# Board of Directors

*Thu 27 January 2022, 09:00 - 13:00*

# Agenda

**09:00 - 09:00**
0 min

## 1. Welcome and Introductions

*Verbal* *Donna Hall*

01. January Board Agenda part one.pdf (2 pages)

**09:00 - 09:00**
0 min

## 2. Patient Story

*Verbal*

**09:00 - 09:00**
0 min

## 3. Apologies for Absence

*Verbal* *Donna Hall*

**09:00 - 09:00**
0 min

## 4. Declarations of Interest

*Verbal* *Donna Hall*

**09:00 - 09:00**
0 min

## 5. Minutes of the meeting held on 25th November 2021

*Minutes* *Donna Hall*

05. Board of Directors Minutes Part 1 - 25.11.21.pdf (12 pages)

**09:00 - 09:00**
0 min

## 6. Action Log

*Action Sheet* *Donna Hall*

06. Board actions November 2021 following meeting.pdf (1 pages)

**09:00 - 09:00**
0 min

## 7. Matters Arising

*Verbal* *Donna Hall*

**09:00 - 09:00**
0 min

## 8. Chair's update

*Verbal* *Donna Hall*

**09:00 - 09:00**
0 min

## 9. Chief Executive Report

*Report* *Fiona Noden*

09. CEO Report with front cover - January 2022_v3.pdf (4 pages)

**09:00 - 09:00**
0 min

## 10. Covid Update

*Report* *Rae Wheatcroft*

**09:00 - 09:00**
0 min

## 11. Quality Assurance Committee Chair Reports

*Report* *Andrew Thornton*

11. QA Chair Reports.pdf (11 pages)

**09:00 - 09:00**
0 min

## 12. Learning from deaths including nosocomial update

*Report* *Francis Andrews*

12. Learning from Deaths Report Board January 2022 v2.pdf (12 pages)

**09:00 - 09:00**
0 min

## 13. Staff Story

*Verbal*

**09:00 - 09:00**
0 min

## 14. Impact of Covid 19 Omicron Variant on Nursing and Midwifery Staffing Levels

*Report* *Karen Meadowcroft*

14. Impact of Covid on staffing.pdf (4 pages)

**09:00 - 09:00**
0 min

## 15. People Committee Chair Report

*Report* *Alan Stuttard*

15. People Committee Chair Report.pdf (4 pages)
15.1 PC Chair report - Jan 2022.pdf (3 pages)

**09:00 - 09:00**
0 min

## 16. Operational Plan

*Presentation* *Sharon Martin*

16. Operational Planning.pdf (15 pages)

**09:00 - 09:00**
0 min

## 17. Integrated Performance Report

*Report*

17. Integrated Performance Report.pdf (53 pages)

**09:00 - 09:00**
0 min

## 18. Lead Roles

*Report* *Esther Steel*

18. Lead Roles.pdf (36 pages)

**09:00 - 09:00**
0 min

## 19. Anti Slavery Statement

*Report* *Esther Steel*

19. Anti Slavery Statement.pdf (3 pages)

**09:00 - 09:00**
0 min

## 20. Finance and Investment Committee Chair Report

*Report*

20. F&I Chair Report.pdf (4 pages)

**09:00 - 09:00**
0 min

## 21. Audit Committee Chair Report

*Report*

21. Audit Committee Chair Report.pdf (4 pages)

**09:00 - 09:00**
0 min

## 22. Any Other Business

*Verbal* *Donna Hall*

**09:00 - 09:00**
0 min

## 23.

# BOARD OF DIRECTORS MEETING

***Date:*** 27 January 2022
***Time:*** 09.00-13.00
***Venue:*** Zoom

NHS Bolton NHS Foundation Trust

## AGENDA - PART 1

| TIME | SUBJECT | LEAD | PROCESS | EXPECTED OUTCOME |
|---|---|---|---|---|
| 09.00 | 1. Welcome and Introductions | Chair | Verbal | To note |
| 09.05 | 2. Patient Story | | Verbal | To note |
| 09.20 | 3. Apologies for Absence | DCG | Verbal | Apologies noted |
| | 4. Declarations of Interest | Chair | Verbal | To note declarations of interest in relation to items on the agenda |
| 09.25 | 5. Minutes of meeting held on 25 November 2021 | Chair | Minutes | To approve the previous minutes |
| | 6. Action Log | Chair | Action log | To note progress on agreed actions |
| | 7. Matters arising | Chair | Verbal | To address any matters arising not covered on the agenda |
| | 8. Chair's update | Chair | Verbal | To receive a report on current issues |
| **Safety Quality and Effectiveness** | | | | |
| 09.30 | 9. Chief Executive's Report | CEO | Report | To receive and note |
| 09.40 | 10. Covid Update | COO | Presentation | To note |
| 09:55 | 11. Quality Assurance Committee Chair Reports | QAC Chair | Report | To provide assurance on work delegated to the sub-committee |
| 10:05 | 12. Learning from deaths including nosocomial update | Medical Director | Report | |
| | **BREAK** | | | |

| | | | | | |
|---|---|---|---|---|---|
| 10:30 | 13. | Staff Story international recruitment | DoP | Verbal | To note |
| 10:45 | 14. | Impact of COVID-19 Omicron variant on Nursing and Midwifery staffing levels and care provision | CN | Report | To receive and note |
| 11:00 | 15. | People Committee Chair Report | PC Chair | Report | To receive assurance from the People Committee |
| **Strategy** | | | | | |
| 11:10 | 16. | Operational Plan | DST | Presentation | To note |
| **Governance** | | | | | |
| 11:30 | 17. | Integrated Performance Report | Exec team | Report | To receive for assurance |
| 11:40 | 18. | Lead roles | DCG | Report | To receive for assurance |
| 11:50 | 19. | Anti-Slavery Statement | DCG | Report | To receive for assurance |
| 12:00 | 20. | Finance and Investment Committee Chair Report | F&I Chair | Report | To receive for assurance |
| 12:10 | 21. | Audit Committee Chair Report | Audit Chair | Report | To receive for assurance |
| 12:20 | 22. | Any Other Business | Chair | Verbal | To note |
| **Questions from Members of the Public** | | | | | |
| | 23. | To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting | | | |
| **Resolution to Exclude the Press and Public** | | | | | |
| 12.30 | | To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted | | | |

**Date of next meeting: 31st March 2022**

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|---|---|
| Meeting: | **Board of Directors (Part 1)** |
| Date: | **Thursday 25th November 2021** |
| Time: | **09:00-13:15** |
| Venue: | **Via Zoom** |

**PRESENT:**

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

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Esther Steel | Director of Corporate Governance | ES |
| Claire Lovick | PA to Director of Corporate Governance and Chair (minute taking) | CL |
| Victoria Crompton | Governance Manager | VC |
| Lianne Robinson | Divisional Director of Operations, Anaesthetics and Surgical Division | LR |
| Rae Wheatcroft | Deputy Chief Operating Officer | RW |
| Lisa Gammack | Deputy Director of Occupational Development | LG |
| James Tunn | Emergency Planning Manager (attended to present EPRR) | JT |
| Catherine Binns | Deputy Head Chaplin (attended to present staff story) | CB |
| Tracey Joynson | Patient Experience Manager (attended to present patient story) | TJ |
| Alison Loftus | Research and Development Manager (attended to present patient story) | AL |
| | There were also seven observers who attended this meeting | |

**APOLOGIES:**

| | | |
|---|---|---|
| Jackie Njoroge | Non-Executive Director | JN |

**1. Welcome**

The Chair welcomed everyone to this meeting.

**2. Patient Story – Research and Development**

This patient story relates to a man (P) who had Covid. Main points to note:

- A video was shown giving details of this patient story.
- P has since been asked to take part in two Covid studies and has been happy to do so as a thank you to the Trust for their care, and to help with learning for the future.
- P suggested the Trust asks more patients if they would be happy to take part in research – they can only say "yes" or "no", and he believes a lot of people would say yes.
- P was very happy with his treatment during his time in the hospital and he is grateful that things were explained so clearly to him.

***Resolved:*** The Board of Directors thanked P for sharing this patient story, and also thanked the Research Team for all their good work.

**3. Declarations of Interest**

There were no Declarations of Interest to report.

**4. Minutes of last meeting**

The minutes of the meetings on 30th September 2021 were approved as an accurate record of the meeting, once two minor amendments are made (Wilfred Green to be amended to Wilfred Gere and Lower body Parkinson to be amended to Lewey Body Parkinson).

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| **ACTION:** CL to make the above amendments to the minutes of 30/09/21. | CL<br>FT/21/78 |

**5. Action log**

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

**6. Matters arising**

There were no matters arising to report.

**7. Chair's Update**

The Chair provided the following update:

- The Governors recently appointed a new Non-Executive Director. Zed Ali is currently a Non-Executive Board member at Bolton Clinical Commissioning Group, and she will be joining the Trust in early 2022. This role has been approved by the Trust's Governors.

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

## 8. Chief Executive Report

The Chief Executive provided the following update on this report:

- The Trust is being assessed as part of the System Oversight Framework.
- The Trust has written letters to the relatives of 92 patients who contracted Covid at hospital and sadly died. There are a few relatives who have asked for a meeting about this and the Bereavement Team are arranging this. Thanks was acknowledged to the Medical Director, Deputy Medical Director and Nicola Caffrey for all their work in this area.
- Letters will shortly be sent to patients who contracted Covid in hospital, and who have fortunately recovered, to express our apologies.
- The Small Things initiative is underway for Our Bolton Charity and everyone is being encouraged to get involved where they can.
- There are pressures in the system currently, particularly in ED. Work is being done to innovate and redeploy staff to the most needed areas. The Trust is also doing all it can to keep elective surgery in place.
- The hospital is doing all it can to discharge patients as soon as possible, with support from social services.

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

## 9. Winter Planning update

The Chief Operating Officer shared the Operational Progress and Recovery Update slides (see appendix 1). Highlights were as follows:

- The 4 hour standard in A&E is being phased out in April 2022 and six new standards are being introduced. Two of these new standards are:
  - Proportion of patients that spend more than 12 hours in the department from arrival.
  - Percentage of ambulance handovers within 15 minutes.
- Bolton is one of the better performing trusts in the NW with regards to 12 hour handover times (5-8% of patients). Whilst this is too many, it is significantly lower than many other areas.
- The Trust reviews patients who have waited a long time to see that no harm is done.
- Bolton still has the busiest A&E in GM.
- Unfortunately, the Trust is one of the worst in the region with regard to ambulance handovers. We are putting some changes in place next week which we hope will improve this.

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| **ACTION:** Rae Wheatcroft will provide an update at the January Board meeting on ambulance handover times and the work being done to create more space. | RW FT/21/69 |

- Covid is creating an impact around flow. We have 2 wards of Covid patients at all times which is 10% of our bed base.
- In critical care, Covid patients are taking up 30% of our bed base.

- The Trust was receiving patients from other sites up to last week, but as we are now under pressures ourselves we are moving patients back to their local areas where possible.

- Flu and RSV is not proving as bad as expected currently.

- The Trust is one of the best performing with regards to elective recovery. We have also been offering assistance to other areas re cancer support. We are doing all we can to keep elective recovery going, but do expect we may need to reduce some of our elective capacity to get through urgent winter pressures.

- Cancer performance in Q1 has been fantastic – we are one of the top 10 performing trusts in the country in this area. We have also achieved our target for Q2.

- Discharge of patients with no criteria to reside is proving a challenge due to pressures in the community. The hospital and community teams are working together to discharge patients where possible and have just created capacity for 50 more community beds. Two weeks ago we have over 100 patients in hospital with no criteria to reside and now it is approximately 80 patients, so this is moving in the right direction.

- The Trust continues to see more patients coming to A&E. This is due to a change in culture and patients feeling this is the best place to come to be seen quickly. There is work going on to accommodate this change in culture, i.e. putting senior clinicians at the front to filter patients to the right area.

It was acknowledged this is our Chief Operating Officer's last ever Board meeting. Bolton has been extremely fortunate to have Andy working at the Trust for so long, and whilst the Board are sorry to see Andy leave, they wish him well in his retirement.

***Resolved:*** The Board of Directors thanked the Chief Operating Officer for this detailed winter planning update.

**10. Quality Assurance Committee Chair Reports**

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

- The QAC have met twice since the last Board meeting (20th October and 17th November).

- QAC meeting on 20th October:
  - Pressures in A&E were brought formally to QAC for escalation to Board.
  - The Acute Adult Division has seen an increase in pressure ulcers in Q1 and this is due to the face masks required to treat Covid. There are now new face masks being used and we are expecting this to reduce the number of pressure ulcers.
  - We continue to achieve the 80% target re pneumonia.
  - We are below target on diabetes and there is work going on to improve this.
  - There is a large amount of work taking place in counting and recoding re mortality. Ward clerks are being trained in this area.

- There is a focus on increasing the number of reviews for SJR's by the Learning from Deaths team.
- There was an update around nosocomial deaths and this has already been covered at this Board meeting in the Chief Executive Report (section eight of these minutes). Thanks was expressed to the Medical Director and all his team for the hard work they have done in this area.
- Two themes which have come out of the National Patient Survey for improvement are noise at night and food. This feedback was provided by patients a year ago.
- Four SI Reports were approved at this QAC meeting.

- QAC meeting on 17th November:
  - The Medical Director provided a detailed update around nosocomial deaths (covered in section eight of these minutes).
  - It was noted that we had the most effective restart of theatres in GM, something the Trust is proud of.
  - The Medical Director provided an update on sepsis and there is work taking place in this area.
  - SHMI mortality rate is within normal range.
  - There was an update on mortuary security and the measures the Trust has put in place following the national request to all trusts. This work is due to be completed by the 30th November.
  - The Maternity Transformation Plan has been set up for oversight of all maternity projects.
  - Seven SI Reports were discussed at this meeting and three were approved. The others required amendments before they could be approved.

- There was nothing in the QAC chair reports requiring escalation to Board of Directors.

***Resolved:*** The Board of Directors were assured by these chair reports.

**11. Nursing, Midwifery and AHP Staffing Report**

The Chief Nurse provided an update on this report and shared slides (see appendix 2). Main points to note:

- It is a competitive market at the moment for nursing staff due to the national shortage of registered nurses and midwives.
- There is a large amount of work taking place at the Trust around recruitment and we are doing all we can to employ staff into roles as soon as possible.
- 89 full time staff were recruited in September.
- The vacancy rate for care support workers is currently at 8.4% and we are aiming to reduce this to 1% by the end of the year.
- Sickness is a challenge with existing staff, and this is higher than usual due to Covid absences.
- The two winter wards have been open all year without a substantive establishment of staff.

- The Trust have reinstated the Nursing Associate Training however trainee nurses currently on a two year course will not qualify and be part of the workforce until 2023.

- We have increased the undergraduate training and are supporting two cohorts of 90 students from Bolton University however it will be 2024 before the can join our workforce.

- The first census using the NHSI Safer Nursing Care Tool was completed in September2021. The second census will be completed in February 2022 this will identify the nursing shortfall using a recognised methodology.

- The use of Health Roster and safer care is a focus and training is being rolled out.

- A matron has been appointed to support the clinical support workers especially the clinical support workers with no background in care this has been a s a result of high attrition in the newly appointed staff.

- The nursing midwifery and AHP staff are supported with a governance framework for professional groups, i.e. Professional Forum, Workforce Forum, Professional Education Forum Professional Standards forum Quality and Patient Experience Forum, and Research Forum.

- We have reinstated the Trust accreditation programme (BoSCA) this has been positively received.

- Each Tuesday senior nurses conduct a senior nurse walkabout offering support to the team.

There was a query around the SMCT tool which is showing a shortfall. It was confirmed this was from January to June and at that point there was more vacancies and therefore a shortfall. Key areas have been identified so improvements can be made.

Board asked if the number of midwifes available at busy times were enough. The Chief Nurse informed Board that at our busiest times in August and September we kept to safe ratios by using bank shifts and staff overtime. The maternity teams have worked extremely hard to ensure safe ratios were met.

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| **ACTION:** The People Committee will do a deep dive on AHPs (better than other areas) and what we can learn from this to share with the rest of the organisation. | JM FT/21/70 |

***Resolved:*** The Board of Directors noted this update.

**12. Sustainability Development Management Plan (Green Plan)**

The Director of Finance provided the following update on this plan:

- All NHS organisations need a Board approved Green Plan to achieve carbon zero emissions by 2038.

- The final document will be brought to Board in March 2022 and this will include key objectives and what we plan to do to achieve them.

- We have some specialist experience in iFM who can assist with this plan, and the Director of Finance and Director of Strategy and Transformation will work closely re key strategies across the Trust.

- There is a lot we can do individually to make small changes.
- Audit work will be taking place around this to provide further assurance from the Audit Committee.

Board queried if the seven working groups being set up for this would have time to focus on this with current hospital pressures. It was clarified the governance around the working groups will be set up over time. This has already been discussed at Trust Management Committee and was well supported.

A question was raised around our water consumption which is higher than many other Trusts of a similar size. This is due to old pipe system and leaks. We have an old estate and it is hoped that if we succeed with our NHP bid improvements will be seen in this area.

We are also using a lot of gas on our old estate. With a new build we would have lower gas usage.

Board asked if it is realistic for us to get to carbon zero emissions without a new hospital. We do expect new technologies to be developed over time and are confident we will achieve the first milestone in 2025. It was acknowledge that to achieve carbon zero emissions by 2038 a new hospital would make things a lot easier.

***Resolved:*** The Board of Directors noted this update.

**13. Staff Story – Disability**

Catherine Binns provided the following staff story:

- This month has been Disabled History Month, with a focus on hidden disability.
- Catherine shared that she has three hidden disabilities. She has struggled academically due to this but is a very creative person.
- With hard work and determination, Catherine got a diploma and nursing degree.
- Six years ago Catherine came to work at Bolton Hospital and declared her disability on the application form and at interview.
- Catherine received support from colleagues at Bolton hospital.
- It would be helpful if support plans were in place for people with specialist disabilities.

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| **ACTION:** James Mawrey will speak with Catherine Binns re her staff story on hidden disabilities to learn more about what we can do as a Trust to support staff in this area, | JM FT/21/71 |

***Resolved:*** The Board of Directors thanked Catherine Binns for sharing this staff story.

**14. People Committee Chair Reports**

The People Committee Chair provided the following update:

- There is a lot of positive work taking place, including Medical Leadership work, Medical Education work and improving KPIs.

- Staff are working exceptionally hard and are exhausted.
- Agency spend has increased but currently this cannot be avoided as we need to ensure we put patient care first.
- There have been two People Committee meetings since the last Board meeting (October and November).
- October People Committee meeting:
  - 33 offers went out to student nurses.
  - 11 overseas nurses have been recruited from Hong Kong and India.
  - An update was provided on the vaccine programme.
  - We are using digital technology to improve what we do, i.e. planning rosters etc.
  - Headcount is red for October.
  - The number of apprentices recruited has dropped. We would receive more money if we had more apprentices and an update on this will be provided to People Committee in January.
  - Freedom to Speak Up is well supported.
- November People Committee meeting:
  - Resourcing is going well.
  - Flu vaccination programme is going well.
  - There is concern around the government mandate for front line NHS staff to be vaccinated to continue working for the NHS. The People Development team are looking into the detail and risk of this.
  - Agency spend is very high. Unfortunately, this cannot be avoided in the current times as we need to ensure we have enough staff to keep our patients safe.
  - Staff absence is at 5% which is the lowest in GM.
  - Work is going on to support staff wherever possible. Our staff are amazing and are working exceptionally hard.
  - Work is taking place with CURE Project to try to stop staff smoking onsite (outside the entrances).
  - We are doing well with Health Education North West and this is being led by our Medical Director.
- The Trust is working with Rachel Tanner and the ICP around apprenticeships. We are aiming to maximise apprenticeships in 2022.

***Resolved:*** The Board of Directors noted this update.

**15. 2021-22 Emergency Preparedness, Resilience and Response (EPRR) Assurance – Statement of Compliance**

James Tunn provided the following update:

- This is a paper about core standards in emergency planning.
- This assessment is to ensure compliance.
- The Trust achieved substantial and is a category one responder, directly involved in emergency services.

- Due to Covid, there has been a delay to training.
- On call systems and training is important so we can respond to emerging risks.
- Core standards were postponed last year due to the pandemic.
- The Trust were fully compliant with 42 of the criteria, and partially compliant with the other 4 criteria (91% compliant). Our result are returned to Shared Services in GM, and once collated with other trusts in GM, these are then sent to NHSI.
- A review is required on how we would manage a critical incident, and this will be done by the end of December 2021.
- We will be looking at our full side evacuation policy to see what improvements need to be put in place.
- The number of trained staff in ED has decreased due to a lack of available staff during the pandemic. Training has now commenced to improve this.

There was a query around how IT issues (i.e. cyber threat) is covered in ERPP. This is an IT specialist subject and is covered in the IT Disaster Recovery plan which is IT led.

***Resolved:*** The Board of Directors thanked James Tunn for all his hard work in this area and for keeping the Trust safe.

**16. Board Assurance Framework (BAF)**

The Director of Corporate Governance provided the following update on the Board Assurance Framework:

- The Board Assurance Framework (BAF) pulls together assurance risk so objectives are controlled.
- Winter Planning is included in the appendix.
- The IPC framework has been done in the same format and will be appended to the next BAF.
- It is important the BAF focusses on assurance and that it links in with the Trust Strategy.

***Resolved:*** The Board of Directors look forward to discussing this in detail in Board Part two on 25/11/21.

**17. Finance and Investment Committee Chair Report**

The Director of Finance provided the following update:

- The H2 financial plan went to the Finance and Investment Committee on Tuesday (23/11/21) and an update will be provided to Board in January.
- A lot of work has taken place in the last month and there is now a plan for the expected funding we are likely to receive nationally. This has not been fully confirmed yet and there is potential risk we will not receive the full amount.
- The Trust is required to deliver cost improvements of 6%.

- The Trust had a deficit at the end of H1 and this has now been resolved.
- We are expecting an update on 2022 financials before Christmas.
- There was a helpful update on agency spend and this will be covered in detail at the next People Committee meeting.
- The immediate focus is to get through the winter pressures and the finance team will look at system savings in the New Year.

There was a question received around our capital position and it was confirmed that this is shifting nationally and regionally at the moment. There is a large range of potential capital and work is taking place to make sure we have some schemes lined up to ensure we receive our share of capital.

It was acknowledged the H2 financial planning process has been well managed by the Director of Finance and her team, and this has put us in a good position for 2022.

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|---|---|
| **ACTION:** Annette Walker will have a conversation with Executive Directors, then bring a detailed finance update to Board in January 2022. | AW FT/21/72 |
| **ACTION:** Annette Walker will invite Sue Johnson from the Council and her colleague from the CCG to a future meeting as part of the financial update. | AW FT/21/73 |

***Resolved:*** The Board of Directors noted this report.

**18. Audit Committee Chair Report**

The Audit Committee Chair provided the following update from the October meeting:

- There were concerns at the last Audit Committee meeting around the number of overdue recommended actions and this has now been dealt with.
- There were two IT reports discussed which the Audit Committee had concerns about. There have been changes in management in IT and the team have been under work pressures. It was acknowledged there are some risks in this area. Vicky Lewis joins us as the Head of IT in the next few weeks and she will then start to look at making improvements.
- It was suggested that a Disaster Recovery Plan re IT can be presented to the Audit Committee at a future meeting.
- The Trust has completed more waivers than usual and the Director of Finance is looking at how we can reduce the number of these coming through.
- The Trust has made a compensation payment re data protection regulations and it is important to highlight all staff need to be confidential with data handling.

***Resolved:*** The Board of Directors noted this report.

**19. Trust Transformation Board Chair Report**

The Trust Transformation Board Chair provided the following update from the October meeting:

- Positive work has taken place on Outpatients Improvement, Advice and Guidance, and patient initiative PIFU follow up.
- We have seen improvements in our do not attend rate since the digital letters system was introduced.
- A project is taking place to bring a number of people in-house to do a QI skills update. We are currently in the early stages of this project.
- There was an update on the ICP business plan.
- Delayed supply of IT equipment is affecting the Agile Working project. There is a national shortage of some IT equipment.
- EPR has been rolled out to paediatrics and the community. This has proved positive but there is still more to be done on EPR.

A question was raised around when we will have a feel for the amount of space agile working can free up for clinical staff. Current work around this is focussing on administration, IT, finance and HR staff, but more work is required before this question can be answered. Cultural work is also ongoing around agile working and Lisa Gammack and her team are looking at this.

***Resolved:*** The Board of Directors noted this report.

**20. Integrated Performance Report**

The Chief Operating Officer provided an update on the Integrated Performance Report and it was noted there were no issues to report in maternity, operational performance, workforce or finance. There have been times when A&E have been overcrowded and extremely busy but they are doing an excellent job of coping with the current work pressures in their area.

Following a discussion around performance, the following was raised:

- There was an ask as to whether or not we capture information around falls in the community. It was clarified that we do monitor Community Division falls, and there are plans in place for improvements in Laburnum Lodge.
- It was also queried if we capture information around falls in primary care. It was confirmed that when district nurses are in attendance we do, but that other falls in primary care will be captured by GPs.
- A question was received around patients who receive antibiotics within 60 minutes of a sepsis diagnosis and how we capture this information. An audit takes place every quarter of patients in a selected period and this is a national request from NHSE. It was acknowledged this audit only captures data from a small special time frame so provides a snapshot of that time frame rather than a full picture of each day.
- A paper on sepsis was discussed in detail at a recent QAC meeting and there is a lot of work taking place to make improvements in this area.

***Resolved:*** The Board of Directors noted this update.

**21. Safeguarding Adult, Children and Looked After Children Annual Report 2020-21**

The Chief Nurse provided the following update on this report:

- This is a statutory report which is required to be shared with the Board.
- The report highlights a lot of what has been happening through the pandemic.
- The report identifies that the amount of work in this area is increasing.
- There is a 42% increase in mental health referrals for children.
- There has been a 42% increase in mental health admissions to A&E for adults
- The team have worked exceptionally hard to safeguard our patients.
- The Chief Nurse is looking at the structure in safeguarding due to the increase in workload.
- Multi agency reviews are taking place re homicide and child protection.
- Safeguarding is becoming an increasing issue and we need to support our staff and patients with these complex issues.
- Thanks was acknowledged to the Bridget Thomas and the Safeguarding Team for all their work during the pandemic. This is a small team and they are doing a great job.

The Chair confirmed she has received a request from Bolton Together around preventative work for 0-19 year olds. This will be discussed at the Trust Transformation Board and then an update will be provided to Board via that committee.

***Resolved:*** The Board of Directors noted this update.

**22. Any other business**

These was no other business discussed at this meeting.

**23. Next meeting**

The next Board meeting will take place on the 27th January 2022.

Resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

**November 2021 Board actions**

| Code | Date | Context | Action | Who | Due | Comments |
|---|---|---|---|---|---|---|
| FT/21/72 | 25/11/2021 | Finance update | finance update to Board in January 2022. | AW | Jan-22 | agenda item |
| FT/21/69 | 25/11/2021 | Ambulance handovers | R Wheatcroft will provide an update on Ambulance handover times and work being done to create more space. | RW | Jan-22 | verbal update |
| FT/21/71 | 25/11/2021 | Supporting staff with hidden disabilities | J Mawrey will speak with Catherine Binns re her staff story on hidden disabilities to learn more around what we can do as a Trust to support staff in this area. | JM/MB | Jan-22 | verbal update |
| FT/21/66 | 30/09/2021 | GM Health and Care Board | DH will raise at the GM Health and Care Board on 01/10/21 the request for clear workplans to be put in place. | DH | Oct-21 | DH provided an update at Board on 25/11/21. This was raised at the GM Health and Care Board on 01/10/21 and DH is now facilitating a workshop fro this. GM Strategy meeting is taking place 29/11/21. Complete |
| FT/21/78 | 25/11/2021 | Minutes of 30/09/21 Board meeting | CL to add R Wheatcroft to attendee list on Board Part 2 minutes of 30/09/21. CL to also make the following two minor amendments to Board Part 1 of 30/09/21 - amend spelling of Wilfred Green to Wildred Gere and also amend spelling of Lower body parkinson to Lewe Body Parkinson. | CL | Nov-21 | Complete 26/11/21. |
| FT/21/77 | 25/11/2021 | Theatres Business Case slide on revenue | A Walker will circulate a slide on revenue re the Theatres Business Case to Board members. | AW | Dec-21 | complete |
| FT/21/70 | 25/11/2021 | Deep dive on AHP sickness rates | AHP deep dive to People Committee | JM | Jan-22 | complete |
| FT/21/29 | 29/07/2021 | Patient Story | KM to revisit MT's patient story in six months time to check if the actions put in place are continuing to be carried out to improve patient care and provide an update through QA Committee to Board. | KM | Feb-22 | |
| FT/21/51 | 30/09/2021 | Mortality | An update will be provided, via the next Mortality report, around review of mortality cases (red and amber). | FA | Mar-22 | |
| FT/21/54 | 30/09/2021 | A&E waiting times | Study on impact of A&E waits to QA Committee. | AE | Mar-22 | |
| FT/21/61 | 30/09/2021 | ICP Business Plan | ICP Business Plan update. | RT | Mar-22 | |
| FT/21/73 | 25/11/2021 | Board invitees for Finance update | A Walker to invite Sue Johnson from Council and colleague from CCG to a future board as part of the finance update. | AW | Mar-22 | |

Key

| complete | agenda item | due | overdue | not due |
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|---|---|
| **Title:** | Chief Executive's Report |

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| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27 January 2021 | | Discussion | |
| **Exec Sponsor** | Fiona Noden | | Decision | |

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

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

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| **Proposed Resolution** | To note the update. |

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

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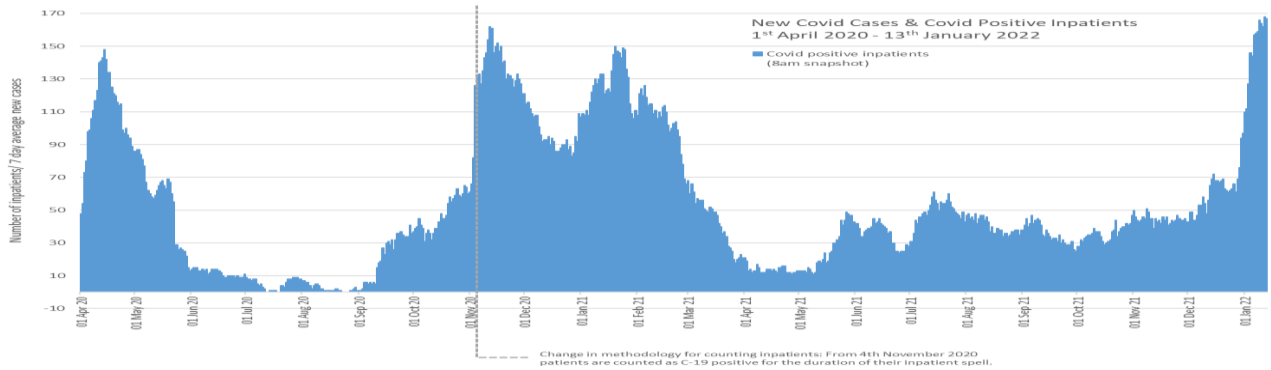
| **Prepared by:** | Fiona Noden<br>Chief Executive | **Presented by:** | Fiona Noden<br>Chief Executive |

## Ambition 1
**Provide safe, high quality care**

As expected, we are experiencing another wave of COVID but we have tried and tested plans in place to deal with the impact. As a result of the pressure we have been under, we reached heightened escalation earlier this month (and Operational Pressures Escalation Level 4), but have since deescalated to OPEL level 3 and surge escalation status.

The number of people in our hospital with COVID has exceeded all previous waves of the pandemic but numbers are slowly starting to reduce and we have been able to downscale our red capacity as a result.




Along with all other NHS trusts, we received a letter this month from the Royal College of Nursing about the extraordinary pressures our nursing workforce is facing and the importance of our duty to protect the health, safety and wellbeing of our staff who are often faced with difficult circumstances.

Some RCN members across the country have expressed concerns about their ability to deliver safe and effective care for their patients. We have reminded our staff of the importance of seeking support when needed, and the processes we have in place for raising concerns including accessing our Freedom to Speak Up champions.

## Ambition 2
**To be a great place to work**

We are currently analysing our 2021 NHS national staff survey results. Early indications show that we have improved a number of our scores and these scores perform strongly against our national comparator group. Our scores that have declined have done so to a lesser extent than our national comparator group. Our results will be presented to the People Committee and Board of Director's in February, and we will continue to ensure that divisions implement impactful action plans that continue to help make Bolton FT a great place to work.

The full results remain under public embargo until mid-March.

We have an extensive wellbeing package in place for our staff, who continue to work in the most challenging of circumstances. We have recently introduced Schwartz rounds, where staff come together in a structured forum to discuss the emotional and social aspects of working in healthcare. Initial feedback is that they have been very well received.

Rae Wheatcroft and I have restarted our online COVID briefings for our staff, to update everyone on what is happening across Greater Manchester, discuss the latest position, and offer the opportunity for staff to ask any questions they may have. The sessions take place once a week and have been attended by up to 200 people per session, from across all divisions and directorates. We have been seeking regular feedback which has been positive, and will continue the sessions as long as our staff find them useful.

## Ambition 3
To use our resources wisely

We finished H1 (the first half of the financial year) in a break even position, and are now forecasting a year to date deficit of £3m.

Our financial plan relies on additional income to allow us to break even in the second half of the year. Our financial position is very challenging due to difficulties of delivering cost improvements whilst also managing the current and on-going pressures of COVID, urgent care, staffing and elective recovery.

We have received significant additional sums of capital quite late in the year and have some large projects getting underway to spend the funds. We are now working to a capital budget in excess of £20m which will be a challenge to fully spend.

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

We have prepared for a continuation in the pressures we are experiencing as a result of Omicron, and indeed for future surges, by preparing additional bed capacity in an area off the main hospital site, which is clinically ready to be opened should we need it.

We have also responded on behalf of GM to a request for additional physical capacity on our site, should the patient numbers warrant us moving into surge capacity. Staffing requirements would be based on a system approach, as staffing continues to remain a challenge. The physical space is prepared and available should we find ourselves in that position as a region.

We plan to increase our theatre capacity as much as investment allows, so that we can deliver our elective activity as quickly as possible when it is safe and we are able to do so. We have also had conversations with colleagues in the independent sector about working closely together to increase capacity across Greater Manchester.

## Ambition 5
To integrate care

The number of patients who we are struggling to discharge home or to another place of residence when they are no longer in need of dedicated hospital care is still far higher than we would like it to be.

NHS England have asked Trusts to increase their focus on discharges and it is the golden thread running through our current pressures.

This month we welcome the Emergency Care Improvement Team (ECIST), a team of experts with substantial experience of the pressures and environment in urgent and emergency care systems. We have asked them to support us by providing ideas and examples of best practice to help us proactively manage our patients' length of stay and to minimise delays to care.

We continue to work closely with our health and care partners across the system including social care, primary care and the VCSE to ensure that patients are being discharged from hospital in a timely manner and with the wrap around support that they need.

## Ambition 6
### To develop partnerships

The new NHS structure and locality models were planned to come into effect from 1st April 2022. However, due to the work this involves and the current pressures on the whole of the NHS, it is planned that this will now take place on 1st July. As part of this, clinical commissioning groups will no longer exist, and across Greater Manchester the commissioning function will sit as part of newly formed Integrated Care Boards.

Earlier this month, the difficult decision was taken to pause some non-urgent surgery and appointments across all hospitals in Greater Manchester. This is not a position that we wanted to be in again but was necessary to be able to keep people safe, maintain the very best infection control standards and make sure we were able to deploy staff to the areas where they were needed most.

We have continued to prioritise urgent treatments and cancer operations and to work together across Greater Manchester to care for patients, to ensure that everyone who needs urgent care and treatment receives it.

We are now in a position to plan for restarting elective treatments as soon as possible, contingent on an improvement of the number of patients awaiting discharge.  Our aim is to have our elective programme fully operational within the next four weeks.

We have continued to maintain the partnership we have with the BMI Beaumont Hospital and have been having further discussions with other independent providers about how we can work together to increase capacity across Greater Manchester, at pace.

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| **Title:** | Quality Assurance Committee Chair Report |

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| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27th January 2022 | | Discussion | |
| **Exec Sponsor** | Karen Meadowcroft, Chief Nurse/ Francis Andrews, Medical Director | | Decision | |

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| **Summary:** | To update the Board on the work and activities of the Quality Assurance Committee in December 2021 and January 2022. |

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| **Previously considered by:** | |

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| **Proposed Resolution** | To note the updates from the Chair 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* | ✓ |

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| **Prepared by:** | | **Presented by:** | Andrew Thornton, QAC Chair |

## Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

NHS Bolton NHS Foundation Trust

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|---|---|---|---|
| Name of Committee/Group: | Quality Assurance Committee | Parent Committee: | Board of Directors |
| Date of Meeting: | 15th December 2021 | Date of Next Meeting | 19th January 2022 |
| Chair | Malcolm Brown (NED) – Deputy Chair | Quorate (Yes/No) | Yes |
| Members present | Malcolm Brown, Esther Steel, Fiona Noden, Francis Andrews, Karen Meadowcroft, Jackie Njoroge, Andy Ennis, Sharon Martin, all Clinical Divisions in attendance | Key Members not present: | Andrew Thornton, Annette Walker |

**Meeting overview/context**

| Key Agenda Items: | RAG | Lead | Key Points | Action/decision |
|---|---|---|---|---|
| Patient Story – Anaesthetic and Surgery Division | | Clare Williams | • Clare Williams updated QAC on a patient story relating to the discharge of a patient on end of life care. Whilst this was not a positive patient story, the importance of being open and honest and being committed to learning from this experience to make improvements for the future was commended. | • Clare Williams is providing a further update on this patient story to QAC in March 2022. |
| Update on current work pressures | | Chief Operating Officer | • The Trust is now significantly compromised due to the impact of the Omicron variant of Covid.<br>• The number of patients in hospital with Covid is increasing and there is pressure in A&E.<br>• Teams are reviewing their elective programme and cancelling elective surgery where required, whilst ensuring they maintain elective surgery wherever possible.<br>• On the 14th December there was an electrical fire on C1 in the room between the two wards. This was caused by a charging pack and safety checks are now taking place across the hospital to ensure there are no other faults. The fire brigade praised how well our staff managed the situation. | • QAC have passed on their thanks to the staff involved with ensuring patient safety during this fire. |

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

## Committee/Group Chair's Report

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| | | | • There has been a flood overnight on the 15th December in the room above HSDU which has caused endoscopy and the kitchen area to be closed. Endoscopy has been temporarily moved to day case and this has caused a knock on effect in that area.<br>• We have a significant number of patients in hospital with no criteria to reside (approximately 100). It is proving a challenge discharging them due to pressures in social care and nursing homes. | |
| Clinical Governance and Quality Committee Chair Report | | Chief Nurse | • The Trust are aiming to find an electronic solution for blood tracking ability in the near future.<br>• There has been a lot of good work done around hot reporting which helps with KPIs. | • Report noted no issues escalated. |
| Patient Safety Strategy | | Debbie Redfern | • This draft paper is in response to the National Patients Safety and Local Patient Safety structures, so we can set a Trust Patient Safety structure with aligns with them.<br>• The paper focuses on strategic insight, health safety and opportunities to improve patient safety. | • It was agreed this paper will be amended so it is clearer to understand for readers who are outside the Trust. The partnership and EDI sections of this paper also need strengthening and DR/ES/SM/CS will discuss this before it is brought back to QAC at a future meeting. |
| Quality Accounts update Q2 – NEWS – ASD Division | | Clare Williams | • KPI data has dipped in Q2 and this is disappointing. Data is being extended for a longer period and linked in with portal data in ward areas so we can gain further understanding of what is being achieved each day.<br>• Work is taking place around patient safety incidents. A meeting takes place to review incidents in the week they take place, and the team link in with Sophie Kimber-Craig on this.<br>• The division is working on a clinical programme with Angela Hansen.<br>• Data monitoring of patients in ICU is continuing, although this has not been progressed from a CQUIN perspective. The team are reviewing patients and ensuring patients are being seen in priority to prevent as many patients as possible needing critical care. | • There was a request for safeguarding incidents in Driver 2 and training figures in Driver 3 to be included in the Q3 report and Clare Williams will ensure this information is included. |

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## Committee/Group Chair's Report

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| Radiology Quality Account – Q2 | | Chinari Subudhi | • There has been good progress on the Radiology Quality Account in the last six to nine months in terms of capturing data, producing dashboards.<br>• There has been an increased turnaround time in hot reporting.<br>• 12 months ago much of the report was red and amber, there is now more green on the report and this shows things are moving in the right direction.<br>• The team are working on a review of job planning for all staff to capture and match demand. | |
| Divisional Governance Report – Diagnostic and Support | | Nadine Caine | • There were two formal complaints in Q2 and no trends were identified.<br>• There were 301 incidents and none of them fell into category 3, 4 or 5.<br>• The division has rolled out risk rates for the first time and they are working well.<br>• Education and best practice on infection control is being shared across the division.<br>• The new electronic blood transfer traceability system is planned to be rolled out in the New Year. Once the system is in place, it is expected to be six months before we see significant improvement.<br>• Hand hygiene is below target at 90-95% and reminders are being circulated about this, including posters in key areas. | |
| Anaesthetics and Surgical Services Division Integrated Governance Report Q2 | | Angela Volleamere | • There were two serious incidents in Q2.<br>• 10 complaints were received in Q2 and these were all responded to in the allocated time.<br>• One never event took place and this is the first since 2019. No harm came to the patient from this.<br>• GIRFT is working well and is an ongoing process.<br>• Theatre staffing pressures are an issue and recruitment to urology is proving difficult.<br>• Recruitment is taking place for ward and nurse specialists for the division.<br>• A lot of work has taken place to get the overdue SI Reports up to date. | |

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## Committee/Group Chair's Report

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| Children and Young Persons Survey 2020 | | Chief Nurse | • It was noted that this survey took place during difficult times in relation to the paediatric department. Covid restrictions on only one visitor per patient have had an impact on this survey.<br>• We received low response rates for the survey at 18%.<br>• Children reported positive experiences, however adults (their parents) reported less positive results. This is likely to be due in part to the Covid restrictions.<br>• Food, privacy and dignity, and ensuring communication is spoken in a way understandable to children were the main areas for improvement identified.<br>• The action plan includes a focus on food and communication. | • The division has achieved the improvements identified in the 2018 survey, and the focus is to now do the same for the improvements identified in this survey. |
| SI Reports | | Medical Director / Chief Nurse | • There were two SI reports discussed at this meeting and the following outcome was agreed.<br>– SI Report 181677 which included the updated action plan as requested at the November QAC meeting was approved.<br>– SI Report 183495 needs some amendments before it can be approved.<br>• There were three other SI Reports which had been discussed at the November QAC meeting and required amendments. The amendments have all been made and the following three SI Reports have been approved: SI 173924, SI 180044 and SI 182097. | • Francis Andrews is making the relevant amendments to SI Report 183495 for approval at the January QAC meeting. |
| Integrated Performance Report - Quality | | Chief Operating Officer | • There were no issues to report. | |
| Risk Management Committee Chair | | Chief Operating Officer | • Work has taken place around the themes in the risk register.<br>• There has been a big improvement in how the outstanding risks are looked at. | |

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## Committee/Group Chair's Report

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| | | | • Mitigation re heating support was highlighted as an emerging risk. | |
| Mortality Reduction Group Chair Report | | Associate Medical Director | • HMSR is currently sitting outside normal range and this is due to a change in the processing of data.<br>• SHMI is within range.<br>• Work is ongoing re mortality and an action plan is in place.<br>• There has been some great work done around heart failure and a further update will be provided to QAC in due course. | • Report noted no issues escalated. |
| Group Health and Safety Committee Chair Report | | Director of Corporate Governance | • Mortuary security has been improved to meet the new national request to all Trusts. This work is now complete.<br>• There is a lot of work taking place around manual handling but outstanding mandatory training in this area needs to be addressed. This delay has been caused in part by a lack of training rooms.<br>• The Fire Safety Committee will continue, initially on a bi-monthly basis. | |
| **For Escalation: Pressures in A&E were highlighted as amber, and it was highlighted this is likely to become even more of a challenge in the coming weeks.** | | | | |

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## Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

NHS Bolton NHS Foundation Trust

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|---|---|---|---|
| Name of Committee/Group: | Quality Assurance Committee | Parent Committee: | Board of Directors |
| Date of Meeting: | 19th January 2022 | Date of Next Meeting | 16th February 2022 |
| Chair | Andrew Thornton (NED) | Quorate (Yes/No) | Yes |
| Members present | Andrew Thornton, Esther Steel, Fiona Noden, Francis Andrews, Karen Meadowcroft, Jackie Njoroge, James Mawrey, Rae Wheatcroft, Sharon Martin, all Clinical Divisions in attendance. | Key Members not present: | Malcolm Brown, Phil Scott and Dawn Murray. |

**Meeting overview/context**

| Key Agenda Items: | RAG | Lead | Key Points | Action/decision |
|---|---|---|---|---|
| Patient Story – Acute Adult Care Division | | A Lucas | • Alicia Lucas updated QAC on a patient story relating to the care of a 33 y/o woman with multiple comorbidities who was cared for by her mother. There were discussions between staff and the mother regarding prescriptions and administering of medication which began to escalate and so Tier 1 were asked to support. The issue was resolved and staff met the day after to discuss the incident and to identify learning. | • The Committee noted the patient story. |
| Chief Nurse/ Medical Director Update | | CN / MD | • Thanks were shared to Andrew as Chair of the Committee to which Andrew thanked members of the Committee for their support and passion for improving patient safety.<br>• KM noted there are significant pressures in the organisation.<br>• FA updated on the Nosocomial Covid work which is moving into Phase 2 where the Trust will be writing to relatives of patients who died with but not because of Covid. | • |
| Operational Update | | COO | • There are 161 Covid inpatients, 1 of these is on Critical Care and there are six Covid positive wards | • |

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## Committee/Group Chair's Report

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| | | | • In the first week of January the Trust reached heightened escalation and OPEL 4 with 171 Covid inpatients. The Trust has since been able to de-escalate thanks to the hard work of staff.<br>• GM had taken the decision to step down elective services excluding cancer and critically ill but there are now plans to restart some of the elective programme from next week.<br>• The Trust continues to focus on no criteria to reside and support from ECIST to give constructive feedback. | |
| Clinical Governance and Quality Committee Chair Report | | Chief Nurse | • The chair report was taken as read with no risks to escalate.<br>• Noted the regional and national recognition of the ICSD for their Oximetry at Home work. | • |
| Covid-19 Impact on Nursing and Midwifery Staffing Levels | | Chief Nurse | • It was noted there had been no guidance received and so work was done following recommendation from the CQC to record the impact on staffing levels.<br>• Paper produced to look at the impact of Omicron on nurse staffing levels with the additional challenge of increased unavailability and increased bed base to staff.<br>• The paper is to provide assurance and included mitigations to ensure patients are safe and a route for oversight including visibility of matrons, use of additional roles, some non-urgent activity stood down and daily staffing meetings to ensure full visibility of trust wide staffing which reported to the Chief Nurse.<br>• N block is being readied to open for GM surge as requested so that it can be opened if needed. The area is equipped and available but hoping this will not be required. Chief Nurse thanked all of those involved. | • |
| Divisional Quality Review – Q2 – Acute Adult Care Division | | R Munshi | • Rauf Munshi presented the Q2 report and informed self-assessment was good other than for responsive. | • |

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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

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| | | | • Have seen a reduction in falls and pressure damage with most incidents being low or no harm. Division have identified an increasing trend in medication incidents and now have a daily review of medicine errors with a dashboard that was developed to help monitor.<br>• There has also been a recent change to the way in which incidents are categorised and so this may be affecting the information whilst also bearing in mind the increased number of patients being seen.<br>• The division are planning a deep dive review on medication with a plan to report back from this through Medicine Safety Committee via Clinical Governance & Quality Committee.<br>• Awareness and open with regard to areas for improvement – action plan outlining areas for focus included with good progress made on transfusion issues. | |
| Divisional Quality Review – Q2 – Integrated Care Services Division | | M Toms | • Overall self-assessment of good with an open and transparent reporting culture.<br>• Incidents were discussed with themes being identified as; missed/wrong dose, self-administer wrong dose or wrong dose.<br>• Medication is again the highest category of incidents despite reduction of errors and no change in insulin incidents.<br>• There has been a significant increase in excellence reporting and recognition of the Admission Avoidance Team and Home First Team. Discussed the opportunity for Home First Team and Admissions Avoidance to work with staff at the back door of the hospital to share learning in order to support discharge. | • Further report on medication incidents through the Clinical Governance Committee |
| Quality Account Update – Q2 - Pneumonia | | R Munshi | • The Trust remains above the North West average and continues to meet its targets despite decline in data given recent pressures. | |

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## Committee/Group Chair's Report

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| | | | • Key areas of focus are; Administration of initial antibiotic dose and Chest X-Ray which is below target in ED due to pressures. | |
| Quarterly Learning from Deaths Report | | S Kimber-Craig | • There has been an increase in the number of trained reviewers and looking to move forward with thematic analysis using key words and themes from the reviews with the Trust also offering to be a pilot site for thematic analysis.<br>• The Learning from Deaths Committee are looking at involving national regulation 28 learning from other organisations in order to identify proactive actions.<br>• Discussed increased MDT support for SJR and the need for the Learning from Deaths Committee to be MDT including non-medical attendance. | • The Committee noted that the recommendations in the report will be monitored via the Learning from Deaths Committee. |
| 2021 National Maternity Survey | | N MacDonald | • National survey included 435 questions to which there were 184 responses and 15 scores were in the top 20% with only three scores in bottom 20%.<br>• Overall there is a national decline in ratings across all services and this needs to be viewed in the context of the pandemic restrictions.<br>• The cleanliness issue is being addressed with iFM – this concern was also raised in the adult and paediatric surveys.<br>• An action plan has been drawn up to address the issues identified and the Committee recognised that although there are no major concerns the Trust has the ambition to be a leading provider.<br>• On reflection it was noted there is a national level of unrest about maternity services and that more needs to be done in the way of keeping service users involved and making sure they have all necessary information as this has been a theme identified. | • The action plan following the 2021 National Maternity Survey was noted by the Committee. |
| Maternal and Paediatric Sepsis Report | | Medical Director | • Report was presented as requested following a previous sepsis report on adults. Following some quality improvement work in ED a recent audit shows screening for children was 96%. | • The Committee noted the report and the ask of the Medical Director to present a further paper on this to update on progress. |

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

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

## Committee/Group Chair's Report

| | | | | |
|---|---|---|---|---|
| | | | • For Maternity sepsis was less embedded with poor use of the screening tool but no cases have been known to have been lost.<br>• Discussed the screening tool and the plans to review as currently use MEWS which is not nationally validated and felt to have triggers which are too sensitive so have volunteered to be in pilot for new nationally validated scoring system. | |
| SI / HSIB Reports | | Medical Director / Chief Nurse | • There were two SI reports discussed at this meeting and the following outcome was agreed.<br>– SI Report 183495 which included amendments by the Medical Director as requested.<br>– SI Report 180578 was approved by the Committee.<br>• The HSIB report 178434 was received by the Committee and the actions were agreed. | |
| Integrated Performance Report | | COO | • A spike was noted in MSSA cases to which Dr Subudhi confirmed this will be addressed via the IPC Committee.<br>• An increase was observed in the C-Section rate which is not believed to be related to the increase in stillbirths and is being seen increasing nationally.<br>• Stillbirths – Noted an increase in rate of stillbirths in December but advised that January is back on track. Also discussed the potential impact of Covid on the increase of rates. | • Committee to ask Business Intelligence to produce report earlier so that Committee can see latest figures. |
| Risk Management Committee Chair | | Medical Director | • The chair report was taken as read with no risks to escalate. | • The Committee received and noted the report. |
| Safeguarding Committee Chair Report | | Chief Nurse | • There are increasing number of safeguarding referrals being received.<br>• The Committee has reviewed the TOR to ensure aligned with statutory requirements. | • The Committee received and noted the report. |
| **For Escalation:**<br>• | | | | |

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

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

| | |
|---|---|
| **Title:** | Learning from Deaths Report |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27th January 2022 | | Discussion | ✓ |
| **Exec Sponsor** | Dr Francis Andrews | | Decision | |

| | |
|---|---|
| **Summary:** | This report includes the most recent information on deaths in adult patients, including data on:<br><br>• Total number of inpatient deaths (including ED deaths)<br>• Total number of deaths subject to case review (SJR)<br>• Of those deaths subject to SJRs, the number of deaths judged more likely than not to have occurred due to problems in care<br><br>Actions and learning that has arisen from these cases is outlined, as is the proposed change to using thematic analysis in the future as the output for these reviews.<br><br>Information on maternal, neonatal and paediatric deaths is included as an appendix.<br><br>A further appendix is included to update board on nosocomial death reviews |

| | |
|---|---|
| **Previously considered by:** | Quarterly reporting QAC and Board – last update October 2021 |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Debbie Redfern, QI Programme Manager; Michelle Parry, Clinical Effectiveness Manager; Sophie Kimber Craig, AMD, Nicola Caffrey, MD Business Manager | **Presented by:** | Dr Francis Andrews<br>Medical Director |

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

| | |
|---|---|
| **LFD** | **Learning from Deaths** |
| **SJR** | **Structured Judgement Review** |
| **LeDeR** | **Learning Disabilities Mortality Review Programme** |
| **RCP** | **Royal College of Physicians** |
| **NQB** | **National Quality Board** |
| **LFDC** | **Learning from Deaths Committee** |
| **QAC** | **Quality Assurance Committee** |
| **NCDRP** | **Nosocomial Covid Deaths review panel** |
| **GMMH** | **Greater Manchester Mental Health Trust** |

## 1. Background

The SJR process is outlined in detail in Appendix 1.

## 2. Summary of progress in Q3 2021/22:

- Four SJR training sessions took place, adding an additional 25 trained reviewers to the corporate Learning from Deaths group – which now equates to 47 active reviewers
- Corporate support from Business Intelligence, Patient Services and Clinical Effectiveness – to facilitate the process and highlight inclusive patients
- Over 800 deaths to date have been reviewed using structured judgement methodology
- Agreement to reconfigure the Learning from Deaths Committee, with the plan to move towards thematic review for trust wide learning
- Initial data analysis and scoping of work to improve data collection and reporting function
- Discussions with Sheffield regarding their approach to thematic review
- Nosocomial Covid-19 Deaths Review Panel (NCDRP) undertaken first thematic review – see Appendix 4.

## 3. Learning from Deaths Data – Adult inpatient deaths only

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

| | Q4 20-21 | | | Q1 21-22 | | | Q2 21-22 to date | | | Q3 21/22 to date[1] | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | Oct | Nov |
| Number of in-patient deaths (excluding ED & paeds) | 167 | 144 | 123 | 97 | 103 | 102 | 106 | 111 | 111 | 75 | 114 |
| Number SJR Cases identified | 42 | 36 | 32 | 15 | 28 | 28 | 21 | 23 | 21 | 22 | 58 |
| % completed | 93 | 83.3 | 78.1 | 80 | 86 | 93 | 71 | 70 | 43 | 50 | 7 |
| Number of deaths caused by problems in care (of those who had an SJR) | 1 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 |

### SJR Allocation and Completion rate

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

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

despite these significant challenges, the average SJR completion rate for Jan 21 – November 2021 is currently 69% which is consistent with the national average.

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

Of the deaths occurring in the above timeframe reviewed using SJR methodology, the following were considered to be more than likely due to problems in care:

| Time period | Number of patients | Cases |
|---|---|---|
| Q4 20/21 | 3 | • Pt 1 (died Jan) – died of Covid-19 pneumonia contracted in hospital from previous admission. All areas rated as good except for overall care due to nosocomial Covid-19*<br>• Pt 2 (died Feb) – developed Covid-19 during inpatient stay with a positive result at day 15 which likely contributed to death*<br>• Pt 3 (died March) – contracted Covid-19 whilst in hospital following an admission with Klebsiella pneumonia, stabilised enough to return home, but readmitted and died due to this nosocomial infection.* |
| Q1 21/22 | 2 | • Pt 4 (died May) – death was due to underlying liver disease exacerbated by the effect of a chain of complications begun by a procedure to investigate the cause of liver disease.<br>• Pt 5 (died May) – death certainly associated with hip fracture sustained whilst in hospital; referred to Coroner. |
| Q2 21/22 | 1 | • Pt 6 (died September) – failure to recognise and manage sepsis likely leading to increased mortality in this case, with concerns initially being raised by the Medical Examiner to refer for an SJR; being investigated as a Serious Incident (185602). |
| Q3 21/22 | 0 | No cases |

**All cases of nosocomial Covid-19 are subject to thematic review at the NCDRP (see below)*

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

Since January 2021, there have been four SJRs which the LfD Committee have sent for Divisional Review/Serious Incident. Please see below table:

| | Date Identified | Review Required | | Status and Key Learning |
|---|---|---|---|---|
| 1 | 09/11/2021 | Divisional Review | JH-386 | • Scoping Panel 08.11.2021. SI declared (Impact 4)<br>• Investigator yet to be identified (target for completion of Jan 22) |
| 2 | 08/07/2021 | Concise Investigation | MS-948 | See Below |

| | | | | |
|---|---|---|---|---|
| 3 | 06/05/2021 | Scoping Meeting – Serious Investigation | GW-835 | Completed with key learning required:<br>•Competency of staff caring for chest drains to be reviewed<br>•Clinical guidance to be produced<br>•Monitoring intervals not recorded 4 hourly as recommended<br>•Chest drain insertion level to be checked as part of monitoring |
| 4 | 15/02/2021 | Divisional Review | AW-467 | Cross Divisional Review – Action plan update required |

**SJRs referred for a Concise Investigation**

One SJR was referred for a concise Investigation:

- The Action Plan recommends an Alert needs to be placed on EPMA for when paper records are used in combination with the EPR
- EPR Medical Handover process was introduced which will further address the findings of the investigation

## 4. Challenges

- **SJR reviewer capacity** – operational pressures have meant some reviews have not been completed in the initial four-week timeframe. An escalation process is followed and cases are reallocated where required. Furthermore, the additional training that took place in November and December has added additional reviewer capacity and therefore going forward just one SJR per month will be allocated per person as a maximum to reduce any particular pressure on staff. We are also aiming to support our new reviewers, and those existing ones, by implementing the following:
    - An offer of a peer-review process, where staff can "buddy up" to quality assure each other's work
    - A newsletter to share case numbers and completed reviews and the learning and actions that have come as a result
    - An open offer to attend the LFD committee whenever a reviewer's case is being reviewed by the group
- **Database analysis** – The current database of cases is held as an excel document and takes considerable time to download in its entirety, either resulting in more limited searches of the data to specific timeframes or multiple different searches that have to be combined at a later stage. Work is ongoing with the Business Intelligence team to transfer this information into a more user-friendly format, in Tableau, which should aid better thematic reviews of the full data set. Amendments are also being made to the data entry form, where a range of key themes (whether positive or negative) that the reviewer can identify in the case are being added (see the table below), to make key word searches easier to perform.

| **Thematic group** | **Theme** |
|---|---|
| Clinical care | Clinical assessment |
| | Deep tissue injuries |
| | Delays in management |
| | Falls |

| | |
|---|---|
| | Investigation (including appropriateness) |
| | Recurrent admissions |
| Decision making & discussion | Advanced care planning |
| | Admission decisions |
| | DNACPR decision making |
| | End of life/palliative care |
| | Situational awareness |
| Interaction with others | Communication |
| | Team working |
| Monitoring and escalation | Deterioration |
| | Escalation |
| | Fluid balance |
| | NEWS |
| | Sepsis pathway |
| Organisational aspects | Tertiary services |
| | Access to services |
| | Equipment |
| | Responsible team/professional |
| Procedural aspects | Consent |
| | Operations |
| | Procedures |
| | Recognition of illness |
| Training and support | Guidelines |
| | Knowledge |
| | Staffing |
| | Supervision |
| | Training and education |

- **Thematic reviews** – In addition to the nosocomial Covid-19 cases thematic review, other themes for review and subsequent database searches that were agreed during the LFD committee meeting have been conducted. These are timely *DNACPR decision making* and *decisions about admission*, along with collation of ENT and Urology cases (those surgical specialities where we are reliant on staff based at other Trust sites). These are all to better understand potential issues that are seen in some mortality cases. These are being shared with the relevant teams working on these issues to act as a baseline and to inform them of the care concerns we have and to highlight excellence where it happens. However, this has also highlighted where there are not clear existing governance structures in place in some areas, such as around timely DNACPR decision making, and these have therefore been escalated and are being addressed. It highlights the issue with regards to finding the right team members to address the committee's queries arising from thematic reviews. The challenge remains for the LFD committee members to be assured that there are processes either in place or being implemented to address care delivery concerns, which is a key focus of the LFD committee. The committee is endeavouring not just to learn from individual mortality cases, but to understand the broader issues by collating data together to get a better understanding of our service provision and seek action where it is required to strengthen that provision.

## 5. Summary and Recommendations

The learning from deaths programme continues to evolve and strengthen, with key areas of progress in Q3 21/22 being:

- Links to the Nosocomial Covid-19 death review panel's work in communicating with all families where a loved one died from nosocomial while in our care
- Agreement to reconfigure the Learning from Deaths Committee, with the plan to move towards thematic review for trust wide learning
- Recent successful training of new staff as reviewers

However, current challenges to the LFD programme are:

- Delayed case reviews, which should see an improvement with the additional reviewer numbers
- The analysis of the existing basis in its current format, which is being addressed by changes to the input form and work by BI to move the data into a more accessibly form
- Ensuring care provision issues are addressed by the right staff – where these issues arise they are escalated to members of the senior management teams for guidance on how to proceed

### Recommendation

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

**Appendix 1**

**Learning from Deaths Methodology – adult inpatient only**

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

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

Cases deemed to be uniformly excellent are also reviewed at LFDC and any actions and learning points are captured are shared.

The benefits realised by this approach include:

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

## Appendix 2: Learning from deaths –data breakdown (adult patients)

NHS Bolton NHS Foundation Trust

| | 2020/2021 | | | 2021/2022 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Quarter 4 | | | Quarter 1 | | | Quarter 2 | | | Quarter 3 | |
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
| Number of In-patient Deaths (ex ED & Paeds) | 167 | 144 | 123 | 97 | 103 | 102 | 106 | 111 | 111 | 75 | 114 |
| Number Cases (Sample) | 42 | 36 | 32 | 15 | 28 | 28 | 21 | 23 | 21 | 22 | 28 |
| COMPLETED | 39 | 30 | 25 | 12 | 24 | 26 | 15 | 16 | 9 | 11 | 2 |
| **Outstanding Cases** | **3** | **6** | **7** | **3** | **4** | **2** | **6** | **7** | **12** | | |
| Not Yet Received - Within Deadline | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26 |
| Outstanding -Supassed Deadline | 5 | 6 | 7 | 3 | 6 | 2 | 6 | 7 | 12 | 11 | 0 |
| Cases requiring reallocation | 7 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| % | **93** | **83** | **78** | **80** | **86** | **93** | **71** | **70** | **43** | **50** | **7** |
| **Source** | | | | | | | | | | | |
| Mandated Death (Alert Diagnosis) | 21 | 14 | 7 | 1 | 0 | 2 | 1 | 0 | 2 | 0 | 5 |
| LD Death | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 |
| Mental Health Death | 8 | 11 | 10 | 10 | 10 | 12 | 5 | 12 | 13 | 14 | 16 |
| sample | 0 | 0 | 5 | 0 | 14 | 10 | 8 | 0 | 0 | 6 | 0 |
| Requested by cons/matron | 1 | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Diabetes Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NELA Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MEDICAL REVIEWER | 9 | 8 | 4 | 2 | 3 | 3 | 6 | 10 | 5 | 2 | 6 |
| BAME + COVID Death | 3 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **42** | **36** | **32** | **15** | **28** | **28** | **21** | **23** | **21** | **22** | **28** |
| **Overall Score** | | | | | | | | | | | |
| 1 (Very Poor) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| 2 (Poor) | 8 | 6 | 3 | 3 | 3 | 2 | 3 | 0 | 1 | 1 | 1 |
| 3 (Adequate) | 7 | 8 | 5 | 1 | 4 | 5 | 4 | 6 | 3 | 5 | 0 |
| 4 (Good) | 23 | 14 | 15 | 8 | 16 | 15 | 7 | 10 | 4 | 4 | 1 |
| 5 Excellent | 1 | 2 | 2 | 0 | 1 | 4 | 1 | 0 | 0 | 1 | 0 |
| | 39 | 30 | 25 | 12 | 24 | 26 | 15 | 16 | 9 | 11 | 2 |

**Appendix 3 – Maternal, still birth and neonatal**

| 2021 | Still births | Early Neonatal deaths | Late Neonatal deaths | Late Termination of Pregnancy |
|---|---|---|---|---|
| Oct | 3 | 2 | 1 | 2 |
| Nov | 2 | 1 | 1 | 0 |
| Dec | 7 | 1 | 0 | 0 |
| **Total** | **12** | **4** | **2** | **2** |

Q3 2021 –

**Summary of stillbirths**

6 classed as unavoidable
4 being reviewed
1 cause unknown
1 potentially avoidable-subject of SI

**Summary of neonatal deaths**

2 unavoidable
2 being investigated

**No maternal deaths**

## Appendix 4

# Nosocomial Covid Deaths Review Panel

**Update and Oversight of Current Position**

The Nosocomial Covid-19 Deaths Review Panel (NCDRP) has provided regular updates through the Learning from Deaths group and Execs regarding progress of the Duty of candour process for the historical Nosocomial Covid-19 cases up to July 2021.

Phase 1 which related to identifying, reviewing, writing to and following up with a telephone call to the families and next of kin of the patients who died due to Nosocomial Covid-19 has now been completed.

Phase 1 Update

- 91 next of kin were sent personalised letters, all individually signed by Fiona Noden These letters were all followed up by phone calls made by Dr Kevin Jones and Dr Harni Bharaj.
- There have been 2 follow up meetings with the families of patients who have died, and 2 further meetings to be held in the coming weeks.
- There were 10 families who requested details of the PALS team to follow up with additional concerns relating to their loved one's care.
- 2 families have requested additional information from the clinical teams managing their loved one's care (not related to Covid) and these are being arranged with the specialities and supported by the PALS team
- 50 next of kin have requested the final reflection report when it's available
- All next of kin were offered bereavement support from the Bereavement team, and this has been accessed so far by 6 families.

The learning from phase 1 has included identification of a continuing issue relating to the poor quality of information recorded in patient records relating to next of kin which has been recognised via the Mortality Working Group via the Counting and Recording Group.

Phase 2 is currently underway and this cohort is relating to patients who died with Nosocomial Covid, but not due to it. There are 64 patients in scope of this cohort, and the same process of a letter to the next of kin, followed by a follow up call will be followed. The same issues relating to identifying the correct next of kin as seen for the phase 1 patients continues to present a challenge, but we are looking to send out the letters by the end of January.

Phase 3 is being supported by a temporary admin colleague, and this cohort is as identified by IPC as having acquired Nosocomial Covid-19, but discharged home. These Duty of Candour letters will be sent to the patients, with due diligence, but will not be followed up with a telephone call.

The team have received challenging feedback which will be included in both the reflection report and brought into organisational learning, with main themes including issues with communication, lost property and multiple moves. The team have also been humbled by the thankfulness of the families, relating to both the care received whilst their loved ones were in hospital, but also the Duty of Candour process and the opportunity to go through their loved one's care.

Due to the recent increase in Nosocomial Covid-19 cases and the increasing burden on clinical teams following extensive Omicron outbreaks, we are looking to support colleagues relating the Nosocomial reviews and Duty of Candour requirements for ongoing cases.

Agenda Item
14

| | |
|---|---|
| **Title:** | **Impact of COVID-19 Omicron variant on Nursing and Midwifery staffing levels and care provision.** |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Trust Board | **Purpose** | Assurance | x |
| **Date:** | 27/01/2022 | | Discussion | x |
| **Exec Sponsor** | Karen Meadowcroft | | Decision | |

| | |
|---|---|
| **Summary:** | As COVID-19 Omicron cases increase in line with national trajectory it is anticipated that staffing levels will be affected across Bolton Hospital NHS Foundation Trust acute and community services. As staffing levels are impacted and decrease it will become increasingly challenging to staff the wards/ departments and community areas in line with national and regional staffing guidance. Therefore, this document has been produced in order to identify the risk and provide the relevant mitigation as part of business continuity planning. |

| | |
|---|---|
| **Previously considered by:** | Executive Directors Team Meeting, People Committee, Quality Assurance Committee |

| | |
|---|---|
| **Proposed Resolution** | Trust Board are asked to note the contents of this paper and the assurance in place to mitigate the potential risk. |

| **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:** | Lianne Robinson, Corporate Director of Nursing | **Presented by:** | Karen Meadowcroft, Chief Nurse |

## Impact of COVID-19 Omicron variant on Nursing and Midwifery staffing levels and care provision.

### Background

The Chief Nurse and Corporate Director of Nursing, in conjunction with the Divisional Nurse Directors, have assessed the current staffing establishments and skill mix. In anticipation of a high level of staff unavailability a professional judgement has been made on the safest minimum staffing levels that each ward and department could tolerate to ensure the fundamental basics of nursing and patient care can be delivered.

Whilst staff will strive to maintain usual care standards, evidence and research correlates reduced staffing to a deterioration in key performance indicators for nursing therefore some aspects of care may not be delivered to current recognised standards.

It is recognised that a reduction in staffing numbers will only be in extremis and a return to established numbers would be expected as soon as operationally possible. In order to manage the increased operational pressure Bolton NHS Foundation Trust has increased its core bed capacity by opening additional beds on base wards by 6 beds and utilising the discharge lounge (R1) and Clinical Assessment Unit (CAU) to accommodate patients overnight dependent on the level of trust escalation. This conversely has reduced the nurse to patient ratios within the Trust

This additional capacity and a proposal to further increase the bed base to support Greater Manchester (GM) system increases the frequency that staffing may fall below minimum levels. This is an extreme situation and on each occasion a dynamic risk assessment will be undertaken and accurate records maintained.

### Potential Risk

The reduction in fill rates and reduced qualified staffing numbers may have an adverse effect on the quality of care that staff are able to provide. It is anticipated that this will impact our key performance indicators in relation to: falls, pressure ulcers, medication incidents and other patient harms. In addition, it is also recognised that this will adversely increase length of stay due to staff unable to discharge in a timely manner and could result in breaches of the Trust Infection Prevention and Control guidance and safeguarding measures. We also recognise that this may also impact on patient experience (Complaints and PALS concerns).

There is the potential for risks and incidents to increase in this heightened level of escalation.

### Mitigation and Oversight

Prior to reducing staffing numbers all divisions will be requested to enact their respective Business Continuity Plans. This includes utilising all available nursing resources:

- Ward basing specialist nurses where possible.
- Ward managers to be included in staffing numbers.
- Matrons to be released from all none clinical duties to increase their visibility and clinical oversight of their areas.
- Consider use of pharmacy technicians and pharmacists to dispense medications on clinical areas.
- None ward based nurses to be redeployed to suitable ward environment.

- Stepping down none urgent clinical activity.
- Increased use of student nurses and utilisation of synergy model where possible with the oversight of the PEFs and educators.
- Utilising the skills within the full multidisciplinary team such as the skills of the Allied Health Professionals (AHPs)

Where bay nursing is not possible ward staff will revert to task allocation.

Ward staffing numbers will potentially look very different and will include a different skill mix and professional support alongside registered nurse/midwife with several support workers, student nurses/student midwives, specialist nurses, outpatient & clinic nurses and AHP's, this will be a dynamic situation and will change accordingly. This will have a significant impact on our workforce and in line with the change in numbers all efforts should be made to increase the number of non- clinical support services such as housekeepers, porters, ward clerks, additional ward runners and volunteers.

In community nursing services when business continuity is fully enacted only essential patients visits will be undertaken.

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

DNDs or their deputies will undertake on a daily basis:

- A full safety walk round across all in patient areas.
- A divisional staffing meeting which will feed into trust wide staffing meeting.
- A divisional safety huddle reviewing incidents from the previous day and identifying any additional risks.
- Daily virtual staffing calls will be undertaken with Director of Nursing or Deputy Chief Nurse
- Matrons will be clinically visible in their portfolio.
- Daily covid Senior Management Team (SMT) brief for escalation of concerns

In addition, daily oversight will be undertaken by the Chief Nurses Senior Nursing Team with daily and weekly staffing meetings. Divisional Nurses Directors will keep a divisional log of the staffing bed capacity and service changes these logs will be held within the respective divisions.

A Quality Impact Assessment has been undertaken and will be reviewed on a weekly basis in line with the arrangements above.

## Conclusion

In light of current operational pressures with regard to bed capacity and workforce availability, it is recognised that in extreme circumstances staffing may fall below the minimum established levels and this carries additional risk as previous detailed. This a dynamic situation and may change frequently throughout the day however mitigation is in place and there is full oversight from Senior Nursing Teams.

## Recommendation

The Executive board are asked to acknowledge that should the staffing absence trajectories outweigh the temporary staffing and redeployment provisions to cover wards and departments with safe staffing levels, the absence of registered nurses and midwives from

rosters may compromise the delivery of care to those wards and departments resulting in a poor experience for both staff and patients .

The Executive board are asked to collectively approve, in times of extremis the revision of nursing and midwifery staffing levels with the risk mitigations outlined within this briefing

| | |
|---|---|
| **Title:** | People Committee Chair Report |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27th January 2022 | | Discussion | |
| **Exec Sponsor** | James Mawrey, Director of People | | Decision | |

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| **Summary:** | To update the Board on the work and activities of the People Committee in December 2021 and January 2022. |

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| **Previously considered by:** | |

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| **Proposed Resolution** | To note the updates from the Chair 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* | ✓ |

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

**Committee/Group Chair's Report**

NHS Bolton NHS Foundation Trust

| | | | |
|---|---|---|---|
| Name of Committee/Group: | People Committee | Report to: | Board of Directors |
| Date of Meeting: | 16th December 2021 | Date of next meeting: | 20th January 2022 |
| Chair: | Malcolm Brown | Parent Committee: | Trust Board |
| Members present/attendees: | James Mawrey, Martin North, Alan Stuttard, Fiona Noden, Francis Andrews, Sharon Martin, Andrew Chilton, Clare Williams, Lianne Robinson, Natasha McDonald, James Logue, Bridget Thomas, Esther Steel, Sharon Martin, Claire McPeake, Lisa Gammack, Paul Henshaw, Carol Sheard, Nicola Caffrey, Rachel Carter, Ryan Calderbank, Michaela Toms, Alex Cottrell, Rachel Hemingway, Kirstie Stott, Dawn Murray, Charlotte Greenhalgh, Lewis Fletcher | Quorate (Yes/No): | Yes |
| | | Key Members not present: | Karen Meadowcroft, Annette Walker, Michelle Cox, Angela Hansen |

| Key Agenda Items: | RAG | Key Points | Action/decision |
|---|---|---|---|
| Resourcing (inc OH Update/DBS Checks) | | • Updates where provided on the vaccination programme, noting that 60% of staff have had booster vaccinations.<br>• Detailed discussion regarding the preparations that are being taken to ensure all staff have received a vaccine by 1st April, 2022 (as per national guidance).<br>• Working alongside the COVID Vaccination programme we have the flu vaccination programme (currently 57% of staff)<br>• Recruitment KPI's reviewed and update on key recruitment activity provided (focused discussion on HCSW and Nursing).<br>• Mortuary services – the Trust received an official letter from NHSEI requesting that all organisations with a mortuary/body store undertake a review of existing mortuary/body store security against existing Human Tissue Authority (HTA) Guidelines. Report noted and received. Further information requested at February Committee. | • The paper was noted. Monthly updates to remain in place.<br>• Further update on Mandatory Vaccination programme at next meeting.<br>• Mortuary Services - Further information requested at February Committee. |
| Agency | | • The Committee received an update on the Nursing Agency performance against trajectory. It was noted that there had been a slight drop in the nurse agency bookings following the mitigating actions that have been taken. | • The paper was noted. Monthly updates to remain in place.<br>• It was requested that the next paper includes both Medical and Nursing Agency. |

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| | 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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| | | • It was noted that with the increase in COVID cases then it was likely that this downward movement would not be sustained.<br>• Bolton's dependency on Agency spend is representative of the wider NHS and is driven by the growth in service demands. | |
| Staff Experience, Health & Wellbeing Update | | • The plethora of actions being taken to support our staff where discussed in detail. Details have been shared and as such are not included to avoid repetition.<br>• During the pandemic our Trust has sustained lower sickness absence levels than the majority of other NHS organisations within Greater Manchester. | • The paper was noted.<br>• Next meeting to provide a full report on the recently published NHS Staff Health & Wellbeing Pledges. Ensuring all good practice is in place at our Trust. |
| People Development Update | | • This paper provides the People Committee with an update on key elements of the people development agenda delivered by the Organisational Development Service.<br>• The report was commended and provided information and assurance on current priorities and planned approaches. Non exhaustive - Leadership & Management Development, Medical leadership, Nurse Development, Coaching and mentoring, BAME Development, Inclusion. | • The Plan was commended |
| Apprenticeship Programme Update | | • It was projected by the year end there would have been 90 colleagues who would have commenced an apprentice programme for 2021/22. This is below the target of 138 and the Committee reported nervousness that the figure of 90 would indeed be achieved.<br>• Discussion ensued about the work being undertaken in the Bolton Locality to support this position. | • The paper was noted.<br>• Report back in the next meeting on confidence levels in the year end position, together with a deeper understanding of the work being undertaken in the locality. |

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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

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| | | • DDoF discussed the financial and noted these would be reported to the Finance Committee.<br>• Benchmark data was provided and other Trusts within the GM footprint are experiencing similar challenges with utilising full levy spend. | |
| 2021 NHS National Staff Survey | | • DDoOD confirmed that the NHS Staff Survey had closed and 2194 of our staff had completed the survey.<br>• Concern was raised that the difficult 12 months may adversely impact on our strong position in this area.<br>• The Committee will receive the full findings following embargo – February / March, 22. | • Verbal Update noted<br>• Full findings to the Committee following embargo. |
| Integrated Workforce Report (inc AHP Sickness Deep Dive) | | • The report triangulated the key workforce data at a Trust and Divisional level. | • Report was noted. |
| Steering Groups<br>• Staff Experience<br>• EDI<br>• Workforce Digitalisation | | | • Chair reports noted. |
| Divisional People Committee<br>• Integrated Care Services<br>• Anaesthetics & Surgery<br>• Diagnostics Services<br>• Family Care | | | • Chair reports noted. |

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

**Committee/Group Chair's Report**

NHS Bolton NHS Foundation Trust

| | | | |
|---|---|---|---|
| Name of Committee/Group: | People Committee | Report to: | Board of Directors |
| Date of Meeting: | 20th January 2022 | Date of next meeting: | 17th February 2022 |
| Chair: | Alan Stuttard | Parent Committee: | Trust Board |
| Members present/attendees: | James Mawrey, Martin North, Fiona Noden, Francis Andrews, Sharon Martin, Andrew Chilton, Esther Steel, Lisa Gammack, Carol Sheard, Nicola Caffrey, Rachel Carter. All the Divisions provided representation. | Quorate (Yes/No): | Yes |
| | | Key Members not present: | Malcolm Brown |

| Key Agenda Items: | RAG | Key Points | Action/decision |
|---|---|---|---|
| Terms of Reference | | • In line with good practice the Committee reviewed the TOR.<br>• Minor amendments were made and it was agreed that it would be helpful for these to be approved at the next meeting when Bilkis takes over as Chair. | • TOR noted and to be approved at next meeting. |
| Resourcing | | • Extensive discussion took place regarding the preparations that are being taken to ensure all staff have received a vaccine by 1st April, 2022 (as per national guidance). Currently 370 staff have not received the vaccine, with a number of these (circa 50-75) noting that they do not intend to have the vaccine.<br>• The Committee received an update on the procedural actions that are taking place over the coming weeks/months. Neighbouring GM organisations are operating in a standard approach. Trade Union organisations have been fully engaged.<br>• Updates where provided on the plethora of recruitment actions that are taking place throughout the organisation. Including updates in International recruitment (Nursing) and hard to fill posts (all). Our recruitment KPI's continue to benchmark positively, albeit staffing remains an acute issue given the extra operational pressures. | • The paper was noted. Monthly updates to remain in place.<br>• Further update on Mandatory Vaccination programme at next meeting.<br>• DoP to ensure he has the most 'up to date' Mandatory Vaccination numbers for BoD on 27th January, 22. |

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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

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| Agency | | • The Committee received an update on the Agency performance (Medical and Non-Medical). It was noted that given the extreme operational pressures then Agency has not reduced in line with the trajectories presented at the last meeting (trajectories set pre-OMICRON wave). | • The paper was noted. Monthly updates to remain in place. |
| Winter Staffing BAF | | • The Committee received the Winter Staffing which summarises our self-assessment and compliance to NHSE/I workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB).<br>• A key requirement was to ensure that the Self Assessment was supported by the necessary evidence to ensure compliance. | • The paper was noted and supported the monitoring arrangements in place.<br>• The Chief Nurse highlighted that it is a requirement for this to receive BoD level scrutiny. |
| Omicron Minimum Staffing Levels | | • The Committee noted that, in light of OMICRON, the Chief Nurse and Corporate Director of Nursing, have assessed the current staffing establishments and skill mix for all ward areas. Minimum staffing levels have been set that each department could tolerate to ensure the fundamental basics of nursing and patient care can be delivered.<br>• It was noted that a reduction in staffing numbers will only be in extremis and a return to established numbers would be expected as soon as operationally possible.<br>• When asked the Corporate Director of Nursing confirmed that no ward areas had operated below these minimum staffing levels. | • The paper was noted.<br>• The Chief Nurse highlighted that it is a requirement for this to receive BoD level scrutiny. |
| NW Staff Wellbeing Pledge Enabling Action Plan | | • The Committee noted that national pledges that have been set. The Committee where assured that the actions put in place met these requirements and felt they were exceeded in this organisation.<br>• During the pandemic our Trust has sustained lower | • The paper was noted and supported the monitoring arrangements in place.<br>• The Committee asked that the various measures be assessed in terms of the uptake by staff. |

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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

| | | | |
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| | | sickness absence levels than the majority of other NHS organisations within Greater Manchester. | |
| Apprenticeship Programme 2021/22 Quarter 3 update | | • The Quarter 3 update was provided to the Committee.<br>• The position has changed little since last month's update and as such is not included in this narrative section. | • The paper was noted. |
| Freedom to Speak Up 2021/22 Quarter 3 update | | • The Committee welcomed this report and commended all the excellent work.<br>• During the period from 1st October 2021 to 31st December 2021 (Q3) a total of 36 cases were reported through the FTSU route. This is a decrease of 13 from the previous quarter (Committee were not concerned by this drop as reporting remains high).<br>• The FTSU champions met all KPI to ensure our staff received a response in a timely manner.<br>• There was no disproportionate amount of concerns raised for colleagues with protected characteristics and attitude remains the main reason for raising a concern. | • The paper was commended. |
| HEENW Action Plan | | • The Committee received a report that provided assurance of the monitoring actions that are taking place to ensure further improvements in our HENW monitoring action plan.<br>• The Committee thanked the Medical Director for personal overseeing this work programme. Noting that it is important that this becomes BAU in the Divisions. | • Report was noted. |
| Integrated Workforce Report (inc AHP Sickness Deep Dive) | | • The report triangulated the key workforce data at a Trust and Divisional level. | • Report was noted. |

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| | Assured – no or minor impact on quality, operational or financial performance |

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

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|---|---|
| **Title:** | 2022/23 Operational Planning Guidance |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | |
| **Date:** | 27 January 2022 | | Discussion | ✓ |
| **Exec Sponsor** | Sharon Martin | | Decision | |

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| **Summary:** | This presentation provides a summary of the 2022/23 Operational Planning Guidance and describes the internal and system approach to plan development and submission. This year's plan is fundamentally transformational for organisations and systems. |

| | |
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| **Previously considered by:** | N/A |

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| **Proposed Resolution** | The Board is asked to note the priorities and the proposed approach to development of the plan. |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Rachel Noble, Deputy Director of Strategy | **Presented by:** | Sharon Martin, Director of Strategy & Transformation |

NHS
Bolton
NHS Foundation Trust

# Operational Planning Guidance: Overview of priorities 2022/23

Sharon Martin
Director of Strategy & Transformation

# In summary

- The 2022/23 Operational Plan requires fundamental transformation, both within organisations and at system level
- The targets summarised in this slide deck will form the basis of our transformation plans for the year
- The plan is based on a low-covid scenario and therefore targets recovery as the highest priority
- This slide pack summarises priorities against each theme

# Workforce

- Accelerate transformation and growth of the workforce
- Improve retention
- Improve belonging and equality
- Introduce new roles and develop the workforce to deliver care closer to home
- Grow for the future through expanded international recruitment and supporting training programmes

# Elective

- Participate in the development and delivery of a system-wide elective care recovery plan with the aim of delivering 10% more elective activity than pre-pandemic
- Reduce long waits and eliminate number of patients waiting over 104 weeks
- Reduce number of patients waiting over 78 weeks
- Extend 3-monthly reviews to all patients waiting over 52 weeks by 1 July 2022
- Outpatient follow-up should reduce by a minimum of 25% against 2019-20 activity levels by March 2023
- Elective, UEC, social care and mental health must be managed in such a way as to protect elective recovery and minimise disruptions

# Cancer

- H2 objectives / standards remain.
- Cancer alliances are asked to work with local systems to improve performance against all cancer standards, with a number of specific areas of focus including:
  - Maximising capacity for cancer care
  - Ensure sufficient diagnostic and treatment capacity to meet increased referral levels
  - Accelerating development of rapid diagnostic pathways

# Diagnostics

- Systems should increase diagnostic activity to 120% of pre-pandemic levels to support elective recovery and early cancer diagnosis. It is expected that capacity will expand further in 2023/24 and 24/25
- This is supported by 3-year capital allocations and planned investment through HEE to train and develop the workforce, and dedicated revenue funding to support the set up and running of Community Diagnostic Centres
- Diagnostic equipment over 10 years old should continue to be replaced

# UEC

- Systems are expected to reduce 12hr waits in ED towards zero and no more than 2%
- Work needed to minimise handover delays between ambulance crews and hospitals to support achievement of ambulance response standards
- Urgent Treatment Centre provision should be expanded

# Community services capacity

- Ensuring timely discharge is a major focus.
- Up to £200m will be available in 2022/23 and up to £250m in 2023/24 to support the development of virtual wards

# Financial

- The 2021 spending review provided a 3-year settlement for both capital and revenue. The next slide details this year's allocations
- One-year revenue allocations will be published shortly, with remaining allocations to be published in the new financial year
- Capital: total capital for the NHS over the next 3 years is £23.8bn, which includes £4.2bn to support the building of 40 new hospitals and the upgrade of over 70 hospitals
- The financial settlement assumes that the NHS takes out costs and delivers additional efficiencies

# Investment – including 2021 spending review commitments

- £2.3bn elective recovery funding has been allocated to support systems recover during 2022/23
- £1.5bn capital has been made available to the NHS over the next 3 years to develop new surgical hubs, increase bed capacity and provide equipment
- £21m programme funding is available to support pathology and imaging networks, and plans should include the use of AI in diagnostics
- C.£93m will go into baselines from 2022/23 to invest in workforce and support the implementation of actions from the Ockendon report
- £250m will be allocated and directed to services that are the least digitally mature

# Financial framework

- Allocations will be based on current system funding envelopes but will ‘begin a glide path to fair share allocations’
- There will be a requirement to deliver a financially balanced system through collective local accountability across system partners
- 2022/23 sees a return to local ownership for payment flows, with signed contracts between commissioners and providers. Local systems are expected to take a partnership approach to establishing payment terms
- Where systems outperform their recovery trajectories, additional revenue will be available

# System plans

- Each system will need to develop delivery plans across elective inpatient, outpatient and diagnostic services for adults and children for 2022/23
- The plans should include how systems will meet the elective recovery ambitions and how services will be organised to maximise productivity
- Recovery must be inclusive, addressing health inequalities

# Approach

- Planning process is led by the Director of Strategy.
- Internally, our annual Task & Finish Group will be reconvened with input from across the organisation.
- Oversight will be through weekly Executive meeting.
- DDOs will be consulted on approach to development of plans
- Expectation that we will submit a system plan. A Greater Manchester working group will meet weekly from 24 January 2022
- Draft plans to be submitted mid-March with final submission deadline of end of April
- Board will be sighted on the draft plan directly and through sub committees prior to submission

# What this means for strategy development

- The plan will inform development of our revised corporate strategy and will underpin conversations around Clinical Service Strategies.
- This in turn will inform development of Estates, Digital, Quality Improvement and People plans / strategies

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|---|---|
| **Title:** | Integrated Performance Report |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | X |
| **Date:** | 27th January 2022 | | Discussion | X |
| **Exec Sponsor** | James Mawrey | | Decision | |

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

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| **Previously considered by:** | Divisional IPMs |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Emma Cunliffe (BI) | **Presented by:** | James Mawrey |

Bolton NHS Foundation Trust

# Integrated Performance Report

December 2021

# Guide to Statistical Process Control

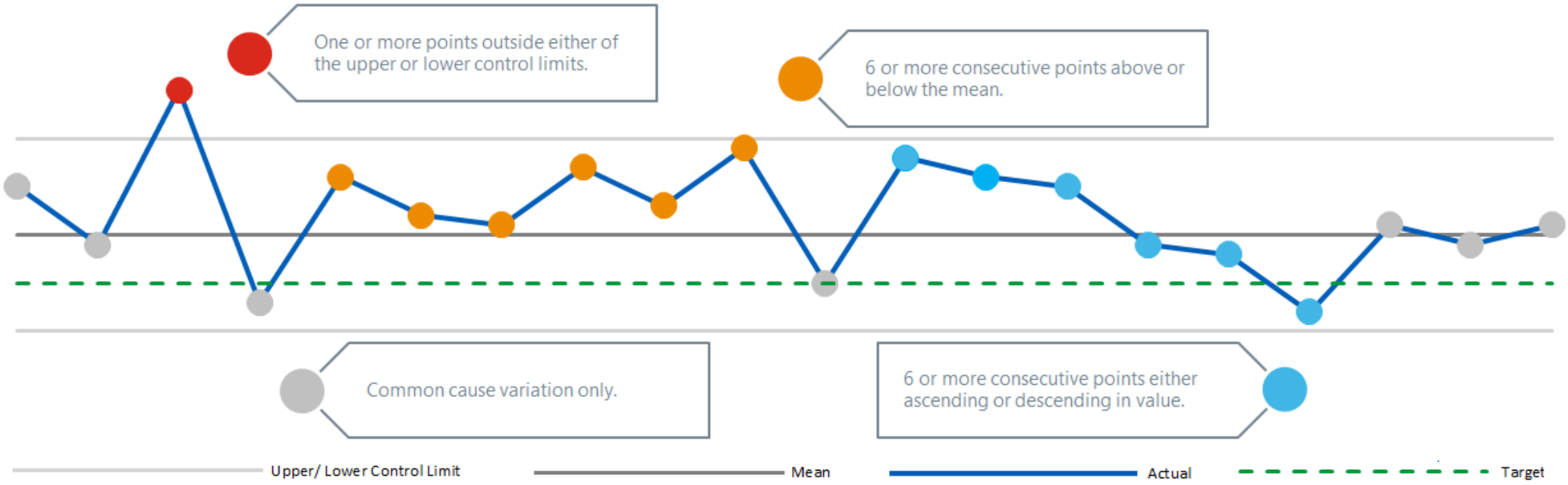
NHS Bolton NHS Foundation Trust

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

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

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

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



# Executive Summary

NHS Bolton NHS Foundation Trust

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

## Variation

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

## Assurance

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

# Quality and Safety

## Harm Free Care

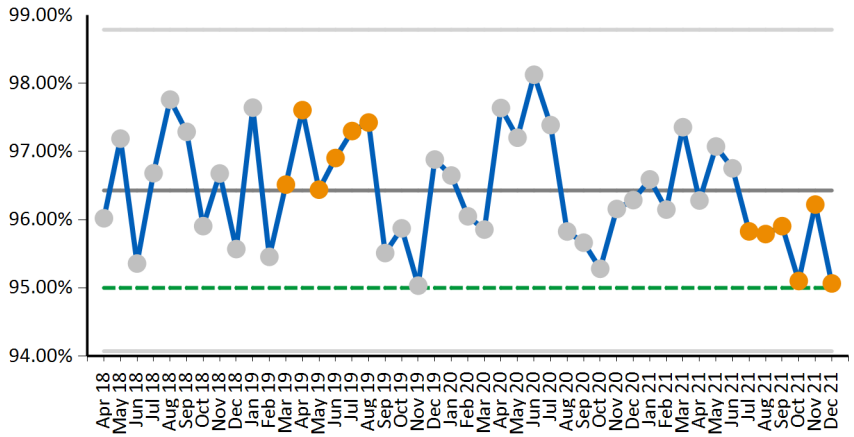
Pressure Ulcer Narrative
Numbers have increased in December in the hospital setting, with an increase to 11 category 2 pressure ulcers, and 1 category 3 pressure ulcer. These incidents are still under review, and work with be undertaken in the divisions to support actions plans.
In the community setting, there were 7 Category 2 pressure ulcers and 1 category 3 pressure ulcer. Learning continues to be shared within the division.

Falls
Falls remain within common cause variation, with a slight decrease on the previous month in falls per 1000 bed days.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 6 - Compliance with preventative measure for VTE | >= 95% | 95.1% | Dec-21 | | >= 95% | 96.2% | Nov-21 | >= 95% | 96.0% | |
| 9 - Never Events | = 0 | 0 | Dec-21 | | = 0 | 0 | Nov-21 | = 0 | 1 | |
| 13 - All Inpatient Falls (Safeguard Per 1000 bed days) | <= 5.30 | 5.64 | Dec-21 | | <= 5.30 | 5.85 | Nov-21 | <= 5.30 | 5.22 | |
| 14 - Inpatient falls resulting in Harm (Moderate +) | <= 1.6 | 6 | Dec-21 | | <= 1.6 | 0 | Nov-21 | <= 14.4 | 24 | |
| 15 - Acute Inpatients acquiring pressure damage (category 2) | <= 6.0 | 11.0 | Dec-21 | | <= 6.0 | 3.0 | Nov-21 | <= 54.0 | 53.0 | |
| 16 - Acute Inpatients acquiring pressure damage (category 3) | <= 0.5 | 1.0 | Dec-21 | | <= 0.5 | 0.0 | Nov-21 | <= 4.5 | 3.0 | |
| 17 - Acute Inpatients acquiring pressure damage (category 4) | = 0.0 | 0.0 | Dec-21 | | = 0.0 | 0.0 | Nov-21 | = 0.0 | 0.0 | |
| 18 - Community patients acquiring pressure damage (category 2) | <= 7.0 | 2.0 | Dec-21 | | <= 7.0 | 2.0 | Nov-21 | <= 63.0 | 67.0 | |
| 19 - Community patients acquiring pressure damage (category 3) | <= 4.0 | 7.0 | Dec-21 | | <= 4.0 | 9.0 | Nov-21 | <= 36.0 | 87.0 | |

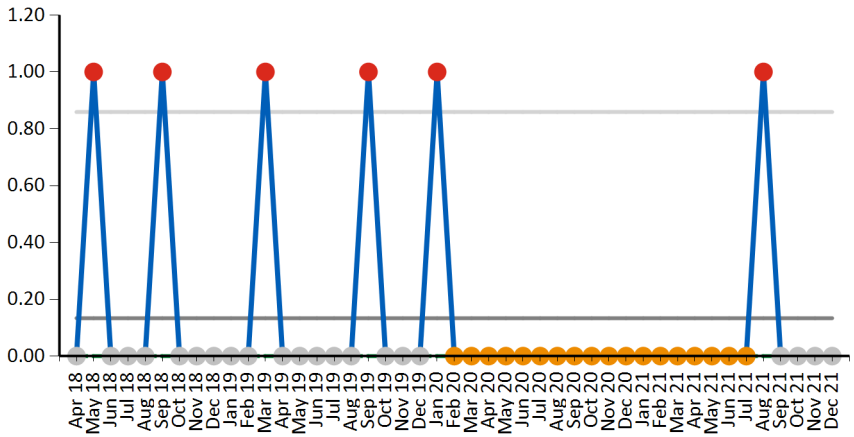
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 20 - Community patients acquiring pressure damage (category 4) | <= 1.0 | 1.0 | Dec-21 | | <= 1.0 | 2.0 | Nov-21 | <= 9.0 | 20.0 | |
| 28 - Emergency patients - screened for Sepsis (quarterly) | >= 90% | 82.1% | Q2 2021/22 | | >= 90% | 66.7% | Q1 2021/22 | >= 90% | 74.3% | |
| 29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) | >= 90% | 100.0% | Q2 2021/22 | | >= 90% | 80.0% | Q1 2021/22 | >= 90% | 90.0% | |
| 513 - Inpatients - screened for Sepsis (quarterly) | | | | | | | | | | |
| 514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) | | | | | | | | | | |
| 30 - Clinical Correspondence - Inpatients %<1 working day | >= 95% | 76.9% | Dec-21 | | >= 95% | 74.0% | Nov-21 | >= 95% | 72.3% | |
| 31 - Clinical Correspondence - Outpatients %<5 working days | >= 95.0% | 68.9% | Dec-21 | | >= 95.0% | 72.9% | Nov-21 | >= 95.0% | 66.0% | |
| 86 - NHS Improvement Patient Safety Alerts (CAS) Compliance | = 100% | 50.0% | Dec-21 | | = 100% | 50.0% | Nov-21 | = 100% | 51.9% | |
| 88 - Nursing KPI Audits | >= 85% | 92.7% | Dec-21 | | >= 85% | 92.5% | Nov-21 | >= 85% | 92.6% | |
| 91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days | = 100% | 0.0% | Dec-21 | | = 100% | 50.0% | Nov-21 | = 100% | 70.0% | |

### 6 - Compliance with preventative measure for VTE




6/6

### 9 - Never Events

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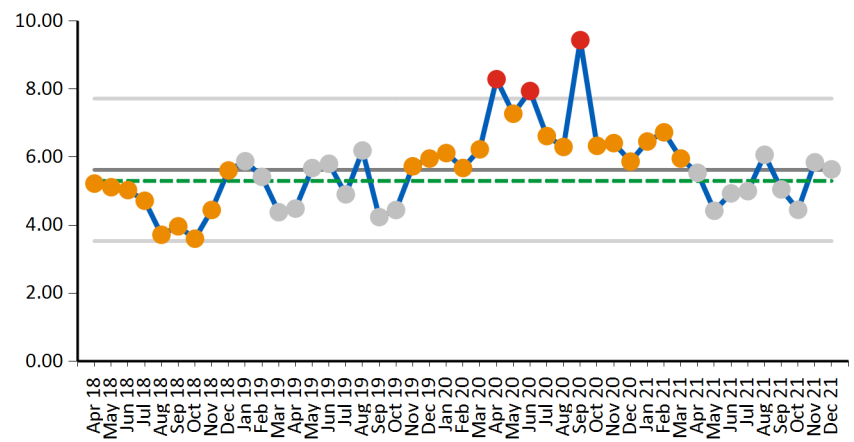
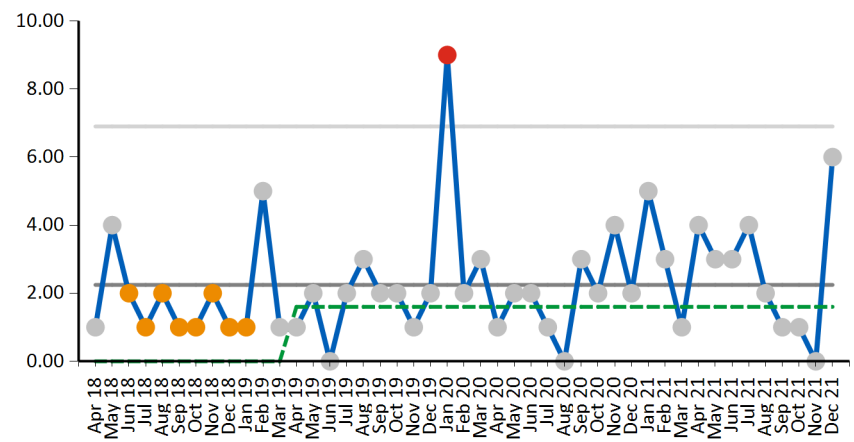
### 13 - All Inpatient Falls (Safeguard Per 1000 bed days)




3/6

### 14 - Inpatient falls resulting in Harm (Moderate +)

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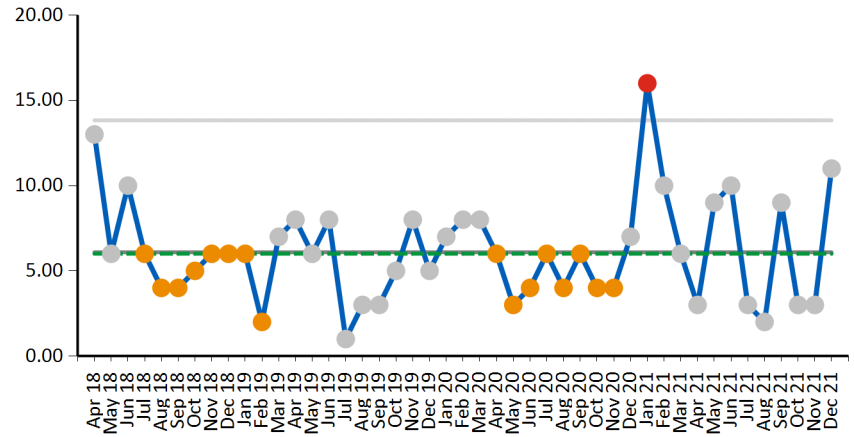
### 15 - Acute Inpatients acquiring pressure damage (category 2)

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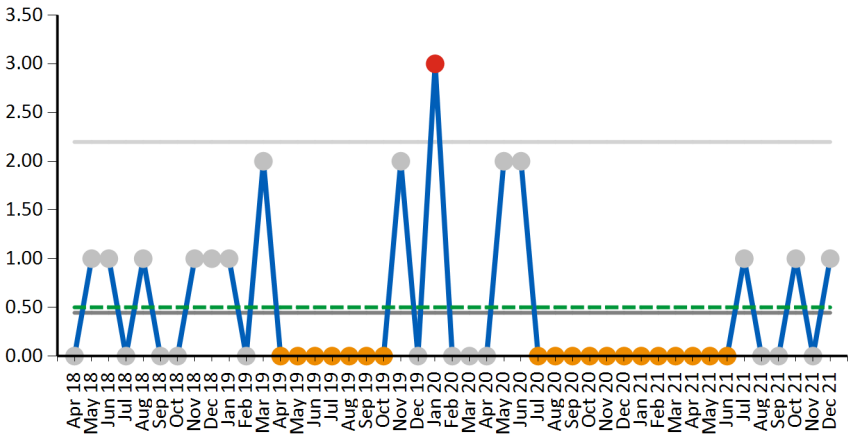
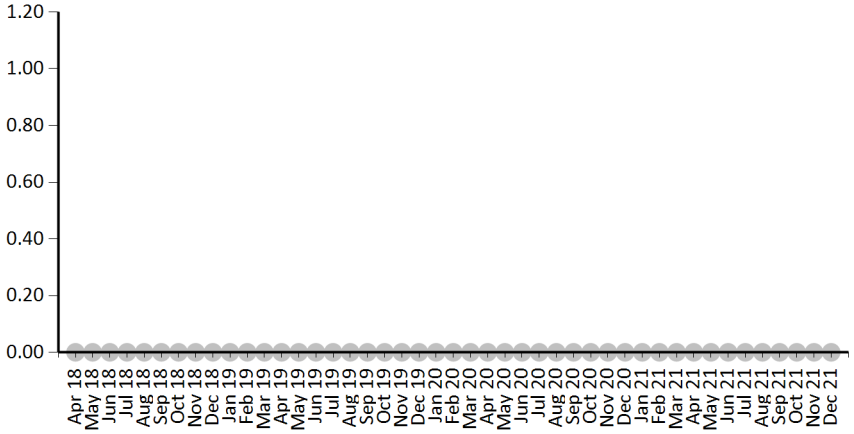
### 16 - Acute Inpatients acquiring pressure damage (category 3)



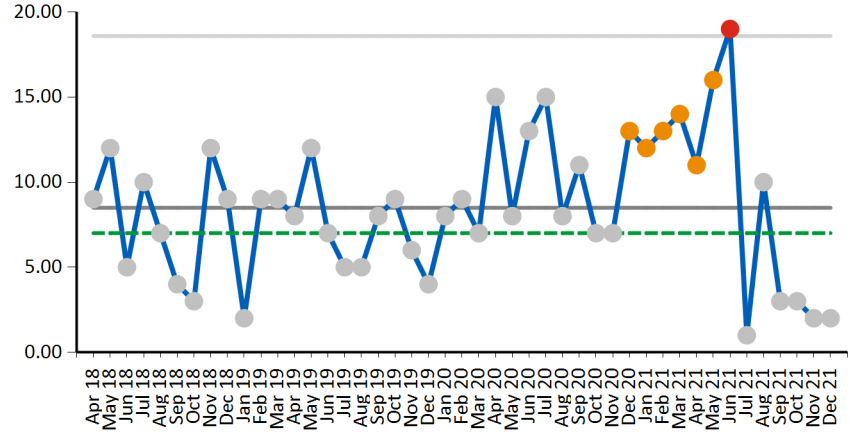

3/6

### 17 - Acute Inpatients acquiring pressure damage (category 4)



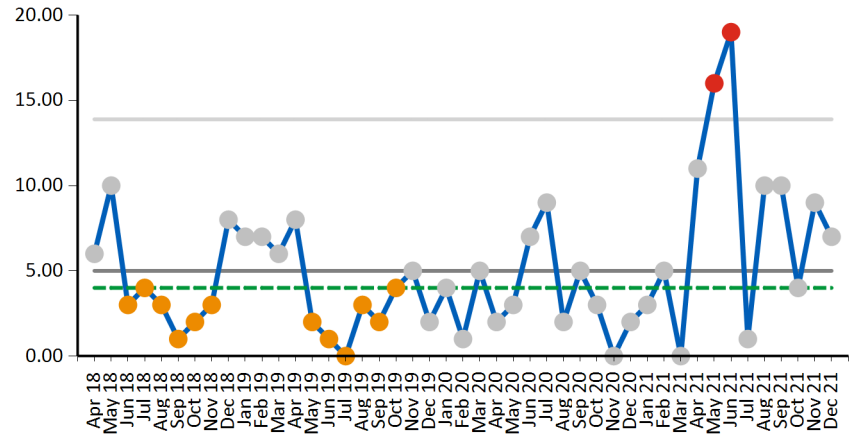

6/6

### 18 - Community patients acquiring pressure damage (category 2)



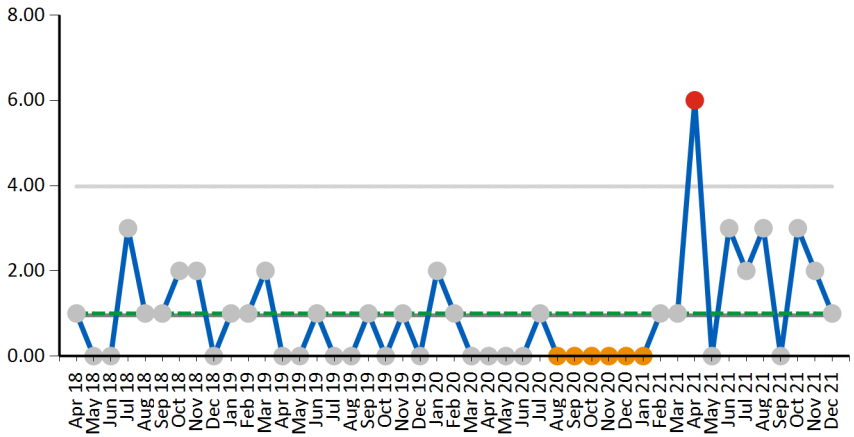

5/6

**19 - Community patients acquiring pressure damage (category 3)**



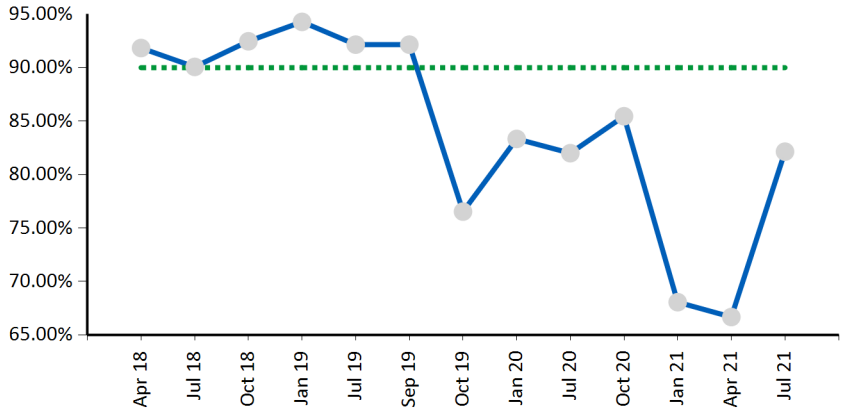

2/6

**20 - Community patients acquiring pressure damage (category 4)**




2/6

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

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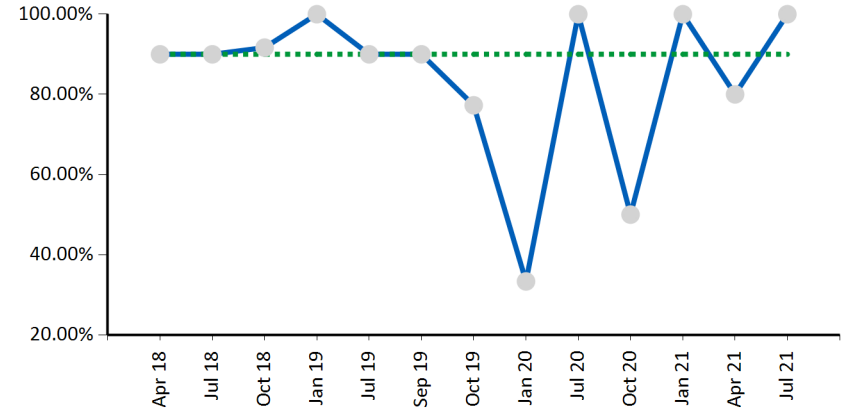
**29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points**

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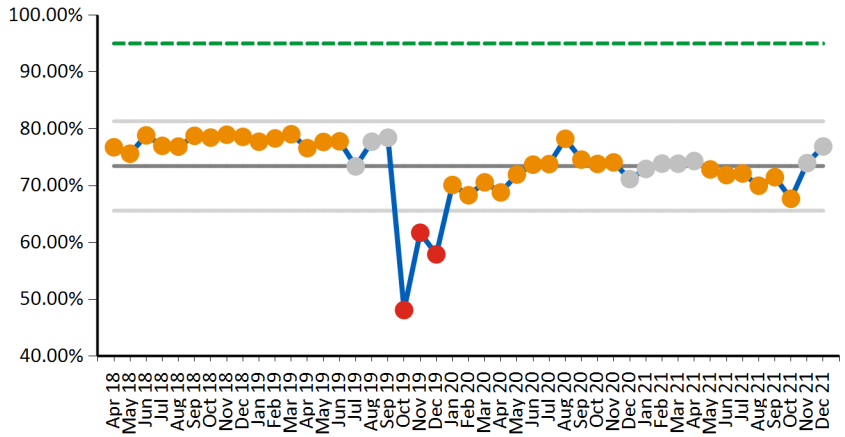
### 30 - Clinical Correspondence - Inpatients %<1 working day

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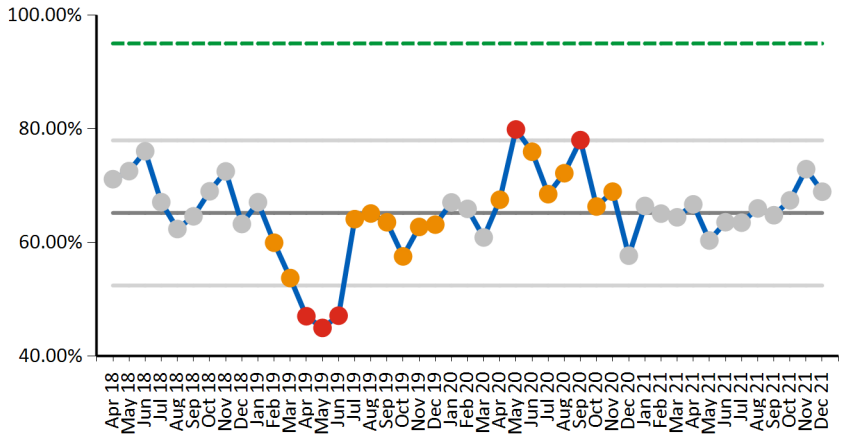
### 31 - Clinical Correspondence - Outpatients %<5 working days

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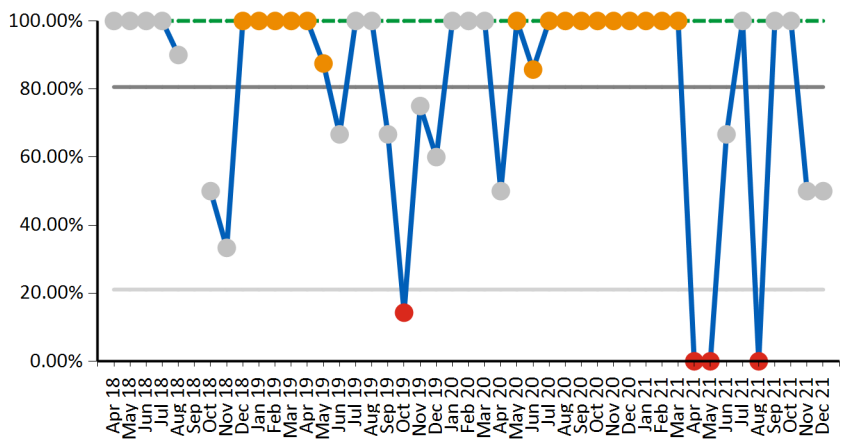
### 86 - NHS Improvement Patient Safety Alerts (CAS) Compliance

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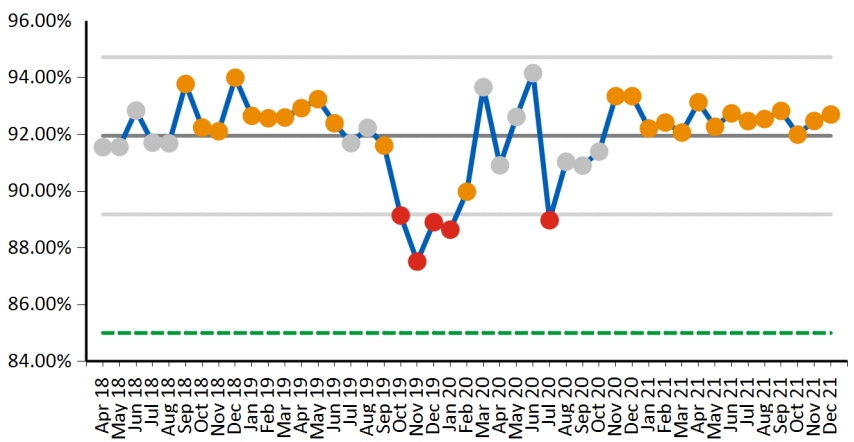
### 88 - Nursing KPI Audits

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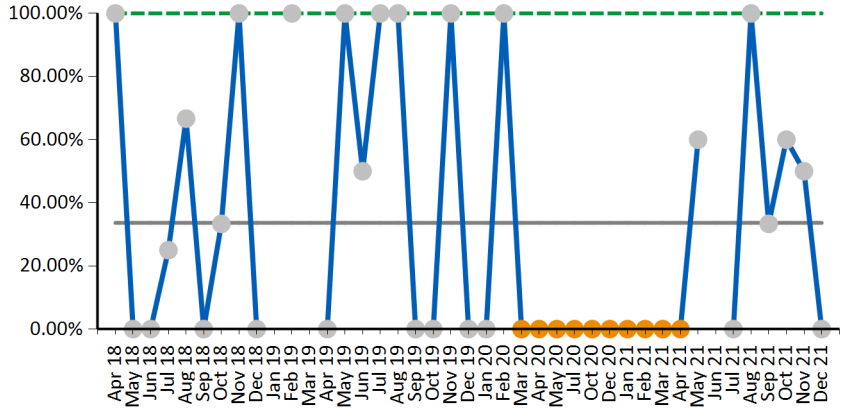
**91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days**



## Infection Prevention and Control

The key recent pressures related to IPC has been the impact of the recent surge of COVID-19 related to the Omicron Variant. There were 47 nosocomial cases in December compared with seven in November. The reason for this has been multifactorial: more patients admitted for reasons other than COVID-19 with no signs/symptoms who were initially screen negative, an increase in the proportion of people who tested negative on their admission screen who may have been incubating infection from admission and have tested positive on their day three or five screen (2.5% in September, 5% in October, 3.5% in November and 7% in December) which have led to effective and rapid nosocomial spread. There has also been a substantial burden of infection on staff with 1947 samples for staff being processed by the Trust labs in December of which 687 (35%) were positive; this compares with 586 and 56 (9.5%) in November. The IPC team and divisional teams have reinforced safe IPC practice in response to this new pressure.

At the end of December, it had been more than 539 days since there had been a hospital-onset MRSA bloodstream infection.

The Trust remains under trajectory for E. coli bloodstream infections (by 11 cases to the end of December) and under trajectory for Klebsiella spp. bloodstream infections (by six cases to the end of December). The internal target for MSSA bloodstream infections has been breached but this may well be reflective of the clinical pressures over the December period; a thematic review was undertaken of the cases in November and one recurrent theme (two cases) noted related to peripheral cannula care. The IPC team are working with the clinical teams to promote best practice with peripheral cannula care.

The Trust remains an outlier for Clostridium difficile infections and has exceed the year-end target of 58 cases by the end of December. The IPC service (IPC team, medical microbiologists and antimicrobial pharmacists) are working with the divisions on the key issues arising from the case reviews; appropriate antibiotic use and review and rational use of clinical sampling to inform treatment. There is no evidence of there being a specific concern related to cross-infection.

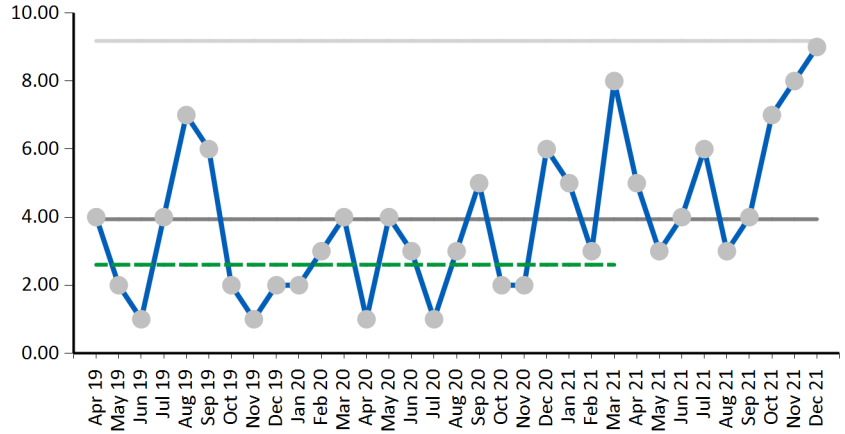
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

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

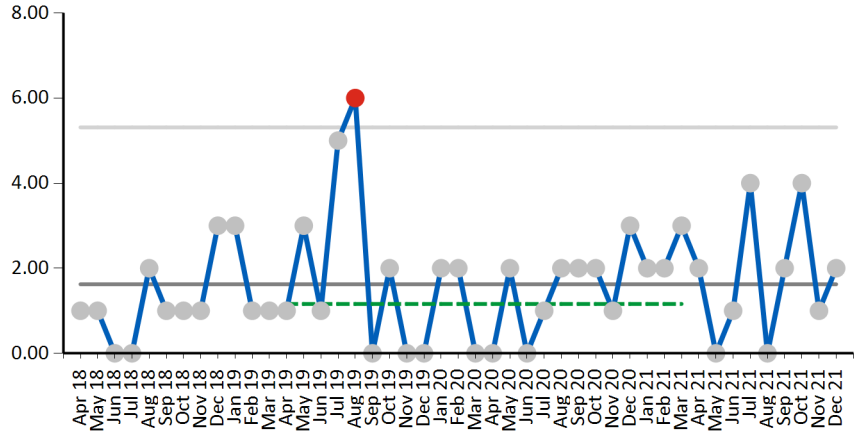
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 215 - Total Hospital Onset C.diff infections | | 9 | Dec-21 |  | | 8 | Nov-21 | | 49 | |
| 346 - Total Community Onset Hospital Associated C.diff infections | | 2 | Dec-21 |  | | 1 | Nov-21 | | 16 | |
| 347 - Total C.diff infections contributing to objective | <= 3 | 11 | Dec-21 |  | <= 3 | 9 | Nov-21 | <= 23 | 65 |  |
| 217 - Total Hospital-Onset MRSA BSIs | = 0 | 0 | Dec-21 |  | = 0 | 0 | Nov-21 | = 0 | 0 |  |
| 218 - Total Trust apportioned E. coli BSI (HOHA + COHA) | <= 2 | 3 | Dec-21 |  | <= 2 | 10 | Nov-21 | <= 16 | 46 |  |
| 219 - Blood Culture Contaminants (rate) | <= 3% | 3.0% | Dec-21 |  | <= 3% | 4.1% | Nov-21 | <= 3% | 3.4% |  |

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 199 - Compliance with antibiotic prescribing standards | >= 95% | 74.8% | Q2 2021/22 | | >= 95% | 84.0% | Q1 2021/22 | >= 95% | 79.4% | |
| 304 - Total Trust apportioned MSSA BSIs | <= 1.0 | 3.0 | Dec-21 | | <= 1.0 | 7.0 | Nov-21 | <= 9.0 | 14.0 | |
| 305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA) | <= 1 | 1 | Dec-21 | | <= 1 | 1 | Nov-21 | <= 5 | 6 | |
| 306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA) | = 0 | 1 | Dec-21 | | = 0 | 1 | Nov-21 | = 0 | 2 | |
| 491 - Nosocomial COVID-19 cases | | 47 | Dec-21 | | | 7 | Nov-21 | | 75 | |

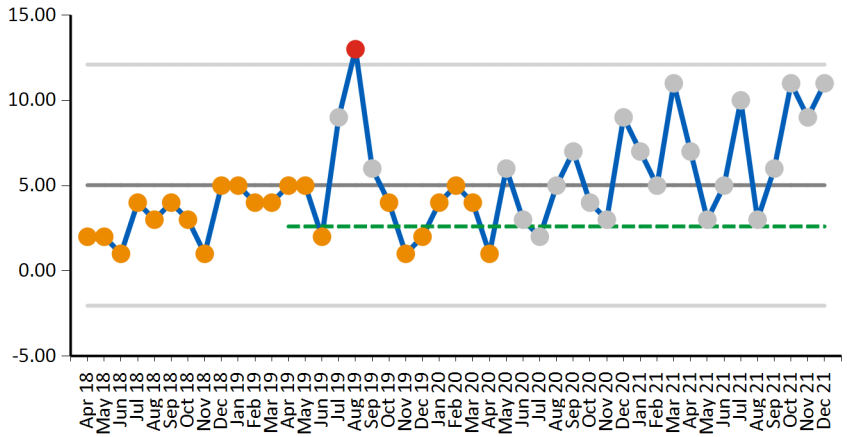
**215 - Total Hospital Onset C.diff infections**




**346 - Total Community Onset Hospital Associated C.diff infections**

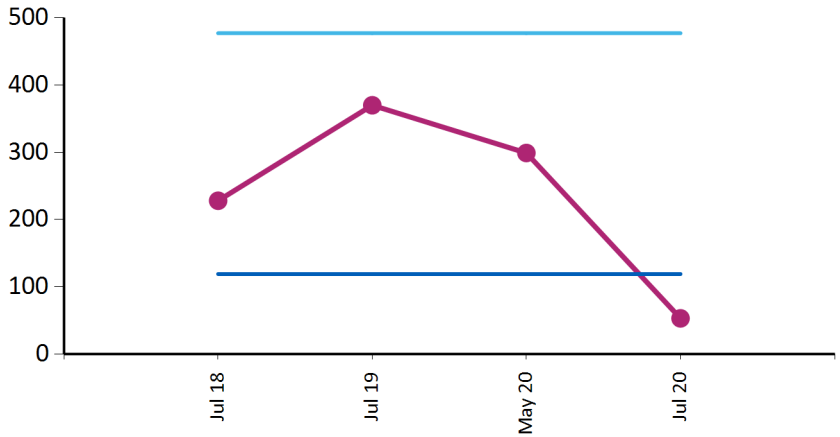


**347 - Total C.diff infections contributing to objective**

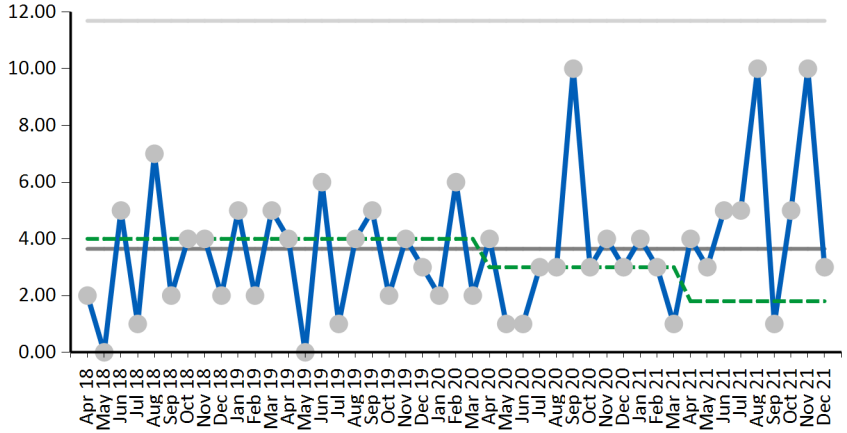




**217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)**

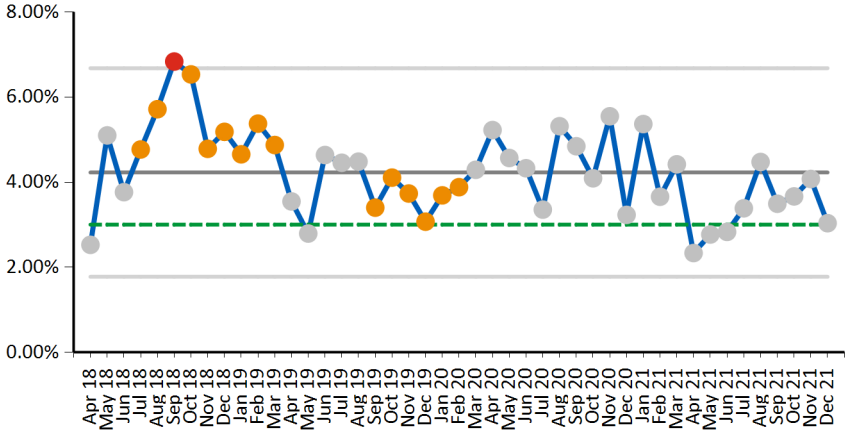



**218 - Total Trust apportioned E. coli BSI (HOHA + COHA)**

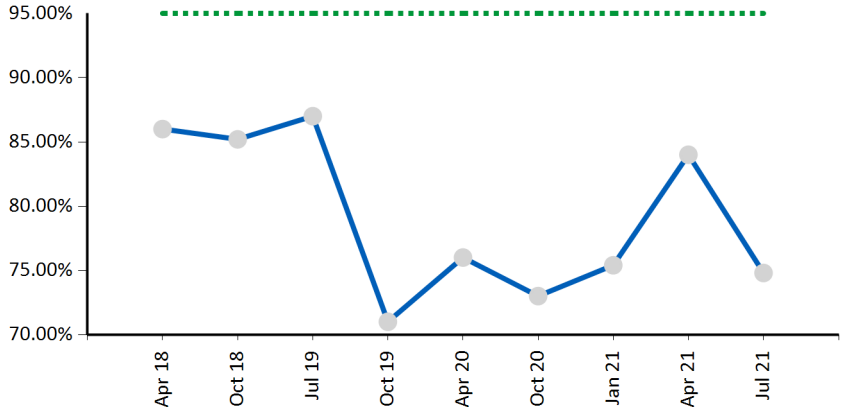




**219 - Blood Culture Contaminants (rate)**




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

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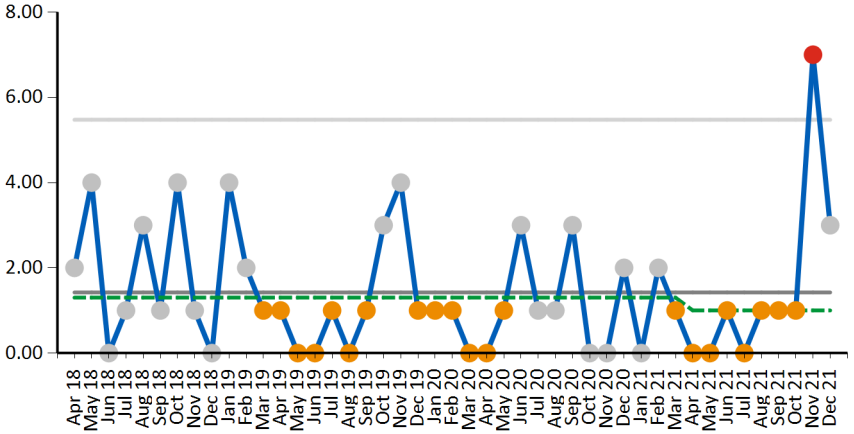
**304 - Total Trust apportioned MSSA BSIs**

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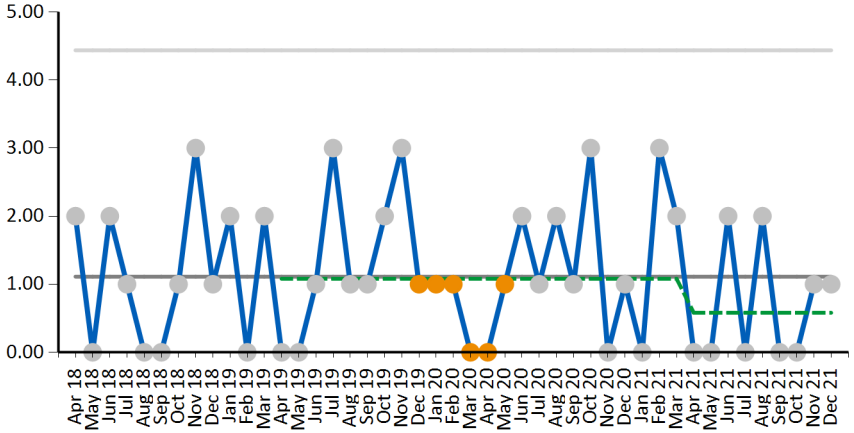
**305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)**

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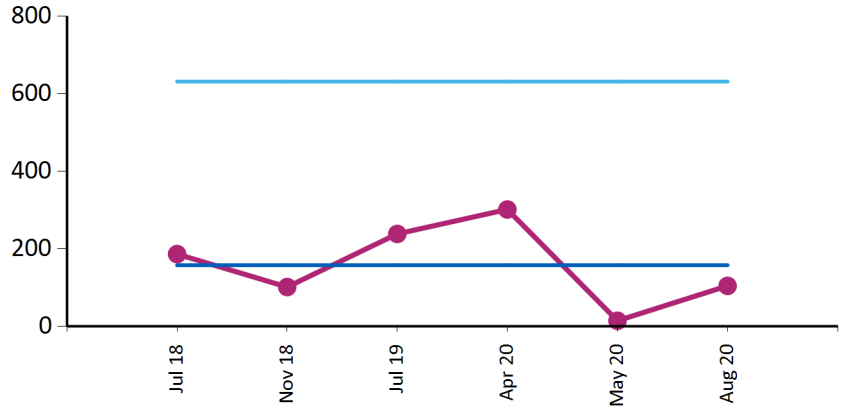
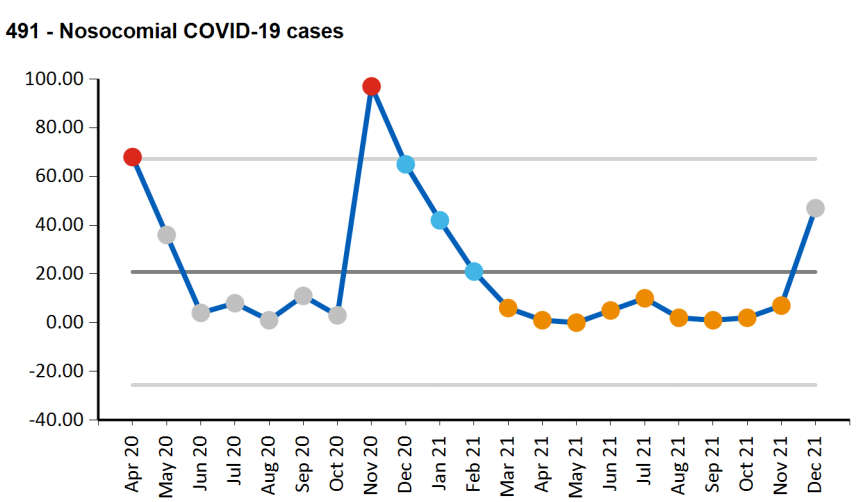
**306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA) - G Chart (Days Between Cases)**




491 - Nosocomial COVID-19 cases
100.00
80.00
60.00
40.00
20.00
0.00
-20.00
-40.00
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21

## Mortality

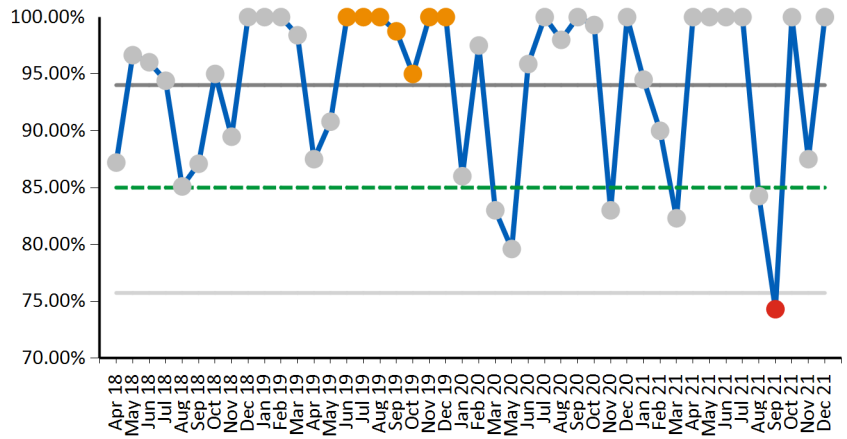
SHMI – in month position is within expected range.  12-month average (August 2020 to July 2021) is 111.92 and is 'as expected'.

HSMR – in month position is within expected range.  12-month average (October 2020 to September 2021) is 116.91 is a red alert and is highest amongst peers. Comparatively, against other trusts, the recording of comorbidities is lower which impacts upon the risk adjusted scores and reducing the overall HSMR (and SHMI). Awareness raising continues throughout the Trust to improve this.

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

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 3 - National Early Warning Scores to Gold standard | >= 85% | 100.0% | Dec-21 | | >= 85% | 87.5% | Nov-21 | >= 85% | 94.0% | |
| 495 - HSMR | | 125.40 | Sep-21 | | | 130.82 | Aug-21 | | 125.40 | |
| 11 - Summary Hospital-level Mortality Indicator (SHMI) | <= 100.00 | 137.34 | Jul-21 | | <= 100.00 | 115.69 | Jun-21 | <= 100.00 | 137.34 | |
| 12 - Crude Mortality % | <= 2.9% | | Dec-21 | | <= 2.9% | 2.5% | Nov-21 | <= 2.9% | 2.4% | |

### 3 - National Early Warning Scores to Gold standard

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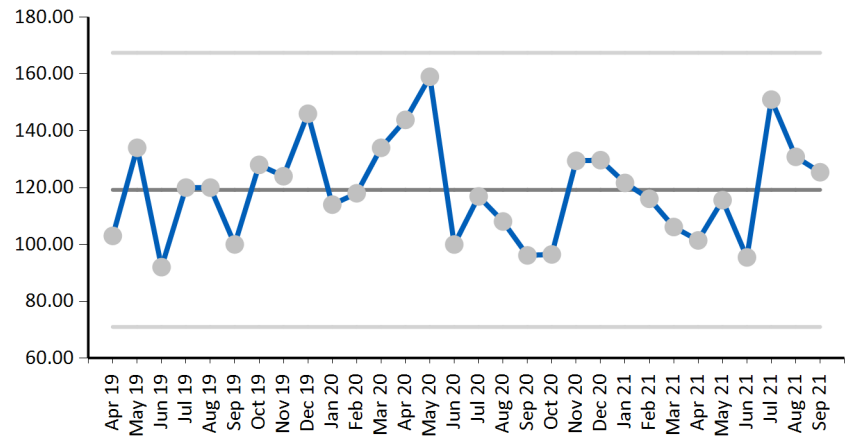
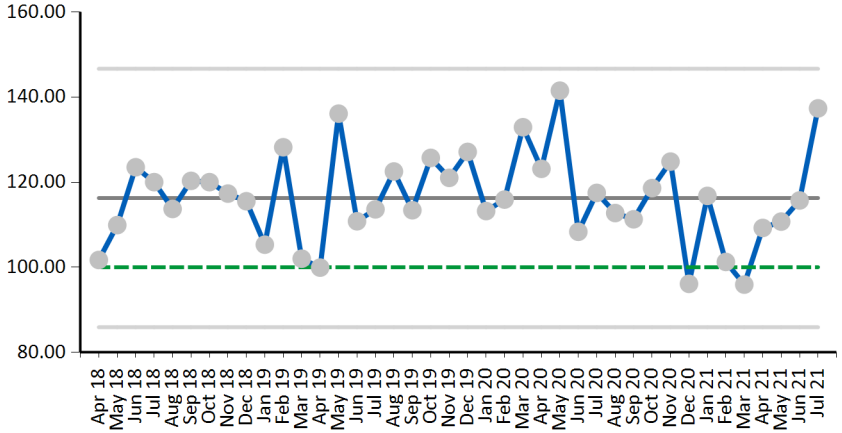
### 495 - HSMR




### 11 - Summary Hospital-level Mortality Indicator (SHMI)

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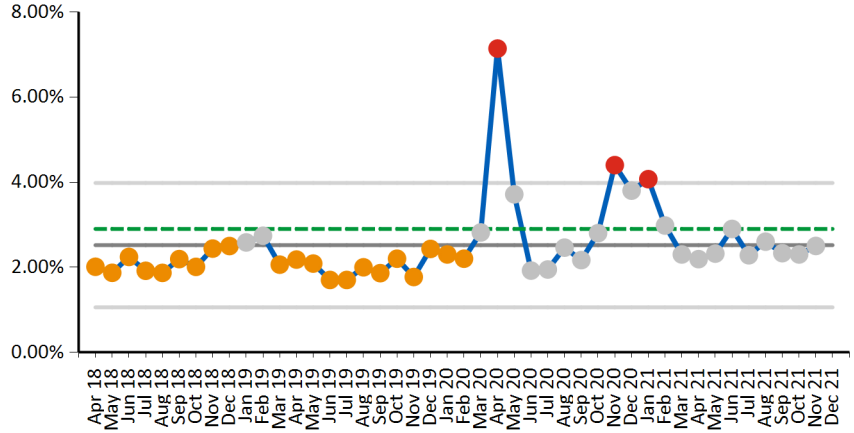
### 12 - Crude Mortality %

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## Patient Experience

FFT
NHSE continue to publish FFT data on their website and all areas within the Trust have improved their collection methods as safely as possible using QR codes and available devices. The response rates are varied with some areas showing above 100%. This is because the latest NHSE guidance is that people can provide feedback as often as they like during their episode of care.

All areas who traditionally collect FFT by paper now have access to QR codes with the expectation that response rates will improve.

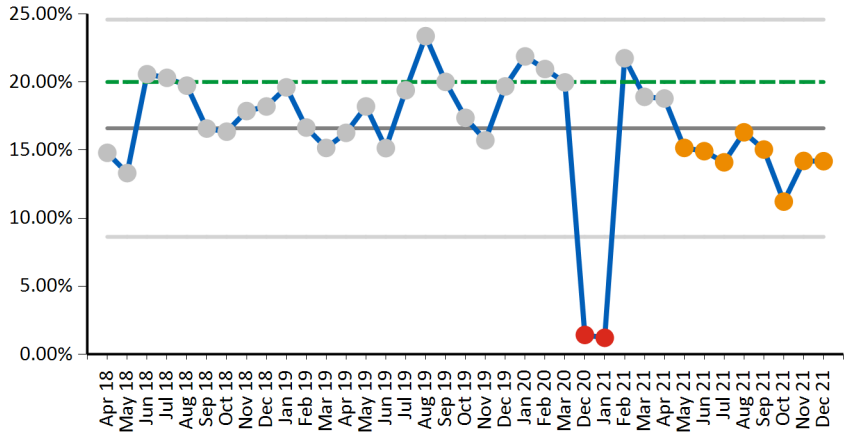
The Patient Experience Team are working with the Maternity Teams to review their collection methods and to identify good practice and work with those areas where improvement is needed. All Divisions have been asked to focus on their recommendation rates as some areas have fallen below 90%.

Complaints
The Trust rate for acknowledging complaints during December was 100%. The response rate was 83.3% with two cases breaching. A review of the breached cases has been undertaken to establish the cause and whether these could have been avoided. The management of complaints is under constant review.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 200 - A&E Friends and Family Response Rate | >= 20% | 14.2% | Dec-21 | | >= 20% | 14.2% | Nov-21 | >= 20% | 14.9% | |
| 294 - A&E Friends and Family Satisfaction Rates % | >= 90% | 85.0% | Dec-21 | | >= 90% | 82.3% | Nov-21 | >= 90% | 84.1% | |
| 80 - Inpatient Friends and Family Response Rate | >= 30% | 14.3% | Dec-21 | | >= 30% | 19.7% | Nov-21 | >= 30% | 19.7% | |
| 240 - Friends and Family Test (Inpatients) - Satisfaction % | >= 90% | 96.1% | Dec-21 | | >= 90% | 97.4% | Nov-21 | >= 90% | 96.7% | |
| 81 - Maternity Friends and Family Response Rate | >= 15% | 13.2% | Dec-21 | | >= 15% | 15.0% | Nov-21 | >= 15% | 12.8% | |
| 241 - Maternity Friends and Family Test - Satisfaction % | >= 90% | 96.7% | Dec-21 | | >= 90% | 86.8% | Nov-21 | >= 90% | 88.4% | |
| 82 - Antenatal - Friends and Family Response Rate | >= 15% | 0.6% | Dec-21 | | >= 15% | 1.1% | Nov-21 | >= 15% | 1.2% | |
| 242 - Antenatal Friends and Family Test - Satisfaction % | >= 90% | 100.0% | Dec-21 | | >= 90% | 100.0% | Nov-21 | >= 90% | 100.0% | |
| 83 - Birth - Friends and Family Response Rate | >= 15% | 29.5% | Dec-21 | | >= 15% | 31.7% | Nov-21 | >= 15% | 27.8% | |
| 243 - Birth Friends and Family Test - Satisfaction % | >= 90% | 82.5% | Dec-21 | | >= 90% | 85.2% | Nov-21 | >= 90% | 87.0% | |

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 84 - Hospital Postnatal - Friends and Family Response Rate | >= 15% | 13.0% | Dec-21 | | >= 15% | 19.0% | Nov-21 | >= 15% | 13.7% | |
| 244 - Hospital Postnatal Friends and Family Test - Satisfaction % | >= 90% | 77.6% | Dec-21 | | >= 90% | 86.1% | Nov-21 | >= 90% | 83.9% | |
| 85 - Community Postnatal - Friend and Family Response Rate | >= 15% | 10.5% | Dec-21 | | >= 15% | 8.7% | Nov-21 | >= 15% | 8.6% | |
| 245 - Community Postnatal Friends and Family Test - Satisfaction % | >= 90% | 73.3% | Dec-21 | | >= 90% | 92.7% | Nov-21 | >= 90% | 86.7% | |
| 89 - Formal complaints acknowledged within 3 working days | = 100% | 100.0% | Dec-21 | | = 100% | 100.0% | Nov-21 | = 100% | 100.0% | |
| 90 - Complaints responded to within the period | >= 95% | 83.3% | Dec-21 | | >= 95% | 71.4% | Nov-21 | >= 95% | 78.3% | |

**200 - A&E Friends and Family Response Rate**

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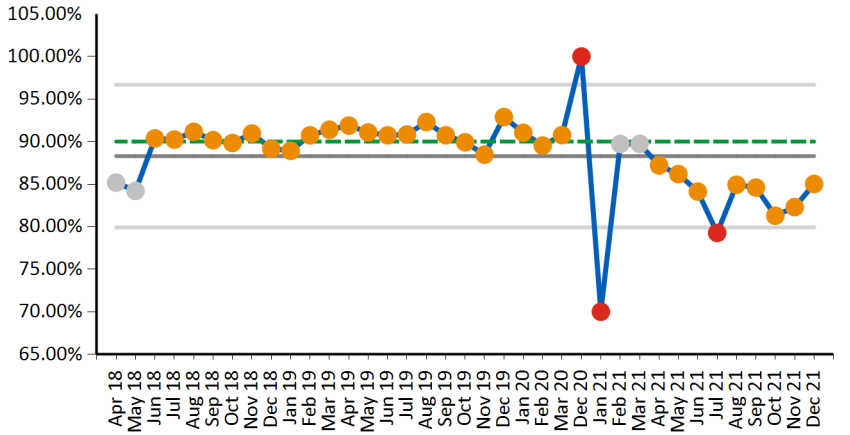
**294 - A&E Friends and Family Satisfaction Rates %**

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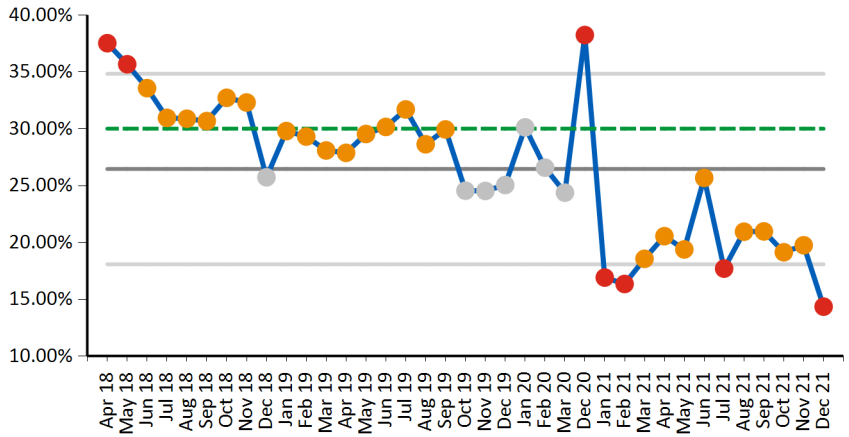
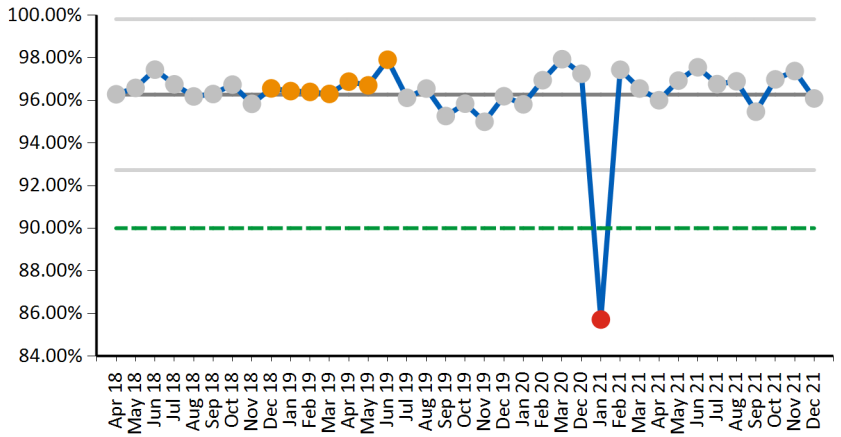
## 80 - Inpatient Friends and Family Response Rate



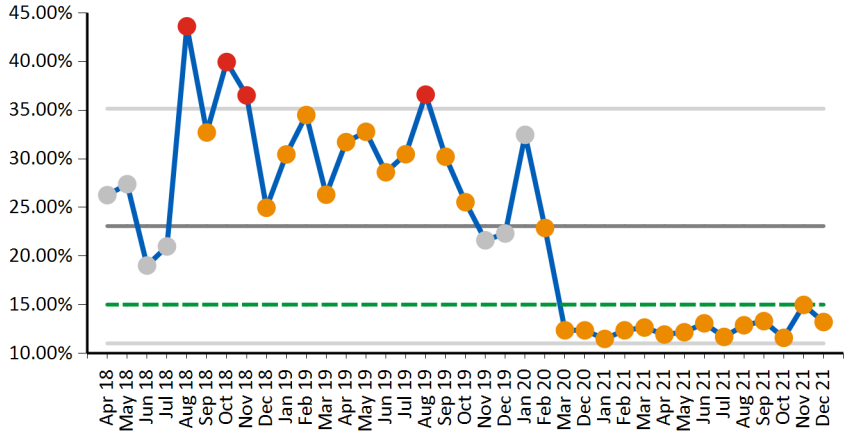


## 240 - Friends and Family Test (Inpatients) - Satisfaction %



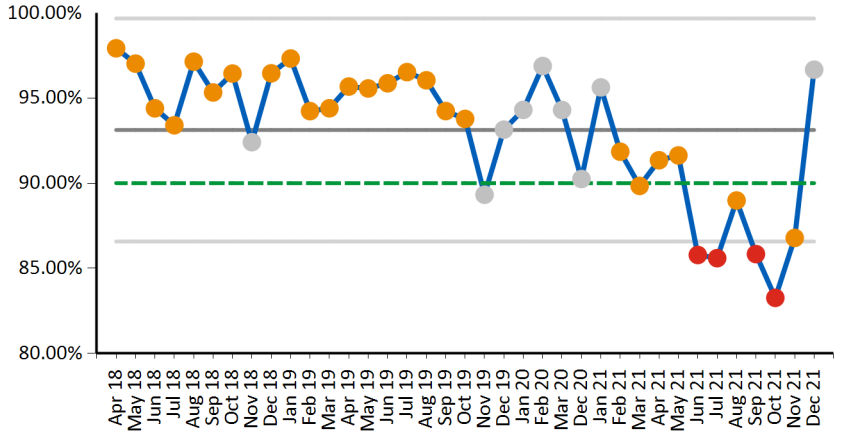


## 81 - Maternity Friends and Family Response Rate

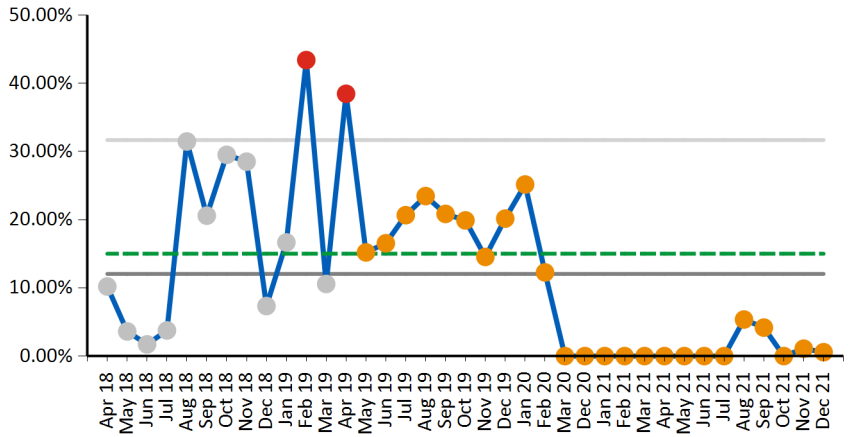




## 241 - Maternity Friends and Family Test - Satisfaction %




## 82 - Antenatal - Friends and Family Response Rate

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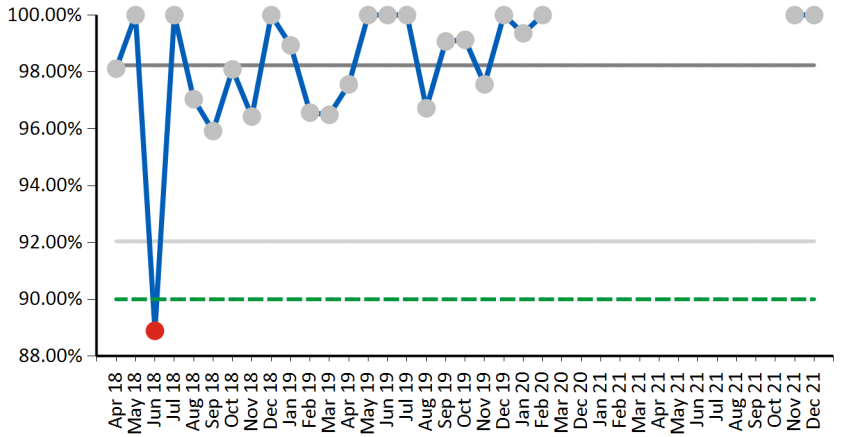
## 242 - Antenatal Friends and Family Test - Satisfaction %

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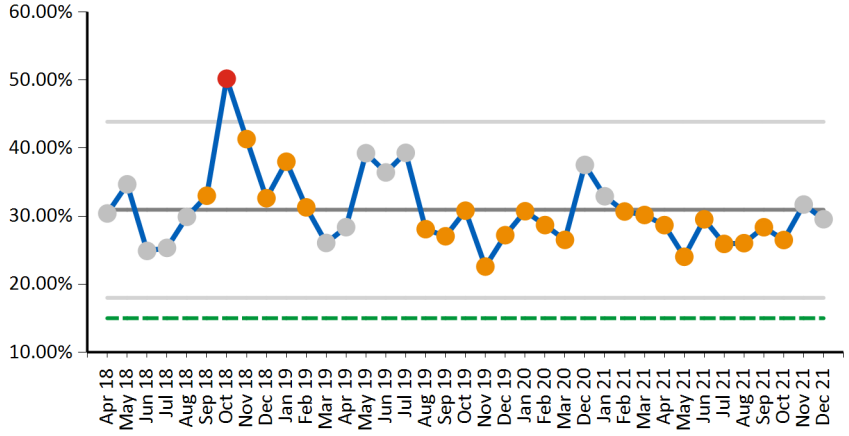
## 83 - Birth - Friends and Family Response Rate

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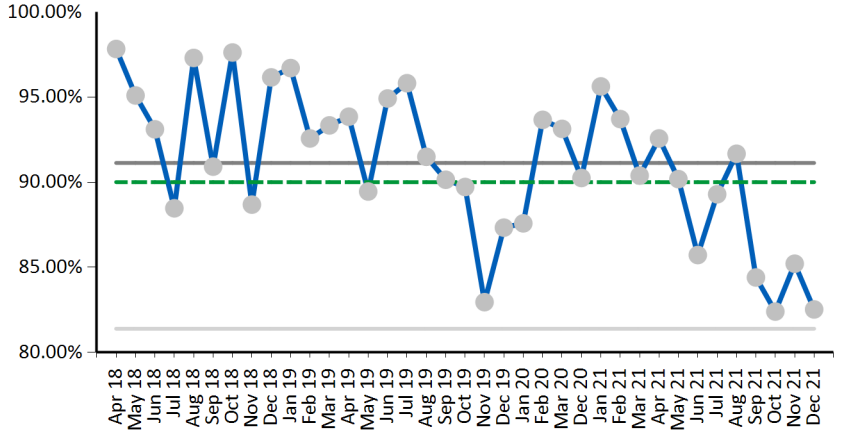
## 243 - Birth Friends and Family Test - Satisfaction %

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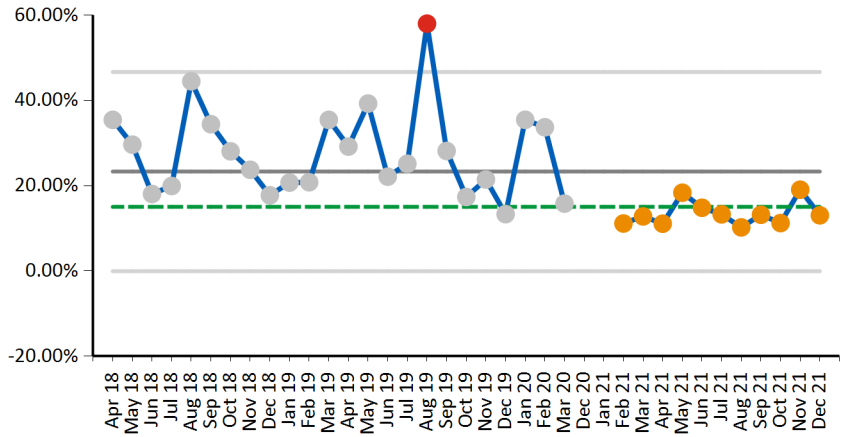
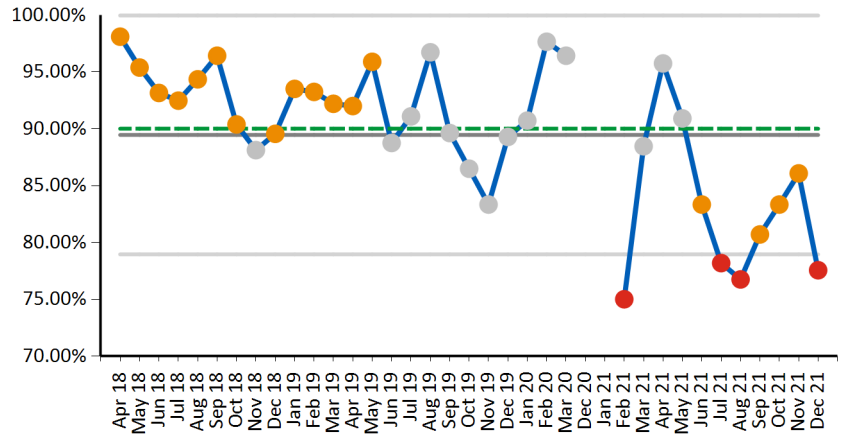
## 84 - Hospital Postnatal - Friends and Family Response Rate



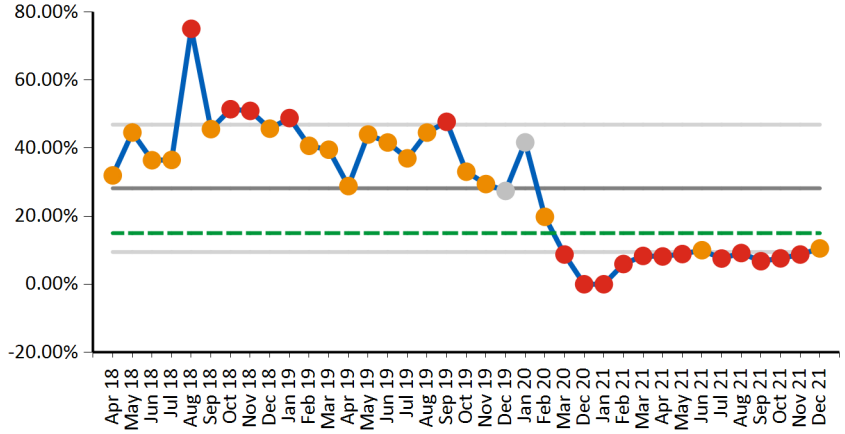


## 244 - Hospital Postnatal Friends and Family Test - Satisfaction %



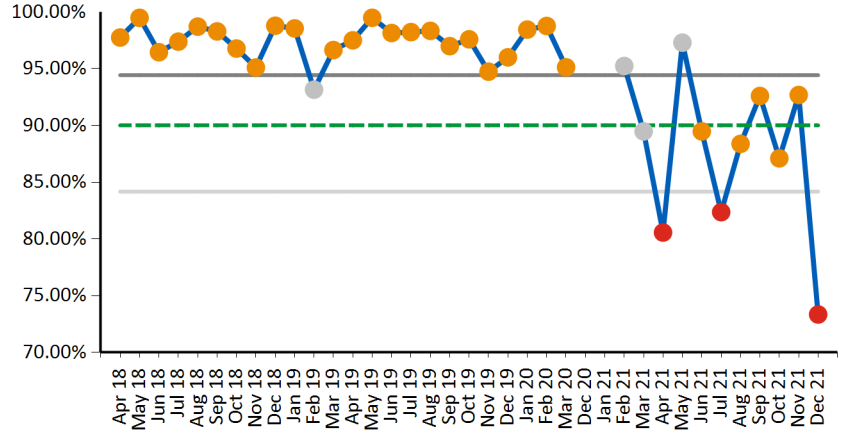


## 85 - Community Postnatal - Friend and Family Response Rate

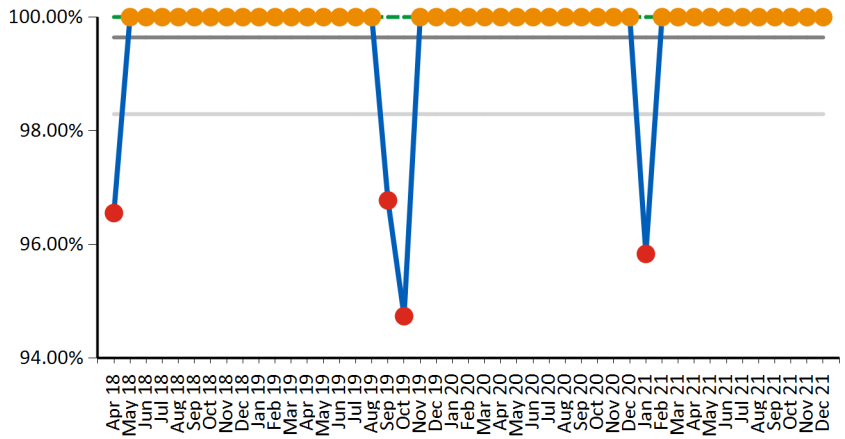




## 245 - Community Postnatal Friends and Family Test - Satisfaction %

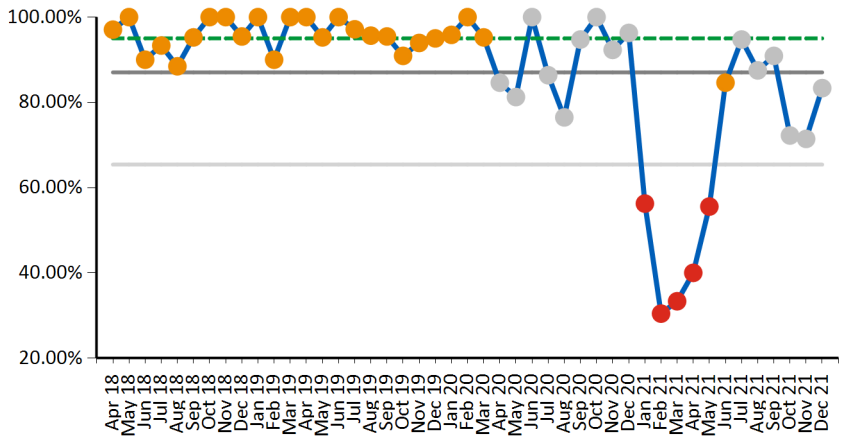



**89 - Formal complaints acknowledged within 3 working days**





**90 - Complaints responded to within the period**



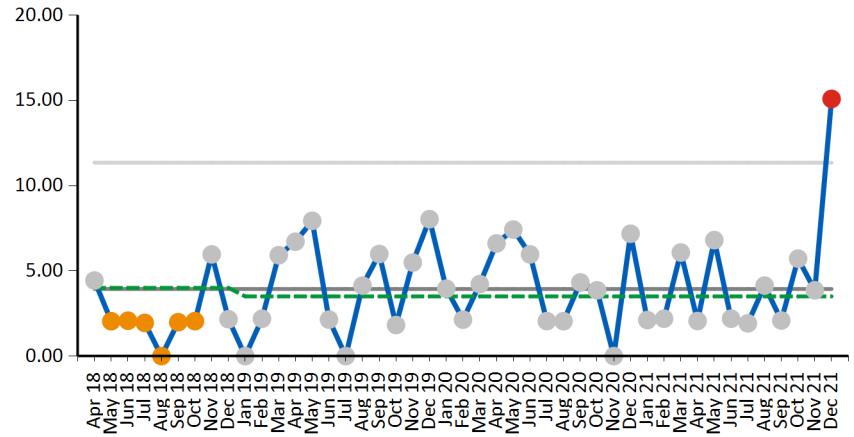

## Maternity

The increased rate of caesareans section rate has been seen predominately in emergency cases, there has been  no change in personnel therefore this is not associated with a change in practice.  We did see a huge rise in number of women attending with Covid this may have contributed.

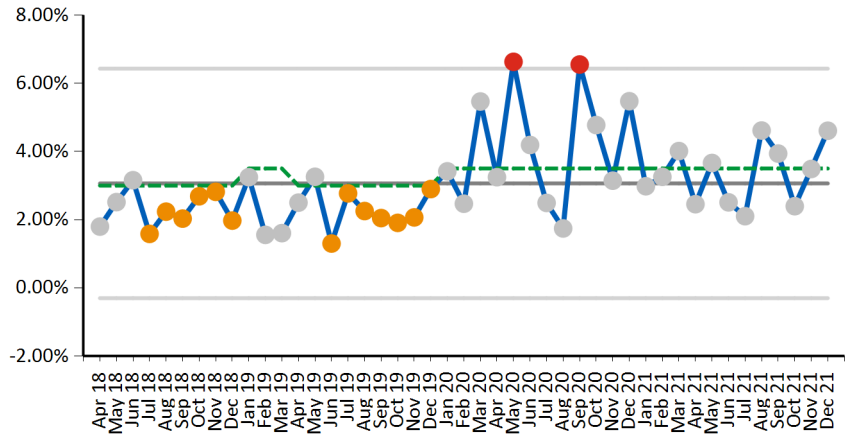
The data for November demonstrates  our Caesarian Section rate was lower than the network average 33.99% vs 35.59%. St Mary's average rate is 39.08%.
The rate in December is high but this is associated with good performance on stillbirth and HIE.
As of Nov our stillbirth rate was second lowest in the network as was our HIE rate.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 322 - Maternity - Stillbirths per 1000 births | <= 3.50 | 15.09 | Dec-21 |  | <= 3.50 | 3.86 | Nov-21 | <= 3.50 | 4.80 |  |
| 23 - Maternity -3rd/4th degree tears | <= 3.5% | 4.6% | Dec-21 |  | <= 3.5% | 3.5% | Nov-21 | <= 3.5% | 3.3% |  |
| 202 - 1:1 Midwifery care in labour | >= 95.0% | 98.2% | Aug-21 |  | >= 95.0% | 98.5% | Jul-21 | >= 95.0% | 98.3% |  |
| 203 - Booked 12+6 | >= 90.0% | 88.7% | Dec-21 |  | >= 90.0% | 89.6% | Nov-21 | >= 90.0% | 90.4% |  |
| 204 - Inductions of labour | <= 40% | 33.8% | Dec-21 |  | <= 40% | 36.0% | Nov-21 | <= 40% | 36.8% |  |
| 208 - Total C section | <= 33.0% | 39.0% | Dec-21 |  | <= 33.0% | 32.3% | Nov-21 | <= 33.0% | 34.6% |  |
| 210 - Initiation breast feeding | >= 65% | 64.84% | Dec-21 |  | >= 65% | 64.82% | Nov-21 | >= 65% | 68.72% |  |
| 213 - Maternity complaints | <= 5 | 0 | Dec-21 |  | <= 5 | 1 | Nov-21 | <= 45 | 12 |  |
| 319 - Maternal deaths (direct) | = 0 | 0 | Dec-21 |  | = 0 | 0 | Nov-21 | = 0 | 0 |  |
| 320 - Rate of Preterm births (rate <37 weeks as a percentage of all births) | <= 6% | 8.7% | Nov-21 |  | <= 6% | 9.5% | Oct-21 | <= 6% | 8.0% |  |

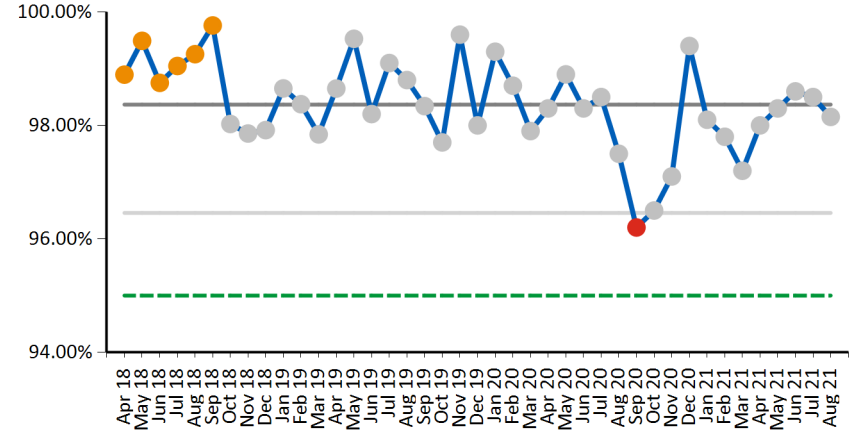
## 322 - Maternity - Stillbirths per 1000 births



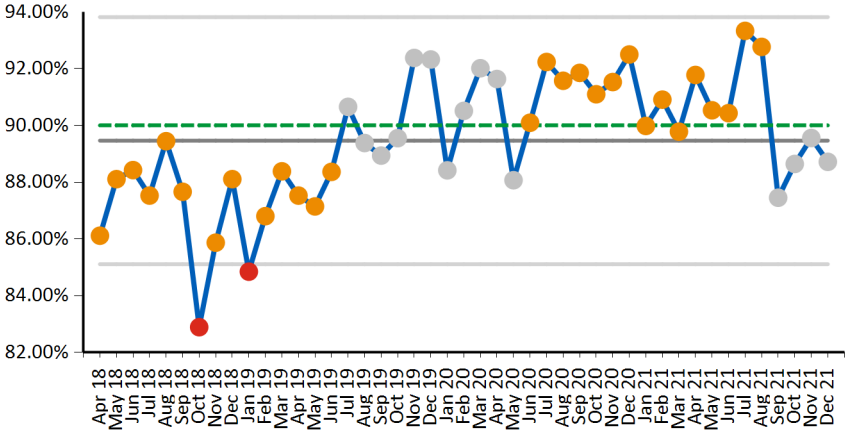

## 23 - Maternity -3rd/4th degree tears



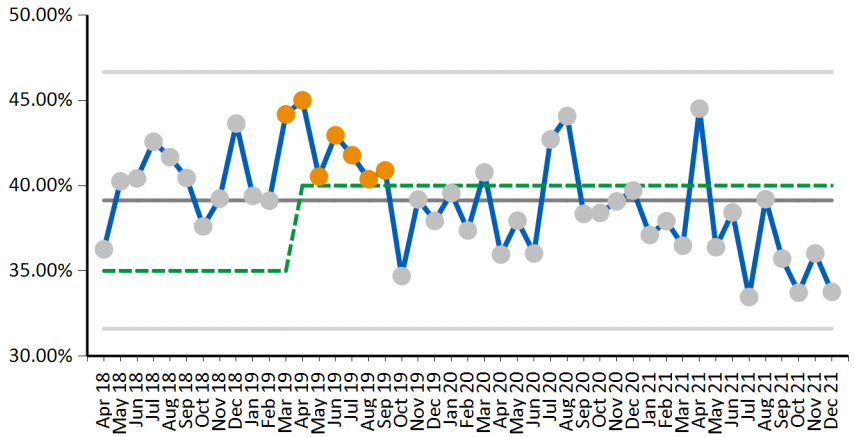

## 202 - 1:1 Midwifery care in labour



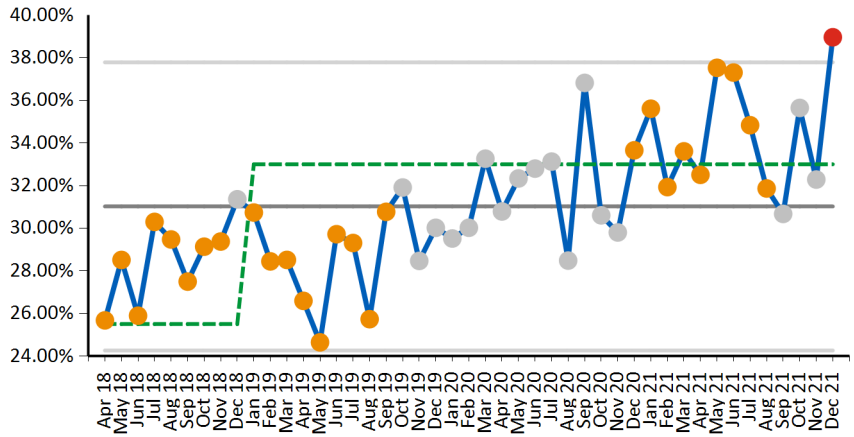

## 203 - Booked 12+6



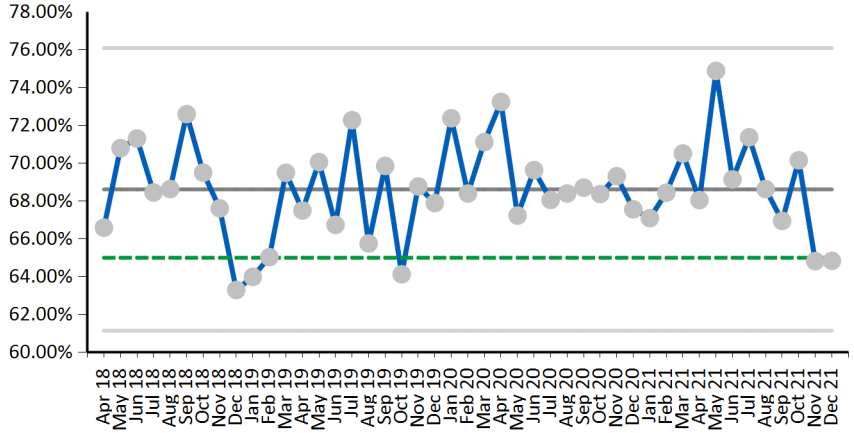
## 204 - Inductions of labour



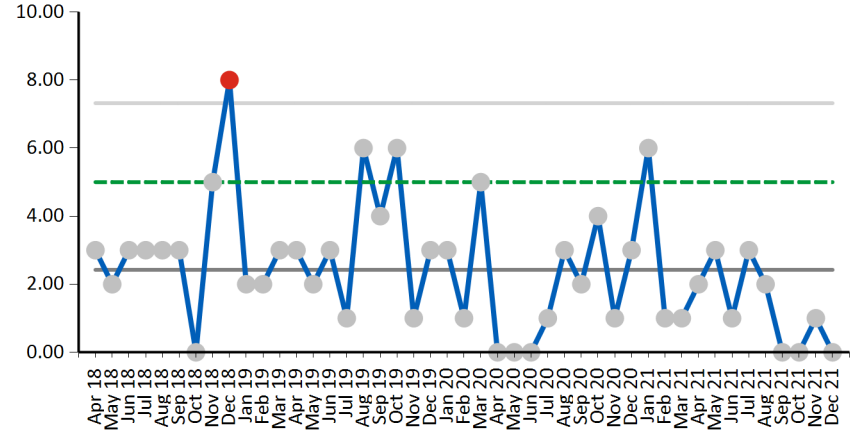

## 208 - Total C section



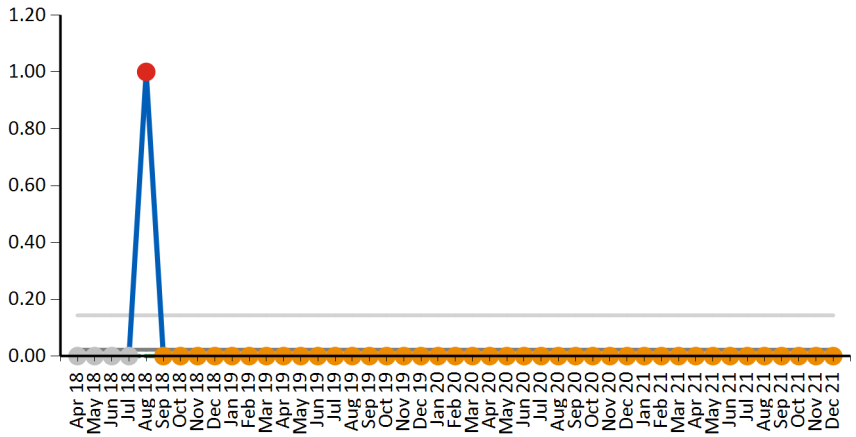

## 210 - Initiation breast feeding




## 213 - Maternity complaints



**319 - Maternal deaths (direct)**

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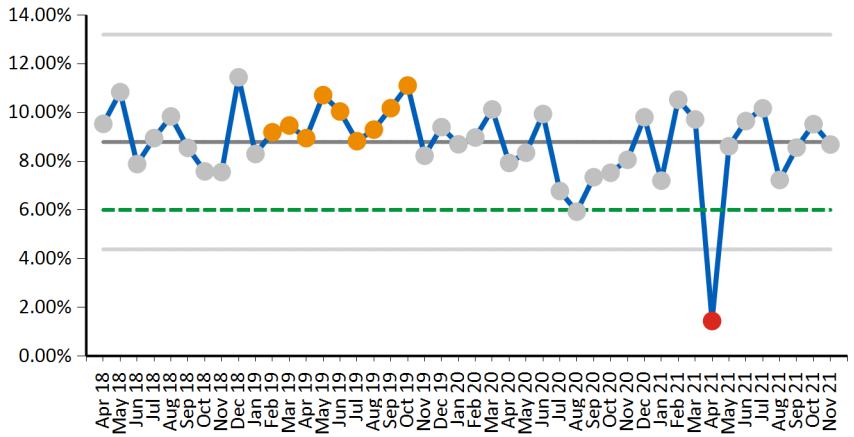
**320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)**

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# Operational Performance

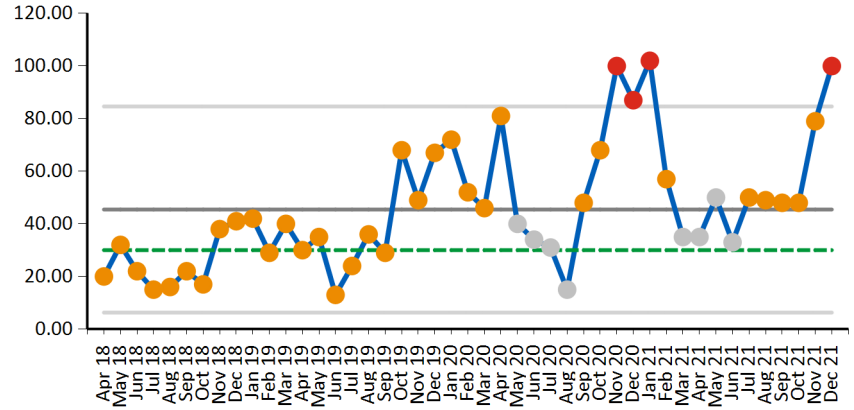
## Access

Significant impact of OMICRON wave has affected flow through whole urgent care system

New Ambulance handover escalation process has been trialled between NWAS and Bolton FT Emergency Dept during Dec

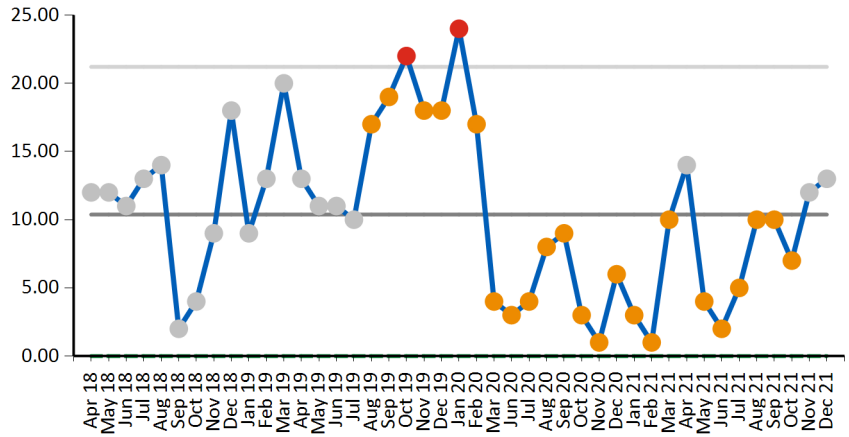
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 7 - Transfers between 11pm and 6am (excluding transfers from assessment wards) | <= 30 | 100 | Dec-21 |  | <= 30 | 79 | Nov-21 | <= 270 | 492 |  |
| 8 - Same sex accommodation breaches | = 0 | 13 | Dec-21 |  | = 0 | 12 | Nov-21 | = 0 | 77 |  |
| 26 - Patients going to theatre within 36 hours of a fractured Neck of Femur | >= 75% | 54.8% | Dec-21 |  | >= 75% | 54.1% | Nov-21 | >= 75% | 67.9% |  |
| 41 - RTT Incomplete pathways within 18 weeks % | >= 92% | 64.9% | Dec-21 |  | >= 92% | 66.3% | Nov-21 | >= 92% | 66.1% |  |
| 42 - RTT 52 week waits (incomplete pathways) | = 0 | 1,649 | Dec-21 |  | = 0 | 1,730 | Nov-21 | = 0 | 18,749 |  |
| 314 - RTT 18 week waiting list | <= 25,530 | 29,440 | Dec-21 |  | <= 25,530 | 29,020 | Nov-21 | <= 25,530 | 29,440 |  |
| 53 - A&E 4 hour target | >= 95% | 63.8% | Dec-21 |  | >= 95% | 67.2% | Nov-21 | >= 95% | 69.8% |  |
| 70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins) | = 0.0% | 13.9% | Dec-21 |  | = 0.0% | 13.5% | Nov-21 | = 0.0% | 10.6% |  |
| 71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins) | = 0.00% | 12.28% | Dec-21 |  | = 0.00% | 12.22% | Nov-21 | = 0.00% | 7.20% |  |
| 72 - Diagnostic Waits >6 weeks % | <= 1% | 34.8% | Dec-21 |  | <= 1% | 25.2% | Nov-21 | <= 1% | 31.2% |  |
| 27 - TIA (Transient Ischaemic attack) patients seen <24hrs | = 100% | 83.3% | Dec-21 |  | = 100% | 91.7% | Nov-21 | = 100% | 81.9% |  |

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



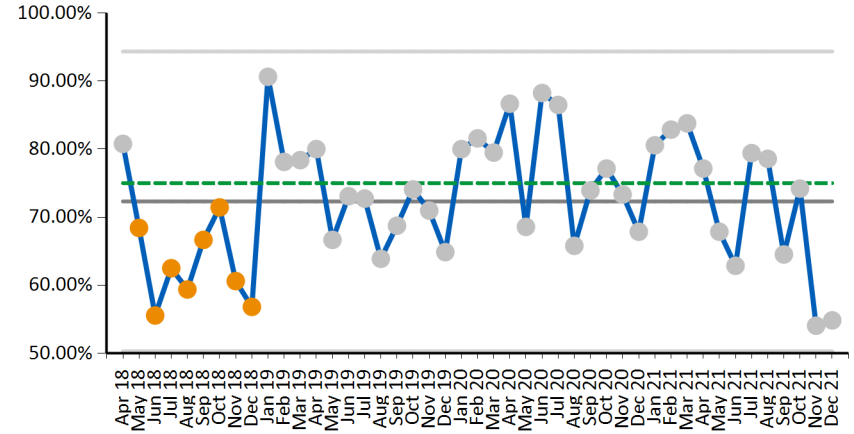


**8 - Same sex accommodation breaches**



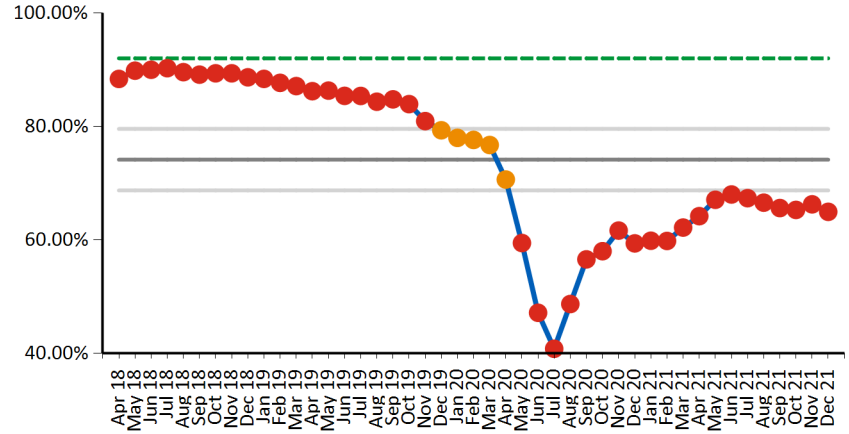


**26 - Patients going to theatre within 36 hours of a fractured Neck of Femur**

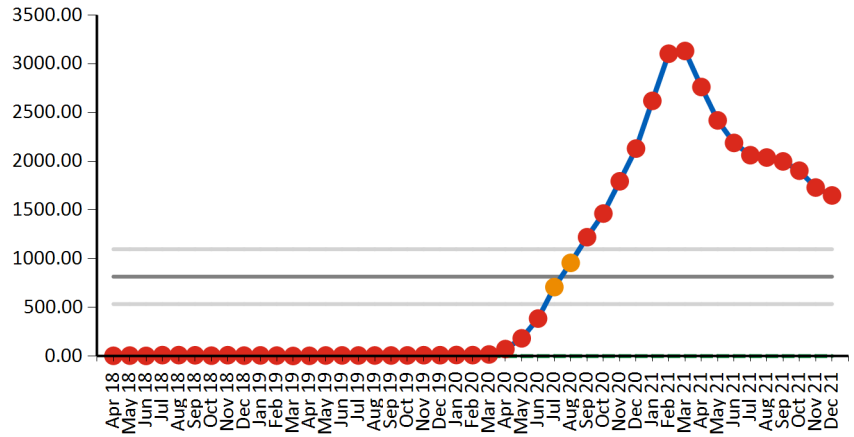




**41 - RTT Incomplete pathways within 18 weeks %**




**42 - RTT 52 week waits (incomplete pathways)**

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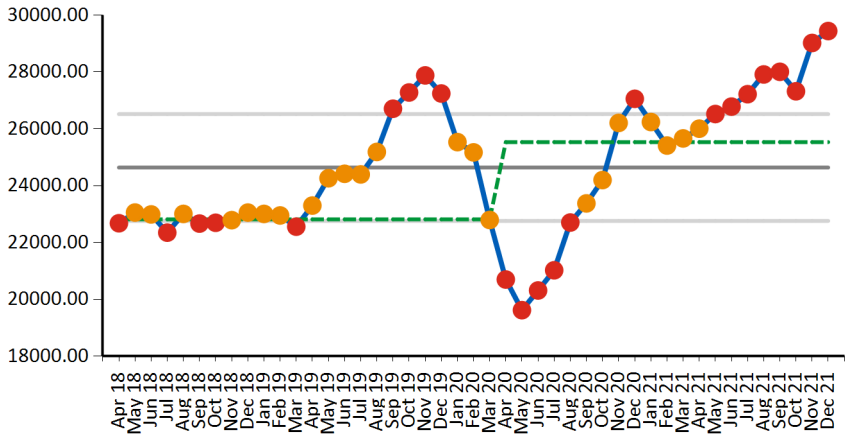
**314 - RTT 18 week waiting list**

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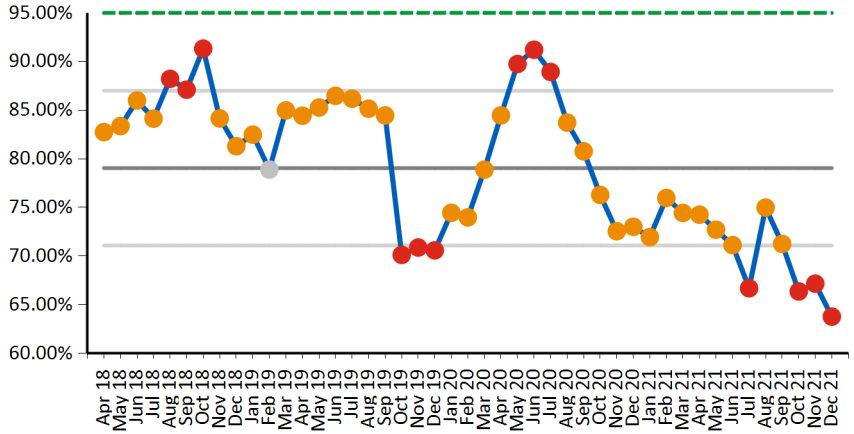
**53 - A&E 4 hour target**

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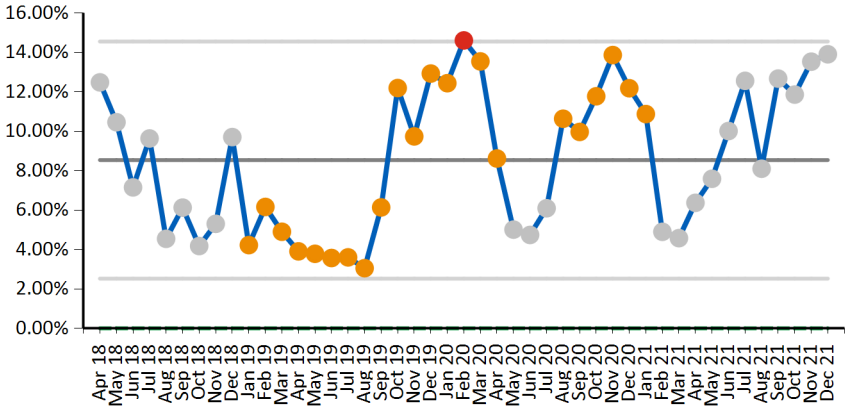
**70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)**

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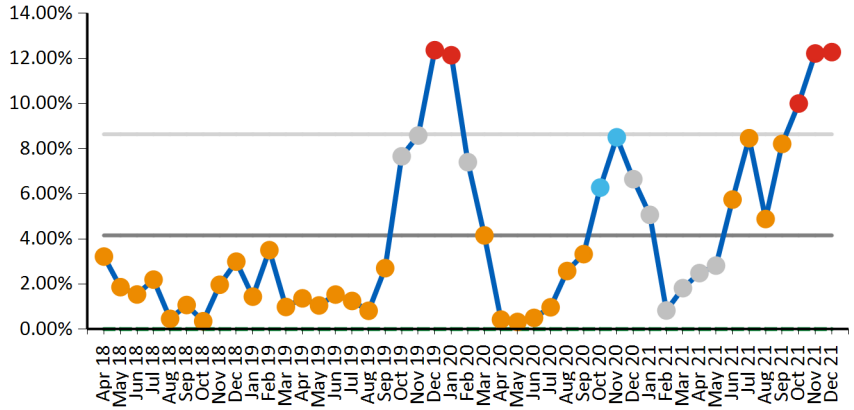
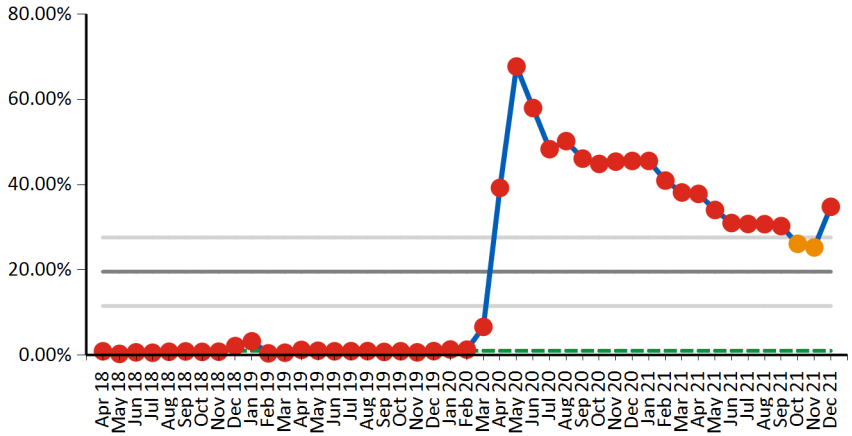
**71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)**



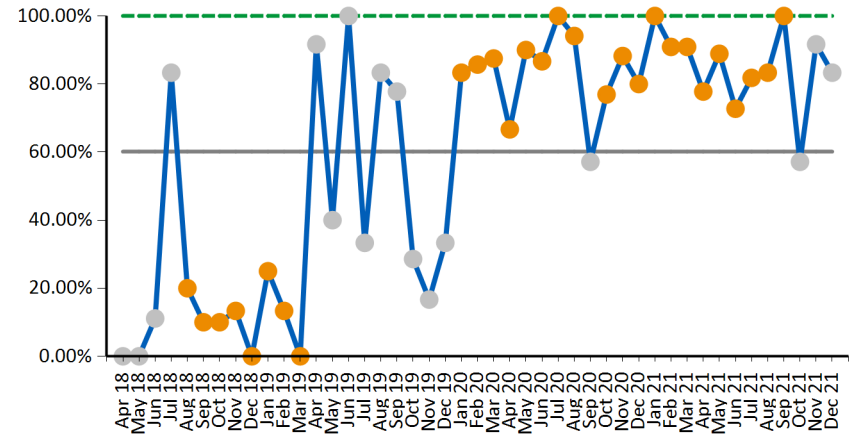


**72 - Diagnostic Waits >6 weeks %**





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



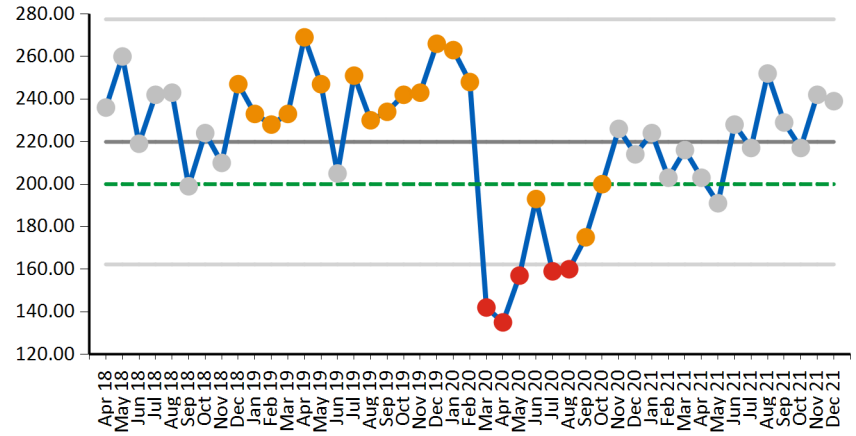

## Productivity

Elective programme scaled down in December and January to create bed and workforce capacity to respond to OMICRON wave- detrimental impact on waiting list size expected for January

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 56 - Stranded patients | <= 200 | 239 | Dec-21 | | <= 200 | 242 | Nov-21 | <= 200 | 239 | |
| 307 - Stranded Patients - LOS 21 days and over | <= 69 | 93 | Dec-21 | | <= 69 | 83 | Nov-21 | <= 69 | 93 | |
| 57 - Discharges by Midday | >= 30% | 20.9% | Dec-21 | | >= 30% | 18.8% | Nov-21 | >= 30% | 21.6% | |
| 58 - Discharges by 4pm | >= 70% | 57.8% | Dec-21 | | >= 70% | 57.0% | Nov-21 | >= 70% | 59.4% | |
| 59 - Re-admission within 30 days of discharge (1 mth in arrears) | <= 13.5% | 10.7% | Nov-21 | | <= 13.5% | 10.6% | Oct-21 | <= 13.5% | 11.4% | |
| 489 - Daycase Rates | >= 80% | 88.9% | Dec-21 | | >= 80% | 89.9% | Nov-21 | >= 80% | 89.0% | |
| 61 - Operations cancelled on the day for non-clinical reasons | <= 1% | 3.5% | Dec-21 | | <= 1% | 1.4% | Nov-21 | <= 1% | 1.3% | |
| 62 - Cancelled operations re-booked within 28 days | = 100% | 81.9% | Dec-21 | | = 100% | 94.6% | Nov-21 | = 100% | 14.2% | |
| 65 - Elective Length of Stay (Discharges in month) | <= 2.00 | 2.71 | Dec-21 | | <= 2.00 | 2.58 | Nov-21 | <= 2.00 | 2.82 | |
| 66 - Non Elective Length of Stay (Discharges in month) | <= 3.70 | 4.05 | Dec-21 | | <= 3.70 | 3.78 | Nov-21 | <= 3.70 | 3.86 | |
| 73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears) | >= 80% | 76.5% | Sep-21 | | >= 80% | 65.2% | Aug-21 | >= 80% | 72.7% | |
| 492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision | = 0 | 35 | Dec-21 | | = 0 | 29 | Nov-21 | = 0 | 190 | |
| 493 - Average Number of Patients: with no Criteria to Reside | >= 35 | 94 | Dec-21 | | >= 35 | 96 | Nov-21 | >= 405 | 706 | |
| 494 - Average Occupied Days - for no Criteria to Reside | | 762 | Dec-21 | | | 594 | Nov-21 | | 3,876 | |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 496 - Average number of excess bed days incurred since patients with a LoS of 14 days+ were declared as no longer meeting the reasons to reaside criteria (ready for dicharge/medically fit) | >= 110 | 668 | Dec-21 | | >= 110 | 497 | Nov-21 | >= 1,380 | 3,170 | |

**56 - Stranded patients**

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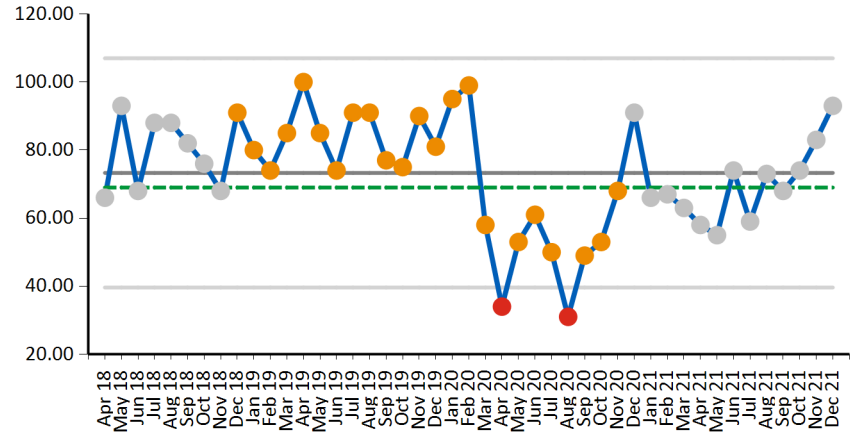
**307 - Stranded Patients - LOS 21 days and over**

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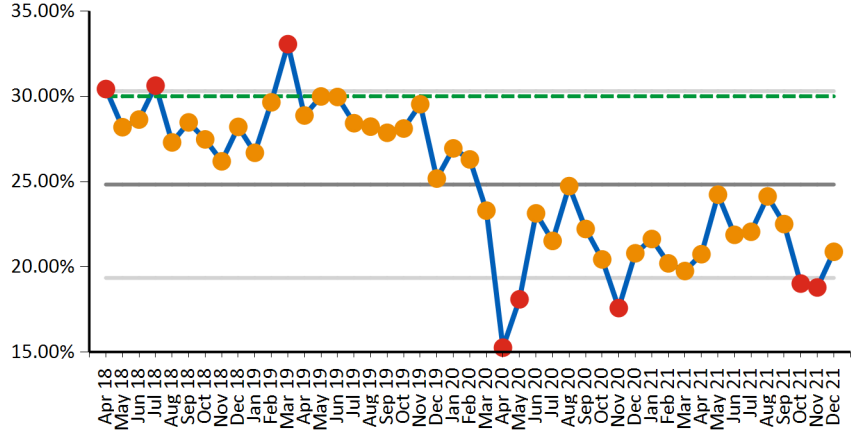
**57 - Discharges by Midday**

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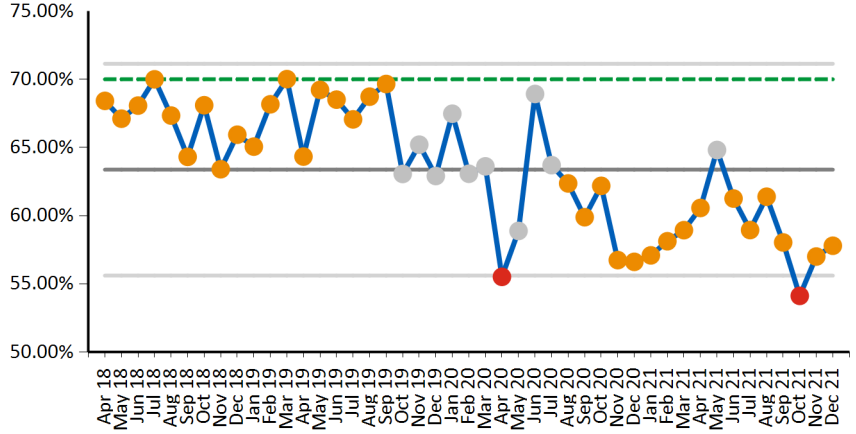
**58 - Discharges by 4pm**

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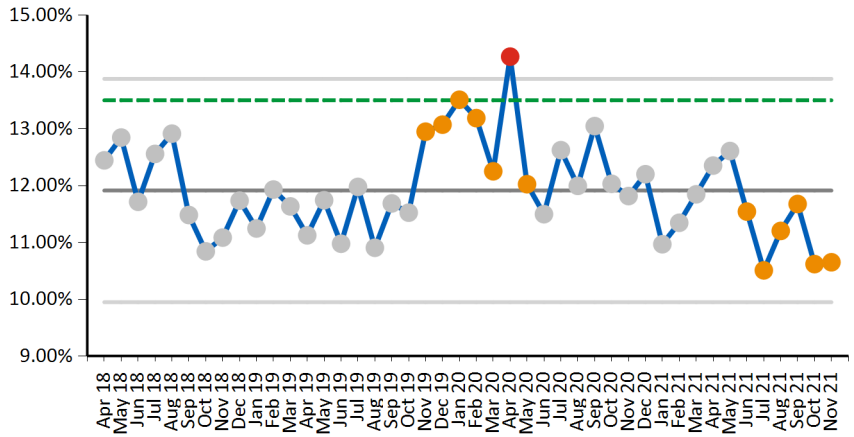
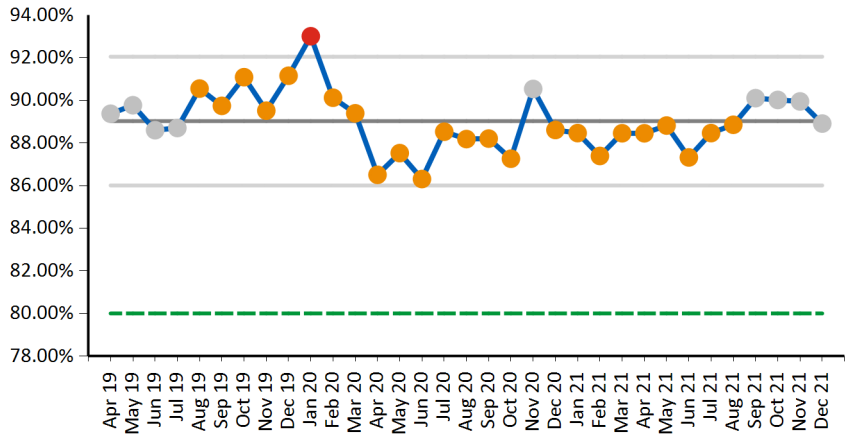
### 59 - Re-admission within 30 days of discharge (1 mth in arrears)



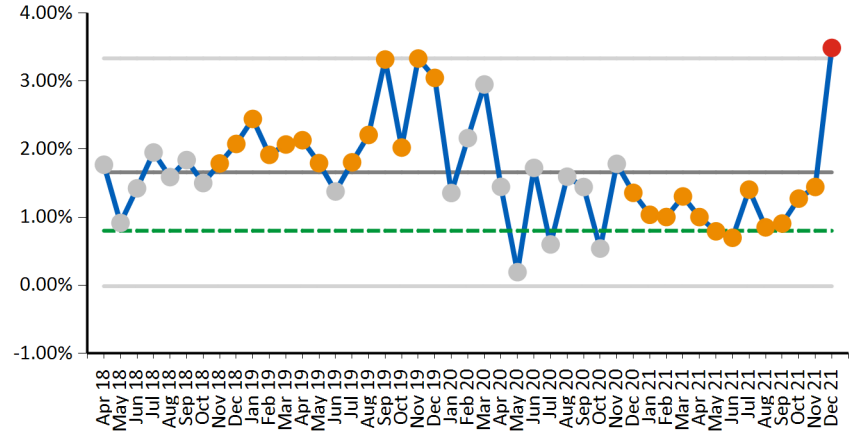


### 489 - Daycase Rates



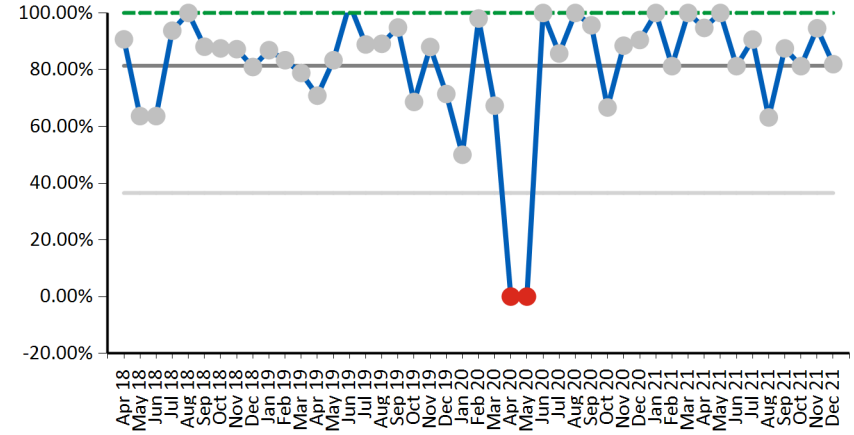


### 61 - Operations cancelled on the day for non-clinical reasons

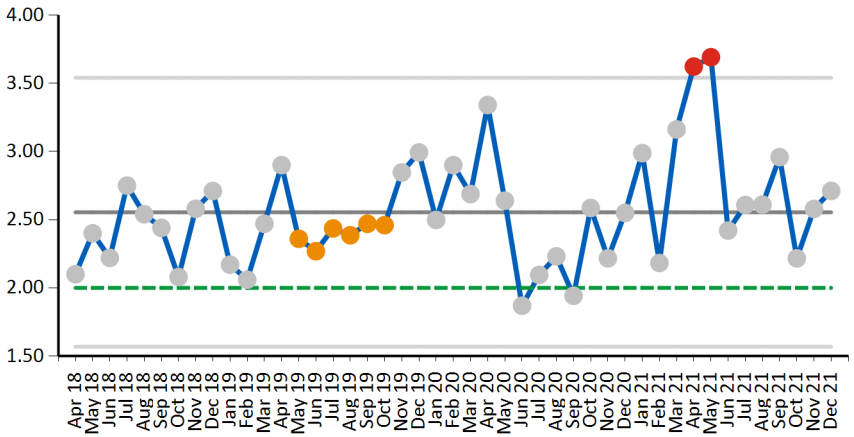




### 62 - Cancelled operations re-booked within 28 days

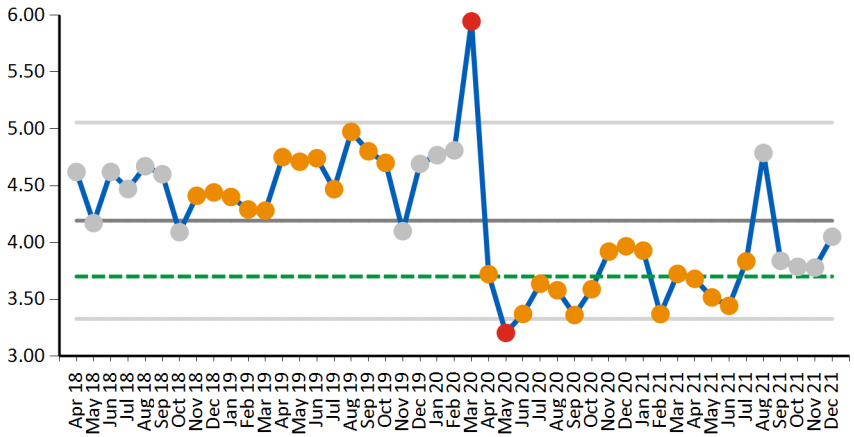



**65 - Elective Length of Stay (Discharges in month)**



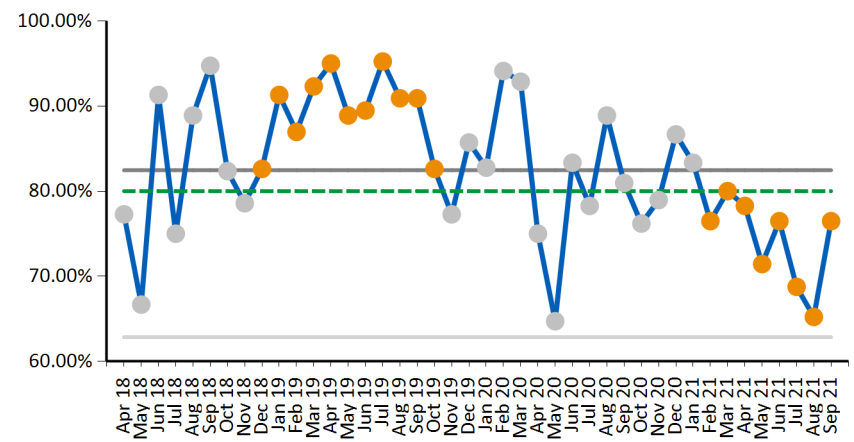


**66 - Non Elective Length of Stay (Discharges in month)**



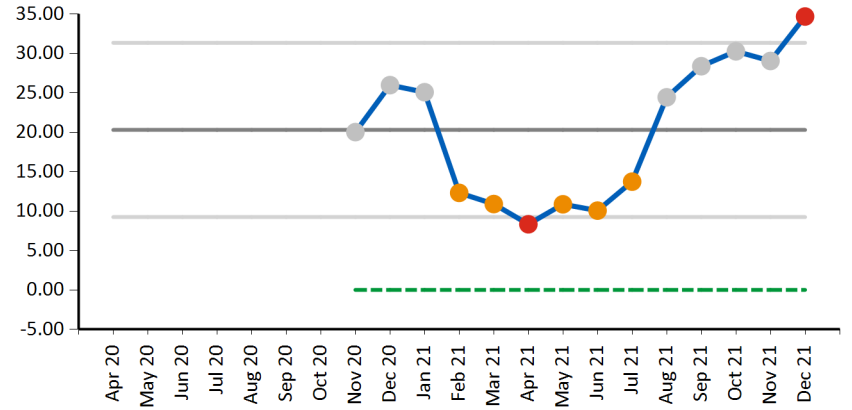


**73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears**

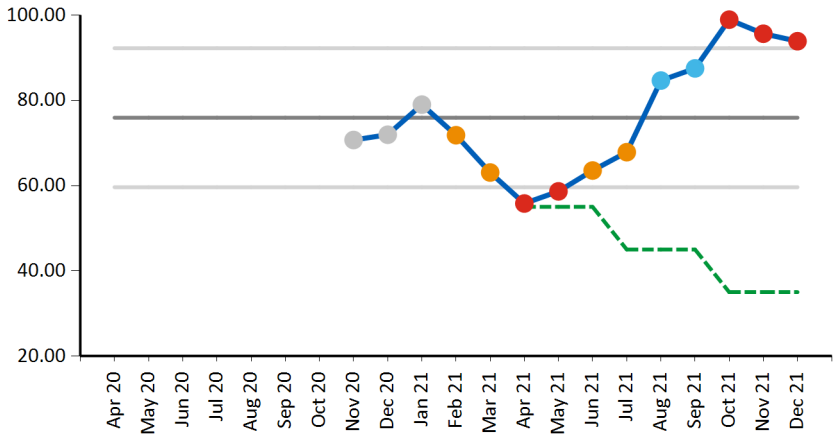




**492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision**

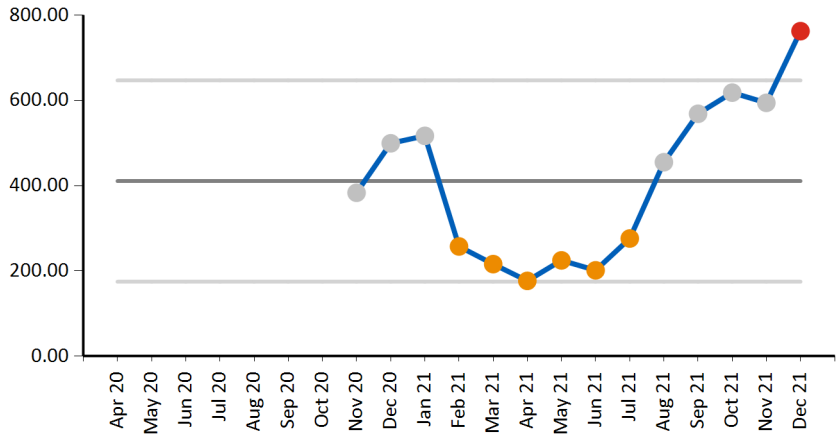



**493 - Average Number of Patients: with no Criteria to Reside**



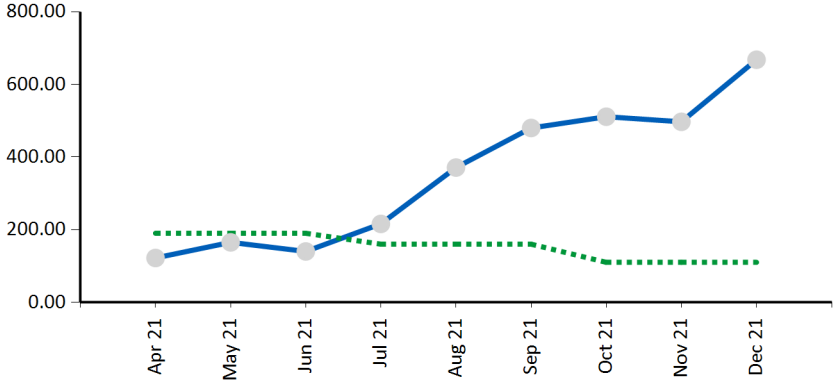


**494 - Average Occupied Days - for no Criteria to Reside**





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



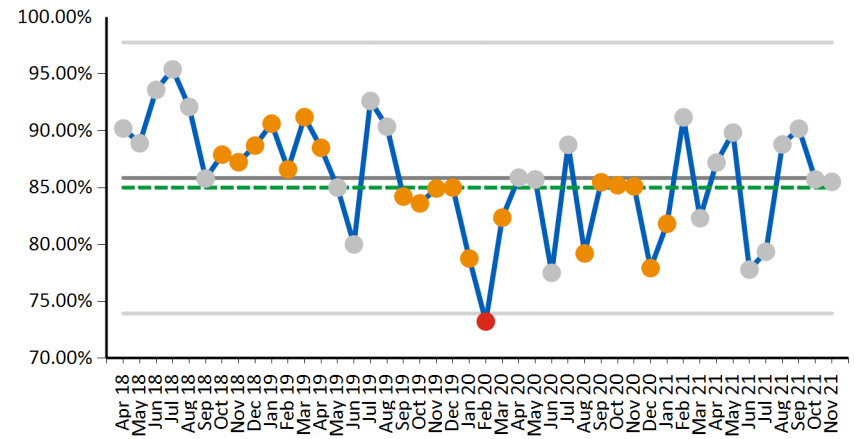

## Cancer

Q3 on track to pass with final validation taking place

Expected impact of OMICRON wave into Q4- workforce availability within cancer services and pathways

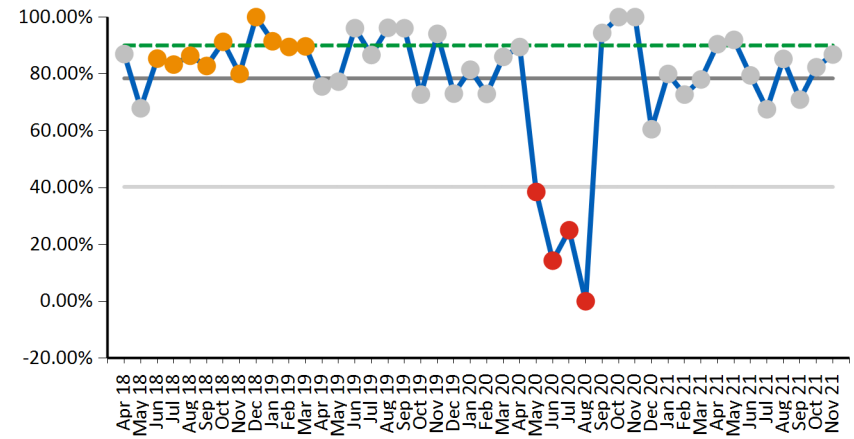
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 46 - 62 day standard % (1 mth in arrears) | >= 85% | 85.5% | Nov-21 | | >= 85% | 85.7% | Oct-21 | >= 85% | 85.6% | ? |
| 47 - 62 day screening % (1 mth in arrears) | >= 90% | 86.8% | Nov-21 | | >= 90% | 82.4% | Oct-21 | >= 90% | 81.8% | ? |
| 48 - 31 days to first treatment % (1 mth in arrears) | >= 96% | 98.4% | Nov-21 | | >= 96% | 97.8% | Oct-21 | >= 96% | 98.5% | ? |
| 49 - 31 days subsequent treatment (surgery) % (1 mth in arrears) | >= 94% | 100.0% | Nov-21 | | >= 94% | 100.0% | Oct-21 | >= 94% | 96.4% | ? |
| 50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears) | >= 98% | 100.0% | Nov-21 | | >= 98% | 100.0% | Oct-21 | >= 98% | 100.0% | P |
| 51 - Patients 2 week wait (all cancers) % (1 mth in arrears) | >= 93% | 94.8% | Nov-21 | | >= 93% | 95.5% | Oct-21 | >= 93% | 96.4% | ? |
| 52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears) | >= 93% | 18.3% | Nov-21 | L | >= 93% | 30.1% | Oct-21 | >= 93% | 29.9% | F |

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



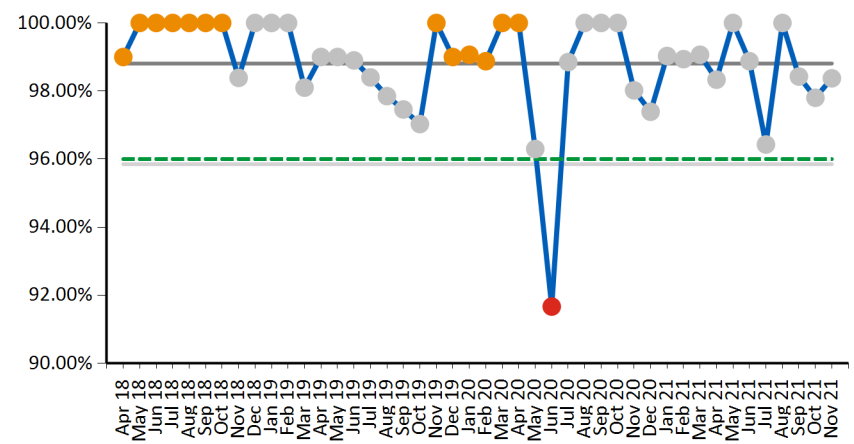


**47 - 62 day screening % (1 mth in arrears)**



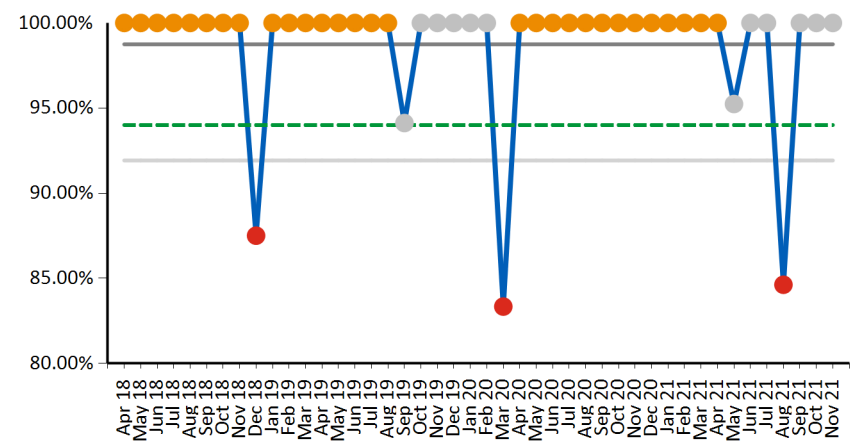


**48 - 31 days to first treatment % (1 mth in arrears)**

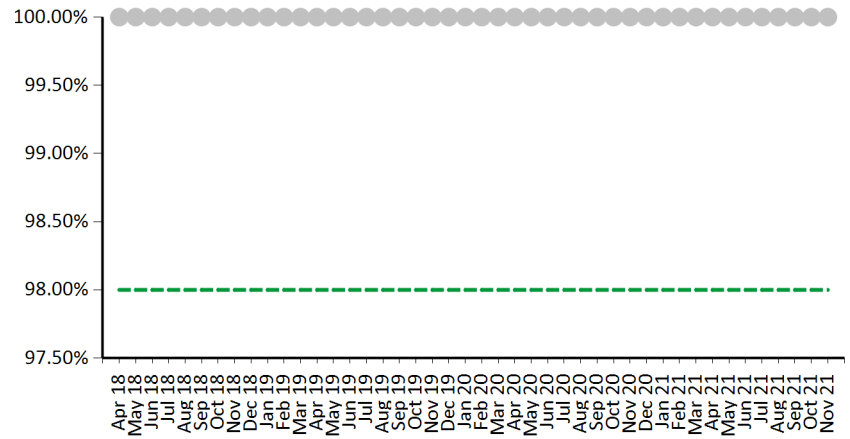




**49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)**




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

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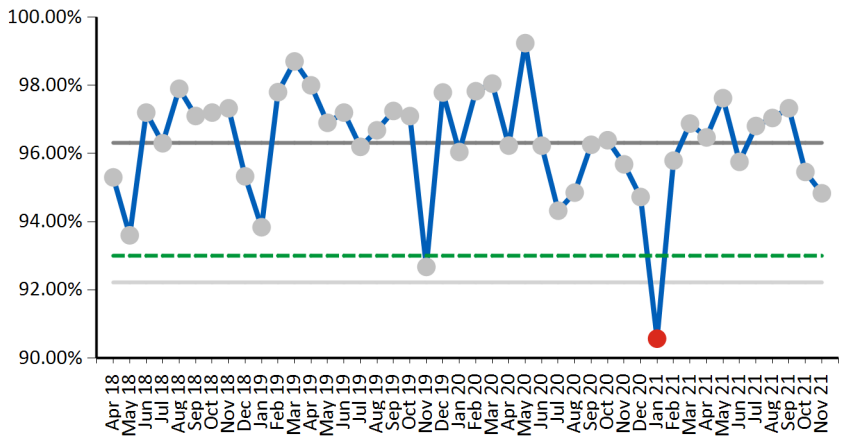
**51 - Patients 2 week wait (all cancers) % (1 mth in arrears)**

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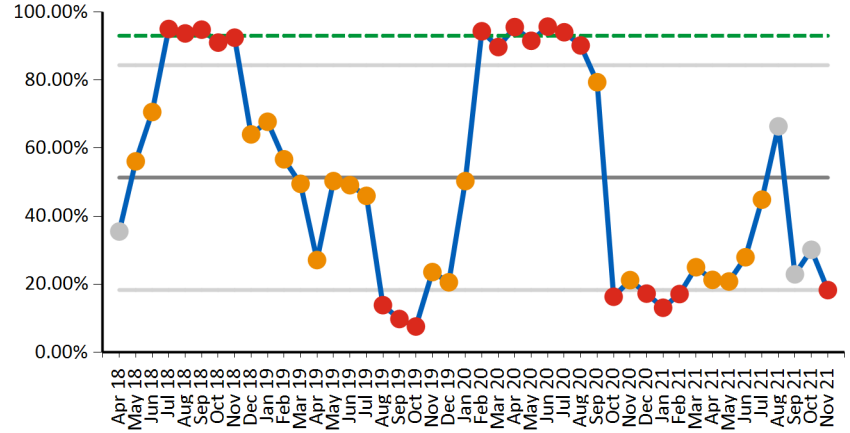
**52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)**

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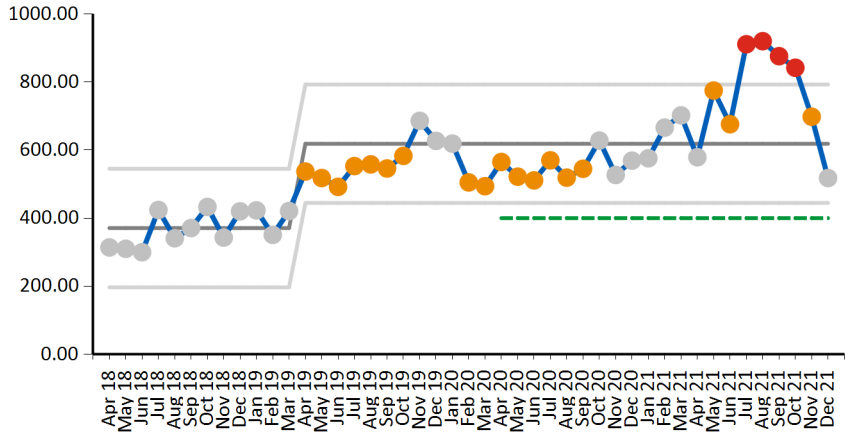
## Community

Discharge pathways 2 and 3 significantly impacted by unit closures due to COVID outbreaks in December

Discharge pathway 1 benefitted from impact of winter resilience schemes in domiciliary care providers

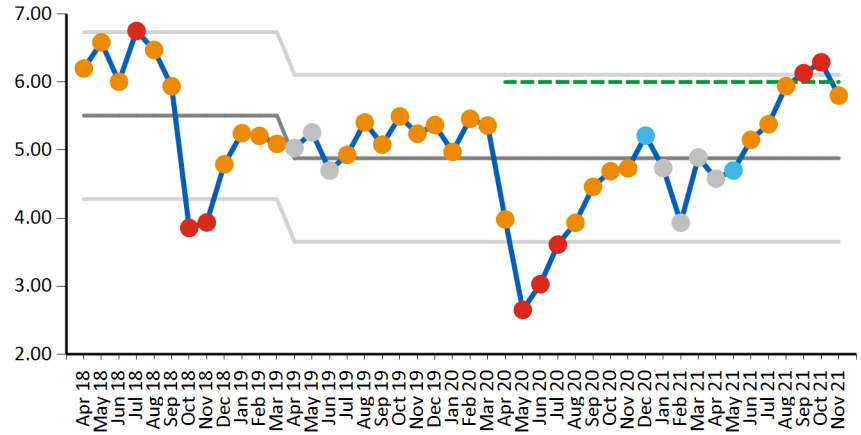
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 334 - Total Deflections from ED | >= 400 | 518 | Dec-21 | | >= 400 | 698 | Nov-21 | >= 3,600 | 6,795 | P |
| 335 - Total Intermediate Tier LOS (weeks) | <= 6.00 | 5.80 | Nov-21 | H | <= 6.00 | 6.29 | Oct-21 | <= 6.00 | 5.80 | ? |

**334 - Total Deflections from ED**





**335 - Total Intermediate Tier LOS (weeks)**




# Workforce

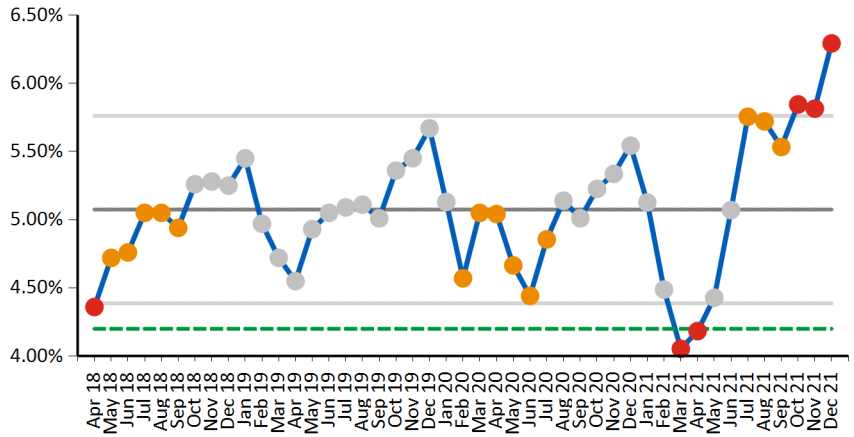
## Sickness, Vacancy and Turnover

Board members will note that sickness has increased in December to 6.29% mainly driven by increased Omicron related absence. Bolton continues to benchmark well against comparator Trusts in GM supported by close follow up and support by the Covid Attendance Team, which has been operating extended hours, across 7 days a week during the recent Wave.

Staff shortages remain a concern and People Committee are sighted on the range of activities underway, including  current international recruitment to fill clinical gaps and the increase in Nursing bank rates, in particular has generated increased applicants.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 117 - Sickness absence level - Trust | <= 4.20% | 6.29% | Dec-21 |  | <= 4.20% | 5.81% | Nov-21 | <= 4.20% | 5.40% |  |
| 120 - Vacancy level - Trust | <= 6% | 6.80% | Dec-21 |  | <= 6% | 4.74% | Nov-21 | <= 6% | 6.31% |  |
| 121 - Turnover | <= 9.90% | 13.31% | Dec-21 |  | <= 9.90% | 13.09% | Nov-21 | <= 9.90% | 13.37% |  |
| 366 - Ongoing formal investigation cases over 8 weeks | | 1 | Dec-21 |  | | 2 | Nov-21 | | 20 | |

### 117 - Sickness absence level - Trust

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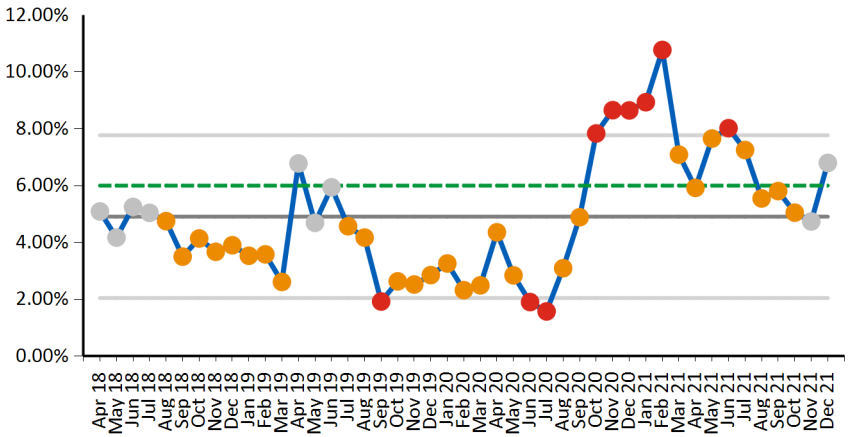
### 120 - Vacancy level - Trust

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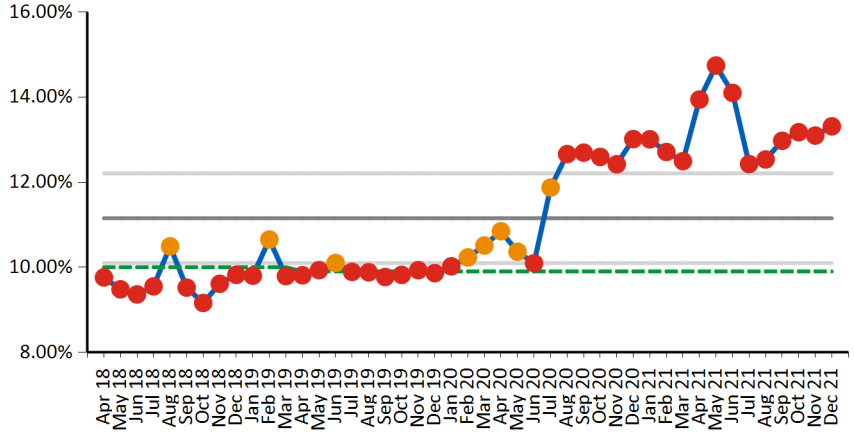
### 121 - Turnover

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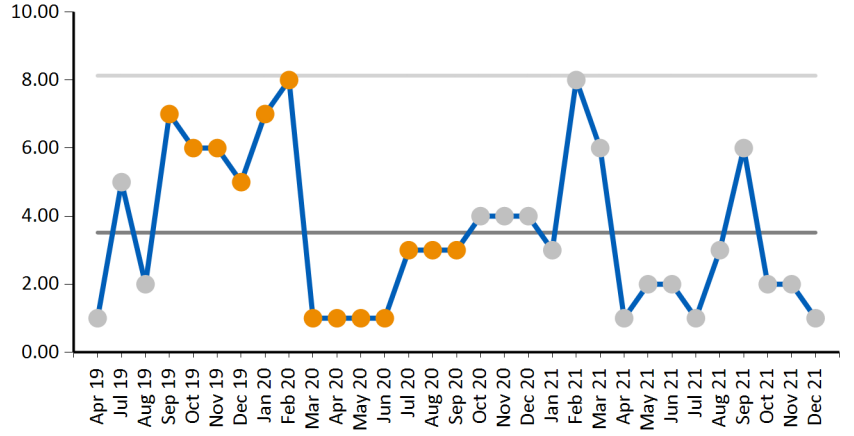
### 366 - Ongoing formal investigation cases over 8 weeks



## Organisational Development

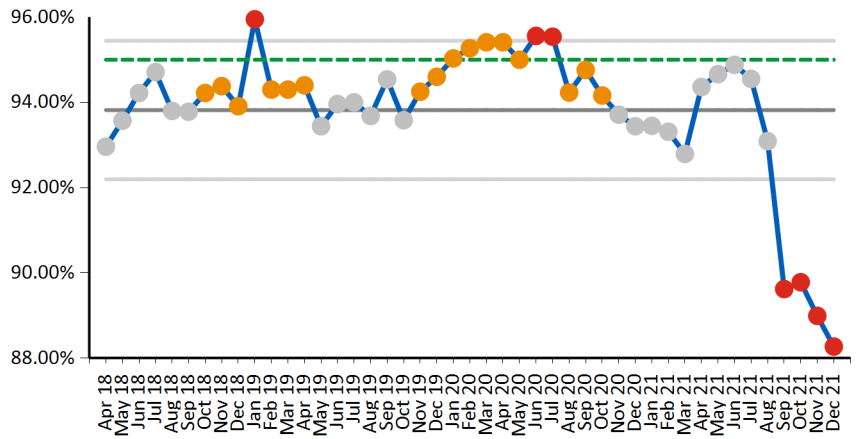
Statutory and mandatory training compliance continues to be a challenge due to operational pressures and high staff absence. The People Development Team are working closely with divisional managers to implement robust recovery plans. We are also exploring new approaches to delivering face to face clinical mandatory training sessions to help increase attendance and improve the learner experience. The People Development Steering Group is closely monitoring plans.

The FABB conversation approach continues to be embedded across the Trust. Completion of annual appraisal conversations has been difficult for many line managers due to high staff unavailability and operational pressures. The People Development Team are continuing to support managers to increase appraisal activity and through our internal communications we are also taking a bottom up approach by encouraging employees to take greater responsibility for scheduling their own appraisal.

We are currently analysing our 2021 NHS national staff survey results. Early indications show that we've improved a number of our scores and these scores perform strongly against our national comparator group. Our scores that have declined have done so to a lesser extent than our national comparator group. Our results will be presented to the People Committee and Trust Board in February 2022. The Staff Experience Steering Group will continue to ensure that divisions implement impactful action plans that help make Bolton FT a great place to work.

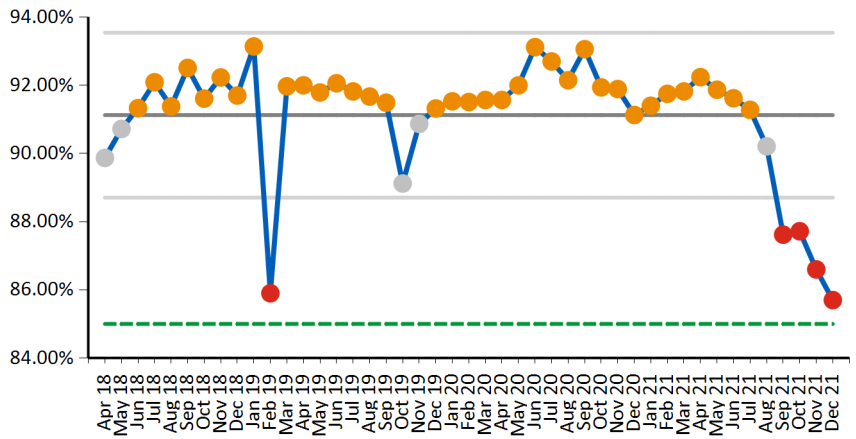
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 37 - Staff completing Statutory Training | >= 95% | 88.3% | Dec-21 |  | >= 95% | 89.0% | Nov-21 | >= 95% | 92.0% |  |
| 38 - Staff completing Mandatory Training | >= 85% | 85.7% | Dec-21 |  | >= 85% | 86.6% | Nov-21 | >= 85% | 89.4% |  |
| 39 - Staff completing Safeguarding Training | >= 95% | 89.40% | Dec-21 |  | >= 95% | 89.84% | Nov-21 | >= 95% | 93.56% |  |
| 101 - Increased numbers of staff undertaking an appraisal | >= 85% | 79.4% | Dec-21 |  | >= 85% | 79.8% | Nov-21 | >= 85% | 79.8% |  |
| 78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) | >= 66% | 70.8% | Q2 2021/22 | | >= 66% | 74.0% | Q1 2021/22 | >= 66% | | |
| 79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) | >= 80% | 63.3% | Q2 2021/22 | | >= 80% | 65.4% | Q1 2021/22 | >= 80% | | |

### 37 - Staff completing Statutory Training



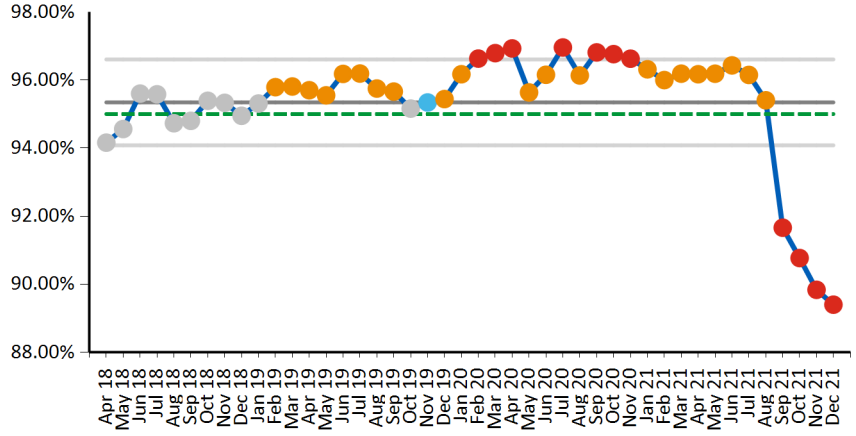


### 38 - Staff completing Mandatory Training



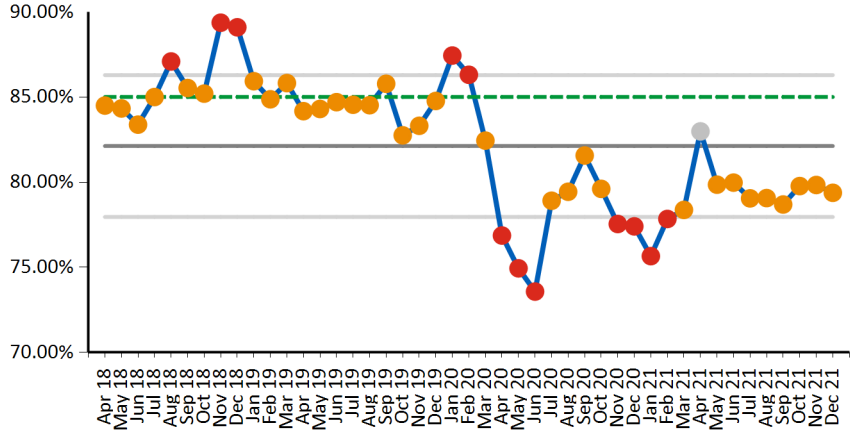


### 39 - Staff completing Safeguarding Training

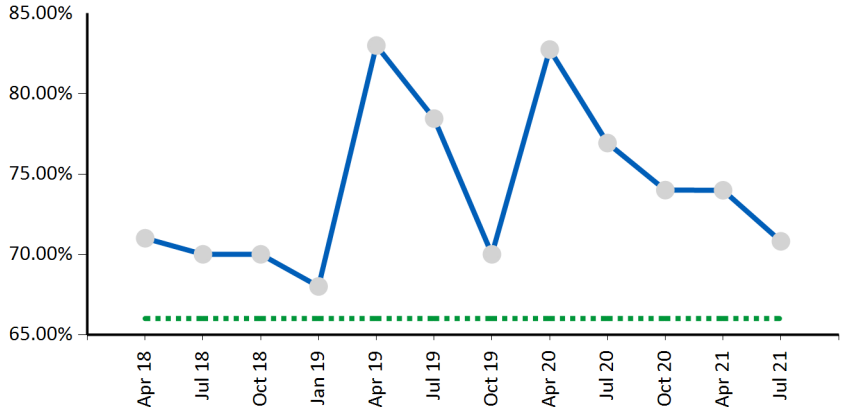




### 101 - Increased numbers of staff undertaking an appraisal




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

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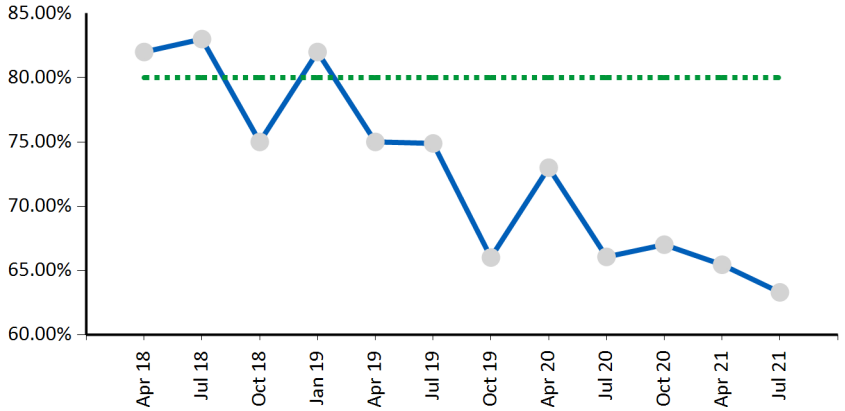
**79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) - SPC data available after 20 data points**

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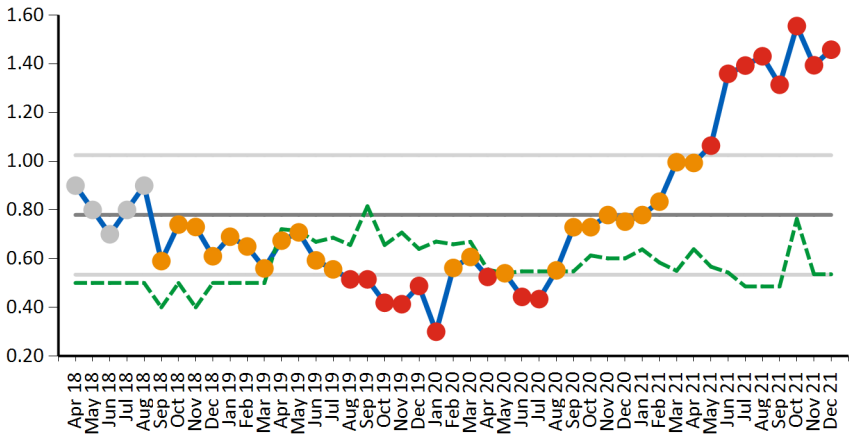
## Agency

Agency usage and spend are regularly reported to People Committee as well as the actions in place to support, including escalation controls, market management and more competitive bank rates.

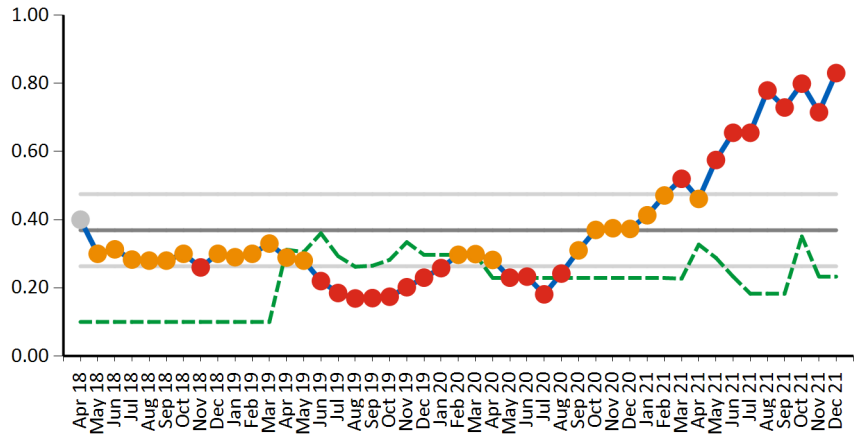
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 198 - Trust Annual ceiling for agency spend (£m) | <= 0.54 | 1.46 | Dec-21 |  | <= 0.54 | 1.39 | Nov-21 | <= 5.04 | 11.96 |  |
| 111 - Annual ceiling for Nursing Staff agency spend (£m) | <= 0.23 | 0.83 | Dec-21 |  | <= 0.23 | 0.72 | Nov-21 | <= 2.21 | 6.20 |  |
| 112 - Annual ceiling for Medical Staff agency spend (£m) | <= 0.23 | 0.47 | Dec-21 |  | <= 0.23 | 0.59 | Nov-21 | <= 2.34 | 4.45 |  |

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



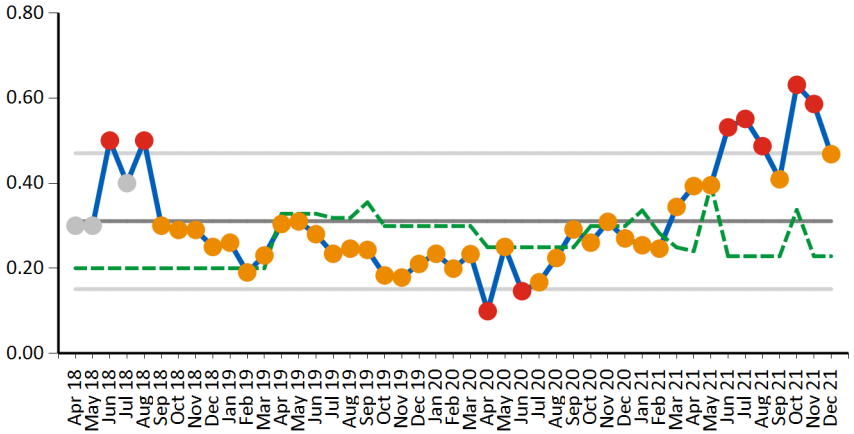


**111 - Annual ceiling for Nursing Staff agency spend (£m)**





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




## Finance

Revenue Performance Year to Date
• We have a year to date deficit of £3.6m
• Revenue performance is currently rated red
• Action to increase CIP delivery and improve controls on variable pay
• Action continue discussions with GM to receive £6m additional funding

Revenue Performance Forecast Outturn
• The Trust is currently forecasting a deficit of £6m for 21/22
• The forecast scenarios range from break even to a deficit of £10m
• Forecast  outturn is currently rated red

Cost Improvement
• The current trackers indicate that savings of £2.6m has been delivered YTD against a target of £7.0m.
• An additional £3.4m of non-recurrent savings has been delivered YTD leaving a shortfall of £1m against the YTD Target
• CIP is rated amber as there is a significant reliance on non-recurrent schemes.
• Action to focus on identifying and delivering recurrent CIP

Variable Pay
• We spent £2.6m on variable pay in month 9 which was consistent with Month 8.
• Variable pay is rated red as spend is significantly above plan.
• Action to improve controls and staff availability

Capital Spend
• Year to date spend is £6.0m.
• Forecast spend for 2021/2022 against FT funds is £13.1m assuming GM slippage is available.
• Additional MOU's outstanding of £12.6m for IT/Digital and £1.5m for Healthier together.
• Potential total capital plan for 2021/22 £27.6m.
• Capital is rated as red as a result of the associated risks.

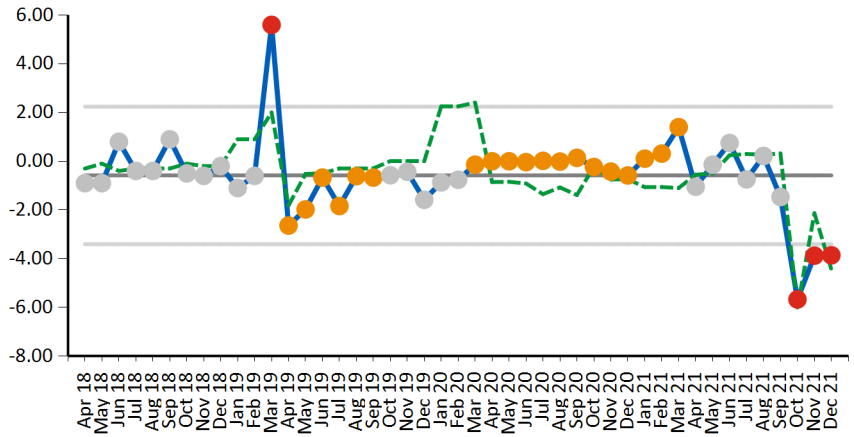
Cash Position
• We had cash of £34.1m at the end of the month.
• Cash is rated green as there are no concerns around cash flow this year.

Loans and PDC
• We have loans of £39.5m.
• Rated green as there are no concerns in this area.

Better Payment Practices Code
• Year to date we have paid 88.4% of our invoices within 30 days. This is below the target of 95%, hence rated amber.
• Action to review and improve performance is underway
Use of Resources Rating
• This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

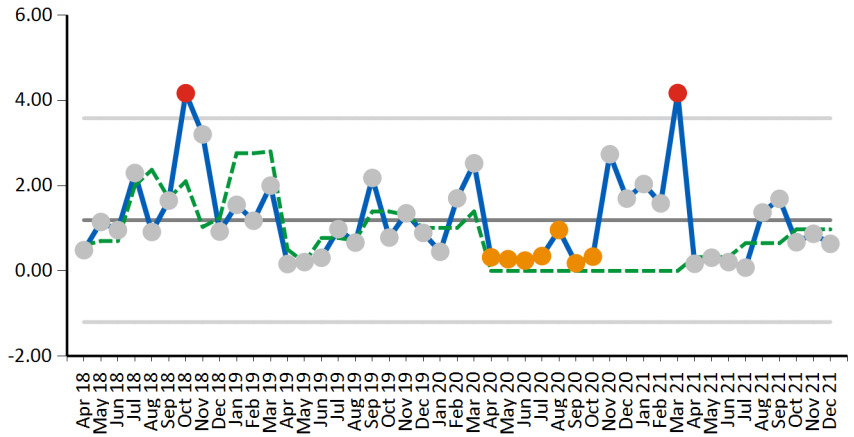
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 220 - Control Total (£ millions) | >= -4.4 | -3.9 | Dec-21 |  | >= -2.1 | -3.9 | Nov-21 | >= -12.5 | -15.8 |  |
| 222 - Capital (£ millions) | >= 1.0 | 0.6 | Dec-21 |  | >= 1.0 | 0.9 | Nov-21 | >= 5.8 | 6.0 |  |
| 223 - Cash (£ millions) | = 0.0 | 34.1 | Dec-21 |  | = 0.0 | 39.0 | Nov-21 | = 0.0 | 34.1 |  |

**220 - Control Total (£ millions)**



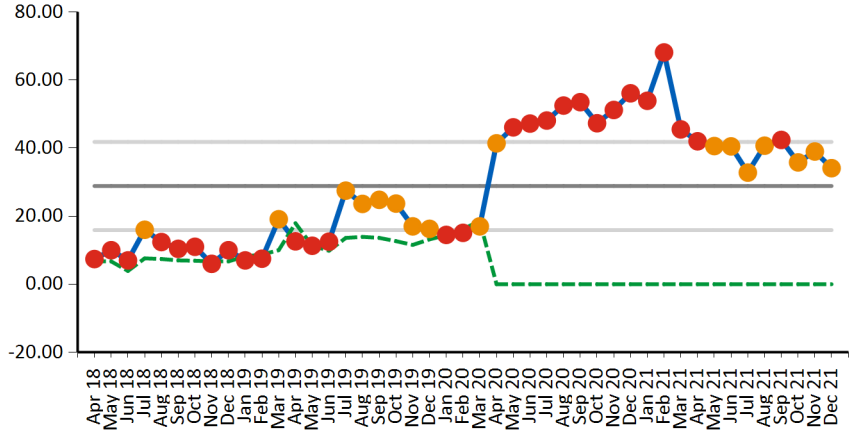


**222 - Capital (£ millions)**





**223 - Cash (£ millions)**




oard Assurance Heat Map - Hospital

| | Indicator | Target | Council | Acute Division | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Families Division | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Lab Lodge | AED-Adults | AED-Paeds | A4 | ACU | B1 (Frailty Unit) | B2 | B3 | B4 | BCAU | C1 | C2 | C3 | C4 | CCU | CDU | D1 (MAU1) | D2 (MAU2) | D3 | D4 | DL | EU (daycare) | H3 (Stroke Unit) | Critical Care | DCU (daycare) | E3 | E4 | F3 | F4 | F6 | G3/TSU | G4/TSU | H2 (daycare) | R1 | UU (daycare) | CDS | E5 | F5 | Ingleside | M2 (AN) | M3 (Birth) | M4 (PN) | M5 (PN) | M6 | NICU | Overall |
| | Average Beds Available per day | *N/a* | 32 | 0 | 0 | 22 | 10 | 23 | 26 | 21 | 22 | 19 | 25 | 24 | 26 | 25 | 10 | 13 | 24 | 22 | 22 | 25 | 12 | 5 | 22 | 18 | 25 | 25 | 25 | 25 | 24 | 10 | 24 | 24 | 11 | 8 | 4 | 15 | 38 | 7 | 4 | 26 | 5 | 22 | 22 | 17 | 38 | 815 |
| Infection Prevention Control | Hand Washing Compliance % | *Target = 100%* | 100.0% | 90.0% | N/R | N/R | 100.0% | N/R | 100.0% | 100.0% | 95.0% | N/R | 100.0% | 100.0% | 90.0% | 100.0% | 80.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | N/R | 100.0% | 100.0% | 100.0% | 100.0% | N/R | 100.0% | 90.0% | 100.0% | 100.0% | N/R | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 90.0% | 98.5% |
| | IPC Rapid Improvement Tool % (Gen) | *Target = 95%* | 93.3% | 83.3% | 81.3% | | | 100.0% | 80.0% | 100.0% | 89.5% | | 94.7% | 95.0% | 88.9% | | 94.4% | 88.9% | 95.0% | 95.0% | 100.0% | 95.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 94.7% | 100.0% | 100.0% | 84.2% | 66.7% | 94.7% | 94.7% | 100.0% | | 100.0% | 94.7% | 94.4% | 94.4% | | 94.1% | | 90.0% | 94.7% | 95.0% | 100.0% | 94.1% |
| | IPC Rapid Improvement Tool % (Med) | *Target = 95%* | | 75.0% | 100.0% | | | 100.0% | | 91.3% | 95.7% | | 95.8% | 86.4% | 91.7% | | 95.0% | 76.2% | 100.0% | 96.0% | 100.0% | 95.8% | 100.0% | 83.3% | 95.5% | 100.0% | 95.0% | 95.8% | 100.0% | 100.0% | 91.3% | 95.8% | 87.0% | 87.0% | 100.0% | | 81.3% | 95.2% | 89.5% | 89.5% | | 91.7% | | 94.1% | 100.0% | 100.0% | 100.0% | 91.9% |
| | Mattress Audit Compliance % | *Target = 100%* | 100.0% | | | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | C - Diff | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| | MSSA BSIs | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | E.Coli BSIs | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| | MRSA acquisitions | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Harm Free Care | All Inpatient Falls (Safeguard) | *Target = 0* | 0 | 3 | 0 | 4 | 0 | 6 | 10 | 0 | 3 | 3 | 5 | 10 | 14 | 9 | 0 | 0 | 3 | 7 | 4 | 3 | 0 | 0 | 2 | 0 | 0 | 3 | 5 | 2 | 1 | 0 | 5 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 105 |
| | Harms related to falls (moderate+) | *Target = 1.6* | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| | VTE Assessment Compliance | *Target = 95%* | | | | 0.0% | 99.2% | 0.0% | 0.0% | 0.0% | 0.0% | 93.7% | 40.0% | 84.2% | 94.3% | 100.0% | 96.3% | 93.6% | 94.9% | 94.8% | 94.7% | 90.3% | | 91.7% | 68.8% | 100.0% | 99.0% | 91.7% | 85.9% | 100.0% | 70.5% | 100.0% | 96.6% | 100.0% | 99.1% | 97.7% | 100.0% | 95.1% | | | | 75.0% | 98.5% | 100.0% | 84.4% | 81.2% | 96.3% | | 95.1% |
| | New pressure Ulcers (Grade 2) | *Target = 0* | 0 | 1 | 0 | 0 | 0 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| | New pressure Ulcers (Grade 3) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | New pressure Ulcers (Grade 4) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | New pressure Ulcers (unstageable) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Audit | Monthly KPI Audit % | *Target = 95%* | 96.7% | 92.5% | 95.7% | | | 86.9% | 82.1% | 87.5% | 89.8% | | 92.3% | 79.7% | 96.2% | 80.5% | 97.5% | 92.1% | 92.1% | 92.1% | 91.0% | 91.5% | 100.0% | 99.5% | 86.2% | 99.4% | 100.0% | 88.5% | 87.4% | 95.8% | 93.2% | 99.0% | 91.7% | 69.3% | 99.2% | | 99.3% | 98.9% | 100.0% | 100.0% | | 97.9% | | 99.1% | 98.0% | 97.1% | 98.0% | 93.0% |
| | BoSCA Overall Score % | *w=<55,b=55, s=75,g>90* | | 75.3% | 75.3% | | | 69.0% | 59.4% | 56.8% | | | 81.6% | 75.6% | 72.7% | 71.7% | 84.3% | 76.4% | 61.2% | 73.7% | 92.9% | 73.5% | 71.8% | 86.3% | 75.3% | 85.3% | | 86.8% | 72.8% | 91.8% | 67.1% | | 75.1% | 67.0% | | | 88.2% | 90.3% | 90.1% | 90.1% | | 91.9% | 90.4% | 71.4% | 71.4% | 80.3% | 90.3% | 82.5% |
| | BoSCA Rating | | | silver | silver | | | bronze | bronze | bronze | | | silver | silver | bronze | bronze | silver | silver | bronze | bronze | platinum | bronze | bronze | silver | silver | silver | | silver | bronze | platinum | bronze | | silver | bronze | | | silver | gold | platinum | platinum | | platinum | gold | bronze | bronze | silver | gold | Silver |
| Patient Experience | FFT Response Rate | *Target = 30%* | | 18.7% | 0.4% | 1.5% | 0.0% | 5.1% | 1.5% | 0.0% | 13.0% | 0.0% | 57.1% | 0.0% | 24.1% | 29.4% | 27.9% | 38.7% | 9.5% | 13.7% | 32.5% | 30.5% | | 26.5% | 23.5% | 0.0% | 25.9% | 4.6% | 6.0% | 14.7% | 0.8% | 13.7% | 26.0% | 35.0% | 21.8% | 52.2% | 44.2% | 29.5% | 3.5% | 0.6% | 29.5% | 0.6% | 29.5% | 13.0% | 13.0% | 1.5% | 48.7% | 14.3% |
| | FFT Recommended Rate | *Target = 97%* | | 84.1% | 100.0% | 100.0% | N/A | 100.0% | 100.0% | N/A | 100.0% | N/A | 96.4% | N/A | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 93.5% | 100.0% | N/A | 93.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 100.0% | 94.7% | 82.5% | 100.0% | 100.0% | 82.5% | 77.6% | 77.6% | 100.0% | 100.0% | 96.1% |
| | Number of complaints received | *Target = 0* | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |
| Governance | Serious Incidents in Month | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | Incidents > 20 days, not yet signed off | *Target = 0* | 3 | 80 | 4 | 3 | 0 | 11 | 2 | 2 | 0 | 2 | 1 | 5 | 2 | 24 | 0 | 1 | 5 | 4 | 0 | 5 | 0 | 4 | 1 | 0 | 0 | 2 | 6 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 58 | 0 | 0 | 4 | 6 | 0 | 0 | 0 | 8 | 1 | 247 |
| | Harm related to Incident (Moderate+) | *Target = 0* | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Staff Development | Appraisals | *Target = 85%* | | 72.7% | | | 92.9% | 57.9% | 76.7% | 61.5% | 37.5% | 68.4% | 53.1% | 72.9% | 74.4% | 97.8% | 76.9% | 94.1% | 87.2% | 94.4% | 89.2% | 76.2% | 25.0% | 75.5% | 65.8% | 89.4% | 79.2% | 100.0% | 87.0% | 93.3% | 80.8% | 90.5% | 97.7% | 69.7% | 100.0% | | 93.8% | 57.9% | 94.8% | | 0.0% | 77.3% | 36.4% | 70.6% | 55.2% | | 61.8% | 74.0% |
| | Statutory Training | *Target = 95%* | | 82.00% | | 93.36% | 76.33% | 71.64% | 60.57% | 56.73% | 89.2% | 66.08% | 84.69% | 75.51% | 90.65% | 92.67% | 90.07% | 90.48% | 85.71% | 94.82% | 85.56% | 94.64% | 91.03% | 78.39% | 86.12% | 97.04% | 90.73% | 89.66% | 91.84% | 75.78% | 86.46% | 82.77% | 86.35% | 91.94% | | 95.59% | 81.0% | 87.6% | | 85.7% | 81.7% | 74.7% | 81.5% | 78.7% | | 83.46% | 84.1% |
| | Mandatory Training | *Target = 85%* | | 87.87% | | 89.7% | 75.8% | 76.6% | 70.0% | 64.5% | 89.3% | 67.5% | 85.6% | 77.3% | 94.0% | 89.6% | 93.8% | 91.0% | 84.4% | 95.7% | 85.1% | 93.5% | 92.6% | 76.1% | 88.5% | 96.3% | 89.7% | 87.7% | 96.9% | 74.4% | 85.9% | 82.7% | 87.6% | 91.8% | | 97.4% | 83.3% | 88.6% | | 100.0% | 86.6% | 80.5% | 80.7% | 77.6% | | 83.8% | 85.6% |
| Staffing & Workforce | Budgeted Nurse: Bed Ratio (WTE) | | 11.85 | -5.38 | -5.38 | 0.00 | 0.00 | 1.53 | 0.91 | 9.34 | 0.00 | 0.00 | 0.39 | 6.83 | 2.00 | -2.04 | 3.53 | 2.37 | 2.43 | 2.19 | 3.72 | -3.52 | 0.00 | 10.25 | 0.14 | 6.83 | -1.45 | 2.47 | 15.10 | -5.74 | 4.87 | 2.17 | 9.19 | -0.01 | 4.68 | 0.00 | -2.75 | 3.18 | 1.21 | 1.21 | 8.29 | 3.31 | 10.76 | -1.78 | 4.67 | -5.27 | 8.88 | 99.13 |
| | Current Budgeted WTE (Ledger) | | 50.74 | 73.28 | 73.28 | | | 38.03 | 43.34 | 45.05 | | | 33.71 | 41.23 | 42.69 | 40.70 | 26.93 | 19.97 | 50.82 | 40.30 | 40.01 | 39.97 | | 60.93 | 36.15 | 113.81 | 32.75 | 35.52 | 41.23 | 37.79 | 30.21 | 44.50 | 44.49 | 18.07 | 60.08 | | 16.01 | 86.31 | 33.42 | 33.42 | 66.93 | 22.00 | 22.12 | 26.34 | 26.34 | 51.47 | 105.69 | 1745.61 |
| | Actual WTE In-Post (Ledger) | | 38.89 | 78.66 | 78.66 | | | 36.50 | 42.43 | 35.71 | | | 33.32 | 34.40 | 40.69 | 42.74 | 23.40 | 17.60 | 48.39 | 38.11 | 36.29 | 43.49 | | 50.68 | 36.01 | 106.98 | 34.20 | 33.05 | 26.13 | 43.53 | 25.34 | 42.33 | 35.30 | 18.08 | 55.40 | | 18.76 | 83.13 | 32.21 | 32.21 | 58.64 | 18.69 | 11.36 | 28.12 | 21.67 | 56.74 | 96.81 | 1634.63 |
| | Actual Worked (Ledger) | | 44.50 | 91.48 | 91.48 | | | 50.02 | 50.34 | 51.05 | | | 41.09 | 45.24 | 47.04 | 51.08 | 24.24 | 25.63 | 55.12 | 45.99 | 40.62 | 49.04 | | 49.42 | 41.45 | 122.71 | 34.82 | 43.26 | 34.69 | 50.17 | 47.71 | 54.78 | 46.20 | 27.74 | 56.33 | | 20.12 | 91.23 | 35.24 | 35.24 | 58.97 | 20.65 | 8.99 | 34.60 | 29.32 | 59.79 | 95.89 | 1903.26 |
| | Sickness (%) | *Target < 4.2%* | | 6.17% | | | 6.23% | 11.63% | 13.33% | 15.16% | 15.94% | 6.59% | 16.68% | 7.80% | 2.95% | 5.57% | 10.71% | 7.67% | 5.22% | 5.19% | 6.64% | 10.35% | 11.46% | 5.96% | 9.20% | 9.02% | 8.07% | 13.15% | 17.84% | 5.97% | 9.21% | 5.56% | 9.16% | 10.13% | 15.68% | | 5.51% | 9.83% | 4.43% | | 3.23% | 12.50% | 2.80% | 4.26% | 6.94% | | 11.12% | 8.84% |
| | Current Budgeted Vacancies | | -5.61 | -12.82 | -12.82 | 0.00 | 0.00 | -13.52 | -7.91 | -15.34 | 0.00 | 0.00 | -7.77 | -10.84 | -6.35 | -8.34 | -0.84 | -8.03 | -6.73 | -7.88 | -4.33 | -5.55 | 0.00 | 1.26 | -5.44 | -15.73 | -0.62 | -10.21 | -8.56 | -6.64 | -22.37 | -12.45 | -10.90 | -9.66 | -0.93 | 0.00 | -1.36 | -8.10 | -3.03 | -3.03 | -0.33 | -1.96 | 2.37 | -6.48 | -7.65 | -3.05 | 0.92 | 110.98 |
| | Pending Appointment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| | Substantive Staff Turnover | *Target < 10%* | | 7.0% | | | 0.0% | 9.5% | 15.0% | 4.9% | 5.3% | 9.1% | 37.8% | 15.7% | 14.0% | 10.8% | 0.0% | 4.9% | 17.9% | 20.8% | 20.9% | 14.6% | 0.0% | 16.7% | 7.2% | 8.9% | 7.4% | 21.4% | 19.0% | 4.2% | 48.3% | 7.7% | 11.8% | 20.6% | 15.6% | | 5.7% | 11.0% | 7.0% | | 66.7% | 9.8% | 42.1% | 15.8% | 9.7% | | 10.0% | 14.70% |

**Data Legend**

| | |
|---|---|
| No data returned | N/R |
| No Eligible patients | |

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

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

Board Assurance Heat Map - District Nursing Domiciliary & ICS Services

| | Indicator | Target | ICS Services | | | | | | | | | | | | | | DN Teams | | | | | | | | | | Treatment Rooms | | Overall |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Admission Avoidance | Acute Therapies | Anti-coagulant Team | Asylum & Refugee/ Homeless & Vunerable | Bladder & Bowel Service | Community IV Therapy | Diabetes & Endo | Dietetics | Falls | Neurology & LTC | Podiatry | Rheum-atology | SLT | Stroke | Wheel-chair Service | Avondale | Breightmet & Little Lever | Crompton | Farnworth | Great Lever | Horwich | Pikes Lane | Waters Meeting | West-houghton | Evening Service | North | South | |
| Infection Control & Harm Free | Hand Washing Compliance % | *Target = 100%* | N/R | | 100.0% | N/R | N/R | 100.0% | | | | N/R | | 100.0% | | | | 100.0% | N/R | N/R | 100.0% | 100.0% | N/R | N/R | N/R | N/R | N/R | N/R | N/R | 100.00% |
| | Monthly New pressure Ulcers (Grade 2) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 3 | 0 | 0 | 0 | 0 | | 7 |
| | Monthly New pressure Ulcers (Grade 3) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 1 |
| | Monthly New pressure Ulcers (Grade 4) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| | Monthly New pressure Ulcers (Unstageable) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | 2 |
| Audit | Monthly KPI Audit % | *Target = 95%* | 96.7% | | | 98.2% | 100.0% | 100.0% | | 92.1% | | | 88.1% | | 77.9% | | 94.2% | 100.0% | 97.7% | 98.4% | 97.6% | 97.0% | 94.4% | 96.3% | 98.8% | 98.8% | 98.4% | 95.7% | 97.0% | 94.00% |
| | BoSCA Overall Score % | *w=<55%, B>55%, S>75%, G>90%* | | | | | | | | | | | | | | | | 94.74% | 91.01% | 94.22% | 85.51% | 93.60% | 94.33% | 97.23% | 83.06% | 97.11% | 94.79% | 95.60% | 89.86% | 93% |
| | BoSCA Rating | | | | | | | | | | | | | | | | | platinum | platinum | platinum | silver | platinum | platinum | platinum | silver | platinum | platinum | gold | silver | platinum |
| Patient Experienc | Friends and Family Response Rate % | *Target = 30%* | 100.0% | | 62.5% | 0.0% | 30.0% | 85.0% | 3.7% | 0.9% | 0.0% | 9.9% | 3.2% | 5.2% | 5.0% | 100.0% | 0.0% | | | | | 23.2% | | | | | | 37.5% | | 26.50% |
| | Friends and Family Recommended Rate % | *Target = 97%* | 100.0% | | 100.0% | | 100.0% | 100.0% | 82.8% | 100.0% | | 100.0% | 96.6% | 91.7% | 100.0% | 100.0% | | | | | | 100.0% | | | | | | 100.0% | | 93.60% |
| | Number of Complaints received | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Staff Development | Sickness (%) | *Target is < 4.2%* | 6.4% | 4.9% | 13.1% | 4.29% | 2.6% | 0.8% | 3.2% | 2.67% | 4.6% | 10.9% | 3.1% | 3.3% | 4.2% | 6.8% | 5.3% | 7.6% | 2.3% | 2.1% | 3.5% | 0.3% | 2.6% | 2.6% | 0.2% | 11.7% | 0.3% | 1.2% | | 3.97% |
| | Total WTE with 19.81% Headroom (Sickness, Training etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substantive Staff Turnover Headcount (rolling average 12 months) | *Target is < 10%* | 10.0% | 12.2% | 20.0% | 18.2% | 0.0% | 14.3% | 18.5% | 24.0% | 6.1% | 28.1% | 4.9% | 19.5% | 5.4% | 12.1% | 23.5% | 14.3% | 20.7% | 0.0% | 0.0% | 8.3% | 0.0% | 0.0% | 12.5% | 0.0% | 12.9% | 11.1% | | 10.75% |
| | 12 month Appraisal | *Target = 85%* | 86.5% | 87.8% | 100.0% | 83.3% | 0.0% | 53.8% | 100.0% | 95.7% | 58.8% | 88.5% | 95.0% | 94.4% | 94.1% | 90.0% | 87.5% | 84.6% | 100.0% | 94.4% | 88.9% | 91.7% | 85.7% | 75.0% | 100.0% | 92.3% | 96.7% | 100.0% | | 87.87% |
| | 12 month Statutory Training | *Target = 95%* | 90.5% | 93.3% | 95.2% | 94.3% | 96.4% | 95.6% | 96.6% | 94.6% | 90.9% | 94.9% | 93.4% | 94.6% | 95.8% | 94.1% | 96.7% | 91.1% | 98.1% | 95.6% | 90.0% | 99.0% | 92.9% | 89.3% | 97.3% | 92.0% | 96.1% | 97.3% | | 93.58% |
| | 12 month Mandatory Training | *Target = 85%* | 93.9% | 93.6% | 89.8% | 96.6% | 73.9% | 97.2% | 95.9% | 93.2% | 90.3% | 94.0% | 93.0% | 91.1% | 95.1% | 95.2% | 97.0% | 91.7% | 96.7% | 95.6% | 94.2% | 95.0% | 97.9% | 96.9% | 93.6% | 89.6% | 97.2% | 100.0% | | 94.11% |

**Data Legend**

| | |
|---|---|
| No data returned | N/R |
| No Eligible patients | |

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

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

| | |
|---|---|
| **Title:** | Board Champions and Nominated Leads |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | January 2022 | | Discussion | |
| **Exec Sponsor** | Director Corporate Gov | | Decision | |

| | |
|---|---|
| **Summary:** | Board members will be aware that until recently there had been an ever increasing demand for non-executive directors to take lead/champion roles to engender board level commitment and focus around key areas of service development or delivery.<br><br>NHSI recently reviewed this requirement and recommended a revised approach (appendix 1) reducing the number of champion roles and recommending the discharge of others through committee structures.<br><br>This paper is not intended to cover Committee Chair arrangements and other non statutory lead roles<br><br>Workplans for the assurance committee will be reviewed to map to this.<br><br>The requirement for Executive leads has not changed and the following changes to these are proposed to align with new portfolios:<br>• Change to Board level net zero lead – now the Director of Finance<br>• Changes to reflect the change of COO – Rae Wheatcroft picks up operational responsibilities and the SIRO role passes to Sharon Martin |
| **Previously considered by:** | Executive Directors |
| **Proposed Resolution** | Board members are asked to approve the designated Board leads to meet regulatory requirements as defined in the paper. |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Esther Steel<br>Director of Corporate Governance | **Presented by:** | Esther Steel<br>Director of Corporate Governance |

**Non-Executive Lead Roles (from 1 Feb 2022)**

| Statutory or Regulatory Role | Regulation/Guidance | Role | Who | Committee |
|---|---|---|---|---|
| Maternity board safety champion | The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended | The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.<br><br>NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9. | Martin North | Quality Assurance |
| Wellbeing guardian | This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision. | The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials. | Malcolm Brown | People Committee |
| Freedom to speak up | The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up | The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with | Bilkis Ismail | People Committee |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Who | Committee |
|---|---|---|---|---|
| | about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. | the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).<br>All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information. | | |
| Doctors disciplinary | Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. | There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only. | Malcolm Brown | People Committee |
| Security Management | Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. | Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement. | Alan Stuttard | Audit Committee |
| Vice Chair | The Trust Constitution requires the Council of Governors (the Council) to appoint a Vice Chair to deputise for and support the Trust Chair. | The Vice Chair shall normally preside at meetings of the Board of Directors or Council of Governors in the following circumstances:<br>a) when the Trust Chair is unavailable to Chair; | Jackie Njoroge | Board |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Who | Committee |
|---|---|---|---|---|
| | | b) on occasions when the Trust Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter | | |
| Senior Independent Director | The Senior Independent Director (SID) is a Non-Executive Director appointed by the Board of Directors as a whole in consultation with the Council of Governors to undertake the role. The SID may be, but does not have to be, the Deputy Chair of the Board of Directors. | The SID will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Chair, Chief Executive, Finance Director and Company Secretary, has failed to resolve or where it would be inappropriate to use such channels.<br><br>Whilst the Council of Governors determines the process for the annual appraisal of the Chair, the SID is responsible for carrying out the appraisal of the Chair on their behalf as set out as best practice in the Code of Governance. The SID might also take responsibility for an orderly succession process for the Chair's role where a re-appointment or a new appointment is necessary.<br><br>The SID should maintain regular contact with the Council of Governors and attend meetings of the Council of Governors to obtain a clear understanding of Governors' views on the key strategic and performance issues facing the Foundation Trust. The SID should also be available to Governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the Chair, for example, the Chair's appraisal or setting the Chair's objectives. | Bilkis Ismail | Board |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Who | Committee |
|---|---|---|---|---|
| | | In rare cases where there are concerns about the performance of the Chair, the SID should provide support and guidance to the Council of Governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action | | |

**Executive Lead Roles**

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| Accountable Officer | The NHS Act 2006 designates the chief executive of an NHS foundation trust as the accounting officer. | The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. | Chief Executive | Fiona Noden | Board |
| Caldicott Guardian | Health Service Circular: HSC 1999/012<br>The NHS IM&T Security Manual (Section 18.4) | To oversee all procedures affecting access to person-identifiable health data. | Deputy Medical Director | Harni Bharaj | Digital reporting to Finance and Investment |
| SIRO | Information Governance Toolkit | Leading and fostering a culture that values, protects and uses information for the success of the organisation and benefit of its customers<br>Owning the organisation's overall information risk policy and risk assessment processes and ensuring they are implemented consistently by IAOs | Director of Strategy and Transformation | Sharon Martin | Digital reporting to Finance and Investment |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| | | Advising the Chief Executive or relevant accounting officer on the information risk aspects of his/her statement on internal controls<br><br>Owning the organisation's information incident management framework | | | |
| Director of Infection Prevention and Control | Health & Social Care Act 2008 – Code of Practice on the prevention and control of infection and related guidance. | Be responsible for the Trust's Infection Prevention and Control Team (IP&CT).<br><br>Oversee local control of infection policies and their implementation.<br><br>Be a full member of IP&CT and regularly attend its Infection Prevention and Control meetings.<br><br>Assess the impact of all existing and new policies on Healthcare Associated Infections (HCAI) and make recommendations for change.<br><br>Oversee the production of an annual report and release it publicly. | Chief Nurse | Karen Meadowcroft | Quality Assurance |
| Responsible Officer for revalidation | The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 | Statutory role in medical regulation.<br><br>Accountable for the local clinical governance processes, focusing on the conduct and performance of doctors.<br><br>Duties include evaluating a doctor's fitness to practise, and liaising with the GMC over relevant procedures.<br><br>Ensure that the organisation has appropriate systems for appraising the performance and conduct of doctors. | Medical Director | Francis Andrew | People Committee |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| Safeguarding Vulnerable Adults | Mental Capacity Act<br>Mental Health Act | Liaising with the Trust's safeguarding leader on a regular basis and participate in awareness raising activities.<br>Liaising with the Trust's lead for overseeing the mechanisms in place to identify and cater for patients with Learning Disabilities.<br>Liaising with the Trust's Dementia Lead to encourage the Trust to operate as a dementia friendly hospital and participate in awareness raising activities as appropriate. | Chief Nurse | Karen Meadowcroft | Quality Assurance |
| Safeguarding Children | Department of Health working together to safeguard children 2010<br>Children Act 2004 section 11, duty to safeguard and promote welfare<br>Children Act 2004 section 13, statutory partners in the local safeguarding children board<br>Children Act 1989 section 27, help with children in need<br>Children Act 1989 section 47, help with enquiries about significant harm. | Act as Board Champion for all safeguarding issues.<br>Inform Board of level of assurance re compliance with safeguarding regulations.<br>To act as the Trust's safeguarding ambassador for the local safeguarding children's board.<br>Ensure that safeguarding systems are robust and appropriately monitored.<br>Ensure that any gaps in compliance are addressed resulting in improvements to safeguarding of vulnerable children.<br>Demonstrate strong leadership for all safeguarding issues.<br>Respond to national policy proposals. | Chief Nurse | Karen Meadowcroft | Quality Assurance |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| Board level lead for maternity services | National Maternity Review: Better Births (2016) | Routinely monitor information about quality, including safety, and take necessary action.<br><br>Promote a culture of learning and continuous improvement to maximise quality and outcomes from their services. | Chief Nurse | Karen Meadowcroft | Quality Assurance |
| Board lead for learning disability | Learning Disability Improvement Standards | Organisational level data collection: to be completed from the perspective of a nominated Executive Learning Disability lead/named board member, who will collate data on policies and activity, thereby assuring the impact of the care being delivered and the quality of service and outcomes. | Chief Nurse | Karen Meadowcroft | Quality Assurance |
| End of Life Care – Executive Director | National Care of the Dying Audit Round 4 2014<br><br>Neuberger Review. More Care: Less Pathway. 2013<br><br>LACDP. One Chance to get it Right. 2014<br><br>National Hospitals End of Life Care Audit 2015<br><br>CQC Inspection Framework: NHS Acute Hospitals 2016 | Take responsibility for and champion End of Life Care at Board level.<br><br>Ensure End of Life Care within the Trust, and provided by the Trust, is appropriately monitored.<br><br>Demonstrate strong leadership and role model for all Trust staff regarding End of Life Care.<br><br>Assess the impact of all existing and new policies on End of Life Care and make recommendations for change.<br><br>Recognise the impact of the perception of poor end of life care on bereaved families and provides Board assurance | Medical Director | Francis Andrews | Quality Assurance |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| | | that complaints and incidents are dealt with in a way that reduces this impact. | | | |
| Authorisation of Authorised Officers in relation to Section 120 of the Criminal Justice and Immigration Act 2008 | Section 120 of the Criminal Justice and Immigration Act 2008 | The procedure for the authorising of authorised officers is not laid out in the act, but it is recommended that authorisation of officers is made in writing by a person at board level in the NHS body<br>They should have assurance as part of this process that the authorised officers and appropriate NHS staff are suitably trained and competent to carry out their roles. | Director of Finance | Annette Walker | Audit Committee |
| Equality and Diversity | Equality Act 2010 - Public Sector Duty<br>The Workforce Race Equality Standard | To act as a Board champion to set an example and demonstrate that the Board is committed to promoting equality.<br>To challenge and promote the E&D agenda in the Trust.<br>Act as a voice at Board meetings for the E&D agenda. | Director of Workforce.<br>The People Plan 2020 states that it is the explicit responsibility of the CEO to lead on equality, diversity and inclusion. | James Mawrey | People Committee |
| Accountable executive for security | Sec of State Direction to NHS Bodies on Security Management Measures 2004 | To be the accountable person for security at an Executive Level within the NHS Trust.<br>To promote security management policy, culture and measures. | Director of Finance | Annette Walker | Audit Committee |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| Board-level net zero leads | Progress and next steps towards delivering a net zero NHS | To support the development and delivery of the Carbon reduction strategy | Director of Finance | Annette Walker | Board |
| Counter Fraud Champion | Directions to NHS bodies on counter fraud measures 2004. To champion the counter fraud message throughout the Trust. | To monitor the effective discharge of the counter fraud function in relation to compliance with the Secretary of State Directions. To promote counter fraud measures. | Director of Finance | Annette Walker | Audit Committee |
| Designated Individual responsible for the application of the Human Tissue Act | Section 18 of the Human Tissue Act | Key role in implementing the requirements of the Human Tissue Act.<br>They have the primary (legal) responsibility under Section 18 of the Human Tissue Act to secure:<br>• that suitable practices are used in undertaking the licensed activity;<br>• that other persons working under the licence are suitable and;<br>• That the conditions of the licence are complied with. | Medical Director | Francis Andrew | Quality Assurance |
| Lead for Ionising Radiation Medical Exposure Regulations (IRMER) | IRMER | Board level responsibility for compliance with IRMER guidance | Medical Director | Francis Andrew | Health and Safety to Quality Assurance |
| Freedom to speak up guardian | Freedom to speak up: whistleblowing policy for the NHS (2016) | The guidance states that the FTSU Guardian will be acting in a genuinely independent capacity and will be appointed by and work alongside the trust board, along with members of the executive team, to help support the | Freedom to Speak up Champion | Tracey Garde | People Committee |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| | | trust to become a more open, transparent place to work<br><br>The FTSU Guardian must be entirely independent of the executive team so they are able to challenge senior members of staff as required.<br><br>Must be a highly visible individual who spends the majority of their time with the front line staff, developing a culture which encourages people to speak up using the local procedures. They must also ensure that staff who speak up are treated fairly through any investigation or review | | | |
| Accountable Officer for Emergency Planning | Civil Contingencies Act/HASC 2012The Civil Contingencies<br><br>Act 2004. NHS Emergency Planning guidelines.<br><br>Health & Social Care Act 2012. | To provide the Board with levels of assurance for emergency preparedness, planning and response as appropriate.<br><br>To act as Board Champion for all emergency planning matters for staff and patients.<br><br>Ensure strategic review of the Trust's emergency planning occurs. | Chief Operating Officer | Rae Wheatcroft | Board |
| | | | Head of Emergency Planning | James Tunn | Board |
| Accountable Officer for Controlled Drugs | Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)). | establish and operate, appropriate arrangements for securing the safe management and use of controlled drugs<br><br>Establish and operate appropriate arrangements for monitoring and auditing the management and use of controlled drugs. | Chief Pharmacist | Steve Simpson | Quality Assurance |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who | Committee |
|---|---|---|---|---|---|
| Guardian of Safe Working<br><br>The guardian is a senior person, independent of the management structure within the organisation, for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. | part of the new Junior Doctors contract | The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors' working hours are safe. | Guardian of Safe Working | Dr Yunus-Usmani | People Committee |

Classification: Official

Publication approval reference: PAR994

Enhancing board oversight

# A new approach to non-executive director champion roles

Version 1, December 2021

# Contents

# 1. Summary

## 1.1 Introduction

This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes ‘named NEDs’ and ‘NED leads’.

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in several reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

Working with stakeholders, we have reviewed the issues the roles were originally established to address, to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making – remains. However, there are many issues where we now consider progress will be best made through existing trust committees rather than through individual NED champion roles.

This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The risk of false assurance among chairs and directors who are not designated ‘champions’ will also be reduced, as oversight of transformational change to

improve care and responsibility to constructively challenge on all issues using Appreciative Inquiry approaches, will rest with the whole committee and not just an individual. By reducing the risk of individual NEDs becoming too involved in operational detail, this approach may also help maintain their independence – something that NEDs are uniquely positioned to bring to a board.

## 1.2 Status of guidance

This new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

## 1.3 Co-developing the approach

The new approach has been co-developed with a working group of trust chairs and we have also held a series of workshops with a range of providers. This enabled us to identify current roles and test alternative approaches to enhancing board oversight of important issues. We have engaged with national policy teams on the issues requiring oversight at board level that have associated NED champion roles. Further detail on each issue is provided in annexes 1 and 2.

We have engaged with the Care Quality Commission (CQC) throughout the development of this approach. While there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate.

## 1.4 New recommended approach

For each issue, we identified the original review or report that recommended the establishment of a NED champion role and worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tools such as walkarounds, for example.

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

| Roles to be retained | | | | |
|---|---|---|---|---|
| Maternity board safety champion | Wellbeing guardian | Freedom to speak up | Doctors disciplinary | Security management |
| **Roles to transition to new approach** | | | | |
| Hip fracture, falls and dementia | Learning from deaths | Safety and risk | Palliative and end of life care | Health and safety |
| Children and young people | Resuscitation | Cybersecurity | Emergency preparedness | Safeguarding |
| Counter fraud | Procurement | Security management-violence and aggression | | |

It should be noted that the table above includes those issues for which a report or review has suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of.

# 2. Implementation and support

To support the effective implementation of this new approach we recommend that trusts take the following steps:

## 2.1 Review current roles

Trusts should undertake a review to identify a list of their current NED champion roles. Annex 1 outlines roles that are statutory roles or that continue to require an individual to discharge those responsibilities. These roles should be retained. All other roles should be embedded in governance arrangements and aligned to committee structures where possible.

## 2.2 Align remaining roles to committee structures

Where we have recommended that issues are now discharged through a committee, we have grouped these issues by 'theme' to align with committee structures commonly used by trusts. However, this is not prescriptive, and trusts will want to align issues with the committee that they believe is the best fit and is aligned with their current governance arrangements.

Understandably some complex issues may fall under the remit of more than one committee structure – in these cases trust boards may wish to adopt a joint approach to ensure appropriate assurance.

## 2.3 Outline reporting structures

It will be up to trusts to decide how committees should report back on their assurance activities to the board, whether that is through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Company secretaries may wish to ensure these issues are included on board/committee forward plans.

## 2.4 Update terms of reference

As trusts review their governance arrangements, they will want to ensure that committee terms of reference reflect any new responsibilities and respective reporting requirements because of these changes. Committee chairs and members

may wish to consider actions needed to discharge the roles effectively, such as regular engagement with an executive lead, background reading, visiting services and attending seminars or training as available and appropriate to the trust.

## 2.5 Ongoing support

While some trusts may already be working with similar arrangements, it is recognised that effective implementation may require cultural and behavioural shifts. To support implementation, it would be useful to receive trusts' feedback on where the proposed approach has worked well, to identify examples of best practice. We (NHS England and NHS Improvement) can then support in disseminating successful case studies and lessons learned with other trusts.

Existing platforms such as the NHS Providers Company Secretaries Network, existing care groups and regional forums will be used to share those learnings and collect feedback.

This guidance will be kept under review and updated as necessary.

Please send feedback and best practice examples to nhsi.providerpolicyengagement@nhs.net.

# Annex 1: Retained NED champion roles

We have identified five NED champion roles which at this point should be retained. These are maternity board safety champion, wellbeing guardian, freedom to speak up guardian (FTSU), doctors disciplinary and security management. These should be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed. This section provides further detail on these roles and additional sources of information are set out in the Resources section.

## 1. Maternity board safety champion

| | |
|---|---|
| Applies to | All trusts providing maternity services |
| Type of role | Assurance |
| Legal basis | Recommended |
| Role description | Maternity NED role descriptor |

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that “Senior trust managers will want to ensure unfettered communication from ‘floor-to-board’ by appointing a board level maternity champion”. The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral

to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.

Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

## 2. Wellbeing guardian

| Applies to | All trusts |
|---|---|
| Type of role | Assurance |
| Legal basis | Recommended |
| Role description | Guardian community website and role description |

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

## 3. FTSU NED champion

| Applies to | All trusts |
|---|---|
| Type of role | Functional |
| Legal basis | Recommended |
| Role description | FTSU supplementary information |

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.

## 4. Doctors disciplinary NED champion/independent member

| Applies to | All trusts (advisory for foundation trusts) |
|---|---|
| Type of role | Functional |
| Legal basis | Statutory |
| Role description | None |

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.

## 5. Security management NED champion

| | |
|---|---|
| Applies to | All trusts, excluding NHS foundation trusts |
| Type of role | Assurance |
| Legal basis | Statutory |
| Role description | None |

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. We have included further guidance on these two functions in Annex 2. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

# Annex 2: Issues that can be overseen through committee structures

This section covers those issues which reports or reviews previously suggested should be overseen by a NED champion, but which we now consider are best overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of.

For the purposes of this guidance the issues are grouped into ‘themes’ aligned to committee structures commonly used by trusts. However, each trust will need to determine whether each issue is relevant to their trust and how best they should be allocated to their committee structures, especially since some issues will cut across several committees. These issues and themes are summarised in table format under the resources section.

## Quality and Safety Committee

### 1. Hip fractures, falls and dementia

All trusts and health boards should have a director with responsibility for falls and the ‘National Audit of Inpatient Falls Audit (NAIF) Report 2020’ recommends a patient safety group which is overseen by a member of the executive and non-executive team. This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.

Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.

The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work.

## 2. Palliative and end of life care

The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis.

The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:

- attendance of a NED from the Quality Committee at the PEoLC Executive Committee
- ensuring the board is aware of standards of care in PEoLC
- reviving PEoLC complaints to see where improvements could be made.

## 3. Resuscitation

Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.

## 4. Learning from deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.

## 5. Health and safety

Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.

Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.

## 6. Safeguarding

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.

## 7. Safety and risk

The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit committees as examples.

CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

## 8. Lead for children and young people

The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then

allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

## Audit and Risk Committee

### 9. Counter fraud

The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud.

NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.

### 10. Emergency preparedness

The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a board level director with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements.

The Framework suggests that a NED or other appropriate board member should support the AEO and endorse assurance to the board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR.

The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on

appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually.

Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

## Finance, Performance and Planning Committee

### 11. Procurement

Procurement should be seen by the board as a value-adding function. The Finance, Performance and Planning Committee should help raise awareness of commercial matters at board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement.

Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.

### 12. Cyber security

Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the board than a committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced.

Each trust should have a senior information risk owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber-security standards are followed throughout their organisation.

The board/committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following:

- Removal of unsupported systems from trust networks.
- Timely patching of systems and prompt action on high severity Alerts when they are issued.
- Ensuring robust and immutable backups are in place.

It is also recommended that boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

## Workforce/People Committee

### 13. Security management – violence and aggression

As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the board may wish to ensure the following:

- The trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the board.

- Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.

- A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board.

The Workforce/People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence.

# Resources

## Summary of roles by suggested committee and further sources of information

The following is a list of further reading that NEDs and other board members may find useful in developing their knowledge and understanding of the issues highlighted in this document.

| Role | Links to further reading |
|---|---|
| **General** | |
| Maternity board safety | • Morecambe Bay Investigation (2015)<br>• Ockenden Review (2020)<br>• NSR Maternity Incentive Scheme Safety Actions<br>• Maternity and Neonatal Safety Champions Toolkit<br>• Transforming Perinatal Safety Resource Pack<br>• NHS England and NHS Improvement Maternity Safety Resources<br>• Safer Maternity Care 2016 |
| Wellbeing guardian | • Guardian Community website and role description<br>• Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) |
| Freedom to speak up | • Report template – NHS England and NHS Improvement website (england.nhs.uk)<br>• Robert Francis Freedom to Speak Up report<br>• FTSU supplementary information<br>• FTSU Guidance and self-review tool |
| Doctors disciplinary | • Directions on Disciplinary Procedures 2005<br>• Maintaining High Professional Standards in the modern NHS |
| Security management | • Directions to NHS Bodies on Security Management Measures 2004 |

| Role | Links to further reading |
|---|---|
| **Quality and Safety Committee** | |
| Hip fracture, falls and dementia | • Patient Information Resource National Audit of Inpatient Falls- Guide for Healthcare Champions<br>• National Audit of Inpatient Falls (NAIF) 2020 Annual Report \| RCP London<br>• NICE Guidance - Falls in Older People: Assessing Risk and Prevention<br>• Dementia Care Pathway- Full implementation guidance<br>• Dementia wellbeing in the COVID pandemic<br>• NHS England Dementia: Good Personalised Care and Support Planning Information for primary care providers and commissioners - Guidance |
| Palliative and end of life care | • Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026<br>• "What NHS England is doing to improve end of life care", NHS England and NHS Improvement webpage<br>• "Resources on End of Life Care", NHS England and NHS Improvement webpage |
| Resuscitation | • Quality Standards: Acute Care, Resuscitation Council UK |
| Learning from deaths | • https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf |
| Safety and risk | • Inspection Framework – trust-wide well led, CQC |
| Lead for children and young people | • Inspection framework – NHS Hospitals services for children and young people, CQC |
| Safeguarding | • Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff |
| Health and safety | • "Leading Health and Safety at Work", HSE webpage<br>• FAQs: Leading health and safety at work, HSE webpage<br>• Leading health and safety at work: Actions for directors, board members, business owners and organisations of all sizes- Guidance, HSE |

| Role | Links to further reading |
|---|---|
| **Audit and Risk Committee** | |
| Counter fraud | • Refer to service condition 24 of the NHS standard contract: 2021/22 NHS Standard Contract, NHS England and NHS Improvement<br>• "Information for Fraud Champions", Fraud Prevention, NHS Counter Fraud Authority webpage |
| Emergency preparedness | • NHS England and NHS Improvement Emergency Preparedness, Resilience and Response Framework – Guidance |
| **Finance, Performance and Planning Committee** | |
| Procurement | • NHS Procurement: Raising Our Game – Best Practice Guidance |
| Cyber security | • 2017/18 Data Security and Protection Requirements- Guidance<br>• Data Security and Protection Toolkit, NHS Digital<br>• The Minimum Cyber Security Standard- Guidance, Cabinet Office<br>• Lessons learned review of the WannaCry Ransomware Cyber Attack – Independent report |
| **Workforce/People Committee** | |
| Security management - violence and aggression | • Violence prevention and reduction standard |

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Agenda Item 20

| | |
|---|---|
| **Title** | Modern Anti-Slavery Statement |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | |
| **Date:** | 27 January 2022 | | Discussion | |
| **Exec Sponsor** | Esther Steel | | Decision | ✓ |

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

| | |
|---|---|
| **Previously considered by:** | Previous statement approved by the Board of Directors |

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

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Esther Steel<br>Director of Corporate Governance | **Presented by:** | Esther Steel<br>Director of Corporate Governance |

## Background

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

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

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

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

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

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

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

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

Bolton NHS Foundation Trust is a major provider of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital and also providing a wide range of community services from locations across Bolton. The Royal Bolton Hospital is a major hub within Greater Manchester for women's and children's services and is the second busiest ambulance-receiving site in Greater Manchester. We employ approximately 6000 staff and in 2020/21 had a turnover of over £400m

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

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

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

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

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

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2022

Signed

27 January 2022

| | |
|---|---|
| **Title:** | Chairs' Report – Finance & Investment Committee |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27th January 2022 | | Discussion | |
| **Exec Sponsor** | Annette Walker | | Decision | |

| | |
|---|---|
| **Summary:** | To update the Committee on the work and activities of the Finance & Investment Committee in November 2021. |

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|---|---|
| **Previously considered by:** | N/A |

| | |
|---|---|
| **Proposed Resolution** | To note the updates from Chairs' Report. |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Annette Walker<br>Director of Finance | **Presented by:** | Annette Walker<br>Director of Finance |

**Committee/Group Chair's Report**

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

| | | | |
|---|---|---|---|
| Name of Committee/Group: | Finance & Investment Committee | Report to: | Board of Directors |
| Date of Meeting: | 23rd November 2021 | Date of next meeting: | 21st December 2021 |
| Chair: | Jackie Njoroge | Parent Committee: | Board of Directors |
| Members Present: | Becks Ganz, Bilkis Ismail, Fiona Noden, Annette Walker, Andy Ennis, James Mawrey, Lesley Wallace, Andy Chilton, Rachel Noble | Quorate (Yes/No): | Yes |
| | | Key Members not present: | Esther Steel, Catherine Hulme |

| Key Agenda Items: | RAG | Lead | Key Points | Action/decision |
|---|---|---|---|---|
| H2 Financial Plan | | Director of Finance | The committee received an update on the financial plan for H2. Key points were noted as follows:<br>• The submission made in September showed a deficit of £2.4m for H1 and a deficit of £49m for H2.<br>• In October the H2 plan deficit reduced to £39m. This was mainly due to the pay award funding and reduced CIP.<br>• An additional submission is due on 25th November which will include the following:<br>  ○ Additional funding of £2.4m has been received for H1.<br>  ○ H2 CIP required is 3% – £7.7m.<br>  ○ There is an assumption that £6.3m of ERF will be received in H2.<br>  ○ This leaves £6.2m of additional income support required.<br>• Bolton has the largest gap in GM due to the system finance allocation.<br>• It was noted that the CIP target of 4.24% will be difficult to achieve. A plan is in place to use balance sheet flexibilities but the Divisions CIP and some of the headline numbers in terms of spend will be challenging.<br>• It was agreed to rate this Amber due to the level of risk in the plan. | • Noted.<br>• The committee approved the submission noting the high level of risk in the plan. |

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

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

**Committee/Group Chair's Report**

| | | | | |
|---|---|---|---|---|
| Month 7 Finance Report | | Deputy Director of Finance | The committee received an update on the financial position as at month 7. Key points were noted as follows:<br>• The in-month deficit was £2.4m after receipt of top up funds of £3.2m.<br>• The year to date deficit was £4.9m after Elective Recovery Fund (ERF) income of £3m and top up funds of £24m. The Trust will receive an additional £2.4m of funding from GM to offset the H1 deficit adjusting the year to date position to a £2.5m deficit.<br>• £2m of CIP has been delivered year to date against a forecast of £2.9m. Work is ongoing to identify more recurrent schemes for H2.<br>• Variable pay spend was £22m year to date. If Covid spend and ERF were removed this would be £17.6m which is significantly more than in previous years.<br>• Capital of £4.5m has been spent year to date which is above plan. Significant increases are expected for capital and IT development of between £7m and £9m. This would need to be spent over the next few months and significant risks associated with capacity, clinical resources and supply chain were noted.<br>• The cash balance is currently £35.8m. | • Noted. |
| Month 7 Cost Improvement Update | | Deputy Director of Finance | The committee received an update on the Cost Improvement Programme for 2021/22. Key points were noted as follows:<br>• £2m has been achieved year to date against a forecast of £2.9m.<br>• £7m of CIP is required in H2 to achieve the target.<br>• Discussions are taking place with Divisions to identify additional schemes. | • The committee noted the progress made. |
| Nursing Agency Trajectory Update | | Director of People | • The committee received an update on a paper that had been discussed at People Committee advising of the actions taken to address agency spend.<br>• It was noted that agency spend will continue to be high throughout the organisation but that the action taken will help with this. It was also noted that benchmarking has been done with other NHS organisations and this shows the same pattern across the NHS. | • The committee noted the work done to minimise agency spend. |

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

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

**Committee/Group Chair's Report**

| | | | | |
|---|---|---|---|---|
| Costing Update | | Head of Financial Management | The committee received an update on the 2021/22 National Cost Collection submission. Key points were noted as follows:<br>• There were issues with the new costing system, Logex. These were escalated within Logex and to NHSI and were eventually resolved.<br>• The submission was made on time but there was very little time to review the data.<br>• Significant areas of variation have now been reviewed and the Trust was offered the potential to resubmit. This will be done on 24th November and will be more accurate than the previous submission.<br>• The PLICS rollout is planned and will be taken through the Contract and Performance Review Group. | • Noted.<br>• Update to be provided in six months. |
| Chairs' Reports | | Director of Finance | The committee noted the Chair's Reports from the following meetings:<br>• CRIG – 2nd November.<br>• Contract and Performance Review Group – 1st November.<br>• Strategic Estates Board – 11th November. | • Noted. |
| Procurement Quarterly Update | | iFM Director of Finance | The committee noted the procurement quarterly update which had been included for information. | • Noted. |
| **Risks escalated**<br><br>None | | | | |

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

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

| | |
|---|---|
| **Title:** | Chairs' Report – Audit Committee |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 27th January 2022 | | Discussion | |
| **Exec Sponsor** | Annette Walker | | Decision | |

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| **Summary:** | To update the Committee on the work and activities of the Audit Committee in December 2021. |

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| **Previously considered by:** | N/A |

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| **Proposed Resolution** | To note the updates from Chairs' Report. |

| **This issue impacts on the following Trust ambitions** | | | |
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| *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* | ✓ |

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| **Prepared by:** | Annette Walker<br>Director of Finance | **Presented by:** | Annette Walker<br>Director of Finance |

**Committee/Group Chair's Report**

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| Name of Committee/Group: | Audit Committee | Report to: | Board of Directors |
| Date of Meeting: | 7th December 2021 | Date of next meeting: | TBC |
| Chair: | Alan Stuttard, Non-Executive Director | Parent Committee: | Board of Directors |
| Members Present: | Alan Stuttard, Bilkis Ismail, Malcolm Brown, Martin North, Annette Walker, Esther Steel, Catherine Hulme, Lesley Wallace, Collette Ryan, Internal and External Auditors | Quorate (Yes/No): | Yes |
| | | Key Members not present: | N/A |

| Key Agenda Items: | RAG | Key Points | Action/decision |
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| Internal Audit | | The committee received details of two reports that had been completed, budgetary control (low risk) and an advisory report on complaints management. The latter incorporated a number of suggested improvements which have been accepted by the Chief Nurse and Chief Executive. The committee agreed that the full complaints management review which was scheduled for Q4 should be deferred until the new financial year to allow time for any changes to be embedded.<br><br>PWC advised that a number of audit reviews had commenced in Q3.<br><br>In terms of the follow up actions on earlier recommendations, PWC reported that a significant proportion of these had now been completed. | Noted. |
| Local Counter Fraud Specialist Progress Report | | The LCFS updated the committee on a number of fraud alerts and also reported on a number of ongoing investigations into potential frauds. The committee were pleased to see the openness and transparency with which staff were prepared to report potential breaches even though in a number of instances there was no case to answer. | Noted. |

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| | 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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| | | The LCFS advised that, following a recent case that had been referred successfully to the relevant professional body, it had been agreed by the Exec Team to use this as a lessons learned exercise. | |
| Updated Standing Financial Instructions and Scheme of Delegation | | The DoF advised that there were no updates to the Standing Financial Instructions and Scheme of Delegation for this year.<br><br>The DoCG also advised that the next review of the Standing Orders was scheduled for next year (two year review). | Noted. |
| Audit Committee Effectiveness Review | | The Audit Committee is currently undertaking a review of its effectiveness and the DoCG asked that all members complete the questionnaire. | Noted. |
| Board Assurance Framework | | The Audit Committee reviewed the BAF. A recommendation was made to update Ambition 1 (to give every person the best care every time – reducing deaths in hospital) to incorporate the recent results on the reduction in SHMI.<br><br>The committee also discussed whether cyber security should be included in the BAF as this was now receiving a lot of local and national attention. The DoCG and DoF advised that the cyber issues were reflected in the risk register. However, consideration would be given to looking at the impact of cyber security on the strategic objectives. PWC advised that they were undertaking a benchmarking review of BAFs and would share the outcome with the Trust to show what other organisations are including in their BAFs. | Noted. |
| Register of Waivers – Bolton FT and iFM Bolton | | The DoF of the Trust and the DoF of iFM gave an update on the register of waivers since the last meeting. Again it was pleasing to note the openness of the reporting and the committee acknowledged that in some cases it was appropriate to waive the tender requirements with relevant explanations being provided. | Noted. |

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**Committee/Group Chair's Report**

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| Losses and Special Payments Reports – Bolton FT and iFM Bolton | | The committee received the losses and special payments report for the Trust and noted that compared to previous years the number of payments was currently lower than previously reported. However, it was noted that the main area in relation to bad debts would be reviewed in Q4.<br><br>The were no losses or special payments in respect of iFM. | Noted. |
| Salary Overpayments Report | | The committee received a report from the DoF on salary overpayments covering the first seven months of the financial year. The number and value of overpayments was very low when taken in the context of the number and value of salary payments made in the period. The Trust was commended for this outcome. | Noted. |
| iFM Bolton Statutory Accounts Year Ended 31st March 2021 | | The DoF of iFM reported on the statutory accounts for the year ended 31st March 2021. These had previously been approved at the iFM AGM in November. | Noted. |
| **Risks Escalated**<br><br>There were no matters to be escalated to the Board of Directors. | | | |

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