# Board of Directors - Part 1

*Thu 29 July 2021, 09:00 - 13:00*

**Zoom**

# Agenda

**09:00 - 09:20**
20 min

## 1. Welcome and Introductions

*Chair*

### 1.1. Patient Story (verbal)

*Karen Meadowcroft*

**09:20 - 09:22**
2 min

## 2. Apologies for Absence

*Esther Steel*

- 2. Agenda Board meeting July 2021.pdf (2 pages)

**09:22 - 09:24**
2 min

## 3. Declaration of Interest (verbal)

*Chair*

**09:24 - 09:27**
3 min

## 4. Minutes of meetings held 27 May 2021, 9 June 2021 and 24 June 2021

*Chair*

- 4.a. Board of Directors Minutes - 27.05.21 (Part 1).pdf (17 pages)
- 4.b. Board of Directors Minutes - 27.05.21 (Part 2).pdf (7 pages)
- 4.c. Board of Directors Minutes - 09.06.21 (Extraordinary Board).pdf (2 pages)
- 4.d. Board of Directors Minutes - 24.07.21.pdf (5 pages)

**09:27 - 09:30**
3 min

## 5. Action Log

*Chair*

- 5. Action log.pdf (2 pages)

**09:30 - 09:32**
2 min

## 6. Matters arising (verbal)

*Chair*

**09:32 - 09:35**
3 min

## 7. Chair's welcome (verbal)

*Chair*

**09:35 - 09:45**
10 min

## 8. CEO Report

*Fiona Noden*

- 8. CEO Report.pdf (8 pages)

**09:45 - 10:00**
15 min

## 9. Integrated Performance Report

*Andy Ennis*

- 9. Trust Board M3 v1.2.pdf (51 pages)

**10:00 - 10:15**
15 min

## 10. Urgent Care Update and 'Winter Planning' (presentation will be shared at meeting)

*Andy Ennis*

**10:15 - 10:25**
10 min

## 11. Quality Assurance Committee Chairs Report

*QA Chair*

- 11.a. QA Chair report June and July 2021.pdf (3 pages)
- 11.b. QA Chair report July 2021.pdf (2 pages)

**10:25 - 10:55**
30 min

## 12. Learning from Deaths Report

*Francis Andrews*

- 12. 12 Board Learning from Deaths Report for July 2021.pdf (12 pages)

**10:55 - 11:00**
5 min

## 13. IPC Business Assurance Framework

*Karen Meadowcroft*

- 13. IPC Board Assurance Framework.pdf (49 pages)

**11:00 - 11:15**
15 min

## 14. Ockenden Update

*Karen Meadowcroft*

- 14.a. Appendix 1 Ockenden Report evidence submission presentation FINAL.pdf (25 pages)
- 14.b. Ockenden July 2021.pdf (1 pages)

**11:15 - 11:25**
10 min

## 15. People Committee Chairs Report

*People Committee Chair*

- 15. People Committee Chairs Report July and June 2021 - July Board v3.pdf (11 pages)

**11:25 - 11:40**
15 min

## 16. Staff Storey - BAME Leadership Group (verbal)

*Fiona Noden*

**11:40 - 11:50**
10 min

## 17. Opening Capital Plan

*Annette Walker*

- 17. Exec Summary Capital 2021.2022aw v2 board.pdf (7 pages)

**11:50 - 12:00**
10 min

## 18. Authorisation of high value supplier payments

*Annette Walker*

- 18.a. Cover sheet High Value contracts.pdf (1 pages)
- 18.b. High value supplier payments.pdf (2 pages)
- 18.c. High Value Contract Appendix 1.pdf (1 pages)
- 18.d. High Value Contract Appendix 2.pdf (1 pages)

**12:00 - 12:10**
10 min

## 19. Board Champions and Nominated Leads

*Esther Steel*

- 19. list of lead roles July 2021.pdf (10 pages)

**12:10 - 12:20**
10 min

## 20. Finance and Investment Committee Chairs Report

*F&I Chair*

- 20.a. F&I cover.pdf (1 pages)
- 20.b. Chair Report - June 2021.pdf (6 pages)
- 20.c. Chair Report - July 2021.pdf (3 pages)

**12:20 - 12:25**
5 min

## 21. Any other business (verbal)

*Chair*

**12:25 - 12:28**
3 min

## 22. Questions from members of the public

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

**12:28 - 12:28**
0 min

## 23. Resolution to Exclude the Press and Public

To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted

# Bolton NHS Foundation Trust – Board Meeting 29 July 2021

**Location: Boardroom** **Time: 09.00 – 13.00**

| *Time* | | *Topic* | *Lead* | *Process* | *Expected Outcome* |
|---|---|---|---|---|---|
| 09.00 | 1 | Welcome and Introductions | Chair | Verbal | |
| 09.05 | | Patient Story | Chief Nurse | Verbal | |
| 09.25 | 2 | Apologies for Absence | DCG | Verbal | Apologies noted |
| | 3 | Declarations of Interest | Chair | Verbal | To note declarations of interest in relation to items on the agenda |
| 09.30 | 4 | Minutes of meeting held 27 May 2021, 9 June 2021 and 24 June 2021 | Chair | Minutes | To approve the previous minutes |
| | 5 | Action sheet | Chair | Action log | To note progress on agreed actions |
| | 6 | Matters arising | Chair | Verbal | To address any matters arising not covered on the agenda |
| | 7 | Chair's Welcome | Chair | Verbal | To receive a report on current issues |
| **Safety Quality and Effectiveness** | | | | | |
| 09.35 | 8 | CEO Report | CEO | Report | To receive |
| 09.45 | 9 | Integrated Performance Report | COO | Report | To receive |
| 10.05 | 10 | Urgent Care Update and "Winter Planning" | COO | Presentation | To provide assurance on actions to recover ED performance |
| 10.25 | 11 | Quality Assurance Committee Chair Report | QA Chair | Report | To provide assurance on work delegated to the sub committee |
| 10.35 | 12 | Learning from Deaths report | Medical Director | Report | To provide assurance on learning from deaths |

Break

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|---|---|---|---|---|---|
| 11.00 | 13 | IPC Board Assurance Framework | Chief Nurse | Report | To receive |
| 11.10 | 14 | Ockenden update | Chief Nurse | Report | To note |
| 11.25 | 15 | People Committee Chair Report | Chair of People Com | Report | To receive assurance from the People Committee |
| 11.35 | 16 | Staff Story – BAME Leadership Group | CEO | Verbal | To note |

Break

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|---|---|---|---|---|---|
| **Strategy** | | | | | |
| 12.10 | 17 | Opening Capital Plan | DoF | Report | To approve |
| 12.20 | 18 | Authorisation of high value supplier payments | DoF | Report | To approve |
| **Governance** | | | | | |
| 12.30 | 19 | Board Champions and Nominated Leads | DCG | Report | To approve |
| 12.40 | 20 | Finance and Investment Committee Chair Report | F&I Chair | Report | To provide assurance on work delegated to the sub committee |
| 12.50 | 21 | Any Other Business | Chair | Verbal | |
| **Questions from Members of the Public** | | | | | |
| | 22 | To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting. | | | |
| **Resolution to Exclude the Press and Public** | | | | | |
| 13.00 | 23 | 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 | | | |

**Next meeting: 30 September 2021**

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| Meeting: | **Board of Directors (Part 1)** |
| Date: | **Thursday 27th May 2021** |
| Time: | **09:00-13.30** |
| Venue: | **Via Zoom** |

NHS Bolton NHS Foundation Trust

**PRESENT:**

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

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Esther Steel | Director of Corporate Governance | ES |
| Claire Lovick | Personal Assistant (attended via recording to minute take) | CL |
| Natasha McDonald | Director of Midwifery (attended CNST Evidence Submission section) | NMD |
| Benash Nazeem | Midwifery (attended Health of the Bolton Population section) | BN |
| Ibrahim Ismail | Shadow NED | IB |
| Debra Carey | Patient's daughter (attended patient story section) | DC |
| Anu Kumar | iFM (attended Estates Masterplan section) | AK |
| Rachel Noble | Deputy Director of Strategy | RN |

**APOLOGIES:**

| | | |
|---|---|---|
| Sharon Martin | Director of Strategy and Transformation | SM |

**1. Welcome**

The Chair welcomed everyone to this meeting.

**2. Patient Story**

Debra Carey updated the Board on her mother's patient story.

Debra confirmed they are not looking for compensation as that would take money away from patient care, they just want to ensure others don't have to experience the mistakes which happened to them.

Debra acknowledged how helpful Tracy Joynson, Patient Experience Liaison, had been. Tracy went above and beyond to help Debra and her mother and it was appreciated. Lucy Bradshaw was also extremely helpful and is a great ambassador for the Trust.

Switchboard were very rude and unhelpful and kept putting Debra through to the wrong departments. Debra therefore contacted the Chief Executive for help in resolving this issue.

The Board acknowledged we need to recruit people for their empathy and not just for their technical ability. Rebecca Ganz advised that iFM would look at this as a priority.

**Resolved:** The Board thanked Debra for her time and feedback, apologised for the mistakes made and offered assurance this will be looked at in detail to ensure we learn from it and improve our services going forward.

**3. Declarations of Interest**

There were no Declarations of Interest to report.

**4. Minutes of last meeting**

The minutes of the meeting on 25th March 2021 were approved as an accurate record of the meeting.

**5. Matters arising**

There were no matters arising to report.

**6. Action log**

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

**7. Chief Executive Report**

This paper has been taken as read. Main points to note:

- BFT currently have the highest number of Covid cases in the country and are the centre of interest nationally.
- Covid patient numbers have been increasing at the Trust – on the 21st April we had 15 Covid patients, on 19th May we had 21 Covid patients and today the number is 49 (9 of which are critical).
- The average age of Covid patients in hospital is younger than for previous waves. Patients in hospital at this time age between 19 and 101.
- The reason we are seeing less elderly patients in hospital with Covid is due to the success of the vaccination programme. The majority of over 70's have had both vaccinations.
- Simon Stevens visited the hospital last week (having given 24 hours' notice ahead of his visit). The Chief Executive introduced Mr Stevens to colleagues at the Trust and in the community.

- During Simon Stevens visit, the Chief Executive and staff members provided a positive reflection on the Trust and Community and all that has been achieved, whilst highlighting that our estate is not as good as it could be (old Victorian buildings) and that we are in need of a new hospital. This will hopefully help with our New Hospital Bid.

- The Trust undertook a Business Continuity Incident on Tuesday to ensure room was made for the extra Covid patients we are anticipating arriving at the hospital over the coming days. 70 bed moves were made to create availability.

- We have not seen a rise in patients from care homes with the majority of the elderly having had both their vaccinations, which shows the success of the vaccination programme.

- The pandemic is being managed better now through the vaccination programme.

It was noted that the voluntary response during the recent rapid vaccination programme in Bolton has been brilliant. Volunteers were knocking on doors etc to encourage as many people as possible to take up the vaccine.

DH will write to everyone involved in the vaccination programme to say a huge thank you on behalf of the Trust Board, particularly Helen Lowey and Helen Wall. ES will draft a letter and put together a list of people we need to give thanks to.

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| **ACTION:** ES to draft a thank you letter and put together a list of people who were involved with the vaccination programme who the Board should thank then these letters can be issued from DH. | ES TB/21/10 |

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

**8. Integrated Performance Report**

The divisional IPM meetings took place yesterday (26/05/21). Main points to note:

- Quality:
  - There has been some improvement in levels of harm, with less serious falls but there are still falls in some areas.
  - There has been an improvement re pressure ulcers. They are less severe and many are device related due to oxygen requirements re Covid.
  - There is a lot of work taking place to improve training. Family Care Division has undertaken training on safeguarding and this has shown real improvement in the Quality Report.

- Performance:
  - Urgent Care is a significant issue.
  - The Trust has not achieved its full target on elective recovery but actions are underway and we are seeing improvement on recovery.
  - The Trust missed its Cancer quarterly target by 0.5% last month, but we are on track to achieve our target this month.
  - Diagnostics remains an issue – particularly around staff numbers.

- Workforce:
  - Absence rates, appraisals and staff wellbeing are all ok.

- There is concern around agency fees which have increased due to Covid, but we have a plan for the way forward.

- Finance:
  - It has been a challenging month re revenue, and we are £0.5m off track in month 1.
  - The majority of the pressure comes from the continued enhanced rates due to Covid. This is not surprising and is being managed.
  - Forecast to break even for the first half of the financial year.
  - The Trust is behind where it wants to be re cost improvement.
  - There are high levels of varying pay and actions are underway to bring this back to where it needs to be.
  - The Trust has had low capital spend in month 1 but plans to spend £15.1m.
  - BFT has not yet received financials for the second half of the financial year. We have to manage costs with elective recovery around that.

There was a discussion around Sepsis. The Medical Director gave assurance there is no issue with prescribing antibiotics to patients who require them for Sepsis. The issue is around data recording and this is due to an issue with flush and signing off the return of stock data. Work is being undertaken by the Chief Pharmacist to correct this. Divisions have also been asked to focus on this and provide updates in their divisional IFM reports. The Medical Director will look at this in detail and provide an update at the next Board meeting.

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| **ACTION:** FA to look at issues around data for antibiotics re Sepsis and provide an update at the next Board meeting. | FA TB/21/16 |

EPR was discussed at the divisional IPM meetings yesterday (26/05/21). All letters are being sent to GP's and patients digitally (unless a patient does not have access to receive digitally, in those cases paper letters are still issued).

Family Care Division had an issue around EPR some time ago. They have worked hard and real improvement has been seen. Other divisions have been asked to learn from the work undertaken around this in the Family Care Division so this can be embedded across all divisions at the Trust.

The Trust is not currently where we would like to be regarding responding to complaints. We need to improve our response time and in some instances the quality of our responses. The Chief Executive and Chief Nurse have held KPI meetings with divisions on complaints to provide focus on this area. Improvement has been recognised since the KPI's have taken place and this will remain a focus to ensure further improvement in this area. The Trust also needs to audit complain responses and the Chief Nurse is working on this.

The Board recognised that every complaint received is feedback to be taken on board and acted upon so we can improve our services for patients going forward. There is a long way to go with this, but we are moving in the right direction.

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

**9. Urgent Care Update**

The Chief Operating Officer provided an update on urgent care. Main points to note:

- Bolton currently has the highest rate of Covid in the country and the Department of Health are taking a keen interest in our system and tracking of Covid cases. The Trust is required to complete a large amount of data for the Department of Health so they can learn from our experience.

- In Covid Wave 4 we have seen a dramatic rise in the number of younger patients who have not yet had the vaccine (mainly as they had not been eligible for it at this time).

- The majority of over 70's have had both vaccinations and are not affected badly if they do contract Covid. This is evidence that the vaccination programme is working, including for the Delta variant.

- BFT have their critical care red areas up and running. We have two red wards currently and are planning on a third by weekend.

- The Business Continuity Incident undertaken on Tuesday has allowed more space in the hospital in time for this weekend when we anticipate patient numbers to increase.

- There is currently a lot of pressure on urgent care due to volume.

- Cancer and elective care are recovering well.

- BFT missed the NW trajectory and this will not improve this month.

- The Trust is looking at increased GP support from Bardos and GP Federation.

- Analysis work is being undertaken on the time it takes for a patient to be seen in A&E, the time it takes to make a decision on diagnosis and bed availability in wards. We have a focused action plan but this will take some time due to pressures in A&E.

- The Chief Executive is chairing weekly meetings with divisions.

- The Trust is working with the CQC on quality and care and with the CCG on GP input.

- Work is also being undertaken in June around why patients choose to visit A&E rather than their GP (each patient who visits A&E will be asked who they have contacted / seen before arriving at A&E).

The Board agreed it would be beneficial to have a GP practice in Bolton associated with the hospital if this is possible in the future.

The Board acknowledged the decisive leadership provided by the Chief Operating Officer and his team. It is apparent much has been learned from the first 3 waves of Covid and there is assurance we are well prepared for wave 4.

The Board also acknowledged the huge amount of work undertaken with the vaccination programme, particularly the recent rapid vaccinations taking place.

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

**10. Quality Assurance Committee Update**

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

- QAC have held two meetings since the last Board meeting took place.

- QAC meeting on 21st April:
  - The new format of the report from the Integrated Care Division did not prove successful and we will be going back to the original format moving forward. There was not enough information in the report for assurance.
  - The Adult Acute Care Division report was in the original format and was an excellent report.
  - The Medical Director provided an update on Mortality. This is an area we are focussing on strongly at the moment.
  - The Admiral Nurse attended and provided an update on the excellent work being undertaken around dementia.
  - There has been a change to the approval process for complaints. These will be recorded in the quarterly Patient Experience Report going forward.
  - There is a shift towards excellence reporting rates instead of focussing solely on bad experiences, so we can learn from the good work taking place as well as learning from complaints and where things have gone wrong.
  - There was one SI Report and one HSIB Report presented to QAC at this meeting. The QAC have expressed their apologies on behalf of the Board.
  - A proposal was received for a revised committee structure which will feed into QAC. This will involve senior members of the nursing team chairing forums going forward and QAC gave their approval for this.

- QAC meeting on 19th May:
  - The Medical Director provided an update on Mortality, which is a big focus for the Trust at the current time.
  - The Medical Director also provided an update on the governance of nosocomial infections. A review was completed which showed the Trust is not lacking in the quality of care provided to patients.
  - The quarterly report for the Family Care Division was presented. There has been exceptional improvement, particularly around reductions in smoking.
  - An update was provided on the evidence to CNST. There is still work to do on action 6.1.
  - The quarterly update on pressure ulcers showed an improvement. Due to the pandemic there is an increase in the number of pressure ulcers, and many of these are facial and due to the use of oxygen devices.
  - The Safeguarding Chairs Report shows training has been taking place and there is a new approach to scope of legislation.
  - The only risk to be escalated is mortality and there is a lot of work being done by the Medical Director and his team around this.
  - There was one SI Report and 1 HSIB Report and these were both signed off and assurance confirmed by the QAC.

The Board acknowledged the great work undertaken by Kerry Lyons in her role as Admiral Nurse. Kerry has taken up a new national position with NHSI but she has trained staff well and set up training courses on dementia so we are well prepared to keep her good work going moving forward.

**Resolved:** The Board thanked the QAC Chair for his great leadership of this committee and noted the report.

## 11. Mortality Update

The Medical Director provided the following update on mortality:

- Mortality figures are measured by SHMI (national comparison) and HSMR (used by CQC).
- The figures in this report go up to the 12 months to end of December 2020 and show we are above where we should be re mortality.
- The area of highest concern is Acute Adult Care.
- The Medical Director and his team are working under the direction of NHSE on an action plan so that going forward we can get an early indication of which conditions to look at.
- Sophie Kimber Craig has been appointed as the Mortality Clinical Lead and will be working closely with the Medical Director on this. It was acknowledged Sophie is doing an excellent job.
- There is a Learning from Deaths Committee and a Mortality Reduction Group which both feed into mortality. These focus on quality of care and looking at different groups where mortality is higher than expected.
- Reviews have been completed for conditions with show SHMI to be higher than expected (there is one review still to be carried out).
- An external review has taken place and early indications show we do not have a fundamental problem with quality of care.
- Coding is an issue and we have recently received data from Health Evaluation Data (HED) which provides detail on mortality by speciality.
- Meetings are being held between clinicians and the depth of coding is being looked at. A new process will be put in place to improve this going forward.

The Board acknowledged we need to share data better with Primary Care. This is challenging due to the different systems used, but the Trust can access Bolton Care records where a lot of patient information is stored.

The Medical Director and Chief Pharmacist (Steven Simpson) are doing some work for a trial on GP systems so we can see patients conditions when they are prescribed medications.

The Medical Director and BI will meet to discuss depravation and demographics in detail.

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| **ACTION:** FA to arrange a meeting with BI re depravation and demographics. | FA TB/21/11 |

**Resolved:** The Board acknowledged there was a long way to go with this, but thanked the Medical Director and Sophie Kimber Craig for all their hard work in this area. The Board are assured everything possible is being done to improve mortality rates.

## 12. Health of the Bolton Population

Benash Nazeem presented on the Health of the Bolton Population. Main points to note:

- The 2011 Census has been used for this data. This will be updated when we receive the results of the 2022 Census. However, we are aware there has been an increase in ethnic communities (mainly South Asian) since the 2011 Census was carried out.

- 30% of the Bolton population live in some of the highest levels of depravation in the country.

- The largest number of pregnancies are from the Pakistani, Indian and black African communities.

- BL3 has the highest level of depravation in Bolton, followed by BL1.

- There is a high level of asylum seekers and refugees in the BL3 area.

- Although BL3 has a diverse BAME community, the largest percentage of the population in this area is still white British.

- Still births are higher than average in the deprived areas of Bolton.

- There is a significant migrant population in Bolton – 31% of still births in 2019 were to mothers who had been born outside of the UK.

- From new mothers who do not keep their follow up physiotherapy appointments, 46% of them are from the BL3 area, and they are more likely to be from the migrant community and born outside of the UK.

- 30% of distressed new mothers in Bolton are missed, and 21% of them go on to get post-natal depression.

- BFT is over represented in complaints from white British patients, and under represented by BAME patients, particularly those from India and Pakistan. Some improvement is starting to take place in this area.

- On average women in Bolton have 22.2% years of ill health. When broken down, white British have an average 10 years of ill health and BAME 25 years. This is very concerning.

- We need to ensure we improve our clinical services / accessibility and health in these areas.

- BFT have done a lot of work on education and workforce training so we can improve equality for our population. Cultural understanding training courses have been set up so staff feel more comfortable having discussions about race etc. Considerations also need to be made in other areas, for example a 15 minute meeting for most patients becomes at 7.5 minute meeting for a patient who needs an interpreter.

- There is a Community Hub in BL3 which runs focus groups for the BAME community and these are proving popular.

This presentation really highlights the inequalities we have in Bolton and it is important we ensure improvements are made going forward. The Chief Executive confirmed she will spread the message at every opportunity to support Benash, Natasha and the Midwifery Team going forward.

The Board noted it will take time for results from the project to show. It will take time to demonstrate the impact.

The Board agreed this presentation needs to been seem by others, particularly decision makers. There are a lot of people who do not fully understand that depravation and inequalities exist in the Bolton area.

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| **ACTION:** BI / Benash Nazeem will meet to discuss depravation and inequality in BL1. | BI/BN TB/21/13 |

Whilst this presentation focuses on midwifery, the Board acknowledged they would like to roll out improvements in caring for our population in the deprived areas of Bolton in all areas and this will be looked at in future.

It was acknowledged that Covid affected patients in the BL3 area disproportionately from other areas.

Demographics for midwives nationally is 87% white British, 2.5% South Asian and 5.5% black African / Caribbean. This is disproportionate with other areas of the NHS and Benash is working with schools and the university to try to encourage students from the BAME community to go into a career in midwifery. There is also a careers event planned at the BL3 Hub in December 2020.

**Resolved:** The Board thanked Benash for all her hard work in this area and noted the update.

## 13. CNST Evidence Submission

Natasha McDonald provided an update on the CNST Evidence Submission. Main points to note:

- CNST is a clinical negligence scheme for trusts. The submission date this year was July 2015.
- This is now in its third year and is aimed at trusts being compliant with the 10 safety actions.
- If the trust is compliant with all 10 safety actions they receive a 10% refund on the money we have paid.
- This paper has been presented at Clinical Governance and Quality Assurance Committee, and is being presented to Board today for approval.
- It is a self-certified process with some external verification around certain aspects of the 10 safety actions. All the evidence we have provided can be found on Admin Control.
- The paper submitted for this meeting shows action 6 as partially completed, but this has recently gone through so we are now fully compliant will all 10 safety actions.
- Work has been done around language. For example, a patient who was diagnosed as possibly having a Downs Syndrome baby requested we used the word ‘chance’ rather than ‘risk’ as she did not see her unborn baby as a risk.
- Training was reduced during the pandemic but this is now back on track.

**Resolved:** Compliant with the 10 safety actions and the Board formally approve the report.

## 14. People Committee Chairs Report

Malcolm Brown provided the following update:

- The People Committee met in April and May 2021.
- April meeting:
  - The Trust held an employment day and appointed 84 nurses.
  - BFT was due to employ 15 nurses in critical care from India, but this is currently on hold until the Covid situation is resolved.
  - The Covid vaccination programme is progressing well.
  - The Go Engage Survey took place in April and we received lots of engagement from staff.
  - The Trusts psychological offer is available but is not being taken up by many people.
  - The Government increased the offer of apprenticeships but due to Covid we have been unable to take on as many apprentices as we had envisaged. However, BFT is now aiming to recruit 138 apprentices instead of the 125 initially expected.
  - EDI plans are not as good as we would like, these have been returned for improvement and we hope to report a better picture on this in June.
  - Freedom to Speak Up report was well received.
- May meeting:
  - Resourcing is going well.
  - There are new Physician Associates starting work at the Trust.
  - Sickness remains low.
  - The Covid vaccination programme continues to be a success.
  - More information is required around exit interviews. They are now online and should start to give us an understanding on how we can retain staff.
  - The International HR Day was acknowledged at this meeting.
  - The Staff Engagement Programme is going well.
  - The Trust apprenticeship target is 138, which is greater than the 125 10% number.
  - There is a lot of work taking place around people development: Medical Leadership Programme, Coaching Programme, Operational Business Managers etc.
  - Guardian and safe working has improved over the last 12 months and we now have good leadership in this area.
  - Health Education England have acknowledged the superb work which James Long and the maternity staff (Natasha etc) are doing.

**Resolved:** The Board acknowledged this update.

**15. Staff Wellbeing Update**

The Staff Wellbeing paper was taken as read. The Director of People confirmed this paper sets out actions which have been undertaken and action planned for going forward. Main points to note:

- It is important we ensure we take care of our fantastic workforce.

- It has been a busy 18 months. Lots of work has taken place to support the wellbeing of staff during this time and this will continue going forward.
- Work done around Occupational Health has proved a success. This is now in-house and will be a greater support to our people.
- Psychological work will stay with us for some time following the effects on staff from dealing with the Covid pandemic.
- Work is being done with the Wellness Champions.

The Board asked how many staff members are suffering from Long Covid.

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| **ACTION:** JM to find out the number of staff suffering from Long Covid and update Board. | JM TB/21/14 |

Wellbeing communications have gone out to staff in various ways – social media, Bob, Fiona's Friday Update, Communications Update, etc.

Physiotherapy for staff can be fast tracked via Occupational Health as required.

Resolved: The Board noted this update.

**16. Nursing and Midwifery Staffing Review**

The Chief Nurse provided an update on the bi-annual Nursing and Midwifery Staffing Review. Main points to note:

- It has been a challenging year for nursing and midwifery.
- There is a shortage of staff nationally to cope with the pandemic and this is a challenge for all trusts.
- In GM, we have been working on expanding our nursing population by increasing the number of students we take on. There is money available as financial support for those studying nursing and this will start in September 2021. It was noted it will be three years before we see the benefit of this.
- BFT is looking at how we deal with our undergraduate programme during the pandemic with social distancing requirements, as there has been concern about the number of people in huddles. Our Chief Nurse is one of the leads on this for GM.
- Vacancies have reduced, mainly due to the number of newly qualified nurses.
- Nursing Associates will be joining the Trust. This is a new role which involves two years of training.
- SNCT uses professional judgement on the number of nurses we need for patients. The Trust plans to use the Safer Nursing Care Tool going forward which will monitor how many patients we have, how sick they are, and therefore the number of staff required to safely care for them. The Trust can obtain a licence free of charge from NHSI and will train staff prior to using this system.
- Some of our staff are working in areas unfamiliar to them as we have needed to move some staff to support critical care.

- There has been a huge amount of work undertaken in the last 12 months to ensure we keep patients safe.
- The Adult Acute Care Division is extremely busy due to Covid and this is proving a challenge. The Family Care Division have redeployed some of their staff to help in Adult Acute Care.
- The Family Care Division have a challenge around staffing for the mental health area for children.
- There is a recommendation for us to recruit more staff into midwifery for neo-natal.
- The Anaesthetics and Surgical Division have been training their staff so they can assist in critical care when required.
- The ICP have been caring for a large number of patients in the community to keep them safe at home, and have been expanding their bed numbers to support with the pandemic.
- There has been a resetting of services. We need to keep the RPC pathways in place (green areas etc).
- There is a recommendation to improve the use of the Health Roster system to make sure staff redeployment and training is recorded correctly.
- In conclusion, safe staffing affects the outcome of patient safety and quality of care. We need to ensure we have the right staff, with the right skill set, in the right place at the right time.

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| **ACTION:** It was noted that page 27 of the report should say 1-27 overall ratio (it says 1-29 overall ratio in the report). KM to ensure this is corrected. | KM TB/21/17 |

**Resolved:** The Board noted the report and recognised the large amount of work taking place in nursing and midwifery.

**17. Operational Plan**

The Chief Operating Officer provided the following update:

- BFT were asked to submit their Operational Plan for 2021/22 to GM for inclusion in the GM Operational Plan. BFT have signed off our plan and the larger GM plan will be submitted following tomorrow's PFB meeting.
- The plan supports recruitment of staff, aiming to build up staff by 5% a month in GM with a view that by month 4 we are at 85% of pre Covid capacity.

| | |
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| **ACTION:** AE to enquire if the 5% monthly increase in staff in GM is across each area and inform Board. | AE TB/21/18 |

- The vaccination programme is included in the plan.
- Transformation services are considered.
- Primary Care fits into the ICS service.
- There is a priority for the Bolton system and GM system to work closely together.

- Bolton is between 93-125% of pre Covid activity levels, but that is not the case for all trusts. We have done really well to achieve this without additional budget or staff.

- Credit to the Anaesthetics and Surgery Division, led by Lianne Robinson, for all the work they have undertaken on outpatients and elective care. Bolton is well placed with their elective recovery plan. Thanks also to Rachel Noble for strategy support around this.

- Not all trusts are in the same place as Bolton re their recovery plans, and in July GM is not expected to meet trajectory.

- Preliminary evidence shows that patients from deprived areas take longer to visit the Trust, therefore being diagnosed further into their illness. There is work to be done to improve equality.

- Risks:
  - Covid Wave 4: BFT are optimistic as we have coped so far, having kept elective care going and we have managed staff and patients safely. There is enormous pressure on urgent care.
  - With GM building back staff numbers to 85% pre Covid, this leaves a risk when services are fully up and running at pre Covid levels as waiting lists will increase.
  - There is an issue re the amount of money available to catch up with various services.
  - Workforce is crucial, our biggest risk is that we do not have enough staff to cope with an increasing workload.

- The Chief Operating Officer will keep Board up to date with developments on the Operational Plan.

- The Trust still needs to work through the elective and diagnostics challenges. We have put bids in centrally for revenue to help increase staff numbers etc.

- BFT are not yet clear on the capital we will receive in H2.

The Board acknowledged how well Bolton are performing, especially in such challenging times.

There was a discussion around if we should look to extend the apprenticeships we offer. Board agreed the priority is to keep patients safe and agreed the 138 apprenticeships currently planned is the right number to ensure we continue a safe service. There could be opportunities to expand the use of the voluntary sector moving forward.

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| **ACTION:** AE to share the Operational Plan Submission 2021/22 slides with Board. | AE TB/21/19 |

**Resolved:** The Board thanked the Chief Operating Officer for this informative and comprehensive presentation.

**18. Estates Masterplan**

Anu Kumar shared a video on the Estates Masterplan. Main points to note:

- The current plan is as follows, but it should be noted that changes are likely to be made to this plan as the development progresses:

- A new temporary car park will be set up.
- Phase 1: construct Women and Children's Unit.
- New staff car park and social facilities to be built.
- Construct new MSCP and Bolton College Medical School.
- Demolition of existing social facility.
- Release of additional land.
- Demolish redundant buildings.
- Demolish old maternity unit.
- Phase 2: construct new wards and Diagnostics.
- Build new Estates accommodation.
- Demolish vacated buildings.
- New Step Down Centre.
- New key workers' accommodation.
- New residential zone.

- The Strategic Outline Case (SOC) of the New Hospital Programme proposal will cover Phase 1 of this project if we are successful with the bid. The SOC has already been reviewed and approved by the Executive Directors.

There was a discussion around how corporate areas are likely to be working different post Covid. Agile working for example is increasing at the Trust. AK confirmed the intension is to rationalise administration space within this plan.

Car parking will also be reduced over time as more of our staff work from home.

Executive Directors are already sharing their office space since Trust Headquarters was refurbished, leading the way with the agile working approach.

There is still a lot of work to be done to ensure we are fully factoring in the community, and we are working closely with Bolton Council and our CCG colleagues to ensure we adapt the site in a way which is beneficial for all.

**Resolved:** The Board thanked Anu and noted this update.

**19. Community Diagnostic Hubs (CDH)**

Rachel Noble provided an update on Community Diagnostic Hubs (CDH). Main points to note:

- CDH is an idea which came from Professor Sir Mike Richards report.
- The aim is to establish diagnostics which are centrally embedded into the community, with easy access to all, quicker diagnosis, faster treatment, and therefore improved health outcomes.
- There will be three CDH's per million people.
- Bolton is in a good position for a CDH and we are preparing a collaborative GM bid.
- The CDH will be located in an area with easy public transport links, so patients from deprived areas can easily access the hub.

- BFT are in conversations with Bolton Council regarding a possible town centre location, and there is also the option of the CDH being based at the hospital. However, the preference is for this hub to be based within the community.

- Spokes will be located off the CDH in different areas of the community, and the endoscopy spoke would be based at BFT.

- The private sector are interested in supporting the CDH. This would help with costs and would also allow us to boost staff numbers, as there is currently a shortage of radiographers within the NHS.

- Timescales:
  - Year 1, 2021/22: possible early implementation of CT, CT colonography, MRI, X-ray and non-obstetric ultrasound.
  - Year 2, 2022/23: full roll out of the hub and spoke model.

- If successful with the bid, this could be rolled out in October / November 2021.

- Financials are not yet clear, and this will be discussed in detail and the Finance and Investment Committee next month once we have received more details. Financials are currently a risk, and we will not go ahead with this unless financials are clear and we can be sure the CDH will be sustainable financially.

- The next steps are to develop a full business case and detailed CDH proposal. This will then go to Financial and Investment Committee then to Board in June.

The Trust is nurturing relationships to help with developing opportunities in the future.

There could be an opportunity to deflect patients from A&E to the CDH for X-rays and scans in the future once the CDH is fully established. This would be a big help to A&E.

**Resolved:** The Board thanked Rachel for all her hard work on this and look forward to receiving a further update on the CDH in June.

**20. Charity Branding**

Rachel Noble provided the following update on charity branding:

- There has been a large amount of work undertaken around charity branding and it has become clear we need to raise the profile of our charity.

- It is about emphasising the services the charity provides to patients and staff.

- The suggested new charity branding logo is aligned with the corporate brand 'For a Better Bolton'.

- New suggested branding is 'Our Bolton NHS Charity'. This incorporates all services at the hospital and in the community.

- The charity would like to launch this new brand at the NHS Big Tea event which takes place in early July 2021.

The Charity Team are in the process of setting out a charity strategy which will incorporate legacy for donors (i.e. buildings named after people etc).

The new charity brand name has gone through full due diligence.

There was a discussion around local businesses which could support the charity. We need to be mindful re how they are aligned with health.

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| **ACTION:** RN will put together a list of possible local sponsors for the charity and share with Board. | RN TB/21/20 |

**Resolved:** The Board acknowledged the hard work which has gone into this and endorsed the use of the new charity brand name.

**21. Finance and Investment Committee (F&I) Update**

Jackie Njoroge provided an update on the Finance and Investment Committee report which was taken as read. Main points to note:

- Annette Walker and Kelly Knowles from the CCG gave a great presentation to the System Finance Group. A question was raised at System Finance around the patient's perspective, particularly their view on how we should operate and how this feeds into transformation. They were given an action to look into this and provide an update at the next meeting.
- F&I are comfortable with the Finance Plan.
- F&I are still adapting to the use of H1 and H2, like all areas.
- Slightly off track with variable pay.
- ICIPS is also slightly off track.

F&I would like to hear from divisional leaders on ICIPS and how they are being delivered, and an invitation has been extended to divisions to discuss this at a future F&I meeting.

The Chairs Report is listed as amber. This is due to the proportion of red risk areas on contract management.

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| **ACTION:** The red section of month 1 of the finance report says '£1m surplus' and should say '£1m deficit'. AW to ensure this is updated. | AW TB/21/21 |

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

**22. Audit Committee Update**

The following update was provided.

- The Audit Committee met on the 4th May.
- The Annual Report and Annual Governance Report have been completed since the report was shared with Board.
- The Annual Accounts were submitted on time and the auditors have completed their work. There is a meeting scheduled with Board next week to sign off these accounts.
- An extension has been agreed for two years for the external audit contract, and for one year for the internal audit.
- This year's Internal Audit has been completed more comprehensively than previous years, and PwC have been able to sign off the external audit for last year.

- There is a deficit of £7-8m in the Annual Accounts. A significant proportion of this is the NHSI technical deficit. Approximately £460k is the operational deficit with BFT and this is in line with other areas of GM.
- There is one high risk noted on the audit and an action plan is in place.
- The Workplace Counter Fraud Report has been signed off for this year. Last year's report has been signed off by Alan Stuttard and is with the Finance Director for final sign off.
- There are some concerns on the Register of Waivers and some of these are Covid related. Work is being done to look into this as we need to ensure appropriate governance is completed around waivers. This has also been flagged at IPM.

The Board thanked the Director of Corporate Governance for all her work on the Annual Governance Report and Governance Statements.

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| **ACTION:** AW will brief Alan Stuttard on the presentation of the balance sheet. | AW TB/21/22 |

**Resolved:** The Board noted this report and assurance from the Director of Finance that there are no concerns.

**23. Next meeting**

The next Board meetings are as follows:

June 9th – Extraordinary Board.

June 24th – Extraordinary Board.

July 29th – full Public Board.

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.

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|---|---|
| Meeting: | **Board of Directors (Part 2)** |
| Date: | **Thursday 27th May 2021** |
| Time: | **13.45-15.15** |
| Venue: | **Via Zoom** |

NHS Bolton NHS Foundation Trust

**PRESENT:**

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

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Esther Steel | Director of Corporate Governance | ES |
| Neil Grice | Archus (attended NHP section of meeting) | NG |
| Claire Lovick | Personal Assistant (attended via recording to minute take) | CL |
| Ibrahim Ismail | Shadow NED | IB |
| Rachel Noble | Deputy Director of Strategy | RN |

**APOLOGIES:**

| | | |
|---|---|---|
| Sharon Martin | Director of Strategy and Transformation | SM |

## 1. Welcome

The Chair welcomed everyone to this meeting and commented on how impressed she was with the large amount of work taking place at the Trust which was highlighted in Board Part 1.

## 2. Chief Executive Update

The Chief Executive provided the following update:

- BFT and the Bolton community as a whole are under immense scrutiny at the moment. Daily updates are being provided to Simon Stevens who is keeping the Prime Minister informed.
- Simon Stevens visited BFT last week, having given 24 hours' notice of his visit.

- Simon Stevens seemed to be looking for assurance that the Trust is on top of things with the local Covid situation and that we are doing things in line with national guidance, as Bolton currently has the highest rates of Covid in the UK.

- Bolton is being monitored closely by the Government. How things go in Bolton with Covid in the next few weeks will be used as data for the Governments roadmap to opening up the country.

- The Chief Operating Officer has spent a lot of time with the BI Team and Rick Catlin on Infection Control to ensure we are doing all we can in this area.

- The condition of our aged Estate was highlighted to Simon Stevens during his visit and the Chief Executive explained to him what we plan to do as a system with the White Paper. He was shown around our organisation and met various staff (A&E, Estec, D4 and maternity / neo-natal).

The Chief Executive highlighted how proud she is of our people. Staff are doing a fantastic job.

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

**3. White Paper**

The Chief Executive and Director of People provided an update on the White Paper. Main points to note:

- There is a lot of work going on in the background. We are working with Rachel Tanner on Section 75s, as there are two elements to this; BFT and Local Authority.

- BFT will be working closely with our community colleagues.

- JM and SM have been leading meetings with the CCG which take place every Wednesday, where they talk through the various options for how we can support CCG staff moving into the Local Care Trust (LCT).

- It is important our values are considered at each stage of this process; kindness, dignity and respect. JM/SM are ensuring this is weaved into all discussions.

- Sensitivity is needed as some of our colleges at the CCG are worried about losing their jobs.

- BFT and the community agree that Bolton CCG staff should be moved into the local LCT and not the central CCG. Current advice is that CCG staff will move central and this move is due to commence on the 1st October 2021.

- BFT and the ICP are working on a proposal requesting CCG staff are moved to the local LCT instead of centrally.

- There are two phases to this proposal:
  - Phase 1: the majority of CCG staff move to the LCT and we create a sub-department (similar to the CCG structure).

- Phase 2: time is required for us to work through where CCG staff would best be integrated into the LCT (i.e. ICP, Finance, Information function, etc).

It is strongly recommended by CCG staff that we follow these two phases.

- The shape of the Executive Team is likely to change, and possibly the Board of Directors and Sub-Committees. The Executive Teams of BFT and CCG are meeting on the 17th June to agree the content for a joint paper which we can submit as our proposal to move CCG staff to the local LCT. Our proposal could be overruled, but we are hopeful it will be approved.

- CCG staff have been very helpful with this process and this is much appreciated.

The Chief Executive acknowledged it has taken six months to get to this position, and we now feel we have support from the national and regional teams with our suggested way forward.

All CCG staff are guaranteed to keep their jobs when they move to the LCT, with the exception of Executives. We don't yet know how long jobs are guaranteed for and we are awaiting guidance on this.

It is likely there will be a cost reduction target over time. The Director of People has requested detail on the cost of transferring people into BFT.

Executive Directors are being kept informed of developments, and as things progress the Board will be updated again on this proposal.

It is important we look to improve the health and wellbeing of our population, working together as a system at BFT and in the community.

It may be beneficial to have a detailed discussion at a future Board meeting around what good looks like. It is important we also speak to patients and families early into this process, to be sure adaptions to our systems benefit patients.

Executives are working as a team during this exceptionally busy time. The Chief Executive is hoping they will take the opportunity to use some annual leave to ensure we are all looking after ourselves and each other.

There has been a huge amount of work undertaken for the Elective Recovery Plan. Lianne Robinson and the DDO's have done a great job. On Tuesday they instigated 70 bed moves to ensure we were safe for extra patients expected due to Covid and the Bank Holiday.

The Chief Executive is working with Tony Oakman at Bolton Council around the ICP and how it works in neighbourhoods. There is a long way to go but this is progressing.

There was a discussion around the importance of GP's and Primary Care being fully integrated within the system. The aim is to create a system where our Community Division becomes a Primary Care Directorate for the ICP, GP's and our Primary Care colleagues. There is still a lot of work to do to achieve this.

The Board requested further detail around what the CCG does – staff structure etc.

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| **ACTION:** ES to obtain details of CCG functions and share them with Board. | ES<br>TB/21/15 |

**Resolved:** The Board acknowledged this update and offered their support as and when required.

**4. Trust Transformation Board (TTB) Chairs Report**

Martin North provided the following update:

- May TTB Chairs Report:
  - There were some minor changes made to the Terms of Reference.
  - Jo Street gave a detailed presentation on the ICP. The TTB were very impressed with the work done and what has been achieved. Jo will be meeting with divisions to update them on the ICP and see how it can assist their divisions.
  - Model Hospital is progressing well. There is a large amount of useful data which the Trust is starting to use on a more frequent basis. Model Hospital also links in to GIRFT. We need to educate our staff on the importance of correctly entering data so we can get the most out of Model Hospital.
  - The CDH proposal is progressing well and this was covered in detail this morning in Board Part 1. The CDH is likely to be a more expensive way of running things, but the benefits are worthwhile. Earlier appointments, earlier diagnosis and treatment means better health outcomes for our patients and reduced pressure on the health service in the long term.
  - PACS has now gone live in GM. There are a few security issues to work through but this is being monitored by Phillipa Winter and her team and we have assurance from GM this will be dealt with.
  - Agile working is progressing. We still need to establish the cost of IT equipment for staff working from home compared to the cost of saving space on the Estate. Information is being gathered from staff who have worked from home, particularly those shielding, so we can learn from their experience going forward.
  - There was an update on Digital Strategy. This will be brought to Board as draft for comment in the near future, and again when it is at the finalising stage.
  - The Informatics Operational Board meeting had not taken place ahead of this meeting, so there was no update in this area.

- April TTB Chairs Report:
  - Terms of Reference, CDH, Agile Working, Digital Strategy and Informatics Operational Board were covered in the May update above.
  - The Trust is now sending out digital letters and text reminders to patients.
  - Steven Simpson provided an update on Pharmacy Hub. There is still a lot of work to do around this but the aim is to have a central GM Pharmacy Hub where medications are sent to our wards as required from a central area. It is important we get this 100% right and SOA's need to be built into this. There is potential for this to make a big difference to our Pharmacy Structure.

The Board agreed strategic ambitions should be linked in to the Terms of Reference.

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| **ACTION:** RN to include strategic ambitions in the Terms of Reference. | RN<br>TB/21/23 |

There was a discussion around different Committees and which information should be shared at each (i.e. TTB seems very operational focussed and would benefit from including Occupational Development).

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| **ACTION:** RN to invite Lisa Gammack and Amraze Khan to future TTB meetings. | RN TB/21/24 |

BI thanked the TTB for including Cultural Transformation in their Terms of Reference.

The Estates Plan will sit under Strategic Estates Board and Trust Management Committee, with updates being provided at TTB as appropriate.

**Resolved:** The Board acknowledged the TTB Chairs Reports.

**5. iFM Review**

The Finance Director provided the following update:

- Executive Directors have been working on a Terms of Reference for the IFM Review. A meeting is taking place later today and we are aiming to sign off the Terms of Reference at this meeting.
- BFT aims to move forward with this work, most likely with EY, but that is subject to discussion at the meeting this afternoon.

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

**6. New Hospital Programme (NHP)**

Rachel Noble and Neil Grice (Archus) presented an update on the NHP [see appended slides]. Main points to note:

- A lot of work has taken place on the Strategic Outline Case (SOC) and this is almost at the finalised draft stage. The SOC will be presented at the next Board meeting in June.
- The Schedule of Accommodation has been completed and we have consulted the Christie regarding their requirements for this. Clinicians have also been involved in discussions. It has been established we need 26,711 square metres of space.
- The Chief Executive and Director of Strategy and Transformation have written to stakeholders and MP's for letters of support, and we have started to receive these letters.
- BFT have an agreement in principal with Bolton Council for some additional land.
- A workshop has taken place with Sir Robert McAlpine, an experienced contractor on building design.
- We have been working with Ramboll on net zero carbon to ensure we have a robust plan in place. The NHS target is to be net zero carbon by 2040 and there are plans in the proposal to achieve this. Currently gas is cheaper than electricity, but this will change over the coming years.

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| **ACTION:** Neil Grice to share Ramboll's net zero carbon report with Board via RN. | NG/RN TB/21/25 |

- NHSI/E are due to visit BFT on the 9th June, but this is likely to be moved to a later date.
- Option B1 is the preferred choice and this links to the Estates Masterplan.
- Capital costs being requested in the bid for the New Hospital are £252,400,678. This is a significant figures but we have submitted the totality of our requirements to ensure we do not end up with a shortfall.
- Archus have undertaken a detailed economic appraisal.
- Meetings have taken place with the Director of Finance to be sure costs have been fully worked through.

There was a discussion around fire evacuation measures as the new build will be a five storey building. The Chief Operating Officer and Medical Director confirmed there are very clear evacuation procedures in place and the new building will be compartmented. Lifts will not be used in the event of an evacuation.

To ensure the building remains relevant as services and requirements change, it has been designed as a flexible space that can be used in different ways as the hospital evolves and adapts to future requirements.

Patient and staff wellbeing has been considered, both in the outside space (greenery etc) and inside where there will be adequate rest space.

Neil Grice confirmed we need the full amount of capital requested in this proposal to carry out all the planned work. The most we could drop to would be £220m and we would then need to find monies from elsewhere to put towards this project.

The Board suggested we arrange a charitable fundraiser to help with any extra work required.

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| **ACTION:** RN to include a NHP Charity Fundraiser in the Charity Strategy. | RN TB/21/26 |
| **ACTION:** RN will share the NHP slides with Board. | RN TB/21/27 |

**Resolved:** The Board thanked Rachel and Neil for this update and acknowledged this is an exciting opportunity.

**7. Notable Resignations**

The following staff members have recently resigned:

- Kathy Stacey, Associate Director of Communications and Engagement:
  - The Board acknowledged the brilliant job Kathy has done during her time at the Trust.
  - Kathy has transformed the Trusts communications and put together a good team.
  - Rachel Carter will be stepping into the position as Acting Associate Director of Communications and Engagement.

- Kathy is moving into a role supporting the Chief Inspector of GM Police and the Board congratulate Kathy on this exciting opportunity.

- Phil Webster, iFM:
  - Phil is leaving to take on consulting roles.
  - Phil has made a large contribution to iFM and will be missed.
  - The Trust needs to look at stability in iFM around what needs to be done in the interim and the leadership of iFM moving forward.
  - Phil has met with Rebecca Ganz and they have discussed some ideas. Rebecca will update the Chief Executive on this conversation ahead of her meeting with Phil.

  Board members discussed the actions needed to agree an exit strategy for Phil and the appointment of a new interim MD for iFM.

  *Board members subsequently agreed by email to delegate these discussions to the Chair of iFM and the COO and DoF of the Trust.*

**Resolved:** The Board noted these resignations.

**8. Next meeting**

The next Board meeting will take place on the 29th July 2021.

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|---|---|
| Meeting: | **Board of Directors (Extraordinary Board)** |
| Date: | **Wednedsay 9 June 2021** |
| Time: | **09:00-10.00** |
| Venue: | **Via Zoom** |

**PRESENT:**

| | | |
|---|---|---|
| Donna Hall | Chair | DH |
| Andy Ennis | Chief Operating Officer | AE |
| Sharon Martin | Director of Strategy and Transformation | SM |
| Karen Meadowcroft | Director of Nursing | MF |
| Annette Walker | Director of Finance | AW |
| Malcolm Brown | Non-Executive Director | MB |
| Rebecca Ganz | Non-Executive Director | RG |
| Jackie Njoroge | Non-Executive Director | JN |
| Martin North | Non-Executive Director | MN |
| Alan Stuttard | Non-Executive Director | AS |
| Bilkis Ismail | Non-Executive Director | BI |

**IN ATTENDANCE:**

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|---|---|---|
| Esther Steel | Director of Corporate Governance | ES |

**APOLOGIES:**

| | | |
|---|---|---|
| Fiona Noden | Chief Executive | FN |
| Francis Andrews | Medical Director | FA |
| James Mawrey | Director of People | JM |
| Andrew Thornton | Non-Executive Director | AT |

## 1. Welcome and Introductions

The Chair welcomed everyone to this meeting.

## 2. Meeting Purpose

The purpose of this Extraordinary Board meeting is to:

- Approve the Annual Accounts
- Approve the Annual Report
- Approve the Annual Governance Statement
- Approve the Quality Account

## 3. Declarations of Interest

There were no Declarations of Interest to report.

## 4. 2020/2021 Annual Report and Accounts approval

Mr Stuttard in his capacity as Chair of the Audit Committee advised that at their meeting earlier in the afternoon, the Audit Committee had received the Annual Report and accounts for 2020/21 and the report of the auditor. No issues had been raised and the Committee were therefore happy to recommend that the Board formally adopt the accounts and report included in the Board pack.

The Chair of the Audit Committee and the Director of Finance provided further detail about the year-end process and the audit process leading to an overall audit opinion of "generally satisfactory" for both the Trust and for iFM Bolton.

One minor error had been identified in the accounts in relation to the valuation however this was not material, and the Board had previously been briefed.

In response to a question about benchmarking with other Trusts, the auditors commented positively in terms of support and focus.

Board members thanked the Audit Committee for their work in reviewing the accounts and report and thanked the finance and governance teams for their work in the production of the mandated returns.

**Resolved**: The Board formally approved the accounts and report for 2020/21

## 7. Next meeting

The next Board meeting will take place on the 29th July 2021.

| | |
|---|---|
| Meeting: | **Board of Directors (Extraordinary Board - Part Two)** |
| Date: | **Thursday 24th June 2021** |
| Time: | **09:00-10.00** |
| Venue: | **Via Zoom** |

**PRESENT:**

| | | |
|---|---|---|
| Donna Hall | Chair | DH |
| Fiona Noden | Chief Executive | FN |
| Francis Andrews | Medical Director | FA |
| Karen Meadowcroft | Director of Nursing | MF |
| Sharon Martin | Director of Strategy and Transformation | SM |
| Andrew Thornton | Non-Executive Director | AT |
| Malcolm Brown | Non-Executive Director | MB |
| Jackie Njoroge | Non-Executive Director | JN |
| Martin North | Non-Executive Director | MN |
| Alan Stuttard | Non-Executive Director | AS |
| Bilkis Ismail | Non-Executive Director | BI |

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Esther Steel | Director of Corporate Governance | ES |
| Claire Lovick | Personal Assistant (minute taking) | CL |
| Rachel Carter | Acting Assistant Director, Communications and Engagement | RC |
| Rachel Noble | Deputy Director of Strategy | RN |
| Anu Kumar | iFM (attended Estates Masterplan section) | AK |
| Michelle Cox | Divisional Director of Operations, Diagnostics and Support | MC |
| Samantha Ball | Associate Director of Improvement and Transformation Team | SB |
| Lisa Gammack | Associate Director of Operational Development | LG |
| Andrew Chilton | Deputy Director of Finance | AC |
| Margaret Parrish | Governor (observer) | MP |

**INVITED GUEST:**

| | | |
|---|---|---|
| Neil Grice | Associate Director – Archus | NG |

**APOLOGIES:**

| | | |
|---|---|---|
| Andy Ennis | Chief Operating Officer | AE |
| Annette Walker | Director of Finance | AW |
| James Mawrey | Director of People | JM |
| Rebecca Ganz | Non-Executive Director | RG |

**1. Welcome**

The Chair welcomed everyone to this meeting.

**2. Meeting Purpose**

The purpose of this Extraordinary Board meeting is to:

- Discuss and seek Board approval for the Strategic Outline Case (SOC) for the New Hospital Programme (NHP).
- Agree the best option to put forward for the Community Diagnostic Hub (CDH).

**3. Declarations of Interest**

There were no Declarations of Interest to report.

**4. New Hospital Programme (NHP)**

SM presented the Strategic Outline Case (SOC) for the New Hospital Programme. Main points to note are:

- The aim of the NHP is to create an hospital where:
  - Acute and community services link seamlessly to help us effectively deal with the ever-growing complex needs of our population.
  - The newest technologies are embedded into the site.
  - Facilities are inclusive and meet the needs of everyone.
  - Space is maximised for efficiency.
  - Connected in a space that can be used by the community.
- Benefits reach beyond improving the environment – they also improve service efficiency.
- Aim to become an employer that our diverse community would like to work for, along with our educational partners that provide training opportunities.
- The Deputy DIPC has been involved with this programme to ensure Infection Control is fully covered in the SOC.
- Case for change:
  - Improve patient safety across the site.
  - Tackling health inequalities and demand with more access to services.
  - Wider social responsibility – carbon zero target, local regeneration plans and enhanced transport links.
  - Staff and patient wellbeing.
  - Technical and digital opportunities.
- Project governance has been set up to feed into stakeholders and up to Board.
- There has been a lot of external engagement:
  - Clinical Workshops with all divisions, Options Workshop, Digital Workshop.
  - Stakeholder meetings.

- NHSE/I are visiting BFT on 26th June. FN and SM are showing them around the site.
- FN has met with MP's and the Council, and has also had a conversation with the Health Secretary.

- Archus (an expert programme delivery team) were appointed early and this has proved very beneficial.
- iFM have worked with AHR, Arcadis and Ramboll to ensure we have received expert advice in each area of the programme.
- The SOC has been written in a format that is ready to submit for the NHP at a national level.
- National Drivers are MMC, digital, net zero carbon (to be achieved in phases from now until 2040) and backlog maintenance.
- A robust Options Development Process has been carried out. We have used the HMT Green Book to review a long list of options and have also carried out SWOT analysis.
- From the shortlist of options, Option 2 – B1 (Phase 1 New Build – Mallet Car Park) is the preferred option.
- An Economic Appraisal has been carried out and this supports Option 2 – B1 as the best option, with the ability to meet forecast demand, improve efficiencies due to better flow, improve efficiencies with digital technology and reduces greenhouse gases to improve energy efficiency.
- Anouska Huggins, Finance Lead at Archus, has gone through the finances with AW who has confirmed she is happy with this.
- Phase 1 is for the Bolton Women and Children Unit, then Phase 2 will relocate A-D blocks and associated other buildings creating a really compact site.
- Thinking into the future, there is a plan for affordable housing, a multi-story care park, and to have a base for Bolton College of Medical Sciences on site.
- Key milestones are for the NHP SOC to come to Board seeking approval today, and if approved it will be sent to NHSE/I in September for approval.
- The NHSE/I process will take three to four months and SM will keep Board up to date with progress.
- Once approval is received from NHSE/I the next stage of the process is to develop the Outline Business Case.

The Board acknowledged having Women and Children (maternity etc), day care facilities and the Christie included in the SOC is likely to be advantageous to our bid.

There was a discussion around finances and Neil Grice provided assurance that finances have been fully accounted for in the SOC. Inflation has been fully considered.

**Resolved:** The Board approved the New Hospital Programme Strategic Outline Case and agreed to conduct further discussion when it is time to develop the Outline Business Case.

SM will present the NHP SOC to Cabinet on 28/06/21.

FN thanked SM for the brilliant piece of work which has been done on this project.

**5. Annual Governance Declarations**

ES confirmed that we do not need to submit the four Annual Governance Declarations for the Trust to NHSE/I this year, but we have completed them for our records.

The Board gave approval for the four Annual Governance Declarations to be put on file in case we need to refer to them in the future.

*Resolution to Exclude the Press and Public*

*To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.*

**6. Community Diagnostic Hub (CDH)**

SM presented on the Community Diagnostic Hub. Main points to note are:

- There has been a national ask to set up CDH's across the country, to increase diagnostic access in England for communities.
- The aim of the CDH is to improve the populations health outcomes. Easier access to diagnostics means earlier diagnosis and treatment, and better recovery rates.
- Implementation Phases:
  - Year 1: MRI mobile unit x 1, CT mobile unit x 1 (estimated start date September 2021).
  - Year 2: Bolton CDH Model (estimated start date July 2022). Operating hours will be phased in a way to meet increasing demands over time.
- Principles:
  - One stop approach.
  - Early access to primary care for patients.
  - New pathways (i.e. vague symptoms).
  - Inclusive of primary and secondary care provision, including the voluntary sector.
  - Targeted reduction in health inequalities.
- Critical success factors:
  - Strategic fit and business need (it needs to work for Bolton).
  - Needs to deliver value for money.
  - Capacity and capability need to work.
  - It needs to be affordable and achievable.
- The preferred option is a CDH in Bolton town centre which can be easily reached by all communities. The suggested option is to use the Diabetes Centre, this would involve moving services out of the building and doing a refurbishment.
- Other options which have been considered are an onsite stand-alone new build at BFT, a modular build behind the Diabetes Centre, and retail space in Market Place Bolton.

- The deadline for submission of the CDH business case is tomorrow (25/06/21).

- There is still a piece of work to do looking into the long term benefits of the CDH. We envisage that by year three we will have caught up in diagnostics following Covid and will then be able to bring lung screening into the CDH.

The Board discussed financials – it is important we get this right as there is a lot of risk in this project and we have not yet received confirmation of the capital and revenue costs.

The Trust are asking for £13,520,000 in capital to cover the building, equipment, digital requirements etc of setting up the CDH. It is anticipated that revenue costs for year two onwards will fall to ICS.

It is assumed that in Year 1 80% of radiology staff will be covered by locum, reducing 20% year on year (premium cost).

The Board confirmed they are happy to endorse this CDH proposal being submitted, with financials to be included at a later date when we have more information around that.

**7. Next meeting**

The next Board meeting will take place on the 29th July 2021.

**May 2021 Board actions**

| Code | Date | Context | Action | Who | Due | Comments |
|---|---|---|---|---|---|---|
| FT/21/11 | 27/05/2021 | Mortality report | FA to catch up with Bilkis Ismail to discuss demographics in relation to mortality | FA | Jul-21 | Complete - FA has met with BI re this. |
| FT/21/04 | 25/03/2021 | patient story | update on learning from March pat story | KM | Jun-21 | Update to QA committee - QA committee agenda item |
| FT/21/14 | 27/05/2021 | Staff well being - | JM to responde to RG regarding number of staff suffering with long Covid and the support being provided | JM | Jul-21 | Complete - report provided |
| FT/21/10 | 27/05/2021 | CEO report | Donna to write to stakeholders and partners to thank them for help | DH | Jun-21 | Complete |
| FT/21/15 | 27/05/2021 | development of LCT | ES to share information on the role of the CCG | ES/AW | Jun-21 | Complete |
| FT/21/27 | 27/05/2021 | NHP | RN will share the NHP slides with Board. | RN | Jul-21 | Complete. |
| FT/21/26 | 27/05/2021 | NHP | RN to include a NHP Charity Fundraiser in the Charity Strategy | RN | Aug-21 | Complete. This will be incorporated in the Charitable Funds Strategy document. |
| FT/21/24 | 27/05/2021 | TTB Chairs Report | RN to invite Lisa Gammack and Amraze Khan to future TTB meetings | RN | Jul-21 | Complete - CL added Lisa and Amraze to TTB meeting invites. |
| FT/21/22 | 27/05/2021 | Audit Committee | AW will brief Alan Stuttard on the presentation of the balance sheet | AW | Jul-21 | AW confirmed this is complete. |
| FT/21/21 | 27/05/2021 | F&I Committee | The red section of month 1 of the finance report says '£1m surplus' and should say '£1m deficit'. AW to ensure this is updated | AW | Jul-21 | AW confirmed this is complete. |
| FT/21/18 | 27/05/2021 | Operational Plan | AE to enquire if the 5% monthly activity in GM is across each area and inform Board | AE | Jul-21 | AE confirmed this is a system issue not just GM. Action closed. |
| FT/21/25 | 27/05/2021 | NHP | Neil Grice to share Ramboll's net zero carbon report with Board via RN | RN | Jul-21 | Complete - circulated to Board 27/07/21. |
| FT/21/23 | 27/05/2021 | TTB Chairs Report | RN to include strategic ambitions in the Terms of Reference | RN | Jul-21 | Complete. |
| FT/21/20 | 27/05/2021 | Charity Branding | RN will put together a list of possible local sponsors for the | RN | Jul-21 | This will go through Charitable Funds Committee and |
| FT/20/40 | 26/11/2020 | performance report | Case study or patient story to be shared to celebrate deflection/home first success | AE | Sep-21 | Tracy Joynson confirmed she agreed with Esther Steel and Andy Ennis that this update would be brought to |
| FT/21/12 | 27/05/2021 | performance report | FA to respond to B Ganz re query on antibiotic prescribing metric | RG | Jul-21 | |
| FT/21/13 | 27/05/2021 | cultural midwife | Bilkis to contact Banesh for data - KM to support | KM | Jul-21 | |
| FT/21/09 | 25/03/2021 | Transformation committee | update on supporting strategies to future Board | SM/ES | Sep-21 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| FT/21/19 | 27/05/2021 | Operational Plan | AE to share the Operational Plan Submission 2021-22 slides with Board | AE | Jul-21 | |
| FT/21/17 | 27/05/2021 | Nursing and Midwifery | It was noted that page 27 of the report should say 1-27 overall ratio (it says 1-29 ovrall ratio in the report). KM to ensure this is corrected | KM | Jul-21 | |
| FT/21/16 | 27/05/2021 | Integrated Performance Report | FA to look at issues around data for antibiotics re Sepsis and provide an update at the next Board meeting | FA | Jul-21 | |
| FT/20/36 | 24/09/2020 | inclusion | review cover page to include inclusivity impact review | ES | Sep-21 | Link with presentation of EDI strategy |
| FT/19/82 | 28/11/2019 | iFM business plan | Carbon Neutral strategy and update on the work of the sustainability group | AE | Sep-21 | |

Key

| complete | agenda item | due | overdue | not due |
|---|---|---|---|---|

| | |
|---|---|
| **Title:** | Chief Executive's Report |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | X |
| **Date:** | 29th July, 2021 | | Discussion | |
| **Exec Sponsor** | Fiona Noden | | Decision | |

| | |
|---|---|
| **Summary:** | The Chief Executive's report:<br>• Provides an overview of the current climate in which we are operating.<br>• Includes a summary of key issues including risks, incidents and achievements.<br>• Includes any key updates from stakeholders and regulatory bodies which the Board of Directors need to be aware. |

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

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

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

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

## 1. Context

Since the last meeting of the Board, we have started to see an increase in the number of patients who require hospital treatment with COVID-19, and numbers are rising again in the community. Our oximetry at home pathway continues to be an invaluable support for our local communities with over 1000 patients who have now benefitted from remote monitoring of symptoms.

With the lifting of Government restrictions this month, we have been reminding staff, patients and their families that the measures we have in place across all of our sites have not altered – everyone is expected to continue to wear the appropriate PPE, keep a safe distance and visiting restrictions are still in place until it is safe to lift them. The Chief Operating Officer/Deputy Chief Executive will outline the current operational challenges in their presentation to the Board of Directors.

The Trust's annual 'For A Better Bolton Awards' event took place on Friday 25th June with over 280 attendees joining us on Zoom to reflect on the last 12 months and celebrate their achievements.

In July, our celebrations continued with the NHS's 73rd birthday. We took part in the NHS Big Tea which was the nation's biggest tea break, to mark the occasion and raise vital funds for our charity. It was great to have support from our Bolton residents and partners and the entire NHS workforce received the George Cross from Her Majesty The Queen for demonstrating the highest standards of public service throughout the pandemic.

## 2. This month's Board papers

This month's agenda includes an update about our Urgent Care services and the plans we are putting in place to ensure that our services are resilient as we approach the winter months.

An update will be provided at the meeting about the Ockenden Report and our progress against the national and local actions required to improve safety and ensure equity in maternity services across the country.

## 3. Awards and recognition

Award winners:

- The Workforce Information Team won the Information Sharing and Data Integration award at the HSJ Partnership Awards for their collaboration with Allocate software to help our teams manage absence during the pandemic.

Individuals and teams have been shortlisted for the following awards:

- Anaesthetic, Critical Care & Theatres Teams in the HSJ Patient Safety Awards Infection, Prevention and Control category.
- Our Retinal Team in the Improving Care for Older People Initiative of the Year category.
- All those responsible for implementing the Acute Medicine Referral List in the HSJ Patient Safety Awards in the Patient Safety Pilot Project of the Year category.
- Our Acute Pain Team was also shortlisted for an RCN Award for developing a new dementia pain tool.

## 4. Reportable Issues Log

Issues occurring between 27th May 2021 to current:

### 4.1 Serious Incidents & Never Events

In the period since our last Board meeting we reported eight serious incidents and one HSIB.

### 4.2 Red Complaints

There have been no red complaints since the last report.

### 4.3 Regulation 28 Reports

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

### 4.4 Health & Safety

There have been eleven incidents:

- Five incidents relate to dermatitis have been reported as occupational diseases.
- Two incidents relate to fractures sustained by members of staff who slipped - one inside and one outside of the workplace.
- One incident relates to a staff member who suffered a soft tissue injury after their arm was twisted by a patient.
- One incident relates to a patient who suffered a fracture following a fall. This has been passed on to the CQC as per the usual process.
- One incident relates to a sharps injury sustained when cannulating a patient.
- One incident relates to a needle stick injury sustained when clearing clinical waste.

### 4.5 Maternity Incidents

There were three stillbirths, one neonatal death, and two medical terminations for fetal abnormalities in May. In June there was one still birth and one neonatal death.

### 4.6 Whistleblowing & Freedom to Speak Up

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

The FTSU Guardian will be presenting the Annual Report to the Board this month. We have seen an 85% increase in the number of concerns raised in 2020/21 and Q1 2021 has been the busiest quarter so far with 44 concerns raised.

### 4.7 Media coverage

Media coverage has included:

- The opening of our new maternity community hub within the BL3 area with the support of Bolton Council of Mosques (BCOM).
- An initiative being run by the Greater Manchester Integrated Stroke Delivery Network for patients to measure their blood pressure at home.
- The FABB Award winners and their achievements.
- Two staff members retired after achieving 62 years of service between them.
- Various coverage about COVID rates in Bolton and the situation at Royal Bolton Hospital.

TV appearances:

- BBC North West Tonight covered a piece about the Maternity Community Hub and this is now featuring on BBC World online so will be seen across the globe.

## 5. Board Assurance Framework Summary

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

The most significant risk to the organisation remains unchanged from the previous Board of Directors meeting - 1.2: To give every person the best treatment, every time. As discussed at Quality Assurance Committee on 21st July, the Board of Directors is asked to note the enhancing arrangements to ensure learning from nosocomial COVID- 19 cases is captured.

**Board Assurance Framework Summary – July, 2021**

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

| | Ambition | Lead | I | L | | Key Risks/issues | Key actions | Oversight |
|---|---|---|---|---|---|---|---|---|
| 1.1 | **To give every person the best treatment, every time**<br><br>**1)Reducing deaths in hospital** | FA | 4 | 4 | 16 | HSMR/SHMI above expected level<br>Prompt identification and escalation of ill patients<br>Depth of coding<br>Numbers of patients referred for specialist palliative care | Work with AQUA and NHS Northwest on pneumonia<br>Root cause analysis of avoidable cardiac arrests<br>Delivery of MRG Work stream<br>Clinical leads appointed for sepsis and deteriorating patients<br>HED benchmarking<br>Mortality plan delivery:<br>• improved coding resource<br>• coding training for clinicians<br>• improve coding clinician interaction<br>• departmental coding meetings<br>• medical reviews of high mortality diagnostic group<br>• To ensure that learning from nosocomial COVID cases is banked by the organisation via existing/enhanced mortality intelligence gathering routes | QA committee<br>Mortality Reduction Group<br>Learning from Deaths |

| | Ambition | Lead | I | L | | Key Risks/issues | Key actions | Oversight |
|---|---|---|---|---|---|---|---|---|
| 1.2 | **To give every person the best treatment, every time**<br><br>**2) Delivery of Operational Performance** | AE | 4 | 5 | 20 | Capacity – physical and staffing exacerbated by COVID 19 infection control requirements<br>Patient confidence to use services following COVID 19<br>Impact of COVID 19 on pathways, including risks associated with overcrowding<br>Back log of work as a result of the cessation of activity during initial outbreak | Redesign of pathways for COVID compliance<br>Urgent Care programme plan to ensure best practice, e.g. SAFER<br>Enhanced pathways as part of the new streaming model<br>Cancer and RTT Patient treatment list management<br>Review of OPD and Theatre capacity and transformation<br>Detailed capacity and demand management<br>Joint working with GM on cancer pathways | Senior team board round (weekly)<br>Covid Reset Group<br>Contract and Performance<br>GM Cancer Board |
| 2 | **To be a great place to work** | JM | 4 | 4 | 16 | Sickness rates (particular increase of stress related issues as a result of Covid)<br>Recruitment and retention in key staffing groups<br>Over reliance on Agency staff<br>Staff experience (particular focus required maternity)<br>Inclusion – workforce not reflective of population | Health and Wellbeing plan in place and positive impact, on-going monitoring in place<br>Recruitment work plan in place and positive impact, on-going monitoring in place<br>Staff experience plan in place and positive impact, on-going<br>Maternity cultural improvement plan, implementation on-going with some improvements being shown<br>Inclusion programme in place, with mixed delivery outputs<br>New EDI strategy being developed | IPM<br>People committee |
| 3 | **To continue to use our resources wisely so that we can invest in and improve our services** | AW | 4 | 4 | 16 | Failure to deliver financial balance and surpluses for reinvestment | Development of locality financial strategy Sep 21<br>5 year financial strategy and trajectories agreed with GM and NHSI Dec 21<br>Reset approach to cost improvement and productivity Sep 21 | F&I committee<br>IPM<br>Contract and Performance Group |

| | Ambition | Lead | I | L | | Key Risks/issues | Key actions | Oversight |
|---|---|---|---|---|---|---|---|---|
| 4 | **Our estate will be sustainable and developed in a way that supports staff and community health and wellbeing** | AW | 4 | 4 | 16 | Availability of capital funding and changes to capital regime.<br>Lack of revenue to support capital<br>Controllability of non FT estate in community | Fully costed estates strategy over 5 years, Dec 21<br>Hospital Improvement Plan bid, approved June 2021<br>Estates Master Plan revised in line with Hospital Improvement Plan<br>Community estates strategy – Dec 21<br>Agile Working programme – ongoing<br>Theatre Improvement plan<br>Community Diagnostic hub | Strategic Estates Board<br>Strategic Estates Group<br>Finance Committee |
| 5 | **To join up services to improve the health of the people of Bolton** | SM | 4 | 3 | 12 | Failure to Deliver Integrated Care Partnership | Monthly exec to exec meetings with NHS Bolton CCG<br>Communication and Engagement Plan across all providers in place - complete<br>Development of an OD Framework to support cultural change, Dec 20<br>Develop Alliance Agreement to support the governance of the partnership, April 20<br>Embed ICP Community Focused Transformation Programme (including Public Sector Reform) within the ICP, on-going<br>Commence development of a public health framework, February 21 | Transformation and Trust Digital Transformation<br>Trust Management Committee<br>QA<br>Board<br>ICP Board |

| | Ambition | Lead | I | L | | Key Risks/issues | Key actions | Oversight |
|---|---|---|---|---|---|---|---|---|
| 6 | **To develop partnerships across Greater Manchester to improve services** | SM | 4 | 4 | 16 | GM Improving Specialist Care (ISC) programme paused in response to COVID-19, halting planned transformation of services including Breast, T&O, Urology etc. No date for programme restart<br><br>NWS Healthier Together (HT) programme has received capital funding from HM Treasury to progress construction of the Acute Receiving Centre at SRFT with anticipated completion in 2023<br><br>New approach to partnership working in GM in response to COVID-19<br><br>GM Radiology and Pathology Cells in development | Watching brief at GM-level and GM collaboration on pinch-point specialties through operational restart (i.e T&O and breast) - ongoing<br><br>Assessment of the changes required for delivery of HT in context of C-19 - ongoing<br><br>Continued involvement of executives at a GM level - ongoing<br><br>Continued involvement of executives and operational/clinical leads at a GM level - ongoing<br><br>Shared approach to elective restart and the management of capacity across GM | Transformation and Trust Digital Transformation committee<br>Trust Management Committee<br>F & I<br>Board |

Bolton NHS Foundation Trust

# Integrated Performance Report

June 2021

# Guide to Statistical Process Control

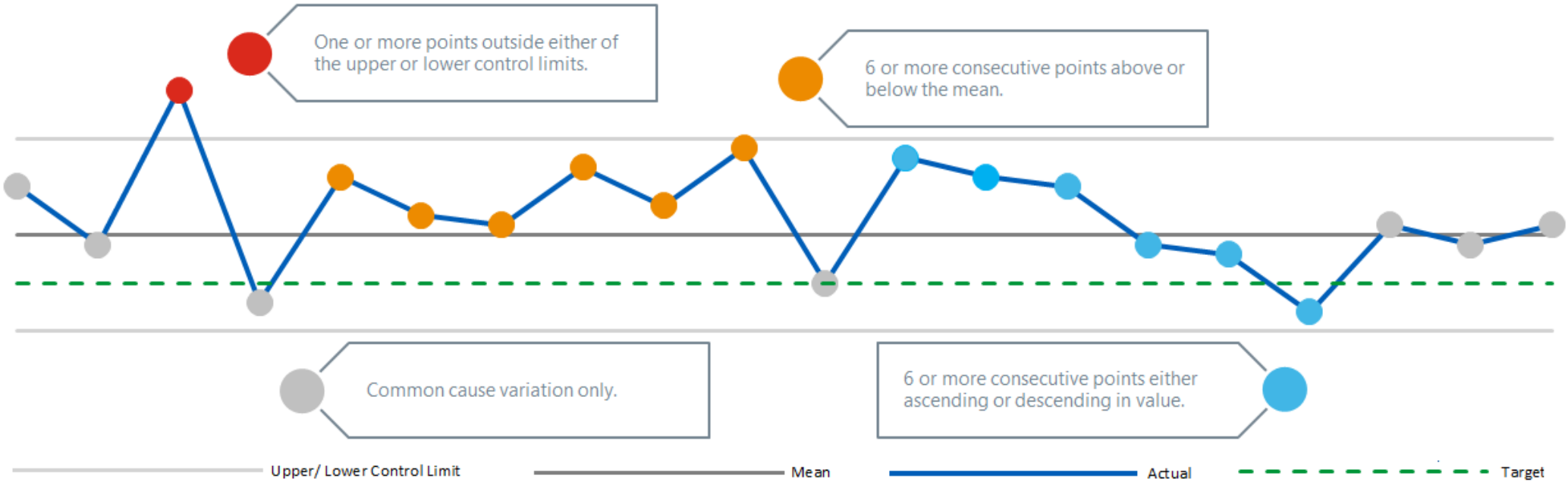
NHS Bolton NHS Foundation Trust

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 | 9 | 2 | 2 | 1 | 1 | 1 | 2 | 12 |
| Infection Prevention and Control | 7 | 0 | 2 | 0 | 0 | 0 | 0 | 7 |
| Mortality | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Patient Experience | 10 | 0 | 0 | 0 | 6 | 3 | 0 | 13 |
| Maternity | 7 | 1 | 1 | 1 | 0 | 1 | 0 | 9 |
| Operational Performance | | | | | | | | |
| Access | 6 | 0 | 0 | 3 | 2 | 0 | 5 | 6 |
| Productivity | 7 | 0 | 2 | 0 | 2 | 1 | 0 | 10 |
| Cancer | 6 | 0 | 0 | 0 | 1 | 2 | 1 | 4 |
| Community | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 |
| Workforce | | | | | | | | |
| Sickness, Vacancy and Turnover | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 2 |
| Organisational Development | 3 | 1 | 0 | 0 | 0 | 1 | 0 | 3 |
| Agency | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 3 |
| Finance | | | | | | | | |
| Finance | 2 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| Appendices | | | | | | | | |
| Heat Maps | | | | | | | | |

## Variation

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

## Assurance

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

# Quality and Safety

## Harm Free Care

Pressure ulcers
There has been an increase in pressure ulcers in both the hospital and community settings in June.
In the hospital, there have been 10 Category 2 pressure ulcers, 5 of these were from medical devices, and a further 2 associated with a patient in the prone position.
In the community, there has been an increase in Category 2 pressure ulcers, with 19 being reported in June. The majority of these pressure ulcers were to the sacral area. In addition, there have been 3 Category 3 pressure ulcers and 1 Category 4 pressure ulcer.

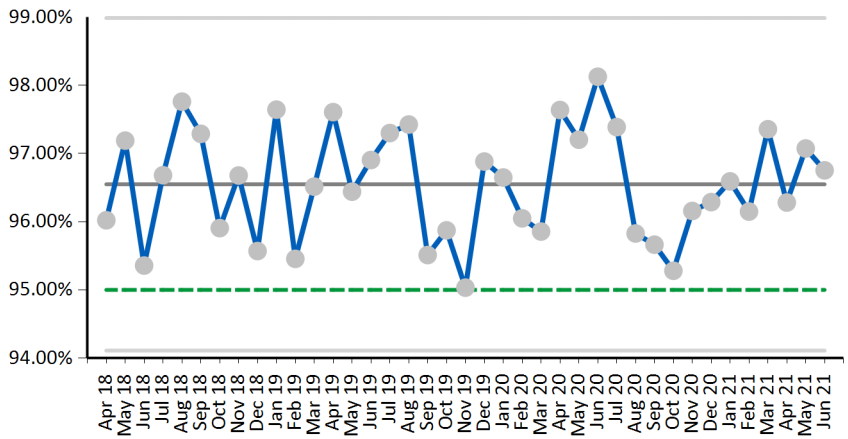
Falls
Falls per 1000 bed days have shown a slight rise in June and falls with harm have stayed at the same level as May. We continue to maintain a sustained increase in occupied bed days over the last 2 months of the quarter. We remain under our local stretch target and well below the national benchmark.

CAS alerts
We had three alerts due in June. Two of them were closed on time. NATPSA/2020/006/NHSPS: Foreign Body Aspiration During Intubation - Alert cascaded to all divisions and Medical Director. Procurement awaiting approval of alternative products. Divisions to confirm development or amendment of local protocols in line with the alert. Alert remains open.

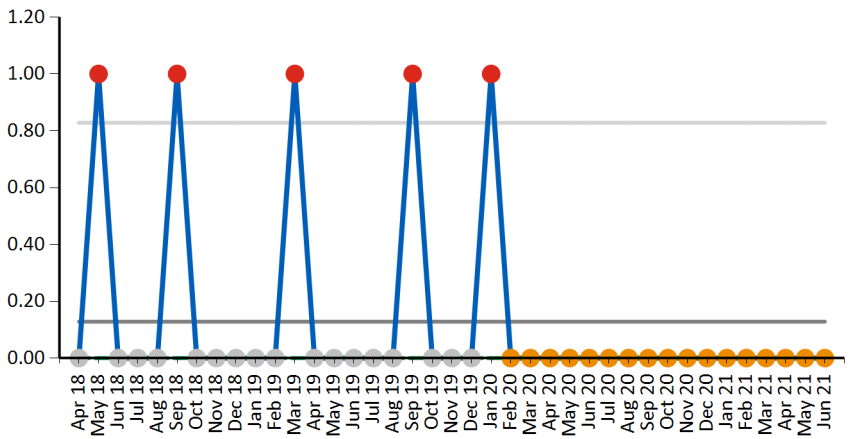
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 6 - Compliance with preventative measure for VTE | >= 95% | 96.8% | Jun-21 | | >= 95% | 97.1% | May-21 | >= 95% | 96.7% | |
| 9 - Never Events | = 0 | 0 | Jun-21 | | = 0 | 0 | May-21 | = 0 | 0 | |
| 13 - All Inpatient Falls (Safeguard Per 1000 bed days) | <= 5.30 | 4.93 | Jun-21 | | <= 5.30 | 4.42 | May-21 | <= 5.30 | 4.94 | |
| 14 - Inpatient falls resulting in Harm (Moderate +) | <= 1.6 | 3 | Jun-21 | | <= 1.6 | 3 | May-21 | <= 4.8 | 10 | |
| 15 - Acute Inpatients acquiring pressure damage (category 2) | <= 6.0 | 10.0 | Jun-21 | | <= 6.0 | 9.0 | May-21 | <= 18.0 | 22.0 | |
| 16 - Acute Inpatients acquiring pressure damage (category 3) | <= 0.5 | 0.0 | Jun-21 | | <= 0.5 | 0.0 | May-21 | <= 1.5 | 0.0 | |

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 17 - Acute Inpatients acquiring pressure damage (category 4) | = 0.0 | 0.0 | Jun-21 | | = 0.0 | 0.0 | May-21 | = 0.0 | 0.0 | |
| 18 - Community patients acquiring pressure damage (category 2) | <= 7.0 | 19.0 | Jun-21 | | <= 7.0 | 16.0 | May-21 | <= 21.0 | 46.0 | |
| 19 - Community patients acquiring pressure damage (category 3) | <= 4.0 | 3.0 | Jun-21 | | <= 4.0 | 0.0 | May-21 | <= 12.0 | 9.0 | |
| 20 - Community patients acquiring pressure damage (category 4) | <= 1.0 | 1.0 | Jun-21 | | <= 1.0 | 1.0 | May-21 | <= 3.0 | 2.0 | |
| 28 - Emergency patients screened for Sepsis (quarterly) | >= 90% | 68.1% | Q4 2020/21 | | >= 90% | 82.0% | Q2 2020/21 | >= 90% | | |
| 29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) | >= 90% | 100.0% | Q4 2020/21 | | >= 90% | 100.0% | Q2 2020/21 | >= 90% | | |
| 30 - Clinical Correspondence - Inpatients %<1 working day | >= 95% | 79.7% | Jun-21 | | >= 95% | 81.6% | May-21 | >= 95% | 81.3% | |
| 31 - Clinical Correspondence - Outpatients %<5 working days | >= 95.0% | 64.0% | Jun-21 | | >= 95.0% | 60.5% | May-21 | >= 95.0% | 63.9% | |
| 86 - NHS Improvement Patient Safety Alerts (CAS) Compliance | = 100% | 66.7% | Jun-21 | | = 100% | 0.0% | May-21 | = 100% | 22.2% | |
| 88 - Nursing KPI Audits | >= 85% | 92.7% | Jun-21 | | >= 85% | 92.3% | May-21 | >= 85% | 92.7% | |
| 91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days | = 100% | | Jun-21 | | = 100% | 60.0% | May-21 | = 100% | 60.0% | |

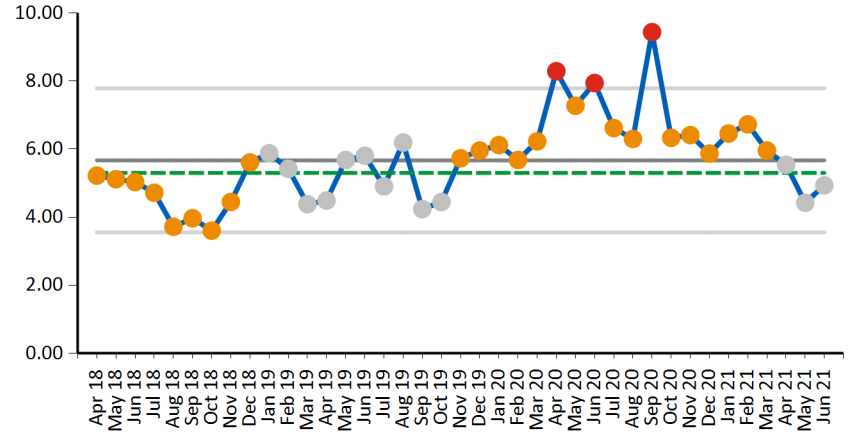
### 6 - Compliance with preventative measure for VTE



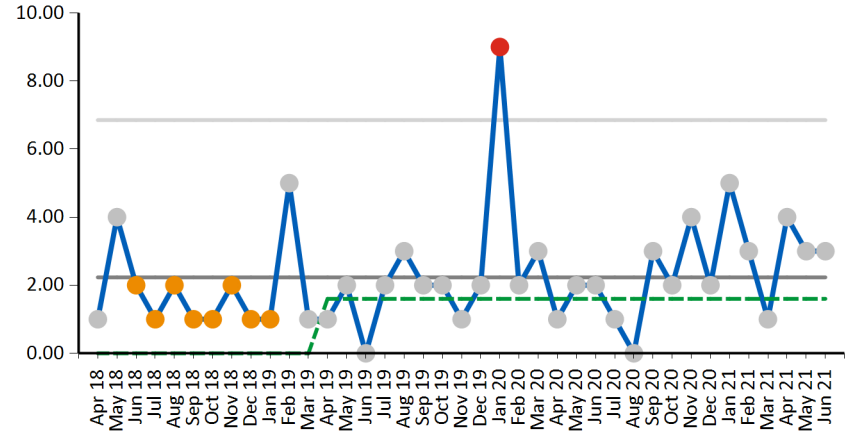

### 9 - Never Events



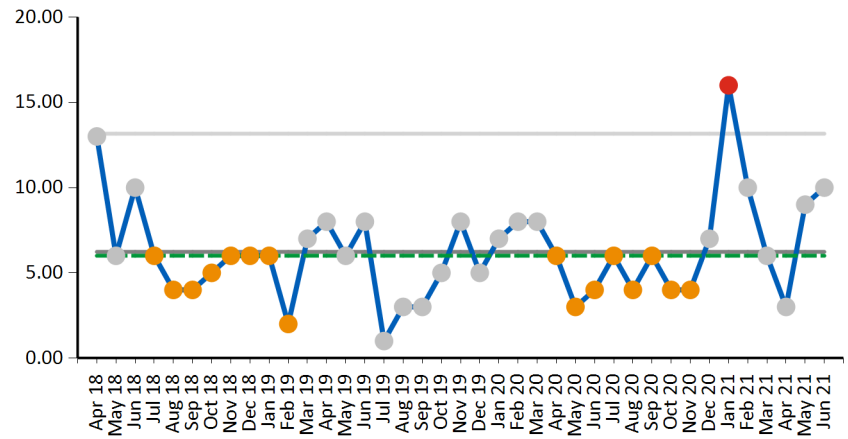

### 13 - All Inpatient Falls (Safeguard Per 1000 bed days)



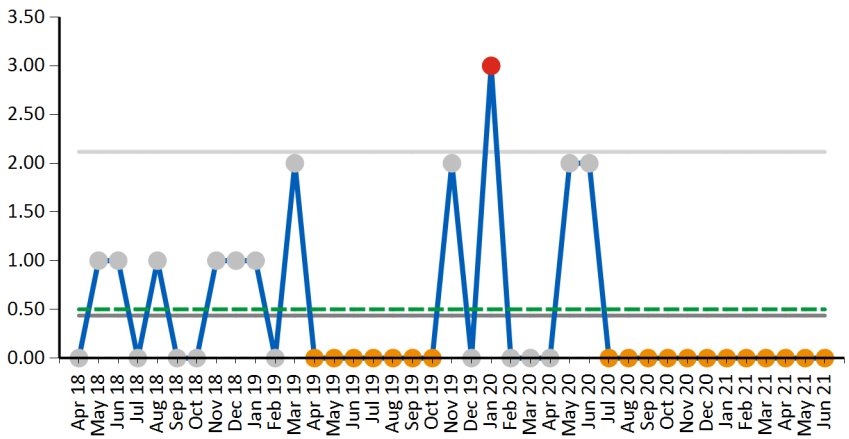

### 14 - Inpatient falls resulting in Harm (Moderate +)



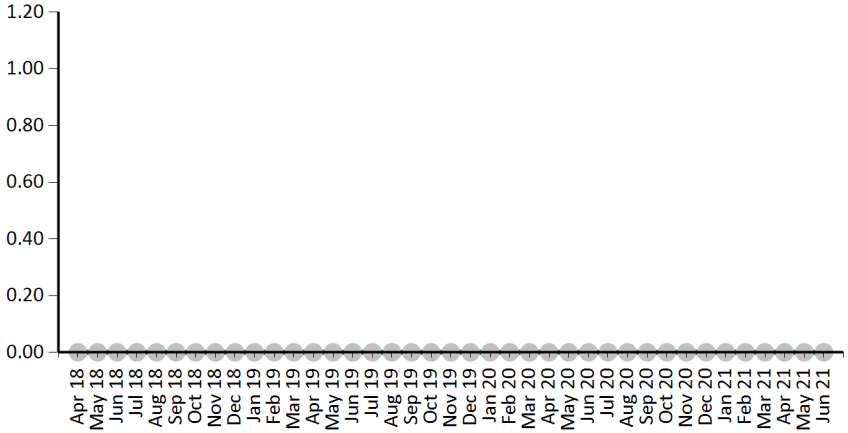
### 15 - Acute Inpatients acquiring pressure damage (category 2)



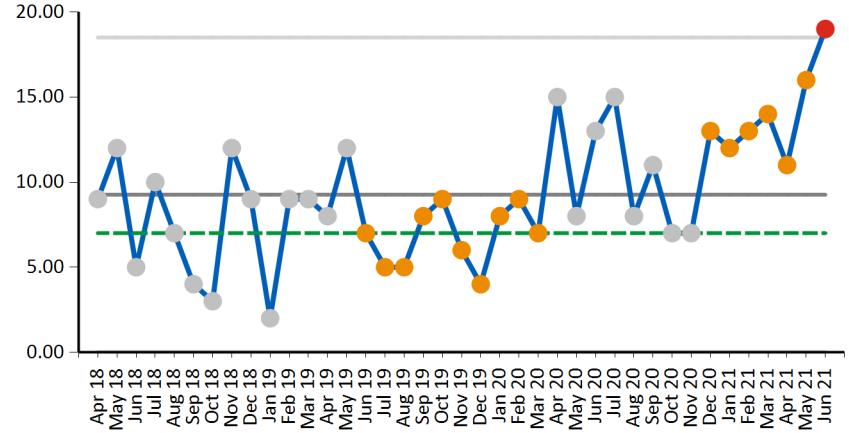

### 16 - Acute Inpatients acquiring pressure damage (category 3)



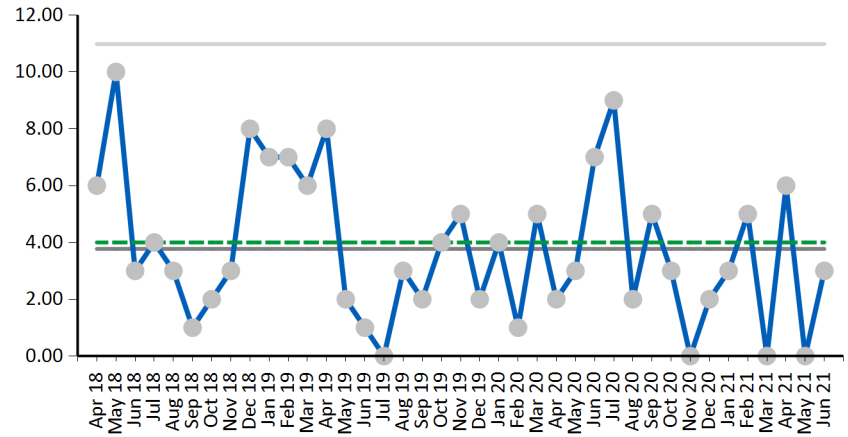

### 17 - Acute Inpatients acquiring pressure damage (category 4)



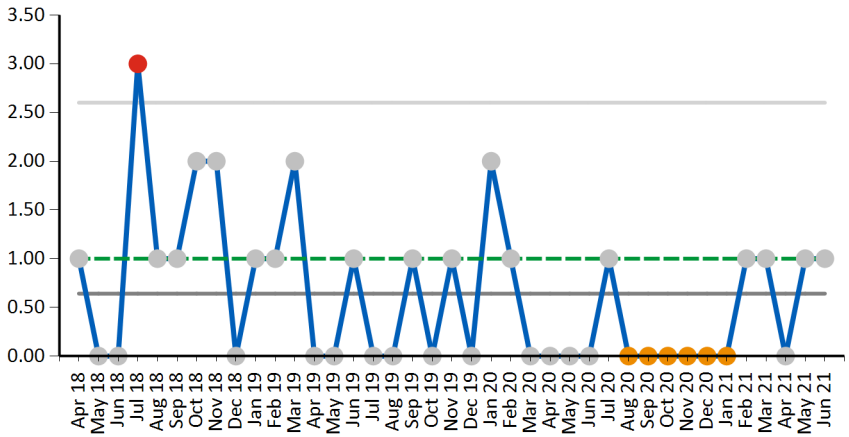

### 18 - Community patients acquiring pressure damage (category 2)



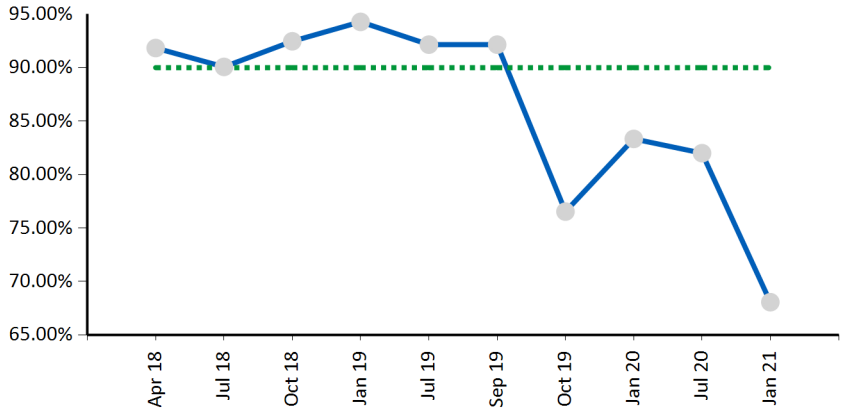
**19 - Community patients acquiring pressure damage (category 3)**



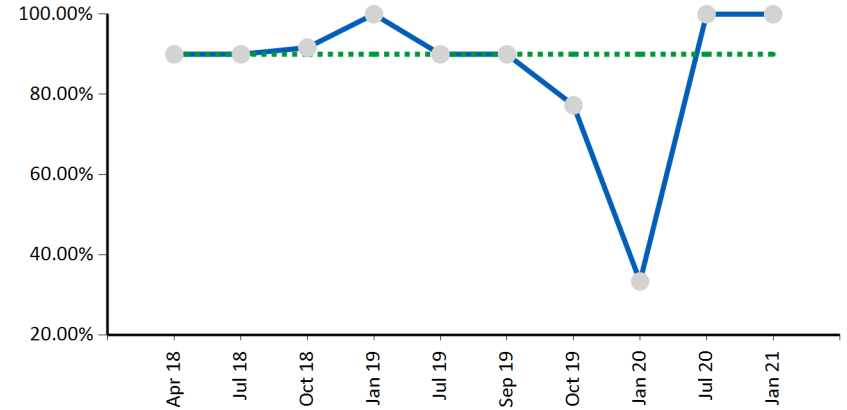

**20 - Community patients acquiring pressure damage (category 4)**



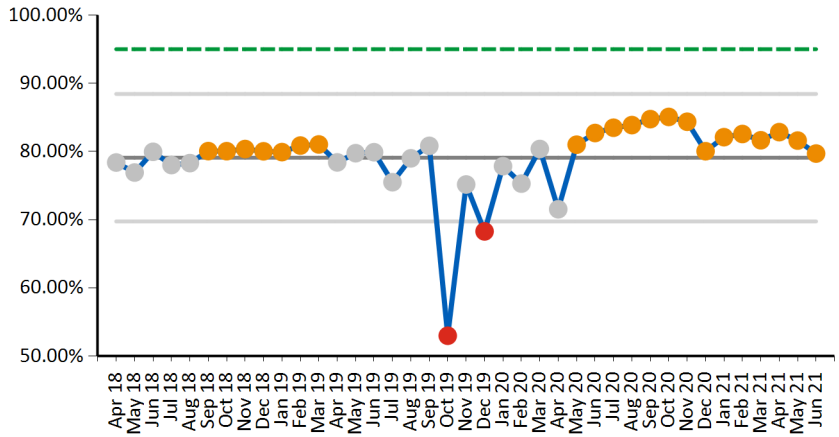

**28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points**



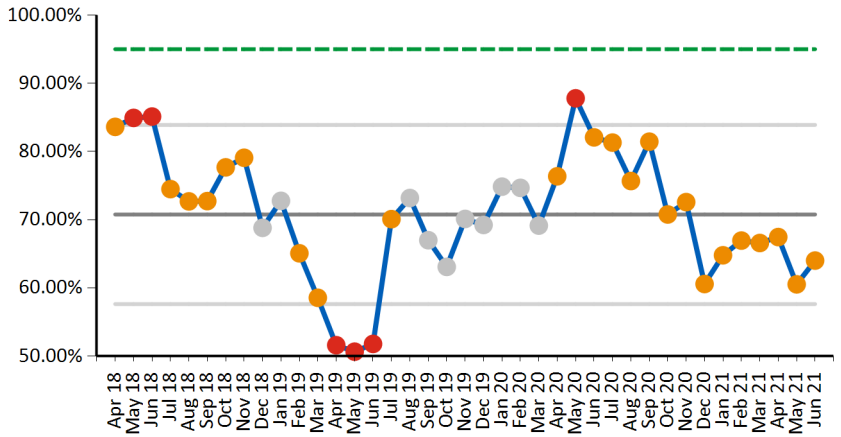

**29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points**



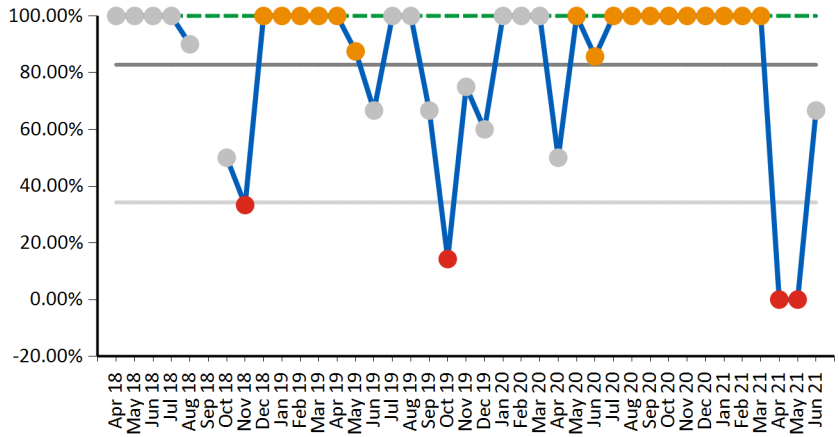
### 30 - Clinical Correspondence - Inpatients %<1 working day



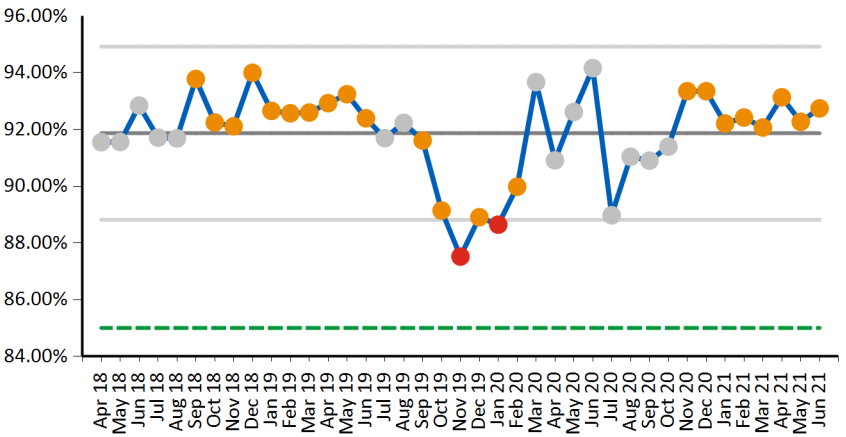

### 31 - Clinical Correspondence - Outpatients %<5 working days



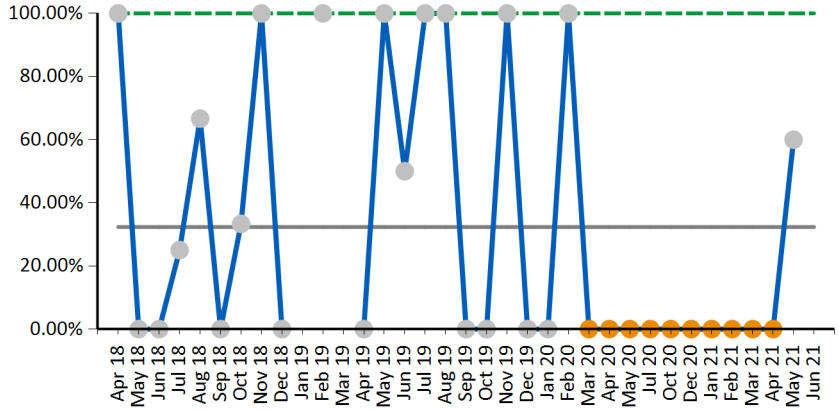

### 86 - NHS Improvement Patient Safety Alerts (CAS) Compliance




### 88 - Nursing KPI Audits



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



## Infection Prevention and Control

The pressures imposed on the Trust by the consistently high rates of COVID-19 in Bolton have had an impact over the past six weeks. After a prolonged period of reliability regarding nosocomial COVID-19 cases for the previous three months, there have been a number of nosocomial cases and some outbreaks. To 20/07/21 there have been 266 COVID-19 cases of which 12 (4.5%) have been nosocomial outbreaks.

Clostridium difficile cases remain higher than plan and the IPC team and microbiologists continue to work with the clinical teams to promote antibiotic stewardship. A working group is looking to implement a deep clean programme on a bay-by-bay basis rather than ward-by-ward given the continued unavailability of a ward to decant patients in order facilitate whole ward deep clean.

It has been more than one full calendar year since the last hospital onset MRSA bacteraemia close to matching the previously longest period between cases of 377 days.

E. coli bacteraemias remain reduced and for the second month in the preceding 12-months, there have been no hospital onset E. coli bacteraemias.

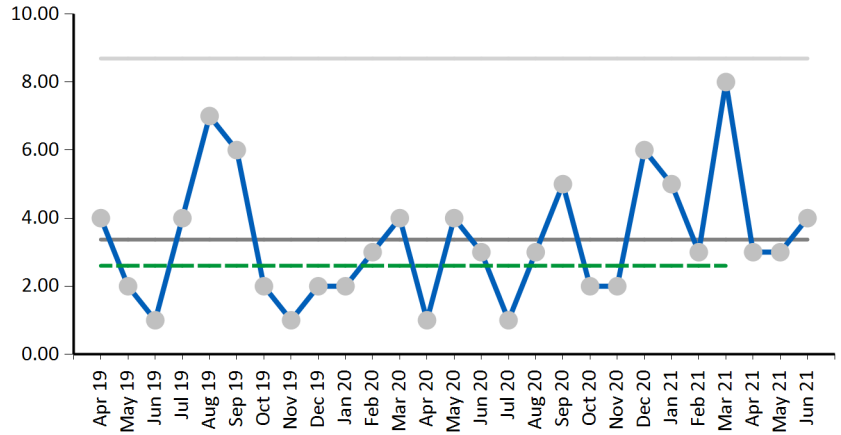
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

Chart 217 and 306 - This is an SPC G Chart. 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.

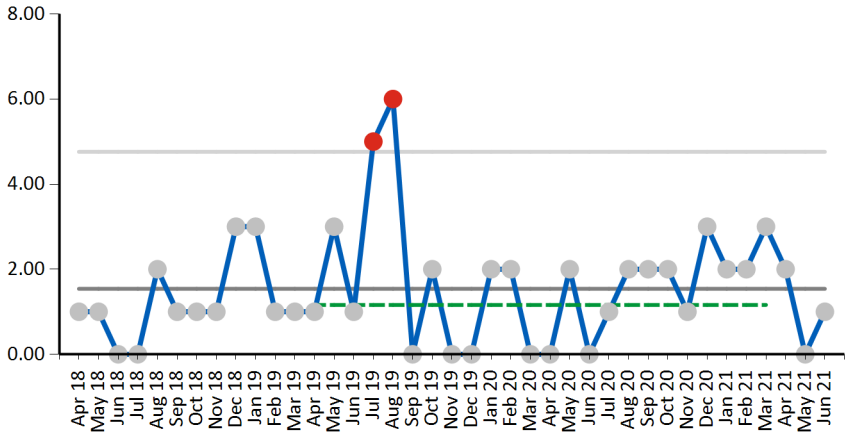
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 215 - Total Hospital Onset C.diff infections | | 4 | Jun-21 |  | | 3 | May-21 | | 10 | |
| 346 - Total Community Onset Hospital Associated C.diff infections | | 1 | Jun-21 |  | | 0 | May-21 | | 3 | |
| 347 - Total C.diff infections contributing to objective | <= 3 | 5 | Jun-21 |  | <= 3 | 3 | May-21 | <= 8 | 13 |  |
| 217 - Total Hospital-Onset MRSA BSIs | = 0 | 0 | Jun-21 |  | = 0 | 0 | May-21 | = 0 | 0 |  |
| 218 - Total Trust apportioned E. coli BSI | <= 2 | 0 | Jun-21 |  | <= 2 | 1 | May-21 | <= 5 | 4 |  |
| 219 - Blood Culture Contaminants (rate) | <= 3% | 2.8% | Jun-21 |  | <= 3% | 2.7% | May-21 | <= 3% | 2.3% |  |
| 199 - Compliance with antibiotic prescribing standards | >= 95% | 75.4% | Q4 2020/21 | | >= 95% | 73.0% | Q3 2020/21 | >= 95% | | |

| Outcome Measure | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 304 - Total Trust apportioned MSSA BSIs | <= 1.0 | 1.0 | Jun-21 | | <= 1.0 | 0.0 | May-21 | <= 3.0 | 1.0 | |
| 305 - Total Trust apportioned Klebsiella spp. BSIs | <= 1 | 1 | Jun-21 | | <= 1 | 0 | May-21 | <= 2 | 1 | |
| 306 - Total Trust apportioned Pseudomonas aeruginosa BSIs | = 0 | 0 | Jun-21 | | = 0 | 0 | May-21 | = 0 | 0 | |
| 491 - Nosocomial COVID-19 cases | | 5 | Jun-21 | | | 0 | May-21 | | 6 | |

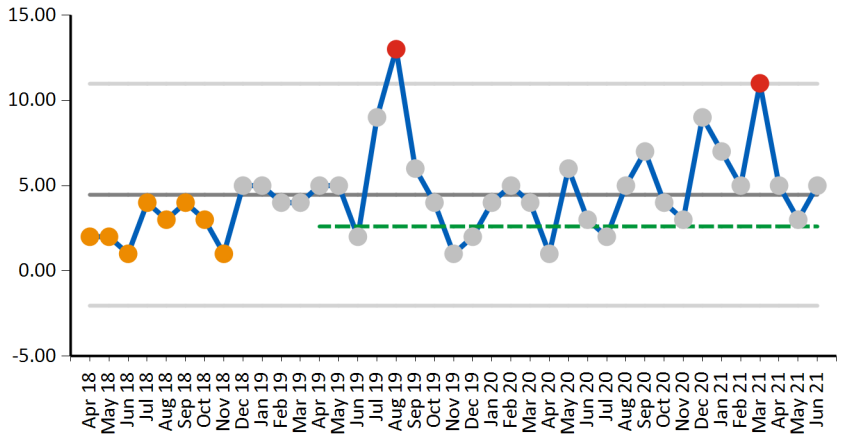
**215 - Total Hospital Onset C.diff infections**



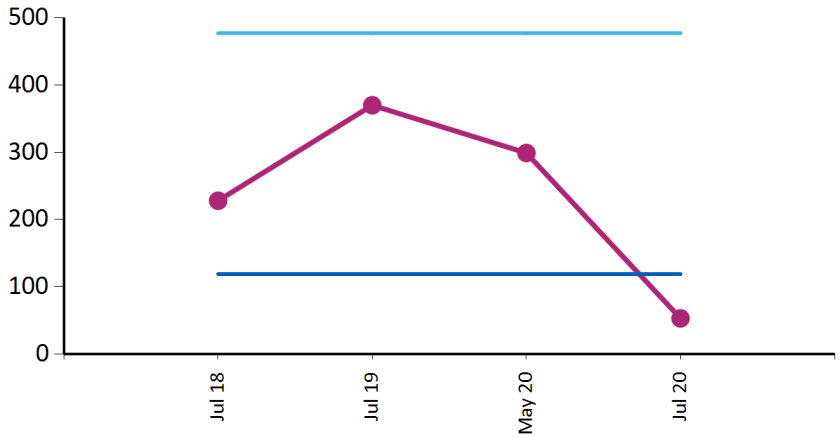

**346 - Total Community Onset Hospital Associated C.diff infections**



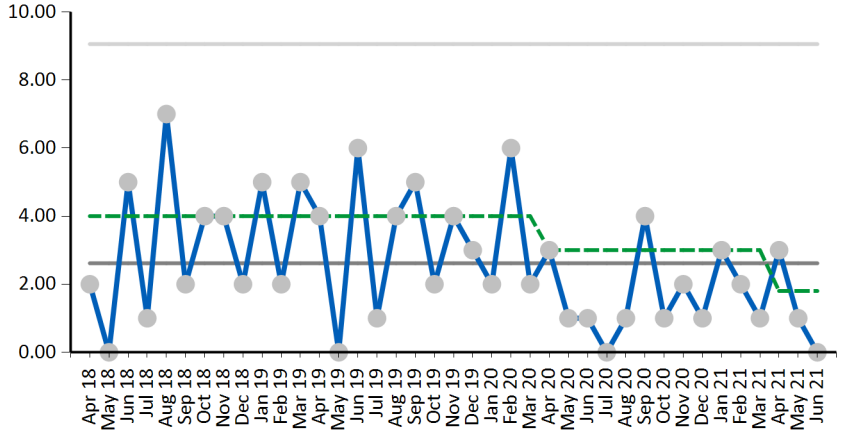
**347 - Total C.diff infections contributing to objective**



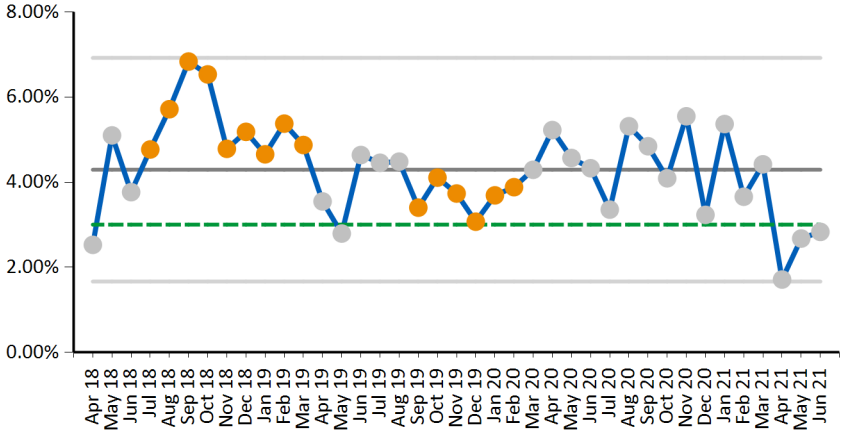

**217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)**



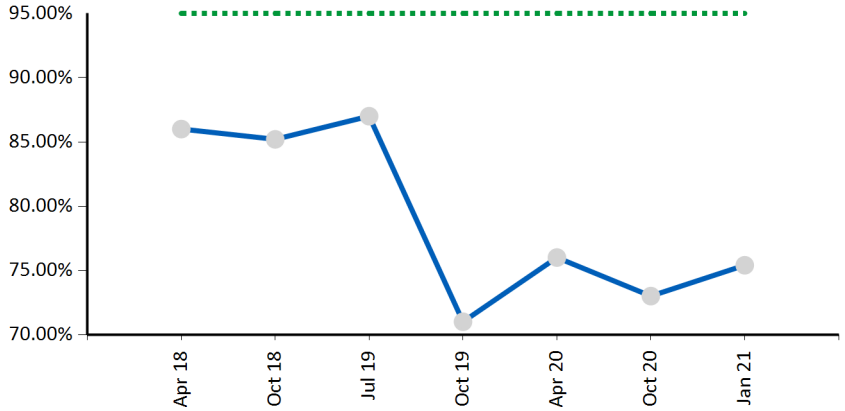

**218 - Total Trust apportioned E. coli BSI**



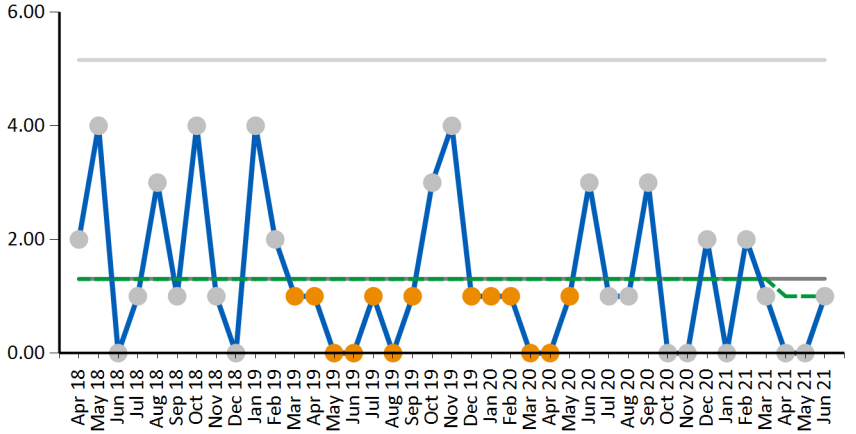

**219 - Blood Culture Contaminants (rate)**



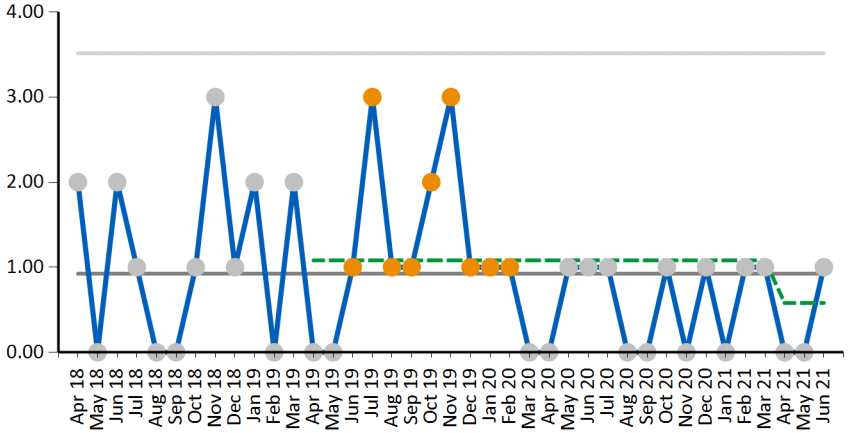
**199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points**



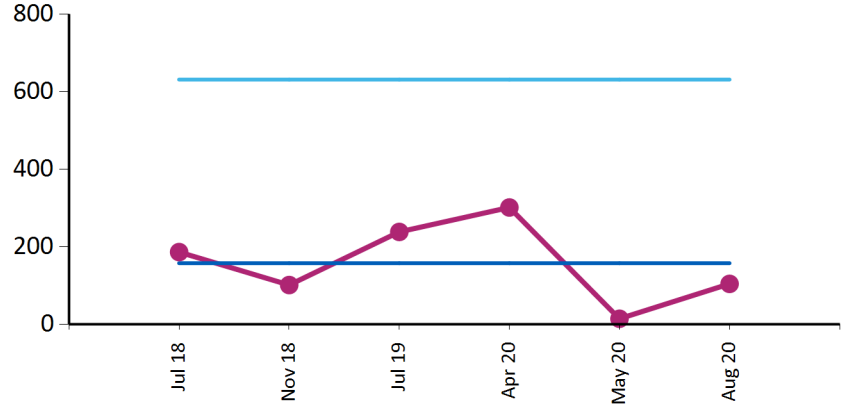

**304 - Total Trust apportioned MSSA BSIs**



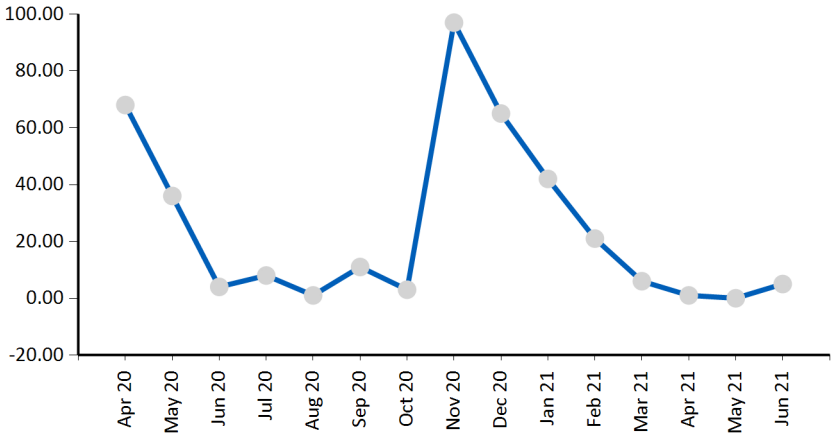

**305 - Total Trust apportioned Klebsiella spp. BSIs**




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



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



## Mortality

Crude – Crude mortality has remained below target and the average for the reporting period with the rate remaining at a similar level to that seen before the pandemic.

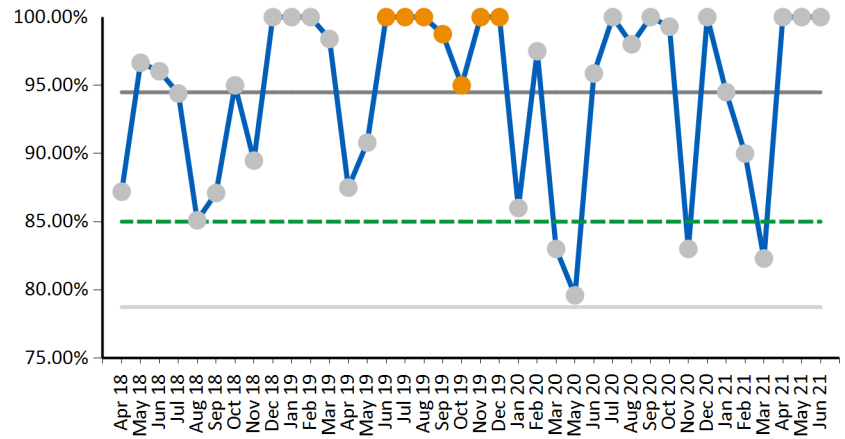
SHMI – the in-month SHMI remains in control despite a rise from December 2020. NHS Digital have released the March 2020 to February 2021 figures where the Bolton SHMI has fallen back within expected levels at 111.79. Investigations into the reductions in SHMI are under investigation by Business Intelligence.

HSMR – the in-month HSMR has remained in control over the reporting period, this indicator is only partially adjusted for covid so the peaks over April/May 2020 and November/December 2020 follow the pattern of the waves of the pandemic in Bolton. The 12 month average for the 12 months to March 2021 is 118.56 and remains highest amongst mortality peers and remains higher than expected.

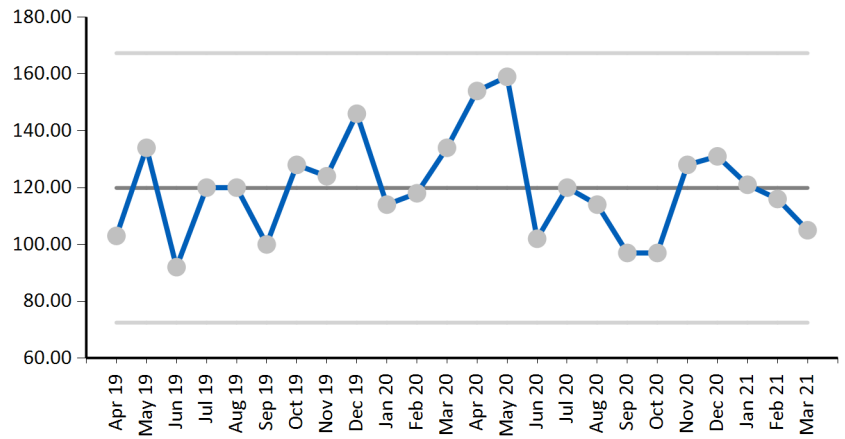
The work to improve the mortality indicators is continuing and the Action Plan reviewed weekly to further reduce SHMI and HSMR. There are specialty meetings under way with coding department and Business Intelligence to raise awareness of the recording issues and to highlight the mortality position within the Trust.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 3 - National Early Warning Scores to Gold standard | >= 85% | 100.0% | Jun-21 | | >= 85% | 100.0% | May-21 | >= 85% | 100.0% | |
| 495 - HSMR | | 105.00 | Mar-21 | | | 116.00 | Feb-21 | | | |
| 11 - Summary Hospital-level Mortality Indicator (SHMI) | <= 100.00 | 110.00 | Jan-21 | | <= 100.00 | 92.00 | Dec-20 | <= 100.00 | | |
| 12 - Crude Mortality % | <= 2.9% | 2.3% | Jun-21 | | <= 2.9% | 2.3% | May-21 | <= 2.9% | 2.2% | |

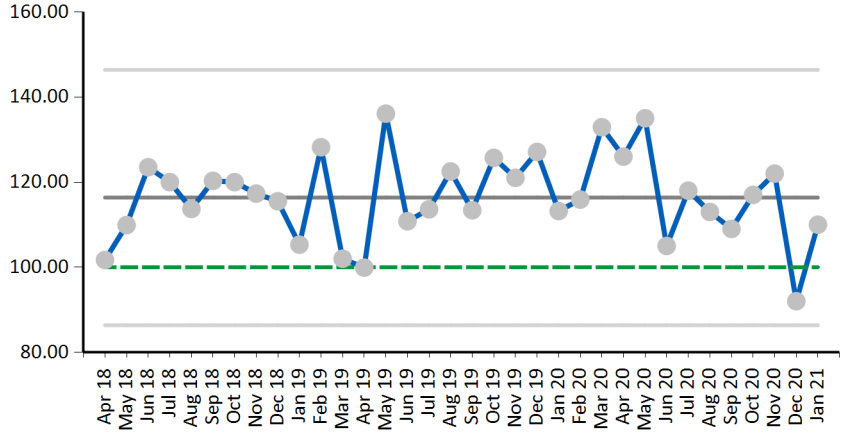
### 3 - National Early Warning Scores to Gold standard



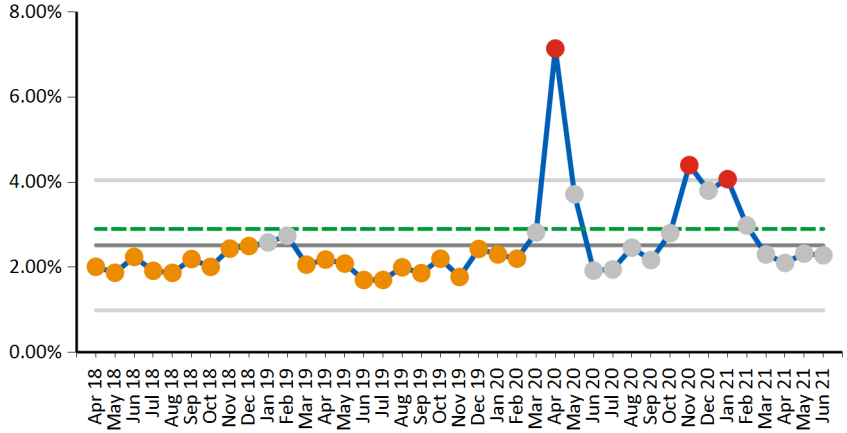

### 495 - HSMR




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




### 12 - Crude Mortality %



## Patient Experience

FFT
NHSE advice continues to be to collect FFT if safe to do so and they have started publishing on their website again.

Initiatives for safe collection of FFT continue including use of QR codes with an increased focus to act on the narrative provided by the patient either negative or positive. Some areas have seen an increase in response rates during June with a real desire to improve response rates with the introduction of contact free collection.

FFT continues to be discussed at newly established Divisional Quality Patient Experience Meetings where scrutiny takes place relating to recommendation rates and patient narrative. Monitoring takes place during the Quality Patient Experience Group held monthly and chaired by a DND.

Complaints
The Trust rate for acknowledging complaints during June was 100%. The response rate was 84% against a recover plan of 50%

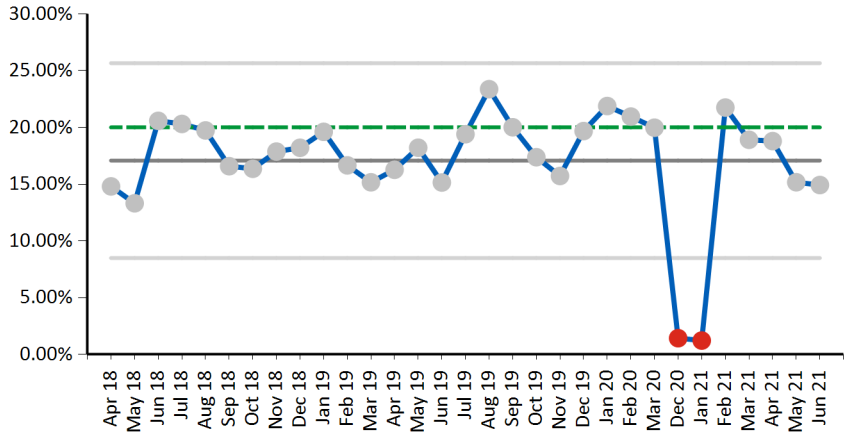
A review of the complaints management process has started with a plan for publication of a report early September 2021.

The recovery plan in place to improve performance has been achieved in the months of May and June with a trajectory of 95% in July following which a further review will be undertaken.

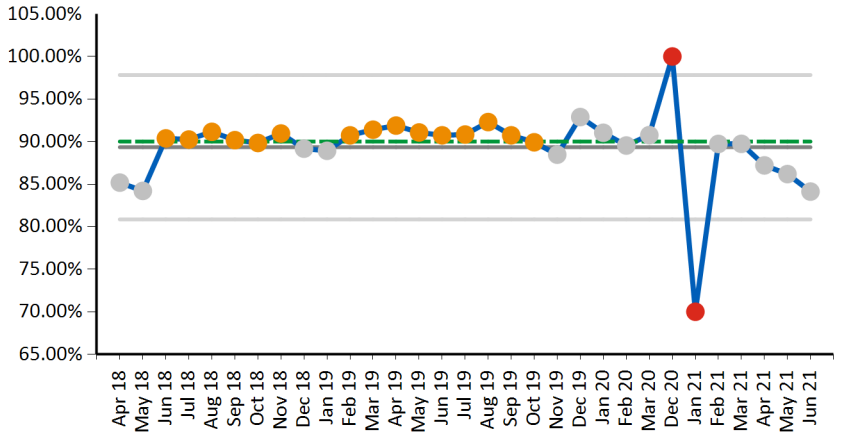
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 200 - A&E Friends and Family Response Rate | >= 20% | 14.9% | Jun-21 | | >= 20% | 15.2% | May-21 | >= 20% | 16.2% | |
| 294 - A&E Friends and Family Satisfaction Rates % | >= 90% | 84.1% | Jun-21 | | >= 90% | 86.2% | May-21 | >= 90% | 85.9% | |
| 80 - Inpatient Friends and Family Response Rate | >= 30% | 25.7% | Jun-21 | | >= 30% | 19.4% | May-21 | >= 30% | 22.0% | |
| 240 - Friends and Family Test (Inpatients) - Satisfaction % | >= 90% | 97.6% | Jun-21 | | >= 90% | 96.9% | May-21 | >= 90% | 96.9% | |
| 81 - Maternity Friends and Family Response Rate | >= 15% | 13.1% | Jun-21 | | >= 15% | 12.2% | May-21 | >= 15% | 12.4% | |
| 241 - Maternity Friends and Family Test - Satisfaction % | >= 90% | 85.8% | Jun-21 | | >= 90% | 91.6% | May-21 | >= 90% | 89.5% | |
| 82 - Antenatal - Friends and Family Response Rate | >= 15% | 0.0% | Jun-21 | | >= 15% | 0.0% | May-21 | >= 15% | 0.0% | |
| 242 - Antenatal Friends and Family Test - Satisfaction % | >= 90% | | Jun-21 | | >= 90% | | May-21 | >= 90% | 100.0% | |
| 83 - Birth - Friends and Family Response Rate | >= 15% | 29.5% | Jun-21 | | >= 15% | 24.0% | May-21 | >= 15% | 27.5% | |

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 243 - Birth Friends and Family Test - Satisfaction % | >= 90% | 85.7% | Jun-21 | | >= 90% | 90.2% | May-21 | >= 90% | 89.5% | |
| 84 - Hospital Postnatal - Friends and Family Response Rate | >= 15% | 14.8% | Jun-21 | | >= 15% | 18.3% | May-21 | >= 15% | 14.5% | |
| 244 - Hospital Postnatal Friends and Family Test - Satisfaction % | >= 90% | 83.3% | Jun-21 | | >= 90% | 90.9% | May-21 | >= 90% | 89.8% | |
| 85 - Community Postnatal - Friend and Family Response Rate | >= 15% | 10.0% | Jun-21 | | >= 15% | 8.9% | May-21 | >= 15% | 9.0% | |
| 245 - Community Postnatal Friends and Family Test - Satisfaction % | >= 90% | 89.5% | Jun-21 | | >= 90% | 97.3% | May-21 | >= 90% | 89.2% | |
| 89 - Formal complaints acknowledged within 3 working days | = 100% | 100.0% | Jun-21 | | = 100% | 100.0% | May-21 | = 100% | 100.0% | |
| 90 - Complaints responded to within the period | >= 95% | 84.6% | Jun-21 | | >= 95% | 55.6% | May-21 | >= 95% | 62.5% | |

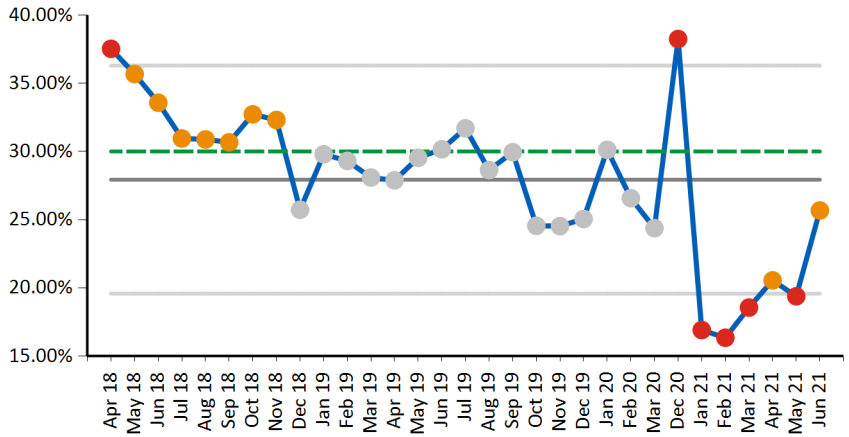
**200 - A&E Friends and Family Response Rate**



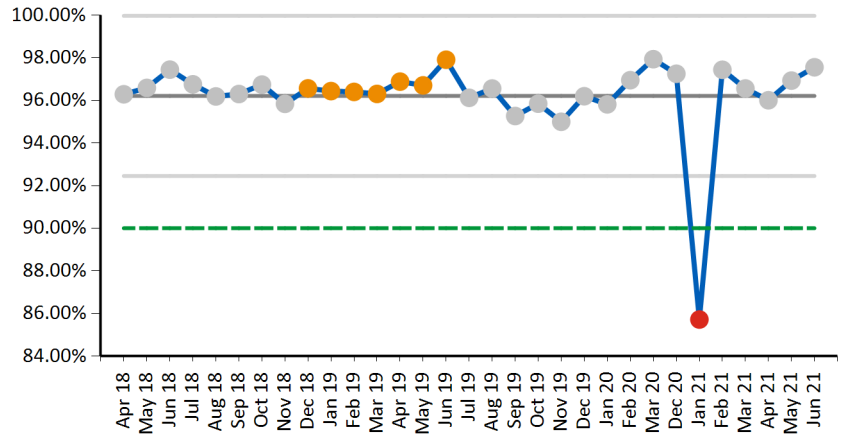

**294 - A&E Friends and Family Satisfaction Rates %**



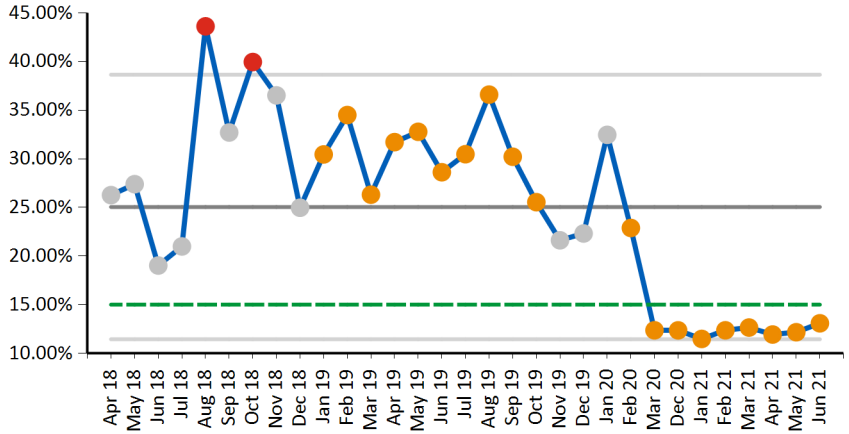
## 80 - Inpatient Friends and Family Response Rate



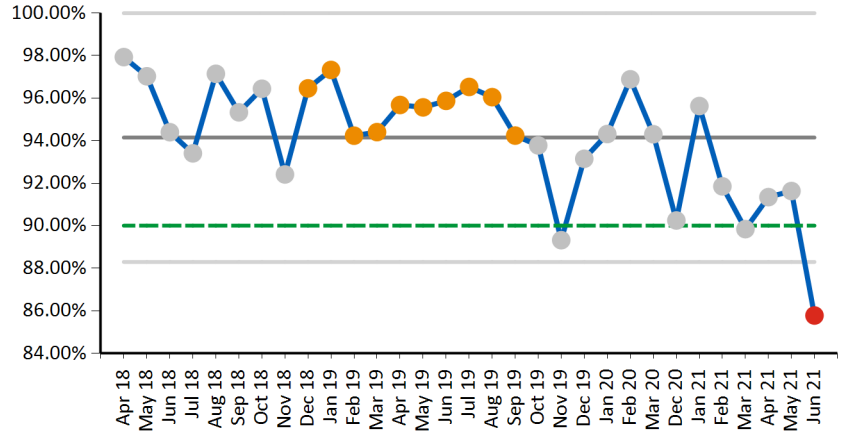

## 240 - Friends and Family Test (Inpatients) - Satisfaction %



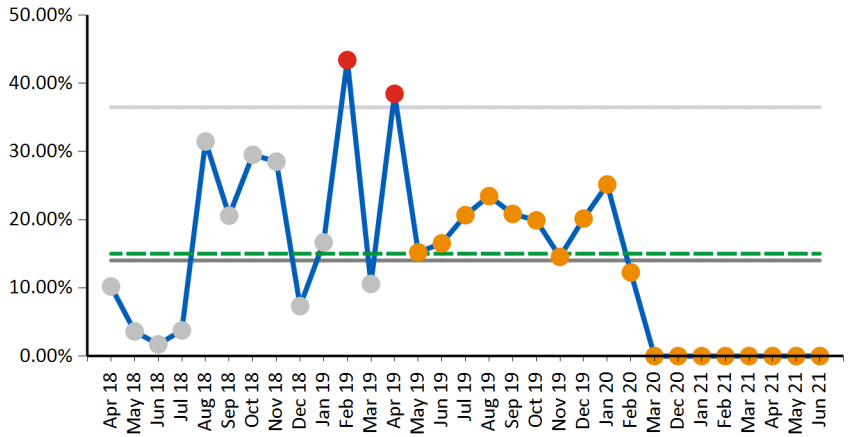

## 81 - Maternity Friends and Family Response Rate



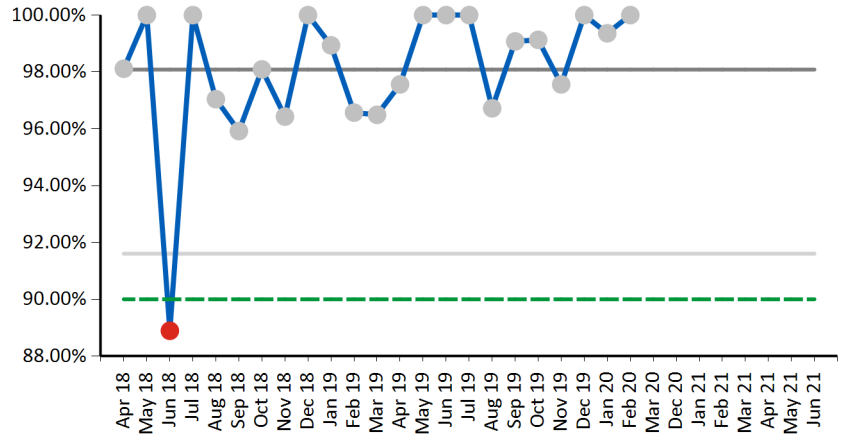

## 241 - Maternity Friends and Family Test - Satisfaction %



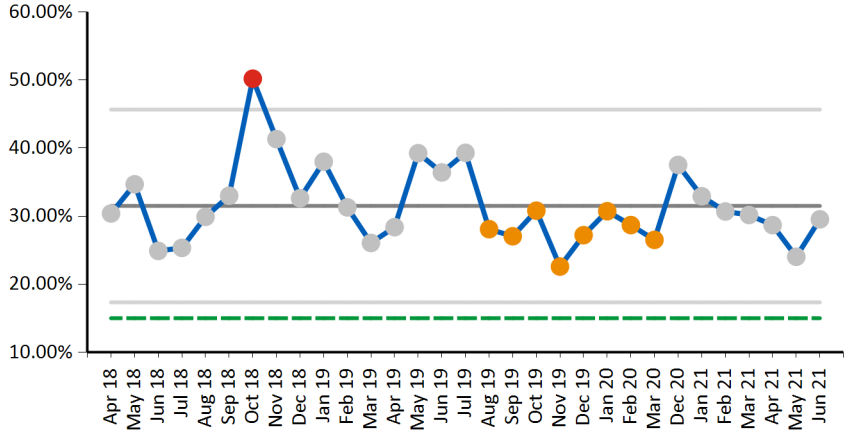
## 82 - Antenatal - Friends and Family Response Rate



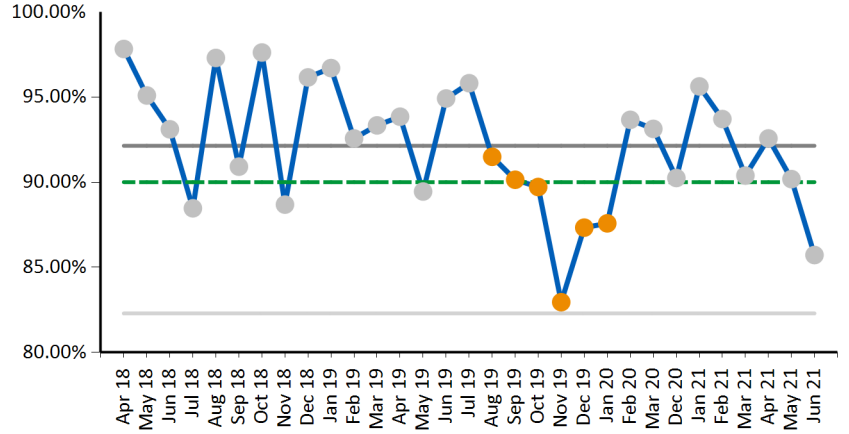

## 242 - Antenatal Friends and Family Test - Satisfaction %



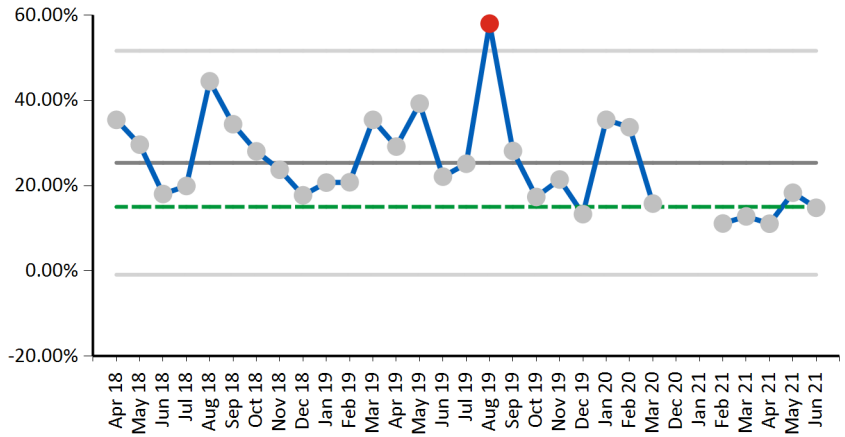

## 83 - Birth - Friends and Family Response Rate



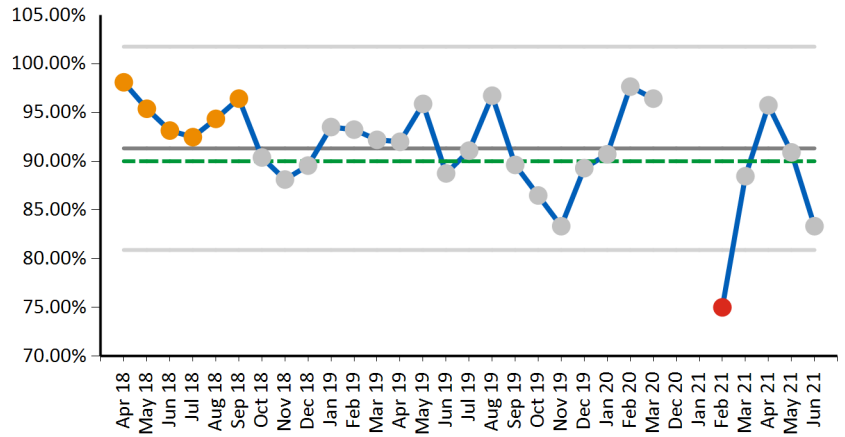

## 243 - Birth Friends and Family Test - Satisfaction %



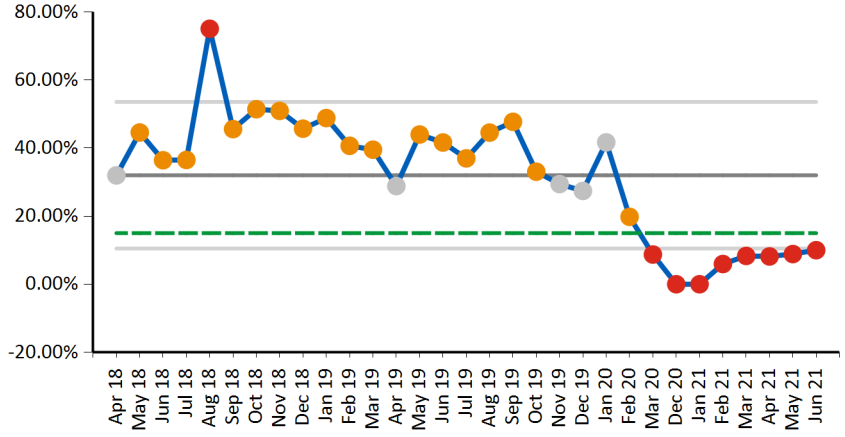
## 84 - Hospital Postnatal - Friends and Family Response Rate



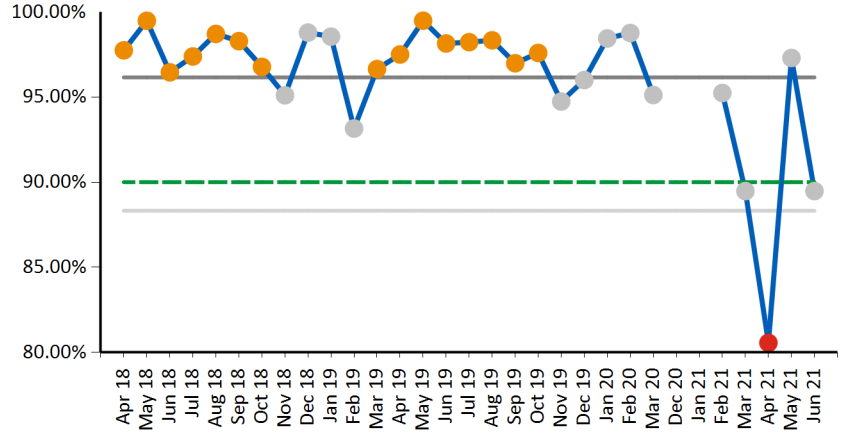

## 244 - Hospital Postnatal Friends and Family Test - Satisfaction %



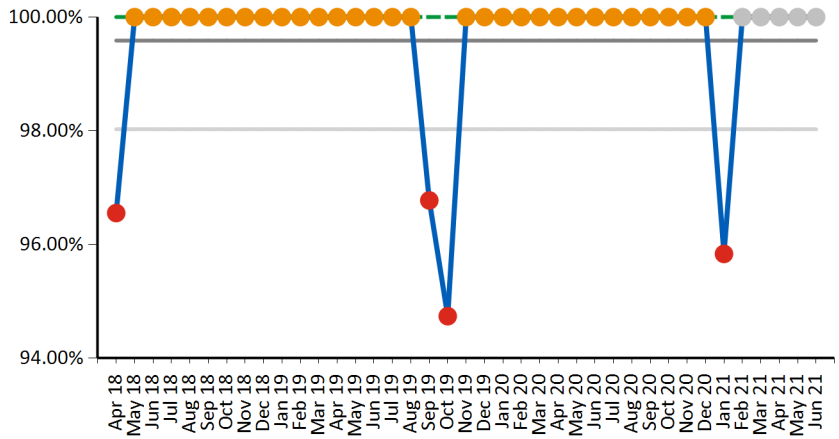

## 85 - Community Postnatal - Friend and Family Response Rate



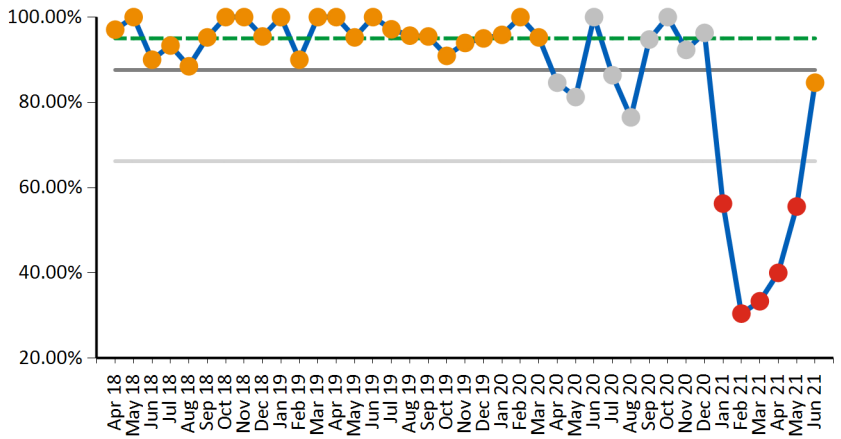

## 245 - Community Postnatal Friends and Family Test - Satisfaction %



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




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

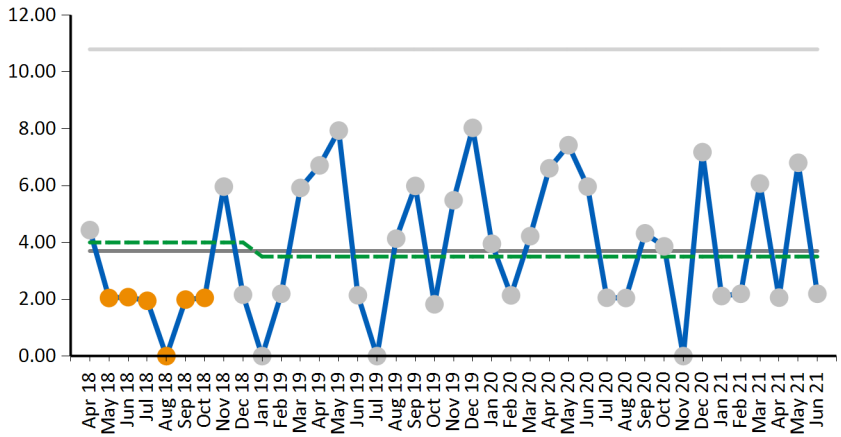


## Maternity

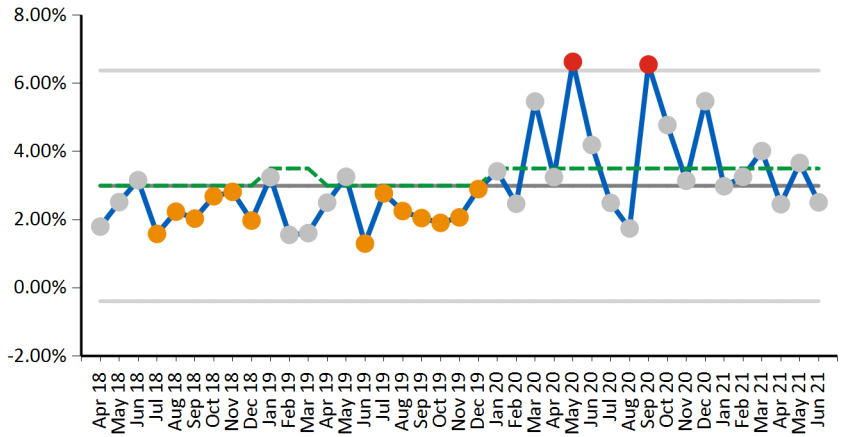
The Caesarean section remains consistently high above the median for GM of 35%, the one to one care in labour remains good despite vacancies and pressure within the maternity system.
Friends and family response rate 20% for first month, recommendation less than acceptable comments made refer to delays in IOL process.

| | 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 | 2.19 | Jun-21 | | <= 3.50 | 6.80 | May-21 | <= 3.50 | 3.62 | ? |
| 23 - Maternity -3rd/4th degree tears | <= 3.5% | 2.5% | Jun-21 | | <= 3.5% | 3.7% | May-21 | <= 3.5% | 2.8% | ? |
| 202 - 1:1 Midwifery care in labour | >= 95.0% | 98.6% | Jun-21 | | >= 95.0% | 98.3% | May-21 | >= 95.0% | 98.3% | P |
| 203 - Booked 12+6 | >= 90.0% | 90.4% | Jun-21 | H | >= 90.0% | 90.5% | May-21 | >= 90.0% | 90.9% | ? |
| 204 - Inductions of labour | <= 40% | 38.4% | Jun-21 | | <= 40% | 36.4% | May-21 | <= 40% | 39.9% | ? |
| 208 - Total C section | <= 33.0% | 37.3% | Jun-21 | H | <= 33.0% | 37.5% | May-21 | <= 33.0% | 35.7% | ? |
| 210 - Initiation breast feeding | >= 65% | 69.14% | Jun-21 | | >= 65% | 74.88% | May-21 | >= 65% | 70.59% | ? |
| 213 - Maternity complaints | <= 5 | 1 | Jun-21 | | <= 5 | 3 | May-21 | <= 15 | 6 | ? |
| 319 - Maternal deaths (direct) | = 0 | 0 | Jun-21 | L | = 0 | 0 | May-21 | = 0 | 0 | ? |
| 320 - Rate of Preterm births (rate <37 weeks as a percentage of all births) | <= 6% | 9.6% | Jun-21 | | <= 6% | 8.6% | May-21 | <= 6% | 6.4% | ? |

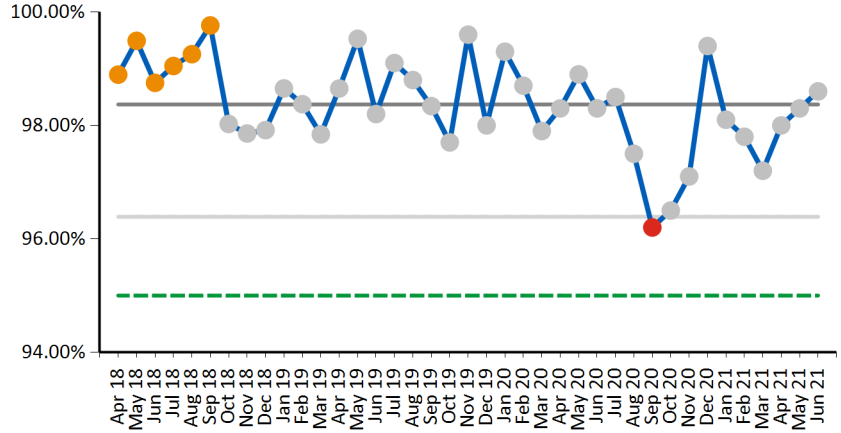
**322 - Maternity - Stillbirths per 1000 births**



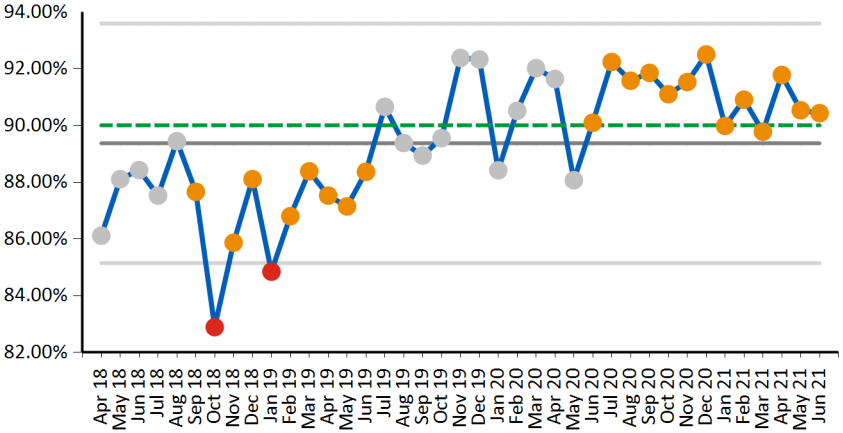

**23 - Maternity -3rd/4th degree tears**



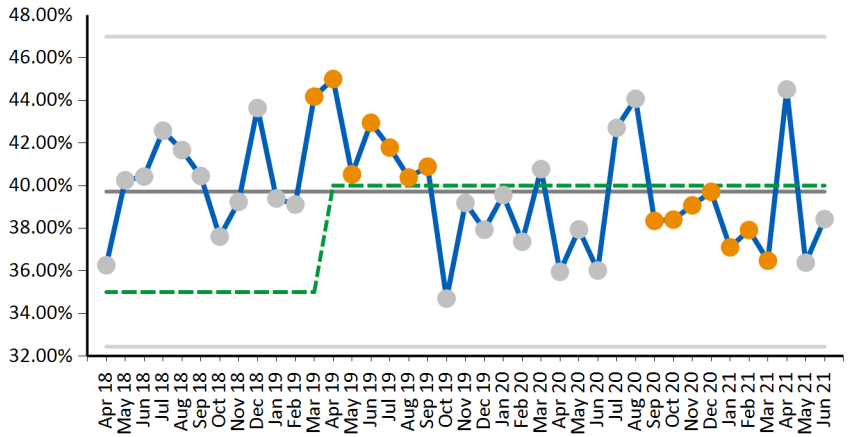

**202 - 1:1 Midwifery care in labour**



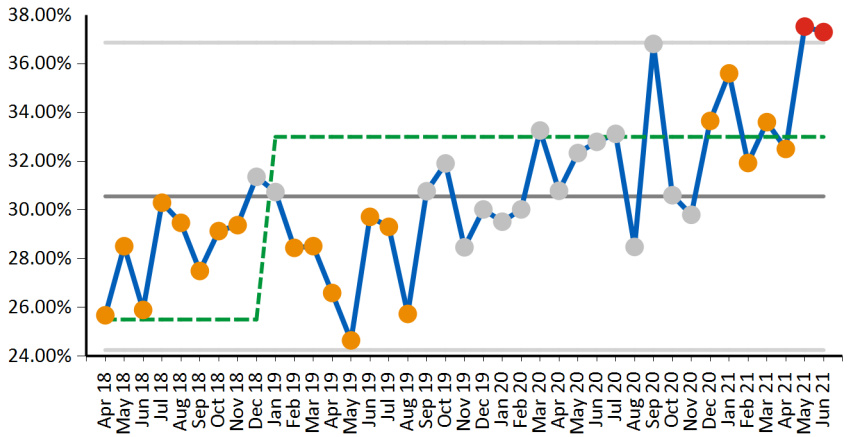

**203 - Booked 12+6**



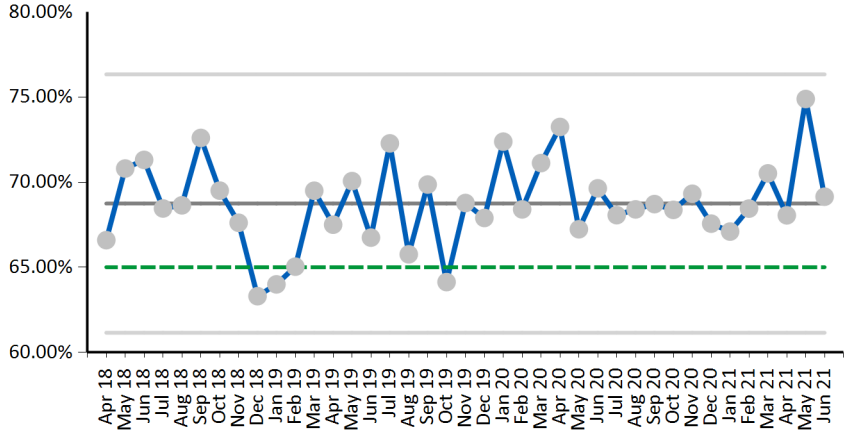
## 204 - Inductions of labour



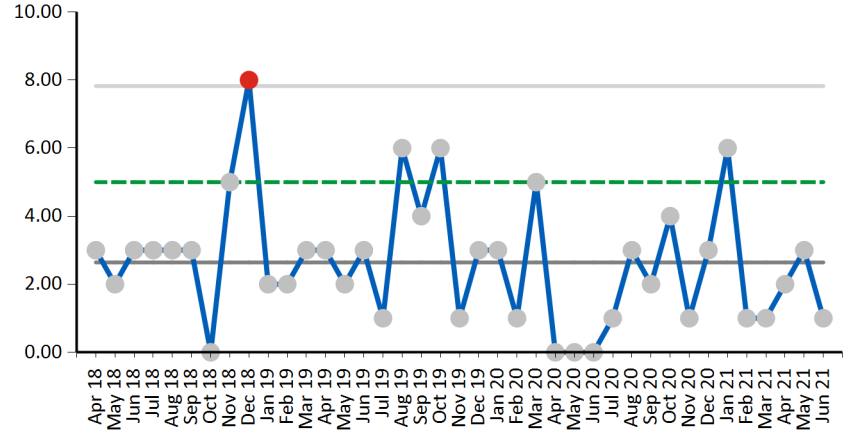

## 208 - Total C section



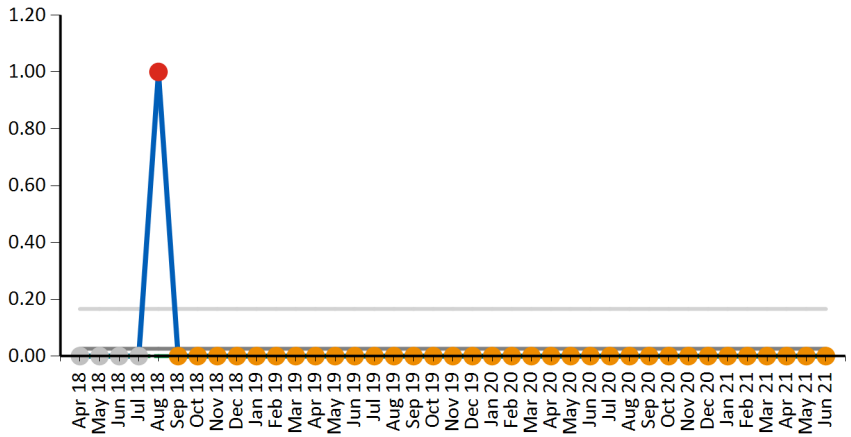

## 210 - Initiation breast feeding



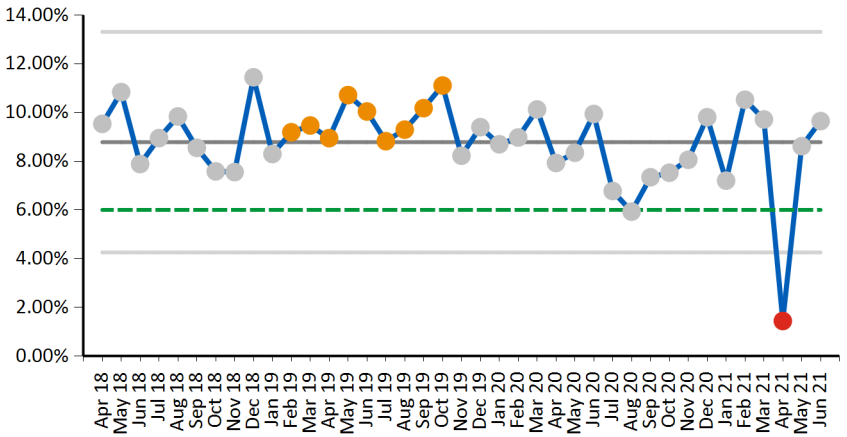

## 213 - Maternity complaints



**319 - Maternal deaths (direct)**




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



# Operational Performance

## Access

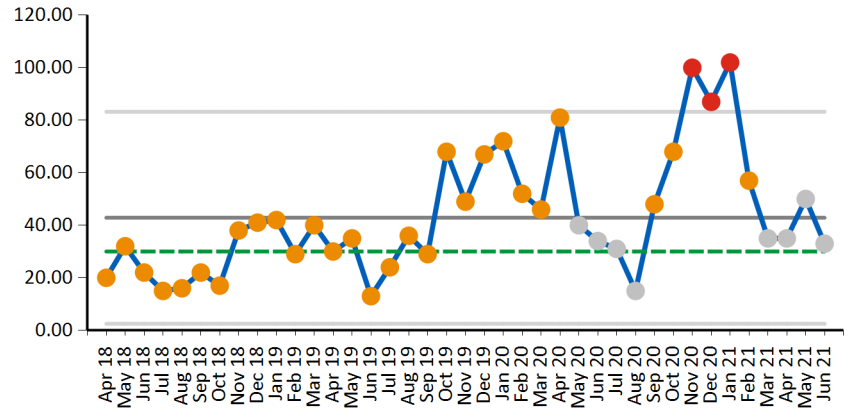
RTT
The Trust Led by the Anaesthetic and Surgical Division team continue to make improvements with reductions in the number waiting more than 52 weeks for treatment and steady improvement in the number waiting more than 18 weeks. However with referrals increasing the overall waiting list continues to rise.  Overall recovery rates compare well to regional and national position, but the Infection control pressures and staffing remain a significant threat to continued improvement in the short term. Diagnostics show improvement too, with endoscopy the main challenge but the recovery on trajectory.

Urgent Care
Numbers of attendances continue to rise month on month, with an average of 415 per day, up from 350 in April. The volume of attendances, mainly walk ins, is causing difficulties in managing the flow through A/E, especially in children. The majority of patients are discharged, and a new triage process is being piloted to direct patients to urgent care elsewhere. This patterns is being seen nationally.

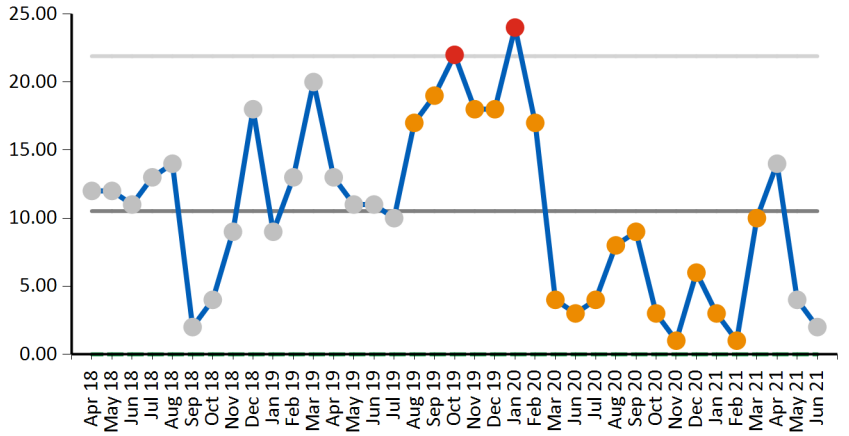
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 7 - Transfers between 11pm and 6am (excluding transfers from assessment wards) | <= 30 | 33 | Jun-21 | | <= 30 | 50 | May-21 | <= 90 | 118 | ? |
| 8 - Same sex accommodation breaches | = 0 | 2 | Jun-21 | | = 0 | 4 | May-21 | = 0 | 20 | ? |
| 26 - Patients going to theatre within 36 hours of a fractured Neck of Femur | >= 75% | 62.9% | Jun-21 | | >= 75% | 67.9% | May-21 | >= 75% | 69.4% | ? |
| 41 - RTT Incomplete pathways within 18 weeks % | >= 92% | 68.0% | Jun-21 | L | >= 92% | 67.1% | May-21 | >= 92% | 66.4% | F |
| 42 - RTT 52 week waits (incomplete pathways) | = 0 | 2,188 | Jun-21 | H | = 0 | 2,419 | May-21 | = 0 | 7,369 | F |
| 314 - RTT 18 week waiting list | <= 25,530 | 26,780 | Jun-21 | H | <= 25,530 | 26,519 | May-21 | <= 25,530 | 26,780 | ? |
| 53 - A&E 4 hour target | >= 95% | 71.1% | Jun-21 | L | >= 95% | 72.7% | May-21 | >= 95% | 72.6% | F |
| 70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins) | = 0.0% | 10.0% | Jun-21 | | = 0.0% | 7.6% | May-21 | = 0.0% | 7.9% | F |
| 71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins) | = 0.00% | 5.74% | Jun-21 | | = 0.00% | 2.81% | May-21 | = 0.00% | 3.60% | ? |
| 72 - Diagnostic Waits >6 weeks % | <= 1% | 31.0% | Jun-21 | H | <= 1% | 34.0% | May-21 | <= 1% | 34.1% | F |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 27 - TIA (Transient Ischaemic attack) patients seen <24hrs | = 100% | 36.4% | Jun-21 | | = 100% | 88.9% | May-21 | = 100% | 60.3% | |

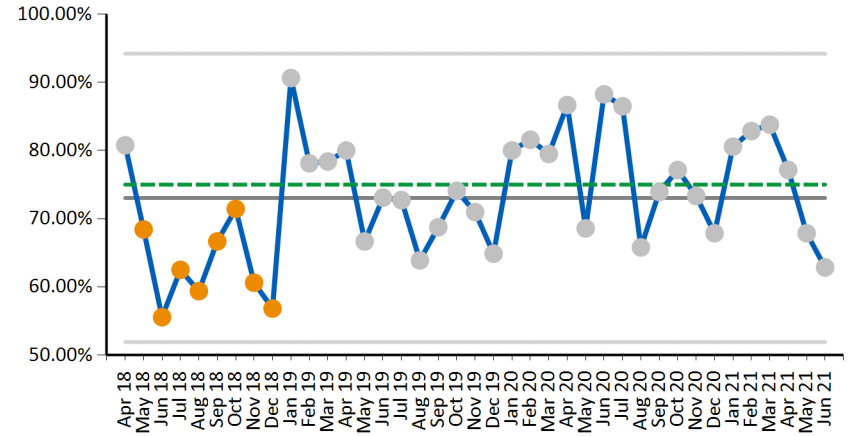
**7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)**



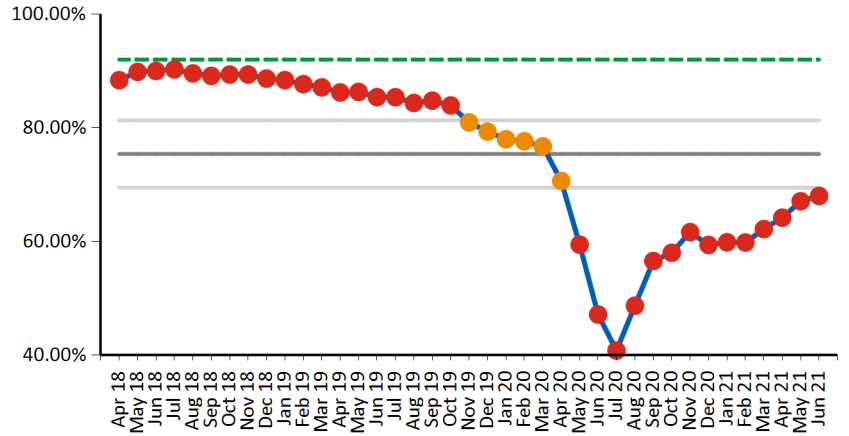

**8 - Same sex accommodation breaches**



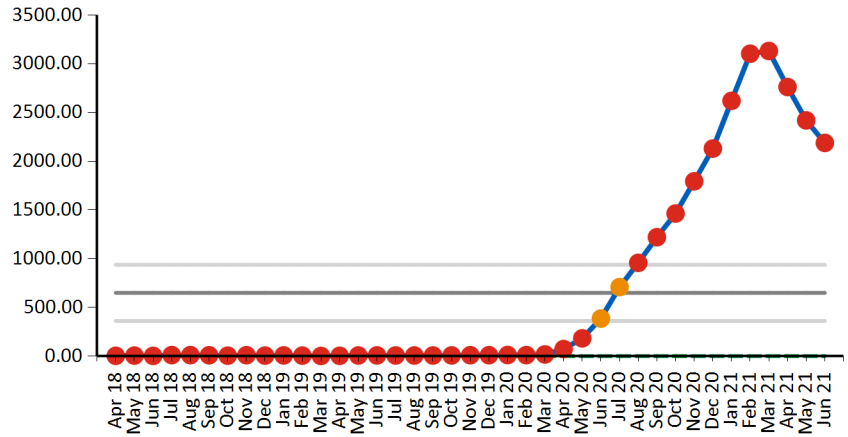

**26 - Patients going to theatre within 36 hours of a fractured Neck of Femur**



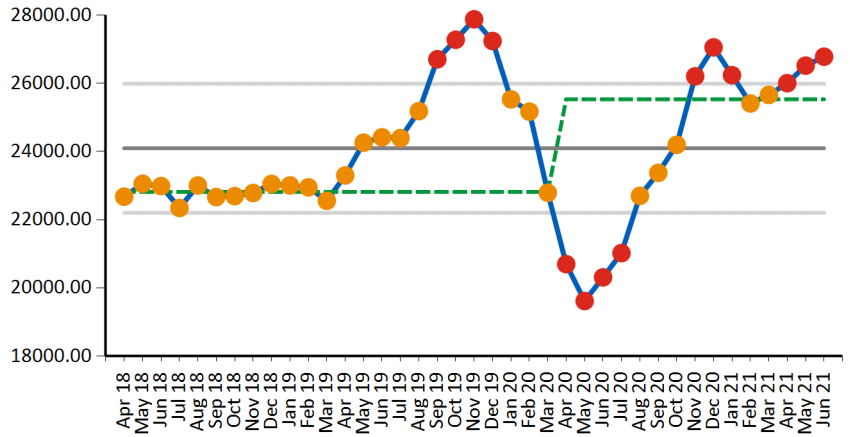

**41 - RTT Incomplete pathways within 18 weeks %**



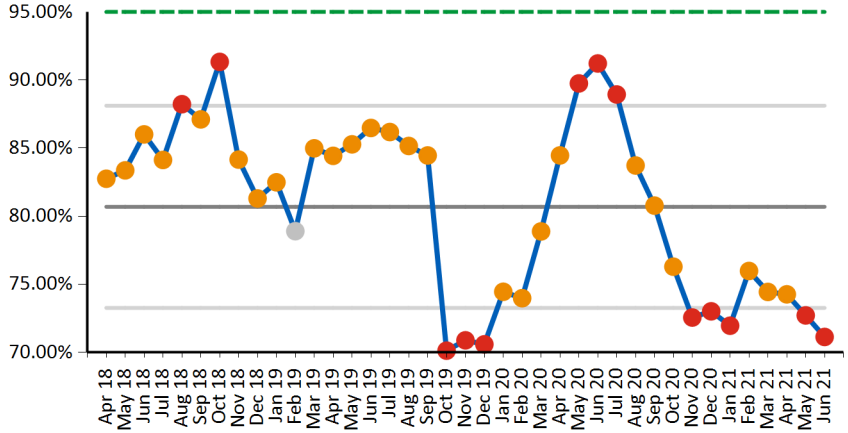
**42 - RTT 52 week waits (incomplete pathways)**



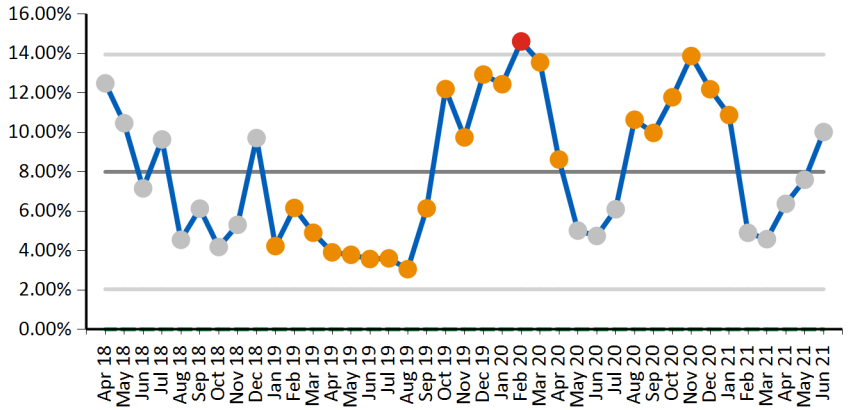

**314 - RTT 18 week waiting list**



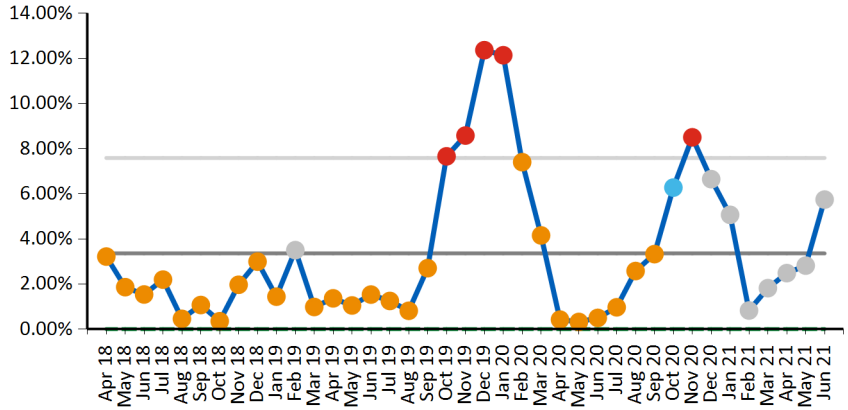

**53 - A&E 4 hour target**



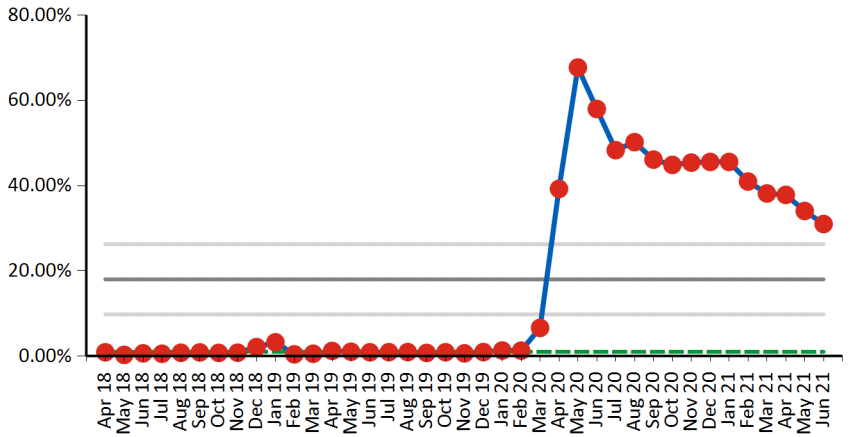

**70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)**



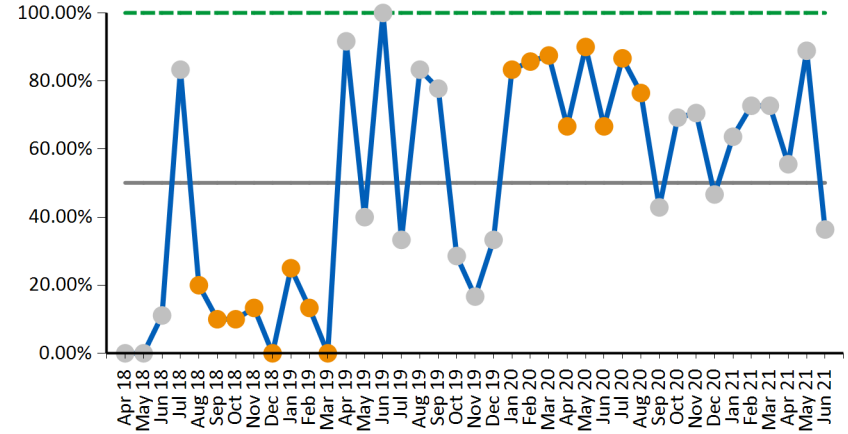
**71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)**




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




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



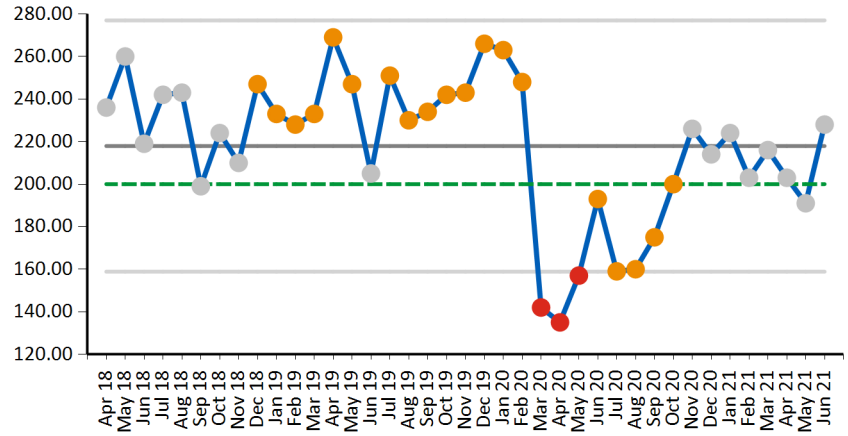
## Productivity

Productivity
Pressure continues with both winter wards opened on beds, with increased IPC restrictions causing flow issues. Over 21 day stay remains 25% below comparable years, but there is a rise caused by various factors the biggest being diagnostic waits for other hospitals Daily meetings are being carried out on all patients over 21 days. To help flow specific focus is on discharge by 12 and 4pm which remains below target.

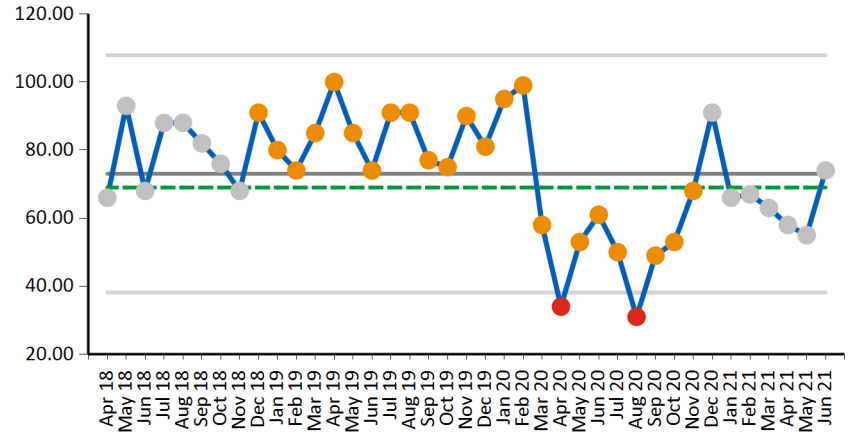
| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 56 - Stranded patients | <= 200 | 228 | Jun-21 | | <= 200 | 191 | May-21 | <= 200 | 228 | |
| 307 - Stranded Patients - LOS 21 days and over | <= 69 | 74 | Jun-21 | | <= 69 | 55 | May-21 | <= 69 | 74 | |
| 57 - Discharges by Midday | >= 30% | 21.9% | Jun-21 | | >= 30% | 24.2% | May-21 | >= 30% | 22.3% | |
| 58 - Discharges by 4pm | >= 70% | 61.3% | Jun-21 | | >= 70% | 64.8% | May-21 | >= 70% | 62.3% | |
| 59 - Re-admission within 30 days of discharge (1 mth in arrears) | <= 13.5% | 14.0% | May-21 | | <= 13.5% | 12.4% | Apr-21 | <= 13.5% | 13.2% | |
| 489 - Daycase Rates | >= 80% | 88.0% | Jun-21 | | >= 80% | 88.9% | May-21 | >= 80% | 88.5% | |
| 61 - Operations cancelled on the day for non-clinical reasons | <= 1% | 0.7% | Jun-21 | | <= 1% | 0.8% | May-21 | <= 1% | 0.8% | |
| 62 - Cancelled operations re-booked within 28 days | = 100% | 80.0% | Jun-21 | | = 100% | 100.0% | May-21 | = 100% | 8.0% | |
| 65 - Elective Length of Stay (Discharges in month) | <= 2.00 | 2.42 | Jun-21 | | <= 2.00 | 3.69 | May-21 | <= 2.00 | 3.24 | |
| 66 - Non Elective Length of Stay (Discharges in month) | <= 3.70 | 3.44 | Jun-21 | | <= 3.70 | 3.52 | May-21 | <= 3.70 | 3.55 | |
| 73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears) | >= 80% | 80.0% | Mar-21 | | >= 80% | 76.5% | Feb-21 | >= 80% | | |
| 492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision | = 0 | 10 | Jun-21 | | = 0 | 11 | May-21 | = 0 | 29 | |
| 493 - Average Number of Patients: with no Criteria to Reside | >= 55 | 64 | Jun-21 | | >= 55 | 59 | May-21 | >= 165 | 178 | |
| 494 - Average Occupied Days - for no Criteria to Reside | | 201 | Jun-21 | | | 225 | May-21 | | 602 | |

| 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) | >= 190 | 140 | Jun-21 | | >= 190 | 165 | May-21 | >= 570 | 427 | |

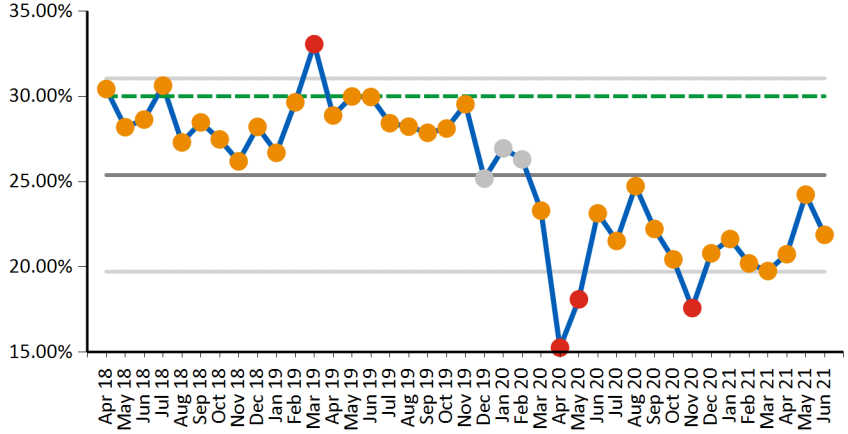
**56 - Stranded patients**



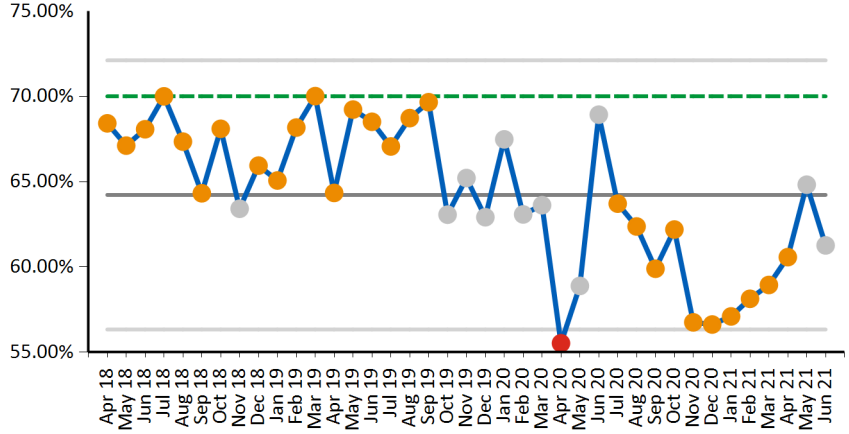

**307 - Stranded Patients - LOS 21 days and over**



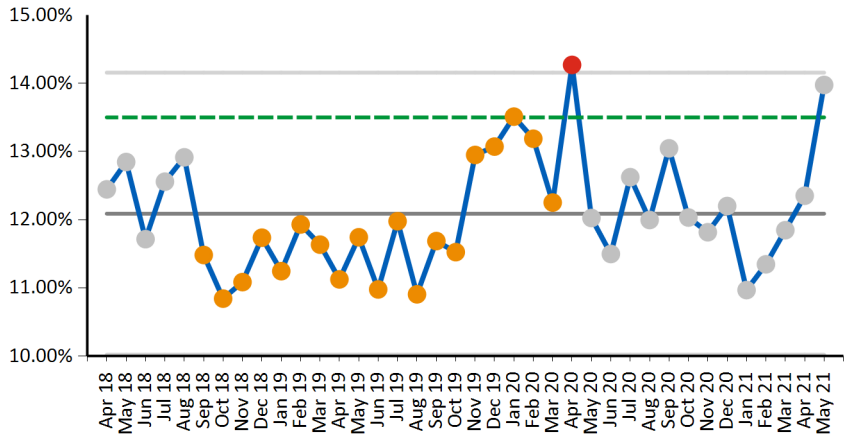

**57 - Discharges by Midday**



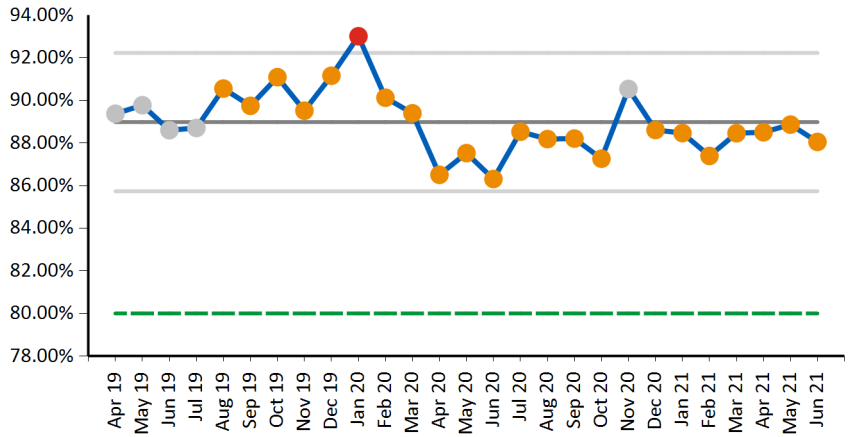

**58 - Discharges by 4pm**



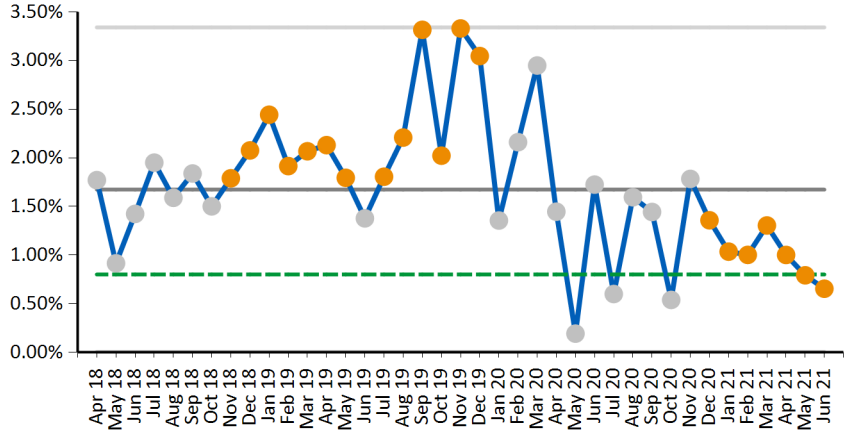
### 59 - Re-admission within 30 days of discharge (1 mth in arrears)



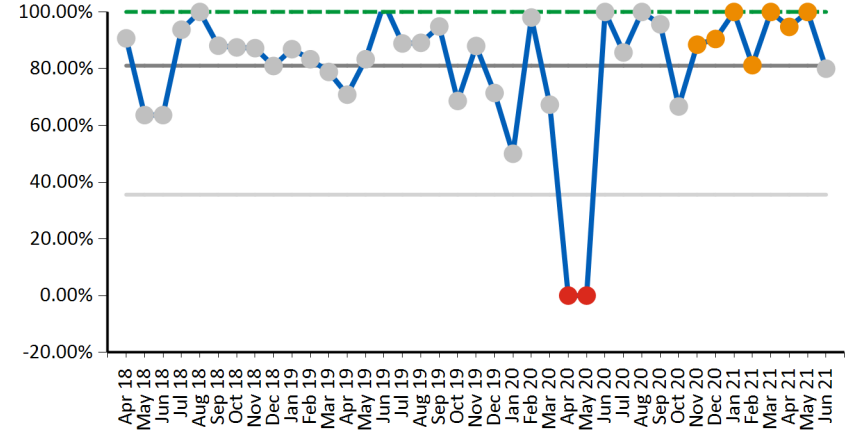

### 489 - Daycase Rates



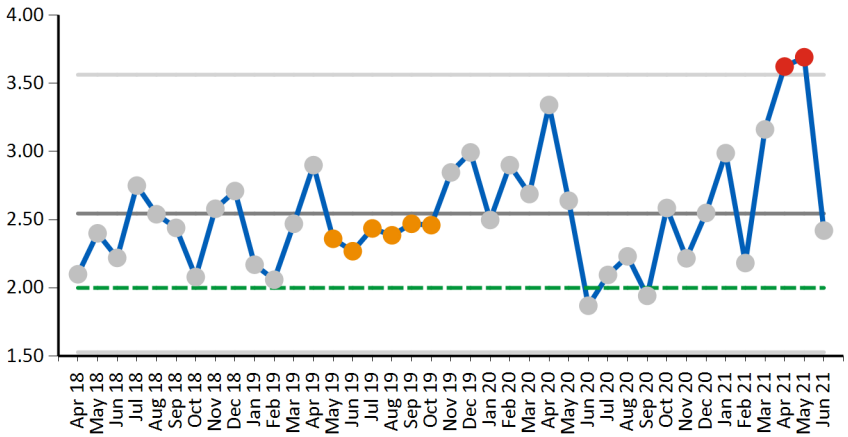

### 61 - Operations cancelled on the day for non-clinical reasons



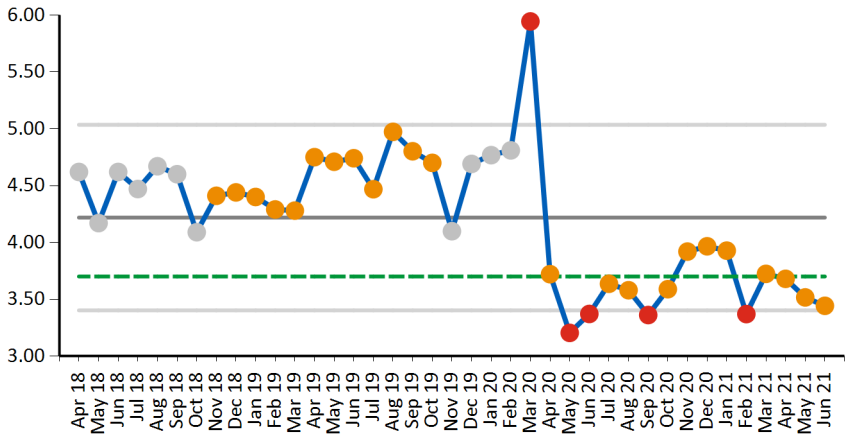

### 62 - Cancelled operations re-booked within 28 days



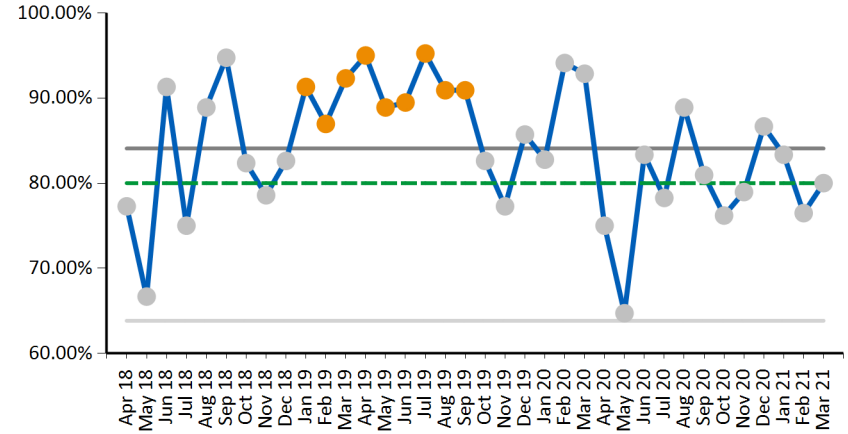
**65 - Elective Length of Stay (Discharges in month)**



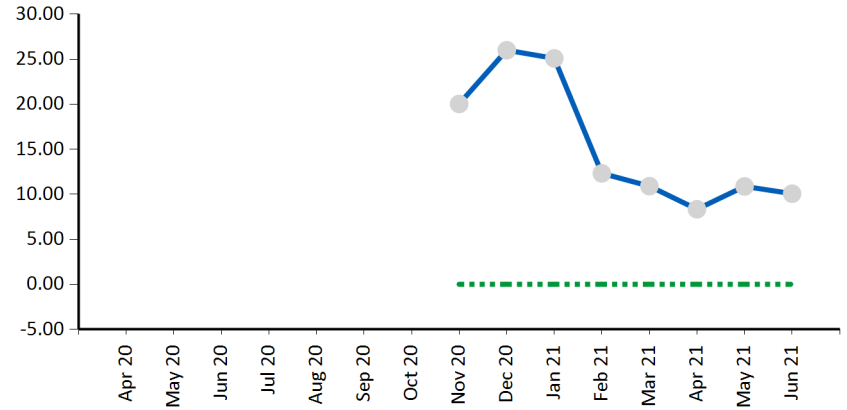

**66 - Non Elective Length of Stay (Discharges in month)**



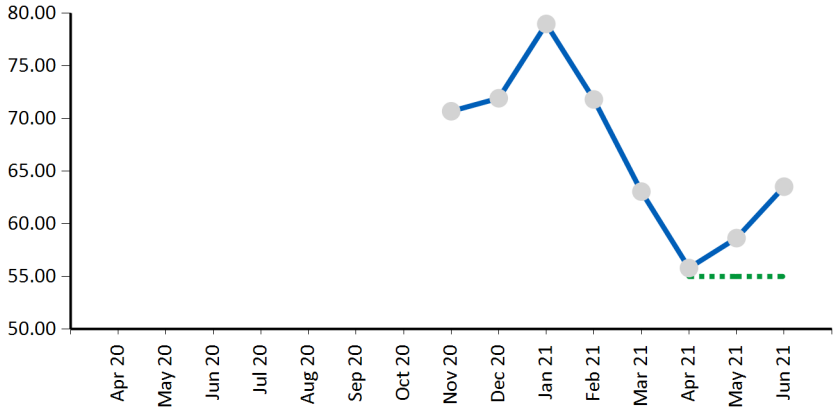

**73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears**



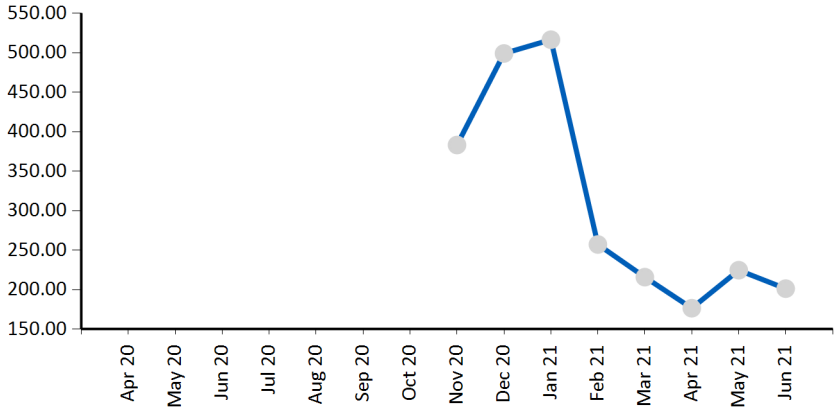

**492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision - SPC data available after 20 data points**



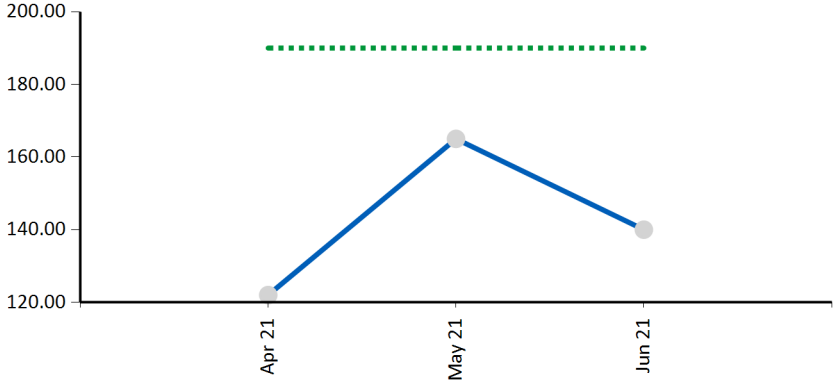
**493 - Average Number of Patients: with no Criteria to Reside - SPC data available after 20 data points**




**494 - Average Occupied Days - for no Criteria to Reside - SPC data available after 20 data points**




**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**

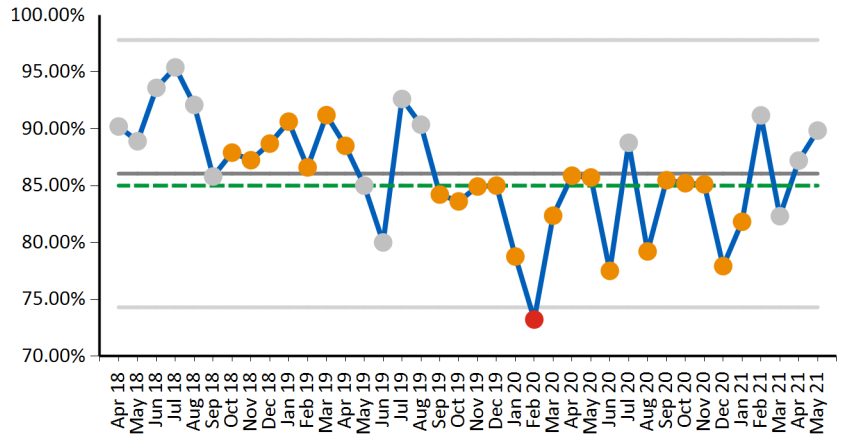


## Cancer

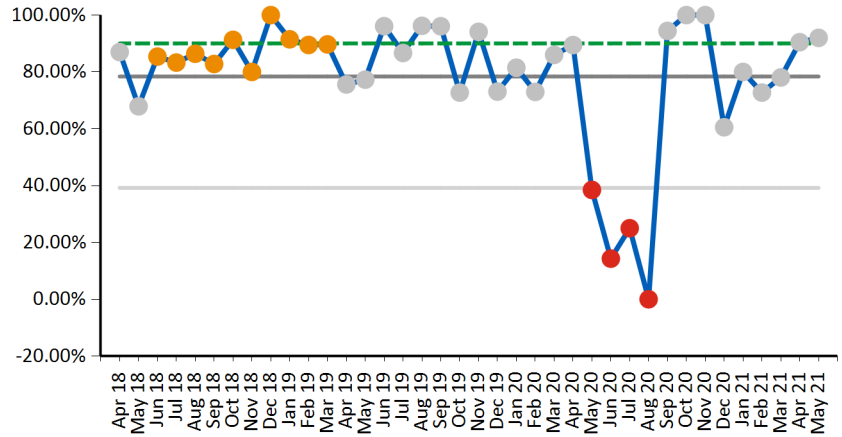
Cancer
Continued focus on ensuring Cancer treatments are optimised is having success with the Trust having the lowest wait times across GM and on track to hit the 62 day standard for the quarter. Breast referrals remain very high and based on risk assessments, led by consultants the symptomatic patients are low risk and are being managed to ensure focus on critical services.

| | 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% | 89.8% | May-21 | | >= 85% | 87.2% | Apr-21 | >= 85% | 88.5% | |
| 47 - 62 day screening % (1 mth in arrears) | >= 90% | 92.0% | May-21 | | >= 90% | 90.5% | Apr-21 | >= 90% | 91.0% | |
| 48 - 31 days to first treatment % (1 mth in arrears) | >= 96% | 100.0% | May-21 | | >= 96% | 98.3% | Apr-21 | >= 96% | 99.1% | |
| 49 - 31 days subsequent treatment (surgery) % (1 mth in arrears) | >= 94% | 95.2% | May-21 | | >= 94% | 100.0% | Apr-21 | >= 94% | 96.3% | |
| 50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears) | >= 98% | 100.0% | May-21 | | >= 98% | 100.0% | Apr-21 | >= 98% | 100.0% | |
| 51 - Patients 2 week wait (all cancers) % (1 mth in arrears) | >= 93% | 97.6% | May-21 | | >= 93% | 96.5% | Apr-21 | >= 93% | 97.0% | |
| 52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears) | >= 93% | 20.8% | May-21 | | >= 93% | 21.3% | Apr-21 | >= 93% | 21.0% | |

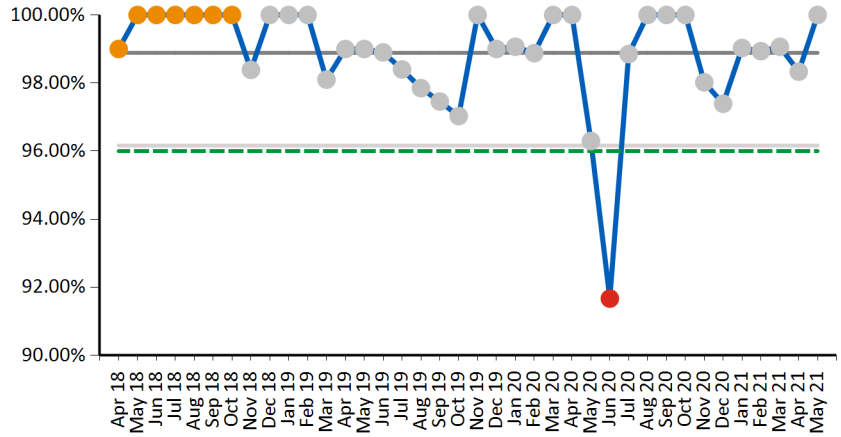
**46 - 62 day standard % (1 mth in arrears)**



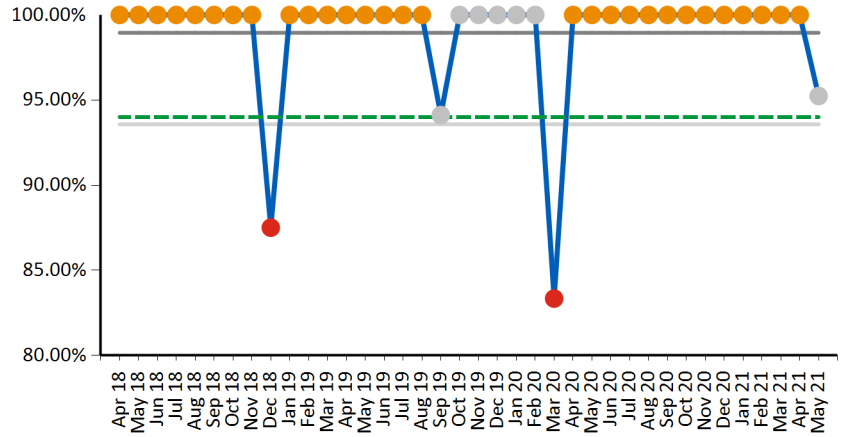

**47 - 62 day screening % (1 mth in arrears)**



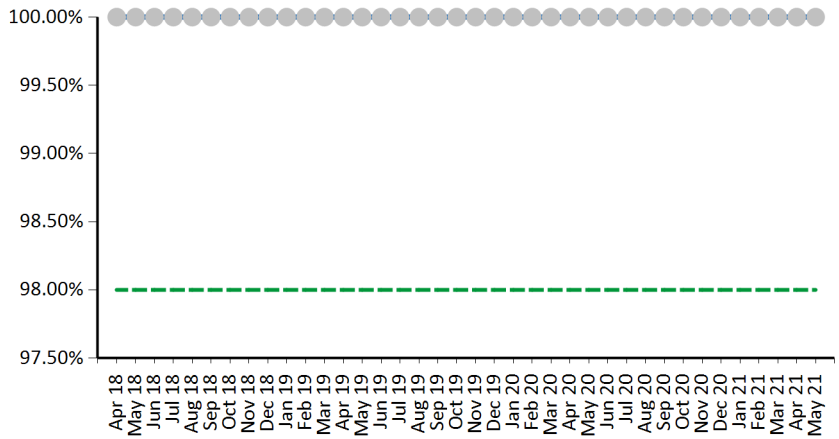

**48 - 31 days to first treatment % (1 mth in arrears)**



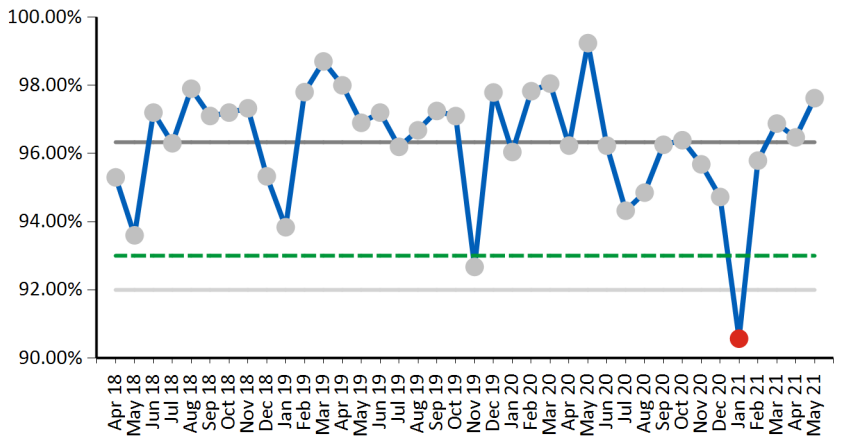

**49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)**



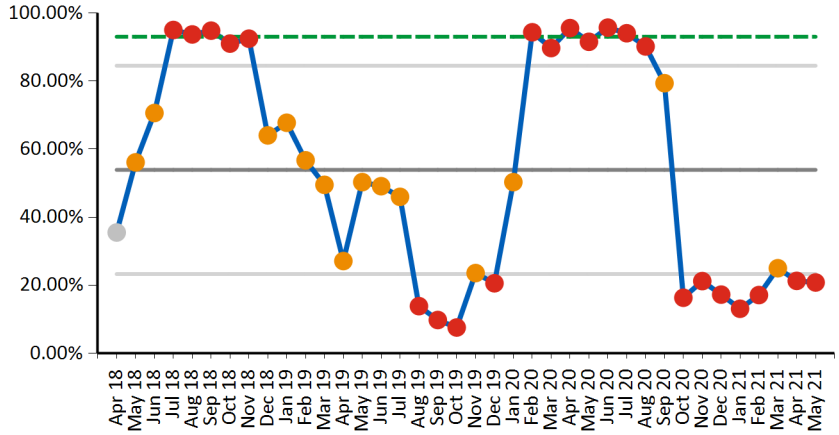
**50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)**




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




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

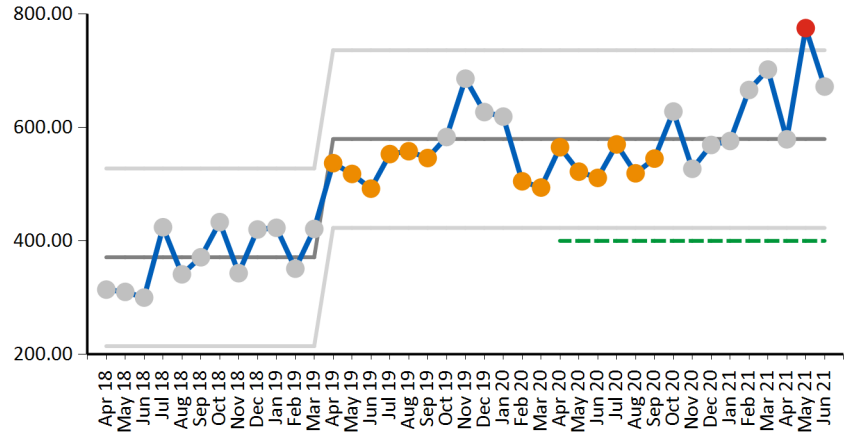


## Community

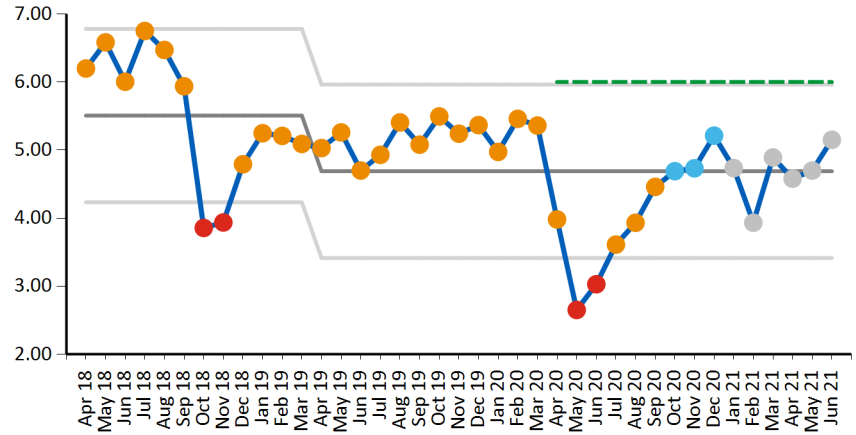
Community
Despite staffing challenges, deflections from A/E by the home care team continue to rise.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 334 - Total Deflections from ED | >= 400 | 672 | Jun-21 | | >= 400 | 775 | May-21 | >= 1,200 | 2,026 | |
| 335 - Total Intermediate Tier LOS (weeks) | <= 6.00 | 5.15 | Jun-21 | | <= 6.00 | 4.70 | May-21 | <= 6.00 | 5.15 | |

**334 - Total Deflections from ED**




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



# Workforce

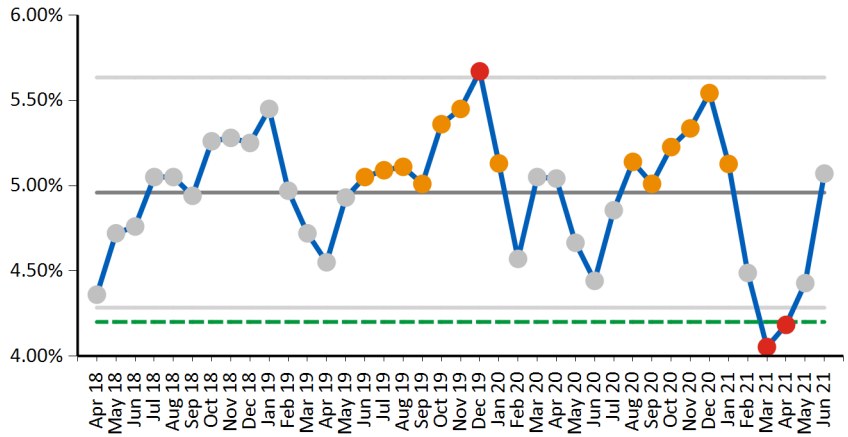
## Sickness, Vacancy and Turnover

Board members will note that the sickness rate has again increased and is now exceeding 5%. The main driver for this change has been the increased number of staff reporting anxiety / mental health conditions, along with a high number of staff off with muscular skeletal problems. People Committee members are sighted on the plethora of activity that is taking place to ensure sickness remains at a manageable level.

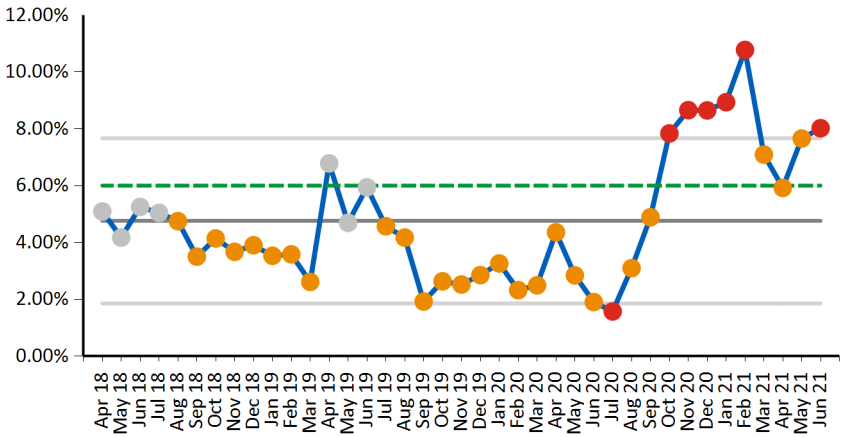
The People Committee received an update on the recruitment position, and in particular those hard to fill posts. The People Committee did note that, given the increased level of activity to support the recovery and urgent care position, then the Divisions are reporting a shortage of staff. The Executive team have recently supported an over-recruitment plan to support organisational pressures..

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 117 - Sickness absence level - Trust | <= 4.20% | 5.07% | Jun-21 | | <= 4.20% | 4.43% | May-21 | <= 4.20% | 4.56% | F |
| 120 - Vacancy level - Trust | <= 6% | 8.02% | Jun-21 | H | <= 6% | 7.66% | May-21 | <= 6% | 7.20% | ? |
| 121 - Turnover | <= 9.90% | 14.10% | Jun-21 | H | <= 9.90% | 14.74% | May-21 | <= 9.90% | 14.26% | ? |
| 366 - Ongoing formal investigation cases over 8 weeks | | 2 | Jun-21 | | | 2 | May-21 | | 5 | |

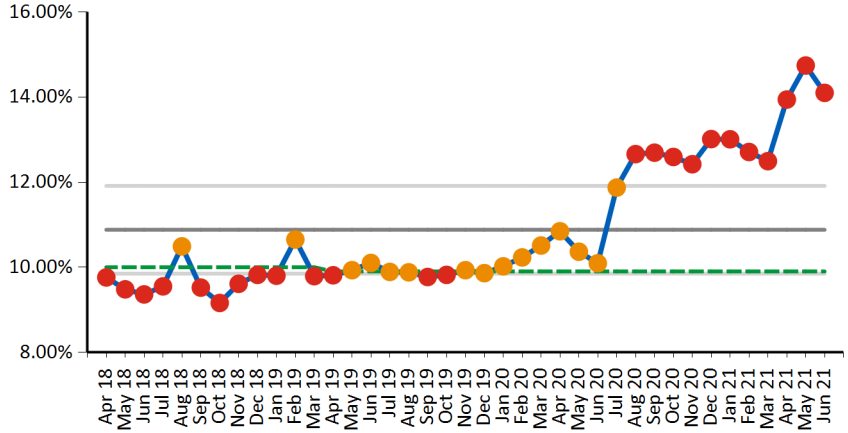
### 117 - Sickness absence level - Trust



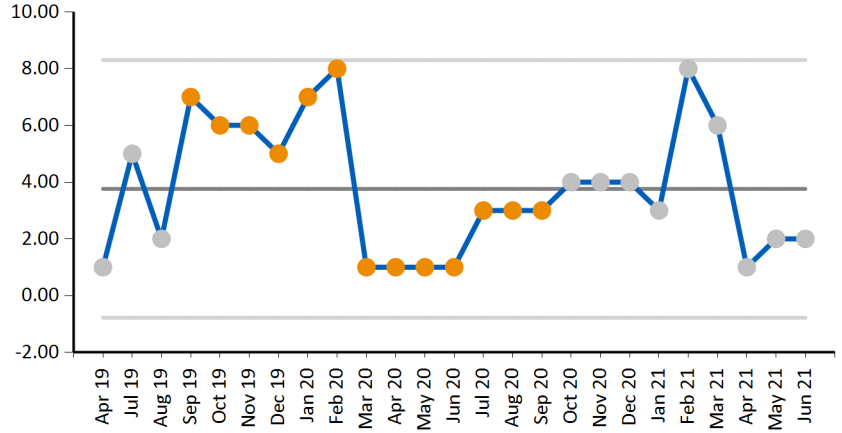

### 120 - Vacancy level - Trust




### 121 - Turnover




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



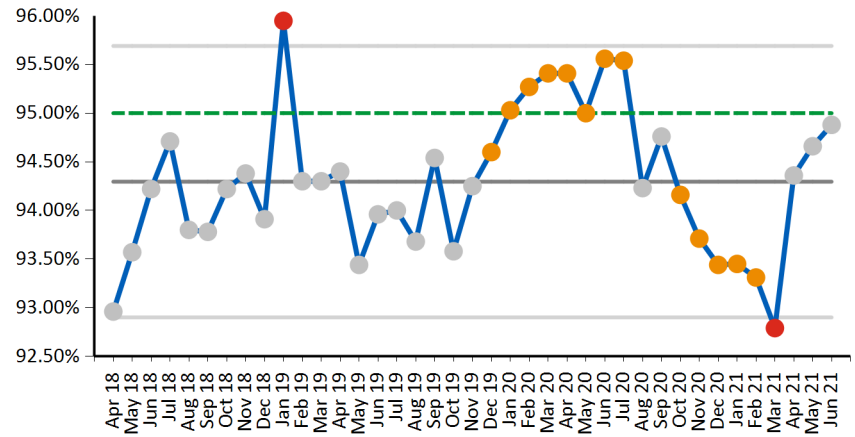
## Organisational Development

Against a backdrop of significant operational pressures the completion of statutory and mandatory training has remained a priority. As predicted Appraisal rates saw a rapid increase as we slowly came out of the Pandemic pressures. A series of recovery actions were implemented to ensure further increases in appraisal activity.

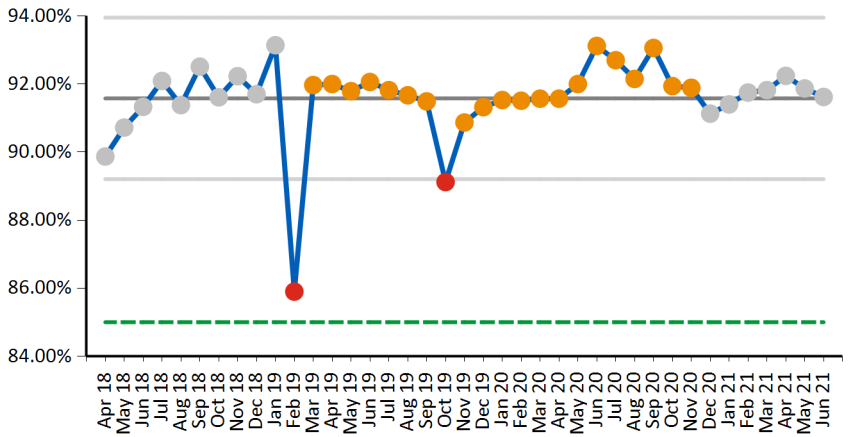
A full update on Staff Engagement was discussed at a previous BoD meeting and an update on the Go Engage results will be provided in the Chair's report narrative.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 37 - Staff completing Statutory Training | >= 95% | 94.9% | Jun-21 | | >= 95% | 94.7% | May-21 | >= 95% | 94.6% | |
| 38 - Staff completing Mandatory Training | >= 85% | 91.6% | Jun-21 | | >= 85% | 91.9% | May-21 | >= 85% | 91.9% | |
| 39 - Staff completing Safeguarding Training | >= 95% | 96.43% | Jun-21 | | >= 95% | 96.18% | May-21 | >= 95% | 96.26% | |
| 101 - Increased numbers of staff undertaking an appraisal | >= 85% | 80.0% | Jun-21 | | >= 85% | 79.9% | May-21 | >= 85% | 80.9% | |
| 78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) | >= 66% | 74.0% | Q3 2020/21 | | >= 66% | 76.9% | Q2 2020/21 | >= 66% | | |
| 79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) | >= 80% | 67.0% | Q3 2020/21 | | >= 80% | 66.1% | Q2 2020/21 | >= 80% | | |

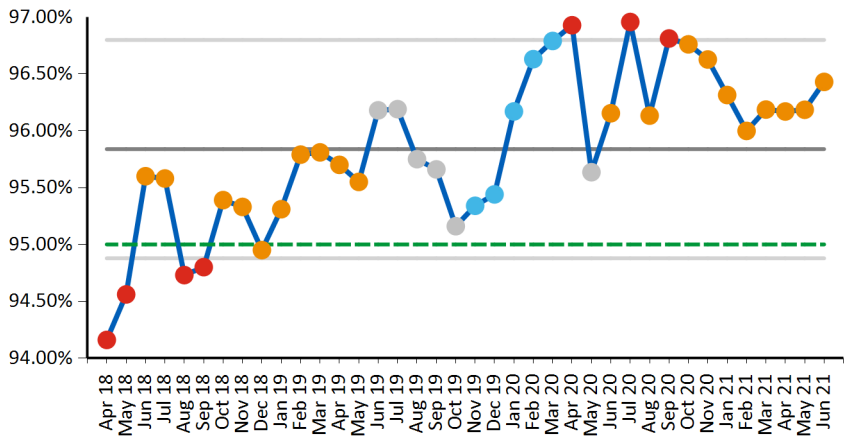
**37 - Staff completing Statutory Training**



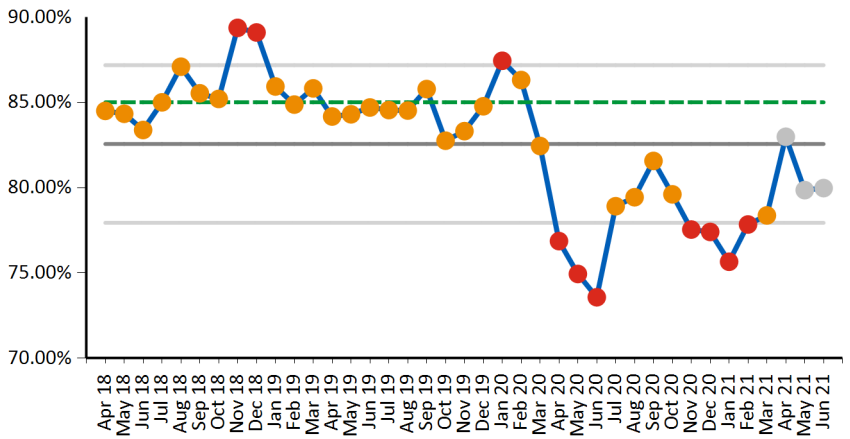

**38 - Staff completing Mandatory Training**



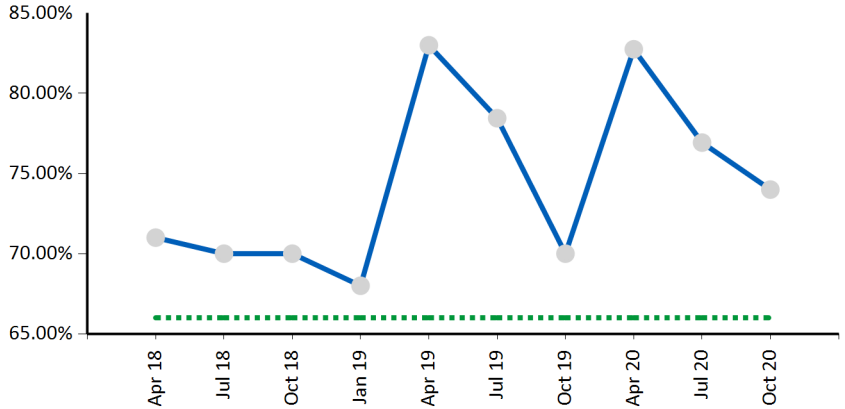
**39 - Staff completing Safeguarding Training**



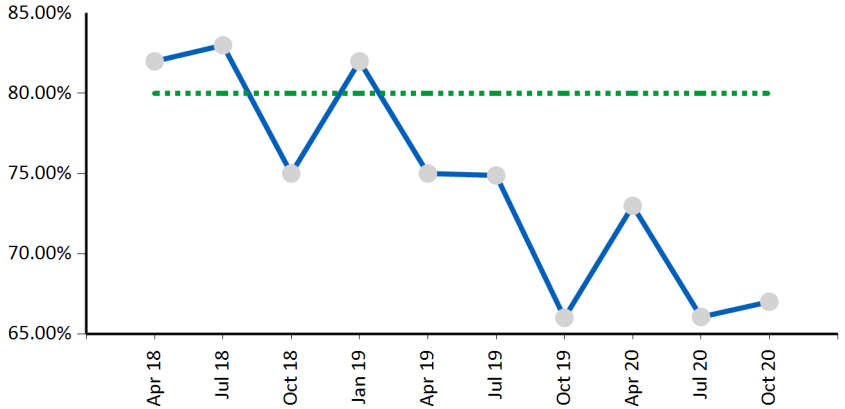

**101 - Increased numbers of staff undertaking an appraisal**




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




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

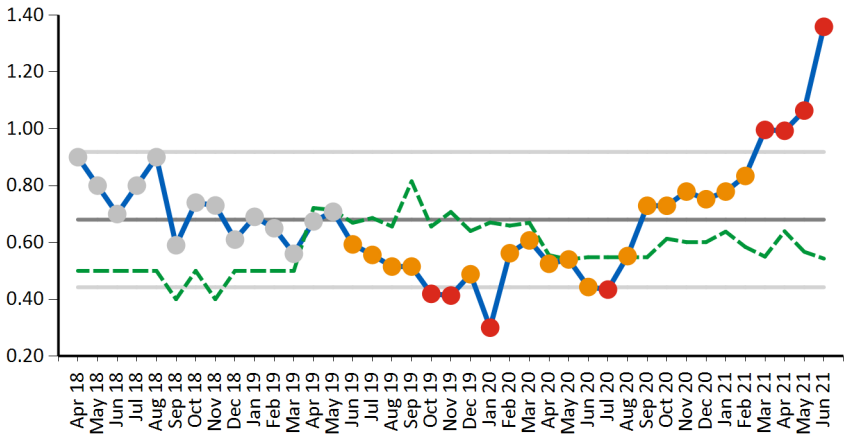


## Agency

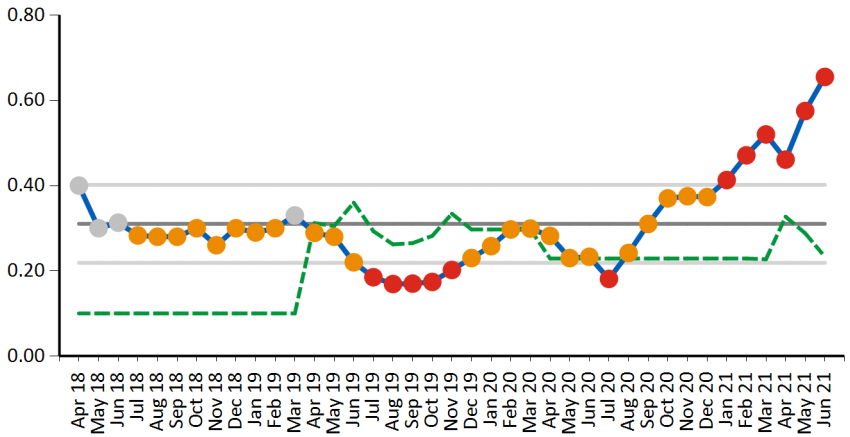
Colleagues will note agency spend remains high. As previously noted in the People Committee and Finance Committee, colleagues are sighted on the work underway to endeavour to reverse this upward movement. Whilst activity and sickness remains high then it is likely that agency spend will continue for the foreseeable future. Nationally a similar picture is playing out (data demonstrated by NHSE/I). The Agency usage is coming predominantly from AACD but it's equivalent to the overall trend of Bank and Agency demand and so the increase is actually proportionally similar across Divisions.

| | 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 | 1.36 | Jun-21 |  | <= 0.57 | 1.06 | May-21 | <= 1.75 | 3.42 |  |
| 111 - Annual ceiling for Nursing Staff agency spend (£m) | <= 0.23 | 0.66 | Jun-21 |  | <= 0.29 | 0.58 | May-21 | <= 0.85 | 1.69 |  |
| 112 - Annual ceiling for Medical Staff agency spend (£m) | <= 0.23 | 0.53 | Jun-21 |  | <= 0.40 | 0.40 | May-21 | <= 0.86 | 1.32 |  |

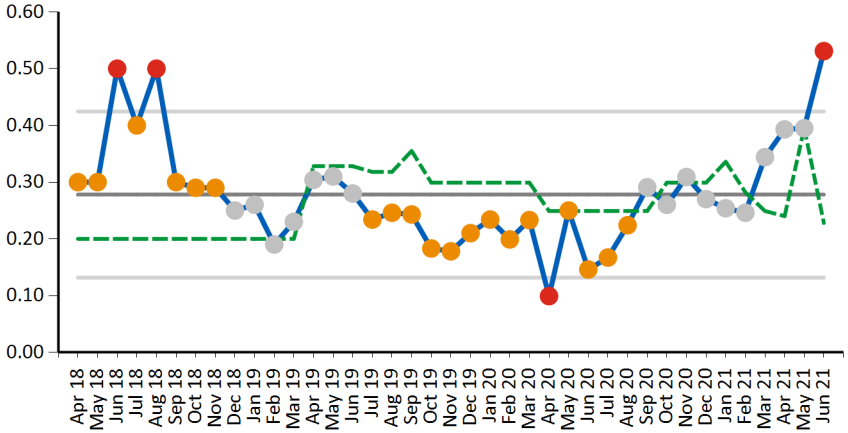
**198 - Trust Annual ceiling for agency spend (£m)**




**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 £0.4m, which is £0.4m better than planned.
• Revenue performance is currently rated amber, although we are better than plan there are some significant variances
• Action to increase CIP delivery and improve controls on variable pay

Revenue Performance Forecast Outturn
• We are forecasting a breakeven position for H1 in our probable scenario assuming we receive ERF funding
• Forecast performance is rated amber as there is significant risk due to a number of uncertainties
• The forecast position scenarios for H1 range from a surplus of £1.6m to a deficit of £1.2m

Cost Improvement
• The current trackers indicate that potential savings of £1.8m for H1 have been identified with a forecast delivery of £1.4m.
• Savings of £0.8m have been delivered year to date against a plan of £0.8m but this includes non-recurrent savings.
• CIP is rated red as there is a significant reliance on non-recurrent schemes.
• Action to focus on identifying and delivering recurrent CIP

Variable Pay
• We spent £2.9m on variable pay in month 3, which was an increase of £0.4m compared to last month.
• Agency usage was the main driver of this increase – spend of £1.3m in month
• Variable pay is rated red as spend is significantly above plan.
• Action to improve controls

Capital Spend
• Year to date spend is £0.7m.
• Forecast spend for 2021/2022 is £15.1m assuming GM slippage is available.
• Capital is rated as red as a result of the associated risks.

Cash Position
• We had cash of £40.5m at the end of the month.
• Cash is rated green as there are no concerns around cash flow this year.

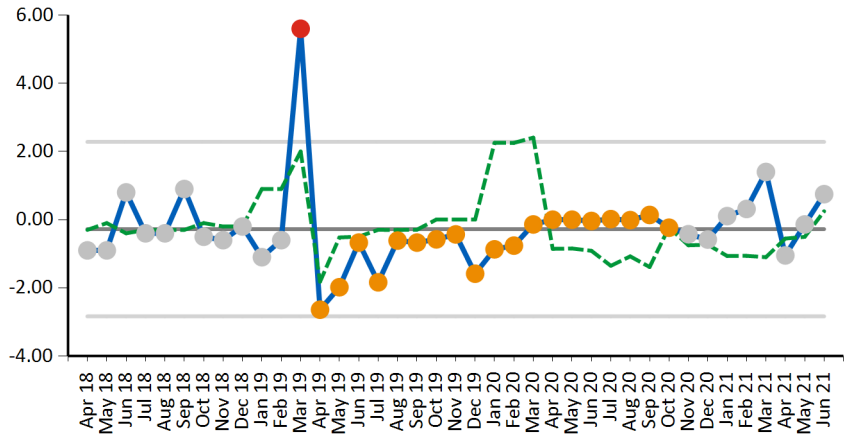
Loans and PDC
• We have loans of £41.5m.
• Rated green as there are no concerns in this area.

Better Payment Practices Code
• Year to date we have paid 89.1% of our invoices within 30 days. This is below the target of 95%, hence rated amber.
• Action to review and improve performance is underway

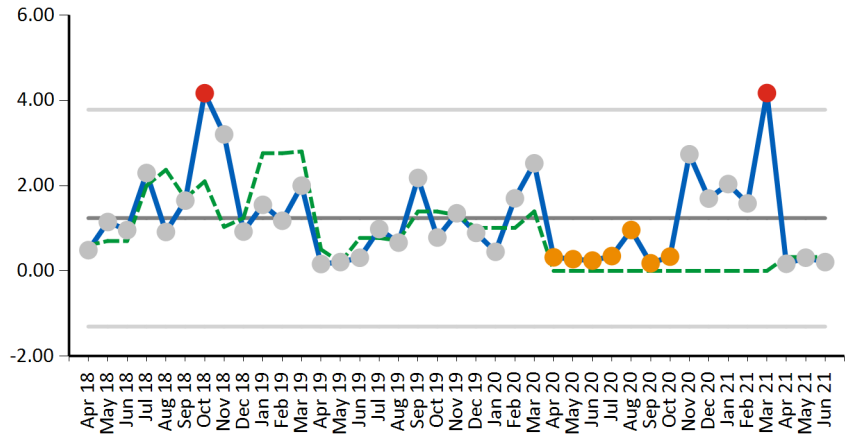
Use of Resources Rating
• This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

| | Latest | | | | Previous | | | Year to Date | | Target |
|---|---|---|---|---|---|---|---|---|---|---|
| Outcome Measure | Plan | Actual | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| 220 - Control Total (£ millions) | >= 0.2 | 0.7 | Jun-21 |  | >= -0.5 | -0.1 | May-21 | >= -0.8 | -0.4 |  |
| 222 - Capital (£ millions) | >= 0.3 | 0.2 | Jun-21 |  | >= 0.3 | 0.3 | May-21 | >= 1.0 | 0.7 |  |
| 223 - Cash (£ millions) | = 0.0 | 40.5 | Jun-21 |  | = 0.0 | 40.6 | May-21 | = 0.0 | 40.5 |  |

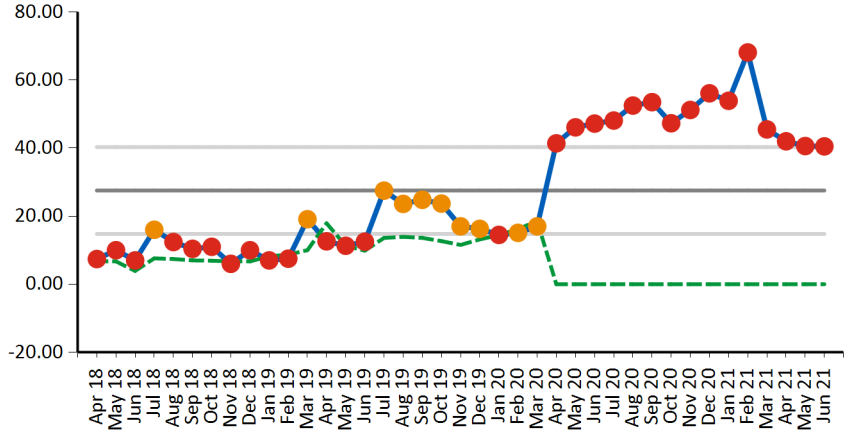
**220 - Control Total (£ millions)**




**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) | UU (daycare) | CDS | E5 | F5 | Ingleside | M2 | M3 (Birth) | M4 | M5 | M6 | NICU | Overall |
| | Total Beds | *N/a* | 32 | 0 | 0 | 0 | 10 | 23 | 26 | 21 | 22 | 19 | 25 | 26 | 26 | 25 | 10 | 13 | 25 | 22 | 22 | 26 | 12 | 5 | 22 | 18 | 25 | 25 | 25 | 25 | 24 | 16 | 24 | 24 | 11 | 4 | 15 | 38 | 7 | 4 | 26 | 5 | 22 | 22 | 17 | 38 | 795 |
| Infection Prevention Control | Hand Washing Compliance % | *Target = 100%* | 100.0% | 85.0% | 100.0% | | 100.0% | 95.0% | 100.0% | 100.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 95.0% | 100.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | | 100.0% | | 100.0% | 100.0% | 100.0% | 95.0% | 98.1% |
| | IPC Rapid Improvement Tool % (Gen) | *Target = 95%* | 93.8% | 89.5% | 94.4% | | | 100.0% | 5.0% | | | | 95.0% | 89.5% | 94.4% | 90.0% | 94.4% | 94.7% | 90.0% | 90.0% | 100.0% | 90.0% | 100.0% | 84.2% | 84.2% | 94.7% | 100.0% | 89.5% | 94.7% | 89.5% | 84.2% | | 100.0% | 100.0% | 100.0% | 94.1% | 94.7% | 100.0% | 100.0% | 93.8% | 100.0% | 100.0% | 94.7% | 100.0% | | 100.0% | 93.8% |
| | IPC Rapid Improvement Tool % (Med) | *Target = 95%* | | 85.7% | 94.1% | | | 100.0% | | | | | 91.3% | 76.2% | 95.5% | | 95.0% | 100.0% | 95.2% | 100.0% | 100.0% | 95.8% | | 93.8% | 79.2% | | 100.0% | 91.7% | 91.7% | 95.7% | 87.0% | | 86.4% | 100.0% | 100.0% | 100.0% | 95.5% | 95.2% | 95.2% | | 91.3% | 100.0% | 70.6% | 91.3% | | 79.0% | 91.5% |
| | 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% | | 96.0% | | 100.0% | | 100.0% | | 100.0% | 100.0% | | 100.0% | 100.0% | | | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | | 100.0% | | 10.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% |
| Harm Free Care | C - Diff | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 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 | 3 |
| | MSSA BSIs | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | E.Coli 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 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 |
| | All Inpatient Falls (Safeguard) | *Target = 0* | 7 | 8 | 0 | 0 | 0 | 7 | 9 | 6 | 4 | 0 | 0 | 7 | 11 | 3 | 0 | 2 | 2 | 5 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 2 | 3 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 84 |
| | Harms related to falls (moderate+) | *Target = 1.6* | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| | VTE Assessment Compliance | *Target = 95%* | | | | 64.0% | 100.0% | 33.3% | | | 0.0% | 97.6% | 100.0% | 60.0% | 89.6% | 25.0% | 96.4% | 98.8% | 98.9% | 97.8% | 100.0% | 85.2% | | 99.9% | 84.6% | 100.0% | 99.0% | 80.0% | 93.3% | 99.7% | 53.3% | 100.0% | 100.0% | 100.0% | 98.8% | 100.0% | 90.4% | | | 60.6% | 100.0% | 90.9% | 76.2% | 90.7% | 99.4% | | 96.8% |
| | New pressure Ulcers (Grade 2) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| | New pressure Ulcers (Grade 3) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 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 |
| Audit | Monthly KPI Audit % | *Target = 95%* | 96.2% | 99.2% | | | | 96.9% | | 91.7% | | | 79.9% | 83.6% | 94.2% | 84.1% | 97.9% | 96.9% | 93.2% | 68.2% | 95.7% | 75.9% | 99.1% | 99.5% | 94.1% | 98.5% | 100.0% | 93.5% | 87.3% | 90.5% | 83.3% | | 93.4% | 90.6% | 98.0% | 96.6% | 99.4% | 98.8% | 98.8% | 98.0% | 99.4% | | 99.4% | 99.6% | 99.3% | 99.7% | 94.9% |
| | BoSCA Overall Score % | *w=<55%, B>55%, S>75%, G>90%* | | 75.3% | 75.3% | | | 64.2% | 58.3% | | | | 81.6% | 75.6% | 82.3% | 75.8% | 84.3% | 76.4% | 75.1% | 83.2% | 92.9% | 90.2% | 71.8% | 86.3% | 85.7% | 94.3% | | 86.8% | 81.7% | 91.8% | 77.7% | | 91.4% | 90.9% | | 88.2% | 90.3% | 90.1% | 90.1% | | 91.9% | 90.4% | 71.4% | 71.4% | 80.3% | 90.3% | 82.5% |
| | | | | silver | silver | | | bronze | bronze | | | | silver | silver | silver | silver | silver | silver | silver | silver | platinum | gold | bronze | silver | silver | platinum | | silver | silver | platinum | silver | | platinum | platinum | | silver | gold | platinum | platinum | | platinum | gold | bronze | bronze | silver | gold | Silver |
| Patient Experience | FFT Response Rate | *Target = 30%* | | 19.2% | 0.3% | 0.0% | 18.3% | 43.1% | 0.0% | 9.6% | 1.0% | 0.0% | 64.2% | 25.3% | 23.8% | 39.3% | 29.4% | 159.7% | 35.3% | 41.7% | 31.7% | 80.8% | | 26.7% | 12.5% | 0.0% | 27.0% | 16.3% | 20.6% | 16.6% | 22.5% | 9.5% | 39.4% | 41.1% | 47.6% | 36.4% | | 51.8% | 0.0% | | 0.0% | 29.5% | 14.8% | 14.8% | 100.0% | 71.9% | 25.7% |
| | FFT Recommended Rate | *Target = 97%* | | 82.9% | 57.1% | | 90.5% | 96.4% | | 100.0% | 0.0% | | 100.0% | 95.2% | 89.5% | 100.0% | 100.0% | 98.0% | 79.2% | 100.0% | 100.0% | 90.5% | | 97.9% | 100.0% | | 98.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 80.0% | 100.0% | 100.0% | | 100.0% | | | | 85.7% | 83.3% | 83.3% | 100.0% | 100.0% | 97.6% |
| Gover-nance | Number of complaints received | *Target = 0* | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 7 |
| | Serious Incidents in Month | *Target = 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 | 0 | 0 | 0 | 1 |
| | Incidents > 20 days, not yet signed off | *Target = 0* | 0 | 76 | 20 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 6 | 1 | 6 | 0 | 0 | 0 | 2 | 0 | 13 | 0 | 1 | 3 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 52 | 3 | 0 | 6 | 8 | 3 | 4 | 2 | 3 | 0 | 216 |
| | Harm related to Incident (Moderate+) | *Target = 0* | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |
| Staff Dev elopment | Appraisals | *Target = 85%* | | 74.0% | | | 77.8% | 91.4% | 88.4% | 66.7% | 72.7% | 72.7% | 78.6% | 59.1% | 80.5% | 87.8% | 80.8% | 89.5% | 72.9% | 86.2% | 93.2% | 69.2% | 100.0% | 78.6% | 75.7% | 87.8% | 91.7% | 78.9% | 83.3% | 84.8% | 54.5% | 58.3% | 88.9% | 72.5% | 82.8% | 78.9% | 77.8% | 82.7% | | 100.0% | 96.7% | 82.4% | 93.9% | 93.8% | | 80.0% | 80.0% |
| | Statutory Training | *Target = 95%* | | 91.61% | | | 95.57% | 92.22% | 85.62% | 77.37% | 89.04% | 96.3% | 89.50% | 86.89% | 91.30% | 95.44% | 96.11% | 95.49% | 91.18% | 94.06% | 96.69% | 93.14% | 100.00% | 94.99% | 84.31% | 95.31% | 98.13% | 94.83% | 95.26% | 98.43% | 82.47% | 96.59% | 93.77% | 93.29% | 98.58% | 99.08% | 91.5% | 95.3% | | 80.0% | 91.7% | 89.7% | 92.8% | 95.6% | | 94.35% | 94.7% |
| | Mandatory Training | *Target = 85%* | | 87.78% | | | 94.5% | 89.6% | 86.1% | 77.6% | 94.4% | 92.9% | 88.0% | 84.6% | 81.7% | 94.2% | 98.9% | 95.8% | 86.4% | 92.3% | 94.6% | 89.9% | 100.0% | 94.4% | 76.4% | 96.0% | 98.4% | 90.2% | 98.1% | 97.6% | 80.0% | 95.8% | 95.9% | 87.6% | 92.7% | 98.5% | 86.7% | 95.3% | | 50.0% | 84.1% | 90.8% | 88.7% | 93.5% | | 87.3% | 91.6% |
| Staffing & Workforce | Budgeted Nurse: Bed Ratio (WTE) | | 11.56 | -1.15 | -1.15 | 0.00 | 0.00 | 0.00 | 4.14 | 10.78 | 5.25 | 0.00 | 2.60 | 2.68 | 5.67 | 1.18 | -11.20 | 1.33 | -1.03 | 6.87 | 2.47 | -0.19 | 0.00 | 3.28 | 3.87 | 5.78 | 1.34 | 4.09 | 1.77 | -4.86 | 5.09 | 0.00 | -0.05 | 6.61 | 5.75 | -2.84 | 6.83 | 0.89 | 0.89 | 13.01 | -0.82 | 4.93 | -4.32 | 1.78 | 2.69 | 10.07 | 93.86 |
| | Current Budgeted WTE (Ledger) | | 50.78 | 73.28 | 73.28 | | | 38.03 | 63.99 | 43.34 | | | 33.71 | 41.23 | 42.69 | 40.70 | 0.00 | 19.97 | 50.82 | 40.30 | 40.01 | 39.97 | | 24.27 | 36.15 | 107.36 | 32.75 | 35.52 | 30.21 | 37.79 | 30.21 | | 44.50 | 44.49 | 18.07 | 15.92 | 86.31 | 33.42 | 33.42 | 66.93 | 22.00 | 22.12 | 26.34 | 26.34 | 46.87 | 105.69 | 1669.59 |
| | Actual WTE In-Post (Ledger) | | 39.22 | 74.42 | 74.42 | | | 33.89 | 52.81 | 38.09 | | | 31.11 | 38.55 | 37.02 | 39.52 | 11.20 | 18.64 | 51.85 | 33.43 | 37.54 | 40.16 | | 20.99 | 32.28 | 101.58 | 31.41 | 31.43 | 28.44 | 42.65 | 25.12 | | 44.55 | 37.88 | 12.32 | 18.76 | 79.48 | 32.52 | 32.52 | 53.92 | 22.82 | 17.19 | 30.66 | 24.56 | 44.18 | 95.62 | 1564.17 |
| | Actual Worked (Ledger) | | 48.38 | 86.86 | 86.86 | | | 48.37 | 56.81 | 44.05 | | | 37.37 | 47.96 | 42.50 | 46.88 | 45.68 | 23.67 | 55.57 | 42.53 | 40.00 | 46.21 | | 21.07 | 38.49 | 106.45 | 31.80 | 40.52 | 39.21 | 46.53 | 40.68 | | 50.33 | 45.95 | 18.66 | 18.14 | 83.60 | 32.35 | 32.35 | 55.85 | 24.39 | 18.00 | 33.02 | 26.75 | 47.01 | 93.47 | 1797.07 |
| | Sickness (%) | *Target is < 4.2%* | | 6.58% | | | 7.31% | 10.98% | 7.00% | 16.25% | 27.15% | 6.36% | 19.45% | 11.01% | 7.05% | 6.86% | 6.34% | 1.25% | 4.48% | 12.56% | 5.09% | 3.12% | 1.34% | 5.65% | 6.43% | 8.15% | 9.07% | 6.45% | 11.02% | 2.56% | 16.12% | 0.00% | 3.80% | 8.82% | 3.86% | 1.37% | 5.20% | 5.39% | | 3.33% | 4.43% | 5.00% | 8.54% | 4.62% | | 4.92% | 5.07% |
| | Current Budgeted Vacancies | | -9.16 | -12.44 | -12.44 | 0.00 | 0.00 | 0.00 | -14.48 | -4.00 | -5.96 | 0.00 | -6.26 | -9.41 | -5.48 | -7.36 | -34.48 | -5.03 | -3.72 | -9.10 | -2.46 | -6.05 | 0.00 | -0.08 | -6.21 | -4.87 | -0.39 | -9.09 | -10.77 | -3.88 | -15.56 | 0.00 | -5.78 | -8.07 | -6.34 | 0.62 | -4.12 | 0.18 | 0.18 | -1.93 | -1.57 | -0.81 | -2.36 | -2.19 | -2.83 | 2.15 | 105.42 |
| | Pending Appointment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0.00 |
| | Substantive Staff Turnover | *Target is < 10%* | | 4.9% | | | 0.0% | 18.6% | 7.0% | 5.4% | 0.0% | 0.0% | 19.7% | 4.1% | 7.3% | 20.9% | 7.0% | 0.0% | 15.9% | 8.33% | 13.8% | 13.3% | 0.0% | 11.7% | 9.6% | 13.5% | 10.4% | 14.8% | 12.3% | 8.9% | 29.6% | 18.8% | 12.4% | 6.4% | 3.5% | 4.9% | 11.3% | 2.4% | | 0.0% | 15.9% | 34.0% | 13.9% | 8.8% | | 6.6% | 0.89% |

**Data Legend**

| | |
|---|---|
| No data returned | |
| 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

| | Indicator | Target | ICS Services | | | | | | | | | | | | | | DN Teams | | | | | | | | | | Treatment Rooms | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 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 | West | South | Overall |
| Infection Control & Harm Free Care | Hand Washing Compliance % | *Target = 100%* | Not Done | | 100.0% | Not Done | Not Done | Not Done | Not Done | | | Not Done | | 100.0% | | | | 100.0% | Not Done | Not Done | 100.0% | 100.0% | Not Done | Not Done | Not Done | Not Done | Not Done | Not Done | Not Done | Not Done | 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 | 4 | 4 | 1 | 4 | 0 | 1 | 2 | 1 | 1 | 0 | | 0 | | 18 |
| | Monthly New pressure Ulcers (Grade 3) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | | 0 | | 3 |
| | 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 | 1 | 0 | 0 | 0 | | 0 | | 1 |
| | Monthly New pressure Ulcers (Unstageable) | *Target = 0* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | 0 |
| Audit | Monthly KPI Audit % | *Target = 95%* | 93.00% | | | | 100.00% | | | 93.02% | | 98.92% | | | | | | 100.00% | 98.40% | 98.74% | 98.43% | 92.66% | 99.10% | 98.68% | 99.18% | 96.30% | 97.28% | 96.52% | 100.00% | 98.23% | 94.88% |
| | 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% | 95% |
| | BoSCA Rating | | | | | | | | | | | | | | | | | platinum | platinum | platinum | silver | platinum | platinum | platinum | silver | platinum | platinum | gold | | silver | platinum |
| Patient Experience | Friends and Family Response Rate % | *Target = 30%* | 30.0% | 19.3% | 60.0% | 40.0% | 5.0% | 100.0% | 10.0% | 0.0% | 65.0% | 100.0% | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% | 100.0% | | | | | | | | | | 100.0% | | | 64.30% |
| | Friends and Family Recommended Rate % | *Target = 97%* | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | N/A | 100.0% | 100.0% | N/A | N/A | N/A | 100.0% | N/A | 99.4% | | | | | | | | | | 100.0% | | | 91.30% |
| | Number of Complaints received | *Target = 0* | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | 3 |
| Staffing & Workforce | Current Budgeted WTE | | 37.80 | 67.67 | 8.53 | 4.05 | 4.60 | 13.45 | 25.54 | 21.24 | 66.98 | 27.93 | 34.28 | 23.07 | 14.73 | 25.79 | 7.89 | 11.24 | 15.00 | 17.18 | 17.81 | 11.44 | 13.40 | 12.60 | 14.21 | 11.40 | 19.97 | 24.16 | | | 551.96 |
| | Actual WTE In-Post | | 33.65 | 71.32 | 7.46 | 6.80 | 4.60 | 11.42 | 24.77 | 19.24 | 58.66 | 28.12 | 32.75 | 21.42 | 15.02 | 25.10 | 6.80 | 12.44 | 13.60 | 15.70 | 17.28 | 12.44 | 11.33 | 11.20 | 13.28 | 11.20 | 17.62 | 22.8 | | | 526.02 |
| | Actual WTE Worked | | 35.04 | 69.50 | 7.29 | 6.40 | 4.60 | 12.03 | 27.63 | 18.64 | 62.81 | 28.67 | 32.62 | 22.72 | 16.70 | 25.32 | 6.80 | 11.40 | 13.75 | 14.87 | 17.12 | 12.25 | 12.41 | 12.53 | 13.65 | 11.25 | 17.86 | 23.09 | | | 536.95 |
| | Pending Appointment | | 4 | 3 | | | | | | | 2.65 | | 2 | | 1.6 | 1 | 0.8 | | | 2 | 0.8 | **1.0** | | | 1 | 1 | | 1 | | | 21.85 |
| | Current Budgeted Vacancies (WTE) | | 4.15 | -3.65 | 1.07 | -2.75 | 0.00 | 2.03 | 0.77 | 2.00 | 8.32 | -0.19 | 1.53 | 1.65 | -0.29 | 0.69 | 1.09 | -1.20 | 1.40 | 1.48 | 0.53 | -1.00 | 2.07 | 1.40 | 0.93 | 0.20 | 2.35 | 1.36 | | | 25.94 |
| Staff Development | Sickness (%) | *Target is < 4.2%* | 13.2% | 3.2% | 7.1% | 0.00% | 0.0% | 0.3% | 3.7% | 1.06% | 0.8% | 1.1% | 2.1% | 0.8% | 5.9% | 5.2% | 0.0% | 5.9% | 9.2% | 0.6% | 15.8% | 0.0% | 4.0% | 9.5% | 0.0% | 12.2% | 0.2% | 4.1% | | | 4.17% |
| | Total WTE with 19.81% Headroom (Sickness, Training etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substantive Staff Turnover Headcount (rolling average 12 months) | *Target is < 10%* | 11.3% | 14.0% | 10.0% | 30.8% | 0.0% | 21.4% | 7.5% | 25.5% | 15.2% | 14.9% | 8.5% | 4.5% | 11.4% | 16.1% | 22.2% | 6.9% | 12.9% | 9.8% | 5.1% | 8.0% | 7.4% | 0.0% | 16.7% | 8.3% | 9.2% | 16.7% | | | 12.06% |
| | 12 month Appraisal | *Target = 85%* | 71.4% | 87.2% | 50.0% | 50.0% | 100.0% | 69.2% | 95.2% | 100.0% | 78.9% | 83.9% | 91.9% | 65.0% | 60.0% | 88.5% | 100.0% | 92.3% | 92.9% | 100.0% | 87.5% | 100.0% | 90.9% | 100.0% | 71.4% | 76.9% | 84.4% | 88.9% | | | 82.34% |
| | 12 month Statutory Training | *Target = 95%* | 94.5% | 94.1% | 100.0% | 100.0% | 96.7% | 100.0% | 99.3% | 98.2% | 94.9% | 98.2% | 97.4% | 94.1% | 98.7% | 98.5% | 100.0% | 98.7% | 98.8% | 96.9% | 98.1% | 98.7% | 100.0% | 100.0% | 97.9% | 95.8% | 98.5% | 95.7% | | | 97.75% |
| | 12 month Mandatory Training | *Target = 85%* | 91.9% | 94.2% | 100.0% | 89.5% | 92.9% | 97.2% | 94.4% | 96.7% | 94.8% | 100.0% | 97.3% | 93.9% | 94.7% | 100.0% | 92.3% | 97.8% | 92.6% | 95.0% | 94.2% | 96.0% | 95.3% | 100.0% | 93.5% | 91.1% | 95.1% | 96.1% | | | 95.70% |

**Data Legend**

| | |
|---|---|
| No data returned | |
| No Eligible patients | |

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

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

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

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

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 29th July 2021 | | Discussion | |
| **NED Sponsor** | Andrew Thornton | | Decision | |

| | |
|---|---|
| **Summary:** | The Quality Assurance Committee has met twice since the last Board of Directors' meeting.<br><br>*Further detail provided in the reports attached*. |

| | |
|---|---|
| **Previously considered by:** | The Quality Assurance Committee |

| | |
|---|---|
| **Proposed Resolution** | Board members are asked to note this report |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Esther Steel<br>Director of Corporate Governance | **Presented by:** | Andrew Thornton<br>Chair of the QA Committee |

| | | | |
|---|---|---|---|
| Name of Committee/Group: | Quality Assurance Committee | Report to: | Board of Directors |
| Date of Meeting: | 16 June 2021 | Date of next meeting: | 21 July 2021 |
| Chair: | A Thornton | Parent Committee: | Board of Directors |
| Members present/attendees: | F Noden, A Ennis, Karen Meadowcroft, J Njoroge, R Ganz, M Brown, E Steel, R Sachs. Representation from the five clinical divisions | Quorate (Yes/No): | Yes |
| | | Key Members not present: | D Hall, F Andrews |

| Key Agenda Items: | RAG | Key Points | Action/decision |
|---|---|---|---|
| Patient Story | | Lucy Bradshaw, matron from the Acute Adult Division shared a story of end of life care provided to a patient. While there were some human errors that impacted on the care provided to the patient and their family, Committee members were assured that the nursing team had taken some important learning from the story and had responded well to the families concerns | The Committee agreed that the story showed good candour and learning from errors |
| Mortality update | | Report presented by the new Associate Medical Examiner. Although this remains a challenge with metrics that show the Trust as an outlier, the Committee were assured that there is a significant focus on this area, including training on data and documentation of care | The Committee noted the update and the comprehensive action plan |
| Learning from Deaths | | Update provided on the learning from deaths process and the introduction of systematic processes to embed a QI approach to this work | The Committee noted the report |
| DNA CPR audit | | The Deputy Medical Director provided an update on the spot audit undertaken in early June. The audit looked at the recording of DNA CPR discussions and while some room for improvement was noted the audit provided assurance that communication with relatives has improved | The Committee noted that while this remains a work in progress, good progress has been made |

**Committee/Group Chair's Report**

| | | | |
|---|---|---|---|
| Divisional Governance Report – Anaesthetic and Surgical | | Comprehensive report provided on work in the division including challenges and ambitions | The committee received the report and noted the update. |
| Divisional Governance Report – Diagnostic and Support | | Comprehensive report which included an update on blood transfusion traceability and the need for the introduction of a systematic proves to improve traceability | The committee received the report and noted the update. |
| SI and HSIB report approval | | The Committee reviewed one SI report and one report from the Healthcare Safety Investigation Branch (HSIB) | The three reports were approved.<br>The QA Committee expressed their apologies on behalf of the Board to those affected by the incidents. |
| SI report follow up actions | | The Committee received updates on two previous SI reports | The Committee noted the requested updates |
| Health and Safety six month update | | Report received providing assurance that most actions are on track | |
| Draft Quality Account | | | Report approved |
| Comments | | | |
| **Risks Escalated – no risks escalated** | | | |

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

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

# Committee/Group Chair's Report

(Version 3.0 October 2020, Review: October 2021)

NHS Bolton NHS Foundation Trust

| | | | |
|---|---|---|---|
| Name of Committee/Group: | Quality Assurance Committee | Parent Committee: | Board of Directors |
| Date of Meeting: | 21st July 2021 | Date of Next Meeting | 18th August 2021 |
| Chair | Andrew Thornton (NED/Deputy Chairperson) | Quorate (Yes/No) | |
| Members present | Andrew Thornton, Karen Meadowcroft, Andy Ennis, Fiona Noden, Sharon Martin, Malcolm Brown. (in attendance: Nicola Caffrey, Harni Bharaj, Nadine Caine, Natasha MacDonald, Carol Sheard (obo JM), Bridget Thomas, Michaela Toms, Angela Volleamere, Clare Williams, Diane Sankey, George Lipscomb, Marie Hart, Jackie Smith, Debora Tinsley, Tracy Walsh, Chinari Subudhi, Sophie Kimber-Craig | Key Members not present: | Esther Steel, James Mawrey (CS representing) |

| **Meeting overview/context** | | | | |
|---|---|---|---|---|
| **Positive meeting. .** | | | | |
| **Key Agenda Items:** | **RAG** | **Lead** | **Key Points** | **Action/decision** |
| Chief Nurse Update | | KM | Noted activity in relation to CQC and management of queries and TMA (ED and WL) | |
| Clinical Governance & Quality Committee | | KM | Chairs Report Noted | |
| Mortality Update | | SK-C | Whilst mortality intelligence shows improvement, we are not complacent as to the underlying reasons and areas for improvement. | • Ongoing work to ensure that clinical recording accurately and fully captures care provided<br>• IM&T challenges continue to impede pace of data entry<br>• Mandatory Fields to be explored |
| Ockenden Report Evidence Submission | | NMacD | Evidence for submission presented at QAC | • To be presented to BoD July 2021<br>• To establish St Mary's Maternity SI process for benchmarking purposes |
| Divisional Governance Report - Acute Adult | | DM | Report Noted | |

| | |
|---|---|
| | 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

| | | | | |
|---|---|---|---|---|
| Divisional Governance Report – Integrated Care | | MT | Report Noted | |
| Diabetes Care Quality Update | | MT | Report Noted | |
| Q4 Patient Experience Report | | RS | Note performance recovery since Q4.<br>Note need to improve quality of complaint responses | • Await PwC Recommendations<br>• Adjust report to format for Q1 21/22 to focus on action plans |
| SI Report 174640 | | FA | Report Noted | Report signed off by QAC, action plan noted |
| HSIB Report 2106 - 2916 | | KM | Report Noted | Report signed off by QAC, action plan noted (apologies to be noted to the family in the minutes) |
| Claims Profile | | RS | Report Noted | Establish division of liability for Neuro Surgery claim settlement |
| Safeguarding Assurance Framework Proposal | | KM | Report Noted | |
| Performance Report | | AT | Report Noted | |
| Risk Management Committee | | RS (obo AW) | Report Noted | To ensure management of external visits is robust |
| Mortality Reduction Group | | SK-C | Noted need for portable devices for fluid monitoring | to note IT infrastructure (EPR and other digital solutions) availability and ease to record pertinent clinical detail across multiple agenda items |
| Safeguarding | | KM | Report Noted | |
| NMAHP Professional Forum | | KM | Report Noted | |
| **For Escalation:** to note IT infrastructure (EPR and other digital solutions) availability and ease to record pertinent clinical detail across multiple agenda items | | | | |

| | |
|---|---|
| | 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

Agenda Item 12

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

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 29th July 2021 | | Discussion | ✓ |
| **Exec Sponsor** | Dr Francis Andrews | | Decision | |

| | |
|---|---|
| **Summary:** | This paper provides an updated position from April 2021 relating to the Learning from Deaths Programme, including data and lessons learned in the form of governance slides. |

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

| | |
|---|---|
| **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:** | Nicola Caffrey, Corporate Business Manager for the MD | **Presented by:** | Dr Francis Andrews, Medical Director |

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

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

## 1. Background

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

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

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

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

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

## 2. Learning from Deaths Methodology – adult inpatient only

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

The benefits realised by this approach include:

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

Initial (primary) reviews are conducted by 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 committee will ask for a directorate or divisional review depending on the breadth of the care issues or refer to a scoping panel for a serious incident where serious harm may have occurred

Cases deemed to be uniformly excellent are also reviewed at LFDC and any actions and learning points are captured are shared monthly via Learning from Deaths Learning slides (LfD slides from June 2021 can be found in appendix 3)

LfD committee have agreed that for future meetings, themes will be identified for quality improvement work rather than address all issues identified

**Summary:**

- Data for last year show a high percentage of cases identified for learning from deaths were completed
- There is a concern that there has been slippage in Q1 this year, and there is a plan to use a retired consultant to help catch up and check the nature of the cases
- There are no action points form divisional reviews for this quarter-this is awaited from 3 divisional reviews
- The estimate of the overall percentage of deaths at the hospital which are due to problems in care is provisional due the numbers of reviews still awaiting completion
- Going forward LfD will identify themes to concentrate on in terms of quality improvement work to reflect learning from deaths

## 3. Reporting schedule:

Due to the way the data is collected, data will always be in retrospect and be continuously updated. However, in order to better synchronise reporting with the quarter ends, the reporting schedule is as follows:

| Month to report latest quarter * | Reporting Committee |
|---|---|
| July (Q1) | QAC and Board |
| October (Q2) | QAC |
| January (Q3) | QAC and Board |
| April (Q4) | QAC |

**Each quarterly report will include a refresh of the four previous quarters to date to ensure up to date performance as per the date of report.*

This proposal was accepted at Board

## 4. Issues raised during Q1 2021/22

- Completion rates are very low for Q1
- Many reviewers are also heavily engaged in additional Covid-19 work
- Fatigue may be playing a part
- Solutions include asking Dr Kevin Jones, retired consultant physician who is fully SJR-trained, to help with catching up on the backlog and also a review of Secondary reviews from nosocomial covid-19 as some need an IPC review rather than a second review

## 5. Learning from Deaths Process – Adult Inpatient Deaths Only – Data

A comprehensive summary of data from the audit inpatient learning from deaths process can be found in appendix 1.

| | **2020/2021** | | | | | | | | | **2021/2022** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | | Quarter 1 | | |
| | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| N of In-patient Deaths | 90 | 111 | 106 | 148 | 82 | 143 | 167 | 144 | 123 | 97 | 103 | 102 |
| Number SJR Cases ID | 14 | 23 | 13 | 28 | 36 | 45 | 42 | 36 | 32 | 15 | 28 | 28 |
| **COMPLETED** | **86** | **100** | **100** | **93** | **100** | **87** | **93** | **83.3** | **78.1** | **26.7** | **28.6** | **0.0** |

*June cases have been allocated 15/07/2021

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

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

The table below details divisional reviews which are either still open or have been identified in Q1

| | Date Identified | Review Required | Status |
|---|---|---|---|
| 1 | 06/05/2021 | Scoping Meeting – Serious Investigation | Draft report available |
| 2 | 15/02/2021 | Divisional Review | Action plan being composed |
| 3 | 15/02/2021 | Divisional Review | To be presented DG June 2021 |

## 7. Estimate of percentage of patient deaths due to problems in care on the balance of probability

1 patient was identified as potentially more than likely to have died during Q1 but this only includes April and May 2021. Therefore given there were 43 deaths for review these 2 months, this would give an estimated rate of 2.3% of deaths overall but it should be noted that there are still outstanding reviews, so this is only a very provisional figure.

## 8. Sharing Learning from Deaths:

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

## 9. Summary

Data for last year show a high percentage of cases identified for learning from deaths were completed

There is a concern that there has been slippage in Q1 this year, and there is a plan to use a retired consultant to help catch up and check the nature of the cases

There are no action points form divisional reviews for this quarter-this is awaited from 3 divisional reviews

The estimate of the overall percentage of deaths at the hospital which are due to problems in care is provisional due the numbers of reviews still awaiting completion

Going forward LfD will identify themes to concentrate on in terms of quality improvement work to reflect learning from deaths

## 10. Recommendation

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

## Appendix 1

Learning from Deaths – data breakdown (adult inpatient)

| | 2020/2021 | | | | | | | | | 2021/2022 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | | Quarter 1 | | |
| | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| Number of In-patient Deaths | 90 | 111 | 106 | 148 | 82 | 143 | 167 | 144 | 123 | 97 | 103 | 102 |
| Number Cases (Sample) | 14 | 23 | 13 | 28 | 36 | 45 | 42 | 36 | 32 | 15 | 28 | 28 |
| Excluded due to COVID Pressures | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| COMPLETED | 12 | 23 | 13 | 26 | 36 | 39 | 39 | 30 | 25 | 4 | 8 | 0 |
| **Outstanding Cases** | **2** | **0** | **0** | **2** | **0** | **6** | **3** | **6** | **7** | **11** | **20** | **28** |
| Not Yet Received - Within Deadline | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 20 | 0 |
| Outstanding -Supassed Deadline | 2 | 0 | 0 | 0 | 0 | 6 | 5 | 6 | 7 | 11 | 0 | 0 |
| Missing notes unable to find | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cases requiring reallocation | 0 | 0 | 0 | 0 | 0 | 3 | 7 | 0 | 2 | 0 | 0 | 0 |
| **%** | **86** | **100** | **100** | **93** | **100** | **87** | **93** | **83.3** | **78.1** | **26.7** | **28.6** | **0.0** |
| Source | | | | | | | | | | | | |
| Mandated Death (Alert Diagnosis) | 6 | 3 | 5 | 3 | 0 | 13 | 21 | 14 | 7 | 1 | 0 | 2 |
| LD Death | 1 | 1 | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 |
| Mental Health Death | 5 | 9 | 8 | 10 | 12 | 5 | 8 | 11 | 10 | 10 | 10 | 12 |
| sample | n/a | 10 | 0 | 9 | 0 | 1 | 0 | 0 | 5 | 0 | 14 | 10 |
| Requested by cons/matron | 1 | 0 | 0 | 2 | 3 | 1 | 1 | 1 | 3 | 1 | 0 | 0 |
| Diabetes Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NELA Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MEDICAL REVIEWER | 1 | 0 | 0 | 1 | 0 | 7 | 9 | 8 | 4 | 2 | 3 | 3 |
| BAME + COVID Death | 0 | 0 | 0 | 0 | 20 | 17 | 3 | 2 | 3 | 0 | 0 | 0 |
| | **14** | **23** | **13** | **28** | **36** | **45** | **42** | **36** | **32** | **15** | **28** | **28** |
| Overall Score | | | | | | | | | | | | |
| 1 (Very Poor) | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| 2 (Poor) | 1 | 5 | 4 | 5 | 10 | 9 | 8 | 6 | 3 | 1 | 0 | |
| 3 (Adequate) | 3 | 3 | 5 | 2 | 8 | 3 | 7 | 8 | 5 | 0 | 4 | |
| 4 (Good) | 8 | 12 | 3 | 11 | 15 | 12 | 23 | 14 | 15 | 3 | 4 | |
| 5 Excellent | 0 | 3 | 1 | 8 | 3 | 1 | 1 | 2 | 2 | 0 | 0 | |
| | 12 | 23 | 13 | 26 | 36 | 26 | 39 | 30 | 25 | 4 | 8 | 0 |

**Appendix 2 – Maternal, still birth and neonatal deaths**

| | Q2 July-Sept 20 | Q3 Oct – Dec 20 | Q4 Jan – March 21 | Q1 April – June 21 |
|---|---|---|---|---|
| Maternal Deaths | 0 | 0 | 0 | 0 |
| Still births | 4 | 5 | 5 | 5 |
| Neonatal deaths | 1 | 2 | 7 | 4 |
| Child deaths (excluding stillbirth and neonatal death) | 0 | 0 | 0 | 1 |

**Details of stillbirths**

**Q2:** Rapid review of all cases, 3 unavoidable, one currently under investigation by HSIB. Scoped as an SI. May have been unavoidable – awaiting outcome.
**Q3:** Rapid review of all cases, 2 unavoidable, one stillbirth at 38 + 2 weeks. Appropriate pathways followed but with some non-compliance with Diabetic pathway. Serial scans and regular monitoring. There were 2 cases of congenital abnormality both referred to St Mary's and offered medical termination of pregnancy which was decline and opted for conservative management – fetal demise at 26+3 weeks and at 30 weeks.
**Q4**:Rapid review completed for all cases. 4 were deemed unavoidable – 1 was an expected death due to congenital abnormality. Compassionate termination was offered but declined. The further 3 unavoidable cases had appropriate management plans. The 1 avoidable death was an intrapartum stillbirth was avoidable and investigated by HSIB as an SI with key learning.
**Q1**: Rapid reviews completed for all cases. 2 cases have been escalated as Sis' and are deemed avoidable. 2 cases were deemed unavoidable both with poor diabetic control. 1 was an undetected SGA, possibly avoidable if 26 weeks scan had been arranged for prior to bank holiday. Was slightly late due to bank holiday and IUD had already occurred.

**Details of neonatal deaths**

**Q2:** Non-viable baby born at home prematurely with signs of life-rapidly died before ambulance arrived. Coroner since agreed to class as a stillbirth
**Q3**: Rapid review of all cases, one expected early neonatal death unavoidable, one Cord prolapse at 23 weeks – baby did not survive.
**Q4:** 1 case of early neonatal death is being investigated by HSIB, baby was born before arrival and had shoulder dystocia. Unavoidable. 3 were late terminations due to abnormalities. 1 was a PROM at 19 weeks. Steroids were given at 24 weeks but baby was born with severe lung disease and pulmonary hypertension and refractory hypotension with GBS septicaemia and was unavoidable. 2 were unavoidable due to extreme prematurity at 22+2 weeks and 18+6 weeks
**Q1:** All unavoidable: 1 case of feticide due to bilateral talipes. 1 compassionate induction for anencephaly. 1 case of extreme prematurity at 18+3 weeks gestation.

**Appendix 3: Learning from Deaths Learning Slides – June 2021**

# Governance Learning Slides 2021-2022
# June 2021 – Learning from Deaths

NHS Bolton NHS Foundation Trust

- Structured Judgement Review (SJR) methodology is used to perform an objective review of the patient's last episode of care as an inpatient, in order to understand areas of good practice and elements of improvement for sharing and learning purposes.
- Certain groups of patients and clinical conditions are mandated to have a SJR performed, plus a random sample per month. Medical Examiners can now request SJR
- There are a group of corporate SJR trained reviewers who represent the clinical MDT and perform reviews on a monthly basis.
- >430 deaths reviewed to date – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive learning
- Learning from Deaths Committee took place on 3rd June 2021
- 8 cases rated as 'poor/very poor', (which 5 did not concur , therefore, 4 changed from 'poor' to 'adequate' and 1 changed from 'poor to' good', One case rated as excellent

...for a better Bolton

NHS Bolton NHS Foundation Trust

- Patient 1
- Date and place of death: 26/12/20 ICU
- Cause of death: Multiorgan failure secondary to pancreatitis
- **Primary review rating of overall care: Poor**

**Summary:**

•Admission and initial management rated as Poor by primary reviewer due to delay in surgical review, however, re-rated to Adequate. The patient was seen in ED and referred to surgery
Significant delay in being seen by surgical junior due to theatre commitments, however, appropriate treatment and investigation implemented after discussion with surgical registrar.
•Ongoing care was adequate - patient remained unwell during a 36 hour stay on surgical ward and was reviewed on multiple occasions by critical care.
The patient had a cardiac arrest and was moved to ITU but continued to deteriorate and died

**Learning:**

- The Committee acknowledged the lack of recognition of deteriorating patient and delays in escalation and admission to ICU/HDU, however, felt that the outcome would have been the same.
- Secondary review of the overall care: Adequate

**Action**

- Action: Contact ST to ascertain if the cardiac arrest RCA has already been undertaken and, if so, what was the outcome.
- **Action completed – a Cardiac Arrest RCA completed and the outcome was non-avoidable.**

...for a better Bolton

- Patient 2
- Date and place of death: 15/12/20 D4
- Cause of death: 1a respiratory failure, 1b covid pneumonitis, COPD; 2 diabetes mellitus type 2
- **Primary review rating of overall care: Poor**

NHS Bolton NHS Foundation Trust

Summary:
- Frail, elderly patient with multiple comorbidities, multiple attendances and admissions who presented in ED.
- The patient was seen early by palliative care ENT and frailty team with a plan to go home but kept in overnight.
- Ongoing care was rated as Poor by the primary reviewer due to nosocomial Covid and institution of dexamethasone after deterioration with Covid pneumonitis taking more than 24 hours.
- He did not require oxygen at that stage but worsened almost a week later, was well managed on the Covid ward and given CPAP
- The Committee noted that if the admission could potentially have been avoided the patient would not have been exposed to Covid.

**Action/Learning:**
- No learning points were identified.
- Secondary review of the overall care: Adequate
- The Committee concluded that it was not likely that the death was due to problems in care

...for a better Bolton

- Patient 3
- Date and place of death: 23/11/20 E4
- Cause of death: 1a aspiration pneumonia, 1b metastatic oropharyngeal carcinoma; 2 coronavirus infection, frailty of old age
- **Primary review rating of overall care: Poor**

NHS Bolton NHS Foundation Trust

**Summary:**
- Good initial management of 88 year old man with 5 month history of swallowing difficulties
- Ongoing care was poor due to very poor coordination of decision making and nutritional input which delayed the start of artificial feeding, delays in MDT decision making regarding suitability for curative treatment
- overly optimistic communication to family by nursing staff and delays in anticipating and instituting end of life care. ENT Dr was commended for excellent communication with the patient's son who was surprised that his father was dying due to previous positive feedback.
- Poor recognition of the patient's dying phase, investigations were being undertaken for cancer rather than focusing on end of life care for Covid. Uncertain why the patient was moved to E4 the day before he died when he was clearly unwell.

**Learning:**
- Secondary review of the overall care: Poor
- Prevention of ward moves when patients are deteriorating and likely to die
- Clear medical responsibilities need to be made when patients are being jointly cared for
- Importance of prompt nutritional decision making

**Action**
- Case to be referred to SH, ENT Consultant to review why in hindsight the case was not taken over by ENT
- Letter for thanks to be sent to Doctor involved

...for a better Bolton

- Patient 4
- Date and place of death: 18/12/20 C3
- Cause of death: 1a spontaneous subdural haemorrhage; 2 coronavirus infection, dementia
- Primary review rating of overall care: Poor

NHS Bolton NHS Foundation Trust

**Summary:**

- •Elderly, frail patient admitted with cellulitis. Admission and initial management was adequate. Escalation plan was in place, IV antibiotics started at 5 hours post admission, DNACPR discussed and documented and seen by consultant at 12 hours post admission.
- •Assessment of ongoing care - patient was in hospital for a considerable length of time with multiple ward moves and developed nosocomial covid at 12 days in the context of an outbreak on B1. Nosocomial covid did not contribute to death.
- The patient was dehydrated and had delirium, there was an unwitnessed fall with possible head injury on 1st December which was reviewed appropriately.
- The patient had been treated for AKI and improved for a time but unfortunately deteriorated

**Action/Learning:**

- No learning points were identified.
- Secondary review of the overall care: Adequate
- The Committee concluded that it was not likely that the death was due to problems in care

:

...for a better Bolton

- Patient 5
- Date and place of death: 19/12/20 HDU
- Cause of death: 1a respiratory failure, 1b pneumonitis, 1c covid-19 infection; 2 alcoholic liver disease, DVT, bronchial asthma
- Primary review rating of overall care: Poor

NHS Bolton NHS Foundation Trust

**Summary:**

- 59 year old man presented at ED with breathing problems – Covid patient who had self-discharged from hospital 3 days before. Very difficult management problem due to his alcoholism and non-compliance.
- Long delay after admission to start specific treatment for Covid pneumonitis although very unlikely that this contributed to his death.
- It was initially thought that the patient had not been clerked in on critical care, however, it was ascertained that a critical care assessment was on EPR which provided assurance that a full review had been undertaken.

**Learning:**

- Referral to appropriate specialties - this patient should have been referred to the on call medical team by critical care following decline. Acute care standards just published will assist this going forward.

- The Committee concluded that it was not likely that the death was due to problems in care
- Secondary review of the overall care: Adequate (given assurance on ICU clerking)

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- Patient 6
- Date and place of death: 20/01/21 C3
- Cause of death: 1a respiratory failure, 1b pneumonitis, 1c covid-19; 2 AF
- Primary review rating of overall care: Poor

NHS Bolton NHS Foundation Trust

**Summary:**

•All areas rated as good except for overall care due to nosocomial covid

**Action**

- Submit the case for infection control review

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- Patient 7
- Date and place of death: 14/11/20 B2
- Cause of death: 1a covid-19 pneumonia; 2 asthma hypertension scoliosis
- Primary review rating of overall care: Poor

NHS Bolton NHS Foundation Trust

**Summary:**

- Good admission and initial management of elderly, frail patient with severe scoliosis and minor comorbidities. Admitted with diarrhoea, AKI and hyponatraemia. Drugs appropriately withheld, fluid resuscitated successfully, appropriate consultant review and negative covid swab. DNACPR discussion with patient but not with daughter. Excellent joint working with MHLT to resolve the patient's delirium.
- Patient became very unwell and tested positive for covid. No rationale for transfer to A4, in hindsight an unwise move due to delirium and covid positive
- End of life care rated as Excellent - family had been informed the patient was sick enough to die and spiritual needs identified well before end of life care phase.

**Learning:**

- Excellent end of life care as the patient was identified as sick enough to die
- Consider prevention of ward moves in delirious patients

**Action**

- Letter of thanks to end of life care team for excellent care

...for a better Bolton

- Patient 8
- Date and place of death: 12/09/20 C2
- Cause of death: Unavailable
- Primary review rating of overall care: Poor

NHS Bolton NHS Foundation Trust

**Summary:**

- 68 year old patient admitted with breathing problems and vomiting. Good efforts in obtaining collateral history from next of kin given language barrier with patient and recognition of a very unwell patient with multiple comorbidities including diabetes, hypertension and thalassemia trait
- Secondary Reviewer agreed with the primary reviewer that initial management was good but felt that there should have been a clear acute renal failure plan with reference to trust guidelines
- In summary, the patient was never well enough to determine whether there was a possible underlying malignancy and had intrinsic renal disease probably secondary to hypertension and diabetes compounded by new upper GI issues.

**Learning:**

- Management of hypoglycaemia
- Use of AKI guidelines
- The Committee concluded that it was not likely that the death was due to problems in care.
- Secondary review of the overall care: Good

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- Patient 9 - RMC01215433
- Date and place of death: 03/03/21 ICU
- Cause of death: Covid-19 pneumonitis

NHS Bolton NHS Foundation Trust

**Summary:**

- Admitted via ED with symptoms compatible with covid and history of family exposure and seen in resus promptly. Sepsis 6 completed appropriately and referred and seen by medics in a timely fashion. Seen next morning by medical consultant and treatment started with Remdesivir. Investigations and treatment all appropriate.
- Good care throughout with excellent collaboration between critical care and the respiratory ward. All appropriate medications given. Good communication with family.

**Action:**

Letter of thanks for excellent care to ED, Respiratory, Medicine and ICU

...for a better Bolton

| | |
|---|---|
| **Title:** | IPC Board Assurance Framework V1.6 – July |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | IPC Committee | **Purpose** | Assurance | ✓ |
| **Date:** | 29/07/21 | | Discussion | |
| **Exec Sponsor** | Karen Meadowcroft | | Decision | |

| | |
|---|---|
| **Summary:** | The IPC Board Assurance Framework has been developed in light of the impact of the COVID-19 pandemic. It has a focus on key lines of enquiry related specifically to COVID-19 but also considers the wider issues of infection prevention and healthcare associated infections (HCAI). The criteria categories are in line with the 10 criteria in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. It is a requirement that the Framework is reviewed by the Board.<br><br>This paper outlines compliance and assurance set out in the most recent version (V1.6) distributed by NHSi in June 2021.<br><br>The Trust can demonstrate assurance for most of the key lines of enquiry. For those where assurance cannot be provided, actions will be undertaken to provide assurance which will be tracked through an IPC BAF Action Plan which will be reviewed and challenged at the IPC Committee on a monthly basis.<br><br>Evidence is embedded in the document – this may not be accessible once the document has been saved as a PDF document – these may be requested from the author upon request, |

| | |
|---|---|
| **Previously considered by:** | IPC Committee 19 July, Executive 26 July |

| | |
|---|---|
| **Proposed Resolution** | The Board is asked to take assurance from this BAF understanding that there KLOEs where there gaps in assurance which will be monitored through the IPC Committee. |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Richard Catlin | **Presented by:** | Karen Meadowcroft |

# Infection Prevention and Control board assurance framework

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| **1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users** | | | |
| Systems and processes are in place to ensure: | | | |
| Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; | The Trust has retained a command and control structure for decision making and review of any relevant COVID-19 risk assessments that have an impact beyond the division and are documented in the minutes and decision logs.<br><br>Local COVID-19 risk assessments are the responsibility of the divisional governance structures following the existing Trust governance processes.<br><br>There are regular updates of the COVID-secure workplace assessments through positive assurance reports to the Group Health and Safety Committee and are evidenced in the Group Health and Safety minutes.<br><br>Bolton's acute services have been under regular pressure due to the prolonged high prevalence of COVID-19 in the borough. The link between community case rates and admissions appears to have weakened: | Collation of the number of completed and any outstanding issues not complete | Divisions to compile a report tabulating their completed risk assessments with a view to undertaking an audit of a proportion of them |
| The documented risk assessment includes:<br>▪ a review of the effectiveness of the ventilation in the area;<br>▪ operational capacity;<br>▪ prevalence of infection/variants of concern in the local area. | | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | 9039 Covid Cases vs Inpatients.xlsx | | |
| Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; | Elective admissions are triaged by the pre-operative assessment services.<br><br>Standard operating procedure (SOP) for the triage and management of patients in the emergency department using lateral flow tests followed by a PCR test for SARS-CoV-2 for all admissions.<br><br>The Trust has a Universal Screening for SARS-CoV-2 Policy.<br><br>REVISED Universal Screening for COVI[<br><br>These have been approved by the Trust COVID-19 Command Structure. | Due to work demands and sickness in the IPC team there hasn't been capacity for screening compliance audits which is a time intensive process. These have now commenced on a rolling programme basis. | The IPC team will be undertaking compliance audits of five inpatient departments/week for compliance with screening on day 0, 3 and 5 of admission. These will be reported into the divisions directly and will be included monthly IPC reports to IPCC. This commenced from 12/07/21.<br><br>Business Intelligence are reviewing the practicalities of creating an automated audit tool. |
| When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given | The Trust has not made changes to the PPE guidance in line with the August 2020 and remains in excess of this guidance because of the risks to staff generated by the limitations of the Bolton estate. The most recent approved Trust guidance is: PPE Use V8 28.01.21 | No gaps identified | Specifically the differences from the national guidance are:<br>▪ Use of FFP3 respirators for all care in high-risk environments at all times. The national guidance advises use only |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | | | for aerosol generating procedures (AGPs)<br>▪ Use of FFP3 respirators for AGPs in all areas regardless of the patient risk group. The national guidance advises use of Type IIR fluid repellent surgical masks (FRSM) for AGPs in low-risk pathways and FFP3 respirators for AGPs in medium and high-risk pathways |
| There are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative | Patients undergoing an urgent admission are offered a lateral flow test (LFT). If the patient has signs/symptoms of COVID-19, they are transferred to a COVID-19 cohort ward and a PCR test undertaken for confirmation. Patients without signs/symptoms are held in the admitting department pending the results of their SARS-CoV-2 PCR test. | Patients are not retained in an assessment area pending a second confirmatory PCR test. There isn't sufficient assessment capacity to accommodate an additional 24-hour stay there for all COVID-19 | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | The Trust in line with the rest of the acute providers in GM has not complied with the guidance to wait for two COVID-19 negative PCR results before moving patients from medium-risk to low-risk pathways.<br><br>For patients that are (COVID-19) asymptomatic, Unless clinically imperative patients should remain in an assessment area until they have a confirmed SARS-CoV-2 negative PCR test. | negative test. This deviation from guidance has been agreed as across the GM acute providers.<br><br>Nosocomial rates are reviewed at IPC Committee monthly including comparisons with other providers in GM. Recent incidence of nosocomial rates at Bolton remains low:<br><br>  <br>04c GM Comparison Report<br><br>  <br>07a COVID-19 Nosocomial Update | |
| That on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance; | All general cleaning following the discharge of all patients is undertaken using a sodium hypochlorite sanitiser at 1000 parts per million (PPM) concentration in line with the national guidance or a Chlorine dioxide based sanitiser at least 240 ppm as approved by the Trust IPC team regardless of who undertakes the cleaning process – there are no other general cleaning agents available to ward/department staff for | No gaps identified | To include audit data. |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | cleaning. When a patient is moved after a confirmed COVID-19 case, the bed space is cleaned by the domestic 'heavy duty' team who clean the bedspace and replace the disposable curtains. These cleans are arranged by the patient flow/site manager team and the record of cleans is recorded on an iFM Bolton portal | | |
| Resources are in place to enable compliance and monitoring of IPC practice including:<br>▪ staff adherence to hand hygiene; | Hand hygiene audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps). 70 departments/services are audited per month.<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), at the Trustwide IPC Operational Group (alternate months) and IPC Committee (monthly). They also report into the divisional Integrated Performance Management reviews (monthly) and through the Quality Assurance Committee by division on a quarterly basis.<br><br>Ad hoc audits may be taken by members of the IPC team with results and outcomes reported to and discussed with the relevant shift lead | No gaps identified | Not applicable |
| ▪ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing | There is a 2-metre distance between each patient in their bed space in all inpatient departments when they are in bed. The wards now have a standard template layout to ensure that when they get out of bed into their chair they | No gaps identified | The Trust is planning for the resumption of visiting when three criteria have been |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| clinical/personal care and are wearing appropriate PPE; | move further away from each other: chair-bed-lock-locker-bed-chair<br><br>Patients are advised to wear face masks as much as possible whilst an inpatient – especially if they leave their bedspace. Face masks are provided for patients.<br><br>  <br>A5 NHS Bolton Foundation Trust C<br><br>Information for patients and their loved ones is available on the Trust website: https://www.boltonft.nhs.uk/services/coronavirus-covid-19/<br><br>There are awareness raising posters throughout the site:<br><br>There is currently no visiting except for end-of-life care and for support for patient with dementia, learning disabilities, paediatrics and maternity.<br><br>Staff are advised to wear as a minimum a Type IIR FRSM and eye protection for all patient contact. This exceeds the current national guidance and is outlined to staff in the approved document 'PPE Use V8 28.01.21'. Staff are advised to wear Type IIR FRSM when within 1m of each other. | | reached in line with the NHSi framework:<br>1. the national restrictions end<br>2. there is a sustained reduction in community COVID-19 rates<br>3. the community rates are below 100 per 100,000 population<br><br>Visiting will be permitted on an appointment basis only with one patient visiting in each bay at any one time to maximise social distancing and support adequate ventilation during and following the visit.<br><br>There are clear signs and guidance for visiting staff when they do return with advice regarding PPE and hygiene measures and there as dispensers for |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | Staff compliance is audited at least monthly as part of the IPC Rapid Improvement Tool audit. These audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps).<br><br>Aggregated Audit Reports 21-22.docx<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), at the Trustwide IPC Operational Group (alternate months) and IPC Committee (monthly).<br><br>Ad hoc audits may be taken by members of the IPC team with results and outcomes reported to and discussed with the relevant shift lead<br><br>Non-clinical areas such as offices have been COVID-secure assessed in line with the government guidelines for COVID-secure workplaces. Compliance is reviewed by the operational divisions six-monthly and assurance provided to Group Health and Safety Committee | | masks at public entrances to the hospital site |
| ▪ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:<br>a. clinical; | We do monthly audits in clinical areas and the reported compliance has been 100% in April, May and June 2021. | There is currently no formal monitoring of FRSM use in non-clinical settings | Non-clinical settings make frequent enquiries to the IPC team to support the use of |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| b. non-clinical setting;<br>▪ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting; | Staff compliance for the use of FRSM and PPE generally is audited at least monthly as part of the IPC Rapid Improvement Tool audit. These audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps).<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), and from July 2021 are included in divisional reports to the Trust IPC Committee (monthly).<br><br>06a AACD Divisional IPC Repor<br>06b ASSD Divisional IPC Report - June 21<br>06c FCD Divisional IPC Report - June 21 | | FRSM use in non-clinical settings including a review of the workspace when staff are struggling with mask adherence on health grounds. Staff make frequent enquiries to the IPC team if they have concerns about staff in their non-clinical setting not adhering to the use of FRSM in non-clinical settings.<br><br>The Trust IPC team function as the local Test & Trace response in the event of a staff member tests positive for COVID-19. Use of PPE is discussed as part of the review and response |
| ▪ that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; | The IPC team have trained the departmental IPC link nurses to act as local PPE guardians | No gaps identified | The IPC team are planning to complete update training for the link nurses in July 2021 |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; | Patient facing staff have offered twice weekly LFTs and are required to report the results locally via a web portal.<br><br>Test & Trace systems are in place: staff who have a positive test, who have signs/symptoms or who have a household contact who is positive/has signs/symptoms are referred to the Attendance Matters team. They advise on self-isolation and arrange for PCR testing as required via the Trust test systems. If there is more than one staff member from a department or service, this is referred to the IPC to review and advise | When the initial request for staff to test twice weekly was made, it wasn't clear that or whether this would be an ongoing proposition (it was initially apparently for a 12-week period). As a consequence, an internal reporting system was set up quickly to facilitate predominantly to flag positives.<br><br>Result reporting for the Trust is taken to the Trust IPC Committee in alternate months | Following the publication of C1276 on the 29th June, the Trust has agreed through the command & control structures to maintain local reporting with a commitment to revising the local reporting processes to enable more frequent and more accurate reporting to the IPC Committee.<br><br>There are regular communications to remind staff to complete the tests and to report them through the web portal. The most recent was week commencing 05/07/21 |
| ▪ additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team; | Whole staff testing has been undertaken on 17 occasions as a core part of the response to clusters or outbreaks of COVID-19 infection. This is reported as an IIMARCH via the NHSi outbreak reporting system: Outbreak Report. In addition, confirmation of testing and outcome is captured in the OCT minutes | No gaps identified | Not applicable |
| ▪ training in IPC standard infection control and | IPC Training including COVID-19 measures is mandatory for all Trust staff. Compliance is | Compliance for June 2021 is 92% for the | This will be an agenda item at July IPCC and |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| transmission-based precautions is provided to all staff;<br>▪ IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; | reported, monitored and discussed at the monthly IPC Committee via a Trustwide HCAI report and divisional HCAI report | Trust overall. This equates to 158 individuals being non-compliant in order to achieve 95% | reporting and monitoring will continue on a monthly basis |
| ▪ all staff (clinical and non-clinical) are trained in:<br>○ putting on and removing PPE;<br>○ what PPE they should wear for each setting and context; | Staff are trained in the safe use of the PPE required for their role as part of local induction. This is evidenced in local induction records | There is currently no clear record of training for existing staff | Following the PPE refresher training, the IPC team will support a review of completion of PPE training on a department/service level to confirm that all staff have received training on PPE choice and use |
| ▪ all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance; | PPE is supplied to clinical departments on a 'push' basis on a daily basis according to their need. Additional PPE is available from the Trust procurement team by telephone request 9-5 Mon-Fri.<br><br>Additional PPE is available 24/7 - a small stock is stored in the site manager's office which is staffed 24/7 and a larger resilience store is accessible 24/7 with additional PPE.<br><br>Non-clinical staff are able to access PPE via the Trust procurement team as required and are also able to access additional PPE using the same method of access as outlined above. There have been no substantiated incident | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | reports or RIDDORs recorded related to the availability of PPE | | |
| ▪ there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;<br>▪ | The Trust has commissioned local poster messages regarding the use of face masks and hand hygiene and are displayed in appropriate areas.<br><br>  <br>Mask.jpg<br><br>  <br>Banner.jpg<br><br>  <br>Pop up.jpg<br><br>Challenging non-adherence is encouraged | No gaps identified | Trust to explore with the Comms team the use of new messaging systems such as a new wayfinding screen in the hospital reception |
| ▪ IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way; | The Trust has a single point of contact (SPC) for nationally distributed communications including IPC guidance (emergency.planning2@boltonft.nhs.uk) which is monitored regularly 7 days/week (by the business continuity manager/ administrative support Mon-Fri) and the Tier 1 manager out of hours. Any relevant guidance is forwarded to the IPC team for review and local interpretation. Changes are agreed through the Trust command and control structure which are currently planned for fortnightly meetings | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | (surging to weekly, twice weekly and daily meetings where required). Should it be required, ad hoc meetings can be convened at short notice for the governance oversight of any documents for approval and communication | | |
| ▪ changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted; | Changes to guidance are discussed at the monthly IPC Committee for approval. There is a monthly IPC Board Report tabled at IPCC where changes would be outlined to take formally to Board as required. Otherwise the Board is kept apprised of key IPC issues via the Trust Board Report which contains a narrative section for IPC. Divisions have their own formal IPC committees and feed into the Trust IPCC | No gaps identified | Not applicable |
| ▪ risks are reflected in risk registers and the board assurance framework where appropriate; | IPC risks which are corporate and Trustwide are discussed initially through the divisional (Diagnostics & Support Services) risk management process and are escalated to the Trust Risk Management Committee for oversight. This is Chaired by the Director of Finance | No gaps identified | Not applicable |
| ▪ robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens; | MRSA and CPE risk assessments are retained in the patient admission documents with policies outlining appropriate practices for each of these. There is a risk assessment process for patients with loose stool related to the risk of *Clostridium difficile* infection – the Diarrhoea Management Plan – which allows staff to undertake a standard assessment of the risk of *Clostridium difficile* infection and which advises on management in line with the national SIGHT protocol. | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | Local reviews of *Clostridium difficile* infections are undertaken to identify gaps in care or points for shared learning.<br><br>The Board has oversight of:<br>▪ MRSA bacteraemia<br>▪ MSSA bacteraemia<br>▪ *E. coli* bacteraemia<br>▪ *Klebsiella spp.* bacteraemia<br>▪ *Pseudomonas aeruginosa* bacteraemia<br>▪ *Clostridium difficile* infections<br>▪ MRSA acquisitions[1]<br><br>These are available in the document below from page 14:<br>▪ MRSA bacteraemia (measure 217)<br>▪ MSSA bacteraemia (measure 304)<br>▪ *E. coli* bacteraemia (measure 218)<br>▪ *Klebsiella spp.* Bacteraemia (measure 305)<br>▪ *Pseudomonas aeruginosa* bacteraemia (measure 306)<br>▪ *Clostridium difficile* infections (measures 215, 346, 347)<br>  <br>10 Integrated Performance Report<br><br>MRSA acquisitions are reported via a departmental heatmap: | | |

[1] Patients who have become screen positive following an initial admission MRSA negative screen

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | Board Assurance Heat Map - Apr 202´ | | |
| ▪ the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep; | The national sitreps are submitted daily before 11am using an automated process developed by the Trust Business Intelligence (BI) team | The sitreps are not signed off by the Chief Executive/Medical Director/Chief Nurse | The Trust Deputy DIPC has delegated responsibility for the review and sign-off of the daily sitreps. They work closely with the BI team about changes in definitions or provision |
| ▪ the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; | The IPC Board Assurance Framework (BAF) is reviewed at the IPC committee when there are changes to the framework or updates that the Board needs to be appraised of. The approved version then goes to the Board via the Trust Quality Assurance Committee | No gaps identified | From August 2021 an associated IPC BAF action plan will be reviewed at IPC Committee monthly as well as an updated BAF as and when changes are made |
| ▪ the Trust Board has oversight of ongoing outbreaks and action plans; | The Trust Board is apprised of any outbreaks and key actions via the narrative supplied as part of the Trust Board Report.<br>05 IPC Board Report July 21 V2.docx | No gaps identified | Not applicable |
| ▪ there are check and challenge opportunities by the executive/senior leadership | The executive team are each 'buddied' with a number of clinical areas and have a process for regular walkarounds for support and challenge. | There is currently no formal process for regular checks and | From July 2021, the senior nurses have re-established regular |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| teams in both clinical and non-clinical areas. | The Trust also has a ward accreditation process – BoSCA (Bolton System of Care Accreditation) which the senior leadership actively participate in; this is an opportunity for check and challenge of care, practice and standards.<br><br>BoSCA Principal Template V.29.06.21 | challenges in non-clinical areas | walkarounds which will include clinical and non-clinical areas |
| **2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** | | | |
| Systems and processes are in place to ensure:<br><br>▪ designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas; | The core services that are designated for managing cohorts of COVID-19 positive patients are:<br>▪ Emergency medicine<br>▪ Urgent care<br>▪ Critical care<br>▪ Respiratory medicine<br><br>If COVID-19 related services are expanded beyond this, then the additional services are reviewed and the appropriate staff are assessed for additional training for their safety and patient safety. Any staff not adequately trained are re-deployed or trained as necessary.<br><br>Staff who may be unsuitable for managing COVID-19 positive patients based on their individual risk assessments may also be re- | There is currently no clear record of training for existing staff | Following the PPE refresher training, the IPC team will support a review of completion of PPE training on a department/service level to confirm that all staff have received training on PPE choice and use |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | deployed in advance if their service is planned to take patients known to be COVID-19 positive | | |
| ▪ designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas; | The Trust has assurance from Bolton iFM that only staff that are suitably trained are deployed to areas where exposure to COVID-19 or patients likely to be COVID-19 positive is likely to occur | Confirmation from iFM Bolton of the designated staff and their training competence | To be shared for the COVID-19 assurance records |
| ▪ decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance; | All general cleaning following the discharge of all patients is undertaken using a sodium hypochlorite sanitiser at 1000 parts per million (PPM) concentration in line with the national guidance or a Chlorine dioxide based sanitiser at least 240 ppm as approved by the Trust IPC team regardless of who undertakes the cleaning process – there are no other general cleaning agents available to ward/department staff for cleaning. When a patient is moved after a confirmed COVID-19 case, the bed space is cleaned by the domestic 'heavy duty' team who clean the bedspace and replace the disposable curtains. These cleans are arranged by the patient flow/site manager team and the record of cleans is recorded on an iFM Bolton portal | No gaps identified | Not applicable |
| ▪ assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; | Terminal cleans following outbreaks require the sign-off of a senior nurse such as a matron or one of the IPC team and are retained by the relevant domestic supervisor from Bolton iFM for future reference | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses; | All general cleaning following the discharge of all patients is undertaken using a sodium hypochlorite sanitiser at 1000 parts per million (PPM) concentration in line with the national guidance or a Chlorine dioxide based sanitiser at least 240 ppm as approved by the Trust IPC team regardless of who undertakes the cleaning process – there are no other general cleaning agents available to ward/department staff for cleaning. When a patient is moved after a confirmed COVID-19 case, the bed space is cleaned by the domestic 'heavy duty' team who clean the bedspace and replace the disposable curtains. These cleans are arranged by the patient flow/site manager team and the record of cleans is recorded on an iFM Bolton portal. Sanitising wipes based on quarternary ammonium compounds are also used for general cleaning purposes – all products are reviewed and approved by the Trust IPC service | No gaps identified | Not applicable |
| ▪ manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/ disinfectant solutions/products as per national guidance; | Trust staff are instructed to use cleaning products in line with the manufacturers' instructions. Bolton iFM staff who undertake the majority of environmental cleaning are trained, competency assessed and audited for cleaning efficacy at regular intervals by their domestic supervisors | Confirmation from iFM Bolton of the designated staff and their training competence | To be shared for the COVID-19 assurance records |
| ▪ a minimum of twice daily cleaning of:<br>○ areas that have higher environmental contamination | All clinical areas have two periods of planned cleaning in line with national guidance. Department based staff have established schedules for them to follow for the regular | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| rates as set out in the PHE and other national guidance;<br>○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails;<br>○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards;<br>○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; | cleaning of 'frequently touched' objects and electronic equipment.<br><br>Cleaning schedules compliance is included in the IPC Rapid Improvement Tool audits as described elsewhere<br><br>  <br>Aggregated Audit Reports 21-22.docx | | |
| ▪ reusable non-invasive care equipment is decontaminated:<br>○ between each use<br>○ after blood and/or body fluid contamination<br>○ at regular predefined intervals as part of an equipment cleaning protocol<br>○ before inspection, servicing or repair equipment;<br>▪ reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk; | This standard is included in the Trust Cleaning, Disinfection and Sterilisation Policy. Standards for the review of equipment cleaning and display of 'I am Clean' stickers is included in the monthly Rapid Improvement Tool audit | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken; | Staff are informed to manage linen from patients with COVID-19 as soiled. It is placed into alginate bags and then into bags to identify them as soiled linen for onward handling and management | No gaps identified | Not applicable |
| ▪ single use items are used where possible and according to single use policy; | Distinguishing and managing single-use items is included in the Trust Cleaning, Disinfection and Sterilisation Policy and IPC training. Staff are trained to understand the differences between single-use and single patient use | No gaps identified | Not applicable |
| ▪ cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment; | Audit of cleaning in non-clinical settings is conducted at the frequency set out in the Specification for the planning, application and measurement of cleanliness services in hospitals (2014) but is planned to be reviewed as part of the roll-out of the revised National standards of healthcare cleanliness 2021: health and safety. Mitigation is the responsibility of the relevant domestic supervisor | No gaps identified | From July 2021 revised cleaning audit reporting will be monitored monthly at the IPC Committee presented by Bolton iFM |
| ▪ where possible ventilation is maximised by opening windows where possible to assist the dilution of air | Staff have guidance to open windows for 5 minutes out of every 60 minutes throughout the day and night | This guidance has not been formally approved | Guidance to be taken to the next Cross-Division Operational Group in July for approval through the Trust Command and Control system and then for information at the August IPC Committee and an audit of compliance outlined |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| **3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** | | | |
| Systems and process are in place to ensure:<br>▪ arrangements for antimicrobial stewardship are maintained<br>▪ mandatory reporting requirements is adhered to and boards continue to maintain oversight | The Antimicrobial Stewardship Committee continues to meet on a quarterly basis and reports into the Drugs and Therapeutics Committee. Quarterly audits of antibiotic stewardship are also tabled and monitored at the IPC Committee.<br>  <br>09 Q4 2020 2021 Antimicrobial prescr<br><br>Compliance with the antimicrobial audits are included as part of the Trust Board Reports on a quarterly basis | No gaps identified | Not applicable |
| **4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.** | | | |
| Systems and processes are in place to ensure:<br>▪ national guidance on visiting patients in a care setting is implemented; | The Trust has currently restricted visiting to end-of-life care and for support of patients with dementia and learning disabilities (generally). Visiting for parents in paediatrics and neonatology and for parents in maternity service are exceptions to this.<br><br>The Trust Command and Control system has agreed three data points to be reached before visiting can be re-commenced:<br>1. End of national lockdown restrictions<br>2. Community case rates less than 100 per 100,000 population | No gaps identified | As of 09/07/21, community case rates in Bolton exceed 300 per 100,000 population and are increasing and there are still national lockdown restrictions.<br><br>Exempted visitors are assessed for safety before admission is permitted:<br>▪ Are they feverish? |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | 3. Sustained reduction in community case rates | | ▪ Do they have any signs/symptoms of COVID-19?<br>▪ Have they been notified that they are any contact of theirs has had COVID-19 confirmed in the preceding 10-days?<br><br>If the answer to any of these questions is yes then there admission is not permitted. Permitted visitors in paediatrics, neonatology and maternity are strongly advised to participate in the national LFT programme.<br><br>Once visiting is re-established, it will be by pre-arranged appointment only. An electronic appointment system has been commissioned and is currently going through a set-up process. |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access; | All inpatient departments have clear signage identifying their status as low, medium or high-risk areas and illustrate what PPE is required for entry.<br><br>There is no unrestricted access to any inpatient department; they are all access controlled by digital lock or card access. | No gaps identified | Not applicable |
| ▪ information and guidance on COVID-19 is available on all trust websites with easy read versions; | The comms team regularly update the section of the Trust providing information on a regular basis here | No gaps identified | Not applicable |
| ▪ infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved; | Service providers are responsible for sharing the infectious status of any patient prior to transfer to another organisation. This is included in the transfer document which has a prompt for known infections | No gaps identified | Not applicable |
| ▪ there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice. | The Trust has commissioned local poster messages regarding the use of face masks and hand hygiene and are displayed in appropriate areas. Challenging non-adherence is encouraged.<br><br>There are floor signs indicating 2-metre distances around the site to encourage social distancing | No gaps identified | Not applicable |
| ▪ Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has | | This paper has not been considered | To be tabled at July IPC Committee and to be discussed at COVID-19 Senior Management Team |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk) | | | |
| **5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people** | | | |
| Systems and processes are in place to ensure:<br>▪ screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases<br>▪ front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance;<br>▪ staff are aware of agreed template for triage questions to ask; | Patients are triaged pre-presentation in the emergency department when they attend by ambulance. Emergency department patients are triaged for signs/symptoms of COVID-19 and placed in accordance with their signs/symptoms (or lack thereof).<br><br>At all other admission points (elective and unplanned), patients are routinely assessed for signs/symptoms of COVID-19 by the reception staff and managed in accordance with any evident signs/symptoms<br><br>Patients in majors are tested using LFT to allow test positive patients to be segregated from test negative patients. LFT positive patients with signs/symptoms of COVID-19 are transferred directly to a COVID-19 cohort department reducing risk of exposure to other patients. This is done in line with REVISED Universal Screening for COVID-19 V8 22 12 20<br><br>Where practicable, all emergency department samples are tested using rapid test platforms returning results in less than 90-minutes allowing | The ability to effectively segregate patients with or without signs/symptoms of COVID-19 is challenging due to increased emergency demand in 2021 given the fixed footprint of the emergency department | ▪ Seating is socially distanced with at least 1m between seats<br>▪ Patients are encouraged to wear a face covering (preferably a FRSM which are provided)<br>▪ Patients are advised to wait outside of the department when the waiting areas are fully occupied for social distancing purposes |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | LFT negative patients to be allocated to a COVID-19 cohort department | | |
| ▪ triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; | Initial assessments are undertaken using the following agreed tool: Assessment Area COVID Triage Tool V1 01 09 20 | Initial triage is undertaken by non-clinical staff based on agreed questions for prompt segregation:<br>▪ Does the patient have a fever?<br>▪ Does the paper have a new/persistent cough?<br>▪ Does the patient have anosmia?<br>▪ Is the patient known to have COVID-19 or from a household with a known COVID-19 case?<br><br>All further clinical triage is undertaken by clinical staff | Not applicable |
| ▪ face coverings are used by all outpatients and visitors; | All patients and visitors are asked to wear face coverings whilst indoors at premises where Bolton FT operate services. All patients and visitors are offered FRSM which are a preference to face coverings | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; | Single rooms are prioritised according to clinical risk according to the Trust Isolation of Patients Policy. Patients who are immune compromised are given a high priority for a single room | The lack of single rooms is an acknowledged risk on the Trust risk register (risk 1315) | 20 additional single rooms have been created since the emergence of the pandemic reducing the medical bed base by 20 beds. There remain inadequate single rooms to provide assurance that all clinically extremely vulnerable patients can be provided with a single room<br><br>The Trust has 733 physical bed spaces 9excluding N-block). Of these 132 (18%) are single rooms |
| ▪ clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;<br>▪ monitoring of inpatients compliance with wearing face masks (particularly when | Patients are advised on admission that they should wear a face covering and there is an approved patient information leaflet: NHS Bolton Foundation Trust Covid Secure Leaflet V1 27 11 20 | As the guidance to wear a face covering is advisory only, compliance is not monitored but is encouraged | IPC to commence spot audits as part of their ward visits from July 2021 |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; | | | |
| ▪ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. | There is a 2-metre distance between each patient in their bed space in all inpatient departments when they are in bed. The wards now have a standard template layout to ensure that when they get out of bed into their chair they move further away from each other: chair-bed-lock-locker-bed-chair.<br><br>At reception areas, screens have been installed for the protection of reception staff | No gaps identified | Not applicable |
| ▪ isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; | In the event that an inpatient on a base ward becomes symptomatic in line with signs/symptoms of COVID-19 and they are tested, their bay is closed to new admissions, transfers and discharges to closed settings while the result is pending.<br><br>The IPC team oversee contact tracing in the event that the test result is positive | There are too few single rooms (currently 18% of the bed base is provided as single rooms) in the Trust to allow for patients to be isolated on the commencement of symptoms which is listed as risk 1315 on the Trust risk register | If patients are discharged to their own home and the symptomatic patient tests positive for COVID-19, the IPC team inform the discharged patient in line with the methodology of Test & Trace |
| ▪ patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly; | Test negative patients should undergo a clinical assessment in line with the agreed standard operating procedure Management of Suspected COVID-19 Cases V4 04 05 20 | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document; | Staff are advised to test patients in accordance with this document and the agreed Trust standard operating procedure: REVISED Universal Screening for COVID-19 V8 22 12 20 | Due to work demands and sickness in the IPC team there hasn't been capacity for screening compliance audits which is a time intensive process. These have now commenced on a rolling programme basis. | The IPC team will be undertaking compliance audits of five inpatient departments/week for compliance with screening on day 0, 3 and 5 of admission. These will be reported into the divisions directly and will be included monthly IPC reports to IPCC. This commenced from 12/07/21.<br><br>Business Intelligence are reviewing the practicalities of creating an automated audit tool. |
| ▪ patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately. | At patients are routinely assessed for signs/symptoms of COVID-19 by the reception staff and managed in accordance with any evident signs/symptoms. Where clinically appropriate these patients are deferred for their visit and advised to return home and arrange for a COVID-19 test. If there visit cannot be deferred, then they are isolated and managed as a suspected COVID-19 case until they are screened and a result is available. | No gaps identified | Not applicable |
| **6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection** | | | |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| Systems and processes are in place to ensure:<br>▪ patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas; | The Trust has clearly identified separate entrances and exits for staff and for patients and limited visitors | The hospital corridor system makes one-way systems unfeasible.<br><br>There aren't sufficient dining areas to have separate staff and patient/visitor areas | There is generally no visiting and the dining areas have limited capacity for seating. All seating provision is socially distanced. |
| ▪ all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe; | Staff are advised to wear as a minimum a Type IIR FRSM and eye protection for all patient contact. This exceeds the current national guidance and is outlined to staff in the approved document 'PPE Use V8 28.01.21'. Staff are advised to wear Type IIR FRSM when within 1m of each other.<br><br>Staff compliance is audited at least monthly as part of the IPC Rapid Improvement Tool audit. These audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps).<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), at the Trustwide | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | IPC Operational Group (alternate months) and IPC Committee (monthly).<br><br>Ad hoc audits may be taken by members of the IPC team with results and outcomes reported to and discussed with the relevant shift lead | | |
| ▪ all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; | Staff are advised to wear as a minimum a Type IIR FRSM and eye protection for all patient contact. This exceeds the current national guidance and is outlined to staff in the approved document 'PPE Use V8 28.01.21'. Staff are advised to wear Type IIR FRSM when within 1m of each other.<br><br>Training on use is provided locally according to local need and is included in the IPC statutory training.<br><br>Fit testing sessions which are recorded separately on the Trust ESR system include fit checking as part of the competency assessment. 4824 staff in current employment have been fit tested | No gaps identified | Not applicable |
| ▪ a record of staff training is maintained; | | Compliance for June 2021 is 92% for the Trust overall. This equates to 158 of 5379 staff being non-compliant in order to achieve 95% | This will be an agenda item at July IPCC and reporting and monitoring will continue on a monthly basis |
| ▪ adherence to PHE national guidance on the use of PPE is | Staff compliance is audited at least monthly as part of the IPC Rapid Improvement Tool audit. | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| regularly audited with actions in place to mitigate any identified risk; | These audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps).<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), at the Trustwide IPC Operational Group (alternate months) and IPC Committee (monthly).<br><br>Ad hoc audits may be taken by members of the IPC team with results and outcomes reported to and discussed with the relevant shift lead as a result of incidents, risks or outbreaks identified | | |
| ▪ hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:<br>○ hand hygiene facilities including instructional posters;<br>○ good respiratory hygiene measures;<br>○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; | There are hand hygiene points at all entrances. There are hand wash basins at the entrance to all inpatient departments. Every hand wash basin has directions for the appropriate method of hand washing or cleaning.<br><br>There are face mask dispensers at every entrance and regular advisory posters about their use and disposal.<br>Expectation of staff behaviours is included regularly in weekly staff comms – including a sustained campaign "Are You Safe to be Here" | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace;<br>○ frequent decontamination of equipment and environment in both clinical and non-clinical areas;<br>○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. | | | |
| ▪ staff regularly undertake hand hygiene and observe standard infection control precautions; | Hand hygiene audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps).<br><br>Results of audits are reviewed in the divisional governance meetings (monthly), at the Trustwide IPC Operational Group (alternate months) and IPC Committee (monthly).<br><br>In June, reported compliance is 55-100%. Where audits are not completed or compliance is poor, the department is responsible for developing a | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | plan to promote compliance with the assistance of the IPC team as required.<br><br>Ad hoc audits may be taken by members of the IPC team with results and outcomes reported to and discussed with the relevant shift lead | | |
| ▪ the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance; | There are no hand dryers in clinical areas.<br><br>Towel dispensers are mounted close to hand wash basins but out of the risk of splash contamination. | No gaps identified | Not applicable |
| ▪ guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas; | Appropriate guidance is displayed | No gaps identified | Not applicable |
| ▪ staff understand the requirements for uniform laundering where this is not provided for onsite; | Appropriate laundering of uniforms and work wear guidance is included in the approved Trust Uniform and Dress Code Policy<br><br>  <br>Uniform and Dress Code Policy FINAL Se | No gaps identified | The policy is currently under review to accommodate for changes made during the pandemic |
| ▪ all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild | The common signs/symptoms of COVID-19 and an expectation of staff to not attend work if they have these symptoms is included in the | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms; | approved document: Staff Pre-Work Health Checks v1 02 11 20<br><br>His is a recurring message as part of the comms department “Are You Safe to be Here” campaign | | |
| ▪ a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals); | Community test rates are shared with the Trust senior management team regularly during the week including the implications for impact on the Trust.<br><br>The Trust has an approved escalation dashboard which includes the hospital COVID-19 cases (COVID alert level - daily dashboard). This is updated and shared daily Mon-Fri and discussed at every Cross Division Operational Group and COVID-19 Senior Management Team meeting | No gaps identified | Not applicable |
| ▪ positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported; | Every COVID-19 case from a sample collected more than eight days after admission is reviewed by the IPC team. This automatically triggers a round of whole ward screening to identify any further cases.<br><br>Two or more cases linked to a department within a 14-day period instigates an Outbreak Control Team convening in line with the Trust Outbreak Management Policy | There is an understood process regarding the monitoring of COVID-19 cases identified more than eight days after admission and consequent actions. This has not been incorporated into a formal approved procedure | The IPC team are developing a standard operating procedure to outline agreed actions in managing cases. For approval at the August IPC Committee |
| ▪ robust policies and procedures are in place for the identification of and management of outbreaks of | The IPC team follows the Trust Outbreak Management Policy. Records of all Outbreak Control Team meetings are kept | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| infection. This includes the documented recording of outbreak meetings. | | | |
| **7. Provide or secure adequate isolation facilities** | | | |
| Systems and processes are in place to ensure:<br>▪ restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/ individuals, visitors or staff; | There is restricted access between pathways of different COVID-19 risk profiles. The exception to this are in assessment areas where suspected COVID-19 cases and patients not suspected of having COVID-19 are managed in the same department albeit segregated. The other exception is critical care which manages COVID-19 and non-COVID-19 cases – again segregated from one another | No gaps identified | Not applicable |
| ▪ areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; | All inpatient departments have clear signage identifying their status as low, medium or high-risk areas and illustrate what PPE is required for entry. | No gaps identified | Not applicable |
| ▪ patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate; | Generally:<br><br>Every effort is made to understand the COVID-19 status of a patient before placement (e.g. using LFT and rapid PCR testing).<br><br>There are designated areas in the emergency and assessment departments where suspected patients are managed separate from patients who are test negative and are asymptomatic. | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | Otherwise confirmed positive patients are managed in whole cohort wards to ensure segregation from non-COVID-19 patients.<br><br>Critical care has designated areas for COVID-19 and non-COVID-19 patients to allow for physical segregation and segregation of staff.<br><br>In specific specialties COVID-19 positive patients may be managed on a ward with non-COVID-19 positive patients due to the delivery of specialist services that can't be duplicated elsewhere. This includes:<br>▪ Paediatrics<br>▪ Neonatology<br>▪ Maternity services<br><br>Occasionally patients need to remain in a specialist area.<br><br>Where these instances occur, the patients are maintained in single rooms with designated toilet facilities on the advice and supported by the IPC team to reduce the risk of transmission. | | |
| ▪ areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance; | | None of the hospital inpatient departments are compliant with national guidance. They were at the time of planning and construction but now fall short in terms of | Due to the limitations of the estate, a model of departments being ring-fenced for single risk pathways with the exception of assessment areas |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | | ventilation, single room provision, provision of en-suite facilities in single rooms and bays and patient space.<br><br>Based on the standards included in the current Health Building Note a current inpatient department should accommodate 50-80% single room capacity. This leaves the Trust short by between 234 (50%) and 544 (80%) single rooms | |
| ▪ patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement. | Patients with alert or resistant organisms are managed according to the relevant policy in combination with the Trust Isolation of Patients Policy.<br><br>See:<br>▪ MRSA Policy<br>▪ Management of *Clostridium difficile* Policy<br>▪ Multi-drug Resistant Organism Policy<br>▪ Carbapenemase Producing Enterobactericae Policy<br>▪ Management of Tuberculosis Policy<br>▪ Norovirus Policy<br>▪ Chicken Pox and Shingles Policy | No gaps identified | Not applicable |
| **8. Secure adequate access to laboratory support as appropriate** | | | |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| There are systems and processes in place to ensure:<br>▪ testing is undertaken by competent and trained individuals; | All COVID-19 testing is done in-house as is the majority of microbiology testing. The Bolton laboratories were re-accredited with UKAS (United Kingdom Accreditation Service) in 2021 | No gaps identified | Despite the increase in PCR capacity enabled by the purchase of the Hologic Panther system, most of the capacity is monopolised for COVID-19 testing. A second platform has been committed to create additional capacity to accommodate flu, RSV and other more routine PCR testing (such as sexual health samples) |
| ▪ patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance; | All COVID-19 testing for staff and patients is undertaken in-house in the local UKAS accredited laboratory using manufacturers guidance. All test platforms have undergone a formal validation process in line with PHE and UKAS standards. The platforms are platforms assessed and approved by PHE:<br>▪ Becton Dickinson Max (now stood down)<br>▪ Hologic Panther<br>▪ Cepheid GeneXpert<br>▪ Roche LIAT | No gaps identified | Not applicable |
| ▪ regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; | Turnaround times a for testing are monitored and since January 2021 95% of samples were processed within 15-hours of sample collection and 98% within 24-hours | Turnaround times have been monitored but not formally reported | Now on the division of Diagnostic Support Services Integrated Performance Management KPIs |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) | The lab reports using the PHE Second Generation Surveillance System | No gaps identified | Not applicable |
| ▪ screening for other potential infections takes place | Patients with symptoms of respiratory infections that are negative for SARS-CoV-2 proceed to testing by influenza (A and B) and RSV – were possible testing for all three is conducted concurrently, if not, then consecutively | | Clear testing pathways are being developed for Trust use in advance of the projected RSV and flu season |
| ▪ that all emergency patients are tested for COVID-19 on admission; | Standard operating procedure (SOP) for the triage and management of patients in the emergency department using lateral flow tests followed by a PCR test for SARS-CoV-2 for all admissions.<br><br>The Trust has a Universal Screening for SARS-CoV-2 Policy.<br><br>These have been approved by the Trust COVID-19 Command Structure. | Due to work demands and sickness in the IPC team there hasn't been capacity for screening compliance audits which is a time intensive process. These have now commenced on a rolling programme basis. | The IPC team will be undertaking compliance audits of five inpatient departments/week for compliance with screening on day 0, 3 and 5 of admission. These will be reported into the divisions directly and will be included monthly IPC reports to IPCC. This commenced from 12/07/21.<br><br>Business Intelligence are reviewing the practicalities of creating an automated audit tool. |
| ▪ that those inpatients who go on to develop symptoms of COVID-19 after admission are | The need for repeat testing should a patient go on to develop symptoms of COVID-19 is outlined in the approved universal screening standard | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| retested at the point symptoms arise;<br>▪ that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission | operating procedure as is the need for repeat screening on days three and five: REVISED Universal Screening for COVID-19 V8 22 12 20 | | |
| ▪ that sites with high nosocomial rates should consider testing COVID negative patients daily; | Bolton is not currently a site with high nosocomial rates.<br>  <br>04c GM Comparison Report<br><br>There is a programme of weekly screens beyond day five in all medical wards and patients in respiratory medicine are screened twice weekly due to the potential for efficient transmission if they do develop COVID-19 | No gaps identified | Not applicable |
| ▪ that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge; | This standard is covered in the approved document: REVISED Universal Screening for COVID-19 V8 22 12 20 | No gaps identified | Not applicable |
| ▪ that patients being discharged to a care facility within their 14 day isolation period are | The Bolton system does not currently provide a facility for the segregation of patients to | No gaps identified | This decision is reviewed regularly in |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| discharged to a designated care setting, where they should complete their remaining isolation | complete their 14-day isolation if they are COVID-19 contacts | | response to the size of the right to reside list |
| ▪ that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission. | This standard is covered in the approved document: REVISED Universal Screening for COVID-19 V8 22 12 20. Some patients with high risk of respiratory complication (and subsequent need for critical care admission) are asked to self-isolate for 14-days | No gaps identified | Not applicable |
| **9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections** | | | |
| Systems and processes are in place to ensure:<br>▪ staff are supported in adhering to all IPC policies, including those for other alert organisms; | The patient administration system has an alerting system and alerts are added to allow staff to visualise patients who may be a risk to others.<br><br>There are policies related to the key alert organisms for appropriate patient management.<br><br>The IPC team are available on site 7-days/week and when they are not available IPC advice is available via the on-call medical microbiologist | No gaps identified | Not applicable |
| ▪ any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff; | The Trust has a single point of contact (SPC) for nationally distributed communications including IPC guidance (emergency.plannin2@boltonft.nhs.uk) which is monitored regularly 7 days/week (by the business continuity manager/ administrative support Mon-Fri) and the Tier 1 manager out of hours. Any relevant guidance is forwarded to the IPC team for review and local interpretation. | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | Changes are agreed through the Trust command and control structure which are currently planned for fortnightly meetings (surging to weekly, twice weekly and daily meetings where required). Should it be required, ad hoc meetings can be convened at short notice for the governance oversight of any documents for approval and communication | | |
| ▪ all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance; | Staff are informed to manage linen from patients with COVID-19 as soiled. It is placed into alginate bags and then into bags to identify them as soiled linen for onward handling and management.<br><br>All discarded waste from COVID-19 positive patients is discarded and managed as infectious or clinical waste | No gaps identified | Not applicable |
| ▪ PPE stock is appropriately stored and accessible to staff who require it. | PPE is supplied to clinical departments on a 'push' basis on a daily basis according to their need. Additional PPE is available from the Trust procurement team by telephone request 9-5 Mon-Fri.<br><br>Additional PPE is available 24/7 - a small stock is stored in the site manager's office which is staffed 24/7 and a larger resilience store is accessible 24/7 with additional PPE. | No gaps identified | Not applicable |
| **10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection** | | | |
| Appropriate systems and processes are in place to ensure:<br>▪ staff in 'at-risk' groups are identified using an appropriate | All managers have been asked to complete a COVID-19 staff risk assessment unless there is a clear and documented rationale for not | No gaps identified | Compliance with the completion of risk assessments to be reported to August IPC |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported;<br>▪ that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff; | completing one. Mitigation for any risks identified is a component of the risk assessment. | | Committee by the divisions |
| ▪ staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally;<br>▪ members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm;<br>▪ a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of | All staff who are required to wear respiratory protective equipment are trained individually using face fit testing and their competence recorded on the ESR system.<br><br>Staff who fail the face fit test or who are unable to be face fit tested (for example – if they wear facial hair) are offered re-deployment to an environment where RPE use won't be required or are trained and competency assessed in the use of a Powered Air-Purifying Respirator (PAPR). This is also recorded on the ESR system and accounts for 111 members of staff<br><br>Records of re-deployment are held in the staff member's personnel file following a discussion with their manager | No gaps identified | Divisions to compile a report of the number of staff who have been redeployed in response to their risk assessment for August IPC Committee |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| employment record including Occupational health;<br>▪ following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; | | | |
| ▪ staff who carry out fit test training are trained and competent to do so; | The Trust has a small number of staff who have been trained as face fit tested from HSE registered training providers and are competent to face fit test and train others to face fit test. There is a larger pool of staff within the division who have all completed training and completed a competency assessment form in line with the Trust Health and Safety Officer and HSE guidance.<br><br>The Trust also has access to external face fit test staff via a contract with the NHS who are also assessed as being competent under HSE requirement. There are two on regular allocation with a third individual who also supports the process. They have been working with the Trust since November 2020 and are currently intended to remain allocated to BFT until at least September 2021. | No gaps identified | This process is being reviewed in light of new guidance regarding the letter published 17/06/21 “FFP3 Resilience in the Acute setting”. A longer-term approach will be developed and taken for discussion and approval through the Trust command and control system<br><br>  <br>FFP3_Resilience_in_the_Acute_setting_1 |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | These staff are assessed as competent to use qualitative or quantitative models for fit testing or both | | |
| ▪ all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used; | Staff are advised that their face fit testing is suitable for a specific model only and in order to use another model they require additional face fit testing. The model they have been tested for is included in their personal training record and on their fit test certificate | No gaps identified | Not applicable |
| ▪ a record of the fit test and result is given to and kept by the trainee and centrally within the organization<br>▪ those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; | There is an approved standard fit test certificate which is given at the end of each successful fit test assessment which includes sensitivity, model, date and guidance for staff. Each staff member is given a copy and a copy is scanned and entered onto the ESR system.<br><br>Failed fit tests are also recorded on the ESR system | No gaps identified | Not applicable |
| ▪ boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board; | All fit test records are held centrally on the Trust ESR system. | The fit testing records are not currently shared with the Board regularly | The Fit Testing Operations Group is reviewing the guidance published in a letter from the Department of Health and Social Care (FFP3 Resilience in the Acute setting 17 June 21). A paper will be submitted to the August IPC Committee for approval |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| ▪ consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/ elective care pathways and urgent/ emergency care pathways as per national guidance; | Staff are rarely moved between risk categories (e.g. from medium to high-risk area). Staff are moved only to provide safe care based on a number of factors.<br><br>Staff movement is a standing agenda item on OCT agendas for COVID-19 outbreaks. | The divisions are unable to provide assurance that staff will not be moved from one pathway to another | Staffing decisions are made on the basis of understanding the totality of the risk. The Pandemic has created a number of contrasting risks related to staffing:<br>▪ Increased staff absence due to COVID-19 illness or self0isolating due to actual or potential household contacts with COVID-19<br>▪ Temporary wards established due to increased demand for beds<br><br>Decisions that have a directly observable risk of COVID-19 transmission related to staff movements are discussed as part of outbreak management meetings |
| ▪ all staff to adhere to national guidance and are able to maintain 2 metre social & | Staff are advised to wear as a minimum a Type IIR FRSM and eye protection for all patient contact. This exceeds the current national | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas; | guidance and is outlined to staff in the approved document 'PPE Use V8 28.01.21'. Staff are advised to wear Type IIR FRSM when within 1m of each other.<br><br>Staff compliance is audited at least monthly 70 wards/departments with a minimum of 10 observations per ward/department per month as part of the IPC Rapid Improvement Tool audit. These audits are undertaken at least monthly in all clinical services. The Trust uses a 'buddy' system where an objective auditor from another service completes the audit. All audits are entered into an internal audit monitoring system (Secure Apps). | | |
| ▪ health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;<br>▪ staff are aware of the need to wear facemask when moving through COVID-19 secure are; | The Trust has retained a command and control structure for decision making and review of any relevant COVID-19 risk assessments that have an impact beyond the division and are documented in the minutes and decision logs.<br><br>Local COVID-19 risk assessments are the responsibility of the divisional governance structures following the existing Trust governance processes.<br><br>There are regular updates of the COVID-secure workplace assessments through positive assurance reports to the Group Health and Safety Committee and are evidenced in the Group Health and Safety minutes. | No gaps identified | Not applicable |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | This includes the requirement to wear a facemask when sharing or moving through a COVID-19 secure area | | |
| ▪ staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing | All COVID-19 related absence is managed by the HR Attendance Matters team. This includes guidance to support for financial hardship in line with the national provision where appropriate.<br><br>Staff are able to access testing via the Attendance Matters for themselves or household contacts through a drive through and limited home visit model | No gaps identified | Not applicable |
| ▪ staff who test positive have adequate information and support to aid their recovery and return to work. | Simple COVID-19 infections in staff are managed by the HR Attendance Matters team. They advise on the duration of self-isolation in line with the current national guidance and what parameters need to be satisfied before returning to work. More complex infections or episodes consistent with Long COVID are referred to the Occupational Health service as required.<br><br>Departmental procedure guides are available. | No gaps identified | HR and OH respectively to supply the total number of staff supported through the Attendance Matters team (simple infections) and currently under the management of OH for long-COVID infections |

# Ockenden Report

# Immediate and Essential Actions

Submission date

June 30th 2021

# What is the Ockenden Report?

- **Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST**
- After reviewing 250 cases and listening to many more families the report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

# What is the Ockenden Report?

- With support of the Department of Health and Social Care and NHSE/I it shares emerging findings and themes, has Local Actions for Learning and makes early recommendations which it sees as Immediate and Essential Actions.
- It appeals for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

# Immediate and Essential Actions

- Following the Report, Immediate and Essential Actions has developed into a request for providers to assess themselves against 47 questions and provide evidence to support their assessment
- This has been undertaken with the support of the Local Maternity System
- There was a requirement to upload all supporting evidence to a central portal by 30th June

| Immediate and Essential Action | Number of questions in action | No evidence | Partial evidence | Full evidence | Comments |
|---|---|---|---|---|---|
| Enhanced Safety | 8 | 0 | 1 | 7 | Exception report and action plan written for Q3 - detail of serious incidents at Trust Board |
| Listening to Women and Families | 6 | 0 | 0 | 6 | ** questions 9 and 10 are not for providers to answer and have been removed from the total |
| Staff Training and Working Together | 7 | 0 | 0 | 7 | |
| Managing Complex Pregnancy | 6 | 0 | 0 | 6 | |
| Risk Assessment Throughout Pregnancy | 4 | 0 | 0 | 4 | |
| Monitoring Fetal Well-being | 5 | 0 | 0 | 5 | |
| Informed Consent | 6 | 0 | 0 | 6 | |
| Midwifery Leadership | 4 | 0 | 0 | 4 | |
| NICE Guidance Related to Maternity | 1 | 0 | 0 | 1 | |
| Total | 47 | 0 | 1 | 46 | |

- We are compliant for 46 of 47 questions, and partially compliant for the 1 remainder.
- We have assessed our evidence against the requirements from NHSE/I and with support from the LMS.
- This has formed the basis for our assessment as partial or full evidence.

| Immediate and Essential Action 1: Enhanced Safety | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 1 | Q1 | Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. | **Confirmation of a Maternity Services Dashboard**<br><br>**Confirmation this is seen by the LMNS at least Quarterly** | Serious Incident Policy - draft<br>Organogram from LMS<br>Family Care Governance Policy<br>Maternity IPM dashboard<br>Action plan from maternity IPM<br>Divisional Governance Report |
| | Q2 | External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. | **Confirmation of external specialist opinion on reviews** | External review process<br>HSIB case update<br>Email from NHSR<br>SI progress report<br>SOP for PMRT |
| | Q3 | All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months | Confirmation that SI **GO TO Trust Board** (nab not a sub group of board such as Quality group)<br><br>Confirmation that a *SUMMARY* of SI key issues goes to Trust Board<br><br>Confirmation that SI **GO TO LMNS Board**<br><br>Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board<br><br>Each of the above happen **quarterly** | ToR from Safety SIG<br>Agendas and minutes from Safety SIGs<br>QAC Chair report to Board<br>Trust Board minutes<br>Incident reporting template<br>ICEO reports<br>Final SI report for QAC<br>Exception report and action plan |

| Immediate and Essential Action 1: Enhanced Safety | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 1 | **Q4** | CNST Action 1 | Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | **Confirmation that PMRT is undertaken** see PMRT Tab | SOP for PMRT<br>Divisional paper on MBRACE report<br>Minutes from case review meeting<br>PMRT Board Report<br>PMRT audit |
| | **Q5** | CNST Action 2 | Are you submitting data to the Maternity Services Dataset to the required standard? | **Confirmation that Monthly score card completed** (13 mandatory criteria) | Dashboard<br>Confirmation email |
| | **Q6** | Action 10 | Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme? | Confirmation that **100% of** cases are reported to HSIB & NHS Resolution | Email from NHSR<br>HSIB case update |

| Immediate and Essential Action 1: Enhanced Safety | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 1 | **Q7** | (a) | A plan to implement the Perinatal Clinical Quality Surveillance Model | Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented | CN Surveillance presentation from National Call<br>Quality Surveillance paper.<br>Presentation to Divisional Board |
| | **Q8** | (b) | All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB | Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group)<br><br>**Confirmation that SI go to LMNS Board**<br><br>**Each of the above happen Monthly** | Serious Incident Policy - draft<br>ToR Maternity Safety SIG<br>QAC Chair report to Trust Board<br>Trust Board minutes<br>SI action plan<br>CEO reports |

| Immediate and Essential Action 2: Listening to Women and Families | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 2 | Q9 | Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. | No expectation that this action is met - national guidance awaited | |
| | Q10 | The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. | No expectation that this action is met - national guidance awaited | |
| | Q11 | Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. | Confirmation of an identified Trust Board Non Exec | Trust Board minutes<br>NED JD<br>Safety Champions poster<br>Safety Champions plan |

| Immediate and Essential Action 2: Listening to Women and Families | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA.2 | **Q12** | Action 1 | Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | Confirmation that PMRT is undertaken<br>Confirmation that Parents are involved | SOP for PMRT<br>Divisional paper on MBRACE report<br>Minutes from case review meeting<br>PMRT Board Report<br>PMRT audit |
| | **Q13** | Action 7 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services | ToR for the MVP<br>Report to Patient Experience and Inclusion Committee<br>Minutes and notes from meetings<br>MVP Charter on service changes due to Covid-19<br>MVP chair job description<br>MVP response to service change (companion policy)Gap analysis comms tool kit<br>Data from focus group session in BL3<br>FFT results<br>GMEC LMS Co-production<br>Spoons evaluation<br>Ingleside evaluation<br>PEIC report<br>7 examples of MVP feedback<br>MVP response to Ockenden<br>Complaints Procedure |
| | **Q14** | Action 9 | Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues? | Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity | MatNeo divisional safety group ToR<br>Minutes from divisional meetings<br>Minutes from meetings with Exec safety champion<br>Safety Champions poster<br>National safety champions roles<br>Safety Champions plan |

| Immediate and Essential Action 2: Listening to Women and Families | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 2 | **Q15** | A | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. | Same score as Q13 | ToR for the MVP<br>Report to Patient Experience and Inclusion Committee<br>Minutes and notes from meetings<br>MVP Charter on service changes due to Covid-19<br>MVP chair job description<br>MVP response to service change (companion policy)Gap analysis comms tool kit<br>Data from focus group session in BL3<br>FFT results<br>GMEC LMS Co-production<br>Spoons evaluation<br>Ingleside evaluation<br>PEIC report<br>7 examples of MVP feedback<br>MVP response to Ockenden |
| | **Q16** | B | In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. | Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director | Chief Nurse JD<br>NED / Safety Champion JD<br>Minutes of Safety Champions Exec meetings<br>Safety Champions plan |

| Immediate and essential action 3: Staff Training and Working Together | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 3 | **Q17** | Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. | **Training together:**<br><br>Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year | PROMPT booking form<br>Training Needs Analysis |
| | **Q18** | Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. | **Working together:**<br><br>Confirmation of **ALL** criteria requested | Ward round standards & audit paper v2 16.04.21<br>Handover Documentation audit<br>Bolton FT Consultant Ward Round Guideline |
| | **Q19** | Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training) | Confirmation of ring fenced Maternity training budget | Training allocation and spend 20/21 |

| Immediate and essential action 3: Staff Training and Working Together | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 3 | Q20 | Action 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | See Section 2 | BoD staffing report<br>BirthRate Plus update report (GMEC)<br>Minutes from LMS meeting<br>Ockenden Report |
| | Q21 | Action 8 | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | 90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers) | TNA<br>PROMPT training report<br>Anaesthetists PROMPT training log<br>Core theatre staff training log |
| IEA 3 | Q22 | | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | See Q18 | Ward round standards & audit paper v2 16.04.21<br>Handover Documentation audit<br>Bolton FT Consultant Ward Round Guideline |
| | Q23 | | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place | See Q17 | TNA<br>PROMPT Booking form<br>PROMPT training report<br>Anaesthetists PROMPT training log<br>Core theatre staff training log |

| Immediate and essential action 4: Managing Complex Pregnancy | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 4 | Q24 | Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. | Agreement reached on Criteria for referral to Mat Med Specialist Centre | Summary Document re Maternal Medicine Network (V3).<br>Screenshot page of where to view guidelines including link to website<br>Management of Complex Pregnancy Audit Proforma<br>10 BFT adopted GMEC guidelines<br>Audit - named consultant<br>Audit - Management of Complex Pregnancy<br>Referral pathways guideline |
| | Q25 | Women with complex pregnancies must have a named consultant lead | Named consultant lead for all women identified = Yes | a. Summary Document re Maternal Medicine Network (V3).<br>b. Screenshot page of where to view guidelines including link to website<br>c. Management of Complex Pregnancy Audit Proforma<br>d. SOP consultant referral<br>e. Complex Pregnancy Audit |
| | Q26 | Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team | Referenced to specialist involvement AND management plans developed | Summary Document re Maternal Medicine Network (V3).<br>Screenshot page of where to view guidelines including link to website<br>Management of Complex Pregnancy Audit Proforma<br>10 BFT adopted GMEC guidelines<br>Audit - named consultant<br>Audit - Management of Complex Pregnancy |

| Immediate and essential action 4: Managing Complex Pregnancy | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 4 | **Q27** | Action 6 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | Confirmation of compliance with **ALL** elements | All evidence from GMEC SBL group (minutes, audits, guidelines, performance)<br>Extracts from data systems<br>Minutes from Bolton SBL meeting |
| IEA 4 | **Q28** | A | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | Confirmation of consultant lead **AND** regular Audit of Compliance in place | Summary Document re Maternal Medicine Network (V3).<br>Screenshot page of where to view guidelines including link to website<br>Management of Complex Pregnancy Audit Proforma<br>SOP consultant referral<br>Complex Pregnancy Audit<br>Leaflets<br>Named Consultant audit |
| | **Q29** | B | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Confirmation that Trust is developing their local actions as part of an agreed Network approach | Summary Document re Maternal Medicine Network (V3).<br>Screenshot page of where to view guidelines including link to website |

| Immediate and essential action 5: Risk Assessment Throughout Pregnancy | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 5 | Q30 | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | Risk Assessment at **EVERY** AN Contact | Standardised risk assessment and audit form:<br>Personalised Care and Support Plan Audit Proforma FINAL V1<br>Personalised Care and Maternal Choice Guideline<br>Audit - Personalised Care and Choice<br>Audit - Risk Assessment at every appt<br>Antenatal Care guideline |
| | Q31 | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Review of place of birth in risk assessment at **ALL** AN contacts | Standardised risk assessment and audit form:<br>Personalised Care and Support Plan Audit Proforma FINAL V1<br>Personalised Care and Maternal Choice Guideline<br>Audit - Personalised Care and Choice<br>Audit - Risk Assessment at every appt<br>Antenatal care guideline |

| Immediate and essential action 5: Risk Assessment Throughout Pregnancy | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 5 | **Q32** | Action 6 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | See Q27 | All evidence from GMEC SBL group (minutes, audits, guidelines, performance)<br>Extracts from data systems<br>Minutes from Bolton SBL meeting |
| IEA 5 | **Q33** | A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. | | Are PCSPs in place AND are they audited | Standardised risk assessment and audit form:<br>Personalised Care and Support Plan Audit Proforma FINAL V1<br>.Digital Personalised Maternity Care Plan GMEC LMS Final<br>Website screenshot<br>Audit - Personalised Care<br>Antenatal Care guideline |

| Immediate and essential action 6: Monitoring Fetal Wellbeing | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 6 | Q34 | All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing. | **BOTH** MW and Obstetrician in place | Obstetrician JD<br>Midwife JD<br>GMEC IA working group minutes<br>PROMPT CTG station AJT<br>CTG training plan<br>SBAR report<br>Incident review |
| | Q35 | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:<br>- Improving the practice of monitoring fetal wellbeing<br>- Consolidating existing knowledge of monitoring fetal wellbeing<br>- Keeping abreast of developments in the field<br>- Raising the profile of fetal wellbeing monitoring<br>- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported<br>- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.<br>- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.<br>- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.<br>- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines. | JD fulfils **ALL** criteria | Obstetrician JD<br>Midwife JD<br>GMEC IA working group minutes<br>PROMPT CTG station AJT<br>CTG training plan<br>SBAR report<br>Incident review |

| Immediate and essential action 6: Monitoring Fetal Wellbeing | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 6 | **Q36** | Action 6 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | See Q27 | All evidence from GMEC SBL group (minutes, audits, guidelines, performance)<br>Extracts from data systems<br>Minutes from Bolton SBL meeting<br>Audit - RFM<br>MatNeo SIP update |
| | **Q37** | Action 8 | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | See Q21 | PROMPT training report<br>Anaesthetists PROMPT training log<br>Core theatre staff training log<br>TNA |

| Immediate and essential action 7: Informed Consent | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|
| IEA 7 | Q39 | All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. | ALL place of birth information easily accessible | Screen shot and Link to My Birth My Choice website with mention of content of website and accessibility tool Browsealoud<br>Guide to Browsealoud<br>Antenatal education website screen shot<br>VBAC study<br>GMEC Unassisted birth guideline FINAL V1.0 14.08.2020<br>SOP - refusing C-section<br>C-section leaflet<br>C-section guideline<br>Antenatal care Guideline<br>Audit - personalised care and Choice<br>BFT Personalised Care and Choice Guideline |
| | Q40 | All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care | ALL information is easily accessible | |
| | Q41 | Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care | Confirmation that trust HAS a method of recording decision making processes that includes women's participation & informed choice | |
| | Q42 | Women's choices following a shared and informed decision-making process must be respected | Reference made to how Women's choices are respected and evidenced | Antenatal Care Guideline<br>BFT Personalised Care and Choice Guideline<br>Audit - Personalised Care and Choice |

| Immediate and essential action 7: Informed Consent | | | | Assessment Criteria | Evidence submitted |
|---|---|---|---|---|---|
| IEA 7 | **Q43** | Action 7 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | See Q13 | ToR for the MVP<br>Report to Patient Experience and Inclusion Committee<br>Minutes and notes from meetings<br>MVP Charter on service changes due to Covid-19<br>MVP chair job description<br>MVP response to service change (companion policy)Gap analysis comms tool kit<br>Data from focus group session in BL3<br>FFT results<br>GMEC LMS Co-production<br>Spoons evaluation<br>Ingleside evaluation<br>PEIC report<br>7 examples of MVP feedback<br>MVP response to Ockenden |
| IEA 7 | **Q44** | Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website. | | All information **ON** trust website | Gap analysis from Bolton MVP |

| SECTION 2: WORFORCE PLANNING | | | Assessment Criteria | Evidence in folder |
|---|---|---|---|---|
| Link to Maternity Safety Actions: | | | | |
| **Q45** | Action 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard | Midwifery workforce planning system **in PLACE** | BoD staffing report<br>BirthRate Plus update report (GMEC)<br>Minutes from LMS meeting<br>Ockenden report |
| **Q46** | Action 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards | BoD staffing report |

| SECTION 2: WORFORCE PLANNING | | Assessment Criteria | Evidence in folder |
|---|---|---|---|
| **Midwifery Leadership** | | | |
| **Q47** | Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director | Evidence the Director/Head of Midwifery responsible and accountable to an executive Director | HoM job description |
| **Q48** | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:<br><br>1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service<br>2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally<br>3. More Consultant midwives<br>4. Specialist midwives in every trust and health board<br>5. Strengthening and supporting sustainable midwifery leadership in education and research<br>6. A commitment to fund ongoing midwifery leadership development<br>7. Professional input into the appointment of midwife leaders | **Meets ALL** that apply<br>**Note - Trusts would not lead on actioning all seven steps** | Midwifery Leadership Review |
| **NICE Guidance related to maternity** | | | |
| **Q49** | We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified. | **ALL** guidance assessed & implemented = Yes (GREEN) | Gap analysis<br>Policy document |

# Next Steps

- As you can see from our submission alone, there is a lot of evidence for NHS England and Improvement to review and assess
- We continue to be guided by our LMS
- We continue to deliver on our essential safety actions e.g.
  - Saving Babies Lives
  - PROMPT training
  - Mat Neo SIP
  - PMRT review
  - Fetal monitoring training

# Ockenden Report

# Immediate and Essential Actions

Thank You

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| **Title:** | Ockenden Report Evidence Submission |

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| **Meeting:** | Board of Directors | **Purpose** | Assurance | X |
| **Date:** | 29th July 2021 | | Discussion | X |
| **Exec Sponsor** | Karen Meadowcroft | | Decision | |

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| **Summary:** | • As recommended by the Ockenden Report, NHS England and Improvement requires providers of maternity services to assess against 47 questions as part of the Immediate and Essential Actions.<br>• With support from their Local Maternity System, all maternity services were asked to submit evidence in support of this assessment by 30th June 2021.<br>• BFT Maternity service are compliant for 46 of 47 questions, and partially compliant for the 1 remainder.<br>• This presentation (Appendix 1) summarises the evidence submitted by Bolton NHS FT. |

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| **Previously considered by:** | Family Care Division – Senior Leadership Team |

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| **Proposed Resolution** | To update on the current Trust position and outstanding actions |

| **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:** | Debora Tinsley<br>Natasha MacDonald | **Presented by:** | Karen Meadowcroft<br>Chief Nurse |

Agenda Item

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| **Title:** | People Committee Chairs' Reports June/July 2021 |

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| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 29th July 2021 | | Discussion | |
| **Exec Sponsor** | James Mawrey | | Decision | |

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| **Summary:** | This report provides an update on the June and July People Committee.<br><br>The following matters are worthy of noting in this summary section:-<br><br>1. Whilst the recent Bolton Go Engage survey notes engagement levels remain consistently high, concern was expressed in the meeting regarding this quarter's drop in the Staff Friends & Family test questions (Recommend as a place to work; Recommend as a place to received care). It was also noted by the Divisions that staff fatigue is having an impact on morale levels.<br><br>2. Agency spend remains high due to the pressures facing the organisation – Urgent Care, Elective Recovery and unavailability (absence/vacancies). A plethora of actions are being taken to mitigate this spend (as detailed in report), that said the agency demands are likely to continue due to the demand pressures.<br><br>3. Staffing. There is a clear pressure on staffing levels as a result of demand pressures. As noted in the report the Executive team have recently agreed an over recruitment plan to support these pressures.<br><br>4. The Committee welcomed the deeper engagement that has taken place on this key document. As a results of this engagement a number of changes have been made. The Committee commend this plan for approval at the September Board of Directors. |

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| **Previously considered by:** | n/a |

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| **Proposed Resolution** | The Board is requested to note and be assured by these 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:** | James Mawrey, Director of People | **Presented by:** | Malcolm Brown, Non-Executive Director |

**Committee/Group Chair's Report**

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|---|---|---|---|
| Name of Committee/Group: | People Committee | Report to: | Board of Directors |
| Date of Meeting: | 15th July 2021 | Date of next meeting: | 16th September 2021 |
| Chair: | M Brown | Parent Committee: | Trust Board |
| Members present/attendees: | J Mawrey, A Ennis, K Meadowcroft, F Andrews, A Stuttard, M North, P Henshaw, L Gammack, K Stott, A Chilton, I Ismail and all the clinical divisions present | Quorate (Yes/No): | Yes |
| | | Key Members not present: | F Noden, E Steel, S Martin, P Scott, A Chilton, C McPeake |

| Key Agenda Items: | RAG | Key Points | Action/decision |
|---|---|---|---|
| Agency Update | | • Colleagues discussed the reasons for the high level of agency spend within the organisation – urgent care pressures, recovery, sickness and vacancies.<br>• With regard to actions the Committee noted that:- the Executive team have agreed an over-recruitment plan; Enhanced controls have been put in place that require a higher level of sign off and scrutiny; investment in Health & Wellbeing remains a priority area. | • The report was noted.<br>• A bi-monthly Agency report to be provided to the Committee. |
| Resourcing | | • The People Committee received an update on the recruitment position, and in particular those hard to fill posts. The People Committee did note that, given the increased level of activity to support the recovery and urgent care position, then the Divisions are reporting a shortage of staff. As noted above the Executive team have | **Action agreed:-**<br>• The reports were noted.<br>• In September provide a further update on the 'hard to fill' posts.<br>• In September provide an update on the 'over recruitment' plan. |

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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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| | | recently supported an over-recruitment plan to support organisational pressures. | |
| EDI Plan | | • The Committee endorsed the plan and supported that the final version be presented to the BoD in September 2021. BoD members will be sent the details of the plan in advance and as such further narrative will not be provided in this section. | • Report noted.<br>• Commended the report to the BoD in September 2021. |
| Bolton Engage Q1 Results | | • The Bolton Engage Q1 survey was open from 4 to 31 May 2021. The overall response rate was 37.8% which was based on 1872 responses out of 5715 employees who were invited to take part.<br>• The Trust obtained an overall engagement score of 4.02 out of 5, which is the same as the last survey completed in February 2021 (Q4).<br>• The Committee did note their concern at the fall in the staff Friends & Family Test scores (Place to work and receive care). Whilst it is too early to tell whether this is a blip or a sustained movement, close monitoring is required, along with enabling plans for improvement. | • The report was noted.<br>• Report back in the next Committee on the Trust & Divisional Engagement plans. |

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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 |
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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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| | | • It was noted that the survey was conducted during a challenging time for our staff as they continued to respond to the COVID-19 pandemic. We know from speaking to staff that they continue to feel fatigued and are showing signs of burnout. This is coupled with staff working and living under Covid restrictions which is taking its toll on individuals. | |
| FTSU Q1 Update | | • The Chair congratulated the FTSU Network for the Be Honest Award in the recent Trust FABB Annual Staff Awards. The network has gone above and beyond to promote and embed the FTSU approach and the award is a testament to their hard work and commitment. The Guardian and the champions plan to celebrate winning the award during October as part of National Speak Up Month<br>• During the period from 1st April 2021 to 30th June 2021 (Q1) a total of 44 cases were reported through the FTSU route. This is an increase of 18 from the previous quarter. Like most NHS organisations – behaviour / interpersonal | • 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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| | | skills was identified as the main reason for concerns being raised. | |
| Integrated Workforce Report | | • The report triangulated key workforce data to support informed discussions. | • The reports were noted. |
| Subgroup Updates | | • The Director of People provided updates on the People Development Group, EDI Group, and Workforce Digital Group. | • The reports were noted. |
| Risks Escalated | | • None. Matters being managed within Committee. | |

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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

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|---|---|---|---|
| Name of Committee/Group: | People Committee | Report to: | Board of Directors |
| Date of Meeting: | 17th June 2021 | Date of next meeting: | 15th July 2021 |
| Chair: | M Brown | Parent Committee: | Trust Board |
| Members present/attendees: | F Noden, J Mawrey, A Ennis, A Hansen, F Andrews, S Martin, E Steel, A Stuttard, M North, P Henshaw, L Gammack, K Stott, A Chilton, I Ismail and all the clinical divisions present | Quorate (Yes/No): | Yes |
| | | Key Members not present: | K Meadowcroft, C Sheard, K Stacey |

| Key Agenda Items: | RAG | Key Points | Action/decision |
|---|---|---|---|
| Therapy Bank | | • Jen Sharples presented the work that had taken place to increase the numbers of staff on the Therapy Bank.<br>• 50 applicants, with 24 being offered employment. Of these 50% being students in the last year of their studies.<br>• The Committee noted that important we learn the lessons of what went very well, along with what could have been better. This process then be used for all staffing groups. | **Action agreed:-**<br>• The reports were noted.<br>• It was requested that an update be provided on the wider Trust Bank productivity at the September meeting. |

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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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| Resourcing | | • The Committee received an update on a number of recent appointments across all staffing groups. It was noted that whilst Vacancy rates are not generally signifying a concern (as per BoD Dashboard), it does feel that 'on the ground' pressures are becoming evident. A deeper focus was considered on the 'hard to fill' posts at Divisional level, along with the enabling actions that are taking place.<br>• The Committee were pleased to learn that the Occupational Health Service KPI were showing improvements since being brought back in-house. | **Action agreed:-**<br>• The reports were noted.<br>• In September provide a further update on the 'hard to fill' posts. |
| EDI Plan | | • The Committee welcomed the additional engagement on this key document and noted that further engagement was planned. | **Action agreed:-**<br>• The reports were noted. |

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

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| Staff Experience | | • Bolton Engage quarterly pulse survey closed at the end of May and the findings will be presented to the next Committee.<br>• The Committee received a presentation on the Trust's Staff Engagement Programme which is focused around the following strategic themes: Improving culture and behaviours; Strengthening relationships; Enhancing our recognition approach; Accelerating our EDI agenda; and Enhancing our staff wellness offer.<br>• Working alongside the Trust's plan each Division have their own Staff Engagement/Culture Change Plans.<br>• Colleagues noted that the on-going organisation pressures may have an impact on Engagement levels. | **Action agreed:-**<br>• The reports were noted.<br>• Go Engage timetable agreed for 21/22 and 22/23<br>• Report back in the next Committee on the Go Engage findings. |

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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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| FTSU Annual Report | | • The Committee commended the annual update on Freedom to Speak Up (FTSU) activity within the Trust during the period from 1st April 2020 to 31st March 2021.<br>• 111 cases were reported through the FTSU route (themes were reported - behaviour & interpersonal skills being the highest reported theme). This is a significant increase from the previous year when 60 cases were reported and demonstrates that the FTSU approach is working as more staff are using the FTSU approach to speak up.<br>• The Committee noted that the positive work has resulted in demonstrable improvements in the 2020 NHS national staff survey results and recent FTSU Index results. | **Action agreed:-**<br>• The reports were noted. |
| Exit Interview Update | | • The Committee were disappointed to note the poor completion rate for Exit Interviews (19.5%). A breakdown of reasons for leaving was noted, albeit given the poor response rate the picture was limited. All commented that this is an essential work programme to help better understand why our staff may be leaving and supposed the improvement plan to drive up Divisional return rates. | **Action agreed:-**<br>• The reports were noted.<br>• Report back in three months times on the progress. |

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| | No assurance – could have a significant impact on quality, operational or financial performance; |
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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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| Integrated Workforce Report | | • The report triangulated key workforce data to support informed discussions. | **Action agreed:-**<br>• The reports were noted. |
| Subgroup Updates | | • The Director of People provided updates on the People Development Group, EDI Group, Staff Expereience Group and Workforce Digital Group. | **Action agreed:-**<br>• The reports were noted. |
| Risks Escalated | | • None. Matters being managed within Committee. | |

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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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| **Title:** | Opening Capital Programme 2021/2022 |

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|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | |
| **Date:** | 29th July 2021 | | Discussion | X |
| **Exec Sponsor:** | Annette Walker | | Decision | X |

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| **Summary:** | To seek approval from the Board for the opening capital programme in accordance with the requirements of the SFIs.<br>To seek approval from the board to amend the SFIs to give authority to Divisional Boards to approve capital business cases within the plan approved for values below £200k |
| **Previously considered by:** | The opening capital programme has been supported by the F&I Committee (June 21), the Executive and consulted on widely through CRIG, DDOs and Divisional boards. |

| | |
|---|---|
| **Proposed Resolution** | The Board is asked to: -<br><br>1 Approve the opening programme;<br>2 Expect to receive updates on significant changes<br>3 Expect to receive and approve business cases for schemes above £2m (theatres redevelopment) |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Sharon Freeman, Annette Walker | **Presented by:** | Annette Walker, Director of Finance |

# OPENING CAPITAL PROGRAMME 2021/2022

## Introduction

The purpose of this paper is to set out the of the opening 2021/2022 capital programme.

## Capital Prioritisation

The most important step in the management of the capital programme is to have a clearly prioritised set of schemes from which the annual plan can be developed.

These plans will be managed and owned at divisional level by Divisional Directors and the overall consolidated plan will be maintained and monitored by Finance.

Divisions have been requested to categorise schemes as below, with priority given to capital schemes which are business critical. These have been ranked in priority in divisions based on a number of risk factors.

| Scheme Category | Example |
|---|---|
| Capital – Business Critical | Schemes that are essential to carry out normal services and would be deemed to be funded from routine deprecation e.g. replacement of key faulty equipment |
| MES* – Business Critical | Equipment acquired through the MES contract with Siemens – contractually committed through a rolling programme |
| Capital – Development | Schemes which can improve or add new services or larger schemes beyond routine depreciation e.g. purchase of new more advanced equipment, re-development of the site, significant compliance projects such as total theatre replacements. These schemes would require full business case presented at CRIG |
| Revenue – Business Critical | Schemes that are essential but the nature of the scheme requires revenue funding |
| Revenue – Development | Schemes which can add improvements to services and would require substantial revenue. These schemes would require full business case presented at CRIG |

**Managed Equipment Service*

A number of schemes have been re-categorised as revenue rather than capital and have been included for completeness. There is the option for some of these schemes to be flexed between capital and revenue creating some flexibility during the year.

## Capital Funding 2021/22

The capital programme is funded via a combination of internally generated cash, equipment leasing arrangements, depreciation and loans. For 2021/22, we have been set an opening capital envelope of **£9.7m** with the ability to over commit to **£15.1m** to absorb capital slippage within GM.

For 2021/2022 the funding arrangements are as follows: -

| **Funding Method** | **£m** |
|---|---|
| Depreciation | 7.0 |
| Replenishment of working balances | (2.2) |
| Loans – EPR | 2.1 |
| Managed Equipment Service | 2.8 |
| **Opening capital envelope** | **9.7** |
| Use of working balances | 5.4 |
| **Over commitment plan** | **15.1** |

Note that this plan excludes Healthier Together capital funding as this sits outside the capital envelope.

## Capital Process 2021/22

Divisions have been asked to submit an annual capital plan for approval at the beginning of the year with business critical schemes <£200k no longer requiring sign off at CRIG. The aim of this is to reduce bureaucracy with the division taking more accountability for capital planning, business cases and associated governance. CRIG may however, at any point, request business case documentation from Divisions and it is proposed to use internal audit to periodically check controls are in place

An 'operational' capital budget will be set on this basis within which Divisions will need to manage overall.

Capital required for development or strategic reasons will continue to require business cases and be approved through CRIG. Note delegated financial limits will still be in operation with schemes above thresholds requiring Finance Committee and/or Board approval.

## Opening Capital Plan 2021/22

Business critical capital requests and slippage from last year total £15.6m. This excludes the theatre replacement project which has been classified as development capital due to the significant level of capital funding required. It is likely that slippage will naturally occur again in 2021/22 given the nature of capital spending and historical spending patterns. This leaves a total of £2.0m to use to fund development capital schemes which total £13.9m.

The opening capital programme is therefore proposed as follows: -

| | **£m** |
|---|---|
| 21/22 Capital Business Critical | 10.8 |
| 21/22 MES – Business Critical | 2.3 |
| 20/21 Slippage | 2.5 |

| | |
|---|---|
| **Opening capital commitments** | **15.6** |
| Expected slippage in 21/22 | (2.5) |
| **Total expected capital spend** | **13.1** |
| Unutilized capital | 2.0 |
| **Over commitment plan** | **15.1** |

A full listing of all schemes in all categories is included in the Appendix for information and is summarized below: -

| Total Capital Requests 2021/2022 | Capital Category | | | | | |
|---|---|---|---|---|---|---|
| Division | Capital Business Critical | MES Business Critical | Capital Development | Revenue business critical | Revenue development | Grand Total |
| Acute Adult | 1,112.0 | | 82.0 | | | 1,194.0 |
| ASSD | 1,467.0 | | 10,100.0 | | | 11,567.0 |
| Diagnostics | 474.8 | 2,317.8 | - | | | 2,792.6 |
| Family Care Division | 476.7 | | 200.0 | | 100.0 | 776.7 |
| ICSD | | | 200.6 | | | 200.6 |
| Informatics | 4,520.0 | | 1,320.0 | 932.0 | 220.0 | 6,992.0 |
| IFM | 2,750.0 | | 2,000.0 | 200.0 | 150.0 | 5,100.0 |
| **Grand Total** | **10,800.5** | **2,317.8** | **13,902.6** | **1,132.0** | **470.0** | **28,622.9** |

Work is underway to assess whether the MES contract can be counted outside the capital envelope. This would increase the unutilized capital available to fund capital development schemes including theatre replacement. In the interim other funding solutions are being explored including revenue models and national capital.

## Recommendation

The Board is asked to: -

1 Approve the opening capital programme;
2 Expect to receive updates on significant changes
3 Expect to receive and approve business cases for schemes above £2m (theatres redevelopment)

Appendix 1

# Capital Requests Template 2021/2022

| Division | Description of capital scheme | Reason for capital expenditure | Capital Costs 2021/2022 £'000 |
|---|---|---|---|
| Acute Adult | Endoscopy - 3 year equipment replacement plan | Capital Business Critical | 751.0 |
| Acute Adult | Additional ECHO kit | Capital Business Critical | 351.0 |
| Acute Adult | Stroke central monitoring unit | Capital Business Critical | 10.0 |
| ASSD | Additional Cancer MDT Rooms (on 2020/2021 Capital Plan) | Capital Business Critical | 130.0 |
| ASSD | ENT Microscopy Replacement and Worktop Reworks (on 2020/2021 Capital Plan) | Capital Business Critical | 150.0 |
| ASSD | Passport Monitor (on 2020/2021 Capital Plan) | Capital Business Critical | 100.0 |
| ASSD | LTV1000 (on 2020/2021 Capital Plan) | Capital Business Critical | 100.0 |
| ASSD | Mini C-Arm (on 2020/2021 Capital Plan) | Capital Business Critical | 160.0 |
| ASSD | Cone Beam CT (on 2020/2021 Capital Plan) | Capital Business Critical | 30.0 |
| ASSD | Goldman Machine | Capital Business Critical | 40.0 |
| ASSD | MRI compatible Ventilator | Capital Business Critical | 80.0 |
| ASSD | ENT Sinks x 2 (on 2020/2021 Capital Plan) | Capital Business Critical | 30.0 |
| ASSD | Dolphin Orthographic Software (on 2020/2021 Capital Plan) | Capital Business Critical | 30.0 |
| ASSD | Intra Oral Digital Scanner (on 2020/2021 Capital Plan) | Capital Business Critical | 40.0 |
| ASSD | Aura Machine (Replacement Tanometer) | Capital Business Critical | 60.0 |
| ASSD | Humphrey Field Analysers (on 2020/2021 Capital Plan) | Capital Business Critical | 40.0 |
| ASSD | Replacement Laser Urology (on 2020/2021 Capital Plan) | Capital Business Critical | 100.0 |
| ASSD | Heine Indirect (on 2020/2021 Capital Plan) | Capital Business Critical | 15.0 |
| ASSD | OCT at Bolton One (on 2020/2021 Capital Plan) | Capital Business Critical | 85.0 |
| ASSD | Ward Kitchens x 5 (on 2020/2021 Capital Plan) | Capital Business Critical | 80.0 |
| ASSD | Plaster Room & OP Refurb (on 2020/2021 Capital Plan) | Capital Business Critical | 100.0 |
| ASSD | Replacement Diathermy H2 Theatres (on 2020/2021 Capital Plan) | Capital Business Critical | 85.0 |
| ASSD | Trauma Meeting PACs Monitor (on 2020/2021 Capital Plan) | Capital Business Critical | 12.0 |
| Diagnostics | Bolton 1 - Room 2 - Ysio - 2 detector | Capital business critical | 200.1 |
| Diagnostics | PACS Workstation replacement | Capital business critical | 150.0 |
| Diagnostics | Nurse/Emergency Patient Call System | Capital business critical | 16.7 |
| Diagnostics | NM - Down flow hood - linked with Gamma Camer Replacement | Capital business critical | 17.0 |
| Diagnostics | NM - QA Flood linked with Gamma Camer Replacement | Capital business critical | 6.0 |
| Diagnostics | LabCentre Developmental Strategy -update of LIMS | Capital business critical | |
| Diagnostics | 4400- Air conditioning required for Cellular pathology labs. | Capital business critical | 10.0 |
| Diagnostics | Air conditioning system required in Red Lab | Capital business critical | 10.0 |
| Diagnostics | Air conditioning system required in Specimen Reception | Capital business critical | 10.0 |
| Diagnostics | Air conditioning system required in POCT/Covid Lab | Capital business critical | 10.0 |
| Diagnostics | Air ventilation system required in the basement store | Capital business critical | 10.0 |
| Diagnostics | Anaerobic Cabinet | Capital business critical | 35.0 |
| Family Care Division | Level one Blood infusor | Capital business critical | 23.0 |
| Family Care Division | CFM Olympic Brainz Monitor x 2<br>NNU usage - provides neurological information during early stages of newborn development | Capital business critical | 25.0 |

| | | | |
|---|---|---|---|
| Family Care Division | 1 x theatre table (costs TBC) | Capital business critical | 70.5 |
| Family Care Division | Tympanometer (incl. OAE) | Capital business critical | 13.5 |
| Family Care Division | Otoacoustic Emissions System (Echoport) | Capital business critical | 12.2 |
| Family Care Division | Paediatric transfer trolley monitor | Capital business critical | 11.5 |
| Family Care Division | Incubators x 10 | Capital business critical | 120.0 |
| Family Care Division | 2 diathermy (costs TBC) | Capital business critical | 20.0 |
| Family Care Division | Ventilators x 10 | Capital business critical | 130.0 |
| Family Care Division | Telemetry CTG monitoring device for CDS birthing pool | Capital business critical | 11.0 |
| Family Care Division | Echo machine for E5 | Capital business critical | 40.0 |
| IFM | Electrical infrastructure LV | Capital business critical | 1,300.0 |
| IFM | Highways , carparks and footpaths | Capital business critical | 250.0 |
| IFM | Upgrade of labs | Capital business critical | 1,200.0 |
| Informatics | EPR Deployment (as per agreed & profiled business case) - supporting technology, resources and activities to continue EPR deployment to A&E, ICPS, ICSD & Outpatients | Capital Business Critical | 2,380.0 |
| Informatics | PatientTrack hardware/capabilities refresh (as per agreed business case) - supporting device refresh & upgrade to ensure continued high & safe utilisation of PatientTrack | Capital Business Critical | 230.0 |
| Informatics | Igel replacment endpoints, current hardware is unable to support new business functionality and is over 6 years old | Capital Business Critical | 560.0 |
| Informatics | Physical PC replacment Programme, current Trust PC hardware is over 6 years old and coming to end of extended warranty, devices need replacing to support clinical systems | Capital Business Critical | 350.0 |
| Informatics | Physical Laptop replacment, Current Trust laptops are ovr 6 years old and have no warranty devices need replacing due to age and no support | Capital Business Critical | 150.0 |
| Informatics | due for replacment (warranty expired in year 5). 24 servers in production currently programme split to replace 50% year one and 50% year 2 | Capital Business Critical | 250.0 |
| Informatics | Community WiFi - as part of the EPR deployment WiFi is required across the community to suipport Agile working and new business process brought by the EPR deployment | Capital Business Critical | 600.0 |
| Diagnostics | ID 02 -somatom Definition AS 64 | MES Business Critical | 627.8 |
| Diagnostics | ID 05 - Ysio - 1 Detector System | MES Business Critical | 200.1 |
| Diagnostics | ID 06 - Axiom Iconons R200 Flurospot Compact | MES Business Critical | - |
| Diagnostics | ID 08 -Axiom Aristos VX Plus | MES Business Critical | 151.5 |
| Diagnostics | ID 09 -Axiom Aristos MX | MES Business Critical | 231.0 |
| Diagnostics | ID 10 - Axiom Aristos VX Plus (Bolton One) | MES Business Critical | 161.5 |
| Diagnostics | ID 12 - Acuson NX3 Elite | MES Business Critical | 23.1 |
| Diagnostics | ID 13 -Planmeca Proline XC Ceph Dimax3 | MES Business Critical | 63.2 |
| Diagnostics | ID 14 - Planmeca ProOne Direct Digital Panoramic X-ray | MES Business Critical | 63.5 |
| Diagnostics | ID 15 - Acuson S2000 | MES Business Critical | 94.7 |
| Diagnostics | ID 16 - Acuson S2000 | MES Business Critical | 94.7 |
| Diagnostics | ID 18 - Gamma Camera | MES Business Critical | - |
| Diagnostics | ID 21 Mammo xray | MES Business Critical | |
| Diagnostics | ID 24 - Acuson S2000 | MES Business Critical | 78.0 |
| Diagnostics | ID 25 - Acuson S2000 | MES Business Critical | 78.0 |
| Diagnostics | ID 29 -Acuson S2000 | MES Business Critical | 66.6 |
| Diagnostics | ID 30 -Acuson S2000 | MES Business Critical | 51.2 |
| Diagnostics | ID 31 -Acuson S2000 | MES Business Critical | 59.3 |
| Diagnostics | ID 38 -Siemens Siremobile Compact | MES Business Critical | 58.5 |
| Diagnostics | ID 39 -Arcadis Varic | MES Business Critical | 65.2 |
| Diagnostics | GE SENO ESSENTIAL 00374MAS11 Room 3 | MES Business Critical | 150.0 |
| Acute Adult | Complex breathlessness service equipment | Capital Development | 77.0 |
| Acute Adult | Sleep studies business case - Kit | Capital Development | 5.0 |
| Acute Adult | B2 ward refurbishment | Capital Development | |
| ASSD | Theatre Development above Urology | Capital Development | 6,500.0 |
| ASSD | Theatre Refurbishment | Capital Development | 3,500.0 |

| | | | |
|---|---|---|---|
| ASSD | Video Assisted Fistula Surgery (New technique) | Capital Development | 100.0 |
| Diagnostics | Vein to Vein IT solution | Capital development | Currently working with procurement |
| Diagnostics | Replacement of Pharmacy Robot RBH Site - currently scoping capital purchase or MES route | Capital development | |
| Family Care Division | Sexual health refurb N Block | Capital development | 200.0 |
| ICSD | | Capital Development | 160.0 |
| ICSD | 4 Video Conferencing screens (not funded from Sparkle fund) | Capital development | 40.6 |
| IFM | Waste yard | Capital development | 150.0 |
| IFM | Remedial plan | Capital development | 350.0 |
| IFM | Relocation of Telecomms | Capital development | 200.0 |
| IFM | Accommodations block 5 | Capital development | 500.0 |
| IFM | SDMP projects | Capital development | 400.0 |
| IFM | Demolition of Buildings | Capital development | 400.0 |
| Informatics | Trust WiFi - as part of the ongoing EPR development current WiFi capability needs increasing and modernising to accommodate the change in business usage | Capital Development | 320.0 |
| Informatics | Production SAN Hardware Replacment - Current production SAN storage is over 5 years old and out of supported warranty phase one replacment | Capital Development | 300.0 |
| Informatics | Business Continuity - Increased capacity to support business continuity objectives with cloud services expansion | Capital Development | 100.0 |
| Informatics | Imprivata IDG - Automated user creation / Information Governance and Security to support automated Govenance and Security across the business | Capital Development | 600.0 |
| IFM | Deep clean | Revenue business critical | 200.0 |
| Informatics | Patient Flow solution (Extramed) contract expiry within FY 21/22 and will require contract extension &/or solution replacement with supporting capability/equipment investment | Revenue Business Critical | 250.0 |
| Informatics | Firewall Renewal / Contract Ex pirartion - The trust firewall is out of contract and requires investment to continue oprational functionality | Revenue Business Critical | 350.0 |
| Informatics | Cisco Ironport cloud email security and encryption, as part of the core business software migration to cloud based email systems Office 365 there is a requirement to secure email in line with the NHS DCB1596 email security standard this is required so that we are able to send emails to NHS net | Revenue Business Critical | 332.0 |
| Family Care Division | Scanning of patient records (costs TBC)<br>Scanning of paper notes from Little Lever to EPR | Revenue development | 100.0 |
| IFM | Painting across the site | Revenue development | 150.0 |
| Informatics | PCYSYS automated penetration testing - This is part of the core security suite deployed in the trust and forms part of the ISO27001 certification held by IT services for Secure Email. | Revenue Development | 150.0 |
| Informatics | Unified Comms - Unified communications updates to subscription based licensing agreement | Revenue Development | TBC |
| Informatics | Imprivata Licensing - Imprivata licensing has been moved to a subscription based license agreement | Revenue Development | TBC |
| Informatics | Microsoft Licensing - Increase in microsoft licensing agreement to support additional users and also additional server capacity required operationally by the trust | Revenue Development | TBC |
| Informatics | Citrix licensing - Citrix have moved to a subscription based licensing model | Revenue Development | TBC |
| Informatics | Agile Working Internet Security - With increased agile working there is a requirement to support internet filtering on Laptop devices with staff working from home | Revenue Development | 70.0 |
| Informatics | Imprivata Virtual Smartcard - This will allow agile working to be expanded across multiple platforms and icrease productivity by automating the smartcard logon process and removing the need to have physical smartcards. | Revenue Development | TBC |

| | |
|---|---|
| **Title:** | Authorisation of High Value Supplier Payments |

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 29 July | | Discussion | |
| **Exec Sponsor** | Annette Walker | | Decision | ✓ |

| | |
|---|---|
| **Summary:** | To provide the Board with an update of the expenditure against the High Value Supplier Payments (expenditure over £1m) for 2020/21.<br><br>The revisions are shown below<br>• 2 additions to the high value contracts have been made.<br>• Revised increase in forecast expenditure of £11.6m for 6 high value supplier payments.<br><br>To provide the Board with details of the 2021/22 register of supplier payments over £2m. |

| | |
|---|---|
| **Previously considered by:** | The March Finance and Investment Committee meeting considered and supported the proposed payments. |

| | |
|---|---|
| **Proposed Resolution** | The Board will be asked to<br>• Approve the proposed amendments to the 2020/21 register of supplier payments<br>• Approve the 2021/22 register of supplier payments over £2m. |

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

| | | | |
|---|---|---|---|
| **Prepared by:** | Catherine Hulme<br>Head of Financial Services | **Presented by:** | Annette Walker<br>Director of Finance |

# High Value Supplier Payments

## Introduction

This paper looks to review the 2020/21 and 2021/22 High Value Supplier Payments. The March 2021 Finance and Investment Committee considered the paper.

The Board is asked to review and authorised the amendments for the 2020/21 and 2021/22 register of forecast supplier payments.

## High Value Supplier Payments 2020/21

There are 2 additions made to the high value supplier payments for 2020/21, these are shown below.

- £2.1m for Becton Dickinson (previously below the £1m threshold). The increase in expenditure is due to the purchase of Covid-19 test kits.
- £1.5m for City Build, this is for capital expenditure via IFM Bolton Ltd.

Of the original 30 high value supplier payments over £1m, 5 are forecasting an increase in expenditure; these are highlighted in bold on Appendix 1 and summarised below.

- iFM Bolton Ltd, increase of £9.0m (this is relating to an increase in capital expenditure)
- Softcat Ltd, increase of £1.4m
- NHS Resolution, increase of £0.9m
- European Electronique, increase of £0.6m
- Virgin Media Business, increase of £0.4m
- Janssen-Cilag Ltd, increase of £0.3m

## High Value Supplier Payments 2021/22

The register of high value supplier payments over £2m is shown in Appendix 2.

Payments to N Power and Berendsen Plc relate to expenditure via IFM Bolton Ltd.

**Recommendation**

The Board is asked to

- Approve the proposed amendments to the 2020/21 register of supplier payments.
- Approve the 2021/22 register of forecast supplier payments.

**Appendix 1**

| Supplier | 2020/21 Reported to Finance Committee March 2020 £'m | 2020/21 Forecast Expenditure £'m |
|---|---|---|
| **IFM BOLTON LTD (OPERATING HEALTHCARE AND CAPITAL)** | **33.6** | **42.6** |
| NHS RESOLUTION | 13.1 | 14.0 |
| ST HELENS & KNOWSLEY | 11.9 | 12.5 |
| NHS SUPPLY CHAIN | 6.1 | 5.3 |
| COMMUNITY HEALTH PARTNERSHIPS | 4.1 | 4.1 |
| HEALTHCARE AT HOME LIMITED | 4.7 | 4.0 |
| **SOFTCAT LTD** | **2.3** | **3.7** |
| NHS PROPERTY SERVICES LTD | 3.7 | 2.9 |
| **EUROPEAN ELECTRONIQUE** | **1.8** | **2.4** |
| SIEMENS HEALTHCARE DIAGNOSTICS LTD | 2.1 | 2.1 |
| BAXTER HEALTHCARE LTD | 2.6 | 2.0 |
| NOVARTIS PHARMACEUTICAL UK LTD | 2.3 | 1.8 |
| CHRYSTAL CONSULTING | 2.0 | 1.7 |
| BOLTON COUNCIL | 1.7 | 1.7 |
| MANCHESTER FOUNDATION TRUST | 1.7 | 1.6 |
| AAH PHARMACEUTICALS LIMITED | 1.8 | 1.5 |
| BAYER PLC | 1.7 | 1.4 |
| **VIRGIN MEDIA BUSINESS** | **1.1** | **1.4** |
| SALFORD ROYAL NHS FOUNDATION TRUST | 1.5 | 1.3 |
| **JANSSEN-CILAG LTD** | **1.1** | **1.3** |
| ALLSCRIPTS HEALTHCARE (IT) UK LIMITED | 2.1 | 1.2 |
| ALLIANCE HEALTHCARE (DISTRIBUTION) LTD | 1.4 | 1.2 |
| LLOYDS PHARMACY CLINICAL HOMECARE | 1.1 | 1.0 |
| PRESCRIPTION PRICING AUTHORITY-PRESCRIP | 1.2 | 0.9 |
| XMA LTD | 1.9 | 0.7 |
| WRIGHTINGTON,WIGAN & LEIGH NHS TRUST | 1.1 | 0.6 |
| STRYKER UK LTD | 1.2 | 0.5 |
| INSIGHT DIRECT UK LTD | 1.1 | 0.4 |
| NPOWER LTD * | 1.2 | 1.2 |
| BERENDSEN PLC * | 1.1 | 1.1 |
| CITY BUILD | 0.0 | 1.5 |
| BECTON DICKINSON | 0.0 | 2.1 |

* expenditure via IFM Ltd

**Appendix 2**

| Supplier | 2021/22 Forecast Expenditure |
|---|---|
| **IFM BOLTON LTD (OPERATING HEALTHCARE AND CAPITAL)** | 35.0 |
| NHS RESOLUTION | 14.3 |
| ST HELENS & KNOWSLEY | 12.8 |
| NHS SUPPLY CHAIN | 5.4 |
| COMMUNITY HEALTH PARTNERSHIPS | 4.2 |
| HEALTHCARE AT HOME LIMITED | 4.1 |
| **SOFTCAT LTD** | 3.8 |
| NHS PROPERTY SERVICES LTD | 3.0 |
| **EUROPEAN ELECTRONIQUE** | 2.4 |
| SIEMENS HEALTHCARE DIAGNOSTICS LTD | 2.1 |
| BAXTER HEALTHCARE LTD | 2.0 |
| NOVARTIS PHARMACEUTICAL UK LTD | 2.2 |
| CHRYSTAL CONSULTING | 2.0 |
| BOLTON COUNCIL | 2.0 |
| MANCHESTER FOUNDATION TRUST | 2.0 |
| AAH PHARMACEUTICALS LIMITED | 2.0 |
| BECTON DICKINSON* | 2.1 |
| NPOWER LTD * | 1.2 |
| BERENDSEN PLC * | 1.1 |

* expenditure via IFM Ltd

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

| | | | | |
|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | |
| **Date:** | 29 July 2021 | | Discussion | |
| **Exec Sponsor** | Director Corporate Gov | | Decision | |

| | |
|---|---|
| **Summary:** | Over the last few years within the NHS, there has been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery.<br>The attached list is a summary of the statutory and other guidance setting out a requirement for a Champion or Board lead.<br>The list has been reviewed and updated to reflect changes to Board membership.<br>The following changes are proposed:<br>• A change to the appointed Caldicott Guardian – to transfer to the Deputy Medical Director<br>• The addition of a Board level net zero lead – it is proposed that this is the Chief Operating Officer. |
| **Previously considered by:** | Executive Directors |
| **Proposed Resolution** | Board members approved the designated Board leads 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 |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| 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 |
| 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 |
| 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<br>Advising the Chief Executive or relevant accounting officer on the information risk aspects of his/her statement on internal controls<br>Owning the organisation's information incident management framework | Chief Operating Officer | Andy Ennis |
| 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>Oversee local control of infection policies and their implementation. | Chief Nurse | Karen Meadowcroft |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| | | Be a full member of IP&CT and regularly attend its Infection Prevention and Control meetings.<br>Assess the impact of all existing and new policies on Healthcare Associated Infections (HCAI) and make recommendations for change.<br>Oversee the production of an annual report and release it publicly. | | |
| Responsible Officer for revalidation | The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 | Statutory role in medical regulation.<br>Accountable for the local clinical governance processes, focusing on the conduct and performance of doctors.<br>Duties include evaluating a doctor's fitness to practise, and liaising with the GMC over relevant procedures.<br>Ensure that the organisation has appropriate systems for appraising the performance and conduct of doctors. | Medical Director | Francis Andrew |
| 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 | Chief Nurse | Karen Meadowcroft |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| | | operate as a dementia friendly hospital and participate in awareness raising activities as appropriate. | | |
| 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 |
| Whistleblowing | Public Interest Disclosure Act 1998 (PIDA)<br>NHS Constitution<br>Freedom to Speak Up Review (2015) | To act as a voice for whistleblowing management and related issues at Board meetings and ensure that any implications arising from items discussed have been considered and appropriately addressed.<br>To gain assurance that the Trust has in place effective and robust | NED | Bilkis Ismail |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| | | whistleblowing management procedures and response systems.<br><br>To work closely with the Workforce Director and the Freedom to Speak up Guardian with regard to monitoring whistleblowing.<br><br>To be recognised as one of the channels for members of staff to raise their concern with. | | |
| 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 |
| Non Executive Lead for Maternity Services | Ockenden 2020 | Oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level.<br><br>They must work collaboratively with their maternity Safety Champions | NED | Martin North |
| 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 |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| 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 that complaints and incidents are dealt with in a way that reduces this impact. | Chief Nurse | Karen Meadowcroft |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| End of Life Care – Non 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 | To have specific responsibility of care of the dying, focusing on the dying patient, their relatives and carers and reviewing how End of Life Care is provided.<br><br>Support , and where necessary challenge, the Executive Director for End of Life Care<br><br>Act as a patient, family and public voice & ensure that the patient, family and public perspective is considered in all End of Life Care related discussions and Board level scrutiny.<br><br>Provide scrutiny to the monitoring of End of Life Care, oversight for End of Life complaints, and the handling of the bereaved within the Trust. | Non-Executive | Malcolm Brown |
| 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><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. | Chief Operating Officer | Andy Ennis |
| Equality and Diversity | Equality Act 2010 - Public Sector Duty | To act as a Board champion to set an example and demonstrate that the | Director of Workforce.<br><br>The People Plan 2020 states that it is the explicit | James Mawrey<br><br>Bilkis Ismail |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| | The Workforce Race Equality Standard | 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. | responsibility of the CEO to lead on equality, diversity and inclusion.<br>NED Champion | |
| 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. | Chief Operating Officer | Andy Ennis |
| 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 | Chief Operating Officer | Andy Ennis |
| 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 |
| 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; | Medical Director | Francis Andrew |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| | | • that other persons working under the licence are suitable and;<br>• That the conditions of the licence are complied with. | | |
| Lead for Ionising Radiation Medical Exposure Regulations (IRMER) | IRMER | Board level responsibility for compliance with IRMER guidance | Medical Director | Francis Andrew |
| 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 trust to become a more open, transparent place to work<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>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 | Freedom to Speak up Champion | Tracey Garde |

| Statutory or Regulatory Role | Regulation/Guidance | Role | Director Lead | Who |
|---|---|---|---|---|
| Accountable Officer for Emergency Planning | Civil Contingencies Act/HASC 2012The Civil Contingencies<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 | Andy Ennis |
| | | | Head of Emergency Planning | James Tunn |
| 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>Establish and operate appropriate arrangements for monitoring and auditing the management and use of controlled drugs. | Chief Pharmacist | Steve Simpson |
| 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 |

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| **Title:** | Chairs' Reports – Finance & Investment Committee |

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|---|---|---|---|---|
| **Meeting:** | Board of Directors | **Purpose** | Assurance | ✓ |
| **Date:** | 29th July 2021 | | Discussion | |
| **Exec Sponsor** | Annette Walker | | Decision | |

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

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

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

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

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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**

(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: | 22nd June 2021 | Date of next meeting: | 20th July 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, Sharon Martin (for the Community Diagnostic Hub update) | Quorate (Yes/No): | Yes |
| | | Key Members not present: | |

| Key Agenda Items: | RAG | Lead | Key Points | Action/decision |
|---|---|---|---|---|
| System Finance Update | | Director of Finance | The committee received an update from the meeting that had taken place the previous week. Key points were noted as follows:<br>• Relative financial positions were discussed. There is a pressure in the system. The Trust financial deficit is £1.2m year to date. The CCG are dealing with a similar scale of financial risk but are currently forecasting to break even.<br>• There was an update on the system estate issues. AW suggested inviting Amanda Williams to a future meeting to provide an update.<br>• A review of urgent care services in Bolton is being undertaken by the CCG to understand the cost and the effectiveness.<br>• There was no whole system data update from Julie Ryan but this is being worked on in the background. | • Noted |

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| | Moderate assurance – potential moderate impact on quality, operational or financial performance |
| | Assured – no or minor impact on quality, operational or financial performance |

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

## Committee/Group Chair's Report

<table>
<tr>
<td>Month 2 Finance Report</td>
<td></td>
<td>Deputy Director of Finance</td>
<td>
The committee received an update on the financial position as at month 2. This showed a year to date deficit of £1.2m.<br><br>
The financial position is summarised in the table below:<br><br>
<table>
<tr><th></th><th colspan="3">In Month</th><th colspan="3">YTD</th></tr>
<tr><th></th><th>Plan £m</th><th>Actual £m</th><th>Variance £m</th><th>Plan £m</th><th>Actual £m</th><th>Variance £m</th></tr>
<tr><td>Income (Exclude Top ups etc)</td><td>29.3</td><td>29.4</td><td>0.1</td><td>58.7</td><td>58.6</td><td>(0.1)</td></tr>
<tr><td>Pay</td><td>(23.6)</td><td>(23.7)</td><td>(0.0)</td><td>(47.4)</td><td>(47.5)</td><td>(0.1)</td></tr>
<tr><td>Non Pay</td><td>(8.6)</td><td>(8.4)</td><td>0.1</td><td>(17.0)</td><td>(17.1)</td><td>(0.1)</td></tr>
<tr><td>Capital charges</td><td>(1.1)</td><td>(0.9)</td><td>0.2</td><td>(2.2)</td><td>(2.0)</td><td>0.2</td></tr>
<tr><td>Sub Total Expenditure</td><td>(33.3)</td><td>(33.0)</td><td>0.3</td><td>(66.6)</td><td>(66.7)</td><td>(0.0)</td></tr>
<tr><td>Surplus / (Deficit) Excluding Top ups & Grants</td><td>(4.0)</td><td>(3.6)</td><td>0.4</td><td>(8.0)</td><td>(8.1)</td><td>(0.1)</td></tr>
<tr><td>NHSI/GM Top Up</td><td>3.5</td><td>3.5</td><td>(0.0)</td><td>6.9</td><td>6.9</td><td>(0.0)</td></tr>
<tr><td>Donated Assets & Grants</td><td>(0.0)</td><td>(0.0)</td><td>(0.0)</td><td>(0.0)</td><td>(0.0)</td><td>(0.0)</td></tr>
<tr><td>Surplus/(Deficit)</td><td>(0.5)</td><td>(0.1)</td><td>0.4</td><td>(1.1)</td><td>(1.2)</td><td>(0.1)</td></tr>
<tr><td>Impairments</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td></tr>
<tr><td>Reported Surplus/(Deficit)</td><td>(0.5)</td><td>(0.1)</td><td>0.4</td><td>(1.1)</td><td>(1.2)</td><td>(0.1)</td></tr>
<tr><td>Exclude;</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Impairments</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td></tr>
<tr><td>PPE Stock</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td><td>0.0</td></tr>
<tr><td>Donated Assets</td><td>0.0</td><td>0.1</td><td>0.1</td><td>0.0</td><td>0.1</td><td>0.1</td></tr>
<tr><td>Performance Surplus/(Deficit)</td><td>(0.5)</td><td>(0.1)</td><td>0.4</td><td>(1.1)</td><td>(1.1)</td><td>(0.1)</td></tr>
</table>
<br>
The Committee also received updates on cost improvement plans, variable pay, capital spend, cash and loans.
</td>
<td>Noted.</td>
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<tr>
<td>Cost Improvement Programme Challenges and Plans</td>
<td></td>
<td>Director of Finance</td>
<td>Deferred to the next meeting.</td>
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| | No assurance – could have a significant impact on quality, operational or financial performance; |
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

**Committee/Group Chair's Report**

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|---|---|---|---|---|
| Opening Capital Programme 2021/2022 | | Director of Finance | The committee received an update on the 2021/22 capital programme prior to it being submitted to Board for approval. Key points were noted as follows:<br>• There has been a change in the way capital is managed in 2021/22 to give more delegated authority to Divisions to run their own capital business.<br>• For 2021/22, we have been set an opening capital envelope of £9.7m with the ability to over commit to £15.1m to absorb capital slippage within GM.<br>• All Divisions have submitted detailed capital plans. These have been reviewed by AW and AE and opening plans for business critical items have been approved.<br>• A financing strategy is being developed to look at how the Theatres work could be funded.<br>AW provided assurance that any significant changes or issues would be cascaded through both the Finance and Investment Committee and Board. | • Noted and supported to go to Board |
| Costing Update | | Director of Finance | The committee received an update on the progress of the Trust's Patient Level Costing system. Key points were noted as follows:<br>• A new Costing System, Prodacapo, has been implemented. Prodacapo have since been taken over by Logex, which presents some risks but these have been mitigated. Overall this should be beneficial.<br>• The 2019/20 reference cost collection was submitted successfully.<br>• We have been commended by NHSI in terms of the progress we have made.<br>• The NCC 2020/21 will include a patient level submission feed for Community for the first time.<br>• PLICs is now up and running in the organisation. It is currently being rolled out and tested within Management Accounts. Once feedback has been received the plan is to roll it out to Divisions. | • Noted. |

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**Committee/Group Chair's Report**

| | | | | |
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| Month 2 iFM Finance Report | | iFM Director of Finance | The committee received an update on the financial position of iFM as at month 2. Key points were noted as follows:<br>• Financial performance for month 2 is a pre-tax profit of £104k based on overall income of £4.61m. This is £11K better than budget.<br>• Income is slightly below plan as limited capital works were undertaken during the month.<br>• The month end cash position has reduced but remains healthy at £2.7m.<br>• A contract proposal has been submitted to the Trust and this forms the basis of the budget. Discussions are ongoing. | • Noted. |
| Staffing Analysis | | Director of People | The committee received an update on staffing levels over the period January 2020 to March 2021. The main focus of the discussion was agency spend which is currently an area of concern.<br>An issue has been identified with incorrect coding. Workforce and Finance are working with the divisions to improve coding of agency spend.<br>This was rated 'red' overall due to agency spend but would otherwise have been 'amber'. | • Noted.<br>• It was agreed that the committee should be kept updated on progress in terms of reducing agency spend. |

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**Committee/Group Chair's Report**

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| Community Diagnostic Hub FBC | | Director of Strategy | The committee received an update on the business case that is currently being prepared. Key points were noted as follows:<br>• An independent review of diagnostics services has been carried out. The review set out the case for increasing diagnostic capacity in England with one of the key recommendations being the rapid establishment of Community Diagnostic Hubs (CDHs).<br>• The option of working with an independent company has been considered.<br>• The Diabetes Centre has been established as a potential preferred location but no decision has been made.<br>• A financial appraisal has been completed looking at both the option of working with an independent company or being run by the Trust. It is proposed that the preferred option is to be run by the Trust.<br>• Capital costs are anticipated to be £12.8m with a further £750k for digitalisation within the building.<br>• This is a national directive and it will not be possible to move forward with it if there is no revenue funding. Conversations are taking place within GM. | • Noted.<br>• A change to the finance slides was suggested prior to presenting to Board. |

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**Committee/Group Chair's Report**

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| New Hospital Programme – Economic Case | | Deputy Director of Strategy | The committee received an update on the economic case for the new hospital programme. Key points were noted as follows:<br>• Five options have been shortlisted with option 2 the preferred option which is for a phase 1 new build on Mallet car park.<br>• Capital investment of £252m is required. A very high level review of the impact on revenue costs has been done. The impact of workforce costs has not yet been reviewed.<br>• The indicative benefits value is £7.7m (mid point).<br>• NHSI/E are looking for 4 on the benefits/cost ratio. Option 2 in the SOC is 0.92.<br>There was a discussion concerning the risk factor around the benefits/cost ratio. It was explained that at OBC it is normal to be less than 1. It was noted that there are a number of Trusts putting forward bids so there will be a lot of competition. NHSI/E will scrutinise bids heavily so it is important to be realistic and able to stand behind the assumptions. | • Noted. |
| Chairs' Reports | | Director of Finance | The committee noted the Chair's Report from the CRIG meeting on 15th June. | • Noted. |
| **Risks escalated**<br><br>Challenges around delivery of ICIP and agency spend. | | | | |

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**Committee/Group Chair's Report**

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

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|---|---|---|---|
| Name of Committee/Group: | Finance & Investment Committee | Report to: | Board of Directors |
| Date of Meeting: | 20th July 2021 | Date of next meeting: | 24th August 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, Catherine Hulme, Matthew Greene, Sam Ball | Quorate (Yes/No): | Yes |
| | | Key Members not present: | Esther Steel |

| Key Agenda Items: | RAG | Lead | Key Points | Action/decision |
|---|---|---|---|---|
| System Finance Update | | FT DoF/CCG CFO | • AW advised that the meeting scheduled for 21st July had been cancelled due to the number of apologies.<br>• The main focus is on developing a system financial strategy. It was agreed that an update will be provided at the September meeting.<br>• Attendance at the meetings has been an issue and AW advised that she will be looking at reformulating the group. | • Noted. |
| Month 3 Finance Report | | Deputy Director of Finance | • There is a year to date deficit of £400k which is £400k better than planned.<br>• In month 3 recognised estimated Elective Recovery Funding (ERF) income of £2.7m was included for the first quarter. This value was based on information provided by GM. It was noted that this has now changed and an ERF income of £1.6m was reported to NHSI.<br>• Capital of £0.7m has been spent year to date.<br>• Cash is currently £40.5m.<br>• This would have been rated Red for agency spend but the overall financial position is Amber. | • Noted. |

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**Committee/Group Chair's Report**

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| Cost Improvement Programme Challenges and Plans | | Associate Director of Improvement and Transformation | • S Ball attended to provide an update on the Cost Improvement Programme Challenges and Plans.<br>• There was a discussion on the difficulties in getting sustained engagement from an exhausted workforce.<br>• FN urged caution around the suggestion of including a section on CIP in the Trust Induction and suggested that S Ball attend a Trust Induction to provide feedback.<br>• There was a discussion on the "Fresh Eyes" approach. FN updated that she does check in with a lot of new staff 6 weeks after their induction and suggested that S Ball / R Noble may like to join these meetings. | • Noted. |
| Month 3 iFM Finance Report | | iFM Director of Finance | • The financial performance for Q1 2021/22 was a pre-tax profit of £206k based on OHF contract income of £5.73m. This is £66k better than planned.<br>• Capital spend has been low but orders are in place to meet the £9m target and it is likely that this will be exceeded.<br>• The month end cash position has increased to £9m.<br>• A contract proposal has been submitted to the Trust and this forms the basis of the budget. Discussions remain ongoing. | • Noted. |
| 2020/21 Annual Report | | Deputy Director of Finance | • AC presented this update which included a review of the performance of the committee for 2020/21 and objectives for 2021/22.<br>• There are two actions rated Amber - Development of the 2021/22 operational financial plan and updated financial strategy and Receive updates on Model Hospital and Use of Resources (UOR). This is largely due to the pandemic.<br>• JN suggested capturing areas of good practice in the forward view for next year. | • Noted. |
| Review of iFM Bolton Standing Financial Instructions and Scheme of Delegation | | iFM Director of Finance | • LW updated that these have both been reviewed and made relevant to what iFM does. No powers for the Board of Directors have been increased.<br>• This has been approved by the iFM Board of Directors and has been reviewed by AW.<br>• It was agreed that governance advice is required on the most appropriate committee to approve these. | • Noted. |

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**Committee/Group Chair's Report**

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| Procurement Strategy | | iFM Director of Finance | • LW updated on the draft Procurement Strategy explaining that this has been through the Procurement Steering Group and feedback has been requested from members. It is planned to bring back the approved version to the October meeting.<br>• It was requested that a progress update is included in the quarterly updates to the committee going forward. | • Noted. |
| Chairs' Reports | | Director of Finance | • The following Chairs' Reports had been included for information:<br>○ Contract and Performance Review Group – 7th June. There was no meeting in July.<br>○ Strategic Estates Board – 1st July.<br>○ CRIG – 6th July. | • Noted. |
| **Risks escalated**<br><br>Agency spend. | | | | |

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| | Moderate assurance – potential moderate impact on quality, operational or financial performance |
| | Assured – no or minor impact on quality, operational or financial performance |

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