AGENDA - BOARD OF DIRECTORS' MEETING

MEETING HELD IN PUBLIC

To be held at 12:30 on Thursday 27 July 2023
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref Nº.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB076/23	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm meeting quoracy*	*Verbal*	Chair	**12:30**
TB077/23	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	**12:35** (15 mins)
TB078/23	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*Report + Verbal*	Chair	
TB079/23	**Minutes of the previous meeting held on 26 May 2023** *Purpose: To **approve** the minutes of the previous meeting*	*Report*	Chair	**12:50** (5 mins)
TB080/23	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB081/23	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Verbal*	Chair	**12:55** (5 mins)
OPERATIONAL PERFORMANCE				
TB082/23	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13:00** (10 mins)

TB083/23	**Initial CQC Feedback** *Purpose: To* ***receive*** *the update*	*Presentation*	CEO	**13:10** (10 mins)
TB084/23	**Operational Update** *Purpose: To* ***receive*** *the Operational Update*	*Presentation*	COO	**13:20** (15 mins)
TB085/23	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance *Purpose: To* ***receive*** *the Integrated Performance Report*	*Report*	DCEO	**13:35** (15 mins)
WORKFORCE				
TB086/23	**Freedom to Speak Up Annual Report** *Purpose: To* ***receive*** *the Freedom to Speak Up Annual Report*	*Report*	Chief People Officer	**13:50** (15 mins)
TB087/23	**People Committee Chair Reports** *Purpose: To* ***receive*** *assurance on work delegated to the Committee*	*Report*	PC Chair	**14:05** (10 mins)
STRATEGY AND PERFORMANCE				
TB088/23	**Draft Clinical Strategy for Engagement** *Purpose: To* ***receive*** *the Clinical Strategy*	*Report*	DoSDT	**14:15** (20 mins)
TB089/23	**Strategy and Operations Committee Chair's Report** *Purpose: To* ***receive*** *assurance on work delegated to the Committee*	*Report*	SoC Chair	**14:35** (10 mins)
	COMFORT BREAK			**14:45**

QUALITY AND SAFETY				
TB090/23	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q1 Update** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q1 Update*	*Report*	Chief Nurse	15:00 (10 mins)
TB091/23	**Quality Assurance Committee Chair's Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	15:10 (10 mins)
FINANCE				
TB092/23	**Review of Financial Position** *Purpose: To **receive** the update*	*Presentation*	CFO	15:20 (10 mins)
TB093/23	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	15:30 (5 mins)
RISK AND GOVERNANCE				
TB094/23	**Board Assurance Framework** *Purpose: To **receive** the Board Assurance Framework*	*Report*	*DCG*	15:35 (10 mins)
TB095/23	**Audit Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	AC Chair	15:45 (5 mins)
TB096/23	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*NEDs*	15:50 (10 mins)

CONCLUDING BUSINESS				
TB097/23	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16:00** (2 mins)
TB098/23	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**16:02** (3 mins)
TB099/23	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16:05** (5 mins)
	Date and time of next meeting: Thursday 28 September 2023			***16:10*** ***close***

Chair: Dr Niruban Ratnarajah

Board of Directors Register of Interests – Updated July 2023

Name:	Position:	Interest Declared	Type of Interest
Francis **Andrews**	Medical Director	Holt Doctors (locum agency) payments for appraisals	Financial Interest
		Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest
Malcolm **Brown**	Non-Executive Director	Family member employed by Trust	Non-Financial Personal Interest
Lynn **Donkin**	Director of Public Health	Nothing to Declare	
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
Bilkis **Ismail**	Non-Executive Director	Director/shareholder of Bornite Legal Limited and Bornite Holdings Limited	Financial Interest
		Director of Azurite Holdings Limited	Financial Interest
		Governor Bolton Sixth Form College	Non-Financial Personal Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	
Naomi **Ledwith**	Delivery Director GM ICP Bolton Locality	Trustee at The Counselling and Family Centre	Non-Financial Professional Interest
		Family member employed by Aqua (until 31/03/23)	Non-Financial Personal Interest
James **Mawrey**	Chief People Officer / Deputy CEO	Trustee at Stammer	Non-Financial Personal Interest

Board of Directors Register of Interests – Updated July 2023

Name:	Position:	Interest Declared	Type of Interest
Jackie **Njoroge**	Non-Executive Director	Director – Salford University	Financial Interest
		Deputy Chair HESPA (non-remunerated position)	Non-Financial Professional Interest
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		The Foundation Trust Network (Trustee NHS Providers	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
Niruban **Ratnarajah**	Chair Elect	GP Partner: Stonehill Medical Centre	Financial Interest
		Associate Medical Director: NHS GMIC	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
Tyrone **Roberts**	Chief Nurse	Nothing to declare	
Alan **Stuttard**	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
		NED Blackpool Operating Company Ltd (Blackpool Sandcastle Waterpark)	Financial Interest
		Non-Executive Director - Blackpool Waste Services Ltd (trading as Enveco)	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
Rachel **Tanner**	Director of Adult Service, Bolton Council	Nothing to declare	
Annette **Walker**	Chief Finance Officer	Chief Finance Officer of both Bolton Foundation Trusts and GM ICP Bolton	Non-Financial Professional Interest
		BOLTON FUNDCO 1 LIMITED	Non-Financial Professional Interest
		BOLTON HOLDCO LIMITED	Non-Financial Professional Interest
		BRAHM FundCo 2 Limited	Non-Financial Professional Interest
		BRAHM FUNDCO 1 LIMITED	Non-Financial Professional Interest
		BRAHM INTERMEDIATE HOLDCO 1 LIMITED	Non-Financial Professional Interest
		BRAHM Intermediate Holdco 2 limited	Non-Financial Professional Interest
		BRAHM LIFT LIMITED	Non-Financial Professional Interest
Rae **Wheatcroft**	Chief Operating Officer	Nothing to declare	
Sharon **White**	Director of Strategy	Trustee at Fort Alice Bolton	Non-Financial Professional Interest
		Trustee George House Trust	Non-Financial Professional Interest
		Judge on She Inspire Awards	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

GUIDANCE NOTES ON DECLARING INTERESTS

The Board believes that interests should be declared if they are material and relevant to the business of the Board and should, in any case, include:

- Directorship, including non-executive directorships held in private companies or private limited companies
- Ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for services with NHS services.

NB If there is any doubt as to the relevance of an interest, this should be discussed with the Trust Chair.

Types of Interests:

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

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

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

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

Board of Directors Minutes of the Meeting
Held on Microsoft Teams
Friday 26 May 2023
(Subject to the approval of the Board of Directors on 27 July 2023

Present

Name	Initials	Title
Jackie Njoroge	JN	Interim Chair/Non-Executive Director
Fiona Noden	FN	Chief Executive
Annette Walker	AW	Chief Finance Officer
Rae Wheatcroft	RW	Chief Operating Officer
James Mawrey	JM	Director of People
Tyrone Roberts	TR	Chief Nurse
Sharon Katema	SK	Director of Corporate Governance
Sharon White	SW	Director of Strategy, Digital and Transformation
Alan Stuttard	AS	Non-Executive Director
Martin North	MN	Non-Executive Director
Rebecca Ganz	RG	Non-Executive Director
Malcolm Brown	MB	Non-Executive Director

In Attendance

Name	Initials	Title
Amy Blackburn	AB	Head of Communications
Harni Bharaj	HB	Deputy Medical Director (on behalf of Francis Andrews)
Laura Smoult	LS	Staff Experience Manager (for item 060)
Lynn Donkin	LD	Director of Public Health
Naomi Ledwith	NL	Delivery Director (Bolton), NHS Greater Manchester Integrated Care
Jake Mairs	JM	Associate Director Organisational Development (for item 60)
Rachel Carter	RC	Associate Director of Communications and Engagement
Rachel Tanner	RT	Managing Director – Bolton Integrated Care Partnership
Victoria Crompton	VC	Corporate Governance Manager
Janet Cotton	JC	Directory of Midwifery (for item 052)

There were also three observers in attendance. .

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB051/23	**Chair's Welcome and Note of Apologies** The Interim Chair welcomed everyone to the meeting. Apologies for absence were noted from Francis Andrews, Bilkis Ismail and Niruban Ratnarajah.	
TB052/23	**Patient and Staff Story** The Chief Nurse introduced both the patient and staff stories advising that he staff story related to Lauren Searle, Community Midwife who had previously presented in July 2022 and requested. Lauren had been asked to return to provide an update, which JC had agreed to attend and present on Lauren's behalf.	

Staff Story

JC read a statement from Lauren advising that she had previously talked about the stresses of on call midwives being called into the unit to relieve when the Maternity Department was under significant pressure. Some negative feedback from her own experiences and of other community midwives were shared.

Lauren advised it was important to address that there has been a huge culture shift, staff are much happier to come in, and help when needed, adding that they feel appreciated and valued. This has mostly always been the case; however, during a difficult few years sometimes staff could be so overloaded that kindness was not always at the forefront of their actions. This has not been the case in last few months and there been significant changes, which are having a positive impact on both staff and students. Lauren recently assisted on the postnatal ward and the team were grateful and helpful and consequently she stayed later to help further.

MN commented he would contact Lauren in his capacity of Maternity Champion to thank her for her story and update.

In response to a query from AS regarding lessons learnt in maternity, TR advised clinical outcomes remain safe within the department. Those in leadership roles regularly walk the floor and hold listening events. There are enhanced internal leadership programmes available and improvements have been seen throughout the Trust including in Accident and Emergency and non-clinical areas.

Patient Story

The Board of Directors received the patient story, a video prepared by the Bolton Maternity Voices Partnership, showing clips from a number of parents, children and their families thanking midwives for their support and hard work during the course of their care.

NL queried what support Bolton ICB could provide for maternity services. FN commented the Bolton locality needs to ensure neighbourhoods are family focussed from the start to end of life.

RESOLVED:

The Board of Directors **received** the patient and staff story.

Action — **FT/23/05**

MN to contact Lauren Searle to thank her for sharing her staff story and providing an update. — **MN**

TB053/23 Declarations of Interest

The Chief Executive Officer declared that she is a member of the Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).

TB054/23 Minutes of the previous meetings

The Board of Directors reviewed the minutes of the meeting held on 30 March 2023 and approved them as a correct and accurate record of proceedings, subject to the following changes:

- Page 5 – Operational update - In response to a query from AS regarding the failure of achieving the cancer target, RW indicated there is an acceptance that Trust's will not achieve 100% as this relies on different pathways. Harm reviews take place on all breaches to ensure no harm is caused to patients due to delays.

RESOLVED:
The Board of Directors **approved** the minutes from the meeting held 30 March 2023, subject to the amendments being made.

TB055/23 Matters Arising and Action Logs

The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions.

RESOLVED:
The Board **approved** the action log

CORE BUSINESS

TB056/23 Chair's Update

The Interim Chair advised that the Care Quality Commission (CQC) had completed an inspection of Children's and Young Persons Services and were due to commence the Well Led inspection from 7 June 2023.

JN advised she had attended the Council of Governors Strategy Meeting and a GM Chair's Meeting. She would also be attending a GM Non-Executive Director event with Martin North.

TB057/23 Chief Executive Report

The Chief Executive presented her report and highlighted the following key points:

- The Trust, in partnership with Age UK Bolton and Urban Outreach, was offering meal bags to people identified as being at risk of malnutrition at the time of discharge. This work was part of Bolton's Nutrition and Hydration Programme.
- The refurbished multi-faith facility and community hub was officially opened at by the Mayor of Bolton.

- The Trust had finalised figures for the last financial year, confirming 2022/23 ended with a £1.5m deficit, and a £42.1m capital spend.
- The Trust had been successful in securing funding to build a Community Diagnostic Centre, which should be ready to use by spring 2024.
- The organisation had been working with partners about the move from nine neighbourhoods to six within the Bolton Locality. The change is intended to make it easier for teams to work together to support people at home and work more closely with key partners.

FN also provided an update on recent events advising on 13 May 2023 she was contacted by a health media outlet advising that concerns had been raised with them from whistle-blowers. These related to concerns the whistle-blowers had previously raised with CQC and NHSE. The media outlet advised the CQC and NHSE were investigating.

FN indicated she had not been made aware of the concerns that the media outlet described. The Trust provided information to the media to assist with the story, which was published on Monday 22 May 2023.

The organisation had not had a CQC Well Led Inspection since 2018, and with several Board changes, and recent concerns, it was expected an inspection would be undertaken. However, in order to, undertake a Well Led Inspection the CQC are required to be on site already undertaking a core inspection. The CQC chose to inspect our Children's Services, as the service was last inspected in 2016. It was expected that this inspection would enable the CQC to both review the service provision for children and young people, whilst also testing learning and interventions from a former serious incident.

During the inspection, the Trust received notification that Well Led Inspection would take place from 7 June 2023. This would involve a series of interviews, stakeholder groups and focus groups. The Trust were collating evidence and information requests from the CQC. The organisation warmly welcomes the CQC as this provides opportunities for staff to meet with the CQC should they wish to speak with them.

Finally, the Trust was notified it had been unsuccessful in the New Hospital Bid, which was disappointing but not unexpected, given the financial climate. The organisation will consider alternatives funding streams are available.

RG queried the work with Age UK to offer meal bags and how this will expand. FN advised the work Age UK were completing was phenomenal, but one of the main issues was the storage of the packs. Discussion is required around how organisations within Bolton collectively support the voluntary section to support patients. RT advised that a number of stakeholders provide funding which is managed by Bolton Council for Voluntary Services (CVS). Consideration should be given to how the commissioning of this offer could be improved.

RESOLVED:
The Board of Directors **received** the Chief Executive Report.

TB058/23 Operational Update

The Chief Operating Officer provided an operational update and the following key points were highlighted:

- The number of patients on the waiting list has increased and although the Trust maintained the 78-week position, there was an increase in the number of patients waiting more than 65 weeks.
- Two-week cancer wait performance continued to decline, however, the organisation has seen an increase in referrals. A cancer recovery plan was in place to ensure the pathway is available to those who need it.
- 62-day cancer performance was 80.1% against Greater Manchester (GM) performance of 62.4%.
- Ambulance handover times continued to improve. The Urgent Care Team presented at the North West ambulance handover collaborative and were commended for their good work.
- Performance against the four-hour standard was 68.9%, which was in-line with the GM average. Nationally, performance was 74.6%.
- There has been a reduction in the number of patients waiting more than 12 hours in the Emergency Department. However, the Trust is still above the GM average. This links to inpatient flow, which the organisation is working to improve across the whole system.
- GM as a system was identified as being in Tier 1 for Urgent and Emergency Care. Whilst, not a regulatory intervention, it is support for the whole system, including Health and Social Care at both ICS and Place level.
- The Trust remained at around 100 patients with no criteria to reside. Whilst the number of patients remained static there was an increase in the days delayed.
- Further industrial action is planned for Junior Doctors between 14 and 17 June. A planning group had been established.

NL advised the system had a part to play in all areas of performance for the Trust. Referrals have increased in all specialities and organisations were being held to account at Greater Manchester (GM) level. Whist there were challenges with resource, there was an aim to complete a full system review this year.

RG queried whether industrial action had created any opportunities for innovation. RW explained that following the first industrial action period a review was undertaken to build on actions and learning. HB added that feedback was provided after each period of industrial action and it was established that having a senior clinical decision maker made a significant difference.

AS noted Accident and Emergency (A&E) attendances had reduced and queried whether the acuity of patients had also improved. TR explained that over winter there was an increase in the number of patients attending with flu. If there is an increase in bed days, then there will be an increase in acuity.

JN sought assurance around how the organisation builds its forward plans to ensure the changes in demand are met. SW advised this will be completed through a piece of work via the Transformation Board which reports to Strategy and Operations committee.

RESOLVED:
The Board of Directors **received** the Operational Update.

TB059/23 Integrated Performance Report

The Deputy Chief Executive presented the Integrated Performance Report, which provided an overview Trust performance during April 2023. The following key points were highlighted:

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- Pressure ulcers figures remained high but it was expected that reductions in pressure ulcer prevalence would be observed in 2023/24 through implementation of focussed interventions and clear expectations.
- The CDiff collaborative, whose intention was to address long-standing issues relating to reduction of C-Diff cases across the Trust, was launched in May 2023 and received good attendance.
- There were no healthcare associated MRSA, MSSA or Pseudomonas aeruginosa bloodstream infection in April.
- There were positive improvements in Friends and Family Test (FFT) following a concerted effort from all divisions.
- The Infant Feeding Team continued to have reduced capacity as team members had been working clinically to maintain safe staffing levels in service. New leadership was introduced to review the current service offer and support Baby Friendly implementation within the service.
- There was a fluctuating trend for the maternity stillbirth rate. A review of perinatal mortality tool process was undertaken to strengthen governance and oversight.

RG congratulated the team for the improvements in FFT. TR advised the changes are improving figures, but they require further embedding as a process to drive further improvements.

In response to a query from JN, TR explained a review had been undertaken with a focus on quality. The response time was the responsibility of the Director of Operations within the Division and there were two divisions who are performing well in meeting this target. FN added it was good to receive feedback from patients and families and to acknowledge where the organisation failed and how lessons can be learnt. It was pleasing to see an improvement in the complaints system, which is beneficial for complainants.

RW highlighted the achievement of the Faster Diagnostic standard in March with a performance of 79.3%. RG advised this was a standard the organisation has been working towards for some time. It is now included in the Operational Plan so will be included on the Integrated Performance report (IPR).

AS commented on the achievement of the Better Payment Practices. AW added plans are in place to ensure the performance is sustained.

RESOLVED:
The Board of Directors **received** the Integrated Performance Report.

TB060/23 Workforce Reports

Staff Survey

The Deputy Chie Executive presented the Workforce report and invited Laura Smoult to deliver the presentation on the Staff Survey Results. LS advised that over 2000 members of staff completed the survey and the Trust scored the best within GM and within the top 20% nationally.

LS provided the Board of Directors with a presentation outlining the response rates for the Trust, what our staff said and what actions will be taken going forward.

In response to a query around offering incentives to improve the response rate, LS commented that there were mixed views around offering incentives but focus should be on staff seeing changes made as a result of their feedback. JM added that there are further steps which could be taken to improve the response rate and these will be taken through People Committee.

FN commented that a 6% decrease in staff recommending the Trust as a place for care is significant and the organisation needs to ensure actions are taken to improve this along with the number of staff who face discrimination at work.

Equality Diversity and Inclusion (EDI) Update

JM presented the report, which provided an update on the approach to EDI within the Trust including key achievements in the previous quarter and the focus areas for the next quarter. JM outlined that the Trust remained committed to ensuring that the workforce was representative of the demographic served adding that there had been an increase in the number of BAME colleagues employed by the Trust over the last three years. There difference in the relative likelihood of BAME staff entering the formal disciplinary process, when compared to white colleagues had been eliminated.

There was an increase in staff recording their disability on the Electronic Staff Record, and a reduction in the percentage of disabled staff saying they felt pressure to come to work. The Trust has also seen an increase in the number of disabled staff feeling their work is valued.

Concern was raised that there has been an increase in the number of staff experiencing discrimination due to their ethnic background and the Trust needs to complete work to reach those from other backgrounds.

An internal audit of EDI was completed which highlighted a number of areas of good practice. The internal audit had four findings, three of which have successfully closed and the remainder is on-track to be closed in July 2023 and relates to EDI training.

MB queried what changes in process had been completed to reduce the number of EDI staff bring taken through the disciplinary process unnecessarily. JM advised a stop and check initiative had been introduced within HR in partnership with the Staff Network chairs.

RG raised concern that a significant amount staff with a disability were unable to access the equipment they required and queried what actions were being undertaken to improve this. JM explained that plans were being developed to centralise the budget for equipment, which would accelerate the approval process. Work is also being completed with Procurement to scope where equipment is sourced from as there have been some issues particularly around the ordering of software due to the cyber and security risks.

In response JN's query on whether the Active Bystander training for staff was mandatory, JM confirmed it was not. It was noted that there was a need to pay attention to these issues as a Board and although actions are required, mandatory training may not be the solution.

Staff Health and Wellbeing Report

JM presented the Health and Wellbeing Report advising that overall the sickness absence position remains good when benchmarked against GM organisations. A plethora of work programmes have been put in place to support our fantastic staff to be healthy and remain in work.

Despite the work in place the Trust acknowledges the added staffing and workload pressures and the impact other challenges are having on colleagues, such as the cost of living crisis and recent industrial action. Following the staff wellness offer review in August 2022, it was recognised not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions.
The Trust is therefore further enhancing its staff health and wellbeing offering at such a critical time and delivering key priority actions set out in the Trust's wellness review action plan.

FN raised that the organisation as a large amount of outside space which can be utilised for staff and patients. SW commented that this is being taken through the Charitable Funds Committee.

Action — **FT/23/05**
Outside space rest facilities such as benches and tables to be discussed at next Charitable funds Committee — **SW**

People Plan

JM presented the People Plan 2023/2026, which had been created following the successful conclusion of the previous Workforce & Organisational Development strategy. The People Plan is structured under four pillars;

- Attracting
- Developing & Leading
- Sustaining & Retaining
- Including

Each pillar has a list of activities we will deliver and key measures of success. The plan will be monitored via People Committee.

The Board of Directors approved the People Plan.

RESOLVED:
The Board of Directors **received** the Workforce Reports and **approved** the People Plan.

TB061/23 People Committee Chair Report

AS presented the People Committee Chair Reports from the meetings held on 18 April and 16 May 2023. Key highlights from the April meeting were the endorsing of the People Plan to be submitted to the Board of Directors for approval and updates were received on agency, sickness and Freedom to Speak Up. The key points from the meeting held in May, included;

- Resourcing Update – noting that future reports will include headcount tracking analysis reporting by staff group.
- A report was received which described the provision and future ambitions to enhance and improve Widening Participation activity such as Work Experience, Employability/Pre-employment Programmes, Careers information, Education advice and guidance, T Levels, Volunteers & Clinical Attachments. A high-level plan will be presented at the July People Committee.
- An update on mandatory and statutory training was received noting the compliance level for mandatory training was 86.2% and statutory training was 92.3%.
- The Guardian of Safe working report was deferred to the June People Committee.

RESOLVED:
The Board of Directors **received** the People Committee Chair's Report.

TB062/23 Strategy and Operations Committee Chair Report

RG presented the Strategy and Operations Committee meetings held on 27 March and 24 April 2023. The following key points from the April meeting were highlighted:

- The committee received the quarterly look back/look forward for Q4 2022-23/Q1 2023-24 against the five organisational priorities of Children & Young People, Data & Digital, Performance & Recovery, Recruitment & Retention and System Transformation.
- The No Criteria to Reside (NCTR) update was received noting the good progress made.

- Operational plan update received noting final submission date of 02 May 2023.
- The 2021-23 Strategy Review was presented. The draft stimulated discussion on the desired approach to be taken to conclude the current strategy and move to a refreshed strategy. The Committee concluded the review is a significant opportunity to celebrate, reflect and acknowledge challenges emerging during the review period. Overall, it was agreed that further work was required to fully reflect successes and acknowledge challenges to ensure that the review was meaningful to the staff and the wider organisation.

RESOLVED:

The Board of Directors **received** the Strategy and Operations Committee Chair's Report.

TB063/23 Nurse and Maternity Staffing Reports

Nurse Staffing Report

The Chief Nurse presented the Nurse Staffing Report outlining the findings of the bi-annual review for the period July to December 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels.

The report provides assurance to the Board of Directors that adult in-patient wards were staffed in line with the national guidance and that where this falls below the standard the relevant mitigations are put in place. The report also detailed a number of next steps and transformation work, which was underway to further develop and enhance Registered Nurse staffing.

Maternity Bi-Annual Staffing Update

The Chief Nurse presented the Maternity Staffing Report outlining the findings of the Bi-annual review for the period July – December 2022. The report highlights:

- There has been a reported increase in acuity (as defined by obstetric, foetal and medical problems).
- As a consequence of increased acuity, the midwife to patient ratio needs increasing leading to a revised establishment and subsequent reported gap against funded establishment of an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles
- A revision of the current skill mix is required to ensure a 90:10 mix is deployed in postnatal clinical areas. Currently 97:3.
- A review of safety indicators with potential to be impacted by staffing illustrate previously reported challenges with; bookings at 12+6 and initiation of breast-feeding. Our compliance is comparable and/or favourable when compared to Greater Manchester and East Cheshire (GMEC)
- Mandatory and statutory staff training compliance during the period July – December 2022 remained below the Trust standard due to ongoing staffing pressures

- A deficit in planned and actual hours worked for registered and non-registered staff was reported during the period July – December 2022 despite the offer of enhanced bank and agency pay to incentivise uptake.

The report details the actions being taken to mitigate the risk within the service and improve training and key staffing related metrics. Further updates will be provided in quarterly Board reports for ongoing oversight and scrutiny. TR added that the report shows a challenged service and work continued with the division to ensure services delivered are safe.

RESOLVED:
The Board of Directors **received** the Nurse and Maternity Staffing Reports.

TB064/23 Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q4 Update

The Director of Midwifery presented the report providing an overview of the safety and quality programmes of work within the maternity and neonatal services and preparations being made in anticipation of the Year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

The Trust has received confirmation that a discretionary payment had been awarded by NHS Resolution (NHSR) in response to submission of the CNST Year 4 declaration in February 2023. Extensive work continued to complete the outstanding actions identified in the Price Waterhouse Cooper action plan prior to the end of May 2023, to strengthen oversight and management of the CNST Year 5 Scheme. To date five of the actions have been completed and 20 actions remain in progress.

A benchmarking exercise to ascertain compliance with the recommendations from the initial Ockenden report and The Morecambe Bay Investigation had been undertaken. The service can evidence full compliance with 31/42 (74%) of the initial Ockenden recommendations and 13/21 (61%) of the recommendations highlighted in the Kirkup report. The service is due to re-assess compliance on the 26 July 2023.

Board members were asked to receive and note the Clinical Negligence Scheme for the Trusts Maternity Incentive Scheme for Q4 update and to approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

NL queried whether any support was required from the ICB in order to ensure the completion of the actions. JC confirmed that support was being received and at present nothing further was required.

RESOLVED:
The Board of Directors **received** the Clinical Negligence for Trusts Maternity Incentive Scheme Q4 Update and approved the sharing of the report within the local maternity

and neonatal system and at the regional surveillance meeting, with subsequent submissions to committees as required.

TB065/23 Quality Assurance Committee Chair Report

MB presented the Quality Assurance Committee Chair Reports from the meetings held on 19 April and 17 May 2023. The following key points from the May meeting were highlighted:

- Integrated Performance Report was received and noted.
- Quality Account Q4 – Rheumatology update was received and noted the main focus has been around implementation of transformation of ideas from the team.
- Health and Safety Committee Chair Report – a fire assurance paper would be presented to the next meeting of the Risk Management Committee. The committee were seeking further assurance around the requirements.

RESOLVED:
The Board of Directors **received** the Quality Assurance Committee Chair Report.

TB066/23 Confirmation of 2023/24 Financial Plan

The Chief Finance Officer presented the 2023/24 Financial Plan which had been submitted to NHS England. The Trust had submitted an expected revenue deficit plan of £12.4m, with a year-end cash balance of £24m. There was a capital plan of £22.2m.

Board members were asked to approve the 2023/24 financial plan and their understanding of the consequences and the actions required to achieve breakeven, agree with the statement as requested by the Integrated Care Board (ICB), and to note the Cost Improvement Tracker had been submitted to GM ICB.

AS queried, whether the pay award would be fully funded. AW confirmed the pay award is a risk which is built into the financial plan. An update will be provided at the Finance and Investment Committee.

Board members approved the 2023 financial plan and agreed with the statement from the ICB.

RESOLVED:
The Board of Directors **approved** the 2023/24 Financial Plan and the statement from the ICB.

TB067/23 Finance and Investment Committee Chair Report

JN presented the Finance and Investment Committee Chair Reports from the meetings held on 22 March and 26 April 2023, and provided a verbal update from the meeting

held on 24 May 2023 highlighting that the month one deficit was £1.7m which is extremely high risk.

RESOLVED:
The Board of Directors **received** the Finance and Investment Committee Chair Report.

TB068/23 Annual Governance Declarations

The Director of Corporate Governance presented the Annual Governance Declaration report, which provides a contextual information and sources of assurance with regards to the Annual Trust Self-Certification against the NHS Provider Licence, Annual Self-Certification. As part of its annual reporting process, the Board is required to self-certify on its compliance with the following conditions of the NHS Provider Licence:

1. General Condition 6 (3): The provider has taken all precautions to comply with the licence, NHS Acts and NHS Constitution.
2. Condition FT4 (8): The provider has complied with all required governance standards and objectives.
3. Continuity of service (CoS7): The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of statement.
4. Section 151(5) of the Health and Social Care Act 2012 Training of Governors: Providers must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this.

In addition, the NHS England Guidance on Good Governance and Collaboration requires the Trust to review its compliance against this guidance during 2022/23.

Board members were asked to approve the self-certification against the conditions provided by the Trust in relation to the NHS Provider Licence Conditions.

RESOLVED:
The Board of Directors **approved** the Annual Governance Declarations.

TB069/23 Audit Committee Chair Report

AS presented the Audit Committee Chair Report from the meeting held on 03 May 2023.

RESOLVED:
The Board of Directors **received** the Audit Committee Chair Report.

TB070/23 Feedback from Board Walkabouts

MB advised he had recently visited Cardiology, which was a fantastic department with friendly and dedicated staff. He had also been to Breast Services and Ophthalmology.

In Ophthalmology he had met a new member of staff who was living and breathing the Trust values.

AS informed the Board he had visited Endoscopy and Bowel Cancer Screening, which was a superb unit with no staffing issues and a rolling programme of replacing equipment. The staff within Bowel Cancer Screening were very proud of their department.

RESOLVED:
The Board of Directors **received** the Feedback from Board Walkabouts.

TB071/23 Constitution

The Director of Corporate Governance presented the Constitution, which had previously been approved by the Board of Directors and Council of Governors. Board members were asked to approve the submission of the Trust Constitution to NHS England and publication on the website.

RESOLVED:
The Board of Directors **approved** the submission of the Trust Constitution to NHS England and publication on the website.

TB072/23 2022/23 Quality Account

The Chief Nurse presented the 2022/23 Quality Account which offered:

- A timeframe for the production and approval of the Quality Account 22/23 document
- A working version of the Quality Account Annual Report 22/23
- Areas outstanding, highlighted in the report
- CEO statement being drafted by Communications Team.
- Quality Account requires an update in relation to seven-day service. This was stepped down during Covid-19 however the Trust will review and progress during 23/24.
- Guardian of Safe Working update is a new requirement for 22/23 Quality Account.

Board members were asked to receive the Quality Account annual report 22/23 production and approval timeline and receive the Draft Quality Account document.

RESOLVED:
The Board of Directors **received** the Quality Account Annual Report 2022/23 and the Draft Quality Account document.

CONCLUDING BUSINESS

TB073/23 Questions to the Board

None.

TB0740/23 Messages from the Board

The following key messages from the Board were agreed:

Workforce reports

Staff and patient story.

TB027/23 Any Other Business

There being no other business, the chair thanked all for attending and brought the meeting to a close 16:15.

The next Board of Directors meeting will be held on Thursday 27 July 2023.

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

March 2022 actions

Code	Date	Context	Action	Who	Due	Comments
FT/23/04	30/03/2023	NED Walkabouts	Capacity and demand modelling for Churchill Unit to be discussed with division	RW/AW	Jul-23	Complete - RW discussed with division
FT/23/05	26/05/2023	Staff Story	MN to contact Lauren Searle, Community Midwife to thank her for her staff stpory and providing an update.	MN	Jul-23	Complete
FT/23/03	30/03/2023	Board Assurance Framework	Risk appetite for ambition five to be discussed at Strategy and Operations Committee.	SK/SW	Sep-23	BAF discussed at SOC with Risk Appetite now at Seek from Mature. Action Completed
FT/23/06	26/05/2023	Staff Health and Wellbeing Report	Outside space rest facilities to be on the next Charitable Funds Committee agenda	SW	Sep-23	

Key

complete	agenda item	due	overdue	not due

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	Thursday 27 July 2023		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Purpose	To update the Board on key internal and external activity that has taken place since the last public Board meeting, in line with the Trust's strategic ambitions.

Summary:	This Chief Executive's report provides an update on key activity that has taken place since the last public Board meeting held in May 2023 including any internal developments and external relations.

Previously considered by:
N/A

Proposed Resolution	The Board is asked to note the update.

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

Prepared by:	Fiona Noden, Chief Executive	**Presented by:**	Fiona Noden, Chief Executive

We are awaiting two reports from the Care Quality Commission following the inspection of our children and young people's services in May, and the well-led inspection undertaken in June. We welcome the findings and the opportunity to learn and understand further the things we are doing well, and where we need to improve.

Three of our nursing teams have been recognised in the shortlist for the national Nursing Times Awards for their commitment to delivering excellent patient care. Our Intravenous (IV) Nursing at Home Team, the Enhanced Care and Support Team, and Theatres' nursing one-stop surgical clinic have been shortlisted in the nursing in the community, patient safety improvement, and theatre and surgical nursing categories. The winners will be announced at the awards ceremony taking place on 25th October in London.

Our Lead Admiral Nurse and Digital Team have implemented a dementia icon as part of our Electronic Patient Record (EPR) system to improve the care we provide for people living with dementia. The icon will mean that our staff can permanently record a patient's diagnosis and see at a glance if a patient has any cognitive issues that may require additional support.

We have been recognised by NIHR Clinical Research Network Greater Manchester for our recent contribution to research in the region. Embedding a research active culture enables patients to have access to wider treatment options and supports the improvement of patient care for the future. The commitment and dedication of our teams has enabled the recruitment of 2,037 local people across a range of research studies spanning many specialties. This makes the Trust the sixth highest recruiting Trust in the Greater Manchester region for all studies, as well as being the 2nd highest recruiting Trust for Hepatology studies within our region.

Our neonatal unit has been awarded the highest level of FiCare (Family Integrated Care) status for the support they provide to families. FiCare is a model that supports and educates parents and carers to become an integral part of their baby's care in partnership with the neonatal team, from the moment their baby is admitted to the neonatal unit. The award reviewed staff education and support, parent education, the NICU environment, and psychological support provided within the service.

Our local communities continue to benefit from the provision of virtual wards, as part of the Hospital at Home programme. One of the first patients to benefit from this in Bolton shared his experience with us after experiencing heart issues earlier in the year, which needed monitoring but not treatment. He was able to recover at home due to new monitoring equipment allowing our clinicians to assess his condition virtually.

We have started a pilot using new technology to support staff who administer patients with blood products such as blood transfusions and platelets. BloodTrack TX, a transfusion software that uses barcodes to ensure the correct blood product is selected from the transfusion fridge and is then safely received by the patient. The devices record details about the transfusions, important information about the patient, reactions to the transfusion and the identity of staff.

This month a new policy and process came to fruition, to ensure the safeguarding of patient's property whilst they are in our care. This was initiated as a result of the work we

did to learn from loved ones during and after the pandemic. To date, several items and valuables have already been returned to owners or family members which has resulted in some heart-warming feedback for the teams responsible.

Ambition 2
To be a great place to work

Our Eye Unit is one of only three in the country to have gained 100% satisfaction in a General Medical Council (GMC) survey of trainees. Our trainees regularly request to return once qualified and results show they experience a supportive environment with good supervision whilst they train with us.

In June we were the first NHS trust to host our own Proud2bOps conference for operational colleagues. Proud2bOps is a national network which aims to energise, connect and develop operational managers and leaders across health and care. Around 50 members of our organisation joined the conference, hearing from a number of guest speakers on a range of topics about supporting, nurturing and developing our operational staff.

This month we celebrated NHS75, a day to reflect on everything the NHS has achieved in the past 75 years, and our plans for the future. In Bolton, we welcomed staff past, present and hopefully future, to a celebration event at the hospital, and staff marked the occasion across the town at our community sites.

We worked with local, regional and national media to put a spotlight on a small handful of our team, some of whom have worked here for up to 50 years. The culmination of this was a special programme across two nights on Channel 5.

Our charity partner, Our Bolton NHS Charity funded and organised a number of special events to mark the occasion, some of which will take place later this year. They have launched a staff innovation challenge, funded refreshments for our patients and staff as part of an NHS75 Tea party, and funded travel costs for a small group of staff to attend a special event at Westminster.

Last week, a special performance at the Adelphi Theatre in Salford, captured the experiences of our frontline staff working during the pandemic as the world changed. 'Healing Tales' was composed as part of the NHS75 celebrations, with all profits going to Our Bolton NHS Charity.

The Trust has been reaccredited as Veteran Aware and received a Silver Award for the Employer Recognition Scheme, one of 147 NHS accredited providers across England. We are now working to ensure that veterans are identified within the electronic patient record and provided with a veteran patient information leaflet, which signposts to local and national support organisations. We will also continue to ensure that all relevant staff are trained and educated in veterans' needs.

Industrial Action has continued to take place. Most recently, junior doctors took part between 7am on 13th July and 7am 18th July, shortly followed by a 48 hour walk out by consultants, from 7am 20th July to 7am 22nd July. Our strategic command has reconvened in order to adopt our contingency plans so that we are prepared and ready to support our patients and staff as best we can during this time.

As a result of the industrial action, some routine appointments and procedures have been postponed to help us focus on keeping our sickest patients safe. All patients affected have been directly contacted and we have continued to remind the public that our urgent and emergency services are here to help those who need it.

Ambition 3
To use our resources wisely

A digital solution designed to help manage our elective waiting lists and improve theatre utilisation has now been implemented in four areas. As one of the more advanced trusts utilising the Foundry CCS (care co-ordination solution) due to us trailing the system since January 2022, our teams have been on hand during question and answer sessions to support other trusts to learn from our experiences.

NHS Greater Manchester has set up a Finance and Performance Recovery sub-committee with NHS provider partners to address the financial challenges we are facing as a region. There is strong clinical and care professional leadership running through the programme to ensure that we save money without compromising on either quality or performance.

A Greater Manchester system wide Recovery Plan is in place which focuses on short term reduction schemes, action plans to improve challenged performance areas and starting a series of improvement projects that are expected to show impact during the current and 2024-25 financial years.

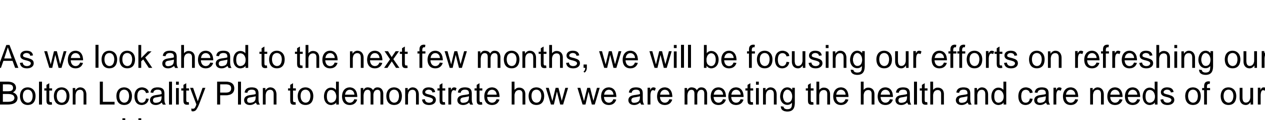
Ambition 4
To develop an estate that is fit for the future

Staff from the trust and iFM held our first Sustainability Week, which was a great opportunity to reflect on our Green Plan, what we've achieved, and where we are going. Throughout the week, the teams shared lots of useful resources and quick hints and tips on how everyone can support the Trust in becoming a more sustainable organisation.

From reducing the carbon footprint, to the pollution levels and the effect of climate change, we can all make a small change which will have a positive impact for the future.
Some of the initiatives include reducing waste by using less plastic gloves, a travel survey to understand where we need to improve our travel facilities, and a focus on recycling.

Our annual service review day was an opportunity to reflect on our current challenges and opportunities across the organisation. Highlights included being recognised as the best performing dermatology service in GM, our nurse-led IV access team growing their service by 400%, the expansion of our theatres, our maternity improvement journey and our work reducing those patients identified as no criteria to reside. We are the most improved trust in the North West for ambulance handovers, which is a huge improvement.

Across the organisation we know we have key areas of challenge that are having an impact on us operationally, these areas continue as our focus to be measured through our integrated performance report. What is clear though is that everyone is working really closely together to deliver our services and provide high quality care against a challenging back drop.



Ambition 5
To integrate care

As we look ahead to the next few months, we will be focusing our efforts on refreshing our Bolton Locality Plan to demonstrate how we are meeting the health and care needs of our communities.

This will include ensuring the plan reflects both the needs of people across Greater Manchester and what is happening more locally in Bolton by addressing some of the gaps that currently exist and concentrating on what really matters to our residents.

We have continued to work with staff across the Bolton locality to progress moving our delivery of services from nine neighbourhoods to six. This change is intended to make it easier for teams to work together across organisational boundaries, support people at home and improve outcomes for the people and families we support.

Working in a different way across six neighbourhoods presents an exciting opportunity for us make changes to the way we work together, for the better and we will continue to work with staff to shape how this will happen.

Ambition 6
To develop partnerships

The Trust is currently in the process of electing nine members of the public and three members of staff to join the Council of Governors, each with a term length of three years. The new Governors will help shape services for communities across Bolton and to play a role in decisions making throughout their term.

Our Bolton NHS Charity has been awarded a £30k grant from NHS Charities Together, which will be used exclusively to invest in the development of the charity. The programme of work will centre around three core themes: fundraising, influencing and operations, and will support our ambition to become the charity of choice for the people of Bolton. The grant will be used to support staff training and development; enhance our in-memory giving offer; develop a Charity Champions programme for Bolton NHS Foundation Trust employees, and fund the annual membership of a business network.

We are appealing for the public to recognise members of the Bolton team who have made a difference to them as part of this year's annual FABB Awards. The People's Choice Award is now open for entries and will highlight individuals and teams who have demonstrated caring, compassionate, innovative and dedicated to delivering high quality care.

Following a regional nomination process, our senior perinatal leadership team has been selected to participate in the fourth intake of the national Perinatal Culture and Leadership Programme. The nationally-funded programme has been developed in direct response to feedback from colleagues across the country and will help craft the conditions for a positive culture of openness, safety and continuous improvement.

All services participating will be encouraged to undertake a culture survey and facilitate cultural conversations with their teams, as part of the programme. The programme also

supports the resultant actions relating to the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals.

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	27/07/2023		Discussion	X
Exec Sponsor	James Mawrey		Decision	

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

Previously considered by:	Divisional IPMs

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

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

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

Bolton NHS Foundation Trust

Integrated Performance Report

June 2023

Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC. There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. There are other resources on the NHS Improvement page that you may find useful **http://www.improvement.nhs.uk/resources/making-data-count**

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

Whilst the SPC charts in this report display data from the last four financial years, the SPC rules and control limits are calculated using data from as far back as 5 years where available. The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.

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

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

7 or more consecutive points above or below the mean.

Common cause variation only.

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

Upper/ Lower Control Limits   Mean   Actual   Target

Executive Summary

Trust Objective	Variation: Common cause	Variation: Improvement (High)	Variation: Improvement (Low)	Variation: Concern (High)	Variation: Concern (Low)	Assurance: Pass (P)	Assurance: Fail (F)	Assurance: ?
Quality and Safety								
Harm Free Care	14	2	2	2	0	1	3	14
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	6	1	0	0	0	0	0	3
Patient Experience	11	5	0	0	0	2	0	14
Maternity	8	0	0	1	0	1	0	8
Operational Performance								
Urgent Care	5	1	1	2	1	1	3	5
Elective Care	3	1	1	2	1	1	2	4
Cancer	6	0	0	0	1	0	1	6
Community Care	2	0	0	1	1	0	1	3
Workforce								
Sickness, Vacancy and Turnover	2	0	1	1	0	0	1	2
Organisational Development	4	1	0	0	1	1	2	3
Agency	2	0	0	1	0	0	0	3
Finance								
Finance	3	0	0	0	0	0	0	3
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety

Harm Free Care

Pressure Ulcers
Hospital
27 pressure ulcers were reported in the month of June 2023, 21 were categorised as category 2, demonstrating special cause variation with cause for concern and six were categorised as unstageable pressure ulcers. In AACD category 2 pressure ulcers have increased from six in May to 13 in June and in ASSD we have seen category 2 pressure ulcers increase from three in May to eight in June.

A thematic review of the increased number of category 2 pressure ulcers has identified gaps and inconsistencies in SKIN Bundle completion and inaccuracies in body map completion. There continues to be a continuing reduction in category 3 pressure ulcers and unstageable ulcers, and the increase in category 2 ulcers, could be evidence of earlier detection and intervention. This requires further review and monitoring in order to confirm and will be monitored as part of the pressure ulcer collaborative. The Deputy Chief Nurse has also reviewed this increase and compared staffing and acuity data from the same time period and there is no correlation between the two.

The Chief Nurse met with all Senior Nurses on Monday 26th June and articulated his concerns with regards to the increasing number of pressure ulcers and reinforced the requirement for Matron and Ward Manger oversight of vulnerable patients and the fundamentals of nursing care. This continues to be raised at every Chief Nurse meeting reinforcing accountability and evidence of care and service delivery concerns. There has now been 5 months with zero category 3 recorded. Whilst no cause and effect can be reliably confirmed, the ongoing increased focus for early detection would support the ongoing increase in category 2 prevalence, resulting in reliable interventions to mitigate risk and prevent deterioration to category 3 and 4. The situation remains fragile and concerted leadership focus remains critical, in parallel to the review of systems and processes as part of the Pressure ulcer collaborative which will ultimately result in improved reliability and effectiveness of interventions.

Community
13 Pressure Ulcers were reported in the month of June 2023, five were categorised as category 2, demonstrating common cause variation. Seven were categorised as unstageable Pressure ulcers. One category 4 pressure ulcer acquired within the family care division demonstrating common cause variation. This is acknowledged as community acquired however, it straddles an inpatient stay.

Areas of focus
A new process for category 3, 4 and unstageable pressure ulcers was introduced on 19th June 2023 requiring a rapid review SBAR within 24 hours of verification of tissue damage. The new process aligns our management of pressure ulcers with the trusts SI process and ensures Chief Nurse oversight of all PSAIs. Consequently, serous incident scoping panels have identified five incidents that have met the criteria of a serious incident in the month of June.
On 19th June, the first of the new Patient Safety Incident Review Panels commenced with a combination of onsite (trust and Community) and virtual panels to share learning and ensure consistency of standards.

Pressure Ulcer Collaborative
The system wide Quality improvement collaborative continues with weekly focused visits by the QI Team. The collaborative is scheduled to conclude in July 2024. It is expected that reductions in pressure ulcer prevalence will be observed 23/24, and specifically Q2 onwards following the collaborative timeline and previous experience with improvement methodology outcomes. A review of the weekly Faculty meeting is currently being undertaken.
Additionally, the Divisional nurse directors continue to implement focussed interventions with clear expectations on objectives.

Falls
Our performance is currently at 4.43 falls per 1000 bed days. We continue to remain under our local target, which is 5.3 falls per 1000 bed days. Falls continue to demonstrate

common cause variation.
We have had one fall with harm in June, which fell, below our monthly target of 1.6.

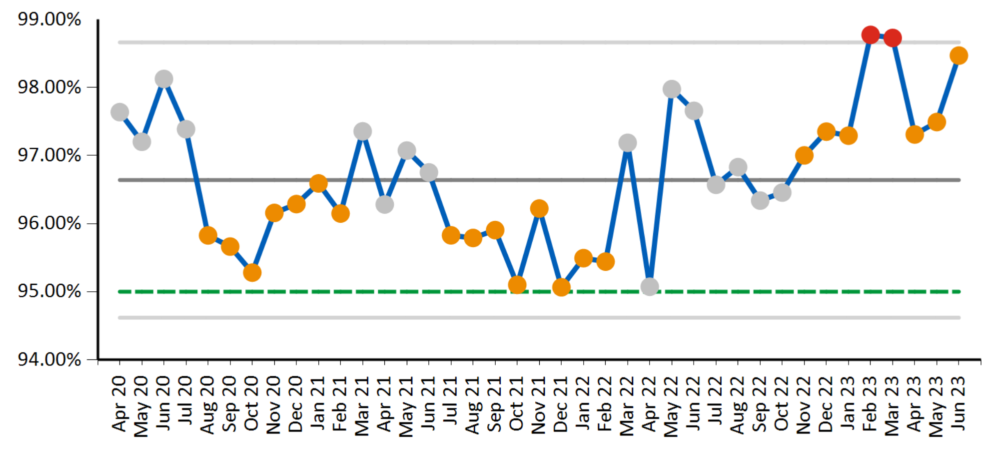
Report to patient/family within 60 working days of incident declaration
In June 2023 there were four SI investigation reports due for approval. Three were approved by the 60-day deadline. The fourth SI due in June has not yet been approved but has been finalised and is scheduled for the next Exec Sign off panel in July 2023.
There are currently ten SI investigations ongoing with one being overdue and the remaining nine are on track to be completed and approved within the 60-day timeframe. Five of the SI's are related to cat 3 and above pressure ulcers.
There is no special cause variation noted however control limits ranged between 0 -100% and as such does not provide assurance in this respect.
Past performance has been variable. Process and practices have been strengthened to support improvement in this area.

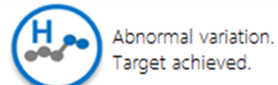
Same sex accommodation breaches
Same sex accommodation breaches continues to be above trajectory with an astronomical point in month. These breaches occur within the critical care unit and are reflective of the constraints on the inpatient bed capacity. This was discussed at clinical governance and quality committee in July and further information and analysis has been requested by the Chief Nurse.

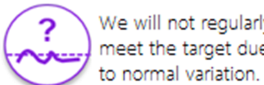
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	98.5%	Jun-23		>= 95%	97.5%	May-23	>= 95%	97.8%	
9 - Never Events	= 0	0	Jun-23		= 0	0	May-23	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.43	Jun-23		<= 5.30	4.35	May-23	<= 5.30	4.17	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Jun-23		<= 1.6	1	May-23	<= 4.8	3	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	21.0	Jun-23		<= 6.0	9.0	May-23	<= 18.0	45.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Jun-23		<= 0.5	0.0	May-23	<= 1.5	0.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Jun-23		= 0.0	2.0	May-23	= 0.0	2.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		6	Jun-23			4	May-23		18	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	5.0	Jun-23		<= 7.0	15.0	May-23	<= 21.0	28.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Jun-23		<= 4.0	1.0	May-23	<= 12.0	1.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Jun-23		<= 1.0	0.0	May-23	<= 3.0	2.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
516 - Community patients acquiring pressure damage (unstagable)		7	Jun-23			4	May-23		15	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Jun-23			0	May-23		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Jun-23			0	May-23		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Jun-23			0	May-23		0	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	93.4%	Q4 2022/23		>= 90%	95.0%	Q3 2022/23	>= 90%		?
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2022/23		>= 90%	100.0%	Q3 2022/23	>= 90%		?
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	32.0%	Q4 2022/23		>= 90%	24.0%	Q3 2022/23	>= 90%		
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2022/23		>= 90%	100.0%	Q3 2022/23	>= 90%		
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	73.5%	Jun-23		>= 95%	73.0%	May-23	>= 95%	74.3%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	84.1%	Jun-23	H	>= 95.0%	73.4%	May-23	>= 95.0%	79.4%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Jun-23		= 100%	100.0%	May-23	= 100%	100.0%	?
88 - Nursing KPI Audits	>= 85%	94.6%	Jun-23		>= 85%	94.6%	May-23	>= 85%	94.7%	P
91 - SI Reports Signed off within 60 days	= 100%	75.0%	Jun-23		= 100%	50.0%	May-23	= 100%	75.0%	?
8 - Same sex accommodation breaches	= 0	24	Jun-23	H	= 0	19	May-23	= 0	62	F

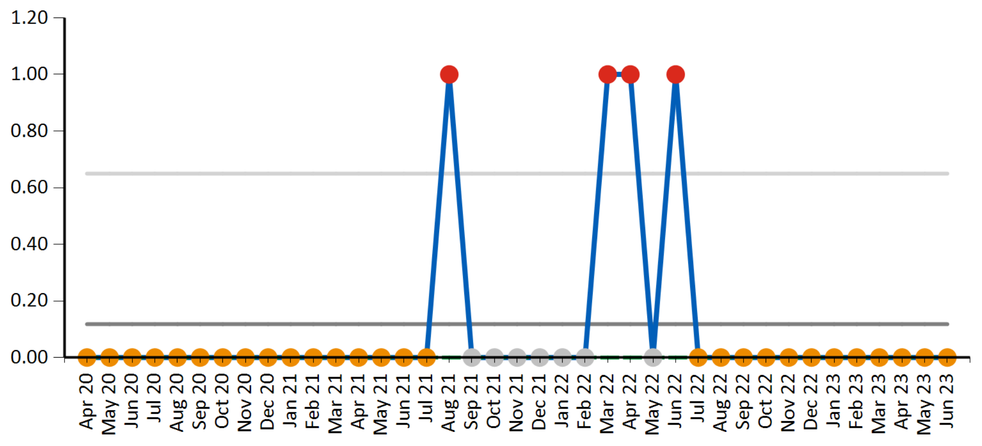
6 - Compliance with preventative measure for VTE

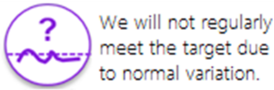




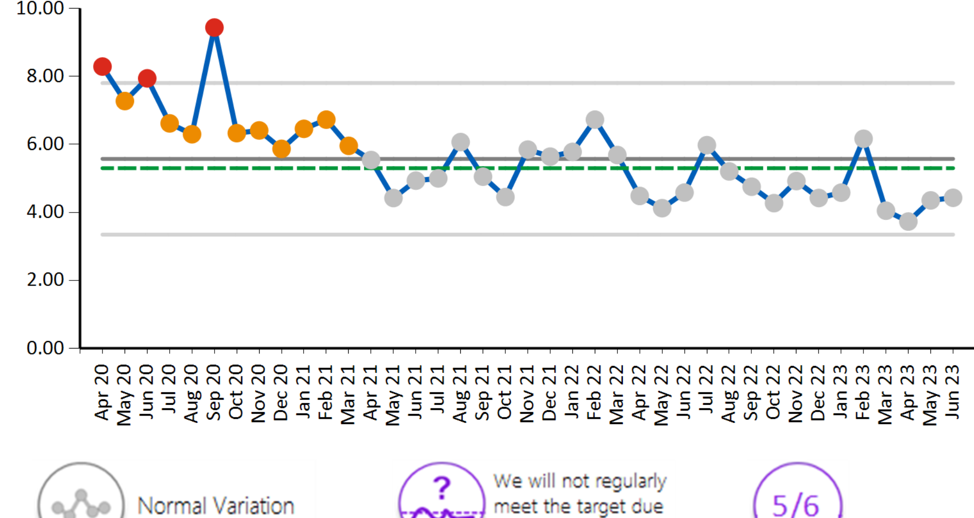


9 - Never Events

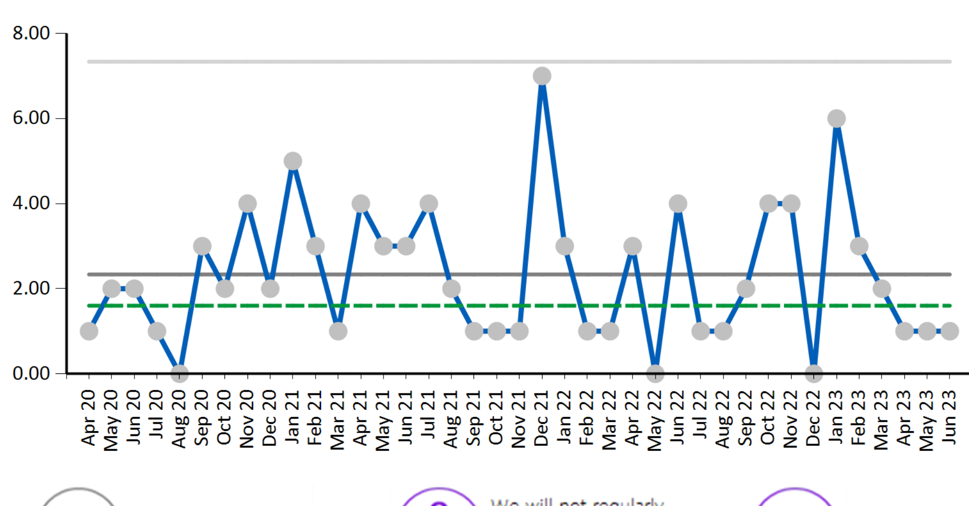


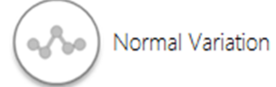


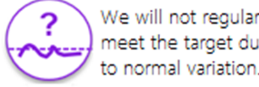
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



14 - Inpatient falls resulting in Harm (Moderate +)







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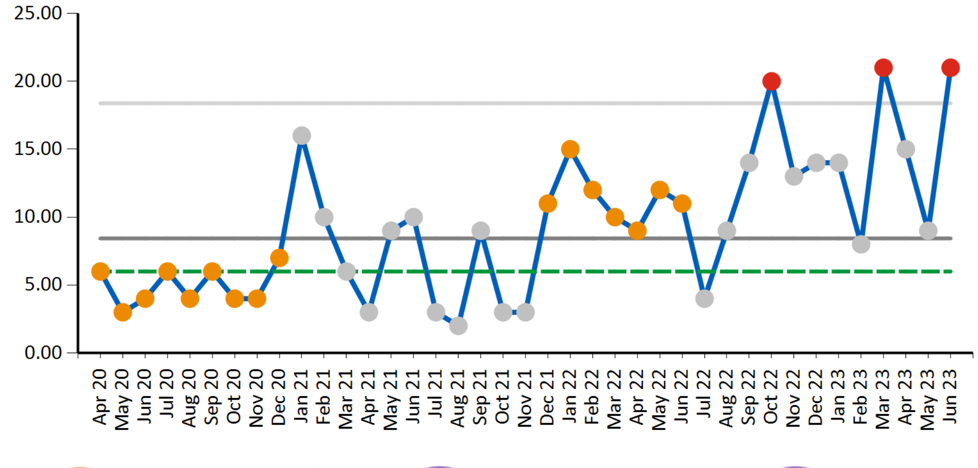
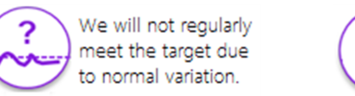
15 - Acute Inpatients acquiring pressure damage (category 2)



Abnormal variation. Target not achieved.



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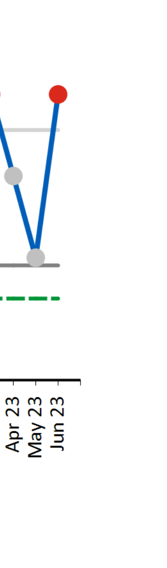
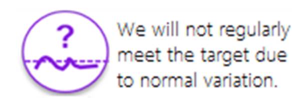


16 - Acute Inpatients acquiring pressure damage (category 3)

Normal Variation



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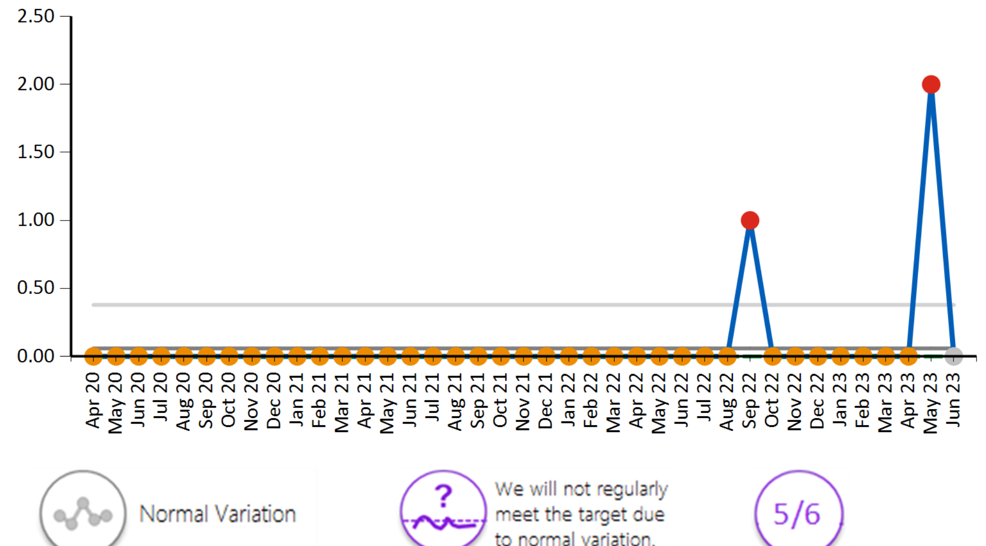
17 - Acute Inpatients acquiring pressure damage (category 4)



Normal Variation

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

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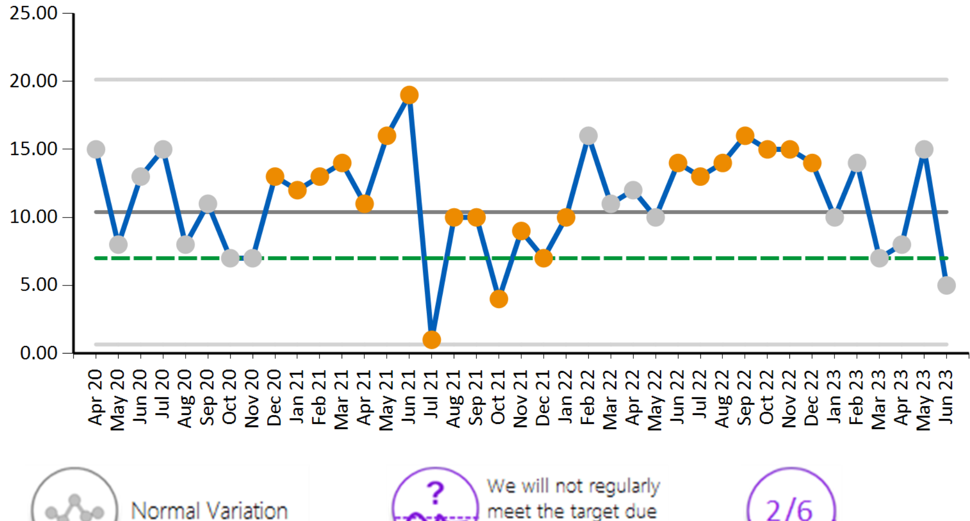
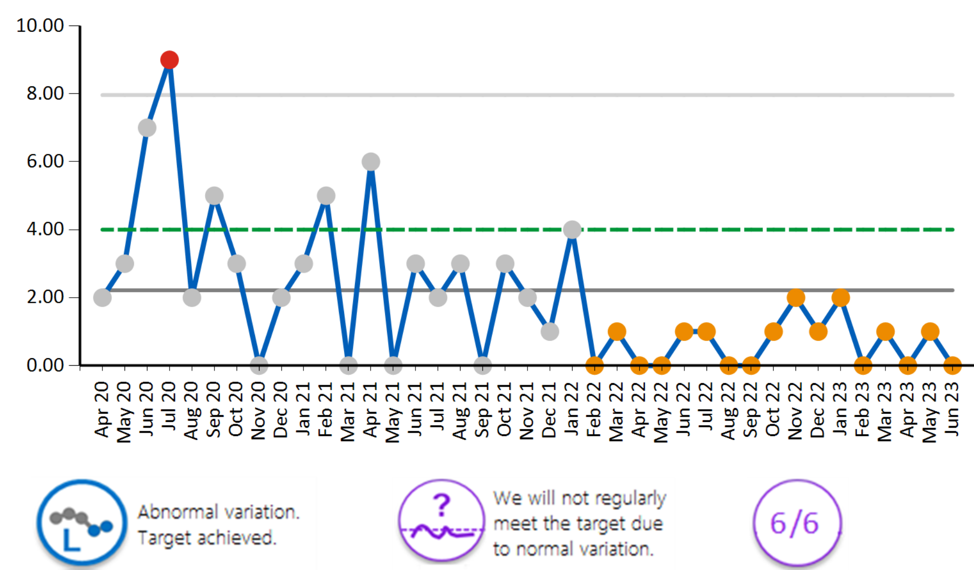
515 - Acute Inpatients acquiring pressure damage (unstagable)

Normal Variation

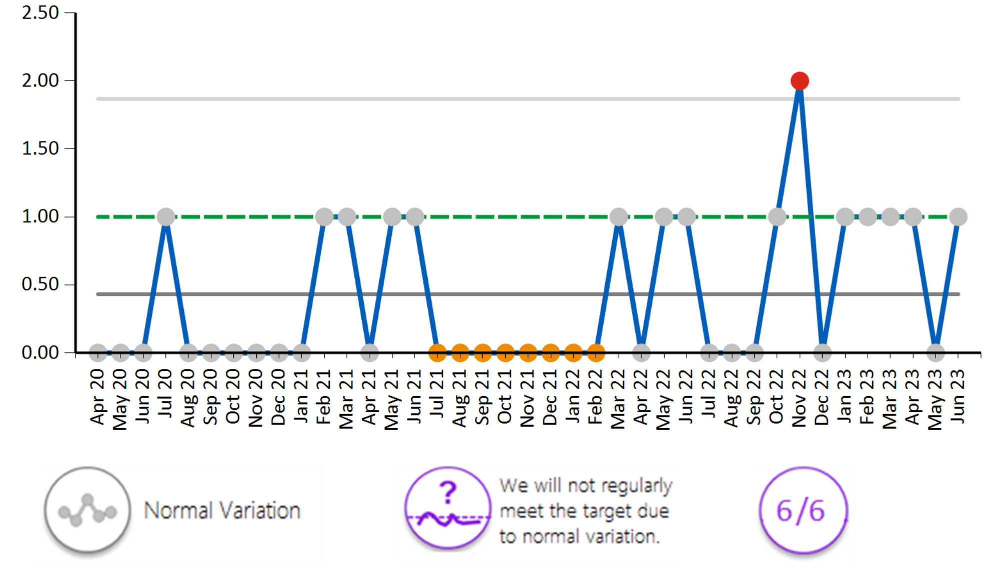
18 - Community patients acquiring pressure damage (category 2)



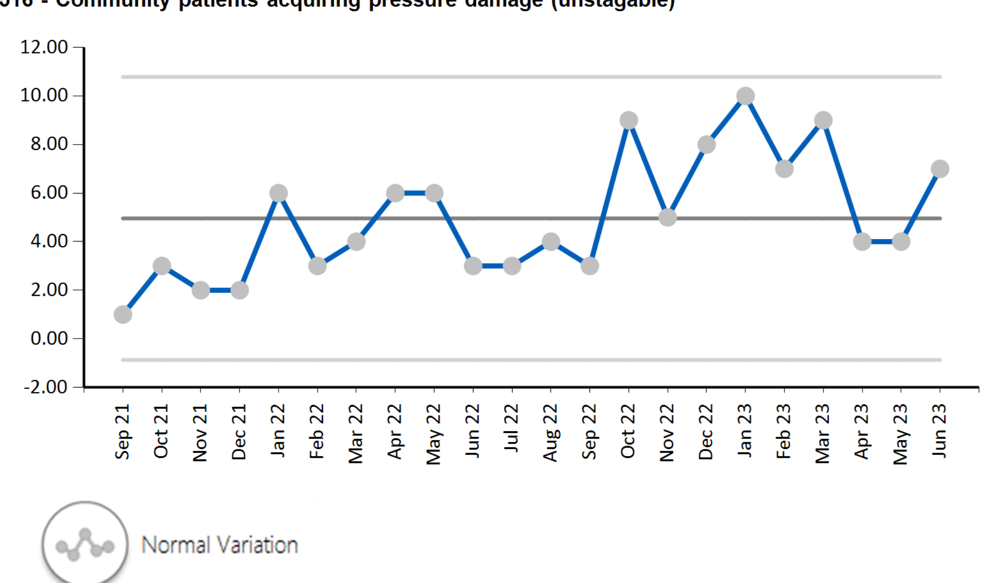
19 - Community patients acquiring pressure damage (category 3)



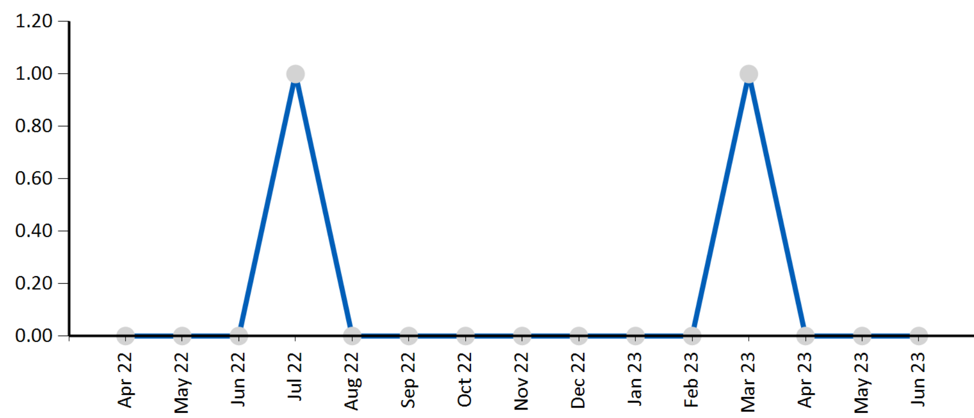
20 - Community patients acquiring pressure damage (category 4)



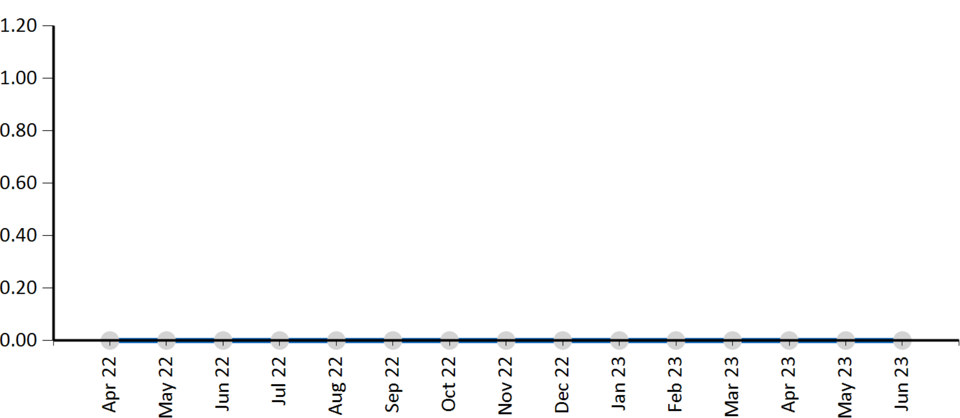
516 - Community patients acquiring pressure damage (unstagable)



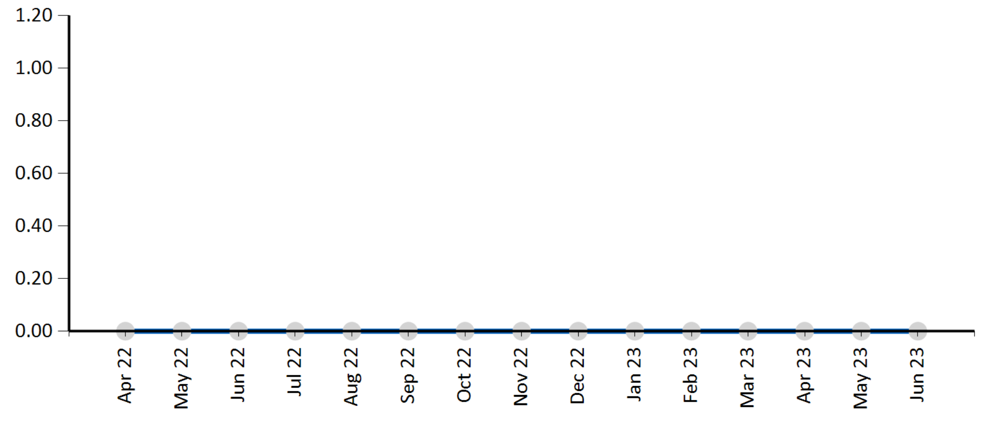
535 - Community patients acquiring pressure damage - significant learning category 2 - SPC data available after 20 data points



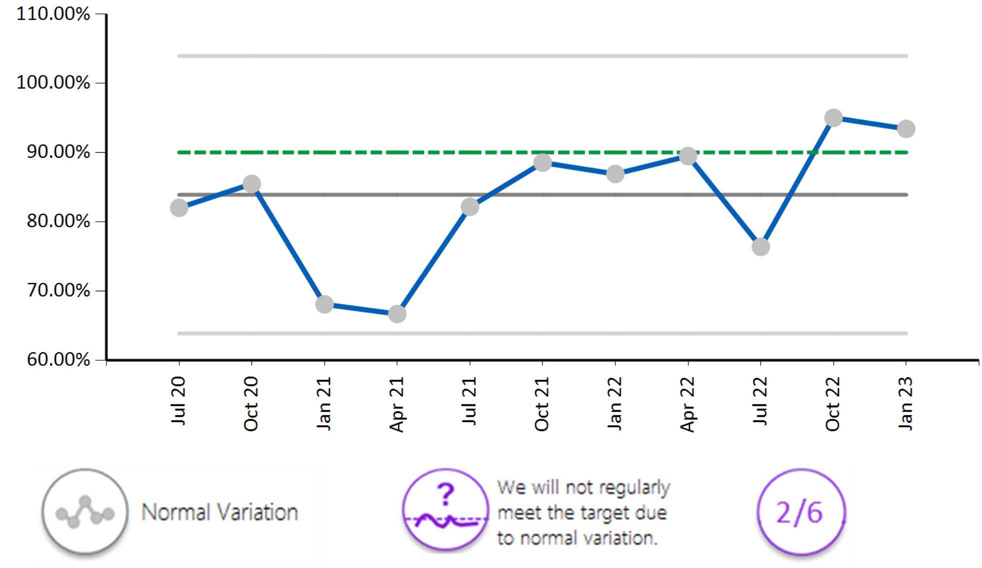
536 - Community patients acquiring pressure damage - significant learning category 3 - SPC data available after 20 data points



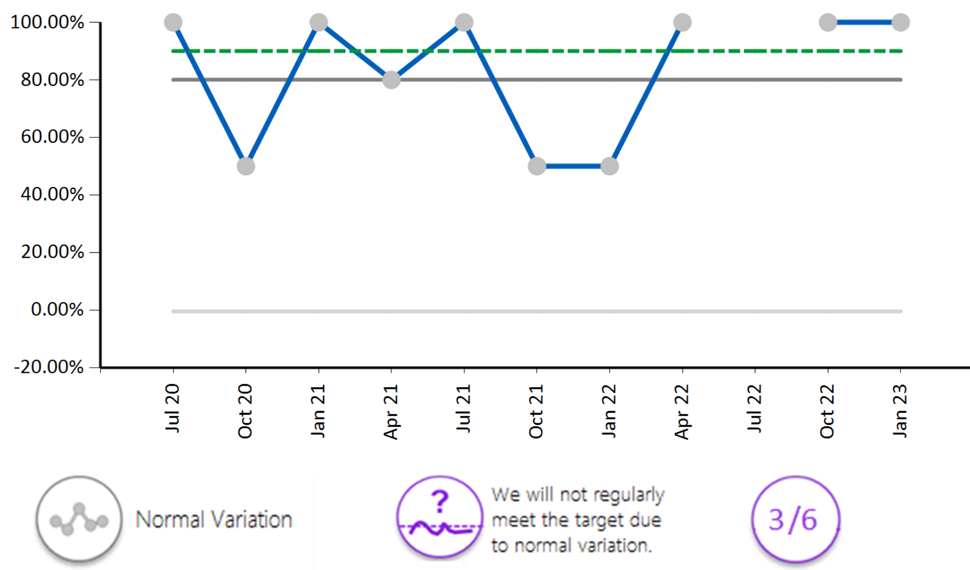
537 - Community patients acquiring pressure damage - significant learning category 4 - SPC data available after 20 data points



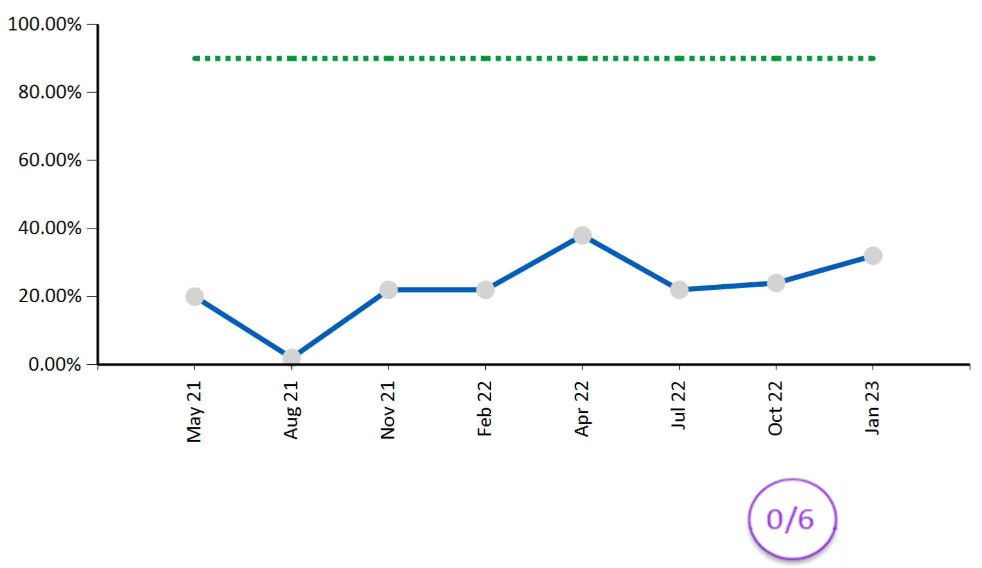
28 - Emergency patients - screened for Sepsis (quarterly)



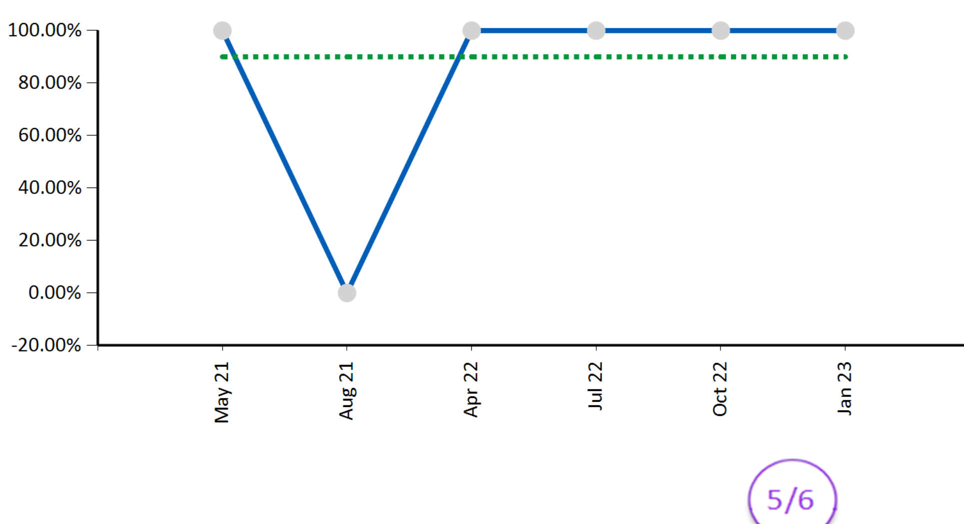
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)



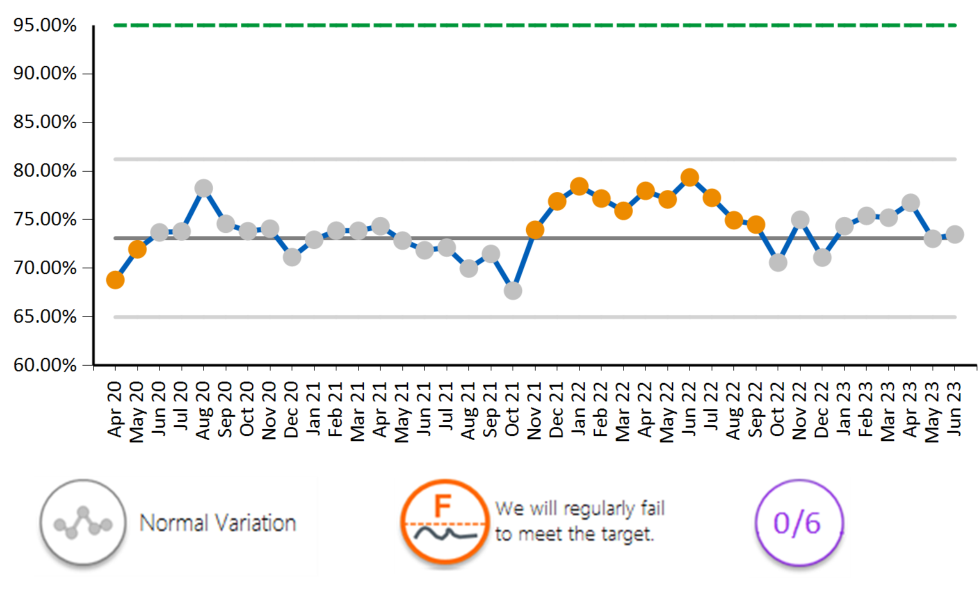
513 - Inpatients - screened for Sepsis (quarterly) - SPC data available after 20 data points



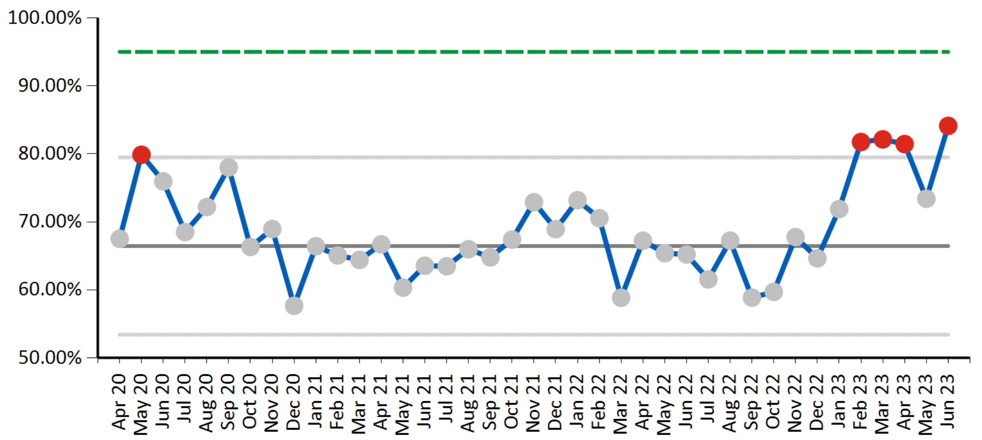
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points

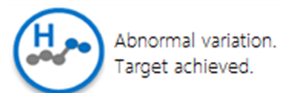


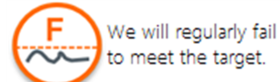
30 - Clinical Correspondence - Inpatients %<1 working day



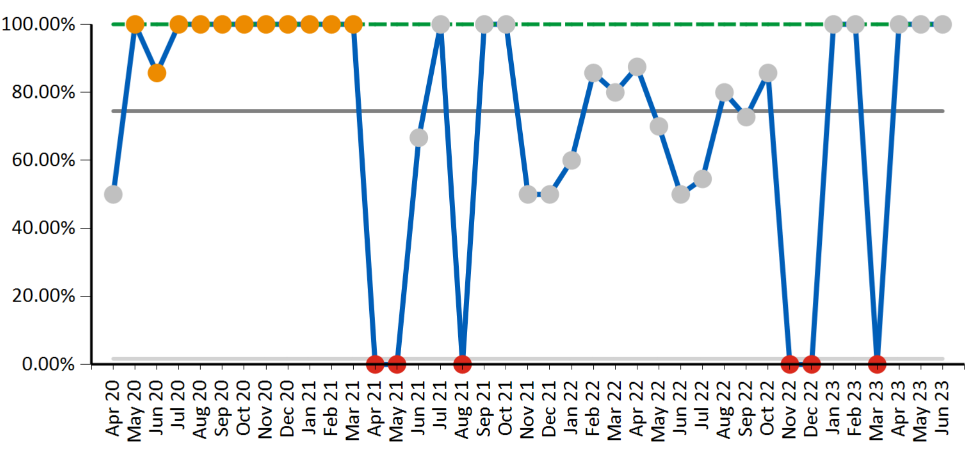
31 - Clinical Correspondence - Outpatients %<5 working days

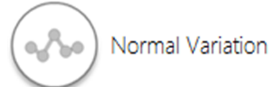


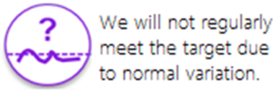




86 - Patient Safety Alerts - Trust position







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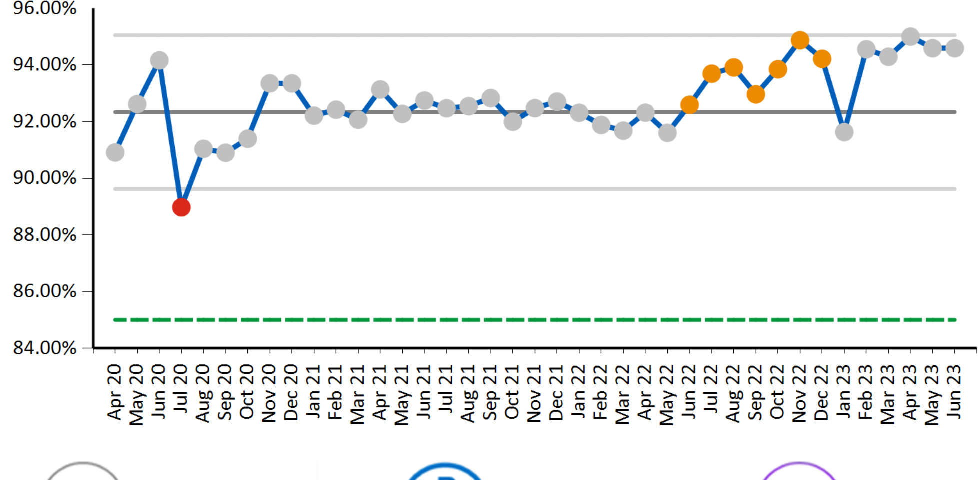
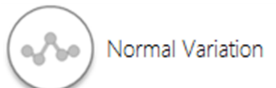
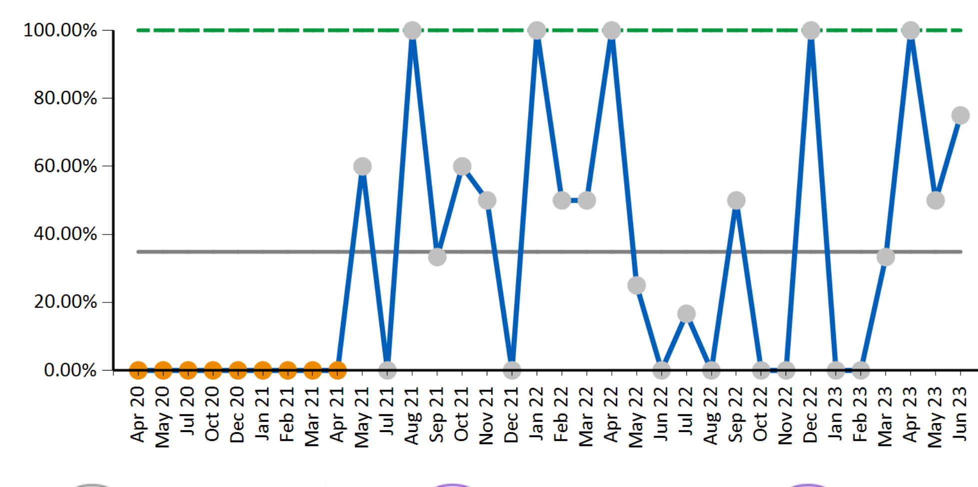
88 - Nursing KPI Audits

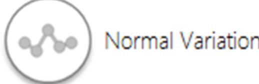


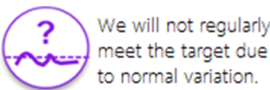


Target will be
regularly met.

91 - SI Reports Signed off within 60 days







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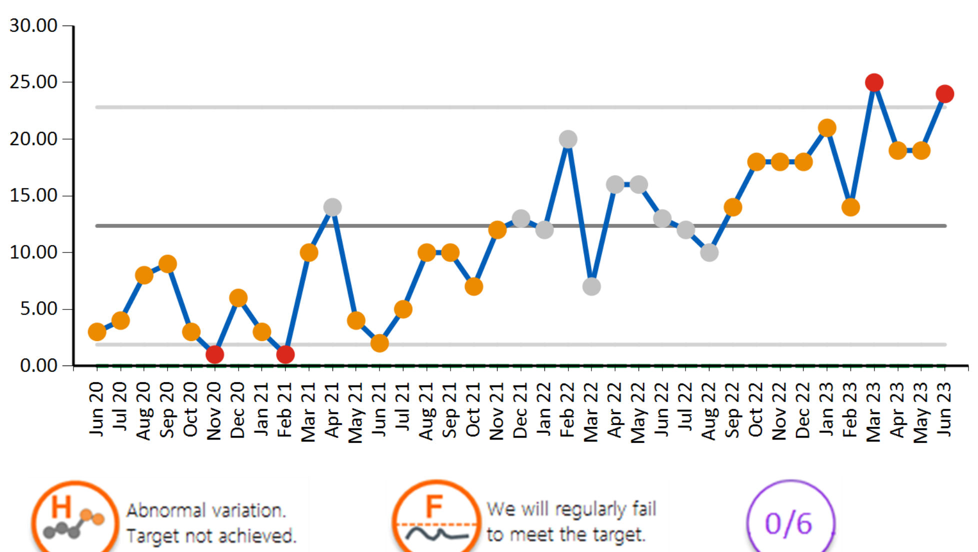
8 - Same sex accommodation breaches



Infection Prevention and Control

In relation to Clostridium difficile, the Trust continues to be challenged on this measure. There are three consecutive months of reduced cases but this is not statistically relevant and the performance remains in normal cause variation. The Trust (by rate) is the fourth of seven providers in GM and for the second time in the past 18 months this rate is below the GM average (in part due to a reduction in cases at Bolton and also due to the average rate in GM increasing).

Departments involved in the QI collaborative are now implementing their tests of change which is being supported by the QI team. The IPC team continue to promote best practice and have supported July as a hand hygiene awareness month which will also include personal protective equipment and will follow this with a focus on the environment in August supported by comms and iFM. There are no new learning points from the case reviews – awareness of patients being identified with symptoms has improved based on audits by the IPC team but there is still no improvement in the timeliness of isolation. A trustwide audit of the number of single rooms has been undertaken and over the next month a trustwide group shared between operations and IPC will be looking at the best solution to enhance the provision of single rooms to improve isolation.

The carbapenamase resistant Acinetobacter baumanii (CRAB) outbreak that has affected B4 ward has now been declared over by the Trust in conjunction with support from the specialist team at UKHSA. The outbreak closed following four weeks of no new cases identified from weekly screening.

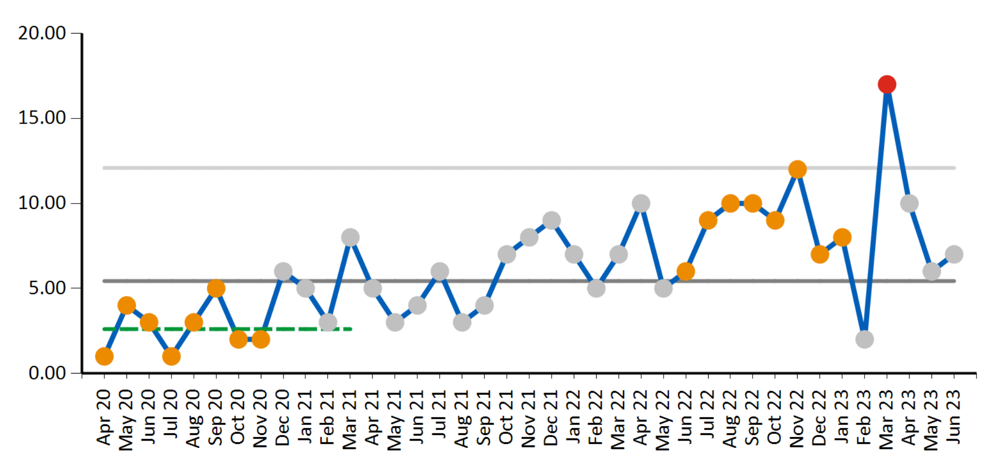
By rate for the first quarter of the year, the Trust is the best performing provider for:
• Healthcare associated E. coli bacteraemia
• Healthcare associated Pseudomonas aeruginosa bacteraemia (albeit there are low numbers of these infections)
• Hospital onset MSSA bacteraemia

For bacteraemia caused by Klebsiella spp. Bolton is the second best performer of the seven GM providers. For MRSA bacteraemia Bolton is seventh out of the seven providers but this (like the Pseudomonas aeruginosa measure) is difficult to assess given that this is based on one case at Bolton in the year. There are four trusts with no cases and two other trusts with cases but their rates are lower as they are measured as cases per 100,000 occupied bed days and they are larger organisations.

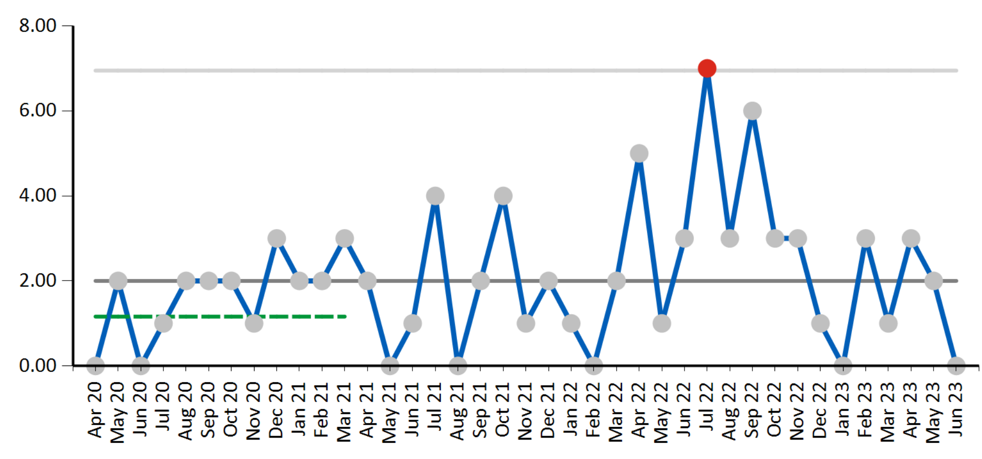
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		7	Jun-23			6	May-23		23	
346 - Total Community Onset Hospital Associated C.diff infections		0	Jun-23			2	May-23		5	
347 - Total C.diff infections contributing to objective	<= 7	7	Jun-23		<= 7	8	May-23	<= 20	28	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Jun-23		= 0	1	May-23	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	4	Jun-23		<= 4	4	May-23	<= 12	13	
219 - Blood Culture Contaminants (rate)	<= 3%	2.8%	Jun-23		<= 3%	3.3%	May-23	<= 3%	2.9%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Jun-23		<= 1.0	2.0	May-23	<= 3.0	3.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Jun-23		<= 1	0	May-23	<= 2	4	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Jun-23		= 0	0	May-23	= 0	0	
491 - Nosocomial COVID-19 cases		10	Jun-23			28	May-23		69	

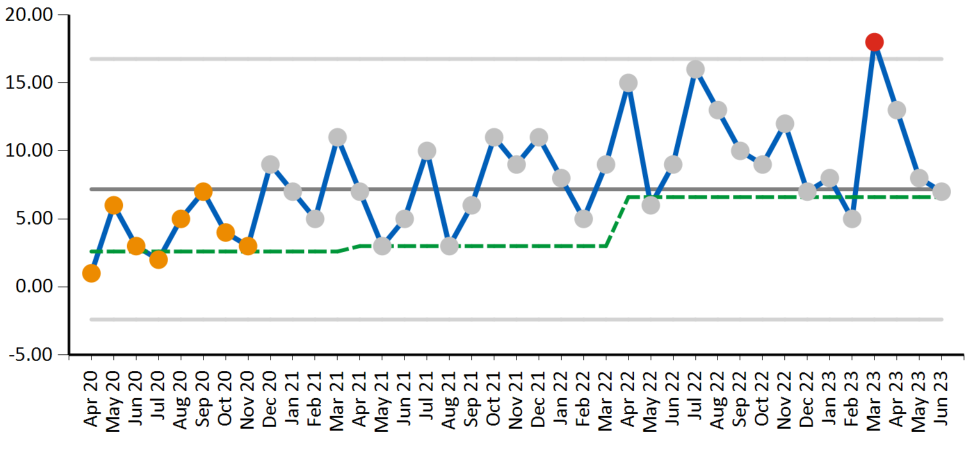
215 - Total Hospital Onset C.diff infections



346 - Total Community Onset Hospital Associated C.diff infections



347 - Total C.diff infections contributing to objective



Normal Variation

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

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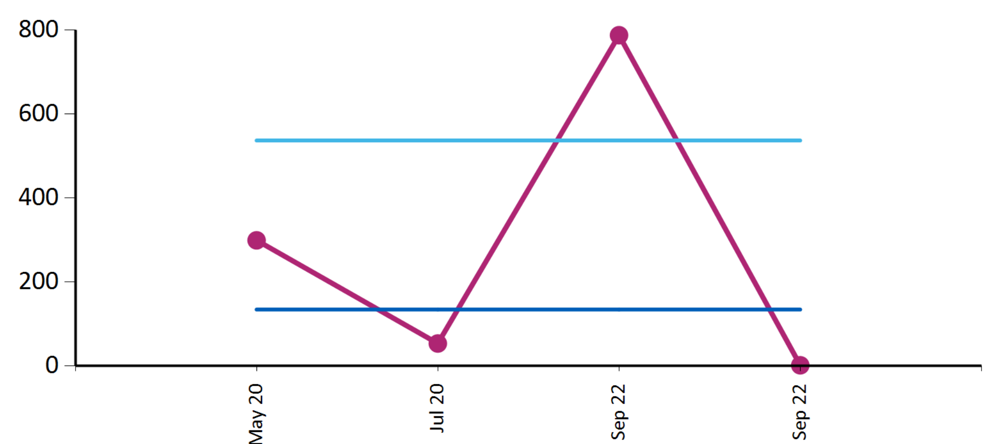
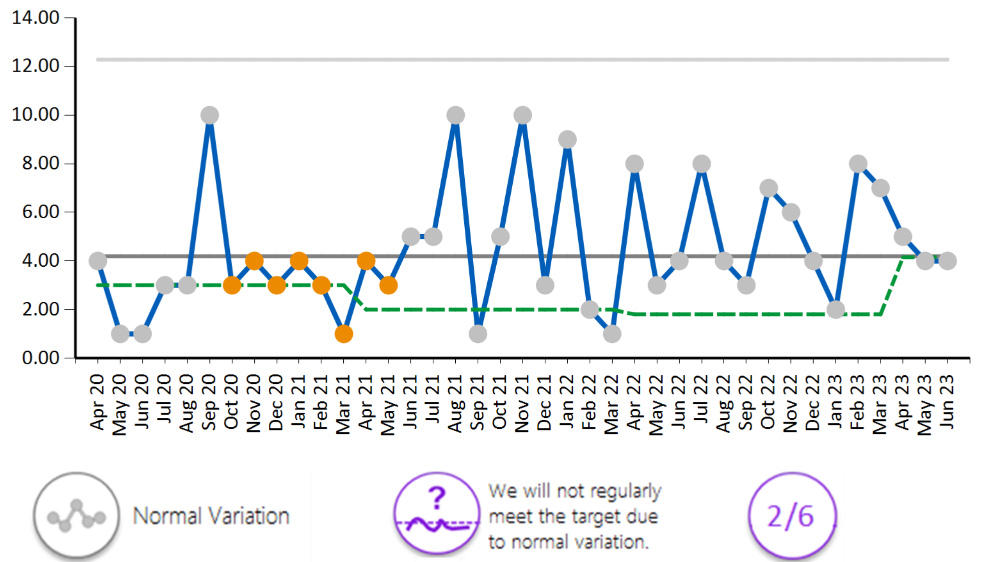
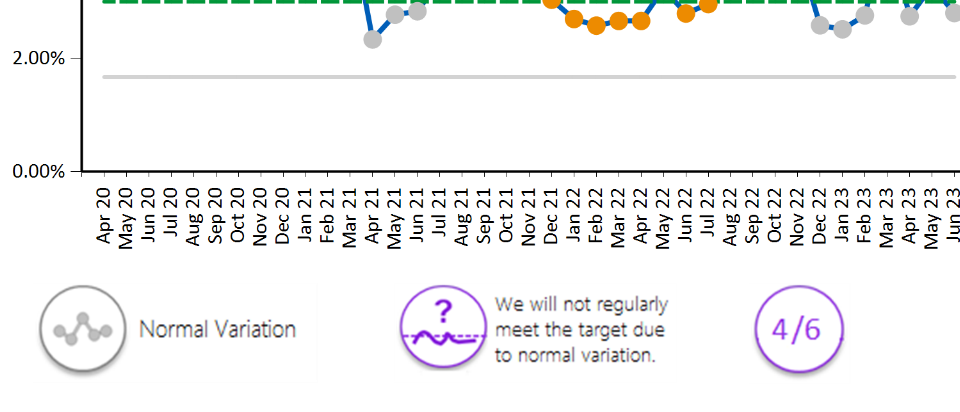
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



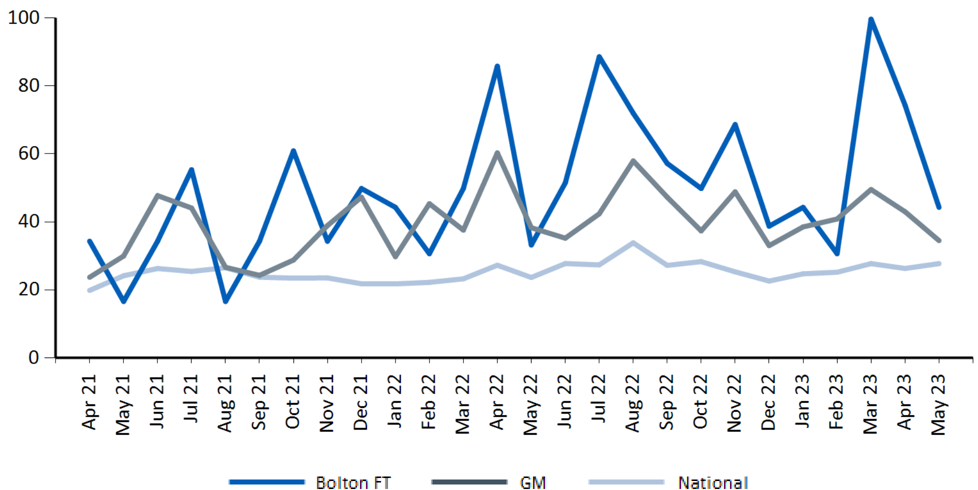
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)



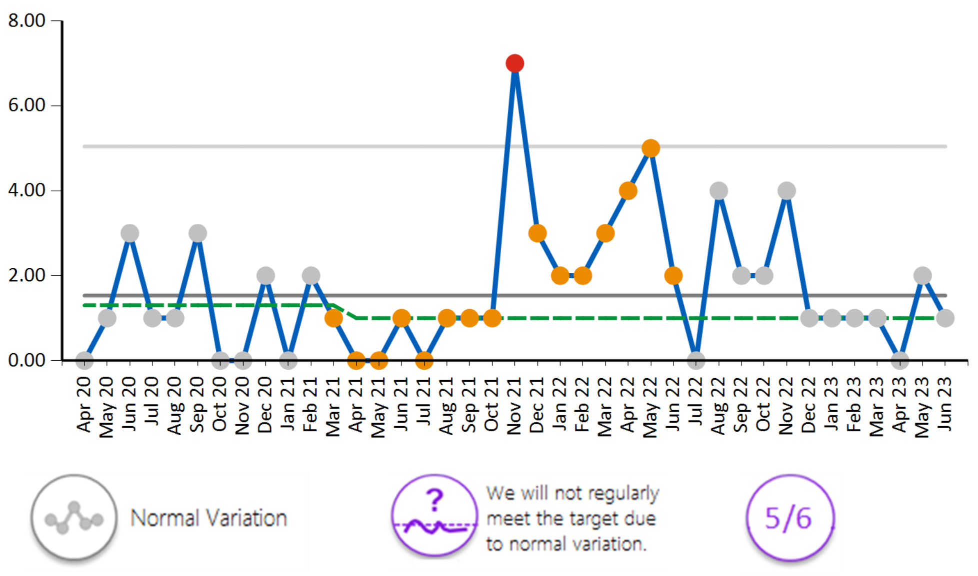
219 - Blood Culture Contaminants (rate)



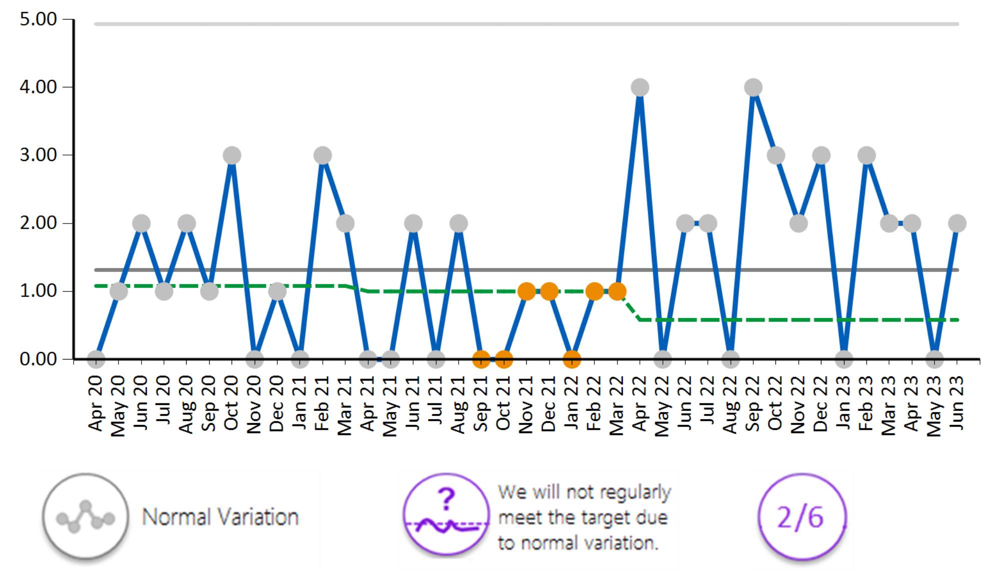
549 - C Diff Rate Comparison



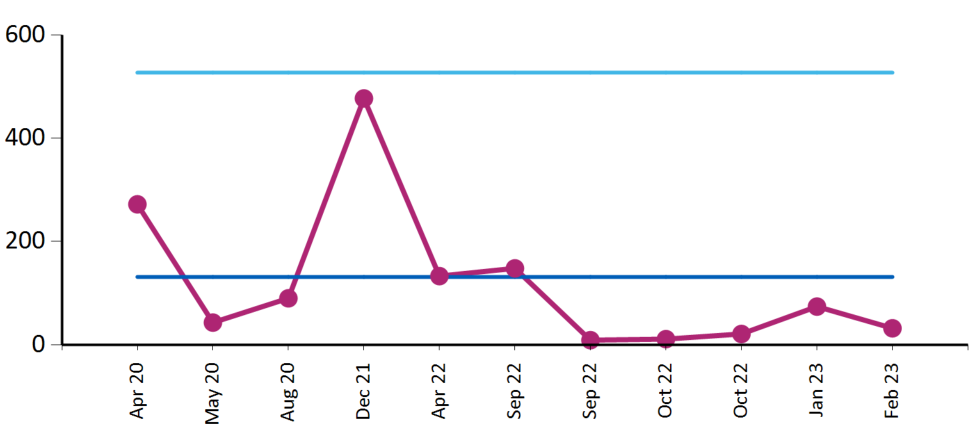
304 - Total Trust apportioned MSSA BSIs



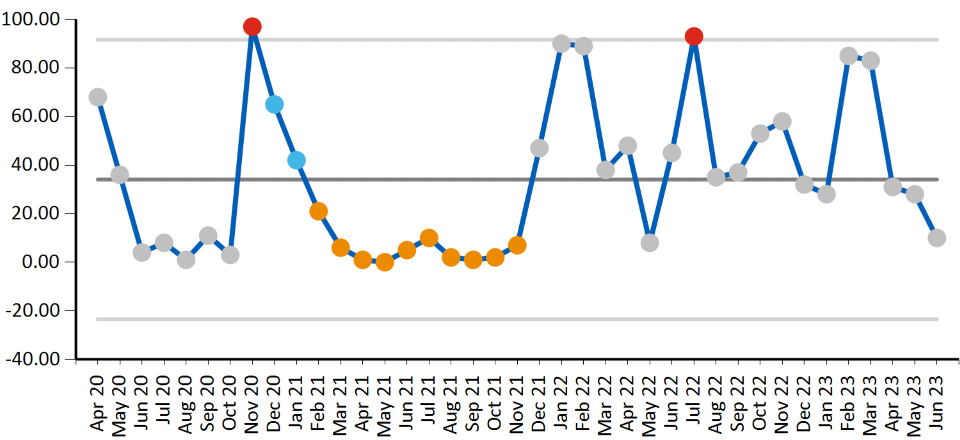
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)



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



491 - Nosocomial COVID-19 cases



Mortality

Crude – in month rate is below Trust target and average for the period. The crude rate has remained in control and has been for more than two years and shows the rate stabilising to a cyclical seasonal variation now the covid peaks are moving out of the timeframe.

HSMR – in month figure is within control limits and below average for the time frame. The 12 month average to March 2023 is 105.05, this is an 'Green' alert and has fallen from 'Amber' in the previous rolling average. The annual refresh of data has been applied to this indicator which has improved Bolton's position.

SHMI – In month figure is above the average for the time period but has remained 'in control' for more than two years. The published rolling average for the period March 2022 to February 2023 is 109.34 'as expected'. The annual refresh of data has delayed the update of this information by NHS Digital hence the extended time lag.

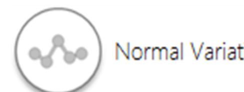
The proportion of Charlson comorbidities and the Depth of Recording remain in control and have done for 12 months. However, both are still lower when benchmarked against the England average of all Acute Trusts.

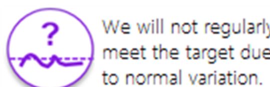
The proportion of coded records at the time of the snapshot download is above the target and average for the time frame. There has been a sustained period of 15 points above the mean since February 2022 indicating sustained improvement.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Jun-23		>= 85%	100.0%	May-23	>= 85%	100.0%	?
495 - HSMR		93.52	Feb-23			106.63	Jan-23			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	120.83	Jan-23		<= 100.00	118.92	Dec-22	<= 100.00		?
12 - Crude Mortality %	<= 2.9%	1.9%	Jun-23		<= 2.9%	2.4%	May-23	<= 2.9%	2.2%	?
519 - Average Charlson comorbidity Score (First episode of care)		3	Mar-23			4	Feb-23			
520 - Depth of recording (First episode of care)		6	Mar-23			6	Feb-23			
521 - Proportion of fully coded records (Inpatients)		98.7%	Apr-23	H		99.8%	Mar-23		98.7%	

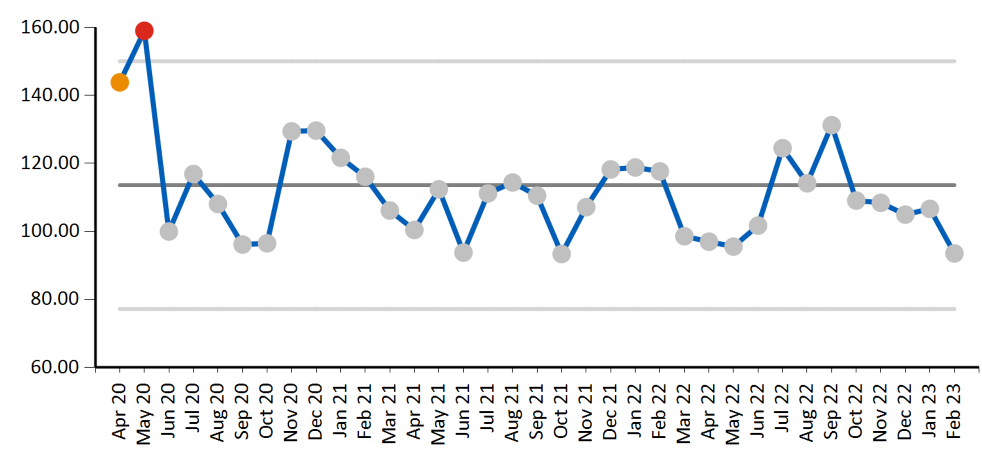
3 - National Early Warning Scores to Gold standard

100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23

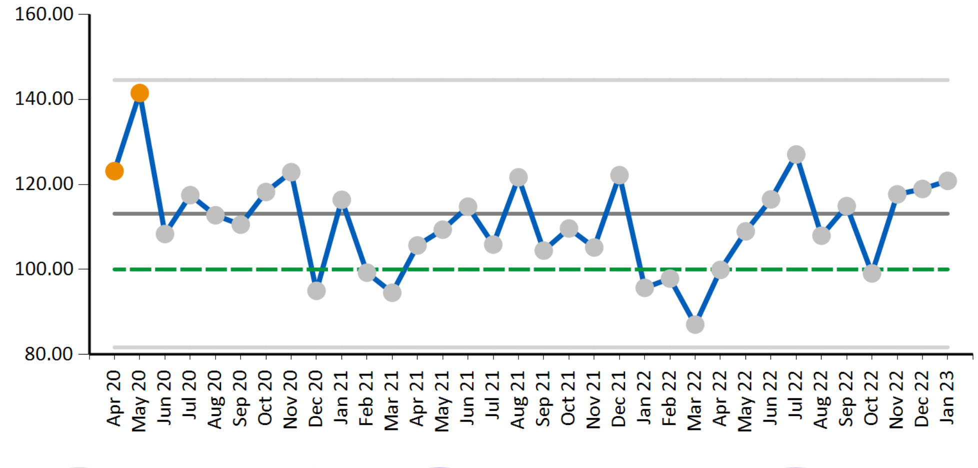


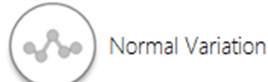


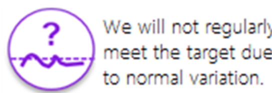
495 - HSMR



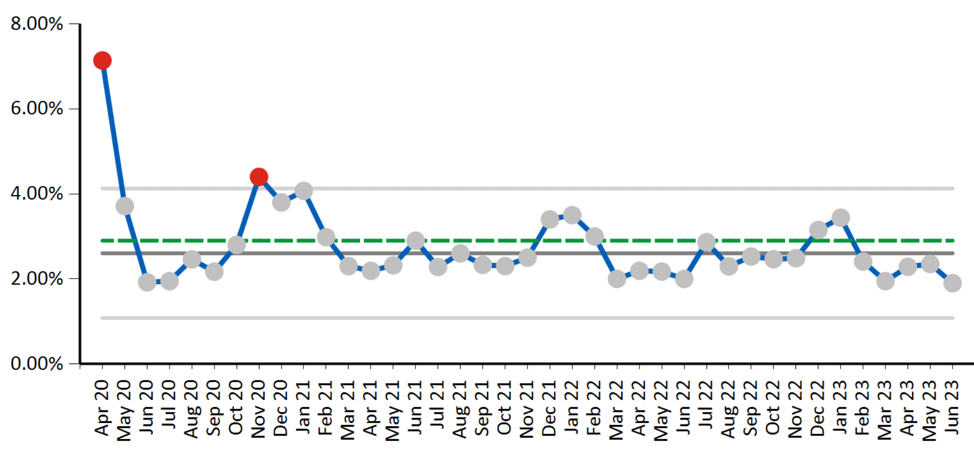
11 - Summary Hospital-level Mortality Indicator (SHMI)

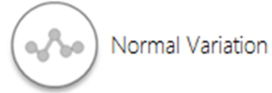


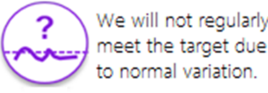




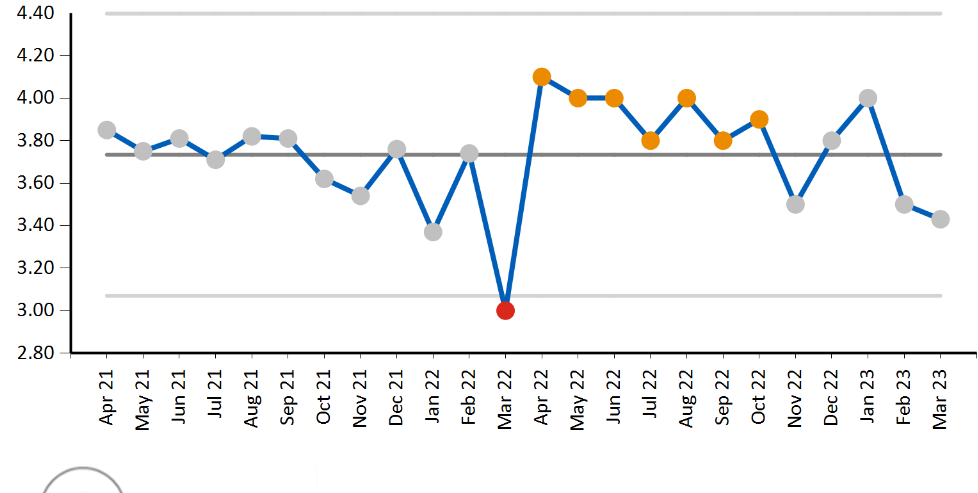
12 - Crude Mortality %





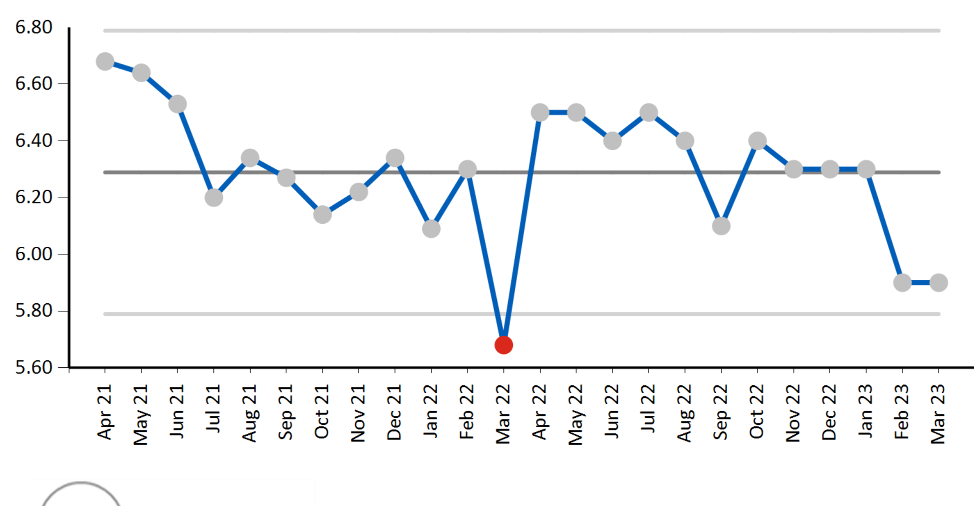


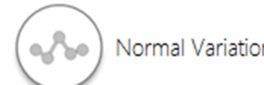
519 - Average Charlson comorbidity Score (First episode of care)



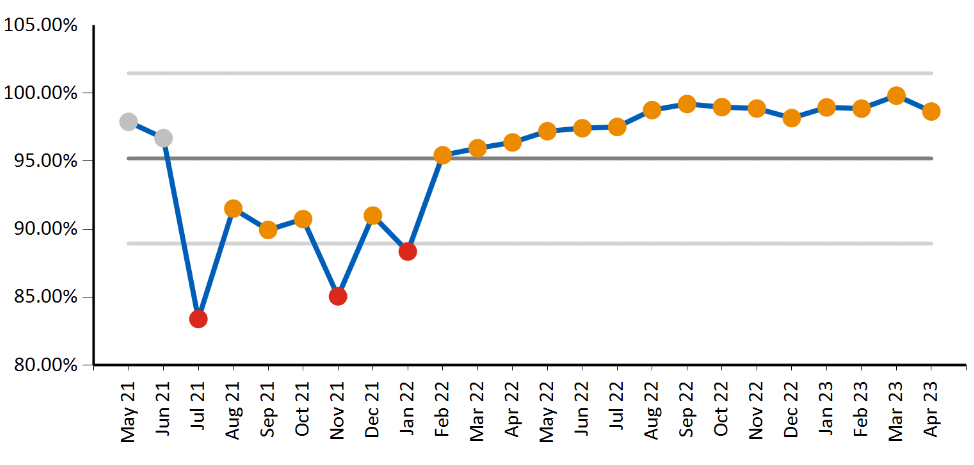
Normal Variation

520 - Depth of recording (First episode of care)





521 - Proportion of fully coded records (Inpatients)



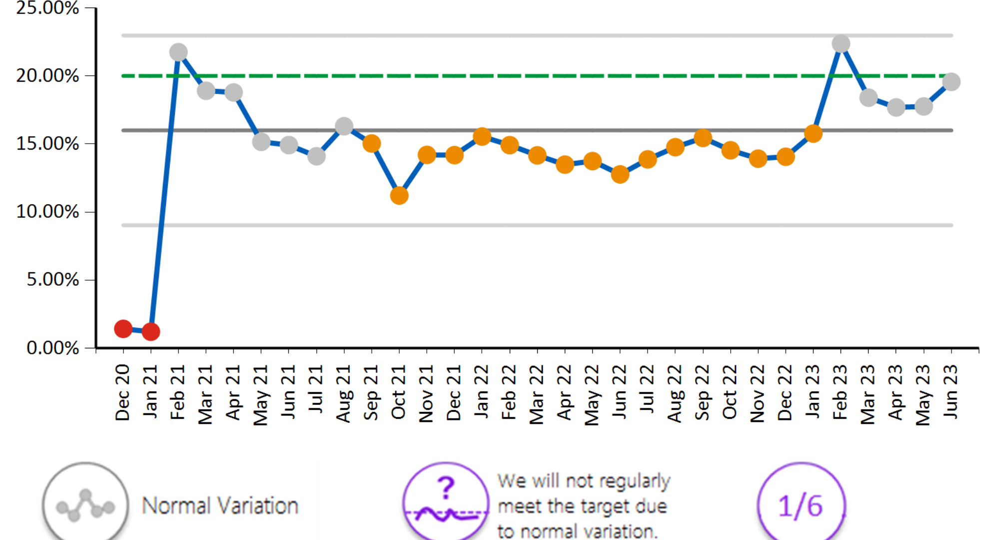
Patient Experience

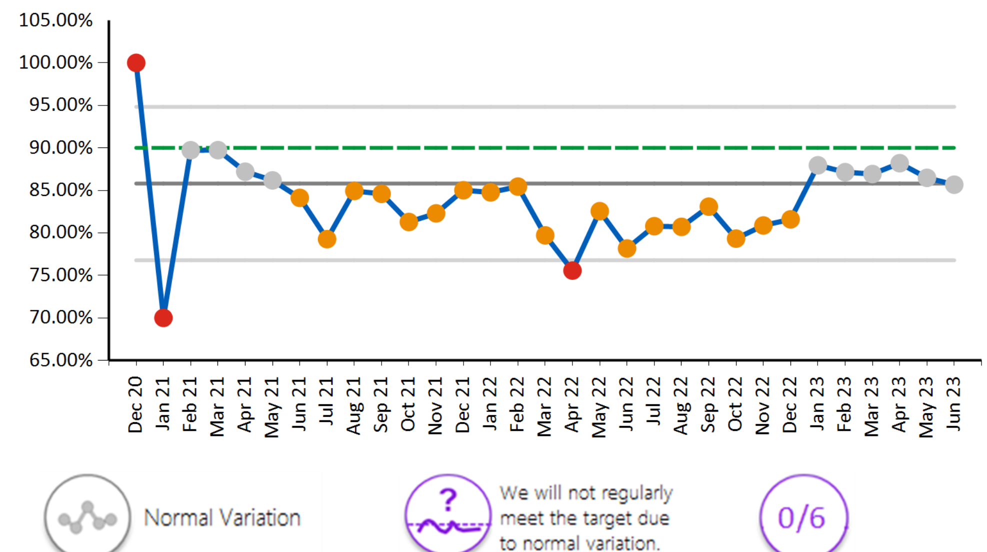
FFT Response and Satisfaction Rates
There continues to be focused work between the Patient Experience Team, Healthcare Communications and Business Intelligence during weekly meetings to review and cleanse the system of reported issues.
Regular training sessions to ensure correct divisional inputting have been implemented and we have received positive feedback that this is impacting reporting and likely to see an increase in response rates next month.

Complaint Response Rates
The Trust had 17 responses due in June and 14 were responded to within this timeframe. In addition to this we were able to respond to three complainants that were overdue from May and have responded early to seven responses due in July.
The complaints response compliance rate was 82.4% against a target of 95%. This is an improvement on May 23 figure of 71.4%. We anticipate that the continued best practice of offering outcome resolution meetings with the embedded digital recording and sharing process, along with improved written response quality, will continue to reflect a rise in compliance.
Complaint training sessions have commenced with staff who require this and a positive session with 4 members of AACD was reported as beneficial for current and future lead investigators.

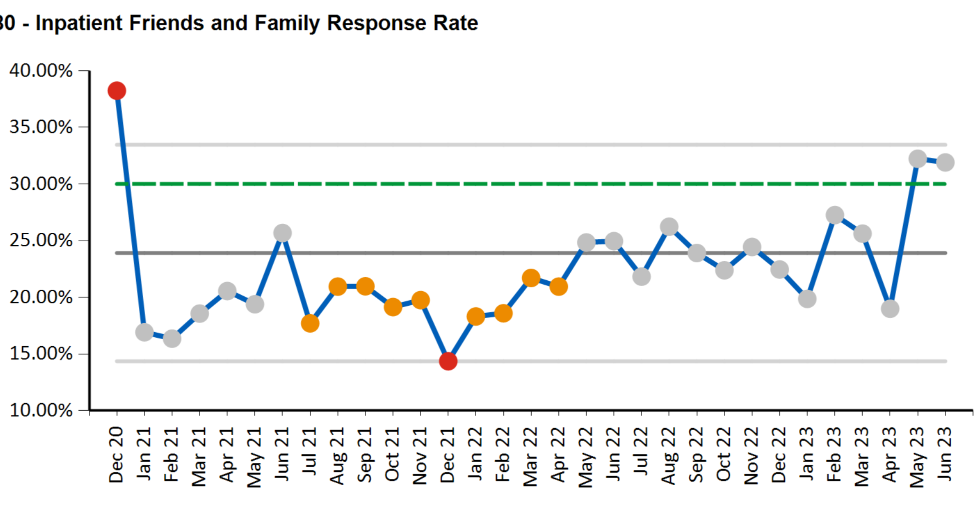
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	19.6%	Jun-23		>= 20%	17.8%	May-23	>= 20%	18.4%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	85.7%	Jun-23		>= 90%	86.5%	May-23	>= 90%	86.7%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	31.9%	Jun-23		>= 30%	32.2%	May-23	>= 30%	28.2%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.0%	Jun-23		>= 90%	96.6%	May-23	>= 90%	95.9%	P
81 - Maternity Friends and Family Response Rate	>= 15%	35.9%	Jun-23	H	>= 15%	46.7%	May-23	>= 15%	41.1%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	92.2%	Jun-23		>= 90%	87.2%	May-23	>= 90%	90.2%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	23.9%	Jun-23	H	>= 15%	38.0%	May-23	>= 15%	32.3%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	98.3%	Jun-23		>= 90%	96.4%	May-23	>= 90%	97.7%	?
83 - Birth - Friends and Family Response Rate	>= 15%	49.1%	Jun-23	H	>= 15%	45.1%	May-23	>= 15%	42.5%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.4%	Jun-23		>= 90%	91.1%	May-23	>= 90%	90.5%	?

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	49.6%	Jun-23		>= 15%	84.3%	May-23	>= 15%	64.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.8%	Jun-23		>= 90%	76.1%	May-23	>= 90%	81.2%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	20.7%	Jun-23		>= 15%	24.3%	May-23	>= 15%	29.0%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	97.2%	Jun-23		>= 90%	93.8%	May-23	>= 90%	96.9%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Jun-23		= 100%	100.0%	May-23	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	82.4%	Jun-23		>= 95%	71.4%	May-23	>= 95%	72.7%	





80 - Inpatient Friends and Family Response Rate



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

100.00%
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23

Normal Variation

Target will be regularly met.

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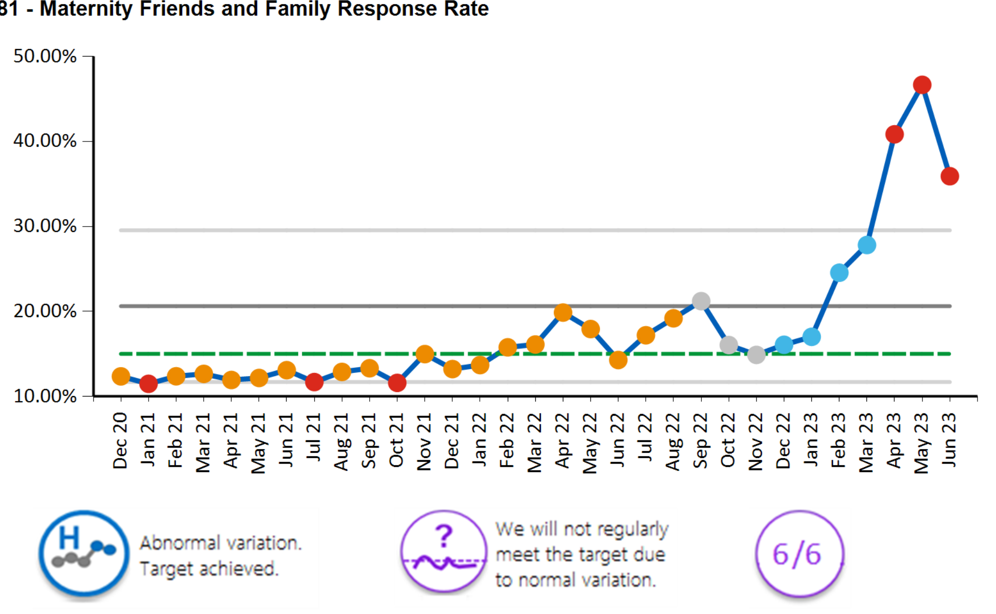
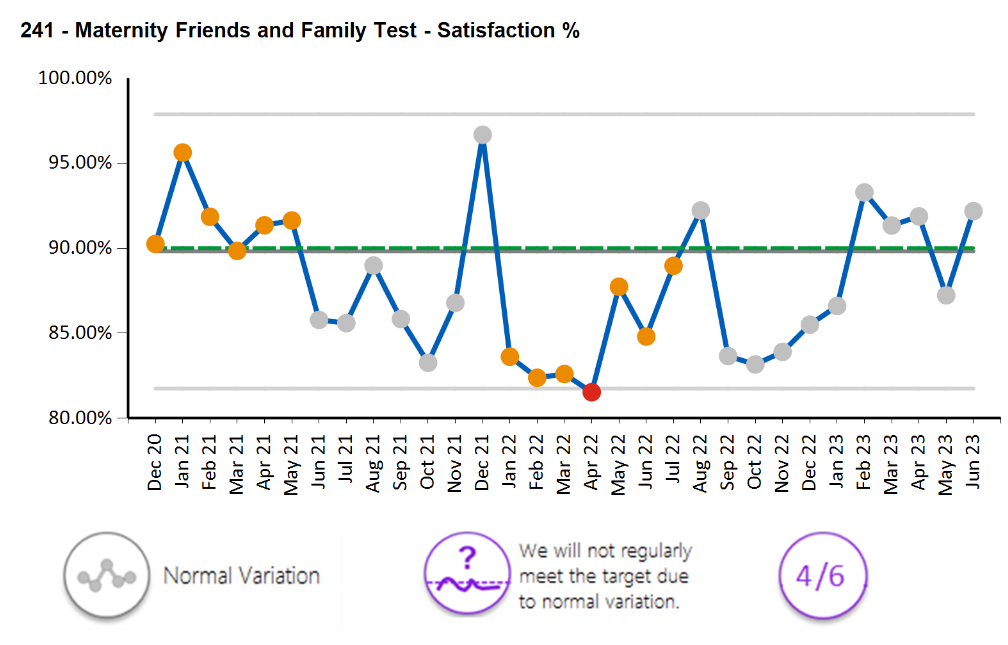
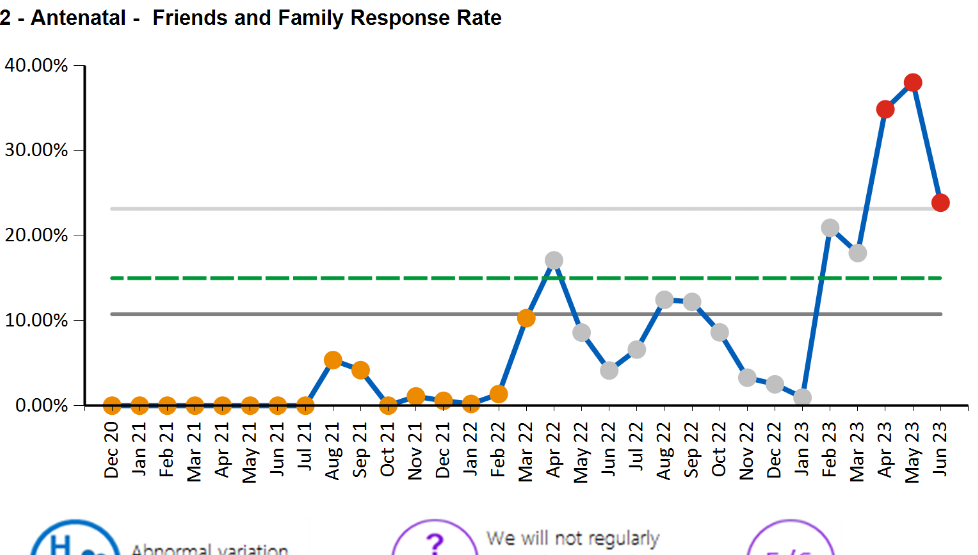
81 - Maternity Friends and Family Response Rate



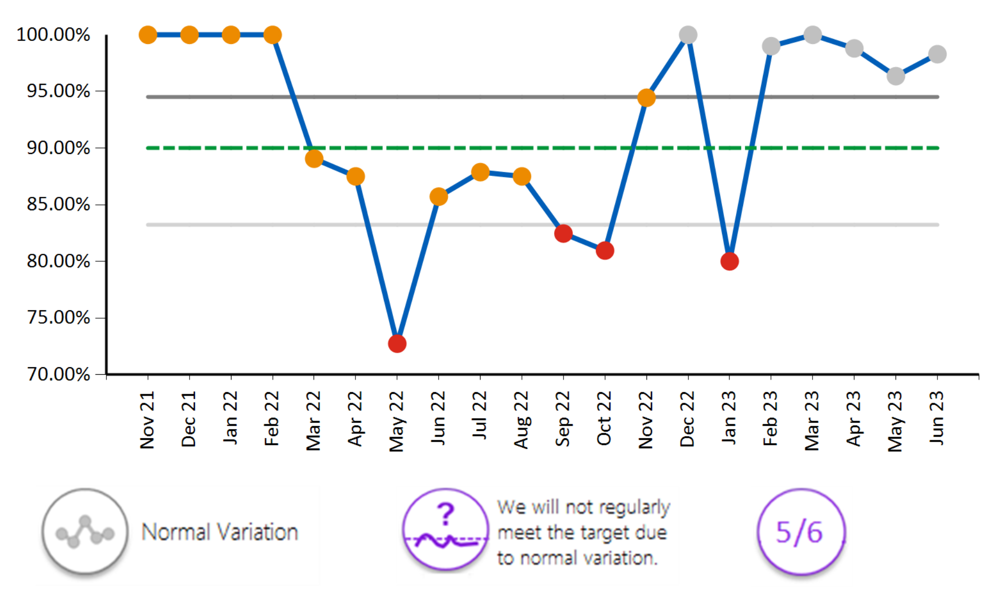
241 - Maternity Friends and Family Test - Satisfaction %



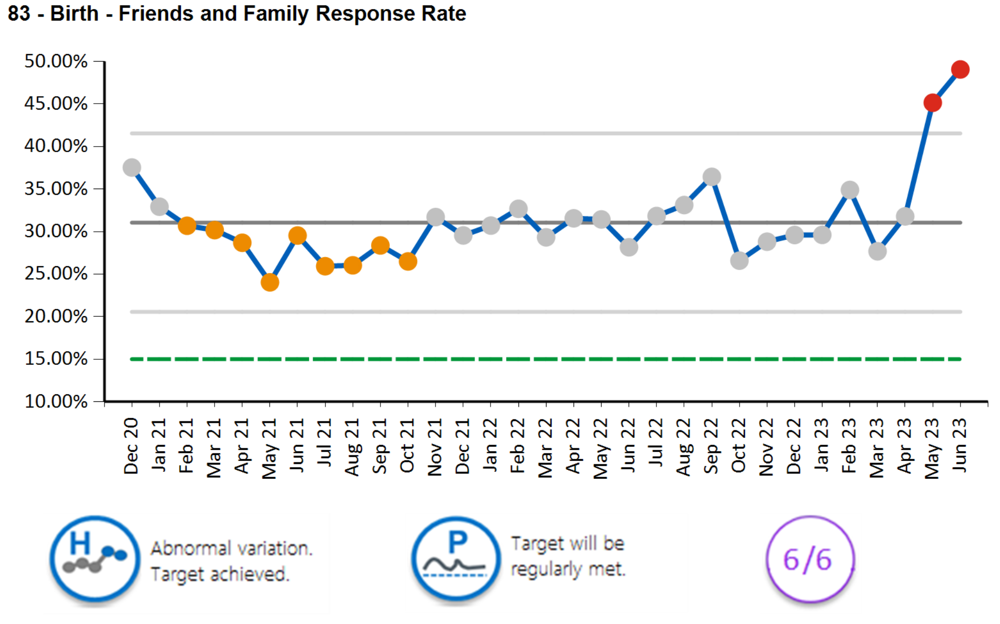
82 - Antenatal - Friends and Family Response Rate



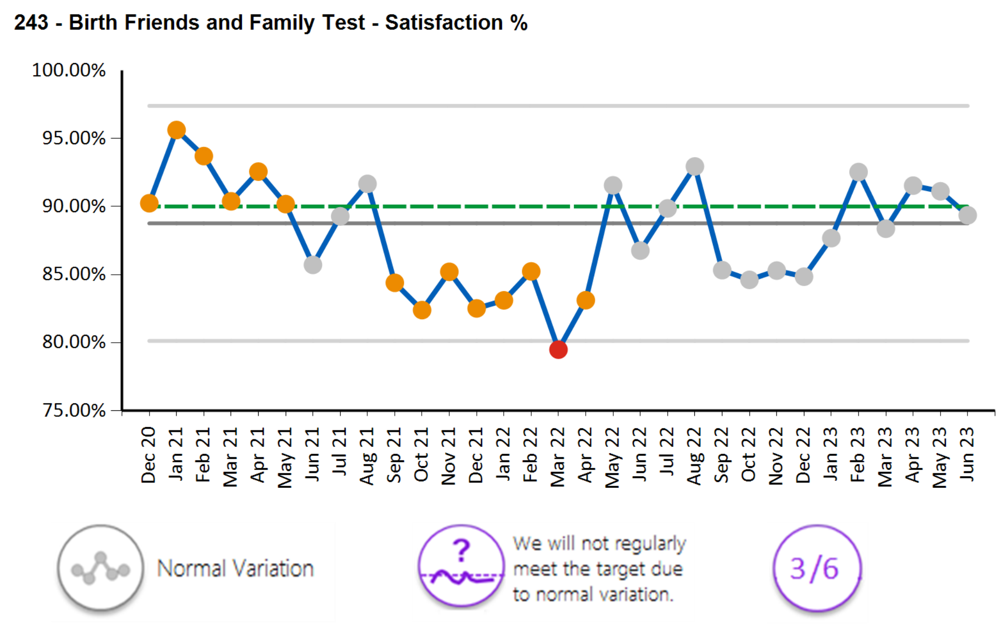
242 - Antenatal Friends and Family Test - Satisfaction %



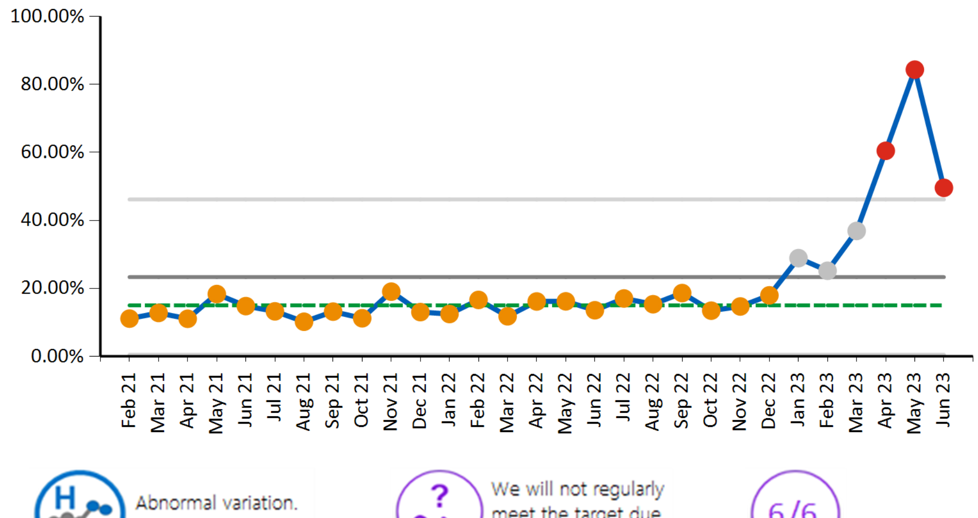
83 - Birth - Friends and Family Response Rate



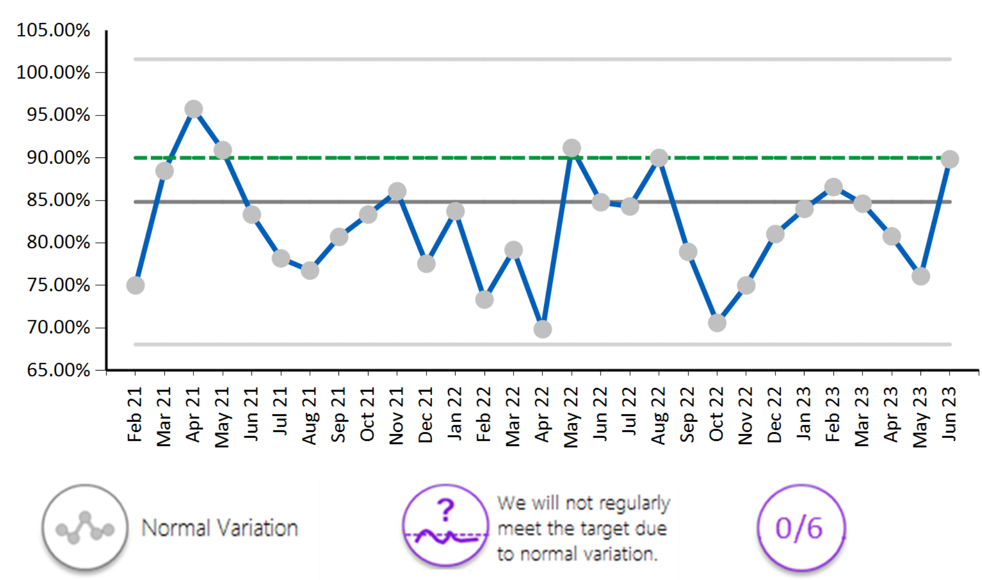
243 - Birth Friends and Family Test - Satisfaction %



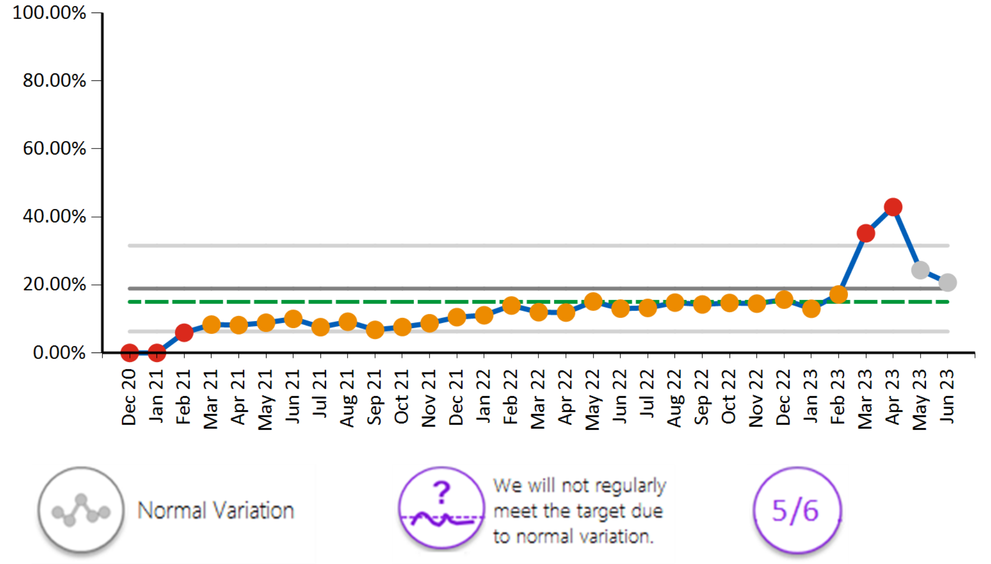
84 - Hospital Postnatal - Friends and Family Response Rate



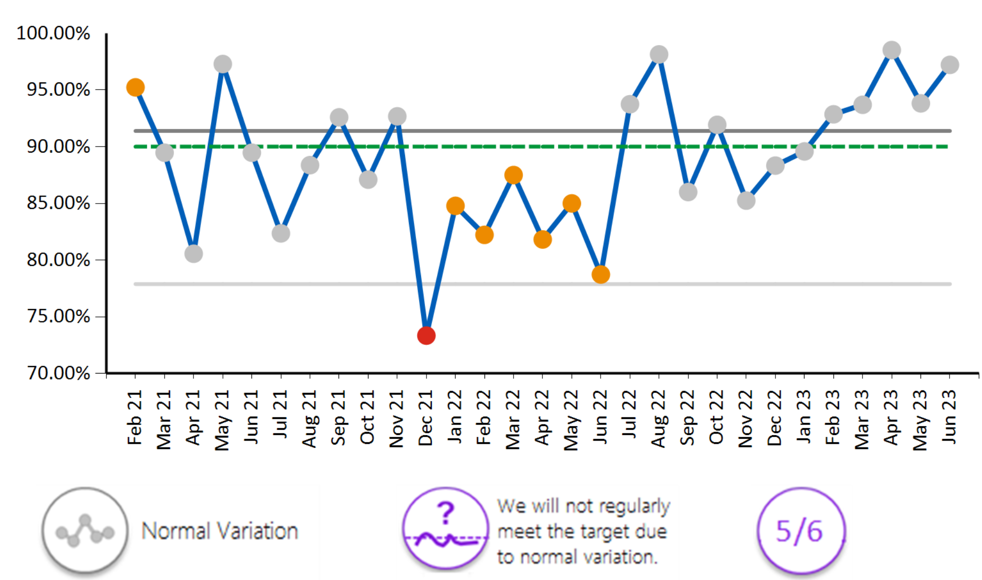
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



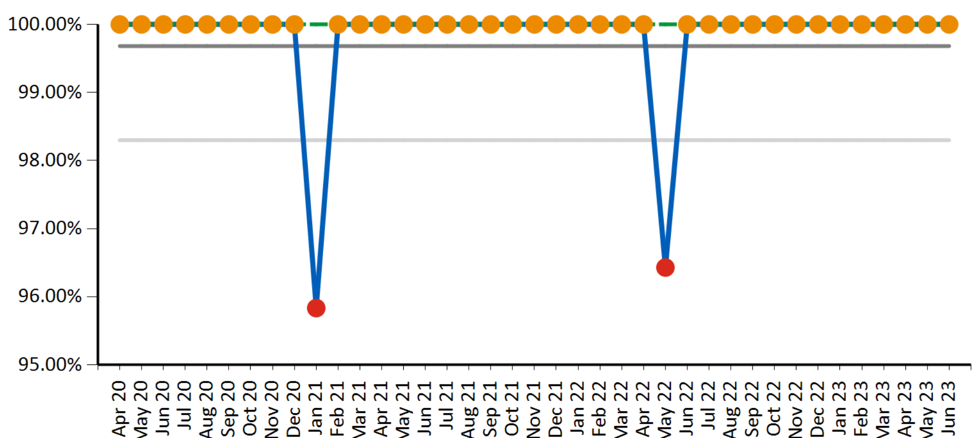
85 - Community Postnatal - Friend and Family Response Rate

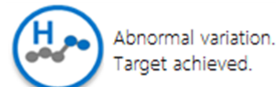


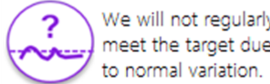
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days

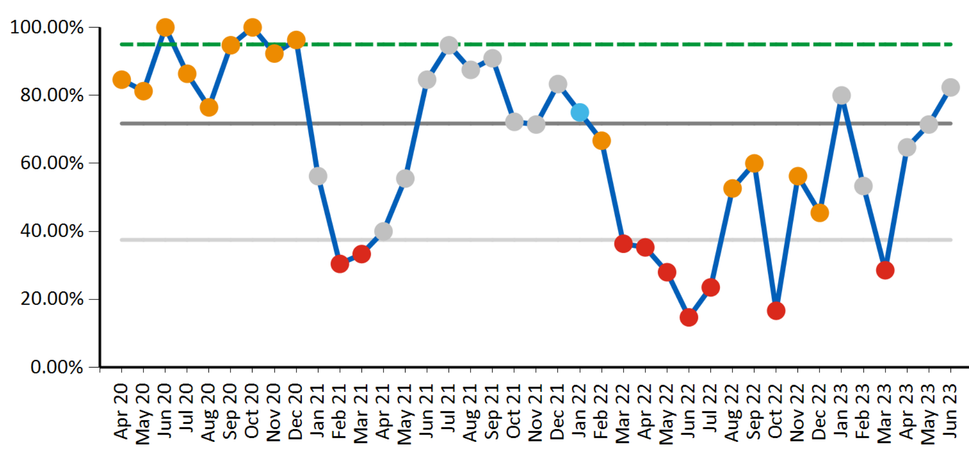


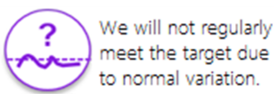




6/6

90 - Complaints responded to within the period





Maternity

81 Friends and Family Response Rate – Sustained trend in response rate reported over past four consecutive months. Improvement noted following establishment of the friends and family task and finish group. Slight improvement noted in overall satisfaction in month. Feedback awaited from the Patient Experience team re datasets included in metrics.

202 - 1:1 care in labour – Trust year to date incidence 89.23% lower than the Greater Manchester and East Cheshire (GMEC) 2022 mean of 95.33% and peer average in similar sized providers (ie Oldham). Reflective of ongoing staffing deficit (50wte) and improvement anticipated from late September 2023 when overall staffing establishment predicted to improve. Incident reported as red flag and monitored on Birth Rate Plus acuity tool every 4 hours. 100% compliance required for CNST Year 5 scheme or detailed action plan to be submitted to meet scheme requirements.

23 – ¾ degree tears – Trust year to date incidence 3.83% slightly higher than GMEC comparator mean of 2.51%. GMEC consensus awaited on use of episcissors in practice to inform Trust practice. Date for relaunch of OASI2 guidance awaited – delayed due to sickness. Q4 review report in draft form awaiting final version. Provisional findings indicate higher incidence during night shift, forceps delivery and delay in episiotomy's being undertaken. Final report due August 2023.

203 – Booked by 12+6 – Improving trend in booking performance continues. New task and finish group to review the booking process commenced 18/04/2023 to streamline process. Trust year to date 88.10% aligns exceeds GMEC comparator mean of 85.58%. Performance target to be amended to 9+6 as per national standard.

210 – Breastfeeding initiation – Slight improvement in performance noted in past 5 months. New leadership has been introduced to review current service offer and support Baby Friendly implementation within service. Trust year to date incidence 68.78% slightly higher than 2022 GMEC mean 60.36%. Service review of capacity and capability will be undertaken when new Matron commences in post.

320 – Preterm birth – Elevated incidence in April 2023 noted on spc chart. No GMEC comparator data accessible on tableau to benchmark performance. Limited data available from North West Operational Delivery Network thus further detail requested. No trends identified by NNU Leads.

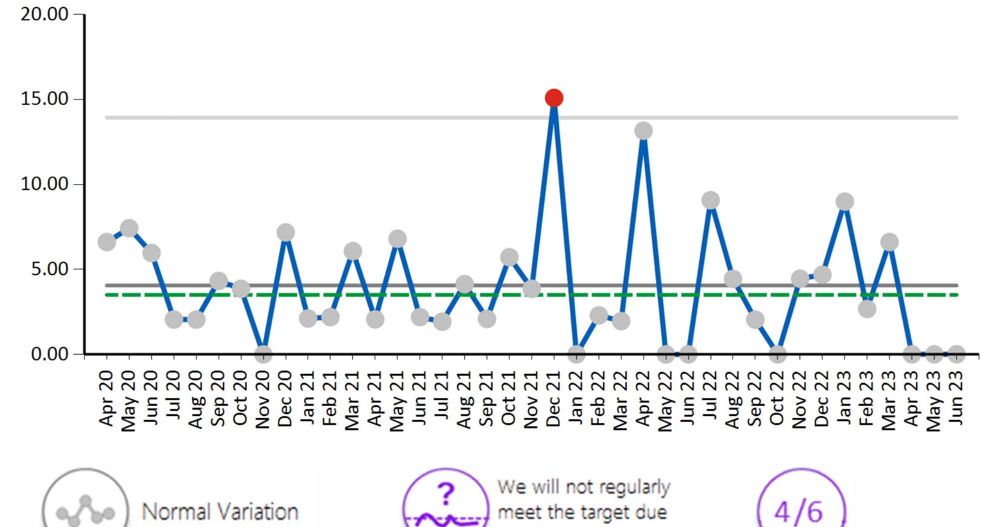
322 – Maternity Stillbirth Rate – Below mean incidence sustained. Review of perinatal mortality tool process undertaken to strengthen governance and oversight. Trust year to date incidence 4.29/1000 compares favourably with GMEC mean 4.97/1000 and lower than peer comparators ie Oldham 7.24/1000.

Total caesarean section rate – The trust incidence of total caesarean section year to date 39.21% aligns favourably with the GMEC position 42.78% and that of comparative providers ie Oldham (48.80%) All maternity services were formally advised in September 2022 via a formal letter "We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently". In response the BFT business intelligence team have started to collate a Trust level dataset on tableau using the robson criteria that the service can use to monitor caesarean section birth outcomes in accordance with the guidance, that details ethnicity and postcode of service users. The dataset is currently being reviewed by the Clinical Director prior to wider sharing and then an allocated obstetric lead will assist the Director of Midwifery with the data interpretation.

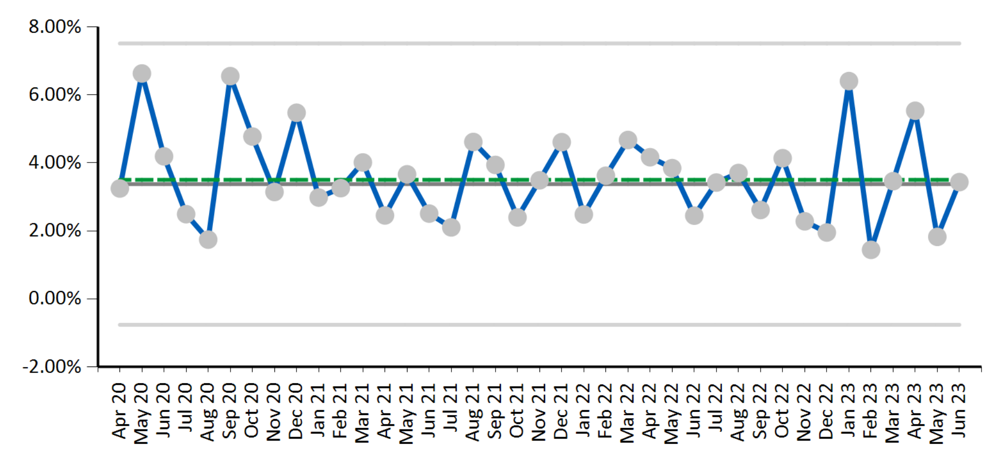
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	0.01	Jun-23		<= 3.50	0.00	May-23	<= 3.50	6.11	?
23 - Maternity -3rd/4th degree tears	<= 3.5%	3.4%	Jun-23		<= 3.5%	1.8%	May-23	<= 3.5%	3.5%	?
202 - 1:1 Midwifery care in labour	>= 95.0%	98.8%	Jun-23		>= 95.0%	99.7%	May-23	>= 95.0%	98.8%	P

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
203 - Booked 12+6	>= 90.0%	85.7%	Jun-23		>= 90.0%	89.1%	May-23	>= 90.0%	88.4%	
204 - Inductions of labour	<= 40%	34.4%	Jun-23		<= 40%	35.0%	May-23	<= 40%	35.1%	
210 - Initiation breast feeding	>= 65%	65.78%	Jun-23		>= 65%	67.80%	May-23	>= 65%	67.27%	
213 - Maternity complaints	<= 5	1	Jun-23		<= 5	2	May-23	<= 15	6	
319 - Maternal deaths (direct)	= 0	0	Jun-23		= 0	0	May-23	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.3%	Jun-23	H	<= 6%	9.6%	May-23	<= 6%	10.7%	

322 - Maternity - Stillbirths per 1000 births



23 - Maternity -3rd/4th degree tears

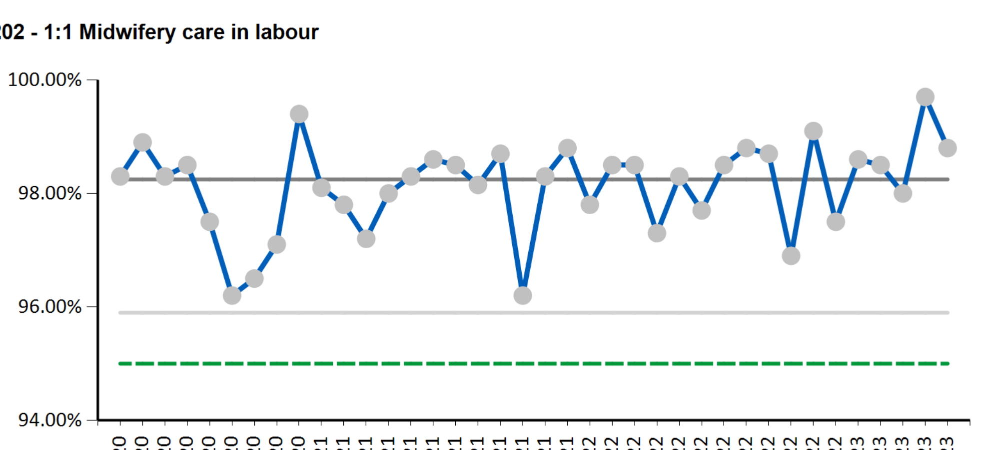


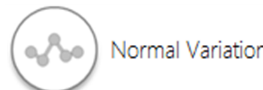
Normal Variation

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

4/6

202 - 1:1 Midwifery care in labour

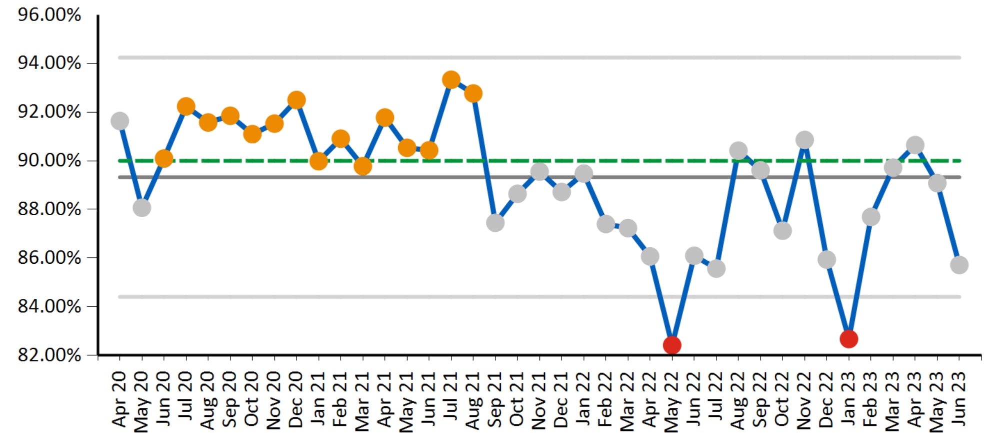



Normal Variation

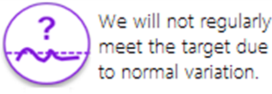
Target will be regularly met.

6/6

203 - Booked 12+6

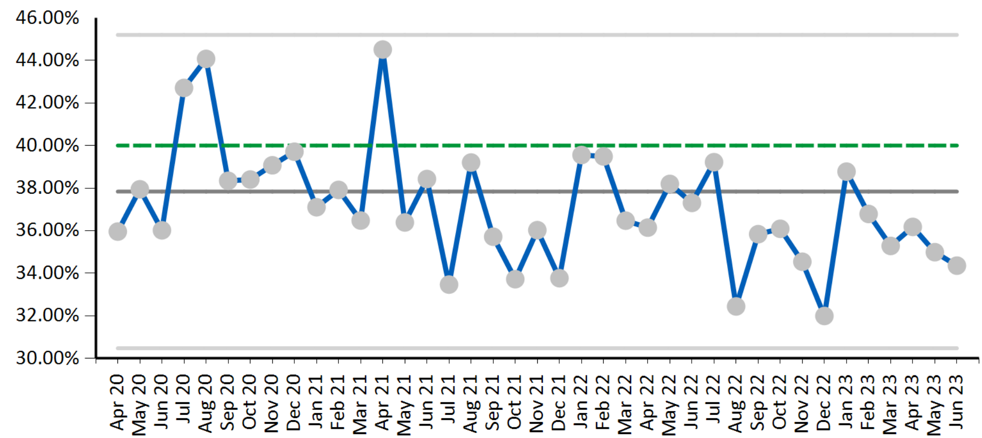


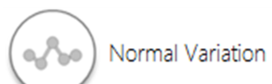
Normal Variation

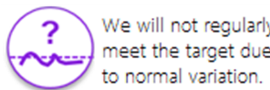

We will not regularly meet the target due to normal variation.

1/6

204 - Inductions of labour

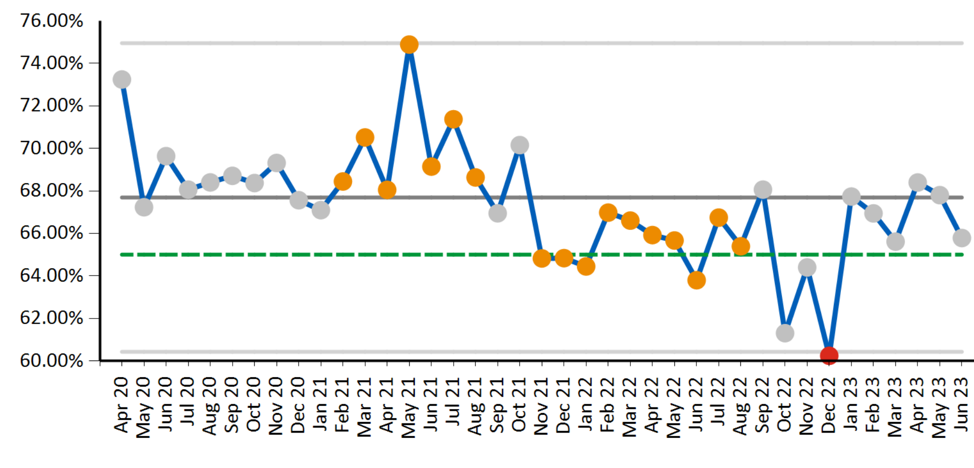


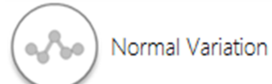

Normal Variation

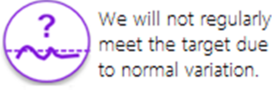

We will not regularly meet the target due to normal variation.

6/6

210 - Initiation breast feeding

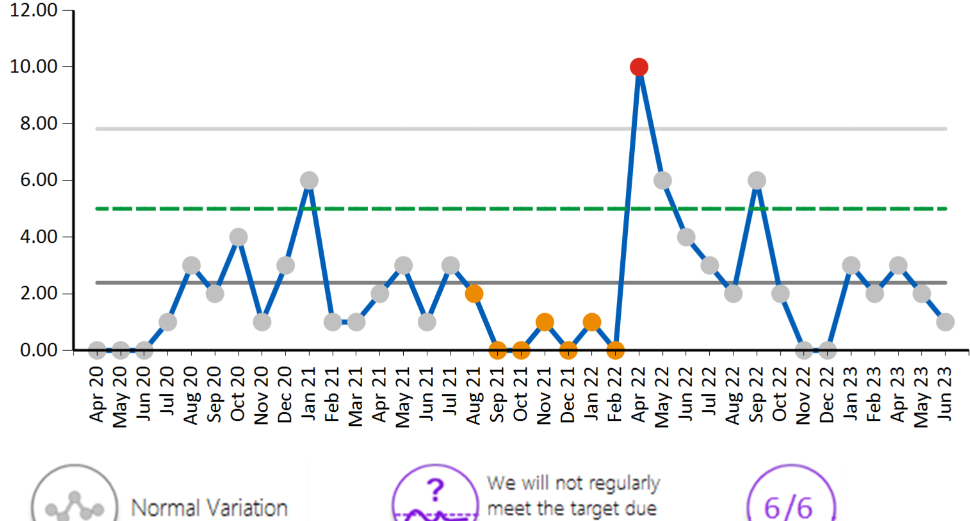



Normal Variation

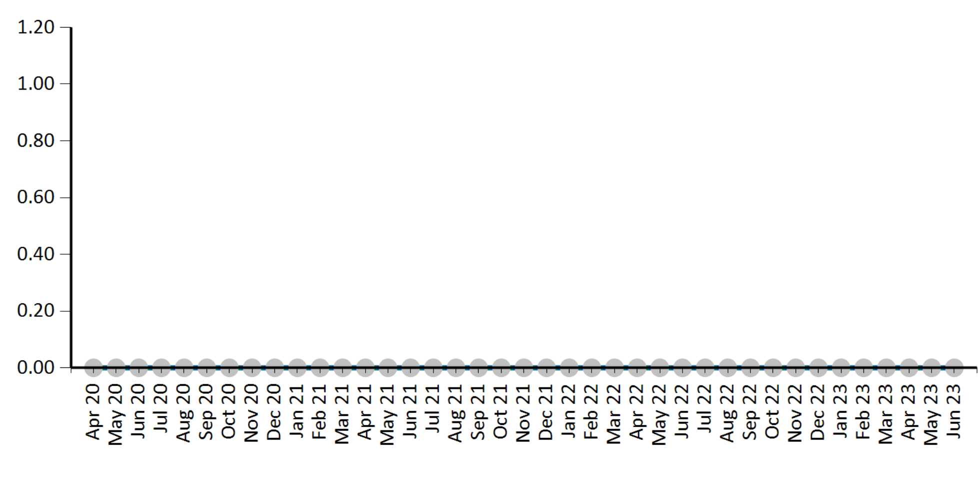

We will not regularly meet the target due to normal variation.

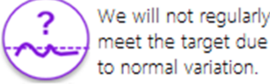
6/6

213 - Maternity complaints



319 - Maternal deaths (direct)

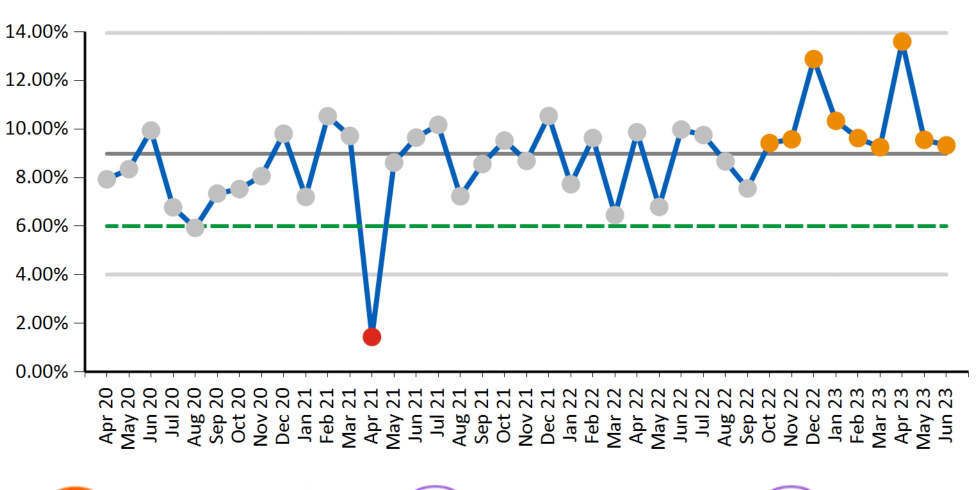


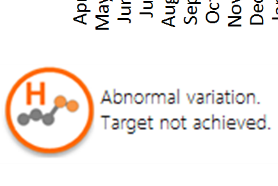


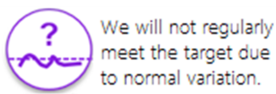
We will not regularly meet the target due to normal variation.

6/6

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







Operational Performance

Urgent Care

In urgent care we saw a small improvement in all metrics over the month, with ambulance handovers within 15 mins at 62.2% just short of the 65% target. For 4 hour performance we were considerably below the plan of 75% however. The driver for this position was predominantly related to internal flow, this having a multi-factorial cause, including infection prevention and control issues which have been a challenge in month.

A number of initiatives continue across the Division in order to improve the position:

- Introduction of SAFER assessment into BoSCA
- Get me Home Meetings
- Redevelopment of the ward clinical boards to reduce days delayed
- Criteria led discharge to improve weekend discharges
- Development of UTC
- Clinical audit of all patients over 21 days

Neck of Femur

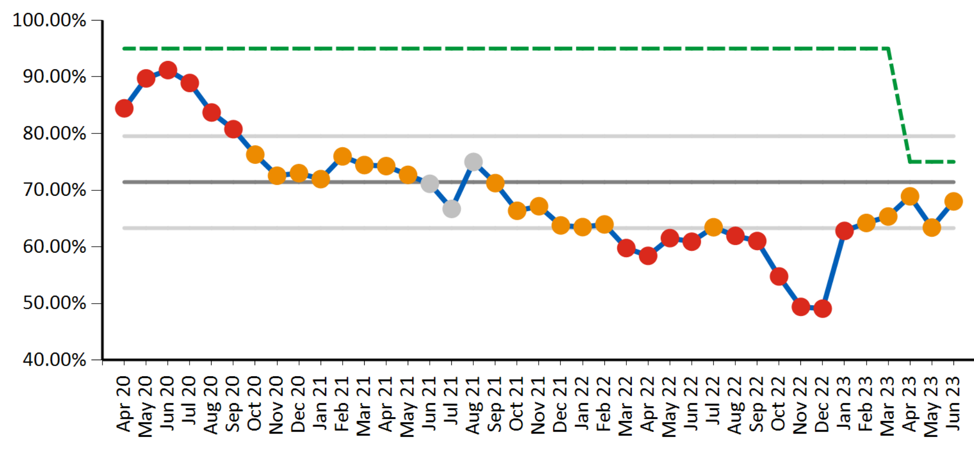
In June, there were 41 people who suffered a fractured neck of femur with 26 of these being treated in theatre within the 36 hour target (65.1%). The key drivers for underperformance are complexity of a number of cases combined with capacity challenges, both trauma theatre capacity and availability of specialist hip surgeons. To prioritise and accommodate our patients with fractured neck of femur, elective surgery was cancelled on 2 occasions in June. The Trauma coordinator team continue to collect detailed data each month to record our compliance and analyse reasons why the target is not met. The team have recently completed a deep dive into the medical reasons why patients do not meet the 36 hour to theatre target to ensure clinical reasoning aligns with NICE guidance. Learning from this will be used within speciality governance.

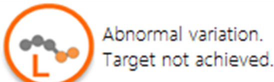
30 Day Readmission Rate

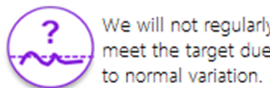
We are continuing to see low levels of readmission rates within 30 days after seeing a downward (improving) trend over the past 3 years. This improvement is likely to be linked to our long-term approach to development of our community proactive and reactive services. Our acute based frailty service has also been developed over this period which works in conjunction with the community services. A recent further enhancement has been the development of the Older Persons Assessment Unit which has directly supported a reduction in length of stay and readmission rates for our older population.

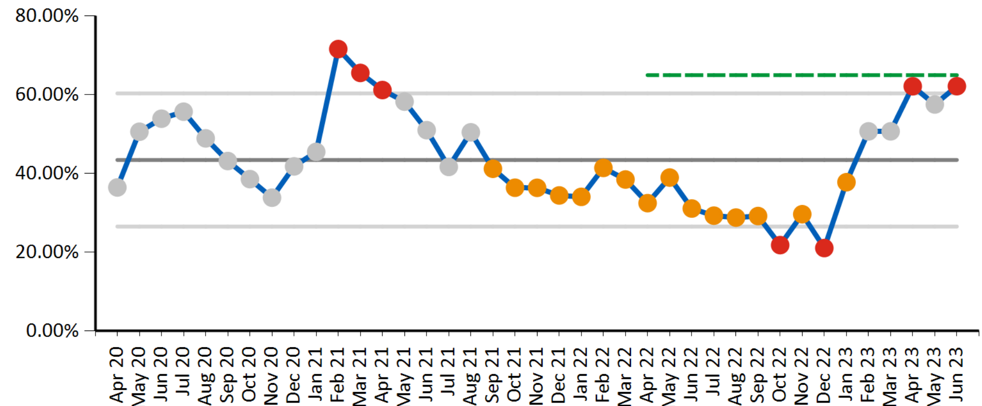
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 75%	68.0%	Jun-23	L	>= 75%	63.4%	May-23	>= 75%	66.7%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	62.2%	Jun-23	H	>= 65.0%	57.5%	May-23	>= 65.0%	60.5%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	86.0%	Jun-23		>= 95.0%	83.1%	May-23	>= 95.0%	86.2%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100.00%	95.27%	Jun-23		= 100.00%	93.75%	May-23	= 100.00%	95.70%	F
545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes		4.7%	Jun-23			6.3%	May-23		4.3%	
539 - A&E 12 hour waits	= 0	1,012	Jun-23		= 0	1,173	May-23	= 0	3,079	

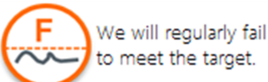
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	65.1%	Jun-23		>= 75%	71.1%	May-23	>= 75%	57.9%	
56 - Stranded patients	<= 200	246	Jun-23	H	<= 200	272	May-23	<= 200	246	
307 - Stranded Patients - LOS 21 days and over	<= 69	91	Jun-23	H	<= 69	106	May-23	<= 69	91	
541 - Adult G&A bed occupancy	<= 92.0%	86.6%	Jun-23		<= 92.0%	86.6%	May-23	<= 92.0%	86.5%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.16	Jun-23		<= 3.70	4.48	May-23	<= 3.70	4.42	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.7%	May-23	L	<= 13.5%	8.7%	Apr-23	<= 13.5%	8.7%	P



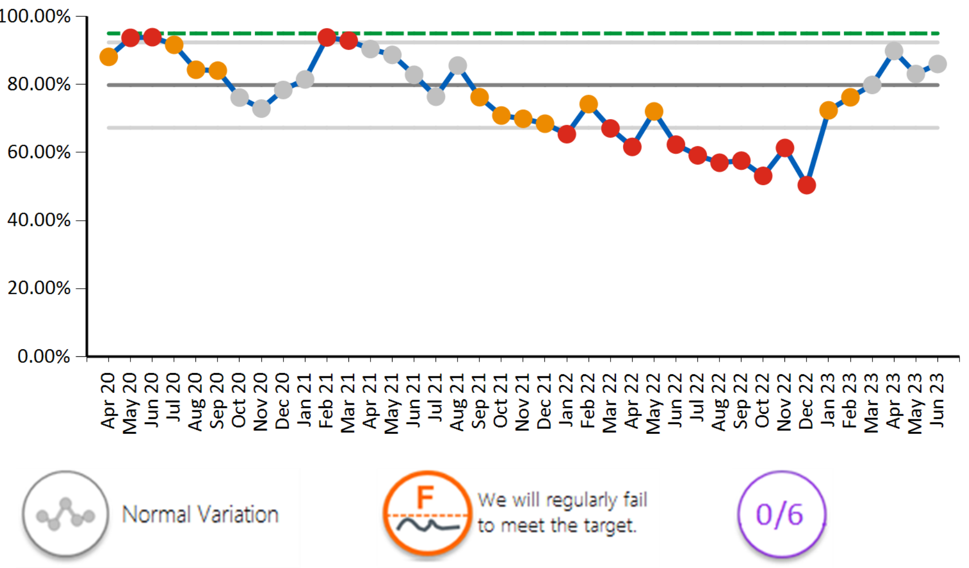








F
We will regularly fail to meet the target.


70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
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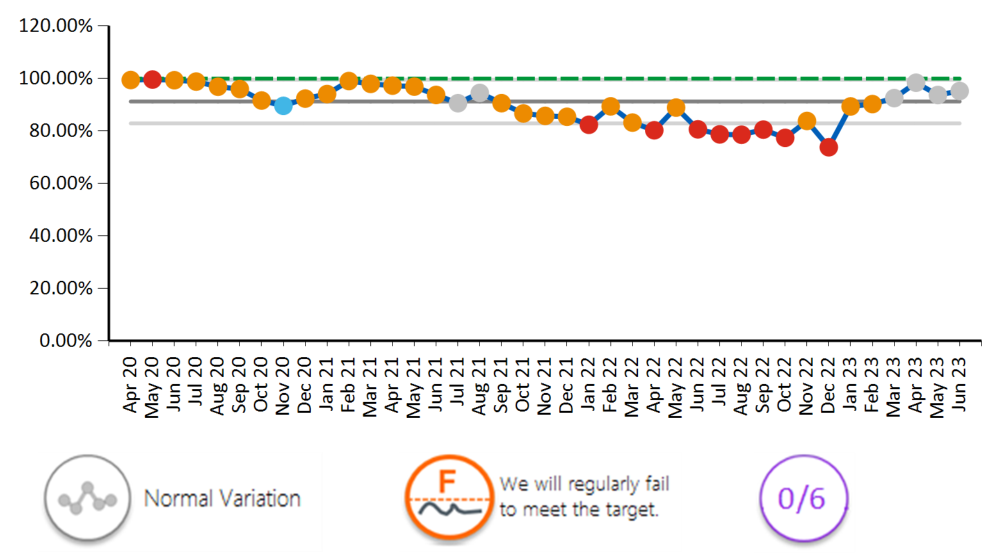
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Normal Variation
F
We will regularly fail to meet the target.
0/6


71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
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May 22
Jun 22
Jul 22
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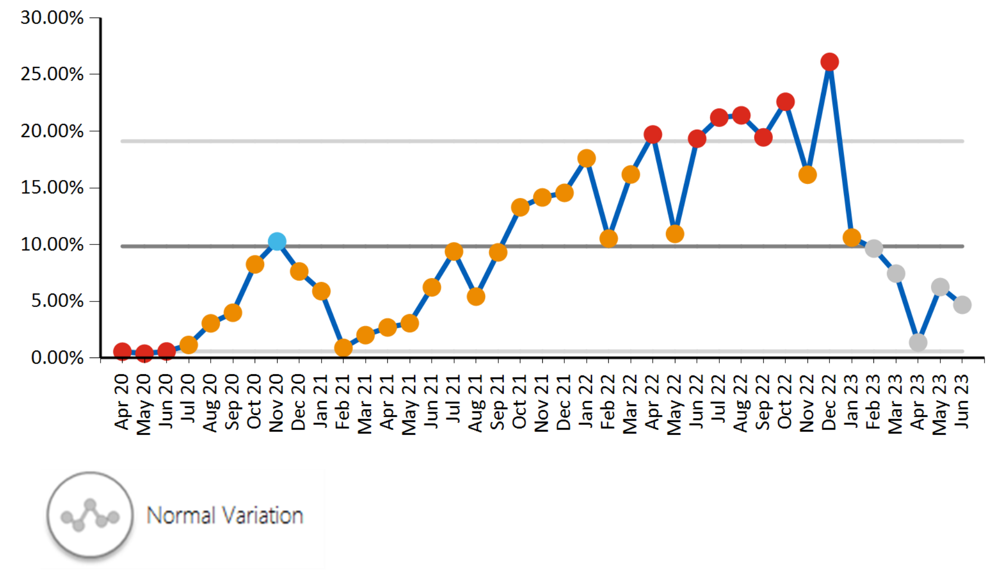
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Normal Variation
F
We will regularly fail to meet the target.
0/6


545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
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Mar 22
Apr 22
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Nov 22
Dec 22
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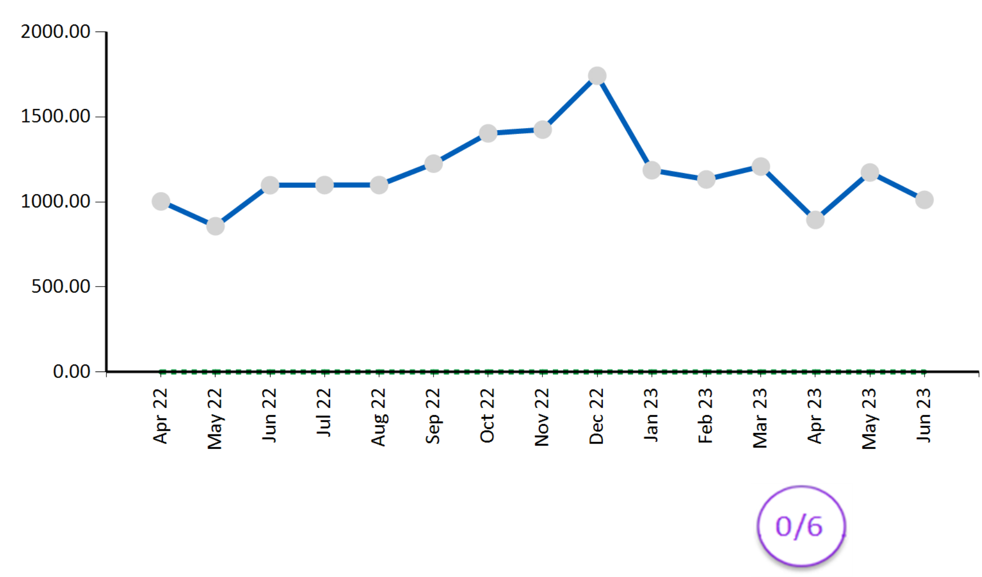
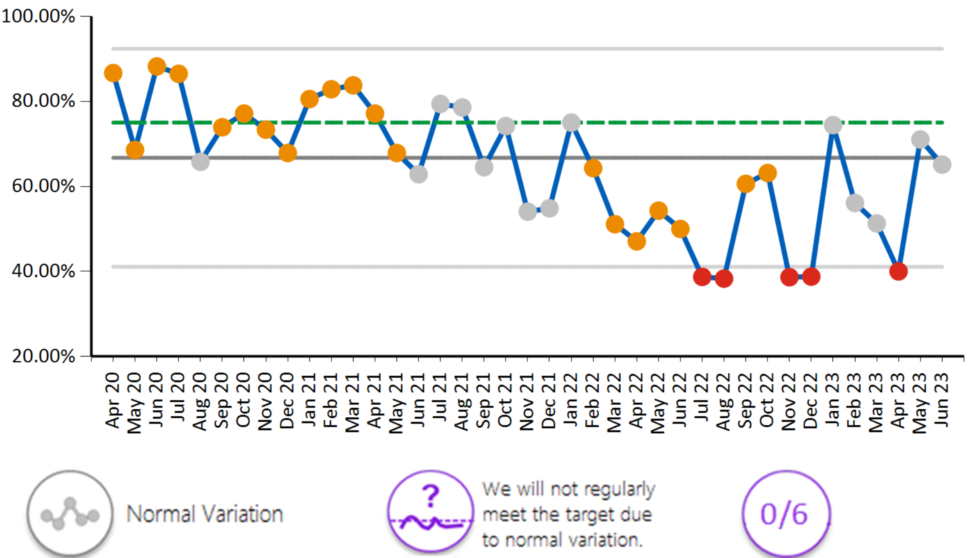
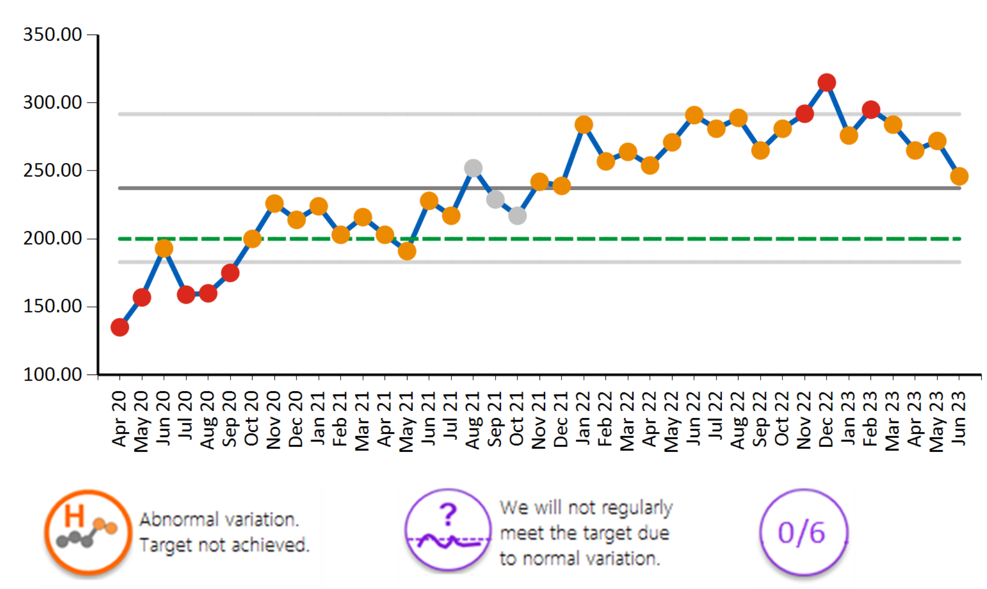
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Normal Variation


539 - A&E 12 hour waits - SPC data available after 20 data points
2000.00
1500.00
1000.00
500.00
0.00
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
0/6

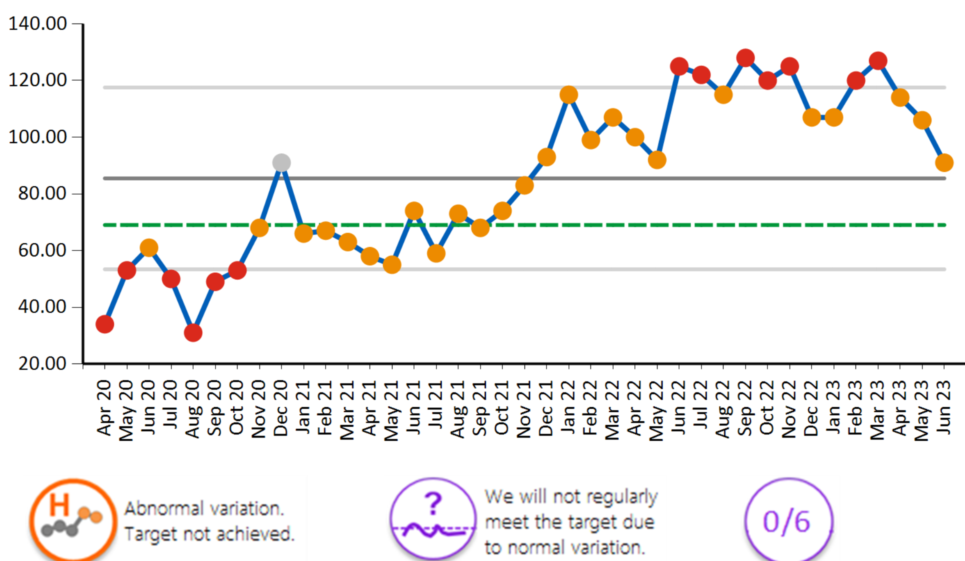
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



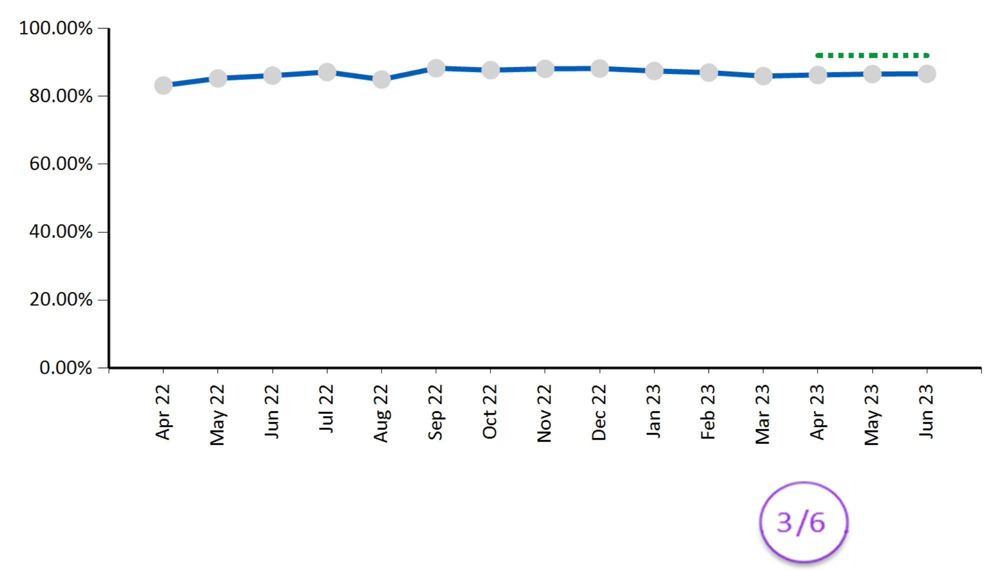
56 - Stranded patients



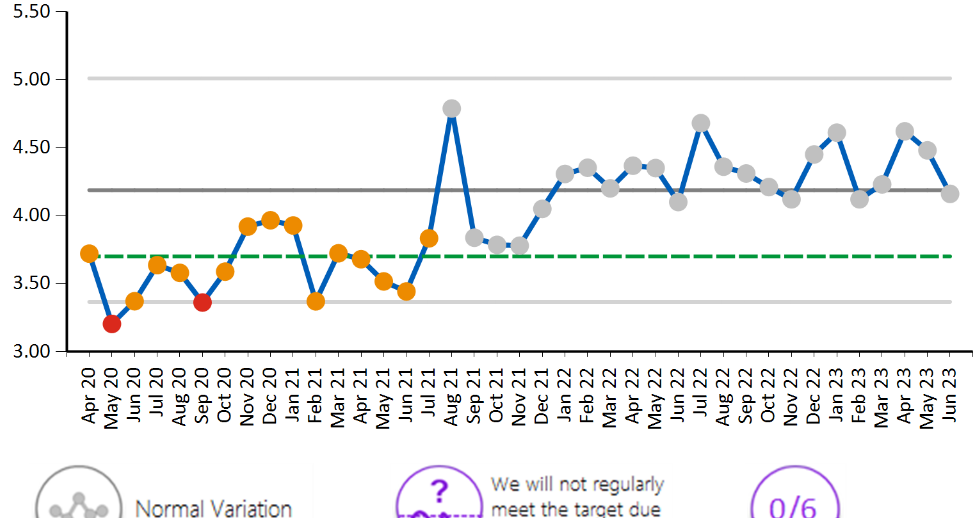
307 - Stranded Patients - LOS 21 days and over



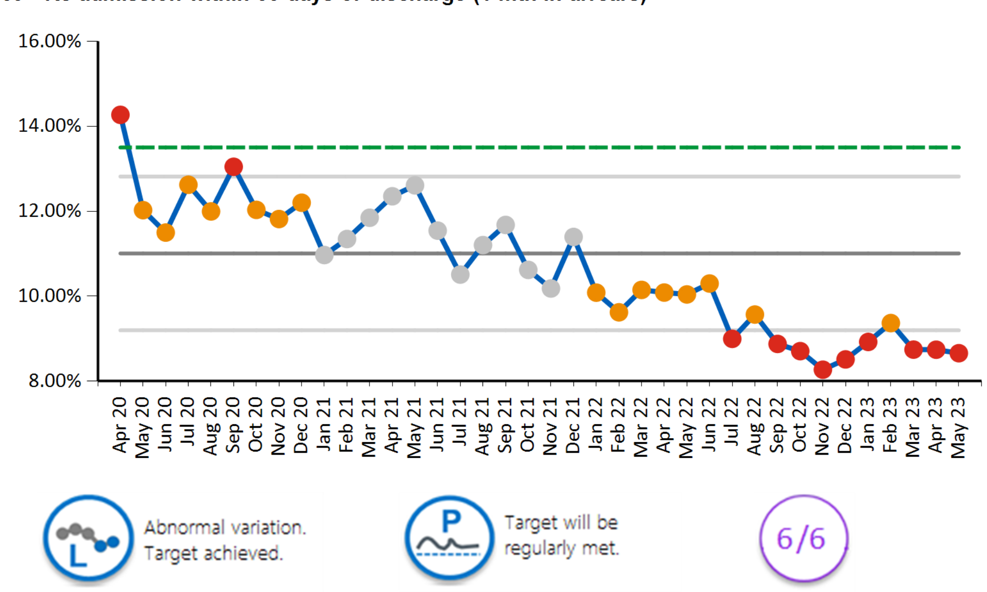
541 - Adult G&A bed occupancy - SPC data available after 20 data points



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



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



Elective Care

Referral to Treatment
We finished June with 33 78-week breaches, of these 8 are awaiting corneal graft material, 18 are due to capacity in Urology and Paediatric Surgery, 3 are due to patient choice and 3 are due to patient clinical complexity We are working with RMCH to put on more paediatric surgery lists where possible and plans are in place to put on additional Urology theatre lists to treat the outstanding Urology patients.

We are making progress against the 65-week milestone plan and delivered over 100% of the submitted operational plans for outpatient first attendance and elective treatments in June despite industrial action.

Diagnostics
The Overall trust position has improved by 7.3% to achieving 85.8% with a further speciality (colonoscopy) now compliant with the DM01 target, and Audiology having made significant progress towards their recovery target. We have seen a positive reduction in both the PTL (by 638 pts) and the number of patients waiting over 6 weeks (303 less patients).

Endoscopy total 28.6%
- Colonoscopy is now compliant reporting a performance measure of 1.6%
- Cystoscopy remains challenging although the waiting List size has reduced. Alternative solutions to support the requirement for additional capacity are currently being explored.

Imaging total 0.0%
- Maintained consistent performance in line with national targets since September 22.

Physiological Measurements total 14.2%
- Cardiology have achieved an increase in performance of 3.4% with a reduction in Waiting List by 151pts and 53 fewer breaches. This service is impacted by clinician capacity, industrial action and clinician sickness so additional capacity is being utilised to address these challenges. The support of an insourcing service is currently being explored to provide the additional capacity required for recovery.
- Audiology have followed the recovery plan and have achieved a 37.4% performance improvement which equates to halving the Waiting list from 650 to 325 pts and reducing breaches from 299 to 28. As a result, recovery should be achieved in September.

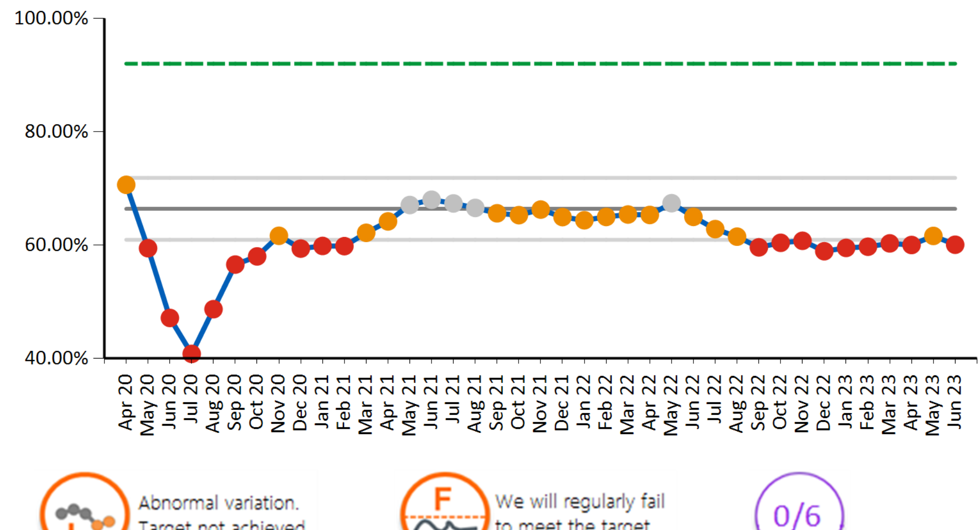
Urodynamics total 48.4%
- Capacity remains an issue for consultant led clinics although this is a small cohort of patients affected. Alternative solutions to support the requirement for additional capacity are currently being explored.

Daycase Rates
We are continuing to consistently meet the day case rate target and are looking at ways to further stretch this performance alongside other productivity improvement for our elective programme.

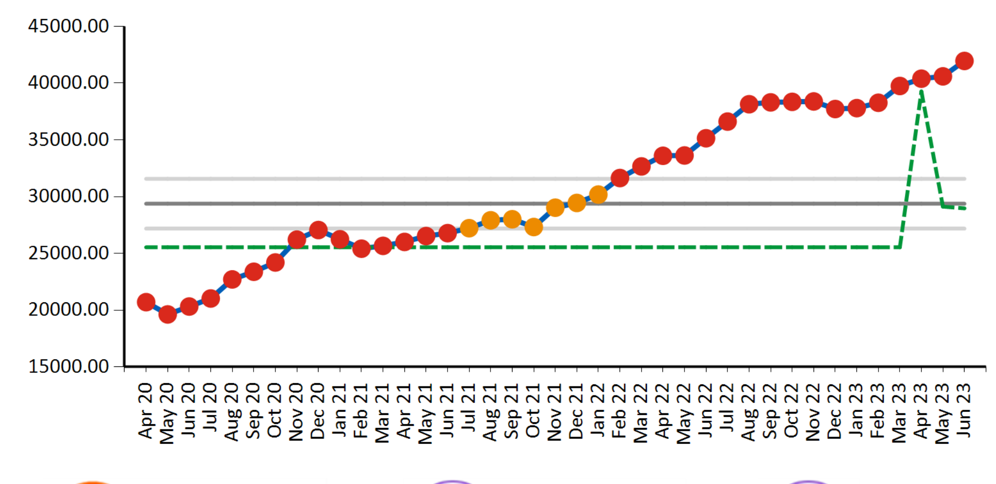
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	60.1%	Jun-23	L	>= 92%	61.6%	May-23	>= 92%	60.6%	F
314 - RTT 18 week waiting list	<= 28,964	41,958	Jun-23	H	<= 29,114	40,597	May-23	<= 28,964	41,958	?
42 - RTT 52 week waits (incomplete pathways)		2,121	Jun-23	H		2,008	May-23		6,040	

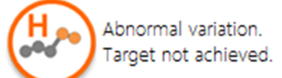
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
540 - RTT 65 week waits (incomplete pathways)	<= 618	554	Jun-23		<= 595	527	May-23	<= 1,806	1,576	
526 - RTT 78 week waits (incomplete pathways)	= 0	32	Jun-23		= 0	33	May-23	= 0	94	
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Jun-23		= 0	0	May-23	= 0	0	
72 - Diagnostic Waits >6 weeks %	<= 5%	14.2%	Jun-23		<= 5%	21.2%	May-23	<= 5%	19.6%	
489 - Daycase Rates	>= 80%	90.8%	Jun-23		>= 80%	91.5%	May-23	>= 80%	91.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.2%	Jun-23		<= 1%	1.9%	May-23	<= 1%	1.6%	
62 - Cancelled operations re-booked within 28 days	= 100%	63.8%	May-23		= 100%	77.1%	Apr-23	= 100%	30.5%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.87	Jun-23		<= 2.00	3.82	May-23	<= 2.00	3.09	

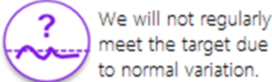
41 - RTT Incomplete pathways within 18 weeks %



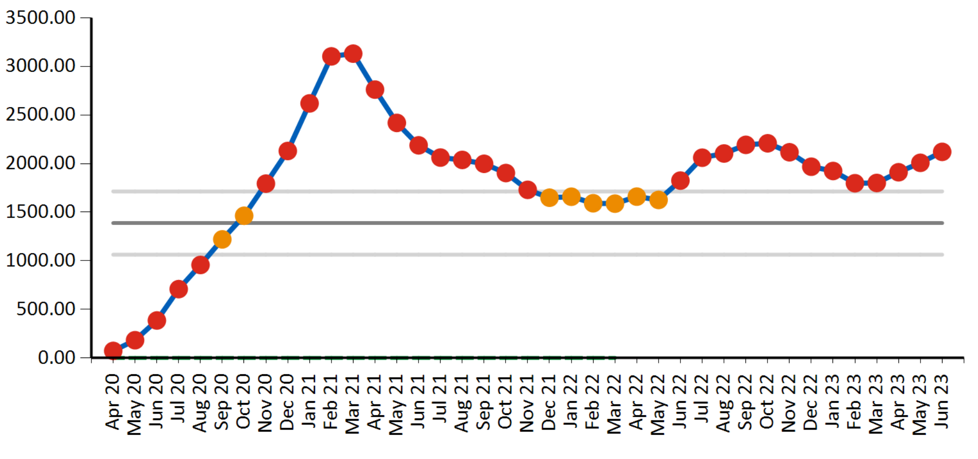
314 - RTT 18 week waiting list





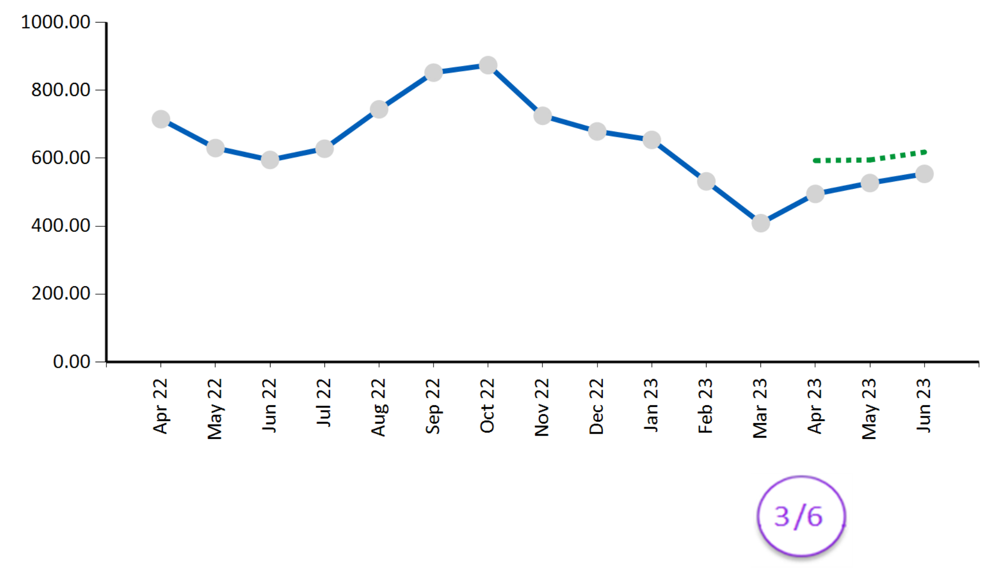


42 - RTT 52 week waits (incomplete pathways)

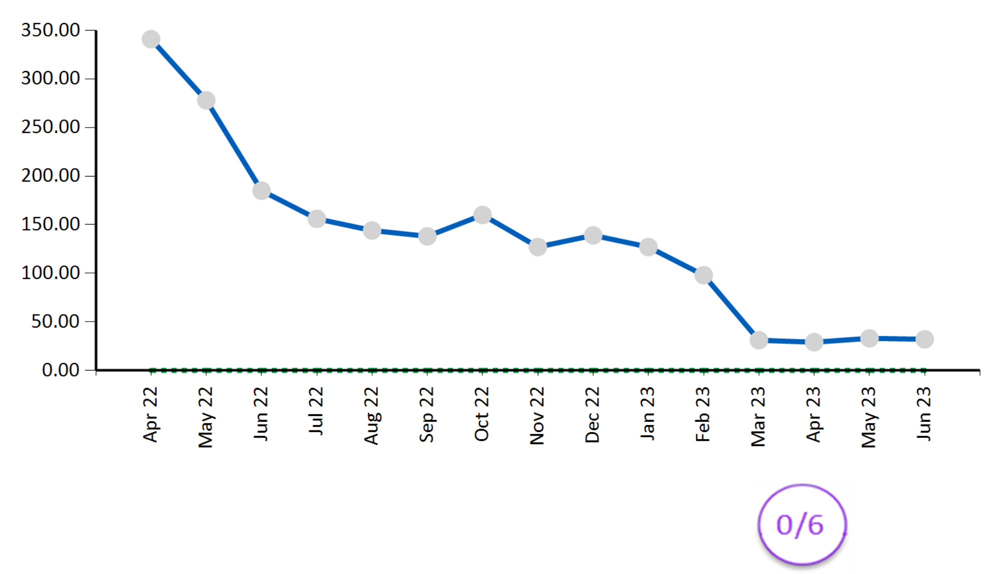


H Abnormal variation. Target not achieved.

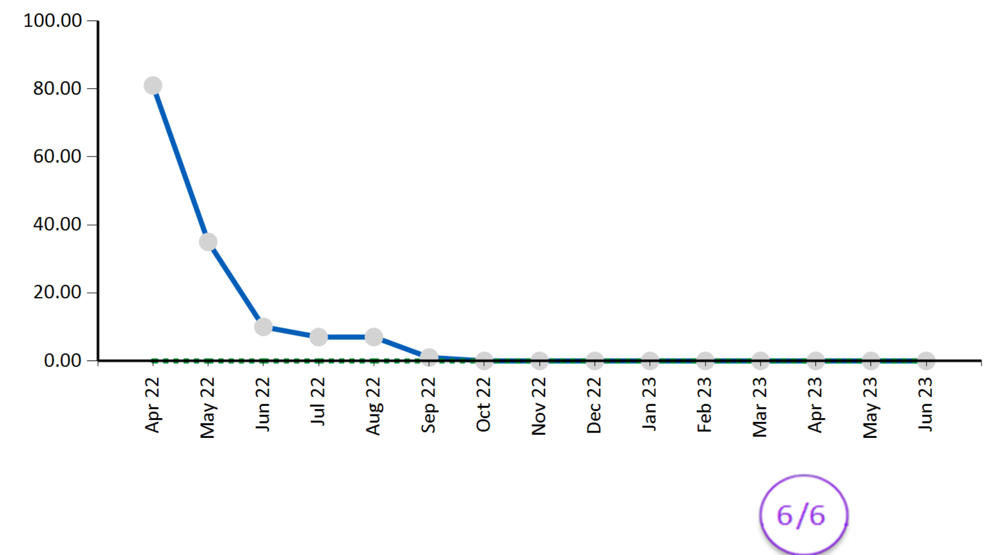
540 - RTT 65 week waits (incomplete pathways) - SPC data available after 20 data points



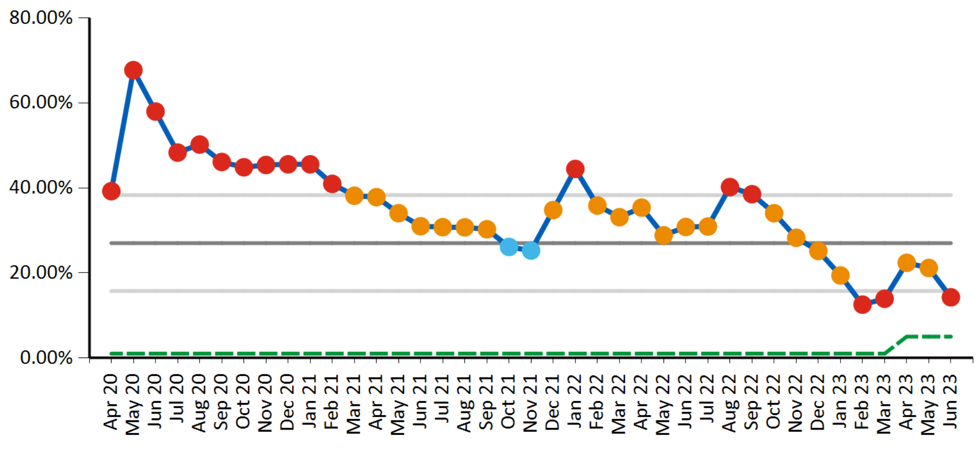
526 - RTT 78 week waits (incomplete pathways) - SPC data available after 20 data points

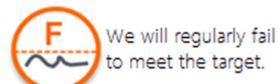


527 - RTT 104 week waits (incomplete pathways) - SPC data available after 20 data points

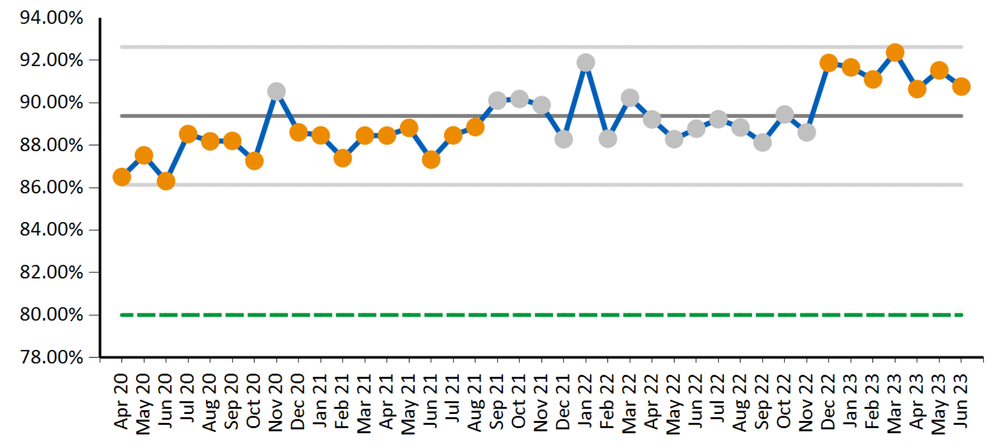


72 - Diagnostic Waits >6 weeks %



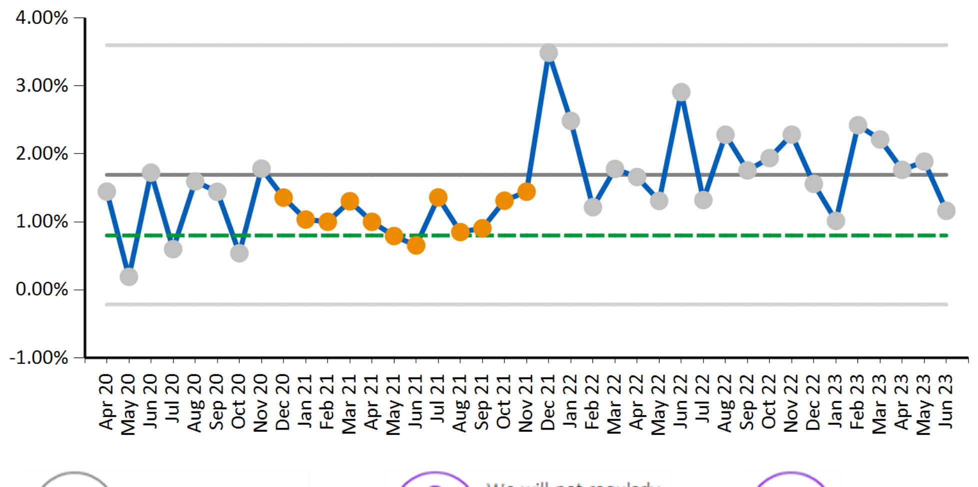


489 - Daycase Rates

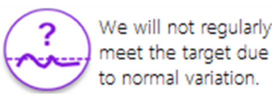


6/6

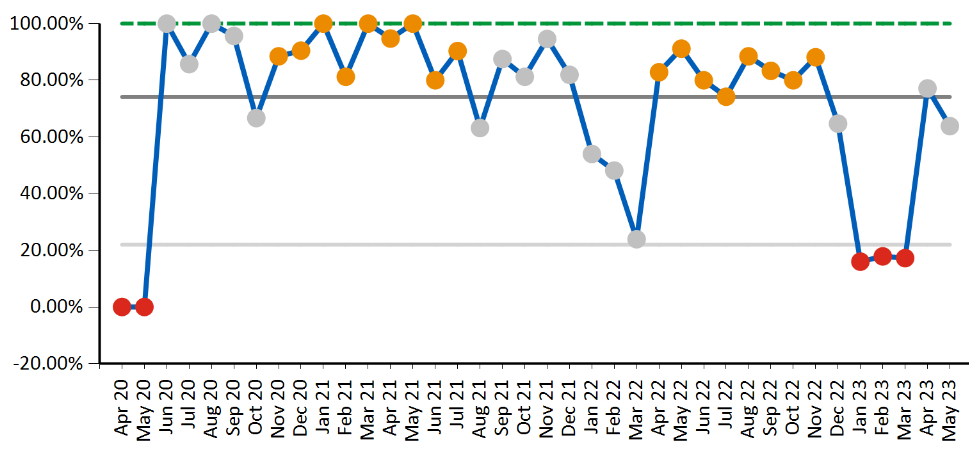
61 - Operations cancelled on the day for non-clinical reasons

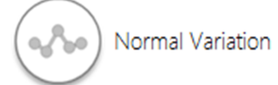


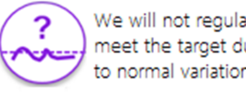
Normal Variation

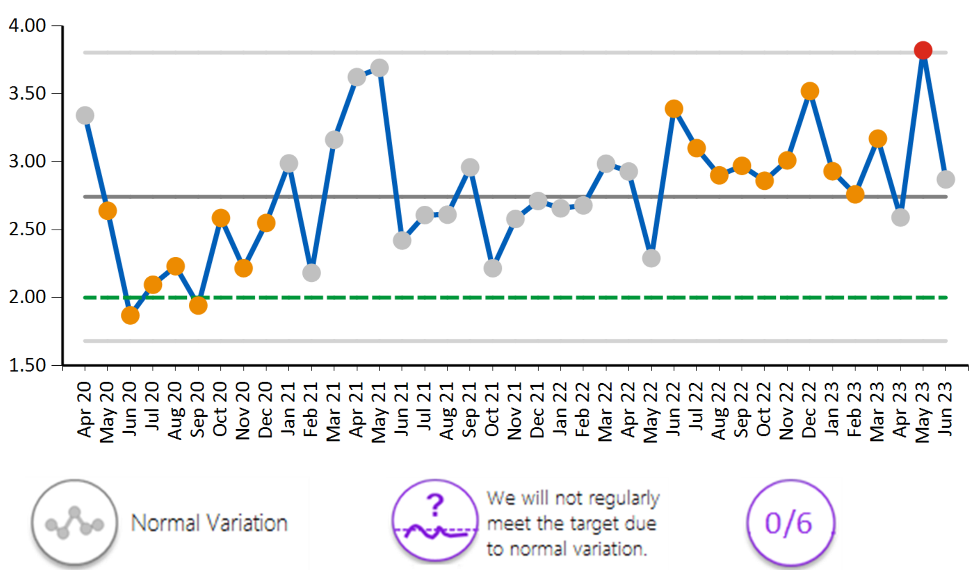


62 - Cancelled operations re-booked within 28 days








65 - Elective Length of Stay (Discharges in month)
4.00
3.50
3.00
2.50
2.00
1.50
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
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Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Normal Variation
?
We will not regularly meet the target due to normal variation.
0/6

Cancer

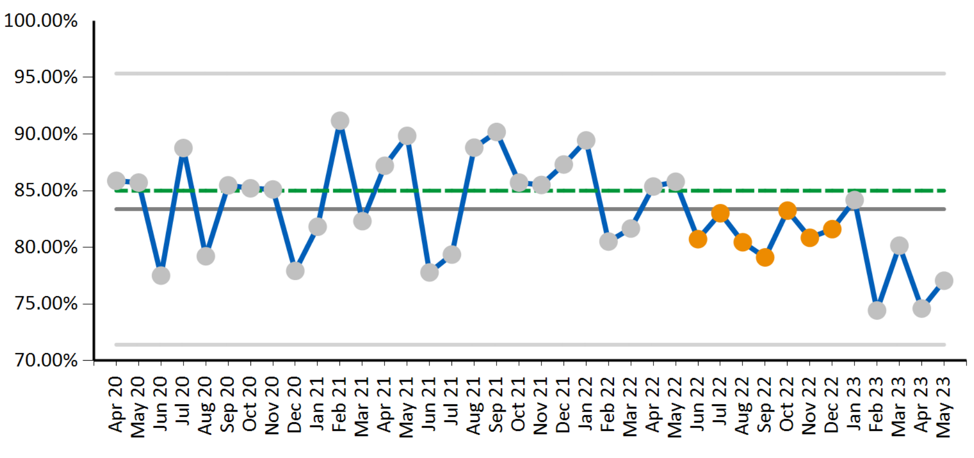
Our 2 week wait performance for May remained static at 77.08% this continues to be largely due to Radiology capacity in Breast services.
We did not achieve the 62-day standard in May, this was again to delays to first appointment in Breast as well as a number of clinically complex patient delays in Colorectal, Gynae and Lung.
Faster diagnosis performance remains below the standard at 66.06% but we are anticipating that this position will improve for June.

We continue to monitor delivery of the trust cancer recovery plan and are working to put on additional capacity in Breast services to recover the waiting times for first appointment.

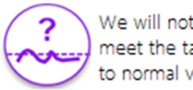
Our 62 day cancer backlog in June was 23 which is an improvement on the target of 28.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	77.0%	May-23		>= 85%	74.6%	Apr-23	>= 85%	75.8%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	86.5%	May-23		>= 90%	73.5%	Apr-23	>= 90%	80.3%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.0%	May-23		>= 96%	97.9%	Apr-23	>= 96%	98.4%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	90.9%	May-23		>= 94%	100.0%	Apr-23	>= 94%	94.1%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	May-23		>= 98%		Apr-23	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	77.9%	May-23	L	>= 93%	77.0%	Apr-23	>= 93%	77.5%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	22.2%	May-23		>= 93%	14.6%	Apr-23	>= 93%	18.9%	F
542 - Cancer: 28 day faster diagnosis	<= 75.0%	66.1%	May-23		<= 75.0%	63.4%	Apr-23	<= 75.0%	64.9%	

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

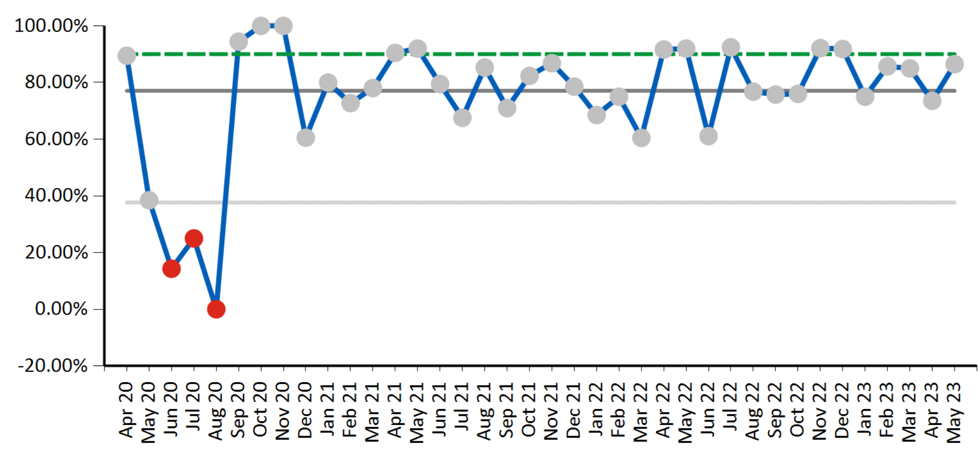


Normal Variation



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

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

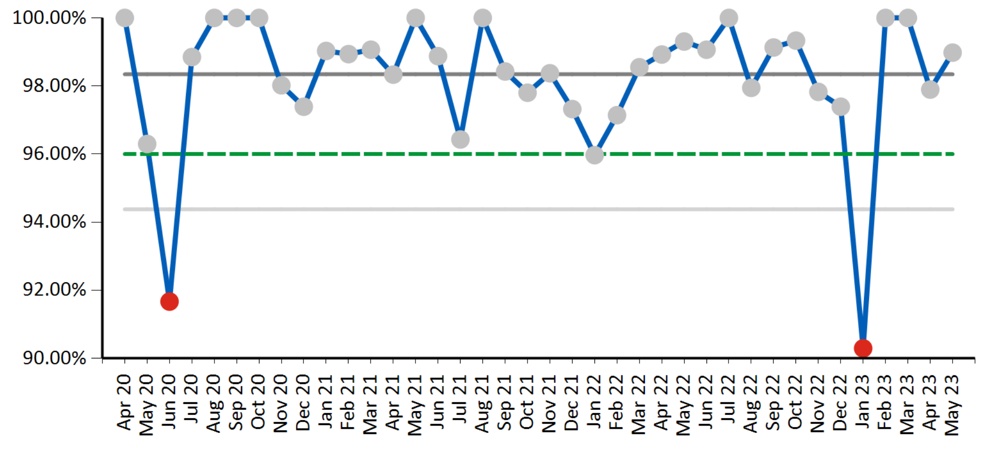


Normal Variation

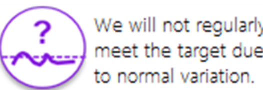
We will not regularly meet the target due to normal variation.

1/6

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



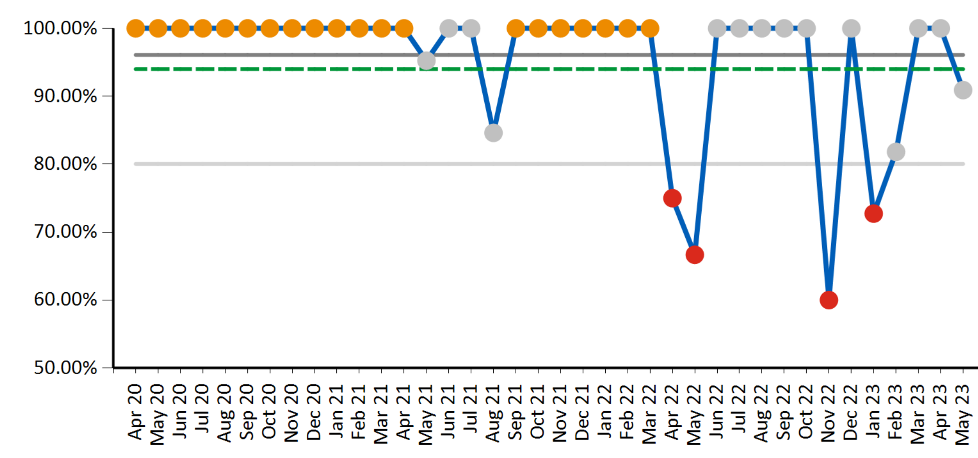
Normal Variation



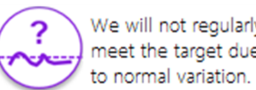
We will not regularly meet the target due to normal variation.

5/6

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

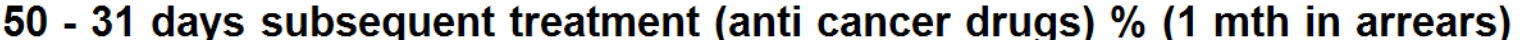


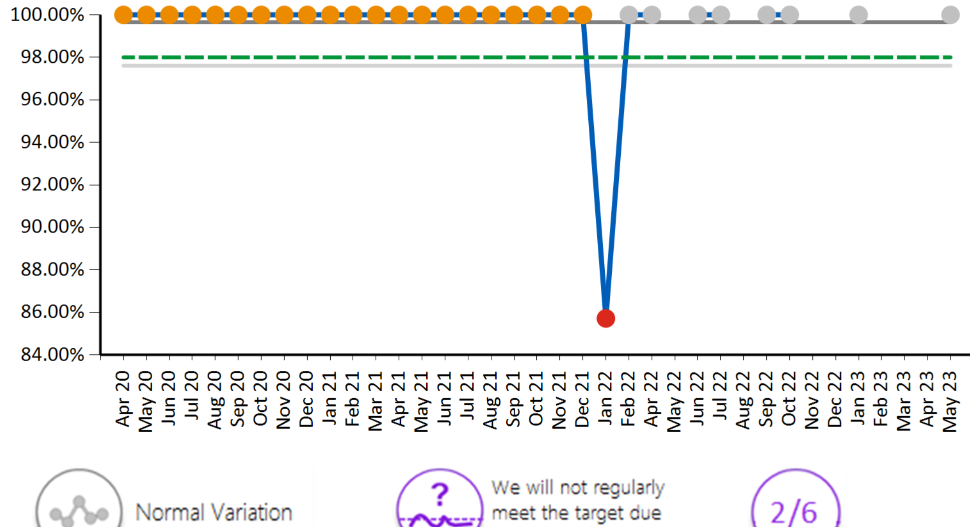
Normal Variation



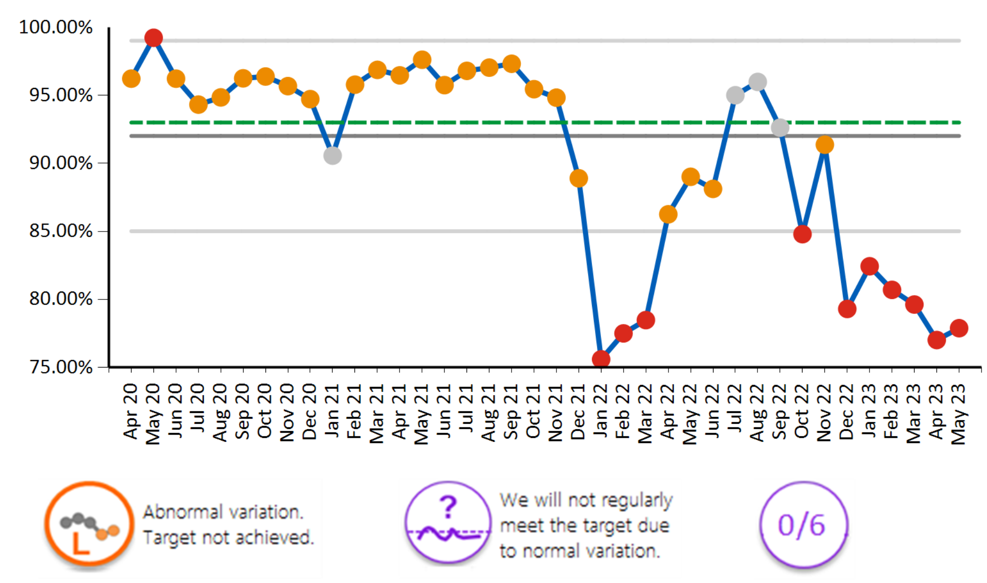
We will not regularly meet the target due to normal variation.

3/6

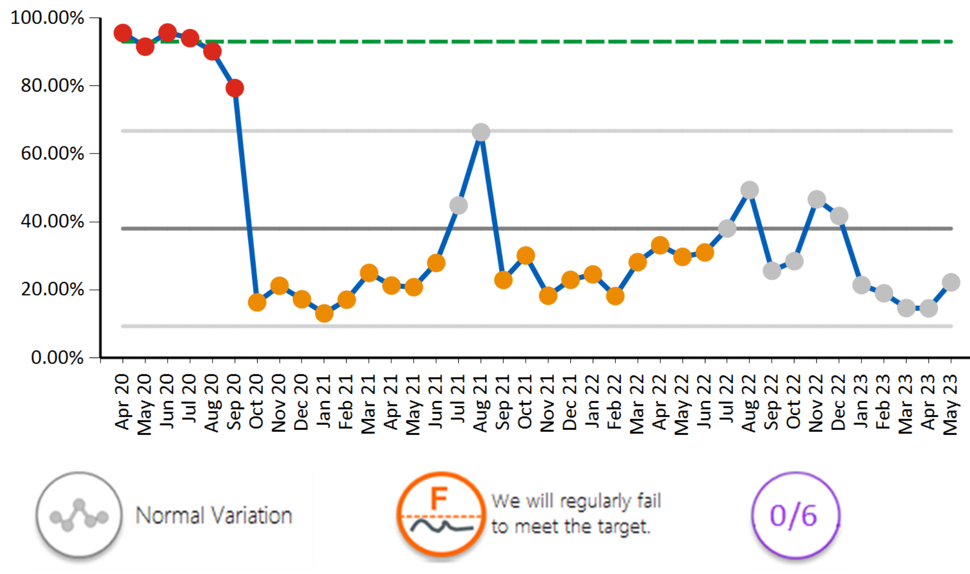




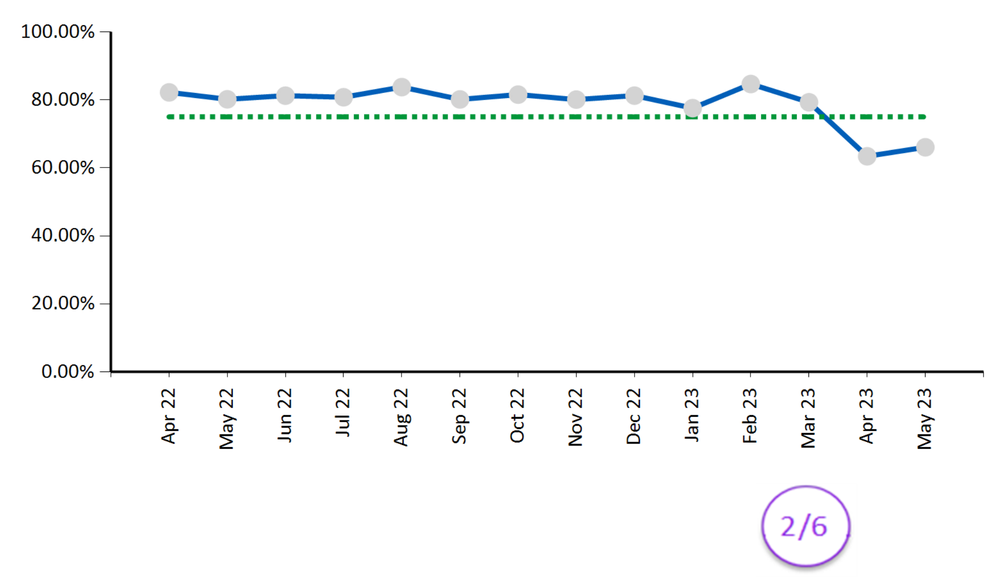
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)



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



542 - Cancer: 28 day faster diagnosis - SPC data available after 20 data points



Community Care

ED deflections
We achieved 496 deflections in month, which is above plan of 400. Focused work remains ongoing to consistently stay above plan of 400 across our Home First and Admission Avoidance teams.

NCTR
The number of patients with No Criteria to Reside (NCTR) has continued to achieve the operational plan in Month 3, with an average of 84 patients in hospital with no criteria to reside.
Average occupied bed days has shown improvement in month from 811 to 575, as anticipated in the previous month with the discharge of a very long staying patient.

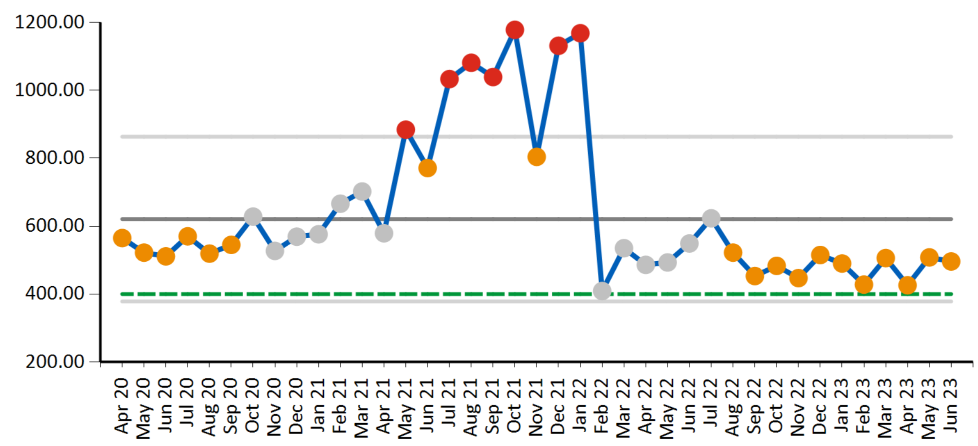
0-5 Health Visitor Mandated Contacts
In June, we have seen a sustained underperformance against the target, with staffing challenges continuing to be the key driver. In order to mitigate the impact, key areas of service delivery are being prioritised. Prioritised service pathways are;
New birth visits – 90.3% June.
6-8 week reviews – 93.8% June
8-12 month assessments – 94.1% June
2-2.5 year assessments – 93.3% June
The main pathway which has been de-prioritised is antenatal visits, where we achieved 36% compliance in June. There is now a plan to recommence antenatal classes which will improve performance. The prioritisation work has meant that while overall performance for health visitor mandated contacts is below the target, the high risk pathways have been protected as far as possible and are close to the standard.

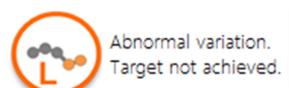
EHCP compliance
In June, we saw a performance of, a deterioration from 86.30% in May. The key driver for the underperformance are delays in paperwork for out of area referrals and staffing challenges within AHP teams. Work is ongoing with ICB colleagues to improve processes for initial appointment following request. Staffing pressures in our AHP teams are improving. These measures mean that we are expecting improved performance for July.

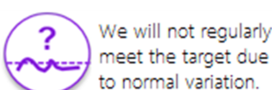
Looked After Children
In June, we saw strong performance (100%) for Initial Health Assessments. With regards to review health assessments, for 0-5 years these are undertaken twice a year by health visitors, for 5 -18 years these are undertaken yearly by school nurses. Compliance for May was 83.6%, with drivers for underperformance being delays to paperwork and non-attendance at appointments.

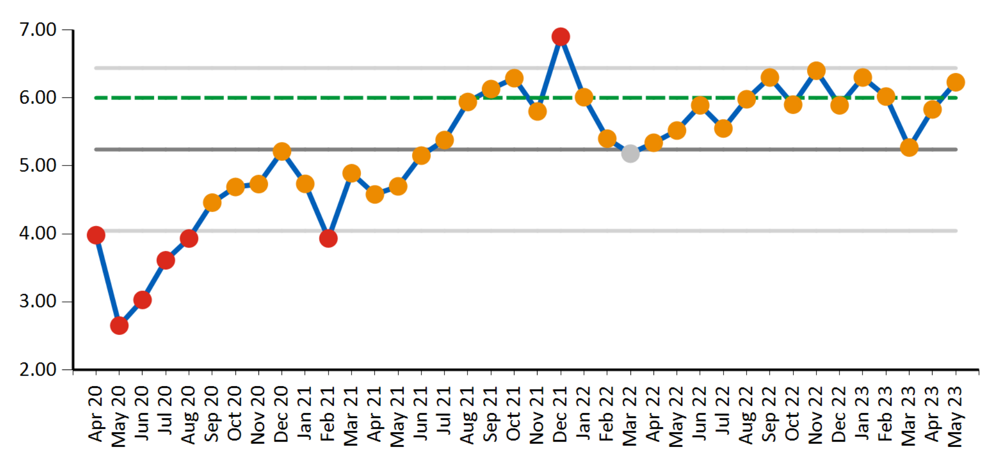
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	496	Jun-23	L	>= 400	508	May-23	>= 1,200	1,430	?
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	6.23	May-23	H	<= 6.00	5.83	Apr-23	<= 6.00	6.23	?
493 - Average Number of Patients: with no Criteria to Reside	<= 55	84	Jun-23		<= 55	90	May-23	<= 55	84	F
494 - Average Occupied Days - for no Criteria to Reside	<= 400	575	Jun-23		<= 400	811	May-23	<= 1,200	2,180	?

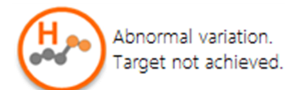
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
267 - 0-5 Health Visitor mandated contacts	>= 95%	77%	Jun-23		>= 95%	76%	May-23	>= 95%	78%	
269 - Education, health and care plan (EHC) compliance	>= 95%	74%	Jun-23		>= 95%	86%	May-23	>= 95%	84%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse		89.0%	Jun-23			83.0%	May-23			
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales		100.0%	Jun-23			76.0%	May-23			
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools		67.0%	Jun-23			100.0%	May-23			

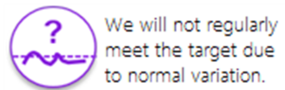






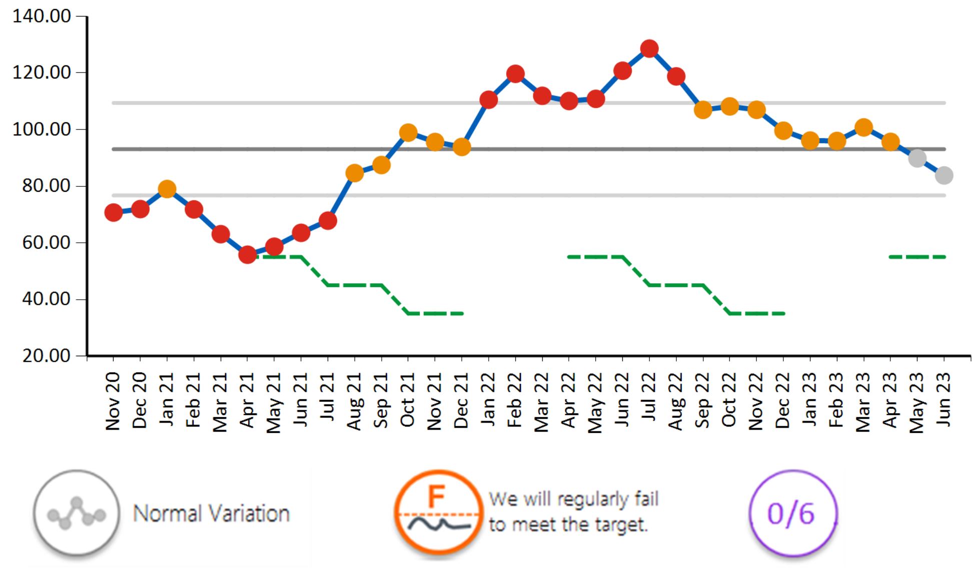




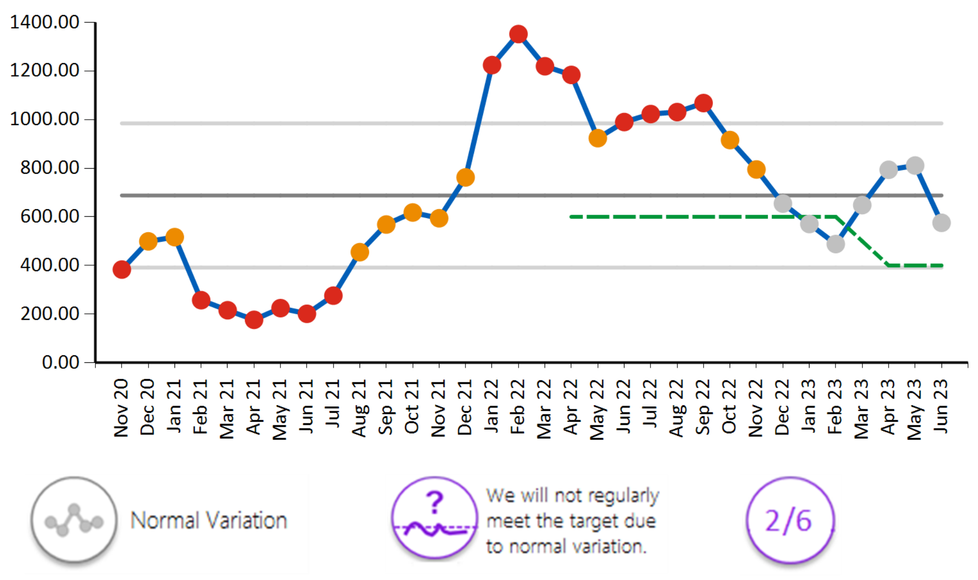


3/6

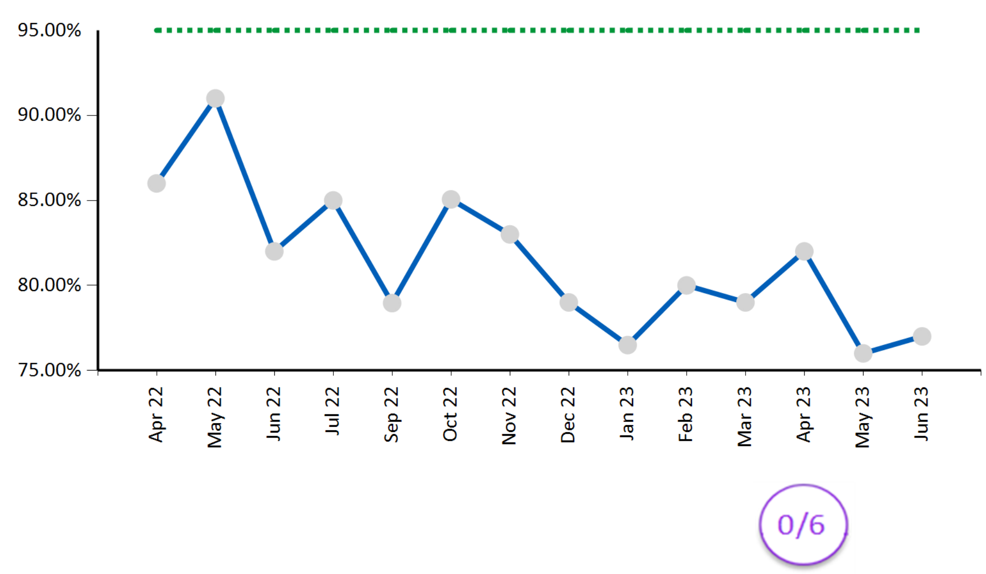
493 - Average Number of Patients: with no Criteria to Reside



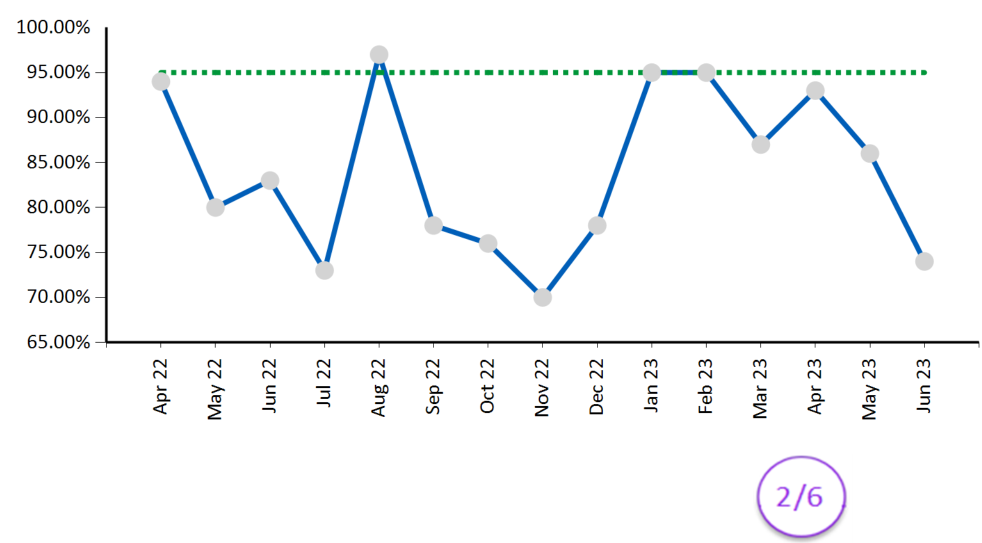
494 - Average Occupied Days - for no Criteria to Reside



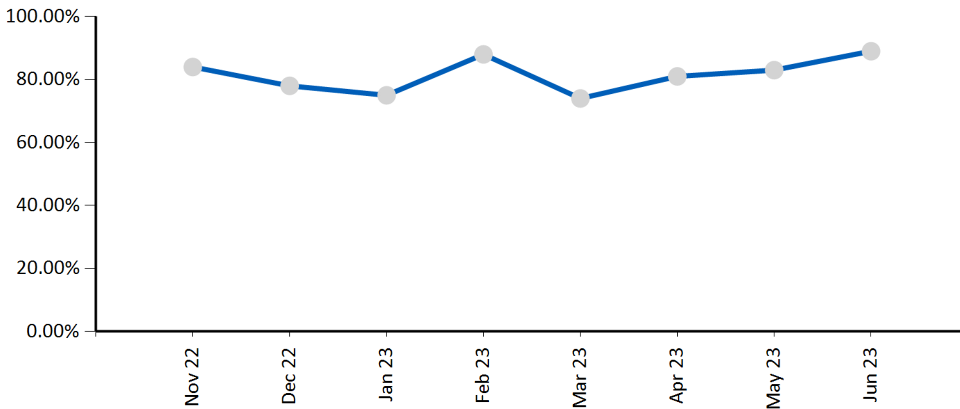
267 - 0-5 Health Visitor mandated contacts - SPC data available after 20 data points



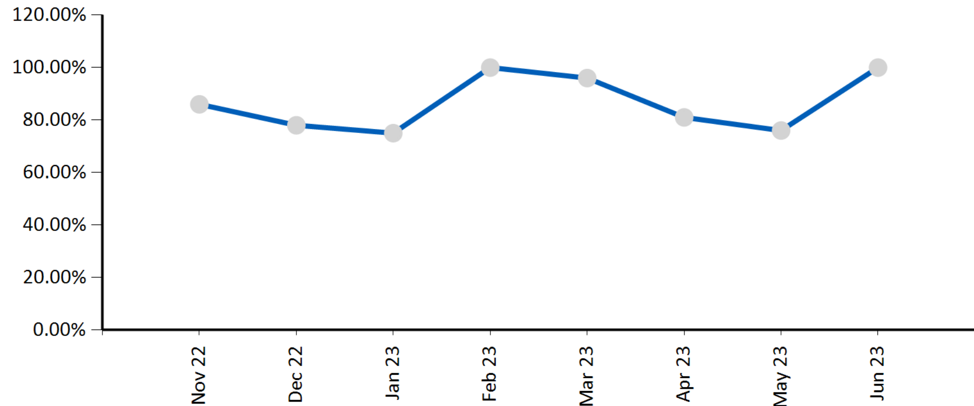
269 - Education, health and care plan (EHC) compliance - SPC data available after 20 data points



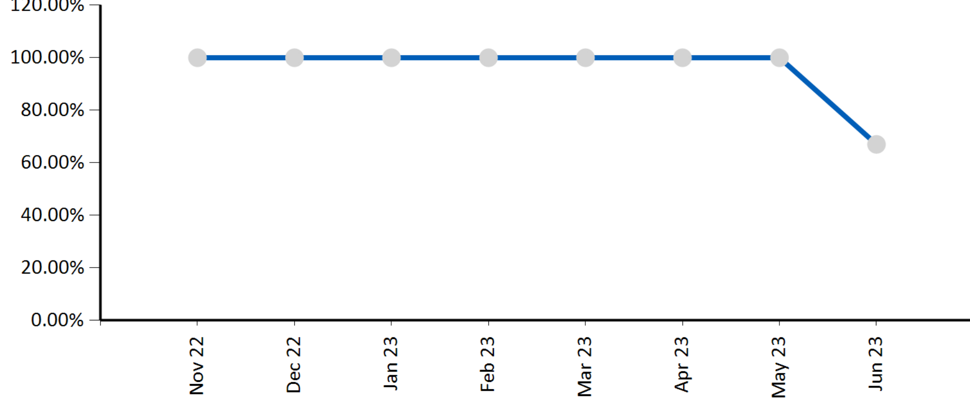
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse - SPC data available after 20 data points



551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales - SPC data available after 20 data points



552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools - SPC data available after 20 data points



Workforce

Sickness, Vacancy and Turnover

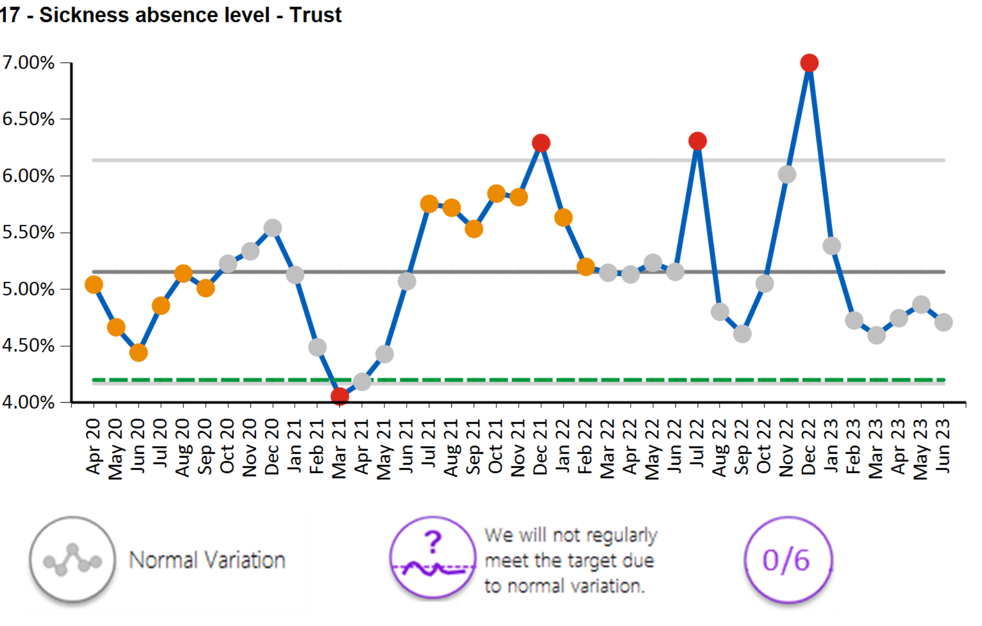
Sickness has reduced slightly in June 2023 to 4.71% from 4.87% in May 2023. The AACD and ICSD Divisions have seen a significant reductions in their levels of absence (0.85% and 0.96% reductions respectively) with a reduction also seen within ASSD. The rates of Covid related absence has reduced across all Divisions and now stands at 0.12% in June 2023.

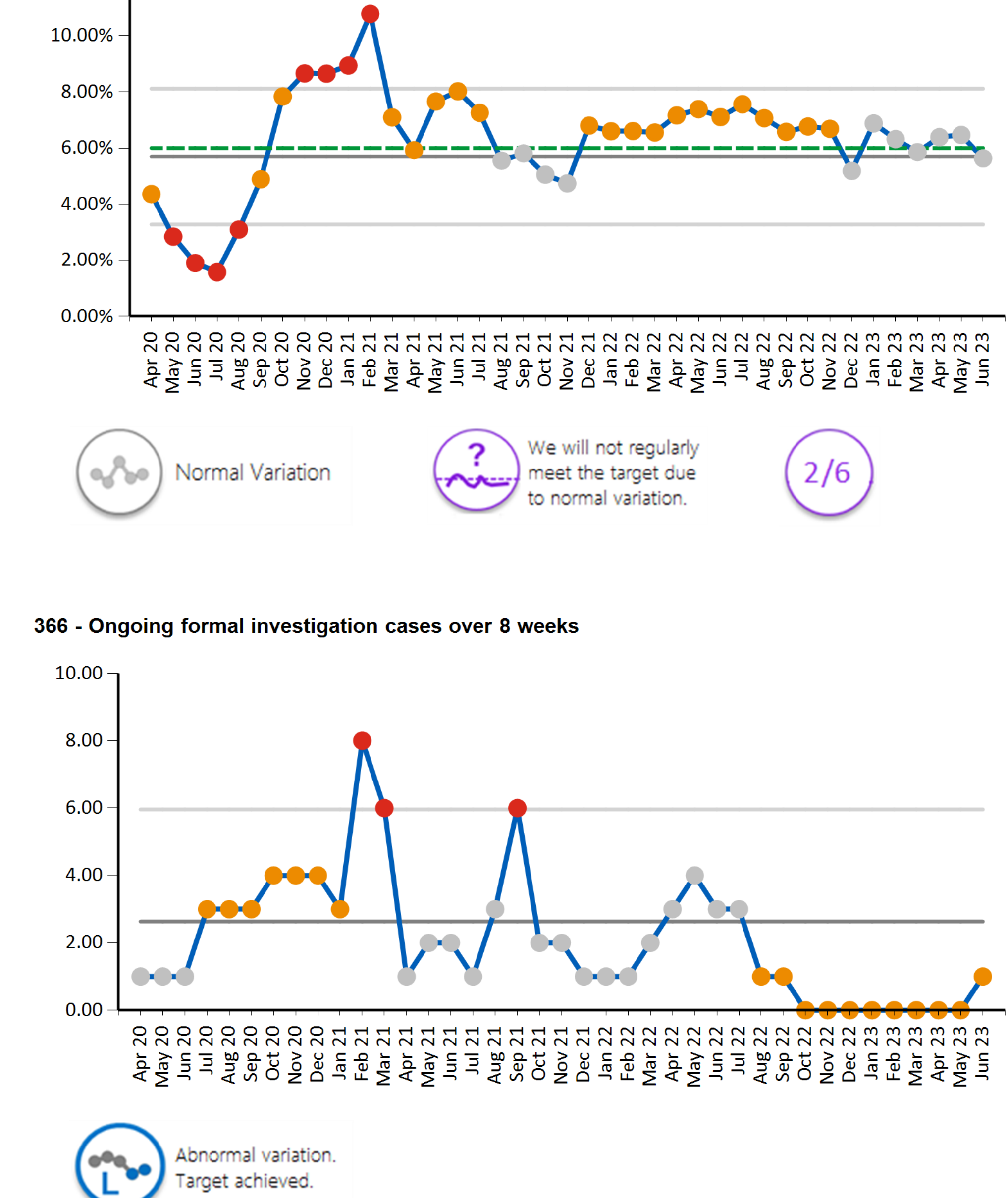
Trust vacancy rates are currently tracking at slightly better than target, and benchmark competitively to other regional and national providers; due to the strong recruitment work underway across the Trust we are hopeful of an improving vacancy position going forward.

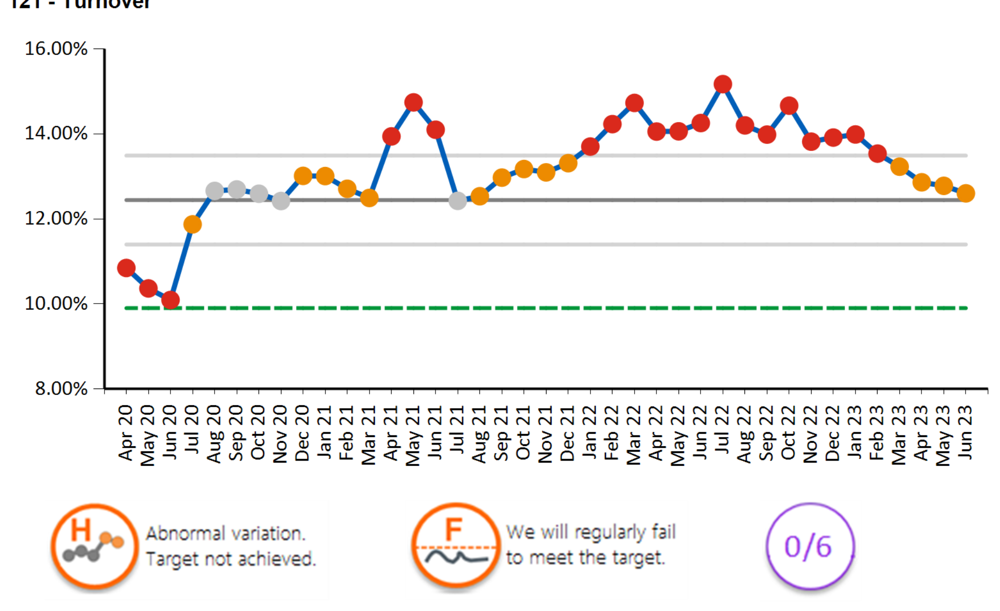
Turnover has reduced further in June now standing at 12.60% from 12.78% in May 23, and is the fifth consecutive month of reducing turnover to the lowest level of turnover in the last 12 months. Turnover remains a focus with the Trust's new People Plan and Divisions will continue to support the reduction in turnover and increased retention of colleagues.

The Trust has seen one HR investigation breach the internal 8 week standard, this is due to the complexity and number of individuals involved. This investigation has now concluded.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.71%	Jun-23		<= 4.20%	4.87%	May-23	<= 4.20%	4.77%	?
120 - Vacancy level - Trust	<= 6%	5.63%	Jun-23		<= 6%	6.46%	May-23	<= 6%	6.16%	?
121 - Turnover	<= 9.90%	12.60%	Jun-23	H	<= 9.90%	12.78%	May-23	<= 9.90%	12.75%	F
366 - Ongoing formal investigation cases over 8 weeks		1	Jun-23	L		0	May-23		1	


117 - Sickness absence level - Trust
7.00%
6.50%
6.00%
5.50%
5.00%
4.50%
4.00%
Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
Normal Variation
?
We will not regularly meet the target due to normal variation.
0/6

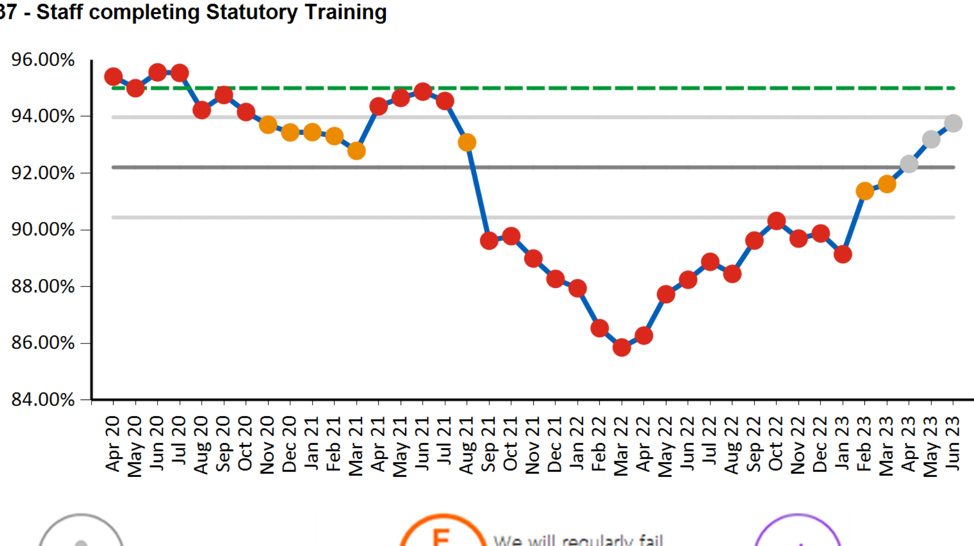

120 - Vacancy level - Trust
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
Normal Variation
?
We will not regularly meet the target due to normal variation.
2/6
366 - Ongoing formal investigation cases over 8 weeks
10.00
8.00
6.00
4.00
2.00
0.00
Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
L
Abnormal variation. Target achieved.


121 - Turnover
16.00%
14.00%
12.00%
10.00%
8.00%
Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
H
Abnormal variation. Target not achieved.
F
We will regularly fail to meet the target.
0/6

Organisational Development

The Trust's overall compliance level for mandatory training was 86.7% (a 1% increase since last month and above our corporate target of 85%) and statutory training was 92% (a 0.7% increase from last month and below our corporate target of 95%). We continue to place great focus on completion and there are agreed targets in place per division; with an update paper going to People Committee in September, which will include a MAST improvement action plan. Appraisal compliance has seen a minor increase this month and remains performing well.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	93.8%	Jun-23		>= 95%	93.2%	May-23	>= 95%	93.1%	F
38 - Staff completing Mandatory Training	>= 85%	89.3%	Jun-23	L	>= 85%	88.2%	May-23	>= 85%	87.9%	P
39 - Staff completing Safeguarding Training	>= 95%	94.83%	Jun-23		>= 95%	94.66%	May-23	>= 95%	94.42%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	86.8%	Jun-23	H	>= 85%	87.6%	May-23	>= 85%	86.6%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	62.0%	Q3 2022/23		>= 66%	72.8%	Q2 2022/23	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	60.3%	Q3 2022/23		>= 80%	73.3%	Q2 2022/23	>= 80%		F


37 - Staff completing Statutory Training
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
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May 22
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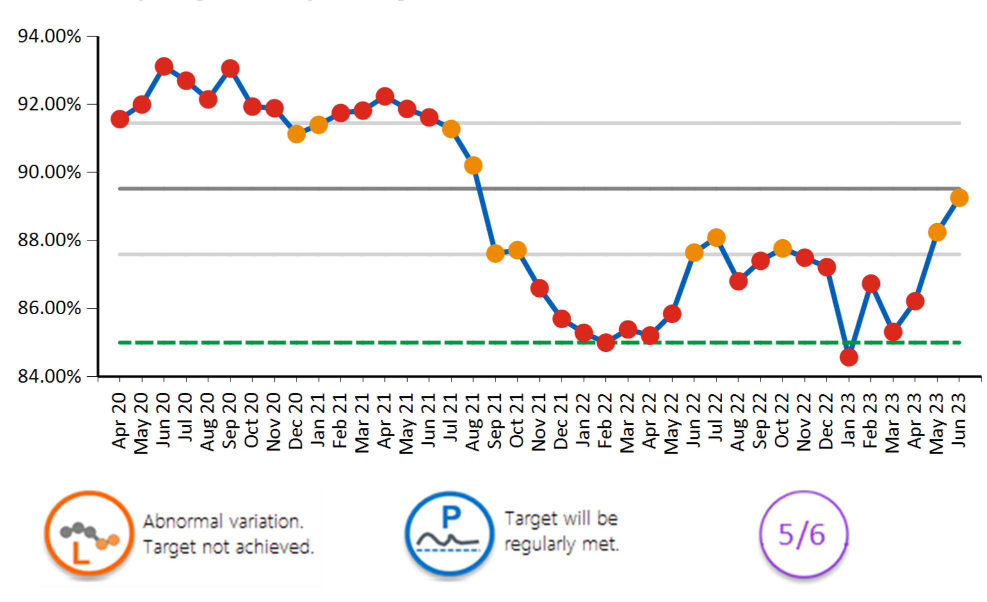
Apr 23
May 23
Jun 23
Normal Variation
F
We will regularly fail to meet the target.
0/6


38 - Staff completing Mandatory Training
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
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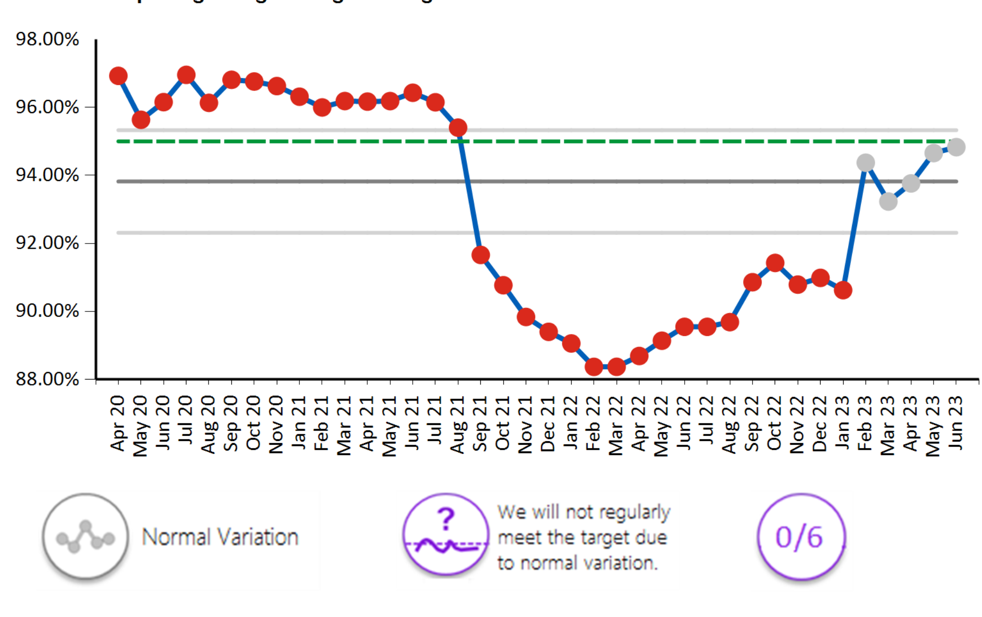
Jun 23
L
Abnormal variation. Target not achieved.
P
Target will be regularly met.
5/6


39 - Staff completing Safeguarding Training
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
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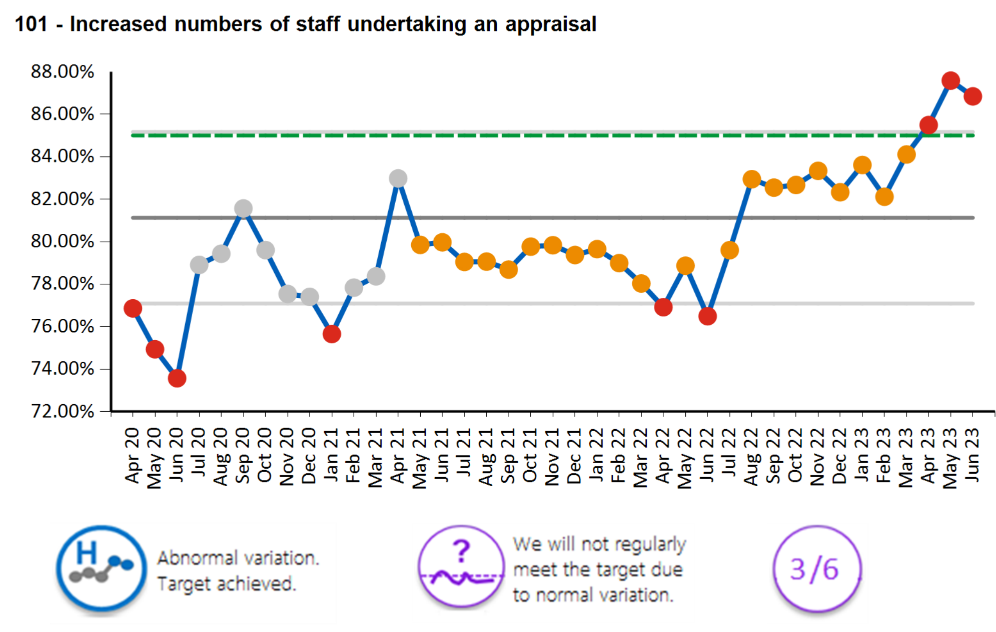
Jun 23
Normal Variation
?
We will not regularly meet the target due to normal variation.
0/6


101 - Increased numbers of staff undertaking an appraisal
88.00%
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
74.00%
72.00%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
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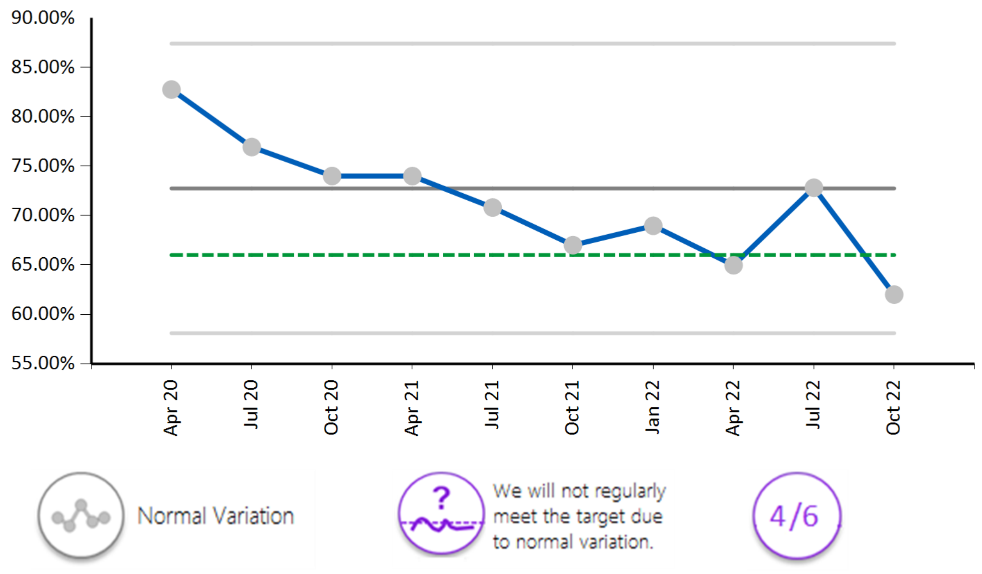
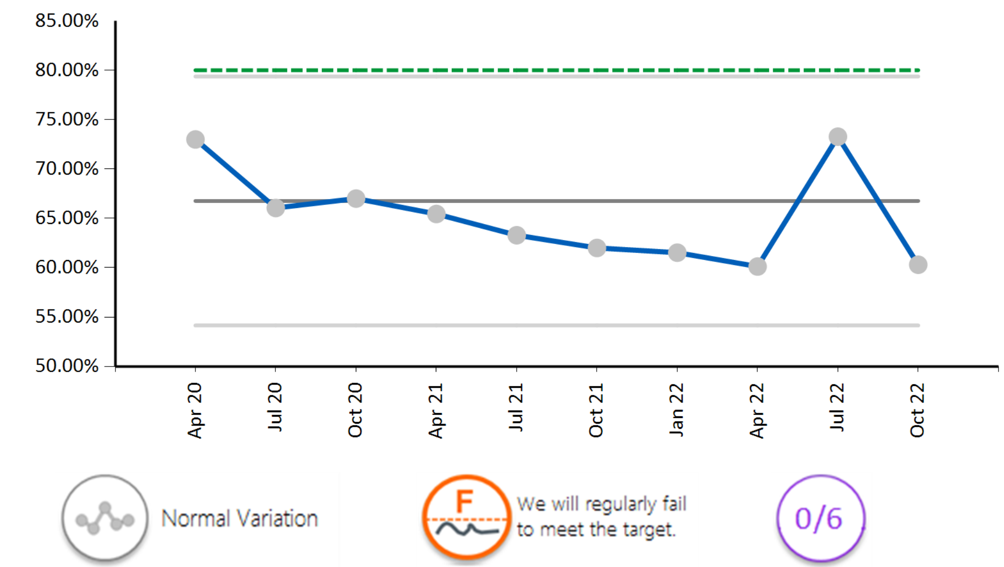
Feb 23
Mar 23
Apr 23
May 23
Jun 23
H
Abnormal variation. Target achieved.
?
We will not regularly meet the target due to normal variation.
3/6

78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears



79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)



Agency

Agency spend reduced in June 2023 by £123k when compared to May 2023. This includes a sustained reduction in nursing agency spending, and reduction of spend in-month on medical agency staffing. Trust cumulative agency spending for the financial year to date is £1.17m above our forecasted plan for the same period, and industrial action and the opening of additional capacity have affected this.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.99	1.34	Jun-23		<= 0.99	1.46	May-23	<= 2.98	4.12	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.48	0.50	Jun-23		<= 0.48	0.54	May-23	<= 1.44	1.57	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.39	0.71	Jun-23	H	<= 0.39	0.78	May-23	<= 1.18	2.25	

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

2.00
1.50
1.00
0.50
0.00

Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23

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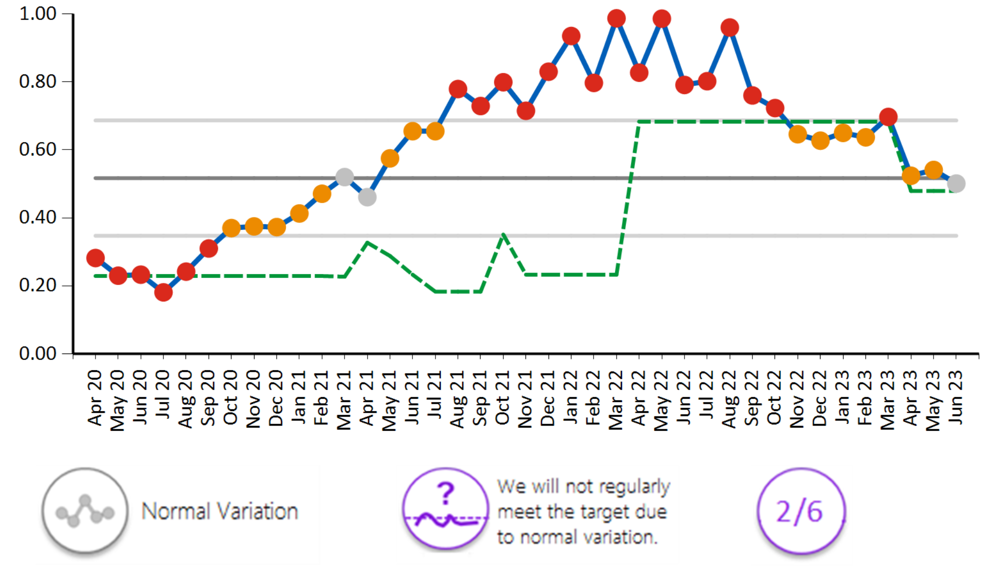
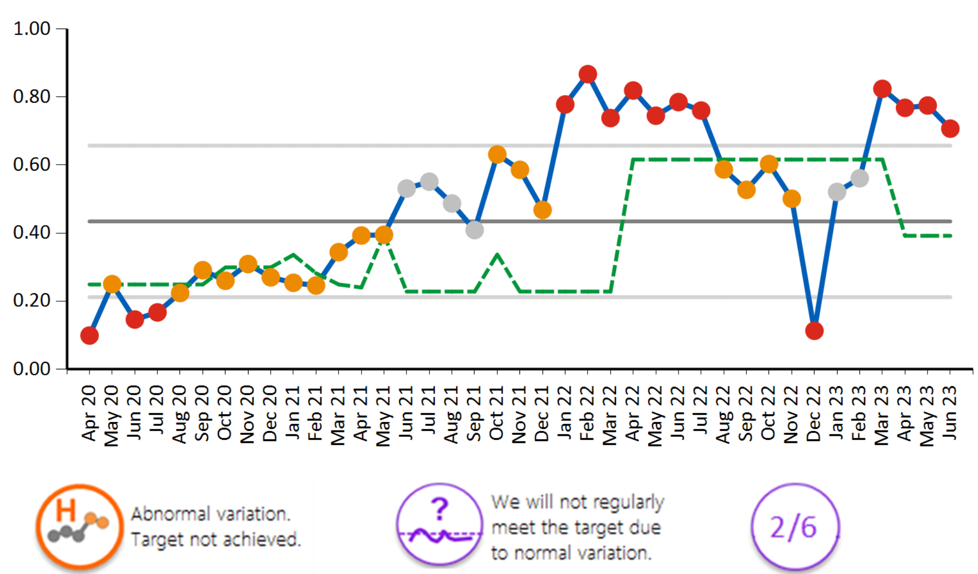
111 - Annual ceiling for Nursing Staff agency spend (£m)



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



Finance

Finance

Revenue – In Month and Year to date
The Trust has a deficit plan of £12.5m for 2023/24. In month 3, the Trust recorded a year to date deficit of £4.7m compared to a planned deficit of £3.2m.
Unidentified CIP remains a significant issue, as only £2.1m has been delivered against a target of £4.8m, leaving a shortfall of £2.7m.

Revenue -Forecast
The probable forecast scenario by March 2024 is a deficit of £18.6m against a plan of £12.4m, which is an improvement from the previous month forecast. This assumes £11m of CIP savings against a target of £19.3m.
It is unlikely that the Trust will deliver its financial plan without additional income or reductions in service delivery.

Cost Improvement
The Trust has cost improvement target of 4% (£19.3m) for 2023/24.
CIP trackers currently show that £2.1m has been delivered against a year to date target of £4.8m.
£12.2m of CIP delivery is currently forecasted, with £5.1m of this is marked as 'Delivered' or 'Green' on the trackers.

Variable Pay
The Trust spent £4.5m on variable pay in month 3 compared to a monthly average of £4.1m in 2022/23.
The trust is required to spend no more than 3.7% of total pay costs on agency in 2023/24, which is £1m per month. A total of £1.3m was spent on agency in Month 3, representing 4.8% of total pay costs in month.

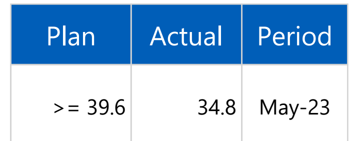
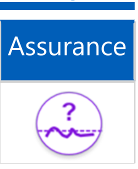
Capital
The Trust has a planned capital spend for 2023/24 of £21.5m. Year to date capital spend to the end of month 3 was £0.6m.
We are currently forecasting a capital overspend of £6m and working with divisions to reduce the risk.

Balance Sheet
Decrease in total assets employed of £4.7m due to the revenue deficit.
Total aged debt is £4.6m, which is a £1m improvement on last month.
Loans outstanding of £35.7m.

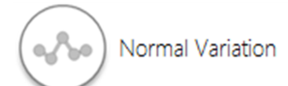
Cash Position
The month end cash balance was £36.3m, which is a slight increase from last month.

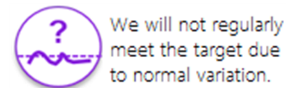
Better Payment Practices Code
Performance of 88.9% in month against target of 95%. Year to date performance by value is 84.1%, which is a slight improvement from the previous month.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.0	1.1	Jun-23		>= -1.0	1.8	May-23	>= -3.1	4.7	
222 - Capital (£ millions)	>= 0.7	0.3	Jun-23		>= 0.7	0.2	May-23	>= 2.2	0.6	

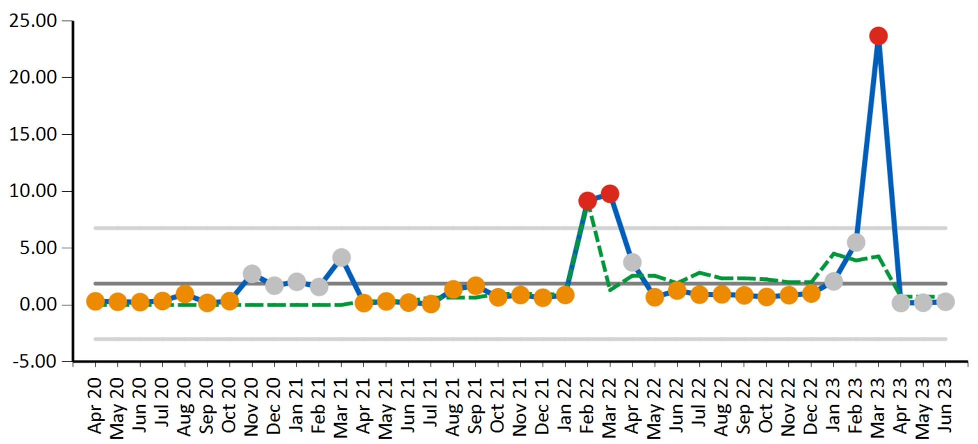
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
223 - Cash (£ millions)	>= 37.5	36.3	Jun-23		>= 39.6	34.8	May-23	>= 37.5	36.3	

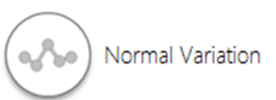
220 - Control Total (£ millions)

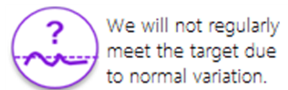




222 - Capital (£ millions)







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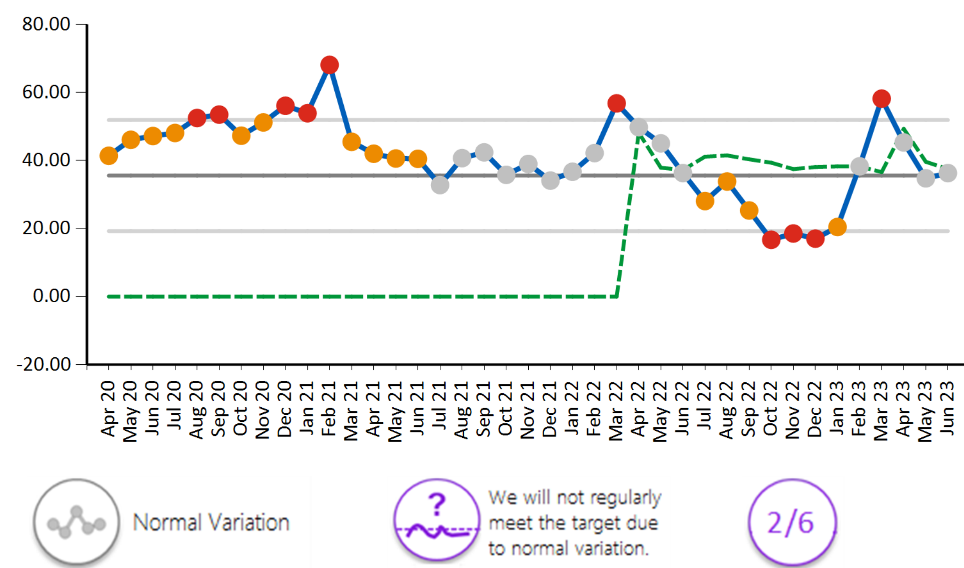
223 - Cash (£ millions)



Report Title:	Freedom to Speak Up Annual Report 2022-23

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	James Mawrey		Decision	

Purpose	This report provides an annual update on Freedom to Speak Up (FTSU) activity within the Trust during the period from 1st April 2022 to 31st March 2023.

Summary:	Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement. The Trust's FTSU approach continues to be embedded to support the organisation to develop an inclusive and transparent culture.

Previously considered by:
The report was presented and discussed at the People Committee who commend the report to the Trust Board

Proposed Resolution	The Board is asked to **receive and approve t**he Freedom to Speak Up Annual Report 2022-23 as assurance of the effectiveness of speaking up arrangements in place across the Trust**.**

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

Prepared by:	Tracey Garde, FTSU Guardian	**Presented by:**	Tracey Garde, FTSU Guardian

1. Introduction

1.1 Effective speaking up arrangements help us to protect our patients and improve the experience of our workers. Making sure all our workers have a voice and feel safe and able to speak up about anything that gets in the way of providing safe, high quality care or affects their workplace experience. This includes matters relating to patient safety, the quality of patient care and the culture within the working environment. To support this, managers need to feel comfortable having decisions and authority challenged. Speaking up and the matters that the issues highlighted, however difficult to hear, should be welcomed and looked at as opportunities for learning and development.

The behaviour of senior leaders, executives and non-executives has the biggest impact on organisational culture. How an executive director or senior manager handles a matter raised by a worker is a strong indicator of a trusts speaking up culture and how well led it is.

FTSU Guardians are an additional route for workers to speak up- but they cannot improve the speak up culture on their own. Research shows that taking a proactive approach to ensuring the health and well-being of workers and a preventative approach to poor behaviours such as bullying, harassment and incivility will have the greatest impact on the working environment. Leading by example and creating a fair, open and inclusive workplace will also have a positive impact on culture.

1.2 In July 2022 we welcomed an additional FTSU Guardian- Rachel Adamson. Rachel works 3 days a week opposite fellow Guardian Tracey Garde. Rachel has a wealth of experience in Human Resource Management and has worked in other NHS organisations as well as other social care and corporate organisations. The Guardians have continued to work with their respective Divisional teams. Tracey Garde supports AACD, ASSD and ICSD and Rachel Adamson supports FCD, DSSD, Corporate Services and IFM. Both guardians have been working with the senior teams to promote speaking up and regularly feedback on any concerns raised within their respective areas and to ensure any learning takes place e.g. reviewing policies, improving team dynamics/culture, helping staff retention, feedback on behaviour etc. The additional Guardian role demonstrates the commitment of the organisation to listening to the concerns of workers and ensuring actions are taken as appropriate.

1.3 We currently have a network of 44 FTSU Champions across the Trust. The FTSU Champions all expressed an interest in this important voluntary role and were interviewed individually alongside their manager to ensure they had the necessary skills and attributes to listen and support their colleagues. These Champions, who come from a variety of roles and backgrounds and reflect the diversity of our organisation, have received formal training by the Guardians and are available to support and encourage workers to speak up and raise their concerns. 39 FTSU Champions are employed by the Trust and 5 by IFM. The Guardians host regular meetings with the FTSU Champions and are available to them for advice and support whenever required. From April 2022, in accordance with guidance from the National Guardian Office, FTSU champions are no longer permitted to formally manage speak up cases. Their role will focus solely on supporting workers, encouraging workers to speak up and signposting them to the Guardian or other appropriate colleagues such as HR, union reps etc.

Appendix one shows the current list of FTSU Champions. The Guardians are currently recruiting further FTSU Champions later in the year particularly from areas and departments that are not currently represented including more individuals from our Black, Asian and Minority Ethnic community, our LGBTQ+ Community and workers who have a disability.

1.4 The Guardians continue to be available to support all workers working within the Trust and IFM including temporary staff, NEDs, volunteers, students and contractors.

1.5 The FTSU approach continues to be promoted via the Trust's normal internal communication channels, Trust induction sessions, presentations, and workplace visits and often feature as part of the CEO bulletin Fiona's Friday. The Guardians also regularly present on preceptorship programmes, care certificate training and other training sessions to ensure the message of speaking up is communicated widely across the organisation.

1.6 The Guardians continue to meet monthly with the Chief Executive, Director of People/ Deputy Chief Executive and Non-Executive Leads for the FTSU approach. During these meetings, the Guardians provide a confidential overview of the new cases reported, the themes identified and actions taken. All open/ ongoing cases are also discussed with an update to ensure timely action. The aim of these meetings is to allow the Chief Executive and Director of People to ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases and ensure that good practice and learning is shared across the organisation. The OD Associate Director and Head of HR are also advised of monthly themes to enable proactive interventions to take place within those vulnerable areas identified within the Trust.

1.7 The Guardians remain fully engaged with the National Guardian's Office and the North West FTSU Guardians Network to learn and share best practice. The NW Guardians meet virtually on a monthly basis to share practice, discuss any issues and provide peer support. The Bolton Guardians have also provided 'buddy' support to new FTSU Guardians in neighbouring organisations. Tracey Garde was appointed Deputy Chair of the North West network in 2023. This commitment at a regional level raises the profile of Bolton NHS Foundation Trust further. Both Guardians attended the first National Guardian's North West conference hosted by Stockport NHS Trust in early December. Bolton's FTSU Guardian Tracey Garde took a key role in helping to organise and facilitate this conference. The National Guardian Dr Jayne Chidgey - Clarke was in attendance and shared her vision for 2023. One aspect she discussed was the recent developments in the creation of the ICBs and the joint work with other health and social care providers who will require mechanisms for speaking up. Both Guardians also attended the National Guardian Conference on Thursday 9 March 2023. There was an excellent presentation by Megan Reitz on speaking truth to power and discussions on supporting workers from overseas to enable them to speak up, as well as discussing the barriers to speaking up.

1.8 The fifth Annual National Speak Up Month took place in October 2022. The theme was "Freedom to Speak Up for Everyone" with each week having a specific focus namely;

Week 1. Speak Up for Safety- highlighted the importance of speaking up about anything that gets in the way of doing a good job, particularly related to patient care and worker safety.

Week 2. Speak up for civility- focused on being kind to colleagues and kind to yourself,

Week 3. Speak up for inclusion- promoted inclusion and breaking down the barriers we know exist to enable all workers to feel safe to speak up and be heard,

Week 4. Speak up for everyone working with all workers to ensure that regardless of job role or background that they feel safe to speak up.

We were honoured to be joined via a Team Talk by Debra Hazeldine MBE who shared her personal experiences from Mid Staffs where her mum was treated but sadly died. Debra was key in supporting a national enquiry and has gone on to become a Patient Safety Champion. There was a multitude of positive activities across the Trust across the month. These included

briefing sessions, cakes, treats, and kindness gifts, to workers wearing green on Wear Green Wednesday on 12th October. There was also the creation of incredible displays on the hospital site and out in the community settings. It was a great period where 9 new and diverse champions were recruited. The Guardians had the pleasure and privilege of speaking to the multi-faith chaplaincy staff and volunteers about the importance of speaking up. The Guardians also supported the North West Ambulance FTSU roadshow that visited outside Bolton's A&E by providing some cakes and moral support for the geographically dispersed FTSU operation that the Ambulance service undertake as well as supporting our own A&E colleagues.

1.9 The National Guardian Office provides a FTSU e-learning package for all healthcare workers called 'Speak Up, Listen Up, Follow Up'. It has been developed in association with Health Education England and is divided into three modules to explain what speaking up is and how it can improve patient care and staff experience. The training is aimed at anyone who works in healthcare, including volunteers and students. The first module, 'Speak Up', was launched in October 2020 as part of the National Speak Up Month and all staff are expected to complete as an introduction to speaking up. The second module 'Listen up' is aimed at line managers and is also available on ESR. All line managers are encouraged to complete the training. The third module 'Follow up' is aimed at senior managers and Executives and was launched in 2022. This is key to ensure lessons are learned and that speaking up becomes business as usual. There is currently a review of mandatory and statutory training and the Speak Up, Listen Up, Follow Up E Learning is being looked at to potentially be mandatory going forward.

2. FTSU Cases

2.1 During the period from 1st April 2022 to 31st March 2023 a total of 186 cases were reported through the FTSU route. This is a significant increase from the previous year when 154 cases were reported and it demonstrates that the FTSU approach is supporting more staff to speak up.

2.2 The graph below shows the number of cases during 2022-23 in Bolton compared to the number of cases reported since April 2018 (Figure 1).This equates to 9.4 cases per 1000 WTE and is in quartile 4 nationally.

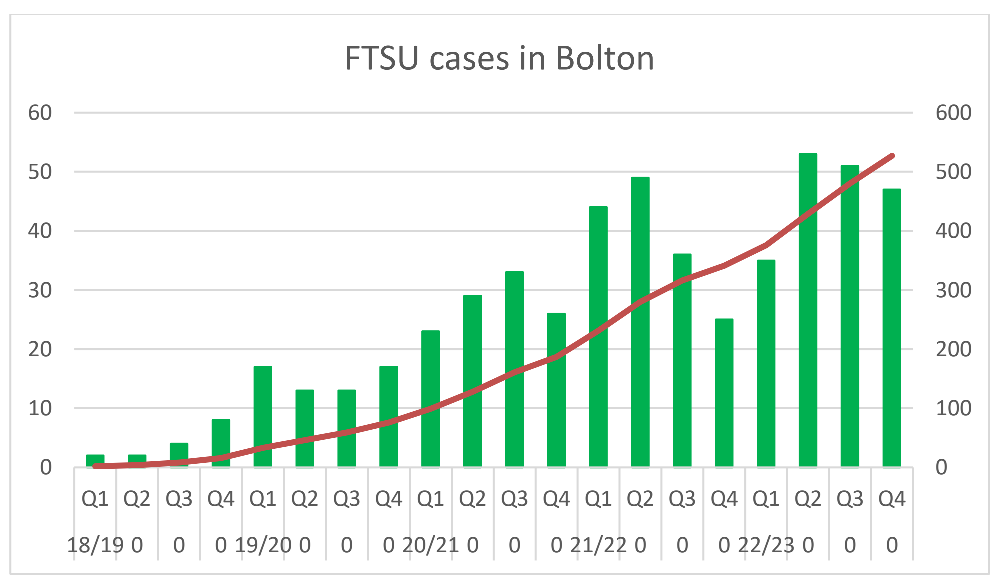


Figure 1: Number of FTSU cases within Bolton FT

2.3 The Guardians formally report the number of cases and themes for each quarterly period to the National Guardian Office. The Guardians have taken appropriate steps to ensure that the workers are being fully supported and their concerns are being addressed appropriately and swiftly.

2.4 The graph below shows a breakdown of the 186 cases raised in 2022/2023 by Division or organisation in the case of IFM. (Figure 2).

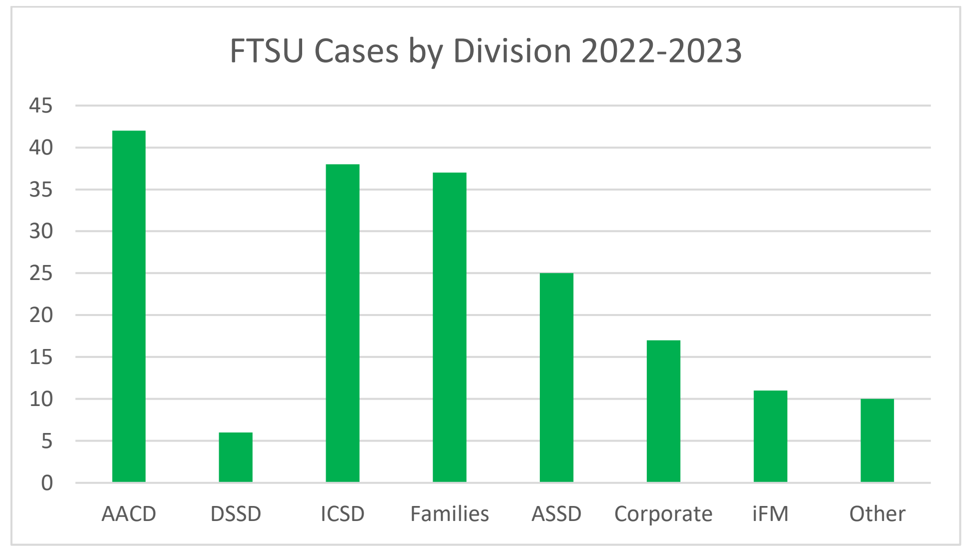


Figure 2: Breakdown of the number of concerns raised by Division/ Organisation

2.5 The graph below (Figure 3) provides a breakdown of the themes of concerns raised across the organisation during 2022-23. Some concerns raised had more than one theme.

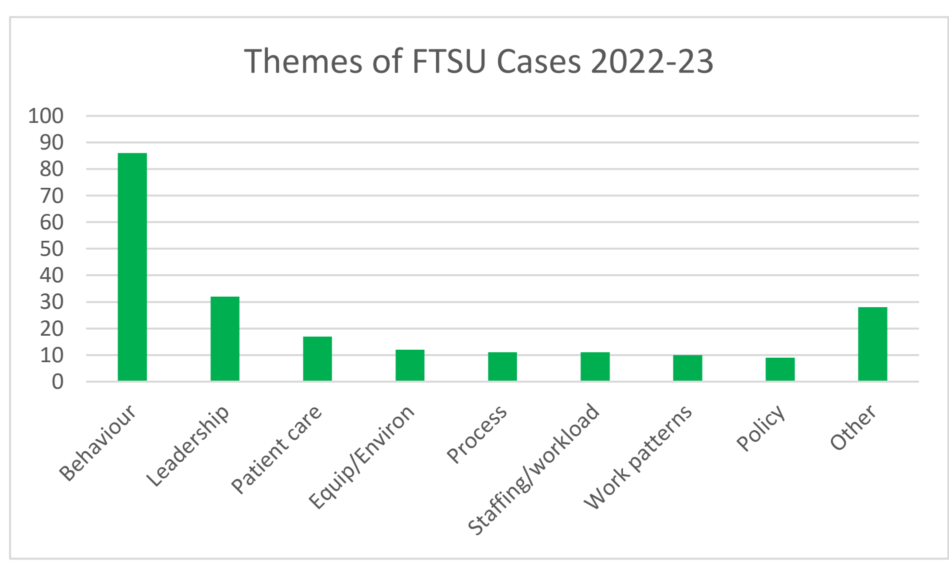


Figure 3: Breakdown of themes across the organisation

2.6 Figures 4-7 show the breakdowns of themes per Division per quarter, which clearly demonstrates that the themes are variable across all areas

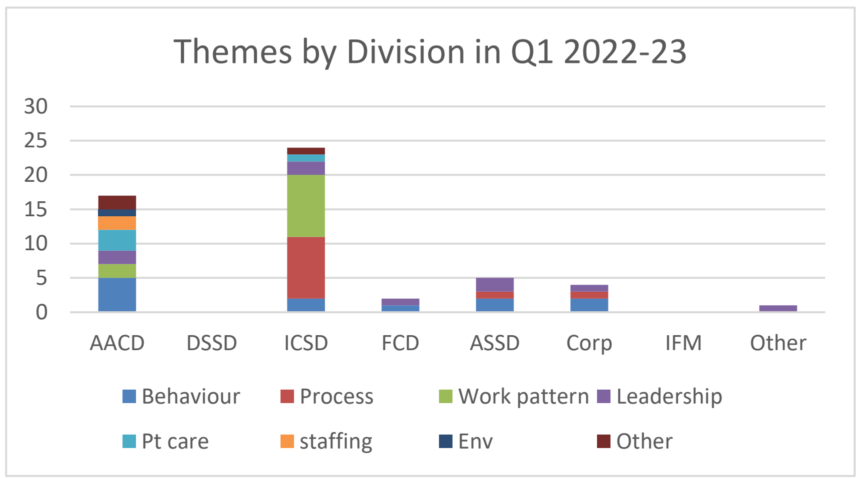


Figure 4: Themes per Division in Q1

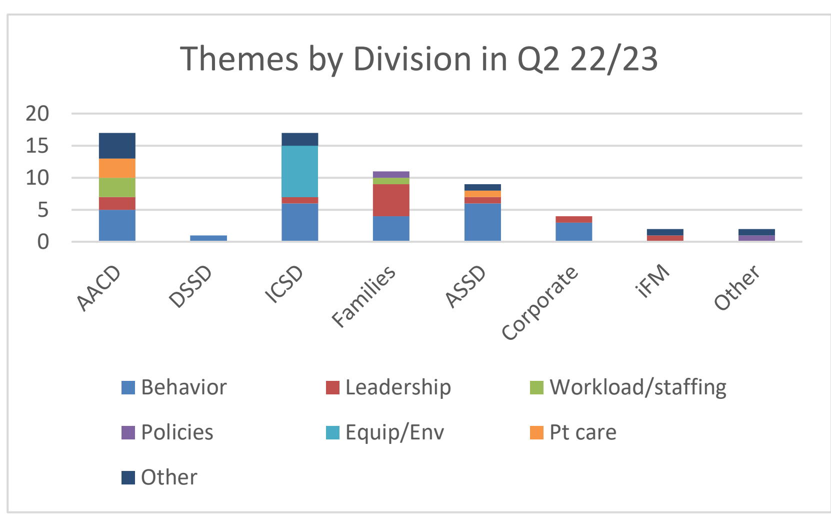


Figure 5: Themes per Division in Q2

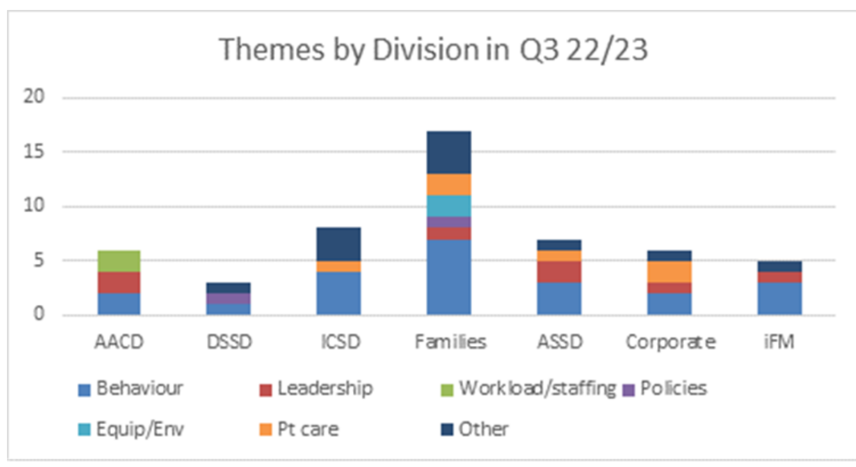


Figure 6: Themes per Division in Q3

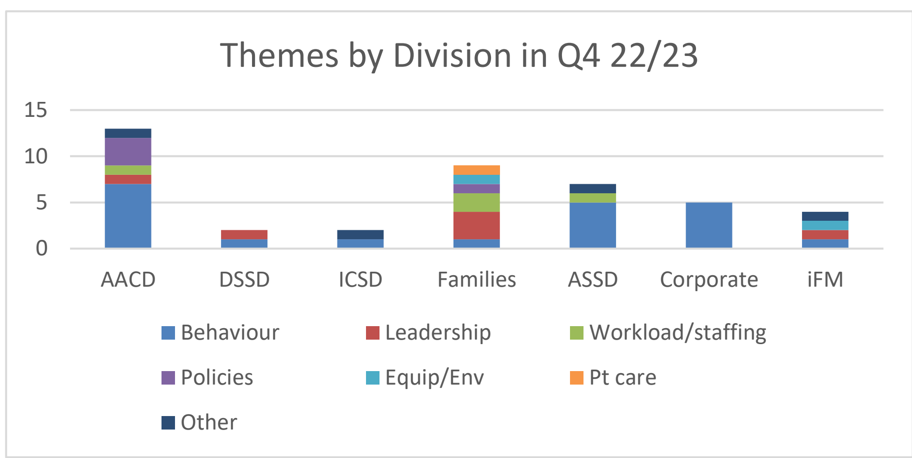


Figure 7: Themes per Division in Q4

2.6 The graph below (Figure 8) provides a breakdown of the concerns raised in 2022-23 by staff group. One of the largest group of staff that raised their concerns was registered nurses, which is our largest staff group and this is also reflected in other NHS organisations.

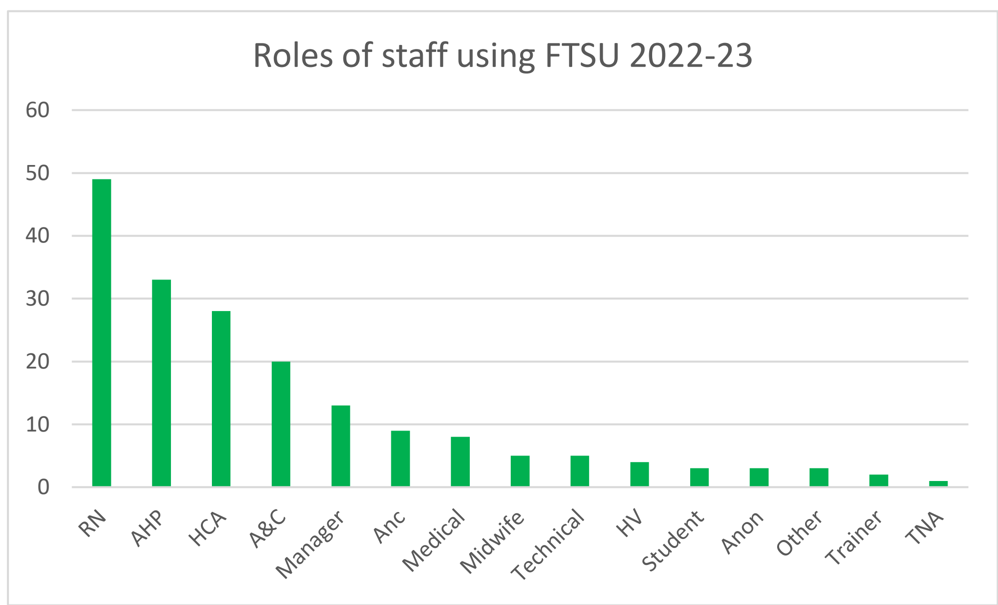


Figure 8: Breakdown of roles utilising FTSU approach

2.7 During 2022/23 a total of 33 concerns (17.7%) were raised by workers from a Black, Asian or Minority Ethnic background (BAME). This is an ongoing increase compared to the previous year by 2% and we have seen a rise each quarter in 2022/23. The Guardians and Champions continue to ensure that BAME staff are aware of the FTSU approach to ensure that they feel safe to speak up as research shows that workers from a BAME background are less likely to speak up. Currently 7 of the 44 FTSU champions (16%) are from a BAME background and more are looking to join. The FTSU Guardians regularly attend the BAME Staff Network and

the Chair of the Network is featured in the new FTSU video which is shown at Trust induction sessions. The Guardians also work closely with the EDI Team and attend the EDI/ People Development Steering Group. The Guardians are also working with the new international nurse recruits and the Clinical Education Teams to ensure that all our international nurse recruits are aware of FTSU and the support available to speak up. .Figure 9 below demonstrates the proportion of staff from a BAME background that have spoken up via the FTSU approach.

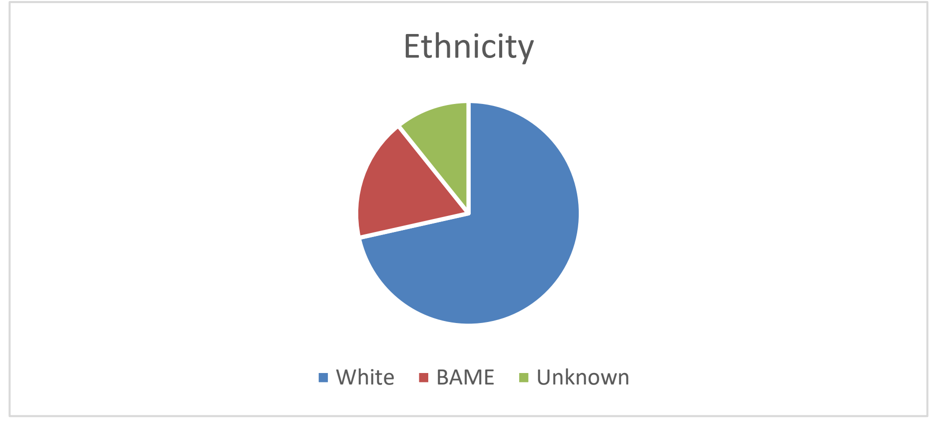


Figure 9: Proportion of BAME staff speaking up

2.8 There is undoubtedly additional work that needs to take place to ensure that our workers with disabilities and underlying health conditions and those from the LGBTQ+ have a voice and feel safe to speak up. The Guardians are actively working with all the staff networks and OD partners and are positively recruiting more FTSU Champions from these groups of workers. As part of Trans Day of Visibility, the Guardians attended a session to celebrate trans and non-binary people to be aware of the discrimination faced by trans and non-binary workers. This session was extremely helpful. The Guardians are also planning to update their Mental First Aider Training (MHFA) to help recognise the signs and symptoms of mental health problems and how to provide initial help and support to someone who is experiencing a mental health crisis. There is also work planned to support staff with neurodiversity as this is an area where we have seen an increase in staff speaking up about how they feel they have been treated. It is evident that some managers need to better understand how to support their workers who have some form of neurodiversity.

2.9 Speaking up takes courage and it is important that the Guardian and Champions respond to individuals in a timely manner. In 2020 a set of KPIs were developed to measure the efficacy of the FTSU approach. One of the KPIs was that workers would receive an initial acknowledgement of their concern within 48 hours. In 2022/ 2023 70% of workers received an initial acknowledgment within 1 hour of reaching out to speak up. 86.5% of staff received an initial acknowledgement within 4 hours of reaching out using the FTSU approach and 94.6% of workers received an initial response within 48 hours. This swift response has shown to workers that their concerns matter and are taken seriously. Figure 10 below shows a breakdown of the initial acknowledgement of the concern being raised.

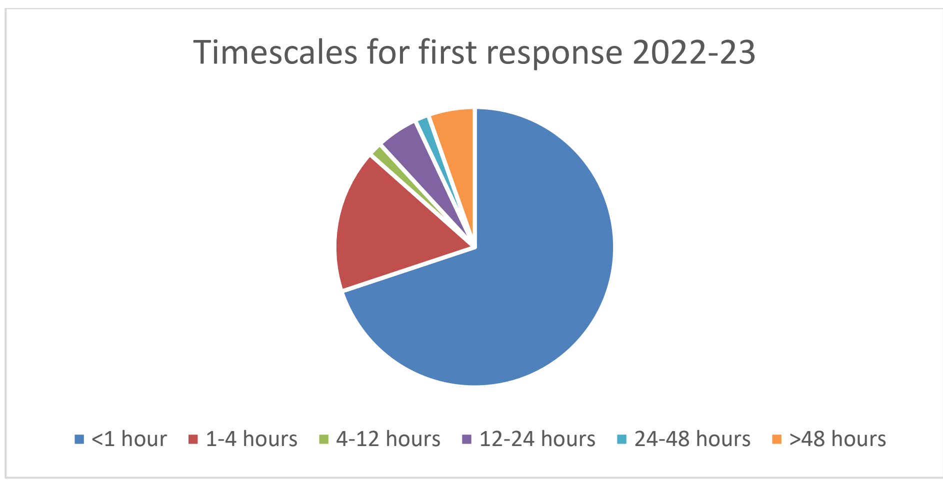


Figure 10: Time to respond 2022/2023

3. Measuring Impact

3.1 Results of the FTSU Guardian National Survey 2021 were published at the end of March 2022. The recommendations from the survey were:

- Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.
- To improve their ability to act as effective role-models for speaking up we encourage all senior leaders to complete the NGO / HEE 'speak up, listen up, follow up' training.
- Senior leaders should discuss the findings of this survey with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time and the balance of time available for reactive and proactive support for speaking up.
- There should be visible action on detriment for speaking up wherever this is reported.
- The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.
- Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.

3.2 'The Freedom to Speak Up: a reflection and planning tool', was discussed and ratings and outcomes were ratified at the People Committee in December 2022. The tool was designed to help identify strengths in the senior leadership and organisation overall – and also identifies any gaps that require attention. Three key areas of development were identified and will be addressed in the next 6-12 months. They are;

  - The creation of a cultural indicator dashboard for our people and culture related data per division, which will include FTSU themes and intelligence. This will allow the Trust to pro-actively identify any issues, or focus FTSU Guardian attention in key areas.

- The creation of a revised OD model within the Trust to help put increased structure and rigour around organisational development and cultural programmes of work; often linked to FTSU intelligence.
- FTSU training is mandated as part of the MAST review.

3.3 Following FTSU cases that have required input from the Guardians, workers are asked to provide feedback on their experience once their case is closed. Closure of a case occurs with the agreement of the individual worker and the Guardian. A link to a survey monkey questionnaire is forwarded to the individual within 3 months of closure. Figures 11-18 provide the responses to the survey questions.

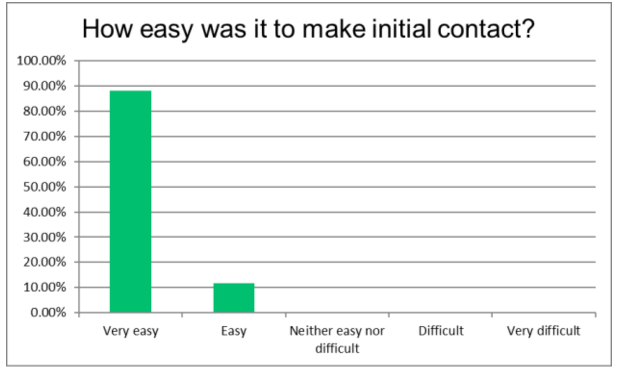


Figure 11

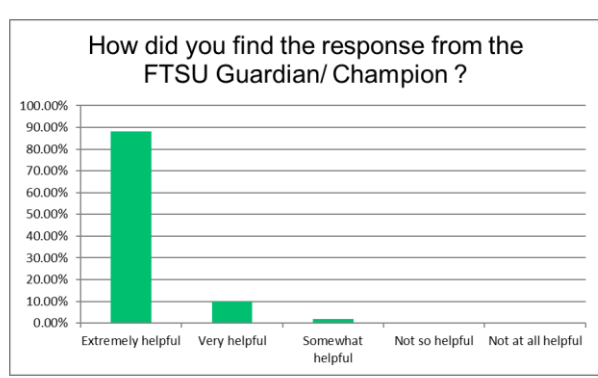


Figure 12

Did you feel your concerns were taken seriously?

120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Yes
No

Figure 13

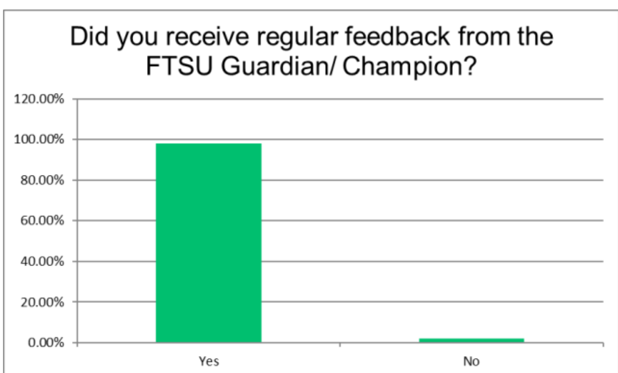


Figure 14

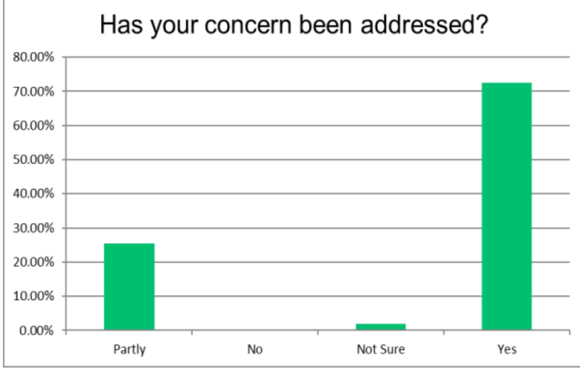


Figure 15

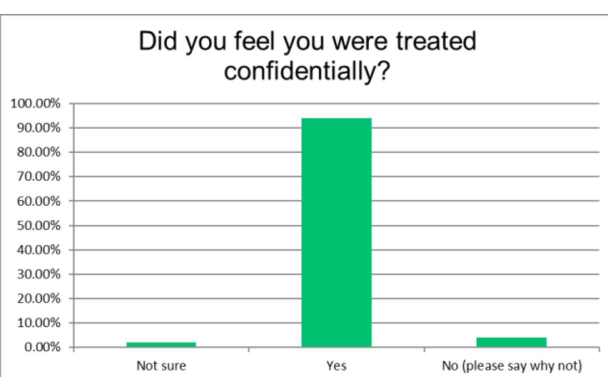
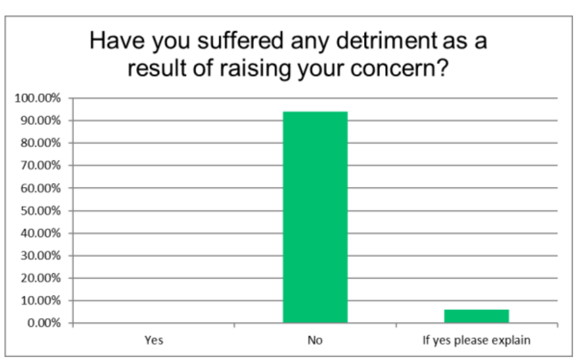


Figure 16



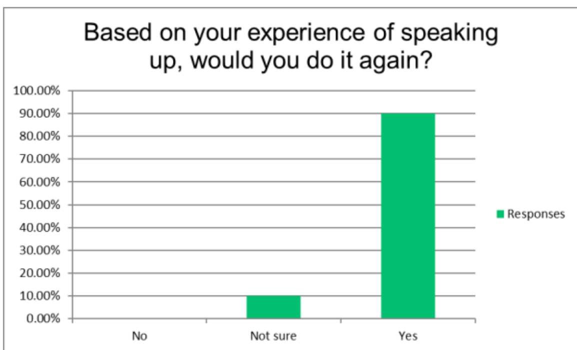


Figure 17 Figure 18

Comments include

- Excellent confidential service; my concerns were taken on board, with steps implemented to address the issues within a reasonable timescale. Thanks:
- The experience was very positive from start to finish. Rachel has been kind, supportive and informative. I would recommend the service to my colleagues if needed.
- I would just like to comment how well supported I felt from everyone FTSU. They have gone up and beyond to ensure that I had the correct support in place to ensure a satisfactory outcome. An amazing team. Thank You !
- I valued that the FTSU guardian drove the issue forward.
- I wouldn't hesitate recommend FTSU Guardians/Champions to other members of staff.
- On behalf of the team we really want to thank Tracey Garde our FTSU guardian for the way she raised our concerns/ kept the team updated and provided us with support we needed She is an excellent ambassador of FTSU role

3.4 The results of the 2022 staff survey with regards speaking up reflect a decrease nationally in workers confidence to speak up. Figure 19 below demonstrates how secure workers feel about speaking up about unsafe clinical practice in Bolton compared to the national average. Although Bolton is above average there has been a slight decline which has also been reflected nationally and Guardians have heard recently some of our senior workers reporting that despite the support they had to initially speak up, they would not speak up again due to their experience of speaking up to leaders. This is a great concern to the Guardians.

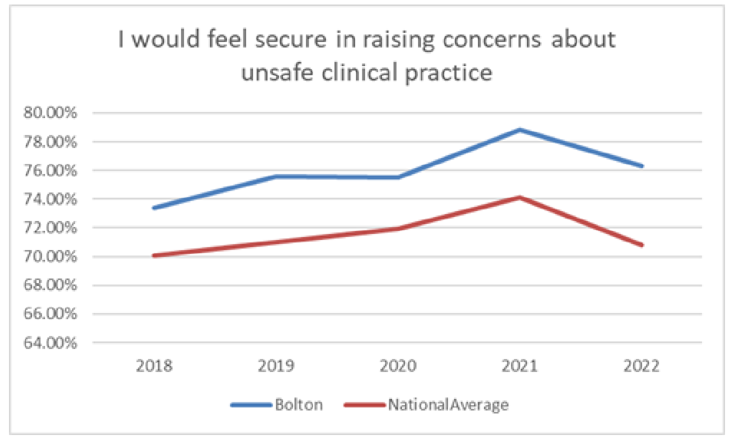


Figure 19 Results from Staff survey 2022

There has also been a slight decline in the percentage of staff in Bolton who feel safe to speak up about any issue within the organisation although this is higher than the national average as seen in Figure 20 below.

Figure 20 Results from Staff Survey 2022

The percentage of staff who feel that if they spoke up about something that concerned them they would be confident that the organisation would address their concerns has dropped by 2.1% whereas nationally it has only dropped by 0.8% - Figure 21 below. The Guardians therefore are looking at ways stories can be shared where workers have had a positive experience without breaching workers confidence.

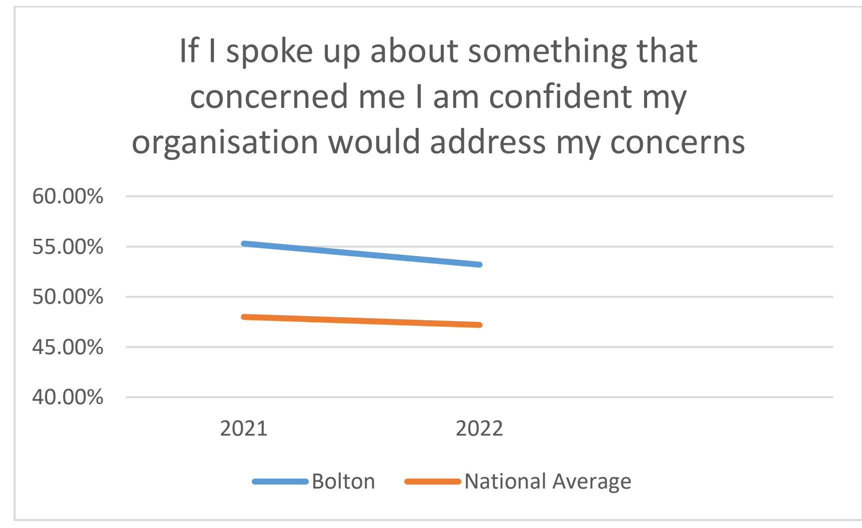


Figure 21 Results from Staff Survey 2022

3.5 It is important as an organisation we learn from the themes that our workers are speaking up about. Some of the learning and developments that are taking place following the issues raised in 2022-23 include:

- Improved levels of compassionate support in sickness/absence process and in day to day management of staff
- Menopause support
- Roll out of active bystander training to help improve culture in teams

- Improved management of sharps and risk of needle stick injury
- Improved induction process for temporary workers
- Bereavement support and a review of the bereavement policy
- Improve support and fairness in redeployment opportunities
- Review smoking/ vaping policy
- Ensure recruitment practices are in line with best practice and follow policy
- Improved education for International recruits
- Ensure reimbursements are calculated correctly in line with contractual arrangements
- Ensure full and supportive debriefs given post clinical incidents
- Improved interpretation services to support clinical teams
- Ensure openness and transparency at all levels.

4. Enhancing our Approach

4.1 2022/23 has been a challenging time for NHS workers following the pandemic and the return to some sort of normality. This has been with a backdrop of continuing pressures on urgent care, huge waiting lists for elective procedures and strike action affecting nurses, doctors and ambulance workers. We have also witnessed many other national FTSU related issues and media coverage of patient safety and bullying concerns that have happened elsewhere across the NHS and more recently this has affected us in our own organisation.

In February 2023, a North West Senior Nurse won an employment tribunal against NHSEI after the judge heard evidence that her employer had treated her unfavourably because of her race and because she was willing to speak up.

There has been a speak up review of Ambulance Trusts nationally “Listening to Workers” and the NGO has called for an independent cultural review to improve the culture of NHS Ambulance trusts. The review found the culture in ambulance trusts did not support workers to speak up and this was having an impact on worker wellbeing and ultimately patient safety. Experiences of bullying, harassment and discrimination were found which contributed to workers feeling not able to speak up.

The ongoing trial of Lucy Letby, a neo natal nurse from Countess of Chester Hospital, where it is alleged that Doctors came under pressure ‘not to make a fuss’ when they spoke up about their concerns to management about a nurse who is accused of killing seven babies and attempting to kill a further ten. Doctors allegedly alerted management eight months before she was removed from frontline duties but this was ignored.

An independent review of the University Hospitals Birmingham NHS Trust had extensive complaints about the organisations conduct and that many were concerned about the toxic atmosphere and bullying at all levels. The review led by Professor Mike Bewick, a former Medical Director with NHS England was commissioned following the death by suicide of Dr Vaishnavi Kumar.

A CQC review of The Christie Hospital following concerns raised about the culture and that staff did not always feel listened to. The CQC found that senior executives were heavily invested in the reputation of the organisation which impacted negatively on some staff. This resulted in a downgrading from ‘outstanding’ to ‘requires improvement’

There have also been issues in other public services such as police and fire service. Misogyny, discrimination, bullying and sexual harassment have been discovered and Baroness Louise Casey has recently published a damning report into the toxic culture of the Metropolitan Police.

As an organisation, we need to learn from these events across the NHS and other public services organisations to ensure we are doing everything we can to prevent similar situations occurring in Bolton. We also need to be aware of what is happening in our own organisation by listening to worker feedback and how we can restore the confidence of certain staff groups and areas. We need to ensure we create an environment where workers feel safe to speak up and when they do so their concerns are addressed appropriately.

4.2 Behaviour that does not reflect the Trust values continues to be the top theme that workers raise concerns about using the FTSU route and this is reflected nationally. More teams are looking to adopt and roll out the Civility Saves Lives initiative and are undertaking Active Bystander Training. Both Guardians accessed the training in April 2023 and they are looking to train all the FTSU Champions to be active bystanders by October 2023.To enable this to happen the Guardians are committed to attend the Train the Trainer Active Bystander training in June 2023 to help deliver these important messages.

An active bystander is someone who takes action to intervene and prevent harm or wrongdoing when they witness a situation where someone is being mistreated, harassed, or abused. Instead of remaining passive or turning a blind eye to the situation, an active bystander recognizes the potential harm and takes steps to de-escalate the situation or provide support to the victim. Active bystander intervention can take many forms, depending on the situation and the individual's comfort level and abilities. Examples of active bystander intervention include speaking up to challenge inappropriate behaviour, checking in with the person who is being targeted, distracting the perpetrator, seeking help from others or authorities, or documenting the incident for later reporting. Active bystander intervention is an important tool for creating a safer and supportive workplace. It can also help to prevent situations from escalating into more serious harm, and can send a message that mistreatment or abuse will not be tolerated.

As an organisation we also need to look at behaviours at all levels from the most senior leaders to our workers in our wards and departments. Leadership behaviour can greatly influence the success of an organization or team as well as the satisfaction and motivation of its workers. Poor leadership behaviours can include but are not limited to micromanagement, bullying, lack of transparency, blame shifting, favouritism, lack of empathy and lack of accountability.

These behaviours can have serious negative consequences for both individuals, teams and the organization as a whole. This can include increased sickness/ absence, increased staff turnover and reputational damage as well as the damaging effects to our patients

5. Conclusion

5.1 Senior leadership teams and boards must always lead by example on what constitutes an open, fair and inclusive culture making sure that all staff feel able to speak up, be supported

and be heard. The fear of detriment such as being excluded, victimised, bullied or undermined as a consequence of speaking up are recognised barriers that stop workers speaking up. When workers witness this happening to others it re-enforces the fear and stops them coming forward. It is extremely concerning to the Guardians, who have worked hard to encourage staff to speak up, to hear that some staff are now reporting that having witnessed detriment in others they would not speak up themselves.

Although the majority of staff who have spoken up in Bolton have found it a positive experience there are clearly a number of staff who have faced detriment and had a negative experience and as a result have escalated their concerns externally. There are a group of workers who have spoken up both to the Guardians and external partners about their concerns about the organisation. There are also a group of workers who have gone directly to outside agencies, the media or spoken to others. All have used their right to speak up and as an organisation we need to reflect on the what this is telling us and not the who. As already mentioned in the introduction -Speaking up and the matters that the issues highlighted, however difficult to hear, should be welcomed and looked at as opportunities for learning and development.

6. Recommendations

6.1 The Board is asked to:

- Approve the FTSU 2022-23 annual report.
- Continue to support the FTSU approach and enable the Guardians and Champions to carry out their important roles.

Appendix 1: Current FTSU Champions Network

Kirsty Buckley	Haematology Specialist Nurse	Adult Acute Division
Dr Natalie Walker	Acute Physician	Adult Acute Division
Karen Keighley	Divisional Governance Lead	Adult Acute Division
Shauna Barnes	Practice Development Lead Nurse	Adult Acute Division
Corinne Houghton	HCA	Anaesthetics & Surgical Division
Julie Pilkington	Acting Divisional Nurse Director	Anaesthetics & Surgical Division
Cath Marrion	Theatre Sister	Anaesthetics & Surgical Division
Ruth Adamson	Anaesthetics/Ops Support Manager	Anaesthetics & Surgical Division
Dr Emma Wheatley	Consultant Anaesthetics/ Critical Care	Anaesthetics & Surgical Division
Lisa Haughton	HCA Critical Care	Anaesthetics & Surgical Division
Rahila Ahmed	Equality, Diversity & Inclusion Lead	Corporate Services Division
Neville Markham	Chaplain	Corporate Services Division
Sharon Lythgoe	EPR Project Manager	Corporate Services Division
Charlotte Anderson (on M/L)	Business Analyst	Corporate Services Division
Gina Riley	Associate Director of Governance/ Patient Safety Lead	Corporate Services Division
Nicola Caffrey	Corporate Business Manager for Medical Director	Corporate Services Division
Robin Davis	Core skills trainer MPVA	Corporate Services Division
Lisa Grognet	Core skills trainer	Corporate Services Division
Cherechi Ochemba	IT IGO	Corporate Services Division
Nannette Gallagher-Ball	Senior Nurse Educator	Corporate Services Division
Dawn Grundy	Library Manager	Corporate Services Division
Lynne Doherty	Staff Wellness Practitioner	Corporate Services Division
Gareth Valentine	TVN	Corporate Services Division

Rachel Davidson	Senior Radiographer	Diagnostic and Support Services
Louise Quigley	Health Records Reception Coordinator	Diagnostic and Support Services
Suzanne Lomax	Clinical Service Lead – Palliative & End of Life Care	Diagnostic and Support Services
Dr Katy Edwards	Consultant Microbiologist	Diagnostic and Support Services
Caroline Burke	Senior Clinical Pharmacist,	Diagnostic and Support Services
Samim Patel	Senior Clinical Pharmacist,	Diagnostic and Support Services
Jeanette Fielding	Midwife	Families Care Division
Vicky O'Dowd	Midwife	Families Care Division
Dr Bim Williams	Obstetrics & Gynaecology Consultant	Families Care Division
Maria Lawton	Pelvic Health Physiotherapist	Families Care Division
Firyal Atcha	Paediatric SALT	Families Care Division
Anne-Marie Price	Medical Secretary	Families Care Division
Simon Crozier	Principle Service Lead / Advanced Physiotherapist- Stroke	Integrated Community Services
Dr Atir Khan	Consultant Physician Diabetes & Endocrinology	Integrated Community Services
Chris Vernon	Integrated Neighbourhood Team Lead	Integrated Community Services
Jenni Makin	Specialist Physiotherapist Community Learning Disabilities Team	Integrated Community Services
Keeley Barlow	Switchboard/ Uniforms Department	IFM
Ryan Brown	Security Operative	IFM
Michelle Barber	Personal Secretary	IFM
David Waite	Materials Management Assistant	IFM
Lorraine Makinson	Catering Supervisor	IFM

NHS
Bolton
NHS Foundation Trust

Appendix 3

Report Title:	People Committee Chair's Reports – June/July 2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	The purpose of these reports is to provide an update and assurance to the Board on the work delegated to the People Committee.

Summary:	The attached reports from the Chair of the People Committee provide an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed by the People Committee at their meetings held on June and July 2023.

Previously considered by:
Discussed and agreed at the at People Committee meetings.

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

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

Prepared by:	James Mawrey, Director of People	**Presented by:**	Alan Stuttard, Non-Executive Director

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	20 June 2023	Date of next meeting:	18 July 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Malcolm Brown, Sharon Katema, Francis Andrews, Lisa Rigby, Ryan Calderbank, Chris Whittam, Paul Henshaw, Andrew Chilton, Lianne Robinson, Rachel Carter, Carol Sheard, Tracey Garde, Samantha Ball	Quorate (Yes/No):	Yes
		Apologies Received From:	Bilkis Ismail, Joanne Street, Fiona Noden, Jake Mairs, Sharon White, Tyrone Roberts

Key Agenda Items:	RAG	Key Points	Action/decision
Agency Update	Amber	Paul Henshaw presented the bi-monthly agency report, which covered agency usage and expenditure for both April 2023 and May 2023, and controls in place to manage that usage. Key points: • In April 2023, the Trust saw an decrease in agency expenditure (of £329k) when compared to March 2023 but that decrease needs to be considered in the context of in-month accrual adjustment reductions of circa £100k. • In May 2023, spending increased to £1.46m in-month when compared to April 2023 (an increase of £140k in-month). • Spending in both April & May 2023 for medical agency tracked above average spending for this staff group in the previous year (by approximately £200k per month). Industrial action and vacancies have contributed to these spending levels. Spending in this staff group is above forecast. • Spending for nursing agency for both April and May 2023 was significantly lower than average monthly spending for 2022/2023. Spending in this staff group is above forecast. • Admin and Clerical agency usage, although much smaller than other staff groups, was discussed; and the need to ensure this was limited to just project roles (as per NHSEI guidance) was highlighted. Spending in this staff group is above forecast.	The Committee received and discussed the report. Key actions agreed were:- • Detailed tracking/forecasting of medical agency expenditure against expected recruitment activity will be provided from August 2023 • Agency & Variable pay expenditure in relation to industrial action will be detailed separately in future reporting to ensure the Committee have a clear view on the impact of such action on usage and spend • The Committee were keen to stress that agency should only be used for patient facing roles; with respect to Admin and Clerical agency there is an expectation from the Committee that such usage should cease within the next 4 weeks with exceptions/requests to that rule being agreed by the Director of People and Chief Finance Officer. • Benchmarking comparisons with other NHS providers will be included in the August 2023 Agency paper • More details will be provided on AHP/Prof & Tech vacancies, and corresponding impact on agency spend, in the August 2023 report

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

People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
	Amber	• AHP/Prof & Tech agency spending is above forecast; being driven in the main by vacancies across a number of Trust departments. • Trust agency forecasting to NHSEI for 2023/2024 outlined a maximum annual spend of £11.9m (set at 3.7% of our pay bill as per NHSEI expectations) – at the end of May 2023 we were £817k above that forecast which is a cause for concern in the context of both that forecast and the reduction of agency spend to support Trust financial management aspirations.	• The Committee agreed to keep agency reporting to a bi-monthly basis to allow robust and detailed reporting.
Freedom to Speak Up Annual Report	Amber	Tracey Garde presented the Annual Report. Key points: • We currently have 2 FTSU Guardians and a network of 44 FTSU Champions across the Trust • During the period from 1st April 2022 to 31st March 2023 a total of 186 cases were reported through the FTSU route. This is an increase from the previous year. • There has been a slight increase in the number of concerns raised by colleagues from a Black, Asian or Minority Ethnic background (BAME). • There is additional work that needs to take place to ensure that our workers with disabilities and underlying health conditions and those from the LGBTQ+ have a voice and feel safe to speak up. • The National Guardian Office provides an e-learning package for all healthcare workers called 'Speak Up, Listen Up, Follow Up' which the Trust is considering as part of a review of mandatory training. • There has been a slight decline in the 2022 staff survey in confidence to speak up. This is reflected nationally and Bolton are above average. • The majority of staff who have spoken up in Bolton have found it a positive experience, however some staff feel they have faced detriment and had a negative experience and as a result have escalated their concerns externally.	• The actions to further improve FTSU highlighted in the report were agreed. • It is important we continue to recognise, build and promote the wide range of opportunities available for staff to speak up, both internally and externally, and take action around the themes raised, particularly in relation to behaviour.

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
	(Amber)	• There was a discussion around detriment. It is important we continue to recognise each person speaking up as an individual with differing perceptions and feelings and consider the speaking up experience through their lens, whilst supporting a fair process and resolution. • Bolton was noted as being in Tier 4 of FTSU reported cases which is the highest tier nationally. This is generally regarded as a positive feature as it demonstrates a culture of openness and transparency.	
Guardian of Safe Working Annual Report & Q4 Report		Francis Andrews presented the report, noting the following key points: • There has been an increase of 29% in exception reporting. Francis Andrews noted that junior doctors are required to report where they have been asked to do additional hours. • Additional hours are remunerated with additional payment or time off in lieu. • The report includes a breakdown of the number of hours claimed. • Trainees are encouraged to speak up. • Francis Andrews informed the Committee that he is confident with the journey that General Surgery are on, the consultants have started to review concerns and will provide an update in 3 months' time. • The total number of reported matters was felt to be in line with expected numbers although there are no benchmarking figures to compare with other organisations.	• Noted that General Surgery is an outlier and requested a deep dive into this area. Lianne Robinson confirmed that the ASSD Divisional Medical Director has dealt with some of the concerns raised.
Steering Group Chair Reports		Noted	

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

People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Divisional People Committee Chair Reports		Noted	• All Divisions to include narrative in the action column to provide assurance to the Committee. • All Divisions requested to include narrative on Exit Interviews and Stay Interviews.
IPM Workforce & OD Dashboard		Noted	

Matters for escalation to the Board: There were no matters for escalation to the Board of Directors.

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

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	18 July 2023	Date of next meeting:	19 September 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Malcolm Brown, Sharon Katema, Chris Whittam, Paul Henshaw, Karl Jones, Rachel Carter, Carol Sheard, Tracey Garde, Laura Smoult, Sharon White, Tyrone Roberts, Fiona Noden, Victoria King, Jake Mairs, Joanne Street	Quorate (Yes/No):	Yes
		Apologies Received from:	Bilkis Ismail, Francis Andrews

Key Agenda Items:	**RAG**	**Key Points**	**Action/decision**
Resourcing Update	Amber	• The report highlighted resourcing activity being undertaken across the Trust, focussing on both turnover, and recruitment, analysis. The report outlined a strong resourcing/staffing position for the Trust and this is a result of both robust recruitment activity and a slowing down of turnover. • The report outlined that average Trust turnover, at June 2023, of 12.60% continues to track above our expectations (KPI for this metric is 9.90%), however a clear reducing trend, over a number of months, has been noted and the Trust benchmarks well against other regional, and national, providers in most of our staffing groups. • The Committee was informed that turnover is not impacted by internal moves, only leavers influence turnover reporting. It was also clarified that Foundation Doctors are included in turnover reporting as they leave the employment of the Trust after 2 years. • Regarding recruitment, the Trust vacancy level (at June 2023) of 6.46% is slightly above our expectations (KPI for this metric is 6%); however, the report demonstrates a continuation of a healthy recruitment pipeline and outlined some of the key activity underway to maintain/enhance this pipeline. • It was noted that the Resourcing and Talent Planning Steering Group will continue to monitor operational resourcing activity, including activity underway to recruit into hotspot areas of vacancies across the Trust). • The significant recruitment requirements needed to support staffing in the new Trust Community Diagnostics Centre (due to open in 2024) was highlighted as an area of concern and progress with CDC will be monitored going forward in resourcing reporting to the Committee.	• A focus on the Trust approach to flexible working will be included in the next paper; flexible working is a key theme in the new NHS Long Term Workforce Plan. • RAG rating for vacancies will be included in the next report. • A deep dive into the AHP staffing group is being undertaken and this will use vacancy, turnover, agency, recruitment, and retention information to understand the challenges in that staff group. This will be included in the next report.

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Organisational Development Update	Amber	• A presentation was received on an enhanced approach to listening and action taken on staff feedback, as a new Trust-wide model to ensure we are acting on feedback in a quick and timely manner. • The programme timescales are being finalised and an update will be brought back to the Committee in September, noting that this work will also need to feed into other governance forums i.e. where the area of focus from colleague feedback links to finances, quality, clinical etc. • The programme will give us a renewed focus on 'a new era for Bolton' where we provide more timely updates on feedback and an enhanced rigour and model; with dedicated resource to drive and support.	• Update to be brought back in September.
Freedom to Speak Up Update	Green	• During the period from 1st April 2023 to 30th June 2023 a total of cases 34 were reported through the FTSU route. This is a decrease compared to 47 the previous quarter but is similar to the figures seen in Q1 the previous year. 11 of these workers were either in, or had been in some form of HR process. • For the first time in a while Admin and clerical staff were the largest groups in Q1 to speak up closely followed by bank staff 2 of which were bank HCAs. • During Q1 a total of 10 concerns (29%) were raised by workers from a Black, Asian or Ethnic Minority (BAME) background (see fig 6 below) which is a slight decrease of 3% from last quarter (32%). Whilst it is positive that our workers from a BAME background are feeling confident to speak up this significant increase raises concerns as this percentage outweighs the demographics of the organisation. The Guardians will continue to work with colleagues in the EDI Team and the BAME Staff Network to ensure all our workers from a BAME background are aware of the FTSU route to raise any concerns and are supported to do so. • In Q1 79% of workers received a response /acknowledgement within 1 hour and 82% received an initial response/ acknowledgement within 4 hours. Overall, 97% of workers received a response in 48 hours. • During Q1 we became aware of concerns raised outside of the organisation to the CQC, NHSE and HSJ. Every worker has the option of speaking up to whoever they wish and whoever they feel is appropriate and if that is to our external partners then that is absolutely acceptable. Some of the concerns raised externally had already been raised to the Guardians internally and the Guardians were told that this was also being raised externally because of the nature of the issues.	

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Key Agenda Items:	RAG	Key Points	Action/decision
	Green	• It was noted that additional Interim FTSU Guardian support is currently being recruited and conversations with GM ICB are underway about support from them. The number of FTSU champions had also increased to 55.	
Employee Relations Update	Amber	• Volume of formal HR casework has increased and centres largely around attendance management. • Themes regarding disciplinary cases noted – behaviours in work and Information Governance standards being recurring themes. • Themes regarding resolution cases demonstrate processes regarding relationships between colleagues, application of Policy and relationships with managers. This mirrors findings through FTSU. • Updates provided on Tribunal cases – AN overall increase in number however cases are being closed through resolution or withdrawal of claims. • Additional learning and reflection to be promoted through partnership forum to improve experience. • Additional support for managers to be explored	• To note findings in report. • To include additional breakdown regarding outcomes (where appropriate). • To include section relating to Nursing and Midwifery (NMC) and other professional bodies to mirror summary provided for medical cases. • To review current approach to IG and action taken for breaches of Trust standards.
EDI Update	Amber	• Introduced the Committee to our new Head of EDI – Toria King. • Ten colleagues are taking part in the North West BAME Leadership programme, with specific Bolton support during and after the programme incl. reciprocal mentoring. • We are due to transition to a new Interpretation & Translation service from 1 August, to improve the experience for patients and colleagues. • WRES, WDES, Bank WRES and MWRES will be taken to the September committee and then to Board, incl. specific actions that will be undertaken to enhance and improve position. • Task & Finish group is underway to improve the process for colleagues declaring protected characteristics, incl. link to the reasonable adjustments process. • Our new staff networks (Gender, Age & Social Mobility) have new Chairs and enhanced launched plans are being prepared. • Equality Impact Assessment is being reviewed and including specific link to Health Inequalities. • Work is about to begin to implement specific EDI objectives for Board colleagues, as part of the NHS Equality & Inclusion Improvement plan.	

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
	(Amber)	• Conversations have been started with our new Chair regarding the NW BAME Anti-racism Framework for the Trust to adopt.	
Board Assurance Framework	(Amber)	Ambition 2 of the Board Assurance Framework was reviewed by the Committee. • The risks continue to be assessed. • The risk rating remains at 16.	• More focus on integration of Health and Social Care across Bolton to be included in future.
Steering Group Chair Reports		Noted	
Divisional People Committee Chair Reports		Noted	All Divisions to use a standard agenda going forward.
IPM Workforce & OD Dashboard		Noted	

Matters for escalation to the Board: There were no matters for escalation to the Board of Directors.

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

Report Title:	Clinical Strategy update

Meeting:	Board of Directors	Purpose	Assurance	✓
Date:	27th July 2023		Discussion	
Executive Sponsor	Francis Andrews		Decision	

Purpose	An engagement draft of the Clinical Strategy is provided for review and assurance.

Summary:	This paper presents to the Board a draft of the Clinical Strategy. The Clinical Strategy is the product of a great deal of work and has taken account of everything the Trust has already achieved, as well as our refreshed aims and objectives, learning and research and, of course, the need to restore our services following the pandemic. The Clinical Strategy now and up to 2028 continues to focus on our primary ambition to Improve Care / Transform Lives. The Board is asked to review the Clinical Strategy and approve the three priorities and the nine supporting themes. Following this the Clinical Strategy will be refined and socialised with our staff, the Public and Patients and our partners. Progress updates will be brought to the Board on a monthly basis with updates to the Board as follows: 1. **July Board** – early draft, to provide an opportunity to agree our three Clinical Strategy priorities and nine supporting themes 2. **September Board** – post-engagement draft which will describe clearer clinical aspirations and activities required to deliver, the outcomes we expect to achieve, and health planning data 3. **November Board** – a concise, edited version of the document ready for final approval and publication

Previously considered by:
N/A

Proposed Resolution	The Board is asked to: • Note the update. • Approve the three Clinical Strategy priorities and the nine supporting themes • Note the next steps in the engagement and refinement of the Clinical Strategy.

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

Prepared by:	Dr Sophie Kimber-Craig, Rachel Noble & Francesca Dean	**Presented by:**	Dr Harni Bharaj / Sharon White

1. Purpose

This paper presents an early draft of the Clinical Strategy. As part of this review, the Board is asked to review and approve the three Clinical Strategy priorities and the nine supporting themes for further development.

Over the next 4 months, the Strategy will be refined and socialised with our staff, the public and patients and our partners. Monthly updates will be provided to the Board and iterations of the document will be brought to the Board as follows:

- **July Board** – early draft, to provide an opportunity to agree our three Clinical Strategy priorities and nine supporting themes
- **September Board** – post-engagement draft which will describe clearer clinical aspirations and activities required to deliver, the outcomes we expect to achieve, and health planning data
- **November Board** – a concise, edited version of the document ready for final approval and publication

2. Progress

Extensive engagement has taken place with clinical and operational teams over the past 12 months, including dedicated service-level and divisional workshops, written feedback and interviews. This engagement has been overseen by the Clinical Strategy Project Group (which includes representatives from the Locality Team) and the Project Board (which includes Locality colleagues and a representative of the Local Medical Committee to bring in the primary care perspective).

All the information collected through our engagement has been analysed and collated into three overarching priorities and nine supporting themes which form the basis of the draft Clinical Strategy:

1. **Improving the health of our population**
   a. Meeting the needs of our population
   b. Addressing healthcare inequalities
   c. Prevention and early identification of disease
2. **Optimising people's experience from start to finish**
   a. Streamlining the patient's journey
   b. Making every contact count
   c. Proactive management of care
3. **Innovating and collaborating for the future**
   a. Adopting a culture of innovation
   b. Integrating across the Trust and with partners
   c. Making evidence-based decisions

The draft Clinical Strategy describes what we heard under each priority, relevant data and information and over the coming weeks, work will take place to further describe the outcomes we aspire to achieve, and what we will do to achieve them.

3. Guidance to inform the July review

In their review of the document, the Board is asked to note the following:

- This draft document is shared at this stage to show progress and to provide assurance. The version shared in September will be:
   a. **Refined -** Be edited and simplified, fully designed and written in Plain English

b. **Outcome Focused -** Include a clearer view of the outcomes we want to deliver and the activities required to get us there, which will follow on from the planned horizon-scanning exercise in August
c. **Clarity of deliverables** – We have collated and reviewed the feedback received through our engagement with clinical teams. Throughout August / September we will be playing this back to the teams along with Horizon Scanning / innovation examples to enable them to further describe their aspirations.
d. **Grounded in evidence** – we are currently working on a robust Health Economic analysis to describe the future state

During our initial listening events the team gathered feedback on areas that were not primarily linked to the Trust's Clinical Strategy development. To ensure these issues are not lost, they will be fed into the Trusts proposed 'Staff Engagement into Action' programme to ensure they are heard and teams get feedback on action taken or planned to be taken.

4. Summary of feedback received

A first draft of the Clinical Strategy was shared internally and with members of Strategy & Operations Committee on 4th July. Colleagues were supportive of the priorities and underpinning themes set within the Clinical Strategy and reported a sense of connection to them. Importantly divisions reported they are able to see how they will contribute to delivery.

The following feedback was received:

Feedback received on first draft	Changes made in second draft	Work to be completed to inform engagement
Needs to be refined and simpler.	First high-level edit completed and background info appended	Full edit to be completed by the Trust's Communications team prior to next Board review with a view to creating a concise, impactful document
Ensure strength of patient/service user voice	Engagement with service users, the public and stakeholders will take place in August/September	Schedule of engagement being developed
Requires clarity of delivery plan.	An example of a delivery plan has been created in the Clinical Strategy for 'Optimising people's experience from start to finish'	Engagement with clinical teams to develop what/how through August, horizon scanning to identify innovation/research/best practice
Requires SMART Outcomes	Some work has been completed to show anticipated outcomes for 'Optimising people's experience'	The outcomes will be developed in August / September
Reference to innovation appears too late in the document and requires strengthening	Innovation has been included in introduction	Engagement with clinical teams to develop what/how through August, horizon scanning to identify

		innovation/research/best practice
Need to ensure the delivery plan resonates with staff so everyone understands what the strategy means for them	Based on feedback through SOC, work underway to develop a '*what the clinical strategy means for me'* approach	Will form part of August engagement
Continue to strengthen evidence base	Further work is needed on the health planning aspect of the project	Will be strengthened throughout August / September
Simplify Language	Document simplified	Will be standardised and addressed in redraft with input from the Trust's Communications Team

5. Further work and engagement

In preparation for the September review, the project team will complete the following work:

- **Refinement -** Continue to refine and edit the document so that the shared version is more concise
- **Outcomes Development -** Complete a horizon scanning exercise to inform the 'what we will do' section, drawing on the latest clinical research, GIRFT reports, and policy to stimulate discussion on our aspirations. This work will inform further divisional and clinical conversations through August and September

- **Finalise the Delivery Plan** – Develop the delivery aspect of the strategy, defining what we will do clinically and how we will do it, and being clearer on what will happen divisionally to work towards our aspirations

- **Describe the evidence base** –work on a robust Health Economic analysis to describe the future state

- **Engage with Staff, Partners and the Public**

  During August and September, the project team will be undertaking intensive engagement with:

  - **Clinical teams** – further engagement will take place during August and early September. This work will include dedicated divisional sessions where colleagues will consider how the three priorities will inform their work programmes over the coming years, and specifically, what this will mean at specialty-level.

  - **Partners** - The GP Board have been members of the Project Board through the development of the Clinical Strategy. We will strengthen this by engaging with all Bolton Locality Partners including Primary Care Networks, Local Authority, Greater Manchester Mental Health FT, VCSE and the Integrated Care Board during August and September.

  - Public and Service Users - engagement with the Public and Service Users will commence in August and September and build on information we already have from previous engagement campaigns.

6. Timeline and next steps

The Board is asked to note the following key dates:

- 27th July –review of the first draft of the Clinical Strategy priorities and the nine supporting themes
- w/c 31st July – completion of final edits
- w/c 7th August – Engagement draft shared with Project Board for approval and engagement to begin
- Monthly updates to Strategy and Operations Committee
- 28th September – second review by Board
- 30th November – final sign-off by Board

7. Recommendations

The Board is asked to:

- Note the update.
- Approve the three Clinical Strategy priorities and the nine supporting themes
- Note the next steps in the engagement and refinement of the Clinical Strategy.

Vision | Openness | Integrity | Compassion | Excellence

Our Clinical Strategy

2023 -2028

A message from the Executive leads for clinical care

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We are delighted to present the Bolton NHS Foundation Trust Clinical Strategy for 2023-28. This comprehensive roadmap is the result of a collective endeavour, drawing insights from our dedicated staff, esteemed partners in health and social care, and the vibrant Bolton community.

We extend a huge thank you to everyone involved. Your valuable contributions, engagement, and feedback have been instrumental in shaping our vision and understanding our clinical future. Your ongoing leadership ensures that this strategy will bring tangible improvements to the health and well-being of the people we serve.

This Strategy comes at a pivotal moment for the Trust. This past year, we have celebrated tremendous accomplishments amidst enormous challenges. We provided vital care to our communities throughout the pandemic and continue to do so, but we know that even before the pandemic, there were significant challenges in the delivery of healthcare and we need to do things differently.

We want to improve the health of our population, ensure people have the very best experience while in our care and continue our own journey of continuous improvement through innovation and collaboration within in the Trust and with external partners. This Clinical Strategy describes our ambitions and areas of focus for our Trust over the next five years centred around the population's need, grounded in equity, with a firm basis in high quality, evidence-based care delivered by a kind and compassionate workforce.

So here we go… for a better Bolton….

Francis and Tyrone signature

About Us

Bolton NHS Foundation Trust is an Integrated Care Provider located in the borough of Bolton in Greater Manchester. We provide more than 100 different health and wellbeing services to a catchment population of around 337,000[1] including:

- Care in the community and people's homes
- General and specialist medical and surgical services
- Maternity care in the community and in hospital
- Paediatric, neonatal and community services for children and young people
- Urgent and Emergency Care

We have over 20 community facilities and the hospital has approximately 740 inpatient beds. We are the second busiest ambulance receiving site in Greater Manchester. At the time of writing in 2023, the Trust employs around 5,800 staff.

About Bolton

Bolton has a proud industrial heritage. It is situated in the foothills of the West Pennine Moors, and is surrounded by beautiful countryside on one side and has easy links into the city of Manchester on the other. Our town's motto is *Supera Moras* which means 'overcoming difficulties,' something we will strive to do through the delivery of our Clinical Strategy,

In recent years, Bolton has seen a larger-than-average increase in its population when compared to the North West and the rest of England and is one of the 30% most densely populated English local authority areas. Our town is richly diverse, with over 25% of the local population describing themselves as coming from an ethnic minority group. Bolton has a higher proportion of older people (65 years old and above) than the overall numbers for Greater Manchester, and this is predicted to increase over the coming decade.

There are some significant challenges for the population of Bolton:

- Bolton is in the 20% most deprived places in England
- 37.5% (22,765) of children live in low-income households
- The number of people who are economically inactive because they are looking after their family or home is rising
- People live with generally poorer health than those for the average across England
- People have a lower life expectancy at birth compared to the national average for men and women, and the extent of this varies across the borough
- One third of people are physically inactive (which is amongst the highest in England) and childhood obesity is above national average
- Bolton was affected by the Covid-19 pandemic more than most areas, specifically the delta variant
- Breastfeeding and smoking in pregnancy are worse than the national average

At Bolton NHS Foundation Trust, we are passionate about doing our very best for the population we serve, which is enshrined in our central Trust ambition of ***Improving care, transforming lives.*** Our Clinical Strategy has been developed in that spirit, with the aim of doing everything we can to design and deliver our services in a way that helps the people of Bolton to live in better health for longer.

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About our services-users

We see a wide range of people in our organisation and, broadly, these can be thought of as falling into three categories:

"Essential" service-users	Those who need care only accessible to them through Bolton NHS Foundation Trust, whether that be for emergency or planned care, wherever it is provided
"Best fit" service-users	Those who do need care, but who could appropriately be supported by other services, such as a pharmacy, Urgent Treatment Centre, or their GP to deal with their problem, but choose to attend our Emergency Department instead
"Safety net" service-users	People who need urgent support, but whose needs may be better served by an alternative provider that they are unable to access at the time, which includes those: - Requiring urgent mental health support - Needing increased social support, either in their own homes or in an alternative setting that they cannot currently access - Entering the last days of their lives, who would benefit from dedicated end of life care better provided outside of an acute setting

During the development of our Clinical Strategy, we have focused on how best we can serve our "Essential" service-users, whilst also considering how we can continue to work collaboratively with our system partners to ensure other users have their needs met in the most appropriate way.

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The purpose of our Clinical Strategy

Our Clinical Strategy is designed to support the delivery of our central Trust ambition of Improving Care, Transforming Lives by:

- Providing an **evidence-based blueprint** for the Trust's clinical future for the next 5 years, helping us to make informed choices about how to deliver innovative and sustainable clinical services that benefit the people we serve
- **Defining how we will respond clinically to the changing needs of our population** and demographics over time, helping us to ensure that the people we serve have equitable access to care
- Supporting the development and delivery of clinical services to **reduce heath inequalities, address the burden of preventable and chronic disease and ill-health, and improve outcomes for all**
- **Guiding how we nurture, develop, and invest in our workforce**, helping us to make the best use of our collective skills, and helping us to work in partnership to develop the workforce of the future
- **Creating a culture of quality improvement and innovation**, where colleagues are encouraged to pursue clinical developments that will make a difference to the health and wellbeing of our population
- **Describing opportunities for investment and transformation** to help us better meet the needs of our population

It provides the guiding principles against which all decisions to deliver and maintain sustainable, clinically effective, operationally, and financially sound services are made. The Strategy will inform and be enabled by:

- Digital development and integration
- Financial investment and future financial stability
- Our future estate needs and plans
- Use of intelligence and insight
- Workforce plans for development, recruitment, and retention

A strategy is nothing without delivery, so within this document we also define our intended outcomes and provide a roadmap for how we will deliver them, so that we can clearly measure its successful implementation.

(Placeholder – this section will be developed ready for the next iteration of the document)

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Our Clinical Priorities

Following an extensive period of engagement (see Appendix C), we have arrived at three priorities for our Clinical Strategy, that support our central Trust ambition for Improving Care, Transforming Lives:

Priority one:

Improving the health of our population

Priority two:

Optimising people's experience from start to finish

Priority three:

Innovating and collaborating for the future

Although these are represented as three different priorities, they are far from mutually exclusive. We expect them to be used collectively and overlap as we review, develop and evolve our services now, and over the next 5 years.

Fundamentally, we believe that by achieving these strategic priorities, we will improve people's access, experience and outcomes when using our services, improve our efficiency and effectiveness, and create a more fulfilling working environment for our dedicated staff. To better understand and articulate these priorities, we have identified 9 supporting areas of focus. These are outlined on the next page and are described in detail in the following chapters.

Our Clinical Strategy and areas of focus

Priority one:

Improving the health of our population

- Meeting the needs of our population
- Addressing healthcare inequalities
- Prevention & early identification of disease

Priority two:

Optimising people's experience from start to finish

- Streamlining the patient's journey
- Making every contact count
- Proactive management of care

Priority three:

Innovating and collaborating for the future

- Adopting a culture of innovation
- Integrating across the Trust & with partners
- Making evidence-based decisions

Improving the health of our population

We want the population we serve to live the best lives they can – to start, live, age and die well.

We know that health inequalities and the social determinants of health impact on people's outcomes and how people access healthcare. Whilst many of these may lie outside our control as a Foundation Trust, we have a key role to play in influencing and improving the health of our population. If we address variation in health and outcomes where we can, people will live without disability for as long as other people across England.

Our focus

Meeting the needs of our population

- Co-designing services with the people we serve through listening to and understanding their needs and experiences
- Addressing the risk factors that contribute to poor health outcomes, such as reducing the prevalence of smoking
- Delivering services in a more accessible way – whether that is through the use of technology, in different settings or by making care more user-friendly for people with additional needs or caring responsibilities
- Providing holistic care that enhances wellbeing and health, from before conception for the best start in life through to ensuring people die comfortably in the place of their choosing

Addressing healthcare inequalities

- Using data to identify where we have inequitable access to our services or disparities in outcomes and working in partnership with local communities and our staff to eliminate this difference and deliver a better experience for all
- Making our services easy to navigate by removing barriers, improving communication, and promoting inclusivity
- Prioritising care for those for whom there is the most existing inequity to reduce that impact on outcomes

Prevention and early identification of disease

- Detecting disease early, through screening and rapid diagnostics, to improve outcomes and reduce the health, social and economic burden of disease
- Working in partnership with our locality and system partners to support public health initiatives to respond to population health needs and to seek to prevent chronic disease for our patients and staff
- Helping people to make positive behavioural changes to improve their physical and mental well-being, by providing the support, resources and education they need to make informed choices

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- Targeting resources and support in areas identified as having the greatest opportunity and impact to reduce future demand
- Helping children and young people to start well and live well, by providing holistic care in both community and hospital settings

Why this is important

There are many social determinants of health that sadly exist and these impact in an inequitable way on people's physical health and outcomes. Deprivation, which is a particular problem in Bolton and the Northwest more generally, is known to be a key factor in these poorer health outcomes, such as a lower life expectancy and higher rates of long-term health conditions. It is unacceptable to have this variation in people's experience and outcomes, so we must work to rectify this as an organisation.

Chronic disease can also have a profound impact on people's lives. The incidence of many conditions, such as diabetes, is climbing, as is the rate of morbid obesity. We are seeing increasing numbers of older people,[3] with concomitant frailty and disability. This will result in an increased need to access the NHS. We must play our part in ensuring we provide the best care for people to either prevent disease or to reduce its burden on individuals, communities and society.

We have a pivotal role in maintaining the population's health. We care for pregnant people, babies, children and young people, in hospital and the community, which means we have a unique opportunity to positively influence children's health in their early years. We provide vital screening and diagnostic services, to identify disease and get people to the treatment they need early in its course. Our clinical teams use evidence-based medicine to care for people with chronic illness, to prevent further complications from those conditions. We deliver palliative care both in hospital and at home, to ensure that when people do reach the end of their life, they die well. We can still do more to improve the health of the population. Our aim for people to live happier, healthier lives, where they can work, care for others and spend more time at home with their family and friends, rather than with us in our healthcare settings, forms a central priority to our Clinical Strategy.

What we heard

There was a clear and consistent theme in our conversations with teams and divisions: the importance of understanding and addressing the diverse needs and challenges experienced by people using our services and the wider population. They told us that to succeed in our ambition to improve care and transform lives, we need a more nuanced approach to how we provide care to all.

We heard the following messages about our population:

- We have people who want to manage their healthcare data and appointments online, and have the technology that enables them to do this – countered against those who live in digital exclusion
- Bolton has a significant variation in overall life expectancy and years lived in ill-health – there are areas of extreme deprivation and with poorer health outcomes, yet some neighbourhoods are much more affluent, living well for longer
- There is variation in people's habits and behaviours that are supportive and protective of health, but rates of preventable diseases could be improved significantly
- People from Bolton often present to us late in the disease process, which makes conditions more difficult to treat with the potential for worse outcomes

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We already have many innovative services that have achieved impressive results in addressing the health of our population, which serve as exemplars as we move forward. These include:

Place holder - we will add examples of innovation in Bolton

What we know

Bolton residents experience poorer health compared to the average UK resident. Circulatory, respiratory and digestive diseases, along with cancer, account for over 60% of the life expectancy gap in Bolton. The local population have also felt the impact of the COVID-19 pandemic disproportionately compared to other areas of the country, with some ethnic minority groups and religious communities in particular being more affected than others,[4] both because of the virus itself and delays in accessing other services. Deprivation also had a pivotal effect on outcomes too; the mortality rates from COVID-19 in the most deprived areas were more than double those in the least deprived.

The population's needs are changing, which we must consider as we develop services for the future:

- We see an increasing diversity in ethnicity, languages and cultures living in the locality and surrounding areas
- There is an increasingly aging population relative to working age, but we also see that those living in disadvantaged areas and with high population mobility tend to be younger
- People are living with multiple medical problems and often have higher care needs

The NHS's Core20PLUS5 approach to tackling health inequalities recognises that the 20% most deprived populations in the UK and those with characteristics that place them at risk of exclusion,[5] are affected by 5 key conditions (dependent on age). As a Foundation Trust, we know we must play our part in addressing these conditions. For adults, this means:

- Improving access to and reducing inequalities in maternity care
- Supporting the physical health for those with mental illness
- Improving vaccination uptake in people living with Chronic Obstructive Pulmonary Disease (COPD)
- Diagnosing cancer earlier
- Identifying and optimally managing people with high blood pressure and lipid levels
- Reducing smoking in the population

For children and young people[6], we will need to:

- Educate people to reduce hospital attendance due to asthma
- Ensure best practice for managing those with diabetes
- Manage those with epilepsy more effectively, especially when people also have learning disabilities or autism
- Reduce the backlog of children waiting for dental extraction due to decay
- Help children and young people to access appropriate mental health services

There is variation across Bolton in how well people can live and their health experiences. Our approach to neighbourhood working affords us the opportunity to understand and address these differences. Bolton has many assets, such as our thriving voluntary sector, and making the most of these will help develop solutions to address the needs of the communities we serve and deliver this Clinical Strategy.

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Place holder:

- *'How we will do it' table to be added*
- *'What we will achieve' list to be added*

Anticipated outcomes

We will ensure equitable access to healthcare services with the goal of achieving equal outcomes; reduce the burden of chronic disease; and contribute to an overall improvement in population health.

Meeting the needs of our population

Improved service design and accessibility

- Improved understanding of our population's needs through active engagement with the public, with evidence of better patient satisfaction and perception of their needs being addressed holistically
- Improved effectiveness and appropriateness of co-designed services based on uptake, satisfaction, and outcomes
- Improved chronic disease management leading to reduced complications and better patient outcomes
- Increased awareness and knowledge among the public and staff on risk factors affecting health and how to access support to address them

Starting, living, ageing and dying well

- Reduced stillbirth rate and increased numbers of premature babies that receive optimal care
- Reduced avoidable hospital admissions through education and best practice management of chronic conditions
- Improvements in health indicators and reduced hospitalisations, particularly in children and young people with asthma and adults with COPD
- Increased percentage of patients able to die comfortably in the place of their choosing

Addressing healthcare inequalities

Improved understanding of population's health

- Increased demographic data completeness
- Increased engagement with community and patient groups
- Continuity of carer during maternity care for those from Black, Asian and minority ethnic communities and most deprived groups

Increased and equitable accessibility

- Increased implementation of inclusive practices, such as interpreter services and accommodations for individuals with disabilities
- Improved equity of access to and uptake of services, demonstrated across all those with protected characteristics and other health inclusion groups

Equal outcomes

- Reduced disparities in health outcomes between people from different demographic groups
- Better physical health for those with severe mental illness
- Reduced mortality for those with learning disabilities and autism

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- Equal outcomes for people using our maternity services and babies born in our care

Prevention and early identification of disease

Measures to reduce disease

- Increased and equitable uptake of our screening offer, with earlier identification of cancer
- Increased percentage of cancers diagnosed being identified at an earlier stage in disease progression
- Increased and equitable uptake of our vaccination offer, particularly in our patients with COPD
- Increased proactive management of patient with high blood pressure and/or lipid levels, in collaboration with primary care colleagues

Positive behavioural changes

- People successfully making positive (self-reported) behavioural changes for physical and mental well-being and prevention of disease
- Increased uptake of smoking cessation support and successful reduction or cessation of smoking, particularly in pregnancy
- Reduced numbers of children requiring dental extraction for decay

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Optimising people's experience from start to finish

We will deliver our services in the best way possible for those that need them, our "essential" service-users. We will make the most of the time we spend together, by optimising our interactions through better access, flow and experience, which will lead to better outcomes. Wherever people receive care, whether at home, from our community and therapy teams or in hospital, we want to deliver streamlined, proactive care.

We will work with our system partners to avoid bringing those better served by an alternative provider (such as mental health services or a social care facility) to the Trust, ensuring collectively that they receive optimal care in the most appropriate place.

Our focus

Streamlining the patient's journey

- Ensuring continuity, coordination and patient-centredness for our service users, by implementing end-to-end pathways with seamless transitions between healthcare professionals and other providers
- Delivering timely, appropriate and high-quality care in the most suitable setting for that them to receive that care
- Minimising unnecessary time spent in the organisation and time spent waiting, through establishing more same-day services, 'one stop shops' and rapid access clinics
- Working collaboratively as a multidisciplinary team and with our external partners to reduce length of stay in hospital through early and effective discharge planning
- Reducing risk and improving patient experience, with a concomitant by-product of improved operational efficiency, productivity and effectiveness
- Utilising novel approaches and technological tools to improve experience and efficiency
- Working towards a 'no wrong front door' approach to the way we deliver our services

Making every contact count

- Being caring, compassionate and people-focused, taking time to better understand people's needs, concerns and expectations to give them the best experience while in our care
- Prioritising quality, safety and experience in every interaction
- Taking every opportunity to prompt people to make positive behavioural changes to improve their physical and mental wellbeing by offering guidance, resources and education
- Recognising opportunities to provide support for people in every stage of life, whether that is helping young people transition to adult services or supporting people as they approach the end of their lives

Proactive management of care

- Empowering, educating and trusting people to be able to manage their own health and wellbeing when living with chronic conditions
- Utilising technological solutions and infrastructure to monitor and manage people more effectively closer to home, responding to changes in their health more promptly to reduce complications

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- Anticipating and addressing people's needs before they escalate, focusing on preventive measures and optimising health outcomes through comprehensive and coordinated care delivery
- Recognising the deteriorating patient, responding appropriately and where people are nearing the end of their lives, supporting them to die comfortably in the place of their choosing
- Targeting resource and support in areas identified as having the greatest opportunity and impact to reduce future demand

Why this is important

There is variation in how people uptake our service offer, which tends to result in differential outcomes. We want people to be able to access our services equitably and experience healthcare that is right for them as an individual. By optimising the patient's journey as they use our services, by building joined up processes and pathways with our communities, we will ensure people get access to the services they need, with better experience and outcomes for all. People also often feel vulnerable when seeking our help, so we must be kind and compassionate and make every moment count towards their recovery and long term wellbeing.

As we start to focus on our "essential" service-users, we can also move to directing people best served by a more suitable service or external provider, to ensure they get the right care from the appropriate professionals in the right place

While optimising the patient's journey will ensure they have a far better experience, it has the additional benefit of being more productive and efficient for the organisation. With growing financial constraints, workforce shortages and demand for healthcare services, we must make the most of our time together and think differently about how we do things – continually focusing on the best interests of the people we serve.

What we heard

In our engagement with clinical and corporate teams from across the organisation, we repeatedly heard about the need for us to coordinate care for people to gain the most benefit from their time spent with us. Whether that is how we maintain safe and effective flow between our services, supporting our children and young people to comfortably transition from paediatric to adult care, prioritising quality and safety in every aspect of the care that we provide, or using our interactions as opportunities to provide advice to help people live healthier lives or plan for how they would prefer to die, it all has a positive impact on the outcomes we deliver.

With growing demand, we need to consider how best to address our capacity needs. Feedback from the clinical teams was clear, in that we need to think 'Community First,' looking for opportunities to deliver care closer to home or virtually, where feasible and agreeable to the patient. This will enable us to better protect acute resources for those who need it most.

People lead busy lives and currently, we may ask them to make multiple trips to visit our services to manage the same condition or issue, which can impact on them in several ways, including:

- Having to take time off work – and for some, this means lost earnings

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- Finding someone to take care of family members while away
- The challenge of locating a suitable car parking space or heavy reliance on public transport or friends and family to get to and from our sites (which are not always co-located)
- The financial impact of these repeated visits to our services – with some people unable to afford to attend

This only serves to widen the health inequalities gap, as it can create inequity in access to our services and the experience that people have in our care. It can also impact on us meeting national targets for care delivery. Teams talked repeatedly about ways to improve the patient journey across our services, and these included:

- "One-stop shops" – where people attend for clinical assessment, undertake diagnostic tests, and receive the results, with an agreed treatment plan, in one appointment
- Increasing day case surgery rates, so that people can go back to their own homes post-operatively
- Increased use of virtual appointments for those that are digitally enabled and prefer this method (with a recognition that we must not increase inequity through digital exclusion)
- Patient-initiated follow up (PIFU) – to empower people to manage their own conditions and reduce the need for routine follow up appointments
- Pre-habilitation and rehabilitation before and after surgery, respectively, to optimise the person's recovery
- Advance Care Planning – where people plan appropriately for the last days of their lives, meaning that they can be supported and cared for in their preferred place of death, rather than being admitted to hospital in crisis as they are dying

We also heard about initiatives that support people to manage their own conditions in the community, meaning they only access our services when they really need to. The use of remote monitoring systems, for example, would support that, and it means people are proactive in their own healthcare.

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What we know

Acting on the leading causes of preventable disease can have a long-term, beneficial impact on population health. There is a drive for people to be more involved in their own care, with a focus on prevention, early diagnosis and intervention. As people are living longer, we will see increasing demand for surgery into older age. This highlights the importance of proactive management of care (such as with preoperative optimisation for surgery).

When it comes to the timeliness and ease of access to healthcare services, we can anticipate that public expectation will only continue to rise over the next decade, to which we will have to adapt. We know that being in hospital has risks; the evidence shows that from the moment a person, particularly someone over the age of 65 years old, lies on a hospital trolley, they can become deconditioned, leading to:

- Reduced muscle strength
- Reduced mobility
- Increased risk of falls
- Increased risk of pressure damage
- Increased confusion or disorientation (particularly if on the background of an existing memory problem)

- Swallowing problems, that can lead to pneumonia

These are often made worse by co-existing medical problems, treated with multiple medications, interacting with the current issue requiring admission.

If we are optimising people's experience from start to finish, there will be times when a person is better served by alternative care providers than Bolton NHS Foundation Trust. If we work with our community partners effectively to ensure that only those people who are "Essential" service-users are admitted to the hospital. For example, those that need urgent social support could receive that in their own home or access care facilities that better serve their needs, including our Intermediate Care facilities. People who are recognised as being frail and very ill, who are entering the last 100 days of their life, with good Advance Care Planning, could be supported to stay at home, where they can be with their family when they want, continue to do what they find pleasure from and maintain their strength to do these things for far longer than if in a hospital bed.

For those people that absolutely do need to come into a hospital setting for management of their condition, we need to be making the most of our time together, by streamlining their journey through our services, making every contact count to ensure an appropriate experience and proactive management of care to mitigate the risks, by:

- Working as a multi-disciplinary team, which includes our skilled Allied Healthcare Professionals, to holistically care for people and to support them to do as much for themselves as possible while with us – making the ward as "home-like" as possible
- Planning for discharge as soon as that person enters hospital, considering what support and rehabilitation they might need, and thinking of innovative ways to deliver that to them
- Using novel approaches to reduce their length of stay, such as improving access to urgent outpatient diagnostic tests, delivering more therapies in people's own homes, using "virtual wards" to follow their progress once discharged and using new technology to monitor people's conditions remotely.

How will we do it

Placeholder: This table format is to be tested with the organisation. It aims to describe the foundational (F), developmental (D) and aspirational (A) actions to deliver our on our priorities and attempts to describe the phasing of delivery. This approach is described in more detail in 'Development and delivery of our Clinical Strategy'

Theme	Action	F	D	A
Engage patients and optimise interactions **Manage own care**	Involve patients in their care planning process and encourage shared decision-making. Educate patients about appropriate care settings and empower them to make informed choices regarding their healthcare utilisation. - Expand mechanisms for patient-initiated care – building on approaches such as Patient Initiated Follow Up (PIFU) Evaluate opportunities to target Making Every Contact Count (MECC) – i.e., pre-habilitation, one stop shops			

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Theme	Action	F	D	A
Harness continuous improvement	**Enable workforce** to identify process bottlenecks, suggest improvements, and participate in problem-solving initiatives.	X		
	Use evidence based best practice, such as Getting It Right First Time (GIRFT), to embed best practice and treatment.	X		
	Monitor and share best practices: Improve mechanisms for sharing best practices and lessons learned across the organisation. Encourage employees to document and share successful improvement projects to inspire and replicate success in other areas.			
	Create and combine cross-divisional teams dedicated to identifying and implementing quality and process improvements. These teams will regularly review performance metrics, engage employees, and drive continuous improvement initiatives.		X	
	Proactive identification. Utilise advanced analytics techniques, such as predictive modelling and prescriptive analytics, to identify improvement opportunities proactively.			X
Relocate services	**Understand** the volume of service users who could be better seen in a different setting; determining highest growth specialities and service user categories.	X		
	Evaluate existing system capacity by analysing patient flow, resource allocation, and infrastructure. Identify bottlenecks, capacity constraints, and areas where improvements are needed through collaboration.	X		
	Alignment of the Six Facet Survey programme to understand condition and quality of the acute estate.	X		
	Collaborate with community organisations and utilise patient feedback and engagement mechanisms to gain a deeper understanding of population needs and preferences.	X		
	Develop and utilise healthcare facilities, such as Bolton One, Breightmet, and community facilities, to support service delivery and meet the needs of the population.	X	X	
	Develop and implement a 5-year organisational plan for shifting care from the hospital site to alternative providers, community settings, retail parks, ambulatory care, home-based care, or virtual care etc. - ensuring hospital capacity is available for more complex cases and maximising the potential of neighbourhoods and system working	X	X	

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Theme	Action	F	D	A
‘One stop shops’	**Collaborate and integrate with system partners** such as primary care, social care, mental health services, public health, Community, Voluntary and Social Enterprise, and community to identify one stop shops for wellness, community health, chronic conditions, family care and geriatrics care	X		
	Develop a comprehensive plan for the location, design, layout and staffing of the one-stop shop facilities. – prioritising off hospital site locations such as retail parks and community settings	X		
	Evaluate one-stop shop provision and redesign services or develop business cases for expansion and new provision		X	
	Refine one stop shops by incorporating personalised medicine and precision health. Adopt personalised medicine approaches, incorporating genomics, biomarkers, and data-driven insights into treatment plans. This could involve tailored therapies, risk assessments, and precision health interventions to optimise individual health outcomes.			X
Prehab, rehab, and enhanced recovery	Optimise preoperative and postoperative care t			
	development of pre-habilitation programs			
	Provide enhanced support after surgery or time with us, cancer services, trauma patient pathways, pain management, and			
Leveraging analytical capabilities	**Improve data recording and support workforce** in understanding how to ‘ask what we don’t know’ of our data	X		
	Provide opportunities for employees to learn about Artificial Intelligence (AI), Machine Learning (ML), and automation tools and encourage them to apply these skills in their work.	X		
	Explore the use of AI and ML algorithms to automate decision-making processes, optimise resource allocation, and identify patterns and trends that can inform process improvements.		X	
	Invest in AI-Assisted Diagnostics and Treatment: AI technologies have the potential to revolutionise healthcare. AI algorithms can analyse medical data, assist in diagnostics, predict disease progression, and recommend treatment plans.			X

Theme	Action	F	D	A
Leveraging technology	**Invest in training to enhance employee's technical skills** and familiarity with emerging technologies.	X		
	Test and implement telemedicine and Virtual Care allowing patients to receive medical consultations and treatment remotely i.e., remote consultations, mobile apps, virtual wards, portable medical devices, and remote monitoring technologies.	X		
	Expand RPA and automation opportunities. Identify processes that can be automated to streamline operations and reduce human error. Prioritise and invest in technology solutions that can automate repetitive tasks and free up employees' time for more value-added activities.	X		
	Evaluate and target telemedicine and Virtual Care investments in		X	
	Develop business cases for uses of Robotics in healthcare – these can be used in surgery, rehabilitation, laboratory, therapy, care, and service		X	X
	Collaborate with academic institutions and industry partners on areas such surgical training and simulation, 3D printing for patient-specific implants, prosthetics, surgical models, and medical devices.			X
	Integrate advanced technologies like augmented reality (AR) and virtual reality (VR) to enhance the patient-doctor interaction.			X
Enhance care coordination and transition	**Roll out and improve functionality of EPR**	X		
	Expand transitional support services. Review and redesign service pathways, improving transitions between care settings, creating integrated care packages, and providing efficient and timely care processes.	X	X	
	Work with system partners to enhance electronic health records (EHR) systems and health information exchanges (HIEs), to enable seamless and comprehensive information sharing and communication across different care settings.		X	

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What will we achieve

Patients receiving the care they need in the most suitable setting, prioritising their well-being and minimising their time in the hospital. Patients enabled to stay in their own homes or as close to home as possible; ensuring their needs are best met.

Patient-Centred Care and Wellbeing:

- Successful adoption of positive behavioural changes leading to improved physical and mental wellbeing. – such as reduced numbers of women smoking during pregnancy.
- Increased evidence of shared decision making with patients.
- Increased use of patient directed care i.e. – patient-initiated follow-up (PIFU)
- Care closer to a setting which suits them

Quality and Safety:

- Reduced occurrence of adverse events, medical errors, or patient harm.
- Reduction in avoidable complications or hospitalisations.
- Improved patient satisfaction and outcomes

Seamless Transitions and Coordinated Care:

- Increased number of patients experiencing seamless transitions between healthcare settings and following a documented care plan consistently.
- Minimised hand-offs or transitions during the patient's care journey.

Timely and Efficient Care Delivery:

- Reduced time between initial referral to decision to treat.
- Reduced time between decision to treat and appropriate intervention.
- Improved wait times for appointments, consultations, and procedures within acceptable limits.
- Reduced average length of stay compared to established benchmarks for elective and non-elective stays

Resource Utilisation and Efficiency:

- Reduction in retesting / repeated tests
- Cost savings or resource optimisation resulting from process improvements
- Reduced healthcare resource utilisation in identified areas of focus - such as emergency department visits or hospital readmissions.
- Increased use of alternative care facilities - i.e., Primary care, community, urgent treatment centres, same-day emergency care, intermediate care, and mental health facilities.
- Reduced time spent in hospital or awaiting admission – i.e., Patients with mental health conditions or social problems.
- Reduced resource utilisation because of targeted interventions and support.
- Maximisation of patient throughput, resource utilisation, and staff productivity.
- Improvement in key performance indicators related to operational efficiency and productivity.

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Innovating and collaborating for the future

Innovating and collaborating are essential; we must adapt where, when, who provides and how we deliver care. We want to build the infrastructure we need to develop our clinical services. With technological advances in healthcare moving at a rapid pace, we have plenty of opportunity to innovate and develop new ways of working. We cannot do that effectively working in organisation silos; we need cross-divisional working with support from our corporate teams. Additionally, as a healthcare provider, we must work collaboratively with our system partners and other stakeholders, along with the people we serve, to develop the services of the future.

Our focus

Building a culture of innovation

- Creating a culture of innovation that fosters creativity, curiosity and encourages experimentation throughout the organisation
- Developing agile and adaptive strategies that enable the organisation to effectively meet evolving population and workforce needs

Integrating across the Trust and with partners

- Designing services and workforce models with partners that meet the needs of our changing population, ensuring that people receive the care they need in the most optimal location for them
- Coordinating the patient journey through healthcare pathways to ensure equitable access and equal outcomes for the population
- Breaking down silos within our services to ensure services are built around the people we serve, to achieve the other priorities of the Clinical Strategy
- Proactively identifying, evaluating, and exploiting opportunities for growth, innovation, and collaboration

Evidence-based decision making

- Adopting best practice for clinical care, using the available evidence to drive shared decision making
- Using our intelligence and insights to establish and maintain the best systems, pathways, and tools to optimise operational efficiency, productivity, and effectiveness within the organisation
- Enhancing data sharing and interoperability between organisations

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Why this is important

We know our population is growing and their healthcare needs are becoming more complex; we need to adapt to this changing healthcare landscape. We have an opportunity to develop new ways of working that mean we can use novel approaches to how we assess, monitor and manage people day-to-day, such as the use of wearable technology, virtual appointments and point of care testing. We can adopt new treatment options or surgical techniques, such as using robotic surgery that will improve outcomes and patient experience. We can use our digital systems to guide us to deliver the best evidence-based care and support patients when they make decisions, with decision-making tools personalised for them. Why is this important?

Through these innovations, we will change how people access and utilise our services and see the results in terms of improved health and wellbeing for the population. It will also support how we achieve the other priorities of the Clinical Strategy.

But innovation alone is not the answer. We must take this opportunity to develop our data utilisation to better understand what we are doing now and to measure the successful achievement of this Clinical Strategy. Our decisions must be data driven. And we must also work collaboratively across the organisation and externally. Integration of the various systems and processes that we require to keep people fit, healthy and safe, is essential for us to maintain the health of our population. Co-design of services through collaboration with patient groups and community residents will ensure our services are fit for the future for the changing population we serve.

What we heard

Through our engagement, many of our staff found this the most challenging topic to input to, and it is important that we acknowledge this. There is work to be done to improve our foundations to support innovation and that some technological solutions are expensive to implement. This is consistent with our other priorities, in that we can build on these foundations once they are in place, which eventually will enable us to aspire to true innovation. It is this approach to phasing the work we do and how we deliver that will enable us to achieve our aims.

We heard the following messages through our engagement sessions:

- There is significant appetite for more insight from our data to help us identify areas of challenge and opportunities
- The areas of greatest opportunity are in Diagnostic and Support Services where technology, automation and artificial intelligence are advancing at a rapid pace
- There is considerable desire for innovation, but our workforce currently feel constrained by the challenges of recovery, high demand, and the financial landscape, along with digital capability issues
- We must work closely with system partners to make sure capacity is in the right places
- We have huge opportunities to develop and train the workforce of the future in partnership with Bolton College and the University of Bolton, and to work with them to pilot and pioneer technology that will improve the quality of care for our service users
- We need to be innovative in our approaches to health improvement, embracing the opportunities technology presents us with

What we know

The public's expectations of how they access services has shifted radically over the last decade. Private companies, such as Amazon and Uber, lead the way in delivering rapid access to services through a combination of user-friendly technological innovation, excellence in logistics and a focus on speed and efficiency. As consumers, we have grown accustomed to choice, short turnaround times, innovation, ease of access and convenience, and as access to most commercial services becomes easier, we should expect an increase in public expectations of the NHS. The King's Fund's 2022 Public Satisfaction survey scores indicate this, as the NHS saw a fall in satisfaction to an all-time low of 29%. Of those who were dissatisfied, 69% cited waiting times to hospital and GP services as the main reason, closely followed by staff shortages. Whilst we know that access and waiting times have been impacted by the pandemic, that only means that more innovative solutions are required to reduce the current pressure on our services.

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Beyond this, the cost of providing comprehensive care to an aging population and advancements in medical technology contribute to the strain on the NHS's financial resources. The NHS is facing significant finance and workforce challenges that have a profound impact on its operations and ability to deliver quality healthcare services. With these financial constraints in place, we must think creatively and innovatively about our future, and how we can work in partnership to improve the care we provide and transform the lives of the people we serve. Our current context is the reason our staff found this the most challenging aspect of our strategy: it is hard to see the future when we are dealing with the pressures of the present. But in focusing on each of our priorities equally, we are hopeful that we can lay strong foundations for innovation and collaboration in the future.

We can embrace change and adopt new technologies to support the delivery of better clinical care as we move forward. We must use the available data, and be clear about what other information we need, to make the right decisions for the people we serve and work for the Trust to gain the best outcomes.

Innovation does not have to be expensive – it can be simple changes in practice that make a considerable difference to access, experience, and outcomes. We are a research active organisation and working with University partners will encourage research and development across all our specialities. Through research, we can identify solutions, innovate, increase knowledge, and improve the way that healthcare professionals work. We will also continue to develop our culture of continuous quality improvement, learning from what we do as well as others.

Integrated care requires everyone involved in the patient's care to work as a team. Each person—whether delivering primary care, secondary care, pharmacy management, or something else—must ask: what are our goals for this patient? What opportunities do we have to achieve a better outcome? In other words, each team member must focus not only on the treatment they are providing, but on the entire care pathway. If this type of integrated approach is used with every person, then we are meeting our ambitions to improve the health of the population and optimise everyone's experience.

Place holder:

- ***'How we will do it' table to be added***
- ***'What we will achieve' list to be added***
- ***Anticipated outcomes to be added***

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What will look and feel different

Our clinical strategic impact outcomes describe what the experience of our key stakeholders will be through the successful delivery of our vision and clinical commitments.

Patients

- I receive excellent care, in a timely way, that is tailored to my individual needs
- My healthcare professionals involve me in the decision about my care – my care is a partnership
- I feel empowered to manage my own health and care
- The care I receive positively impacts my quality of life
- It is easy for me to access the services I need
- All healthcare professionals involved in my care communicate in an appropriate way to share relevant information about me

Workforce

- I have excellent job satisfaction and am clear what is expected of me
- I have job security and there are opportunities for me to progress if I want
- I can participate in quality improvements, research and innovation in my role
- My trust has an excellent reputation for patient care and is forward-thinking
- My organisation offering opportunities for advancing clinical roles across all clinical professions
- I am supported to work across organisational barriers
- I can spend more time on population care instead of avoidable issues

Organisation

- We deliver services in the right places for our patients without duplication
- We communicate in a timely and personal way in the best interest of our patients
- We work together to deliver end-to-end pathways of care
- We offer services close to the patient and in partnership with others
- We consistently achieve quality and performance standards and always seek to improve
- We are financial sustainable

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Development and delivery of our Clinical Strategy

Structure

Our strategy so far has set the direction and describes our priorities and areas of focus.

As we said at the start, a strategy is nothing without delivery, so delivery of the clinical strategy will be underpinned by a complex, but clear, delivery plan and is structured into three delivery phases:

- **Foundational**
  Priorities, targets, outcomes and developments which can be realised in 1-2yrs
- **Developmental**
  Priorities, targets, outcomes and developments which can be realised in 3-5yrs
- **Aspirational**
  Priorities, targets, outcomes and developments which can be realised in 5yrs or more

Although the priorities and impact outcomes will remain our fixed focus, our roadmap/delivery plan will be a live and agile document that is monitored and reviewed regularly. It will be responsive to the insights and intelligence we receive to ensure we deliver our vision and intended outcomes. Each of our supporting plans and strategies will also be incorporated and linked back to the corporate strategy.

Three Delivery Phases

Foundational

These two years are where we focus on getting the basics rights, and from a clinical perspective, that should be rooted in consistent provision of safe, sustainable, compassionate, high-quality care. It is where we truly take ownership of the things that are in our control, and we focus on getting things right every time.

We will focus on areas of our service provision where we have genuine issues of sustainability and produce plans to mitigate this.

We start to define 'how we do things' and 'what we stand for', and we communicate so that everyone understands 'the Bolton way' and it is easy to see where things are falling outside of the standards, we set ourselves for every interaction.

During this time, we better describe productivity and efficiency and take it out of purely financial language and make it about the people we serve. For example, no criteria to reside (NCTR) stops solely being a target we must deliver, and instead is about the positive impact of getting someone into a more suitable location so they are not deconditioned. In this period, we will set clear plans for our enabling functions underpinned by key problems we need address:

- How do we make the best use of our current workforce? Can we utilise their skills better?

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- Where do we have genuine workforce gaps? Are there any solutions available to us to address them?
- Which services can we deliver off the Hospital site? Would changing their location have a positive impact on care and finances?
- How many services do we need to move offsite to enable us to effect change on the Hospital site? The only way we can save money through this is by closing buildings, so is there any opportunity for us to do that?
- What is the investment needed to transform the acute site - we can only do this work to understand what is needed when we have done the pre-work (moving services off site and driving productivity)?
- What are our options to finance estates transformation?
- How do we deliver the digital foundations we need?

We will also work with our partners through the locality planning exercise to map out who needs to do what over the long term.

Bolton College of Medical Sciences (BCMS) will open during the foundational phase and University of Bolton (UoB) will have its first medical students. We need to maximise what we get from this massive opportunity, for current and future staff.

Using data differently, understanding the metrics we want to deliver against to demonstrate health improvement and better outcomes, and how we plan for transforming our services.

There will be a general election in this period, which may stimulate some change to NHS funding

We will start to understand at look at new pathways

Developmental

At this point, we should be starting to see the fruit of our efforts from the foundational phase.

Services will feel more resilient because they are safer and more productive. If there has been a change in Government, we may see a change to funding and more cash and we will be working towards that - preparing ourselves by developing business cases for the things we want and need to better serve our population so that if funding becomes available, we have evidenced cases ready to go. We will have a capital plan that is more closely aligned to our strategy and a shared view of our investment priorities.

During this phase, we will be focused on becoming better across each area of business. We will no doubt be continuing to develop our technical foundations but, in this period, we will be looking towards tangible improvements in internal logistics around diagnostics and potentially developing a plan for future-focused labs through the Health Innovation Bolton partnership. In this phase, we might have students from UoB coming to do their medical rotations. Again, we will be asking ourselves more questions - how do we prepare for this, and what opportunities does it give our consultant workforce to diversify their careers?

We should be starting to see the green shoots of health improvement and have active screening programmes and one-stop shops (and the downstream capacity for treatment) to enable us to contribute to an improvement in life expectancy. From a system perspective, we are confident that people are better able to access care where they need it, rather than defaulting to ED.

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Aspirational

This is where we make the future come to life!

This will be where we know how our estate will be transformed (and actively working towards this), where we are investing in innovative kit and MedTech that makes a tangible difference to outcomes and efficiency.

It is where we have become as productive and efficient as we can be, making us a highly investible proposition in GM. Our reputation is such that people know an investment in Bolton will be quickly realised, because we will make new kit and tech work hard for us.

By this point, we will know that our population's health is on target to improve and see a shifting profile of demand. We will be able to spot issues like rising obesity, cancer rates etc. early and we would react to that by changing the way we do things.

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Enablers

Drafting note: The Communications team is working on a visual presentation of this information with the aim of simplifying and shortening this section

Throughout our engagement process, we have seen that there are clear organisational and underpinning systems, services and teams that will act as enablers for us to deliver our Clinical Strategy. We need the support of these corporate teams to deliver the ambitions of the divisional teams. The Clinical Strategy will also act as the blueprint for many of our plans and will ensure we are aligned in our aims and objectives as an organisation as we go forward.

The following enablers are outlined in this section:

- **Intelligence and insight –** Providing actionable intelligence and analysis to enhance decision-making
- **Workforce –** Developing organisational capacity, capabilities and leadership, and investing in education and training to 'grow our own' and equip staff for new roles and ways of working, making best use of our skill mix, including equipping the organisation to thrive and achieve transformational change at scale
- **Digital –** Deploying technology to integrate and share clinical information and build new and innovative capability for our future
- **Estates –** Making the best use of the Trust's estate and providing greater clarity on the future developments and plans.
- **Finances –** Achieving financial sustainability and predictability

Each of these is discussed in the context of the relevant plan and/or strategy related to that enabler.

Intelligence and insight

The fundamental purpose of any clinical strategy is to support the safe, evidence-based and effective delivery of high-quality clinical services through good planning and operational oversight, responsiveness to demand and agility in the face of challenge and change. We are already building for our future and recognising opportunities within our services and divisions for development; we heard that during the engagement phase of this strategy development. Our ambition now is to take areas of excellent practice and replicate them across our organisation, to ensure that we are making the most of our resources and optimising the time spent with patients to achieve the best outcomes for them.

We need to be planning for our future, using data to inform how we best deliver care in an equitable way, now and in the future, and to identify opportunities to transform, improve and innovate to make sure our services are sustainable. We have access to a wealth of data, but we need to enhance our skills around looking for insights within that data and to ensure that we have a high standard of data quality; we need to be able to trust the information we are basing our decisions upon. Understanding more about the trends in how people access our services, their experience, our performance, where we excel could improve, will all help us to deliver improved outcomes for patients.

"The strongest incentive is the performance data we share with our physicians. Performance data allow them to see the results of their actions and to identify ways in which they can further improve patient care."

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Workforce

Staffing challenges are being faced across many roles in the NHS, but with challenges with recruiting and retaining appropriately skilled frontline clinical workers. We see significant issues with our staffing establishment, with a heavy reliance on agency and temporary workers, which is both a financial pressure and clinical governance risk. We need a sustainable, skilled workforce to delivery this Clinical Strategy. With this Strategy comes opportunity though, to better understand the organisational workforce needs now and going forward. The Clinical Strategy will inform the Trust Workforce Plan and will align with the NHS Long Term Workforce Plan1.

To build our workforce, close working will be required not only with partners in the local healthcare system, but also with other organisations such as local educational institutions. A clear area of feedback from the clinical teams is that there is a need for Bolton to "grow its own" staff by recruiting to junior posts and providing suitable development, training and especially progression posts that staff members can not only see but achieve, to ensure we deliver safe, effective and compassionate care. Strong examples of this are already evident in services such as Theatres and NNU, where their in-house training and development focus is both highly regarded and attracts exceptional candidates. Utilising apprenticeships and looking and new training models will help us further.

Rotation of staff between the acute and community sites where possible will also give rise to a wider breadth of skills and varied working life for staff, whilst also providing better community care and associated potential reductions in acute patient admissions.

The Clinical Strategy will serve as an excellent tool for recruitment of new staff; we will be able to show prospective employees where we are and where we hope to be clinically. It will articulate to people interested in working at Bolton what our priorities are and how we want to deliver our services.

Digital

During the engagement sessions, we heard from teams that they have experienced challenges with the Trust's digital provision that has unfortunately impacted on how they deliver care to patients in the past. A lack of equipment or availability of Wi-Fi has limited how people use digital solutions within the Trust. There is an ongoing roll-out plan in place to rectify these issues.

Internally, work is being completed on the EPR roll out across the organisation to link the outpatient services to the wards, and the wards to Pharmacy, along with other improved options. This will only yield its full potential however once all areas of the Trust have access to reliable IT connectivity through either Wi-Fi or hard wire. Equipment used in the community setting is being updated, to be of an appropriate level of functionality, to support the remote working needs of the staff group and offer reliable system integration with the Trust's systems.

Integration of the multitude of IT systems in use both within and external to the Trust is essential. The free flow of information between teams and organisations is a key element in the joined-up approach to care along the patient's pathway. Externally, work needs to be undertaken for our services to be able to access the primary care record (and vice versa), with automatic population of fields where possible to reduce admin time and the risk of errors inherent in the use of multiple systems and manual transferring of data.

1 NHS England » NHS Long Term Workforce Plan

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Many patients in the younger age ranges are wanting to access healthcare services quickly but virtually, with a much lower expectation of a face-to-face appointment than some of the older generations. Technology is a foundation of the successful delivery of virtual wards, and options for Emergency Department admission avoidance will rely heavily on communications between the ED and several other organisations within the health and social care system.

Estates

Some of our buildings need considerable investment and development to make them fit for the future and provide the infrastructure and capacity that we need to meet demand over the next decade. In 2020, we submitted a strong and compelling proposal for investment as part of the Government's New Hospital Programme, but unfortunately our bid was unsuccessful. We therefore need to develop a compelling plan for the development of our estate and how we plan to execute this. The Clinical Strategy will help us prioritise our Estate Plans, to ensure we meet the foundational, developmental and aspirational aims of the plan, and that we do not undertake developments that will not add value to the people we serve. We will use this strategy to help us arrive at a baseline understanding of capacity and demand for next 10 years for acute and community estate, which will be achieved by:

- Completion of the Six Facet Survey programme to understand condition and quality of the acute estate
- Development of plans for individual clinical services and determining where opportunities exist for services to be delivered differently, away from the acute site if appropriate
- Completion of the data exercise related to access to the Emergency Department to understand the volume of service users who could be better served by other providers
- Using data analysed as part of the Delivery Plan for this Strategy to determine highest growth specialities and map against current capacity
- Working with public health and locality team colleagues, to implement an approach to Making Every Contact Count and public health messaging to begin to effect long term demand

Financial

The Clinical Strategy cannot just be an extensive shopping or wish list of the things we want and believe would make what we do easier, more effective or more efficient. It must balance aspiration with realism and deliverability. We need to understand the financial implications and opportunities of the Clinical Strategy, specifically:

- Where could we save money, invest more smartly, drive efficiency and/or productivity?
- Are there opportunities to change how we spend our money, either as a provider or as a system?
- What are the longer-term opportunities to spend more wisely and where could we invest to save?
- What investments would we want to prioritise?
- What are the business cases we should develop so they are ready should money become available?
- Could we start to define our top priority investments?
- Is there any scope for commercial enterprise within the Trust, to build a revenue stream?

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Roadmap/Delivery plan

Placeholder – a very high-level visual is included below to indicate how the roadmap will be presented but more work is needed to describe this section in more detail. This will follow on from the horizon scanning work and further development of the document so that delivery is appropriate phased

Closing comments from our Chief Executive

Placeholder – this section is to be drafted once further work is completed on the draft.

ENGAGEMENT

Appendix X - Methodology

Overall Approach

Developing a clinical strategy starts with considering and discussing the Trust's vision and values and how these are interpreted by those that work within the organisation. Collectively, to develop the strategy, we think about three key questions:

Consideration and collaboration

The specific approach taken for the development of this clinical strategy for Bolton NHS Foundation Trust involved different phases and a number of associated meetings, due to the complexity and scope of work. These meetings fell into 3 broad categories:

Cross-Divisional Workshops

These workshops involved the Executive Directors and divisional Senior Leadership Teams, where the following was undertaken:

- The context of for the workshop and strategy development exercise was set out
- The expectations and governance process for its development were outlined
- Overarching themes for the strategy were developed, ensuring they were reflective of and relatable to the wider Trust strategy and vision

Clinical Services Meetings

For this series of meetings, Clinical Leads, Operational Business Managers, and other key personnel, from current services within the Trust Structure (either individually or in small groups), were invited to consider:

- The current provision, with any recognised existing weaknesses in the service
- Known and predictable changes expected in the pipeline, along with any potential desirable developments
- Horizon-scanning to understand what might be needed or possible in the future

Divisional / Corporate group meetings

These sessions were to review the output from the other meetings from the service and divisional teams, to understand and consider the enablers needed to achieve these changes.

ENGAGEMENT D

In addition to the divisional Senior Leadership Teams, the following teams were included in these discussions:

- Estates
- Digital
- Workforce
- Transformation
- Finance
- Community services

What we asked

The following set of questions and prompts were used to help the various stakeholders focus their thinking on the future strategy for clinical care:

- What works well?
- What does not work well?
- What can you see in the future for the service? (Visioning)
- What national drivers influence your service?
- What local drivers exist (such as those in our locality, across Greater Manchester and in different partner services)?
- What are the Trust drivers?
- What advances in technology to improve or develop your service do you envisage?
- How can we improve our interface with system partners?
- What is the impact of research on the service? (What are you as a service involved in?)
- What would excellent look like?

Bringing it all together

After compiling the feedback from service and divisional teams, common themes were identified by the Clinical Strategy Project Group and analysed along with data to understand our population demographics and changes we might see in those over the next decade, and the Clinical Strategy was formed. Three Clinical Strategy Priorities were developed, that also deliver against our Trust ambition of ***Improving Care, Transforming Lives***, and are now presented in this document.

ENGAGEMENT DRAFT

Report Title:	Strategy and Operations Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	Sharon White and Rae Wheatcroft		Decision	

Purpose	The purpose of these reports is to provide an update and assurance to the Board on the work delegated to the Strategy and Operations Committee.

Summary:	The attached reports from the Chair of the Strategy and Operations Committee provide an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meeting held on 26 June 2023. Due to the timing of the meetings, the report from meeting held on 24 July will be included in the September board pack.

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

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

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

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

Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	26 June 2023	Date of next meeting:	24 July 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Francis Andrews. In attendance: Sam Ball, Matthew Greene, Sophie Kimber-Craig, Sharon Katema, Rachel Noble, Lisa Rigby, Julie Ryan, Jo Street, Brett Walmsley, Maddie Szekely, Rachel Carter, Louise Clarkson, Michelle McConvey (minutes)	Quorate (Yes/No):	Yes
		Apologies received from:	Sharon White, Andrew Chilton, Tyrone Roberts, Lianne Robinson, Jake Mairs, James Mawrey.

Key Agenda Items:	Lead	Key Points	Action/decision
Terms of reference	R Ganz	The Committee reviewed the Terms of Reference and noted the following amendments: • The alignment of the duration of the Digital Strategy (3 years) and Corporate Strategy (5 years) to be reviewed • ToRs to include deployment of Clinical Strategy as part of the remit & add Deputies for the Medical Director and Chief Nurse as members • The survey on Committee effectiveness was discussed. Overall the feedback confirmed the Committee is performing well in year 1 of operation. Committee remit needs ongoing review annually with a strong ongoing focus on outcomes.	Resolution: The Committee noted ToR Actions: • S White and R Noble to review duration alignment of the various Trust strategies / plans • S Katema is currently reviewing all committee memberships
Service Spotlight: Clinical Strategy		Update presented on the overview of the programme, outlining the 3 clinical strategy priorities and requesting of recommendations from the committee. The following areas were highlighted: • The 3 core themes are: Optimising our intentions, Improving the Health of our population, and Innovating and collaborating for the future. • The draft delivery plan structure is prioritised as follows: Foundation 1-2 years, Development 2-5 years, and Aspirational 5 years+ • The Trust has taken finalisation of the clinical strategy back in house from Archus following an internal review. This will support generating an ambitious yet realistic strategy reflecting the engagement with Divisions.	Resolution: The Committee noted the update with the following responses to members' questions: • Fully supportive of bringing the clinical strategy finalisation back in house and commended it as an appropriate and brave decision • Single item agenda SOC meeting to be organised to review draft strategy in early July • Final version for review by July SOC before sharing with Board for approval end of July

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

Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Month 2 – Operational IPM	J Street	The Committee received the presentation. Key points to note were: **Urgent Care:** • There has been deterioration on a number of key metrics within the last month. However, more than 50% of ambulance handovers were completed in 15 minutes. The Trust remains the second most improved in GM. June see significant pressures within infection control and length of stay. • Performance against the 36 hour fractured NOF has improved this month in comparison to April. This is noted as normal variation as there is a lot of variation from month to month. • Continuing to see low levels of re-admissions rates within 30 days. **Elective Care:** • A total of 36 x 78-week breaches at the end of May, due to internal and external impacts. In particular, a growing number with SLA provision from MFT for paediatric surgery. The RTT wait list continues to grow with a recorded 42K at the end of last week impacted by increased referrals and industrial action. • Slight improved position within Diagnostics of 1.3% in May with continuing good performance of Imaging. • Audiology are back on track and are continuing to follow a revised recovery plan, with the 2 Audiologists back from long term sick leave. **Community Care** • The deflection rate from ED has improved this month, this is due to a strong focus on the engagement work with NWAS. • NCTR shows a reduction in month 2, showing an average of 90 patients which is the first month BFT's internal target has been met. However, the target and average of 4 days delayed has not been met. This was in the context of having 2 wards closed. • New children's metrics have been added to the IPM report: 0-5 HV Mandated Contacts, EHCP Compliance, and Looked after Children. Working with the Division and BI to ensure plans and target lines are in place. • Challenges within the Education Health and Care Plan due to 50% increase in referrals.	Resolution: The Committee noted the IPM presentation. • NCTR performance assisted by having 2 wards closed due to concentrated staffing on fewer wards. Working to keep both wards closed to enable greater capacity for winter • Children's services were confirmed as being integrated with CAMHS when required • Fracture Neck of Femur performance while improved has some breaches where variability in clinical practice as a contributor Actions: • An update on fractured neck of femur performance will be provided at the next meeting • An update on the SEND inspection review will be provided next month.

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Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Cancer Recovery Trajectory update	R Wheatcroft & J Street	The Committee received the Cancer Recovery Trajectory update. The paper outlined the recovery trajectory as failing to achieve the standard recovery. An early indication from Manchester Cancer shows that the Trust is failing both regionally and nationally around the faster diagnosis standard performance. The following areas were highlighted: • The Trust has not met the 62-day standard since May 2022, performance has deteriorated markedly from January 2023. A recovery plan has been in place since November 2022. • The PTL for all cancer referral sources was 1,671 patients as at 31 May 2023. There has been an 80% increase in the PTL size compared to pre pandemic. Most of the challenges are in Breast and urology, this is also coupled with the increase in the breast PTL size. • Best scenario trajectory forecasts a return to achievement of the national cancer 62-day standards for January 2024. • Likely case scenario will assume recovery in Breast and Urology but with none of the other benefits in other pathways and no deterioration. This will move recovery to February 2024. • Worst case scenario is built around assumptions of failing to deliver the improvements within the recovery plan for both Breast and Urology. This would see us not recover during 23-24 and continue to fail the 62-day standard. • Cancer performance and the risk of Recovery are now reflected on the corporate operations risk register.	Resolution: The Committee noted the update. • The 'likely' scenario was discussed as being potentially too optimistic and to be revisited. Actions: • Further information is to follow what it means for the Trust to be on a "Worry List". • Update on the three scenarios at September SOC.
Digital Performance and Transformation Board Chairs Report	B Walmsley	The Chair's report was presented and the following key points were noted: • 5 risks are rated 12 and above on the risk register. • Temporary smart cards are no longer in use within Acute from 23 May 2023. • The full Digital Maturity Assessment is run regionally and nationally to see where Bolton sits, further work is ongoing with the Digital Team to review domains. • Work is in progress with Deputy DDOs to review legacy and orphaned requests through the project office. • A video consultation proposal is to be submitted to Execs for discussion.	Resolution: The Committee noted the Chairs Report noting that there is good work that is not publicised. Actions: • Provide an update on increasing the reach of Digital's comms plan

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Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Digital Strategy Progress update across 4 priorities	B Walmsley & M Szekely	The Committee received the update. The following areas were highlighted: • The four priorities of Integration, Care, Workforce and Infrastructure were each mapped against being Completed, Started and On track together with Additions to the work program and Challenges. Completed projects included community WIFI and Phase 1 Community & Adult Outpatients roll outs • Resource continues to be the key constraint for the digital team and BAU is impacted accordingly. E.g. the service desk can't close cases as quickly with May having 15% open at month end. • The worst case scenario for Maternity EPR is to be unable to extract information for CNST at April 2024. Legal advice is ongoing together with considering alternative suppliers. However, there are both implementation and financial implications including recovering funds already invested.	Resolution: The Committee noted the update. • Significant traction was noted across the 4 digital priorities • The Committee noted the worst case scenario for Maternity EPR Actions: • A maternity EPR briefing paper will be provided at June SOC.
Update on GM BI Ways of Working	J Ryan	The Committee received the update. The following areas were highlighted: • Proposal to bring the FT and ICB Team together to improve collaboration, reduce duplication and provide better support e.g. around Data Science expertise • The new approach and ways of working will help further mitigate risks. • The consultation process is still ongoing.	Resolution: The Committee noted the update. Actions: None
Risk – Ambition 5	S Katema	The Committee reviewed the risk appetite for Ambition 5, 'If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed'	Actions: • The Committee recommended the Risk Appetite be moved from Mature to Seek.
Strategy, Planning & Delivery Committee Outcomes	J Ryan	The Committee received the verbal update around the system wide outcomes work taking place within the Locality Performance and Outcomes Group. The following areas were highlighted: • The outcome work concentrates on the Core20plus5 national framework focusing on reducing health inequalities. • The Core20 element represents the 20% deprived of the national population. In Bolton 26% of the population live in an area that is among the 10% most deprived nationally and 45% live in an area that is among the most 20% deprived nationally. • The 5 Group is 5 clinical areas of focus requiring accelerated improvements for adults. There is also a Core20Plus5 for children which follows a similar pattern. • Once the plus groups have been defined at a local level, this will be brought back through monitoring against the outcomes and for oversight and assurance.	Resolution: The Committee noted the update. Actions: None

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Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Performance and Transformation Board Chairs Report	R Wheatcroft	The Committee received the Chairs report from the meeting held in June 2023.	Resolution: The Committee noted the Chairs Report. Actions: None
Benefits realisation – IV Line Insertion Service update	R Wheatcroft	The Committee received the update.	Resolution: The Committee commended the impact of the IV Line Insertion Service and the transparency of the benefit realisation analysis. Actions: None

Items to note or be escalated to the Board:

- NCTR at 90 patients for the first time, hitting the Trust's internal target (GM target for BFT is 60)
- Cancer recovery is forecast not to meet the standard recovery profile. Scenarios note recovery from best case, January 24 to worse case, beyond March 24
- Clinical strategy is on track for delivery to Board for review and approval in July
- Legal advice ongoing regarding Maternity EPR delivery challenges and alternatives being considered
- Ambition 5 – integration of care – recommended risk appetite to be 'Seek' rather than 'Mature'
- GM consultation on BI still ongoing with the team working on innovative approaches to mitigate the reduction of staff from 10-3 through collaborative system working
- Survey of Committee members confirmed that SOC is performing effectively in its first year of operation

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Bolton
NHS Foundation Trust

Report Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

Purpose	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and to outline the anticipated challenges relating to delivery of the Year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) launched on the 31 May 2023.

<table>
<tr><td>Summary:</td><td>
On the 31 May 2023 NHS Resolution launched year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. As in previous years the scheme incentivises ten maternity safety actions.
Key highlights:
Three CNST safety actions within the year 5 scheme continue to remain at risk namely:

Safety Action 5 - The attainment of 100% supernumerary status of the Delivery Suite Coordinator. The service has maintained compliance in month but this action remains at risk due to the ongoing staffing deficit of circa 50wte Registered Midwives.
Safety Action 6 - Collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset.
Safety Action 8 - Attainment of the training requirements set out in the Core Competency Framework that require 90% attendance of relevant staff groups to be calculated as from January 2023.

Safety Action 2 has been flagged on the progress tracker as amber this month as 90% compliance for the submission of ethnicity data cannot yet be evidenced. Retrospective entry will be undertaken to improve compliance if required prior to submission.
15 of the 26 actions within the Price Waterhouse Cooper audit action plan are now complete and the remaining actions will be completed following the approval of the standard operating procedure, receipt of the reporting cycle of business for the local maternity and neonatal system and receipt of three outstanding audits.
The service can evidence full compliance with 34/42 (80%) of the initial Ockenden recommendations and 24/31 (77%) of the recommendations highlighted in the Kirkup report.
</td></tr>
</table>

Previously considered by:
Report previously discussed at the Quality Assurance Committee

Proposed Resolution	*It is recommended that the Board:* *i. Receive the contents of the report* *ii. Approve the actions plan detailed within this report* *iii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.*

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

Prepared by:	T Roberts, Chief Nurse J Cotton, Director of Midwifery/ Divisional Nurse Director	**Presented by:**	T Roberts, Chief Nurse J Cotton, Director of Midwifery/ Divisional Nurse Director

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

ATAIN	Avoiding Term Admissions into Neonatal Units
CNST	Clinical Negligence Scheme for Trusts
MIS	Maternity Incentive Scheme
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training

1. Introduction

1.1 The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and to outline the anticipated challenges relating to delivery of the year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) launched on the 31 May 2023.

2. CNST Year 5 Scheme Update

2.1 On the 31 May 2023 NHS Resolution launched year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. As in previous years the scheme incentivises ten maternity safety actions.

2.2 Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

3. Price Waterhouse Cooper (PWC) Audit

3.1 In accordance with the recommendations of the internal audit report published by Price Waterhouse and Cooper in February 2023 every effort is being made to optimise the operational and governance arrangements associated with delivery of the year 5 scheme that relate to:

- Optimising compliance with the scheme
- Allocating roles and responsibilities
- Enhancing planning and oversight
- Confirming the clinical audit plan
- Establishment of a working group

3.2 As of 5 July 2023 15 of the 26 actions have been completed and the remaining actions will be completed following the approval of the standard operating procedure, receipt of the reporting cycle of business for the local maternity and neonatal system and receipt of three outstanding audits.

4. Progress Tracker

4.1 A summary of progress to date with regard to the attainment of all MIS ten safety actions identified within the CNST year 5 scheme are summarised in the table 1 below. To date three of the safety actions, remain at risk and seven of the actions are on track. The table also shows compliance at indicator level.

Table 1 – CNST Progress Tracker

CNST Year 5 Progress Tracker						
Action No.	**Maternity Safety Action**	**RAG**	**Number of Indicators**	**Red (Failed)**	**Amber (Awaiting detail)**	**Green (On track)**
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		12			12
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		11		1	10
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		21			21
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		35			35
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		5			5
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		27		27	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		13			13

8	Can you evidence the following 3 elements of local training plans and 'in house', one day multi professional training?		23		23	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		20			20
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		10			10
Total			177	0	51	116

5. Mandatory Updates

5.1 Safety Action 1 - Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? GREEN

5.2 The CNST schedule requires quarterly reports to be submitted to the Trust Board that includes details of deaths reviewed and themes identified with consequent action plans.

5.3 5 cases have been reported to MBRRACE during this period and the required standard has been met for all cases to date (Appendix 1). All cases are currently awaiting their final report and identification of thematic learning to be identified prior to the sharing of themes and consequent action plans.

5.4 Safety Action 3 Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? GREEN

5.5 A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks is undertaken quarterly. The Q4 report has now been published and shared with the local maternity and neonatal system. The focus of the review is to identify whether separation could have been avoided and the action plan to address findings is detailed in Appendix 1a.

6. Safety actions at risk

6.1 The underpinning detail relating to three safety actions considered to be at risk of non-attainment and one safety action that is being closely monitored as follows:

6.2 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? AMBER

6.3 Ensuring a valid ethnic category for at least 90% of women booked in the month of July 2023 is required to meet this standard.

6.4 The pre-assessment audit undertaken on the 5 July 2023 highlighted that only 85.9% of women had their ethnicity data captured on the Euroking maternity system. In response formal communication have been issued to advise staff to complete the data for all women booked from the 1 July 2023.

6.5 The outcome of compliance submissions is reported in retrospect to the Trust formally via digital scorecard each month.

6.6 Compliance with the July submission is currently being tracked weekly.

6.7 Retrospective data entry will be undertaken to improve compliance if required prior to submission.

6.8 Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? AMBER

6.9 Submission of data for this safety action during the year 5 period needs to be made using a national implementation tool that will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle. The tool was published on the 4 July 2023 and therefore will be included in future reports when appropriate access has been enacted.

6.10 The relevant data items for these process indicators should already be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the Maternity Services Data Set (MSDS) submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.

6.11 Unfortunately, the delay in the implementation of the maternity electronic record has impacted upon the collation of the required digital data and it is unknown currently if multiple datasets can be migrated into the data collection tool as part of the submission and /or whether all required datasets are currently recorded digitally.

6.12 Scoping work is being undertaken by the business intelligence team currently to verify the trust position and legal advice is being sought with regard to the delayed maternity electronic patient record implementation.

6.13 Failure to submit the required data in the correct digital format is likely to impact upon attainment of this safety action as submission via audit is not permitted during the year 5 period.

6.14 A copy of the current saving babies lives dashboard is detailed within Appendix 2 to illustrate progress to date.

6.15 Contact has been made with the Integrated Care Board representative to establish formal quality improvement sessions using the new national implementation tool as from September 2023 as currently the updates are provided informally.

6.16 Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? AMBER

6.17 The year 5 training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups to be attained in six specified training elements

starting from the maternity incentive scheme in August 2021 and up to July 2024. Compliance will be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme. The year 4 submission was based upon the January 2023 dataset and therefore this will be the starting point of the 12-month consecutive period.

6.18 Due to staffing challenges profession specific training compliance has remained below the expected standard of compliance throughout the year 4 scheme and at the point the compliance was reported. The current compliance rate remains below the 90% standard as of July 2023 for 5 of the 6 indicators (Appendix 3)

6.19 The current service training offer is being updated to align with the revised guidance and this will necessitate the addition of another full day of fetal monitoring training to be undertaken by staff groups from August 2023.

6.20 A locally held database continues to be used prior to the transfer of the data to the electronic staff record system which requires significant manual oversight. Currently this is being managed by a bank worker as recruitment to the appointment of administrative support has been delayed and thus the transfer of the education data to the electronic staff record has not progressed as planned.

6.21 As the need for robust training data is an essential part of service reporting requirements both internally and externally, approval has been given to recruit substantively to the Band 4 1WTE administrative post to support the required data collation.

6.22 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? GREEN

6.23 Supernumerary Status of the Co-ordinator

6.24 The Trust can report compliance with this standard if non-compliance is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time.

6.25 The year 5 guidance stipulates that the midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

6.26 If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard).

6.27 There were three reported breaches of the supernumerary standard in June 2023 on the Birth Rate Plus tool whereby the Delivery Suite Co-ordinator was noted to have delivered 1:1 care to a woman and thus the safety action recommended standard was breached. When reviewed in detail the breaches related to an inputter error by a new staff member and therefore the standard has been maintained. Training has been provided to address the concern.

6.28 In order to optimise compliance every effort will be made to continue to review each incidence of non-compliance and identify if the frequency is within the remits of acceptance in accordance with the technical guidance provided by NHS resolution. Monthly compliance rates will be included in all future Board/Committee reports for oversight and scrutiny as part of the maternity champions dashboard.

6.29 The service has maintained compliance in month but this action remains at risk due to the ongoing staffing deficit of circa 50wte Registered Midwives. Every effort will be made to mitigate this risk using formal escalation procedures.

7. Ongoing performance oversight

7.1 The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the 'Implementing a revised perinatal quality surveillance model' guidance published in 2020.

7.2 In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance and will be included in all future reports. All serious incident reviews continue to be shared for the approval of Quality Assurance Committee when completed. Additional required datasets from staff feedback sessions are displayed in Appendix 4.

7.3 Table 2 – Safety Champions locally agreed dashboard

CQC rating	Overall	Safe	Effective	Caring	Well -Led	Responsive
Regional Support Programme	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Indicator	Goal	Red Flag	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Quality & Safety								
CNST attainment	Information only			30%				
Critical Safety Indicators								
Births	Information only		427	445	374	454	398	451
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			2	4	1	3	1	2
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	3.4	4.2	4.2	4.6	3.8	4.1
HIE Grades 2&3 (Bolton Babies only)	0	1	3	1	1	0	0	0
1HIE (2&3) rate (12 month rolling)	<2	2.5	0.9	0.9	0.9	0.9	0.9	0.9
Early Neonatal Deaths (Bolton Births only)	Information only		3	2	1	2	1	1
END rate in month	Information only		7.0	4.5	2.7	4.4	2.5	2.2
END rate (12 month rolling)	2.4	>3.1	3.3	3.5	3.5	3.9	3.8	4.0
Late Neonatal deaths	Information only		0	1	0	0	0	1
Perinatal Mortality rate (12 month rolling)	7.5	8	7.3	8.4	8.5	9.1	8.1	8.9
Serious Untoward Incidents (New only)	0	2	2	1	1	2	0	0
HSIB referrals			0	1	0	0	0	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			1	2	1	1	0	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	97.5%	98.6%	98.5%	96.7%	98%	99.7%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	1	3	2	2	1	1
Saving Babies Lives Care bundle training – e learning	<90%	>90%						13.36%

Fetal monitoring training compliance (overall)	<90%	>90%		77.74%	77.00%	72.16%	78.00%	75.05%
PROMPT training compliance (overall)	<90%	>90%	86.50%	86.10%	82.34%	72.16%	78.00%	63.43%
Neonatal basic life support (defined cohort)	<90%	>90%						
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:28.9	1:27.5	1:27.1	1:26.9	1:26.8	1:28.9
RCOG benchmarking compliance	Information only		54%	100%	86%	95.8%	100%	93%
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

8.1 The dashboard highlights an elevated early neonatal death rate. When compared to Greater Manchester and Eastern Cheshire (GMEC) peers the Trust total early neonatal death rate is 0.95/1000 year to date compared to 2.96/1000 when compared with all GMEC maternity providers. The Trust stillbirth rate also compares favourably with peers at 4.29/1000 year to date compared with 4.97/1000 within all other GMEC providers.

8.2 A review of the local training plan and training database is being to ensure all six core modules of the Core Competency Framework can be monitored to demonstrate 90% compliance before July 2024. A revision of the integrated performance speciality dashboard is being undertaken to capture this data. Compliance as detailed in the local maternity and neonatal system quarterly submission is detailed in Appendix 3.

8.3 Administrative band 4 1WTE support has been funded to support this data collation and revision of the dashboard with the intention of migration to the Electronic Staff Record metrics for all e-learning metrics.

8.4 The business intelligence unit is currently collating a dataset that will detail the % of caesarean section births in accordance with the robson criteria (a perinatal classification system promoted by the World Health Organisation which will assist in the understanding of birth needs to be served by the maternity service).

8.5 Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity serious Incidents is required. All serious incidents are therefore presented to Quality Assurance Committee in full for oversight and scrutiny and metrics of quality are detailed in the safety champions dashboard. Additional metrics are also included in the monthly integrated performance dashboard published monthly. Staff feedback from Executive / Non-Executive engagement sessions is detailed in Appendix 4.

8.6 The Q4 triangulation of incident, complaint and scorecard data report was presented at Trust Clinical Governance and Quality Committee in July 2023 and is scheduled to be shared at the Family Care Divisional Governance meeting held on 13 July to meet the scheme requirements.

8.7 To be noted the maternity service is due to participate in cohort 4 of the perinatal culture and leadership programme due to commence in September 2023.

9. Ockenden / Kirkup benchmarking

9.1 A recent benchmarking exercise to ascertain compliance with the recommendations from the initial Ockenden report published in December 2020 and The Morecambe Bay Investigation (Kirkup) report published in 2015 has been undertaken by all providers within Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System.

9.2 Currently the service can demonstrate full compliance with 34/42 (80%) of the initial Ockenden recommendations and partial compliance with the remaining 8 recommendations.

9.3 The verified position is required to be shared at a public Board and is detailed in Table 3. The detail will be included in the May Board report.

Table 3 - Ockenden initial report compliance as of March 2023

IEA number	Immediate and Essential Action	Required Standard	Number of questions in action	No of questions with no evidence collected to meet requirements	No of questions that require updated evidence	No of questions with all evidence collected to meet requirements
1	**Enhanced Safety**	Trusts must work collaboratively to ensure serious incidents are investigated thoroughly and Trust Board must have oversight of these	7	0	1	6
2	**Listening to Women and Families**	Maternity Services must ensure women and their families have their voices heard	5	0	0	5
3	**Staff Training and Working Together**	Staff who work together must train together and MDT Ward Round Twice Daily	6	0	3	3
4	**Managing Complex Pregnancy**	There must be robust pathways in place for managing women with complex pregnancies	6	0	4	2
5	**Risk Assessment Throughout Pregnancy**	Staff must ensure that women undergo risk assessments in pregnancy at each contact	3	0	0	3
6	**Monitoring Fetal Well-being**	Dedicated leads for Fetal Monitoring who champion best practice in fetal surveillance	4	0	2	2
7	**Informed Consent**	Women must have access to accurate information to enable informed choice	6	0	0	6
WF	**Workforce and compliance with NICE guidelines**		5	0	1	4
		Total	**42**	**0**	**11**	**31**

9.4 Areas of further improvement relate to:

- IEA1 – Collation of a standard operating procedure for perinatal surveillance monitoring
- IEA 3&6 – Training trajectory
- IEA4&6 – Audit of complex pregnancies and full Saving Babies Lives bundle implementation
- Workforce – NICE benchmarking of new guidance and risk assessments if not compliant.

9.5 The service can evidence current compliance with 24/31 (77%) of the recommendations highlighted in the Kirkup report. Areas of ongoing focus include:

- Review preceptorship package and induction package for locums
- Review induction programme for locum doctors
- Implementation of staff rotation plan
- Improvement of management of confidential enquiry reports within governance process in service

9.6 Recruitment to an additional band 7 maternity governance lead post and re-alignment of the governance arrangements in line with the Ockenden recommendations remains ongoing to support the governance arrangements within the Division.

10. FiCare Accreditation

10.1 On the 11 July 2023 the neonatal unit were awarded green FiCare accreditation status (family integrated care). The visiting team commended the efforts made by the service to embed FiCare within practice and commended the work of the team to achieve the status.

11. Risk

11.1 The review of the year 5 scheme requirements undertaken by the Director of Midwifery has highlighted that limited assurance can be provided that all ten safety actions will be attained during the CNST year 5 scheme. The risk to the financial reimbursement awarded to the Trust upon completion of the year 5 scheme (circa £1,000,000) is to be acknowledged.

12. Financial

12.1 On the 9 June 2023 the Trust was received £221k discretionary funds to support the delivery of the safety actions that were not attained in the CNST year 4 programme of works following approval of a detailed action plan.

12.2 A briefing update was presented to the Executive Directors on the 12 June 2023 and approval was given to recruit substantively to all of the funded posts identified in the formal submission to NHS resolution in order to optimise delivery of the year 5 recommendations and an additional administrative post was also approved.

13. Summary

13.1 The report provides an overview of the safety and quality programmes of work within the maternity and neonatal services and preparations being made in anticipation of the Year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme**.**

13.2 Assurance can be provided that work continues to deliver the actions defined within the recent PWC audit to improve oversight and management of future CNST schemes.

13.3 Three CNST safety actions within the year 5 scheme continue to remain at risk.

14. Recommendations

It is recommended that the Board

i. Receive the contents of the report

ii. Approve the actions plan detailed within this report

iii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Cases reported to MBRRACE from 30 May 2023

Case ID no	SB /NND /	Gestation	DOB /	Reported within 7 days	1 month surveillance Deadline Date	PMRT Started 2 Months Deadline Date	Date parents informed/concerns questions	Report to draft Deadline Date	Report published Deadline Date
87653	SB	33 +4	26.5.23	0	26.6.23	26.7.23	26.5.23 27.5.23	26.9.23	26.11.23
87775	SB	26 +6	1.6.23	2	1.7.23	1.8.23	31.5.23	1.10.23	1.12.23
87828	SB	36 +2	6.6.23	0	6.7.23	6.8.23	8.6.23 15.6.23	6.10.23	6.12.23
88155	SB	32 +2	24.6.23	5	28.6.23	28.6.23	28.6.23	24.10.23	24.12.23
88233	SB	24 +3	30.6.23	3	30.08.2023	30.09.2023	30.06.2023	30.10.2023	30.12.2023

Appendix 1a ATAIN action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4	
1	**A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided.**	Review current data collection process to enable capture and validation of future data in digital format and identify trends and themes	Business Intelligence Lead Postnatal Ward Manager	30 June 2023	03/07/2023 Reviews on data capture being explored. Improvements continuously being made dependant on report findings to capture data and promote effective data analysis and cleansing to highlight areas for improvement and outcomes.		
		Complete quarterly reviews of term admissions to NeoNatal Units with the aim being on identifying if separation could be avoided	Governance Lead	As per LMNS schedule	11.07.23 Q4 audit completed.	**Q4**	4
						Q1	
						Q2	
						Q3	
2		Ensure action plan is shared when approved with the quadrumvirate	Director of Midwifery	1 February 2024	12/07/23 Action plan sent for inclusion on Divisional Board agenda	4	
		LMNS	Director of Midwifery	1 February 2024	03/07/2023 JC to share with LMNS 11.07.23 Q4 report and plan shared	**Q4**	4
						Q1	
						Q2	
						Q3	

					on 11 July 2023	
		ICB	Director of Midwifery	1 February 2024		
		Trust Board	Director of Midwifery	1 February 2024	12.07.23 Action plan shared at QAC – delegated committee of Board	
3		Use national ATAIN for auditing purposes	Maternity Governance Lead	30 July 2023	12.07.23 National tool used for data collation and review.	
4		Add further detail to the ATAIN pro-forma to support identification of trends and contributory factors to unexpected Neonatal Admissions in Q1 2023-2024 audit proforma	Maternity Governance Lead	30 July 2023		
5		Undertake a deep dive review of respiratory distress as the main cause of admission to NNU at term	Consultant Neonatologist	1 February 2024		
6	Potentially unavoidable admissions	Review Trust lactate guideline as a contributory factor for potentially avoidable admissions to Neonatal Unit	Consultant Neonatologist	1 February 2024		
7	Trusts should have or be working	Review and update the Transitional	Matron Complex Care	30 April 2023	03/03/2023 Guideline reviewed and	

	towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late	care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.			updated and awaiting ratification at guideline group. On agenda for Guideline Group March 2023. 12/07/23 Guideline updated May 2023	
8	preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	Implement full the BAPM transitional care framework for practice	Postnatal Ward Lead Complex Care Matron	1 February 2024		

Appendix 2 – SBLV2 dashboard

Indicator	Frequency of Audit	Target	Q4 (22-23)	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded	Annual	80% Action plan required to achieve >95%	100% (E3 Data - 93.92 %)	**93.99 %**	**93.00 %**	**95.52 %**	**71.96 %**	**86.60 %**	Awaiting data
Percentage of women where CO measurement at 36 weeks is recorded	Annual	80% Action plan required to achieve >95%	80% (E3 Data - 61.05 %)	**57.77 %**	**57.68 %**	**67.71 %**	**65.56 %**	**56.53 %**	Awaiting data
Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan	Annual	80.00%	97.50 %	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)
Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	N/A	No Target	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

In pregnancies identified as high risk at booking uterine artery Dop pler flow velocimetry is performed by 24 completed weeks gestation	N/A	No Target	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant
There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	Quart erly	No Target	Compli ant 2.81%				Awaiting data		
The Trust have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identificatio n and managemen t of FGR was a relevant issue (using the PMRT).	N/A	No Target	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant
The risk assessment and managemen t of growth disorders in multiple pregnancy complies with NICE	N/A	No Target	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant	Compli ant

guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.									
Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.	Annual	80%	100%	Audit Annual (not repeated)	100%	Audit Annual (not repeated)	95%	100%	Audit Annual (not repeated)
Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).	Annual	80%	100%	Audit Annual (not repeated)	100%	Audit Annual (not repeated)	100%	100%	Audit Annual (not repeated)
Trust board sign off	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC
That staff training on using their local CTG machines	Annual	No Target	In Progress	In Progress	In Progress	In Progress	In Progress	In Progress	In Progress
That staff training on fetal monitoring in labour	Annual	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

are conducted annually									
The Trust board should specifically confirm that within their organisation: - 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.	Annual	90%	70.69%				76.16%	Awaiting data	Awaiting data
A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest.	N/A	N/A	Non Compliant	Non Compliant	Non Compliant	Non Compliant	Non Compliant	Non Compliant	Non Compliant
Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	Monthly	80% *(Does not fail CNST if <80%)	58%	66.67%	50% (Remaining 50% had partial course)	72.72% (18.18% had partial course)	40% (30% had partial course)	Awaiting data	Awaiting data

Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Monthly	'As low as possible '	11%	33.33 %	0%	0%	20%	Awaiting data	Awaiting data
Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	Monthly	80% *(Does not fail CNST if <80%)	95.33 %	100%	100%	100%	75%	Awaiting data	Awaiting data
Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	Monthly	80% *(Does not fail CNST if <80%)	91.66 %	100%	100%	100%	100%	100%	Awaiting data
They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention.	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic	Annual	80% *(Does not fail CNST if <80%/Action plan required for achieving >80%)	97.5% Assessed 100% Correctly referred	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)	Audit Annual (not yet repeated)

and pathway									
Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Appendix 3

Name of Maternity Provider: Royal Bolton Hospital – 28/06/23				
Time Period reporting on (please tick) January to April (Report in May) x May to August (Report in September) ☐ September to December (Report in January) ☐				
Core training as per core competency assessment	**Percentage of staff who are compliant with training**			
	Midwifery staff	Obstetric Staff	Anaesthetic Staff	Other Staff Groups
Fetal Monitoring Training	*86%*	*70%*	*N/A*	*N/A*
Saving Babies Lives Care Bundle	*72%*	*40%*	*N/A*	*N/A*
Maternity Emergencies and multi-professional training *Please specify which topics under this heading you have undertaken for this period* • Breech Birth • Antepartum Haemorrhage • Impacted Fetal Head • Cord Prolapse/	*92%*	*96%*	*98%*	*80%*
Neonatal Life Support	*84%*	*N/A*	*N/A*	*N/A*
Care during labour and the immediate postnatal period *Please specify which topics under this heading you have undertaken for this period* • Management of epidural anesthesia • Recovery care after general anesthetic	*48%*	*N/A*	*N/A*	*N/A*
COVID-19 Specific training	*N/A*	*N/A*	*N/A*	*N/A*
Maternal Critical Care	*No data*	*No data*	*No data*	*No data*
Personalised Care *Please specify which topics under this heading you have undertaken for this period* *Safeguarding* *Mental Health*	*48%*	*N/A*	*N/A*	*N/A*
Targeted local learning	*48%*	*N/A*	*N/A*	*N/A*

Appendix 4

Feedback from Executive / Non-Executive Staff Walkabouts

You Said	We did
A reflective covering needed to be placed on the postnatal ward windows to help assist with temperature control during the summer months	A date for the work to be undertaken was confirmed for wc 12 June by the estates team
A new clinical room is needed on M4	A new clinical room was fitted in April 2023
An updated mobile phone is required for the Neonatal Unit Co-ordinator	A new mobile phone was provided in May 2023
Benches are needed for families outside of the maternity unit	We are currently seeking funding from our Trust charitable fund for benches to be installed

Report Title:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	Purpose	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	Francis Andrews		Decision	

Purpose	The purpose of these reports is to provide an update and assurance to the Board on the work delegated to the Quality Assurance Committee.

Summary:	The attached reports from the Chair of the Quality Assurance Committee provide an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed by the Committee at the meetings held on 21 June and 19 July 2023.

Previously considered by:
Discussed and agreed at Quality Assurance Committee.

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

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

Prepared by:	Malcolm Brown Non-Executive Director	Presented by:	Malcolm Brown Non-Executive Director

Quality Assurance Committee Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	21 June 2023	Date of Next Meeting	19 July 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Tyrone Roberts, Niruban Ratnarajah, Francis Andrews and Divisional Representation.	Apologies received from:	Fiona Noden, Sharon White, Rae Wheatcroft, Sophie Kimber-Craig, Martin North and Harni Bharaj.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report	Amber	Chief Nurse	The paper was taken as read with the Committee noting the following: • The Pressure Ulcer Collaborative continues to run with a duration of 18 months. • There have been two further Category 4 pressure ulcers, one was on A4 and is currently going through the Serious Incident process as gaps in turning were considerable and not a random lapse in care. • The Chief Nurse commented that following review it was felt there were no omissions in care provided in the Community but the harm free care process had failed to review the patients' health journey prior to accessing community care, and this is where the sub-optimal care was detected. • The second Category 4 was on B1 and had been escalated owing to a lack of assurance of the harm free care process. Going forward it was noted that all Category 3&4 will go through Serious Incident reviews. • This may lead to an increase in cases seen due to the focus on this but need to see that outcomes and leadership can be addressed. • It was noted that Serious Incidents have seen a real improvement with respect to completion and delivery to families within 60 days however, there are still concerns within Maternity around the lack of cause to maintain liability so have agreed interim support around this. • There were13 healthcare associated C-difficile cases in April, which is a decrease from March but still above the trajectory. • The first learning collaborative was launched in March looking to address long standing issues relating to c-difficile such as identifying and managing symptomatic patients but also reducing the risk of transmission.	**Decision**: The Quality Assurance Committee received and noted the report.

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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
			• It was noted that C-section birth rates would be included on the IPR report going forward as part of the Robson score framework. They will show without a target as required nationally. JN raised a query regarding the increased number of blood culture contaminations and c-difficile outbreaks to which DND DSSD confirmed that there is a Safer Clean bundle being launched shortly, which is linked to fundamental care.	
Clinical Governance & Quality Committee Chairs Report		Chief Nurse	This item was not received as the meeting was postponed due to the CQC Inspection.	**Action:** To be received at the next meeting.
Quality Account Q4 – Priority 1 – Antibiotic Prescribing Standards		AACD	The report was received and noted: • An education programme was created by the junior doctors to train and raise awareness on the appropriate method of prescribing and reviewing antibiotics through EPR. • Induction information will be created for both objectives by the junior doctors and the Antimicrobial Stewardship Committee with the support of the Digital Education Team in time for the doctor changeover in August. • Quarterly antibiotic prescribing audits will resume from October. The performance data will then be shared with the teams in divisions to be discussed in their Divisional Governance meetings. • A chairs report will be submitted to the Antimicrobial Stewardship Committee with action plans for improvement that will feed through Drug and Therapeutics and into Quality Assurance Committee. • RM noted a discussion with the junior doctors revealed that they felt uncomfortable to stop prescribing unless asked to do so and there were comments that antibiotics were not prescribed to appropriate standards when consultants overrule them. There was a discussion amongst the Committee regarding culture changes needed and this can only be done through induction and mandatory training.	**Decision:** The Quality Assurance Committee received and noted the update.

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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Quality Account Q4 – Priority 3 – Improving Information to Patients	Amber	FCD	The report was received and noted: • Benchmarking was initially carried out the results were good but then there was a change in leadership etc. within the division and so had seen a loss of traction but Q3 & Q4 had seen recent improvements. • Maternity had a good response rates regarding discharge and admission but communication on M2/Delivery Suite had been the main focus. • Communication with induction labour plan is the key focus and is being led by Midwives, Matrons and Consultants. This plan will be for those awaiting time from admission to Delivery Suite and any communication in-between. • Information to patients when booked in has been updated and there were some noted quick wins with the increase of recruitment and improving patient waiting time and changes to ultrasound appointments.	**Decision:** The Quality Assurance Committee received and noted the update.
Quality Account Q4 – Priority 5 – Accessible Information Standards	Green	DSSD	The report was received and noted: • The Division has reached its goal of implementing multiple written and audio translation options via the digital letter service and text reminders and have implemented the use of yellow paper, larger font and to opt out of digital letters. • The Division had also rolled out a communications card across Centralised Support Services to collect patient communication needs and ensuring that these are electronically registered and stickers placed of paper notes so staff are aware of these needs. • It was noted that whilst the Quality Account had ended the work being undertaken would continue to be monitored via the Divisional Governance Committee, Divisional Board and Clinical Governance and Quality Committee.	**Decision:** The Quality Assurance Committee received and noted the update.

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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Bolton Quality Account 2022/23		S Bates	The report was received and noted: • It was confirmed that the recently finished Quality Account priorities would continue to be monitored through the Divisional Governance and Clinical Governance & Quality Committee. • The final Quality Account 2022/23 will be taken to the Audit Committee and Board of Directors before the final publication. • The DMD AACD confirmed that 25% was the figure pre-audit and that the Quality Account target was to increase this by another 10% to take it to 35%. The DMD AACD advised that the re-audit had not yet been completed and so the figures are not accurate. • It was agreed that the Family Care Division would provide narrative to be included alongside the Improving Information to Patient section of the report in relation to the leadership changes. In relation to a query raised by the Chair, regarding if the Trust had a target for stopping Category 2 Pressure Ulcers TR confirmed that a reducing in the SPC was what the Trust was looking to achieve.	**Action:** SB will amend the report in line with discussion held at the Committee. **Decision**: The Quality Assurance Committee received and noted the update.
Bolton Quality Improvement Plan – Working Document		S Bates	The report was received and noted: • The report provided the draft working document of the Trust Quality Improvement Plan for 2023-2028 alongside a draft stakeholder engagement plan. • The report noted the definition of quality as per the NQB's national definition, the model for improvement and the improvement collaborative and the delivery plan in terms of measurement, governance and collaborative working with other Trusts. • The Committee were informed that there will be an annual review of the plan and the outcomes along with plans for the forthcoming year linked to the key goals, which will be the Trust's Quality Account Improvement Priorities. JN queried the level of patient/carer involvement in the plan, as there is readily available feedback that there are many professional involved in care and how these can be joined together. SB confirmed that if the draft Quality Improvement plan was agreed then this would open up the opportunity for system partners to also engage and assist as part of a system collaborative.	**Action:** SB to ensure the high-level information is understood by ground floor staff as per the Chairs request. **Decision:** The Quality Assurance Committee received and noted the update.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
BoSCA Quarterly Update	Amber	Deputy Chief Nurse	The Deputy Chief Nurse brought attention to the following; • A total of eight areas had been assessed in Q4 including 2 District Nursing Services which were Gold and other areas were awarded Bronze and Silver. • Standards noted with poor compliance were ACE Audit Compliance and Harm Free Care. It was noted that ACE Audit compliance was consistently poor but has seen change whereby each Ward /Department Manager completes monthly audits and review areas for improvement, which has seen compliance increase in this last quarter. • It was discussed that ASSD had one ward assessed this quarter, which showed five standards of compliance were rated as red, which was a concern. • There are plans to ensure all divisions are on the standard action plans to get them to the same standard. This will be seen in the Q1 report in August. • LR concluded the report by informing the Committee that going forward there will be additional support from Business Intelligence to provide support in making the data retrieved more meaningful.	**Decision**: The Quality Assurance Committee received and noted the update.
Learning from Deaths Quarterly Update	Amber	Medical Director	The Medical Director highlighted the following; • The Lead Medical Examiner is now a member of the Learning from Deaths Committee, which will provide valuable input to the learning. • Themes that have been identified so far have included; anticoagulation, lack of advanced care planning and a recognition of dying. • There was a concern noted regarding the backlog of cases, which have been assigned but not yet completed and so there is a focus to have these prioritised before allocating any additional cases for review. • Training sessions are to be held for those wishing to participate in Structured Judgement Reviews.	**Decision:** The Quality Assurance Committee received and noted the update.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Fire Safety Assurance Report		C McPeake	A report was presented to the Committee by Claire McPeake regarding the Trust fire safety policy, procedures and provisions, training, exercising and simulation which are carried out across the Trust. Four areas of improvement have been identified as being; clarity on roles and responsibilities including a nominated Fire Safety Officer, developing a risk based approach to remedial work required, reviewing the fire warden provision and arrangement and clarify and agree ongoing standards for completion of exercises and simulations relating to evacuation. The Medical Director queried if the action to define whom the nominated Fire Safety Director would be completed in line with the action plan in June. CMcP confirmed that this action will be closed within the agreed timeframe and an update will be shared with the Group Health & Safety Committee and then feedback to the Committee.	**Decision:** The Quality Assurance Committee received the report shared for assurance.

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Quality Assurance Committee Chair's Report

Maternity Incentive Scheme Year 4 Progress Update (CNST)		Head of Midwifery	JC presented the report to the Committee noting the following key points: • Following receipt of the year 5 document launched by NHS Resolution on the 31 May 2023 an initial review of the year 5 recommendations was undertaken. • Three potential areas of significant challenge have been identified that may impact upon full attainment of the CNST Year 5 recommendations. o Safety Action 5 – Ensuring supernumerary status of the Delivery Suite Co-ordinator status is retained at all times given the current service staffing pressures and Registered Midwife deficit of circa 50wte. Successful recruitment of newly qualified Midwives in September 2023 would help mitigate this further. The safety action has currently been achieved since year 5 commenced 1st June 2023. Limited assurance due to above noted risks. o Safety Action 6 - Collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset. The Digital Team are working hard to optimise submissions and have raised in excess of 30 queries to NHS resolution. Limited assurance. o Safety Action 8 - Attainment of the training requirements set out in the Core Competency Framework that require 90% attendance of relevant staff groups to be calculated as the 12 consecutive months from the end date used to inform percentage compliance in the year 4 scheme. JC confirmed that from Jan 23 to June 23 the Trust has not achieved the 90% required and remains a risk due to workforce vacancies previously referenced. There is also a requirement this year to evidence training completed in previous years which presents a risk due to previous sub-optimal recording of face to face training. Limited assurance therefore remains with safety action 8 • JC noted that there was limited assurance that the Trust would achieve all 10 standards year 5 but that it was important to acknowledge the hard work, which is still ongoing. There are a total of 115 requirements to be met within the year 5 scheme which is a significant amount. The impact of not achieving year 5 had been escalated and discussed with the Executive Directors previously.	**Action:** The Quality Assurance Committee agreed to the suggested reporting arrangements. **Decision:** The Quality Assurance Committee received and noted the update.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
			• It was confirmed that work to meet with recommendations from the PWC audit and further improve oversight and governance arrangements would continue. • JC made the Committee aware that the Trust were on the Regional Support Programme overseen by the CQC which has further added to the actions and requests that need to be completed. The Chief Nurse highlighted that the Committee should be aware the Trust was receiving Regional support and not National support owing to the Trusts candidness and the CQCs confidence that this would be sufficient. The Committee were asked to consider a proposal to have monthly updates on year 5 progress at Quality Assurance Committee and bimonthly updates shared at Board of Directors.	
GDPR Risk – Patient Records			RC presented a report proposing a plan for the indexing of 12,293 boxes of patient records currently archived with Restore. These files present a risk to the Trust under GDPR and must be indexed and destroyed where appropriate as soon as possible. The estimated cost of indexing these files is circa £63k however the risk of fines, should this piece of work not be undertaken, is of much greater value up to £8.7m. It had been agreed that the Divisions would each contribute to this cost from within their existing budgets.	**Decision:** The Quality Assurance Committee received the report that was shared for assurance.
Risk Management Committee Chairs Report		Chief Nurse	The Chief Nurse presented the report noting that the Fire Safety Assurance Report was to be escalated given there were recommendations to be completed.	**Decision:** The Quality Assurance Committee received the chairs report.
Group Health & Safety Committee Chairs Report		S Bates	The Chair's report was taken as read with no items noted for escalation.	**Decision:** The Quality Assurance Committee received the chairs report.
For Escalation: Pressure Ulcers: Two further Category 4 pressure ulcers had been declared and it was agreed that going forward all Category 3 or 4 pressure ulcers will be taken through the Serious Incident review process. Maternity: There are three potential areas of significant challenge which have been identified that may impact upon full attainment of the CNST Year 5 recommendations.				

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Quality Assurance Committee Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	19 July 202	Date of Next Meeting	27 September 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Tyrone Roberts, Martin North, Fiona Noden, Francis Andrews, Rae Wheatcroft, Sharon White and Divisional Representation.	Apologies received from:	Sophie Kimber-Craig, Lianne Robinson, Bridget Thomas and Rebecca Bradley.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report	Amber	Chief Nurse	The paper was taken as read with the Committee noting the following: • Pressure Ulcers: TR confirmed that more narrative had been added regarding pressure ulcers to demonstrate the focus on leadership and the thematic reviews undertaken already. • There has been six months of no category three pressure ulcers which is encouraging. • An increase in category two pressure ulcers has been seen but, from experience, it is likely linked to the increased focus, detection and intervention, and reduction in category 3 (earlier detection and subsequent intervention) • Falls: There continues to be normal variation and no concerns to be noted however TR would like to see special cause reduction for falls resulting in moderate+ harm • IPC: Greater Manchester comparative data has been included to see how the Trust fares overall, not to allow complacency. C-difficile remains normal variation and outlier across GM • There are currently ten SI investigations ongoing with one being overdue and the other nine are on track to be completed within the 60-day receipt by families timeframe. Data pre June 2022 monitored the 60 days as submission date to quality assurance committee. Steady improvement noted • Friends and Family Test have seen good progress overall with response rate and satisfaction level.	**Decision**: The Quality Assurance Committee received and noted the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
			• Complaints have achieved 100% for five weeks consecutively responding to formal complaints within required local agreed timeframes • Mortality continues to be an improving picture and work remains ongoing in relation to coding. • VTE – The Trust has been noted as exemplar and is benchmarking well. J Njoroge discussed sepsis screening data and concerns that this has a large gap between target and actual and if this should be concerning for the Trust. H Bharaj explained that this was because patients only need to be screened once but keep reaching the screening threshold. F Andrews added that a change of process to reduce the frequency of screening had been agreed by CGQC. FN noted the same sex accommodation breaches and asked for assurance regarding the 62 which had been seen in the year to date. FA and TR confirmed that the term astronomical referred to a factual description used in statistical process charts where data falls outside of either lower or upper control limits. In relation to MSA breaches, TR confirmed discussion had taken place within C&QG committee with agreement to separate those relating to critical care step-downs and to ensure this is either included in the narrative and/or displayed. Regarding missed sex accommodation, TR confirmed that at no point had there been any escalations of patients of the opposite sex having to share bathroom facilities, but that they may have to walk past a member of the opposite sex e- route. Such occasions are linked to demands on in-patient bed capacity and only ever made in the event of clinical priority and safety taking understandable precedence. That said, improvement is clearly required and will continue to be monitored.	

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Clinical Governance & Quality Committee Chairs Report (June and July 2023)	Amber	Chief Nurse	The chairs reports were received and the Chief Nurse noted: • CQC Improvements in ED re Mental Health: It was noted that all actions identified by the CQC had been completed but there was only partial assurance due to an internal query regarding the potential requirement for an additional specific policy • CQC Improvement Plan: Most of the actions have been completed and those which haven't are on track to do so. Partial assurance was noted until mock assessments are carried out to provide evidence that implementations have been embedded into practice. • TR confirmed the call bells were still being replaced but that there were mitigations in place for those areas still awaiting the new system. It was noted that B2, F4 and G3 are the only remaining wards still to be installed. B2 on track for completion this week. Mitigation in place for F4 and G3 • 2222 Calls to GMMH and SRFT: It was noted that CGQC had agreed to proceed with option three in the report which was the withdrawal of the Medical In Reach Team. This prompted discussion amongst members of the Committee with a request made for the Medical Director to provide a detailed update in October. F Noden raised concerns regarding Blood Traceability noting that the Trust should be achieving 100% to which R Catlin advised that those with highest use are being prioritised and pilots are being carried out in a way that is sustainable and not rushed in order to resolve the issue.	**Action:** F Andrews to provide assurance to Committee regarding 2222 calls in October. **Decision**: The Quality Assurance Committee received the chairs report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Clinical Correspondence Update		Medical Director	The report was received and noted: • A working group has been established and there was a request to have Non-Executive Director attend this group going forward. – J Njoroge nominated herself. • A workshop had been help to identify the key drivers and appoint the relevant leads to help deliver the outcomes identified. • There are ongoing issues with data quality in particular the nurse led clinics are there is no assurance with regard to what clinical correspondence is being sent out. • Inpatients: These will begin to have a summary discharge status every 12 hours and will be shared with ward clerks also. • Outpatients: Hopeful that can reach a point where correspondence can be sent direct to the patients as opposed to current situation. JN commented on the theme seen regularly of data quality and concerns that the robustness needs to be assessed. Both S White and R Wheatcroft agreed to discuss this further and present an assurance update to the Committee.	**Action:** S White and R Wheatcroft to present assurance report to the Committee regarding data quality. **Decision:** The Quality Assurance Committee received and noted the update.
Trust Mortality Update		Medical Director	The Medical Director highlighted the following; • SHMI (NHS Digital published figures, not HED) shows Bolton at 109.92, which is in the 'Expected' range and the trend in HSMR has fallen to 'Amber' at 108.68. • On average, Bolton patients have a recorded Charlson average score around 1 lower than peers and the national average. The inclusion of mandatory comorbidity recording with auto-population of the Health Issues section of EPR should result in an improvement in the average comorbidity score in coming months. There was a discussion around coding staying with patients which it was confirmed it would take 2-3 years to fully embed this as can only be done on the data which can be pulled through.	**Decision:** The Quality Assurance Committee received and noted the update.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Quality Improvement Update		S Bates	The report was received and noted: • Draft was shared at last committee meeting and comments have been incorporated and will be finalised this month. • There have been two Pressure Ulcer Collaborative and one C-Difficile collaborative as well as the launch of bite size modules for the quality improvements fundamentals. • Work is ongoing to establish centralised governance for all quality improvement projects this will be used as register of learning.	**Decision:** The Quality Assurance Committee received the report shared for information.
Board Assurance Framework		S Katema	The report was received and noted: • Since the presentation in March, the BAF has been reviewed by the Medical Director (1.1) and Chief Nurse (1.3) and there are no proposed changes to the risk score. • S Katema noted that there had been two actions added under Ambition 1.1 regarding the Standard operating Procedure for coding and application for access to Greater Manchester Care Record. • Ambition 1.3 had an action for the review of the Duty of Candour Policy which was due to be completed in May and has been done so will be moved into the control column. • With regard to Ambition 1.1 there was discussion amongst the Committee regarding the accuracy of coding and digital solutions to which it was agreed S White would provide an update on this as there is assurance available. The Committee discussed the risk appetite for both Ambition 1.1 and 1.3 and if these should be considered 'Cautious' or 'Open' and agreed to remain as in the report.	**Action:** S Katema will provide an opportunity for a learning session so that divisions can be included in risk appetite. **Decision**: The Quality Assurance Committee received the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Maternity Incentive Scheme Year 4 Progress Update (CNST)		Head of Midwifery	JC presented the report to the Committee noting the following key points: • Three CNST safety actions within the year 5 scheme continue to remain at risk namely: ○ Safety Action 5 –The attainment of 100% supernumerary status of the Delivery Suite Coordinator due to the ongoing staffing challenges of circa 50wte Registered Midwives. ○ Safety Action 6 - Collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset. JC commented that discussions with NHS resolution have increased confidence level with this safety action ○ Safety Action 8 - Attainment of the training requirements set out in the Core Competency Framework that require 90% attendance of relevant staff groups to be calculated as from January 2023. • 15/26 actions within the Price Waterhouse Cooper (PWC) audit action plan have now been completed and the remaining actions will be completed following the approval of the standard operating procedure (SOP), receipt of the reporting cycle of business for the Local Maternity and Neonatal System and receipt of three outstanding audits. • JC advised that the service can evidence full compliance with 34/42 (80%) of the initial Ockenden recommendations and 24/31 (77%) of the recommendations highlighted in the Kirkup report.	**Action:** Medical training to be included as part of the next Divisional update shared at CGQC following concern raised by F Andrews and the relatively low levels amongst medical staff. **Decision:** The Quality Assurance Committee received and noted the update.
Risk Management Committee Chairs Report		Chief Nurse	The Chair's report was taken as read with no items noted for escalation. It was noted by the Chair that the action regarding EPR and connectivity issues was of concern but was assured this will be reported back through the committees.	**Decision:** The Quality Assurance Committee received the chairs report.
Group Health & Safety Committee Chairs Report		S Bates	The Chair's report was taken as read noting the lack of timescales for actions to be finalised regarding the fire risks under action number 8.3.	**Decision:** The Quality Assurance Committee received the chairs report.
Safeguarding Committee Chairs Report		Chief Nurse	The Chairs report was taken as read with no items noted for escalation. TR advised that work needs to be done in order to make the chairs report more meaningful.	**Decision:** The Quality Assurance Committee received the chairs report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
For Escalation: Serious Incident – There was a discussion regarding paper records/EPR following an SI report and prompted a request from the Committee to have a report shared on the gaps, issues, rollout and benefit of EPR. S White agreed to present this to the Committee in October.				

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Report Title:	Finance & Investment Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Finance & Investment Committee meetings held since the last Board of Directors meeting.

Summary:	The attached reports from the Finance and Investment Committee Chair provide an overview of items discussed, key decisions taken, and key actions agreed at the meetings held on the 24 May and 21 June. Due to the timing of the July meeting, a verbal report will be provided by the Committee Chair to the Board reflecting discussions held on 26 July.

Previously considered by:
Discussed and agreed at the Finance and Investment Committee meetings.

Proposed Resolution	The Board of Directors are asked to **note** the Finance & Investment Committee Chairs' Reports.

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

Prepared by:	Annette Walker Chief Finance Officer	**Presented by:**	Jackie Njoroge, Chair Finance and Investment Committee

Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	24 May 2023	Date of next meeting:	28 June 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rebecca Ganz, Rae Wheatcroft, Sharon Katema, James Mawrey, Rachel Noble, Andrew Chilton, Matthew Greene, Samantha Ball, Alison Lil	Quorate (Yes/No):	Yes
		Apologies received from:	Bilkis Ismail

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Confirmation of Finance Plan 2023/24		A Walker	The Chief Finance Officer presented confirmation of the financial plan for 2023/24 submitted to NHS England to ensure clarity. The key points were noted as follows: **Bolton FT** Revenue deficit plan of £12.4m. Year end cash balance of £24.0m. Capital plan of £22.2m. **GM ICS** GM revenue balance overall but with a system efficiency target of £123m. GM capital overcommitted and discussion still ongoing to resolve. **Board Statement** GM ICB has requested that Boards confirm their support to a statement in relation to the system efficiency target. The Board will be asked to confirm approval of the 2023/24 financial plan and their understanding of the consequences and the actions required to achieve break even, to agree with the statement as requested by the ICB, and to note that the cost improvement tracker has been submitted to GM ICB as requested.	Noted with associated risks.

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Month 1 Finance Report	Amber	A Chilton	The Committee received an update on the month 1 finance position. The key points were noted as follows: • Year to date deficit of £1.7m compared with a planned deficit of £1m. • The Trust spent £4.6m on variable pay in Month 1, compared to a monthly average of £4.1m in 23/24. • Capital spend for month 1 2023/24 is £169k of which £77k relates to Theatres. • Cash of £45.3m at the end of the month, which is a decrease of £12.8m from month 12 2022/2023. • BPPC performance year to date is 95.0%. A number of actions are underway to improve and maintain this performance.	Noted.
Divisional CIP Plans		S Ball	The Committee received an update around the cost improvement programme progress to date for 2023/24. A single page document is being provided by each division each month detailing the following: • Cost improvement target and identified amount. • Productivity target and identified amount. • Top three value cost reduction schemes. • Top three productivity schemes. • Month financial position. • Top three grip and control actions. The divisions have received their targets and the direction positively and have welcomed the clarity, with a competitive feel across GM.	Noted.

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Business Case Benefits Realisation Update		S Ball	The Committee was assured that the benefits realisation review process has commenced and will be robustly monitored on a monthly basis. The key points were noted as follows: • From June each benefit will be given a review date to be taken to CRIG for benefits realisation review. • The Benefits Realisation Review Programme document will be amended to incorporate comments. • An updated paper will come back through this Committee in September.	Noted.
High Value Supplier Payment Register		A Walker	The Committee was provided with an update of the High Value Supplier Payments register. The revisions were: • 10 additions to the high value payments register have been made. • Revised increase in expenditure of £20.6m for 10 high value supplier payments for 2022/23.	Noted.
Chairs' Reports	Amber	A Walker	The Committee noted the following reports for information: **Capital Revenue & Investment Group** The Chair's report was noted from the meeting, which took place on the 02 May. **Place Based Finance & Assurance Committee** A verbal update was provided from the meeting, which took place on the 16 May.	Noted.

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Finance and Investment Committee Chair's Report

<table>
<tr><th>Key Agenda Items:</th><th>RAG</th><th>Lead</th><th>Key Points</th><th>Action/decision</th></tr>
<tr><td>Any Other Business</td><td></td><td>R Noble</td><td>Second Floor Refurbishment of J Block
The purpose of this paper is to review the occupancy options for J-Block, in conjunction with the creation of the Community Diagnostic Centre (CDC).

The options considered within this paper include:
• Option 1: - Re-instate the first floor
• Option 2: - Refurbishment of second floor creating additional clinical space.
• Option 3: - Fit-out the second floor to "first fix" and mothball until such time as capital is made available.

The Committee approved option 2.
Tender – Sexual Health
Currently we provide sexual health services for BFT and Salford.
The Committee were informed that a decision had been made not to tender for Salford this time as it was felt we would not be successful.
The Committee agreed with this decision.</td><td>Approved.

Approved.</td></tr>
<tr><td>Comments</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Risks escalated
No items escalated</td></tr>
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Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	21 June 2023	Date of next meeting:	26 July 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Rebecca Ganz, Sharon Katema, James Mawrey, Samantha Ball	Quorate (Yes/No):	Yes
		Apologies received from:	Bilkis Ismail, Rachel Noble, Fiona Noden, Rae Wheatcroft, Andrew Chilton

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM/National System Update		A Walker	The Committee received an update on the GM/National System. The key points were noted as follows: • GM revenue position is £62.7m deficit year to date for month 2, which is £48.1m off plan. • CIP delivery £28.1m year to date, month 2, compared to plan of £45.8m • ERF risk year to date for month 2 is £23.7m. • Risk of a reduction to capital budgets by £25m to reduce the over commitment. Bolton's reduction is £1.3m.	Noted with associated risks.
Cost Improvement Plan	Red	S Ball	The Committee received an update on the Cost Improvement Plan. The following areas were highlighted: • June CIP Position of £12.8m. • 5 cost cutting opportunities identified in workforce, facilities management, procurement, income generation/cost avoidance and digital transformation. • Productivity Opportunity Packs have been put together for each division. • Quality Impact Assessment process identified which is monitored weekly and clinically led by DMD and DND and has been to Execs for assurance.	Escalated to Board due to concern around delivery of CIP.

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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Month 2 Finance Report	Red	A Chilton	The Committee received an update on the Month 2 Finance Report. The key points were noted as follows: • In Month 2, we have an NHSI reported year to date deficit of £3.5m compared with a planned deficit of £2.1m. Unidentified CIP is a significant issue, as only £0.8m has been delivered against a target of £3.2m, leaving a shortfall of £2.4m. • The Trust spent £4.6m on variable pay in Month 2, similar to Month 1, compared to a monthly average of £4.1m in 23/24. Variable pay remains an issue with Bolton breaching the agency spend cap. NHSP contract has been delayed with a deferred start date of 16th of September. • Capital spend for month 2 2023/24 is £194k of which £11k relates to CDC. Capital is constrained. • We had cash of £34.8m at the end of the month, which is a decrease of £10.6m from Month 1 2023/2024. The Trust cash position will become challenging during 23/24 and this has been flagged as a key concern during planning discussions with the ICB. • Our BPPC performance year to date has dropped to 82.0% due the processing of a late payment of £6m. A number of actions are underway to improve and maintain this performance. • Bolton was nominated for HFMA teams of the Year Award and won. Praise was given to the finance team for this achievement. AW added that Bolton will be going for more National Awards this year.	Escalated to board due to concern around variable pay.
Chairs' Reports		A Walker	The Committee noted the following reports for information: **Capital Revenue & Investment Group** The CRIG meeting on the 6th June was cancelled due to the CQC visit. The next meeting is on the 4th of July. **Place Based Finance & Assurance Committee** Minutes from the meeting on the 16th May were received for information. AW gave a verbal update for the meeting held yesterday with key points noted:	Noted.

Comments

Risks escalated
Reported issues with variable pay (month 2 report) and CIP to be escalated to Board.

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

Title:	Board Assurance Framework

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	27 July 2023		Discussion	✓
Exec Sponsor	Sharon Katema		Decision	

Purpose:	The Purpose of this report is to present the Board Assurance Framework following review.

Summary:	The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. Since presentation at the last meeting, a review of the BAF was undertaken by the executive directors to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level. There is no change in risk score.

Previously considered by:	Executive Directors and Board Committees

Proposed Resolution	The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

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

Prepared by:	Sharon Katema	**Presented by:**	Sharon Katema

1. DEFINITIONS

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

2. INTRODUCTION

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

2.2. This year the BAF has continued to reflect the existing Trust Strategy as a result it has been subject to periodic review and has been developed throughout the year.

2.3. The BAF has been considered by respective Executive Director Leads prior to presentation at Committees to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level

2.4. There are no changes to the assessment of assurance.

3. RISK SCORE

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

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

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

Key

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

4. RISK APPETITE

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

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

4.3. The Risk appetite for each Strategic goal (Ambition) of the Trust is reviewed quarterly and discussed at Committees and Board.

4.4. The Board agreed the following risk appetite statement for each level of risk:

Appetite statement 5 (Seek/Mature*)
In relation to this area of work, the Trust is willing to accept risks that may occur and would then lead to some degree of damage to its reputation, possible financial loss, exposure, or short term disruption to no
Appetite statement 4 (Open)
In relation to this area of work, the Trust is willing to accept risks that are likely to occur and would then lead to some degree of damage to its reputation, or possible financial loss, exposure or short term disruption to one or more service area.
Appetite statement 3 (Cautious)
In relation to this area of work, the Trust is willing to accept risks might occur in certain circumstances that could lead to some degree of damage to its reputation, possible financial exposure, or minor disruption to one or more service areas.
Appetite statement 2 (Minimal)
In relation to this area of work, the Trust is willing to accept improbable risks that might, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.
Appetite statement 1 (Avoid)
In relation to this area of work, the Trust is not willing to accept any risks that could lead to damage to its reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public.

5. **CONTROL OF THE RISK.**

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

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

6. **CONCLUSION.**

The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

Board Assurance Framework Explanatory Notes

- The ambitions for the Trust have been agreed in consultation with the Board and wider stakeholders. The ambition description used within this BAF is as set out in the summary Strategic Plan 2019 – 2024
- For each objective the Executive team consider the risks and issues that could impact on the achievement of the ambition, the BAF is then populated with these risks/issues, the controls in place and the assurance that the controls are having the desired impact. Actions to address gaps in controls and assurance are identified.
- Actions should be SMART and should include an expected date of completion.
- The "oversight" column is used to provide details of the key operational and assurance committee.
- The RAG column is used to indicate the level of assurance the Executive has that the risk is being managed.

RAG	Description
Red	• No or limited assurance– could have a significant impact on the achievement of the objective;
Amber	• Moderate assurance – potential moderate impact on the achievement of the objective
Green	• Assured – no or minor impact on the achievement of the objective

- The full BAF should be reviewed at least once a year at Board and twice a year at the Audit Committee
- The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF;

Ambition 1 Provide safe, high quality care	LEAD DIRECTOR	Medical Director	1.1
	LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT										Linked Risks
	Inherent Risk Rating			**Current risk rating**			**Target Risk Rating**			**No linked risks**
Date of last review	Consequence	Likelihood	Score	Consequence	Likelihood	Score	Consequence	Likelihood	Score	
March 2023	4	4	16	4	4	16	4	3	12	

PRINCIPAL RISK: IF THE TRUST DOES NOT GIVE THE BEST CARE EVERY TIME THEN THIS MAY RESULT IN INCREASED MORTALITY IN HOSPITAL AND IN THE 30 DAYS FOLLOWING DISCHARGE

RISK APPETITE:

Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

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

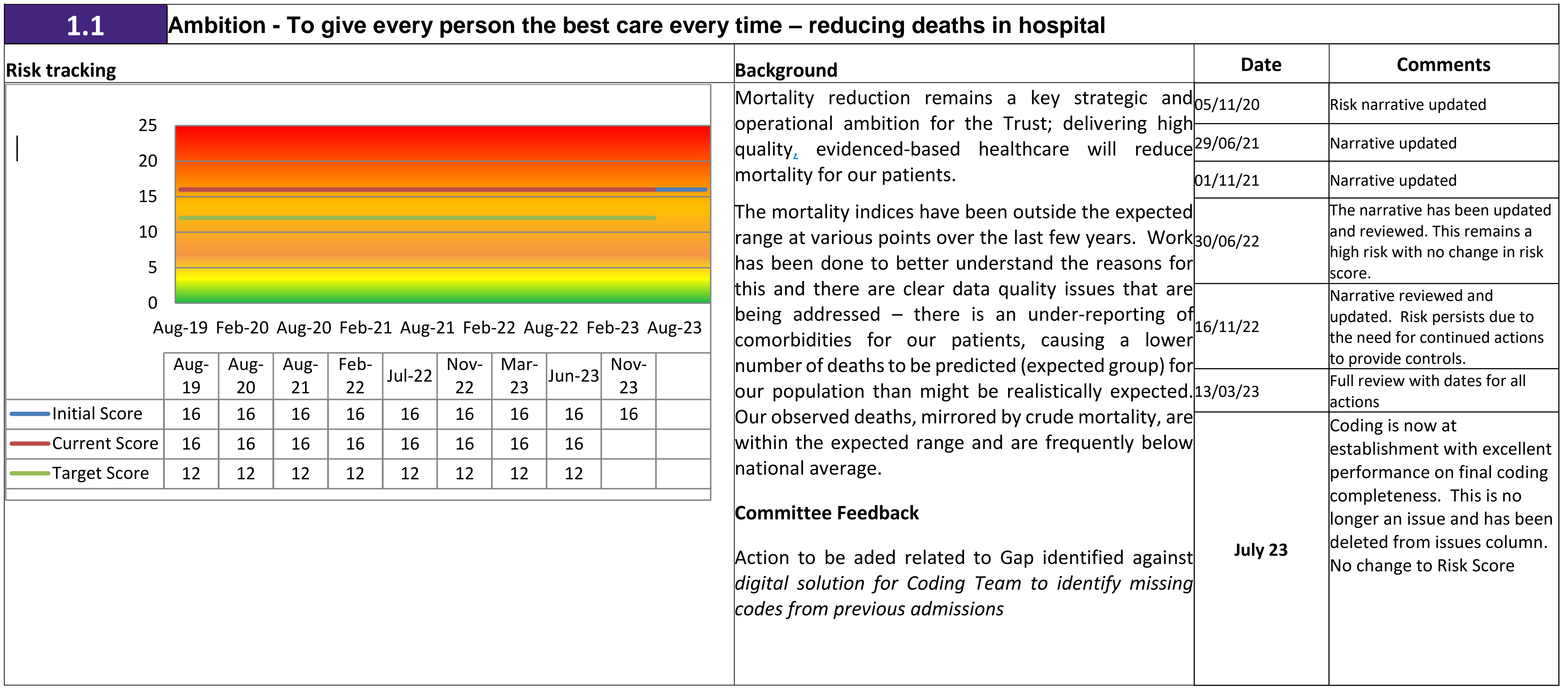
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Overall Assurance Level: Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
MORTALITY METRICS • HSMR and SHMI at risk of going outside of expected range • ~~Coding establishment below expected~~ DIAGNOSIS AND COMORBIDITY RECORDING • Recording of diagnosis done using terminology that cannot be coded	• HED ~~using~~ used to alert ~~T~~trust to areas of clinical concern - monitored monthly and reviewed with clinical teams for triangulation with other data sources regarding quality of care; presented at Trust Mortality Reduction Group (MRG) • MRG monitoring and maintaining the achievement of >98% Coding completeness with accuracy confirmed annually through external assessor.	• DQ issues mean expected deaths under-predicted – lack of time for clinical validation of data • Clinical time & lack of consistent EPR solution • ~~Lack of optimal process with EPR to facilitate and improve the~~	***1st Line of Defence (Operational Management)*** - **Local BI monitoring on HED** diagnostic group mortality outlier alerts with clinical review initiated when indicated - **Mortality Review Group (MRG)**- Review of Monthly monitoring of HED SHMI & HSMR, mean Charlson comorbidity score & depth of coding ~~at MRG~~plus - ~~Q~~quarterly divisional mortality reports, along with service-level reports as per workplan	• Mortality metric variations may reflect recording and data quality issues, rather than a true care concern ~~Quality Accounts to address (with own KPIs): NEWS compliance Antibiotic prescribing compliance~~ • Performance data limited by systems and processes for recording	• **Mortality Action Plan** - Supporting Clinical and Coding plan (**30 September 2023)** - Amend EPR to facilitate improved comorbidity recording and depth and consistency of coding (**30 June 2023** • **MRG**: - ~~Review MRG TOR and~~ Continued adoption of new workplan and reporting methodology ~~template~~ to ensure ~~identif~~identification ~~y~~

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Failure to record all relevant Comorbidity • Comorbidity recording inconsistent between admissions QUALITY OF CARE • Care delivery concerns identified through Learning from Deaths process not fully addressed • Compliance with NEWS observation policy and escalation algorithm not at ~~compliance currently under~~100% ~~90%~~ consistently • Failure by individuals/teams to recognise or respond to a deteriorating patient (identified via ~~seen in~~ Serious Incident Reports and Structured Judgement Reviews)	• Diagnoses and ~~C~~comorbidity education at induction • Clinicians can now access GMCR for comorbidities • Staff upload data into Health Issues section • SOPs for Coding Team and application for access to GMCR • Learning from Deaths (LfD) case reviews and actions with Medical Examiner input with reviews at LfD committee • AASD Quality Account continuing to address NEWS compliance • Revised fluid balance charts on EPR • RR-SAFER implementation and AIMS training	~~comorbidity index recording.~~ • Awaiting approval for automated solution to comorbidity recording in EPR • IT kit access to record data (roll out in progress) • No digital solution for Coding Team to identify missing codes from previous admissions • Training compliance not at 100% for nursing and medical staff • Improving mandatory resuscitation and AIMs training sessions	~~- Quarterly reports and audits from Sepsis Forum, Resuscitation & Deteriorating Patient group~~ • **Learning from Deaths Committee reports to MRG:** - Monthly review of SJR dashboard - Receive thematic analysis reports, including national Regulation 28s and Medical Examiner data report - MDT secondary review of cases of concern • DNACPR reports • Harm Free Care Panel • Quarterly Quality Account updates to CG&QA committee (on NEWS and antibiotic prescribing compliance)	and/or reporting (e.g. Sepsis screening and NEWS compliance); being rectified • Learning panel – actions have to be directed to specific groups/ departments, etc – now to Patient Quality Group	and improvement in triangulation with other KPI and quality metrics (**30 September 2023**) • Ongoing review of AQuA, GIRFT and other care reviews • **Improving LfD to ensure:** - Increase trained assessors and improvement in response time and case identification processes - Thematic analysis of existing database of LfD cases. - ~~Amend mandated group in line with current data (September 2023)~~ • **Patient Quality Group**: • Enact changes to reduce inappropriate resuscitation attempts, by improving compliance with DNACPR and MCA documentation. • ~~Reduce harm free care with targeted interventions~~ • QI collaboratives: - Pressure ulcer collaborative to reduce harm from skin damage **(September 2023)** ~~- Quality Accounts to address~~
			2nd Line of Defence (Reports at Board and Committee Level) • Integrated Performance Reports to QAC and Board • Reports on IPC, transfusion, Medicines Safety, Safeguarding • Quarterly MRG and LfD reports to QAC • Mortality reports to QAC and Board	• Cases reviewed in arrears with reports collated quarterly – risks delay in sharing learning	

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Sepsis screening and Sepsis 6 performance not at 100% • Patients waiting longer in ED for inpatient beds which may impact on outcome • Patients admitted to hospital when nearing end of life/dying, when may be better cared for/more appropriately placed in other care facilities/at home	• Deteriorating Patient Lead in post • EoL committee actions to improve ACP • Resuscitation Committee monitoring Cardiac Arrest RCAs • Patient Quality Group actions to improve compliance with DNACPR documentation • Educational programme to improve communication with patients, families and carers • Quarterly Sepsis KPIs reported to MRG • Current AACD QA to improve antibiotic compliance • Daily flow meetings • SAFER process to improve patient ADT • Procedural Document Oversight Committee reviews all documents related to evidence-based care • Use of EPACCs system to document and define EOL plans	• Coordination between NEWS, sepsis and recognition of deterioration work required to ensure consistency across Trust • Quarterly sepsis KPIs pulled from only one system; data recorded in >1 • Public misunderstanding of EOL and DNACPR decision making processes	***3rd Line of Defence (Independent or Semi-independent assurance)*** • Trust HED benchmarking against national acute trusts' data • Regional benchmarking and peer review (e.g. Critical Care peer review, Ockenden Insight report, PMRT) • National reporting and benchmarking (e.g. NELA, national hip fracture database) • AQuA audits of care (e.g. sepsis, pneumonia) • GIRFT reviews into care provision (e.g. cancer services, CIAD) • External assessments and accreditation (e.g. RCOA ACSA assessment, RCS reviews) • CNST MIS assessment	HED data published nationally in arrears – system does allows some early identification	- ~~NEWS compliance and antibiotic prescribing compliance~~ - Combine workplans for Sepsis Forum, Deteriorating Patient and NEWS QA to coordinate processes, monitoring and compliance across Trust • **Recognition of deterioration:** - Complete TNA and develop educational training plan - Implement RR-SAFER by training RNs from wards & ratification of PGDs for fluid bolus - Triangulate NEWS compliance data with other mortality metrics and quality measures to determine areas for focus - Review Trust NEWS Policy - Ratify Trust DNACPR Policy • **Improve sepsis screening & management:** - ~~Implementation of EPR sepsis bundle across organisation following pilot~~ - Implement agreed changes to Sepsis Screening Process (to improve clinical compliance and reporting accuracy) - AQuA audit of emergency admissions - Exploration of Digital solution for Coding Team to identify missing codes from previous admissions Target tbc -



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

Risk tracking

	Aug-19	Aug-20	Aug-21	Feb-22	Jul-22	Nov-22	Mar-23	Jun-23	Nov-23	
Initial Score	16	16	16	16	16	16	16	16	16	
Current Score	16	16	16	16	16	16	16	16		
Target Score	12	12	12	12	12	12	12	12		

Background

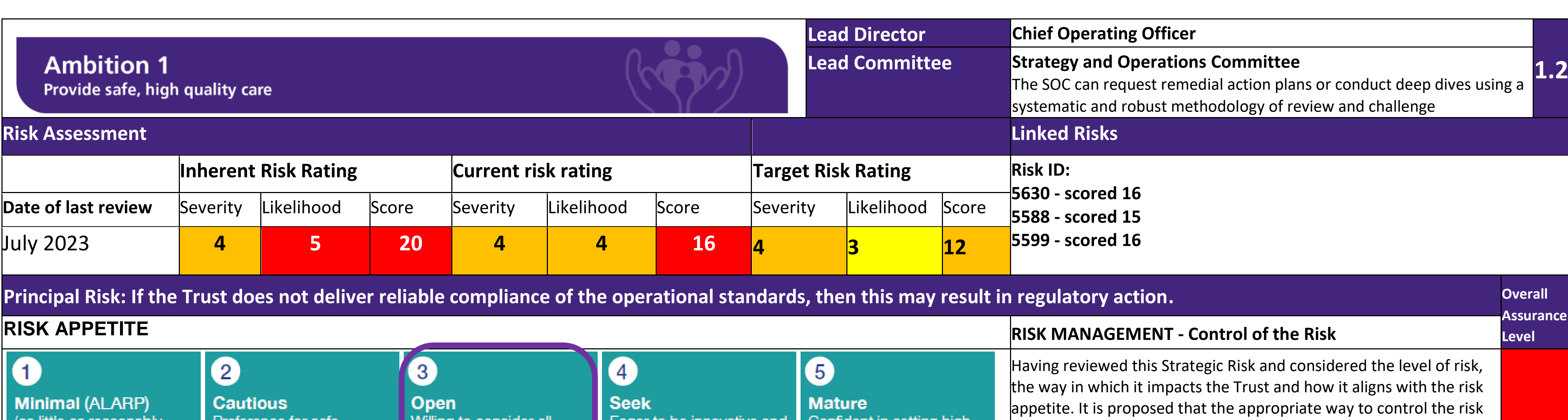
Mortality reduction remains a key strategic and operational ambition for the Trust; delivering high quality, evidenced-based healthcare will reduce mortality for our patients.

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

Committee Feedback

Action to be aded related to Gap identified against *digital solution for Coding Team to identify missing codes from previous admissions*

Date	Comments
05/11/20	Risk narrative updated
29/06/21	Narrative updated
01/11/21	Narrative updated
30/06/22	The narrative has been updated and reviewed. This remains a high risk with no change in risk score.
16/11/22	Narrative reviewed and updated. Risk persists due to the need for continued actions to provide controls.
13/03/23	Full review with dates for all actions
July 23	Coding is now at establishment with excellent performance on final coding completeness. This is no longer an issue and has been deleted from issues column. No change to Risk Score



Ambition 1 Provide safe, high quality care	Lead Director	Chief Operating Officer	1.2
	Lead Committee	**Strategy and Operations Committee** The SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

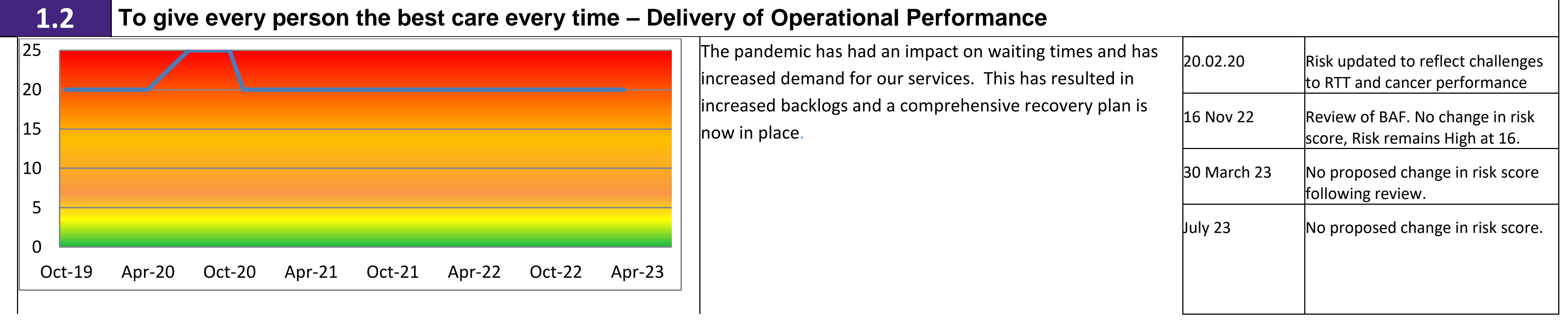
Risk Assessment										Linked Risks
	Inherent Risk Rating			Current risk rating			Target Risk Rating			**Risk ID:** **5630 - scored 16** **5588 - scored 15** **5599 - scored 16**
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score	
July 2023	4	5	20	4	4	16	4	3	12	

Principal Risk: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

RISK APPETITE					RISK MANAGEMENT - Control of the Risk	Overall Assurance Level
1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust	Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to: **Treat.** *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*	

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Failure to admit, treat or discharge patients from the hospital in a timely manner Key Causes • Increased waiting list size since 19/20 baseline • Increased cancer backlog size since 19/20 baseline • Insufficient theatre capacity to meet current demand • Insufficient diagnostic capacity within cancer pathways	Escalation policy Access policy Discharge policy Flow meetings and reports (four a day) Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge System Operational Response Taskforce (SORT)	Lack of monitoring of the effectiveness of policies Weak monitoring of the implementation of ward SAFER principles Lack of a robust Capacity & Demand planning cycle	**1st Line of Defence (Operational Management)** • Regular performance monitoring at Divisional level. • Monthly Integrated Performance Management (IPM) meetings to review performance data • Review of Divisional Risk Registers at Risk Management Committee • Review of all Urgent Care and Community workstream at Performance and Transformation Board. • Monthly review of assurance programmes at Performance & Transformation Board	Review and refresh of IPR dashboard	Updated IPM dashboard to be developed and available to Board of Directors **(May 2023)** Review of Escalation Policy, Access Policy & Discharge Policy monitoring to be undertaken and implemented **(September 2023)** Robust audit of ward SAFER principles to be undertaken and reported **(June 2023)** Capacity & Demand cycle **(March 2024)** Review of OPD and Theatre capacity and transformation

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Insufficient capacity within the Emergency Department to deal with the demand • Lack of a sustainable Urgent Treatment Centre model • Failure to reliably meet the SAFER ward standards • Discharge capacity frequently does not meet demand	Cancer and RTT Patient treatment list management meetings Theatre Scheduling meetings Detailed capacity and demand management reviews Joint working with GM on cancer pathways Joint working with GM to ensure equality of access across GM Regular validation of waiting lists Development of the Urgent Treatment Centre Pilot Attendance and monitoring at • System Urgent Care Integrated Partnership Group • Planned Care Board Integrated Partnership Group • System Strategy, Planning & Delivery Committee		**2nd Line of Defence (reports and metrics monitored at Board/Committees** • Review of Integrated performance report at Strategy and Ops Committee • Spotlight service reviews at Strategy and Ops • Bi-monthly presentation to Board of IPR and Operational Update • Monitoring of performance at GM meetings including **3rd Line of Defence (Independent Assurance)** • NHSE Oversight framework and monitoring arrangements • NHS benchmarking data including Model Hospital Dashboard and North West performance data • Getting it right first time (GIRFT) programme. • Monitoring and scrutiny of performance targets by GM ICB & PFB teams • Internal Audit reviews • External Peer Reviews by expert groups • Regionally arranged ECIST visits & reviews	GM ICS Performance meetings	



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

The pandemic has had an impact on waiting times and has increased demand for our services. This has resulted in increased backlogs and a comprehensive recovery plan is now in place.

20.02.20	Risk updated to reflect challenges to RTT and cancer performance
16 Nov 22	Review of BAF. No change in risk score, Risk remains High at 16.
30 March 23	No proposed change in risk score following review.
July 23	No proposed change in risk score.

Ambition 1

Provide safe, high quality care

LEAD DIRECTOR	Chief Nursing Officer	1.3
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
March 2023	3	4	**12**	3	4	**12**	3	2	6

Linked Risks

- Risk 5192 - Scored 12
- Risk 5535 – Scored 12
- Risk 5536 – Scored 12
- Risk 5638 – Scored 12

PRINCIPAL RISK: if the trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

RISK APPETITE:

1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

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

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

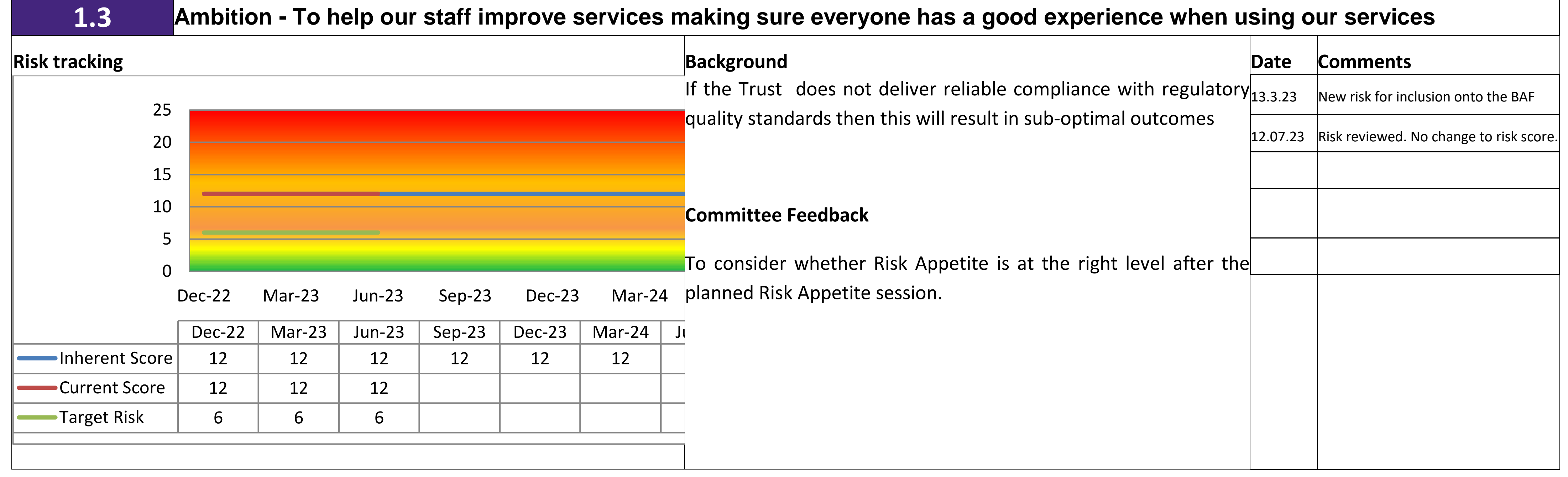
Overall Assurance Level: Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Sustained achievement and visibility of safe staffing levels • Demand for services exceeding capacity • Inconsistency with divisional governance processes • Regulatory breaches • Unreliable application of quality	• Quality Account Priorities now overseen by QI team with reporting to CG&QC committee quarterly • Two QI collaborative to support embedding of QI methodology around priority areas • QI training available to all staff. • Internal audit process (PWC, mock CQC)	• Sub-optimal compliance with serious incident process and duty of candour • Divisional reports lack assurance • Lack of established process for senior visibility, including 'work-withs'	***1st Line of Defence (Operational Management)*** • IPM meetings • Reports to Clinical Governance & Quality Governance committee including underpinning sub-group chairs report • Daily operational staffing reviews • Professional observations • Nurse and Midwife key • Risk management committee • Nurse/midwife performance indicators (monthly)	• Quality and clinical governance work-plan sub-optimal • Assurance of ward to Board 'golden thread' through clinical assurance governance standardised framework • Development of NMAHP&HCS workforce plan • Minimal access real-time patient experience feedback	• ~~Monthly safe staffing reports to be reported to CN and shared on organisation website. Target Completion 31.05.23.~~ **Action Completed** • Implementation of serious incident process and revisions – **31.7.23** • Review of duty of candour policy – **31.05.23** • Commission and review of all Clinical Divisional governance processes against best practice – **31.08.23**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
improvement science methodology • Leadership inconsistency with application of required standards	• Accreditation process (BoSCA) • Statistical process control charts for key indicators • Daily / weekly reports to divisional teams in relation to governance performance metrics • 2:1 meetings with Director of Quality Governance and Divisional Governance teams • Revised serious incident process and policy • Revised Duty of Candour policy • Phase 1 implementation of changes to QG & CG with removal of 'reassurance' reports – • Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS) • Objective setting against agreed corporate priorities for senior NMAHP&HCS • BoSCA escalation framework agreed and in place	• Lack of reliable access analyst expertise in safer nursing care tool output creation • ~~Finalisation of learning from experience report~~ • Revised Quality Governance Dashboard and performance reporting • Lack of risk management framework/strategy • ~~Review of duty of candour policy~~	• Chief Nurse ~~vsiibilty~~visibility of overall staffing provision including vacancies/ ratios • Monthly Workforce score cards per division to provide chief nurse and divisional visibility • Monthly safe staffing report produced in line with CHPPD and shared on organisation website. • Reports through safeguarding committee detailing actions of PWC review. • Live safeguarding improvement plan • Midwifery dashboard in alignment with national requirements		• Finalisation of learning from experience report – end Q4 22/23 • Finalise QG&CG work-plan to align with domains quality and CQC KLOE **– 31.07.2023** • Introduction of corporate quality related reports into CG&QC and onto QAC ~~**30-06-23**~~ **Revised completion date 30.09.2023** • ~~Enhancement of accreditation process (BoSCA) to include accountability~~ **– 30.04.23 Action Completed.** • ~~Implementation of internal PWC audit of safeguarding systems action plan and processes.~~ 31.3.23 **Action Completed.** • Quality Governance Dashboard and performance reporting – ~~**31.05.23**~~ **Revised Target Completion 31.12.2023** • Establishment of project management office type template to monitor **Target Completion December 23** • Refresh of Quality improvement strategy with all stakeholders – **Target Completion Date 30.06.23** • ~~**Inclusion of A&E, Theatres, critical care and community nurses. 31.05.23**~~
			2nd Line of Defence (Reports at Board and Committee Level) • Integrated Performance Report at Quality Assurance Committee and Board • Quality Account • Mandatory training • Bi-annual Nurse & Midwifery establishment reviews • CNST reports to QAC and Board • Patient Safety Report monthly to Clinical Governance & Quality Committee (from 07.22) • Quarterly Learning Report to Clinical Governance & Quality Committee and Quality Assurance Committee (from 12.22)	• ~~Safe staffing report does not include A&E, critical care, theatres , neonates or community nursing~~ • Sub-optimal Maternity dashboard indicators reporting • Sub-optimal assurance from safeguarding committee chairs reports, quarterly report required.	

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
			3rd Line of Defence (Independent or Semi-independent assurance) • Internal Audit reviews • CQC Inspection Reports • CQC inspection visits, Insight Reports, • National Audits • Peer Reviews and accreditation. • Internal Audit review of safeguarding systems and processes concluded. • Internal Audit review of risk management process •	• Implementation of Internal PWC audit of clinical negligence scheme for trusts (CNST) systems and processes within Families division • ~~Family Care Division governance review against GGI framework~~ • Implementation of recommendations from PWC internal audit of risk management process • GGI Review of Divisional Governance processes	• Further Development of NMAHP workforce plan with trajectories – **Target Completion Date 31.10.23** • Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.24** • Development of real time patient feedback across in-patient areas and community long-term caseloads – **Target Completion Date 31.7.23** • ~~Development of Midwifery dashboard in alignment with national requirements – **Target Completion Date 31.3.23**~~ • ~~Development of workforce dashboard to provide Chief Nurse visibility – **30.4.23**~~ • Business continuity improvement with analyst access to safer nursing care tool output reporting. Recruitment complete requires induction and embedding – **Target Completion Date 30.9.23** • Transition to NHSP for temporary staffing provision and improved reporting **Target Completion Date 31.9.23** • Quarterly safeguarding reports to Clinical governance and quality to be developed for assurance **Target Completion Date 30.8.23** • Finalise action plan following PWC internal audit or risk management

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
					Target Completion Date 31.08.2023 • Development of Risk management framework with stakeholder engagement **Target Completion Date 30.09.2023**



1.3	Ambition - To help our staff improve services making sure everyone has a good experience when using our services

Risk tracking

	Dec-22	Mar-23	Jun-23	Sep-23	Dec-23	Mar-24	Ju
Inherent Score	12	12	12	12	12	12	
Current Score	12	12	12				
Target Risk	6	6	6				

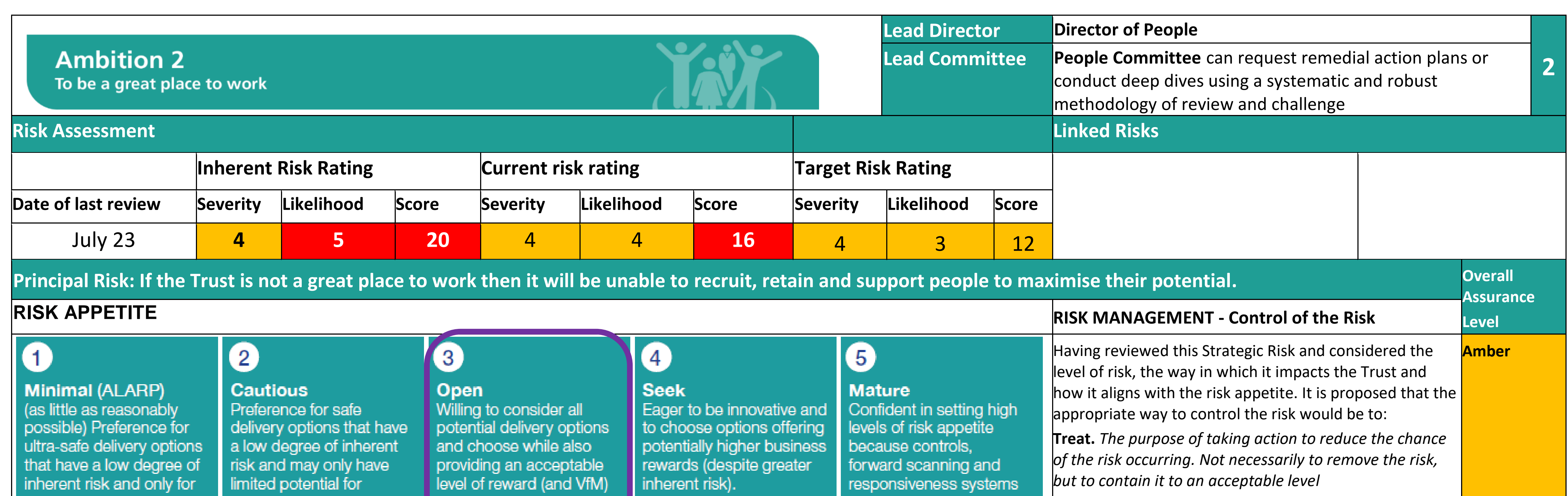
Background

If the Trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

Committee Feedback

To consider whether Risk Appetite is at the right level after the planned Risk Appetite session.

Date	Comments
13.3.23	New risk for inclusion onto the BAF
12.07.23	Risk reviewed. No change to risk score.



Ambition 2
To be a great place to work

Lead Director	Director of People
Lead Committee	**People Committee** can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

2

Risk Assessment | **Linked Risks**

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
July 23	4	5	20	4	4	16	4	3	12

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

RISK APPETITE

1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

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

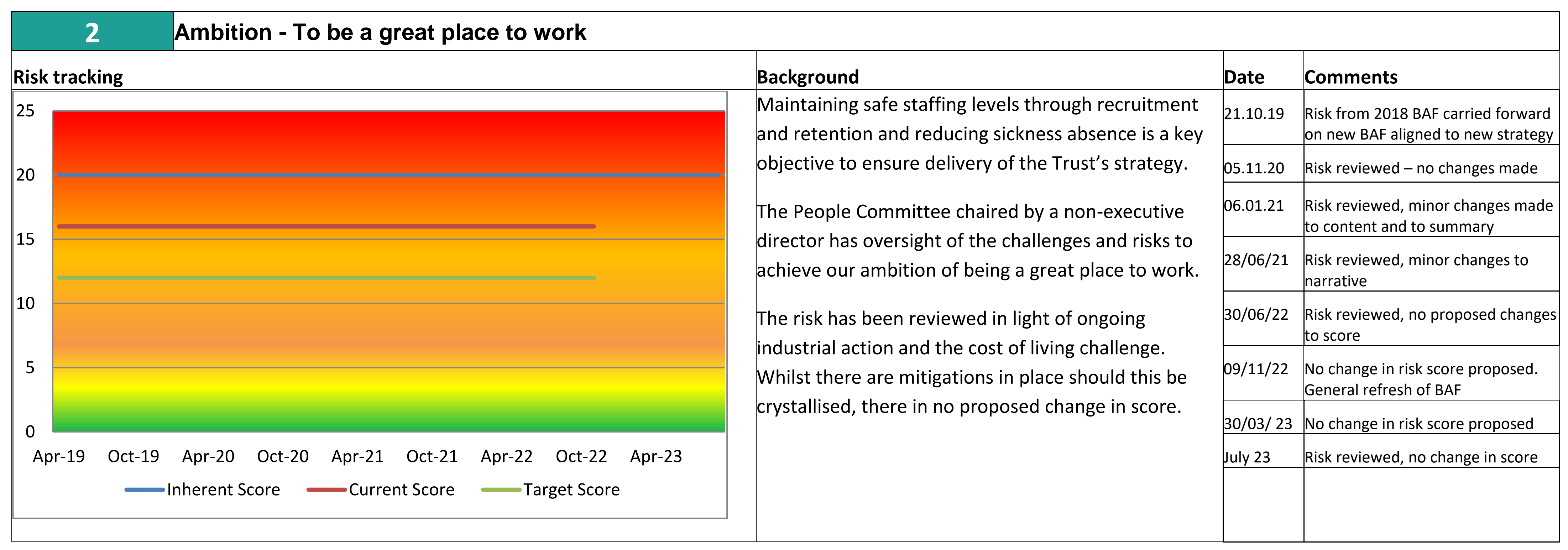
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Overall Assurance Level: Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
• Health and Wellbeing of workforce – If the Trust does not reduce sickness absence rates there will be a service delivery and financial impact • Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will be a potential impact on improvement initiatives,	• Staff Health and Wellbeing Plan • Our People Plan. • Occupational Health Provision • Staff Experience and Inclusion Steering Group • Staff Health and Wellbeing programme • Great Place to Work Plan	Identified and actioned from Internal Audit of identified key areas. EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (Gaps in control also identified through	***1st Line of Defence (Operational Management)*** • Attendance KPI • NHS Staff survey (annual) • HR Policies and Procedures • Friends and Family • Pulse Survey Staff Survey • Divisional People Committees reports to People Committee • IPM meetings with Divisions • Resourcing and Talent reports to PC	EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee	• ~~Pillar Healthy Organisation Culture and Pillar Workforce Capacity. Both have full action plan on measures being taken across full organisation. Regular updates provided to Subgroups and People Committee on controls being taken~~ • ~~Consultation on updated People Plan in line with refresh of Trust~~

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
discretionary effort and attendance • Recruitment and retention – if the Trust does not recruit and retain staff with the right skills and values the delivery of all other objectives will be at risk. • Agency use – failure to reduce reliance on agency staff has a financial impact but also a potential impact on the wellbeing of substantive staff and the care of our patients • Inclusion – if the Trust workforce does not represent the diversity of the population we serve this can impact on care provision, reputation and future recruitment and retention • Education and Development – if the Trust does not provide opportunities for education and development this will impact on retention, engagement and wellbeing of staff and the future capability of the workforce • Failure to maximise digital HR systems could lead to lost opportunities for increased efficiency and effectiveness • Workforce Transformation – failure to support and enable the workforce to adapt, modernise and transform how	• Weekly / Monthly Safe Staffing meeting • Consultants Job planning • EDI Plan & 2023 specific action plan • Staff Network groups • Revalidation • Appraisals • Mandatory and Statutory Training • ESR Benefits realisation plan • Agile Working policy • Workforce and OD Strategy • Trust Health and Financial Wellbeing • Our People Plan • EDI Plan • Attendance and membership of Bolton wide People and culture group. • Vacancy Control Panels • NHS Workforce Plan	corporate check and challenge process Bolton response to NHS England newly published Workforce Plan to be presented at People Committee Vacancy Control Panel Meetings	***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Report to People Committee and Board. Includes • recruitment and retention • Temporary staffing • Sickness • Staffing report, • HR reports on vacancies • Ward to Board heat map • Staff Story included as a standing item in Board • EDI Plan monitored at People Committee quarterly • Bolton Integrated Partnership locality plan ***3rd Line of Defence (Independent or Semi-independent assurance)*** • WRES, • WDES, • Annual Gender Pay gap report • Annual Quality report • NHS Staff Survey • Local, Regional & national Benchmarking • Internal Audit reviews	Reports from Vacancy Control Panel Meetings	~~Strategy. Completed and approved by Board in May 2023.~~ • ~~EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee~~ • Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Ongoing** • Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Ongoing** • ~~Establishing Agency control panel~~ and vacancy control panel meeting. **Target Nov 23.** • Commence Listening into Action with regular reports to People Committee on a bi-monthly basis. **Target Sep 23** • Regular meeting and expansion of Community voices group. **Ongoing** • Trust's response to the NHS Workforce Plan to be presented at People Committee for ongoing monitoring. **Target September 23**

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



2 Ambition - To be a great place to work

Risk tracking

Background

Maintaining safe staffing levels through recruitment and retention and reducing sickness absence is a key objective to ensure delivery of the Trust's strategy.

The People Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of being a great place to work.

The risk has been reviewed in light of ongoing industrial action and the cost of living challenge. Whilst there are mitigations in place should this be crystallised, there in no proposed change in score.

Date	Comments
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy
05.11.20	Risk reviewed – no changes made
06.01.21	Risk reviewed, minor changes made to content and to summary
28/06/21	Risk reviewed, minor changes to narrative
30/06/22	Risk reviewed, no proposed changes to score
09/11/22	No change in risk score proposed. General refresh of BAF
30/03/ 23	No change in risk score proposed
July 23	Risk reviewed, no change in score

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

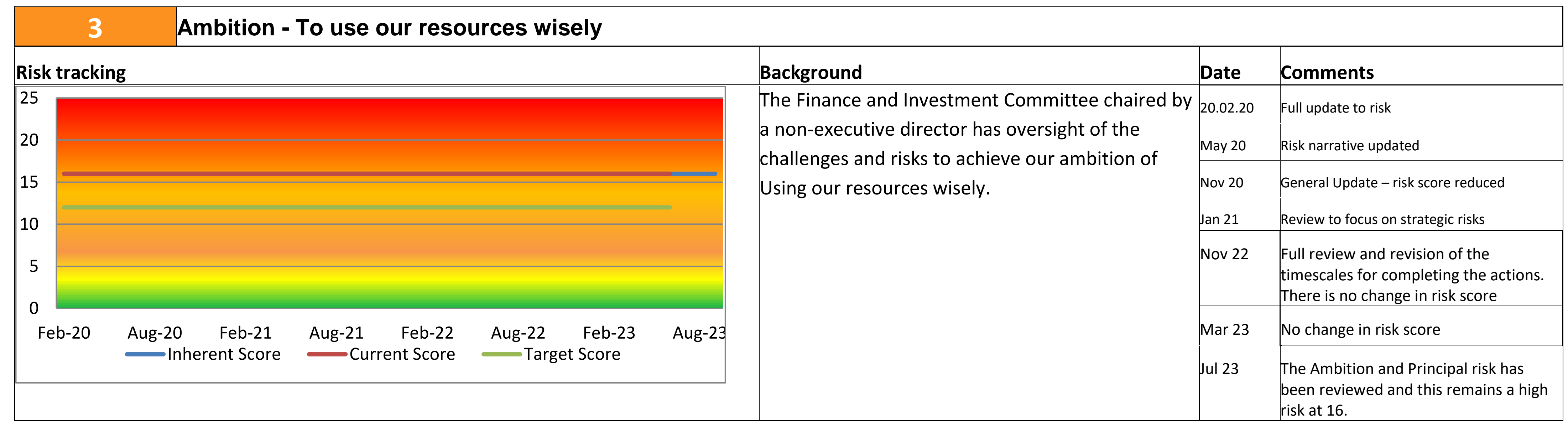
RISK ASSESSMENT										Linked Risks	
	Inherent Risk Rating			Current risk rating			Target Risk Rating				
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score		
July 23	4	4	16	4	4	16	4	3	12		

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

RISK APPETITE					RISK MANAGEMENT - Control of the Risk	Overall Assurance Level
1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust	Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to: **Treat.** *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*	**Amber**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Delivery of year on year cost improvements. Cost control and managing inflation effects. Shortage of revenue and capital funding Meeting NHS England Productivity requirements Working within GM ICB (jointly responsible and reliant on others results)	• Executive / CRIG approval of business cases • Improvement and Transformation Team coordination of PCIP • Monthly financial reporting to budget holders • Divisional accountability through IPM • Annual budget setting and planning processes • Finance department annual business planning process • Development of annual procurement savings plans • Monthly accountability reporting to DOF • Standing Financial Instructions	GM ICB overarching strategy and financial strategy. Disparate access to GM Provider Performance Productivity Reporting	**1st Line of Defence (Operational Management)** Capital Revenue Investment Group (CRIG) reports Reports to Integrated Performance Management Meetings Monthly cash flow forecast Reports to Finance and Intelligence Group (FIG) **2nd Line of Defence** (reports and metrics monitored at Board/Committee) Monthly Finance Report to F&I Trust staffing levels to F&I Committee PLICs reporting and updates to F&I Cost improvement progress reports to F&I Quarterly benchmarking reporting to F&I Committee	Model Hospital benchmarking reporting to F&I Committee	Development of place based approach to service and financial planning ~~April 22~~ *July 23* Understand cost and income base through active use of patient level and roll out throughout organisation. ~~esting December 21~~ Ongoing 5 year financial strategy refresh subject to clarity on financial regime from 22/23 onwards and ICS Financial Strategy ~~June 21 Dec 22 April 23~~ Mar 24 ~~Re-establish quarterly~~ 2023 ~~benchmarking reporting to finance Committee July 22~~ April Re-establish quarterly benchmarking of Model Hospital to drive our areas of

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Achieving the System Efficiency Target	• Scheme of Delegation • Establishment of Pay / Vacancy Control Group • Representation at Place Based Finance and Assurance Committee		SFI breach report to Audit committee Procurement report to F&I Committee Monthly Chair's Report from CRIG to F&I Variable pay reporting in People Committee **3rd Line of Defence (independent/ semi-independent assurance)** Internal audit reviews External audit reports System Reports to Greater Manchester ICS and NHS England Reporting to Finance committee from the system finance group Costing returns National Agency Team reports		productivity improvement and drive by **October 2023** Closer / joint local working in Bolton System. **Ongoing** Develop overarching GM PMO Productivity reporting. **Target completion December 23** FIG reviewing Provider Performance and benchmarking **December 2023** Clarity on GM Financial Strategy which would inform local Strategic Planning. **Target Completion December 23**



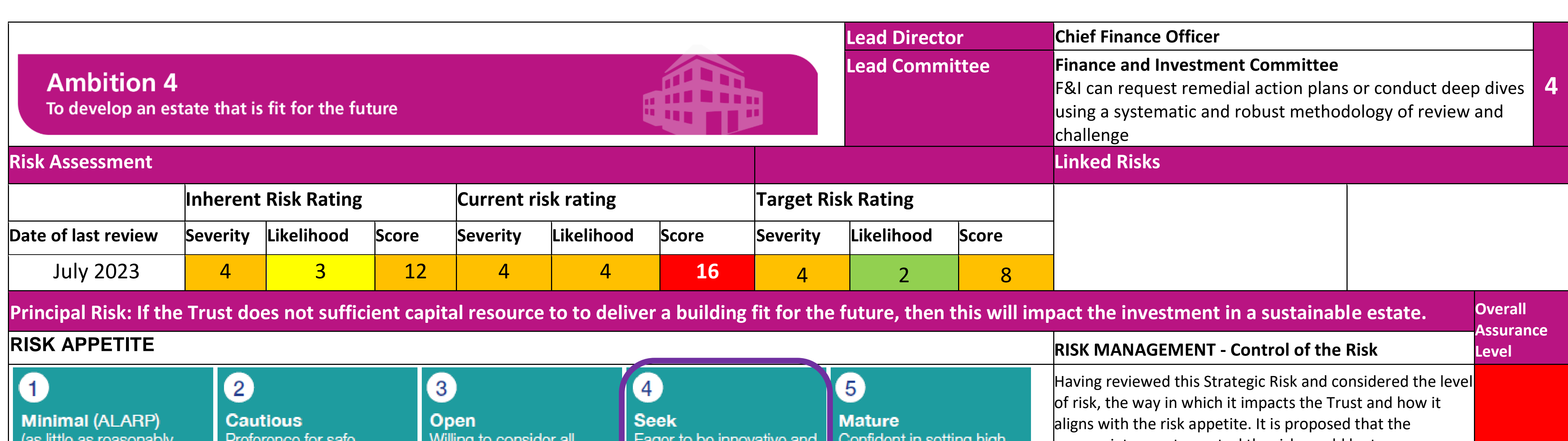
3	Ambition - To use our resources wisely

Risk tracking

Background

The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of Using our resources wisely.

Date	Comments
20.02.20	Full update to risk
May 20	Risk narrative updated
Nov 20	General Update – risk score reduced
Jan 21	Review to focus on strategic risks
Nov 22	Full review and revision of the timescales for completing the actions. There is no change in risk score
Mar 23	No change in risk score
Jul 23	The Ambition and Principal risk has been reviewed and this remains a high risk at 16.



Ambition 4 To develop an estate that is fit for the future										Lead Director	Chief Finance Officer	4
										Lead Committee	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	
Risk Assessment											**Linked Risks**	
	Inherent Risk Rating			**Current risk rating**			**Target Risk Rating**					
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**			
July 2023	4	3	12	4	4	16	4	2	8			

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

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

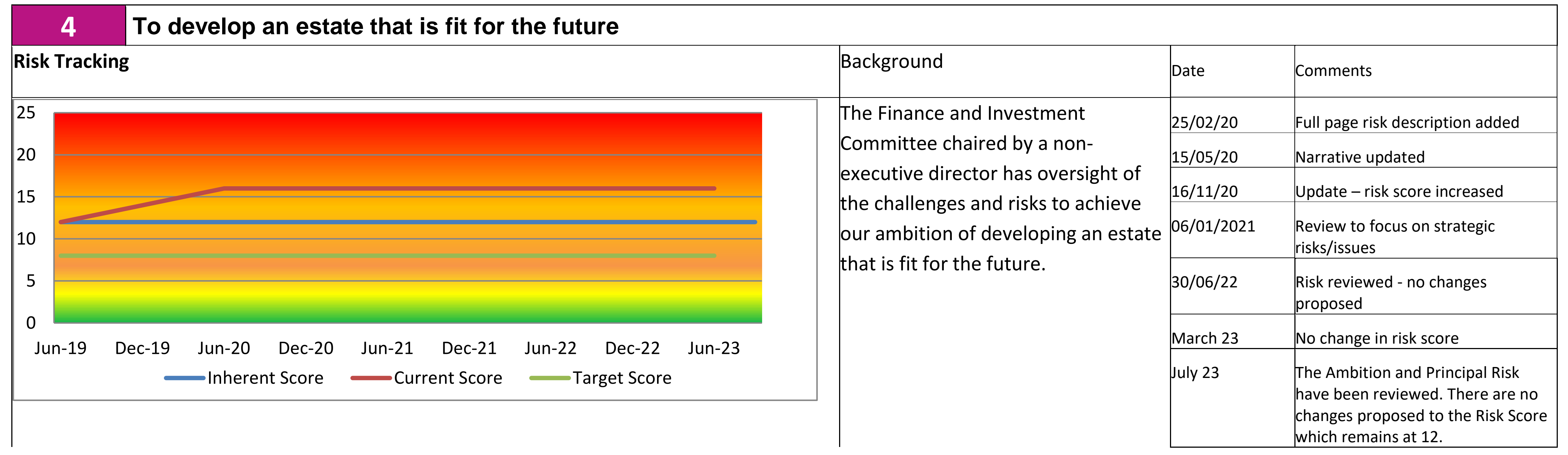
RISK MANAGEMENT - Control of the Risk

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

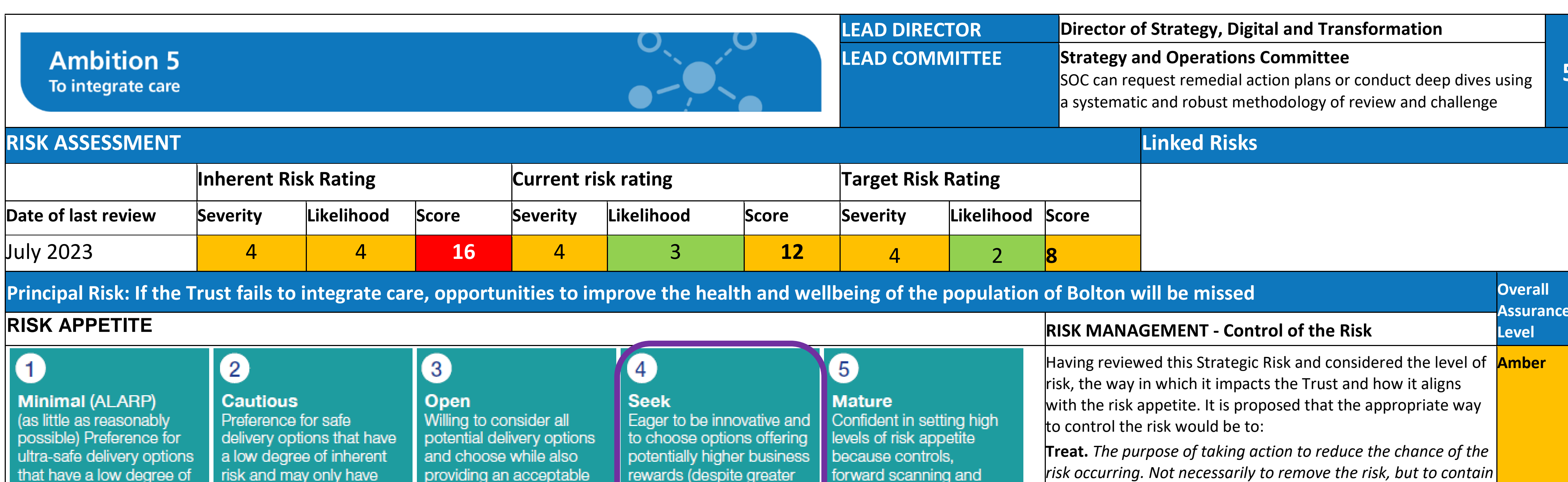
Treat. The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
shortage of capital and revenue funding Changes to capital regime High levels of backlog maintenance Planning, traffic constraints to the site	• Estates Strategy and supporting Business Cases to make the case for external capital. • Established links to GM and NHSI • Capital processes to ensure correct prioritisation • Links with local partners including LA, University	Digital Performance Management Framework being developed PDC bids / funding not linked to Strategy	**1st Line of Defence (Operational Management)** • Monthly review of business cases at CRIG and Executive Directors. • Reports into 6 Facet Survey to Strategic Estates Group with output tracker presented at Execs • Monthly IPM meetings to review performance data • Reports to the Digital performance and transformation Board which reports into sub-committees of the Board	Periodic reports from Bolton Strategy Estates Groups	Developing dynamic 5 year Estates Strategy. **Ongoing** ~~Develop bids for HIP programme, March 21 April 22~~ ~~New Hospital Bid one of 2 supported by GM ICS for submission to new hospital team~~ 6 facet survey reporting to Board annually. **December 23** Clinical Strategy, ~~May 2023~~ **September 23**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Controllability of community estates not owned by Bolton FT Constraints around capital and revenue funding If the Trust does not have a robust digital transformation and delivery plan, the organisation will be unable to function Availability of investment for Digital programmes against need and expectations. PDC bids/funding not linked to Strategy	• Membership of Bolton Strategic Estates Group • Premises Assurance Model • Enterprise Asset Management. • Backtrac system • Agile Working Programme • ~~New Hospital Programme Bid~~ • Refreshed Clinical Strategy • Working with LA and other partners • Our Green Plan • Demolition and Disposal Strategy • IFM asset management • Digital Plan that maps back to the Trust strategy	Re-establishment of Space Utilisation Group	**2nd Line of Defence (reports and metrics monitored at Board/Cttees** Monthly review of Integrated performance report at F&I. Digital performance and transformation Board which reports into sub-committees of the Board **3rd Line of Defence (Independent Assurance)** • ERIC reports • Model Hospital estates and facilities metrics • Use of resources benchmarking • Locality Board oversight • Management Framework • NHS England IG Toolkit • Cyber Security national assessments		~~Community estates strategy, April22 May 2023 22~~ ~~Establishment of Locality Plans~~ **~~April 2023~~** ~~Digital Plan in final stages of development and will be complete by September 2022 January 2023~~ Digital Performance Management Framework being developed ~~January 2023~~ July 2023 Digital Project Management Officer oversight of all programmes Introduce quarterly reporting from Bolton Strategy Estates Groups. **October 23** Re-establishment of Space Utilisation group. **September 23**



4	**To develop an estate that is fit for the future**		
Risk Tracking	Background	Date	Comments
[chart]	The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of developing an estate that is fit for the future.	25/02/20	Full page risk description added
		15/05/20	Narrative updated
		16/11/20	Update – risk score increased
		06/01/2021	Review to focus on strategic risks/issues
		30/06/22	Risk reviewed - no changes proposed
		March 23	No change in risk score
		July 23	The Ambition and Principal Risk have been reviewed. There are no changes proposed to the Risk Score which remains at 12.



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

RISK ASSESSMENT

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
July 2023	4	4	16	4	3	12	4	2	8

Linked Risks

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

RISK APPETITE

1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential

2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)

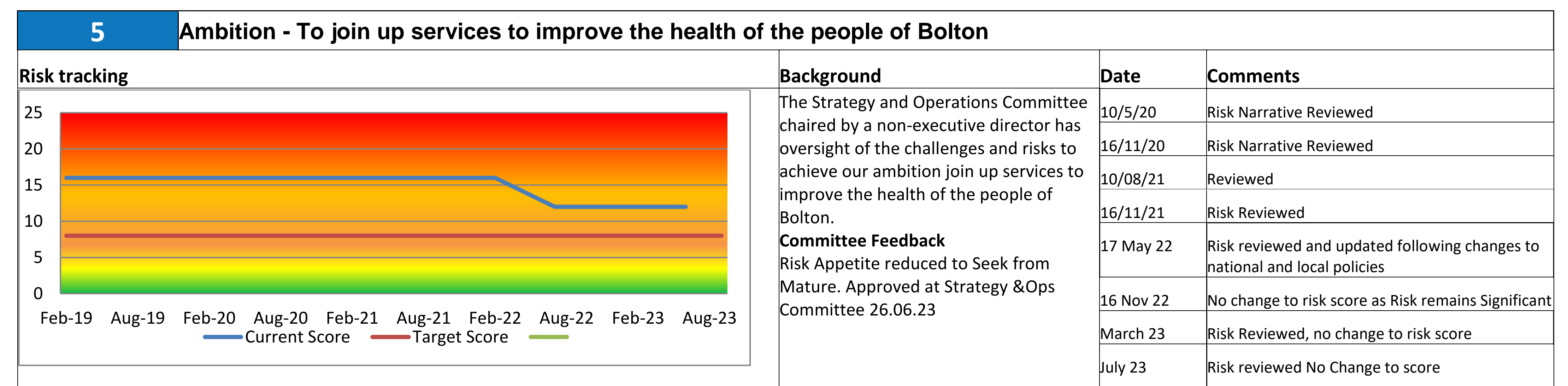
4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).

5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

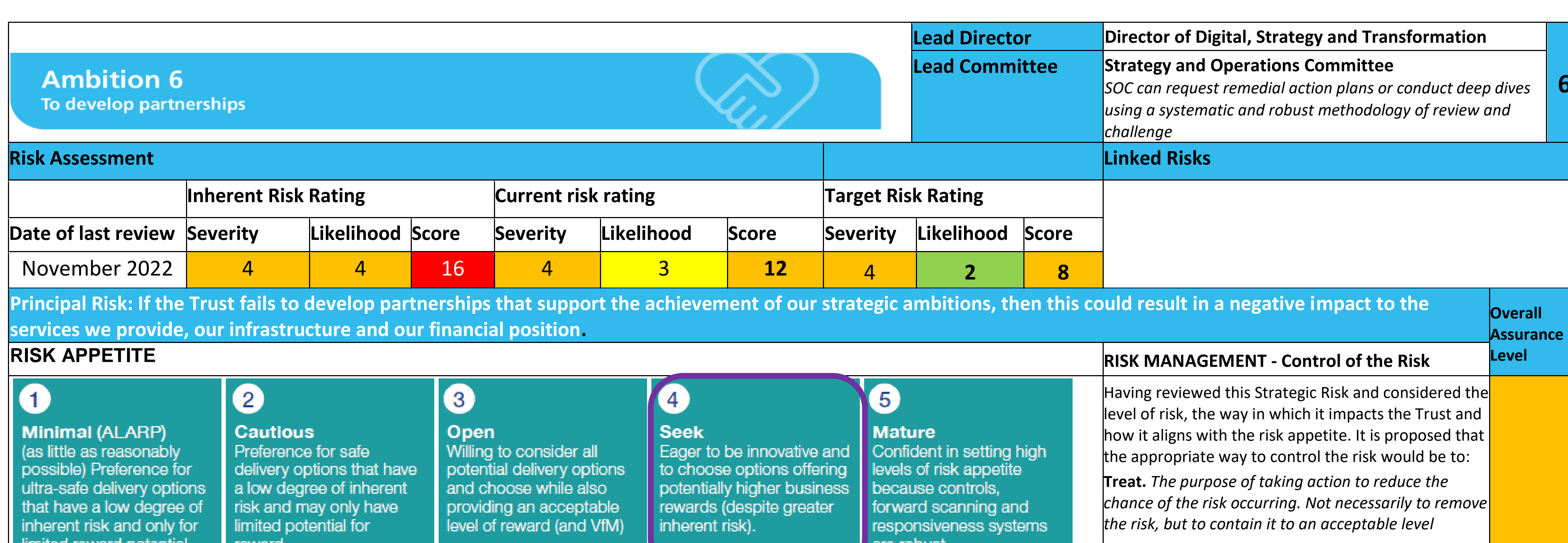
RISK MANAGEMENT - Control of the Risk	Overall Assurance Level
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to: **Treat.** *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*	Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
If the organisation does not cooperate with its partners to understand, respond to and seek to improve population health, then the people of Bolton will not experience improved health outcomes, and demand for acute and community services will remain high in future **Causes** • Not understanding the impact of changes to the Health and Care Act 2022 • Impact of organisations financial Cost Improvement Programmes on the development of the ICP	• Reports to ~~Development of~~ Locality Board with engagement from key partners • Refresh and ~~E~~embed the ~~ICP Business~~Locality ~~Plan~~ Strategy and ensure delivery ~~of the Business Plan~~. • ~~Stakeholder~~ Community engagement plan • Accountability through the Place Based Lead • Alliance Agreement to support the governance of the partnership	• Locality Strategy and delivery plans ~~yet to be developed~~in development • ~~Develop the section 75 (under development awaiting guidance) to support the governance of the partnership~~ • System transformation plan to transform	***1st Line of Defence (Operational Management)*** Monthly report to Performance and Transformation Board on Community Transformation ~~Transformation programme across neighbourhoods, workforce and communities ICP Organisational Development Programme~~ Report to Bolton Strategy Delivery and Planning Committee from 7 Transformation workstreams delivering against key priorities	• New/immature structures – ongoing development including collaborative workshops across the system • Lack of agreed locality strategy, plans and approach to delivery (though these are in development and will be available in Q4~~2~~ 2023/24) • ~~Date for delegation from GM TBA~~	• ~~Transfer of Adult Social Care teams into the FT which is linked with the formation of the LCT.~~ • ~~Develop the section 75 (under development awaiting guidance)~~ • Revision and refresh of the Trust Strategy. ~~**November 2023**~~**Q4 2023/4** • Locality strategy~~, plan s and approach to delivery (though these are in~~ development ~~and will be available in~~by ~~**Q2**~~**Q4 2023/24**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development • Lack of collaboration with system partners to understand and respond to the wider determinants of health **Consequences** • Changes in the wider health economy may destabilise our organisation • the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future • potential fragment integration and slow development	• ~~Locality Governance structure~~ • ~~Development of an Alliance Agreement which ensures shared responsibility around delivering organisational Cost Improvement Savings.~~ • Report to ~~The~~ Locality Board and System Finance Board ~~will have oversight~~on use of the -of the Bolton £ ~~and a system finance Board will put structure in place to allow organisation to ensure controls are in place~~. • Delegation agreement with GM in place • Governance model for delivery in place.	services and drive integration being developed • System finance plan in development • ~~Delegation from GM yet to be confirmed~~	**2nd Line of Defence (Reports to board and Committees)** • Reports to the Strategy and Operations Committee including oversight of indicators through IPR • Spotlight on service transformation of the Neighbourhoods to SOC • Oversight of system finance and any impact to the FT through F&I • Oversight of workforce Transformation through People Committee 3rd Line of Defence (independent and semi-independent assurance) ~~Joint~~ Bolton Locality ~~Executive~~ Meeting reports Reports to Bolton Health and Overview Committee Reports to GM scrutiny and oversight	• ~~Completion of neighbourhood sprints – March 2023~~Fully functioning neighbourhood Teams in place Q4 2023 • System transformation plans to transform services and drive integration are being developed and agreed • Locality workforce strategy being developed	• Work with the ICB to agree the model for delivery under the Place Based Lead. **Sept 2023 - complete~~Ongoing~~** • Development of a System Financial recovery Plan **~~Ongoing~~** • Development of System transformation plan to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the system to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.– **exact date TBA 2023/24**



5	**Ambition - To join up services to improve the health of the people of Bolton**		
Risk tracking	**Background**	**Date**	**Comments**
(chart)	The Strategy and Operations Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition join up services to improve the health of the people of Bolton. **Committee Feedback** Risk Appetite reduced to Seek from Mature. Approved at Strategy &Ops Committee 26.06.23	10/5/20	Risk Narrative Reviewed
		16/11/20	Risk Narrative Reviewed
		10/08/21	Reviewed
		16/11/21	Risk Reviewed
		17 May 22	Risk reviewed and updated following changes to national and local policies
		16 Nov 22	No change to risk score as Risk remains Significant
		March 23	Risk Reviewed, no change to risk score
		July 23	Risk reviewed No Change to score



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

Risk Assessment | **Linked Risks**

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

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

Overall Assurance Level

RISK APPETITE

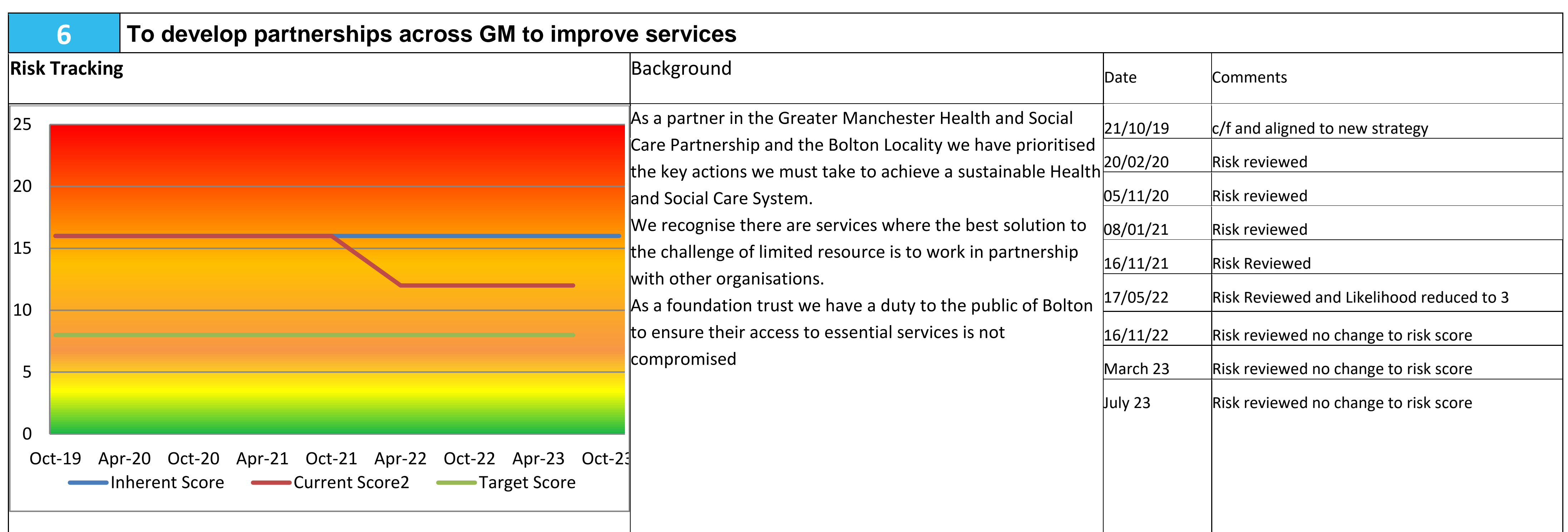
RISK MANAGEMENT - Control of the Risk

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

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

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Demand on services across Greater Manchester and workforce shortages are resulting in resilience issues in some services and requires different partnership approached to mitigate risk. ~~If the GM system introduces a new clinical transformation or service re configuration programme, then there is a risk that some of our service will fall in scope, which could ultimately result in changes~~	• ~~Membership of the~~ Strong Educational partnership through Bolton Health and Academic Partnership Board to support workforce development • Strong Private sector partnerships through Health Innovation Bolton Partnership	Continue to strengthen partnerships with local academic providers Engagement in the development of service transformation programmes through Directors of Strategy and other Exec Director Forums Development of Local pathology, radiology	***1st Line of Defence (Operational Management)*** • Attendance at GM Director Forums • Membership of Health Innovation Bolton group • ~~There is a developing programme of work which currently sits with GM Directors of Strategy, enabling us to contribute to the programme~~ • Report to the Bolton Health and Academic Partnership	• GM Sustainable Services work programme at an early stage though conversations ongoing through Directors of Strategy and Executive Medical Directors • Finalisation of GM network agreements • Finalisation of GM Forward Plan	• Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **ongoing during 2023/24** • ~~Establish a programme structure to support the academic partnership – **June 2023**~~ • Continued participation in GM working group to shape and influence the developing programme - **ongoing** • Implementation of GM PACs and LIMS procurements **- Ongoing** • Finalisation of GM network agreements ~~July 2023~~ **Ongoing**

~~to how our population accesses care~~ and could change the services we provide **Causes** • Resilience of GM clinical services • Increasing demand for services • Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services • Develop Provider Collaborative across GM • Sustainable Workforce Pipeline • Lack of relationships with neighbouring landowners and developers. • Missed opportunity for strategic partnerships **Consequences** • Inadequate workforce to deliver safe, effective care. • strategic partnership opportunities will be missed • adjacent land may be developed in a way that negatively impacts the Trust estate, meaning that our ambitions to improve our estate may be limited • Impact to access, experience and outcomes for the people of Bolton	• ~~Regular meetings with Peel Holdings and Bradford Estates~~ • ~~Membership and~~ Attendance at Greater Manchester (GM) Provider Collaborative and its work streams • ~~Pharmacy transformation programme~~ • Participation in the GM Sustainable Services programme • Engagement through GM Exec Director Forums/PFB • Reporting structure for Bolton Academic Partnership and Programme Management/Support	and pharmacy clinical service strategies ~~Radiology network agreements remain key to assurance on this programme of work~~ ~~Reporting structure for Bolton Academic Partnership and Programme Management/Support~~ ~~Development of a GM laboratory information management system (LIMS) and Picture Archiving and Collaboration (PACs)~~	• Reports to the Bolton Health Innovation Partnership ***2nd Line of Defence (Reports at Board and Committee Level)*** • Reports into People Committee • Reports into Strategic Operations Committee ***3rd Line of Defence (Independent or Semi-independent assurance)*** Membership and attendance at GM Provider Collaborative Board and other Joint Leadership Group		• Development of Local pathology, radiology and pharmacy clinical service strategies • Phase 2 of the CDC programme – Building Commenced • Completion ~~of GM provider collaborative linked to~~ Financial Plan and Digital Plan - **Ongoing** • Working group to move towards medical school **Ongoing** • Expansion of clinical courses and programmes mapped to workforce demand **November 2023** • Development of new programmes to fulfil recruitment issues e.g. health informatics **November 2023** • Production of a shared vision for the site and neighbouring land – **Q4**~~**July 2023**~~ongoing



6 To develop partnerships across GM to improve services

Risk Tracking

Background

As a partner in the Greater Manchester Health and Social Care Partnership and the Bolton Locality we have prioritised the key actions we must take to achieve a sustainable Health and Social Care System.
We recognise there are services where the best solution to the challenge of limited resource is to work in partnership with other organisations.
As a foundation trust we have a duty to the public of Bolton to ensure their access to essential services is not compromised

Date	Comments
21/10/19	c/f and aligned to new strategy
20/02/20	Risk reviewed
05/11/20	Risk reviewed
08/01/21	Risk reviewed
16/11/21	Risk Reviewed
17/05/22	Risk Reviewed and Likelihood reduced to 3
16/11/22	Risk reviewed no change to risk score
March 23	Risk reviewed no change to risk score
July 23	Risk reviewed no change to risk score

Bolton
NHS Foundation Trust

Report Title:	Audit Committee Chair Report

Meeting:	Board of Directors	Purpose	Assurance	✓
Date:	27 July 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Audit Committee meeting held since the last Board of Directors meeting.

Summary:	The attached report from the Audit Committee Chair, provides an overview of items discussed at the meeting held on 28 June 2023.

Previously considered by:
Discussed and agreed at the at People Committee meetings.

Proposed Resolution	The Board of Directors is asked to **receive** the Audit Committee Chair's Report.

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

Prepared by:	Annette Walker Chief Finance Officer	Presented by:	Alan Stuttard, Chair Audit Committee

Audit Committee Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	28 June 2023	Date of next meeting:	13 September 2023
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Malcolm Brown, Annette Walker, Fiona Noden, Sharon Katema, Othmane Rezgui, Debra Chamberlain, Imogen Milner, Andrew Chilton, Matthew Greene, Sharon Freeman	Quorate (Yes/No):	Yes
		Apologies received from:	Karen Finlayson, Catherine Hulme, Collette Ryan,

Key Agenda Items:	RAG	Key Points	Action/decision
Audit Committee Annual Report	Green	The Audit Committee considered the Annual Report. This report has been prepared for the attention of the Board of Directors and reviews the work and performance of the Audit Committee for 2022/23 in satisfying its terms of reference.	The Audit Committee **approved** the Audit Committee Annual Report for consideration by the Board of Directors.
Internal Audit Opinion	Green	The Internal Auditors (PWC), presented the Internal Audit Opinion report for 2022/23. The report sets out the internal audit work carried out during the last financial year and provides the Head of Internal Audit Opinion. The Internal Auditors advised that for both Bolton Hospital NHS Foundation Trust and IFM Bolton Ltd their opinion was reasonable/moderate assurance. It should be noted that this is the second highest rating (out of 4) used by the Internal Auditors. In terms of the work plan the audits not only covered those agreed as part of the original work plan but also reviews that were undertaken at the request of the Trust during the course of the year. This can be recognised as a proactive use of the internal audit service. This was the last meeting for PWC as the Trust's Internal Auditors following the conclusion of their current contract. The Trust has appointed Mersey Internal Audit Agency as the new Internal Auditor from 2023/24. The Audit Committee expressed their appreciation of all the work undertaken during the term of their contract.	The Audit Committee **noted** the Internal Audit Opinion, which will now form part of the Trust's Annual Governance Statement.

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

Audit Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Compliance with Code of Governance		The Director of Corporate Governance presented the Trust Compliance with the FT Code of Governance for the 2022/23 Financial Year. The Board of Directors is required to make a statement in the Annual Report that it has complied with the report and note any areas of non-compliance. The Audit Committee reviewed the compliance prior to consideration by the Board.	The Audit Committee **approved** the proposed declaration of compliance with both sections of the code for consideration by the Board of Directors.
Annual Report and Governance Statement		The Director of Corporate Governance presented the Annual Report and Governance Statement for 2022/23. The Annual Report provides an overview of Bolton Hospital NHS Foundation Trust's performance and achievements for the year. It also provides detail and assurance on how the Trust met and achieved compliance with its statutory and regulatory obligations during 2022/23. The Annual Report and accompanying Annual Governance Statement have been prepared in accordance with the Foundation Trust Annual Reporting manual. Following approval by the Board of Directors the report will be submitted to NHSE prior to being laid before Parliament. The Audit Committee considered the report and a few minor amendments were noted. The Audit Committee expressed their appreciation to the Director of Corporate Governance and her team for the production of the comprehensive reports.	The Audit Committee **approved** the Annual Report and Annual Governance Statement for consideration by the Board of Directors.
Audited Annual Accounts		The Chief Finance Officer presented the Audited Annual Accounts for 2022/23 for review and sign off. The key points to note from the accounts were: • Year-end surplus of £2.8m • Year-end adjusted financial deficit of £1.5m • Gross Capital expenditure of £42.7m • Closing cash balance of £58.2m Taking everything into account, in terms of the financial pressure during 2022/23, this represented a very satisfactory outcome. The Trust has been able to undertake significant investment in a number of capital schemes and successfully managed its resources over the course of the year. The Audit Committee thanked the finance team for their work in producing the accounts and providing all the answers to the queries raised by the External Auditors.	The Audit Committee **approved** the Audited Annual Accounts 2022/23 for consideration by the Board of Directors.

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Audit Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Annual Quality Account Report	Green	The Audit Committee considered the Annual Quality Account Report presented by the Director of Corporate Governance on behalf of the Chief Nurse. The Quality Account is a report regarding the quality of services provided by an NHS Provider. There is a requirement to publish a Quality Account annually. The Quality Account has been considered by the Quality Assurance Committee. The Chair of QAC is also a member of the Audit Committee who confirmed that they were happy with the Quality Account. There were some questions regarding pressure ulcers and these will be followed up by QAC.	The Audit Committee **approved** the Annual Quality Account Report for consideration by the Board of Directors.
KPMG Year End Report 2023/23 (ISA260)	Green	The External Auditors (KPMG) presented their year-end report. This report is prepared in connection with the Audit of the consolidated financial statement for the Trust for the year ending 202/23. The report summarises the key issues identified during the Audit. Overall, the Auditors did not identify any major issues arising from the audit of the accounts and had not identified any significant weakness in the arrangements to secure value for money. There were a few minor items still to be completed but the Auditors indicated that they hoped to be in a position to sign the Audit Opinion by the end of June. The External Auditors identified a few minor recommendations in auditing the accounts and management accepted these. The audit represented a very satisfactory outcome for the Trust in preparing the annual accounts for 2022/23.	The Audit Committee **noted** the external year-end report produced by KPMG.
Auditor's Annual Report 2022/23	Green	The Auditors Annual Report (ARR) provides a summary of the findings and key issues arising from the 2022/23 audit of the Trust. This report has been prepared in line with the requirements set out by the code of audit practice published by the National Audit Office and is required to be published by the Trust alongside the Annual Report and Accounts. IT should be noted that this report appears in the public domain.	The Audit Committee **noted** KPMGs Annual Audit Report for 2022/23.

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Audit Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
	Green	The report did not identify any material issues in the Audit of Accounts nor were any significant risks identified in terms of value for money. The value for money assessment covers financial sustainability, governance and improving economy efficiency and effectiveness. The Auditors also advised that they had considered elements of the CQC well led inspection in arriving at their conclusion. The Audit Committee thanked the External Auditors for their comprehensive reports on the audit for the accounts for 2022/23 noting the significant amount of work that is required.	
Letter of Representation	Green	The Chief Finance officer presented the Management Letter of Representation for consideration by the Audit Committee. The Chief Finance Officer or Chief Executive for and behalf of the Board usually sign this.	The Audit Committee recommended the Management Letter of Representation for **approval** by the Board of Directors.
Salary Overpayment Report	Green	The Audit Committee considered a report on the salary overpayments for the previous year. The Trust had incurred 96 salary overpayments totalling £98.5k for staff who had left the organisation. To date it was noted that approximately half of the overpayments by value had been repaid. The report did not include salary overpayments made to existing staff and which were being recovered by deductions to salary. Nevertheless, in overall context, the Trust processes 80,000 salary transactions per annum and in terms of the number of overpayments, this represented a very satisfactory outcome.	The Audit Committee **noted** the salary overpayment report.
Board of Directors Compliance Report	Green	The Director of Corporate Governance set out the report providing assurance that the Board of Directors are compliant with the regulatory requirements of the fit and proper person's tests. All Board members completed the code of conduct declarations and confirmed that they remained fit and proper to undertake their roles. In addition, the Director of Corporate Governance undertook a review of personal files and conducted checks against the Insolvency Register and Disqualified Director Register as part of due diligence checks.	The Audit Committee received this report as **assurance** that the Trust has discharged its requirements to meet fit and proper person requirements for its Directors.

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Audit Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Comments		The Chair of the Audit Committee thanked the Trust Executive and their Teams, the External Auditors and Internal Auditors for their comprehensive reports relating to the requirements as part of the end of year processes. There is a huge amount of work to be completed in a short space of time and the Trust and Auditors have met all their obligations.	
Risks Escalated : There were no risks to be escalated to the Board of Directors			

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