Bolton NHS Foundation Trust – Board Meeting 27th September 2018

Location: Boardroom **Time: 0900 – 1300**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story - Acute Adult	CEO	Presentation	To note
09.30	1.	Welcome and Introductions	Chairman	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chairman	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 30th August 2018	Chairman	Minutes	To approve the previous minutes
	5.	Action sheet	Chairman	Action log	To note progress on agreed actions
	6.	Matters arising	Chairman	Verbal	To address any matters arising not covered on the agenda
	7.	Chairman's Report	Chairman	Verbal	To receive a report on current issues
	8.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
10:00	9.	Quality Assurance Committee Chair Report	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	10.	Finance and Investment Committee – Chair Report	FC – Chair	verbal	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	11.	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
	12.	Audit Committee Chair Report	AC Chair	Report	AC Chair to provide a summary of assurance from the Audit Committee
10:30	13.	Urgent Care Delivery Board Chair Report	CEO	Report	To receive a report on the Urgent Care Delivery Board
10:45	14.	Urgent Care/Seasonal Plan update	COO	Verbal/ Presentation	To receive the seasonal plan update

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
11:00	15.	RTT update/Elective Care Expectation	COO	Report	To receive the RTT update

11:15 Coffee

11:30	16.	Performance Report	Chief Executive	Report	To receive
Strategy					
11:45	17.	Workforce and OD Strategy	Director of Workforce	Report	To approve the Workforce and OD Strategy
Governance					
12:00	18.	Complaints Annual Report	Director of Nursing	Report	To approve the Complaints Annual Report
12:15	19.	WRES	Director of Workforce	Report	To receive the WRES Report
12:25	20.	Freedom to Speak Up	Director of Nursing	Report	To note
12:30	21.	EPRR report	COO	Report	To note
12:45	22.	Revalidation	Medical Director	Report	To approve
Reports from Sub-Committees (for information)					
12:55	23.	Any other business			
Questions from Members of the Public					
	24.	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					
	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				

13:00 Lunch

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	30 August 2018
Venue	Ingleside Maternity Unit

Present:-

Mr A Thornton	Non-Executive Director/Deputy Chair (Chair)	AT
Dr J Bene	Chief Executive	JB
Mrs T Armstrong-Child	Director of Nursing	TAC
Mr A Ennis	Chief Operating Officer	AE
Ms A Gavin Daley	Non-Executive Director	AGD
Ms B Ismail	Non-Executive Director	BI
Mrs J Njoroge	Non-Executive Director	JN
Mr M North	Non-Executive Director	MN
Mr J Mawrey	Director of Workforce	JM

In attendance:-

Dr M Brown	Non-Executive Director (elect)	MB
Mrs E Steel	Trust Secretary	ES
Miss R Hurst	Deputy Director of Finance	RH

Apologies

Mr D Wakefield Mr A Duckworth, Dr F Andrews, Mrs A Walker

Welcome and Introductions

The Chairman welcomed Board members and attendees to the meeting.
Introductions were made

3. Declarations of Interest

Mr J Mawrey	Non-Executive Director iFM Bolton
Ms B Ismail	Non-Executive Director iFM Bolton Councillor Bolton Local Authority (item 1)
Mrs E Steel	Company Secretary iFM Bolton

4. Minutes of The Board Of Directors Meetings Held 26 July 2018

The minutes of the meetings held on 26 July 2018 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

The action sheet was updated to reflect progress made to discharge the agreed actions.

6. Matters Arising

There were no matters arising.

7. Chairman's Report

In the absence of the Chairman, Mr Thornton reminded Board members that the meeting would be Ms Gavin Daley's last before the end of her tenure as a Non-Executive. Mr Thornton read from an email sent by the Chairman thanking Ann for her commitment and support for the Trust as an integral part of the team.

Ms Gavin Daley responded that it had been a privilege to be part of a strong team and to have the opportunity to engage with frontline staff with a passion for the fundamentals of care.

8. Chief Executive report

The Chief Executive highlighted key points from her written report:

Bolton Partnership

The first shadow meeting of the emergent integrated care alliance board has now been held. The CEO advised that as the only representative of the FT she expressed concern about the membership of the group and the need for equity in voting and future decision making as ultimately it is envisaged that the governance arrangements being established will allow for delegated decision making.

iFM Bolton

The ongoing unrest regarding the pay award for former ISS staff continues to be a concern; Unison are planning to present their concerns to the iFM board on 4th September 2018 and may request the opportunity to present to a future FT Board meeting.

Media Issues

A neonatal death previously reported to the Board as an SI received significant media coverage, the external advisor had concluded that the Trust had followed national guidance for breast feeding however the coroner has indicated that the Trust should expect a regulation 28 letter.

In response to a question from Miss Ismail, the Director of Nursing confirmed that staff are provided with support and preparation for attending the Coroners Court

and where litigious issues are anticipated the Trust ensure appropriate legal representation. However there has recently been an increase in regulation 28s that had not been anticipated. The Director of Nursing advised that she had recently requested a review of all regulation 28 letters received over the last five years.

Shared Services

In response to a question regarding the potential VAT implications of shared services the Deputy Director of Finance agreed to take an action to ensure potential VAT implications of any shared service agreement were considered.

FT/18/71	Check if there are VAT implications to shared services through an SLA

Board Assurance Framework

The Board noted that the staffing levels risk had been increased to reflect current pressures and sickness absence levels

Resolved: the Board noted the CEO report.

9. Quality Assurance Committee Chair Report

Mr Thornton presented his report as Chair of the Quality Assurance Committee and highlighted the discussion points from the meeting which provided assurance or highlighted risks:

- The Acute Adult division presented their report trialling a new format designed to capture salient information based on CQC KLOEs to ensure Committee members are fully assured on all aspects of care. Committee members welcomed the new format and agreed that this level of detail was beneficial to provide assurance.
- Sepsis – the quarterly report was received but Committee members felt further information and triangulation against ICNARC data would provide further assurance.
- Mortality Committee – QA Committee members expressed concern that this vital Committee had not been quorate. The new Medical Director had advised QA committee members that he would ensure it received the appropriate focus.
- Risk Management committee – the ongoing concerns at Darley court were escalated to the QA committee – the CEO advised that the Council had responded and were addressing the issues.

Resolved: The Board noted the report from the Chair of the Quality Assurance Committee.

10. Workforce Assurance Committee Chair Report

The Chief Executive presented the Chair report from the July meeting of the Workforce Assurance Committee and highlighted the following areas from within the report:

- The Committee reviewed the draft Workforce and OD Strategy to provide input before presenting to the Board in September.
- Sickness absence remained a concern, especially within the Acute Adult division where performance deteriorated – further work was requested.
- Agency spend – although there has been a slight reduction in the rate of agency spend committee members were not assured that there is sufficient grip to provide the required results.
- Draft WRES reviewed, committee members agreed that the action plan required further work particularly with regard to actions to support BME staff to progress to senior positions.

Board members discussed the report and requested further detail particularly with regard to the actions being taken to reduce sickness absence and agency spend.

The Director of Nursing advised that absence rates within the HCA workforce are a particular concern and actions are being taken to focus on both recruitment and retention, this will include work to augment the Care Certificate and a piece of work to ensure clear expectation about the commitment expected.

In response to a question about data from exit interviews, the Director of Workforce advised that prior to March 2018 data collection in this area was inadequate. The process has now been revised so an analysis of trends will be undertaken when 6 months of data has been collated.

Board members discussed the ongoing challenge of reducing expenditure on agency staff, although a slight improvement had been achieved a significant amount was spent on covering for hard to fill posts – filling these posts should improve performance against the agency target.

Resolved: The Board noted the report from the Workforce Assurance Committee

FT/18/72	revise chair report to include actions and reissue

11 **Urgent Care Delivery Board Chair Report**

The Chief Executive presented the report from the Urgent Care Delivery Board and highlighted the discussion points from the meeting which provided assurance or highlighted risks to delivery of the nine high impact workstreams.

- The Urgent Care Board discussed the system response to black escalation and in particular the lack of a robust response from system partners to support discharges. Actions were agreed to share learning from this and to agree a revised escalation process.
- Some evidence to indicate that actions taken by NWAS to reduce admissions from care homes are starting to have an impact – agreed to monitor data for a further month and then take a decision with regard to the future of the immedicare contract.
- Although DTOC rates have reduced there are still high numbers of stranded patients and further work required to fully embed SAFER. The local authority is working on a process for a trusted assessor for CHC – good progress has been made with two of the biggest homes agreeing to

trust one assessment.

- RAID gave a presentation on capacity and demand but the inadequate bed provision for mental health patients remains a concern.

Board members discussed the national challenge of access to mental health beds and accepted that while the challenge of increasing demand is recognised as a national priority the strain this places on the system remain a significant risk.

The Chief Operating Officer advised that intoxicated patients are also a risk – discussions are ongoing to encourage the CCG to commission a safe and sober facility.

Resolved: The Board noted the report from the Chair of the Urgent Care Delivery Board.

FT/18/73	Check to ensure that risks associated with mental health patients are captured on the risk register

12. Performance Report

The Chief Executive presented the performance report.

Members of the Executive team responded to questions on the area of the report within their portfolio, the following key points were noted:

Quality and Safety

Ms Gavin Daley asked if there was any correlation between the staffing challenges and the increase in pressure sores, the Director of Nursing advised that staffing is identified as a factor in some cases there was also an emerging correlation between the number of transfers a patient made.

In response to a question about infections attributed to a lapse in care, the Director of Nursing advised that actions have been identified including a focus on antimicrobial stewardship and adherence to SIGHT to ensure appropriate sampling and testing.

The Director of Nursing reminded Board members that the Quality Assurance Committee receive a quarterly report on themes from pressure ulcer reviews and the actions taken to learn and address areas of concern which include education, adhering to policies and flow. Mrs Gavin Daley advised that she had attended a number of harm free care panel meetings hand had been assured by the accountability and process.

Board members discussed the metrics on the maternity dashboard and with reference to the presentation from the maternity team to the July Board agreed that the metrics and targets for interventions should be reviewed to ensure a consistent and appropriate picture balancing the professional opinions of midwifes and obstetricians with NICE guidance and maternal choice. Action agreed to review targets.

Operational

The Chief Operating Officer advised that performance against the A&E target had been challenged in July but had improved in August however although the number of breaches had reduced this remained fragile. Ambulance handover time has also improved – this is attributed in part to the work on streaming.

RTT performance – all trusts received a letter from Ian Dalton setting

expectations for RTT performance. The number of patients who have waited more than 52 weeks has increased in month from 3 to 20 and 140 patients are shown as having waited more than 40 weeks – the chief 'operating Officer caveated this data advising that some cases had been identified as data entry errors where clock stop rules had not been correctly applied.

The Trust continues to work with the CCG to negotiate funding for additional capacity in pressured specialities – a more detailed report is being prepared for the September 2018 Board meeting.

Cancer performance remains strong however a 20% increase in referrals is having an impact on diagnostic capacity – this is being managed by providing additional clinics – an additional 65 WLI clinics were provided in endoscopy. This challenge is expected to continue as demand for screening continues to increase. Demand for breast screening has also increased with the impact of activity transferring from Salford and Bury contributing to an additional 200 referrals in Q1. The future provision of breast services in included within theme three of Healthier Together.

The provision of a TIA service is included in sector discussions and is not something the Trust can achieve without collaboration with partners – update planned to QA Committee.

As discussed previously, late night transfers and multiple transfers can be detrimental to patients, on average one patient per night is transferred late – a task and finish group has been agreed to consider actions to resolve this.

Workforce

In response to a question about turnover, specifically whether the target is too high, the Director of Workforce confirmed that this in line with NHS benchmarking but is higher than would be expected in the private sector.

Board members recognised the benefits of a lower turnover rate and a stable workforce – the Workforce Assurance Committee receive a more detailed breakdown of workforce metrics by division, the Director of Workforce agreed to ensure the narrative of the performance report captured this information.

Finance

The Board noted that although capital expenditure was currently above plan it was unlikely to remain so however the position against the cap would be monitored with action taken to reduce expenditure towards the end of the year if required.

Use of Resources

Board members noted the "Use of Resources" data and recognised that while this was still underdevelopment it provided useful benchmarking metrics for more detailed review within allocated committees.

Resolved: Board members noted the Board Performance Report and agreed the following actions.

FT/18/74	review target/threshold for interventions in labour

FT/18/75	Update on RTT to September Board
FT/18/76	report to Workforce Assurance Committee to benchmark turnover rates
FT/18/77	Ensure narrative to explain and actions to address vacancies.
FT/18/78	Include internal target and NHSI target for agency spend within workforce metrics

13. **Any other business**

No other business.

19. **Questions from Members of the Public**

No questions submitted.

Date and Time of Next Meeting

27 September 2018

Resolved: 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.

August 2018 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/18/72	30/08/2018	Workforce Assurance Committee	revise chair report to include actions and reissue	JM	Sep-18	verbal update - complete
FT/18/47	28/06/2018	F & I Committee Chair report	Committee to request an update on benchmark performance against Carter procurement metrics	AW	Sep-18	verbal update
FT/18/61	26/07/2018	Patient Story	AE to check on environmental issues raised, other issues to be captured through patient experience team	AE	Sep-18	verbal update
FT/18/71	30/08/2018	Chief Exec Report	Check if there are VAT implications to shared services through an SLA	RH	Sep-18	verbal update
FT/18/73	30/08/2018	Urgent Care Board Chair report	Check to ensure that risks assoicated with mental health patients are captured on the risk register	JB/TAC	Sep-18	raise as aob at Risk Management Committee
FT/18/70	26/07/2018	SI report ophthalmology	report to be revised in view of comments	SH?	Aug-18	agenda item
FT/18/64	26/07/2018	Urgent Care Board Chair report	brief update on Seasonal plan	AE	Sep-18	agenda item
FT/18/31	26/04/2018	Data Security	update on plans for full implementation	AE	Sep-18	update on EPR implementation - agenda item
FT/18/56	28/06/2018	Workforce Annual Report	Workforce Assurance Committee to discuss implications of age profile and staff leaving after 1 - 5 years	JM/JB	Sep-18	Workforce Assurance Committee Chair report
FT/18/57	28/06/2018	Workforce Annual Report	Workforce Assurance Committee to discuss implications of flexible working	JM/JB	Sep-18	Workforce Assurance Committee Chair report
FT/18/58	28/06/2018	Workforce Annual Report	quarterly Friends and Family update to WAC with themes escalated to Board through Chair report	JM	Sep-18	Workforce Assurance Committee Chair report
FT/18/67	26/07/2018	Performance report	briefing on E Coli infections to QA committee	DIPC	Sep-18	QA agenda item - QA chair report
FT/18/69	26/07/2018	Performance report	Report to QA Committee on stroke and TIA service including retrospective audit	AE	Sep-18	QA agenda item - QA chair report
FT/18/75	30/08/2018	Performance update RTT	Update on RTT to September Board	AE	Sep-18	agenda item
FT/18/77	30/08/2018	Performance report - workforce metrics	ensure narrative to explain vacancies and actions to address.	JM	Sep-18	performance report - agenda item
FT/18/78	30/08/2018	Performance report - workforce metrics	Include internal target and NHSI target for agency spend	JM/RH	Sep-18	performance report - agenda item
FT/18/50	28/06/2018	Mortality Report	Update to Board on the application of technology for patient care within the Trust	FA	Oct-18	
FT/18/68	26/07/2018	Performance report	update on fracture neck of femur - evidence of good outcome measures to QA Committee	FA	Oct-18	
FT/17/92	26/10/2017	Board Assurance Framework	Audit Committee to discuss potential to revise report to include a projected score if actions have desired effect	ES	Oct-18	date changed to align with BAF presentation to Board
FT/18/38	31/05/2018	Patient Story	six month update on Patrick's story to QA committee	ES	Oct-18	
FT/18/74	30/08/2018	Performance report - maternity targets	review target/threshold for interventions in labour	TAC/RH	Oct-18	
FT/18/76	30/08/2018	Performance report - turnover	report to Workforce Assurance Committteee to benchmark turnover rates	JM	Oct-18	

Key


complete
agenda item
due
overdue
not due

Agenda Item No: 8

Meeting	Board of Directors

Date	27 September 2018

Title	Chief Executive Update

Executive Summary	The Chief Executive update includes a summary of key issues since the previous Board meeting, including but not limited to:
	• NHS Improvement update
	• Stakeholder update
	• Reportable issues log
	  ○ Coroner communications
	  ○ Never events
	  ○ SIs
	  ○ Red complaints
	• Board Assurance Framework summary

Previously considered by	

Next steps/future actions	To note				
	Discuss		Receive		
	Approve		Note	✓	
	For Information	✓	Confidential y/n	n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work	✓	To be fit for the future	✓

Prepared by	Esther Steel Trust Secretary	Presented by	Jackie Bene Chief Executive

All information provided in this written report was correct at the close of play 25/09/2018 a verbal update will be provided during the meeting if required

1. Awards and recognition

The Business Intelligence teams of the FT and CCG won the 2018 Team of the Year award in the Health Innovation Manchester Informatics Awards.

The Trust HQ secretariat team are the only NHS entrant to have been shortlisted as PA team of the year in the North West PA awards.

The shortlists for this year's Trust Awards have now been announced, tickets are on sale for what we hope will be a sell-out event at the University of Bolton (formerly Macron) stadium on 26th October 2018.

2. Stakeholders

2.1 CQC

We have received the initial notification for our CQC Well Led inspection, the initial document request has been submitted and in due course we will receive notification of the dates for the formal Well Led inspection. In addition to this we can expect unannounced inspections of at least one core service.

2.2 NHSI

The National Director of Urgent and Emergency Care has written to all NHS bodies and the Directors of Adult Social Services reminding organisations of the 90% operational target and outlining expectations of key actions organisations will be required to make towards the achievement of this target.

2.3 Greater Manchester

The CCG have provided a response to a GM request for assurance on the management of the RTT targets. *"The CCG and Bolton NHS FT have been working in partnership to trial new ways of working to manage elective capacity and demand. In the last year this has included: roll out of advice and guidance in primary care, the implementation of virtual models (for example in ophthalmology follow ups), shifting activity from inpatient to daycase, and improved utilisation of community settings. Further programmes of work are being reviewed and expedited as necessary in response to ongoing pressures."*

2.4 North West Sector

Exec to Exec meetings with WWL have continued, the two teams met on 21st September and are scheduled to meet again in October before providing a written update to a future Board meeting

2.5 Bolton

Work to develop the partnership governance arrangements for the Integrated Care Partnership continues.

Along with the Chief Executives of the Local Authority and Bolton CCG, I will be presenting at the Devolution Difference event which will be held in Bolton on 3rd October 2018. This event is intended to provide an opportunity for patients, staff, stakeholders and the public to hear about the plans for the transformation of health and care in Bolton.

2.6 iFM Bolton

We have received formal notification that a number of staff employed by our subsidiary estates and facilities company will be taking industrial action. An update will be discussed in the part two Board meeting.

Reportable Issues Log

Issues occurring between 20/08/18 and 25/09/18

3.1 Serious Incidents and Never events

One serious incident occurred during the reporting period, this was in relation to a failure to follow up.

3.2 Red Complaints

One red rated complaint was received in relation to the care of premature infant in 2015

3.3 Regulation 28 Reports

The Trust received two regulation 28 reports on 24 August 2018, these relate to a neonatal death (previous SI report) During evidence there was concern from the Assistant Coroner that midwives said they still follow national guidance and advise breastfeeding in bed whilst lying side-by-side. The Assistant Coroner also raised issues regarding documentation not being properly completed.

A patient who was treated in A&E following a head injury, was for transfer to SRFT for neurological management. NWAS were contacted for an ambulance to transfer which did not arrive until 1.5hours after being called. The Assistant Coroner issued a Reg 28 to cover the urgent transfer of patients and in the event of a delay a process for escalation and guidance for ongoing anaesthetic review (all of which had been covered in the Divisional Review and actions).

The Director of Quality Governance is currently undertaking a thematic review of Regulation 28s to better understand the reasons behind why the HM Coroner needed to issue. The terms of reference have been noted by the September Clinical Governance & Quality Committee and plans to report back at the November meeting.

3.3 Whistleblowing

Nothing to report

3.4 Media issues

There has been some adverse local media coverage relating to the potential industrial dispute amongst iFM staff.

4 Board Assurance Framework

The Board Assurance Framework has been developed to provide the Board with assurance with regard to the actions in place to ensure achievement of the objectives in the 2017/19 Operational Plan.

The risk score – the product of the likelihood of failing to achieve and the impact of a failure to achieve each objective is reviewed monthly in alignment with the production of the performance report.

For objectives given a score of 16 and higher, the full Board Assurance Framework sets out the risks to achieving the objective, the controls and assurance in place to mitigate the risks and the actions required where there are gaps in controls or assurance. A summary of this is provided on the following page.

The full Board Assurance Framework will be reviewed at the November Audit Committee

	Trust Wide Objective	Lead	I	L		Sept	Aug	June	May	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	16	Sub-optimal of robust clinical engagement with Antimicrobial Stewardship.	Implementation of all key actions from the IPC review – July 2018	IPC committee
1.2.1a	For our patients to receive safe and effective care (pressure ulcers)	DON	5	2	-	10	10	10	10	No identified risks, sharing, learning arrangements robust.	Maintain current governance arrangements and enhance ward based training (calibrated to releasing staff safely)	QAC and Harm Free Care
1.2.1b	For our patients to receive safe and effective care (falls)	DON	5	3	-	15	15	15	15	Sub-optimal adoption of all preventative falls measures consistently	Implemented updated Falls Action Plan	QAC and Harm Free Care
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	4	-	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Roll out mortality review process Drive further improvement in ward observation KPI's Ensure Patient Track Oversight Group delivers on action plan Deliver on Quality Account 2017/18 sepsis actions (March 2019)	Mortality reduction
1.4	Staff and staff levels are supported	DoW	4	5	-	20	20	16	20	Recruitment, limited pool of staff Staffing for escalation areas Sickness rates esp within AACD	Recruitment workplan in place overseen through Workforce Assurance Committee Targeted actions to reduce sickness absence New Workforce Strategy to be approved by the Board in September 2018	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	20	Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Urgent Care pressure and increased demand on Diagnostic and Elective work	Urgent Care programme plan SAFER ECIP support Enhanced pathways as part of the new streaming model commences Oct 2018	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	20	Healthier Together Access to Transformation Fund Delivery of cost improvement plans Lack of workforce leading to agency costs Impact of GM theme work Fragmentation of commissioning Organisational change NHS funding settlement Efficiency requirements	Develop Estates Master Planning Implement Capital planning process – RIBA implementation Develop strategic approach to cost improvement Locality plan delivery Joint system savings approach LCO Development Strategic financial planning for 5 year timeframe	IPM F&I comm System groups:-System Board Strategic Estates group HWBE
4.4	Compliance with NHS improvement agency rules	DoW	4	4	-	16	16	16	16	Sickness absence Workforce shortage Gaps in rotas	Additional admin support for wards. Ongoing recruitment Targeted actions to address sickness absence	IPM Workforce comm
5.4	Achieving sustainable services through collaboration within the NW sector	Dir Strat.	5	4	-	20	20	20	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing discussions with WWL – paper planned for future Board	Board F&I
5.5	Supporting the urgent care system	COO	4	4	-	16	16	16	20	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Estates improvements to A&E – Phase 2 (new resuscitation and ambulance triage) expected completion Nov 2018, Phase 3 (increased triage/consultation rooms and new reception/ wait area) expected Dec 2018 Further work with Community services on discharge to assess/home based care	Urgent care prog board

All information provided in this written report was correct at the close of play 25.09.18 a verbal update will be provided during the meeting if required

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	19th September 2018	Date of next meeting:	17th October 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Members present/attendees:	A Thornton, J Bene, M Brown, J Mawrey. Representation from three of the four clinical divisions	Quorate (Yes/No):	No
		Key Members not present:	T Armstrong Child, A Ennis, F Andrews, S Martin, Integrated Care not in attendance

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story – Acute Adult		The Assistant Divisional Nurse Director had been gathering real patient experience information in urgent and emergency care and provided three examples of feedback from patients and their comments on what a gold standard would represent.	Feedback noted and methodology deemed effective.
Clinical Governance and Quality Committee Chair Report		Noted low compliance for NBTC competency assessments. Assurance provided that only fully trained staff will be expected to complete transfusions.	Divisions to provide updated status of compliance in October.
Divisional Quarterly Report – Elective Care		Comprehensive report received, the committee were assured the division have a good awareness of the challenges with actions in place to address these.	
Divisional Quarterly Report – Family Care		Report received outlining the challenges and successes for the division. Committee members raised concern around a recent incident regarding a birthing ball.	RW to take this issue through Medical Devices Committee
E Coli Infection Briefing		Assistant Director of Infection, Prevention and Control presented the report outlining the clinical implications of Gram negative infections and the emergence of new national mandatory reporting schemes.	Report noted

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

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

Committee/Group Chair's Report

Stroke and TIA Update		Paper presented following Board concern with regard to the performance against the TIA target. The Committee discussed the emerging risk of pressure within the stroke network and concerns regarding the number of stroke patients not accepted at the specialist stroke unit in Salford Noted that improvements in accessing speech and language therapy would improve SSNAP rating.	Further report requested on the number of incidences relating to capacity at the specialist stroke unit. CCG representative took an action to discuss at a commissioner level, the CEO agreed to pick up issues raised within GM
HBPC Quarterly Update		The Committee received the quarterly report on colposcopy. The majority of actions required against the March 2017 external QA report have been addressed. with just two outstanding Histology recommendations remaining. KPIs have been affected due to workforce issues which have now been resolved so improvements should start to be seen.	Report noted
Quality Account Acute Kidney Injury (AKI)		Noted that agreement been made to develop the outreach team to include AKI and a business case is being developed to support this.	
Performance Report		Received for information	
NHS Breast Screening QA Visit Report and Action Plan		Report and action plan received outlining progress made against the 33 recommendations made following QA visit. The Committee were assured with actions taken so far and noted the ongoing work on longer term actions	Noted one action around the environment which was an action from the previous QA visit and will depend on long term planning for Breast Services. Team advised to escalate any actions where support is required
Antenatal New born screening – QA Visit Report and Action Plan		The Divisional Medical Director presented the report advising the new Head of Midwifery has taken ownership of the action plan and the QA team are assured with the progress being made on the actions.	

	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

Patient Experience, Inclusion and Partnership Committee		Lack of assurance noted around the Patient Experience Plan for the Emergency Department.	Patient Experience Lead for ED to attend the next meeting to provide an update.
Risk Management Committee		Concerns around security arrangements at Lever Chambers.	RS to commission Violence and Aggression sub group to review security incidents at Lever Chambers and report to Health and Safety
IT and Information Committee		Concern raised regarding availability of technical resources related to the Malinko Scheduling.	Plans to be developed to include risks to delivery
Safeguarding Committee		No risks to escalate	
Comments			
Risks Escalated			

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	25th September 2018	Date of next meeting:	23rd October 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Members Present:	A Duckworth, J Bene, A Walker, S Martin	Quorate (Yes/No):	Yes
		Key Members not present:	D Wakefield, B Ismail, A Ennis

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 5)		Director of Finance	Key points noted from the Finance & Activity Report: • the Trust has a year to date deficit of £2.5m when PSF and impairments are excluded from the position; £0.4m worse than plan; • against the control total the Trust has a surplus of £0.2m; £0.9m less than plan; • there were no additional non-recurrent Balance Sheet adjustments released into the position; • agency costs are at £3.9m against a year to date NHSI target of £2.8m; • ICIPs at £2.5m are £1.8m below plan for the year. • the month end cash balance is £12.4m which is better than plan by £5.0m this month; • year to date capital spend is £5.7m which is £0.9m above the capital plan; and, • the Trust Use of Resource Rating is 2 as at the end of Month 5 which is on plan. ICIP performance remains well below plan with the low level of risk adjusted schemes still a concern. Agency costs remain well above the NHSI target. It was noted that the Trust would experience cash flow challenges towards the end of Q4 under the mid case forecast unless mitigating action was taken. This could reduce funding available for capital expenditure.	The key material risk for the year remains Divisional performance/ICIP delivery. Agency spend remains significantly above plan and shows no sign of improvement despite significant efforts being reported. Urgent progress required. Divisional forecasts have improved but continue to exceed Trust plans by a significant amount, reflecting poor ICIP achievement. The risk remains high that forward PSF targets may be missed. Potential pay award risks were noted in respect of medical and iFM staff as well as AfC staff Cash and UoR ratings are still regarded as key risks. Mitigation plans in hand (see next item).

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Cash Management		Director of Finance	The Committee received an update on the Trust's Cash Management Strategy and in particular potential mitigation plans to address potential cash flow challenges in Q4. Options presented: • placing surplus cash on deposit • managing aged debt • managing supplier payments • reduction of cap ex spend.	The Committee approved the use of the HM Treasury National Loan Funds to place surplus cash on deposit as requested. Further plans to reduce aged debt, manage supplier payments and a potential reduction in capex spend were also noted, although the Committee Chair stressed that the first two items ought to be part of the normal day to day cash management process.
NHSI Self-Assessment Checklists		Director of Finance	The paper was presented to update the Committee on the various NHSI self-assessment checklists aiming to support ICIP delivery and to provide assurance in this regard.	The Committee agreed the importance of demonstrating that the FT makes full use of NHSI resources, including these checklists. It was however noted that it was equally important not to discourage development of local initiatives.
Reference Costs for 2017/18		Deputy Director of Finance	The Deputy Director of Finance provided a regular update to the Committee on the reference cost process for the current year.	The Committee confirmed its approval of the costing process outlined in the paper.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Chair Reports from CRIG		Director of Finance	The Committee received the Chair's reports from the CRIG meetings held on 14th August and 11th September. Concern was expressed about the number of items not approved at August's meeting due to poor preparation of Business Cases. It was acknowledged that the Divisions may require more support and this will be reviewed. The Committee noted an escalated risk at the 11th September meeting regarding the accuracy of forecasting of the larger schemes, for example A&E and EPR. The CEO confirmed that this was due mainly to the delay in iFM improving its project management resource but this has now been addressed and improvement should be seen in the future.	Chair reports noted. Support for Divisions in preparing comprehensive Business Cases to be reviewed.
Chair Reports from the Strategic Estates Board		Chief Executive	The Committee received the Chair's reports from the Strategic Estates Board meetings held on 8th August and 12th September. It was noted that iFM had still not formally responded to a question regarding bringing forward the potential completion date of the A&E refurbishment, although it is understood that this is not going to be possible.	Chair reports noted.
Chair Report from the Digital Transformation Board		Chief Executive	The Committee received the Chair's report from the Digital Transformation Board meeting held on 13th August. No risks were escalated.	Chair report noted.
Report on GM Developments		Director of Finance	A verbal update was provided by the Director of Finance on a recently issued GM paper on the financial target operating model. This paper is being discussed by GM Directors of Finance and will be shared at the next Finance & Investment Committee meeting.	Update noted.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Tender Update		Director of Finance	The Committee received and noted an overview of the competitive tender exercises that the Trust is presently engaged in. The joint proposal for the Greater Manchester Diabetic Eye Screening Programme was not successful. The impact on Bolton FT is being assessed but could be significant.	It was agreed that a letter to question the decision on the GM Diabetic Eye Screening Programme tender would be raised although legal opinion suggests that a formal challenge would probably not succeed.
Provision of IT Services to Bolton CCG		Director of Finance	The Committee received for information a paper outlining the CCG's Business Case for the transfer of IT services currently provided by GM Shared Services to Bolton FT. This is to be considered by Bolton CCG's Board at its meeting on 28th September. The matter had been handled at Bolton FT through the Digital Transformation Board (DTB) but no formal paper had been prepared to date.	The Committee requested formal assurance that Bolton FT has fully appraised its ability to deliver and that it has identified and is able to mitigate any potential risks, particularly in the areas of: 1. Finance 2. Technical Resource/Capability 3. Reputation It was agreed that the DTB should be asked to provide such assurance by way of a paper to the Finance & Investment Committee.

Comments

Risks escalated for 2018/19

- Divisional Performance: Forecasts/ICIP identification and delivery/Pay Costs (agency) - key material risks for the year
- PSF Achievement (A&E and Financial)
- National Pay Award (AfC) – potential funding shortfall, and also iFM and medical pay awards
- Cash and UoR ratings (especially potential cash constraints under mid case forecasts)
- CapEx delivery (in particular if cash constrained)
- GM Integrated Care Control Total: risk for 18/19 capped at £263k, but longer term risks are more uncertain

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Trust Board
Date of Meeting:	20th September, 2018	Date of next meeting:	16th October, 2018
Chair:	Jackie Bene	Parent Committee:	Trust Board
Members present/attendees:	J Bene, J Mawrey, A Walker, C Sheard, R Sachs all clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	T Armstrong Child, A Ennis, F Andrews, S Martin

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & Organisational Development Strategy (Draft subject to Board approval)		• The improvements made to the Workforce & Organisational Development were very well received. • It was noted that the Strategy has been developed through consultation with operational managers, Executive / Non-Executive Directors, staff-side partners and staff.	Actions agreed:- • The Workforce Assurance Committee fully supported the details of the Strategy and it is recommended to the Trust Board for approval.
Freedom to Speak Up Annual Report		• The FTSU Guardian noted that three concerns were raised in the organisation (April, 17 - March, 18). The three concerns related to culture (two) and low staff morale as a result of staff moves (one). All concerns raised with the Guardian have been closed. • It was noted that whilst the NHS Staff Survey reported that staff were able to raise concerns the Committee were minded that few concerns were being raised with the Freedom to Speak Up Guardian when compared to peer organisations. • The Committee then discussed (and approved) a re-energised approach to this important agenda. This re-energised approach will then be launched by Dr Henrietta Hughes, National Guardian Office in late October, 2018.	• The Workforce Assurance Committee fully supported the need to strengthen arrangements and the proposals to re-energise this critical agenda were supported.

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Committee/Group Chair's Report

Staff Engagement Update		• The report provided an update on the NHS Friends and Family quarter 1. The results indicated that there had been no material changes since last quarter and the Trust continues to benchmark well. • The arrangements for the 2018 NHS National Staff Survey were discussed with survey being issued on 23rd September, 2018. • A discussion took place regarding the plans to adopt the Go Engage Model to help develop a self-sufficient and sustainable approach to driving staff engagement within the Trust.	Agreed actions: • A full presentation on the Go Engage model to come to WAC in November, 2018.
Sickness Absence	•	• The sickness rate in August showed minimal improvement when compared to last month. • Full discussion was given regarding the enabling actions that were being taken at Trust and Divisional level. These include:- On 1st October additional support will be in place for the Acute Division (area of highest sickness absence) via the Attendance Matters support team; The Trust has recently increased the number of mental well-being sessions being offered (from mid-September); a Resilience Programme was launched on 20th September with up to 400 places being offered; targeted work has been commissioned to look at high sickness levels amongst HCSW.	Agreed actions: • Feedback to WAC on the findings of the task & finish group looking at why sickness is high for HCSW and the associated actions. • Additional detail to be provided in the next report on the enabling actions that are being taken at both a Trust and Divisional level. Report to include timescales to deliver trajectories.

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Committee/Group Chair's Report

Occupational Health Update		• First report received by Committee on OH performance. Noting that OH is provided by a Joint Venture between Bolton, WWL and Preston. • Paper highlighted concerns about Q1 performance. Specifically the poor delivery against critical Key performance indicators. This led to further discussion on governance arrangements that had been in place over the recent years.	Agreed actions: • Terms of Reference for Joint Collaboration Board to be reviewed at the next meeting. • Trajectories for improvements to be agreed between FT and Joint Venture and reviewed at WAC. • Survey to be undertaken on manager satisfaction levels of the service.
Agency		• Year to date the Trust is £260,000 behind Annual Plan forecast. Disappointingly there has been an increase in reliance on Medical Agency staff in August and a very slight decrease in Agency spend for Nursing and AHP. There remains agency pressures in IFM (Senior Management). • The majority of agency spend is due to 'hard to fill' vacancies. The Committee received an update on the enabling actions that are taking place to recruit into these areas and therefore drive down Agency Spend. Elective Care in particular are forecasting a significant reduction in agency spend in October when a number of these key roles will be filled. • It was noted that there is a detailed piece of work underway that may have a positive impact on the year to date agency spend.	Agreed actions: • Remain a standing item on the agenda with an update being provided on the enabling actions being taken at a Divisional and Trust level to drive down Agency rates. • Update at next WAC on the work being undertaken by Workforce & Finance colleagues to reconcile respective data.

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Committee/Group Chair's Report

WRES		• It was noted that whilst some improvement had been made in some of the WRES indicators a sharpened focus is required on this important agenda. • It was noted that delivery against the WRES will be a key strategic target for the Workforce & organisational Development Strategy	Agreed actions:- • The Workforce Assurance Committee fully supported the proposals set out within the paper and the details were recommended to the Trust Board for approval. • Subject to Trust Board approval then WRES findings and associated actions will be published on the Trust website at the end of September, 2018.
Guardian of SafeWorking report		• The Guardian of Safeworking presented his report and noted that the level of understanding of the Junior Doctor's contract and exception reporting continues to improve. The main concern raised by the Guardian was that no information was returned from the Guardian in A&E, General Surgery and T&O.	Agreed actions:- • Divisional Directors to raise with Departments where information had not been provided to the Guardian. Update to then be provided to the next WAC by these Divisional Directors.
Workforce Operational Committee		• The Director of Workforce presented his Chairs report to the Committee.	
Comments • The Workforce Assurance Committee recommended to the Trust Board:- A. Workforce & Organisational Development Strategy B. Freedom to Speak Up Report and proposed actions C. WRES Report and associated actions			
Risks escalated • None			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	20th September 2018	Date of next meeting:	22nd November 2018
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	J Njoroge, M Brown, A Walker, C Hulme, Internal Audit, External Audit, C Ryan	Quorate (Yes/No):	Yes
		Key Members not present:	S Martin

Key Agenda Items:	RAG	Key Points	Action/decision
Internal Audit Progress Report		On track to complete workplan.	
Waste Management Final Report		Report has previously been seen by Audit Committee as high risk report. Two high risk, three medium risk and one low risk findings. Report has been presented at iFM Board	Follow up report to be undertaken and reported to November Audit Committee
Agency Staffing Final Report		High risk report - urgent actions have been implemented. Not currently seeing financial improvement that would be expected from actions so a detailed piece of work is being completed to look at this.	J Mawrey attended to discuss actions
Risk Management		Low risk report noting good progress especially in relation to risk register procedures. Robust controls in place.	
Payroll Final Report		Low risk report with three low risk findings and one medium risk finding. Committee members raised concern around delays in managers terminating employment on SimpleSAF and the implications around this.	Briefing report to be brought to the next meeting.
Technical Update		Update received no concerns raised.	
Local Counter Fraud Specialist Report		Increase in referrals and investigations noted.	
Fraud Survey Report		Counter fraud now included on mandatory training and Counter Fraud Workshops are taking place.	
Assessing the Performance of Audit Committee		Review against the HFMA standards for NHS Audit Committee	Highlighted need for Audit Committee training for Non-executive Directors.

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Committee/Group Chair's Report

Standing Financial Instructions and Scheme of Delegation		Proposed changes to SFIs regarding single supplier waivers. Concern was raised regarding the level of risk around this. Discussed options around implementing and planning follow up audit.	Agreed to approve change subject to advice from Procurement.
Waivers		Concern regarding some waivers highlighted as a single supplier.	Committee requested further details on single supplier waivers
Losses		Report noted.	
iFM Bolton Losses		No losses noted.	

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Urgent Care Board	Report to:	Board of Directors
Date of Meeting:	11th September 2018	Date of next meeting:	9th October 2018
Chair:	Dr J Bene/Su Long	Parent Committee:	Board of Directors
		Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Bolton Acute & Community Funding	Green	FT	• Urgent Care Board approved £1.5 million to FT for the winter schemes	
Mental Health Strategy & Proposals	Amber	GMMH	• Presentation by Commissioners on the schemes an impact • Capacity being increased • FT still concerned re long waits in A&E	• Further work to be done with GMMH on risk assessing waits in A&E
High Impact Changes	Amber	NWAS/ CCG	• Ambulance call out and Care Homes • Further data needed but promising signs	• Further work with NWAS and Mental Health on uptake
Streaming	Red	FT	• Deterioration in discharge times • GP streaming picked up • Super stranded/stranded too high	• FT to review discharge times • Delay in new build • Work needed on medical optimised
Reducing Medical Optimised	Red	CCG/LA	• Action plan presented • Needs system support	• CCG & LA to work with IDT on solution by end of September
Closure of Four Seasons	Red	CCG/FT	• Closure due at end of month • No assurance that 10-12 beds needed available	• FT to provide specific update on what needed • CCG to confirm Commissioning intentions
Comments				
Risks escalated				

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Agenda Item No: 15

NHS Bolton NHS Foundation Trust

Meeting	Trust Board

Date	Thursday 27th September 2018

Title	RTT Performance Update

Executive Summary	To provide and update on the RTT positon within the Trust, and the activity delivered as part of backlog reduction project.

Previously considered by	N/A

Next steps/future actions	Future update to be reported to Trust Board			
	Discuss	✓	Receive	✓
	Approve		Note	
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work		To be fit for the future	✓

Prepared by	Lisa Galligan-Dawson, Deputy Divisional	Presented by	Andy Ennis, Chief Operating Officer

NHS
Bolton
NHS Foundation Trust

RTT (18 weeks) Incomplete Positon, and Backlog Reduction Project Update

Purpose of paper

In May 2018 a paper was presented to Trust Board providing an overview of RTT performance and the actions being taken.

The purpose of this paper is to provide an update on the Trust's RTT position, and the backlog reduction work that has been undertaken May to August 2018 (inclusive).

Background

Nationally there has been a deterioration in the performance of the 18 week incomplete standard (92%). This is as a result of urgent care pressures, workforce challenges and increased demand. The Trust has failed to deliver the standard since September 2017.

In recognition of the challenges faced the recent joint NHS England and NHS Improvement planning guidance does not stipulate adherence to the 92% incomplete standard. Instead it states that the RTT waiting list should be no higher in March 2019 than it was in March 2018.

Both Bolton NHS Foundation Trust and NHS Bolton CCG are committed to achieving the constitutional standard of 92% in the current year and beyond. In order to do this, underlying deficits in capacity and demand need to be addressed. In the short term, a project on backlog reduction commenced over the summer months.

Current Position

The RTT position improved in June and July following the delivery of additional outpatient and theatre activity. However, the improvement was not sustained in August. There are a number of reasons why improvement was not sustained and the paper will go through some of the key factors below.

Month	Number of Patients	Under 18 Weeks	Over 18 Weeks	% < 18 weeks
Mar-18	22812	20178	2664	88.45%
Apr-18	22675	20038	2637	88.37%
May-18	23054	20707	2347	89.82%
Jun-18	22985	20683	2302	89.98%
Jul-18	22367	20169	2198	90.17%
Aug-18	23009	20605	2404	89.55%

Specialty teams had planned to deliver 1447 units of additional RTT activity up until the end of August. This is activity above plan. The predicted performance was 92.7% at the end of September 2018.

As of 31 August 2018, 1215 units of additional RTT activity have been delivered. A further 246 units of activity are planned for September.

However, the activity has not resulted in the planned number of clock stops (Patients treated and no longer on an open 18 week pathway). This is due to a number of reasons:

- As part of clinical risk management, and in discussion with the CCG, the amount of RTT activity in Ophthalmology was reduced in order to deliver high risk follow up capacity. There was a reduction in planned RTT activity from 740 slots to 321 (with a further 110 planned for September). This is a reduction of 309 slots of which 260 were expected clock stops.

- Theatres / anaesthetics staffing has impacted on the ability to deliver the volume of admitted activity (operations / procedures) detailed in the original plan (which is guaranteed to stop the 18 week clock). The plan also assumed the delivery of theatre lists at Leigh Infirmary from July. Leigh Infirmary have been unable to accommodate activity currently, although trial lists with General surgery are due to commence from October 18.

- As specialties were unable to deliver some of the planned admitted activity, additional outpatient activity has been delivered instead. Although outpatient activity does contribute towards the treatment of more patients on an RTT pathway not all of these patient will have had first definitive treatment in this time period, and it has reduced the number of clock stops expected.

- The number of cancellations has been higher than expected. There have been 622 cancellations (year to date up to July 18) compared to 614 for the same period 2017/18. In the 3 months where additional RTT surgical activity was planned (June, July, August), the project plan included expected cancellations of 292; the actual cancellations were 385; an additional 93 above the projected figures.

  Of the 385 cancellations impacting the project period, there were 147 cancellations in T&O predominantly as a result of trauma demand and 109 of the cancellations were as a result of bed pressures. The remaining cancellations were a combination of non-clinical reasons, but unprecedented amounts of sickness and emergency leave in theatres and anaesthetics were contributory factors.

  Cancellations can result in patients over 18 weeks continuing to be untreated (backlog) or patients who were to be treated in time becoming over 18 weeks (added to the backlog).

  Although there has been a recent increase in day care beds, this has not mitigated against the number of cancellations as a result of bed pressures.

- The Trust has seen a significant increase in 2ww suspected cancer referrals (20%), and subsequently some planned RTT patients have been postponed to deal with the clinically urgent patients referred on these pathways.

Finance

The planned expenditure for the RTT project was estimated as £1,110,480 to £1,164,484.

Delivery costs have been calculated as:

Activity Period	Cost of Activity
5 months to August 18	£535,000
Forecast – specialty estimate for September activity	£253,000
Forecast outturn – sum of above	£788,000

This can be seen by specialty, and activity unit in Table A. Some of the activity delivered in specialties is non RTT (clinical high risk follow ups) and some activity relates to pathway management (follow up appointments for the new outpatient appointments etc.). This accounts for the variation between the RTT activity numbers in the previous section.

Table A

		ACTUALS 5 mths to Aug-18		FORECAST Sep-18		FORECAST OUTTURN	
Specialty	**Activity type**	**Activity**	**Cost £**	**Activity**	**Cost £**	**Activity**	**Cost £**
T&O / OIS	Admitted	44	141,289	34	109,171	78	250,460
	Non admitted	122	39,255	41	13,140	163	52,395
General Surgery	Admitted	39	64,924	33	54,452	72	119,376
	Non admitted	48	11,063	37	8,639	85	19,702
Plastic Surgery	Admitted	87	87,133	8	7,985	95	95,117
	Non admitted	53	11,061	0	0	53	11,061
Opthalmology	Non admitted	459	71,598	195	30,830	654	102,428
Gynaecology	Admitted	6	10,553	6	10,553	12	21,107
	Non admitted	7	1,691	24	5,907	31	7,598
Cardiology	Non admitted	66	15,783	42	9,698	108	25,481
Clinical Haematology	Non admitted	0	0	40	2,421	40	2,421
ENT	Non admitted	694	78,550	0	0	694	78,550
Oral Surgery	Non admitted	7	2,075	0	0	7	2,075
		1,632	**534,977**	**460**	**252,795**	**2,092**	**787,772**

Table B demonstrates the activity delivered by the key RTT specialties. There is underperformance in ENT. In part this links to the resignation and departure of a consultant, and the inability to back fill all sessions over the summer months. Additional core activity is now being delivered to meet the planned activity level.

Table B

Activity – Actual v Plan for 5 months to Aug-18

Specialty	Activity type	Plan	Actual	over / (under)	Underlying contract delivery variance	RTT activity
T&O / OIS	Admitted	1,091	1,153	62	15	44
	Non admitted	13,214	13,885	671	549	122
General Surgery	Admitted	2,568	3,420	852	813	39
	Non admitted	7,517	7,470	(47)	(95)	48
Plastic Surgery	Admitted	277	358	81	(6)	87
	Non admitted	1,185	1,379	194	141	53
Opthalmology	Non admitted	19,855	21,612	1,758	1,299	459
Gynaecology	Admitted	558	511	(47)	(53)	6
	Non admitted	7,409	7,805	395	388	7
Cardiology	Non admitted	11,401	12,352	951	885	66
ENT	Non admitted	7,873	8,011	138	(556)	694
Oral Surgery	Non admitted	3,123	3,296	173	166	7

- RTT activity in Table B includes all activity as part of the project plan (including high risk follow up etc.)
- Activity is for the 4 months to July as actual, and estimated for August.

Next Steps

The funding allocated was initially up to the end of September 2018. However, the plan is to utilise the remaining funds to continue to deliver additional activity in October and November to improve performance.

At present there is no resolution to the underlying capacity and demand shortfalls. The original paper presented in May indicated business cases were needed for General Surgery, Endoscopy, Trauma & Orthopaedics and Ophthalmology. Discussions are ongoing to resolve this with the CCG.

Without the continuous delivery of additional activity, and resolution to the significant capacity and demand gaps the Trust will continue to fail to deliver the RTT standard, and is also at risk of failing to achieve the planning guidance requirement that RTT waiting list should be no higher in March 2019 than it was in March 2018. The Trust needs to deliver an additional 89 treatments (clock stops) per month to prevent the backlog growing. Each treatment pathway includes outpatient attendance, and the majority include multiple appointments, diagnostics and admitted treatments. At present all additional activity, and all activity being delivered to bridge the underlying capacity and demand deficit is being delivered at premium rate. This method of delivery is not sustainable operationally or financially.

Following a two day visit from NHSI to review RTT processes, initial feedback was positive. A full report will be sent through in the coming weeks. Initially NHSI have agreed to support us with a check and challenge process relating to capacity and demand, and to help us develop a training strategy.

Risks

The waiting list is expected to grow if the underlying capacity and demand deficit is not addressed. Once funding is agreed, there will be a significant period of recruitment needed, and a lead in time before the necessary activity can be delivered.

Continuing to deliver additional activity will not be reliable as it is dependent on good will. The cost of delivering additional activity will be at premium rate internally. The use of any third party providers / locums will increase the costs further.

There is expected to be a peak in Trauma demand late November / early December. This will further impact the elective T&O programme of work. Elective T&O work will also be suspended to support Urgent Care bed flow from 23.12.18, this suspension will be in place in line with any regional and national directives. 2017/18 saw T&O elective activity using inpatient beds suspended for 6 weeks.

Surgical specialties have planned elective downtime from 23.12.18; this suspension will be in line with any regional and national directives. 2017/18 saw routine surgical activity using inpatient beds suspended for 5 weeks.

Elective downtime is expected to further impact the RTT positon. An increase in Day care capacity has been introduced to help reduce the impact.

Bolton NHS Foundation Trust

RTT & 2WW Information

March -August 18

End of Month Signed off Position

Month	Number of Patients	Under 18 Weeks	Over 18 Weeks	% < 18 weeks	PTL Growth/ Reduction	Backlog Growth/ Reduction	Backlog Reduction Required	Target
Mar-18	22812	20178	2664	88.45%	N/A	N/A	840	92%
Apr-18	22675	20038	2637	88.37%	-137	-27	823	92%
May-18	23054	20707	2347	89.82%	242	-317	503	92%
Jun-18	22985	20683	2302	89.98%	173	-362	464	92%
Jul-18	22367	20169	2198	90.17%	-445	-466	409	92%
Aug-18	23009	20605	2404	89.55%	197	-260	564	92%

*August Position still needs final sign off and may change

End of Month Pre-validated Position

Month	Number of Patients	Under 18 Weeks	Over 18 Weeks	% < 18 weeks	% Increase through validation	Reduction through validation
Mar-18	22891	20178	2713	88.15%	0.31%	49
Apr-18	22706	20038	2668	88.25%	0.12%	31
May-18	23077	20707	2370	89.73%	0.09%	23
Jun-18	23189	20686	2503	89.21%	0.78%	201
Jul-18	22490	20169	2321	89.68%	0.49%	123
Aug-18	23234	20605	2629	88.68%	0.87%	225

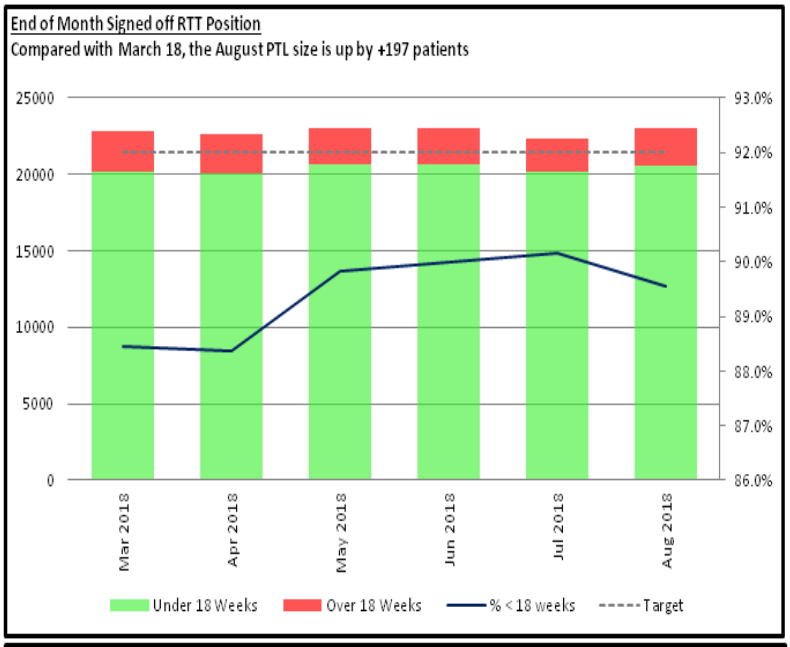
New Demand

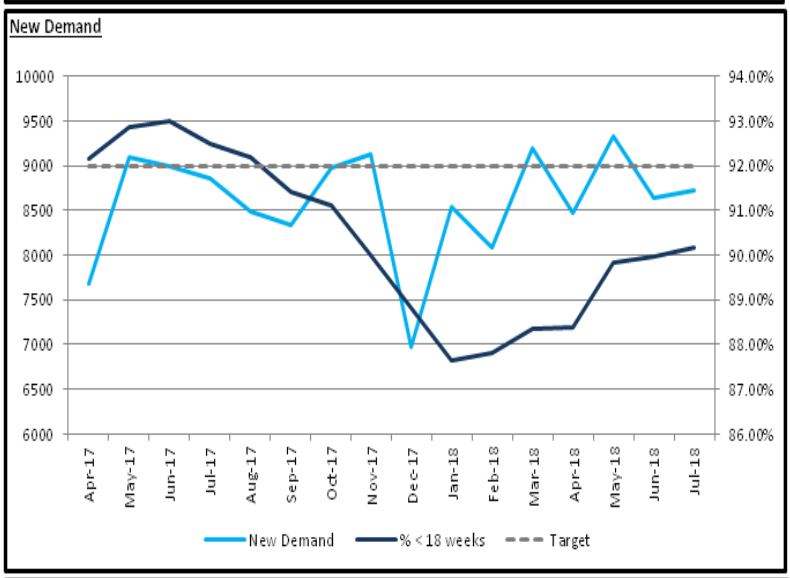
Month	Number of New Pathways	Demand Growth/ Reduction	% < 18 weeks	Target
Apr-17	7686	-1705	92.14%	92%
May-17	9098	1412	92.87%	92%
Jun-17	8995	-103	93.01%	92%
Jul-17	8853	-142	92.51%	92%
Aug-17	8483	-370	92.21%	92%
Sep-17	8340	-143	91.42%	92%
Oct-17	8974	634	91.11%	92%
Nov-17	9131	157	90.01%	92%
Dec-17	6971	-2160	88.84%	92%
Jan-18	8538	1567	87.64%	92%
Feb-18	8092	-446	87.80%	92%
Mar-18	9196	1104	88.34%	92%
Apr-18	8479	-717	88.37%	92%
May-18	9331	852	89.82%	92%
Jun-18	8642	-689	89.98%	92%
Jul-18	8730	88	90.17%	92%
Aug-18				

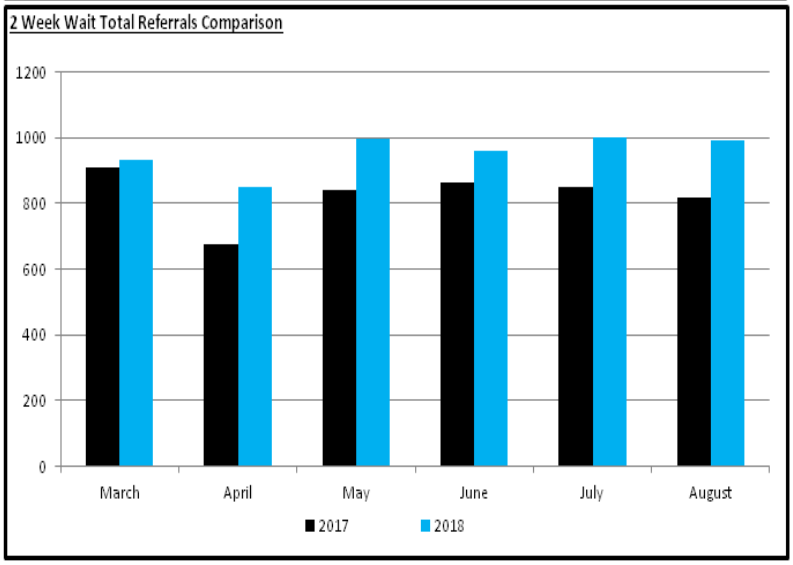
*August's figure unavailable until final position is confirmed

2 Week Wait Referrals Comparison

Month	2017 Total New Referrals	2018 Total New Referrals	Diff	% Diff	Total
March	909	932	23	2.5%	1841
April	675	849	174	25.8%	1524
May	840	997	157	18.7%	1837
June	864	961	97	11.2%	1825
July	847	998	151	17.8%	1845
August	819	990	171	20.9%	1809



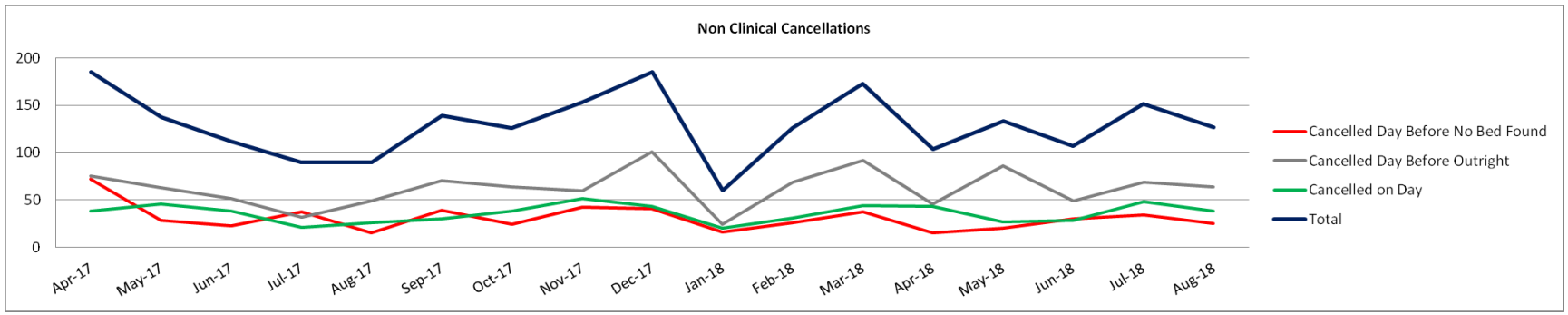




Appendix 1

Bolton NHS Foundation Trust
Non Clinical Cancellations
All

	2017/18												2018/19					Comparison June to August 17/18 to 18/19
Month	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	
Cancelled Day Before No Bed Found	***72***	***28***	***23***	***37***	***15***	***39***	***24***	***42***	***41***	***16***	***26***	***37***	***15***	***20***	***30***	***34***	***25***	***14***
Emergencies / trauma	8	6	5	9	7	6	11	5	4	4	13	13	7	9	9	14	14	16
Other	14		3	9			6	5					3		1	1		-10
Ward beds unavailable	50	22	15	19	8	33	7	32	37	12	13	24	5	11	20	19	11	8
Cancelled Day Before Outright	***75***	***63***	***51***	***32***	***49***	***70***	***64***	***60***	***101***	***24***	***69***	***92***	***46***	***86***	***49***	***69***	***64***	***50***
Emergencies / trauma	28	29	16	16	22	20	17	6	23	2	24	36	17	24	17	24	21	8
Other	9	16	13	13	17	13	18	23	23	7	19	35	25	24	14	29	40	40
Ward beds unavailable	38	18	22	3	10	37	29	31	55	15	26	21	4	38	18	16	3	2
Cancelled on Day	***38***	***46***	***38***	***21***	***26***	***30***	***38***	***51***	***43***	***20***	***31***	***44***	***43***	***27***	***28***	***48***	***38***	***29***
Emergencies / trauma	3	24	2	4	3	2	2		5		3	7	7	2	4	3	4	2
Other	24	15	29	14	19	23	31	33	20	12	22	20	27	18	18	36	27	19
Ward beds unavailable	11	7	7	3	4	5	5	18	18	8	6	17	9	7	6	9	7	8
Total	**185**	**137**	**112**	**90**	**90**	**139**	**126**	**153**	**185**	**60**	**126**	**173**	**104**	**133**	**107**	**151**	**127**	**93**



Agenda Item No: 17

Meeting	Board of Directors

Date	

Title	Workforce & Organisational Development Strategy

Executive Summary	The purpose of this report is to seek Trust Board approval for the implementation of the Workforce & Organisational Development Strategy. The Strategy has been developed through consultation with operational managers, Executive / Non-Executive Directors, staff-side partners and staff.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	The Workforce Assurance Committee fully supports the Strategy and is recommended to the Trust Board for approval.

Next steps/future actions	Delivery will be monitored through the Workforce Assurance Committee with an annual report to the Trust Board.				
	Discuss	Y	Receive		
	Approve	Y	Note		
	For Information		Confidential y/n	N	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	Y	To be well governed	Y
Valued Provider	Y	To be financially viable and sustainable	Y
Great place to work	Y	To be fit for the future	Y

Prepared by	James Mawrey	Presented by	James Mawrey

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Workforce and Organisational Development Strategy

2018 – 2021

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1> Foreword and introduction 3

2> Framework for the strategy 4

3> Healthy organisational culture 5

4> Sustainable workforce 6

5> Capable workforce 7

6> Effective leadership and managers 8

7> Delivering and monitoring the strategy 9

8> Conclusions 10

Acronyms

AHP	Allied health professionals
BFT	Bolton NHS Foundation Trust
GM	Greater Manchester
HR	Human resources
LDA	Learning and development agreement
OD	Organisational development
PSED	Public Sector Equality Duty
VOICE	Vision, Openness, Integrity, Compassion, Excellence
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Document information

Version	11
Date	September 2018
Audience	Bolton NHS Foundation Trust Board
Status	Final
Authors	James Mawrey – Director of Workforce

1> Foreword and introduction

We are delighted to be introducing our sharpened Workforce and Organisational Development Strategy. This strategy identifies the trust's workforce priorities for the next three years.

Our aim is to deliver high quality patient care which is supported by a workforce who are engaged, highly skilled and competent. The quality of experience and clinical outcomes of the people who use our services are a direct result of interactions with staff.

Our staff really are our greatest asset and this strategy describes the support and opportunities that we will make available to them. The strategy is underpinned by our VOICE values. These values form the basis of our expectations of how we will operate on a day-to-day basis to deliver the highest quality of care for each and every patient we serve.

Our thanks go out to the number of stakeholders that have been involved in the development of this document (staff, staff side partners, managers, and executive / non-executive directors).

We will regularly review progress being made against this strategy at the trust's Workforce Assurance Committee and in doing so updates will be provided to the Trust Board.

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Jackie Bene
Chief Executive

James Mawrey
Director of Workforce

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

2> Framework for the strategy

The strategy will be delivered through four priorities for action:

1. Healthy organisational culture

By developing and sustaining a healthy organisational culture (based on VOICE values) we will create the conditions for high quality care. This includes ensuring a clear focus is given on the health and well-being of our workforce to prepare them to meet future service needs.

2. Sustainable workforce

Our workforce will need to change to match new ways of delivering services and new ways of working. Critical will be attracting, recruiting and retaining high calibre skilled staff.

3. Capable workforce

All staff need to be appropriately trained and developed in a positive learning environment. We will ensure our education and development offering delivers a competent workforce who then in turn provide a responsive, equitable, safe and compassionate service.

4. Effective leadership and managers

Our managers and leaders have a key role to play in driving service improvement and cultural change. They need to be valued and supported to flourish in their roles, so that they can support and develop their own teams. Focus will be placed on strengthening the leadership and management interventions and developing improved talent management and succession planning.

3> Healthy organisational culture

What we will do

We will:

- Implement the health and wellbeing strategy and ensure that our staff sickness rate is below 4.2%.
- Review and refresh the occupational health specification. This will include developing a more proactive service that delivers improved health awareness programmes such as mental health support, alcohol management, weight management, smoking cessation, mindfulness and resilience programmes.
- Engage and involve staff in decisions and change that affects them. This will include full implementation of *Go-Engage* and the delivery of the staff engagement plan.
- Take action to ensure that staff are clear about the values and behaviours expected of them and align these with HR practices
- Re-energise our *Freedom to Speak Up* approach to ensure that our staff know how to raise concerns and have the confidence that these will be managed in a confidential manner.
- Revitalise our commitment to diversity and inclusion (from Ward to Board) to ensure that our workforce better reflects the community that we serve.
- Ensure that there is a zero tolerance policy in relation to bullying, harassment and discrimination.

How outcomes will be measured

- Sickness absence rates
- National staff survey engagement scores
- *Go-Engage* pulse surveys
- Whistleblowing data
- WRES data
- Reporting of bullying and harassment in the national staff survey

4> Sustainable workforce

What we will do

We will:

- Demonstrate that workforce planning includes a long term perspective and supports new and emerging service delivery models, ensuring that the workforce plan is integrated in to the trust's strategy and financial plans. Where appropriate this will be across the Bolton locality.
- Ensure a refreshed approach to recruitment and retention is undertaken to deliver a strong Bolton brand. This will include innovative plans to address medical, nursing and allied health professional (AHP) staffing pressures.
- Develop a total reward package that provides a positive offering – both pay and non-pay benefits. This includes ensuring that there are appropriately balanced flexible working opportunities to support attracting staff to work within the trust.
- Create a flexible workforce utilising our human resource effectively to provide fully established services and reduce the requirement for temporary staff.
- Ensure consultant job plans match service demand and support 24/7 delivery. Extend the use of job plans to other staff who manage caseloads, for example AHPs and nurse consultants.

How outcomes will be measured

- Recruitment data
- Vacancy rates
- Turnover rates
- Exit interview data
- Bank and agency usage data
- E-Rostering key performance indicators
- NHS staff survey data

5> Capable workforce

What we will do

We will:

- Maximise sources of funding to support our commitment to learning and development.
- Maintain and improve the quality and compliance levels of appraisal, mandatory training and statutory training.
- Further enhance working relationships with local education providers, to ensure strong academic links and the translation of new clinical roles into service delivery.
- Develop a more bespoke approach to learning and development that recognises the local challenges the organisation faces. This will include ensuring that all divisions have developed a training needs analysis.
- Provide a suite of multidisciplinary clinical skills training to ensure clinical competency in practice.
- Expand and develop the apprenticeship workforce in all areas creating roles that are patient centred and provide a career structure.

How outcomes will be measured

- Increase in learning and development agreement (LDA) funding
- National staff survey engagement scores
- Appraisal, mandatory and statutory training data
- Apprenticeship data
- Learning and development outcomes– including short / long term benefits realised as a result of L&D intervention

6> Effective leadership and managers

What we will do

We will:

- Develop a robust talent and succession planning programme that identifies future leaders. This will include a bespoke Trust succession plan for business critical roles.
- Build leadership capacity and capability as part of our workforce plan. This will involve developing a breadth of leadership development opportunities both internally and externally to the organisation.
- Develop a transformational leadership framework that ensures a robust process of coaching, mentoring and supervision for leaders at all levels.
- Implement the *Trust Alumni* made up of staff who have been supported through various development programmes to support other staff and trust projects

How outcomes will be measured

- NHS staff survey data
- Internal promotion
- Leadership and development data – including short / long term benefits realised as a result of L&D intervention
- Well Led Inspection

7> Delivering the strategy

Infrastructure

Appropriate infrastructure is required to support the delivery of the strategy and plans include:

- Active engagement of the Trust Board, clinical and managerial leadership.
- Effective workforce systems and processes that utilise latest technology to support, measure, and assure.
- Productive, proactive workforce and organisational development professionals.
- Targeted communication that effectively utilises technology and social media.
- Effective partnership working with trade unions.
- Productive partnerships with universities, further education providers, schools and wider local and national networks.

Risks

It is important to note that there are workforce and organisational development risks that could pose a risk to delivery of business outcomes and outputs. These key workforce risks are included on risk register and to avoid duplication are not included within this document. The work programmes associated with the workforce and organisational development strategy will aim to mitigate these risks.

High level Strategic targets

The key workforce and organisational development targets that the strategy will aim to deliver are:

- To be in the top 20% of NHS organisations for staff engagement scores (as measured by NHS staff survey)
- To have a workforce which reflects the population that we serve – specifically ensuring that the organisation is as diverse as the population we serve (as measured by the Workforce Race Equality Standard)
- Reduced reliance on premium variable spend – specifically delivering the agency forecast set out in the trust's annual plan
- An achieved sickness rates of under 4.2%
- An achieved and sustained appraisal rate of 85% (88% from 1st April, 2018).
- An achieved mandatory training rate of 92%.
- An achieved statutory training rate of 95%
- An achieved turnover rate of 8-10%

7> Delivering the strategy

Monitoring the targets

The workforce and organisational development senior management team will lead the implementation of the workforce and organisational development strategy, ensuring that the strategic workforce plans are converted into deliverable operational actions. A very detailed year one monitoring action plan has been presented to the Workforce Assurance Committee. This action plan will be finalised subject to Trust Board approval.

Delivery against the strategy and related action plan will be formally monitored through the Workforce Assurance Committee with an annual report to the Trust Board.

8> Concluding comments

There is no doubting the challenge and 'stretch' detailed within this document but committing to meeting this challenge will in itself send a message to staff about our determination to continue to provide safe effective services in which there is a recognition of the importance of every individual.

This is not just a strategy or work programme for the workforce and organisational development department – it requires real commitment and input from the whole organisation, particularly those in a leadership position.

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Agenda Item No: 18

Meeting	Board of Directors

Date	27th September 2018

Title	Annual Complaints & Patient Advice and Liaison Service (PALS) Report 1 April 2017 to 31 March 2018
Executive Summary	This paper is to provide a summary of the complaints received in 2017/2018 and provides key information of our performance in responding to complaints and concerns; what learning has been identified as a result of investigations undertaken and how practice has changed in response to the issues raised through the complaints process.
Previously considered by *Name of Committee/working group and any recommendation relating to the report*	The annual report was discussed at QAC 16th August 2018
Next steps/future actions	

Discuss	✓	Receive	
Approve	✓	Note	
For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	
Valued Provider		To be financially viable and sustainable	
Great place to work		To be fit for the future	

Prepared by	Tracy Joynson Patient Experience Manager	Presented by	Trish Armstrong-Child, Director of Nursing & Midwifery

Bolton NHS Foundation Trust

Annual Complaints & Patient Advice and Liaison Service (PALS) Report

1st April 2017 – 31st March 2018

Our Bolton NHS FT Values

Bolton NHS Foundation Trust

Content

Section	Title
1	Introduction
2	Purpose
3	Key successes/progress since 2016/17
4	Number of complaints received
5	Source of complaints
6	Analysis of themes
7	Response rates
8	Days to respond
9	Re-opened cases
10	Outcomes
11	Examples of learning/service improvements
12	Parliamentary and Health Services Ombudsman (PHSO)
13	PALS
14	Benchmarking
15	Equality Diversity and Inclusion monitoring
16	Challenges for 2018/19

1.0 Introduction

Bolton NHS Foundation Trust is an integrated organisation providing acute hospital services; specialist and general out patients; Maternity and Women's Health; Emergency Department; and Community Services which are continuing to be developed many as shared services across health and social care (Local Authority). In 2015/16 a 3 year Patient and Carer Experience Strategy was agreed which provides a focus for delivering the best experience for all our patients over a 3 year period building on current achievements. In this report from time to time it talks in terms of 'upheld' and 'not upheld' which is terminology that the NHS is required to use. However, whether upheld or not, the Trust will always seek to learn from complaints as it values greatly the time that patients and relatives spend feeding back to us about the services we provide.

2.0 Purpose

The Trust is required to publish an Annual Complaints report in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and this report sets out a detailed analysis of the nature and number of complaints and concerns received by Bolton NHS Foundation Trust from 1st April 2017 to 31st March 2018. It provides key information of our performance in responding to complaints and concerns; what learning has been identified as a result of investigations undertaken and how practice has changed in response to the issues raised through the complaints process.

3.0 Key successes/progress since 2016/2017

A number of challenges were set from the previous report and the progress towards these is set out below.

Challenge	Progress
Undertake a comprehensive review of the complaints process within the Trust and update the Trust Concerns and Complaints Policy	Achieved The policy was reviewed and amended and implemented Trust wide in July 2017.
Develop a robust monitoring processes to improve the Trust's overall response rate to achieve 95% or above	Achieved A daily management system was introduced along with an escalation process which has resulted in an annual performance of 96%
Further develop the Customer Care elements of the complaints handling process to reduce the number of re-opened cases by a further 5%	2% away from target A number of methods were introduced to assist in ensuring that the Trust fully understood the issues to be investigated. This has resulted in 7% of re-opened complaints compared with 10% from the previous year. This will continue to be a challenge in the following year and further steps in the process will be introduced to assist in achieving this.
Continue to develop the PALS Service with a view to reducing the number of formal complaints by 5%	1.5% away from target Progress has been made with the number of formal complaints in 2017/18 being reduced by 3.5%. This will continued to be a challenge in the following year with further focus on the PALS service to resolve complaints at source.
Strengthen the training programme for complaints handling and aim to deliver a minimum of 6 sessions throughout the year	Achieved A variety of training sessions have been delivered to a number of staff groups throughout the year totaling 10.

There were a number of successes from 2017/18:

- A reduction in the number of formal complaints received
- Performance above the Trust trajectory of 95% responses issued within 35 working days
- A reduction in the number of cases re-opened
- No investigations undertaken by the Parliamentary and Health Services Ombudsman

4.0 Number of complaints received

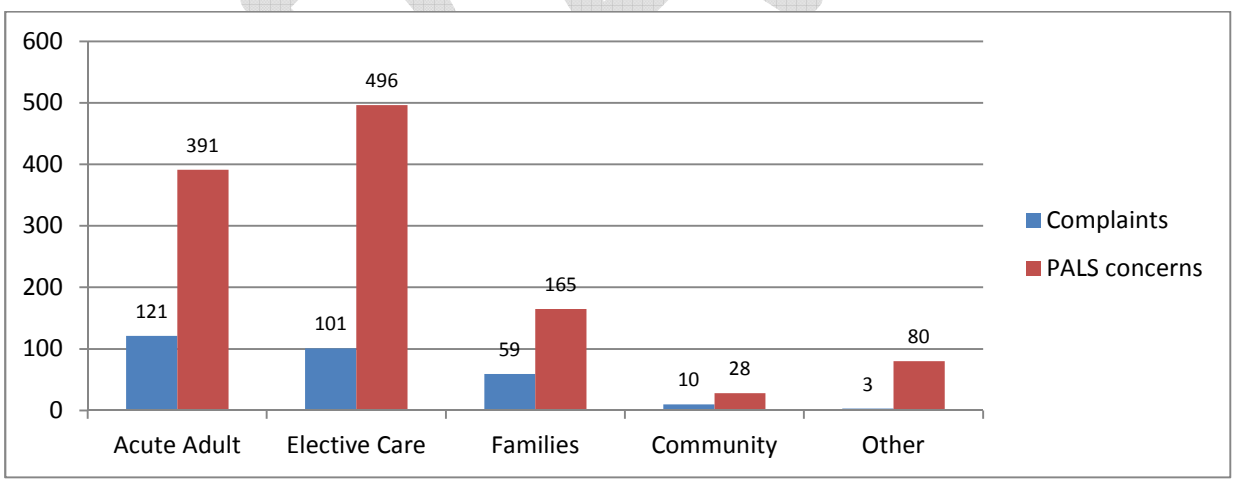
From 1st April 2017 to 31st March 2018, the Trust received 294 written complaints that were responded to under its Complaints and Concerns Policy. The table below provides details of how these compare with episodes of care with comparative data for the previous year.

	2015/2016	2016/2017	2017/2018
Complaints	398	305	294
PALS	942	1190	1158
Episodes of care delivered	1,232,422	1,194,472	1,193,718
Ratio complaints/PALS concerns v episodes of care delivered	1:919	1:1003	1:822

The above information shows:

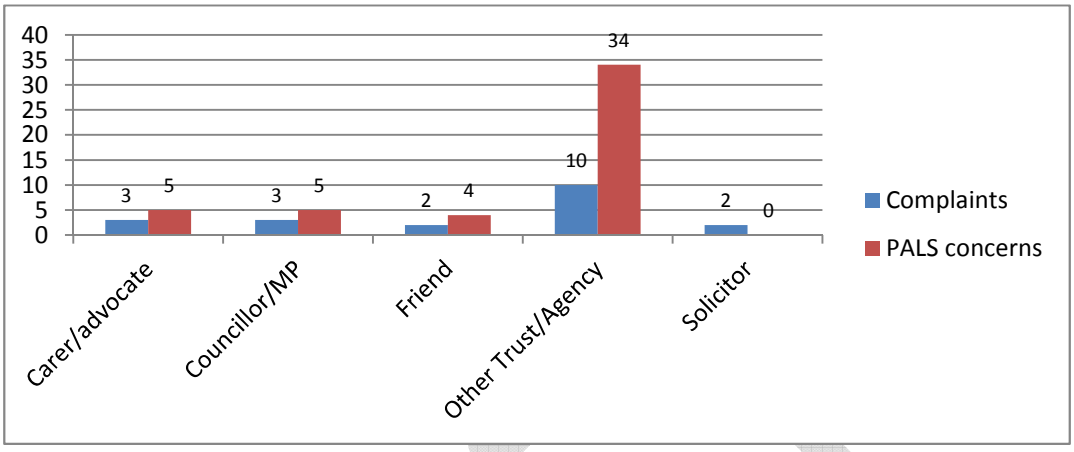
- That although there has been a reduction in the number of formal complaints and PALS contacts, a slight decrease in activity has given a greater ratio of patients making a complaint or contacting PALS.

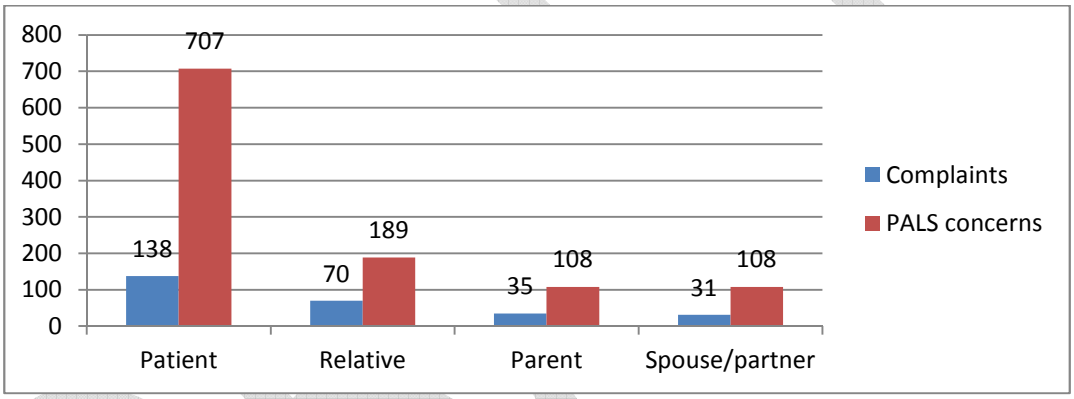
The tables below show the complaints and PALS concerns received by Division.



5.0 Source of complaints

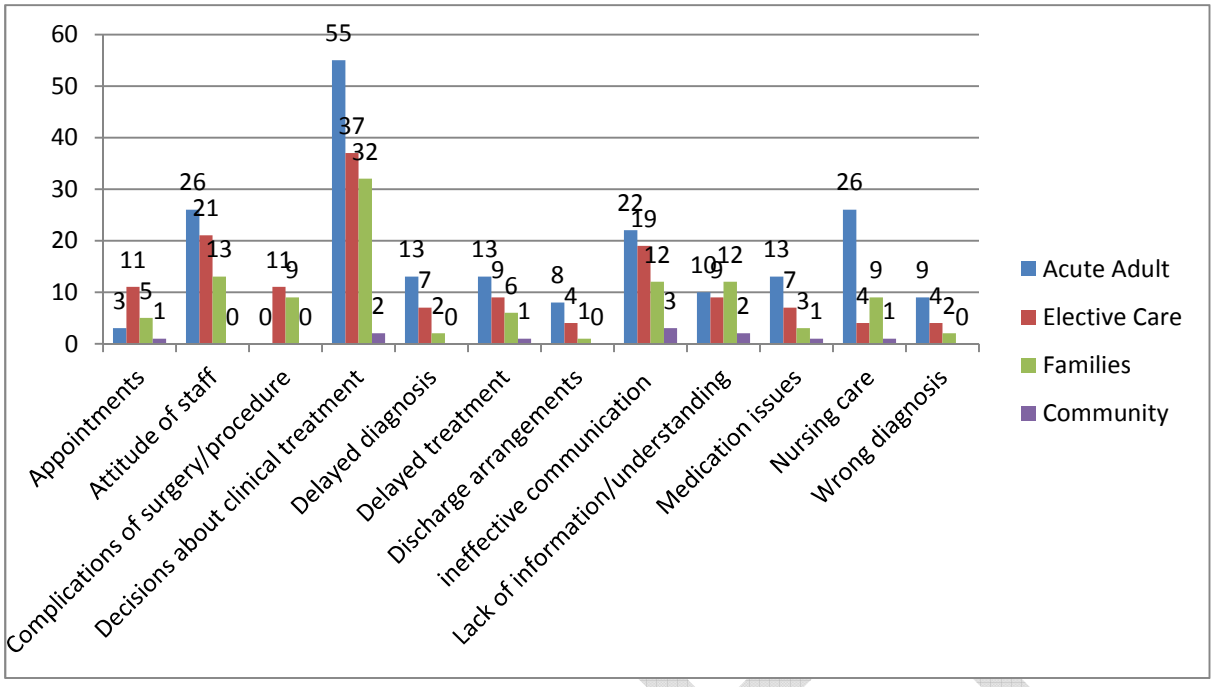
The Trust receives complaints and PALS from a variety of sources and the charts below provide details of this:





6.0 Analysis of themes

Previous reports have shown the categories of complaint by main issue recorded. This report and the graph below provide an analysis of all categories recorded (*this will be greater than the number of complaint letters received as each complaint may have more than one category recorded against it).*

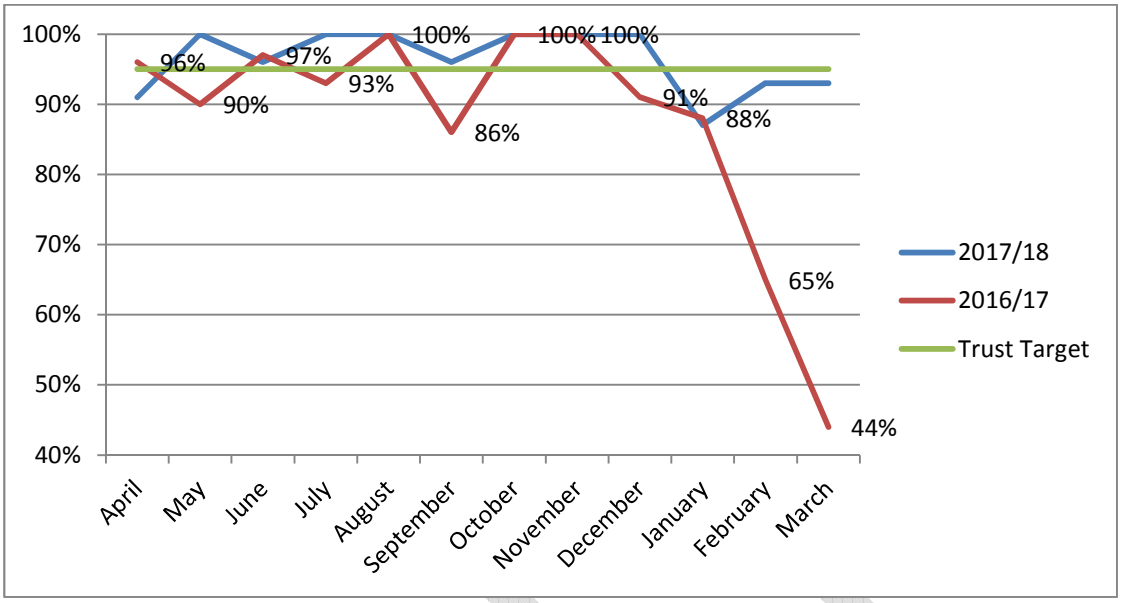


7.0 Response rates

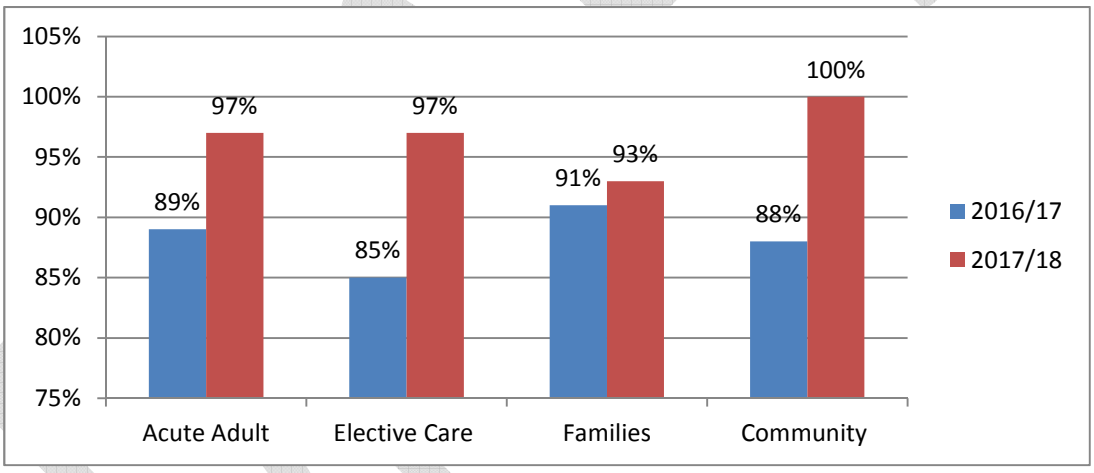
The Trust Policy is that complainants will be sent a written response from the Chief Executive within 35 working days or longer at the complainants request or where the complaint relates to other NHS providers or is complex in nature.

The Trust aims for an overall annual response rate of 95% and in 2017/2018 the Trust was successfully in achieving a 96% performance. The Trust breached on only 11 occasions compared with 34 in the previous year. Most breaches occurred as a result of delays within the process often where there was a need to seek clarification/information to ensure the response met the needs of the complainant.

The chart below shows the target achieved by month with comparisons for the previous year.



The chart below shows performance by Division with a comparison for the previous year:

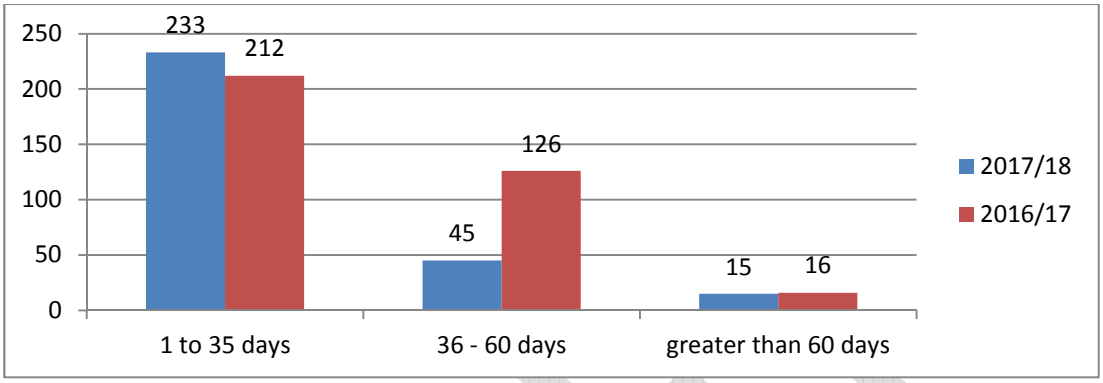


Without exception, each Division has improved their performance in 2017/2018.

8.0 Days to respond

During 2017/18 the Trust did not have any complaints exceeding the 6 month target set out in the Local Authority Social Services and National Health Service Complaint (England) Regulations 2009.

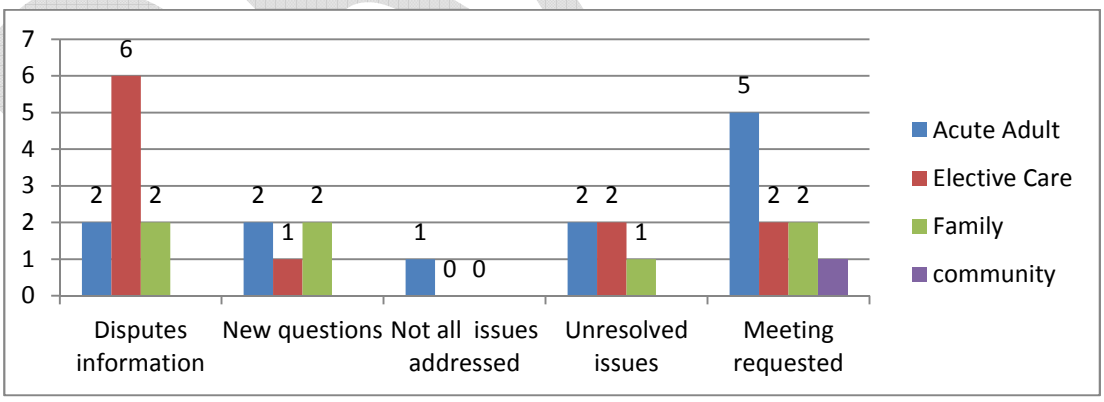
The table below shows the days to respond compared with the previous year and demonstrates the improvements that have been made this year.



In addition, during 2016/17 there were 157 responses that were issued on the day of the 35 working day target or the day before and this was reduced to 125 during 2017/18.

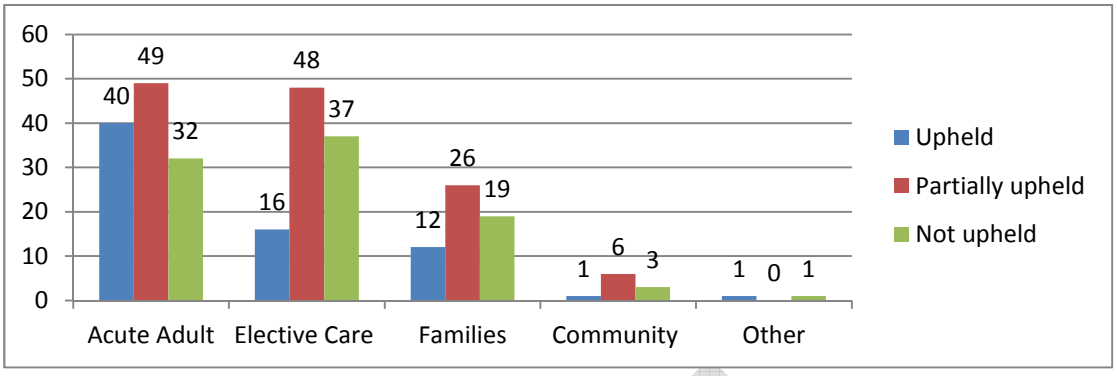
9.0 Re-opened cases

During the period 2017/18, 21 complaints were re-opened (excluding meeting requests) compared with 32 the previous year. There are often a number of reasons why complaints are not resolved initially. The Trust proactively offers a meeting which allows a further opportunity to provide an explanation and achieve a resolution. The charts below provide details of the reasons the cases were re-opened and which Division they related to:



10.0 Outcomes

Of the 294 complaints received during the year 2017/18, 292 have received a response at the time of this report being finalised. The table below indicates whether they have been upheld, partially upheld or not upheld based on the outcome of the investigation and are shown by Division.



11.0 Learning/Service Improvements

The Trust is committed to learning from complaints received regardless of whether they are considered to be upheld or not. The outcome of the investigation which includes details of the actions and learning identified are monitored at the weekly Incident, Complaint, Claims Action Monitoring meeting (WICCAM) where complaints are discussed alongside incidents and claims to ensure governance arrangements are robustly embedded to improve patient safety. Monthly reports on outstanding actions from complaints are monitored in this way. To ensure that Trust wide learning is shared, monthly slides are produced and circulated across the organisation providing details of examples of learning from complaints.

What have we changed as a result of complaints in 2017/18:

- We have reviewed the pre-assessment information for our Cataract Surgery patients and amended this to include further information about the risk of transfer to Manchester Eye Hospital for further treatment if complications occur. This also includes the need to be accompanied by a friend or relative. A site location map of the Eye Hospital has also been sourced and is now provided to all patients on transfer together with the car/taxi driver.
- We have amended our breast screening letter for following up patients to include a sentence asking them to contact the Trust if they are under a consultant or had a mammogram in the last 6 months.
- We have reviewed and amended our Enhanced Care Policy and included a live register of patient moves in and out of hours to be monitored daily by the duty matron to ensure they are followed up.
- All children under 12 months old who attend the Emergency will be reviewed by a doctor graded ST4 or above before leaving the department.
- Our Pharmacy team has reviewed our policy for Heparin infusions to make this clearer for nursing and medical staff to use.
- We have improved the environment in the Early Pregnancy Unit waiting room for the comfort of our patients including wall art, improved seating and flooring.
- Our Emergency department opened 3 extra cubicle spaces which are available when there is an increase in ambulance arrivals to facilitate urgent assessment. It increased senior nurse support within the department from 9am until 9pm to support the department and help maintain quality and patient safety. The department also has a capital redevelopment plan which began in January 2018 which includes expanding the resuscitation room and building a 3 bedded ambulance receiving room which will support the rapid facility to triage ambulance patients on arrival.
- Weighing scales have been made available in the Emergency Department to enable staff to weigh all babies attending the department as routine.
- We have implemented a process for staff to contact the Matron on-call to arrange for or to assist patients in clinics who may have mobilisation issues and need the use of a hoist to use the bathroom.

12.0 Parliamentary and Health Service Ombudsman (PHSO)

There have been no cases accepted by the PHSO for investigation during 1 April 2017 to 31 March 2018 compared with 7 for the previous year and the Trust was only notified of 1 enquiry during this period.

As the PHSO no longer publishes data for Trust's it is therefore not possible to establish whether this is a trend and to enable benchmarking against neighboring Trusts.

The Trust's complaints management policy ensures that complaint investigations and responses meet the PHSO principles of good complaints management and it is therefore assumed that this may be one of the reasons for the improvement seen in this financial year.

13.0 PALS

The Trust received 1158 PALS concerns during 2017/18 showing a decrease of 32 when compared with the previous year. This is consistent with the results of the National Adult In-Patient Survey where patients indicate that they do not know how to raise a concern or make a complaint. Work is currently underway to address this.

The Divisional breakdown can be seen at section 4. All concerns are dealt with quickly by telephone or in person by senior staff visiting the patient or relative on a ward. There is however occasions when it is not possible to resolve a concern to the patient's satisfaction and in these instances, the complaints process will be offered to allow for a thorough investigation and written response to be provided.

In order to manage patient expectations, during the winter months, the PALS team maintained a presence in our Emergency Department to support patients whilst waiting to be seen and to resolve any issues that arose at the time. The PALS team also supported our Elective Care Division by providing patients who contacted them in relation to cancellations of elective surgery with a full explanation.

14.0 Benchmarking

The Trust provides data quarterly to the NHS Digital Strategic Data Collection Service on the number of complaints it has received in that period. This is the statutory based mechanism for collating written complaints data about NHS care and treatment across all NHS organisations in England. There are some exceptions to the criteria; such as if a complaint investigation is led by another Trust and therefore the numbers do not assimilate to the total number. The table below provides some level of benchmarking in relation to other North West Acute Trusts that has been published:

Financial year	Bolton FT	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5
2013/14	562	391	383	1192	813	708
2014/15	467	377	418	1035	756	775
2015/16	398	365	319	1152	607	771
2016/17	305	337	288	743	491	521
2017/18	294	480	378	482*	761	476

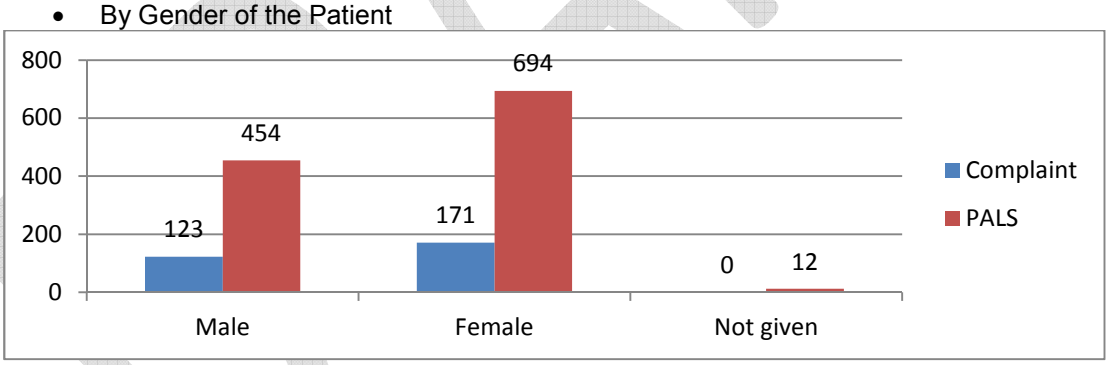
**Q1 and 2 only available*

The table above demonstrates a continuous reduction in the number of formal complaints at Bolton FT and is favorable when compared with similar sized Trusts in the Region.

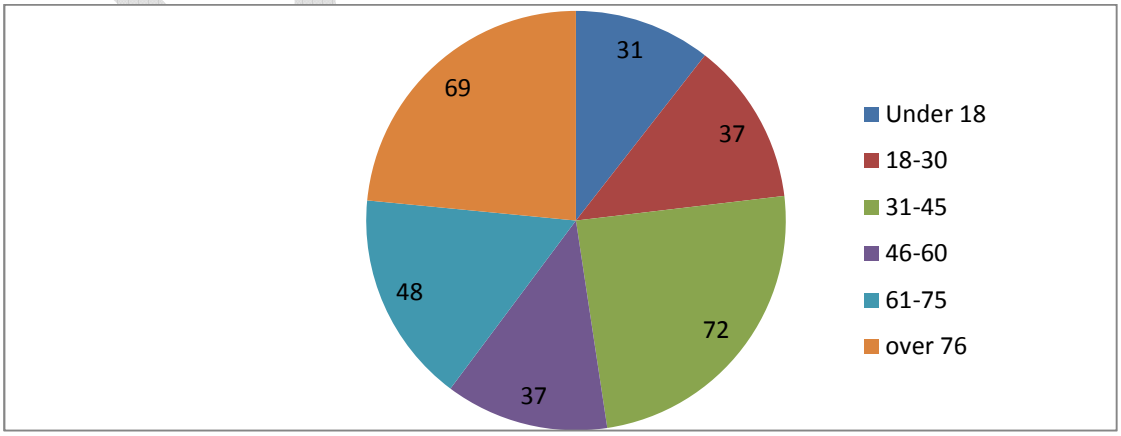
15.0 Equality Diversity and Inclusion

Complaints are currently analysed against the Age, Ethnicity and Gender of the patient in order to assist the Trust in establishing whether the services provided meet the needs for all. These are recorded on our Safeguard complaint database and shared with our Equality, Diversity and Involvement Lead. The Trust did not routinely collect age and ethnicity data for PALS in 2017/18. This data is currently being collected in 2018/19 and will be included in the next report.

- By Gender of the Patient



- By the Age group of the patient



- By Ethnicity of the patient

Ethnic Group	Complaints
Bangladeshi - Asian Or Asian British	1
Black African - Black Or Black British	4
Black Caribbean - Black Or Black British	2
British - White	217
Indian - Asian Or Asian British	8
Not Asked	1
Not Given	15
Not Stated	29
Other Asian - Asian Or Asian British	3
Other Black - Black Or Black British	1
Other Ethnic Category - Other Ethnic	2
Other Mixed - Mixed	2
Other White - White	2
Pakistani - Asian Or Asian British	5
White & Asian - Mixed	1
White & Black African - Mixed	1
White & Black Caribbean - Mixed	0

Challenges for 2018/2019

Although this has been a successful year, there is always room for improvement and there are a number of challenges that have been set going into 2018/2019:

Challenge
Increase the number of complaints training sessions to a minimum of 12 per year.
Review and strengthen the process to evidence learning from complaints.
Maintain the Trust's response rate of 95% or above in year
Further develop the role of PALS to achieve a 2% decrease in the number of formal complaints and a 5% increase in the number of PALS concerns.
Develop the Trust's database for complaints management (Safeguard) to include a review of the categories used to record complaints, improve the recording and monitoring of evidence of learning and access for Divisional complaints leads.
To develop a method of analysis for all patient experience data i.e. FFT, National Survey results, NHS Choices; to include complaints and PALS with the aim of providing a Patient Experience Annual report for 2018/19.

NHS
Bolton
NHS Foundation Trust

Agenda Item No : 19					
Meeting	Board of Directors				
Date	27th September 2018				
Title	Workforce Race Equality Standard 2018 (WRES)				
Executive Summary	1. Our commitment to ensuring Equality Diversity and Inclusion within our workforce is essential to the Trust to ensure we deliver safe, caring and excellent services in line with our Trust values. 2. Implementing the Workforce Race Equality Standard is part of our commitment to meeting the Equality Delivery Standards, which is now a required component of the standard NHS contract. 3. Colleagues will be aware that the main purpose of the WRES is to: a. enable NHS organisations to review their performance against the nine WRES indicators b. produce action plans to close the gap in workforce experience between white and BAME (black and minority ethnic) staff 4. Whilst some improvement has been made in many of the WRES indicators a sharper focus is required on this important agenda. 5. The WRES findings and associated actions will be published on the Trust website at the end of September, 2018.				
Previously considered by	The paper has been fully considered at the Workforce Assurance Committee and fully recommends to Trust Board the details contained within.				
Next steps/future actions	Discuss		x	Receive	
	Approve		x	Note	
	For Information			Confidential y/n	n
Quality, Safety and Patient Experience		✓	To be well governed		✓
Valued Provider		✓	To be financially viable and sustainable		
Great place to work		✓	To be fit for the future		✓
Prepared by:	James Mawrey, Director of Workforce		Presented by:	James Mawrey, Director of Workforce	

1. Introduction

1.1 The Workforce Race Equality Standard (WRES) provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that employees from black and ethnic minority (BAME) backgrounds receive fair treatment in the workplace and have equal access to career opportunities.

1.2 The requirement to have signed up to the Workforce Race Equality Standard (WRES) has been included in the NHS standard contract since 2016. It focuses on meeting requirements around ethnicity and hinges on nine Race Equality Indicators as part of the Equality Delivery System. These indicators are a combination of workforce data and results from the National Staff Survey.

1.3 Trusts are required to publish their data by the end of September, 2018.

1.4 This paper has been produced with the support from a number of BAME colleagues within the Trust.

2. Performance / Key Findings

2.1 The following improvements have been made since the last reporting year:-

- In the last three yeas there has been a 1.9% increase in the overall number of BAME staff employed - from 9.7% (2014/15) to 11.6% (2017/18). Deeper analysis shows that the majority of BAME staff are clinical and clustered at Band 5.

	< Band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a-b	Band 8c-d	Band 9	VSM	Medical
BME Non-Clinical	0.06%	0.04%	0.45%	0.28%	0.34%	0.13%	0.04%	0.02%	0.02%	0.00%	0.00%	0.02%	-
BME Clinical	0.02%	0.00%	1.06%	0.57%	0.38%	3.27%	1.57%	0.76%	0.11%	0.00%	0.00%	0.00%	2.49%
Overall BME	0.08%	0.04%	1.51%	0.85%	0.72%	3.40%	1.60%	0.77%	0.13%	0.00%	0.00%	0.02%	2.49%

- There has been a reduction in the likelihood of BAME staff entering the disciplinary process (from 2.34) however, BAME staff are still 1.87 times more likely to be subject to formal process than white staff. A score of 1.0 indicates equity. A score of greater than 1.0 for BME staff indicates they are more likely to be subject to formal process.

- The relative likelihood of White staff being appointed from interview is 1.4, up from 1.37 in 2016/17. Whilst this compares against the national picture of 1.6, there remains scope for improvement. A score of 1.0 indicates equity. A score greater than 1.0 shows an advantage to White staff.

- Board representation as a percentage of the overall workforce has improved over the last two years. However, similar to the NHS nationally, this relates to Non- Executive Director roles.

2.2 There has been no change in the levels of Bullying & Harassment reported from patients & relatives towards BAME staff. In the same reporting period there has unfortunately been an increase of more white staff reporting harassment from patients & relatives.

2.3 The following deteriorations have been made in WRES performance since the last reporting year:-

- There has been an increase in the number of staff from BAME background reporting that they personally experienced discrimination – up from 14% in 2016/2017 to 20% in 2017/2018 (5% for white staff in 2017/2018). As noted later in the report the Trust will develop a BAME Diversity Network who will be charged with specifically looking at the underlying reasons for this.
- Confidence in equal opportunities for career progression and promotion has reduced amongst BAME staff from 88% (2016/2017) to 79% (2017/2018). 90% of White Staff believe that the Trust provides equality of opportunity. Whilst the Trust benchmarks better than the national average (50%) there is work that needs to be undertaken in this area to more deeply understand the reasons.

3. Actions to be taken

3.1 The data indicates an improvement in some areas for BAME staff. However, there is still a need to further develop in some areas, and therefore the WRES action plan will be revitalised in order to address each of the WRES metrics with a view to improve next year's results.

3.2 Whilst the full action plan will be monitored at the Workforce Assurance Committee the following themes will be the key priorities for action (non exhaustive):-

3.2.1 Workstream 1. Make recruitment fairer:

- Ensure job adverts and website clearly welcome applications from BAME people.
- Develop and train a designated BAME staff network in interviewing skills and unconscious bias. These Network members will then act as a guardian of a fair process by inputting into recruitment processes of band 7-9 job vacancies. In conjunction with the Workforce & Organisational Development team the BAME Network members will hold support sessions aimed at current BAME staff to help with the application form process and interviewing skills.
- Monitor recruiting panels and ensure that panel has had training in unconscious bias or anti discriminatory interviewing techniques.
- Accountability – Human Resources to monitor and inform Head of Resourcing of interviewing panels that did not appoint a BME candidate

to a Band 8 to 9 post; and provide Chair's contact details. Updates to then form part of Workforce Dashboard

How will this workstream be measured?
By improving equal opportunities for BAME applicants through recruitment process that show a direct impact on reducing WRES indicator 2 from 1.4 to 1.0, which means that BAME staff are as likely as White staff to be appointed following interview. (indicator 2).

3.2.2 Workstream 2. Workplace Experience:

- Review exit interviews and report regularly into Diversity Steering Group on reasons for staff leaving, highlighting numbers of leaving due to harassment or bullying
- Review Investigator training and amend as necessary to bring a strong focus on Equality and Diversity issues and remove unconscious bias.
- Ensure list of Investigating Officers (IO) is representative of the BAME population in the BFT workforce
- Introduce explicit step in the application of the formal case management process, for disciplinary and performance management cases, whether there is a need for participation of a member of the BAME staff network to as observers to the process. All BAME reported discrimination cases will have 100% evidence of actions and outcomes.
- A deeper analysis of the cultural issues facing BAME staff will be undertaken with a view to further considering HR Policies & Practices that can be refined / improved. For example how we can better support our staff during Ramadan.

How will this workstream be measured?
By improving the workplace experience of our BAME staff by decreasing the level of discrimination against BME staff from 20% to 5%, the same as that reported for White staff. (Indicator 8)

3.2.3 Workstream 3. Support and enable career development:

- Devise training packages in interview skills and application writing, this training to be offered centrally and via the BAME staff network.
- Develop coaching and mentoring training to enable colleagues and BAME Staff Network members to act as internal coaches and mentors.
- Ensure there is a mechanism in the appraisal system to audit career progression plans for BAME staff.
- The Trust will actively encourage attendance on the NHS Leadership Academy programme named 'The Stepping Up programme', which is a leadership development programme for black, Asian and minority ethnic (BAME) colleagues in bands 5 - 7 (or equivalent) roles, who work within healthcare (the NHS or an organisation providing NHS care). The programme is designed to bridge the gap between where applicants are and where they need to be, to progress into more senior roles.

How will this workstream be measured?

By increasing the % of BAME staff who believe there are equal opportunities for career progression or promotion from 79% to 90%, the same as that reported for White staff. (Indicator 7)

3.3 Pivotal to the above workstreams will be the development of the BAME network. Members of this network will sponsor the BAME staff voice and ensure it is heard and acted upon. A number of colleagues have already expressed their support to becoming members of the BAME network. The Trust has recently appointed an Equality Adviser who will play a critical role in the development of this network.

3.4 The WRES action plan will be regularly monitored by the Equality and Diversity Steering Group and the Workforce Operational Committee. The Workforce Assurance Committee will provide oversight and reporting to the Board via the Chair report. The WRES data and action plan will be published on the NHS England WRES portal and the Trust's website.

4. Recommendations

4.1 The Trust Board is asked to:

4.1.2 Note the details of the Report.

4.1.3 Note the actions that will be taken to improve performance against key WRES Indicators. The Trust Board will be updated on the progress being made via the Workforce Assurance Committee Chair's report.

4.1.4 Highlight any specific additional assurance / workforce information required.

APPENDIX 1 – KEY FINDINGS AGAINST WRES INDICATORS 2018

	WRES Indicator*	2014/15	2015/16	2016/17	2017/18	Analysis
	Total number of staff	5250	5356	5482	5298	6.19% of the workforce have chosen not to declare their ethnicity. However, with 93.81% of staff self-reporting it is a strong indicator. The proportion of BME staff working at the Trust has increased incrementally since the introduction of the WRES in 2015.
	Proportion of BAME staff employed	9.7%	10.66%	10.96%	11.61%	
	The proportion staff who have self-reported their ethnicity	94.7%		93.63%	93.81%	
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	Details shown within report table				Analysis of the Trust workforce breakdown shows a gap between white staff and BAME staff ; with very few employees holding senior management positions in non-clinical roles, it is slightly more positive within the Trusts clinical workforce from a BAME background.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	1.08	0.96	1.37	1.40	This indicator shows that white applicants are 1.40 times more likely to be appointed from shortlisting than BAME applicants.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	1.81	1.94	2.34	1.87	This indicator demonstrates that BAME staff are 1.87 times more likely to enter a formal disciplinary process than white staff. There has been a significant improvement with this indicator over last 12 months which is encouraging and a positive indicator that some of the case management controls put in place over this period has had an impact. However further work is required to eradicate the gap between BAME and white staff.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	0.91	0.96	0.97	0.95	This indicator shows that BAME staff and white staff have equal access to non-mandatory training and CPD.
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 28% BAME: 25%	White: 31% BAME: 39%	White: 27% BAME: 20%	White: 27% BAME: 20%	BAME staff for the last 3 reporting periods have reported lower levels of bullying and harassment from patients, relatives or the public.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 18% BAME: 26%	White: 21% BAME: 36%	White: 24% BAME: 27%	White: 19% BAME: 27%	BAME staff reporting higher levels of bullying and harassment from colleagues than white staff, has been consistently higher since the introduction of the WRES.
7	7 KF 21. Percentage believing that	White: 94%	White: 92%	White: 93%	White: 90%	79% of BAME staff believe that the Trust provides equal

	WRES Indicator*	2014/15	2015/16	2016/17	2017/18	Analysis
	trust provides equal opportunities for career progression or promotion.	BAME: 72%	BAME: 71%	BAME: 88%	BAME: 79%	opportunities for career progression compared to 90% of white staff.
8	8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager/team leader or other colleagues	White: 4% BAME: 14%%	White: 5% BAME: 14%%	White: 6% BAME: 14%	White: 5% BAME: 20%	The number of BAME staff who have experienced discrimination within the workplace rose within the reporting period. Within every reporting period there have been a gap between white and BAME staff who report experiencing discrimination.
9	Percentage difference between the organisations' Board voting membership and its overall workforce	White: 100%	White: 100%	White: 17.3% BAME: -11%	White: 10.1% BAME: -3.9%	The Trust BAME representation at Board level has improved during the reporting period. In order for the Trust board to be aligned to the overall workforce, 2 of its 13 members would be from a BAME background.

Agenda Item No: 20

Meeting	**Board of Directors**

Date	**27th** September, 2018

Title	Freedom to Speak Up

Executive Summary	This report provides an annual update from the Trust's Freedom to Speak Up Guardian and Director of Workforce on progress and on-going plans for strengthening arrangements for staff to raise concerns.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	The paper has been fully considered at the Workforce Assurance Committee and fully recommends to Trust Board the details contained within.

Next steps/future actions	If supported by the Trust Board the Workforce Assurance Committee will oversee the associated actions.			
	Discuss	✓	Receive	✓
	Approve	✓	Note	✓
	For Information		Confidential y/n	

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	
Great place to work	✓	To be fit for the future	✓

Prepared by	James Mawrey / Angela Wendzicha	Presented by	James Mawrey / Angela Wendzicha

1. Introduction

1.1 This report provides an annual update from the Trust's Freedom to Speak Up Guardian and Director of Workforce on the progress and on-going plans for strengthening arrangements for staff to raise concerns.

1.2 Colleagues may be aware that the National Guardian's Office published guidance for NHS Trusts and NHS Foundation Trust Boards on Freedom to Speak Up (May, 2018), this guidance was accompanied by a self-review tool. The Director of Workforce and the FTSU Guardian have completed this self-review document (Appendix 2). Subject to any further comments from the Trust Board it is proposed that the self-assessment be finalised by the Non-Executive FTSU Lead and Executive FTSU Lead. Progress will then be reported to the Workforce Assurance Committee in December, 2018.

2. Background Information

2.1 Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

2.2 The NHS Contract for 2016/17 required every NHS Trust to have a Local Freedom to Speak Up Guardian (LFTSUG) from 1 October 2016 (Angela Wendzicha has been undertaking this role). Trusts are also required to have a Non-Executive Director Lead for Freedom to Speak Up (Bilkis Ismail kindly agreed to undertake this role) and the new guidance requires a named Executive Lead for Freedom to Speak Up (James Mawrey, Director of Workforce has agreed to undertake this role).

3. Update for April 2017 - March 2018

3.1 The Freedom to Speak Up Guardian Report is contained within Appendix 1. This report notes that, for this reporting period, three concerns were raised in the organisation. The three concerns related to culture (two) and low staff morale as a result of staff moves (one). An overview of these concerns and the actions taken are included within the report (Appendix 1).

3.2 Bolton benchmarks positively in all of the NHS Staff Survey questions in respect of raising concerns (across the period 2015-2017).

	2015	2016	2017	2017 Avg
13a - If you were concerned about unsafe clinical practice, would you know how to report it?	87%	97%	95%	95%
13b - I would feel secure raising concerns about unsafe clinical practice.	73%	75%	72%	70%
11c - The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?	95%	93%	95%	95%

12b - My organisation encourages us to report errors, near misses or incidents.	91%	93%	90%	88%
12a - My organisation treats staff who are involved in an error, near miss or incident fairly.	47%	59%	60%	55%

3.3 Whilst the above results are positive the Trust is minded that very few concerns are raised with the Freedom to Speak Up Guardian when compared to peer organisations. Benchmarking has been undertaken and the details are as follows:-

Greater Manchester	
Tameside Hospital NHS Foundation Trust	25
The Christie NHS Foundation Trust	17
Pennine Acute Hospitals NHS Trust	16
Stockport NHS Foundation Trust	16
Wrightington, Wigan and Leigh NHS Foundation Trust	16
Pennine Care NHS Foundation Trust	12
Salford Royal NHS Foundation Trust	11
GM West Mental Health NHS Foundation Trust	10
Manchester University NHS Foundation Trust	5
Bolton NHS Foundation Trust	3

4. **Actions to be taken**

4.1 The Executive Team have recently approved a re-energised approach to this important agenda. The intention is that the re-energised approach will be launched by Dr Henrietta Hughes, National Guardian Office in October, 2018. The re-energised approach will include (non-exhaustive):-

a. Recruiting into a Freedom to Speak Up Guardian role on a part-time basis (Angela Wendzicha currently undertakes this role in addition to her substantive role).
b. Introducing Freedom to Speak Up Champions throughout the organisation. Given the size, geography and diversity of the workforce then the FTSU Champions will support the Freedom to Speak Up Guardian by helping to reach out to all pockets of the organisation. Given the findings of the WRES the Trust will ensure that there is a Freedom to Speak Up Champion to link with minority groups. Furthermore IFM will be requested to follow a similar approach as their parent group.
c. Enhanced marketing and communication to ensure a higher profile of the Freedom to Speak Up approach. This will include further promoting the role of the NED champion for this important agenda.
d. Monthly meetings between the Freedom to Speak Up Guardian and the Chief Executive / Director of Workforce will take place. This will help to ensure that the highest level of oversight is being given to this important agenda.

4.2 As previously noted, the National Guardian's Office published guidance for NHS Trusts and NHS Foundation Trust boards on Freedom to Speak Up (May, 2018). This guidance sets out expectations of Boards and Board members in relation to Freedom to Speak Up. The Director of Workforce and the FTSU Guardian have completed a first draft of the self-review document which is attached at Appendix 2. It is worthy of note that this is a standard template set nationally. Noting that this standard template does not include timescales for delivery, it has been agreed that the Workforce Operational Committee will oversee local timescales for actions and a progress report will then be provided to the Workforce Assurance Committee. Subject to further comments from the Trust Board it is proposed that the self-assessment be finalised by the Non-Executive FTSU Lead and Executive FTSU Lead. The progress will be reported to the Workforce Assurance Committee in December, 2018.

5. Recommendations

5.1 The Trust Board is asked to

a. Note findings of the Freedom to Speak Up Guardian report and the Executive Team plans for a re-energised approach to this critical agenda.

b. Support the details and proposed approach of the recently published Board level self-review tool. Colleagues are reminded that this is a standard template set nationally and local timescales will be developed at the Workforce Operational Committee.

Appendix 1

Freedom to Speak Up
Guardian

Annual Report

2017/2018

Angela Wendzicha
Deputy Director Governance
Freedom to Speak Up Guardian

Introduction / Background

The requirements for Trusts and Foundation Trust to have a Freedom to Speak Up Guardian has been in place since October 2016 following a recommendation made by Sir Robert Francis in his 2015 Report Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS. The aforementioned review highlighted that a defensive culture had begun to develop within the NHS which actively discouraged staff from raising concerns and when they did they were not treated in a fair way.

The Trust's Freedom to Speak Up Guardian operates independently, impartially and objectively whilst working in partnership with individuals and groups of staff, including the senior leadership team. The role and function of the Guardian is now embedded in the Values based corporate induction where attention to the role is centred within the Integrity session. Regionally the Freedom to Speak Up Groups have been established of which the Trust's Guardian is a member.

This is the first Annual Report from the Freedom to Speak Up Guardian and illustrates the activity from April 2017 to March 2018.

The Freedom to Speak Up Guardian role

- Offering a confidential service to staff, volunteers, students, sub-contractors, agency workers and any other persons undertaking duties within the Trust. The role ris independent from the current structures within the Organisation.

- To work alongside the National Guardian and the National Guardian's Office.

- To undertake a review where it is highlighted by any intelligence, that there has been evidence of staff not being able to raise concerns for whatever reason, or where concerns raised have not been acted upon.

- To work alongside key stakeholders in promoting an open and honest "no blame" culture, where staff are able to raise concerns safely without fear of reprisal.

- To support and signpost individuals in raising concerns.

- To ensure investigations following the raising of concerns are undertaken in a timely manner and outcomes fed back to the individual/individuals who raised them.

- To ensure all concerns are stored and recorded in a confidential manner, for themes to be identified and reported to the Workforce Assurance Committee regularly.

- Provide training on the importance of and how to raise concerns within the Organisation and how to manage concerns when they are raised.
- Work with HR and other key stakeholders to ensure a continuous process improvement on speaking up.

- To be visible and accessible to all within the Organisation.

- To work alongside key stakeholders on tackling bullying and harassment within the Organisation.

- To contribute to a culture where speaking up becomes “the norm” and raising concerns is seen as business as usual.

Guardian Activity during the period April 2017-March 2018

From April 2017 to March 2018 only three cases were reported through the Freedom to Speak Up Guardian route. The three matters recorded related to the following:

- Concerns around culture. A concern was raised by a member of the administrative team within a Division that they had been unfairly treated and felt they had no option to leave the organisation. The individual had raised this with a member of the senior management team but they claimed they had not heard anything in response from them. The matter was resolved following the intervention by the Guardian who, following discussion with the senior managers identified that dialogue was ongoing with the individual. This was fed back to the individual who agreed and no further action was required.

- Concerns around low staff morale. A concern was raised by one individual (on behalf of a number of members of staff) around the adverse impact on patient safety from staff being constantly moved from the clinical area to assist in other clinical areas. The staff did not feel that their concerns were listened to by management colleagues. The matter was resolved following discussions with the senior management team who were able to articulate and support the staff in understanding the rationale for the actions and supporting them through the period.

- Concerns around culture. A concern was raised by a non-clinical staff member (on behalf of a number of staff within a Division) relating to what they described as problems with the culture within the Division, specifically how staff are spoken to in a derogatory manner by senior managers. The member of staff was supported throughout by the Guardian and an agreed plan of action was commenced. This involved speaking with the senior management team and relaying the concerns raised in a confidential way. The matter is now closed as the member of staff has reported a significant improvement and has agreed no further action required at this time.

Additional matters for noting

- The Guardian is supported by the Executive lead, James Mawrey, Director of Workforce in addition to a Bilkis Ismail, Non-Executive Director.

- Issues raised during 2017/2018 were all raised by the individuals initiating contact with the Guardian directly. However, the guardian remains concerned that the numbers of people raising concerns remains very low.

- The Raising Concerns Policy is currently under re-development and will be re-launched in October.

- During 2017/2018 a total of eight awareness sessions have been carried out with the average attendance of fifteen members of staff. Awareness sessions have been booked for the remainder of 2018.

- The Guardian has raised concerns in relation to the lack of cases being raised over the last year, although it is noted that the NHS staff survey for 2017 provided some assurance regarding raising concerns (as detailed within main paper).

- The Guardian welcomes the suggested refreshed approach to this critical agenda.

Appendix 2

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Compliant	Whilst this is compliant it is recognised that a refreshed approach to FTSU is required.	CEO Monthly report provides update to Board and regular reporting to WAC from the FTSU Guardian.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval of refreshed approach there will be high level communications to reiterate FTSU service.	Evidence of learning incorporated into regular reports from FTSU Guardian. WAC Chairs report include updates

They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Developing	Trust Board support of the Workforce & Organisational Development Strategy. One of the priorities of this Strategy is Leadership. Steps will be taken to ensure embedded within Leadership Framework.	The Trust Board will receive regular updates on progress against the Workforce & Organisational Development Strategy. Detailed within this is the refreshed FTSU approach. Evidence of learning incorporated into regular reports from FTSU Guardian. WAC Chairs report include updates.
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Achieving	Continue to reiterate FTSU service and aims of the service	Regular reporting to WAC from the FTSU Guardian. Escalation via Chairs report
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval of refreshed approach there will be	Regular reporting to WAC from the FTSU Guardian. Escalation via Chairs report

		high level communications to reiterate FTSU service.	
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Achieving – (Whistleblowing policy in place)		Via monitoring from Workforce Assurance Committee
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval of refreshed approach there will be high level communications to reiterate FTSU service.	Via monitoring from Workforce Assurance Committee
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Developing	More visibility/publicity still required to ensure all colleagues aware and feel safe to speak up	Via monitoring from Workforce Assurance Committee. Albeit further work is required on this reporting moving forward.
Leaders actively shape the speaking up culture			

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Achieving		The Trust Board will receive regular updates on progress against the Workforce & Organisational Development Strategy. Trust Board receive NHS Staff Survey findings on annual basis and this is a linked question.
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Achieving		Ongoing focus via discussions at Trust committees & Trust Board.
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Achieving	The Trust has an Executive Buddy approach, although this will be reviewed on ongoing basis. Further work required on Communication approaches.	Via monitoring from Workforce Assurance Committee. Board receives annual findings of NHS Staff Survey.
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Developing	FTSU Guardians known to senior leaders across	Via monitoring from Workforce Assurance Committee. Albeit

		the organisation	further work is required on this reporting moving forward.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Developing	Trust Board support of the Workforce & Organisational Development Strategy. One of the priorities of this Strategy is Leadership. Steps will be taken to ensure embedded within Leadership Framework.	Via monitoring from Workforce Assurance Committee and specifically WOD delivery
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval of refreshed approach there will be high level communications to reiterate FTSU service.	Via monitoring from Workforce Assurance Committee and specifically WOD delivery.

Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Achieving	Ongoing focus	Completed Director of Workforce – Executive Director Bilkis Ismail, NED
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Developing	Regular meetings will be in place with CEO/Exec Lead and FTSU. Chair available as required.	CEO report includes matters raised.
Other senior leaders support the FTSU Guardian as required.	Developing	Ongoing focus	Via monitoring from Workforce Assurance Committee and specifically WOD delivery.
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Achieving		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian

The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Achieving	The FTSU Guardian has full access to senior leaders (inclusive of CEO) and others	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval of refreshed approach there will be high level communications to reiterate FTSU service.	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval will include FTSU BME Guardian.	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian
Speak up issues that raise immediate patient safety concerns are quickly escalated	Process in place. Non received to date that directly		Via monitoring from Workforce Assurance Committee. Receives

	affect patient safety		regular reports form FTSU Guardian
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Developing	Refreshed approach with heightened communication.	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. More work in the reports are required to address this area.
Lessons learnt are shared widely both within relevant service areas and across the trust	Developing		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. More work in the reports are required to address this area.
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Developing	Routine audits need to be developed locally with the FTSU guardians to ensure policy being implemented	Via monitoring from Workforce Assurance Committee. Audit findings incorporated in FTSU reports to WAC

		appropriately.	
FTSU policies and procedures are reviewed and improved using feedback from workers	Developing		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. More work in the reports are required to address this area.
The board receives a report, at least every six months, from the FTSU Guardian.	Developing. Although standing item on CEO Report		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian.
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Developing		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. More work in the reports are required to address this area.

Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Developing		Quarterly meetings have commenced between the FTSU Guardian and Trust CQC Engagement Lead
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Compliant		Included in monthly CEO Report
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Developing	Further information to be contained within the quality report next year.	Annual Report received at Board
Reviews and audits are shared externally to support improvement elsewhere.	Developing		
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Developing		Quarterly meetings have commenced between the FTSU Guardian and Trust CQC Engagement Lead Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. More

			work in the reports are required to address this area.
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Achieving	Ongoing focus and support for this work	FTSU Guardian is a member of the Regional Group
Senior leaders request external improvement support when required.	Achieving		The Guardian has previously used the support and resource within the National Office
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval will include FTSU BME Guardian.	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. F FTSU bring together the soft intelligence from PALS, complaints, incident reporting, staff surveys and FTSU

			disclosures to triangulate and help define where there are issues and what they are
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Developing		Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. Guardian confirmed that get a lot out of attending both the local and national meetings
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Achieving	Exception meetings to be arranged following publication of new guidance or case reports generated from the National Office	Via monitoring from Workforce Assurance Committee. With refreshed approach will come review of reporting
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Achieving	One of the priorities of this Strategy is Leadership. Steps will be taken to ensure embedded within	

		Leadership Framework.	
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Developing	The reviewed WOD strategy ensures it is strengthened regarding FTSU activity and focus	Via monitoring from Workforce Assurance Committee. Receives NHS Staff Survey
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Achieving	Review the WOD to ensure it is strengthened regarding FTSU activity and focus	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. Improvements in this reporting to WAC to be implemented.
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told	Developing	It is recognised that a refreshed approach to FTSU is required. Subject to Board approval improvements will be made, including. • Letters of	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. Improvements can be made on this report to WAC

of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		personal thanks from senior leaders where staff are happy to be identified; for those who not further consideration on an individual case by case basis. • Managers involved encouraged to thank colleagues for raising issues with them	
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Developing	It is recognised that a refreshed approach to FTSU is required.	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian. Improvements can be made on this report to WAC

Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Compliant		
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Developing	Recognised that a refreshed approach to FTSU is required. Appointment of a dedicated Guardian in place but further time/resources needed	Via monitoring from Workforce Assurance Committee. Receives regular reports form FTSU Guardian.
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Noted		
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Compliant		In place, national guardian visit to Trust and meeting with executives, Ned and FTSU guardians

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Compliant	Regular meetings will be in place with CEO/Exec Lead and FTSU. Chair available as required.	
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Compliant		Via monitoring from Workforce Assurance Committee. Report to Trust Board.
Overseeing the creation of the FTSU vision and strategy.	Developing	Strengthen FTSU approach and WOD Strategy to ensure in line with national learning	Via monitoring from Workforce Assurance Committee.
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Developing	Subject to Board approval refreshed approach to take place	Via monitoring from Workforce Assurance Committee.
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Developing	Identified that additional time/resources needed and agreement reached with Executive team	Via monitoring from Workforce Assurance Committee. Guardian report to include details of time/resources

			needed
Ensuring that a sample of speaking up cases have been quality assured.	Developing	Further work is required in this area.	Via monitoring from Workforce Assurance Committee. Guardian report to include details of time/resources needed
Conducting an annual review of the strategy, policy and process.	Compliant	Strategy reviewed but work needed. Subject to Board discussion	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board
Operationalising the learning derived from speaking up issues.	Developing	Recognised that a refreshed approach to FTSU is required.	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Achieving	Further work required on evidence of cases where allegations of detriment have been raised are investigated in a timely way	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board

Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Developing	Strategy reviewed but work needed. Subject to Board discussion	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Compliant	Provided by the FTSU Guardian on an exception basis	Opportunity to comment on CEO report at Trust Board
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Compliant	It is recognised that further work is required on the FTSU approach and NED pivotal in roll out	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Compliant	It is recognised that further work is required on the FTSU approach and NED pivotal in roll out	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board Supported as having the recent national guardian

			visit to the Trust
Role-modelling high standards of conduct around FTSU.	Compliant		Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board. NHS Staff Survey
Acting as an alternative source of advice and support for the FTSU Guardian.	Compliant	Further work is required and more regular meetings with FTSU Guardians to be held	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board
Overseeing speaking up concerns regarding board members.	Compliant	As necessary	As necessary
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of	Compliant	Refreshed Workforce & Organisational Development Strategy	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board

FTSU culture or indicators of barriers to speaking up.			
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Developing	Refreshed Workforce & Organisational Development Strategy	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board WOD Strategy delivery
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Developing	Refreshed Workforce & Organisational Development Strategy	Via monitoring from Workforce Assurance Committee. Annual FTSU report to Trust Board WOD Strategy delivery Engagement activity
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Compliant, albeit developing further	Refreshed approach to FTSU developed. Implementation subject to Board discussion	Workforce Assurance Committee

Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Compliant, albeit developing further	Refreshed approach to FTSU developed. Implementation subject to Board discussion	Workforce Assurance Committee
Ensuring learning is operationalised within the teams and departments that they oversee.	Developing	Refreshed approach to FTSU developed. Implementation subject to Board discussion	Workforce Assurance Committee

- *Colleagues are reminded that this is a standard template set nationally. Noting that this standard template does not include timescales for delivery (for areas that require development) it was agreed that this would be locally produced and monitored at the Workforce Operational Committee. A progress report will then be provided to the Workforce Assurance Committee. Subject to further comments from the Trust Board it is proposed that the self-assessment be finalised by the Non-Executive FTSU Lead and Executive FTSU Lead. The progress will be reported to the Workforce Assurance Committee in December, 2018.*

Agenda Item No : 21

Meeting	Board of Directors

Date	Thursday 27th September 2018

Title	2018-19 Emergency Preparedness, Resilience and Response (EPRR) Assurance. Statement of Compliance / action plan

Executive Summary	NHS England require all health organisations participating in the 2018 -19 EPRR Core Standards (V 5.0) self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period.

Previously considered by	This is presented annually to the Board.

Next steps/future actions	To note compliance level and document in the minutes as a matter of public record			
	Discuss		Receive	
	Approve		Note	✓
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	
Valued Provider		To be financially viable and sustainable	
Great place to work		To be fit for the future	

Prepared by	Jimmy Tunn, Emergency Planning Manager	Presented by	Andy Ennis Chief Operating Officer

2018-19 Emergency Preparedness, Resilience and Response (EPRR) Assurance

STATEMENT OF COMPLIANCE

Bolton NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v 5.0). After self-assessment, and in line with the criteria of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2018-19 standards: **Substantial**

Overall EPRR assurance rating	Criteria
Full	The organisation is **100% compliant** with all Core Standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is **89-99% compliant** with the Core Standards they are expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is **77-88% compliant** with the Core Standards they are expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is **compliant with 76% or less** of the Core Standards they are expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The actions plans will be monitored on a quarterly basis to demonstrate progress towards compliance

The self-assessment results were as follows:

Number of applicable Core Standards	Compliance level		
	Standards rated as **Fully compliant**[1]	Standards rated as **Partially compliant**[2]	Standards rated as **Not compliant**[3]
64	**62**	**2**	**0**
	Definition		
Applicable standards by organisation type: Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers: **54** CCGs: **43**	*[1]Fully compliant with the Core Standard* ***NOTE**: This is the number that is used in order to determine the organisation's overall assurance rating as generated by the self-assessment tool*	*[2]Not compliant with the Core Standard.* *The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months*	*[3] Not compliant with the Core Standard.* *In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months*

Where areas require further action, this is detailed in the *EPRR Action Plan* and these will be reviewed in line with the organisation's governance arrangements.

I confirm that the organisation's overall assurance rating has been/will be:

- signed off by the organisation's Board / Governing Body / Senior Management Team
- presented at a public Board meeting
- published in the organisation's annual report

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of public Board meeting

Date signed

Appendix: EPRR Action Plan:

A	B	C	D	F	G	H	I	J	K
Overall assessment:			Substantially compliant						
Ref	Domain	Standard	Detail	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard	Action to be taken	Lead	Timescale	Comments
20	Duty to maintain plans	Shelter and Evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Over the previous 12 months All wards have undertaken evacuation exercises and now have evacuation cards that outline the immediate response if an evacuation is required. These arrangements have been augmented by the additon of a senior person action card to assist the co-ordination and a "Ward in a Cage" and evacuation cupboards which can provide immediate basic equipment as / if required. There is currently no provision for an evacuation of the entire trust Site.		Attending EPRR Workshop in Oct 2018 to discuss further with GMH&SCP	J Tunn	2 Months	Will report to AEO
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	The Emergency Department currently has access to 9 x PRPS for immediate deployment against an agreed target of 13. The trust is wholly reliant on the current suppliers to deliver the new generation PRPS in time for the expiry of the current interim PRPS. This gap in resourse has been communicated to NHS England and GM H&SC P		Remain in dialogue with NARU & Suppliers to confirm delivery date.	J Tunn	6 Months	Affecting this date may well fall outside of the scope of influence of the EPRR manager

NHS Bolton NHS Foundation Trust

Agenda Item No	

Meeting	Board of Directors

Date	Thursday 27th September 2018

Title	Medical Staff Appraisal and Revalidation Annual Board Report

Executive Summary	• The medical appraisal and revalidation system at Bolton FT continues to confirm with national requirements and is performing well within the required standards. • Appraisal rates have improved to 90% of all eligible staff • strong corporate and divisional governance, and robust employment checks resulted in a low number of medical staff requiring formal remediation. Our performance and processes have satisfied NHS North in their annual desktop review of Designated Bodies. • Trust Board is asked to support completion of our annual statement of compliance (Annex E) for submission to NHS North.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	No

Next steps/future actions				
	Discuss		Receive	Y
	Approve	Y	Note	Y
	For Information		Confidential y/n	N

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	Y	To be well governed	Y
Valued Provider		To be financially viable and sustainable	
Great place to work		To be fit for the future	Y

Prepared by	Dr Francis Andrews	Presented by	Dr Francis Andrews, Medical Director

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D - Annual Board Report Template

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

Updated: 16 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

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1. Executive summary

Performance in 2017/18 demonstrates our Appraisal and Revalidation system is fit for purpose. Appraisal rates have improved overall to over 90%. Strong corporate and divisional governance and robust employment checks have resulted in a low number of medical staff requiring formal remediation. Our performance and processes have satisfied NHS North in their annual desktop review of Designated Bodies and we compare well in performance with respect to national results.

2. Purpose of the Paper

The purpose of this report is to inform Trust Board of the status of our processes and performance against requirements as a designated body employing doctors. This covers the domains of appraisal, revalidation recommendations, identifying and responding to concerns and recruitment and engagement background checks. The Board is required to receive this report on an annual basis. If the Board are satisfied, the statement of compliance with the regulations (Attachment 3-FQA Annex E) needs to be signed off by the Chairman or Chief Executive and submitted to the Responsible Officer for NHS North.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

The governance of the appraisal and revalidation system is provided by a team comprising Francis Andrews (Responsible Officer), Priya Bhatt (Trust Clinical Lead for Appraisal and Revalidation) and Rabeya Rashid and Lorraine Bowman (who share the role of Appraisal and Revalidation Administrator). Support for responding to concerns and employment checks is provided from the Human Resources Department. Our electronic appraisal system allows real time monitoring of the rates and timeliness of medical staff appraisals. Our electronic system, Premier IT, is compliant with national requirements. There is close communication between our Employee Service Centre and the appraisal and revalidation team to ensure that newly appointed medical staff are connected to Bolton FT as their Designated Body. In addition, leavers are disconnected from Bolton FT promptly. There is an escalation plan in place to ensure appraisals are performed in a timely fashion. Appraisal rates are shared with the individual departments on a monthly basis. Appraisal quality is monitored formally by Priya Bhatt overseen by Francis Andrews. The four members of the governance team meet monthly to monitor progress; Francis attends the quarterly regional Responsible Officer Network and Priya attends the regional quarterly Medical Appraisal Lead network to ensure new and updated guidance is understood and implemented locally.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Our 2017-18 Annual Organisation Audit (AOA) shows our appraisal performance data for 2017-18 with the 2017-18 Annual Comparator Report showing how we compare with other organisations.

There is a marked improvement in appraisal quality and timeliness for the year 2017-18 compared to the previous year but also against the national average. Despite a stricter definition of completed appraisal requiring all appraisals to be completed by the 12 month due date, our appraisal rate is higher in both the ‘Same Sector’ and ‘All Sector’ category (measures 1a and 1b combined).

Compared to last year’s performance there has been a 7.1% increase in performance. There has been notable increase in SAS Doctors performance at 96% which is 8% above the national average for this group.

The below table breaks down our appraisal performance against Same/All Sector average:

2017/18 AOA Indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 884
		Completed appraisals (Measure 1a & 1b)		
2.1	Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 – 31 March 2018	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	All sectors appraisal rate
2.1.1	Consultants	150 (94.5%)	92.0%	92.7%
2.1.2	Staff grade, associate specialist, specialty doctor	48 (96.0%)	89.4%	85.9%
2.1.3	Doctors on Performers Lists	N/A	71.4%	94.4%
2.1.4	Doctors with practising privileges	N/A	66.7%	93.0%
2.1.5	Temporary or short term contract holders	11 (57.9%)	77.2%	82.8%
2.1.6	Other doctors with a prescribed connection to the designated body	N/A	63.9%	87.1%
2.1.7	Total number of doctors who had a completed annual appraisal	249 (92.2%)	86.3%	91.3%

While figures have shown a marked improvement, we are currently reviewing our appraisal policy and escalation process. This is currently tabled for discussion at the Joint Local Negotiating Committee (JLNC). It is expected that the suggested changes will help to increase our appraisal timeliness and target 'serial offenders'.

I am the Responsible Officer for Bolton Hospice and ABL Health Limited (a small private organisation that delivers services on the Royal Bolton site). The arrangement with Bolton Hospice is collaborative and voluntary, whereas, with ABL it is commercial with a signed Service Level Agreement. Both organisations use our appraisers and appraisal systems.

b. Appraisers

We have a total of 54 trained appraisers. All our appraisers have received a one day face-to-face training at Arrowe Park Hospital, Wirral. Appraiser performance is monitored by inspection of the appraisal output forms by our Appraisal and Revalidation Clinical Lead. Our electronic appraisal system provides the opportunity for appraisee feedback. This information is collated, and a report generated for each appraiser prior to their own appraisal meeting for discussion and reflection. The Appraisal & Revalidation Clinical Lead chairs the Appraiser Network Meetings which is held every 6 months. These meetings are aimed at continuous improvement in the quality and consistency of appraiser performance and an opportunity to discuss topical issues.

We have recently undergone an exercise for 'Appraiser Allocation' to ensure fair distribution of appraisals. Most of our appraisers now perform between 4-6 appraisals per year.

c. Quality Assurance

Appendix B of this report contains the summary of the Quality Assurance of appraisal inputs and outputs performed by our Appraisal and Revalidation Lead. All appraisals are reviewed by our Appraisal and Revalidation Lead and Responsible Officer looking for evidence listed below:

Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available.
- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs-by whom and sign offs.

For the individual appraiser:

- An annual record of the appraiser's participation in Trust appraisal meetings.
- 360°feedbackfrom doctors for each appraiser.

For the organisation:

- Audit of timelines of process of appraisal by department.
- System user feedback.
- Review of lessons learned from any complaints.
- Review of lessons learned from any significant events.

d. Access, Security and Confidentiality

All appraisal and revalidation information is now stored electronically on our appraisal system. This is compliant with national IT security standards. An individual's appraisal folder is accessible to the individual, the appraiser, Trust Revalidation and Appraisal Lead and Responsible Officer only. The only patient specific data contained within appraisal portfolios relate to complaints which do not contain any patient identifiable data. There have been no information governance breaches reported relating to appraisal documentation.

e. Clinical governance

The annual consultant level performance data is provided by CHKS, our data analysts, and is available to Consultant/Senior medical staff to upload into their appraisal folder. Our Complaints and Litigation Team send complaints relating to senior medical staff to our Appraisal and Revalidation Team to be uploaded into the input folder to ensure

discussion at the appraisal meeting. Consultants are expected to use individual and departmental performance in national audits in their appraisal portfolios.

6. Revalidation Recommendations

The year 2017-18 was the first year of the second 5-year revalidation cycle. There were 29 doctors with a revalidation due date between 01/04/2017-31/03/2018. We were able to make positive recommendations for 27 doctors with 2 requests for deferral due to 'Insufficient evidence for a recommendation to revalidate'

7. Recruitment and engagement background checks

These are detailed in Appendix E-audit of recruitment and engagement background checks. We are fully compliant with essential checks for example DBS but for some temporary doctors some items require improvement such as confirmation of appraisal completion.

8. Monitoring Performance

Annual satisfactory appraisal is a key component of monitoring individual doctor's performance. Engagement with the process and portfolio content including clinical outcomes, colleague/ patient feedback and engagement in quality improvement activity are an indicator of satisfactory performance. Medical staff performance is also monitored by our systems of clinical governance including clinical incidents and complaints which are all seen by the Responsible Officer. An individual doctor's performance is closely linked to that of their department. Bench marked departmental performance is monitored by our CHKS data, outcomes of National Audits and via our own internal governance systems.

9. Responding to Concerns and Remediation

A small number of doctors became the subject of conduct concerns and in all cases advice was sought from NCAS. These are detailed in appendix C

10. Risks and Issues

The number of temporary employed and locum doctors used is a risk mitigated by robust employment checks. Reducing this usage by recruitment to substantive posts will reduce the risk and also deliver value for money. This is a corporate and divisional priority being addressed by the model hospital work.

11. Board Reflections

This report demonstrates that our appraisal and revalidation processes are fit for purpose with outputs being comparable with other organisations. Our appraisal and revalidation system is supported by the strong systems of clinical governance in place in the organisation. Combined these are a key component of delivering high quality patient care.

Following the peer review that took place between Bolton, Salford and Mid-Cheshire in summer 2017, there has been considerable effort in implementing systems and processes to ensure better practice. Below are 'headlines' of some of these actions;

Items that have been implemented:

- Appraiser Allocation
- Preventing consecutive appraisers for more than 3 years
- Ceasing appraisals due in March to boost appraisal return rate for the NHS England annual report
- Establishing monthly starters and leavers reporting with HR
- Revalidation Entry Form for inclusion in doctors' pre-employment packs
- Generate feedback reports for Appraisers
- Complaints reporting for upload in to Doctor's portfolios
- Cross speciality appraisal guideline – however we have only managed to receive about one third of speciality forms so far.

Items that have been deferred:

- Workforce committee report has been created however this has yet to be tabled at a meeting.
- Annual reporting template for Board of Directors to undergo a refresh ready for 2019 submission
- Monitoring 'Appraisal Repeat Offenders' – a matrix was developed to help monitor and engage serial offenders in remedial action however currently the appraisal policy is undergoing major revision.

12. Corrective Actions, Improvement Plan and Next Steps

Objectives for 2018-19 include:

1. Continue to increase appraisal rates done within required timescale.
2. Implementation of remainder peer review actions.
3. Ratification of Appraisal Policy
4. Capturing New Starters in a timely manner
5. Better engagement for short term appointees who in the past have not had access to our electronic systems. We accept that this group may benefit from our current processes.
6. Required detail for all missed/delayed appraisal reasons

13. Recommendations

The board are asked to accept the report. The Board are asked to note that it will be shared, along with the annual audit, with the higher-level responsible officer.

The board are requested to approve the 'statement of compliance' confirming that Bolton NHS Foundation Trust, as a designated body, is in compliance with the regulations. This is also submitted annually to the higher-level responsible officer.

14. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors	
Maternity leave during the majority of the 'appraisal due window'	*7*
Sickness absence during the majority of the 'appraisal due window'	*6*
Prolonged leave during the majority of the 'appraisal due window'	*1*
Suspension during the majority of the 'appraisal due window'	*0*
New starter within 3 month of appraisal due date	-
New starter more than 3 months from appraisal due date	-
Postponed due to incomplete portfolio/insufficient supporting information	-
Appraisal outputs not signed off by doctor within 28 days	-
Lack of time of doctor	-
Lack of engagement of doctor	-
Other doctor factors (describe)	*30*
Appraiser factors	
Unplanned absence of appraiser	-
Appraisal outputs not signed off by appraiser within 28 days	-
Lack of time of appraiser	-
All appraiser factors (above detail not currently recorded)	*5*
Organisational factors	
Administration or management factors	-
Failure of electronic information systems	-
Insufficient numbers of trained appraisers	-
Total organisational factors	*0*

Note: some missed or incomplete appraisals have more than 1 contributing factors

15. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		249
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	50	47
Scope of work: Has a full scope of practice been described?	50	50
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	50	47
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	50	47
Patient feedback exercise: Has a patient feedback exercise been completed?	**No (Not in all cases for this specific year. This is done at an appropriate stage in the 5-year revalidation cycle**	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	50	45
Review of complaints: Have all complaints been included?	50	50
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	50	50
Is there sufficient supporting information from all the doctor's roles and places of work?	50	47
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	50	47
Appraisal Outputs		
Appraisal Summary	50	50
Appraiser Statements	50	50
Personal Development Plan (PDP)	50	50

16. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	0	2	1	3
Capability concerns (as the primary category) in the last 12 months				0
Conduct concerns (as the primary category) in the last 12 months				3
Health concerns (as the primary category) in the last 12 months				0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	0
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

17. Annual Report Template Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	36
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	36
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	21
Temporary employed doctors	63
Locums brought in to the designated body through a locum agency	259
Locums brought in to the designated body through 'Staff Bank' arrangements	37
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	380

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	21	21	0	0	0	21	21	21	21	21	0	21	21	21	21	0
Temporary employed doctors	63	63	0	0	0	63	63	24	24	24	0	63	24	24	24	0
Locums brought in to the designated body through a locum agency	259	259	0	0	0	259	259	259	259	259	0	259	259	259	259	0

Locums brought in to the designated body through 'Staff Bank' arrangements	37	37	0	0	0	37	37	37	37	37	0	37	37	37	37	0
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	380	380	0	0	0	380	380	304	304	304	0	380	304	304	304	0

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	124.13	336.06		683.03	1019.09
Medicine	106.13	166.69		714.22	880.91
Psychiatry					
Obstetrics/Gynaecology	45.70	25.44	0	133.42	158.86
Accident and Emergency	38.40	68	0	1027	1095
Anaesthetics	66.48	10.94		299.14	310.08
Radiology	21.58	321.57			321.57

Pathology	15.00	85.12			85.12
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)	417.42	1013.82		2856.81	3870.63
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total	See note below	See note below	See note below	See note below	See note below

Note: Details regarding individual locum attachments are not currently recorded but will be once e rostering is in place.

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board of Bolton NHS Foundation Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Confirmed

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Confirmed

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Confirmed

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Confirmed

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Confirmed

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Confirmed

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Confirmed

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Confirmed

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Confirmed

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2017-18

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	07760
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	23 March 2018
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2016/17 AOA cleared with Publications Gateway Reference 06491
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

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Annual Organisational Audit (AOA)

End of year questionnaire 2017-18

Version number: 2.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016, 24 March 2017, 23 March 2018

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Please do not use this version of the form to submit your response.

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1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play of medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of medical revalidation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2017/18;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2018** for the year ending 31 March 2018. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2018.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 28 September 2018.
- The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Bolton NHS Foundation Trust	
	Head Office or Registered Office Address if applicable line 1 Trust Headquarters	
	Address line 2 Minerva Road	
	Address line 3 Farnworth	
	Address line 4	
	City Bolton	
	County	Postcode BL4 0JR
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) ***** Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☑
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

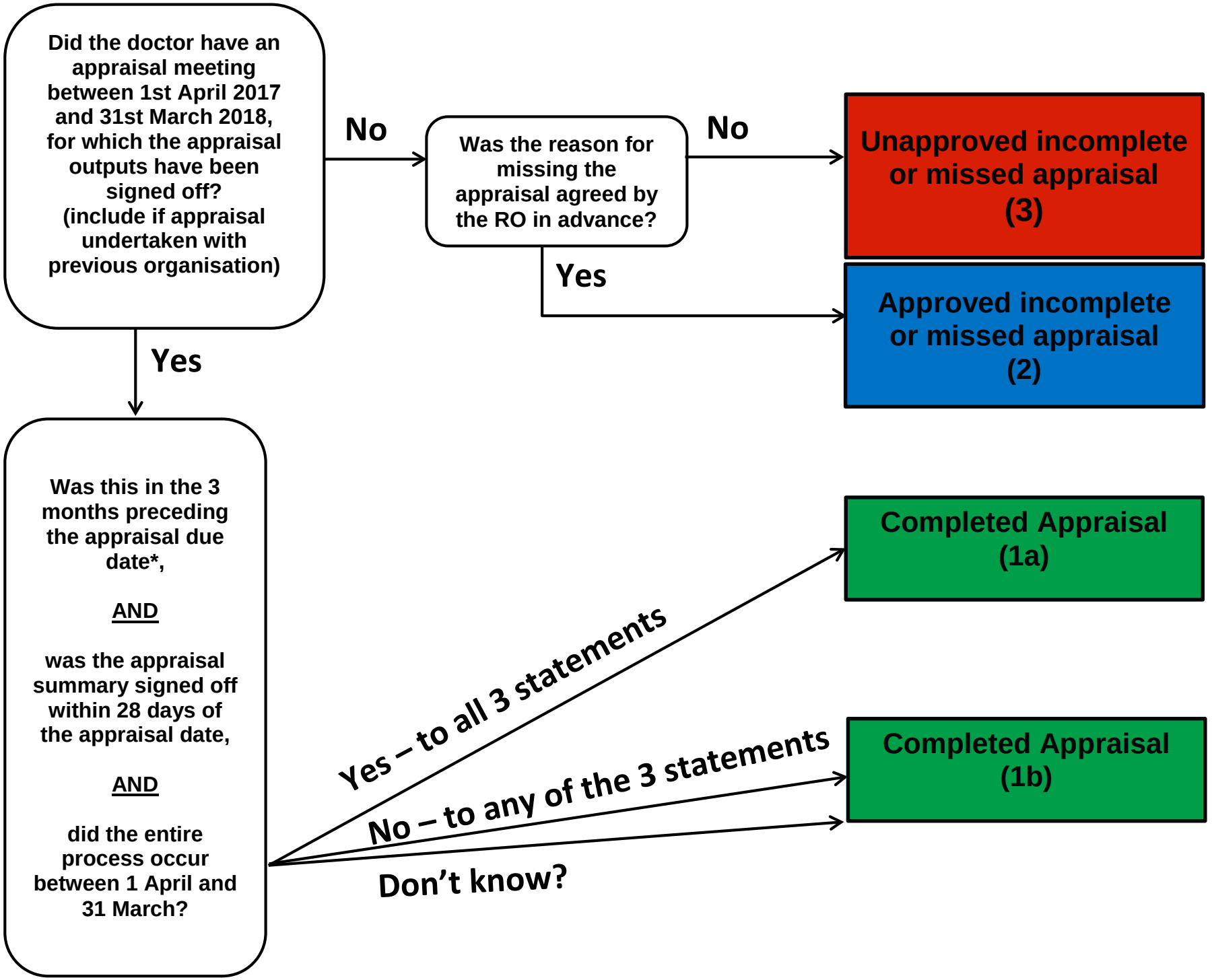
1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	201	30	160	10	1	201
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	50	5	43	1	1	50
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	19	6	5	8	0	19
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	270	41	208	19	2	270

Please do not use this version of the form to submit your response.


Did the doctor have an appraisal meeting between 1st April 2017 and 31st March 2018, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2018. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2017/18 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☐ Yes ☑ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1	2.1 - New doctors with no ARCP recorded have been categorised within Category 2 - Approved Incomplete or Missed Appraisal. This equates to a total of 10 Doctors. 2.2 - Processes are being reviewed to tackle delayed appraisals.	

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Appraisal in the Independent Health Sector* (British Medical Association and Independent Healthcare Advisory Services, 2012)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2012)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

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27 July 2018

Our Ref: 74
Publications Gateway Reference 08225

Mr Stephen Hodgson
Responsible Officer
Bolton NHS Foundation Trust

Dear Mr Hodgson

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 74 - Bolton NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 17/18 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The AOA exercise is designed to help designated bodies assure themselves and their boards (or equivalent management bodies) that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, and the arrangements for medical appraisal and responding to concerns, are in place and are effective. It also provides a mechanism to assure NHS England that the processes supporting medical revalidation have been implemented and work properly.

In this fifth year of the AOA, and the ninth consecutive year of monitoring medical revalidation, I am pleased to report a continuing upward trend, not only in the overall appraisal rate, but also an improvement of the system in general. This is extremely reassuring and I would like to thank you once again for your continued work to ensure that thorough revalidation and clinical governance processes are in place across the healthcare system.

On reviewing the results presented below, designated bodies should produce an action plan to address any development needs that are identified. If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Mike Prentice
Your local revalidation team's lead contact	Rachel Stephenson
Your local revalidation team's contact details	england.revalidation-north@nhs.net

Board-level accountability for the quality and effectiveness of these systems is important and this report, along with the resulting action plan, should be presented to the board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2018. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing assurance to your higher level RO, and to NHS England, of your processes.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer

cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 834 returns from designated bodies (DBs) to the 2017/18 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2018

The following information is presented as per your own AOA submission.

Name of designated body:	Bolton NHS Foundation Trust
Name of responsible officer:	Mr Stephen Hodgson
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - North)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Rachel Stephenson at england.revalidation-north@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2017/18 for the full indicator definitions if required.

2017/18 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	98 (99.0%)	823 (98.7%)
1.5	Where a conflict of interest or appearance of bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?	N/A	This question is not applicable to many DBs	
1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.	Yes	97 (98.0%)	814 (97.6%)
1.7	The responsible officer is appropriately trained and remains up to date and fit to practice in the role of responsible officer.	Yes	98 (99.0%)	819 (98.2%)
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.	Yes	99 (100.0%)	826 (99.0%)
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.	Yes	99 (100.0%)	818 (98.1%)

2017/18 AOA indicator SECTION 1 (cont.): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.	Yes	99 (100.0%)	826 (99.0%)
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.	Yes	99 (100.0%)	820 (98.3%)
1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)	Yes	84 (84.8%)	656 (78.7%)

2017/18 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	201	26315	51297
2.1.2	Staff grade, associate specialist, specialty doctor	50	5494	12060
2.1.3	Doctors on Performers Lists	0	7	46972
2.1.4	Doctors with practising privileges	0	3	2065
2.1.5	Temporary or short-term contract holders	19	7485	21455
2.1.6	Other doctors with a prescribed connection to this designated body	0	610	6325
2.1.7	**Total number of doctors with a prescribed connection**	270	39914	140174

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Completed appraisals (Measure 1a & 1b)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	190 (94.5%)	92.0%	92.7%
2.1.2	Staff grade, associate specialist, specialty doctor	48 (96.0%)	88.4%	88.9%
2.1.3	Doctors on Performers Lists	N/A	71.4%	94.7%
2.1.4	Doctors with practising privileges	N/A	66.7%	93.0%
2.1.5	Temporary or short-term contract holders	11 (57.9%)	77.2%	82.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	63.9%	87.1%
2.1.7	**Total number of doctors who had a completed annual appraisal**	249 (92.2%)	88.3%	91.3%

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Approved incomplete or missed appraisal (Measure 2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Approved incomplete or missed appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	10 (5.0%)	4.9%	4.3%
2.1.2	Staff grade, associate specialist, specialty doctor	1 (2.0%)	7.9%	7.5%
2.1.3	Doctors on Performers Lists	N/A	28.6%	4.8%
2.1.4	Doctors with practising privileges	N/A	33.3%	5.5%
2.1.5	Temporary or short-term contract holders	8 (42.1%)	17.2%	11.2%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	18.5%	9.8%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	19 (7.0%)	7.8%	6.1%

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Unapproved incomplete or missed appraisal (Measure 3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Unapproved incomplete or missed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	1 (0.5%)	3.1%	3.0%
2.1.2	Staff grade, associate specialist, specialty doctor	1 (2.0%)	3.8%	3.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	1.5%
2.1.5	Temporary or short-term contract holders	0 (0%)	5.6%	6.0%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	17.5%	3.1%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	2 (0.7%)	3.9%	2.7%

2017/18 AOA indicator SECTION 2 (cont.): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded.	No	This question is not applicable to many DBs	
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group).	Yes	99 (100.0%)	810 (97.1%)
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.	Yes	99 (100.0%)	815 (97.7%)
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.	Yes	98 (99.0%)	809 (97.0%)
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.	Yes	99 (100.0%)	814 (97.6%)
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.	Yes	97 (98.0%)	801 (96.0%)

2017/18 AOA indicator SECTION 3: Monitoring Performance and responding to concerns SECTION 4: Recruitment and Engagement		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
3.1	There is a system for monitoring the fitness to practice of doctors with whom the designated body has a prescribed connection.	Yes	99 (100.0%)	824 (98.8%)
3.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).	Yes	99 (100.0%)	820 (98.3%)
3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	Yes	99 (100.0%)	818 (98.1%)
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers.	Yes	96 (97.0%)	775 (92.9%)
4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).	Yes	99 (100.0%)	821 (98.4%)

2017/18 AOA indicator SECTION 5: Comments	Your organisation's response
5.1	2.1 - New doctors with no ARCP recorded have been categorised within Category 2 - Approved Incomplete or Missed Appraisal. This equates to a total of 10 Doctors. 2.2 - Processes are being reviewed to tackle delayed appraisals.