BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 27 March 2025
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB026/25	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB027/25	**Patient and Staff Story** ***Purpose:*** *To* ***receive*** *the patient and staff story*	*Presentation*		
TB028/25	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB029/25	**Minutes of the previous meeting held on 30 January 2025** ***Purpose:*** *To* ***approve*** *the minutes of the previous meetings*	*Report*	Chair	
TB030/25	**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				
TB031/25	**Chair's Report** ***Purpose:*** *To* ***receive*** *the Chair's Report.*	*Verbal*	*Chair*	**13:20** (10 mins)
TB032/25	**Chief Executive's Report** ***Purpose:*** *To* ***receive*** *the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)
IMPROVING CARE, TRANSFORMING LIVES				
TB033/25	**Integrated Performance Report** ***Purpose:*** *To* ***receive*** *the Integrated Performance Report.*	*Report*	*Exec Directors*	**13:40** (25 mins)

TB034/25	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.*	*Verbal*	*QAC Chair*	**14:05** (05 mins)
TB035/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** ***Purpose:*** *To* ***receive*** *the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.*	*Report*	*CNO + Director of Midwifery*	**14:10** (10 mins)
TB036/25	**2025/26 Quality Account Improvement Priorities** ***Purpose:*** *To* ***receive*** *the 2025/26 Quality Account Improvement Priorities.*	*Report*	*CNO*	**14:20** (10 mins)
TB037/25	**Controlled Drugs Accountable Officers (CDAO) Self-Assessment and Improvement Framework** ***Purpose:*** *To* ***approve*** *the Controlled Drugs and Accountable Officers Self-Assessment and Improvement Framework.*	*Report*	*Medical Director*	**14:30** (10 mins)
	A GREAT PLACE TO WORK			
TB038/25	**People Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:40** (05 mins)
	COMFORT BREAK (10 mins)			**14:45**
	A HIGH PERFORMING PRODUCTIVE ORGANISATION			
TB039/25	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**14:55** (05 mins)
TB040/25	**Audit and Risk Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*ARC Chair*	**15:00** (05 mins)
TB041/25	**Charitable Funds Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*CFC Chair*	**15:05** (05 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE				
TB042/25	**Health and Safety Annual Report 2023/24** ***Purpose:*** *To* ***receive*** *the Health and Safety Annual Report.*	*Report*	*CNO*	**15:10** (10 mins)
TB043/25	**Operational Plan** ***Purpose:*** *To* ***receive*** *the Operational Plan.*	*Presentation*	*CSP*	**15:20** (20 mins)
A POSITIVE PARTNER				
TB044/25	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**16:00** (05 mins)
TB045/25	**Feedback from Board Walkabouts** ***Purpose:*** *To* ***receive*** *feedback following walkbouts.*	*Verbal*	*Members*	**16:05** (10 mins)
CONCLUDING BUSINESS				
TB046/25	**Messages from the Board** ***Purpose****: To agree messages from the Board to be shared with all staff.*	*Verbal*	*Chair*	**16:10** (05 mins)
TB047/25	**Any Other Business** ***Purpose:*** *To* ***receive*** *any urgent business not included on the agenda*	*Report*	*Chair*	**16:15** (05 mins)
	Date and time of next meeting: • Thursday 29 May 2025			***16:20*** ***Close***

Chair: Niruban Ratnarajah

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	Nil Declaration	
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 (Leigh)	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 George House Trust	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

NHS Bolton NHS Foundation Trust

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

Draft Minutes of the Board of Directors Meeting

Held in Boardroom

Thursday 30 January 2025

Subject to the approval of the Board of Directors Meeting on Thursday 27 March 2025

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Andrews	Francis	FA	Medical Director
Crofts	Seth	SC	Associate Non-Executive Director
Fairchild	Tosca	TF	Non-Executive Director
Ganz	Rebecca	RG	Non-Executive Director
Harriss	Sean	SH	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance
Noden	Fiona	FN	Chief Executive
North	Martin	MN	Non-Executive Director and Deputy Chair
Stuttard	Alan	AS	Non-Executive Director
Taylor	Fiona	FLT	Non-Executive Director
Roberts	Tyrone	TR	Chief Nursing Officer
Walker	Annette	AW	Chief Finance Officer
Wheatcroft	Rae	RW	Chief Operating Officer
White	Sharon	SW	Chief of Strategy and Partnerships

In Attendance

Ali-Ross	Nadia	NA	Clinical Director for Obstetrics (for item 012)
Carter	Rachel	RC	Associate Director of Communications and Engagement
Crompton	Victoria	VC	Corporate Governance Manager
Cotton	Janet	JC	Director of Midwifery (for item 012)
McDonnell	Fiona	FM	Managing Director, iFM Bolton
Noble	Rachel	RN	Deputy Director of Strategy (for SW)
Rigby	Lisa	LR	Assistant Director of Organisational Development (For JM)
Tart	Aileen	AT	Senior Practitioner Specialist Palliative Care (for item 002)
Toms	Michaela	MT	Divisional Nurse Director, Integrated Care Services (For item 002)

Apologies

Mawrey	James	JM	Chief People Officer/Deputy Chief Executive

There were seven observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead

TB001/25 Chair's Welcome and Note of Apologies

The Chair welcomed everyone to the meeting and apologies for absence were as noted above.

TB002/25 Patient and Staff Story

Michaela Toms, Divisional Nurse Director for Integrated Care Services, presented the story of a 66-year-old male (now deceased) diagnosed with advanced prostate cancer. He was referred to Specialist Palliative Care, where a Senior Practitioner prescribed steroids for nerve pain and initiated pregabalin within his home.

The patient, who lived alone with family support, struggled psychologically with his declining independence and advancing illness. When a family member contacted the team about severe pain, the patient was assessed via telephone and advised to go to the Emergency Department (ED) due to the risk of a pathological fracture. The patient was met by the same member of staff who cassessed him at home and a full assessment conducted wihin ED. Imaging revealed a pathological fracture of the sacral bone, along with signs of further disease progression. A revised pain management plan was implemented and the patient returned home the same day with follow up care from Specialist Palliative Care.

Discussions highlighted how early involvement of specialist care could have led to more effective pain management and psychological support. Improved collaboration between community and hospital services would have facilitated prompt assessment and the implementation of care plans in both settings. Discussion also highlighted how access to diagnostics directly from the community could have avoided a visit to ED and provided an improved paitent journey.

Staff Story

Aileen Tart, Senior Practitioner Specialist Palliative Care presented the Staff Story advising she had been working within the Palliative Care Team for the previous 14 years and in her current role for 18 months. The new role had been challenging, but she was beginning to see the benefits and had incredible support from colleagues within the Emergency Department (ED). By seeing patients within ED, the team had improved patient experience and reduced length of stay.

AT had recently cared for a patient who had attended ED multiple times and she developed an advanced care plan with the patient which would be shared with her GP.

Colleagues were being trained on Advanced Care Planning to provide better patient experience. The role was demanding, but she felt very privileged to support patients during their most vulnerable time.

SC queried how the Trust collaborated with hospices and AT confirmed the organisation worked closely with the local hospices and held weekly Multi-Disciplinary Team meetings with relevant stakeholders to discuss individual patients.

SW asked how the Board of Directors could support the team. AT responded that advanced care planning was a critical area that required significant attention, with an emphasis on integrating it into practice through targeted collaboration with care and residential homes. The overarching vision was to expand the team by increasing staff capacity, with additional medical support and the incorporation of virtual wards.

RESOLVED:
The Board of Directors ***received*** the Patient and Staff Story from the Integrated Care Services Division.

TB003/25 Declaration of Interests Concerning Agenda Items

The Board noted FN's ongoing 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. FLT also disclosed that she was a Trustee at St Anne's Hospice, a position which was duly noted on the register, in relation to the patient and staff story.

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

RESOLVED:
The Board of Directors ***received*** the Declarations of Interest.

TB004/25 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 28 November 2024, and approved them as a correct and accurate record of proceedings subject to the following amendments:

- Page 8 – DN01 should read DM01
- Strategy and Operations Committee Chair's Report – Rebecca Ganz presented.

RESOLVED:

The Board of Directors ***approved*** the minutes from the meeting held on 28 November 2024.

TB005/25 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 of Directors ***approved*** the action log.

TB006/25 Chair's Update

The Chair advised there were was one item under the consent agenda the Care Hours Per Patient Day (CHPPD).

NR had met with Emergency Care Improvement Specialist Team (ECIST) who fed back the on the positive leadership within the organisation and how colleagues had embraced the improvement work. The data evidenced there had been an improvement in performance following the actions taken.

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

TB007/25 Care Hours Per Patient Day (CHPPD)

The Chief Nursing Officer presented the report advising the CHPPD metric was introduced in 2018 and was calculated by the sum of all hours rostered over a 24 hour period, divided by the number of patients at midnight. Organisations were required to publish their percentage fill rates for registered nurses, midwives and support staff.

To ensure Board visibility, these would be distributed monthly to the Board of Directors as well as being published on the Trust website. For the reporting period, safe staffing levels had been maintained.

RESOLVED:
The Board of Directors ***received*** the Care Hours Per Patient Day (CHPPD) Report.

TB008/25 Chief Executive's 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 Neonatal Unit had introduced a new app to keep parents updated and involved in their baby's care.
- Royal Bolton Hospital had become the first location in Greater Manchester to carry out digital autopsies that reduced the need for invasive post mortems.
- Three community nurses had been recognised by the Queen's Nursing Institute for their commitment to ongoing learning, leadership and excellence in healthcare.
- The Elective Care Centre celebrated one year since the doors to the state-of-the-art complex opened. The centre had four theatres which had been used to help with waiting lists and treat thousands of patients.
- A substantial amount of work had taken place to establish the six neighbourhood teams and the locality had started to see the results of a cultural shift and the impact that could be made on communities.

In response to a query, FN explained that following the incident at the Royal Oldham Hospital, communications had been sent to colleagues to gather their input on measures that could enhance their sense of safety at work. Meetings were held with community staff, who had established systems and processes, but still reported concerns regarding safety. Several staff members provided valuable suggestions on potential improvements.

ACTION:
AS requested that the Director of Operations provided an update at the Audit and Risk Committee on security within the organisation.

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

TB009/25 Corporate Governance Framework

The Director of Corporate Governance presented the report advising the framework was the system by which an organisation was directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. The Corporate Governance Framework brought together the governance arrangements and provided a detailed update on the approach to Board and Committee arrangements.

TF stated it would be beneficial to include a section on the role of the Director of Corporate Governance and how they support the Board of Directors.

RESOLVED:
The Board of Directors ***approved*** the Updated Governance Structure.

TB010/25 Integrated Performance Report

The Director of Operations reported on the Trust's operational performance during December and shared a presentation to outline the organisations improvement journey and the impact the continuous improvement methodology had on a number of areas.

In January 2024, the Emergency Care Improvement Support Team (ECIST) reviewed urgent care pathways and provided recommendations. In collaboration with ECIST and system partners, the Trust launched an improvement programme implementing key changes. In January 2025 performance had improved by 10% year-on-year. In December 2024, 665 more patients were treated and discharged compared to December 2023, with 296 fewer waiting over four hours. By 28 January 2025, ED had seen 697 more patients, with 986 fewer waiting over four hours than the previous year.

Attendances and admissions had increased slightly, which confirmed improvements were not due to lower activity. December 2024, saw 689 additional attendances compared to the previous year. Admission rates had shown special cause variation over six months, with ECIST confirming admissions aligned with expected criteria.

Key process changes, including discharge planning board rounds, a dedicated discharge unit, and the “Your Next Patient” initiative, had improved patient flow. Discharges before 12pm and 4pm had shown sustained improvement since April/May, which correlated with ECIST coaching.

Non-elective length of stay remained stable, with the Acute Adult Care Division showing notable improvement. External collaboration with system partners had strengthened escalation processes, particularly for out-of-area patients and mental health services.

Despite urgent care pressures, elective care continued uninterrupted over Winter for the first time, with no proactive cancellations. More elective patients had been treated than last, and the waiting list had decreased for six consecutive months.

The Trust’s improvement programme had delivered significant positive change, driven by the staffs commitment and strong collaboration with ECIST. These efforts were making a measurable impact on patient care and system efficiency.

Quality and Safety

The Chief Nurse and Medical Director provided an update on Quality and Safety and the following key points were highlighted:

- Your Next Patient' relaunched to improve admission timeliness and reduce delays.
- Falls Prevention: Zero falls with harm in month nine.
- VTE Prevention: Compliance had been recovered. Issue previously related to recording LLP activity.
- University of Bolton Infection Prevention Control Training: Matrons trained on-site. Enhanced modules for nurse/midwife assistants and divisional directors.
- Ward Upgrade/Decant Programme: On track to commence April 2025.
- Clinical Correspondence: Inpatients percentage less than one working day improved, with targeted work in gynaecology and paediatrics.
- Outpatients percentage less than five working days target met, but worsening due to increased WLI and sickness; plan for EPR outpatient digital dictation.

Financial Performance

The Chief Finance Officer presented the month nine finance update, highlighting the following key points:

- Deficit of £2.5m which was off plan by £1.2m due to the impact of the pay award.
- Most likely forecast outturn was an adverse variance to plan of £3.6m, including the impact of the pay award. Best case scenario was off plan by £0.5m.
- Capital year to date spend was £4.5m compared to full year plan of £16.8m.

Workforce

The Director of People reported agency usage and associated expenditure were lower than anticipated, due to the effective controls in place. The vacancy rate overall was very competitive, with similar trends observed across most clinical staffing groups. However, compliance with compulsory and mandatory training had experienced a slight decline.

TF queried readmissions had increased due to No Criteria to Reside. RW noted that readmissions were highlighted in the IPR and fell within special cause variation.

In response to TF's query, RW acknowledged the impact of industrial action on elective work, noting that elective cases were stepped down during this period. However, the greatest impact was on unbooked cases, as the prior notice of the action allowed for advanced planning.

Regarding ECIST, MN asked about the factors contributing to its success and how it could be sustained. AS expressed appreciation for the staff's commitment to

embracing the ECIST model. RW explained that both the Board of Directors and the teams had actively supported and driven the recommendations. While the Trust had previously believed it had completed ECIST recommendations, this time colleagues truly challenged themselves to implement them fully. The sustainability tool was being used to ensure ongoing progress.

TR highlighted a special cause reduction in C. difficile cases, indicating that the collective efforts were beginning to show statistically significant positive outcomes.

Finally, RG queried when the organiation would require cash support, with AW confirming a submission would be made in February, with an aim for approval by June.

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

TB011/25 Quality Assurance Committee Chair's Report

Fiona Taylor presented her Chair's Reports from the Quality Assurance Committee meetings held on 27 November 2024 and 22 January 2025; highlighting the following key points:

- Mortality and Learning from Deaths – the mortality rate was above expected, due to the inclusion of covid-19 cases and other changes in the methodology. An action plan had been developed to address issues identified.
- Fractured Neck of Femur - performance had deteriorated as a result of increased demand and acuity, and changes to the theatre timetable. The Division would continue to work through the action plan. It was expected an improvement in performance would be seen by Q4 2025.

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

TB012/25 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

The Director of Midwifery presented the report highlighting the following key points:

- Assurance was provided that the service successfully met the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint review undertaken on 09 January 2025.
- Ongoing monitoring of defined action plans within the programme would continue until commencement of the CNST year 7 scheme, and detailed updates were included in the report.
- The report provided assurance that the service had not received any external reports that would contradict the maternity incentive scheme declaration and

confirmed that the final position had been shared with commissioners prior to submission to the Board of Directors.

The report confirmed that compliance with all requirements of the CNST year 6 maternity incentive scheme could be evidenced in accordance with the requirements detailed in the declaration form.

In response to query from MN, JC clarified the scheme was developed incrementally each year, with additional requests being incorporated. While it was not expected the Year 7 would be any less challenging, the team felt confident and well-prepared.

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

TB013/25 In-Patient Survey Report

The Chief Nursing Officer presented the report, noting that the organisation's scores were generally consistent with sector averages and stable year on year. IQVIA's survey and benchmarking revealed 15 scores in the top 20%, 33 in the intermediate 60%, and one in the bottom 20%. National CQC benchmarking indicated the Trust was "about the same" as others for 44 questions, "somewhat better" for one, and "better" for four. The findings from the IQVIA report had been presented at the Quality Patient Experience Forum (QPEF) and a number of actions had been agreed.

TR informed that, based on feedback from patients and their families, a review of protected meal times had been conducted. As a result, families would no longer be required to leave during meal times and could remain to support the patient. AW queried whether this applied to visitors who were not classed as family and TR confirmed that it would.

RESOLVED:
The Board of Directors ***received*** the In-patient Survey Report.

TB014/25 Learning from Deaths and Mortality Report

The Medical Director presented the report advising that NHS Digital data for SHMI between August 2023 and July 2024 showed the Trust at 117.65, which was in the 'higher than expected' range. The SHMI had increased since the last reported figure of 114.97, which was largely driven by the change in methodology. A number of key areas of focus had been identified to impact and improve the SHMI.

The report was the second iteration following the review of the governance, structure and efficiency of the Learning from Deaths (LfD) Committee which reported into the Mortality Steering Group. Between September and October 2024 there were 195 deaths and 57 were identified for primary review, 17 had been completed to date. There are no secondary reviews, but the number would increase as the primary reviews were completed due to the reporting lag of two months. 18 secondary reviews outstanding which had been carried over from Q2. Action plans relating to both work streams were included in the report.

RESOLVED:
The Board of Directors ***received*** the Learning from Deaths and Mortality Report.

TB015/25 People Committee Chair's Report

Tosca Fairchild presented her Chair Report from the People Committee meeting held on 21 January 2025; highlighting the following key points:

- EDS2022 2024 - the committee were advised of the progress made in the last 12 months. It highlighted the need for increased focus on patient equity and health inequalities to improve each domain score next year.
- Freedom to Speak up Q3 Update - 39 concerns were raised in Q3 via FTSU. The Committee thanked the FTSU Guardians for the report.
- Guardian of Safe Working Q3 Update - during the reporting period, 51 exception reports were submitted, compared to 34 in the same period in 2023. Of the two reports related to patient safety, it was agreed that these should be escalated to the Quality & Safety Committee.

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

TB016/25 Gender Pay Gap Report

The Assistant Director of Organisational Development presented the report which provided an analysis of the Gender Pay Gap across the Trust for 2024, and also included:

- An update of the 2024 Gender Pay Gap data position
- A summary of work undertaken during the last 12 months to support the reduction of the Gender Pay Gap
- Specific actions the organisation will take to continue to address the Gender Pay Gap over the next 12 months, led by the revised EDI Governance Structure with measurable outcomes

RG raised concerns that the metrics were trending in the wrong direction and LR responded by advising that targeted actions had been implemented to address the issues.

RESOLVED:
The Board of Directors ***approved*** the Gender Pay Gap Report.

TB017/25 Finance and Investment Committee Chair's Report

Rebecca Ganz presented her Chair's report from the meeting held on 27 November 2024, and provided a verbal update from the meeting held on 22 January 2025. The following key points were highlighted:

- The likely variance to plan for 2024/25 was £3.6m which included the impact of the unfunded pay award. There were further developments which would affect the forecast and these were being considered, but Trust was still aiming to achieve plan.
- The assumed Cost Improvement Target (CIP) for 2025/25 was 3% which left a deficit of £32m which would be the subject of further discussion with the Integrated Care Board (ICB).
- There was a risk associated with the Maternity Electronic Patient Record (EPR) go live date.

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

TB018/25 Audit and Risk Committee Chair's Report

Alan Stuttard presented his Chair' report from the meeting held on 04 December 2024, and the following key points were highlighted:

- Review of Terms of Reference and Work Plan: The Committee approved the updated Terms of Reference, which now include Risk and Information Governance, and recommended them for Board approval. The Annual Work Plan was also approved.
- Internal Audit Reports: The Internal Auditors presented their progress report, noting the final outstanding report from 2023/24 would be presented at the next meeting. Two final reports from the 2024/25 plan were referred back to the respective Committees, with thanks to staff for their contributions.
- Board Assurance Framework (BAF): The Committee received the BAF, which provided assurance on the Trust's five Strategic ambitions, and commended the comprehensive work in its development.
- Corporate Risk Register – the committee received the Corporate Risk Register noting there were 32 risks which scored at 15 and above. The Committee made

two recommendations to strengthen the link between the Corporate Risk Register and the Board Assurance Framework.

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

TB019/25 Our Bolton NHS Charity Annual Report

Martin North, Chair of the Charitable Funds Committee presented the report which described the structure, governance and management of the Charity; provided a breakdown of income and expenditure; outlined some of our key priorities for 2024/25 and set out the financial position for the year ending 31 March 2024.

The annual report and accounts would be submitted to the Charity Commission by the deadline of 31 January 2025.

SW highlighted the primary focus of the Charity over the next 12 months would be to engage with local communities to increase fundraising efforts.

RESOLVED:
The Board of Directors ***approved*** the Our Bolton NHS Charity Annual Report.

TB020/25 Strategy and Operations Committee Chair's Report

Sean Harriss presented the Chair's Report from the Strategy and Operations Committee meeting held on 25 November 2024.

It was noted the committee had now been disbanded. SH commended the effective transition of the committee's work, highlighting the successful continuation of key initiatives by both the Quality Assurance and Finance and Investment Committees.

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

TB021/25 iFM Report

The Chief Finance Officer presented the report which provided an overarching review of the performance of iFM, including the key achievements and challenges for the period April 2023 to March 2024. The report also included the iFM Outlook Priorities for 2024/25 and the closing thoughts on the financial year 2023/24.

Board members commended the report, acknowledging that colleagues within the iFM department play a critical role and are responsible for some of the most important functions within the organisation.

RESOLVED:
The Board of Directors ***received*** the iFM Report

TB022/25 Questions to the Board

There were no questions received from members of the public to the Board of Directors.

TB023/25 Feedback from Board Walkabouts

SC reported on his visit to the Surgical Unit, describing it as a highly dynamic environment with a cohesive team effectively managing numerous challenges. He noted a strong sense of collaboration and a positive "can-do" attitude within the team. Additionally, SC visited the Theatres, where he observed strong leadership and significant progress in reducing the elective wait lists.

MN shared his visit to E3, where the impact of low flu vaccine uptake among staff was evident, with high levels of sickness reported.

NR provided an update on the introduction of digital autopsy technology, praising it as a ground-breaking initiative. He highlighted the inspiring work being done, noting the significant care and personal pride demonstrated by staff in this area.

SK reminded Board members to complete the feedback forms following their site visits.

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

TB024/25 Messages from the Board

The messages from the Board were agreed:

TB025/25 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 14:30.

The next Board of Directors meeting would be held on 27 March 2025 at 1pm in the Boardroom.

Meeting Attendance 2025						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓					
Fiona Noden	✓					
Francis Andrews	✓					
James Mawrey	A					
Tyrone Roberts	✓					
Annette Walker	✓					
Rae Wheatcroft	✓					
Sharon White	✓					
Rebecca Ganz	✓					
Martin North	✓					
Alan Stuttard	✓					
Sean Harriss	✓					
Fiona Taylor	✓					
Seth Crofts	✓					
Tosca Fairchild	✓					
Sharon Katema	✓					
✓ = In attendance A = Apologies						

November 2024 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/25/01	30/01/2025	Chief Executive Report	Director of Operations to provide an update at the Audit and Risk Committee on security within the organisation	RW	May-25	

Key

complete	agenda item	due	overdue	not due

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	
Executive Sponsor	Chief Executive		Decision	

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

Previously considered by:	Not Applicable.

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 note 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	**Yes**	

Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

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

Ambition 1: Improving care, transforming lives

Patients have shared their positive experiences after receiving a new, innovative procedure at Royal Bolton Hospital. Eight patients have received Thumb Carpometacarpal Joint (CMCJ) replacement, a relatively new procedure in the UK which aims to reduce pain in the hand and improve movement and grip. The operation is typically used for people experiencing arthritis in the base of the thumb by replacing the joint with an artificial joint. Eight people in Bolton have received the revolutionary thumb replacement since the procedure was first carried out in March last year.

A potentially life-saving blood borne virus (BBV) opt-out testing programme is underway in our Emergency Department to help diagnose HIV, Hepatitis B (HBV), and Hepatitis C (HCV) and make sure even more people are offered support and treatment, which can ultimately save lives. The approach is aiming to normalise testing, reduce stigma and ensure those who are unaware of their status receive timely care. Since the programme launched in Greater Manchester in December 2021, over 300,000 people have been tested. More than 120 people have been newly diagnosed with HIV, 320 with HCV and 140 with HBV. Frequently Asked Questions and links for support are available on our website.

Bolton's Bowel Cancer Screening Programme has celebrated 18 years of screening people in Bolton, Salford and Wigan to help detect bowel cancer as early as possible. The programme launched on 12 February 2007 and since then has invited more than **one million people** to take part in screening. The aim is to detect bowel cancer at early stages in patients with no symptoms and prevent the disease by identifying and removing small growths on the bowel wall called polyps to reduce the risk of them developing into bowel cancer.

The time it takes to get patients out of hospital and back to the comfort of the place they call home has halved thanks to significant improvements that have taken place. Our Integrated Discharge Teams have increased their capacity to support the timely discharge of patients who are medically fit. This work has resulted in the number of delayed days falling from 1,100 in February 2024 to 516 in December 2024, meaning 500 days of people being in the place they call home, instead of our hospital.

Our teams work closely with Bolton Council, community organisations and patients' relatives to understand where the best place is for people who are well enough to leave hospital care and continue their rest and recovery at home. People who stay longer in hospital are at a high risk of harm and infection, and by recovering in a place they feel comfortable and familiar with we can reduce their risk of deconditioning, which can impact their ability to do daily activities of living.

Staff working in our Neonatal Unit (NNU) have received Green status reaccreditation for FiCare. FiCare is a model that integrates families as partners in the NICU care team, and provides a structure that supports the implementation of family-centred care. All our NNU staff attend a yearly FiCare update as part of their mandatory training and to date 85% of all neonatal and medical staff have been trained in FiCare. On admission each family receive an admission passport pack explaining FiCare and how to become involved in the family centred care of their baby, reducing parental anxiety, stress and encourages bonding, giving parents unrestricted access to their baby. The model reduces instances of infection, length of stay on the unit and has been proven to have a positive effect on weight gain, breast feeding rates and long term neuro-development.

A baby receiving care in our Neonatal Unit has become the first to benefit from a ground-breaking gene test which aims to prevent lifelong hearing loss. Our hospital was one of the first to go live with the cutting edge Genedrive System, which uses a cheek swab to rapidly detect potential genetic mutations which can cause permanent hearing loss in babies when they are given aminoglycoside antibiotics. The system means babies admitted to the Neonatal Intensive Care Unit with sepsis are rapidly tested and given an alternative antibiotic if they are positive, avoiding a lifetime of deafness. The Genedrive System, funded as a pilot study by Health Innovation Manchester, was developed in partnership with Manchester University NHS Foundation Trust.

The relaxed restrictions on visiting during mealtimes on our wards have been greatly received and are set to improve emotional health and wellbeing support for patients and families. The changes were made following a wide review of evidence by our Library and Knowledge Team, in which systematic reviews found no demonstrable benefit to excluding family, friends and carers during mealtimes. Evidence around patient mealtimes did also highlight the importance of support, patient positioning, leadership of registered nurses and the area leader, availability of menu information and ease of opening food products.

Ambition 2: A great place to work

Our NHS Staff Survey results for 2024 have been published. The annual survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. This year it was great to see our response rate increase to **48%** which means that our results are representative of a broader range of experiences.

We are extremely grateful for all those who took the time to tell us about their experiences at work and will use what our staff shared to guide what we do next. Our ambition to make our organisation one where every single person has a good experience remains, and we are really pleased to see that improvements have been made in all of the NHS People Promise areas.

We are particularly pleased to see from our results that morale has noticeably improved, and that we have an engaged workforce who are supported by their line managers – all of which are interlinked. Some of the results confirm to us that we have more work to do when it comes to making sure everyone has adequate materials to be able to fulfil their roles and that discrimination is eliminated across our Trust.

We are also concerned to see a slight decrease in the number of people who would be happy with the standard of care provided by our organisation for their friends and relatives. This is indicating the need for us to do further work to truly understand the reasons for that, so we can take action wherever it's possible. The feedback will inform the next wave of the Our Voice Change Programme which has been highlighted as good practice nationally as part of the People Promise Exemplar programme.

Overseas NHS Workers' Day gave us an opportunity to recognise the contributions of our frontline and support staff from around the world. From Nigeria to Poland, Ireland to Spain, our Trust is proud to have **67** different nationalities working across the organisation to provide the best care possible for our Bolton's communities. We have an international clinical recruitment team who walk alongside our new

staff and provide a wide range of support both as they arrive in Bolton, including finding good quality affordable accommodation, arranging social shares, registering with GPs, opening bank accounts and registering children in school.

Healthcare Science Week gave us the opportunity to celebrate and raise awareness of healthcare science and its vital contribution to the NHS and patient care. One of our Healthcare Scientists has been recognised for dedicating more than twenty years of her career to improving patient care and healthcare standards. Carolyn Williams, Head of Department for Biochemistry and Clinical Lead for Laboratory Medicine, received a Lifetime Achievement Award at the North West Healthcare Science Awards 2025, which aim to spotlight individuals and teams who have made a profound impact in their field.

One of our Apprentice Student Nursing Associates is a finalist at the Student Nursing Times Awards 2025. Maxine Brennan, who works for SHINE, the Trust's sexual and reproductive health service, has been shortlisted in the Student Nursing Associate of the Year category. In the nomination, Maxine was praised for being a dedicated student nursing associate who goes above the beyond to provide an exceptional contribution to the team. The winners will be announced on Friday 2 May 2025 in a ceremony at the Grosvenor House Hotel in London.

As part of National Apprenticeship Week we highlighted the **150** different apprenticeship courses on offer to both staff working at the Trust and people looking to start a career in healthcare. During the week we announced that we are one of the few NHS trusts in England who will be helping to kick start the careers of the next generation of theatres nurses and practitioners, after launching a brand new theatre support worker apprenticeship.

The Theatre Support Worker apprenticeship includes clinical on the job training and dedicated learning time at Bolton College. Our new apprentices will be given the opportunity to work in the busy Operating Theatre Department at Royal Bolton Hospital, providing support by transferring patients between clinical areas, preparing clinical areas before procedures and supporting clinical teams during an operation.

Our Trust is one of the first in the country to endorse #SASsix, a campaign founded by the SAS Collective to improve the career development and retention of specialist, associate specialist and specialty (SAS) doctors across the UK. SAS and locally employed doctors (LEDs) make up around 30% of the medical workforce, playing a vital role in the NHS. Most SAS doctors work in senior roles in the NHS, treating and caring for thousands of patients every day, many running their own clinics and working autonomously. As patient care grows ever more complex, with new technologies and treatments, the NHS needs highly skilled, specialist doctors who can care for an ageing population with multiple chronic conditions.

Ambition 3:
A high performing, productive organisation

The Prime Minister announced recently that NHS England will be brought back into democratic control within the Department for Health and Social Care (DHSC). A transformation team will be established to enact the process, containing two clinical directors – one covering primary care and another covering secondary care.

Integrated Care Boards (ICBs) are also expected to make significant efficiencies, with ICBs asked to make 50% reductions in their running costs by Q3 2025/26.

Given the challenging financial context, it is right that we all do everything we can to ensure that the maximum possible amount of taxpayers' money goes to where it can deliver the biggest impact. Our role in that will be to relentlessly focus on cost improvement and productivity so that we can deliver efficiencies, whilst ensuring all those who need us get the high-quality support and care they deserve, as soon as possible.

Our focus will always remain on doing what's right for our patients and communities but the scale of the challenge is significant. It will not be possible to get where we need to be without making some difficult decisions. We are clear that the decisions we make cannot come at the expense of patient safety and must not compromise our performance against national standards and targets.

As part of the plans, Trusts are expected to reduce their corporate services budgets back to pre-pandemic levels and a programme of work is underway, through our Financial Improvement Group. A rapid action team has also been established to consider further opportunities for cost improvement, transformation and operational performance to ensure the delivery of our operational plan.

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

Earlier this year we reiterated our pledge to be a Smokefree hospital site, along with other hospitals in Greater Manchester. To support this we have introduced a vape zone across from the Emergency Department and away from our main entrance.

This No Smoking Day, we took the opportunity to remind our Bolton communities that help is available to support them to stop through Smokefree Bolton which supports local smokers, aged 12 years and above with free personalised support and tobacco replacement therapies. We know that people are three times more likely to succeed with specialist help. Patients who are admitted to hospital and smoke, will be encouraged to access a specialist team on site from **The CURE Project**, who will work with them to provide nicotine replacement, and follow up support for once they leave hospital.

Work on our maternity and women's health development will begin in earnest this month, with the first stage of the development being the work to maternity theatres. Once underway, this stage is expected to be completed towards the end of the summer. The whole development is expected to be completed late 2026 early 2027.

We continue to work hard to make improvements to our car parks across the hospital site. Work is planned in a number of smaller staff car parks to improve the surfaces and introduce space marking. Ongoing works on-site will also mean that more spaces will gradually be introduced upon completion, which will support the spaces temporarily being lost to works on bigger developments such as the Maternity block works.

The latest PLACE report (patient-led assessment of the care environment) has unfortunately shown a reduction in our scores for food at Royal Bolton Hospital. We are working hard to improve this, including diversifying our menu to support patients with complex needs more appropriately, and rolling out an electronic meal ordering service to allow greater flexibility for our patients.

Ambition 5: A positive partner

We continue to work closely with our partners at the University of Greater Manchester to shape plans for the opening of the Medical School to students in September. We have introduced processes for colleagues who wish to develop and expand their portfolios with either clinical or academic positions at the Medical School and will continue to support this and the development of the new School.

It's important that we understand the views of our public, and earlier this month we supported one of our six neighbourhood teams to work with partners from Bolton's Voluntary, Community and Social Enterprise (VSCE) sector and NHS Greater Manchester to hold an NHS Fit for the Future event. The event, held in the Central North neighbourhood, was an opportunity for community members to come together and also take part in the conversation about the biggest challenges facing Greater Manchester's health and care system. Further work will begin to theme and respond to the feedback, once events have taken place in each neighbourhood.

Last month we relaunched our Pennies from Pay scheme, in support of Our Bolton NHS Charity. The salary micro-giving scheme allows colleagues to round up the pennies from their pay and donate to the charity each month, with all funds allocated to the staff wellbeing fund. The charity has funded over £700k in projects since 2020 that support staff wellbeing including (but not limited to) the new faith facilities and community hub, reclining chairs, white goods and equipment for staff rooms and an annual contribution to the For a Better Bolton (FABB) awards.

Our Bolton NHS Charity Ramadan has funded gift packs a for our patients who are observing Ramadan which contain honey, a tasbeeh (prayer beads), Safawi dates, a bottle of Zam Zam water and a prayer book. Throughout Ramadan, reasonable and flexible adjustments are in place to help staff observe their religious obligations, feel comfortable embracing their identity in the workplace and enable them to bring their whole selves to work.

We are also extremely grateful to our colleagues at Bolton Council of Mosques (BCoM) who have donated packs of dates and water for staff and patients to enjoy whilst breaking the fast in the hospital's Mosque and Faith Hub. We hope that this small gesture will provide some comfort to families whilst they visit their loved ones in hospital during the month of Ramadan.

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	✓
Executive Sponsor	Deputy Chief Executive/Chief People Officer		Decision	

Purpose of the report	To present the Month 11 Integrated Performance Report

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

Executive Summary	The Integrated Performance Report provides an overview of the Trust's performance against the reported metrics in February 2025. The narrative describes issues that are affecting performance and any mitigating actions to improve performance.

Proposed Resolution	The Board of Directors is 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	**Yes**	**Trust performance included within report, for any areas of concern narrative is provided.**
Legal/ Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

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

Bolton NHS Foundation Trust

Integrated Performance Report

February 2025

Guide to Statistical Process Control

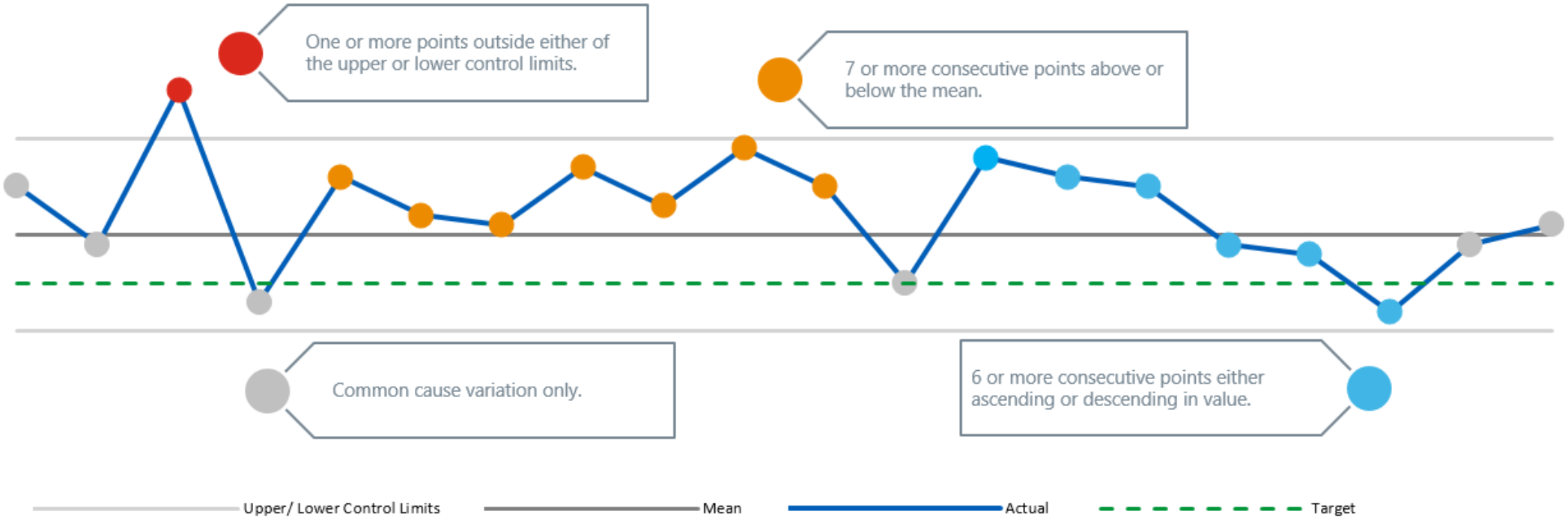
NHS Bolton NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	2	3	1	1	1	3	12
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	5	1	1	0	1	0	0	3
Patient Experience	15	1	0	0	0	2	0	14
Maternity	9	0	0	1	0	1	0	8
Operational Performance								
Urgent Care	8	0	1	1	1	2	7	2
Elective Care	5	0	6	1	3	1	7	4
Cancer	0	1	0	0	0	0	0	1
Community Care	8	0	0	0	0	0	2	6
Workforce								
Sickness, Vacancy and Turnover	3	0	1	0	0	0	2	1
Organisational Development	1	3	0	0	2	1	2	3
Agency	1	0	2	0	0	0	1	2
Finance								
Finance	2	0	0	0	1	1	0	2
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

Pressure Ulcers - In month 11, zero category three pressure ulcers developed in the hospital. A new Patient Safety Review process has commenced to ensure that all hospital acquired category 3 and category 4 pressure ulcers are reviewed with Corporate Nursing oversight, to support the identification of appropriate learning and themes, which will be monitored through the Pressure Ulcer Faculty. Month 11 saw an increase in category 2 pressure ulcers developing in the hospital, which indicates special cause variation. A thematic review of quarter 3 category 2 pressure ulcers is being finalised by the Corporate Nursing team to determine themes and actions to support an improvement in this, and will be presented at Patient Safety Group in April to feed into Clinical Governance and Quality Committee. .
There were zero category four pressure ulcers reported in the community setting in month 11, and ten category 3 pressure ulcers. Divisional PSIRF processes continue to identify learning and actions.
To note: Pressure Ulcer data remains unvalidated for 60 days from date of reporting whilst patient safety incident response framework review underway

Harm Free Care Falls - The organisation has maintained strong performance in falls prevention, recording zero falls with harm during month 11. Overall falls rate has slightly increased to 5.35 per 1000 bed days. This remains within common cause variation, and is monitored by the falls lead. The corporate team continues to collaborate with Divisions to review falls incidents, identify themes and implement targeted actions for sustained improvement.

	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%	95.2%	Feb-25	L	>= 95%	95.4%	Jan-25	>= 95%	95.8%	?
9 - Never Events	= 0	0	Feb-25	L	= 0	0	Jan-25	= 0	0	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.35	Feb-25		<= 5.30	4.41	Jan-25	<= 5.30	4.33	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	0	Feb-25		<= 1.6	1	Jan-25	<= 17.6	8	?
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	22.0	Feb-25	H	<= 6.0	19.0	Jan-25	<= 66.0	165.0	?
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	0	Feb-25		<= 1	4	Jan-25	<= 6	35	?
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Feb-25	L	= 0.0	0.0	Jan-25	= 0.0	0.0	?
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	7.0	Feb-25		<= 7.0	13.0	Jan-25	<= 77.0	100.0	?

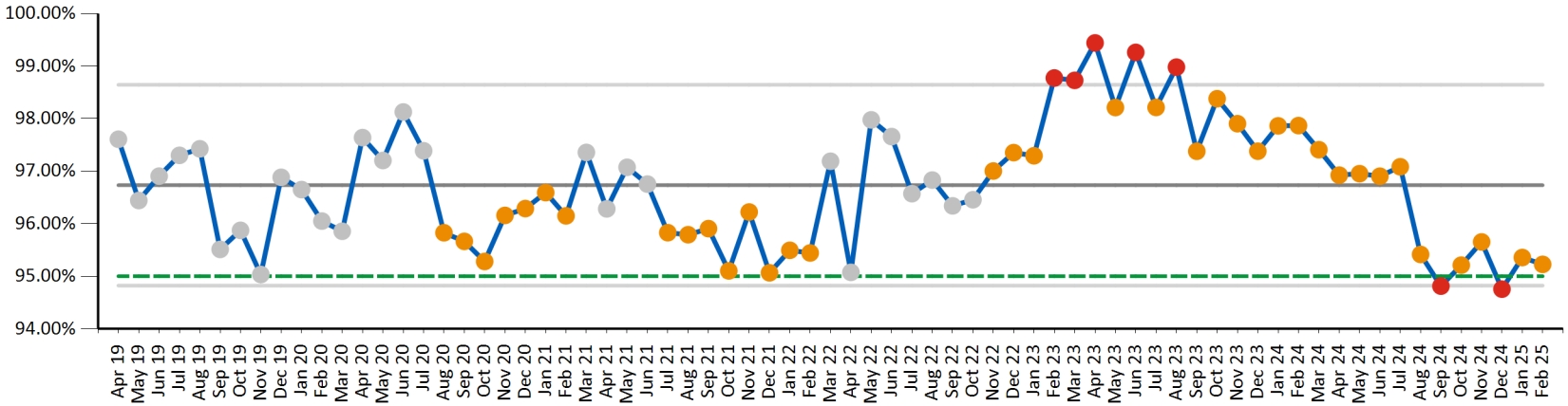
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	10	Feb-25		<= 4	10	Jan-25	<= 44	90	?
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	0.0	Feb-25		<= 1.0	1.0	Jan-25	<= 11.0	5.0	?
535 - Community patients acquiring pressure damage - significant learning category 2		0	Feb-25	L		0	Jan-25		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Feb-25			0	Jan-25		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Feb-25			1	Jan-25		1	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	79.2%	Feb-25	H	>= 95%	80.4%	Jan-25	>= 95%	80.3%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	62.6%	Feb-25		>= 95.0%	65.5%	Jan-25	>= 95.0%	66.8%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Feb-25		= 100%	100.0%	Jan-25	= 100%	95.5%	?
88 - Nursing KPI Audits	>= 85%	95.2%	Feb-25	H	>= 85%	95.2%	Jan-25	>= 85%	95.1%	P
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	100.0%	Feb-25		= 100%	100.0%	Jan-25	= 100%	57.1%	?
8 - Same sex accommodation breaches	= 0	16	Feb-25		= 0	18	Jan-25	= 0	181	F

6 - Compliance with preventative measure for VTE

Special cause variation with deteriorating performance

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

4/6



Latest

Plan	Actual	Period
>= 95%	95.2%	Feb-25

Previous

Plan	Actual	Period
>= 95%	95.4%	Jan-25

Year to Date

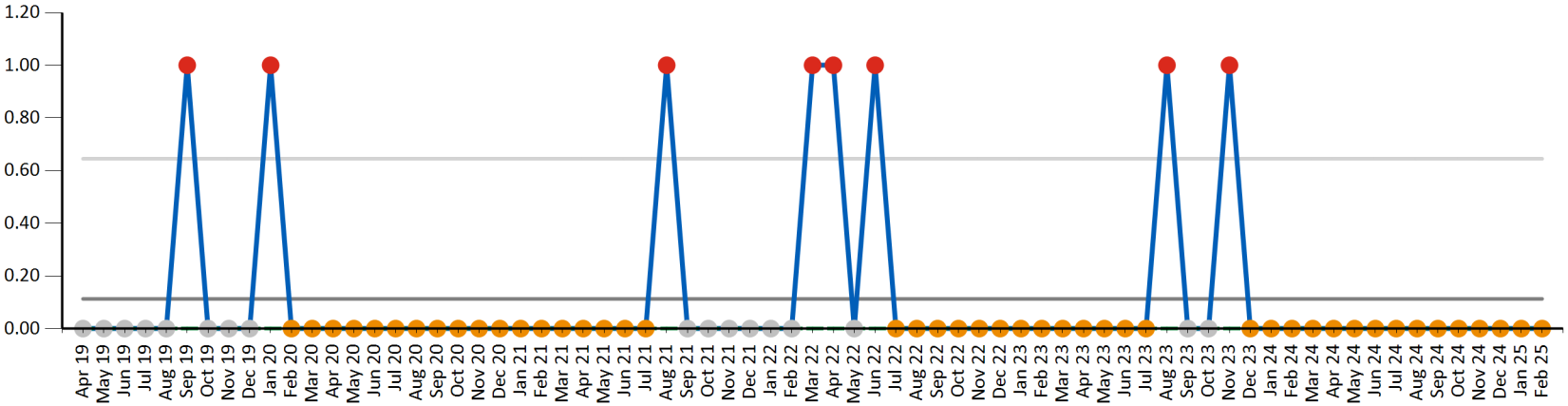
Plan	Actual
>= 95%	95.8%

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	Feb-25

Previous

Plan	Actual	Period
= 0	0	Jan-25

Year to Date

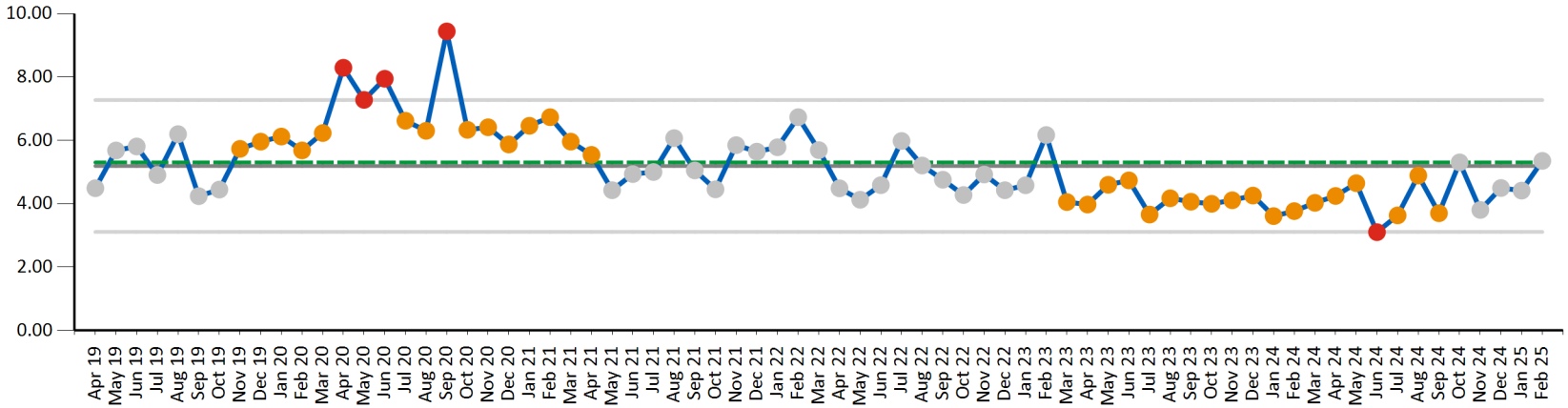
Plan	Actual
= 0	0

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 5.30	5.35	Feb-25

Previous

Plan	Actual	Period
<= 5.30	4.41	Jan-25

Year to Date

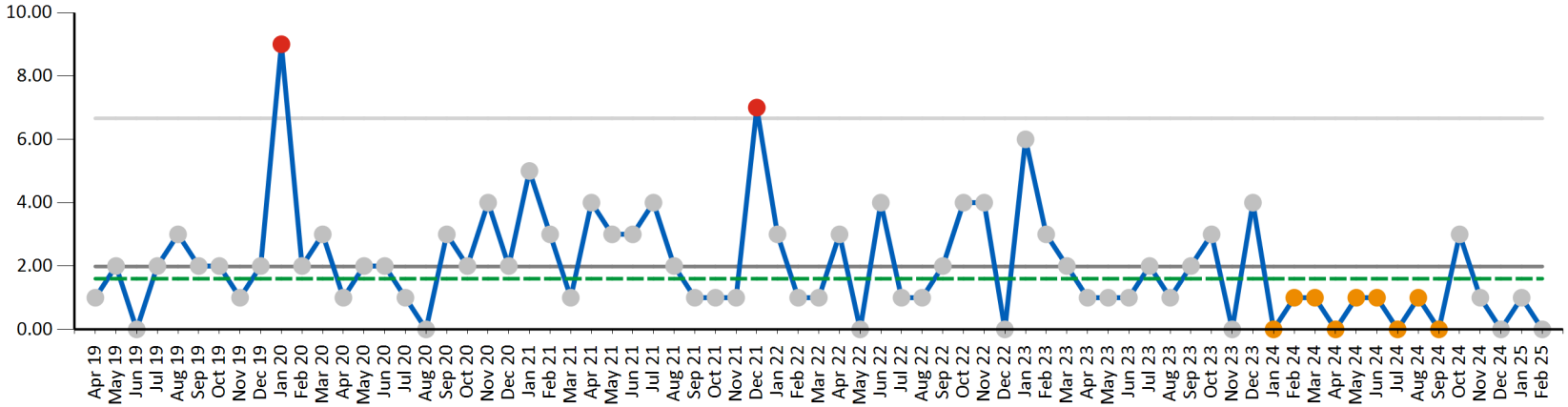
Plan	Actual
<= 5.30	4.33

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 1.6	0	Feb-25

Previous

Plan	Actual	Period
<= 1.6	1	Jan-25

Year to Date

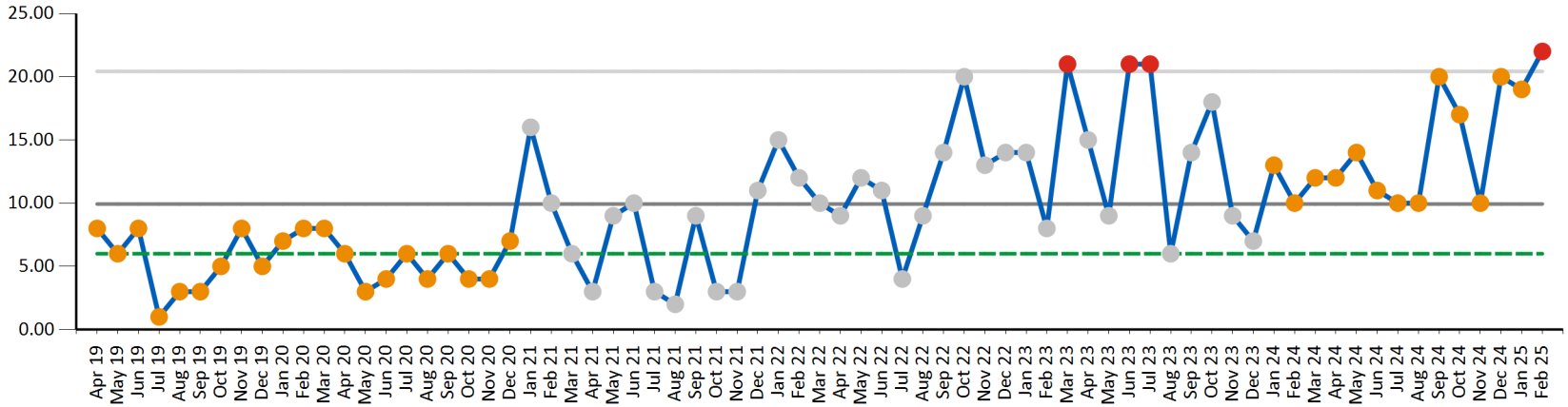
Plan	Actual
<= 17.6	8

15 - Number of Acute Inpatient incidences - 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	22.0	Feb-25

Previous

Plan	Actual	Period
<= 6.0	19.0	Jan-25

Year to Date

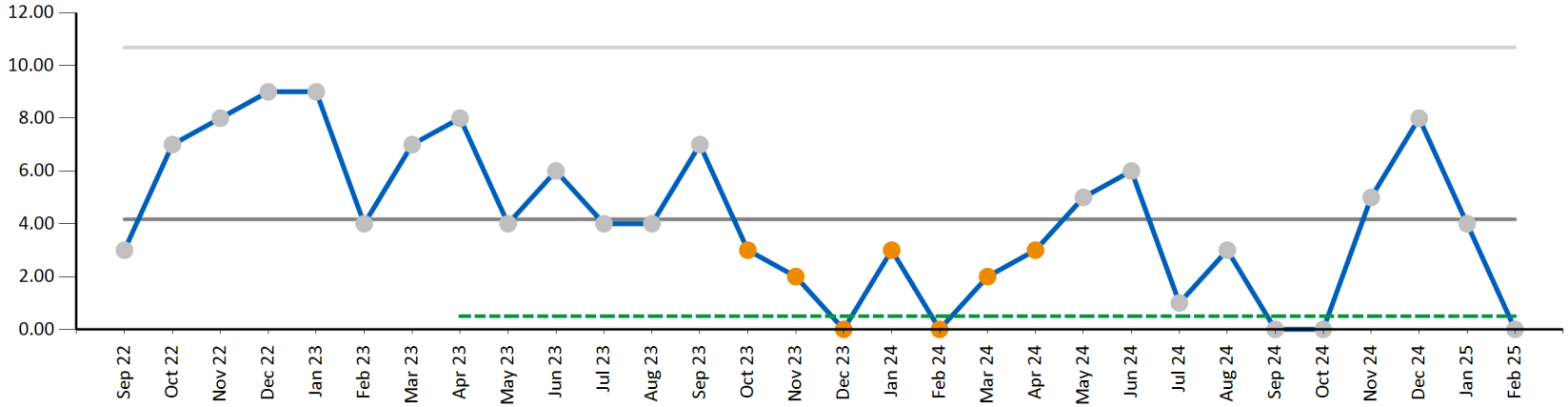
Plan	Actual
<= 66.0	165.0

620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1	0	Feb-25

Previous

Plan	Actual	Period
<= 1	4	Jan-25

Year to Date

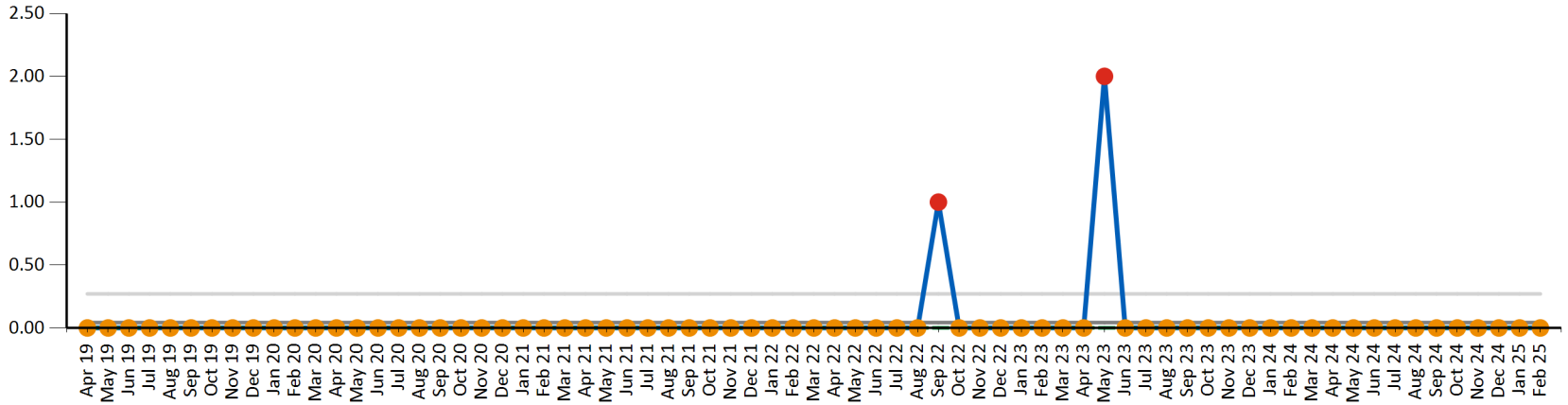
Plan	Actual
<= 6	35

17 - Number of Acute Inpatient incidences - 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	Feb-25

Previous

Plan	Actual	Period
= 0.0	0.0	Jan-25

Year to Date

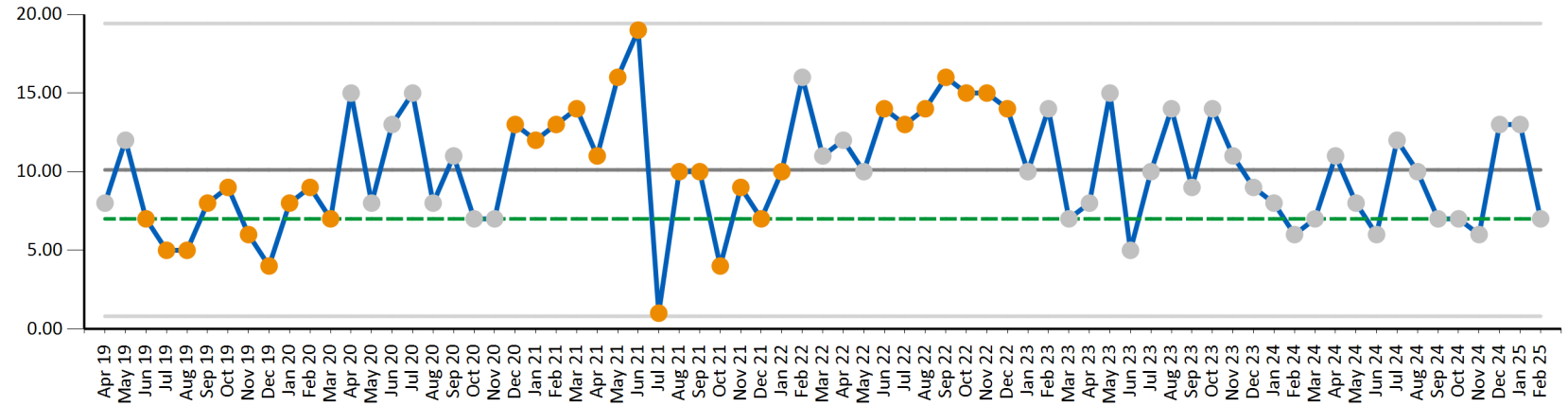
Plan	Actual
= 0.0	0.0

18 - Number of Community incidences - pressure damage (category 2)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 7.0	7.0	Feb-25

Previous

Plan	Actual	Period
<= 7.0	13.0	Jan-25

Year to Date

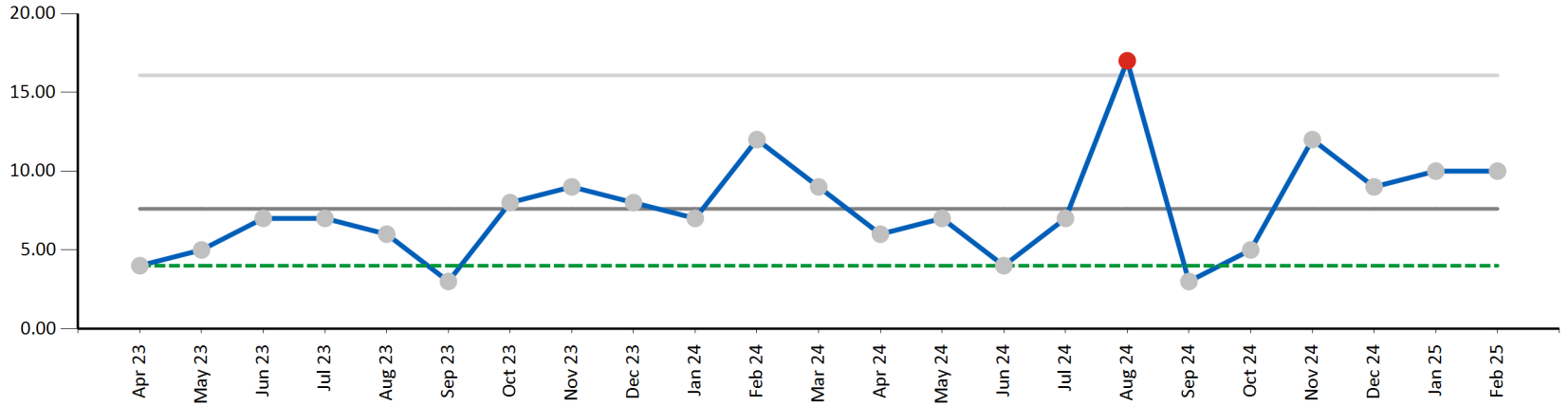
Plan	Actual
<= 77.0	100.0

621 - Number of Community incidences - pressure damage (category 3 plus unstageables)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 4	10	Feb-25

Previous

Plan	Actual	Period
<= 4	10	Jan-25

Year to Date

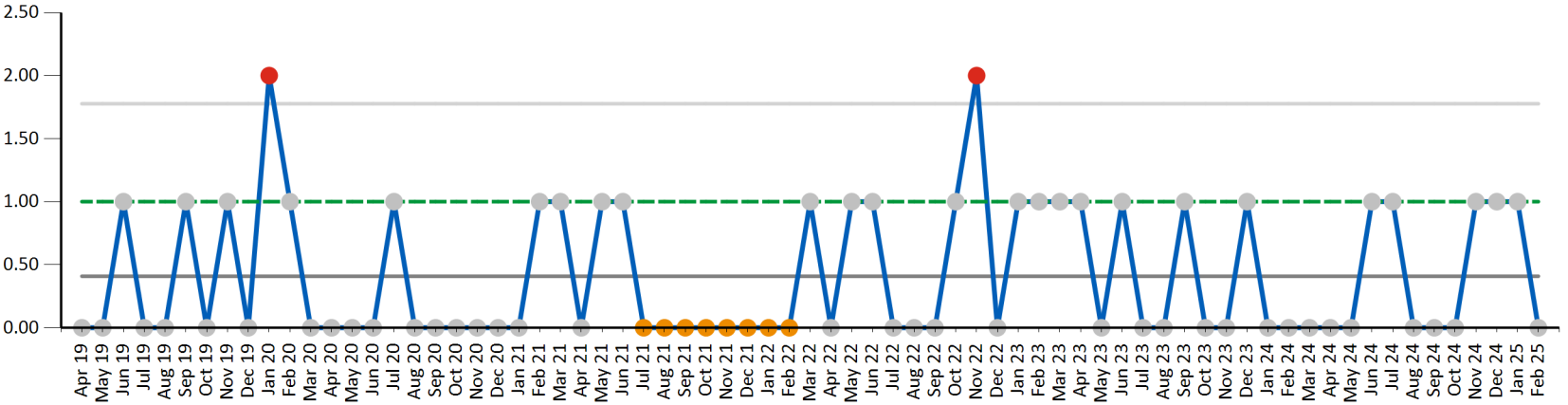
Plan	Actual
<= 44	90

20 - Number of Community incidences - 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	Feb-25

Previous

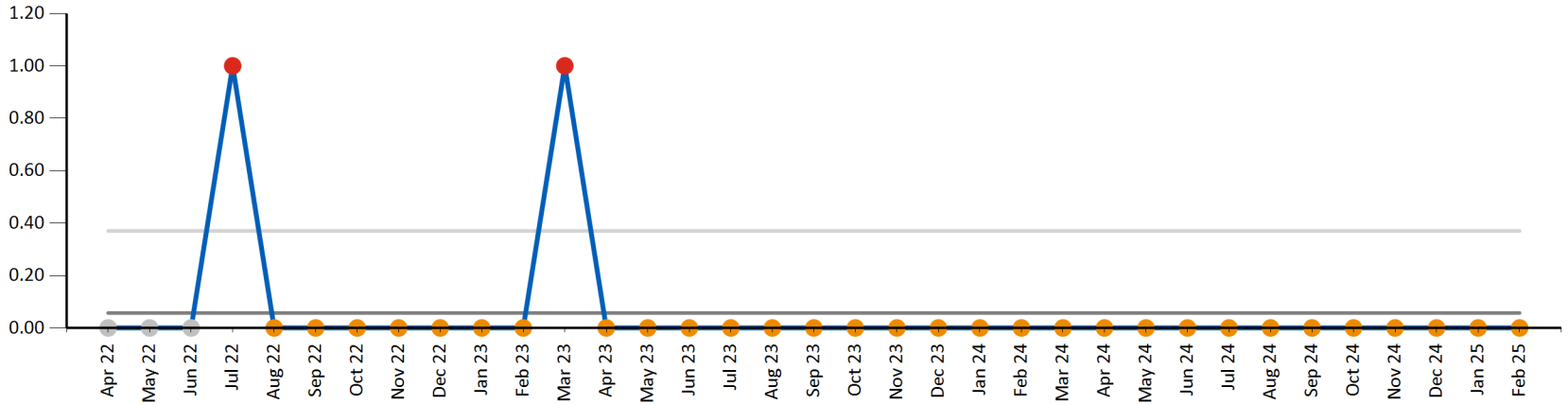
Plan	Actual	Period
<= 1.0	1.0	Jan-25

Year to Date

Plan	Actual
<= 11.0	5.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Feb-25

Previous

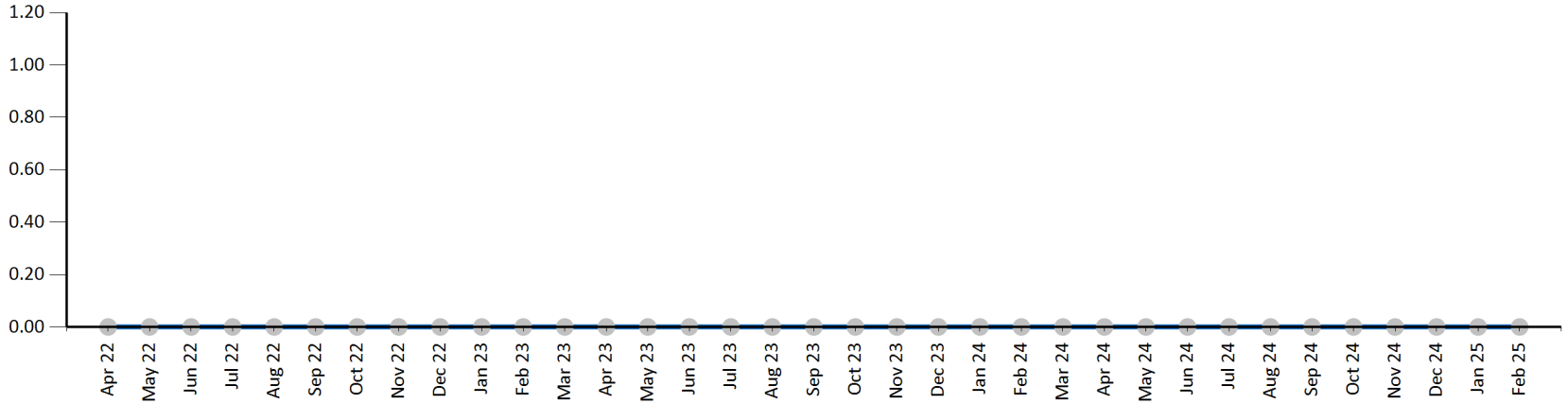
Plan	Actual	Period
	0	Jan-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-25

Previous

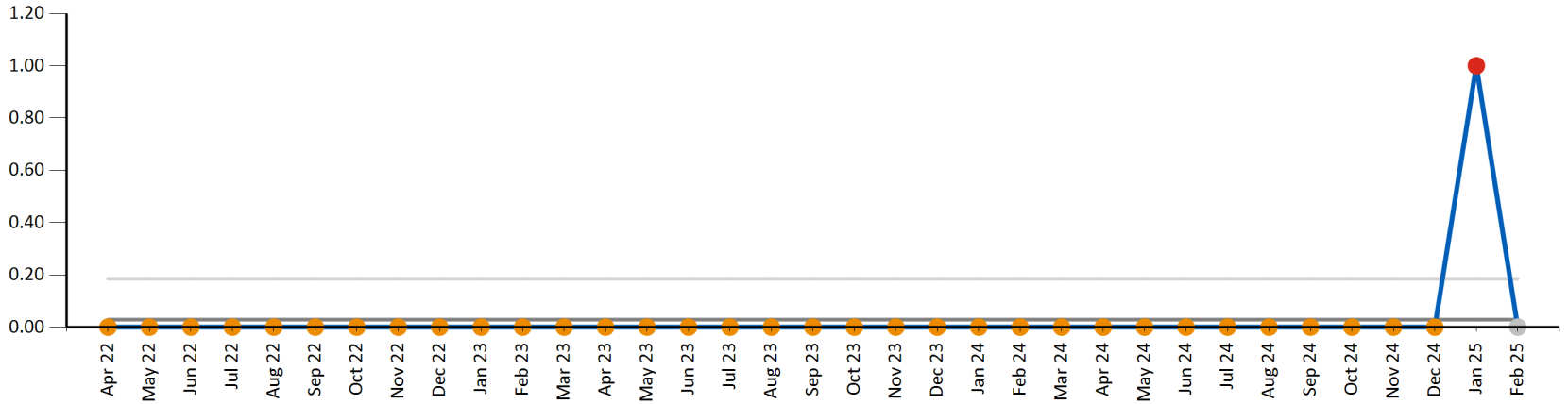
Plan	Actual	Period
	0	Jan-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-25

Previous

Plan	Actual	Period
	1	Jan-25

Year to Date

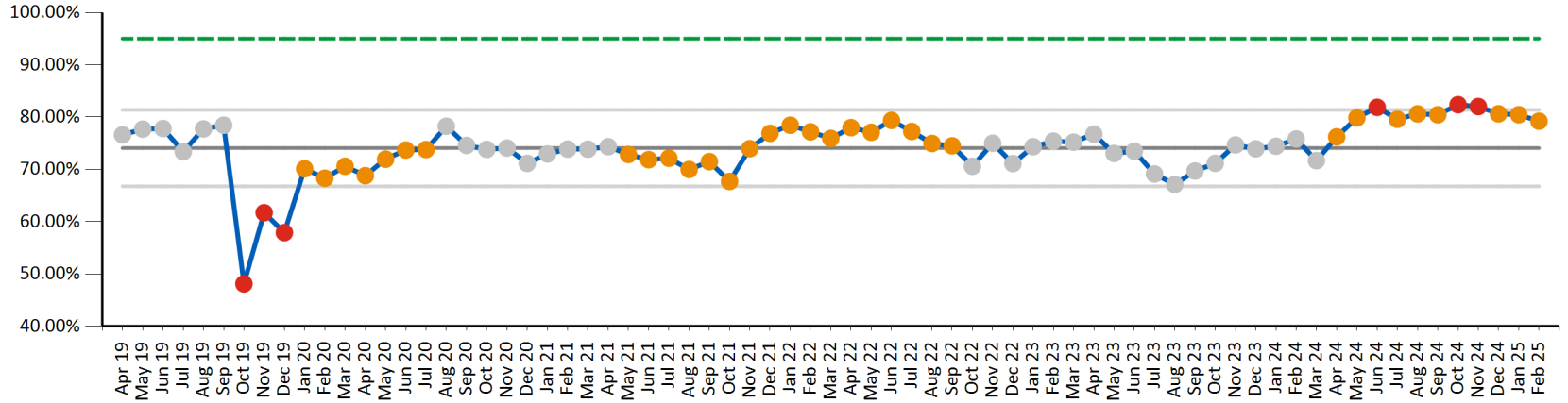
Plan	Actual
	1

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	79.2%	Feb-25

Previous

Plan	Actual	Period
>= 95%	80.4%	Jan-25

Year to Date

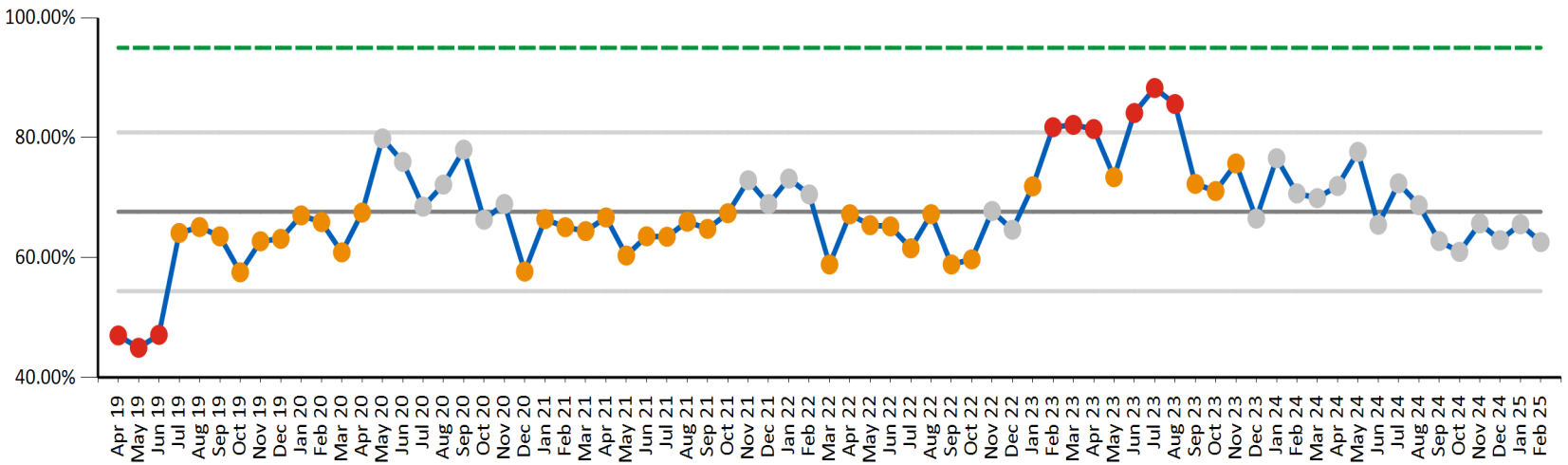
Plan	Actual
>= 95%	80.3%

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%	62.6%	Feb-25

Previous

Plan	Actual	Period
> = 95.0%	65.5%	Jan-25

Year to Date

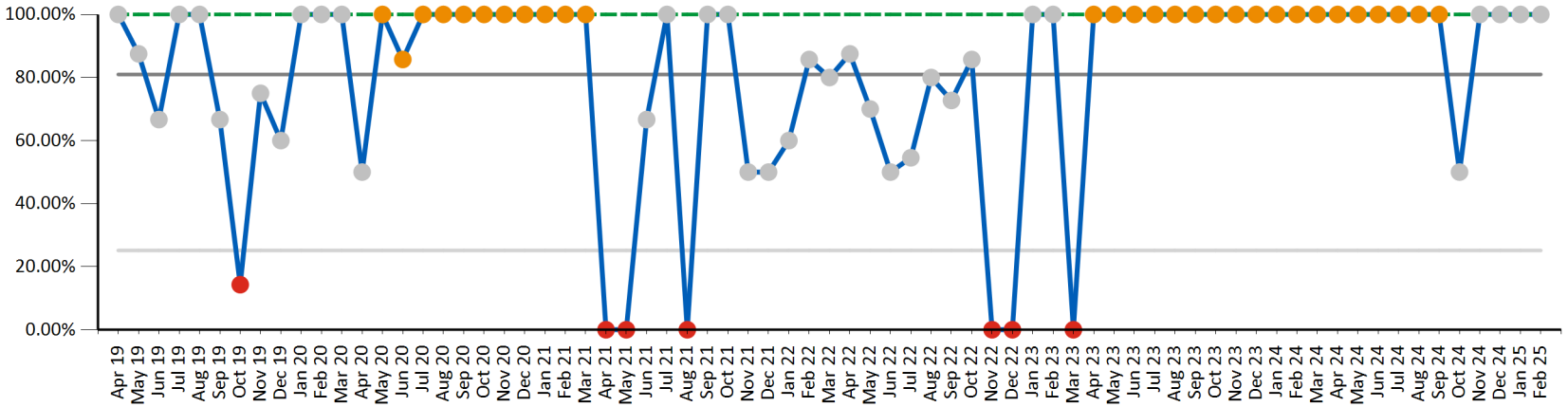
Plan	Actual
> = 95.0%	66.8%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Feb-25

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-25

Year to Date

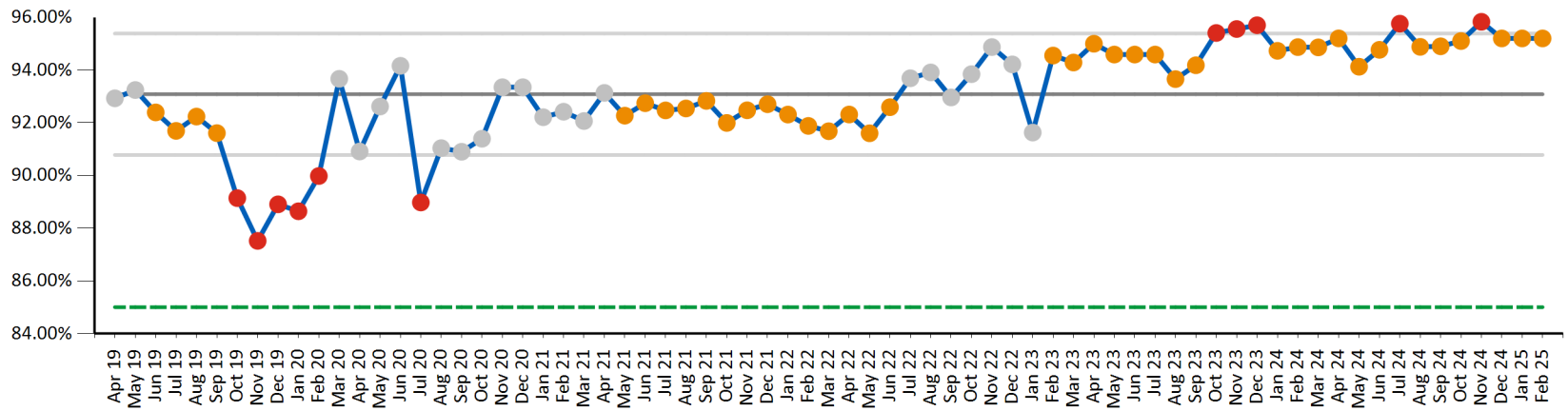
Plan	Actual
= 100%	95.5%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.2%	Feb-25

Previous

Plan	Actual	Period
>= 85%	95.2%	Jan-25

Year to Date

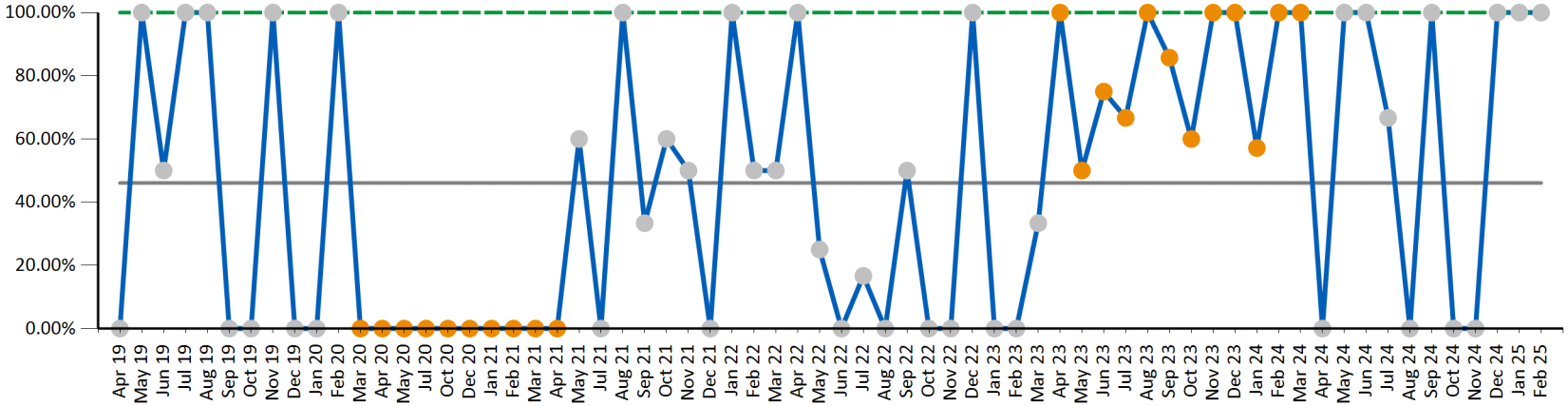
Plan	Actual
>= 85%	95.1%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	100.0%	Feb-25

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-25

Year to Date

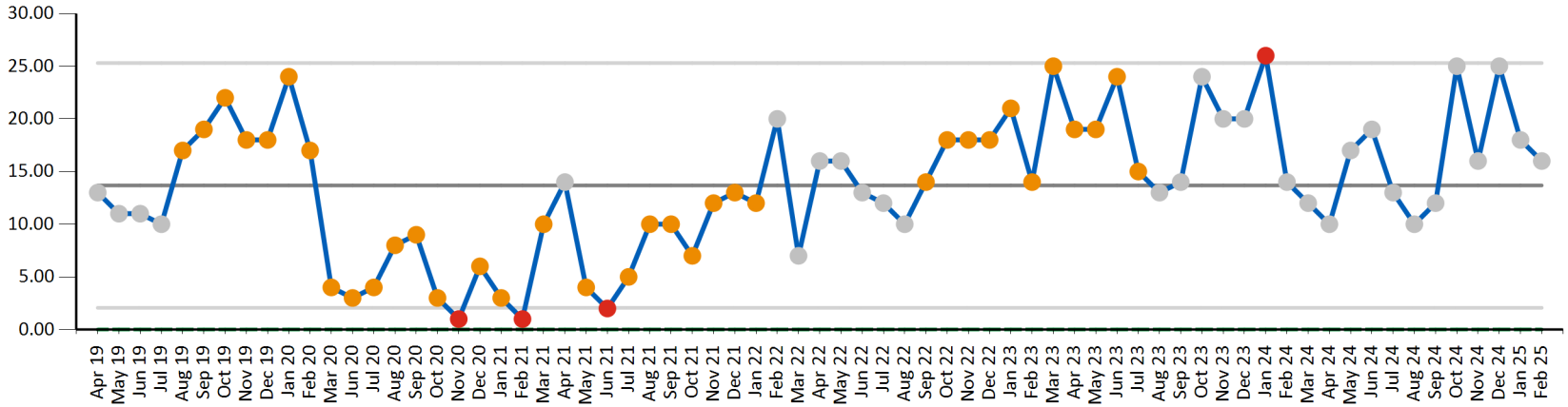
Plan	Actual
= 100%	57.1%

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	16	Feb-25

Previous

Plan	Actual	Period
= 0	18	Jan-25

Year to Date

Plan	Actual
= 0	181

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

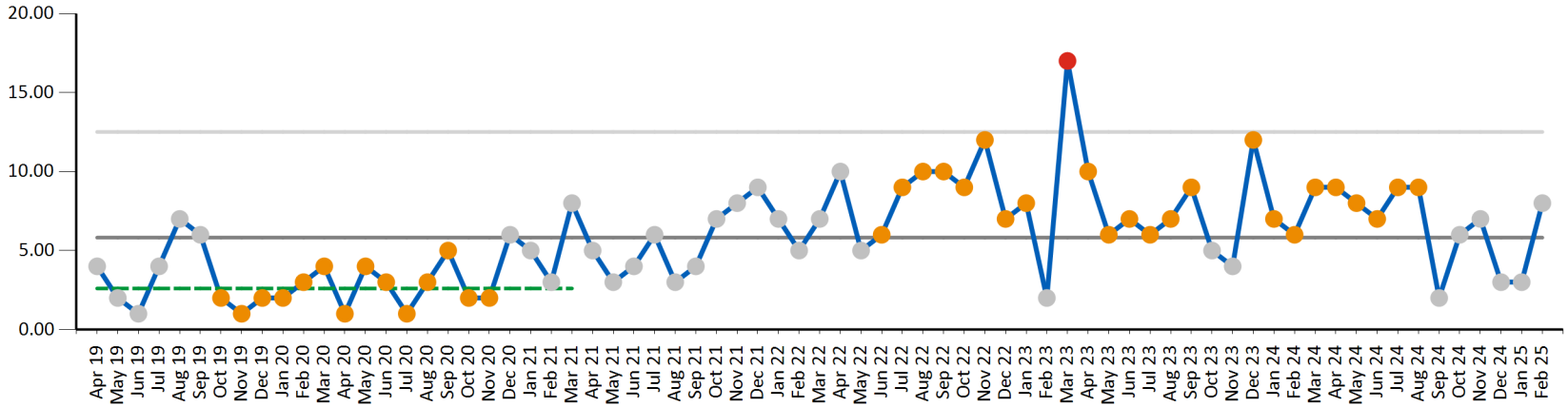
There has been an increase in CDT cases in February. This is likely to be related to two factors: 1) the impact of norovirus which has been significant and has impacted on the ability to isolate patients quickly 2) operational pressures for bed availability - again impacting on isolation capacity. The impact of norovirus has had a compounding impact on the operational pressures.

There is a clear correlation between isolation compliance and CDT performance and the operational and clinical teams are re-focussing on the control measures to get back to the 10 weeks of consistent performance seen in December and January.

	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		8	Feb-25			3	Jan-25		71	
346 - Total Community Onset Hospital Associated C.diff infections		3	Feb-25			2	Jan-25		41	
347 - Total C.diff infections contributing to objective	<= 10	11	Feb-25		<= 10	5	Jan-25	<= 109	112	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Feb-25		= 0	0	Jan-25	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	6	Feb-25		<= 5	4	Jan-25	<= 58	51	
219 - Blood Culture Contaminants (rate)	<= 3%	4.0%	Feb-25		<= 3%	2.2%	Jan-25	<= 3%	3.1%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	3.0	Feb-25		<= 1.0	1.0	Jan-25	<= 11.0	17.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Feb-25		<= 1	1	Jan-25	<= 6	19	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Feb-25		= 0	1	Jan-25	= 0	4	
491 - Nosocomial COVID-19 cases		4	Feb-25			15	Jan-25		192	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	8	Feb-25

Previous

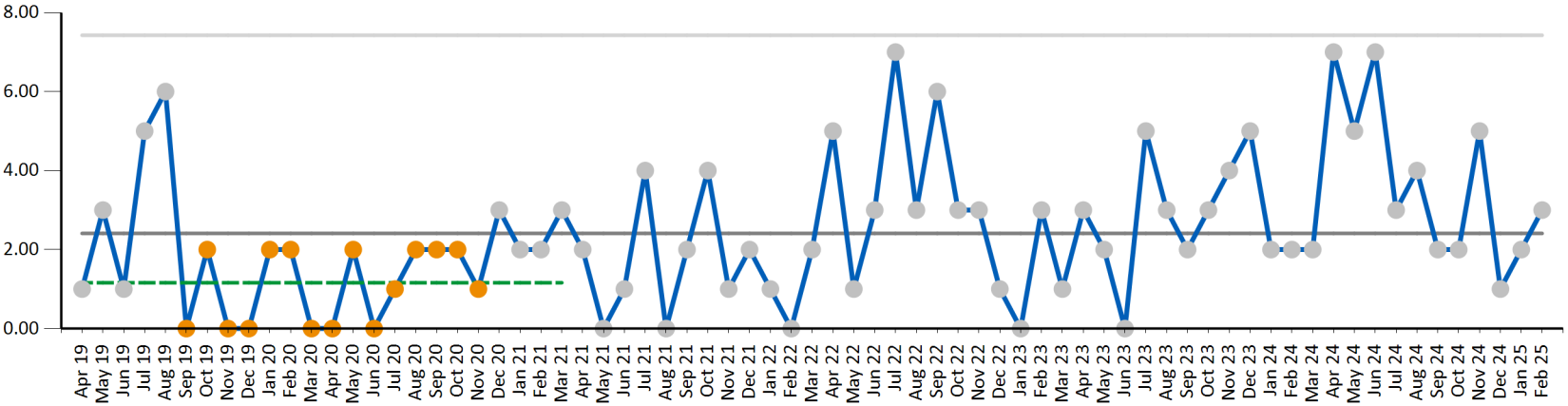
Plan	Actual	Period
	3	Jan-25

Year to Date

Plan	Actual
	71

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	3	Feb-25

Previous

Plan	Actual	Period
	2	Jan-25

Year to Date

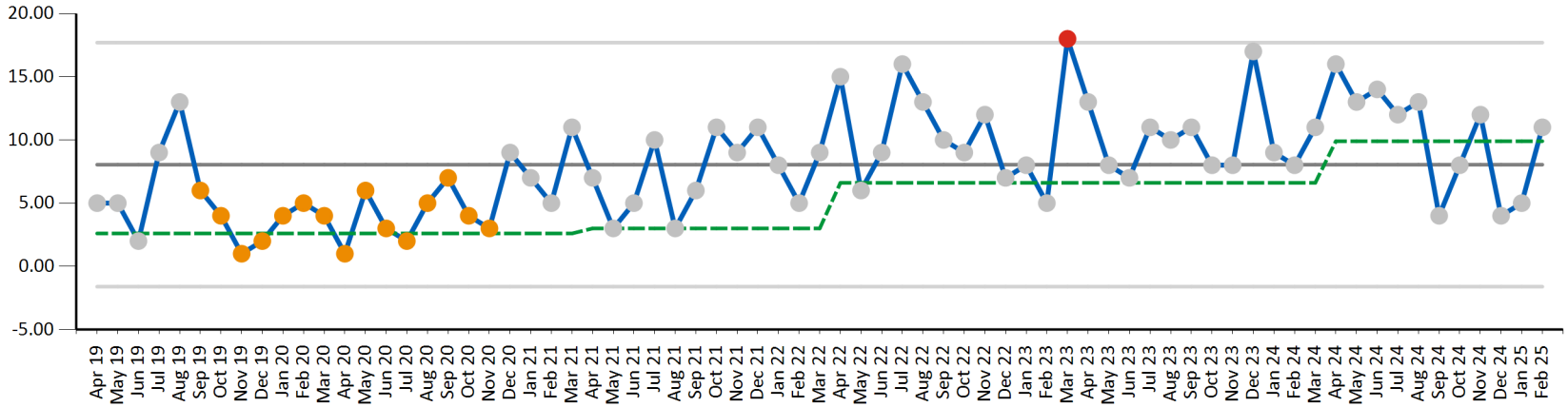
Plan	Actual
	41

347 - Total C.diff infections contributing to objective

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 10	11	Feb-25

Previous

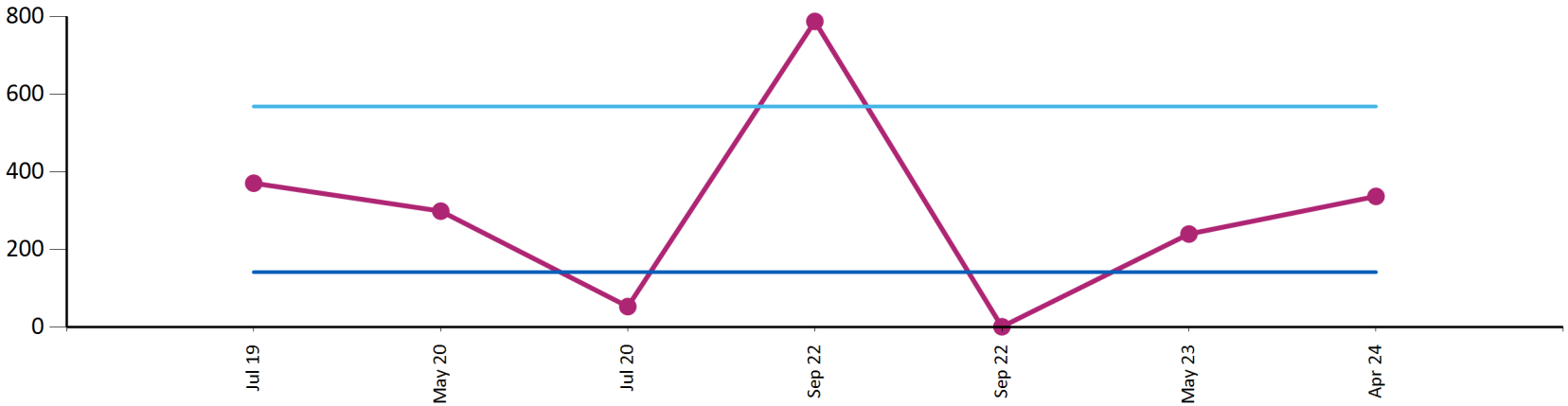
Plan	Actual	Period
<= 10	5	Jan-25

Year to Date

Plan	Actual
<= 109	112

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Feb-25

Previous

Plan	Actual	Period
	0	Jan-25

Year to Date

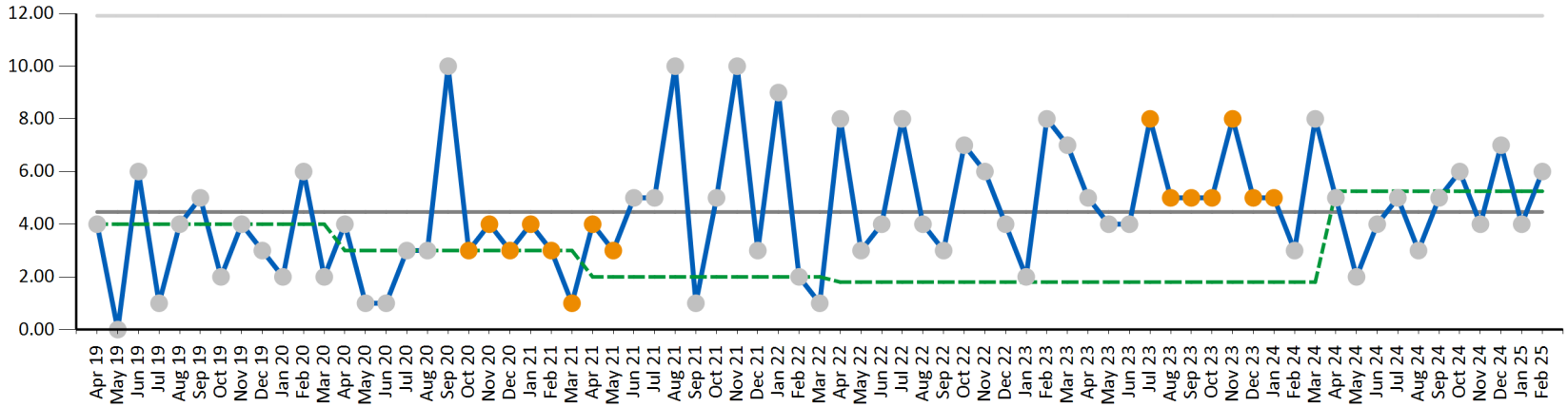
Plan	Actual

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
<= 5	6	Feb-25

Previous

Plan	Actual	Period
<= 5	4	Jan-25

Year to Date

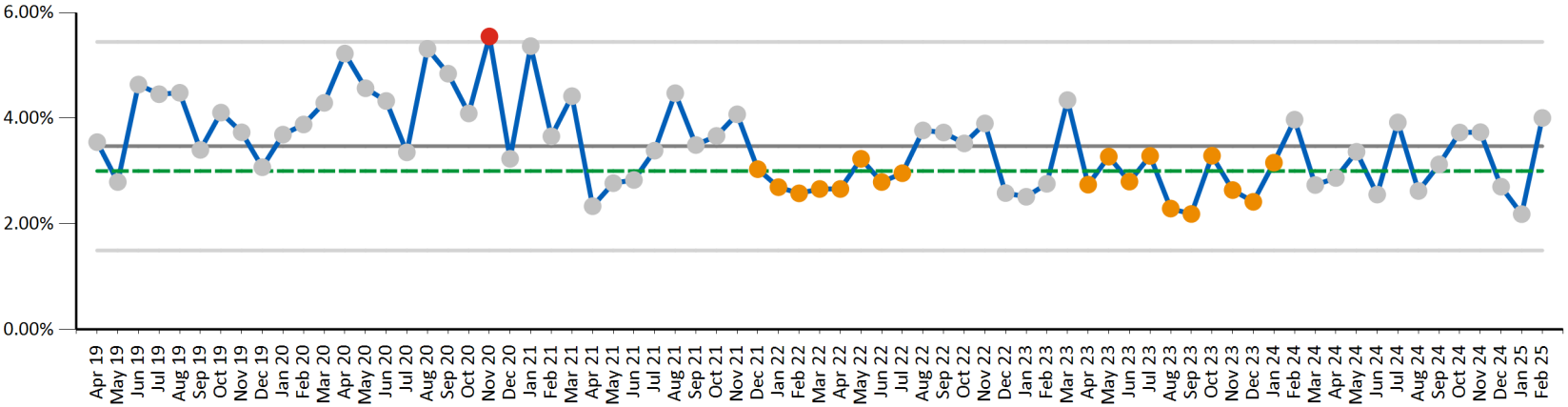
Plan	Actual
<= 58	51

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 3%	4.0%	Feb-25

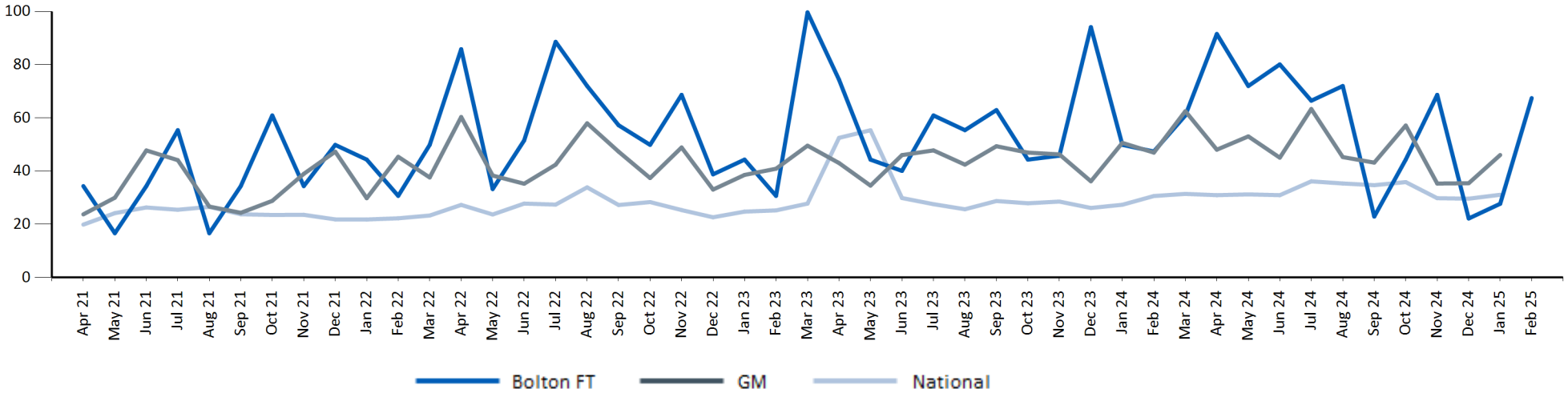
Previous

Plan	Actual	Period
<= 3%	2.2%	Jan-25

Year to Date

Plan	Actual
<= 3%	3.1%

549 - C Diff Rate Comparison

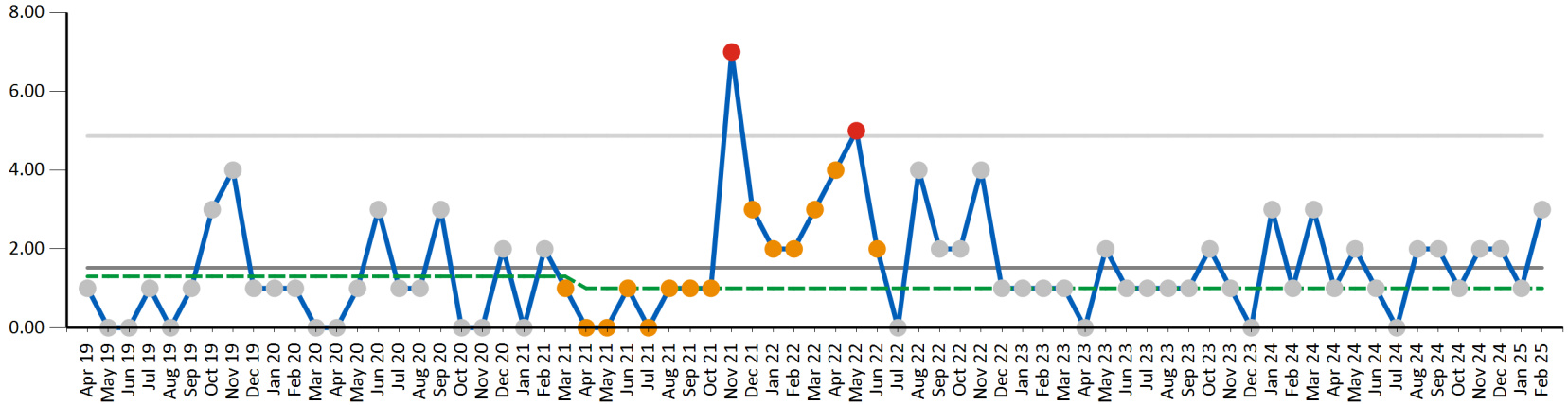


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1.0	3.0	Feb-25

Previous

Plan	Actual	Period
<= 1.0	1.0	Jan-25

Year to Date

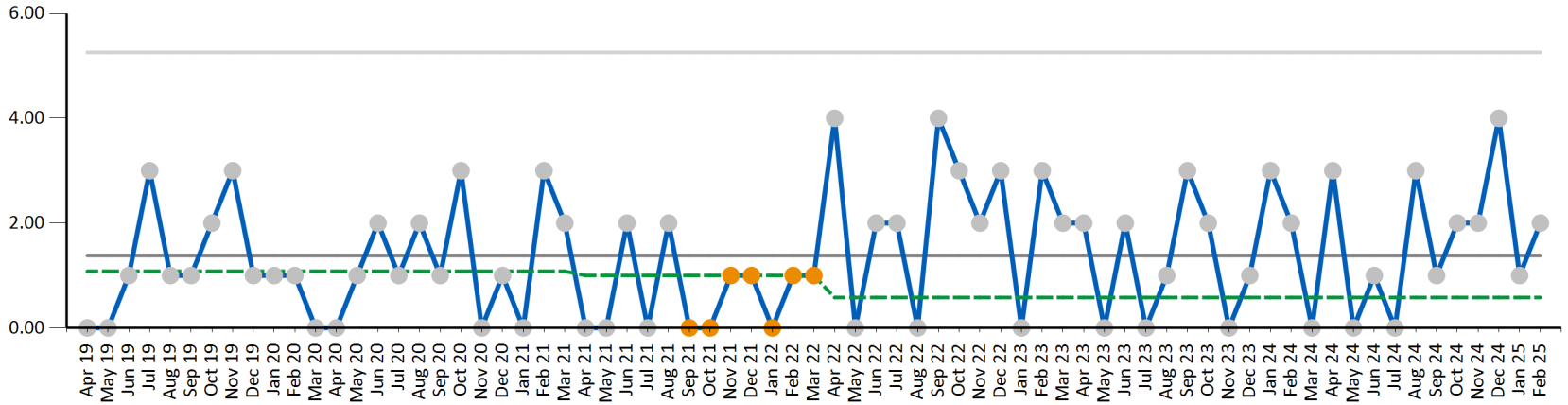
Plan	Actual
<= 11.0	17.0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1	2	Feb-25

Previous

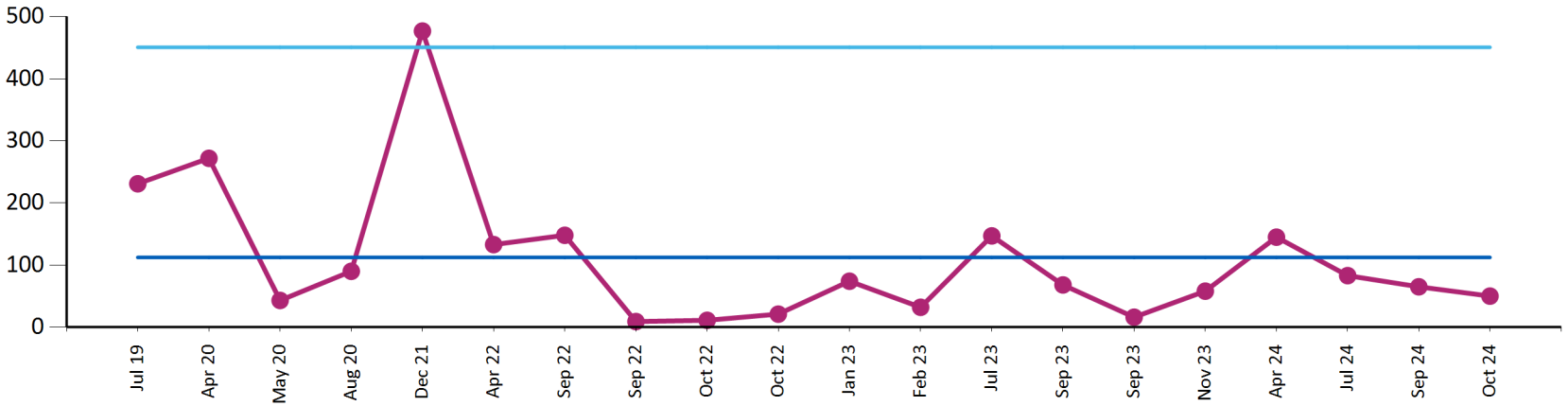
Plan	Actual	Period
<= 1	1	Jan-25

Year to Date

Plan	Actual
<= 6	19

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

0/6



Latest

Plan	Actual	Period
	0	Feb-25

Previous

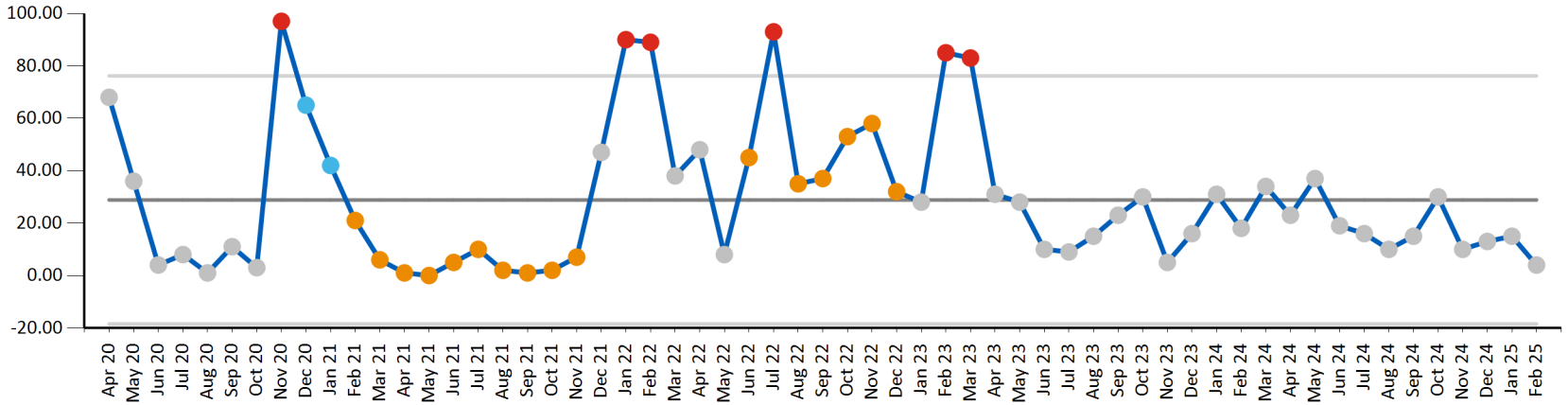
Plan	Actual	Period
	0	Jan-25

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	4	Feb-25

Previous

Plan	Actual	Period
	15	Jan-25

Year to Date

Plan	Actual
	192

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing an improvement of 13 months below the average. It has now remained in control for more than three years.

HSMR – in month figure is above the average for the period, however remains in control. The 12 month rolling average to November 2024 is 117.88 which is an 'Red' alert when compared to other Trusts.

SHMI – In month figure is just below the average for the time period and remains in control. The published rolling average for the period November 2023 to October 2024 is 118.34 which is 'higher than expected'.

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 and is in special cause being under the average for ten months. Both indicators 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 just above average.

The early neonatal mortality remains in control and has been for the timeframe.

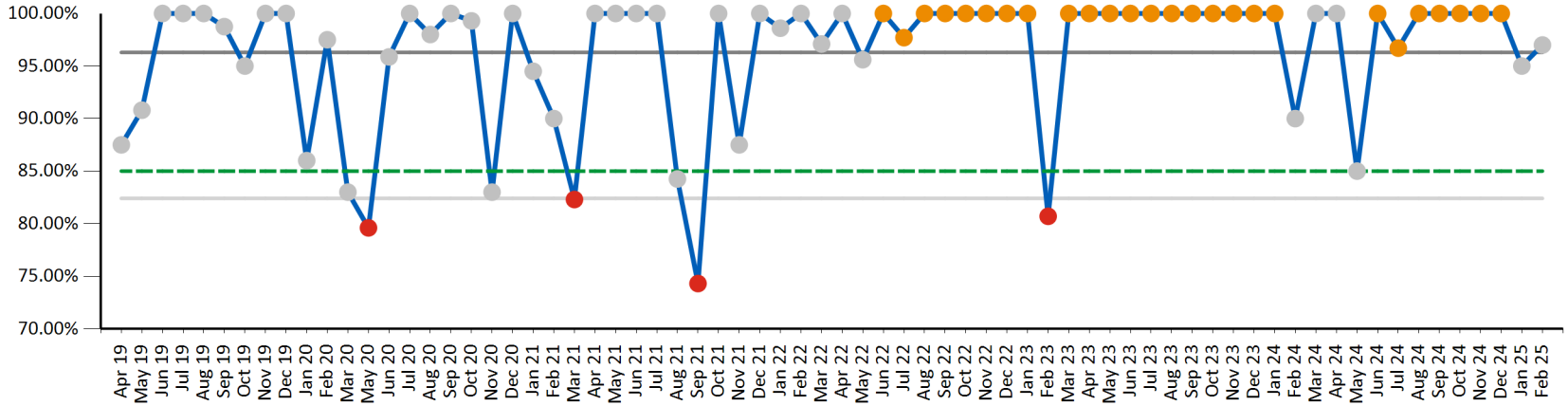
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	97.0%	Feb-25		>= 85%	95.0%	Jan-25	>= 85%	97.6%	
495 - HSMR		127.58	Oct-24			125.21	Sep-24		127.58	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	110.80	Sep-24		<= 100.00	123.26	Aug-24	<= 100.00	110.80	
12 - Crude Mortality %	<= 2.9%	2.0%	Feb-25	L	<= 2.9%	2.0%	Jan-25	<= 2.9%	2.2%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Oct-24			4	Sep-24		27	
520 - Depth of recording (First episode of care)		6	Oct-24	L		6	Sep-24		41	
521 - Proportion of fully coded records (Inpatients)		96.6%	Nov-24	H		96.6%	Oct-24		96.9%	
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		1.00	Feb-25			3.00	Jan-25			

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%	97.0%	Feb-25

Previous

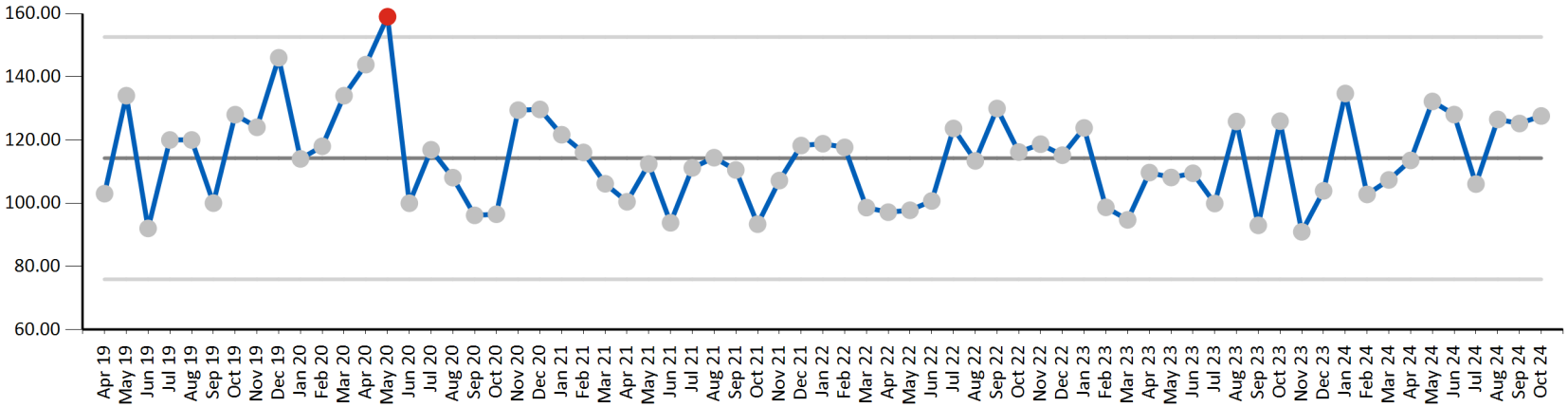
Plan	Actual	Period
>= 85%	95.0%	Jan-25

Year to Date

Plan	Actual
>= 85%	97.6%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	127.58	Oct-24

Previous

Plan	Actual	Period
	125.21	Sep-24

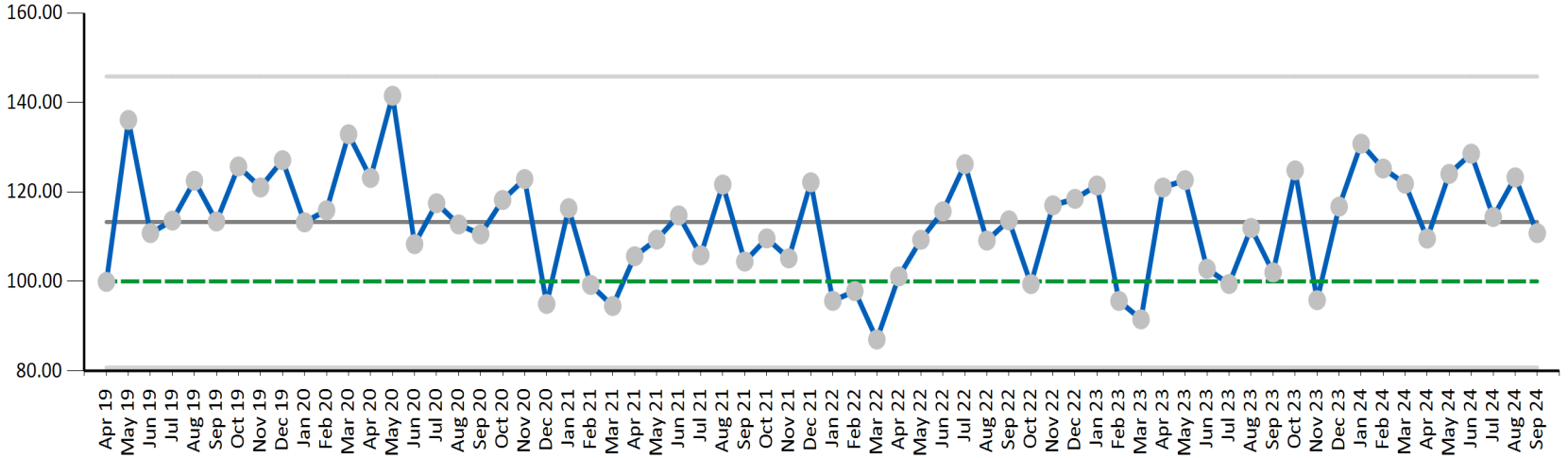
Year to Date

Plan	Actual
	127.58

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

We will not regularly meet the target due to normal variation. 0/6



Latest

Plan	Actual	Period
<= 100.00	110.80	Sep-24

Previous

Plan	Actual	Period
<= 100.00	123.26	Aug-24

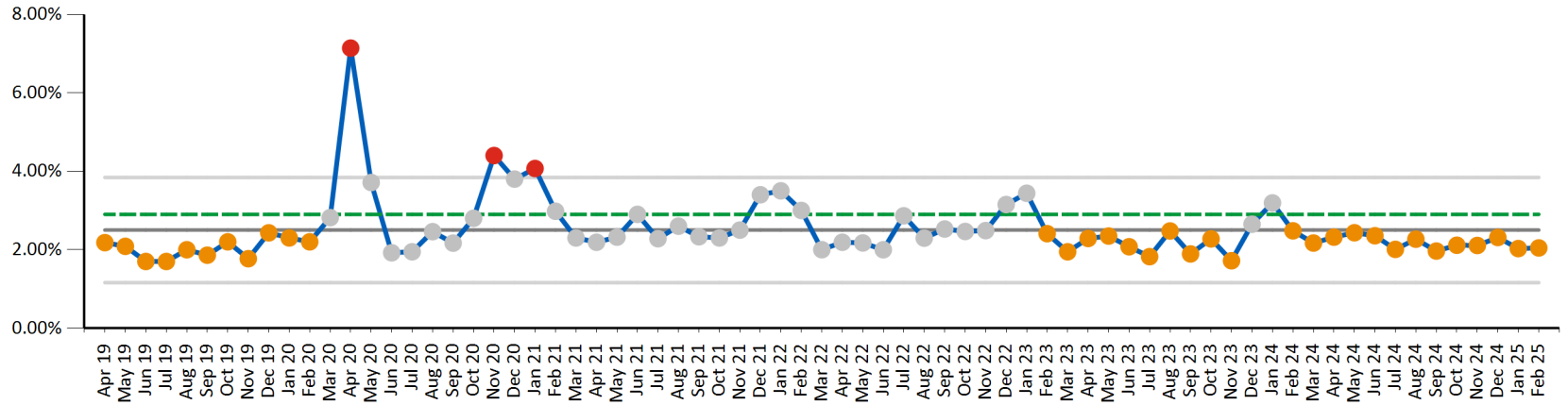
Year to Date

Plan	Actual
<= 100.00	110.80

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%	2.0%	Feb-25

Previous

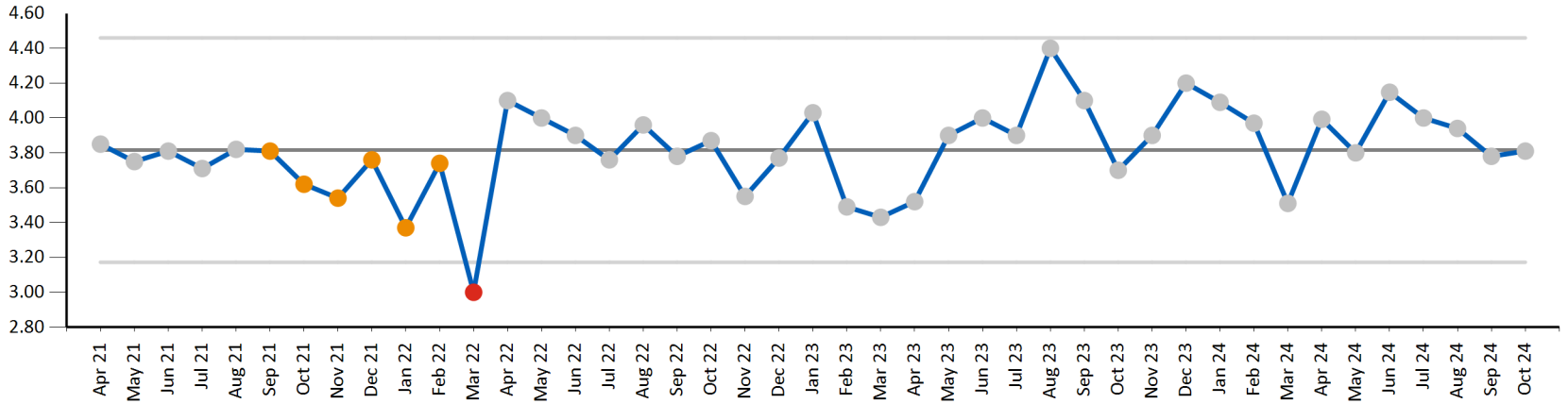
Plan	Actual	Period
<= 2.9%	2.0%	Jan-25

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	Oct-24

Previous

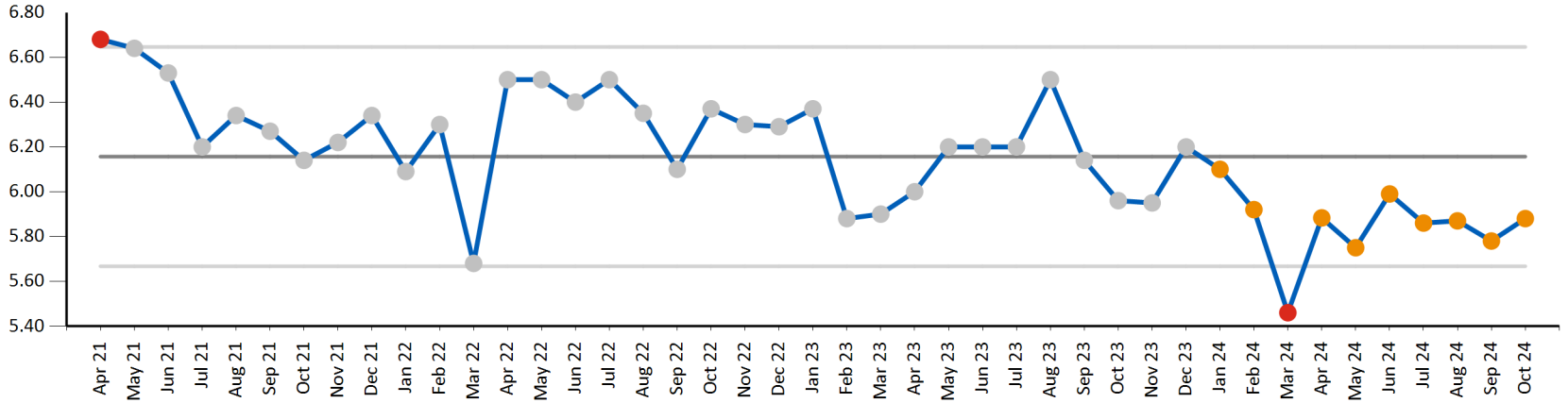
Plan	Actual	Period
	4	Sep-24

Year to Date

Plan	Actual
	27

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Oct-24

Previous

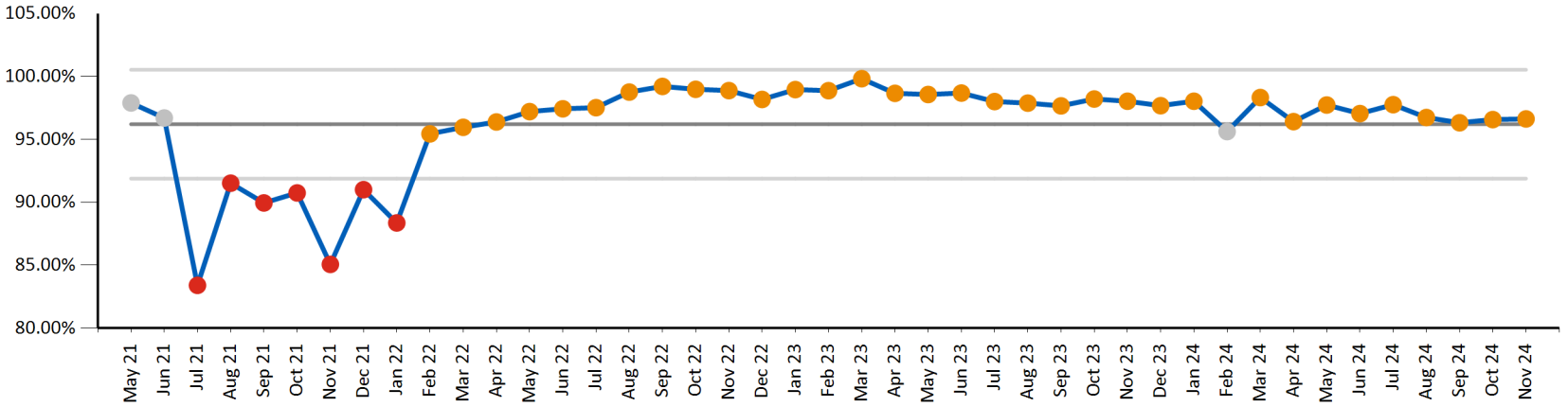
Plan	Actual	Period
	6	Sep-24

Year to Date

Plan	Actual
	41

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	96.6%	Nov-24

Previous

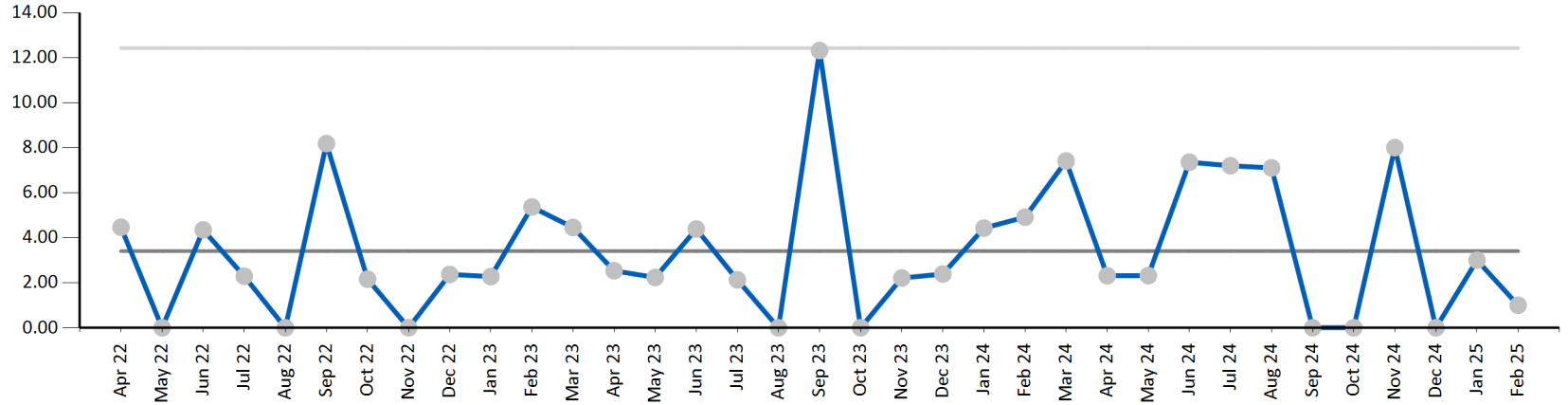
Plan	Actual	Period
	96.6%	Oct-24

Year to Date

Plan	Actual
	96.9%

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

Common cause variation.



Latest

Plan	Actual	Period
	1.00	Feb-25

Previous

Plan	Actual	Period
	3.00	Jan-25

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction Rates

Inpatient response rates show a slight increase although remain below target level, however satisfaction rates have increased and are above target. Accident and Emergency department response rates show a slight increase however satisfaction rates show a slight decrease from previous month and remain below target, but remain within common cause variation.

Maternity response and satisfaction rates continue to be above target. Antenatal response rates show a slight increase from last month however remain below the target rate. Antenatal satisfaction rates are however 100% for the fourth consecutive month. Birth response rates indicate special cause variation remaining above the target rate. However the satisfaction rate has reduced slightly from the previous month and has fallen below the target rate. Postnatal response and satisfaction rates for both hospital and community have improved from last month and are all above the target rates.

Complaint Response Rates

The Complaints response compliance rates remain within common cause variation however below target.

In February 2025 there were six complaint responses due. Five responses were provided within timeframe. The complaint response that breached the target response date was in AACD; this response is currently with the division for final amendments prior to CEO approval.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.0%	Feb-25		>= 20%	13.7%	Jan-25	>= 20%	14.6%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	83.4%	Feb-25		>= 90%	86.1%	Jan-25	>= 90%	85.2%	
80 - Inpatient Friends and Family Response Rate	>= 30%	25.4%	Feb-25		>= 30%	23.4%	Jan-25	>= 30%	27.4%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.2%	Feb-25		>= 90%	95.3%	Jan-25	>= 90%	95.6%	
81 - Maternity Friends and Family Response Rate	>= 15%	24.0%	Feb-25		>= 15%	51.8%	Jan-25	>= 15%	24.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	92.8%	Feb-25		>= 90%	94.2%	Jan-25	>= 90%	92.4%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	12.6%	Feb-25		>= 15%	10.1%	Jan-25	>= 15%	8.0%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Feb-25		>= 90%	100.0%	Jan-25	>= 90%	95.5%	

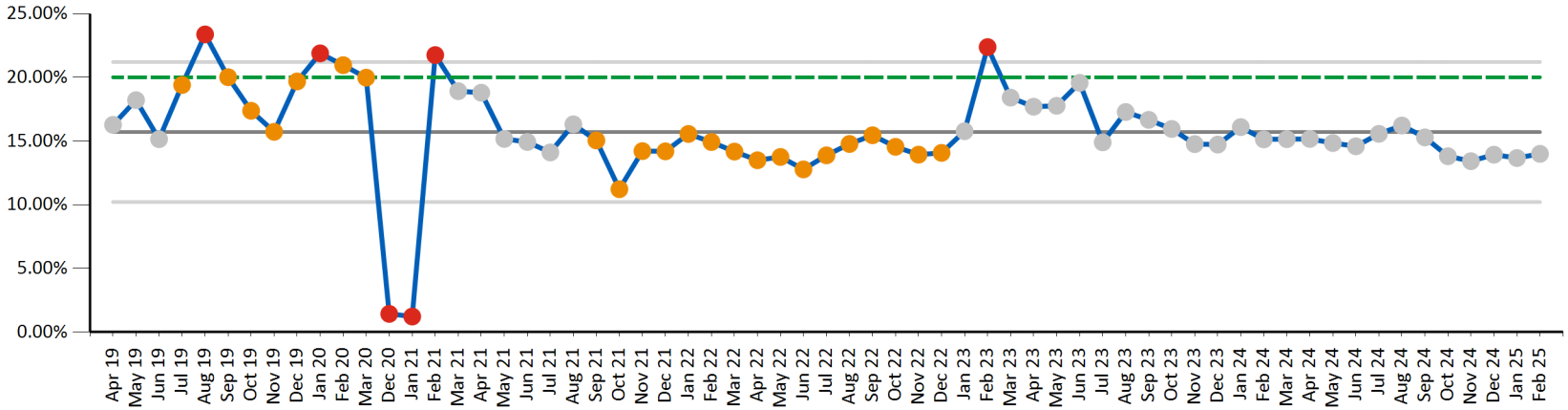
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
83 - Birth - Friends and Family Response Rate	>= 15%	44.4%	Feb-25	H	>= 15%	127.0%	Jan-25	>= 15%	47.9%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.2%	Feb-25		>= 90%	95.0%	Jan-25	>= 90%	92.1%	?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	16.0%	Feb-25		>= 15%	30.4%	Jan-25	>= 15%	26.8%	?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	91.2%	Feb-25		>= 90%	88.2%	Jan-25	>= 90%	91.2%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	22.3%	Feb-25		>= 15%	27.5%	Jan-25	>= 15%	17.0%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	95.4%	Feb-25		>= 90%	92.1%	Jan-25	>= 90%	91.4%	?
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Feb-25		= 100%	100.0%	Jan-25	= 100%	98.5%	?
90 - Complaints responded to within the period	>= 95%	83.3%	Feb-25		>= 95%	52.4%	Jan-25	>= 95%	72.1%	?

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	14.0%	Feb-25

Previous

Plan	Actual	Period
>= 20%	13.7%	Jan-25

Year to Date

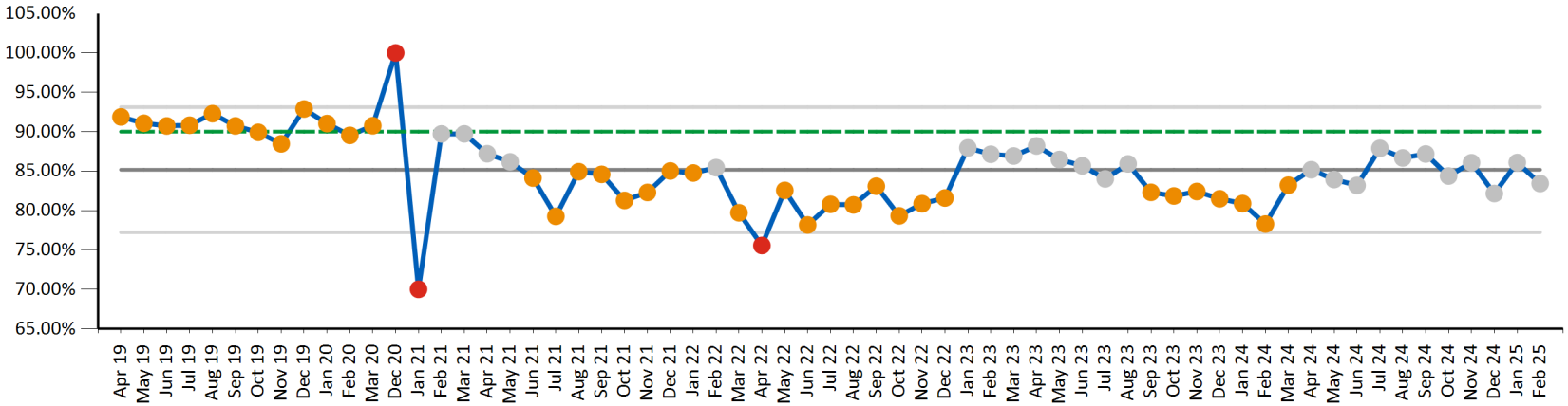
Plan	Actual
>= 20%	14.6%

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%	83.4%	Feb-25

Previous

Plan	Actual	Period
>= 90%	86.1%	Jan-25

Year to Date

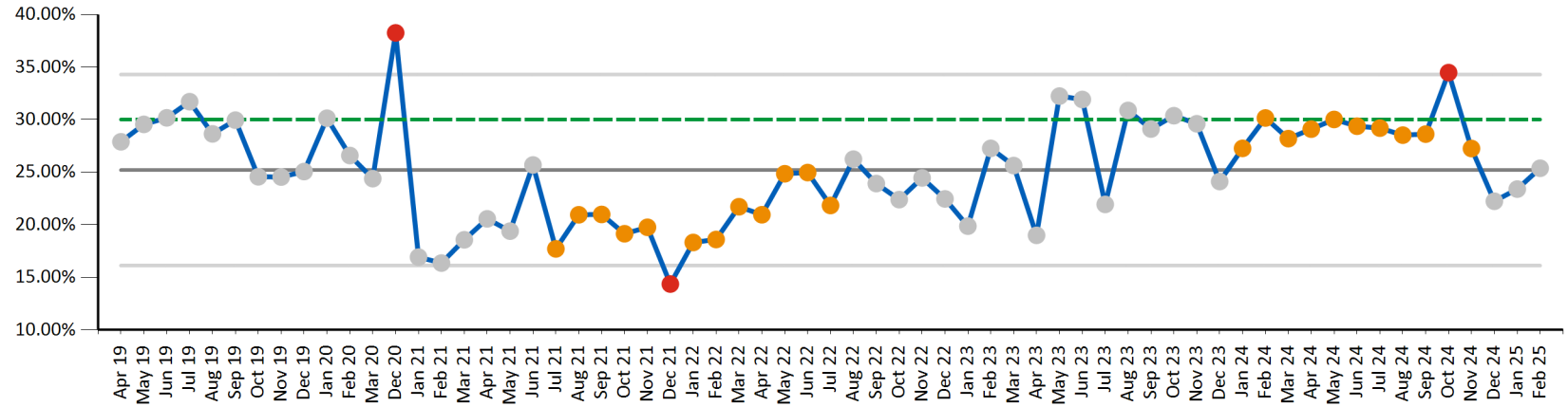
Plan	Actual
>= 90%	85.2%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 30%	25.4%	Feb-25

Previous

Plan	Actual	Period
>= 30%	23.4%	Jan-25

Year to Date

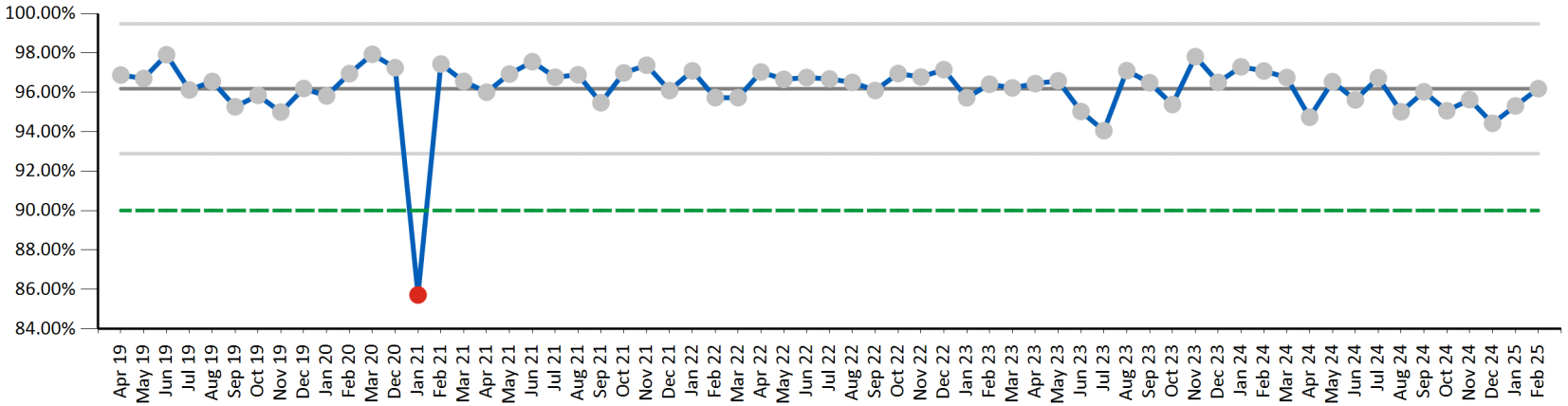
Plan	Actual
>= 30%	27.4%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	96.2%	Feb-25

Previous

Plan	Actual	Period
>= 90%	95.3%	Jan-25

Year to Date

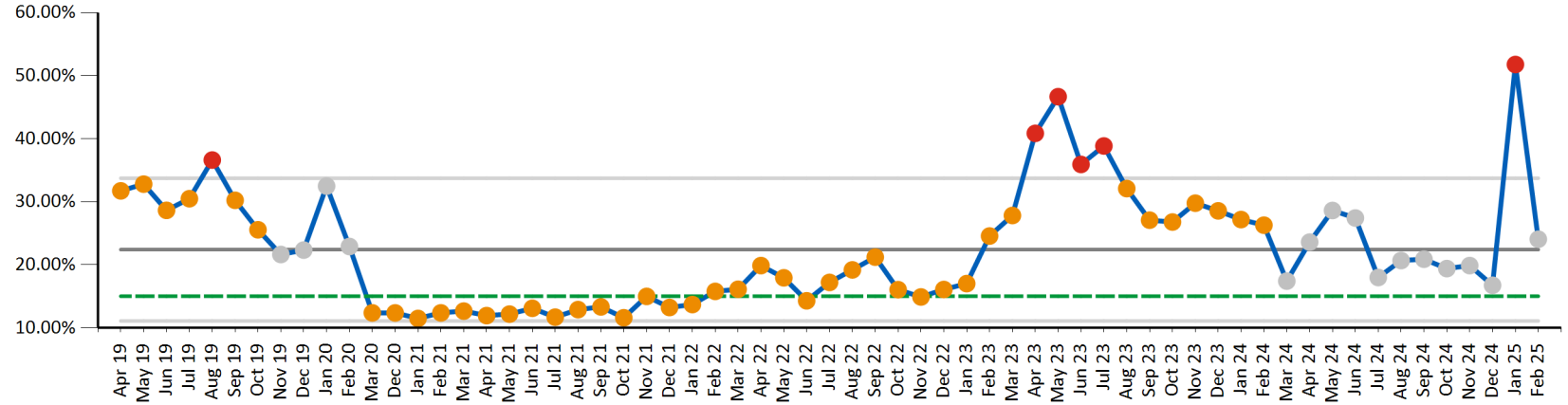
Plan	Actual
>= 90%	95.6%

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%	24.0%	Feb-25

Previous

Plan	Actual	Period
>= 15%	51.8%	Jan-25

Year to Date

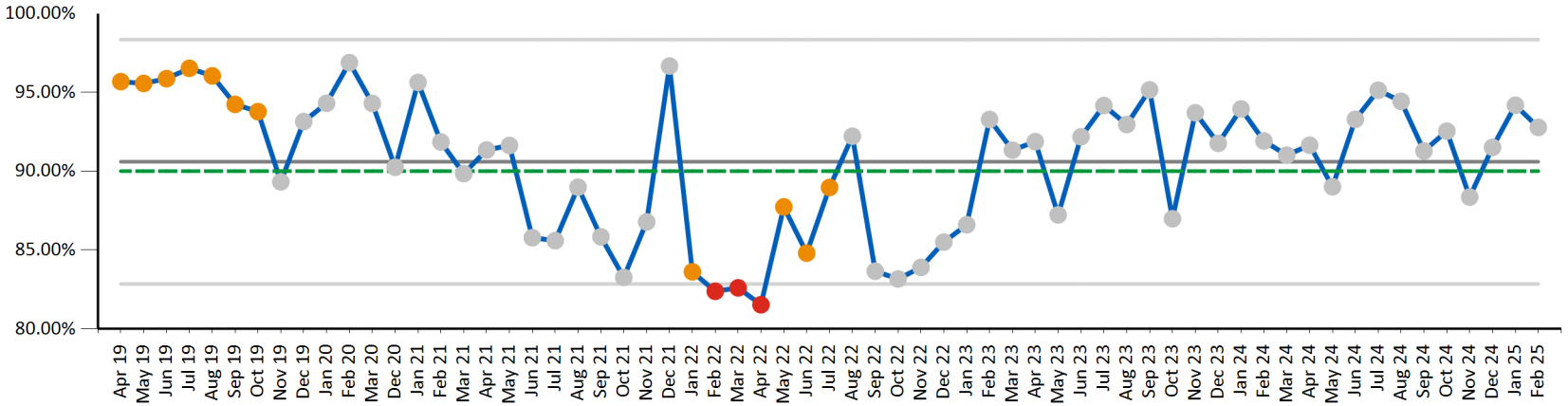
Plan	Actual
>= 15%	24.6%

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%	92.8%	Feb-25

Previous

Plan	Actual	Period
>= 90%	94.2%	Jan-25

Year to Date

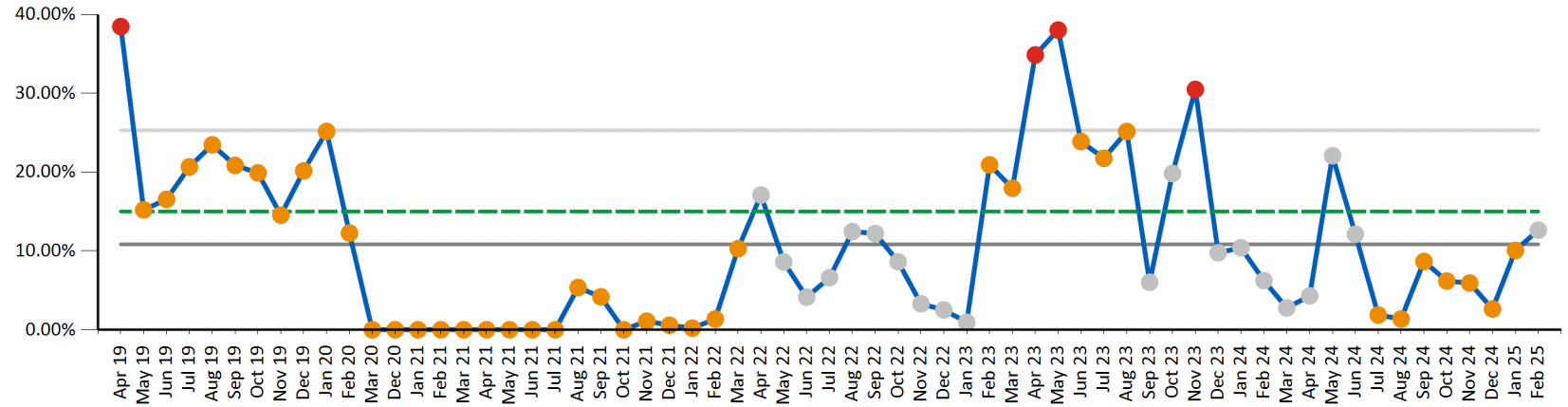
Plan	Actual
>= 90%	92.4%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 15%	12.6%	Feb-25

Previous

Plan	Actual	Period
>= 15%	10.1%	Jan-25

Year to Date

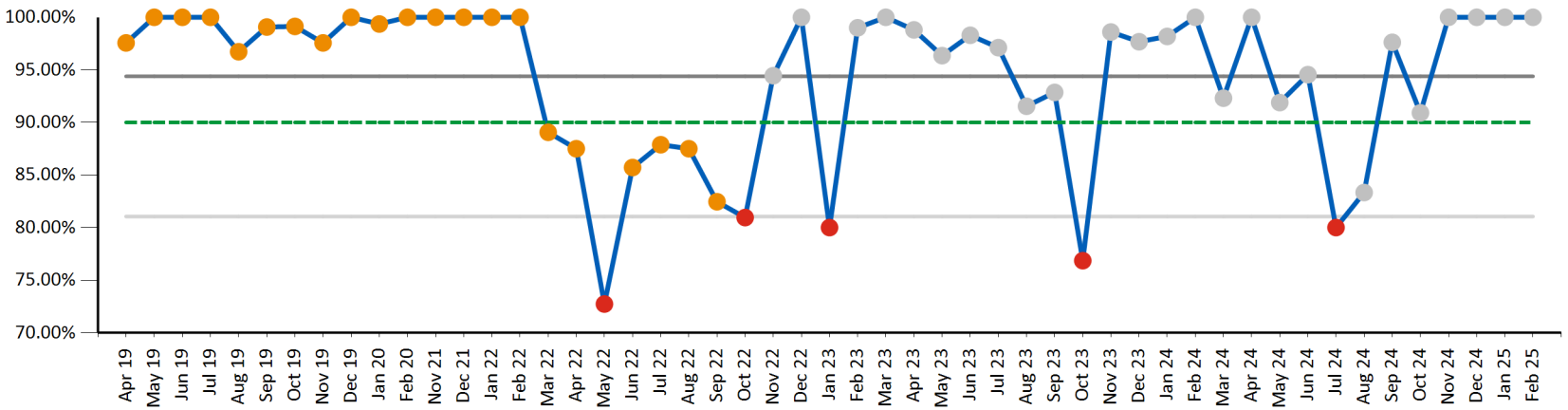
Plan	Actual
>= 15%	8.0%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	100.0%	Feb-25

Previous

Plan	Actual	Period
>= 90%	100.0%	Jan-25

Year to Date

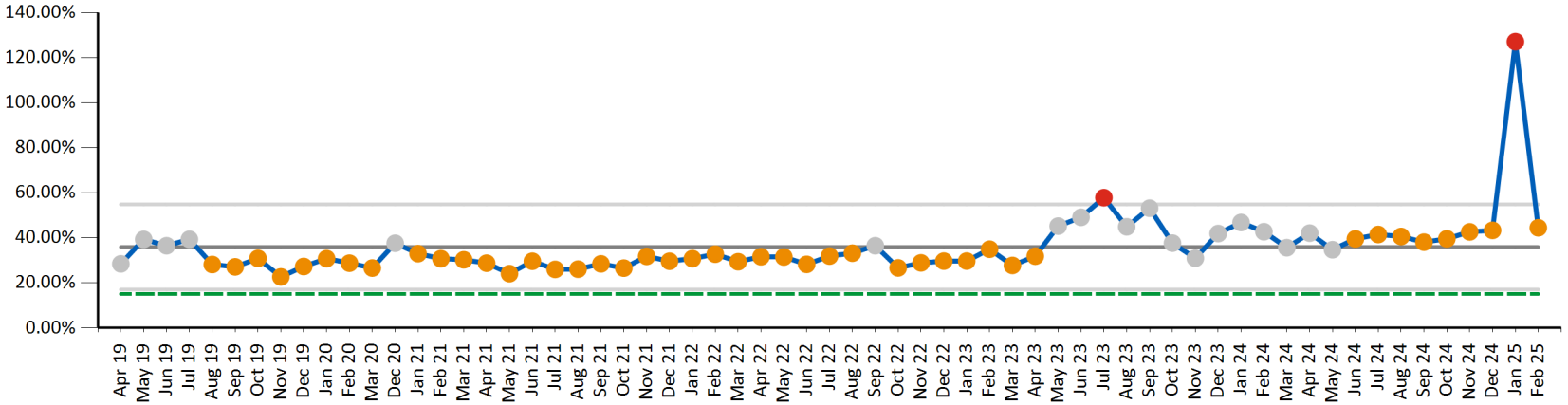
Plan	Actual
>= 90%	95.5%

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%	44.4%	Feb-25

Previous

Plan	Actual	Period
>= 15%	127.0%	Jan-25

Year to Date

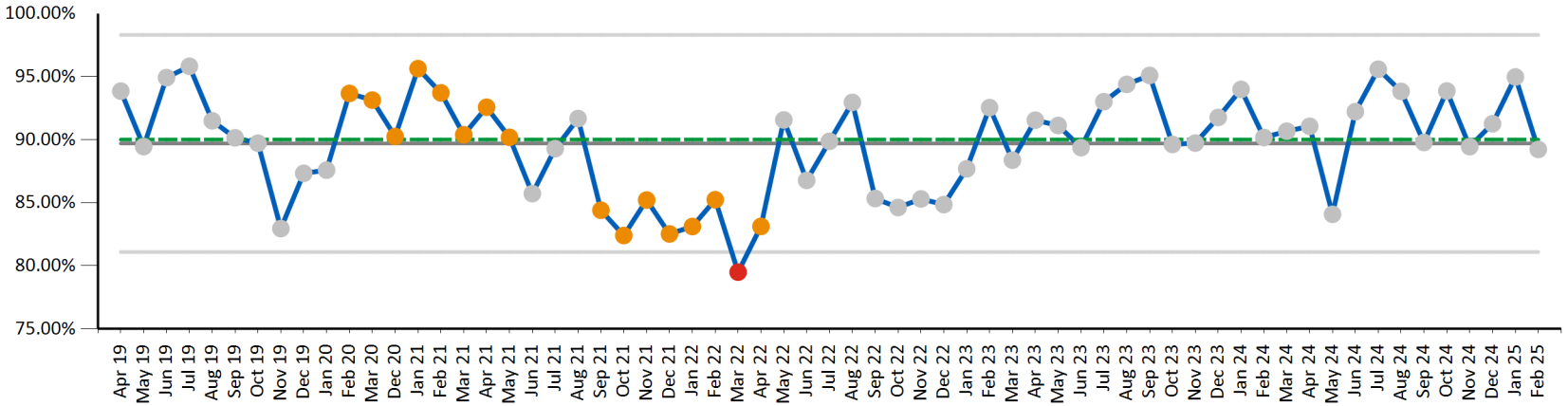
Plan	Actual
>= 15%	47.9%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90%	89.2%	Feb-25

Previous

Plan	Actual	Period
>= 90%	95.0%	Jan-25

Year to Date

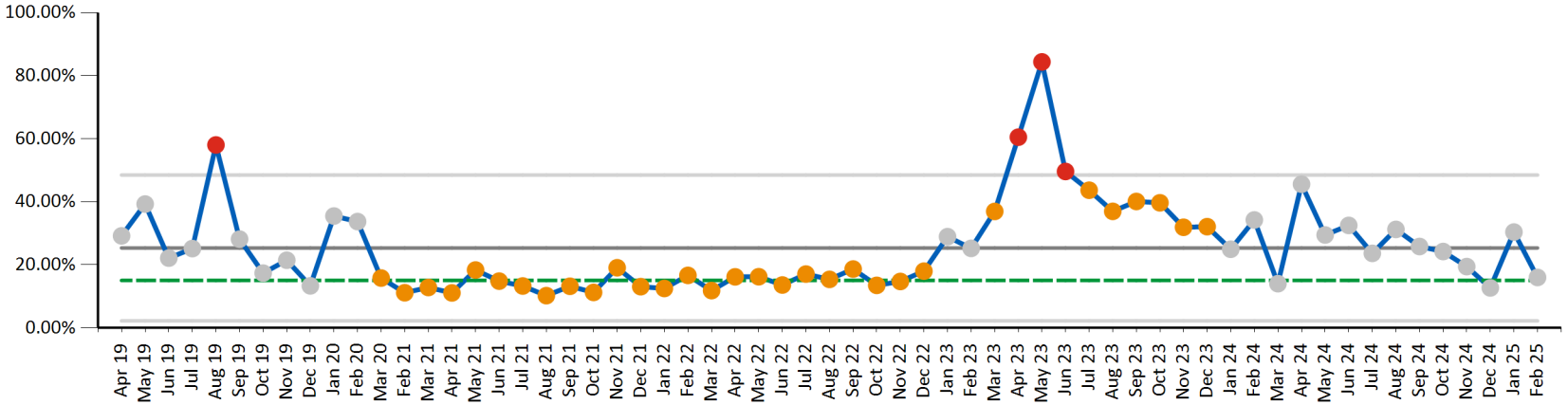
Plan	Actual
>= 90%	92.1%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	16.0%	Feb-25

Previous

Plan	Actual	Period
>= 15%	30.4%	Jan-25

Year to Date

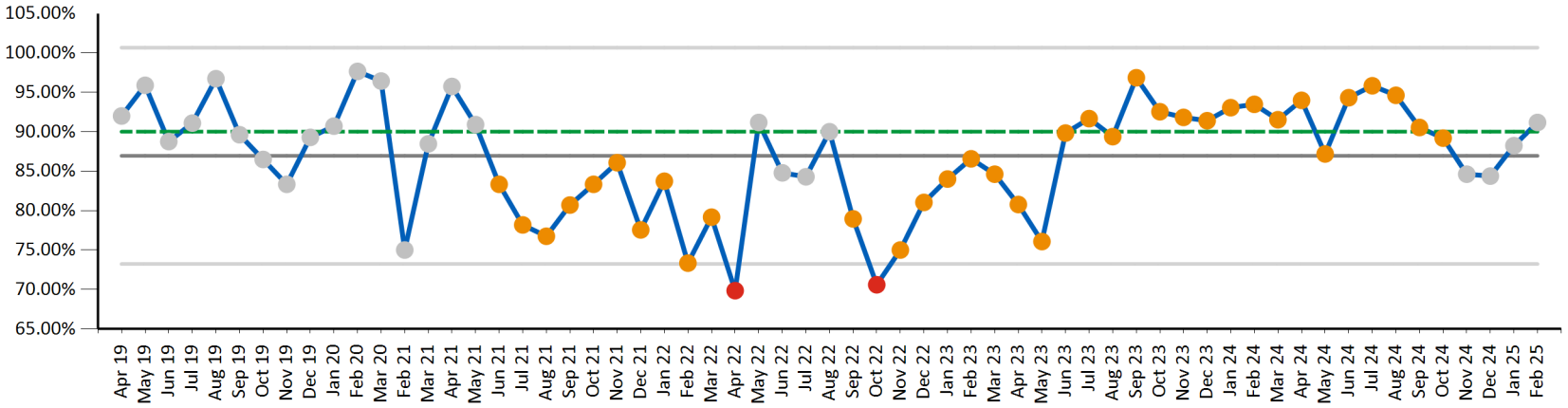
Plan	Actual
>= 15%	26.8%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90%	91.2%	Feb-25

Previous

Plan	Actual	Period
>= 90%	88.2%	Jan-25

Year to Date

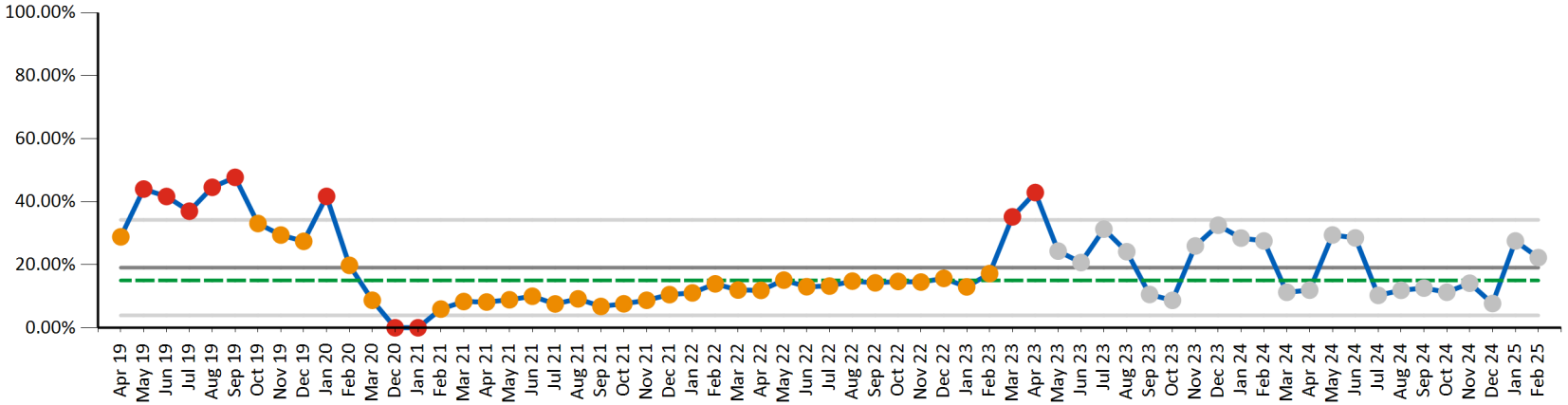
Plan	Actual
>= 90%	91.2%

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%	22.3%	Feb-25

Previous

Plan	Actual	Period
>= 15%	27.5%	Jan-25

Year to Date

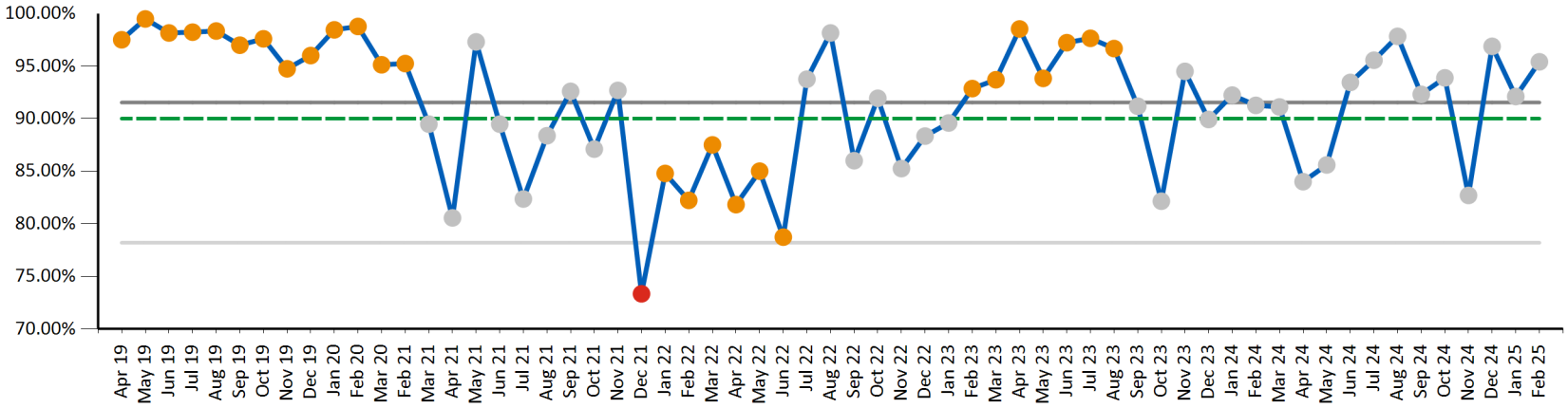
Plan	Actual
>= 15%	17.0%

245 - Community Postnatal 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%	95.4%	Feb-25

Previous

Plan	Actual	Period
>= 90%	92.1%	Jan-25

Year to Date

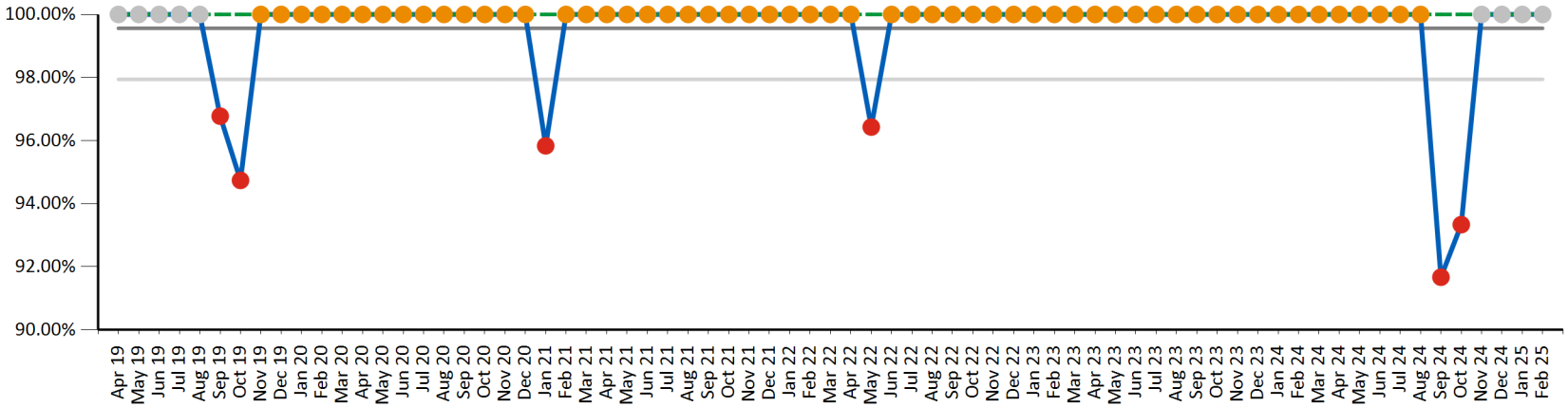
Plan	Actual
>= 90%	91.4%

89 - Formal complaints acknowledged within 3 working days

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	100.0%	Feb-25

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-25

Year to Date

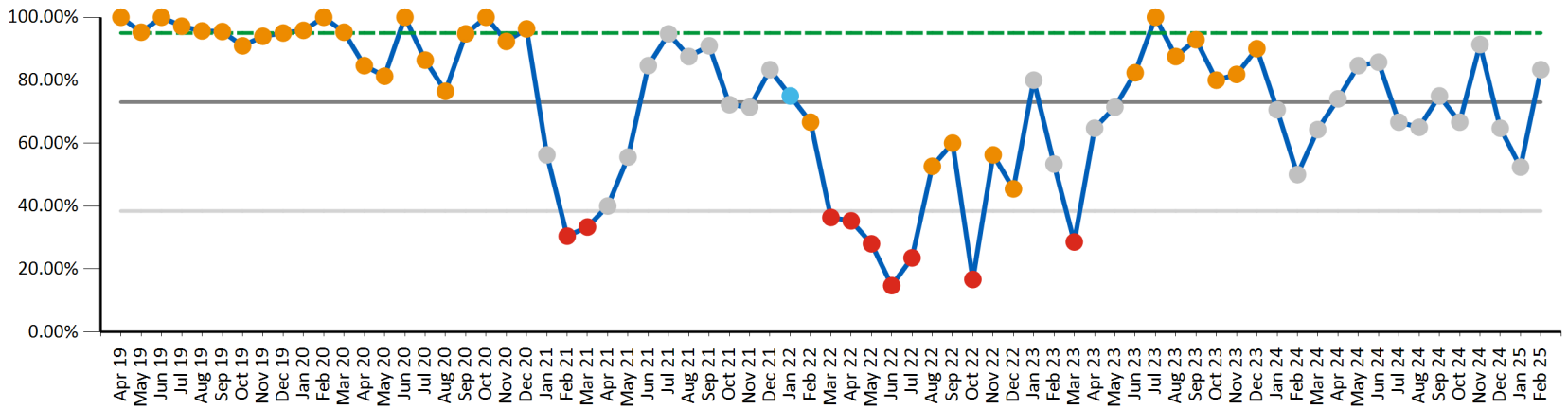
Plan	Actual
= 100%	98.5%

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%	83.3%	Feb-25

Previous

Plan	Actual	Period
>= 95%	52.4%	Jan-25

Year to Date

Plan	Actual
>= 95%	72.1%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family Response Rate – Response rate had decreased from astronomical point in February 2025 to 24% - stabilisation of rate anticipated. Areas of ongoing focus continue to be the antenatal settings and action plan in place. Overall maternity satisfaction rate in month 92.8%.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Incidence 0/1000 births in February 2025. Training has commenced to implement the REACH (involves 8-10 pregnant women who live close together having their antenatal care and education in a community setting together) pregnancy circles in areas of high deprivation with a focus on the pregnant cohort between 24-27 weeks gestation as per findings of recent annual stillbirth report. The REACH project pilot will be focussed on the areas of deprivation in Bolton highlighted in the annual review of cases. Trust findings presented at regional perinatal forum in March 2024 and a further update will be presented to Quality Assurance Committee in July 2025.

¾ degree tears – There has been a sustained rate of 3.8% in month and a decrease in GM average rate over last 12 months at 2.81/1000. Recruitment to recurrently funded posts to establish a GMEC perinatal pelvic health service is ongoing. The service will serve population of Bolton and receive referrals from other Trusts which will be a new local maternity system offer led by the Bolton maternity team.

1:1 care in labour – Slight improvement in rate at 97.8% within month. Action plan in place as per CNST requirements.

Booked by 12+6 is a clinical indicator relating to the timing of the initial antenatal booking visit that ensures women access care in a timely way and are still in a position to have a scan and antenatal screening blood tests taken. Common cause variation noted in January 2025 with 84.3% reported in February 2025.

Booked by 10 weeks (target reflects bookings by 10+0 gestation as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact). Operational focus ongoing to address the issues identified with booking of the initial appointment. Trust performance 50.1% reported in February 2025.

Inductions of labour delayed by >24 hours – 32% of induction of labour cases were delayed by 24 hours in February 2025 – this is noted to be a common cause variation in the statistical process chart evaluation. Quality improvement project time frame for completion is September 2025. Overall reduction noted since introduction of Flow Co-ordinator in service.

Breastfeeding initiation – Slight improvement noted in incidence in month to 74.6%. Service has a plan in place to attain Baby Friendly stage 2 status by September 2025.

Preterm birth (less than 37 weeks gestation) – Common cause variation in preterm incidence within month reported to 9.1% from 11.5% last month. Awaiting audit proforma to be shared from peer maternity provider (Northern Care Alliance) who have reduced their rate following a detailed analysis of their cases of induction of labour which highlighted early induction of labour this was impacting on their preterm rate.

	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	0.00	Feb-25		<= 3.50	11.99	Jan-25	<= 3.50	4.54	

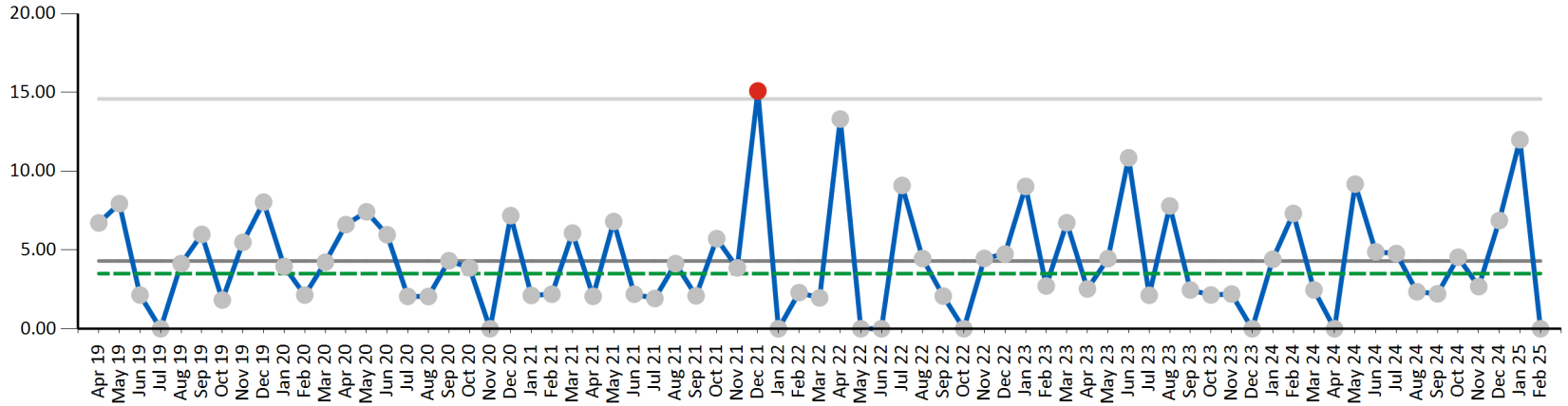
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
23 - Maternity -3rd/4th degree tears	<= 3.5%	3.8%	Feb-25		<= 3.5%	3.5%	Jan-25	<= 3.5%	2.8%	
202 - 1:1 Midwifery care in labour	>= 95.0%	97.8%	Feb-25		>= 95.0%	97.3%	Jan-25	>= 95.0%	98.6%	
203 - Booked 12+6	>= 90.0%	84.3%	Feb-25		>= 90.0%	85.1%	Jan-25	>= 90.0%	87.6%	
586 - Booked 10+0		50.1%	Feb-25			49.7%	Jan-25		53.9%	
204 - Inductions of labour - over 24 hours	<= 40%	32.0%	Feb-25		<= 40%	38.6%	Jan-25	<= 40%	33.3%	
210 - Initiation breast feeding	>= 65%	74.60%	Feb-25		>= 65%	70.47%	Jan-25	>= 65%	69.74%	
213 - Maternity complaints	<= 5	0	Feb-25		<= 5	0	Jan-25	<= 55	10	
319 - Maternal deaths (direct)	= 0	1	Feb-25		= 0	0	Jan-25	= 0	1	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.1%	Feb-25		<= 6%	11.5%	Jan-25	<= 6%	9.2%	

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	0.00	Feb-25

Previous

Plan	Actual	Period
<= 3.50	11.99	Jan-25

Year to Date

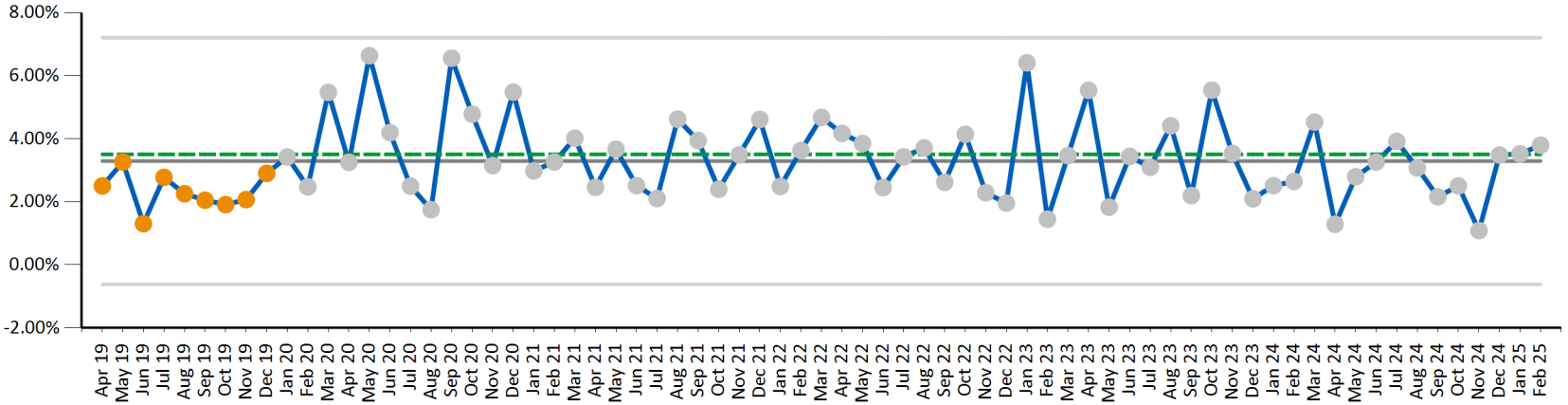
Plan	Actual
<= 3.50	4.54

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%	3.8%	Feb-25

Previous

Plan	Actual	Period
<= 3.5%	3.5%	Jan-25

Year to Date

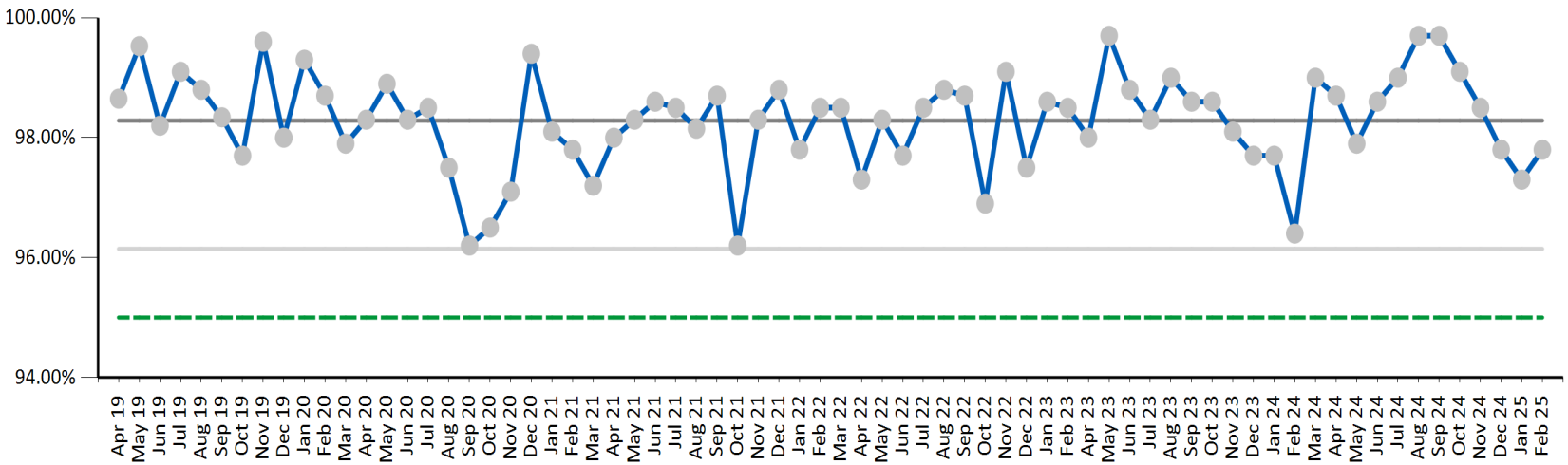
Plan	Actual
<= 3.5%	2.8%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	97.8%	Feb-25

Previous

Plan	Actual	Period
>= 95.0%	97.3%	Jan-25

Year to Date

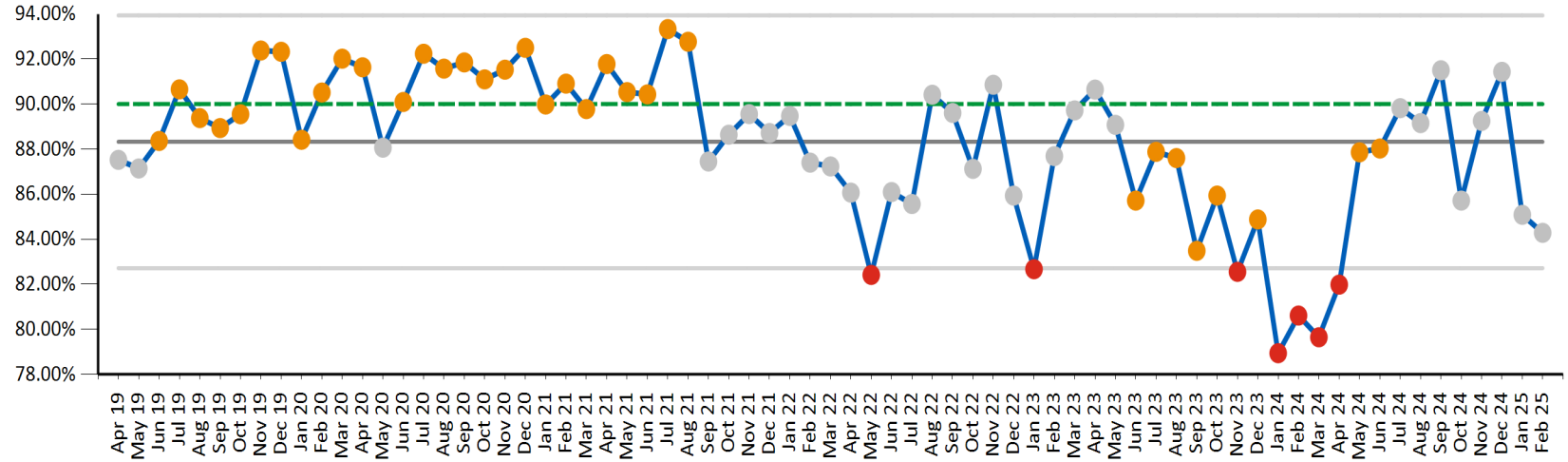
Plan	Actual
>= 95.0%	98.6%

203 - Booked 12+6

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90.0%	84.3%	Feb-25

Previous

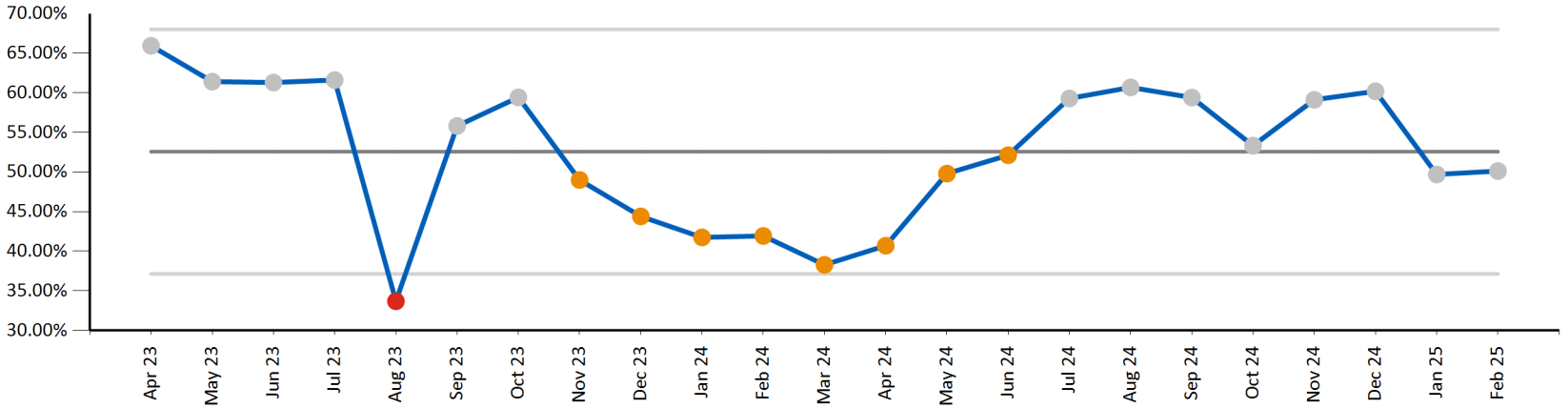
Plan	Actual	Period
>= 90.0%	85.1%	Jan-25

Year to Date

Plan	Actual
>= 90.0%	87.6%

586 - Booked 10+0

Common cause variation.



Latest

Plan	Actual	Period
	50.1%	Feb-25

Previous

Plan	Actual	Period
	49.7%	Jan-25

Year to Date

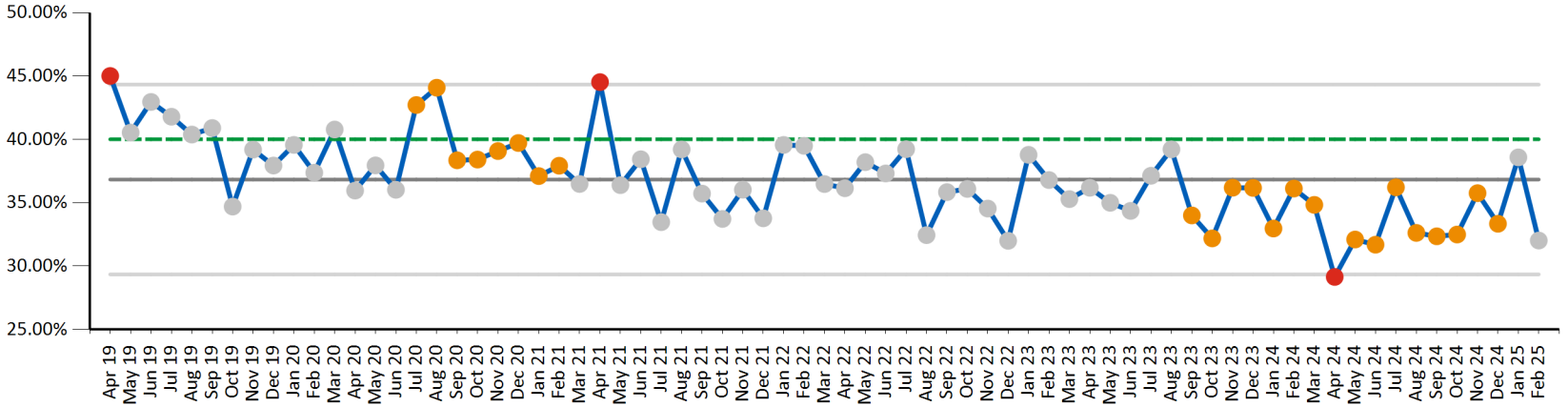
Plan	Actual
	53.9%

204 - Inductions of labour - over 24 hours

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	32.0%	Feb-25

Previous

Plan	Actual	Period
<= 40%	38.6%	Jan-25

Year to Date

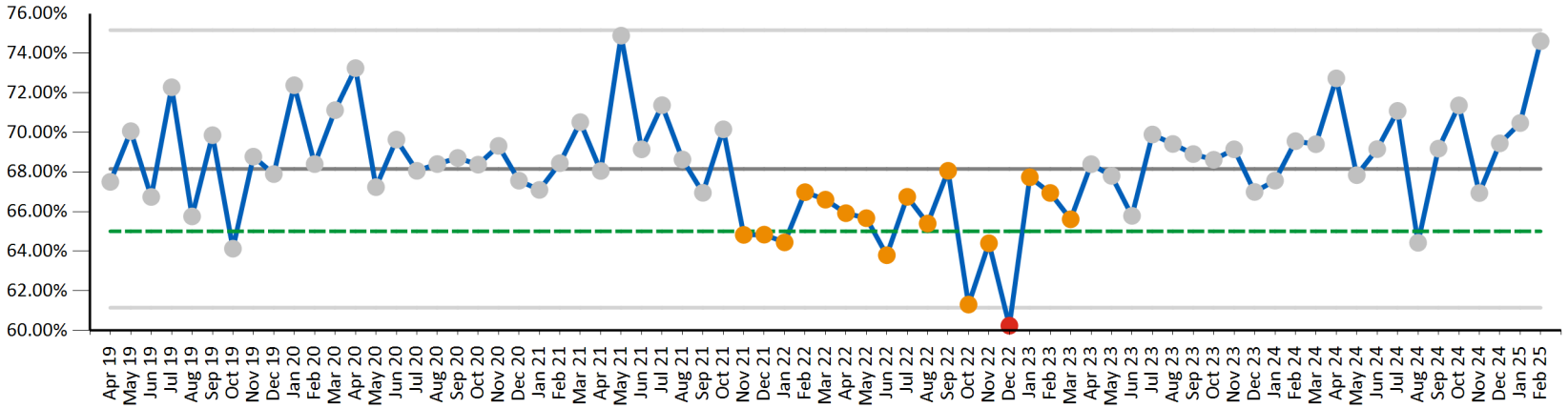
Plan	Actual
<= 40%	33.3%

210 - Initiation breast feeding

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	74.60%	Feb-25

Previous

Plan	Actual	Period
>= 65%	70.47%	Jan-25

Year to Date

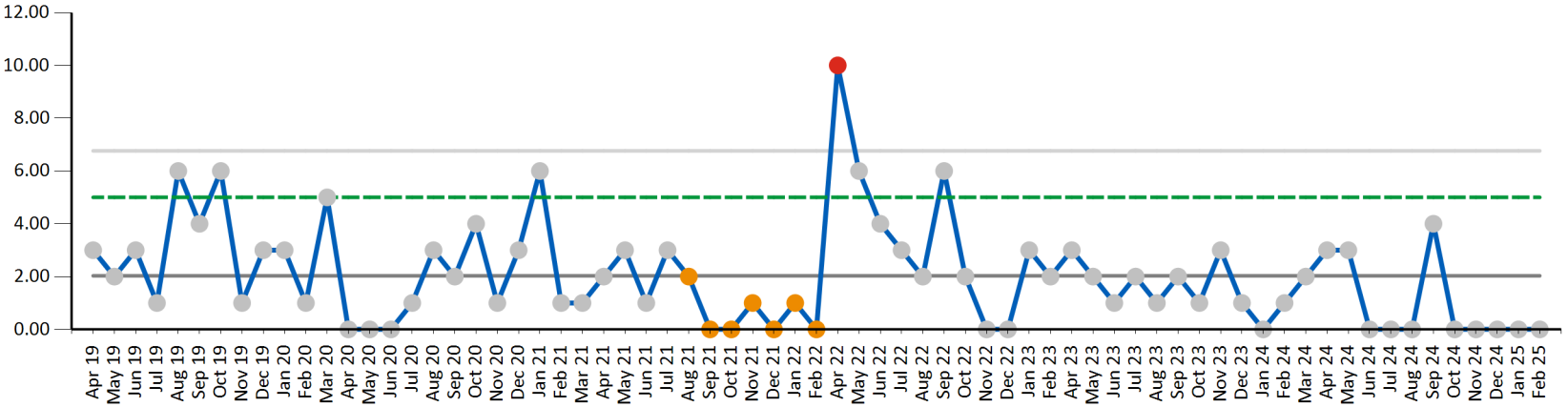
Plan	Actual
>= 65%	69.74%

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	Feb-25

Previous

Plan	Actual	Period
<= 5	0	Jan-25

Year to Date

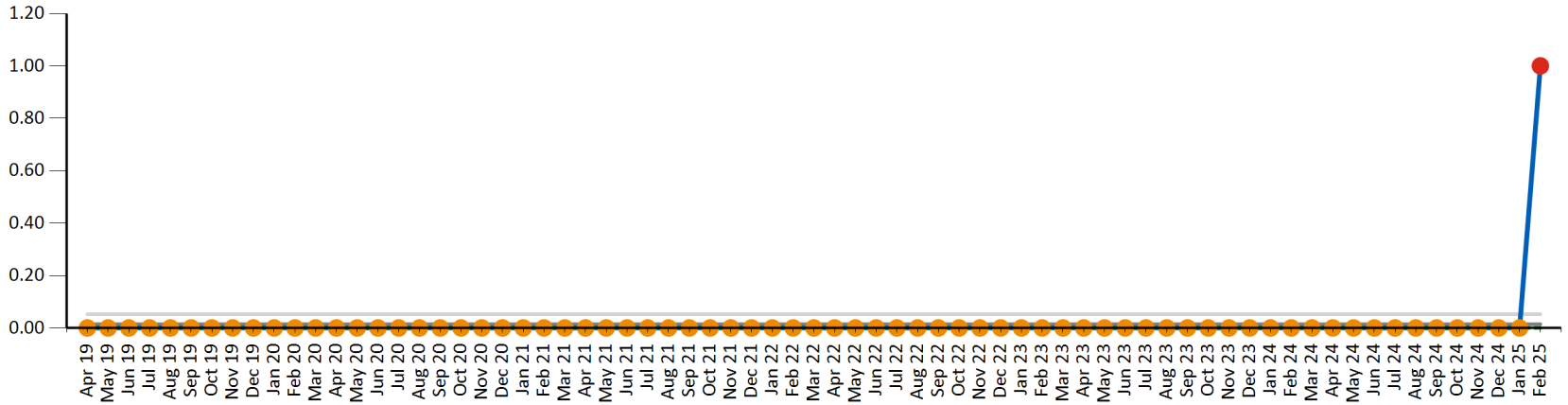
Plan	Actual
<= 55	10

319 - Maternal deaths (direct)

Special cause variation with deteriorating performance

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

5/6



Latest

Plan	Actual	Period
= 0	1	Feb-25

Previous

Plan	Actual	Period
= 0	0	Jan-25

Year to Date

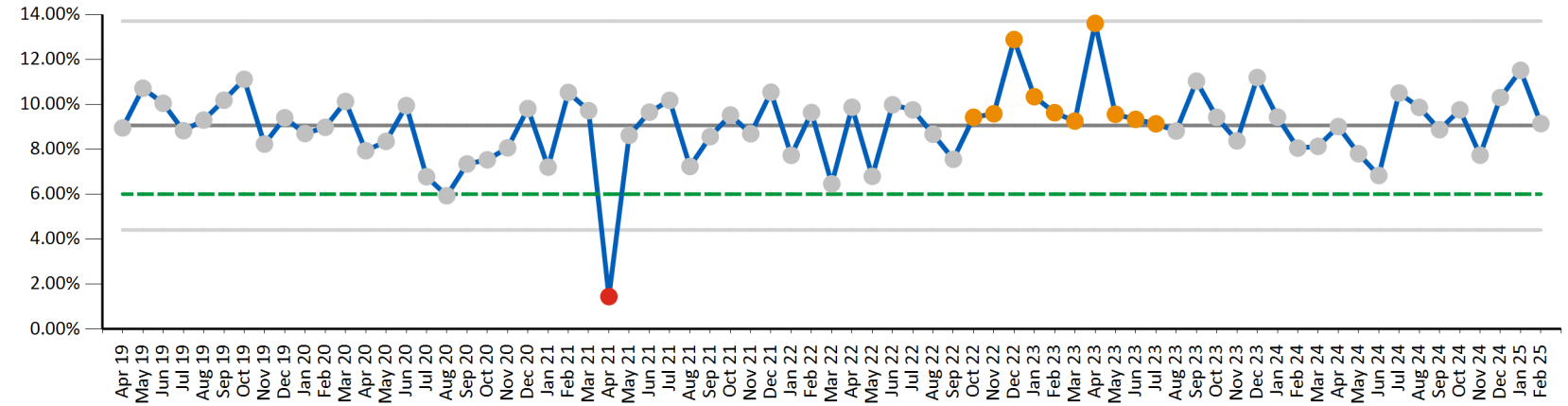
Plan	Actual
= 0	1

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%	9.1%	Feb-25

Previous

Plan	Actual	Period
<= 6%	11.5%	Jan-25

Year to Date

Plan	Actual
<= 6%	9.2%

Operational Performance - Urgent Care

Bolton NHS Foundation Trust

Urgent Care

In February 2025, performance against the all-types 4-hour standard was 63.7%, which is a decrease of 2.3% from January 2024. Attendances remained within common cause variation in relation to both walk in and ambulance arrivals. Ambulance handover within 15 and 30 minutes both declined to 46.5% and 74.8% respectively. In February 2025, A&E 12-hour waits were broadly static at 1068 patients, this is an increase of 37 patients from January. Non-elective length of stay has increased by 0.1 days month-on-month, during a period where length of stay typically increases, this metric remains in common cause variation. Re-admissions within 30-days of discharge has increased by 0.9% month-on-month to 9.7% however, this metric remains in special cause improvement.

NOF

For February, our fractured neck of femur performance decreased to 14.3% from 27.5%, which is the lowest performance over the course of the previous 5 years, with 6 of 42 eligible patients getting to theatre within the 36 hour window. Of the 36x patients who breached the target, the vast majority of the patients (33) related to delays due to theatre capacity, with 3x related to optimisation of patients including anticoagulants.

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. A paper outlining key required actions has been submitted and discussed through Clinical Governance and Quality Committee and Quality Assurance Committee, for which the actions remain on track. Performance for March is currently on track to be significantly improved against February's performance, returning to January's levels.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 77%	63.7%	Feb-25		>= 75%	66.0%	Jan-25	>= 77%	63.8%	F
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	46.5%	Feb-25		>= 65.0%	52.6%	Jan-25	>= 65.0%	48.7%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	74.8%	Feb-25		>= 95.0%	82.2%	Jan-25	>= 95.0%	77.8%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	87.51%	Feb-25		= 100%	92.85%	Jan-25	= 100%	90.14%	F
539 - A&E 12 hour waits	= 0	1,068	Feb-25		= 0	1,031	Jan-25	= 0	13,052	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	14.3%	Feb-25	L	>= 75%	27.5%	Jan-25	>= 75%	30.2%	?
56 - Stranded patients - over 7 days	<= 200	286	Feb-25	H	<= 200	303	Jan-25	<= 200	286	F

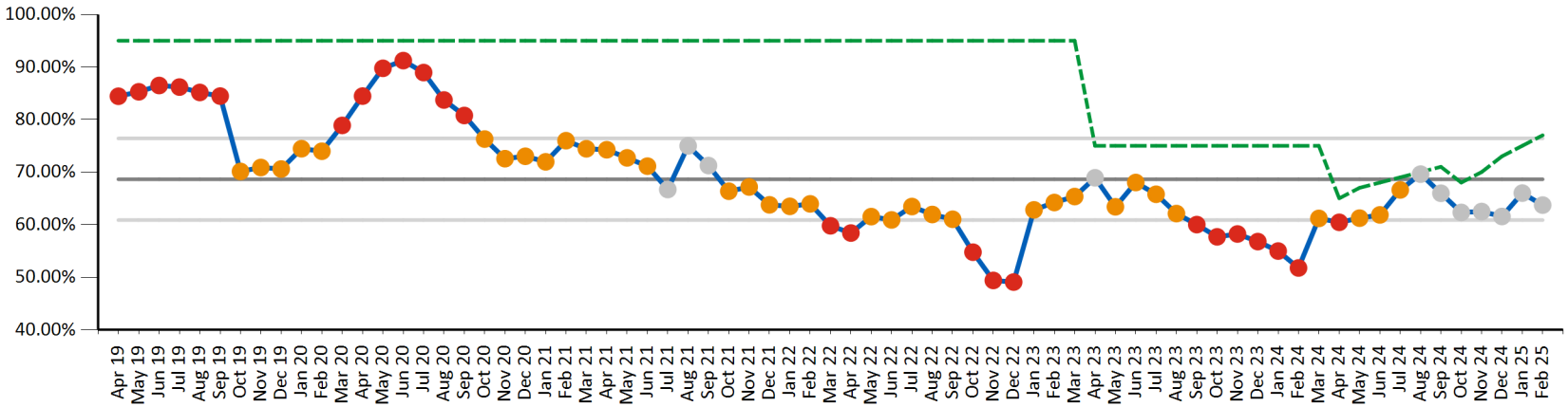
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	103	Feb-25		<= 69	119	Jan-25	<= 69	103	?
541 - Adult G&A bed occupancy	<= 92.0%	88.8%	Feb-25		<= 92.0%	89.7%	Jan-25	<= 92.0%	89.0%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.27	Feb-25		<= 3.70	5.17	Jan-25	<= 3.70	5.60	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	9.7%	Jan-25	L	<= 13.5%	8.8%	Dec-24	<= 13.5%	9.4%	P

53 - A&E 4 hour target

Common cause variation.

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 77%	63.7%	Feb-25

Previous

Plan	Actual	Period
>= 75%	66.0%	Jan-25

Year to Date

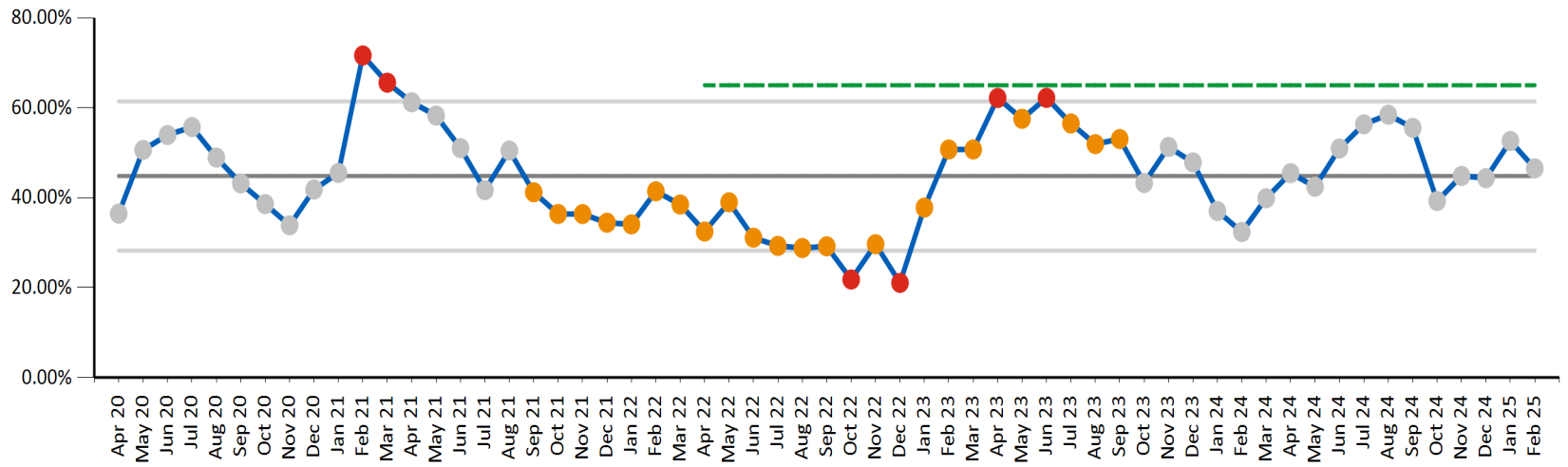
Plan	Actual
>= 77%	63.8%

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%	46.5%	Feb-25

Previous

Plan	Actual	Period
>= 65.0%	52.6%	Jan-25

Year to Date

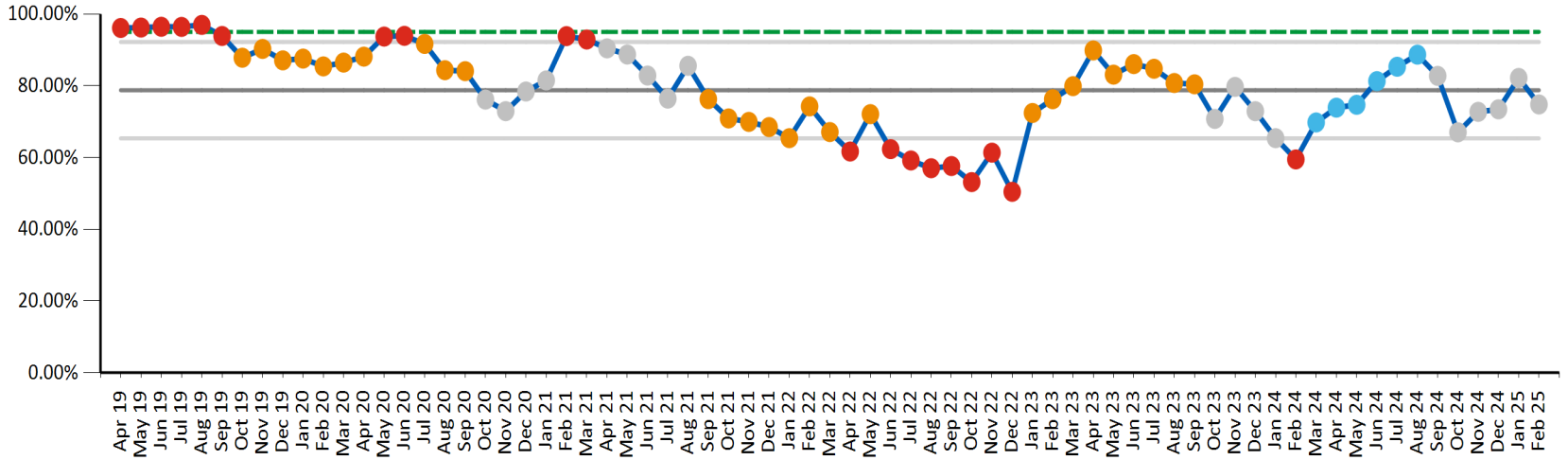
Plan	Actual
>= 65.0%	48.7%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	74.8%	Feb-25

Previous

Plan	Actual	Period
>= 95.0%	82.2%	Jan-25

Year to Date

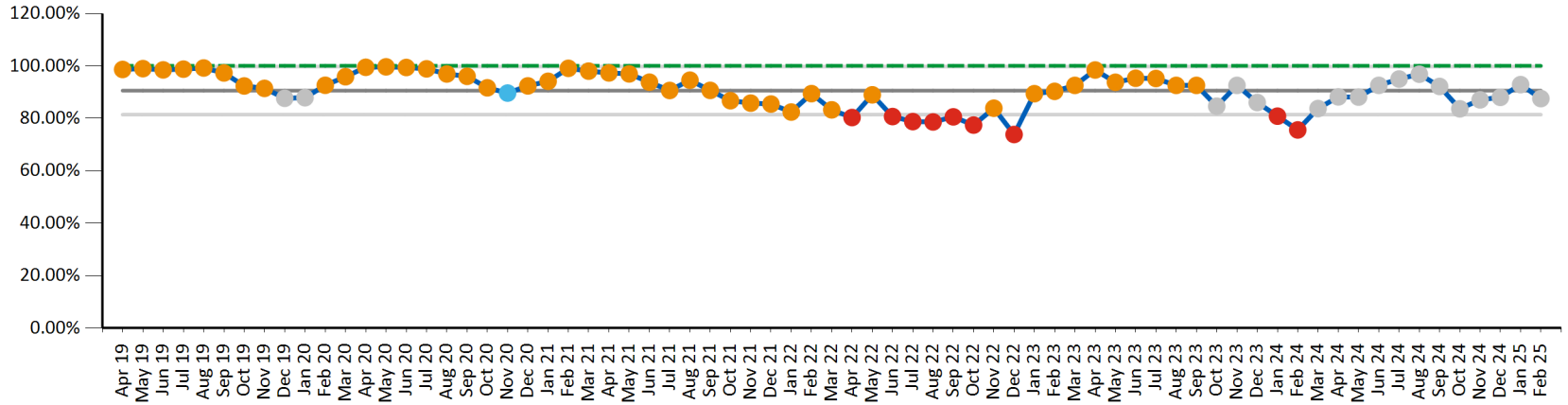
Plan	Actual
>= 95.0%	77.8%

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%	87.51%	Feb-25

Previous

Plan	Actual	Period
= 100%	92.85%	Jan-25

Year to Date

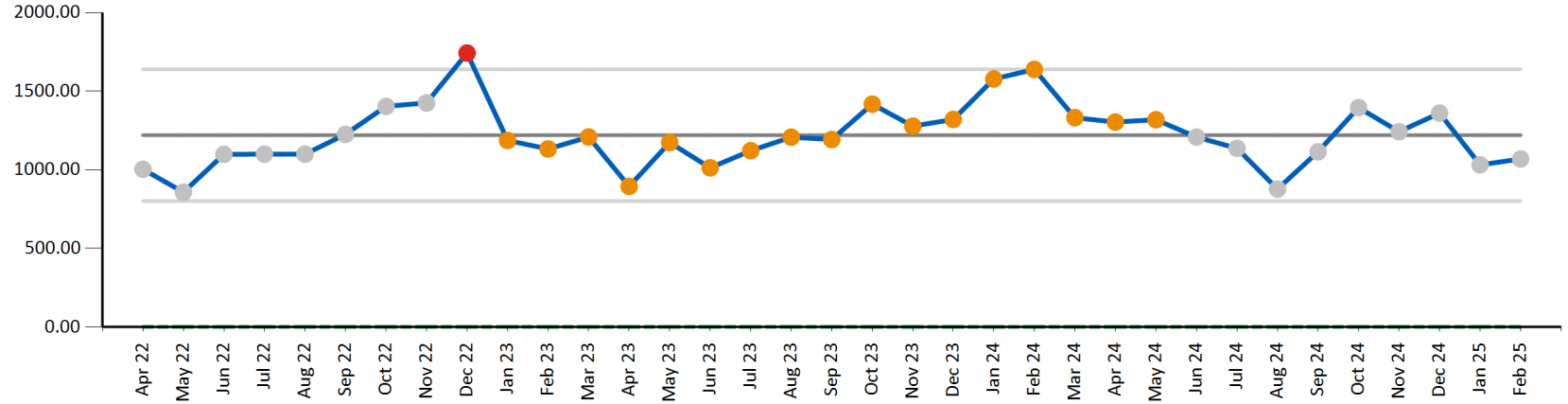
Plan	Actual
= 100%	90.14%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,068	Feb-25

Previous

Plan	Actual	Period
= 0	1,031	Jan-25

Year to Date

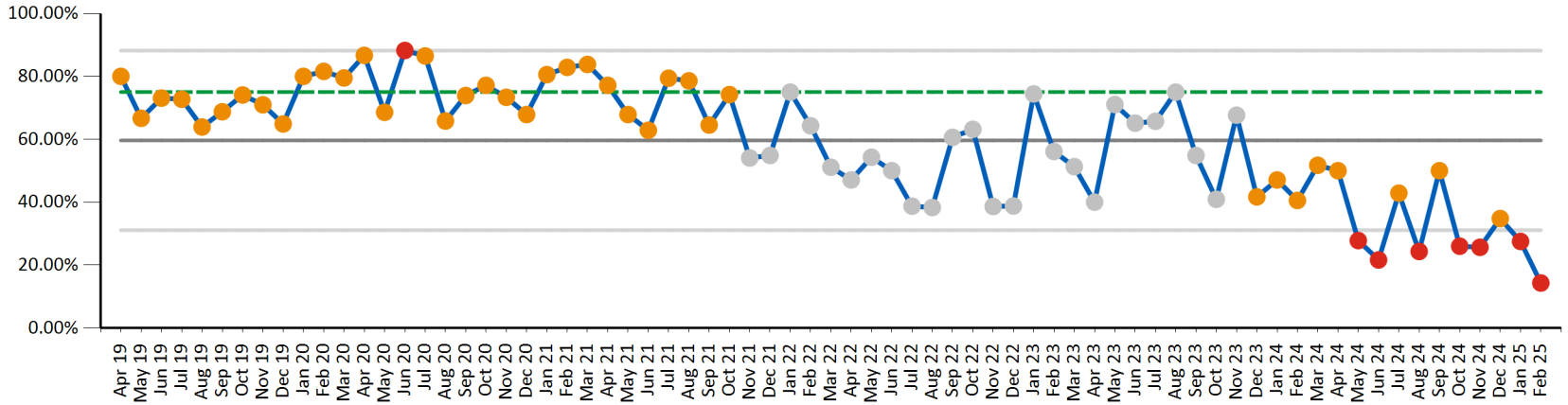
Plan	Actual
= 0	13,052

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%	14.3%	Feb-25

Previous

Plan	Actual	Period
>= 75%	27.5%	Jan-25

Year to Date

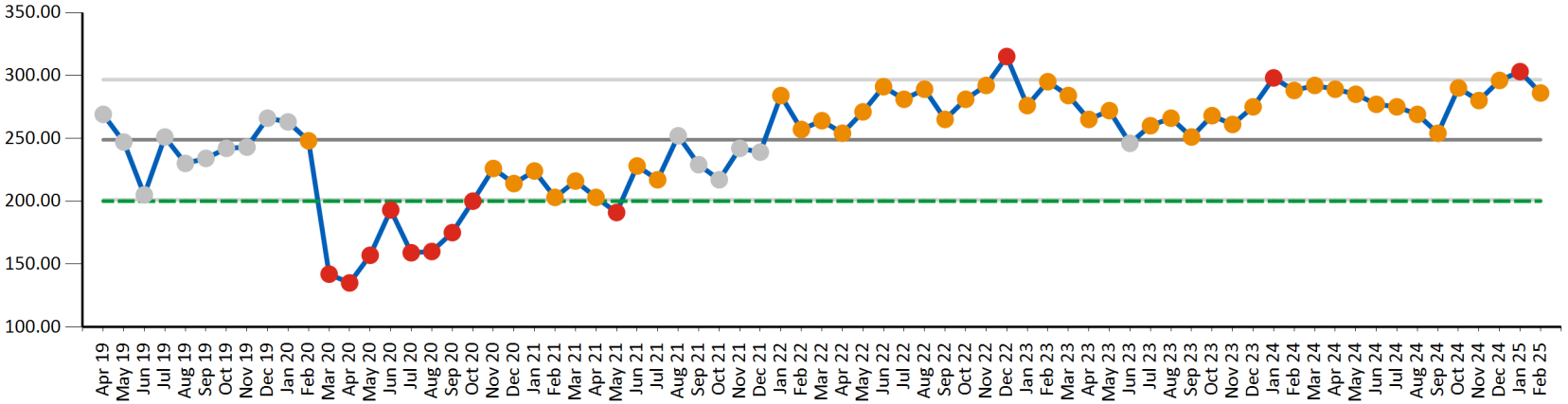
Plan	Actual
>= 75%	30.2%

56 - Stranded patients - over 7 days

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	286	Feb-25

Previous

Plan	Actual	Period
<= 200	303	Jan-25

Year to Date

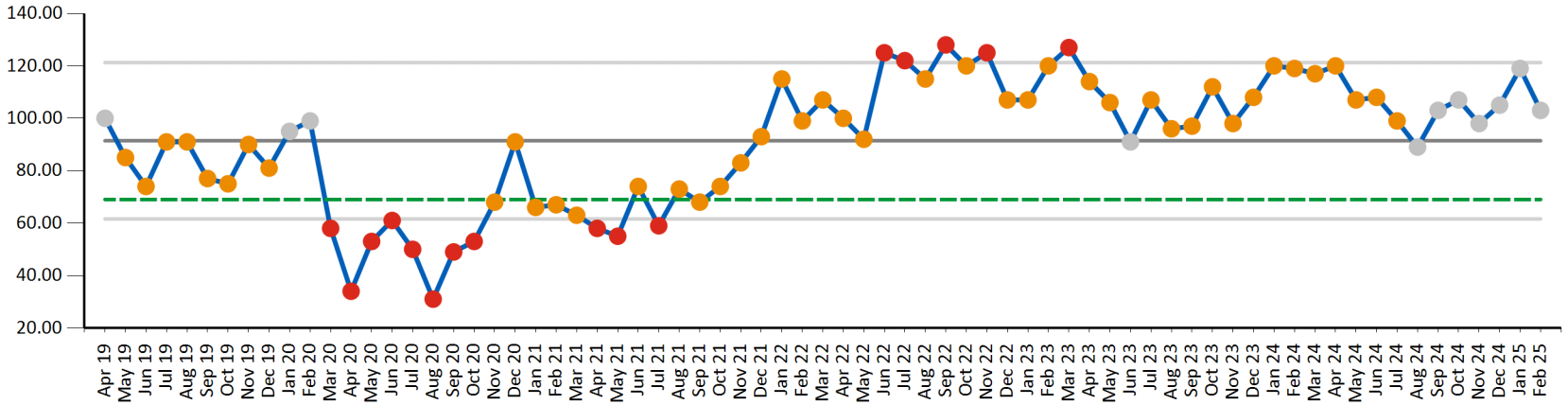
Plan	Actual
<= 200	286

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	103	Feb-25

Previous

Plan	Actual	Period
<= 69	119	Jan-25

Year to Date

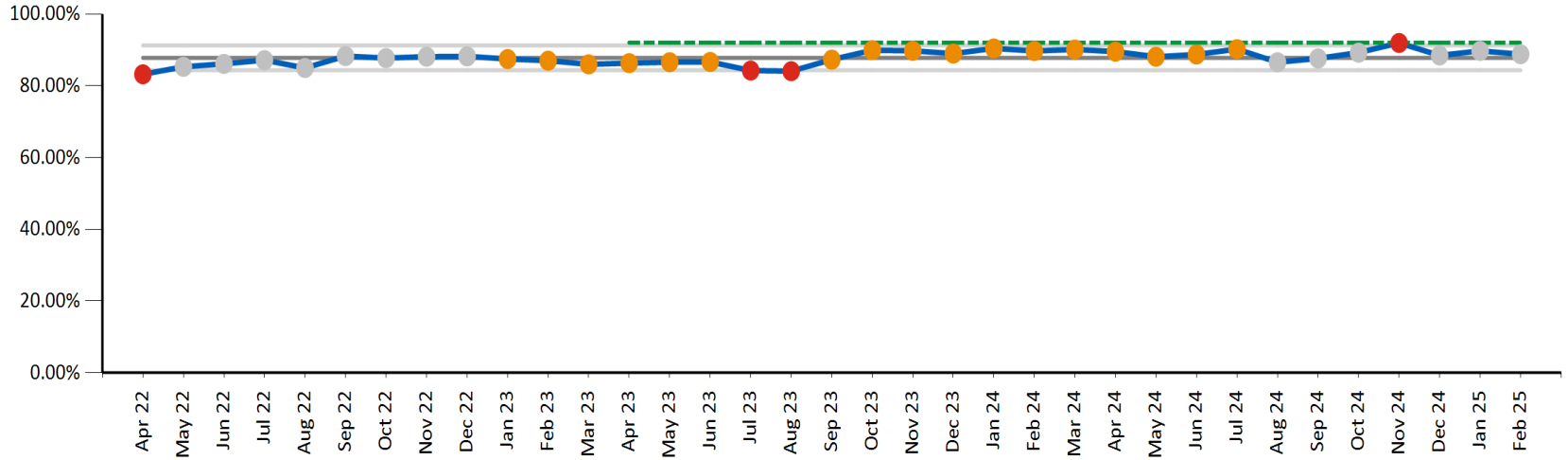
Plan	Actual
<= 69	103

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	88.8%	Feb-25

Previous

Plan	Actual	Period
<= 92.0%	89.7%	Jan-25

Year to Date

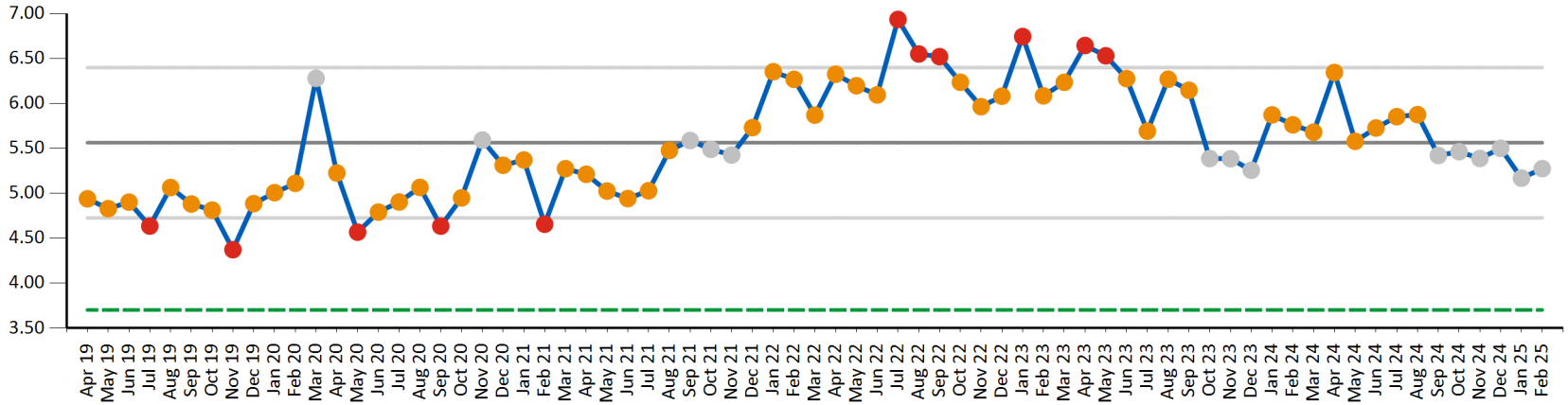
Plan	Actual
<= 92.0%	89.0%

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	5.27	Feb-25

Previous

Plan	Actual	Period
<= 3.70	5.17	Jan-25

Year to Date

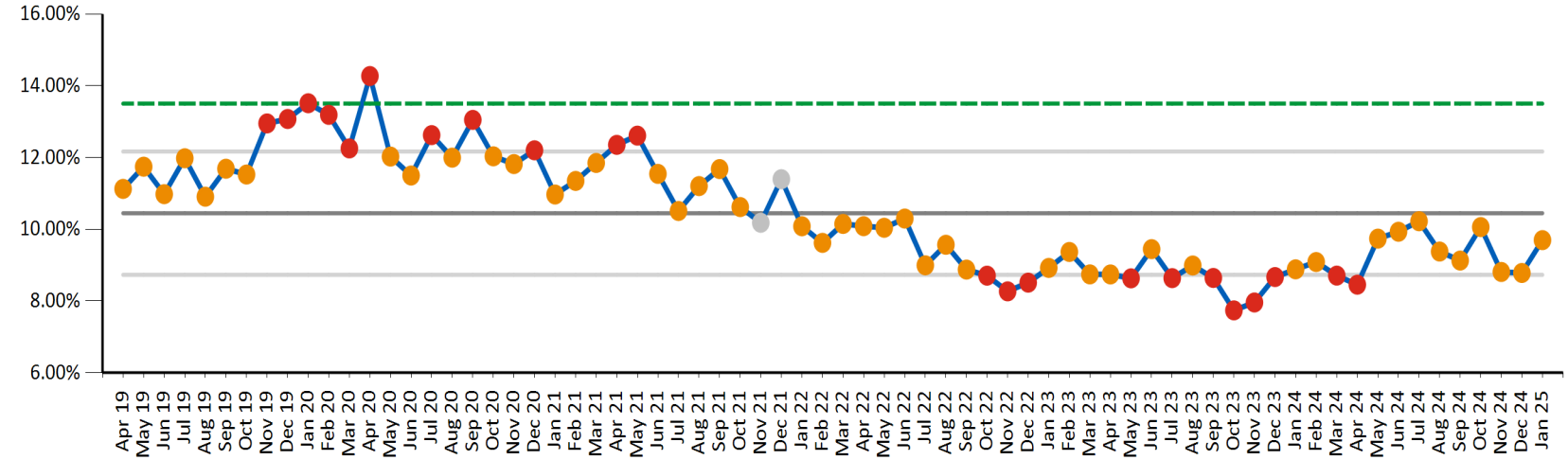
Plan	Actual
<= 3.70	5.60

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%	9.7%	Jan-25

Previous

Plan	Actual	Period
<= 13.5%	8.8%	Dec-24

Year to Date

Plan	Actual
<= 13.5%	9.4%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished February with 5x 78-week breaches, 3x of which were graft patients and 2x patients requiring additional orthodontic capacity.

We finished February with 70x 65-week breaches. This is ahead of our trajectory of 98x patients waiting longer than 65-weeks for treatment. Our February position is an improvement against January's position.

We finished February with 1,323x 52-week breaches. This continues to improve and has now fallen for 8 consecutive months.

DM01

Performance shows a continued improvement by 3.6% in month as teams have continued to utilise an increased capacity to achieve an overall Trust performance of 12.2.%. As a result 53 less patients waited over 6 weeks for their diagnostic testing despite the trust seeing an increase in the number of patients referred for a test. Individual specialities continue to focus on their recovery plans with Cardiology achieving their target, meeting the national standard. In order achieve the national standard of 5% in March 25 specialities will continue to utilise additional, short term resource to recover their performance and this is currently being monitored closely.

	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%	54.8%	Feb-25		>= 92%	54.5%	Jan-25	>= 92%	52.2%	
314 - RTT 18 week waiting list	<= 37,764	39,987	Feb-25		<= 37,914	40,391	Jan-25	<= 37,764	39,987	
42 - RTT 52 week waits (incomplete pathways)		1,323	Feb-25			1,421	Jan-25		27,489	
540 - RTT 65 week waits (incomplete pathways)	= 0	70	Feb-25		= 0	134	Jan-25	<= 4,613	5,113	
526 - RTT 78 week waits (incomplete pathways)	= 0	5	Feb-25		= 0	5	Jan-25	= 0	150	
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Feb-25		= 0	0	Jan-25	= 0	2	
72 - Diagnostic Waits >6 weeks %	<= 5%	12.2%	Feb-25		<= 5%	15.8%	Jan-25	<= 5%	13.5%	
489 - Daycase Rates	>= 85%	79.7%	Feb-25		>= 85%	80.5%	Jan-25	>= 85%	81.9%	
582 - Theatre Utilisation - Capped		74.8%	Feb-25			75.1%	Jan-25		74.2%	

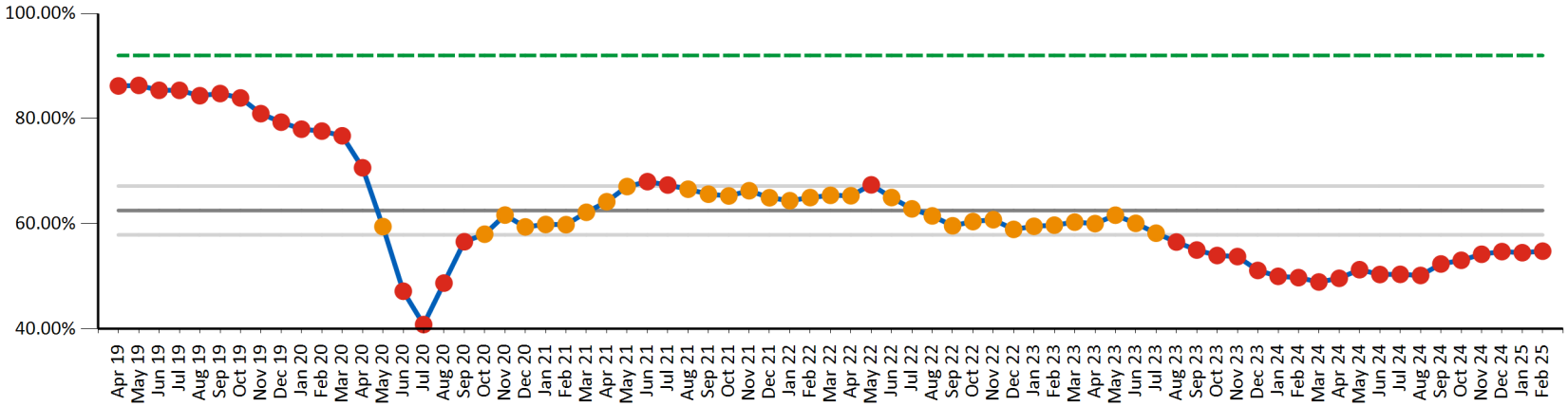
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
583 - Theatre Utilisation - Uncapped		78.3%	Feb-25			77.9%	Jan-25		78.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.4%	Feb-25		<= 1%	2.7%	Jan-25	<= 1%	1.9%	
62 - Cancelled operations re-booked within 28 days	= 100%	74.7%	Jan-25		= 100%	61.3%	Dec-24	= 100%	29.9%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.60	Feb-25		<= 2.00	2.66	Jan-25	<= 2.00	2.87	
309 - DNA Rate - New	<= 6.3%	9.7%	Feb-25		<= 6.3%	10.7%	Jan-25	<= 6.3%	10.0%	
310 - DNA Rate - Follow up	<= 5.0%	8.0%	Feb-25		<= 5.0%	8.4%	Jan-25	<= 5.0%	8.7%	

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%	54.8%	Feb-25

Previous

Plan	Actual	Period
>= 92%	54.5%	Jan-25

Year to Date

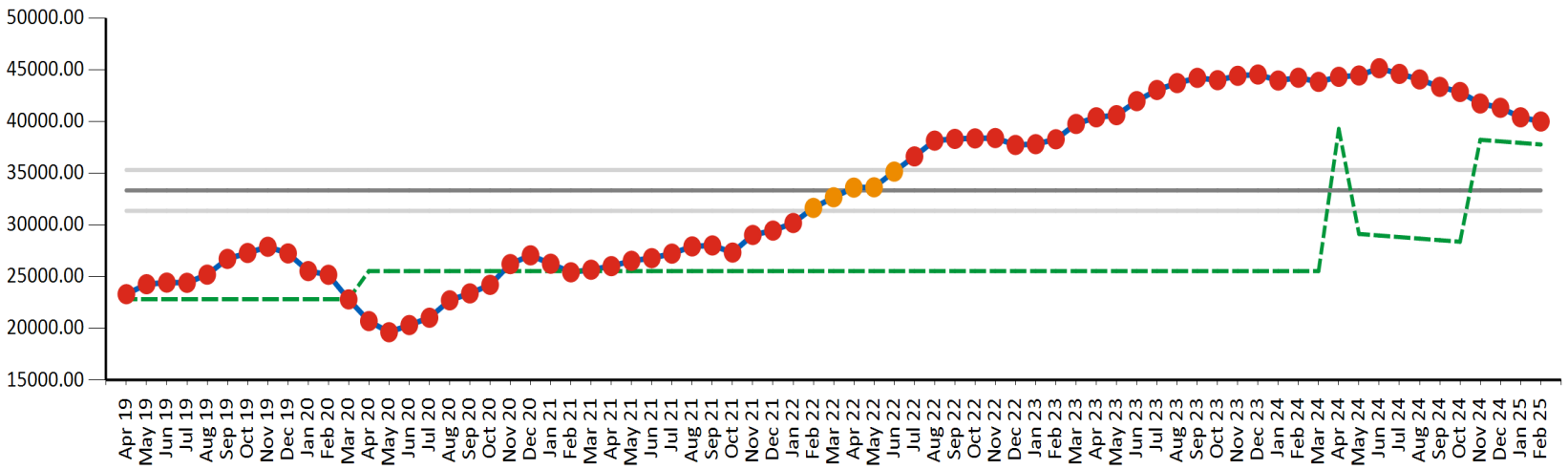
Plan	Actual
>= 92%	52.2%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
<= 37,764	39,987	Feb-25

Previous

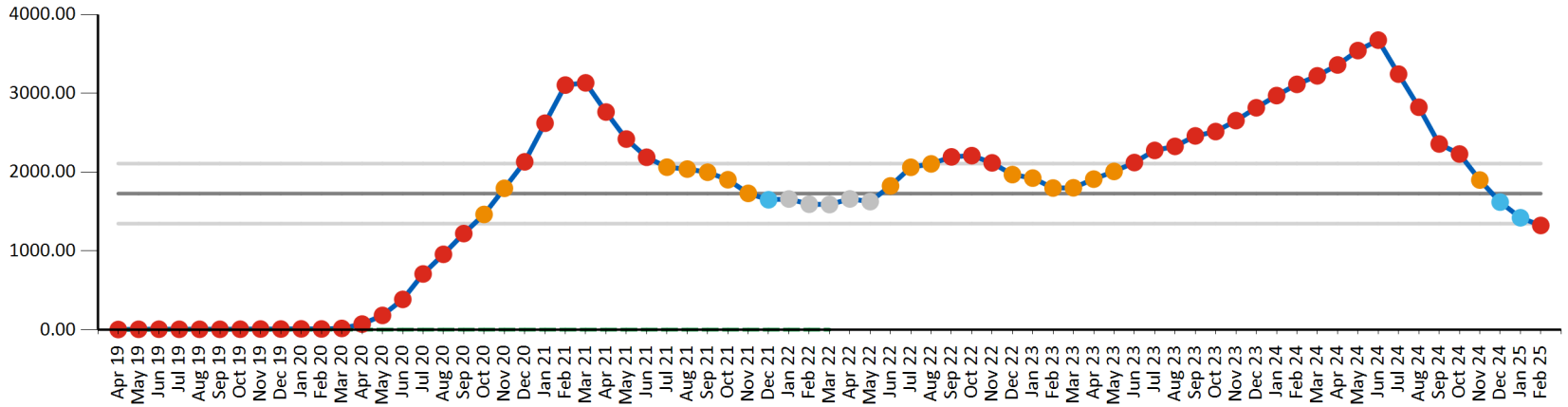
Plan	Actual	Period
<= 37,914	40,391	Jan-25

Year to Date

Plan	Actual
<= 37,764	39,987

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1,323	Feb-25

Previous

Plan	Actual	Period
	1,421	Jan-25

Year to Date

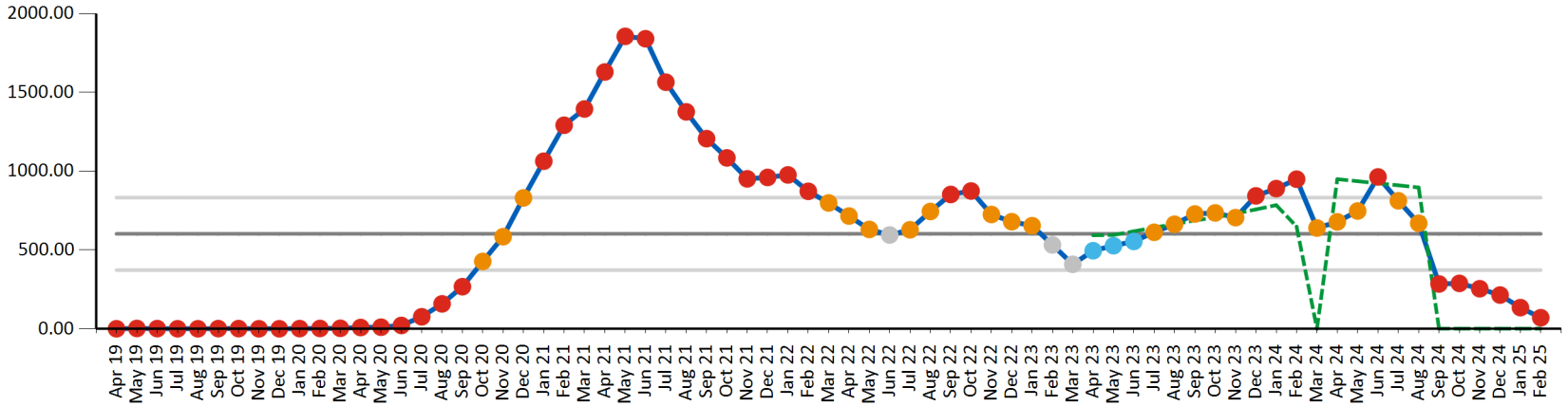
Plan	Actual
	27,489

540 - RTT 65 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	70	Feb-25

Previous

Plan	Actual	Period
= 0	134	Jan-25

Year to Date

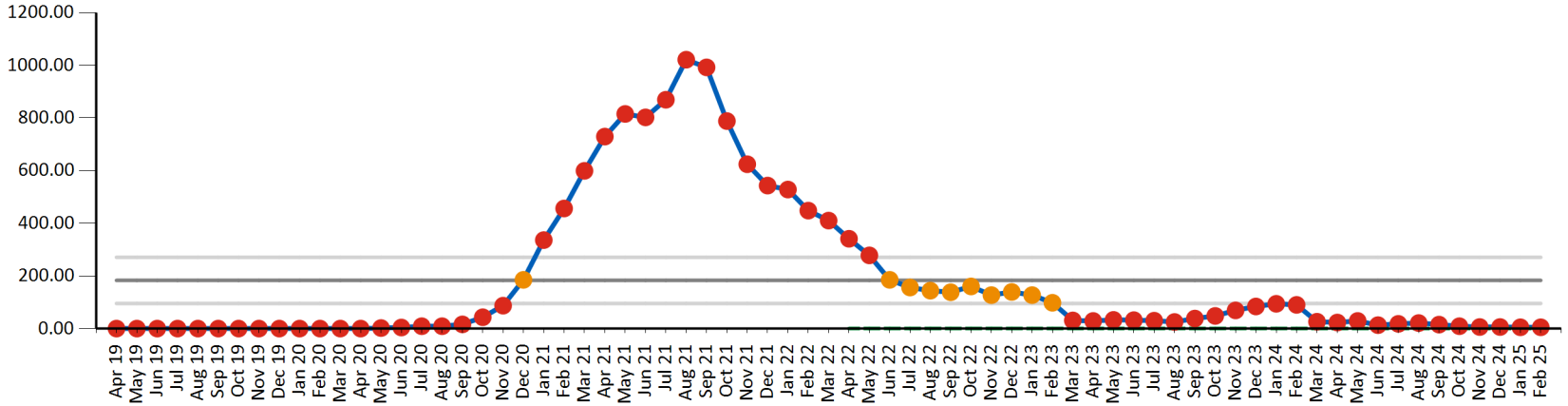
Plan	Actual
<= 4,613	5,113

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	5	Feb-25

Previous

Plan	Actual	Period
= 0	5	Jan-25

Year to Date

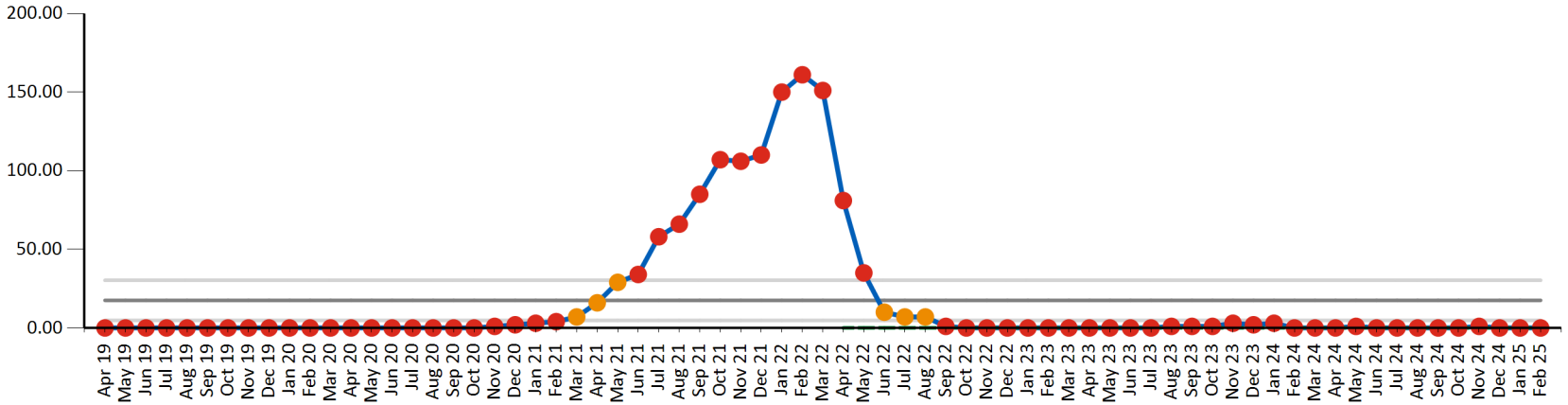
Plan	Actual
= 0	150

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	Feb-25

Previous

Plan	Actual	Period
= 0	0	Jan-25

Year to Date

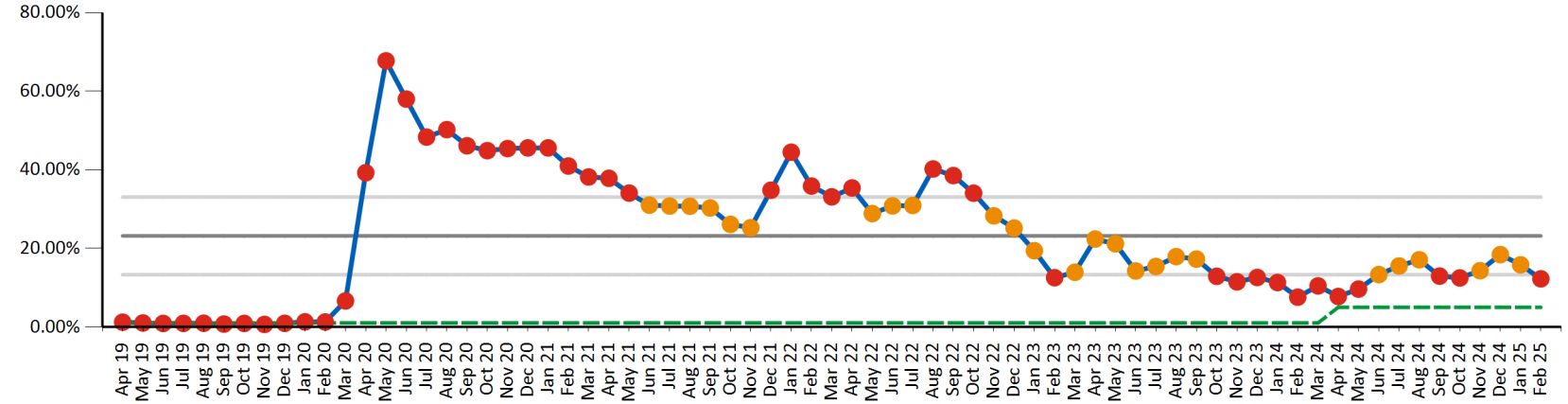
Plan	Actual
= 0	2

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5%	12.2%	Feb-25

Previous

Plan	Actual	Period
<= 5%	15.8%	Jan-25

Year to Date

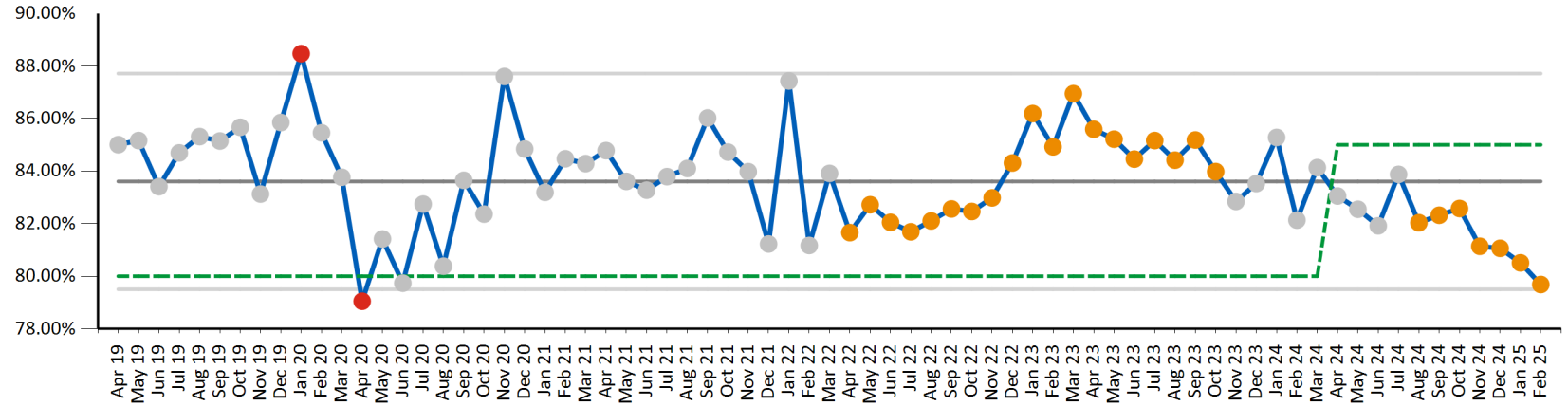
Plan	Actual
<= 5%	13.5%

489 - Daycase Rates

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 85%	79.7%	Feb-25

Previous

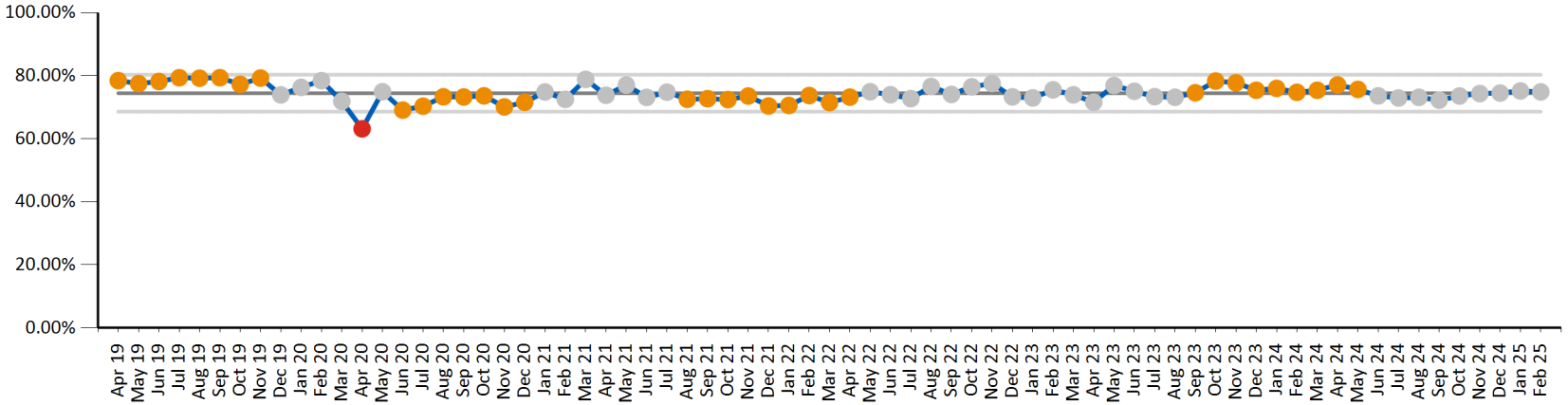
Plan	Actual	Period
>= 85%	80.5%	Jan-25

Year to Date

Plan	Actual
>= 85%	81.9%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	74.8%	Feb-25

Previous

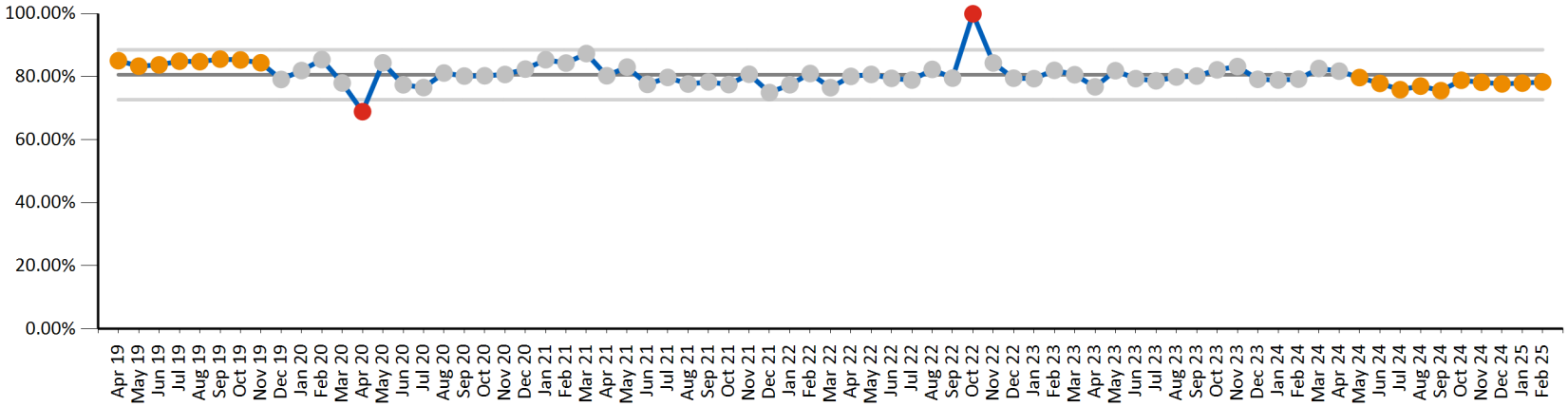
Plan	Actual	Period
	75.1%	Jan-25

Year to Date

Plan	Actual
	74.2%

583 - Theatre Utilisation - Uncapped

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	78.3%	Feb-25

Previous

Plan	Actual	Period
	77.9%	Jan-25

Year to Date

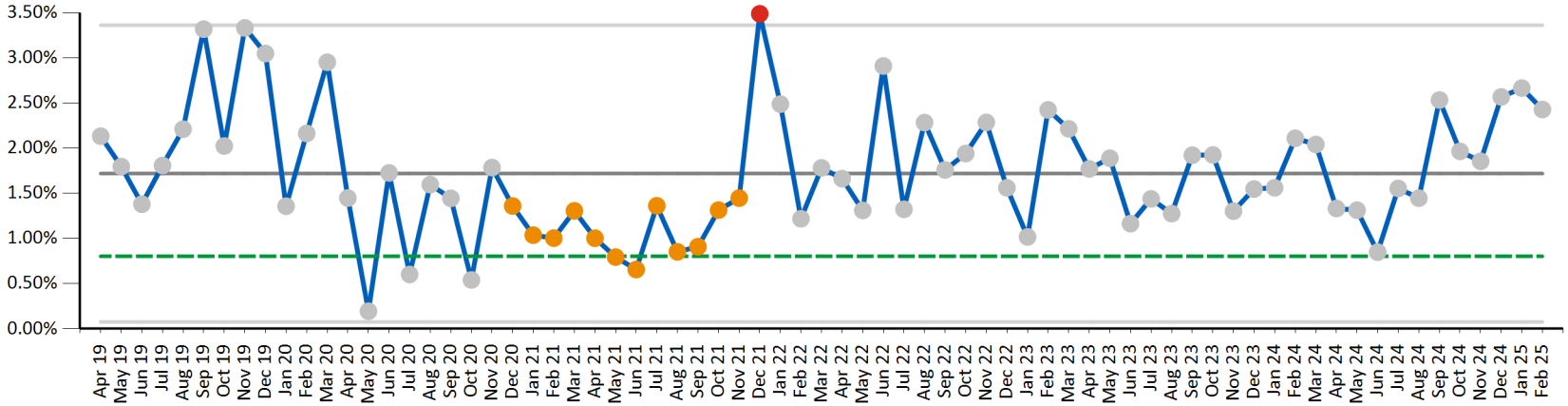
Plan	Actual
	78.0%

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%	2.4%	Feb-25

Previous

Plan	Actual	Period
<= 1%	2.7%	Jan-25

Year to Date

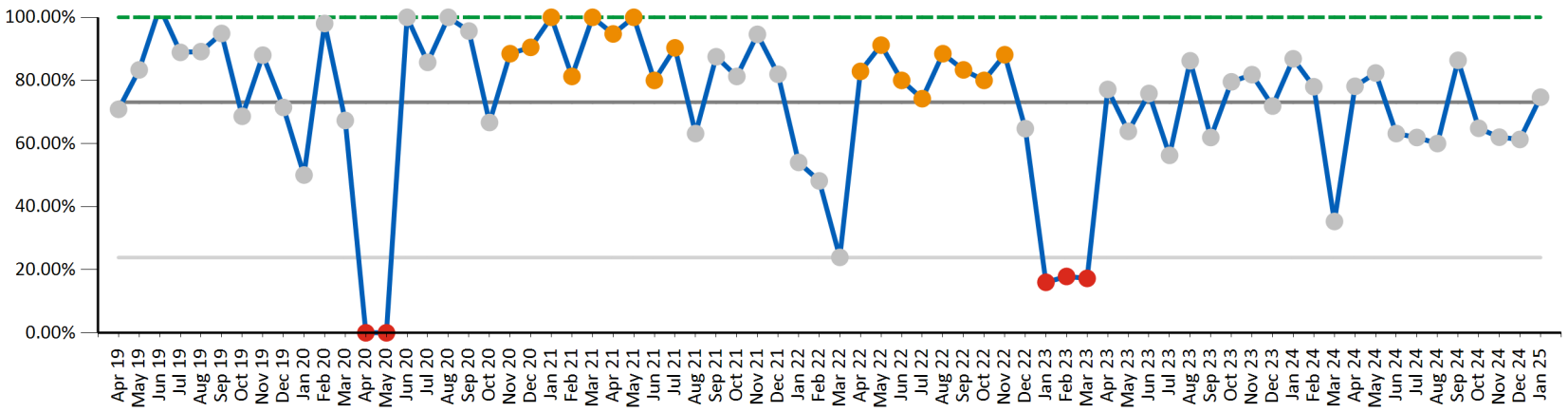
Plan	Actual
<= 1%	1.9%

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%	74.7%	Jan-25

Previous

Plan	Actual	Period
= 100%	61.3%	Dec-24

Year to Date

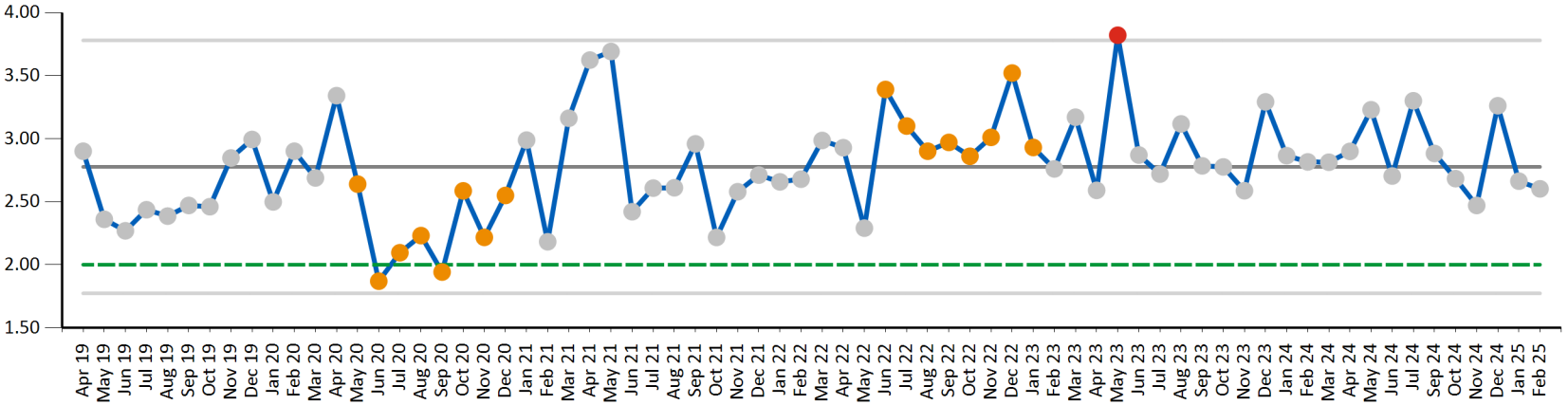
Plan	Actual
= 100%	29.9%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	2.60	Feb-25

Previous

Plan	Actual	Period
<= 2.00	2.66	Jan-25

Year to Date

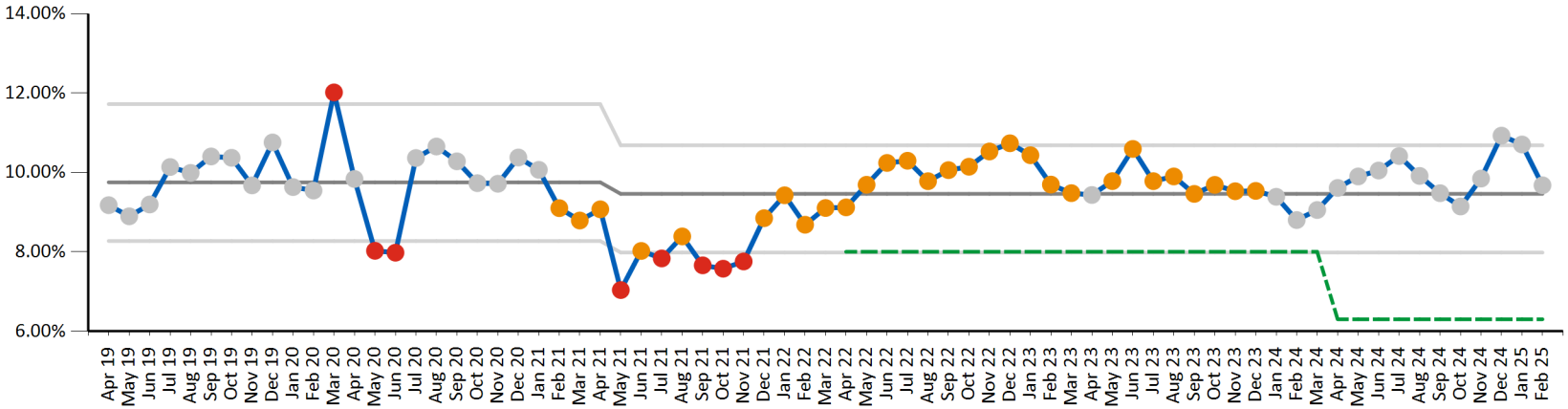
Plan	Actual
<= 2.00	2.87

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.7%	Feb-25

Previous

Plan	Actual	Period
<= 6.3%	10.7%	Jan-25

Year to Date

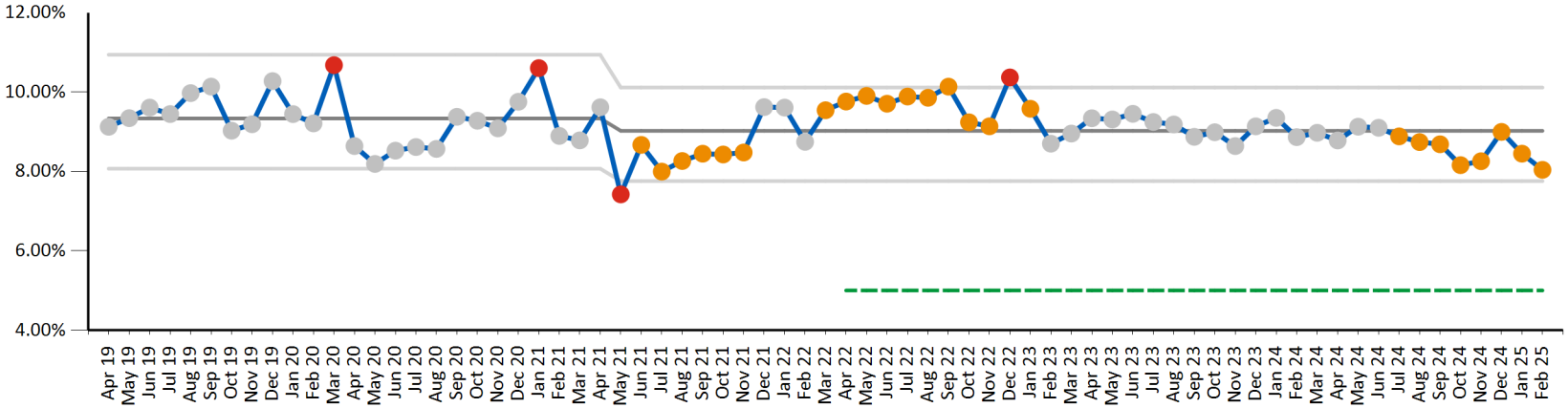
Plan	Actual
<= 6.3%	10.0%

310 - DNA Rate - Follow up

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.0%	Feb-25

Previous

Plan	Actual	Period
<= 5.0%	8.4%	Jan-25

Year to Date

Plan	Actual
<= 5.0%	8.7%

Operational Performance - Cancer

NHS Bolton NHS Foundation Trust

For January, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We also achieved performance the 62-day standard for January, however it is not expected that we will achieve performance in February. All specialties have recovery actions in place to return to sustained performance.
Achievement in January has signified 7 months of consecutive achievement of all standards. For January's performance, Bolton ranked 1st nationally for the faster diagnosis standard, and 3rd nationally for the 62-day standard.

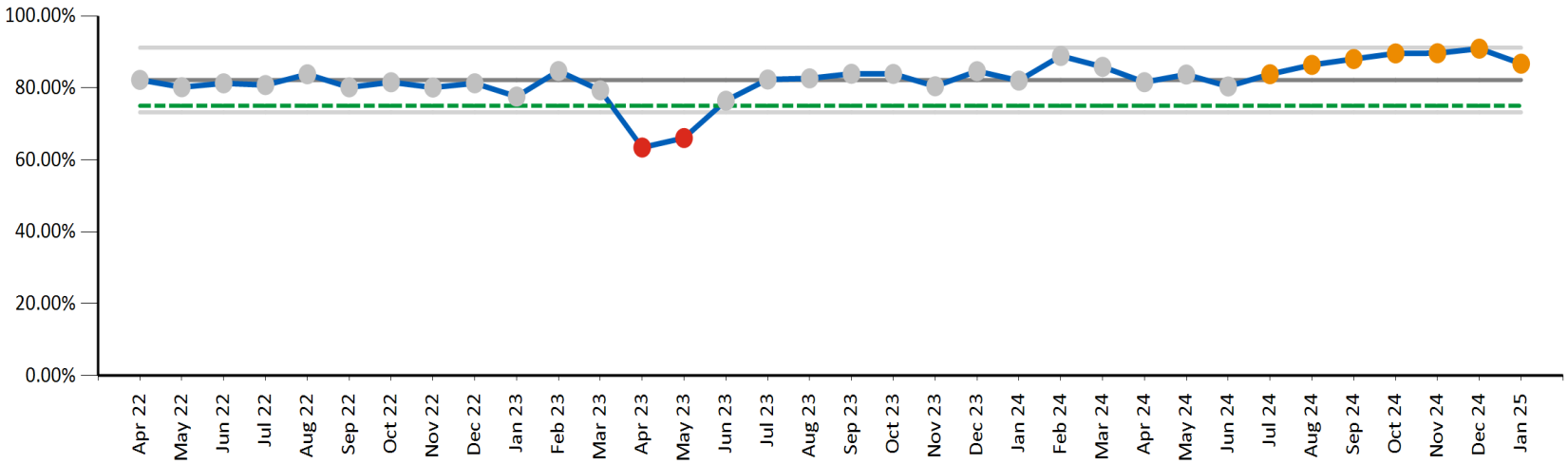
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	86.7%	Jan-25	H	>= 75.0%	90.9%	Dec-24	>= 75.0%	86.0%	?
584 - 31 Day General Treatment Standard	>= 96%	99.2%	Jan-25		>= 96%	99.3%	Dec-24	>= 96%	99.0%	
585 - 62 Day General Standard	>= 85%	86.3%	Jan-25		>= 85%	89.0%	Dec-24	>= 85%	84.4%	

542 - Cancer: 28 day faster diagnosis

H Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	86.7%	Jan-25

Previous

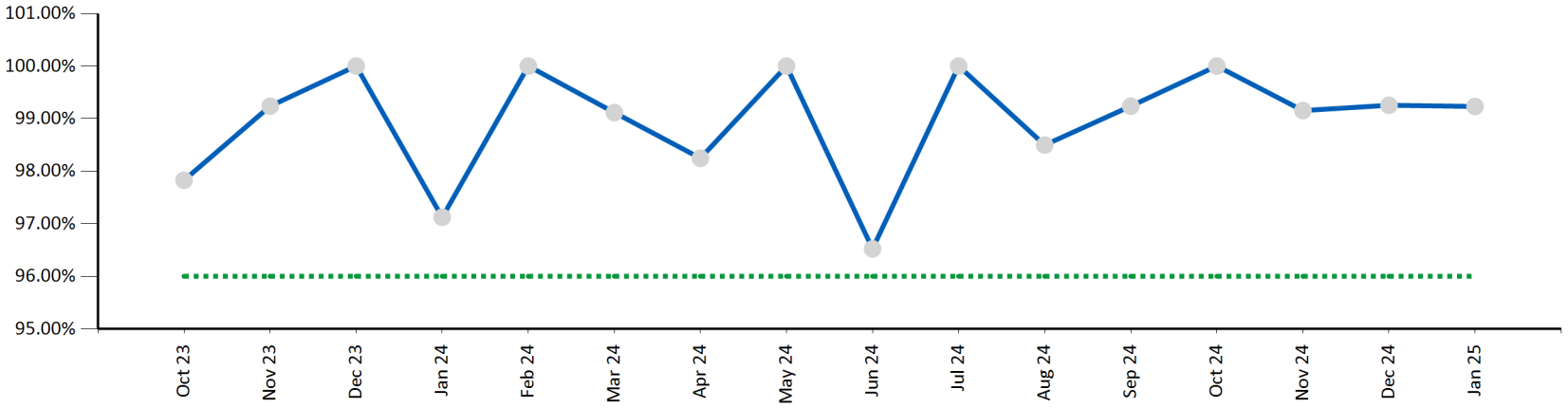
Plan	Actual	Period
>= 75.0%	90.9%	Dec-24

Year to Date

Plan	Actual
>= 75.0%	86.0%

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

6/6



Latest

Plan	Actual	Period
>= 96%	99.2%	Jan-25

Previous

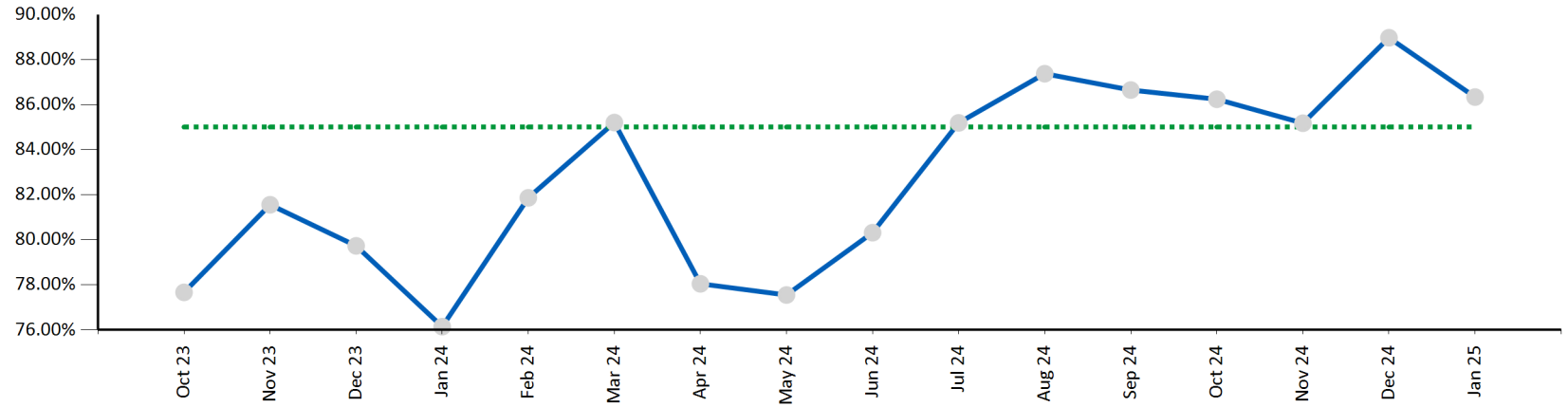
Plan	Actual	Period
>= 96%	99.3%	Dec-24

Year to Date

Plan	Actual
0.96	99.0%

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

6/6



Latest

Plan	Actual	Period
>= 85%	86.3%	Jan-25

Previous

Plan	Actual	Period
>= 85%	89.0%	Dec-24

Year to Date

Plan	Actual
0.85	84.4%

Operational Performance - Community Care

Bolton NHS Foundation Trust

Emergency Department deflections

ED deflections for Month 10 have reduced to 532 from 628, remaining 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. An overall reduction in AAT referral activity was noted in M11, which resulted in the reduction in deflections from ED. This reduction in referrals into the service is related to some seasonal variation also noted in February 2024, a 28 day month in M11 and a pause in the call before you convey test for change. The pilot has been restarted from 1st March 2025 and ongoing discussions are taking place to agree a sustainable model going forward into 25/26 to ensure it continues in M1. The team continue to promote the pathway with system partners and proactively encourage patients and carers to access the service directly. 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 decreased by 8, above operating plan at an average of 92 across the month. Delayed bed days has increased to 617 from 607 in month 10. The NCR position forecasted at month 10 is in line with seasonal variation, although the maintained position for lost bed days demonstrates a continued high turnover of patients and significant grip and control for our longest waiting patients. For context this position remains a reduction on 912 at Month 2 and this has been a result of progress with implementation of the NCTR Urgent Care Improvement Group actions.

Our focused recovery actions implemented on 27th February 2024 remain ongoing and progress updates against these actions are included as part of the NCTR Urgent Care Improvement Group update and highlights are shared at the operational safety wall.?We continue to work with partners across GM localities due to the high numbers of patients residing in the hospital who don't live in Bolton.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts has improved although remains off target at 82% in February 2025 (vs 79% in January 2025). This was largely due to improvements in % of new birth visits within 14 days (92.3% in February 2025 vs 85.2% in January 2025). Underperformance can be attributed to staffing challenges within the 0 -19 service, and disruption due to transition to the new service model. Recruitment remains ongoing for health visitors, however, vacancies are still causing pressures and this is recorded on the divisional risk register (R6036). Work is ongoing to build a tableau dashboard that will enable real time monitoring of performance.

EHCP compliance

Improved compliance has been maintained at 92% for February 2025 (92% in January 2025). This demonstrates three months of sustained recovery following a drop in performance in October and November 2025. Performance is expected remain positive throughout 2025.

Looked after Children

Review Health Assessment performance improved in February 2025 to 94.7% (from 89% in January 2025). Previous months performance were affected by breaches beyond service control, so increased performance is reflective of ongoing service delivery.

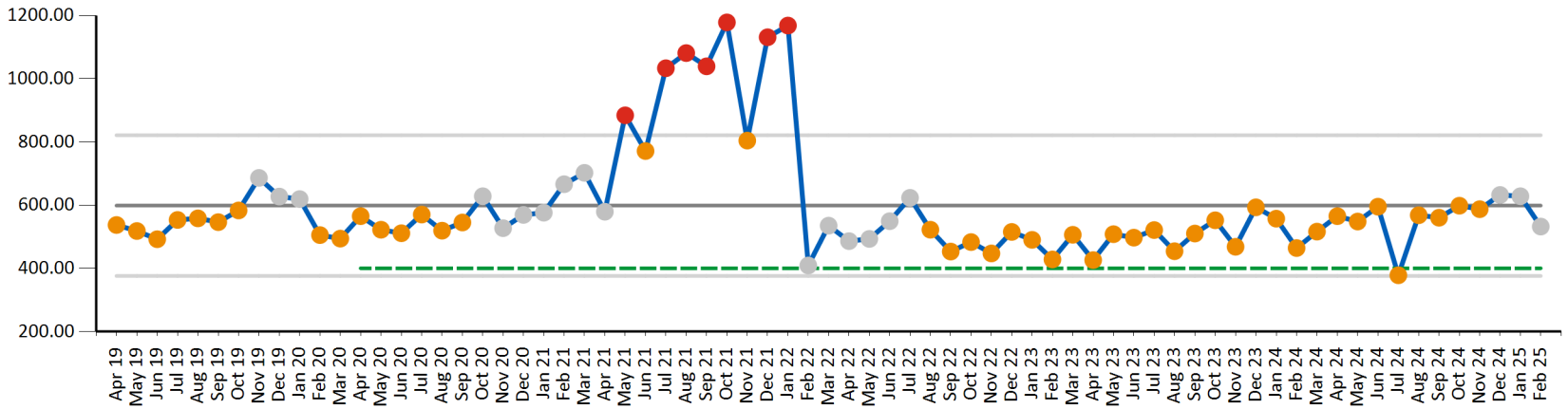
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	532	Feb-25		>= 400	628	Jan-25	>= 4,400	6,191	
493 - Average Number of Patients: with no Criteria to Reside	<= 99	92	Feb-25		<= 98	100	Jan-25	<= 99	92	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	617	Feb-25		<= 360	607	Jan-25	<= 3,960	7,895	
267 - 0-5 Health Visitor mandated contacts	>= 95%	82%	Feb-25		>= 95%	79%	Jan-25	>= 95%	77%	
269 - Education, health and care plan (EHC) compliance	>= 95%	92%	Feb-25		>= 95%	92%	Jan-25	>= 95%	81%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	89.0%	Feb-25		>= 90.0%	97.0%	Jan-25	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	94.7%	Feb-25		>= 90.0%	91.0%	Jan-25	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Feb-25		>= 90.0%	100.0%	Jan-25	>= 90.0%		

334 - Total Deflections from ED

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 400	532	Feb-25

Previous

Plan	Actual	Period
>= 400	628	Jan-25

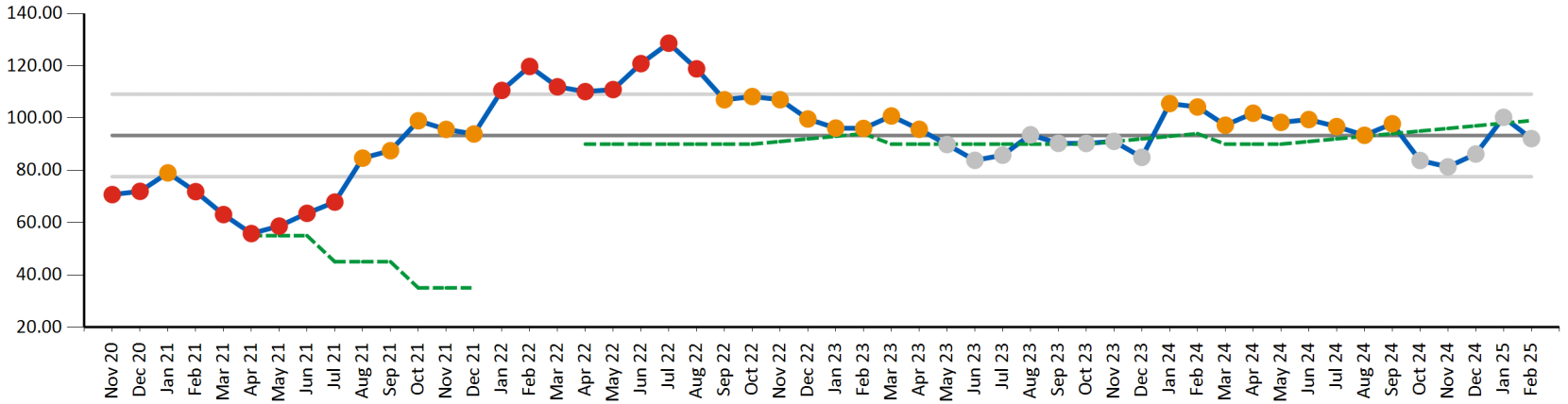
Year to Date

Plan	Actual
>= 4,400	6,191

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

Common cause variation.

We will not regularly meet the target due to normal variation. 4/6



Latest

Plan	Actual	Period
<= 99	92	Feb-25

Previous

Plan	Actual	Period
<= 98	100	Jan-25

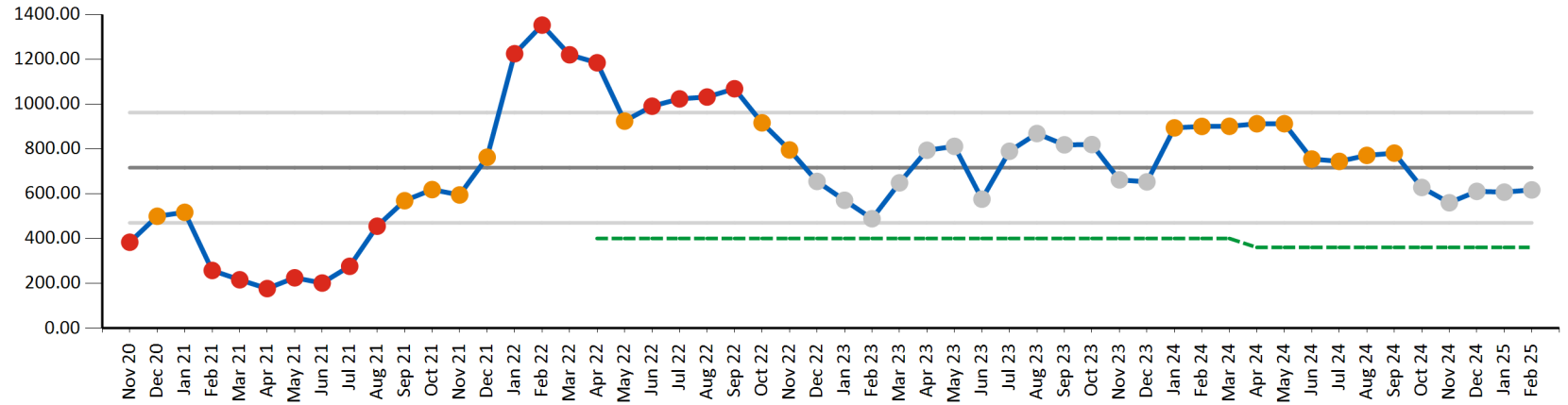
Year to Date

Plan	Actual
<= 99	92

494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

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



Latest

Plan	Actual	Period
<= 360	617	Feb-25

Previous

Plan	Actual	Period
<= 360	607	Jan-25

Year to Date

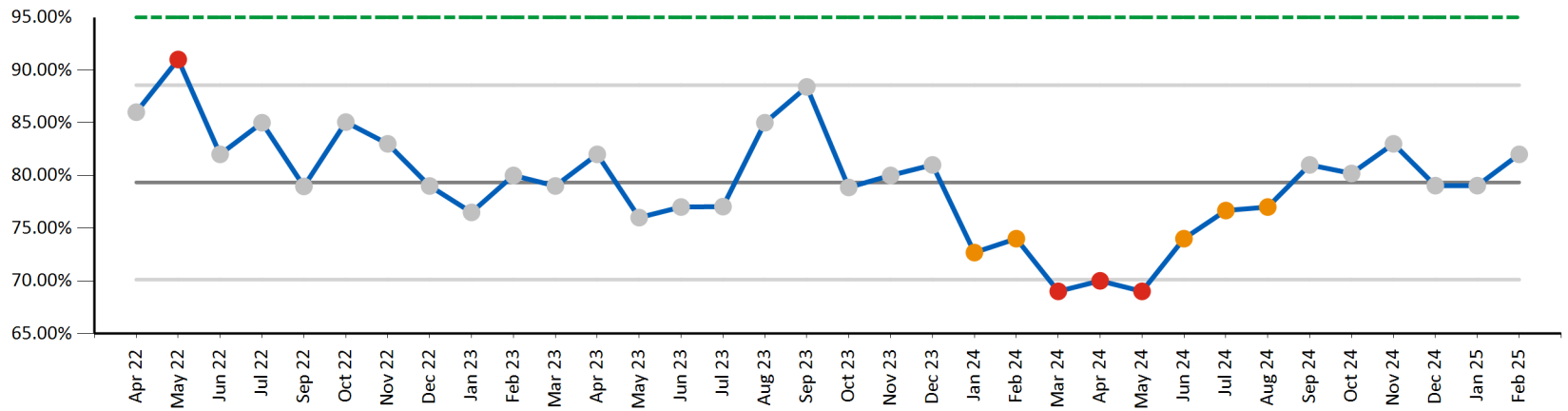
Plan	Actual
<= 3,960	7,895

267 - 0-5 Health Visitor mandated contacts

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	82%	Feb-25

Previous

Plan	Actual	Period
>= 95%	79%	Jan-25

Year to Date

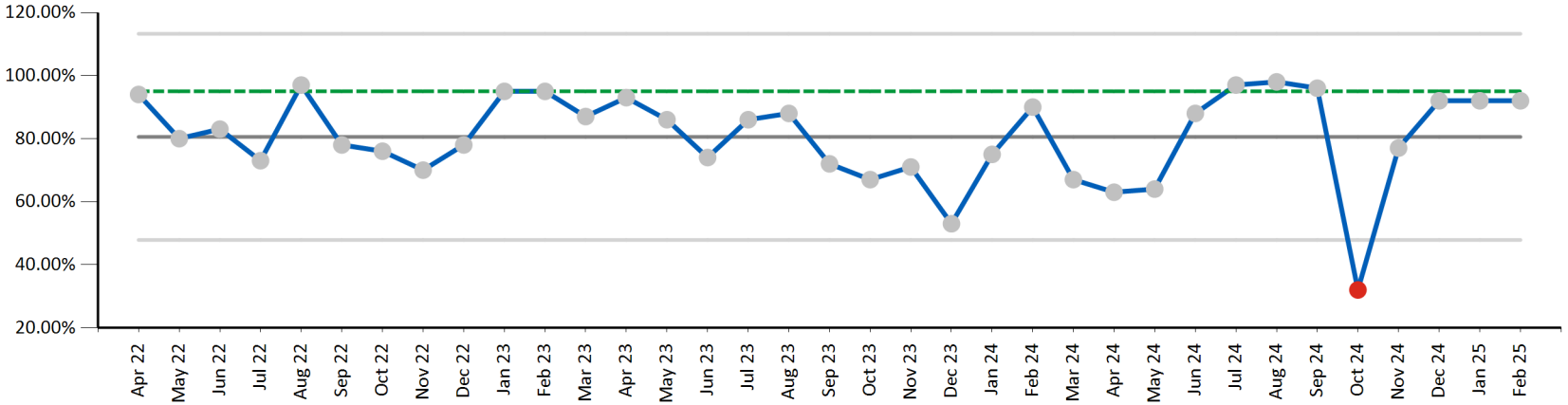
Plan	Actual
>= 95%	77%

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 95%	92%	Feb-25

Previous

Plan	Actual	Period
>= 95%	92%	Jan-25

Year to Date

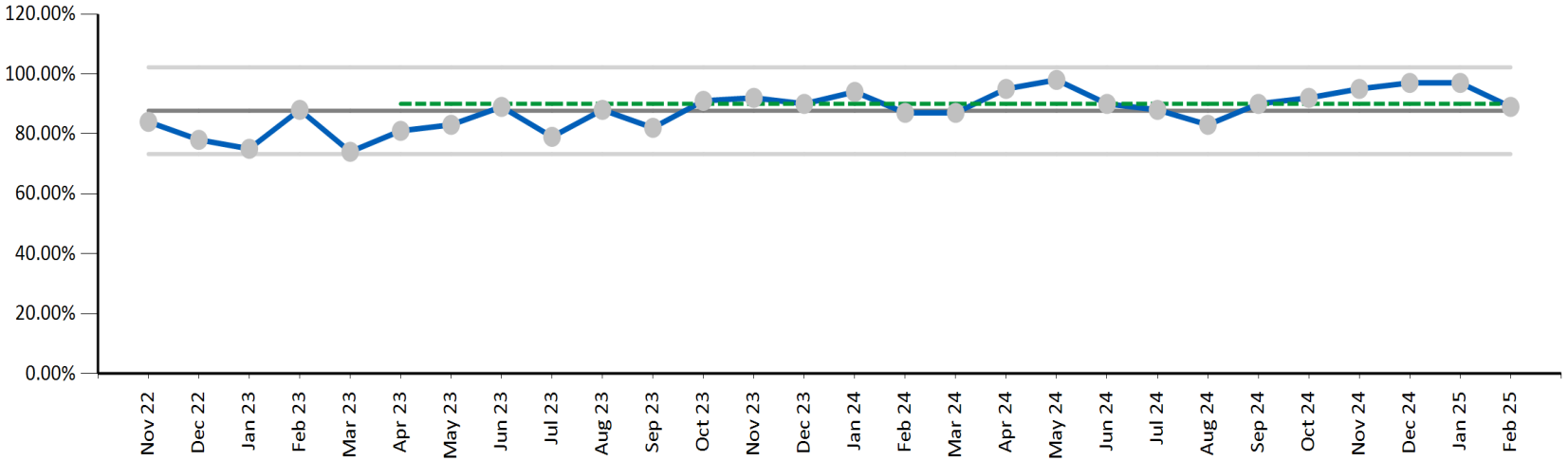
Plan	Actual
>= 95%	81%

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.

5/6



Latest

Plan	Actual	Period
> = 90.0%	89.0%	Feb-25

Previous

Plan	Actual	Period
> = 90.0%	97.0%	Jan-25

Year to Date

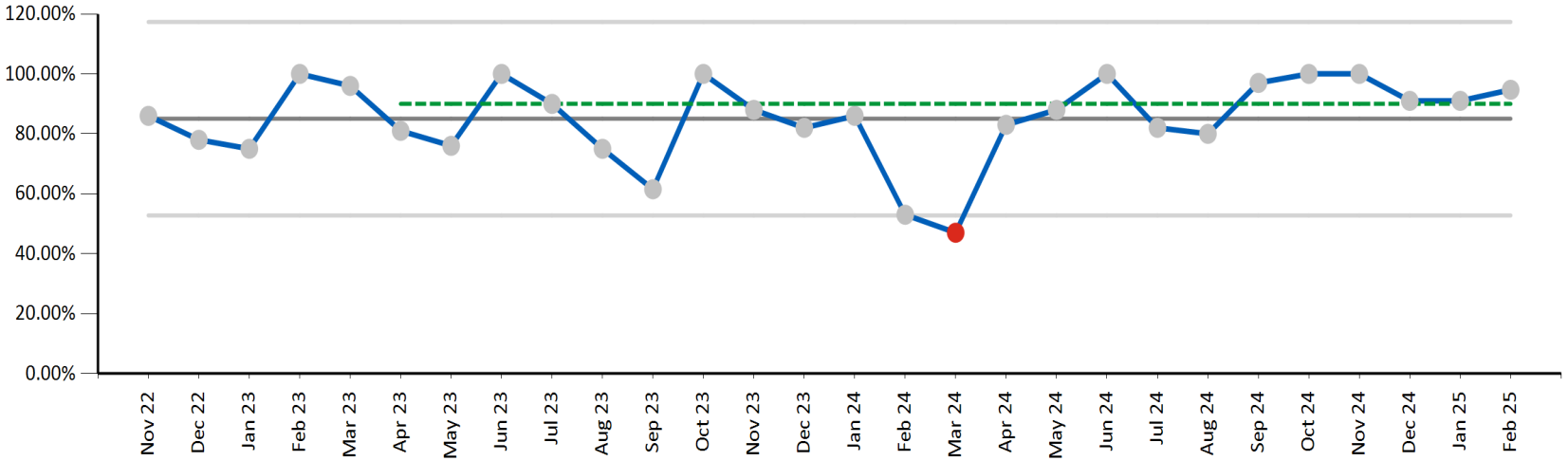
Plan	Actual
> = 90.0%	

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.

6/6



Latest

Plan	Actual	Period
> = 90.0%	94.7%	Feb-25

Previous

Plan	Actual	Period
> = 90.0%	91.0%	Jan-25

Year to Date

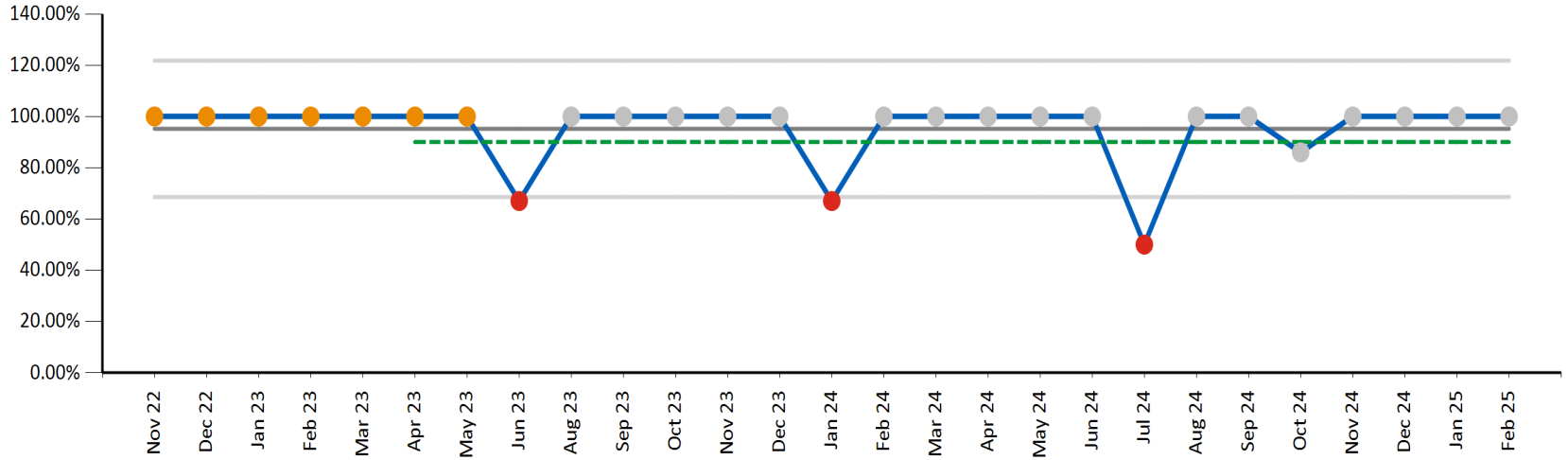
Plan	Actual
> = 90.0%	

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%	Feb-25

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Jan-25

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness has reduced in February 25 to 4.88% compared to 5.59% in January 2025. There has been a decrease in sickness absence across all clinical Divisions with the particular reductions in DSSD (reduction of 1.43%) and ICSD (reduction of 1.04%). Each Division continues to undertake a review of sickness, with an increased focus on providing wellbeing support through Occupational Health and wider wellbeing initiatives. 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.

Vacancy:
Vacancy rate reduced in February 2025 to 5.08%. Most clinical staff groups are showing low vacancy rates, particularly Nursing and Midwifery (3.88%), and Medical and Dental (1.41%).

Turnover:
Turnover reduced in month to 11.24%. The Trust has seen a static turnover trend in the YTD, which has followed our expectations.

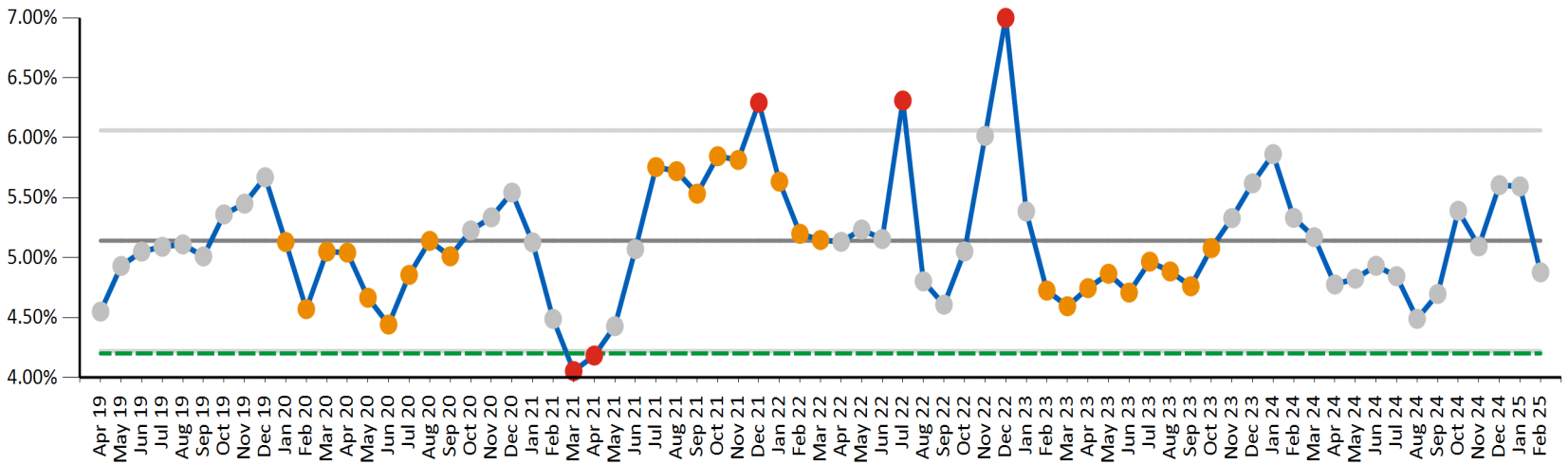
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.88%	Feb-25		<= 4.20%	5.59%	Jan-25	<= 4.20%	5.01%	F
120 - Vacancy level - Trust	<= 6%	5.08%	Feb-25		<= 6%	5.69%	Jan-25	<= 6%	5.37%	?
121 - Turnover	<= 9.90%	11.24%	Feb-25	L	<= 9.90%	11.62%	Jan-25	<= 9.90%	11.65%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Feb-25			1	Jan-25		11	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	4.88%	Feb-25

Previous

Plan	Actual	Period
<= 4.20%	5.59%	Jan-25

Year to Date

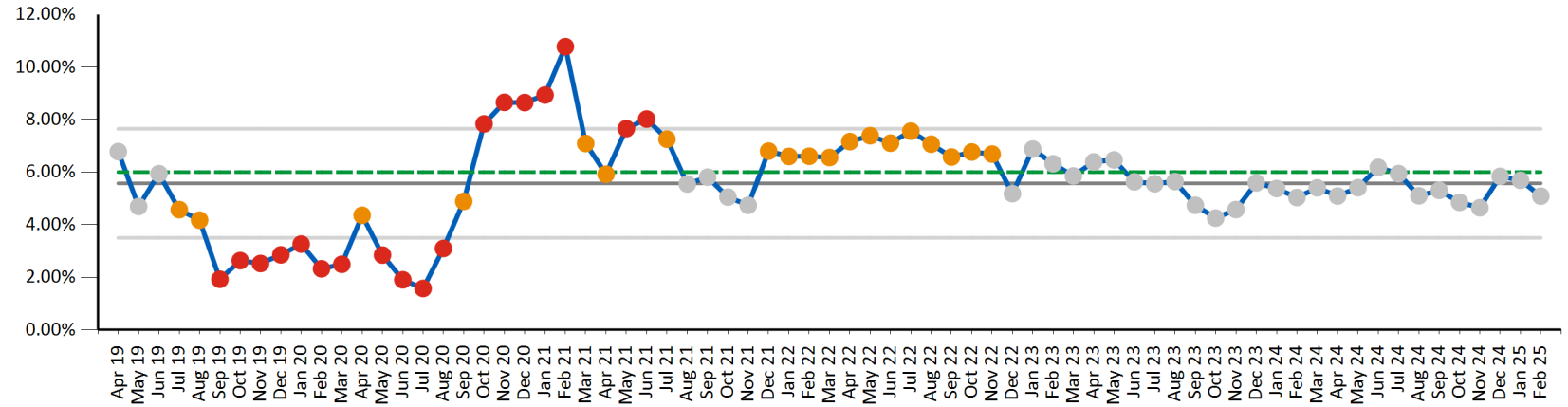
Plan	Actual
<= 4.20%	5.01%

120 - Vacancy level - Trust

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 6%	5.08%	Feb-25

Previous

Plan	Actual	Period
<= 6%	5.69%	Jan-25

Year to Date

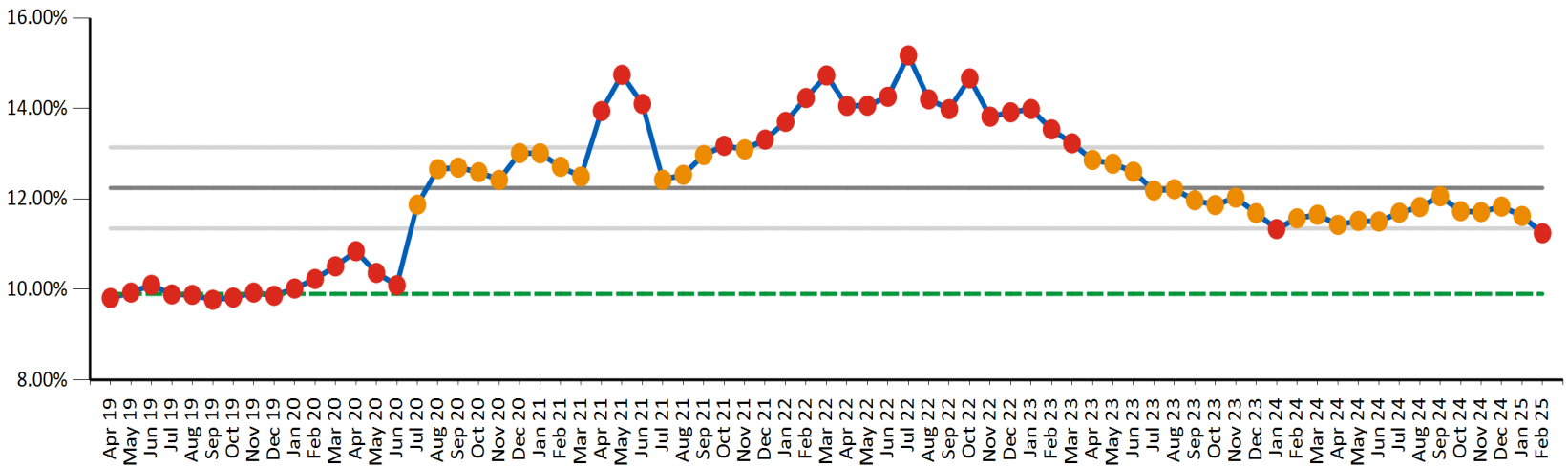
Plan	Actual
<= 6%	5.37%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.24%	Feb-25

Previous

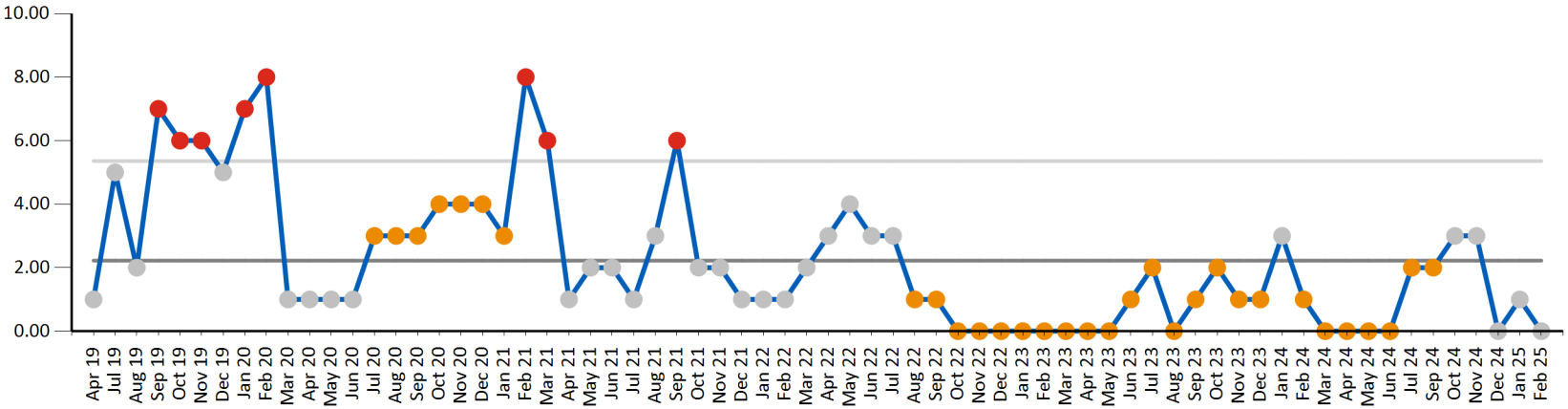
Plan	Actual	Period
<= 9.90%	11.62%	Jan-25

Year to Date

Plan	Actual
<= 9.90%	11.65%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-25

Previous

Plan	Actual	Period
	1	Jan-25

Year to Date

Plan	Actual
	11

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training

The divisions / directorates have continued to promote compulsory training throughout February. This has resulted in a 0.3% improvement to achieve 93.5% in March 2025. Although slightly under target by 1.5% this is the first year we have reported an improved Trust positon during the winter months. The high DNA rate for face to face training (BLS/ M&H /Safeguarding Adults) is contributing to the overall position and is the focus of improvement over the coming months. It is acknowledged that AACD and ASD are challenged to maintain their position resulting in winter pressures and have a small dip in their compliance.

Trust Mandated Training

All divisions / directorates have improved upon the 85% target set, giving an overall performance of 90.6%. This is a very positive position and one that has been maintained steadily for the past 12 months.

Appraisal

A further deterioration this month to 84.3% has resulted in compliance dipping below the 85% target for the first time since June 2024. We continue to provide targeted support for divisions /directorates with the lowest compliance. It is also anticipated that the launch of the blended learning bundles for appraisal (for staff and leaders) in February and focus on FABB appraisal conversations during the 2 day 'Our Leaders' events, also launched Trust wide in February, will contribute towards an improved position over the coming months.

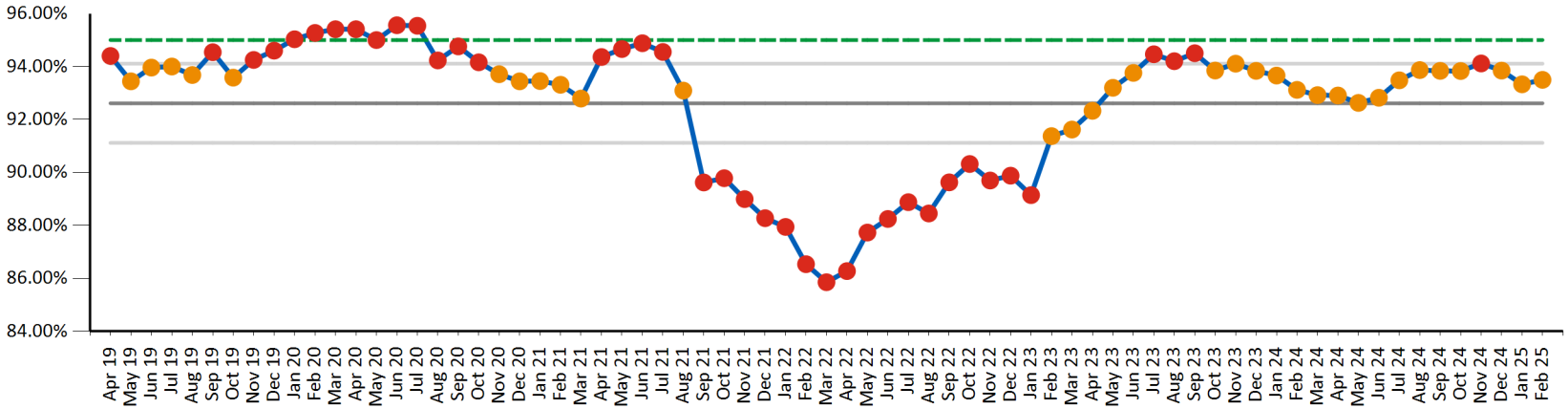
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.5%	Feb-25		>= 95%	93.3%	Jan-25	>= 95%	93.5%	
38 - Staff completing Trust Mandated Training	>= 85%	90.6%	Feb-25		>= 85%	89.8%	Jan-25	>= 85%	90.2%	
39 - Staff completing Safeguarding Training	>= 95%	93.42%	Feb-25		>= 95%	92.55%	Jan-25	>= 95%	92.16%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.3%	Feb-25		>= 85%	86.1%	Jan-25	>= 85%	85.8%	
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%	93.5%	Feb-25

Previous

Plan	Actual	Period
>= 95%	93.3%	Jan-25

Year to Date

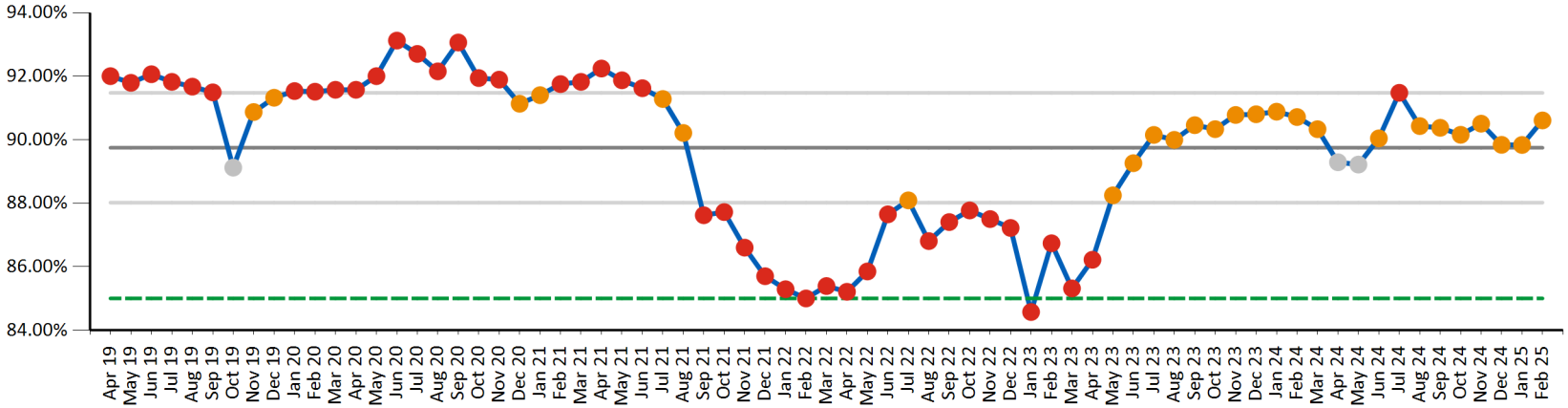
Plan	Actual
>= 95%	93.5%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.6%	Feb-25

Previous

Plan	Actual	Period
>= 85%	89.8%	Jan-25

Year to Date

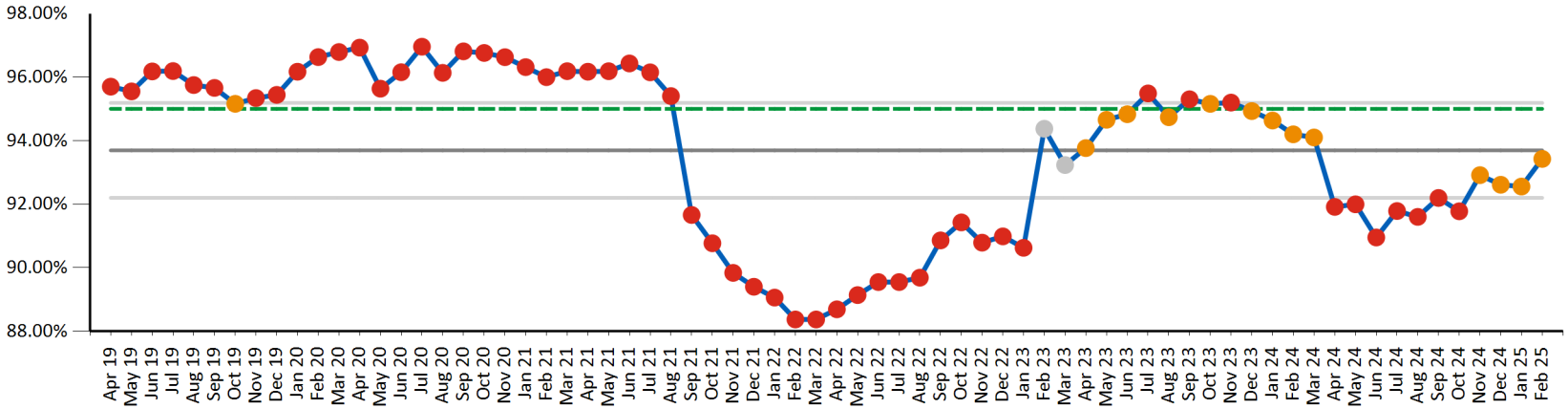
Plan	Actual
>= 85%	90.2%

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%	93.42%	Feb-25

Previous

Plan	Actual	Period
>= 95%	92.55%	Jan-25

Year to Date

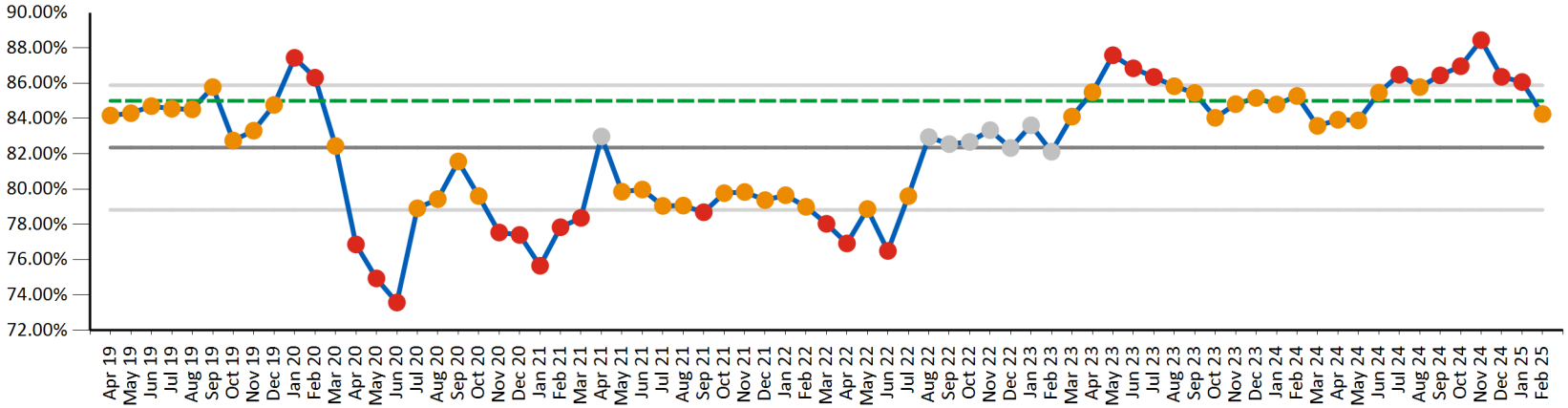
Plan	Actual
>= 95%	92.16%

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.

5/6



Latest

Plan	Actual	Period
>= 85%	84.3%	Feb-25

Previous

Plan	Actual	Period
>= 85%	86.1%	Jan-25

Year to Date

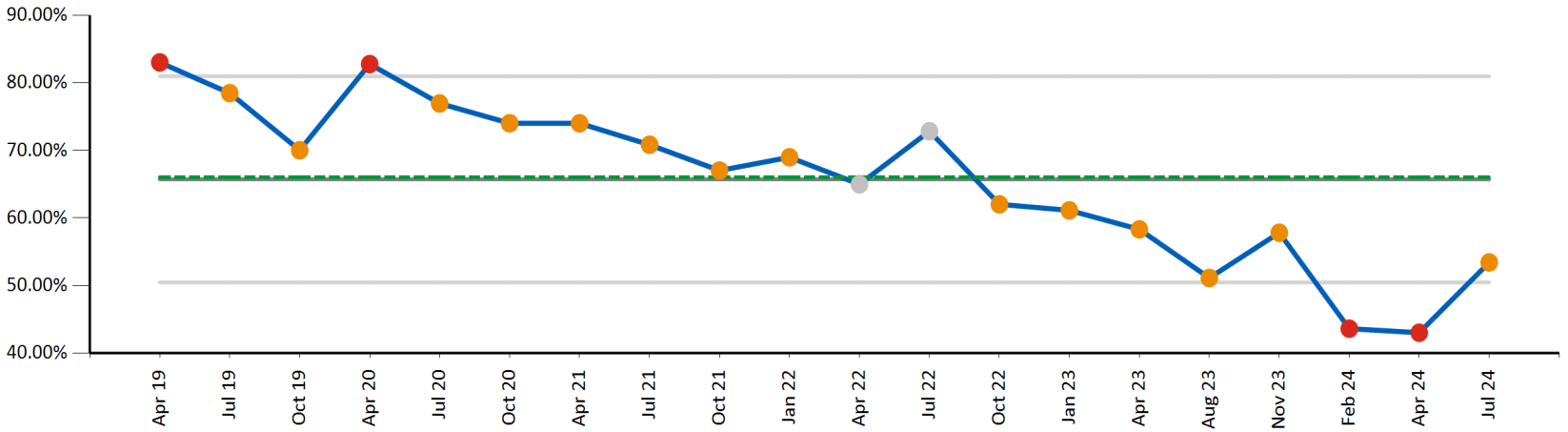
Plan	Actual
>= 85%	85.8%

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

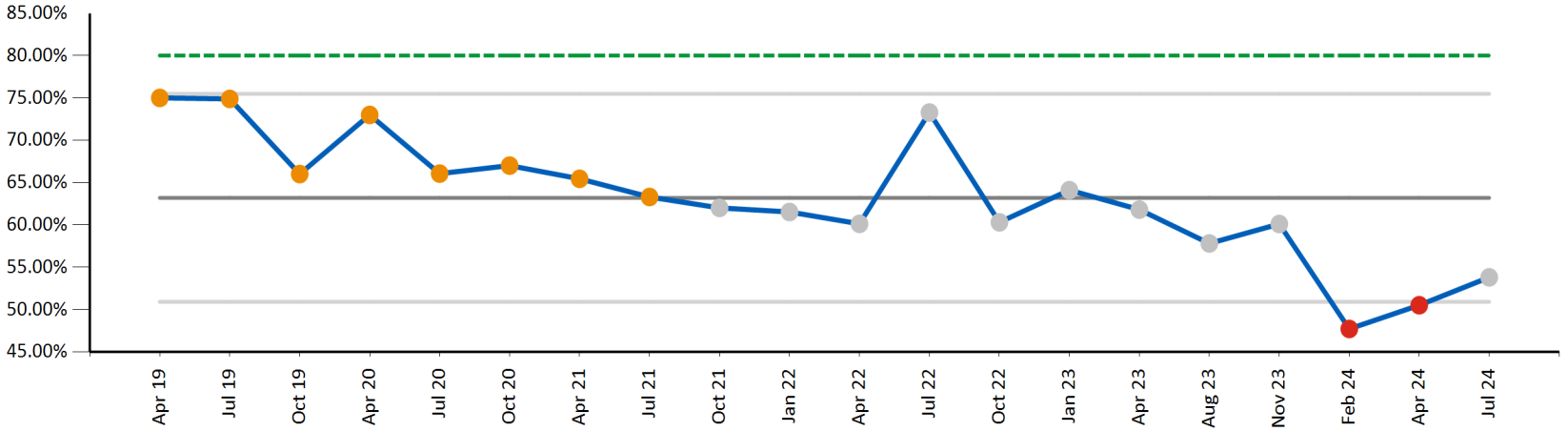
Plan	Actual
>= 66%	

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

Agency spend in February 2025 was relatively static (small reduction of £17k noted). The Trust is under our agency spend forecast for the YTD by £1.6m, and we are under NHSE spend target (agency spend should not exceed 3.2% of pay budget) at 2.3%.

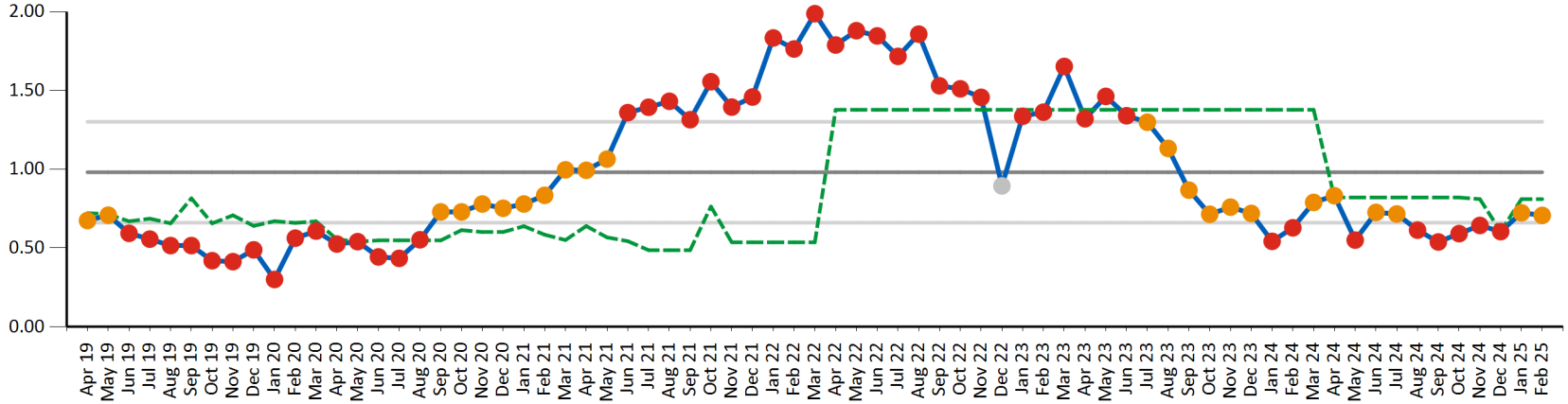
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.81	0.71	Feb-25		<= 0.81	0.72	Jan-25	<= 8.77	7.24	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.09	0.09	Feb-25		<= 0.09	0.12	Jan-25	<= 0.92	0.68	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.61	0.52	Feb-25		<= 0.61	0.49	Jan-25	<= 6.51	5.49	

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 0.81	0.71	Feb-25

Previous

Plan	Actual	Period
<= 0.81	0.72	Jan-25

Year to Date

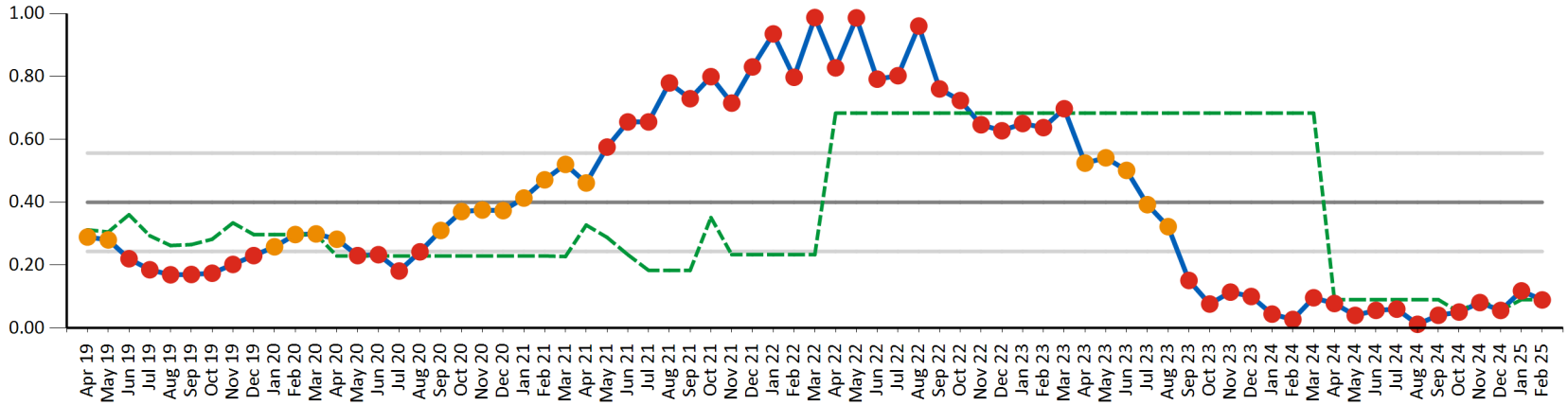
Plan	Actual
<= 8.77	7.24

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

Special cause variation with improving performance

We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 0.09	0.09	Feb-25

Previous

Plan	Actual	Period
<= 0.09	0.12	Jan-25

Year to Date

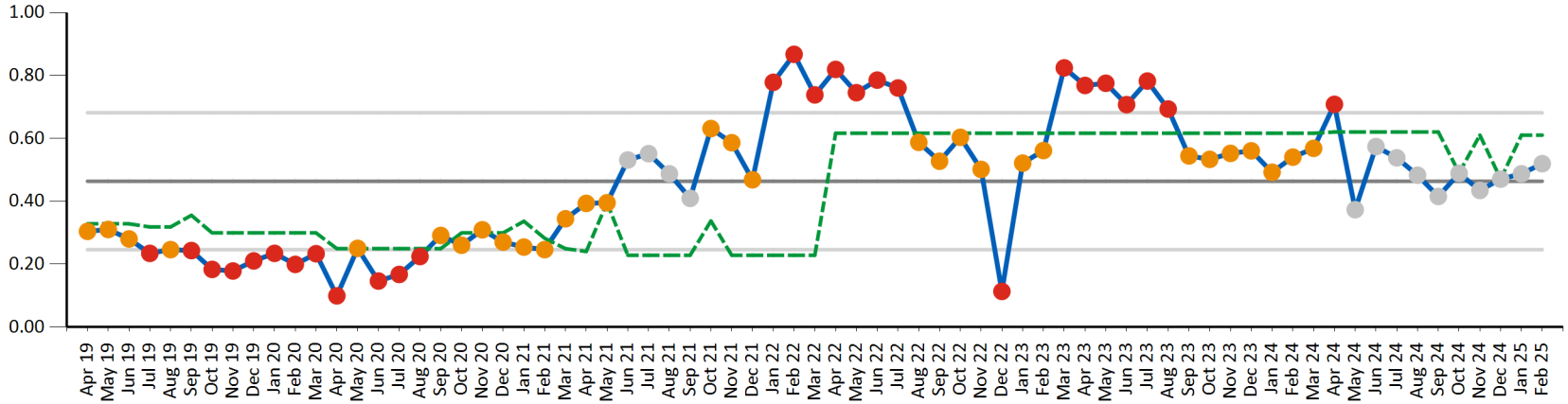
Plan	Actual
<= 0.92	0.68

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 0.61	0.52	Feb-25

Previous

Plan	Actual	Period
<= 0.61	0.49	Jan-25

Year to Date

Plan	Actual
<= 6.51	5.49

Finance - Finance

NHS Bolton NHS Foundation Trust

Surplus / (Deficit)
The Trust is on plan with a deficit of £2.7m YTD. This improvement in the position is due to raising a disputed invoice to Bolton Council for the impact of the AFC pay award.

Income
ERF overperformance of £3.3m has been included YTD at Month 11.

Pay
Overspend is driven by a combination of additional expenditure driving the elective income overperformance and the variation in type of delivered CIP versus the planned delivery.

Non Pay
The Trust is incurring additional cost with various insourcing / outsourcing providers which has supported additional elective income offset by the variation in type of delivered CIP versus the planned delivery.

Non Operating
Interest received has been higher than planned. It is anticipated that interest will reduce throughout the year as cash balances reduce.

Cash
The Trust was above plan by £0.1m Month 11. In the likely case forecast scenario, the Trust will be overdrawn by £4.9m at the end of March. However, PDC funding cash that the Trust is has received means that the Trust does not end up overdrawn in 24/25.

CIP Delivery
The Trust has released significant non recurrent benefit to support in year delivery of plan. FYE of recurrent schemes is £19.3m un risk rated (c£16.4m RAG - 68% of REC)

Capital
Plan values now represent the latest capital forecast agreed with the GM ICB. CDEL spend is £2.9m behind the GM forecast YTD and IFRS 16 spend is £1m lower than forecast.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -0.7	0.2	Feb-25		>= 0.7	-0.4	Jan-25	>= 0.0	-5.4	
222 - Capital (£ millions)	>= 4.1	2.4	Feb-25		>= 4.1	2.4	Jan-25	>= 21.2	10.4	

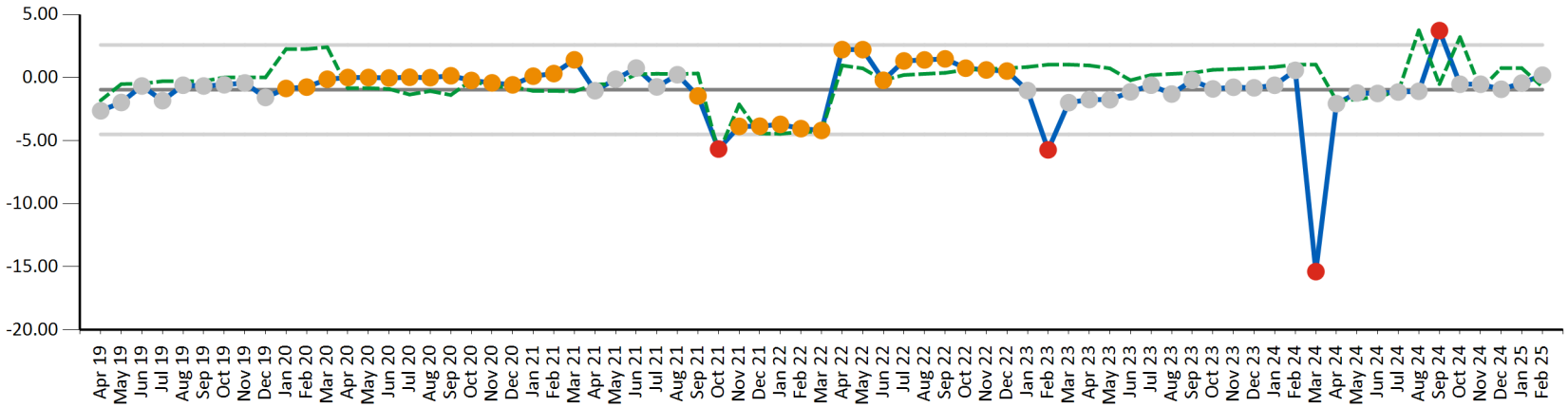
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
223 - Cash (£ millions)	>= 7.3	7.4	Feb-25	L	>= 8.1	8.1	Jan-25	>= 7.3	7.4	P

220 - Control Total (£ millions)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= -0.7	0.2	Feb-25

Previous

Plan	Actual	Period
>= 0.7	-0.4	Jan-25

Year to Date

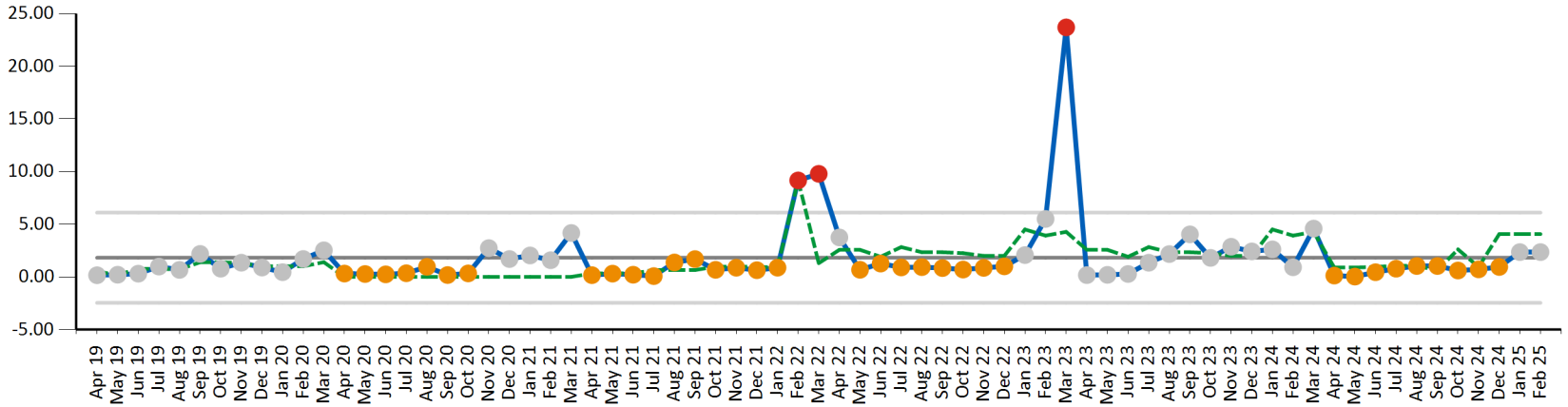
Plan	Actual
>= 0.0	-5.4

222 - Capital (£ millions)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 4.1	2.4	Feb-25

Previous

Plan	Actual	Period
>= 4.1	2.4	Jan-25

Year to Date

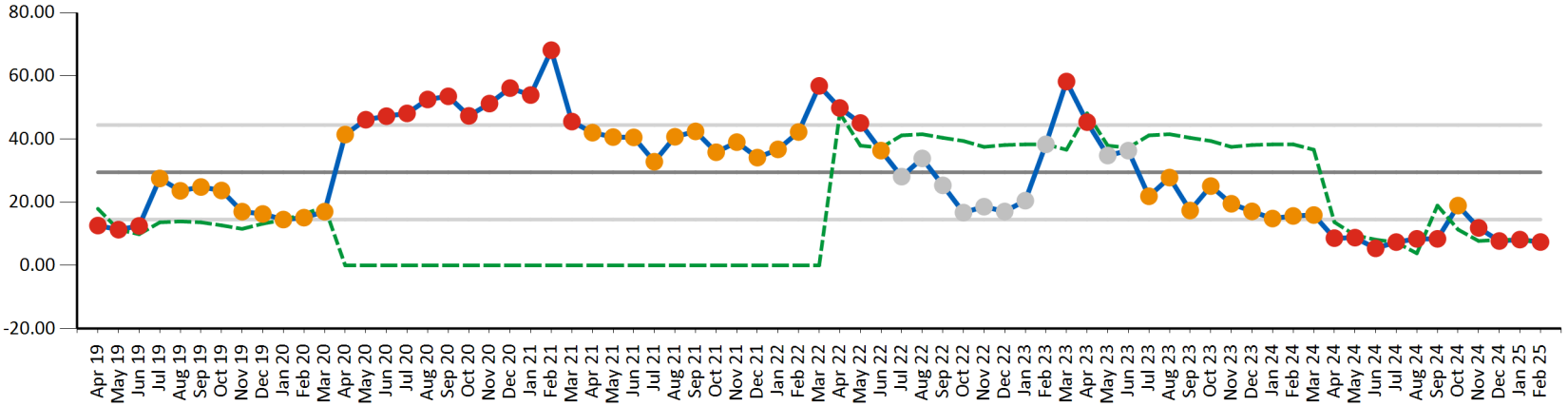
Plan	Actual
>= 21.2	10.4

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

4/6



Latest

Plan	Actual	Period
>= 7.3	7.4	Feb-25

Previous

Plan	Actual	Period
>= 8.1	8.1	Jan-25

Year to Date

Plan	Actual
>= 7.3	7.4

Report Title:	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	

Purpose of the report	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 year 6 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee – 05 March 2025 Quality Assurance Committee – 26 March 2025

Executive Summary	Assurance can be provided that the completed CNST year 6 declaration form was submitted to NHS Resolution on the 17 February 2025 and safe receipt acknowledged. Ongoing monitoring of defined action plans within the programme will continue until commencement of the CNST year 7 scheme and detailed updates are provided within this report. The Trust has received formal notification that the CNST year 7 scheme document and accompanying resources will be published on the 2 April 2025. NHS Resolution has confirmed they anticipate year 6 payments will be made to all Trusts from the end of April 2025 following the external publication of all results.

Proposed Resolution	The Board of Directors are asked to: i. Receive the contents of the report. ii. Approve the action plans detailed within this report. iii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required

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	Potential impact upon maternity incentive scheme fund reimbursement.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse	**Presented by:**	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse

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
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
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 year 6 (CNST) Maternity Incentive Scheme (MIS).

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

Assurance can be provided that the completed CNST year 6 declaration form was submitted to NHS Resolution on the 17 February 2025 and safe receipt acknowledged.

The Trust has received formal notification that the CNST year 7 scheme will be launched on the 02 April 2025.

NHS Resolution has confirmed they anticipate year 6 payments will be made to all Trusts from the end of April 2025 following the external publication of all results.

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 maternity service was advised formally in June 2024 that that upon conclusion of the year 6 scheme all activities to meet the year 6 SA1 standards should continue, prior to commencement of the CNST year 7 scheme.

The maternity service will therefore continue to submit a report each quarter that includes details of all deaths reviewed from the 8 December 2024 and continue to monitor the required indicators in future board reports 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 fin your Trust multi-disciplinary reviews using the PMRT should be carried out from 02 April 2024; 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.

All cases that have occurred since 08 December 2023 are detailed with Appendix 1 with progress relating to thematic actions identified from the completed reviews detailed in Appendix 1a.

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 of consultant attendance for the clinical situations listed in the RCOG workforce document and this is detailed in the safety champion's dashboard (table 4).

The Q3 2024/2025 RCOG attendance audit report has been published and one breach relating to the birth of a preterm infant out of hours was reported. The consultant was unable to attend as the incident occurred out of hours and needed to travel to the maternity unit. The breach was discussed at the maternity and gynaecology audit meeting held on the 15 January 20205 as per required standard.

c) Neonatal medical workforce

The reallocation of the PAs following the recent appointment of an additional SAS doctor remains ongoing 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

d) Neonatal nursing workforce

The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cot side 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. There are currently 5 staff members in training and further due to commence training in September 2025.

Progress with regard to the newborn life support training plan is detailed in appendix 2.

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 board safety champions and perinatal leadership team last met on the 02 January 2025 and discussed the cultural action plan. Engagement sessions are currently being held with both medical and midwifery staff groups to improve communication and engagement between all parties.

A survey has recently been completed to seek the wider views of medical staff with regard to improving the culture and working practices within the maternity service. Feedback sessions have been planned.

As part of the work of the safety champions walkabouts are held bi-monthly. During the visit in January 2025 feedback was sought from service users regarding the friends and family test and the ideal location of the posters for the QR responses – this was enacted immediately during the visit. Information gathered continues to be collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 4).

The Board Safety Champion continues to work with the safety champions to address the reduced bed capacity within the ward G3/G4 environment and review the impact upon safety outcomes using the integrated performance dashboard metrics.

4. 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 4.

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 is 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 held on the 02 January 2025.

There were three stillbirths in December 2024 (including one case of compassionate termination) and one neonatal death. Two of the cases were related to an antepartum haemorrhage and resulted in subsequent death. The remaining cases are currently being reviewed using the perinatal mortality tool.

A case of maternal death occurred in February 2025 and the cause of death was confirmed as pulmonary embolism and deep vein thrombosis in the third trimester of pregnancy. The baby was born via peri-mortem caesarean section and care was later withdrawn. The case has been referred to MNSI for an external review and support is being provided to both family and staff members involved.

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	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		419	426	451	441	374	434
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			2	1	1	2	0	3
Still Birth rate per thousand	3.5	≥4.3	4.8	2.3	2.2	4.5	0.0	6.9
HIE Grades 2&3 (Bolton Babies only)	0	1	1	1	0	0	0	0
HIE (2&3) rate (12 month rolling)	<2	2.5	2.2	1.8	1.4	1.2	1.2	1.2
Early Neonatal Deaths (Bolton Births only)	Information only		3	3	0	0	3	0
END rate in month	Information only		7.2	7.1	0.0	0	8.0	0
Late Neonatal deaths	Information only		0	0	0	0	0	1
PSII Incidents (New only)	0	2	0	0	0	0	0	0
MNSI referrals (Steis reportable)			1	2	0	0	0	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0

Moderate harm events			1	2	0	1	0	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	99.0%	99.7%	99.7%	99.1%	98.5%	97.8%
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 indirect (neonatal unit)	>99%	<79%	98%	99.0%	100.0%	99.00%	100.0%	95%
Fetal monitoring training compliance (overall)	<90%	>80%	87.40%	88.00%	83.62%	83.90%	94.23%	92%
PROMPT training compliance (overall)	<90%	>80%	86.22%	83.00%	85.10%	82.37%	99.63%	99%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:22.6	1:22.9	1:22.8	1:21.9	1:21.3	1:21.1
RCOG benchmarking compliance	Information only		60%	100%	100%	100%	80%	100%
Compensatory rest breaches			0	1	0	0	0	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

5. Summary

This report confirms the completed CNST year 6 declaration form was submitted to NHS Resolution on the 17 February 2025 and safe receipt acknowledged.

This report provides assurance of the ongoing monitoring of the relevant CNST action plans and of defined key performance safety metrics.

6. Recommendations

It is recommended that the Committee:

I. Receive the contents of the report.
II. Approve the action plans detailed within this report.
III. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Perinatal mortality review tool cases as from 08 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	20.12.2023	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	03.01.2024	0	03.01.2024	03.01.2024	20.6.2024
91589	ENND	35+3	29.01.2024	0	29.01.2024	29.01.2024	**27.06.2024**
91686	ENND	38+0	04.02.2024	0	06.02.2024	04.02.2024 and 06.02.2024	**04.07.2024**
91814	SB	25+3	09.02.2024	0	09.02.2024	10.02.2024	**25.07.2024**.
91853	SB	26+3	11.02.2024	1	11.02.2024	11.02.2024	18.07.2024
91945	Post NND > 29 DAYS OLD	30	18.01.2024 17.02.2024	0	17.04.2024 Assigned to Blackpool	20.02.2024	18.07.2024
91972	SB	40+0	19.02.2024	0	19.02.2024	19.02.2024	19.08.2024

91991	ENND	26+1	18.02.2024 20.02.2024	0	20.04.2024 Assigned to MFT (NMGH)	24.02.2024	20.08.2024
92299	SB T2	27+ DIAG/36+ BIRTH	11.03.2024	0	07.06.2024	10.03.2024	11.09.2024
92395	NND	34	07.02.2024 29.02.2024	15 due to not known-Community /home Death	19.03.2024	05.06.2024	29.08.2024
92646	Late Fetal Loss	22+3	02.04.2024	0	02.04.2024	05.04.2024	02.10.2024
92923	NND	24+	14.04.2024 20.04.2024	0	21.04.2024	22.04.2024	22.10.2024
93126	SB	38+1	01.05.2024	0	03.05.2024	02.05.2024	01.11.2024
93150	SB	29	02.05.2024	0	03.05.2024	20.05.2024	02.11.2024
93167	SB	40	05.05.2024	0	06.05.2024	06.05.2024	05.11.2024
93360	ENND	22+1	16.05.2024	2	18.05.2024	18.05.2024	16.11.2024
93394	SB	25	19.05.2024	1	20.05.2024	21.05.2024	19.11.2024
93618	SB	24+6	03.06.2024	0	04.06.2024	15.06.2024	03.12.2024

93712	SB	39+2	09.06.2024	1	10.06.2024	10.06.2024	07.11.2024
93915	ENND	40	16.06.2024 21.06.2024	0	24.06.2024	21.06.2024	21.12.2024
94081	ENND	23+	28.06.2024 01.07.2024	0	02.07.2024	01.07.2024	01.01.2025
94116	SB	31+4	02.07.2024	0	02.07.2024	03.07.2024	02.01.2025
94292	SB	26+2	13.07.2024	2	13.09.2024	14.07.2024	13.01.2025
94328	ENND	24+3	16.07.2024	1	16.08.2024	16.07.2024	16.01.2025
94798	ENND	22+1	19.08.2024	0	assigned to Wigan 23.08.2024	19.08.2024	19.02.2025
94819	SB	25+5	19.08.2024	1	20.08.2024	20.08.2024	19.02.2025
95000	LATE MISC	23+2	01.09.2024	1	02.09.2024	05.09.2024	01.03.2025
95082	SB	27+1	06.09.2024	3	01.11.2024	11.9.24	06.03.2025

95672	NND	24+1	09.09.2024 17.10.2024	1			
95666	SB T1	28+4	18.10.24	1	18.11.24	19.10.24	18.04.2025
95840	SB	27+2	29.10.2024	1	30.11.2024	29.10.2024	29.04.2025
96169	NND	23+0	21.11.2024 23.11.2024	0	23.01.2025	25.11.2024	23.05.2025
96354	SB	24+4	04.12.2024	1	04.02.2025	04.12.2024	04.06.2025
96351	NND	29+1	04.12.2024		04.02.2025	04.12.2024	04.06.2025
96412	SB	33+1	09.12.2024	1	09.02.2025	10.12.2024	09.06.2025
96482	LFL	22-23	13.12.2024	3	13.02.2025	16.01.2025	13.06.2025
96621	LFL	22+3	26.12.2024	1	26.02.2025	26.12.2024	26.06.2025
96707	SB	38+5	31.12.2024	1	31.02.2025	31.12.2024	31.06.2025
96723	SB	24+3	03.01.2025	0			03.07.2025
96783	SB	37+1	06.01.2025	1	06.03.2025	07.01.2025	06.07.2025
96865	SB	31+4	11.01.2025	0	11.03.2025	13.01.2025	11.07.2025
96927	NND	27+	15.01.2025 AN care at Preston	1	15.03.2025	16.01.2025	15.07.2025
97050	SB	35+4	24.01.2025	0	24.05.2025	24.01.2025	24.07.2025
97091	ENND	22+6	25.01.2025	0	25.05.2025	25.01.2025	25.07.2025
97179	ENND	22+2	31.01.2025	1	31.05.2025	31.01.2025	31.07.2025
97164	ENND	32+3	02.02.2025	0	02.06.2025	02.02.2025	02.08.2025

Appendix 1a – Ongoing themes actions highlighted in completed reviews relevant to the deaths reviewed

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	Antenatal booking appointment to be completed within recommended timeframe	Trudy Delves	01/10/2024	08.10.24 Ongoing Improvement Plan for Maternity Bookings in place. Self-referral booking process progressing with digital support. Monitoring of compliance undertaken monthly via IPM pack of 10+0 and 12+6 pathways.	**3**
2.	Inclusion in the ASAP national programme to promote early booking	Trudy Delves	01/10/2024	17.12.24 Link made with lead from national ASAP programme and initial draft communications shared.	**3**
3.	CO monitoring to be undertaken at each appointment	Trudy Delves	01/10/2024	08.10.24 CO monitors in clinics and all areas. Maternity Tobacco Dependency Midwife allocated training time	**3**

				on new SBLV3 training day agenda. 22.11.24 Ongoing audit of compliance continued in accordance with CNST guidance	
4.	Domestic Abuse question to be asked at booking appointment	Trudy Delves / Fran Ireland	01/12/2024	08.10.24 Undertake audit of compliance and identify actions to be undertaken in response. 20.02.24 Audit awaited	**2**
5.	Triage BSOT assessment to be undertaken with evidence of audit	Emma Jones	01/10/2024	08.10.24 BSOTS action plan and review of triage in progress. 30.08.24 BSOTs audit ongoing as per clinical audit schedule to monitor delays in assessment and actions as appropriate.	**4**
6.	Sepsis 6 pathway to be followed	Lizzy Dean/Emma Jones	01/3/2025	08.10.24 National MEOWS in process of being implemented as a formal project. 1.11.24 E-learning implementation offered to all staff and added to ESR learning package 20.02.24 National MEWS launch planned for the 28.2.25	**2**

7. 5	Targeted offer for multigravida families in highest risk areas to be considered using REACH pregnancy circles service.	Trudy Delves	01/03/2025	18.12.24 REACH pregnancy circle training commenced. 20.02.24 REACH circles to areas of high deprivation to be piloted.	**2**
8.	No bereavement care since death of baby			03.01.25 Review of funding for counselling offer for bereaved families completed. Funding secured for an external service to provide this offer.	**4**
9.	Book ANDU appointment at point of discharge			All Ward Clerk staff on CDS advised and trained to offer appts at the point of discharge from Triage rather than advise woman to call to make subsequent apt.	**4**

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Appendix 2 – NLS training plan

f	NLS	Actions Required	Rating
8.18	Is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid resuscitation council NLS certification or local assessment in line with BAPM basic capability guidance by year 7 of MIS and ongoing.	All Medics to complete a LOCAL NLS teaching session in line with BAPM basic capability guidance on Doctors induction which occurs every 6 months when the doctors rotate	
		Confirmation from the deanery of which doctors will be attending NLS for a rotation place at Bolton NICU is received approximately 4 weeks before rotation. Doctors will be contacted by Medical Teaching Lead for confirmation of when they completed the 4 yearly NLS course and if anyone is overdue/due we aim to accommodate them on the next course we have candidate availability	
		All permanent medical staff who are not GIC instructors receive annual NLS teaching session in line with BAPM basic capability guidance	
		All permanent medical staff who are GIC instructors but have not taught on a course in 12 months will receive an annual NLS teaching session in line with BAPM basic capability guidance. Staff identified to attend the annual training to maintain full compliance.	

Appendix 3 - Cultural improvement plan developed to align with the Family Care Division Staff Survey Plan

Theme	Observation	Actions
Capacity and resource	**Burnout is seen as high post Covid.** Majority of staff resonate with high burnout climate, some saw it an issues for senior staff	• **Actively promote resources such as Vivup, Occupational Health, GM Resilience Hub.** • **Take time to check in with colleagues and focus on wellbeing and health** • **Ensure timely referrals and sign posting to support wellbeing** • **Encourage breaks and hydration** • **Encourage self-care and boundaries between work and personal time** • **Encourage staff to engage in activities that recharge them Continue to roll out team engagement days and activities to encourage positivity and teambuilding in the workplace**
	Lack of resources, staffing and duplication in process impacting on burnout. Most staff felt that there were insufficient resources and staffing with appropriate systems and process that required duplication of effort	• **Full staffing review of the service, now recruited to staffing deficit.** • **Further funds to be sought to actively recruit into maternity leave.** • **Staffing updates to be feedback to the team so they are aware of staffing plans and feel included.** • **To continue with ongoing recruitment to support turnover and improve skill mix. Staff to be encouraged to support the recruitment process to allow them exposure and involvement in making improvements and strengthening the team.** • **Management team to remain visible.** • **Ensure staff are utilising annual leave appropriately to support rest and recuperation.** • **Encourage staff to access unit psychology support (once in post)**
	Work life balance and burn out. Some staff feel this was compounded by issues outside work, e.g. cost of living	• **Ongoing reviews of processes to avoid duplication of workload** • **Timely occupational health referral's and reasonable adjustments put in place if necessary.**

		• **Ensure staff are utilising annual leave appropriately to support rest and recuperation.** • **Encourage staff to access unit psychology support (once in post)** • **Continue to ensure team members access FABB conversations and have an open-door policy.**
	Support to staffing in training / preceptorship and review skill mix.	• **Training gaps to be identified- to support staff** • **To continue to provide educational support and training to support staff to time manage and review resources which may avoid duplication, and labour intensive measures**
	Perception of a lack of space for rest breaks. A number of staff commented on the physical estate and the lack of space for rest breaks.	• **Support timely meal breaks in clinical areas.**

Theme	Observation	Actions
Collaboration within teams	**Positive team working in community.** Some staff commented positively on elements of team working in community.	• **Daily huddle format updated to incorporate staff daily health and wellbeing concerns.**
	Communication breakdown are often drive by trust system and process. Some staff report that breakdown in communication were exhibited by sub-optimal systems and process	• **Encourage staff to speak out and vocalise the need for support if they feel pressure which may compromise the care they provide and / or their wellbeing.** • **review workloads and allocation on a shift by shift basis**
Leadership & learning	**Visibility of the leadership team**. Some staff would welcome the opportunity for more visibility	• **Encourage staff to engage in Family care connect sessions to share any issues or any concerns.** • **Management team to remain visible and accessible to all.** • **Fortnightly walk rounds**

	Positive local line management. Staff felt the community line manager was positive and supportive	• **Continue to ensure team members access FABB conversations and have an open-door policy.** • **Daily check in with staff at safety huddles.** • **To continue to share FCD good news with all staff** • **To improve feedback mechanisms and encourage current measures** • **To encourage staff to attend IPM, CLIP and specialist locality meetings where possible and be involved.** • **Encourage open and honest feedback** • **Invest in development – sharing information about upcoming courses, study days etc.** • **Take the time to say Thank You**
	Opportunity for learning and feedback. Some staff felt this needed to be prioritised, as t had fallen off during the pandemic.	• **Continue to champion FTSU guardians as a point of contact for raising concerns.**
Other	**Change in Neonatal guidelines.** The majority of nurses spoken to were concerned with the change in guidelines and line to increased burnout climate.	

Appendix 4 – Staff and patient feedback from the safety walk rounds.

You Said	We did
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.	Giraffe unit being procured
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.
September 2024 Room for telephone Triage awaited	Estates request approved for sink removal in consultant room Work commenced – October 2024
Staff not aware of progress of RAAC works	Engagement sessions scheduled to promote staff and service user engagement.
Midwifery staffing	Professional judgement review of all clinical areas undertaken and staff will be realigned to the new allocations Staffing consultation process due to commence early in 2025.
November 2024 Trolley needed with rails to support the safe transfer of patients to CDS when required	Trolley provided

January 2025 Antenatal QR code used to collect patient feedback needs updating. Posters to be relocated in cubicle areas with ANDU	Communication team contacted to refresh QR survey offer Posters to be relocated by ward lead.

Report Title:	2025/26 Quality Accounts Improvement priorities			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	27 March 2025		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	To summarise the chosen **three** Quality Account Improvement Priorities for 2025/26 and outline divisional requirements and next steps

Previously considered by:	Patient Safety Group – December 2024 Clinical Governance and Quality – February 2025 and March 2025 Quality Assurance Committee – March 2025

Executive Summary	The Board of Directors is asked to note the requirement to select three Quality Account Improvement Priorities to focus on in 2025/26, which must demonstrate a clear link to quality improvement/patient safety. Based on discussions during February and March, Clinical Governance and Quality Committee meetings, the priorities being proposed are: • Recognition and Response to the deteriorating patient • Releasing time to care – part one - a focus on documentation • Communication – 'involvement in decision making' as rated by our patients / service users

Proposed Resolution	The Board of Directors is asked to ***receive*** the 2025/26 Quality Account Priorities.

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:	Debbie Redfern Stuart Bates, Director of Quality Governance	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Introduction:

The Quality Account annual report requires organisations to select **three** improvement priorities for the forthcoming financial year and to publish progress in these areas in the following year's report. Priorities must demonstrate a clear link to quality improvement/patient safety. This paper is an update from discussions held at February and March's, Clinical Governance and Quality Committee, where the following three priorities were agreed to be proposed.

1. **Recognition and Response to the Deteriorating Patient**
2. **Releasing time to care**
3. **Communication -** 'involvement in decision making' as rated by our patients / service users

Outline of priorities and next steps:

There is the option to have multi-year Quality Account improvement priorities. Therefore the following is suggested, with an outline of next steps for divisions in terms of specific areas of focus and timeline regarding reporting.

1. **Recognition and Response to the Deteriorating Patient – started 13/02/25**
   - Participating areas: Gastroenterology, Respiratory, Orthopaedics, General surgery, Paediatrics, Maternity, Admission Avoidance, Learning Disability Team.
   - Project leads – QI Team, reporting to Deteriorating Patient Group

2. **Releasing time to care**
   - Scope: year 1 – a focus on documentation
   - Aim – TBC – likely focus on reduction in time on documentation/away from patients
   - Participating areas: TBC – initially focussing/testing on 1 x base ward from AACD and ASSD
   - Project lead: David Fletcher, supported by QI

3. **Communication -** 'involvement in decision making' as rated by our patients / service users
   - Scope: year 1 – improving response rate with evidence of inclusive feedback - all in-patient areas / assessment areas / patients long term community caseloads (need to define long term) / must include all age groups

- Aim a) achieve min 30 responses per month per team / dept / ward as per current format by 31/03/25 – source Envoy FFT Q. b) Evidence inclusivity in feedback from service users such as; no / reduced capacity (carers), non-English as first language
- Project leads: Divisionally lead using QI principles.
- Requirements of Divisions:
- Q1 and Q2
    - response rate baseline (12 months 24/25) collection per area
    - Monthly tracking of response rates against minimum target per area
    - Data analysis for trends, areas of good practice, areas for improvement
    - Development of PDSAs to improve response rate
- Q3/Q4:
    - PDSA cycles of improvement ideas
    - Monitor and sustain
- Reporting: Quarterly data and narrative to be provided to qualityimprovement@boltonft.nhs.uk for collection in central report as per timeline below:

Reporting quarter	CG&QC date	Update from divisions to QI by
Q1	03/07/25	19/06/25
Q2	05/11/25	23/10/25
Q3	04/02/26	22/01/26
Q4	01/04/26	19/03/26

Summary and Recommendations:

The following Quality Account Improvement priorities have been put forward by Clinical Governance and Quality Committee.

1. Recognition and Response to the deteriorating patient
2. Releasing time to care – year 1 - a focus on documentation
3. Communication - improving response rate with evidence of inclusive feedback

The Board of Directors is asked to receive the priority areas and note progress against these will be reported to Clinical Governance and Quality Committee.

Report Title:	Controlled Drugs Accountable Officer's Self-Assessment and Improvement Framework			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	✓
Executive Sponsor	Medical Director		Decision	

Purpose of the report	The purpose of the report is to assess compliance with the Controlled Drugs Regulations 2013 & 2020 and identify areas for improvement in governance, prescribing oversight, and board-level reporting. It provides recommendations to strengthen information sharing, monitoring systems, and strategic assurance to enhance patient safety and regulatory adherence.

Previously considered by:	Clinical Governance and Quality Committee Quality Assurnace Committee

Executive Summary	The NHS England – North West Region has requested the completion of the Self-Assessment and Designated Body (DB) Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025. This framework ensures compliance with The Controlled Drugs Regulations 2013 & 2020 (as amended) and supports Care Quality Commission (CQC) "well-led" and "safe" domains. The self-assessment covers governance, workforce training, reporting, incident investigation, and prescribing oversight. Key findings indicate that while processes are in place for monitoring and reporting controlled drug (CD) concerns, areas for improvement remain, particularly in formal information-sharing, prescribing oversight, and board-level reporting. Analysis highlights three main gaps: (1) The absence of an explicit policy for sharing personal identifiable information regarding CD concerns with regulatory and law enforcement bodies; (2) The need for a more robust system for identifying and addressing unusual prescribing patterns beyond ward-level pharmacy oversight; and (3) The lack of structured board-level assurance reporting regarding CD governance. Recommendations include:

	1. Updating the CD policy (part of the Medicines Policy) to explicitly include procedures for sharing staff personal information with police, professional regulators, and NHS England CDAOs. 2. Invest in CD electronic registers as a way to enhance audit trail relevant when investigating diversion concerns. 3. Enhancing prescribing oversight, with the development of a BI-generated prescribing report due by the end of Q2 2025/26. 4. Strengthening board assurance by implementing an annual CDAO report for Clinical Governance & Quality Assurance Meeting, feeding into Board.

Proposed Resolution	The Board of Directors is asked to ***receive*** the report and ***approve*** the proposed recommendations.

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	yes	
Health Inequalities	yes	
Equality, Diversity and Inclusion		

Prepared by:	Ana Freitas	**Presented by:**	Francis Andrews, Medical Director

Background

The NHS England – North West Region requires all Designated Bodies (DBs) to complete the CDAO Self-Assessment and Improvement Framework for 2025. This framework ensures DB compliance with The Controlled Drugs Regulations 2013 & 2020 (as amended) and supports CQC requirements under the "well-led" and "safe" domains. The assessment evaluates key areas, including:

- Systems for handling concerns and reporting incidents.
- Workforce training and knowledge of Controlled Drugs (CD) governance.
- Processes for investigating CD-related incidents.
- Monitoring and oversight of CD prescribing.
- The role and reporting structures of the Controlled Drugs Accountable Officer (CDAO).

The self-assessment findings indicate that while the organisation demonstrates strong governance in reporting and incident investigation, areas requiring enhancement include formalising information-sharing protocols, strengthening prescribing oversight, and improving board-level reporting.

Summary

Key Findings

1. Systems and Processes for Handling Concerns
    - Staff demonstrate confidence in identifying and reporting CD-related concerns.
    - Reporting systems are well established, with staff trained via medicines management mandatory training, nursing perceptorship and safeguard reporting system.
    - However, there is no explicit information written in the medicines policy on sharing personal identifiable information with regulatory bodies and law enforcement.
2. Workforce Knowledge and Skills
    - Staff training in CD governance and incident reporting is well documented.
    - Induction training, policy updates, and learning from incidents are embedded in practice.

3. Incident Investigation & Learning
    - CD-related incidents are investigated using Patient Safety Incident Response Framework (PSIRF) methodology.
    - Lessons learned are documented into the Safeguard system for continuous improvement.
    - Low-impact CD incidents are reviewed quarterly via medicines safety divisional reports.
4. Information Sharing with Responsible Bodies
    - The organisation shares CD-related concerns with senior leadership (Medical Director, Director of Nursing, Medicines Safety Officer). Police and the CD Local Inteligence Network (CD LIN) are informed of incidents of concern or requiring further investigation.
    - However, formal information-sharing with police and NHS England CDAOs is not explicitly documented in the Medicines Policy.
5. Prescribing, Clinical Monitoring & Action-Taking
    - Pharmacists currently review and challenge prescribing practices, but oversight remains manual and ward-based.
    - A BI-generated report for prescribing trends is under development, with completion targeted for Q2 2025/26.
6. CDAO Reporting and Board Assurance
    - The CDAO reports directly to the Medical Director, with informal discussions on risks and mitigations.
    - However, no formal reports are submitted to the Board.
    - The proposal is to introduce an annual CDAO report to the Clinical Governance & Quality Assurance Meeting, which will then feed into the Board for assurance.
7. Process Improvements from CD Investigations
    - The organisation has made process changes based on CD investigations in the past 24 months.

- Staff well-being and substance misuse support are available through Occupational Health (OH) referrals and the Alcohol Specialist Team.
- Alleged drug diversion incidents have been investigated and documented via Safeguard.

8. CDAO Governance and Resources
    - The CDAO regularly meets with a Board member to discuss risks and mitigations.
    - The CDAO role is adequately resourced to meet organisational and regulatory requirements.

Recommendations

1. Formalise Information Sharing in CD Policy
    - Update the CD policy part of the Medicines Policy to explicitly include protocols for sharing personal identifiable information with police, professional regulators, and NHS England CDAOs when necessary.
    - Staff must ensure the names of individuals involved in CD incidents are recorded in Safeguard to monitor concerns and recurrence.
    - Transitioning to electronic CD registers will enhance tracking and oversight of staff with concerns.
    - Target completion: End of year 2025.
2. Strengthen Prescribing Oversight & Monitoring
    - Currently, pharmacists provide manual oversight of CD prescribing at the ward level.
    - A BI-generated report is under development to enhance monitoring and systematically identify unusual prescribing patterns.
    - Target completion: End of Q2 2025/26.
3. Enhance Board-Level Assurance & Reporting
    - The CDAO currently reports to the Medical Director, but no formal assurance reports are presented to the Board.

- Proposal: Introduce an annual CDAO report to the Clinical Governance & Quality Assurance Meeting, which will then feed into the Board for assurance.
- Target completion: End of Q2 2025/26.

By implementing these improvements, the organisation will strengthen Controlled Drug governance, enhance regulatory compliance, and ensure patient safety remains at the forefront of its operational priorities.

Appendix 1 – Improvement framework 2025

Self-Assessment and Designated Body CDAO Improvement Framework for 2025

This Framework supports Designated Body (DB) Boards to meet their duties under the Controlled Drugs Regulations 2013 & 2020 (as amended) and provide evidence for CQC "well-led" and "safe" domains.

Systems and processes to handle concerns

1. How confident is the DB CDAO that all relevant areas* know how to report CD-related concerns, including suspected diversion and misuse of CDs by colleagues?

(*The designated body will define the relevant areas, and these may include clinical areas where CDs are stored and used, and where CDs are prescribed, administered or denatured. It may also include nonclinical departments which should identify concerns such as HR, estates, security services)

(1= not confident to 5 = fully confident) *

1 2 3 4 **5**

2. How confident is the DB CDAO that all relevant areas* of the organisation are reporting CD concerns including suspected diversion and misuse of medicines by colleagues?

(*The designated body will define the relevant areas, and these may include clinical areas where CDs are stored and used, and where CDs are prescribed, administered or denatured. It may also include nonclinical departments which should identify concerns such as HR, estates, security services)

(1= not confident to 5 = fully confident) *

1 2 3 4 **5**

3. Workforce Knowledge and Skills -

(*the designated body will define relevant staff and this could include agency staff. The designated body will also define the SOPs for handling CDs and for identifying and reporting concerns) *

	Yes	Somewhat	No	Don't know	No recruitment in past 24 months
Can the DB provide evidence (in past 24 months) that relevant* staff are trained on induction about vigilance and	√ (Meds management				

reporting concerns about unsafe behaviour and systems ?	MT; nursing preceptorship)				
Can the DB provide evidence that relevant* staff receive training on SOPs for handling CDs and reporting concerns?	√ (medicines policy)				
Can the DB provide evidence that relevant*staff are updated following SOP/policy reviews for reporting concerns and handling CDs?	√ (medicines policy)				
Can the DB provide evidence that relevant* staff are updated on learning from incidents related to CDs?	√ (safeguard)				

4. System in place to investigate CD related incidents *

	Yes	Somewhat	No	Don't know	No incidents in past 24 months	Agree	Strongly agree
Can the DB provide evidence (from the past 24 months), that a system improvement methodology is used to examine the cause of CD-related incidents?	√ (PSIRF)						
Can the DB provide evidence (from the past 24 months), that lessons from	√ (Safeguard)						

CD-related incidents are implemented?							

5. How frequently are low impact incidents involving controlled drugs reviewed to identify themes*?

- Never
- Annually
- Twice yearly
- **Quarterly** (meds safety divisional reports)
- More frequently than quarterly
- This Organisation has not had any incidents in the past 24 months

6. Information sharing with responsible bodies *

Is there a policy that makes clear the requirement for the CDAO to share personal identifiable information with police, professional regulators, NHS England CDAO?

- Yes
- **Somewhat** (Implicit to practice as not written in the meds policy)
- No
- Don't know

7. Can the designated body provide evidence of sharing concerns and information related to controlled drugs with any of the following in the past 24 months

Select all that apply

- **Medical Director**
- **Director of Nursing**
- **Human Resources/Organisational Development**
- **Pharmacist(s)**
- **Medicines Safety Officer**
- Medical Examiner
- Safeguarding
- Security/Fraud
- Estates
- Commissioner (CCG medicines optimisation or quality and safety)
- Professional regulator (e.g. GPhC, NMC, GMC, HCPC)
- CQC
- **Police**
- Organisation has not had concerns/incidents in past 24 months

8. Prescribing, clinical monitoring and taking action

Prescribing includes supplying under PGDs and exemptions such as for paramedics and midwives.
Unusual prescribing is outside of clinical guidelines/ formulary*

	Yes	Somewhat	No	Don't known	Not applicable
The designated body has systems in place for identifying unusual prescribing* of CDs (Schedules 2-5) in relevant areas		√ (through EPR; BI report is in development)			
Evidence (from the past 24 months) can be provided that all unusual prescribing* of Sch 2-5 CDs in relevant clinical areas has been/is being investigated.		√ (Pharmacists review/challenge prescribing; ePACT data)			

9. Does the DB have any evidence (from the past 24months) that there have been changes in process(es) from the outcome of a CD investigation? *

	Yes	No	Don't know how / no capacity
The designated body has support available for staff well-being including substance misuse support	√ (OH referrals; alcohol specialist team)		
Evidence (from the past 24 months) can be provided that all identified alleged diversion of drugs liable to misuse (including CDs), have been investigated.	√ (safeguard)		

The CDAO is set up for success: suitably experienced and resourced

10. Does the Designated Body CDAO either sit on the Board, or report directly to a Board member?

Please select at most 2 options.

- the CDAO is a Board member
- **the CDAO has regular "catch-ups" with a Board member to discuss CDAO specific risks and mitigations**

- the CDAO reports to the Board via written reports that are distinct from Pharmacy/ Medicines management reports
- the CDAO does not report into the Board
- Other (provide further information)

11. Is the DB CDAO adequately resourced to carry out responsibilities on behalf of the Board?
- **Yes**
- Somewhat
- No
- Don't know

12. Have you or your organisation contributed to the North West Controlled Drug LIN in the past 24 months through one or more of the following:
- **Attended a LIN meeting**
- Led a break-out room discussion at a LIN meeting
- Provided feedback from a break-out room discussion
- Participated in an Action Learning Set related to safe use of CDs
- Presented case study related to safe use of CDs (for example at the LIN meeting or to your organisation)
- **Buddying with another CDAO**
- Short Life Working Group member
- Other (provide further information)

Supplementary Information

13. Name of organisation *
Bolton NHS Foundation Trust

14. ODS Code (this can be found on your CQC inspection report) *
RMC

15. Type of organisation
- **Acute NHS Trust**
- Community NHS Trust
- Mental Health NHS Trust
- Independent Hospital
- Hospice
- Prison Healthcare Service
- Ambulance NHS Trust
- Other (provide further information)

16. Integrated Care System (ICS) linked to *
- Cheshire & Merseyside
- **Greater Manchester Health & Social Care Partnership**

- Lancashire & South Cumbria
- Work across multiple ICS areas

17. Name of person completing form *
    Ana Freitas

18. Are you the CDAO?
- **Yes**
- No
- Other (provide further information)

19. Email of person completing form

20. How long did the self-assessment take to complete *
- 0-10 minutes
- 10-20 minutes
- 30 minutes or more

21. Do any of the statements in this self-assessment need to be revised?
    please provide details

Report Title:	People Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	
Executive Sponsor	Chief People Officer		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 March 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 18 March 2025. 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, Chief People Officer	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:	18 March 2025	**Date of next meeting:**	20 May 2025
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- NHS Staff Survey Results
- Compulsory and Trust Mandated Training Update
- Resourcing & Retention Update
- Health & Wellbeing Update
- Medical School Update
- Operational Plan Update
- BAF
- IFM Monthly People Report
- Steering Group Chair Reports
- Divisional PC Chair Reports

ALERT

ADVISE

Resourcing & Retention Update

Staffing summary:
Total WWTE increased in January 2025 by 87 WWTE (mainly due to increased bank working).

Agency summary:
Agency spend increased in January 2025 by £119k. Despite this we are under internal agency plan in-month and for the YTD.

The Trust continues to be under the NHSE target of agency being no more than 3.2% of total pay bill (January 2025 performance was at 2.3%, and
YTD is running at 2.1%).

Bank summary:
Bank spend significantly increased in January 2025 when compared to the previous month. As noted above

Vacancy Rate 2024/25**:**
Vacancy rates reduced slightly to 5.7% which is still under Trust KPI and will support staffing during winter.

Turnover 2024/25:
Turnover is mirroring our expectations for the year, remaining relatively static and under 12% for January 2025.

- The Director of Operations noted that the increase in bank/agency spend in January was due to both unplanned Urgent Care and planned Elective Care activities.
- The Chief People Officer noted changes to bank rates from April 1st, moving from the top of the band to the mid-point. Changes to the Medical Staff Bank Rate are currently under consultation and and will be implemented GM wide.

- The Chief Finance Officer and Chief People Officer emphasised the need for triangulation between Workforce and Finance.

Health & Wellbeing Update

The Deputy Director of People presented the Health and Well Being update and set the wider context in relation to the intrinsic link to how staff are treated, supported to be their whole self at work and the financial position both locally and more broadly in the NHS. The Chair added that the broader context of welfare reforms was also relevant. Fiona Taylor, Non-Executive Director, welcomed the report and noted the Trust coaching offer can also be seen as a component of the well-being offer. Well-being provision in IFM was queried and this will be included in future IFM updates. The opportunity provided by the Trust Occupational Health and Well Being service as part of an anchor institution to the local community was also highlighted.

Medical School Update

The presentation provides an update on development of the Medical School including next steps. Following the approval of the SLA in 2024, the presentation includes updated Governance and reporting arrangements and also separates core projects to support the Trust to deliver Medical School placements from the estate, library and venue booking projects.

It was agreed that there are huge benefits and opportunities for the Trust with the relationship with the University going from strength to strength. It was noted that the Board will sign off any contractual/financial agreements. Engagement with clinical staff regarding how they can be involved is ongoing.

Operational Plan

The People Committee discussed the workforce implications of the Operatonal Plan 2025/26. As this will be discussed at Board no further information is necessary.

IFM Monthly People Update

iFM Workfoce KPIs - Data as at 31st January 2025

- Absence rate - decreased to 5.60%
- Mandatory Training - steady increase to 86.6%
- Appraisal rates - non-compliant at a rate of 62.8%

Bank Worker Programme

Project initiated to consider the reliance on bank workers and the impact this has on our services and the workforce.

Staff Survey

Being developed to enable benchmarking with Trust survey results. Temperature checks being undertaken until wider survey developed.

ASSURE

NHS Staff Survey Results

- The Trust achieved an overall response rate of 48.1% which was 6% higher than last year's response rate (41.5%). As the 2024 response rate was 6% higher than 2023, the results provide a more representative view of our workforce.
- Overall, our survey results have seen a positive improvement, and we have significantly outperformed our sector comparator group in the theme of morale and in six of the seven People Promise elements

(Appendix 1- Slide 4). Additionally, when comparing 2023 to 2024 survey results we have significantly improved for 'We are Safe & Healthy' and 'We Work Flexibly and Morale.

- A full survey response will be provided for Board in May 2025 which will also includes the next phase of the Our Voice Change Programme.

Compulsory and Trust Mandated Trainig (CaTM) Update

- An overview of CaTM compliance over the past 6 months, against the current targets of 95% (compulsory training) and 85% for (trust mandated training) was provided and confirmed we have now met the Trust Mandated target for over 12 months and are close to reaching the compulsory target.
- Further work is taking place to review DNA rates.
- Assurance was provided on the progress being made by the Trust towards alignment with emerging national CaTM recommendations being led by NHS England. The next steps are to consider impact for Bolton and provide options on how we take the recommendations forward.
- A discussion took place about a wider review and fresh look at CaTM requirements and content.

Board Assurance Framework

The Board Assurance Framework (BAF) offers a systematic approach that allows the Board to assess its key goals, evaluate whether the Trust has established adequate and solid mechanisms to control strategic risks, and determine the effectiveness of the assurance that those mechanisms provide. Following the last presentation of the BAF it has been reviewed by the Chief of People and updated to reflect the new Trust Strategy.

Taking account of the Operational Plan, the BAF for Ambition 2 will need to reflect the challenges and risks in terms of delivery in terms of the assurance process. The accompanying BAF is based on Ambition 2 To be a great place to work.

New Risks identified at the meeting: None

Review of the Risk Register: None

Members	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Tosca Fairchild (Chair)		✓		✓		**A**					
Fiona Taylor		✓		✓		✓					
Alan Stuttard		✓		✓		✓ **chair**					
James Mawrey		✓		✓		✓					
Tyrone Roberts		✓		**A**		✓					
Sharon White		✓		✓		**A**					
Sharon Katema		✓		✓		**A**					

Annette Walker				✓		✓					
Sean Harriss		✓		✓		✓					
Francis Andrews						**A**					
Seth Crofts		**A**		✓		✓					

Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		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 meetings held in January and February.

Executive Summary	The Chairs' reports attached provide an overview of matters discussed at the meeting held on the 22 January and 26 Februray 2025. The reports also set out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the March 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:	Rebecca Ganz, Finance and Investment Committee Chair	**Presented by:**	Rebecca Ganz, Finance and Investment Committee Chair

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

Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**22 January 2025**	**Date of next meeting:**	**26 February 2025**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Cost Improvement Programme 2025/26
- Month 9 Finance Update
- Planning Update 2025/26
- GM/National System Update
- National Cost Collection 2023/24
- Green Plan Update
- MES Contract Extension
- EPR update for Maternity, Out-Patient and Community EPR Deployment
- Digital Performance and Transformation Board Chair's Report

ALERT

2024/25
The likely variance to plan for 2024/25 is £3.6m including the impact of the unfunded pay award. There have been further developments which will affect the forecast and these are being worked through currently. The Trust is still aiming to achieve plan.

2025/26
The assumed CIP target for 2025/26 is 3% which leaves a deficit of £32m which will be the subject of further discussion with the ICB. A number of other Trusts are aiming for higher levels of CIP.

Digital
Risk associated with the Maternity EPR go live date.

All Alert items to be discussed at Board of Directors meeting on 30 January 2025.

ADVISE

Cost Improvement Programme 2025/26

- £26.8m CIP has been identified in year against the target of £24.3m of which £21.2m is recurrent.
- A number of high risk schemes are included in the overall identified value giving a risk rated position totalling £25m in year and £16.8m recurrent. £19.2M has been delivered YTD with a recurrent impact of £6M. The impact on the run rate may be lower due to the misalignment between budgets. This will be corrected for 2025/26, once budgets have been rebased to outturn.

Month 9 Finance Report

- The Trust is £1.2m behind plan year to date.
- The adverse variance is driven by the unfunded pay award pressure of £1.6m which has subsequently been revised and is now £1.1m.
- The unfunded pay award pressure is due to not receiving funds from the Local Authority for the 2023/24 and 2024/25 pay awards. GM have advised that the funding has been given to the Local Authorities. Following guidance received the Chief Finance Officer has highlighted this to the Treasurer.
- ERF over performance of £2.8m has been included YTD at Month 9.

- Agency spend is at 2.1% of the pay bill which is better than the internal target of 2.2% and NHS target of 3.2%
- The Trust had £1.7m less cash than planned at Month 9. Due to cash timing issues it is unlikely cash support will be required in quarter 4.

Planning Update 2025/26
The Operational Director of Finance updated that it is not clear if the GM system will hit the 2024/25 plan and that this is still under discussion.

In terms of 2025/26 guidance has not yet been issued and is expected next week. The final plan submission deadline is the 27th of March with a draft provided prior which was acknowledged as being tight deadlines. High level planning for 2025/26 suggests a target of 3% CIP which would leave a £32m deficit. The Chief Finance Officer highlighted that we need to build a path to financial recovery.

Contract Extension
A two year extension to a contract within laboratory medicine was recommended for approval by the Board.

EPR update for Maternity, Out-Patient and Community EPR Deployment
The Chief of Strategy updated the Committee on the EPR Programme. There are risks but the plan for Maternity EPR is still to go live on the 1st of April. The principle risks are around the data set and build. Patients would like the red books which are given to women to be hand held and a business case is going to Executive Directors net week around this. A further update will be provided at the Board of Directors on the 30th of January 2025. Community and Outpatient EPR are on track for go live on 18th June.

Digital Performance and Transformation Board Chair's Report
The Chief of Strategy highlighted the risk around digital resource and advised a piece of work is being undertaken with Wigan on what work can be shared. A report is expected to be completed by the end of March.

ASSURE

National Cost Collection 2023/24
The Associate Director of Finance presented the National Cost Collection submission for 2023/24 highlighting the Trust's NCC index of 93 indicating above average levels of efficiency. The data needs to be validated with the divisions and the costing team will release information on a quarterly basis and work on a plan to improve cost information aiming to identify areas for potential efficiency improvements supporting the Cost Improvement Programme.

Green Plan Update
The revised NHS Green Plan guidance for 2025/2030 was expected in 2024 but has not yet been published nor has it been confirmed when the guidance will be finalised, it is however anticipated to be June 2025. The original target date was the end of January 2025 for the revised draft Green plan. It is proposed to have a target date of June 2025 for board approval for the new Bolton FT green plan which the Committee supported. IFM Bolton Ltd reported the Trust is on track for meeting the 2032 net zero targets.

New Risks identified at the meeting:

None identified.

Review of the Risk Register: NA

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**26 February 2025**	**Date of next meeting:**	**26 March 2025**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Operational Planning Submission 2025/26
- Month 10 Finance Report
- Revenue Support Cash Submission
- CDC Utilisation Update
- Procurement Update
- Citrix Licence Extension
- Financial Viability of Sexual Health Services
- EPR Update
- Artificial Intelligence Update
- Draft Digital Performance Framework
- Digital Performance and Transformation Board Chair's Report
- Chair's Report

ALERT

Operational Planning

The Chief Finance Officer updated the Committee on the progress, status and plans against the 2025/26 operational planning round and subsequent return to GM. Key points were noted as follows:

- Plans discussed at previous meetings detailed a 3% CIP target which would leave a gap of £32m in 2025/26. This position has since improved to £29m through income assumptions.
- However, all Providers in GM have since been issued with a control total. GM have been advised that the maximum deficit they are permitted to report is £200m.
- All Trusts have been given a list of principles of non-delivery (things that they should be doing if they are unable to accept the control total). These are around expectations on CIP, difficult decisions, productivity pack requirements and capital (failure to comply with the control total will have implications around cash).
- The Trust Board have previously agreed that a 3% CIP target should be doable, although challenging. A contingency of £6m has been included in this.
- It is anticipated that GM will be challenging us to deliver 5% CIP. They have also questioned the contingency. This would lead to a forecast deficit of £13.1m.
- If the Trust had to achieve a control total of £6.5m further measures would be required (further 0.4% CIP).
- In the £29.6m scenario the basic assumption of the organisation is that, subject to further work, we would have the funds to hit performance targets. However, if 5% CIP was required this would questionable. In the control total scenario there is a high risk and a great deal of uncertainty as to whether we could hit the performance requirements.
- Trust Board will be required to show a route map to hitting the control total.

All Executive Directors and Non-Executive Directors were invited to offer their opinions on this. It was agreed that the Board must agree on the approach and noted that the next two years are anticipated to be very difficult.

Revenue Support Cash Submission

The Chief Finance Officer advised that, based on the current run rates, the Trust will run out of cash in quarter 1

2025/26 and require revenue cash support of circa £16m. It is anticipated that an application for cash support will be required to be submitted by early March. RAAC cash drawdown may impact on this.

It was noted that the Trust Board approved the drawdown of cash if required in September 2024.

The Committee also queried the plan for if the application is rejected and were advised that GM has agreed a process to ensure that no organisation is unable to process payroll.

EPR Update

The Chief of Strategy and Partnerships updated the Committee on the current status of the EPR Programme. Key points highlighted included:

- Maternity Services are transitioning from the current Euroking system to Altera EPR addressing national safety alerts and governance concerns. Serious risks to delivery were highlighted at the Board meeting in January 2025 and Executive Directors agreed that the risks were sufficient to delay the planned go live date of March 2025 and the Project Board were to work to address these risks and re-plan the project. This work is underway. There is no timeline at the moment and a decision will not be made about CNST until April so best case scenario is Autumn 2025 and worst case scenario is April 2026.

- Deployment is set for 18 June 2025 for Outpatient and Community Services who are moving away from paper based records to improve clinical safety and operational efficiency. Risks have been identified as follows:
    - Resource strain due to competing priorities.
    - Programme complexity affecting coordination.
    - Limited contingency for delays.
    - Multiple risks identified related to items in scope that have not been defined in detail yet.

It was noted that there is risk on the Civica scheduling used by the District Nursing Team as the DDO for the Integrated Community Services Division does not want to go live without the RPA in place to enable moving data between the two. A business case will go to CRIG next week to address this.

The Committee queried the requirement for more resource on Outpatient and Community EPR. It was confirmed that this has not been signed off. The Commercial Director of Finance advised that the Civica Interface needs to be done through the RPA and that this will prevent the need for extra administration resource.

ADVISE

Month 10 Finance Report

The Commercial Director of Finance updated the Committee on the Month 10 financial position. Key points highlighted included:

- The Trust is behind plan by £0.9m YTD. The adverse variance is driven by the unfunded pay award pressure which is £2.0m in total for 24/25.
- ERF over performance of £2.8m has been included YTD at month 10.
- The balance of overspends is a combination of pay awards, additional expenditure driving the elective income over performance and unidentified CIP.
- The Trust is incurring additional cost with various insourcing / outsourcing providers which has supported additional elective income.
- Interest received has been higher than planned. It is anticipated that interest will reduce throughout the year as cash balances reduce.

- The Trust cash balance was on plan at Month 10. The Trust will likely be overdrawn by month 11 and finish the year £4.9m overdrawn. However, the Trust has had PDC funding approved for capital schemes which may support cash balances in the short term.
- The Trust has released significant non recurrent benefit to support in year delivery of plan.
- YTD CDEL spend is £6.5m which is £0.8m behind plan in line with revised forecast outturn. YTD IFRS16 spend is £1.1m which is £0.8m behind plan in line with revised forecast outturn. Disposal of additional CDC scanners gives a benefit of £0.9m.

The Chief Finance Officer advised that she has been working with the Local Authority on the 0-19 contract and that the Trust will be raising an invoice for the full amount of the pay award next week.

Procurement Update

The Commercial Director of Finance updated the Committee on the progress made by the Procurement Department in 2024/25. Key points were noted as follows:

- Ratified savings of £5.04m against a forecast of £4m have been achieved YTD in 24/25 through cost avoidance (£3.37m), cash releasing (£1.82m) and inflation avoidance (£1.05k). This has been achieved through collaborative working with the Divisions, NHSE, Supply Chain and GM Procurement.
- Procurement are looking at more collaboration opportunities across GM and have already started this with the Inventory Management System.
- A new Procurement Act launched on 24 February. This involves having to disclose further information to the market and be more transparent and publish the performance indicators of external suppliers on the Atamis system.

Citrix Licence Extension

The Director of Digital advised that the Citrix software licence is due to expire at the end of February 2025. The software is a key component of the Trust infrastructure.

Negotiations have taken place and a three year contract of £978k plus VAT has been procured via the Crown Commercial Services G14 framework, this represents a saving of £29k per annum.

It was noted efforts had been made to do this as part of a GM initiative but that this was unsuccessful. However, it has been built into the contract that Bolton would receive any financial savings from any future GM initiatives on this.

The Committee approved the Citrix Licence extension.

Artificial Intelligence Update

The Chief Data Officer provided an update from the AI Steering Group, advising that this is a small new group with representation across the organisation. It was noted that the Trust are currently in a state of AI Preparedness, as there is no internal team responsible for the development or ongoing maintenance of AI.

The absence of any mention of health inequalities in the paper was noted and assurance was provided that there is a significant amount of work being done on this but that it had been omitted from the paper and that it will be included in the next update.

The Director of People expressed concern that there is not a GM AI Group, noting that it would be helpful and more cost effective to work together on this. The Chief Data Officer advised that the Data Science Collaboration Group,

which she Chairs, has committed to put together a statement for the TPC to ask some of the Directors Groups for advice on how best to tackle this.

The Committee thanked the Chief Data Officer for the work that had gone into this with no resource and asked that the Committees thanks are passed on to everyone involved. It was noted that Bolton are currently ahead of the rest of GM on this.

Draft Digital Performance Framework

The Chief Data Officer presented this report which provided a draft performance framework template, which it was suggested could be used for the high level reporting of and assurance against Digital and Data KPIs.

The Committee suggested looking at some of the pain points such as delivery of projects, equipment, service performance, coding etc and also suggested making the information tell more of a story. It was noted that some of the Business Intelligence projects are very difficult to measure and the Chief Data Officer agreed to look at this for the next report.

Digital Performance and Transformation Board Chair's Report

The Chair's report from the Digital Performance and Transformation Board meeting held on 6th February 2025 was brought to the Committee for information and assurance.

The Committee noted that approval to proceed with the purchase of the robot had been received. It has since been agreed to proceed with a price per procedure arrangement.

Chairs' Report

The Committee received the Chair's Report from the Capital Revenue and Investment Group meeting on 4th February 2025 and the minutes from the Place Based Finance & Assurance Committee meeting on 16th January 2025.

ASSURE

Financial Viability of Sexual Health Services

The Chief Finance Officer updated that as part of the contract sign off it was agreed that a review would be done as to whether this service is financially viable. In isolation the Sexual Health part of the service is making a small loss, although when HIV is included this results in a surplus of £111k.

The Committee agreed that they were content for this service to continue as it is not currently loss making, although advised of the need to continue to review this in 6-9 months as is done for all services. The Chief of Strategy and Partnerships noted that this is a high risk service in terms of GM centralisation.

CDC Utilisation

The Chief Operating Officer updated the Committee on the current activity and financial performance of Bolton's CDC, challenges relating to delivery of activity and actions being taken to drive activity improvements. Key points to note included:

- Revenue has been received based on a plan and there was an agreed 10% tolerance around underperformance.
- The volume of activity around imaging is within the 10% tolerance.
- The latest position is a £1.6m clawback, based on the forecast outturn from December.

The Committee expressed surprise at the scale of the underutilisation and queried what the plan is to create the demand. It was also suggested looking at other organisations that are doing well on this. The Chief Operating Officer advised of the need to continue working with GPs in order to fill the capacity and issued a reminder that the CDC only opened early in 2024. The Chief Finance Officer suggested that going forward CDC activity may be counted as part of the routine tariff.
New Risks identified at the meeting: *None identified.*
Review of the Risk Register: NA

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		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 February.

Executive Summary	The Chair's Report attached from the Audit and Risk Committee provides an overview of matters discussed at the meeting held on 12 February 2025. 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		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

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

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	12 February 2025	**Date of next meeting:**	07 May 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Internal Audit Reports
- External Audit Plan
- Local Counter Fraud Progress report
- Arrangements for the Annual Report 2024/25
- Register of Interests, Gifts and Hospitality
- Register of Waivers for Bolton FT and IFM
- Account Update
- Losses and Special Payments Report Bolton FT and IFM
- Standing Financial Instructions Breach Report Bolton FT and IFM
- Risk Management Chair's Report

ALERT

None

ADVISE

None

ASSURE

Internal Audit Reports

The Internal Auditors Presented 3 reports:

Internal Audit Progress Report
This summarised the progress against remaining audits from the 2023/24 Internal Audit Plan and the progress being made in delivery of the 2024/25 Internal Audit Plan. One review has been finalised and three reviews are at draft report stage. The remaining 2024/25 reviews are at fieldwork and planning stages. It was agreed the UEC and Elective Recovery Audit would be deferred to this time next year which would not affect the Internal Audit Opinion.

Escalation of a Deteriorating Patient
This report summarised findings following the review commissioned in 2023/24. The review provided an overall assurance opinion of moderate and raised 4 recommendations. This report has been referred to the Quality Assurance Committee for further discussion and updates particularly to ensure that the high and medium risk recommendations were being addressed and implemented.

Follow Up Report Q4 2024/25
The paper summarised the follow up work on the status of the implementation of previously agreed internal audit recommendations. Of the 25 recommendations in scope, 4 have been fully implemented, 5 partially implemented and 1 not yet implemented. 15 recommendations are not yet due. The Internal Auditors are to conduct awareness sessions with divisions to improve understanding and practical implementation of audit recommendations.

External Audit Reports
The Director of Forvis Mazars (DW) set out the plan for the Audit for the year ending 31 March 2025 outlining the materiality levels, significant risks and value for money work with the aim to compete the fieldwork by the end of May and report back in June.

Local Counter Fraud Progress report
The Counter Fraud Specialist provided an update on counter fraud activities including ongoing investigations, an increase in referrals and the creation of a task and finish group for salary overpayments, though the current approach is proving successful in recovering overpayments.

Arrangements for the Annual Report 2024/25
The Director of Corporate Governance outlined the process for preparing the Annual Report, highlighting the new requirement to share a draft report with External Auditors by 30 April. The final report will be presented at the Audit and Risk Committee meeting in June.

Register of Interests, Gifts and Hospitality
The Director of Corporate Governance highlighted the changes to the 2017 guidance documented in the report. The main change is redefining the banding of decision makers from Band 8C to band 8D. The revised policy will be brought to the Committee in its entirety at a later date.

Register of Waivers for Bolton FT and IFM
The Associate Director of Finance reported on the volume, value and reasons for waivers raised across the group against the Standing Financial Instructions. Overall there has been a decrease in the number and value of waivers for the Trust, but an increase in value for IFM. Procurement are working with the Operational Business Managers to reduce the amount of waivers and it was agreed to add a column to the report to demonstrate the level of value for money achieved where a waiver has been used.

Accounting Update
The Associate Director of Finance provided an update on the preparation for the 2024/25 Annual Accounts including the revaluation of the estate and the implementation of a new finance ledger. All processes are on track.

Losses and Special Payments Report for Bolton FT and IFM
At of 31 December 2024, the Trust had incurred costs of £392k for losses and special payments. IFM Bolton incurred no losses or special payments in 2024/25. This includes £5.5k for litigation payments and £65.8k in losses and ex-gratia payments.

Standing Financial Instructions Breach Report for Bolton FT and IFM
The Standing Financial Instructions are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. No major breaches have occurred during the last 12 months.

Risk Management Chair's Report
There was nothing to alert or escalate to the Audit and Risk Committee from RMC.

New Risks identified at the meeting:
None

Review of the Risk Register:
None

Meeting Attendance 2025/26												
Members	**Feb**	**May**	**June**	**Sept**	**Dec**	**Feb**	**May**	**June**	**Sept**	**Dec**		
Alan Stuttard	**A**											
Sean Harris	**A**											
Tosca Fairchild	✓											
Fiona Taylor	✓											
In Attendance	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**		
Annette Walker	✓											
Sharon Katema	✓											
Collette Ryan	✓											
Darrell Davies	**A**											
Patrick Clarke	✓											
Catherine Hulme	✓											
Ian Gilroy	**A**											
Daniel Watson	✓											
Catherine Watts												
✓ = In attendance A = Apologies												

Report Title:	Charitable Funds Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	
Executive Sponsor	Chair of Strategy and Partnerships		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 10 March 2025.

Executive Summary	The attached report from the Chair of the Charitable Funds Committee provides an overview of matters discussed at the meetings held on 10 March 2025. 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:	10 March 2025	**Date of next meeting:**	02 June 2025
Chair	Martin North	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Highlight Report
- Finance Report
- Year in Review 2024/25
- Outlook Report
- Outlook Report
- Our Bolton NHS Charity 2025/26 Plan
- Transfer of charity bank account to Government Banking Service

ALERT

Agenda items	Action Required
• N/A	

ADVISE

Transfer of charity bank account to Government Banking Service

The Committee received an update regarding the transfer of the charity's bank account from Royal Bank of Scotland to the Government Banking Service. Based on current assets and a 4.64% interest rate, the charity would raise an additional £28k in interest per year. Funds are immediately accessible and the interest rate is variable so will be subject to change.

ASSURE

Highlight report

The Committee received the highlight report for Q3 and Q4, including activity updates and learning insights across different income streams and wider team functions.

The Committee noted the report.

Finance report

The Committee received the finance report. As of 1 April 2024, the charity had fund balances of £1,084k. The charity had a net decrease in funds of £123k for the 10 months to 31 January 2025 comprising of income of £165k and expenditure of £288k. The charity's fund balances total £794k at 31 January 2025.

The Committee noted the report.

Year in review 2024/25

The Committee received the Year in Review 2024/25 report, which provides an account of achievements, challenges and valuable learning insights from 2024/25 and sets out the charity's areas of focus and growth for 2025/26.

The Committee noted the report.

Outlook report

The Committee received the Outlook report, which set out:

- Forthcoming changes in legislation and governance/accounting practice
- An indication of the management fee for 2025/26
- An overview of our plans to drive staff advocacy and support during Q1 2025/26
- A brief horizon-scan of potential funding opportunities through NHS Charities Together

The Committee noted the report.

Outlook report (management fee)

Work is underway to review the annual management fee for 2025/26. Time commitments are under review and the final fee will be brought to the CFC meeting in June 2025.

New Risks identified at the meeting:

None identified

Review of the Risk Register:

Risks have now been transferred to the Safeguard system and form part of the Communications & Strategy risk portfolio.

Report Title:	Health and Safety Annual Report 2023/24			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	27 March 2025		Discussion	
Executive Sponsor	Chief Nurse		Decision	

Purpose of the report	To provide the Quality Assurance Committee with the Health and Safety Annual Report for April 2023 to March 2024

Previously considered by:	Clinical Governance and Quality Committee – 04 December 2024. Quality Assurance Committee – 26 March 2025.

Executive Summary	In 2023/24, the Trust was compliant with all the relevant Health and Safety Legislation The Trust did not meet the compliance target 95% with its Moving and Handling Level 2 in 2023/24. Actions are in place to increase compliance in divisions. Recruitment to the Manual Handling Advisor post substantively to take place in 2024/25. Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2023/24. The total number of incidents reported between April 2023 and March 2024 has increased on the previous year from 673 to 813 but the actual harm remains no or low harm in the majority of the incidents reported with violence and aggression being the top cause. The number of RIDDOR incidents reduced from seven to five in 2023/24. Two Health and Safety Executives inspections took place in 2023/24 with full satisfaction of the actions taken and processes in place to comply with regulations. The Trust and iFM Bolton maintained at 95% compliance with Fire risk assessments.

	Work has continued with Security risk assessments and the compliance is now within the Trust target of 95% The Trust is fully compliant with Health and Safety Legislation

Proposed Resolution	The Board of Directors is asked to ***receive*** the Health and Safety Annual report for 2023/24. The Health and Safety Annual Report 2024/25 is scheduled to be presented in July 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	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Adrian Wrigley QHSE Associate Director IFM Gina Riley Assistant Director of Quality Governance Michael Hodds Health and Safety Manager Stuart Bates, Director of Clinical Governance	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Health and Safety Annual Report

April 2023 - March 2024

for a better Bolton

Contents

Executive Summary:

- In 2023/24, the Trust was compliant with all the relevant Health and Safety Legislation
- The Trust did not meet the compliance target 95% with its Moving and Handling Level 2 in 2023/24.
  Actions are in place to increase compliance in divisions. Recruitment to the Manual Handling Advisor post substantively to take place in 2024/25.
- Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2023/24
- The total number of incidents reported between April 2023 and March 2024 has increased on the previous year from 673 to 813 but the actual harm remains no or low harm in the majority of the incidents reported with violence and aggression being the top cause
- The number of RIDDOR incidents reduced from 7 to 5 in 2023/24
- Two Health and Safety Executives inspections took place in 2023/24 with full satisfaction of the actions taken and processes in place to comply with regulations.
- The Trust and iFM Bolton maintained at 95% compliance with Fire risk assessments
- Work has continued with Security risk assessments and the compliance is now within the Trust target of 95%
- iFM Bolton has an appointed specialist contractor who undertakes inspections for asbestos and provides recommendations on best practice and control. Where existing asbestos containing materials are in good condition and are not likely to be damaged, their condition will be managed to ensure they have not been disturbed, we continue to monitor periodically (every 12m) as per Health and Safety Executive guidance

Overview:

Although monitoring and reviewing health and safety (H&S) performance is legally required, there is no legal or regulatory obligation to publish this information in annual reports. This is however considered best practice and for openness and transparency, the H&S Team have produced this annual report to highlight the work undertaken across the Bolton NHS Foundation Trust in relation to H&S.

The purpose of this report is to provide an overview on compliance with legislation and against Bolton NHS Foundation Trust (the Trust) policies to the Group Health & Safety Committee (GH&SC) and the Trust Board. Included within the report is statistical analysis and key information regarding H&S activity, audit programme and progress, training compliance, reported incidents & RIDDOR data across the Trust.

The report also provides summative information for the following key areas:

- Alerts
- Asbestos
- Audits
- Claims
- Fire Safety
- Inspections
- Manual Training
- Occupational Health
- Overview of Legal Compliance
- Policies
- Safety - Summary of Accident data, RIDDOR and Performance
- Security
- Training Compliance
- Ventilation/Heating and Temperature control
- Water Safety

This is the fifth Health & Safety annual report. The report and purpose of it conforms to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.

*Note: *Data provided in this reports ended 31 March 2024*

Overview of Legal Compliance:

At the conclusion of this reporting period the Trust was compliant with all its H&S legal requirements.
The table below outlines the main H&S legislation and identifies the reactive and proactive work that the Trust has carried out in order to ensure compliance.

Legislation	Description of Actions/Compliance	Status
Health and Safety at Work Act 1974	• Trust H&S Management Policy published • Competent persons in place to provide compliance advice. • GH&SC held monthly	
Management of Health & Safety at Work Regulations 1999	• Annual H&S Audit programme • Annual H&S Work plan	
Display Screen Equipment Regulations 1992	DSE self-assessment tool has been updated and includes an action plan for users.	
Reporting of Injuries, Disease and Dangerous Occurrences Regulations 19995 (RIDDOR)	Investigations have been implemented for all RIDDOR incidents and the findings are shared with the GH&SC and divisions / iFM Bolton Management Teams	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 19996 Safety Representatives and Safety Committees Regulations 1977	• Terms of reference have been reviewed for the GH&SC • Trust H&S Policy in place • H&S Trade Union Reps in place • GH&SC is well attended by Managers, Trust Competent Persons and TU Safety Reps. • GH&SC reports on audits, action plan progress, KPIs and risk register. GH&SC also acts as consultative committee for H&S policies	

Legend:	
Compliant	
Non-compliant	

Safety Summary of Accident data, RIDDOR and performance:

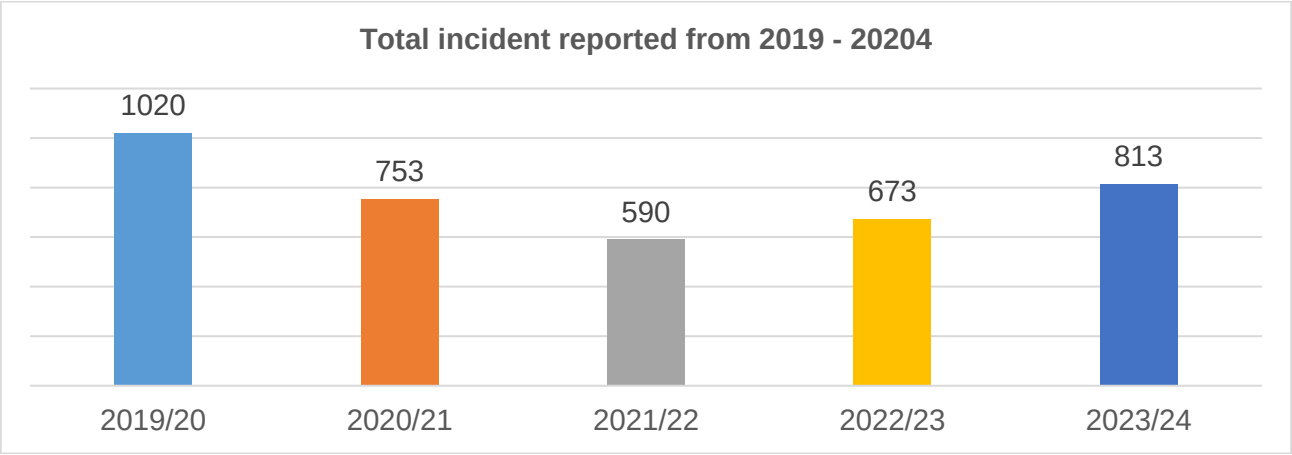
Health & Safety Incidents are reported on the on-line Ulysses Safeguard (Safeguard) system. From 01 April 2023 to 31 March 2024 a total 813 incidents were reported in relation to H&S.

Data in this report relates to incidents reported on Safeguard covering a staff, visitor or contractor accident/incident under the following cause groups:

- Accident/Incident;
- Aggressive, Disruptive Behaviour;
- Blood Exposure/Needle stick Injury;
- Falls;
- Moving & Handling;
- Workplace Environment and Welfare.

Incidents Reported by Financial Year

The total number of incidents reported between April 2023 and March 2024 has increased on the previous year from 673 to 813.

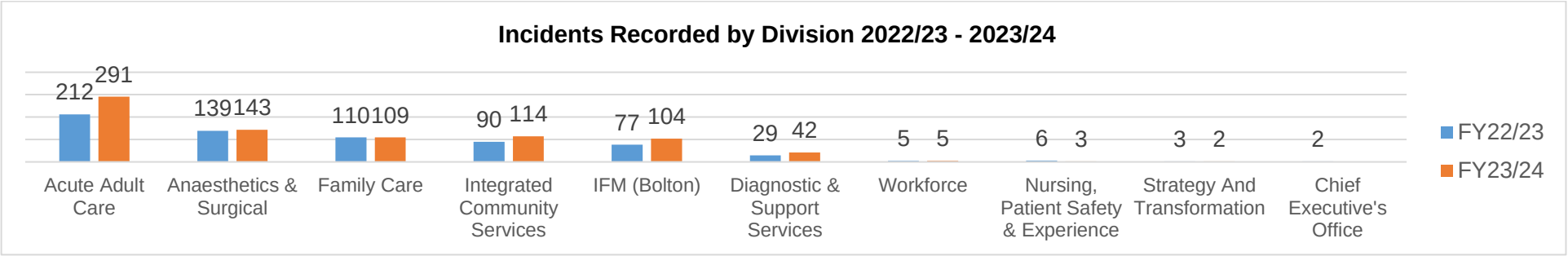


The reason for the increased incident figures since 2021/22 are believed to be;

- Increase of violent and aggression incidents
- Awareness of staff to report incidents has improved

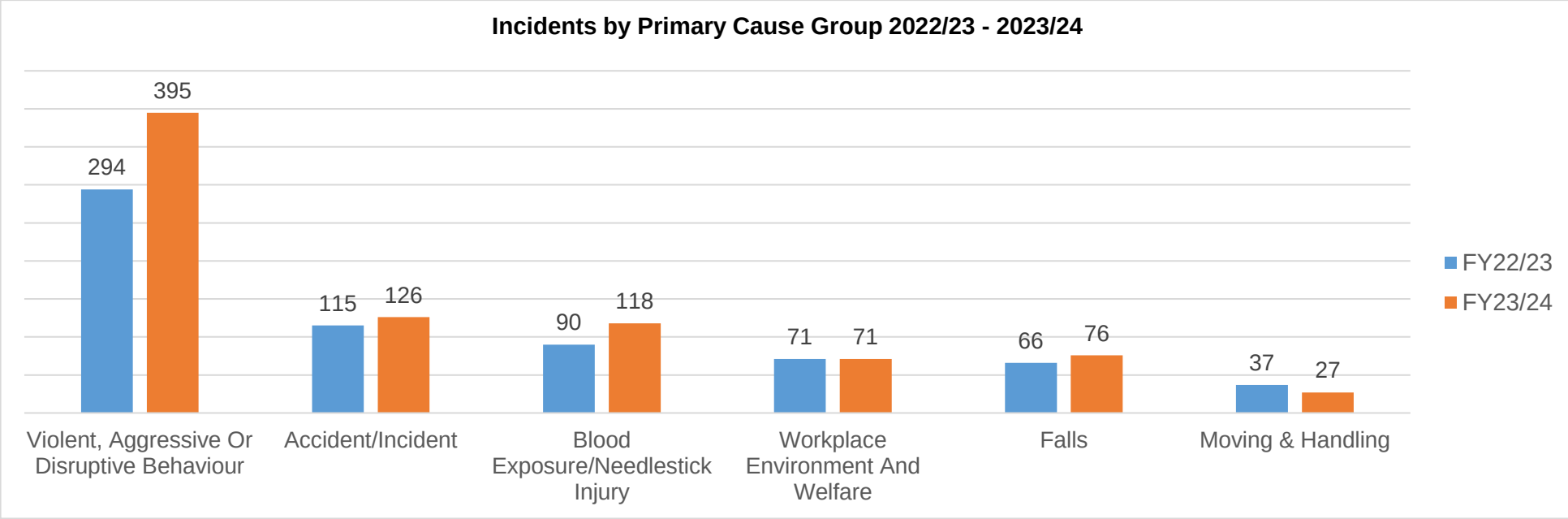
Incidents recorded by Division

Acute Adult Care Division remain the highest reporters of the divisions reporting 291 incidents which equates to 36% of the total number.



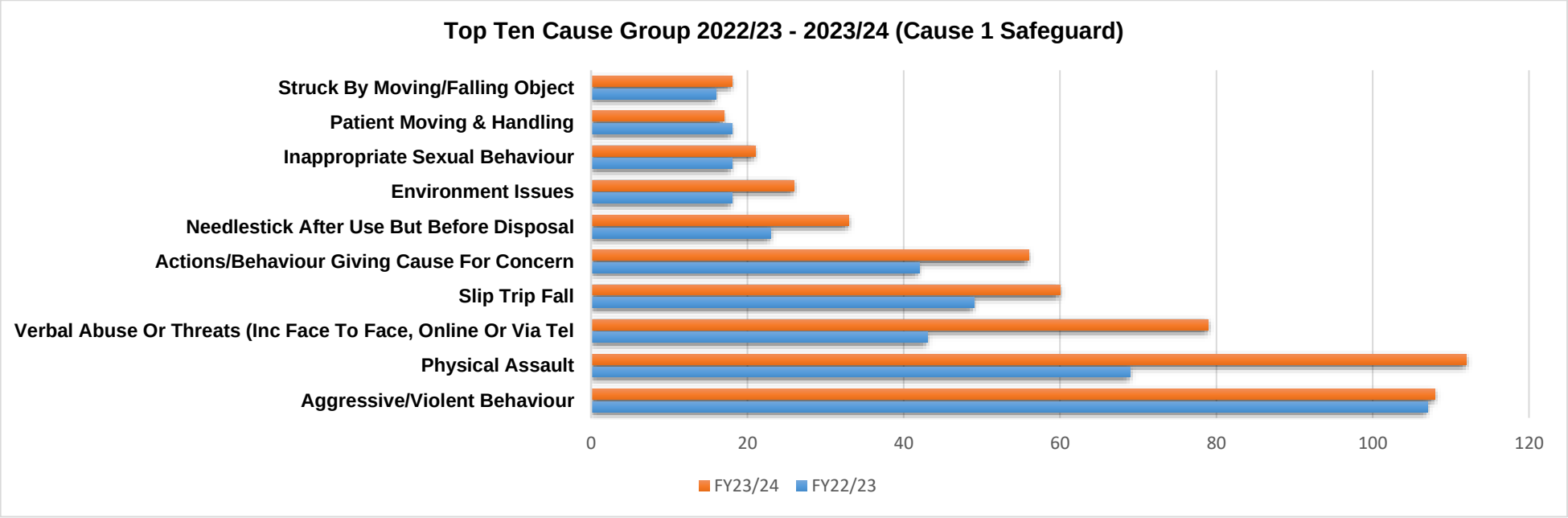
Incident by Primary Cause Group

- The theme of cause groups is consistent with the previous year with the highest cause group reported remaining Violence, Aggressive or Disruptive behaviour. Acute Adult Care Division reported 210 of the 395 incidents in ED.



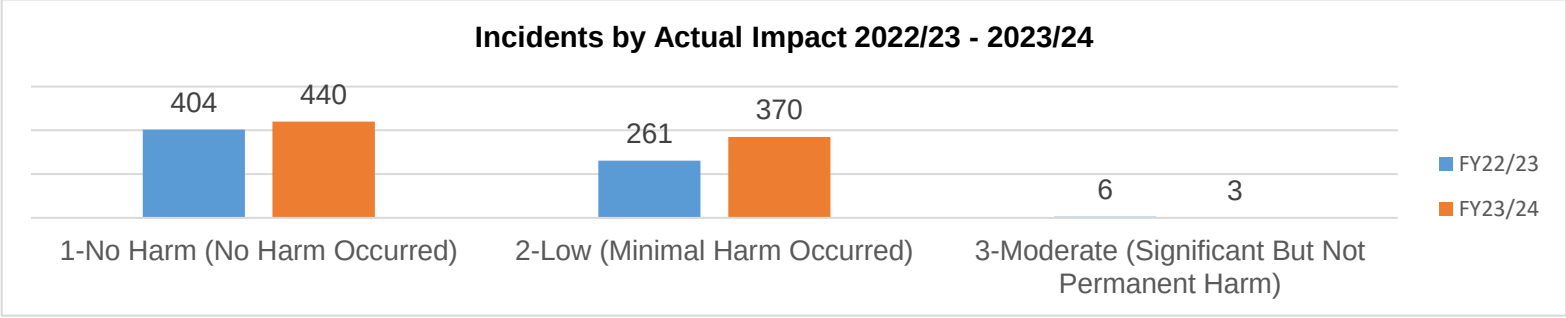
- Aggressive, Disruptive Behaviour incidents account for **48.5%** of all Health & Safety incidents reported between April 2023 - March 2024 which is a slight increase on the number reported in 2022/23 which totalled 44% of the total Health and Safety incidents during that period.

Top Ten Cause Groups



Incidents by Actual Impact

99.5% of the total Health and Safety incidents reported were of ‘no or low harm’.



Moderate Harm Incidents

In 2023/24 three (3) incidents caused moderate harm, of which there are no themes and the details are as follows:

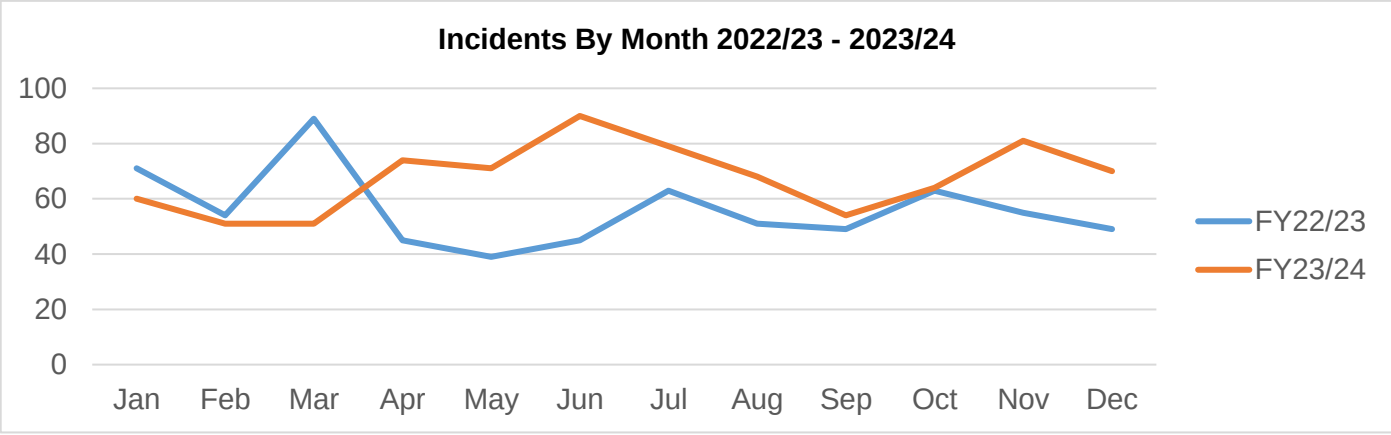
- Incident 238964: Moving and Handling - a staff member attempted to move a heavy load causing muscular injuries to both shoulders and groin. Staff member advised to reduce the load where necessary to avoid injuries in the future. The incident when reviewed was upgraded from a 2 to 3.

- Incident 242391: Physical attack – a staff member was punched in the face bursting her lip by a patient who required enhanced level care 4 and did not have capacity. First aid provided to the staff member

- Incident 220243: Fall – a staff member fell whilst walking across uneven ground from Kitchener car park believing it to be a pavement, sustaining a fracture of the left tibia. There is a plan to install railings to the actual pavement from the car park so this will prevent anyone from walking on the uneven ground

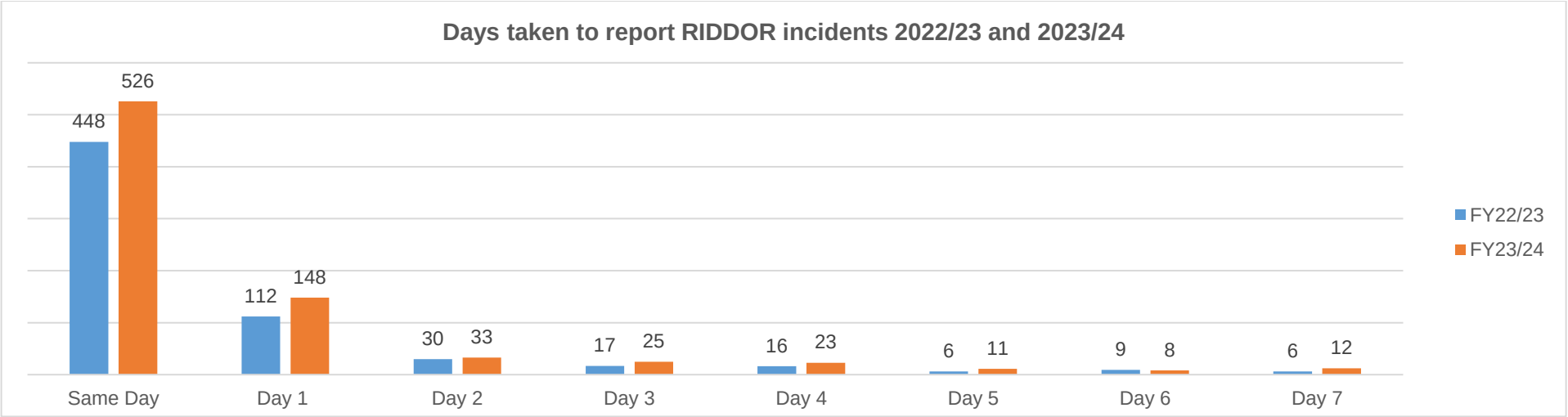
Incidents by Month

There does not appear to be any correlation with the number of H&S incidents reported per month in comparing incidents occurring by month in 2022/23 and in 2023/24.



Days taken to report an incident

Most of the H&S incidents were reported within one day of occurring (83% n=674) which indicates a good timely reporting culture.



Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR).

Types of reportable incidents

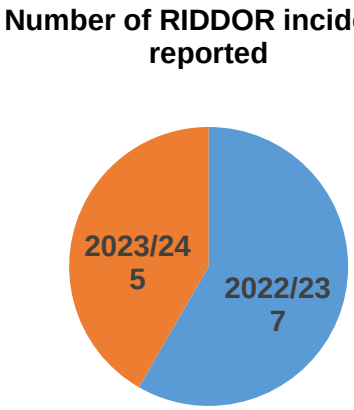
There are presently four types of reportable incidents is scope of RIDDOR

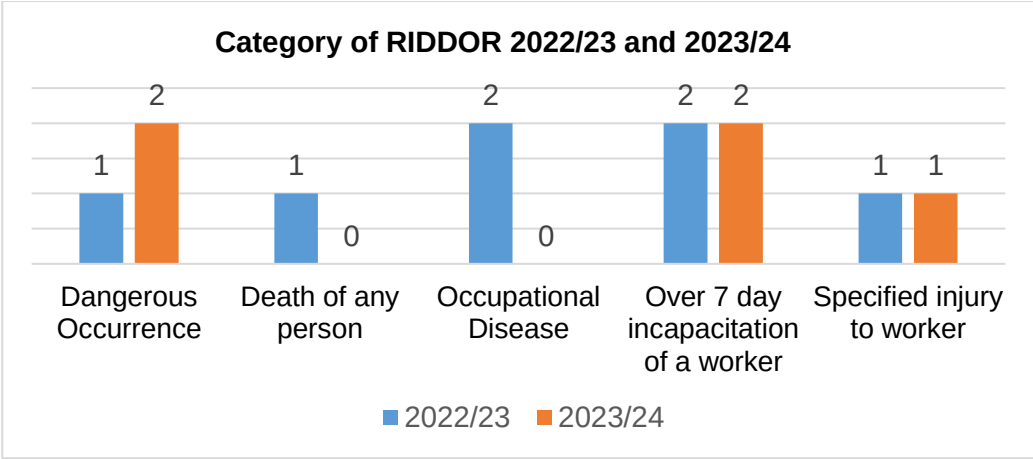
1. Reportable injuries – Death of any person (with the exception of a suicide) if it resulted from a work related accident, Specified reportable injuries to a work, Over-7-day incapacitation of a worker, non-fatal accidents to people other than workers (member of the public, patient, volunteer).

2. Occupational diseases - diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work.

3. Dangerous occurrences - A dangerous occurrence is one which ‘arises out of or in connection with work’ and could risk harm to others. The HSE has detailed guidance dangerous occurrences that must be reported under Schedule 2 of RIDDOR

4. Gas incidents - Distributors, fillers, importers and suppliers of flammable gas must report incidents in connection with that gas, where someone has: died, lost consciousness, or, been taken to hospital for treatment diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work.





Timeframes of reporting to HSE RIDDOR reportable incidents

For most types of incidents, the responsible person must notify the enforcing authority without delay, in accordance with the reporting procedure a report must be received within 10 days of the incident.

For accidents resulting in the over-seven-day incapacitation of a worker, the responsible person must notify the enforcing authority within 15 days of the incident, using the appropriate online form.

The Trust and iFM Bolton reported 3 incidents outside of the HSE timeframe (of 10 days) from a total of 5 – 60% were reported late for 2023/24

- Incident 227174 – Due to when the staff member went off sick, the incident was not formally reported and absence from work was initially thought not be work related, this only came to light during the HR sickness process.

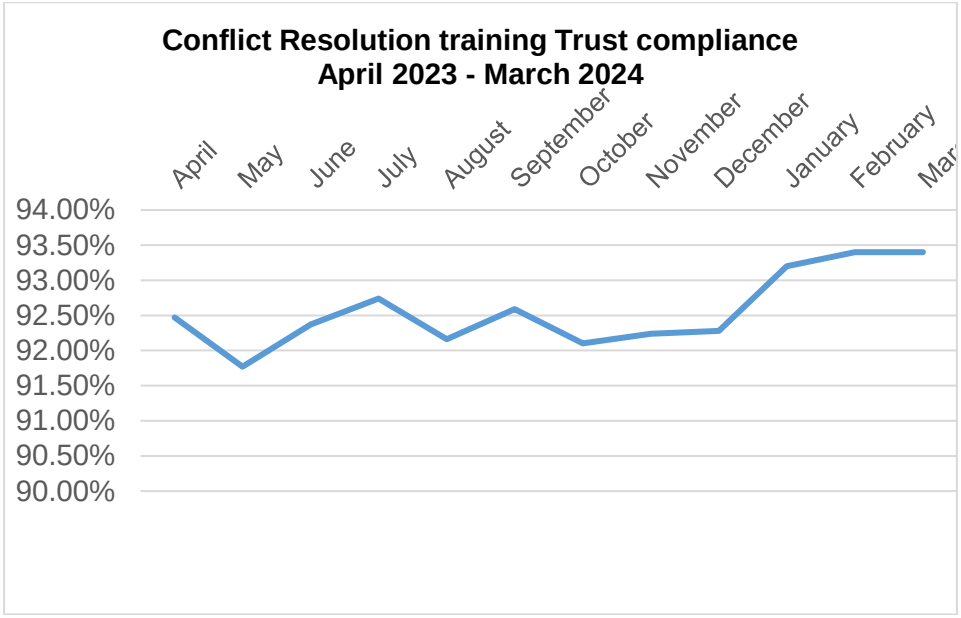
- Incident 226379 – The delay was due to a lack of understanding by the manager and staff regarding what incident types require reporting to HSE (reported under over 7 days incapacity)

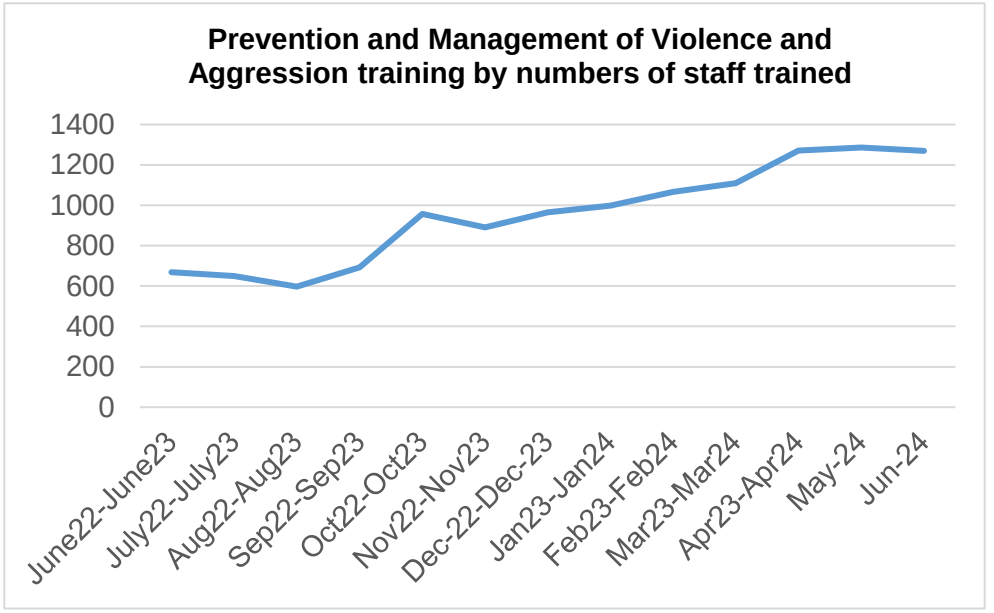
- Incident 229545 – The delay was due to the patient involved in the incident being identified as a positive source not identified within the incident. A communication failure between OH and H&S has resulted in a review of the process between OH and H&S to mitigate any further delays in reporting.

Training compliance:

- **Conflict Resolution & Prevention and Management of Violence and Aggression (PMVA) Training**

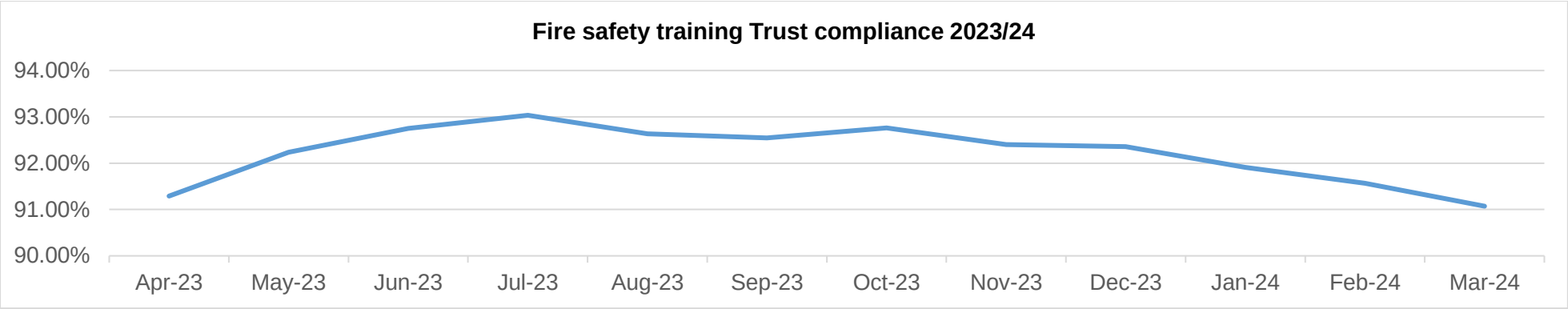
Both Conflict Resolution training compliance and the uptake of the Prevention and Management of Violence and Aggression (PMVA) training has progressively increased during 2023/24. Conflict Resolution training however remained below the Trust target which increased from 85% to 95% in October 2023.





- **Fire Safety Training**

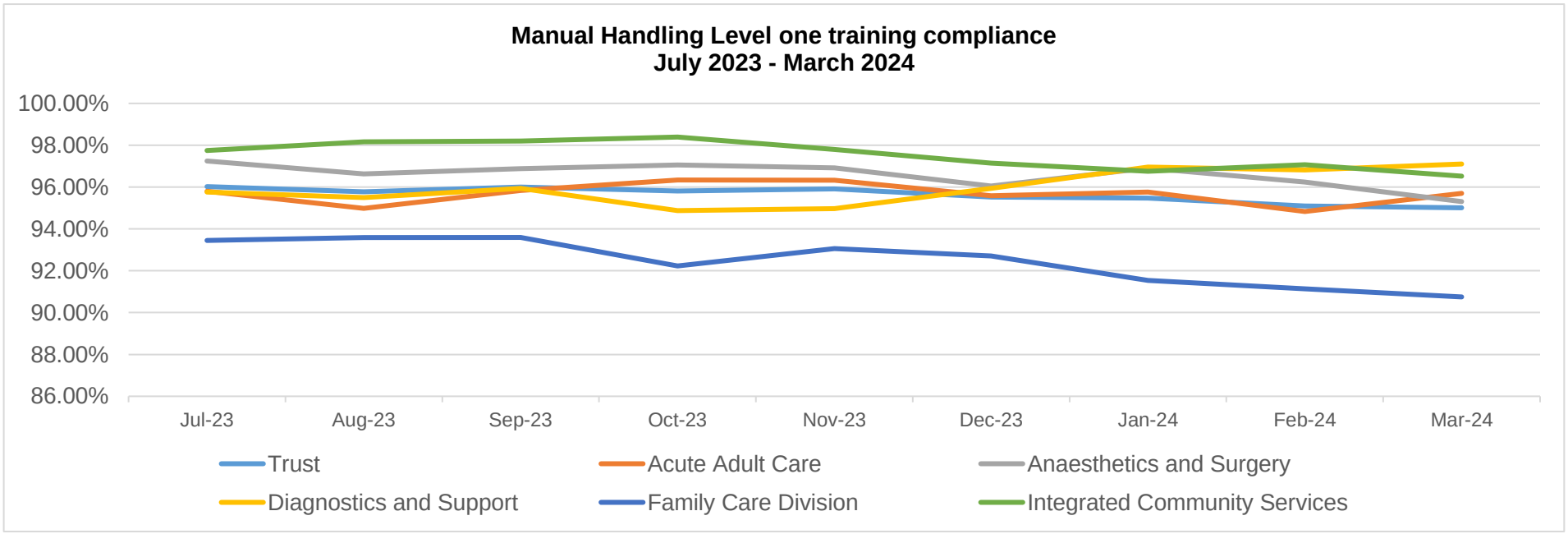
Fire safety training remained consistently under the Trust target of 95% during 2023/24 but remained above 91% throughout the year. Fire Warden training is non-mandatory with 117 staff members receiving training during this period.

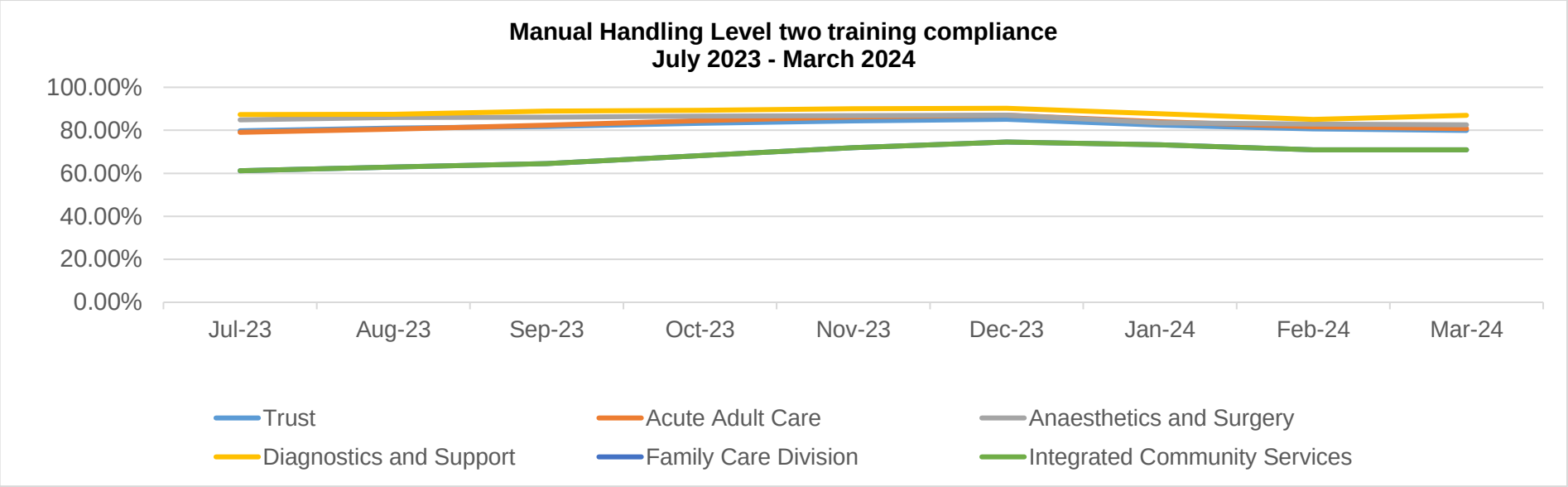


- **Manual Handling Training**

  The Trust did not meet the compliance target 95% with its Moving and Handling Level 2 in 2023/24. Divisions are to focus on improving their Moving and Handling Training figures and promotion of why training is important.

  The graphs below show the compliance figures for Manual Handling Level 1 & 2 during July 23 & March 2023

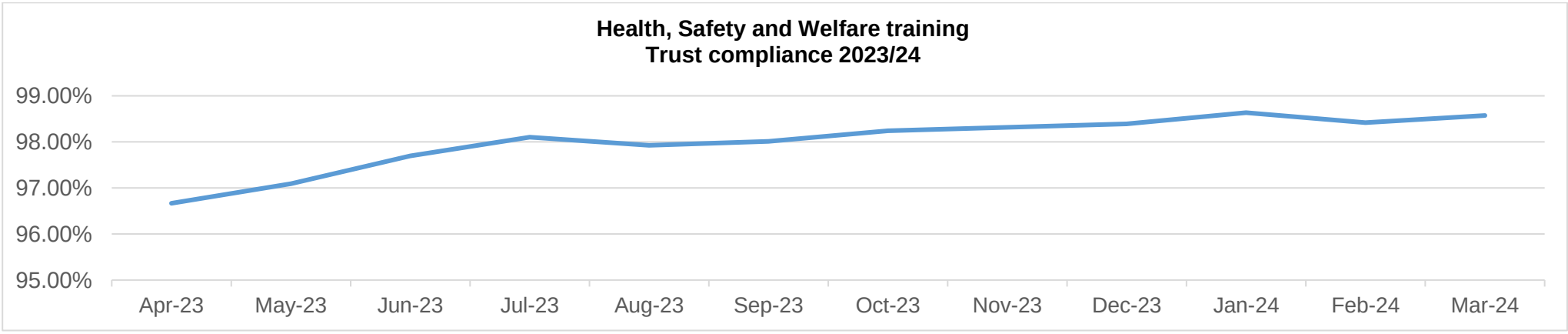




- **Health and Safety Training**

All staff that work in a health and social care setting are required to undertake Health, Safety and Welfare training which is included within the 11 core topics captured under the UK Core Skills Training Framework (CSTF).

For the Trust, Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2023/24.



Manual Handling:

During 2023/24 across all divisions the number of incidents reported per quarter are in single figures which would suggest that Manual Handling incidents are not a common issue across the Trust
There is no area that is an outlier in terms of large numbers being reported per quarter which suggests that there isn't a theme or trend in any one department to present concerns.
The level of harm caused by the Manual Handling incidents reported was 'no or low harm' with no Manual Handling incidents resulting in the Trust reporting to HSE under RIDDOR.
Note: *iFM Bolton reported separately a staff injury through Manual Handling as a RIDDOR (Incident 227174)*

Actions for 2024/25

- Recruit substantively to Manual Handling Advisor Post
- To develop a training schedule for Train the trainer courses and refresher courses for Manual Handling Training Assessors and Log Roll Training Assessors
- To support and liaise with Divisions directly to aim to increase training compliance
- To create monthly reports with EPR workforce team for division specific training percentages to support areas/ departments in identifying compliance more regularly
- Liaise with People development team and arranged for a new lesson plan to be implemented.
- Aim within next 12 months to review Manual Handling training on induction and refresher training updates to remove self-competency assessments and attendees to achieve appropriate competency during face to face training session
- Ongoing support to review and analyse incident reports and support management to investigate as required
- Review post falls process and flowchart.
- Liaise with high risk areas including Theatres. Maternity and Community services to identify bespoke needs and solutions

Claims:

The Liabilities to Third Parties Scheme (LTPS) handles all non-clinical negligence claims against member NHS bodies. The LTPS is run and administered by NHS Resolution (NHSR). The LTPS covers the Trust against Employers Liability claims (EL) and Public/Occupiers Liability claims (PL).

The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year. Individual member contribution levels are influenced by the number of staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions.

LTPS claims are reported to NHSR through the Ministry of Justice Personal Injury Portal. There are some types of claims that are not reported via the Portal and these are Data Protection claims and claims which involved assault on a member of staff by a patient. Claims that fall into this category are reported in accordance with the LTPS reporting guidelines.

Learning from claims and applying the learning plays an essential role in reducing the costs to the Trust associated with EL and PL claims. The excess payable by the Trust under the LTPS cover to the Trust's insurer is £10,000 (EL) and £3000 (PL) for each claim.

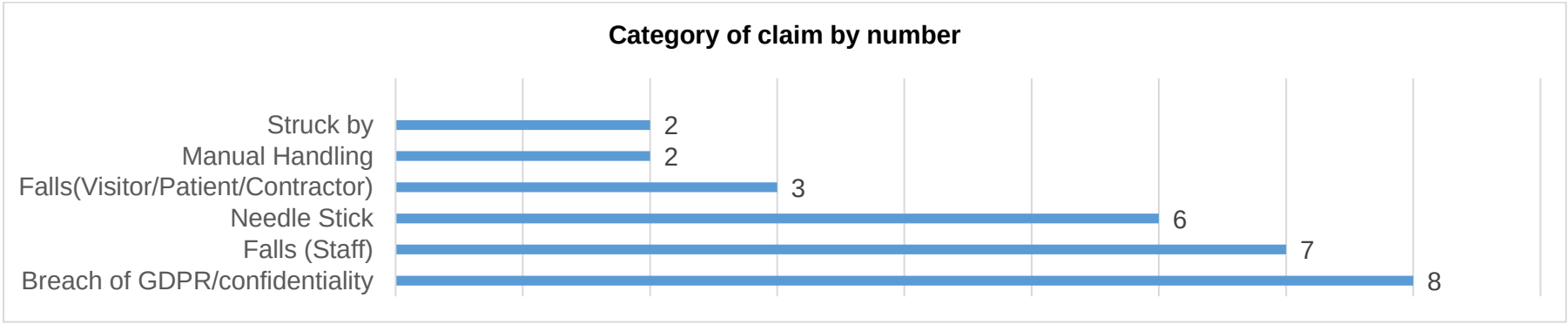
In addition to the cost of damages, there are additional costs related to the administration of legal actions, the costs related to sickness and absences, such as agency costs and the physical and psychological costs to staff involved. Other costs to consider are the impact on visitor wellbeing arising from injuries sustained.

The Trust is part of the Risk Pooling Scheme for Trusts (RPST) which is a scheme managed by NHS Resolution whereby members of the scheme contribute an annual premium and this then indemnifies the Trust against claims made under the Liabilities to Third Parties Scheme (LTPS) which covers claims made under Employers Liability and Occupiers/Public Liability and the Property Expenses Scheme.

Regardless of the value of any given claim, the Trust is indemnified and in the event of a claim the Trust will pay the excess under the LTPS relevant to whether an employer (£10k) or public liability claim (£3k). This means that the excess paid would be the maximum cost to the Trust for any individual claim and the remaining balance of any agreed claim cost will be paid by the RPST.

The Trust's contribution to the RPST for the year 2023/2024 was £185,623 which is a reduction on the previous year's cost of £213,288 in 2022/23. In calculating the Trusts annual contribution to NHSR's RPST, the Trust's claims history over the last five-year period is taken into account. Also taken into account is the Trust's total income, number of average WTEs and total pay cost.

In the period 1 April 2023 – 31 March 2024 28 claims were received. The category and number of each is shown in the table below:



During the period of 1 April 2023 to 31 March 2024, 24 claims were closed. It should be noted that some of the closed claims in 2023/24 will relate to claims received in other financial years.

- A total of 10 claims were settled with damages totalling £117,057, claimant costs of £136,933 and defence costs of £43,180
- 5 of the settled claims were claims from employees, the maximum cost payable by the Trust is the excess of £10,000 for each claim. The remaining 5 were public liability claims from either visitors or iFM Bolton employees, the excess for these claims is £3000.
- 7 of the closed claims had been defended, and in twelve of the claims the Trust was not the correct Defendant.

Learning from claims in 2023/24.

A summary of learning from claims received in 2023/24 are detailed below:

Reason for claim	Learning
A patient was anaesthetised and it was then identified that they had not consented for surgery. The patient had to be woken up and relisted for surgery.	The consent process was not followed correctly due to this not being clear to staff. Therefore A review of the consent process was undertaken and education provided to staff.
A patient who had an ectopic pregnancy was not diagnosed or treated correctly.	The handover between the clinicians had failed to relay that would have resulted in correct investigations, diagnosis and treatment of the ectopic pregnancy. A review of the handover procedures was undertaken and training and education was provided to staff related to ectopic pregnancy.
An in-patient sustained injuries following a fall.	The patient was not reviewed correctly post fall. The patient also did not receive the correct assessment prior to the fall related to measurements of lying and standing Blood pressures. Comfort rounds were also not carried out timely to support the patient which may have avoided them from falling. A review of the processes regarding post fall assessments, measuring lying and standing blood pressures and comfort rounds,
A maternity patient suffered a 3rd degree tear that was sutured incorrectly and resulted in this needing to be repaired in theatre.	The patient's 3rd degree tear was not sutured correctly and there was no guidance available for this procedure. Obstetric and Sphincter Injury (OASI) Care bundle was developed to reduce the incidence of OASI which is taught to staff on the maternity training programme.

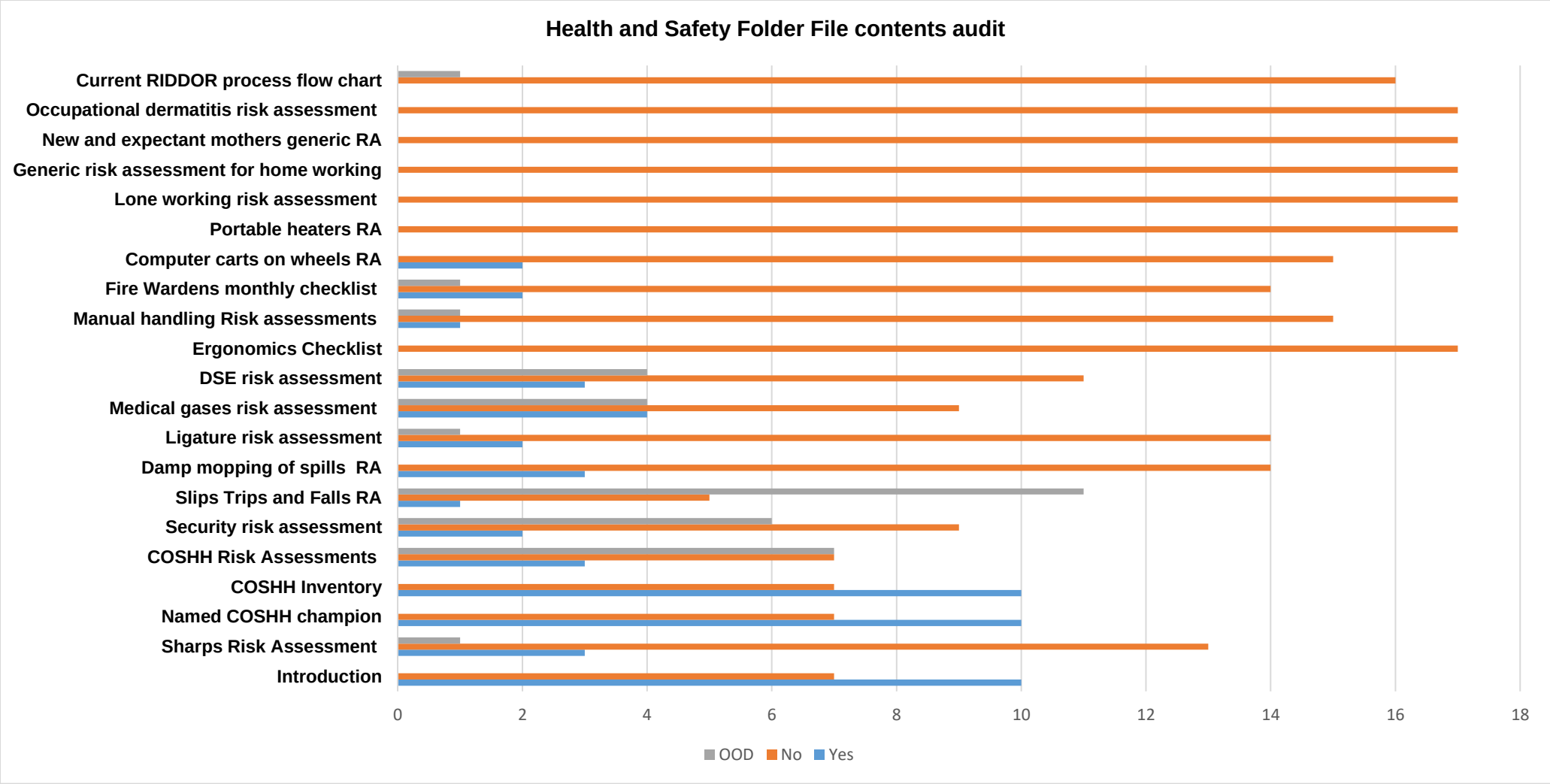
Audits:

The Trust has a legal responsibility to inform its employees of its Health & Safety arrangements. This can take the form of The Health & Safety Policy, (and other related Policies available on the Trust intranet), the Trust Risk Register and by the formulation of Risk Assessments stored within the Health & Safety file.

The Health & Safety file should cover all relevant aspects of health and safety, ensuring that the safety and welfare of our staff is at the core of our values. A Health & Safety file can also be a valuable training tool and resource. Having received various pieces of soft intelligence and requests for support in relation to Health & Safety Files in general. The Health & Safety team began a piece of work to focus on this which started in November 2023.

As a way of benchmarking current practice within the Trust in respect to Health & Safety files, the Trust team have undertaken a series of audits. An audit template was formulated and trialled. The audit template covered a number of established Trust generic risk assessments and Risk assessment tools. 18 Departments were visited one of which was excluded due to infection control reasons. The audit results were returned to the relevant to the ward/ departmental manager (and where applicable nominated staff member) and Divisional Governance lead

An individual action log tracker was created to enable each ward/ department to record the completion of the relevant actions generated from the audit process. One of the most surprising results was that of the 17 departments visited, three areas had no Health and Safety File. One of the most common findings during the audits was the presence of large quantities of out of date/ obsolete Trust policies. Risk assessments were present were often not updated or reviewed regularly some files having obsolete versions. The time periods being from a year to over 10 years out of date. Multiple versions of risk assessment templates were also found including draft versions.



The results from the audit have been consistent with the soft intelligence provided by staff and previous results from the joint H&S/ Occupational Health drop in audits.

On conclusion of the audit the issue of staff **not** having access to up to date risk assessments appears not to be related to a specific division but to be across departments on the hospital site; at this point, no community workplaces have currently been audited.

The H&S Team have programmed in audits across the Divisions including community workplaces in Q1 (2025/26), with feedback being provided through the GH&SC.

The H&S team made the Health & Safety File Template available on the Trust intranet page. Going forward into FY24/25 the Health & Safety File project will continue, the creation of an electronic template for departments within divisions to utilise. The Health & Safety team have formulated a divisional assurance template along with a Health & Safety Assurance Calendar that now forms part of GHSC work plan.

Drop in Audits

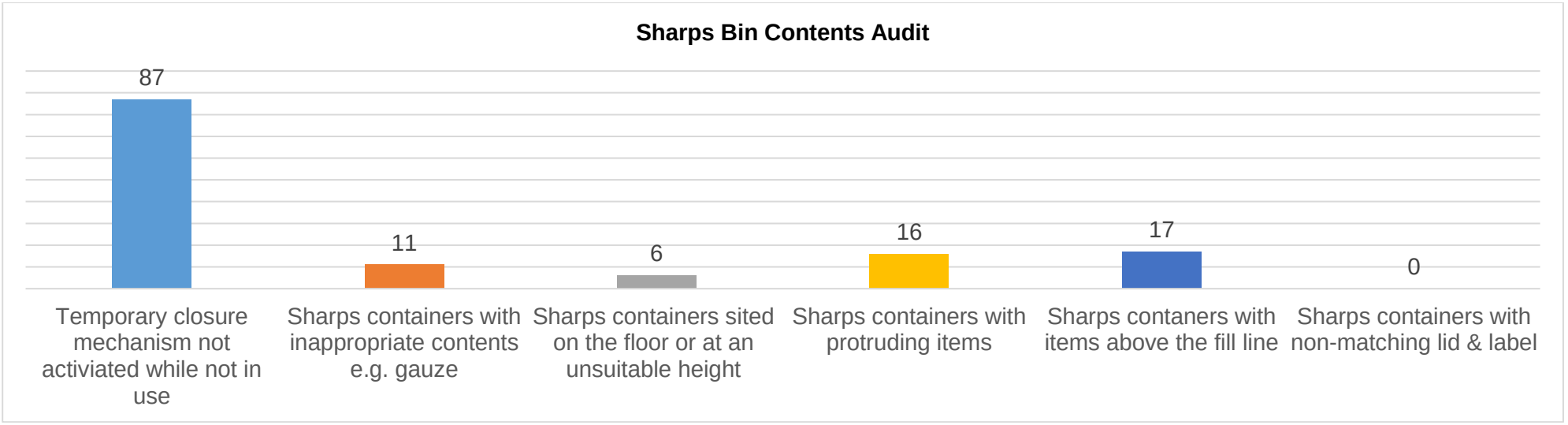
The Health and Safety Team with Occupational Health have a rolling programme of drop in audits with a three-pronged focus:

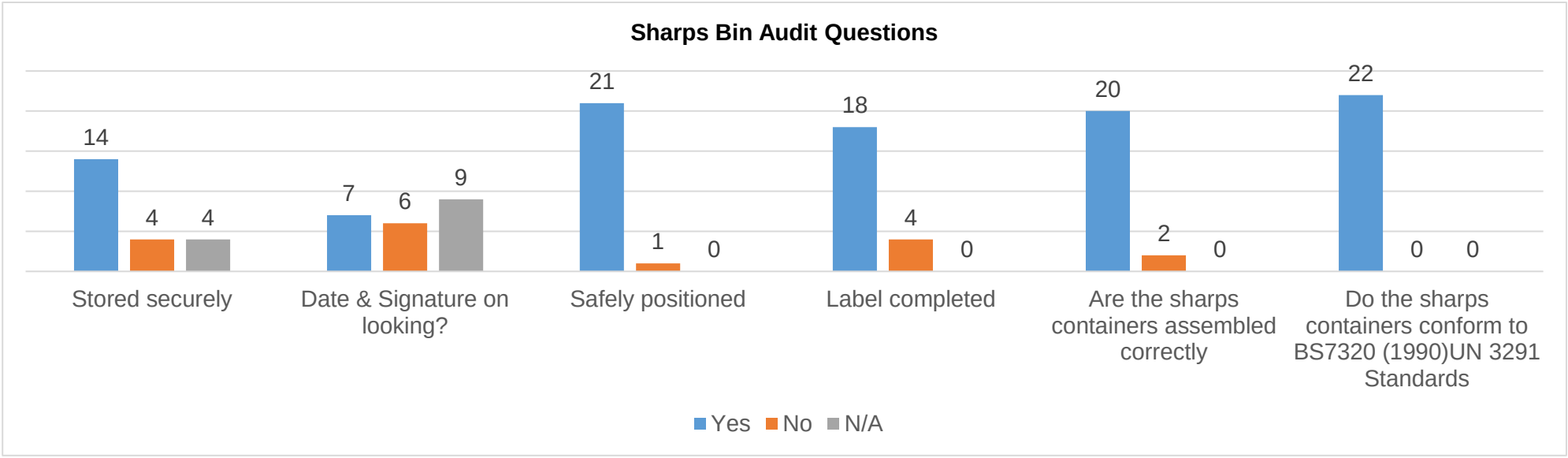
- Sharps bin safety
- Health & Safety Generic Risk Assessment Compliance *(this led to the above audit of health & Safety files and associated work plan etc)*
- Skin care - *See OH section*

Currently a total of 23 departments have been audited with further audits both on the main hospital site and community scheduled to be completed. On completion of the audits each ward manager is sent the results, along with nominated staff with delegated responsibilities within these areas. Returned audit results will also include any missing or up to date documentation and any identified actions.

In relation to Sharps Bin Safety only across the 23 departments audited the continued themes are:

- Temporary closure mechanism not activated while the sharps bin was not in use
- Items above the fill line
- Protruding items
- Inappropriate items
- Sited on the floor
- Sharps bins did not have lids or the lid clicked on securely.





Needle stick & sharps bins incidents continue to be reported and appear to come in peaks and troughs aligned to increased staff awareness either through audits being undertaken, training slides being sent out or the production of SBAR's.

Drop in audits will continue on a rolling programme with Occupational Health & Wellbeing

Health and Safety Executive (HSE) inspections:

During 2023/24 the Health and Safety Executive (HSE) undertook two inspections to the Trust.

Due to the number of RIDDORS for Occupational Dermatitis reported by the Trust, particularly from one department, Neonatal Unit (NNU), the HSE requested a visit to observe / assess current practice for the management of Occupational Dermatitis. The visit took place on 19th April 2023. The Trust Hand Hygiene policy and OH Standard Operating Procedures were forwarded prior to the visit, along with local risk assessments completed for the Neonatal unit.
The HSE Inspectors visited NNU and observed hand washing facilities, information available for staff and interviewed the Matron who gave excellent assurance and described a robust management system from a unit perspective.

No issues were identified throughout the visit and the HSE gave very positive feedback stating `From the visit, it is clear that the Trust have taken have a robust system in place for diagnosing and reporting incidents of occupational dermatitis as well as systems for raising awareness and ensuring that all cases are investigated, and remedial actions taken`. No actions were required by the Trust.

The HSE undertook a visit to the Trust in July 2023. The visit was in support of the Trust's Radiology department compliance with the Ionising Radiations Regulations 2017. The HSE identified that the Trust was in contravention (Notice of Contravention) of the following:

- Ionising Radiations Regulations 2017, Regulation 19(6) – Monitoring in Controlled Areas
- Ionising Radiations Regulations 2017, Regulation 16 – Co-operation between employers
- Ionising Radiations Regulations 2017, Regulation 10 – Personal Protective Equipment
- Ionising Radiations Regulations 2017, Regulation 15 – Information, Instruction and Training

The Trust were given until the 25th August 2023 to comply with these regulations.

The Trust were also issued an Enforcement Notice (Improvement Notice) with regards to permitting employees to enter or remain in your controlled areas, under written arrangements, without demonstrating that the doses to the lens of the eye are restricted by personal dose monitoring or other suitable measurements

The Trust were again given until the 25th August 2023 to comply

The Trust completed all actions to the complete satisfaction of the HSE by the date specified:
Actions successfully implemented to the satisfaction to the HSE inspector was:

- Review and produce an up to date current risk assessment

- Produce and implement an appropriate Standard Operating Procured (SOP) for iFM Bolton staff working within Radiology
- Produce and implement and appropriate SOP for staff entering Radiology rooms
- Implement staff dose monitoring for those entering or remaining in controlled areas

Alerts:

During 2023/24 there was one National Patient safety Alert related to Health and Safety as detailed below:

Date	Reference No.	Alert Type	Title of the Alert	Date Closed	Outcome
31/08/2023	NATPSA/2023/ 010/MHRA	National Patient Safety Agency	National Patient Safety Alert: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls (NatPSA/2023/010/MHRA)	22/04/2024	Compliant All Actions undertaken.

Policies: Status of health and safety policies

Name	Doc Type	Review Date	Status
Controlling Contractors Safety Policy.pdf	Policy	01/05/2018	To work with iFM Bolton on this policy
Security Policy including Risk Based Management of Violence & Aggression .pdf	Policy	01/05/2024	
Personal Protective Equipment Policy (PPE).pdf	Policy	01/04/2025	
Trust Fire Safety Policy.pdf	Policy	01/06/2025	
Medical Devices Training Policy.pdf	Policy	01/08/2025	
Control Of Substances Hazardous to Health (COSHH) Policy.pdf	Policy	01/12/2026	
Medical Devices Operational Policy v10.pdf	Policy	01/12/2026	

Name	Doc Type	Review Date	Status
Electrical Safety Policy.pdf	Policy	01/04/2027	
Health and Safety Policy.pdf	Policy	01/04/2027	
Workplace Ergonomics and Display Screen Equipment	Policy	01/09/2025	
First Aid at Work Policy	Policy	01/05/2027	
Control of vibration at work policy.pdf	Policy	01/06/2027	
Safe Management of Sharps Policy	Policy	01/06/2027	
Latex Policy	Policy	01/06/2027	
Using Bedrails Safely Policy	Policy	01/06/2027	
Log Roll Technique and Training Policy .pdf	Policy	01/08/2027	
Manual Handling Policy .pdf	Policy	01/08/2027	

Fire Safety:

IFM Bolton provides support and guidance for fire safety across the Trust and maintained 95% compliance for **Fire Risk Assessments** (FRA) for all Royal Bolton Hospital buildings including Community buildings for FY 2023/24.

In comparison to the previous year, there is a 19% increase in completion of FRA. This has been a continual monthly achievement for clinical, non-clinical and community premises and is presented to the Fire Safety Committee. There have been 65 FRA's undertaken in the reporting period of FY23/24.

We have worked collaboratively with GMMH to find a solution to split the alarm systems whilst ensuring both parties maintained a safe fire alarm system providing early warnings in the event of fire. We continue to ensure the Trust's compliance with statutory obligations.

In addition, we monitor, track and aim to reduce the number of Unwanted Fire Signals (UWFS) - False Alarms. By monitoring and reviewing the cause, we established 45% of our false alarms were associated with Greater Manchester Mental Health (GMMH K Block). As a result, our Unwanted Fire Signals reduced by 18%.

Fire Safety Governance

The Joint Fire Safety Committee maintains oversight of Fire Safety for the Trust and reports through on a monthly basis to the GHSC via a chairs report. The Fire safety Dashboard is presented to the Fire Safety committee, to ensure assurance is provided and any areas of concern are escalated through the applicable Governance Route.

The dashboard gives oversite of key areas of performance which are listed an illustrated below;

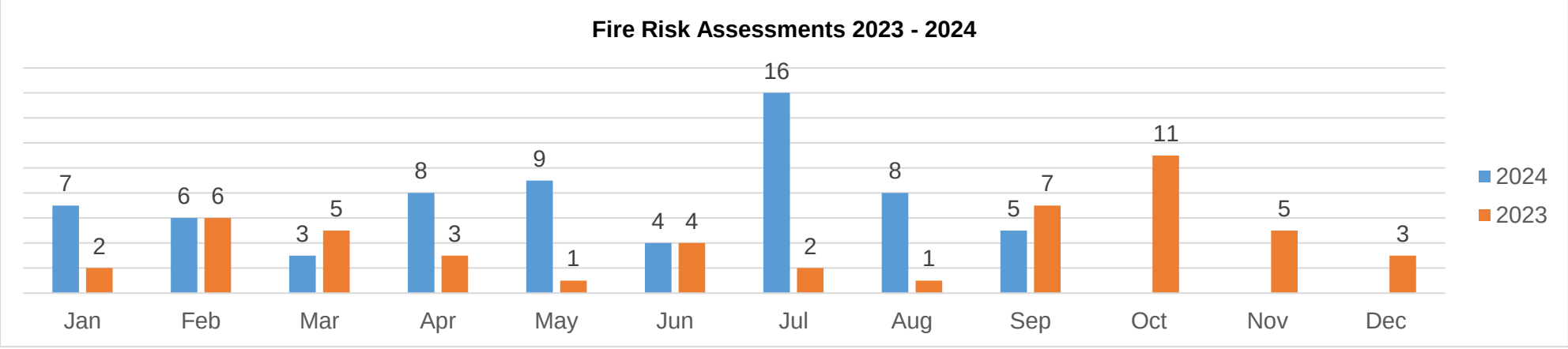
- False Alarms – Including types of Unwanted Fire Signals
- Fire Risk Assessment Compliance
- Fire Risk Assessments completed monthly
- Total actions open – By due date and status

Fire Risk Assessments for all Royal Bolton Hospital buildings including Community buildings

Maintained 95% compliance and tracked monthly at Fire Safety Committee for Assurance of over 191 Fire Risk Assessments

Fire Risk Assessments tracked monthly

To ensure progress is made, monthly monitoring on the completion of Risk assessments is tracked through the Fire Safety Group presented by the iFM Fire Safety Advisors.



Present Risks

- **Compartmentation**

Work within the Trust site both in clinical, and none-clinical areas remains outstanding. A program of work was agreed to complete the clinical areas as a priority, as part of the ward-based closure program. However, due to high patient demands, the presence of RACC being discovered within the trust site, this option was difficult to achieve. The Trust and iFM Bolton are considering what options are available to progress the compartmentation work during 2024/2025. The trust has an evacuation strategy for all occupied areas of the Trust buildings, Fire safety training is provided to all staff and additionally to individual wards as part of the Emergency Response Teams training program, this training helps to ensure staff have the knowledge and skills to safely continue any evacuation if required.

- **Incidents**

The Trust has experienced one (1) fire incident in 2023/2024, which was minor. The cause of the fire was a battery charging device in the laundry failing. No flames were evident however the fire service did attend.

Actions, post fire included the removal of all the devices, a contractor attending the site and testing all the remaining equipment which provided assurance that the devices and battery's where safe to use. There have been no re occurring issues related to this incident.

IFM Bolton continue to support the Trust with all fire safety related compliance, and fire safety issues.

The Fire Safety Group have oversight and monitor actions, reporting to Group Health and Safety Committee.

Security:

This section includes Security Risk Assessment assurances covering premises/teams/departments for both the Community and RBH sites

In May 2023 the iFM Security Team consisted of 8 permanently employed officers responsible for the Trust hospital site. Individual officers were fully PMVA trained. The remaining 13 other positions were filled by on our third-party company. The conclusion was that this joint approach made the whole team less effective and less robust.

The staffing plan for 2024/25 is to recruit 21 Trust employed Officers, all being fully trained in PMVA. These 21 officers are to be supported by 2 bank officers (IFM), with no more third-party company involvement. By having permanently employed officers this will improve the teams' effectiveness to provide support across the Trust.

Trust Group Security Committee:
Group Security Committee is a subcommittee of Trust Health and Safety and is authorised to set standards, for the management and control of security related issues across the Trust.

The purpose of the committee is to ensure arrangements are in place to manage security related risks to staff, patients and others in compliance with the Management of Health and Safety at Work Regulations 1999.

Assurance
Each of the clinical divisions provide an assurance report to the committee on a bi-monthly basis. This report provides assurance on compliance with Security Risk Assessments, Lone Worker risk assessments, new security related risks and controls, training compliance for Conflict Resolution and the Prevention and Management of Violence and Aggression and learning from security related incident reporting.

Security Risk Assessments

In May 2023 the percentage rate of completed Risk Assessments in RBH was at 5%
May 2023 percentage rate of completed RA in Community sites 0%
Note: *This Committees meeting is held bi-monthly – no meeting was held in April 2023* and therefore 2023/24 year end data was reported May 2024.

The percentage rate that stands now in May 2024

May 2024 percentage rate of completed RA in RBH were at 98%
May 2024 percentage rate of completed RA in Community sites 100%

Violence prevention and reduction

Violence and abuse towards NHS colleagues is one of the many factors that can have a devastating and lasting impact on health and wellbeing.

Analysis of violence and aggression cause groups took place in 2024 to enable more accurate reporting of incidents in safeguard.

An understanding of the incidents being reported is needed to determine if any actions are required to support staff therefore each division will be requested to analyse the violence and aggression incidents in 2024 25.

iFM Bolton Security related policies

All policies set out have been reviewed and updated.

Asbestos:

Annual inspections

IFM Bolton has an appointed specialist contractor who undertakes inspections and provides recommendations on best practice and control measures.

Where existing asbestos containing materials are in good condition and are not likely to be damaged, their condition continues to be managed to ensure it's not disturbed, and is monitored periodically (at least every 12 months) as per HSE guidance.

These routine annual inspections present no risk of harm to staff, patients or others and are carried out as part of a normal control procedure. The purpose is to simply provide instruction and safe management of asbestos, with the aim of having no accidents and reducing the likelihood of individuals exposed to harm along with a continual inspection to the immediate environment.

The purpose of an asbestos survey aims to:

- Provide accurate information on the location, amount and condition of asbestos-containing materials (ACMs)
- Assess the level of any damage or deterioration of the ACMs and whether remedial action is required
- Provide information to produce an asbestos register and an asbestos management plan for the premises
- Identify hidden ACMs to be removed before refurbishment work or demolition

There are presently 59 locations on the Asbestos Register requiring an annual inspection, all of these having been inspected in FY23/24, helping to ensure any risk is appropriately managed.

Incidents, Shortfalls and Learning

An asbestos survey/inspection would report any highlighted damaged ACM's or high-risk ACM's along with confirmation on assurance that any actions (control measures) taken would be sufficient to manage and avoid exposure to individuals.

There has been no asbestos related incidents covering the period of this report.

The below table provides a summative overview on the arrangements in place for the management of Asbestos

Key compliance area	RAG	Brief Description of Compliance	Outstanding actions	Responsible person	Target completion date
Annual asbestos survey		Surveys undertaken	N/A	AW	N/A
Asbestos registers up to date		Via contractor Portal	N/A	AW	N/A
Asbestos management plan up to date		As per asbestos register and policy	Review and add to share point	AW	Dec 2024
Policy		Approved Policy	Review management responsibilities	AW	Dec 2024
SOPs		Specific details of SOP'S are submitted as part of the any project prior to works being undertake	Information	Information	Information
Training		Asbestos awareness	Information	Information	Information
Risks / controls		As per survey guidance	Information	Information	Information
Protection of contractors		Permits, site induction, policy and process of contractors	Information	Information	Information

Legend:	
Compliant	
Non-compliant	

Ventilation/Heating and Temperature Control:

There is a functional Ventilation Safety Group with agreed Terms of Reference (ToR). This group has been re-launched over the past two years and is a collaborative group between the Trust and iFM Bolton.
It is chaired by a Trust representative (Deputy Director Infection Prevention & Control (IPC)) with the Group having oversight around safety, risk and assurance. There is now sufficient assurance being received into the group that the frequency of the meetings have been reduced from monthly to alternate months.

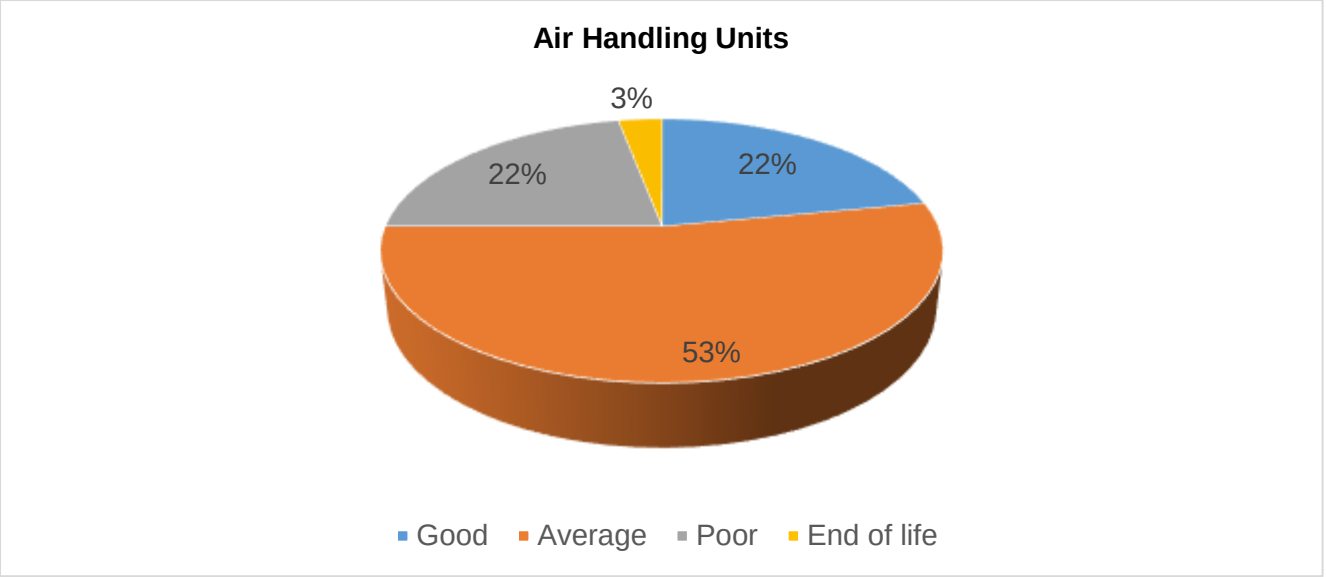
The group has identified and escalated that the condition of much of the critical ventilation currently in use within the hospital site is in poor condition. There are 36 Air Handling Units (AHUs) – 3% (one air handling unit) is end of life, 22% are in poor condition, 53% are in average condition and 22% are in good condition.

This risk has been added to the Trust Risk Register with assurance it is being managed accordingly is through the Risk Management Committee.

The ventilation risk is number 3194 owned by IFM.
If the Ventilation plant fails in Ophthalmology and Maternity Theatres, then there will be no air supply to the Theatres. This will pose an infection risk to patients and will ultimately lead to cancelled lists.
The Controls to mitigate the risk are

- Building management system monitors temperatures and alarms during hot weather staff are deployed to ensure as much free cooling can be diverted onto the wards utilising external night time temperatures to cool the environment.
- Annual audit of ventilation plant undertaken to inform maintenance management of general condition.
- Fans have a backup motor available
-

Actions in place: Business case to secure funding to upgrade/replace ventilation system



The serviceable life of an AHU is approximately 20 to 25 years, and the condition of the plant reflects the age of much of this equipment:

There are areas where the condition of the ventilation is acceptable but due to the old designs of the facilities are outdated compared with the current guidance for design and operation. An example of this is Ophthalmology and day care theatres. There will need to be consideration of how the current design and operational functions with acknowledgement that some of these services need to be re-furbished at some point in the future.

The Authorised Engineer for Ventilation – AE (V), has rated the overall risk for the Trust ventilation systems as 6 out of 25. This is based on condition, age and mitigation.

The Ventilation Safety Group meeting has oversight and monitors actions, reporting to the Group Health and Safety Committee.

Water Safety:

There is a functional Water Safety Group (WSG) with an agreed Terms of Reference (ToR). This has been re-launched over the past two years and is a collaborative group between the Trust and iFM Bolton. It is chaired by a Trust representative (Deputy DIPC) and has oversight around safety, risk, experience and assurance. There is now sufficient assurance being received to the group that the frequency of the meetings has been reduced from monthly to alternate months.

There are no issues that the Water Safety Group feels necessary to escalate as an issue to alert to Group Health and Safety Committee.

The group is currently developing a new Water Safety Policy for the Trust – this will outline the actions required by Trust staff to maintain the safety of water provided by iFM Bolton.

A new Water Safety Policy for iFM Bolton has been approved and a corresponding Water Safety Plan has been developed and approved by the Water Safety Group.

The Trust and iFM Bolton have commissioned regular water testing (thermal controls for Legionella control and regular sampling for *Legionella spp.* and *Pseudomonas aeruginosa*) in compliance with HSE Approved Code of Practice (ACOP) L8 publications and Health Technical Memoranda (HTM) 04-01 Water Systems respectively from a new contractor. This new contract includes access to a data repository which is searchable and offers more assurance and active alerting than the services provided by the previously contracted service.

Over the past 14-months the three main water tanks have been refurbished. All three tanks had been assessed and were in a poor state and have now been re-lined. This ensures that Royal Bolton Hospital has 24-hours of tanked water supply in the event of service interruption from United Utilities.

The Water Safety Group meeting has oversight and monitors actions, reporting to the Group Health and Safety Committee.

Occupational Health:

The Occupational Health (OH) Service continues to provide expert, trusted, effective Occupational Health advice to the Trust and over the last twelve months has provided an effective response to a number of new potential health hazards that may impact staff such as measles, pertussis and Occupational Disease (Dermatitis).

Occupational Health continued during this reporting period, to roll out the extensive Health Surveillance programme linked to occupational dermatitis and skin health, which commenced in 2021. A total of 188 surveillance was completed in this reporting year, with one RIDDOR of Occupational Dermatitis. This is a marked decrease in reported RIDDOR's compared to the 12 reported in 2022/23. The HSE visit in April 2023 identified the robust system, clinical governance and programmes the OH department has in place and the data for 2023/24 is reflective of this. The success of the HSE visit in April 2023 was reassurance to the Trust of full compliance with Occupational Dermatitis. This had been triggered due to the amount of RIDDOR cases in the previous year. A full review of all departmental documentation was conducted, including SOPs, risk assessment and policy. No issues were identified throughout the visit, and the HSE gave very positive feedback stating `From the visit, it is clear that the Trust have a robust system in place for diagnosing and reporting incidents of occupational dermatitis as well as systems for raising awareness and ensuring that all cases are investigated, and remedial actions taken`.

There has been more awareness of the Trust OH Team through their attendance and reports raised through numerous groups, including the Trust Groups Health & Safety committee and its work along-side the Health & Safety Team in its continual audit programme.

The Occupational Health team have supported with the delivery of the 2023/2024 seasonal flu, vaccination to our staff. The coming year will see the OH team take over full co-ordination of the programme.

Occupational Health worked tirelessly to continually improve the resource around Mental Wellbeing. The service has worked within KPI to get staff assessed and access to relevant services. They continue to house the Trust staff self-referral physiotherapy service within our Bolton Hospital site, and working in collaboration has resulted in staff members returning to substances roles in a timely manner.

From 01 April 2024, the Wellbeing function will move into the OH portfolio and this will enable the service to deliver and be responsible for the full suite of Occupational Health and Wellbeing services available to staff.

Actions for 2024/25:

Action	By Whom	By when
Recruitment to Manual Handling Advisor post	Health and Safety Manager	April 2024
To develop a training schedule for Train the trainer courses and refresher courses for Manual Handling Training Assessors and Log Roll Training Assessors	Manual Handling Advisor	August 2024
Amend Incident report to include prompt for potential RIDDOR incident	Health and Safety Manager/Risk and Assurance Team	May 2024
To develop actions re compartmental options to be available to progress the compartmentation work during 2024/2025	Trust/iFM Bolton Management	May 2024
To recruit Security staff	IFM Bolton	May 2024
To receive divisional assurance risk assessment reports at Group Health and Safety Committee	Divisional Governance Leads	June 2024
Divisions to analyse violence and aggression incidents to identify and themes and actions required.	Divisional Governance Leads	January 2025
Review Manual Handling training on induction and refresher training updates	Manual Handling Advisor/Clinical Skills Lead	March 2025
To liaise with high risk areas including Theatres. Maternity and Community services to identify bespoke manual handling needs and solutions	Manual Handling Advisor	March 2025