues - Aging estates and layout (new theatres) - Hard to recruit posts - national shortage of ODPs and Anesthetists - Legacy demand - Backlog pre Covid was significant

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
							- Industrial action - Ongoing and future action has significant impact on elective delivery - Covid/flu impact - Bad flu season again results in cancelled electives - Inflation - Cost to run a theatre is higher than last year **Risk** Only Bolton and Stockport originally said that they would still have 65+ waiters at the end of March 24, this changed to all but 3 providers in GM showing a 0 position following first draft submission. There is no financial risk associated with this target, the risk is reputational and having longer waits for patients which could have an adverse effect on patient outcomes. This target will be monitored through existing governance channels and programmes, including Elective Recovery Group and Performance and Transformation Board.

...for a **better** Bolton

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
Outpatients Reduce outpatient follow-ups by 25% by March 2024 (against the 2019/20 baseline)	245,068	246,298	261,922	6%	Reduce by 25%	**14.6%**	**Bolton Outpatient follow ups are set to grow +6% on 19/20, however, the national target is to reduce by 25%.** For Bolton, we have significant backlogs which have contributed to our high follow up ratios. However, our new to follow up ratios has always been good. **Risk** Increasing follow ups to meet a target without understanding the true impact on patients. We as GM, have given challenge to this as unrealistic and await feedback on stance; Bolton are not an outlier. However, as part of productivity reviews through Finance and Intelligence Group we will be monitoring whether we are bringing people back unnecessarily, – this also links to existing work-streams such as Advice & Guidance and PIFU.

...for a **better** Bolton

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
No Criteria To Reside GM 650 Bolton 22/23 - 60 Bolton 23/24 - 58			90		60	90	**Bolton will miss this target by 30, with a final figure of 90.** A target of 60 for Bolton as a system is a real challenge, based on where we've been for the last year. However, significant work has already been undertaken this last year within the Trust and Locality; and continues to do so to improve further. <u>Main challenges to improving the position include:</u> - The number of patients vs days delayed – we place quite a bit of emphasis on days delayed in Bolton and so we will continue to focus on delayed days – we've reduced from an average of 1400 days delayed in Feb-22 to around 600 in Feb-23. - System flow- achievement of this target is not solely in the gift of the Hospital. The work we have done with system partners will continue, especially the bridging service, discharge to assess pathway and the high needs dementia beds. **Risks** Reputational and performance. Patient outcomes/impact managed through existing governance channels.

Theme - Target	Adjusted: Apr-19 - Mar -20	Actual: Apr-19 - Mar -20	Final Draft: Apr-23 - Mar-24	Final Draft: Diff from 19/20 baseline	Target	Achievement	Notes
A&E Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024; with further improvement in 2024/25.	79%	79%	76.0%		No less than 76%	76%	**Bolton will achieve the target.** **Risk** Reputational and performance. Patient outcomes/impact managed through existing governance channels
Beds Reduce adult general and acute (G&A) bed occupancy to 92% or below.			94%		92%	92%	**Bolton will achieve the target.** **Risk** Reputational and performance. Patient outcomes/impact managed through existing governance channels
Diagnostics 95% having a diagnostic test within 6 weeks					95%	95%	Bolton will achieve the target. **Risk** Reputational and performance. Patient outcomes/impact managed through existing governance channels
Cancer Reduce 62 day waits – by end March 2024.GM target for Bolton is 18			18		18	18	**Bolton will achieve the target.** **Risk** Reputational and performance. Patient outcomes/impact managed through existing governance channels

3   Finance

This section provides an as-is summary of the Finance return. A detailed view will be shared prior to Board.

3.1 Elective Recovery Fund (ERF)

2023/24 Contract Payment

In 2020/21 & 2022/23, providers have been paid via a block contract. For 2023/24, the ICB payment mechanism will be via Aligned Payment and Incentive (API) – fixed & variable elements.

The variable element will pay for activity in scope of the ERF activity target, plus diagnostic imaging, chemotherapy & excluded drugs/devices. The fixed payment will cover Outpatient Follow Ups, Critical Care, Radiotherapy & any other activity

The points of delivery in scope of the ERF activity target include inpatient elective admissions, day cases, new outpatient attendances and outpatient procedures

ERF

The 2023/24 priorities & operational planning guidance reconfirmed goals for elective recovery – including delivery by 2024/25 of around 30% more elective activity than before the pandemic. Additional funding has been made available to support recovery of elective services for 23/24 – this funding is within our baseline contract value (£16m for 23/24; increased by £2m from 22/23).

ERF activity covers the majority of elective, daycase, new outpatient (OP) appointments and OP procedures. It excludes payment for Maternity/Obstetric activity – this is covered by the fixed payment; as is community activity.

Targets

The NHS, nationally, is being asked to deliver 107% of 2019/20 value-weighted ERF activity. Each ICB has been given an individual target dependent on performance in H1 of 22/23. GM ICB has a target to achieve 103% by the end of the financial year and Bolton's target performance against the 19/20 baseline is 106% by March 2024; starting at 97.8% in April and moving 0.75% each month.

Risks

We will be paid for the ERF activity we do at 100% tariff. The ERF work is now a 'variable' aspect of the contract with commissioners; do no elective activity, receive no income.

There is no floor or baseline level of ERF activity funding. The funding is allocated to ICBs on the basis of the system performance; NHS England will only give additional funds to GM if it's providers are above the system value weighted target as a whole. The system will potentially need to move funds from provider to provider.

Potential gap of £1.4m away from the 106% value-weighted target.

3.2 Elective activity and value weighted risk

If we do not deliver at least 103.8%, then we will have an increased financial risk. This elective target is also a key contributor to achievement of other targets, such as 65ww and cancer.

The 130% national target, reduced to 120% for GM target, was always an ambitious target and was set with the view that providers would be delivering significantly more high volume low complexity procedures. This is not the reality, with most patient's complexity worsening, not improving. As a result, the amount of activity required to deliver the value-weighted target of 106% for Bolton is significantly less than 120/130%.

As detailed in section 3.1, 'Elective' activity in the context of the value-weighted target refers to ordinary elective admissions, daycases, new outpatient attendances and Outpatient procedures. However, increases to elective or daycase work, given the relative value is higher, would have the most impact on this target.

A version of the activity submission was priced using an assumed 22/23 casemix – full year, the value was 104% of 19/20 baseline; which equated to £1.4m away from target.

If there was an increase in the elective ordinary and elective daycases target, our working assumption is that this will reduce the gap in our achievement of the 106% value-weighted elective target, however, further work is needed to understand to what extent.

In summary, it is of high priority that we achieve at least the 103.8% elective target projected and also strive to improve this.

Mitigations

Due to the intrinsic link this target has with both wider performance and finance a set of mitigations will be put in place to manage, these include:

- Low level activity plan to be priced – this allows us to understand our actual level of risk and inform Trust/Divisional response and action
- Focus on recording and counting – a key component in accuracy and assurance of our performance
- Finance and Intelligence Group oversight and monitoring – with a particular focus on efficiency and productivity

3.3 Finance Plan

The financial plan submission deadlines are not required until the 22nd and 27th March. The wider financial plan will therefore continue to change. An update against this will be provided in the presentation prior to Board.

4   Workforce Headlines

The workforce return is linked to the finance plan and so final positions are not known at this time. An update against this will be provided in the presentation prior to Board.

4.1 Supporting metrics

Our workforce is an intrinsic component to delivery of our plan, so it is important we consider the impact of sickness, vacancy rates and turnover on our delivery. This section will detail our current and forecast positions against these. As with our activity targets, we are not expecting to be an outlier in GM.

4.1.1   Sickness

Absence rates have steadily increased, initially influenced by Covid related sickness. This is gradually reducing with a forecast of 5% sickness for 23/24; support is being provided to staff and managers.

Sickness and Covid-19 Related Absence Trend
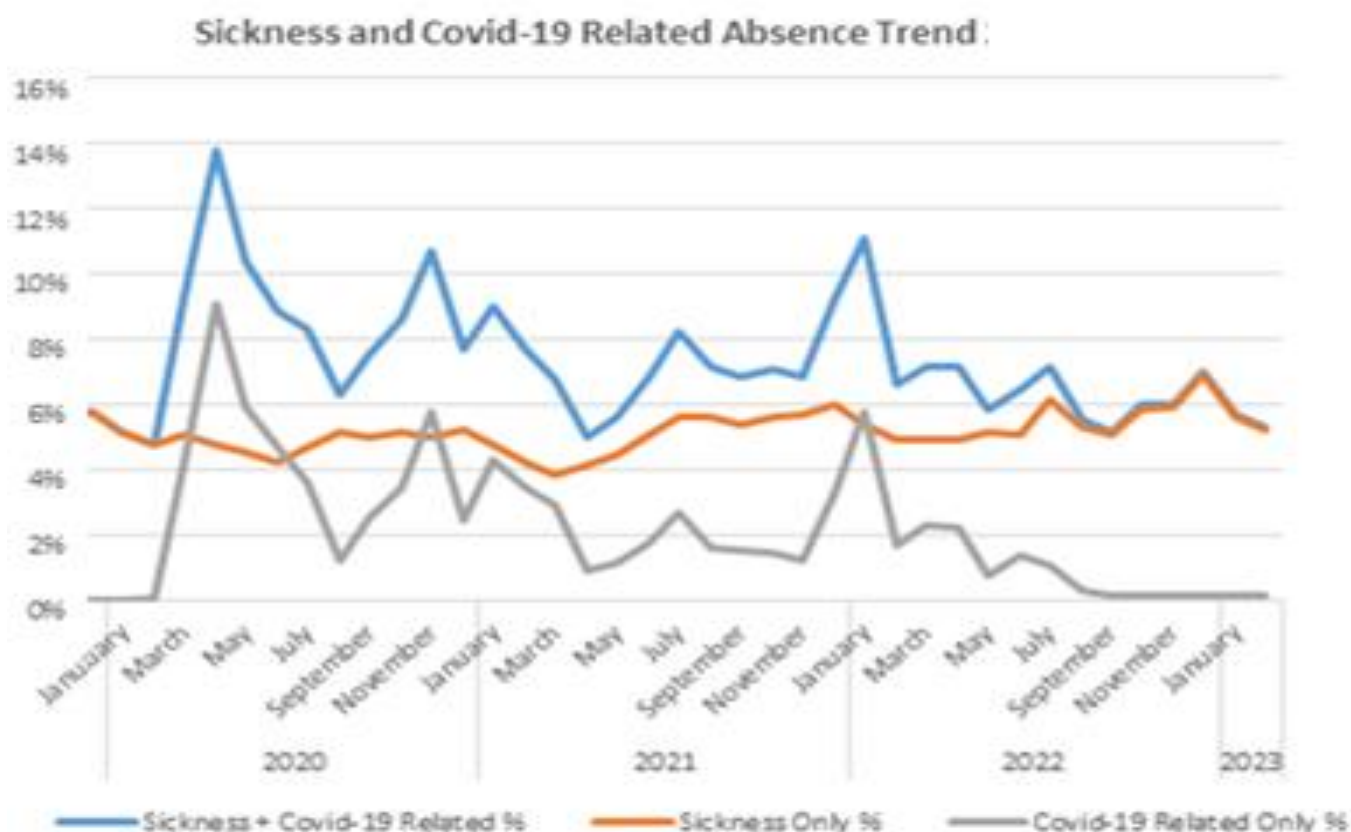
4.1.2   Vacancy Rate

Vacancy rate has remained fairly static for 2 years and reflects a growth in the establishment in recent years. Performance remains close to Trust Target, of 6%, with strong recruitment; the focus will be on improving retention to support further.

4.1.3 Turnover

19/20 rates of turnover were approx. 12% compared to approx. 14% in 22/23. The initiatives regarding retention are expected to see a reduction; with the Trust aiming to reduce turnover back to 19/20 levels and towards the Trust target of 9.9%.

Vacancy		
	Target	Actual
2020	6%	4.87%
2021	6%	6.31%
2022	6%	6.83%

Turnover		
	Target	Actual
2020	9.90%	11.84%
2021	9.90%	13.30%
2022	9.90%	14%

5 Challenges to Delivery

Across the plan we can see there are several thematic challenges affecting our ability to improve the final position and could present added risk to future delivery. These are listed below and, due to the cross over with more than just operational plan delivery, are already being addressed within existing programmes of work.

- Workforce
  - Hard to recruit posts
  - BMA rate card
  - Pension issues
  - Industrial action

- Estate
  - Ageing
  - Layout
  - Access to capital for maintenance

- Legacy Demand
- Inflation - £25-30m pressure. Energy alone represents c.£4m additional expenditure
- Wider GM and system pressures
- Covid and Winter impact

6 Monitoring, performance and delivery

The Finance and Intelligence Group will monitor and oversee progress against key operational planning targets. As targets, and associated delivery plans, are already aligned to existing Divisional, Improvement and Transformation programmes the group will take a lead role in ensuring a co-ordinated and Trust level view; with escalation, analysis and cross cutting work activities directed through the group.

The existing Tableau dashboard will support the ability to monitor key targets at Trust, Divisional and Speciality level. For 2023/24 the dashboard will also be expanded to include a range of supporting efficiency and productivity measures.

The Finance and Intelligence Group reports into Performance and Transformation Board and subsequently to the Strategic and Operations Committee. Along with

frequent updates to The Executives and alignment to Divisional IPMs, this will ensure robust governance and risk management around delivery is in place.

7 Recommendation

The Board is asked to:

- **Approve** the final operational activity template described in this paper; and associated presentation
- **Acce**pt the risk of underperformance against the 4 highlighted targets

NHS
Bolton
NHS Foundation Trust

Report Title:	GM ICP Strategy

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	30 March 2023		Discussion	✓
Exec Sponsor	Sharon White		Decision	

Purpose	The following document is the draft Strategy of the Greater Manchester Integrated Care Partnership, *Improving Health and Care in Greater Manchester, 2023-28.*

Summary:	The following document describes Greater Manchester's five-year Strategy and vision. The document is draft subject to approval by the GM ICP Board with sign-off anticipated on 24th March. The Strategy is provided for discussion and information, and the Board is asked to note that the priorities outlined by GM will be incorporated into the Trust's new corporate Strategy, which will be developed in 2023.

Previously considered by:
Not previously considered.

Proposed Resolution	The Board is asked to note the ICP Strategy.

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

Prepared by:	Greater Manchester ICP	Presented by:	Sharon White, Director of Strategy, Digital & Transformation

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

ICP	Integrated Care Partnership

Greater Manchester Integrated Care Partnership Strategy

Improving health and care in Greater Manchester
2023-2028

Contents

Foreword

This is Greater Manchester Integrated Care Partnership's strategy for the next five years. It follows our first strategy 'Taking Charge' Together published in 2015.

Our first strategy helped us develop our model of integrated neighbourhood and place based working. We established strong provider collaborations across secondary, primary, mental health and social care. We established an expansive strategic partnership with the Voluntary, Community and Social Enterprise (VCSE) sector, pioneering new approaches to community led care and support. We progressed a system wide Population Health Plan alongside scaled improvements and innovation in mental health access and provision, extended access in primary care and significant improvements in social care quality. Finally we established a nationally leading model to connect the health and care system with academic and industry partners in the pursuit, discovery and spread of innovation.

This work generated an increase in life expectancy for our residents prior to the COVID-19 pandemic, which bucked the trend nationally when compared with other areas of the country. Highlighting the success of health devolution in Greater Manchester and establishing a positive foundation of which to move forward, especially given the ongoing challenges of national austerity.

In spite of the progress we made, too many people living in Greater Manchester still spend far too much of their lives in poor health and severe inequalities remain.

The pandemic, which affected Greater Manchester more deeply than other areas in the country, set back our progress in tackling these challenges. Its impact means that the backlog of people waiting for care and support in Greater Manchester has reached levels that we would never have wished to see. This has a profound effect on people's ability to get on with their lives, exacerbating poverty and inequalities across our city-region.

Looking ahead, the impact of the current cost of living crisis is likely to last well into this decade and is anticipated to impact Greater Manchester harder and for longer. Resources for public services, in terms of both money and people, will be constrained for some time into the future.

Realising our ambition for the next five years also means taking on the more immediate challenges we face including the significant care backlog, workforce shortages, our health and care estate, the ongoing impact of inflation and the lack of a long-term national strategy for social care.

We won't be overcome by these challenges, Greater Manchester will come together with common purpose. Our task is nothing less than to mobilise all the resources at our disposal and point them to improving the health and well-being of our population. This means health and care services, local government, the Greater Manchester Combined Authority (GMCA), the VCSE, academia, businesses, the arts and culture – the whole of civic society.

We must accelerate our work to bring the NHS, public services, and the wider community together to deliver a neighbourhood based, integrated, preventative, person-centred model of care and support that enables people to live a good life. We must work as equal partners with communities across Greater Manchester and empower people to be much more active participants in their own health and well-being.

We must capitalise on our history of joint working with our ten councils, and our unique position as an Integrated Care Partnership co-terminus with a Mayoral Combined Authority, to tackle the social determinants of health and put health and wellbeing at the heart of every policy. These activities hold the key to preventing poor health and reducing demand for services in primary care, formal social care and our hospitals.

We must ensure that we utilise the potential of the integrated care system to organise care to generate maximum impact on health according to standards informed by our quality ambitions, addressing unwarranted variation in access, experience and outcomes for every resident receiving care.

We must harness the power of innovation and technology in the cause of population health improvement. Greater Manchester will be an integrated care system which is alert to discovery, open to innovative change and equipped to ensure it is spread effectively across our city region.

This strategy describes the improved outcomes we want to achieve for all people in Greater Manchester and how we will work together to achieve these. It will be supported by a more detailed delivery plan that we will complete by June 2023.

Sir Richard Leese
Chair, NHS Greater Manchester Integrated Care

Paul Dennett
Chair, Greater Manchester Integrated Care Partnership

1. Executive Summary

This is Greater Manchester's Integrated Care Strategy. It sets out how we intend to work together to improve the health of the people of our city-region through the Greater Manchester Integrated Care Partnership.

It follows on from our first strategy 'Taking Charge' published in 2015, through which we established our model of integrated neighbourhood and place-based working, supported by strong provider collaborations and strategic partnerships. While good progress was made, including an increase in life expectancy compared to other similar areas nationally, too many people living in Greater Manchester still spend more of their lives in poor health than people in other parts of the country – serious and longstanding inequalities remain.

Greater Manchester is home to more than 2.8 million people and is growing. The ten councils - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - and the Mayor of Greater Manchester work together as the Greater Manchester Combined Authority (GMCA) and with businesses, communities and other partners including the NHS, Greater Manchester Police and Transport for Greater Manchester, as described in the Greater Manchester Strategy (GMS)[1].

Our Integrated Care Strategy sets out how we, as an Integrated Care Partnership, comprising the NHS, local authorities, and partners across the VCSE, Healthwatch and the trade unions, will improve health and care for the people of Greater Manchester, playing a key role in delivering the GMS.

Our vision

As partners in Greater Manchester, we share the GMS vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city-region.

Specifically we as an Integrated Care System want to see a Greater Manchester where:
- ✔ Everyone has an opportunity to live a good life
- ✔ Everyone has improved health and wellbeing
- ✔ Everyone experiences high quality care and support where and when they need it
- ✔ Health and care services are integrated and sustainable

What we will do to achieve these:
- ✔ Ensure our children and young people have a good start in life
- ✔ Support good work and employment and ensure we have a sustainable workforce
- ✔ Play a full part in tackling poverty and long-standing Inequalities
- ✔ Help to secure a greener Greater Manchester with places that support healthy and active lives
- ✔ Help individuals, families and communities feel more confident in managing their own health
- ✔ Make continuous improvements in access, quality, and experience – and reduce unwarranted variation

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[1] https://aboutgreatermanchester.com/

- ✔ Use technology and innovation to improve care for all
- ✔ Ensure all our people and services recover from the effects of the COVID-19 pandemic as effectively and fairly as possible
- ✔ Manage public money well to achieve our objectives
- ✔ Build trust and collaboration between partners to work in a more integrated way

How we will work

Our strategy sets out how we will work together as a system to:

- ✔ Understand and tackle inequalities
- ✔ Share risk and resources
- ✔ Involve communities and share power
- ✔ Spread, adopt, adapt
- ✔ Be open, invite challenge, take action
- ✔ Focus on names not numbers

The current situation

Greater Manchester has some of the lowest life expectancy in England, with differences between the most and least deprived areas of 9.5 years for men and 7.7 years for women[2]. Further differences exist between communities according to race and ethnicity, gender, disabilities, poverty and social exclusion, sexuality and age, as shown through a range of external analyses.

This, coupled with increasing demand and a workforce crisis, is putting strain on our services. Residents have told us they have real concerns about funding and staffing levels, difficulties in accessing appointments, and waiting times for hospital care. We are responding to these challenges by:

Embedding the Greater Manchester Model for Health

Our Model for Health sets out how we will work together, with our communities, to enable the conditions for good lives, prevent poor health and ensure support is available before crises occur and to provide consistent and high-quality care wherever it is accessed. This is a social model for health, rather than a predominantly medical one, so focuses on the role of people and communities as well as health and care services.

Acting on our missions

Our strategy sets out the following missions, which are our priority actions in response to the current challenges.

✔ Strengthening our communities

We will help people, families and communities feel more confident in managing their own health. We will act on this with a range of programmes, including working across Greater Manchester to support communities through social prescribing, closer working with the VCSE and co-ordinated approaches for those experiencing multiple disadvantage.

✔ Helping people get into, and stay in, good work

One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by expanding our Work and Health programmes, working with employers on employee wellbeing, through the Greater

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[2] https://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020/greater-manchester-evaluation-2020.pdf

Manchester Good Employment Charter[3] and developing social value through a network of anchor institutions[4].

✔ Recovering core NHS and care services

We will work to improve ambulance response and A&E waiting times, reduce elective long waits and cancer backlogs, improve access to primary care services and core mental health services, improve quality and reduce unwarranted variation

✔ Helping people stay well and detecting illness earlier

We will collaborate to reduce smoking rates, increase physical activity, tackle obesity and alcohol dependency. We also want to do more to identify and treat high blood pressure, high cholesterol, diabetes, and other conditions which are risk factors for poor health and early We will embed a comprehensive approach to reducing health inequalities.

✔ Supporting our workforce and our carers

We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people choosing health and care as a career and feeling supported to develop and stay in the sector. We will consistently identify and support Greater Manchester's unwaged carers.

✔ Achieving financial sustainability

Financial sustainability - 'living within our means' - requires an initial focus on financial recovery to achieve a balanced position. We will confirm, quantify and tackle the main reasons for financial challenges in Greater Manchester, implementing a system wide programme of cost improvement, productivity, demand reduction and service transformation.

Monitoring Our Progress
We are clear about the progress we intend to make and are committed to demonstrating it. Our strategy sets out progress measures against our outcomes and missions, which focus on helping people to live good lives, improved health and wellbeing, better standards of care and support and greater integration of services.

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[3] https://www.gmgoodemploymentcharter.co.uk/
[4] https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

2.   Introduction

The way in which health and care services are organised in every part of England changed on 1 July 2022, when the Health and Care Act 2022 came into force. Greater Manchester is now an Integrated Care System (ICS) – a partnership of organisations that come together to plan and deliver joined up health and care services and improve the lives of people who live and work here. Our ICS is called Greater Manchester Integrated Care Partnership.

There is a requirement for all ICSs to develop a strategy. NHS organisations and local authorities must then have regard to this strategy when making decisions about the use of health and care resources.

This document is Greater Manchester Integrated Care Partnership's strategy. It sets out how we intend to work to improve the health of the 2.8m residents here. It focuses on the contribution of health and care to enabling everyone to live a good life through improved wellbeing.

In Greater Manchester we had a strategy for health and care, called "Taking Charge"[5], which was developed in 2015 following the devolution of funding for health and social care from the Government to the city-region and covered 2016-2021.

This new strategy builds on the work undertaken across Greater Manchester through Taking Charge, sustaining and extending examples of progress whilst acknowledging and addressing evident challenges.

It recognises and responds to today's context of an extended period of austerity affecting public services, the aftermath of a global pandemic and the pressures associated with the cost-of-living crisis on families, businesses, charities and public services. Those stresses have shown the impact of deprivation on health outcomes for our citizens, compounded by a multitude of wider inequalities. This is a challenge for the whole of Greater Manchester and reinforces the ongoing need for a broad public service reform agenda, linked to a demanding environmental agenda and the building of a more inclusive economy. In all of these integrated health and care has a significant role to play.

We will develop and publish a Joint Forward Plan (JFP) by the end of June 2023 as a delivery plan for the ambitions in this strategy and this plan will be updated annually.

[5] https://www.greatermanchester-ca.gov.uk/media/1120/taking-charge-of-our-health-and-social-care-plan.pdf

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3.　Context

About Greater Manchester

Greater Manchester is home to more than 2.8 million people and has an economy bigger than that of Wales or Northern Ireland. Greater Manchester's population in the 2021 Census was estimated to be 2,867,800. This is an increase of 185,272 on the 2011 Census and represents a growth of 6.9% in ten years, higher than the growth across England and Wales (6.3%) over the same period. All Greater Manchester local authorities have seen population growth since 2011, with the highest rate of growth being in Salford (15.4%). This was also the highest actual percentage growth of any metropolitan district in the country. The City of Manchester's population has grown by the most within Greater Manchester with an increase of 48,873 in the ten years. Amongst the 36 metropolitan districts in England, only Birmingham (71,855), had a larger actual growth than Manchester.

There are ten councils in Greater Manchester: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. All are unitary authorities, eight are metropolitan borough councils and two, Salford and Manchester, are city councils.

The Greater Manchester Combined Authority (GMCA) is made up of the ten Greater Manchester councils and the Mayor, who work with other local services, businesses, communities and other partners to improve the city-region.

The ten councils have worked together for many years on issues that affect everyone in the region, like transport, regeneration and attracting investment.

The Greater Manchester Strategy

The Greater Manchester Strategy (GMS) is developed by GMCA on behalf of multiple partners across the city-region. It is our collective blueprint for a decade from 2021-2031, setting out how, working collectively across Greater Manchester, with our communities, we can deliver the shared vision:

> "We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city-region"

The GMS focuses on improved wellbeing for the people here, with better homes, jobs and transport. The strategy describes how we will work to continue to make Greater Manchester a great place to visit, invest and study, with thriving businesses which are both UK and world leading, in sectors including low carbon and digital. The GMS is designed to ensure that activity supports the achievement of a greener, fairer and more prosperous Greater Manchester, in a way which is inclusive, innovative and forward thinking. It builds on the pioneering and progressive culture which underpins Greater Manchester. It also shows how Greater Manchester can be held to account, with a delivery plan showing the collective actions being taken, and a performance framework to demonstrate progress.

As an Integrated Care Partnership, we have an integral role in delivering the GMS. The GMS focuses on the following shared outcomes:

The wellbeing of our people
- A Greater Manchester where our people have good lives, with better health; better homes; culture and leisure opportunities and better transport
- A Greater Manchester of vibrant and creative communities; a great place to grow up get on and grow old, with inequalities reduced in all aspects of life

Vibrant and successful enterprise
- A Greater Manchester where diverse businesses can thrive, and people from all our communities are supported to realise their potential
- A Greater Manchester where business growth and development are driven by an understanding that looking after people and planet is good for productivity and profitability

Greater Manchester as a leading city-region in the UK and globally
- Greater Manchester as a world-leading low carbon city-region
- Greater Manchester as a world-leading digital city-region

4.   Greater Manchester Integrated Care Partnership

In July 2022, Greater Manchester's health and care arrangements changed, as they did everywhere in the country, under the Health and Care Act 2022. The following bodies and organisations were established:

Greater Manchester Integrated Care Partnership (this is the name of our integrated care system) connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, councils and partners across the VCSE, Healthwatch and the trades unions. It is one of 42 integrated care systems across England. It is one of the largest and one of only two which covers the same geographical area as a Mayoral Combined Authority.

Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS Greater Manchester Integrated Care and councils within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop this Integrated Care Strategy - a plan to address the wider health, and care needs of the population.

NHS Greater Manchester Integrated Care, or NHS Greater Manchester (our integrated care board) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in a geographical area. It supports ten place-based integrated care partnerships in Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

Our shared vision, outcomes and commitments
As partners in, and participants of, the Greater Manchester Strategy, we share the vision of wanting Greater Manchester to be a place where *everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city-region.*

For the Greater Manchester Integrated Care Partnership this means we want to see a city region where:

- ✔ Everyone has an opportunity to live a good life
- ✔ Everyone has improved health and wellbeing
- ✔ Everyone experiences high quality care and support where and when they need it
- ✔ Health and care services are integrated and sustainable

Our shared commitments to ensure we achieve those outcomes are to:

- ✔ Ensure our children and young people have a good start in life
- ✔ Support good work and employment and ensure we have a sustainable workforce
- ✔ Play a full part in tackling poverty and long-standing Inequalities
- ✔ Help to secure a greener Greater Manchester with places that support healthy and active lives
- ✔ Help individuals, families and communities feel more confident in managing their own health
- ✔ Make continuous improvements in access, quality, and experience – and reduce unwarranted variation
- ✔ Use technology and innovation to improve care for all
- ✔ Ensure all our people and services recover from the effects of the COVID-19 pandemic as effectively and fairly as possible
- ✔ Manage public money well to achieve our objectives
- ✔ Build trust and collaboration between partners to work in a more integrated way

How we work

The creation of NHS Greater Manchester, and our new Integrated Care Partnership, gives health and care partners the opportunity to work together to face the challenges the current economic climate presents to our communities and to public services.

Transforming public services, integrating care to provide solutions which are more than medicine, and working with communities; not simply 'doing to', will fundamentally challenge our approaches to delivery and working together. The way that members of the Integrated Care Partnership work together, with each other and with our communities, will play an important part in achieving our vision.

Our Ways of Working:

Behaviours	We will …
Understand and tackle inequalities	✔ Take action at individual, team, organisation, and system levels, informed by data, to understand and tackle inequalities.
Share risk and resources	✔ Set out our expectations of each other, share data effectively, support joint working with shared resource and create a culture of collaboration. This must happen at every level and in every place.
Involve communities and share power	✔ Consistently take a strengths-based approach with co-design, co-production and lived experience as fundamental ingredients.
Spread, adopt, adapt	✔ Share best practice effectively, test, learn and celebrate success, with supportive governance and resources. Adapt and implement best practice locally, in organisations and across systems.
Be open, invite challenge, take action	✔ Be open, honest, consistent and respectful in working with each other. Work on the boundaries and differences that we have in a constructive way, to support effective change.
Names not numbers	✔ Ensure we all listen to people, putting them at the centre, and personalising their care.

This will involve rapidly increasing the level of integrated neighbourhood and locality working that connects all partners and communities who can contribute to improving health and tackling inequalities. This will move us to a stronger model of collaboration at a Greater Manchester level, ensuring more consistent and standardised responses to systemic challenges.

To ensure we play our part in delivering our shared vision across Greater Manchester, we will capitalise on both:

- The connection with neighbourhoods and communities that locality working offers – to integrate health and care with wider public services and tackle the root causes of poor health; and
- The scale that a single Greater Manchester organisation offers – to drive consistent improvement, reduce unwarranted variation and make the best use of our collective resources

Figure 1, highlights how partners across health and care, wider public services and the VCSE work together as part of integrated neighbourhood teams in place based partnerships across our ten localities and, where appropriate, across the whole of Greater Manchester.

GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP

Operating at **3 levels** to ensure that...
- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable

① Across Greater Manchester system
2.8 million people
- Greater Manchester Integrated Care Partnership Board
- NHS Greater Manchester Integrated Care
- Provider Collaboratives - All NHS Trusts (Provider Federation Board) and all Primary Care (Primary Care Board)
- Greater Manchester Combined Authority
- Health Innovation Manchester
- Social care providers
- Voluntary, community and social enterprise sector

③ Neighbourhoods
1 of 66 areas
- Local Primary Care Network (all GP practices)
- Dentists, pharmacists and opticians
- Social care teams
- NHS therapists and community teams
- Other public services e.g. schools & housing providers
- Voluntary, community and social enterprise sector

② Local place
1 of 10 places
- Local Integrated Care Partnership Board
- Council
- Social care providers
- NHS Trust(s)
- Primary Care
- Healthwatch
- Voluntary, community and social enterprise sector

Figure 1

Within Greater Manchester we have arrangements for providers to work together effectively at scale, including:

- The Greater Manchester **Provider Federation Board** (PFB): a membership organisation made up of the eleven NHS trusts and foundation trusts who provide NHS funded services across Greater Manchester and East Cheshire. It includes the NHS providers of 111, 999, patient transport services (PTS), community mental health and physical health services and hospital mental health and physical health services.
- The Greater Manchester **Primary Care Board (PCB)** has been supporting collaboration and integration since 2015 and will continue to support the delivery of outcomes at all levels of, and across, the system, through its various programmes and its work with all 67 Primary Care Networks[6] (PCNs) in Greater Manchester.
- Greater Manchester **Directors of Adults' and Children's Social Care** collaborating to support transformation of social care at scale. For adult social care this also includes joint working with the Greater Manchester Independent Care Sector Network.
- **Voluntary, Community and Social Enterprise (VCSE) sector providers** are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE sector represented by the Greater Manchester VCSE Leadership Group, based on a relationship of mutual trust, working together and sharing responsibility, and providing a framework for collaboration. The VCSE has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations

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[6] Primary Care Networks involve GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs).

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operating at scale across Greater Manchester. It provides an infrastructure for alternative providers to engage with NHS Greater Manchester on a Greater Manchester footprint.

5. Influences on this strategy

We have drawn on a variety of sources in order to identify our vision, shared outcomes and commitments:

- ✔ What the data and research is telling us about health needs
- ✔ What the evidence and evaluation is telling us
- ✔ The pressures on current services and the health and care workforce
- ✔ What residents are telling us

These influences together identify a series of challenges for Greater Manchester Integrated Care Partnership, to which this strategy responds.

Data and health needs

Among its population of 2.8m people, Greater Manchester has some of the lowest life expectancy in England, with differences between the most and least deprived areas of 9.5 years for men and 7.7 years for women[7].

Significant disparities exist between and within Greater Manchester's ten localities. In some those living in the neighbourhood with the shortest life expectancy can, on average, expect to die a whole decade before those in neighbourhoods which fare best. In some places the disparity is as big as 17 years.

Further disparities exist between communities according to race, ethnicity, gender, disabilities, poverty, social exclusion, sexuality and age. For example:

- The poorest children are four times as likely to have a mental health difficulty as the wealthiest[8]
- Black people are almost five times as likely to be detained under the Mental Health Act[9]
- The rate of mental health problems in adults with a learning disability is 40% at any one time, and 36% for children and young people[10]. Almost eight in ten autistic adults experience a mental health problem[11], compared with one adult in six in the general population[12]
- LGBT people are less satisfied with their life nowadays than the general population, scoring it 6.5 out of 10, compared with 7.7 for the general UK population[13]
- More than eight in ten women in Britain have felt as though they have not been listened to by healthcare professionals[14]

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[7] Codling, K. & Allen, J., Health Equity in Greater Manchester: The Marmot Review 2020. London: IHE, 2020 https://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020/greater-manchester-evaluation-2020.pdf

[8] https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/newcentury.pdf

[9] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

[10] https://www.nice.org.uk/guidance/ng54/chapter/Context

[11] Lever and Geurts (2016) https://doi.org/10.1007/s10803-016-2722-8

[12] https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249mp_/http://digital.nhs.uk/media/35660/APMS-2014-Full-Report/pdf/Mental_health_and_wellbeing_in_England_full_report

[13] https://www.gov.uk/government/publications/national-lgbt-survey-summary-report/national-lgbt-survey-summary-report#the-results

[14] https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

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- Black women are 3.7 times more likely to die during pregnancy or childbirth compared to white women with women from Asian backgrounds facing 1.8 times the risk of maternal mortality[15]

In each case there are direct implications for the design and delivery of health and care services to achieve equity in terms of timely access, experience of care and the outcomes of that care.

The 2021 Census confirmed the broad trends of continuing population growth that we see for Greater Manchester, and especially the cities of Manchester and Salford,[16]. The scale of growth in recent decades across Greater Manchester outstrips the population losses of the 1970s and 1980s.

The scale and characteristics of the growth in Greater Manchester's population will have implications for services such as health and social care for the elderly, school places and public transport but will also mean that Greater Manchester public services' funding from central government should be expected to change in accordance with these population changes.

In 2020, the **Institute of Health Equity** (IHE), led by Professor Sir Michael Marmot, published an update on the 2010 Marmot Review of health inequalities in England, which included a parallel report dedicated to Greater Manchester[17].The IHE followed this with a detailed analysis of how Greater Manchester could become a Marmot city-region by tackling inequalities across the life course, published as Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives[18].

The principle of 'proportionate universalism'[19] emphasised as part of that work, recognises that, in order to reduce inequality, greater help will be needed by those with greater challenges to overcome.

The **Independent Inequalities Commission** (IIC)[20], showed the main socioeconomic inequalities in Greater Manchester to be centred on housing and the lived environment; education and skills; power, voice and participation; income, wealth and employment; connectivity and access to care and support. In a bid to address these inequalities, the IIC recommended that Greater Manchester focus its energy and resources on attaining two main goals: equality and wellbeing.

The IIC identified that in terms of income, wealth, and employment:

- Nearly a quarter of Greater Manchester adults of working age (24%) are economically inactive, well above levels for England as a whole (21%)
- For people from minority ethnic groups in Greater Manchester, employment rates are over 10% below the overall working-age employment rate
- Only half of Greater Manchester working-age residents with a disability are in employment

[15] Saving Lives, Improving Mothers' Care 2018-20 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf
[16] https://greatermanchester-ca.gov.uk/what-we-do/research/research-demographics/census-2021-first-results
[17] Codling, K. & Allen, J., Health Equity in Greater Manchester: The Marmot Review 2020. London: IHE, 2020. https://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020/greater-manchester-evaluation-2020.pdf
[18] Marmot, M., Allen, J., Boyce, T., Goldblatt, P. & Morrison, J., Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives. London: IHE, 2021. https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives
[19] Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.
[20] The Next Level: Good Lives for All in Greater Manchester https://www.greatermanchester-ca.gov.uk/media/4605/the-next-level-good-lives-for-all-in-greater-manchester.pdf

- 37% of the city-region's working-age population have higher level (Level 4+) skills, compared to the England average of 40%; and Greater Manchester has a disproportionately high proportion of working-age people with no qualifications (9%)
- The skills deficit reinforces the predominance of lower value, low pay employment in the city-region compared to the south of England and Greater Manchester's international comparators. Low income levels underpin high levels of child poverty (26%) in Greater Manchester, which are well above the national rate of 18%
- There is compelling evidence of ageism in recruitment and retention of older workers, leading to low incomes and lack of social roles in mid-life and later life

Greater Manchester commissioned an **Independent Prosperity Review** in 2019 which was updated in 2022[21] in the light of the COVID-19 pandemic, the UK's exit from the European Union and the inflation and energy price shock.

It showed that:
- Greater Manchester's productivity has been about 10% below the national average in recent years
- Among the causes – explaining about 30% of the productivity gap - is lower labour market participation caused by health problems.
- There are very strong correlations between employment levels and health conditions. Research found that as much as 75% of the variance in employment rates across the neighbourhoods of Greater Manchester is accounted for by health (correlations for mental and physical ill-health were similar)

Greater Manchester is relatively deprived compared to other ICSs in England – with the third highest percentage of the most deprived areas in England, compared with the 42 ICSs. Deprivation varies across localities within Greater Manchester, as our analysis of needs and plans from each locality demonstrates (Appendix 1)

Evidence and evaluation

The years following health and care devolution in 2016 have been times of change for the whole population and a range of improvements in health have been achieved:

- Reductions in smoking prevalence
- Supporting more children to be school-ready
- Reductions in people who are physically inactive
- Positive employment outcomes for people with health-related barriers to work
- All of these show sustained performance compared to the rest of England

Taken together, these changes contributed to an improvement in life expectancy against comparable areas. A study by University of Manchester researchers published in Lancet Public Health[22] shows life expectancy in Greater Manchester was higher than comparable areas between 2016 and 2019, In the short-term, life expectancy remained constant in Greater Manchester but declined in comparable areas in England. In the longer-term, life expectancy increased at a faster rate in Greater Manchester than in comparable areas. The study showed the benefits, linked to devolution on life expectancy, were felt in the most deprived localities where there was poorer health, suggesting a narrowing of inequality.

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[21] https://greatermanchester-ca.gov.uk/what-we-do/economy/greater-manchester-independent-prosperity-review/ipr-2022-evidence-update/
[22] Britteon P et al, published October 2022, https://doi.org/10.1016/S2468-2667(22)00198-0

There is much about our Model for Health, connecting social, medical and behavioural factors, which has been demonstrated to work and will remain the focus of our work with communities in neighbourhoods throughout the life of this strategy.

Pressures on current services and the health and care workforce

Like all health and care systems, Greater Manchester is facing a range of challenges, some of which can be addressed within Greater Manchester while others also require changes at a national level. The impact of the COVID-19 pandemic has been huge, and exacerbated many of the challenges which were already having an effect on the wellbeing of staff and the sustainability of services:

Demand for NHS services

- Over 535,000 people were waiting for treatment as of February 2023 compared to 220,000 before the COVID-19 pandemic
- Prior to the pandemic, Greater Manchester was not meeting national standards for cancer, and the equivalent of five additional theatres are required now, five days a week, to address the cancer surgical backlog
- Mental health demand and acuity is high as a direct consequence of the pandemic, with national predictions that mental health needs will remain at elevated levels for some time to come
- Two thirds of GP practices in Greater Manchester were reporting increased levels of demand, with a further one fifth reporting significant or very significant increased demand in February 2023. Over one quarter of pharmacies and two fifths of dental practices and optometrists are reporting challenges – sometimes significant - to the delivery of their service

NHS resources

The Greater Manchester system has both an efficiency and a productivity challenge. NHS Greater Manchester inherited a system structural budget deficit (commitments over revenue) of over £500 million (out of a total budget of £6.5 billion) on its establishment on 1st July 2022. This reflects the ongoing cost of additional resources (mainly workforce) put in place during the COVID-19 pandemic. One of the national requirements of an ICB is to bring the system into balance.

Demand for social care

- There is growing demand on local authorities for social care support, and expenditure on social care continues to rise[23]: 600 people a day join a waiting list nationally[24]
- 64% of local authorities reported local provider closures, contract hand backs, or ceased trading[25]
- There are disproportionately high numbers of children and young people across Greater Manchester who are at risk, vulnerable or have complex needs. At the end of 2021/22, there were 92.1 looked after children per 10,000 under 18 years olds in the care of the local authorities of Greater Manchester, compared to 69.8 per 10,000 in care of authorities across England overall[26]
- The financial challenges in children's services are being driven largely by a combination of increased demand for and cost of placements for looked-after children, alongside unprecedented workforce challenges also common to adult social care, particularly around recruitment and retention of social workers and other professionals, with increased use and rising cost of agency staff

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[23] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-statistics-in-england/an-overview#summary
[24] https://www.adass.org.uk/surveys/waiting-for-care-july-22
[25] https://www.adass.org.uk/autumn-survey-report-2022
[26] https://democracy.greatermanchester-ca.gov.uk/documents/s24692/Item%206%202023%2002%2010%20ICPB%20-%20An%20Integrated%20Approach%20to%20delivering%20our%20Ambition%20for%20Children.pdf

Pressures on the health and care workforce[27]

- Recruitment and retention – with particular pressures in nursing and midwifery, dental nursing, care workers and within the VCSE sector. We also know that we have an ageing workforce and a high turnover of people within adult social care
- Health and wellbeing - the COVID-19 pandemic and subsequent recovery has been really challenging for our workforce. As a result, sickness absence levels remain extremely high, putting further strain on our workforce and our finances
- Lack of diversity amongst our workforce must be addressed, to ensure decisions are being made and care is being provided that meets the needs of everyone
- Lack of parity between the NHS and social care – payment of the living wage, access to occupational sick pay and wellbeing support needs to span the totality of the workforce including social care, primary care and the VCSE.
- Cost of living crisis – our staff, in common with our communities, face increasing fuel and food costs. In areas of primary care and social care we know that turnover is impacted by people finding better pay in the retail sector
- Financial challenges - the workforce crisis is contributing to our financial strain with high sickness absence rates, agency and locum spend and reduced workforce productivity. Resolution to the workforce crisis must focus on retention, as well as thinking about working in a different way, embracing digital advancements and reducing costly agency and locum spend

What residents are telling us

Phase Two of the Big Conversation[28] took place in October 2022 and involved a range of methods for engaging people across the length and breadth of Greater Manchester. More than 2,000 individuals were involved, including men and women, older and younger people, carers, LGBTQ+, people with disabilities, members of different BAME communities, asylum seekers, refugees and other excluded groups including sex workers and the street homeless.

Across Greater Manchester residents told us there is:

- Widespread concern with funding and staffing levels for the NHS, as well as social care and the local VCSE
- Widespread concern about the difficulties experienced in accessing GP appointments, as well as other access problems such as waiting times for hospital care
- Demand for more personalised and person-centre care, which takes account of the different needs of different individuals and communities, and recognises that one size does not fit all
- Demand for more and better partnership working with the VCSE sector which is seen as ideally placed to help statutory services negotiate some of the above
- An expressed need for more action on prevention and the wider determinants of health, including help with the cost of living

Throughout the engagement the first two themes overshadowed all others. Further details of the engagement process with residents, staff and the Greater Manchester Integrated Care Partnership are given in Appendix 2.

The latest Greater Manchester Residents' Survey (Jan 2023)[29] highlights relevant challenges relating to the cost-of-living crisis:

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[27] GM People and Culture Strategy https://gmintegratedcare.org.uk/workforce/
[28] https://gmintegratedcare.org.uk/big-conversation/
[29] https://greatermanchester-ca.gov.uk/what-we-do/research/resident-surveys/

- As a result of the cost-of-living crisis, employed respondents in Greater Manchester are more likely than those across Great Britain to be working more hours than usual (33% v 18%); looking for a job that pays more money (23% v 18%) or working more than one job (13% v 3%)
- 71% of respondents are worried about the rising cost of living, with more being 'very worried' in Greater Manchester than nationally. 85% of people who are disabled or not in work due to ill health or disability are worried
- 40% of respondents had a food security level classified as 'low' or 'very low'– and have experienced food insecurity in last twelve months. Food security is where people are confident that they can access a sufficient amount of affordable, nutritious food
- 36% of respondents noted that their household experienced some form of digital exclusion (not being able to get online). Disabled people and older residents are more likely to be digitally excluded

Young people in Greater Manchester, participating in #BeeWell (a programme that annually measures the wellbeing of young people across Greater Manchester) have indicated[30]:

- In 2021, the average life satisfaction and mental wellbeing scores of young people across Greater Manchester were lower than those of young people in England (in studies using the same measures as in #BeeWell)
- 16% of young people responding to the 'Me and My Feelings' measure reported a high level of emotional difficulties and are likely to need significant additional support.
- The life satisfaction average score is 6.2 out of 10 for girls but 7.2 for boys. There are sizeable inequalities for young people who identify as LGBTQ+
- Across Greater Manchester, just over one in three young people (34%) are reaching the recommended levels of physical activity set by the Government's Chief Medical Officer of at least one hour per day. This falls to 27% of girls, 27% of Asian pupils, and 18% of Chinese pupils
- Pupils from a range of ethnic groups (for example, over a third of Black and Chinese pupils) report experiencing discrimination because of race, skin colour, or where they were born (occasionally, some of the time, often or always)
- Over a third of young people who identify as gay or lesbian report at least occasionally experiencing discrimination because of their gender, and this rises to around 40% for young people who identify as bisexual or pansexual, or transgender

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[30] https://gmbeewell.org/research/publications/beewell-reports-briefings/

The challenges

This information demonstrates that there are challenges which demand a response through this strategy:

- How to continue the improvements already made
- The wider influences on health and good lives
- Health and work
- Access to services and increasing demand
- Health outcomes and heath inequalities
- Workforce recruitment and retention
- Financial resources
- Ensuring equitable opportunity and service provision across the whole of Greater Manchester

6. Responding to the challenges

There are three core elements of this strategy which describe how we will respond to the challenges highlighted through data, evidence and engagement:

1. *Embedding the Greater Manchester Model for Health (Figure 2).* This shows how we work with communities to prevent poor health, and ensure support is available before crises occur, to reduce demands on formal NHS and social care services. It shows how we work together to provide consistent and high-quality care so Greater Manchester residents can be assured that care is just as good wherever it is accessed. It is a social model for health (rather than predominantly a medical one), has people and communities at its heart, and is based on innovating and spreading what works.

2. *Identifying and acting on our missions to address today's challenges.* This strategy outlines our shared commitments - everything we will do together across the next five years – and focuses on the missions which connect the whole system to our most significant and deep-rooted challenges. Each mission responds directly to what the residents of Greater Manchester have told us, the pressures facing public services and our workforce and the evidence and research into what drives our health needs and what works to respond to them.

3. *Monitoring our progress.* We will ensure that we are clear about the progress we intend to make, and that we can demonstrate how we are meeting it.
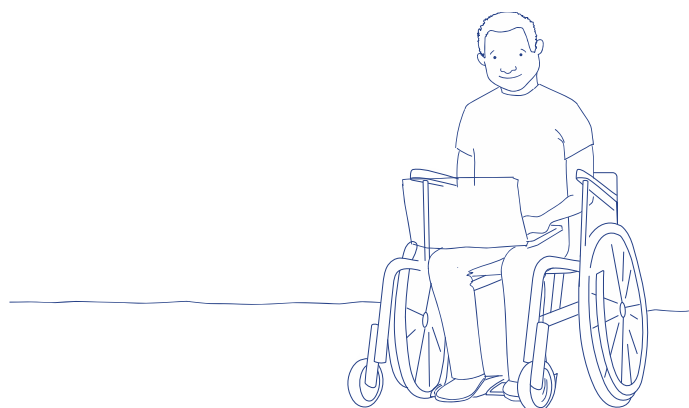
7. Embedding the Greater Manchester Model for Health

In 2015 we described the key elements to transforming our health and care model in our plan 'Taking Charge'[31]. That approach, responding to NHS England's Five Year Forward View[32] committed us to:

- ✔ A radical upgrade in population health and prevention
- ✔ Transforming community-based care and support
- ✔ Standardising acute and specialist care
- ✔ Standardising clinical support services
- ✔ Enabling better care

This was ambitious, comprehensive, and relevant to the long-term transformation of health and care. There are significant areas of progress since 2015, as well as important areas for further development. The model for health has evolved and developed over the last seven years and it must now frame how we work.

The Greater Manchester Model for Health

We have the opportunity to realise a 'social' (rather than a predominantly medical) model for health, including population health and prevention, given the depth of relationships between the NHS, councils, wider public service partners and the VCSE in Greater Manchester. This is a model which offers more than medicine and positively addresses the full range of determinants of health.

The Greater Manchester Model for Health is based on core principles of co-production, working with people and communities rather than 'doing to'. We have exceptional examples of integrated neighbourhood working, mature provider collaboration, public service reform and evidence of impact since 2015.

We have a unique opportunity to drive our research, innovation and discovery efforts and support deployment at scale through Health Innovation Manchester[33].

Our challenge is that this Model is not universally realised across Greater Manchester. Our aim through this strategy therefore is to confirm the actions and approaches necessary to achieve this and maximise the effectiveness of how we work together to improve our outcomes.

The following section describes the core characteristics of the Model and the focus of its further development.

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[31] https://www.greatermanchester-ca.gov.uk/media/1120/taking-charge-of-our-health-and-social-care-plan.pdf
[32] https://www.england.nhs.uk/five-year-forward-view/
[33] https://healthinnovationmanchester.com/

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Figure 2

A social model for health - People & community approaches - Innovation & spread

Local acute hospitals
Ambulance services
Clinical support services
Specialist care
Specialist mental health
Residential & nursing care

INTEGRATED CARE

GREATER MANCHESTER

MODEL FOR HEALTH

Living well at home & adult social care
Integrated urgent care
Dental & community pharmacy
Health screening & immunisation
Reducing harm from tobacco, alcohol & drugs

Primary care networks & neighbourhood teams
Social prescribing 'Live Well'
Children's services & family hubs
Community mental health 'Living Well'

NEIGHBOURHOOD WORKING / PREVENTION & REDUCING HARM

| Arts & culture | Mentally healthy schools | Strong communities & families | Active travel GM 'Bee Network' | Inclusive economy | Age friendly GM | Support for carers | Education, skills & good work | Physical activity 'GM Moving' | GM 'Make Smoking History' | Good homes & supported housing | Clean air & sustainable development | Diet & food security | Health & justice |

CONDITIONS FOR GOOD LIVES

Creating the conditions for good lives

We pursue a 'health in all policies'[34] approach to maximise our influences on the social determinants of health. These include:

Strong communities and families - as part of the response to the COVID-19 pandemic, we saw that improved levels of volunteering assisted the wellbeing and health of both those volunteering and those receiving support. The appetite for rapid innovation saw services blended with the VCSE sector due to their direct reach into communities, services run from local community buildings and befriending services bridging the gap for people. The willingness to care and volunteer offers real potential to secure a lasting legacy from the pandemic.

An inclusive economy - an approach to economic development where everyone can participate in local economic life; where local resources and wealth are redirected into the local economy and where local people have more control. Where the contribution of public services is maximised through the Greater Manchester social value framework[35], including our contribution to the local economy in relation to employment, procurement, building and land use, and our environmental impact.

An age friendly Greater Manchester - responding to the opportunities and challenges of an ageing population in our city-region, focusing on reducing inequalities and ageing well. This requires a change in approach to health and social care to ensure more proactive care, healthy and active ageing and ensuring people get the right care when they need it.

Skills, education and good work - supporting early years development to enable more children to be school ready; ensuring successful educational experiences in schools and colleges which support positive mental health and securing more control of the post-19 skills system to lead to better employment opportunities across the city-region. Focussing also on good work through the spread of the Greater Manchester Good Employment Charter, improving pay and supporting wellbeing in work.

Good Homes - connecting with the GMCA, councils and Greater Manchester's housing providers to improve the availability and quality of housing, including supported housing. Tackling and preventing homelessness and developing homeless healthcare as part of an approach to health that includes people who are socially excluded (inclusion health[36]).

Healthy places - developing neighbourhoods with cleaner air and access to green spaces where communities can come together, connect and support each other, enjoying their local environment and benefitting their physical and emotional health; where active travel through walking and cycling is made easy and supported by our collective work through GM Moving, our city-region wide movement to get people moving.

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[34] https://www.gov.uk/government/publications/local-wellbeing-local-growth-adopting-health-in-all-policies
[35] https://www.greatermanchester-ca.gov.uk/what-we-do/economy/social-value-can-make-greater-manchester-a-better-place/
[36] https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health

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CASE STUDY: Greater Manchester Moving

Greater Manchester Moving, known as GM Moving, is a movement of people, communities and organisations, from every sector and place across the city-region, with a shared goal of enabling active lives for all.

Together, we believe that:
• Moving matters to us all
• We need to design movement back into our lives
• Everyone has a role to play

Our collective strategy 'GM Moving in Action 2021-31' sets out our whole system approach for achieving this mission, and how we aim to help people move a little more; making it easier to be active and a natural part of how we all live, travel, work and play.

Why is this important? Because movement and activity contributes to our physical and mental wellbeing and leads to happier and healthier lives. This in turn will help us to develop an economically and environmentally sustainable Greater Manchester.

Data shows that prior to the pandemic, GM was successfully reducing inactivity levels at 2.5 times the national rate. However, in the first 12 months of Covid our inactivity rose twice as fast as the national average. We also experienced unequal impacts between different people and communities, such as disabled people, those with long-term health conditions, culturally diverse communities, and people of different age groups and incomes.

The aim of GM Moving is to close those inequality gaps and ensure an active life for all by 2031.

CASE STUDY: Improving lung health and the environment

Inhalers, widely prescribed for those with asthma or COPD (chronic obstructive pulmonary disease), make a significant contribution to Greater Manchester's carbon footprint. In any given month, there are over 300,000 inhalers prescribed in the city region with an environmental impact equivalent to the emissions from 28,000 cars.

Joint working between GP practices and their patients in 2021-22 helped to reduce greenhouse gases by the equivalent of 563 metric tons of CO2e in the last year. This is equivalent to 3774 fewer cars on Greater Manchester roads.

For example GPs and staff at Kirkholt Medical Centre, a GP surgery in Rochdale, have worked with patients to improve asthma care while reducing the carbon footprint of prescribed inhalers. This was achieved through encouraging lifestyle changes, such as stopping smoking, addressing reliever overuse (salbutamol), encouraging preventer use, and when appropriate supporting a change to dry powder inhalers.

The inhaler programme is GP led and a collaboration of work between GP practices, nurses, hospital staff, patient groups and the GMCA. The programme is one of the key programmes of work within the NHS Greater Manchester Green Plan.

Diet and food security - improving diets and tackling food insecurity (where people are not confident that they can access enough affordable, nutritious food) to improve physical and mental health, educational and economic outcomes. In children, food security positively affects happiness and life satisfaction, social skills, and quality of life scores.

Health and justice - addressing the health, social care and criminal justice factors that can lead to life-long poor physical and emotional health, and reduced life-expectancy, for people in the criminal justice system, as offenders or victims. Working with Greater Manchester Police, the National Probation Service, education professionals, youth justice and local authorities to address the underlying causes of violent crime and work together with communities to prevent it. This forms part of Greater Manchester's approach to tackling serious violent crime, ensuring victims of violent crime get the right support, and improving the criminal justice response to all forms of serious violence.

Providing proactive and preventative integrated care through our neighbourhood model

Utilising people and community centred approaches alongside proactive primary care as part of a comprehensive neighbourhood model spanning public services, local business and community-led groups. This aims to maintain good health and independence and reduce demand on acute and crisis services. This ambition is underpinned by our blueprint for primary care which is being developed.

Integrated neighbourhood teams - typically organised for 30-50,000 residents and coterminous with primary care networks, which are groups of GP practices working together in local areas.

Our integrated neighbourhood teams work to connect all primary care services including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service). We will not miss the opportunity to maximise the enormous potential of community pharmacy within those integrated teams to reduce pressure on GPs and hospitals.

Utilising population health management tools to anticipate care needs and provide support and preventative care before crises occur. Integrating local urgent care to provide an urgent community response and reduce the need for people to need ambulance or hospital support.

Our digital transformation plans are key to connecting and improving this aspect of the Model through improved data availability, particularly for community services, ensuring those at highest risk are identified and supported appropriately, and the expansion of remote monitoring and virtual wards. We are continuing to enhance the Greater Manchester Care Record and its use for direct care, secondary uses and research. For the integrated care workforce, we are promoting the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme.

The neighbourhood model is the key to making our model for health a reality, ensuring that people are supported to live well and continue doing the things they love, with the support they need, whether they're diagnosed with a long term condition, cancer, dementia, or they're at the end of their life and receiving palliative care.

CASE STUDY: Healthy Hyde

Healthy Hyde began in December 2021 after the local Primary Care Network (PCN) was tasked with improving the health and wellbeing of the most deprived 10% of its population.

The programme aims to make changes to someone's life early on, in order to improve their life before they hit crises. Much of their work is with the homeless population, refugees, asylum seekers, food bank users, children struggling in schools, and parents with young children. The range of support includes help with employment, housing, health, nutrition, social care, pre and post-natal education.

Funded through the Locally Enhanced Service scheme, Healthy Hyde is run from the 30-strong PCN office comprising a variety of health and wellbeing practitioners, a PCN manager and two clinical directors. The team partners with housing organisations, domestic violence organisations, voluntary and community groups, the local council, housing shelters and statutory services at a variety of levels.

By taking the time to get to know their communities, listen to what they want and adapt their offer to fit their needs, Healthy Hyde has introduced a number of initiatives, including English lessons for refugee and asylum seekers with incorporated wellbeing checks, advice sessions at local food banks, health drop-in sessions for homeless people, post-natal courses, mum and toddler groups with an emphasis on health matters, and a memory café run by mental health practitioners aimed at combating loneliness among carers.

Screening and immunisation - identifying those at greatest risk and supporting early detection and therefore earlier treatment and support. Reducing health inequalities and addressing differences in uptake among different groups.

Reducing harms from tobacco, alcohol and drugs - reducing smoking prevalence as part of our Make Smoking History programme; reducing alcohol and tobacco harms especially during pregnancy and changing lives with those experiencing multiple disadvantage and struggling with the complexities of drug, alcohol, mental health and associated problems. This has been a key element of our public service reform journey for a number of years now and ensures we work across sectors to tackle the root causes of demand on services, while improving population health on a more sustainable basis.

CASE STUDY: Making Smoking History in Greater Manchester

Smoking is the single biggest cause of preventable illness and premature death in the world, and the greatest driver of health inequalities. It pushes people into poverty and ill health with a devastating impact on individuals, communities, and the economy. Illnesses where smoking is a major risk factor include cancer, heart disease, stroke, and respiratory diseases. Non-smokers that are exposed to second-hand smoke (also known as passive smoking) are also at risk of the same illnesses – especially vulnerable adults, children, and babies.

In 2017, Greater Manchester Health and Social Care Partnership (the forerunner to our current Integrated Care Partnership published its 'Making Smoking History' strategy, taking a whole-system and hugely ambitious approach to creating a smoke-free city-region. Against a challenging backdrop of higher-than average smoking prevalence and exacerbated health inequalities, Greater Manchester has made huge progress in reducing smoking rates – saving thousands of lives and providing millions in cashable savings to the NHS and public services.

As a result, smoking prevalence has fallen to the lowest on record, from 18.4% in 2016 to 15.4% in 2021 – meaning there are now 66,000 fewer smokers living in Greater Manchester. Furthermore, smoking at time of delivery (SATOD) – the benchmark used to measure smoking status for women at the time of giving birth – has declined by a quarter, from 12.6% in 2017-18 to 9.5% in 2021-22, preventing many tragic outcomes in pregnancy and birth.

Living well at home - social care in Greater Manchester is fundamentally about better lives, not the provision of services. It is rooted in the power of co-production with people, carers and families to deliver better outcomes for all. It is much more than how we meet the challenge of supporting the flow of people in to and out of our hospitals, although that remains critical. It includes all the changes needed to ensure people have greater independence and enhanced wellbeing within stronger, more resilient communities. Our adult social care ambitions support people to 'live well at home', as independently as possible, making sure that the care and support they receive responds to their strengths and what matters most to them; valuing and respecting carers through recognition and support; supporting people with complex needs with enhanced care at home to prevent them going into hospital and to return home as quickly as possible; and working with social care providers to improve quality and ensure a resilient and diverse market for care.

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CASE STUDY: Better outcomes – better lives

Manchester's Better Outcomes, Better Lives is improving people's independence by focusing on what they can do (their strengths) rather than what they can't do, known as a strengths-based approach. This approach has led to the prevention, reduction and delay of people needing formal adult social care services.

This strengths-based practice is embedded within teams through behaviour change and a shared passion for the preventative approach, with a robust performance and evidence-based framework in place to drive improvement.

Through a combination of strengthened commissioning arrangements, improved early support with the right interventions, support for people to regain independence and a focus on safeguarding people in a timely manner, the programme has successfully met increased demand without a proportionate increase in workforce.

As well as contributing to the wider adult social care service delivering within budget, other achievements include a 10% reduction in the use of Manchester's residential care, a decrease in the cost of 22% of care packages following review, and a total of 66% of people not needing a package of care at the end of a reablement intervention.

Supporting children and young people - providing early help to families with a focus on improving educational attainment, speech and language and healthy weight. Ensuring good emotional wellbeing with earlier targeted intervention and expansion of community based mental health services. Co-produced support for children and young people with special educational needs. Support through transitions as part of a 0-25 model and boosting outcomes for young people leaving the care system through support in education, employment and training, health and finances.

Integrating care through our providers

Urgent and emergency care - using a clinically guided Greater Manchester approach to develop the pathways between local urgent care services such as GP out of hours, 111 and Accident and Emergency and more specialist emergency care such as for major trauma, hyper-acute stroke and heart failure. Empowering the Greater Manchester provider collaboratives to organise and deliver a consistent approach to triage, treatment and transfer across urgent and emergency care sites.

Planned care - using the provider collaboratives to direct planned care recovery and address the backlog through a single shared patient list targeting health inequalities, offering virtual outpatient services and managing staff wellbeing. Managing the flow of new patients needing diagnosis and treatment enabling access to specialist opinion and developing models for community diagnostic hubs.

End of life and palliative care - The Greater Manchester commitments to palliative and end of life care[37] provide the foundation for working collaboratively to ensure people can live well as they approach the end of their life, and die as comfortably as possible in the place of their choice. Equitable access to high quality, holistic, personalised palliative and end of life care,

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[37] https://peolc.net/about-us/

at home and through our hospices and other providers, not only ensures a more positive experience of death and dying for Greater Manchester individuals and their families, but also protects other health care services

Cancer care - comprehensive preventative approaches to reduce people's risk of developing cancer. Orientating the whole system towards early detection, diagnosis and treatment to improve survival outcomes and experiences. Considering the full range of people's needs to enable them to live well with and beyond cancer. Bringing together world class researchers and clinicians with our research bodies to constantly improve the lives of people affected by cancer.

Mental health - multi-disciplinary, strengths based team connecting to neighbourhood and community-based care. Increases access to evidence based clinical interventions, psychological therapies and social support. Using "Thrive" principles[38] to meet the dynamically changing needs of children, young people, adults and older people with common mental health problems, severe mental illness, and those with very complex needs who may not currently meet the thresholds for secondary care services. People receiving support can move between different types of help as their needs change.

Sustainable services – responding to the need for a proactive approach to acute service sustainability, to identify services that are vulnerable without intervention and taking earlier action. The initial priorities are in dermatology and ophthalmology.

Health innovation and spread – reducing the time from discovery to spread by connecting the healthcare system with academia and industry to respond to health and care challenges and be at the forefront of the national and global agenda in discovery science, innovation into practice and population health. Developing our approaches to unlock the full potential of our digital and data assets to support redesign and transform care to benefit Greater Manchester residents.

Transforming how people engage with health and care services digitally by bringing in new technologies and using data to provide more accurate and effective care and treatment. Harnessing the power of data and technology to move beyond the basic ability to share information, to digitally reimagine services to fully support the integration of care, empower people to take greater control of their health and wellbeing and accelerate innovation into practice.

Using technology appropriately so people will be able to receive care and treatment based on the most accurate information, where and when they need it, allowing people to better monitor their own health and plan their care, alongside professionals.

Analysing de-identified personal data to better review and plan services based on accurate information. Supporting ground-breaking research into new cures and treatments that could save lives here and around the world.

Significantly growing our activity in community-based research. Through Health Innovation Manchester, using our available resource for research and innovation to tackle local problems, developing and deploying proven innovation at scale through leveraging industry and national resource and investment; maximising our contribution to economic development in Greater Manchester.

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[38] http://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf

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> ### CASE STUDY: Accelerating the deployment of the GM Care Record
>
> The GM Care Record (GMCR) provides health and care workers with access to vital patient information to provide better informed direct care and treatment on the frontline.
> It is also providing the platform for research and secondary uses and the basis of digital transformation of clinical pathways.
>
> Since the GMCR was launched during the pandemic, it is now being access by over 18,000 frontline workers to support the care and treatment of over 180,000 patients each month. It has become a major digital asset for Greater Manchester, with the potential to support programmes to tackle health inequalities and transform care in areas such as dementia/frailty, virtual wards and heart failure.
>
> During the pandemic and through close collaboration between the GM clinical-academic community, health and care partners and citizens, 22 COVID-19 related research studies using de-identified data from the GMCR were approved to understand the impact on the communities of Greater Manchester.
>
> In future, data from the GMCR will help researchers to understand other major health and care issues affecting the city-region through GM's Secure Data Environment.
>
> All of this activity to support both direct care and research has been underpinned by engagement and strong governance across GM data controllers, providers, commissioners, and central GM bodies.

8.   Meeting today's challenges – our missions

Section 5 sets out the challenges this strategy responds to, and it is through our missions that the current challenges will be addressed.

Everyday life for many is precarious and repeated shocks affecting people's sense of security and wellbeing are now widespread; for example, the effects of the cost-of-living crisis and what that means for food and fuel security, digital exclusion, housing, and employment security. These directly impact people's health.

Poor health remains the single most important factor driving long term exclusion from employment and participation in the economy. That exclusion affects a quarter of our working age population.

Participants in our Big Conversation emphasised their concern about the problems accessing core health and care services. Reducing long waits as core services are restored is essential to maintain the confidence of those residents requiring our care, in the context of increasing demand.

The failure to prevent illness and its late detection means that our health and care system remains locked in a cycle of responding to crisis. Greater Manchester's population experiences higher mortality than it should and people spend a greater proportion of their lives in poor health, especially those with disabilities, those from racially minoritised communities and those facing multiple disadvantage. An upstream model of care and earlier intervention remains a consistent ambition to improve health outcomes and reduce health inequalities.

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Addressing our workforce challenges gives us our biggest opportunity to improve the way we provide health and care for our communities. The Greater Manchester public has expressed its own concerns about the pressure on our health and care workforce, in terms both of numbers and staff wellbeing. We must also recognise the additional pressure and challenge faced by unpaid carers supporting their loved ones every day; the more that stresses emerge in public services the greater the consequent demands move to families and carers.

The pressure on public finances over an extended period means resources don't match the demand on health and care services; long term financial sustainability is a huge challenge.

It is these challenges which have led us to identify six missions requiring action in each neighbourhood, in all ten localities and across the whole of Greater Manchester:

- ✔ Strengthening our communities
- ✔ Helping people get into, and stay in, good work
- ✔ Helping people stay well and detecting illness earlier
- ✔ The recovery of core NHS and care services
- ✔ Supporting our workforce and our carers
- ✔ Achieving financial sustainability

All of these missions are underpinned by the need to ensure equity, which means providing greater help for those with greater challenges to overcome in order to reduce inequality.

Strengthening our communities

This strategy recognises the stresses on daily life for many of our residents, which have been significantly increased through the cost-of-living crisis. This will lead to a crisis in health. This strategy needs to enable individuals, families and communities feel more confident in managing their own health. This is about helping communities support each other.

NHS Greater Manchester works closely with leaders from Greater Manchester's VCSE sector, and we have put in place an accord agreement[39] which contains eight commitments shared across the sector, NHS Greater Manchester the GMCA and its constituent councils. We want to further develop how we work together to improve outcomes for Greater Manchester's residents, enabling good lives for all and strengthening our communities.

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[39] https://www.vcseleadershipgm.org.uk/about-the-vcse-accord/

CASE STUDY: Social prescribing

Recruited in March 2022, alongside a Network Dietician, the Diabetes Social Prescribing Link Worker in Gorton and Levenshulme Primary Care Network offers an alternative approach to managing a health condition with medication alone.

The role is dedicated to supporting people with Type 2 diabetes and a high BMI, or those at risk of developing the disease; working with them to find out what matters to them and what they want to achieve.

Darab, for example, a 39-year-old with limited English, moved to England in 2016 after serving in the armed forces. His wife and children currently remain in another country.

He had a part-time job but wanted to improve his English to enhance his working ability and access to services. He also wanted to lose weight, join a gym and learn about healthy eating so he could improve his health. After visiting his GP a number of times with low mood and joint pain, Darab was diagnosed with pre-diabetes and referred to the social prescribing service.

Working together with the social prescriber and with the help of an interpreter, Darab was able to join a smoking cessation service, English lessons and secure a gym membership. He also received some visual information sheets to help with healthy eating.

In just two months, Darab has increased his health confidence scale from 4 to 12 out of 12; lost more than 16kg in weight, reducing his BMI from 30.2 to 25 and stopped smoking. He goes to the gym four times a week and now walks daily. He has also reduced visits to his GP and seen an increase in his mood and confidence.

He said: "This service has helped me so much.; I have managed to make many changes to better my health and wouldn't have known where to start without it. I am now eating better, feel fitter and have lost weight."

Our focussed actions here include:

✔ Continue to develop social prescribing in Primary Care Networks to enable people to be able to get opportunity, advice and support in their community to lead a healthy happy life

✔ Coordinate our response to poverty - food, fuel, and transport.

✔ Address historic under-investment in mental health, learning disability and autism and expand our community-based provision through the Living Well model

✔ Embed the VCSE Accord to grow the role of the VCSE sector as an integral part of a resilient and inclusive economy

✔ Progress our Net Zero climate change contribution to achieve a net zero carbon footprint by 2038

✔ Deliver a Greater Manchester-wide consolidated programme to deliver better outcomes for those experiencing multiple disadvantage and co-occurring conditions building on learning and effective approaches from the Supporting Families (Troubled

Families) programme, Rough Sleeper Initiative, Housing First, Changing Futures and Working Well.

- ✔ Equip people with the skills, connectivity and technology to get online, partnering with the Digital Inclusion Action Network[40], and focusing on all under-25s, over-75s and disabled people.

CASE STUDY: Responding to multiple disadvantage

The Changing Futures programme in Oldham provides essential support and treatment for vulnerable adults facing a combination of homelessness, substance misuse, poor mental health, domestic abuse, or contact with the criminal justice system.

Originally set up with National Lottery Community funding, the service works with other public and voluntary sector services to help co-ordinate the support that is needed. It has helped people with learning difficulties to access local services, provided support with housing applications, helped people to access addiction support, make and attend appointments, provided support to parents to rebuild relationships with children that have been taken away from them, reduced drug use, and helped people access police support that reduces their vulnerability to crime.

The programme in Oldham now plans to secure a community space for hot drinks, showers, changing facilities and advice develop an online directory of services and recruit a peer support worker.

Other localities including Rochdale, Wigan and Manchester are working on similar programmes.

Helping people get into, and stay in, good work

One of the purposes of integrated care systems is to support wider social and economic benefits from NHS investment. This is important everywhere, but for Greater Manchester it has the potential to be nationally significant in raising overall productivity and supporting a necessary rebalancing of the national economy.

Current Government economic policy is centred on creating the conditions for accelerated economic growth. The public sector in the North makes a greater contribution to Gross Domestic Product (GDP), employment and economic activity than elsewhere in the country. We believe that approaching this mission with focus and energy is essential to helping to address the widening inequalities that we see across our communities. We also believe that supporting people to have full lives and to be healthy and well is the best way to reduce public service demand pressures over the medium and long term.

All ICSs are developing the role of the NHS in local economies and Greater Manchester is developing a network of anchor institutions[41] to further develop our contribution to the local economy in relation to employment, procurement, building and land use, and our environmental impact. We must consider what needs to be done to drive prosperity across Greater Manchester and the role of the Integrated Care Partnership in achieving this. In

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[40] https://www.greatermanchester-ca.gov.uk/what-we-do/digital/digital-inclusion-agenda/
[41] https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

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considering this we need to understand why children fall behind, why long term worklessness persists, and how Greater Manchester's health and skills inequalities can be addressed in order to reverse longstanding and structural inequality.

Our focussed actions here include:

- ✔ Expansion of our Work and Health Models[42] to prevent people falling out of work, getting people back into work, and supporting people with learning disability, Autism and severe mental illness to be placed and trained in work

- ✔ Working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter, to ensure new and existing jobs right across Greater Manchester are 'good work'[43].

- ✔ Implementing the Greater Manchester Social Value Framework[44] and community wealth building approaches through a Greater Manchester network of anchor institutions

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CASE STUDY: Working well early help

The Working Well Early Help (WWEH) programme has supported more than 7,000 individuals who had become newly unemployed (within the last six months) or were on medical leave from their jobs due to a health condition or disability.

As well as employment-related support, such as help with CV writing, interview techniques and signposting to training or job fairs, participants received health and wellbeing support in the form of Cognitive Behaviour Therapy (CBT), physiotherapy, dietary advice and help with managing stress and anxiety.

Additional signposting was provided for those who required grief counselling or help with financial, debt, housing or benefits advice.

The majority of participants reported a positive outcome in relation to their health and wellbeing, with 'health' and 'coping and confidence' showing the most positive change by the end of the programme.

Just over a third (38%) experienced a positive employment outcome by the end of the programme.

WWEH participant Zoe said the support she received had helped 'massively' with her health and wellbeing after undergoing a course of CBT and acknowledging she had a mental health condition. After a succession of short-term, unsatisfying jobs since leaving school, Zoe got a job as a support worker for a charity and said: "I would never have gone into this role without their support. I will be forever grateful, they were so great."

The WWEH model relied on integration with local services and involved key partners from local authorities, GP practices and Job Centre Plus.

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[42] https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/
[43] https://www.shawtrust.org.uk/what-is-good-work-and-why-is-beneficial/
[44] https://www.greatermanchester-ca.gov.uk/what-we-do/economy/social-value-can-make-greater-manchester-a-better-place/

Helping people stay well and detecting illness earlier

We have described the features of a Greater Manchester Model for Health focused on putting health at the heart of all our city-region policies and integrating public services to address the wider determinants of health, alongside NHS Greater Manchester's ambitions for how health and care services are provided.

Many conditions which contribute to shorter healthy life expectancy are preventable. We will collaborate with focus and purpose to deliver comprehensive, scaled approaches to the main modifiable risk factors - tobacco, physical activity, obesity/food and alcohol – which can lead to death. At the same time we will also prioritise secondary prevention[45] - treating high blood pressure, high cholesterol, diabetes and other conditions which are risk factors for poor health and early death from cancer, cardiovascular, diabetes and respiratory diseases. We will move away from siloed approaches by partnering with our residents and communities, spreading evidence-based approaches, involving all providers and utilising innovative data architecture and capability to develop interventions and models of care that engage those from higher risk populations.

We recognise that specific communities face greater challenges concerned with prevention, early detection and early treatment. These include people with severe mental illness, people with disabilities, communities facing disadvantage or discrimination as a result of ageism, racially minoritised communities and communities in poverty. We will, therefore, embed a comprehensive approach to reducing health inequalities to deliver improved equity, equality and sustainability across health and care.

Our focussed actions here include:

✔ Application of CORE20PLUS5[46] to reduce health inequalities across Greater Manchester, drive early cancer diagnosis, hypertension case finding, reduce hospitalisation for COPD, increase health checks for people with severe mental illness or learning disability, and improve maternity outcomes

✔ Drive prevention through increased physical activity, reductions in smoking and obesity

✔ Expansion of culturally appropriate services that better reach into disadvantaged communities

✔ Apply evidence-based falls prevention approaches consistently across Greater Manchester.

✔ Monitor and target unwarranted variation for populations affected by inequalities.

✔ Expand the use of tools for finding people at risk of poor health and providing anticipatory care, partnering with our residents.

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[45] "catching the causes of ill health as early as possible to prevent or reduce the chances of them leading to more serious conditions" https://www.england.nhs.uk/ourwork/prevention/about-prevention-programme/
[46] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

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CASE STUDY: Targeted lung health checks

People at risk of lung cancer had the disease detected at a much earlier stage thanks to a pilot scheme in Manchester and Tameside. The Lung Health Check was aimed at past and current smokers aged 55 to 74 through a series of roadshows and mobile CT scanner units set up in supermarket car parks.

Lung cancer is the most common cause of death in Manchester in people under the age of 75, and most cases are diagnosed at a late stage when survival is poor. Through targeted screening, the Lung Health Check detected lung cancer and other lung conditions such as Chronic Obstructive Pulmonary Disease (COPD) at a much earlier stage than they would normally have been diagnosed – after reporting symptoms, for example.

As a result, people were offered potentially curative treatment and advice to manage their previously undiagnosed disease. Early detection, intervention and treatment is not only beneficial for the patient but also less costly for the NHS.

In Manchester, more than 2,500 individuals undertook a lung check with just over half deemed to be high risk and qualifying for a CT scan on site. The team found 46 lung cancers affecting 42 individuals, with the majority (8/10) being at an early stage and therefore offered potentially curative treatment (9/10). In comparison, half of lung cancers diagnosed outside of screening are advanced and therefore curative treatment is not an option.

The recovery of core NHS and care services

Improving access to high quality, core services and reducing long waits is the main issue raised by Greater Manchester residents participating in the Big Conversation and this will be delivered through our approach to the recovery of services. This covers the full range of core NHS and care services where reliable and timely access has been set back.

Our focussed actions here include:

- ✔ Improving ambulance response and A&E waiting times

- ✔ Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard

- ✔ Making it easier for people to access primary care services, particularly general practice

- ✔ Ensuring universal and equitable coverage of core mental health services and continuing to value parity between mental and physical health

- ✔ Pursuing best practice to improve quality and reduce unwarranted variation

There are activities underway already to ensure these improvements occur, but we are also signalling where further action needs to be undertaken through this strategy. Recognising that NHS Greater Manchester must have regard to this strategy in developing its own plans with NHS partners, additional detail is provided here in relation to those areas where NHS Greater Manchester has the most direct influence.

Primary care – We recognise the role of primary care as part of the wider Greater Manchester urgent and emergency care system and its aim to deliver responsive same day services. In organising primary care, we always seek to balance convenience and continuity of care in

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relation to who sees a patient, between online or face to face appointments according to the patient's wishes and needs. NHS Greater Manchester will seek to secure additional capacity when periods of surge demand occur, which we assess through our framework for reporting pressures. Primary care providers will enable the spread of access to online advice on symptoms and self-care, going to a community pharmacy, a GP appointment, an urgent treatment centre, or the 111 out-of-hours clinical assessment service. NHS Greater Manchester and primary care providers will also engage on options to address the current issues surrounding access to NHS dental services and develop a dental access plan.

Urgent and emergency care – Our collective improvement activities will support people to be seen more quickly in emergency departments through better ambulance handover and initial decision making. Improved flow across the system will be supported through embedding approaches such as 'Discharge to Assess'[47]; and to reduce need for hospital attendance and admission through a two-hour urgent community response in all ten localities in Greater Manchester, improved NHS 111 call handling, and enhanced support to care homes.

Planned care –we will increase the number of surgical hubs – focused only on planned surgical procedures to protect capacity for elective (planned) activity. We will reduce unwarranted clinical variation through approaches including 'Getting It Right First Time'[48] and maximise bed and workforce capacity, including expanding the availability of virtual wards. We will increase system theatre utilisation, reducing length of stay for elective patients and overall day case rate. Improved support for patients waiting for treatment will be provided through better care navigation, consistent patient initiated follow up and more 'While You Wait'[49] and 'My Recovery' resources. A focus on health inequalities will run through each of the elements of the elective recovery plan.

For children and young people, we will reduce waiting times to within national standards through a Greater Manchester-wide approach to paediatric elective recovery with common clinical prioritisation, establishment of dedicated paediatric surgery hubs, sharing of best practice to maximise activity and transforming pathways.

Cancer Care **–** We will strengthen Greater Manchester compliance with best practice pathways defined nationally, initially in breast, skin, head and neck, breast and gynaecology and then on to tumour sites where national guidance does not yet exist. We will improve diagnostics through enhanced mutual aid (organisations supporting each other) and increased diagnostic capacity and reporting dedicated to cancer. We will roll out the 'Single Queue' diagnostics approach[50] and increase sustainable diagnostic capacity through community diagnostic centres[51]. We will implement the Greater Manchester lung model of care and accelerate roll out of targeted lung health checks.

Mental Health and Learning Disability – We will continue to support high levels of mental health needs and the ongoing provision of crisis services including increases in liaison and system working with Greater Manchester Police (GMP) and the North West Ambulance Service (NWAS). We will also work in partnership to support people with a serious mental illness to access housing and employment and. to reduce long waits, additional support to tackle waiting lists will be sought alongside reducing waits for physical health checks, as it will for with a learning disability.

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[47] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess
[48] https://gettingitrightfirsttime.co.uk/
[49] https://whileyouwait.org.uk/
[50] https://gmcancer.org.uk/single-queue-diagnostics/
[51] https://www.gov.uk/government/news/40-community-diagnostic-centres-launching-across-england

We will adopt a proactive approach to supporting children and young people to reduce the impact of mental health problems, and specifically to improve the pathway for eating disorders, and improve the interfaces of inpatient services with the whole system including alternatives to admission and discharge.

We intend to increase our longer-term baseline investment in mental health services, recognising that demand now is substantially above pre- pandemic levels and that Greater Manchester has historically under-invested in mental health, learning disability and autism compared to other areas. This has resulted in significant variation in the availability of services across Greater Manchester, which must be properly resourced going forward through an agreed investment plan. This is consistent with seeking parity of esteem for mental health services with physical health services and will be challenging for the Greater Manchester system in terms of allocating limited resources. Recognising the starting position, our ambition would be to move Greater Manchester to the middle quartile of expenditure per capita with consequent improvements in access and outcomes across the life of this strategy.

Supporting our workforce and our carers

These are extremely challenging times for our health and care services as we face significant financial pressures and a workforce crisis. We have high sickness absence rates, recruitment and retention challenges. At the same time, we recognise the enormous pressures faced by carers, making life harder for the people they are trying to support. As an Integrated Care Partnership, we need to take action to create the conditions to allow our people to provide the best possible care – including our paid and unwaged workforce.

We have a People and Culture Strategy[52] to promote integration, better partnership working and good employment practices. The strategy also seeks to address the causes of sickness to keep our workforce well and addressing the inequalities we know people face in the workplace.

Our intention is to ensure we have more people choosing health and care as a career of choice, and that they feel supported to develop and stay in the sector. We want a cultural shift to create a more compassionate and inclusive leadership culture, bolstering a culture of collaboration and a culture where wellbeing matters.

Our actions will demonstrate the value we place on those providing care across health and care and our commitment to support, retain, develop and enable wellbeing in our workforce, as well as at home for unwaged carers.

Our focussed actions here include:

✔ Increase in membership of the Greater Manchester Good Employment Charter[53] and payment of the Real Living Wage, which will improve employment standards including security, flexible working, employee engagement, recruitment, people management, wellbeing provision and inclusion.

✔ Improve workforce wellbeing: we will increase access to wellbeing and absence management resources, with the aim of improving wellbeing and reducing sickness to support better workforce planning and ensure safe staffing.

✔ Address inequalities: we will improve diversity at senior manager and executive level and improve the experience for our workforce with protected characteristics

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[52] GM People and Culture Strategy https://gmintegratedcare.org.uk/workforce/
[53] https://www.gmgoodemploymentcharter.co.uk/

✔ Grow and develop our workforce: we will increase recruitment to the sector from within our own communities, including key areas such as nursing, midwifery, social care and mental health. We will support more people to develop and stay and improve our workforce planning system infrastructure.

✔ Workforce Integration: we will increase the opportunities for sharing and partnership working across our system and organisational boundaries and increase the number of people working in integrated roles.

✔ Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers, building on the Greater Manchester Carers' Charter and the Greater Manchester Working Carers' Toolkit.

CASE STUDY: A new approach to recruitment

NHS Greater Manchester and key partners across the system have delivered a number of recruitment events in localities.

Events in Salford and Oldham collectively attracted more than 500 people, with 143 job offers made on the day and another 200 interviews to take place afterwards.

Attendees were given the opportunity to discuss career pathways, enrol onto a course or a pre-employment programme, or interview for a job vacancy.

Candidates secured entry-level roles as Healthcare Support Workers, porters, care workers, as well as roles in primary care and the voluntary sector.

Plans are in place to work with the Prince's Trust to support younger people into health and care roles at future events.

Similarly, a jobs fair in Brinnington promoted a number of entry level and local roles, including part time and flexible jobs, drawing in 120 job seekers from one of Stockport's most deprived areas.

This event involved employers from a range of industries – not just health and social care – including construction, transport, digital, and a local brewery. A further jobs fair is planned for another deprived area of the town.

These events are developing a novel recruitment model that:
• Helps break down barriers to recruitment
• Puts greater emphasis on lived experience
• Can be utilised to target under-represented groups
• Reduces the time and costs to recruit
• Gives all good candidates the opportunity to be recruited

Achieving financial sustainability

Achieving financial sustainability for the health and care system can be described as 'living within our means' and ensuring that expenditure does not exceed income. As previously highlighted, our system has a deficit because spending has been higher than income. Action is urgently required to address the drivers of both cost and demand in the system.

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In the initial phases of delivering this strategy a necessary focus on financial recovery, to achieve a balanced position, will drive our activities.

The first step is to address each of the principal reasons for the financial, efficiency and productivity challenges in the Greater Manchester integrated care system, in order that the Greater Manchester system leadership collectively owns the outputs from this process and agrees to the actions necessary to address the challenges.

Our focussed actions here include:

✔ Develop and implement a comprehensive system wide programme spanning cost improvement, productivity, demand reduction and service transformation.

✔ Identify factors from successful system working to implement the programme, including the behaviours and incentives for system working.

This programme will be specific and well-defined, requiring close monitoring and tracking of each of the system financial improvement interventions, and comprises the following:

- Identifying and addressing the most significant demand drivers across the Greater Manchester integrated care system
- Developing a comprehensive system wide programme spanning cost improvement, productivity, demand reduction and service transformation.
  Specifically, to:
    - Confirm the assessment of in-year cost improvement opportunities
    - Maximise patient flow and theatre productivity approaches
    - Incentivise Provider Collaboratives to optimise their collective sites and workforce and reduce structural costs
    - Balance incentives and funding to support the management of new demand in primary and social care and reduce demand elsewhere in the system
    - Scale social support and prevention to reduce demand for formal health and social care

9. Monitoring Our Progress

We are committed to reporting on how successful we are in achieving the ambitions set out in this strategy and have identified progress measures against our outcomes and missions. These are high-level measures, on which we expect to see change in the longer term.

We want to see a Greater Manchester where ….

Everyone has an opportunity to live a good life		
This is prioritised in our missions for…	**We will measure**	
Strengthening our communities	✔ Reduced anxiety ✔ Improved life satisfaction ✔ Feelings of safety	These measures are already monitored through the GMS and progress can be seen here: GMS improved health and reduced inequalities measures
Helping people get into, and stay in, good work	✔ Number of people starting work ✔ Number of people staying in work	GMS safe and vibrant communities measures These are from the Work and Health programmes regular monitoring

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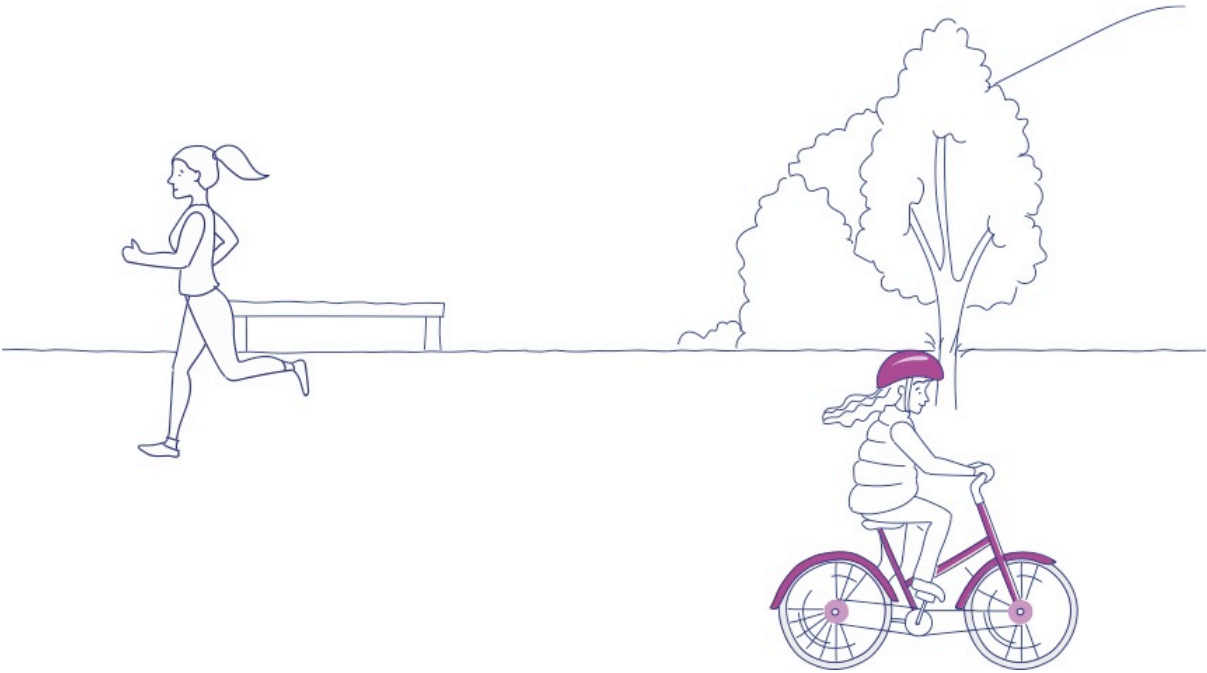
Everyone experiences high quality care and support where and when they need it

This is prioritised in our missions for…	We will measure	
The recovery of core NHS and care services	✔ Year-on-year improvement in meeting national targets for core services	Taking the number of measures in the NHS operating framework (as defined each year) as a base and measuring the number where Greater Manchester has met the target compared to other ICSs We are aiming for an increase in the % of targets being met year on year
	✔ Equitable service provision across all areas in Greater Manchester	Specific initiatives will be identified each year, from priority programmes for spread, and equitable provision monitored until it is achieved
Supporting our workforce and carers	✔ Increase in Good Employment Charter membership from the health and care sector	This will be monitored through the People and Culture strategy
	✔ Number of health and care organisations paying the RLW	

Health and care services are integrated and sustainable		
This is prioritised in our missions for…	**We will measure**	
Achieving financial sustainability	✔ Deliver balanced recurrent ICB and system financial position by 2024/25	This will be monitored through routine ICB reporting
The recovery of core NHS and care services	✔ See above	

Utilising data to address inequality

We are committed to utilising the intelligence generated to give us a better understanding of inequality across the city-region, in terms of both spatial and demographic variation. We also want to understand how outcomes vary for our diverse communities, including variance by age, sex, ethnicity, disability, sexual orientation and trans status, and religious affiliation. The development of our Greater Manchester Health and Care Intelligence Hub is key to this, building on the Greater Manchester Digital Platform[54]. The hub is a web-based portal that is being co-designed to bring together data, community insight, web-based tools, guidance, shared learning and workforce development resources to support people working in health and care to better understand health inequalities and variation in care in their areas and implement models of care.

We will develop and publish a Joint Forward Plan (JFP) by the end of June 2023 as a delivery plan for the ambitions in our Integrated Care Partnership Strategy and this plan will be updated annually. It will include progress measures for the elements of the plan which support the overall ambitions in this strategy.

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[54] https://greatermanchester-ca.gov.uk/what-we-do/digital/empowering-people/the-greater-manchester-digital-platform/

Appendix 1 – Locality plans

Our ten localities in Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - all have local authority plans (or strategies), locality plans for health and care and Health and Wellbeing plans. The Joint Strategic Needs Assessments (JSNAs) in each locality have specifically informed the Health and Wellbeing plans, as well as the other plans.

It is a statutory responsibility for the ICP strategy to have regard to these plans[55], which have informed the whole of the strategy.

Links to each of these plans for each of the localities, where information is available at time of writing, are given in the table below, along with a link to the Health and Wellbeing Board in each locality. This information will be updated as plans in localities are updated and confirmed.

Locality	Local Authority Plans/ Corporate Plans	Health & Care (Locality) Plans	Health & Wellbeing Plans Health and Wellbeing Board	Commonalities
Bolton	Bolton Vision 2030 (currently being updated)	Currently being updated	Same as LA plan H&WB Board: Active, Connected and Prosperous Board 2014 Onwards > The Active, Connected and Prosperous Board (bolton.gov.uk)	LA plan = H&WB Plan
Bury	Let's Do It! Strategy (bury.gov.uk)	Currently being updated	Same as LA plan H&WB Board: Browse meetings - Health and Wellbeing Board - Bury Council	LA plan = H&WB Plan
Manchester	Our Manchester Strategy- Forward to 2025 | Manchester City Council	Refreshed 2019/20 https://democracy.manchester.gov.uk/documents/s14060/Locality%20Plan%20Refresh.pdf	Making Manchester Fairer https://www.manchester.gov.uk/makingmanchesterfairer H&WB Board Browse meetings - Health and Wellbeing Board (manchester.gov.uk)	3 separate plans
Oldham	Corporate Plan | Corporate Plan | Oldham Council - 2022-27	currently being updated	Currently being updated H&WB Board: Committee details - Health and Well Being Board (oldham.gov.uk)	3 separate plans
Rochdale	https://www.rochdale.gov.uk/downloads/download/393/corporate-plan	Rochdale Borough Locality Plan 2020-2024	Same as locality plan **H&WB Board** https://democracy.rochdale.gov.uk/mgCommitteeDetails.aspx?ID=558	Locality plan = H&WB Plan

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[55] https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

Locality	Local Authority Plans/ Corporate Plans	Health & Care (Locality) Plans	Health & Wellbeing Plans Health and Wellbeing Board	Commonalities
Salford	Our priorities, the Great Eight • Salford City Council	Salford Locality Plan 2020-25 (partnersinsalford.org)	Same as locality plan H&WB Board Browse meetings - Health and Wellbeing Board • Salford City Council	Locality plan = H&WB Plan
Stockport	borough-plan.pdf (onestockport.co.uk)	Enc 1 - One Health and Care Plan.pdf (stockport.gov.uk)	Same as locality plan H&WB Board https://www.stockport.gov.uk/health-and-wellbeing-board	Locality plan = H&WB Plan
Tameside	'Our People Our Place Our Plan'	Currently being updated	Currently being updated H&WB Board https://tameside.moderngov.co.uk/mgCommitteeDetails.aspx?ID=221	LA plan = Locality Plan (possibly)
Trafford	Corporate-Plan-2021-2024.pdf (trafford.gov.uk)	2021 refresh Trafford Together Locality Plan (traffordpartnership.org)	2019 version http://www.traffordpartnership.org/about/Docs/Trafford-Health-and-Wellbeing-Strategy.pdf H&WB Board: Health and Wellbeing Board (traffordpartlonership.org)	3 separate plans
Wigan	The Deal 2030 (wigan.gov.uk)	Currently being updated	Same as locality plan H&WB Board: Committee details - Health and Wellbeing Board (wigan.gov.uk)	Locality plan = H&WB Plan

Appendix 2 – Engagement on the strategy

This strategy has been developed through engagement with the public, staff and stakeholders in the Greater Manchester system, in addition to the analysis of a wide range of documents and reports (see Appendix 1). This process has been iterative with comments from initial engagement used to inform versions of the strategy considered later in the process.

Public engagement
Phase one of the Big Conversation took place in Spring 2022, with organisations, staff and citizens giving their views on the vision and priorities at that time, through an on-line survey. 1,334 people responded (including staff and citizens).

Respondents were somewhat representative of the population but less representative of sex (males) and age (younger and older people). In general, there was overwhelming support for the vision and principles, however, it was suggested that the language used to describe priorities was not accessible to some groups of people and did not give a clear indicator of what was being done.

Findings from phase one were considered at a collaborative event attended by over 100 VCSE organisations and NHS engagement leads. This led to a further deep dive to reach underserved communities and understand what matters most and we named this Big Conversation phase two.

Phase two took place in October 2022 and was led by the voluntary and community sector including GM=EqAl[56], Healthwatch and local infrastructure organisations. This enabled us to reach deep into communities and involve those who are less likely to take part in surveys or provide their views in traditional ways. Phase two was more detailed and focused on priorities and actions.

Individuals and groups considered the following questions, which were developed in partnership with the public and a range of VCSE organisations:

For community groups: What would make the biggest difference for communities you serve in relation to being healthier, happier, and better?

For individuals: What would make the biggest difference to your life in relation to being healthier, happier, and better?

- What's stopping this?
- What would help this?
- What's the most important thing health and care services need to improve?

Engagement from phase two reached over 2,000 people representing communities of identity/interest and elicited over 10,000 views. Responses are summarised in the strategy section 'what residents are telling us'.

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[56] https://www.gmcvo.org.uk/GMEqualityAlliance

Staff engagement

Although staff, as members of the public, may have taken part in the Big Conversation, we carried out a separate engagement process with staff from across Greater Manchester in February 2023, using an online survey with telephone support if needed. This engagement focused on the missions and the ways of working.

Responses from 156 staff indicated broad support for the missions, although with feedback on the language and terminology used, and strong support for the missions for prevention and early detection, and for our workforce and carers. The ways of working were also supported, with many describing how they could promote them in their own role. Communication of the ways of working across the whole system was regarded as important.

System engagement

We have taken an iterative and inclusive approach to engagement across the Greater Manchester system since the initial development of the outline for the strategy.

March-Sep 2022

We established a strategy working group comprising a range of stakeholders from across the system, including localities, which met monthly from March 2022, to support this strategy development work. The group developed a set of draft outcomes and shared commitments during the first part of 2022, taking into account the four national objectives for ICSs and the original principles from devolution which were reaffirmed in the review of partnership working undertaken during the pandemic. These were tested through the Big Conversation phase one.

Sep-Dec 2022

A revised version of the strategy was therefore developed, discussed, and agreed by the strategy development group in September, prior to approval by the Integrated Care Partnership (ICP) Board at its first (shadow) meeting on 20th September 2022, with further development and the engagement process considered at the first formal (public) meeting of the ICP Board on 28th October 2022[57].

The ICP Board held a workshop focused specifically on the ICP strategy on 2nd Dec 2022, where the Board was supportive of the proposed missions which had been developed from the analysis of data and evidence undertaken to date.

Jan-Feb 2023

During this period, a written 'Engagement Draft' and accompanying slide set was considered by stakeholders across the system, including at the ICP Board on 20th Feb 2023[58] where the importance of the Joint Forward Plan, now under development, being the delivery plan for the strategy was emphasised[59].

Much of the feedback during this time came from a range of meetings including locality boards and Health & Wellbeing Boards, Trust boards, Greater Manchester networks spanning primary, secondary, social care and VCSE sectors, trade unions, professional networks including public health leadership, finance and estates, and clinical networks including medical and nursing directors and Allied Health Professionals. Over 30 meetings

were attended with feedback gathered through those discussions, and written feedback also received from localities, VCSE leadership and interest groups.

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[57] https://gmintegratedcare.org.uk/wp-content/uploads/2022/10/developing-the-gm-integrated-care-partnership-strategy.pdf
[58] https://democracy.greatermanchester-ca.gov.uk/documents/s24691/Item%205%202023%2002%2010%20ICPB%20-%20Integrated%20Care%20Strategyv2.pdf
[59] https://gmintegratedcare.org.uk/wp-content/uploads/2023/03/2023-24-planning.pdf

This enabled the missions and the Model for Health to be refined, ensuring that they align with other plans and strategies, with emphasis on the response to the key challenges facing the system.

We would like to thank all those who have been involved in any way in this development process and look forward to ongoing engagement as the delivery plans are developed and agreed across Greater Manchester.

Report Title:	Strategy and Operations Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Sharon White & Rae Wheatcroft		Decision	

Purpose	The purpose of the reports is to provide assurance for the Board on work delegated to the Committee.

Summary:	The attached reports from the Strategy and Operations Committee Chair provide an overview of items discussed at the meetings held on 20 February 2023 and 27 March 2023. Due to the timing of the March meeting, a report will be circulated and uploaded following publication of the meeting pack. The Strategy and Operations Committee Chair will also provide a verbal update at the Board meeting.

Previously considered by:
Discussed and agreed at the Strategy and Operations Committee.

Proposed Resolution	The Board of Directors is asked to receive assurance from the Strategy and Operations Chairs Report

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

Prepared by:	Sharon White & Rae Wheatcroft	Presented by:	Rebecca Ganz Non-Executive Director

Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee		Report to:	Board of Directors
Date of Meeting:	20 February 2023		Date of next meeting:	27 March 2023
Chair:	Rebecca Ganz, Non-Executive Director		Parent Committee:	Board of Directors
Members Present:	Alan Stuttard, Sharon White, Rae Wheatcroft, Tyrone Roberts, Sharon Katema. In attendance: Jo Street, Jake Mairs, Rachel Noble, Brett Walmsley, Rayaz Chel, Julie Ryan, Jo Bolger, Michelle McConvey (minutes)		Quorate (Yes/No):	Yes
			Apologies Received from:	Francis Andrews, Martin North.

Key Agenda Items:	Lead	Key Points	Action/decision

Service Spotlight Data & Data Quality	J Ryan	• Data Quality Maturity Index (DQMI) current score from October 22 is 86.8% across all national datasets combined. The national score is 71.8%.
		• There are 27% of patients on our Waiting List Minimum Dataset who do not have a recorded ethnicity.
		• In the last 12 months the RTT Validation and Data Quality Team have Removed 19,872 patients from the PTL; Validated 103,488 patients and 1,548 cancer treatments; Allocated 1,416 NHS Numbers to patients; Updated 20,688 patient records with correct commissioner code; And, Added 3,912 cancer diagnoses onto Somerset.
		• The Clinical Coding Team have to code between 7500 and 8700 inpatient episodes a month; Read 200-900 pages of documentation per single episode of care; and, it takes 3 years to train to become a Coder with refresher exams every 3 years.
		• Despite recruitment challenges, the Clinical Coding performance shows 100% of episodes coded each month within this financial year.
		• Current reporting priorities include: Operational Planning Round for 22/23, and virtual wards recording and reporting process including national and GM submissions.
		• The self-serve Tableau portal currently has 1,013 users with 1,651 individual sheets of intelligence. The RTT dashboard is the most popular with 4,866 views.
		• The Data for the future includes:
		   • Consolidate more dashboards into Tableau and drive the vision for locality level visualisations, working with our partners and share intelligence across the locality.
		   • Bring more data science tools and techniques into our work – actively setting up a Data Science Collaborative across GM.
		   • Data Quality promotion and education, and promote our data quality champions.
			• By way of context, it was understood that Data & Data quality was in effect the 4th Q4 priority (only 3 noted were noted for Q4 at Jan SOC)
			• The Committee noted the report and the COO's view that the BI team are fundamental to the effective operation of BFT
			• It was confirmed that the BI team does 'push back' on the growing volume of requests from both national and GM
			• Gaps in ethnicity data were noted as a historical problem and work will be prioritised as part of the Health Inequalities Group on barriers to recording ethnicity, which is needed to support effective locality outcomes
			• The breadth of work performed by the GM analytic data science platform including Primary, Social and Secondary care is expected to be beneficial to the risk stratification of needs at neighbourhood level enabling a 'whole of pathway' view.
			• Data champions to be identified which will build on existing work e.g. at ward level, to further embed the culture around the importance of quality data. The Committee fully supported the establishment of Data Champions at the frontline

Strategy and Operations Committee Chairs Report

Digital Performance and Transformation Update	S White	• There is a significant of work with the Deployment of equipment. The team have achieved the re-accreditation of ISO 27001 and 9001. • The EPR Quarterly Update will provide a timeline on the risks around Maternity. • The Risk Register has the same known Red rated risks in terms of the level of capacity the Team has to deliver to the programme. The IG risk linked to the Toolkit remains on the risk register. • Wifi has now been installed in a number of community practices. There is a local shortage of access points which is delaying the rollout. •	• The Committee noted the report • The Red RAG of both the CSIDB and the ED clinical correspondence for a few months was discussed. • New Terms of reference for CSIDB supported by Divisional engagement is expected to improve this • Regarding ED correspondence, SW is meeting with S Irving, CCIO and C McPeake in relation to the missed information in the diagnosis section of the EPR discharge letters for patients attended A&E.
Business Intelligence Structure	S White	• Staff have been mobilised across the ICB and the FT. • The proposed model shows that GM are taking a one organisation approach, with a single consultation across NHS GM to cover all function and localities. • Some staff will continue to work in the locality which will be 1 x Band 8A and 2 x Band 7 Analyst posts. JR will be employed by the FT and will manage this team. • The integrated BI team will move to the central team and the FT Team will be halved. The Local Data Scientist will also be moved into the central team. • We are still trying to build the specialist roles into the locality however this will cause more pressure on the FT due to no locality buffer. • SW and JR have met with the Lead from GM and have managed to get more capacity for the local team. However, there is no guarantee of funding of an extra Band 7 role in N Ledwith's team. • SW is unable to provide assurance to the Committee at this time as to the full impact of the restructure and will continue to work on the mitigation. • This will be implemented from April 2023.	• The Committee noted the reduction of the BI team due to the GM approach. It was understood that Bolton are leaders in BI in GM and as such are particularly adversely impacted by the restructure. • The impact on staff retention was queried, which is yet to be understood due to this being a recent development. • Potential capacity issues were noted as a result of the restructure. • The Committee requested a 'Plan B' be developed and will be provided with a high level overview of expectations and risks will be brought to the April meeting
Month 10 Operational IPM	J Street	• Ambulance handovers over 60 minutes significantly improved in January. • Continuing to reduce the number of patients waiting over 78 weeks and are on target to achieve zero 78 week waiting patients by end of March 23. This is with a small exception of the patients awaiting corneal graft surgery. • The DM01 position has improved by a further 5.81% with the final position at 19.39%. Paediatric Audiology performance has improved by 9.3% and the service remains on track for full recovery by end of March 23. • There is a continued focus on reducing the number of patients at any one time with No Criteria to Reside. The re-admission within 30 days of discharge shows a positive position. • The 2 week wait performance for December was below target at 79.3%, this is due to reduced Radiology capacity in Breast and lack of outpatient capacity in Gynaecology. The Gynaecology position has now improved. We are forecasting a continuing gap between demand and capacity in Breast Radiology which will have a detrimental impact on 62 day performance for several months. All opportunities to resolve this are being explored.	• The Committee noted the report and commended the continued 'green shoot' traction across key areas despite the backdrop of the extreme Winter pressures • Performance was overall better than expected in Jan such that discharges were sufficient to enable demand being met supported by a continued review of sustainability including reducing LOS • The Committee fully supported the drive to further embed and grow the belief in the sustainability of operational improvements. • Innovative recruitment approaches for Breast Radiology will continue including offshore employment models. However, mutual aid is being explored now to mitigate this risk.

Strategy and Operations Committee Chairs Report

Performance and Transformation Board Chairs Report	J Street	An update from the Chairs Report was included in the Month 10 Operational Plan update above.	- The Committee noted the report - JS to provide further Information on the Tommy's app delays, project plan and benefits of implementation.
Virtual Wards	J Bolger	- A National forecast estimated that we could save 50 patients per 100,000 population from coming into hospital. This means for Bolton, it was estimated around 100-120 patients could be supported in their own homes. - A Governance structure was established with a joint network board with Wigan, to share learning. - A Respiratory Hospital at home service has been developed - An Old Persons Assessment Unit was opened to support early discharges, working across Community Services. - The current trajectory was to achieve 30 patients by end of March 23 in line with target. At any one time there are 25-49 patients being managed in their own home, supported by Community Services or Hospital at Home. The trajectory being worked on is to is to expand this.	- The Committee noted the report and that the FT is on track to meet delivering 30 virtual ward beds by March 23 - The ability to fund virtual ward from savings was queried as both virtual wards and the hospital contribute to managing demand. Further work is needed to report back on this. - Bolton has had a slow start on virtual wards but good traction is now in place with effective clinical engagement, such that the 'duty of care' aspect is being carefully managed on a pathway by pathway basis.
Clinical Strategy	N/A	There was nothing to report this month.	NA
Operational Plan 2023-24	S White	- RTT elimination of 65 week waits by March 24. Have submitted a position of missing this target by 1,465. GM requested for all Trusts to review and resubmit data after 8 Trusts inaccurately projected zero 65 week waiters by end of 24/25. - There has been feedback from GM regarding Outpatients, the projected system of reducing follow up appointments is 11% against a target of 25%. GM are to discuss this with the regional team. - There is an opportunity to improve the Elective position from 30% more activity. - There is confidence A&E will meet the national target is 76% of patients seen within 4 hours by March 24 - The first submission for NCTR is 90 versus a target of 58. More work is required and are waiting feedback from GM. - The Final submission milestones are: - 6th March, Senior Triangulation Review. - 8th March, check and confirm session - 13th March, virtual sign off - 16th March, final review to GM	- The Committee noted the report and queried the 'green' rating for Diagnostic and Cancer. - These along with other operational targets will be monitored by Finance and Intelligence Group for realism. - The Committee encouraged an ambitious approach to exceeding selected targets - Implications of not meeting the targets e.g., eliminating 65 weeks waits by 2024, are currently unknown. - Next steps: - F& Int Group to maintain oversight of the actions and performance - Narrative requests to divisional colleagues - Continual updates to Execs on a weekly basis
Strategy Review	R Noble	The proposal to the Committee is: - Perform a review of the performance against the current strategy, which expires in 2024. - Develop a new 23-26 strategy is over the Summer, taking into account new local, regional and national plans and strategies for publication in September 2023.	- The Committee approved: - The proposal for a draft review of the current strategy to be presented in April/May. - The development a new 23-26 strategy with monthly progress updates from May, a draft received in August and finalised in September for Board approval

Strategy and Operations Committee Chairs Report

NMAHP's Transformation	T Roberts	• The enabling priorities are:
		  • Developing our quality governance
		  • Developing our quality improvement strategy
		  • Transforming our workforce
		  • Maintaining and improving patient and service user experience
		  • Understanding inequalities in health
		  • Building on our professional leadership
		• Quality Governance involves changes to serious incident investigation process. This includes declaring SI process to be more timely, with improvement to date from 18.6 days to 8.5 days.
		• Workforce – the main message is that there is good progress on supply of talent. There is a key focus on retention with nursing and midwifery attrition rates of 12.4% / 203 wte RNs and 14.5% / 30 wte RMs together with continuing feedback on lessons learnt.
		• Service-user experience and a focus on how people feel, the most feedback is from complaints, friends and family, inpatient A&E and other surveys. An extra 2 questions will be added to a monthly survey carried out across all inpatient services and community patients. This will be rolled out in pilot areas by April.
		• The Bolton workforce transformation team is to look at the different roles and work with Adult Social Care colleagues focusing on Pathway 1.
		• There is a continuing theme on moving to being process led rather than person led to enable consistency of service user experience across all four pathway levels
			• The Committee noted the report was for information
			• As such this paper would be reviewed by People Committee.
			• It was confirmed that Bolton is leading on GM Inequalities and had secured a year's funding for a learning disabilities nurse as part of this workstream.

Strategy & Development Planning Group Minutes	S White	• Following the workshop in January the 3 priorities for the system were identified:
		  1. Neighbourhoods and Community including LTC and Mental Health
		  2. Children including Mental Health
		  3. Workforce, OD and Digital
		• At the first meeting following the workshop, there was a review of the neighbourhoods. K Smith, Co-chair of the Neighbourhoods Integrated Partnership will now provide regular updates on progress on developments with neighbourhood plans.
		• Performance and outcomes will be overseen through the Strategy Delivery Planning Group.
		• A GM performance dashboard that will be monitored through this group.
		• A maturity matrix for Neighbourhoods is in place to help understand the deprivation and outcomes within each neighbourhood and help us inform how to allocate resources.
			• The Committee noted the minutes
			• A maturity matrix will be available in the next neighbourhood update for Committee review.
			• It was confirmed that there is a lot of work going through locality Workforce Transformation with J Mairs and L Rigby leading on this work.
			• Timeframes for outcomes measures for the 3 locality priorities are to be confirmed.

Items to escalate to the Board:

- BFT's Business Intelligence team are viewed as leaders in GM. There are future BI capacity risks due to GM 'one organisation' restructure expected from April 23
- 27% of patients on the waiting list have no ethnicity data, with work to understand how to improve this to support locality Health Inequalities work
- While the Committee commended strong operational performance in Jan, mutual aid is being sought with WWL to assist with Breast Radiology
- BFT is on track to meet the 30 virtual wards target by March 23
- The current strategy performance review will be considered in April/May and 2023-2026 strategy designed during summer for Board approval Sept 23
- Locality top 3 priorities have been confirmed with outcome measures being a work in progress

Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	27th March 2023	Date of next meeting:	30th March 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Sharon White.	Quorate (Yes/No):	Yes
	In attendance: Sam Ball, Rachel Carter, Rayaz Chel, Andy Chilton, Francesca Dean, Sharon Katema, Jake Mairs, Rachel Noble, Julie Ryan, Kate Smith, Jo Street, Brett Walmsley, Judith Richardson (minutes)	Key Members not present:	Francis Andrews, James Mawrey, Tyrone Roberts, Rachel Tanner.

Key Agenda Items:	Lead	Key Points	Action/decision
Terms of Reference	R Ganz	The Strategy and Operations Committee were asked to review the ToR as part of the six monthly review since its evolution in September 2022 Comments received: • time constraints of people having to attend so many committee meetings acknowledged but there is a need for rationalisation of meeting papers to different committees • The work of the system delivery and planning group will be included in the oversight of organisational transformation programmes section • The outcome of the committee effectiveness review survey will shape the ToR going forwards	• The Director of Strategy, Digital and Transformation will include the work of the system delivery and planning group in the Transformation section of the ToR and agreed to provide the Director of Corporate Governance with appropriate wording

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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

Strategy and Operations Committee Chairs Report

Service Spotlight: Health Inequalities	Jo Street J Ryan	Update provided on the work undertaken by the Health Inequalities Enabling Group (HEIG) since its formation in March 2022 along with a look forward at the work planned for the next 12 months to tackle health inequalities: • Three key enabling priorities identified for 2023-24, Education and awareness; Health equity impact assessment and Knowing our patients • HI are unfair, can be prevented and are costly, not just to individuals but also to health, care and economic systems and therefore it is in our interest as a healthcare provider to focus on reducing HI • Bolton residents live disproportionately in the most deprived areas in comparison nationally along with population and experience-wide disparities in life expectancy • Business Intelligence have created a 'bus tour' concept to illustrate the health inequalities that exist within Bolton. As a result of this work, a tool has been rolled out across GM to allow all localities to benefit from this illustrative analysis • The Bolton 2030 Vision for the borough to be Active, Connected and Prosperous is underpinned by six outcomes which provide the framework for action by a range of partners and sectors. • Health is shaped by a complex interaction between many factors including accessibility and quality of health and care services, individual behaviours and, most importantly, wider factors such as housing and income. • To effectively act on HI, we need to be able to identify the areas and groups of patients that require additional focus. The Trust holds a wealth of data that can be "cut" at multiple various levels, including by ethnic group, age, sex and deprivation and as an example can be used to analyse waiting lists. • Work across the Bolton locality involves looking at our community activity by neighbourhood and area and layering this with intelligence from our partners on the delivery of different services, to build a unique picture of service delivery per neighbourhood and to help with decision making. A series of "data walks" is planned, which is a technique to look at data by theme/neighbourhood and brings intelligence together from all partners plus service users.	• Strategy and Operations Committee received the report as an excellent, comprehensive update noting the work to date and the plan for the next 12 months • 6 monthly summary update and an Annual report to be received by SOC on headline traction for 3 key priorities, Education and awareness; Health equity impact assessment and Knowing our patients • Strong OD element identified so need to ensure that the principles and priorities are also applied to our staff as well as our patients • Communication is part of proportional universalism across Bolton and is driving inequality and access to services. Future updates via the education and awareness priority will explicitly show how this is being tackled • Due to the size and complexity of the work to be carried out there are risks to delivery but the structured approach to overseeing the work by the HIEG will be a mitigation against this risk.

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Strategy and Operations Committee Chairs Report

Month 11 Operational IPM	J Street	**Access:** • Ambulance handovers over 60 mins show a slight improvement • The early focus of ED improvement has seen an increase in performance to 64.2% against an improvement trajectory of 60%, Feb 2022 at 63%. Feb 2023 we were third out of 6 in GM with Type 1 A&E with best at 66% worst at 59% • RTT - 78 week waiting patients continues to reduce and we are on target to achieve zero waiting patients by the end of March 2023. This was only slightly impacted by strike action. There are 2 breaches which will not fall within the criteria for the nationally agreed exemptions and there is a concentrated effort to resolve these in time. At 30.6.22 when focus moved from 104 week waits to 78 week waiting patients, we had 4098 patients and we have now treated almost all those patients. • DM01 position improved by a further 6.87% in February with a final position at 12.5%. Continued improvements with physiological measurements in echocardiography, paediatric audiology and urodynamics pathways and are still on track for full recovery by the end of March 2023. **Productivity:** • NCTR remains positive - still continuing to reduce along with a continued decrease in occupied bed days • Re-admission within 30 days of discharge remains positive. **Cancer:** • 2 week wait performance for January below target at 82.4%, due to Radiology capacity in Breast services and it is expected that this will continue to be impacted in the medium-term until it is resolved. Across GM we are mid-table with only 2 trusts achieving the standard in January, best at 83% and worst at 68%. • We failed the 62-day standard for January with performance at 84.2%, the deterioration in the 2 week wait standard for Breast services is now starting to impact delivery of the 62-day standard. • On track to meet our elective recovery milestones by the end of March 2023, with our 62 day backlog of patients recovered to 19 patients as of 27.3.23 against a trajectory of 20.	• Impact of strike action on public behaviours/attendances to A&E felt during the ambulance strikes but less so during the 72hr junior doctor strike due to planning. • National shortage of Breast Radiologists and we are using a whole range of options to increase capacity including international recruitment but no quick fix. An update will be provided in the Operational IPM report for Month 12 • COO and DoOp will carry out an analysis of the LoS and NCTR data to understand why LoS is going up but NCTR average days is going down. The Chair requested that this is included within the narrative of future Operational IPM reports • In relation to our internal flow measures for 12 midday and 4pm discharges, some positive outcomes have been identified from staff working in different ways/in different roles during the recent junior doctors strike. The learning from this is being captured by the Transformation Team led by Sam Ball to make sustainable changes that will contribute to improving our internal flow standards going forwards.

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Strategy and Operations Committee Chairs Report

Performance and Transformation Board Chairs Report	R Wheatcroft	**Urgent Care Transformation Programme:** • Detailed improvement plan requested to come to the next PTB meeting in relation to stroke performance **Finance and Intelligence Group** • This work of this Group is becoming an enabler to a wide range of other work and presents an opportunity as a provider of data/data quality and outcome analysis.	• Reviewed simultaneously with the Month 11 Operational IPM above

Digital Performance and Transformation Board Chairs Report	B Walmsley	• The meeting in March had been stood down due to the lack of availability of key members who were required to deal with the impact from the junior doctor strike action
		• B Walmsley provided a verbal update on the deployment of equipment in March
		   − 100 Ormis Lone Working devices
		   − 33 new clinical pack workstations
		   − 66 new laptops for HR with docks
		   − Community Wifi now in Farnworth, Great Lever, Egerton, Dunscar and Horwich
		• Now have an established IG SLA with GM
		• GP SLA making progress
		• On track for the Data Protection Toolkit submission with a reminder to staff needed to complete their IG training
			• The key area of risk relates to the resources to carry out future projects as noted in the previous Digital & Data spotlight

GM ICB Business Intelligence Update	J Ryan	• The whole of GM is going out to a staff consultation including locality BI staff commencing on 29th March for 45 days • Locally the re-designed function will have 3 analytical staff down from 10 • Preparatory work currently taking place in readiness for the outcome of the consultation as we will have to work with the new way of working. In the process of reviewing all the reporting and analysis within ICB team across the whole of the locality to deliver ICB and FT objectives along with looking at how the centralised BI resource across GM can be used to deliver this as well • GM have not consulted with Bolton FT on their proposed new model. J Ryan, N Ledwith and S White are currently working through the mitigations to look at what can be done differently within Divisions to train and develop them to use the tools that are already in place.	• The Director of Strategy, Digital and Transformation advised that the risk of losing a cohort of highly skilled staff due to the consultation remains a significant risk to the Trust and GM. • The Chair advised of the need to have an appetite for being creative with our boundaries to make this work as the need for BI is growing not reducing.

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Strategy and Operations Committee Chairs Report

Operational Plan 2023-24	R Noble	• R Noble advised that the focus of the report related to the activity element. The Strategy and Operations Committee were asked to provide comments and input on the plan ahead of submission to Part 1 and 2 of the Board of Directors on 30.3.23. • There is a wider locality component to the delivery of the plan and therefore the approach this year will be different and will include a Locality Steering Group which is already in place and currently developing a locality narrative on how we will work collectively across the system to deliver the Plan • The Finance and Intelligence Group will monitor and oversee progress against key operational planning targets • GM will submit a system operational planning return, of which Bolton's return is a component part, and the North West region of NHS England will monitor the GM system's performance against operational planning targets. If GM does not achieve their targets, but Bolton do, we could still be negatively impacted in order to support the wider system • Granularity of the Plan is provided at speciality level with more rigour and engagement this year at specialty level to target where improvements are needed. • GM is one of the lowest performing regions in the country so is under much scrutiny	• The Strategy and Operations Committee approved the final operational activity template accepting the risk of underperformance against the 4 key targets to deliver 30% more elective activity (than before the pandemic); eliminate 65 week waits; reduce no criteria to reside (NCTR) to 60; reduce outpatient follow ups by 25% • It is anticipated that national scrutiny will push GM system to work together across GM more innovatively. • R Noble formally noted the high level of engagement with planning passed on her thanks to everyone involved in the production of the Plan
Clinical Strategy Update	R Chel	• Following the 3-month extension for the completion of the Clinical Strategy in January 2023, Archus have updated the programme which now runs from March to the beginning of July at which point the Clinical Strategy will be submitted to the Board of Directors for formal approval • First draft of the high level Clinical Strategy expected w/c 3rd April 2023 for initial review by the Programme Director, Associate Medical Director and Deputy Director of Strategy with Archus in advance of any circulation. • Significant engagement with Divisional triumvirates and cross divisional discussion to assess the impact of a divisions plan on another Division • The governance arrangements supporting the Clinical Strategy includes a project group and project board that meet on a monthly basis and a review against milestones of the programme will be a standing agenda item.	• The Strategy and Operations Committee noted the update • Draft documents will be shared with Strategy and Operations Committee and Board of Directors in May 2023 for discussion. • First draft to be received w/c 3 April enabling 14 weeks to ensure sufficient 'ambition' is embedded within the clinical strategy •

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Strategy and Operations Committee Chairs Report

Board Assurance Framework	S Katema	• The BAF was presented as a live document ahead of submission to the Board of Directors on 30.3.23 • Following the last iteration of the BAF to this Committee in November 2022 and January 2023, a review of the risk appetite for ambitions, 1.2, 5 and 6 has taken place with the Exec leads with no change to the risk scoring. • The Director of Strategy, Digital and Transformation advised of a couple of minor changes to Ambition 5 around 'transfer of adult social care teams into FT' and advised that this is no longer the plan but that this will be taken forward with integrated teams in the Neighbourhoods.	• The Chair agreed that she would discuss the suggestion for the 'Mature' risk appetite for ambition 5 to be updated to Seek at the BoD meeting along with the lines of defence for assurance of ambition 6 • The Committee accepted the proposal to amend the current risk appetite for ambition 1.2 from cautious to open
Strategy, Planning and Delivery Committee Minutes	S White	The Committee received the minutes of the last meeting held on 7th March, chaired by S White Deputy Chair: • Terms of Reference agreed • Voice of the Public – FT will lead on engagement and Council will lead on Marketing and will come together to lead on Communications. 3 priorities agreed – children, neighbourhoods and workforce • Locality Plan – presentation received on the Locality Plan 2020-24. Key priorities include Prevention and Early Intervention, Mental Wellbeing, Keep People Living Well in their Community, Develop our workforce and culture as a locality and Digital First approach. Plan will be finalised in June • Integrated Partnership and 7 x Enabler Group Plans - plan on a page methodology will be used and will come through to future SOC • Areas for escalation – Primary Care Commissioning Committee, main risks highlighted were regarding delivery of IT on a PCN footprint and Estates • Presentation received on the proposed Bolton Quality Contract for 2023/24 signed for recommendation to the Locality Board	• The Committee noted the Locality's SPDG Committee minutes • Due to the large membership, core group members will meet monthly with partnership leads attending a quarterly workshop. • Carer Strategy will be submitted to the next SOC meeting • The Committee noted 12 months extensions to 0-19 contract and S White will provide update to the Chair outside of the meeting
Neighbourhoods Maturity Matrix	K Smith	K Smith, Co-chair of the Neighbourhoods Integrated Partnership shared the maturity matrix for information and welcomed feedback: • Further to Locality Board approval to move to a 6 neighbourhoods delivery footprint, the Maturity Matrix summarises how we expect to move towards fully enabled, integrated, place-based working across neighbourhoods over the coming years. • Part of a wider piece on how measure success and working with data leads on system wide measures. This year is about establishing teams in Neighbourhoods with clear leadership.	• The Committee received and noted the Maturity Matrix • The word 'culture' needs to be more at the forefront of the matrix as clear leadership enabled by strong cultural glue is necessary for a successful One Team n'hood approach. OD very much involved to enable this • Major risks requested to be highlighted as part of the Matrix

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Strategy and Operations Committee Chairs Report

Items to note or be escalated to the Board:

- Cancer, 2 week wait performance for January below target at 82.4%. Radiology capacity in Breast services is a national issue and likely to continue into the medium-term given the backlog of patients.
- Cancer, failed 62-day standard for January with performance at 84.2%, the deterioration in the 2 week waits for Breast services is starting to impact 62 day delivery.
- 78-week wait, 2 breaches noted that are not exempted. Strikes had a minor impact and team working to meet the zero target by 31/2/23.
- Digital programme continuing at pace, however continues to be at risk due to resourcing available
- GM ICB Model means a reduction from 10 to 3 staff locally. Team focused urgently on different ways of working and a range of mitigations given increased BI demand
- Operational plan is extremely challenging with some targets not achievable within the context of GM being one of the lowest performing regions in the country
- Draft clinical strategy due w/c 3rd April with 14 weeks to finalise for approval by the Board
- Maturity Matrix formulated to support 6 neighbourhood's having a 'One Team' approach with high level measurable outcomes TBC

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NHS
Bolton
NHS Foundation Trust

Report Title:	Quality Account 22/23 Annual Report Governance Arrangements and 23/24 Quality Account Improvement Priorities Proposal

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	✓
Exec Sponsor	Chief Nurse		Decision	

Summary:	This paper seeks to offer: - An assumed time frame for the completion of the Quality Account 22/23 annual report - Suggested approach for the 23/24 Quality Accounts Improvement Priorities

Previously considered by:
✓ The paper was received and endorsed by the Quality Assurance Committee

Proposed Resolution	The Board of Directors are asked to: - Note assumed Quality Account annual report 22/23 production timeline - Note assumed approach to the Quality Account 23/24 improvement priorities

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

Prepared by:	Debbie Redfern, QI Programme Manager	Presented by:	Francis Andrews Medical Director

Quality Account 2022/23 annual report governance arrangements and 2023/24 Quality Account improvement priorities proposal

Introduction:

This paper seeks to outline arrangements for:

- An <u>assumed</u> time frame for the completion of the Quality Account 22/23 annual report
- Suggested approach for the 23/24 Quality Accounts Improvement Priorities

Provisional Quality Account annual report 22/23 timeframe

Central guidance yet to be released, however, we are proceeding with the assumption that the Quality Account annual report 22/23 and will be required. The schedule in appendix one outlines the committees where the Quality Account annual report 22/23 will be reviewed/signed off

Revised arrangements from 2019/20 are still applicable – these being:
- "NHS foundation trusts are no longer required to include a **quality account/report** in their annual report. This will continue for 2021/22 and beyond."
- "NHS foundation trusts are not required to commission assurance on their quality report for 2020/21 and beyond"

The project management and governance arrangements for the collation of the Quality Account annual report is being reviewed.

Quality Account Improvement Priorities 2023/24

The Quality Account annual report requires the selection of three improvement priorities for the forthcoming financial year and to nationally publish progress in these areas in the following year's quality account annual report. The only caveats on selecting priorities are:
- Must demonstrate a link to Quality Improvement/Patient Safety
- Must have clear deliverables, with a measurable outcome aim
- Must have data from which to measure progress
- Must have governance arrangements to report performance and escalate issues

In Q4 22/23 part of the trust's new QI team will be in post, therefore offering new capacity and capability to facilitate trust and system-wide QI activities. Therefore, we suggest focussing the three quality account priorities for 2023/24 on trust/system wide areas for improvement; using the IHI's Improvement collaborative model. The QI team will be responsible for the oversight and delivery of these trust/system wide priorities. The three quality account improvement priorities for 23/24 are being discussed, one of which will be the Pressure Ulcer Collaborative which is already underway.

For the outgoing 2022/23 priorities – we suggest this could progressed as part of the divisional quality improvement projects that will have the support from the corporate QI Team. The reporting of progress to be remitted to divisional governance, and reported up to Clinical Governance and Quality via Chair's report/IPM exceptions.

Advantages:

- The quality account improvement collaboratives will be centrally facilitated and project managed by the corporate QI Team.

- Improvement Collaboratives will be chosen based on data and their impact on patient safety, experience with a key link to QI Strategy, Trust Strategy and National Patient Safety Strategy.

- Central co-ordination, benefits tracking and shared learning of corporate improvement collaboratives

- Ability to engage staff in QI on a wider scale through the workshops and learning sessions.

- Support would available from the QI team to help frame and coach the divisional quality improvement priorities – which would also assist with gathering a trust-wide library of improvement activities.

NHS England Quality Accounts List 2023-24 – Clinical Audits, Clinical Audits, Clinical Outcome Review

NHS England Quality Accounts List 2023-24 which outlines the National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2023-24 has been released.

Any which pertain to the Trust will be registered or renewed by the Divisional Clinical Audit Officer, to start 01/04/23 – please contact clinical audit for more information.

Summary and Recommendations

The Committee is asked to:

- Note preparations have begun for the collation of 22/23 Quality Account annual report. As at 26th January 2023 no national guidance published. If guidance is forthcoming this may requirement adjustments to timescales and/or content.

- Note suggested approach to Quality Account improvement priorities 23/24 – three trust-wide areas are selected, which the Quality Improvement Team will lead on and report progress to this committee e.g. Pressure Ulcer Collaborative

- Note that the "NHS England Quality Accounts List 2023-24 National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes has been published

Debbie Redfern – Quality Improvement Programme Manager
27th January 2023

Appendix 1 – Quality Account annual report 22/23 – Review and Approval Schedule

(NB this schedule below could be subject to change based on national guidance from Department of Health and Social Care, following National Quality Board review):

Committee	Date	Actions Required
Clinical Governance and Quality	February 2023	• To note Quality Account annual report 22/23 cycle is due to commence • To note proposed approach to the 23/24 Quality Account priorities
Audit Committee	February 2023	• To note commencement of Quality Account 22/23
Quality Assurance Committee	March 2023	• Receive an outline of the chosen Quality Account priorities for 23/24 and a written update on the formulation of the Quality Account 22/23
Quality Assurance Committee	April 2023	• To receive a draft Quality Account 22/23 for sign off
Council Overview and Scrutiny Committee	May 2023	• To receive Draft Quality Account for comment
Healthwatch Bolton	May 2023	• To receive Draft Quality Account for comment
GM ICB	May 2023	• To receive Draft Quality Account for comment
Audit Committee	May 2023	• To review Final Quality Account
Board of Directors	May 2023	• To sign off the Final Quality Accounts
Publish & Communicate	30th June 2023	• As a standalone document to NHS Choices

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Report Title:	Care Quality Commission (CQC) Inspection & Improvement Plan

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	To provide the Board of Directors with an update in relation to the Trusts current CQC rating (Appendix 1) and assurance in relation to the Trust's response to the recently published CQC reports.

Summary:	The Trust was inspected by the CQC in November 2022.
	The CQC undertook an announced inspection of our maternity services as part of the National Maternity Inspection Programme and an unannounced inspection of urgent care and medical services.
	The reports following these inspections have been published in February 2023 (urgent care and medical services) and March 2023 (maternity).
	The urgent care report contained areas of outstanding practice and areas for improvement. Specifically the report contained three "must do" recommendations. These recommendations resulted in two requirement notices.
	As a result of two requirement notices, both in the safe domain, the rating for urgent care services was amended from good to requires improvement. The service overall remains as good.
	The maternity services report identified areas of outstanding practice and areas for improvement. Specifically the report contained six "must do" recommendations. These recommendations were across the safe and well led domains. As a result the rating for maternity services was amended in both domains from good to requires improvement. The impact of this was that the overall rating for maternity services has been amended to requires improvement from good.
	Due to the rating for the safe domain now being requires improvement in both urgent care and maternity services, the trust overall rating for safe is now requires improvement. Overall the trust remains rated as good. See Appendix 1 for outcome of inspections and impact on ratings.
	The Trust has developed an improvement plan to respond to the recommendations. This is being monitored through the relevant divisional governance process and is also being overseen by Clinical Governance & Quality Committee with monthly reporting of progress. Currently, all actions are complete or on track with no overdue actions.

Previously considered by:
✓ The Quality Assurance Committee whereupon it was agreed that the Committee will be kept informed of progress through the Clinical Governance and Quality Committee Chair's report. An improvement plan is now in place with progress in relation to the actions from the CQC reports is being monitored at divisional level and overseen by Clinical Governance & Quality Committee. All actions are either complete or on track. No actions are overdue.

| **Proposed Resolution** | The Board of Directors is asked
• To **receive** and **note** the contents of this paper and the updated position in relation to the trust CQC rating.
• To **receive** the CQC Improvement Plan actions noting the assurance in relation to monitoring and oversight of progress via Clinical Governance & Quality Committee and Quality Assurance 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:	Stuart Bates, Director of Quality Governance	**Presented by:**	Tyrone Roberts, Chief Nurse

1. Introduction and background

The CQC inspection report for the unannounced visit to the urgent care and the medical wards was published on 17 February 2023. This report contains three 'Must Do' actions and three 'Should Do' actions. "Must Do" actions are attributed to a breach of a regulatory requirement.

The inspection report for maternity services was published on 3 March 2023. The report contained six 'Must Do' recommendations.

2. Current Position

To ensure that all of the recommendations and subsequent actions from the CQC inspection are monitored and completed, a trust wide CQC improvement plan has been developed.

The CQC improvement plan captures the recommendations for all divisions/corporate teams in one working document.

At present the actions to address recommendations have been considered by the divisions and added to the plan. Two actions related to the Emergency Department have now been completed.

The Director of Quality Governance has worked with divisional colleagues to ensure SMART actions to address all recommendations. A focus of this will need to be on embeddedness and sustainability.

Progress of the actions will be monitored and reported to the Clinical Governance and Quality Committee on a monthly basis to include updates on actions and through to QAC via Chair's report.

3. Summary

All recommendations and actions from the CQC inspection are included in a trust wide improvement plan that will be overseen and monitored at Clinical Governance and Quality Committee on a monthly basis and reported to Quality Assurance Committee.

4. **Recommendations / next steps**

- Note the Trust has developed an improvement plan with actions to address all CQC recommendations
- Note actions have been completed or are on track with no overdue actions.
- Confirm assurance in relation to monitoring and oversight of progress via Clinical Governance & Quality Committee and Quality Assurance Committee.

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CQC Inspection & Improvement Plan

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CQC Inspection

- Announced focused inspection of Maternity Services in November 2022 as part of the CQC National Maternity Inspection Programme in November 2022.

- Unannounced focused inspection of Urgent Care services and Medical services in November 2022.

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Urgent Care and Medical Services

- Inspection report published on 17 February 2023
- Inspection covered all CQC domains (Safe, Effective, Caring, Responsive, Well Led)
- Report contained three "Must Do" recommendations and three "Should Do" recommendations
- "Must Do" recommendations indicate a regulatory breach and resulted in two requirement notices.
- All "Must Do" recommendations were in the Safe domain and as such this domain rating deteriorated from "Good" to "Requires Improvement"
- All other domains remained "Good"

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Urgent Care and Medical Services

Outstanding practice

We found the following outstanding practice:

- The Enhanced Care and Support team provided an outstanding service to patients with complex needs on the wards and supported them through to a safe discharge.

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Urgent Care - Recommendation

Action the trust MUST take to improve:

Royal Bolton Hospital Emergency department

- The trust must ensure that staff receive safeguarding training that is relevant and updated at appropriate intervals to keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13(2)
- The trust must ensure that it mitigates the risks to the health and safety of service users receiving care or treatment including patients with mental health illness waiting for assessment and/or admittance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(a)(b)
- The trust must ensure that risk assessment relating to the health, safety and welfare of people using their service are completed including ligature risk assessments in the waiting room where mental health patients wait for extended periods of time to allow for reasonable adjustments to be made. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation (12(2)(a)

Action the trust SHOULD take to improve:

Royal Bolton Hospital Emergency department

- The trust should ensure that patients both adult and children are triaged within the nationally set out timeframe.
- The trust should ensure that out of date equipment is not in circulation and that daily checks carried out are meaningful.

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Medical Services – Recommendations

Action the trust SHOULD take to improve:

Medical wards

- The service should ensure that the paper "do not resuscitate" orders contain the appropriate clinical information as reflected in the electronic records.

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	

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Maternity Services

- Inspection report published on 3 March 2023
- Inspection covered only two domains (Safe & Well Led)
- Report contained six "Must Do" recommendations
- "Must Do" recommendations were across both domains and as such both domain ratings deteriorated from "Good" to "Requires Improvement"
- Maternity Services overall rating deteriorated from "Good" to "Requires Improvement"

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Maternity

Is the service safe?
Requires Improvement ● ↓

Is the service well-led?
Requires Improvement ● ↓

Maternity
Requires Improvement ● ↓

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Maternity Services – Recommendations

Action the trust MUST take to improve:

- The trust must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons to safely care for women and birthing people. Regulation 18(1)

- The trust must ensure staff complete mandatory training in line with the trust's own target. Regulation 12(1)(2)(a)(c).

- The trust must ensure equipment is checked in line with trust policy and documented clearly. Regulation 15 (1)(2)(c)(d)(e)

- The trust must ensure incidents and complaints are handled in a timely way and in line with trust policy. Regulation 17 (1)(a)

- The trust must ensure staffing, waiting times and other key metrics are in line with national standards. Regulation 12(2)(b); 17(1)(2)(e)

- The trust must ensure staff receive such appropriate support and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a)

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Trust position

Ratings for Royal Bolton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019
Medical care (including older people's care)	Good ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Surgery	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Critical care	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Maternity	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Requires improvement →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
End of life care	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Outpatients	Good →← Aug 2016	N/A	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Overall*	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

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Trust position

Ratings for Royal Bolton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Medical care (including older people's care)	Good ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Surgery	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Critical care	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Maternity	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Requires improvement →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good Aug 2016	Good →← Aug 2016
End of life care	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Outpatients	Good →← Aug 2016	N/A	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016	Good →← Aug 2016
Overall*	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

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Overall Trust position

Latest inspection: 24 November 2022   Report published: 3 March 2023

Safe	Requires improvement 🟠
Effective	Good 🟢
Caring	Good 🟢
Responsive	Good 🟢
Well-led	Good 🟢

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Trust position – Well Led

CQC rating

Outstanding ☆

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Well Led

The updated well-led framework: Key Lines of Enquiry — CareQuality Commission

Does the **leadership have capacity and capability** to deliver high quality, sustainable care?

Is there a **culture** of high quality, sustainable care?

Is there a clear **vision** and credible **strategy** to deliver high quality sustainable care to people, and robust plans to deliver?

Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?

Are services well-led?

Are there clear and effective processes for managing **risks**, issues and **performance**?

Is robust and appropriate **information** being analysed and challenged?

Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to ensure high quality sustainable services?

Are there robust systems, processes for **learning**, continuous **improvement** and **innovation**?

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Report Title:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Francis Andrews		Decision	

Purpose	The purpose of the reports is to provide assurance to the Board on work delegated to the Committee.

Summary:	The attached reports from the Quality Assurance Committee Chair, provide an overview of items discussed at the meetings held on 15 February and 15 March 2023.

Previously considered by:
Discussed and agreed at Quality Assurance Committees

Proposed Resolution	The Board of Directors Committee is asked to **receive** and note the chairs reports.

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:	Molly Cooper	Presented by:	Malcolm Brown Non-Executive Director

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Quality Assurance Committee Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee	Quality Assurance Committee	Reporting to:	Board of Directors
Date of Meeting:	15 February 2023	Date of Next Meeting	15 March 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Martin North, Tyrone Roberts, Francis Andrews, Rae Wheatcroft, Harni Bharaj, Sharon White All Clinical Divisions in attendance	Apologies received from:	Fiona Noden, James Mawrey, Carol Sheard, Gareth Hughes

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report		TR/FA	The Chief Nurse and Medical Director provided an overview of the IPR; • Pressure Ulcer Collaborative had one learning session and another planned in March. • Community pressure ulcers are under review as there is vast variation across GM regarding how data is presented. Pressure ulcers in community need to reflect how care interventions are often reliant upon other agencies and/or families and carers and hence the 24/7 visibility that in-patient areas have is absent. • Complaints are much more focused on the response quality and timeframes have shown some initial improvement in January • 3rd & 4th degree tears have increased by 6% and the 12+6 days bookings have 18% missed of the last data set in February, both of which are being reviewed by the Head of Midwifery. • Clinical correspondence will be presented back at the Quality Assurance Committee in two months' time to provide assurance. • SHMI and HSMR are still within range.	**Decision:** The Committee received and noted the report.
Quality Account – Priority 5 Q3 – Accessible Information Standards		DND for ASSD	RC presented the report and highlighted the following: • A lot of progress has been made regarding the scoping work, however there has been limited progress with IT due to changes in leads. • This is a priority to enable communication needs to be added to LE2 to ensure patients' needs are clearly recorded for all specialties to provide information to the patient in an appropriate way.	**Decision:** The Committee received and noted the report.
Quality Account Annual Report for 2022/23 and Governance Arrangements for 2023/24		SB	• It is proposed that now there is a Quality Improvement Team established the Trust will move to focus on three priorities to take forward and use the model for improvement across the Trust as whole which the Quality Improvement Team will lead on.	**Decision:** The 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

Quality Assurance Committee Chair's Report

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Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Clinical Governance & Quality Committee Chair Report		TR	Chief Nurse presented the chairs reported and noted the following; • Agency access card - This has made some really good progress with interim mitigation to ensure temporary staff have required digital access • Observations – SKC/IT have worked towards issues and have impressed with clear plans. • CQC formal report is yet to be published but the first drafts of an action plan to address feedback is underway. • Patient safety report – Three divisions had open Serious incident actions from 2022. Feedback was requested immediately and confirmation received that all except one action closed. The one remaining action relates to workforce and GR is liaising with PH. • IPM Quality Dashboard – An options appraisal will be presented with respect to heat-map future reporting.	**Decision:** The Committee received and noted the report.
Quality Account – Priority 2 Q3 – Rheumatology		DSSD Clinical Lead	The Clinical Lead for Rheumatology presented the report and highlighted the following: • The service has worked collaboratively during Q3 to review and challenge existing practices with a positive appetite to work towards service redesign aimed at both increasing clinical capacity and improving patient access, responsiveness and experience. • However, at the end of Q3 performance continues to deteriorate with patients waiting longer for appointments (i.e. 54 weeks for routine new appointment first availability–with a further 658 newly referred patients undated) and the service is at clear risk of 78 week breaches from April 2023. • This is due to a new patient referral demand that is consistently higher than the reducing core medical capacity available.	**Decision:** The Committee received and noted the report.
Learning Report Quarter 3		SB	• This was the second report to be received by the Committee which includes the Friends and Family Test, BoSCA and Complaints in a detailed report. • It was noted that Ward M5 was rated as white. However, the Chief Nurse confirmed that this may partially be due to the adult nursing template that was used not being entirely appropriate for use in Maternity. • For example, there are sections regarding end of life care information displays and M5 is a postnatal ward area and so would not be appropriate. Reviews of the document with maternity have been undertaken subsequently. • The Committee discussed the appetite to continue receiving this report and members agreed that proved useful to see alongside the CQGC chairs report.	**Decision:** The 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

Quality Assurance Committee Chair's Report

NHS Bolton

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Maternity Incentive Scheme Year 4 Progress Update		TR / JC	• TR / JC had requested the internal audit due to concerns with reliability and validity of CNST systems and processes. The outcomes of the audit have confirmed initial concerns as follows; - Compliance with the scheme: High risk - Roles and responsibilities: High risk - Planning and oversight: High risk - Clinical audit plan: Medium risk - Working group: Medium risk • The audit report details the management actions to be undertaken and the recommended timescales for completion. All actions require completion prior to May 2023 in anticipation of the CNST Year 5 Scheme. • Ongoing monitoring with regard to completion of these actions will be undertaken at the monthly intervals at the Divisional Governance and Quality Committee with oversight at the Clinical Governance and Quality Committee until all actions have been completed. • Noted the increased confidence within the Division following the BCG Vaccination turnaround, student learner's feedback and the recent CQC inspection.	**Decision:** The Committee received and noted the report.
Safeguarding Committee Chair Report		BT	• The Safeguarding Committee chair report was taken as read with it being noted that the lack of DBS update is a risk and has been escalated appropriately to the Deputy Chief Nurse.	**Decision:** The Committee received and noted the Chairs Report.
Group Health & Safety Committee Chair Report		SB	• The Director of Quality Governance presented the chairs report noting the red rating given to the Security item which is in relation to a lack of a Prevention and Management of Violence and Aggression (PVMA) Specialist at the Trust and so a training needs analysis is also being undertaken	**Decision:** The Committee received and noted the Chairs Report.
Professional Forum Chair Report		TR	• The Professional Forum chair report was taken as read and it was noted that the Research Innovation and Healthcare is rated red due to the lack of traction in some areas although small progress is being made.	**Decision:** The Committee received and noted the Chairs Report.
For Escalation: No additional concerns to be escalated to Board of Directors.				

	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

Quality Assurance Committee Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Reporting To:	Board of Directors
Date of Meeting:	15 March 2023	Date of Next Meeting	19 April 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Martin North, Tyrone Roberts, Stuart Bates, Harni Bharaj, Sharon Katema, Rae Wheatcroft, Fiona Noden All Clinical Divisions in attendance	Apologies received from:	Francis Andrews, Carol Sheard, Bridget Thomas, Gareth Hughes, Susan Moss, Mike Robinson, Michelle Cox, Rebecca Lennon, Rebecca Bradley.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Committee Effectiveness Review		SK	• An overall positive report with slight concern noted regarding timely circulation of meeting papers. • The amount of responses received were not reflective of the Committee membership but were fully indicative of the current operational pressures. The timing of the effectiveness assessment will be amended to November with a full report presented in December.	**Action:** Next review planned for November **Decision:** The Committee received and noted the report.
Quality Account – Priority 4 Q3 – NEWS Improving Response to Escalation		ASSD	• The majority of the drivers were noted to be on track excluding training which was still recoverable.	**Decision:** The Committee received and noted the report.
Board Assurance Framework		SK	• A quarterly review of the BAF was undertaken. There is no proposed change in current risk score. • There has been an additional risk for the Chief Nurse identified and included as Ambition 1.3.	**Action:** The Committee approved the inclusion of Ambition 1.3 into the Board Assurance Framework.
BoSCA Q3 Update		TR	• Areas of lowest continuous scores have been asked to be presented in an SPC format. • Peer audit scores were noted to be lower than expected and so will move to monthly peer reporting	**Decision:** The Committee received the quarterly update.
Cultural Dashboard		Lisa Rigby	• LR presented the dashboard noting that it provided an early warning system for both positive and negative culture. • Appendix 1 outlined how NHSE/I recommend the data is used and this is done through four phases and the background work has already commenced. • The Committee discussed the over-reliance on data, needing to gather soft intelligence and how the Non-Executives can be used as well as gathering student experiences.	**Decision:** The Committee received the report and agreed to receive a further report once the data had been gathered and analysed.

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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Clinical Governance & Quality Committee Chair Report		TR	• C-Diff: There are concerns that rates remain in normal variation despite interventions focussing on SIGHT principles. Bolton FT has the highest 12 month rolling rate at 129% increase, compared to GM rolling rate increase of 40.5% and 29% for the North west. This will be a focus for a second Quality Improvement Collaborative due to commence May 2023. The deputy DiPC is also arranging for a peer review of our systems and processes. • TR also highlighted the increasing prevalence of pressure ulcers and c –diff since circa 2020/21 and confirmed that this increase was not mirrored in previous organisation nor model hospital data. TR re-iterated the process for improvement science using the collaborative series whilst cautioning also for realistic timeframes for improvement when acknowledging the long-standing sub-optimal performance in these two key aspects of harm reduction. TR also highlighted that draft national changes to pressure ulcer recording recommends un-stageable pressure ulcers being recorded as minimum category 3. The organisation has already had in excess of 55 un-stageable pressure ulcers this financial year. TR commented that he has not observed such high prevalence of pressure ulcers for over 9 years • ASSD: There were un-stageable pressure ulcers noted and these will feature in Divisional discussions • DSSD: Concerns were raised regarding the medical record storage and the solutions to be put in place with an update to come back in two months' time. • AACD: Clarity is needed regarding the sepsis data as it is not clear if the ipm data is current or from the month previous due to the less frequent report refreshes. Similarly, the ipm audit is believed to be auditing an incorrect element and hence present a false picture of low assurance. NEWS quality account audit demonstrate far better compliance. This is being monitored via Q&C governance committee.	**Action:** To receive an update on the medical record storage solutions in two months. **Decision:** The Committee received and noted the report.
Quality Account – Priority 1 Q3 – Antibiotic Prescribing Standards		AACD	• It was noted that some of the drivers are off track but can still be delivered • TR highlighted the sub-optimal performance however in relation to antimicrobial stewardship and linked this to the ongoing increased prevalence of c-dif	**Action:** Document education to be looked into after the Junior Doctor Industrial Action. **Decision:** The 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

Quality Assurance Committee Chair's Report

NHS Bolton

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Trust CQC Update		SB	• This is a hybrid report including the Maternity and Urgent Care inspections which are now in the public domain. • Noted that there are 6x 'Must Do' actions for Maternity and 6x 'Must Do' actions for Urgent Care. • Action plans for these are being monitored via the CGQC which will feed into this Committee. • Safe and Well-led in Maternity services rated as requires improvement • Safe in UeC rated as requires improvement • Trust remains 'Good' overall but the Safe domain is 'Requires Improvement' due to the actions identified during the inspections • TR highlighted the overwhelmingly positive narrative within the reports and further re-iterated that the CQC noted all areas for improvement were already underway	**Decision:** The Committee received the report and will be provided updates on the action plans through the CGWC Chair Report.
NMAHPHCS Priorities Update		TR	• TR presented the report which noted the progress to date on the six enabling priorities across Nursing, Midwifery, AHPs and HCSs. • It was noted that the declaration of SI timeframe has reduced from 18 days to 8 whilst some over the last year had been as long as 86 days to declare. • Other items to note were the expansion of the QI Team there will be a QI Strategy Review for 223/24 and the launch of the Pressure Ulcer Collaborative. • There was a discussion regarding unstageable pressure ulcers that are a minimum category 3 and noted there has been 55 in-patient recorded at the Trust this financial year to date	**Decision:** The Committee received and noted the report with further reports to be presented on a six monthly basis.
Maternity Incentive Scheme Year 4 Progress Update (CNST)		JC	• The Trust declared its position in February 2023 having completed 3/10 actions. A response is awaited in relation to the financial reward but is expected in the next few weeks. • Although Year 4 has been completed and declared Year 5 cannot commence just yet however JC is keen to establish the regular quarterly updates in advance of the next year commencing. • PWC audit was shared and there is assurance that the action plans will be completed by May 2023. • Benchmarking has been included with regard to Ockenden (80%) and Kirkup (61%) but this is only based on the evidence gathered to date and so can continue to build on this further.	**Action:** There is an error in the dashboard regarding Early Neonatal Death Rate which is 2.7 not 8.2 within the report and so this will be circulated to members outside of the meeting. **Decision:** The Committee received and noted the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Triangulation of Trust Scorecard, Incidents and Complaints	🟧	JC	• This report will be presented on a six monthly basis going forward. • The overarching themes identified in the Q3 analysis related to; failure and delays in the treatment pathway, failure to recognise the complications of pathways of care and delay in diagnosis.	**Decision:** The Committee received the report and agreed to see this on a six monthly basis.
Risk Management Committee Chair Report	🟧	TR	• It was noted that there is progress being seen in the detail of risks. • Patient Safety & Experience have been asked to present additional information at the next meeting for assurance.	**Decision:** The Committee received and noted the Chairs Report.
Mortality Reduction Group Chair Report	🟥	TR	• CGQC discussed concerns regarding the number of items not received/ presented and have asked the Committee to encourage appropriate representation at future meetings.	**Decision:** The Committee received and noted the Chairs Report.
Group Health & Safety Committee Chair Report	🟧	SB	Fire Safety Committee: • The two reports outstanding have since been received and an additional request has been made for a full review which will be fed through the relevant committees. • This item has now been requested to present monthly for ongoing assurance. Noted thanks to IFM/ Occupational Health and Governance Team for their collective support whilst recruiting the Health & Safety Manager .	**Decision:** The Committee received and noted the Chairs Report.
For Escalation: No additional concerns to be escalated to Board of Directors.				

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Report Title:	Finance & Investment Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Finance & Investment Committee meetings held since the last Board of Directors meeting.

Summary:	The attached reports from the Finance and Investment Committee Chair provide an overview of items discussed at the meetings held on 25 January and 22 February 2023. Due to the timing of the March meeting, a verbal report will be provided by the Committee Chair to the Board reflecting discussions held on 22 March 2023.

Previously considered by:
Discussed and agreed at the Finance and Investment Committee meetings.

Proposed Resolution	The Board of Directors are asked to note the Finance & Investment Committee Chairs' Reports.

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, Chair Finance and Investment Committee

Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee			Report to:	Board of Directors	
Date of Meeting:	25 January 2023			Date of next meeting:	22 February 2023	
Chair:	Jackie Njoroge			Parent Committee:	Board of Directors	
Members Present:	Annette Walker, Fiona Noden, Rebecca Ganz, Rae Wheatcroft, Sharon Katema, Lesley Wallace, Rachel Noble, Carol Sheard, Andrew Chilton, Bilkis Ismail, Paul Henshaw, Adele Morton, Matthew Greene, Claire McPeake			Quorate (Yes/No):	Yes	
				Apologies received from:	James Mawrey	
Key Agenda Items:		**RAG**	**Lead**	**Key Points**		**Action/decision**
No Criteria to Reside 2			M Greene	MG presented the work completed which was discussed by the Committee in detail. Key points noted: • 100 patients currently in the hospital with no criteria to reside. • RW confirmed the focus is on days delayed as patients with no criteria to reside will always be present and referenced a paper which went through Strategic Ops this week which noted that the days delayed figure has been halved from 1400 days delayed last year to 700 currently, due to the work the divisions have been undertaking. BI asked for sight of this paper. • In terms of what the cost would be for a patient to be in a care home vs a hospital bed, this is not yet known and more work is needed to triangulate the numbers. A more detailed piece of work is required to create a business case. • The Committee agreed that although cost savings are required the focus has to be on what is best for the patient.		NCR2 paper to be added to the Finance & Investment Committee agenda July 2023.

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Emergency Department Staffing		T Roberts	The business case outlines a case for investment of £2.1m to enable substantive recruitment to these posts. This is a reduction of circa £0.5m from previous version through inclusion of alternative roles and challenge provided to staffing models initially presented. Current overall Nursing run-rate for A&E is £2.8m. In developing the business case, ratios adhere to National institute for clinical effectiveness (NICE) standards for A&E. These remained in draft due to national policy changes, yet remain the main source of benchmarking across all A&Es and when reviewed by external regulators	The Finance & Investment Committee approved the Emergency Department Staffing Business Case to go through to Board for further approval.
NHS Professionals Managed Bank Services		J Mawrey	This business case seeks approval to enter into a 4 year contract with NHS Professionals for the provision of a fully managed bank and agency service. This will offer multiple operational and financial benefits to Bolton NHS FT, and bring the Trust in line with the majority of other NHS provider organisations in Greater Manchester (GM). Over the 4-year contract, NHSP will receive £3.8m in fees. Including associated bank and agency expenditure, the total spend with NHSP will be £149m over 4 years. The shift to NHSP should generate net savings of up to £3.7m per year for BFT. Planning guidance for 23/24 requires all Trust's to ensure expenditure with staffing agencies represents no more than 3.7% of the total pay bill. Currently at BFT, agency expenditure accounts for 5.9% of the Trust's pay bill. A reduction of 2.2%, which is £7.3m, is required to achieve the agency cap. Without a shift to NHSP, this will be incredibly difficult to achieve. A 16-week implementation period is required, with a likely go live date of 01/07/23 if approved.	The Finance & Investment Committee approved the NHS Professionals Managed Bank Services Report to go to Board for approval.

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Operating Plan		A Chilton	AC presented the Operating Plan for 2023/24 detailing the priorities, funding and planning assumptions, planned timetable and concerns. Areas of priority are Urgent & Emergency Care, Elective Care, Cancer, Diagnostics in terms of CDC, Maternity and Neonatal care. Revenue assumptions: • 2 year allocations for 2023/24 and 2024/25 • Inflation at 2.9% and efficiency at 1.1% • 2.1% pay uplift subject to review with outcome of pay review • No longer separate funding for Covid • Elective activity to be paid at 100% tariff • ERF £130m for GM (£30m increase) • GM overall increase 3.1% - effectively flat cash AC drew attention to the change in rules where the expectation to reduce Agency spend within the system is 3.7% of the bill which equates to a reduction of £8m for Bolton. Another significant change is that any overspends on plan are carried forward to be repaid over 3 years. Work has started prior to guidance being available, co-ordinated by the Strategy team. Regular meetings taking place between Operations, Business Intelligence, Finance and Workforce colleagues. First draft of plans to be submitted to NHS England by 23rd February.	The Finance & Investment Committee received and noted the Operating Plan.

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Lease Agreement at Little Lever Health Hub		L Wallace	This paper seeks approval for iFM Bolton Ltd entering into a 25- year lease at Little Lever Health Hub with Bolton MBC at a rent of £1.125m over the term of the lease. Little Lever Health Hub is a new development which forms part of the Councils masterplan providing health facilities together with a community hub incorporating a library. The CCG has invested £1.8m into the development, which is reflective in the rent payable. iFM Bolton will take the head lease for the health-care area of the Health Hub subletting dedicated areas to 3 GP's and managing the bookable space.	The Finance & Investment Committee approved the Lease Agreement at Little Lever Health Hub.
GM ICS Financial Positon/System Locality Position		A Walker	The paper is to update the committee on the GM financial position which was shared with finance colleagues in GM on 17 January. The numbers will come back through this Committee once finalised.	The Finance & Investment Committee noted the GM ICS Financial Position / System Locality Position.

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| Month 9 Finance Report | | A Chilton | Year to date deficit of £10.3m compared with a planned deficit of £4.4m. The forecast outturn scenarios have been refreshed and range from a worse case deficit of £16.1m to a likely case of a £12.1m deficit. BFT is taking all possible actions to control expenditure while maximising income to deliver a £12.1m deficit. However, no further support from the system has been agreed to enable delivery of the £7.2m deficit. Variable pay remains a significant issue for BFT averaging at £4.1m per month in 2022/23 compared with £1.7m per month in 2019/20. Agency spend has reduced throughout the year, with Trust utilising additional Bank and overtime resource instead which should bring both value for money and quality improvements. Our year to date capital spend is £10.9m of which £4.8m relates to Theatres. NHSE have approved the CDC business case and BFT will receive £14.7m over the current and next financial year. The Theatres TIF bid has now been approved in principle with the full £19.6m awarded which is an incredibly positive development for BFT. Various capital scenarios have been developed, of which 2 remain at £40.9m and £42.9m, and we are working closely with clinical and operational colleagues to allocate the capital budget accordingly. We had cash of £17.0m at the end of the month which significantly lower than planned cash levels. With the forecast deficit, this is now a cause for concern. Tighter management of cash flow forecasting and debt recovery is now in place to support the cash position. Our BBPC performance year to date is now 89.8% and | The Finance & Investment Committee noted the Month 9 Finance Report. |

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			is improving overall. A number of actions are underway to improve and maintain this performance.	
Updated on Bank and Agency Rates		P Henshaw	At the November 2022 Finance & Investment Meeting, a question was asked about the impact of the Trusts decision to increase bank rates of pay and analysis reporting was requested. This paper provides a summary of that analysis.	
			Analysis shows that, after the increased bank rates were introduced, bank fill numbers (for both nursing and HCA) increased. Estimated savings from using more bank as a result of increased rates, rather than agency, have been included. Colleagues will be aware that the Trust will be moving to an NHSP service model going forward.	
Chairs' Reports		A Walker	The Committee noted the following reports: **Capital Revenue & Investment Group Chair's Report** **-** meeting stepped down, next meeting 7th February 2023 **Place Based Finance & Assurance Committee Minutes** **-** Meeting 17th January 2023 (minutes	
Comments				
Risks escalated No items escalated				

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Name of Committee/Group:	Finance & Investment Committee		Report to:	Board of Directors
Date of Meeting:	22 February 2023		Date of next meeting:	22 March 2023
Chair:	Jackie Njoroge		Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rebecca Ganz, Rae Wheatcroft, Sharon Katema, Bilkis Ismail, Matthew Greene, Paul Henshaw, Sam Ball		Quorate (Yes/No):	Yes
			Apologies received from:	Andrew Chilton, Rachel Noble, James Mawrey

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM/National/System Update		A Walker	The Committee received an update on a paper that had been presented to the Provider Federation Board on 10th February. The key points were noted as follows: • The paper describes the forecast revenue outturn position for GM, which now stands at break even, and an adjustment to offset provider deficits to move around the cash. The resulting forecast deficit for BFT will be £1.5m. • The 22/23 capital position is also now balanced with a few organisations offering underspends and the residual gap being apportioned across providers. • Planning for 23/24 is well underway and it is expected that there will be a very significant revenue and capital gap to bridge next year. • GM has also commenced a 'Diagnostic' to understand the reasons for the efficiency, productivity and financial challenges across the ICS. The timescales for this are end of March but this is felt to be very challenging.	Noted
Draft Financial Plan 2023/24		M Greene	The committee received an update on the draft financial plan for 2023/24. • Draft 23/24 revenue deficit of £66.8m pre CIP. • An initial CIP of 2.2% or £10.1m has been included reflecting the national headline CIP. No agreement has been reached across GM relating to this. Planned deficit post CIP is £56.7m • Planned 23/24 Net CDEL of £22.6m. • Trust would need additional cash in Month 8 at this level of run rate • Inflation Pressures of £18.8m identified due to costs exceeding inflationary income uplifts. • Further work to iterated the plan underway.	Noted

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Cash Management Strategy	Risk / Assurance	M Greene	• The Trust is forecasting a year end cash balance of £33.5m, assuming a forecast outturn of £1.5m deficit is achieved. • The Trust is forecasting a reduction in its cash balance during 2023/24 and potentially needing to secure external cash during the year. A deficit scenario of £30m would see a forecast cash balance of £6.2m overdrawn by March 2024. • The Trust will need to look at mitigating actions to preserve its cash balance during 2023/24. AW confirmed that the run rate, income and expenditure and cash are reviewed monthly so conversations would be started early if this looked like a possibility. It is expected a number of l Trusts in GM will be in a similar position.	Noted
Month 10 Finance Report		M Greene	• The Trust now has a year to date deficit of £9.2m compared with a planned deficit of £5.2m. The forecast outturn scenarios have been refreshed and range from a worse case deficit of £10.3m to a £1.5 deficit. Variable pay remains a significant issue for BFT averaging at £3.9m per month in 2022/23 compared with £1.7m per month in 2019/20. Agency spend has reduced throughout the year, with the Trust utilising additional bank and overtime resource instead which should bring both value for money and quality improvements. • The year to date capital spend is £12.8m of which £5.9m relates to Theatres. Various forecast capital scenarios have been developed, of which two remain at £40.9m and £42.9m, and we are working closely with clinical and operational colleagues to allocate the capital budget accordingly. • There was cash of £20.5m at the end of the month which was significantly lower than planned cash levels. With the forecast deficit, this is now a cause for concern. Tighter management of cash flow forecasting and debt recovery is now in place to support the cash position. Our BBPC performance year to date is now 90.1% and is improving overall. A number of actions are underway to improve and maintain this performance.	Noted
Chairs' Reports		A Walker	The Committee noted the following reports: • Capital Revenue & Investment Group Chair's Report - 7th February 2023 • Place Based Finance & Assurance Committee Minutes - February meeting stepped down. Next meeting 22nd March 2023.	Noted
Comments				
Risks escalated No items identified for escalation				

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🟩	Assured – no or minor impact on quality, operational or financial performance

Report Title:	Audit Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Audit Committee meeting held since the last Board of Directors meeting.

Summary:	The attached report from the Audit Committee Chair, provides an overview of items discussed at the meeting held on 15 February 2023.

Previously considered by:
NA

Proposed Resolution	The Board of Directors is asked to **receive** the Audit Committee Chair's Report.

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

Prepared by:	Annette Walker Chief Finance Officer	**Presented by:**	Alan Stuttard, Chair Audit Committee

Audit Committee Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	15 February 2023	Date of next meeting:	3 May 2023
Chair:	Martin North, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Malcolm Brown, Annette Walker, Sharon Katema, Othmane Rezgui, Karen Finlayson, Imogen Milner, Collette Ryan, Martin North, Catherine Hulme	Quorate (Yes/No):	Yes
		Apologies received from:	Alan Stuttard, Deborah Chamberlain

Key Agenda Items:	RAG	Key Points	Action/decision
Health Technical Update		The Committee noted the Health Technical report and thanked KPMG for their insight. KPMG highlighted increased NHS England oversight on Trusts financial plan.	Noted.
External Audit Plan		KPMG outlined the external audit risk assessment and planned audit approach in respect of the consolidated financial statements audit. The Committee noted and accepted the plan.	Noted.
Internal Audit Progress Report		The Internal Auditor reported on the reasonable progress against the plan despite the pressure within the Trust and highlighted the Thought Leadership publications around the post Covid 19 road to recovery.	Noted.
Internal Audit Reports		The Internal Auditor reported on the overdue actions of which 27 are currently open. 10 are overdue although most of those are complete but awaiting evidence. The following reports were presented: **Maternity Incentive Scheme** Every Trust has to verify compliance against the scheme. The Internal Auditor reported on the scope of work on 5 of the safety actions within the review. The report highlighted 3 high risk and 2 medium risk findings overall reported as high risk. All actions will be followed up diligently with a target completion date of May 2023 which is when the next reporting window commences. **Equality, Diversity & Inclusion** Overall the report rated medium noting a low risk score in relation to lack of EDI elements in the quarterly staff survey & low response rates. The report also highlighted 3 medium risk findings, firstly	

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Key Agenda Items:	RAG	Key Points	Action/decision
	🟧	with regards to WRES and WDES results which noted 2 reductions in key metrics associated with WRES and WDES. The report highlighted concern over the delivery of the comprehensive action plan with respect to resource constraints and insufficient EDI training for the Executive and Non-Executive Team. Management accepted the findings and action plan. **Sickness Absence iFM** The Internal Auditor reported on the summary of findings of this medium risk report with 3 medium risk findings and one low. Medium risk findings were found in relation to the compliance with the Attendance Management Policy whereby the report found that the return to work forms were not routinely completed, a weakness in the e roster system to note when an absence hits a trigger, and the Attendance Management Policy not being easily accessible to staff and not aligning with the guide for Line Managers. The last finding was low risk around notification of Absence Audit Documentation. Management accepted the findings and action plan.	The Committee accepted the findings and action plan for all reports.
Local Counter Fraud Specialist Progress Report	🟩	The Local Counter Fraud Specialist reported on the period from Dec-Jan 2023 of activities undertaken. It was highlighted that the Trust isn't an outliner in terms of Fraud activity across the UK.	Noted.
Account Update		The Associate Director of Finance (Financial Services) updated the Committee on the Account Update. The report provided an update on the preparation for the 2022/23 Annual Accounts.	Noted.
Arrangements for the Annual Report 2022/23		The Committee were provided with information on the approach and arrangement of the 2022/23 Annual Report. The Director of Corporate Governance provided assurance on the processes being undertaken. A draft report will be provided at the next meeting in May.	Noted.
Audit Committee Effectiveness Review	🟩	The Committee received the report which is to demonstrate the extent to which the Audit Committee met its Terms of Reference during 2022/23. The results are generally positive and indicate the Committee has continued to build on its effectiveness since its last report. There were a number of neutral survey submissions. The Committee will continue to review ideas of how it can improve effectiveness.	Noted.
Register of Interests, Gifts and Hospitality	🟧	The Director of Corporate Governance informed the Committee that the new software for reporting declarations of interests was live which enables all staff to make their declarations on line. It is believed this process will improve the transparency of gifts and hospitality.	Noted.

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Audit Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
		It was highlighted that there needs to be oversight of the declarations to strengthen the effectiveness.	
Register of Sealing's Report		The Director of Corporate Governance advised the Committee that the Trust Seal was used on six occasions during the reporting period and it is not expected that the Seal will be used for remainder of the current financial year.	Noted.
Register of Waivers for Bolton FT and iFM		The Chief Finance Officer reported on the waivers issued for the period September 2022 to January 2023. The Committed noted the proactive work being undertaken to reduce non-compliant spend.	Noted.
Losses and Special Payments Report Bolton FT and iFM		The Committee received the Losses and Special Payments Report for the period 1st April 2022 to 31st December 2022. The Committee discussed which Committee is responsible for the oversight of litigation for costs and claims.	Action to be taken in relation to the line of sight for litigation for the Trust and iFM.
Any Other Business		**Reappointment of Auditors** The External Audit Contract is due to expire at the end of August. The Committee was informed that the Governors agreed to honour a one year's Contract Award to KPMG from the procurement framework. During that year a market assessment will be carried out to look at the options. Arrangements will be made for discussion with the Governors. The Internal Audit Contract is also up for renewal for which a plan is already in place. Invitation to quote has gone out. The Internal Auditors have been advised of the process using the framework.	Noted.
Risks Escalated : There were no risks to be escalated to the Board of Directors			

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Report Title:	Charitable Funds Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide the Board of Directors with a summary of discussion and decisions made at the Charitable Funds Committee meeting on 6 March 2023

Summary:	Chair's report from the Charitable Funds Committee meeting, covering the following items: - Our Bolton NHS Charity Q4 2022/23 Highlight Report 2022/23 Year in Review - Ramadan and Eid 2023 - Finance Report - Risk register - NHS Charities Together - £36k underspend

Previously considered by:
Discussed and agreed at the Charitable Funds Committee

Proposed Resolution	The Board of Directors is asked to receive and note the report.

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

Prepared by:	Sarah Skinner, Charity Manager	Presented by:	Martin North, Chair of the Charitable Funds Committee

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

CFC	Charitable Funds Committee
SLA	Service level agreement

Charitable Funds Committee Chair's Report

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Name of Committee:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	06 March 2023	Date of next meeting:	05 June 2023
Chair:	Martin North	Parent Committee:	Board of Directors
Members Present:	Sharon White, Annette Walker, Alan Stuttard, Sharon Katema, Rachel Noble, Catherine Hulme, Rachel Carter, Sarah Skinner and Abdul Goni	Quorate (Yes/No):	Yes
		Apologies received from:	Francis Andrews and Zed Ali

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Our Bolton NHS Charity Q4 2022/23 Highlight Report		SS	The Charity Manager shared the Q4 2022/23 highlight report with the CFC to provide an overview of activity against key themes: • Fundraising and grants • NHS 75 • Communications, marketing and media • Charity-funded schemes • Risks	The Charitable Funds Committee noted the highlight report.
2022/23 Year in Review		SS	The Charity Manager presented Our Bolton NHS Charity's year in review, focusing on the key highlights from the last 12 months (including but not limited to operations, charity strategy and development, income and fundraising, and charity-funded projects and expenditure) and the areas of growth and focus for 2022/23, namely investing in the charity team (through the NHS Charities Together development grant) and delivery of year one of the charity strategy.	The Charitable Funds Committee noted the key achievements for 2022/23 and areas of focus for 2023/24.

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Ramadan and Eid 2023		SS	The Charity Manager provided the Charitable Funds Committee with an overview of forthcoming initiatives designed to showcase the hospital's new multi-faith centre; show care and compassion to our Muslim patients during Ramadan and Eid, and raise funds for Our Bolton NHS Charity's general purposes charitable fund.	The Committee noted the report but asked the charity team to ensure other religious festivals (e.g. Easter) are considered and incorporated into plans.
Finance Report		CH RN	The Associate Director of Financial Services presented the finance report to the CFC noting a net increase in funds of £410k for the 10 months to 31 January 2023. The Charity has received £505k in legacies this year with just four legacies outstanding (for £2.6k). Work continues on streamlining the call on funds, which now stands at £780k. The charity's fund balances totalled £1,067k at 31 January 2023. The Associate Director of Financial Services set out the SLA and management fee for 2022/23 and the Deputy Director of Strategy advised there would be a review of the management fee for 2023/24 to ensure best value.	The Charitable Funds Committee noted the report and acknowledged all the work that had been done to streamline the call on funds. **Action: review the management fee and bring back recommendations to the CFC meeting in June 2023.**
Risk register		RN	The charity's risks are categorised (governance, operational, financial, external and compliance) and managed in line with the Charity Commission's Charities and Risk Management (CC26) guidance. The Deputy Director of Strategy presented the risk register, advising risks are proactively managed by the Charity Manager and the team. Any risk over 12 is logged on the Trust's Safeguard system and overseen by the Risk Management Committee.	The Charitable Funds Committee noted the risk register.

	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

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				The Charitable Funds Committee:
NHS Charities Together - £36k underspend		RN	The Deputy Director of Strategy advised that the delivery of the staff rest facilities programme had been delayed beyond the agreed adaption date meaning the £36k underspend was now at risk. RN shared an alternative, viable proposal with the CFC to use the £36k towards the community hub within the new faith facilities at Royal Bolton Hospital, which would allow the grant to be fully utilised by 31st March 2023, in line with the grant terms and conditions.	• Noted the risk to the £36k underspend • Supported the proposal to submit a further grant adaption request to NHS Charities Together • Approved the proposal to utilise the underspend as part of the faith facilities project (subject to approval from NHS Charities Together) **Action: propose the alternative, viable option to NHS Charities Together**

Comments

Risks escalated

There are no risks to be escalated to the Board of Directors.

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

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Report Title:	People Committee Chair Report – March 2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	The purpose of this report is to provide assurance to the Board on work delegated to the Committee.

Summary:	The attached report from the People Committee Chair, provide an overview of items discussed at the meetings held on 21 March 2023.

Previously considered by:
Discussed and agreed at the People Committee

Proposed Resolution	The Board of Directors Committee is asked to **receive** and note the chairs reports.

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

Prepared by:	James Mawrey, Director of People	Presented by:	Alan Stuttard, Non-Executive Director

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People Committee Chair's Report

Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21 March 2023	Date of next meeting:	18 April 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	Martin North, James Mawrey, Fiona Noden, Tyrone Roberts, Sharon White, Joanne Street, Andrew Chilton, Jake Mairs, Paul Henshaw, Chris Whittam, Lianne Robinson, Francis Andrews, Lisa Rigby, Amy Blackburn, Amanda Weatherstone, Claire Partridge	Quorate (Yes/No):	Yes
		Apologies received from:	Malcolm Brown, Bilkis Ismail, Carol Sheard, Sharon Katema

Key Agenda Items:	RAG	Key Points	Action/decision
People Plan		The final draft of the People Plan 2023-2026 was shared with the Committee for their feedback and review. • It was noted that the People Plan was presented in four key sections: Attracting, Developing & Leading, Sustaining & Retaining and Including; each with clear measures of success and timeframes for the activity. • It was noted that a separate People Plan will be produced for iFM which will align but address their own workforce challenges. • The People Plan will progress to Board for approval and will be monitored via the People Committee.	• People Plan supported and approved by People Committee, noting the suggested amendments • That the People Plan be taken to BoD in May for formal ratification and approval.
2022 National NHS Staff Survey Results		The Committee was updated on our results from the 2022 National NHS Staff Survey, with the following headlines; • We remain the best Acute and Community Trust in Greater Manchester for staff engagement, with a score of 7.0, and are still within the top 20% nationally. • Despite retaining some good results, we have decreased in 71% of the questions , which is a national trend, although Bolton has decreased at a further rate. • It was noted that the messaging in the organisation around the results has been different to previous years, acknowledging the ongoing challenges and pressures that staff are working under. • Particular areas of focus were the 'recommending as a place for care', which has reduced by 6% to 61% and also 'experienced discrimination due to ethnic background', which has increased by 8% to 39%.	• The Committee noted the results. • The Committee agreed for the report to be shared at BoD in May, including the actions being taken where appropriate.

🟥	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

Key Agenda Items:	RAG	Key Points	Action/decision
		• The Chief Nurse commented on the positive results we have seen around patient safety and incidents. • The Committee was updated on the next steps of the survey results, which include additional analysis at divisional-level and action planning for the year ahead. • It was suggested and agreed that we will target efforts from the OD service in the divisions that require it.	
Resourcing Update		• Turnover – The paper showed that the turnover rate continues to fall after the Covid high (seen nationally). Breakdown was provided by Trust and Division level. The Committee has been sighted on the plethora of activities introduced to support this downward trajectory. • Recruitment - The report highlights the continuing resourcing activity being undertaken by the Trust. The pace of work being undertaken is pleasing to note and this indicates some positive news in relation to a relatively healthy pipeline of candidates across staffing groups. • The Trust successfully submitted a further bid to NHSEI in support of an additional 35 nurses who would arrive between January and March 2023. This is in addition to the 129 already in place.	• The report was noted. • It was agreed that we should move to bi-monthly reporting.
Agency Update		• Pleasingly the report shows that we continue to show a downward trajectory for Agency, albeit agency spend remains at an unprecedented high. • We now expect to deliver a better year-end spend position than we forecasted to NHSE at the start of the financial year (tracking to beat that forecast by £1.3m); albeit that we are tracking to be above our internally set stretch target by £2.06m at current spending levels. • The report outlines the controls in place across the Trust to mitigate agency spend and usage, and it is felt that these controls have contributed to our improved agency expenditure position; it is anticipated that this position will continue to improve in the remainder of the financial year. • Reference was also made to the target set by NHSE for 2023/24 that Agency spend should be no more than 3.7% of the pay bill. The Committee challenged the Trust to set a target lower than this and the move to NHS Professionals should help in this aim.	• The report was noted • It was agreed that we should move to bi-monthly reporting • In the next report outline the target / trajectory for 23/24

🟥	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

People Committee Chair's Report

NHS Bolton NHS Foundation Trust

Key Agenda Items:	RAG	Key Points	Action/decision
Staffside & Employee Relations Update	🟧	The Committee was provided with an update on: • Volume of formal casework being supported by the HR Team. • The majority of work relates to supporting sickness management and improving levels of absence in the Trust • Assurances provided regarding the management of ongoing disciplinary and resolution casework, with current investigations meeting the internal 8 week standard. • Ongoing tribunal cases were noted and discussed, particularly in relation to disability discrimination. It was discussed that a significant number of ongoing claims were from current employees which was unusual. Assurances were provided regarding the current tribunal processes and lessons learnt to be undertaken following each process. • Summary provided in relation to WRES and BAME staff undergoing formal HR processes, with Quarter 3 showing that BAME colleagues were not disproportionately affected by ongoing processes. • Ongoing industrial action and the Trusts management and response. Hopeful of resolution to ongoing national discussions regarding pay but the Trust would continue to plan for any further action.	The report was noted. Additional lessons learnt to be conducted following conclusion of tribunal claims. Feedback to be shared with the Committee at a future date with an Action Plan.
EDI Annual Report	🟩	The Committee was presented with the annual Equality Information Monitoring report, which is statutory as part of our duties under the Equality Act. The data included was not new to the committee as has been presented previously as part of WRES and WDES. The actions included are built into the EDI Action Plan 2023, which has also previously been to the committee for their support and endorsement.	• The Committee approved the report for submission under its delegated authority.
Career Framework	🟩	The Committee considered the Career Framework and associated report. The Career Framework has been designed initially for AHP, Nursing, Midwifery and Healthcare Scientists.	• The framework was welcomed, noted and next steps agreed • It was agreed a future phase of the framework would be to develop a version that supports attraction of

🟥	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

NHS Bolton NHS Foundation Trust

Key Agenda Items:	RAG	Key Points	Action/decision
	(green)	The aim is to support growth and development and support workforce planning, talent and succession. The Framework: • Sets out the career progression and development opportunities available for staff. to help grow and retain our existing workforce and utilise our apprenticeship levy. • Provides the foundations to develop new and emerging roles and grow our own health care workforce. • Help address full current and future resource and skills gaps and prioritise the most critical areas of focus. • Next steps are to test the Framework with a group of current and aspiring AHP, Nursing, Midwifery and Healthcare Scientists.	our future workforce showcasing the range of careers across health & social care in Bolton • It was agreed a version would be developed for IFM • It was noted that some levels roles covered in the framework do not currently exist in Bolton FT therefore the language would be changed to make this clearer • It was agreed that an update would be brought to the Committee in October
Gender Pay Gap Update		The Committee was presented with the Trust's Gender Pay Gap report for 2022, a statutory requirement for our organisation. • The mean hour gap has reduced by 1.6% to 28.3% • The median hourly gap has reduced by 0.3% to 14.5% • It was noted that we are aligned, if not performing better, than other Trusts in this space • It was agreed that further analysis would be completed, taking out medical colleagues and that this work would be picked-up via the Equality, Diversity & Inclusion steering group.	• The report was noted and will be published on the Trust website by the end of the month. • Additional analysis will be completed following suggestions from the committee and reviewing by the Equality, Diversity & Inclusion Steering Group.
Workforce & Communities Transformation Update	*(amber)*	A report was presented on Workforce & Communities Transformation which included: • Launch of the Bolton Strategic People & Culture Group • Bolton Workforce Challenges and Ambitions • Update on MECC (Making Every Contact Count) • Update on Neighbourhood review • Update on People / Patient Engagement	• The report was welcomed and noted • There was a discussion around capacity to support this work and whether it means other things have to stop. It was agreed a lot of the work is happening anyway but the

(red)	No assurance – could have a significant impact on quality, operational or financial performance;
(amber)	Moderate assurance – potential moderate impact on quality, operational or financial performance
(green)	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

Key Agenda Items:	RAG	Key Points	Action/decision
			group is an opportunity to bring it all together in a more strategic and co-ordinated way and avoid lots of duplication • It was agreed the key programmes have grown and warrant their own programme • The MECC task and finish group was discussed and a timescale of around June was provided for the group to conclude
Steering Group Chair Reports		Noted. Some Steering Groups stood down in March to support Industrial Action Planning.	
Divisional People Committee Chair Reports		Noted. Some Divisional People Committees stood down in March to support Industrial Action Planning.	

Matters for escalation to the Board: There were no matters for escalation to the Board of Directors

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

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

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Title:	Board Assurance Framework

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 March 2023		Discussion	✓
Exec Sponsor	Sharon Katema		Decision	

Purpose:	The Purpose of this report is to present the Board Assurance Framework following review.

Summary:	The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. This BAF reflects the existing Trust Strategy and has been subject to review, through engagement and consultations with the respective executive directors and Lead Committees. Since the BAF was last presented at Board, a review of the BAF was undertaken at the Strategy Session. There is no change in ri

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.

   - **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. Since presentation at the last meeting, a review of the BAF was undertaken by the executive directors.to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level

3. **PROGRESS**

3.1. The BAF was discussed at the Strategy session in February and now includes Risk 1.3 which sits under the Chief Nursing Officer.

3.2. At the end of March 2023, none of the strategic risks have seen any improvements in the current risk score.

3.3. 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

4. RISK APPETITE

4.1. 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.

4.2. 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.

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

5. CONCLUSION.

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.

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;

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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

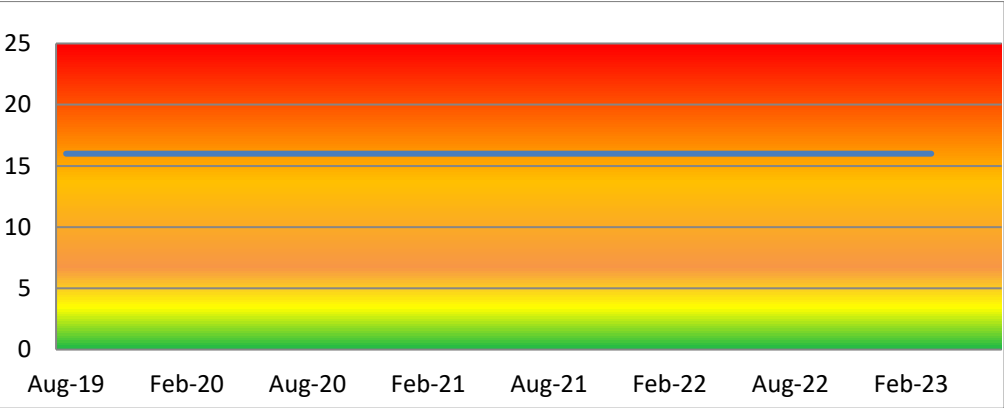|	Inherent Risk Rating			Current risk rating			Target Risk Rating			Linked Risks
Date of last review	Consequence	Likelihood	Score	Consequence	Likelihood	Score	Consequence	Likelihood	Score	No linked risks
March 2023	4	4	16	4	4	16	4	3	12	

PRINCIPAL RISK: IF THE TRUST DOES NOT GIVE THE BEST CARE EVERY TIME THEN THIS MAY RESULT IN INCREASED MORTALITY IN HOSPITAL AND IN THE 30 DAYS FOLLOWING DISCHARGE

RISK APPETITE:

	Overall Assurance Level

1. **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

2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5. **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 and SHMI at risk of going outside of expected range • Coding establishment below expected • Recording of diagnosis done using terminology that cannot be coded • Failure to record all relevant Comorbidity	• HED using to alert trust to areas of clinical concern - monitored monthly at Trust Mortality Reduction Group (MRG) • MRG monitoring and maintaining the achievement of >98% completeness • Comorbidity education at induction • Clinicians can now access GMCR for comorbidities • Staff upload data into Health Issues section	• DQ issues mean expected deaths under-predicted – lack of time for clinical validation of data • Clinical time & lack of consistent EPR solution • Lack of optimal process with EPR to facilitate and improve the	*1st Line of Defence (Operational Management)* - **Local BI monitoring on H**ED diagnostic group mortality outlier alerts - **Mortality Review Group (MRG)**- Monthly monitoring of HED SHMI & HSMR, mean Charlson comorbidity score & depth of coding at MRG - Quarterly divisional mortality reports - Quarterly reports and audits from Sepsis Forum, Resuscitation & Deteriorating Patient group	• Mortality metric variations may reflect recording and data quality issues, rather than a true care concern • **Quality Accounts** to address (with own KPIs): - NEWS compliance - Antibiotic prescribing compliance	• **Mortality Action Plan** - Supporting Clinical and Coding plan (**30 September 2023**) - Amend EPR to facilitate improved comorbidity recording and depth and consistency of coding (**30 June 2023** • **MRG**: - Review MRG TOR and new report template to identify and improve triangulation with other KPI and quality metrics (**30 September 2023**)

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Comorbidity recording inconsistent between admissions • Care delivery concerns identified through Learning from Deaths process not fully addressed • NEWS compliance currently under 90% • Failure to recognise or respond to a deteriorating patient seen in Serious Incident Reports	• Learning from Deaths (LfD) case reviews and actions with Medical Examiner input with reviews at LfD committee • AASD Quality Account continuing to address • Revised fluid balance charts on EPR • RR-SAFER implementation and AIMS training • Deteriorating Patient Lead in post • EoL committee actions to improve ACP • Resuscitation Committee monitoring Cardiac Arrest RCAs • Patient Quality Group actions to improve compliance with DNACPR documentation • Educational programme to improve communication with patients, families and carers • Quarterly Sepsis KPIs reported to MRG	comorbidity index recording. • IT kit access to record data (roll out in progress) • Training compliance not at 100% for nursing and medical staff • Improving mandatory resuscitation training sessions	**Learning from Deaths Committee reports to MRG:** - Monthly review of SJR dashboard - Receive thematic analysis reports, including national Regulation 28s and Medical Examiner data report - MDT secondary review of cases of concern • DNACPR reports • Harm Free Care Panel • Quarterly Quality Account updates to CG&QA committee (on NEWS and antibiotic prescribing compliance)	• Learning panel – actions have to be directed to specific groups/ departments, etc – now to Patient Quality Group	• Ongoing review of AQuA, GIRFT and other care reviews • **Improving LfD to ensure:** - Increase trained assessors and improvement in response time and case identification processes - Thematic analysis of existing database of LfD cases. - Amend mandated group in line with current data **(September 2023)** • **Patient Quality Group**: - Enact changes reduce inappropriate resuscitation attempts, by improving compliance with DNACPR and MCA documentation - Reduce harm free care with targeted interventions
			2nd Line of Defence (Reports at Board and Committee Level) • Integrated Performance Reports to QAC and Board • Reports on IPC, transfusion, Medicines Safety, Safeguarding • Quarterly MRG and LfD reports to QAC • Mortality reports to QAC and Board	• Cases reviewed in arrears with reports collated quarterly – risks delay in sharing learning	• QI collaboratives: - Pressure ulcer collaborative to reduce harm from skin damage **(September 2023)** • **Quality Accounts** to address NEWS compliance and antibiotic prescribing compliance
• Sepsis screening and Sepsis 6 performance not at 100%	• Current AACD QA to improve antibiotic compliance • Daily flow meetings • SAFER process to improve patient ADT • Procedural Document Oversight Committee reviews		***3rd Line of Defence (Independent or Semi-independent assurance)*** • 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)	HED data published nationally in arrears – system does allows some early identification	• **Recognition of deterioration:** - Complete TNA and develop educational training plan - Implement RR-SAFER by training RNs from wards & ratification of PGDs for fluid bolus

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
●Patients waiting longer in ED for inpatient beds which may impact on outcome	all documents related to evidence-based care		●GIRFT reviews into care provision (e.g. cancer services, CIAD) ●External assessments and accreditation (e.g. RCOA ACSA assessment, RCS reviews) ●CNST MIS assessment		- Triangulate NEWS compliance data with other mortality metrics and quality measures to determine areas for focus - Review Trust NEWS Policy - Ratify Trust DNACPR Policy ●**Improve sepsis screening & management:** - Implementation of EPR sepsis bundle across organisation following pilot - AQuA audit of emergency admissions

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

Risk tracking

	Background	Date	Comments
	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.	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.
		13/03/23	Full review with dates for all actions

Ambition 1 – Provide safe, high quality care		Lead Director	Chief Operating Officer	1.2
		Lead Committee	Strategy and Operations Committee The 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			Linked Risks
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score	**Risk ID:** 5630 - scored 16 5588 - scored 15 5599 - scored 16
March 2023	4	5	20	4	4	16	4	3	12	

Principal Risk: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

RISK APPETITE	RISK MANAGEMENT - Control of the Risk	Overall Assurance Level

1 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

2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

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 • Increased waiting list size since 19/20 baseline • Increased cancer backlog size since 19/20 baseline • Insufficient theatre capacity to meet current demand • Insufficient diagnostic capacity within cancer pathways	Escalation policy Access policy Discharge policy Flow meetings and reports (four a day) Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge System Operational Response Taskforce (SORT)	Lack of monitoring of the effectiveness of policies Weak monitoring of the implementation of ward SAFER principles Lack of a robust Capacity & Demand planning cycle	**1st Line of Defence (Operational Management)** • Regular performance monitoring at Divisional level. • Monthly Integrated Performance Management (IPM) meetings to review performance data • Review of Divisional Risk Registers at Risk Management Committee • Review of all urgent care and community workstream at Performance and Transformation Board. • Monthly review of assurance programmes at Performance & Transformation Board	Review and refresh of IPR dashboard	Updated IPM dashboard to be developed and available to Board of Directors **(May 2023)** Review of Escalation Policy, Access Policy & Discharge Policy monitoring to be undertaken and implemented **(September 2023)** Robust audit of ward SAFER principles to be undertaken and reported **(June 2023)** Capacity & Demand cycle **(March 2024)** Review of OPD and Theatre capacity and transformation

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Insufficient capacity within the Emergency Department to deal with the demand • Lack of a sustainable Urgent Treatment Centre model • Failure to reliably meet the SAFER ward standards • Discharge capacity frequently does not meet demand	Cancer and RTT Patient treatment list management meetings Theatre Scheduling meetings Detailed capacity and demand management reviews Joint working with GM on cancer pathways Joint working with GM to ensure equality of access across GM Regular validation of waiting lists Development of the Urgent Treatment Centre Pilot Attendance and monitoring at • System Urgent Care Integrated Partnership Group • Planned Care Board Integrated Partnership Group • System Strategy, Planning & Delivery Committee		**2nd Line of Defence (reports and metrics monitored at Board/Cttees** • Review of Integrated performance report at SOC. • Spotlight service reviews at SOC • Bi-monthly presentation to Board of IPR and Operational Update • Monitoring of performance at GM meetings **3rd Line of Defence (Independent Assurance)** • NHSE Single Oversight framework and monitoring arrangements • NHS benchmarking data including Model Hospital Dashboard and North West performance data • Getting it right first time (GIRFT) programme. • Monitoring and scrutiny of performance targets by GM ICB & PFB teams • Internal Audit reviews • External Peer Reviews by expert groups • Regionally arranged ECIST visits & reviews	GM ICS Performance meetings	

1.2	To give every person the best care every time – Delivery of Operational Performance
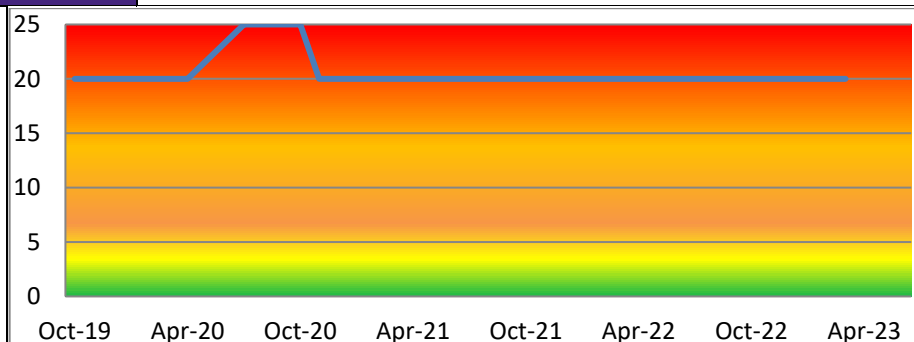
The pandemic has had an impact on waiting times and has increased demand for our services. This has resulted in increased backlogs and a comprehensive recovery plan is now in place.

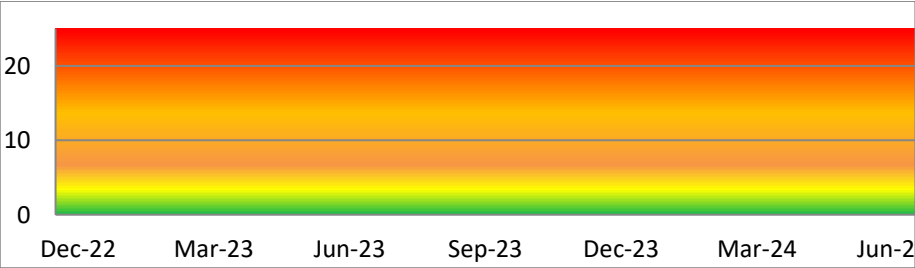|	
20.02.20	Risk updated to reflect challenges to RTT and cancer performance
16 Nov 22	Review of BAF. No change in risk score, Risk remains High at 16.
30 March 23	No proposed change in risk score following review.

Ambition 1 Provide safe, high quality care		**LEAD DIRECTOR**	**Chief Nursing Officer**	**1.3**
		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			Linked Risks
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	Risk 5192 - Scored 12 Risk 5535 – Scored 12 Risk 5536 – Scored 12 Risk 5638 – Scored 12
March 2023	3	4	**12**	3	4	**12**	3	2	6	

PRINCIPAL RISK: IF THE TRUST DOES NOT deliver reliable compliance with regulatory quality standards THEN THIS WILL RESULT IN sub-optimal outcomes

Overall Assurance Level

RISK APPETITE:

RISK MANAGEMENT - Control of the Risk

1. **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

2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

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
• Sustained achievement and visibility of safe staffing levels • Demand for services exceeding capacity • Inconsistency with divisional governance processes • Regulatory breaches • Unreliable application of quality	• Quality Account Priorities • Internal audit process (PWC, mock CQC) • Accreditation process (BoSCA) • Statistical process control charts for key indicators • Daily / weekly reports to divisional teams in relation to governance performance metrics • 2:1 meetings with Director of Quality Governance and	• Sub-optimal compliance with serious incident process and duty of candour • Divisional reports lack assurance • No enabling professional priorities established for Nursing,	***1st Line of Defence (Operational Management)*** • IPM meetings • Reports to Clinical Governance & Quality Governance committee including underpinning sub-group chairs report • Daily operational staffing reviews • Professional observations • Nurse and Midwife key • Risk management committee • Nurse/midwife performance indicators (monthly)	• Quality and clinical governance work-plan sub-optimal • Assurance of ward to Board 'golden thread' through clinical assurance governance standardised framework • Development of NMAHP&HCS workforce plan	• Monthly safe staffing reports to be reported to CN & shared on organisation website – **31.05.23** • Implementation of serious incident process and revisions – **31.7.23** • Review of duty of candour policy – **31.05.23** • Commission and review of all Clinical Divisional governance processes against best practice – **31.08.23**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
improvement science methodology • Leadership inconsistency with application of required standards	Divisional Governance teams • Revised serious incident process • Phase 1 implementation of changes to QG & CG with removal of 'reassurance' reports – •	Midwifery, AHPs and Health-care scientists (NMAHP&HCS) • No objective setting against agreed corporate priorities for senior NMAHP&HCS • Lack of established process for senior visibility, including 'work-withs' • Lack of reliable access analyst expertise in safer nursing care tool output creation • Finalisation of learning from experience report • Revised Quality Governance Dashboard and		• Minimal access real-time patient experience feedback • Sub-optimal Chief Nurse visibility of overall staffing provision to include vacancies / ratios • Development of workforce dashboard to provide Chief Nurse visibility	• Finalisation of learning from experience report – end Q4 22/23 • Finalise QG&CG work-plan to align with domains quality and CQC KLOE – **31.07.2023** • Introduction of corporate quality related reports into CG&QC and onto QAC **30-06-23** • Enhancement of accreditation process (BoSCA) to include accountability – **30.04.23** • Implementation of Internal PWC audit of safeguarding systems action plan and processes – **31.3.23** • Quality Governance Dashboard and performance reporting – **31.05.23** • Establishment of project management office type template to monitor • Refresh of Quality improvement strategy with all stakeholders – **30.06.23** • Inclusion of A&E, theatres, critical care and community nursing - **31.05.23**
			2nd Line of Defence (Reports at Board and Committee Level) • Integrated Performance Report at Quality Assurance Committee and Board • Quality Account • Mandatory training • Bi-annual Nurse & Midwifery establishment reviews • BOSCA accreditation programme • CNST • Patient Safety Report monthly to Clinical Governance & Quality Committee (from 07.22) • Quarterly Learning Report to Clinical Governance & Quality Committee and Quality Assurance Committee (from 12.22)	• Safe staffing report does not include A&E, critical care, theatres , neonates or community nursing • Sub-optimal Maternity dashboard indicators reporting	

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
		performance reporting • Review of duty of candour policy	*3rd Line of Defence (Independent or Semi-independent assurance)* • Internal Audit reviews • CQC Inspection Reports • CQC inspection visits, Insight Reports, • National Audits • Peer Reviews and accreditation.	• Implementation of Internal PWC audit of clinical negligence scheme for trusts (CNST) systems and processes within Families division • Family Care Division governance review against GGI framework	• Development of NMAHP workforce plan – **31.5.23** • Roll out of community safer nursing acuity tool – **timeframe tbc** • Development of real time patient feedback across in-patient areas and community long-term caseloads – **31.7.23** • Development of Midwifery dashboard in alignment with national requirements – 31.3.23 • Development of workforce dashboard to provide Chief Nurse visibility – **30.4.23** • Business continuity improvement with analyst access to safer nursing care tool output reporting – **31.5.23**

1.3	Ambition - To help our staff improve services making sure everyone has a good experience when using our services

Risk tracking	Background	Date	Comments
		13.3.23	New risk for inclusion onto the BAF

	Ambition 2 To be a great place to work		Lead Director	Director of People	
			Lead Committee	**People Committee** can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	2

Risk Assessment

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

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.

RISK APPETITE	RISK MANAGEMENT - Control of the Risk	Overall Assurance Level
1 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 **2 Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. **3 Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) **4 Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). **5 Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust	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 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 • • Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will be a potential impact on	• Staff Health and Wellbeing Plan • Our People Plan. • Occupational Health Provision • Staff Experience and Inclusion Steering Group • Staff Health and Wellbeing programme • Great Place to Work Plan	Identified and actioned from Internal Audit of identified key areas. EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups	*1st Line of Defence (Operational Management)* • Attendance KPI • NHS Staff survey (annual) • HR Policies and Procedures • Friends and Family • Pulse Survey Staff Survey • Divisional People Committees reports to People Committee • IPM meetings with Divisions • Resourcing and Talent reports to PC	EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee	• ~~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~~

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
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 the workforce to adapt,	• Weekly / Monthly Safe Staffing meeting • Consultants Job planning • EDI Plan & 2023 specific action plan • Staff Network groups • Revalidation • Appraisals • Mandatory and Statutory Training • ESR Benefits realisation plan • Agile Working policy • *Workforce and OD Strategy*	(EDI Steering group) and People Committee Gaps in control also identified through corporate check and challenge process	**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 • Bolton Integrated Partnership locality plan **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 •		• ~~Extensive actions within the Staff Engagement Action plan~~ • Consultation on updated People Plan in line with refresh of Trust Strategy • EDI Action plan updated with SMART objectives and 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 • Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay.

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
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
30/03/ 23	No change in risk score proposed

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

Date of last review	Inherent Risk Rating			Current risk rating			Target Risk Rating				
	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score		
March 23	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

RISK APPETITE

RISK MANAGEMENT - Control of the Risk

Amber

1 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	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

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	Development of place based approach to service and financial planning ~~April 22~~ July 23 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	Date	Comments
	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.*	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
		Mar 23	**No change in risk score**

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

Lead Director	**Chief Finance Officer**	
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	**4**

Risk Assessment

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

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 | **RISK MANAGEMENT - Control of the Risk**

1 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

2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

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
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~~ May 2023 ~~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~~ July 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
		March 23	No change in risk score

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
March 2023	4	4	16	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 | RISK MANAGEMENT - Control of the Risk | **Amber**

1. **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

2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

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
If the organisation does not cooperate with its partners to understand, respond to and seek to improve population health, then the people of Bolton will not experience improved health 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 with engagement from key partners • ~~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 – ongoing development including collaborative workshops across the system • Lack of agreed strategy, plans and approach to delivery (though these are in development and will be available in Q2 2023/24) • Date for delegation from GM TBA	• 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) • Revision and refresh of the Trust Strategy. **November 2023** • Lack of agreed strategy, plans and approach to delivery (though these are in development and will be available **in Q2 2023/24**

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 • Lack of collaboration with system partners to understand and respond to the wider determinants of health **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 GM scrutiny and oversight?	• Completion of neighbourhood sprints – March 2023 • System transformation plans to be developed and agreed	• Work with the ICB to agree the model for delivery under the Place Based Lead. **Ongoing** • Development of a System Financial recovery Plan **Ongoing** • 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 £.– **exact date TBA 2023/24**

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

Risk tracking	Background	Date	Comments
	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.	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	No change to risk score as Risk remains Significant
		March 23	Risk Reviewed, no change to risk score

Ambition 6
To develop partnerships

Lead Director	Director of Digital, Strategy and Transformation
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*

6

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	3	12	4	2	8

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 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

2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5 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
If the GM 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 and could change the services we provide **Causes** • Resilience of GM clinical services • Increasing demand for services • Resilience of sector and GM Radiology, Pharmacy and	• Membership of the Bolton Health and Academic Partnership Board • Health Innovation Bolton Partnership • Regular meetings with Peel Holdings and Bradford Estates • Membership and attendance at Greater	Strengthen partnership with local academic providers Engagement in the development of service transformation programmes through Directors of Strategy and other Exec Director Forums	*1st Line of Defence (Operational Management)* • Attendance at GM Director Forums • Membership of Health Innovation Bolton group • 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 programme HIB and the Academic Partnership management plan to be agreed in March 2023 • GM Sustainable Services work programme at an early stage though conversations ongoing through Directors of Strategy	• Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **ongoing during 2023/24** • Establish a programme structure to support the academic partnership – **June 2023** • Continued participation in GM working group to shape and influence the developing programme - **ongoing**

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. • 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 • Impact to access, experience and outcomes for the people of Bolton	Manchester (GM) Provider Collaborative. • Pharmacy transformation programme • Participation in the GM Sustainable Services programme • Engagement through GM Exec Director Forums/PFB	Development of Local pathology, radiology and pharmacy clinical service strategies Radiology network agreements remain key to assurance on this programme of work Reporting structure for Bolton Academic Partnership and Programme Management/Support Development of a GM laboratory information management system (LIMS) and Picture Archiving and Collaboration (PACs)	*2nd Line of Defence (Reports at Board and Committee Level)* *3rd Line of Defence (Independent or Semi-independent assurance)*	• Finalisation of GM network agreements	• Implementation of GM PACs and LIMS procurements • Finalisation of GM network agreements **July 2023** • Development of Local pathology, radiology and pharmacy clinical service strategies • Phase 2 of the CDC programme • Completion of GM provider collaborative linked to Financial Plan and Digital Plan **July 23** • Working group to move towards medical school **Ongoing** • Expansion of clinical courses and programmes mapped to workforce demand **November 2023** • Development of new programmes to fulfil recruitment issues e.g. health informatics **November 2023** • Production of a shared vision for the site and neighbouring land – **July 2023**

6	**To develop partnerships across GM to improve services**

Risk Tracking	Background	Date	Comments
	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. 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	21/10/19	c/f and 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
		March 23	Risk reviewed no change to risk score