NHS Bolton NHS Foundation Trust

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 12:30 on Thursday 30 May 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB059/24	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm quorum*	*Verbal*	Chair	**12:30**
TB060/24	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	
CORE BUSINESS				
TB061/24	**Declaration of Interests** *Purpose: To record interests relating to items on the agenda.*	*Report + Verbal*	Chair	**12:45** (05 mins)
TB062/24	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the previous meeting held on 28 March 2024.*	*Report*	Chair	
TB063/24	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB064/24	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Verbal*	Chair	**12:50** (5 mins)
TB065/24	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**12:55** (10 mins)
STRATEGY AND PERFORMANCE				
TB066/24	**Operational Update (including dashboard)** *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**13:05** (20 mins)

TB067/24	**Patient Flow** *Purpose: To **receive** the Patient Flow presentation*	*Presentation*	COO	**13:25** (10 mins)
TB068/24	**Corporate Strategy** *Purpose: To **approve** the Strategy*	*Report*	DoSDT	**13:35** (10 mins)
TB069/24	**Digital Strategy Update** *Purpose: To **receive** the Digital Strategy Update*	*Report*	DoSDT	**13:45** (15 mins)
TB070/24	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**14:00** (05 mins)
QUALITY AND SAFETY				
TB071/24	**Quality Assurance Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**14:05** (5 mins)
TB072/24	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme*	*Report*	Chief Nurse	**14:10** (10 mins)
	COMFORT BREAK			**14:20**
WORKFORCE				
TB073/24	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	PC Chair	**14:30** (05 mins)
TB074/24	**Nursing and Midwifery Staffing Reports** **a) Nursing Staffing Reports** **b) Midwifery Staffing Reports**	*Report*	Chief Nurse	**14:35** (10 mins)

	*Purpose: To **receive** the Nursing and Midwifery Staffing Report*			
TB075/24	**Staff Survey Results 2023** *Purpose: To **receive** the 2023 Staff Survey Results*	*Report*	DoP	**14:40** (10 mins)
FINANCE				
TB076/24	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	**14:50** (5 mins)
GOVERNANCE AND RISK				
TB077/24	**Register of Interests** *Purpose: **To receive** the Register of Interests*	Report	DCG	**14:55** (05 mins)
TB078/24	**Compliance with NHS Provider Licence Self-Certification** *Purpose: To **approve** the NHS Provider Licence Declarations*	Report	DCG	**15:00** (10 mins)
TB079/24	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*All*	**15:10** (10 mins)
CONSENT AGENDA				
TB080/24	**EIA Process Report** *Purpose: To **approve** the EIA Process*	*Report*	DoP	**15:20**
CONCLUDING BUSINESS				
TB081/24	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**15:20** (02 mins)
TB082/24	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**15:22** (03 mins)

TB083/24	**Any Other Business**	*Report*	*Chair*	**15:25**
	*Purpose: To **receive** any urgent business not included on the agenda*			
	Date and time of next meeting: Thursday 25 July 2024			**15:30 Close**

Chair: Jackie Njoroge

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
Seth **Crofts**	Associate Non-Executive Director	External Academic, Appointed Representative, The Open University, Academic Quality and Governance Committee	Non-Financial Professional interest
Tosca **Fairchild**	Non-Executive Director	Chief of Staff – South East London Integrated Care Board	Financial Interest
		Trustee – South East London ICB Charity	Non-Financial Professional Interest
		Client Executive (Consultancy) – Bale Crocker Associates	Financial Interest
		Partner is Consultant in Emergency Care / Deputy Medical Director – University Hospitals of Derby NHS Foundation Trust	Non-Financial Interest
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest
		Director, Harriss Interim and Advisory	Financial Interest
		Family member works for Astra Zeneca	Non-Financial Personal Interest
		Non-Executive Director Borough Care	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	
James **Mawrey**	Chief People Officer / Deputy CEO	Trustee at Stammer	Non-Financial Personal 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
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	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
		Egerton Pre School Committee Chair	Non-Financial Personal Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
Fiona **Taylor**	Non-Executive Director	Chair of Governors St Georges CE Primary & Nursery School	Non-Financial Personal Interest
		Trustee St Ann's Hospice	Non-Financial Personal Interest
		Trustee Women for Well Women	Non-Financial Personal Interest
Annette **Walker**	Chief Finance Officer	Chief Finance Officer of both Bolton Foundation Trusts and GM ICP Bolton	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

NHS Bolton NHS Foundation Trust

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

***Draft* Board of Directors Minutes of the Meeting**
Held in the Boardroom
Thursday 28 March 2024
(Subject to the approval of the Board of Directors on 30 May 2024)

Present

Name	Initials	Title
Niruban Ratnarajah	NR	Chair
Alan Stuttard	AS	Non-Executive Director
Annette Walker	AW	Chief Finance Officer
Fiona Noden	FN	Chief Executive
Fiona Taylor	FLT	Non-Executive Director
Jackie Njoroge	JN	Non-Executive Director
James Mawrey	JM	Director of People and Deputy CEO
Martin North	MN	Non-Executive Director
Rae Wheatcroft	RW	Chief Operating Officer
Rebecca Ganz	RG	Non-Executive Director
Seth Crofts	SC	Associate Non-Executive Director
Sean Harriss	SH	Non-Executive Director
Sharon Katema	SK	Director of Corporate Governance
Sharon White	SW	Director of Strategy, Digital and Transformation
Tosca Fairchild	TF	Non-Executive Director
Tyrone Roberts	TR	Chief Nurse

In Attendance

Name	Initials	Title
Cath Bainbridge	CB	Matron, Neonatal unit (for item 031)
Rachel Carter	RC	Associate Director of Communications and Engagement
Victoria Crompton	VC	Corporate Governance Manager

There were two observers in attendance.

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		

TB030/24 **Chair's Welcome and Note of Apologies**

The Chair welcomed everyone to the meeting of the Board.

TB031/24 **Patient and Staff Story**

The Board of Directors heard the story of Michelle who described the care she received following her son Jacob arriving before his due date. Michelle had to confront the possibility of her baby, Jacob, not surviving after being born at 24/25 weeks. Dr Mishra, Jacob's main consultant, provided her with survival statistics and potential outcomes for a baby born at such an early stage. After delivery, Michelle faced an incredibly difficult moment when she was informed in a shared unit that

Jacob was unlikely to survive. Despite the initial grim prognosis, Jacob began to breathe on his own, leading to a period of cautious observation.

Dr Mishra took the lead on Jacob's care, addressing issues that arose from different consultants providing varied information. Though the staff apologised, Michelle felt that parents could be better prepared for the potential outcome of their premature baby not surviving if they were given more direct information alongside statistics.

Eventually, Jacob made significant progress, nearly weaning off oxygen and thriving without complications. The experience profoundly affected Michelle, who praised the hospital staff for their exceptional care and felt inspired to pursue nurse training.

Staff Story

Cath Bainbridge, Matron of a Neonatal Unit, attended to provide her Staff story, advising that the unit provides care for infants from 22 weeks gestational age and manages a variety of critical cases. The unit has around 130 staff and is known for its excellent outcomes, having received multiple awards in 2023. The staff are dedicated, often going above and beyond, which is reflected in the positive feedback from families and the donations received.

The unit operates in a high-pressure environment, offering both the joy of facilitating a parent's first cuddle and the sorrow of possibly the last. One of the main challenges is a lack of understanding about the services provided. Staffing and capacity issues, compounded by a national shortage of 4000 neonatal nurses, create additional pressures. Despite being under national scrutiny, the unit has taken the opportunity for reflection and improvement.

Cath Bainbridge mentioned the need for better psychological support for both staff and parents, a need that was partially addressed with the hiring of two psychologists and the introduction of Human Factors Training and the tailored Schwartz Round.

To improve staff retention, the unit had introduced a buddy system for new recruits and provided new staff with a pin badge to indicate their newcomer status. These measures have led to an improvement in retention.

Access to the VCreate system was noted as a significant potential improvement for the unit, as it has been praised by NHS England and could reduce the length of stay for patients, while also providing translation services in over 400 languages, which would enhance communication with non-English speaking families.

The unit also provides weekly coffee mornings for parents, special days for fathers, and psychological support for both mothers and fathers.

The Board thanked CB for her staff story.

RESOLVED:

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

TB032/24 **Declarations of Interest**

There were no declarations of interest relating to agenda items.

TB033/24 **Minutes of the previous meetings**

The Board of Directors reviewed the minutes of the meeting held on 25 January 2024 and approved them as a correct and accurate record of proceedings.

RESOLVED:

The Board of Directors ***approved*** the minutes from the meeting held 25 January 2024.

TB034/23 **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

TB035/24 **Chair's Update**

The Chair advised the Gender Pay Gap Report was included on the consent agenda and had been discussed and approved at People Committee, the discussions were reflected within the Chair Report.

The Chair wished Ramadan Mubarak to colleagues who were observing the celebration and wished a happy and bright Holi to those who had celebrated the Hindu festival. The Chair reflected on the celebration of Easter and extended thanks to all colleagues for the work they continue to do and particularly to those who were working over the Easter weekend.

April was stress awareness month and NR highlighted the support which was available to colleagues via the Occupational Health team.

The Trust had welcomed the first patients to the Community Diagnostic Centre (CDC) which housed the latest technology in MRI, CT, X-ray and ultrasound to provide accurate and potentially life-saving diagnostic tests and scans for patients.

RESOLVED:

The Board of Directors ***received*** the Chair's Update.

TB036/24 Chief Executive Report

The Chief Executive presented her report, which summarised activities, awards and achievements since the last Board meeting. The following key points were noted:

- Urgent and emergency care services continued to operate under considerable pressure. The Trust was working towards ensuring 76% of patients were either admitted, transferred, or discharged within four hours of their arrival to the Emergency Department (ED). Unfortunately, the organisation was not on track to deliver this performance standard by the end of March, but had plans in place to improve performance during 2024/25.
- The NHS Staff Survey results had been published. The results confirmed there was work to do on fair career progression, feeling safe to raise concerns and people feeling burnout or emotionally exhausted.
- As part of the ongoing actions to address the reinforced autoclaved aerated concrete (RAAC) on the hospital site, inspections continued alongside daily monitoring of the props in the affected areas.
- The new theatres had officially opened and were in use for inpatient and day case adult patients.
- The neighbourhood teams would be fully co-located in their new areas and operational soon after Easter. Each neighbourhood would have a designated team lead in place.
- To mark the beginning of the holy month of Ramadan, the Equality, Diversity and Inclusion lead shared her insightful reflections and personal experiences with staff.

RESOLVED:

The Board of Directors ***received*** the Chief Executive's Report.

TB037/24 Operational Update (including Integrated Performance Report)

The Chief Operating Officer reported on the Trust's operational performance during February and drew attention to the following issues:

- Urgent and emergency care services continued to operate under intense pressure. There was a significant level of scrutiny around ambulance handovers and four hour performance.
- The national standard for four hour performance was 76% and given the challenges a realistic performance trajectory for the Trust was 65%. This had been achieved with the exception of one week.
- An Urgent Care Improvement Group was established to drive the actions in response to the Emergency Care Improvement Support Team (ECIST)

recommendations. Short term measures to improve performance were put in place with support from system and regional colleagues.

- The Admission Avoidance Team worked with a small cohort of care homes to prevent their residents being transferred to the ED. There were good results with contacts to North West Ambulance Service (NWAS) reduced and attendances from the care homes to ED also lower.
- The Trust were expected to have no patients waiting for treatment more than 78 weeks by the end of March. Teams worked hard to achieve this, but there were a number of patients who would not receive treatment for a variety of reasons. The Trust were also expected to reduce the number of patients waiting more than 65 weeks. Whilst this had grown throughout the year, it was expected to reduce and to achieve the trajectory.
- The Trust continued with good cancer performance, achieving the 28 day faster diagnosis standard. 62 day performance had not achieved the required standard.

Quality and Safety

The Chief Nurse and Medical Director provided an update on quality and safety advising what had already been improved within the organisation and what could be even better. It was noted that:

- There was a reduction in category 2 pressure ulcers with the review of these being led by the divisions through the Patient Safety Incident Response Framework (PSIRF).
- There were no reported unstageable, category 3 or category 4 pressure ulcers acquired in hospital
- Crude mortality in month rate was slightly below Trust target and average for the period and had remained in control for more than three years.
- Hospital Standardised Mortality Measures (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) figures remained below average for the period in control.

In response to RG's query regarding the special cause variation around the depth of recording, FA advised that the critical measure was the proportion of fully coded records by the submission date, and this stood at 97.7%.

Financial Performance

The Chief Finance Officer provided an overview of the Trust's financial performance advising that:

- The Trust had a forecast outturn deficit of £9.3m which was against a planned deficit of £12.4m.
- The capital spend for the year was £23.3m

- There was a year-end forecast cash balance of £12m.
- The 2024/25 financial plan was in draft and would be signed off in April/May 2024.

Workforce

The Director of People provided a workforce update advising there had been a deterioration in some key questions of the NHS Staff Survey and there remained some recruitment hotspots for hard to fill posts. However, there had been an increase in the NHS Staff Survey response rate, sickness rates had decreased and vacancy rates remained below tolerance levels.

TF queried the progress against the ECIST actions. SH advised the ECIST report had been discussed in Strategy and Operations Committee and the Trust was under increasing pressure about the actions being taken. RW added that ECIST report had made a number of recommendations which had been added to the urgent care project, and the structure around those recommendations were being monitored by the improvement group. If progress was made against the recommendations then the organisation would not need further scrutiny and could provide updates through Board of Directors.

JN raised concern that the number of deflections from ED had reduced despite the work undertaken with care homes and occupied bed days had also increased due to Social Work capacity. RW advised the capacity issues in Social Work were due to a temporary gap which had been recruited to. Issues were flagged through system meetings.

AS stated it would be beneficial to have sight of a month by month forecast which could be used as an early warning indicator and would provide a tool to ascertain the trust position at the end of the year.

AS queried whether as diagnostics were improved and the number of patients being seen through CDC increased would this impact on the number of patients being added to waiting lists. RW advised that increases in diagnostics would not increase waiting lists due to patients awaiting diagnostics already being on waiting lists.

RESOLVED:

The Board of Directors ***received*** the Operational Update (including the Integrated Performance Report).

TB038/24 **Strategy Review and Update**

The Director of Strategy, Digital and Transformation presented the draft Strategy advising the document would be shared with staff and stakeholders for consultation. A set of Key Performance Indicators (KPIs) were in development and the Board Committees would receive the Strategy and associated KPIs for detailed review and sign-off, following which the final iterations would be brought to Board of Directors for approval in May.

RG commented the Ambitions appeared linear, and it was not necessarily possible to highlight the Improving Care and Transforming Lives ambition, as the main Ambition for the Trust.

JN queried how the strategy would be shared with key partners to influence their organisational strategies. SW confirmed the draft strategy had been presented at the Locality Board and all stakeholders had been consulted with to ensure the strategy aligned with their organisational vision.

RESOLVED:

The Board of Directors ***received*** the Strategy Review and Update

TB039/24 **Strategy and Operations Committee Chair Report**

Martin North, presented the Chair's report from the Strategy and Operations Committee meeting held on the 26 February 2024. Rebecca Ganz presented her Chair's report detailing proceedings from the meeting held on 25 March 2024, the key points highlighted were:

- There was a recurring theme across the agenda which related to a risk around leadership capacity and the impact on strategy implementation.
- The Board Assurance Framework (BAF) was reviewed and risk 1.2 which related to operational standards was increased to a rating of 20 from 16, due to the prevailing backdrop. Risk 5 (integrating care) and 6 (partnerships) remained unchanged.
- Urgent Care was a key focus, it was noted the ECIST work was system focused and triangulated with a locality perspective.
- Cancer 62 day performance trajectory moved from expected best case of >85% in January to May due to bank holidays, industrial action and an uptick in lung referrals.
- The productivity programme demonstrated clear benefits of doing more with less resource starting to be quantified in terms of financial and non-financial wins. Capacity for the programme confirmed as part of existing workstream.

RESOLVED:

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

TB040/24 Operational Plan Submission 2024/25

The Director of Strategy, Digital and Transformation advised the Trust had submitted the first draft of its Operational Plan for 2024/25 which described the Trust's projected performance against activity, finance and workforce. The submission would be consolidated into a single Greater Manchester return and submitted to NHS England for consideration, and feedback was expected in April.

RESOLVED:

The Board of Directors ***received*** the Operational Plan

TB041/24 Quality Assurance Committee Chair's Report

Fiona Taylor presented her Chair's report detailing proceedings of the Quality Assurance Committee which was held on 27 March 2024. The committee had approved the updated Terms of Reference and received the Quality Improvement Plan, CNST update and an update from the Medical Director on the CQC Well Led Recommendations

AS queried the Pharmacy risk. FLT advised there were a number of challenges and risks which required oversight and consideration by the Executive Team. FA advised the main risk was around medicine reconciliation arriving within 24 hours.

RESOLVED:

The Board of Directors ***received*** the Quality Assurance Committee Chair's Report.

TB042/24 Quality Account Objectives

The Chief Nurse presented the Quality Account priority proposals for 2024/25 and the timeline for the Quality Account Annual Report for 2023/24. It was noted that in the absence of the national guidance for the Quality Account Annual Report which was yet to be released, the 2023/24 Quality Account publication timeline would follow the assumed timeline with final publication being 30 June 2024.

The Proposed Quality Account improvement priorities for 24/25 were:

- Deteriorating Patient Collaborative – new for 24/25
- C.*diff* Collaborative – continuation

- QI skills capability building – continuation

RESOLVED:

The Board of Directors ***approved*** the Quality Account Objectives

TB043/24 **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme**

The Chief Nurse reported that the Trust had submitted its compliance declaration for Year 5 of the CNST (Clinical Negligence Scheme for Trusts) to NHS Resolution on January 29, 2024. The Trust expects to be notified about the financial award from the scheme by April 30, 2024. The details for the Year 6 scheme are scheduled to be published on April 2, 2024.

On February 9, 2024, the Care Quality Commission (CQC) released the Maternity survey results, which included feedback from women who gave birth between January and March 2023. The survey indicated a 57% improvement in responses compared to the previous year, and actions to address the feedback were already in place.

A Local Maternity Neonatal System (LMNS) visit to the Trust was conducted on February 19, 2024. The visit provided assurance that the service was meeting all immediate and essential actions recommended by the Ockenden report. The Trust also demonstrated progress on the implementation of a unified delivery plan. A formal report from the LMNS visit is pending, which will determine if the Trust can exit the regional support programme.

It was noted that the Trust was working closely with the national team regarding Reinforced Autoclaved Aerated Concrete (RAAC)

RESOLVED:

The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

TB044/24 **Mortality Report**

The Medical Director presented the Mortality Report advising that Summary Hospital-level Mortality Indicator (SHMI) showed the Trust at 108.06, which was in the 'Expected' range. The trend in Hospital Standardised Mortality Ratios (HSMR) remained within the expected range at 102.22. The crude rate remained at a similar level as compared to last year.

The key challenges:

- Improving comorbidity and diagnosis recording
    - Significant reductions in the number of discharges where patients had 0 comorbidities over the last three years had been fundamental to the movement of SHMI and HSMR back into expected range.

- Maintaining clinical coding completeness
    - The Clinical Coding Team continued to achieve the >98% coding completeness at the data freeze point.
- Clinical scrutiny of mortality data
    - Influenza, Aspiration pneumonitis and other perinatal conditions had been reviewed with learning from these reported.

.**RESOLVED:**

The Board of Directors ***received*** the Mortality Report**.**

TB045/24 **Learning from Deaths Report**

The Medical Director presented the report advising that during the last quarter of the 39 cases reviewed, three had been escalated for secondary review. Key themes from the cases included:

- Decisions made by clinical teams were not always easily conveyed through Electronic Patient Record (EPR) or between EPR and external systems, which could influence care.
- Surgical Liaison Physicians were a vital resource for patients, given their increasing comorbidity and acuity.
- Pressure ulcers required surgical assessment and intervention, therefore medical input to the QI work in this area may confer some benefit.

With regards to the incorrect implementation of the changes to mental health case definitions, FA advised that the definitions had been re-evaluated to ensure alignment with national guidelines. The refined case definitions would enhance the Trust's ability to identify individuals with mental health issues who should be considered for the review process. Additionally, an increased number of case reviewers have been trained, which is expected to boost the efficiency of completing primary and secondary reviews.

RESOLVED:

The Board of Directors ***received*** the Learning from Deaths Report

TB046/24 **People Committee Chair's Report**

Tosca Fairchild presented her Chair's Report detailing proceedings from the People Committee meetings held on 20 February and 19 March 2024.

At the March meeting alert was raised regarding the NHS Staff Survey and the committee welcomed a detailed discussion on the results and the actions being taken to ensure the Trust met its Strategic aim of being a great place to work.

The Committee also raised concern that updates were not received from iFM Bolton with regard to the People agenda. It was noted this would be useful as iFM was a key part of the group model.

RESOLVED:

The Board of Directors ***received*** the People Committee Chair Report.

TB047/24 **Finance and Investment Committee Chair Report**

Jackie Njoroge presented her Chair's report from the Finance and Investment Committee held on 28 February 2024, and provided an update on the key points from the meeting held on 27 March 2024, which included:

- The month 11 Finance Report was presented and it was noted there was a year to date deficit of £9.3m compared with a planned deficit of £11.5m and capital spend for the month was £0.9m.
- The Committee approved the accounts for 2023/24 to be prepared on a going concern basis.
- The committee approved the contract extension with Inspired Energy for 2024/25 and to join the NHS Energy Basket for the purchase of energy from April 2025 for a term of 30 months.
- The committee approved the transfer of solid-tumour oncology activity at the Trust to a Christie@ Bolton onsite in line with the GM Cancer Oncology Delivery Strategy.
- The committee approved the proposed extension of the 0-19 contract.

RESOLVED:

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

TB048/24 **Financial Controls Committee Chair Report**

Jackie Njoroge presented her Chair's reports detailing the proceedings of the Financial Controls Committee meetings held 17 January and 21 February. She also provided a verbal update from the meeting held on 20 March 2024. The following key points were noted:

- An update was received from the Finance Performance Recovery Meeting (FPRM) noting that the focus of the next meeting would be around

completeness and robustness of the Cost Improvement Plan (CIP) together with operational performance and the plan for 2024/25.

- The committee received an update on the vacancy and variable spend noting that a reduction in headcount was built into the plan.

It was noted the Financial Controls Committee had been established as a time limited committee and would therefore be subsumed into the Finance and Investment Committee from April 2024.

RESOLVED:

The Board of Directors ***received*** the Financial Controls Committee Report.

TB049/24 Charitable Funds Committee Chair's Report

Martin North presented his Chair's report detailing proceedings of the Charitable Funds Committee held on 11 March 2024. It was noted that a review of the Charity's core costs had taken place, resulting in a proposed 6% reduction in the Charity's management fee. Work would continue into 2024/25 to deliver on the full scope of the review. The proposed reduction in management fee was approved.

NR advised that one of the themes from the staff survey was around staff rest facilities and he asked whether the charity could support this. TR advised a walkaround had been undertaken to understand requirements and a request would be submitted to the Charitable Fund for this.

RESOLVED:

The Board of Directors ***received*** the Charitable Funds Committee Chair Report.

TB050/24 Audit Committee Chair's Report

Alan Stuttard presented his Chair's report detailing proceedings from the Audit Committee held on 14 February 2024 advising that the iFM Bolton accounts had been submitted. The External Audit was out to tender and dates were being considered for the presentations at the end of April which would include a cohort of governors whose role it was to appoint the External Auditor for the Trust.

RESOLVED:

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

TB051/24 Board Assurance Framework

The Director of Corporate Governance presented the Board Assurance Framework (BAF) which had been reviewed by the Executive Directors and Board committees to

ensure the process of identifying the main sources of risk continued to be balanced against the controls and assurances that were in place to enable discussion and scrutiny at the Board level.

RG queried whether the scoring of Ambition three “To Use our Resources Wisely” should be increased. JN confirmed discussion had taken place at Finance and Investment Committee who considered it to be an escalating risk, and noted there was some lag in the BAF which was acknowledged.

The Board discussed the BAF and agreed it was not the sole method of assurance and acknowledged that it continued to be used constructively as the key mechanism by which the Board evaluated its strategic risks and received assurance on the effectiveness and appropriateness of mitigations were in place to address those gaps in controls and assurance.

RESOLVED:

The Board of Directors ***received*** the Board Assurance Framework.

TB052/24 **Fit and Proper Declaration**

The Director of Corporate Governance presented the report which confirmed Trust's adherence to the Fit and Proper Person Test (FPPT) Framework set by NHS England, ensuring that director-level appointees are suitable for their positions according to established regulations. The Trust had updated its policy to align with the FPPT Framework, which mandated that directors must have good character, appropriate qualifications, competencies, skills, and experience, and must not have a history of serious misconduct or mismanagement.

The Trust had systems in place to ensure that only individuals who meet the FPPT standards were hired for director roles and to monitor ongoing compliance. Additionally, the Trust would integrate the Leadership Competency Framework (LCF) into annual director appraisals in the first quarter of the fiscal year 2024/25. The Chair would consider if all directors met the 'fit and proper' criteria, and this would be reported in the NHS England Annual Review for 2023/24. Updates following the appraisals would be provided to the Remuneration and Nominations committees of the Board and Council of Governors.

AS queried section 8.4.1 around Board member references and whether this was in line with the Trust’s Recruitment Policy. JM confirmed that he would clarify.

FT/24/03	**ACTION:** JM to clarify whether 8.4.1 of the Fit and Proper Person Policy around Board member references was in-line with the Trust's Recruitment Policy	**JM**

SH queried the process around social media searches and SK confirmed as part of the Fit and Proper checks a search of social media check was undertaken as this was recommended in the Kark review. In addition, the Trust had a Social Media Policy and all Board members signed a Code of Conduct each year. FN added that all staff were expected to adhere to the Social Medical Policy and as a Board of Directors they should lead by example. SW advised the Social Media Policy was being refreshed and she would work with SK to ensure it also covered Non-Executive Directors.

RESOLVED:

The Board of Directors ***received*** the Fit and Proper Declaration and ***approved*** the Fit and Proper Policy.

TB053/24 **Anti-slavery Statement**

The Director of Corporate Governance presented the Anti-Slavery and Human Trafficking Statement for 2023/24 which sought to provide assurance on the Trust's compliance with the Modern Slavery Act 2015.

RESOLVED:

The Board of Directors ***approved*** the Anti-slavery Statement.

TB054/24 **Feedback from Board Walkabouts**

The Chair invited members who had undertaken walkabout since the last meeting of the Board to provide an update following the visits.

- G3 – was a very pressured ward, but there was a real commitment and evidence of solid team working. There were a few challenges noted including the diversity of patient groups and some equipment not being available, but there was good proactive management.
- AS visited the new Theatres which were fantastic and there was a lot of space. There had been some teething issues and some snagging issues, but this was to be expected.
- AS had visited Neonatal, SDEC and CDU. Within SDEC there had been some frustration around the flow of patients, but the issues had been rectified.

There were also some IT issues within the area. Each area visited displayed good team working.

- FLT advised she had also visited SDEC and IT issues were raised. The staff were passionate and caring, but raised how they could connect as a team when they worked in such a fast paced area

RESOLVED:

The Board of Directors ***received*** the Feedback from Board walkabouts.

TB055/24 **Gender Pay Gap Report**

The Director of People presented the Gender Pay report following review at the People Committee.

RESOLVED:

The Board of Directors ***received*** the Gender Pay Gap Report and ***approved*** its publication on the Trust website.

CONCLUDING BUSINESS

TB056/24 **Questions to the Board**

No questions to the Board of Directors were received.

TB057/24 **Messages from the Board**

The following key messages from the Board were agreed:

- Patient and Staff Story
- Pressures in Urgent Care
- Strategy

TB058/24 **Any Other Business**

There being no other business, the chair thanked all for attending and brought the meeting to a close at 16:30.

The next Board of Directors meeting will be held on Thursday 30 May 2024.

Meeting Attendance 2024						
Members	Jan	March	May	July	Sept	Nov

Niruban Ratnarajah	✓	✓				
Fiona Noden	✓	✓				
Francis Andrews	✓	✓				
James Mawrey	✓	✓				
Tyrone Roberts	✓	✓				
Annette Walker	✓	✓				
Rae Wheatcroft	✓	✓				
Sharon White	✓	✓				
Rebecca Ganz	✓	✓				
Jackie Njoroge	✓	✓				
Martin North	✓	✓				
Alan Stuttard	✓	✓				
Sean Harriss	✓	✓				
Fiona Taylor	A	✓				
Seth Crofts	✓	✓				
Tosca Fairchild	✓	✓				
Sharon Katema	✓	✓				
✓ = In attendance	A = Apologies					

November 2023 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/24/02	28/03/2024	Chief Execitve Update	Presentation on patient flow to be shared with Board of Directors	RW	May-24	Complete - on Board of Directors agenda May 2024
FT/24/03	28/03/2024	Fit and Proper Person Declaration	JM to clarify whether 8.4.1 of the Fit and Proper Person Policy around Board member references was in-line with the Trust's Recruitment Policy	JM	May-24	Complete - reference to the Fit and Proper Person Policy added to the Recruitment Policy specifically with relation to the F&PPT reference procedure. Employment History and Reference Checks section of the Recruitment Policy amended to include NHS Fit and Proper Persons regulations which outline additonal reference checking and recording requirements for Executive Directors, NEDS, any other position deignated by the Chair and CEO as being a role that performs a function of, or functions equivalent or similar to those of a Director. This would include Associate NED appointments, interim appointments, permanent, interim and associate positions, irrespective of their voting.

Key

complete	agenda item	due	overdue	not due

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Purpose	To update the Board of Directors 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 including any internal developments and external relations.

Previously considered by:
N/A

Proposed Resolution	The Board is asked to ***receive*** the Chief Executive'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:	Fiona Noden, Chief Executive	**Presented by:**	Fiona Noden, Chief Executive

Ambition 1
Provide safe, high quality care

Our Urgent Care Improvement Group continues to monitor and manage the delivery of the recommendations made by the clinically led national NHS Emergency Care Improvement Support Team (ECIST), following their review of our services. So far progress includes an increase in the streaming of patients to our Urgent Treatment Centre (UTC), the standardisation of board rounds on our wards and an increased focus on patient flow – all with the aim of making sure our patients get the care they need, when they need it.

A new study is underway to improve understanding of the different healthcare issues that are affecting South Asian communities, including higher rates of heart disease and diabetes. By looking more closely at how genes work, and how diseases develop, researchers are hoping to identify better treatments to cure or help prevent them.

The study is taking place in Bradford, East London and Greater Manchester, with 24 volunteers recently recruited to take part in Bolton. Anyone who wishes to sign up and volunteer is encouraged to do so by visiting the Genes and Health study website.

A new initiative has helped to drastically reduce the number of days patients need to stay in hospital after knee or hip replacements. Since January this year the length of stay has reduced to one day from three to four days previously. We have also seen our first-ever same-day discharge for a hip replacement and he shared with us just what a difference it makes being able to return home sooner thanks to the new way of working.

A new project has launched to monitor patients who have lung disease in the comfort of their own homes. The technology will allow patients to keep track of their own lung function with the aim of detecting if their condition worsens as early as possible, so our staff can intervene sooner.

Previously, patients with lung disease received a lung function test approximately twice a year, whereas the new trial allows patients to take readings as often as they would like. Clinical staff are able to routinely monitor patients through a central dashboard that alerts them to any deterioration and to arrange a consultation for further checks.

We have made some evidence based changes to our uniform policy, shifting the emphasis to the things that matter most to our patients including good communication, continued hand hygiene and infection, prevention and control measures. The changes to the policy celebrate diversity and inclusion, and support our staff to be their true selves when they come to work.

Ambition 2
To be a great place to work

The Our Voice Change Programme has continued to gather momentum with all five change teams on their way to achieving the three key objectives they set, over the coming months. A highlight this month was the launch of a series of digital drop in sessions for staff who require support with their systems or equipment, or those who want to offer feedback about their experience to help with further improvements.

The first session took place in the Boardroom on our hospital site, as part of a 'digital day' which also included our technical team visiting the wards to ensure their equipment and digital set up is fit for purpose. Future sessions are set to take place across our community sites in June.

Our Digital Team has also been working with our partners at Microsoft to develop our 365 package and maximise the accessibility tools that can be applied to our systems, for people with low vision, with dyslexia, or who require different adjustments.

The last couple months have presented the opportunity to shine a spotlight and show appreciation for some of our professions.

International Day of the Nurse took place on 12th May to coincide with the birthday of Florence Nightingale. This year, in addition to our nurses working across all our settings to provide personalised care every day, we took a moment to recognise the impact our internationally trained nurse colleagues have had here in Bolton.

In the last two years we have welcomed more than 200 nurses who have trained internationally and thank them for their courage to move abroad and join the Bolton family. Embracing colleagues from throughout the world diversifies our workforce and brings us together with new knowledge, skills and experience for a better Bolton.

To mark International Day of the Midwife on 5th May our teams shared their pride about the privilege of helping to deliver 5,186 babies, whilst 1,130 babies received extra special care in Royal Bolton Hospital's Neonatal Unit (between March 2023 and March 2024).

We have also recognised our admin' professionals as part of Administrative Professionals Day on Wednesday 24th April, our Operating Department Practitioners day on 14th May, and International HR Day on 20th May.

One of our nurses, Jean Cummings, celebrated sixty incredible years of proudly serving the NHS, having first put on a uniform on January 1st 1964. Jean began her career as a Cadet Nurse following an interview in our boardroom and soon became the youngest student nurse of her year group and split her time between hospitals to complete placements.

Although Jean has looked after countless people in the past, her current work as one of our Clinical Research Nurses is helping to discover new and better ways to treat illnesses for patients well into the future.

Our specialist homeless and vulnerable adult and diabetes teams has been shortlisted for two awards at the Diabetes Nursing Awards 2024. Led by Diabetes Specialist Nurse, Lynne Wooff, Bolton's teams have been shortlisted for Service Improvement Project of the Year and the Innovation Award.

The team has made incredible improvements for homeless people with diabetes in Bolton including introducing a new programme of health checks, developed specific screening support for homeless people attending our Emergency Department and carrying out screening sessions at Bolton's three main hostels.

Jody Petersen, Practice Educator, and Sean Griffiths, Plaster Technician have been shortlisted for a Greater Manchester Health and Care Champion Award, in the Equalities Champion category. Jody and Sean have spearheaded the Trust's neurodiversity agenda,

working alongside the staff network to develop resources to support patients and colleagues with neurodiversity.

Jody has developed a toolkit to support colleagues across the organisation, which features a guide to starting conversations around neurodiversity and how reasonable adjustments can be made to working environments to ensure every member of staff is empowered in their role. Sean has worked with Our Bolton NHS Charity to enhance the waiting room in the plaster room to be a more autism friendly environment for young patients.

Both have championed and developed the Trust's first neurodiversity support group, a safe space for colleagues to raise and share issues, support each other, and identify areas that need to improve in the workplace.

The Trust received the NHS Pastoral Care Quality Award for its work supporting international staff by providing pastoral care, support and commitment to our international nurses and midwives. Support includes maintaining contact with successful candidates, understanding what matters to them and sharing places of interest as part of their orientation into the Bolton family.

Ambition 3
To use our resources wisely

Along with all other NHS organisations in Greater Manchester, we continue to operate in a period of financial recovery and improvement to address the significant deficit we are in across the region. As part of this, we continue to attend the Provider Oversight Group, which replaces the Finance and Performance Recovery meetings, to report on our progress and future plans.

In order to deliver financial sustainability, there is a continuing need for us to make cost improvements at every available opportunity. We have continued to monitor our cost improvement programme through our Financial Improvement Group to oversee the work that will enable us to continue to improve our financial position, with Executive leadership and representation from all divisions and corporate services meeting weekly to plan how these savings will be met.

The group continues to proactively identify areas for efficiency, without compromising patient quality or safety.

NHS Greater Manchester has established its key priorities for this year which are to improve population health inequalities, improve performance and achieve financial balance.

A public engagement exercise is due to launch under the umbrella title 'An NHS Fit for the Future' to increase awareness and understanding of the priorities, reassure the public that any investments and decisions made will be of benefit to them both now and in the future, and involve people and communities in meeting the challenges faced across the region.

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

Since identifying RAAC on our hospital site in November 2023 we have been taking action to make sure that our staff, patients and visitors remain safe in our buildings, specifically in our maternity and pathology departments.

We are working with national experts in the NHS to safely manage the RAAC and make plans for how we manage RAAC in our estate longer term, and have now agreed that a business case will be submitted for the eradication of RAAC roof panels within our maternity and gynaecology wards. Several options are being considered as part of the business case, to ensure suitable decant facilities for any affected services.

Construction of the University of Bolton's new £40m Institute of Medical Sciences (IMS) facility on the hospital site was completed at the start of this month. Work is underway on the internal fit-out, ahead of the facility opening in September.

IMS is set to deliver training to approximately 3,000 learners per year and provide continuing professional development opportunities for existing NHS staff in Bolton and other local healthcare providers in subjects including physiotherapy, nursing and midwifery.

Subject to General Medical Council approval in June, the five-storey state-of-the-art building will become a medical school and home to student doctors from September 2025. The building will contain high-tech facilities, including simulation suites designed to recreate various healthcare delivery scenarios.

Our new Community Diagnostic Centre (CDC) has welcomed its first patient for X-Ray. The CDC first opened to MRI, CT and ultrasound patients at the end of March and will support thousands of patients by providing quick and easy access to vital tests and scans.

Located on the ground floor of J Block at Royal Bolton Hospital, the dedicated centre aims to increase diagnostic capacity and reduce waiting times for our patients.

Ambition 5
To integrate care

At both this month's Strategy, Planning and Delivery Committee, and Locality Board, teams across our health and care partnership shared updates on the delivery of our Locality Plan.

The colocation of health and care professionals as part of our new neighbourhood model is starting to have a positive impact on our communities. Examples include staff being able to facilitate multi-disciplinary conversations at their neighbourhood hubs, getting the people the support and help they need more quickly.

Since opening, Bolton Family Hubs have become warm and welcoming places in the community where people can come together to experience parenthood together, accessing positive activities for children and support for families including advice on breastfeeding, baby's first food, childhood development, and professional support with all aspects of parenting including help with debt, welfare and housing issues.

The hubs are delivered by the council, in partnership with the Trust, Greater Manchester Mental Health, Bolton Together, Bolton Community and Voluntary Service and other

community organisations, and are funded through the government's Family Hub and Start for Life fund.

One of our Specialist Community Public Health Nurses has explored how public health workers can help tackle the trend of rising numbers of teenagers choosing to use e-cigarettes, in a new publication for the British Journal of Child Health. The research paper identifies key themes to improve understanding around why more young people are choosing to vape, and makes a number of recommendations to support school nurses in their work to support young people.

Bank holidays typically see an increase in demand for our urgent and emergency services. We appealed for the public to support us over the May bank holiday weekend by choosing the most appropriate service for their needs and ensure emergency services are available for those who need them. NHS 111 online provides quick and easy medical help, and for minor conditions people were asked to contact their local pharmacist or the out of hours GP and dental services for advice and treatment.

Ambition 6
To develop partnerships

We continue to work in partnership with our communities and public, to make a lasting difference through Our Bolton NHS Charity.

Some of our nurses and healthcare workers ran the first-ever Bolton Community Run 10k to raise thousands of pounds for patients, service-users and their families. The inaugural event was organised by Bolton Wanderers in the Community and took place on Sunday 28th April 2024.

The Lancashire Ladies Fundraising Group hosted a spring lunch fundraising event in support of Our Bolton NHS Charity and to contribute towards the Neonatal and Paediatrics Specialty Fund.

A mother whose daughter experienced our Neonatal Intensive Care Unit (NICU) care teamed up with the Bolton Butchers Association (BBA) to raise £3,000 for our Neonatal and Paediatrics Speciality Fund through Our Bolton NHS Charity. The Neonatal Paediatrics Speciality Fund is used to enhance the experience of patients and their families on the children's wards and the neonatal unit and the family wanted to give a little back to the team who had been there for them when they needed it the most.

A family from Bury have raised more than £7,300 for Our Bolton NHS Charity to support parents and their families who use Royal Bolton Hospital's Neonatal Unit. The family wanted to acknowledge the care support received when their twins were born prematurely at our hospital in 2019, and spent 126 days on the Neonatal Unit (NNU).

The former Mayor of Bolton, Councillor Mohammed Ayub, raised more than £6,000 in vitals funds to support patients and families since selecting Our Bolton NHS Charity as one of his three chosen causes to support during his term in office. The official inauguration of our new Mayor, Councillor Andy Morgan, has taken place and we look forward to continuing to work with him in his new capacity.

Our Bolton NHS Charity and Bolton Wanderers in the Community are coming together to host three hours of non-stop dancing and a community health and wellbeing event at the Toughsheet Community Stadium. Residents, businesses and community organisations in Bolton are being encouraged to find their rhythm and help change lives across the town and our services will be providing information and advice about support available to people living in Bolton.

Report Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	✓
Exec Sponsor	James Mawrey		Decision	

Purpose	To present the Month 1 Integrated Performance Report

Summary:	The Integrated Performance Report provides an overview of the Trust's performance in against the reported metrics in April 2024. The narrative describes issues that are affecting performance and any mitigating actions to improve performance.

Previously considered by:
The report was previously discussed at Integrated Performance Meetings and at May committees.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Integrated Performance 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:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey, Deputy Chief Executive/Director of People

Bolton NHS Foundation Trust

Integrated Performance Report

April 2024

Guide to Statistical Process Control

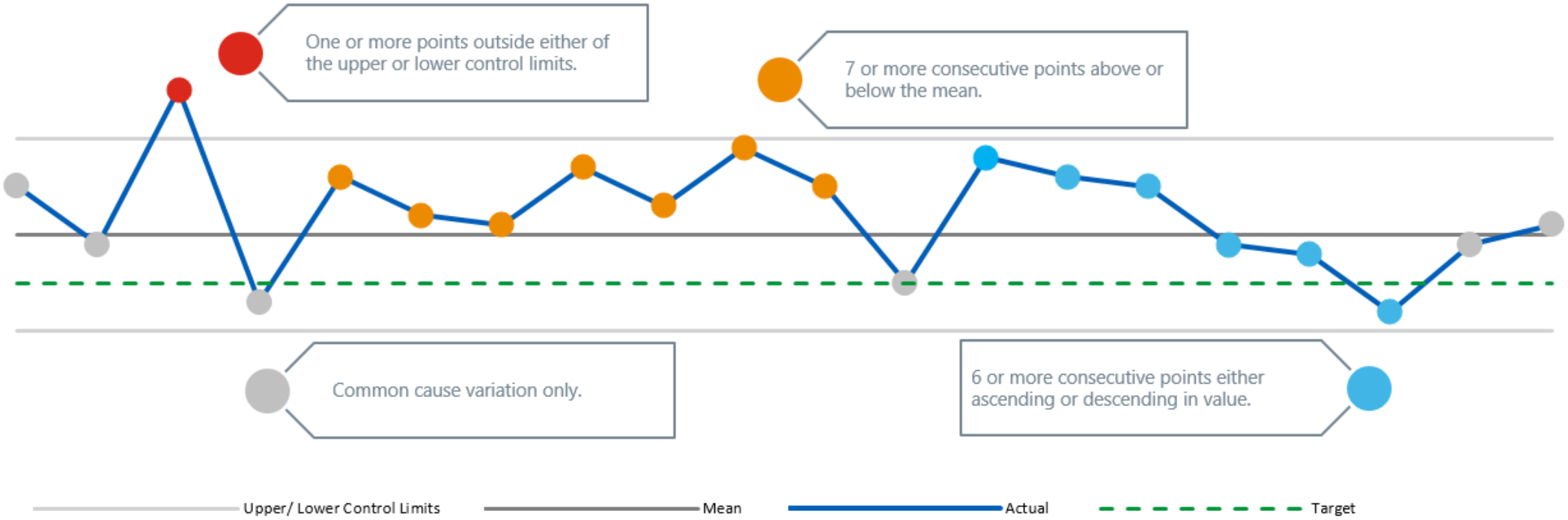
NHS Bolton NHS Foundation Trust

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	3	3	2	1	2	3	11
Infection Prevention and Control	9	0	0	1	0	0	0	7
Mortality	7	0	0	0	0	0	0	3
Patient Experience	12	3	0	0	1	2	0	14
Maternity	7	0	1	0	1	1	0	8
Operational Performance								
Urgent Care	4	0	1	5	1	2	5	4
Elective Care	7	1	3	3	1	1	6	5
Cancer	1	0	0	0	0	0	0	1
Community Care	4	0	0	0	1	0	2	3
Workforce								
Sickness, Vacancy and Turnover	2	0	2	0	0	0	2	1
Organisational Development	2	2	0	0	2	1	2	3
Agency	0	0	2	1	0	0	1	2
Finance								
Finance	2	0	0	0	1	1	0	2
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

Pressure Ulcers

Pressure ulcers; from 1st April, the organisation adopted the recommendation to include unstageable pressure ulcers within the definition for category 3 in-patient pressure ulcers. In April, 3 category 3 were recorded (which would formerly have met the unstageable definition). These are subject to the usual verification and analysis.

**To note: Pressure Ulcer data remains unvalidated for 60 days from date of reporting whilst patient safety incident response framework review underway. **

Patient Safety Incident Investigation turnaround performance by agreed deadline

In April there was one Patient Safety Incident investigation report due for approval. However, following review the report required further work and is due for sign off at the end of May 2024.

There are currently two Patient Safety Incident Investigations underway including the one that is now overdue.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.9%	Apr-24	H	>= 95%	97.4%	Mar-24	>= 95%	96.9%	?
9 - Never Events	= 0	0	Apr-24		= 0	0	Mar-24	= 0	0	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.73	Apr-24	L	<= 5.30	3.81	Mar-24	<= 5.30	3.73	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	0	Apr-24		<= 1.6	1	Mar-24	<= 1.6	0	?
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	12.0	Apr-24		<= 6.0	12.0	Mar-24	<= 6.0	12.0	?
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	3.0	Apr-24	H	<= 0.5	0.0	Mar-24	<= 0.5	3.0	?
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Apr-24	L	= 0.0	0.0	Mar-24	= 0.0	0.0	?
515 - Acute Inpatients acquiring pressure damage (unstagable)		0	Apr-24	L		2	Mar-24		0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	11.0	Apr-24		<= 7.0	7.0	Mar-24	<= 7.0	11.0	?
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	6.0	Apr-24	H	<= 4.0	1.0	Mar-24	<= 4.0	6.0	P

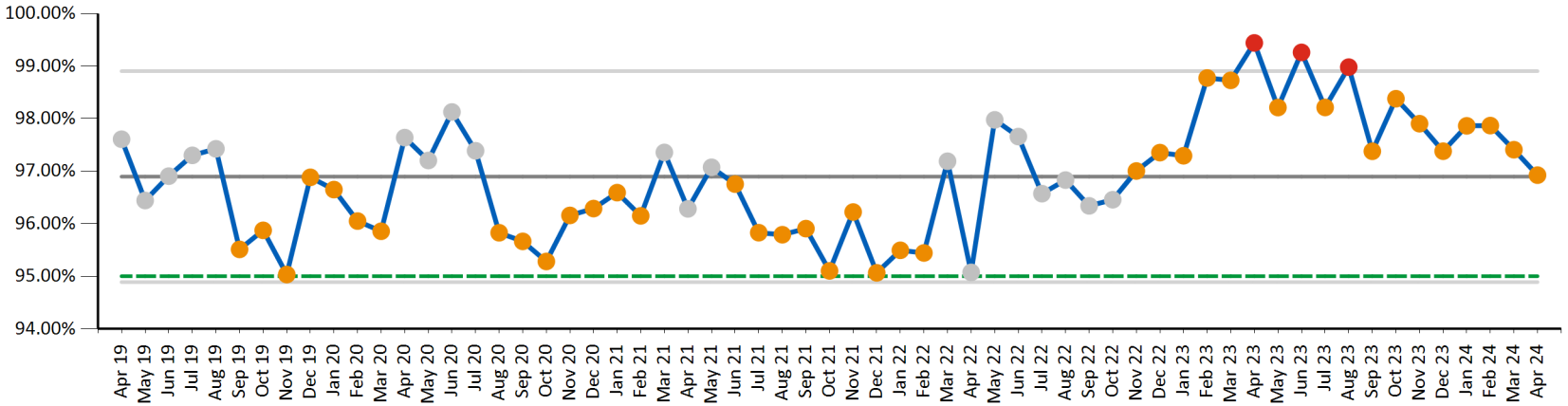
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Apr-24		<= 1.0	0.0	Mar-24	<= 1.0	0.0	
516 - Community patients acquiring pressure damage (unstagable)		0	Apr-24			8	Mar-24		0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Apr-24			0	Mar-24		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Apr-24			0	Mar-24		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Apr-24			0	Mar-24		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	76.2%	Apr-24		>= 95%	71.7%	Mar-24	>= 95%	76.2%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	71.9%	Apr-24		>= 95.0%	69.9%	Mar-24	>= 95.0%	71.9%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Apr-24		= 100%	100.0%	Mar-24	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	95.2%	Apr-24		>= 85%	94.9%	Mar-24	>= 85%	95.2%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Apr-24		= 100%	100.0%	Mar-24	= 100%	0.0%	
8 - Same sex accommodation breaches	= 0	10	Apr-24		= 0	12	Mar-24	= 0	10	

6 - Compliance with preventative measure for VTE

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 95%	96.9%	Apr-24

Previous

Plan	Actual	Period
>= 95%	97.4%	Mar-24

Year to Date

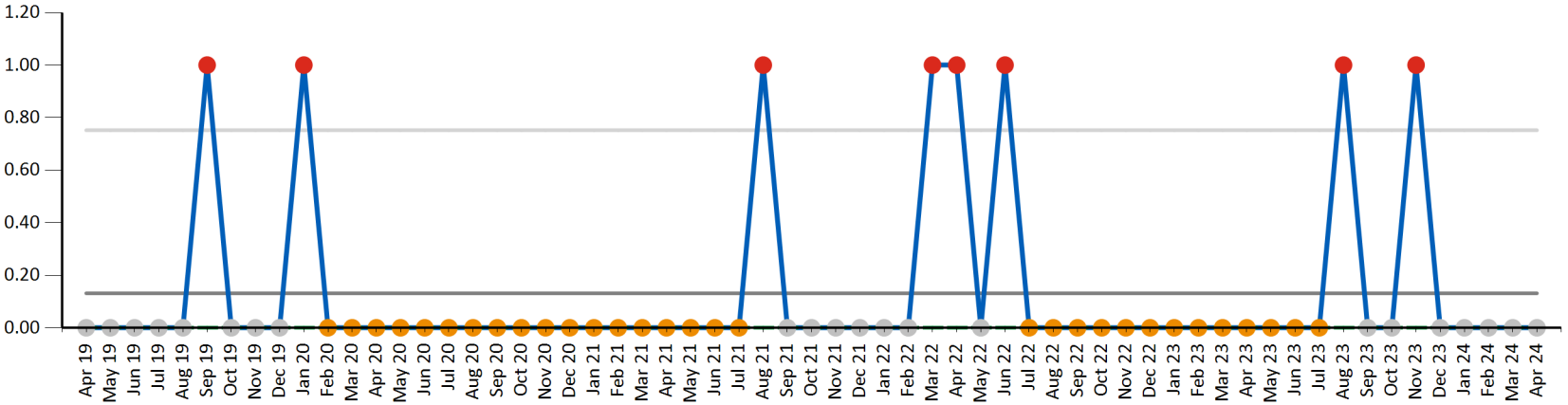
Plan	Actual
>= 95%	96.9%

9 - Never Events

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Apr-24

Previous

Plan	Actual	Period
= 0	0	Mar-24

Year to Date

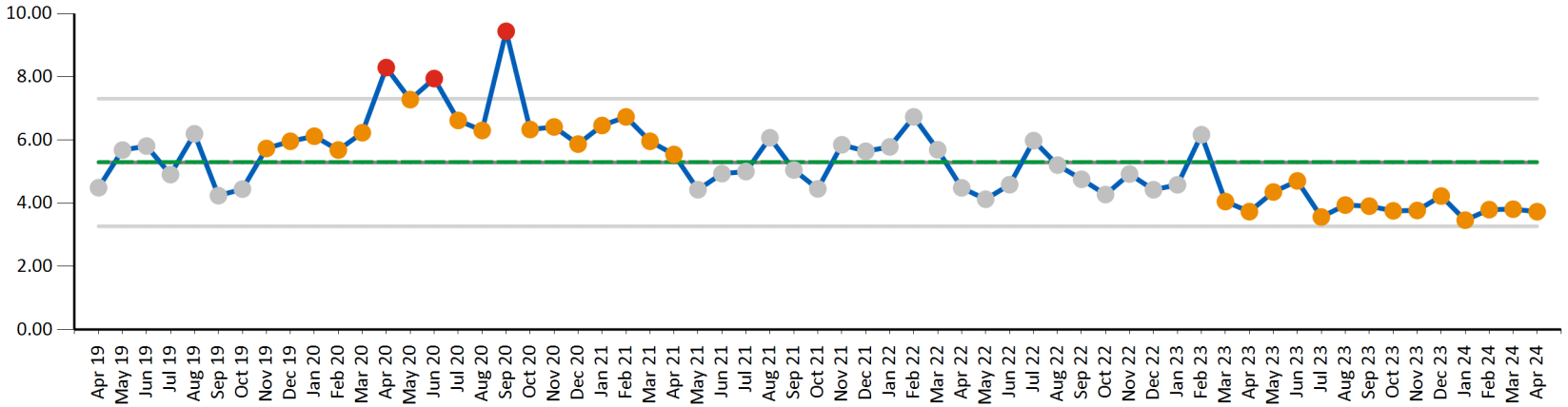
Plan	Actual
= 0	0

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 5.30	3.73	Apr-24

Previous

Plan	Actual	Period
<= 5.30	3.81	Mar-24

Year to Date

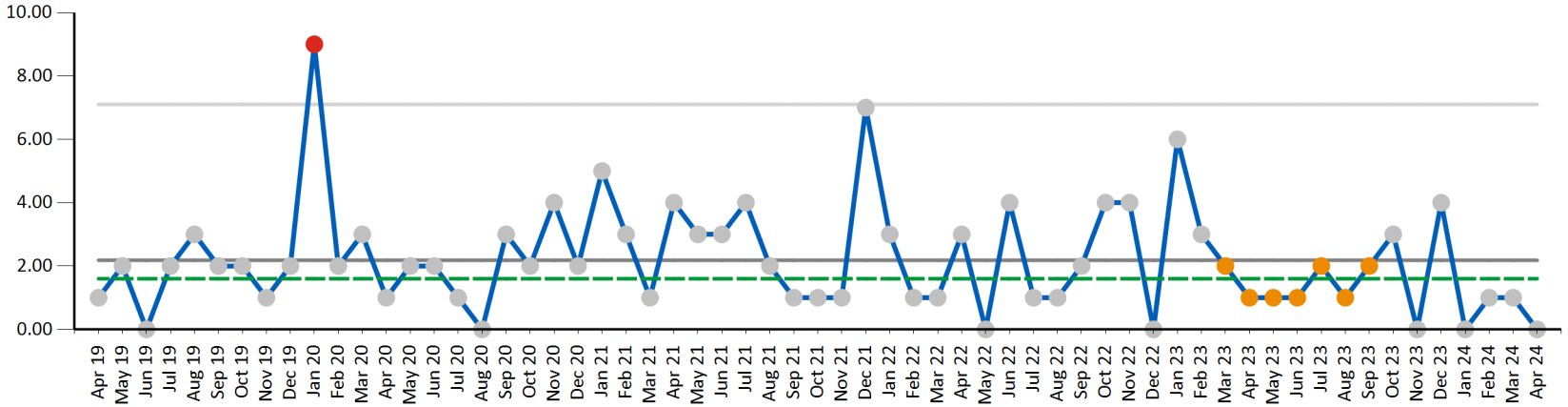
Plan	Actual
<= 5.30	3.73

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 1.6	0	Apr-24

Previous

Plan	Actual	Period
<= 1.6	1	Mar-24

Year to Date

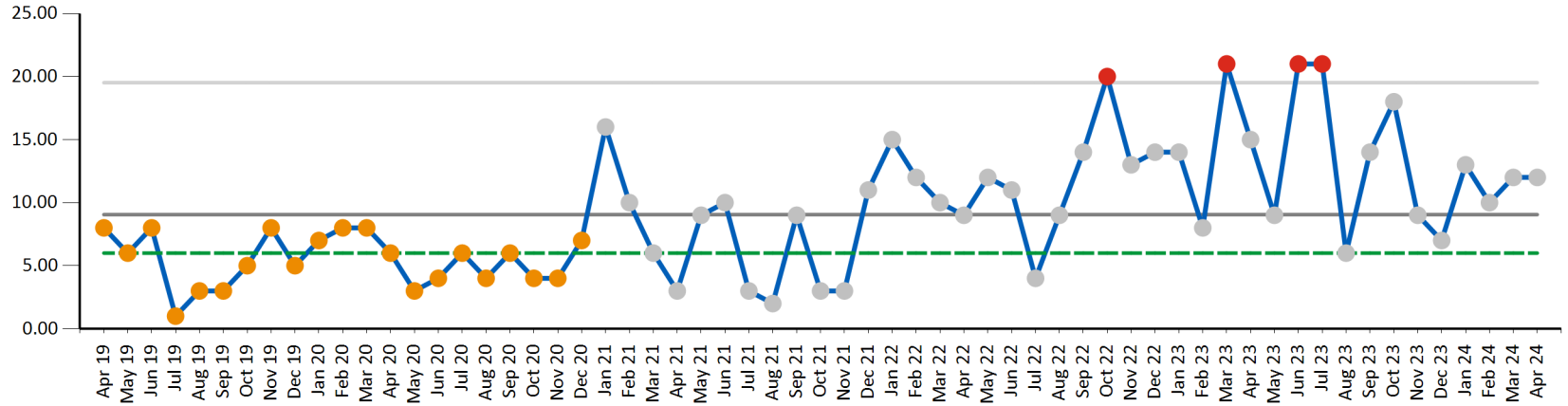
Plan	Actual
<= 1.6	0

15 - Acute Inpatients acquiring pressure damage (category 2)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6.0	12.0	Apr-24

Previous

Plan	Actual	Period
<= 6.0	12.0	Mar-24

Year to Date

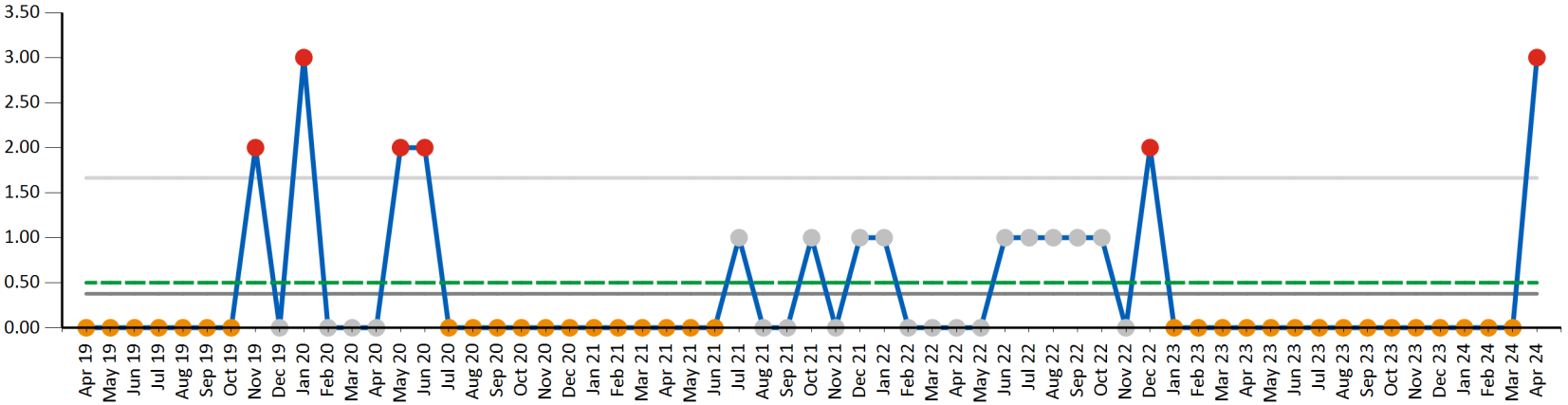
Plan	Actual
<= 6.0	12.0

16 - Acute Inpatients acquiring pressure damage (category 3)

Special cause variation with deteriorating performance

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

5/6



Latest

Plan	Actual	Period
<= 0.5	3.0	Apr-24

Previous

Plan	Actual	Period
<= 0.5	0.0	Mar-24

Year to Date

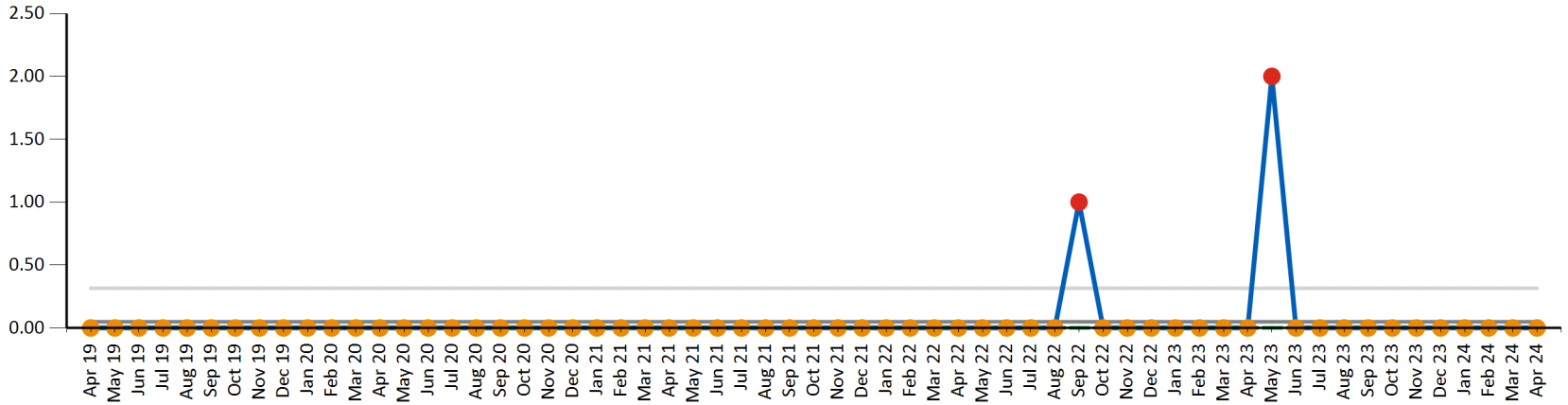
Plan	Actual
<= 0.5	3.0

17 - Acute Inpatients acquiring pressure damage (category 4)

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 0.0	0.0	Apr-24

Previous

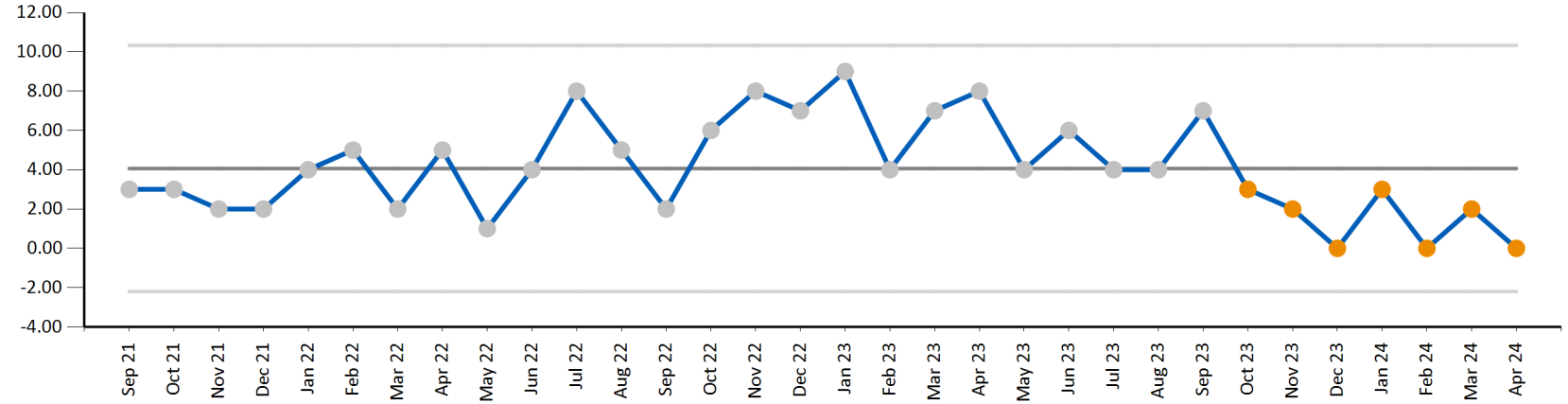
Plan	Actual	Period
= 0.0	0.0	Mar-24

Year to Date

Plan	Actual
= 0.0	0.0

515 - Acute Inpatients acquiring pressure damage (unstagable)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	0	Apr-24

Previous

Plan	Actual	Period
	2	Mar-24

Year to Date

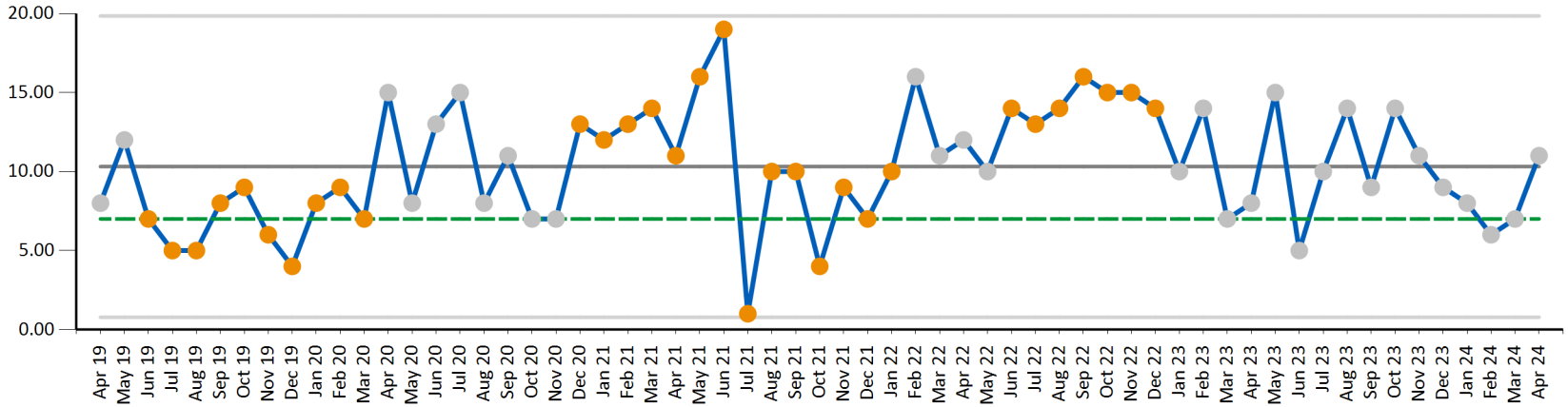
Plan	Actual
	0

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 7.0	11.0	Apr-24

Previous

Plan	Actual	Period
<= 7.0	7.0	Mar-24

Year to Date

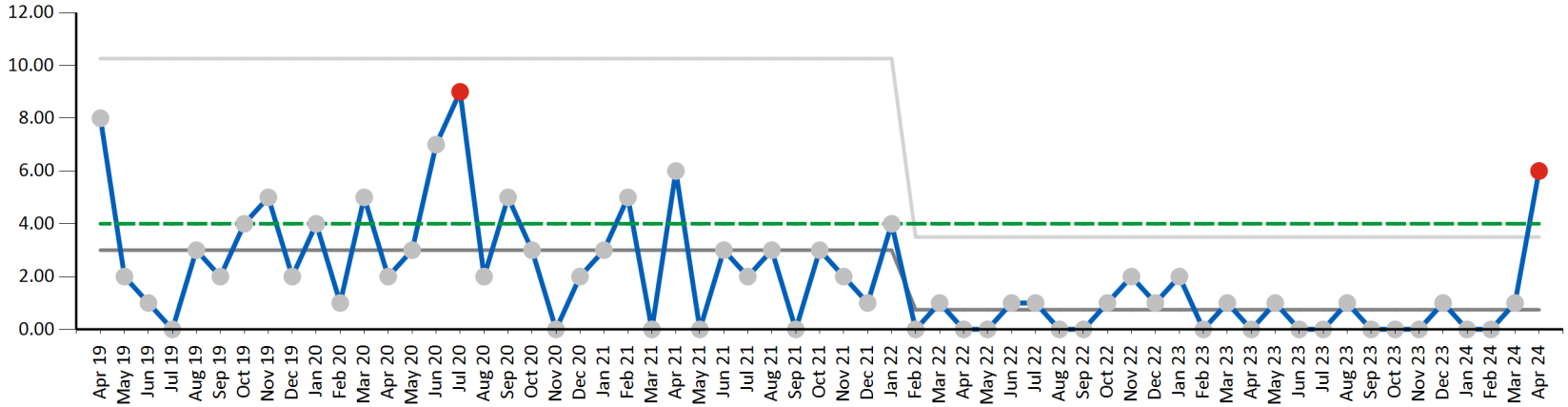
Plan	Actual
<= 7.0	11.0

19 - Community patients acquiring pressure damage (category 3)

Special cause variation with deteriorating performance

Target will be regularly met.

5/6



Latest

Plan	Actual	Period
<= 4.0	6.0	Apr-24

Previous

Plan	Actual	Period
<= 4.0	1.0	Mar-24

Year to Date

Plan	Actual
<= 4.0	6.0

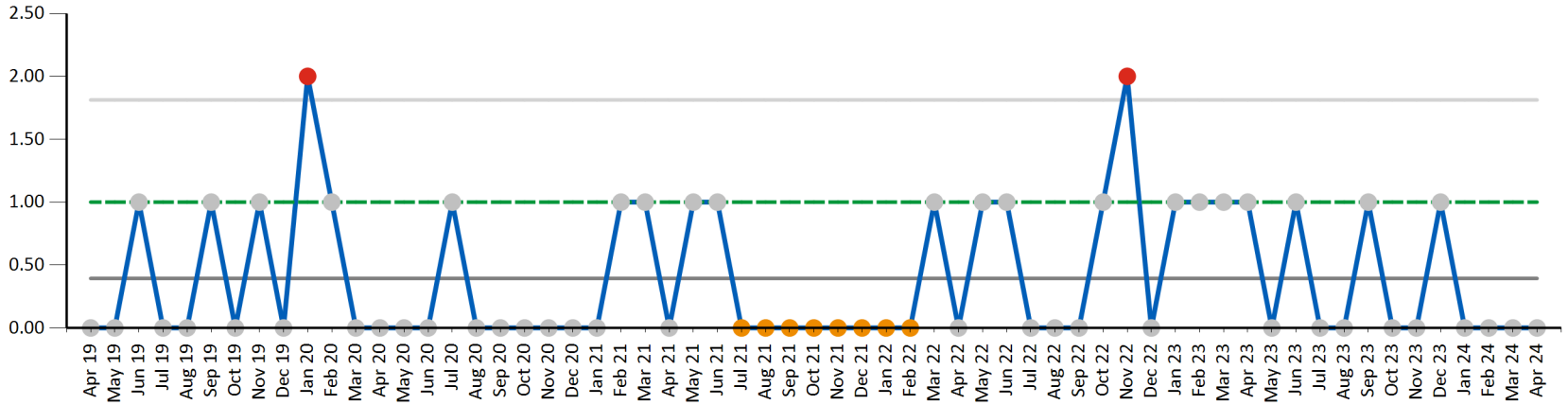
Please note - from April 24 this includes unstageables.

20 - Community patients acquiring pressure damage (category 4)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 1.0	0.0	Apr-24

Previous

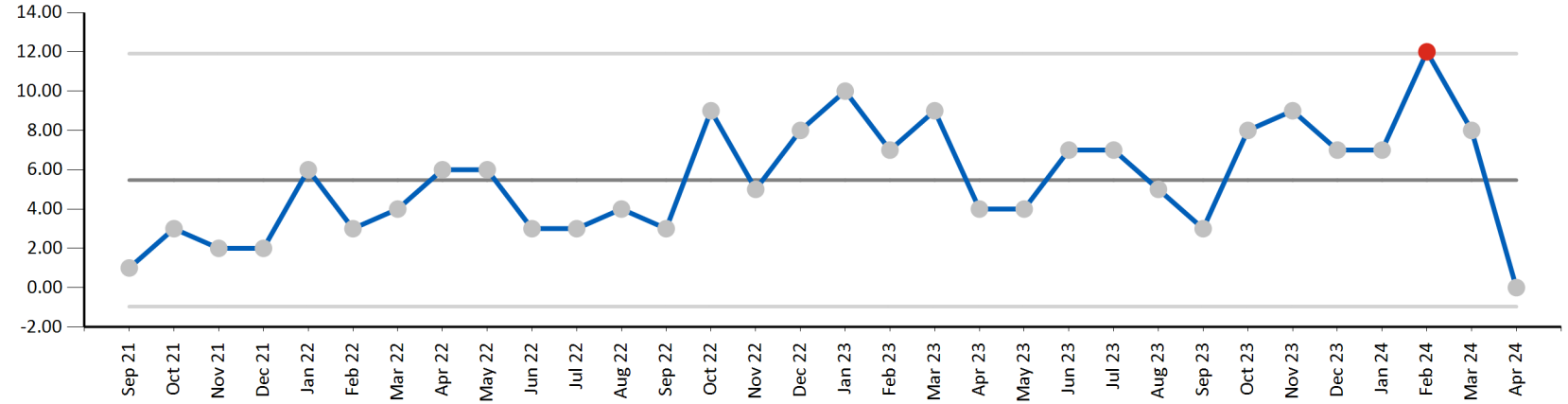
Plan	Actual	Period
<= 1.0	0.0	Mar-24

Year to Date

Plan	Actual
<= 1.0	0.0

516 - Community patients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-24

Previous

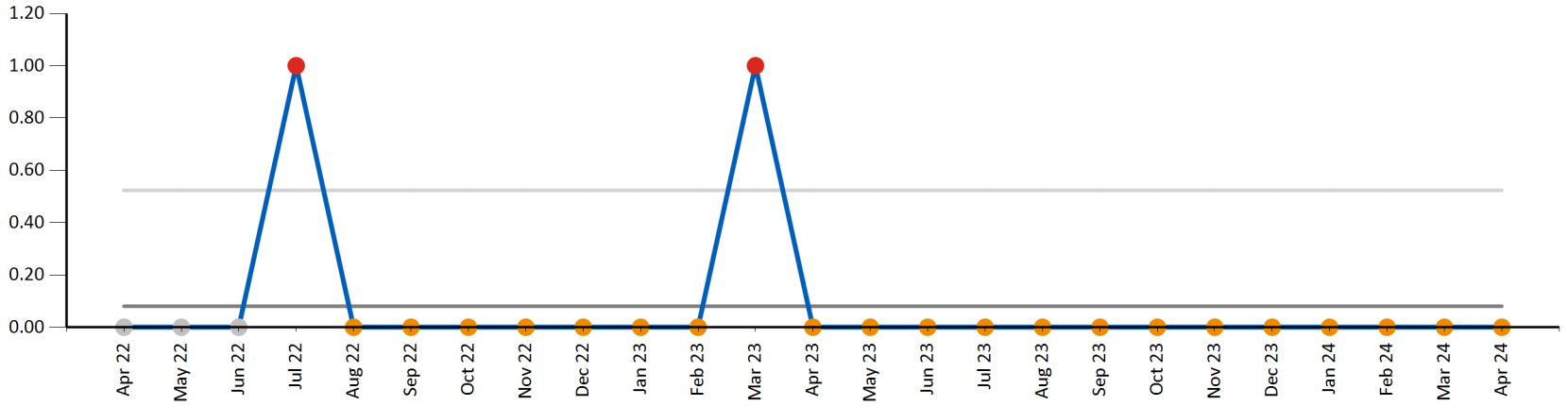
Plan	Actual	Period
	8	Mar-24

Year to Date

Plan	Actual
	0

535 - Community patients acquiring pressure damage - significant learning category 2

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Apr-24

Previous

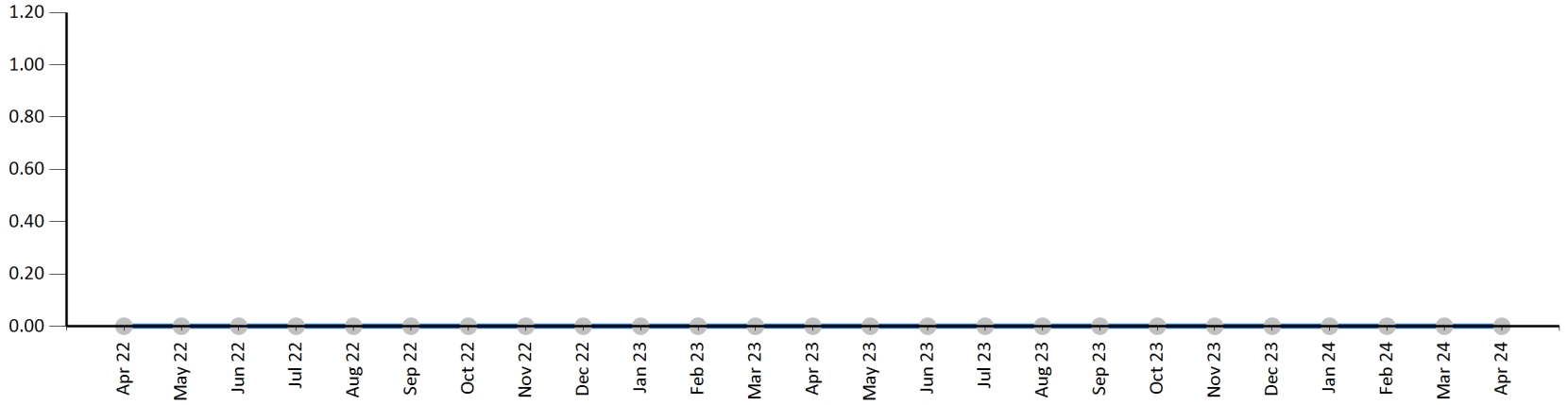
Plan	Actual	Period
	0	Mar-24

Year to Date

Plan	Actual
	0

536 - Community patients acquiring pressure damage - significant learning category 3

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-24

Previous

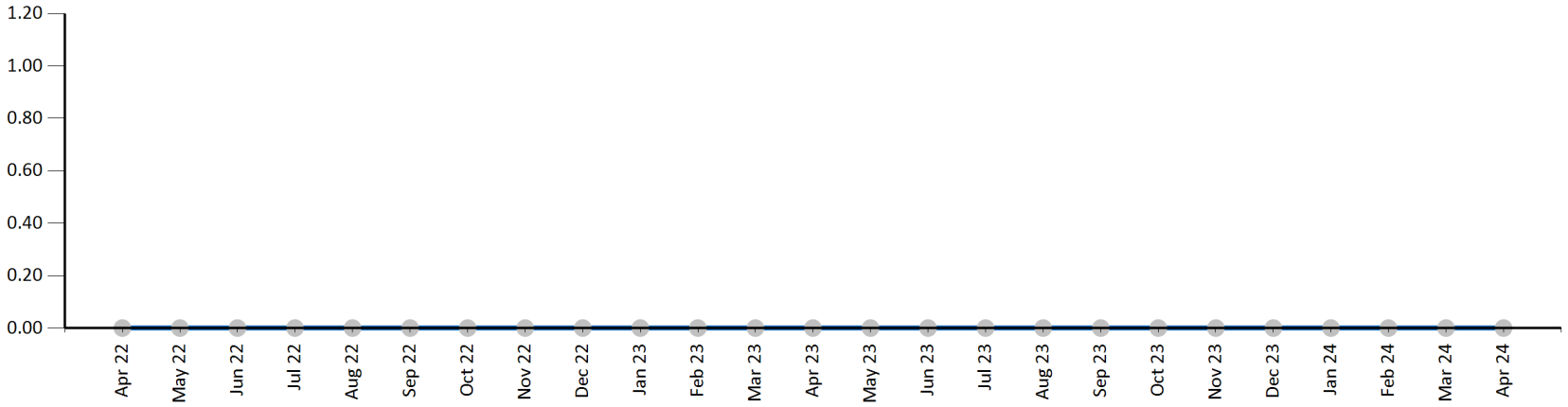
Plan	Actual	Period
	0	Mar-24

Year to Date

Plan	Actual
	0

537 - Community patients acquiring pressure damage - significant learning category 4

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-24

Previous

Plan	Actual	Period
	0	Mar-24

Year to Date

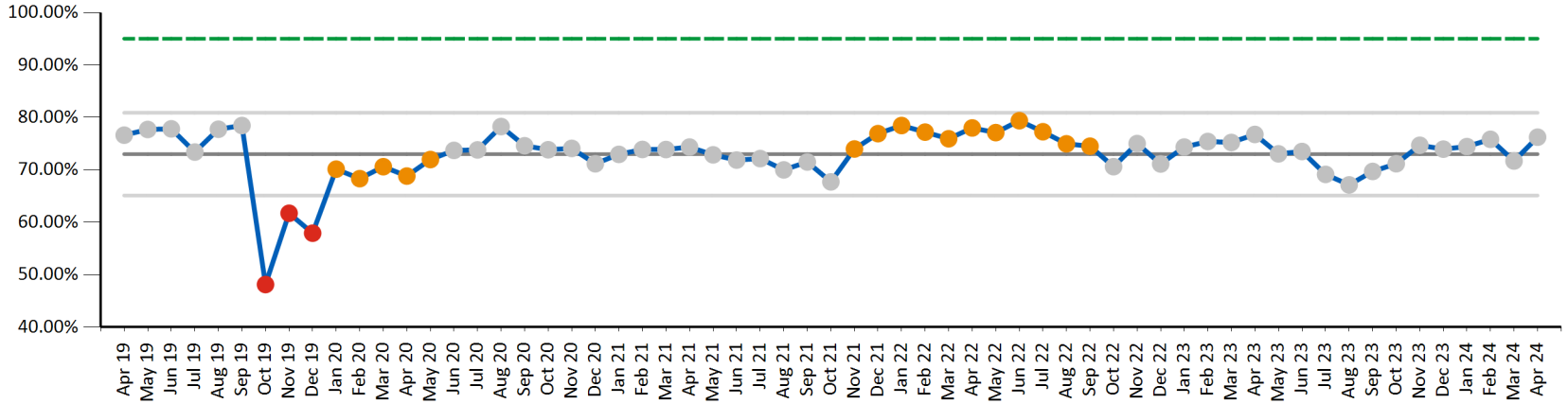
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	76.2%	Apr-24

Previous

Plan	Actual	Period
>= 95%	71.7%	Mar-24

Year to Date

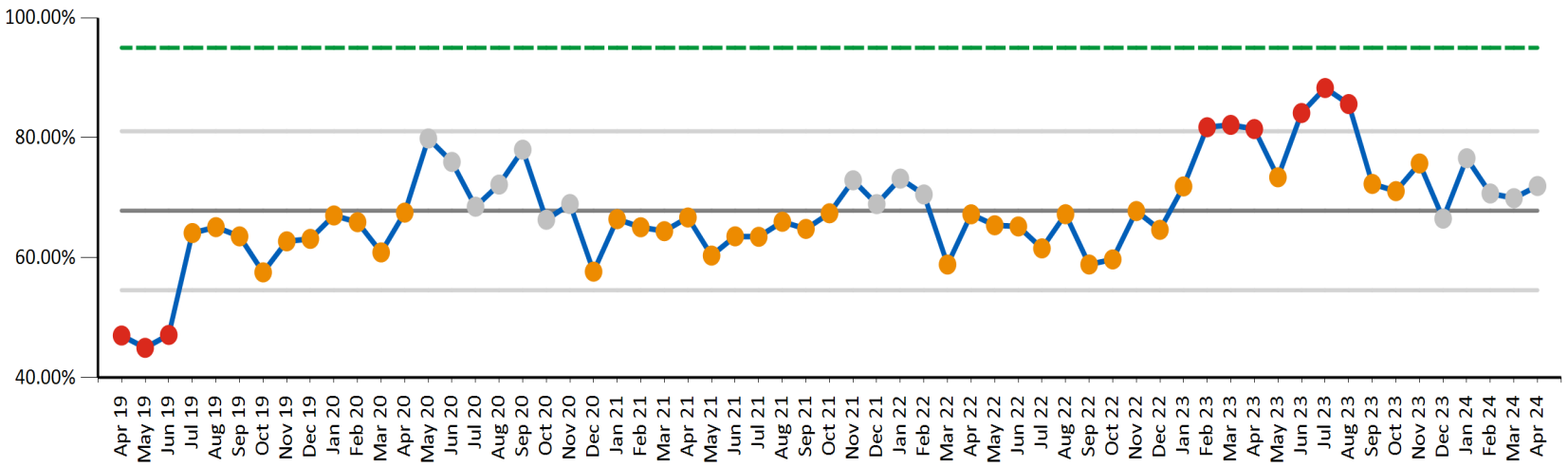
Plan	Actual
>= 95%	76.2%

31 - Clinical Correspondence - Outpatients %<5 working days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	71.9%	Apr-24

Previous

Plan	Actual	Period
>= 95.0%	69.9%	Mar-24

Year to Date

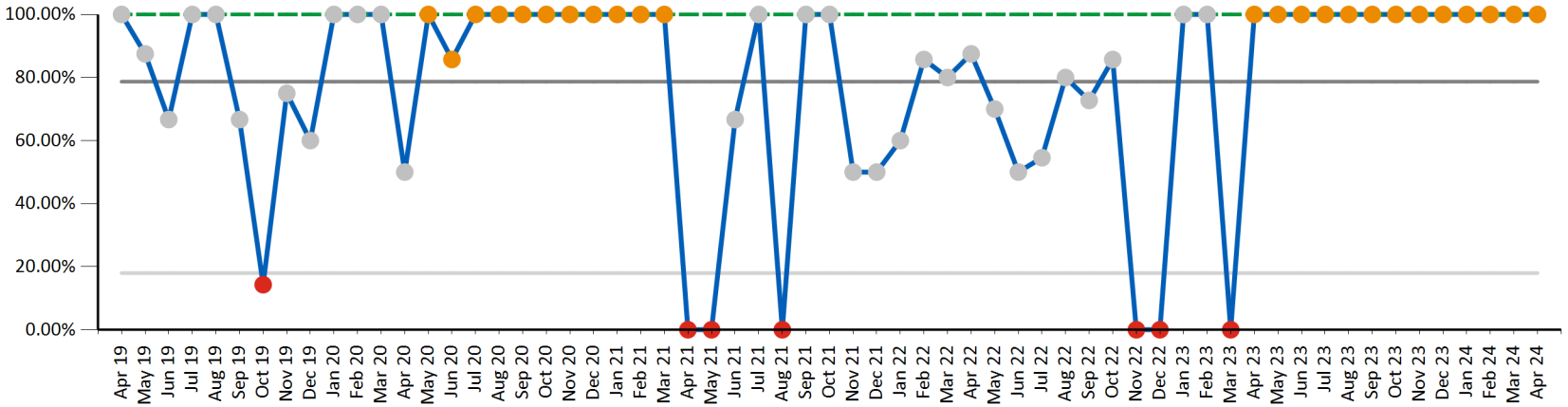
Plan	Actual
>= 95.0%	71.9%

86 - Patient Safety Alerts - Trust position

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Apr-24

Previous

Plan	Actual	Period
= 100%	100.0%	Mar-24

Year to Date

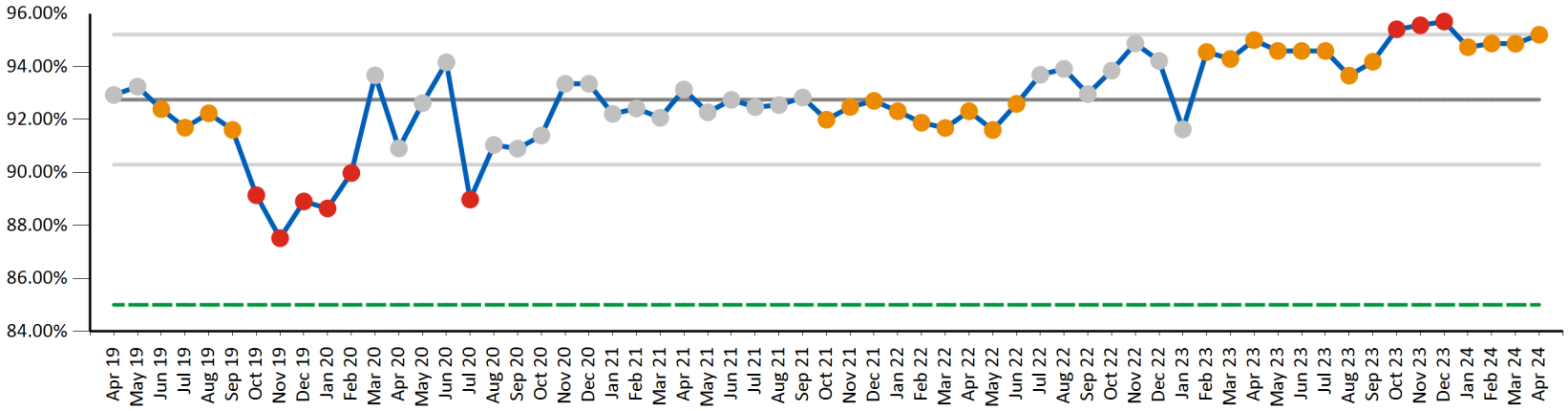
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.2%	Apr-24

Previous

Plan	Actual	Period
>= 85%	94.9%	Mar-24

Year to Date

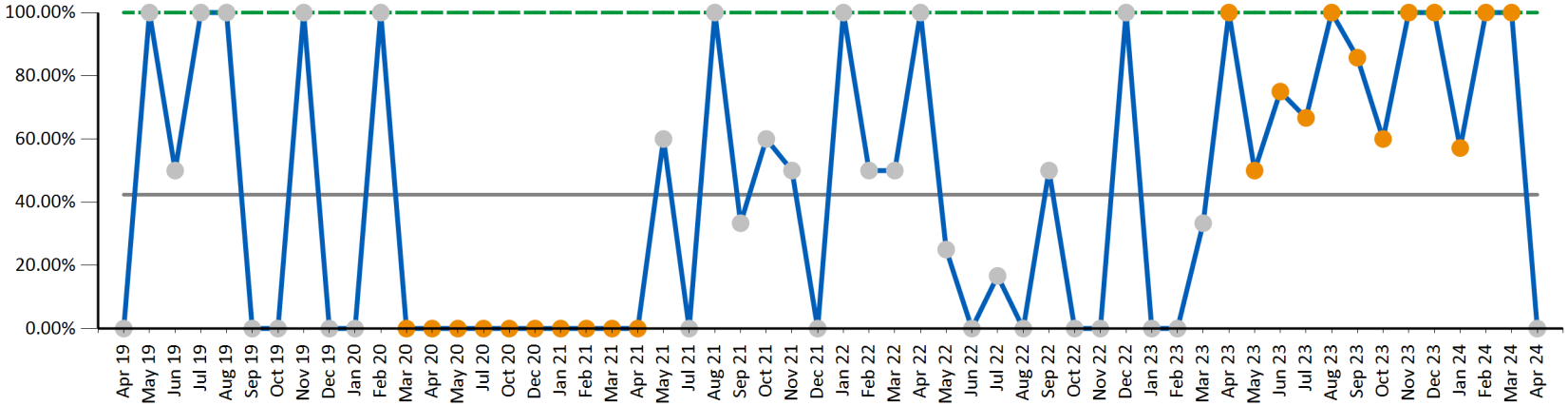
Plan	Actual
>= 85%	95.2%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	0.0%	Apr-24

Previous

Plan	Actual	Period
= 100%	100.0%	Mar-24

Year to Date

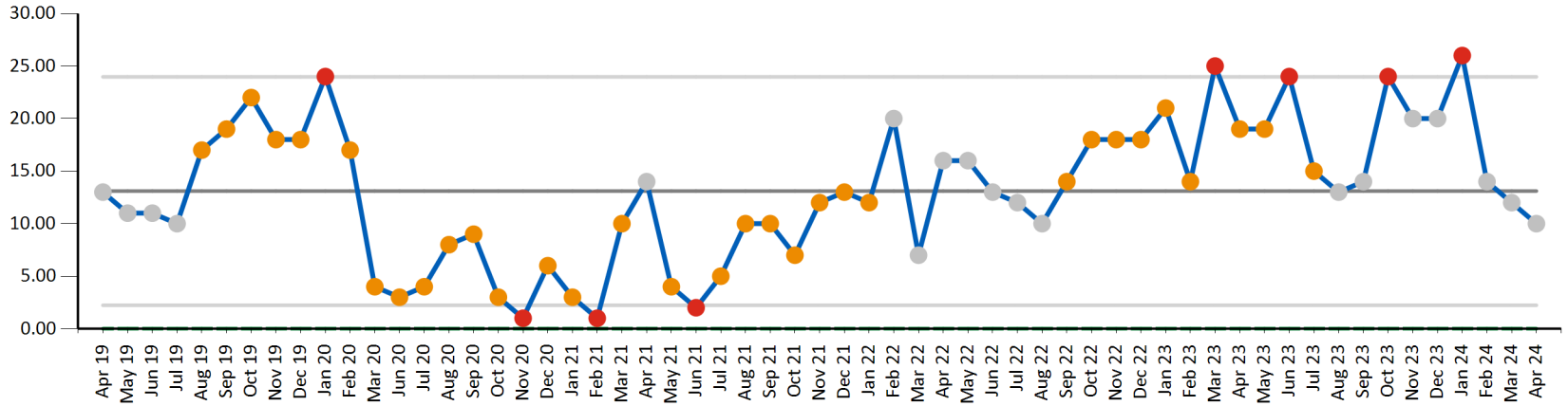
Plan	Actual
= 100%	0.0%

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	10	Apr-24

Previous

Plan	Actual	Period
= 0	12	Mar-24

Year to Date

Plan	Actual
= 0	10

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

C. diff prevalence at Bolton FT currently remains outlier across GM. This has been a deteriorating trend for last 3.5 years. Actions to date have included;
• Seeking peer review from NCA IPC lead – undertaken in 2023
• Linking in with NHSE IPC Lead Rosie Dixon for improvement plan critique – 2023
• Establishment of improvement plan focussed on SIGHT (suspect, isolate, gloves, hand-washing, testing). Since January 2023 focus on SIGHT included process measure monitoring. Area of concern remains isolation
• Isolation; compliance with 'escalation' of requirement to 'isolate' a patient within 2 hours was <30%. Now at circa 50%. Compliance with 'implementation of isolation once escalation received, within 2 hours', remains <40%
• Deterioration mirrors increased operational performance pressures over previous 3 years and is likely inextricably linked, however, C. diff prevalence has been a worsening outlier compared to GM / Northwest providers for the past 5 years suggestive of wider drivers to poor performance (hence above focus on SIGHT)
• C. diff collaborative using Quality Improvement methodology launched 04/2023. Improvements to date noted around aspects of SIGHT except for 'escalation and isolation' with operational pressures cited as driving limiting factor

Actions;

1. Agreement for a C. diff cohort ward – operational planning meetings commencing 20th May 2024
2. Daily review of failures to escalate continue with weekly oversight to CNO – reconfiguration of 'flow' team to incorporate IPC flow lead in place from 06/05/24. Improvement trajectories to achieve 95+% compliance with 'escalation within 2 hours' in development for sign off by 28/05/24 by CNO

Additional actions;

1. Enhanced visibility of antimicrobial stewardship as follows;
• Antibiotic order sets on EPR (advise of recommended antibiotic for condition). 'Live' from November 2022
• Antimicrobial stewardship dashboard – to provide real time data on key WHO metrics (including review of antibiotics within 72 hours). Date for 'go live' 01/06/24 reporting on the proportion of patients on antimicrobials with metrics for compliance with stop/review date compliance and compliance with allergy documentation 'going live' 01/07/24
• Antibiotic review kit (ARK) – this will require prescribers to identify whether antimicrobials are for a 'possible', 'probable' or 'confirmed' infection when commencing treatment and prompt them to be stopped early if the initial 'possible' assessment is not proven. Date for 'go live' 01/08/24 (requires training of medical staff – aim 75% trained by 1.8.24)

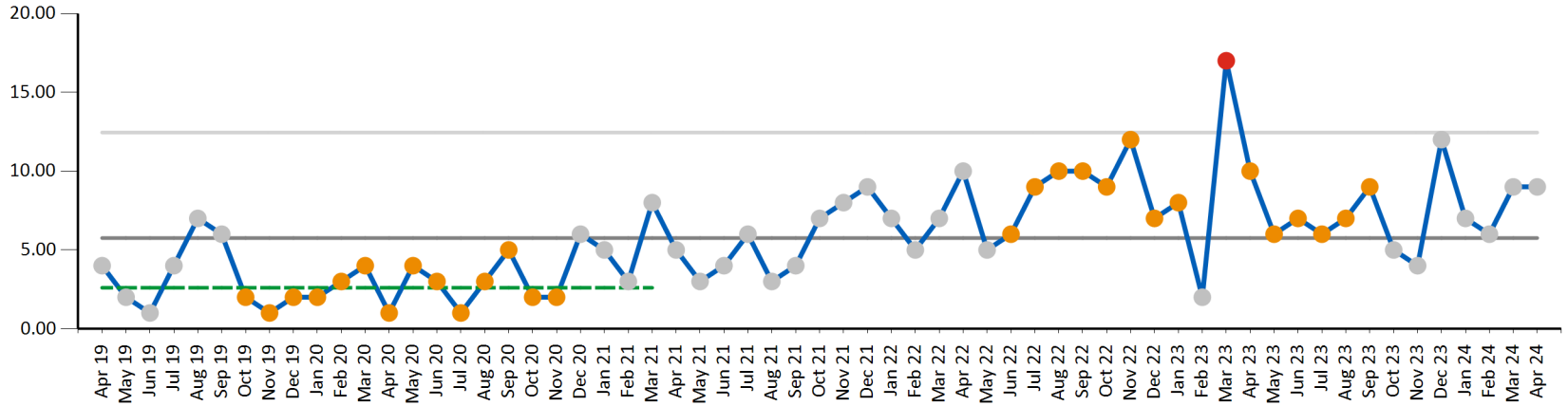
There was one MRSA bacteraemia in April. The patient had blood cultures collected due to neutropenic sepsis and was positive for MRSA as well as three other bacteria; the patient was screen negative for MRSA and it is probable that the MRSA was a contaminant of the blood cultures rather than a true blood stream infection. A review has been undertaken and will be reviewed at June IPC Committee – all learning from the review has been implemented in the division.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		9	Apr-24			9	Mar-24		9	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
346 - Total Community Onset Hospital Associated C.diff infections		7	Apr-24			2	Mar-24		7	
347 - Total C.diff infections contributing to objective	<= 7	16	Apr-24		<= 7	11	Mar-24	<= 7	16	
217 - Total Hospital-Onset MRSA BSIs	= 0	1	Apr-24		= 0	0	Mar-24	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	5	Apr-24		<= 2	8	Mar-24	<= 4	5	
219 - Blood Culture Contaminants (rate)	<= 3%	2.9%	Apr-24		<= 3%	2.7%	Mar-24	<= 3%	2.9%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Apr-24		<= 1.0	3.0	Mar-24	<= 1.0	1.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	3	Apr-24		<= 1	0	Mar-24	<= 1	3	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Apr-24		= 0	0	Mar-24	= 0	1	
491 - Nosocomial COVID-19 cases		23	Apr-24			34	Mar-24		23	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	9	Apr-24

Previous

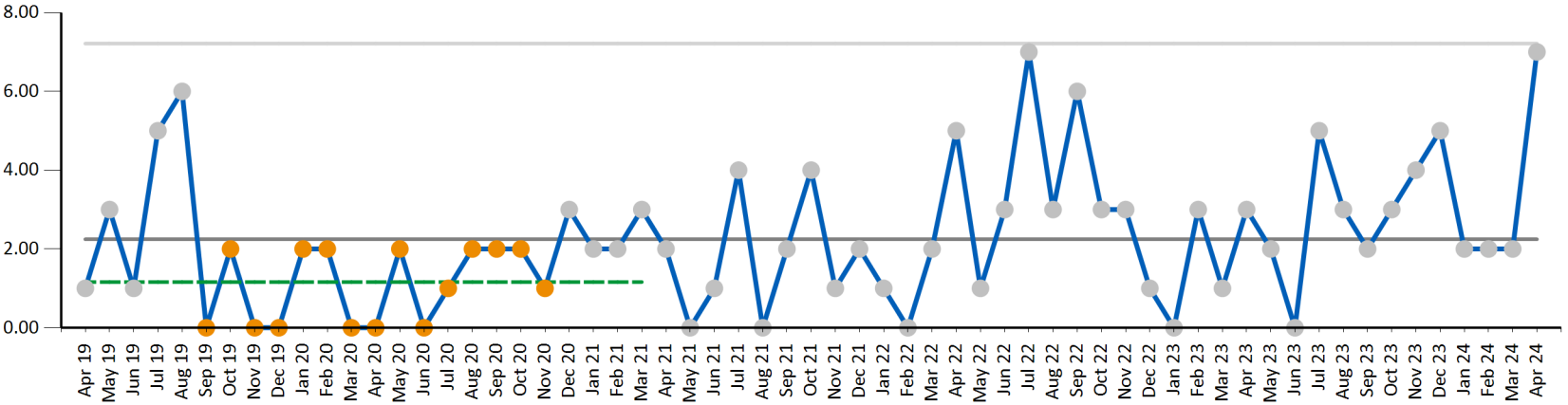
Plan	Actual	Period
	9	Mar-24

Year to Date

Plan	Actual
	9

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	7	Apr-24

Previous

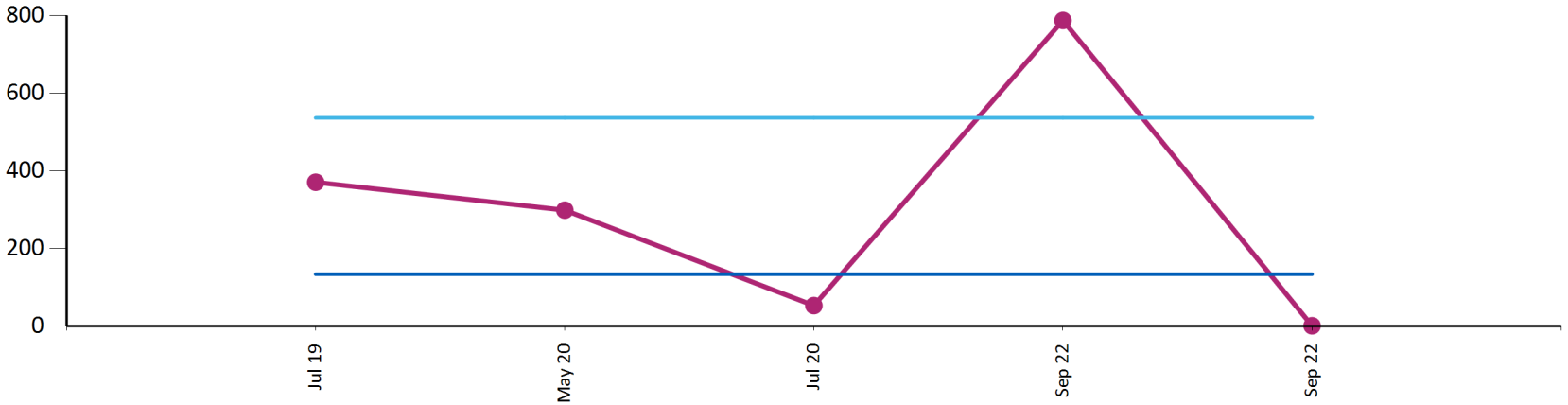
Plan	Actual	Period
	2	Mar-24

Year to Date

Plan	Actual
	7

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Apr-24

Previous

Plan	Actual	Period
	0	Mar-24

Year to Date

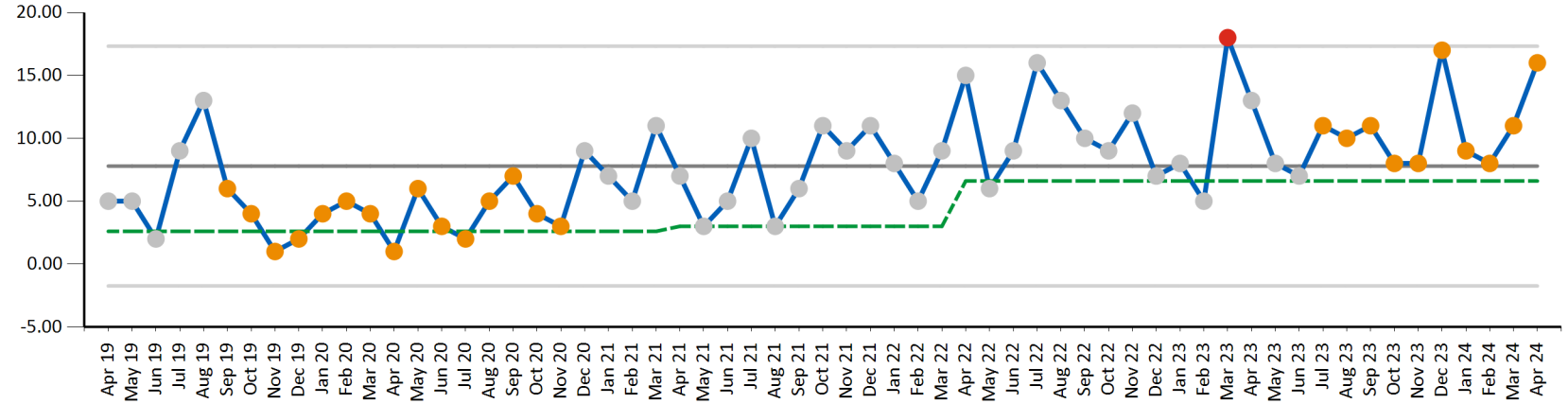
Plan	Actual

347 - Total C.diff infections contributing to objective

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 7	16	Apr-24

Previous

Plan	Actual	Period
<= 7	11	Mar-24

Year to Date

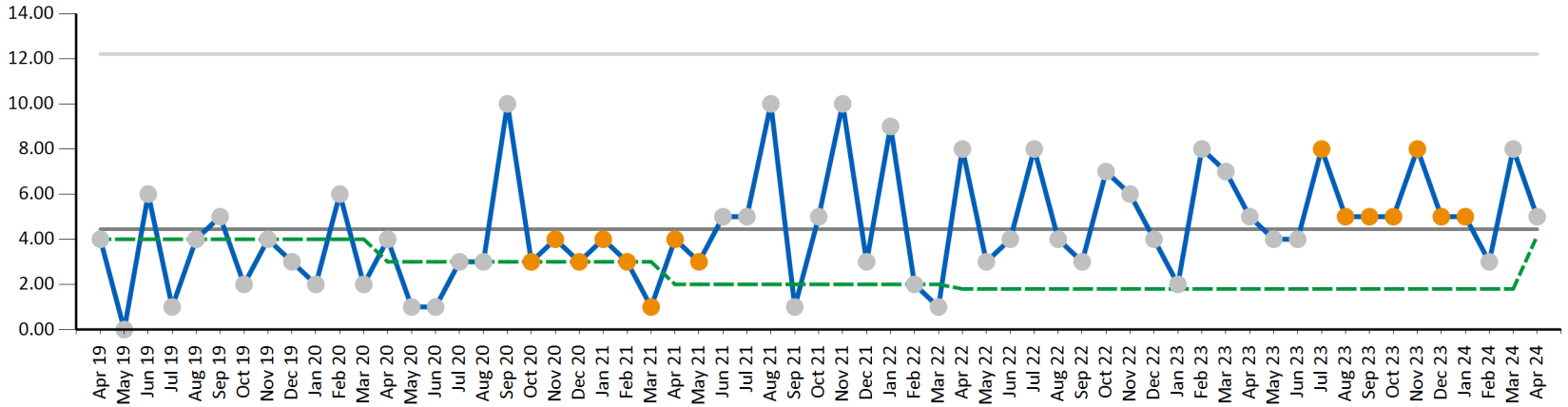
Plan	Actual
<= 7	16

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 4	5	Apr-24

Previous

Plan	Actual	Period
<= 2	8	Mar-24

Year to Date

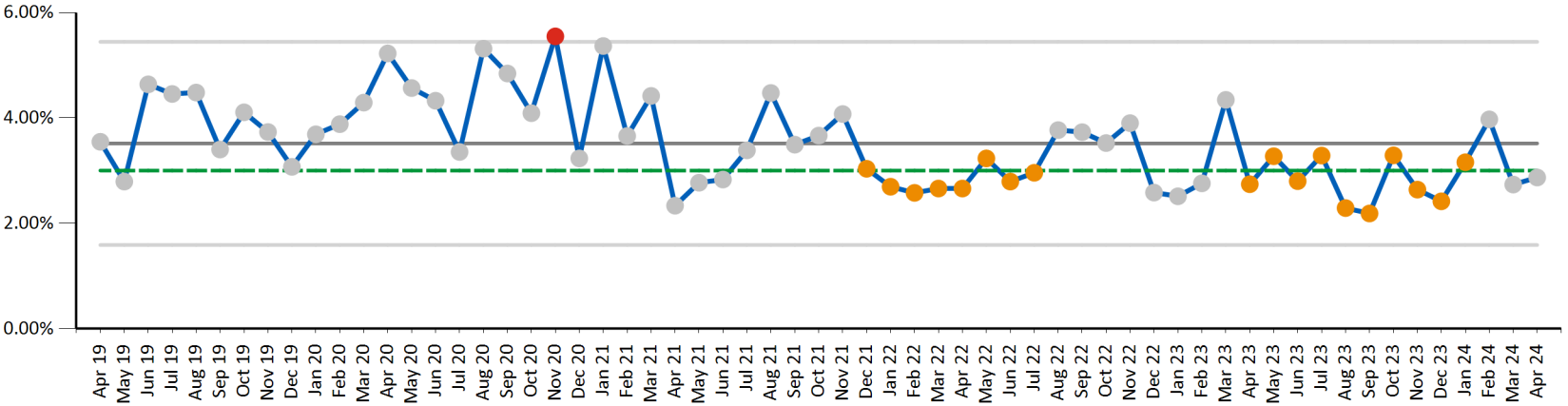
Plan	Actual
<= 4	5

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3%	2.9%	Apr-24

Previous

Plan	Actual	Period
<= 3%	2.7%	Mar-24

Year to Date

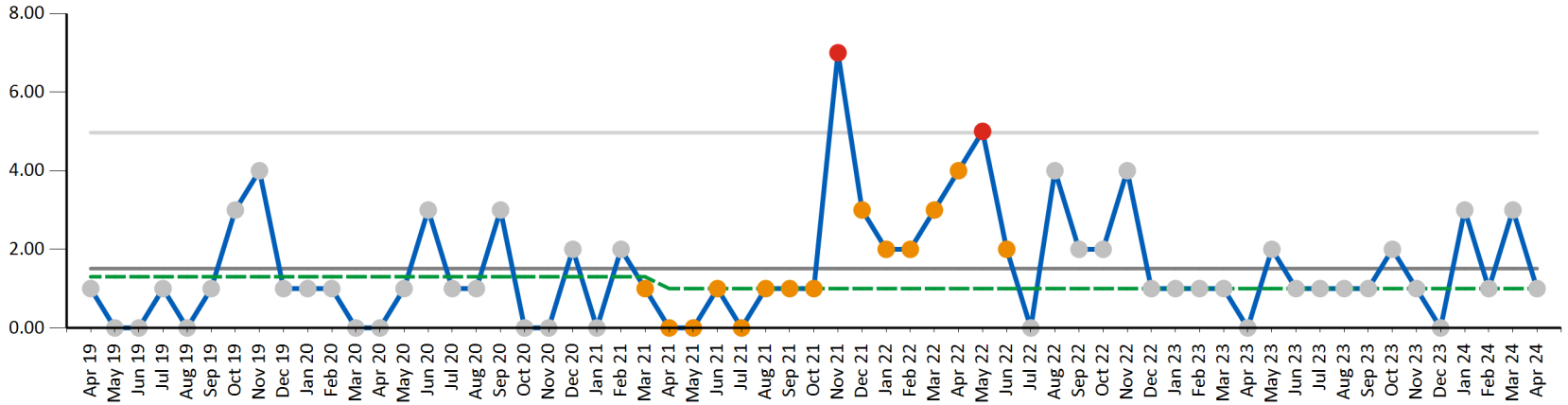
Plan	Actual
<= 3%	2.9%

304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Apr-24

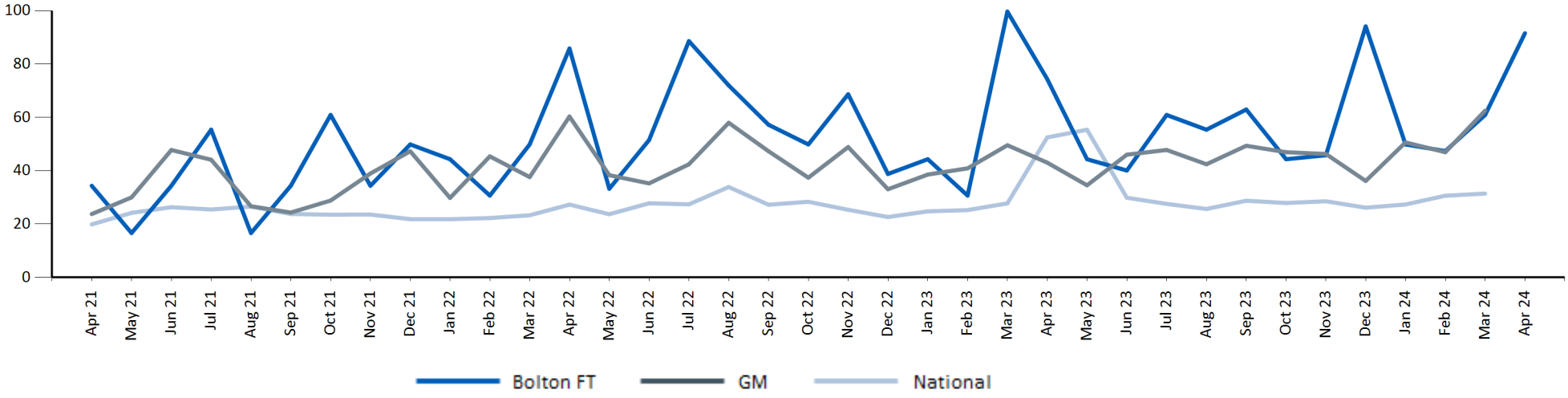
Previous

Plan	Actual	Period
<= 1.0	3.0	Mar-24

Year to Date

Plan	Actual
<= 1.0	1.0

549 - C Diff Rate Comparison

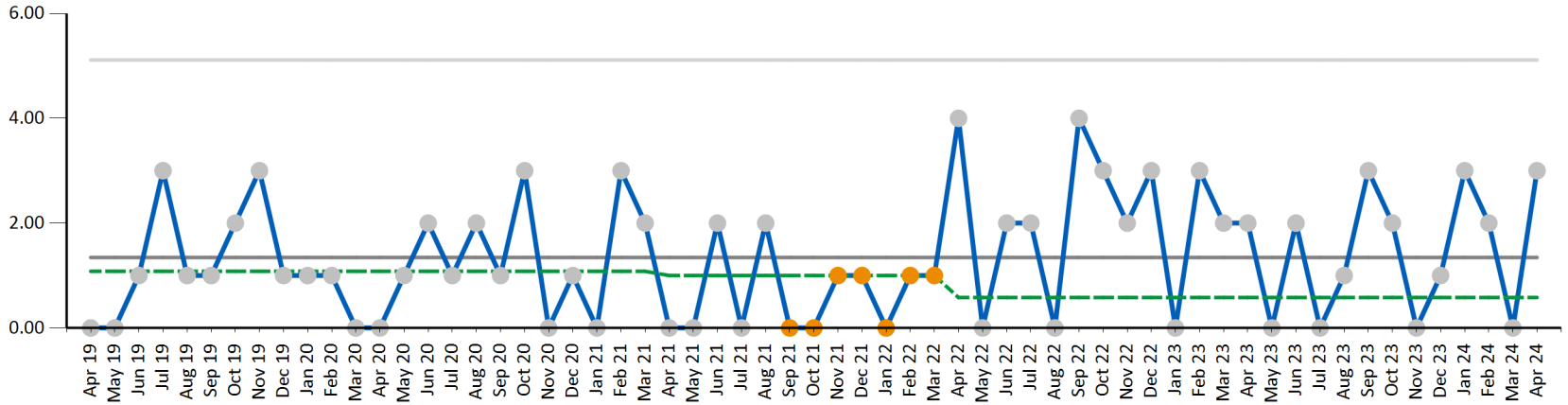


305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	3	Apr-24

Previous

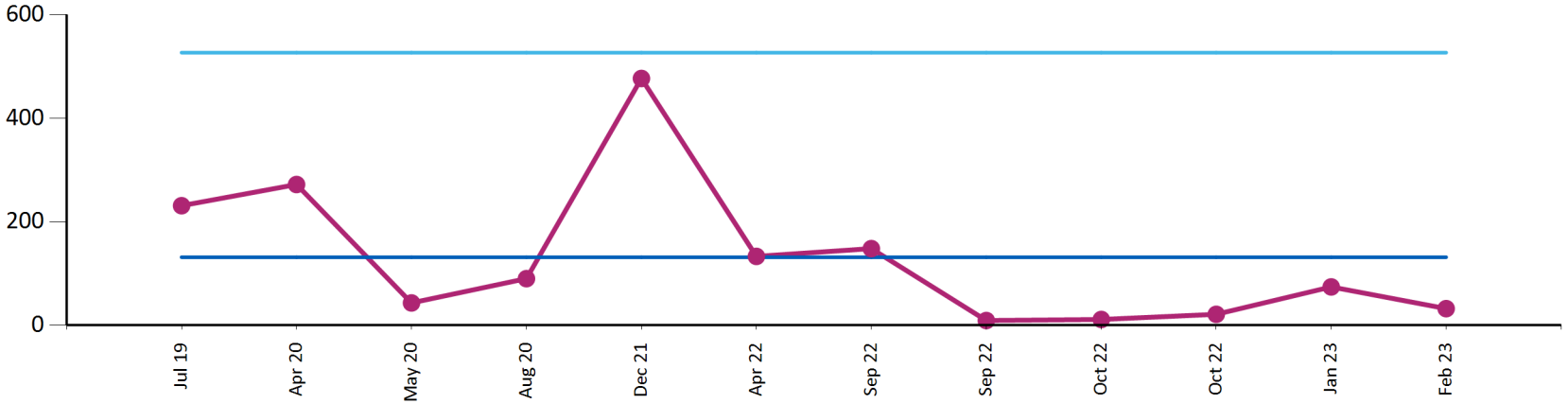
Plan	Actual	Period
<= 1	0	Mar-24

Year to Date

Plan	Actual
<= 1	3

306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)

0/6



Latest

Plan	Actual	Period
	0	Apr-24

Previous

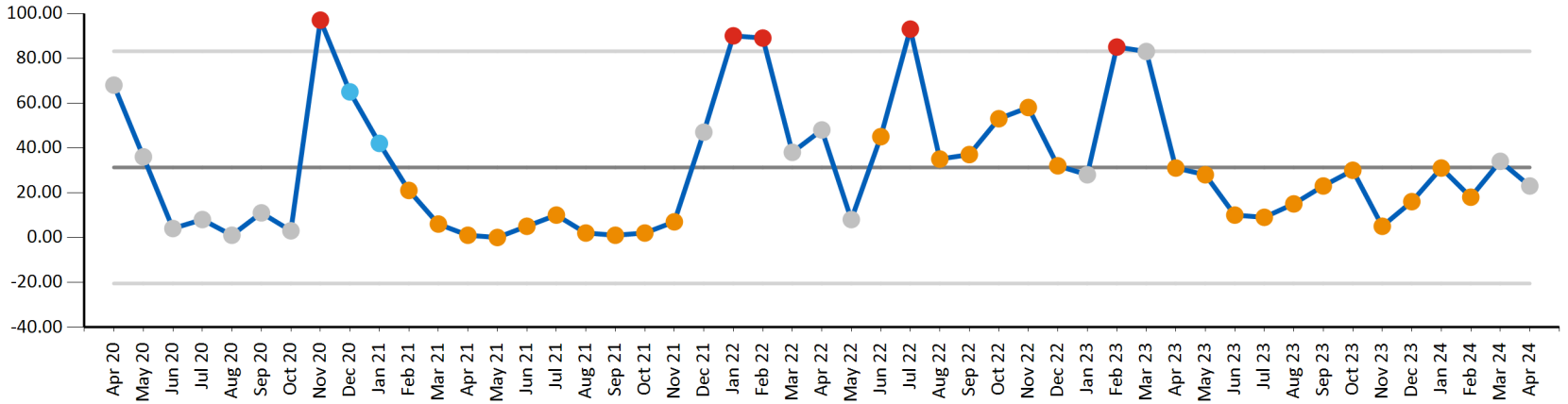
Plan	Actual	Period
	0	Mar-24

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	23	Apr-24

Previous

Plan	Actual	Period
	34	Mar-24

Year to Date

Plan	Actual
	23

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe. It has now remained in control for more than 3 years.

HSMR – in month figure is above average for the period and remains in control. The 12 month rolling average to December 2023 is 105.48 remaining as 'Green' when compared against other Trusts.

SHMI – In month figure is below average for the time period and remains in control. The published rolling average for the period January to December 2023 is 110.83 'as expected'.

The proportion of Charlson comorbidities remains in control and has been since April 2022. The depth of recording continues to be within range following two consecutive points outside of the control limits. Both are still lower when benchmarked against the England average of all Acute Trusts, but the mortality metrics remain in range despite this.

The proportion of coded records at the time of the snapshot download is slightly below average for the time frame but remains within range.

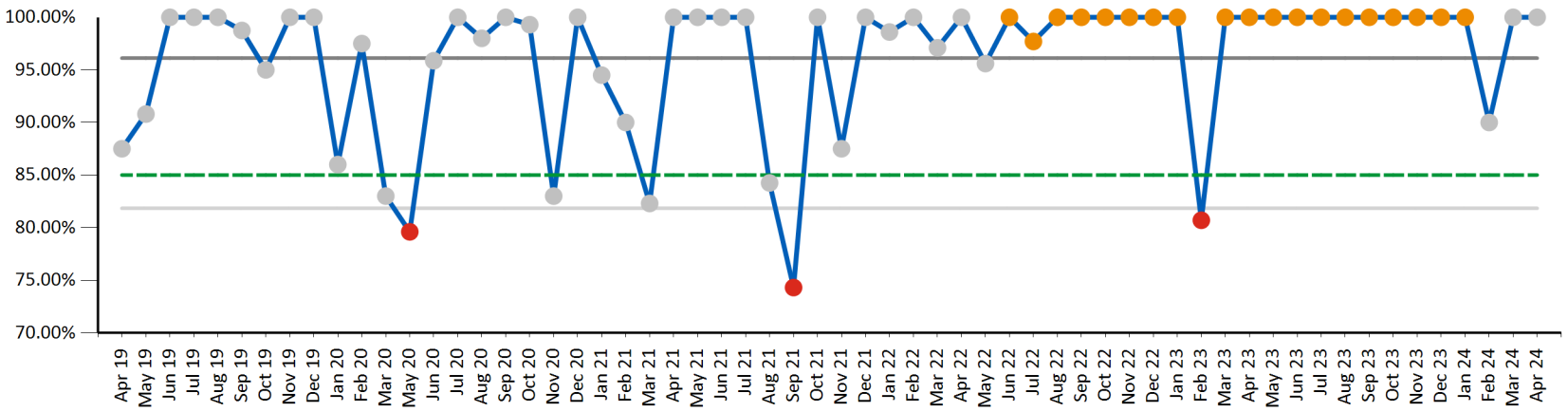
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Apr-24		>= 85%	100.0%	Mar-24	>= 85%	100.0%	
495 - HSMR		128.54	Jan-24			102.73	Dec-23			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	90.00	Nov-23		<= 100.00	116.00	Oct-23	<= 100.00		
12 - Crude Mortality %	<= 2.9%	2.2%	Apr-24		<= 2.9%	2.2%	Mar-24	<= 2.9%	2.2%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Jan-24			4	Dec-23			
520 - Depth of recording (First episode of care)		6	Jan-24			6	Dec-23			
521 - Proportion of fully coded records (Inpatients)		95.6%	Feb-24			98.0%	Jan-24			

3 - National Early Warning Scores to Gold standard

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 85%	100.0%	Apr-24

Previous

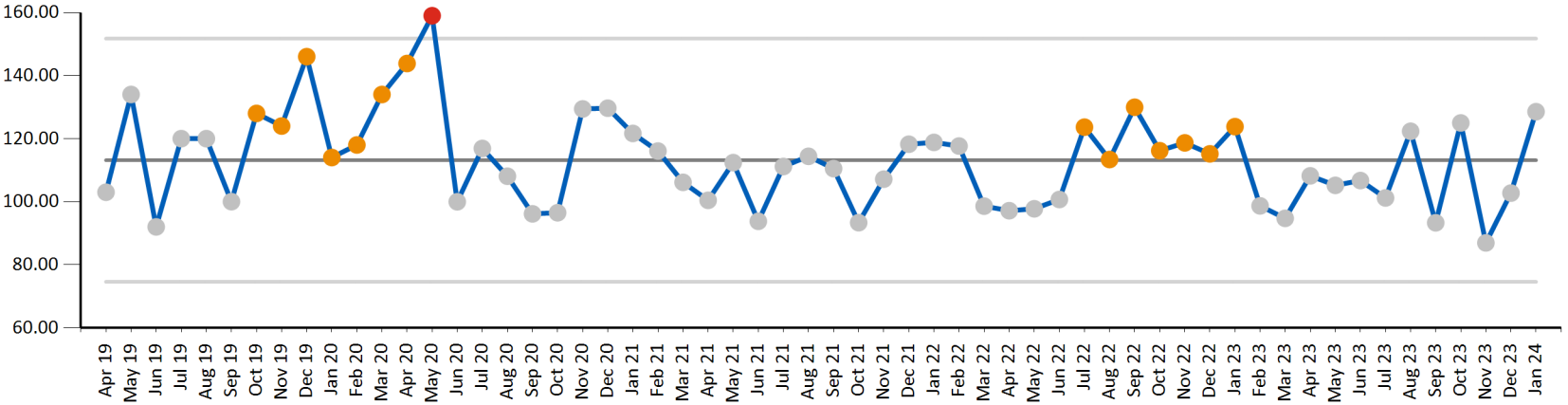
Plan	Actual	Period
>= 85%	100.0%	Mar-24

Year to Date

Plan	Actual
>= 85%	100.0%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	128.54	Jan-24

Previous

Plan	Actual	Period
	102.73	Dec-23

Year to Date

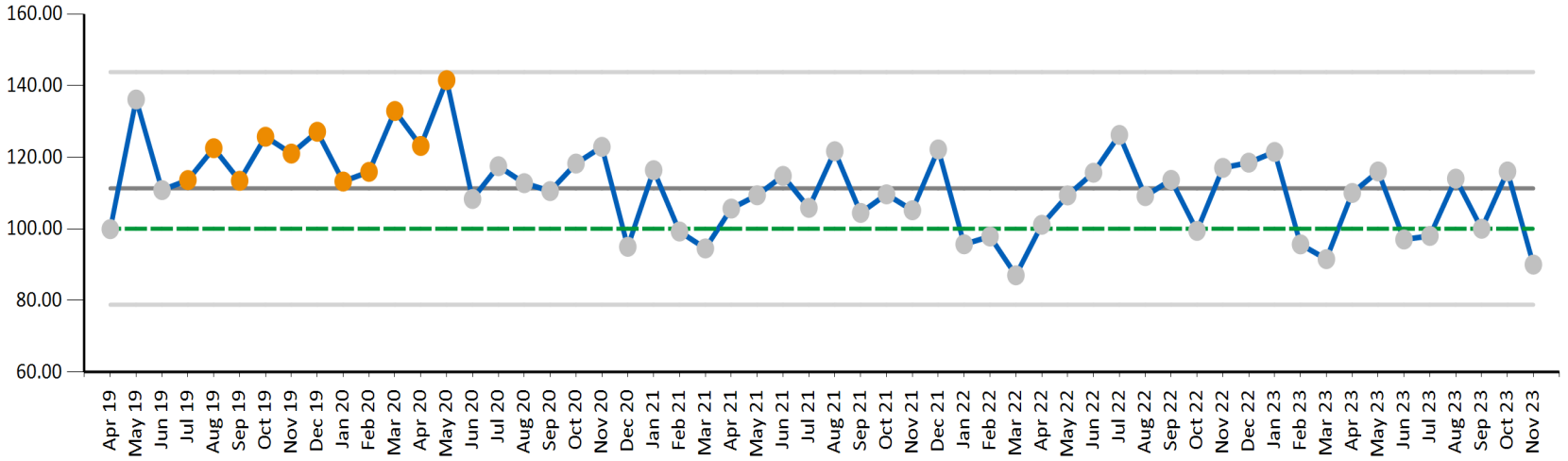
Plan	Actual
	128.54

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 100.00	90.00	Nov-23

Previous

Plan	Actual	Period
<= 100.00	116.00	Oct-23

Year to Date

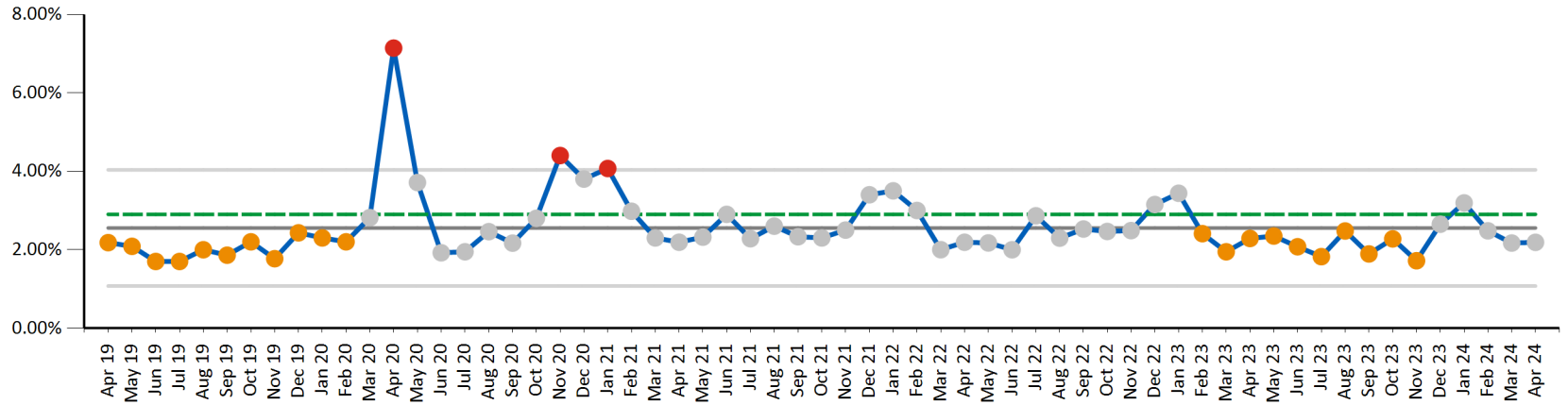
Plan	Actual
<= 100.00	90.00

12 - Crude Mortality %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 2.9%	2.2%	Apr-24

Previous

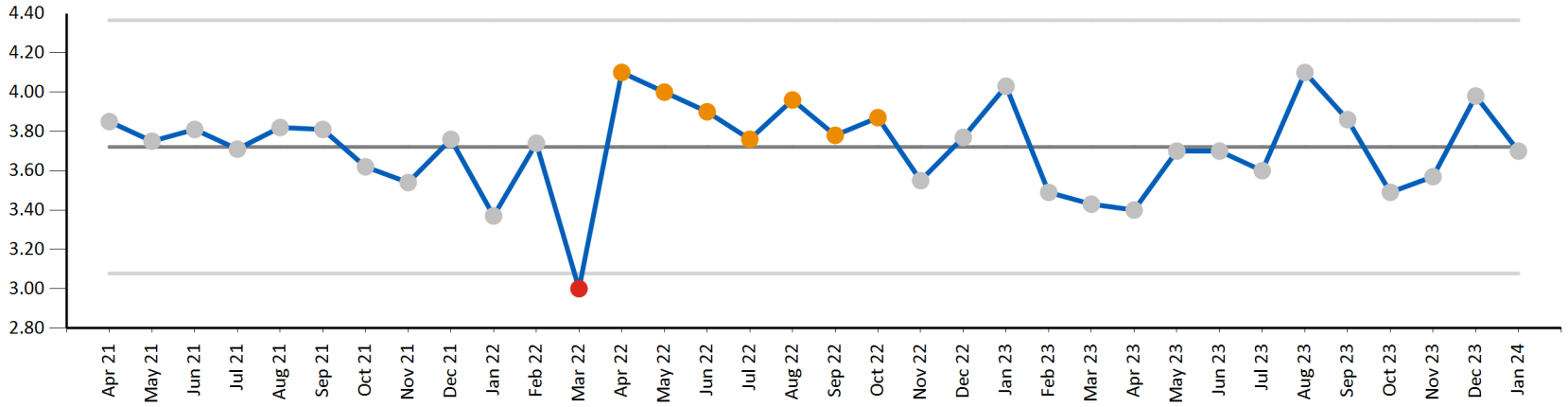
Plan	Actual	Period
<= 2.9%	2.2%	Mar-24

Year to Date

Plan	Actual
<= 2.9%	2.2%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Jan-24

Previous

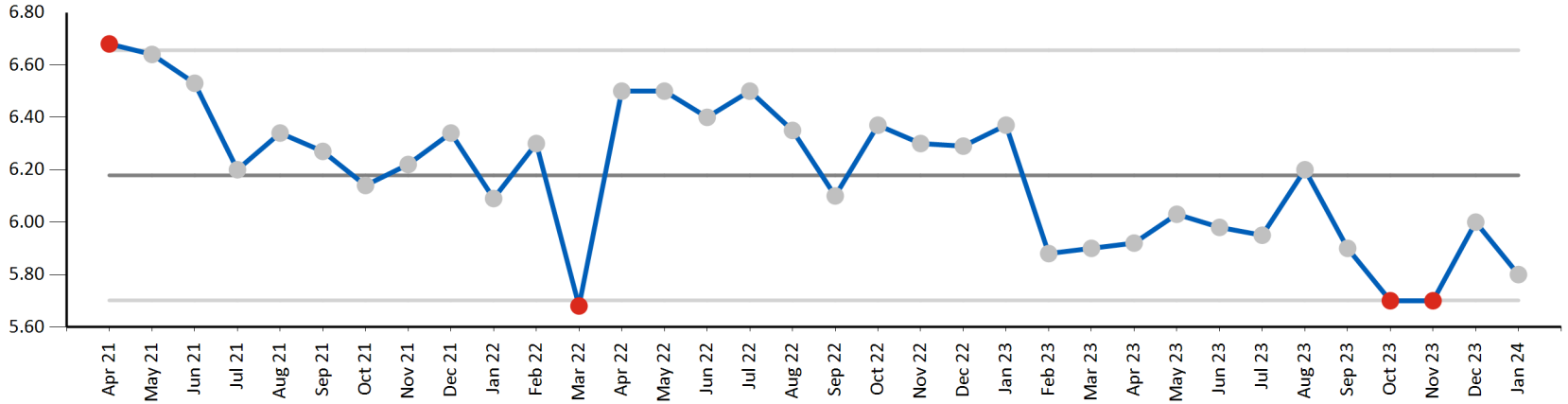
Plan	Actual	Period
	4	Dec-23

Year to Date

Plan	Actual
	37

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	Jan-24

Previous

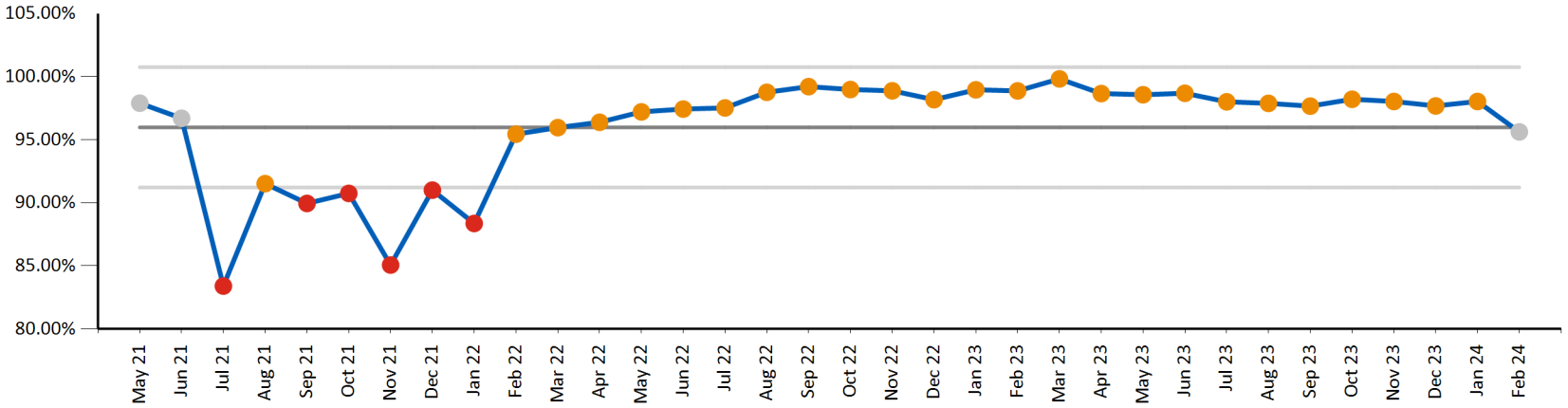
Plan	Actual	Period
	6	Dec-23

Year to Date

Plan	Actual
	59

521 - Proportion of fully coded records (Inpatients)

Common cause variation.



Latest

Plan	Actual	Period
	95.6%	Feb-24

Previous

Plan	Actual	Period
	98.0%	Jan-24

Year to Date

Plan	Actual
	97.9%

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction Rates April 2024
Accident and Emergency Department response and satisfaction rates remain below target however are within common cause variation. The Patient Experience Manager is working with the Volunteer Manager to seek support with collection in Paediatric ED where low response rates are affecting the overall A&S response rates.
AACD recognise that extended wait times in (ED), including bed waits exceeding 20 hours, have a significant negative impact on patient experience. A thorough data analysis is being undertaken to identify specific themes and areas for improvement.
Progress is being made by ED Matrons to establish a Patient Experience Group to obtain direct insight from patients and service users with the support of Healthwatch and the Patient Experience Team.
Antenatal response rates remain below target but within common cause variation. Postnatal satisfaction rates are below target and are being monitored by the Divisional Matrons. A review of collection methods has been undertaken and as yet has not been fully implemented. Other options to improve response rates continue to be considered. This is being routinely monitored each month at Divisional QPEF and at Trust QPEF.

Complaint Response Rates April 2024
Compliance rates remain within common cause variation, however below the mean.
In April there were 27 complaints due a response. 3 are ongoing. 20 were provided within timeframe; 10 in March and 10 in April.
An increase in the number of complaint meetings has had a positive impact on response rates and continues to be best practice for early resolution and continues to be encouraged.
Complaint training sessions continue to be provided via the Practice Educators with individual training offered to staff at all levels as requested and where possible. A training programme is also being developed.

	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%	15.2%	Apr-24		>= 20%	15.1%	Mar-24	>= 20%	15.2%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	85.2%	Apr-24	L	>= 90%	83.2%	Mar-24	>= 90%	85.2%	
80 - Inpatient Friends and Family Response Rate	>= 30%	29.1%	Apr-24		>= 30%	28.2%	Mar-24	>= 30%	29.1%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	94.7%	Apr-24		>= 90%	96.7%	Mar-24	>= 90%	94.7%	P
81 - Maternity Friends and Family Response Rate	>= 15%	23.6%	Apr-24		>= 15%	17.4%	Mar-24	>= 15%	23.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.6%	Apr-24		>= 90%	91.0%	Mar-24	>= 90%	91.6%	

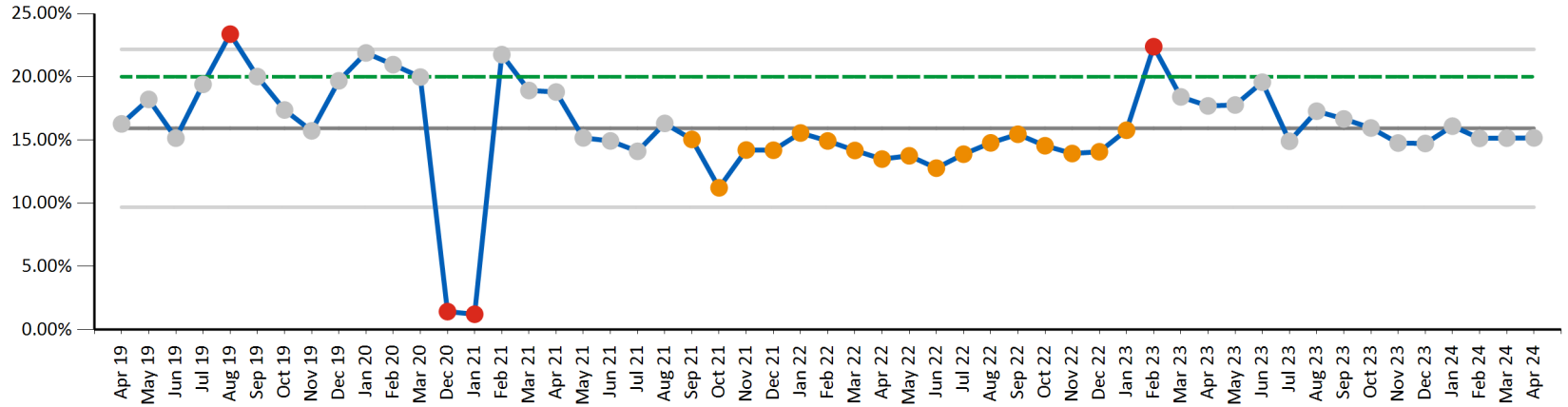
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
82 - Antenatal - Friends and Family Response Rate	>= 15%	4.3%	Apr-24		>= 15%	2.8%	Mar-24	>= 15%	4.3%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Apr-24		>= 90%	92.3%	Mar-24	>= 90%	100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	42.0%	Apr-24		>= 15%	35.5%	Mar-24	>= 15%	42.0%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	91.1%	Apr-24		>= 90%	90.7%	Mar-24	>= 90%	91.1%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	45.5%	Apr-24		>= 15%	14.0%	Mar-24	>= 15%	45.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	94.0%	Apr-24		>= 90%	91.5%	Mar-24	>= 90%	94.0%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	11.9%	Apr-24		>= 15%	11.3%	Mar-24	>= 15%	11.9%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	84.0%	Apr-24		>= 90%	91.1%	Mar-24	>= 90%	84.0%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Apr-24		= 100%	100.0%	Mar-24	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	74.1%	Apr-24		>= 95%	64.3%	Mar-24	>= 95%	74.1%	

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	15.2%	Apr-24

Previous

Plan	Actual	Period
>= 20%	15.1%	Mar-24

Year to Date

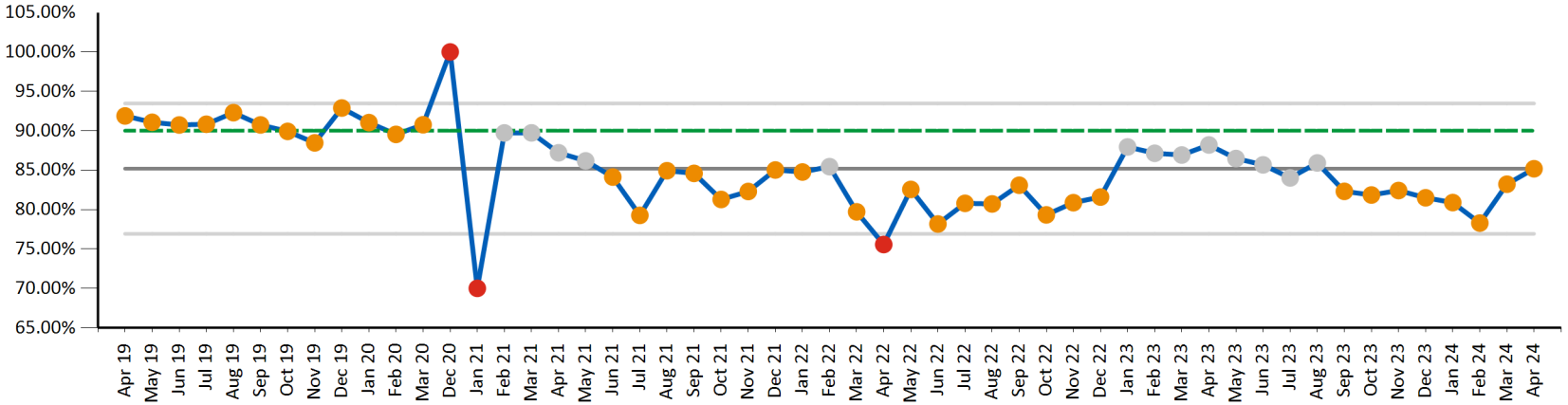
Plan	Actual
>= 20%	15.2%

294 - A&E Friends and Family Satisfaction Rates %

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 90%	85.2%	Apr-24

Previous

Plan	Actual	Period
>= 90%	83.2%	Mar-24

Year to Date

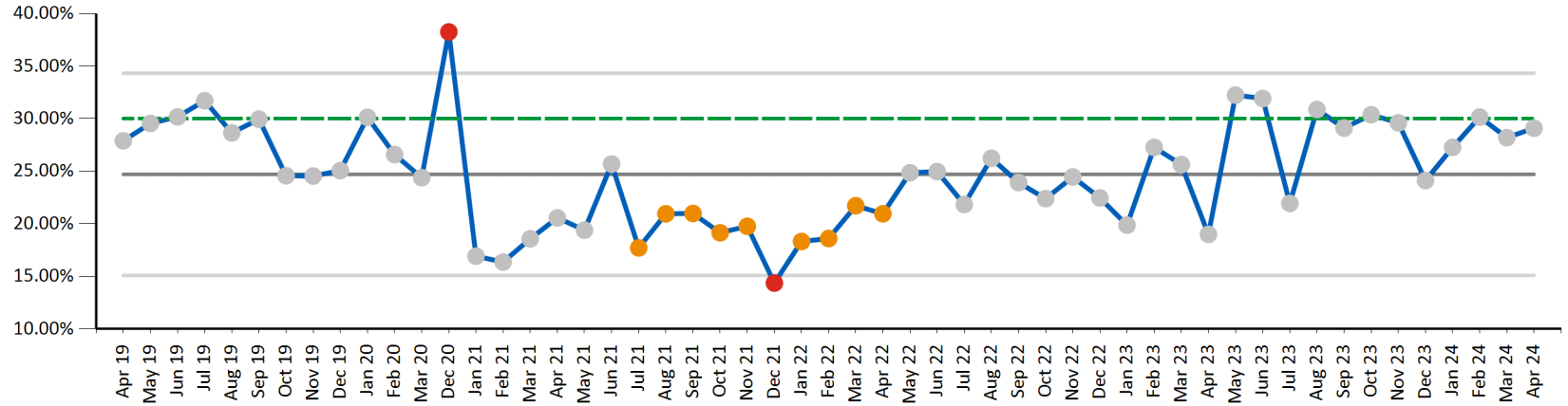
Plan	Actual
>= 90%	85.2%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 30%	29.1%	Apr-24

Previous

Plan	Actual	Period
>= 30%	28.2%	Mar-24

Year to Date

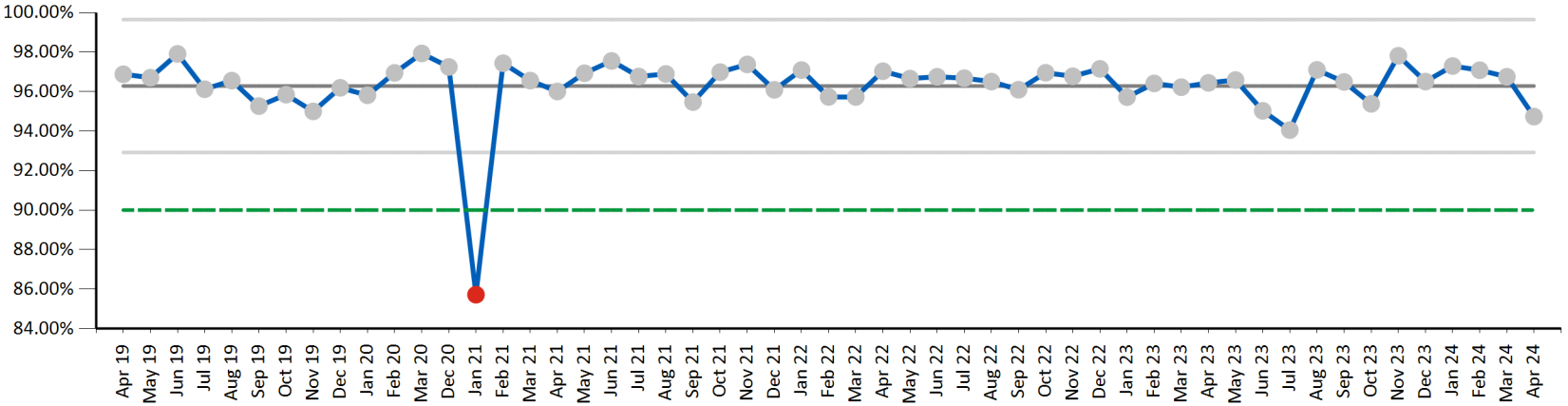
Plan	Actual
>= 30%	29.1%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	94.7%	Apr-24

Previous

Plan	Actual	Period
>= 90%	96.7%	Mar-24

Year to Date

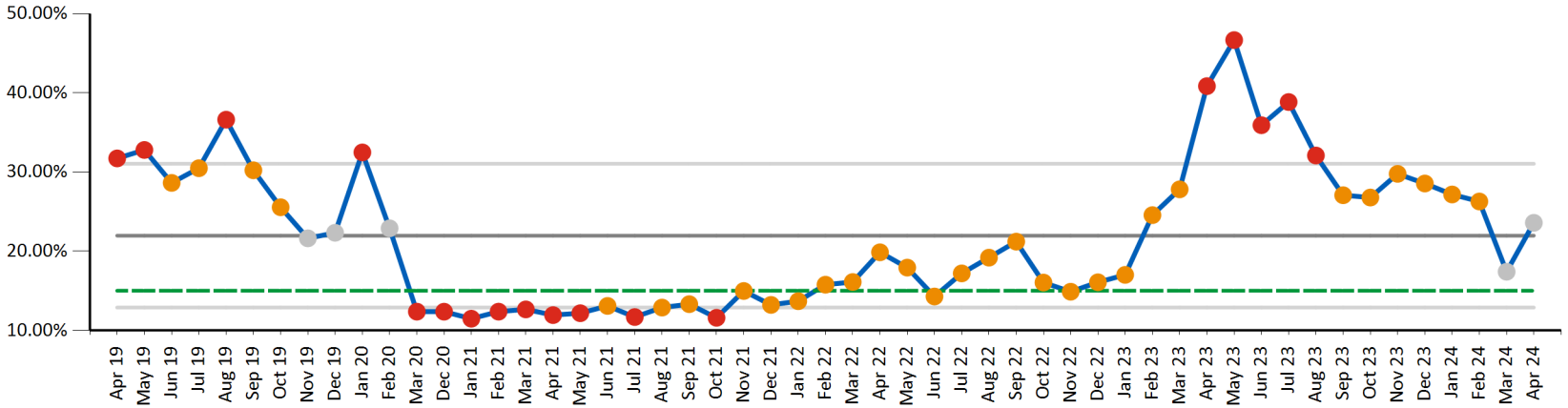
Plan	Actual
>= 90%	94.7%

81 - Maternity Friends and Family Response Rate

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 15%	23.6%	Apr-24

Previous

Plan	Actual	Period
>= 15%	17.4%	Mar-24

Year to Date

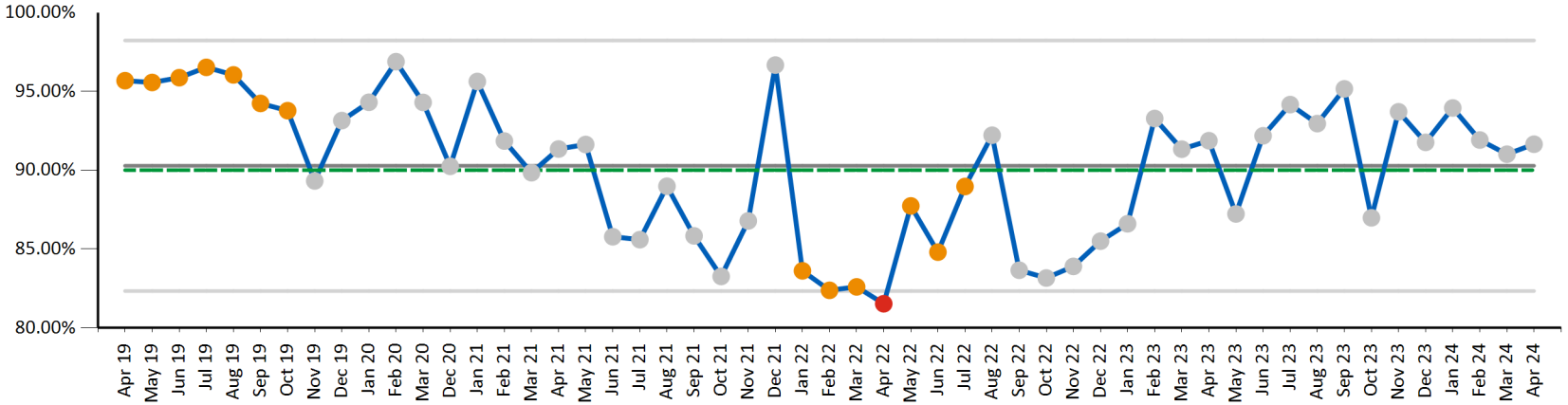
Plan	Actual
>= 15%	23.6%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	91.6%	Apr-24

Previous

Plan	Actual	Period
>= 90%	91.0%	Mar-24

Year to Date

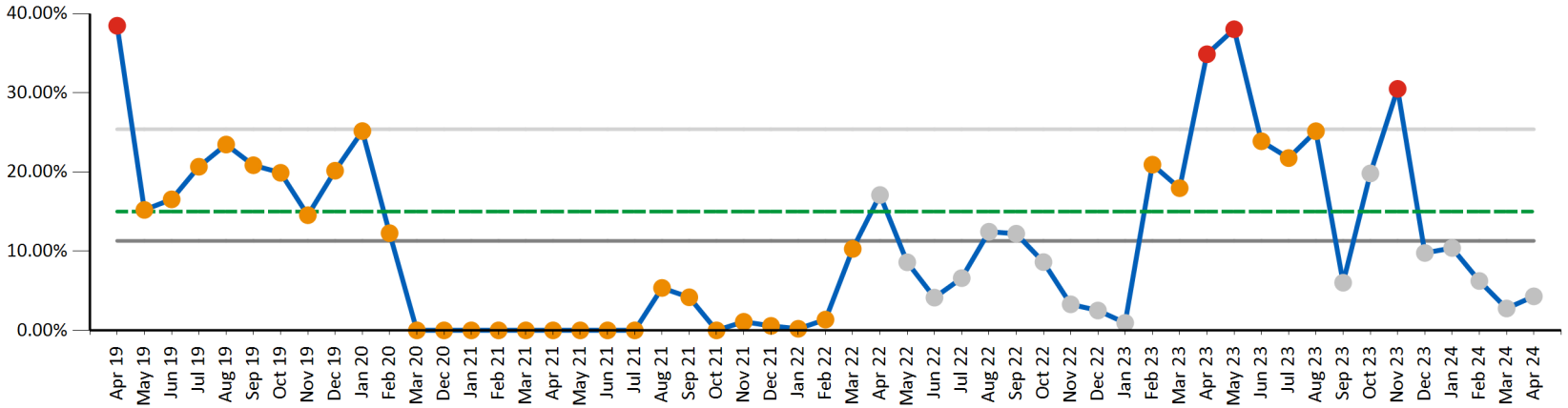
Plan	Actual
>= 90%	91.6%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 15%	4.3%	Apr-24

Previous

Plan	Actual	Period
>= 15%	2.8%	Mar-24

Year to Date

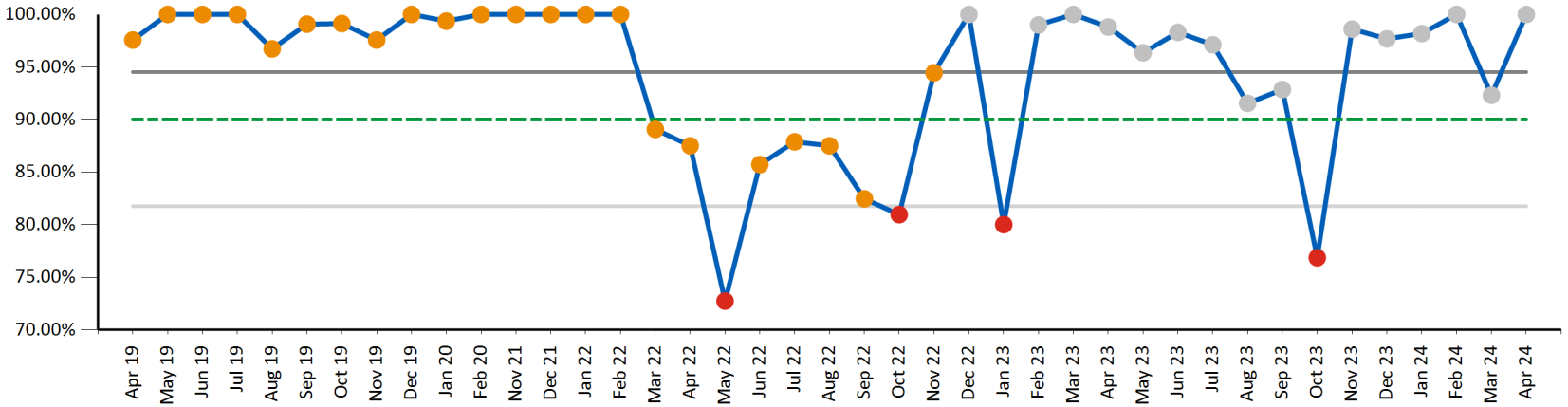
Plan	Actual
>= 15%	4.3%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	100.0%	Apr-24

Previous

Plan	Actual	Period
>= 90%	92.3%	Mar-24

Year to Date

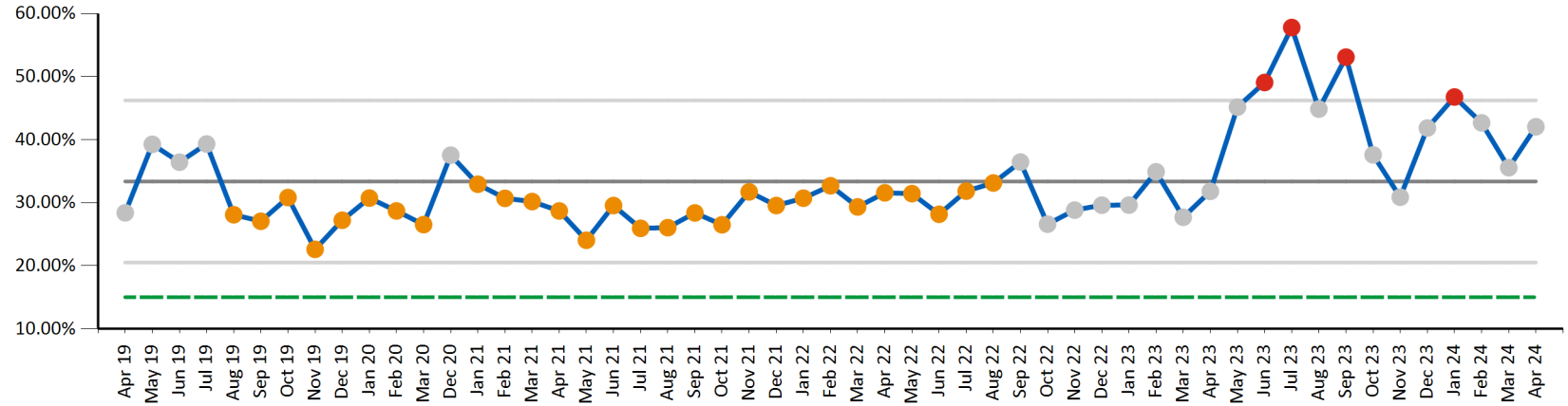
Plan	Actual
>= 90%	100.0%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	42.0%	Apr-24

Previous

Plan	Actual	Period
>= 15%	35.5%	Mar-24

Year to Date

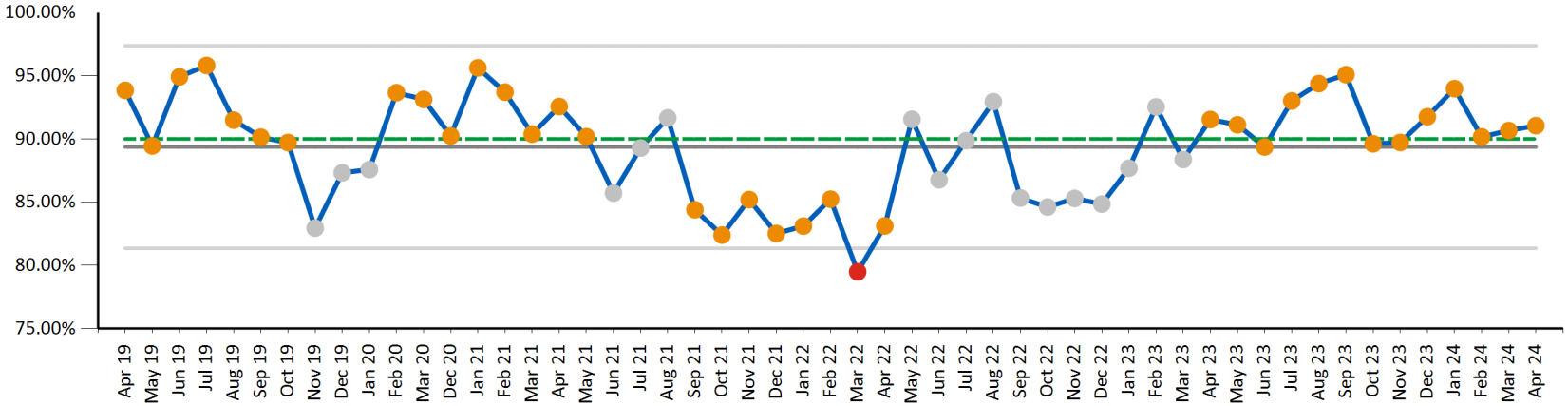
Plan	Actual
>= 15%	42.0%

243 - Birth Friends and Family Test - Satisfaction %

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
>= 90%	91.1%	Apr-24

Previous

Plan	Actual	Period
>= 90%	90.7%	Mar-24

Year to Date

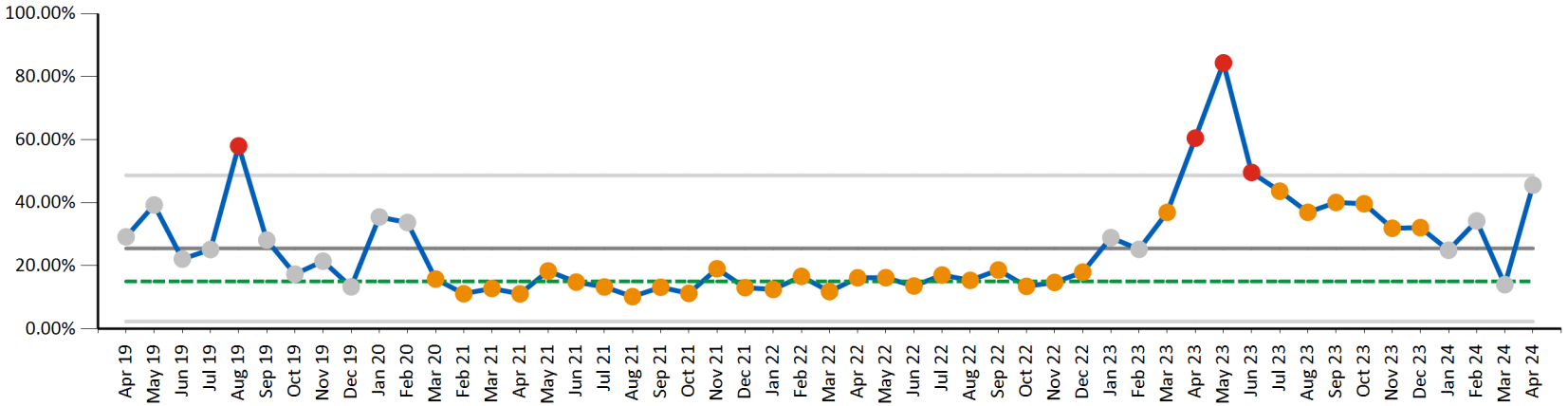
Plan	Actual
>= 90%	91.1%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	45.5%	Apr-24

Previous

Plan	Actual	Period
>= 15%	14.0%	Mar-24

Year to Date

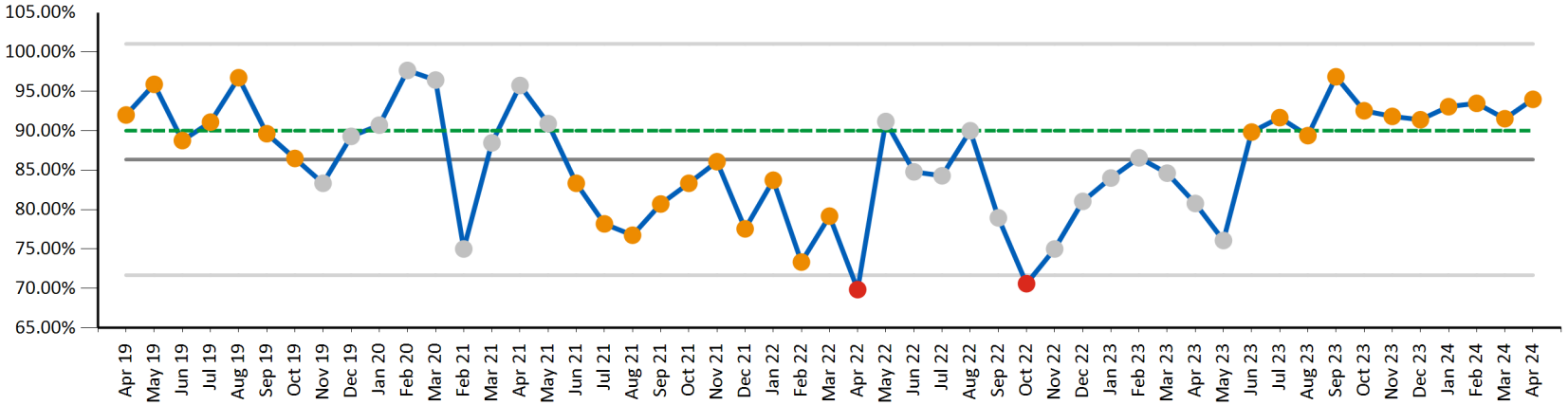
Plan	Actual
>= 15%	45.5%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 90%	94.0%	Apr-24

Previous

Plan	Actual	Period
>= 90%	91.5%	Mar-24

Year to Date

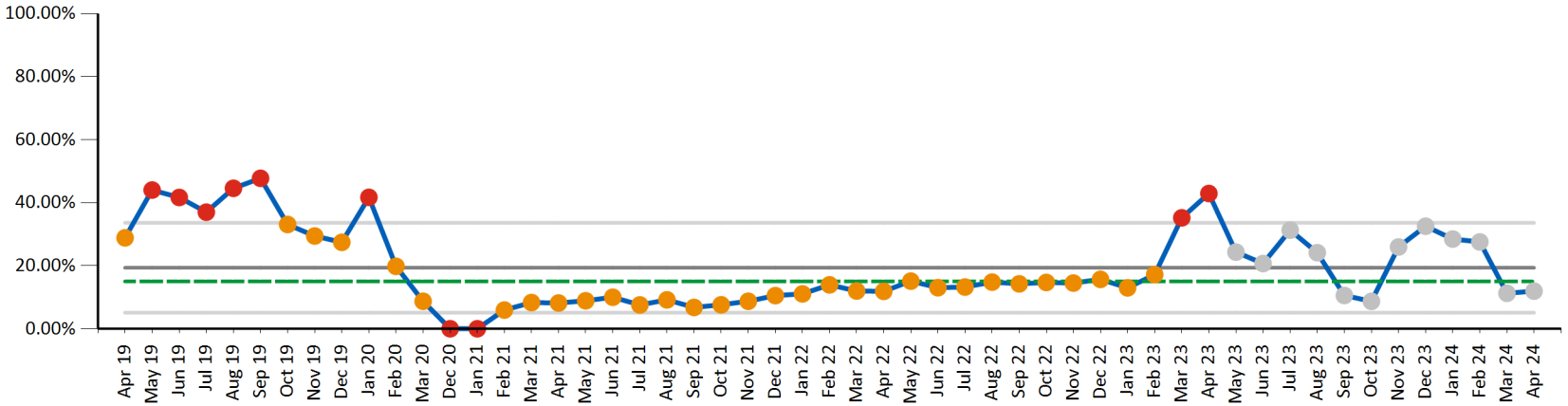
Plan	Actual
>= 90%	94.0%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	11.9%	Apr-24

Previous

Plan	Actual	Period
>= 15%	11.3%	Mar-24

Year to Date

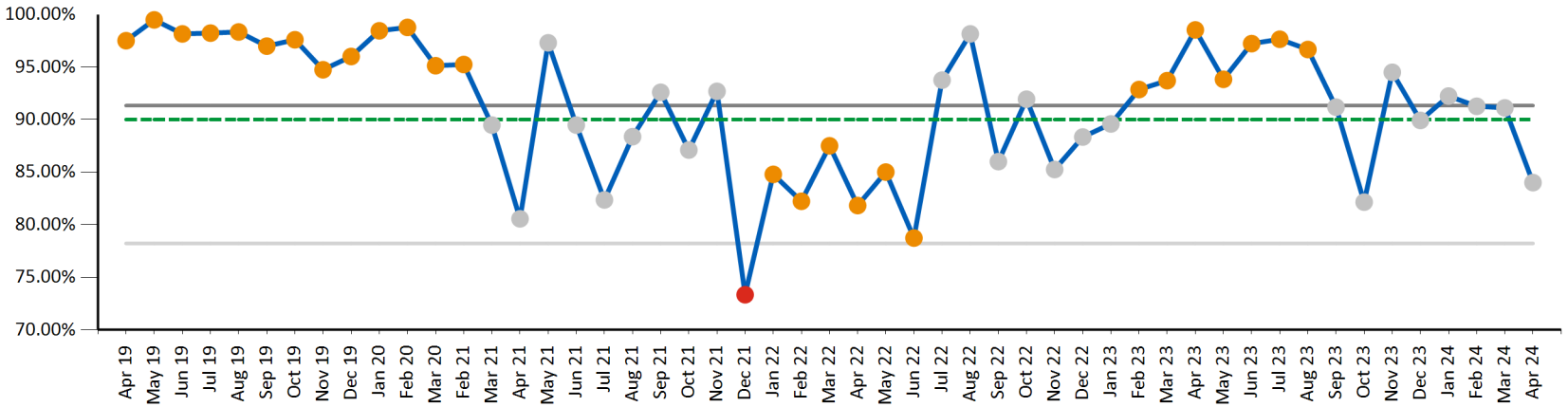
Plan	Actual
>= 15%	11.9%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 90%	84.0%	Apr-24

Previous

Plan	Actual	Period
>= 90%	91.1%	Mar-24

Year to Date

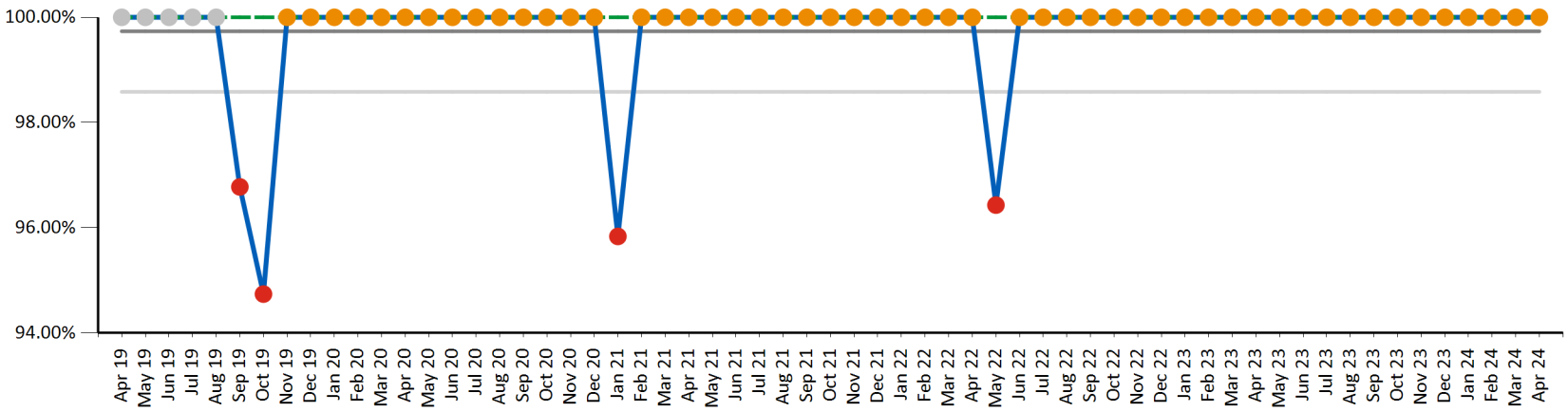
Plan	Actual
>= 90%	84.0%

89 - Formal complaints acknowledged within 3 working days

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Apr-24

Previous

Plan	Actual	Period
= 100%	100.0%	Mar-24

Year to Date

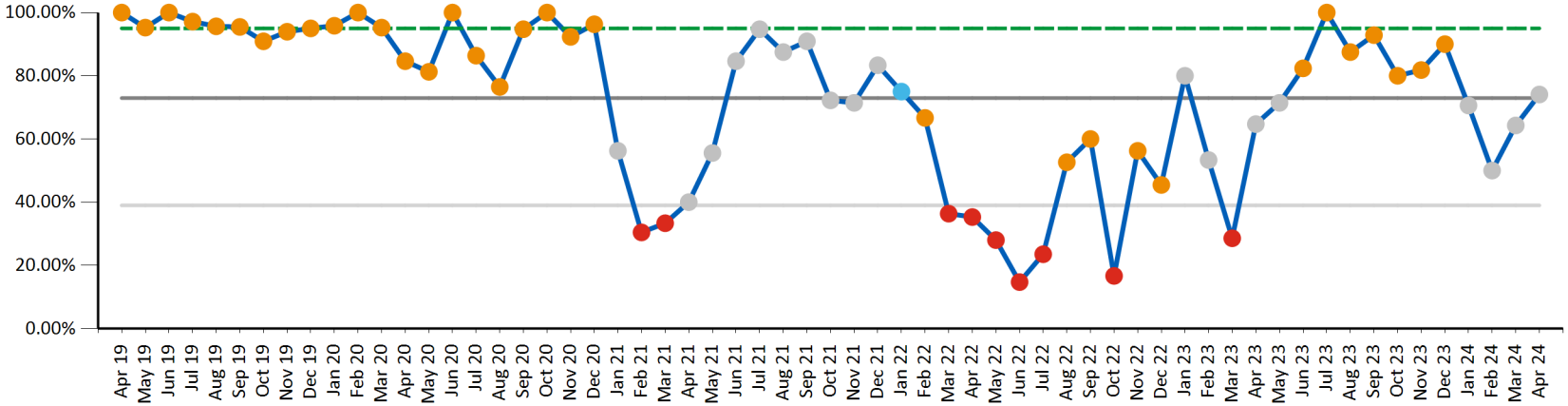
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	74.1%	Apr-24

Previous

Plan	Actual	Period
>= 95%	64.3%	Mar-24

Year to Date

Plan	Actual
>= 95%	74.1%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

81 - Friends and Family Response Rate – Slight recovery in the overall maternity friends and family response rate to 23.6%. Further improvement still required in antenatal and community response rate. Support being provided following a change in leadership within antenatal clinical areas. QR codes received and poster template requested from communications. Issue relates to delay in inputting paper format returns in a timely manner – thus transition to QR code requested via sticker on patients notes with code (in progress)

23 – ¾ degree tears – Reduction in incidence this month (1.3%). Year to date incidence 3.48% slightly higher than rolling 12 month Greater Manchester and Eastern Cheshire (GMEC) comparator average of 2.73% - flagged at Greater Manchester & East Cheshire (GMEC) safety assurance panel and system wide learning event being planned for May 2024 to share learning across providers.

322 – Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Decrease in incidence this month to (0%). New oversight table developed to aid review of data. Trust 2024 rolling GMEC average rate 4.46 /per1000 slightly higher than GMEC rolling 12 months rate 4.06/1000. Implementation of all of the revised saving babies lives care bundle v3 elements continues and all advanced perinatal optimisation measures continues. Revision of IPM datasets in progress to align with GMEC/MBRRACE.

202 - 1:1 care in labour – Sustained increase in Trust rate noted (98.7%) within month. Trust incidence 88.20% lower than the rolling 12 month Greater Manchester and East Cheshire (GMEC) average rate of 93.01% and peer average in similar sized providers (ie Oldham). No breaches of supernumerary status as per Clinical Negligence Scheme for Trusts (CNST), classification reported.

203 – Booked by 12+6 – Slight recovery in booking performance noted in month. Action plan in place. Digital issues addressed and work ongoing to implement a digital referral form on the Trust website. Trust performance higher than peer GMEC comparator and rolling 12 months average. Pilot of revised booking process in place to reduce duplication of inputting and release time ongoing within the Sunflower community midwifery team.

586 – Booked by 10 weeks (new standard)– Target reflects bookings by 10+0 as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact upon compliance rate. Operational focus ongoing to address the issues identified and wifi issues in community issues resolved. Trust performance 49.98% above GMEC median of 53.37%. Implementation of direct referral to community midwifery team via self referral form will improve oversight of performance and highlight when increased capacity required.

204 – Inductions of labour – New metric on dashboard indicates that 29.1% of induction of labour cases by 24 hours were delayed in April 2024, such cases can be associated with poor outcomes for mother and baby. Decrease in number of cases reported noted following introduction of discharge lounge on G4. Deterioration in performance anticipated in May as discharge lounge being used as a holding area for caesarean section activity and thus alternatives being scoped.

210 – Breastfeeding initiation – Sustained improvement in performance noted in month to 72.73%. Trust year to date incidence 69.44% slightly higher than GMEC 12 months average of 63.37%.

320 – Preterm birth – 9.0% incidence within month reported. Trust incidence (9.22%) slightly higher than GM average 8.86% but less than peer comparator (10.64%)

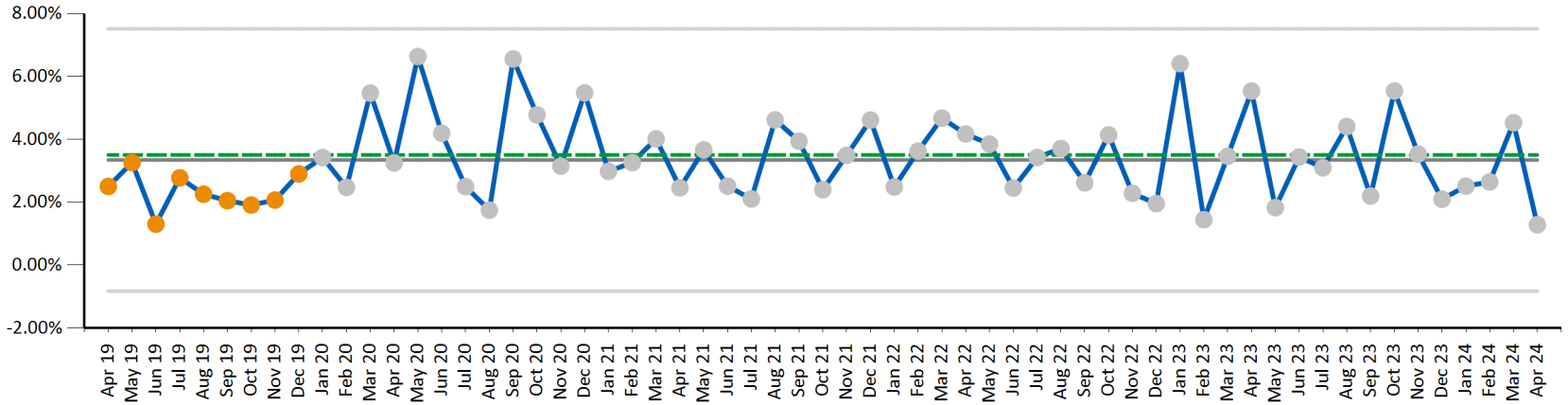
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnance)	<= 3.50	0.00	Apr-24		<= 3.50	2.48	Mar-24	<= 3.50	0.00	
23 - Maternity -3rd/4th degree tears	<= 3.5%	1.3%	Apr-24		<= 3.5%	4.5%	Mar-24	<= 3.5%	1.3%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.7%	Apr-24		>= 95.0%	99.0%	Mar-24	>= 95.0%	98.7%	
203 - Booked 12+6	>= 90.0%	82.0%	Apr-24		>= 90.0%	79.6%	Mar-24	>= 90.0%	82.0%	
586 - Booked 10+0		40.7%	Apr-24			38.3%	Mar-24		40.7%	
204 - Inductions of labour - over 24 hours	<= 40%	29.1%	Apr-24		<= 40%	34.8%	Mar-24	<= 40%	29.1%	
210 - Initiation breast feeding	>= 65%	72.73%	Apr-24		>= 65%	69.40%	Mar-24	>= 65%	72.73%	
213 - Maternity complaints	<= 5	3	Apr-24		<= 5	2	Mar-24	<= 5	3	
319 - Maternal deaths (direct)	= 0	0	Apr-24		= 0	0	Mar-24	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.0%	Apr-24		<= 6%	8.1%	Mar-24	<= 6%	9.0%	

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	1.3%	Apr-24

Previous

Plan	Actual	Period
<= 3.5%	4.5%	Mar-24

Year to Date

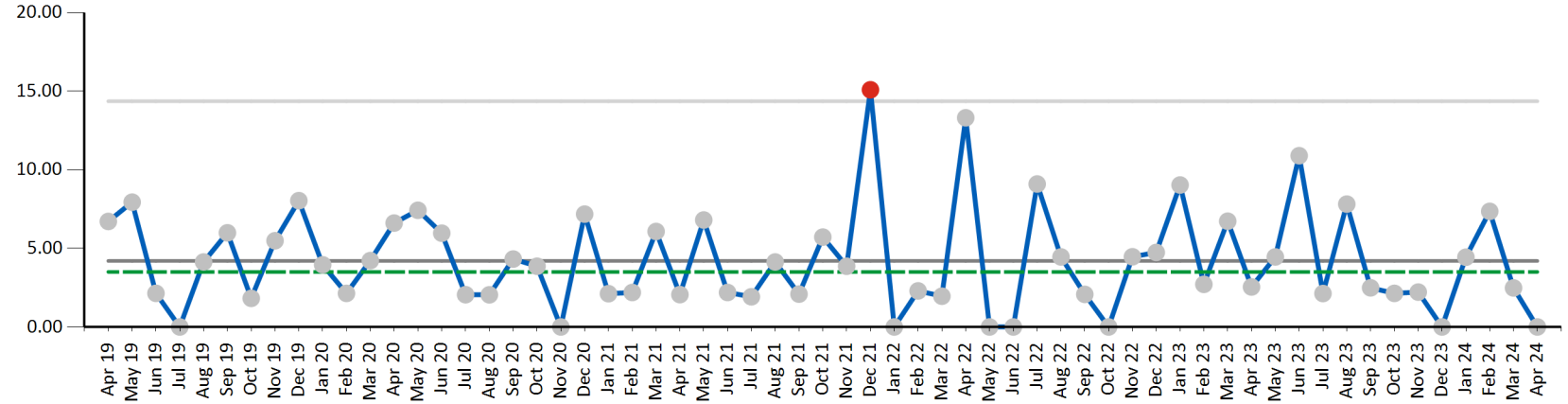
Plan	Actual
<= 3.5%	1.3%

322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnance)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.50	0.00	Apr-24

Previous

Plan	Actual	Period
<= 3.50	2.48	Mar-24

Year to Date

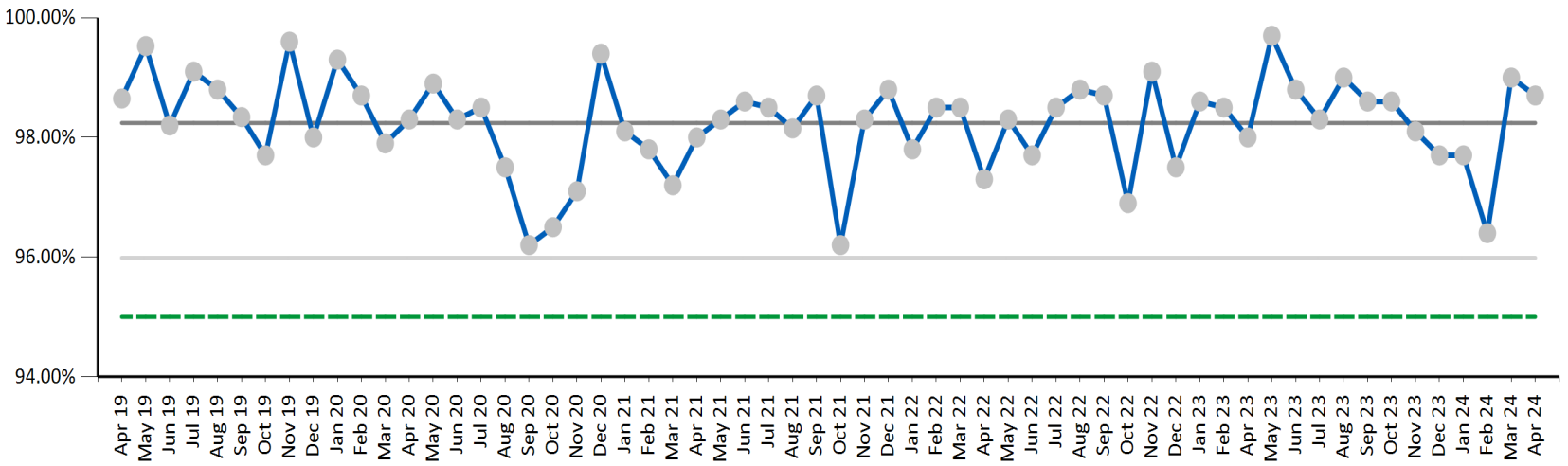
Plan	Actual
<= 3.50	0.00

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	98.7%	Apr-24

Previous

Plan	Actual	Period
>= 95.0%	99.0%	Mar-24

Year to Date

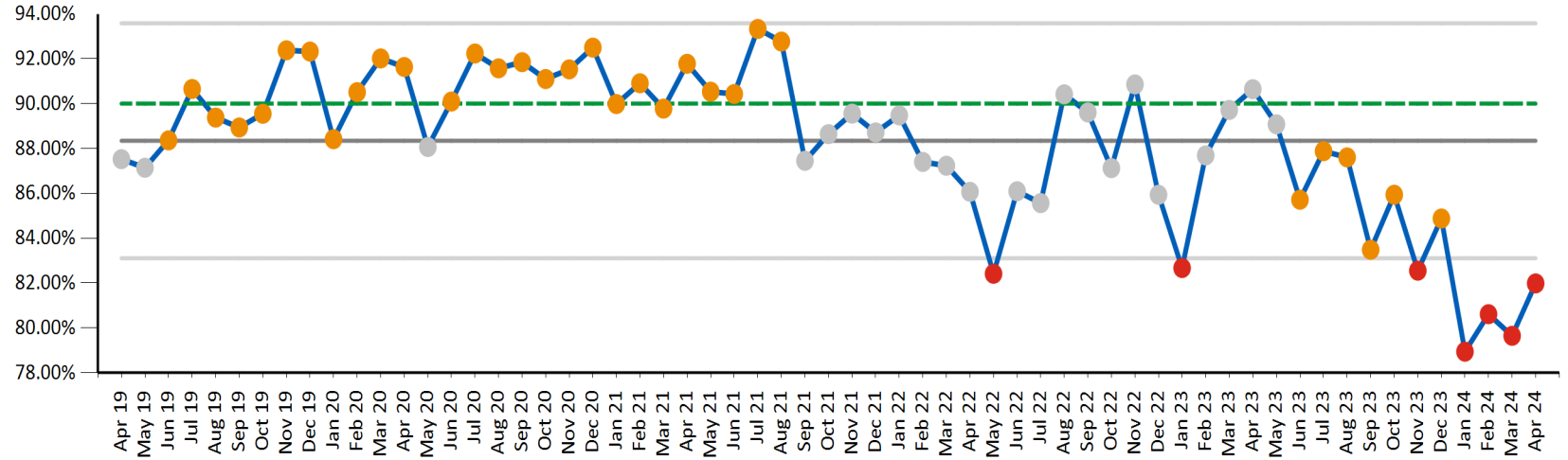
Plan	Actual
>= 95.0%	98.7%

203 - Booked 12+6

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 90.0%	82.0%	Apr-24

Previous

Plan	Actual	Period
>= 90.0%	79.6%	Mar-24

Year to Date

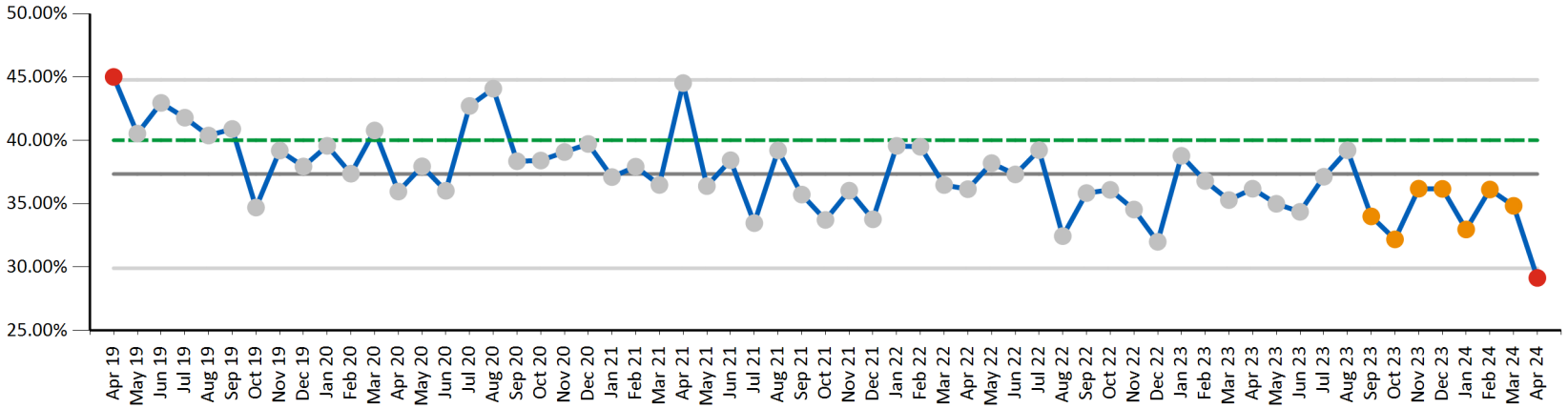
Plan	Actual
>= 90.0%	82.0%

204 - Inductions of labour - over 24 hours

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 40%	29.1%	Apr-24

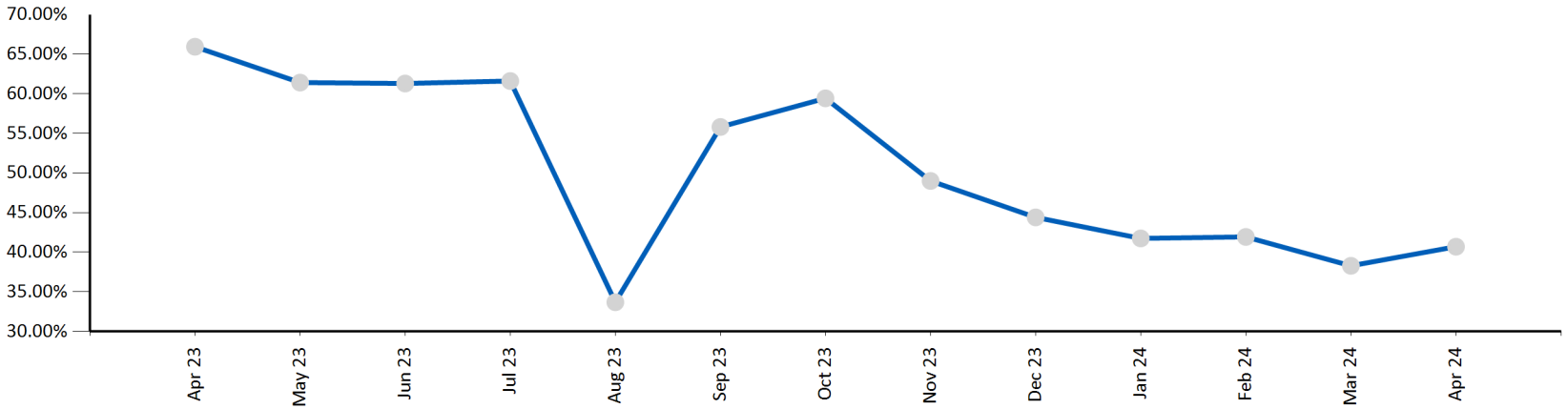
Previous

Plan	Actual	Period
<= 40%	34.8%	Mar-24

Year to Date

Plan	Actual
<= 40%	29.1%

586 - Booked 10+0 - SPC data available after 20 data points



Latest

Plan	Actual	Period
	40.7%	Apr-24

Previous

Plan	Actual	Period
	38.3%	Mar-24

Year to Date

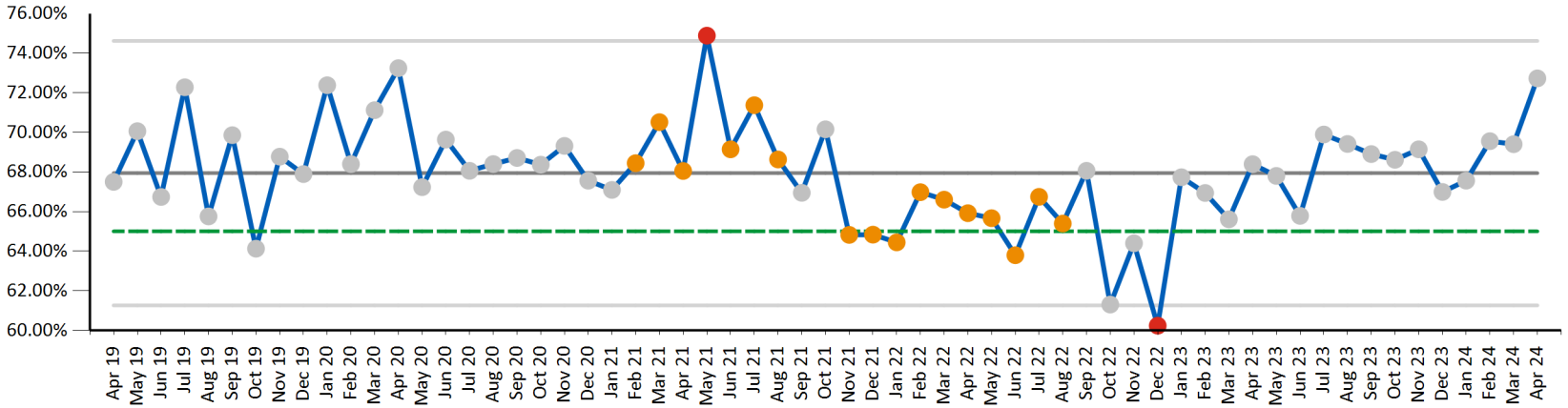
Plan	Actual
	40.7%

210 - Initiation breast feeding

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	72.73%	Apr-24

Previous

Plan	Actual	Period
>= 65%	69.40%	Mar-24

Year to Date

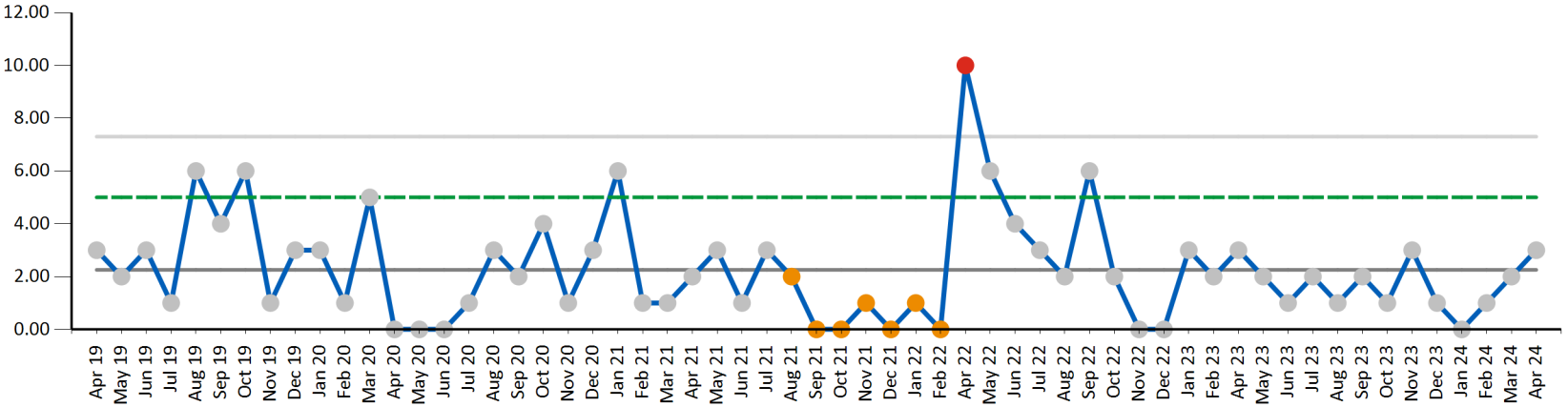
Plan	Actual
>= 65%	72.73%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	3	Apr-24

Previous

Plan	Actual	Period
<= 5	2	Mar-24

Year to Date

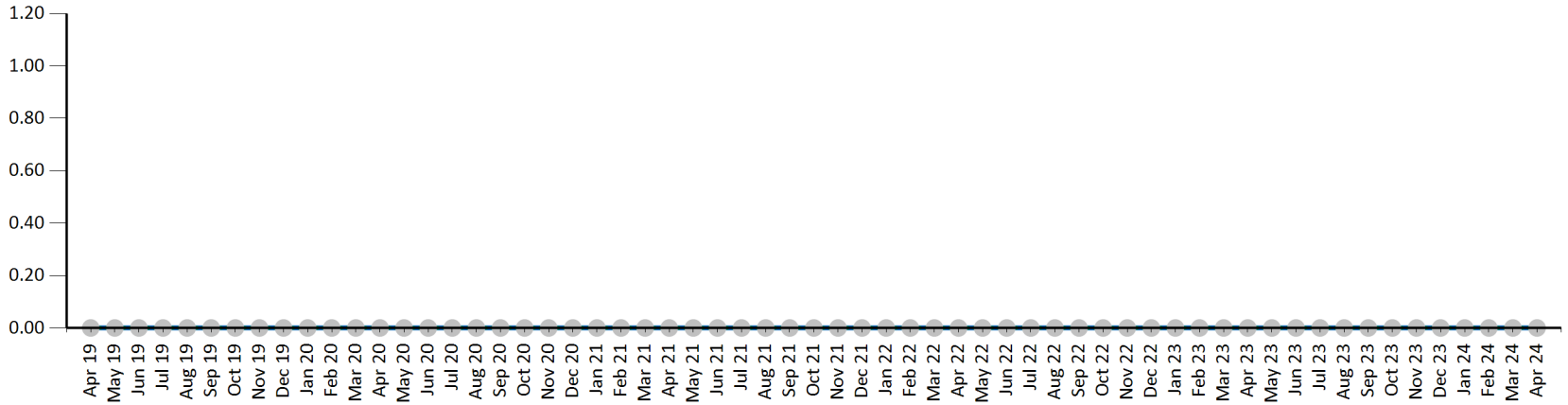
Plan	Actual
<= 5	3

319 - Maternal deaths (direct)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 0	0	Apr-24

Previous

Plan	Actual	Period
= 0	0	Mar-24

Year to Date

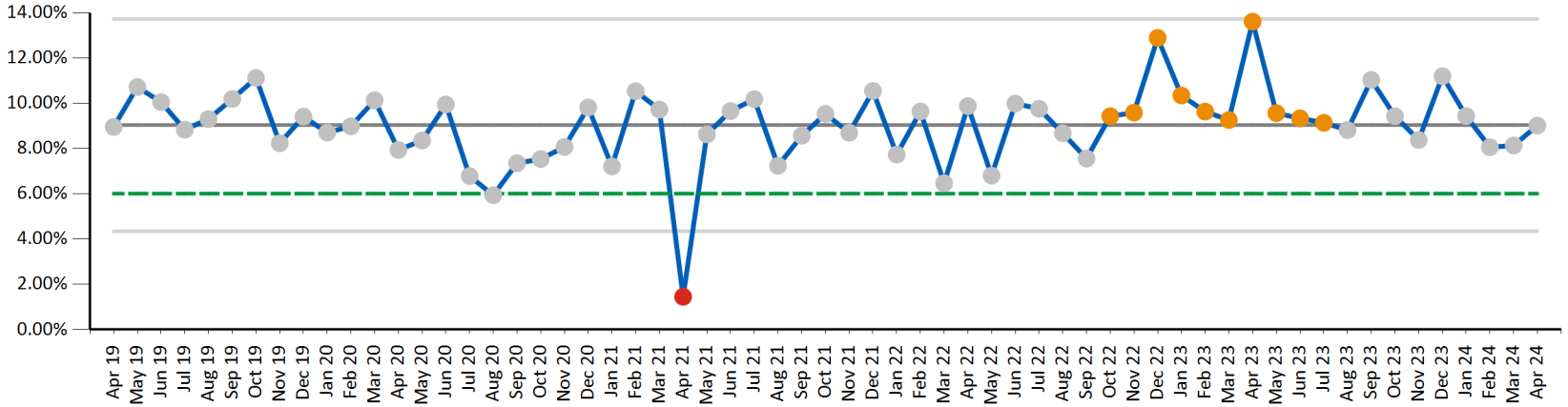
Plan	Actual
= 0	0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6%	9.0%	Apr-24

Previous

Plan	Actual	Period
<= 6%	8.1%	Mar-24

Year to Date

Plan	Actual
<= 6%	9.0%

Operational Performance - Urgent Care

Bolton NHS Foundation Trust

Emergency Department

Performance against the 4-hour standard was 60.5%, which was a 0.8% deterioration on March 2024. Type 3 Urgent Treatment Centre performance was 90.9%, which represents a 12.4% increase since February. Time to see a decision maker in the ED continued to improve and was 128 minutes from a February peak of 154 mins.

Ambulance handover within 15 minutes increased by 5.6% to 45.5%, which is the best figure since September 2023, however, there are still challenges around delayed admissions to hospital though some of this is due to the multiple norovirus outbreaks in month.

Recovery of the emergency department 4 hour standard and associated metrics is being supported through delivery of the Urgent Care Improvement Plan. We are receiving targeted support from ECIST and have commissioned additional improvement support. Plans are being monitored through our weekly executive urgent care improvement group.

In Hospital Flow

A further workstream within the Urgent Care Improvement Plan focuses on in hospital flow and also receives weekly oversight via the executive urgent care improvement group.

Discharges by 12 noon improved to 21.7% however; there was a more significant increase in discharges before 4pm to 56.9%, which is the best performance in the last 12 months. There was an increase in 21-day length of stay to 41.9%, which is a deterioration and the highest figure in 12 months.

NOF

For April, our fractured neck of femur performance remained largely static at 50%, with 18 of the 36 eligible patients getting to theatre within the 36 hour window.

The majority of breaches continue to relate to challenges with theatre capacity, with other breaches relating to further optimisation and delay in the Emergency Department.

Work is approaching completion with regards to job plans to enable distribution of trauma capacity across the week, which will provide an improvement in the number of patients delayed due to theatre capacity. We also continue to facilitate the separation of elective and non-elective capacity.

	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%	60.4%	Apr-24	L	>= 95%	61.2%	Mar-24	>= 75%	60.4%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	45.5%	Apr-24		>= 65.0%	39.9%	Mar-24	>= 65.0%	45.5%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	73.9%	Apr-24		>= 95.0%	69.8%	Mar-24	>= 95.0%	73.9%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	88.17%	Apr-24		= 100%	83.71%	Mar-24	= 100%	88.17%	F
539 - A&E 12 hour waits	= 0	1,303	Apr-24	H	= 0	1,331	Mar-24	= 0	1,303	F

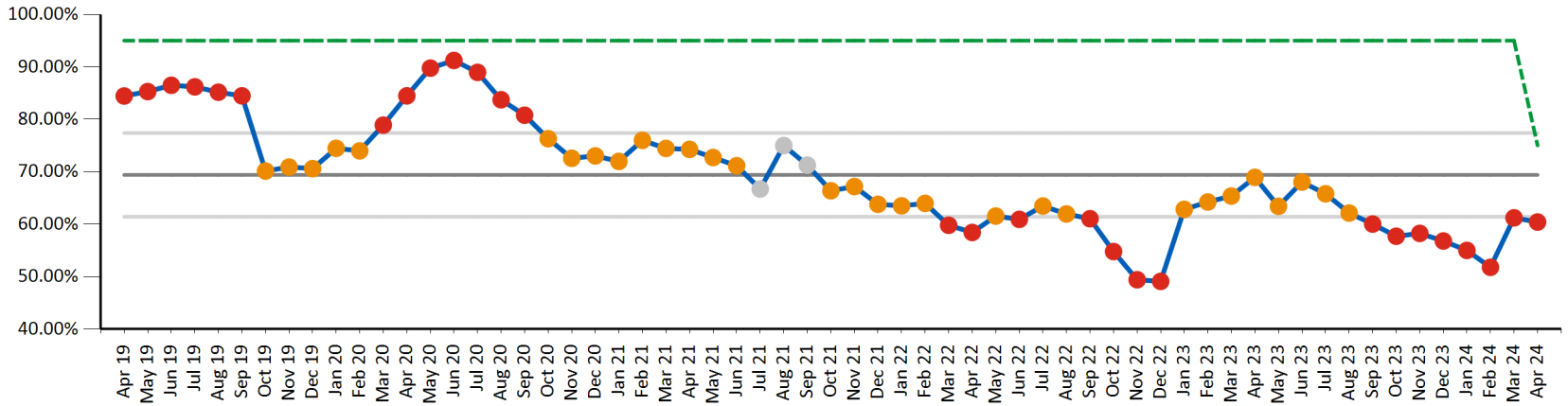
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	50.0%	Apr-24		>= 75%	51.7%	Mar-24	>= 75%	50.0%	?
56 - Stranded patients - over 7 days	<= 200	289	Apr-24	H	<= 200	292	Mar-24	<= 200	289	?
307 - Stranded Patients - LOS 21 days and over	<= 69	120	Apr-24	H	<= 69	117	Mar-24	<= 69	120	?
541 - Adult G&A bed occupancy	<= 92.0%	89.5%	Apr-24	H		90.1%	Mar-24	<= 92.0%	89.5%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	7.22	Apr-24	H	<= 3.70	5.68	Mar-24	<= 3.70	7.22	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.7%	Mar-24	L	<= 13.5%	9.1%	Feb-24	<= 13.5%		P

53 - A&E 4 hour target

L — Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	60.4%	Apr-24

Previous

Plan	Actual	Period
>= 95%	61.2%	Mar-24

Year to Date

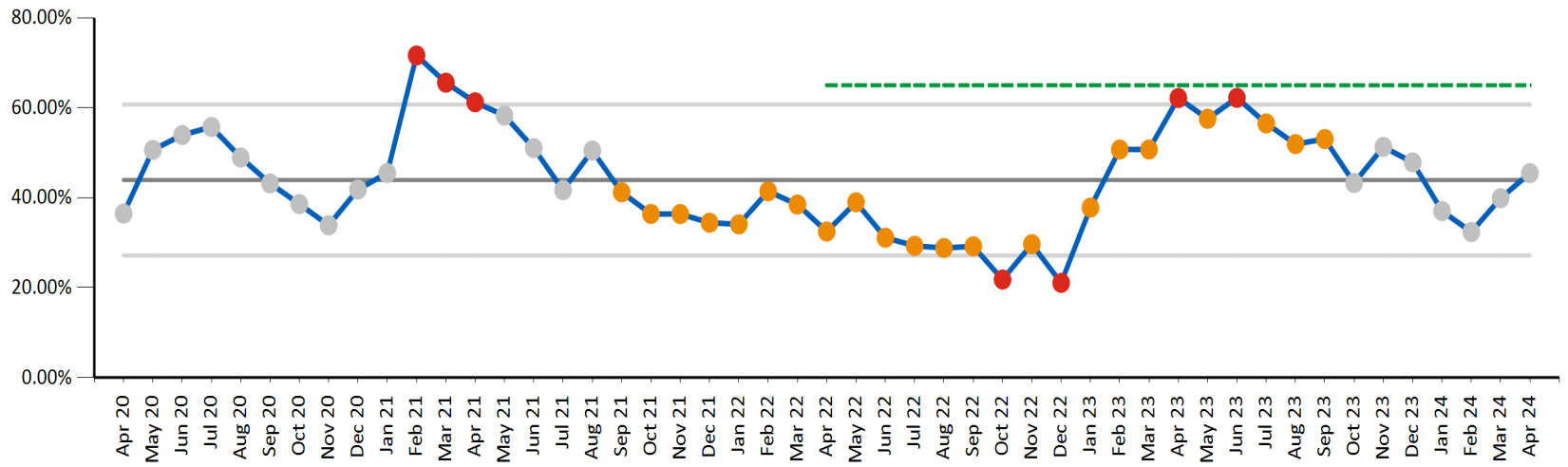
Plan	Actual
>= 75%	60.4%

538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 65.0%	45.5%	Apr-24

Previous

Plan	Actual	Period
>= 65.0%	39.9%	Mar-24

Year to Date

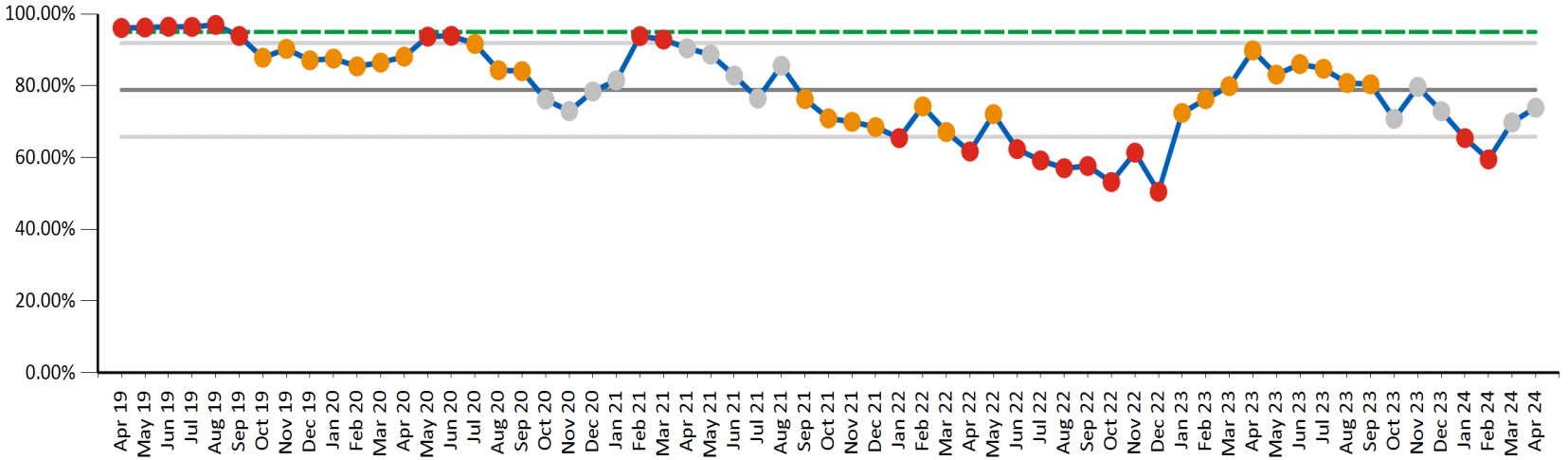
Plan	Actual
>= 65.0%	45.5%

70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	73.9%	Apr-24

Previous

Plan	Actual	Period
>= 95.0%	69.8%	Mar-24

Year to Date

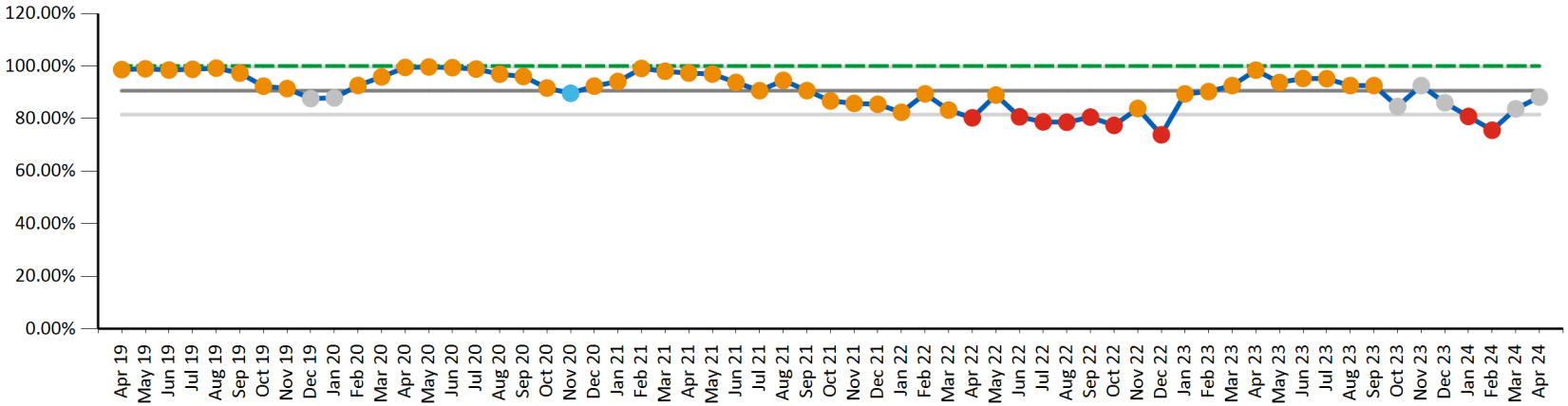
Plan	Actual
>= 95.0%	73.9%

71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	88.17%	Apr-24

Previous

Plan	Actual	Period
= 100%	83.71%	Mar-24

Year to Date

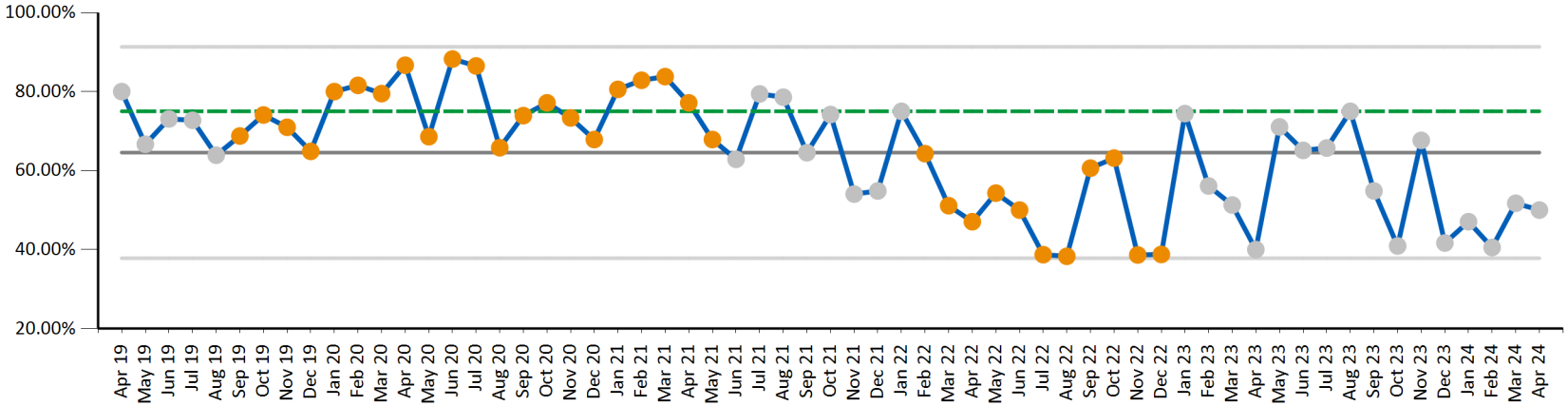
Plan	Actual
= 100%	88.17%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 75%	50.0%	Apr-24

Previous

Plan	Actual	Period
>= 75%	51.7%	Mar-24

Year to Date

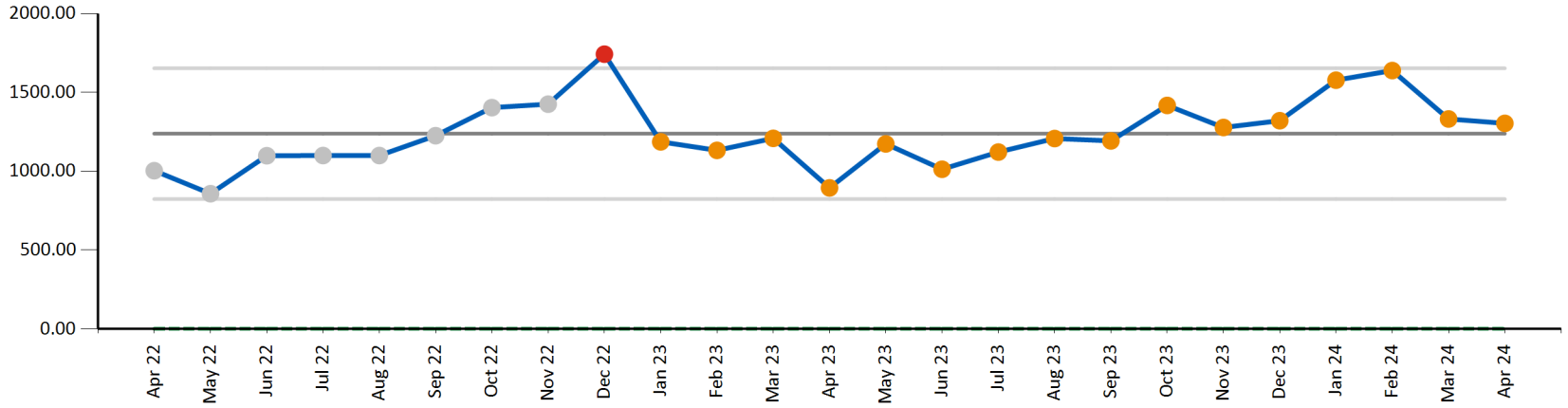
Plan	Actual
>= 75%	50.0%

539 - A&E 12 hour waits

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,303	Apr-24

Previous

Plan	Actual	Period
= 0	1,331	Mar-24

Year to Date

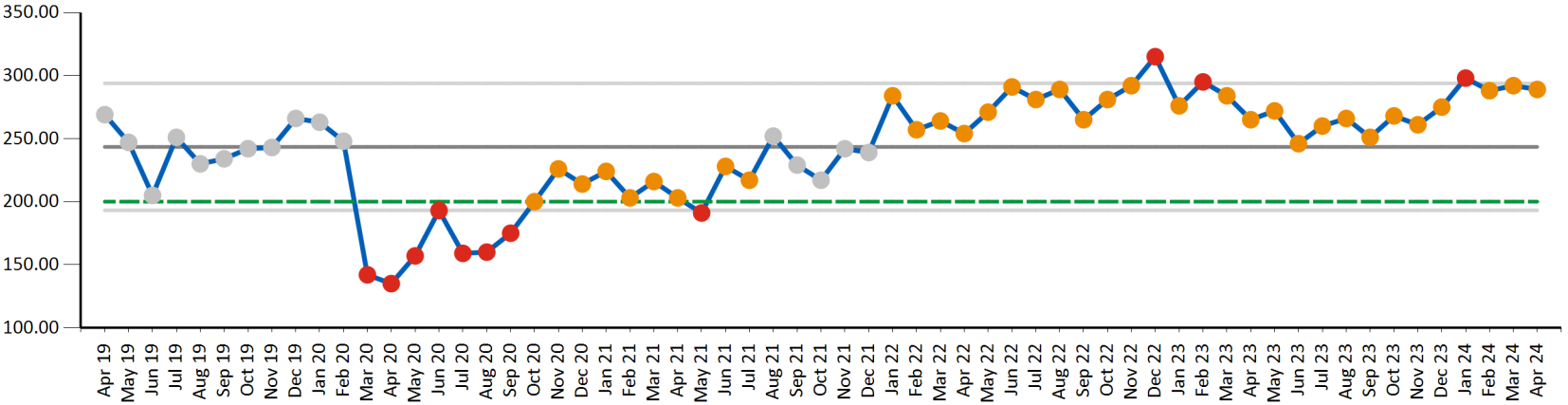
Plan	Actual
= 0	1,303

56 - Stranded patients - over 7 days

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 200	289	Apr-24

Previous

Plan	Actual	Period
<= 200	292	Mar-24

Year to Date

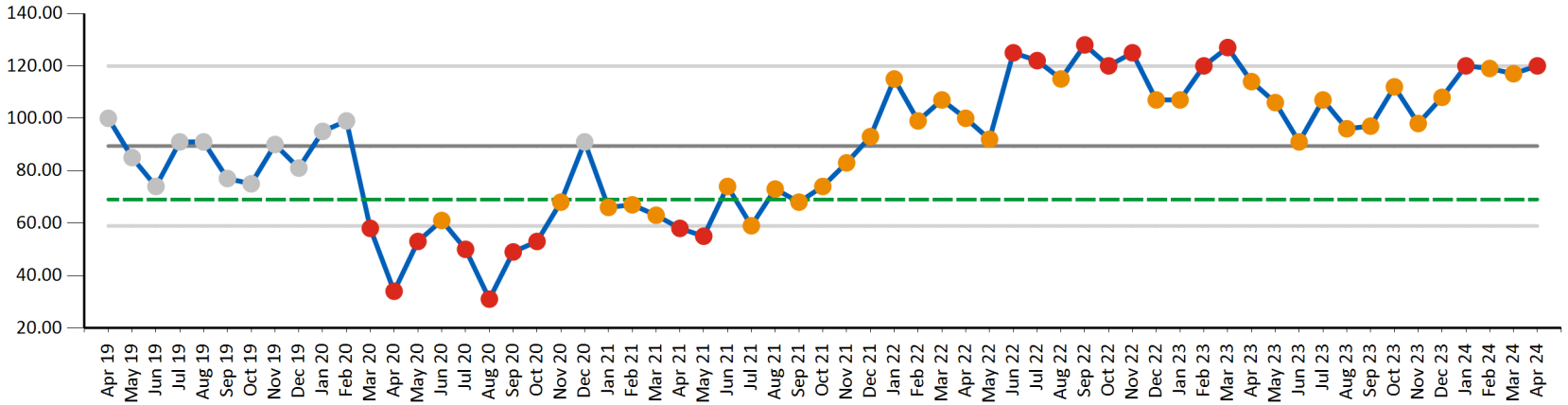
Plan	Actual
<= 200	289

307 - Stranded Patients - LOS 21 days and over

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 69	120	Apr-24

Previous

Plan	Actual	Period
<= 69	117	Mar-24

Year to Date

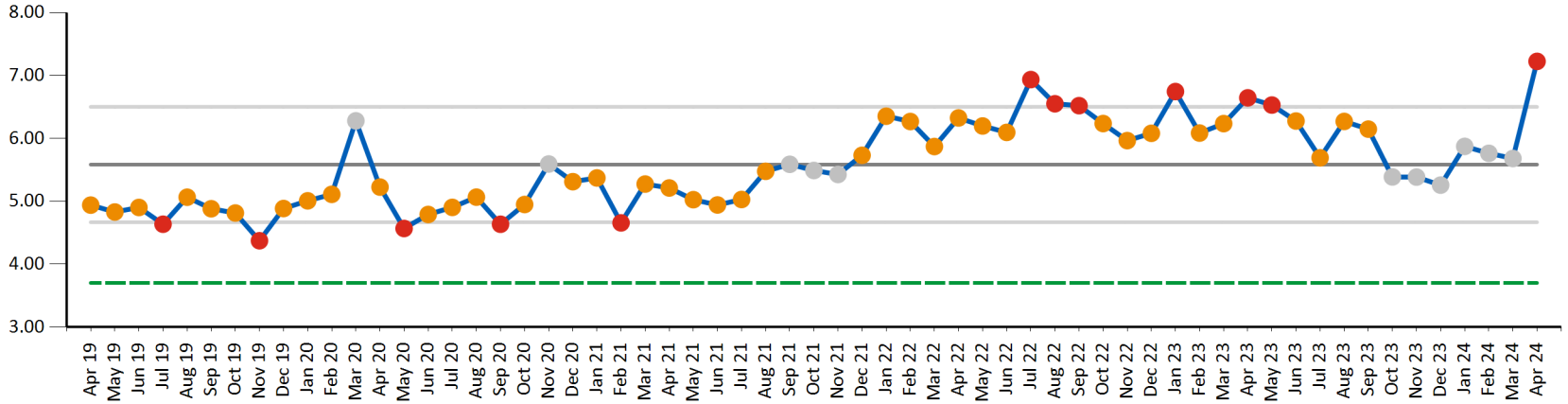
Plan	Actual
<= 69	120

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

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	7.22	Apr-24

Previous

Plan	Actual	Period
<= 3.70	5.68	Mar-24

Year to Date

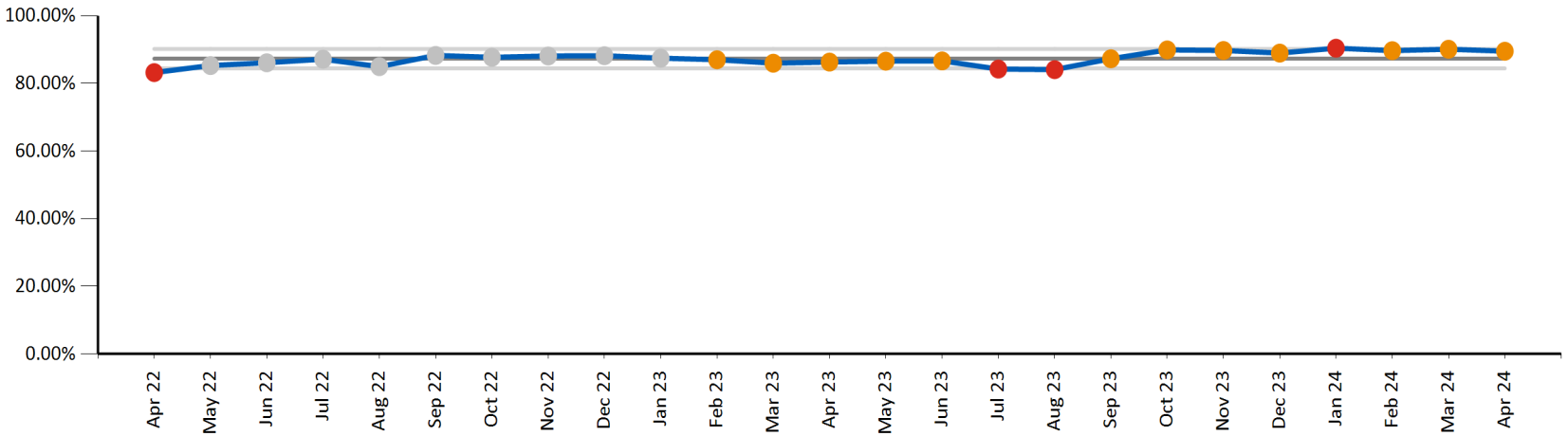
Plan	Actual
<= 3.70	7.22

541 - Adult G&A bed occupancy

Special cause variation with deteriorating performance

Target will be regularly met.

1/6



Latest

Plan	Actual	Period
< = 92.0%	89.5%	Apr-24

Previous

Plan	Actual	Period
	90.1%	Mar-24

Year to Date

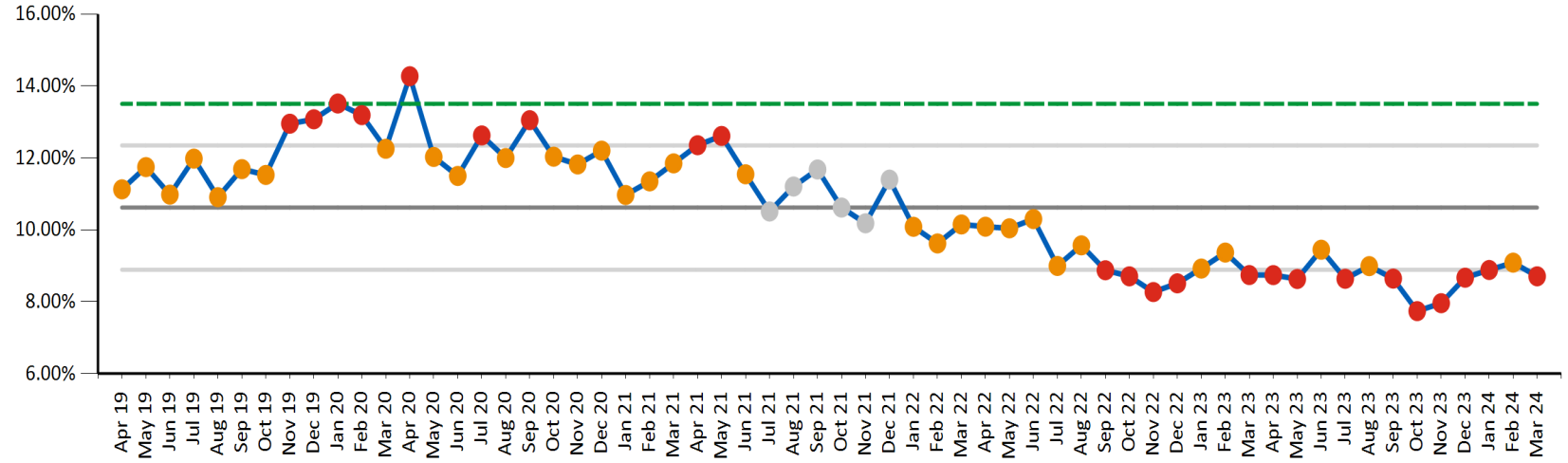
Plan	Actual
< = 92.0%	89.5%

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

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
< = 13.5%	8.7%	Mar-24

Previous

Plan	Actual	Period
< = 13.5%	9.1%	Feb-24

Year to Date

Plan	Actual
< = 13.5%	8.7%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished April with 23 patients having experienced a wait for planned care of 78 weeks or longer. The reasons for these long waits were a combination of patient choice for a more convenient date, capacity issues, clinical complexity and patients awaiting corneal graft material.

We are working towards getting to 0 78-week breaches (excluding graft patients) as soon as possible, with the regional deadline as the end of June. This is being closely managed by all specialties and with oversight via the waiting list meeting.

We also finished April with 678 patients having experienced a wait for planned care of 65 weeks or longer. Work is ongoing to achieve 0 65-week breaches by the end of September, with additional activity being identified in pressured specialties. Specialties with high risk of achieving this milestone are ENT (both adult and paediatric), Gynaecology, Urology, and Plastic Surgery. All of which have worked up specific delivery plans to create the additional capacity required, which are being closely monitored.

DM01

The Trust position has improved this month, with a final position of 7.7%. Although many of the specialities have maintained their recovery programmes, we have seen particular improvement within Imaging who have completed their recovery, and report a final compliance position of 3.5%. Overall there were 176 fewer patients waiting more than 6 weeks for their diagnostic procedure, and the Trust waiting list volume has also been reduced by 770 patients. Cystoscopy remains the area with the biggest capacity challenge at present, however, there has been progress within this area too, with an improved position by 3.3% this month. Overall, work against the recovery trajectory continues and the plans in place to bring the Trust in line with the National target of 5% remains likely to be completed by February 2025.

	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%	49.6%	Apr-24	L	>= 92%	48.9%	Mar-24	>= 92%	49.6%	F
314 - RTT 18 week waiting list	<= 39,264	44,308	Apr-24	H	<= 25,530	43,816	Mar-24	<= 39,264	44,308	P
42 - RTT 52 week waits (incomplete pathways)		3,359	Apr-24	H		3,221	Mar-24		3,359	
540 - RTT 65 week waits (incomplete pathways)	<= 593	678	Apr-24	H		639	Mar-24	<= 593	678	?
526 - RTT 78 week waits (incomplete pathways)	= 0	23	Apr-24	L	= 0	26	Mar-24	= 0	23	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Apr-24	L	= 0	0	Mar-24	= 0	0	F
72 - Diagnostic Waits >6 weeks %	<= 5%	7.7%	Apr-24	L	<= 1%	10.4%	Mar-24	<= 5%	7.7%	F

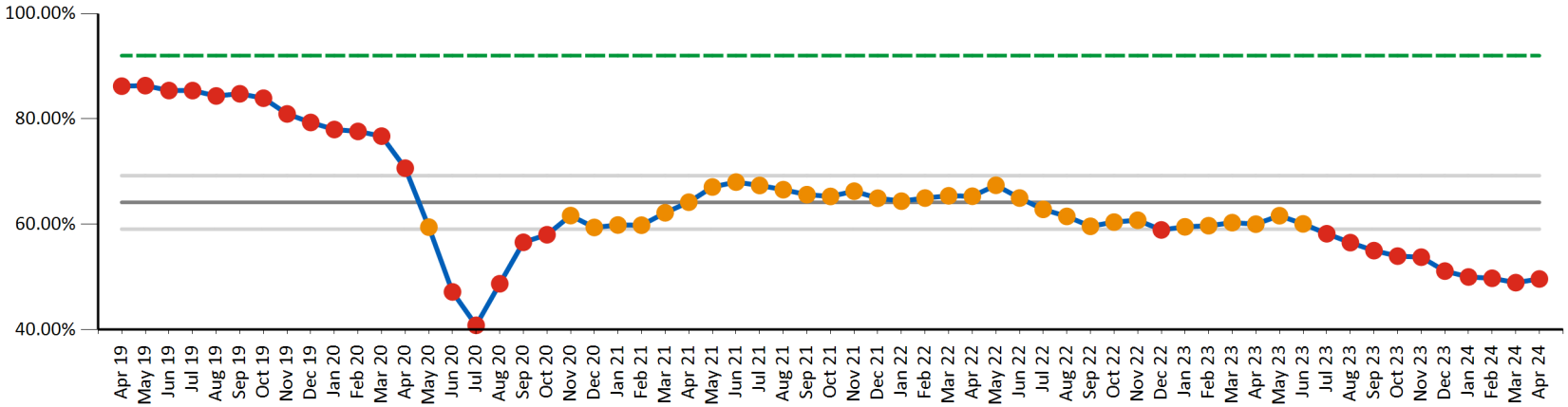
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
489 - Daycase Rates	>= 85%	83.1%	Apr-24		>= 80%	84.1%	Mar-24	>= 85%	83.1%	?
582 - Theatre Utilisation - Capped		77.0%	Apr-24	H		75.3%	Mar-24		77.0%	
583 - Theatre Utilisation - Uncapped		81.7%	Apr-24			82.6%	Mar-24		81.7%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Apr-24		<= 1%	2.0%	Mar-24	<= 1%	1.4%	?
62 - Cancelled operations re-booked within 28 days	= 100%	35.3%	Mar-24		= 100%	78.0%	Feb-24	= 100%		?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.90	Apr-24		<= 2.00	2.81	Mar-24	<= 2.00	2.90	?
309 - DNA Rate - New	<= 6.3%	9.6%	Apr-24		<= 8.0%	9.1%	Mar-24	<= 6.3%	9.6%	F
310 - DNA Rate - Follow up	<= 5.0%	8.8%	Apr-24		<= 5.0%	9.0%	Mar-24	<= 5.0%	8.8%	F

41 - RTT Incomplete pathways within 18 weeks %

L Special cause variation with deteriorating performance

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	49.6%	Apr-24

Previous

Plan	Actual	Period
>= 92%	48.9%	Mar-24

Year to Date

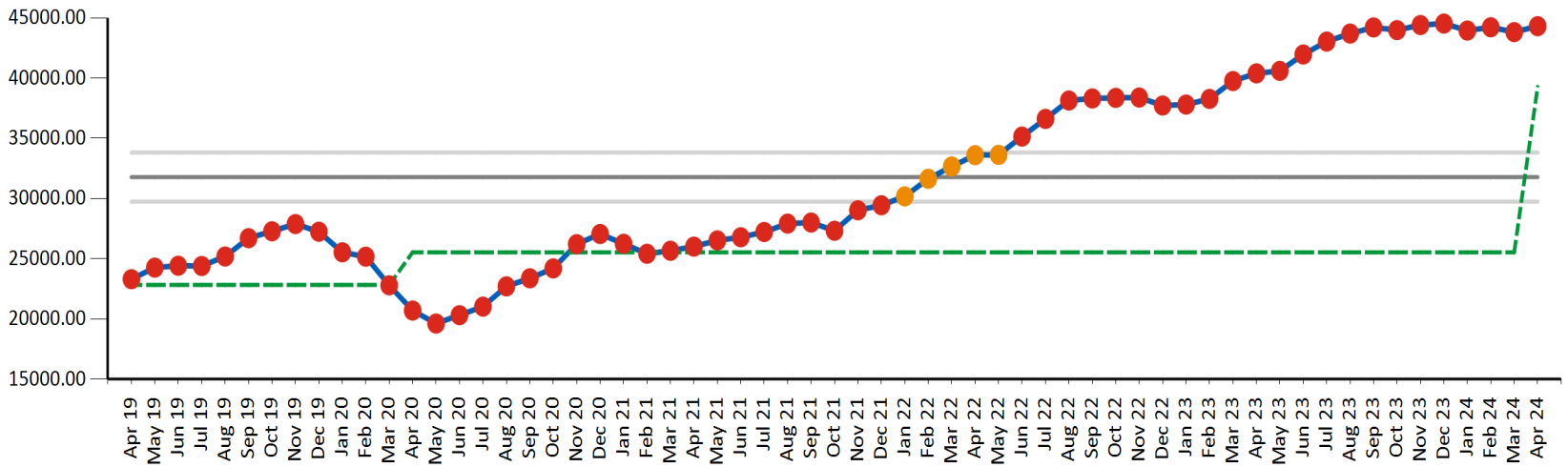
Plan	Actual
>= 92%	49.6%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
<= 39,264	44,308	Apr-24

Previous

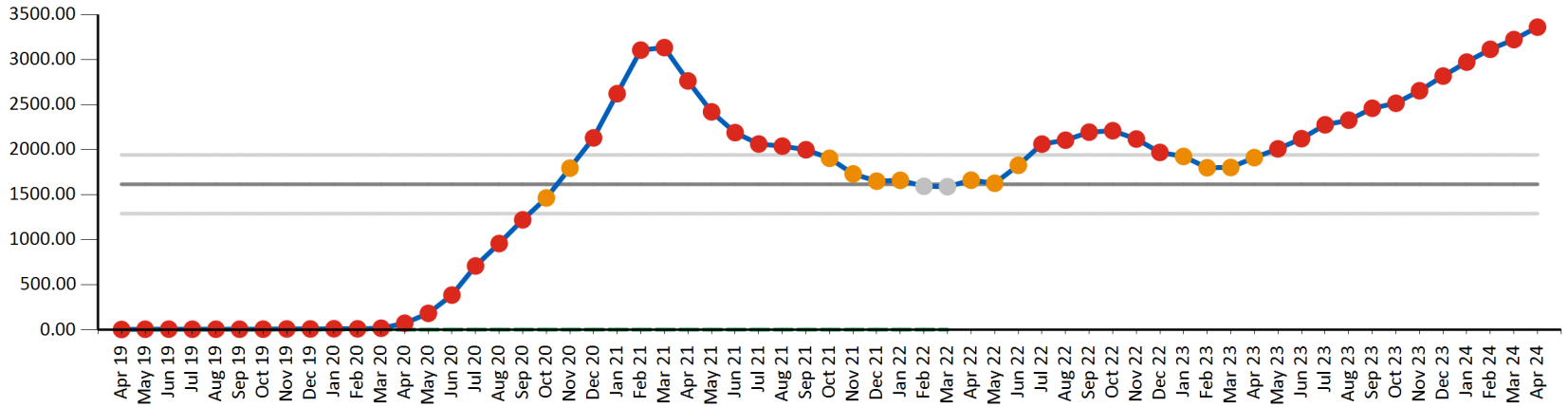
Plan	Actual	Period
<= 25,530	43,816	Mar-24

Year to Date

Plan	Actual
<= 39,264	44,308

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	3,359	Apr-24

Previous

Plan	Actual	Period
	3,221	Mar-24

Year to Date

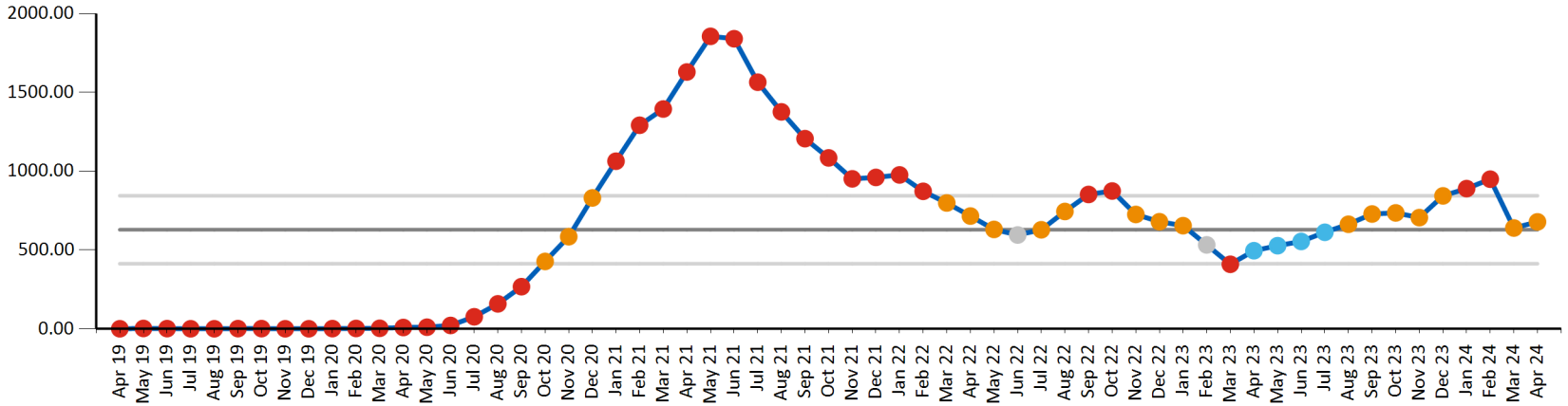
Plan	Actual
	3,359

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 593	678	Apr-24

Previous

Plan	Actual	Period
	639	Mar-24

Year to Date

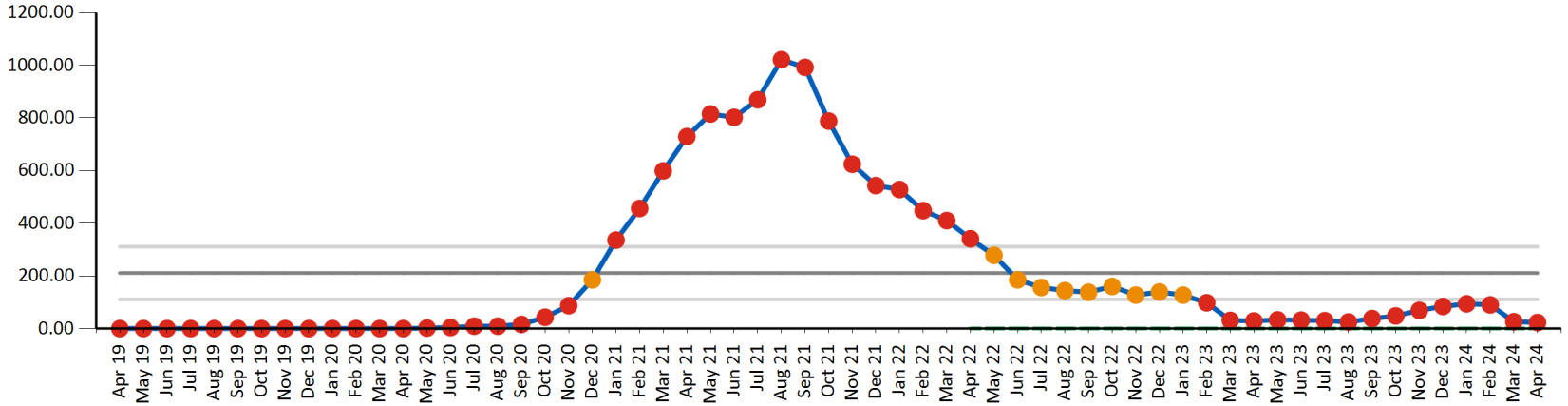
Plan	Actual
<= 593	678

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	23	Apr-24

Previous

Plan	Actual	Period
= 0	26	Mar-24

Year to Date

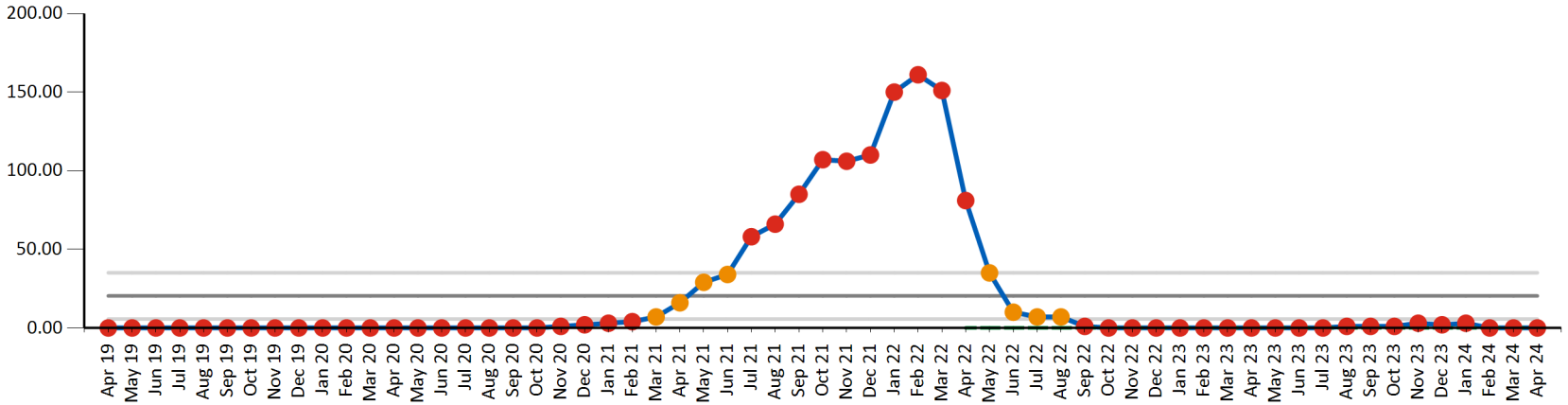
Plan	Actual
= 0	23

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

3/6



Latest

Plan	Actual	Period
= 0	0	Apr-24

Previous

Plan	Actual	Period
= 0	0	Mar-24

Year to Date

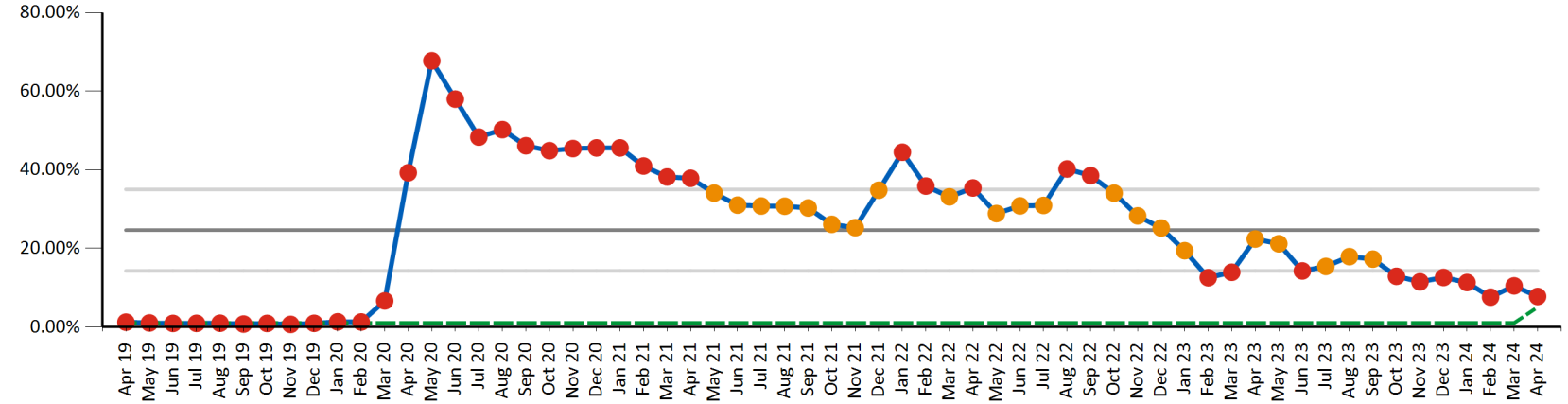
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5%	7.7%	Apr-24

Previous

Plan	Actual	Period
<= 1%	10.4%	Mar-24

Year to Date

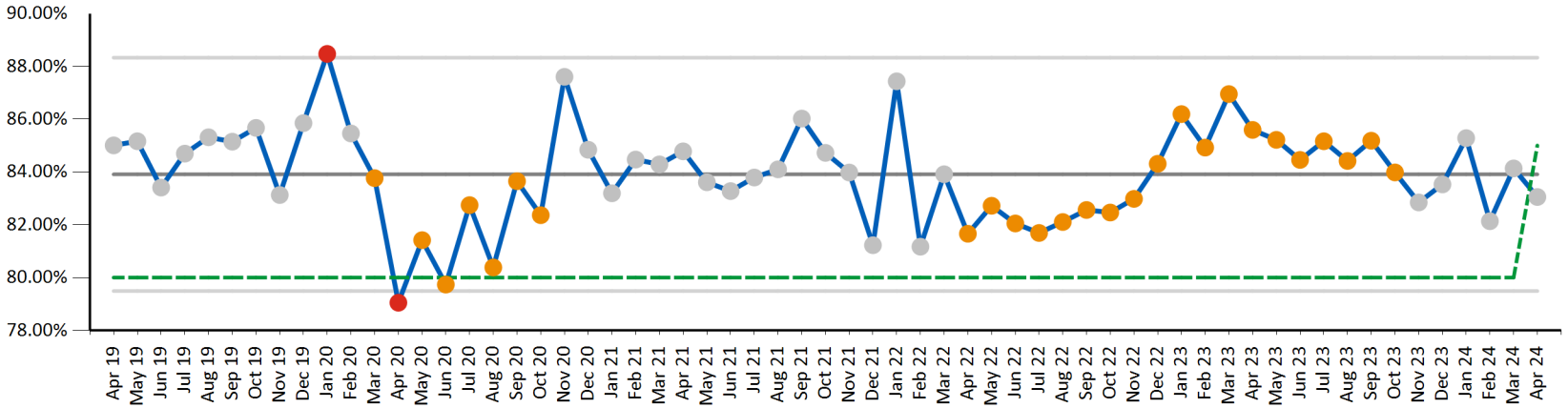
Plan	Actual
<= 5%	7.7%

489 - Daycase Rates

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 85%	83.1%	Apr-24

Previous

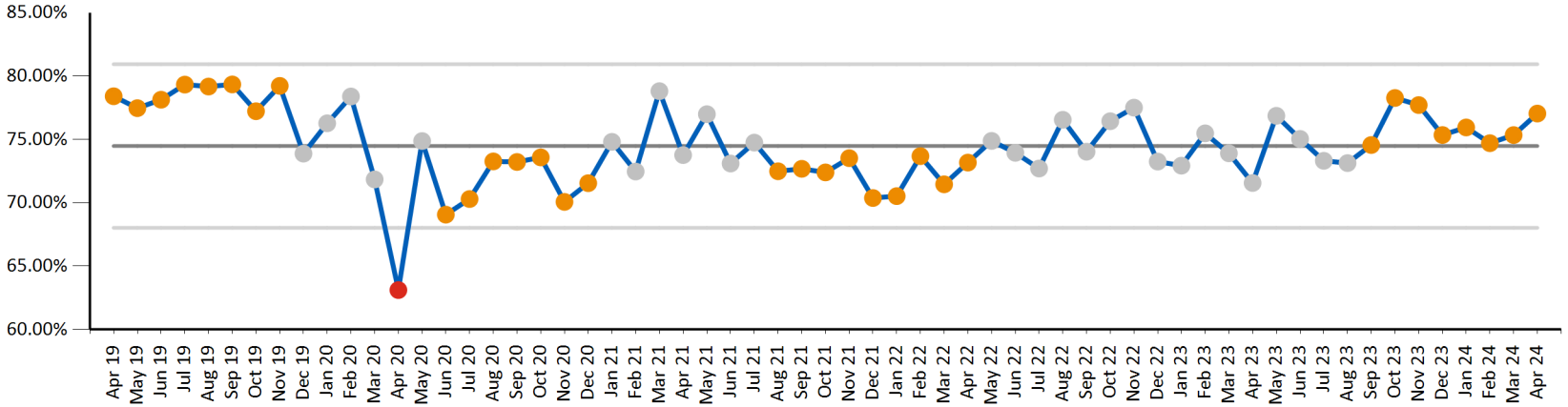
Plan	Actual	Period
>= 80%	84.1%	Mar-24

Year to Date

Plan	Actual
>= 85%	83.1%

582 - Theatre Utilisation - Capped

Special cause variation with improving performance



Latest

Plan	Actual	Period
	77.0%	Apr-24

Previous

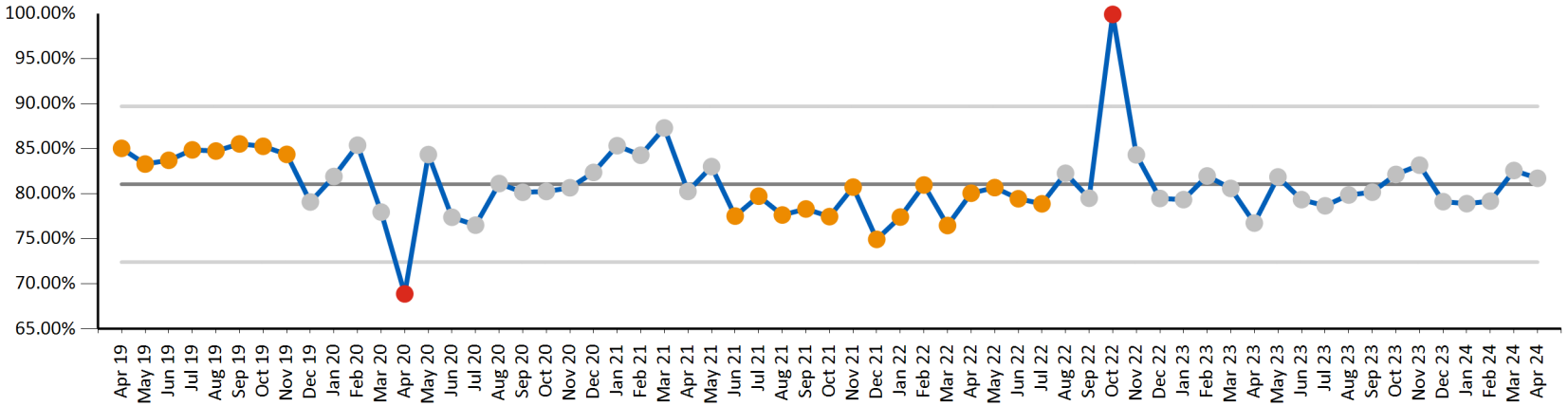
Plan	Actual	Period
	75.3%	Mar-24

Year to Date

Plan	Actual
	77.0%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	81.7%	Apr-24

Previous

Plan	Actual	Period
	82.6%	Mar-24

Year to Date

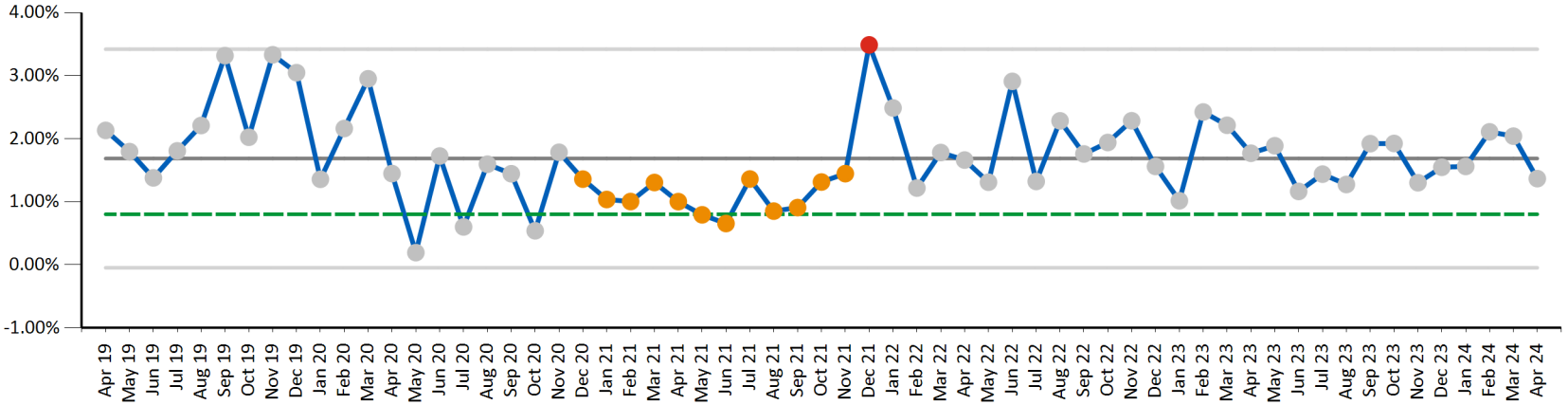
Plan	Actual
	81.7%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1%	1.4%	Apr-24

Previous

Plan	Actual	Period
<= 1%	2.0%	Mar-24

Year to Date

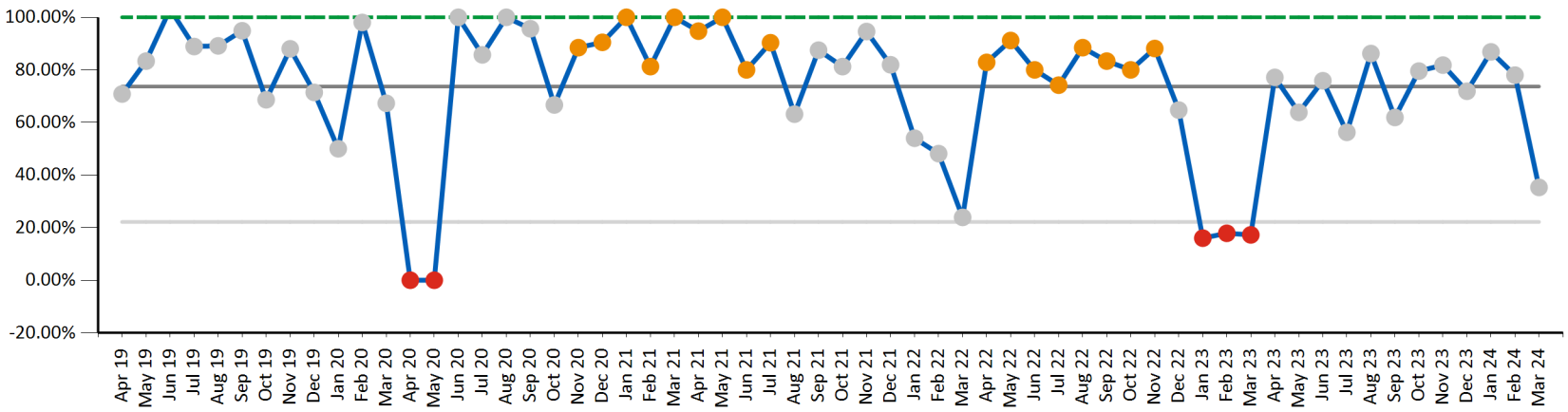
Plan	Actual
<= 1%	1.4%

62 - Cancelled operations re-booked within 28 days

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	35.3%	Mar-24

Previous

Plan	Actual	Period
= 100%	78.0%	Feb-24

Year to Date

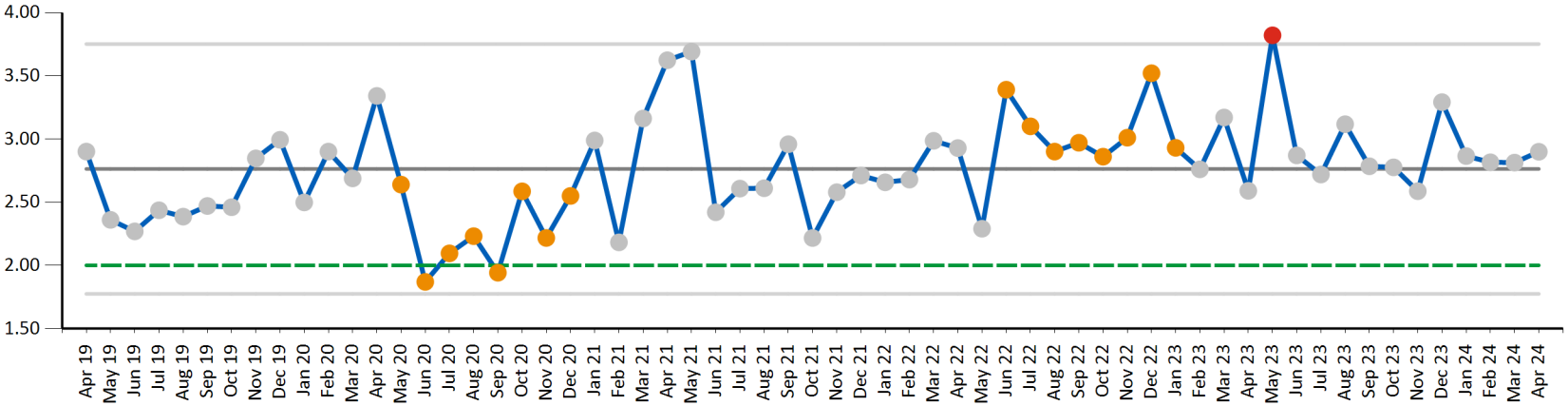
Plan	Actual
= 100%	26.8%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	2.90	Apr-24

Previous

Plan	Actual	Period
<= 2.00	2.81	Mar-24

Year to Date

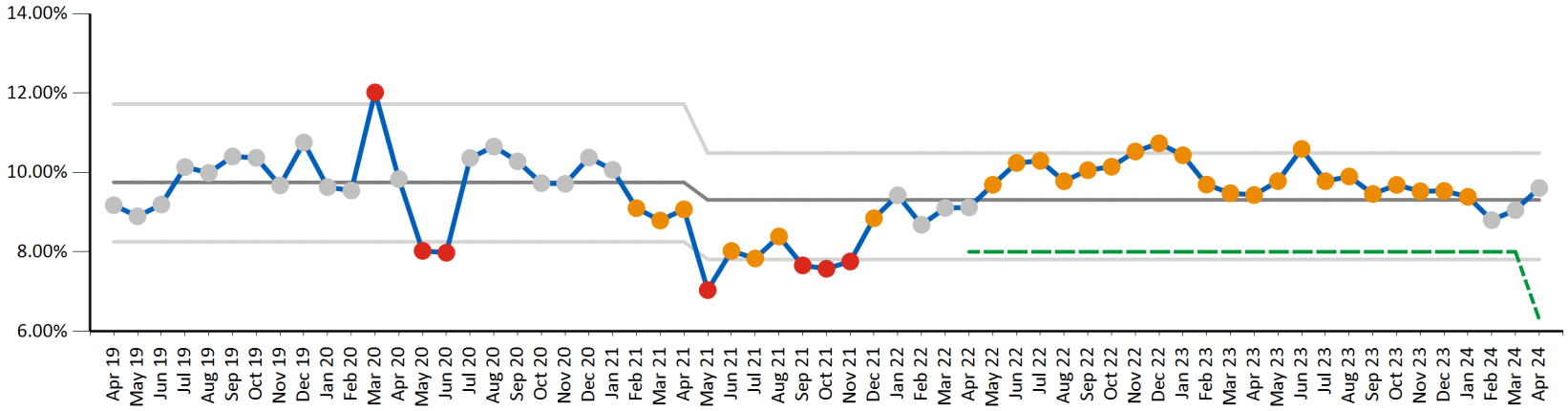
Plan	Actual
<= 2.00	2.90

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.6%	Apr-24

Previous

Plan	Actual	Period
<= 8.0%	9.1%	Mar-24

Year to Date

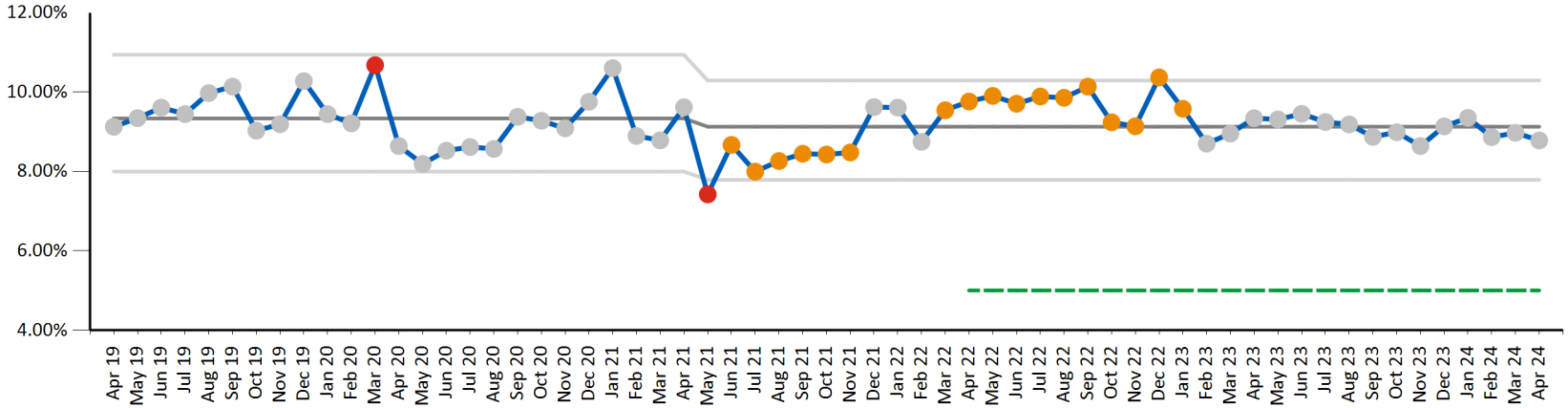
Plan	Actual
<= 6.3%	9.6%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.8%	Apr-24

Previous

Plan	Actual	Period
<= 5.0%	9.0%	Mar-24

Year to Date

Plan	Actual
<= 5.0%	8.8%

Operational Performance - Cancer

NHS Bolton NHS Foundation Trust

For March, we achieved the faster diagnosis standard, and the 31-day treatment standard. We achieved performance against the 62-day standard, however it is not expected that this will be sustained in April. We remain on track for sustained recovery of the 62 day standard from May 2024 as a result of delivery of the cancer recovery plans at specialty level.

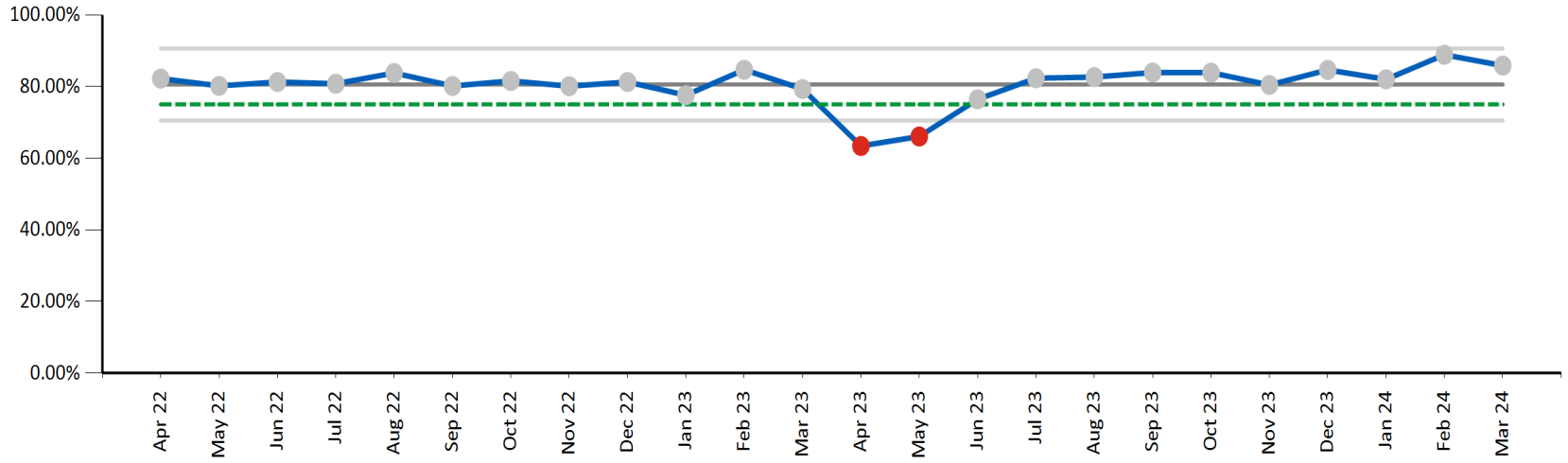
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	85.8%	Mar-24		>= 75.0%	88.9%	Feb-24	>= 75.0%		
584 - 31 Day General Treatment Standard	>= 96%	99.1%	Mar-24		>= 96%	100.0%	Feb-24	>= 96%		
585 - 62 Day General Standard	>= 85%	85.2%	Mar-24		>= 85%	81.9%	Feb-24	>= 85%		

542 - Cancer: 28 day faster diagnosis

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	85.8%	Mar-24

Previous

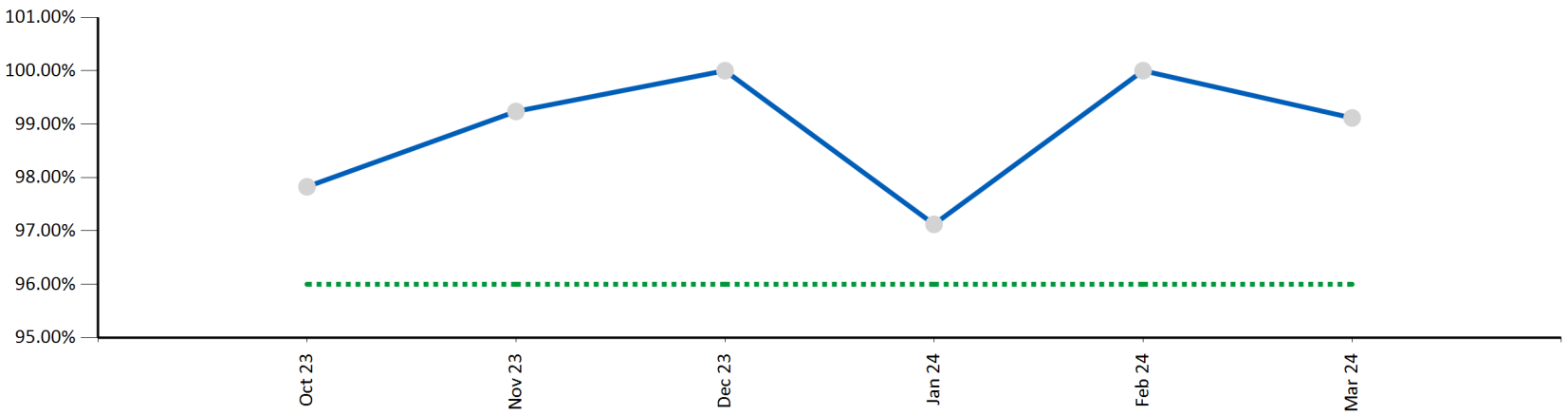
Plan	Actual	Period
>= 75.0%	88.9%	Feb-24

Year to Date

Plan	Actual
>= 75.0%	80.4%

584 - 31 Day General Treatment Standard - SPC data available after 20 data points

6/6



Latest

Plan	Actual	Period
>= 96%	99.1%	Mar-24

Previous

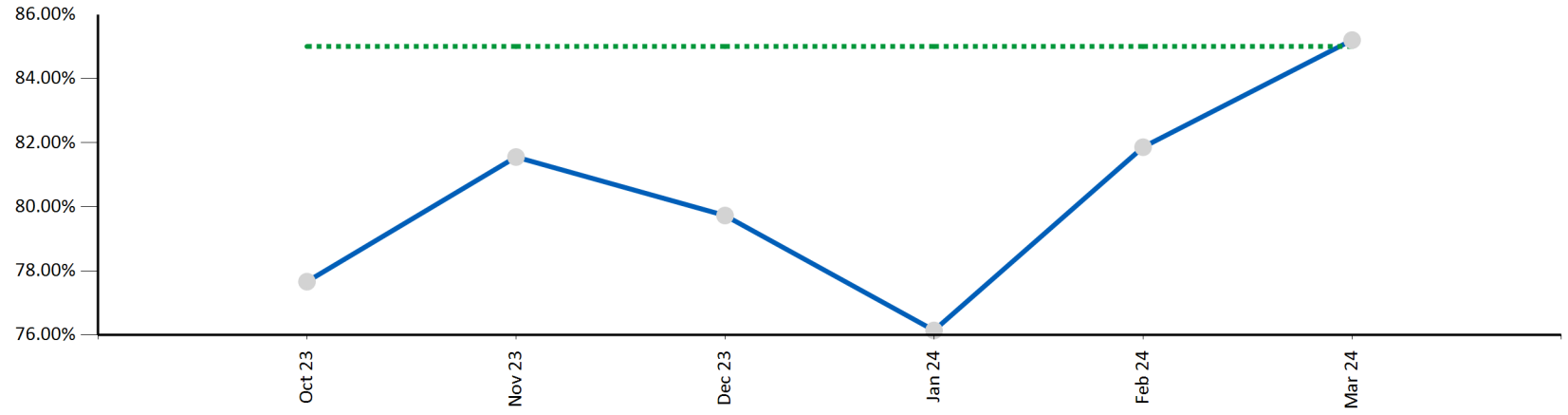
Plan	Actual	Period
>= 96%	100.0%	Feb-24

Year to Date

Plan	Actual
0.96	98.8%

585 - 62 Day General Standard - SPC data available after 20 data points

1/6



Latest

Plan	Actual	Period
>= 85%	85.2%	Mar-24

Previous

Plan	Actual	Period
>= 85%	81.9%	Feb-24

Year to Date

Plan	Actual
0.85	80.3%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

ED deflections

ED deflections for Month 1 have increased to 565, which is above plan of 400. This continued increase in deflections demonstrates the impact of the continued work by AAT in relation to promotion of the 2 hour Urgent Care Response pathways into the service from NWAS, Primary Care and Care Homes. An 'alternatives to ED' day was held in April, the aim of the event was to support the use of community options, promote the use of deflection pathways and scope opportunities to implement new virtual ward pathways. Ongoing work has been identified to support ED deflections and use of the 30 day readmission pathway.

NCTR

The number of patients with No Criteria to Reside has increased in month, above our operating plan, at an average of 102. Additions to NCTR were in line with usual variation however continued ongoing backlog from M12 has resulted in challenges in reducing NCTR to operating plan of 90.
Occupied bed days has slightly increased to 912 from 900. We continue above plan for occupied bed days due to backlog from the 4 day bank holiday weekend, social work capacity within IDT, IPC ward closures and OOA flow to Bury and Salford. A recovery plan is in place and forecasted to provide a reduction by end of M2 in relation to NCTR numbers and lost bed days.

0-5 Years Mandated Contacts

We are seeing continued underperformance in this area due to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors (a national shortage). Health visitors are unfortunately continuing to leave the organisation and we are now below the threshold of 40 WTE which is required to maintain our core services. This issue is identified within our organisational risk register. Our contract negotiations are progressing well with Bolton Council regarding the 0-19 service.

EHCP compliance

There has been a deterioration in month due to staffing pressures within the service. There were 7 breaches in total, 2 of which were delayed submission from clinical teams (due to the staffing pressures). The service completed/finalised 19 EHCP's in April. An escalation process has been put in place and prioritisation of EHCP co-ordination in order to manage the situation until the staffing pressures are resolved.

Looked After Children

There has been good performance across our pathways of care for Looked After Children; Initial health assessments increased this month to 82.6% from 47.0%, review health assessments by health visitors and school nurses improved to 95% and review health assessments in special schools achieved 100%.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	565	Apr-24	L	>= 400	516	Mar-24	>= 400	565	?
493 - Average Number of Patients: with no Criteria to Reside	<= 90	102	Apr-24		<= 90	97	Mar-24	<= 90	102	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	912	Apr-24		<= 400	900	Mar-24	<= 360	912	F

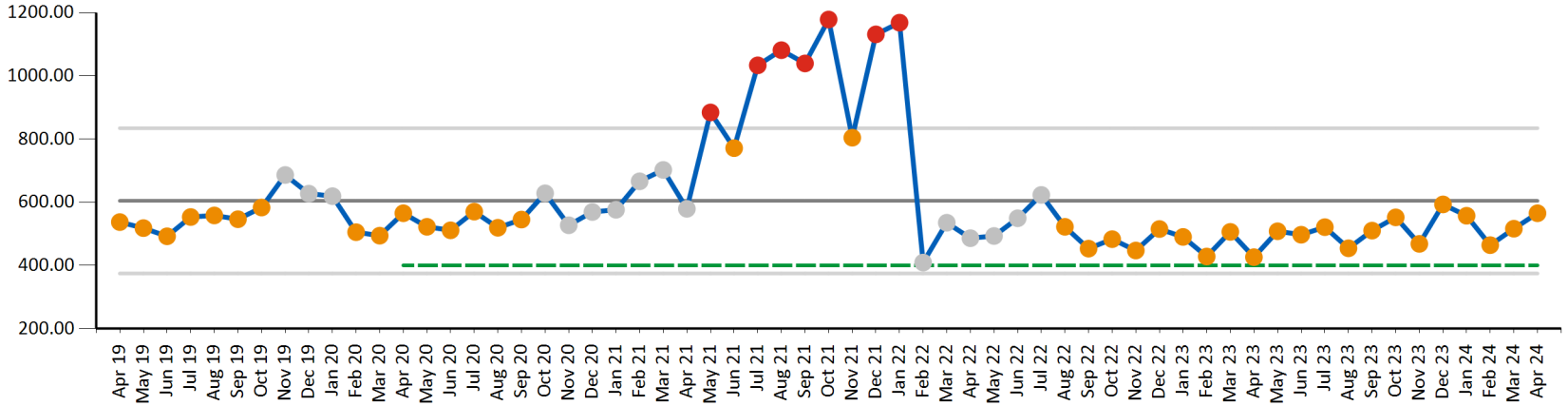
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
267 - 0-5 Health Visitor mandated contacts	>= 95%	70%	Apr-24		>= 95%	69%	Mar-24	>= 95%	70%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	63%	Apr-24		>= 95%	67%	Mar-24	>= 95%	63%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	95.0%	Apr-24			87.0%	Mar-24	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	83.0%	Apr-24			47.0%	Mar-24	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Apr-24			100.0%	Mar-24	>= 90.0%		

334 - Total Deflections from ED

L — Special cause variation with deteriorating performance

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

6/6



Latest

Plan	Actual	Period
>= 400	565	Apr-24

Previous

Plan	Actual	Period
>= 400	516	Mar-24

Year to Date

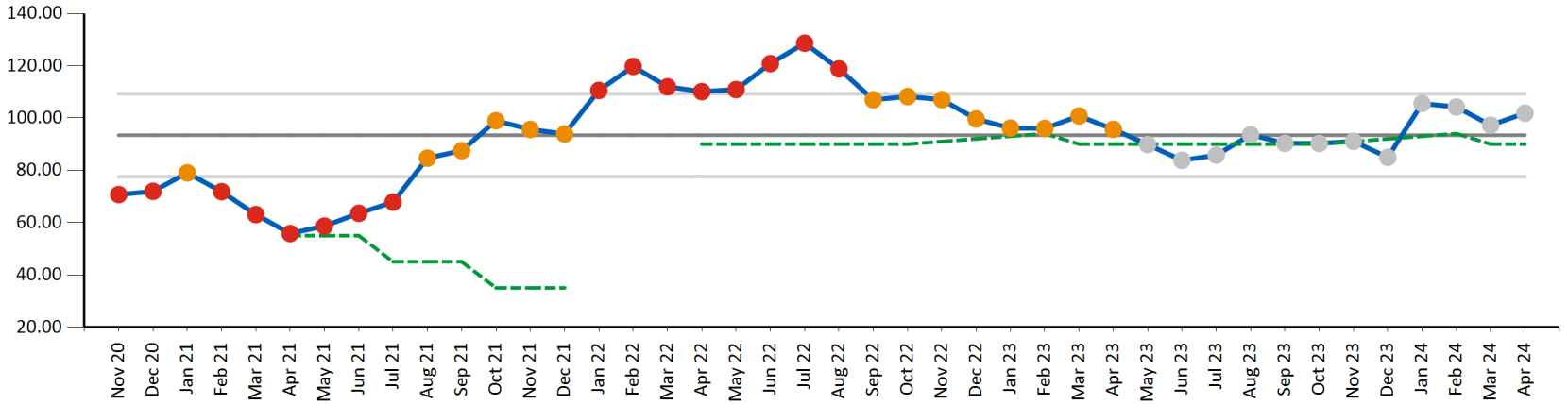
Plan	Actual
>= 400	565

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 90	102	Apr-24

Previous

Plan	Actual	Period
<= 90	97	Mar-24

Year to Date

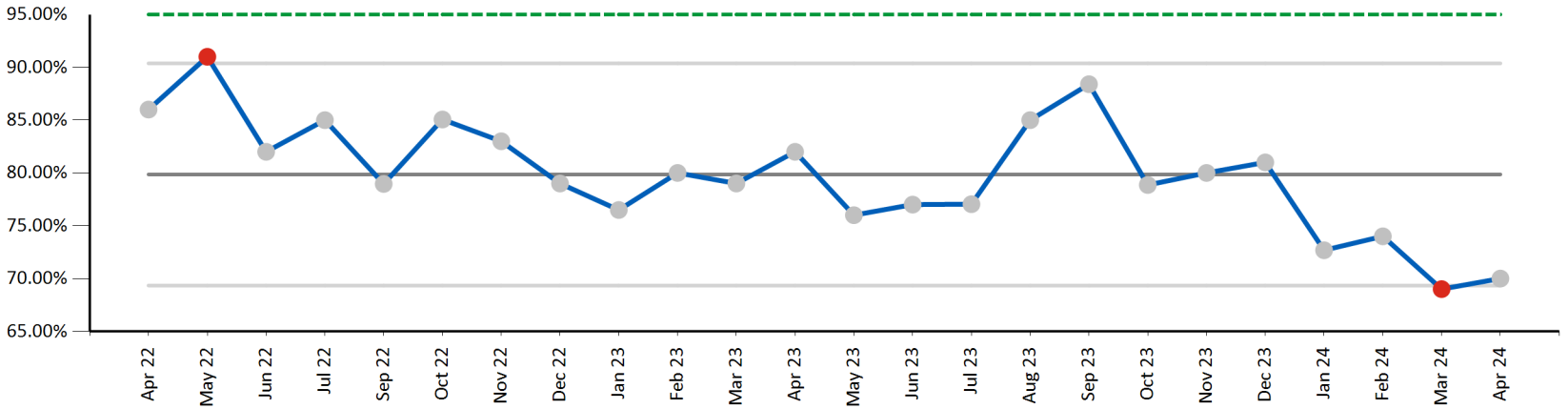
Plan	Actual
<= 90	102

267 - 0-5 Health Visitor mandated contacts

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	70%	Apr-24

Previous

Plan	Actual	Period
>= 95%	69%	Mar-24

Year to Date

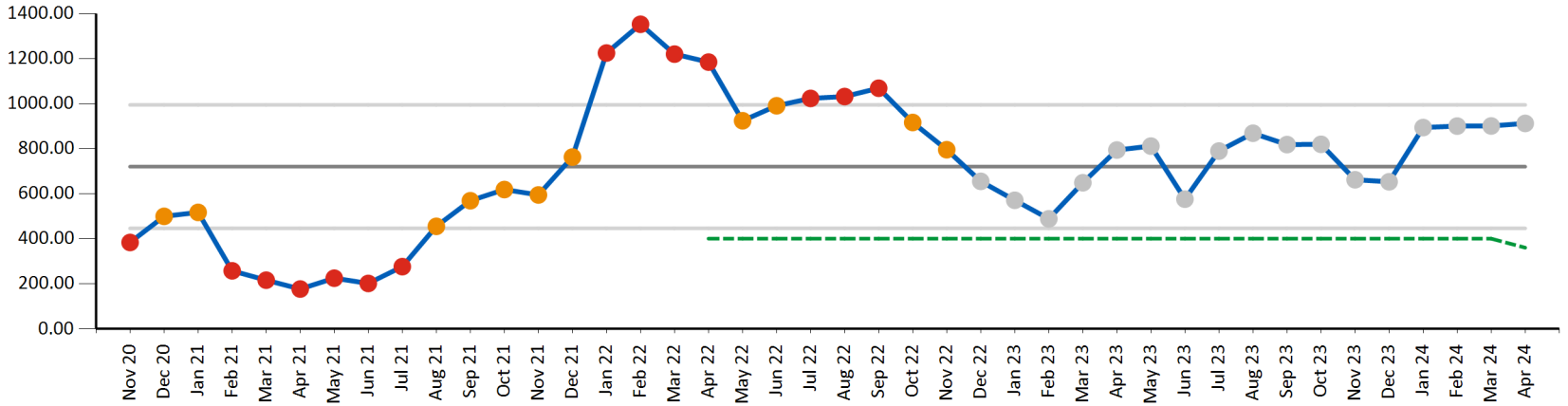
Plan	Actual
>= 95%	70%

494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	912	Apr-24

Previous

Plan	Actual	Period
<= 400	900	Mar-24

Year to Date

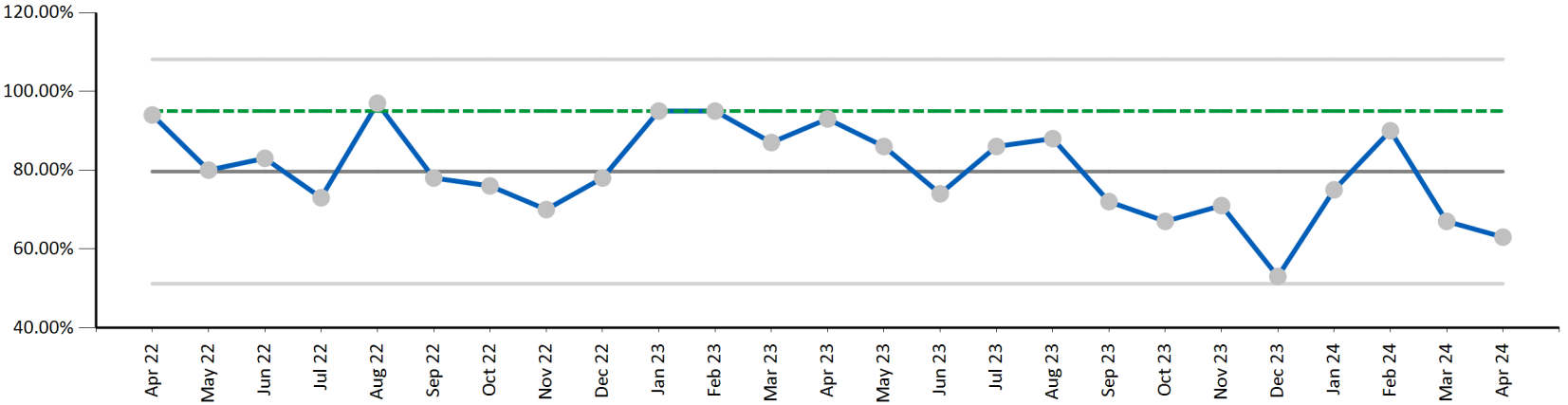
Plan	Actual
<= 360	912

269 - Education, health and care plan (EHC) compliance

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	63%	Apr-24

Previous

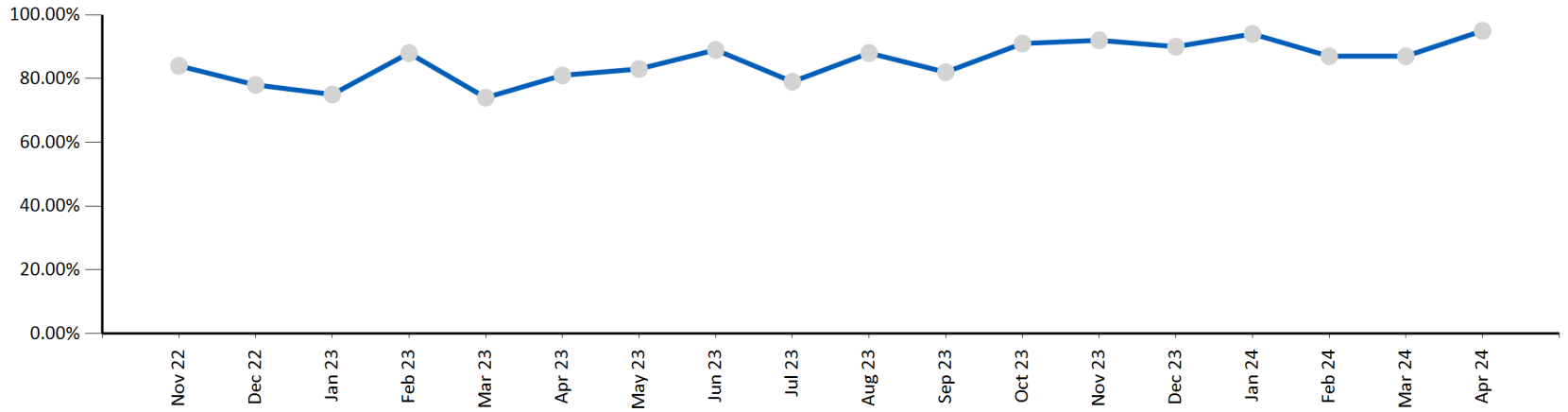
Plan	Actual	Period
>= 95%	67%	Mar-24

Year to Date

Plan	Actual
>= 95%	63%

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

1/6



Latest

Plan	Actual	Period
> = 90.0%	95.0%	Apr-24

Previous

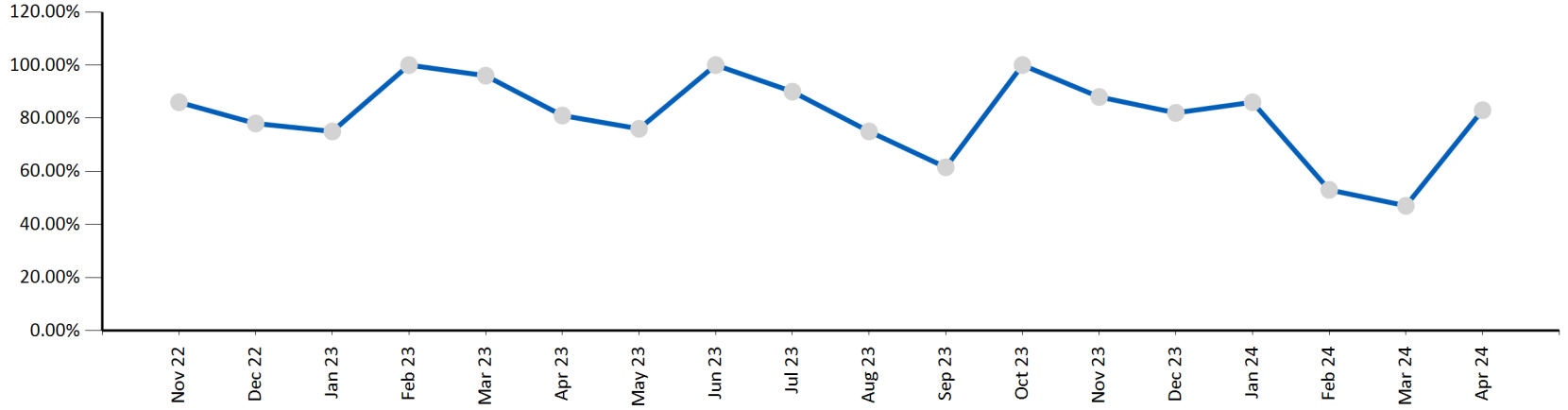
Plan	Actual	Period
	87.0%	Mar-24

Year to Date

Plan	Actual
0.9	

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

0/6



Latest

Plan	Actual	Period
> = 90.0%	83.0%	Apr-24

Previous

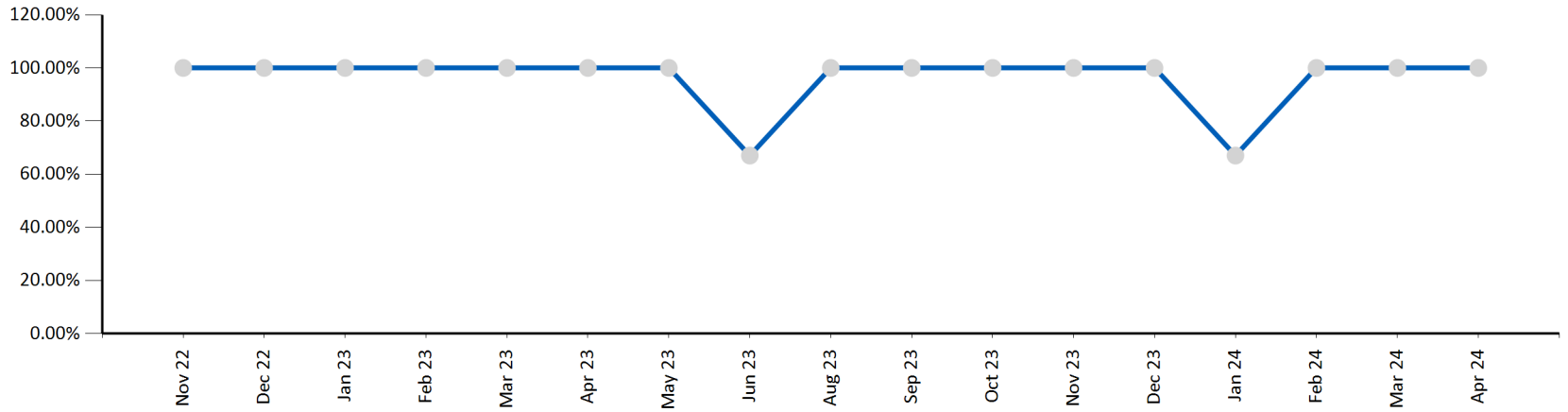
Plan	Actual	Period
	47.0%	Mar-24

Year to Date

Plan	Actual
0.9	

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

1/6



Latest

Plan	Actual	Period
>= 90.0%	100.0%	Apr-24

Previous

Plan	Actual	Period
	100.0%	Mar-24

Year to Date

Plan	Actual
0.9	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness reduced significantly in month from 5.17% to 4.78% in April 2024 and is the third consecutive month of reduction in sickness absence. There were significant reductions in sickness rates within ASSD, DSSD and ICSD (0.64%, 0.53% and 0.44% reductions respectively) with DSSD now achieving the Trust target. The Divisional and Workforce teams continue to work together to closely monitor sickness, and provide a range of health and well-being support to our staff.

Turnover:
Trust Turnover showed a small reduction in April 2024 to 11.43%. We expect turnover in the 2024/2025 financial year to be relatively static following 2023/2024 where we saw a significant reducing trend.

Vacancy:
Trust vacancy level reduced to 5.09% in April. We have been under our target of a 6% vacancy level since June 2023. We expected the in-month reduction in line with strong recruitment activity which has filled (in the main) clinical vacancies across the Trust.

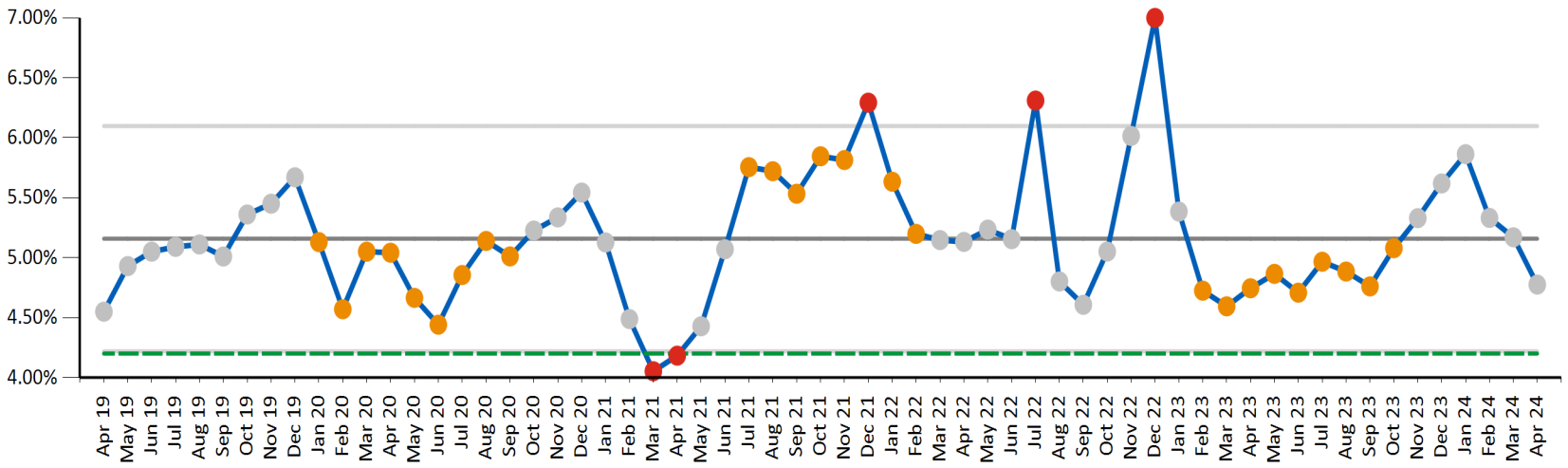
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.78%	Apr-24		<= 4.20%	5.17%	Mar-24	<= 4.20%	4.78%	F
120 - Vacancy level - Trust	<= 6%	5.09%	Apr-24	L	<= 6%	5.40%	Mar-24	<= 6%	5.09%	?
121 - Turnover	<= 9.90%	11.43%	Apr-24	L	<= 9.90%	11.65%	Mar-24	<= 9.90%	11.43%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Apr-24			0	Mar-24		0	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	4.78%	Apr-24

Previous

Plan	Actual	Period
<= 4.20%	5.17%	Mar-24

Year to Date

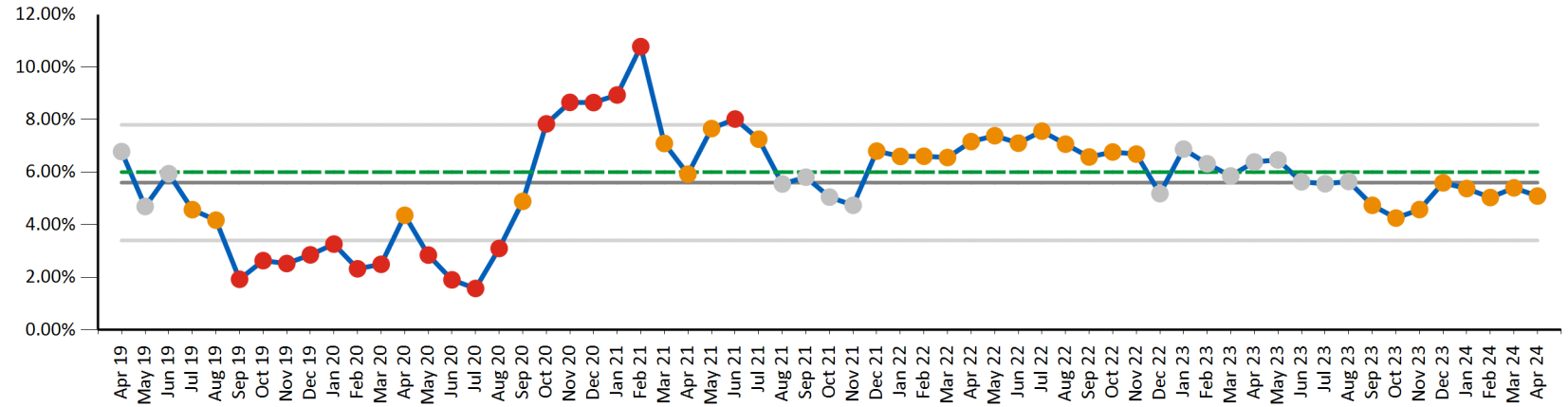
Plan	Actual
<= 4.20%	4.78%

120 - Vacancy level - Trust

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 6%	5.09%	Apr-24

Previous

Plan	Actual	Period
<= 6%	5.40%	Mar-24

Year to Date

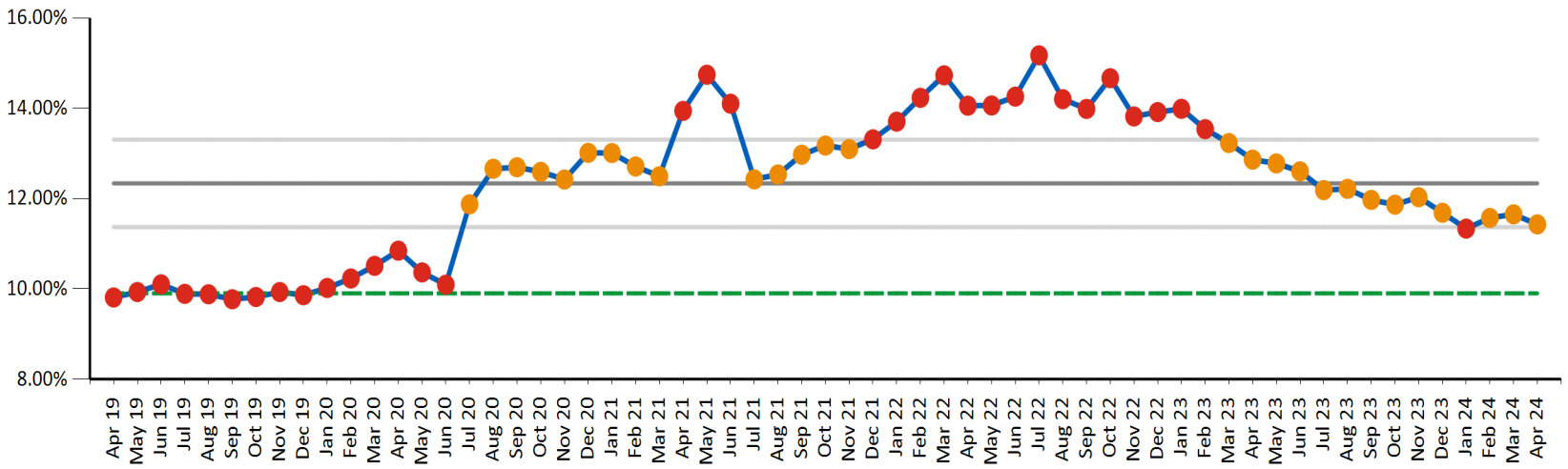
Plan	Actual
<= 6%	5.09%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.43%	Apr-24

Previous

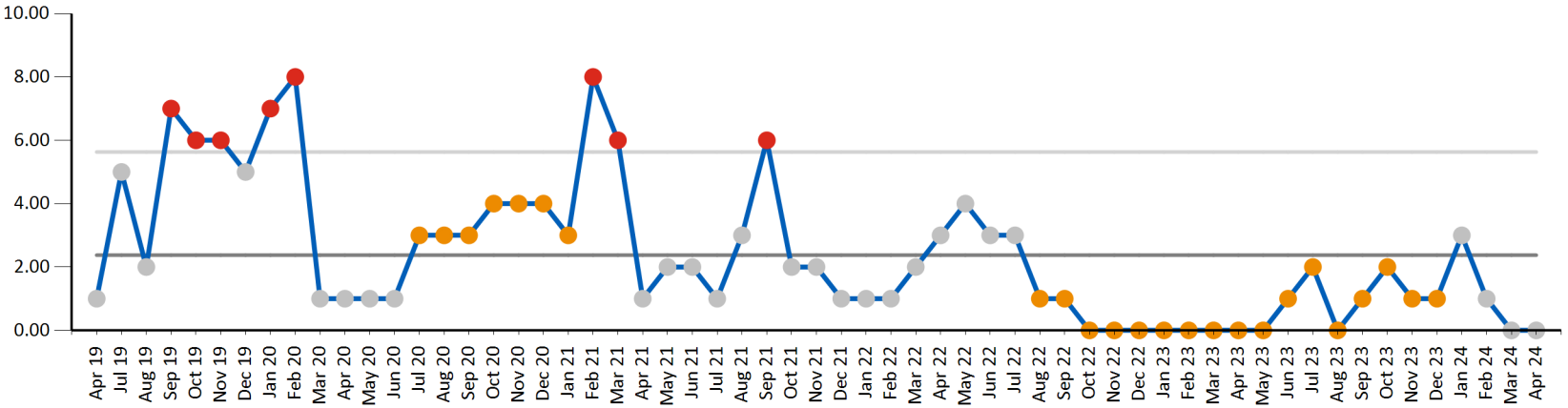
Plan	Actual	Period
<= 9.90%	11.65%	Mar-24

Year to Date

Plan	Actual
<= 9.90%	11.43%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-24

Previous

Plan	Actual	Period
	0	Mar-24

Year to Date

Plan	Actual
	0

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training
Safeguarding level 3 has been added to the Compulsory training reports this month making us compliant with the Core Skills Training Framework Subjects.
The Trust has remained static in month reporting 92% compliance against a target of 95%

Trust Mandated Training
There has been a small dip in Trust compliance from last month and for the first time in seven months we have dipped below 90% (89.29%). In line with national requirement Oliver McGowan (Learning Disability and Autism) has been added to the e-learning subjects that are to be completed by clinical staff. This has contributed to the slight dip overall

Appraisal
There has been a slight improvement in the appraisal rate compliance in month from 83.5% to 83.9%, however this still falls below the 85% target rate. Staff groups with low compliance rates have been contacted to determine what help they require to support an improvement

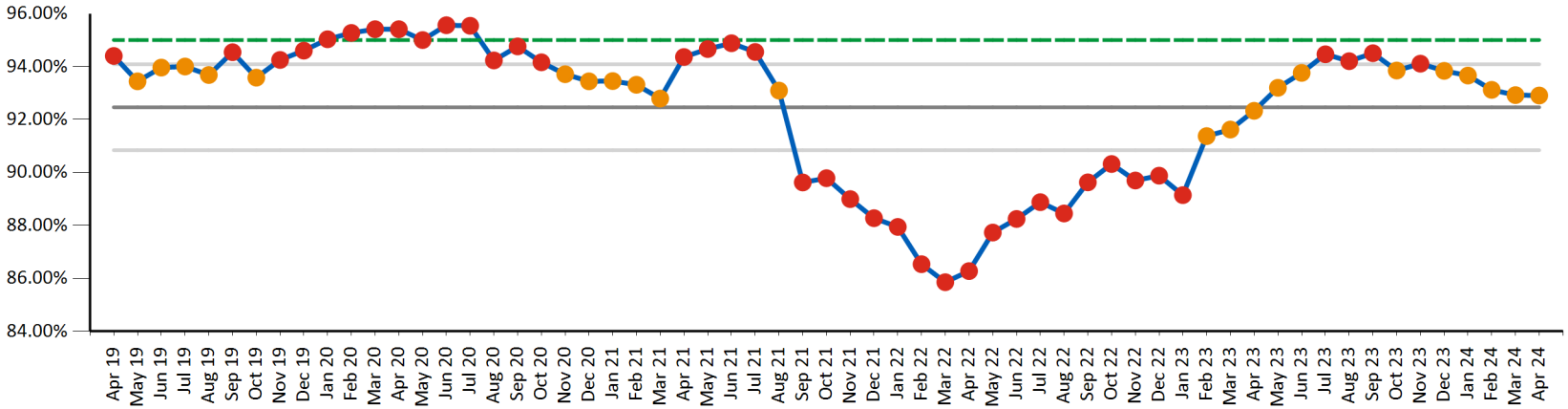
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	92.9%	Apr-24	H	>= 95%	92.9%	Mar-24	>= 95%	92.9%	F
38 - Staff completing Trust Mandated Training	>= 85%	89.3%	Apr-24		>= 85%	90.3%	Mar-24	>= 85%	89.3%	P
39 - Staff completing Safeguarding Training	>= 95%	91.91%	Apr-24	L	>= 95%	94.10%	Mar-24	>= 95%	91.91%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	83.9%	Apr-24	H	>= 85%	83.6%	Mar-24	>= 85%	83.9%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	51.1%	Q2 2023/24	L	>= 66%	58.3%	Q1 2023/24	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	57.8%	Q2 2023/24		>= 80%	61.8%	Q1 2023/24	>= 80%		F

37 - Staff completing Compulsory Training

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	92.9%	Apr-24

Previous

Plan	Actual	Period
>= 95%	92.9%	Mar-24

Year to Date

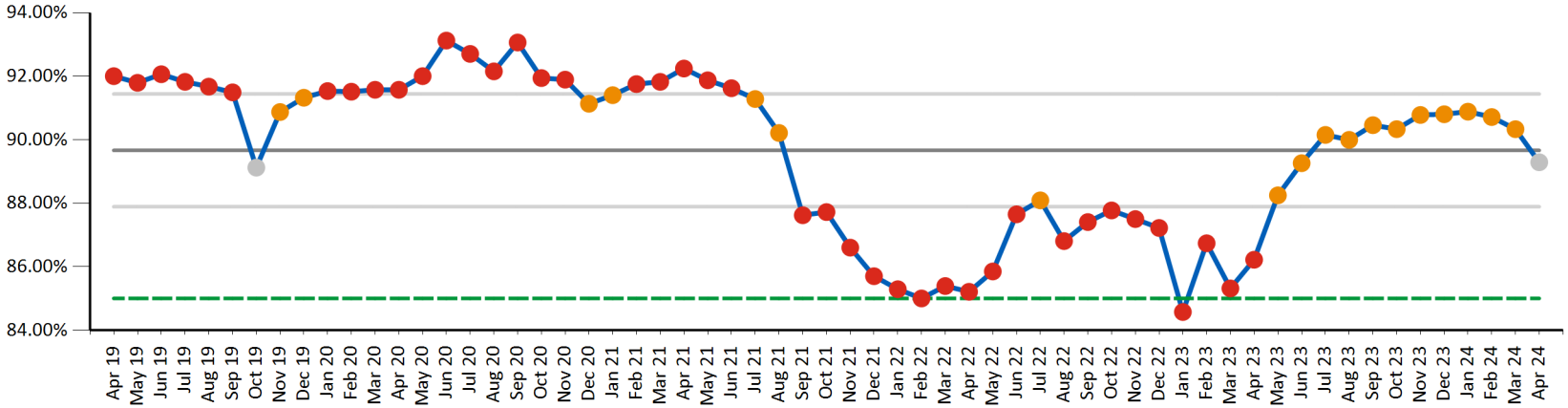
Plan	Actual
>= 95%	92.9%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	89.3%	Apr-24

Previous

Plan	Actual	Period
>= 85%	90.3%	Mar-24

Year to Date

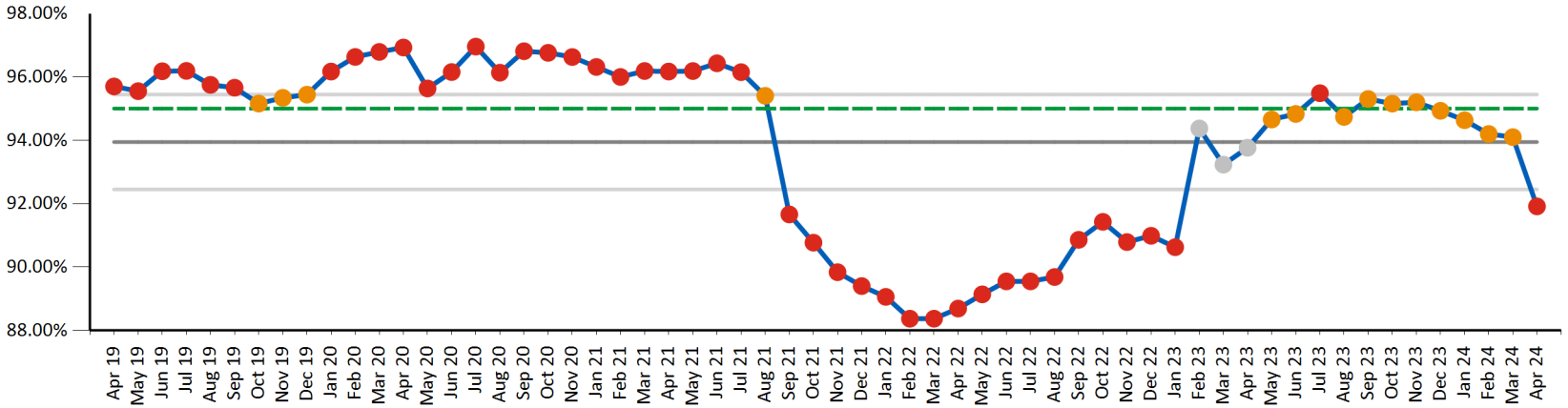
Plan	Actual
>= 85%	89.3%

39 - Staff completing Safeguarding Training

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
>= 95%	91.91%	Apr-24

Previous

Plan	Actual	Period
>= 95%	94.10%	Mar-24

Year to Date

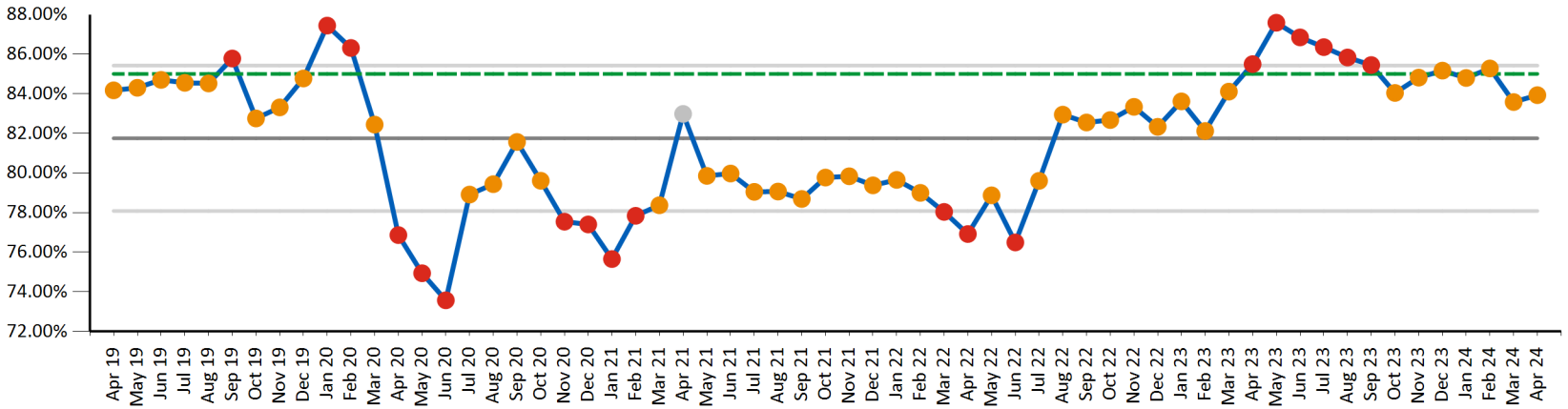
Plan	Actual
>= 95%	91.91%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

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

2/6



Latest

Plan	Actual	Period
>= 85%	83.9%	Apr-24

Previous

Plan	Actual	Period
>= 85%	83.6%	Mar-24

Year to Date

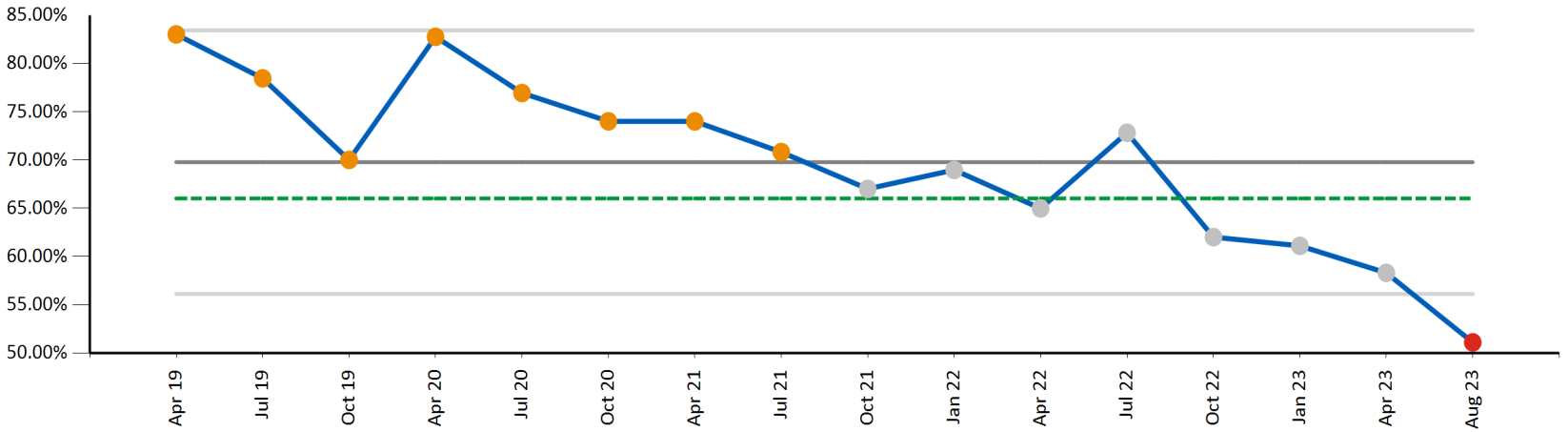
Plan	Actual
>= 85%	83.9%

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

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
>= 66%	51.1%	Q2 2023/24

Previous

Plan	Actual	Period
>= 66%	58.3%	Q1 2023/24

Year to Date

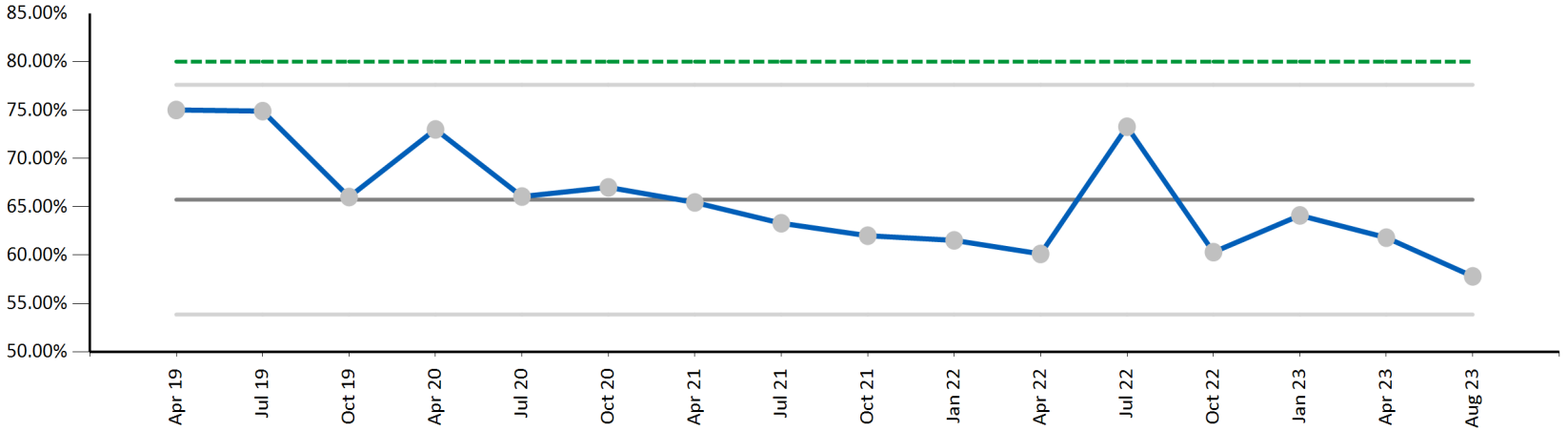
Plan	Actual
>= 66%	

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	57.8%	Q2 2023/24

Previous

Plan	Actual	Period
>= 80%	61.8%	Q1 2023/24

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Agency spend increased by £42k in April 2024. All agenda for change staffing groups showed a reduced spend trend in-month, and the entirety of the increase was driven by the Medical staff group (which increased overall by £139k in-month) – the majority of medical spending relates to vacant roles (either true vacancies or covering sickness or maternity leave).

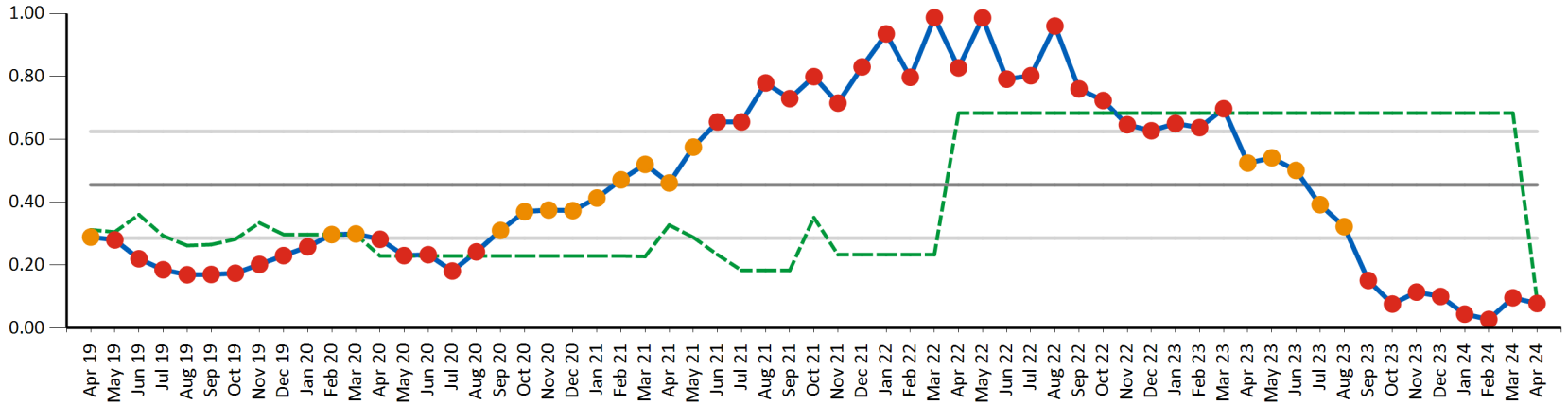
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.82	0.83	Apr-24	L	<= 1.38	0.79	Mar-24	<= 0.82	0.83	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.09	0.08	Apr-24	L	<= 0.68	0.10	Mar-24	<= 0.09	0.08	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.71	Apr-24	H	<= 0.62	0.57	Mar-24	<= 0.62	0.71	?

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

L Special cause variation with improving performance

F We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
<= 0.09	0.08	Apr-24

Previous

Plan	Actual	Period
<= 0.68	0.10	Mar-24

Year to Date

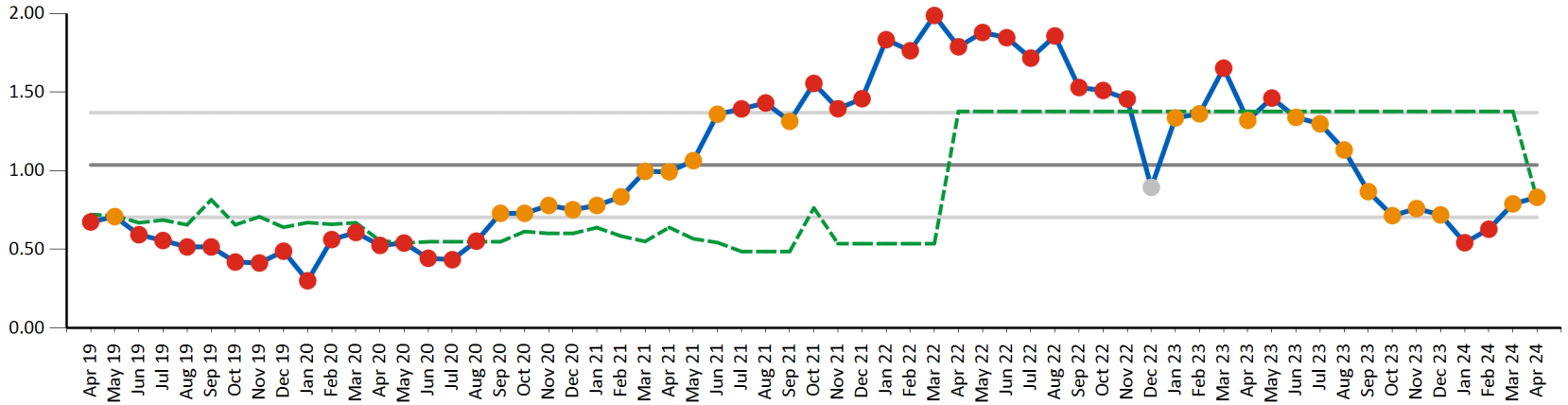
Plan	Actual
<= 0.09	0.08

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

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
<= 0.82	0.83	Apr-24

Previous

Plan	Actual	Period
<= 1.38	0.79	Mar-24

Year to Date

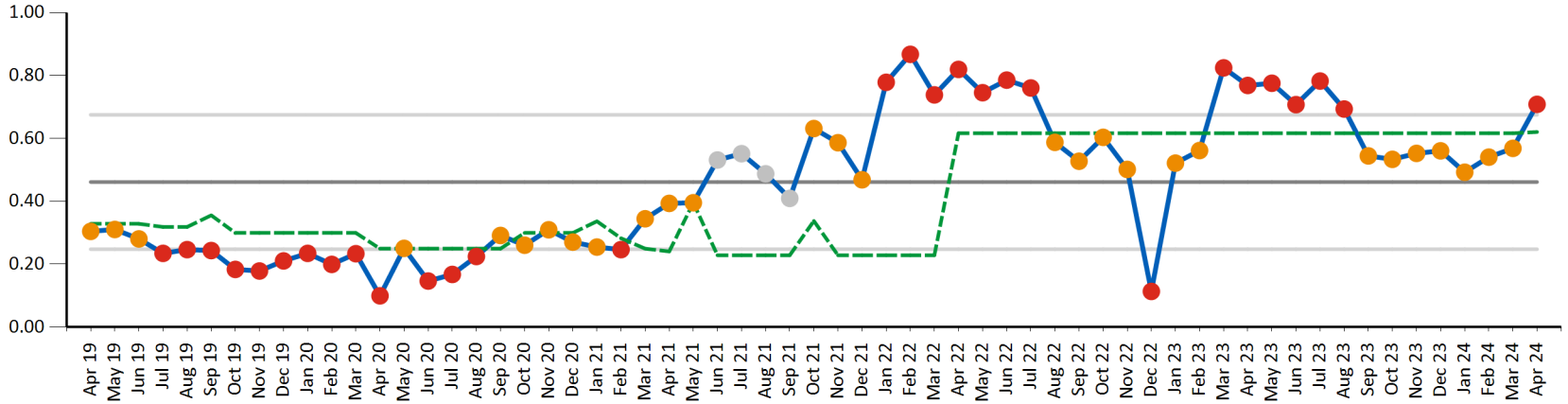
Plan	Actual
<= 0.82	0.83

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

Special cause variation with deteriorating performance

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

5/6



Latest

Plan	Actual	Period
<= 0.62	0.71	Apr-24

Previous

Plan	Actual	Period
<= 0.62	0.57	Mar-24

Year to Date

Plan	Actual
<= 0.62	0.71

Finance - Finance

Revenue YTD - Deficit of £2.1m, off plan by £0.2m
Revenue forecast - High level forecast, assuming current run rate, suggests deficit of £29.7m compared to plan of £11.2m.
Cost improvement - Month 1 delivery £0.1m higher than plan.
Variable pay - Agency spending 2.8% of pay costs compared to target of 3.2% and a plan of 2.2%.
Capital - Continued pressure on forecast.
Balance Sheet - Decrease on total assets employed due to deficit.
Cash Position - Current Cash of £8.3m vs plan of £13.7m. Forecast £3.4m overdrawn before support, based on delivering plan. Planned cash support of £5m from Q3.
BPPC - 93.6% YTD v target of 95% (by volume)

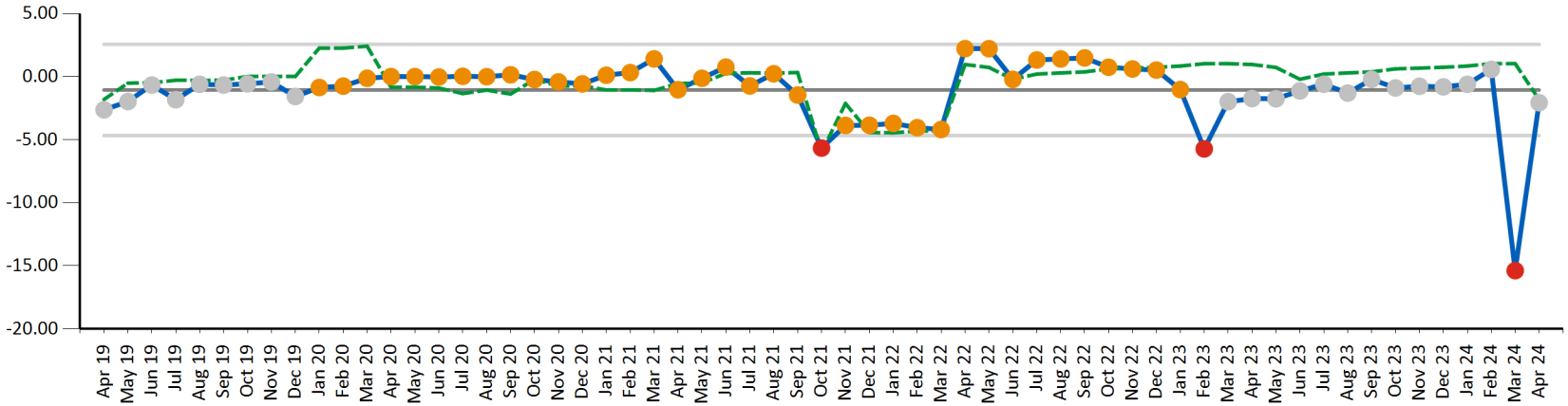
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.8	-2.1	Apr-24		>= 1.0	-15.4	Mar-24	>= -1.8	-2.1	
222 - Capital (£ millions)	>= 0.9	0.1	Apr-24		>= 4.3	4.6	Mar-24	>= 0.9	0.1	
223 - Cash (£ millions)	>= 13.7	8.6	Apr-24		>= 36.6	15.9	Mar-24	>= 13.7	8.6	

220 - Control Total (£ millions)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= -1.8	-2.1	Apr-24

Previous

Plan	Actual	Period
>= 1.0	-15.4	Mar-24

Year to Date

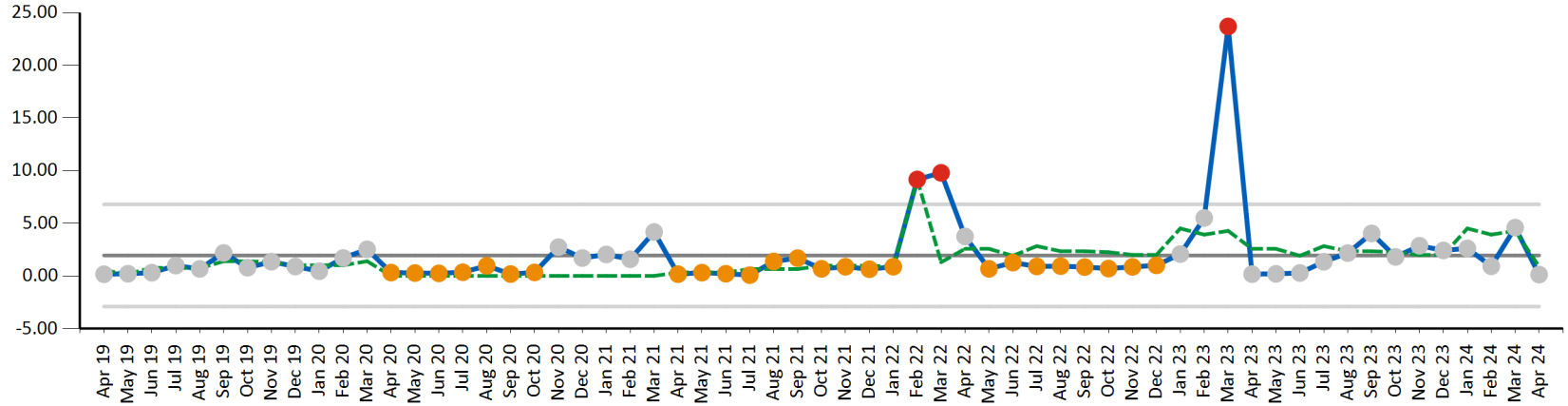
Plan	Actual
>= -1.8	-2.1

222 - Capital (£ millions)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 0.9	0.1	Apr-24

Previous

Plan	Actual	Period
>= 4.3	4.6	Mar-24

Year to Date

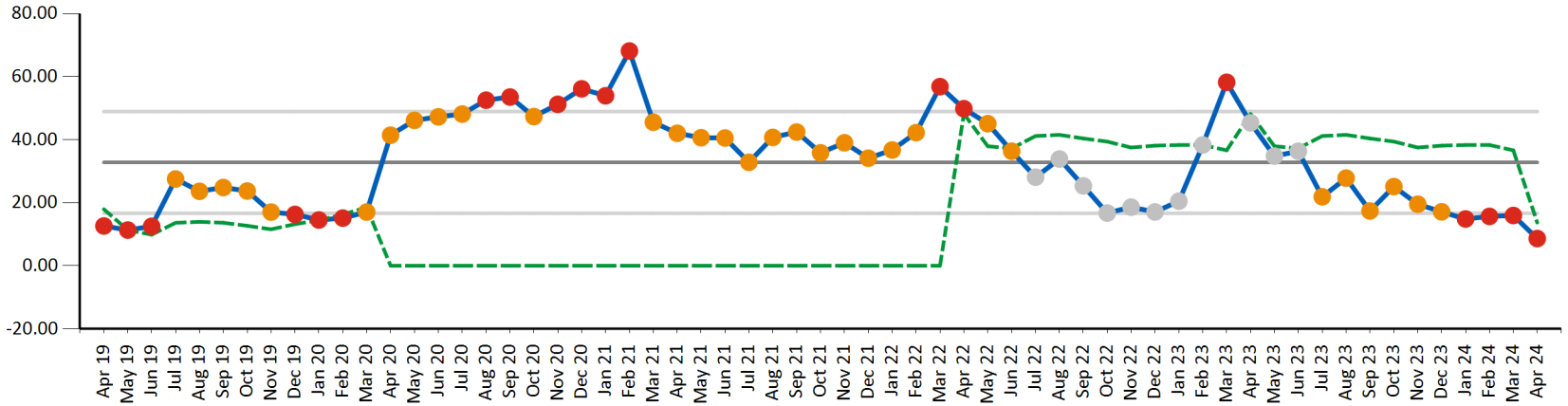
Plan	Actual
>= 0.9	0.1

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
>= 13.7	8.6	Apr-24

Previous

Plan	Actual	Period
>= 36.6	15.9	Mar-24

Year to Date

Plan	Actual
>= 13.7	8.6

Report Title:	Trust Strategy 2024-29

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Sharon White		Decision	✓

Purpose	To present the Trust Strategy 2024-29 for approval.

Summary:	Following review and endorsement by the Committees of the Board, the 2024-29 strategy is presented to the Board for final approval. The Board is also asked to approve the high-level summary of the strategy.

Previously considered by:
The Strategy was presented to the Finance & Investment Committee, Governors' Strategy Committee, People Committee, Quality Assurance Committee and the Strategy & Operations Committee.

Proposed Resolution	The Board is asked to ***approve*** the strategy and summary document

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

Prepared by:	Rachel Noble, Deputy Director of Strategy Sharon White, Director of Strategy, Digital and Transformation	**Presented by:**	Sharon White, Director of Strategy, Digital and Transformation

1. Introduction

This paper introduces the final version of the Trust strategy for 2024-29 and a short, summary document for approval by the Board. This follows review by all of the Committees of the Board and Governors' Strategy Committee in May.

2. Feedback from Committees of the Board and changes made

The draft strategy document and KPIs were presented to Finance & Investment Committee, People Committee, Quality Assurance Committee and Strategy & Operations Committee in May. All Committees were content to recommend the strategy document for approval by the Board subject to minor amendments, which have been incorporated into the narrative document.[1]

A summary document is also enclosed which provides a more accessible view of our ambitions and outcomes for the next five years.

3. Actions to be completed pre-publication

Discussion at the Committees of the Board predominantly focused on the KPIs and measures of success. A number of simple edits and amendments have been made to the list of KPIs, but further work will be completed to:

- Make the KPIs more specific by including anticipated dates for delivery and percentage targets where appropriate
- Clarifying priority KPIs/measures so our core focus is clearer
- Refining and editing KPIs/measures so that the list is as concise as possible
- Ensuring that the balance is right between quantitative and qualitative measures

To enable this work to be completed, the KPIs are not included for approval, and amendments will be discussed and agreed with the Executive prior to publication.

4. Timescales and next steps

Final edits and amendments will be made to the KPIs by early June to enable sign off by the Executive.

The summary document and strategy will be designed ready for publication, and an animation will be produced to support the launch.

The strategy will be launched at the service review day in June, and published on both the Trust website and intranet. In line with the recommendations from the CQC, work will continue to ensure that staff know about and understand the strategy with the following priority actions taking place:

- Continuing to embed the ambitions and outcomes in staff communications
- Developing and publishing the annual plan to deploy the strategy into the organisation

[1] A suggestion was made to amend the 'financially sustainable' outcome to make the language more accessible. This amendment will be made in the final designed version of the document.

- Aligning existing documentation with the new strategy branding so that it is clear how each document aligns to the strategy
- Refresh of the appraisal process and behaviour framework to align with our ambitions
- Commitment to regular progress reports to Committees, staff and our population

5. Recommendation

The Board is asked to **approve** the strategy and the summary document.

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Our Trust Strategy

2024 - 2029

... for a better Bolton

Foreword from our Chief Executive and Chair

Our strategy for 2024-2029 sets out our vision for the future, and the work that will be delivered to make it a reality over the next five years.

It has been developed based on the knowledge, experience and ambition we share across our teams and most importantly, based on what matters most to the people we serve – our patients, families and communities.

We are proud to be an integrated community and acute Trust, delivering services across Bolton.

We know that for some, life is not easy with the cost of living on the rise, life expectancy in Bolton being lower than the England average and health outcomes differing greatly depending on postcode.

Our strategy demonstrates our commitment to addressing the challenges we face by improving our care and transforming the lives of our local population, through the delivery of five core ambitions.

To be able to achieve this and consistently provide the high quality care our communities deserve, we know that we need to push boundaries by embracing technology, research and innovation to transform health and care. This will only be possible by creating the right conditions for our staff to be able to learn, develop and have long and fulfilling careers with us.

A huge thank you for the contributions you have made in shaping our strategy, and for the part you will play in bringing it to life.

Fiona Noden
Chief Executive Officer

Dr Niruban Ratnarajah
Chair

Our 2019-24 strategy

What we achieved

When we developed our previous five-year strategy, we did not anticipate the years ahead to be some of the most challenging we have ever faced in the history of healthcare. Despite this we still managed to achieve some incredible things. Highlights included:

- Opening four new theatres and a community diagnostic centre (CDC) following national investment in our estate.
- Delivering against our recovery targets to eliminate the longest waits for our care.
- Becoming an exemplar site for the recruitment of international nurses.
- Working in partnership with the University of Bolton to develop a medical learning facility on our hospital site.
- Our Chief Executive was appointed as Place-Based lead for Bolton.

What we learned

Through our review of the 2019-24 strategy, it was clear that we did not always set the right performance indicators that would enable us to track and report on our progress. The learning from this has resulted in a very different approach to tracking and monitoring for our new strategy, with clear measures of success and key performance indicators aligned to each outcome.

When we developed our previous five-year strategy in 2019, we set out to improve the outcomes and experience of the people we serve and address the gaps we identified in quality, workforce, finance and efficiency. Whilst we have seen good progress in these areas over the last few years, there is still work to be done to address these gaps. All of the priorities from 2019-24 that remain important and relevant to our progress, are embedded in our new ambitions and outcomes[1].

Where we are now

Through our work to develop this strategy, we have considered the key challenges we face that require our focused attention over the next five years.

1. Our population is growing and changing

- Bolton's population is approaching 300,000 people in 2024 and is predicted to rise by 4.3% per year. This means that our town may grow by around 55,000 people by 2029. We can therefore expect that demand for our services will rise unless we do more to prevent ill health and improve pathways of care.
- Unfair differences in health between different groups of people, known as health inequalities, are more pronounced.

[1] A full report of performance against our 2019-24 measures of success is included at Annex A.

- 26% of Bolton residents live in an area that is among the 10% most deprived in England and 56% live in an area that is in the most deprived. We know that this is likely to contribute towards their overall health and wellbeing, with the most deprived living on average, 11 years less than people living in areas that are more affluent.
- Circulatory, respiratory, cancer and digestive diseases account for over 60% of the life expectancy gap in Bolton.

2. How we organise and deliver our services is more important than ever

- Providing the highest quality of care for the people we serve remains our top priority but this is becoming more challenging with constraints in staffing and finances.
- Reducing waiting times is a national priority and people in Bolton are still waiting longer that we would like for treatment.
- There is a national shortage of some clinical staff groups, meaning that it is becoming harder to recruit staff to certain specialties. Without adequate staffing in place, reducing waiting times and meeting the needs of our population becomes more challenging.
- Our ageing estate is affecting our ability to provide services in the way we want to and the Greater Manchester financial position means that we have less money to invest in our estate.
- As our population grows, we will need to be more innovative in how we plan to meet demand for our services. We know that growing and expanding our workforce and our buildings is not a long-term solution, and we therefore need to think differently about how we serve our population.
- Delivering services at a neighbourhood level in Bolton means we have an opportunity to better meet the needs of our population, by delivering more services locally.
- Advances in medicine and technology mean that we have opportunities to improve quality through a focus on safety, experience, effectiveness and efficiency.
- We have good relationships with our local partners and we work together to achieve shared outcomes that benefit our local communities.
- To support our population we need to work towards integrating and consolidating our services across the providers, standardising patient pathways and bringing together the healthcare organisations to work collectively to improve health care delivery and health outcomes.
- We want our clinicians to lead the way in designing new ways of working with services users and communities, so we are in a strong position to address the complex challenges they face.

3. The NHS needs to deliver savings

Delivering this strategy will require the Trust to be financially sustainable so we can plan for investment in our people, estate and equipment. The financial impact that COVID-19 has had and is continuing to have on our Trust and the wider NHS system is still being felt, it is significant and will impact on the decisions that we make about the use of our collective resources going forwards.

We will work as part of a wider system to develop a 3-5 year sustainability plan that will return the Greater Manchester Integrated Care Board to financial sustainability.

To achieve this we need to reduce costs whilst still delivering quality services and improving productivity. We therefore need to focus on ways to make our services more efficient, effective and productive.

Working to reduce the impact of these three primary challenges is critical to our success over the next five years, and our new ambitions and objectives are structured to help us respond to them.

What people told us was important to them

Our new strategy is not just about addressing the challenges we face, but about building an organisation that we can all be proud of. To do that, we asked our patients, communities, local carers and our staff to tell us what is most important to them.

Our patients and population told us that:

- They want services to be easy to access when they need them.
- They want to be able to make choices about their care and appointments.
- They want to be treated with compassion and respect, and to be involved in decisions about their care.
- They want regular communication and updates about their care.
- They want services in Bolton to be more joined-up and easier to navigate.

Carers told us:

- They want to be listened to and supported to access healthcare in ways that work for them.
- They want to feel valued for the contribution and recognised as an expert in the care they provide.
- They want to be listened to and action taken to address concerns they raise.

Our staff told us that:

- They want to be supported to do their best for the people we care for.
- They want to contribute to clear, shared goals that reflect their top priorities.
- They want to provide personalised care, supporting their patients to best use services and take control of their own care.
- They want to expand clinical areas, being aspirational for ourselves and our patients.

Our Guiding Principles

Our values, vision and ambitions are our guiding principles and have been developed with the feedback of patients, staff and our population who told us what matters most to them. Delivering the best quality and safest care requires teamwork and within our organisation, this means staff supporting each other to achieve our shared ambitions.

Outside of our hospital and community services, it's about working more effectively with other providers across the health and social care sector. Underpinning our vision and values and aligning to the Trust objectives and priorities are the foundations of getting the basics right, and aspiring to be better and to be the best we can possibly be.

Our Values

Since their development, our values – Vision, Openness, Integrity, Compassion and Excellence (VOICE) - have become deeply embedded in our culture.

Over values underpin the way we work, reflecting who we are and our aspirations for the future. The development of the strategy has reinforced our commitment to these values and they are the bedrock of our organisation. Our values, and their associated behaviours are described below:

- **Vision**
  - We have a plan that will deliver excellent healthcare for future generations, working collaboratively towards sustainability.
  - We make decisions that are best for long-term health and social care outcomes for our communities.

- **Openness**
  - We communicate clearly to our patients, families and our staff, with transparency and honesty.
  - We encourage feedback from everyone to help drive innovation and improvements.

- **Integrity**
  - We demonstrate fairness, respect and empathy in our interactions with people.
  - We take responsibility for our actions, speaking out and learning from any mistakes.

- **Compassion**
  - We take a person-centred approach in all our interactions with patients, families and our staff.
  - We provide compassionate care and demonstrate understanding to everyone.

- **Excellence**
  - We put quality and safety at the heart of all our services and processes.
  - We continuously improve our standards of healthcare with the patient in mind.

Our values directly inform our recruitment processes and run through our appraisals, so that staff are held to account and encouraged to challenge each other on the way we behave towards those we work with, and those we care for.

Our Vision

Our vision for how things should be in five years' time is *to deliver exceptional care to improve the health and wellbeing of our communities*. If we consistently do this, we will collectively contribute towards a better Bolton for the people we serve.

To help us to make this a reality, we have set five ambitions to guide us over the next five years.

Our five core ambitions

Our core ambition is to deliver the best care for people when they use our services, and that's why *Improving Care, Transforming Lives* is the central ambition in our strategy. Each and every member of our team plays a role in bringing this ambition to life and in making sure that the care we provide is the best it can be.

Our four enabling ambitions 'orbit' around *Improving Care, Transforming Lives*. They are no less important as they are the building blocks of success for the next five years.

NHS
Bolton
NHS Foundation Trust

Our strategy on a page

Our Vision

To deliver exceptional care to improve the health and wellbeing of our communities.

Our Values

Vision	Openess	Integrity	Compassion	Excellence
Be Postive	Be Inclusive	Be Honest	Be Kind	Be Bold

Our five core ambitions

A great place to work

We will invest in our staff and support them to develop their skills so they are able to provide the best care. Our workforce will feel a sense of belonging and be reflective of our communities.

What this means in practice:

- Improving staff experience
- Unlocking our potential
- Reflecting our population

A high performing, productive organisation

We will make the best use of our resources and identify opportunities to innovate, develop research and continually evolve so that we can be the best we can possibly be, both now, and in the future.

What this means in practice:

- Improving access to our services
- Being efficient and productive
- Delivering financial sustainability

Improving care, transforming lives

We will continuously improve the care that we provide, and will transform the lives and outcomes of the people of Bolton.

- Improving quality, safety & experience
- Innovating & collaborating for the future
- Playing our part in improving health

A positive partner

We will embrace and build on the partnerships we have with our communities and organisations in Bolton and across Greater Manchester, and to improve health and outcomes for our population.

What this means in practice:

- Developing our neighbourhoods
- Working as one team
- Partnering for local benefit

An organisation that's fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

What this means in practice:

- Being digitally enabled & inclusive
- Improving our estate
- Proactively planning for the future

... for a better Bolton

Delivering our ambitions

Ambition 1: Improving care, transforming lives

We will continuously improve the care that we provide, and will transform the lives and outcomes of the people of Bolton.

Our objectives:

- Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care.
- Create a culture where staff can innovate and collaborate to improve care.
- Play our part in improving health and preventing illness, so that people live healthier lives.

Why are these objectives important?

People who use our services should expect to have a positive experience of the care that we provide, and we all have a role to play in helping people achieve the outcomes that are important to them.

Alongside this, we must also work with our partners to address inequalities, improve health and support the identification and management of ill-health and disease at an earlier stage.
Over the next five years, we want to become known as an organisation that relentlessly pursues and delivers the highest quality care through a focus on safety, experience and effectiveness, is committed to improvement and innovation to achieve these standards, and acts with care and compassion in everything we do.

How we will do it

1. **We will deliver high quality, safe care and make sure that everyone has a positive experience of our care by:**

- Focusing on the continued and sustained improvement of our ward and departmental standards, to ensure consistently high standards of care for all.
- Listening to, understanding and acting on what matters to the people we care for, and supporting our patients, service users, carers and families to provide feedback.
- Consistently improving our approach to patient, service user, carer and public involvement and engagement in how we design and deliver our services.
- Getting the basics right every time, making sure that people in our care are well nourished, hydrated, and are treated with compassion, dignity and respect.
- Reducing the avoidable harms across all of our services by making our environment and processes safer, focusing on prevention, and learning from harm so that everyone is safe in our care.
- Establishing new models of care in the community and through our neighbourhoods that are more accessible, better meet the needs of our population and reduce pressure on our hospital services, including frailty services, elderly care and access to therapies.

- Implementing continuous improvement techniques and methodologies so we keep improving the things we do.
- Using more technology to support people with Long Term Conditions to live well at home.

2. We will make it easier for our staff to innovate and collaborate to improve care by:

- Growing a culture that supports innovation, creating an environment where our colleagues are comfortable in their place of work and enabling them to suggest and trial changes.
- Scoping the areas where innovation has the potential to improve access, experience and outcomes – such as robotic surgery to reduce complications and improve surgical recovery time, and new genomics tests to improve diagnoses – and working together to deliver these innovations.
- Training staff in quality improvement techniques so that they have the skills to improve quality through a focus on safety, experience and effectiveness.
- Introducing the use of artificial intelligence (AI) and robotic process automation to free-up time and support decision-making.
- Increasing access to research trials, so that more people can benefit from innovative therapies.

3. We will play our part in improving health and preventing illness to help people live healthier lives by:

- Improving pathways to link seamlessly across primary, community, secondary, and social care, so that people are able to access the right services and get the right advice when they need it.
- Ensuring the information we provide is accessible, timely and relevant, so that everyone gets the information they need, when they need it.
- Increasing our focus on prevention and public health, ensuring equitable access, experience and outcomes for all of our population, regardless of postcode or background.
- Identifying and involving carers in care planning, decision making and discharge so that we improve experience.
- For our population who live in areas where the life expectancy gap is most profound, we will strengthen their voice, identifying and reducing any barriers to access via health literacy and communication.
- Ensuring continuity of care in our maternity services for all residents and particular from those most at risk, including women from Black, Asian and minority ethnic communities and from the most deprived groups.
- Diagnosing 75% of cancers at stage I or II by 2028.
- Increasing health promotion guidance offered by our teams through programmes like Making Every Contact Count.

What will be different for our patients, carers and our staff?

- More of our patients, carers and staff will recommend us a place to receive care.
- More of our staff will have the skills and support to improve quality, to innovate and make positive changes to the services they provide.
- There is a measurable reduction in inequalities in our services, improved continuity of care and improved rates of early diagnosis.
- People report easy access, positive experience, and effective outcomes.
- People are kept safe from avoidable harm.
- More people provide feedback, in a way that works for them.
- We consistently recognize and celebrate the things that go well, and we learn and change when things go wrong.
- There is measured new learning through research and innovation.
- We co-produce and implement ways to measure the quality of our services.
- Service users and carers have access to effective advocacy support when they need it.

Associated Plans

Bolton Carers' Strategy
Bolton Locality Plan
Clinical Strategy
Nursing, Midwifery & Allied Health Professionals Priorities
Patient safety priorities
Quality Improvement Plan
Research Strategy (in development)

Ambition 2: A great place to work

We will invest in our staff and support them to develop their skills so they are able to provide the best care. Our workforce will feel a sense of belonging and be reflective of our communities.

Our objectives:

- Improve the experience of our staff and make our organisation a great place to work.
- Help all staff to unlock their potential.
- Ensure that our workforce reflects the population we serve.

Why are these objectives important?

When staff are able to do their best at work, develop their skills, feel safe to speak up and are valued for their contribution, our organisation and our population benefits from improved performance, enhanced outcomes, and increased staff retention. This in turn helps us to meet the access needs of our service users now and in the future.

As an anchor institution and the largest employer in Bolton, we want to continue to ensure we offer fulfilling career opportunities for our diverse communities, and make sure our workforce reflects the population we serve, at all levels.

Over the next five years, we will focus on ensuring staff have a good experience at work, can unlock their potential and deliver the standards of care and outcomes that we all aspire to. We want our staff to be able to recommend Bolton as a place to work to their colleagues, family and friends, and for our patients and population to receive the positive benefits that flow from staff who feel fulfilled in their work.

How we will do it

4. **We will improve the experience of our staff and make our organisation a great place to work by:**

- Valuing the voices and experiences of our staff members by ensuring all staff feel they can shape change, provide feedback and most importantly speak up.
- Responding to and acting on all feedback from staff, and - through the *Our Voice* change programme - using feedback to make Bolton a great place to work for all.
- Working towards improved staffing ratios across our clinical areas so we can better meet the needs of our patients and service users, and create an environment where we can all do our best.
- Embedding our VOICE values in everything we do, so that they are understood and role-modelled by all of our staff.
- Reviewing our behaviour framework to reflect the way we do things in Bolton.
- Creating a culture of excellence where we are clear on our priorities and everyone is accountable for the work that they do, and can aspire to excellence.

- Prioritising investment to improve our estate through the development of our estates strategy.

5. We will help all staff to unlock their potential by:

- Refreshing our appraisal process so that all staff can develop, understand their priorities and objectives, and how their work contributes to Trust's ambitions.
- Implementing our new leadership programme to ensure that our managers and leaders have the right skills and behaviours to help them lead effective, high-performing teams and supporting managers and leaders to succession plan and cultivate the next generation of leaders.
- Working with our academic partners to provide enhanced training and development opportunities for our staff.

6. We will make sure that our workforce reflects the population we serve by:

- Promote a workforce culture where differences are celebrated and where every employee feels included and respected.
- Continuing to work towards the Workforce Race Equality Standard so that our workforce reflects our Bolton communities at all levels of the organisation.
- Continuing to deliver recruitment processes that are fair, equitable and accessible for all, and improving access to recruitment information.
- Continuing to deliver our schools outreach programme so that our young people understand the breadth of employment opportunities in our organisation and how to access them.
- In partnership with our local academic institutions, providing the people of Bolton with equitable access to training opportunities and healthcare careers.

What will be different for our patients, carers and our staff?

- More of our staff will recommend us a place to work.
- More of our staff will feels valued and supported to develop.
- Our organisation will be more reflective of our diverse population at all levels so that we are an employer our population aspires to be part of.
- Our recruitment will not disadvantage anyone or give an unfair advantage.
- People feel heard and see action from their feedback.
- People agree we are a flexible, equitable and inclusive employer

Associated Plans

- Equality, Diversity and Inclusion Plan 2022-2026
- Medical Workforce Plan
- People Plan

Ambition 3: A high performing, productive organisation

We will make the best use of our resources and identify opportunities to innovate, develop research and continually evolve so that we can be the best we can possibly be, both now, and in the future.

Our objectives:

- Improve access to our services.
- Be more productive and efficient.
- Be in a good financial position.

Why are these objectives important?

Over the last ten years, demand for NHS services has increased and waiting lists have reached record highs as a consequence of the pandemic. Long waits for treatment have a detrimental impact on the health and wellbeing of our patients and service users, and NHS England has now placed a firm focus on driving a national improvement in productivity to bring down waiting times and improve access. As our population grows, rates of ill-health rise, and funding continues to be restricted, we need to think differently about how we meet demand for our services.

When delivered in tandem with a focus on quality and safety, productivity becomes the gold standard of care that we can be proud to deliver. We need to make sure that each and every member of staff understands and plays a role in delivering improvements in productivity and performance.

Over the next five years, we will make our services more productive and accessible so that we make the best use of the time and space we have to see and treat people. Alongside this, we will make the best use of the money we have so that we deliver value alongside quality.

How we will do it

7. **We will improve access to our services by:**

- Reducing the length of time people stay in hospital to a minimum that is clinically required for them.
- Ensuring every patient has an Expected Discharge Date that all services work towards so that fewer people stay in hospital or community beds when they could be at home or another place of residence.
- Reducing the number of people waiting for operations and procedures.
- Reducing the time people spend waiting for urgent and elective care.
- Making better use of our capacity and identifying opportunities to innovate.
- Working with our local partners to identify and reduce the barriers people experience in accessing our services, to deliver equitable access to care.

8. We will be productive and efficient by:

- Embedding improvement methodology and learning from best practice so that all of our services function at peak performance.
- Making the best use of our capacity to improve flow, reduce waiting times, improve utilisation of our theatres and clinics, and reduce missed appointments.
- Promote a culture where everyone understands the positive impact of productivity on waiting times, experience, outcomes and on our finances, and is empowered to contribute to improvements.
- Reducing waste, inefficiency and bureaucracy in our systems, processes and ways of working so that we spend more time on the activities that deliver the greatest value.
- Using our data and best practice examples to identify opportunities to improve what we do and how we do it, and committing to implementing them.
- Facilitating earlier discharge by expanding into enhanced 7-day provision of therapies, with therapy services delivered closer to home.

9. We will be in a good financial position by:

- Delivering recurrent cost improvement efficiencies and processes to make best use of public money.
- Making the best use of available technology to reduce waste and improve efficiency and effectiveness.
- Regularly reviewing investments to make sure that we are delivering identified benefits and financial savings.
- Developing our Bolton NHS Charity into a thriving charity that can continue to invest in and enable developments that enhance the NHS offer.

What will be different for our patients, carers and our staff?

- Our patients will report improved access to the services they need, reduced waiting times and spend less time in hospital.
- We will be able to demonstrate better use of our hospital and community capacity and we have eliminated waste and inefficiency through our work on becoming more productive.
- Our organisation will be financially sustainable and we will be able to use resources to invest in service improvement.

Associated Plans
Clinical Strategy
Financial Plan
Green Plan

Ambition 4: An organisation that's fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

Our objectives:

- Be digitally enabled and inclusive.
- Improve our estate and make it more environmentally sustainable.
- Proactively plan for the future.

Why are these objectives important?

To be fit for the future means that we understand and are planning for the changes we expect to occur over the next five years, enabling us to respond to the opportunities and challenges that lie ahead. This means that we need to implement the right technology and innovations to support efficient services, patient access to information and wider digital transformation, that our buildings and physical environment can meet and adapt to changing future demand, and that we are investing in and supporting our workforce to deliver.

Over the next five years, we will improve our environment and infrastructure in a way that supports us to deliver, both now and in future. We will create a culture where staff are comfortable and confident to capture and use data, so that we make the best decisions for our patients, their carers and families, and for our organisation.

How we will do it

10. We will be digitally enabled and inclusive by:

- Delivering our Electronic Patient Record across all our services.
- Delivering integrated health and care records with social care.
- Ensuring patients and service users have the data and tools to manage their own records, bookings, and ensuring they have access to information to support their health and wellbeing.
- Ensuring that - wherever we offer a digital solution for our patients and service users - that non-digital alternatives are always available.
- Using digital technology to transform service delivery.
- Develop systems and data so clinical teams have the right information.

11. We will improve our estate by:

- Developing an estates strategy that responds to the changing demand for our services, describes our vision for our hospital and community estate and the plans to realise that vision.
- Continue to improve how we design, use, and build our estate to create an improved environment to work and receive care in.

- Identifying opportunities to develop and enhance our estate through partnership working and collaboration.
- Reduce our carbon footprint and strive to deliver net zero targets to create a greener, more sustainable future.

12. We will proactively plan for the future by:

- Setting annual priorities each year through our annual planning cycle, which will drive the practical actions that deliver our strategic objectives and will be how we will deliver our organisational priorities.
- Reviewing our clinical services to make sure that they are sustainable and delivered in a way that best meets the needs of the people who use them, both now and in the future.
- Using our data and intelligence to inform planning and decision-making, and creating a workforce that is comfortable and confident in capturing and using information.
- Developing our approach to workforce planning to make sure that we have the right staffing levels and skill mix in our organisation.
- Working with our academic partners to offer training and development opportunities to our existing workforce, and to develop the workforce of the future.

What will be different for our patients, carers and our staff?

- Our digital infrastructure supports improvements in our services and enables productivity. Our population can access information in the best way for them.
- We have a clear plan for our hospital and community estate that supports the delivery of high quality services and is in line with NHS Net Zero targets.
- Net Carbon Zero targets are met through procurement, more sustainable sources of power, increased recycling, and greater access to energy efficient transport.
- We have a clear understanding of the medium to long-term impacts of population growth and rising rates of ill health, and proactively plan to meet future challenges.

Associated Plans
Clinical Strategy
Digital Strategy
Green Plan

Ambition 5: A positive partner

We will embrace and build on the partnerships we have with our communities and organisations in Bolton and across Greater Manchester, and to improve health and outcomes for our population.

Our objectives:

- Develop our neighbourhoods in partnership with our communities
- Work as one team across our organisation and with our locality partners
- We will develop partnerships for local benefit

Why is this important?

Bolton has some of the starkest differences in health outcome and life expectancy in Greater Manchester, and we know that the wider determinants of health – which include access to good quality housing, work and education – play a significant role in shaping people's health outcomes.

As one of the largest employers in Bolton, we can play an important role in shaping the health, social and economic future of our town by acting as a positive partner to our people, our population and our partner organisations.

Over the next five years, we will use our neighbourhoods to bring together the people and teams required to provide the best service and experience for the people in that area. We will help people to live well at home and will work in partnership to make it easier for our communities to access our services, focusing on the people who need our services the most.

How we will do it

13. We will develop our neighbourhoods by:

- Continuously improving our understanding of our population and communities, and building local services that are responsive to need.
- Delivering community services in six neighborhoods that support connections in our communities.
- Developing and embedding our neighbourhood delivery model to provide integrated care where people live.
- Building strong partnerships with existing and new stakeholders with integrated services to enhance care outcomes.
- Using our infrastructure to support our partners in the voluntary and community sector, Primary Care Networks and other care providers.
- Through our service reviews, identifying services that could be better provided in our neighbourhoods.
- Working with other organisations and partners to tackle ill health and inequalities.

14. We will work as one team by:

- Collaborating across primary, secondary and social care to find shared solutions to issues of access and flow.
- Increasing the number of co-located services with other public bodies in our neighbourhoods, moving to a vision of one public estate across Bolton.
- Improving digital integration across Bolton so that information and records can be shared easily.
- Undertaking training and development across the system to increase staff understanding of health inequalities, ensuring we make every contact count.
- Ensuring all our plans deliver clinically led collaboration with health and care partners to reduce unfair differences in health.
- Ensuring that all partner services shape their offer to address the wider determinants of health, including deprivation and poverty e.g. cold homes, lack of access to transport, insecure employment.

15. We will develop partnerships for local benefit by:

- Working with our local education institutions to develop and grow the training programmes that we deliver.
- Building on our partnerships with academic institutions to develop the healthcare workforce of the future.
- Evolving our partnerships with academic institutions to develop research and education capability, moving towards becoming a University Hospital by 2025.
- Continuing to include a focus on social value when we put out contracts for services, helping us to work with companies that give back.
- Investing back into our local economy and purchasing locally wherever possible.
- Build on our partnership with Wrightington, Wigan and Leigh Foundation Trust and other GM Provider Partners to maximise services for the benefits of our populations.

What will be different for our patients, carers and our staff?

- Our patients and service users have access to neighbourhood services that feel more connected and responsive to their needs.
- We work seamlessly with our partners for the benefit of the people of Bolton and beyond, so our population feels the benefit of more joined-up, easily accessible service provision.
- We will ensure we are focused on giving back local community creating opportunities for local people to train and gain employment in Bolton.

Associated Plans
Bolton Carers Strategy
Clinical Strategy
Locality Plan

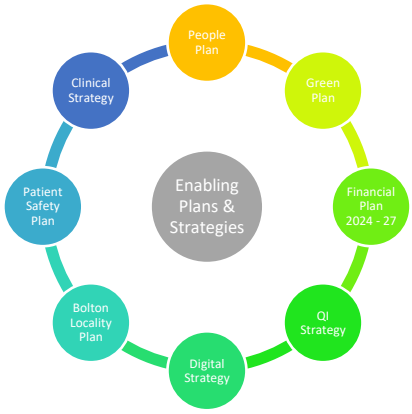
How we will get there

This strategy provides a clear and ambitious vision for the next five years, shaping our future and responding to the challenges ahead.

We are confident that by working together with our partners, we can make it a reality. To deliver our vision and objectives, we need substantial change in how we provide services. We do not underestimate the scale of the challenge and have developed delivery plans that set out the steps required and have a Clinical Strategy that is ambitious and will deliver the 5 ambitions set out in this strategy.

Annual priorities will be set each year through our annual planning cycle, which will drive the practical actions that deliver our strategic objectives and how we will deliver our strategy priorities. This will be coupled with the delivery of the enabling strategies and plans which form our strategic framework.

Strategic Framework



The Board of Directors and Council of Governors will receive reports twice a year on the progress we are making and importantly, the impact we are having for services users, carers and our colleagues. We will review our strategy each year to ensure that it remains up to date and responds to any evolving local or national context.

Our measures of success

- **See excel sheet**

Annex A - Review of 2019-24 Strategy

KPI/measure of success	Achieved	To be included in 2024-29 strategy
All GIRFT-reviewed specialties have implemented all appropriate GIRFT recommendations	Yes	Ongoing
Bolton FT is fully compliant with Better Births recommendations	Yes	Retire
Trust break even delivered in 2020-21	Yes	Ongoing
BFT generating annual revenue from sale of Digital Services	Yes	Retire
New technologies in place to support the delivery of clerical services	Yes	Ongoing
100% of SLAs will be reviewed and refreshed as required	Yes	Ongoing
Capital Plan is informed by the plan for the development of BFT's estate	Yes	Ongoing

BFT to enter the top 20% of Trusts for total costs per weighted average unit (WAU)of activity on the Model Hospital portal	Yes	Retire
All new business cases to follow the new process	Yes	Retire
Implementation of Attend Anywhere and development of virtual hubs	Yes	Retire
To support the delivery of system financial changes	Yes	Retire
Financial and productivity benefits realised and reported on	Yes	Retire
Master Plan published and development programme in place (estates)	Yes	Retire
College open	Yes	Retire
All our community services have access to developed technologies	Yes	Retire
All patients to be streamed in A&E	Yes	Retire
Document published (Digital Strategy)	Yes	Retire
Document published (Communications and Engagement Strategy)	Yes	Retire
BFT contributes to the equitable delivery of services across GM	Yes	Ongoing
Document published (Research and development strategy)	Yes	Ongoing

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NHS Foundation Trust

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Summary version

Our Trust Strategy

2024-2029

... for a better Bolton

Where we are now

When we developed our previous five-year strategy in 2019, we wanted to improve the outcomes and experience for the patients we serve. Whilst we have seen major progress in these areas over the last few years, a lot has changed in the last five years, and our world looks very different.

A growing population means that demand for our services is rising, but without the central funding to support it. We know that our communities experience significant health inequalities compared to other parts of the country – and compared to other parts of the town.

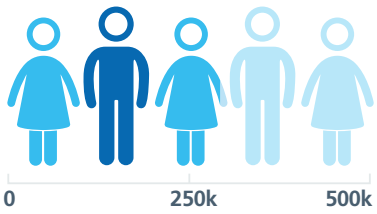
Our recovery from the pandemic has meant that some people in Bolton are waiting longer than they should to be supported with health conditions that have been impacted by delays to care.

Alongside this, our ageing estate and increasing responsibility to the green agenda are impacting on our ability to provide services in the way we want to.

What we know about our communities

Bolton's population is approaching

300,000



28%

are from communities facing racial inequality

9.8% of Bolton's population provide between **1 and 50 hours** of unpaid care per week

49%

of Bolton's adults would have difficulty understanding health information

5.4%

of people are not in paid work due to being long-term sick or disabled

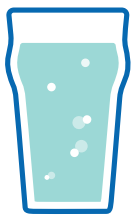
The percentage of people aged 16+ have a disability

18%

Main languages spoken English, Gujarati, Punjabi, Polish, Arabic and Somali

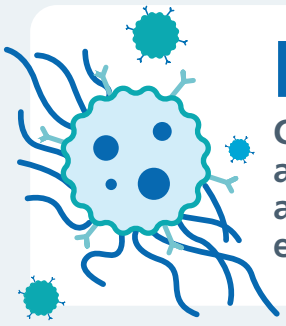
11 Years

Difference in life expectancy between our communites



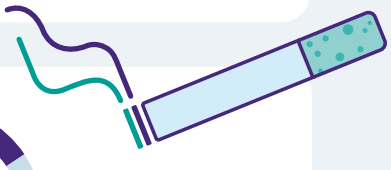
Alcohol

23% of Bolton's adults drink over **14 units** of alcohol per week



Diseases

Circulatory, respiratory, cancer and digestive diseases together account for over **60%** of the life expectancy gap within Bolton



14%

of Bolton's adult population are smokers

32% of Bolton's adults are physically inactive

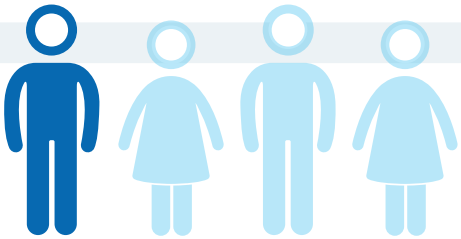
50% of Bolton's adults are eating the recommended 5-a-day

24.7% Primary school pupils eligible for free school meals

England average **24%**

60+ **17%** of people currently on the Housing Register are aged 60+

72,458 the number of children in Bolton



1 in 4 adults in Bolton experience at least one mental health problem

71% Of people surveyed in 2022 that reported high or very high anxiety

National average **40%**

5,695 LGBTQ+

Data collected for the first time tells us that there are 5,695 LGBTQ+ people

1,469 Bolton residents have a different sex from the one registered at birth

26% live in an area that is among the **10%** most deprived nationally

56% of the population live in an area that is among the **30%** most deprived nationally

29% of respondents to a Bolton survey were really struggling with the rising costs and were unable to cope financially

The proportion of Bolton's children living in relative poverty **22%**

5,368 Number of babies born in Bolton this year

10,444 adults receiving care and support from the local authority

4,331 adults in Bolton are receiving long-term support

Where do we want to be

In five years' time, we want to be providing high quality and safe services across Bolton, making sure we are meeting the needs of our diverse population.

We want to have a happy, skilled and diverse workforce that is reflective of the people we care for, and that feels like they belong.

We will innovate, develop research, and continually evolve so that we can be the best we can possibly be.

We will work with our partners and our communities to deliver the best services, as close to the people that need them as possible.

What people told us was important to them

Our patients and population told us that:

- They want services to be easy to access when they need them
- They want to be treated with compassion and respect, and to be involved in decisions about their care
- Those with caring responsibilities and those who are cared for said that they want to be listened to and supported to access healthcare in ways that work for them

Our staff told us that:

- They want to be supported to do their best for the people we care for
- They want to contribute to clear, shared goals that reflect their top priorities
- They want to provide personalised care, supporting their patients to best use services and take control of their own care
- They want to expand clinical areas, being aspirational for ourselves and our patients

Our Vision

To deliver exceptional care to improve the health and wellbeing of our communities.

Our Values

Vision	**Be Postive**	**We have strong plans and make decisions with Bolton's communities**
Openess	**Be Inclusive**	**We communicate clearly and encourage feedback**
Integrity	**Be Honest**	**We are fair, show respect and empathy**
Compassion	**Be Kind**	**We have a caring person-centred approach**
Excellence	**Be Bold**	**We prioritise quality, safety and continuous improvement**

Our five core ambitions

Our core ambition is to deliver the best care for people when they use our services, and that's why Improving Care, Transforming Lives is the central ambition in our strategy. Each and every member of our team plays a role in bringing this ambition to life and in making sure that the care we provide is the best it can be.

Our four enabling ambitions 'orbit' around Improving Care, Transforming Lives. They are no less important as they are the building blocks of success for the next five years.

Underneath these ambitions are the things we need to focus on in order to achieve these goals, that will make a lasting and meaningful difference to the people of Bolton.

As a Trust, and as part of a wider health and care system, we will support the greatest possible improvements in health, wellbeing and outcomes for everyone.

A great place to work

We will invest in our staff and support them to develop their skills so they are able to provide the best care. Our workforce will feel a sense of belonging and be reflective of our communities.

What this means in practice:

- Improving staff experience
- Unlocking our potential
- Reflecting our population

A high performing, productive organisation

We will make the best use of our resources and identify opportunities to innovate, develop research and continually evolve so that we can be the best we can possibly be, both now, and in the future.

What this means in practice:

- Improving access to our services
- Being efficient and productive
- Delivering financial sustainability

Improving care, transforming lives

We will continuously improve the care that we provide, and will transform the lives and outcomes of the people of Bolton.

What this means in practice:

- Improving quality, safety & experience
- Innovating & collaborating for the future
- Playing our part in improving health

A positive partner

We will embrace and build on the partnerships we have with our communities and organisations in Bolton and across Greater Manchester, and to improve health and outcomes for our population.

What this means in practice:

- Developing our neighbourhoods
- Working as one team
- Partnering for Local benefit

An organisation that's fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

What this means in practice:

- Being digitally enabled & inclusive
- Improving our estate
- Proactively planning for the future

Ambition 1: Improving care, transforming lives

We will continuously improve the care that we provide, and will transform the lives and outcomes of the people of Bolton.

What this means in practice

- Improving quality, safety & experience
- Innovating & collaborating for thefuture
- Playing our part in improving health

Why is this important?

We want the people who use our services to have a positive experience of the care that we provide, and to achieve the outcomes that are important to them. Over the next five years, we want to be known as an organisation that pursues and delivers the highest standards of care and experience, achieves the right outcomes for the people who use our services, and acts with care and compassion in everything we do.

What will we achieve over the next five years

- Improved pathways across primary, community, secondary and social care.
- A shift from "what is the matter" to "what matters most to me" – actively engaging our patients and service users in service improvements and design.
- Continued and sustained improvement of our ward and departmental standards.
- Reviewed our services to make sure that they are sustainable and delivered in a way that best meets the needs of the people who use them.
- Embedded a culture of continuous quality improvement that provides our people with the time and tools they make positive changes.
- Listened to and acted on feedback and complaints.
- Created the conditions for research to flourish, piloting and collaborating on new initiatives, and implementing new technologies and innovations.

Ambition 2: A great place to work

We will invest in our staff and support them to develop their skills so they are able to provide the best care. Our workforce will feel a sense of belonging and be reflective of our communities.

What this means in practice

- Improved staff experience
- Unlocking our potential
- Reflecting our population

Why is this important?

We know that to achieve our goals, our people must have the skills and support to be the best they can be. We want to create a positive experience of work so that our people feel included, able to speak up and safe to be themselves, because we know that this in turn improves patient care.

What will we achieve over the next five years

- Work will be a place where everyone feels consistently valued, and they feel the work they do is worthwhile.
- Everyone has the skills and confidence to champion the best possible quality of patient care.
- A more inclusive workplace, promoting equality, celebrating diversity, and challenging discrimination.
- A culture where everyone is supported and accountable for the work that they do, and can aspire to excellence.
- Set clear standards, behaviours and values and our managers and leaders have the right skills and behaviours to help them lead effective, high-performing teams.

Ambition 3: A high performing, productive organisation

We will make the best use of our resources and identify opportunities to innovate, develop research and continually evolve so that we can be the best we can possibly be, both now, and in the future.

What this means in practice

- Improving access to our services
- Being efficient and productive
- Delivering financial sustainability

Why is this important?

As our population grows, rates of ill-health rise, and funding continues to be restricted, we need to make sure we can meet future demand. Waiting lists are at record highs and we know we need to be more productive so that we improve both the patient journey, and our financial position.

What will we achieve over the next five years

- A year-on-year reduction in waiting times for planned care and in our ED.
- Improved discharge so that fewer people stay in hospital beds when they could be at home or another place of residence.
- 75% of cancers diagnosed at stage 1 or 2 by 2028.
- Implemented our clinical strategy.
- Achieved the targets in our financial recovery plan.
- Every staff member will have a clear understanding of the part they play in making improvements and the impact it has.

Ambition 4: An organisation that's fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

What this means in practice

- Being digitallyenabled & inclusivee
- Improving our estate
- Proactively planningfor the future

Why is this important?

We need to improve patient and colleague satisfaction by making sure we have digital infrastructure that is fit for purpose, so that people can do their jobs to the best of their ability, and patients can access our services more easily. We need our building and estates to be able to meet the needs of our growing population, whilst improving health and wellbeing now and for future generations through reducing our carbon footprint.

What will we achieve over the next five years

- An increase in the number of co-located services with other public bodies in neighbourhoods, towards our vision of one public estate across Bolton.
- Our health and care records will be digitised and integrated with our partners.
- A reduced carbon footprint.
- Patients will be empowered with the data and tools to manage their own health and wellbeing.
- A new Estates strategy that describes our long-term vision for how we will invest in and maintain our buildings and environment.

Ambition 5: A positive partner

We will embrace and build on the partnerships we have with our communities and organisations in Bolton and across Greater Manchester, and to improve health and outcomes for our population.

What this means in practice

- Developing our neighbourhoods
- Working asone team
- Partnering for Local benefit

Why is this important?

Bolton experiences higher-than-average rates of diabetes, cancer, respiratory and cardiovascular disease, and some of the starkest disparities in health outcomes between the wealthiest and most deprived communities in our town. We need to work in partnership to make it easier for our communities to use our services and ensure we are proactive in targeting care to people who need our services the most.

What will we achieve over the next five years

- Strong partnerships with existing and new stakeholders.
- Integrated services, which will improve outcomes for Bolton people.
- Evolved our partnerships with academic institutions to develop research and education capability, moving towards becoming a Teaching Hospital by 2025.
- Delivered clinically-led collaboration with health and care partners to redesign pathways of care based on a person-centred approach.
- A thriving Trust charity that benefits patients, supports staff and improves facilities.

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Report Title:	Digital Strategy -18 Month Review

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	The report provides an evaluation of the progress since the implementation of the Digital Strategy. It assesses delivery to date, outstanding actions and risks to delivery.

Summary:	In November 2022, Bolton NHS Foundation Trust approved a three year Digital Strategy. The aim of the strategy was not to be all encompassing, but to set the direction of travel with a view that this strategy would be refreshed regularly. The digital objectives included in the strategy are based on the Bolton locality-level ambitions, as well as national and regional priorities. The plans are also structured around four strategic objectives, these are: - Digital Integration - Digital Care - Digital Workforce - Digital Infrastructure and Estate Against each of these strategic objectives are a series of work plans with key deliverables and associated timescales.

Previously considered by:
Delivery of the digital priorities are overseen by the Strategy and Operations Committee.

Proposed Resolution	The Board is asked to ***receive*** the progress made against delivering the Digital Strategy and the ongoing assurance reporting through the Strategy and Operations Committee.

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

Prepared by:	Madeleine Szekely Deputy Director of Digital Brett Walmsley Director of Digital	**Presented by:**	Sharon White, Director of Strategy, Digital & Transformation Brett Walmsley Director of Digital

1. Introduction

In November 2022 the Board of Directors approved a new three year Digital Strategy. The aim of the strategy was not to be all encompassing, but to set the direction of travel with a view that the strategy would be refreshed regularly. It was anticipated this approach would allow the Trust to incorporate technology developments, align with the Trusts Clinical Strategy and the Greater Manchester (GM) Strategy for Digital as they were developed.

The digital objectives included in the strategy are based on the Bolton locality level ambitions, as well as national objective. These are:

- Digital Integration
- Digital Care
- Digital Workforce
- Digital Infrastructure and Estate

Against each of these strategic objectives are a series of work plans with key deliverables.

2. Current State.

Following feedback from the CQC in June 2023, the Trust undertook a review of progress against the strategy, alignment to the wider GM Digital Strategy and opportunities for acceleration.

The review concluded that the Trust Digital Strategy is ambitious, with the desire to move forward quickly. The Digital Strategy also closely aligns with the GM Digital Strategy with similar themes and goals. The following areas of opportunity for acceleration were identified in order to progress the organisations digital maturity forward:

- Deployment of the Electronic Patient Record (EPR) to Outpatients and Community services – investment of £1.5m was agreed at Finance & Investment Committee and the programme commenced in January 2024.
- Deployment of voice recognition capability across the Trust to support improvements in outpatient correspondence turnaround times and improved utilisation of EPR. Investment was approved February 2024, and the project has now commenced.
- More rapid deployment of Microsoft 365 full suite to provide significant productivity and efficiency to the organisation and to maximise the current investment the trust has made in licencing. Deployment of this on track to deliver in November 2024
- Deployment of additional equipment to ward areas to increase access to hardware for clinical staff utilising safer staffing ratio's to drive equipment numbers with the aim of achieving 1:1 staff to equipment ratios.
- Deployment of mobile phones and laptops to all staff within community services to support connectivity and prepare for access to EPR.

3. Progress to Date

The Digital Strategy is now 18 months old and as a result of this it is an opportunity to review what has been achieved to date, what is in progress, and what is yet to be delivered. **Appendix One** outlines the current progress to date against the work plans.

4. Risk to Delivery

The risks to delivery of the strategy are mainly consistent with some that where highlighted at its inception: These risks include:

- **Lack of available resource** within the digital team to deploy the solutions as outlined within the work plan whilst maintaining business as usual management of the IT service.

This risk is currently on the department risk register and is rated 16. The risk is being mitigated through robust prioritisation of digital schemes with Divisions and Departments.

- **Lack of available capital investment** to be able to purchase solutions or technologies. Risk related to capital investment is included on the trust risk register.
- **Supplier capability to meet the trusts needs or requirement.** The trust works closely with suppliers to ensure they have the capacity and capacity to meet the complex needs of the organisation.

5. Measurement of Improvement

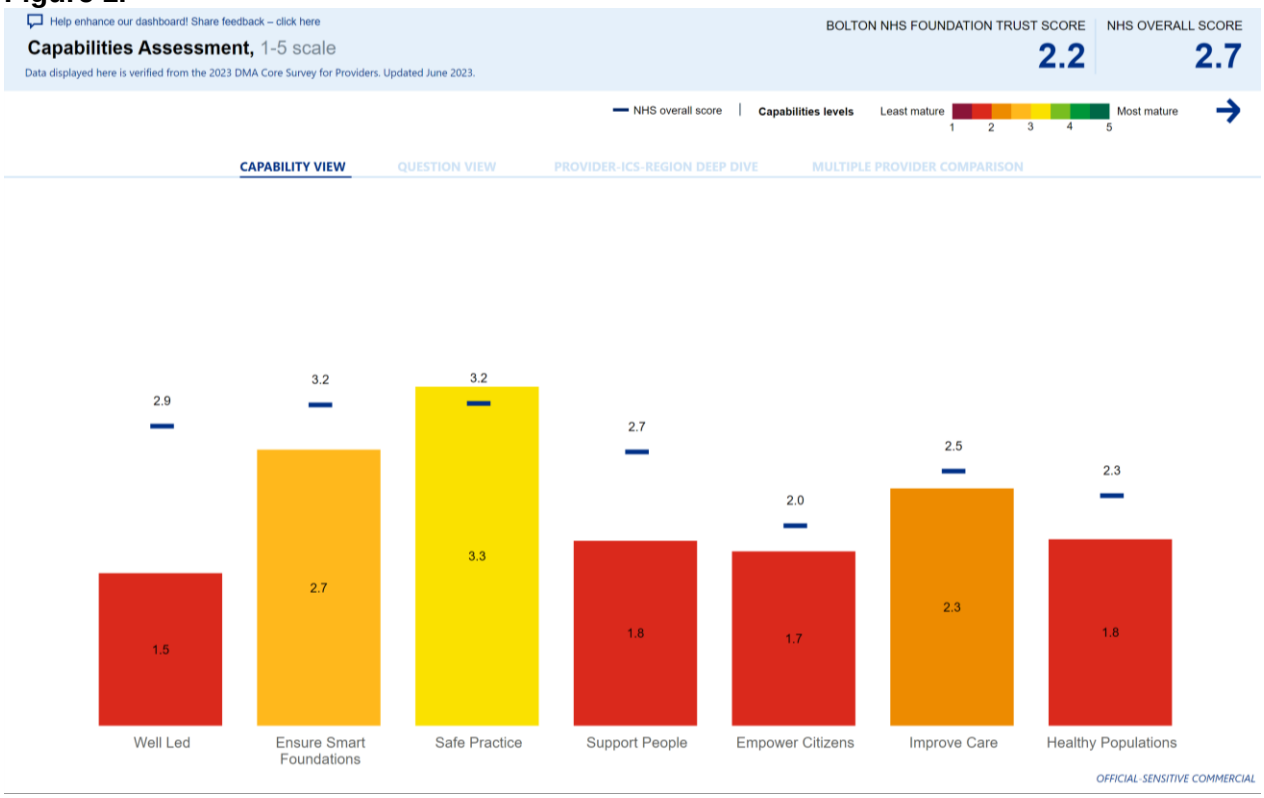
We want to measurement improvement to ensure the changes we are implementing are making a difference to the people who use them. This is being achieved through a number of mechanisms. These include:

- Temperature checks as part of the Our Voice Programme. The digital team have recently hosted a digital and data team day across the trust. We will be repeating this quarterly and holding focus groups so we can listen to and act on staff feedback of their experience.
- Service improvement metrics included within the service desk improvement programme. This includes seeing improvements in telephone response rates, dropped calls and timescale for repair.
- Attendance at Divisional Boards, Divisional service review sessions with each divisional leadership team to understand outstanding issues.
- Induction feedback sessions with the Chief Executive

6. Digital Maturity

Each year we complete the national digital maturity model to understand our progress as an organisation. **Figure 1**, is a summary of the latest Digital Maturity Model - What Good Looks Like, assessment for Bolton from March 2023.

Figure 1.



The Digital Maturity Model has been updated for 2024/25 and the results are due imminently. Desktop review of the domains would indicate improvement, however, it is not possible to confirm the scale of this improvement until it is published in June 2024. The Digital Strategy will be updated to reflect any areas of improvement the digital maturity model identifies We will see our digital maturity score increase significantly in 2025/26 following the implementation of the Digital Strategy and projects outlined in this paper.

The EPR is central to the delivery of the digital strategy. **Appendix Two** outlines the current progress against the EPR roadmap. Following deployment of the outpatient and community services EPR later in 2024, the Trust are looking to undertake the Healthcare Information and Management Systems Society (HiMMS) Electronic Management Record Adoption Model (EMRAM) Assessment. This will allow us to undertake an objective assessment of the maturity of our EPR implementation and will suggest areas of improvement for us based on best practice.

7. Summary

A significant amount of work has been achieved over the past 18 months and multiple projects are already in progress, to support delivery of significant further capability. Capital investment and resourcing remains the biggest risks to delivery and the biggest opportunity to expedite the strategy.

Progress will be monitored through Strategy and Operations Committee and reported to the Board of Directors.

8. Recommendation

The Board of Directors is asked to receive the progress made against delivering the Digital Strategy and note ongoing assurance reporting through the Strategy and Operations Committee.

Appendix 1

a. Completed Work

The following projects have been completed.

Project	What will we do	Status
Primary Care Digital Strategic Objectives	Bolton place model will be the continued technical integration between Primary and FT health & care services. This takes the form of – • Common access and security layer to clinical and corporate systems. • In properties with shared tenancy adoption of the new FT WiFi by practices.	Complete
Greater Manchester Care Record (GMCR)	Give health and care workers access to information from across Greater Manchester ensuring patients receive the treatment. The GM Care Record joins together our Greater Manchester different NHS and care organisations to help hospitals and other care services access individual health and care records quickly and securely.	Complete continued development with GM
Trust Website	New trust website to support patient and community engagement	Complete continue to develop and upgrade
Electronic Patient Record Phase 1A	Upgrade to EPR Infrastructure to support further roll out • Deployment to Community Bedded Units • Deployment to A&E	Complete
GM: Imaging archive	Implementation of a single GM Imaging archive and harnessing the new solution to implement new ways of working within Radiology and wider services	Complete
Digital Pharmacy	Support the implementation of digital pharmacy solutions including prescription tracking, robot replacement, pixis machines implementation	Complete
Digital Pre-Operative Assessment P1	Digital capture of patient questionnaires to support pre-operative assessment	Complete
Agile Working Phase 1	We will support our staff to work in an agile way safely. Phase 1. Dowling house: as corporate office service hub on-site working area.	Complete

Project	What will we do	Status
IDG & Virtual Smart Cards	Further extend ability to provide new member of staff with immediate access to Clinical & Corporate systems.	Complete
New Trust Intranet	New trust intranet to support sharing of information and communication and act as a digital hub for staff	Complete continue to develop and upgrade
Apps to aid staff	We will use Apps where possible to support staff with easy processes. 1st Phase: Room Booking, Staff Leave Carry Forward Authorisation	Complete
Community Laptops	Implementation of further equipment to support EPR 650 community laptops	Complete
Community WiFi	Wi-Fi services to the sites in which staff from Community & Social Care services operate.	Complete
Desktop/Laptop devices	Replace 50% of our desktop devices (circa 3500) across BFT estate. This will provide greater memory and processing capacity necessary to operate the profile of current and future clinical & back-office systems.	Complete
Lone Worker Mobile Phones	Supply 1200 mobile phones for Families/Community Division for use with the Lone Workers app	Complete
Community Mobile Phone Signal Boosters	Roll out of boosters across identified community sites.	Complete
Server Re-fresh:	Replace Servers / Databases / Storage and licensing to support new/additional application services/upgrades to enhance performance to end users of clinical systems	Complete
Computer On Wheel's	Roll out additional computers on wheels to wards and departments to numbers agreed with clinical teams.	Complete
Community Diagnostic Centre	Support the creation of digitally enabled estate	Complete
Theatre Build and Refurbishment	Support the creation of digitally enabled estate	Complete
Christie@	Support the creation of a Christie @ site within Bolton	Complete
NHS Professionals	Setup of new agency function and workflows	Complete

Project	What will we do	Status
Cyber Security/iBoss	Upgrade data filter to provide a more secure basis for internal/external bound traffic.	Complete
Telehealth / Care – Virtual Wards	To provide telehealth and telecare solutions to our patients to support patient empowered care and greater efficiencies in care provision.	Complete.

b. In progress

The following projects are current in progress

Project	What we will do	Strategy Planned Delivery Date	Status
Electronic Patient Record Phase 2	Deployment to OPD Deployment to Community Remaining Gaps in paediatrics EPR & prescribing	2022-2025	Funding agreed and project expedited Phase 2 Completion 2024
Voice Recognition	We will implement Voice Recognition solution allowing clinicians to create the clinical documentation at source which offers direct integration to our EPR platform. The Trust has been asked to become one of three Microsoft national beta site for this solution.	2023/2024	Business case approved On track to complete revised date Nov 2024
GM Pathology (LiMS)	There is a GM strategy for Trusts to standardise on operating Pathology services and functions - Laboratory Information Management System (LIMS) We are working towards implementation of this.	2022-2024	On Track revised date August 2024
Robotics & Artificial Intelligence	Support back-office admin functions and clinical decision making/intelligence through the use of Robotic and AI. Opportunities include write back to Patient Administrative System / Theatre systems for elective recovery patient prioritisation, patient registration.	2022-2023	Access Booking and Choice. November 2023 On track to complete June 2024

Project	What we will do	Strategy Planned Delivery Date	Status
Maternity EPR	Implementation of a maternity specific EPR	2022-2025	Has incurred significant delay due to RAAC. Revised Date to be agreed with division
Open Eyes EPR	Continue implementation of the OpenEyes EPR to support transformation of ophthalmology services	2022-2025	Continues to progress within resource constraints
Replace Patient Flow: (ExtraMed)	We will develop a Business Case to replace the current ExtraMed platform to one which offers the Trust greater interoperability capability as well as more appropriate functionality to support patient flow.	2023/2024	Provisional Go Live End May 2024
WiFi	Wi-Fi services to the sites in which staff from Acute services operate.	Q2 2022/23 – Q3 2023/24	Delays due to RAAC and inability to decant. Go-Lives phased over the next 6 months subject to iFM cabling completion
Digital Menu Ordering	Implementation of an App to enable ordering of food for patients in the hospital	Q4 2022/2023	Delays due to resourcing and product issues. Revised dates agreed June 2024. At risk due to product issue
Microsoft 365	Roll out and optimize the solution	Q4 2023	Delays to commencement of the project due to resourcing. Revised date of Nov 2024 agreed and on Track
GM Cancer	Roadmap defined by GM Cancer Alliance to establish three programmes with a common digital set of system/standards – Patient Stratified Follow Up (PSFU) Single Queue Diagnostic MDT	2022-2024	Project previously on hold. Now reinstated with timeline to complete end of Q1.

Project	What we will do	Strategy Planned Delivery Date	Status
Informed and Intelligence Analytics Services	Develop analysis to support divisions in elective recovery, particularly monitoring of the operating plan and highlighting areas of good practice and areas of challenge *(monitoring of ops plan first draft by July 22)* Develop data flows to support national and local requirements Ensure robust analysis is available to support health inequalities, and provide actionable insights to help operational teams pinpoint areas of focus Supporting new system rollouts/upgrade: Provide BI and coding support to new system rollout / upgrade plans to ensure continuation of data supply, data integrity and the ability to report effectively from our system	Ongoing	On-going
Data Quality & Coding	Referral To Treatment (RTT) validation to help manage a growing RTT waiting list and work with operational teams to look at new ways of working Increase identification of data quality issues and education to staff Undertake and support data quality initiatives like the Big Clinic Clean up and Know Your Patient Run internal initiatives across teams to improve data quality and internal processes(*Identification of Community Activity Sprint - July 22)* Release our coding information assurance leads to work more closely with specialties and wards to improve clinical data quality and provide targeted help to improve known problem data quality areas.	Ongoing	On-going

Project	What we will do	Strategy Planned Delivery Date	Status
Intelligence infrastructure (inc Tableau):	Facilitate further datasets into the Data Warehouse, such as Workforce data Investigate ways the Data Warehouse can be used for cross organisation working with our partners Promote, develop and encourage the use of Tableau including the creation of a "Data Champions" programme Further democratise our data by encouraging teams to create and explore data within Tableau Further stabilise the Data Warehouse structure with full roll out of Development areas and SQL standards into the team.	Ongoing	On-going
Agile Working	We will support our staff to work in an agile way safely. Remote working from home: enabling the agile working approach in line with rationalization of office capacity.	2022-2023	Progressing in line with Trust agile working group
Innovation Hub	Bolton is part of a local innovation hub including the council, university and Private Business who want to engage with private Business to become partners in co-development and research.	2023/2024	On Track
Digital Exclusion	We must ensure that we do not exclude patients or communities due to digital inaccessibility. Not everyone has access to digital technology and it is vital that we maintain systems and processes which allow people to connect with us using more analogue methods.	22/23 & 23/24	On track In development with council

c. Projects where plans / business cases are being developed

Project	What we will do	Status
Virtual Consultation	Patients will have access to online consultation services using Microsoft Teams to support this mode of consultation	Software platforms being reviewed
Patient Apps	Patients will have access to self-help information. People are increasingly turning health apps, to help support them with their physical and mental health and wellbeing.	Focus on embedding NHS App and Bolton Community Information hub through the Borough Wide Digital Transformation Board
GM Maternity supporting Longitudinal Care Record	To ensure national Maternity EPR system support the national aims of a shared care record clinically defined data sets will be extracted from each GM Maternity service to upload into the patient GM Care Record. Bolton is providing project direction on delivery of this programme.	Will be developed post Maternity EPR implementation
Patient Entertainment System	To provide a robust patient entertainment platform to support improve patient experience and accessibility	On Hold due capital investment required
Mobile Phone Signal Booster FT Site	Provide robust mobile phone signal on the hospital site and act as backup for WiFi in event of failure for mobile devices, pagers etc.	Business case to be developed and prioritised against capital allocation Approximately Capital investment of £1m
Radio Frequency Identification (RFID) Phase 1	RFID tracking helps staff to pinpoint the location of any patient / equipment in the hospital to ensure their safety and sustain the care process.	Business case to be developed and prioritised against capital allocation post WiFi upgrade
Service Desk and Server Monitoring	Robust monitoring of the network and server infrastructure to ensure reliable delivery of It service is maintained	Business case to be developed and prioritised against capital allocation Approximately Capital investment of £100k
Network Refresh	The trusts core IT network was refreshed 5 years ago this requires updating every 7 years to ensure adequate bandwidth if available or it will slow systems down and cause errors to appear	Business case to be developed and prioritised against capital allocation Approximately Capital investment of £3-5m
Smart devices/Bleep Replacement	The Digital Team are working on a with IFM to test Smart devices & pagers to support alerting	Business case in development and will be prioritised against capital allocation

Medical device integration	Currently our clinicians manually extract key patient vital signs data and input to our electronic observations platform or onto paper (ICU, HDU, NICU & Theatres). We will provide direct integration of the devices to free up key clinical time.	Business case to be developed and prioritised against capital allocation
PAS/ Scheduling/ Theatre Solution	Procure and implement a new PAS / Scheduling solution to meet the modern needs of the organisation and enable effective use of resources	Business case to be developed and prioritised against capital allocation - likely to be a split phase Business Case Approximately £3-5m capital investment

d. Emergent Projects / New Projects

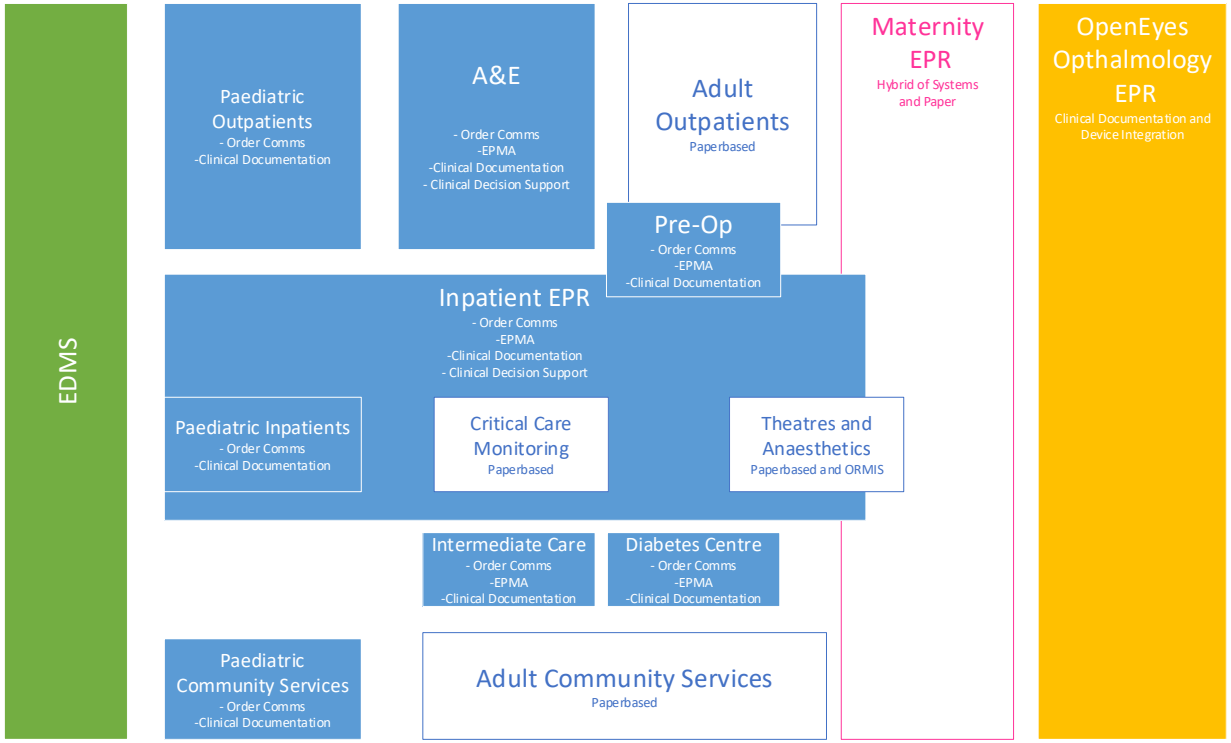
The following emergent projects have occurred during the first year of the strategy:

Project	What we will do	Delivery Date	Status
Electronic Document Management System	Explore the use of electronic document management to digitise medical records	2024/2025	High priority Business case to be developed and prioritised against capital allocation

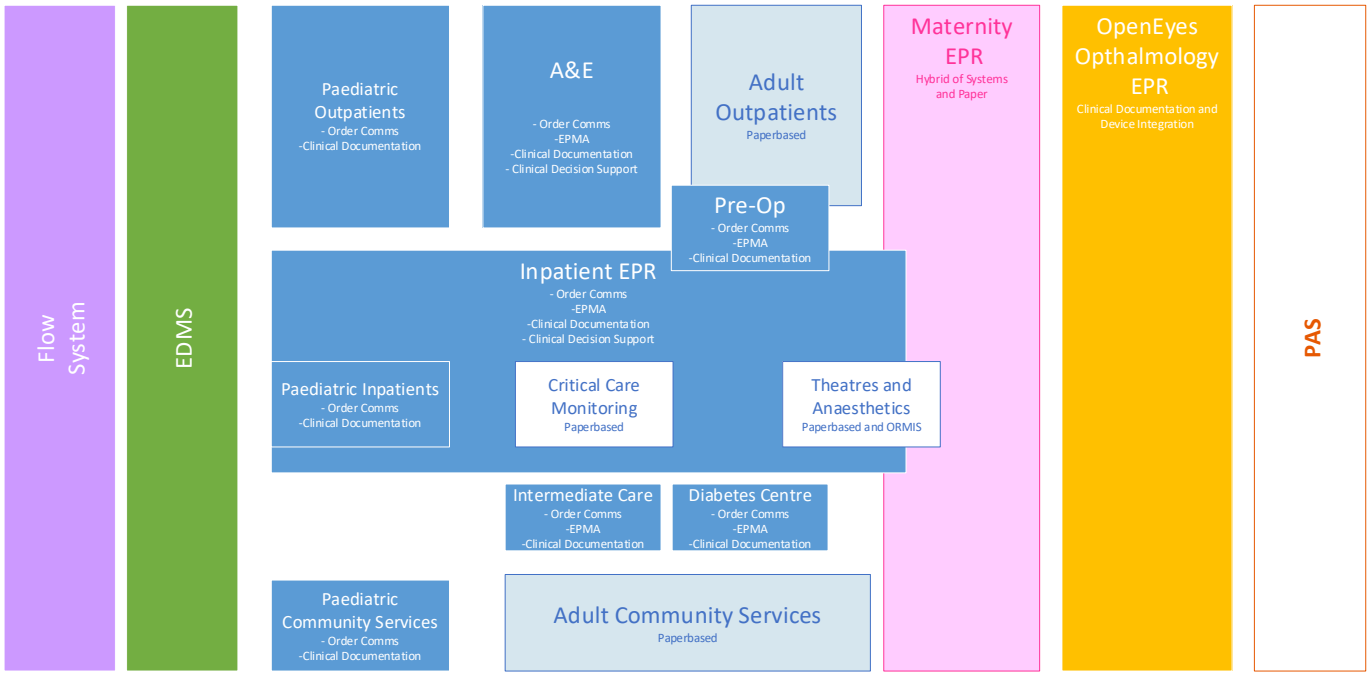
Appendix 2

Solid colour = Deployed
White = yet to Deploy
Pale colour = In deployment phase

January 2023



February 2024



Report Title:	Strategy and Operations Committee Chairs Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Sharon White and Rae Wheatcroft		Decision	

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

Summary:	The attached report from the Chair of the Strategy and Operations Committee provide an overview of matters discussed at the meeting held on 25 March 2024. The report also set out the assurances received by the committee and identifies the specific concerns that require attention of the Board of Directors. Due to the timing of the May meeting of the Strategy and Operations Committee, a verbal update will be provided to the Board with a written report presented to the subsequent meeting.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the Strategy and Operations Committee meetings held in March.

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:	Rebecca Ganz Non-Executive Director	**Presented by:**	Rebecca Ganz Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	25 March 2024	Date of next meeting:	28 March 2024
Chair	Rebecca Ganz, Non-Executive Director	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Minutes of the previous meeting
- Matters Arising and Action Log
- Review of Terms of Reference
- Board Assurance Framework
- Urgent Care Improvement Plan
- Cancer Recovery Update
- Productivity Update
- Month 11 Operational IPM
- Digital Resourcing Update
- Digital Performance & Transformation Board Chairs Report
- Bolton Strategy, Planning and Delivery Committee Minutes
- Operational Planning Update
- Performance and Transformation Board Chairs Report
- Locality Plan
- MIAA Internal Audit: Digital Plan

ALERT

Agenda items	Action Required
Recurring theme across the whole agenda relating to the risk around leadership capacity and the resulting impact on strategy implementation / priorities. Noted that the scale of the ask on leadership across all the different areas at the same time is within a short window to create sustainable change before getting back into Winter plans.	
Urgent Care Improvement Plan - 6 operational themes with Execs leading. Noted that one of the 5 supporting workstreams being data, information and reporting. Noted that the FT target for UTC is 93% and ECIST recommending a 98% target for 4 hour performance by focussing on improving pathways and flow through UTC. FT accessing additional support from ECIST and regionally.	
Business Intelligence - lack of SLA still with GM to protect resource for Bolton priorities. There is a substantially reduced team in Bolton at a time when the right data to prioritise the right decisions at the right time is under further pressure. June is the new date for an SLA.	
Digital Resourcing update - On-going prioritisation of the 136 Schemes underpinned by quantified hours required. Key challenge is resource. Committee requested an understanding of how oversubscribed digital is based on the must have programmes and where the hard choices need to be/have been made.	

Review of BAF risks x 3 - Risk 1.2 relating to operational standards, supported to increase current risk rating of 20 from 16, due to the prevailing backdrop. Risks 5 (integrating care) and 6 (partnerships) unchanged.	
ADVISE	
Urgent Care - noted UC is 'everyone's business, like FIG.' This requires a key shift in ownership of the 'front door' across the organisation. This is not yet the case and is a key focus. Query as to whether NED involvement would be of benefit, as it has with FIG. Noted that the ECIST work was very system focused, which was welcomed, triangulating with locality perspective and Carnall Farrar work.	
NCTR - The number of patients with No Criteria to Reside has slightly reduced in month but remains above operating plan at an average of 104. Occupied bed days have increased from the previous month of 894 to 900 in month 11 due to social work capacity within IDT, closures across our care home and intermediate bed base. Local Authority partners working with the FT to prioritise social work capacity across the borough.	
Digital Performance & Transformation Board Chairs Report - Resourcing issues as noted above. The concept of the 'Digital Factory' becoming embedded to help manage scarce resources.	
ASSURE	
Cancer 62 day performance - trajectory moved from expected best case of >85% in January to May due to bank holidays, industrial action and an uptick in lung referrals. The latter require a complex range of diagnostics synchronously compounded by reduced PET CT scan capacity at WWL. Christie in support**.**	
Productivity Programme - demonstrated clear benefits of doing more with less resource starting to be quantified in terms of financial and non-financial wins. Capacity for the programme confirmed as part of existing workstream.	
IPM **Elective Care –** high risk of 78 week breaches (19 with 9 corneal graft patients) and on track with 65 week waits for non-admitted patients by 31/3 and admitted timeline of 30/9. **Diagnostic performance** - improved by 3.7% in month to 7.6% versus a target of 5%.	
0-5 Mandated contacts – Health Visitor shortage noted as recurring issue, which will inform the approach to a stabilised 0-19 service	
Locality Plan - The Committee noted the plan as the result of 12 months' work across the system with our partners. Clarifying if a dashboard or heatmap may be available to assist with line of sight of progress**.**	
MIAA Internal Audit - Digital plan - Referred to SOC due to concern about capacity to follow through on the actions. Exec confirmed the majority are already resolved with a minority with longer close out dates**.**	
New Risks identified at the meeting: Triangulation of the capacity for leaders to manage so many intertwined priorities and the strategic implications thereof.	
Review of the Risk Register: As above	

Report Title:	Quality Assurance Committee Chair's Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Francis Andrews		Decision	

Purpose	The purpose of this report it 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 matters discussed at the meetings held on 27 March and 22 May 2024. The reports also set out the assurances received by the Committee and identifies the specific concerns that require the attention of the Board of Directors.

Previously considered by:
The matters included in the Chair's reports were discussed and agreed at the Quality Assurance Committee meetings held in March and May.

Proposed Resolution	The Board of Directors are asked to **receive** and note the chairs reports for Quality Assurance Committee.

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

Prepared by:	Fiona Taylor Non-Executive Director	**Presented by:**	Fiona Taylor Non-Executive Director

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	27 March 2024	Date of next meeting:	22 May 2024
Chair:	Fiona Taylor, Non-Executive Director	Meeting Quoracy: (Y/N)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Patient Story - FCD Division
- Review of Terms of Reference
- Integrated Performance Report
- Board Assurance Framework
- Quality Improvement Priorities Update
- Maternity Incentive Scheme Year 5 Progress Update (CNST)
- CQC Well Led Recommendation – Medical Director Update
- Clinical Governance & Quality Committee Chairs Report

ALERT

• Maternity Incentive Scheme Year 5 Progress Update (CNST): The Committee noted a discussion at the Sub Committee regarding stillbirth data from the MBRACE 2022 report which showed that the organisational stabilised and adjusted stillbirth rate, excluding deaths due to congenital anomalies, was 3.26 per 1,000 total births. This is around the average for similar Trusts & Health Boards and a further response in relation to the MBRACE report will follow in due course.	Action required

ADVISE

- Board Assurance Framework: The Committee noted that the risk appetite for both Ambition 1.1 and Ambition 1.3 had been received and that there were no changes to the current score. The Committee welcomed the opportunity to be involved in engagement and discussion around the Board Assurance Framework for 2024/25.

- Integrated Performance Report: Noted the key points highlighted by Chief Nurse and Deputy Medical Director including the cohort ward for c-difficile to be opened in April following final pathway sign off, there have been 15 consecutive months of no falls or inpatient category 3 pressure ulcers and that there are divisional meetings in place to continue to address the issues around clinical correspondence.

- Review of Terms of Reference: The Committee approved the revised terms of reference which had been amended to reflect the Board's decision to move to bi-monthly frequency. The Committee also noted that a full review of the Committees terms of reference will be undertaken in the next quarter and presented in July 2024.

- Quality Improvement Priorities Update: The Committee noted the proposed account priorities for 2024/25 were; Deteriorating Patient Collaborative, C-difficile Collaborative and QI skills capability building. There will also be quality improvement support provided to Urgent and Emergency Care. The Committee received an update on the ongoing account priorities for 2023/24 with the final Quality Account to be presented in due course.

- Maternity Incentive Scheme Year 5 Progress Update (CNST): Declaration confirming Trust position in relation to CNST Year 5 was submitted in January and notification of the financial award is due in April. Publication of the CNST Year 6 is due in April 2024.

ASSURE
• Patient Story – FCD Division: The Committee received the patient story which was in relation to a mother and the care she received following the delivery of her child prior to their due date despite having plans in place for the baby to arrive on time. During the patients experience it was noted that she was advised on the survival chances following early delivery. The patient discussed how the news that the baby would not survive was not delivered in a suitable environment and that there were other mothers with their children in the same area which was quite distressing and could have been done differently. The Committee received the patient story and thanked the patient for sharing their experience and the division for their learning. It was confirmed that the patient will receive feedback on the changes that the division have put in place. • CQC Well Led Recommendation – Medical Directors Update: The Committee were informed that a review of the pharmacy workforce had been undertaken and a business case will be presented to the Executive Directors regarding the workforce costs identified. The other recommendations regarding medicine reconciliation and the establishment of a task and finish group have both been completed. • Clinical Governance & Quality Committee Chairs Report: The Chairs Report was received by the Committee with no items to be escalated.
New risks identified at the meeting: None.
Review of the Risk Register: Not reviewed.

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	22 May 2024	Date of next meeting:	24 July 2024
Chair:	Fiona Taylor, Non-Executive Director	Meeting Quoracy: (Y/N)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Patient Story - ICSD Division
- Integrated Performance Report
- Trust Mortality Report
- Learning from Deaths Report
- Harms in ED Report
- Mortality Report for Family Care
- Maternity Incentive Scheme Year 6 Progress Update (CNST)
- Quality Account Annual Report
- Quality Improvement Plan Update Q4
- Clinical Claims Governance
- Clinical Correspondence Quarterly Update
- Medical Examiner Service Level Agreement
- Trust Strategy – KPIs and Measures of Success
- Serious Incident Investigation Reports x2
- Clinical Governance & Quality Committee Chairs Report

ALERT

• Integrated Performance Report (C-difficile) – It was noted that the Trust has been an outlier in GM for over three years. The committee were concerned that the start of the new financial year in April had seen a continued upward trend. The use of antimicrobials; especially with Covid19 and the nature of Bolton's population are definitely contributing factors. It was noted that whilst performance targets are not being achieved there are further measures being put in place to address this, such as the opening of a cohort ward, daily review of failure to escalate, establishment of multi-disciplinary operational planning meetings, analysis of antimicrobial use and peer support from other organisations. The committee were provided with reassurance regarding the matter and will keep this are under close scrutiny at the next QAC. • Medical Examiner Service Level Agreement – The Committee received and approved the report which had previously been discussed and approved by the Executive Directors.	<u>Action required</u>

ADVISE

- Integrated Performance Report – The Committee were provided an update which included the following key points; there were x3 category 3 pressure ulcers which will be subject to the usual verification and analysis. In April there was one PSIRF report due for approval however this required additional work and will be approved in May, mortality indicators remain within range, maternity have seen a reduction in 3rd degree tears and booking at 12+6 has significantly improved.
- Trust Mortality Report – The report was received and the Committee noted that the SHMI/HSMR are within the expected parameters. There was a need to review the leadership of this area and the Medical Director is working with the team. The next steps will be to further improve Charlson comorbidities which will be assisted by the new EPR changes and for the clinical teams to continue to review any alerting conditions.
- Learning from Deaths Report – The report was received and it was highlighted that the cases to be reviewed are proportionately the same as previous reports, despite it looking to have increased. As per a previous request by the Committee there was no data included in regards to the day to day variations and so this will be included in future reports.

- Harms in ED Report – The Committee received and noted that the comprehensive report concluded that there was no significant relation to deaths within ED due to the increased waiting times. There remains concern over the number of delayed and omitted drug doses including critical medicines. It was noted, that this was related to patients regular medication and not that prescribed as part of their ED treatment plan. The Chief Pharmacist is considering how this may be supported. Committee members suggested ways in which communications could be sent out to the public, NWAS and Out of Hours services to remind patients to bring any medications regularly prescribed into hospital.
- Mortality Report for Family Care – The Committee noted that the MBRACE report for 2021 had shown issues regarding stillbirth and neonatal deaths. The Trust has reviewed all of these cases and there are no concerns regarding quality of care. The focus is now to be on data quality and the data reporting mechanisms. There is a proposal for additional metrics to be added into the Integrated Performance Report going forward which will be the same as that used for both GMEC and MBRACE and allow a real time review.
- Maternity Incentive Scheme Year 6 Progress Update (CNST) – The Committee were informed that the Trust was well placed to achieve Year 6 however there will be more assurance checks throughout the year. The challenge will be releasing staff to attend training which takes place over five days. Feedback from the LMNS visit and recommendations are received in the report. Since the report was produced it has been announced that the Trust has been stood down from the Regional Support Programme.
- Quality Improvement Plan Update Q4 – The update was received and it was noted that the Quality Improvement Plan had now been finalised and published on B.o.B. There will be a Trust wide launch in June 2024.
- Clinical Claims Governance – The Committee noted that the report had identified a need to strengthen claims governance to ensure robust, standard approach to review of claims upon receipt. A Clinical Claims Panel will be established in Q1 2024/25 for which the terms of reference had been shared for comment. A thematic analysis of the top 5 specialties for clinical claims is being undertaken and will be shared with relevant specialties for learning.
- Clinical Correspondence Quarterly Update – The report was received which provided an update which included a Tableau report for the extraction of ward and specialty data, which has allowed for a review of all areas to identify those which are appropriate for exclusion. The Committee were partially assured but it was agreed to maintain quarterly updates until full assurance is provided.
- Trust Strategy (KPIs and Measures of Success) – The draft strategy was shared with the Committee for comments prior to final submission at Board of Directors. There was a discussion regarding the inclusion of qualitative analysis and to ensure that there is an emphasis on the effectiveness aspects of the strategy. It was noted that the strategy will report annually into the Committee once launched and that the extensive list of KPIs will be revised in due course.
- Serious Incident Investigation Reports x2 – The reports were received and the Committee agreed with the recommendations identified. A thematic report on recommendations will be produced and shared as part of the PSIRF process.
- Clinical Governance & Quality Committee Chairs Report – There were no issues raised for escalation by the Committee however it was noted that in line with other organisations Bolton NHS FT had received a letter from the CQC regarding Paediatric Audiology and this will be reported on in due course for assurance.

ASSURE

- Patient Story - ICSD Division – The story centred on the Admission Avoidance Team (AAT) and the support provided to an elderly husband and wife who had full time guardianship of their grandchild. The wife was a carer for her husband who had dementia and was also working part time to support the family. On reaching out to the Admission Avoidance Team it became apparent that the wife also required support. This was provided through the collaborative working of the AAT and the voluntary sector. The Committee noted the importance of ensuring resource is being provided in the right areas through a review of capacity and demand within the intermediate care services.
- Quality Account Annual Report – The report was a working document shared for any final comments before the approval of Board of Directors and publication in June 2024.

New risks identified at the meeting: None.
Review of the Risk Register: Not reviewed.

Report Title:	Clinical Negligence Scheme for Trusts Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		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 ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Summary:	Key highlights: • Confirmation has been received within the Trust that the CNST year 5 results have been approved following an external verification process and all ten safety actions have been met. Formal receipt of the payment is awaited within Trust. • The CNST year 6 scheme guidance was launched on the 2 April 2024 with an associated benchmarking tool. • An initial review of the year 6 scheme safety requirements has been undertaken and data collection has commenced. The maternity service is well placed to achieve the year 6 scheme recommendations and has re-established the monitoring procedures commenced in year 5 to ensure rigorous oversight and monitoring of the year 6 scheme requirements. • The report following the Local Maternity Neonatal System (LMNS) visit undertaken on the 19 February 2024 has been received by the maternity service with recommendations for future practice. Positive improvements were noted in culture within the report and additional assurance was requested regarding timeframes for the restoration of paused digital and clinical activity. In summary the CNST year 6 scheme has been launched and ongoing monitoring of the safety actions has commenced. The assurance report has been received following the LMNS visit in February 2024 and a detailed action plan has been collated in response.

Previously considered by:
The report has been previously considered by the Family Care Divisional Board, Clinical Governance and Quality Committee and Quality Assurance Committee

Proposed Resolution	*It is recommended that the Board:* *i. Receive the contents of the report.* *ii. 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:	Tyrone Roberts, Chief Nurse Janet Cotton, Director of Midwifery/ Divisional Nurse Director	**Presented by:**	Tyrone Roberts, Chief Nurse

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
LMNS	Local maternity and neonatal system
GMEC	Greater Manchester and East Cheshire
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries

1. Introduction

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 ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) year 6 Maternity Incentive Scheme (MIS) launched on the 2 April 2024.

The incentive scheme continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

2. CNST year 6 update

The CNST year 6 scheme guidance was launched on the 2 April 2024 with an associated NHS Resolution benchmarking tool.

An initial review of the year 6 scheme safety requirements has been undertaken and data collection has commenced. The maternity service is well placed to achieve the year 6 scheme recommendations and has re-established the monitoring procedures commenced in year 5 to ensure rigorous oversight and monitoring of the year 6 scheme requirements. Oversight of the year scheme compliance will be monitored using the NHS Resolution benchmarking table that is updated following population of the NHSR tool.

Table 1 – CNST year 6 progress update

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	6	0	0	0	6
2	2	0	0	0	2
3	4	0	0	0	4
4	20	0	0	0	20
5	5	0	0	0	5
6	6	0	0	0	6
7	7	0	0	0	7
8	18	0	0	0	18
9	8	0	0	0	8
10	8	0	0	0	8
Total	84	0	0	0	84

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

The Board of Directors is required to receive a report each quarter that includes details of all deaths reviewed from the 8 December 2024. The detail for Q1 is detailed with Appendix 1 and confirms the PMRT tool has been used to review all eligible cases

and the required standards have been met. Ongoing action plans will be published in subsequent reports following review of the cases.

3. Ongoing monitoring

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.

In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022 as detailed in table 2. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance.

Additional required datasets from staff and service user feedback sessions are displayed in Appendix 2.

A revision of the dashboard metrics has been undertaken to align with the GMEC reporting requirements. The revised stillbirth metric now excludes cases of termination of pregnancy and thus is more reflective of cases in which learning can be identified.

The dashboard will be used in conjunction with monthly integrated performance management reports to evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. The dashboard will continue to be presented by a member of the perinatal leadership team to provide supporting context.

Ongoing monitoring of the metrics will be undertaken at bi-monthly safety champion meetings with the perinatal quadrumvirate leadership team where any additional support required of the Board can be identified an escalated. The next bimonthly meeting is scheduled for the 15 May 2024.

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	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
CNST attainment	Information only					100%		
Critical Safety Indicators								
Births	Information only		468	451	419	451	408	403
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			1	1	0	2	3	1
Still Birth rate per thousand (excluding termination of pregnancy cases)	3.5	≥4.3	2.1	2.2	0.0	4.4	7.4	2.5
HIE Grades 2&3 (Bolton Babies only)	0	1	1	0	0	0	0	1
HIE (2&3) rate (12 month rolling)	<2	2.5	2.7	2.5	1.9	1.6	1.5	1.6
Early Neonatal Deaths (Bolton Births only)	Information only		0	0	1	1	2	1

END rate in month	Information only		0.0	2.2	2.4	4.4	2.5	7.4
Late Neonatal deaths	Information only		0	0	0	0	0	0
Serious Untoward Incidents (New only)	0	2	1	1	0	1	0	0
HSIB referrals			1	0	0	0	0	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	0	0	0	0	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98.6%	98.1%	97.7%	97.7%	96.4%	99.%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0
BAPM compliance (neonatal unit)	>99%	<79%	90.2%	94%	98.5%	97.9%	97%	87%
Fetal monitoring training compliance (overall)	<80%	>80%	83.0%	84.00%	86.00%	91.95%	93.33%	95.82%
PROMPT training compliance (overall)	<80%	>80%	83.0%	84.00%	88.60%	95.76%	94.00%	95.31%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:24.3	1:23.2	1:23.4	1:23.2	1:22.9	1:22.8
RCOG benchmarking compliance	Information only		100%	100%	100%	100%	100%	100%
Compensatory rest breaches			0	0	0	0	0	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual					59.4%		
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

4. LMNS Assurance Visit

Since 2023, the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity & Neonatal System (LMNS) has taken on the role of assurance and oversight of maternity services for the ICB. In response a LMNS assurance was undertaken the 19 February 2024.

The visit was undertaken to seek assurance that the provider was compliant with all Ockenden Immediate and Essential Actions (IEA's) (Appendix 3) and ensure the guidance was embedded in practice. The visit was also be used as an opportunity to review implementation of the three year delivery plan for maternity and neonatal services published in 2023 and seek assurance with regard to wider national and local pieces of work and care standards.

The Trust provided assurance during the visit that all immediate and essential recommendations have been implemented within the service (Appendix 3) and progress to evidence delivery of the single delivery plan was presented.

A detailed assurance report was presented the Trust on the 02 April 2024 following the visit.

Key highlights of the report:

- The LMNS has noted a real shift within the culture and leadership within Bolton in the last 18 months
- There has been a positive shift within accessing Freedom To Speak Up (FTSU) and champions in each area
- There is a positive approach to reviewing data including thematic analysis
- Staff who were spoken to during the walk rounds were positive about their experience at Bolton, highlighting the ease of escalation, scale of support available, good appraisal and mentorship schemes and good cross-functional relationships.
- The culture work that has been undertaken is fantastic and a good opportunity to share with the wider system
- The approach to postnatal readmissions (women attending triage) is a positive one

Areas for improvement

- The visiting team would have liked more data to be used in the presentations to provide additional assurance on outcomes associated with the work undertaken
- During the presentations there was limited involvement form the obstetric and neonatologist elements of the quadrumvirate and as such it is difficult to determine if there is an equal voice amongst all elements of maternity care. There was also a lack of information regarding if obstetric staff are suitably resourced to support the safety and quality work in an MDT approach
- Reinforced Aerated Autoclaved Concrete (RAAC) is having a large impact on flow causing bed blocking
- There is an estates issue with triage, with it currently being hot, loud and quite medicalised. There are risks associated with the triage area including lack of triage bed capacity, time taken waiting for medics review and a lack of direct eyes on the women in the waiting room.
- Some IT projects have been stalled for a long period of time which can appear as a lack of priority within staff members.
- Choice of place of birth is noted as an issue for Bolton
- Some staff who have joined the trust due to continuity of carer may not stay due to this not currently being offered
- Lack of antenatal education may be a contributing factor to instability in the number of 3rd & 4th degree tears
- There is only one matron and consultant within the governance team structure – this may be a risk due to single point of failure
- The feedback loop to service users regarding changes needs to be strengthened through the MNVP

A detailed list of recommendations with defined timeframes for action was included within the report with a requirement for the formal submission of evidence to be made to the LMNS (Appendix 4).

5. Serious incidents Q4

No serious incidents were reported in Q4 2023-2024.

One moderate harm incident was reported in Q4. This related to a third /fourth degree tear following a failed kiwi delivery due to an episiotomy not being performed.

Triangulation of learning Q4

The formal triangulation scorecard is due to be presented to the Divisional Governance and Quality Committee on 9 May 2024 as per CNST requirements. There were no explicitly shared themes shared across the claims scorecard, incident and complaints data presented in Q4.

A thematic review was undertaken during Q4 of incidents relating to fetal loss >24 weeks. Learning identified related to:

- Provision of guidance
- Telephone Triage pathway
- Assessment of risk
- Management of test results
- Human factors

A detailed action plan has been collated in response to the findings of the thematic review.

6. Summary

This report provides an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

The report provides assurance of ongoing monitoring of the CNST year 6 scheme requirements and of successful verification of the CNST year 5 submission. Notification of the financial award within the Trust is awaited.

This report outlines the key findings of the LMNS Assurance Visit undertaken on the 19 February 2024 and the recommendations for practice.

7. Recommendations

It is recommended that the Board:

i. Receive the contents of the report.

ii. 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 – Perinatal mortality review tool cases as from 8 December 2023

Case ID no	SB/NND / TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/concerns questions	PMRT Information letter given	Report published Deadline Date 6 months
90970	Postnatal NND. 28 days	24	20.12.23	0	20.2.23 done 2.1.24	20.12.23		20.6.23
90993	ENND	22	21.12.23	0	Assigned to MFT 21.02.24	21.12.23		21.6.24
91162	SB	25+2	03.01.24	0	03.03.24 done 03.01.24	03.01.24	12.1.24	03.07.24
91589	ENND	35+3	29.1.24	0	29.3.24 done 29.1.24	29.1.24	29.1.24	29.7.24
91686	ENND	38+0	4.2.24	0	4.4.24 done 6.2.24	4.2.24 6.2.24	6.2.24	4.8.24
91814	SB	25+3	9.2.24	0	9.4.24 done 9.02.24	9.2.24 - need to add parent concerns to PMRT report	9.2.24	9.8.24
91853	SB	26+3	11.02.24	1	11.04.24	11.02.24	12.2.24	11.08.24

					done 11.02.24			
91945	NND	30	18.1.24 17.2.24	0	17.4.24 Assigned to Blackpool	20.2.24		17.8.24
91972	SB	40+0	19.2.24	0	19.4.24 Done 19.2.24	19.2.24	19.2.24	19.8.24
91991	ENND	26+1	18.2.24 20.2.24	0 Needs amending to delivery at NMGH when returned	20.4.24 Assigned to MFT (NMGH)			20.8.24
92395	NND	34	7.2.24 29.2.24	15 due to not known- Community/home Death	29.4.24 done 19.3.24	Unknown	No	29.8.24
92646	MISC	22+3	2.4.24	0	2.6.24 done 2.4.24			2.10.24

Appendix 2 - Feedback from Executive / Non-Executive Walkabouts undertaken including service user and staff feedback

You Said	We did
March 2024	
Feedback from staff and service users indicated that the restricted visiting arrangements in place on the maternity wards did not support the religious requirements of Ramadan.	Urgent review of visiting arrangements undertaken and visiting timescales extended from 0900 - 2100hrs in all ward areas with unrestricted access for two persons and restricted visiting times for persons under that age of 16yrs. Open visiting arrangements continued in intrapartum areas.

Appendix 3 – Ockenden immediate and essential actions compliance

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**	**0**	**7**
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**	**0**	**6**
4	**Managing Complex Pregnancy**	There must be robust pathways in place for managing women with complex pregnancies	**6**	**0**	**0**	**6**
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**	**0**	**4**
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**	**0**	**5**
		Total	**42**	**0**	**0**	**42**

Appendix 4 – LMNS recommendations for Trust

	Recommendation	Timeframe
1.	A triage action plan related to improvements and changes within the triage area to be provided to the LMNS	30 / 04 / 24
2.	A timescale surrounding the reopening of Ingleside MLU & alongside MLU as a choice of place of birth option to be provided to the LMNS	30 / 04 / 24
3.	Plans surrounding the establishment of Continuity of Carer to be provided to the LMNS	31 / 05 / 24
4.	List of paused data projects (due to RAAC) to be provided to the LMNS	30 / 04 / 24
5.	RAAC removal and estate work timelines to be provided to the LMNS	30 / 04 / 24
6.	Report following Alex Hazel's meeting with the doctors to be provided to the LMNS	30 / 04 / 24
7.	Plan for the reintroduction of Antenatal education amongst relevant staff	31 / 05 / 24
8.	Previous 15 steps undertaken with the MNVP should be reviewed and timelines allocated to outstanding improvements	30 / 04 / 24
9.	Review the feedback loop associated with closing activities that have come due to MNVP involvement to ensure that there is adequate communication	31 / 05 / 24
10.	Those involved within the implementation of the MSW competency framework should reach out to engage with the LMNS support group	Oct – 24
11.	Ensure engagement with LMNS support in regards to labour ward coordinator framework and retention midwife progress towards developing a retention plan	Oct - 24
12.	At subsequent Assurance Visits For the Quad to present as a united voice, to give assurance of collective responsibility	Oct – 24
13.	At subsequent Assurance Visits data is used to assure changes implemented in response to issues identified within the service	Oct – 24

Report Title:	People Committee Chair Report – May 2024

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	James Mawrey		Decision	

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

Summary:	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 21 May 2024. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the People Committee.

Proposed Resolution	The Board of Directors is asked to ***receive*** the People 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:	James Mawrey, Director of People	**Presented by:**	Alan Stuttard, Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21 May 2024	Date of next meeting:	16 July 2024
Chair	Alan Stuttard, Non-Executive Director	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

• Terms of Reference • Trust Strategy KPIs • FTSU Q4 Report • Nursing & AHP Bi-annual Staffing Report • Midwifery Bi-annual Staffing Report • EIA Process	• Staff Survey Action Plan • Resourcing & Retention Update • Workforce Digitalisation Update	• Steering Group Chair Reports • Divisional People Committee Chair Reports

ALERT

There are no matters to Alert the Board on.	Action required

ADVISE

Trust Strategy KPIs (Ambition 2) - A final draft of the Strategy and associated Workforce/OD section were approved by the Committee (with minor amends). It was felt that the KPI's needed to be more outcome focused and aligned to the People Committee Pillars.

Freedom To Speak Up Q4 Report – A total of 58 cases have been reported via the FTSU route during this quarter. Cases have been discussed with the relevant divisional senior leadership teams and are being dealt with accordingly. Similar to other NHS organisation the highest number of themes noted are leadership/support and behaviour. The actions from the recent MIAA Audit have been updated and outlined in the paper. A discussion did take place on the NHS Staff Survey FTSU questions and the actions being taken.

Resourcing & Retention Update – March 2024 saw an increase of WWTE of 47 and reduction of 15 in April 2024. Temporary staffing increased in March as a result of both additional capacity being opened and annual leave cover. Agency expenditure increased by £160k in March 2024 and reduced by £42 in April 2024 (delivery against the NHSI Agency target are contained elsewhere within the papers). Bank spend increased in March, but reduced by £266k in April. Vacancy rates have been broadly tracking downwards (positively) throughout 2023/24. Turnover shows a reducing trend and benchmarks well in most staff groups. Resourcing has good activity on nursing, midwifery, HCA and medical recruitment. Continued work underway to fill posts which drive temporary staffing expenditure.

Workforce Digitalisation Update – the presentation outlined the Digital / Workforce Systems Plan – simplifying People/HR systems and process to make life easier for our people. The People Committee supported the actions being taken.

ASSURE

Terms of Reference – approved. Noted that further changes may be required following recent Board & Committees review being undertaken. **Staff Survey Action Plan –** The Committee reviewed the Plan and recommended it to the Board for approval. **EIA (Equality Impact Assessment) Process and toolkit -** The Committee reviewed the refreshed EIA process and toolkit and recommended it to the Board for approval. **Nursing & AHP Bi Annual Staffing Report - The Committee approved the Report.** The Board is asked to note the People Committee's support of the Chief Nurse recommendations, specifically noting the assurance that he felt that safe staffing levels were in place for the reporting period. Matters were raised regarding rostering which the Chief Nurse will pick up and report back to the next meeting. **Maternity Bi Annual Staffing Report – The Committee approved the Report.** The Board is asked to note the People Committee's support of the Chief Nurse & Director of Midwifery's recommendations, specifically noting that the assurance that they felt that safe staffing levels were in place for the reporting period.
New Risks identified at the meeting: None
Review of the Risk Register: None

Report Title:	Bi-Annual Nurse Staffing Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Purpose	The purpose of this report is to outline the findings of the Bi-Annual nurse staffing review for the period July- December 2023.

Summary:	The Bi- Annual nurse staffing report provides an overview of available data to provide assurance to the Board of Directors of safe staffing levels. The report triangulates workforce information with patient safety measures to ensure that staffing is balanced in line with patient acuity. The report follows the guidance as set out by the National Quality Board (NQB) to meet the three expectations, right staff, right skills, right place and time. **Right Staff** - The report provides assurance that the recommendation of 1:8 in adult in patient areas is being met, that the trust uses recommended national tools to review acuity, has agreed headroom uplift and utilises professional judgement in order to maintain staffing. **Right Skills** - The report provides evidence that staff are undertaking relevant mandatory training and have been supported to undertake leadership programmes. **Right Place and Time** - The report provides evidence and assurance that ongoing assessment is place for monitoring E-rostering KPIs and that staff are utilising temporary staffing solutions in order to maintain safety as and when required The report provides assurance that adult registered nurse staffing levels are safe and details a number of next steps and transformation work that is underway to further develop and enhance Registered Nurse staffing.

Previously considered by:
People Committee

Proposed Resolution	The Board of Directors is asked to ***receive*** the Bi-annual Nurse Staffing 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:	Lianne Robinson, Deputy Chief Nurse Sonia Griffin, Assistant Director of Nursing Tyrone Roberts, Chief Nurse	**Presented by:**	Tyrone Roberts, Chief Nurse

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

BAPM	British Association of Perinatal Medicine
DOH	Department of Health
NICE	National Institute for Clinical Excellence
NQB	National Quality Board
NWNODN	North West Neonatal Operational Delivery Network
ODN	Operational Delivery Network

Executive Summary

The bi-annual nurse staffing report provides a comprehensive overview of available data to assure the board that safe staffing levels are being maintained across the trust. The report triangulates workforce metrics with key patient safety measures, ensuring staffing is continuously balanced and aligned with patient acuity needs. In accordance with the National Quality Board (NQB 2018) guidance, the report analysis performance is against the three core expectations of having the right staff, with the right skills, deployed at the right place and time.

Right Staff

- For adult inpatient areas, the average ratio each month has remained in line with the NQB.
- For paediatrics, Bolton's children's unit operates as part of the Greater Manchester network, which has an agreed 1:5 nurse to patient ratio standard for all age groups 24 hours per day. Further work is required in order to fully understand and report against this metric.
- For neonates, in a 6-month period the average staffing level is calculated at 93%, the BAPM standard is between 90-100%.
- Daily staffing is monitored using SafeCare linked to e-rostering, with plans to fully embed its use over the next year.

Right Skills

- The Professional Development & Education team delivered an in-house bridging the gap programme, which included a session on leadership and staffing.
- All inpatient areas now have ward managers in fully supervisory roles to enable effective ward leadership.
- HR metrics including sickness, turnover, appraisals, statutory and mandatory training, and return to work interviews were monitored monthly through divisional performance meetings and the Trust People Committee.

Right Place and Time

- E-rostering reports track approval lead times, finalisation compliance, additional duties beyond budgeted establishment, fill rates, time owed/owing, unavailability, and temporary staffing usage. Whilst this provides visibility, more work is required to improve rostering effectiveness.
- Divisions have made reductions in bank/agency use as substantive registered staff numbers increase gradually.

Clinical outcomes

Out of the 509 staffing incidents reported from July to December 2023, zero resulted in moderate patient harm. This can be directly credited to the appropriate escalation protocols and mitigation actions followed, such as redeploying staff from other clinical areas to cover staffing gaps. When examining the actual impact, 402 were no harm events and 101 were low harm events. Only one incident was still pending a final determination of impact level, but had been initially reported as no harm.
While any staffing incidents are undesirable, the absence of moderate patient harm demonstrates the effectiveness of the processes implemented to maintain safe staffing levels despite arising challenges. Professional judgment proved paramount in managing unplanned

absences or increased demand, coupled with ensuring the right skill mix and competencies of the nursing staff to facilitate effective patient care delivery.

Summary

The data provided and subsequent analysis conducted substantiates the recommendation that Bolton NHS Foundation Trust successfully maintained appropriate safe staffing levels during the July to December 2023 period. By triangulating workforce information with safety, patient experience, and clinical effectiveness metrics, the report provides overarching assurance that proper staffing standards aligned with patient needs and acuity. Moving forward, key priorities have been established for the next 12 months that will be monitored. These include reviewing healthcare assistant retention rates and factors influencing turnover across Greater Manchester, implementing a Fundamentals of Care package for all HCAs, fully rolling out the SafeCare software's functionality to record staffing red flags and enable live staff redeployment, and continuing to embed the Safer Nursing Care Tool (SNCT) in community settings to build a second dataset for evidence-based skill mix reviews.

1. Introduction

1.2 This report details the findings of the Bolton Foundation Trust July- December 2023 bi-annual nurse staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the organisation.

1.3 The report fulfils the requirements outlined in the National Quality Board (NQB 2018), that recommends acute hospitals should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months. The review incorporates all national guidance relating to the provision of safe staffing levels, National Institute for Clinical Excellence (NICE) guidance 2016, National Quality Board (NQB) 2018.

1.4 The report provides assurance to the Board of Directors that in-patient wards are staffed in line with the national guidance and that where this falls below the standard the relevant mitigation is put in place.

2. Background - Adult in-patient areas

2.1 In January 2018, the National Quality Board (NQB)[1] released updated guidance in respect of adult in-patient areas, defined as wards that provide overnight care for adult patients in acute hospitals.

Table 1; NQB's expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

[1] National Quality Board *Safe, sustainable and productive staffing* an improvement resource for adult inpatient wards in acute hospital

3. Current Situation

3.1 Expectation 1 – Right Staff – adult and paediatrics

Table 2; Compliance against key recommendations all wards during the months of July - December 2023

Recommendation	Assessment
RN to Patient ratios not exceeding 1:8 day shifts for adults.	An in depth review has been undertaken and, across all adult wards in total, the average ratio each month has not exceeded the 1:8 and is in line with NQB
RN to Patient ratios not exceeding 1:5 24 hours a day for Children.	Bolton children's unit works as part of the Greater Manchester Network where an agreed nurse / patient ratio of 1:5 24 hours a day is the agreed standard for all age groups, as it is very difficult to predict the age groups that will be admitted. The staff cover E5 ward, High Dependency Unit, Day Case Surgical patients, F5 Assessment Unit and ward attenders. Therefore, the ratio of nurse to patient is difficult to accurately monitor. Further work is required in order to fully understand and report against this metric.
Evidenced based Tool	The organisation has deployed the Safer Nursing care tool and completed a minimum of 2 census within 12 months.
Headroom/uplift	Headroom/uplift is calculated at 23% - compliant
Skill Mix	Reviewed as part of bi- annual staffing review.
Professional judgement	All areas are reviewed Bi annually with a focus on RN to Patient ratios and overall shift numbers (budgeted) vs actual

3.2 Neonates

Staffing levels on the Neonatal Unit are monitored in line with the British Association of Perinatal Medicine (BAPM 2021, DOH 2019 and NICE 2018). The model indicates the staffing levels in relation to patient acuity i.e. 1:1 for Intensive Care, 1:2 for High dependency care and 1:4 for special care and a supervisory shift coordinator (band 7) in charge.

The neonatal nursing workforce calculator is used to assess compliance annually and was last completed in October 2023. The last review highlighted deficit of 10.76WTE in the neonatal nurse qualified in specialty standard (QIS) (Appendix 2) .Assurance can be provided the action plan to address the staffing deficit was presented to the Board of Directors in November 2023 and remains ongoing.

The service aims to achieve 90% - 100% compliance with BAPM staffing levels and attained an average of 93% compliance during the period July – December 2023.

We aim to achieve 90% - 100% staffing as per BAPM.

Table 3: Average levels from July – Dec 23 of staffing as per BAPM incorporating all patient: staff ratios.

MONTH	Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
BAPM COMPLIANCE	95%	89%	88%	91%	97%	98%

>95% Green 90-95% Amber < 90% Red

Additional detailed information can be found in Appendix 2

3.3 Process for review of safe staffing

Bi Annual Acuity review

The trust utilises the Safer Nursing Care Tool (SNCT) in order to undertake the bi annual reviews of staffing and acuity. This is a national evidence based tool that allows ward staff to input their staffing levels and patient acuity on a daily basis, for a period of 14 days. During this period, an independent reviewer undertakes a further review to ensure reliability and accuracy of data.

The trust has utilised the tool for the past five years however the Chief Nurse rejected the outputs from 21/22 and 2022 due to concerns with a lack of process validity and reliability.

The Chief Nursing Officer instructed a full review of the SNCT process. This commenced in 2022 with three subsequent data sets. However, concerns again were raised with the inter-rater variability. Following a significant period of re training, education and a revised assessment process, a full data set for adult inpatient wards was gathered in July 2023, with the second data set successfully undertaken in February 2024.

The outcome of these two data sets will now form the basis for establishment setting with a plan to repeat six monthly in line with NQB recommendations.

The outcome of these two reviews confirms that overall staffing establishments are correct, yet notes there are opportunities for some adjustments between and within divisional areas. This is underway, which a plan to conclude by the end of Q2.

Daily staffing and acuity reviews

The Divisional Nurse Directors utilise SafeCare (web based tools linked to allocate the e-rostering system) in order to review staffing on a daily basis. This provides the ability to have a full overview of the organisation and ward acuity to enable us to move staff around to balance and mitigate any risks to patient and staff safety.

The use of SafeCare is part of the workforce transformation objectives for the next 12 months to fully embed into practice and ensure accuracy of data.

Further information can be found in appendix 3.

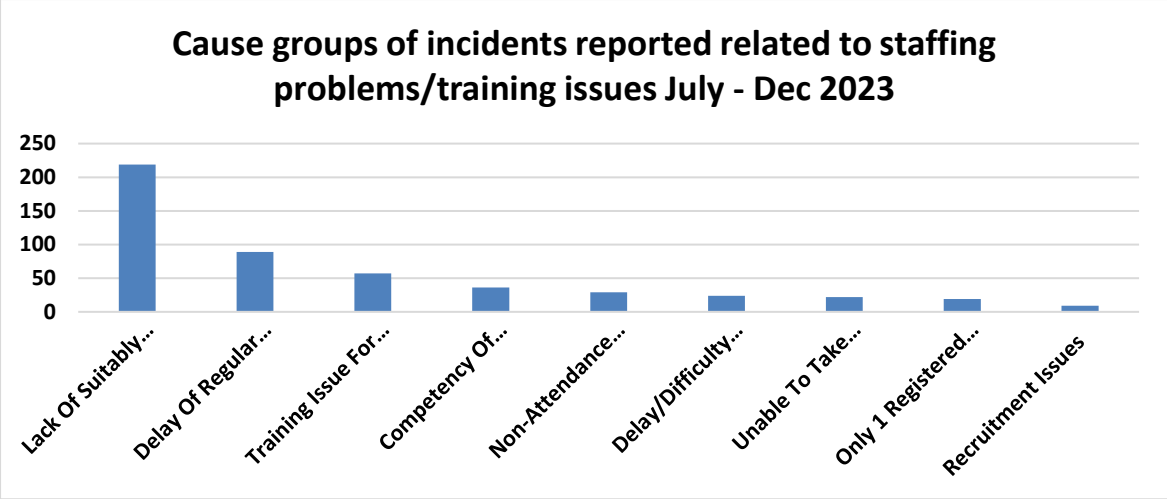
3.4 Reporting staffing concerns/ Red flags

In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

- An unplanned omission in providing medications

- A delay in providing pain relief
- An incidence where vital signs have not been assessed or recorded
- Missed intentional rounding
- A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
- Less than two Registered Nurses or Midwives available on a shift.

Chart 1: Incidents reported related to staffing problems/ training issues July - Dec 2023



3.4.1 Appropriate escalation was undertaken for all of the incidents reported and the mitigation taken included the following actions:

- Additonal staff were moved to support from other areas.
- Matron reviews were undertaken and a dynamic risk assessment and professional judgement was used to determine deployment of staffing.
- Escalation to Senior Divisional Management to review incidents.

In total there were 509 staffing incidents. This is an increase on the number of incidents reported in the previous period (Jan -June 23) of 413, but a significnat reduction in the same period (July- Dec 22) of 714.

The actual impact of the incidents reported was 402 no harm, 101 low harm and 1 incident has yet to be given a final actual impact, with the initial impact being reported as no harm.

Nineteen incidents were reported under the cause group of one Registered Nurse/ Midwife on duty. Of the nineteen incidents submitted with a cause group of only one Registered Nurse/ Midwife on duty, thirteen were reported correctly. The remaining six included two duplicates and four were incorrectly reported, as the narrative demonstrated there was more than one Registered Nurse/ Midwife on duty.

For the thirteen reported correctly, appropriate escalation took place with support provided by staff from other areas in seven of the incidents. For the remaining six, Matron reviews were undertaken and a dynamic risk assessment and professional judgement was used to determine deployment of staffing and escalation to Senior Divisional Management to review incidents.

All incidents detailed appropriate escalation of the lack of registered staffing.

4.0 Expectation 2: Right skills

4.1 Leadership

The Professional Development & Education team developed and delivered an in-house bridging the gap programme, which included a specific session regarding leadership and staffing. All Ward Mangers attended a foundation level and Matrons an enhanced level.

All in patient areas now have ward managers as fully supervisory to enable effective ward leadership.

4.2 Staff measures

The below tables show the HR metrics for each month July to December 2023. This provides an overview of sickness, absence and turnover across the organisation. The turnover rates exclude internal staff moves.

HR metrics are monitored and reported through divisional Integrated Performance Meetings and at the Trust People Committee.

Table 4: HR metrics

Measure Type	No.	No.	%	%	£	%	%	%	%	%
Period to Measure	In-month	In-month	In-month	12 months	In-month	12 months	12 months	12 months	12 months	In-month
Month	HC (Active)	WTE	Sickness Absence (includes Covid sickness)	Sickness Absence Rolling	Est. Sickness £ (in-month)	Labour Turnover %	Appraisal (excluding medical staff)	Statutory Training	Mandatory Training	RTW
Jul-23	5982	5208.39	5.10%	5.42%	£873,135.62	12.64%	86.35%	94.46%	90.15%	63.34%
Aug-23	5997	5214.19	5.09%	5.38%	£866,721.01	12.21%	85.83%	94.20%	89.99%	59.42%
Sep-23	6052	5266.56	5.08%	5.36%	£837,030.25	11.97%	85.45%	94.50%	90.46%	59.87%
Oct-23	6080	5287.61	5.66%	5.34%	£975,285.32	11.86%	83.97%	93.85%	90.33%	66.45%
Nov-23	6076	5275.38	5.55%	5.29%	£948,334.37	12.03%	84.81%	93.99%	90.74%	60.92%
Dec-23	6065	5267.58	5.77%	5.20%	£1,005,900.16	11.69%	85.17%	93.84%	90.80%	63.86%

RAG KPI's	RED	AMBER	GREEN
Sickness	>=4.75%	>4.20% & <4.75%	<=4.20%
Turnover	>=10%	-	<=10%
Appraisal	<=75%	>75% & <85%	>=85%
Stat Training	<=94.99%	-	>=95%
Mand Training	<=79.99%	>=80% & <85%	>=85%
RTW	<100%	-	100%

5. Expectation 3 – Right place, right time

5.1 E-Rostering

E-Rostering and the production of rostering is closely monitored to ensure all rosters are fully optimised. Rostering KPI reports are issued monthly at Trust, Divisional and Ward level. Divisions are able to see opportunities to improve performance. These can be found in appendix 4 and contain data including;

- Roster approval lead time (how far in advance teams receive their roster)

- Roster Finalisation (payroll) compliance
- Additional duties (exceeding budgeted establishment)
- Fill-rates (planned vs. actual staffing)
- Time-owing/ owed (use of contracted hours)
- Unavailability (absence and non-clinical work time)
- Temporary Staffing (bank and agency)

The E-Roster reports demonstrate that there is more work required to ensure effectiveness of rostering. Work continues with the Deputy Chief of People to build reporting against these scorecards into the current meeting structure. Divisions will be required to provide assurance on action being taken in order to improve performance against the KPIs.

5.2 Temporary staffing

Where a staffing shortfall is identified, the escalation process found in the rostering policy should be followed. However, Ward Managers or the Nurse-in-Charge must demonstrate that they have exhausted all potential options via the E-Roster or by using the safer nursing care tool prior to making a request.

The tables 7 & 8 below demonstrate the month by month breakdown of WTE hours for Registered and Unregistered Bank and Agency staff across the trust from July 2023 to December 2023. This is the culmination of all registered staff employed by the respective divisions including out-patient departments and specialist nursing services.

The clinical divisions have been making significant reductions in the use of bank and agency as the number of substantive registered staff increase. Table 5 demonstrates the gradual increase in substantive worked and this is resulting in the reduction of bank and agency usage.

When reviewing the data it is important to recognise that a –red position in the funded vs worked line demonstrates that the area is over staffed against the agreed establishment and this is due to sickness and absence (mainly covered in the agreed uplift), maternity leave, increased acuity, enhanced care and additional escalation areas that are open, with the latter being the key driving factor when budgets are reviewed monthly.

Table 5: Registered bank and agency usage (Worked WTE)

Qualified	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Funded	2,079	2,535	2,595	2,593	2,612	2,626
Substantive Worked	-1,829	-2,264	-2,309	-2,370	-2,392	-2,380
Overtime Worked	-1	-4	-2	-3	-2	-2
Bank Worked	-86	-107	-125	-111	-129	-117
Agency Worked	-51	-47	-34	-23	-12	-10
Sub Total Worked	-1,967	-2,421	-2,470	-2,507	-2,535	-2,510
Funded vs Worked	112	114	125	87	77	117

Table 6: Unregistered bank and agency usage (Worked WTE)

Unqualified	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Funded	1,203	1,207	1,207	1,205	1,208	1,234
Substantive Worked	-1,104	-1,549	-1,587	-1,565	-1,590	-1,583
Overtime Worked	-2	-4	-3	-3	-2	-2
Bank Worked	-173	-194	-207	-162	-158	-168
Agency Worked	0	-0	0	0	0	0
Sub Total Worked	-1,279	-1,747	-1,797	-1,730	-1,750	-1,754
Funded vs Worked	-76	-540	-591	-525	-542	-519

6. Update on planned next steps from last report

Following on from the previous report January 2023- June 2023, the table below demonstrates current progress against the identified project areas by exception only.

Table 7: Progress against projects

Project Number	Project Title	Progress Update	RAG rating
1	SNCT Inpatient areas	A further two census collections have taken place in July 2023 and February 2024. Data outputs have completed.	
	SNCT ED	A further census collection has taken place in February 2024. Data output to be completed and analysis and professional judgement.	
	SNCT Community	Census collection completed in April & October 2023. Further work being undertaken with GM group on tool to allow for outputs from census.	

7. Further Transformation

Additional priorities for the next 12 months have been set out in below. These are monitored via the Chief Nurses Business Meetings and Professional Forum. In addition, updates are provided via the Resource and Talent Planning meeting.

- Health Care Assistant retention- to review our current turnover rates and work with partners across Greater Manchester to review retention and reasons for leaving the NHS. To review a Fundamentals of Care package for all HCAs
- Fully roll out functionality of safecare- including ability to record red flags and live movement of staffing.
- To continue with the embedding of the SNCT tool including in community to gain a second data set that will enable evidence based establishment and skill mix reviews.

8. Summary

This report provides a comprehensive review of the framework used to assess safe staffing levels, both in real-time, and bi-annually. **The additional data provided and forensic review supports the recommendation that safe staffing levels were maintained during the periods of July to December 2023.**

The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within Bolton NHS Foundation Trust.

9. Recommendations

It is recommended that the Board of Directors Committee:

I. Receive the bi-annual staffing report and recommendations.
II. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

Appendix 1 – NQB Recommendations

Detailed breakdown.

1.0 Expectation 1 - Right staff

1.1 The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months. The NQB references various tools that can be used.

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

1.4 The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for a maximum of 6-8 patients each during a day shift. There is no specific guidance regarding night duty. This is based on NICE[2] evidence highlighting that there is increased risk of harm to patients when RNs care for more than eight patients at any one time. The ward Sr/CN should have supervisory capacity – the extent of which is subject to local Chief Nurse determinant **Headroom / Uplift**

1.5 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

1.6 The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. Current headroom/uplift provided is 23% with national ranges varying between 19% and 25%

1.7 Skill Mix

1.8 This is the ratio of RNs to unregistered staff such as healthcare assistants. Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%. More recent NICE guidance has focused more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

1.9 Professional judgement

1.10 The judgement of senior experienced nurses remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements

[2] NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals* July 2014

- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

1.12 NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were stated as specifically affected by the presence (and hence absence) of **registered** nursing staff. These indicators included;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

1.13 The NQB (2018) has highlighted that these indicators can be challenging to monitor consistently and recommends a thorough audit programme be agreed.

1.14 Patient reported outcome measures

1.15 NICE (2014) also recommend monitoring of the following;

- Adequacy of meeting patients' nursing care needs
- Adequacy of provided pain management
- Adequacy of communication with nursing team
- National in-patient survey

1.16 Staffing data & Training and education

- Appraisal, retention, vacancy, sickness
- Mandatory training, clinical training

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles.
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "Ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Appendix 2- Neonates Information and BAPM compliance.

The NNU is a level 3 regional unit which consist of 35 cots. (9 Intensive care cots, 7 High dependency and 19 Special care cot) We provide care for extreme infants on the cusp of viability to sick Term infants requiring Neonatal input. Activity within Neonates is unpredictable – with staffing levels often reflecting the activity on the NNU and the acuity of infants on the unit, to maintain adequate skill mix to accommodate for any unexpected admissions, transfers etc.

The British Association of Perinatal medicine (BAPM) outlines Neonatal nurse staffing requirements for all Neonatal units. Workforce data is submitted quarterly to the network to review as part of the CRG Nursing workforce calculator, numbers submitted reflect direct patient care only. Compliance to the following standards are reported:

- A band 7 supervisory nurse in charge - Bolton are currently compliant.
- At least 70% staff of nurses should be QIS (qualified in speciality trained) current compliance is 51% the latter does not reflect nurses currently due to finish the training / currently on the course. However, the NNU recognise the ratio of senior to junior skill mix and note the risk associated with this in a tertiary unit. Whilst not unique to Bolton, in view of the national shortage of Neonatal nurses, this has been added to the Unit Risk register and highlighted at ODN level. The risk has been acknowledged by NWNODN with a network wide Training Need assessment to be reviewed to support Network wide education to allow for enhanced consolidation.
- Whilst recruitment is ongoing, with a significant number of new starters and turnover greater than trust average. The Neonatal Unit has implemented a Buddy system to support with retention of new and existing staff. The unit has been commended for this initiative.
- For special care, registered nurse to non-registered staff ratios are calculated 70-30 – this allowing for skill mix flex. Bolton NNU are currently compliant.

BAPM neonatal nursing workforce assessment – October 2023

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 110.78, of which 77.55 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	106.09	83.59	101.10	4.99	-17.51
Total reg nurses	101.93	79.43	92.93	9.00	-13.50
Total QIS	84.78	49.06	73.85	10.93	-24.79
Total non-QIS	17.15	30.37	19.08	-1.93	11.29
Total non-reg	4.16	4.16	8.18	-4.02	-4.02
Reg nurses as % nursing staff	96.1%	95.0%	91.9%		

Appendix 3- Process for reviewing safe staffing:

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

The trust utilises the Safer Nursing Care Tool (SNCT) and SafeCare (web based tools linked to allocate the e-rostering system) in order to review staffing on a daily basis. This is an evidenced based tool used widely across the NHS to assist organisations when reviewing staffing. This provides the ability to have a full overview of the organisation and the ability to review ward acuity and move staff around to balance and mitigate any risks to patient and staff safety.

Divisional Nurse Directors or their deputies undertake on a daily basis:

- A full safety walk round across all in patient areas.
- A full review of Safe Care ensuring each area has provided professional judgement in relation the safe staffing of that ward.
- A divisional staffing review with decisions made to move staff around according to greatest need and level of risk.
- Trust wide staffing meeting at 9:30 am and 15:00pm led by the, Assistant Divisional Nurse Director or Deputy Chief Nurse, with escalation to the Chief Nurse when there is evidence of potential red flag incidences.
- Matrons are clinically visible in their portfolio.
  Safe Staffing information is reported through the trust bed meetings at 9:00am, 1pm, 4pm and 7.30pm

In addition, there is daily oversight undertaken by the Chief Nurses Senior Nursing Team with twice daily and weekly staffing meetings.

In instances where the staffing falls below the recommended establishment the following mitigation and actions put in place utilising all available nursing resource:

- Ward basing specialist nurses where possible.
- Ward managers to be included in staffing numbers.
- Matrons to be released from all none clinical duties to increase their visibility and clinical oversight of their areas.
- Consider use of pharmacy technicians and pharmacists to dispense medications on clinical areas.
- Non- ward based nurses to be redeployed to suitable ward environment.
- Stepping down none urgent clinical activity.
- Increased use of student nurses and utilisation of synergy model where possible with the oversight of the PEFs and educators.
- Utilising the skills within the full multidisciplinary team such as the skills of the Allied Health Professionals (AHPs)

In the out of hours' period there is a late Matron, site manager and hospital at night team who are available for escalation of any staffing issues and are able to be redeployed to the ward to maintain safe staffing levels should they be required.

NHS
Bolton
NHS Foundation Trust

e-Rostering KPIs Report

November 2023

National Targets

Source Data: HealthRoster

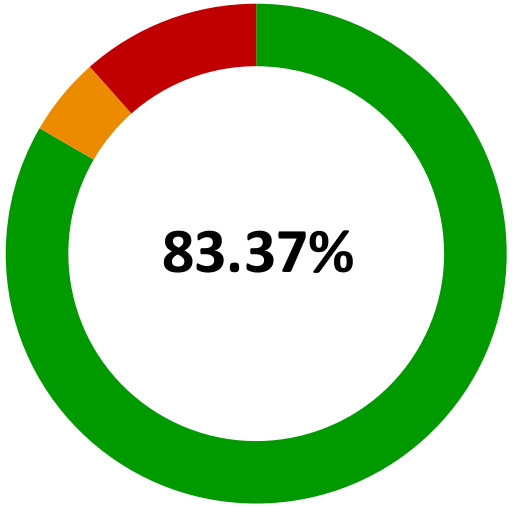
HealthRoster Rollout Progress

Key:	
	Yes
	Partially
	No

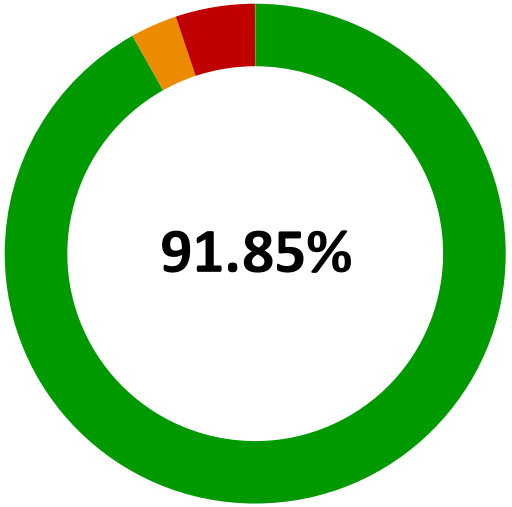
Parameters:

The report summarises the proprtion of the employee headcount
Includes only substantive, primary assignments

Actively Rostering in HealthRoster - Total



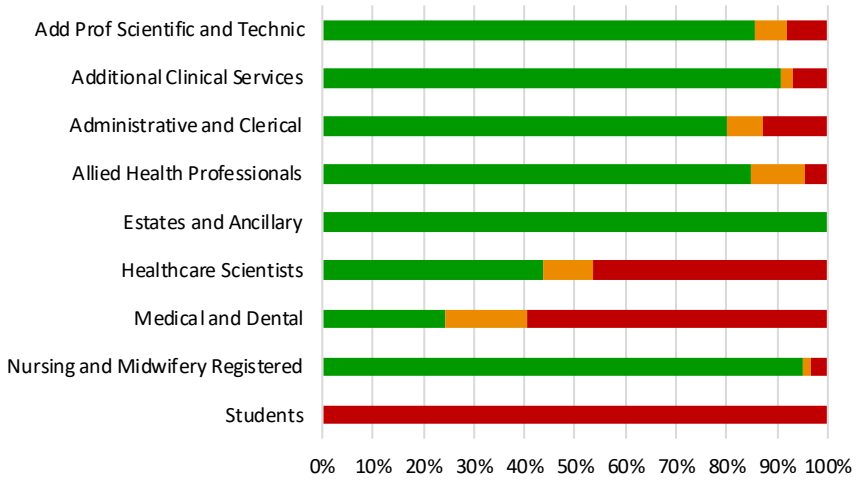
Record All Unavailability in HealthRoster - Total



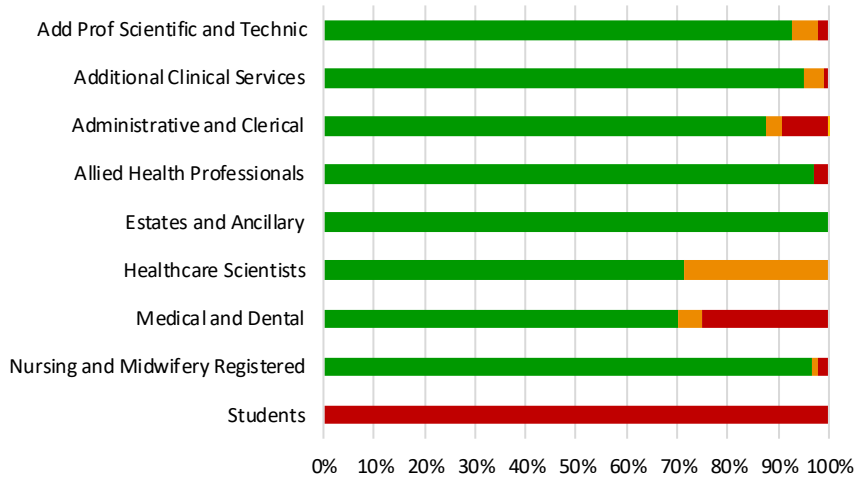
National Targets

Source Data: HealthRoster

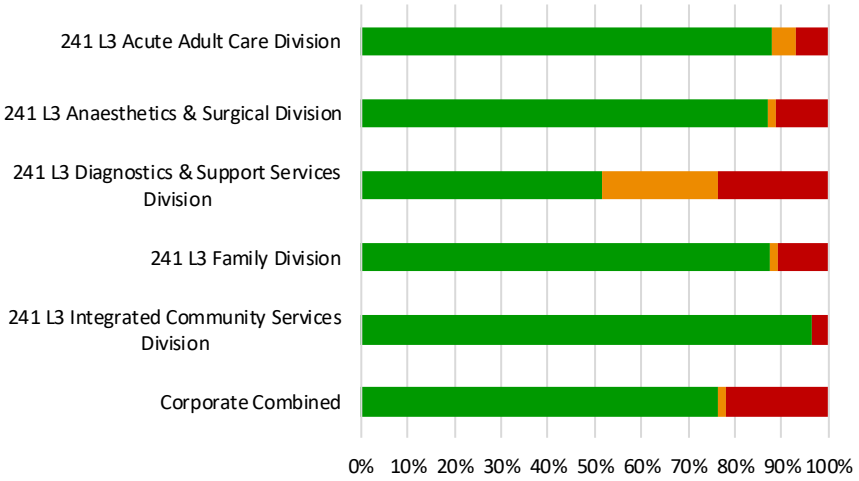
Actively Rostering in HealthRoster by Staff Group



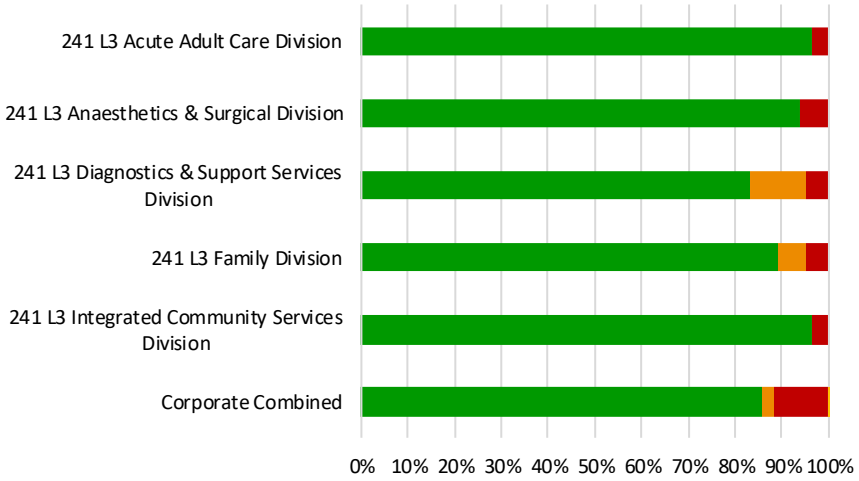
Record All Unavailability in HealthRoster by Staff Group



Actively Rostering in HealthRoster by Division



Record All Unavailability in HealthRoster by Division



Report Scope

Source Data: HealthRoster

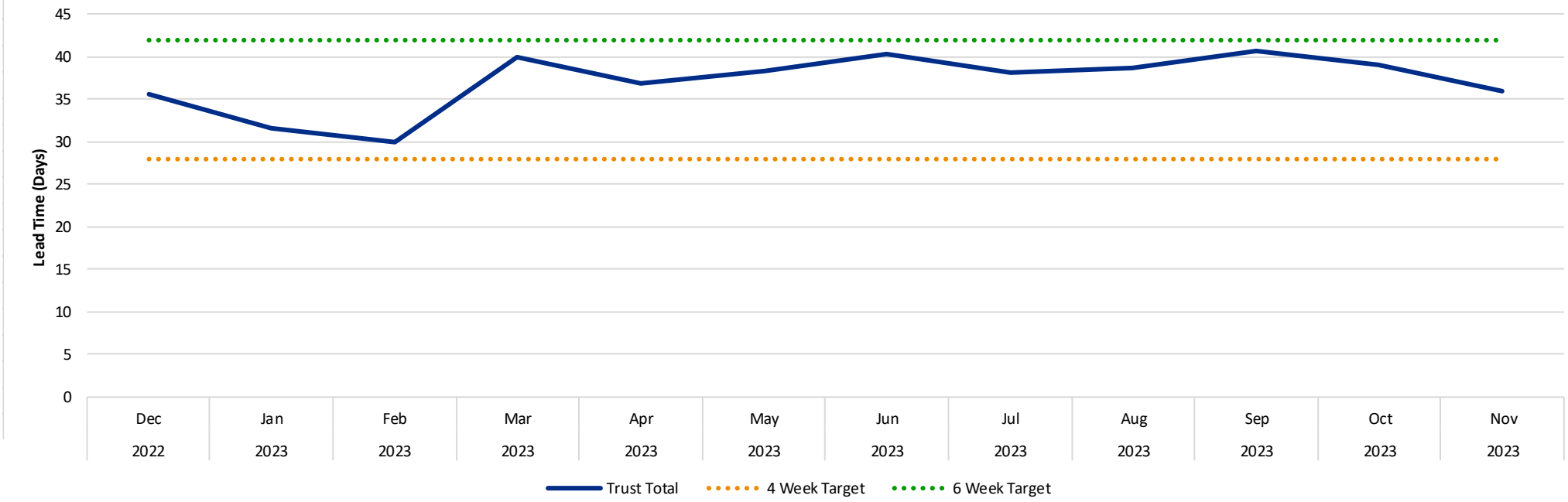
241 L3 Acute Adult Care Division	241 L3 Anaesthetics & Surgical Division	241 L3 Diagnostics & Support Services Division	241 L3 Family Division	241 L3 Integrated Community Services Division
A&E Majors (0419)	Critical Care Unit (1935)	Infection Control (5103)	Antenatal Clinic - ANDU [3009]	District Nursing - Avondale [3917]
A&E Minors (0422)	DCU Ward (1931)	Infection Control Community (4002)	Bolton Birth Centre [3010]	District Nursing - Breightmet [3918]
A&E Paeds (0423)	Anaesthetics (ODP) (1910)	Nurse Led IV Access Service [5102]	Central Delivery Suite (CDS) [3011]	District Nursing - Crompton [3919]
CCU (Coronary Care Unit) [0121]	Recovery (1910)	OPD General Nursing (3205)	CM - Bluebell (3007)	District Nursing - Evenings & Nights (38
CDU (Clinical Decisions Unit) (0420)	Theatres Scrub (1909)	Pharmacists (6201)	CM - Daffodil (3007)	District Nursing - Farnworth [3921]
Discharge Lounge (0415)	Ward E3 (1513)	Pre Op Assessment Outpatients (3207)	CM - Enhanced Midwives Team (3007)	District Nursing - Great Lever [3922]
SDEC (0404)	Ward E4 [1517]	Radiography (4303)	CM - Lavender (3007)	District Nursing - Horwich [3923]
Ward A4 (0214)	Ward F3 (1529)	Radiology Assistants (4303)	CM - Office (3007)	District Nursing - Pikes Lane [3924]
Ward B1 [0206]	Ward F4 (1515)	Ultrasound (4309)	CM - Sunflower (3007)	District Nursing - Waters Meeting [392
Ward B2 (0207)	Ward F6 (0703)		CM - Wildflower (3007)	District Nursing - Westhoughton [3926
Ward B3 (0408)	Ward G3 [0705]		Maternity Triage (3011)	Laburnum Lodge (3818)
Ward B4 (0208)	Ward G4 (0707)		Mental Health Midwives [3018]	
Ward C1 [0105]	Ward H2 (1003)		Neonatal Unit [3013]	
Ward C2 [0109]			Specialist Midwives [3002]	
Ward C3 [0115]			Ward E5 [2309]	
Ward C4 (0216)			Ward M1 [3101]	
Ward D1 (0409)			Ward M2 - Obstetrics (3004)	
Ward D2 (0411)			Ward M4 - Post Natal [3005]	
Ward D3 [0117]			Ward M5 - Post Natal (3006)	
Ward D4 [0119]				
Ward H3 - Stroke [0204]				
Ward R1 (0309)				

Clinical Governance Indicators

Source Data: HealthRoster

Roster Approval Lead Time KPI Performance					
Period	No. Rosters (Teams) in Scope	Average Lead Time (in Month)	No. Rosters Compliant (6 Weeks/42 Days or More)	No. Rosters Compliant (4 Weeks/28 Days or More)	No. Rosters Non-Compliant (Less than 4 Weeks/28 Days)
Nov 2023	68	36.03	30 (44.12%)	21 (30.88%)	17 (25%)

Roster Approval Lead Time Trend



Clinical Governance Indicators

Source Data: HealthRoster

Roster Approval Lead Time (Days) per Month by Division								
Year	Month	Trust Total	241 L3 Acute Adult Care Division	241 L3 Anaesthetics & Surgical Division	241 L3 Diagnostics & Support Services	241 L3 Family Division	241 L3 Integrated Community	Corporate Combined
Total		37.22	41.23	35.97	28.29	39.32	35.57	0.00
2022	Dec	35.63	44.82	29.66	23.46	34.74	40.14	0.00
2023	Jan	31.60	38.21	34.10	27.56	26.86	28.84	0.00
2023	Feb	29.98	33.11	29.81	34.31	20.67	36.33	0.00
2023	Mar	39.97	44.22	41.40	36.00	42.17	30.36	0.00
2023	Apr	36.86	41.83	32.99	25.09	45.55	30.07	0.00
2023	May	38.30	38.90	36.40	29.40	44.79	36.23	0.00
2023	Jun	40.41	44.59	43.95	25.57	45.70	32.21	0.00
2023	Jul	38.18	44.84	32.96	20.76	44.35	37.93	0.00
2023	Aug	38.79	40.48	40.90	23.65	42.88	40.32	0.00
2023	Sep	40.61	42.40	39.97	35.31	42.23	39.76	0.00
2023	Oct	39.05	42.14	38.33	29.61	43.64	35.42	0.00
2023	Nov	36.03	38.94	37.08	24.14	39.12	36.85	0.00

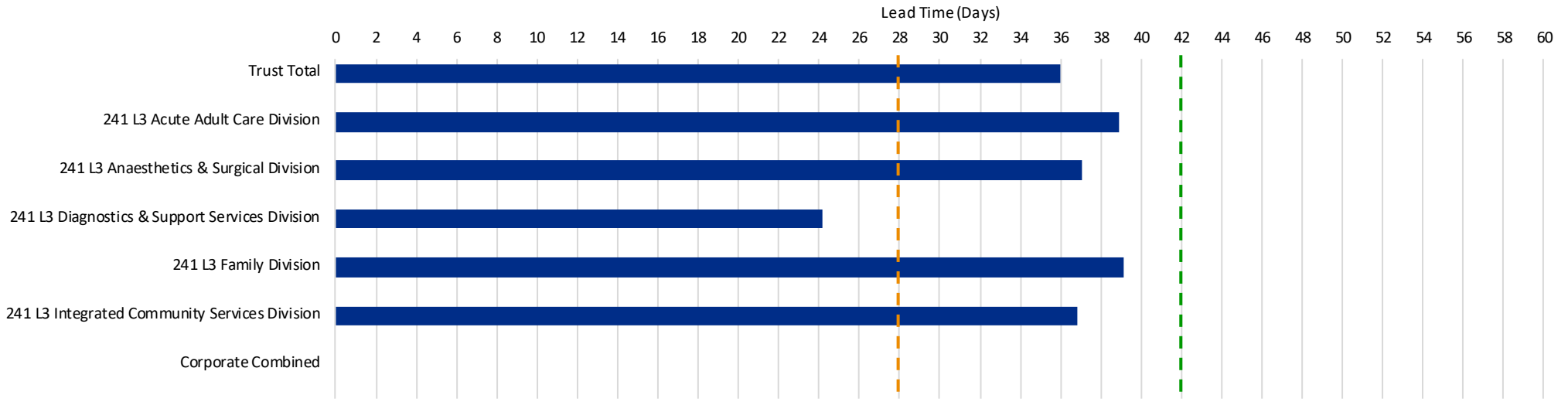
Key (RAG Status):		
Red		Less than 28 days
Amber		Between 28 and 41 days
Green		More than 41 Days

e-Rostering KPIs Report

Clinical Governance Indicators

Source Data: HealthRoster

Roster Approval Lead Time (Days) In-Month Performance by Division



Monthly Best Performing Wards/Teams	Division	Lead Time (Days)
Ward G4 (0707)	ASSD	47.63
Ward B1 [0206]	AACD	46.60
Ward C4 (0216)	AACD	46.60
Ward D1 (0409)	AACD	46.59
Anaesthetics (ODP) (1910)	ASSD	46.59
Recovery (1910)	ASSD	46.59
Theatres Scrub (1909)	ASSD	46.59
Ward C2 [0109]	AACD	46.57
CCU (Coronary Care Unit) [0121]	AACD	46.57
Ward C1 [0105]	AACD	46.57

Monthly Worst Performing Wards/Teams	Division	Lead Time (Days)
Nurse Led IV Access Service [5102]	DSSD	-24.70
Pharmacists (6201)	DSSD	2.37
Pre Op Assessment Outpatients (3207)	DSSD	13.42
Ward E5 [2309]	FCD	19.39
OPD General Nursing (3205)	DSSD	19.55
Ward E3 (1513)	ASSD	19.67
DCU Ward (1931)	ASSD	22.50
Ward D2 (0411)	AACD	23.42
Laburnum Lodge (3818)	ICSD	25.45
CDU (Clinical Decisions Unit) (0420)	AACD	27.40

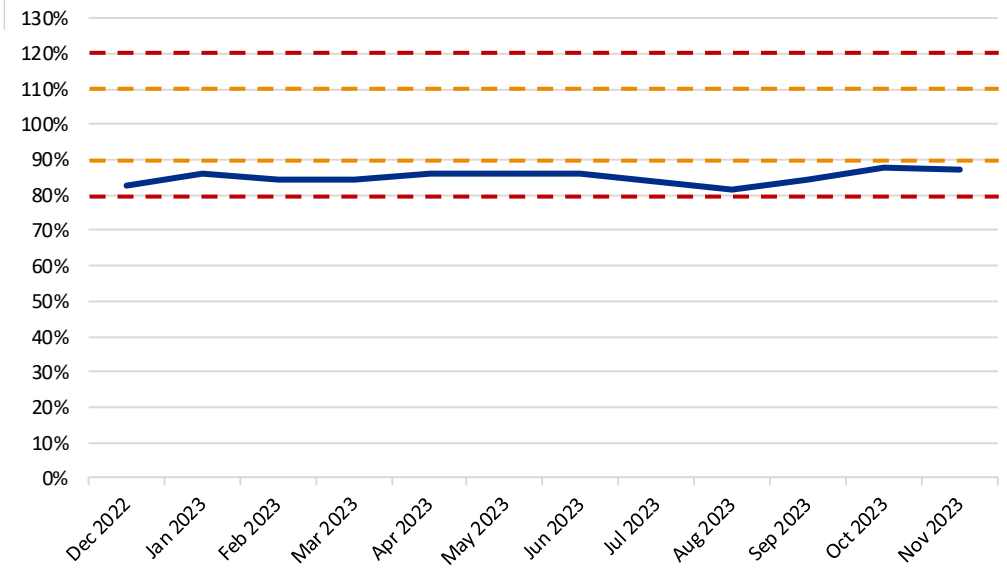
e-Rostering KPIs Report

Clinical Governance Indicators

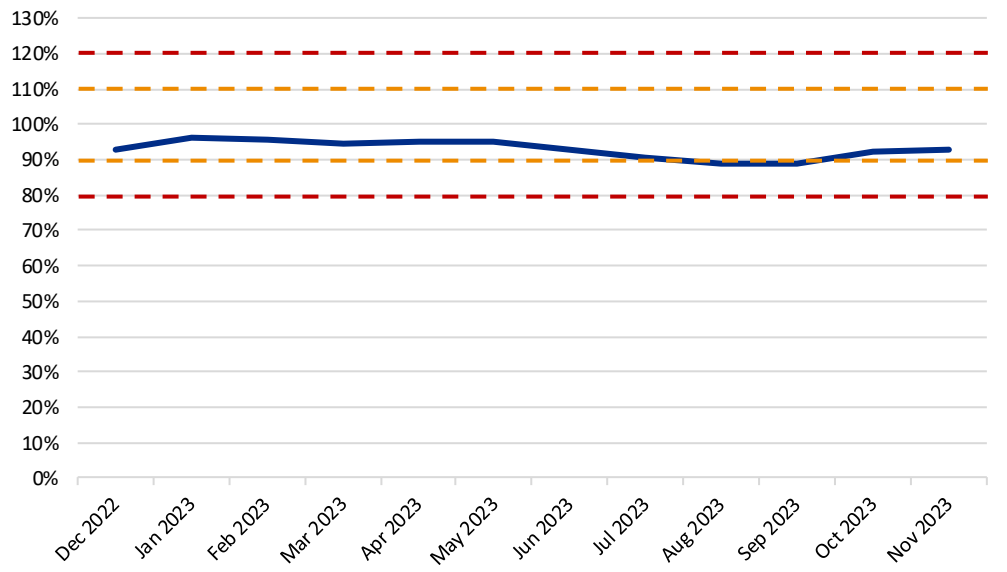
Source Data: HealthRoster

Roster Fill Rate Performance - Registered				
Period	No. Rosters (Teams) in Scope	Total	Days	Nights
Nov 2023	66	88.74%	87.01%	92.68%

Registered Days



Registered Nights



Key (Tram Lines):		
Red	- - - -	Lines at 80% and 120%, i.e. staffing >=20% above or below planned
Amber	- - - -	Lines at 90% and 110%, i.e. staffing >=10% above or below planned

e-Rostering KPIs Report

Clinical Governance Indicators

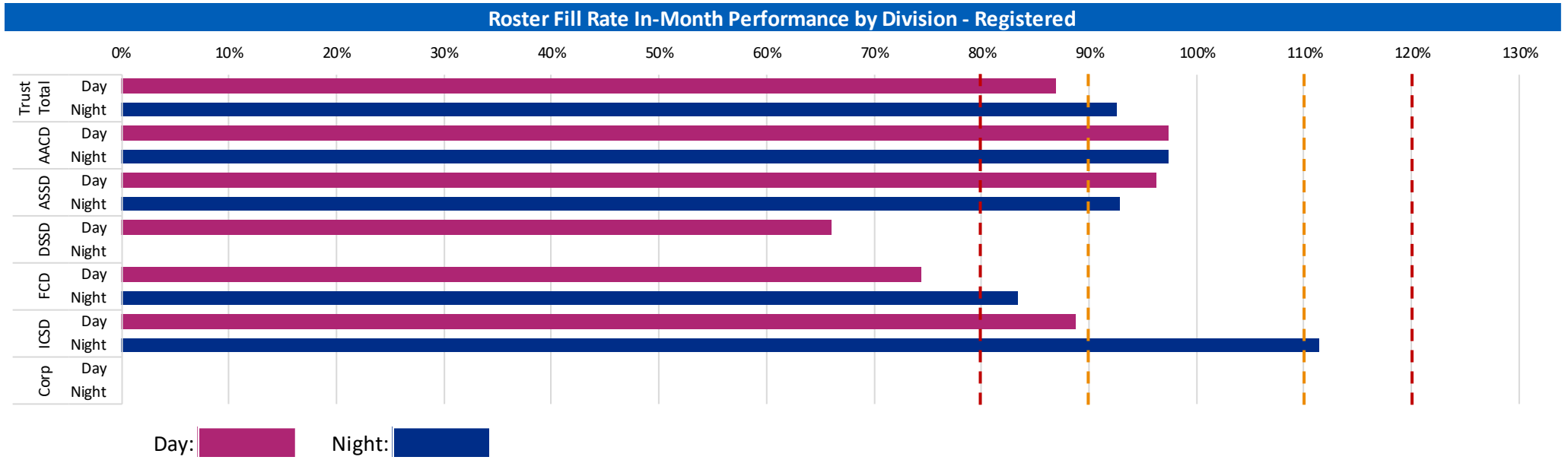
Source Data: HealthRoster

Roster Fill Rate Performance per Month by Division - Registered															
Year	Month	Trust Total		241 L3 Acute Adult Care Division		241 L3 Anaesthetics & Surgical Division		241 L3 Diagnostics & Support Services		241 L3 Family Division		241 L3 Integrated Community		Corporate Combined	
		Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Total		84.93%	92.86%	93.97%	95.62%	87.64%	94.41%	66.24%	99.14%	82.76%	86.05%	85.45%	105.66%	*N/A*	*N/A*
2022	Dec	82.79%	93.07%	91.45%	96.79%	84.00%	92.62%	65.23%	98.05%	83.20%	87.81%	86.22%	108.63%	*N/A*	*N/A*
2023	Jan	85.94%	96.30%	95.84%	103.52%	85.13%	97.44%	70.26%	98.48%	87.78%	87.21%	86.23%	106.45%	*N/A*	*N/A*
2023	Feb	84.44%	95.57%	96.71%	101.07%	84.67%	95.91%	68.50%	99.35%	85.53%	88.28%	81.15%	107.02%	*N/A*	*N/A*
2023	Mar	84.35%	94.54%	95.24%	100.36%	84.31%	94.51%	71.16%	99.36%	84.54%	87.83%	82.71%	97.91%	*N/A*	*N/A*
2023	Apr	85.90%	94.80%	94.94%	96.15%	84.46%	96.95%	69.75%	99.60%	87.17%	89.70%	84.61%	100.68%	*N/A*	*N/A*
2023	May	85.84%	94.93%	94.87%	94.50%	88.61%	97.25%	65.69%	99.40%	87.91%	92.25%	82.31%	103.45%	*N/A*	*N/A*
2023	Jun	85.80%	93.07%	91.82%	93.50%	89.80%	97.11%	68.76%	99.81%	86.67%	86.52%	85.05%	109.57%	*N/A*	*N/A*
2023	Jul	83.68%	90.53%	90.22%	90.53%	85.94%	91.96%	58.15%	*N/A*	80.91%	87.72%	89.97%	107.76%	*N/A*	*N/A*
2023	Aug	81.52%	88.80%	91.72%	92.41%	83.40%	89.78%	55.52%	*N/A*	78.00%	80.48%	84.32%	104.31%	*N/A*	*N/A*
2023	Sep	84.28%	89.04%	93.18%	91.84%	89.86%	92.43%	62.51%	*N/A*	76.98%	79.98%	86.70%	104.88%	*N/A*	*N/A*
2023	Oct	87.61%	92.16%	95.36%	96.90%	97.56%	94.35%	66.04%	*N/A*	80.39%	81.54%	87.04%	105.96%	*N/A*	*N/A*
2023	Nov	87.01%	92.68%	97.47%	97.36%	96.32%	92.86%	65.98%	*N/A*	74.32%	83.35%	88.81%	111.48%	*N/A*	*N/A*

Key (RAG Status):		
Red		80% and less or 120% and more
Amber		Between 80% and 90% or between 110% and 120%
Green		Between 90% and 110%

Clinical Governance Indicators

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	Diff. to Plan (Hrs)
District Nursing - Great Lever [3922]	ICSD	2.00
Ward D3 [0117]	AACD	8.25
Ward G4 (0707)	ASSD	8.50
Ward F3 (1529)	ASSD	14.50
Ward G3 [0705]	ASSD	14.75
Ward D1 (0409)	AACD	15.00
Ward D4 [0119]	AACD	16.00
Ward E3 (1513)	ASSD	16.72
CM - Lavender (3007)	FCD	17.00
CCU (Coronary Care Unit) [0121]	AACD	18.75

Monthly Worst Performing Wards/Teams	Division	Diff. to Plan (Hrs)
Specialist Midwives [3002]	FCD	3150.72
Critical Care Unit (1935)	ASSD	2207.08
Ward B2 (0207)	AACD	2064.25
Bolton Birth Centre [3010]	FCD	1719.00
Pharmacists (6201)	DSSD	1304.42
Ward M5 - Post Natal (3006)	FCD	1171.92
A&E Majors (0419)	AACD	1085.75
Pre Op Assessment Outpatients (3207)	DSSD	1082.08
CM - Bluebell (3007)	FCD	961.50
Neonatal Unit [3013]	FCD	945.25

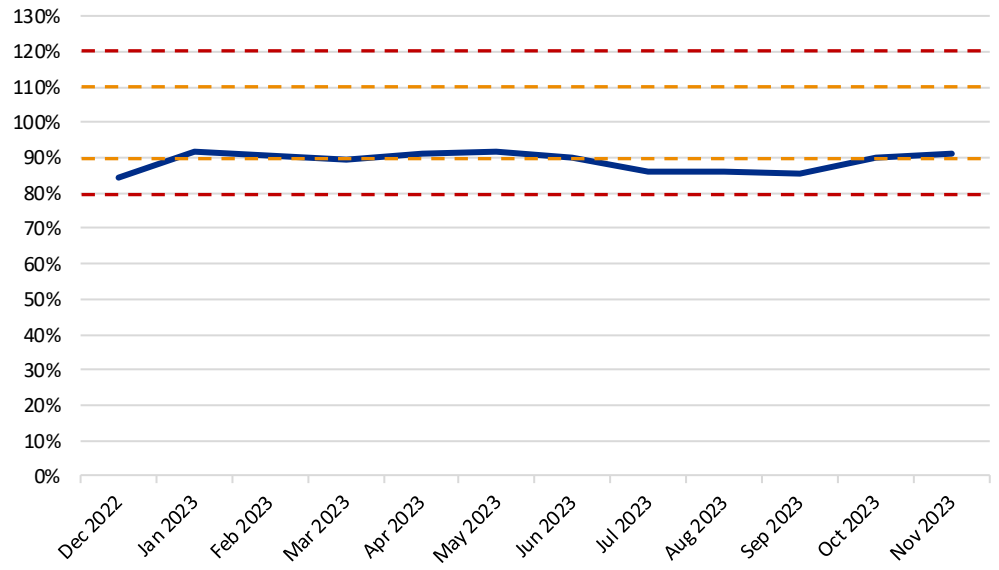
e-Rostering KPIs Report

Clinical Governance Indicators

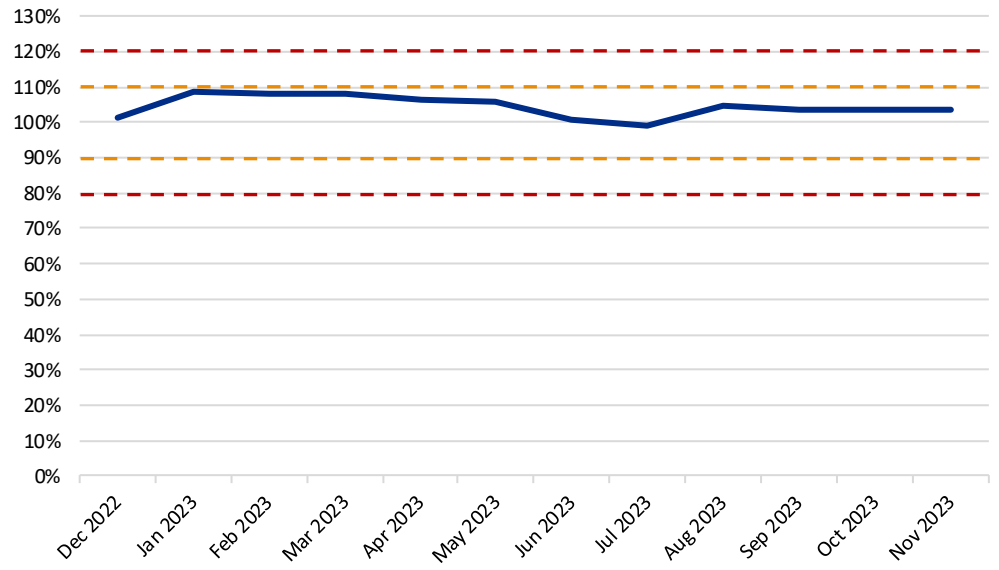
Source Data: HealthRoster

Roster Fill Rate Performance - Non- Registered				
Period	No. Rosters (Teams) in Scope	Total	Days	Nights
Nov 2023	60	95.86%	91.39%	103.33%

Non-Registered Days



Non-Registered Nights



Key (Tram Lines):		
Red	- - - -	Lines at 80% and 120%, i.e. staffing >=20% above or below planned
Amber	- - - -	Lines at 90% and 110%, i.e. staffing >=10% above or below planned

Clinical Governance Indicators

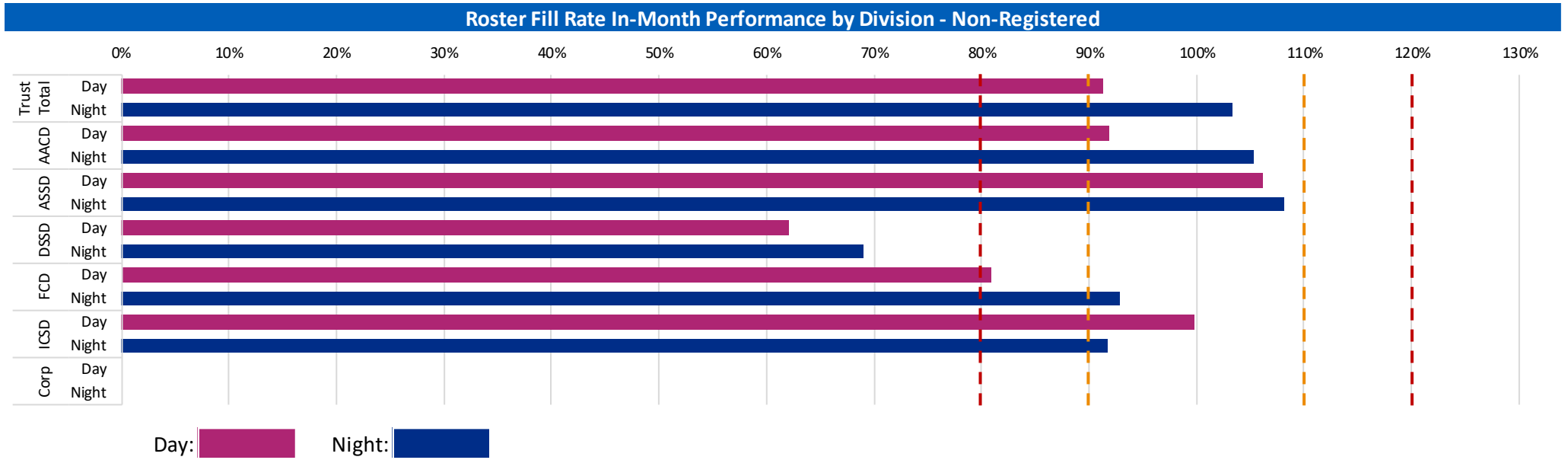
Source Data: HealthRoster

Roster Fill Rate Performance per Month by Division - Non-Registered															
Year	Month	Trust Total		241 L3 Acute Adult Care Division		241 L3 Anaesthetics & Surgical Division		241 L3 Diagnostics & Support Services		241 L3 Family Division		241 L3 Integrated Community		Corporate Combined	
		Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Total		88.91%	104.30%	93.91%	112.68%	98.44%	110.41%	57.82%	45.60%	71.48%	70.69%	99.06%	93.83%	*N/A*	*N/A*
2022	Dec	84.27%	101.21%	92.59%	112.25%	90.72%	107.22%	47.95%	*N/A*	66.17%	61.68%	92.07%	93.49%	*N/A*	*N/A*
2023	Jan	91.46%	108.73%	99.16%	118.52%	97.07%	118.34%	64.31%	*N/A*	73.20%	69.67%	97.78%	93.93%	*N/A*	*N/A*
2023	Feb	90.45%	108.18%	98.10%	121.48%	98.66%	111.57%	59.45%	*N/A*	70.35%	67.12%	97.14%	95.35%	*N/A*	*N/A*
2023	Mar	89.34%	107.80%	94.62%	118.05%	98.33%	110.56%	56.39%	*N/A*	71.01%	71.16%	103.45%	112.63%	*N/A*	*N/A*
2023	Apr	90.86%	106.42%	97.00%	114.68%	103.47%	114.63%	50.72%	*N/A*	70.89%	73.12%	96.20%	90.69%	*N/A*	*N/A*
2023	May	91.86%	105.55%	98.29%	113.08%	102.52%	113.61%	54.54%	45.65%	71.78%	73.14%	102.15%	98.51%	*N/A*	*N/A*
2023	Jun	89.73%	100.59%	93.73%	108.45%	95.45%	106.21%	56.31%	37.66%	76.28%	69.91%	107.20%	94.11%	*N/A*	*N/A*
2023	Jul	86.30%	99.16%	88.41%	105.93%	96.47%	108.85%	60.13%	41.50%	69.90%	66.07%	104.16%	98.10%	*N/A*	*N/A*
2023	Aug	86.20%	104.70%	89.65%	116.42%	95.26%	107.75%	59.13%	17.08%	67.65%	62.72%	104.53%	95.99%	*N/A*	*N/A*
2023	Sep	85.24%	103.70%	90.30%	112.35%	96.29%	108.65%	58.33%	42.18%	68.91%	70.23%	84.92%	86.11%	*N/A*	*N/A*
2023	Oct	89.94%	103.43%	93.81%	109.01%	101.57%	109.43%	61.33%	35.88%	73.17%	80.84%	99.75%	81.25%	*N/A*	*N/A*
2023	Nov	91.39%	103.33%	91.92%	105.33%	106.18%	108.11%	62.06%	68.95%	80.91%	92.85%	99.76%	91.76%	*N/A*	*N/A*

Key (RAG Status):		
Red		80% and less or 120% and more
Amber		Between 80% and 90% or between 110% and 120%
Green		Between 90% and 110%

Clinical Governance Indicators

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	Diff. to Plan (Hrs)
Ward D3 [0117]	AACD	1.00
Neonatal Unit [3013]	FCD	5.00
CCU (Coronary Care Unit) [0121]	AACD	11.50
CM - Lavender (3007)	FCD	15.00
A&E Paeds (0423)	AACD	19.75
Ward M1 [3101]	FCD	25.00
CM - Daffodil (3007)	FCD	26.00
CM - Sunflower (3007)	FCD	28.50
Ward H3 - Stroke [0204]	AACD	28.87
Nurse Led IV Access Service [5102]	DSSD	32.75

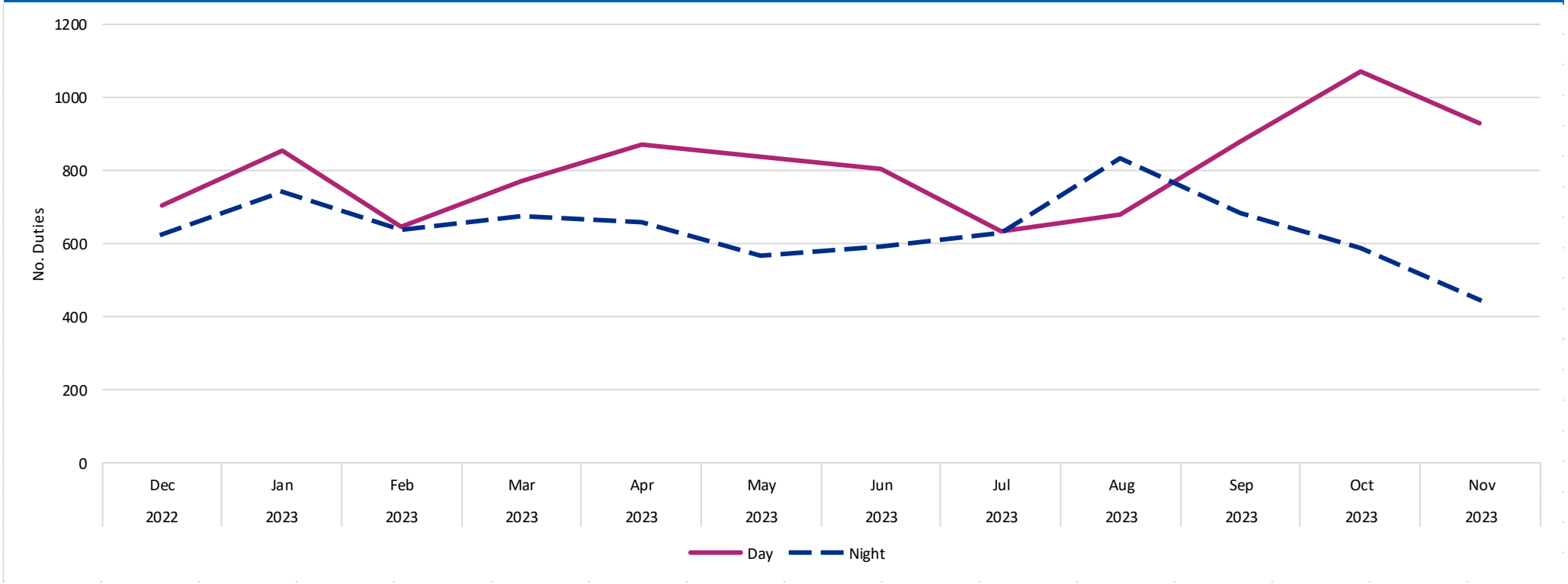
Monthly Worst Performing Wards/Teams	Division	Diff. to Plan (Hrs)
Ward B2 (0207)	AACD	3084.00
OPD General Nursing (3205)	DSSD	1165.75
Radiology Assistants (4303)	DSSD	694.75
Bolton Birth Centre [3010]	FCD	690.00
Ward M5 - Post Natal (3006)	FCD	684.75
Ward D2 (0411)	AACD	675.00
Laburnum Lodge (3818)	ICSD	654.00
Ward E5 [2309]	FCD	584.33
Ward G4 (0707)	ASSD	549.67
Ward C4 (0216)	AACD	531.75

Clinical Governance Indicators

Source Data: HealthRoster

Additional Duties				
Period	Total	Registered	Non-Registered	Other
Nov 2023	1377	494	873	10

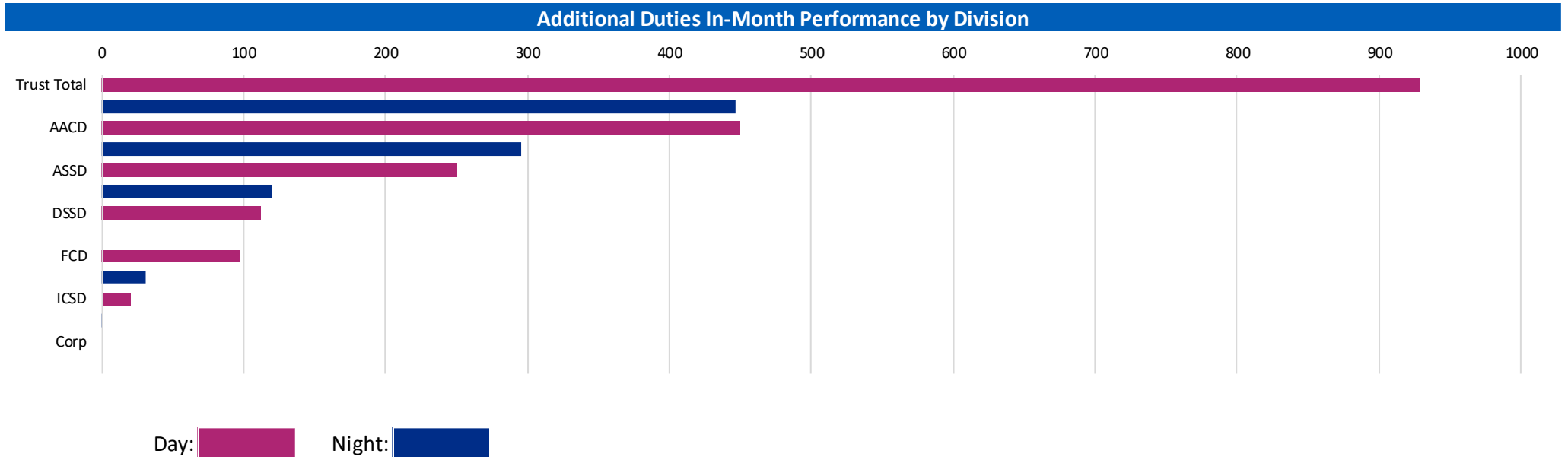
Additional Duties Trend



e-Rostering KPIs Report

Clinical Governance Indicators

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	No. Duties
Pharmacists (6201)	DSSD	1
District Nursing - Breightmet [3918]	ICSD	1
District Nursing - Great Lever [3922]	ICSD	1
CM - Office (3007)	FCD	1
Discharge Lounge (0415)	AACD	1
District Nursing - Pikes Lane [3924]	ICSD	2
Infection Control (5103)	DSSD	2
CCU (Coronary Care Unit) [0121]	AACD	2
A&E Minors (0422)	AACD	2
Ward M5 - Post Natal (3006)	FCD	3

Monthly Worst Performing Wards/Teams	Division	No. Duties
Ward D2 (0411)	AACD	92
Radiography (4303)	DSSD	89
Ward B4 (0208)	AACD	85
Ward G4 (0707)	ASSD	84
Ward B1 [0206]	AACD	81
Ward C4 (0216)	AACD	79
Ward F4 (1515)	ASSD	71
Ward C2 [0109]	AACD	68
A&E Majors (0419)	AACD	57
CDU (Clinical Decisions Unit) (0420)	AACD	57

Clinical Governance Indicators

Source Data: HealthRoster

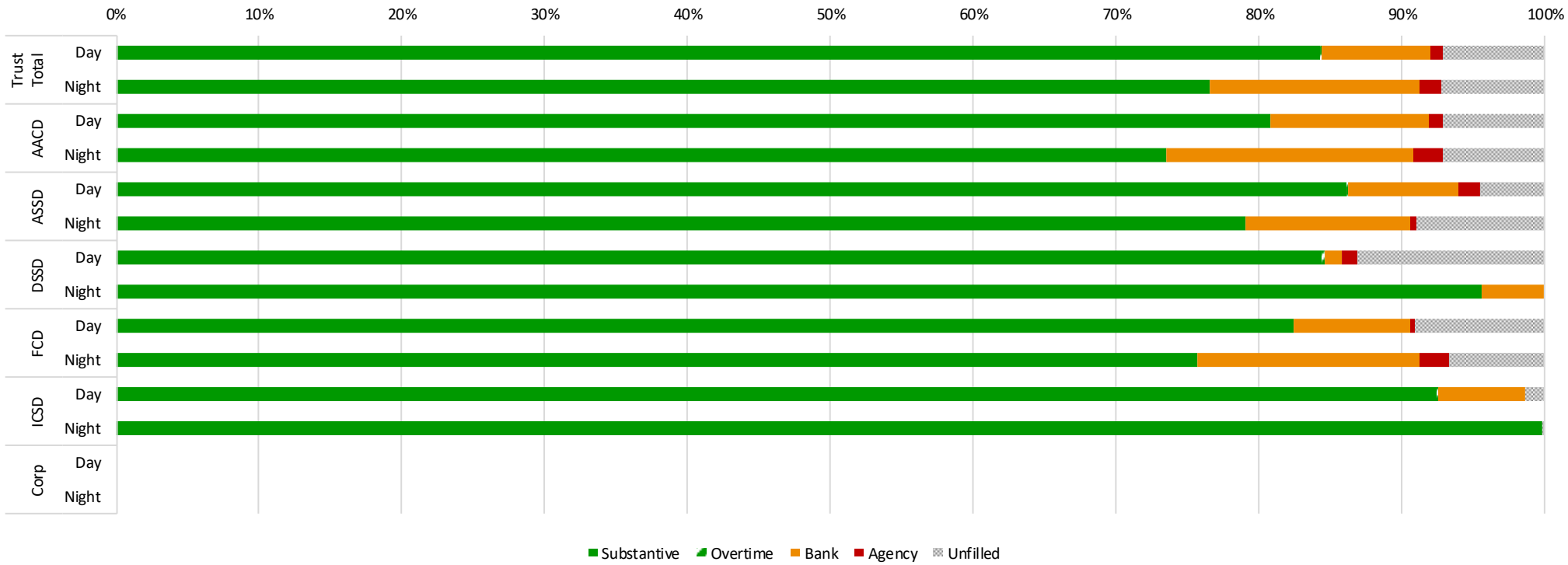
Additional Duties per Month by Division (Days and Nights)															
Year	Month	Trust Total		241 L3 Acute Adult Care Division		241 L3 Anaesthetics & Surgical Division		241 L3 Diagnostics & Support Services		241 L3 Family Division		241 L3 Integrated Community		Corporate Combined	
		Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Total		9694	7692	4080	5547	2913	1847	1018	1	1439	281	244	16	0	0
2022	Dec	705	628	278	432	231	178	105	1	74	17	17	0	0	0
2023	Jan	854	743	280	491	247	194	121	0	146	57	60	1	0	0
2023	Feb	648	639	240	434	215	187	84	0	98	16	11	2	0	0
2023	Mar	772	677	245	477	285	169	94	0	118	24	30	7	0	0
2023	Apr	872	660	288	452	305	186	114	0	152	21	13	1	0	0
2023	May	840	566	269	382	331	169	67	0	167	15	6	0	0	0
2023	Jun	804	593	351	443	218	120	44	0	188	30	3	0	0	0
2023	Jul	636	630	325	487	143	118	53	0	104	24	11	1	0	0
2023	Aug	681	835	298	691	212	131	76	0	82	13	13	0	0	0
2023	Sep	880	686	487	532	203	140	62	0	100	12	28	2	0	0
2023	Oct	1073	588	569	431	273	135	86	0	113	21	32	1	0	0
2023	Nov	929	447	450	295	250	120	112	0	97	31	20	1	0	0

Clinical Governance Indicators

Source Data: HealthRoster

Roster Filled Hours by Type - Registered					
Period	Substantive	Overtime	Bank	Agency	Unfilled
Nov 2023	150574 (81.94%)	127 (0.07%)	17968 (9.78%)	1985 (1.08%)	13098 (7.13%)

Roster Fill Proportion per Type by Division and Day/Night - Registered

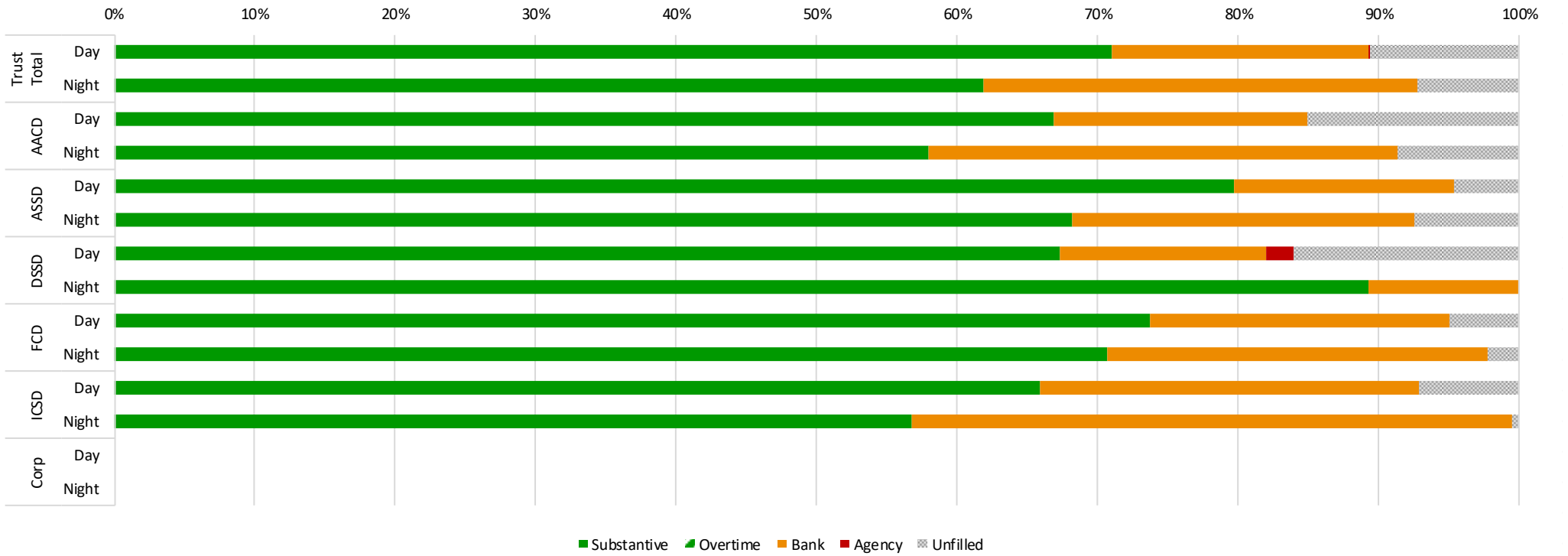


Clinical Governance Indicators

Source Data: HealthRoster

Roster Filled Hours by Type - Non-Registered					
Period	Substantive	Overtime	Bank	Agency	Unfilled
Nov 2023	69540 (67.52%)	0 (0%)	23765 (23.07%)	98 (0.09%)	9587 (9.31%)

Roster Fill Proportion per Type by Division and Day/Night - Non-Registered

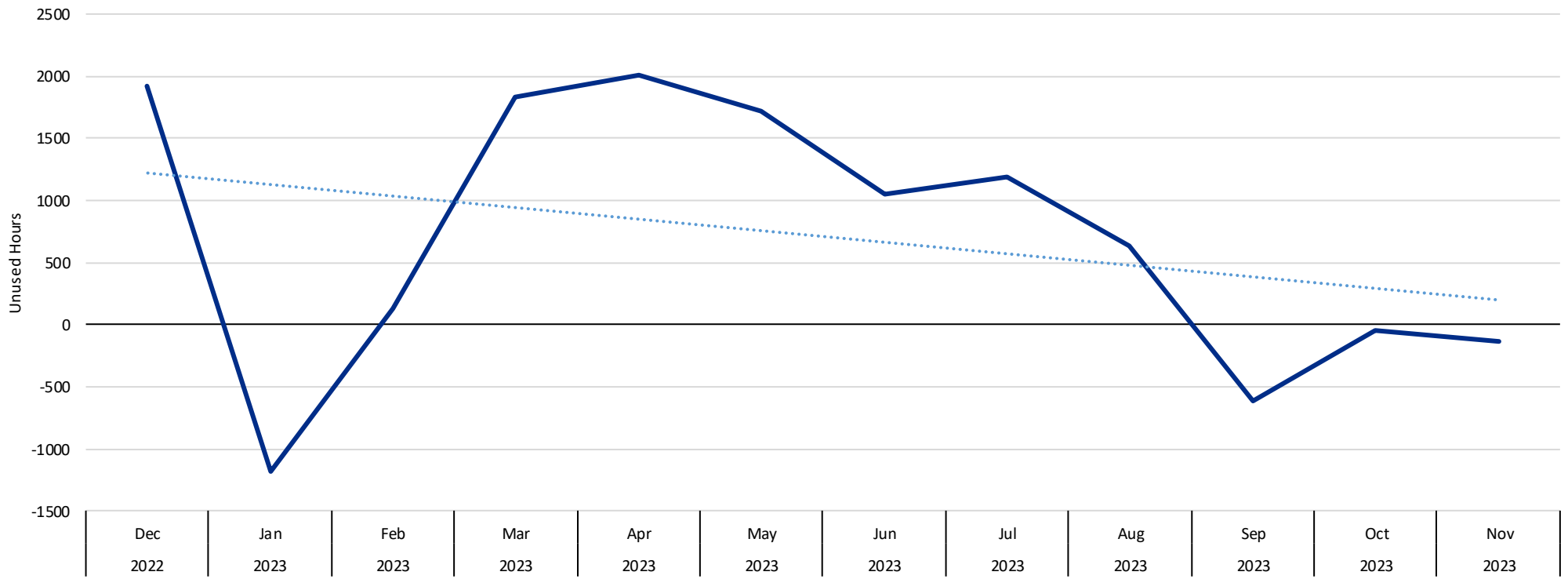


Roster Effectiveness Indicators

Source Data: HealthRoster

Unused Hours - Registered					
Period	Available Contracted Hours	Unused Hours	Unused WTE	Hours Filled Bank/Agency/OT	Avoidable Bank/Agency/OT
Nov 2023	204777	-134 (-0.07%)	-3.56	20081	-134 (-0.66%)

Unused Hours per Month by Division - Registered

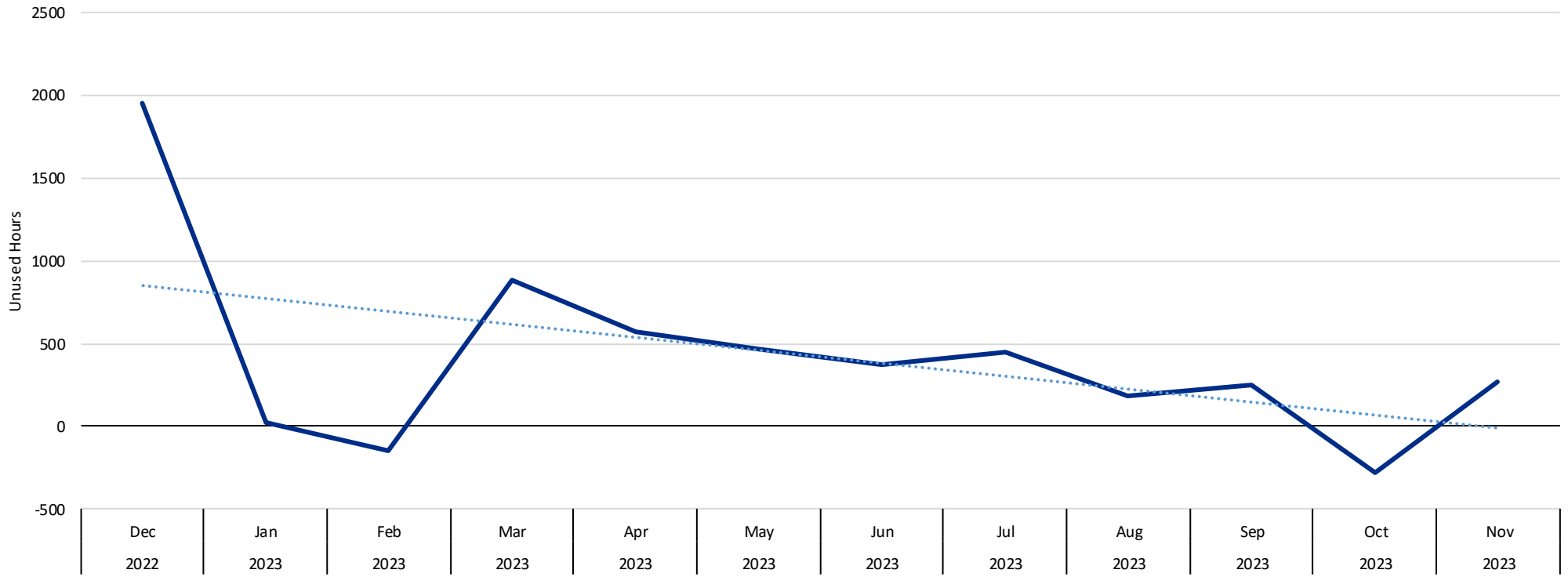


Roster Effectiveness Indicators

Source Data: HealthRoster

Unused Hours - Non-Registered					
Period	Available Contracted Hours	Unused Hours	Unused WTE	Hours Filled Bank/Agency/OT	Avoidable Bank/Agency/OT
Nov 2023	90356	273 (0.13%)	7.29	23862	273 (1.36%)

Unused Hours per Month by Division - Non-Registered



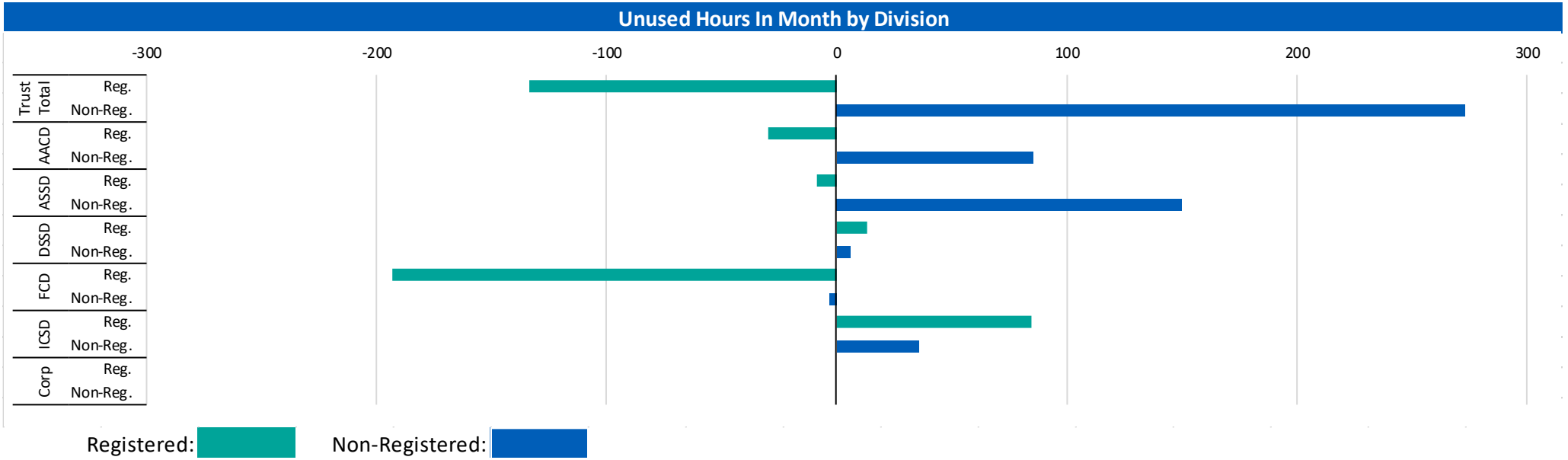
Roster Effectiveness Indicators

Source Data: HealthRoster

Unused Hours per Month by Division and Grade Type Category															
Year	Month	Trust Total Trust Total		241 L3 Acute Adult Care Division AACD		241 L3 Anaesthetics & Surgical Division ASSD		241 L3 Diagnostics & Support Services DSSD		241 L3 Family Division FCD		241 L3 Integrated Community ICSD		Corporate Combined Corp	
		Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total		**8510**	**4986**	**2896**	**1699**	**2778**	**1513**	**867**	**139**	**153**	**1234**	**1816**	**401**	**0**	**0**
2022	Dec	**1916**	**1953**	403	968	833	646	43	3	512	191	124	145	N/A	N/A
2023	Jan	**-1181**	**20**	-792	-148	-195	2	-3	18	-541	159	349	-11	N/A	N/A
2023	Feb	**127**	**-152**	336	-301	-253	2	57	-35	2	157	-15	24	N/A	N/A
2023	Mar	**1834**	**886**	653	89	926	577	91	6	42	183	122	31	N/A	N/A
2023	Apr	**2006**	**571**	729	120	666	153	110	-19	260	262	242	54	N/A	N/A
2023	May	**1723**	**465**	1013	268	393	192	153	24	105	-7	59	-12	N/A	N/A
2023	Jun	**1049**	**377**	410	501	72	-70	308	34	-123	-81	381	-6	N/A	N/A
2023	Jul	**1188**	**445**	487	459	257	-89	134	15	25	23	284	37	N/A	N/A
2023	Aug	**639**	**182**	182	-119	221	111	-45	-15	233	172	48	34	N/A	N/A
2023	Sep	**-615**	**248**	-398	-105	194	43	-48	96	-470	131	106	83	N/A	N/A
2023	Oct	**-42**	**-283**	-98	-119	-331	-204	54	7	301	47	31	-15	N/A	N/A
2023	Nov	**-134**	**273**	-30	85	-8	150	13	6	-193	-3	85	36	N/A	N/A

Roster Effectiveness Indicators

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	Unused Hours
CM - Office (3007)	FCD	**0.00**
Nurse Led IV Access Service [5102]	DSSD	**0.00**
Ward B2 (0207)	AACD	**0.00**
Mental Health Midwives [3018]	FCD	**0.00**
CM - Daffodil (3007)	FCD	**4.00**
District Nursing - Evenings & Nights (3802	ICSD	**4.25**
Radiology Assistants (4303)	DSSD	**5.25**
SDEC (0404)	AACD	**6.50**
Pre Op Assessment Outpatients (3207)	DSSD	**8.33**
Infection Control (5103)	DSSD	**8.70**

Monthly Worst Performing Wards/Teams	Division	Unused Hours
Laburnum Lodge (3818)	ICSD	**345.58**
District Nursing - Waters Meeting [3925]	ICSD	**115.50**
Ward D4 [0119]	AACD	**108.70**
Ward C2 [0109]	AACD	**107.70**
A&E Majors (0419)	AACD	**95.38**
Critical Care Unit (1935)	ASSD	**86.25**
Ward E4 [1517]	ASSD	**82.25**
Ward H3 - Stroke [0204]	AACD	**78.20**
Ward G4 (0707)	ASSD	**77.67**
Ward B1 [0206]	AACD	**60.85**

e-Rostering KPIs Report

Roster Effectiveness Indicators

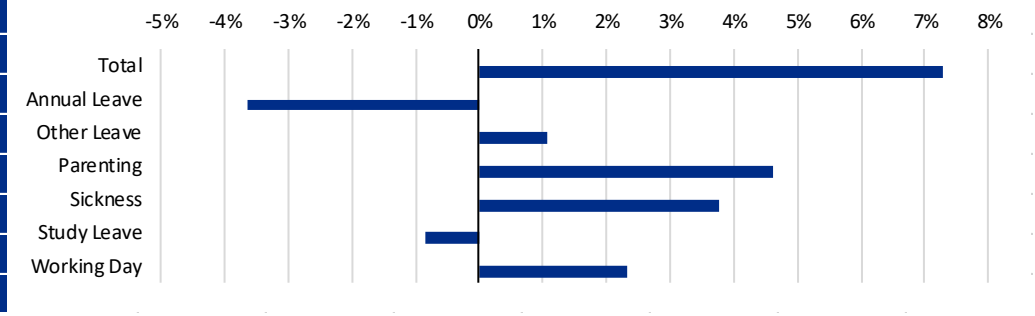
Source Data: HealthRoster

Unavailability In Month					
Period	Contracted Hours	Funded Unavailability Hours	Total Unavailability Hours	Hours Filled Bank/Agency/OT	Unfunded Bank/Agency/OT
Nov 2023	293457	68082 (23.2%)	99148 (33.79%)	43943	31066 (70.7%)

Registered

Type	Funded Hrs	Funded %	Actual Hrs	Actual %	Difference Hrs	Difference %
Total	**47211**	**23.20%**	**62042**	**30.49%**	**14831**	**7.29%**
Annual Leave	31949	15.70%	24546	12.06%	-7403	-3.64%
Other Leave	0	0.00%	2180	1.07%	2180	1.07%
Parenting	0	0.00%	9394	4.62%	9394	4.62%
Sickness	9157	4.50%	16846	8.28%	7689	3.78%
Study Leave	6105	3.00%	4371	2.15%	-1734	-0.85%
Working Day	0	0.00%	4704	2.31%	4704	2.31%

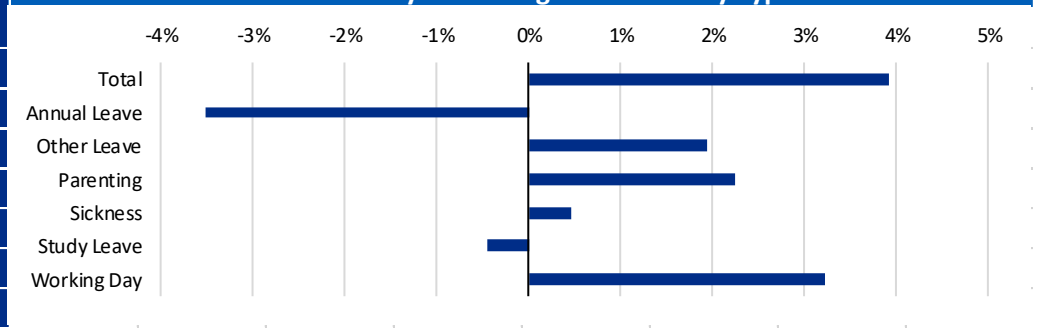
Unavailability Exceeding Funded - % by Type



Non-Registered

Type	Funded Hrs	Funded %	Actual Hrs	Actual %	Difference Hrs	Difference %
Total	**20871**	**23.20%**	**24391**	**27.11%**	**3520**	**3.91%**
Annual Leave	14124	15.70%	10955	12.18%	-3169	-3.52%
Other Leave	0	0.00%	1745	1.94%	1745	1.94%
Parenting	0	0.00%	2024	2.25%	2024	2.25%
Sickness	4048	4.50%	4472	4.97%	423	0.47%
Study Leave	2699	3.00%	2303	2.56%	-396	-0.44%
Working Day	0	0.00%	2893	3.22%	2893	3.22%

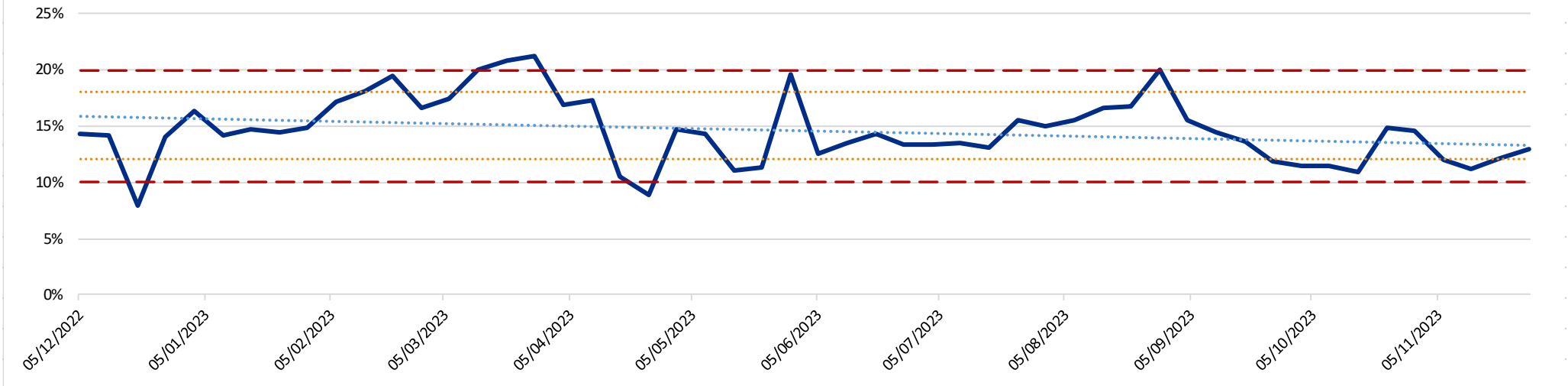
Unavailability Exceeding Funded - % by Type



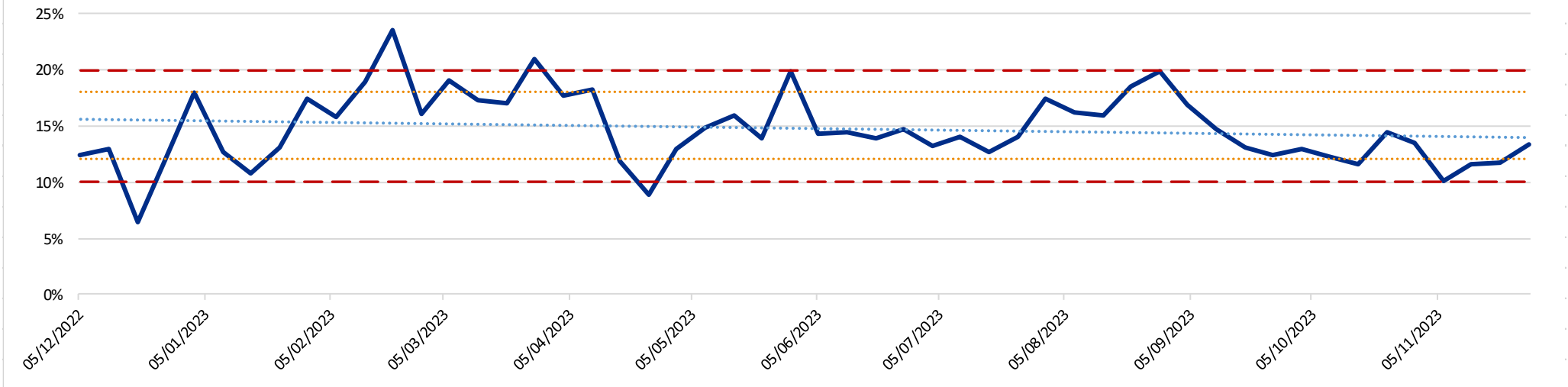
Roster Effectiveness Indicators

Source Data: HealthRoster

Annual Leave - Registered

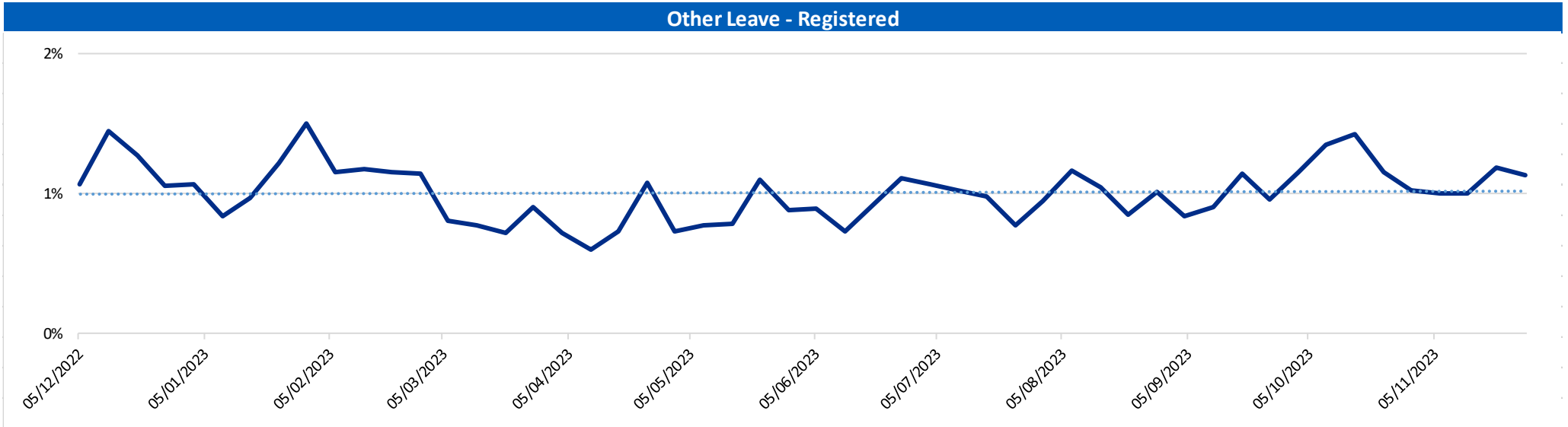


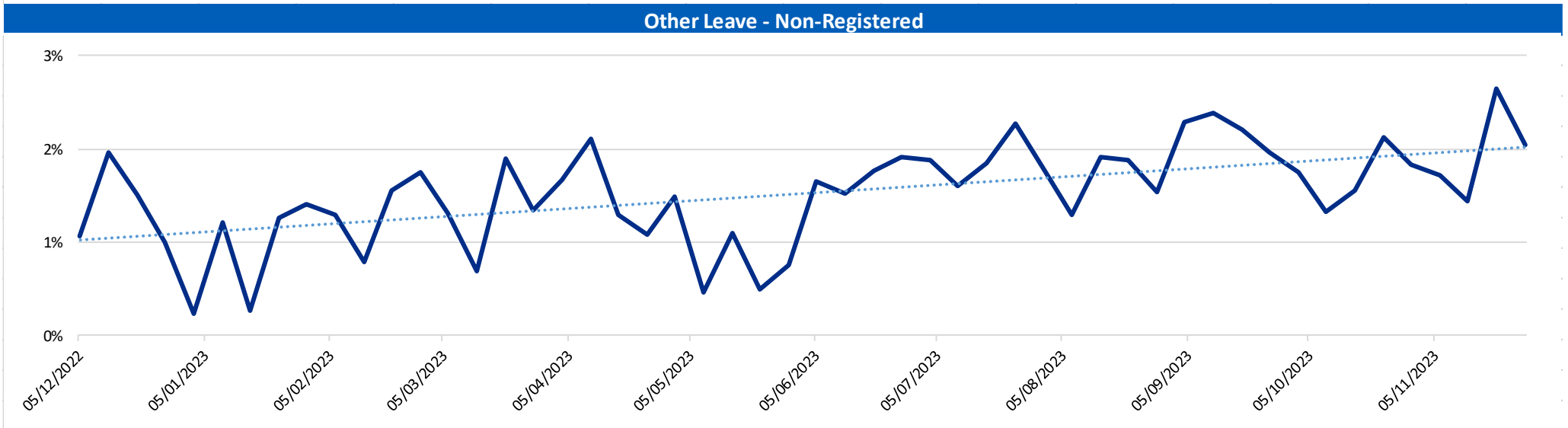
Annual Leave - Non-Registered



Roster Effectiveness Indicators

Source Data: HealthRoster





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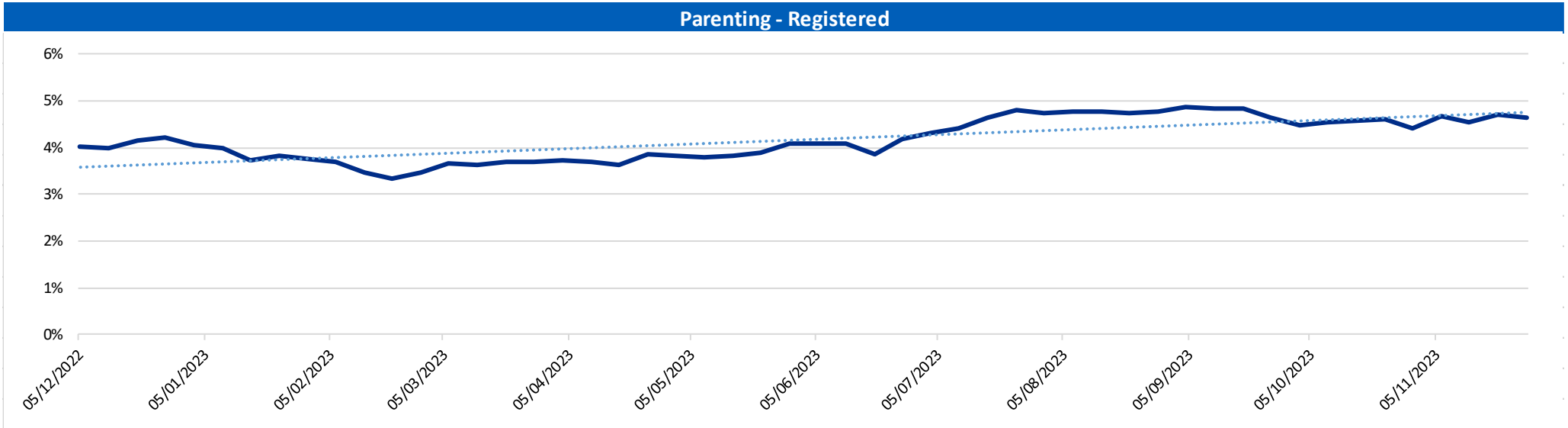
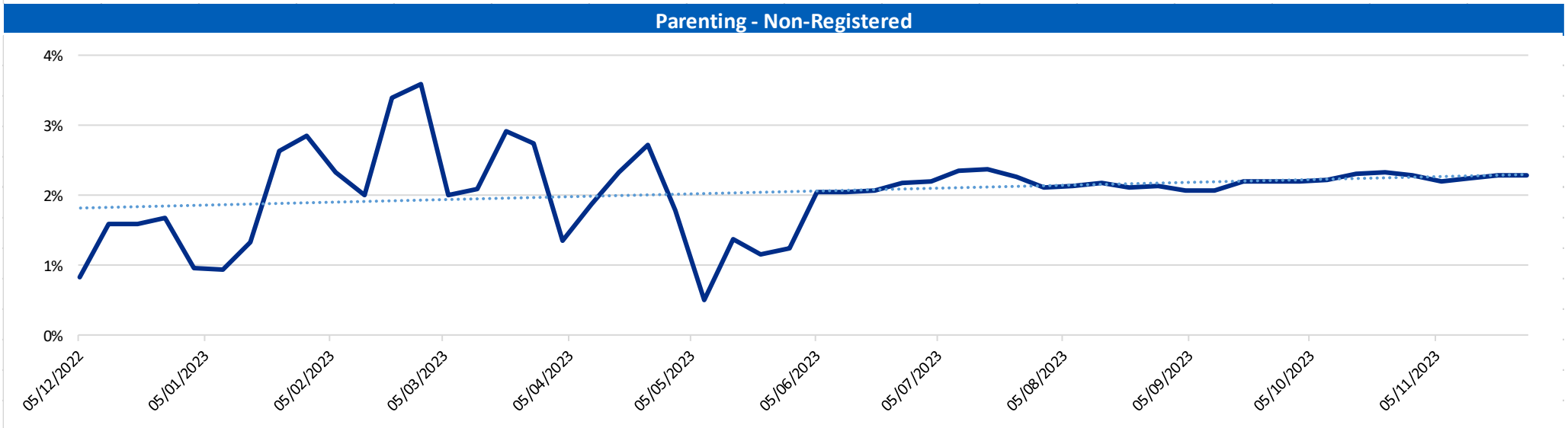
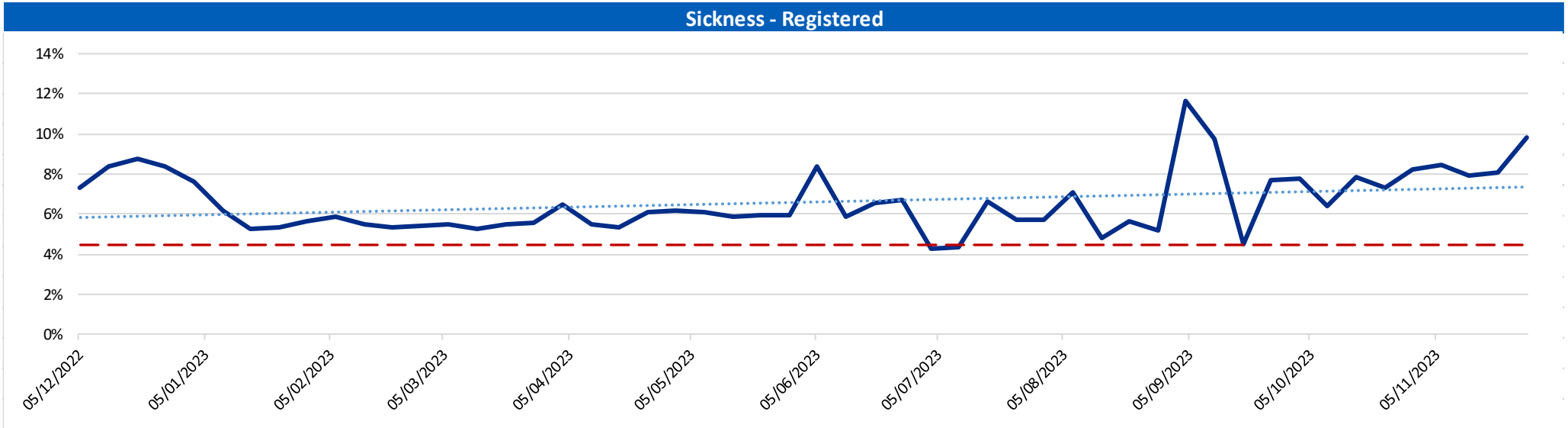
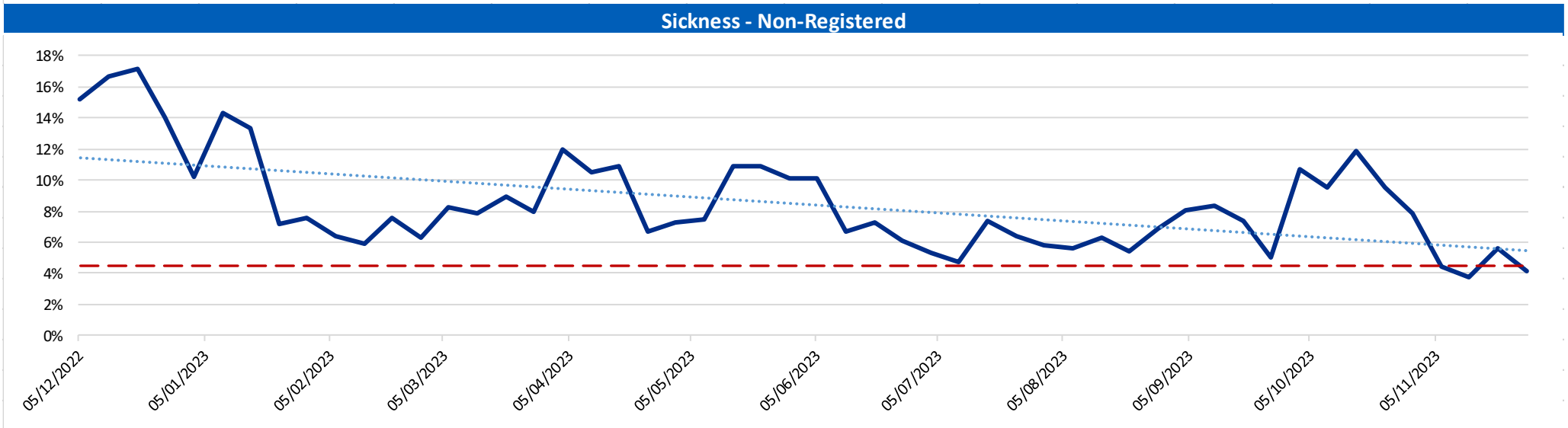




Roster Effectiveness Indicators

Source Data: HealthRoster





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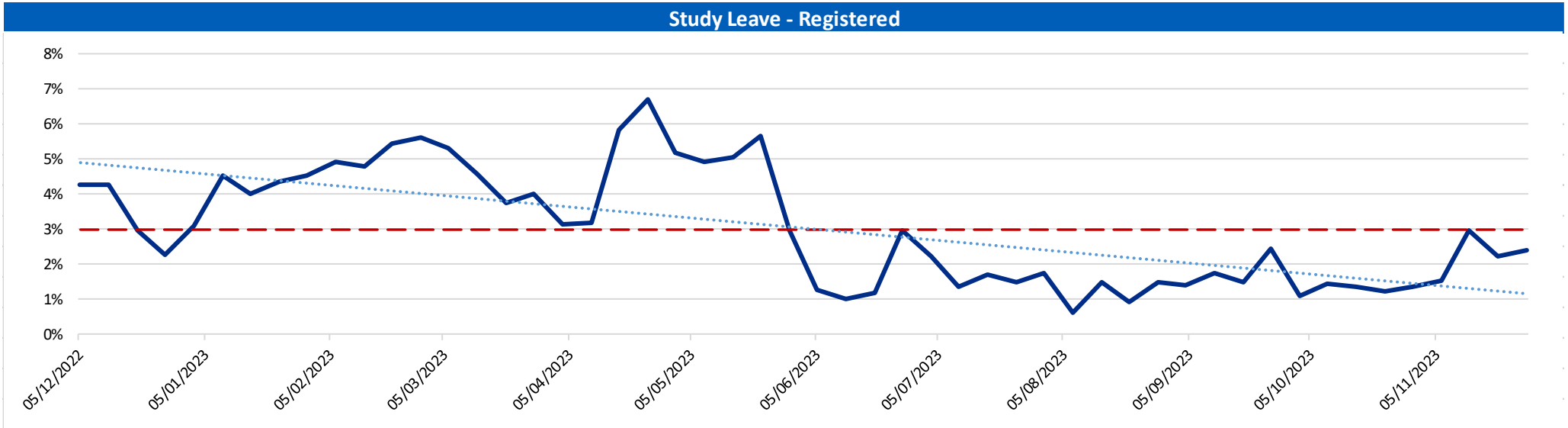
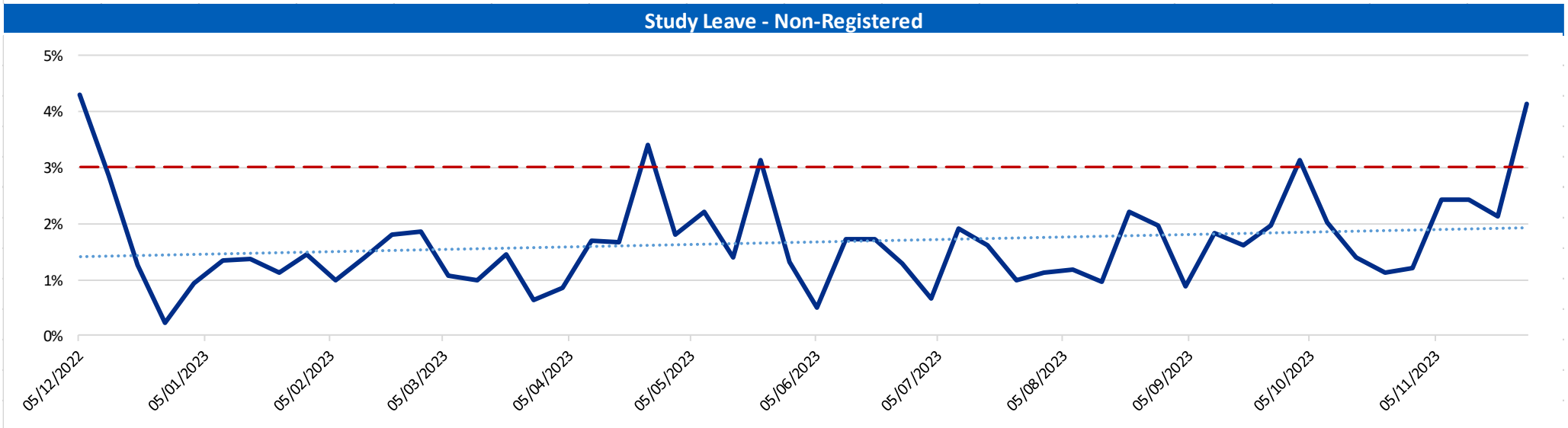
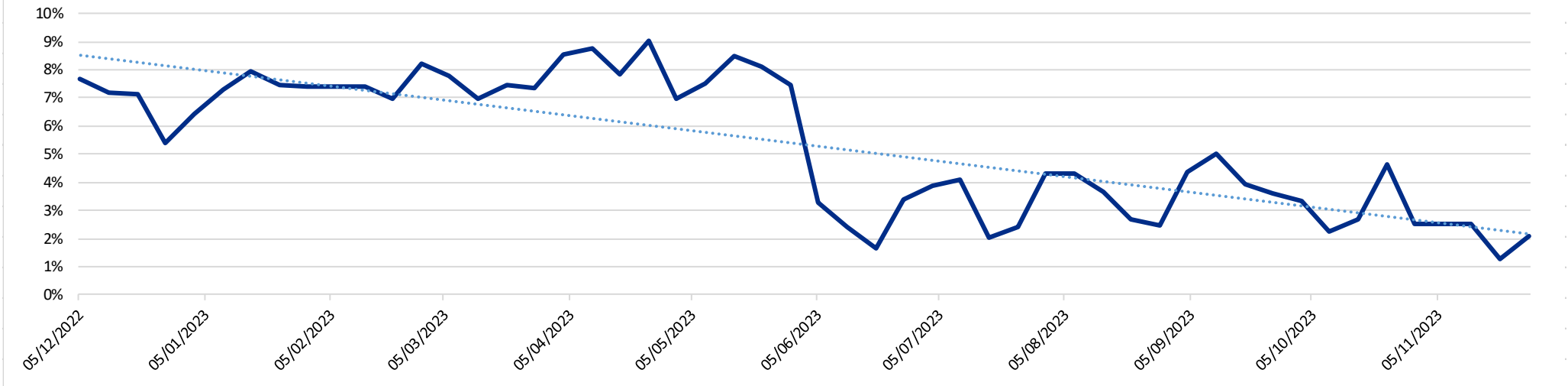




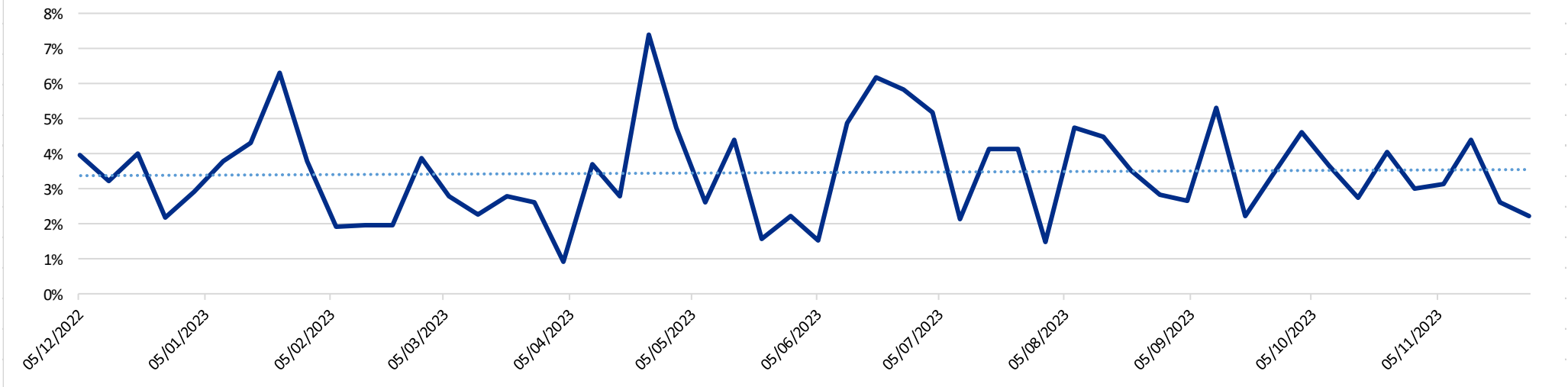
Roster Effectiveness Indicators

Source Data: HealthRoster

Working Day - Registered

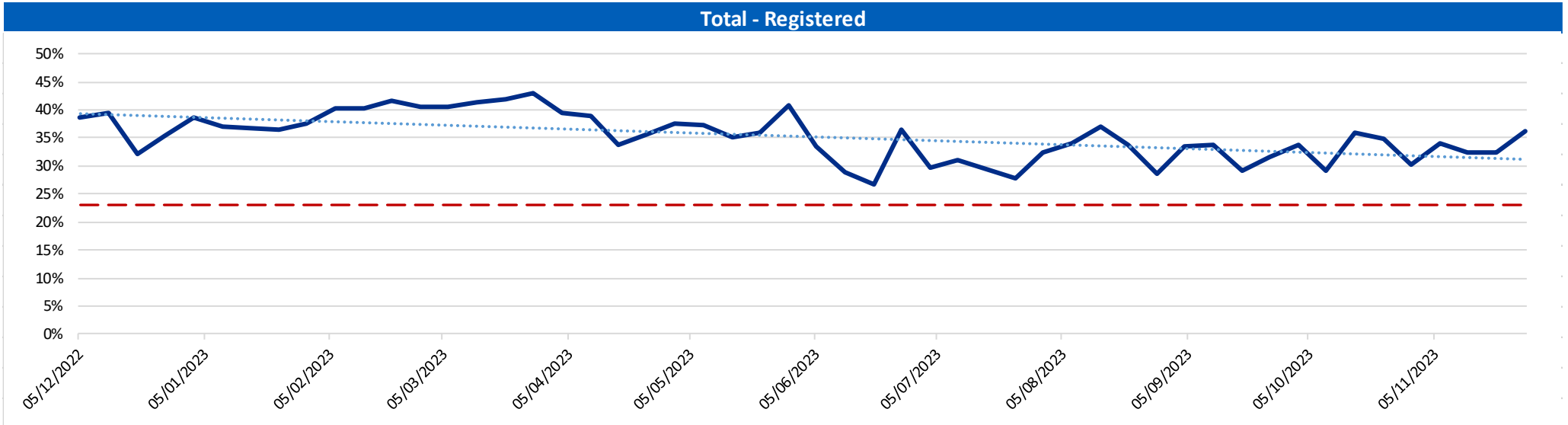


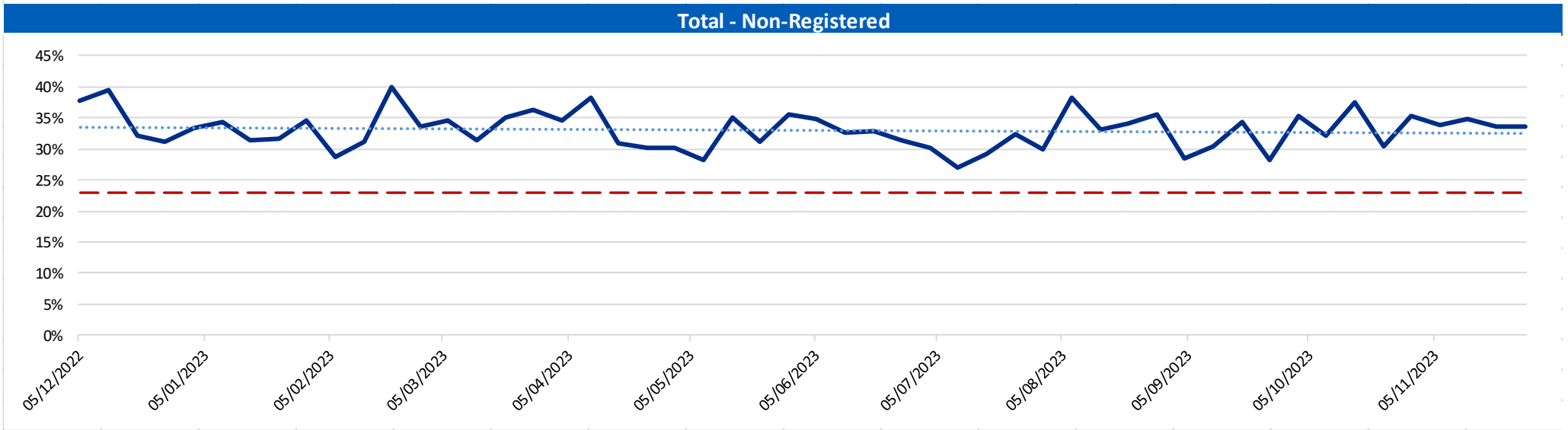
Working Day - Non-Registered



Roster Effectiveness Indicators

Source Data: HealthRoster

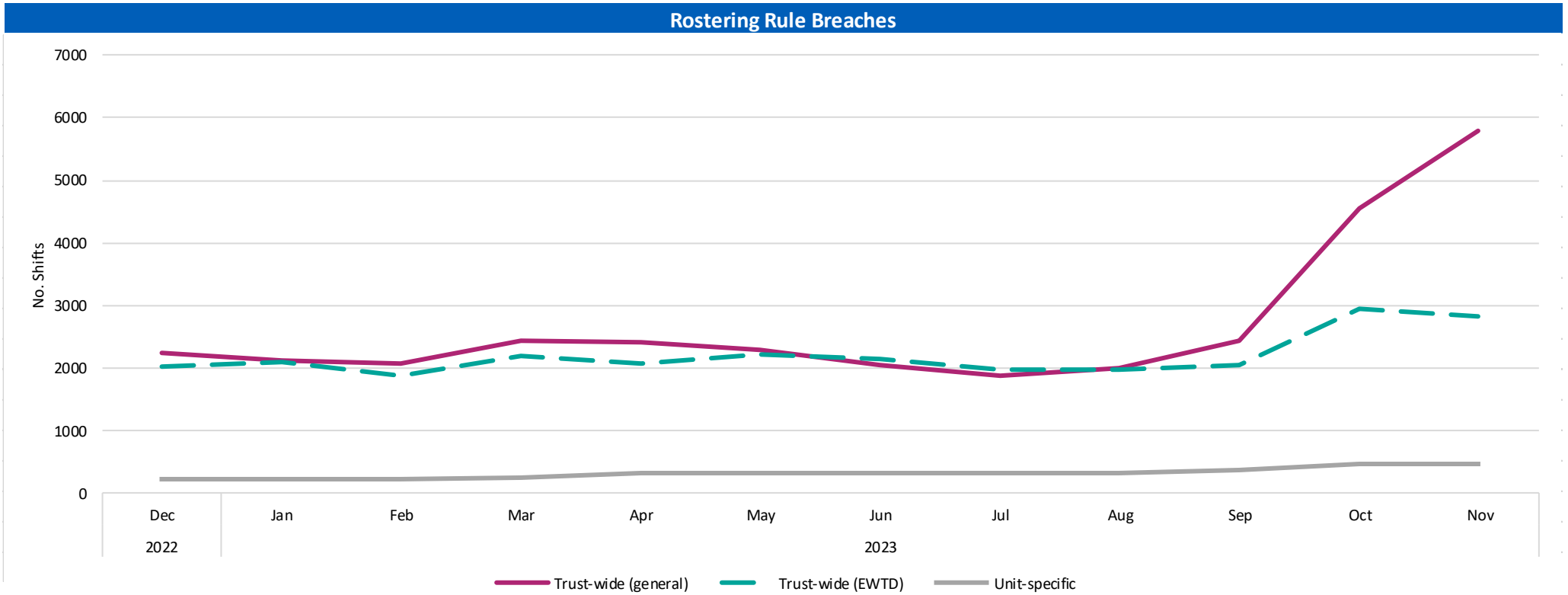




Roster Fairness and EWTD

Source Data: HealthRoster

Rostering Rule Breaches					
Period	Trust-Wide (General)	Trust-Wide (EWTD)	Unit-Specific		
Nov 2023	5781	2826	459		



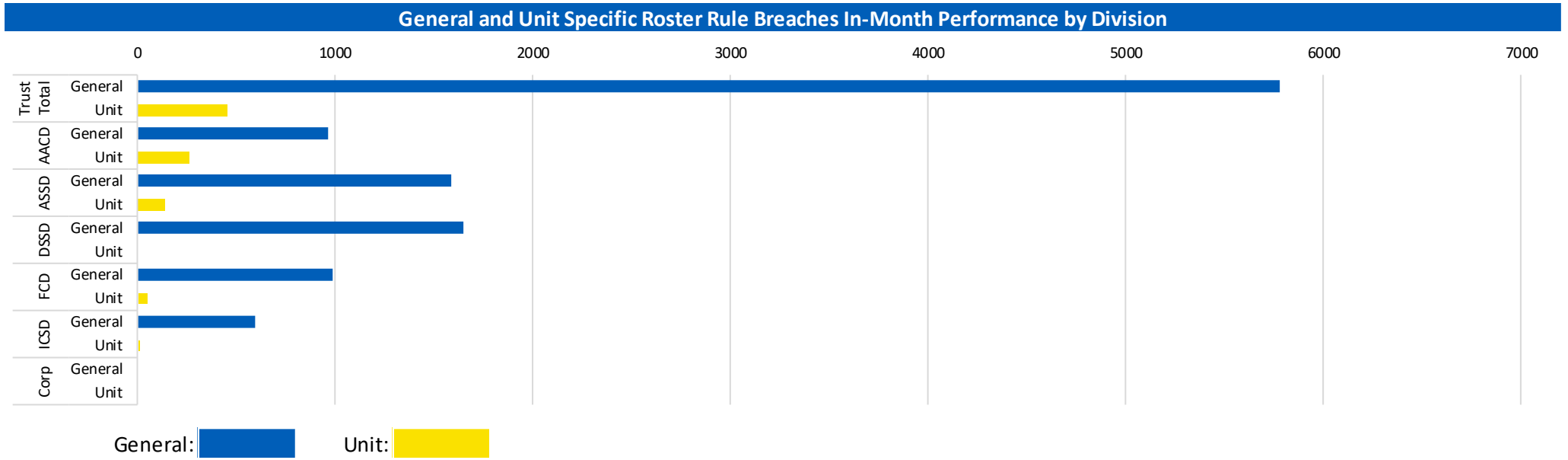
Roster Fairness and EWTD

Source Data: HealthRoster

General and Unit Specific Roster Rule Breaches per Month by Division															
Year	Month	Trust Total		241 L3 Acute Adult Care Division		241 L3 Anaesthetics & Surgical Division		241 L3 Diagnostics & Support Services		241 L3 Family Division		241 L3 Integrated Community		Corporate Combined	
		General	Unit	General	Unit	General	Unit	General	Unit	General	Unit	General	Unit	General	Unit
Total		**32311**	**3810**	**5918**	**2257**	**8142**	**996**	**7428**	**0**	**8496**	**496**	**2327**	**61**	**0**	**0**
2022	Dec	**2233**	**223**	287	130	619	52	496	*N/A*	671	39	160	2	*N/A*	*N/A*
2023	Jan	**2127**	**228**	302	118	552	62	410	*N/A*	692	45	171	3	*N/A*	*N/A*
2023	Feb	**2084**	**238**	340	131	543	59	336	*N/A*	705	48	160	0	*N/A*	*N/A*
2023	Mar	**2442**	**260**	395	150	538	57	455	*N/A*	880	53	174	0	*N/A*	*N/A*
2023	Apr	**2410**	**313**	601	191	600	77	395	*N/A*	723	35	91	10	*N/A*	*N/A*
2023	May	**2300**	**315**	538	207	716	69	363	*N/A*	571	34	112	5	*N/A*	*N/A*
2023	Jun	**2055**	**318**	411	211	484	69	466	*N/A*	594	32	100	6	*N/A*	*N/A*
2023	Jul	**1885**	**314**	325	187	431	71	501	*N/A*	535	52	93	4	*N/A*	*N/A*
2023	Aug	**2012**	**319**	369	201	463	71	592	*N/A*	459	36	129	11	*N/A*	*N/A*
2023	Sep	**2436**	**364**	492	222	584	99	552	*N/A*	617	33	191	10	*N/A*	*N/A*
2023	Oct	**4546**	**459**	892	242	1028	170	1216	*N/A*	1059	44	351	3	*N/A*	*N/A*
2023	Nov	**5781**	**459**	966	267	1584	140	1646	*N/A*	990	45	595	7	*N/A*	*N/A*

Roster Fairness and EWTD

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	Rule Breaches
Discharge Lounge (0415)	AACD	**2**
CM - Bluebell (3007)	FCD	**3**
Recovery (1910)	ASSD	**4**
CM - Sunflower (3007)	FCD	**5**
Pre Op Assessment Outpatients (3207)	DSSD	**5**
Ward M4 - Post Natal [3005]	FCD	**9**
CM - Wildflower (3007)	FCD	**10**
CM - Daffodil (3007)	FCD	**11**
Infection Control (5103)	DSSD	**13**
OPD General Nursing (3205)	DSSD	**14**

Monthly Worst Performing Wards/Teams	Division	Rule Breaches
Theatres Scrub (1909)	ASSD	**1111**
Radiography (4303)	DSSD	**1065**
Neonatal Unit [3013]	FCD	**427**
Ward E5 [2309]	FCD	**243**
Pharmacists (6201)	DSSD	**226**
A&E Majors (0419)	AACD	**222**
Ward F3 (1529)	ASSD	**124**
Radiology Assistants (4303)	DSSD	**122**
District Nursing - Breightmet [3918]	ICSD	**119**
Central Delivery Suite (CDS) [3011]	FCD	**114**

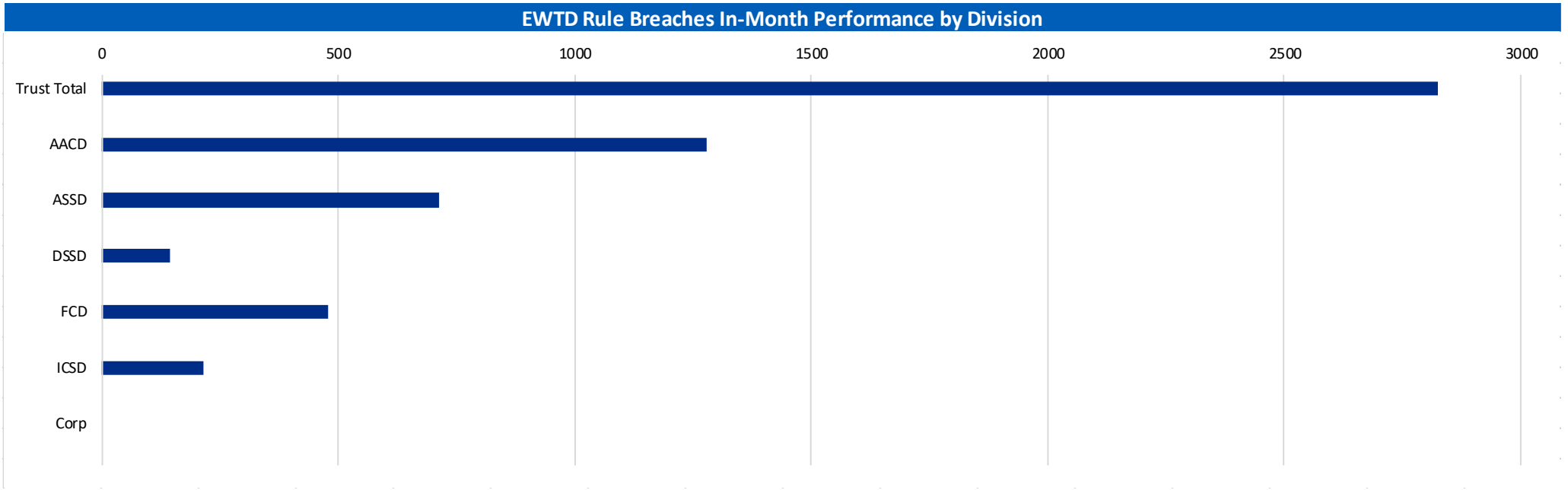
Roster Fairness and EWTD

Source Data: HealthRoster

EWTD Rule Breaches per Month by Division								
Year	Month	Trust Total	241 L3 Acute Adult Care Division	241 L3 Anaesthetics & Surgical Division	241 L3 Diagnostics & Support Services	241 L3 Family Division	241 L3 Integrated Community	Corporate Combined
Total		26442	10515	6789	859	5707	2572	0
2022	Dec	2025	589	538	69	544	285	*N/A*
2023	Jan	2105	720	618	65	451	251	*N/A*
2023	Feb	1883	609	525	89	445	215	*N/A*
2023	Mar	2206	714	568	69	626	229	*N/A*
2023	Apr	2076	859	571	56	440	150	*N/A*
2023	May	2220	979	592	43	423	183	*N/A*
2023	Jun	2142	924	493	54	483	188	*N/A*
2023	Jul	1985	743	518	54	460	210	*N/A*
2023	Aug	1977	845	485	86	371	190	*N/A*
2023	Sep	2054	855	509	55	424	211	*N/A*
2023	Oct	2943	1399	659	76	563	246	*N/A*
2023	Nov	2826	1279	713	143	477	214	*N/A*

Roster Fairness and EWTD

Source Data: HealthRoster



Monthly Best Performing Wards/Teams	Division	Rule Breaches
Bolton Birth Centre [3010]	FCD	**1**
CM - Sunflower (3007)	FCD	**1**
Antenatal Clinic - ANDU [3009]	FCD	**1**
CM - Lavender (3007)	FCD	**1**
Infection Control (5103)	DSSD	**1**
Anaesthetics (ODP) (1910)	ASSD	**1**
OPD General Nursing (3205)	DSSD	**1**
Ward B2 (0207)	AACD	**2**
CM - Bluebell (3007)	FCD	**3**
Pharmacists (6201)	DSSD	**3**

Monthly Worst Performing Wards/Teams	Division	Rule Breaches
A&E Majors (0419)	AACD	**282**
Theatres Scrub (1909)	ASSD	**212**
Ward E5 [2309]	FCD	**177**
Ward D1 (0409)	AACD	**126**
Central Delivery Suite (CDS) [3011]	FCD	**123**
Radiography (4303)	DSSD	**116**
SDEC (0404)	AACD	**100**
Ward R1 (0309)	AACD	**99**
Neonatal Unit [3013]	FCD	**93**
Ward G4 (0707)	ASSD	**93**

Roster Fairness and EWTD

Source Data: HealthRoster

EWTD Rule Breach Types by Division							
Type/Description	**Trust**	**AACD**	**ASSD**	**DSSD**	**FCD**	**ICSD**	**Corp**
Total	**2826**	**1279**	**713**	**143**	**477**	**214**	**0**
Number of shifts where a person who IS NOT 'opted out' of EWTD has worked, on average, more than 48 hours per week over a 17 week reference period	**281**	185	81	0	10	5	0
Number of shifts where a person who IS 'opted out' of EWTD has worked, on average, more than 56 hours per week over a 17 week reference period	**39**	19	19	0	0	1	0
Number of shifts where a person who IS NOT 'opted out' of EWTD has worked, on average, more than 48 hours in one week	**1265**	603	308	91	114	149	0
Number of shifts where a person who IS NOT 'opted out' of EWTD has worked, on average, more than 56 hours in one week	**525**	291	161	12	56	5	0
Number of shifts where a person has not consecutively had either 24 hours in 7 days or 48 hours in 14 days rest (N.B. cannot opt out)	**111**	55	25	14	5	12	0
Number of shifts where a person has not had 11 or more consecutive hours of rest (N.B. cannot opt out)	**212**	73	60	22	18	39	0
Number of shifts where a person working 6 hours or longer has not had at least 20 minutes' break (N.B. cannot opt out)	**393**	53	59	4	274	3	0

Report Title:	Maternity Bi-Annual Staffing Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Purpose	The purpose of this report is to outline the findings of the maternity bi-annual review for the period July - December 2023.

Summary:	The bi-annual maternity staffing report provides an overview of available data to provide assurance to the Board of Directors of safe staffing levels. The report triangulates workforce information with patient safety measures to ensure that staffing is balanced in line with patient acuity. The Chief Nurse and Director of Midwifery are satisfied that current staffing levels are safe, albeit due to the reduced capacity, and mitigated by the deployment of non-ward based midwives at times of service pressure. The report follows the guidance as set out by the National Quality Board to meet the three expectations, right staff, right skills, right place and time. In summary, the report highlights the ongoing maternity workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance in order to provide assurance of a safe maternity service.

Previously considered by:
The safe staffing review has been considered by the Chief Nurse, discussed with Executive Directors and presented to People Committee in May 2024.

Proposed Resolution	The Board of Directors are asked to: • Approve the report and recommendations in order to fulfil the CNST scheme requirements. • 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:	Janet Cotton – Director of Midwifery/ Divisional Nurse Director Tyrone Roberts, Chief Nurse	**Presented by:**	Tyrone Roberts, Chief Nurse

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

BR+	Birthrate Plus (Staffing Review)
CNST	Clinical Negligence Scheme for Trusts
NICE	National Institute for Clinical Excellence
NQB	National Quality Board
RCOG	Royal College of Obstetricians and Gynaecologists
OASI	Obstetric Anal Sphincter Injury

1. Executive Summary

This report details the findings of the Bolton NHS Foundation Trust 2023 bi-annual maternity staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

The review incorporates national guidance relating to the provision of safe staffing levels within maternity services and findings of the formal Birthrate Plus (BR+) assessment of the midwifery establishment staffing levels published in 2023.

The report fulfils the requirements outlined in the National Quality Board (NQB 2018) and the Clinical Negligence Scheme Trusts guidance (CNST 2024) that recommended maternity services should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months.

The report follows the guidance as set out by the National Quality Board to meet the three expectations, right staff, right skills, right place and time.

Right Staff

- The current funded Registered Midwife establishment of 240.94WTE is compliant with the 2019 Birthrate Plus report recommendations.
- The specialist midwifery establishment is 9% of the overall establishment and within expected parameters
- The last Birthrate Plus review was undertaken in 2022 and published in January 2023. The next review is due in 2025.
- A business case to seek an uplift to the funded establishment to meet the Birthrate Plus 2023 report recommendations was approved at CRIG in May 2024 and escalated to Finance and Investment Committee for consideration due to the value.
- The BR+ business case recommends an uplift to the establishment as indicated, which can be phased over 2025 in line with re-opening of current reduced capacity.
- The service maintained the supernumerary status of the 2nd Delivery Suite Co-ordinator throughout the July – December 2023 period.
- One to one care in labour compliance rates remained below the 100% standard, due a Registered Midwife vacancy position that ranged from 41.45WTE in July 2023 to 21.16wte in December 2023. An action plan to recover performance is detailed within this report.

Right Skills

- Mandatory and statutory staff training compliance during the reporting period remained below the Trust standard due to ongoing staffing pressures
- The dashboard highlights deficiencies in the professional specific training compliance during the period July – December 2023 that were reflective of the staffing challenges during this period. Assurance can be provided attainment of the required 90% standard with PROMPT, fetal monitoring and newborn life support training compliance was attained in February 2024.

Right Place and Time

- Throughout the period July – December 2023 Wards M4 and Ward M5 were staffed independently, yet often due to staffing levels were relocated onto one ward. The planned versus actual staffing levels reflect the staffing pressures during this period. To ensure safety activity was cohorted into one of the ward areas for the majority of this time yet this will not be reflected in the planned versus actual data until January 2024 when both wards were relocated to Ward G4.

Clinical outcomes

- Inconsistent performance with regard to the booking of women prior to 12+6 week gestation has continued due to the ongoing registered midwifery staffing deficit within the community setting. Wider issues relating to estate and digital access are being addressed in response.
- Local variation in the incidence of stillbirth was identified on the Trust integrated performance dashboard in September 2023 and a detailed review of contributing factors was undertaken in response.
- CQC 2023 maternity survey highlighted no statistical change in the response to 47 questions when compared with the 2022 survey findings and a slight statistical increase in 2 questions. The report findings reflected the overall service challenges in early 2023, the decrease in place of birth choice at Bolton since 2022.
- Significant improvement noted in the overall friends and family response rate noted during the period of review.

In summary, the report demonstrates the ongoing workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance. Safe staffing levels were maintained during this period, in part mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICB colleagues.

2. Background

In January 2018, the National Quality Board (NQB) released updated guidance in respect of nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Table 1: NQB expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

3. Expectation 1 - Right staff

The NQB recommends that there is an annual strategic staffing review, with evidence that it is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months.

3.1 Birthrate Plus - Evidence based workforce planning

Birthrate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The Birthrate Plus assessment was last undertaken in January 2023 and included case mix data from June to August 2022.

The report acknowledged that the Beehive alongside birthing centre and the Ingleside freestanding birthing centre were closed to birthing activity at the time of the assessment. Both clinical areas remain closed and the re-opening of additional will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

The report confirmed that there had been a noticeable change in the number of women in category V (highest acuity) category of case mix in the 2023 with the % increasing from 29.3% in 2019 to 51.4% in 2023. This increase in acuity had a significant impact upon the required staffing ratio.

Within Greater Manchester and Eastern Cheshire, Bolton has the highest number of women in the highest acuity with 72% in the Cat IV and V classification. This has increased from 63% in 2019. To be noted a rise in acuity has been noted in most maternity services over the last 3-4 years. This increase has been discussed with regional colleagues and a request made by GM ICB Chief Nurse for LMNS Birthrate+ lead to attend a Chief Nurse discussion to discuss the findings, specifically to explain how one locality report can highlight such a significant increase in acuity.

The majority of maternity services have seen an increase in the % of women with significant safeguarding needs which adds to the clinical workload and additional staffing is included in the community staffing for 600 women with significant safeguarding needs in the 2023 report in response to the assessment undertaken.

Findings of the Birthrate Plus 2023 review confirmed that a total clinical staffing establishment of 283.07 Whole Time Equivalent (WTE) was required to deliver a safe midwifery service. This includes an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles. The breakdown as to how the staffing establishment has been calculated by Birthrate Plus is detailed in Appendix 1.

A revision of the skill mix is ongoing to ensure a 90:10 mix is deployed in postnatal clinical areas has been undertaken in accordance with professional judgement. This will be completed following authorisation of the Birthrate plus business case and approval to reconfigure the support worker establishment. Currently the skill mix for Registered Midwives: Support Workers is 97:3 – adjusting this skill mix to 90:10 will reduce the impact upon the Registered Midwife uplift required. Without this adjustment being enacted there is an overall shortfall of 31.30WTE of which 30.44WTE (97%) of current clinical WTE are RMs and 3% (0.86WTE) maternity support workers providing postnatal care.

The current funded Registered Midwife establishment of 240.94WTE is compliant with the 2019 Birthrate Plus report recommendations that is being used to model current roster templates.

The funded establishment is not yet compliant with the 2023 Birthrate Plus report recommendations as the required uplift to the funded establishment has not yet been considered fully by the Trust. A business case to seek an uplift to the funded establishment to meet the Birthrate Plus 2023 report recommendations was approved at CRIG in May 2024 and escalated to the finance and investment group for consideration due to the value. The BR+ business case recommends an uplift to the establishment which can be phased over 2025 in line with re-opening of current reduced capacity. Approval of the business case will inform the plan and timescale for achieving the required uplift as per CNST requirements.

Monthly establishment reconciliations continue to be shared with the service that detail the funded and vacant positions within the funded establishment. The monthly reconciliation as of December 2023 is detailed in Appendix 2. The reconciliation undertaken in December 2023 was based upon the total funded clinical WTE establishment defined in the 2019 Birthrate Plus report of 239.70WTE as alignment to the 2023 Birth report recommendations had not yet been fully approved.

Since the last Birth Rate Plus report was published in 2023 the activity has remained static, yet capacity pressures have exacerbated due to closure of maternity areas following the finding of reinforced autoclaved aerated concrete within the maternity building and subsequent relocation of ward areas resulting in a loss of 34 beds. As a result low risk and high risk birth activity is currently being managed on Delivery Suite which is significantly impacting upon patient flow within the maternity unit. The previous occupancy data on the 24 bedded M4 ward showed at times a 102% occupancy rate with overflow to the sister ward M5 of up to 52 cases per month. It is the lack of this overflow that is causing the current delays in flow within the unit despite the relocation of intrapartum activity to CDS and the implementation of a discharge lounge (four spaces) on G4. This lack of overall bed capacity on CDS is delaying the timely transfer of cases of induction of labour which has safety implications for both mother and baby.

Approval of the staffing business case and recruitment to the recommended uplift is required to meet the CNST year 6 requirements as the Trust is required to provide assurance of compliance with the latest BR+ guidance and/or provide a timeframe for implementation.

The Birth Rate Plus review is due to be repeated in 2025 and should acuity in next BR+ be increased as per national predictions' then a further increase in midwifery establishment can be anticipated

3.2 Specialist Midwifery Roles

Specialist midwives support the delivery of the maternity service providing expert guidance and specialist support to the midwifery team. In December 2023 25.11WTE specialist midwives were employed within the maternity service undertaking a range of roles including infant feeding specialist, digital midwife and pastoral support.

Birthrate Plus advises that the additional workforce should equate to no more than 8-10% of the funded clinical midwifery establishment to provide specialist support for the delivery of a safe service. The specialist establishment (25.11WTE) is therefore within the recommended specialist midwifery requirements of the service at 9 %.

The specialist workforce calculation reflects the non-clinical element of the specialist and management roles. The additional clinical element of the role is included in the overall clinical establishment.

3.3 Registered Midwife to birth ratio

An overall recommended ratio of 1.23 births to 1WTE was highlighted in the 2023 Birthrate Plus report. This ratio was calculated using the case mix and acuity data. Differing ratios are applicable to hospital and community areas as the acuity of the patients differs i.e. community midwifery ratio 1:92.4.

The 2023 report advised the overall ratio that should be applied to the service at Bolton based upon activity and acuity in all areas is to 1:23. This ratio differs from that recommended in the 2019 report namely 1:27 and reflects the increase in acuity reflected in the recent review.

On a monthly basis the Birthrate plus midwife to birth ratio is calculated to provide assurance that staffing levels (including bank and agency usage broadly align with the recommended standard). Fluctuation in the ratio is notable at times of low shift fill. Table 2 highlights that the mean staffing ratio (calculated to include all worked hours) between July and December 2023 meets the required 2023 Birthrate standard when bank and agency usage is taken into account.

Table 2: Midwife to birth ratio (in accordance with 2019 recommendation)

Indicator	Goal	Red Flag	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:26.9	1:27.1	1:25.5	1:24.3	1:23.2	1:23.4
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		1:23.9	1:23.5	1:22.6	1:22.9	1:21.2	1:22.7

3.4 Supernumerary Status

The Delivery Suite Coordinator is a supernumerary member of the team (defined as having no caseload of their own during their shift).This indicator is a safety proxy indicator identified within the clinical negligence scheme for trusts guidance to ensure there is oversight of all birth activity within the service at all times. Currently non-compliance is recorded on the Birthrate Plus acuity tool when the Co-ordinator is the named person providing 1:1 care and is thus unable to retain the status of supernumerary co-ordinator.

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status at the start of every shift. Table 3 highlights that with the exception of one approved breach (in accordance with CNST standards) whereby care was provided to a postnatal woman the Trust maintained the supernumerary status of the 2nd Delivery Suite Co-ordinator throughout the July – December 2023 period.

Since April 2023 quarterly red flag reports have been collated to provide assurance that the Delivery Suite Co-ordinator was not allocated as the named midwife for a woman requiring 1:1 care. All cases of non-compliance are reviewed by the Intrapartum Matron on a monthly basis and collated in a red flag report on a quarterly basis.

Table 3: Supernumerary status episodes of non-compliance (per shift)

	13/12/2023	2023									
	Delivery Suite	May 30/31	June	July	Aug	Sept	Oct	Nov	Dec 0-7th	TOTAL	% of red flags recorded
	Assessments completed - all data entries	11	164	166	162	166	202	178	39	1088	NA
RF1	Delayed or cancelled time critical activity	0	7	1	3	3	3	1	0	18	2
RF2	Missed or delayed care (for example, delay of >60 minutes for suturing)	0	5	2	1	0	4	0	0	12	1
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0	0	0	0	0
RF5	Delay between presentation and triage	0	2	0	0	0	3	0	0	5	1
RF6	The coordinator is the named midwife for a woman requiring 1:1 care	0	4	0	0	0	3	0	0	7	1
RF7	Delay of 2 hours or more between admission for induction and beginning of process	0	11	2	0	3	4	0	0	20	2
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0	0	0	0	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	1	3	0	0	4	1	1	10	1
RF10	Delay of 24hrs in accessing CDS for continuation of IOL once identified as ready for transfer	7	146	114	72	150	201	139	32	861	92
	TOTAL	7	176	122	76	156	222	141	33	933	100

3.5 Headroom / Uplift

Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered. Current headroom/uplift provided within the Trust is 23% with national ranges varying between 19% and 25%.

3.6 Professional judgement

The judgement of senior experienced midwives remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). The last professional judgement review was undertaken in August 2023.The review included the Director of Midwifery, Maternity Matrons, workforce, and finance colleagues and considered:

- Acuity requirement
- Ward/dept leadership
- Ward/dept layout and environment
- Additional specific training requirements
- Support of carers/patients

3.7 Safety outcome indicators

Maternity sensitive staffing metrics are displayed on the integrated performance maternity dashboard each month and alert the team to factors that reflect deficits in

staffing levels that may cause potential harm and thus need investigation and prompt action. The dashboard reflected in Table 4 highlights the staffing related key performance metrics for the period July – December 2023.The dashboard reflects an increase in maternity diverts in October 2023 due to staffing pressures.

The maternity dashboard indicators reflect a challenged yet improving service during the period July – December 2023. One to one care in labour compliance rates remained below the 100% standard, due a decreasing vacancy position between July – December 2023 that ranged from 41.45WTE to 21.16wte in December 2023.

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with the 1:1 care in labour standard and an action plan if the standard cannot be demonstrated. The action plan to recover performance is detailed in appendix 3.

Inconsistent performance with regard to the booking of women prior to 12+6 week gestation has continued due to the ongoing registered midwifery staffing deficit within the community setting during the period of review. Community midwifery staffing remained a challenge during this time and this deficit impacted upon the team's ability to flex availability and offer weekend/evening clinics for booking to positively influence the 12+6 compliance. To note the Trust mean or median (as GMEC states median) for 12+6 booking compliance aligned with the Greater Manchester and Eastern Cheshire (GMEC) median of 84.88% during this period.

Local variation in the incidence of stillbirth was identified on the Trust integrated performance dashboard in September 2023. An increase in the incidence was also noted on the GMEC tableau dashboard for the corresponding period and a review of cases was requested by the LMNS programme board. A trust review of the cases to identify contributing local factors was undertaken in response.

Key findings of the review:

- 21 stillbirths (21 babies/ 20 mums/cases) occurred during the period January to August 2023 and a total of 19 eligible maternal cases and 20 babies were included in the review undertaken.
- The review highlighted that women from the white British ethnic group had the highest rates of stillbirths in Bolton, and the babies were born to mothers living in the most deprived areas. This finding does not correlate with the national data relating to ethnic groups, which demonstrates, that women from the BAME population are most at risk of stillbirth and may reflect the small sample of cases reviewed.
- The main cause of death was classified as 'unexplained' in 46.1% (6/13) of cases. 15.4% (2/13) were due to placental abruption associated with pre-eclampsia in 1 of the cases, which was an unbooked pregnancy. 7.7% (1/13) were due to maternal vascular malperfusion, 15.4% (2/13) of cases were due to abnormalities and 15.4% (2/13) due to cord entanglement.

The Trust incidence of Obstetric Anal Sphincter Injury (OASI) (3rd and 4th degree) tears was flagged on the Trust dashboard as 3.65% and noted to be slightly higher than rolling 12 month GMEC comparator rate of 2.60%. The local relaunch of the specific OASI package was delayed due to CNST training prioritisation during this period and the elevated incidence flagged at GMEC safety assurance panel. In response peer

support was requested from Local Maternity and Neonatal System (LMNS) with wider sharing of learning as a sustained incidence was also noted in another provider.

Table 4 - Critical Safety Indicators

Indicator	Goal	Red Flag	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Critical Safety Indicators								
Still Birthrate (12 month rolling)per thousand	3.5	≥4.3	4.5	4.9	5.0	5.2	5.0	4.6
HIE Grades 2&3 (Bolton Babies only)	0	1	0	3	2	1	0	0
% Completed Bookings by 12+6 BI calculation	90%	<90	88.50%	87.80%	85.80%	86.60%	82.20%	84.90%
ICU/ HDU Admissions	Information only		2	0	0	2	1	0
Post-Partum Hysterectomy	0	>1	2	0	0	2	1	0
2nd Maternity theatre requested to be opened but delay or unable to open changed to rag rate Aug 21	0	>=1	0	0	0	0	0	0
Admissions to Maternity CCU level 2 care	Information only		9	6	3	2	3	4
1:1 Midwifery Care in Labour	95%	<90%	98.3%	99.0%	98.6%	98.6%	98.1%	97.7%
% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	9.83%	12.89%	10.92%	12.07%	10.09%	11.84%
3rd /4th Degree Tears (rate in month)	3%	>3.1%	3.07%	4.39%	2.18%	5.52%	3.52%	2.08%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.4%	3.4%	3.4%	3.5%	3.6%	3.6%
Breastfeeding Initiated within 48 Hours	65%	<65%	69.7%	69.1%	68.9%	69.8%	69.1%	67.1%
SUI'S (New only)	0	2	1	0		1	1	0
HSIB referrals	Information only		1	1	3	1	0	0
Access Standards								
Unit Closures	0	1	1	0	0	3	1	1

4. Expectation 2 – Right Skills

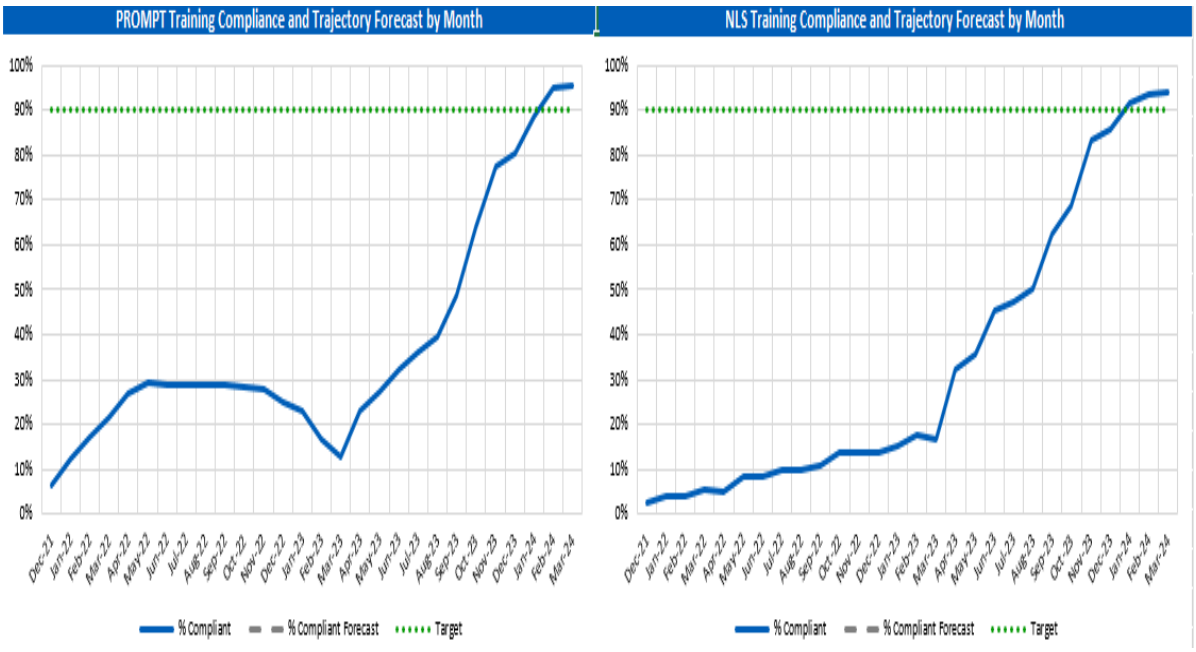
Mandatory and statutory staff training compliance during the period July - December 2023 remained below the Trust standard due to a Registered Midwife vacancy position

that ranged from 41.45WTE in July 2023 to 21.16WTE in December 2023. In response the service had to prioritise elements of essential training namely emergency skills training and fetal monitoring training within the service.

Following the launch of the CNST year 5 maternity incentive scheme in May 2023 the professional specific training requirements were revised to align with the national core competency framework version 2 and the GMEC standards. Compliance is now monitored on a profession specific training database.

The dashboard highlights deficiencies in the professional specific training compliance during the period July – December 2023 that were reflective of the staffing challenges during this period. Assurance can be provided attainment of the required 90% standard with PROMPT, fetal monitoring and newborn life support training compliance was attained in February 2024. The improvement trajectory is detailed in Table 5 and compliance is detailed in Appendix 4.

Table 5 – Training improvement trajectory



5. Expectation 3 – Right place, right time

5.1 Planned versus actual midwifery staffing levels

The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels. The planned staffing levels outlined in Table 6 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff. Table 6 highlights a significant gap in the planned and worked hours for both registered and non-registered staff groups within M4 and M5 inpatient wards. This gap in fill is reflective of the staffing deficit during this period.
Assurance can be provided agency and bank shifts were and continue to be offered to mitigate staffing gaps and pressures when indicated. Safety risks are mitigated within the service by redeploying staff within the service and clinical areas on a daily basis.

Throughout the period July – December 2023 Wards M4 and Ward M5 were staffed independently, yet often due to staffing levels were relocated onto one ward. The planned versus actual highlighted in table 6 reflects the staffing pressures during this period. To ensure safety activity was cohorted into one of the ward areas for the majority of this time yet this will not be reflected in the planned versus actual data until January 2024 when both wards were relocated to Ward G4.

Table 6: Planned versus actual fill for maternity ward inpatient areas.need to explain / justify the over fill

Ward/Team	Grade Type Category	Day/Night	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
			Fill %	Fill %	Fill %	Fill %	Fill %	Fill %
Ward M2 - Obstetrics (3004)	Registered	Day	99.27 %	94.44 %	107.68 %	102.60 %	105.53 %	101.35 %
	Non-Registered	Night	164.38 %	168.93 %	194.86 %	191.30 %	193.91 %	199.30 %
	Registered	Day	97.37 %	96.84 %	91.67 %	97.25 %	88.49 %	88.86 %
	Non-Registered	Night	80.65 %	93.27 %	100.00 %	100.85 %	96.67 %	112.92 %
Ward M4 - Post Natal [3005]	Registered	Day	85.65 %	89.70 %	93.49 %	82.57 %	90.23 %	78.23 %
	Non-Registered	Night	57.75 %	63.28 %	70.27 %	68.09 %	80.50 %	83.56 %
	Registered	Day	88.08 %	89.67 %	87.69 %	88.26 %	97.71 %	81.74 %
	Non-Registered	Night	49.23 %	59.05 %	91.67 %	93.68 %	96.23 %	91.92 %
Ward M5 - Post Natal (3006)	Registered	Day	75.94 %	50.98 %	37.14 %	49.08 %	67.60 %	77.04 %
	Non-Registered	Night	47.47 %	28.91 %	25.34 %	40.03 %	72.78 %	83.08 %
	Registered	Day	95.69 %	52.98 %	45.55 %	11.99 %	29.48 %	50.94 %
	Non-Registered	Night	37.70 %	28.73 %	23.70 %	38.33 %	60.73 %	71.74 %

5.2 Mitigating actions

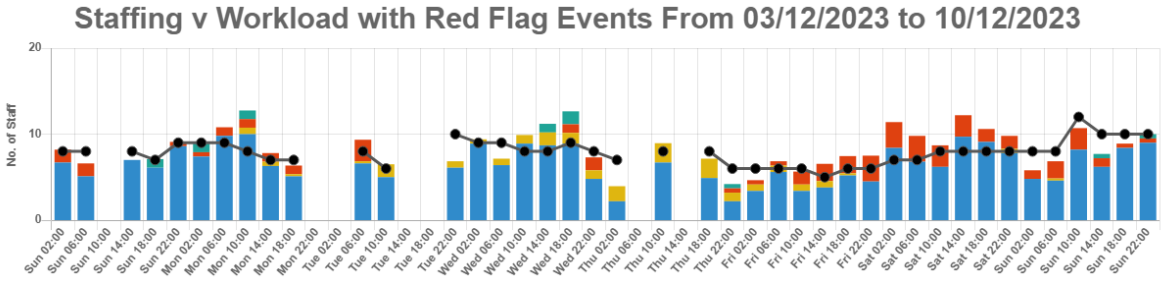
The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

- Incident reporting system is used to report staffing incidents and all red flag incidents are audited on a quarterly basis.
- Regular reviews with ward managers, Matrons and the Director of Midwifery
- Daily operational safety huddle meetings are held by matrons to assess and respond to changes in pressure and demand.
- Midwives move flexibly between delivery suite, maternity wards, birth centres and community to ensure women's needs are met.
- Ward managers work clinically as part of the clinical establishment with matrons, if required, to support patient care.

- Safety huddles occur in maternity twice daily to assess the activity and acuity
- Escalation guidelines are in place and used to respond to elevated demand, to preserve patient safety.
- The publication of rosters in a timely manner so staffing deficits can be safely managed.
- Approval of agency and bank usage to mitigate shortfalls in staffing levels

For additional oversight and scrutiny on a daily basis staffing figures and the acuity levels within the maternity intrapartum areas are input into an additional electronic Birthrate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. Table 7 details the acuity recorded on the intrapartum acuity tool in December 2023, highlighting the 4hrly review of staffing levels undertaken by the Delivery Suite Co-ordinator and the periods of increased staffing pressure.

Table 7: Birthrate Plus intrapartum acuity/staffing modelling tool example - December 2023



5.3 Midwifery Continuity of Carer

The maternity service received formal notification on 21 September 2022 thereafter from NHS England that there was no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders were advised to focus on retention and growth of the workforce, and develop plans that would work locally taking account of local populations and current staffing to support the maternity team to work to their strengths.

A recent review of the staffing positon has been undertaken and the Trust is still unable to proceed with MCoC as the default model of maternity care due to the ongoing midwifery staffing deficit and the need to reinstate the midwifery led services within the service in the first instance.

5.4 Workforce Metrics

The sickness absence data for the period July - December 2023 demonstrated a sustained trend in sickness absence reported within the maternity service**.** The main cause of absence related to stress and anxiety. Matrons continue to be supported by

workforce partners to monitor absence and support staff members during their absence to return to work.

Table 8: Sickness absence per WTE July – December 2023

Indicator			July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Monthly percentage sickness	4%	>=4.75%	6.22%	5.85%	4.47%	4.54%	5.17%	4.66%

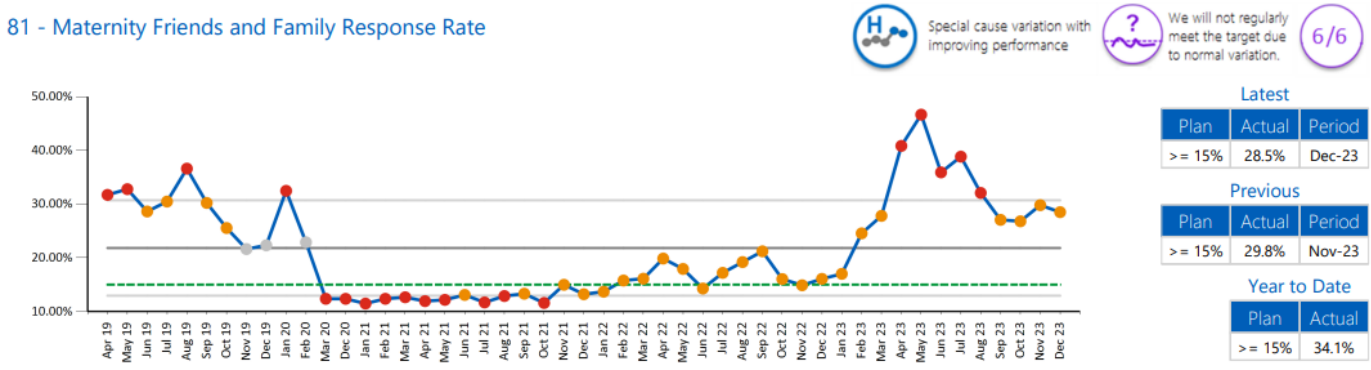
5.5 Red Flags

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Within the maternity service midwifery red flag events are monitored currently using the Birthrate Plus acuity tool as detailed in Table 7. Alignment of the red flags with the nationally defined flags as per current NICE guidance was undertaken in January 2024.

6. Patient Experience

Over the last 12 months, the maternity service has actively sought feedback from service users. The friends and family test feedback can be evidenced in the maternity survey, feedback sought from the maternity voices partnership and the friends and family response rates illustrated below. The service established a task and finish group to improve the response rate in January 2023. The result of which has been a stabilisation in the overall response rate peaking in May 2023. Table 9 demonstrates the improvement in compliance rate since April 2019

Table 9: Friends and Family Response Rates



6.1 Maternity Survey

On 9th February 2024, the CQC published their annual maternity 2023 survey results as part of the NHS Patient Survey Programme. The NHS Patient Survey

Programme (NPSP) is commissioned by the CQC to collect feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

All eligible individuals, who had a live birth between 1 January and 31 March 2023 were invited to participate in the maternity survey. The Trust had a 35% response rate from the 628 individuals invited to take part.

6.2 Themes from the CQC Maternity Care Survey

The 2023 CQC maternity survey highlighted:

Areas of strength

- Maternity service users receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.
- Maternity service users discharge from hospital not being delayed on the day they leave hospital.
- Maternity service users feeling that if they raised a concern during their antenatal care it was taken seriously.
- Maternity service users having confidence and trust in the staff caring for them during their antenatal care.
- Maternity service users being given information about their own physical recovery after the birth.

Areas of further improvement

- The cleanliness of the hospital room or ward maternity service users were in during their stay at the hospital.
- Partners or someone else close to the service user were involved in their care as much as they wanted to be during labour and birth.
- Maternity service users feeling that if they raised a concern during labour and birth it was taken seriously.
- Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.

The report highlighted no statistical change in the response to 47 questions when compared with the 2022 survey findings and a slight statistical increase in 2 questions.

The report findings reflected the overall service challenges in early 2023, the decrease in place of birth choice at Bolton since 2022 and the staffing pressures at the time of the survey (circa 53WTE Registered Midwives) that impacted upon the quality of the care provided to families.

6.3 Complaints

Thematic analysis of all complaints is undertaken within the service to identify trends and actions to be undertaken on a monthly basis and a quarterly triangulation review is undertaken to review themes from claims, incidents and complaints data.

The Q3 2023 Triangulation of learning Q3 highlighted there were no explicitly shared themes shared across the claims scorecard, incident and complaints data presented. However the overarching themes relate to the need for:

More robust systems and processes

Better communication between teams

Training provision to be updated

7. Conclusion

This report details the findings of the Bolton NHS Foundation Trust 2023 bi-annual maternity staffing review in order to provide assurance of safe staffing levels within the maternity service. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

This report provides assurance that a systematic evidence based process to calculate the staffing establishment has been undertaken that has highlighted a funded staffing establishment deficit when compared to the 2023 Birthrate Plus recommendations.

The report provides assurance that the funded midwifery staffing establishment as of December 2023 met the 2019 Birthrate Plus report recommendations. This report confirms that the specialist midwifery establishment is within recommended Birthrate Plus expected parameters. Alignment to the 2023 Birthrate Plus recommendations has not yet been undertaken.

A business case to seek an uplift to the funded establishment to meet the Birthrate Plus 2023 report recommendations is in progress. The BR+ business case was approved at CRIG in May 2024 and escalated to the finance and investment group for consideration due to the value. Approval of the uplift to the establishment, can be phased over 2025 in line with re-opening of current reduced capacity. Approval of the business case will inform the plan and timescale for achieving the required uplift as per CNST requirements. The mitigations to address shortfalls in establishment are detailed within this report.

The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with one to one care in labour rates remains below the required standard and an area of ongoing focus. Training metrics also highlight sub-optimal compliance with the Trust standard and reflect the Registered Midwife vacancy position that ranged from 41.45WTE in July 2023 to 21.16wte in December 2023 within the maternity service during the period of review.

The report details the actions required to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny.

Safe staffing levels were maintained during this period, in part mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

8. Recommendations

It is recommended that the Board of Directors:

I. Approve the report and recommendations.

II. 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 – Birthrate Plus summary of establishment – January 2023.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Princess Anne Maternity Unit Bolton NHSFT

Final version 23/01/2023

Annual period 2021/22

Combined births — Total births in service: 5922

June to Aug 2022	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	0.2	2.1	25.7	20.6	51.4
Generic %Casemix	1.7	5.1	24.5	19.7	49.0

	Annual Nos.	Required WTE	
Delivery Suite			
Births	5842	77.83	**77.83**
Other DS Activity			
Antenatal Cases	920	4.83	**6.00**
PN Readmissions	36	0.13	
Escorted Transfers OUT	23	0.12	
Non-viables	47	0.56	
Inductions (10%)	196	0.36	
Triage	8455	11.02	**11.02**
Beehive Birth Suite			
Service not fully operating so not assessed and activity within hospital total wte.			
M2 Ward			
Antenatal admissions	1680	16.53	**16.53**
Inductions (90%)	1768		
M4 and 5 Wards			
Postnatal women	5842	58.51	**64.21**
Postnatal Ward Attenders	0	0.00	
Postnatal Re-admissions	235	1.25	
NIPE Clinics		2.88	
Extra Care Babies	177	1.18	
Frenulotomies	775	0.39	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife Booking & Follow up clinics		5.27	**11.03**
Specialist Midwife clinics		1.59	
Obstetric clinics		1.46	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	11640	6.35	**6.35**
COMMUNITY SERVICES			
Home Births	80	2.36	**64.38**
Community Cases	5732	58.83	
Attrition cases	670	0.89	
Additional safeguarding		2.30	
INGLESIDE BIRTH & COMMUNITY CENTRE		257.34	
Service closed so not assessed and activity within community total.			
CLINICAL MIDWIFERY WTE REQUIRED			257.34
Additional Specialist and Management wte		25.73	
TOTAL WTE REQUIRED		283.08	

Appendix 2 – Birthrate Plus establishment reconciliation as of December 2023

Midwives								
Grade	Sum of Clinical WTE	Sum of Specialist WTE	Sum of WTE not included in BR+	**Funded Ledger WTE**	**WTEC Included M9**	**WTEW Included M9**	WTEW Bank M9	WTEW Agency M9
Antenatal Clinic - ANDU	17.83		0	11.21	**17.83**	**17.38**	1.39	
Birth Suite - Beehive	1.92		0	16.44	**1.92**	**1.92**		
Central Delivery Suite	64.74	0	0	70.56	**64.74**	**60.49**	6.22	0.11
Maternity Triage	10.18				**10.18**	**10.18**		
Community Midwives	45.1		0	55.13	**45.1**	**40.03**	5.38	
Divisional Management Family Care Division				2	**0**	**0**		
Ingleside Birth Centre			0	2	**0**	**0**		
Maternity Smoking Cessation Team	1		0	1	**1**	**1**		
Midwifery Management				3	**0**	**0**		
Perinatal Mental Health Team	2.8	0.6	0	4.45	**3.4**	**3.4**		
Specialist Midwives	13.15	11.96	1.61	27.23	**25.11**	**23.9**	0.88	
Ward M4 - Post Natal Ward	16.79		0	16	**16.79**	**15.87**	0.35	0.14
Ward M2 - Antenatal Ward	16.79		0	15.92	**16.79**	**16.35**	0.65	
Ward M5 - Post Natal Ward	9.68		0	16	**9.68**	**9.61**	1.57	0.29
	199.98	**12.56**	**1.61**	**240.94**	**212.54**	**200.13**	**16.44**	**0.54**

Appendix 3 – Action plan to improve 1:1 care in labour compliance.

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

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	**Ensure service is recruited to funded establishment**	Continue regular recruitment events to recruit to full establishment	Recruitment and Retention Lead	October 2024	15.03.24 Recruitment ongoing vacancy deficit 16WTE. Recruitment event planned for 18 May 2024. Automatic offer of posts to student midwives continues.	
		Increase post registration student places within service	Director of Midwifery	March 2024	15.03.24 Expression made to University for post reg students	

Appendix 4 – *Midwifery profession specific training matrix*

Workforce								
Indicator	**Goal**	**Red Flag**	**July 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**
Shifts covered by NLS trained staff	Information only		79%	97%	77%	81%	81%	85%
Medical Device Compliance Training Midwifery why so low	95%	80%					45.20%	59.05%
Safeguarding compliance level 3	95%	80%	88.79%	88.36%	88.26%	84.87%	90.00%	91.00%
Safeguarding supervision outreach only	Information only		90.00%	90.00%	75.00%	90.00%	90.00%	90.00%
PROMPT training (added Oct 21) (CNST requirement)	90%	<90%	93.00%	93.94%	86.00%	83.00%	84.00%	88.60%
Fetal monitoring training compliance (overall) (CNST requirement)	90%	<90%	84.00%	85.92%	83.00%	83.00%	84.00%	86.00%
Return to work interview percentage completed (number due and completed in comments please)	Information only		40.00%	50.00%	39.02%			45.45%
Exit Interview percentage completed (number due and completed in comments please)	Information only		0%	100%	0%			
Monthly attendance	Information only		93.78%	94.15%	95.53%	95.46%	94.95%	94.87%
Monthly percentage sickness	4%	>=4.75%	6.22%	5.85%	4.47%	4.54%	5.17%	4.66%
Statutory Training	95%	<95%	84.93%	84.98%	86.12%	84.36%	85.50%	85.76%
Mandatory Training	85%	<80%	78.40%	80.27%	80.01%	87.86%	81.63%	81.65%
Completed Staff Appraisals	85%	<=75%	94.03%	88.36%	87.38%	84.98%	84.09%	82.30%

Report Title:	Staff Survey Response and People Promise Plan

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	✓
Exec Sponsor	James Mawrey		Decision	

Purpose	This report proposes how the organisation intends to respond to the 2023 staff survey – specifically the trust wide cross cutting themes.

Summary:	Colleagues will be aware that the Staff Survey provides invaluable insights into the experiences, perceptions, and opinions of the Trust's workforce. People Committee and the wider Trust Board members have already received a very detailed independent presentation from the IQVIA (our NHS Staff Survey provider) regarding our NHS Staff Survey 2023 findings. Staff and the leadership teams throughout the organisation have also had the opportunity to receive similar presentations of these findings. Based on these findings the People Committee have supported the actionable recommendations made in this paper to enhance staff satisfaction and organisational performance. Please note that the report focuses on the Trust wide cross cutting themes. Divisional actions will of course continue to take place to meet their more local needs.

Previously considered by:
The Staff Survey report and action plan was presented at the People Committee

Proposed Resolution	The Board of Directors is asked to ***receive*** the Staff Survey Response and People Promise Plan 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:	Lisa Rigby, Associate Director Organisational Development Dawn Grundy, People Promise Manager Lynne Doherty, Staff Wellness Practitioner	**Presented by:**	James Mawrey, Director of People/ Deputy Chief Executive

1. Introduction

The Bolton NHS Foundation Trust Staff Survey 2023 provides invaluable insights into the experiences, perceptions, and opinions of the Trust's workforce. This report aims to provide a high level recap on the key findings of the survey, identify areas of strength and improvement, and propose trust-wide actionable recommendations to enhance staff satisfaction and organisational performance.

2. Staff Survey 2023

The Staff survey utilises a comprehensive questionnaire designed by NHS England. The questions cover areas such as such as job satisfaction, work environment, communication, leadership, and opportunities for professional development. 2023 questions were themed across the seven People Promise elements and two themes, those being:

- Elements:
  - We are compassionate and inclusive
  - We are recognised and rewarded
  - We each have a voice that counts
  - We are safe and healthy
  - We are always learning
  - We work flexibly
  - We are a team
- Themes:
  - Staff Engagement
  - Morale

Data was collected anonymously to encourage honest feedback with results being managed and analysed through our contracted survey provider, Quality Health, also known as IQVIA. Appendix 1 shows the analysis from IQVIA which were recently presented to Trust Board. The full findings of the NHS Staff Survey have already been published via the data co-ordination centre and shared throughout the organisation.

3. Survey Findings

The 2023 Staff Survey provides invaluable insights into the experiences, perceptions, and opinions of the Trust's workforce. A total of 2518 staff completed the 2023 survey from a headcount of 6067 staff, this is almost a 6% increase from 2022. It is good to see that the enhanced promotion of the staff survey by staff experience and communications colleagues has supported the increase in participants. Though there is more to do as we are still behind our national benchmark group which for 2023 stands at 45.23%.The People Promise scores are noted below:-

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
Theme - Staff engagement	7.13	Not Significant	7.07	Significantly Better	6.88
Theme - Morale	5.99	Not Significant	6.04	Not Significant	5.92
People Promise 1 - We are compassionate and inclusive	7.59	Not Significant	7.53	Significantly Better	7.24
People Promise 2 - We are recognised and rewarded	6.16	Not Significant	6.19	Significantly Better	5.91
People Promise 3 - We each have a voice that counts	7.07	Not Significant	6.93	Significantly Better	6.69
People Promise 4 - We are safe and healthy	6.11	Not Significant	6.18	Not Significant	6.07
People Promise 5 - We are always learning	5.69	Not Significant	5.78	Not Significant	5.63
People Promise 6 - We work flexibly	6.26	Not Significant	6.26	Not Significant	6.17
People Promise 7 - We are a team	7.01	Not Significant	7.07	Significantly Better	6.73

3.1. Key Findings:

- The staff survey finding is an opportunity to celebrate what we have done well but to also ensure that focus is given to those areas requiring improvement.
- IQVIA have communicated that our results show we are a Trust that is responding well to the current challenges being faced across the NHS.
- The survey did tell us, however that there are areas showing a decline which require improvement.

3.2. Areas of Strength

- **Team work and Culture:** The survey indicates a strong sense of team work within the Trust, with 84% of staff reporting they enjoy working with colleagues. This positive culture is further bolstered by 74% of staff feeling their immediate manager encourages them at work.

  Overall we achieved a score of 7.07 for People Promise 7 – 'We are a team' which is significantly better than the sector average of 6.73.

  Of the 12 questions that feed into this element, the Trust scored significantly better than the sector average in 11 questions.

- **Job Satisfaction & Making a Difference:** Overall, the majority of staff expressed satisfaction with their roles. Of significance 89% of staff believe their role makes a difference to patients, highlighting staff motivation and purpose.

- **Four People Promise themes** scored significantly better than our sector comparators, those being:
  - We are compassionate and inclusive
  - We are recognised and rewarded
  - We each have voice that counts
  - We are Team

- **Staff Engagement:** The Trust's score for this theme was significantly better than our sector comparators.

  Overall we achieved a score of 7.07 with the sector average score being 6.88. , the majority of staff expressed satisfaction with their roles. Of significance 89% of staff believe their role makes a difference to patients, highlighting staff motivation and purpose.

The Trust also had a significant number (33) question level scores in the top 20% range.

3.3. Areas for Improvement

- **Recommended as a Place of Care:**
  When asked if they would be happy with the standard of care provided for friends and relatives, 60% of respondents felt confident recommending the Trust as a place of care. Staff providing a negative response (they disagreed or strongly disagreed) accounted for 14% of responses and those providing a neutral response to this question (neither agree nor disagree) accounted for 26% of responses.

  Understanding the reasons for this, will help to improve conditions for staff and patients. We are analysing data further to break this question down by division.

- **Recommended as a Place to Work:**
  When asked if they would recommend the Trust as a place to work, 58% of staff responded positively that they would recommend the Trust as a workplace. Staff selecting they disagreed or strongly disagreed with recommending the organisation as a place of work accounted for 16% of respondents, with 27% of staff selecting they neither agreed or disagreed.

  More work needs to be done to further understand the reasons for the gradual decline in score for this question over the last few years but looking at the wider details of the survey, it is likely caused by workload, work-life balance, feelings of lack of recognition and lack of opportunity for career progression.

  Again, we are analysing data further to break this down by division.

- **Discrimination:**
  The results of the 2023 Staff Survey indicates a rise in staff reporting experiences of discrimination. When asked if the organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age, only 53% of staff responded positively which was a decrease from 59% in 2022. The number of staff who gave a negative response accounted for 12% with 34% advising they didn't know the answer to this question.

  Staff were asked if in the last 12 months they had experienced discrimination at work from a manager/team leader or other colleague and 7% of staff indicated they had experienced this with the remaining 93% indicating they had not.

  When asked on what grounds they had experienced discrimination, most respondents reported this was due to their ethnicity, age or disability. A large proportion of staff who reported discrimination (22%) chose the category 'Other' and so no clear data is available for this category.

  - **Ethnicity:** Compared to 2022, the percentage of staff reporting discrimination based on ethnicity rose from 38% to 47%, with 85 staff reporting discrimination due to their ethnic background in 2022 versus 135 staff in 2023.
  - **Disability:** Reports of discrimination based on disability rose from 10% in 2022 to 12% in 2023, with 21 staff reporting discrimination due to their disability in 2022 versus 33 staff in 2023.

- **Age:** There was a slight reduction in staff reporting age discrimination with 19% reporting this in 2023 compared to 21% in 2022, with 66 staff reporting discrimination due to their age in 2022 versus 64 staff in 2023.

- **Speaking Up:** 61% of staff responded positively (agreed/strongly agreed) that they felt safe to speak up about anything that concerns them, this number represents a decline from 2022 (66%). Staff who responded negatively (strongly disagreed/ disagreed) accounted for 17% of the score. 22% neither agreed nor disagreed with this question.

  Staff were asked if they felt secure raising concerns about unsafe clinical practice and 73% indicated they agreed or strongly agreed with this, a 4% decline compared to 2022. 10% of staff disagreed or strongly disagreed with this question compared to 7% in 2022.

  Staff were also asked if they felt confident the organisation would address their concern about unsafe clinical practice and 57% responded positively with 13% responding negatively. 30% of staff neither agreed nor disagreed.

- **Staff Wellbeing:** A significant proportion of respondents indicated concerns regarding workload, stress levels, and work-life balance. Around a third of staff indicated they felt tired and burnt out due to work and fewer staff this year (54% vs 55%) felt the Trust took positive action about health and wellbeing.

  Only around half of respondents felt they achieved a good balance between work and home life and the same again felt the Trust was committed to helping them achieve this.

- **Flexible Working:** Just over half of staff (54%) indicated they were satisfied/very satisfied with opportunities for flexible working patterns, a 1% decrease compared to 2022. A fifth of staff (22% indicated they strongly disagreed or disagreed with this statement with a quarter indicating they were neither satisfied nor dissatisfied. Despite these results, around 70% of staff responded positively that they could approach their manager to talk openly about flexible working.

- **Leadership:** Feedback on leadership was mixed, with some staff praising the support and guidance provided by managers, while others expressed dissatisfaction with decision-making processes and perceived lack of recognition for their efforts.

- **Work Environment:** The majority of staff reported feeling safe and supported in their work environment, however there were concerns raised about issues such as staff shortages, equipment availability, and workplace culture.

  Only around half of staff indicated they had adequate materials, supplies and equipment to do their work with around 30% indicating they did not and 20% providing a neutral response to this question.

- **FABB Appraisals:** A large number of staff (92%) reported having had an annual FABB appraisal, only 22% indicated it definitely helped them improve how they did their job. 50% of staff felt the appraisal helped them to some extent with 28% feeling it did not help them improve how they worked.

  Around 30% of staff felt their appraisal helped to agree clear objectives with 52% indicating it helped to some degree and 18% feeling it was no help in agreeing clear objectives.

3.4. Divisional Data

IQVIA (survey providers) recommended we explore the following themes in more detail by location / division to explore any themes or areas of focus:

- Recommend as a place to work and receive treatment
- Career progression
- Balance of work /home life

In summary, the data shows that FCD, ICSD and Chief Execs tend to have higher scoring responses around these themes. DSSD, Informatics and Patient Safety & Experience have some of the lower scoring responses.

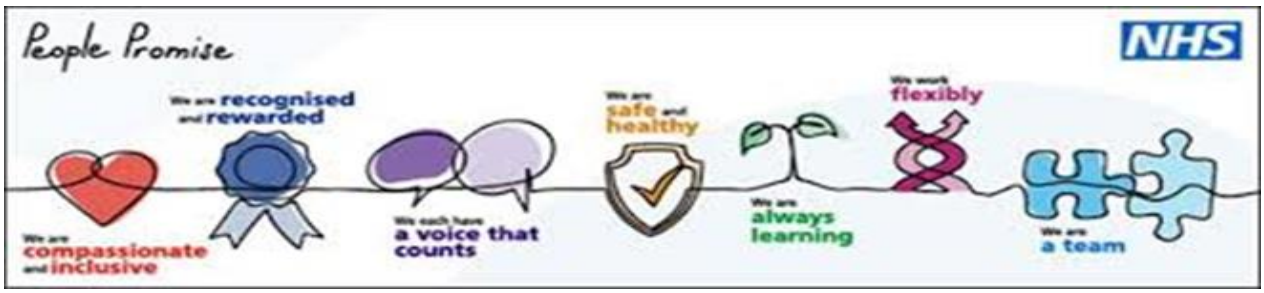
The Organisational Development team emailed local results to each division on 7th March 24 along with a heatmap by question to help make the results clearer. Members of the team have also been out to support divisions who requested support with interpreting their results.

The Divisional action plans will be reviewed at the next Staff Experience Group and this will of course be discussed at the subsequent People Committee.

4. Key Deliverables / actions

4.1 Trustwide actions

The following are the key deliverables identified as part of the 2023 staff survey results. These were shared via a series of Staff Briefings in March 2023. Highlighted in bold is how these actions support the two People Promise themes and seven People Promise elements.



Action	Response
Understand and remedy the decline in staff confidence in recommending the Trust as a **place of care** and a place of work	The Chief Nurse and the Medical Director are working within their Teams to consider views on the reasons for this decline. Actions have already been taken by our Chief Nurse. Recommendation of organisation as place to receive care and questions relating to safety processes now linked to CNO work-plan 24/25. The CNO has added to all N&M, AHP objectives to review their results, by location/team to understand themes over and above the expected concerns. Finally the CNO and MD are working closely with operational teams to ensure that our extreme pressures continue to support strong patient care.
Understand and remedy the decline in staff confidence in recommending the Trust as a	Through the Our Voice Change Teams, information and ideas are being sought by staff to better understand and improve working conditions at the Trust. Through the actions arising from these change teams, a

place of care and a **place of work**	bettering of culture, conditions and the working environment is already being achieved and in turn should address the majority of concerns that resulted in the loss of staff confidence in recommending the Trust as a place to work. Committee and Board members have already received an update on the Our Voice Change programme.
Improve culture **"We are always learning"** **"We are a team"**	• Refresh and relaunch the Trust VOICE values. Work within the organisation has started, a pilot approach will take place over the summer months with relaunch in September/October. • Improve learning and development opportunities through the Our Leaders programme to equip managers and leaders to understand compassionate leadership and gain skills to effectively manager negative behaviours. The first cohort is taking palce in June, 2024. • A Culture Dashboard has been developed by the Head of Workforce Information to better understand and measure culture across the Trust
Action against discrimination **"We are compassionate and inclusive"**	The EDI Team have begun accelerating our equality, diversity and inclusion programme with steps already taken as follows (non exhaustive): • Introduction of the reasonable adjustments passport has taken place and being rolled out; • A Neurodiversity Peer Support Group has recently been introduced; • Unconscious bias training provided to hiring managers; • Reciprocol mentoring • Active bystander training is further being rolled out; • Enhancements to the BAME staff forum and Disability and Health Conditions staff networks; • LGBTQ+ and Gender Network listening events; • Rainbow badge assessment; and • Celebration of various events to promote inclusive working environments
Improve Speaking Up **"We each have a voice that counts"**	Actions already taken since the 2023 survey: • The expansion of our Freedom to Speak Up Champions network • Arrangements for staff to speak up to an external guardian at Greater Manchester ICB have been introduced. • An internal audit of our FTSU processes has been undertaken and substantial assurane was provided regarding the application. Where imporvements were identified then an action plan for further improvement has been produced and monitored via the People Committee from the FTSU quaterly reports. Further improvements are being developed including:

	• Campaign to support ways in which staff can report concerns in a range of different ways in addition to the FTSU route such as talking to managers or colleagues • Introducing further FTSU training. In the summer all Leaders and Managers must udnertake a FTSU awareness training programme. Discussions are very close to being finalised regarding a rollout for all staff.
Address Staff Wellbeing: **"We are safe and healthy"**	The Trust already has a significant staff wellbeing offer covering access to mental health, physical health and financial wellbeing support. However, better communication and promotion of the existing offer is required, to ensure all staff are aware of the support available. This is being taken forward by the Head of Occupational Health. Through the Our Voice Change programme with change teams covering themes of flexible working; values and culture; and working environment, actions will be taken forward to improve working conditions and access to flexible working, which will invariably help improve staff wellbeing and staff achieving a better work-life balance.
Increase Flexible Working opportunities **"We work flexibly"**	The existing Flexible Working Our Voice Change Team have identified the following priorities for action: • Review of the existing policy flexible working and other associated policies • Training and development for staff to include a 'master class' with real life examples and scenarios to focus policy understanding and application • Creation of myth-busting guide around flexible working • Collaborative working between the Agile Working Group and Flexible Working Change Team to ensure joined up approach
Invest in Leadership Development: **"We are compassionate and inclusive"**	The Trust is launching in June the 'Our Leaders' programme which is a Trust-wide leadership social movement. The details of this programme are under developmnet and a pilot is due to launch in June. Culture, compssion and inclusivity are key themes throughout.
Improve the Work Environment **"We are safe and healthy"**	Through the existing 'Your Working Environment' Our Voice Change Team, actions are being developed to improve: • Toilet facilities across the site • Access to appropriate rest spaces • Catering and break facilities • Smoking cessation for staff and patients across Trust site
Review and development of FABB Appraisals **"We are always learning"** **"We are recognised and rewarded"**	Undertake a review of the FABB appraisals process –with feedback and insight from the Living Our Values' Change Team. Work within the organisation has started, a pilot approach will take place over the summer months with relaunch in September/October.

4.2 Divisional actions

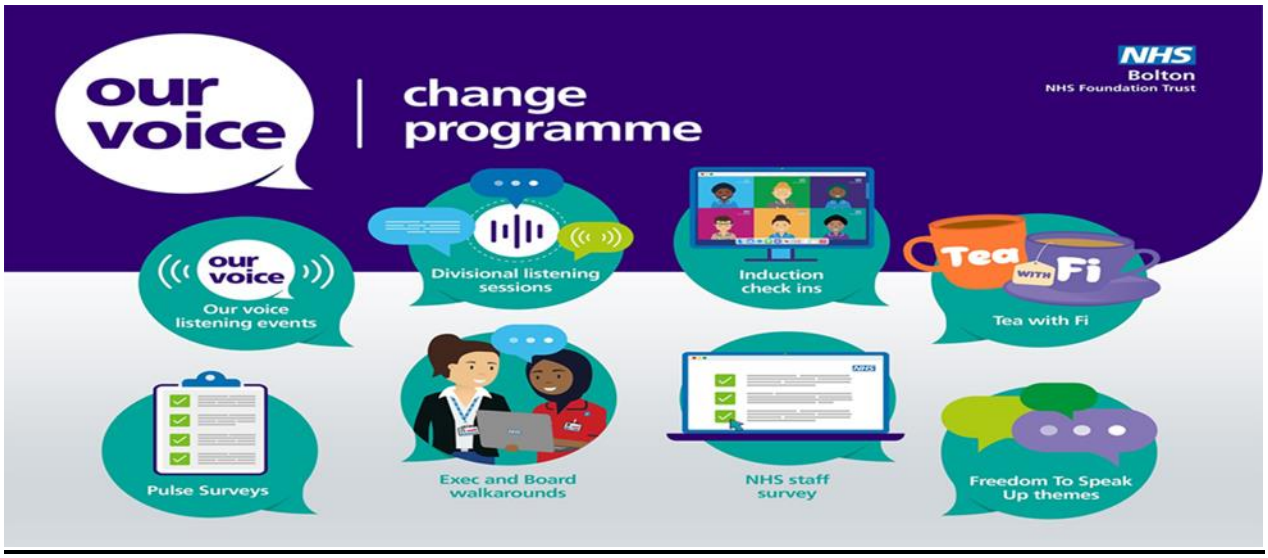
As noted in section 3, the Divisional Teams are in the process of pulling together their action and these will be discussed at their Divisional People Committee, the Staff Experience Group and reported up to the People Committee.

5. Staff Intelligence and Insights

5.1 Our Voice Change Programme and the NHS People Promise

In addition to the data discussed in section three of this report, the five themes identified as part of the Our Voice Our Change Programme represent a large percentage of the free text comments in the 2023 Staff Survey. This demonstrates that the change team priorities are the right focus for the organisation. The continued new membership and engagement ensure that staff feel part of the movement by discussing issues and co-creation of solutions with subject matter experts with support from Executive sponsors to make those changes. As part of the Our Voice Change programme we ensure that everyone has a voice that counts. This supports the organisations engagement and listening activity – a data driven approach and strong drive for continuous quality improvement across the Trust as illustrated below.

Figure 2



6. Communications & Engagement

Enhancing our Communications Channels to increase reach at pace is a priority. Other measures of success to support the actions and responses to the staff survey and the work which will be undertaken as part of the People Promise includes regular updates from Change Teams progress as part of Monthly Team Brief and the development of BOB pages to support the understanding of our commitment to the People Promise.

7. Governance and next steps

The Staff Experience Team will be monitoring delivery of the Bolton NHS FT Staff Experience Action Plan overall. In addition, the Staff Experience Team is supporting divisions to maximise the insights gained from the 2022 NHS national staff survey at a local level. It is intended for

the Trust-wide action plan to set the overall direction of travel with the Divisional action plans complementing and picking up the nuances within their Divisions for appropriate areas of focus needed for their teams.

The Trust-wide action plan and Divisional action plans will be monitored and reported on through the Staff Experience Steering Group, Divisional People Committee and People Committee.

8. Conclusion

The delivery of the Bolton NHS FT Staff Experience Plan is important to ensure that the Trust makes improvements on the priority areas of focus detailed within this paper. This will ensure that the Trust continues to build on its successes, learns where things can be even better and most importantly takes action as a result of staff feedback to ensure that Bolton NHS Foundation Trust is a great place to work.

9. Recommendations

The Board is asked to note the People Committee's support of the actions resulting from the 2023 National Staff Survey Results and other listening mechanisms.

Appendix 1

Bolton NHS Foundation Trust

2023 National NHS Staff Survey Results

Charlie Bosher | Head of Market Research and Consultancy, Insight & Feedback
Email: MR-Consultancy@iqvia.com

Why is staff engagement important?

One of the key parts of the NHS Long Term Plan is **"Supporting our current NHS staff".** The National Staff Survey can be used to assess Trust performance against this goal.

NHS England recognise that the "immediate collective challenge is to **improve staff retention** through a **systematic focus** on all elements of the **NHS People Promise**."

High turnover means you **lose talent and organisational memory** and **incur costs for recruitment and training**. For example, a large Acute Trust with 3,000 nurses and typical 10-12% turnover can spend £3.6m annually replacing fully trained nurses.

There is a body of evidence that engaged staff deliver better healthcare in terms of **patient experience, safety** and **outcomes.**

Engagement is linked to the health and wellbeing of the workforce: scores for the people promise **"We are safe and healthy"** and particularly questions about burnout, correlate with and impact all other people promises.

Methodology

Main survey

- Survey run on paper and online between September and November 2023
- Two reminders sent to staff who didn't respond to paper survey, six reminders for online
- Sample designed to ensure good statistical comparability between organisations and over time
- The comparator group is made up of 63 Acute and Acute & Community Trusts contracted to IQVIA.

National results were published by NHS England on **Thursday 7th March 2024.**

Response Rate

	Usable Sample	Completed				Response Rate
		Paper	Online	Telephone	Total	
2023 Org.	6,067	175	2,343	0	2,518	41.5%
2023 IQVIA	761,555	24,740	341,872	15	366,627	48.1%
2022 Org.	5,835	41	2,040	0	2,081	35.7%
2022 IQVIA	717,423	23,641	294,123	8	317,772	44.3%

- Impacts on response rate:
  - Accuracy of staff records, and internal distribution
  - Communication
  - Pro-active management of survey process
  - Communication of results
  - Response and action from senior management.

- These are **good results**, and give an indication of a **well managed Trust** which is continuing to improve the experiences of staff

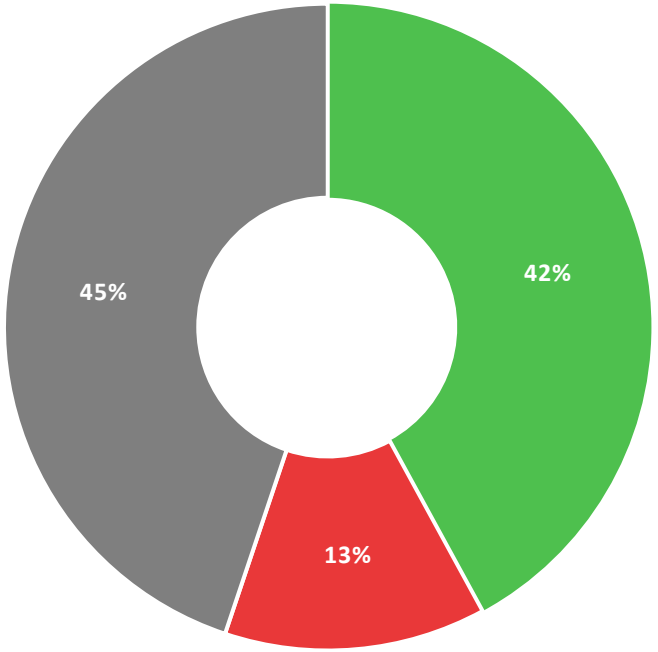
- Seek to **celebrate the positive results** with staff.

- In what remains an incredibly challenging time for the NHS, **the results show a Trust** which is responding well to current challenges.

Summary of Scores

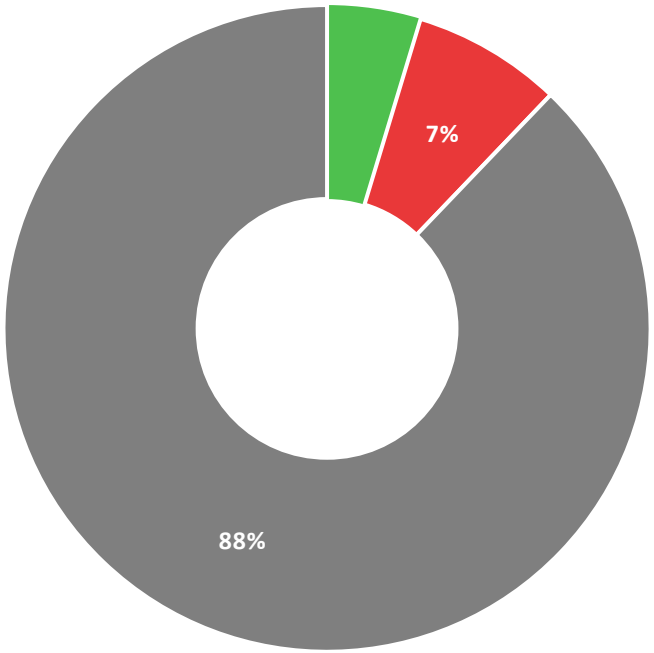
People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
Theme - Staff engagement	7.13	Not Significant	7.07	Significantly Better	6.88
Theme - Morale	5.99	Not Significant	6.04	Not Significant	5.92
People Promise 1 - We are compassionate and inclusive	7.59	Not Significant	7.53	Significantly Better	7.24
People Promise 2 - We are recognised and rewarded	6.16	Not Significant	6.19	Significantly Better	5.91
People Promise 3 - We each have a voice that counts	7.07	Not Significant	6.93	Significantly Better	6.69
People Promise 4 - We are safe and healthy	6.11	Not Significant	6.18	Not Significant	6.07
People Promise 5 - We are always learning	5.69	Not Significant	5.78	Not Significant	5.63
People Promise 6 - We work flexibly	6.26	Not Significant	6.26	Not Significant	6.17
People Promise 7 - We are a team	7.01	Not Significant	7.07	Significantly Better	6.73

Headline Findings – Question Benchmarking



- 45 (42%) question(s) scored significantly better than the sector
- 14 (13%) question(s) scored significantly worse than the sector
- 48 (45%) question(s) showed no significance in relation to the sector average or comparisons could not be drawn

Headline Findings – Question Local Changes



- 5 (5%) question(s) scored significantly better than in 2022
- 8 (7%) question(s) scored significantly worse than in 2022
- 94 (88%) question(s) showed no significance in relation to the 2022 score or comparisons could not be drawn

Staff Engagement & Morale

Staff Engagement

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
Theme - Staff engagement	7.13	Not Significant	7.07	**Significantly Better**	6.88
Subscore 1 - Motivation	7.30	Not Significant	7.24	**Significantly Better**	6.99
2a. I look forward to going to work.	56.4%	Not Significant	55.2%	Not Significant	54.2%
2b. I am enthusiastic about my job.	71.5%	Not Significant	70.1%	**Significantly Better**	68.0%
2c. Time passes quickly when I am working.	76.6%	Not Significant	75.4%	**Significantly Better**	71.3%
Subscore 2 - Involvement	7.15	Not Significant	7.13	**Significantly Better**	6.83
3c. There are frequent opportunities for me to show initiative in my role.	75.2%	Not Significant	75.8%	**Significantly Better**	73.3%
3d. I am able to make suggestions to improve the work of my team / department.	73.6%	Not Significant	74.1%	**Significantly Better**	70.8%
3f. I am able to make improvements happen in my area of work.	57.4%	Not Significant	56.5%	Not Significant	55.9%

Staff Engagement (continued)

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
Subscore 3 - Advocacy		6.94	Not Significant	6.85	Not Significant	6.81
25a.	Care of patients / service users is my organisation's top priority.	76.8%	Not Significant	74.9%	Not Significant	75.2%
25c.	I would recommend my organisation as a place to work.	60.4%	Not Significant	58.5%	**Significantly Worse**	61.2%
25d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	61.9%	Not Significant	60.5%	**Significantly Worse**	65.2%

Morale

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
Theme - Morale	5.99	Not Significant	6.04	Not Significant	5.92
Subscore 1 - Thinking about leaving	6.27	Not Significant	6.17	Not Significant	6.07
26a. I often think about leaving this organisation.	29.5%	Not Significant	30.0%	Not Significant	28.6%
26b. I will probably look for a job at a new organisation in the next 12 months.	20.5%	Not Significant	21.5%	Not Significant	20.9%
26c. As soon as I can find another job, I will leave this organisation.	15.0%	Not Significant	15.6%	Not Significant	15.7%
Subscore 2 - Work pressure	5.09	Not Significant	5.28	Not Significant	5.29
3g. I am able to meet all the conflicting demands on my time at work.	45.7%	Not Significant	46.5%	Not Significant	47.0%
3h. I have adequate materials, supplies and equipment to do my work.	50.1%	Not Significant	52.1%	**Significantly Worse**	56.5%
3i. There are enough staff at this organisation for me to do my job properly.	28.2%	**Significantly Improved**	32.9%	Not Significant	31.6%

Morale (continued)

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
Subscore 3 - Stressors		6.62	Not Significant	6.66	**Significantly Better**	6.39
3a.	I always know what my work responsibilities are.	88.2%	Not Significant	87.2%	Not Significant	86.5%
3e.	I am involved in deciding on changes introduced that affect my work area / team / department.	54.7%	Not Significant	53.9%	**Significantly Better**	51.2%
5a.	I have unrealistic time pressures.	24.2%	Not Significant	24.8%	Not Significant	25.2%
5b.	I have a choice in deciding how to do my work.	56.3%	Not Significant	57.0%	**Significantly Better**	52.4%
5c.	Relationships at work are strained.	45.8%	Not Significant	47.0%	Not Significant	46.0%
7c.	I receive the respect I deserve from my colleagues at work.	74.1%	Not Significant	74.6%	**Significantly Better**	71.3%
9a.	My immediate manager encourages me at work.	72.2%	Not Significant	74.1%	**Significantly Better**	71.3%

People Promises

We are compassionate and inclusive

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 1 - We are compassionate and inclusive		7.59	Not Significant	7.53	**Significantly Better**	7.24
People Promise 1, Subscore 1 - Compassionate culture		7.29	Not Significant	7.22	Not Significant	7.10
6a.	I feel that my role makes a difference to patients / service users.	87.8%	Not Significant	88.7%	Not Significant	87.8%
25a.	Care of patients / service users is my organisation's top priority.	76.8%	Not Significant	74.9%	Not Significant	75.2%
25b.	My organisation acts on concerns raised by patients / service users.	74.7%	**Significantly Declined**	71.3%	Not Significant	70.0%
25c.	I would recommend my organisation as a place to work.	60.4%	Not Significant	58.5%	**Significantly Worse**	61.2%
25d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	61.9%	Not Significant	60.5%	**Significantly Worse**	65.2%

We are compassionate and inclusive (continued)

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 1, Subscore 2 - Compassionate leadership		7.27	Not Significant	7.28	**Significantly Better**	6.95
9f.	My immediate manager works together with me to come to an understanding of problems.	70.8%	Not Significant	71.2%	**Significantly Better**	68.1%
9g.	My immediate manager is interested in listening to me when I describe challenges I face.	72.7%	Not Significant	74.5%	**Significantly Better**	70.7%
9h.	My immediate manager cares about my concerns.	72.9%	Not Significant	72.6%	**Significantly Better**	69.3%
9i.	My immediate manager takes effective action to help me with any problems I face.	68.6%	Not Significant	68.8%	**Significantly Better**	66.2%

We are compassionate and inclusive (continued)

	People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 1, Subscore 3 - Diversity and equality		8.50	Not Significant	8.35	**Significantly Better**	8.05
15.	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	59.6%	**Significantly Declined**	53.9%	Not Significant	55.0%
16a.	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	5.9%	Not Significant	6.7%	**Significantly Better**	9.1%
16b.	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	6.8%	Not Significant	7.3%	**Significantly Better**	9.6%
21.	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	72.7%	**Significantly Declined**	69.9%	Not Significant	69.5%

We are compassionate and inclusive (continued)

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 1, Subscore 4 - Inclusion	7.31	Not Significant	7.26	**Significantly Better**	6.86
7h. I feel valued by my team.	73.7%	Not Significant	72.0%	**Significantly Better**	69.7%
7i. I feel a strong personal attachment to my team.	70.4%	Not Significant	68.0%	**Significantly Better**	63.7%
8b. The people I work with are understanding and kind to one another.	75.0%	Not Significant	72.9%	**Significantly Better**	69.8%
8c. The people I work with are polite and treat each other with respect.	75.3%	Not Significant	73.5%	**Significantly Better**	70.7%

Additional – Discrimination

Question	2022 Score	Significance	2023 Score	Significance	Sector Score
16c01. On what grounds have you experienced discrimination? Ethnic background	38.0%	Significantly Declined	46.7%	Significantly Better	54.8%
16c02. On what grounds have you experienced discrimination? Gender	20.5%	Not Significant	18.2%	Not Significant	18.8%
16c03. On what grounds have you experienced discrimination? Religion	10.2%	Not Significant	7.9%	Not Significant	5.4%
16c04. On what grounds have you experienced discrimination? Sexual orientation	5.4%	Not Significant	4.4%	Not Significant	4.2%
16c05. On what grounds have you experienced discrimination? Disability	9.4%	Not Significant	11.5%	Not Significant	8.1%
16c06. On what grounds have you experienced discrimination? Age	18.9%	Not Significant	17.5%	Not Significant	16.3%
16c07. On what grounds have you experienced discrimination? Other	29.9%	Not Significant	22.7%	Not Significant	23.1%

Additional – Unwanted sexual behaviour

	Question	2022 Score	Significance	2023 Score	Significance	Sector Score
17a.	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public?	-	N/A	8.6%	Not Significant	8.0%
17b.	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues?	-	N/A	2.8%	**Significantly Better**	3.9%

We are recognised and rewarded

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 2 - We are recognised and rewarded	6.16	Not Significant	6.19	**Significantly Better**	5.91
4a. The recognition I get for good work.	55.9%	Not Significant	54.5%	Not Significant	53.3%
4b. The extent to which my organisation values my work.	45.6%	Not Significant	43.0%	Not Significant	43.7%
4c. My level of pay.	31.3%	Not Significant	33.9%	**Significantly Better**	29.8%
8d. The people I work with show appreciation to one another.	72.0%	Not Significant	69.8%	**Significantly Better**	66.7%
9e. My immediate manager values my work.	74.1%	Not Significant	74.2%	**Significantly Better**	71.4%

We each have a voice that counts

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 3 - We each have a voice that counts		7.07	Not Significant	6.93	**Significantly Better**	6.69
People Promise 3, Subscore 1 - Autonomy and control		7.28	Not Significant	7.27	**Significantly Better**	6.96
3a.	I always know what my work responsibilities are.	88.2%	Not Significant	87.2%	Not Significant	86.5%
3b.	I am trusted to do my job.	91.5%	Not Significant	91.2%	Not Significant	90.4%
3c.	There are frequent opportunities for me to show initiative in my role.	75.2%	Not Significant	75.8%	**Significantly Better**	73.3%
3d.	I am able to make suggestions to improve the work of my team / department.	73.6%	Not Significant	74.1%	**Significantly Better**	70.8%
3e.	I am involved in deciding on changes introduced that affect my work area / team / department.	54.7%	Not Significant	53.9%	**Significantly Better**	51.2%
3f.	I am able to make improvements happen in my area of work.	57.4%	Not Significant	56.5%	Not Significant	55.9%
5b.	I have a choice in deciding how to do my work.	56.3%	Not Significant	57.0%	**Significantly Better**	52.4%

We each have a voice that counts (continued)

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 3, Subscore 2 - Raising concerns		6.87	**Significantly Declined**	6.59	Not Significant	6.42
20a.	I would feel secure raising concerns about unsafe clinical practice.	76.3%	**Significantly Declined**	73.1%	**Significantly Better**	70.4%
20b.	I am confident that my organisation would address my concern.	61.7%	**Significantly Declined**	56.7%	Not Significant	56.0%
25e.	I feel safe to speak up about anything that concerns me in this organisation.	66.4%	**Significantly Declined**	61.5%	Not Significant	61.4%
25f.	If I spoke up about something that concerned me I am confident my organisation would address my concern.	53.2%	**Significantly Declined**	48.1%	Not Significant	49.2%

Additional – Errors, near misses or incidents

	Question	2022 Score	Significance	2023 Score	Significance	Sector Score
18.	In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users?	34.7%	Not Significant	37.3%	Significantly Worse	34.9%
19a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	62.8%	Not Significant	60.1%	Not Significant	59.9%
19b.	My organisation encourages us to report errors, near misses or incidents.	88.3%	Not Significant	88.5%	Significantly Better	85.4%
19c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	71.7%	Not Significant	70.5%	Significantly Better	68.5%
19d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	66.7%	Not Significant	66.6%	Significantly Better	61.0%

We are safe and healthy

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 4 - We are safe and healthy		6.11	Not Significant	6.18	Not Significant	6.07
People Promise 4, Subscore 1 - Health and safety climate		5.34	Not Significant	5.45	Not Significant	5.45
3g.	I am able to meet all the conflicting demands on my time at work.	45.7%	Not Significant	46.5%	Not Significant	47.0%
3h.	I have adequate materials, supplies and equipment to do my work.	50.1%	Not Significant	52.1%	**Significantly Worse**	56.5%
3i.	There are enough staff at this organisation for me to do my job properly.	28.2%	**Significantly Improved**	32.9%	Not Significant	31.6%
5a.	I have unrealistic time pressures.	24.2%	Not Significant	24.8%	Not Significant	25.2%
11a.	My organisation takes positive action on health and well-being.	55.7%	Not Significant	53.8%	**Significantly Worse**	57.1%
13d.	The last time you experienced physical violence at work, did you or a colleague report it?	65.9%	Not Significant	66.1%	Not Significant	68.7%
14d.	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	47.0%	Not Significant	50.7%	Not Significant	49.6%

We are safe and healthy (continued)

People Promise/Theme/Question		2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 4, Subscore 2 - Burnout		4.98	Not Significant	5.05	Not Significant	4.99
12a.	How often, if at all, do you find your work emotionally exhausting?	38.2%	Not Significant	35.9%	**Significantly Worse**	33.9%
12b.	How often, if at all, do you feel burnt out because of your work?	33.7%	Not Significant	34.0%	**Significantly Worse**	31.4%
12c.	How often, if at all, does your work frustrate you?	39.2%	Not Significant	38.7%	**Significantly Worse**	36.5%
12d.	How often, if at all, are you exhausted at the thought of another day/shift at work?	30.4%	Not Significant	30.1%	Not Significant	28.4%
12e.	How often, if at all, do you feel worn out at the end of your working day/shift?	45.2%	Not Significant	42.6%	Not Significant	43.1%
12f.	How often, if at all, do you feel that every working hour is tiring for you?	20.9%	Not Significant	20.2%	Not Significant	20.0%
12g.	How often, if at all, do you not have enough energy for family and friends during leisure time?	32.7%	Not Significant	31.1%	Not Significant	30.4%

We are safe and healthy (continued)

	People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 4, Subscore 3 - Negative experiences		8.02	Not Significant	8.06	**Significantly Better**	7.78
11b.	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	27.0%	Not Significant	27.2%	**Significantly Better**	30.5%
11c.	During the last 12 months have you felt unwell as a result of work related stress?	43.1%	Not Significant	42.7%	Not Significant	42.5%
11d.	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	56.2%	Not Significant	57.2%	Not Significant	55.3%
13a.	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	14.9%	Not Significant	14.1%	Not Significant	14.1%
13b.	In the last 12 months how many times have you personally experienced physical violence at work from managers?	0.2%	Not Significant	0.4%	**Significantly Better**	0.8%
13c.	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	0.8%	Not Significant	1.2%	**Significantly Better**	2.0%
14a.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	24.9%	Not Significant	22.7%	**Significantly Better**	25.7%
14b.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	10.1%	Not Significant	8.6%	**Significantly Better**	10.1%
14c.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	16.3%	Not Significant	15.6%	**Significantly Better**	18.8%

Additional – Health, well-being and safety at work

Question		2022 Score	Significance	2023 Score	Significance	Sector Score
10b.	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	34.4%	Significantly Improved	29.3%	Significantly Better	38.6%
10c.	On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	54.4%	Significantly Improved	49.7%	Not Significant	51.7%
11e.	Have you felt pressure from your manager to come to work?	20.6%	Not Significant	20.0%	Not Significant	21.8%

Additional – Food

Question	2022 Score	Significance	2023 Score	Significance	Sector Score
22. I can eat nutritious and affordable food while I am working.	-	N/A	49.5%	Significantly Worse	51.7%

We are always learning

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 5 - We are always learning	5.69	Not Significant	5.78	Not Significant	5.63
People Promise 5, Subscore 1 - Development	6.52	Not Significant	6.58	Not Significant	6.45
24a. This organisation offers me challenging work.	73.0%	Not Significant	72.0%	**Significantly Better**	68.3%
24b. There are opportunities for me to develop my career in this organisation.	54.0%	Not Significant	52.7%	**Significantly Worse**	56.5%
24c. I have opportunities to improve my knowledge and skills.	67.0%	Not Significant	68.4%	Not Significant	70.1%
24d. I feel supported to develop my potential.	54.2%	Not Significant	56.4%	Not Significant	56.3%
24e. I am able to access the right learning and development opportunities when I need to.	54.6%	**Significantly Improved**	59.6%	Not Significant	59.3%

We are always learning (continued)

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 5, Subscore 2 - Appraisals	4.85	Not Significant	4.96	Not Significant	4.80
23b. It helped me to improve how I do my job.	21.7%	Not Significant	22.2%	**Significantly Worse**	26.6%
23c. It helped me agree clear objectives for my work.	29.9%	Not Significant	29.5%	**Significantly Worse**	36.1%
23d. It left me feeling that my work is valued by my organisation.	30.1%	Not Significant	30.2%	**Significantly Worse**	33.5%

Additional – Personal development

Question		2022 Score	Significance	2023 Score	Significance	Sector Score
23a.	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	90.8%	Not Significant	92.0%	Significantly Better	83.6%

We work flexibly

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 6 - We work flexibly	6.26	Not Significant	6.26	Not Significant	6.17
People Promise 6, Subscore 1 - Support for work-life balance	6.29	Not Significant	6.36	Not Significant	6.23
6b. My organisation is committed to helping me balance my work and home life.	46.3%	Not Significant	45.9%	**Significantly Worse**	48.0%
6c. I achieve a good balance between my work life and my home life.	53.3%	Not Significant	54.6%	Not Significant	55.0%
6d. I can approach my immediate manager to talk openly about flexible working.	68.0%	Not Significant	70.0%	Not Significant	68.6%
People Promise 6, Subscore 2 - Flexible working	6.22	Not Significant	6.16	Not Significant	6.11
4d. The opportunities for flexible working patterns.	55.7%	Not Significant	53.6%	Not Significant	55.2%

We are a team

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 7 - We are a team	7.01	Not Significant	7.07	**Significantly Better**	6.73
People Promise 7, Subscore 1 - Team working	6.95	Not Significant	7.03	**Significantly Better**	6.68
7a. The team I work in has a set of shared objectives.	74.4%	Not Significant	76.8%	**Significantly Better**	73.5%
7b. The team I work in often meets to discuss the team's effectiveness.	63.1%	**Significantly Improved**	66.5%	**Significantly Better**	61.2%
7c. I receive the respect I deserve from my colleagues at work.	74.1%	Not Significant	74.6%	**Significantly Better**	71.3%
7d. Team members understand each other's roles.	74.2%	Not Significant	73.9%	**Significantly Better**	71.5%
7e. I enjoy working with the colleagues in my team.	83.4%	Not Significant	83.7%	**Significantly Better**	80.8%
7f. My team has enough freedom in how to do its work.	61.2%	Not Significant	60.2%	Not Significant	60.1%
7g. In my team disagreements are dealt with constructively.	60.0%	Not Significant	59.8%	**Significantly Better**	56.7%
8a. Teams within this organisation work well together to achieve their objectives.	56.1%	Not Significant	57.4%	**Significantly Better**	54.9%

We are a team (continued)

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
People Promise 7, Subscore 2 - Line management	7.06	Not Significant	7.12	**Significantly Better**	6.78
9a. My immediate manager encourages me at work.	72.2%	Not Significant	74.1%	**Significantly Better**	71.3%
9b. My immediate manager gives me clear feedback on my work.	65.2%	Not Significant	65.8%	**Significantly Better**	63.9%
9c. My immediate manager asks for my opinion before making decisions that affect my work.	60.2%	Not Significant	61.5%	**Significantly Better**	58.6%
9d. My immediate manager takes a positive interest in my health and well-being.	69.8%	Not Significant	71.6%	**Significantly Better**	69.0%

Summary of Key Themes

- The overall Staff Engagement score for the organisation is **7.07** and the score for Morale is **6.04**
- Successes to Celebrate
  - *Four People Promise theme scores are significantly better than similar organisations surveyed by IQVIA – 'We are compassionate and inclusive', 'We are recognised and rewarded', 'We each have a voice that counts' and 'We are a team'*
  - *The score for 'Staff engagement' was also significantly better and the Trust has a significant amount (33) of question level scores in the top-20% range.*
  - *Celebrate the Trust's scores around negative experiences, such as discrimination, physical violence an unwanted sexual behaviour.*
- Areas of Focus for 2024
  - *Work directly with staff groups to understand why some would not recommend the organisation to a friend or relative if they needed treatment. Prioritise action plans that address any factors related to health and safety. Explore staff data/comments to identify whether this view is held across the organisation or limited to a particular area / staff*
  - *Ensure that the pathways to jobs with greater responsibility are clear to all staff and that the training and support mechanisms for personal development are signposted clearly to all staff. Direct managers to discuss the career aspirations of their staff members and provide appropriate support for their development.*
  - *Evaluate why staff are feeling burnt out and frustrated with their work. Speak to staff to see what they key issues are and whether under resourcing is having a major impact here.*

Next steps with your results

IQVIA can partner with you to accelerate an improvement in staff engagement

- Share the results across the organisation including breakdowns for staff groups / directorates.
- **Analyse the results** to understand if issues are prevalent in certain areas.
- Read free-text comments to gain depth into the issues.
- **Thematic analysis of free-text comments**

- Encourage teams to discuss the results and share their understanding of the issues.
- **Facilitate staff representative groups** to collate issues and ideas.
- Run **staff focus groups** if there are issues in a specific area.
- Undertake **root cause analysis** if required for organisational issues.

- Review previous action plan – what has and hasn't worked?
- **Prioritise 3 areas** where you can make a **step change**.
- Communicate your organisation-wide action plan to all staff.
- Engage managers across the organisation in creating action plans for their own teams - **provide training if needed.**

- Create, and publicise, opportunities for staff members to be involved in initiatives.
- Invest in **external support to accelerate the implementation of changes: from process development and toolkits to capability development, training and culture change.**
- Measure the impact of your actions and share regular updates with all staff on the progress you are making.

Speak to us if you would like support in any of these areas. Email: MR-Consultancy@iqvia.com
Website: https://www.iqvia.com/locations/united-kingdom/solutions/nhs-solutions/insight-and-feedback

DEARDENHR Tricordant IQVIA

Questions?

For any further information or help:

Charlie Bosher

Head of Market Research and Consultancy, Insight & Feedback

charlie.bosher@iqvia.com

IQVIA provides a range of services to help you improve further:

Bespoke survey app

On-line survey platform

SMS

Telephone

Paper-based surveys

Full range of qualitative research methodologies

Bespoke consultancy and performance

improvement services

Appendix

Questionnaire Changes

- In 2021 the questions were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be by 2024. The survey tracks progress towards the seven elements of the People Promise.

Substantive Survey

- Four new questions have been added for 2023: q17a-b on unwanted sexual behaviour, q22 on food availability and q33 on home working
- Three questions have been removed since 2022 (concerning work during the Covid-19 pandemic)
- One question from 2022 has been modified for 2023: Multiple response options have changed on q35 (occupational group)

Bank Survey

- Mandatory in 2023 for any organisation with at least 200 eligible bank only workers
- Nine new questions have been added for 2023: q9 on shift patterns, q22a-b on unwanted sexual behaviour, q27 on food availability, q29f on help/support, q32c and q33 on Bank work, q42 on home working and q45 on substantive contracts
- Four questions have been removed since 2022 (concerning work during the Covid-19 pandemic and appraisals/reviews)
- One question from 2022 has been modified for 2023: Multiple response options have changed on q46 (occupational group)

For more information, please find the survey documents here

Report Title:	Finance & Investment Committee Chairs' Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		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 Chair of the Finance and Investment Committee provides an overview of matters discussed at the meetings held on 27 March and 24 April 2024. The reports also set out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the May meeting of the Finance and Investment Committee, a verbal update will be provided to the Board with a written report presented to the subsequent Board meeting.

Previously considered by:
The matters included in the Chair's reports were discussed and agreed at the Finance and Investment Committees held in March and April.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Finance & Investment 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:**	Annette Walker Chief Finance Officer

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	27 March 2024	Date of next meeting:	24 April 2024
Chair	Jackie Njoroge	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Review of Annual Terms of reference
- 2024/25 Planning Update
- Month 11 Finance Report
- 2023/24 Accounts Going Concern Assumptions
- Age Debt Write off
- National Cost Collection
- National Energy Procurement
- GM Consolidation – Christie @ Bolton
- 0-19 Contract – proposed resolution
- BAF Ambition 3 and 4

ALERT

None reported.

Action Required

ADVISE

2024/25 Planning Update
The Chief Finance Officer gave a planning update for 2024/25 which was presented at the last FPRM on the 25th of March. The Committee discussed the plan and associated risk which was recommended for further discussion and approval at the Board of Directors meeting tomorrow.

Month 11 Finance Report
The Operational Director of Finance updated the Committee on the Month 11 financial positon. The Trust is forecasting a likely case year end deficit of £9.3m which is £3.1m better than the original planned deficit of £12.4m. Capital spend for month 11 is £0.9m. YTD £18.8m has been spent. The forecast spend is £23.2m. We had a closing cash position of £15.6m, which is an increase of £0.8m from Month 10. The Trust cash position will become challenging early in 2024/25 and this has been flagged as a key concern during planning discussions with the ICB. This month the Finance team have hit every metric within the Better Practice Payments Code which is a first and a great achievement. In relation to the deferred tax issue it was agreed that a briefing will be sent to the Committee electronically once a decision on whether to reverse it this year has been made.

Age Debt Write Off
As of the 22nd February 2024, the Group (Trust & iFM) had £10.5m of debt outstanding comprised of 1,767 invoices. £1.4m of this debt is 241+ days old, comprised of 1,015 invoices. In total it is proposed to write off £323k which would adversely impact the Trust's 23/24 I&E position. However, the bad debt provision would be reviewed to reflect the impact of this debt write off on the overall debt balance.

ASSURE

Review of Annual Terms of Reference
Various minor amendments were discussed. The Terms of reference will be further reviewed and approved in July.

2023/24 Accounts Going Concern Assumptions
The Finance & Investment Committee approved the accounts for 2023/24 be prepared on a going concern basis.

National Cost Collection
The Committee was asked to note that the 2023 final National Costing Collection (NCC) has been submitted and gain assurance the submission is fully compliant with national standards and principles.

National Energy Procurement
Energy is currently procured via Inspired Energy through the Countess of Chester Framework. This framework has provided competitive rates through an aggressive buying strategy. The Commercial Director of Finance presented this paper to seek approval to enter into a contract extension with Inspired Energy for 2024/25 and to join the NHS Energy basket for the purchase of energy from April 2025 for a term of 30 months. The Finance & Investment Committee approved the Contract Extension**.**

GM Consolidation – Christie @ Bolton
The Director OF Operations, Jo Street (JS), presented this paper which seeks approval to transfer solid-tumour oncology activity at Bolton FT to a Christie@ Bolton on site in line with the GM Cancer Oncology Delivery Strategy. The Finance & Investment Committee supported the proposal for Board approval.

0-19 Contract – proposed resolution
The Chief Finance Officer presented this paper which seeks a proposed extension of the 0-19 contract by direct award through the Provider Selection Regime (PSR). The latest 3 year proposal was discussed at Executive Directors this Monday where the Chief Nurse, Tyrone Roberts proposed slight changes to the model which affects the numbers marginally. The Committee were supportive but wanted to discuss more at Board tomorrow.

BAF Ambition 3 and 4
Since presentation of the BAF in November 2023, the BAF has been reviewed by the Chief Finance Officer. There is no proposed change in Risk Score for Ambition 3 or 4.

New Risks identified at the meeting:

None identified.

Review of the Risk Register:

There were no risks reviewed.

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	24 April 2024	Date of next meeting:	22 May 2024
Chair	Jackie Njoroge Rebecca Ganz (Deputy Chair)	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Financial Plan 2024/25
- Cost Improvement update
- Month 12 Finance Report
- Trust Banking Arrangements
- Finance Department Business Plan Update

ALERT

Agenda Items	Action Required
Shortage of capital funds and the impact on the management of the estates and replacement of kit. GM is overcommitted on capital budget and there is a process underway to prioritise additional capital as it becomes available.	

ADVISE

The meeting was Chaired by the Deputy Chair for first agenda item (Financial Plan 2024/25). The Chair joined and took over thereafter.

Financial Plan 2024/25

The Operational Director of Finance presented the Financial Plan for 2024/25. The following key points were highlighted:

- Current position is a deficit of £11.6m.
- Revenue risks total £16.9m.
- GM current deficit for 2024/25 £228m.
- Capital is challenging for GM with a current plan of £155m.
- Bolton's Capital allocation is £7.1m. Original figure was £21.07m.
- The 6-facet survey in 2022 identified backlog of maintenance totally £79.6m.
- The cash flow forecast for 2024/25 suggests the Trust will need cash support in November 2024. The plan is to apply for cash for quarter 3 with the Board being required to approve the request by June.
- The Whole Time Equivalent (WTE) reduction due to CIP has been reduced to 87 following review of schemes.

The Committee was asked to approve the revenue, cash and capital plan for recommendation at Board which was collectively agreed.

Cost Improvement Update

The Chief Finance Officer gave an update on the Cost Improvement Plan for 2024/25. Key headlines included:

- CIP Target is £24.3m. Progress is made weekly via the Financial Improvement Group led by Sharon white.
- The Top 10 highest value schemes are detailed. The Director of Strategy, Digital and Transformation, Sharon White (SW) added that top of the list is the Trust wide administration review.
- The Committee will receive updates on delivery versus plan from month 1.

ASSURE

Month 12 Finance Report

The Operational Director of Finance updated the Committee on the Month 12 financial positon. Key points highlighted included:

- At month 12, the Trust achieved its adjusted financial performance of £9.3m, but due to flexibilities at the ICB the Trust was able to write off the deferred tax asset (DTA) of £3.9m giving a recorded performance of £13.4m. This was in line with revised regional and national expectations.
- Capital spend for month 12 is £4.5m. Full year, £23.3m was spent, which means the 2023/24 capital allocation was fully met.
- We had a closing cash position of £15.9m, which is an increase of £0.3m from Month 11.
- Variable pay was higher but remained within tolerances which was mainly due to annual leave being taken in March.
- BPPC is 96.1% in month and 92.1% Year to date.

The Chair and the Committee thanked the finance team on the tremendous work achieved.

Trust Banking Arrangements

The Trust, IFM and Charitable funds have separate bank accounts. The operation of the bank accounts is in line with the Standing Financial Instructions with two authorised signatories required to authorise a payment.

Finance Department Business Plan

Every year the Finance Department sets new deliverables and reviews its performance against the previous year.

The Finance Team has two major overarching objectives for 2024/25:

- Achieve Level 3 Re-Accreditation
- Successful implementation of Integra Centros

There are 13 smaller objectives for 24/25, of which 3 link to the Integra Centros Project and 4 support Level 3 Re-Accreditation leaving 6 standalone objectives.

The Committee were impressed with the work and were pleased to see a lot of positives from the Finance Team.

New Risks identified at the meeting:
No new risks identified.

Review of the Risk Register:
There were no risks reviewed.

Report Title:	Register of Interests, Gifts and Hospitality

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	

Purpose	This report seeks to provide assurance and reinforce the Trust's commitment and integrity in decision-making, thereby upholding public trust in its governance and operations.

Summary:	The Trust maintains the following registers of interest: • A register of interests for all staff, including contractors, agency, volunteers and governors. • A register of gifts and hospitality for all staff • A register of sponsorship for courses/conferences for all staff • A register of any secondary employment for all staff This report seeks to provide assurance that the declarations of interest are appropriately published and accessible to the public, where relevant, to maintain transparency and public confidence.

Previously considered by:
Audit Committee

Proposed Resolution	The Board of Directors is asked to **receive** the Register of Interests' report, note the progress made and the measures in place to assist with adhering to the regulatory requirements.

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, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

1. Introduction

1.1. Collaboration with other organisations in delivering safe, high-quality patient care is a defining characteristic of the work conducted by and with Bolton NHS FT. Such partnerships are beneficial and are aimed at ensuring public funds are utilised efficiently and judiciously. However, the possibility of conflicts of interest emerging is recognised.

1.2. In response to this risk, the Managing Conflict of Interest Policy aligns with guidance from NHS England. All staff declarations are published on the website as a measure to safeguard against these risks

1.3. The Trust is required to maintain and publish a Register of Interest for Board members and for the Council of Governors. These registers are available on the website with the Board Register now included in every meeting pack to ensure that all our dealings are conducted to the highest standards of integrity.

2. Register of Interests

2.1. The Audit and Risk Committee monitors compliance with the Trust's policies on conflicts of interest. This includes ensuring that declarations are made timeously and accurately by all individuals who are required to do so.

2.2. The Managing Conflict of Interest Policy, which was revised in November 2023, codified and introduced consistent principles and rules for managing conflicts of interests at Trust level.

2.3. The Trust migrated to a web portal that is managed by Civica and houses the Managing Conflicts of Interest policy as well as some guidance and FAQ to support all staff to make their declarations and enable the public to see what has been declared.

2.4. The Trust Register of interests is published on this link and provides an efficient and easier way to confirm compliance. The register includes the following declarations:

- A register of interests for all staff, including contractors, agency, volunteers and governors.
- A register of gifts and hospitality for all staff
- A register of sponsorship for courses/conferences for all staff
- A register of any secondary employment for all staff

2.5. A separate but complementary register is held for all Board of Directors and is included in every meeting pack.

2.6. Whilst governor's interests are not directly covered by the national policy, a register of Governor's Interests is held in accordance with the trust's Standing Orders for the Council of Governors.

3. Compliance with Declaration Process

3.1. In line with the annual proactive declaration, all decision making staff are required to make a declaration on appointment and as standard practice at the start of each financial year. The compliance rate for decision makers for the financial year 2023/24 was 88%.

3.2. It is worth highlighting that efforts are underway to encourage staff who are not decision makers to submit their initial declaration. To address this, the Trust has implemented a bi-weekly reminder system for decision makers, and all new employees receive a monthly

email regarding this matter, with follow-up reminders as necessary. Information on how to declare an interest has also been added to the Staff Handbook.

4. Conclusion

4.1. The Board of Directors is asked to **receive** the Register of Interests' report, note the progress made and the measures in place to assist with adhering to the regulatory requirements.

Report Title:	Compliance NHS Provider Licence

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 May 2024		Discussion	✓
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Purpose	The purpose of this report is to provide the proposed content of the self-certification against the NHS Provider Licence.

Summary:	This report and supporting appendices 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.

Previously considered by:
The Board considers this declaration on an annual basis.

Proposed Resolution	The Board is asked to **review** the evidence and **confirm** compliance with the NHS Self Certification for the NHS Provider Licence.

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, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

1. **Introduction**

1.1. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023. All NHS foundation trusts and NHS trusts are required to hold a licence and self-certify that they can meet the obligations set out in the NHS provider licence.

1.2. The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

1.3. The functions of Bolton NHS Foundation Trust are conferred by 2006 Act. The Trust will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

1.4. The modified and updated NHS provider licence, is in line with current statutory and regulatory requirements. The conditions within the Licence are detailed at ***Appendix 3*** with assessment of compliance made against each condition.

2. The Self-Certification requirements

2.1. The Trust is required to carry out self-certification as assurance that it complies with the conditions. Where the Trust is not compliant, it is required to explain why and develop an action plan to achieve compliance.

2.2. Whilst there is no requirement for the Trust to submit the Self-Certification to NHSE, the Trust is required to make the Self-Certification public on its website. NHSE will contact a select number of trusts to ask for evidence of self-certification.

2.3. The Trust is required to self-certify the following Licence Conditions after the financial year-end:

a) **General Condition G6** - The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution

b) **Continuity of Services Condition CoS7** - If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service

c) **Condition FT4** is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.

d) **Section 151(5) of the Health and Social Care Act 2012 Training of Governors** - NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles

Appendix 1 NHS Provider Licence - Self Certifications for 2023/24

Bolton NHS FT undertakes an annual assessment against each of the NHS Improvement Provider Licence requirements. Once approved, these declarations will be published on the Trust's website.

1. General Condition 6 - Systems for compliance with licence conditions

1.1. The Licensee should 'take all reasonable precautions against the risk of failure to comply with:

- the conditions of this Licence;
- any requirements imposed on it under the NHS Acts; and
- the requirement to have regard to the NHS Constitution'.

1.2. The steps the Trust is expected to take (paragraph 2(a) and 2(b) of the Licence) are:

- the establishment and implementation of processes and systems to identify risk and guard against their occurrence; and
- regular review of whether those processes and systems have been implemented and of their effectiveness.

2. Evidence of Compliance

2.1. The Board and supporting Committees (Audit and Risk Committee, Quality Assurance Committee, Finance and Investment Committee, People Committee, Strategy and Operations, and the Trust Risk Management Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

2.2. The Board Assurance Framework is reviewed by the Board and the Audit and Risk Committee and the Risk Registers are reviewed through the Risk Management Committee.

2.3. The Trust has a comprehensive monthly dashboard, which on a monthly basis triangulates key performance indicators using Statistical Protocol Control (SPC) tools to understand whether change results in improvement and provides an easy way to track the impact of improvement. The Integrated Performance Report is presented to all committees prior to presentation at Board.

*Please see **Appendix 3** for a full break down of the assessment of compliance with the licence conditions*

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution

2.4. The Board is required to sign off on self-certification no later than: **G6: 31 May 2024.**

3. Continuity of Services Condition CoS7

3.1. Commissioner Requested Services CRS are defined as *"services that will be subject to regulation by NHSE in the course of a licensee's operations that, in the event of a provider failure, must be identified and kept in operation at that specific locality."*

3.2. The Board is asked to consider confirmation of the following statement:

3.3. **After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate**.

3.4. **Evidence of compliance**

The Going Concern Statement, which was considered by the Audit and Risk Committee on 08 May 2024, provides evidence that the Trust will continue to have the resources required to operate

4. Declaration of compliance with conditions of the NHS Provider Licence: Condition FT4

4.1. The standards set out in FT4 are similar to the standards of governance set out in the NHSE general objective.

4.2. There is no set approach to these standards and objectives but there is an expectation that any compliant approach will involve effective board and committee structures, reporting lines, performance and risk management systems.

4.3. NHSE will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

4.4. **Evidence of compliance**

The Board is required to provide a specific declaration with regard to Condition FT4(8) of the provider licence in the form of a **'Corporate Governance Statement'**. To support the self-certification against Condition FT4(8), the Board of Directors will be required to certify that they are satisfied with the risks and mitigating actions against each area listed.

Appendix 4 sets out the detail for the Corporate Governance Statement declaration.
The Board is required to sign off on self-certification no later than: FT4: 30 June 2024.
The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time

5. Section 151(5) of the Health and Social Care Act 2012 Training of Governors

5.1. A Governor training programme has been in place since the election of the shadow council of Governors in 2008.

5.2. The Trust has an established Governor Training Programme and Governor Induction Handbook both of which have been used to support new governors elected during 2023/24 and are undergoing a refresh ahead of the new term.

5.3. During the reporting period, a formal governor induction session took place for each newly elected Governor.

5.4. An externally facilitated Governor session on Core Skills was held in November 2023 with support from NHS Providers.

5.5. In addition, it is planned that there is a continuation at the Council of Governors meetings, for a presentation from a Non-Executive Director on their role and work of their Committee thus allowing Governors knowledge over the governance of the Trust to be enhanced.

6. Self-Certification Recommendation

6.1. Whilst the deadlines for self-certification are different, the Board is recommended to consider:

- Confirmation of self-certification against the requirements of General Condition 6 of the Licence.
- Confirmation of the continuity of services condition (CoS7)
- *Each statement within the Corporate Governance Statement and confirms compliance.*
- Approving the declaration of compliance with regard to Governor training

6.2. All Self-Certifications will be made public on the Trust's website by 30 June 2024.

6.3. The Board is asked to note and support the proposed declarations which will be published on the Trust website on **30 June 2024.**

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Appendix 2 – proposed declaration using a modified version of the template *(to be published on 30 June 2024)*

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence		
1 & 2	**General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)**	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**
3	**Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**
	Statement of main factors taken into account in making the above declaration In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:	
	The Board reviewed a detailed paper providing assurance with regard to compliance with the provider licence. The Going Concern report reviewed by the Board in June 2024 and included within the Annual Report and Accounts sets out the assurance provided to the Board to confirm that the management of the Trust are confident that the Trust will remain a Going concern and will therefore be able to continue the provision of Commissioner Requested Services with due regard to the NHS Constitution.	
	Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors	

Appendix 3 - Checklist of Compliance to underpin self-certification against NHS Provider Licence Standard Conditions:

Licence Condition	Compliance	Evidence
Section 1 – Integrated care		
IC1: Provision of integrated care *'The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS is integrated'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition and played a full part in the development of Greater Manchester Integrated Care Board and within Bolton Locality.
IC2: Personalised Care and Patient Choice *'The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition as required. The ERS directory of services provides patients with easily accessible information by speciality
Section 2 – Trusts Working in Systems		
WS1: Cooperation *'The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.
WS2: The Triple Aim *"When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.
WS3: Digital Transformation *The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.

Section 3 – General Conditions		
G1: Provision of information *'the Licensee shall provide NHS England with such information, documents, and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required. All information requested by NHS England is supplied in a timely manner in the format requested.
G2: Publication of information '*The Licensee shall comply with instruction from NHS England , issued for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services it provides for the purposes of the NHS.'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required Information is published as required in accordance with the Code of Governance and the Annual Reporting Manual.
G3: Fit and proper persons as Governors and Directors '*The Licensee must ensure that a person may not become or continue as a Governor of the Licensee' if that person is not fit and proper.* *'The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper'*	**Confirmed**. The Trust complies with this condition as required.	Trust Employment policies ensure compliance. The Trust has fully implemented the Fit and Proper Persons Framework and the Leadership Competency Framework. There are robust pre-employment compliance checks for new directors and self-declarations and associate checks for existing directors to ensure ongoing compliance with FPPR. Governor eligibility and disqualification criteria and code of conduct ensures compliance. All Governors are also subject to DBS checks on appointment. CQC review Director files to test fit and proper person documentation
G4: NHS England guidance '*the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2)*	**Confirmed**. The Trust complies with this condition.	Self-assessment against Code of Governance, compliance with the Annual Reporting Manual, routine review and compliance with all directives issued by NHSI.

G5: Systems for compliance with licence conditions and related obligations	**Confirmed**. The Trust complies with this condition.	Risk Management system in place throughout the Trust including Board Assurance Framework and Risk Registers
G6: Registration with the Care Quality Commission	**Confirmed**. The Trust is fully registered, without conditions, with the Care Quality Commission (CQC). All sites are registered.	An internal assurance process is in-place to minimise the risk of non-compliance with essential standards of quality and safety. The Trust is rated Good overall by the CQC with a rating of excellent for the Well Led review.
G7: Patient eligibility and selection criteria	**Confirmed**. The Trust complies with this condition.	There is an annual review of the contract is in place to agree eligibility criteria in accordance with Department of Health and Social Care guidance
G8: Application of Section 6 (Continuity of Services)	Refer to Section 6 below.	
Section 4 – Trust Conditions		
NHS1: Information to update the register *The Licensee shall ensure that NHS England has available to it written and electronic copies of the following documents:* *a) the current version of Licensee's constitution;* *b) the Licensee's most recently published annual accounts* c) *any report of the auditor on them, and the Licensee's most recently published annual report'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. The Annual Accounts, Annual Report, and Auditors opinion are submitted to NHSE annually in accordance with requirements. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.

NHS2: Governance arrangements *'The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. Please refer to **Appendix 3** and separate declaration
Section 5 – NHS Controlled Providers Conditions		
N/A		
Section 6 – Continuity of Services		
COS1: Continuing provision of Commissioner Requested Services *'The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service (CRS)…'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition
COS2: Restriction on the disposal of assets '*The Licensee shall establish, maintain and keep up to date, an asset register'* *'The Licensee shall furnish NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition

COS3: Standards of corporate governance and financial management and quality governance '*The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management…'*	**Confirmed**. No compliance issues identified	Position against Code of Governance regularly assessed and reviewed through the Audit and Risk Committee The annual audit plan which is approved by the Audit and Risk Committee ensures that systems of internal controls are regularly reviewed by the Internal Auditors. Monthly monitoring of quality governance, operational and financial performance and risks at monthly Committee meetings and Board
COS4: Undertaking from the ultimate controller **'***The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee'*	N/A	Not applicable (relates to non-FT whose ultimate controller may be a separate legal organisation).
COS5: Risk pool levy **'***The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public liability schemes.
COS6: Co-operation in the event of financial or quality stress **'***if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern…the Licensee will: provide such information as NHS England may direct to Commissioners, allow such persons as NHS England ay appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition The Trust is not in financial special measures, but would cooperate fully with NHS England should this ever be the case

COS7 Availability of resources **'***The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. Robust plan and quarterly profile that is approved as part of the Operating Plan submission
Section 7 – Costing Conditions		
C1: Submission of costing information '*the Licensee shall obtain, record and maintain sufficient information about the costs which it expends in the course of*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition and produces cost information in relation to both the annual National Cost Collection submission (in line with the nationally prescribed costing methodology) and the annual accounts submission.
C2: Provision of costing and costing related information '*the Licensee shall furnish to NHS England such information and documents, and shall prepare or procure and furnish to NHS England such reports, as NHS England may require for the purpose of performing its functions'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition.
C3: Assuring the accuracy of pricing and costing information *'Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition. Bolton NHSFT costing methodology aligns to nationally prescribed costing guidance and standards.
Section 8 – Pricing Conditions		

P1: Compliance with the NHS payment scheme '*the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition and produces cost information in relation to both the annual National Cost Collection submission (in line with the nationally prescribed costing methodology) and the annual accounts submission

Appendix 4: Corporate Governance Statement

Corporate Governance Statement	Compliant	Risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Yes	**Risk:** not adhering to accepted standards of corporate governance or best practice **Assurance and Mitigating actions:** • Director of Corporate Governance holds responsibility for corporate governance. • Systems and controls assurances are obtained via the Audit and Risk Committee. • CQC Improvement Plan is in place and recommendations from the CQC Inspection were the Trust was rated as Requires Improvement for Well Led • Compliance with FT Code of Governance for Provider Trusts regularly assessed and reported through Audit and Risk Committee • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Director of Corporate Governance/Trust Secretary who has accountability for its maintenance. There are no material conflicts of interest in the Board. • All governors elections and by elections held in accordance with election rules. • A peer review of Board and Committee governance was undertaken in February and March 2024. A formal external governance review will take place during the 2024/25 financial year as required by NHSE. • More complete explanations about systems of corporate governance are set out in the annual governance statement and the Trust's annual report
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Yes	**Risk**: non-compliance with FT Code of Governance for Provider Trusts and other governance guidance issued by the regulator **Assurance and Mitigating actions:** • Compliance with the Code of Governance assessed each year as part of the annual reporting process.

		• Any guidance requirements are routinely assessed and implemented as necessary. Assurance and advice is provided as required by the Audit and Risk Committee
3. The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Yes	**Risk**: Ineffective board and committee structures in place which are not reviewed and updated. Unclear reporting lines **Mitigating actions:** • Board committees established with clear lines of reporting. • Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary? These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. • Standardised Chair reports to escalate assurance and concerns in line with reporting structure. • Clear delegation of actions to committees • Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
4. The Board is satisfied that the Licensee effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but	Yes	**Risk:** Lack of systems to assess compliance with Licensing requirements **Assurance and Mitigating actions:** • Risk Management Policy in place and regularly reviewed. • Board Assurance Framework • Safeguard risk management system in place. • Use of internal and external audit services to investigate any areas of concern. • Inpatient and other CQC surveys utilised with action plans put in place where necessary. • External reviews undertaken where appropriate or necessary.

not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		• Contracts for services agreed with GM Integrated Care Board. • Finance and Investment Committee considers detailed financial performance report at each meeting • Monthly performance report considered by Board, detailed performance discussed at monthly performance reviews. • Comprehensive agendas for Board meetings circulated to directors at least 3 days before each meeting • Cost Improvement Plans in place which are risk assessed for quality • Standing Financial Instructions and Standing Orders are reviewed each year and are in place • Counter Fraud specialist reports to the Audit and Risk Committee • In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. The four areas are: quality and safety, finance, operations and governance • Points as set out in 1), 2) and 3) above apply. **Risk**: Potential loss of control through devolution of authority to the Trust's wholly owned subsidiary **Mitigating actions:** • Group Audit and Risk Committee and Risk Management Group • Group Health and Safety Committee which reports to Quality Assurance Committee.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should	Yes	• The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust).

include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity • Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Clinical quality, patient safety & patient experience metrics are reported to the Board monthly. • Quality Assurance Committee – chaired by a NED – Terms of Reference include reporting from Clinical Governance Committee and other reporting groups. • Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to Clinical Audit Committee. Full list included within the Quality Account • Learning from national reports with comparative reports undertaken and action plans devised and implemented. • National reports and benchmarking e.g. NICE guidelines – NPSA safety alerts managed via Clinical Governance Committee • Regular ward and department visits undertake by all Board members • Attendance and active participation in Bolton Locality meetings. • Ward to board heat map • Exec team ward buddies • All members of the Board are paired between Exec Director and Non-Executive Directors and each month undertake walkabouts which are reported to the following Board meeting and support the Cultural Dashboard. • Processes in place to escalate and resolve issues – Risk Management Group re-established with reporting line to the Audit and Risk Committee
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in	Yes	• The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • All Executive Directors' performance and competencies are reviewed through annual appraisals which now includes the Leadership Competency Framework.

number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		• Collective & individual skill-sets reviewed as part of board development • Chairman receives an annual performance appraisal from the Senior Independent Director, • NEDs receive an annual performance appraisal from the Chairman who advises the governors • NEDs have been appointed by the Council of Governors as advised by the governors' Nominations Committee. • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance, and, OD. Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. • Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. • NED progress is monitored by the Chair each quarter via one to one meetings including a formal appraisal session utilising the Leadership Competency Framework to ensure there is consistency in review of achievements against objectives and a personal development plan are established. • This is supplemented by a number of Board development/strategy sessions to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. • Divisions are led by experienced and capable teams consisting of a Divisional Medical Director, a Divisional Director of Operations and a Divisional Director of Nursing. The Family Care Division has an additional Director of Midwifery role as part of its leadership team. • Nursing levels on wards are reported to Board and are monitored and published on a daily basis on the ward staffing boards.

Report Title:	Refreshed Equality and Health Inequality Impact Assessment process (EIA)

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	30 May 2024		Discussion	
Exec Sponsor	James Mawrey		Decision	✓

Purpose	The purpose of this report is to present the refreshed Equality and Health Inequality Impact Assessment (EIA) Process following approval at People Committee.

Summary:	The refreshed EIA process was developed as a result of: • Feedback from updated EIA forms trial and divisional training. • New NHSEI Health Inequality Impact Assessment (HEAT) tool launched to be used by partners for system wide Core20Plus5 clinical change programmes. • Statutory requirements including Equality Act 2010, Health and Care Act 2022 and Health and Social Care Act 2012. • Feedback from EDI Steering group, leadership groups - including Executive Directors. Promoting equality, diversity and inclusion, and addressing health inequalities are at the heart of the NHS's values. Each time the Trust takes a decision, reviews its policies and practices or wants to introduce new ones, we must consider how it will impact on diverse people. EIAs are an effective tool to help meet our statutory duties. The EIA form is embedded with the Procedural Document Committee template and completion is mandated for all policies and strategies. However, spot checks revealed it was not fit for purpose in its current form. Limited data is being used to inform decision making whilst EIAs are not being completed against some activities, which presents a legal risk to the organisation. The equality and health inequality agendas have also been aligned as per our statutory duties to go beyond analysis of need for people with protected characteristics. The Health Inequalities Enabling Group approved the documentation and process on 12 March 2024. As this will have an impact on all governance and assurance routes across the Trust.

	Alongside the introduction of this document will be an education and awareness programme to ensure colleagues feel able to complete.

Previously considered by:
EDI Steering Group, Leadership meetings (including Executive Directors) and the People Committee

Proposed Resolution	The Board are asked to ***approve*** the revised Trust wide EIA process including forms, guidance document and implementation plan.

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

Prepared by:	Rahila Ahmed, EDI Lead	**Presented by:**	James Mawrey, Director Of People & Deputy Chief Executive

1. Background

1.1. The Trust undertakes Equality Impact Assessments (EIAS) when developing or reviewing policies, procedures and to some extent services and strategies. This has ensured that we have considered impact on people with protected characteristics and met a number of statutory duties.

1.2. The consideration of impact on inequalities in health or on the social determinants of health has not been included to date. The disciplines of health inequality and equality, diversity and inclusion (EDI) overlap in many ways but have a different focus and status. More often now there is an expectation that reducing health inequalities is incorporated into the EDI landscape, where once it was solely the domain of public health professionals. This provides a real opportunity to incorporate and align the two agendas. This helps to move to more equitable access, experiences and outcomes for communities.

1.3. The roll out of the revised EIA framework has been delayed due to the launch of the new NHSEI HEAT template and the proposal to implement a new NHS EIA template, which never came to fruition.

2. Introduction

2.1. Equality and Health Inequality Impact Assessments (EIA) aim to improve our services and employment practices by ensuring we avoid discrimination and promote equality for both patients and employee.

2.2. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. One of the simplest measures of health inequality is life expectancy data. In England, the ONS has found there is a 19-year gap in healthy life expectancy (years lived in good health) between the most and least affluent areas of the country. People in the most deprived neighbourhoods, some ethnic minority and inclusion health groups get multiple long-term health conditions 10 to 15 years earlier than the least deprived communities, spend more years in ill health and die sooner.

2.3. A refreshed toolkit and guidance document are proposed which offer a combined approach, bringing together the Equality Impact Assessment and the NHSEI Health Impact Assessment into a single tool. The new tool, takes into account the requirements of the Health and Care Act 2022 duties and other statutory requirements to work in collaboration to reduce inequalities:

a) Equality Act 2010 and the need to ensure equality analysis are completed as prescribed

b) Health and Care Act 2022, which strengthens the Trusts legal duty to involve local community and patients groups around any potential change specifically in relation to service change or development (Section 242) - Applies at strategic level and includes decisions around setting priorities and targets, allocating

resources and commissioning services. It is suggested to extend these considerations to the workforce also.

c) Health and Social Care Act 2012 duty to give regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Its aim is to remove barriers for diverse groups due to service design and support employment of people in inclusion health groups

2.4. The refreshed EIA documentation will also be embedded within business cases, large-scale transformation projects, board papers (as per EDS20222 Domain 3 requirements), procurement paperwork and beyond. Abbreviated versions will become available in due course. Individual committees will be responsible for monitoring and assurance that EIAS have been completed and actively influence final decision making.

2.5. The refreshed process was trialled with the Adult Acute Division and Children and Families in September 2023. This was supported by face to face training to upskill staff. Positive feedback was received. However further analysis of the health inequalities agenda and national HEAT toolkit emphasised the need for staff to take greater account of people who face health inequalities both within service delivery. This is particularly relevant where the Trust is participating in Core20plus5 collaborative programmes of work focusing on adult and children clinical areas of focus. They allow fuller recognition of the extent of issues affecting diverse groups in the Borough and solutions are put in place, including allocation of resources to groups with the greatest need.

2.6. It was also imperative to update the current EIA template, introduced in 2010 and which is mandated within the Document Control Policy. It is embedded within the non-clinical trust wide procedural document template and clinical guidance templates. Development of strategies are also expected to comply with this document and complete an EIA. The previous template has its limitations, of which some are listed as follows:

a) Where impacts are significant or unknown, no improvement plan template is available to record actions taken which is necessary to evidence due diligence. (Full EIA improvement plan). A central repository is required and publishing must take place.
b) No alignment to the focus on the Trusts duties to reduce health inequalities although these may overlap with people with protected characteristics - Health and Social Care Act 2012
c) Fails to encourage staff to place specific consideration of the needs of people with a disability and more favourable treatment if required
d) Little emphasis on the need to record evidence base used to inform judgment.

e) Meaningful involvement opportunities not always being activated as per statutory duties in the Health and Care Act 2022.
f) A considerable gap in training since its first inception in 2010
g) Poor quality EIAs being completed
h) Larger programmes of work and quality improvements initiatives, restructuring, cost saving decisions and strategies and plans do not consistently utilise EIAs to inform decision-making or being published which is a legal requirement.
i) To strengthen transparency it proposes a central repository of all EIAS to be sent to and recommends publishing a list of all completed EIAs allowing stakeholders to request copies if required. This will support compliance with the requirements within the ICB Equality, Diversity and Human Rights contract schedule.

2.7. The above issues pose a considerable risk of legal challenge. Judicial review will test whether a decision was lawful and give a judgement on whether the duty has been complied with. It is likely to rely on evidence including primary documentation, effective governance processes and risk management when reaching a decision. Robust EIA processes and documentation of compliance with the duty mitigates the risk of challenge.

3. Progress to date.

3.1. Progress in implementing the refreshed EIA form and process is as follows:

- The first version of the refreshed EIA tool was trialled with Adult Acute Division and children and young people department. This was supported by a two-hour staff training session.
- Agreement has been reached with the Clinical Governance Team to replace the current EIA template within PDOC templates.
- Embedded within the Quality Improvement templates - Transformation Projects & Quality Improvement Projects – as part of Cost Improvement Plan (CIP)
- Link to forms within Quality Improvement Strategy as a necessary step.
- Initial agreement to embed within business cases to be approved by CRIG once final form is approved.

3.2. The following areas have also made some progress :

- Meetings have been held with the Executive members to embed EIA summaries within board papers leading to greater assurance (Linked to Equality, Delivery System 2022 Domain 3 outcomes) ,
- Discussions ongoing to ensure large scale transformation projects that are not CIP related undergo IA, NHS charities funding applications. Team capacity has led to delays.
- Other processes have also been identified including attaching to procurement paperwork

4. Actions taken and Next steps

Action to be taken	Target date
a) Finalise and gain Health Inequalities Enabling Group approval to utilise the new forms, guidance documents and approve the implementation plan – COMPLETED	March 2024 - complete
b) Executive Team sign off refreshed EIA framework including forms, guidance and approach.	April 2024 - complete
c) People Committee approve refreshed EIA framework	May 2024 - complete
d) Board consent for refreshed EIA process to support Trust wide implementation.	May 2024
e) Liaise with Governance Directorate to replace EIA forms within document control procedure.	May – June 2024
f) Identify and liaise with governance committees to embed the new EIA process	May – June 2024
g) Produce webinar and intranet resources	May 2024
h) Launch - empowering staff use (training/self-serve)	May 2024
i) Produce abbreviated version of the EIA form for board papers and request approval	June 2024
j) Embed within additional structures including Board papers, NHS charities, large scale transformation projects	April to June 2024

5. Recommendations

5.1. The Board are asked to consent for the revised Trust wide EIA process including forms, guidance document and implementation plan.

Appendix – EIA toolkit & forms

Equality Impact Assessment (EIA) Toolkit

What does a robust EIA look like?
How clear am I about what I am trying to achieve?
Have I made good use of evidence to understand the likely impact?
Does my policy, plan, project or service (activity) work for everyone? Does it have the intended effect?
Have I involved the right stakeholders in completing my EIA?
Am I making use of the EIA at all the right stages of my policy, plan, project or service review cycle?
Am I confident that my analysis is robust and meaningful?
Are there plans to eliminate or reduce any negative impacts or maximise positive impacts?
How will you monitor the actual impact of the proposal once implemented?
Has the authoring committee had site of your EI and made arrangments for assurance pourpses ?
Do I need to record and publish the full EIA improvement plan?

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1 Introduction

Equality Impact Assessments (EIA) aim to improve Trust services and employment practices by ensuring we avoid discrimination and promote equality for both patients and employees. Each time the Trust takes a decision, reviews its policies and practices or wants to introduce new ones, we must consider how it will impact on diverse groups, before a decision is made. They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining whether an activity will affect people differently, with reliable data.

EIAs are an assessment of the effect of current, intended or draft proposed policy, project, plan, procedure or service change (referred to as activity). They provide the structure to implement actions to eradicate any adverse, negative or detrimental outcomes, issues or inequalities and maximize positive benefits. This is on the basis of 'protected characteristics' (i.e. age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights.

The refreshed EIA template also considers the needs of those living in the most deprived communities and people facing health inequalities, in relation to both service delivery and employment practices. By doing so, we can ensure health resources are distributed according to groups with the greatest health needs.

The assessment should be carried out by someone or a team of people with a good knowledge of the activity, and sufficient influence over it. It is good practice to take a team approach to completing the EIA, particularly where medium or large scale activities are being assessed.

The questions in the EIA forms lead you to consider the potential impact of an activity, and how to make things as fair as possible for anyone who is likely to be affected. The level of detail required for an EIA depends on how complex the activity is, and to what extent people are likely to be affected by it. In practice, the earlier the EIA is undertaken the better. This means that if any issues are highlighted - such as a need to make reasonable adjustments for disabled people - they can be addressed as part of the project itself and costly mistakes can be avoided.

EIAs also inform plans for engagement with the most affected and co-production, which will result in a set of recommendations to mitigate against any negative and enhance positive impacts.

Undertaking EIAs allow you to:

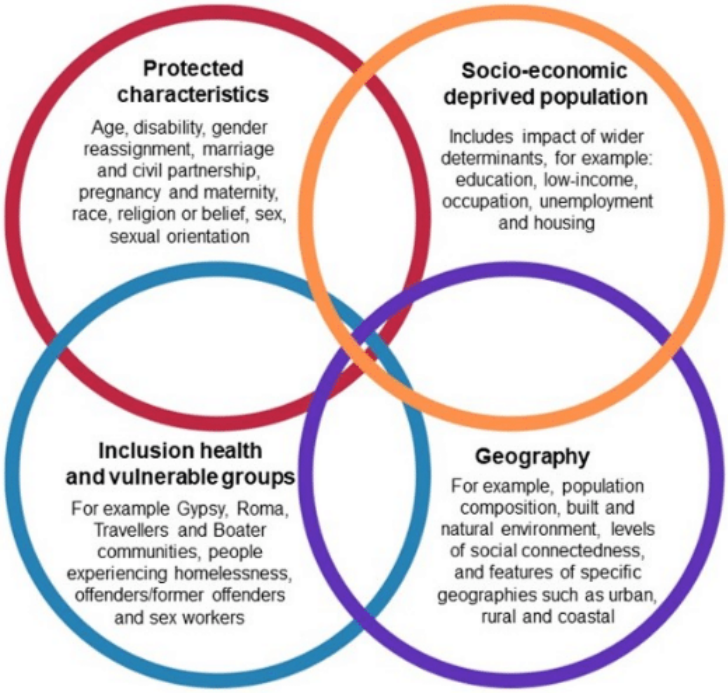
- reduce inequalities and improve outcomes.
- deliver high quality, safe, personalised and effective services
- develop better policy making, procedures and services for patients and staff that are safe, effective and responsive.
- improved staff retention and associated costs
- become more accountable to the people that we serve.

- protect the Trust from legal action and reputation damage.

Note on health inequalities

⇒ Equality – means ensuring that everyone gets access to the same resources.

⇒ Equity – means ensuring that everyone has the opportunity to get the same outcome, with resources distributed according to need.



People who share protected characteristics, as defined in the Equality Act 2010, may also experience poorer health outcomes as a direct result of discrimination. However this may also be due their experiences of factors associated with health inequalities.

Health inequalities are avoidable, unfair and create systematic differences in access, experiences and outcomes for health between different groups of people (socially excluded/ inclusion health groups,).

The effects of inequality are multiplied for those who have more than one type of disadvantage and are often analysed across four main categories or dimensions described in the image above.

Inclusion health groups are defined as people who are socially excluded and experience a greater number of risk factors for poor health – such as stigma, discrimination, poverty, violence and complex trauma. This results in insecure and inadequate housing, very poor access to healthcare services due to service design, poor experience of public services, poorer health than people in other socially disadvantaged groups. Inclusion health groups include people who experience homelessness, people with drug and alcohol dependence, Vulnerable migrants and refugees, Gypsy, Roma, and Traveller communities, people in contact with the justice system, Victims of modern slavery, Sex workers and other marginalised groups

Health inequalities can involve differences in:

- health status, for example, life expectancy
- access to care, for example, availability of given services
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

A long-term approach is required to tackle entrenched inequalities between and within places across the UK. Wider determinates of health – poverty, discrimination, educational attainment, employment and housing – relate to barriers that the NHS by itself cannot overcome. Collaboration brings an opportunity to capture a holistic view of inequalities and work with people and communities. Local authorities and other partners are well placed to understand the social determinants of health and how they can be addressed together and the legal frameworks in place in England promote and require this.

As such service leads working on locality based projects alongside partner agencies may be required to additionally complete the National Health Equity Assessment Tool (HEAT). This is most likely for any activity directly related to CORE20PLUS5 programmes, and contains links to specific data to inform analysis. This will be collectively within Integrated Care Systems (ICS) where local partners plan health and care services in a joined-up, coordinated way, to meet the needs of their local population. Their clinical priorities are as follows:

- Adult clinical focus - Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension.
- Children clinical focus - Asthma, Diabetes, Epilepsy, Oral Health and Mental Health.

These clinical areas require a stronger focus on groups facing health inequalities to address the social detriments of health. The programmes of work involve a partnership approach across the locality to jointly development improvements and approaches, understand barriers to access, prioritise resources based on greatest impact and ultimately to design services in partnership with people so they meet their needs and preferences. Legal responsibilities exist where collaborative programmes of work are being undertaken, involving the Trust working together within and across systems to plan, deliver and transform services. Bolton FT must meet its legal duty to involve people when planning and developing proposals for changes through the collaborative. (Health and Care Act 2022).

While involving people and communities is a legal requirement, working with them also supports the wider objectives including population health management, personalisation of care and support, addressing health inequalities and improving quality. The legal duties provide a platform to build collaborative partnerships that start with people and focus on what matters to communities.

2 Impact Assessment Process

Discrimination is usually unintended and can even remain undetected, until someone complains or is adversely affected by the action. The EIA tool will help you to assess the equality relevance of your activity to diverse groups through an assessment of data and take appropriate action.

EIAs involve a two part process consisting of a mandatory screening process (Stage 1) and a possible full EIA improvement plan process (Stage 2) if adverse impacts are found or further investigation is required.

EIAs must be completed and attached to all policies, procedures, business cases, plans, papers etc. The authorising committee is responsible for gaining assurance, reviewing the quality of the EIA, regular monitoring and assessing progress.

Undertaking EIAs at the design stage of your activity helps to identify and set about removing any risk of widening health and care gaps from the outset. It provides the best opportunity for closing existing gaps. They should be repeated on a regular basis to ensure the Trust is continually offering an equal service. The Trust can be challenged and asked to provide completed EIAs at any time, for example as freedom of information requests or in case of any legal challenge.

Remember - the quality of an assessment is not measured by the number of pages produced but by the quality of the analysis but rather action taken as a result, and the outcomes achieved through implementation

STAGE 1 - EIA Screening Form - MANDATORY

Step 1 - Identify who will lead the EIA

The relevant author who has lead responsibility for the activity is required to conduct the EIA. It is advised not to complete in isolation and to instead work with at least one other person in conducting the EIA screening to ensure a thorough analysis and challenge is presented. There is no statistical test available for identifying positive and negative impact and is purely based on professional judgement, it is therefore highly recommended to bring in different perspectives.

For larger scale projects involve other team members, key stakeholders and partners. Where joint partnership projects are being undertaken the most appropriate officer will be required to complete the process ensuring it is undertaken by someone with a good understanding of the service.

Step 2 - Summarise what your activity entails

List the main aims, objectives and intended outcomes of the activity and which groups of people are intended to benefit (Section 1). Provide a sufficient summary to allow the reader to gain a good understanding of what you are trying to achieve through your activity.

Have you involved staff, patients or the public?
What process for engagement, participation, involvement, co-production or consultation with the groups involved has been undertaken and when? The purpose of the involvement is to outline to the specific groups how the implementation of the policy will affect them and to gather feedback.

If an EIA is being carried out in relation to a service change or development, the Trust has a legal duty to involve local community and patients groups around the potential change (Health and Care Act 2022 - Section 242).

Step 3 - **Assessment of activity**
Identify and agree the activity being assessed. Divide your activity into different parts and prioritise which ones will be assessed in order, if applicable.

Example: In reviewing the PALS service they may consider the different components of the service including how it is publicised, patients profile to understand who is and is not using the service, accessible ways patients are able to communicate, provision of information in different formats including questionnaires, staff training etc.

Step 4 - Gather relevant data
Think of an EIA like a business delivering a new product or service – first steps will be to find out who the audience is and what their different requirements will be to ensure your activity will be fit for purpose and deliver you the profit you need for your business. Your business will not succeed if you have not done your market research.
Consider each protected characteristic individually and in combination as barriers people face arise as a result of multiple layers of identity interacting, known as intersectionality.

Begin by reviewing what is and is not working well and what would make it better. Record the data on the template to gather an insight into what you know about each relevant group and to what extent you have provision in place to meet those needs. Next, gather relevant data and explore it to identify the differences between population groups. These differences can be understood in terms of access, experience and outcomes for patients and staff:

• **Access:** Who is and isn't accessing your service? Is it reflective of the demographic population?

- **Experience:** Do certain groups discontinue their treatment or have worse experiences? Do staff survey results or feedback raise any concerns? What do patients and staff providing care tell you about the extent of the issue at hand? What can staff and patients experiencing the inequity tell you about the barriers they face and solutions they would benefit from?
- **Outcomes:** Do certain groups do less well, for example have increased readmissions or limited staff uptake?

Draw upon a variety of relevant data and intelligence to form a comprehensive equality picture. This may include comparisons with similar activities, team knowledge, recent research, feedback, community demographic data compared to current access, research, DNA rates, readmission, incidence, morbidity and survival, waiting times, PALS, complaints and survey data, inclusion staff network feedback, trade unions etc.

In situations where data is insufficient or of poor quality consider what amount of data is necessary for an informed decision ensuring it is proportionate e.g. undertake short studies, surveys or additional engagement work. Stakeholders may include staff, service users, volunteers, Board members, voluntary and community sector organisations, patient groups, staff groups, unions, and potential employees or service users.

Depending on the scale of the decision, you can decide to put in place an evidence collection plan (Stage 2 - full EIA) or move ahead without available evidence. This is permissible, but will require a plan to review and monitor the consequences by completing the Part 2 – Full EIA improvement plan form.

Step 5 – Assessment of impacts on diverse groups

Analyse the activity for any differential impacts on people with protected characteristics and those facing health inequalities. Assess the *relevance* (likelihood) and *proportionality* (how strong the affect is) of the activity is on people with protected characteristics, and for service delivery how the activity may affect people facing inequalities in society.

Any negative impacts may be reduced or mitigated against and/or positive impacts introduced or strengthened during the screening stage. Where possible, put in place short term measures where minor changes can be made to the activity to meet needs of groups. For example: A policy states that people with a physical impairment will not be able to access the treatment. This will have a negative impact on people with disabilities and could be illegal. The policy is re-written to state that reasonable adjustments will be identified and discussed with the patient to ensure equal access.

Consider what questions will help you to understand the potential impact of activity o diverse groups.
In light of the above, how is your work likely to affect protected groups and health inequalities? (positively or negatively)

a. Equality and protected groups
- Do activity outcomes and service take-up differ between people with different needs?
- If there is a greater impact on one group, is that consistent with the activity's aims?
- What are the key findings of your engagement?
- Will the activity deliver practical benefits for certain groups?
- Does any part of the activity discriminate unlawfully?
- If the activity has negative impacts on different people, what steps can be taken to mitigate or remove these effects?
- Do other activities need to change or be improved to enable this activity to be effective?
- Does the activity miss opportunities to advance equality of opportunity and foster good relations?

b. Health inequalities
Could your work widen inequalities by:
- requiring self-directed action which is more likely to be done by affluent groups
- not tackling the wider and full spectrum of causes?
- not being designed with communities themselves?
- relying on professional-led interventions?
- not tackling the root causes of health inequalities?

Click here for an example on digital inclusion

Types of impacts

Four possible likely impacts may be identified having considered relevant qualitative and quantitative data. Positive impacts will be welcomed; whist negative impacts may require further investigation (A stage 2 Full EIA may be required dependent upon the how time and resource intensive the action/s may be). It is quite possible that some policies or practices will be more relevant to one or more protected characteristic/s or group/s than others or none.

1. NEUTRAL IMPACT - where the activity does not have any relevance to people with protected characteristic.
For Example: a policy that deals with the storage of medical gases is unlikely to be relevant to equality

2. UNSURE OF IMPACT

For example, it is unclear how patients with various needs will be able to access online digital consultation platforms therefore further consultation is required. If possible, hold the event and use the feedback to inform the assessment or plan to do this in the future by completing the stage 2 – Full EIA improvement plan.

3. POSITIVE IMPACT - Evidence demonstrates the activity is robust; there is no potential for discrimination or any negative impact and all opportunities to promote equality have been taken.

Examples:
- A policy which refers to emergency blood transfusions includes a statement to ensure staff check if an advance directive on refusing bloods is in place. This policy has considered the impact on certain religious groups and what actions will be put in place in such instances. This is a positive impact on religious groups, in particular Jehovah's Witness
- Publications are available in different languages and formats upon request, Flexible-working arrangements are in place to meet the needs of staff who are carers, have a disability or health condition etc., interpretation services are readily available, home visits are conducted etc

4. NEGATIVE OR ADVERSE IMPACT - Evidence identifies potential problems or missed opportunities and could be potentially discriminatory.

Example:
- If an organisation only accepts complaints in writing it could have a negative impact on people with learning disabilities and learning difficulties, people who don't speak English as their first language, people with sight impairments, people with limited dexterity, British Sign Language users who may not have strong writing skills etc.

New facilities are being built with little or consideration for the needs of patients with disabilities, male or female only interview panels, data shows that there are an increased number of Black, Asian and Minority Ethnic (BAME) patients who do not attend specific clinics.

Where a negative adverse impact is found, make a decision to do one of the following to mitigate against or remove the disadvantage:

1. Stop	Stop the policy, practice, project or service due to the evidence showing adverse impact to one or more groups.
2. Adjust or mitigate	Alter the policy, practice, project or service to eliminate the adverse impact. Can you take any specific measures to reduce or avoid the

	negative impact identified in the screening tool? If so, amend the activity as appropriate and make a record of the change. For example: Breast cancer services identify that information is aimed only at women and could have a negative impact on male, trans and non-binary patients. They make a decision to obtain more inclusive information and review promotion of the service. Consider if further research or consultation is necessary? Would the research be proportionate to the importance of the activity? Is it likely to lead to different outcomes? For example: a review of DNA rates shows significantly higher rates for BAME patients than White British groups. They decide to hold a focus group with BAME patients to understand this issue and will need time to complete this activity.
3. Justify	Take an active choice to continue with the policy, practice, project or service, as there is no reasonable alternative to achieve the aims set out. This is only an option where the policy does not unlawfully discriminate or where the policy can be **objectively justified (**i.e. "a proportionate means of achieving a legitimate aim" as defined by the Equality Act). This may include government directives or health and safety measures for example. For example, NICE guidelines may suggest the treatment will be ineffective for pregnant people or those within a specific age band. Nevertheless, if challenged, you will have to satisfy a court that you have given due regard.
4. Continue	Continue with the policy, practice, project or service in the full knowledge that it is biased against specific groups which has its own risks and leaves the Trust open to challenge.

Step 6 - Summary, evaluation and monitoring

Indicate factor scores impact - High Medium or Low
Consider the size of the potential impact, not necessarily the size of the policy, plan, or project. Remember – some small actions can have significant impact. Could your policy, plan or project or service have a high, medium, or low impact?

You will need to use your judgement and consultation findings to decide. Negative Impact score will illustrate a need to complete an Full EIA – Stage 2 Improvement Plan. However, it may be useful to complete this even if the negative impact scored low to ensure that a more thorough assessment is carried out. NB: Please retain a copy of the EIA on your files for audit purposes and address any queries to the EDI Team @EDI@boltonft.nhs.uk

Monitoring arrangements - Otherwise confirm how the activity will be monitored through its lifecycle and submit the EIA for review and publishing through the relevant committee.

STAGE 2: Complete the Full Impact Assessment Template - Only if an improvement plan is required

This is a necessary step if negative impacts are found which lead to a potential for exclusion or discrimination or you are unclear how the activity will affect different groups and engagement is required. This consists of developing a remedial or improvement plan to document steps to be taken to:

- remove/mitigate against negative or adverse impacts/disadvantage
- maximise positive benefits and/or
- provide details of further consultation required to understand needs and wants.

The Full EIA improvement form will allow you to record actions you will put in place to address any gaps in information or changes you will make. For example, amendments to the way the policy/ project/ service is put into practice, find alternative ways of achieving the aims of the activity or introduce additional measures.

Step 1 - Develop an improvement plan
Agree actions required to mitigate any actual or potential negative impacts in the action plan, identifying who is responsible for completion and expected timescale. This may require engagement/ consultation / involvement with community or staff groups. It will help you to understand the impacts further, explore options, draw conclusions and make recommendations. This may take the form of face-to-face meetings, focus groups, questionnaires, discussion papers etc.

Additional actions may also consist of plans to improve equality monitoring data, changes in communication methods, assessment tools, increased staff awareness and training etc.

Step 2 - Monitoring arrangements
Make arrangements to regularly review the improvement plan / Full EIA usually through the responsible committee.

Step 3 - Publish Full EIA improvement Plan
Full EIA should be published for transparency and accountability where it is likely to have significant impact. Forward your completed documents to the Equality, Diversity and Inclusion Team at EDI@boltonft.nhs.uk
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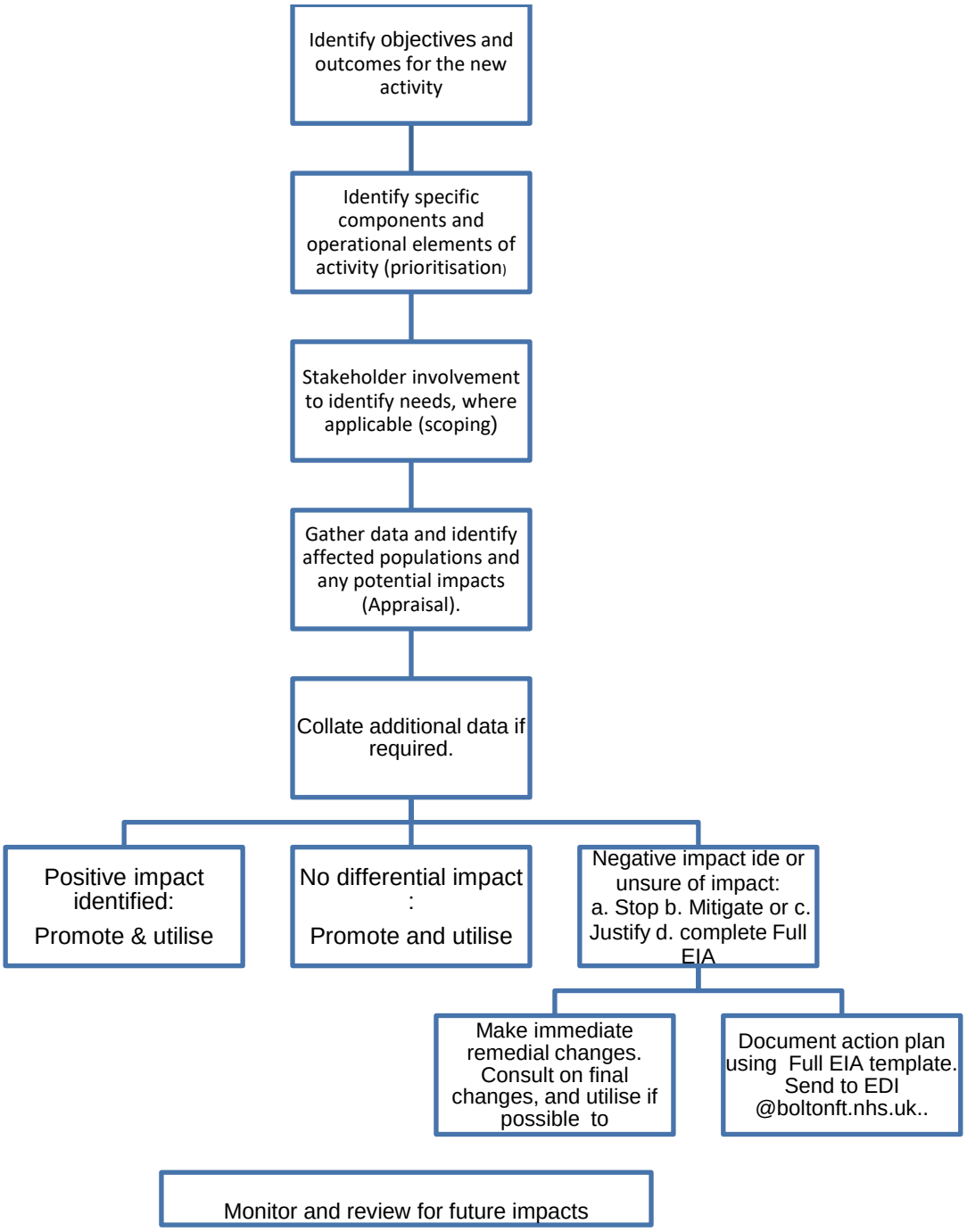
Appendix 1: EIA Process Flowchart



Appendix 1: EIA Forms

EQUALITY IMPACT ANALYSIS SCREENING FORM – STAGE 1

Use the screening tool to identify the need for action to promote equality and inclusion and reduce health inequalities. If negative impacts are found, or further exploration is required to understand the likely impact, a full in-depth EIA must be completed. Attach the EIA Screening to any documents submitted.

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Title of Policy/Plan/ Project			
Service/ Team/ Department		Division	
Type of activity	Function ☐ Policy ☐ Project ☐ Plan ☐ Service☐ Other☐		
Name of Assessor			

1. Description

What are the main aims and purpose of your activity?
What is the expected outome?
Who will be affected? ☐ Patients ☐ Carers ☐Staff ☐Other
Has any involvement activity taken place to inform this assessment? ? If so, what was the feedback and what changes were made?

2. **Assessment of impact**

A. Protected characteristics	**How will the activity affect diverse groups? Include evidence you have used to assess the likely impact and any changes you will make a result.**	**Impact**			
		Positive	**Negative***	**Neutral**	**Unsure**
Age	E.g. treatment age limits, safeguarding and consent issues				
Disability	E.g. physical, information, communication, or attitudinal barriers				
Gender Reassignment	E.g. data privacy, harassment, sex related tests				
Marriage and Civil Partnership	E.g. working arrangements, caring responsibilities, language etc.				

Pregnancy and Maternity	E.g. Suitability of treatment				
Race or Ethnicity	E.g. cultural or language barriers, specific individual care needs related to culture				
Religion and Belief	E.g. consent, end of life, belief systems				
Sex	E.g. access to services, gender neutral language				
Sexual Orientation	E.g. inclusive language, access and attitudinal and social barriers).				
Human Rights	E.g. FREDA principles (fairness, respect, equality, dignity and autonomy)				

B. Is there an impact on other disadvantaged or inclusion health groups at risk of health inequalities?	Carers	☐	Families On A Low Income	☐	Gypsy, Roma & Traveller	☐
	Homeless People	☐	Vulnerable Migrants & Refugees	☐	Armed Forces Community	☐
	Drug & Alcohol Dependence	☐	Looked After Children & Young People	☐	Contact With Justice System	☐
	Living in Deprived areas	☐	Living In Remote Locations	☐	Other (e.g. Sex Workers ……	

Groups affected	**Do inequalities exist for the above groups or in combination with peoples protected characteristics? Could the activity reduce or widen inequalities in access to healthcare, experience or health outcomes? If yes, describe how and include evidence used to inform impact**	**Impact**			
		Positive	Negative *	Neutral	Unsure

*C. Can any negative impacts be justified?	**Yes** ☐ Detail how:	**No** ☐ - Complete a full EIA

3. Supporting people with disabilities

What reasonable adjustment, if any, will you put in place to ensure people with disabilities/health conditions/differences receive an equal service?

4. Changes made or action to be taken

Did you make any changes to your original proposal following the screening or have further recommendations been made to reduce any negative/adverse impacts or maximise positive impact - (Part 2 Full EIA Improvement Plan will need to be completed)

Concern	Action	Lead person	Deadline

5. Full Equality Impact Assessment required?

Criteria	* Yes	No
Are you unsure of the potential affects and need to investigate further?	☐	☐
Are any groups excluded from this activity and cannot be justified?	☐	☐
Does the activity create any problems or barriers for communities?	☐	☐
Can it lead to widening health inequalities?	☐	☐
Will the document have a negative impact on community relations?	☐	☐
Full EIA (Stage 2) required No ☐ *Yes ☐ - To access a copy of the form please see the intranet. - For advice and guidance contact the Equality, Diversity and Inclusion Team for advice and guidance, if required. Copies of Full EIAs much be sent to EDI@boltonft.nhs.uk		

6. Monitoring Arrangements

How will the future outcomes of the activity be monitored to ensure diverse groups are not disadvantaged in any way?

Area to be monitored	Methodology	Lead	Reported to	Frequency

7. Impact Score

Level of impact	High ☐ Medium ☐ Low ☐	Date EIA completed

FULL EQUALITY IMPACT ASSESSMENT (EIA) FORM – STAGE 2

This form should only be completed where a policy, plan, project or service has been screened using the initial EIA screening tool (Stage 1) and likely negative/ adverse impacts have been identified, unsure of impact or positive benefits can be maximised. An outline of actions to take corrective action must be recorded in the form below. Arrangements will need to be made with the responsible committee to monitor the action plan. Completed copies are to be sent to the Equality Diversity and Inclusion Team for record keeping and publishing purposes, accompanied by the initial screening form. Email: EDI@boltonft.nhs.uk

Activity Title:		Lead officer:	
Service/ Team/ Department:	Division:	Date published:	Review date:

1. Summary of findings

1. What negative impacts have been found or what areas need further exploration? Include feedback from stakeholders and data used to identify potential differences.	
2. If you are unsure of the impact and need to carry out further consultation with specific groups, please detail how you intend to implement and methods to be used.	

2. Equality Improvement Plan

Use the table below to summarise your findings from the screening form, details of actions to be taken forward and monitoring arrangements to ensure success.

Negative Impact identified	Group(s) affected	Action / Mitigation	Lead	Success monitoring arrangements	Timescale	Progress/ outcome/ changes made	Date completed

3. Implementation, Evaluation and Monitoring

Detail in the table how you evaluate the effectiveness of your project on equality and inequality and who will be responsible for reviewing the outcome of proposed changes.

Area to be monitored	Methodology	Lead	Reported to	Frequency

Appendix 2: Key considerations

Risks to widening Inequalities
Being inaccessible, consider physical access, communication needs, geographical location, digital exclusion, unintended costs (care, travel etc)
Needing self-directed action (more likely to be done by well-off groups)
Not being designed with communities / users
Not tackling the root causes of health inequalities

Age
Does your activity make assumptions about people simply because of their age?
Does your activity give out positive messages about all ages?

Disability
Do you routinely record the communication and information needs of patients with a disability when sending out appointments etc?
Do colleagues know how to book interpretation and translation services, including communications professionals? Do they know how to use an induction loop?
Is core information available in alternative formats?
Have you thought about your assessment materials and methods and made sure that they are accessible to people with disabilities?

Religion or Belief
Is your activity religiously and culturally sensitive? E.g. treatment or intervention, dietary needs, dress, prayer space etc.
Are you aware of key festivals to avoid?

Race
Do you need core information available in other languages?
Do colleagues know how to access an interpretation and translation services?
How culturally competent are staff teams? Are assumptions being made?

Sex
Do you need to review your activity and accommodation with regard to dignity and respect i.e. with regard to bed, toilet and bathroom space, or changing facilities?
Do you have flexible working arrangements for either sex or gender?
Do you need to consider positive action to get the gender balance even?

Sexual Orientation
Do you give positive messages and a positive reception to gay men, lesbians, bisexual+ people?
Does information only use visual images that depict mainly heterosexual couples?
During assessments, do you make it easy for someone to talk about their sexual orientation if it is relevant or do you assume that they are heterosexual?
Would colleagues feel comfortable about being 'out'?

Gender Reassignment

Is your activity sensitive to transgender individuals or those undergoing gender reassignment?
Do your staff understand transgender terminology?
Are gender Neutral toilets available?

Pregnancy and Maternity
Any impacts on a new, expectant or breastfeeding mother?
Are private breastfeeding facilities available?
Are baby changing facilities available and accessible to all genders?

Human Rights
Affecting someone's right to life
Caring for other people or protecting them from danger Investigating deaths
The detention of an individual
Inadvertently place someone in a humiliating situation or position

Appendix 3: Legal requirements

EIAs assist the Trust to demonstrate compliance with the legal duties under the Equality Act 2010 requiring public authorities to promote equality. Section 149 of the Act places a general equality duty on public bodies, and all staff, to consider the needs of all individuals in their day to day work in shaping policy, delivering services and in relation to employees. In the exercise of our functions we must have 'due regard' to the need to:

1. **Eliminate discrimination, harassment and victimisation**:
   Consider whether the activity:
   - result in less favourable treatment for particular groups;
   - Give rise to indirect discrimination
   - give rise to unlawful harassment or victimisation;
   - Lead to discrimination arising from disability;
   - builds in reasonable adjustments where these may be needed

2. Advance equality of opportunity between
Consider whether it will help you to:
- remove or minimise disadvantage;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
- encourage increased participation of particular groups; and
- take account of disabled people's impairments.

3. Foster good relations between people
- Consider whether steps have been taken to tackle prejudice and promote understanding.
- If the activity will have a positive result of increasing take up or participation by protected groups.

Having 'due regard' is about using good equality information and analysis at the right time as part of decision-making procedures. How much regard is 'due' will depend on the circumstances as the greater the potential impact, the higher the regard required by the duty.

Case law has established that what is important is not the preparation of a particular document, but that staff give proper, informed consideration to equality issues at the right time and that they keep a record of that consideration. Key case law Principles are set out in the Brown principles

The Brown principles – Steps to consider
In response to a legal challenge, Brown v Secretary of State for Work and Pensions (2008)12, about the public sector equality duty, the court set out a set of principles which lawyers suggest are also relevant to the health inequalities duty.

a. 'Decision-makers must be made aware of their duty to have 'due regard' and to the aims of the duty.'
b. "Due regard" must be fulfilled before and at the time a particular decision is considered.
c. The duty must be exercised in substance, with rigour and an open mind.
d. The duty is non delegable.
e. The duty is a continuing one.
f. It is good practice to keep an adequate record showing the duty had been considered.

EIAs are a valuable method of internally scrutinising ourselves and everything that we do, prior to external scrutiny from regulatory bodies such as the Commission for Equality & Human Rights (EHRC), the Care Quality Commission, and commissioners as per the Trusts contractual obligations.

Failing to undertake or a poor quality EIA on an activity can lead to legal challenge and reputational damage and can result in the EHRC issuing an enforcement notice.

Note on positive action in the Equality Act 2010
Positive action is a range of measures allowed under the Equality Act 2010 which can be lawfully taken to encourage and develop people from under-represented groups to help them overcome disadvantages in competing with other applicants.

- An example of a positive action is the NHS Leadership Academy's Stepping Up Programme, which is an employment development programme supporting the development of aspiring black and minority ethnic (BME) leaders in the NHS.
- Putting in place singles -sex provision where there is a need for it.
- A recruitment scenario where there are two candidates – one who has a protected characteristic, and one who does not - that are deemed to be equally qualified for a specific role, an employer could offer a role to the individual with protected characteristic. This action is called a tie-break scenario, and is allowed under the Equality Act 2010 to help address historic and social disadvantage.

Positive action must not be confused with **positive discrimination** which is unlawful. In the recruitment context, unlawful positive discrimination would be where an employer recruits a person because he or she has a relevant protected characteristic rather than because he or she is the best candidate. It is also unlawful, for example, to set quotas to recruit or promote a specific number or proportion of people with a particular protected characteristic.

Where positive action has been taken to encourage applicants from disadvantaged groups to apply, every applicant must be considered on individual merit and selection for interview and appointment must be based strictly on the agreed selection criteria rather than offering preferential treatment.

The Equality Act 2010 permits reasonable adjustments which may give preferential treatment to an individual with a disability.

Socio Economic disadvantage

The Health and Social Care Act 2012 requires health authorities to give regard to the need to reduce inequalities *between* patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

It's a 'regard' duty which echoes the requirements of the PSED to some extent (duty to reduce inequalities of access and outcomes among patients; report on what we are planning to do to reduce inequalities) but it relates to characteristics that are not currently covered by the PSED in Great-Britain – people's socio-economic background.

Health inequalities may be driven by:

- Different experiences and distribution of the wider determinants of health or structural factors. e.g., the environment, community life, income or housing.
- Different exposure to social, economic and environmental stressors and adversities. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.
- Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions.
- Unequal access to, or experience of, health and other services between social groups.

Involvement duties on commissioners and providers

To reinforce the importance and positive impact of working with people and communities, NHS England, ICBs and trusts all have legal duties to make arrangements to involve the public in their decision-making about NHS services. The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:

- section 13Q for NHS England
- section 14Z45 for ICBs
- section 242(1B) for NHS trusts and NHS foundation trusts.

A requirement to involve the public is also included as a service condition in the NHS Standard Contract for providers. Each of the organisations listed above is accountable and liable for compliance with their public involvement obligations. However that does not mean that each organisation should carry out its public involvement activities in isolation from others within the ICS and beyond. Plans, proposals or decisions will often involve more than one organisation, particularly in respect of integration and service reconfiguration, in which case it is usually desirable to carry this out in an joined up and co-ordinated way, reducing the burden on both the public and the organisations themselves.

The legal duties require arrangements to secure that people are 'involved'. This can be achieved by consulting people, providing people with information, or in other

ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.

Neither the legal duties, nor this statutory guidance, seek to prescribe exactly how to involve people in any given case. Indeed, what is necessary will always depend upon the circumstances. Therefore, while this guidance is ambitious in its intent, it is not intended to place additional legal obligations on organisations and does not mandate that organisations may only discharge their duties in a particular way.

Health and Care Act 2022

Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in—
(a) The planning of the provision of those services,
(b) The development and consideration of proposals for changes in the way those services are provided, and
(c) Decisions to be made by that body affecting the operation of those service

*I*n England the National Health Service Act 2006, as amended, requires due regard to be given to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

In 2022, further provisions were introduced by the Health and Care Act 2022 included a statutory performance and reporting framework including health inequalities and promotion of integration and partnership-working to improve health and tackle health inequalities. Working in partnership with people and communities: Statutory guidance (Working in partnership with people and communities: Statutory guidance) reinforces the importance and positive impact of working with people and communities. Additionally it states that NHS England, Integrated Care Boards and NHS Trusts have legal duties to make arrangements to involve the public in their decision-making about NHS services, as well as the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources.

Social Value

The Public Services (Social Value) Act 2012 requires people who commission public services to think about how they can also secure wider social, economic, and environmental benefits. Before they start the procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.
The Act is a tool to help commissioners get more value for money out of procurement. It also encourages commissioners to talk to their local provider market or community to design better services, often finding new and innovative solutions to difficult problems.

Human Rights

The Human Rights Act 1998 (HRA) - rights and freedoms are set out in the European Convention on Human Rights, a treaty that has been in force since 1953 and are underpinned by what we call the 'FREDA' principles:

Fairness - Respect - Equality - Dignity - Autonomy

It requires that all public authorities must follow the Human Rights Act when they plan services, make policies and take decisions. There are 16 basic rights protected by the Human Rights Act, of which 4 most relevant are:

- **Article 2** - The right to life
- **Article 3** - Freedom from torture and inhuman treatment (such as serious physical or psychological abuse in a health or care setting and degrading treatment such as treatment that is extremely humiliating and undignified). Whether treatment reaches a level that can be defined as degrading depends on several factors. These include the duration of the treatment, its physical or mental effects and the sex, age, risk factors and health of the victim. This concept is based on the principle of dignity - the innate value of all human beings.
- **Article 8** – The right to respect for your private and family life, your home, and your correspondence.
- **Article 14** requires that all of the rights and freedoms set out in the Act must be protected and applied without discrimination.

  Both articles 2 and 3 are absolute rights (can never be interfered with in any circumstances) as opposed to 8 and 14 which are limited and qualified rights.

Appendix 4: Glossary of terms

Policies – The sets of principles or criteria that define the different ways in which an organisation carries out its role or functions and meets its duties. Policies also include formal and informal decisions made in the course of their implementation.

Functions– The full range of activities carried out by the Trust to meet its duties.

Activity – The term used, for the purpose of EIAs, when referring to any policy, function, procedure, service or initiative within the Trust in connection with the delivery of healthcare and the employment of our workforce.

Protected characteristics - This is a term from the Equality Act 2010 and refers to groups including age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

The Trust also considers the needs of groups that face inequalities in service delivery

Equality Monitoring - The process of gathering and analysing data on the various protected groups Equality monitoring can include some or all of the equality strands.

Positive Impact– Something that has a positive effect on one or more group. For example, a targeted training programme aimed at people with disabilities, to improve representation within the workforce.

Negative Impact– Something that could disadvantage people from one or more group. For example, complaints must be made in writing, which means some groups could be excluded such as people with disabilities, non-English speakers etc

Consultation– Consultation is a means of giving our staff and service users a 'voice' and gaining a clear idea of their needs in order to bring about change, and an improvement in the service they receive. Consultation methods might include: Focus groups, surveys, interviews, use of community venues, informal meetings, patient feedback sheets, special interest groups/meetings (young people, gypsies etc), lay advisory groups, PALs, Local Healthwatch.

Objective Justification– Where an activity which excludes a group/sis allowed to continue due to exceptional circumstances and may initially seem unacceptable. For example, if a service is provided to children between the ages of 2-6 years, and not other age groups. This may be due to the funding being ring fenced for that particular age group. It may even be that NICE guidelines recommend that the service is provided in such a way.

Appendix 5: Protected Characteristics & Inclusion Health Groups

In line with the Equality Act, we need to assess the impact of decisions on individuals with protected characteristics. These include:

Age
Ageism is prejudice or discrimination on the grounds of a person's age and can affect anybody, regardless of their age.

Disability
A person has a disability (by law) if they have a : physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities, is substantial and expected to last for more than 12 months.

Gender reassignment
Gender reassignment is a personal, social, and sometimes medical process. . Anyone who proposes to, starts or has completed a process to change his, her or their gender is protected from discrimination under the Equality Act. A person does not need to be undergoing medical supervision to be protected. So, for example, a woman who identifies as a man can decide to live as a man without undergoing any medical procedures would be covered. Trans is an umbrella term that identifies the spectrum of those who feel that their assigned sex at birth does not match or sit easily with their sense of self. Gender identity could include (but is not limited to) gender queer, non-binary, or agender.

Marriage and civil partnership
This is the relationship between two people who are husband and wife, or people of the same sex (as defined by Marriage (Same Sex Couples) Act 2013).Civil partners must be treated the same as married couples on a wide range of legal matters.

Pregnancy and maternity (adoption is covered within this) Pregnancy is being pregnant or expecting a baby. Maternity is the period after the birth or adoption and is linked to maternity and adoption leave in the employment context.

Race
Race characteristics refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.

Religion and belief
Religion refers to any religion while belief comprises religious and philosophical beliefs including lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Sex
This is defined as a person's legal sex, in the UK this is recognised as either being a man or a woman. Sex is more commonly referred to as gender identity, which is the internal sense of being male, female, a combination of male and female, or neither male or female.

Sexual orientation

Refers to a persons' orientation or attraction towards; the same sex, opposite sex or to both sexes.

People in inclusion health groups include:

- Carers
- Gypsy, Roma, and Traveller communities
- Looked after children and young people.
- Other marginalised groups
- People in contact with the justice system - offenders in prison/on probation, ex-offenders
- People who experience homelessness - people on the street; staying temporarily with friends/family; in hostels/B&Bs with no fixed abode.
- People with drug and alcohol dependence
- Sex workers
- Victims of modern slavery
- Vulnerable migrants and refugees

People in other groups who face health inequalities including:

- Low income families
- limited internet access,
- Poor literacy lack digital skills
- veterans,
- Living in remote, rural and island locations.
- Living in deprived areas.