BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC / PRIVATE

To be held at 13:00 on Thursday 26 September 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB107/24	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB108/24	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*		
TB109/24	**Declaration of Interests concerning agenda items** *Purpose: To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB110/24	**Minutes of the previous meeting** a) Meeting held on 25 July 2024 *Purpose: To **approve** the minutes of the previous meetings*	*Report*	Chair	
TB111/24	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included anywhere on agenda, review outstanding and approve completed actions.*	*Report*	Chair	
WELL LED FRAMEWORK				
TB112/24	**Chair's Report** *Purpose: To **receive** the Chair's Report.*	*Verbal*	*Chair*	**13:20** (10 mins)
TB113/24	**Consent Agenda** a) Complaints Annual Report b) Staff Health and Wellbeing Report *Purpose: To **receive** items on the Consent Agenda*	*Verbal*	*Chair*	**13:30**

TB114/24	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report.*	*Report*	*F Noden*	**13:30** (10 mins)

IMPROVING CARE, TRANSFORMING LIVES

TB115/24	**Integrated Performance Report** *Purpose: To **receive** the Integrated Performance Report*	*Report*	*Exec Directors*	**13:40** (10 mins)
TB116/24	**Quality Assurance Committee Chair's Report** *Purpose: To **receive** assurance on the work delegated to the Committee.*	*Report*	*QAC Chair*	**13:50** (05 mins)
TB117/24	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme*	*Report*	*CNO*	**13:55** (10 mins)
TB118/24	**Organ Donation and Transplantation Report** *Purpose: To **receive** the Organ Donation and Transplantation Report*	*Report*	*Medical Director*	**14:05** (10 mins)
TB119/24	**NHS England Self-Assessment for Placement Providers 2024** *Purpose: To **receive** the NHS England Self-Assessment for Placement Providers 2024*	*Report*	*Medical Director*	**14:15** (10 mins)

A GREAT PLACE TO WORK

TB120/24	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:25** (05 mins)
TB121/24	**Workforce Race Equality Standard and Workforce Disability Equality Standard Reports** *Purpose: To **receive** the WRES and WDES Report.*	*Report*	*DOP*	**14:30** (10 mins)

TB122/24	**Anti Racist Framework: Statement of Intent** *Purpose: To **receive** the Anti Racist Framework: Statement of Intent*	*Report*	*DOP*	**14:40** (10 mins)
TB123/24	**Appraisal and Revalidation Report** *Purpose: To **receive** the Revalidation Report*	*Report*	*Medical Director*	**14:50** (10 mins)

COMFORT BREAK (10 mins)

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB124/24	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**15:15** (05 mins)
TB125/24	**Audit and Risk Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Verbal*	*Audit Chair*	**15:20** (05 mins)
TB126/24	**Charitable Funds Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*CFC Chair*	**15:25** (05 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE

TB127/24	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*SOC Chair*	**15:30** (05 mins)
TB128/24	**Winter Plan** *Purpose: To **receive** the Winter Plan.*	*Report*	*COO*	**15:35** (10 mins)

A POSITIVE PARTNER

TB129/24	**Questions to the Board** ***Purpose:** To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:45** (05 mins)

TB130/24	**Feedback from Board Walkabouts**	*Verbal*	*Members*	**15:50** (10 mins)
	Purpose: *To* ***receive*** *feedback following walkbouts.*			
CONCLUDING BUSINESS				
TB131/24	**Messages from the Board**	*Verbal*	*Chair*	**16:00** (05 mins)
	Purpose*: To agree messages from the Board to be shared with all staff.*			
TB132/24	**Any Other Business**	*Report*	*Chair*	**16:05** 10 mins)
	Purpose: *To* ***receive*** *any urgent business not included on the agenda*			
	Date and time of next meeting:			***16:15*** ***close***

- Thursday 28 November 2024

Chair: Niruban Ratnarajah

NHS Bolton NHS Foundation Trust

Name:	Position:	Interest Declared	Type of Interest
Francis **Andrews**	Medical Director	Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest
Seth **Crofts**	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
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
		Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).	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
		Lead for GP Strategy and Placements at the University of Bolton	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Nothing to declare	
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

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 25 July 2024
(Subject to the approval of the Board of Directors on 26 September 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
Francis Andrews	FA	Medical Director
Jackie Njoroge	JN	Deputy Chair /Non-Executive Director
James Mawrey	JM	Director of People and Deputy CEO
Martin North	MN	Non-Executive Director
Rae Wheatcroft	RW	Chief Operating Officer
Sean Harriss	SH	Non-Executive Director
Seth Crofts	SC	Associate 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 Nursing Officer

In Attendance

Name	Initials	Title
Charlotte Rowson	CR	Staff Nurse in Emergency Medicine (for item 085)
David Fletcher	DF	Head of Nursing for Emergency Care (for item 085)
Janet Cotton	JC	Director of Midwifery (for item 094)
Louise Cartin	LC	Freedom to Speak Up Guardian (for item 098)
Rachel Carter	RC	Associate Director of Communications and Engagement
Tracey Garde	TG	Freedom to Speak Up Guardian (for item 098)
Victoria Crompton	VC	Corporate Governance Manager

There were four observers in attendance.

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		

TB0084/24 **Chair's Welcome and Note of Apologies**
The Chair welcomed everyone to the meeting of the Board and noted apologies from Rebecca Ganz.

TB085/24 **Patient and Staff Story**

David Fletcher, Staff Nurse in Emergency Medicine attended to present the patient story of Keith. The presentation provided a personal insight into Keith's life and family, and outlined his previous medical history. It also drew attention to Keith's negative experience of the Emergency Department, which included a 13 hour wait spent in a wheelchair within the waiting room. The significant impact on Keith's quality of life resulting from the long wait was highlighted, and the family stated that they wanted to share their story to provide a learning opportunity for the Trust.

DF advised the division had recognised there were a number of missed opportunities particularly around communication, and had taken away the importance of the story and how staff communicate with patients and their families.

TR stated that colleagues within the department had been holding patient forums to ascertain what could be done to improve the patient experience within the department.

Staff Story

Charlotte Rowson, Staff Nurse presented her staff story of working in the Emergency Department advising that over the previous three years there had been an increase in pressures within the department which had impacted on staff and the care that they were able to provide. This was difficult for colleagues within the team. The waiting area was one of the most challenging areas to work and she felt staffing within this area should be protected as having correct staffing helped with the pressures being faced.

TF queried whether the staff within the Emergency Department had adequate access to pastoral care. CR confirmed the team received a lot of support from various sources.

AS asked whether staff were consulted on and involved in any changes within the department. CR advised that colleagues felt listened to and supported and were able to suggest changes for improvement. The team were constantly considering what changes can be made to enhance the patient and staff experience.

In response to a query from FA, CR advised that the thing she was most proud of was the small things that she did to care for and support patients.

NR thanked DF and CR for their continued work to care for patients under such pressures and gave assurance that the Board was aware of the difficulties they faced and acknowledged their amazing work.

RESOLVED:

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

TB086/24 **Declarations of Interest**

The Board noted FN's declaration as Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity and Neonatal System (LMNS) with regards to the CNST paper. The declaration was noted on the register.

There were no other declarations of interest relating to agenda items.

TB087/24 **Minutes of the previous meetings**

The Board of Directors reviewed the minutes of the meeting held on 30 May 2024 and approved them as a correct and accurate record of proceedings.

RESOLVED:

The Board of Directors ***approved*** the minutes from the meeting held 30 May 2024.

TB088/23 **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

TB089/24 **Chair's Update**

The Chair advised this would be Jackie Njoroge's final Board of Directors meeting before completing her tenure as Non-Executive Director and Deputy Chair. Jackie joined the Trust in September 2016 and held roles including Chair of Audit Committee and latterly as Chair of Finance and Investment Committee. The Board of Directors thanked JN for her support to the organisation over the previous eight years.

RESOLVED:

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

TB090/24 **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:

- The Trust's services for Children and Young People with Special Educational Needs and/or Disabilities (SEND) were inspected in July. The inspection was carried out jointly by Ofsted and the Care Quality Commission (CQC). The Trust was awaiting the formal report.
- The organisation was part of a pilot scheme to feed parents and carers who found themselves staying at the hospital whilst their children were being cared for. Sophie's Legacy was created in memorial of Sophie Fairall who was just nine years old when she was diagnosed with Rhabdomyosarcoma, a rare form of childhood cancer. This meant she and her parents spent a lot of time in hospital.

RESOLVED:

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

TB091/24 Operational Update (including Integrated Performance Report)

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

- Urgent and emergency care continued to be the main operational focus. Whilst actions had been implemented at pace, tangible improvements in the data had been slow, however, there were some early signs of improvement.
- Despite a 13% increase in ambulance attendances there had been an improvement in both 15 and 60 minute ambulance handovers.
- Four hour performance continued at a consistent rate with a 0.7% improvement in June. Performance had been in the bottom 5% of trusts nationally. However, following the start of the improvement journey with ECIST some marginal improvements had been made.
- Community services offered a service to respond for urgent care in the community within two hours of referral. The national expectation was 70% of patients referred and the Trust achieved 95.1% for June.
- The Trust still had a small number of patients who had waited over 78 weeks for treatment. It was expected there would be no patients waiting more than 65 weeks for treatment by the end of September.
- The Trust achieved the 28 day faster diagnosis standard for cancer and the 31 day treatment standard. There remained work to do to consistently achieve the 62 day performance standard.

Quality and Safety

The Chief Nurse and Medical Director provided an update on Quality and Safety advising that:

- Zero in-patient category 3 pressure ulcers in 18 months and zero in-patient category 4 pressure ulcers in 13 months.
- A focus on service user/patient experience to ensure all voices were heard was launched at the annual Chief Nurse conference.
- The birth-rate plus business case was approved which led to increased midwife and maternity support worker establishment.

The Chief Nurse provided an update on the Clostridium Difficile and the actions which had been taken to date, he also outlined the suggested next steps which would be taken following the outcome of the antimicrobial stewardship audit at the end of August.

Financial Performance

The Chief Finance Officer advised that a high-level forecast suggested a deficit of £25.5m compared to the plan of £10.2m before mitigations/delivery of the Cost Improvement Programme (CIP). The most likely scenario after mitigations was £4.9m worse than plan.

Workforce

The Director of Workforce provided an update on workforce, advising that:

- Turnover had been stabilised, but needed to reduce further to achieve target.
- Mandatory training and appraisal rates exceeded the targets.
- Agency spend remained under target and there had been strong recruitment to clinical vacancies.

JN queried the 13% increase in ambulance attendances and whether the increase was reflected across Greater Manchester. RW confirmed the organisation had seen a greater increase than other trusts and this had been escalated to commissioners and North West Ambulance Service NHS Trust (NWAS). Assurance had been received that patients being brought to the organisation were appropriate.

AS asked whether the issues around achieving the 65 week wait target could be achieved if further funding was made available. RW explained that the financial assumptions for the current financial year were included in the Operating Plan and was part of the work completed to support the achievement of the elective recovery. It was too late to add increased activity for September but was worth some consideration for the remainder of the financial year. Achievement of the 65 week target would be difficult as there were operational issues which could occur that made success difficult. The Trust had requested mutual aid from partners, and RW added

that all patients on the list were risk stratified, but more consideration could be given to factoring in health inequalities.

In response to a query from FLT, FA advised that Fractured Neck of Femur data did not show an increase in mortality. Not all surgeons within the organisation were specialised which could increase the wait for treatment, but the Division had been asked to review data due to the increased waits for treatment.

NR queried the reduction in safeguarding training which TR confirmed was a capacity issue which the team were aware of and were working to address.

Board members acknowledged the work of the Integrated Care Division to support the Emergency Department deflections.

RESOLVED:

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

TB092/24 **Strategy and Operations Committee Chair Report**

Sean Harriss provided a verbal update from the Strategy and Operations Committee held on 22 July 2024, the key points highlighted were:

- There were two alerts raised in relation to urgent care and the elective recovery position. In relation to urgent care it was noted there would be increased scrutiny from NHSE and for elective recovery the waiting list was being micromanaged at individual case level.
- The committee received the Digital Strategy Annual Report and noted the risks to the delivery of the strategy due to the digital resource available.
- The Maternity EPR business case was presented and recommended by the committee to be submitted for approval.

RESOLVED:

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

TB093/24 **Quality Assurance Committee Chair's Report**

Fiona Taylor provided a verbal update from the proceedings of the Quality Assurance Committee, which was held on 24 July 2024. The key points highlighted were:

- The committee received the Learning from Deaths Report and the Mortality Quarterly Report.

- An update was received on actions to address and improve Clostridium Difficile rates.
- The committee approved the BOSCA platinum application process.

RESOLVED:

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

TB094/24 **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme**

The Director of Midwifery presented the report which provided 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). It was confirmed that formal receipt of the payment from the CNST year 5 scheme had been received.

The CNST year 6 scheme guidance was launched on 02 April 2024 with an associated benchmarking tool. The service was progressing well with all ten safety actions and had fully attained three of the 84 recommendations. Work was progressing with the remaining 81 recommendations.

Further work was required to meet the required 90% standard for relevant staff groups with regard to multi-professional training. In response the service had scheduled additional training sessions to accommodate the upcoming demand and leads were utilising trajectories of performance to forecast the improvement.

The dashboard highlighted an increased incidence of stillbirth during the month of May 2024. This related to four cases in total of which one mother declined care, two of the cases related to foetal abnormality and one case related to the management of maternal raised blood pressure that was still under review.

JC advised that the Division was confident that due to the robust systems put in place last year to support the achievement of the CNST objectives, they could be achieved again this year.

AS commented on a recent visit to the Antenatal Department it had been highlighted during staff feedback that some patients were opting to receive care outside of clinical guidance. JC advised that the issue had been raised with the Local Medical Council (LMC) and was also being considered nationally. The Division had put support in place for staff.

RESOLVED:

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

TB095/24 **Learning from Deaths' Report**

The Medical Director presented the report advising that during the quarter 39 cases were reviewed. Three cases that underwent secondary review were discussed and it was determined that any issues with care did not contribute to their deaths.

It was noted that patients from Mental Health and/or social care facilities were admitted despite them having comorbidities or diagnoses that indicated them being at the end of their lives. Therefore, there was an opportunity to enhance advance care planning processes and work with community colleagues to reduce the admission of patients to hospital during this phase of their lives.

Further analysis of data presented showed that although overall numbers of cases reviewed had fallen, there was no significant variation in the overall rating of cases. In fact, there has been a slight increase in those rated good or excellent over the course of this year. The case completion rate remains lower than required and this needs to be reviewed.

RESOLVED:

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

TB096/24 **Mortality Quarterly Report**

The Medical Director presented the report which provided an update on the recent mortality metrics and details of key actions and priorities for improving the metrics. The key points were highlighted:

- SHMI (NHS Digital published figures) showed the Trust at 111.45, which was in the 'Expected' range.
- The trend in HSMR had worsened slightly to an 'amber' alert at 107.46
- The crude rate remained at a similar level as compared to last year.
- There had been a change in the methodology used to calculate SHMI, this now included all patient stays with a Covid diagnosis (previously excluded).
- Covid-19 was alerting 'red' following the methodology change and would undergo a full clinical and coding review.
- Assurance had been provided for diverticulosis/diverticulitis and pneumonia.

RESOLVED:

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

TB097/24 People Committee Chair's Report

Tosca Fairchild presented the Chair's Report detailing proceedings from the People Committee meeting held on 16 July 2024. The following key points were highlighted:

- The Committee received an update on the Our Voice Change Programme which was constantly evolving to ensure the Trust took on board on-going feedback. The programme would be a key enabler in delivering the Trust's ambition to be a 'Great Place to Work'.
- Launch events for the Our Leaders Programme were being held and an update would be brought back to People Committee in September. It was requested that IFM be included in this programme from the inception.
- The Anti-Racism Framework outlined the actions to change racial inequality in the workplace, services and organisational cultures. All NHS Trusts and Integrated Care Boards (ICB's) in the region were expected to adopt the framework by March 2025. The Trust was able to demonstrate achievement of some deliverables in each of the three Bronze, Silver and Gold awards, but must meet all deliverables in the individual category to progress to the next level. The People Committee supported that the Trust should make a submission for Bronze status in April 2025 and move forward to then progress to Silver and Gold status.

RESOLVED:

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

TB098/24 Freedom to Speak Up Annual Report

Tracy Garde, Freedom to Speak Up Guardian presented the report which outlined Freedom to Speak Up (FTSU) activity within the Trust during the period from 01 April 2023 to 31 March 2024. During the reporting period 201 cases were reported through the FTSU route in comparison to 186 the previous year.

The FTSU Guardians welcomed the support provided by the organisation advising that regular meetings continued to take place with Divisional leads and also the meetings with the Chief Executive, Deputy Chief Executive and Non-Executive Directors were helpful in identifying any blockages in resolution.

NR thanked the Freedom to Speak Up Guardians for their continued work during what was a difficult period for the organisation and highlighted that the report showed confidence in the process.

RESOLVED:

The Board of Directors ***received*** the Freedom to Speak Up Annual Report

TB099/24 **Finance and Investment Committee Chair Report**

Jackie Njoroge presented the Chair's report from the Finance and Investment Committee held on 22 May and 26 June 2024, and provided a verbal update on the key points from the meeting held on 22 July 2024 advising that the main focus of the meeting had been on the delivery of the Cost Improvement Programmes (CIP).

RESOLVED:

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

TB100/24 **Audit and Risk Committee Chair's Report**

Alan Stuttard presented the Chair's report from the Audit and Risk Committee held on 08 May and 26 June 2024 and thanked the Director of Corporate Governance and team for their work on annual assurance reports which had been completed.

RESOLVED:

The Board of Directors ***received*** the Audit and Risk Committee Chair's Report.

TB101/24 **Audit and Risk Committee Annual Report**

Alan Stuttard presented the report which provided a summary of the activities of the Audit and Risk Committee and how the Committee met its terms of reference and key priorities in 2023/24.

RESOLVED:

The Board of Directors ***received*** the Audit and Risk Committee Annual Report

TB102/24 **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.

- MN had visited Lever Chambers Health Centre and advised there was an opportunity to make better use of the building. Issues raised were around connectivity of digital devices.
- AS had visited Endoscopy and Antenatal and there were some processes which would benefit from being digitalised for both services. There were some very positive examples of team working. The literature available for patients was only available in English and TR advised that there was a feature on-line which would translate the information.

- SH visited theatres and Pharmacy. There were environmental issues affecting Pharmacy but the team were impressive in maximising capacity.
- JN had visited the Churchill Unit and issues feedback were around space and people smoking behind the unit.
- SC visited C2 and the mortuary and commented the environment in the mortuary had been made very nice for families.

RESOLVED:

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

TB103/24 **Annual Counter Fraud Report**

The Annual Counter Fraud Report was received following approval at the Audit and Risk Committee.

RESOLVED:

The Board of Directors ***received*** the Annual Counter Fraud Report.

CONCLUDING BUSINESS

TB104/24 **Questions to the Board**

There were no questions to the Board of Directors received.

TB105/24 **Messages from the Board**

The following key messages from the Board were agreed:

- Freedom to Speak Up
- Continued efforts of staff despite the challenges being faced
- Pressure ulcers

TB106/24 **Any Other Business**

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 15:30.

The next Board of Directors meeting will be held on Thursday 26 September 2024.

Meeting Attendance 2024						
Members	Jan	March	May	July	Sept	Nov
Niruban Ratnarajah	✓	✓	A	✓		
Fiona Noden	✓	✓	✓	✓		
Francis Andrews	✓	✓	✓	✓		
James Mawrey	✓	✓	✓	✓		
Tyrone Roberts	✓	✓	✓	✓		
Annette Walker	✓	✓	✓	✓		
Rae Wheatcroft	✓	✓	✓	✓		
Sharon White	✓	✓	✓	✓		
Rebecca Ganz	✓	✓	✓	A		
Jackie Njoroge	✓	✓	✓	✓		
Martin North	✓	✓	A	✓		
Alan Stuttard	✓	✓	A	✓		
Sean Harriss	✓	✓	✓	✓		
Fiona Taylor	A	✓	✓	✓		
Seth Crofts	✓	✓	✓	✓		
Tosca Fairchild	✓	✓	A	✓		
Sharon Katema	✓	✓	✓	✓		
✓ = In attendance		A = Apologies				

May 2024 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/24/04	30.05.24	Patient Flow Presentation	RW to provide an further update on patient flow in six months	RW	Nov-24	

Key

complete	agenda item	due	overdue	not due

Report Title:	Annual Concerns and Complaints Report 2023-2024			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Chief Nursing Officer		Decision	

Purpose of the report	The purpose of the paper is to present the Annual Complaints Powerpoint presentation for 2023-24, detailing the Trust's complaint management performance and highlighting improvements in handling patient concerns and feedback.

Previously considered by:	Clinical Quality and Governance Committee

Executive Summary	Bolton NHS Foundation Trust's Annual Complaints report for 2023/24 reveals significant improvements in complaint management and resolution. The Trust adapted its Concerns and Complaints Policy to align with new NHS complaints standards published by the Parliamentary and Health Services Ombudsman in 2023. Overall case management decreased by 7%, handling 2131 individual cases compared to 2302 in the previous year. Formal complaints saw a 15% reduction, with 188 registered compared to 220 in 2022-23. Informal concerns and enquiries also decreased by 9%. Complaint response performance improved significantly, reaching 78% against a 95% target, up from 50% the previous year. Notably, no complaint exceeded the six-month resolution timeframe set by regulations. The Trust demonstrated enhanced effectiveness in addressing concerns, with only 3% of complainants (6 cases) returning for further resolution, down from 7% (15 cases) the previous year. This improvement suggests increased satisfaction with initial responses. External escalation to the Parliamentary and Health Services Ombudsman remained low, with only two cases referred, of which one was investigated. This indicates effective local resolution processes. These figures reflect the Trust's commitment to improving patient experience and complaint handling, showing progress in addressing concerns efficiently and effectively at the local level.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Annual Complaints report, noting the improvements in complaint handling and response times, and to endorse the Trust's ongoing efforts to enhance patient experience.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**Yes**	The Trust is required to publish an Annual Complaints report in accordance with The Local Authority Social Services and NHS Complaints (England) Regulations 2009."
Health Inequalities	**Yes**	Analysis of complaints data can highlight potential health inequalities. The Trust will use this information to identify and address any disparities in care or access to services across different patient groups.
Equality, Diversity and Inclusion	**Yes**	The complaints process must be accessible to all patients. The report should be reviewed to ensure complaints are representative of the Trust's diverse patient population and that the process is inclusive. Any identified gaps should inform improvements in the complaints handling process**.**

Prepared by:	Tracy Joynson Patient Experience Manager	**Presented by:**	Tyrone Roberts Chief Nursing Officer

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Concerns and Complaints Annual report 2023-2024

Author: Tracy Joynson, Patient Experience Manager

... for a better Bolton

Content

- Executive summary
- Progress in 2022/23
- Trust wide activity
- Divisional activity
- Learning from Complaints
- Our performance
- Quality Monitoring
- How we have improved our services
- Equality Monitoring
- Neighbourhoods
- Our Focus for the Next 12 months

Executive summary

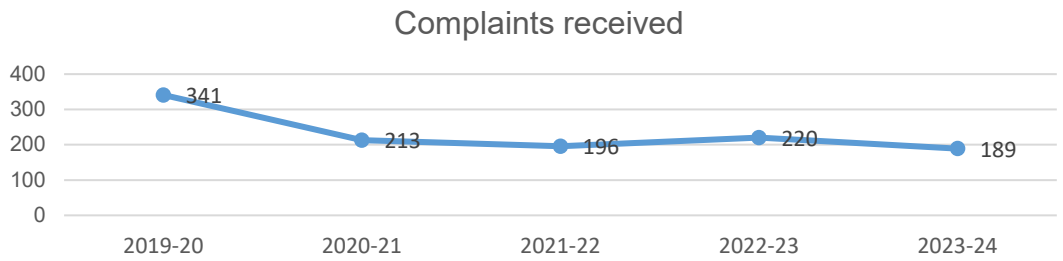
- Bolton NHS Foundation Trust provides Acute Hospital Services; Specialist and General out-patients; Maternity and Women's Health; Emergency Department; and `Community Services.
- The Trust is required to publish an Annual Complaints report in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and this report sets out a detailed analysis of the nature and number of complaints and concerns received by Bolton NHS Foundation Trust from 1st April 2023 to 31st March 2024. It provides key information of our performance in responding to complaints and concerns; what learning has been identified as a result of investigations undertaken and how practice has changed in response to the issues raised through the complaints process.
- The New NHS complaints standards were published by the Parliamentary and Health Services Ombudsman in 2023. A review of our Concerns and Complaints Policy was undertaken with amendments made to reflect the new standards.
- Overall, the team managed 2131 individual cases during 2023-24, which is a decrease when compared to the 2302 individual cases recorded the previous year.
- In 2023-24 there were 189 formal complaints registered. This represented a 16% decrease year on year compared to the 220 received in 2022-23. The team also managed 1942 informal concerns, and 616 enquiries each contact enabling the team to support patients, relatives and carers.

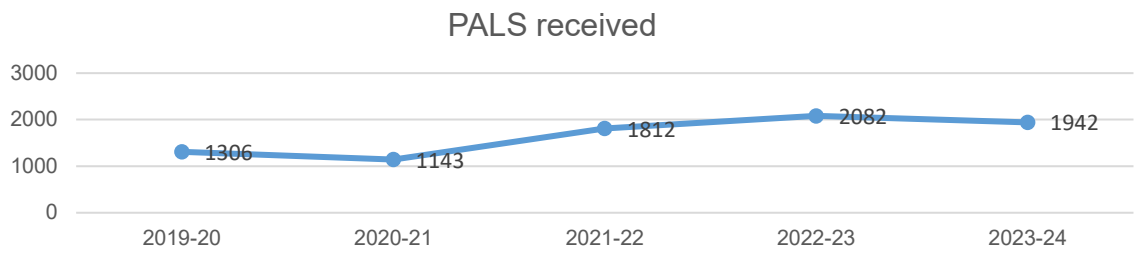
Progress in 2023/2024

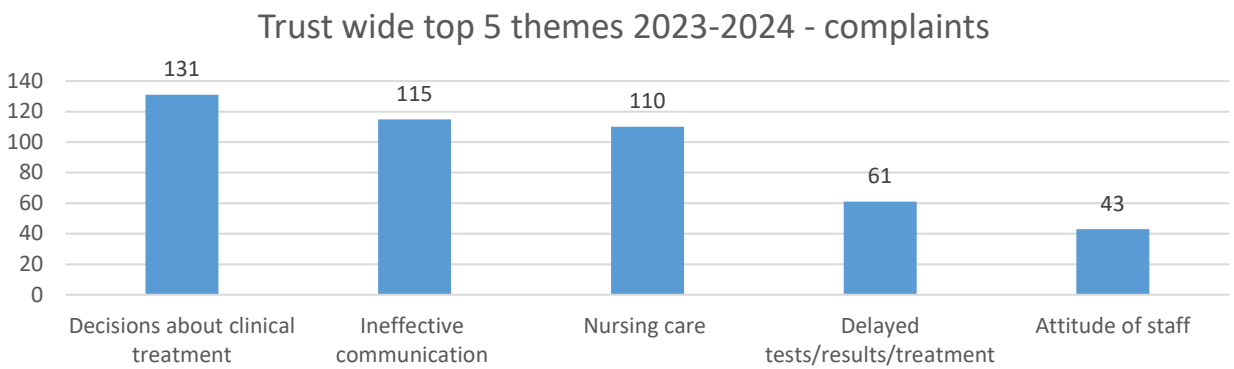
FOCUS	OBJECTIVE	PROGRESS
To have a sustained improvement in complaint response rates	Work with complainants to ensure focused questions/concerns being responded to.	Fully implemented and embedded into practice
	Use digital solutions to resolve concerns earlier.	Not progressed Focus for 2024-2025
To provide a quarterly overview of complaints performance to strengthen oversight and monitoring.	To provide a Complaints quarterly report to Clinical Governance and Quality Committee	Fully implemented and on work plan.
Work collaboratively with the Information Governance Team to find a solution that securely delivers recordings and saves these as per data requirements	Increase the number of complaint outcome resolution meetings to increase service user satisfaction and support earlier resolution	An increase of 22% in year has been achieved.
	Devise a new process for digital recording and sharing of complaint outcome resolution meetings to meet the expectations of services users and the PHSO	Process fully implemented.
Increase of PET input to support divisions in meeting target dates	Ensure regular communication with divisional colleagues and oversight of cases to establish any issues at the earliest opportunity within the process	Weekly reports introduced. Regular monitoring meetings held.
To understand the reason why a complaint may be reopened, and to ensure re-opened complaints are accurately recorded	To perform a full review of any reopened cases to understand why a complainant feels their concerns have not been resolved and whether there are any improvement opportunities for the complaint process.	All re-opened cases reviewed by Patient Experience Manager and any areas of concern discussed with lead Division to identify learning from process.
Support Divisions by providing training packages for complaint leads	Develop and deliver regular training packages for complaints leads to ensure high standards of complaint responses are maintained.	Training delivered to a variety of staff. Improved training programme being developed for 2024-2025

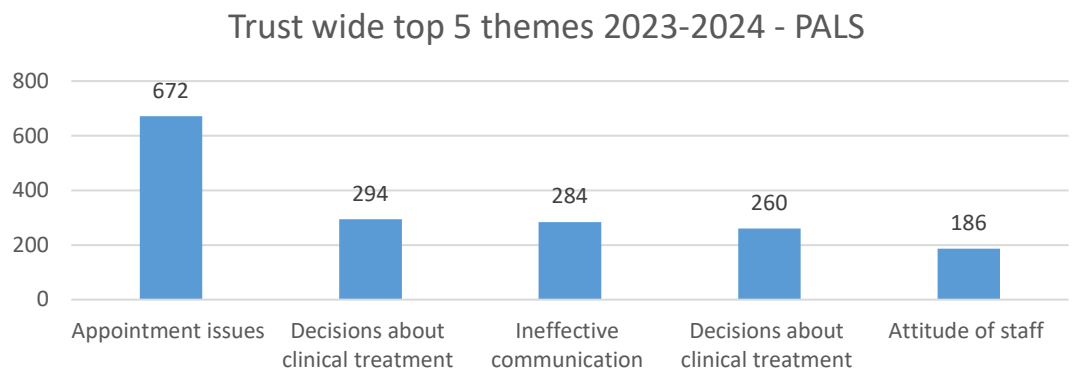
Trust Wide Activity

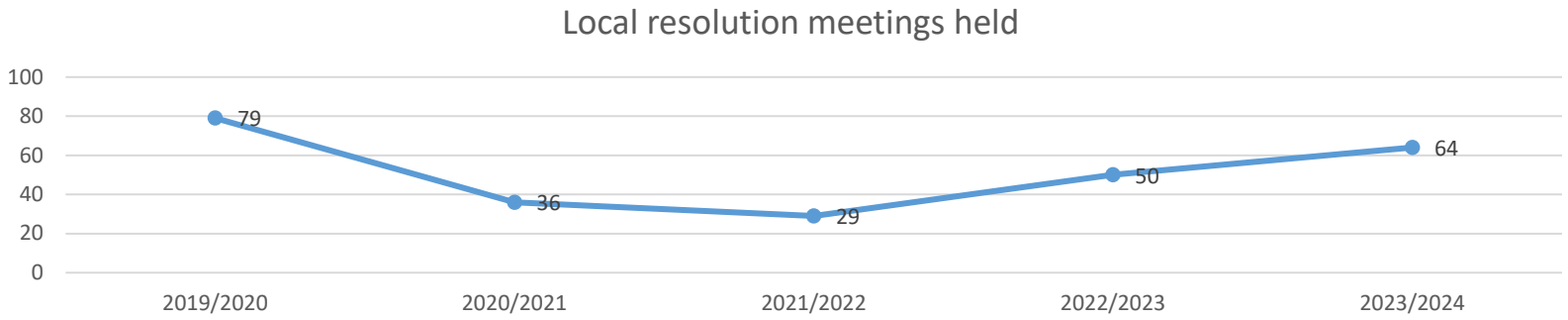
The Royal Bolton Hospital is a major hub in Greater Manchester for women's and children's services and is the second busiest ambulance-receiving site in Greater Manchester





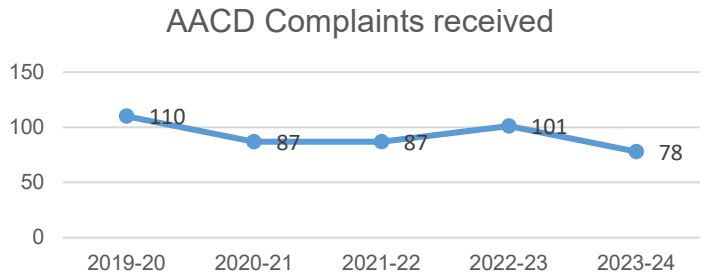


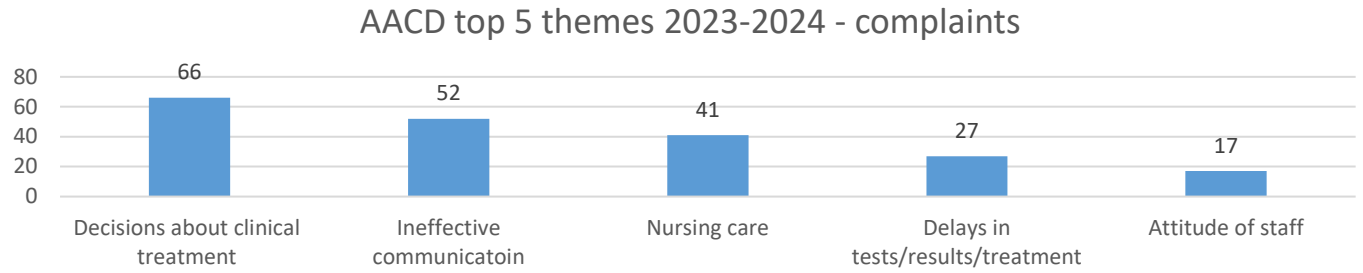


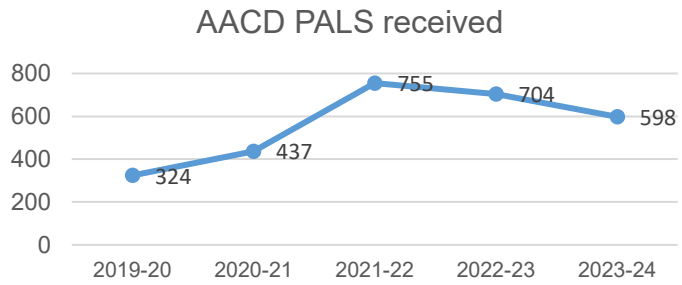


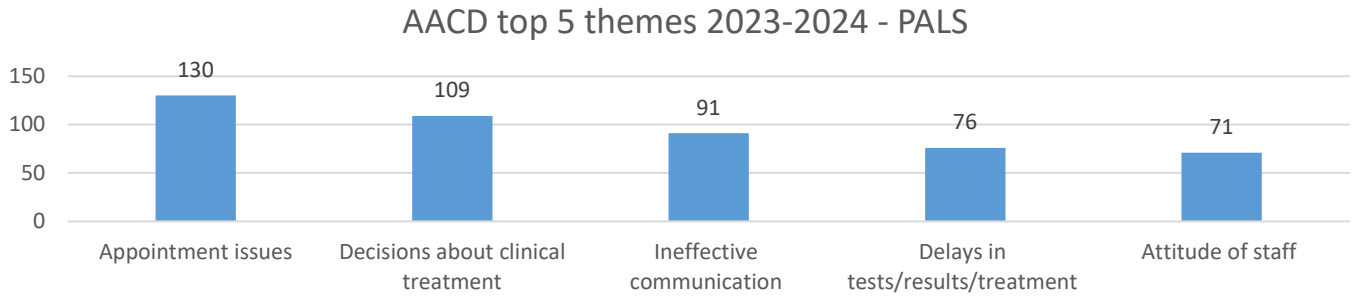
Acute Adult Care Division (AACD) Activity

The Acute Adult Care Division contains the busiest single site Emergency Department in Greater Manchester and has 17 adult inpatient wards providing acute medicine and specialist medical services.





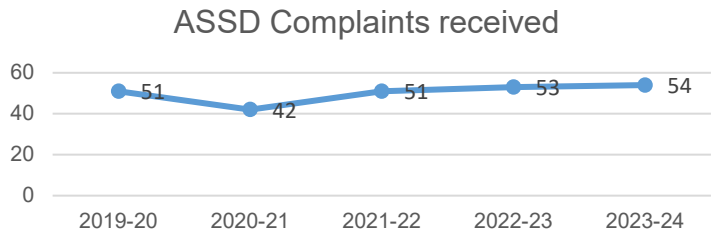


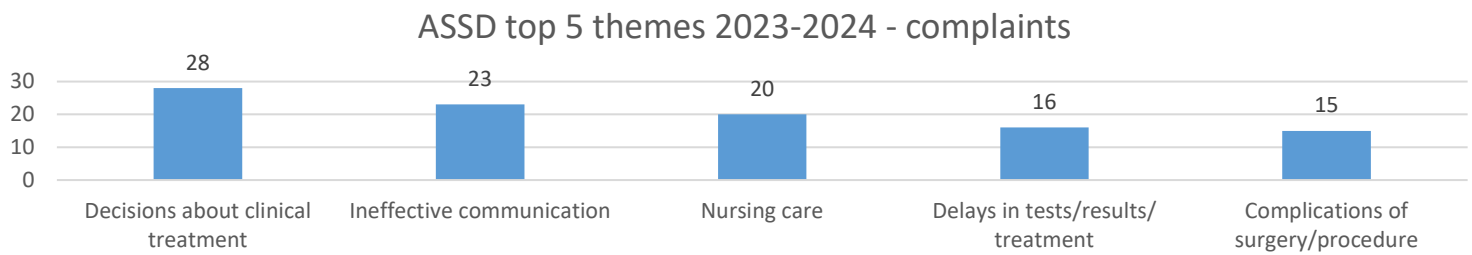


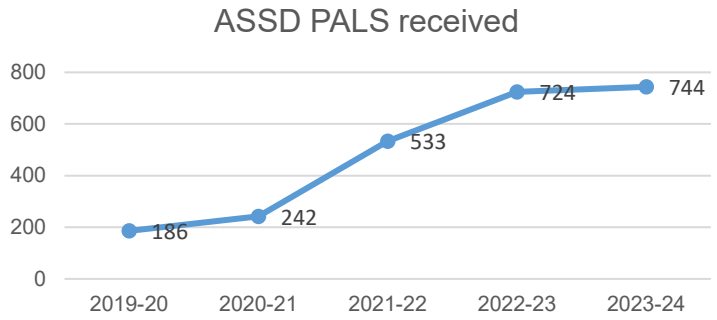
- AACD have seen a reduction in the number of complaints and PALS received when compared with 2022-2023.
- The main theme is from patients raising concerns about decisions made about their treatment which are often linked to ineffective communication and staff attitude.
- The main theme from PALS is in relation to appointment issues where they have been cancelled, re-arranged or the wait is too long.
- Delays in tests/test results or treatment features in both complaints and PALS.

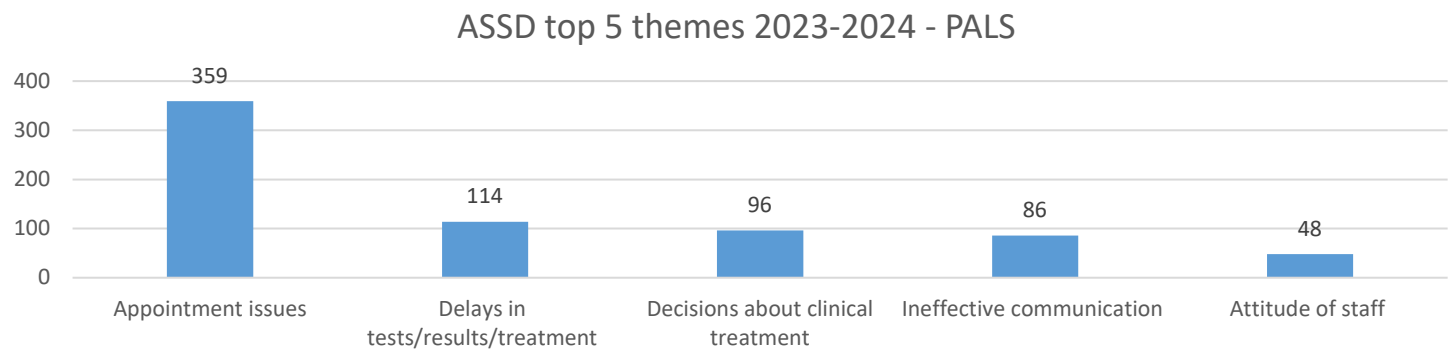
Anaesthetics & Surgical Division (ASSD) Activity

ASSD delivers elective and non-elective specialist care across a wide range of clinical specialties





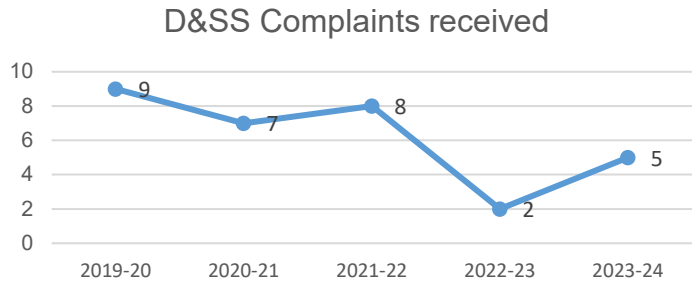


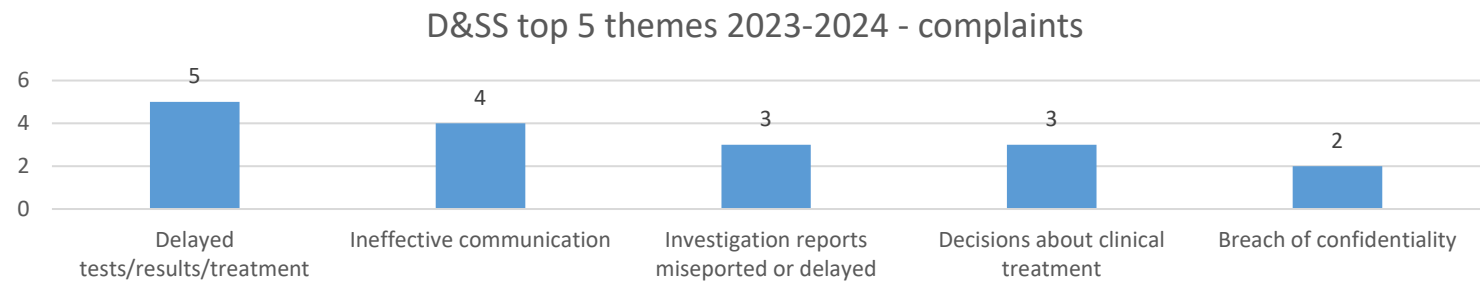


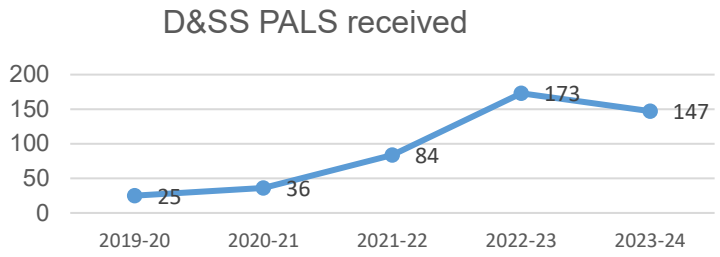
- ASSD have seen a consistent number of complaints over the past 3 years and a steady rise in the number of PALS received over the last two years.
- The main theme from complaints is about decisions made about clinical treatment which includes assessment and investigations.
- The main theme from PALS is in relation to appointment issues which include cancellations and delays.
- Ineffective communication also features in both complaints and PALS.

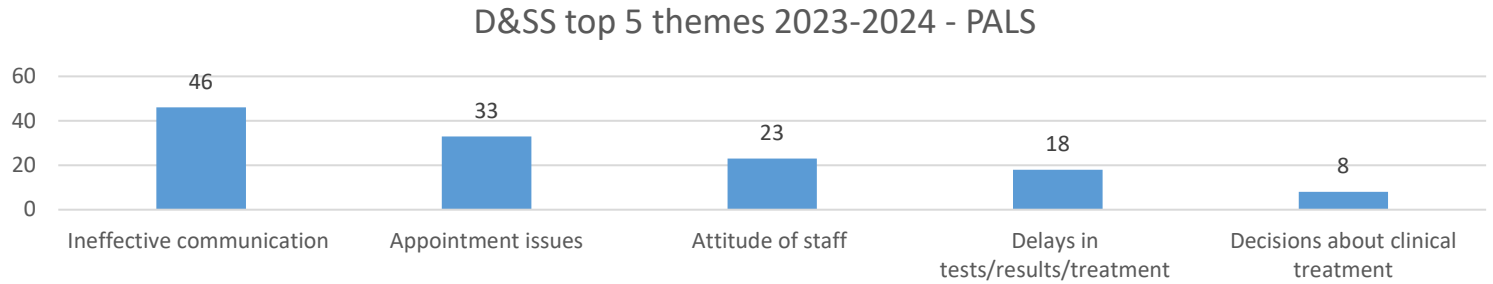
Diagnostics & Support Services Division (D&SS) Activity

D&SSD is a key support for Trust services and interacts with patients on many different inpatient and outpatient pathways. The division operates services including Pharmacy, Laboratory Medicine, Radiology and Infection Prevention and Control.







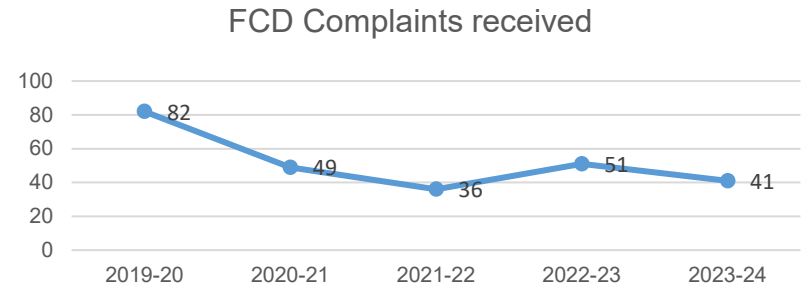


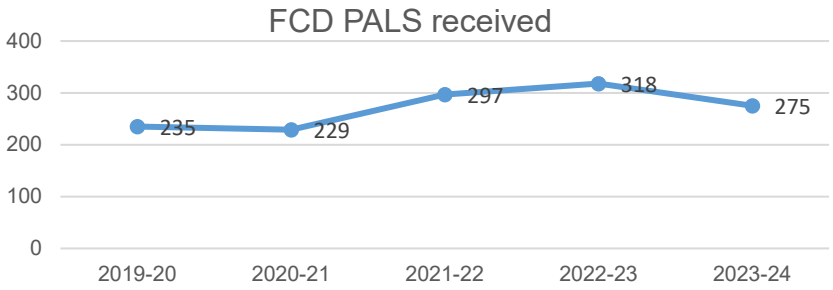
- D&SS have a low number of complaint although they contribute to investigations undertaken by other Divisions where their services are involved.
- There has been a reduction in PALS compared with last year prior to which there had been a steady increase.
- Ineffective communication is a main theme from both complaints and PALS.

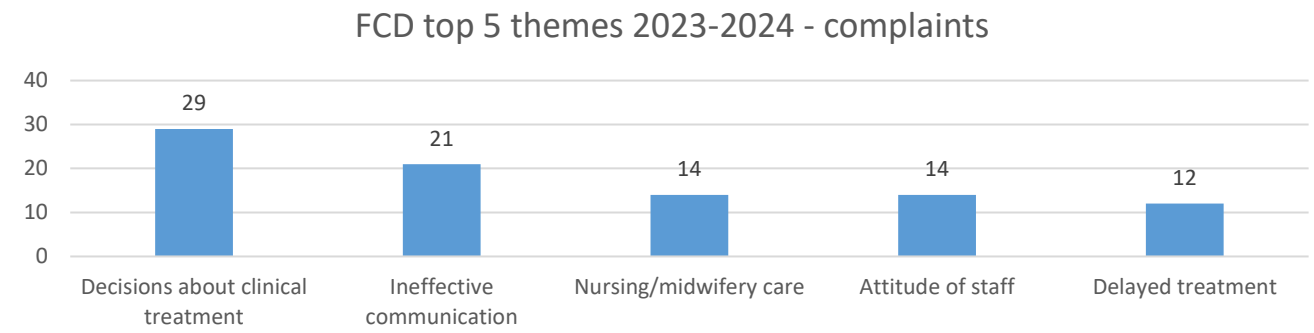
Family Care Division (FCD) Activity

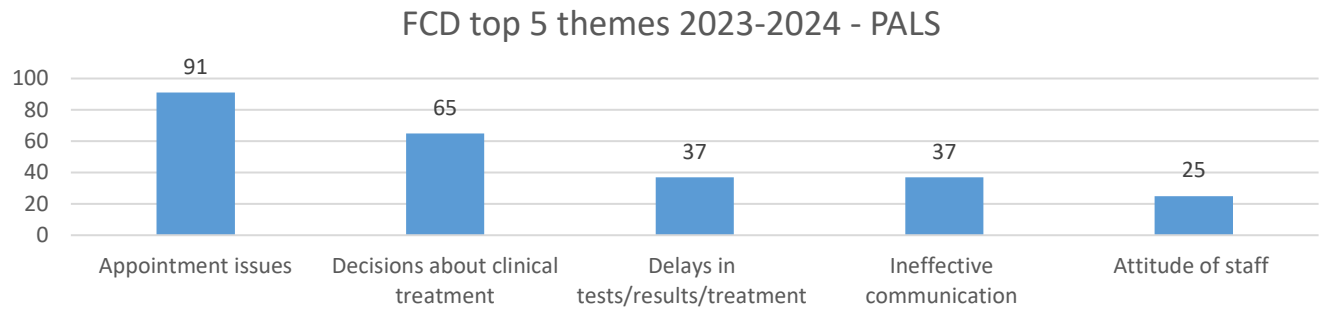
The FCD delivers maternity, neonatal, sexual health, gynaecology and a range of acute and community children's services including hospital and community based children's clinical services, 0-19 Public Health Nursing, Paediatric Allied Health Professionals and Paediatric Learning Disability.

More than 6,000 babies are delivered under our care and we carry out around 1,500 gynaecological procedures each year. We also have a tertiary level Neonatal Intensive Care Unit and a level 2 Paediatric High Dependency service working in collaboration with GM Acute paediatric services.





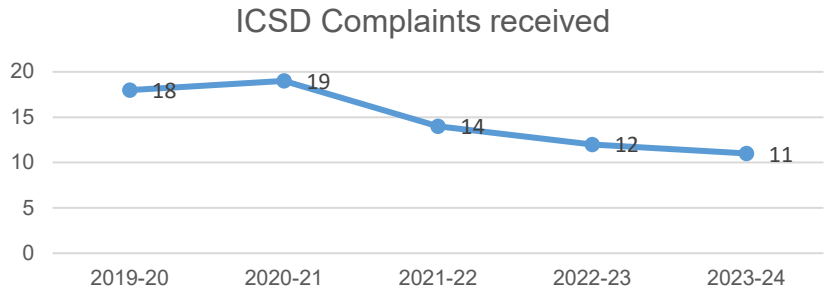


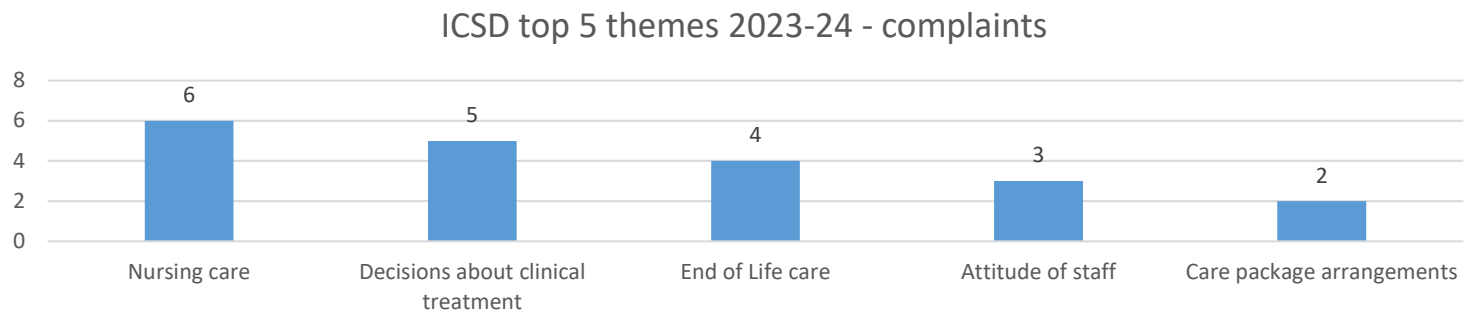


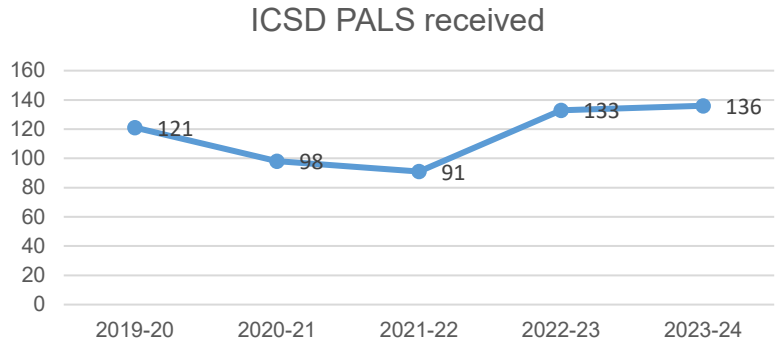
- The FCD have seen a steady number of complaints over the past three years and a reduction in PALS compared with last year.
- Decisions about clinical treatment features as a mina theme in both complaints and PALS which include treatment and investigations.
- Attitude of staff also features in both complaints and PALS.

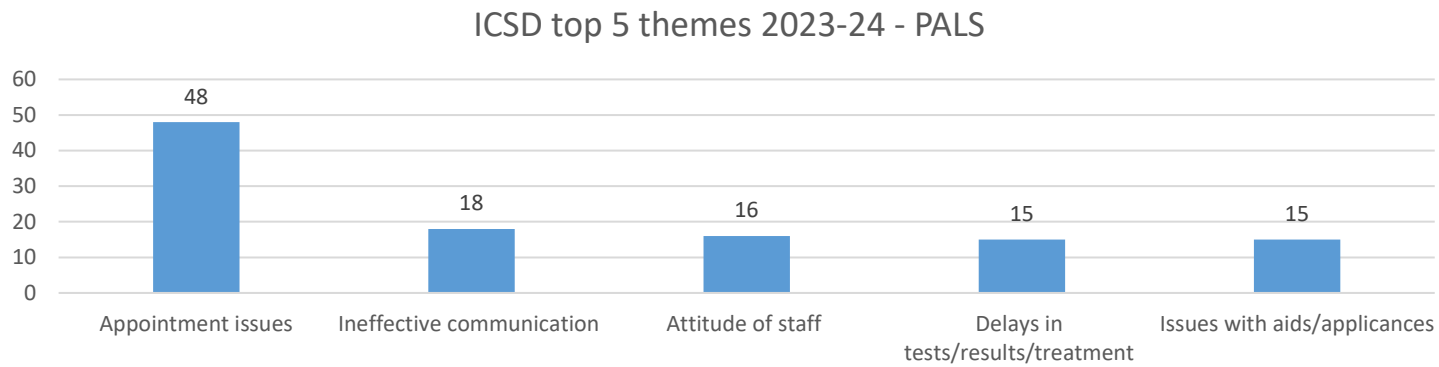
Integrated Community Services Division (ICSD) Activity

ICSD places an emphasis on avoiding hospital attendances and admissions by responding to health and social care issues in our community, which includes providing intensive therapy and re-ablement packages to support our patients' independence.









- The ICSD has seen a steady reduction of complaints over the past four years. PALS has not increased significantly.
- The main theme from complaints is around nursing care in the community either in the patient's home or in a clinic setting.
- Appointment issues remains the top theme for PALS.

Learning from Complaints

Learning from Complaints – AACD

- Concerns and complaints raised about the service provided to patients with learning disabilities/Autism attending our Emergency Department resulted in a number of actions including a sensory room, staff completing the Oliver McGowan training and the development of a working group to further support neurodiverse patients.

- A review of concerns and complaints identified a theme of ineffective communication. As a result of further detailed analysis, a plan has been developed to drive improvement initiatives in relation to communication which will be monitored at Divisional and Corporate level.

Learning from complaints – ASSD

- A specific paediatric audiology test was not carried out on a baby referred to our Audiology Service following new born hearing screening, as they had no 'risk factors' identified; the child went on to develop hearing loss. Action taken as a result the local protocol was changed to ensure that all babies referred to Audiology have this test undertaken whether they have 'risk factors' or not.

- Concerns raised by an Ophthalmology patient who was unaware of appointment cancellation/change as they did not receive the letter in time as the patient did not answer calls from withheld numbers. As a result, the Ophthalmology Booking team use switchboard to contact patients without withholding the number.

Learning from complaints – FCD

- Concerns relating to delayed treatment, decisions about clinical treatment and medication was made to our Maternity Service. As a result they implemented two actions which included asking women in the latent phase of labour about their previous pregnancies. They also produced and implemented a patient information leaflet in relation to the use of the medication Ferrinject.

- In our Gynaecology Service, we investigated concerns relating to delayed care. As a result the service undertook a review of the booking service, clinicians annual leave notice period and revised the process for co-ordinating activity operationally, with clinical and administrative staff.

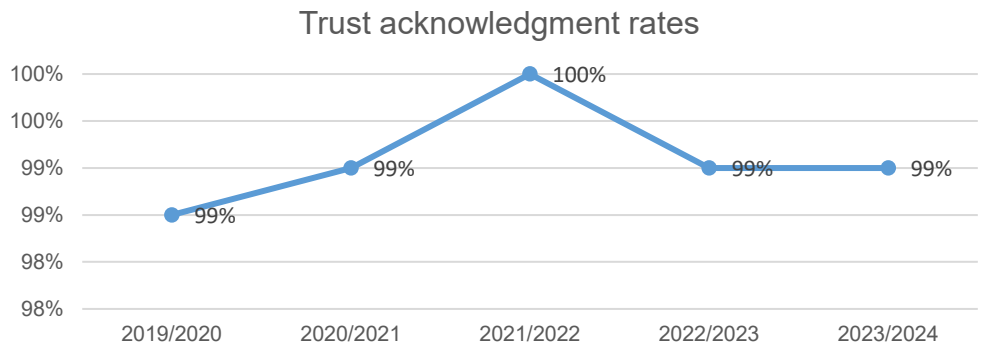
Learning from complaints – ICSD

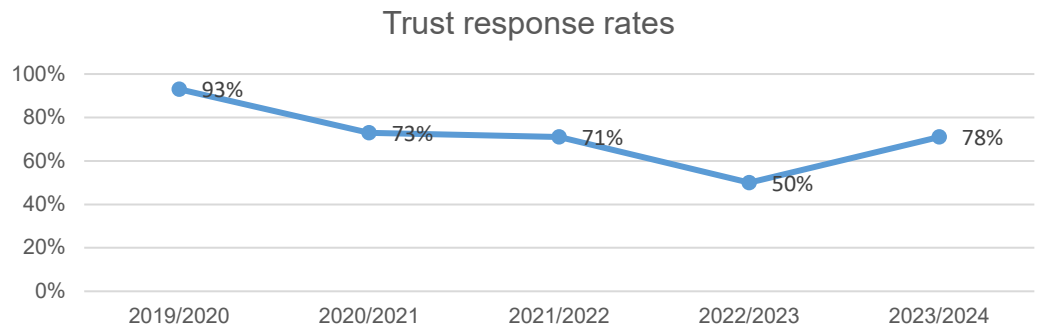
- Our Rheumatology Service received a complaint from a patient who had experienced a long wait for treatment. As a result, a review of the consultants job plans was undertaken with the support of the Choose and Book Service and a communication plan was implemented to ensure that patients are kept fully up to date about their appointment schedule.

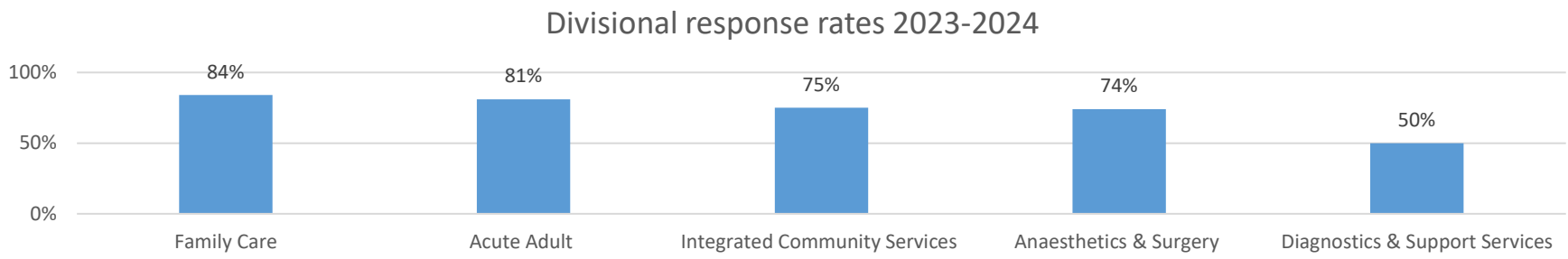
- A lack of understanding relating to the mental health of a patient resulted in an individual member of staff undertaking "making every contact count" training to ensure they have a full understanding of the needs of patients with a mental illness.

Our performance

- Performance is measured by monitoring our complaint acknowledgment rates within three working days from the day of receipt of a complaint. During 2023/2024, 99% of complainants received an acknowledgement of their complaint within the three working days' target.
- The response target rate is for 95% of complainants to receive a response by 35 working days or 60 working days if the complaint is complex and/or crosses multiple providers. In 2023/2024, 78 % of our complainants received a response within this timeframe. In all cases where compliance with timescale was not achieved, the complainant was kept fully informed of progress and the cause of any delays throughout the complaints process. None of our complaints received a response outside of the six-month timescale set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.



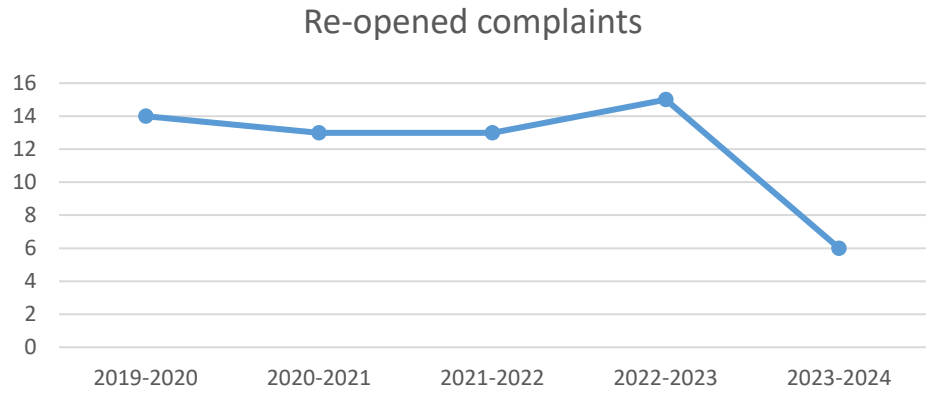


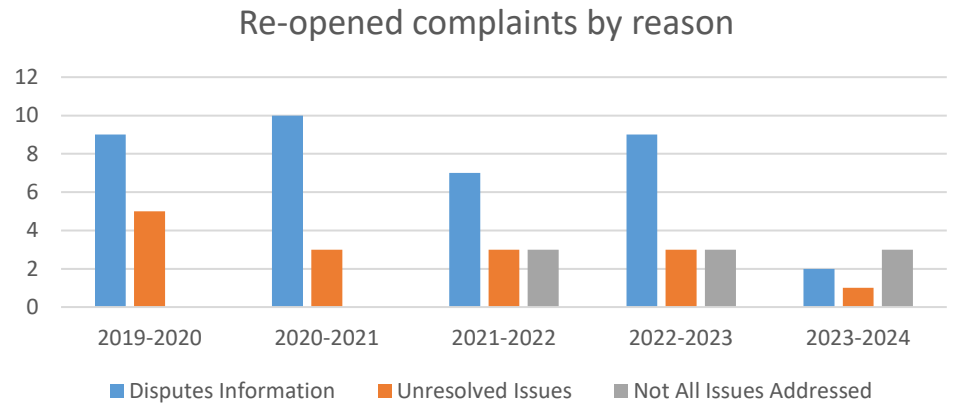


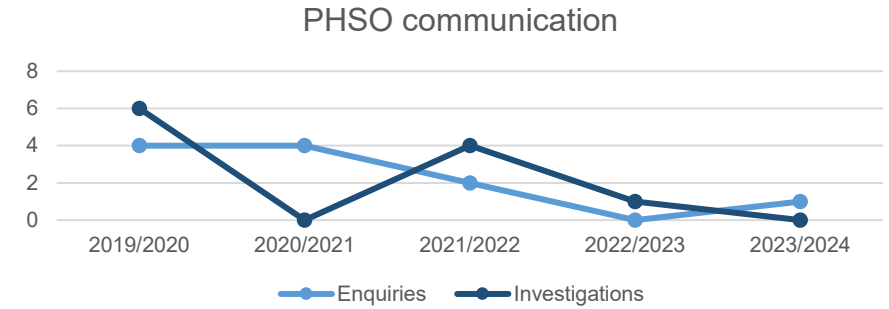
Family Care	38 out of 45
Acute Adult Care	58 out of 72
Integrated Community Services	9 out of 12
Anaesthetics & Surgery	39 out of 53
Diagnostics & Support Services	2 out of 4

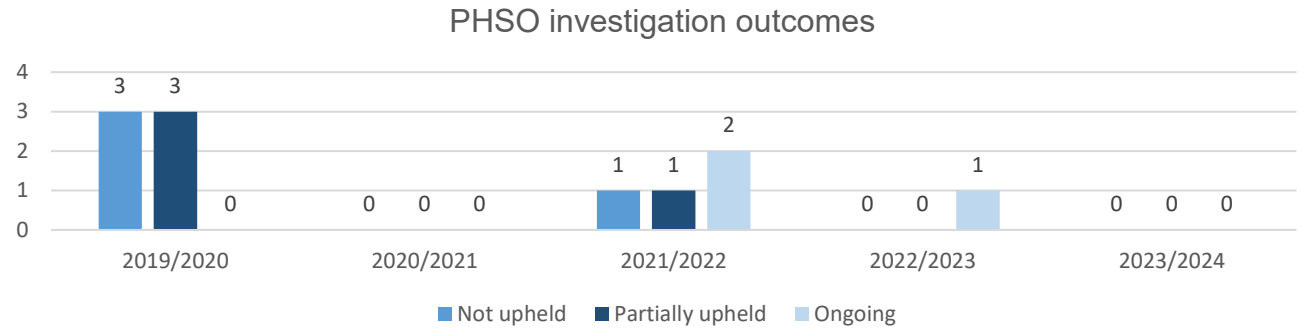
Quality Monitoring

We measure the quality of the responses provided to our complainants by monitoring re-opened cases, referrals to the Parliamentary and Health Services Ombudsman (PHSO) and offering local resolution meetings.





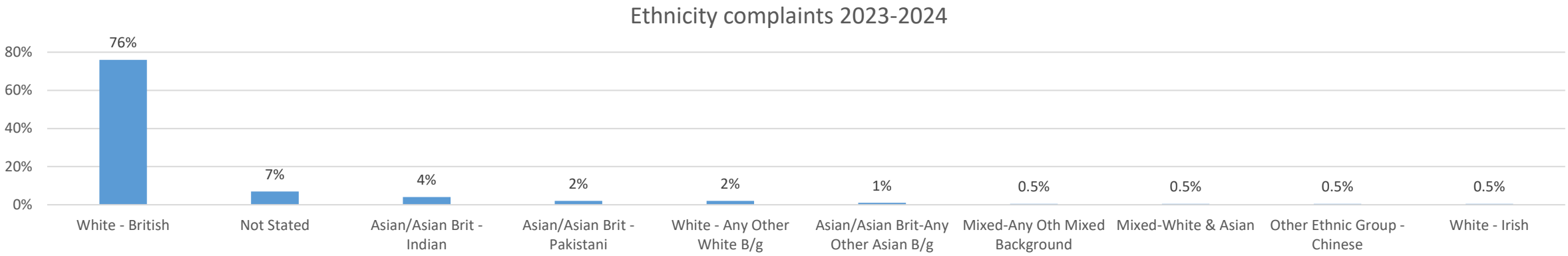


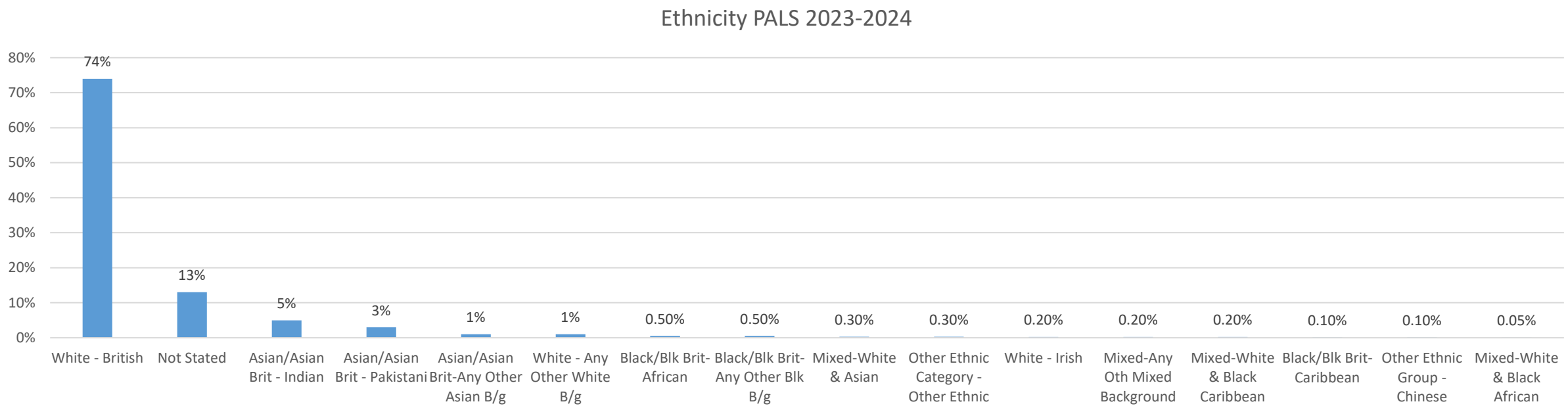


The above data demonstrates that we have continued to improve the quality of our responses to complaints with a reduction in the number of re-opened cases and only 1 case being referred to the PHSO which is undergoing investigation.

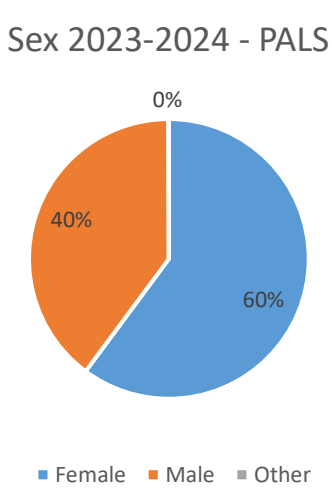
Equality Monitoring 2023-2024 Ethnicity

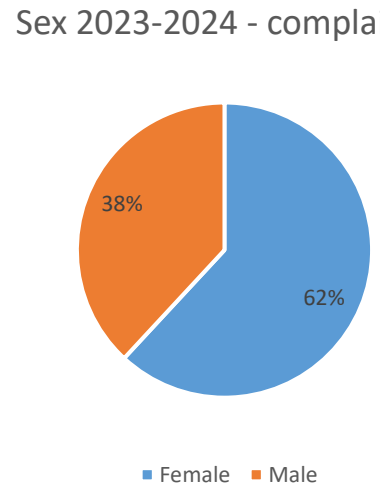
The Trust takes seriously that all members of the public should feel comfortable in accessing the PALS and complaints service and as such captures information on the patient's age, gender and ethnicity to support this. A summary of this data is provided which has been measured against patient profile activity.

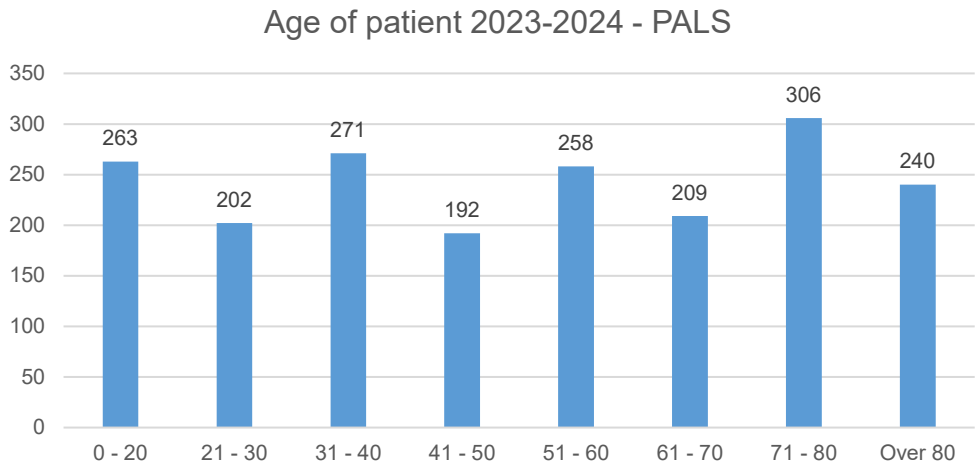


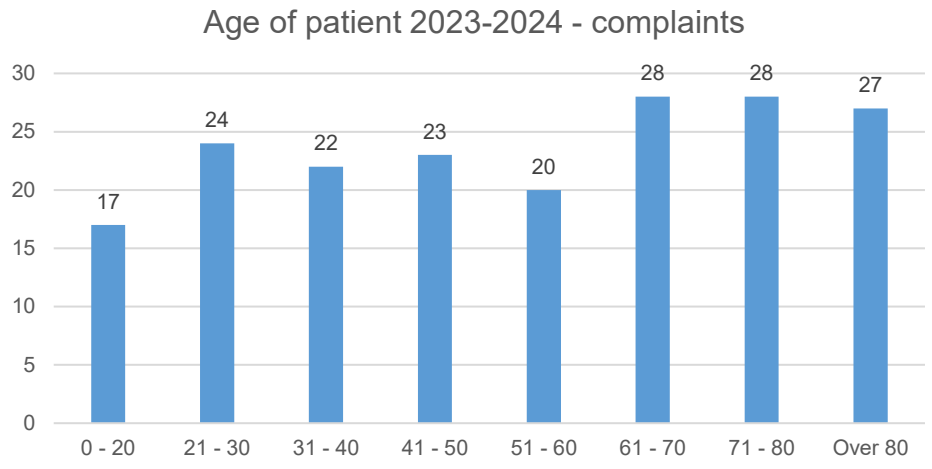


Equality Monitoring 2023-2024 Sex and age





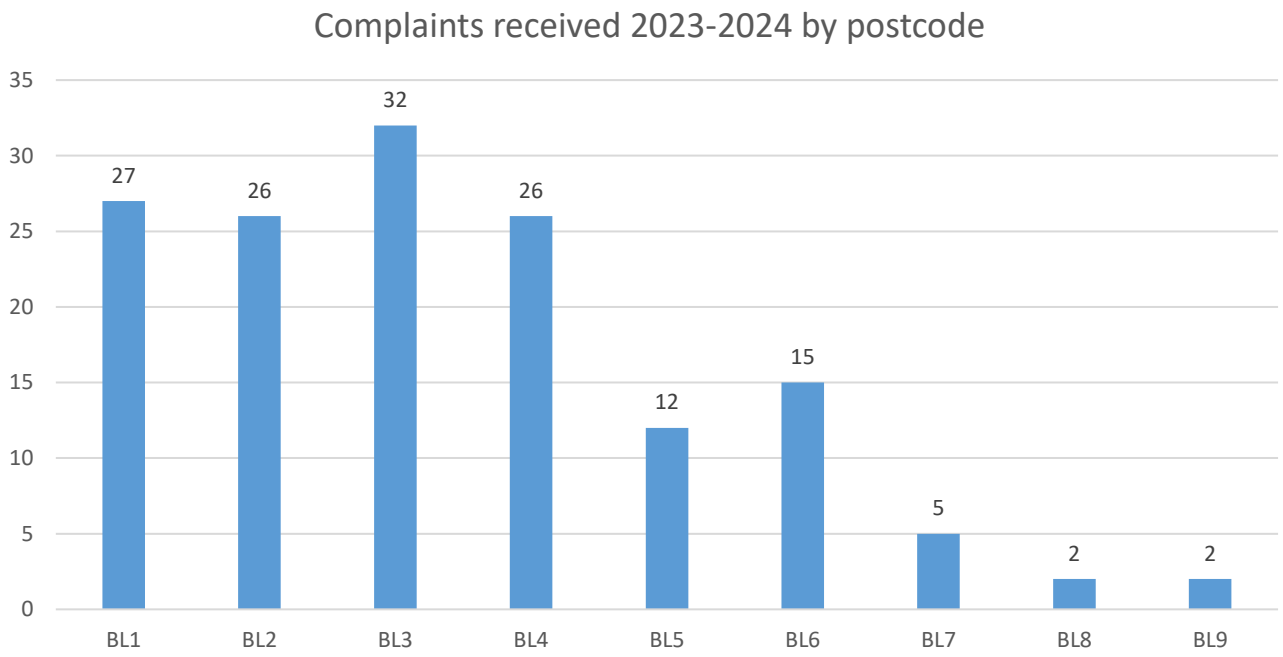


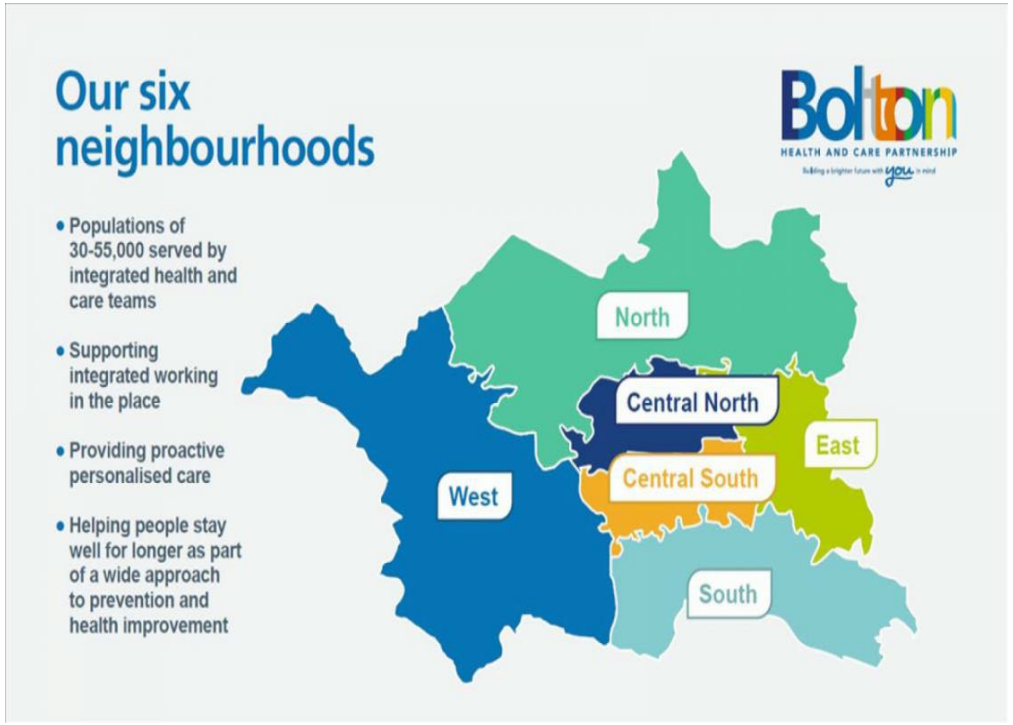


Our Neighbourhoods

Our data shows that in relation to formal complaints, 28% were received on behalf of patients who live/lived outside of the Bolton borough for example Manchester, Wigan, Salford, Preston and Oldham with the majority received from the Manchester area. This is due to the residents of nearby towns and boroughs being able to choose where they go to for treatment, maternity services and for emergency care in the region.

The highest number of complaints in Bolton were related to patients living in the BL3 postcode area. The lowest number of complainants live in the BL7, BL8 and BL9 postcodes each of which sit on the outskirts of Bolton and on the border with Bury and therefore may not access our services. There are six neighbourhoods that sit within Bolton postcodes but within some postcodes the deprivation levels and ethnicity can vary widely. Therefore, it may be useful to breakdown the data into those neighbourhoods to truly understand what this data means.





Our focus for 2024/2025

FOCUS	OBJECTIVE
Development of improved training programme	To ensure that staff responsible for conducting and responding to complaints are fully equipped with the skills necessary to undertake a through investigation.
Development of information available on Trust website for complaints and PALS	Develop the Patient Experience web page to link patients to the information they need to support them accessing the PALS and complaints services.
Engagement	Plan engagement events within the Community to establish why some patient groups are not accessing the PALS and complaints service and what measures can be put in place to break down any barriers.
PALS digital solutions	To continue to explore digital solutions to enable PALS enquiries to be addressed in real time and available 24 hours per day.
Involving complainants in the learning process	Ensure that where appropriate, complainants are given the opportunity to contribute to the learning outcomes from their complaint.
Equality monitoring	Undertake further detailed analysis of equality and demographic data to inform a work programme for 2025-2026 to focus on which patient groups are not accessing the PALS and complaints services.

Report Title:	Staff Health and Wellbeing Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Deputy Chief Executive/Director of People		Decision	

Purpose of the report	To provide an overview of the Trust's wellbeing action plan, as well as an update on key initiatives to support colleagues to look after themselves in order to be best placed to look after our patients.

Previously considered by:	This report was discussed at the People Committee which will continue to oversee any relevant actions.

Executive Summary	This report sets out the Trust's enhanced staff health and wellbeing offerings and associated actions to support our dedicated colleagues. In prioritising the health and wellbeing of staff, we aim to create a supportive and productive work environment that enables all staff to thrive and deliver the best possible care to our patients. Overall, the sickness absence position remains favourable when benchmarked against GM organisations. A plethora of work programmes have been implemented to support our fantastic staff to be healthy and remain in work. These actions include regular health check-ups, stress management workshops, and access to counseling services. However, despite the existing efforts, this report acknowledges that more can always be done to support our staff given the workload pressures facing our organisation and the NHS more broadly. The People Committee will continue to monitor and evaluate these programmes to ensure their effectiveness and to identify areas for improvement.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Health and Wellbeing Report

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	Yes	Adherence to legislation such as the Disability Discrimination Act is a key responsibility for our organisation.
Health Inequalities	Yes	There is a linkage between Health & Wellbeing and Bolton's demographics. Ensuring our workforce is representative of the population we serve and free from discrimination is critical to equal patient care.
Equality, Diversity and Inclusion	Yes	There is a linkage between Health & Wellbeing and demographics. Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	Carol Sheard, Deputy Director of People Lisa Roberts	**Presented by:**	James Mawrey, Director of People and Deputy CEO

1. Introduction

This paper provides an update to the People Committee on the Trust's wellbeing action plan, as well as an update on key initiatives to support colleagues to look after themselves in order to be best placed to look after our patients. . It has been requested that this same paper then subsequently go to Trust Board for consent/information in accordance with the Boards existing workplan.

Health & Wellbeing of our staff is a key element in delivering our 'Great place to work' ambition outlined in our organisational strategy and is of course a fundamental pillar of the Trust's People Plan.

Overall our sickness absence position remains good when benchmarked against GM organisations. The Trust's sickness rate for August has dropped to 4.66%, the most recent data shows that the GM sickness rate is 5.9% as at July 2024. Colleagues are reminded that a 1% reduction in sickness absence equates to approximately 55 WTE. Whilst IFM are not included in the NHS return their sickness absence rate is 7.56%*, which would take the group position to 4.87%.

The staff survey 2023 showed a slight reduction on the previous year for the question ' *My organisation takes positive action on health and well-being*' with positive responses reducing from 55% in 2022 to 53.9% in 2023. The national average for 2023 was 56.95%

2. Background.

The following provides a non-exhaustive overview of the support provided as part of our existing Health & Wellbeing offer:-

1. The Trust offers a number of measures to support colleagues, whether this be whilst still in work or during any period of sickness absence. The biggest offers of staff health and wellbeing are via the Trust's Occupational Health (OH) service (with 1,997 staff referrals in the last financial year) and also using the Trust's Employee Assistance Programme and via ViVUP (Appendix 1 details all the support provided via Vivup). Staff also benefit from the Schwartz Rounds, TRIM (support for trauma cases), psychologist support and Physiotherapy.

2. The Trust's revised Workplace Health and Positive Attendance Policy is close to being agreed with Trade Union partners. These changes provide additional clarity and support for those staff experiencing sickness absence. The Trust's Stress at Work Policy is also currently under review and being updated to reflect the additional Trust offer and best practice regarding risk assessments, as stress continues to be the highest reason for sickness absence.

3. Colleagues may be aware that the Trust launched (November 2023) the Disability Passport which has been developed in conjunction with the Equality, Diversity and Inclusion team and Staff Disability network. The passport is designed to encourage staff with long term health conditions to have open and honest conversations with their line managers to establish any additional support or adjustments and support these colleagues to remain in work and undertake their roles effectively. The feedback received through the staff network has been

positive to date with additional training and guidance to be developed to support managers in using the passport with their teams.

4. The HR team support an ongoing review of Trust Policies and assurance through additional audits of return to work documents and 'hotspot' audits of teams/departments where sickness has increased to provide proactive support.

3. Measures being taken to complement the actions already being taken to support our staff.

The following provides a short overview of the additional actions that are being taken to develop our existing Health & Wellbeing offer:-

1. The transfer of the well-being portfolio from Organisational Development to Occupational Health services took place earlier in the year. The reason for this move was to support our Occupational Health Department in providing a more holistic offer to our staff. Due to workload pressures the Occupational Team had become a more reactive service, and whilst the service demonstrated positive KP's e.g. time to be seen, more work was required on a pro-active and in-reaching offer. As such additional resources (from within wider HR&OD budgets) were put in place to offer a more holistic service. Upon taking on this service the Head of Occupational Health, in conjunction with the Well Being Practitioner and divisions, conducted a comprehensive review of the Trust well-being offer and action plan. The impact of this has been to streamline and provide greater focus on the areas that our data and our staff tell us make a difference to them e.g. Mental health support and access.

2. The Our VOICE change programme very much supports our wellbeing direction of travel through the 'working environment' (improved rest facilities); 'flexible working' and Living our values change teams (FABB appraisals; FABB conversations incorporate a discussion on well-being) and of course it is well recognised that the role of the line manager has significant impact on staff's experience at work therefore the implementation of the VOICE 'Our Leader' programme (leadership development) supporting our leaders to be the best they be so they can support our staff.

3. The further enhancement of the staff networks has also been a key feature in developing our wellbeing offer. We have seen these networks having real impact, for example the Disability network providing a real lever for policy change; the Global Majority/BAME network providing clarity on how to support our staff during the recent riots.
4. The menopause policy and support for staff through the menopause café have been welcomed and we are now working towards achieving 'Menopause Friendly Accreditation' which involves employers being assessed by an Independent Panel and demonstrate effectiveness across six areas including culture, policy and practice, training, engagement, facilities and evaluation.
5. The Disability and Long Term condition network continue to provide a wide range of support to colleagues, with particular success and additional support being provided to colleagues with Neurodiversity.
6. 01 July saw the first summer health and well-being event held on site and included a range of health and well-being offers including holistic treatments from Bolton College; our chaplaincy

service, financial, estate and will planning. As well as the 'Be Seen Be Screened' campaign that the Trust, along with other local employers has supported to promote screening services to staff and grant time-off to attend screening appointments

7. The Trust has a calendar of health and well-being days which provide a focus throughout the year. In October resources and communications will promote World Mental Health Day; International Stress Awareness week and World Menopause Day.
8. As well as Trust wide initiatives, Divisions are supported to host their own well-being weeks and a systematic offer is being developed through well-being inventory and a forward plan for key areas.

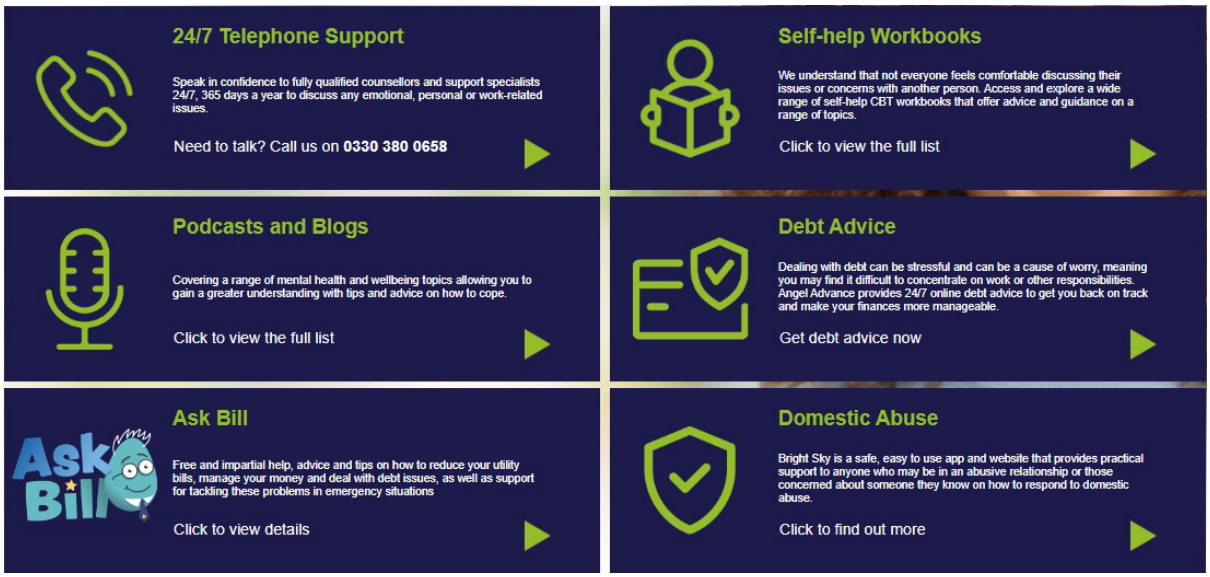
4. Governance and monitoring of our Health & Wellbeing offer

Detailed plans and updates on progress are managed through the Staff Experience Steering Group who are also charged with overseeing Occupational Health and Well-Being metrics. The Head of OH&WB is also member of Group Health and Safety Committee to ensure oversight of staff accidents and incidents as well as health surveillance.

5. Recommendations

The People Committee and Board of Directors are asked to note the report and identify any further assurance that may be required.

Appendix 1 – Overview of support our staff can access via VivUP



Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Chief Executive		Decision	

Purpose of the report	The purpose of this report is to provide an update on key internal and current local issues since the last Board of Directors meeting, in line with the Trust's strategic ambitions.

Previously considered by:	N/A

Executive 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.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Chief Executive's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	NO	

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

Ambition 1: Improving care, transforming lives

The Trust's new strategy for 2024-29 has now been published. 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, communities and staff. Our five ambitions to guide us over the next five years are:

- Improving care, transforming lives – our primary ambition
- A great place to work
- A high performing, productive organisation
- An organisation that's fit for the future
- A positive partner

An annual planning process is underway to outline the actions we need to take this year and the measures of success that will help us track our progress. This was explored at our annual Service Review Day which also involved our clinical divisions and corporate services looking ahead to their future priorities, as well as reflecting on what they have achieved over the last 12 months. Both the summary and full versions of the strategy can be viewed on our website.

A new Discharge Unit has opened at the Royal Bolton Hospital site to improve patient experience and the care they receive while waiting to return to the place they call home. The facility, located in D block, off the main hospital corridor, aims to reduce delays for people leaving hospital and free up much-needed bed space ready for patients being admitted from the Emergency Department.

A team of highly skilled nurses will continue to provide care in the unit as people prepare to leave hospital, with patients having access to hot and cold meals. The Discharge Unit is equipped with 18 chairs and six bed spaces for those who require additional comfort. The next stage of this development will be the locating of a new 'Flow Command Centre' based in the unit to support wards and services with discharge planning and to enhance collaboration between teams.

We know how important it is for our patients to be able to spend time with their loved ones while in our care, and the positive impact this can have on their recovery. Following a review of our policies, open visiting is available throughout the Royal Bolton Hospital site to allow greater flexibility for those coming to visit. People are being encouraged to visit between 10am and 7pm to allow staff to provide treatment, investigations and rest for patients but visiting outside of these times can also be arranged with a member of the ward team.

In addition, we are also proud to support John's Campaign which allows for open visiting times for relatives and carers of patients with dementia. Carers are welcomed onto the ward and made to feel valued and respected as carers who look after their loved one living with dementia, and will receive support from dedicated teams of highly skilled nurses, doctors and allied healthcare professionals.

Ambition 2: A great place to work

There have been some changes to our team of Non-Executive Directors (NED) who form part of the Board of Directors. Last month we said goodbye to Jackie Njoroge who as well as being a NED, was Deputy Chair of the Trust. Martin North, current NED, has now commenced post as the Deputy Chair and Seth Croft, who was previously an Associate Non-Executive Director has now been appointed as a Non-Executive Director and Senior Independent Director.

The Our Voice Change Programme teams continue to progress the improvements that will make a meaningful difference for our workforce. Recent developments include the introduction of digital days in our community, bringing technical support to staff who are experiencing issues, remedial work to prepare the former flow office to be a staff rest facility, and engagement with staff to co-produce the imminent launch of a brand new development programme for our leaders across the organisation.

We provided enhanced support and put in place assistance for staff who were affected by the unrest in Bolton and beyond including alternative transport into work and network support sessions. Our organisation will always be proud of our diversity, welcoming people from all different walks of life with open arms – whether that be our staff, our patients, their families or members of the public. We will not under any circumstances tolerate any form of racism, discrimination or unacceptable behaviour.

We have committed to the North West BAME Assembly Antiracism Framework, which is a strategic initiative designed to eradicate systemic racism within public services across the North West of England by embedding antiracism principles into organisational policies, practices, and cultures. This focuses on accountability, transparency, and measurable actions to address racial disparities and promote equity. To demonstrate our commitment, we will publish our statement of intent on antiracism, and ensure that antiracism is embedded into our core values and operations.

One of our Practice Education Facilitators celebrated the anniversary of his life-saving heart transplant by winning two gold medals at the European Transplant Sports Championships. On July 27th, exactly 28 years after undergoing the surgery, Rob Hodgkiss secured gold in the discus and 200m track events, which added to the four silver medals he achieved earlier in the week in the swimming pool and volleyball. The British team also topped the medal table and won trophies for the best Heart and Lung Transplant Team and best Overall Team at the 2024 edition of the games held in Lisbon, Portugal.

Our staff expressed their deep responsibility to represent and be a voice for South Asian communities and celebrate what motivates them to mark South Asian Heritage Month. In the NHS, staff from South Asia make up 5.3% of the workface which is more than 75,000 people, according to the latest figures from the House of Commons Library. This year's theme was 'free to be me', and encouraged people to share their unique journey that has helped to share who they are today.

The For A Better Bolton (FABB) Awards shortlist has now been published ready for the annual awards ceremony on 27th September. Staff were invited to nominate their colleagues in twelve categories, all aligned to the Trust's new five year strategy and ambitions. In total we received 782 nominations, including those made by members of the public, patients and their relatives who were invited to nominate someone who has made a difference to

them in the People's Choice category. We are grateful to our corporate partners who have sponsored the evening, making it possible to celebrate our incredible workforce. There will be opportunities on the evening for attendees to donate and raise money for Our Bolton NHS Charity to enable it to continue to make a lasting difference to our patients and staff.

Our teams continue to gain external recognition including our International Recruitment Team who won the Royal College of Nursing North West Award for Outstanding Contribution to Equality, Diversity and Inclusion, and our Finance Team who were shortlisted for Finance Team of the Year at the Public Finance Awards.

One of our senior specialist nurses has been accepted as the first nurse from Bolton to join the Florence Nightingale Fellowship. The Florence Nightingale Foundation offer the prestigious fellowships as a once-in-a-lifetime opportunity to develop nursing or midwifery careers, whilst also improving clinical and health outcomes. Anna works on Bolton's CURE team, who work to try and support patients away from smoking and nicotine addiction. The CURE Project is supported by the Greater Manchester Integrated Care Partnership, as part of a whole system approach, which aims to significantly reduce smoking rates in Greater Manchester.

Jean Cummings has been shortlisted for an NHS Parliamentary Award and is a finalist in the Lifetime Achievement Award category. Jean started as a Cadet Nurse in January 1964 following a very formal interview in the boardroom of Bolton General Hospital, known today as Royal Bolton Hospital. Although Jean has looked after countless people in the past, her current work as a Clinical Research Nurse is helping to discover new and better ways to treat illnesses for patients well into the future.

Ambition 3:
A high performing, productive organisation

There is a huge amount of work happening across our services to make lasting improvements in our Emergency Department (ED). Our teams have continued to implement the recommendations made by the clinically led national NHS Emergency Care Improvement Support Team (ECIST), following their review of our services. In August, our validated performance against the urgent care standard was 69.6% which is our best performance since September 2021.

Recent work has included:

- Implementing the Rapid Assessment and Treatment (RAT) Model which has meant our patients are directed to the most appropriate place for treatment, quicker.
- Embedding the 'why not home and why not home today' ethos. We know that setting an estimated discharge date within 24 hours of admission means planning for home starts straight away, alongside the acute care that the patient requires.
- Supporting the Greater Manchester 'Super Multi-agency Discharge Event' (Super MaDE) with a focus on 'why not home, why not home today', which has included a number of schemes that aim to increase discharge, increase usage of the discharge lounge and optimise our discharge to assess capacity.
- We have opened our new discharge unit, allowing patients to move from a hospital bed early in the morning on the day that they are going to the place they call home.

- Working together as one Bolton team to design and implement a transfer of care hub in Bolton. This brings together partners from a number of services to coordinate care and support for people who need it. The ambition is to streamline discharge from hospital and prevent unnecessary long stays.

We are continuing to focus efforts on reducing the number of patients waiting more than 65-weeks for their elective treatment. This includes seeking mutual aid from partners across Greater Manchester, working with the independent sector and our teams have also increased the number of theatre lists we are running at the weekend to ensure as many patients as possible are treated.

'100 Voices' saw a dedicated week of action to improve understanding about what is working well for patients, and what could be improved to help them stay well and recover. A team made up of nursing, medical and operational staff attended each of the 34 wards at the hospital to speak to patients. The aim of the visits were to open up the conversation around how the patient was feeling, their understanding of the care they received, and their involvement with getting ready to return to the comfort of the place they call home. The voices and feedback will directly shape future changes to improve care and treatment for the future.

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

An Independent Investigation of the National Health Service in England was commissioned by the Secretary of State for Health and Social Care to provide a definitive view of NHS performance and inform the Government's upcoming ten-year plan for health. The Darzi Investigation has been led by Professor Lord Darzi, a surgeon and former health minister, who now sits in the House of Lords as an independent peer. He also led a similar review in 2008, leading to the report High Quality Care For All.

The investigation so far highlights four heavily interrelated drivers of current performance: austerity and constrained funding; the impact of the pandemic; a lack of patient voice and staff engagement; and management structures and systems. The NHS Confederation has provided a summary and analysis of the investigation and its areas of focus.

A new patient flow system, Miya Flow, from health tech company Alcidion, went live across the Royal Bolton Hospital site to help healthcare professionals enhance patient safety and make the most of bed availability for patients. The system uses journey boards to show live bed status and helps clinical and operational teams to understand where patients are in their hospital journey – from admission to discharge.

The University of Bolton has been successful in its bid to become a Medical School. This involved a rigorous application process with the General Medical Council, the result of which is that we expect the University to welcome its first medical students to the University of Bolton Medical School, on the hospital site, in 2025. We are continuing to work really closely and in partnership with the university to understand what this facility and opportunity will mean for both our organisations. Together we are developing a business case and a service level agreement to allow us to explore how we continue to expand this partnership, and maximise its potential.

Our pharmacy service based at Bolton One will be permanently closed. This is due to a significant reduction in the demand for the service and the availability of several nearby alternatives for patients. A number of measures have been taken to minimise the impact and ensure that everyone who needs access to medication, receives it

when they need it. Some pre-planned medicines will be available in clinic from Bolton One and for other routine medication, patients will be provided with a form that will allow them to collect their prescription from a community pharmacy of their choice, including one of the eight community pharmacies located less than a mile from Bolton One. Items that must be dispensed by the hospital, will be available via the free standing prescription collection point at the Royal Bolton Hospital site.

Ambition 5: A positive partner

The report following an inspection of services for children with special educational needs and disabilities (SEND) has now been published. The joint inspection carried out by Ofsted and the Care Quality Commission focused on how effectively the local authority and the integrated care board (ICB) jointly plan, develop and evaluate services, for children and young people with SEND.

Inspectors highlighted several areas where the SEND partnership in Bolton is performing well including the involvement of children and families in care planning, strong collaboration between partners, and effective work to prepare young people for adulthood. Areas identified for improvement include reducing waiting times, the need for more support to those children experiencing social, emotional and mental health difficulties, as well as improving the timeliness of assessments and planning.

A Horwich Health and Wellbeing Hub has opened and provides a number of primary and community care services to support the needs of our communities. Our teams including audiology, health visiting and paediatrics have joined colleagues from Greater Manchester Mental Health and local GP practices to provide care, including for those with complex needs, closer to home from a larger primary care team and our community services.

A brand new scheme is being trialled to feed parents who find themselves staying in hospital while their children are being cared for. Funding has been secured for the Resident Parents Food Provision Direct Support Programme thanks to Sophie's Legacy, working in partnership with NHS England. Sophie's Legacy was created in memorial of Sophie Fairall, who was diagnosed with a rare form of childhood cancer and wanted to put provisions in place for parents to be fed when staying with their child. Our Bolton NHS Charity has funded a fridge freezer and Team 1C have provided furniture, a TV and crockery and cutlery for the parent kitchen on our children's ward to make Sophie's Legacy a reality.

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	

Purpose of the report	To present the Month 5 Integrated Performance Report

Previously considered by:	The report was previously discussed at Integrated Performance Meetings (IPMs) and at September Commitees.

Executive Summary	The Integrated Performance Report provides a comprehensive overview of the Trust's performance against the reported metrics for August 2024. The report includes a detailed narrative that describes the issues affecting performance and outlines the mitigating actions taken to improve performance. The report aims to ensure transparency and accountability in the Trust's performance and to provide assurance that appropriate measures are being implemented to achieve continuous improvement.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Integrated Performance Report

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	There are no financial implications arising out of the content of this report.
Legal/ Regulatory	**No**	There are no legal implications to bring to the Board's attention.
Health Inequalities	**No**	There is no impact on Health Inequalities arising from this report.
Equality, Diversity and Inclusion	**No**	There is no impact on Equality, Diversity and Inclusion arising from this report**.**

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey, Director of People/Deputy Chief Executive

Bolton NHS Foundation Trust

Integrated Performance Report

August 2024

Guide to Statistical Process Control

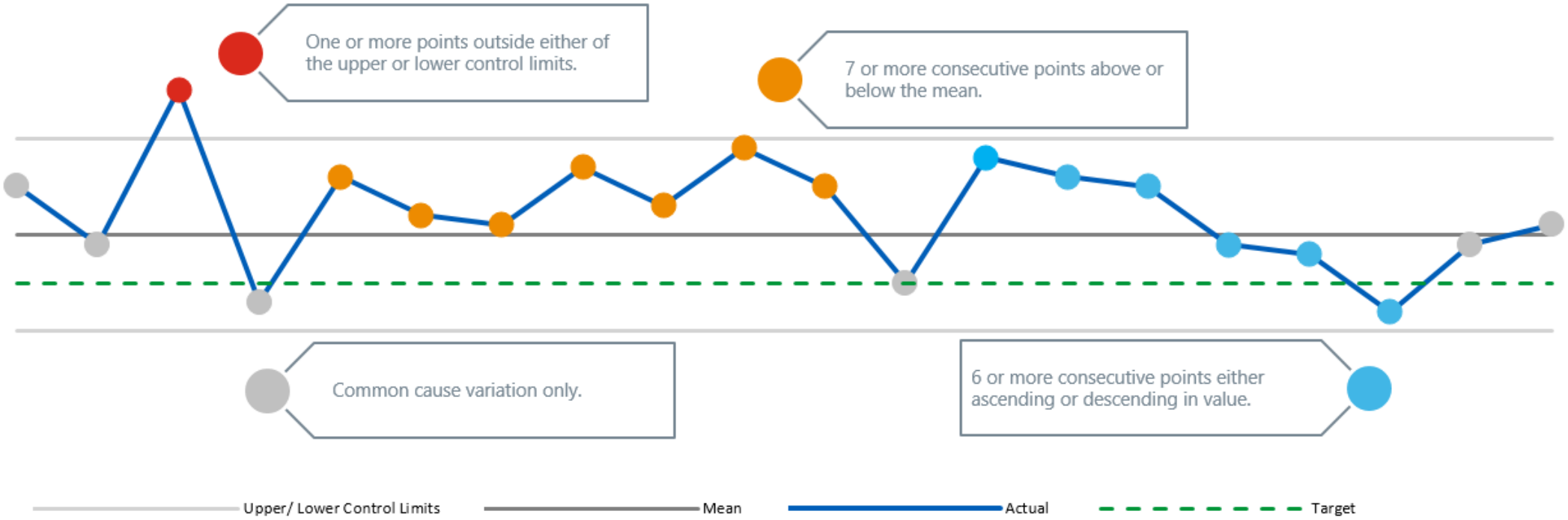
NHS Bolton NHS Foundation Trust

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

Variation

Common	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

Since April 2024, Bolton NHS Trust has implemented new pressure ulcer guidelines, categorising “unstageable” pressure ulcers as a minimum of Category 3. This change may result in an apparent increase in Category 3 ulcer reports. For accuracy, current numbers are compared with last year’s unstageable cases. In the past month, three Category 3 ulcers were reported, which would have previously been classified as one Category 3 ulcer and 2 unstageable. No Category 4 ulcers were reported, and no concerns have been identified through the Trust’s learning processes.
Falls have been below target for 18 months, with notable improvements in moderate harm falls. The current fall numbers are the lowest since April 2019, highlighting the Trust’s success in reducing falls

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

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	95.4%	Aug-24		>= 95%	97.1%	Jul-24	>= 95%	96.7%	
9 - Never Events	= 0	0	Aug-24	L	= 0	0	Jul-24	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.83	Aug-24	L	<= 5.30	3.36	Jul-24	<= 5.30	3.81	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Aug-24	L	<= 1.6	0	Jul-24	<= 8.0	3	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	10.0	Aug-24	H	<= 6.0	10.0	Jul-24	<= 30.0	57.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	3.0	Aug-24	H	<= 0.5	1.0	Jul-24	<= 2.5	18.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Aug-24	L	= 0.0	0.0	Jul-24	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	10.0	Aug-24		<= 7.0	12.0	Jul-24	<= 35.0	47.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	17.0	Aug-24	H	<= 4.0	7.0	Jul-24	<= 20.0	41.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Aug-24		<= 1.0	1.0	Jul-24	<= 5.0	2.0	

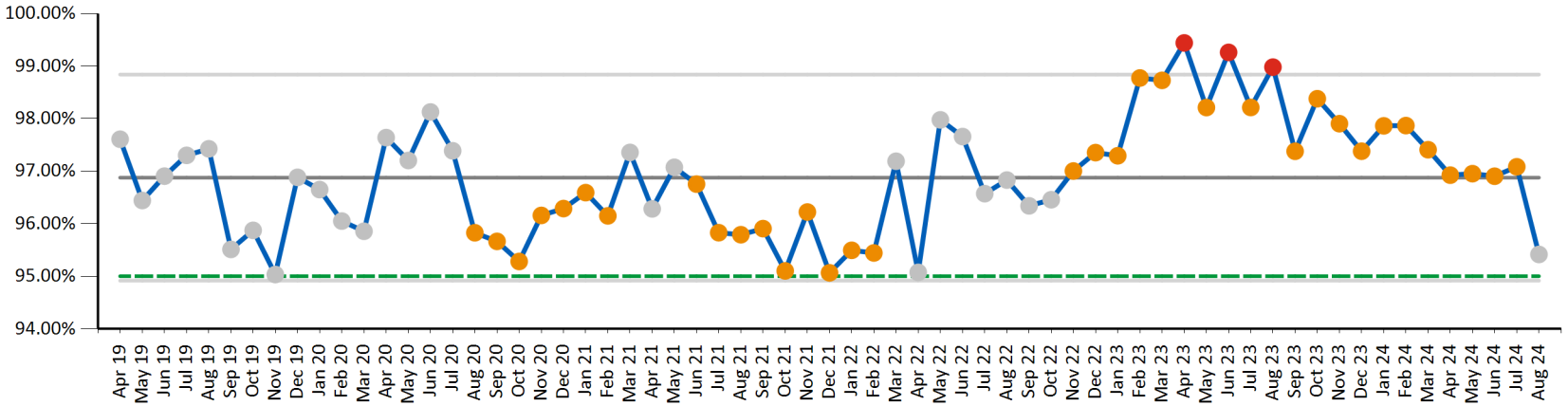
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
535 - Community patients acquiring pressure damage - significant learning category 2		0	Aug-24			0	Jul-24		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Aug-24			0	Jul-24		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Aug-24			0	Jul-24		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	80.6%	Aug-24		>= 95%	79.6%	Jul-24	>= 95%	79.6%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	68.7%	Aug-24		>= 95.0%	72.4%	Jul-24	>= 95.0%	71.3%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Aug-24		= 100%	100.0%	Jul-24	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	94.9%	Aug-24		>= 85%	95.8%	Jul-24	>= 85%	94.9%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Aug-24		= 100%	66.7%	Jul-24	= 100%	33.3%	
8 - Same sex accommodation breaches	= 0	10	Aug-24		= 0	13	Jul-24	= 0	69	

6 - Compliance with preventative measure for VTE

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 95%	95.4%	Aug-24

Previous

Plan	Actual	Period
>= 95%	97.1%	Jul-24

Year to Date

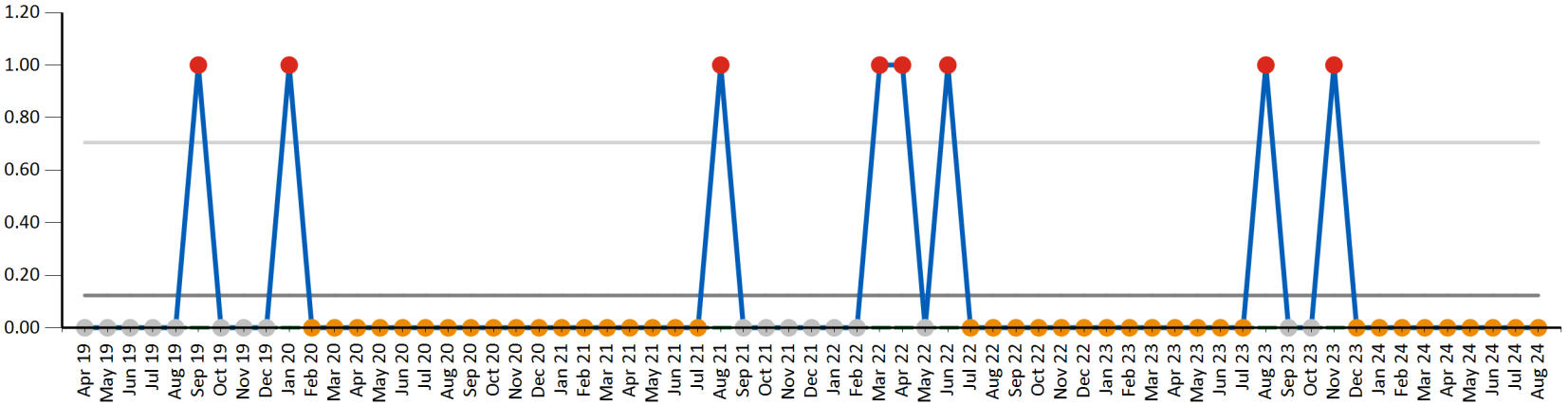
Plan	Actual
>= 95%	96.7%

9 - Never Events

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	Aug-24

Previous

Plan	Actual	Period
= 0	0	Jul-24

Year to Date

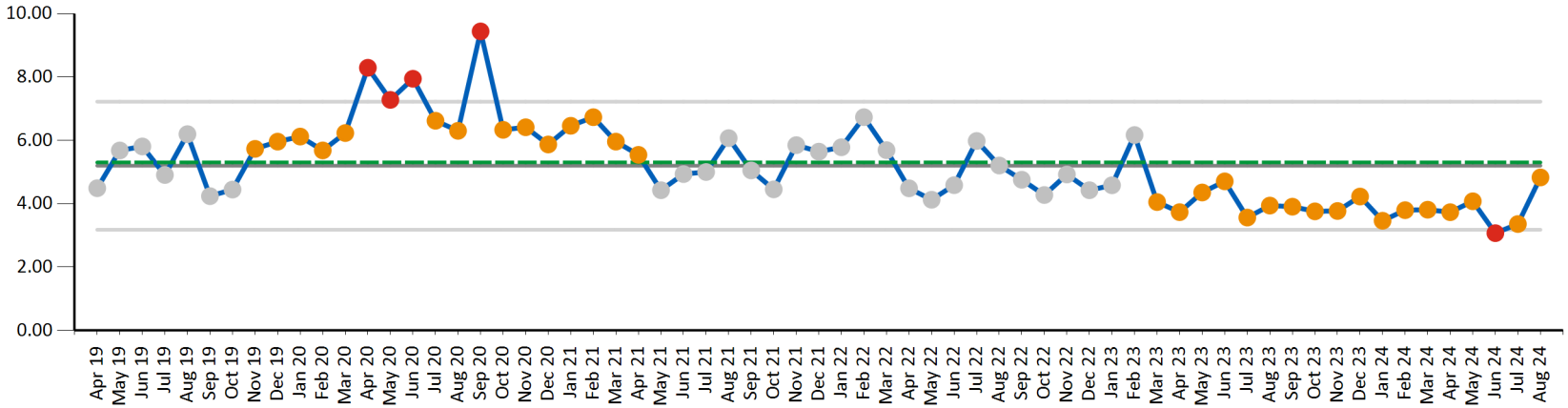
Plan	Actual
= 0	0

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	4.83	Aug-24

Previous

Plan	Actual	Period
<= 5.30	3.36	Jul-24

Year to Date

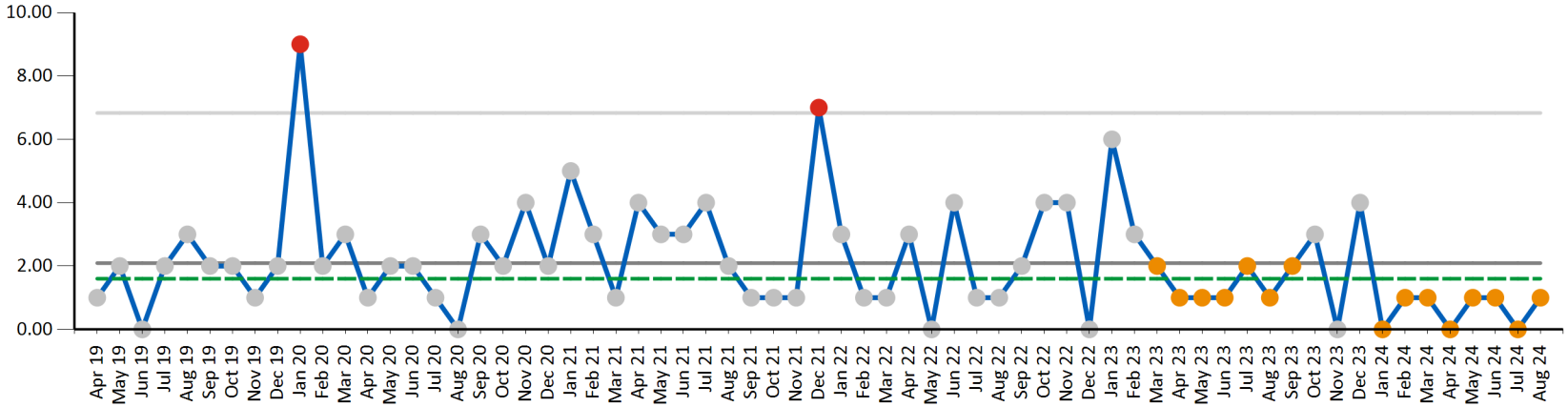
Plan	Actual
<= 5.30	3.81

14 - Inpatient falls resulting in Harm (Moderate +)

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 1.6	1	Aug-24

Previous

Plan	Actual	Period
<= 1.6	0	Jul-24

Year to Date

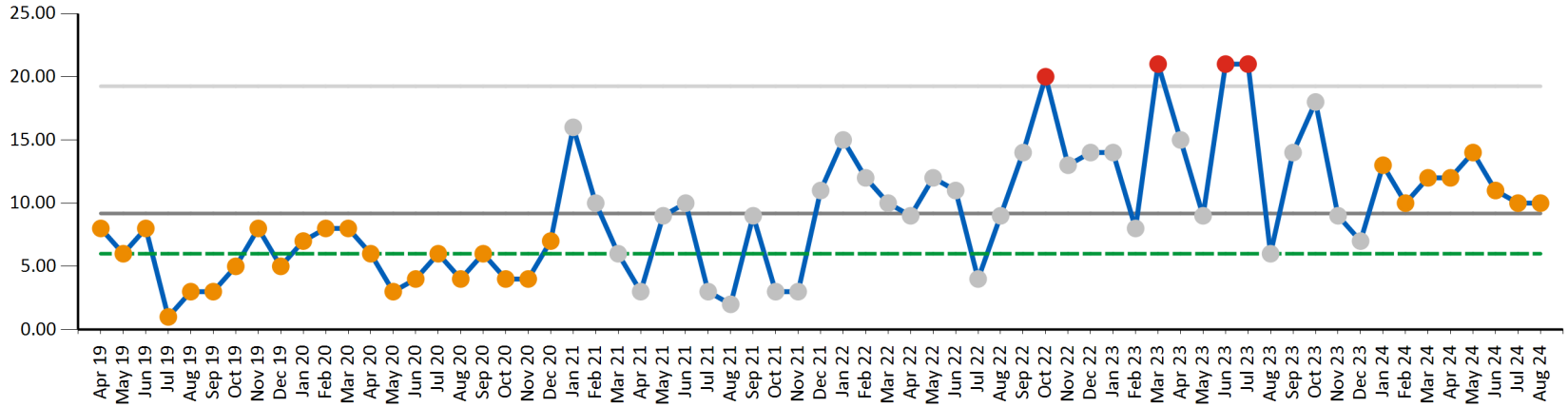
Plan	Actual
<= 8.0	3

15 - Acute Inpatients acquiring pressure damage (category 2)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 6.0	10.0	Aug-24

Previous

Plan	Actual	Period
<= 6.0	10.0	Jul-24

Year to Date

Plan	Actual
<= 30.0	57.0

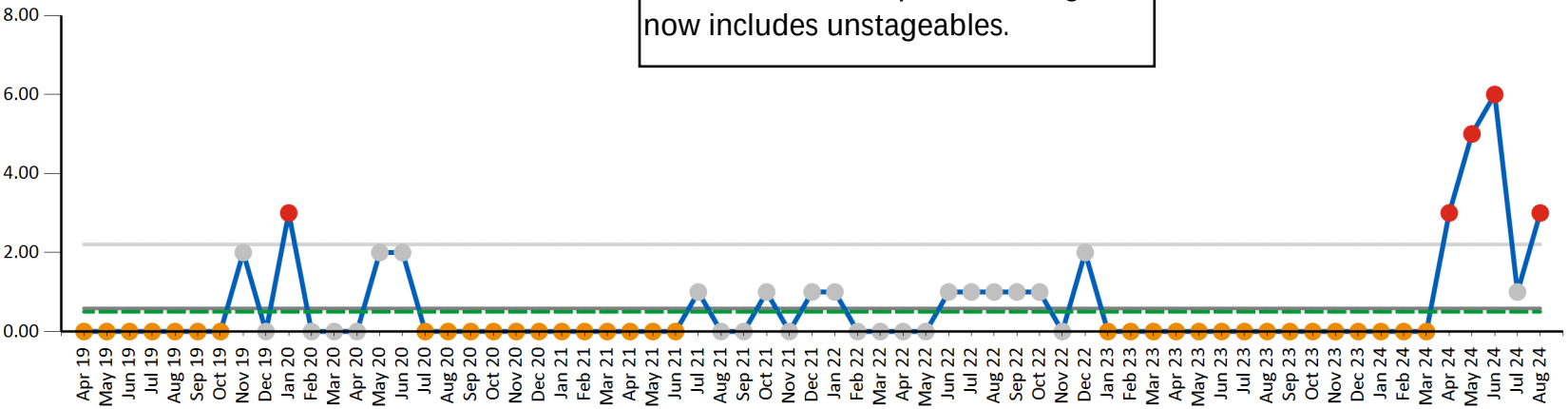
16 - Acute Inpatients acquiring pressure damage (category 3)

Special cause variation with deteriorating performance

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

1/6

Please note from April 24 this figure now includes unstageables.



Latest

Plan	Actual	Period
<= 0.5	3.0	Aug-24

Previous

Plan	Actual	Period
<= 0.5	1.0	Jul-24

Year to Date

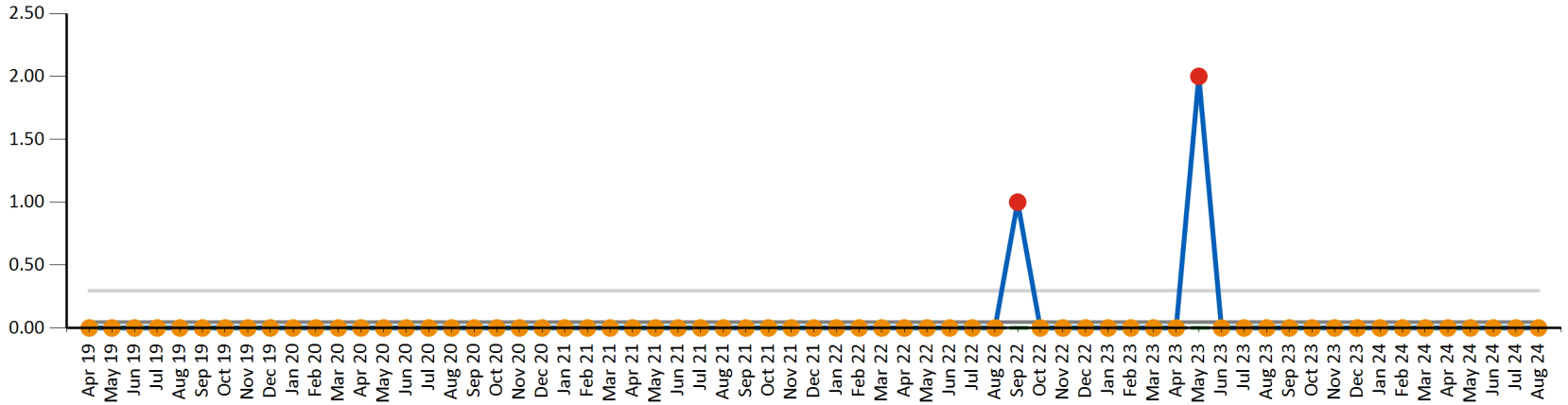
Plan	Actual
<= 2.5	18.0

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	Aug-24

Previous

Plan	Actual	Period
= 0.0	0.0	Jul-24

Year to Date

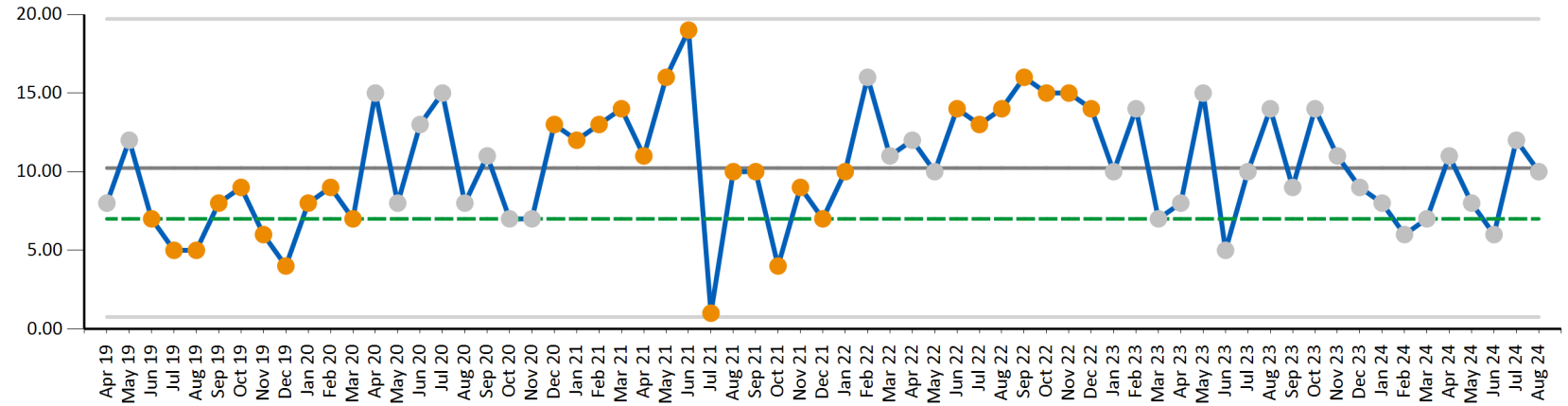
Plan	Actual
= 0.0	0.0

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	10.0	Aug-24

Previous

Plan	Actual	Period
<= 7.0	12.0	Jul-24

Year to Date

Plan	Actual
<= 35.0	47.0

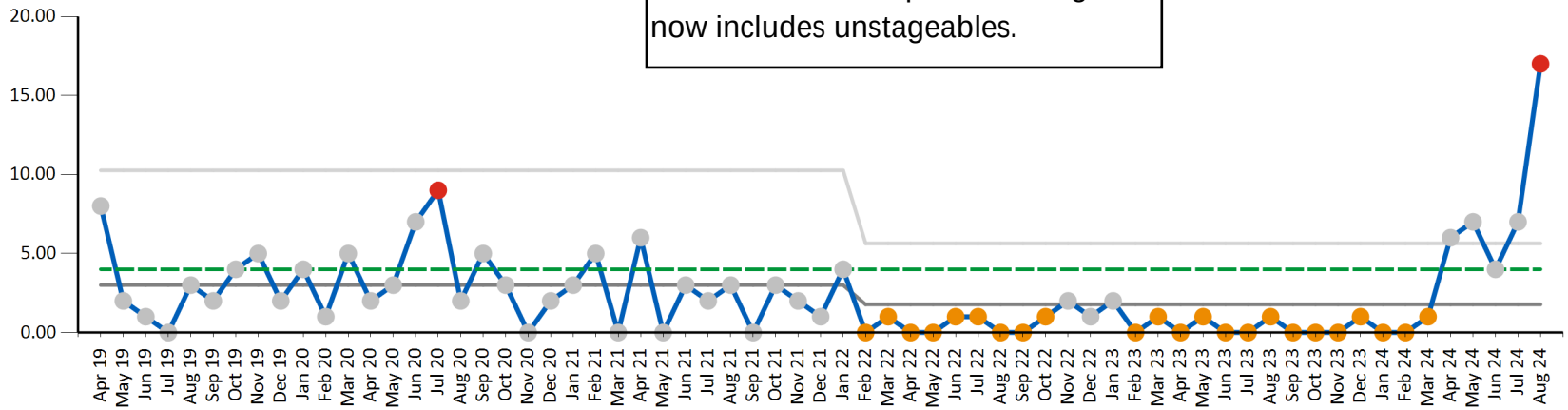
19 - Community patients acquiring pressure damage (category 3)

Special cause variation with deteriorating performance

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

2/6

Please note from April 24 this figure now includes unstageables.



Latest

Plan	Actual	Period
<= 4.0	17.0	Aug-24

Previous

Plan	Actual	Period
<= 4.0	7.0	Jul-24

Year to Date

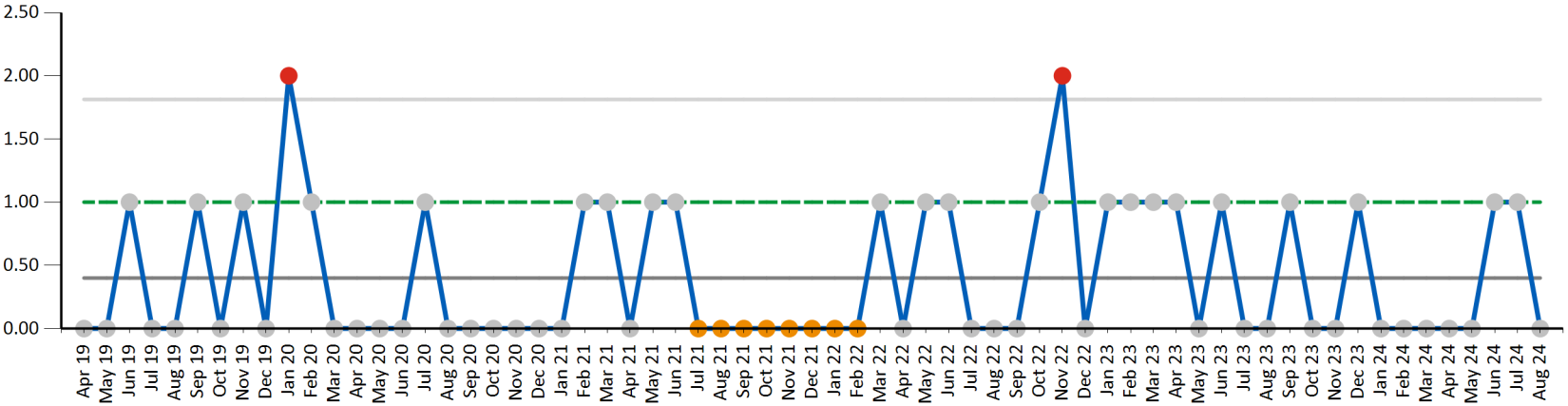
Plan	Actual
<= 20.0	41.0

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	Aug-24

Previous

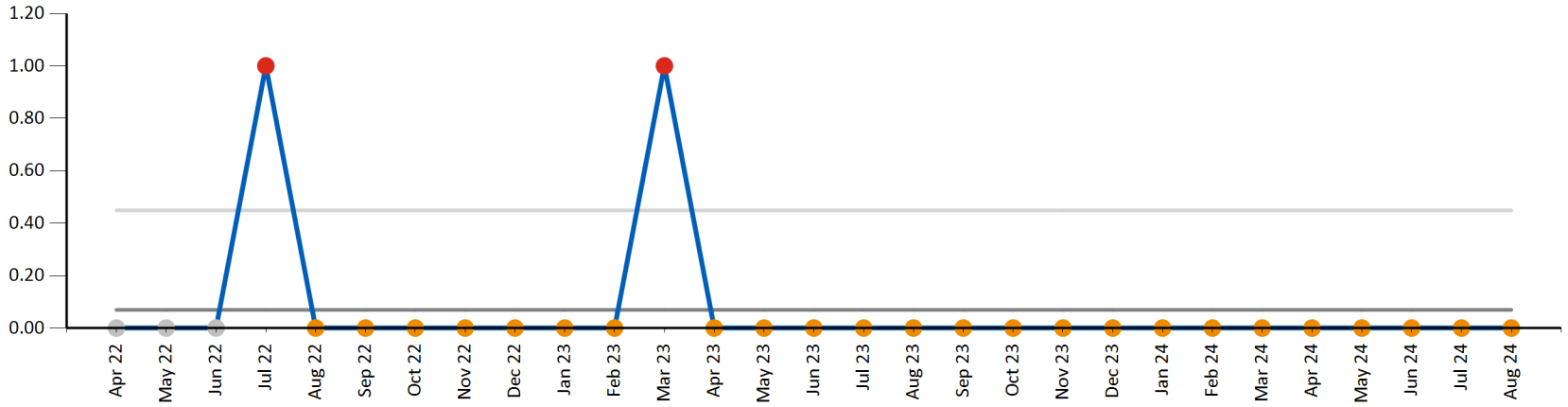
Plan	Actual	Period
<= 1.0	1.0	Jul-24

Year to Date

Plan	Actual
<= 5.0	2.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Aug-24

Previous

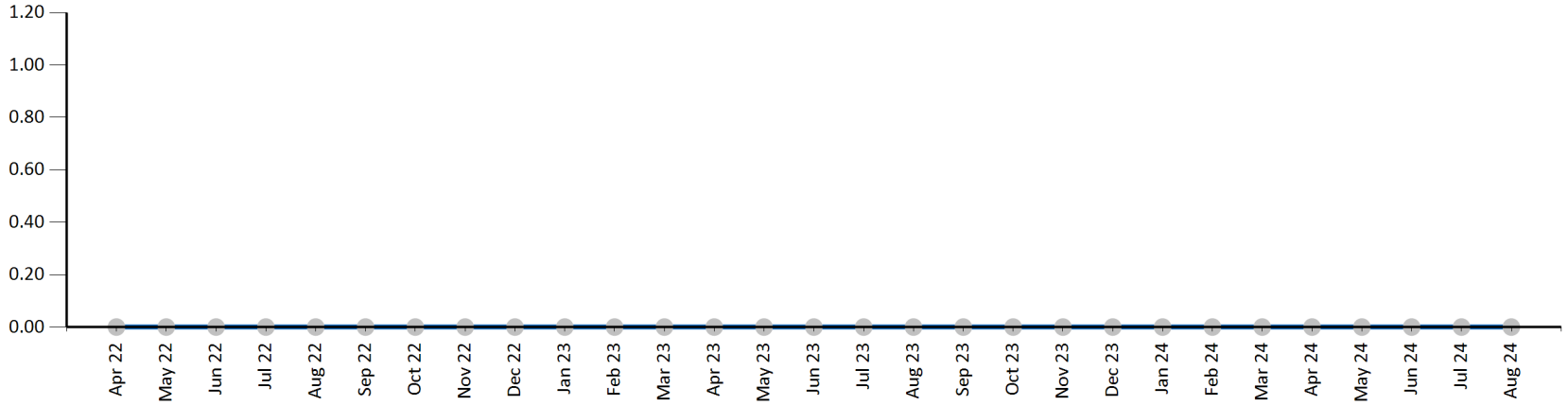
Plan	Actual	Period
	0	Jul-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Aug-24

Previous

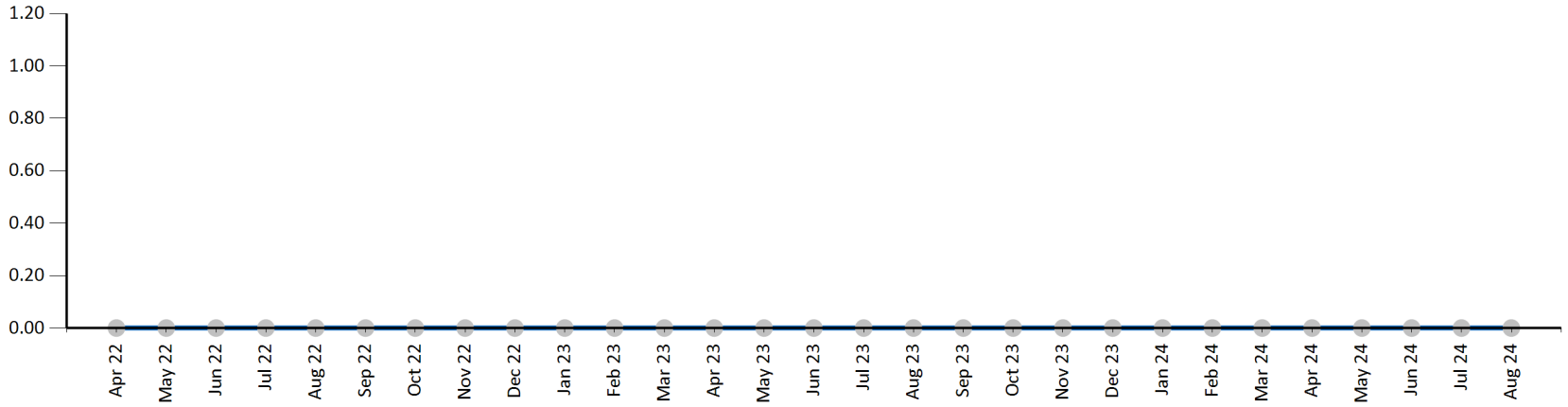
Plan	Actual	Period
	0	Jul-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Aug-24

Previous

Plan	Actual	Period
	0	Jul-24

Year to Date

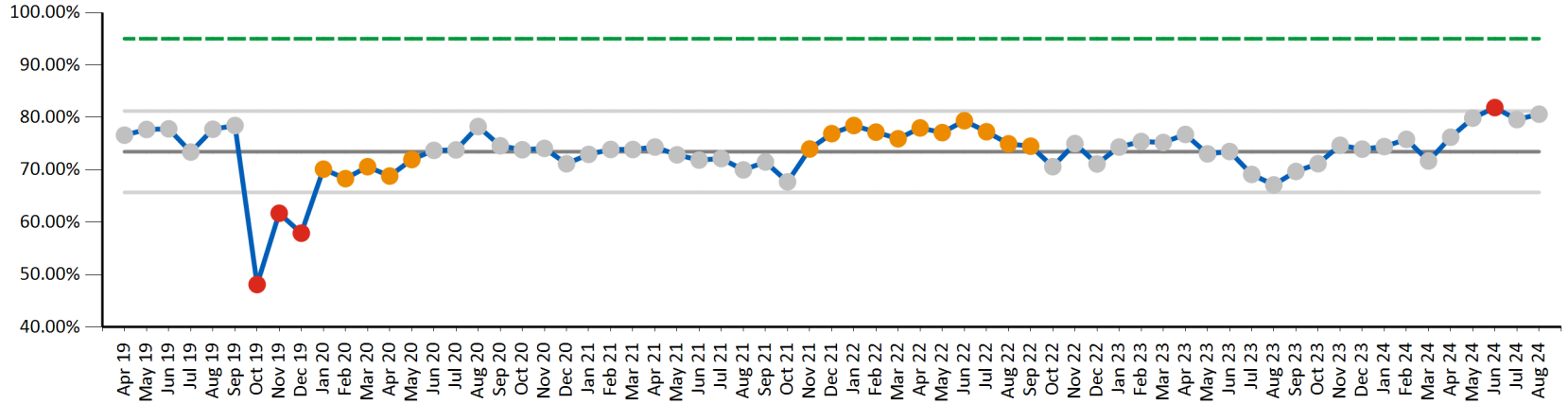
Plan	Actual
	0

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%	80.6%	Aug-24

Previous

Plan	Actual	Period
>= 95%	79.6%	Jul-24

Year to Date

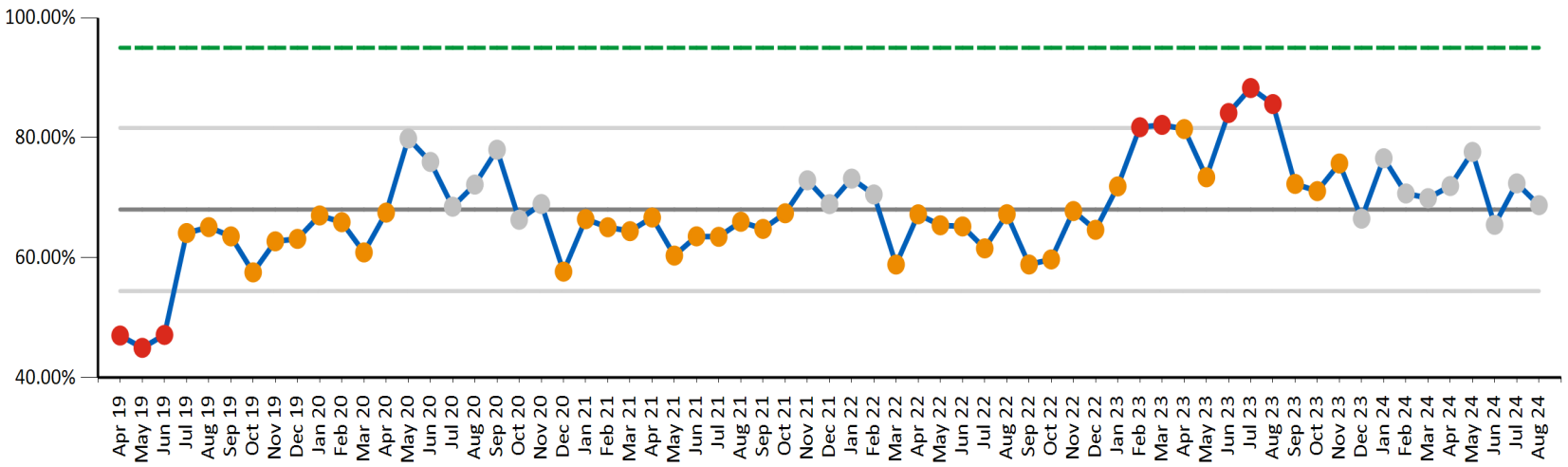
Plan	Actual
>= 95%	79.6%

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%	68.7%	Aug-24

Previous

Plan	Actual	Period
>= 95.0%	72.4%	Jul-24

Year to Date

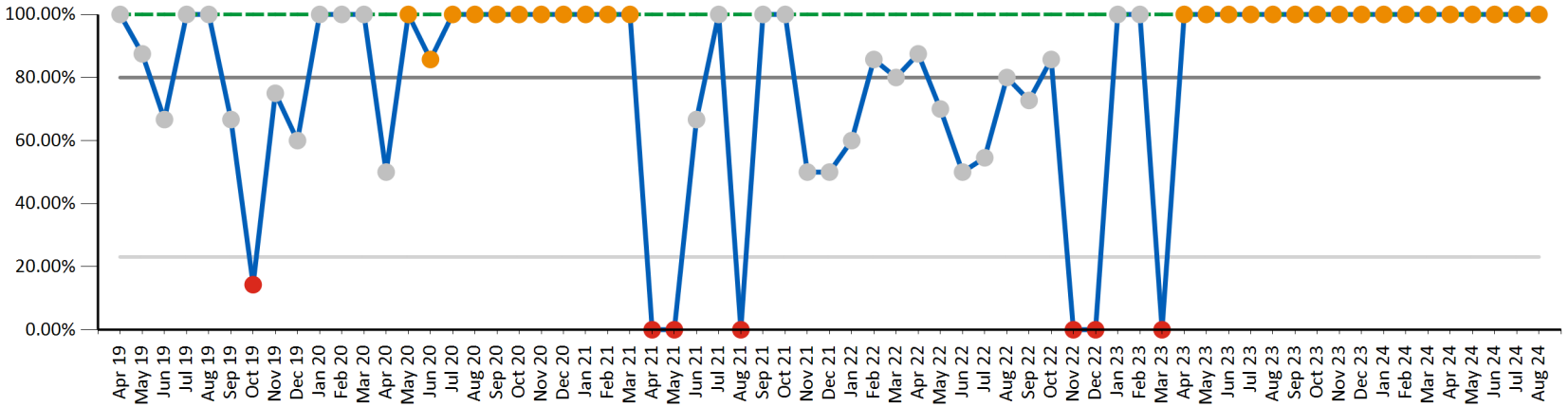
Plan	Actual
>= 95.0%	71.3%

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%	Aug-24

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-24

Year to Date

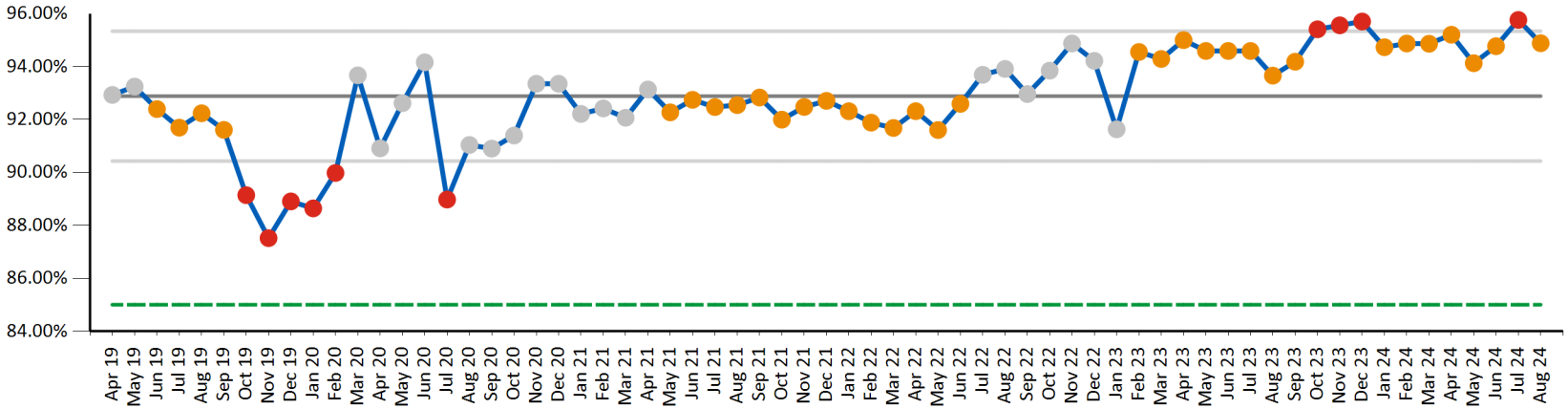
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

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

Previous

Plan	Actual	Period
>= 85%	95.8%	Jul-24

Year to Date

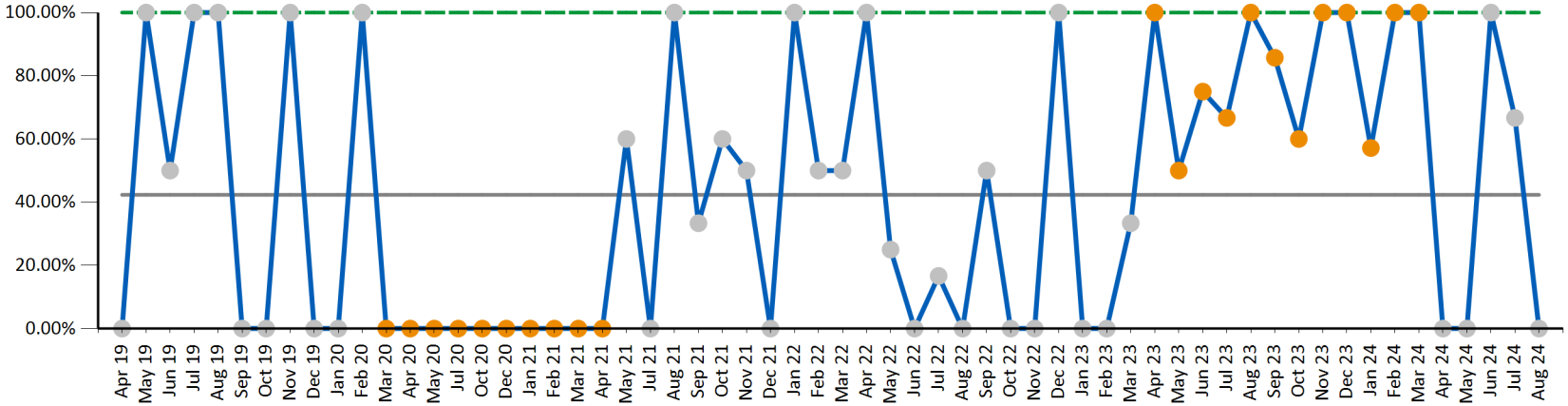
Plan	Actual
>= 85%	94.9%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
= 100%	0.0%	Aug-24

Previous

Plan	Actual	Period
= 100%	66.7%	Jul-24

Year to Date

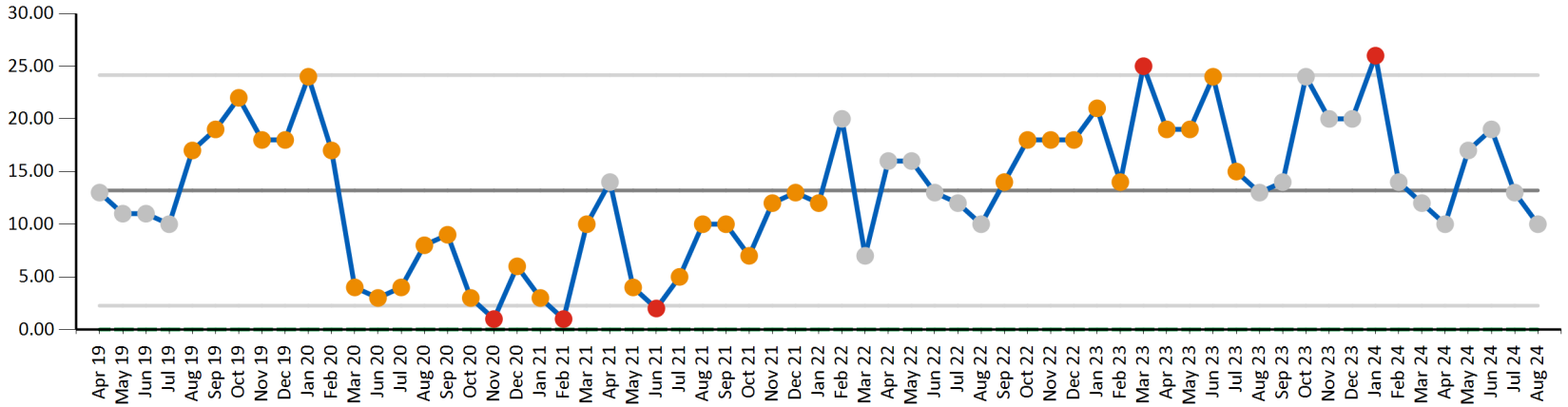
Plan	Actual
= 100%	33.3%

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	10	Aug-24

Previous

Plan	Actual	Period
= 0	13	Jul-24

Year to Date

Plan	Actual
= 0	69

Quality and Safety - Infection Prevention and Control

Bolton NHS Foundation Trust

Clostridium difficile infections remain the key IPC challenge. In relation to the other HCAIs that are reported, Bolton ranks as either the second best out of the six providers in GM (for MSSA, E. coli, Klebsiella spp. and Pseudomonas aeruginosa bacteraemias) or third (for MRSA bacteraemias).

Addressing Clostridium difficile infections the IPC Committee is now receiving increasing assurance from weekly monitoring of:
- Hand hygiene compliance (staff and patient)
- Use of PPE
- General cleaning by iFM
- Prompt suspicion of infection from symptoms starting

The areas of ongoing focus:
- Timely isolation of patients – numerous new processes are being used to improve accountability for isolation including breach meetings for non-compliance and additional work with night teams to understand why there are overnight delays. There are now six wards engaged in isolation with the flow team as part of the QI collabrative
- Antimicrobial stewardship – the Divisional Medical Directors will be reporting audit data for August prescribing to the IPC Committee 25/09/24 for assurance
- Completion of cleaning rotas by ward staff – this is being addressed by a new QI workstream as part of the collaborative

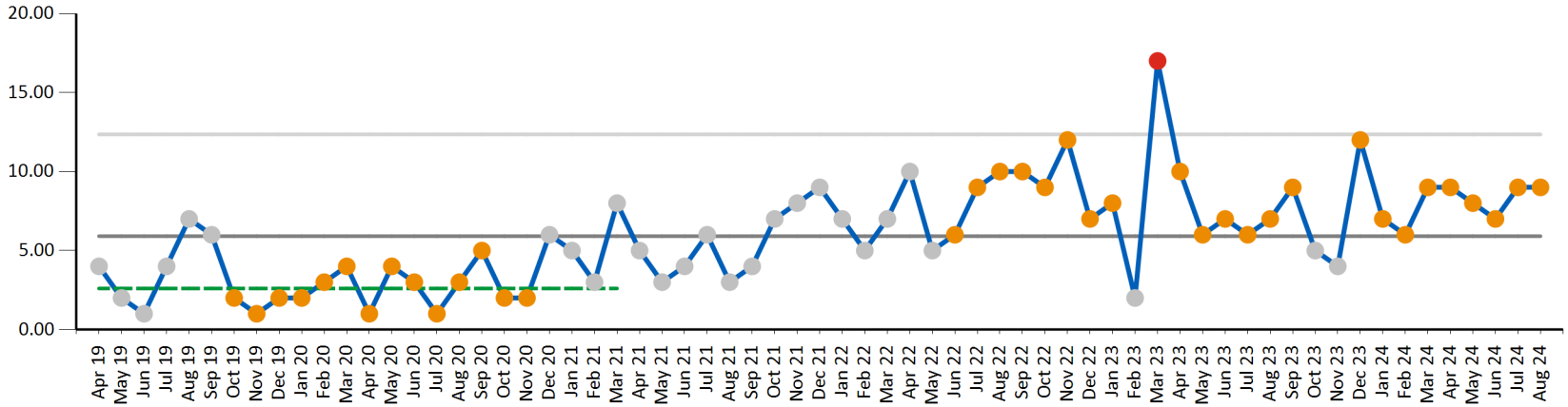
A paper has been completed for discussion with the Executive team regarding the operational and clinical options for a Clostridium difficile cohort ward; this preparation and planning work is being undertaken in parallel to the isolation workstreams.

	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	Aug-24			9	Jul-24		42	
346 - Total Community Onset Hospital Associated C.diff infections		4	Aug-24			3	Jul-24		26	
347 - Total C.diff infections contributing to objective	<= 7	13	Aug-24		<= 7	12	Jul-24	<= 33	68	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Aug-24		= 0	0	Jul-24	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	3	Aug-24		<= 4	5	Jul-24	<= 21	19	
219 - Blood Culture Contaminants (rate)	<= 3%	2.6%	Aug-24		<= 3%	3.9%	Jul-24	<= 3%	3.1%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Aug-24		<= 1.0	0.0	Jul-24	<= 5.0	6.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	3	Aug-24		<= 1	0	Jul-24	<= 3	7	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Aug-24		= 0	1	Jul-24	= 0	2	
491 - Nosocomial COVID-19 cases		10	Aug-24			16	Jul-24		105	

215 - Total Hospital Onset C.diff infections

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	9	Aug-24

Previous

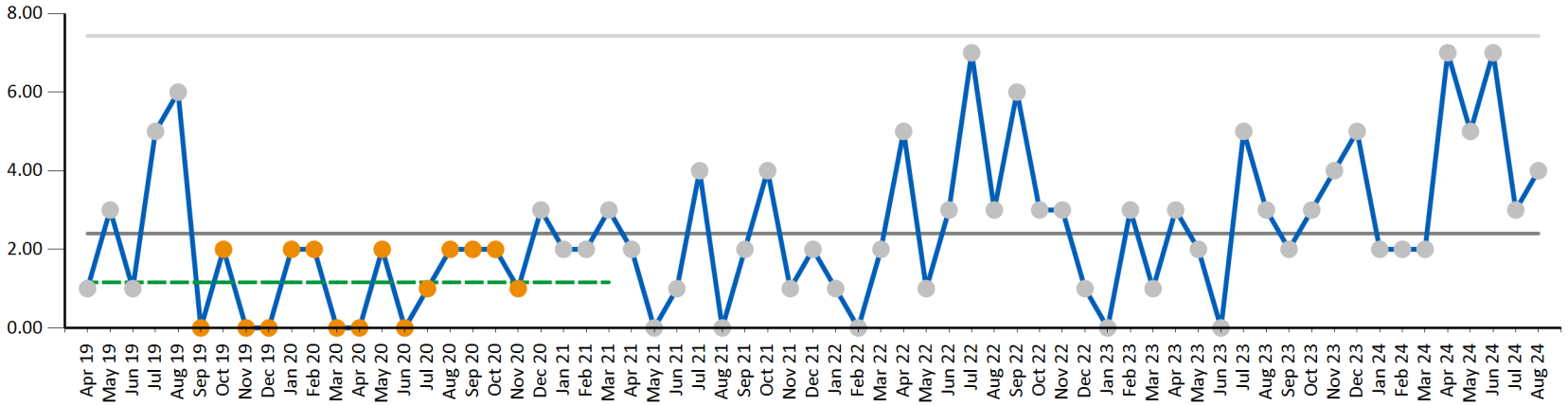
Plan	Actual	Period
	9	Jul-24

Year to Date

Plan	Actual
	42

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	4	Aug-24

Previous

Plan	Actual	Period
	3	Jul-24

Year to Date

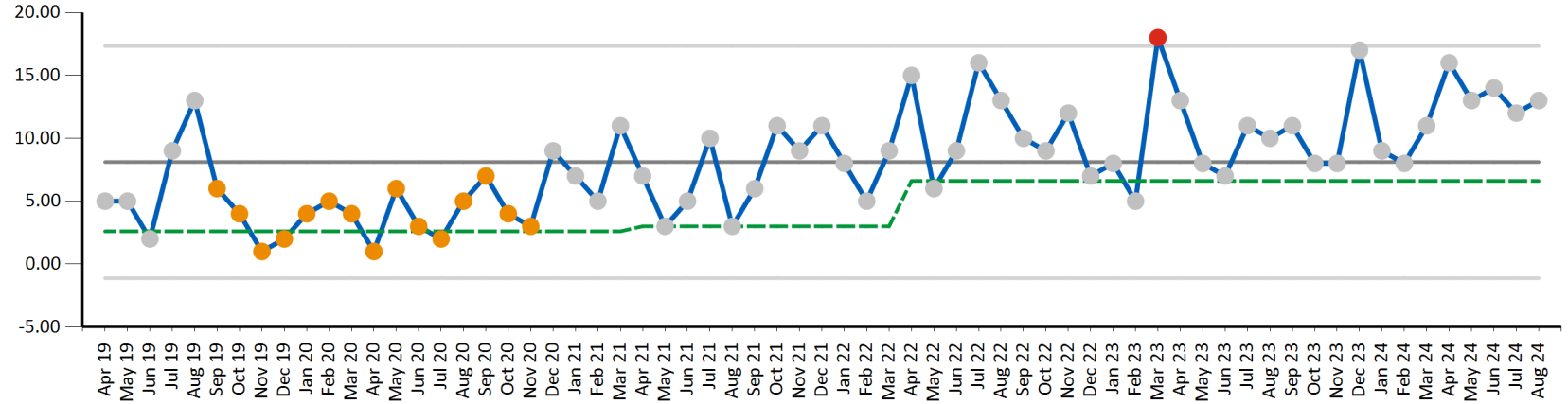
Plan	Actual
	26

347 - Total C.diff infections contributing to objective

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 7	13	Aug-24

Previous

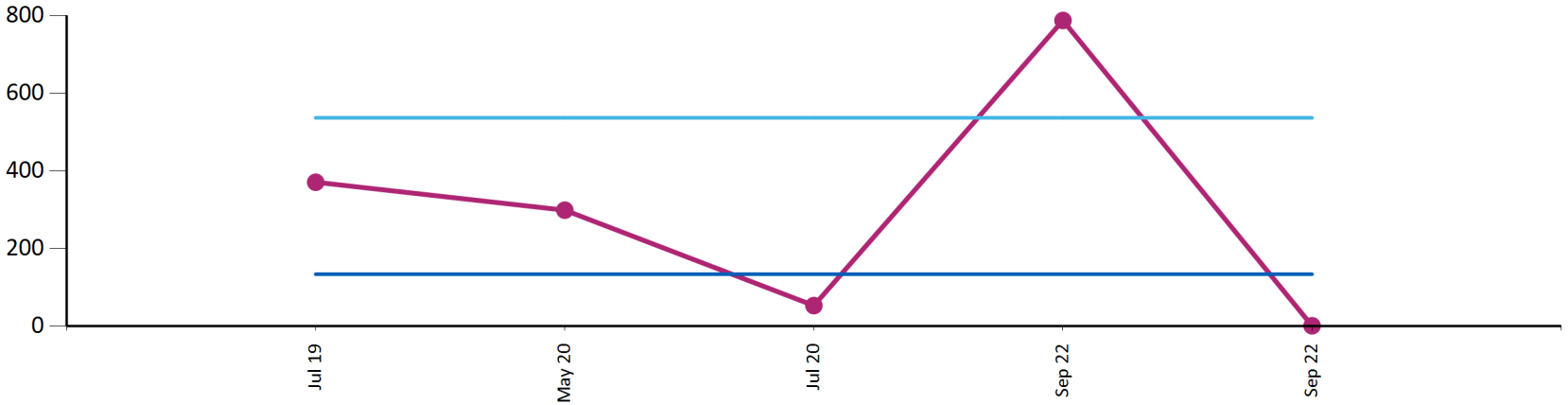
Plan	Actual	Period
<= 7	12	Jul-24

Year to Date

Plan	Actual
<= 33	68

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Aug-24

Previous

Plan	Actual	Period
	0	Jul-24

Year to Date

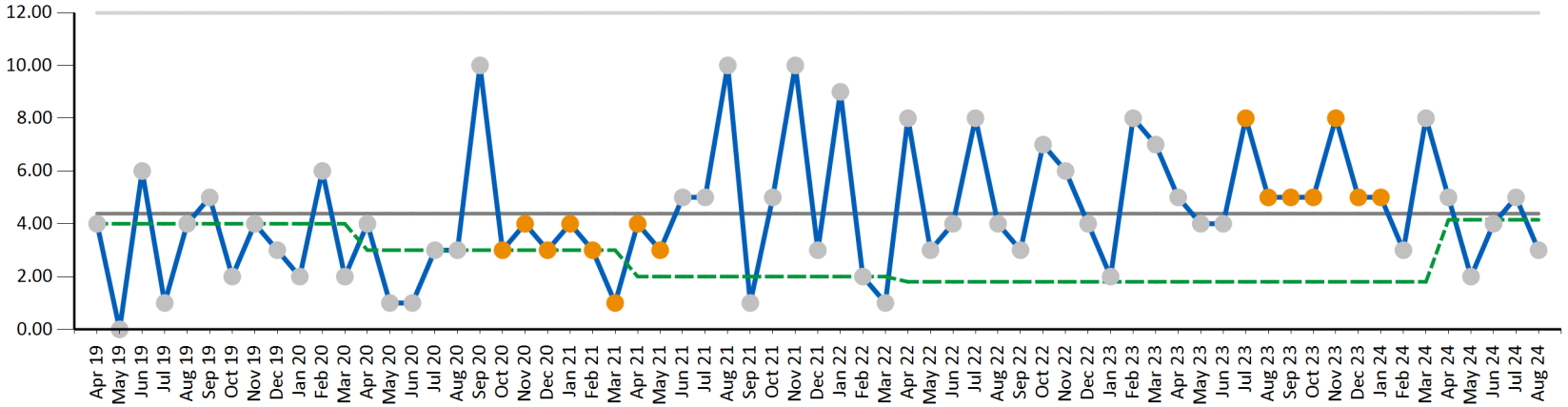
Plan	Actual

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 4	3	Aug-24

Previous

Plan	Actual	Period
<= 4	5	Jul-24

Year to Date

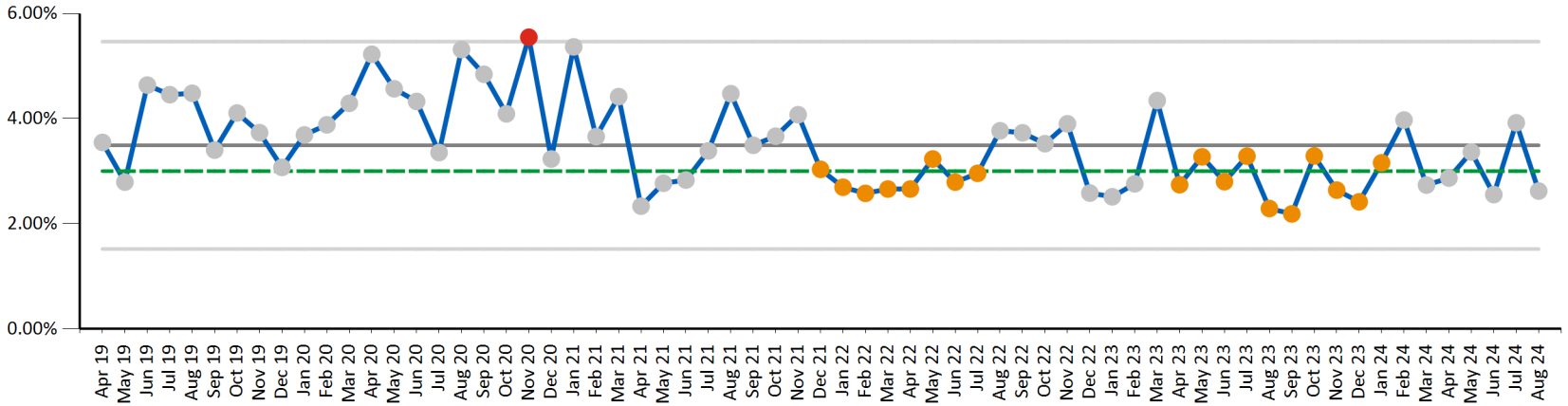
Plan	Actual
<= 21	19

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%	2.6%	Aug-24

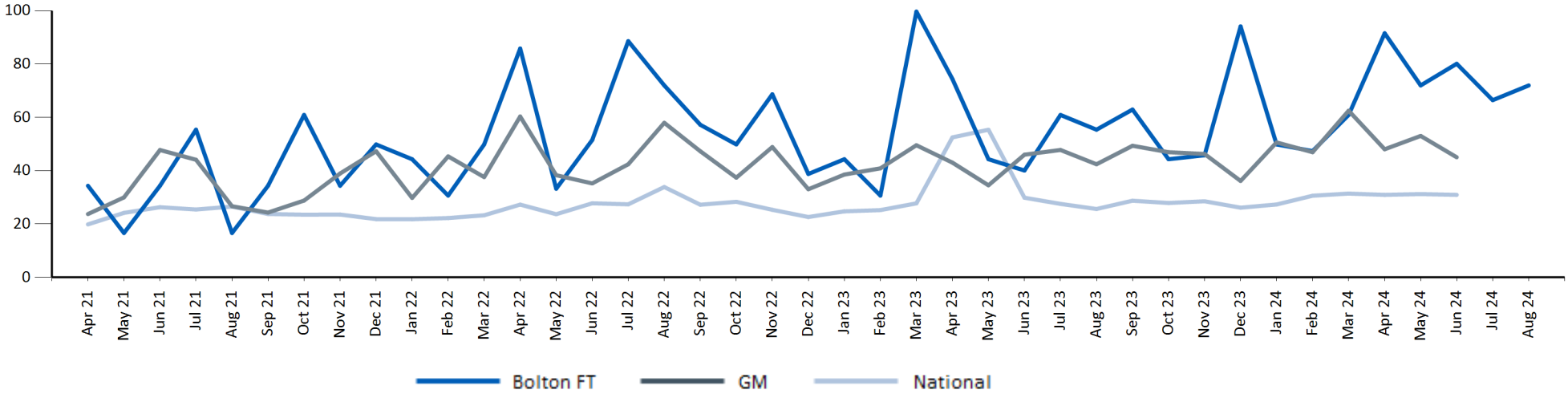
Previous

Plan	Actual	Period
<= 3%	3.9%	Jul-24

Year to Date

Plan	Actual
<= 3%	3.1%

549 - C Diff Rate Comparison

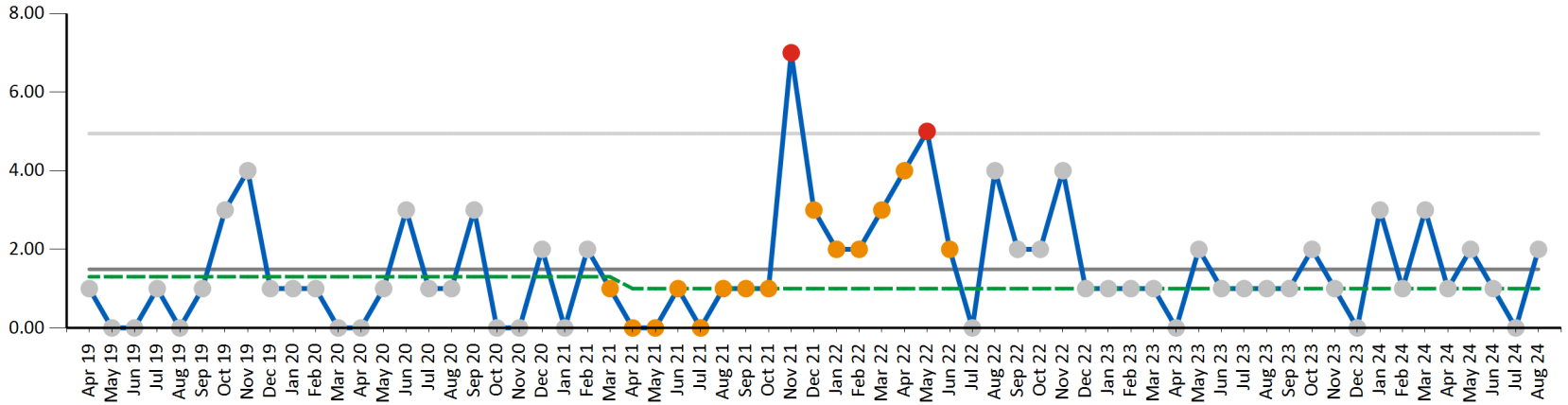


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Aug-24

Previous

Plan	Actual	Period
<= 1.0	0.0	Jul-24

Year to Date

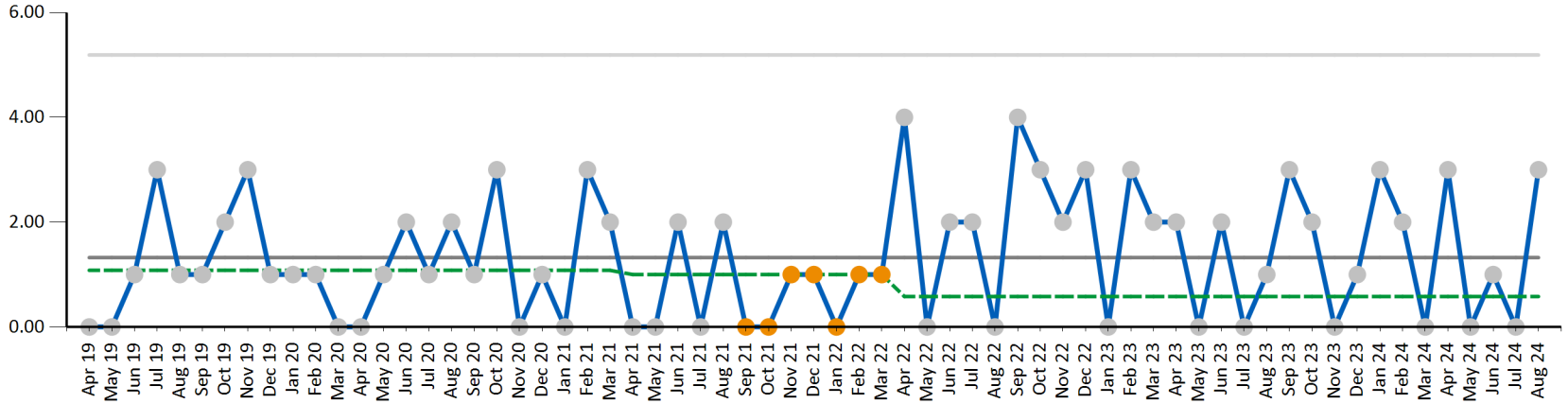
Plan	Actual
<= 5.0	6.0

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1	3	Aug-24

Previous

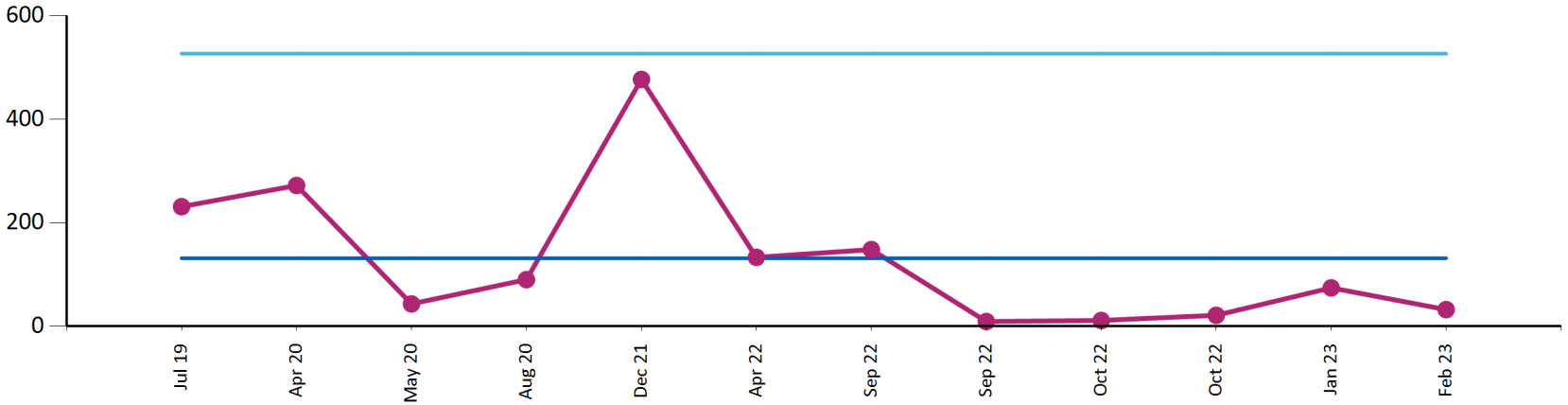
Plan	Actual	Period
<= 1	0	Jul-24

Year to Date

Plan	Actual
<= 3	7

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

0/6



Latest

Plan	Actual	Period
	0	Aug-24

Previous

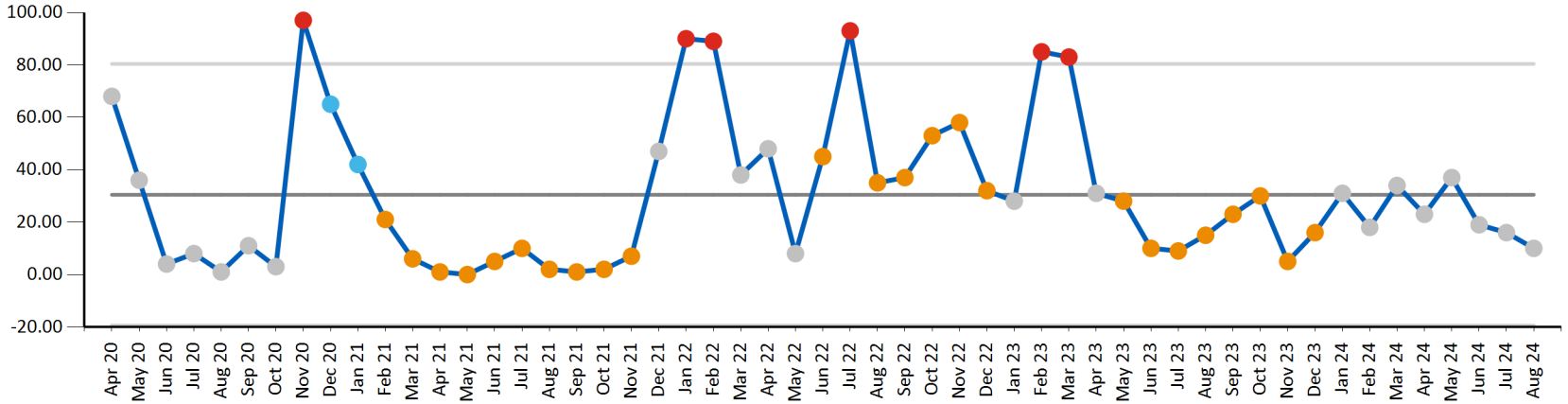
Plan	Actual	Period
	0	Jul-24

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	10	Aug-24

Previous

Plan	Actual	Period
	16	Jul-24

Year to Date

Plan	Actual
	105

Quality and Safety - Mortality

NHS Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is now showing an improvement of 7 months below the average. It has now remained in control for more than 3 years.

HSMR – in month figure is below average for the period and remains in control. The 12 month rolling average to March 2024 is 110.82 which is an 'Red' alert when compared to other Trusts.

SHMI – In month figure is above average for the time period and remains in control. The published rolling average for the period May 2023 to April 2024 is 114.6 which is 'higher than expected'. The methodology behind the calculation has changed at national level causing an increase in Bolton's SHMI due to the inclusion of any patient with a diagnosis of covid who were previously excluded.

The proportion of Charlson comorbidities is at the average for the time frame. The depth of recording remains in control but is lower than average. Both indictors are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot remains within range and slightly above average.

The early neonatal mortality remains in control and has been for the last 11 months. The neonatal mortality (7-28days) when shown as an SPC becomes patient identifiable so is not included in these papers.

	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%	Aug-24		>= 85%	96.7%	Jul-24	>= 85%	96.3%	
495 - HSMR		108.92	Apr-24			107.35	Mar-24		108.92	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	121.83	Mar-24		<= 100.00	125.24	Feb-24	<= 100.00		
12 - Crude Mortality %	<= 2.9%	2.1%	Aug-24		<= 2.9%	1.9%	Jul-24	<= 2.9%	2.2%	
519 - Average Charlson comorbidity Score (First episode of care)		4	May-24			4	Apr-24		8	
520 - Depth of recording (First episode of care)		6	May-24			6	Apr-24		12	
521 - Proportion of fully coded records (Inpatients)		97.0%	Jun-24			97.7%	May-24		97.1%	

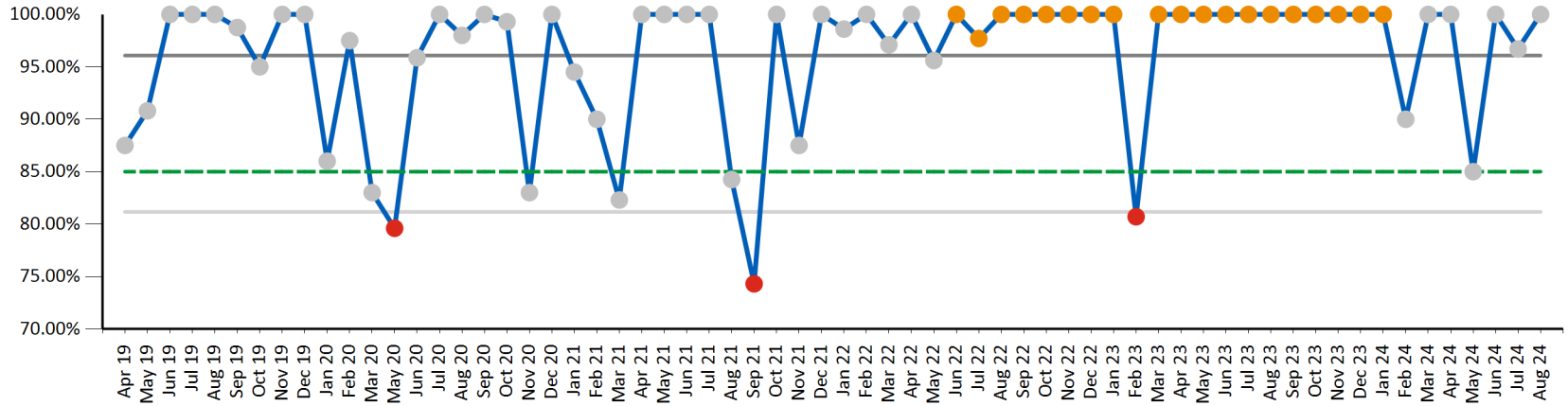
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		7.10	Aug-24			7.19	Jul-24			

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%	Aug-24

Previous

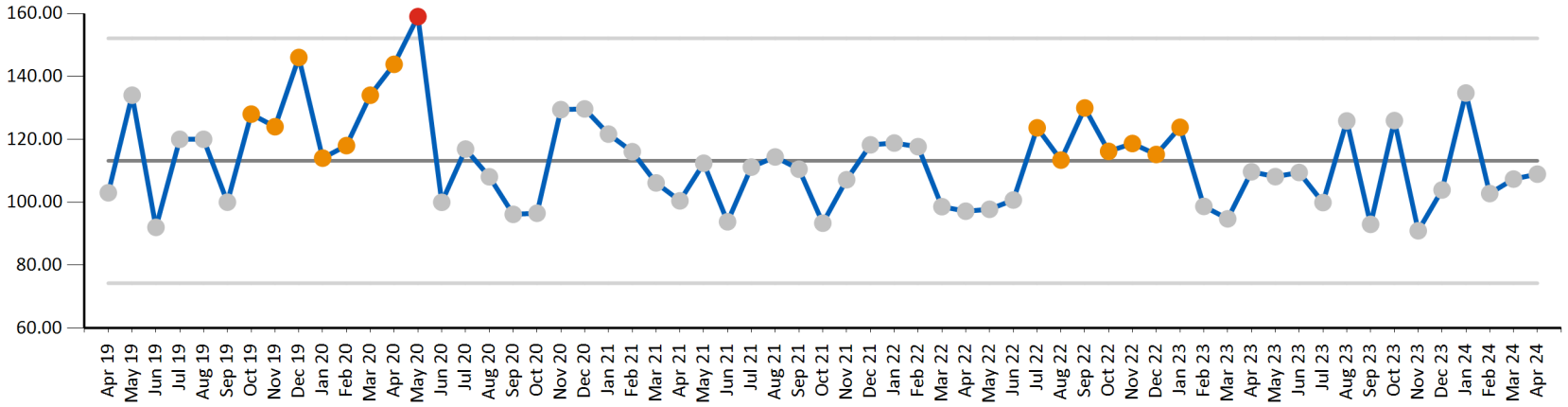
Plan	Actual	Period
>= 85%	96.7%	Jul-24

Year to Date

Plan	Actual
>= 85%	96.3%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	108.92	Apr-24

Previous

Plan	Actual	Period
	107.35	Mar-24

Year to Date

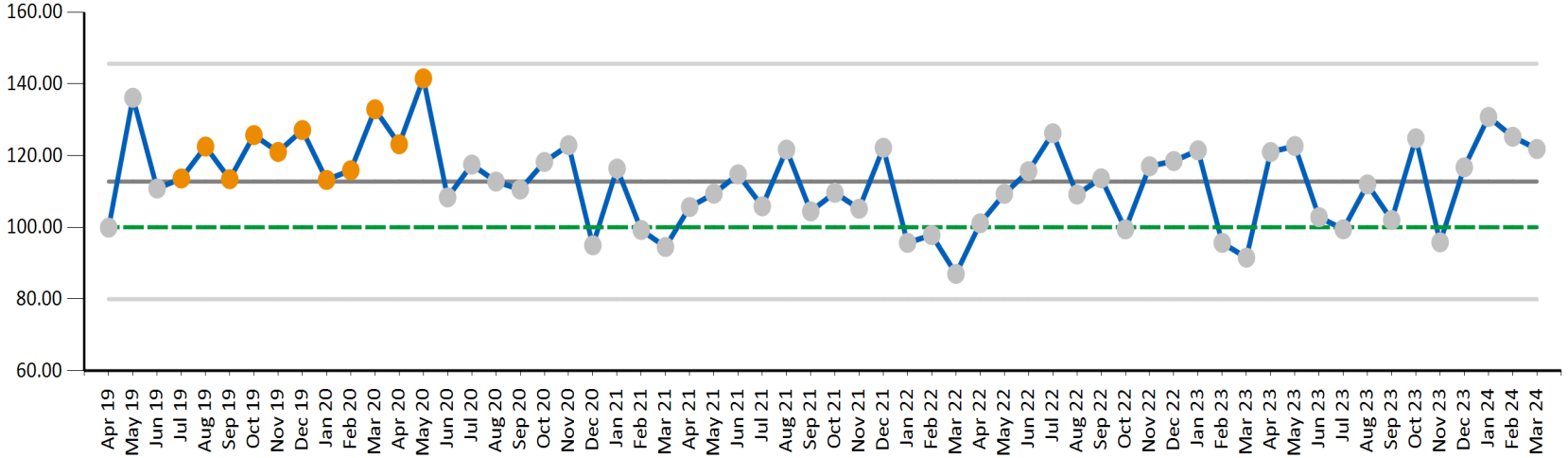
Plan	Actual
	108.92

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 100.00	121.83	Mar-24

Previous

Plan	Actual	Period
<= 100.00	125.24	Feb-24

Year to Date

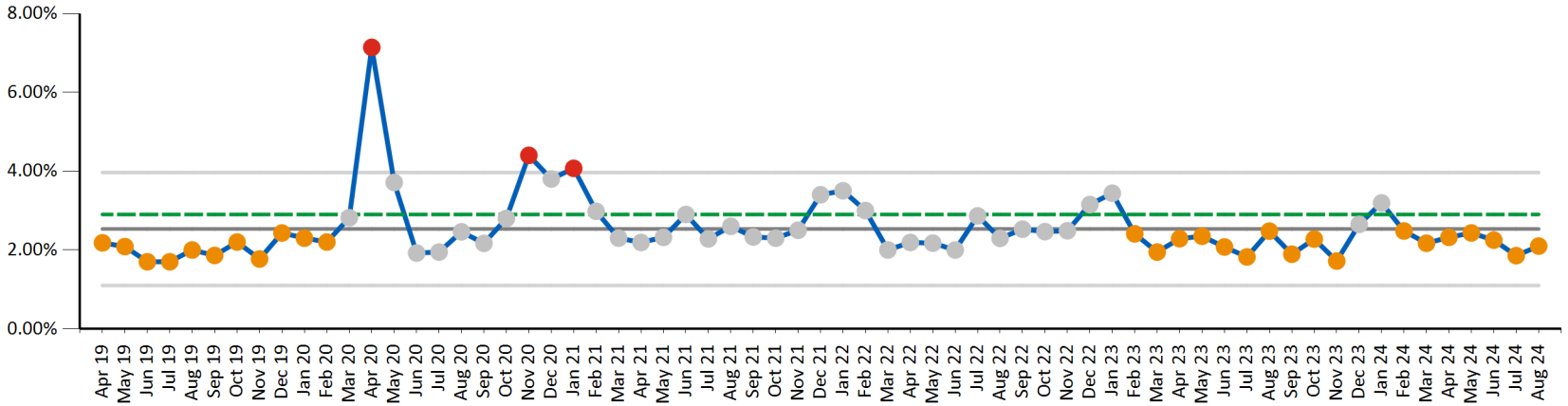
Plan	Actual
<= 100.00	121.83

12 - Crude Mortality %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 2.9%	2.1%	Aug-24

Previous

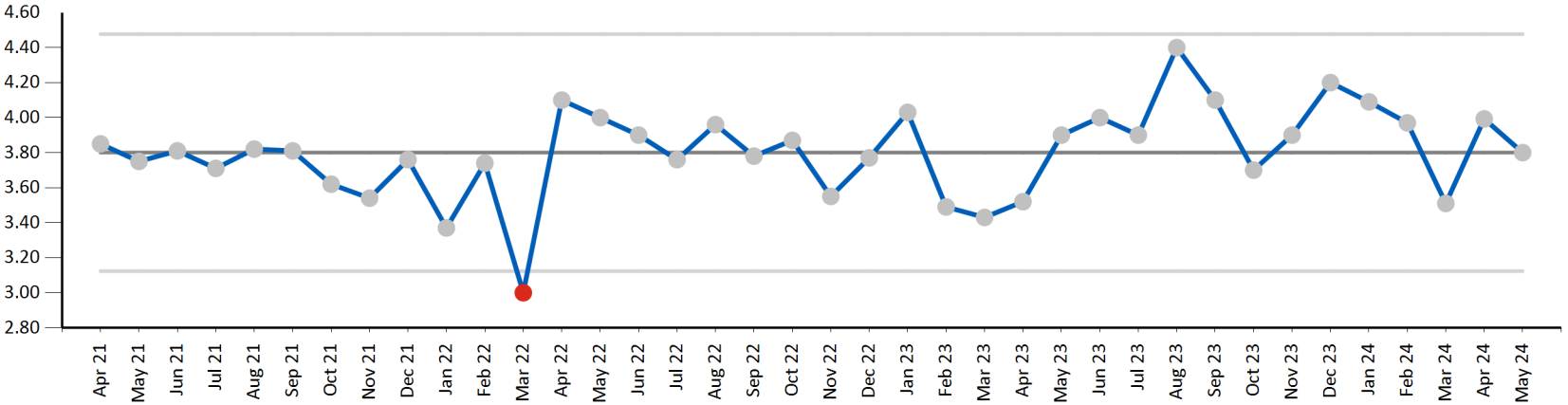
Plan	Actual	Period
<= 2.9%	1.9%	Jul-24

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	May-24

Previous

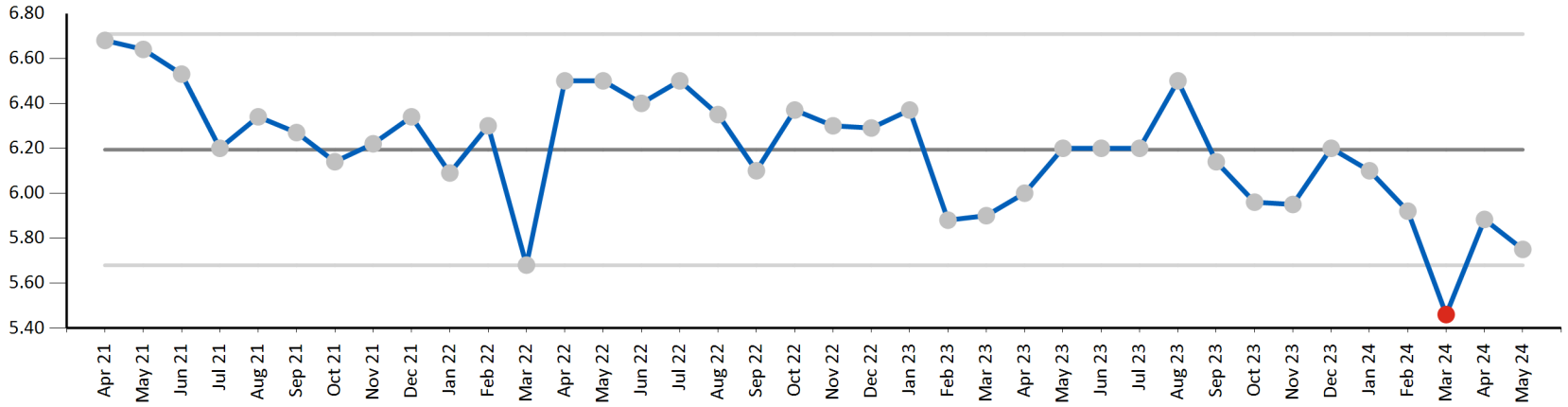
Plan	Actual	Period
	4	Apr-24

Year to Date

Plan	Actual
	8

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	May-24

Previous

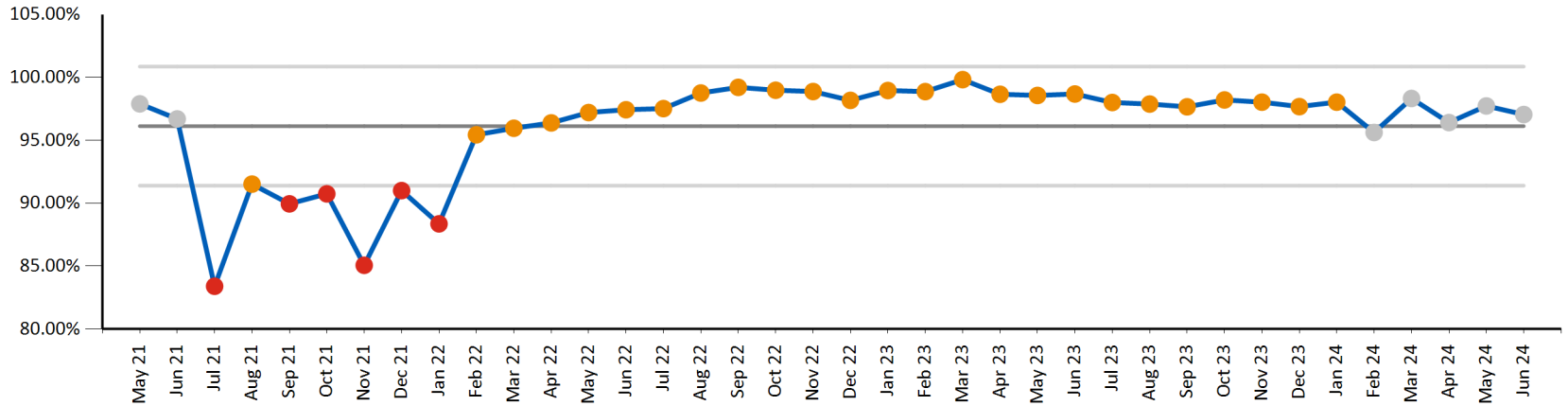
Plan	Actual	Period
	6	Apr-24

Year to Date

Plan	Actual
	12

521 - Proportion of fully coded records (Inpatients)

Common cause variation.



Latest

Plan	Actual	Period
	97.0%	Jun-24

Previous

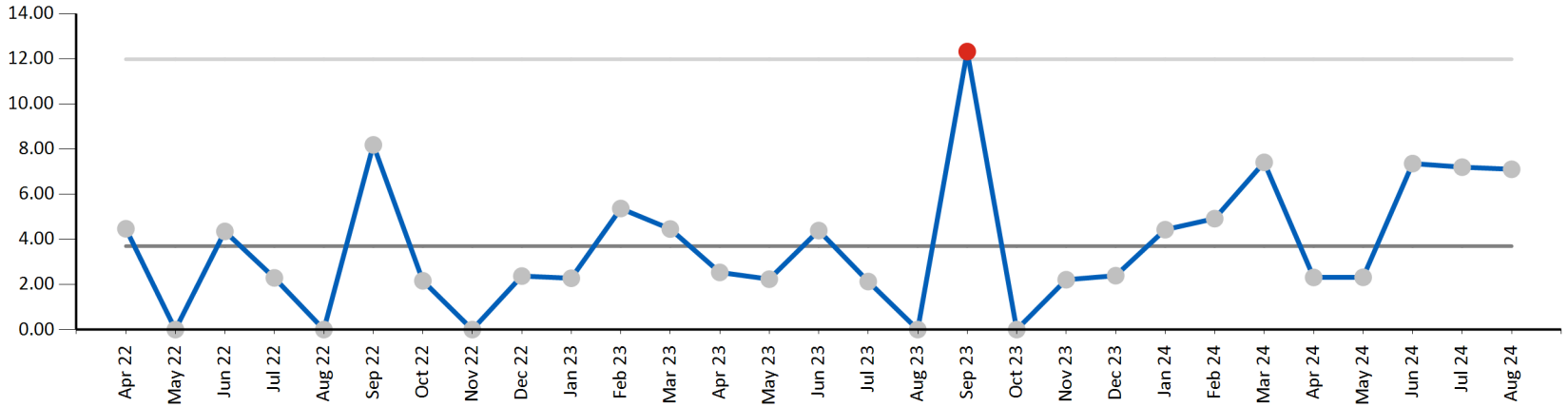
Plan	Actual	Period
	97.7%	May-24

Year to Date

Plan	Actual
	97.1%

604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)

Common cause variation.



Latest

Plan	Actual	Period
	7.10	Aug-24

Previous

Plan	Actual	Period
	7.19	Jul-24

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

Bolton NHS Trust is relaunching the Patient Experience Group, incorporating the Very Important Person (VIP) forum to enhance feedback inclusivity across hospital and community services. This initiative aims to amplify the patient voice in decision-making processes, focusing on two key areas: dignity in treatment and involvement in care decisions. Bolton NHS Trust is enhancing its executive engagement strategy with renewed visual communications. Updated patient experience posters will be displayed by month 6 end, covering bed spaces, trolleys and community clinics for maximum visibility and impact across all facilities. Maternity Services: Friends and Family Test response rate increased to 20.7% via the use of QR codes. Satisfaction slightly decreased to 94.4%. Monitoring continues. Emergency Department: Response rate below target at 16.2%, satisfaction at 86.9%. Issues include wait times and communication. New patient experience forum launched to address concerns collaboratively.

	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%	16.2%	Aug-24		>= 20%	15.6%	Jul-24	>= 20%	15.3%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	86.7%	Aug-24		>= 90%	87.9%	Jul-24	>= 90%	85.4%	
80 - Inpatient Friends and Family Response Rate	>= 30%	28.5%	Aug-24	H	>= 30%	29.2%	Jul-24	>= 30%	29.2%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.0%	Aug-24		>= 90%	96.7%	Jul-24	>= 90%	95.8%	P
81 - Maternity Friends and Family Response Rate	>= 15%	20.7%	Aug-24		>= 15%	18.0%	Jul-24	>= 15%	23.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	94.4%	Aug-24		>= 90%	95.1%	Jul-24	>= 90%	92.4%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	1.4%	Aug-24		>= 15%	1.9%	Jul-24	>= 15%	8.4%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	83.3%	Aug-24		>= 90%	80.0%	Jul-24	>= 90%	92.6%	
83 - Birth - Friends and Family Response Rate	>= 15%	40.5%	Aug-24	H	>= 15%	41.4%	Jul-24	>= 15%	39.6%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	93.8%	Aug-24		>= 90%	95.6%	Jul-24	>= 90%	91.5%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	31.2%	Aug-24		>= 15%	23.6%	Jul-24	>= 15%	32.4%	

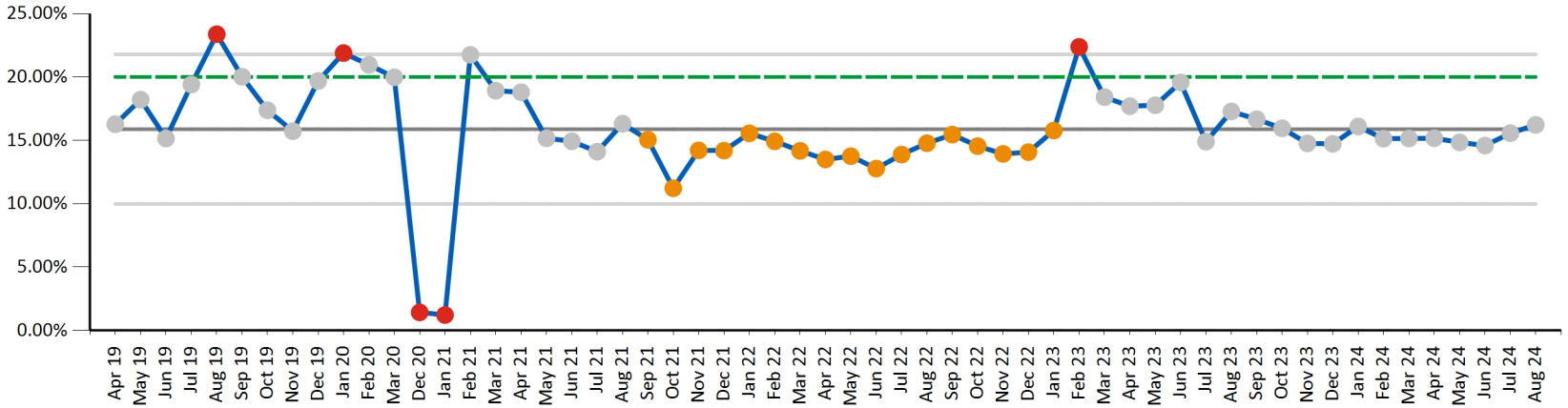
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	94.6%	Aug-24	H	>= 90%	95.8%	Jul-24	>= 90%	93.3%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	11.9%	Aug-24		>= 15%	10.3%	Jul-24	>= 15%	18.4%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	97.8%	Aug-24		>= 90%	95.6%	Jul-24	>= 90%	90.6%	?
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Aug-24	H	= 100%	100.0%	Jul-24	= 100%	100.0%	?
90 - Complaints responded to within the period	>= 95%	65.0%	Aug-24		>= 95%	66.7%	Jul-24	>= 95%	74.3%	?

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%	16.2%	Aug-24

Previous

Plan	Actual	Period
>= 20%	15.6%	Jul-24

Year to Date

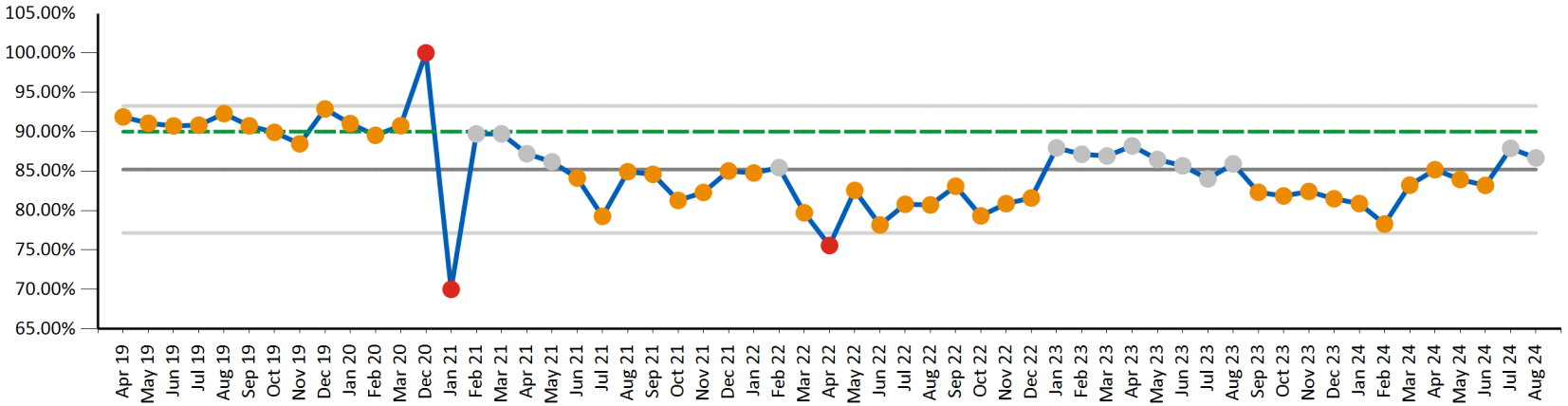
Plan	Actual
>= 20%	15.3%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90%	86.7%	Aug-24

Previous

Plan	Actual	Period
>= 90%	87.9%	Jul-24

Year to Date

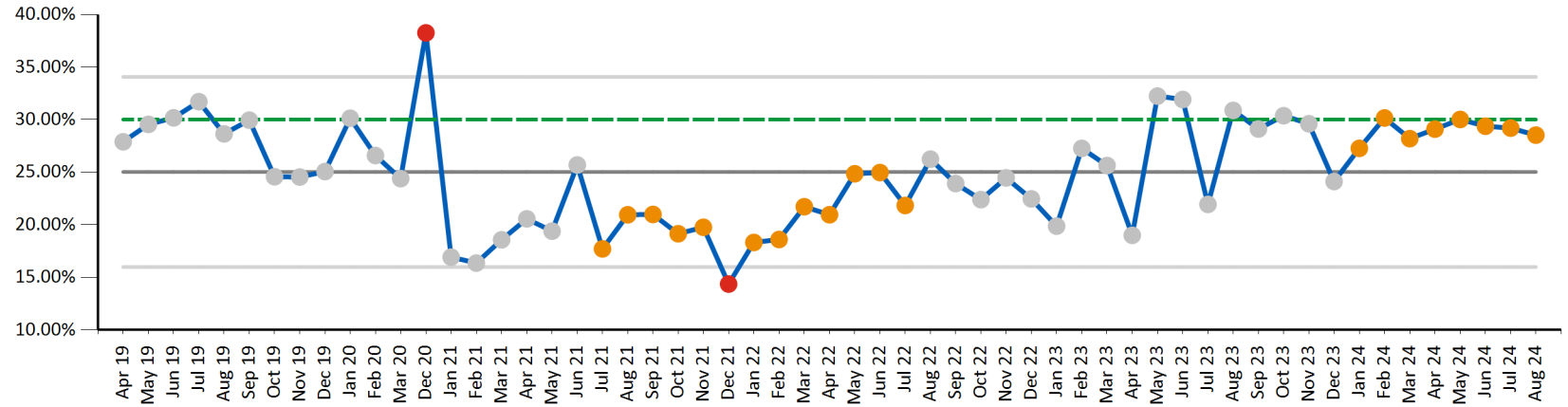
Plan	Actual
>= 90%	85.4%

80 - Inpatient Friends and Family Response Rate

Special cause variation with improving performance

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

1/6



Latest

Plan	Actual	Period
>= 30%	28.5%	Aug-24

Previous

Plan	Actual	Period
>= 30%	29.2%	Jul-24

Year to Date

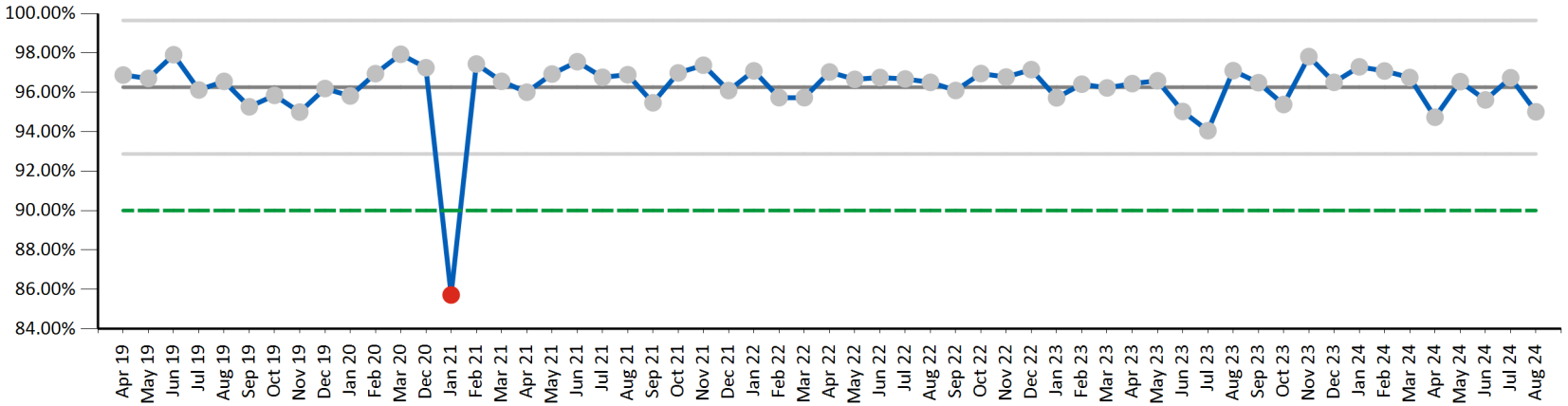
Plan	Actual
>= 30%	29.2%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	95.0%	Aug-24

Previous

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

Year to Date

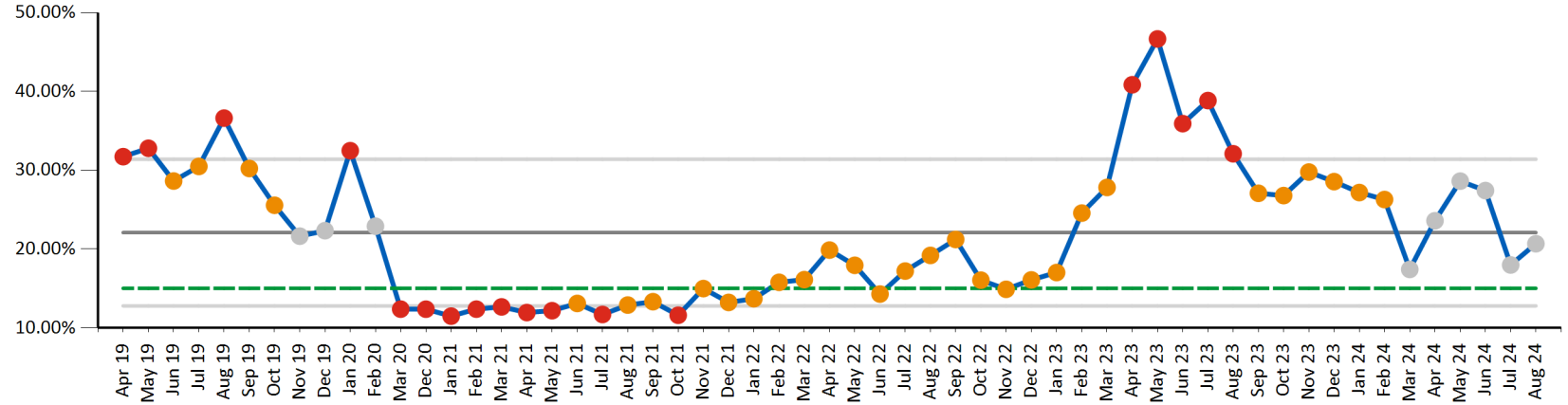
Plan	Actual
>= 90%	95.8%

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%	20.7%	Aug-24

Previous

Plan	Actual	Period
>= 15%	18.0%	Jul-24

Year to Date

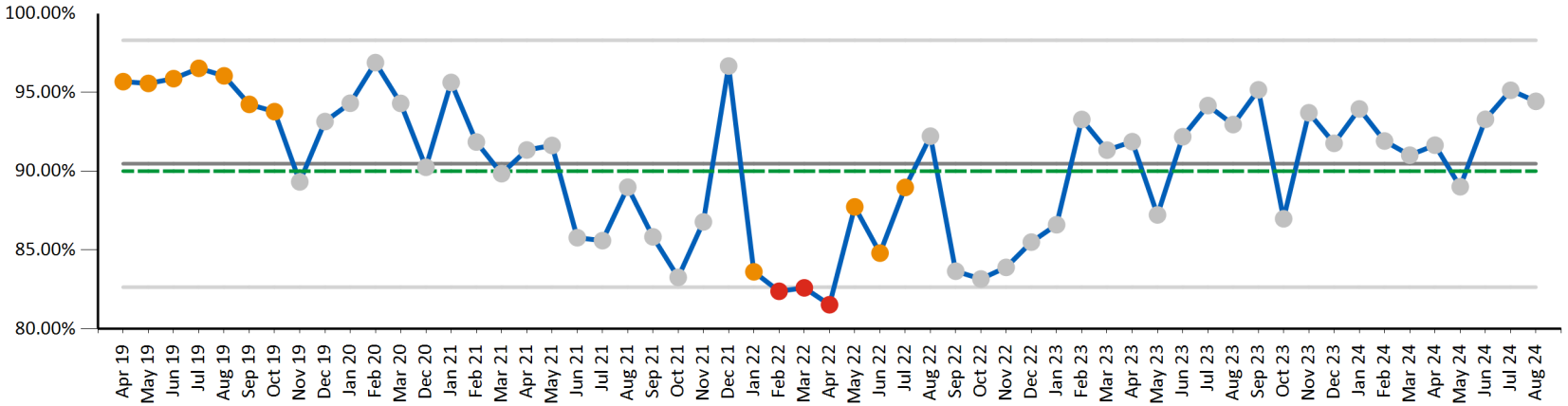
Plan	Actual
>= 15%	23.6%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	94.4%	Aug-24

Previous

Plan	Actual	Period
>= 90%	95.1%	Jul-24

Year to Date

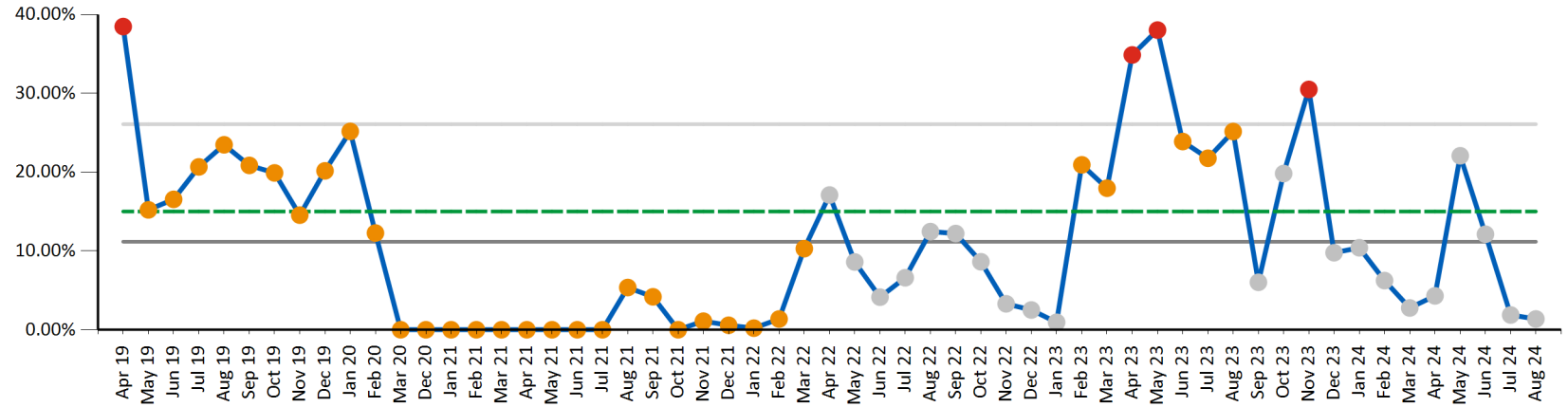
Plan	Actual
>= 90%	92.4%

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%	1.4%	Aug-24

Previous

Plan	Actual	Period
>= 15%	1.9%	Jul-24

Year to Date

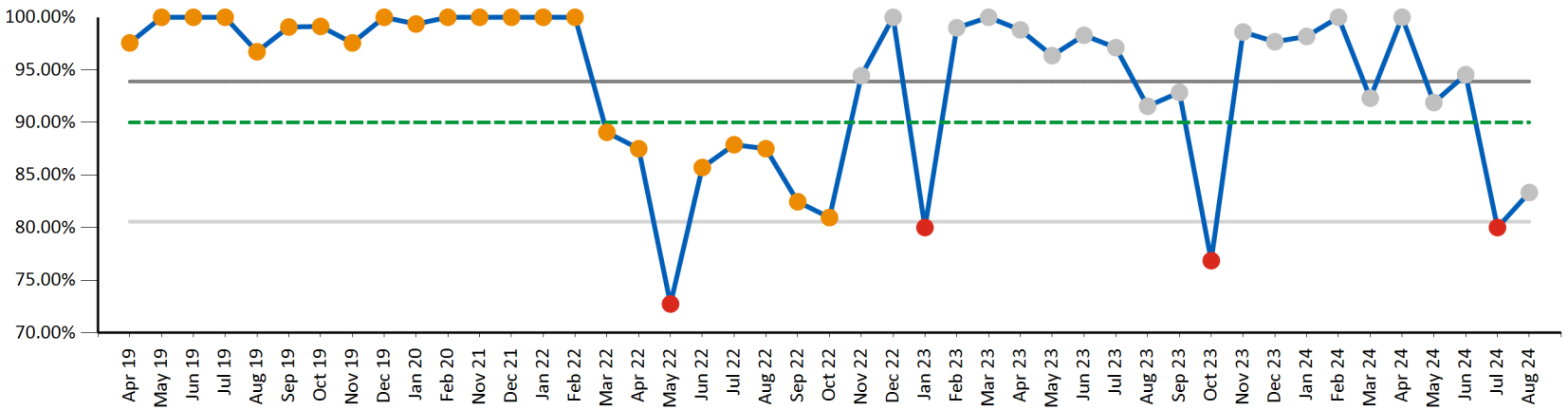
Plan	Actual
>= 15%	8.4%

242 - Antenatal 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%	83.3%	Aug-24

Previous

Plan	Actual	Period
>= 90%	80.0%	Jul-24

Year to Date

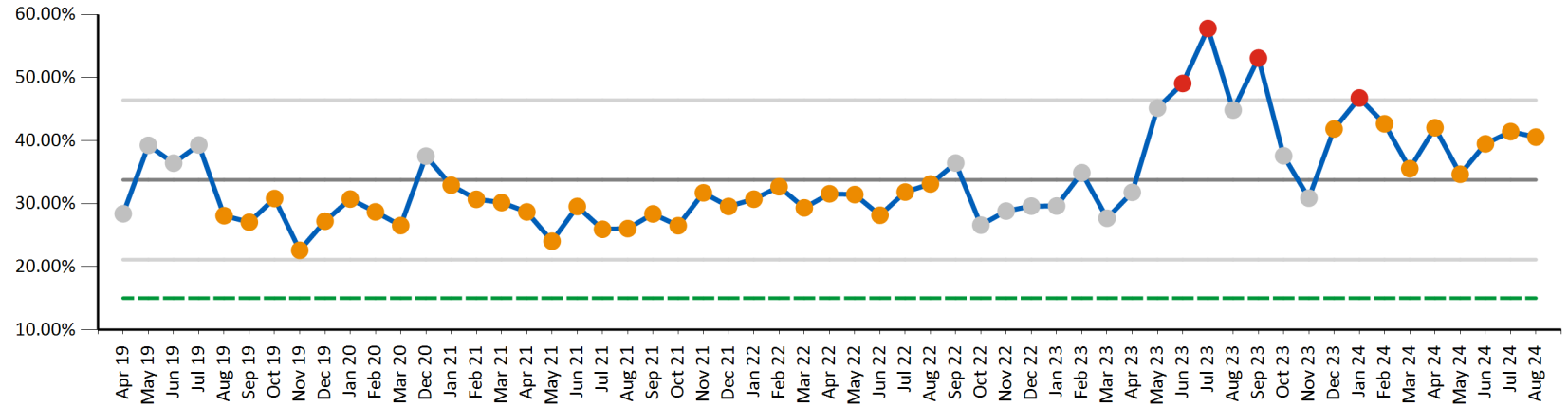
Plan	Actual
>= 90%	92.6%

83 - Birth - Friends and Family Response Rate

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	40.5%	Aug-24

Previous

Plan	Actual	Period
>= 15%	41.4%	Jul-24

Year to Date

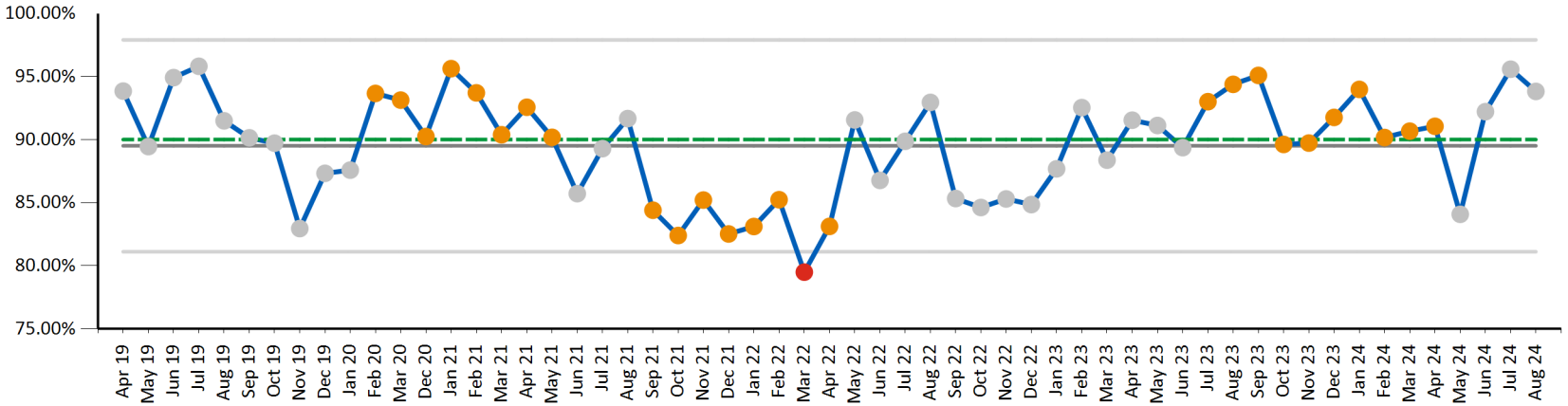
Plan	Actual
>= 15%	39.6%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	93.8%	Aug-24

Previous

Plan	Actual	Period
>= 90%	95.6%	Jul-24

Year to Date

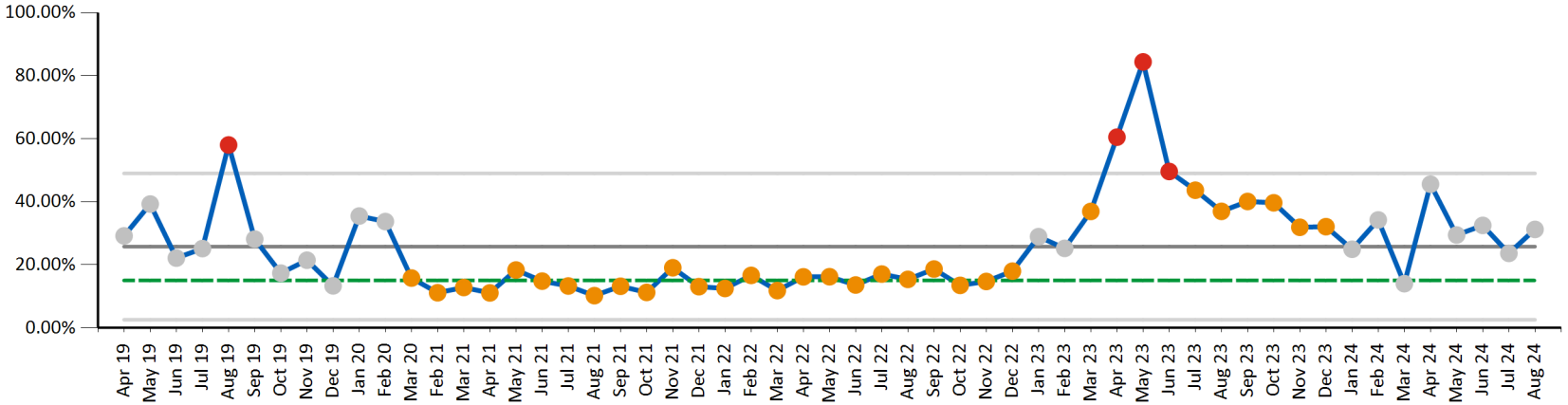
Plan	Actual
>= 90%	91.5%

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%	31.2%	Aug-24

Previous

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

Year to Date

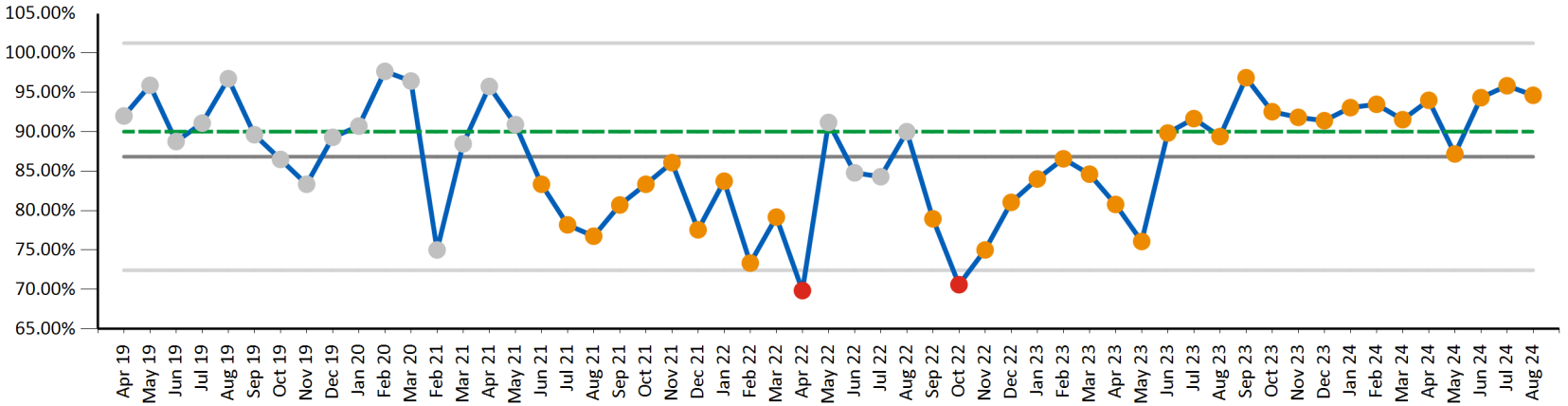
Plan	Actual
>= 15%	32.4%

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.

5/6



Latest

Plan	Actual	Period
>= 90%	94.6%	Aug-24

Previous

Plan	Actual	Period
>= 90%	95.8%	Jul-24

Year to Date

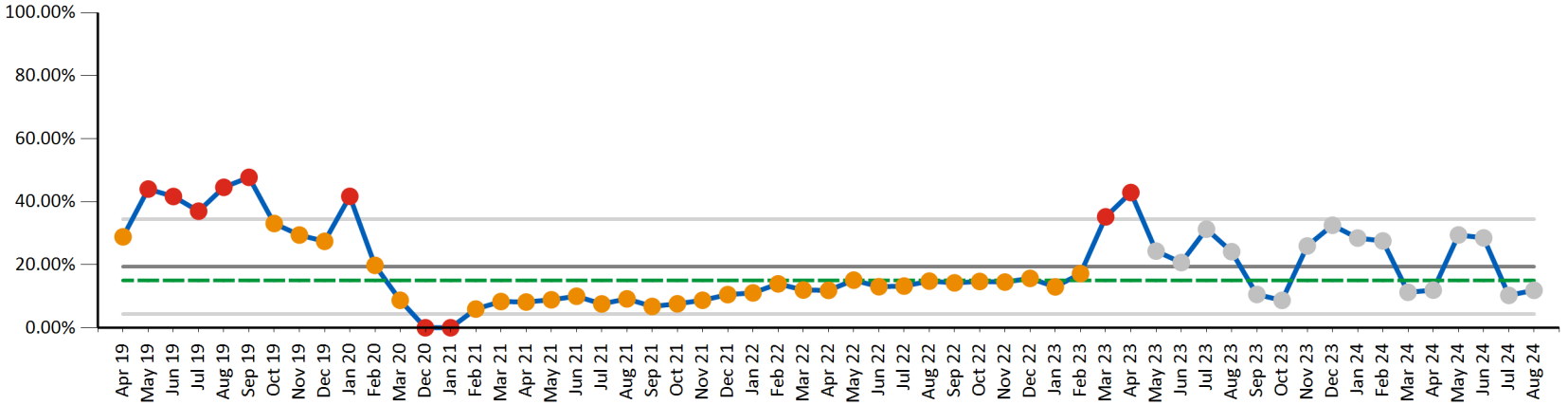
Plan	Actual
>= 90%	93.3%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

2/6



Latest

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

Previous

Plan	Actual	Period
>= 15%	10.3%	Jul-24

Year to Date

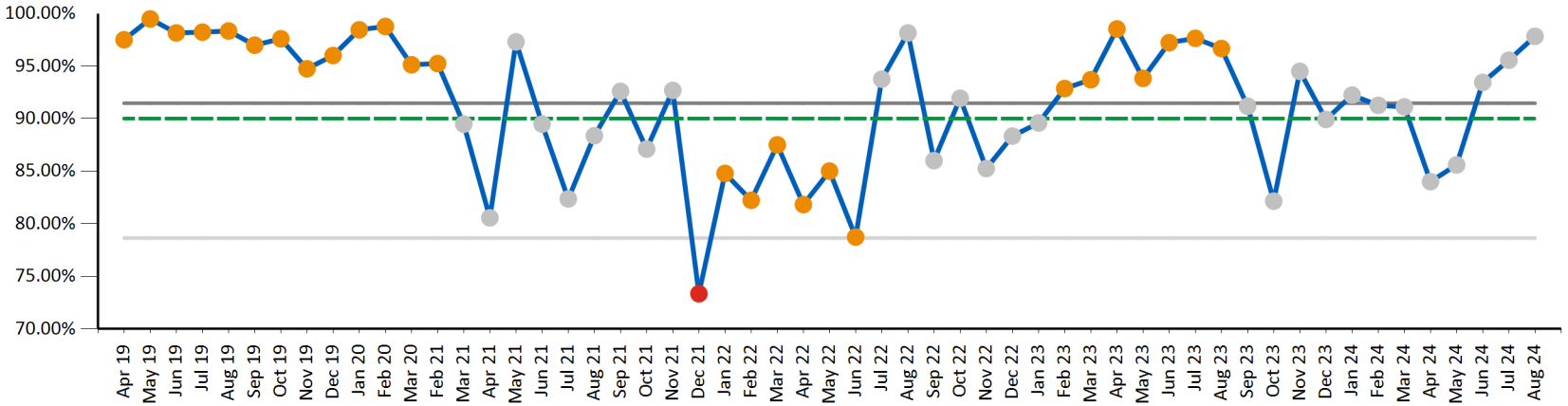
Plan	Actual
>= 15%	18.4%

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%	97.8%	Aug-24

Previous

Plan	Actual	Period
>= 90%	95.6%	Jul-24

Year to Date

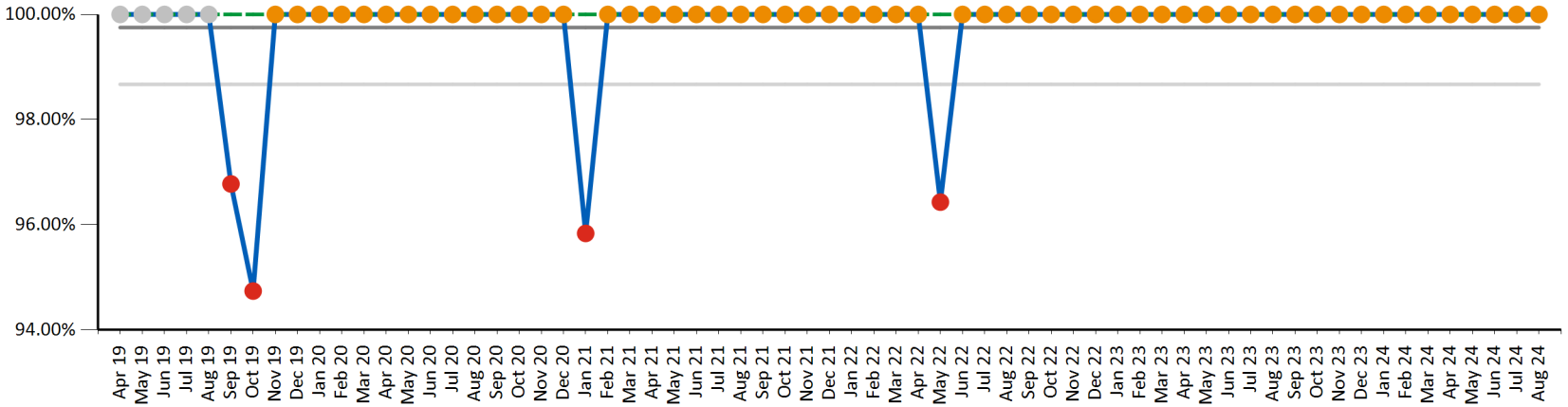
Plan	Actual
>= 90%	90.6%

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%	Aug-24

Previous

Plan	Actual	Period
= 100%	100.0%	Jul-24

Year to Date

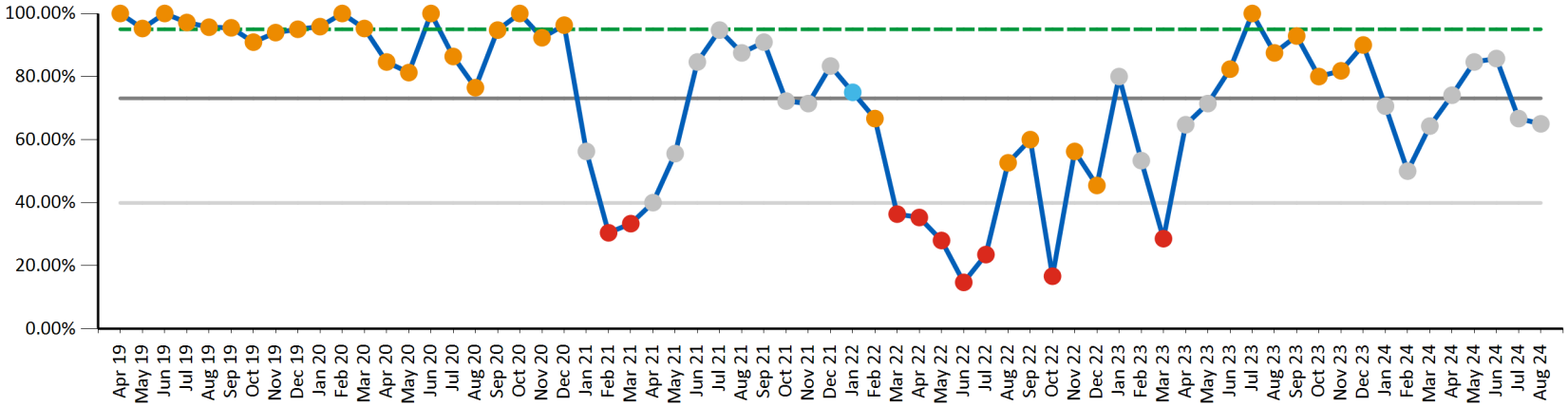
Plan	Actual
= 100%	100.0%

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%	65.0%	Aug-24

Previous

Plan	Actual	Period
>= 95%	66.7%	Jul-24

Year to Date

Plan	Actual
>= 95%	74.3%

Quality and Safety - Maternity

NHS Bolton NHS Foundation Trust

In August, the incidence of 3rd and 4th degree tears decreased from 3.9% to 3.1%, with a year-to-date rate of 2.9%, slightly above the Greater Manchester and Eastern Cheshire (GMEC) average of 2.81%. The Trust presented at a shared learning event and identified improvement actions, including birth simulation training and support for new staff performing episiotomies. The maternity stillbirth rate was 2.35 per 1000 births. A new oversight table and monthly data verification were introduced. The Trust's rolling rate up to July 2024 was 4.24 per 1000, slightly higher than the GMEC rate of 4.00 per 1000. 1:1 care in labour improved to 99.7%, but the Trust's rate of 86.25% remains below the GMEC average of 95.23%. Booking by 12+6 weeks decreased slightly to 89.2%. The digital self-referral form is progressing. Booking by 10 weeks is at 60.7%, aligning with the GMEC rate of 58.80%. Inductions of labour delayed by 24 hours decreased to 32.6%. A quality improvement project is underway. Breastfeeding initiation decreased from 71.08% to 64.42%, with a year-to-date rate of 69.06%, above the GMEC average of 64.51%. Preterm birth incidence was 9.9% in the month, with a rolling rate of 8.8%, aligning with the GMEC average of 8.73%.

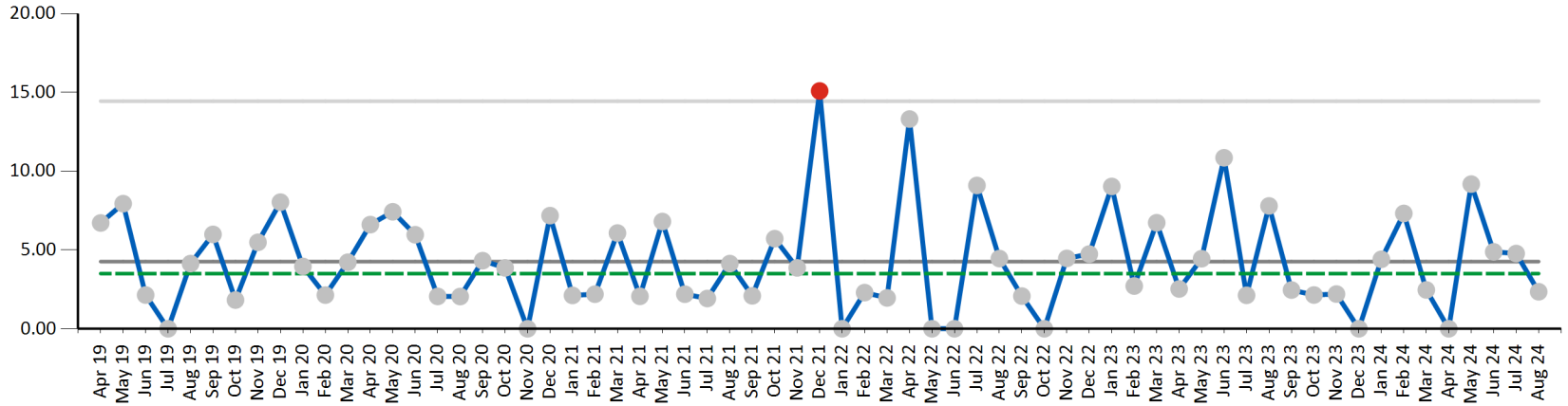
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	2.35	Aug-24		<= 3.50	4.77	Jul-24	<= 3.50	4.24	
23 - Maternity -3rd/4th degree tears	<= 3.5%	3.1%	Aug-24		<= 3.5%	3.9%	Jul-24	<= 3.5%	2.9%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.7%	Aug-24		>= 95.0%	99.0%	Jul-24	>= 95.0%	98.8%	
203 - Booked 12+6	>= 90.0%	89.2%	Aug-24		>= 90.0%	89.8%	Jul-24	>= 90.0%	87.3%	
586 - Booked 10+0		60.7%	Aug-24			59.3%	Jul-24		52.3%	
204 - Inductions of labour - over 24 hours	<= 40%	32.6%	Aug-24		<= 40%	36.2%	Jul-24	<= 40%	32.3%	
210 - Initiation breast feeding	>= 65%	64.42%	Aug-24		>= 65%	71.08%	Jul-24	>= 65%	69.06%	
213 - Maternity complaints	<= 5	0	Aug-24		<= 5	0	Jul-24	<= 20	6	
319 - Maternal deaths (direct)	= 0	0	Aug-24		= 0	0	Jul-24	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.9%	Aug-24		<= 6%	10.5%	Jul-24	<= 6%	8.8%	

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3.50	2.35	Aug-24

Previous

Plan	Actual	Period
<= 3.50	4.77	Jul-24

Year to Date

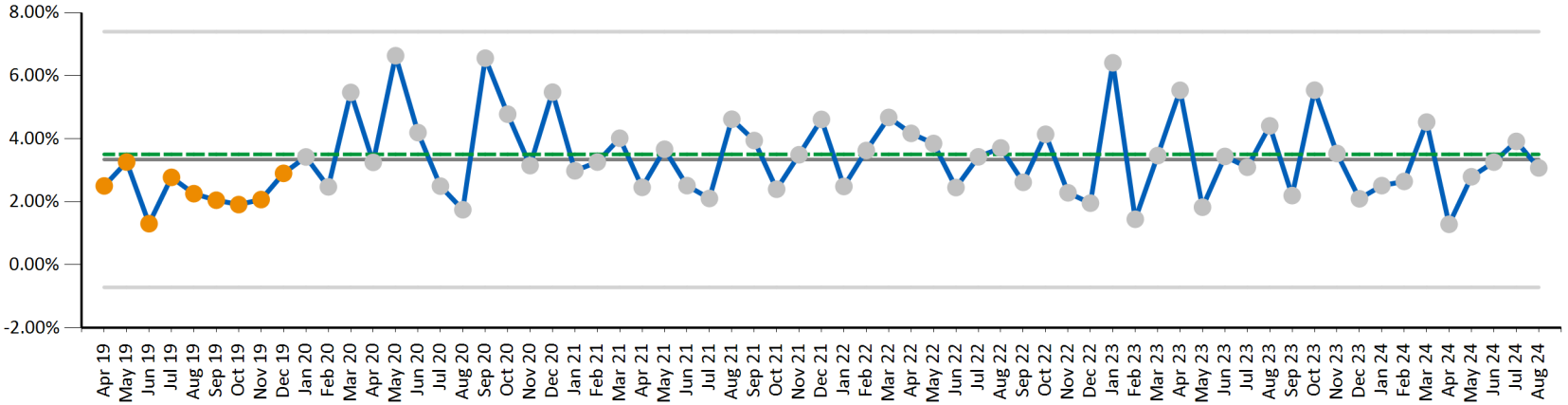
Plan	Actual
<= 3.50	4.24

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%	3.1%	Aug-24

Previous

Plan	Actual	Period
<= 3.5%	3.9%	Jul-24

Year to Date

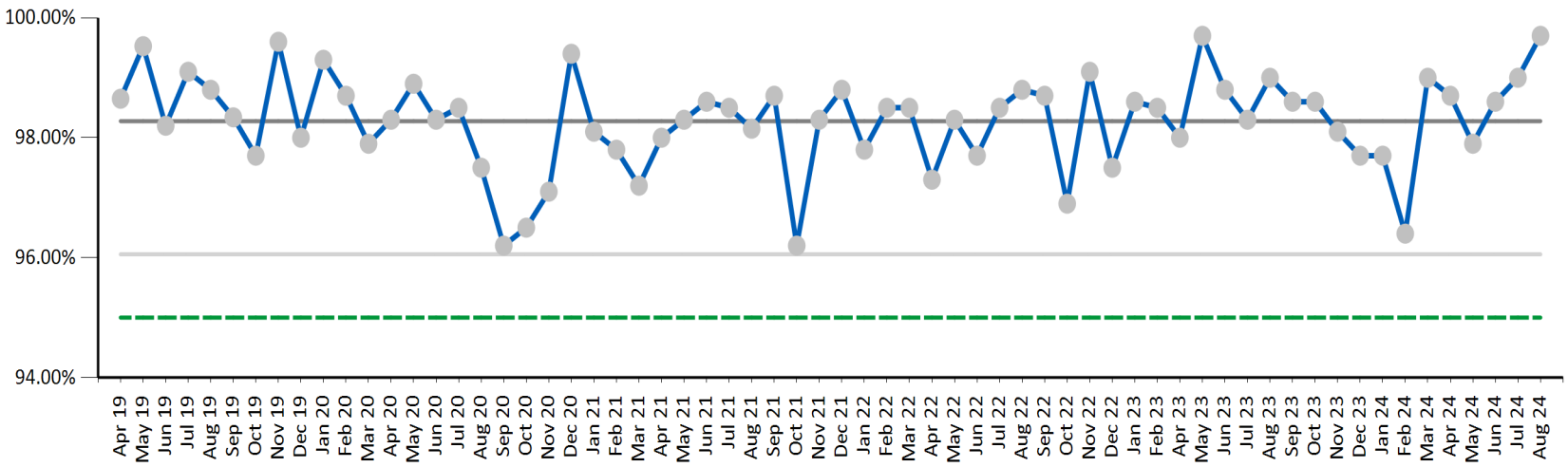
Plan	Actual
<= 3.5%	2.9%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	99.7%	Aug-24

Previous

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

Year to Date

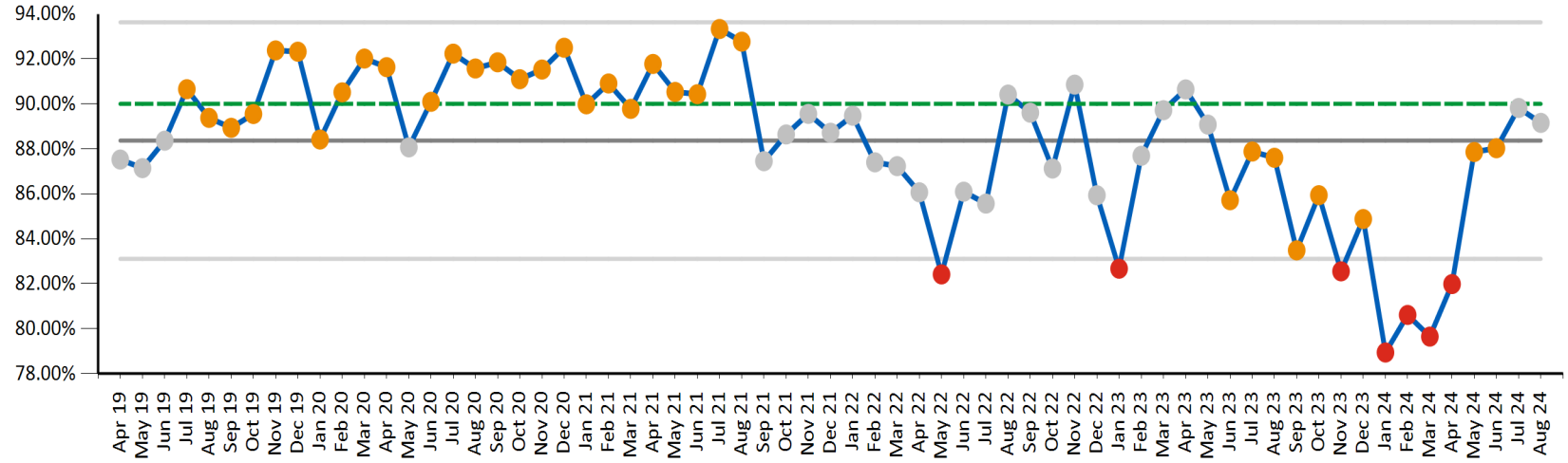
Plan	Actual
>= 95.0%	98.8%

203 - Booked 12+6

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90.0%	89.2%	Aug-24

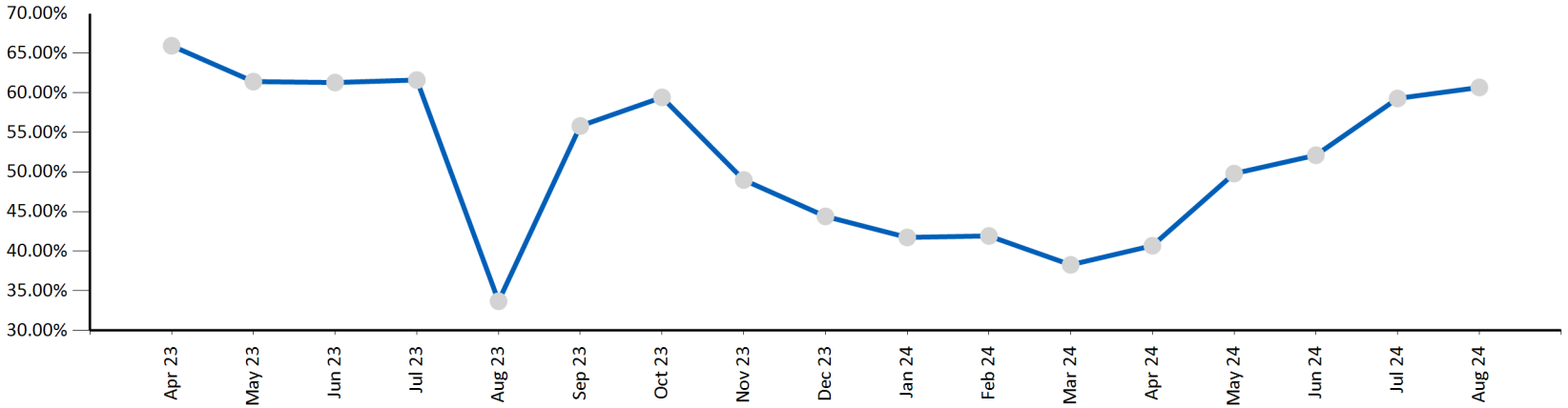
Previous

Plan	Actual	Period
>= 90.0%	89.8%	Jul-24

Year to Date

Plan	Actual
>= 90.0%	87.3%

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



Latest

Plan	Actual	Period
	60.7%	Aug-24

Previous

Plan	Actual	Period
	59.3%	Jul-24

Year to Date

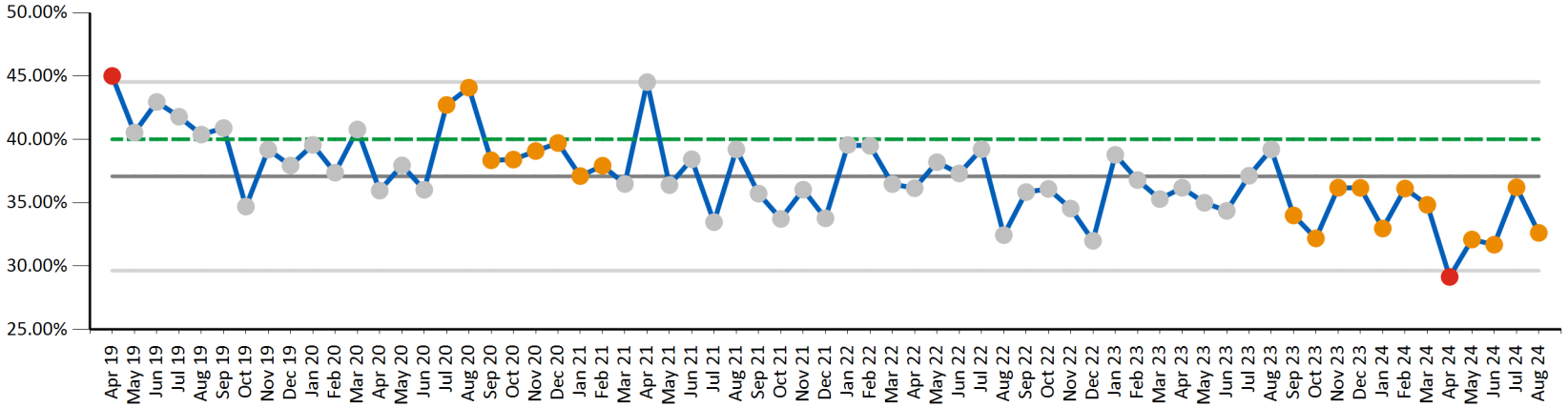
Plan	Actual
	52.3%

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%	32.6%	Aug-24

Previous

Plan	Actual	Period
<= 40%	36.2%	Jul-24

Year to Date

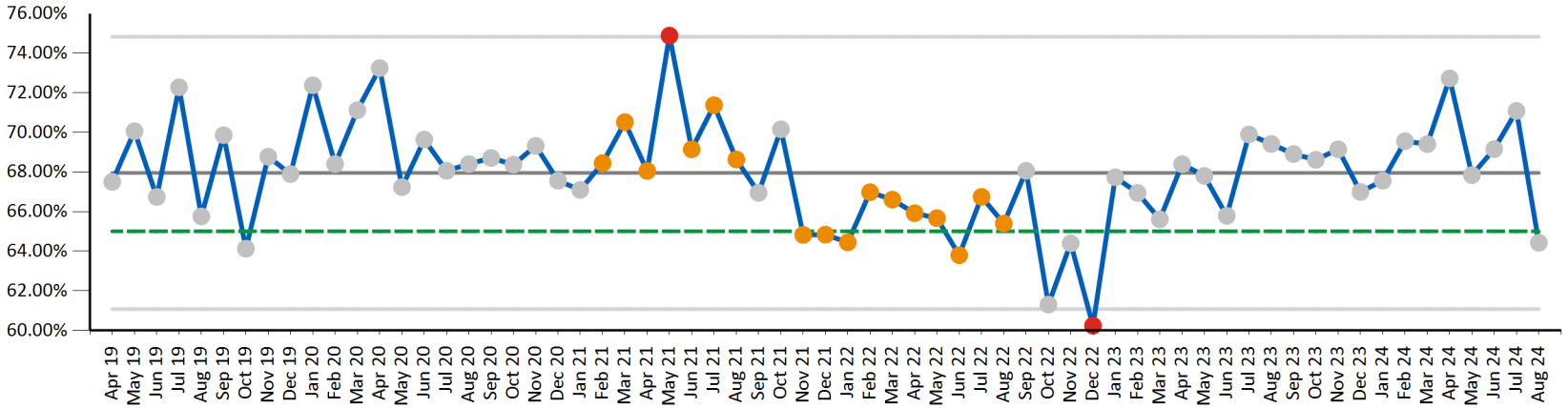
Plan	Actual
<= 40%	32.3%

210 - Initiation breast feeding

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 65%	64.42%	Aug-24

Previous

Plan	Actual	Period
>= 65%	71.08%	Jul-24

Year to Date

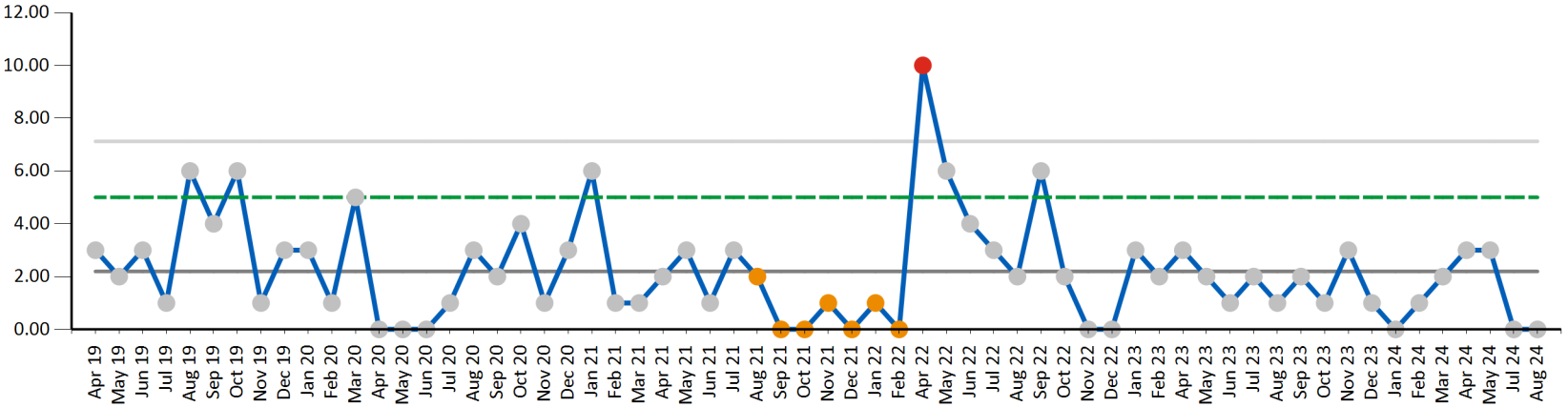
Plan	Actual
>= 65%	69.06%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	0	Aug-24

Previous

Plan	Actual	Period
<= 5	0	Jul-24

Year to Date

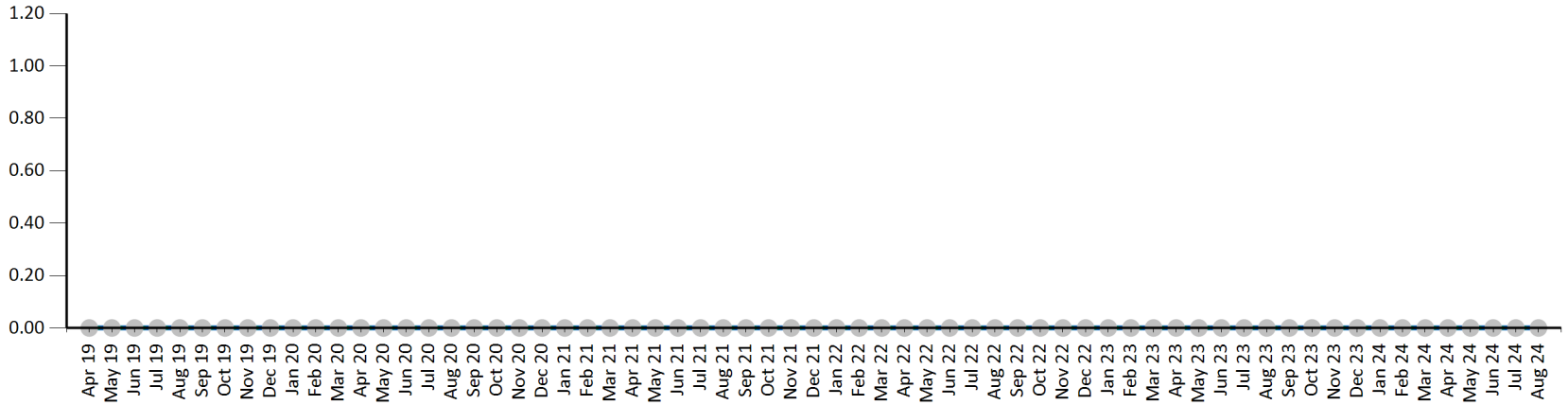
Plan	Actual
<= 20	6

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	Aug-24

Previous

Plan	Actual	Period
= 0	0	Jul-24

Year to Date

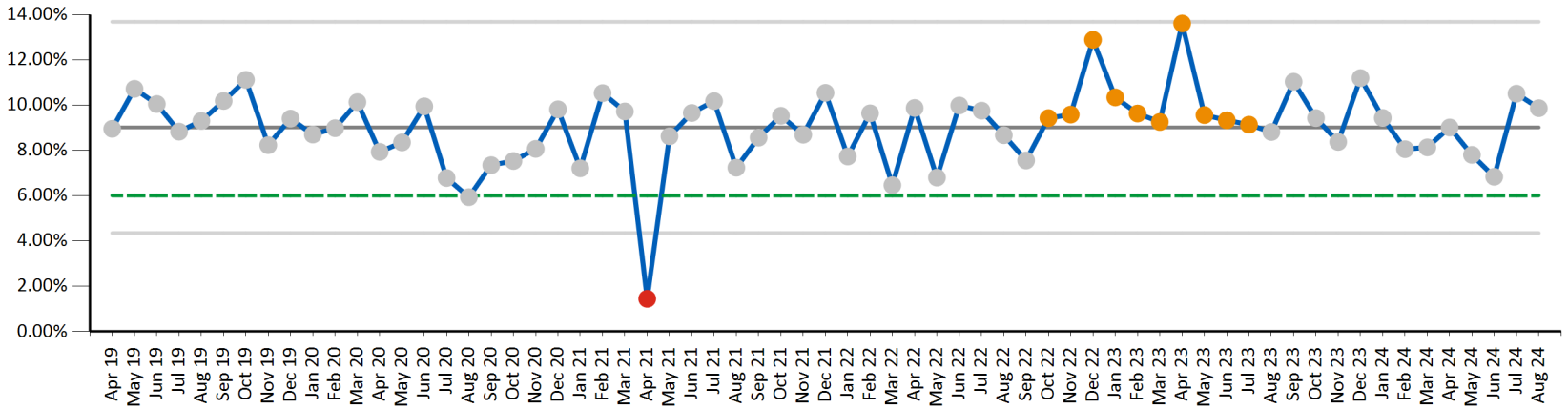
Plan	Actual
= 0	0

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%	9.9%	Aug-24

Previous

Plan	Actual	Period
<= 6%	10.5%	Jul-24

Year to Date

Plan	Actual
<= 6%	8.8%

Operational Performance - Urgent Care

Bolton NHS Foundation Trust

Urgent Care

The 4-hour standard was 69.6%, which was an increase of 3% on July 2024. UTC standard was 95.1%, which was an improvement on the previous month. Attendances fell back to normal parameters in august in relation to both walk in and ambulance arrivals. Time to see a decision maker continues to improve. Ambulance handover within 15 mins improved to 58.4% and there was an associated reduction in the number of delayed admissions to hospital, which continues to improve. Emergency department conversion rate also continues to improve at 17%.

NOF

For August, our fractured neck of femur performance improved to 32%, with 12 of 37 patients getting to theatre within the 36 hour window.

The majority of breaches continue to relate to challenges with theatre capacity (14), with other breaches relating to further optimisation (6) and delays on the ward / in making a decision regarding treatment plan (5).

July's performance was hampered by an increase in demand over the course of one night. We are in the process of recruiting for assistant practitioners to extend the trauma coordination team to 7-days, which should improve trauma theatre utilisation over weekends.

Performance against the 36-hour standard remains in line with the average across the country and Bolton performs well against GM peers for several key metrics.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 70%	69.6%	Aug-24		>= 69%	66.6%	Jul-24	>= 70%	63.9%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	58.4%	Aug-24		>= 65.0%	56.3%	Jul-24	>= 65.0%	50.7%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	88.7%	Aug-24	H	>= 95.0%	85.3%	Jul-24	>= 95.0%	80.7%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	96.83%	Aug-24		= 100%	94.99%	Jul-24	= 100%	92.12%	F
539 - A&E 12 hour waits	= 0	877	Aug-24		= 0	1,136	Jul-24	= 0	5,842	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	24.3%	Aug-24	L	>= 75%	42.9%	Jul-24	>= 75%	33.1%	?
56 - Stranded patients - over 7 days	<= 200	269	Aug-24	H	<= 200	275	Jul-24	<= 200	269	?

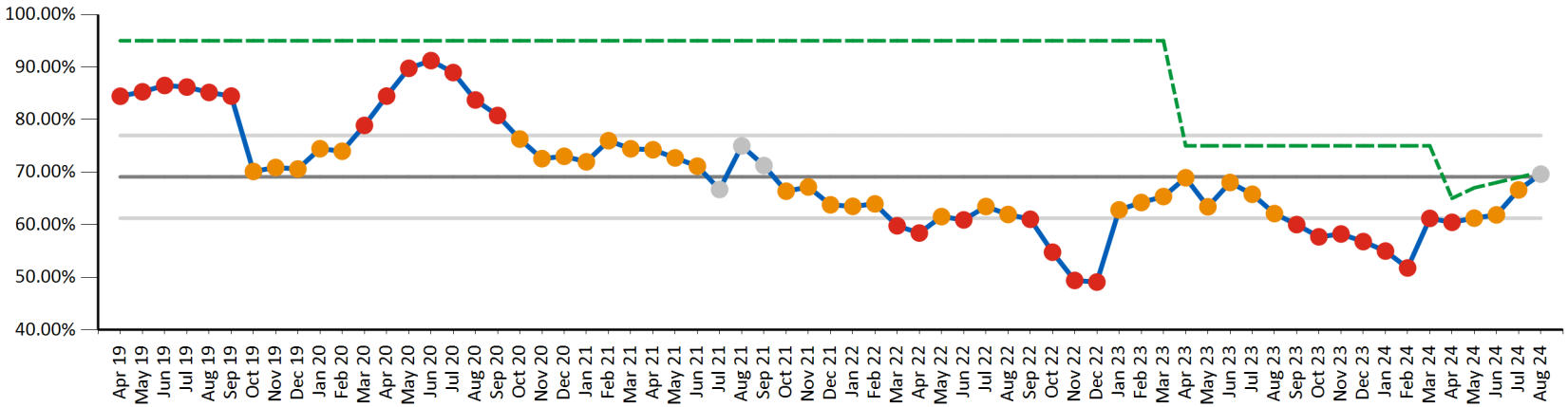
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	89	Aug-24		<= 69	99	Jul-24	<= 69	89	?
541 - Adult G&A bed occupancy	<= 92.0%	86.5%	Aug-24		<= 92.0%	90.2%	Jul-24	<= 92.0%	88.6%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.87	Aug-24		<= 3.70	5.85	Jul-24	<= 3.70	6.05	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.1%	Jul-24	L	<= 13.5%	9.9%	Jun-24	<= 13.5%	9.5%	P

53 - A&E 4 hour target

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 70%	69.6%	Aug-24

Previous

Plan	Actual	Period
>= 69%	66.6%	Jul-24

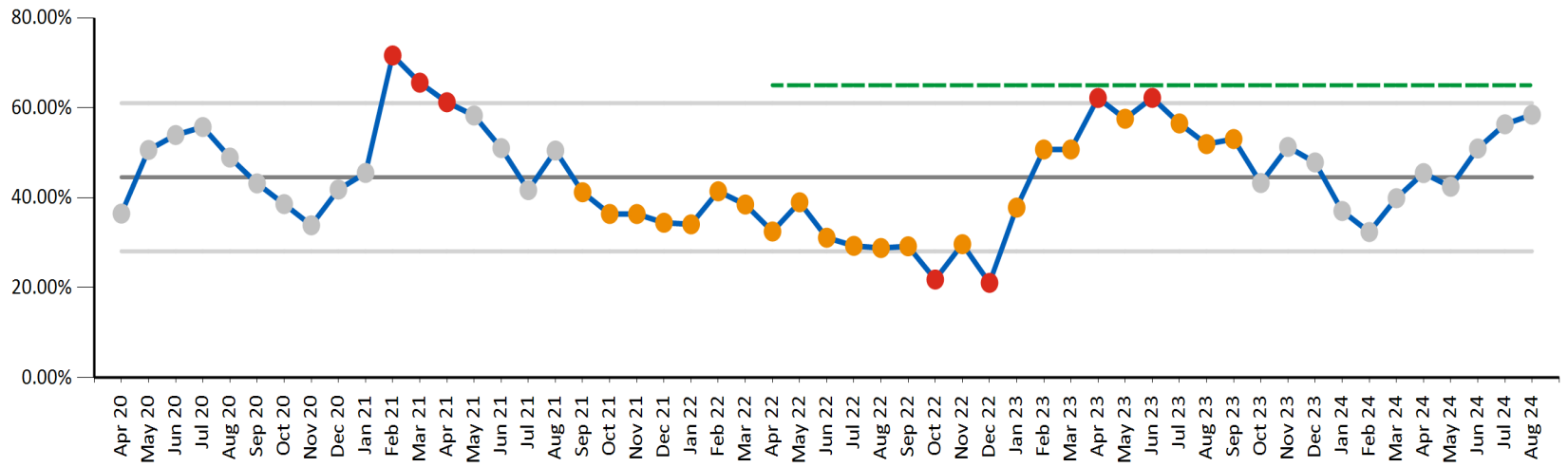
Year to Date

Plan	Actual
>= 70%	63.9%

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%	58.4%	Aug-24

Previous

Plan	Actual	Period
>= 65.0%	56.3%	Jul-24

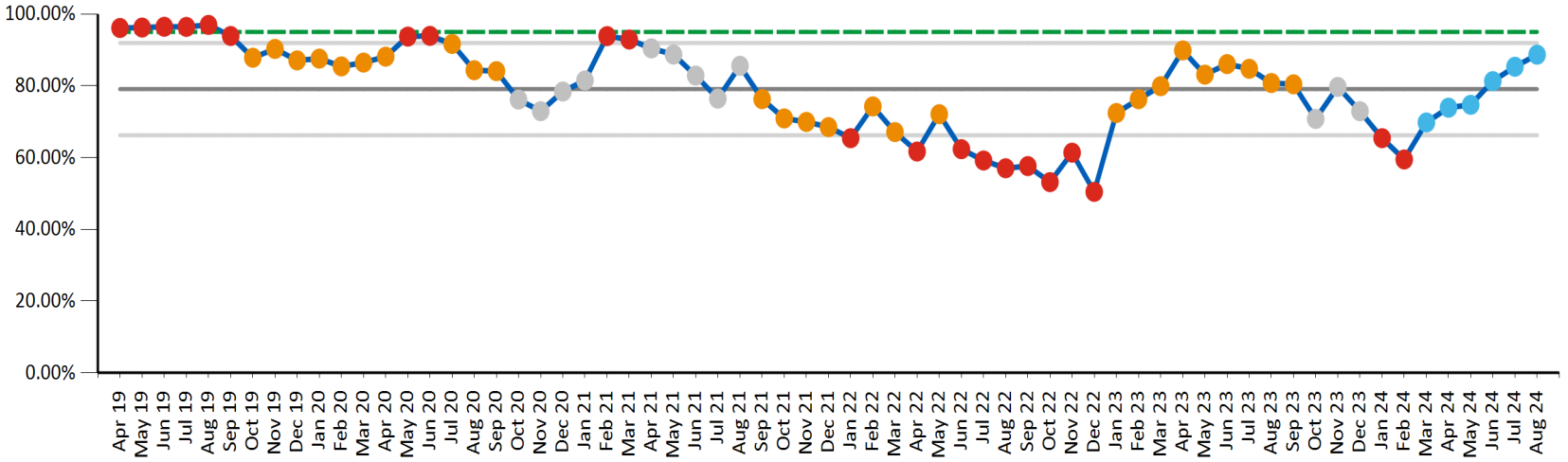
Year to Date

Plan	Actual
>= 65.0%	50.7%

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

Special cause variation with improving performance

We will regularly fail to meet the target. 0/6



Latest

Plan	Actual	Period
>= 95.0%	88.7%	Aug-24

Previous

Plan	Actual	Period
>= 95.0%	85.3%	Jul-24

Year to Date

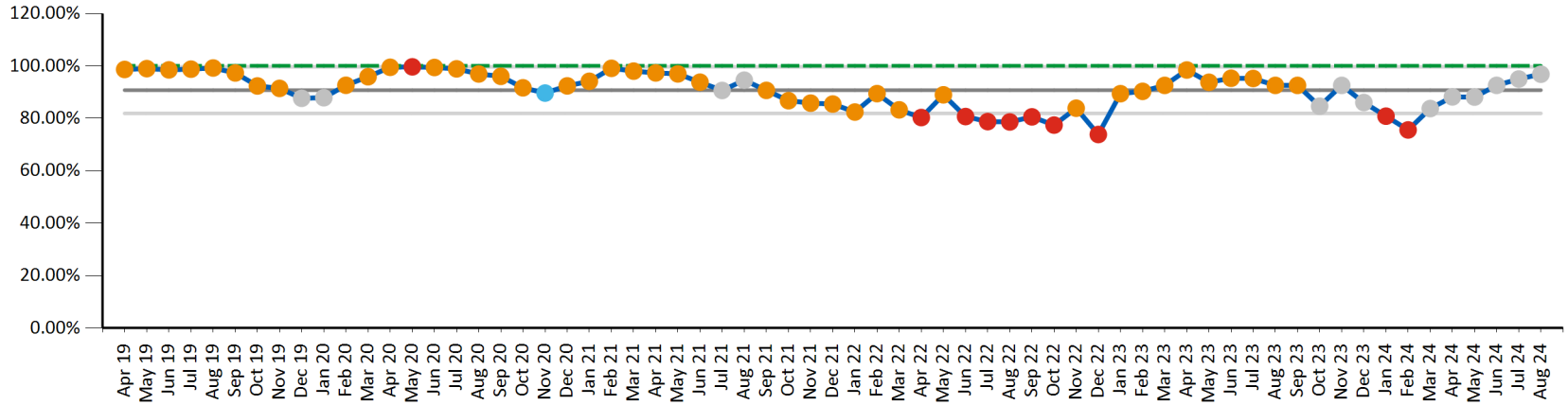
Plan	Actual
>= 95.0%	80.7%

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%	96.83%	Aug-24

Previous

Plan	Actual	Period
= 100%	94.99%	Jul-24

Year to Date

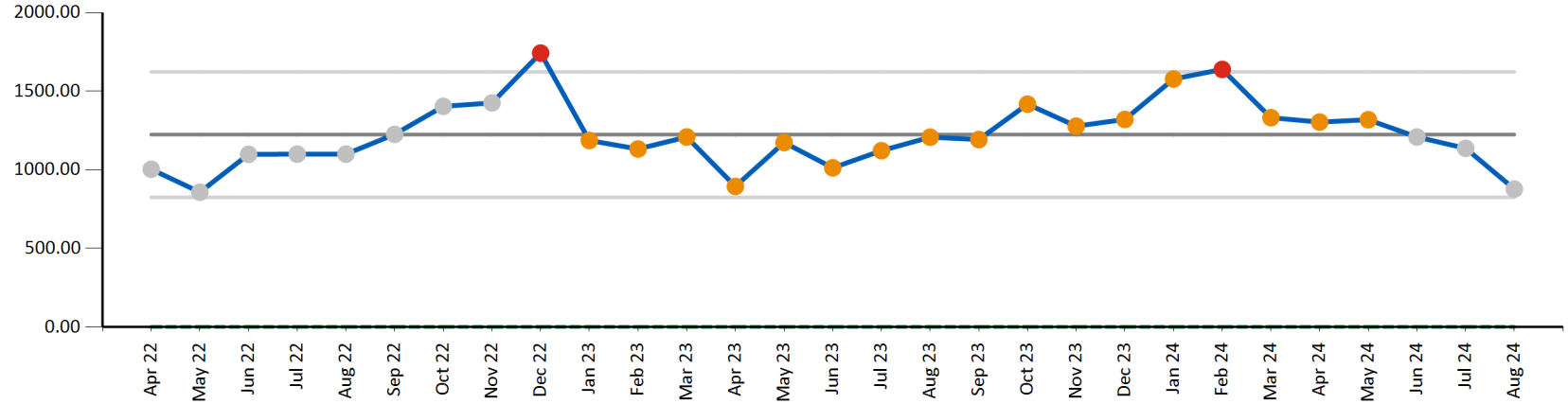
Plan	Actual
= 100%	92.12%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	877	Aug-24

Previous

Plan	Actual	Period
= 0	1,136	Jul-24

Year to Date

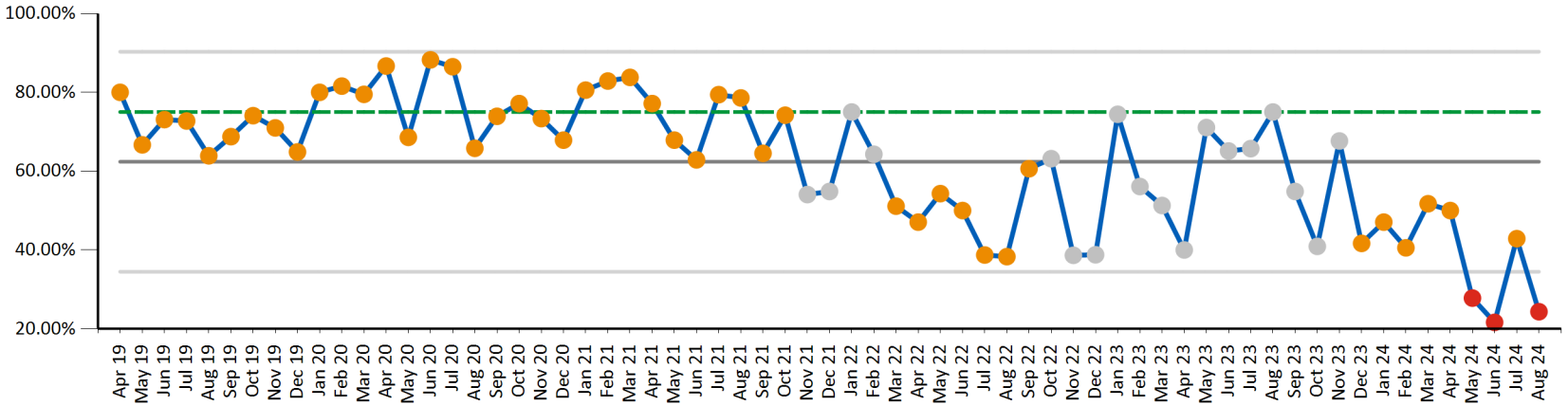
Plan	Actual
= 0	5,842

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	24.3%	Aug-24

Previous

Plan	Actual	Period
>= 75%	42.9%	Jul-24

Year to Date

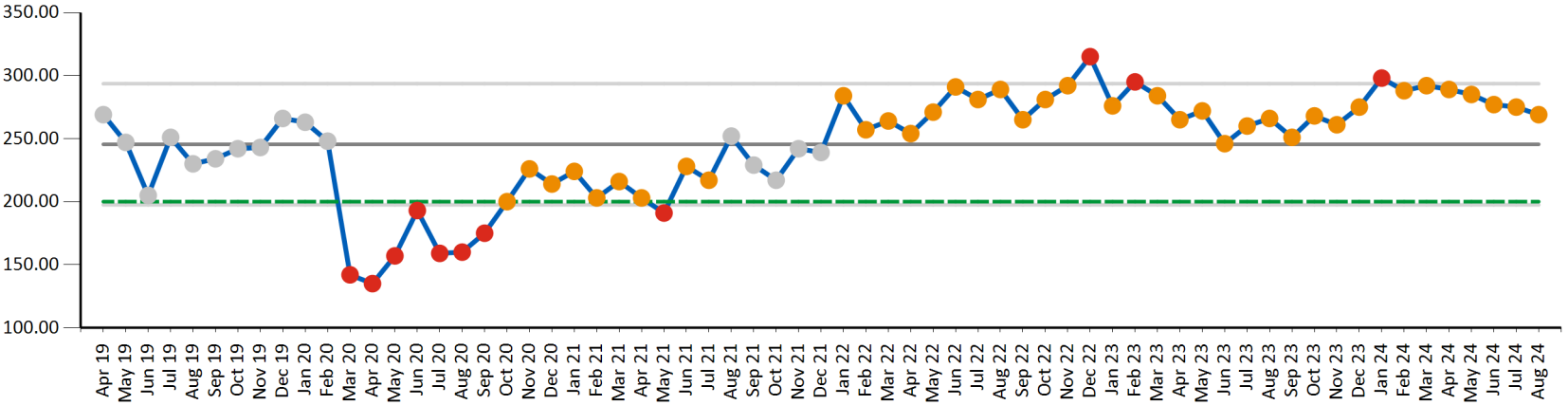
Plan	Actual
>= 75%	33.1%

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	269	Aug-24

Previous

Plan	Actual	Period
<= 200	275	Jul-24

Year to Date

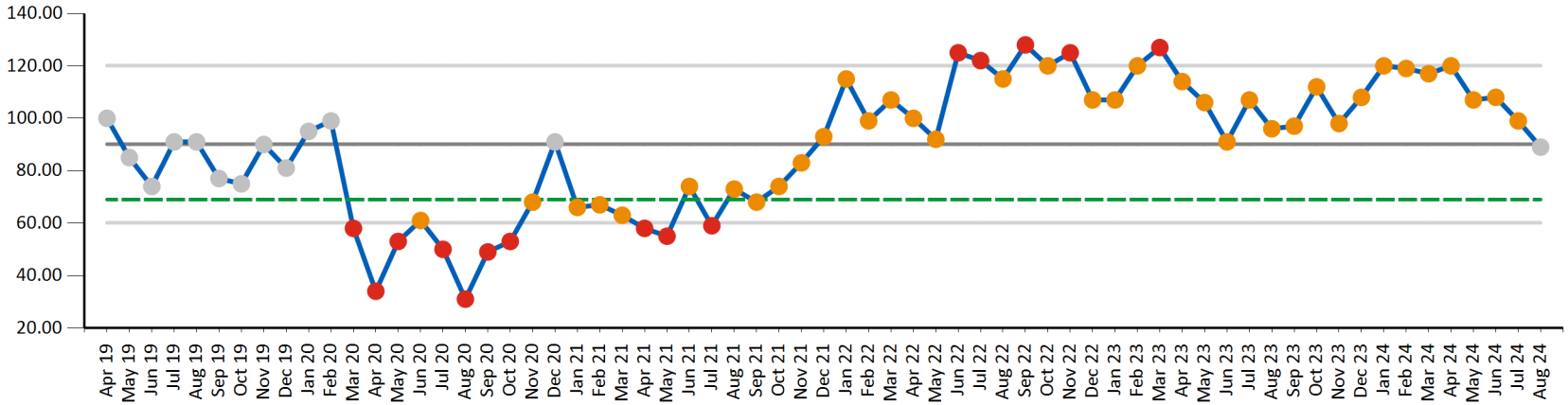
Plan	Actual
<= 200	269

307 - Stranded Patients - LOS 21 days and over

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 69	89	Aug-24

Previous

Plan	Actual	Period
<= 69	99	Jul-24

Year to Date

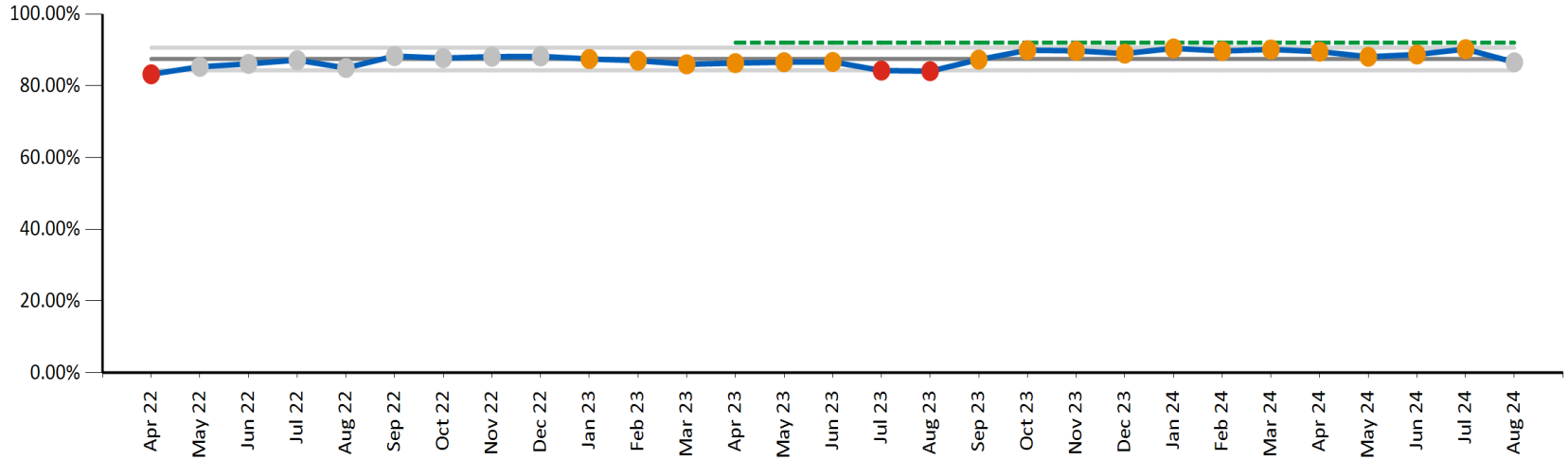
Plan	Actual
<= 69	89

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	86.5%	Aug-24

Previous

Plan	Actual	Period
<= 92.0%	90.2%	Jul-24

Year to Date

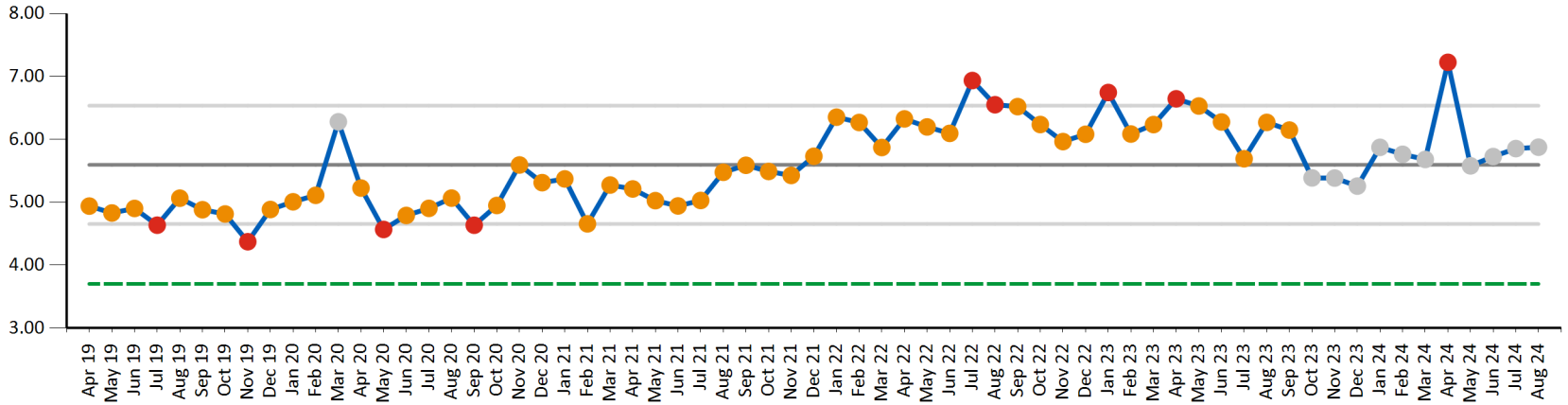
Plan	Actual
<= 92.0%	88.6%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	5.87	Aug-24

Previous

Plan	Actual	Period
<= 3.70	5.85	Jul-24

Year to Date

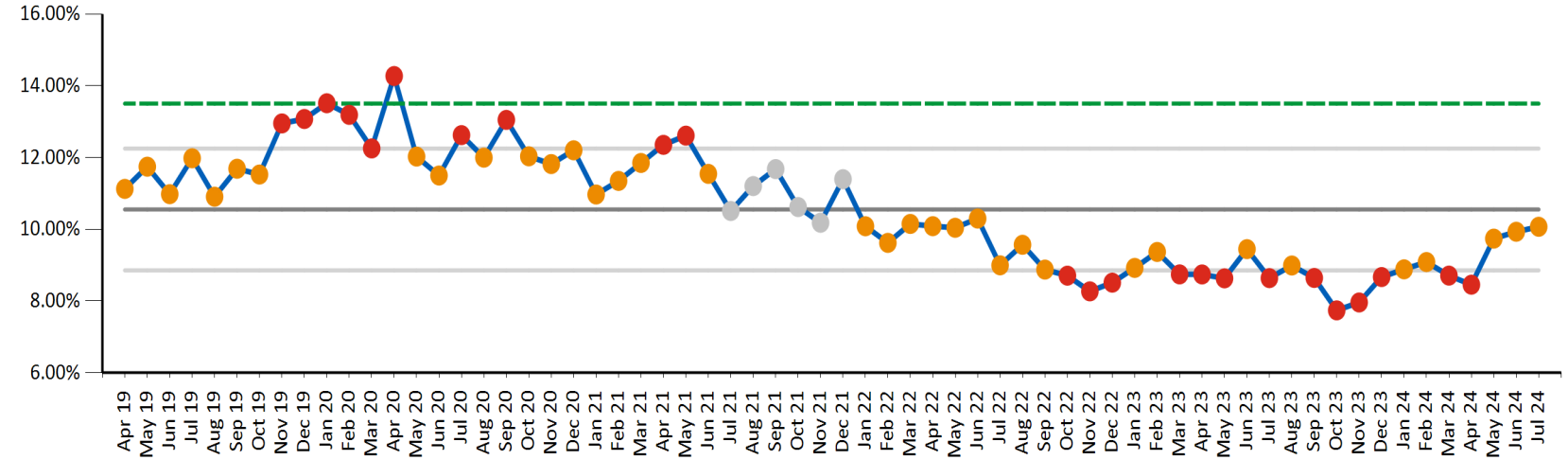
Plan	Actual
<= 3.70	6.05

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%	10.1%	Jul-24

Previous

Plan	Actual	Period
<= 13.5%	9.9%	Jun-24

Year to Date

Plan	Actual
<= 13.5%	9.5%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT
We finished August with 21x 78-week breaches:
- 4 were due to patient choice,
- 2 were due to capacity issues,
- 7 was due to patient complexity,
- 8 were patients awaiting corneal graft material.

We had 0 104-week waiters at the end of August.

We continue to work towards eliminating 78-week breaches (excluding graft patients, due to a national graft shortage) as soon as possible and maintaining that position. Progress continues to be made towards achieving 0 65-weeks waiters by the end of September and to sustain that position. Mutual aid has been received for ENT and Plastic Surgery, plus additional capacity has been identified for ENT, Urology, Gynaecology, General Surgery, and Trauma & Orthopaedics. We have worked to put on a significant amount of additional activity with theatre lists through weekend activity, and we are working collaboratively with the Beaumont to review how we can distribute patients to support our waiting lists.

DM01
The trust position has moved away from target by 1.7% this month which was anticipated as actions from our recovery plans are implemented. The final position is 17.2% but there has been an over all decrease in the number of patients on our waiting lists, with 318 fewer people waiting over all for a diagnostic test. As the number of patients waiting over the 6 weeks has remained almost static, the performance appears to have worsened due to the ratio between these two measures, but it is actually a positive outcome to have less people waiting for a diagnostic test. Cardiology have seen their performance decrease which is part of their complex recovery plan, and remain on track to delivery their recovery trajectory on time, and before the national target in March 2025. The expected decrease in performance mirrors the same recovery process which we saw earlier in the year with Imaging which have now recovered and maintained their position. We have also seen Respiratory services recover this month reporting a final performance measure of 0% with Imaging, Endoscopy (ASSD), Flexi Sigmoidoscopy, Gastroscopy (AACD), Neurophysiology all maintaining their performance in line with the national 5% or less target.

	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%	50.1%	Aug-24	L	>= 92%	50.4%	Jul-24	>= 92%	50.3%	F
314 - RTT 18 week waiting list	<= 28,664	44,055	Aug-24	H	<= 28,814	44,590	Jul-24	<= 28,664	44,055	F
42 - RTT 52 week waits (incomplete pathways)		2,823	Aug-24	H		3,243	Jul-24		16,641	
540 - RTT 65 week waits (incomplete pathways)	<= 896	669	Aug-24	H	<= 910	812	Jul-24	<= 4,613	3,869	P

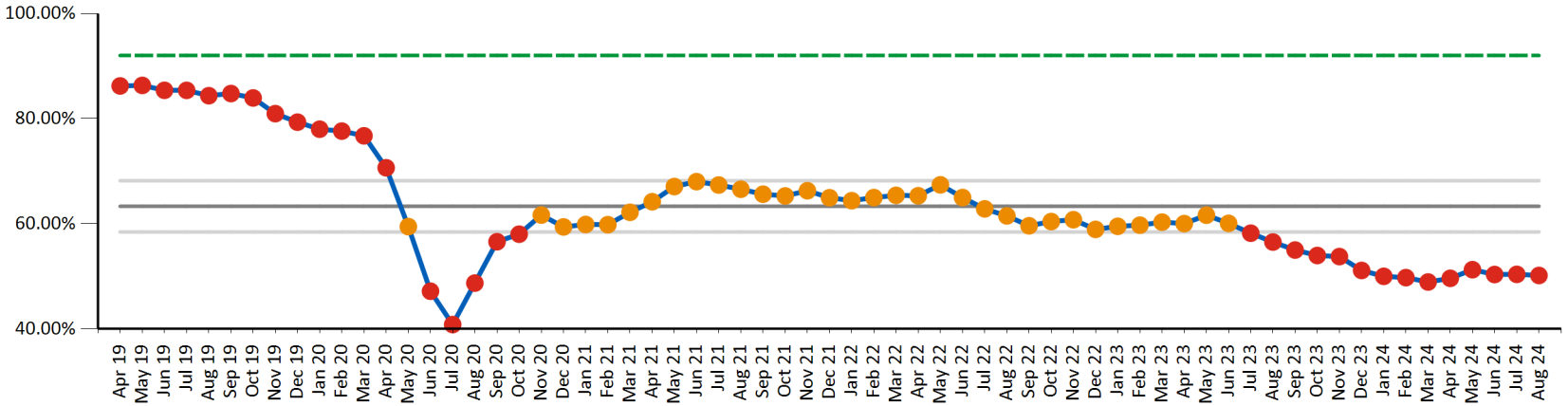
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
526 - RTT 78 week waits (incomplete pathways)	= 0	21	Aug-24		= 0	18	Jul-24	= 0	104	
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Aug-24		= 0	0	Jul-24	= 0	1	
72 - Diagnostic Waits >6 weeks %	>= 5%	17.1%	Aug-24		>= 5%	15.5%	Jul-24	>= 5%	12.6%	
489 - Daycase Rates	>= 85%	82.0%	Aug-24		>= 85%	83.9%	Jul-24	>= 85%	82.7%	
582 - Theatre Utilisation - Capped		73.1%	Aug-24			72.9%	Jul-24		74.5%	
583 - Theatre Utilisation - Uncapped		77.0%	Aug-24			75.8%	Jul-24		78.4%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Aug-24		<= 1%	1.5%	Jul-24	<= 1%	1.3%	
62 - Cancelled operations re-booked within 28 days	= 100%	61.9%	Jul-24		= 100%	63.2%	Jun-24	= 100%	28.6%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	4.48	Aug-24		<= 2.00	3.30	Jul-24	<= 2.00	3.32	
309 - DNA Rate - New	<= 6.3%	9.9%	Aug-24		<= 6.3%	10.4%	Jul-24	<= 6.3%	10.0%	
310 - DNA Rate - Follow up	<= 5.0%	8.7%	Aug-24		<= 5.0%	8.9%	Jul-24	<= 5.0%	8.9%	

41 - RTT Incomplete pathways within 18 weeks %

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	50.1%	Aug-24

Previous

Plan	Actual	Period
>= 92%	50.4%	Jul-24

Year to Date

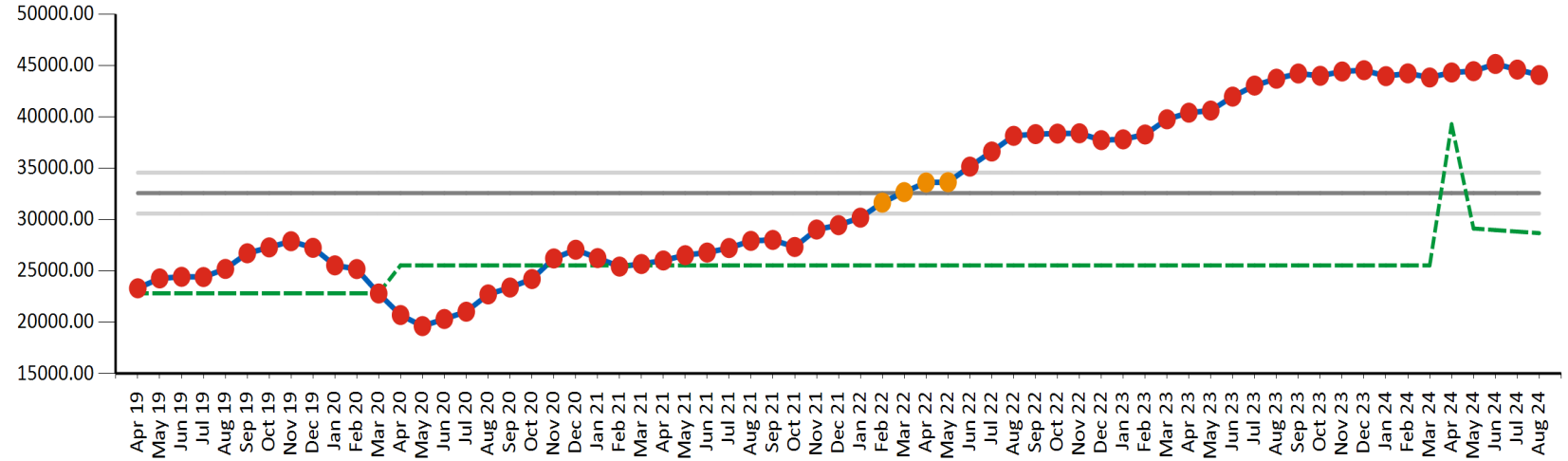
Plan	Actual
>= 92%	50.3%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 28,664	44,055	Aug-24

Previous

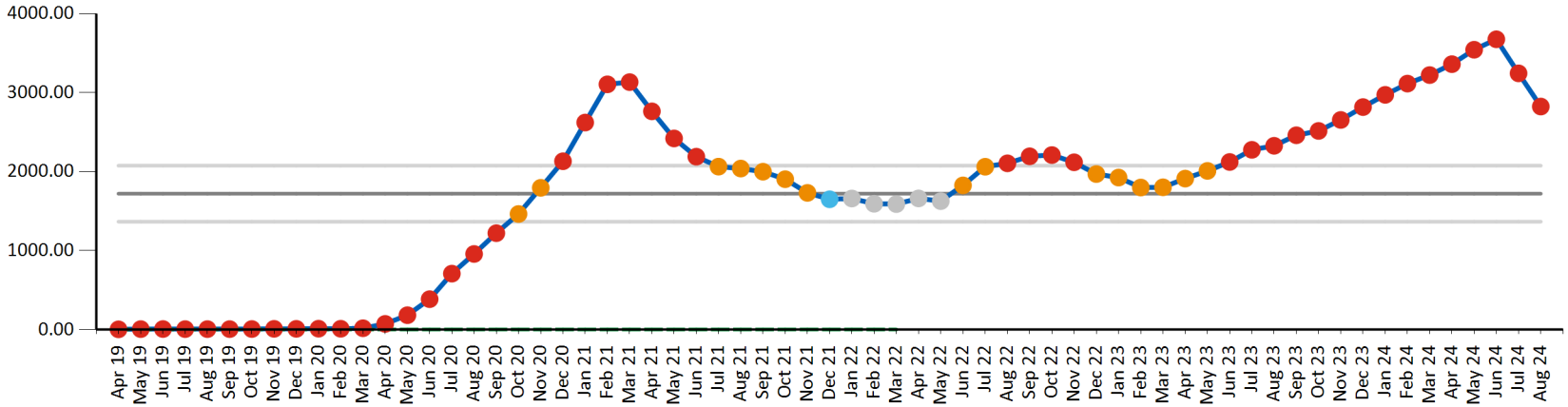
Plan	Actual	Period
<= 28,814	44,590	Jul-24

Year to Date

Plan	Actual
<= 28,664	44,055

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	2,823	Aug-24

Previous

Plan	Actual	Period
	3,243	Jul-24

Year to Date

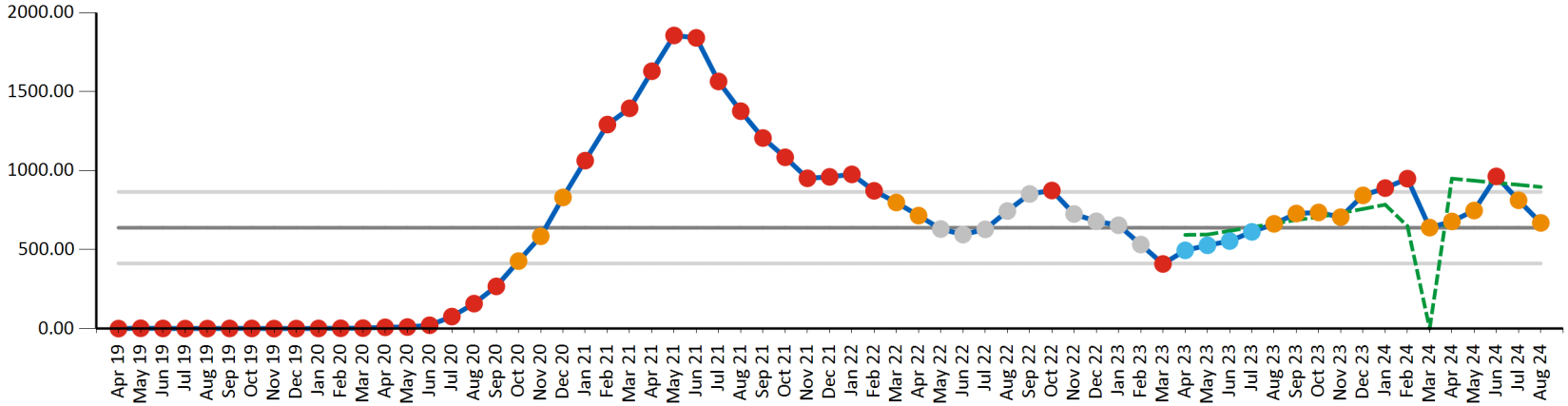
Plan	Actual
	16,641

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with deteriorating performance

Target will be regularly met.

4/6



Latest

Plan	Actual	Period
<= 896	669	Aug-24

Previous

Plan	Actual	Period
<= 910	812	Jul-24

Year to Date

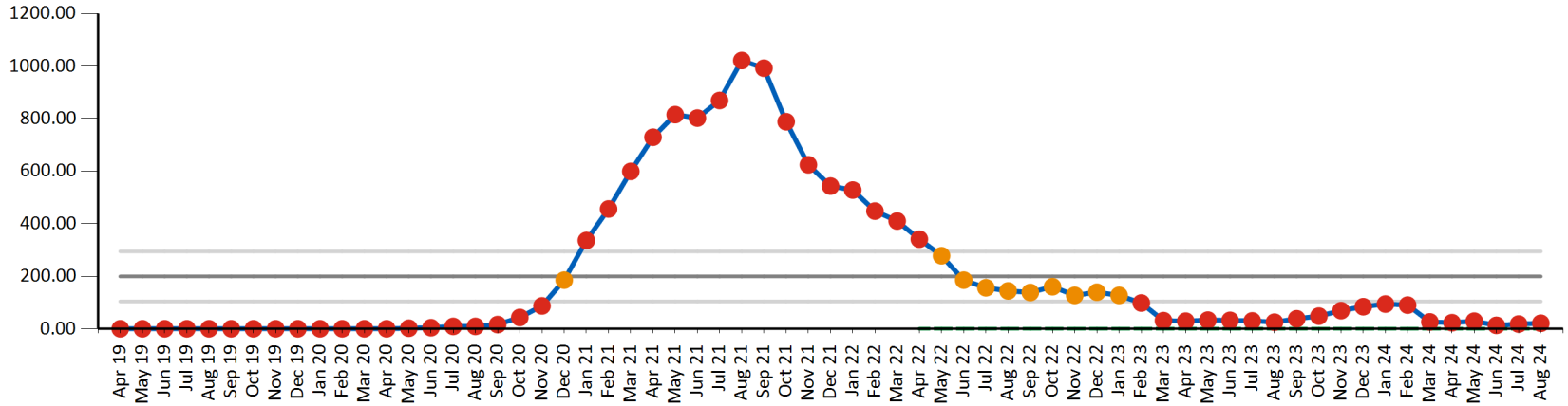
Plan	Actual
<= 4,613	3,869

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	21	Aug-24

Previous

Plan	Actual	Period
= 0	18	Jul-24

Year to Date

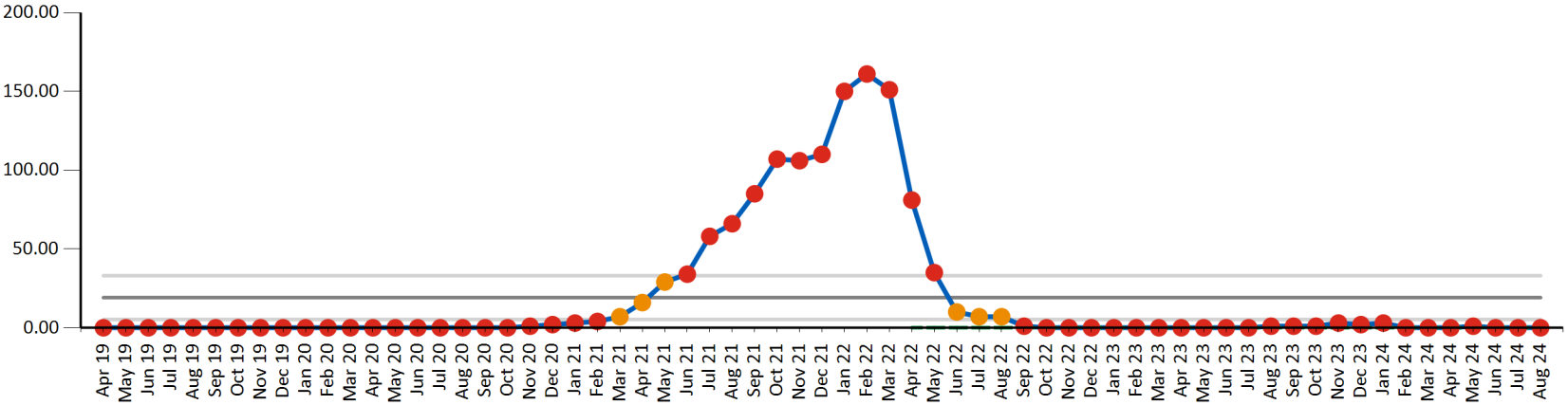
Plan	Actual
= 0	104

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
= 0	0	Aug-24

Previous

Plan	Actual	Period
= 0	0	Jul-24

Year to Date

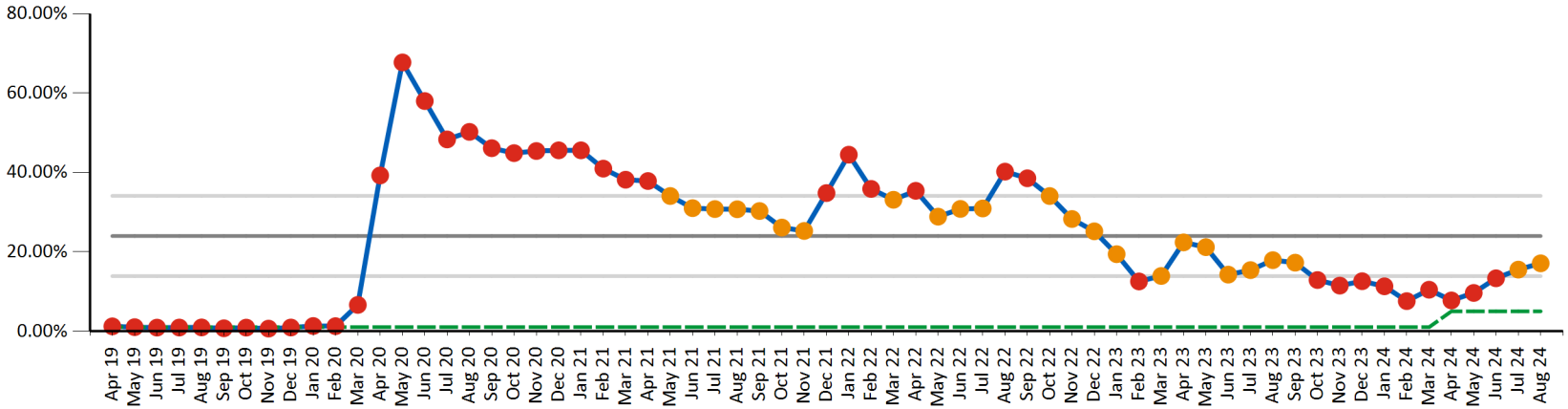
Plan	Actual
= 0	1

72 - Diagnostic Waits >6 weeks %

Special cause variation with deteriorating performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 5%	17.1%	Aug-24

Previous

Plan	Actual	Period
>= 5%	15.5%	Jul-24

Year to Date

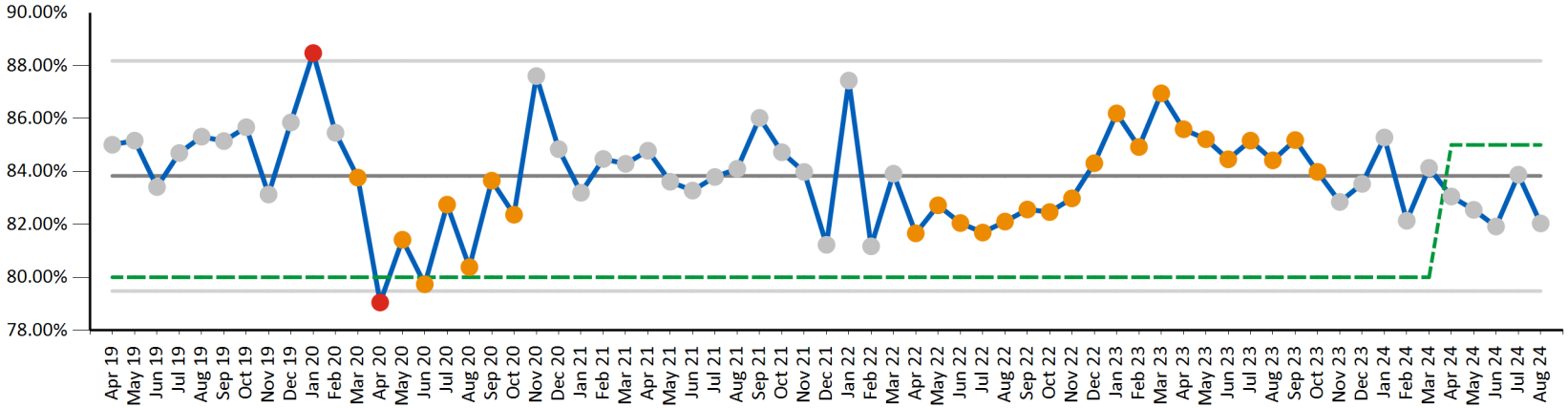
Plan	Actual
>= 5%	12.6%

489 - Daycase Rates

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 85%	82.0%	Aug-24

Previous

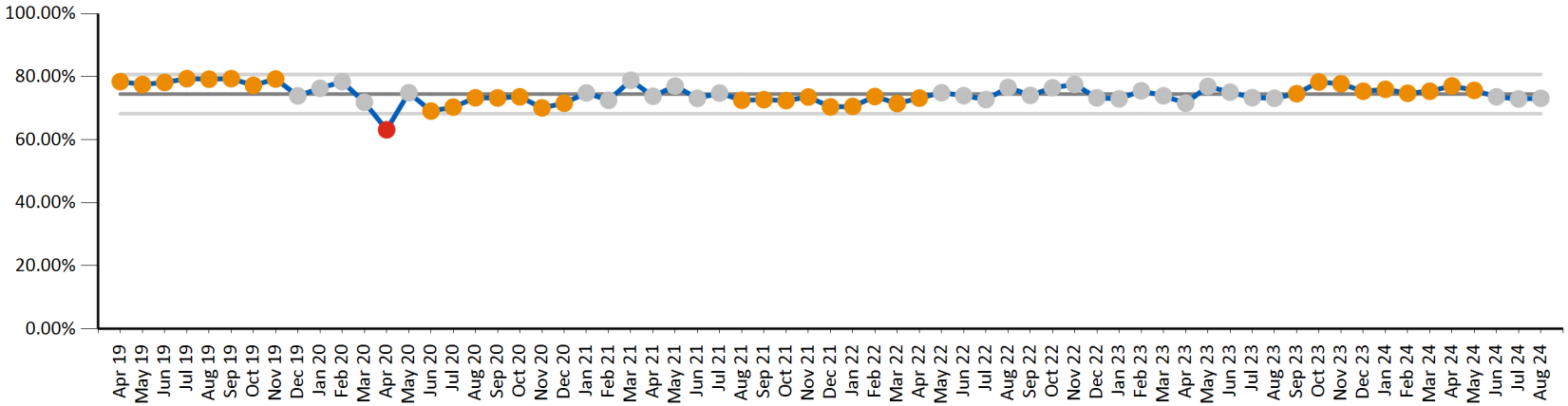
Plan	Actual	Period
>= 85%	83.9%	Jul-24

Year to Date

Plan	Actual
>= 85%	82.7%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	73.1%	Aug-24

Previous

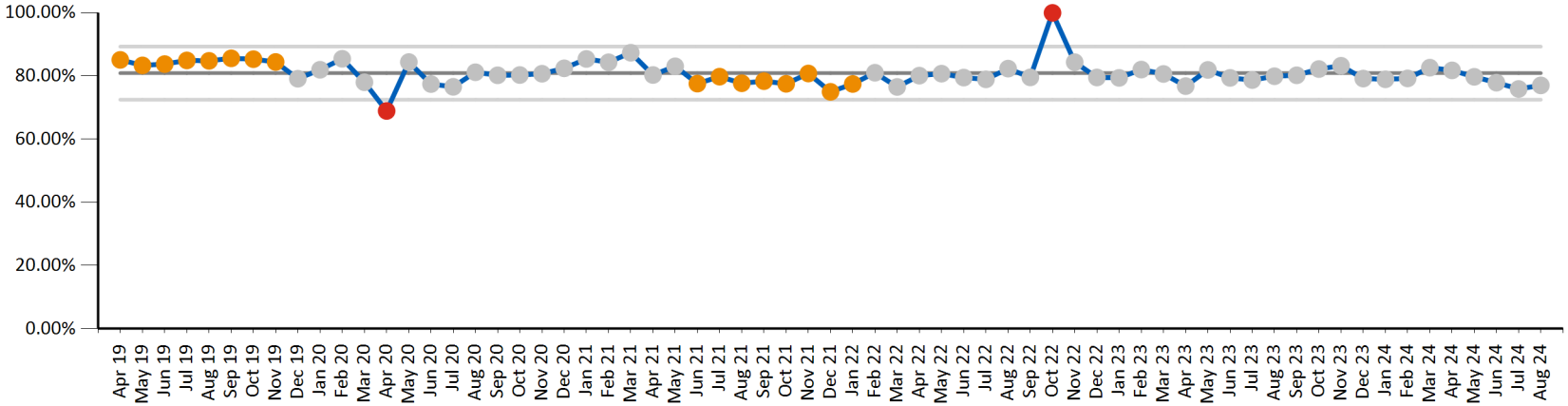
Plan	Actual	Period
	72.9%	Jul-24

Year to Date

Plan	Actual
	74.5%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	77.0%	Aug-24

Previous

Plan	Actual	Period
	75.8%	Jul-24

Year to Date

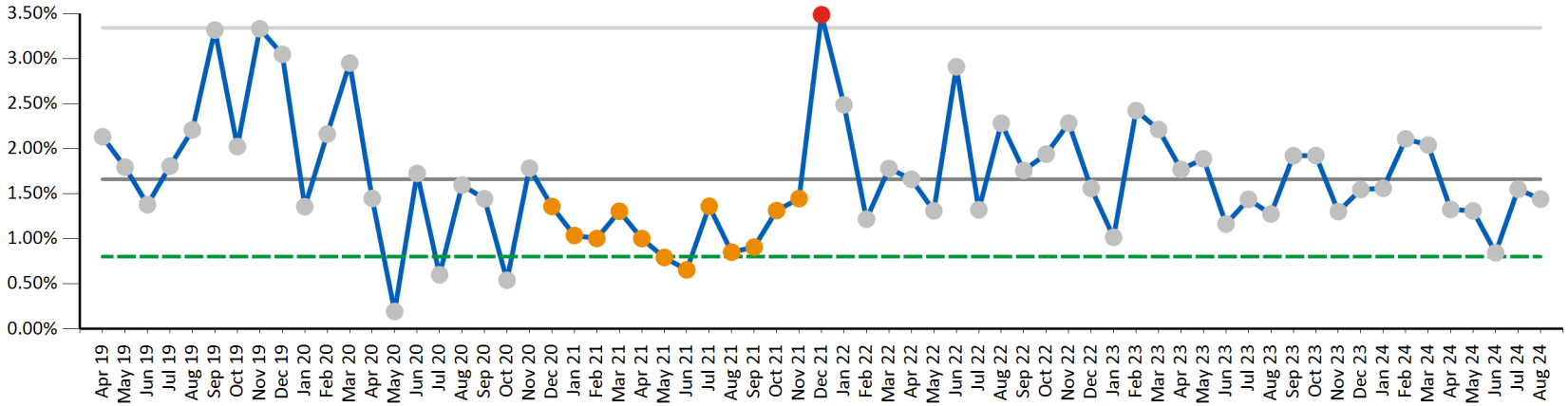
Plan	Actual
	78.4%

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%	Aug-24

Previous

Plan	Actual	Period
<= 1%	1.5%	Jul-24

Year to Date

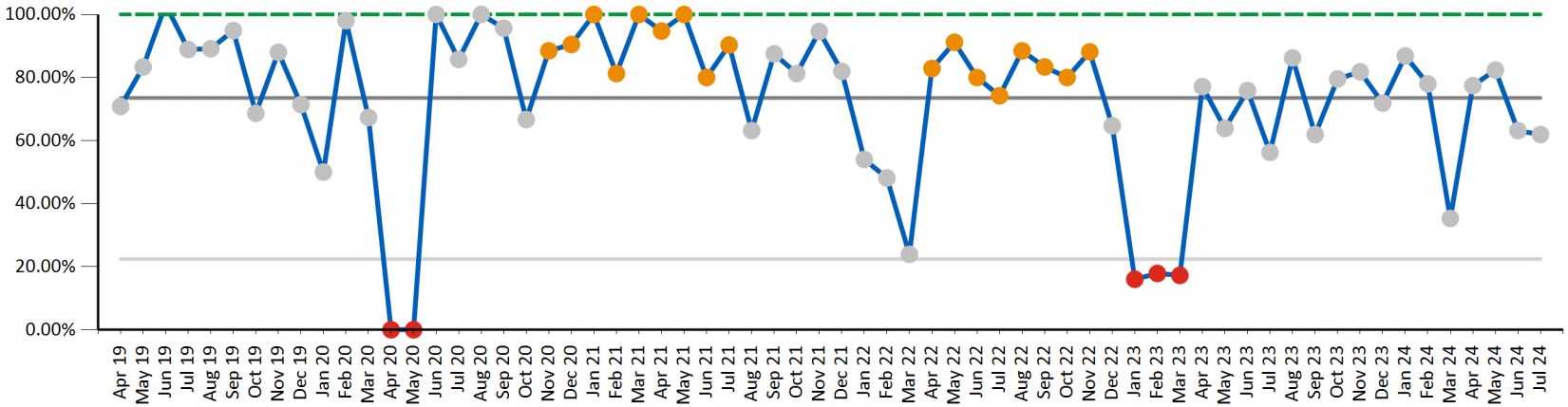
Plan	Actual
<= 1%	1.3%

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%	61.9%	Jul-24

Previous

Plan	Actual	Period
= 100%	63.2%	Jun-24

Year to Date

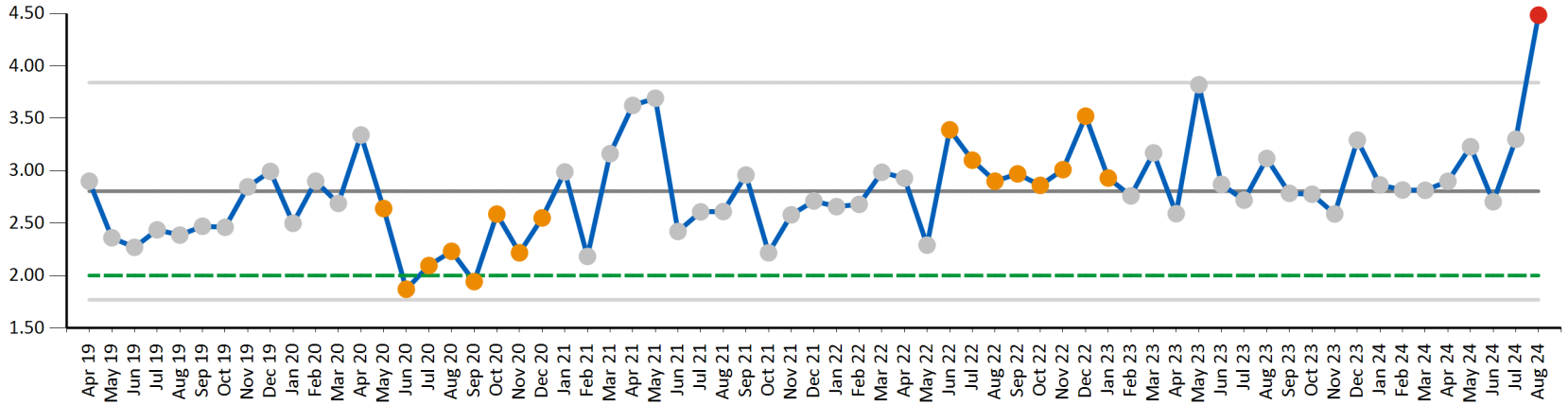
Plan	Actual
= 100%	28.6%

65 - Elective Length of Stay (Discharges in month)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 2.00	4.48	Aug-24

Previous

Plan	Actual	Period
<= 2.00	3.30	Jul-24

Year to Date

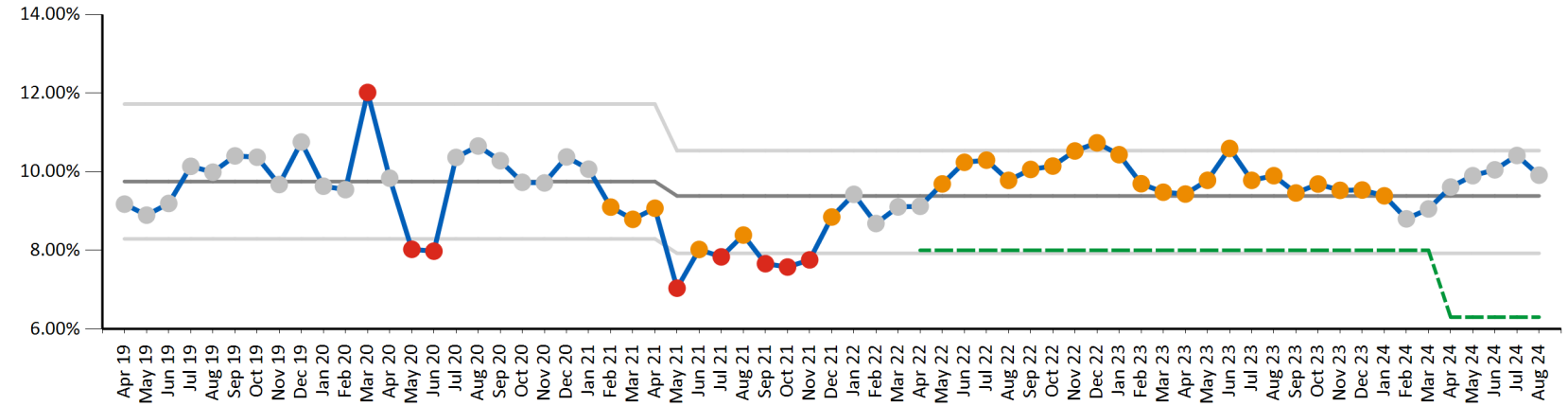
Plan	Actual
<= 2.00	3.32

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.9%	Aug-24

Previous

Plan	Actual	Period
<= 6.3%	10.4%	Jul-24

Year to Date

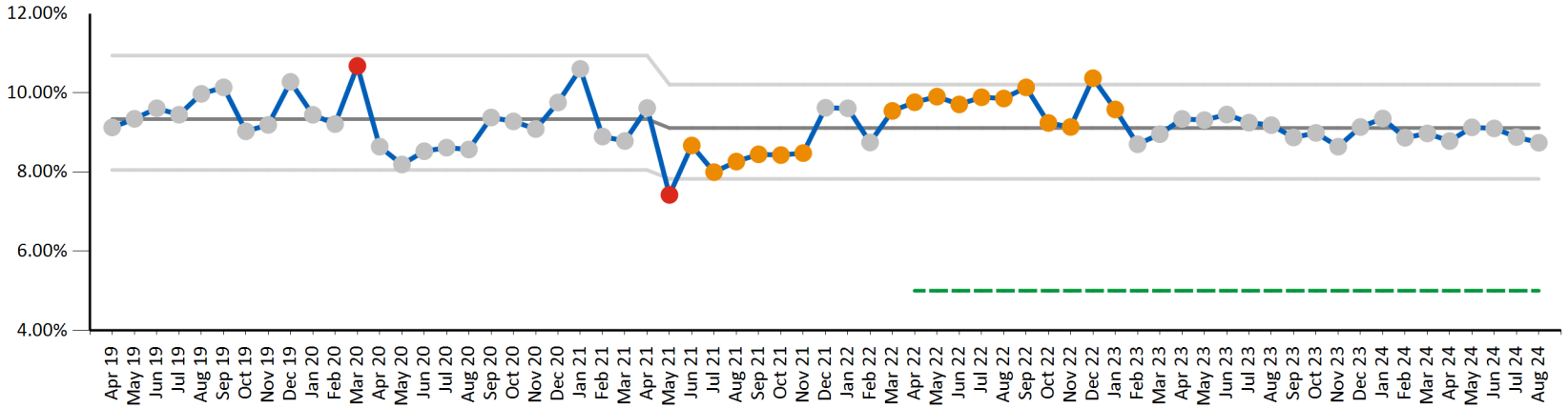
Plan	Actual
<= 6.3%	10.0%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.7%	Aug-24

Previous

Plan	Actual	Period
<= 5.0%	8.9%	Jul-24

Year to Date

Plan	Actual
<= 5.0%	8.9%

Operational Performance - Cancer

Bolton NHS Foundation Trust

For July, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We also achieved performance the 62-day standard, and it is expected that we will achieve performance in August. All specialties have recovery actions in place to return to sustained performance, with a view to sustaining recovery the 62-day performance from September onwards.

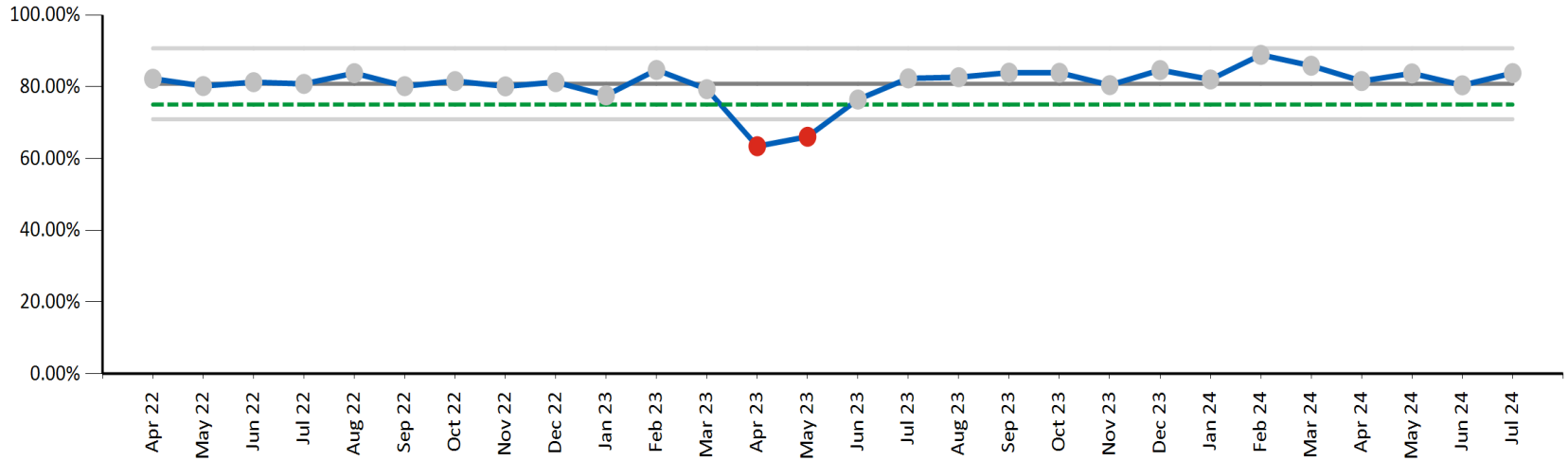
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	83.8%	Jul-24		>= 75.0%	80.4%	Jun-24	>= 75.0%	82.4%	
584 - 31 Day General Treatment Standard	>= 96%	100.0%	Jul-24		>= 96%	96.5%	Jun-24	>= 96%	98.7%	
585 - 62 Day General Standard	>= 85%	85.2%	Jul-24		>= 85%	80.3%	Jun-24	>= 85%	80.5%	

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%	83.8%	Jul-24

Previous

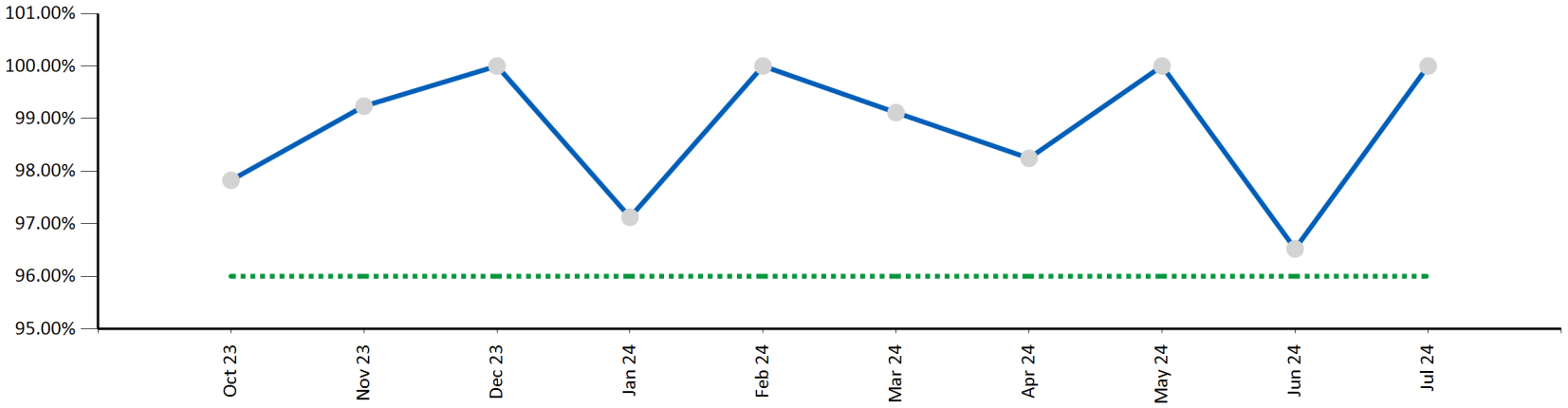
Plan	Actual	Period
>= 75.0%	80.4%	Jun-24

Year to Date

Plan	Actual
>= 75.0%	82.4%

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

6/6



Latest

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

Previous

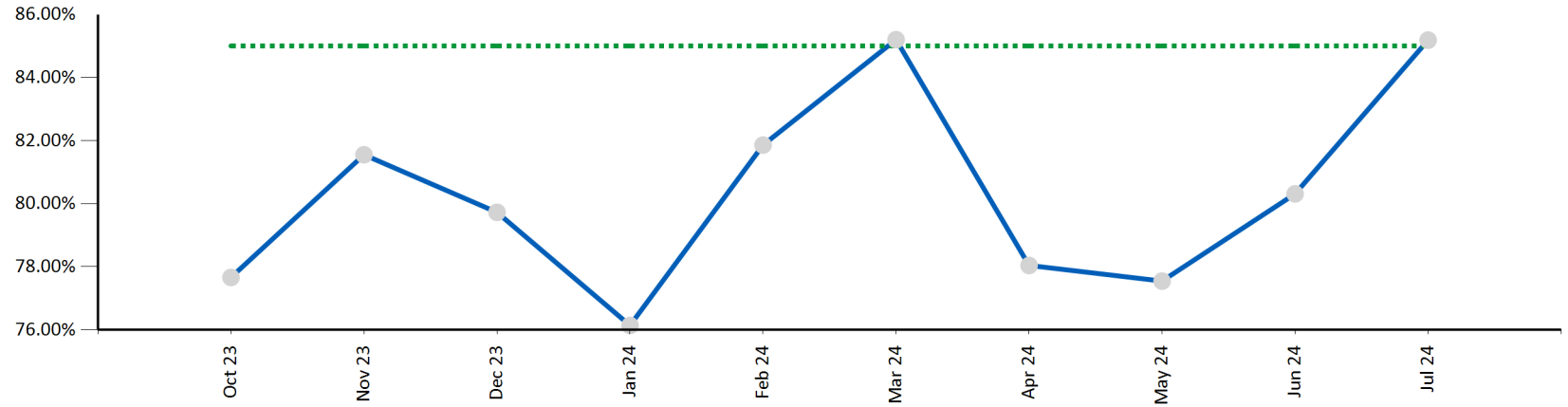
Plan	Actual	Period
>= 96%	96.5%	Jun-24

Year to Date

Plan	Actual
0.96	98.7%

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

2/6



Latest

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

Previous

Plan	Actual	Period
>= 85%	80.3%	Jun-24

Year to Date

Plan	Actual
0.85	80.5%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

Emergency Department deflections

ED deflections for Month 5 have increased to 568, which remains above the plan of 400. The number of deflections has continued to remain above 500 and this demonstrates the impact of the continued work by the Admission Avoidance Team in relation to promotion of 2hr Urgent Care Response and pathways into the service from North West Ambulance Service, Primary Care and Care Homes. Work is ongoing support ED deflections, use of the Admission Avoidance Team 30 day readmission pathway and a wider focus on the top ten care homes with high attendances to ED and NWAS callouts. Further improvements to ED deflections are expected incrementally over the remainder of the year as the team develop an improvement plan based upon nationally mandated criteria of 157 referrals per 100,000 population per month for 2 hr UCR.

NCTR

The monthly average number of patients with No Criteria to Reside has reduced by 4, above our operating plan at an average of 93. Additions to No criteria to reside were in line with usual variation however the August bank holiday has resulted in challenges in reducing to operating plan of 90

Occupied bed days has increased to 771 in month 5, although variation between months should be expected. For context this remains a reduction on 912 in Month 2. This has been a result of progress with implementation of the NCTR Urgent Care Improvement Group actions. This is an overall improving position, however average lost bed days continued to be above plan of 400 due to backlog from August bank holiday and Out of Area flow. NCTR recovery plan and UCIG NCTR actions are ongoing alongside additional improvement schemes planned during September's Greater Manchester super multi agency discharge event. It is expected there will be further improvements in relation to lost bed days in Month 6.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts has remained stable (77%) although remains off target. Underperformance can be attributed to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors (nationally). Despite the positive recruitment, health visitor vacancies are still causing pressures and this has been recorded on the divisional risk register (risk 6036).

EHCP compliance

As forecasted by the service, EHCP compliance has continued to improve to 98% in August vs 97% in July with a year to date position of 82%. This increase is due to an improvement in staff sickness levels across the service.

Looked after Children

Performance continues to be strong across our Looked After Children (LAC) pathways. Special school reviews are well above target with 100% compliance (no breaches).

Performance for review health assessments has dropped to 83% against a 90% target, with 34 out of 41 reviews completed within timescale. However, 5 of these breaches were outside of service control.

Initial Assessments dropped to 80% against a target of 90%, with 12 out of 15 completed within time. However, upon review, none of these breaches were within the control of the service.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	568	Aug-24		>= 400	378	Jul-24	>= 2,000	2,654	

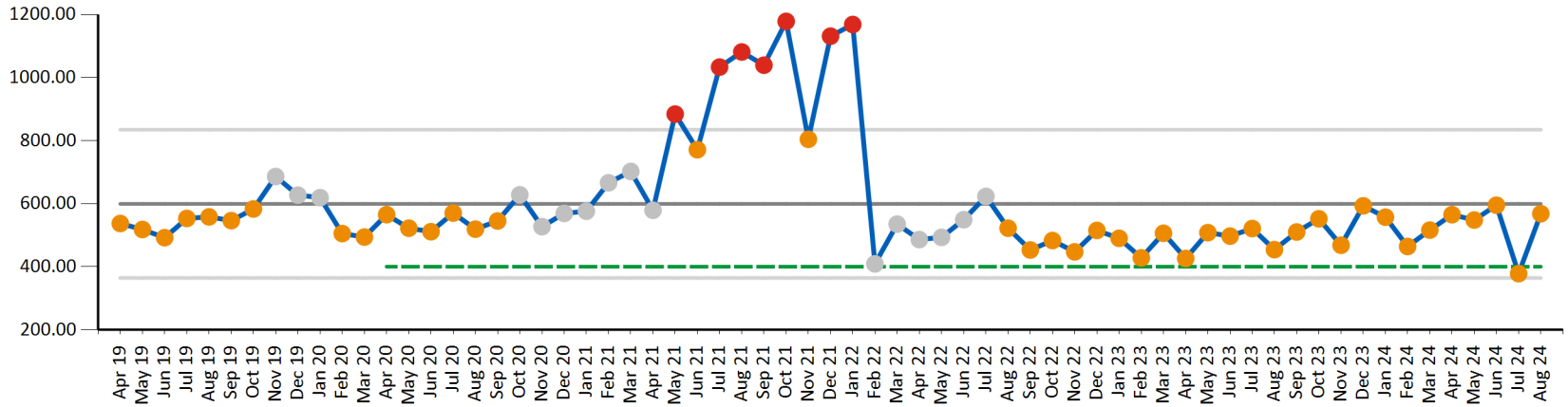
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
493 - Average Number of Patients: with no Criteria to Reside	<= 93	93	Aug-24		<= 92	97	Jul-24	<= 93	93	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	771	Aug-24	H	<= 360	744	Jul-24	<= 1,800	4,093	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	77%	Aug-24	L	>= 95%	77%	Jul-24	>= 95%	73%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	98%	Aug-24		>= 95%	97%	Jul-24	>= 95%	82%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	83.0%	Aug-24		>= 90.0%	88.0%	Jul-24	>= 90.0%		?
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	80.0%	Aug-24		>= 90.0%	82.0%	Jul-24	>= 90.0%		?
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Aug-24		>= 90.0%	50.0%	Jul-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.

5/6



Latest

Plan	Actual	Period
>= 400	568	Aug-24

Previous

Plan	Actual	Period
>= 400	378	Jul-24

Year to Date

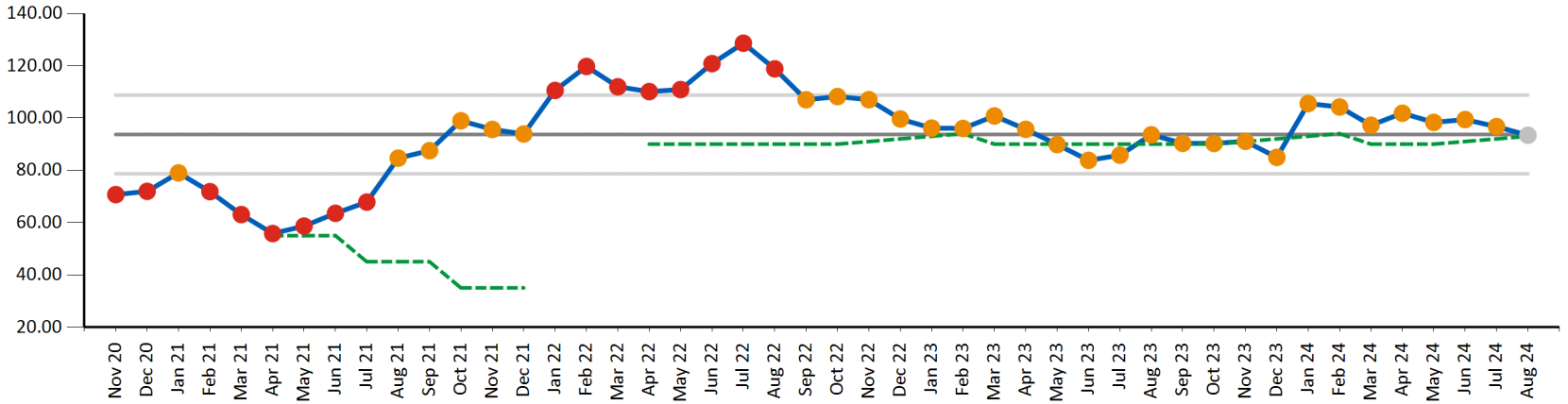
Plan	Actual
>= 2,000	2,654

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 93	93	Aug-24

Previous

Plan	Actual	Period
<= 92	97	Jul-24

Year to Date

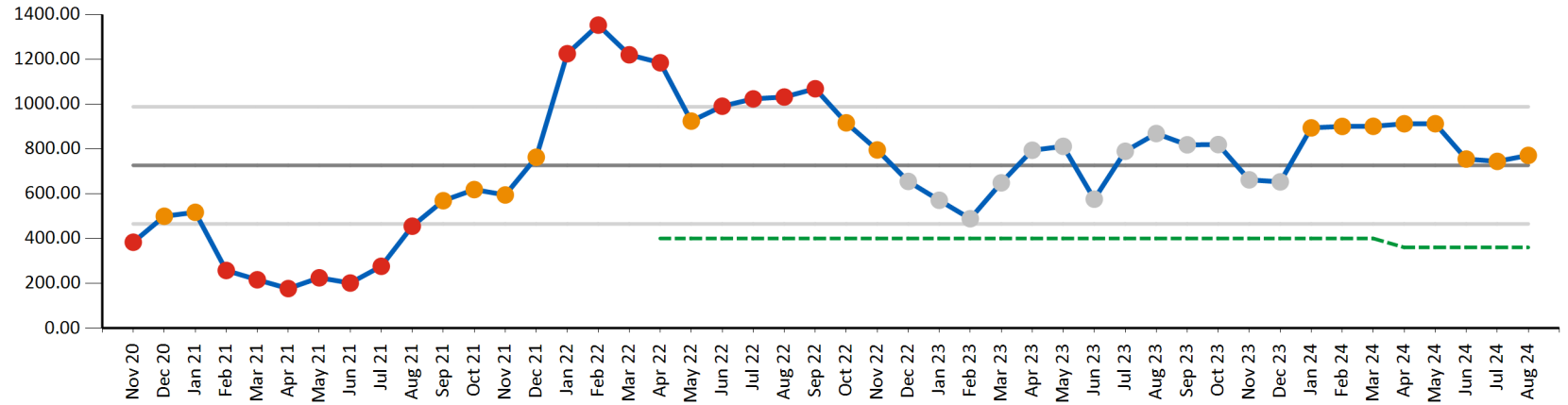
Plan	Actual
<= 93	93

494 - Average Occupied Days - for no Criteria to Reside

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	771	Aug-24

Previous

Plan	Actual	Period
<= 360	744	Jul-24

Year to Date

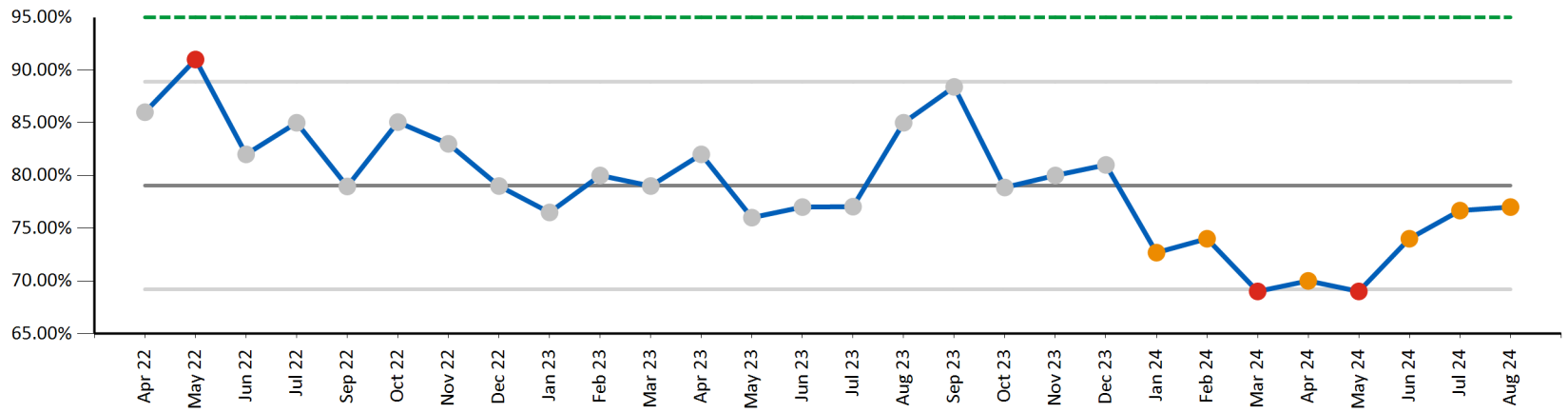
Plan	Actual
<= 1,800	4,093

267 - 0-5 Health Visitor mandated contacts

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	77%	Aug-24

Previous

Plan	Actual	Period
>= 95%	77%	Jul-24

Year to Date

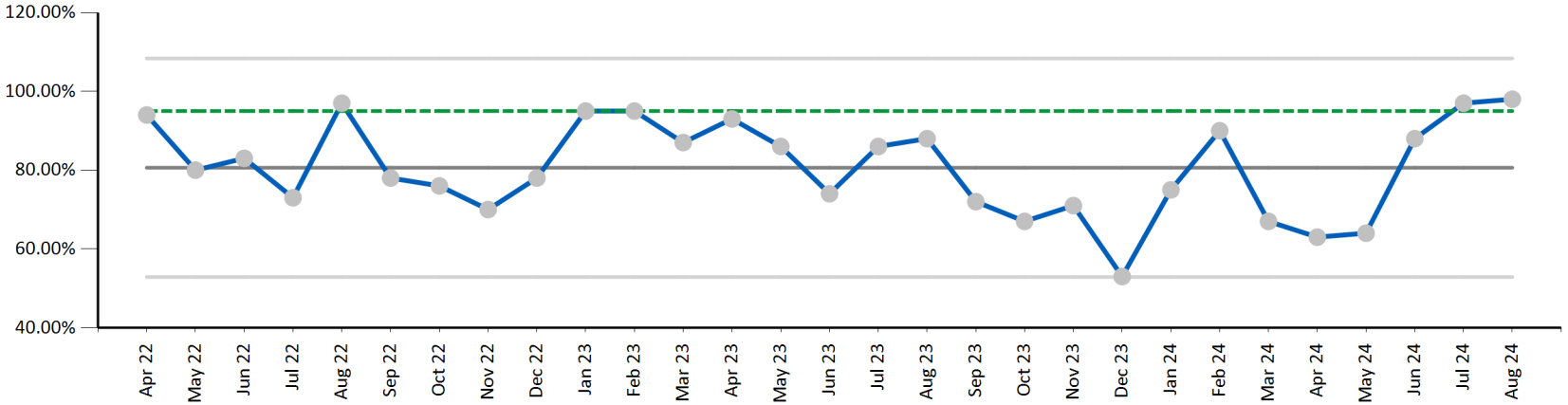
Plan	Actual
>= 95%	73%

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 95%	98%	Aug-24

Previous

Plan	Actual	Period
>= 95%	97%	Jul-24

Year to Date

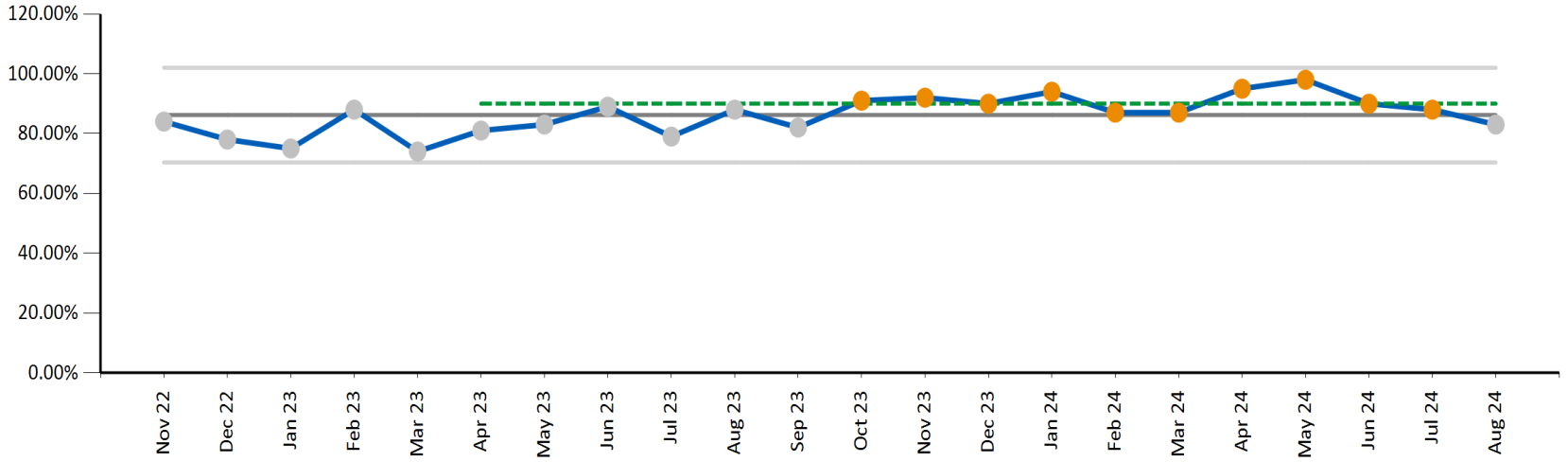
Plan	Actual
>= 95%	82%

550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse

Common cause variation.

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

3/6



Latest

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

Previous

Plan	Actual	Period
> = 90.0%	88.0%	Jul-24

Year to Date

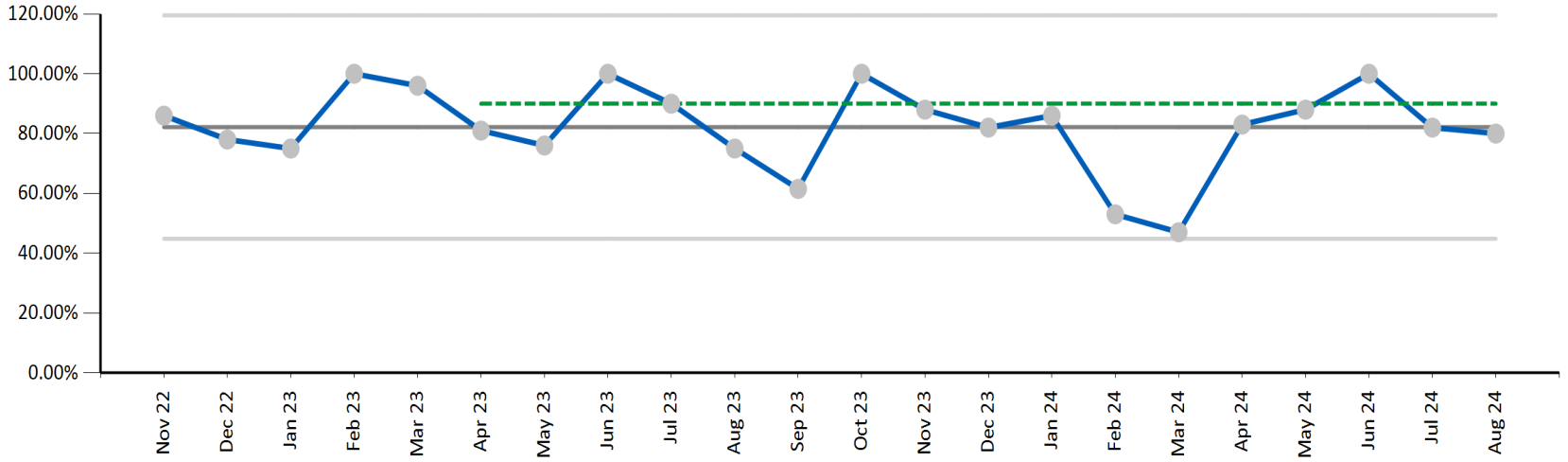
Plan	Actual
> = 90.0%	

551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
> = 90.0%	80.0%	Aug-24

Previous

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

Year to Date

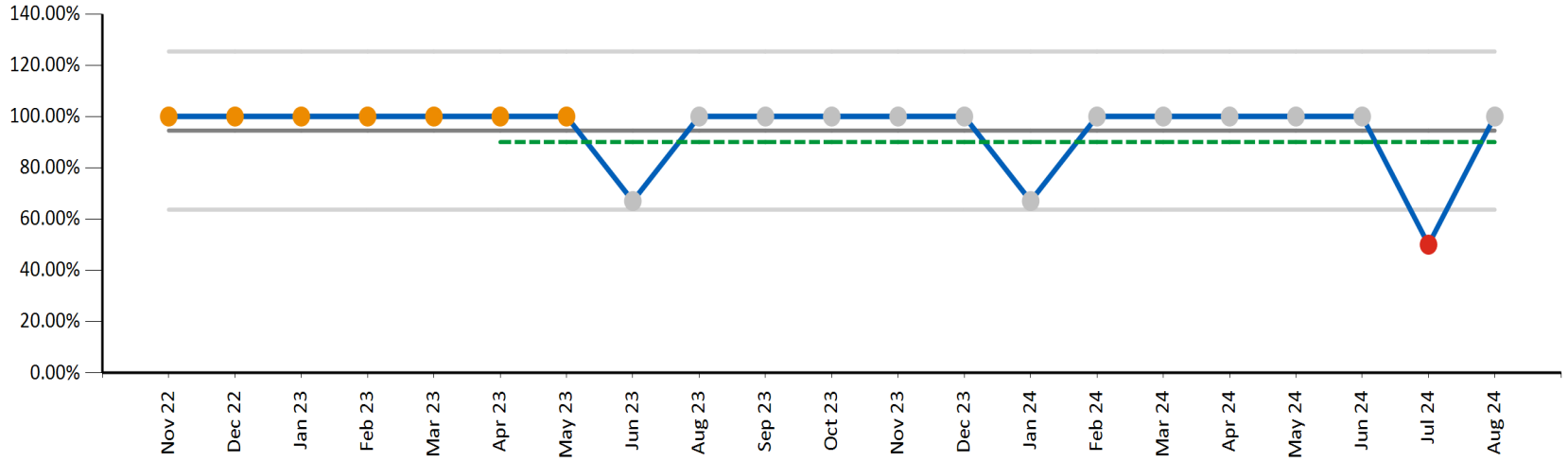
Plan	Actual
> = 90.0%	

552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools

Common cause variation.

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

5/6



Latest

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

Previous

Plan	Actual	Period
> = 90.0%	50.0%	Jul-24

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness decreased slightly in month from 4.84% to 4.49% in August 2024. There has been a reduction in sickness absence across the majority of the Divisions with notable reductions in the AACD, ASSD, DSSD and ICSD divisions. The ICSD division in particular have seen a notable reduction in month, that whilst remaining above target, their absence rates have reduced by 1.03%. 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:
August 2024 performance was at 11.82% at overall Trust level, which is a slight increase from the previous month. Performance in the year 2024/25 to date has mirrored our forecasting which suggested that we would see a fairly static trend following a two year period of peaks and troughs.

Vacancy:
Vacancy rate reduced to 5.10% which is the lowest level seen in this financial year and is under our plan of 6%. This was primarily driven by new starters in clinical roles, including a large intake of medical staff (28.7 WTE) in-month.

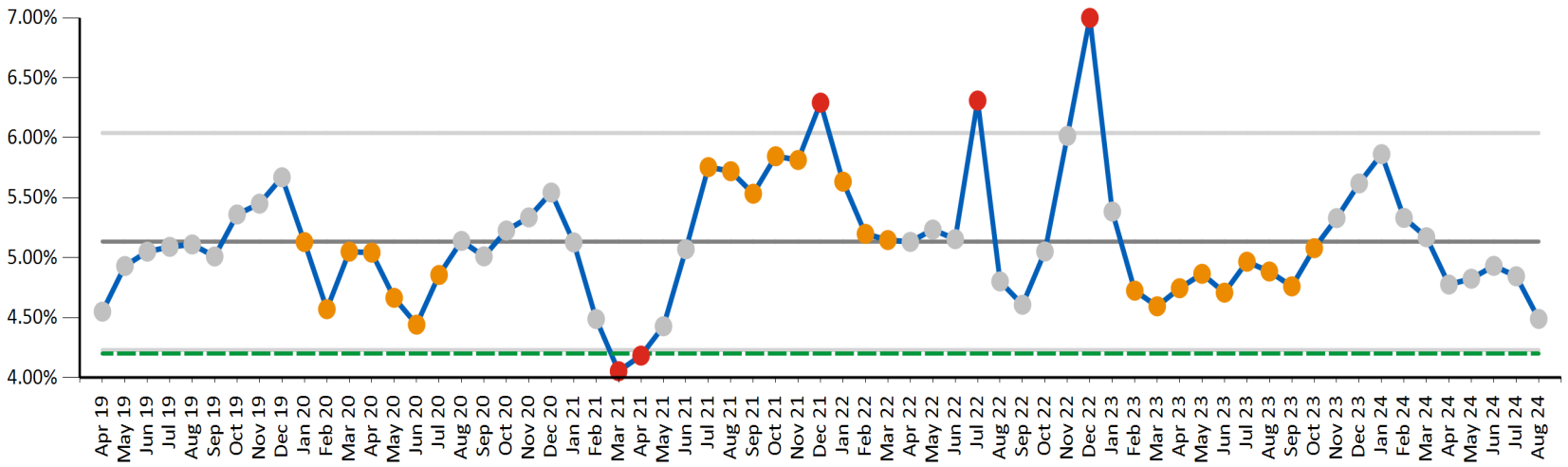
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.49%	Aug-24		<= 4.20%	4.84%	Jul-24	<= 4.20%	4.77%	F
120 - Vacancy level - Trust	<= 6%	5.10%	Aug-24		<= 6%	5.94%	Jul-24	<= 6%	5.54%	?
121 - Turnover	<= 9.90%	11.82%	Aug-24	L	<= 9.90%	11.69%	Jul-24	<= 9.90%	11.59%	F
366 - Ongoing formal investigation cases over 8 weeks		2	Jul-24			0	Jun-24		2	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	4.49%	Aug-24

Previous

Plan	Actual	Period
<= 4.20%	4.84%	Jul-24

Year to Date

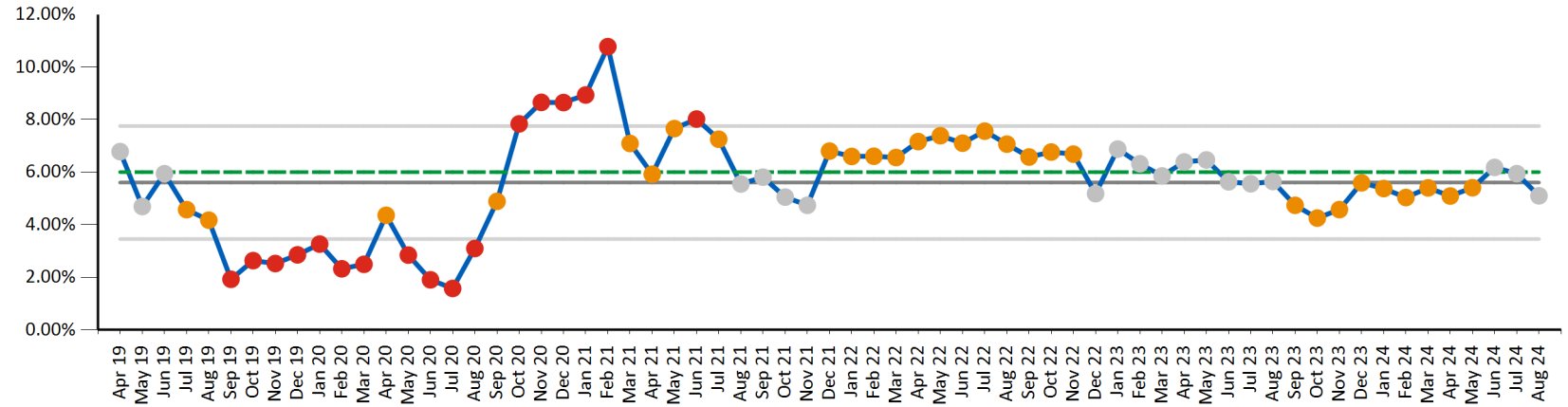
Plan	Actual
<= 4.20%	4.77%

120 - Vacancy level - Trust

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 6%	5.10%	Aug-24

Previous

Plan	Actual	Period
<= 6%	5.94%	Jul-24

Year to Date

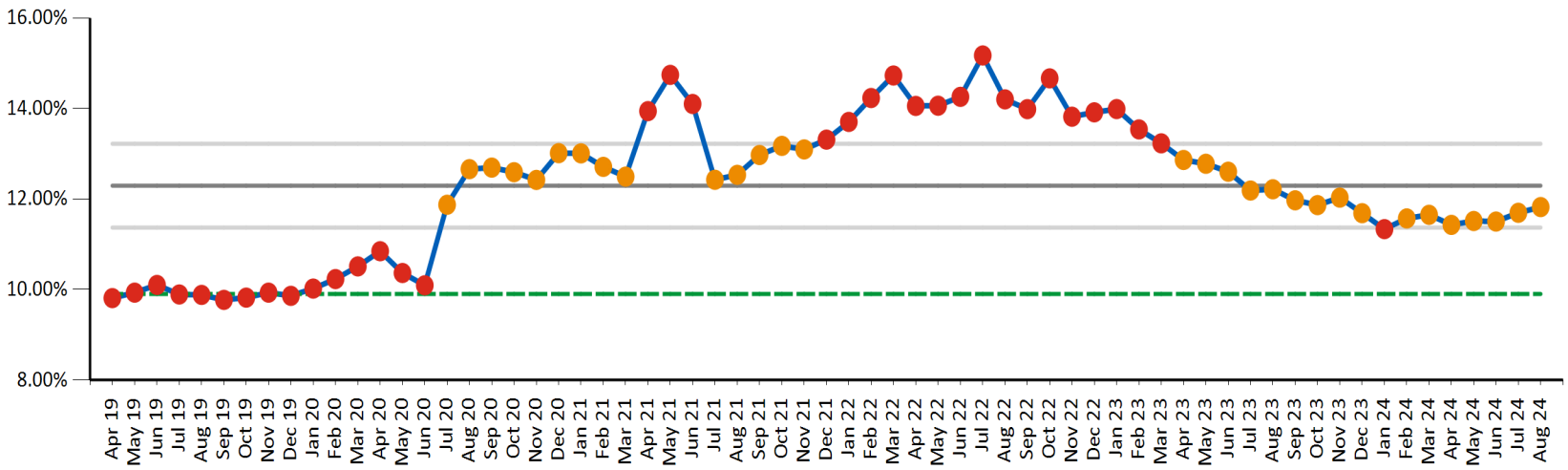
Plan	Actual
<= 6%	5.54%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
< = 9.90%	11.82%	Aug-24

Previous

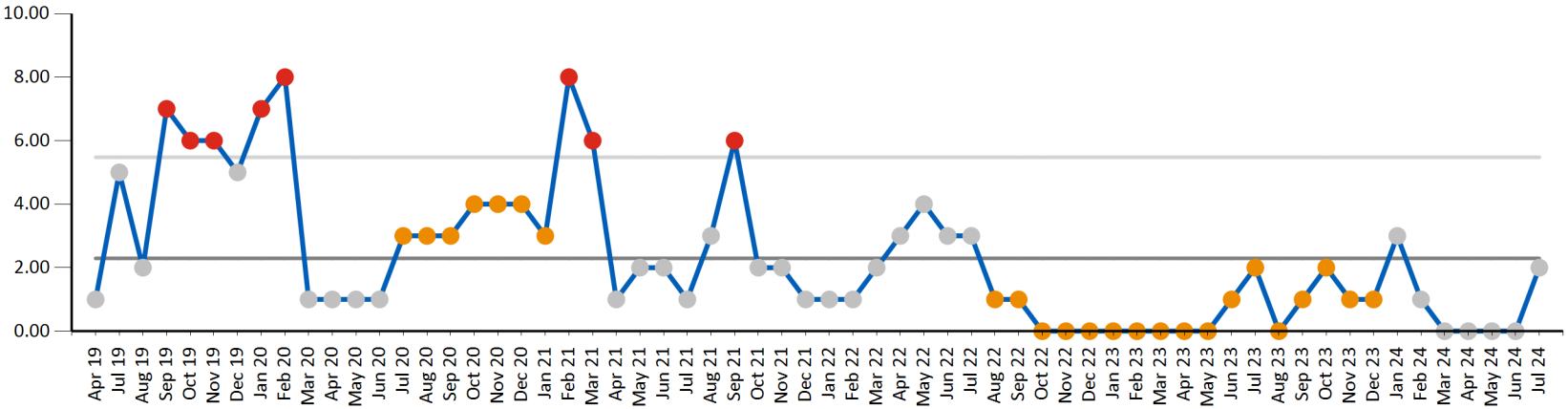
Plan	Actual	Period
< = 9.90%	11.69%	Jul-24

Year to Date

Plan	Actual
< = 9.90%	11.59%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	2	Jul-24

Previous

Plan	Actual	Period
	0	Jun-24

Year to Date

Plan	Actual
	2

Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory training
Improved position in month to 93.48%. All divisions/ directorates have exceeded 90% with 8 reaching the 95% target. This is the first time in four years our monthly position has not deteriorated in the month of August

Trust Mandated Training
The position deteriorated very slightly in month to 90.43% which remains well above the 85% target. 12 of the 13 divisions/directorates have achieved over 90%

Appraisals
The position deteriorated by 0.7% in month at 85.78%, this was influences by a marked reduction in compliance for the Strategy Directorate (27.27%)

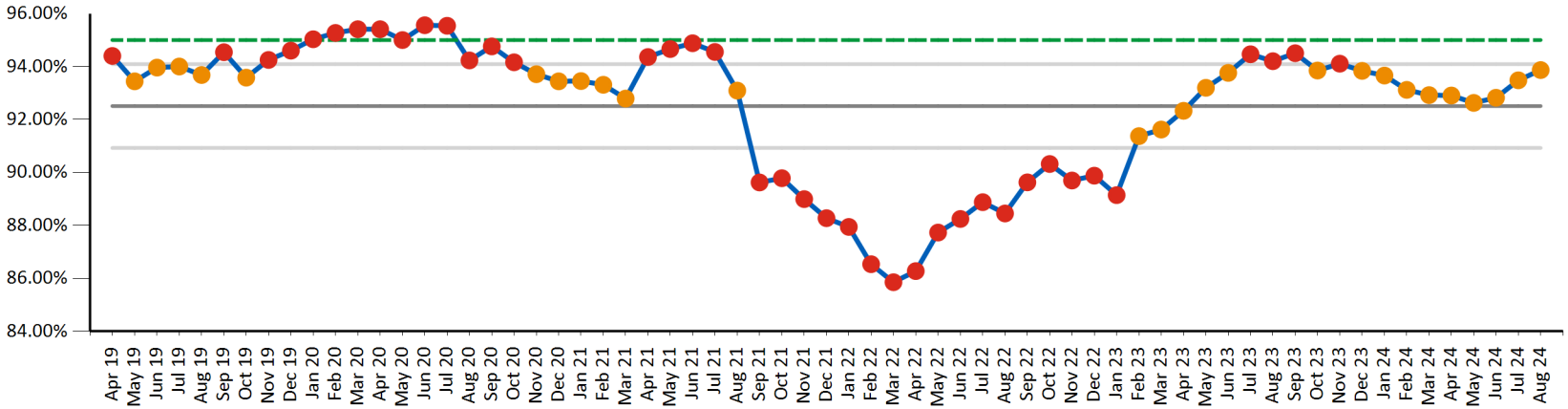
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.9%	Aug-24		>= 95%	93.5%	Jul-24	>= 95%	93.1%	
38 - Staff completing Trust Mandated Training	>= 85%	90.4%	Aug-24		>= 85%	91.5%	Jul-24	>= 85%	90.1%	
39 - Staff completing Safeguarding Training	>= 95%	91.60%	Aug-24		>= 95%	91.78%	Jul-24	>= 95%	91.65%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.8%	Aug-24		>= 85%	86.5%	Jul-24	>= 85%	85.1%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	53.4%	Q2 2024/25		>= 66%	43.0%	Q1 2024/25	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	53.8%	Q2 2024/25		>= 80%	50.5%	Q1 2024/25	>= 80%		

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%	93.9%	Aug-24

Previous

Plan	Actual	Period
>= 95%	93.5%	Jul-24

Year to Date

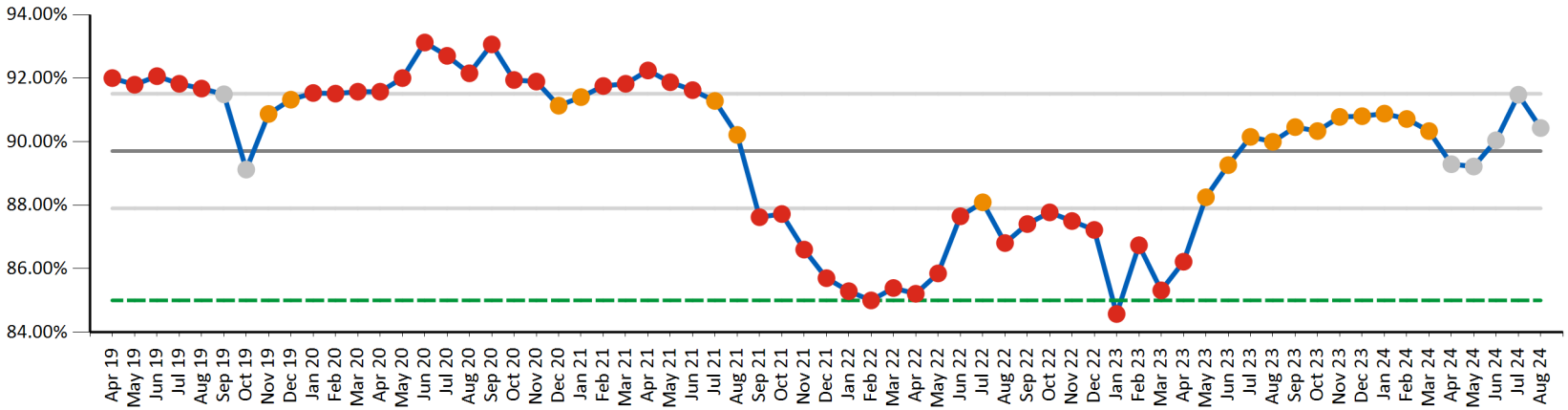
Plan	Actual
>= 95%	93.1%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.4%	Aug-24

Previous

Plan	Actual	Period
>= 85%	91.5%	Jul-24

Year to Date

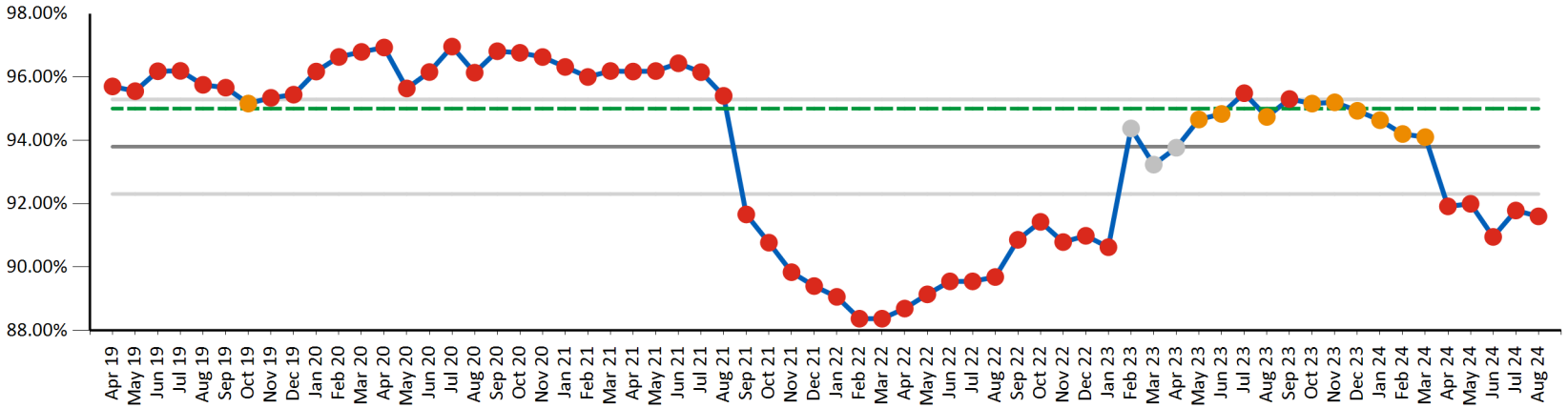
Plan	Actual
>= 85%	90.1%

39 - Staff completing Safeguarding Training

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 95%	91.60%	Aug-24

Previous

Plan	Actual	Period
>= 95%	91.78%	Jul-24

Year to Date

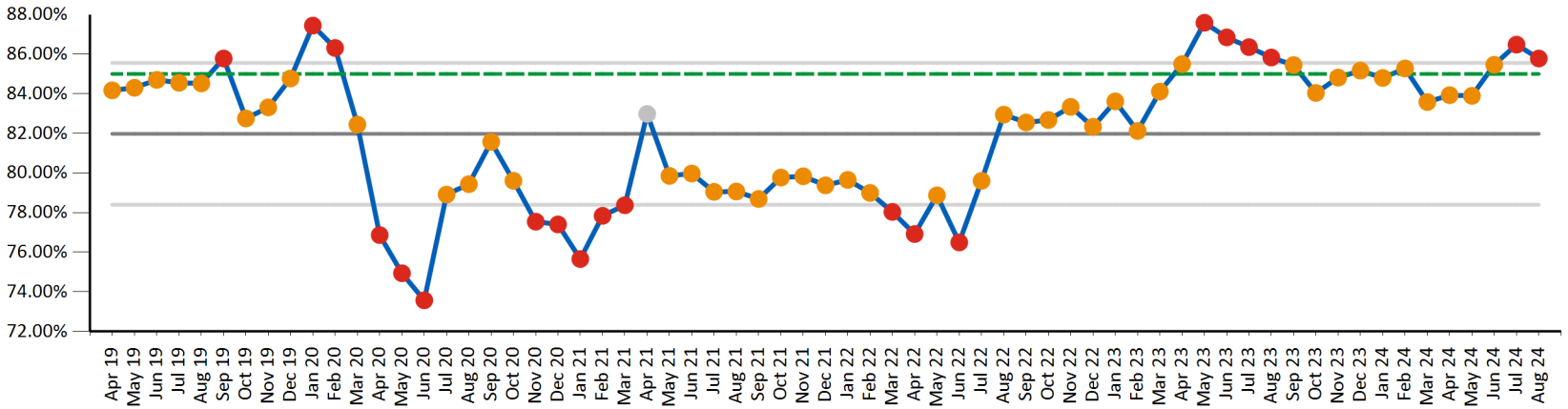
Plan	Actual
>= 95%	91.65%

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.

3/6



Latest

Plan	Actual	Period
>= 85%	85.8%	Aug-24

Previous

Plan	Actual	Period
>= 85%	86.5%	Jul-24

Year to Date

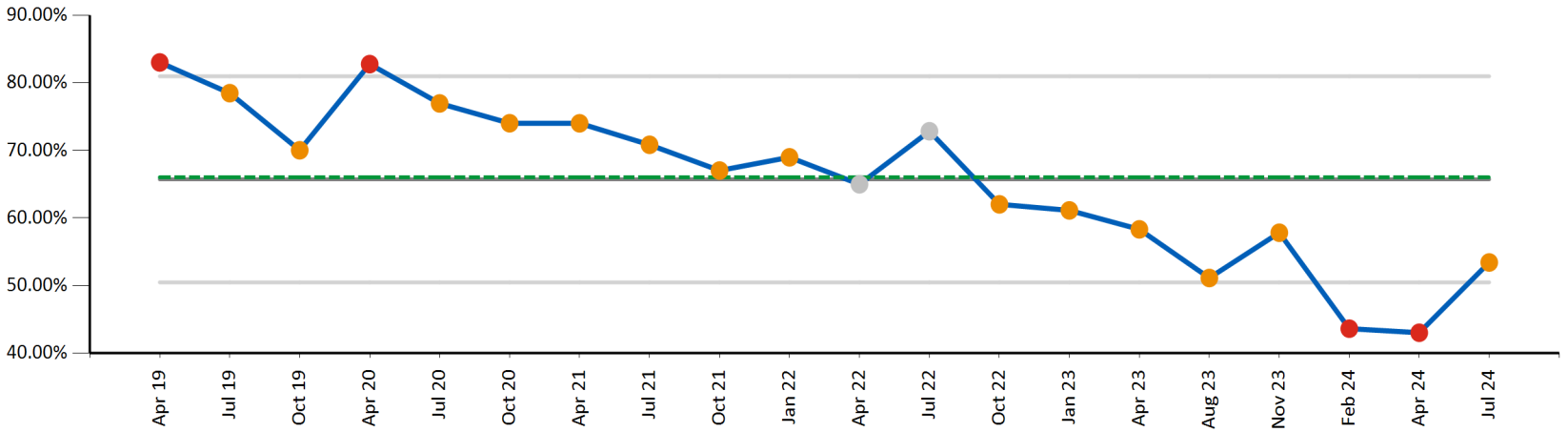
Plan	Actual
>= 85%	85.1%

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.

0/6



Latest

Plan	Actual	Period
>= 66%	53.4%	Q2 2024/25

Previous

Plan	Actual	Period
>= 66%	43.0%	Q1 2024/25

Year to Date

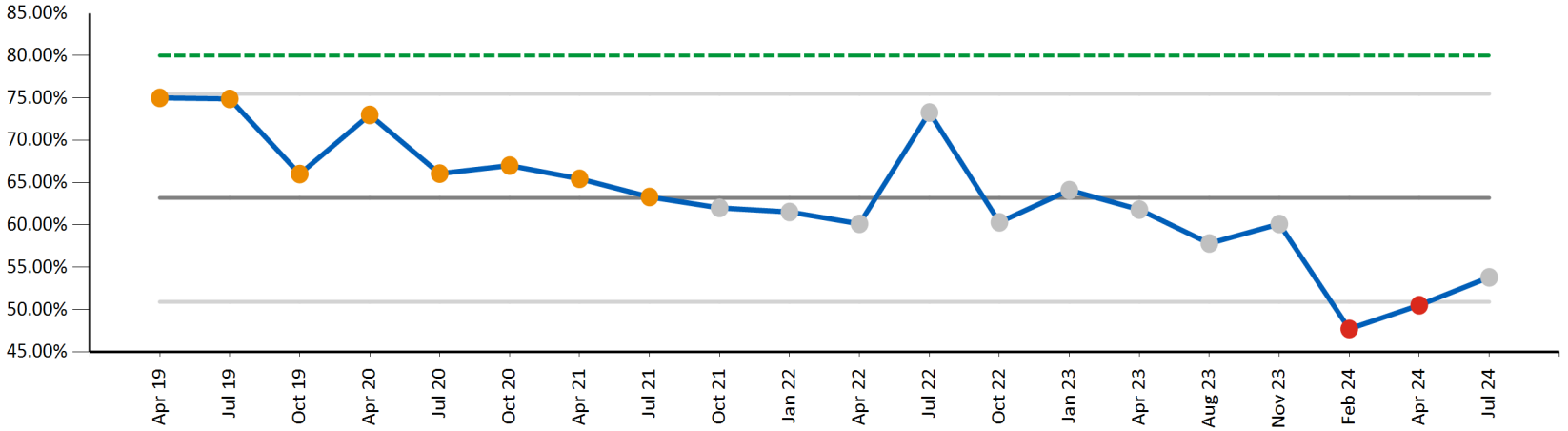
Plan	Actual
>= 66%	

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%	53.8%	Q2 2024/25

Previous

Plan	Actual	Period
>= 80%	50.5%	Q1 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

The reduced spend trend seen in July 2024 continued into August 2024 where spending reduced by £103k in-month. This was driven by reductions in medical agency (reduction of £55k), and nursing and midwifery (reduction of £48k). Other staffing groups remained static.

The Trust continues to be under the NHSE target of agency being no more than 3.2% of total pay bill (Aug 2024 performance was at 2.1%, and YTD is running at 2.3%). We are currently under our internal agency spend plan (at the end of M5 24/25) by £630k (total actual spend of £3.44m against a planned spend of £4.07m).

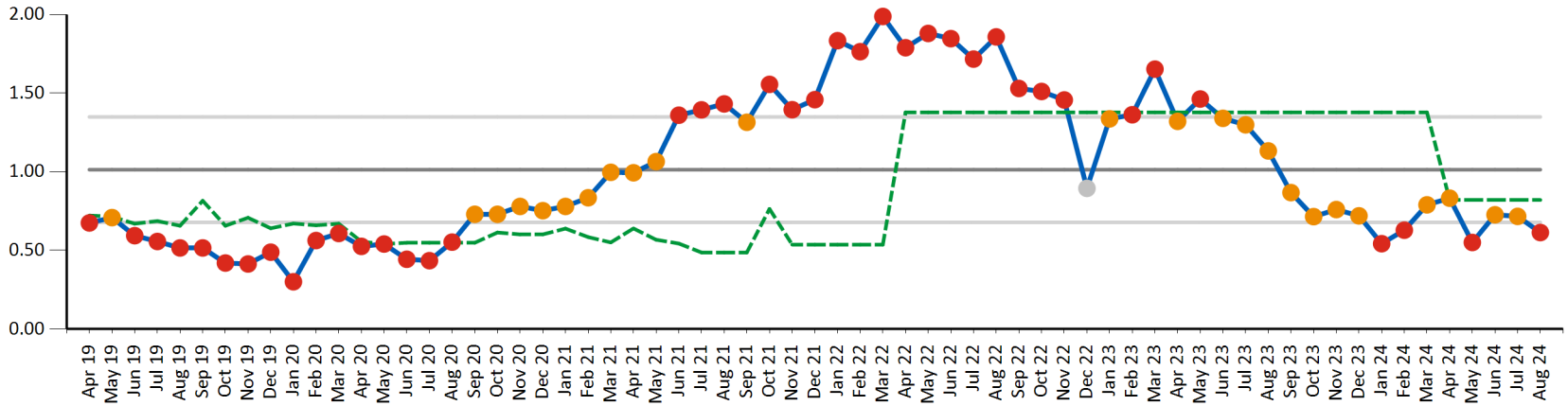
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.82	0.61	Aug-24	L	<= 0.82	0.72	Jul-24	<= 4.10	3.44	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.09	0.01	Aug-24	L	<= 0.09	0.06	Jul-24	<= 0.45	0.25	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.48	Aug-24		<= 0.62	0.54	Jul-24	<= 3.10	2.67	?

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

L — 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	0.61	Aug-24

Previous

Plan	Actual	Period
<= 0.82	0.72	Jul-24

Year to Date

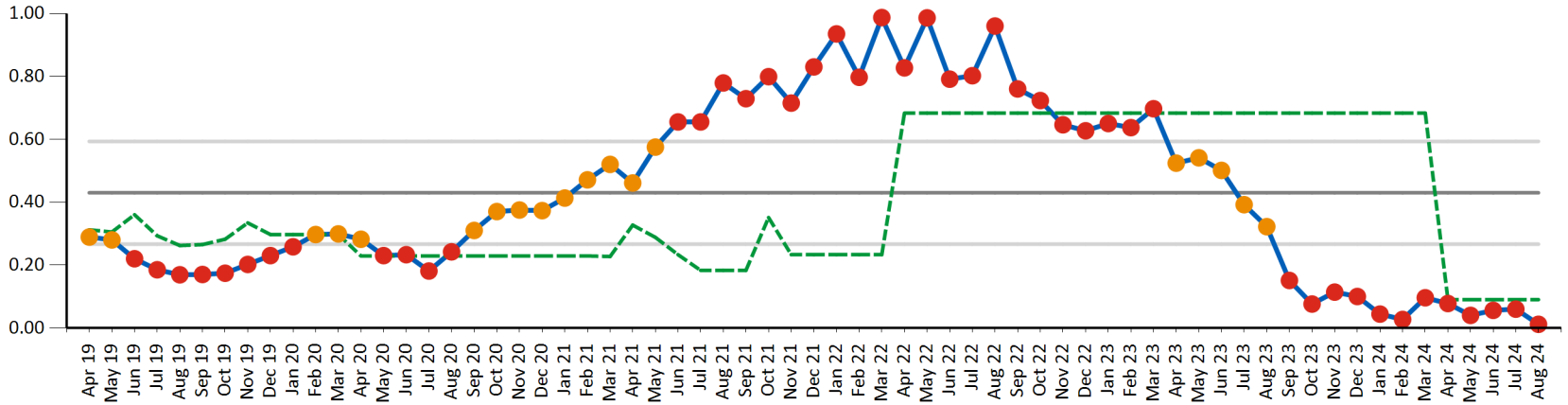
Plan	Actual
<= 4.10	3.44

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

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
<= 0.09	0.01	Aug-24

Previous

Plan	Actual	Period
<= 0.09	0.06	Jul-24

Year to Date

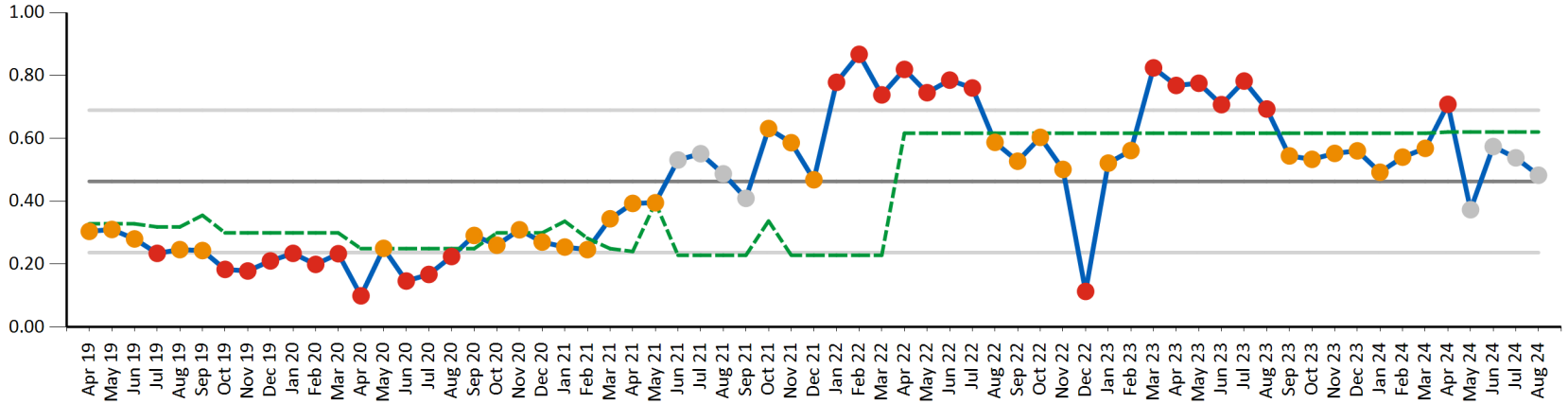
Plan	Actual
<= 0.45	0.25

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

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 0.62	0.48	Aug-24

Previous

Plan	Actual	Period
<= 0.62	0.54	Jul-24

Year to Date

Plan	Actual
<= 3.10	2.67

Finance - Finance

Bolton NHS Foundation Trust

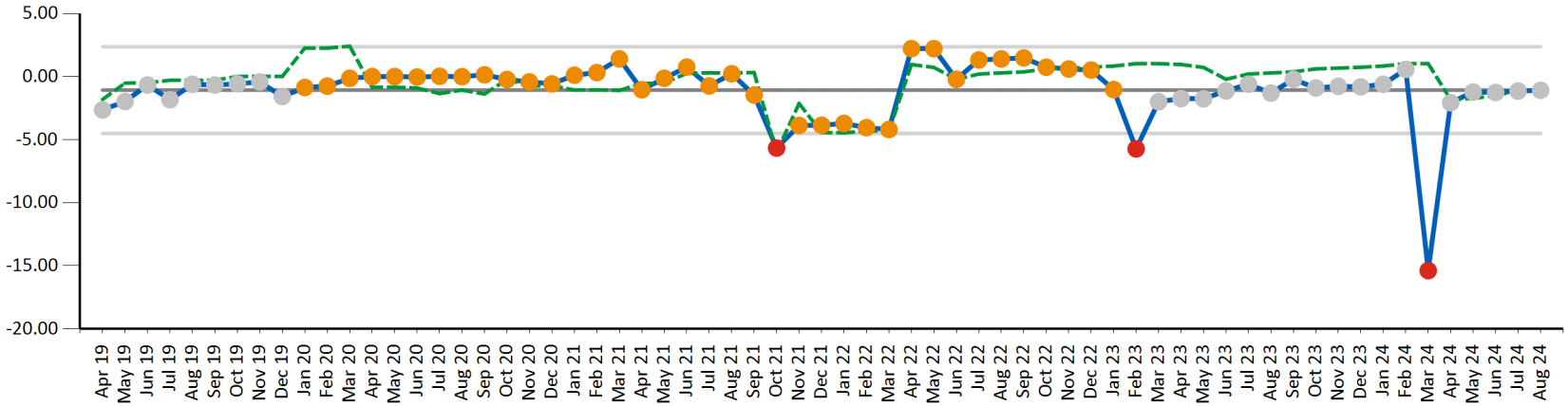
Revenue YTD - Deficit of £6.7m, better than plan by £0.5m.
Revenue forecast - Likely forecast outturn is currently to achieve plan, assuming £4.9m of mitigations are fully delivered. However, the worst-case scenario suggests an adverse variance to plan of £11.9m.
Cost improvement - Year to date delivery £1.8m behind plan.
Variable pay - Agency spending is 2.3% of pay costs compared to NHSE target of 3.2% and a plan of 2.2%.
Capital - Continued pressure on forecast allocation.
Balance Sheet - Decrease on total assets employed due to deficit.
Cash Position - Current cash of £8.3m vs plan of £6.4m. Forecast £16m overdrawn before support, based on delivering plan. Planned cash support of £15m from Q3.
BPPC - 96.6% 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)		-1.1	Aug-24		>= -1.1	-1.2	Jul-24	>= -6.2	-6.8	
222 - Capital (£ millions)		1.0	Aug-24		>= 1.1	0.8	Jul-24	>= 3.8	2.4	
223 - Cash (£ millions)		8.4	Aug-24		>= 7.3	7.4	Jul-24		8.4	

220 - Control Total (£ millions)

Common cause variation.

2/6



Latest

Plan	Actual	Period
	-1.1	Aug-24

Previous

Plan	Actual	Period
>= -1.1	-1.2	Jul-24

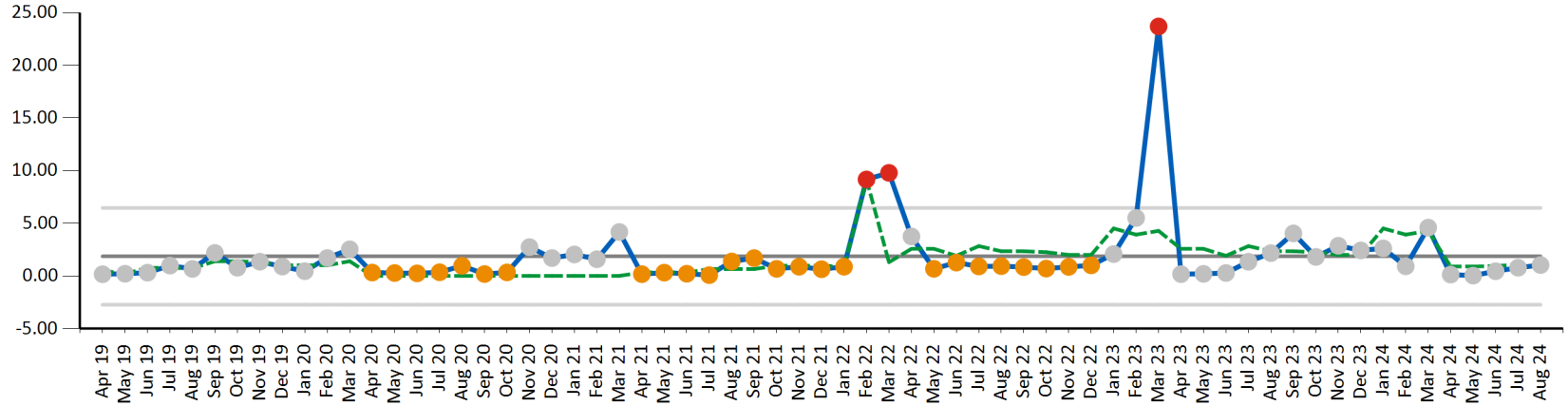
Year to Date

Plan	Actual
>= -6.2	-6.8

222 - Capital (£ millions)

Common cause variation.

1/6



Latest

Plan	Actual	Period
	1.0	Aug-24

Previous

Plan	Actual	Period
>= 1.1	0.8	Jul-24

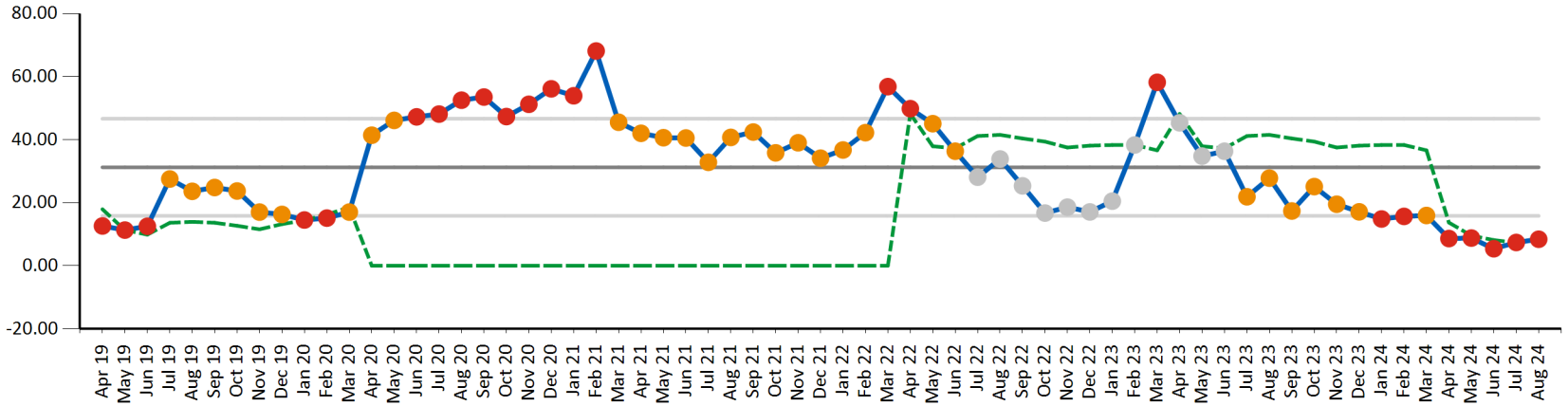
Year to Date

Plan	Actual
>= 3.8	2.4

223 - Cash (£ millions)

Special cause variation with deteriorating performance

1/6



Latest

Plan	Actual	Period
	8.4	Aug-24

Previous

Plan	Actual	Period
>= 7.3	7.4	Jul-24

Year to Date

Plan	Actual
	8.4

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Medical Director		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the Quality Assurance Committee.
Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee meeting held in July 2024.
Executive Summary	The attached report from the Chair of the Quality Assurance Committee provide an overview of matters discussed at the meeing held on 24 July 2024. The report also sets out the assurance received by the Committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the September meeting of the Quality Assurance Committee, a verbal update will be provided to the Board of Directors with a written report presented to the subsequent Board meeting.
Proposed Resolution	The Board of Directors are asked to ***receive*** the Quality Assurance Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓		✓	✓	

Summary of Key Elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

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:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	24 July 2024	**Date of next meeting:**	25 September 2024
Chair	Fiona Taylor, Non-Executive Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Patient Story - AACD Division
- Integrated Performance Report
- Trust Mortality Report
- Learning from Deaths Report
- Safeguarding Adults, Children and Looked After Children
- Learning from Independent Review of GMMH
- CQC Paediatric Audiology Report
- Maternity Incentive Scheme Year 6 Progress Update (CNST)
- BoSCA Platinum Application Process
- CQC Improvement Plan Update
- Annual Concerns and Complaints Report
- Patient Safety Incident Investigation Reports
- Clinical Governance & Quality Group (CGQG) Chairs Report

ALERT

Agenda items	Action Required
• **Integrated Performance Report (C-difficile)** – It was noted that all other aspects of IPC are good when compared to GM however c-diff remains to be a concerning outlier. This is due partly to the inability to isolate and so the Trust continues to look at a cohort ward however this will have wider impact across the Trust and needs to be considered carefully. There is also a manual audit of antimicrobial stewardship being undertaken across all wards to see if this is also a contributing factor. • **CQC Paediatric Audiology Report** – The report noted that the Paediatric Audiology Service had its accreditation revoked by UKAS in December 2021. The services is working towards reaccreditation, with an anticipated date for achieving this being November 2026. The Committee noted that more understanding of the service is required and that there is a need for transformational change and an improvement trajectory to provide further assurance.	Both items to be monitored through the CGQG in September with any issues escalated up via the Chairs Report.

ADVISE

- **Trust Mortality Report** – The report was received and the Committee noted that the SHMI/HSMR are within the expected parameters. There has been a change to the methodology used to calculate SHMI which now includes Covid deaths and will alter the data.
- **Learning from Deaths Report** – The report was received and it was highlighted that 39 cases had been reviewed and of which three were subject to secondary reviews and it was found that there

would have been no change to the outcome. The Learning from Deaths Committee is undergoing a full review of both membership and purpose.

- **Safeguarding Adults, Children and Looked After Children** – It was noted that there had been an increase in referrals seen by the Safeguarding department and that there is work ongoing to introduce a comprehensive digital system which will capture all safeguarding referrals across various channels with the hope of improving data accuracy and analysis. The Trust has also recently appointed new leads for MCA, DoLs and Looked After Children.
- **Learning from Independent Review of GMMH** - The report shared with the Committee provided a high level outline in response to the specific questions raised following the review and the Committee were asked note the contents of the briefing. The Trust will continue to work towards implementation of Martha' Rule for which it is a pilot site for and will be revising the 'Three Steps to Execs' framework.
- **CQC Improvement Plan Update** – The Committee noted that the plan was progressing well with further recommendations completed and validated. With regards to the overdue recommendation relating to Pharmacy workforce, a business case has been produced and approved in July.
- **Annual Concerns and Complaints Report** – The report was received and would be recommended to the Board. The Committee noted that discussion had taken place at CGQG where each of the Divisions had been asked to reflect on their own learning and will contribute towards the quarterly and annual complaint reports.
- **Maternity Incentive Scheme Year 6 Progress Update (CNST) –** The Committee were informed that formal receipt of payment for Year 5 has been received. The service is progressing well with all ten safety actions and have already attainted some of the 84 recommendations. Further work is needed to meet the required 90% staff training and so additional training sessions are being implemented to accommodate demand.

ASSURE

- **Integrated Performance Report** – The Committee noted;
  - VTE compliance is levelling at 97% which is an improvement,
  - Falls for inpatients has seen special cause improvement,
  - No Cat3 in patients pressure ulcers for 18 months and no Cat4 inpatient pressure ulcers. Concerns remained regarding data interpretation for community based pressure ulcers as the Trust does not provide 24/7 care cover and so rely on external providers also.
  - Induction of labour had seen best performance and sustained improvement since 2019 and booking at 12+6 had seen steady improvement.
- **BoSCA Platinum Application Process** - The Committee received and approved the report presented by B Mason and D Redfern regarding the application process for Platinum BoSCA status. The Committee discussed how well the BoSCA framework is embedded within the Trust and asked that more consideration be given to sharing these positive stories more widely with the public.
- **Clinical Governance & Quality Committee Chairs Report** – There were no issues raised for escalation by the Committee.

New Risks identified at the meeting: None

Review of the Risk Register: *Not reviewed.*

Report Title:	Clinical Negligence Scheme for Trusts (CNST)Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	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 CNST Maternity Incentive Scheme (MIS).

Previously considered by:	This report was discussed at the Clinical Quality and Governance Group and will be discussed at the Quality Assurance Committee on 25 September 2024.

Executive Summary	The CNST year 6 scheme guidance was launched on the 02 April 2024 with an associated benchmarking tool. The service is progressing well with all ten safety actions and has attained 13 of the 92 recommendations to date. The CNST evidence collated to date has been uploaded to the Futures Collaboration platform and will be subject to external oversight by the LMNS prior to submission. Ongoing work continues to meet the required 90% standard for relevant staff groups with regard to multi-professional training with a particular focus on medical staffing groups. Training relating to maternity emergencies, fetal monitoring and newborn life support is being prioritised and trajectories of compliance have been compiled to track progress.

Proposed Resolution	The Board of Directors are asked to: i. **Receive** the report and **approve** the action plans contained within, and 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.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	Achieving CNST standards may impact insurance premiums and potential financial incentives. Mitigation includes prioritising compliance to maximise financial benefits.
Legal/ Regulatory	**Yes**	Compliance with CNST year 6 scheme is a regulatory requirement. The Trust is progressing well with 13 of 92 recommendations met. Ongoing work ensures adherence to safety standards and regulatory obligations.
Health Inequalities	**Yes**	CNST standards aim to improve maternity safety for all patients. Implementing these standards may help address health inequalities in maternity care.
Equality, Diversity and Inclusion	**Yes**	Multi-professional training requirements ensure diverse staff groups are adequately prepared, promoting inclusive care. Monitoring compliance across all staff groups supports equality in skill development

Prepared by:	Tyrone Roberts, Chief Nursing Officer Janet Cotton, Director of Midwifery/ Divisional Nurse Director	**Presented by:**	Tyrone Roberts, Chief Nursing Officer Director of Midwifery/ Divisional Nurse Director

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

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWODN	North West Neonatal Operational Delivery Network
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
RCOG	Royal College of Obstetricians and Gynaecologists

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 launched on the 2 April 2024.

Oversight of the year scheme compliance continues to be monitored using the NHS Resolution benchmarking table that is updated following population of the NHSR tool.

The evidence collated to date has been uploaded to the Futures Collaboration platform and will be subject to external oversight by the LMNS prior to submission.

Table 1 – CNST year 6 progress update as of 20 August 2024

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	3	0	0	3
3	0	2	3	0	5
4	4	13	1	0	18
5	0	5	2	0	7
6	2	4	1	0	7
7	0	6	2	0	8
8	3	15	0	0	18
9	0	6	4	0	10
10	0	9	0	0	9
Total	9	70	13	0	92

Key:

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

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

The Trust Board is required to receive a report each quarter that includes details of all deaths reviewed from the 08 December 2024.

All cases that have occurred during the period up to the 20 August 2024 are detailed with Appendix 1 and confirm the required standards have been met for all cases namely:

a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.
b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
c) **Review the death and complete the review**: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

Actions identified in the reviews completed from the 8 December 2023 are detailed in Appendix 1a.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

A recent audit of compliance with the transitional care standard operating procedure highlighted an overall compliance rate of 100% with the current guidance.

Additional mattress warming equipment has been procured using charitable funding and the pathway relating to normothermia (maintenance of normal core temperature) will be the focus of an upcoming quality improvement initiative within this cohort.

Progress on the quality initiative project is due to be presented at the Maternity Safety Champions meeting scheduled for the 20 September 2024.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a**) Obstetric medical workforce**

The service continues to monitor compliance with the RCOG compensatory rest guidance and the RCOG workforce document relating to consultant attendance in person for defined clinical situations. Compliance for both metrics is recorded on the maternity safety champions dashboard (Table 4).

b) **Anaesthetic medical workforce**

The anaesthetic service has provided a copy of the August 2024 roster and the current operating policy to evidence that a duty anaesthetist is immediately available for the obstetric unit and has clear lines of accountability to the anaesthetic consultant at all times, in accordance with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. Assurance has been provided that an external (ACSA) re-accreditation of the anaesthetic service was undertaken in March 2022.

c) Neonatal medical workforce

An assessment of the neonatal medical staffing has been undertaken during Q1 2024/2025 which has highlighted a 2WTE gap in the 24/7 Tier 3 practitioner presence within the service.

Progress since submission of the year 5 action plan can be evidenced as resident cover has now commenced two days per week and successful recruitment has taken place during the interim period. A reallocation of the PAs following the recent appointment of an additional SAS doctor will be undertaken to release Consultant cover for the Tier 3 rota prior to collation of a business case for the remaining uplift.

Table 2 - Neonatal medical staffing – overview of compliance with British Association of Perinatal Medicine (BAPM) standards for neonatal medical staffing

NICUs	Tier 1 separate rota compliance 24/7	Tier 2 separate rota compliance 24/7	Tier 3 separate rota compliance 24/7	Tier 3 presence on the unit
Greater Manchester				
RBH	Compliant	Compliant	Compliant	Non-compliant

The action plan to attain full compliance and demonstrate progress since the CNST year 5 scheme is detailed in Appendix 2.

d) Neonatal nursing workforce

An assessment of the neonatal nursing workforce summary tool was last formally undertaken by the North West Neonatal Operational Delivery Network (NWODN) as part of an annual review in conjunction with the service in Q4 2023/2024 and is due to be repeated in November 2024.

The Q1 NWODN return completed in July 2024 confirmed the service identified a 22.07 WTE Registered Nurse deficit. Following recent recruitment this has reduced to 14.39WTE as of 20 August 2024.

BAPM optimum standards for Neonatal care recommend that 70% of the "Nursing establishment" should be Qualified in Speciality (QIS) trained. All NHSE returns require direct cot side only to be reported.

The NNU nursing establishment (inclusive of quality roles) is currently 71% Qualified In Speciality (QIS) trained and 62.14% compliant with the QIS standard for direct cot side only. The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cotside care with ongoing recruitment and progression of staff to undertake further training.

The service continues to support and identify staff to undertake the QIS training which occurs twice per year (October and February). The service has 4 staff identified to attend the QIS in October 24 which will further increase the QIS compliance within the service.

See appendix 2a for ongoing action plan that reflects progress since the CNST year 5 action plan was collated.

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

The next bi-annual maternity staffing report is due in November 2024.

In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Assurance can be provided that the business case seeking uplift to meet the 2023 Birth Rate Plus recommendations was approved at CRIG on the 7 May 2024 and Trust Finance and Investment Committee on the 26 June 2024.

The predicted vacancy position as of August 2024 is 12.83WTE Registered Midwives which includes 9WTE uplift for maternity leave and the additional 14.94WTE required to meet the 2023 Birth Rate Plus recommendations. In response offers are currently being made to midwifery professionals on the recruitment waiting list and to the January 2025 cohort of student midwives.

Monitoring of the supernumerary status of the Delivery Suite Co-ordinator continues to be undertaken in Table 4 with 100% compliance reported to date. An internal quarterly assurance audit of the acuity tool is undertaken for assurance and any reported breaches are reviewed in detail by the intrapartum Matron.

The Q1 2024/2025 quarterly audit report highlighted that 2 breaches of the standard had been reported. When reviewed neither were verified breaches as the 28 April 2024 reported breach related to an inputting error and the second breach on 5 May 2024 reflected the co-ordinator supporting a supernumerary midwife with a high-risk patient.

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

A quarterly assurance review of the bundle implementation was held on 24 June 2024 attended by the LMNS / ICB (as commissioner) and the Trust. The discussion included a review of progress to date, monitoring of progress against local plans and reviewing of themes and trends with regard to each of the six elements of the care bundle.

The service is currently on track for full implementation of all elements of the care bundle and the next formal quarterly assurance review with the LMNS is scheduled for 02 September 2024.

A showcase of the smoking cessation improvement work (element one) was presented at the LMNS Maternity Safety Conference in January 2024 and the reduction in the smoking at time of delivery since 2016 from 13.2% to 8.9% in 2024 was commended.

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

Further work is required to meet the required 90% standard for relevant staff groups with regard to multi-professional training as highlighted in Table 3. In response the service has scheduled additional training sessions to accommodate the upcoming demand and leads are utilising trajectories of performance to forecast the improvement.

Table 3: CNST professional training matrix.

Course	Target	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW/HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	90%	NA	88.89%	76.47%	76.12%	86.36%	NA	NA	NA	78.95%	76.92%
Foetal Monitoring Core Competency Stds.	90%	NA	83.33%	64.71%	NA	90.08%	NA	NA	NA	NA	NA
Neonatal Life Support	90%	100%	NA	NA	NA	79.84%	100%	100%	87.38%	NA	NA

On the 24 June 2024 the Trust was notified by NHS Resolution that a minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024).

Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised by year 7 of MIS and ongoing. A review of the current position is underway and an action plan will be shared in a future report as required.

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

The recent SCORE cultural survey was published in May 2024 following completion of the perinatal quadrumvirate cultural leadership programme. Formal feedback is due to be provided to the quadrumvirate team on the 29 August following engagement sessions with staff groups.

The board safety champions and perinatal leadership team continue to meet bi-monthly and have continued the ongoing engagement sessions with staff as per year 5 of the scheme and are next due to meet on 20 September 2024. Information gathered is collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 3).

During the past month support received from Executive Board members has helped improve digital access for community staff and implementation of digital blood pressure machines funded by the LMNS.

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Triangulation of learning Q1

The Q1 triangulation review of the Trust scorecard, incident and complaints review for Q1 is detailed in Appendix 4.

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 1 2024 – 2025. The external maternity Healthwatch report published in May 2024 reported was used to inform the triangulation of themes this quarter.

- Improve communication in service with regard to telephone access to booking and telephone triage services.
- Lack of information to inform decision making
- Delays in care relating to lack of bed capacity

Ongoing quality improvement projects are currently in progress to address the bed capacity issue and improve the current access to telephone support and triage when indicated.

Assurance audit

An internal audit to ascertain compliance with the reporting of qualifying cases for MNSI*/ NHS Resolutions Early Notification scheme has been undertaken for the period from 1st April 2024 until 30th June 2024.

The audit demonstrated that 100% of criteria was met relating to the reporting of the cases, administration of duty of candour and provision of information to the families.

As Trust Board sight of evidence of compliance with the statutory duty of candour.is required NHS Resolution have confirmed anonymised copies of the duty of candour letter are to be included in Board reports (Appendix 5).

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 4. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff / service user feedback sessions are displayed in Appendix 3.

The dashboard is 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 last bimonthly meeting was undertaken on the 11 July 2024.

Table 4 – 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	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24
CNST attainment	Information only		100%					
Critical Safety Indicators								
Births	Information only		451	408	403	432	433	405
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			2	3	1	0	4	2
Still Birth rate per thousand	3.5	≥4.3	4.4	7.4	2.5	0.0	9.2	4.9
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	1	1	1	1
HIE (2&3) rate (12 month rolling)	<2	2.5	1.6	1.5	1.6	1.7	1.7	2.0
Early Neonatal Deaths (Bolton Births only)	Information only		2	1	3	1	1	3
END rate in month	Information only		4.4	2.5	7.4	2.3	2.3	4.9
Late Neonatal deaths	Information only		0	0	0	0	0	0
Serious Untoward Incidents (New only)	0	2	1	0	0	0	0	0
MNSI referrals (Steis reportable)			0	0	0	0	2	2
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	1	0	0	1	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	97.7%	96.4%	99.%	98.7	97.9	98.6
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0
BAPM compliance ratio/nurses acuity (neonatal unit)	>99%	<79%	97.9%	97.0%	87.0%	87.0%	92.0%	94.0%
Fetal monitoring training compliance (overall)	<80%	>80%	91.95%	93.33%	95.82%	91.0%	88.00%	84.33%
PROMPT training compliance (overall)	<80%	>80%	95.76%	94.00%	95.31%	84.00%	81.00%	81.61%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:23.2	1:21.7	1:21.5	1:21.4	1:21.1	1:20.8

RCOG benchmarking compliance	Information only	100%	100%	92%	100%	100%	85.7%
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						

The dashboard highlights 85.7% compliance with the RCOG attendance at defined clinical situation standard in June 2024. In June there were 7 complex cases where the Consultant presence was required. In 6 of the cases the consultant was present and one occasion during a Caesarean birth <28/40 where the consultant was not present. The woman arrived on CDS at 07.15 hours with a pathological fetal heart trace. The consultant was informed however not on site. The decision for delivery was at 07.30 hours and the birth was at 07.50 hours. In line with recommendations, episodes where attendance has not been possible; the case was reviewed at the maternity audit meeting on 16 August 2024 and there was the overall opinion that the case was managed correctly as waiting for the Consultant to attend would have been detrimental to the safety of the neonate and thus the breach of standard was appropriate.

The service reported two cases of stillbirth in June 2024, both were above 24+0 gestation and are now subject to the perinatal mortality review process.

The LMNS Safety Assurance Panel held on the 1 August 2024 requested assurance to be provided regarding the maternity profession specific training compliance rates due to the level of compliance reported in the recent LMNS submission.

A formal response was provided to the LMNS that advised the maternity service had planned to implement all 5 training days to align with core competency v2 framework as per national recommendations. However, challenges were noted releasing medical and midwifery staff to attend all 5 days with a subsequent impact seen upon training compliance.

The panel were advised It had been noted that there was an Inequity in number of training days offered across GMEC maternity providers and a request had been made to the LMNS for alignment across all providers.

In response to the deteriorating position a local decision was taken by the Director of Midwifery to reduce the maternity training offer to 4 days with priority focus on CNST elements namely maternity emergencies, fetal monitoring and newborn life support. Local reporting continues for all elements and trajectories for improvement monitored for four key elements of training. Fortnightly oversight by the senior leads and bi-monthly oversight at Board level will continue.

4. 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 CNST Maternity Incentive Scheme (MIS). The report provides assurance of ongoing monitoring of the CNST year 6 scheme requirements.

5. Recommendations

It is recommended that the Board of Directors:

i. Receive the contents of the report.

ii. Approve the action plans within this report.

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

Appendix 1 – 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	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 **Done 30.5.24**
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	20.6.24
91589	ENND	35+3	29.1.24	0	29.3.24 done 29.1.24	29.1.24	29.7.24 **done 27.6.24**
91686	ENND	38+0	4.2.24	0	4.4.24 done 6.2.24	4.2.24 6.2.24	4.8.24 **done 4.7.24**
91814	SB	25+3	9.2.24	0	9.4.24 done 9.02.24	10.02.24	9.8.24 done 11.7.24 - pre published. **Done 25.7.24.**
91853	SB	26+3	11.02.24	1	11.04.24 done 11.02.24	11.02.24	11.08.24 done 18.07.2024
91945	Post NND > 29 DAYS OLD	30	18.1.24 17.2.24	0	17.4.24 Assigned to Blackpool	20.2.24	17.8.24 done 18.07.2024
91972	SB	40+0	19.2.24	0	19.4.24 Done 19.2.24	19.2.24	19.8.24
91991	ENND	26+1	18.2.24 20.2.24	0	20.4.24 Assigned to MFT (NMGH)	24.2.24	20.8.24

92299	SB T2	27+ DIAG/36 + BIRTH	11.03.24	0	11.05.24 done 7.6.24	10.03.24	11.09.24
92395	NND	34	7.2.24 29.2.24	15 due to not known- Community/home Death	29.4.24 done 19.3.24	05.06.24	29.8.24
92646	Late Fetal Loss	22+3	2.4.24	0	2.6.24 done 2.4.24	05.04.2024	2.10.24
92923	NND	24+	14.04.24 20.04.24	0	20.06.24 done 21.04.24	22.04.2024	22.10.24
93126	SB	38+1	01.05.24	0	01.07.24 done 3.5.24	02.05.24	01.11.24
93150	SB	29	02.05.24	0	02.07.24 done 03.05.24	20.05.24	02.11.24
93167	SB	40	05.05.2024	0	05.07.24 done 06.05.24	06.05.2024	05.11.2024
93360	ENND	22+1	16.05.2024	2	16.07.24 done 18.5.24	18.05.2024	16.11.2024
93394	SB	25	19.05.2024	1	19.07.24 done 20.05.24	21.05.2024	19.11.2024
93618	SB	24+6	03.06.2024	0	03.08.24 done 04.06.24	15.6.24	03.12.2024
93712	SB	39+2	09.06.2024	1	09.08.24 done 10.06.24	10.06.2024	09.12.2024
93915	ENND	40	16.06.2024 21.06.2024	0	21.08.24 done 24.06.24	21.06.2024	21.12.2024
94081	ENND	23+	28.06.2024 01.07.2024	0	01.09.24 done 02.07.24	01.07.2024	01.01.2025
94116	SB	31+4	02.07.2024	0	02.09.24 done 2.7.24	3.7.24	02.01.2025

94292	SB	26+2	13.07.2024	2	13.09.24	15.07.24	13.01.2025
94328	ENND	24+3	16.07.2024	1	16.08.24	18.07.24	16.01.2025

Appendix 1a – Ongoing actions highlighted in completed reviews

Perinatal Case ID	Issue comment	Action plan text	Implementation update	Person responsible	Target completion date
90970/1	There is no evidence in the notes that this mother was asked about domestic abuse at booking	CM Matron review booking process/documentation	Review of booking process in progress to support documentation	Trudy Delves	29/08/2024
90970/1	Family were not able to be cared for in a designated room/suite where someone (e.g. her partner) was able to stay overnight with her because the necessary facilities are not available	Review NNU Facilities	CDS has bereavement facilities however if in use no facilities on Neonatal Unit. Parent accommodation available off NICU	Catherine Bainbridge	29/08/2024
90970/1	No bereavement care since death of baby	Bereavement process for neonatal deaths > 28 days requires clarification.		Maternity Governance Matron	30/09/2024

Appendix 2 – Safety Action 4 – Neonatal medical workforce action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve BAPM Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	1. Re-assess compliance with BAPM standard for medical staffing published in 2021 2. Identify gaps in compliance	Operational Business Manager – Neonates	June 2025	**August 2024:** Compliance re-assessed. 2WTE GAP identified using NWODN tool. Resident presence now available 2 days per week. **October 2023** Service not compliant with standard. 1 WTE consultants recruited in September 2023 to cover existing gaps but a further 2 WTE consultants (minimum) required to ensure 12 hour consultant presence on all days of the week.	
2		3. Develop business case for 2WTE additional Consultant Neonatologists to achieve BAPM compliance	Operational Business Manager – Neonates Clinical Director	Nov 2024		

Appendix 2a – Safety Action 4 – Neonatal nursing workforce action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve neonatal nursing staffing requirements as per Clinical Reference Group workforce tool.	1. Ensure 14.39 WTE (Band 5 8.45 and Band 6 5.94 WTE inclusive) staffing deficit reported in bi-annual staffing review and escalated to the Chief Nurse.	Divisional Nurse Director Neonatal Matron	October 24	Current staffing deficit calculated using Trust staff list (vacancies and new starters) included and North West Operational Delivery network staffing tool (Last reported in July 24). On going recruitment continues.	Copy of Copy of Bolton Neonatal Wc
		2. Ensure that 70% of the Neonatal workforce are QIS trained (Qualified in Speciality) as per BAPM standards.	Neonatal Matron	March 25	The NNU nursing establishment (inclusive of quality roles) is currently 71% Qualified In Speciality (QIS) trained and 62.14% compliant with the QIS standard for direct cot side only. The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cotside care with ongoing recruitment and progression of staff to undertake further training. We have 4 staff identified to attend the QIS in October 24 which will further increase the QIS compliance. Further actions include managing retention with implementations of new systems which have been commended by NHSE and the NWNODN.	
		3. Secure funding to appoint to the vacancies	Neonatal Matron	August 24	All posts funded within current establishment and within NCCR allocation 1.8.24	
		4. Recruit to vacant Psychology position	Divisional Nurse Director OBM Neonatal Matron	March 24	08.11.23 Funding secured as part of NCCR monies May 22 to support Allied Health and Psychology presence on the Neonatal unit. 26.7.24 Successful recruitment of 2x Psychologist providing unit support at a shared 0.5WTE. 1x Psychologist now in post- commenced 26/7/24. 1x Psychologist to commence following completed checks provisional start date of 31/8/24.	

Appendix 3 – Staff and patient feedback from the safety walkarounds.

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.
May 2024 Lack of bed capacity remains an ongoing concern for staff.	Staff briefed on the submission of the RAAC business case to NHS England and the interim actions taken to reduce the ongoing pressure such as the provision of an extra doctor at weekends and a NIPE Midwife to support activity. Options appraisal in progress to consider short to medium term actions to be taken until all works completed.
Battery pack needed in baby resuscitation units to ensure heating can be provided during transfer to other areas.	Battery packs ordered.
July 2024 Additional ward equipment required	Request made for additional equipment to be provided namely: - CTG machines on G3 - Additional computer G4 - Medicine trolley for G4 - Examination of the newborn equipment.

Appendix 4

Scorecard triangulation report – Q1 2024-2025

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q1 2024-2025

Claims Scorecard April 2013 – March 2023

Top 5 injuries by volume for Obstetrics	Top 5 injuries by value for Obstetrics
Injury 1 Unnecessary Pain 2 Stillborn 3 Fatality 4 Add'tl/unnecessary Operation(s) 5 Cerebral Palsy	Injury 1 Cerebral Palsy 2 Brain Damage 3 Hypoxia 4 Wrongful Birth 5 Deafness
Top 5 causes by volume for Obstetrics	**Top 5 causes by value for Obstetrics**
Causes 1 Failure/Delay Diagnosis 2 Fail To Recog. Complication Of 3 Fail / Delay Treatment 4 Fail To Make Resp To Abnrm FHR 5 Inappropriate Treatment	Causes 1 Fail To Make Resp To Abnrm FHR 2 Fail To Interpret USS 3 Fail Antenatal Screening 4 Fail / Delay Treatment 5 Failure/Delay Diagnosis

Themes from complaints Q1

Complaints have been divided into informal and formal complaints and themes have been outlined below.

- Lack of information
- Decisions about clinical treatment
- Attitude of midwife,
- Ineffective communication
- Missing records.

Incident themes: Cause Group 1

714 incidents were reported within the maternity specialty throughout Q1 2024,25, and of those, none had a final impact of a category 3, 4 or 5 level harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Incident Cause group 1	Number of Incidents
NNU - Unexpected Admission	80
Communication Failure	63
Documentation - Missing/Inadequate/Illegible/found	37
Documentation - Wrong	30
Post Partum Haemorrhage	29

Triangulation of learning Q1

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 1 2024 – 2025. An external maternity Healthwatch reported was used to inform the triangulation of themes this quarter.

- Improve communication in service with regard to telephone access to booking and telephone triage services.
- Lack of information to inform decision making
- Delays in care relating to lack of bed capacity

Ref	Key actions	Lead Officer	Deadline	Progress Update	Status
Improve telephone communication	Review and update telephone triage access and booking access	Intrapartum and community matron	Oct-24	31.07.24 Room identified for dedictaed telephone traige - estates work ongoing.	
Delays in care relating to lack of capacity on G3/G4	QI improvement work on G3/G4	Maternity matrons	Dec-24	31.07.24 QI project commenced	

Appendix 5 – Anonymised duty of candour letter ref 245513

Telephone: 01204 390390 Ext 5611
Email: familycaregovernance@boltonft.nhs.uk
Our ref: 245513

1st May 2024

PRIVATE & CONFIDENTIAL

Dear xxxx

Thank you for speaking with me on the 29th of April 2024 on ward G4. On behalf of Bolton NHS Foundation Trust, may I once again offer my sincere apologies for the incident which occurred on the 28 April 2024 when your son was born and admitted to the Neonatal Unit for therapeutic cooling.

As discussed, we will be undertaking a review of your care and treatment that you received whilst in the care of our organisation and identify if there were any opportunities for us to have done things differently. We will also refer your case to the Maternity and Neonatal Newborn Investigations (MNSI) who will decide to investigate your care if certain criteria are met. An investigation by MNSI will only be undertaken if this is something that you agree to, you can find more information in the leaflets that you were given. Your case will also be referred to the NHS Early Notification Scheme as discussed with you when we met.

When we met you had no concerns about your care but this may change, please do not hesitate to contact me if you have any questions. I will endeavour to update you at regular intervals but please feel free to contact me directly if you need to by phone or email, 01204 487503

The Trust is committed to being open and honest when something has gone wrong and to

Appendix 5 – Anonymised duty of candour letter ref 246060

Telephone: 01204 390390 Ext 5611
Email: familycaregovernance@boltonft.nhs.uk
Our ref: 246060

14th May 2024

PRIVATE & CONFIDENTIAL

providing a full explanation and apology to you. It is important to us that we communicate our findings with you and we will contact you once the investigation is complete in order to do so.

Yours sincerely,

Clinical Governance Midwifery Matron

Dear XX,

On behalf of Bolton NHS Foundation Trust, may I once again offer my sincere apologies for the incident which occurred on the 05 of May 2024 where your daughter X was stillborn.

As discussed by XX our bereavement midwife when she saw you at home we will be undertaking a review of your care and the treatment that you received whilst a maternity patient in our organisation and identify if there were any opportunities for us to have done things differently. We referred your case to the Maternity and Neonatal Newborn Investigations (MNSI) with your consent. You have informed MNSI that you do not want them to investigate or have access to your medical records. We will not share any of your clinical records with them.

The Trust will conduct our own internal review of your care and provide you with an opportunity to receive the findings from this when it is completed.

Please do not hesitate to contact me if you have any questions, by phone or email, 01204 487503

Yours sincerely,

Clinical Governance Midwifery Matron

Report Title:	Organ Donation and Transplantation Annual Report 2023/24			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Medical Director		Decision	

Purpose of the report	The purpose of this report is to present the Organ Donation and Transplantation Annual Report for 2023/24.

Previously considered by:	The report was presented at the Clinical Governance and will be presented at Quality Assurance Committee on 25 September 2024.

Executive Summary	The Organ Donation and Transplantation Annual Report outlines and provides assurance around: • The annual data regarding organ and tissue donation across the Trust. • The role of the Organ Donation Committee. • The future plans to improve organ and tissue donation and to move forward in line with national guidance.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Organ Donation and Transplantation Annual Report 2023/24.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	Yes	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Suzanne Lomax, Clinical Service Lead Bereavement and Organ Donation	**Presented by:**	Francis Andrews, Medical Director

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

NHSBT	**National health service blood and transfusion**
CLOD	**Clinical lead organ donation**
SNOD	**Specialist nurse organ donation**

Background

Organ transplantation is one of the greatest success stories of modern day medicine; it saves and transforms lives.

Since 2008, the national implementation of the Organ Donation Taskforce recommendations. In May 2020 deemed consent legislation changed in England so that people are considered organ donors after death unless they have decided not to donate. The decisions rests with the individual. (*Max and Keira's law*)

However, despite the 60% increase in organ donors, it is still estimated that an average of three people die every day in the UK through lack of a suitable donor organ, whilst many more never even get onto the transplant waiting lists because there is no realistic prospect of them ever receiving the offer of an organ.

The launch of **The Organ Donation and Transplantation 2030, – Meeting the need in 2020** sets the following primary objectives for NHS Trust:

'Living and deceased donation will become part an expected part of care, where clinically appropriate, for all in society'.

Within the Trust the Organ Donation Committee, as it functions today, was established in 2016. The primary role of the Organ Donation Committee is:

- To ensure that National Policies, local policy, guidelines and best practice are implemented and followed consistently within the Trust**.**
- Providing the necessary on-going training, support and resources to clinical and nursing staff to achieve this.
- To advice on how to utilise the NHS Blood and transplant NHSBT Annual donor recognition funding.

We receive at present funding from NHSBT
CLOD funding 1 PA per week
Donor recognition monies =£4957.77 (22/23) awaiting 23/24

Executive sponsor – Dr Francis Andrews
Chair – Suzanne Lomax – Clinical Service Lead Bereavement
CLOD – Dr Hannah Durrant – ED consultant
Dr Carl Oakden – CCW consultant

Organ donation referrals and data – Bolton 2015

year	Referrals	Donors	Number of organs used	Number of lives saved	Missed referrals
15/16	0	0	0	0	No data
16/17	26	4	12	12	0
17/18	41	9	25	22	0
18/19	34	4	4	5	0
19/20	30	3	3	5	0
20/21	37	2	7	7	0
21/22	18	4	3	11	1
22/23	14	2	2	5	2
23/24	46	8	4	11	2

All missed referrals are reviewed and incident completed on safeguard system with learning identified For assurance, the missed referrals all were deemed not suitable for donation

23/24-Organ and Tissue Donation activity and update in detail

The trust referred 46 patient to NHSBT for consideration for organ donation 23 met the referral criteria.

A specialist nurse was present for all organ donation discussions with eligible families

From eight consented donors the Trust facilitated four actual solid organ donations resulting in 11 patients receiving a transplant.

Additionally 27 corneas received by NHSBT Eye retrieval bank (one eye retrieval can save up to 10 peoples sight)

We held organ donation awareness day on 14 May 2024 in the Trust which have been very well attended over 80 people with very positive feedback.

We include Organ and tissue donation training in our education programme for bereavement ambassadors, medical staff and are working with the university to be involved in Bereavement and Loss modules.

We now have a shared CLOD role, which gives us greater awareness across departments about organ donation

What next – future plans

- Ensure the Trust supported the organ donation committee to increase and promote organ and tissue donation
- Discuss activity at Trust Board
- Recognises any successes with facilitation of donors – Butterfly awards

- Work with Simulation team to organize a Simulation day for organ donation
- Working with IT to look at required referral for all deaths, for consideration for eye and tissue retrieval.
- Plan an awareness day for eye and tissue retrieval 2025- we have received some charitable funds specifically for organ donation to support this

FINAL THOUGHTS

NORTH WEST DATA 23/24

381 people benefited from solid organ donation transplant

However, 79 people died waiting.

Please discuss and make sure your loved ones knows your wishes regarding organ donation

Report Title:	NHS England Self-Assessment for Placement Providers 2024			
Meeting:	Board of Directors	**Action Required:**	Assurance	✓
Date:	26 September 2024		Discussion	✓
Executive Sponsor:	Medical Director		Decision	✓

Purpose of the report:	The NHS England Self-Assessment for placement providers is an annual process by which organisations carry out their own quality evaluation again a set of educational standards.

Previously considered by:	This report was discussed at People Committee in September 2024.

Executive Summary	The report requires the Trust to confirm whether standards are being met across all professions/learner groups and it is noted that the vast majority are being met. Challenges include; • increasing numbers of trainings exceeding supervisor capacity in medicine • supervisor training in psychology • Midwifery supervision in practice • Trainees are facing increasing wellbeing (especially anxiety issues) and apprenticeships are restricted due to problems with backfill funding • Some Medical trainees cannot access teaching due to service pressures and some clinical tutors are not job planned NMC exception reporting is highlighted for Midwifery student concerns and the action plan has been completed with good subsequent feedback. A Sexual Harassment Policy needs to be adopted to support learners. Service redesign and reconfiguration in the Trust requires an understanding of the impact on education. There needs to be a clear understanding of the use of funding provided via the NHS Education Funding Agreement (EFA). Areas of good practice are highlighted including RePAIR workshops in Nursing,

	International Medical Graduate support and Clinical Psychology teaching initiatives Educational leads from across professions have contributed to the report and once approved the report will be submitted to NHS England using the online portal.

Proposed Resolution	The Board of Directors are asked to **approve** the NHSE Self-Assessment Report for Placement Providers 2024.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	

Summary of Key Elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	There is no financial impact arising from the content of this report
Legal/ Regulatory	Yes	NHSE Self-Assessment Report for Placement Providers 2024
Health Inequalities	No	There is no impact on Health Inequalities arising from this report
Equality, Diversity and Inclusion	No	There are no EDI implications arising from this report.

Prepared by:	Joanne Warburton, Medical Education Lead, in conjunction with Educational Leads across professions.	**Presented by:**	Francis Andrews, Medical Director Tyrone Roberts, Chief Nurse

NHS England Self-Assessment for Placement Providers 2024

The Placement Provider Self-Assessment Tool

Introduction

The Placement Provider Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete an online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions to provide comments to support answers.

The sections of the SA

Section 1. This section asks you to provide details of (up to) three challenges within education and training that you would like to share with us.

Section 2. This section asks you to provide details of (up to) three achievements or good practice within education and training that you would like to share with us.

Section 3. This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract.

Section 4. This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract. It is important that those responsible for these areas are able to feed into this section.

Section 5. This section asks about your policies and processes in relation to equality, diversity and inclusion. This should normally be completed by your nominated placement provider EDI lead.

Section 6 - 11. These sections ask you to self-assess your compliance against the Education Quality Framework and standards.

There is an opportunity to share examples of good practice. You are asked to confirm whether you meet the standard for all professions / learner groups, or provide further details where you do not meet or partially meet the standard (s). Where you are reporting exceptions you are asked to provide the professions affected and a summary of the challenges you face in meeting the standard.

Section 12. Final sign-off.

Region and Provider Selection

Region:	North West
Provider:	Bolton NHS Foundation Trust

Training profession selection:

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Clinical Practice	x	
Allied Health Professionals	x	
Dental		x
Healthcare Science	x	
Medical Associate Professions	x	
Medicine Postgraduate	x	
Medicine Undergraduate	x	
Midwifery	x	
Nursing	x	
Paramedicine	x	
Pharmacy	x	
Psychological Professions	x	

Section 1 - Provider challenges

This section asks you to provide details of (up to) three challenges within education and training that you would like to share. Please consider whether there are any challenges, which impact your ability to meet the education quality framework standards.

Challenge 1: Supervisors/Educators

- Ongoing increases to student numbers across all areas of the Trust has put increased pressure on the current cohort of supervisors/educators.
- The foundation faculty is currently providing educational supervision for foundation trainees; however, with the increased number of doctors this system is not sustainable within the current resources.
- Some issues around supervision in practice, due to skill mix and experience. Midwifery is a particular issue. (For ACP supervision there is a new lead in place one day per week)
- Within clinical psychology, staff supervisor training is limited and we have staff who would like to be supervisors that still require basic supervisor training.

Challenge 2: Burnout/Wellbeing

- We continue to see an increase in burnout of the current workforce who are working under significant pressure. There is increased anxiety amongst learners across all areas and we have seen an increase in the number of occupational health referrals in some areas, particularly for foundation doctors.

Challenge 3: Apprenticeships

- We have an approved career framework in the Trust and a number of staff keen to apply for apprenticeships, particularly in nursing. However, the reduced number of vacancies and funds available for backfilling of posts means that this is currently not sustainable and not affordable.

Section 2 - Provider achievements and good practice

This section asks you to provide details of (up to) three achievements within education and training that you would like to share with us. Please select the category, which best describes the achievement you wish to share, along with a brief description.

Achievement 1: Innovative training/course development

A number of training developments have taken place across different areas.

- Within nursing, there are Year 2 RePAIR workshops run in collaboration with Professional nurse advocates. There are three throughout the year to support and build students confidence and resilience. They are available and accessible to all student nurses. Going forward there are plans to introduce into midwifery, from 2025, following the success of the workshops.
- For International Medical Graduates (IMGs) we have delivered a comprehensive induction programme to help them settle into the NHS, the Trust and their local training programme in conjunction with educational leads across the Trust and General Practice. We have also run a number of courses to give supervisors the skills they need to ensure the IMGs are afforded the development they need not only to thrive in their role, but also to overcome the unique challenges they face when joining the NHS.
- Within clinical psychology, trainees have the opportunity to provide training for qualified staff during placement. This gives the trainees the opportunity to teach and also the opportunity to ensure qualified staff remain up to date with current practices. A clinical psychology trainee audit has taken place assessing access and inclusion to cancer psychology services. Action based on this feedback has been possible.

Achievement 2: Recruitment/retention initiatives

- Nursing and midwifery students receive a recruitment forum in Year 3 Semester 1 with involvement from the chief nurse, divisional leads and the education teams, explaining the Trust process and offering guidance.

Achievement 3: Increased simulation for training

- The nursing and midwifery practice education team link in closely with the Trust simulation lead and have launched simulation for nursing and midwifery students in clinical practice promoting multi-disciplinary working.
- All foundation doctors have received a simulation induction on commencement in post, which provides then with essential skills and learning to support their first weeks in placement.

Section 3 - Contracting and the NHS Education Contract

This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract (2021-24). This should be completed once on behalf of the whole organisation.

Please confirm your compliance with the contractual key performance indicators of the NHS Education Contract.		
	Yes	No
There is board level engagement for education and training at this organisation.	x	
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	x	
We undertake activity in the NHS Education Funding Agreement, which is being delivered through a third party provider.		x
The provider or its sub-contractor did not have any breaches to report in relation to the requirement of the NHS Education Funding Agreement (EFA).	x	
We are compliant with all applicable requirements of the Data Protection Legislation and with requirements of Schedule 5 of the NHS Education Funding Agreement.	x	
The provider did not have any health and safety breaches that involve a learner to report in the last 12 months.	x	
The organisation facilitates a cross-system and collaborative approach, engaging the ICS for system learning.	x	
We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.	x	

If ‘no’ please provide further detail:

The funding provided via the education contract is used explicitly for its intended purpose, but there is ongoing work to provide further clarity around medical funding streams.

Section 4 - Education Quality

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the NHS Education Funding Agreement. This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section.

Can you confirm as a provider that you...			
	Yes	No	N/A
We are aware of the requirements and process for an education quality intervention, including who is required to attend.	x		
We are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.	x		
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	x		
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners.	x		
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners.	x		
Are aware of the Safe Learning Environment Charter (SLEC).	x		
Are actively implementing and embedding the SLEC multi-professionally.	x		

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

- The freedom to speak up guardian details are given to all learners at induction and are promoted via noticeboards and newsletters.
- The guardian of safe working actively promotes the process of raising concerns and exception reporting. The GOSW attends People Committee on a quarterly basis and exception-reporting information is sent to divisions on a monthly basis.

As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc.)
Note: we are not seeking information about the referral of an individual learner.

We have not been referred to a regulator.	
We have been referred to a regulator and the details are shared below.	x

If you have received conditions from a regulator, please provide more details including the regulator, the profession involved and a brief description

NMC exception report instigated in partnership with host Higher Education Institutions due to student feedback and concerns around quality of supervision and significant staffing issues, leading to reduction to intrapartum areas. NMC feedback has been positive and the Trust has kept them updated with progress. There has been a continued reduction in student capacity this year whilst intrapartum areas closed and there was a lack of practice assessors, but the action plan has been signed off as complete and capacity reviews with the Head of Midwifery (HoM) are ongoing.

Did you actively promote the National Education and Training survey (NETS) to all healthcare learners?

Yes

Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of the National Education and Training Survey (NETS)

Yes

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

The results are reviewed amongst teams and covered at regional and in house meetings. For medical staff the results are reviewed in conjunction with the GMC survey results, for which we get a much greater response rate, and monitored through Medical Education Board.

2024s NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

• We will continue to send out the link to NETS to all learners and promote via email and social media platforms and through word of mouth. Educators visible in clinical areas will also encourage completion. • The Trust is engaged in the Learner Appreciation week, commencing 14th October, so will use events during this time to further promote and encourage completion. • In 2023, 283 learners completed the survey, which is an increase from 200 in 2022.

Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Tyrone Roberts – Chief Nurse tyrone.roberts@boltonft.nhs.uk
Name and email address of your non-executive director representative for Patient Safety	Fiona Taylor fiona.taylor@boltonft.nhs.uk
Name and email address of your Patient Safety Specialist/s	Helen Lodmore helen.lodmore@boltonft.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	399 overall total completed

Section 5 - Equality, Diversity and Inclusion

This section asks about your policies, processes in relation to equality, diversity and inclusion, and should normally be completed by your nominated EDI lead.

Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

Yes

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alongside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

- The Equality, Diversity and Inclusion Team consists of four officers including a Head of EDI, EDI Lead, EDI Officer and Link Worker. They are based in the Organisational Development Team under the workforce directorate and work very closely with the education and training team.

- Strong governance and assurance processes are in place. The EDI Steering Group leads on EDI work at the Trust. It is made up of inclusion practitioners, senior leaders including education and training representatives from the directorates, staff-side colleagues, staff equality networks and allies amongst others. The group ensures compliance with our legal duties and the various regulatory obligations. There is a clear focus on continually improving organisational culture, learning and development, employment experiences of our diverse staff and the quality of care to our patients. The EDI Steering Group reports into the People Committee and is accountable to the Trust Board.

Contacts:
Rahila Ahmed, Equality, Diversity & Inclusion Lead Rahila.Ahmed@boltonft.nhs.uk
Toria King, Equality, Diversity & Inclusion Manager Toria.King@boltonft.nhs.uk

Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...		
	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	x	
Implement reasonable adjustments for disabled learners?	x	
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	x	
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	x	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?		x
Do you have initiatives to support reporting of sexual harassment?		x

Has your organisation signed up to the NHS England Sexual Safety in Healthcare – Organisational Charter?	x	
Does your organisation have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	x	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

- The Trust has an Equality Impact Assessment procedure that is applicable to learners.
- Learners have access to a reasonable adjustment passport and 'soft landing' placements to help them reach their potential. Adjustments are made for disabled learners, including adapting training to support learners with additional needs relating to disability or educational need, to access and complete both face to face and e learning.
- While we do not have a policy specifically in place at the moment to manage sexual harassment in the workplace, we do have policies that cover this, including disciplinary and resolution.
- We take concerns regarding sexual harassment and assault extremely seriously and we actively encourage staff to raise any concerns they have via the Trust's Resolution Policy and Raising Concerns policy. It has recently been reviewed and strengthened to include definitions of inappropriate behaviour. Learners are able to raise their concerns through their supervisors, the education teams, HR, Trade Union representatives, staff diversity networks and Freedom to Speak Up Guardians and Champions.
- The Trust's designated sexual safety lead is the Director of People.
- The Trust has signed up to the sexual safety charter and has an active working group that is working through the principles and will include specific initiatives to support the reporting of sexual harassment in the workplace.

How does your organisation manage sexual harassment reports?

Allegations of sexual harassment would be managed through the Trusts disciplinary policy.

For education and training, what are the main successes for EDI in your organisation?

- EDI mandatory e-learning training programme every three years for all staff. One to one support and face-to-face training is offered to staff as part of the reasonable adjustment process to access.
- Active bystander training to encourage staff to challenge bullying, harassment or discrimination. This is now embedded in the standard leadership and management modules.
- Inclusive leadership training.
- Civility and respect training rolled out.

- Unconscious Bias training for recruiting managers.
- Cultural competency training rolled out initially aimed at managers of International Educated Nurses.
- Series of lunch and learn sessions on various topics including disabilities.
- Annual review of the Workforce Race Equality Standard and Workforce Disability Equality Standard findings and actions in place to ensure our diverse staff are treated fairly in relation to access to training and career progression.
- BAME Leadership Programme.

For education and training, what are the main challenges for EDI in your organisation?

There is a proposal currently being considered to address existing concerns and ensure all staff who have management responsibilities have specific EDI related refresher training. We will embed themes such as active bystander, macroaggressions, bias, civility and respect and cultural competency training.

Section 6 - Assurance Reporting: learning environment and culture

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer. This section should be completed once on behalf of the whole organisation; however, it is important that those responsible for these areas are able to feed into this section.

Quality Framework Domain 1 - Learning environment and culture
Please select only one option for each row.

	We meet the standard for all professions /learner groups	We have exceptions to report and provided narrative below
The learning environment is one in which education and training is valued and championed.	x	
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	x	
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	x	
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	x	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	x	
The environment is one that ensures the safety of all staff, including learners on placement.	x	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	x	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	x	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	x	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	x	
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.	x	
The learning environment promotes multi-professional learning opportunities.	x	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	x	

Section 7 - Assurance Reporting: educational governance and commitment to quality

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer.

This section should be completed once on behalf of the whole organisation; however, it is important that those responsible for these areas are able to feed into this section.

Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training.

- We hold monthly Professional Education Forums where the learner voice is promoted and heard for us to understand what it is like to be a learner at Bolton NHS FT. This allows us to learn and put in measures to improve experience and highlight and share good practice.
- We now have foundation representatives at the Foundation Leads monthly meeting to share information on progress with the foundation teaching programme, curriculum and provide feedback from the NW regional foundation forum.

Quality Framework Domain 2 – Educational governance and commitment to quality Please select only one option for each row.		
	We meet the standard for all professions/learner groups	We have exceptions to report and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.	x	
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	x	

The governance arrangements promote fairness in education and training and challenge discrimination.	x	
Education and training issues are fed into, considered and represented at the most senior level of decision-making.	x	
The provider can demonstrate how educational resources (including financial) are allocated and used.	x	
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	x	
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	x	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).		x

Areas of exception
Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Trust wide

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

There can be lack of engagement with educational leads regarding reconfiguration, which can impact learner placements and activity.

Section 8 - Assurance Reporting: developing and supporting learners

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Quality Framework Domain 3 – Developing and supporting learners Please select only one option for each row.		
	We meet the standard for all professions/learner groups	We have exceptions to report and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	x	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	x	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	x	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	x	
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	x	
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	x	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	x	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	x	

Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	x	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	x	
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	x	

Section 9 - Assurance reporting: developing and supporting supervisors

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Quality Framework Domain 4 – Developing and supporting supervisors **Please select only one option for each row.**		
	We meet the standard for all professions/ learner groups	We have exceptions to report and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.		x
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).	x	
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	x	
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	x	
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	x	
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	x	

Supervisors can easily access resources to support their physical and mental health and wellbeing.	x	

Areas of exception
Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Medicine – Postgraduate/Undergraduate

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Some education roles are not included in job plans mainly relating to clinical tutor roles within undergraduate medical education.

Thinking about the Educator Workforce Strategy, please confirm that your organisation

	Yes	No
Is aware of the Educator Workforce Strategy.	x	
Ensures educators/supervisors undertake a skills gap/learning development needs analysis for this role.	x	
Ensures educators/supervisors have formal development to undertake this role.	x	
Considers the educator workforce in wider clinical workforce planning	x	

Implementation of the Educator Workforce Strategy:

We have **fully implemented** the recommendations of the educator Workforce Strategy.	
We have **partially implemented** the recommendations of the Educator Workforce Strategy.	x
We have **not yet started** implementation of the recommendations of the Educator Workforce Strategy.	

Section 10 - Assurance reporting: delivering programmes and curricula

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Quality Framework Domain 5 – Delivering programmes and curricula **Please select only one option for each row.**		
	We meet the standard for all professions/learner groups	We have exceptions to report and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	x	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	x	
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	x	
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	x	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	x	
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.		x

Areas of exception
Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Medicine postgraduate

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Due to work pressures in clinical areas, doctors in training are not always released to attend teaching sessions. It also remains difficult in some areas to take self-development time where it is not rostered into the working week. All doctors are encouraged to exception report missed educational opportunities.

Section 11 - Assurance reporting: developing a sustainable workforce

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Quality Framework Domain 6 – Developing a sustainable workforce **Please select only one option for each row.**		
	We meet the standard for all professions/learner groups	We have exceptions to report and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	x	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues.	x	
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	x	
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	x	

Section 12 - Final Submission

Board level sign-off (Premises, Learning Environment, Facilities and Equipment)

☐ I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health & Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

Board level sign-off

I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

Please confirm the date that board level sign off was received:

DD/MM/YYYY

Final Submission (please only tick this box when you ready to submit your self-assessment)

☐ I confirm that all sections of this self-assessment have been completed and that this is the final version for submission.

Report Title:	People Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Director of People		Decision	

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

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

Executive Summary	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 17 September 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.

Proposed Resolution	The Board of Directors are asked to ***receive*** the People Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	An optimal workforce is key to the delivery of our financial plan.
Legal/ Regulatory	Yes	Adherence to employment legislation is a key responsibility for our organisation.
Health Inequalities	Yes	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to equal patient care.
Equality, Diversity and Inclusion	Yes	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

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	**Reports to:**	Board of Directors
Date of Meeting:	17 September 2024	**Date of next meeting:**	19 November 2024
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- WRES/WDES Reports
- Anti-Racist Framework
- Appraisal & Revalidation Submission
- NHS National Staff Survey – Staff Engagement Plan Update
- Staff Health & Wellbeing Update
- Compulsory and Trust Mandated Training Update
- Guardian of Safe Working Annual Report
- Professional Referrals Summary
- NW SAR Submission
- Steering Group Chair Reports
- Divisional People Committee Chair Reports
- Resourcing & Retention Update
- Freedom to Speak Up Self Reflection Tool

ALERT

Agenda items	Action Required
Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES) – The Committee received the Annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The Trust has achieved an improved position since 2023 for a number of indicators (5 out of 9 for WRES and 8 out of 11 for WDES.) which is a positive above average result. There are however several indicators where we scored worse than the national average, which are outlined in the paper. The Committee recognised the progress but all agreed further work is required for this key work programme. The reports will be published on the external website by 31 October for contractual and transparency purposes. The Committee requested a number of actions particularly in relation to the recruitment processes to discuss further at the meeting of the Board of Directors and the next meeting of the People Committee. The actions are noted within the wider Board papers.	

ADVISE

- **Anti-Racist statement** - The People Committee commended to the Board this public statement of intent / antiracism statement from Bolton NHS Foundation Trust. The details are noted within the wider Board papers.
- **Health & Wellbeing report** - Overall our sickness absence position remains good when benchmarked against other Health Service organisations in Greater Manchester. A plethora of work programmes have been put in place to support our fantastic staff to be healthy and remain in work. Despite the work in place this paper acknowledges that more can always be done to support our staff given the workload pressures facing our organisation and the NHS more broadly (some of which is being picked up via the Our Voice Work programme).
- **NHS National Staff Survey** - The Trust's NHS Staff Survey dates are agreed as 1 October to 29 November 2024. The report sets out the communications & engagement activity that will take place to update our workforce and key stakeholders and provide the staff with the knowledge to promote and engage with the survey. It was noted that a range of actions are being taken to drive up the response rate further and to hear from as many of our staff

as possible. It was noted that the recent quarterly pulse check had the highest response rate for a number of years and we received more positive scores when compared to the last quarter and for the same period next year.

- **Compulsory and Trust Mandated Training** - The report provided an update with regards to the changes in reporting and recording of Compulsory and Trust Mandated Training, including an overview of the present compliance set against the standards of 95% for Compulsory Training (currently 91.48%) and 85% for Trust Mandated Training. (currently 93.48%). Whilst this is showing improving trajectories it was noted that the Committee would like to see both reach a compliance level of 95%. Actions to achieve this were discussed at the meeting.

Resourcing Update

- **Staffing summary**: In August 2024, we were over our planned position by 23 Whole Time Equivalents (WTE). This increase was driven in the main by substantive recruitment in the medical and dental staffing group (we saw 29.7 WTE substantive medics join the Trust in-month). In the Year To Date (YTD) 2024/2025 we are cumulatively under over submitted Workforce Plan by 27 WWTE.
- **Agency summary:** Agency spend reduced by £10k in July 2024. A static spend trend was noted in most staff groups – pleasingly nursing and midwifery spend remains at relatively low levels (certainly much lower than the average seen in 2023/24). The reduced spend trend noted above continued into August 2024 where spending reduced by £103k in-month. This was driven by reductions in medical agency (reduction of £55k), and nursing and midwifery (reduction of £48k). Other staffing groups remained static. The Trust continues to be under the NHS Executive target of agency being no more than 3.2% of total pay bill (Aug 2024 performance was at 2.1%, and YTD is running at 2.3%). We are currently under our internal agency spend plan (at the end of M5 24/25) by £630k (total actual spend of £3.44m against a planned spend of £4.07m).
- **Bank summary:** Spend increased overall by £84k in July 2024. The bulk of the in-month increase was driven by admin bank (£102k increase, mostly in relation to centralised admin support services, but also in maternity, and emergency medicine) and AHP bank (increase of £27k mainly in relation to Podiatry, and Radiology services). In more positive news, bank spend reduced sharply in August 2024, by £142k in-month. Reductions in expenditure were noted in the Admin, HCA, and AHP, staffing groups. Over the last two months the Nursing and Midwifery staffing group is showing reduced bank spending back to the levels seen in the later stages of 2023/24.
- **Vacancy Rate 2024/25:** Vacancy rates in July 2024 remain under the Trust target (6%) at 5.94%.
- **Turnover 2024/25:** August 2024 performance was at 11.46% at overall Trust level, which is a slight decrease from July 2024 (11.7%). Performance in the year 2024/25 to date has mirrored our forecasting which suggested that we would see a fairly static trend following a two year period of peaks and troughs.The Committee discussed the actions that are being taken to support these metrics along with a discussion on difficult to recruit areas (mainly specific medical posts which drive our agency spend).
- **Professional Referrals Summary** - The Trust has made a combined total of 7 referrals to professional bodies over the previous 12 months. There is no evidence to suggest that a particular staff group are more likely to be referred to a professional body, however the Trust continues to ensure that all referrals are given full consideration and referenced to the Trust's Equality, Diversity and Inclusion (EDI) agenda and the nature of the concern. It was requested that future papers include details of timings and whether suspension are in place.

ASSURE

Freedom To Speak Up (FTSU) Self Reflection Tool - The FTSU Non-Executive Director and FTSU Executive lead take responsibility for completion of the self-reflection tool on a two yearly basis. The purpose of the tool is to ensure that FTSU is embedded throughout the organisation and ensuring that our staff have the opportunities to speak up when required. A review by Internal Audit and The Annual FTSU Report concluded that FTSU is well recognised within the organisation and works well. There are actions that have been taken forward e.g. Independent FTSU Guardian from outside of the organisation and further work is being undertaken to ensure all staff in our organisation are aware of the FTSU arrangements. The Committee requested that the paper makes clear the positive position the Trust takes in reference to FTSU Guardian time and FTSU Champions of which there are now over 80.

2023-2024 Annual Appraisal & Revalidation Submission to NHS England North West (Professional Standards for Doctors) - The Committee received the Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement. The submission sets out the information and metrics that a designated body (in this case, the Trust) is expected to report upwards, to assure compliance with the NHS and General Medical Council (GMC) regulations and commitment to continual quality improvement in the delivery of professional standards for doctors. The Committee noted that the appropriate policies are in place. The Committee noted that there is a shortage of appraisers and heard of the actions being taken to address this matter. It was noted that whilst complaints are automatically uploaded to doctor's appraisal portfolios, a mechanism will be devised to ensure involvement in 'never events' and serious incidents is similarly captured.

Guardian of Safe Working (Junior Doctors/Doctors in Training) - Doctors in training are required to submit exception reports when they work over their contracted hours, when they are unable to achieve rest breaks or missed educational opportunities. Within the reporting period (1 April 2023 – 31 March 2024) there were 193 exception reports submitted. This has decreased from the previous year when 299 exception reports were submitted (Payment for additional hours was the largest reason for exception reports) All safety concerns raised have been resolved. The Guardian of Safe Working noted that the level of trainee satisfaction is generally more positive than it has been in previous years.

NHS England Self-Assessment for Placement Providers 2024 - The Committee received and approved the submission for placement providers, which is an annual process by which organisations carry out their own quality evaluation against a set of educational standards for clinical trainees. Challenges include increasing numbers of trainees exceeding supervisor capacity in medicine, supervisor training in psychology and midwifery supervision in practice. Trainees are facing increasing wellbeing challenges (especially anxiety issues) and apprenticeships are restricted due to problems with backfill funding. Some medical trainees cannot access teaching due to service pressures and some clinical tutors are not job planned.

New Risks identified at the meeting: None

Review of the Risk Register: *None*

Report Title:	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2024 Reports			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Director of People		Decision	✓

Purpose of the report	The purpose of this paper is to present the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Previously considered by:	This paper was presented at the EDI Steering Group prior to presentation at People Committee. The People Committee discussed this paper in detail and agreed a series of actions to bring back to the next meeting as detailed within this Board report.

Executive Summary	The WDES and WRES reports are designed to measure the experiences of disabled staff and staff from Black, Asian and Minority Ethnic (BAME) backgrounds. The metrics and data are designed to be used to develop and publish action plans designed to improve experiences of staff ultimately aiming to create a more inclusive background. The Trust is required to publish the WRES and WDES on the external website by 31 October for contractual and transparency purposes. The Board is asked to approve the reports noting that respective action plans will be monitored through the People Committee. The Trust has achieved an improved position since 2023 for a number of indicators (5 out of 9 for WRES and 8 out of 11 for WDES.) which is a positive above average result. However, there are several indicators where the Trust scored worse than the national average. These are outlined in the paper.

Proposed Resolution	The Board of Directors are asked to ***receive*** and **approve** the WRES and WDES Report. details of this report and that the People Committee will oversee all relevant actions on behalf of the Board

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**Yes**	WRES/WDES is a statutory return required for all NHS organisations.
Health Inequalities	**Yes**	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to strong patient care
Equality, Diversity and Inclusion	**Yes**	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	Rahila Ahmed, EDI Lead Toria King, Head of EDI	**Presented by:**	James Mawrey, Director of People and Deputy CEO

1. Introduction

1.1. The People Committee received the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) at their last meeting. A full and detailed discussion took place and this Committee of the Board requested a series of actions to bring back to the next meeting (detailed within the report).

1.2. Board members will be aware that fostering a culture of inclusion remains a critical priority for Bolton Foundation Trust and is a key ingredient of the Trust Strategy and People plan.

2. High level summary of findings for Board members

2.1 Board members can see the full findings of the WRES and WDES contained within the attachment to this report. As noted this paper has been discussed in detail at the People Committee and this Committee of the Board has requested a series of actions to bring back to the next meeting (detailed within the next section is a non exhusative overview of those actions).

2.2 The Trust has achieved an improved position since 2023 for a number of indicators (5 out of 9 for WRES and 8 out of 11 for WDES.) which is a positive above average result. There are however several indicators where we scored worse than the national average, which are outlined in the paper.

3. People Committee discussions and actions

3.1 Whilst the Committee of the Board were pleased to read of the progress that has been made in key areas, it was noted that they remain uncomfortable with many of the findings and further worked is required to ensure our Trust is a truly inclusive organisation. In particular areas of focus required being:-

- Further work is required to ensure out workforce is representative of the population we serve. As we know the Bolton citizens are a beautifully diverse community with 28% of the population being from a BAME heritage, compared to 20.6% of our workforce – which whilst it has increased year on year it is not at the same level of our community changes. Further detailed work was requested by staffing groups to understand whether there is deeper focus required in certain areas. The Head of Resourcing has been tasked with working with our communities and organisational leaders to improve access to our work opportunities within our organisation and reviewing our recruitment processes.
- There is evidence of a 'glass ceiling' in our organisation. Specifically within the WRES. Whilst work is clearly underway in this area (Leadership programmes) there is further work that can be done (leadership and recruitment actions) to

ensure our workforce is representative throughout the Agenda for Change and Medical paybands.

- There is evidence that discrimination can occur in our organisation and this must not be tolerated, with a zero tolerance approach. Members will note that within the Board Papers there is a recommendation to adopt an Anti-Racist Statement (in line with the Anti-Racist framework). A similar approach will be taken for all protected characteristics. Whilst a statement in itself won't of course route out racism it does set a clear tone from the top of the organisation that there is a zero tolerance approach.
- There is clearly underreporting in our organisation (as with all NHS organisations) of colleagues who have a disability. Further work is required to understand the reasons for this. Specifically whether this is a reporting matter on our ESR system, further clarity is required on the definitions of disability or whether our staff don't feel able to declare their disability. The Deputy Director of People has been asked to provide a full review of our reporting systems and enhancements that can be made to our HR policies.
- There is clearly a plethora of actions taking place on this very important programme of work. The People Committee have requested that the action plan that will come to the Committee in November identify the high priority actions, which will have the greatest impact. A more focused approach was considered by the Committee to be helpful. The Head of EDI will oversee this action and will make recommendations at the next Committee.
- It would be helpful to understand this data for our IFM colleagues and where possible adopting a group approach. The Deputy Director of People, Head of EDI and the Director of People at IFM have been asked to work together on developing a group approach.
- The EDI group (Chaired by the Director of People) and Inclusion networks (all have Chairs and Deputies with a time allowance) have developed in the recent years to play a pivotal role in our inclusion journey. It is recognised that enhancing both the EDI group and the networks will provide further penetrating work. As such the Head of EDI will bring back to the Committee a series of recommendations. These are likely to include recognised time allowance for key Inclusion network work programme work and a refreshed EDI Group with enhanced representation from our senior leaders within the organisation (noting that Network Chair will of course continue to be represented at this group).

4. Recommendation to the Board of Directors

4.1 The Board of Directors is asked to receive the details of this paper and that the People Committee will continue to oversee all relevant actions.

WRES and WDES Annual Report

Presented to the People Committee on 17th September, 2024

1. Introduction

1.1. Fostering a culture of inclusion remains a critical priority for Bolton Foundation Trust. An inclusive work environment provides a place where everyone feels welcome and can be the best version of themselves. This in turn enables our staff to thrive and deliver the best possible care for the people of Bolton.

1.2. Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. This necessitates targeting any nationally known workplace inequalities that could prevent the Trust being a great place to work for everyone.

1.3. Nationally, it is well known that colleagues from a BAME background and those who have a disability/long term health condition have a poorer experience of working within the NHS. The COVID-19 pandemic has further highlighted the prevalence of health inequalities and how they manifest to the detriment of diverse communities.

1.4. The importance of inclusion is embedded into the NHS People Plan and the Trust's Strategy 2019-2024. In addition, the Trust has articulated its' vision and priorities for improving EDI practice and health outcomes within its EDI Plan 2022-2026.

1.5. Each year the Trust is required to publish the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Trust level Medical Workforce Race Equality Standard (MWRES) and Bank Workforce Race Equality Standard (BWRES) were mandated last year but not required by the NHS national Team in 2024.

1.6. Each of these provide a framework for NHS organisations to report, demonstrate and monitor progress against a number of indicators of workforce equality. They measure to what extent employees from a BAME backgrounds and those that have a disability, receive fair treatment in the workplace and have equal access to career opportunities at all levels. They also expose discrimination levels, and are therefore a platform from which to produce an improvement action plan.

- **Workforce Race Equality Standard (WRES)** – First introduced in 2016 in the NHS standard contract, it focuses on meeting requirements around ethnicity and hinges on nine race equality indicators. They relate to a combination of workforce data and results from the NHS national staff survey. A local action plan to take corrective action is required to be published by 31 October 2024.
- **Workforce Disability Equality Standard (WDES)** - A requirement of the CCG contract and NHS contract since 2018. The WDES is a set of ten specific metrics that will enable organisations to compare the employment

experiences of disabled and non-disabled staff. By 31 October 2024, an action plan to demonstrate progress must also be published externally.

1.7. The new NHS EDI Improvement plan sets targets for organisations that will help to improve WRES and WDES performance on the above frameworks. Their action plans have been incorporated within the wider EDI action plan, which is out of the scope of this report.

2. WRES: Performance and Key Findings 2024

2.1. The following section provides an update on Bolton NHS Foundation Trust's WRES results for 2024. Where relevant, comparators have been given against known national averages gathered via the NHS national staff survey 2023 and the latest NHS England national WRES report.

2.2. The following improvements have been noted since the previous year:

a) Workforce representation: Of the 6188 employees, 1277 are of BAME heritage. There has been a 2.7% increase of BAME staff employed at the Trust in the last year, now at 20.6%. However, further effort is required to match the local Bolton resident population demographic at 28%

b) Senior positions – 13% increased representation of BAME staff within Band 8a plus position. However, the vast majority clustered in remain clustered in Band 5 positions (A higher 33% in 2024 compared to 24% in the previous year).

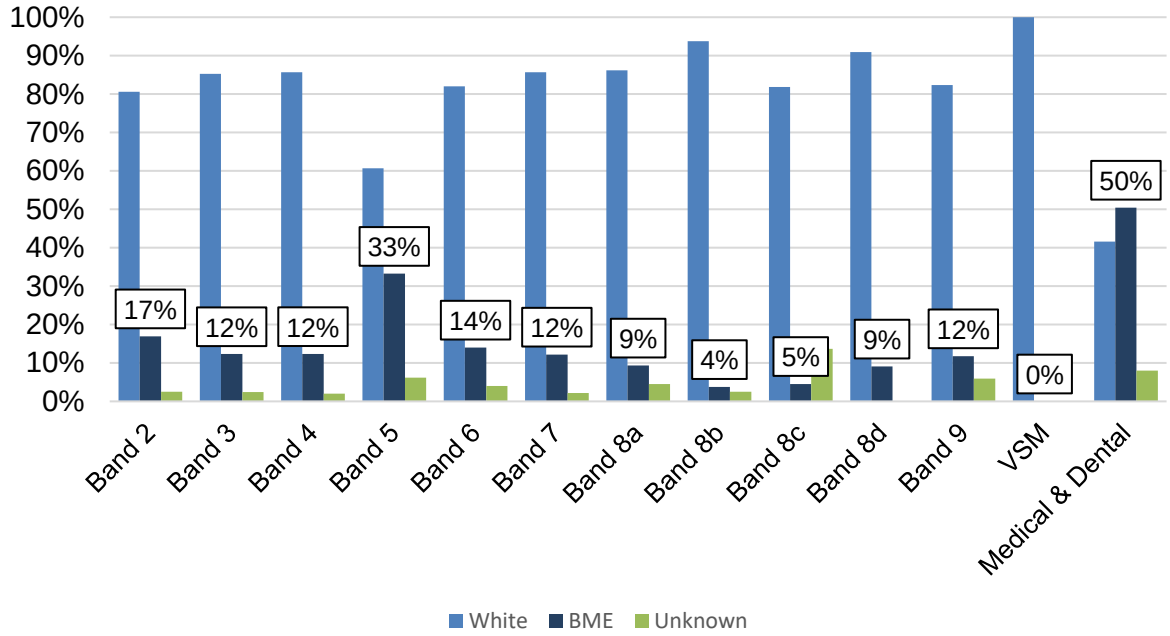


Fig 1: Distribution of BAME and white staff across AfC pay bands at Bolton FT.

c) **Disciplinaries** – A reversal from the year where the relative likelihood of BAME staff entering the formal disciplinary process has reduced by 0.43 points (0.78 score), which is lower than the national average at 1.03. BAME staff are now less likely to enter the formal disciplinary process than white staff.

d) **Training access** - Another trend reversal is noted from the previous year where BAME staff are now slightly more likely to access non-mandatory or statutory training than white staff, which supports career progression (an improvement of 0.3 points). The Trust's score at 0.99 is better than the national average at 1.12 where White staff are more likely to take advantage of learning opportunities..

e) **BHA from colleagues** - 1.14% reduction in reports of bullying, harassment and abuse from managers and colleagues in the past year and 1.5% over the past 5 years. The Trust's results at 23.56% remain 2.64% lower than the national average at 26.2%. However, 5% more BAME staff report experiencing bullying, harassment and abuse from colleagues and managers (23% vs 18% White staff).

f) **Board representation** - The percentage of BAME board members has increased by 4.4% (17.7%) which is 2.1% better than the national average at 15.6%.This figure has more than doubled in the last 5 years.

g) **Freedom to Speak up** During 2023/24, 43 concerns (21.3%) were raised by workers from a Black, Asian or Minority Ethnic background (BAME) which is a 3.6% increase from the previous year. Currently 12 of the 75 FTSU champions (16%) are from a BAME background and more are looking to join. The FTSU Guardians regularly attend the BAME Staff Network, work closely with the EDI Team and attend the EDI/ People Development Steering Group.

2.3. The following deteriorations have been noted in the WRES performance since the last reporting year:

a) **Appointed from shortlisting** - This year saw a negative trend reversal where White staff were 1.61 times more likely to be appointed from shortlisting (from 0.51). This is in line with the national average (1.59) but will still be a priority focus for the Trust to investigate any reasons why it has deteriorated since 2023 and agree an improvement plan.

b) **Equal opportunities (career progression)** - 40% of BAME staff believe the Trust provides equal opportunities for career progression or promotion, which has declined by 8% over the past year and is 10% lower than the national average. .

c) **Discrimination from Managers** – There has been a 1.1% increase in the past year of BAME staff reporting they have personally experienced discrimination at work from manager/team leader or other colleague (18.8%) and is 13.9% higher than reported from White staff. The Trust's score is 2.6% higher than the national average (16.2%)..

d) **BH&A patients** - 2.5% increase in BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last year. However, the Trust's figure (25.7%) is 2% lower than the national average at 27.7%.

3. WRES: Action Taken 2023-24

3.1. From 2023 to 2024 the following actions have been taken with the aim of helping to improve the Trust's EDI practices in relation to race and ethnicity to create an inclusive work culture:

- Maintaining an active Black Asian Minority Ethnic Staff Network with attendance from Executive Sponsors. The Network have been pivotal in providing a safe space for BAME staff and their allies to discuss key issues affecting them, to highlight and support leads with improvements. Examples include advising on inclusive recruitment practices, signing up to the anti-racism framework, education and learning for members and participation in events such as Black History Month, International Women's Day amongst other activities to ensure diversity is represented and valued.
- The Trust has officially signed up to the North West BAME Assembly's Anti-Racism Framework. The framework outlines the actions to tackle historical racial inequality in the workplace, services and organisational cultures. It is a systematic plan to review status, assess inequalities, celebrate success and encourage continuous improvement. A plan is place with a view to achieve the Bronze level by April 2025.
- Twelve aspirant Black, Asian and other Minority Ethnic leaders successfully attended the North West Positive Action Leadership Programme. This bespoke development programme aimed to address the barriers in the talent pipeline and build confidence, capacity and the ability to influence positive change. A further localised support package was put in place where attendees were offered places on the Trust's leadership and management modules to allow a thorough understanding of the Trust's operational perspective.
- Reciprocal mentoring was rolled out for BAME colleagues with participation from senior managers and Executives. The initiative involves the two-way sharing of knowledge, expertise, skills, values and experiences between senior experienced employees and those more junior. This enables people in senior positions to learn from and understand issues from the perspective of BAME colleagues.
- Continued to embed inclusion considerations into existing management and leadership development programmes and delivering bespoke training. EDI training for hiring managers has been rolled out to raise awareness of factors that affect ethnic communities and to disrupt biases of colleagues and recruiting managers and others are planned.
- Active bystander training continued to be rolled out by a number of trainers across the Trust. Its objective is to encourage colleagues to make a positive intervention to challenge inappropriate behaviour or language aimed at people with protected characteristics and to support the individual.
- Continued to embed our Freedom to Speak Up Approach and actively recruited a number of FTSU champions from a diverse background. The Team are active in supporting colleagues and providing an open and inclusive service promoting speaking up on issues such as bullying, harassment, abuse, victimisation aimed at protected characteristics, through investigations and

signposting to a wide range of health and wellbeing offers in place. The Guardians also spent time working with the new Internationally Educated Nurse (IEN) recruits and the Clinical Education Teams to ensure that all our IEN recruits are aware of FTSU and the support available to speak up.

- The Trust has been awarded the International Recruitment kite mark for its practice, which include extensive induction and pastoral support for internationally recruited staff. Cultural competency training was delivered to managers to ensure they are able to provide tailored support and equal opportunities. Our International recruits are offered a strong package of support including pre –arrival support and on-boarding programme.
- The Trust's Inclusive Recruitment Framework action plan continues to be reviewed and implemented to improve the Trust Race Disparity Ratio to ensure inclusion is at its heart. Action plans have been developed with a focus on ensuring policies and procedures are updated to support diverse talent to progress, job advert improvements, support to colleagues and applicants, to mention a few.
- The Trust's HR team have continued to review disciplinary and employee relations processes. This is to ensure all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Disciplinary cases are monitored quarterly via the People Committee. There is ongoing work and an active review of all cases by the Head of HR to fact find and spot any racism, and where trends are identified, they are discussed with the EDI Team
- An anti –bullying and harassment communications video campaign is in action, to deter bullying, harassment, and abuse by patients. A series of video screen slides showcasing diverse staff were created and displayed in the waiting areas
- Active use of new Equality Impact Assessment template to review OD and HR policies and processes to identify and differential impact for BAME staff and patients.
- Marked various inclusion events including Ramadan awareness, Diwali celebrations, Black History Months and South Asian Heritage Month, to increase awareness of cultures and needs and promote inclusive working and caring environments.
- Developed an annual EDI and wellbeing events calendar to increase awareness and to better support staff in advance with requests for changes in working patters or leave during key festivals.

4. WRES: Further In-Year Actions

4.1. Whilst some positive improvements have been made, we are fully committed to take further action to improve our WRES performance.

4.2. The actions are linked with the mandatory frameworks that exist such as the NHSE EDI Improvement Plan. Some of the actions are listed below:

- Implement NHS Northwest Anti-Racism campaign action plan. The vision is to be at the forefront of challenging any racism and tackling inequalities affecting the Trust's BAME workforce and communities.
- Continue to undertake OD interventions at an individual, team, and organisational level. High-risk areas are identified and appropriate interventions are in place to create more inclusive working environments
- Review and deliver the Inclusive Recruitment Framework actions including interview preparation checklists, ensuring diverse interview panels are in place, further inclusive recruitment training (starting October 2024), review standard interview questions (EDI/Values) and review the current process and content of sample EDI interview questions. The BAME staff recruitment targets will also be reset as the Trust aspiration is to be reflective of the population we serve, increasing from 20.6% to achieve 28.1%.
- Exploring diverse recruitment panels as business as usual for some roles/bands.
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes . Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.
- Embed EDI into the annual and check in FABB conversation toolkit, appraisals and performance reviews.
- Stronger focus on producing good quality Equality Impact Assessments and ensuring the Board holds services to account & allocate resources relating to equality and HIEs, and raise issues relating to equality and health inequalities on a regular basis.

5. WDES: Performance and Key Findings 2023

5.1. The following section provides an update on Bolton NHS Foundation Trust's WDES results for 2024. Where relevant, comparators have been given against known national averages gathered via the NHS National Staff Survey 2023.

5.2. It is recognised that the data is poor across the whole of the NHS and much work is required to improve declaration rates to ensure true visibility of issues related to our disabled workforce. This remains a priority for our Trust.

5.3. The following improvements have been made since the last reporting year and compared to the last four years where applicable:

a) **Workforce representation** –1% increase in disability self-declaration now at 4.9% (306 staff) in line with the national average, whilst 76.4% of colleagues report not having a disability. However the NHS National Staff survey 2024 shows a higher 24.1% (596 respondents out of 2471) declared they "had a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more", which is a more inclusive and relevant questions to many colleagues. This is almost the same rate as the national average at 24.3%.

b) **Declaration rates -** Over the last year there has been a 3.1% reduction in the 'unknown' category now at 18.6% (or 1 in 4 staff), which has improved by 7.9% over the past 5 years. Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who disclose a disability on ESR, compared to those sharing this information when completing the anonymous NHS Staff Survey. However the Trust's 'unknown' category is still 2% higher than the national average at 16.6% and as such will remain a priority for the Trust

c) **Seniority** - The highest proportion of Disabled staff are represented at Band 9 (18%) and band 8d positions (9%). However, limitations with data prevent a meaningful analysis to take place.

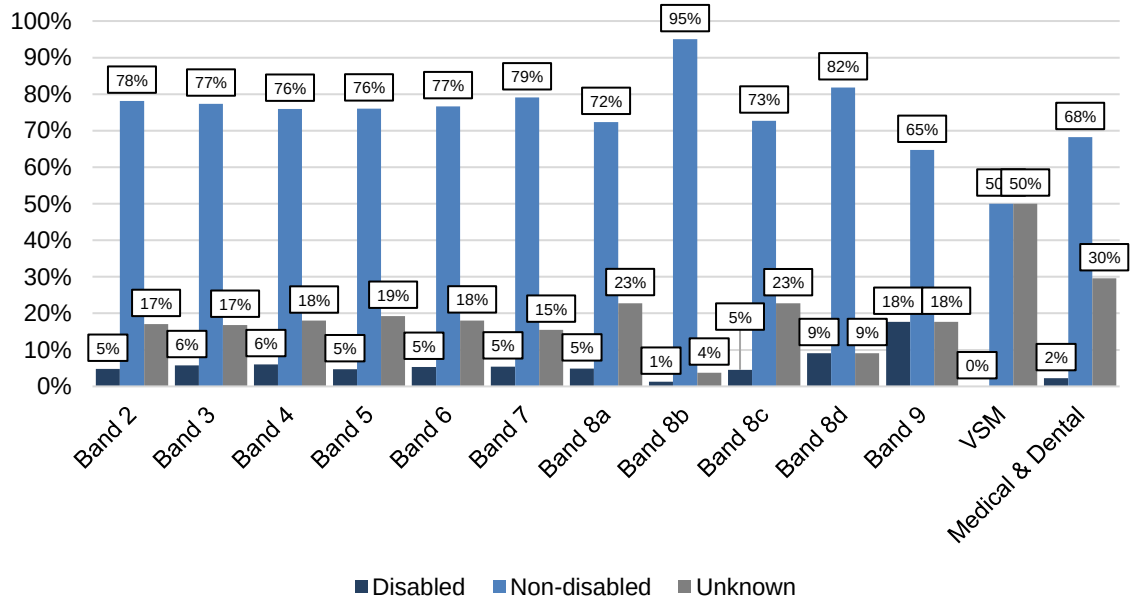


Fig 2: Distribution of disabled and non-disabled staff across AfC pay bands at Bolton FT.

d) **Capability** - The numbers of staff entering the capability process for both disabled and non-disabled staff have been proportionally so low that the relative likelihood is 0. Nationally however the relative likelihood is 2.17.

e) **Bullying, Harassment and Abuse (BH&A) from patients** - 1.8% reduction in bullying and harassment of disabled staff from patients/service users/relatives (27.4%) which is 6% higher than their non-disabled counterparts and 3% lower than the national average

f) **BH&A from colleagues** - 1.7% reduction over the past year, and a considerable 9.9% over the past 5 years of staff with a disability reporting bullying, harassment and abuse from colleagues. The Trust's score is also 4.9%% lower than the national average (25.9%) Rates however remain higher than non-disabled staff (21.0% disabled compared to 13.8 non-disabled).

g) **Reporting incidents** - The proportion of disabled staff stating that they felt confident to report bullying, harassment and abuse increased by 0.3% over the

past year (51.4%) and are 1% more likely to report than non-disabled colleagues. . This is 2.1% higher than the national average at 49.3%. Over the past five years there has been a significant 25.2% decline noted in reporting confidence levels by disabled staff and a higher 35.7% from non-disabled staff.

h) **Engagement** - There has been a marginal increase of 0.05 in engagement scores for staff with a disability in the past year. The Trust's score is same at the national average at 6.5. Over the past 5 years there has been a slight 0.37 decline for both staff with and without a disability.

i) **Appointments** - 0.1 point reduction in the relative likelihood of non- disabled staff being appointed from shortlisting, although they are more likely to be appointed that their disabled counterparts. The Trust's score at 1.04 is worse than the national average which is at 0.99 in 2023 which requires improvement.

j) **Reasonable adjustments** - One in four (27%) disabled staff do not believe that they are not getting the necessary equipment and support needed for them to perform their role as effectively as possible. The rates have marginally improved by 0.7% over the past year. However the Trust's score is 0.6% lower than the national average.

5.4. The following deteriorations have been noted in the WDES performance since the last reporting year and require improvements along with the above last three points.

a) **Career progression** –. Staff with a disability are 7.4% less likely to agree the Trust provides equal opportunities (47.9%) based on last year's figures. The Trust's score is 4.2% lower than the national average at 52.1%.

b) **BH&A from Managers -** Staff with a disability report higher rates of bullying and abuse from managers (14.1% disabled compared to 6.8% of non-disabled) and this figure has increased over the last year by 0.7%. Overall, the figure has declined by 5% over the past. Nevertheless, the Trust's score is 1.8% is better than the national average (at 15.9%)

c) **Feeling valued -** 0.7% decline over the last year is noted from staff with a disability not feeling their work is valued (36.8% compared to a higher 45.2% satisfaction rates from white staff resulting in a 8.4% difference). However, on a positive note the Trust's score is 1.2% higher than the national average.

6. WDES: Action Taken 2022-23

6.1. From 2023 to 2024 the following actions have been taken with the aim of helping to improve the Trust's EDI practices in relation to disability, Health conditions and differences to create an inclusive work culture

a) Maintained an active and purposeful Disability and Health Conditions Staff Network with regular attendance from the Executive Sponsor.. The Network have been pivotal in providing a safe space and making improvements for colleagues. The Freedom to Speak up Guardian also attends each network meeting and offers support where required.

Monthly drop-ins are also held with the staff network Chair and Director of People where individuals can raise concerns and seek support to reach a

successful resolution and provide guidance. Examples of the networks successes include strengthening the reasonable adjustments process, co designing the passport and guidance on self-declaration, story telling shwartz round event, phased returns, education, learning, and participation in various events to ensure diversity is represented and valued.

b) The new Neurodiversity Peer Support Group was established during Disability History Month 2023 with attendance from over 30 colleagues. Monthly meetings are held where neurodivergent colleagues and family members can share advice and support others who understand their situation. They provide a forum to share lived experiences, seek advice and guidance from peers, guide managers, learn tips and tricks and create connections.

c) Various other initiatives took place during Disability History Month. This included a story-telling event to help build empathy and strengthen identity of our diverse colleagues, a lunch, learn session on hearing impairments, and shared e-learning with staff on visual impairments. Access to work also held an event at the Trust to promote their service and encourage timely support for staff to secure any aids and adaptations.

d) The Reasonable adjustment passport was launched. This document provides a conversation prompt and live record of adjustments agreed with the manager and action plan. It continues to be embedded within organisational structures and processes and promoted widely.

e) Improving self-declaration disability rates to allow a thorough analysis, was also key priority and remains so. The Electronic staff Record fields to disclose data have been updated which were previously restricted and not user friendly to allow disability recording, following feedback from thenetwork. They also advised on new guidance on the importance of recording on ESR. This alsong with a dedicated page have been published on BOB. A wide selection of categories are also now available for staff to choose from. Also as part of the there process mapping exercise, we identified key touch points where staff would be encouraged to update their ESR status. A new process was also set up with the Human resources Team to ensure new starters are encouraged to declare.

f) The Trust's Resolution Policy has been updated to support raising of concerns and strengthening the zero tolerance approach to bullying/harassment.

g) Staff sickness data continues to be analysed to identify themes and develop organisational wide solutions.

h) In addition, the active bystander training now includes a focus on disability issues and was rolled out to encourage colleagues to intervene appropriately and speak up if they observe negative behaviours. This has been embedded in the leadership and management module. Alongside this civility and respect, training was successfully delivered to various teams.

i) A wide selection of psychological support is available to victims of bullying, harassment, discrimination or violence. To support this a fact sheet was produced to raise awareness of the extensive support available for staff with a disability and health conditions.

j) The Trust Health and Wellbeing offer has continued to expand including trained Mental First Aiders, Counselling services, Trauma & Risk Management (TRiM) assessors, Physiotherapy service, Occupational Health amongst others.

k) The Trust retained its Disability Confident Employer level 2 certification that includes a guaranteed interview scheme, promotion of staff networks and support within recruitment pack to increase appeal, flexible working offer and provision of reasonable adjustments during the interview process and on a one to one basis

l) Unconscious Bias training for hiring managers was also rolled out with more sessions planned to increase the employment opportunities of applicants with a disability.

m) The Flexible Working policy was also updated and is one of the key people promise workstreams. Myth busting and educational initiatives are being developed through the change programme group in liaison with the staff network.

n) National and promotional courses and training opportunities are promoted intended to have a positive benefit for staff opportunities are promoted

o) Raised the profile of disability equality and inclusivity through our annual calendar of diversity and inclusion campaigns and engagement activities such as Disability History Month, Deaf Awareness Week, Visual Impairments, Neuridoversity etc.

7. WDES: Further In-Year Actions

7.1. Whilst some positive improvements have been made, it is clear that there is much more work to do in our approach to supporting our workforce who identify as having a disability or long term conditions. There are a number of actions which we are committing to which will ensure our disabled workforce receive the best experience of working for the Trust. These actions are particularly targeted around the indicators that we have identified should be priorities.

7.2. The actions are linked with the mandatory frameworks that exist such as the NHSE EDI Improvement Plan, Equality Delivery System 2022 etc. Some of the actions are listed below:

- Continue to Improve self-declaration rates in ESR e.g. Disability categories (Count Me in Campaign), Set up process with HR to ensure new starters are encouraged to declare. Include a clearer definition of disability.
- Continue to strengthen the reasonable adjustment process to ensure timely support and access to aids and adaptations. This includes implementation of the flexible working change programme actions to increase uptake as part of the reasonable adjustment process.
- Embed EDI and wellbeing conversations into the annual and check in FABB conversation toolkit, appraisals and performance reviews.
- Work with the Disability and Long Term Health Conditions Network, The Neurodiversity Support Group and Recruitment Team to ensure our recruitment processes are as disability and neurodivergent-friendly as possible.

- Work with the relevant staff networks to understand the core cause of presenteeism and what we can do to discourage it.
- Enhance the EDI training offer, ensuring EDI is embedded in existing training packages aimed at different staff groups and develop bespoke packages. We will embed themes such as compassionate leadership, active bystander, micro aggressions, bias, civility and respect and cultural competency training.
- Prioritise and use national campaigns to drive engagement and raise understanding and awareness across the organisation.
- Develop resources to support colleagues experiencing bullying harassment intimidation and build an allyship module to encourage challenge. Alongside this we will develop a joint approach and process with Human Resources, Freedom to Speak Up Guardian, Unions and Staff Network Chairs, to analyse staff concerns and implement effective interventions
- Review HR policies and practices with the Disability and Health Conditions Network including the Informal Capability Process, Resolution Policy, Attendance Management Policy and disability leave uptake
- Seek to understand barriers to progression into leadership positions in response to the survey findings. Discuss and agree actions with the staff network that would improve opportunities available for Disabled staff to advance their careers.
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes.
- Develop a communication campaign focused on the benefits of employing Disabled people, aligning to the NHS People Plan
- Expand the selection of support services to ensure when at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health condition
- Increase patient equality monitoring declaration rates including a staff education programme on the importance of asking patients to provide their diversity information to meet full compliancy of the Accessible Information Standard. .

8. Next Steps

8.1. The Trust's WRES and WDES overall summary performance reports and action plans will be submitted and published on 31st October 2024 following consultation with the relevant inclusion staff networks. The full action plans will be shared with the People Committee in November, and will be monitored via the EDI Steering Group regularly.

9. Recommendations

- The Committee are asked to: note and consider the contents of this report and agree the list of key actions.

Appendix 1: WRES 2024 dashboard

	WRES indicator		2017	2018	2019	2020	2021	2022	2023	2024	Difference between 2023 & 2024
1	Percentage of BME staff	**Overall**	11.00%	11.60%	12.40%	12.90%	14.10%	15.00%	17.97%	20.60%	2.63% ↑
		VSM	0.00%	4.80%	6.30%	8.30%	0.00%	0.00%	0.00%	0.00%	0% ↔
2	Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants		1.37	1.4	1.53	1.3	0.62	0.84	0.51	1.61	1.1 ↑
3	Relative likelihood of BME staff entering the formal disciplinary process		2.34	1.87	1.59	1.64	0.93	1	1.21	0.78	-0.43 ↑
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		0.97	0.95	0.91	0.9	0.99	0.99	1.02	0.99	-0.03 ↓
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BME**	26.70%	20.00%	32.00%	28.80%	23.90%	27.70%	23.20%	25.70%	2.5% ↓
		White	26.80%	27.10%	31.00%	21.90%	25.70%	26.50%	25.90%	22.70%	-3.2% ↑
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BME**	26.80%	20.00%	29.00%	25.00%	27.00%	26.70%	24.70%	23.56%	-1.14% ↑
		White	23.90%	27.10%	16.00%	23.60%	19.80%	20.50%	20.10%	18.12%	-1.98% ↑
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	**BME**	87.90%	79.20%	75.00%	67.50%	74.80%	47.40%	48.00%	40.00%	-8% ↓
		White	92.70%	90.00%	90.00%	86.50%	90.10%	62.30%	61.10%	56.40%	-4.7% ↓
8	Percentage of staff personally experienced discrimination at work from manager/team leader or other colleague	**BME**	14.00%	20.00%	18.00%	21.20%	15.30%	16.30%	17.70%	18.90%	1.2% ↓
		White	6.10%	4.53%	5.00%	5.30%	5.30%	4.60%	5.20%	5.00%	-0.2% ↑

9	BME board membership	0.00%	7.70%	6.70%	6.70%	8.30%	15.40%	13.33%	17.65%	4.32% ↑

Appendix 2: WDES 2023 Dashboard

WDES metric			2019	2020	2021	2022	2023	2024	Difference between 2023 & 2024
1	Workforce representation of Disabled staff (AfC)	Overall	2.8%	2.6%	2.9%	3.3%	3.9%	4.9%	1% ↑
		8c and above	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0% ↔
2	Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff		1.41	1.57	1.57	1.04	1.05	1.04	-0.01 ↑
3	Relative likelihood of Disabled staff entering the performance management capability process compared to non-disabled staff		0	0	0	0	0	0	0 ↔
4(i)	Percentage of staff experiencing harassment, bullying or abuse in the last 12 months by patients/service users, their relative or other member of the public	Disabled	34.0%	26.1%	30.8%	33.7%	29.2%	27.4%	-1.77% ↑
		Non-disabled	24.0%	21.9%	24.2%	24.2%	24.5%	21.4%	-3.09% ↑
4(ii)	Percentage of staff experiencing harassment, bullying or abuse from managers	Disabled	10.0%	19.1%	15.7%	12.5%	13.4%	14.1%	0.71% ↓
		Non-disabled	11.0%	9.9%	9.4%	9.7%	9.0%	6.8%	-2.16% ↑
4(iii)	Percentage of staff experiencing harassment, bullying or abuse from other colleagues	Disabled	20.0%	29.9%	23.3%	20.4%	22.6%	21.0%	-1.64% ↑
		Non-disabled	16.0%	14.6%	14.3%	15.2%	14.4%	13.8%	-0.56% ↑
4(iv)	Percentage of staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled	68.0%	42.1%	54.0%	49.0%	51.1%	51.4%	0.34% ↑
		Non-disabled	50.0%	41.3%	49.8%	46.0%	47.4%	50.4%	2.99% ↑

WDES metric			2019	2020	2021	2022	2023	2024	Difference between 2023 & 2024
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	**Disabled**	85.0%	76.6%	80.9%	55.0%	57.6%	47.9%	-9.67% ↓
		Non-disabled	89.0%	86.1%	89.6%	62.1%	59.3%	55.3%	-3.97% ↓
6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled**	27.0%	31.7%	28.2%	25.0%	27.6%	27.0%	-0.63% ↑
		Non-disabled	19.0%	14.7%	21.4%	18.0%	17.1%	17.3%	0.21% ↓
7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work	**Disabled**	47.0%	43.2%	37.7%	40.7%	37.5%	36.8%	-0.68% ↓
		Non-disabled	57.0%	55.4%	51.4%	47.5%	47.0%	45.2%	-1.84% ↓
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	74.0%	69.4%	77.0%	73.8%	72.1%	72.9%	0.8% ↑
9	Staff engagement score (a composite based on several questions in the NHS Staff Survey)	**Disabled**	6.80	7.10	6.70	6.80	6.50	6.55	0.05↑
		Non-disabled	7.40	7.40	7.30	7.20	7.10	7.03	-0.07 ↓
10	Representation of disabled Board Members	**Disabled**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0 ↔
		Non-disabled	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0 ↔

Report Title:	Anti-Racist Framework: Statement of Intent			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Director of People and Deputy CEO		Decision	✓

Purpose of the report	The People Committee commend to the Board this public statement for the organisation.

Previously considered by:	People Committee

Executive Summary	The North West BAME Assembly Antiracism Framework is a strategic initiative designed to eradicate systemic racism within public services across the North West of England, by embedding antiracism principles into organisational policies, practices, and cultures. It focuses on accountability, transparency, and measurable actions to address racial disparities and promote equity. The involvement of the Board of Directors is crucial because they hold the authority to drive systemic change, allocate resources, and ensure that antiracism efforts are prioritised and sustained at all levels of the organisation. Their leadership is essential in setting the tone for the entire organisation and ensuring that antiracism initiatives are not only implemented but also embedded into the core values and operations. We have committed to apply for Bronze in April 2025. One of the first steps to Bronze in the NW BAME Assembly's Anti Racism Framework is for the Board to write and publish a statement of intent on antiracism. The statement aims to align the Trust VOICE values with our new Trust Strategy and has been inspired by statements from other Trusts in our locality. The actions requested at People Committee have been completed and an updated statement of intent is presented to the Board of Directors. The requested changes include a stronger focus on being an anti-racist organisation, creating a shared commitment for all staff and pateints, simplifying the statement to make it more impactful and finally streamlining the actions the Trust will take to deliver on the anti-racist statement.

	Should the statement be approved by the Board of Directors, a communications plan will be enacted which has been developed by the Associate Director of Communications and Engagement to ensure maximum impact.

Proposed Resolution	The Board of Directors is asked to ***approve*** this public statement of intent in advance of wider publication and communication.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**Yes**	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to strong patient care
Equality, Diversity and Inclusion	**Yes**	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	Toria King, Head of EDI Rachel Carter, Associate Director of Communications and Engagement	**Presented by:**	James Mawrey, Director of People/Deputy

Bolton NHS Foundation Trust Anti-Racism Statement of Intent

We know that racial inequalities exist in Bolton and have a profound impact on the experiences and outcomes of our staff, patients and the communities we serve.

Not being racist is simply not enough and our commitment is more than just words. **We are an actively anti-racist organisation** which means we do not tolerate any form of racism, and actively root out and address racial unfairness of any form.

For our words to become a reality for everyone, we have defined the action we will take.

Together we will:

- Embrace our responsibility to call out, address and eradicate racism so that everyone is able to reach their full potential.
- Have specific antiracist objectives that will be monitored through our FABB appraisal process.
- Ensure that our workforce feels a profound sense of belonging and is reflective of the diverse communities we serve. This includes equal opportunities for career development and advancement, free from discrimination and bias.
- Continue to tackle health inequalities and eliminate racial disparities, so that no one is disadvantaged because of their ethnicity or background. All patients will receive high quality care, feel respected and understood through every step of their care.
- Collaborate closely with our Black, Asian, and Minority Ethnic (BAME) Staff Network and other community partners to develop and implement our Anti-Racist Action Plan. This plan will be aligned with the NHS Patient Carers Race Equality Framework and our Workforce Race Equality Standard (WRES).
- Address instances of bullying and harassment and actively create a culture of transparency and dialogue about racism within our organisation.
- Review and revise our policies, procedures and training programs to address and eliminate racial bias. This includes ensuring that our recruitment, retention, and promotion practices are equitable and inclusive.
- Actively engage with local and regional initiatives to address racial inequalities and support efforts to influence broader societal change. We will advocate for and contribute to community-led initiatives that aim to reduce racial disparities and improve outcomes for all.

Every member of our Bolton team has a responsibility to address racism, and we know this will be a journey of continuous learning, unlearning and transformation.

To keep us on track and hold ourselves to account, we will measure and report transparently on our progress towards creating a consistently inclusive environment, including the areas that need further work.

With best wishes,

Board of Directors
Bolton NHS Foundation Trust

Report Title:	2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	✓
Executive Sponsor	Medical Director		Decision	

Purpose of the report	To assure the Board of Director that governance systems for Appraisal and Revalidation and Professional tandards for Non-Training Grade Medical Staff are in place and are fit for purpose.

Previously considered by:	The report was discussed at the People Committee in September 2024.

Executive Summary	The 2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement sets out the information and metrics that a designated body (in this case, the Trust) is expected to report upwards, to assure compliance with the NHS and GMC regulations and commitment to continual quality improvement in the delivery of professional standards for doctors. Please note that the formatting and sizing of this template is fixed, resulting in differing font sizes. • Sufficient funding and resource is in place but increasing numbers of bank and junior clinical fellows means that a business case will be needed to support Appraisal and Revalidation (A&R) Team expansion. • The Medical Appraisal and Revalidation 2024 policy has been completed. • A recent Appraisal & Revalidation peer review has been undertaken and requires an action plan now report has been received. • There is an increasing shortfall of appraisers with a plan to externally recruit. • Whilst complaints are automatically uploaded to doctor's appraisal portfolios, a mechanism will be devised to ensure involvement in 'never events' and serious incidents is similarly captured.

	• Transfer of information about incoming and departing doctors using the MPIT process is not assured and the process will be checked and audited. • A process for responding to national reports that impact upon medical professional standards needs to be provided to People Committee. • Duration of concerns whilst being addressed will be monitored. • A separate report to People Committee regarding concerns about medical staff and assurance of parity will be added to the People Committee work plan.

Proposed Resolution	The Board of Directors are asked to approve the 2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓		✓	✓

Summary of Key Elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory	Yes	Annual submission to assure compliance with the NHS and GMC regulations.
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Joanne Warburton, Medical Education Manager Francis Andrews, Medical Director	**Presented by:**	Francis Andrews, Medical Director

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bolton NHS Foundation Trust
What type of services does your organisation provide?	Acute district hospital providing NHS health care services

	Name	**Contact Information**
Responsible Officer	Dr Francis Andrews	francis.andrews@boltonft.nhs.uk
Medical Director	Dr Francis Andrews	francis.andrews@boltonft.nhs.uk
Medical Appraisal Lead	Dr Wyn Price	wyn.price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Joanne Warburton	joanne.warburton@boltonft.nhs.uk
Additional Useful Contacts	Rabeya Rashid	rabeya.rashid@boltonft.nhs.uk
	Lynne Hardy	lynne.hardy@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No	No

If yes, who is this with?

Organisation:

Please describe arrangements for Responsible Officer to report to the Board:

Date of last RO report to the Board:

Action for next year:

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

Bolton NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None
Comments:	The Medical Director was appointed as RO in August 2018.
Action for next year:	No action required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	The Responsible Officer is supported by the Clinical Lead for Appraisal and revalidation (A&R), a part time A&R Officer (18 hours per week) and an A&R Administrator (30 hours per week). Funds are in place to support licences for the online appraisal and revalidation system (Premier IT).
Action for next year:	Business case for funding to increase administrative support for A&R

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	no action
Comments:	The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. New Starter reports from ESR, Induction registers and GMC connect notifications inform of new starters to the Trust.
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Medical Appraisal Policy due for review
Comments:	agreed and finalised at JLNC and uploaded to the intranet
Action for next year:	None - policy next due for review in May 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	We are in the process of organising a peer review with a neighbouring Trust for Autumn 2023. Terms of Reference for the review have been circulated between Trusts and final details are being confirmed.
Comments:	Peer Review took place with neighbouring Trust in March and May 2024.
Action for next year:	review feedback report received following the recent peer review

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	New starter entry form introduced for all new starters, including short term doctors, to ensure they are aware of appraisal requirements and to provide support with the process. Doctors are encouraged to attend the online training provided by Premier IT which gives them a step by step demonstration of the system and the opportunity to ask questions.
Comments:	All information relevant to appraisal is supplied within a welcome email and offer of face to face meeting should they need.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Yes
Comments:	the Trust uses the Premier IT appraisal system. The appraisal portfolio is compliant with the latest national reuqirements and is based on the GMC framework for good medical practice
Action for next year:	None

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	None
Comments:	Special circumstances and postponements agreed where a doctor has not been able to achieve timely annual appraisal i.e. longterm sickness, maternity etc. There is an escalation process for doctorss who do not qualify for sepcial circumstances and who do not engage, involving the Responsible Officer and the GMC.
Action for next year:	Continue ongoing process

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	appraisal policy update due and is underway
Comments:	Ratified in May 2024
Action for next year:	none - next due for update in May 2027

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	recruitment of more appraisers
Comments:	There is a current shortfall in the number of appraisers. Recruitment by invitation has not been successful in increasing numbers significantly.
Action for next year:	Looking at alternative means for appraisals to remove the backlog. We are engaging with the NHS Emeritus consultant scheme to sourcemore appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	None
Comments:	Appraisers attend initial training through external providers funded by study leave budget. An appraiser network meeting is held every 6 months to support quality and consistency of appraiser performance and updates. Appraiser feedback is collected and fed to appraisers.
Action for next year:	Continue to monitor attendance and training requirements for appraisers and arrange refresher training as necessary.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To continue reporting in to People's Committee
Comments:	Monthly meetings with MD/RO to discuss issues and concerns and where revalidation recommendations are signed off by the RO. An A&R action plan and appraisal figures monitored via the People Development Steering Group, which feeds into the Trust People.
Action for next year:	to continue as above

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	A plan is put in place to minimise the number of deferral recommendations made and to help the doctor to achieve the necessary requirements for a positive recommendation. Every doctor is kept fully abreast with recommendations especially where it is likely that a deferral or non-engagement recommendation will be made.
Action for next year:	implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	A plan is put in place to minimise the number of deferral recommendations made and to help the doctor to achieve the necessary requirements for a positive recommendation. Every doctor is kept fully abreast with recommendations especially where it is likely that a deferral or non-engagement recommendation will be made.
Action for next year:	implement email notifications to encourage patient and colleague feedback to take place in year 2 of a revalidation cycle to ensure completion and inclusion in a completed appraisal cycle and avoid revalidation deferral recommendations.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	A&R Team to include reports for Serious Incidents and Never Events in to doctors portfolios. Complaints reports are already uploaded.
Comments:	MD/RO heavily involved in clinical governance eg quality Committee member, PSIIRF. All direcorates have an active clinical governance lead
Action for next year:	To establish reports for SUI's and never events for uploading to doctors portfolios-delayed due to maternity and sickness leave in team

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	To continue existing processes
Comments:	Information from appraisals, complaints, incident reports, outside agencies and direct reports to the medical direcotr team are monitored and actioned
Action for next year:	Re-establishment of complaints team providing quarterly list of docotrs involved in complaintsincluding locums

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Continue existing processes.
Comments:	HED data is available upon request for Consultants which is downloaded as a pdf report. Complaints reports are uploaded for all doctors, including reports with a nil return. Patient and Colleague feedback is completed via the electronic appraisal system, Premier IT which is uploaded directly to a doctors portfolio.
Action for next year:	To establish reports for SUI's and never events for uploading to doctors portfolios

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None
Comments:	There is a well-established process including capability, conduct and remediation policy and disciplinary policy. GMC fair decision process followed. Bank of trained investigators.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None
Comments:	All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document Principles of a good investigation.
Action for next year:	A report does need to come to people committee to analyse these cases. An report will be provided in November 2024, and in future after the end ot the financial year.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	To continue existing processes
Comments:	MPIT forms are used to transfer information between RO and RO when a doctor leaves/commences employment. The RO is responsible for informing other organisations where a concern had been identified.
Action for next year:	To review this process to ensure it is being adhered to.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	To continue existing processes
Comments:	The capability and conduct for medical staff policy includes the NHS England Just Culture Guide which encourages managers to treat staff in a consistent, constructive and fair way. A second independent opinion is sought for cases going to formal investigation. RO/investigators EDI mandatory trained.
Action for next year:	To continue existing processes

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	none
Comments:	This process is undertaken by the MD, but there is a need to provide a response to the people committee after review of relevant national reports for assurance.
Action for next year:	To provide assurance to people committee following relevant national reports and reviews

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	None
Comments:	GMC good medical practice 2024 has been reviewed by the MD/RO and is now summarised at induction for key points, and has been distributed to all doctors.
Action for next year:	Incorporate these standards into the medical leadership programme. There have been 3 successful medical leadership cohorts which align to the Messenger recommendations

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	To continue existing processes
Comments:	TRAC electronic system for completion of all pre-employment checks in line with NHS Employment Check Standards for all substantive staff, bank medical staff and foundation doctors before employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements.
Action for next year:	To continue existing processes

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	none
Comments:	There is comprehensive clinical governance including clinical audit committee and quality assurance committee and sub groups to monitor excellence in clinical care
Action for next year:	none

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	none
Comments:	Trust our voice programme to support compassion, fairness, respect diversity and inclusivity
Action for next year:	MD/RO actively supports programme

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	none
Comments:	Voices programme, extensive FTSUG and champions embedded and monitored at peole committee. Trust developing quality improvement function to support learning
Action for next year:	none

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	none
Comments:	These mechanisms are embedded in our policies around capability, conduct and remediation and the disciplinary policy and consultation os sought when these policies are reviewed
Action for next year:	none

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	none
Comments:	Only a small number of formal and disciplinary cases are undertaken each year but the characteristics do need reporting annually .
Action for next year:	A report does need to come to people committee to analyse these cases. An report will be provided in November 2024, and in future after the end ot the financial year an dneeds to be on the people committee workplan.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	none
Comments:	RO attends and contributes to all network meetings. There is no higher level RO quality review process. A peer review programme has just been completed with WWL NHS TRust.
Action for next year:	Action plan folowing peer review (delayed by sickness)

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 31 March 2024

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	331

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	301
Total number of appraisals approved missed	17
Total number of unapproved missed	13

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	73
Total number of late recommendations	9
Total number of positive recommendations	52
Total number of deferrals made	21
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	21

2D – Governance

Total number of trained case investigators	17
Total number of trained case managers	5
Total number of new concerns registered	8

Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March	not monitored

Median duration of concerns processes closed	not monitored
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	0
Number of new employment checks completed before commencement of employment	113

2F – Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
A peer review with WWL NHS FT has been undertaken. All doctors are now on the electronic appraisal system. The medical appraisal and revalidation 2024 policy has been completed
Actions still outstanding
There are still actions to complete on including never events and serious incidents into appraisal portfolios and also a business case for increased appraisal administraton support.
Current issues
There is a current shortfall in the number of appraisers. Recruitment by invitation has not been successful in increasing numbers significantly.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Business case for increased administrative support; Review peer review feedback report; External recruitment to tackle appraiser shortage; serious incidents/never events uploading to portfolios Transfer of information about incoming and departing doctors assurance; Responding to national reports impact medical professional standards process; Duration of concerns monitoring; action on concerns about medical staff and assurance of parity
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We have a robust and mature appraisal and revalidation system in Bolton, with u to date policies and processes. The results of the peer review will be analysed and developed into an action plan. Some areas of the governance process require further assurance which is detailed in theis submission

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	Bolton NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

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

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Finance and Investment Committee held in July.

Executive Summary	The Chair's report attached provides an overview of matters discussed at the meeting held on 24 July 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. There was no meeting held in August though the Monthly Finance Report was circulated to members. Due to the timing of the September meeting, a verbal update will be provided to the Board with a written report presented to the subsequent Board meeting.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Finance and Investment Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

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

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

Name of Committee /Group:	Finance and Investment Committee	**Reports to:**	Board of Directors
Date of Meeting:	24 July 2024	**Date of next meeting:**	25 September 2024
Chair	Jackie Njoroge	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Terms of Reference
- Cost Improvement Programme Update
- Month 3 Finance Report
- GM/National System Update
- High Value Supplier Payment Register

ALERT

Agenda items	Action Required
• The Trust forecast outturn is currently off track by approximately £4.9m. • Cash support of £5m will most likely be required in Q3.	

ADVISE

Cost Improvement Programme Update

- The Head of PMO highlighted the key points from the update:
- £23.8 million CIP identified in year, an increase of 2.2m.
- £25.8 million recurrent identified, an increase of 0.9 million.
- Risk rated CIP has increased in month to £18.4 million, an increase of £1.5m.
- Following a successful triumvirate sprint held on the 3rd of July, monthly CIP events are being held to help address blockers and ensure progress against larger schemes and identify new schemes.

Month 3 Finance Report

- The Operational Director of Finance reported on the Month 3 position. The Trust had a deficit of £4.5m compared with a plan of £5m with the most likely forecast outturn being £4.9m worse than plan. £5m CIP has been delivered compared to a plan of £3.7m. Current cash is £5.4m vs plan of £8.1m. Planned cash support is likely from quarter 3.

GM/National System Update

- The Chief Finance Officer updated the Committee that PWC have been re engaged with 9 ICBs out of 42. In the North West 3 are in receipt of support. There is a meeting being held for all Chief Executives on the 1st of August regarding the GM position.

ASSURE

Terms of Reference

The Terms of Reference proposed tracked changes were approved subject to any potential changes following the peer review discussion at the Board of Directors meeting being held on the 25 July 2024.

High Value Supplier Payment Register The Chief Finance Officer presented the register which was noted.
New Risks identified at the meeting: None
Review of the Risk Register: *There were no risks reviewed*

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an update from the Audit and Risk Committee meeting held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in September.

Executive Summary	The Chair's Report attached from the Audit and Risk Committee provides provides an overview of matters discussed at the meeting held on 18 September 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.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Audit and Risk Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	There are no financial implications arising from the content of the report
Legal/ Regulatory	**No**	There are no Legal or Regulatory implications arising from the content of the report
Health Inequalities	**No**	There are no Health Inequality implications arising from the content of the report
Equality, Diversity and Inclusion	**No**	There are no Equality Diversity and Inclusion implications arising from the content of the report

Prepared by:	**Annette Walker** **Chief Finance Officer**	**Presented by:**	**Annete Walker** **Chief Finance Officer**

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

Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	18 September 2024	**Date of next meeting:**	04 December 2024
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Internal Audit Progress Reports 2024/25
- External Audit Update/Progress Report
- Local Counter Fraud Specialist Progress Report
- Register of Waivers for Bolton FT and iFM
- Losses & Special Payments Report Bolton FT & iFM
- Review of Whistleblowing Arrangements
- Information Governance Annual Report
- Risk Management Chair's Reports

ALERT

Agenda items	Action Required
None	

ADVISE

There were no items to Advise.

ASSURE

Internal Audit Progress Reports 2024/25
MIAA presented their Internal Audit Progress reports against audits from the 2023/24 Internal Audit plan and progress made in delivery of the 2024/25 Internal Audit Plan. The following 5 reviews have been finalised:

- **Waiting List Management** – substantial.
- **Legal Services** - substantial.
- **Stakeholder Engagement** – high.
- **DSPT Phase II** - substantial (self-assessment) and moderate (National Data Guardian Standards assessment).
- **Critical Application Review (SECTRA-PACS)** – limited.

The main discussion was around the Critical Application Review (SECTRA-PACS) and the actions required in respect of this audit. Some concerns were raised regarding the consortium arrangements as this project was a pan Greater Manchester arrangement**.** Also it was felt that the target date for some of recommendations could be brought forward. It was agreed that this report will be taken up with the Director of Strategy in terms of the findings.

External Audit Update/Progress Report
The New External Auditors Forvis Mazars advised that they were commencing the work with regard to the 2024/25 External audit and were liaising with the finance team over the requirements for the Audit.

The Associate Director of Finance gave an update on the IFM Accounts 2023/24 which were currently being audited by KPMG. The Charitable Funds Accounts have been completed and the Audit arrangements were being finalised.

Local Counter Fraud Specialist (LCFS) Progress Report
The LCFS presented the progress report setting out an update on the cases currently under investigation, those that had been closed and training events. Discussion took place on 2 of the closed cases and assurances were provided on the process that had been followed regarding their closure. Overall the LCFS reported on the very positive staff engagement across the Trust and IFM.

Register of Waivers for Bolton FT and IFM
The Associate Director of Finance presented the Register of Waivers for the Trust and IFM for the period 01 April to 31st August 2024. Overall the number of waivers had increased but the value had decreased when compared to the previous period. The main concern raised was around the retrospective waivers and the need to ensure that waivers were raised in a timely manner. In context the total number of waivers is relatively low compared to the total value of non-pay expenditure. In a number of cases the actions taken as a result of the waivers mean that in future these will be subject to the appropriate tendering arrangements.

Losses and Special Payments Report Bolton FT and iFM
The Associate Director of Finance presented the Losses and Special Payments report for period 1st April to 31st August 2024. The losses were mainly made up of pharmacy drugs and a small number related to patient property. Details were also provided of the bad debts written off and the ADOF advised that the Trust was using a more proactive approach to recover bad debts through the engagement of the bad debt collection company CCI. The Audit Committee received assurance on the process being followed for the write off of bad debt.

Review of Whistleblowing Arrangements
The Director of Corporate Governance presented the report on the whistleblowing arrangements and the process for raising concerns. This mainly centred on the Freedom to Speak Up process and the Audit Committee recommended that the Local Counter Fraud Specialist Report be added into this overview of the whistleblowing arrangements.

Information Governance Annual Report
In line with the change to the Terms of Reference of the Audit Committee, the Director of Digital presented the Information Governance Annual Report. The report highlighted areas including the Data Security and Protection Toolkit, Freedom of Information requests, Subject Access requests, data protection incidents and ensuring data security. The Audit Committee received and accepted the Annual Report which provides assurance on the information governance and security activity for the period 1st July 2023 to 30th June 2024. In addition the report sets out objectives for the forthcoming year.

Risk Management Committee Chair's Reports
The Chief Finance Officer presented the update from the Risk Management Committee and advised that there were currently 497 risks across the Trust, 43 of which are scoring 15 or above. It was noted that the total number of risks represented a significant reduction over the last 12 months. In addition following comments made from the Audit Committee the risk on the Estates Backlog had now been broken down into separate risks in relation to each service area. However there is an overarching strategic risk on the Board Assurance Framework relating to the Estate for assurance purposes. The Audit Committee's attention was brought to an issue in the obstetric emergency theatres regarding air quality and the Committee were advised that the Risk Management Committee were investigating the risk and mitigations required, part of which was linked to the RAAC issue. The Chief Finance Officer advised that the Trust was placing an order for the new units, at risk, in advance of receiving the funding.

New Risks identified at the meeting:
None

Review of the Risk Register:
None

Report Title:	Charitable Funds Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Director of Strategy, Digital & Transformation		Decision	

Purpose of the report	To provide an update from the Chairitable Funds Committee meetings held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Charitable Funds Committees held on 03 June 2024.

Executive Summary	The attached report from the Chair of the Charitable Funds Committee provides an overview of matters discussed at the meetings held on 03 June and 09 September 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 Dircetors.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Charitable Funds Committee Chair's Reports

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Sarah Skinner, Charity Manager	**Presented by:**	Martin North, Chair of the Charitable Funds Committee

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

Name of Committee /Group:	Charitable Funds Committee	**Reports to:**	Board of Directors
Date of Meeting:	03 June 2024	**Date of next meeting:**	09 September 2024
Chair	Martin North	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Q1 highlight report
- NHS Charities Together national conference: reflections
- Q1 finance report
- Application for charitable funds: hot cots
- Application scoping: RTT validation using AI
- Active risks
- Outlook report – Q2 2024/25

ALERT

Agenda items	Action Required
N/A	

ADVISE

Finance report

A further loss was highlighted, pertaining to a staff lottery winner's cheque, which was cashed twice.

The Committee noted the loss, the advanced security measures already in place, and acknowledged plans to further review the resilience of staff lottery processes. **Post-meeting update: staff lottery processes have been tested and no further action is required.**

Application scoping: RTT validation using AI

The Committee received a presentation from JR regarding the potential use of charitable funds to support a pilot using AI in the RTT (referral to treatment) validation process.

Outlook Report – Q1 2024/25

The Committee received a 'state of the sector' update highlighting key issues, risks and opportunities, and an overview of proposed /planned activity for Q2 2024/25. The Committee noted the report.

ASSURE

Highlight report

The Committee received the Q4 2023/24 highlight report noting updates on: fundraising and grants; communications, marketing and media; charity-funded schemes; events; and risks.

NHS Charities Together national conference: reflections

The Committee received a presentation including reflections from the NHS Charities Together national conference, attended by the Deputy Director of Strategy and the Charity Manager.

Finance report

The charities fund balances totalled £997k at 31 March 2024. The charity had a net decrease in funds of £313k for the 12 months to 31 March 2024, comprising of income of £245k and expenditure of £558k. The Charity received £81k in legacies with 8 legacies outstanding. Work continues on streamlining the call on funds, which now stands at £98k.

Application for charitable funds: hot cots

The Committee received an application to the value of £28,326.58 for the purchase of eight hot cots for the post-natal ward, to enable delivery of a robust Transitional Care (TC) service and avoid maternal and neonatal separation.

The Committee approved the application, subject to evidence of cash-releasing benefits to mitigate the impact to revenue or development of a statement of case to cover ongoing revenue costs

New Risks identified at the meeting: None

Review of the Risk Register:

The Committee received an update on active risks following the Q1 review. Following the Q1 review, one new risk has been identified (see below) and one risk score has increased from 12 to 16. The charity is now monitoring eleven live risks, with two risks scoring 12 or above (before mitigation).

Bolton Hospital Cup

The Deputy Director of Strategy advised that Our Bolton NHS Charity is not a beneficiary of funds raised via the Bolton Hospital Cup and previous attempts to engage with the organisers had failed. The Deputy Director of Strategy confirmed that the Trust had sought legal advice and a letter was in draft instructing the organisers to rebrand the cup, removing any reference to Bolton Hospital. The Director of Corporate Governance advised the purpose of the name change request is to mitigate the risk of the public wrongly assuming that the Bolton Hospital Cup is associated with either Our Bolton NHS Charity or Bolton NHS Foundation Trust. The Committee noted the update.

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Charitable Funds Committee	**Reports to:**	Board of Directors
Date of Meeting:	09 September 2024	**Date of next meeting:**	20 December 2024
Chair	Martin North	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Highlight report
- Finance report
- Draft annual report and accounts
- Risk report
- Application for charitable funds: purchase of a new ophthalmic laser for glaucoma procedures
- Application scoping: operating table to support robotic-assisted surgery at Bolton
- Terms of reference
- Outlook report

ALERT

Agenda items	Action Required
N/A	

ADVISE

N/A

ASSURE

Highlight report

The Committee received the Q2 2024/25 highlight report noting updates on: fundraising and grants; communications, marketing and media; charity-funded schemes; the power of partnerships; and risks.

The Committee noted the report and suggested an away day to look at fundraising and income opportunities, to build on the progress of the past four years.

Finance report

The charities fund balances totalled £1,078k at 1 April 2024. For the five months to the 31 August there has been a net decrease in funds of £25k and the charity had a call on funds (commitments) of £254k leaving an available balance of 799k.

The finance department is migrating to a new finance system – Centros – and has a go live date of 1st April 2025. As part of this migration, the charity's finance processes will become fully automated.

The Committee noted the report, including the Centros update.

Draft annual report and accounts

The annual report and financial statements describe the structure, governance and management of the Charity; provide a breakdown of income and expenditure; outline some of our key priorities for 2024/25 and set out the financial position for the year ending 31 March 2024.

The financial statements will be subject to independent review, once an Auditor has been appointed.

The Committee noted the annual report.

Application for charitable funds: purchase of a new ophthalmic laser for glaucoma procedures

The Committee received an application for £43,500 to purchase a new DSLT machine to treat glaucoma patients much earlier in the disease.

The application was approved by the Committee with £27.5k coming from the Ophthalmology Fund and the remaining balance coming from the General Purpose Funds. Recurrent costs were approved by CRIG.

Application scoping: charitable support for robotic assisted surgery at Bolton

The Committee received a presentation outlining a request for £103k to purchase a specialist operating table to maximise the benefits of robotic-assisted surgery at Bolton.

The Committee approved the application for the specialist operating table (subject to the approval of the business case for the surgical by the Board).

Outlook report

The Committee received a 'state of the sector' update highlighting key issues, risks and opportunities, and an overview of proposed /planned activity for Q3 2024/25.

The Committee noted the report.

New Risks identified at the meeting:

None

Review of the Risk Register:

Following the Q2 review, four risk scores have been reviewed and corrected (as impact was scored differently pre and post-mitigation).

There are currently 0 risks with an overdue target date and 0 risks with outstanding reviews

It is proposed that BCF/Risk/18 relating to the Trust's investment priorities is closed due to robust mitigating actions and processes.

The Committee suggested BCF/Risk/14 and 17 pertaining to the cost of living crisis and diversification of charitable income (respectively) are reviewed and scores increased.

Report Title:	Strategy and Operations Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	
Executive Sponsor	Chief Operating Officer and Director of Strategy, Digital and Transformation		Decision	

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

Previously considered by:	The matters included in the Chair's Report were discussed and agreed at the Strategy and Operations Committee meeting held in July.

Executive Summary	The attached report from the Chair of the Strategy and Operations Committee provides an overview of matters discussed at the meeting held on 22 July 2024. The report also sets out the assurances received by the Committee and may identify specific concerns that require the attention of the Board of Directors. Due to the timing of the September meeting of the Strategy and Operations Committee, a verbal update will be provided to the Board of Dircetors with a written report presented at the subsequent Board meeting.

Proposed Resolution	The Board of Dirfectors is asked to ***receive*** the Strategy and Operations Committee Chair's Report

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Rebecca Ganz, Chair Strategy and Operations Committee	**Presented by:**	Rebecca Ganz, Chair Strategy and Operations Committee

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	Strategy and Operations Committee	**Reports to:**	Board of Directors
Date of Meeting:	22 July 2024	**Date of next meeting:**	26 September 2023
Chair	Sean Harriss Non, Executive Director	**Meeting Quoracy**	(**Yes** ~~/ No~~)

AGENDA ITEMS DISCUSSED AT THE MEETING

- Spotlight on: Urgent Treatment Centre (UTC)
- Urgent Care Improvement Update
- Winter Planning
- Month 3 Operational IPM
- Annual report on Delivery of the Digital Strategy
- Maternity EPR Update
- Data Strategy – overview of the plan to develop
- Performance and Transformation Board Chairs Report
- Digital Performance and Transformation Group Chairs Report
- Bolton Strategy, Planning and Delivery Committee Update

ALERT

Agenda items	Action Required
• Urgent Care continues in Tier 1 (national oversight) and Elective Care in Tier 2 (regional oversight). Implications are increased scrutiny from NHSE. • Elective Care – recovery of 65 and 78 week waits – The current position is challenged as there have been some considerable challenges from a pre-op perspective in relation to staff sickness on top of planned annual leave. Anaesthetic capacity as a result of sickness has also had a negative impact along with the recent industrial action. The PTL is being micromanaged at individual case level.	

ADVISE

- **Urgent Treatment Centre (UTC)** - Currently managing to sustain an improved Type 3 performance (Urgent Treatment Centre) at 94%, which represents a 3% increase since June.
- **Urgent Care Improvement Programme** – ECIST have acknowledged the number of actions that are being carried out which are aligned to their report recommendations and the elements of improvement to date, however they recognise that it will take a considerable time to see marked improvements in performance.
- **The System Urgent Care Board** is now starting to gain traction from system partners due to the recent reconstitution.
- **Annual report on the delivery of the Digital Strategy** – The biggest risk to delivery of the strategy is 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 along with lack of available capital

investment and supplier capability to meet the Trusts needs or requirements. Continued engagement with staff is needed in order to manage the expectations from staff in the current financial envelope and not being able to increase the headcount in Digital to support systems effectively. • **Maternity EPR** – the business case was presented and recommended by the committee to go through the Trusts Governance Systems for approvals.
ASSURE
• Winter Planning - assurance received that from the external support and scrutiny from ECIST on all of our plans, ECIST are extremely happy with the level of activity, the amount of engagement, the plans in the right place and that having as much traction on those as it is possible to do provides a degree of confidence on delivery. • Data Strategy – Proposed approach to developing a Trust-wide data and intelligence strategy was received. The engagement process has commenced with a first draft being provided to the Board in November.
New Risks identified at the meeting: None
Review of the Risk Register: *Not conducted*

NHS Bolton NHS Foundation Trust

Report Title:	Bolton NHS Foundation Trust Winter Plan 2024/25			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	26 September 2024		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	

Purpose of the report	The purpose of this paper is to describe the key actions and approach Bolton NHS Trust is taking to manage winter demand

Previously considered by:	Strategic Operations Committee (SOC) 22 July 2024.

Executive Summary	The Winter Plan 24/25 outlines Bolton NHS Trust's strategy to manage winter demand while maintaining patient experience and meeting clinical quality indicators. The plan focuses on ensuring the best possible care, safety, and experience for patients, managing flu and COVID-19, and delivering the Clinical Strategy for Urgent Care Key actions include increasing virtual ward capacity, enhancing falls pick-up services, and improving discharge processes. Additionally, a new winter ward will be established to provide extra bed capacity during the winter months. The plan is designed to complement the Urgent Care Improvement Plan, aiming to achieve 78% performance for the 4-hour access standard by March 2025. Overall, the Winter Plan aims to support patients and staff, ensuring a high standard of care throughout the winter season.

Proposed Resolution	The Board of Directors are asked to ***receive*** the progress, monitoring and escalation process for the winter plan 2024/2025.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	Costs associated with opening a winter ward in N3 – Costs to be determined
Legal/ Regulatory	**Yes**	N3 ward will require CQC registration
Health Inequalities	**Yes**	Actions within the plan aim to reduce health inequalities
Equality, Diversity and Inclusion	**No**	

Prepared by:	Michelle Cox, Director of Operations	Presented by:	Rae Wheatcroft, Chief Operating Officer

1. Introduction

The purpose of this paper is to provide an update on the key actions and approach Bolton NHS Trust is taking to manage winter demand, whilst maintaining patient experience, meeting clinical quality indicators, and ensuring the key deliverables for recovery are achieved. This year's Winter Plan has been formulated within the context of what is predicted to be another challenging winter, with a continuing increase in demand for urgent care services, the impact of Reinforced Autoclaved Aerated Concrete (RAAC) on the bed base and the need to continually improve urgent care performance throughout the year. Our winter plan sets out to:

- Ensure the best possible care, safety and experience for patients and service users
- Safely manage and protect patients from Flu and COVID-19 across all settings
- Deliver the Clinical Strategy for Urgent Care to make significant, sustainable improvement to urgent care services
- Deliver care in the right setting, close to home to support our population, through initiatives such as Home First, Admission Avoidance and Hospital at Home (Virtual Wards)
- Continue to progress our elective recovery
- Protect and support our staff, looking after staff wellbeing and protecting staff from COVID-19 and flu

The Winter Plan has been provided by the Director of Operations to Strategic Operations Group in July 2024 for review and scrutiny and key highlights include:

- The Plan has been constructed to complement the Urgent Care Improvement Plan, which has the over-arching aim of ensuring that we achieve the Urgent Care recovery milestone of no less than 78% for the 4 hour access standard by March 2025.
- A review of Winter 2023/24 has been carried out and the approach focuses on seasonal preparedness, divisional capacity planning and colleague well-being. Divisional capacity plans are focused on schemes which create alternatives to admission and reduce length of stay. Our seasonal preparedness approach centres on known periods when we expect demand to be high such as school holidays, religious holidays and bank holidays. Our colleague wellbeing offer is being led by the Occupational Health and Wellbeing Service and includes both physical and mental wellbeing offers.
- The winter bed modelling exercise will be completed in September 2024 and will reflect the changed use of our bed base following discovery of RAAC in Maternity.
- The Plan sits as part of the Bolton Locality winter plan overseen through the Locality Urgent Emergency Care (UEC) Board. The locality plan focuses on schemes which will help to

keep our residents well at home and prevent the need for access to secondary urgent care services.

- Most of the plan is expected to be delivered within existing baseline expenditure. The addition of a winter ward in N block will provide additional bed capacity during the winter months and the cost of this is currently being assessed. Additional expenditure for Winter will be considered in the context of a significant deficit position for Greater Manchester.
- Oversight of the Plan will be carried out through the Urgent Care Transformation Group and Performance and Transformation Board.

2. Divisional Capacity Planning

This year, as in all years, we expect demand for beds to outstrip available capacity. A first draft of the annual bed modeling suggests that the likely scenario is that we will need 29 additional beds, with the worst case scenario being 57 additional beds (see Table 1)

Table 1:

Best Case Increase(+)/Decreases (-)	
High	+21
Low	-27
Avg. (Median)	-9
Likely Case Increase(+)/Decreases (-)	
High	+29
Low	-22
Avg. (Median)	-3
Worst Case Increase(+)/Decreases (-)	
High	+57
Low	-10
Avg. (Median)	+2

As part of the winter planning process all divisions have a transactional capacity plan that supports their business-as-usual activities during the winter period. The trust winter plan has oversight and checks on the progress of these plans. The Integrated Community Services Division works closely with Bolton Council colleagues to ensure sufficient capacity in Integrated Services. The capacity plans identified by Divisions include;

Alternatives to admission

- Increase virtual ward capacity and usage
- Frailty support to nursing and care homes
- Formal surgical Same Day Emergency Care (SDEC) pathways and breast abscess pathways
- Improve utilisation and pathways for GP direct
- Enhance falls pick up service to develop a 24-hour model and increase pathways into the admission avoidance team.

Reducing Length of Stay

- Re-design of acute medical footprint
- Improved rostering, skill mix and flexibility to meet changing demands
- Fit for purpose, operational discharge lounge
- Weekend discharge doctors
- Increased workforce out of hours
- Nurse led discharge pathways
- Point of Care (POC) testing- Flu/Covid
- Pharmacy discharge on wards (TTOs dispensed at ward level) and an additional ED pharmacist
- Additional radiologist to increase vetting/on call and increase in outpatient appointments for inpatients to discharge to follow up
- Increase in discharge to assess home capacity and commission additional capacity for discharge to assess in flats.

Regular check and challenge sessions are in place to ensure that divisional plans are being delivered within the agreed timeframes and are having the intended impact. Following a review in September 2024, the following progress has been made:

- A new dedicated discharge lounge opened in August 2024 which has supported early flow throughout the Trust. The discharge lounge can now accommodate 18 patients in chairs and 6 patients in cubicles. The new lounge accommodates more patients categorised as level 3 and below (including patients on beds.) There has been improved communication throughout the trust of when patients are fit for discharge and patients are moving to the new discharge lounge from 7.30am daily

- A pilot for a weekend roaming discharge team has commenced. The team includes a Consultant, Physiotherapist, Occupational Therapist and Pharmacist. The aim of the team is to expedite weekend discharges from Complex Care wards, by creating a 7 days/week service model
- Point Of Care testing within our Emergency Department and the Paediatric Assessment Ward goes live in October and November 2024, allowing testing within the departments for RSV and Influenza
- New digital 'Discharge Planning boards,' to support proactive management and discharge planning go live on six wards in October 2024
- The Acute Pain service is now operating over seven days and is demonstrating a positive impact on continuous discharge planning and improving patient flow
- A new pathway for general surgical patients went live in August 2024 providing SDEC to patients through an alternative pathway to admission
- A new pathway for Gynaecology patients to the trust discharge lounge is live. Previously gynaecology patients did not routinely leave the hospital via the discharge lounge due to limited capacity
- Recruitment is underway for a number of posts to support winter pressure and reduce reliance on bank and agency workforce during the predicted period of pressure
- A Pilot commenced in September as part of the MADE event to increase Discharge to Assess capacity from 6 to 7 patients per day. The impact will be reviewed and subject to benefits, implementation by December 2024.

3. Urgent Care Improvement

There is a well-established Urgent Care Improvement Programme which is progressing well and working in collaboration with ECIST colleagues. As a locality and with the support of NHS England Emergency Care Improvement Support Team (ECIST), we are reviewing and implementing alternative care to A&E.

The structured review explores;

- Existing services which are already an alternative to A&E
- Whether or not those services are visible through a local 'directory of services'
- Ease of navigation and how simple it is to access those services

The findings report presents the local system with a score against each of the above and several recommendations for improvement. Our teams across the locality are working collaboratively to explore and pursue those improvement recommendations.

In July the Rapid Assessment and Treat (RAT) Model was implemented in the Emergency Department and this means that the A&E Consultant is the first person that the patient sees, and they can refer the patient directly to one of the following places;

- Home with advice
- Urgent Treatment Centre (UTC)
- Same Day Emergency Care Unit (SDEC)
- A&E Majors
- A&E Ambulatory Care

Since implementation of this model an improvement in non-admitted breaches has been observed and there are plans to extend the time that this model is operational and therefore further improvement is anticipated.

In October a new approach to board rounds will be implemented with support from an interactive digital board known as 'Discharge Planning boards,' the ethos will be why not home and why not home today. The board round will become a proactive discharge planning conversation with the multi-disciplinary team. We anticipate that this will result in an increased number of discharges per day and better performance against the discharge by 12 midday and 4pm metric.

4. Winter Ward

In response to the changes in the bed base due to RAAC in winter 23/24 and initial outputs of the bed modeling, it has been agreed that N3 ward will become the winter ward from November 2024, accepting patients from December 2024. N3 will provide 23 nursing beds for patients with no criteria to reside in order to support the Trust through winter pressure (during December 2024 – March 2025.) Following winter, N3 ward will remain open for patients with no criteria to reside, allowing a ward on the main hospital spine to be closed to restart the annual decant and ward upgrade process which ceased in 2024/2025 due to limited capacity.

5. Colleague Wellbeing Offer

As part of the winter planning process the Occupational Health and Wellbeing team have been part of all the winter planning sessions, enabling them to listen to the workstreams and challenges the divisional teams face. This has been timely as Occupational Health are relaunching and advertising their current offer and as part of this, have created a winter specific wellbeing offer.

- The Vivup platform, which includes benefits schemes and Employee Assistance Programme (EAP) provision, is set to be refreshed and promoted to increase user registration and awareness. The promotion will include informing all employees that there is a 24/7 access to services for them.
- There is a focus on enhancing both physical and mental health wellbeing part of the occupational health offer. For physical health there is a focus on fitness with cycle shelters and the gym. The mental health support offer includes the Staff Health & Wellbeing Champions Network and training additional Mental Health First Aiders (MHFA). Further improvement to support services such as Schwartz Rounds, and Trauma Risk Management training (TRiM,) and to promote wellbeing campaigns that will support divisions with winter wellbeing plans.

6. Bolton Locality System-wide Winter Plan

Greater Manchester Integrated Care System (Bolton locality) is supporting the Trust with the delivery of their winter plans and the wider locality, having oversight of all the plans through the Urgent and Emergency Care Board. The wider locality is reviewing the following schemes, which will support the trust in the delivery of their plans:

- Strengthening the resilience of D2A beds
- Maximising Primary Care Access
- Admission avoidance work with Age UK
- Resident engagement exercise to understand usage of same day care in Bolton
- Expanding the use of advanced care planning
- Continuing to invest in our GMMH (Greater Manchester Mental Health) mental health offer including step-down beds, crisis beds, and Psychiatric Intensive Care Unit (PICU) beds
- Tenancy brokerage schemes which include support to address social isolation and build connections in the community.

The locality contribution to delivering urgent care improvement and sustainability is rooted in the living well at home model, which is overseen by the Locality Strategy, Planning and Delivery Committee.

7. Next Steps

The winter planning process is well established within the Trust and locality. Plans for winter 2024/2025 continue to progress well with regular check and challenge gateway reviews are in place to ensure that there is pace and completion of agreed actions. The next gateway review is planned for November 2024 and regular feedback will continue to be provided through the governance structures set out above.

8. Recommendation

The Board of Directors is asked to receive the monitoring and escalation process for the winter plan 2024/2025.