AGENDA - BOARD OF DIRECTORS' MEETING

MEETING HELD IN PUBLIC

To be held at 13.15 on Friday 26 May 2023
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB051/23	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm meeting quoracy*	*Verbal*	Chair	**13.15**
TB052/23	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	**13.15** (15 mins)
TB053/23	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*Report + Verbal*	Chair	
TB054/23	**Minutes of the previous meeting held on 30 March 2023** *Purpose: To **approve** the minutes of the previous meeting*	*Report*	Chair	**13.30** (5 mins)
TB055/23	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB056/23	**Chair's Update** *Purpose: To **receive** the update from the Chair.*	*Verbal*	Chair	**13.35** (5 mins)
OPERATIONAL PERFORMANCE				
TB057/23	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13.40** (10 mins)
TB058/23	**Operational Update** *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**13.50** (10 mins)

TB059/23	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance *Purpose: To **receive** the Integrated Performance Report*	*Report*	DCEO	**14.00** (15 mins)
WORKFORCE				
TB060/23	**Workforce Reports** a) Staff Survey b) EDI Update c) Staff Health and Wellbeing Report d) People Plan *Purpose: To **receive** the Workforce Reports*	*Report*	Chief People Officer	**14.15** (15 mins)
TB061/23	**People Committee Chair Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	PC Chair	**14.30** (10 mins)
STRATEGY AND PERFORMANCE				
TB062/23	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**14.45** (10 mins)
	COMFORT BREAK			**14.55**
QUALITY AND SAFETY				
TB063/23	**Nurse and Maternity Staffing Reports** *a) Nurse Staffing Report* *b) Maternity Bi-Annual Staffing Update* *Purpose: To **receive** the Nurse Staffing Report*	*Report*	Chief Nurse	**15.05** (10 mins)
TB064/23	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q4 Update**	*Report*	Chief Nurse	**15.15** (10 mins)

	*Purpose: To **receive** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q4 Update*			
TB065/23	**Quality Assurance Committee Chair's Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**15.25** (10 mins)
FINANCE				
TB066/23	**Confirmation of 2023/24 Financial Plan** *Purpose: To **receive** the 2023/24 Financial Plan*	*Report*	Chief Finance Officer	**15.35** (5 mins)
TB067/23	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	**15.40** (5 mins)
RISK AND GOVERNANCE				
TB068/23	**Annual Governance Declarations** Purpose: To **receive** the Annual Governance Declaration	*Report*	*DCG*	**15.45** (10 mins)
TB069/23	**Audit Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	AC Chair	**15.55** (5 mins)
TB070/23	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*NEDs*	**16.00** (10 mins)
CONSENT AGENDA				
TB071/23	**Constitution** *Purpose: To **approve** the upload of the Constitution to Trust website*	*Report*	*DCG*	
TB072/23	**2022/23 Quality Account**	*Report*	Chief Nurse	

*Purpose: To **receive** the 2022/23 Quality Account*

CONCLUDING BUSINESS

TB073/23	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16.10** (2 mins)
TB074/23	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**16.12** (3 mins)
TB075/23	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16.15** (5 mins)
	Date and time of next meeting: 09.00 on Thursday 27 July			***16.20*** ***close***

Chair: Jackie Njoroge

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

Also available on Bolton FT website

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

Also available on Bolton FT website

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

Also available on Bolton FT website

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

Also available on Bolton FT website

***Draft* Board of Directors Minutes of the Meeting**
Held on Microsoft Teams
Thursday 30 March 2023
(Subject to the approval of the Board of Directors on 26 May 2023)

Present

Name	Initials	Title
Jackie Njoroge	JN	Acting Chair
Fiona Noden	FN	Chief Executive
Annette Walker	AW	Chief Finance Officer
Francis Andrews	FA	Medical Director
Rae Wheatcroft	RW	Chief Operating Officer
James Mawrey	JM	Director of People
Sharon Katema	SK	Director of Corporate Governance
Sharon White	SW	Director of Strategy, Digital and Transformation
Alan Stuttard	AS	Non-Executive Director
Martin North	MN	Non-Executive Director
Rebecca Ganz	RG	Non-Executive Director

In Attendance

Name	Initials	Title
Amy Blackburn	AB	Head of Communications
Lianne Roberts	LR	Deputy Chief Nurse (for Tyrone Roberts)
Liz Nightingale	LN	Matron, Accident and Emergency Department (for item 029)
Lynn Donkin	LD	Director of Public Health
Naomi Ledwith	NL	Delivery Director (Bolton), NHS Greater Manchester Integrated Care
Niruban Ratnarajah	NR	AMD Greater Manchester ICS
Rachel Carter	RC	Associate Director of Communications and Engagement
Rachel Tanner	RT	Director Adult Services (DASS)
Victoria Crompton	VC	Corporate Governance Manager

There were also nine observers who attended this meeting.

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB028/23	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting. Apologies for absence were noted from Donna Hall, Bilkis Ismail, Zada Ali Shah, Malcolm Brown and Tyrone Roberts.	
TB029/23	**Patient and Staff Story** **Patient Story** The Chief Nurse presented the patient story, which relates to Harry Jones who at the time of recording was waiting in the Accident and Emergency Department (A&E) for specialist diabetic help. Harry had attended A&E	

three weeks earlier after a blister developed on his toe, which subsequently burst and became infected. He was told he would be prescribed antibiotics and discharged.

Three weeks later he returned to A&E as his toe had turned black. Harry was placed in a cubicle and despite asking on a number of occasions what was happening, he was not seen for a number of hours. He was also concerned, as during this time his toe was left without a dressing on it. Harry felt that despite the staff being busy they ensured he was comfortable throughout his wait by bringing him regular drinks.

To improve his experience Harry advised he would have preferred for his toe to have been dressed whilst he was waiting to be seen, but ideally he would have preferred to have been admitted on his first visit to A&E so the issue would not have developed as it did.

Staff Story

LN attended to present the staff story of David Ainsworth, Senior Charge Nurse in A&E. During the completion of his nursing degree David had a placement within A&E, he was impressed by the teamwork displayed, and wanted to be part of the team. At the time, it was fast paced with high patient turnover. David qualified in 2019 and commenced a role within A&E. The season started badly and got progressively worse as Covid-19 emerged. Patient acuity increased, and it was a lot to take on as a newly qualified nurse, but he had incredible colleagues who guided him through.

One night in Resus, he had four separate cardiac arrests. David was able to keep going only because of the fantastic people around him. Counselling is common amongst newly qualified A&E nurses and David himself underwent six weeks of telephone counselling shortly after qualifying.

Covid brought big changes to the way staff worked. There were still emergencies to deal with, but that was alongside caring for patients who had been in the department for 20+ hours. The team had to adapt and support each other through every change and every new challenge.

Teamwork is the reason David got into emergency nursing and why he stays. It is also the reason patients are cared for as well as they are despite space, staffing and funding issues. Working with such excellent health care professionals and seeing how they have adapted and continue to have positive impacts on patient care, despite the pressures has given David immense pride to be a part of their team.

FN thanked LN for attending to present David's story at short notice and thanked all the staff within A&E for their continued hard work.

RG queried that the patient highlighted he had not received any care or treatment for seven hours whilst in the department. LR confirmed a review of the patient notes indicated he was seen within the time, but it is important to acknowledge the patient's perspective, as this is what is important.

AW commented it was a good idea to capture the patient story whilst they were still an inpatient. LR advised the Communications Department have been supporting capturing patient stories in real time.

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

TB030/23 Declarations of Interest

There were no declarations of interests in relation to the agenda items.

TB031/23 Minutes of the previous meetings

The Board of Directors reviewed the minutes of the meeting held on 26 January 2023 and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors **approved** the minutes from the meeting held 26 January 2023.

TB032/23 Matters Arising and Action Logs

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

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

CORE BUSINESS

TB033/23 Chair's Update

JN led the Board in extending thanks to Donna Hall for her work as Chair of the organisation since 2019 and throughout the Covid 19 pandemic.

JN welcomed and thanked governors who were in attendance and were observing the meeting and for participating in the patient meal testing and the visit to the new Theatre building.

TB034/23 Chief Executive Report

FN delivered her report and highlighted the following key points:

- There had been significant planning ahead of the 72-hour industrial action by Junior Doctors to minimise the impact on patients.
- A bid to NHSE Acute Deterioration Team resulted in a grant of £30,000 and the opportunity to work with NHSE to develop a "Worry and Concern" pilot.
- On International Women's Day, the Trust celebrated the huge contributions of our female staff and patients.
- The Trust will soon be launching three new staff networks. They will cover the themes of gender, generational differences and social and economic influences.
- The iFM Catering Department received a five-star rating following an unannounced food hygiene audit of the services on the hospital site.
- Work will shortly commence on the Community Diagnostic Centre (CDC), which will increase the ability to provide thousands of tests and scans every year, and support the elective recovery work.
- NHS England released its 2023/24 priorities and operational planning guidance. The Trust responded with our operational plan, working with GM to ensure there was alignment with organisations across the system.
- The Bolton College of Medical Sciences build continues and remains on track to welcome its first learners next September.

In response to RG's query on whether the three new staff networks would report into the People Committee. JM confirmed the People Committee would receive updates from all of the staff networks.

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

TB035/23 Operational Update

RW provided an operational update and the following key points were highlighted:

- Over winter, NWAS and RCN took strike action, which indirectly affected services. In February, Junior Doctors took 72 hours of industrial action. The period ran as an internal business critical incident and a review undertaken to capture learning.
- The 52-week wait position reduced and the Trust were on track to deliver the 78-week target. It was expected, once patients who are exempt were excluded, four patients would wait over 78 weeks.
- The long wait focus continued to eliminate all over 65 week waiters. There is a risk and the Trust continue to work with GM partners to seek mutual aid to mitigate risk.

- The Trust had the lowest number of patients who have been waiting over 62 days for cancer treatment, in the North West and was on track to deliver the target to pre-pandemic levels.
- The enabling works had begun to expand the diagnostic and scanning facilities as part of the Community Diagnostic Centre, with building expected to start in April.
- There had been improvements in the organisations 30 minute and 60-minute ambulance handover delays.
- In December, there were significant pressures in Urgent Care and whilst still incredibly pressured, it was now calmer and more manageable. Performance against the 4-hour standard was 64.2%.
- Work within the Bolton locality continued, and the Trust were below 100 patients with no criteria to reside. Whilst there was a reduction in the number of patients, the greatest reduction was the days delayed for each of those patients.

AS asked, whether there had been a change in public behaviours during the industrial action periods. RW advised there was a reduction in A&E attendances during the first NWAS strike. Possibly, due to less publicity around the Junior Doctor strike, there was no change in behaviours at the onset, but this did change as the strike period continued.

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

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

TB036/23 Integrated Performance Report

JM led the Executive Directors in presenting the Integrated Performance Report for February 2023 which detailed that:

- The Quality Improvement Collaborative held a second learning session relating to pressure ulcers. The collaborative is due to conclude in July 2024. Divisional Nurse Directors are implementing focussed interventions with clear expectations on objectives.
- Healthcare associated Clostridium Difficile infections reduced for a second time in 2022/23, and was below the objective rate.
- Crude mortality is below Trust target and average for the period.
- HSMR in month figure is below average for the period and SHMI in month figure is above average, for the period, but has remained 'in control for more than two years.
- Sickness reduced in February to 4.72% from 5.38% in January.
- Turnover reduced slightly in February at 13.54% from 13.99% in January.

- Year to date financial deficit of £3.5m compared with a planned deficit of £6.2. The In-month position was a £5.7m surplus.

RG commented that response rates for FFT had improved. LR advised volunteers had supported the capturing of patient experience information, and QR codes were being displayed across the organisation. Patients were now being informed the FFT text message service is free of charge so there had been an increase in the number of patients completing the FFT by text. LR felt these were sustainable improvements.

RG raised concern the number of Healthcare Associated Infections had exceed the target for 2023/24 and queried how confident the Trust was the CDI collaborative was working. LR advised it was recognised the figure is outside of the expected range and the organisation had sought external assistance on this. A number of actions were being completed to ensure learning is embedded across the organisation.

RG asked when NHS Providers would commence. JM highlighted this is a large piece of work, but is expected to commence on either 01 July or 01 August 2023.

JN queried whether the turnover rate could be linked to the cost of living crisis and what actions were being undertaken to support staff. JM advised a discreet service was being offered to staff, which includes providing meal vouchers and financial support. He added it is important for the organisation to drive every element of non-pay ensuring it is a good place for staff to work.

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

TB037/23 2023/24 Operational and Financial Plan

SW presented the 2023/24 Operational and Financial advising that the operational planning round was broken down into three distinct segments with submissions on activity, finance and workforce.

It was noted that the Trust was expected to achieve the 65-week target. However, the numbers relating to financial forecast were still iterating, although there was a planned deficit of £34.8m with a cash balance at year-end of £1.9m. AW advised that the Finance and Investment Committee (F&I) would be seeking to ensure the Trust is in a better financial position and will be monitoring the reduction in deficit, CIP and Capital spend that were currently at £10.6m and £22.2m respectively. It was noted the workforce submission suggested there would not be a growth in the workforce.

With regards to MN's query around the No Criteria to Reside (NCTR) target, RW highlighted the importance of recognising that there would always be a number of patients who are ready to leave the organisation but are unable to, therefore focus should be on the number of days patient are delayed.

RG queried the GM position and whether the non-achievement of the activity target would affect finances. AW advised a paper had been presented to Finance and Investment Committee which outlined some of the variable aspects of the plan.

RESOLVED:
The Board of Directors **received** the 2023/24 Operational and Financial Plan.

TB038/23 Greater Manchester Integrated Care Partnership (ICP)Strategy Update

SW presented the draft report, which detailed the five-year strategy and vision of the ICP and set out how the ICP sought to Improve Health and Care in Greater Manchester. It was noted that the Strategy was currently in draft and therefore subject to approval by the GM ICP Board.

It was noted that the priorities outlined by GM would be incorporated into the Trust's new corporate Strategy, which will be developed in 2023.SW advised that previously the focus had been on waiting times and this strategy shifts the focus to health and health progression. RT stated the strategy connects the local vision in an overarching one, and LD added the strategy is aspirational and is a document, which will provide organisations within GM something to work with.

RESOLVED:
The Board of Directors **received** the 2023/24 Operational Planning Guidance.

TB039/23 Strategy and Operations Committee Chair Report

RG presented the Strategy and Operations Committee Chair Reports from the meetings held on 20 February and 27 March 2023. In March, the committee had received a number of updates including the Operational Plan 2023-24, Clinical Strategy, GM ICB Business Intelligence and Board Assurance Framework.

RESOLVED:

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

TB040/23 Quality Account Arrangements

FA presented the report which provided an assumed time frame for the completion of the Quality Account 2022/23 Annual Report and the suggested approach for the 2023/24 Quality Account improvement priorities. The paper had previously been presented at Quality Assurance Committee who received and endorsed the report.

RESOLVED:
The Board of Directors **received** the Quality Account Arrangements.

TB041/23 Care Quality Commission (CQC) Inspection and Improvement Plan

LR presented the report, which provided Board members with an update in relation to the Trust's CQC rating and assurance in relation to the Trust's response to the recently published CQC reports. The Trust was inspected in November 2022. An announced inspection of our maternity services was undertaken as part of the National Maternity Inspection Programme, and an unannounced inspection of urgent care and medical services. The reports were published in February and March 2023.

The urgent care report contained areas of outstanding practice and areas for improvement. Specifically, the report contained three "must do" recommendations. These recommendations resulted in two requirement notices. As a result of two requirement notices, both in the safe domain, the rating for Urgent Care Services was amended from Good to Requires improvement. The service overall remains as good.

The Maternity services report identified areas of outstanding practice and areas for improvement. The report contained six "must do" recommendations. The recommendations were across the safe and well led domains. As a result, the rating for maternity services was amended in both domains from good to requires improvement and the overall rating for maternity services was amended to requires improvement from good.

Due to the rating for the safe domain now being requires improvement in both urgent care and maternity services, the Trust overall rating for safe is now requires improvement. Overall, the Trust remains rated as good.

An improvement plan has been developed to respond to the recommendations which will be monitored through the relevant divisional governance process and overseen by Clinical Governance & Quality Committee.

RESOLVED:
The Board of Directors **received** the Care Quality Commission (CQC) Inspection and Improvement Plan.

TB042/23 Quality Assurance Committee Chair Report

JN presented the Quality Assurance Committee Chair Reports from the meetings held on 15 February and 15 March 2023. The following key points were highlighted:

- Committee effectiveness review results were overall positive. The timing of the next survey will be amended to November with a report presented in December.

- The cultural dashboard provides an early warning system for both positive and negative culture. The committee discussed over-reliance on data and the need to gather soft intelligence.
- Quality Account Priority 1 Antibiotic Prescribing Standards – it was noted some of the drivers are off track, but could still be delivered.
- Maternity Incentive Scheme Year 4 – awaiting a response in relation to the financial reward, which is expected shortly.

RG queried what the culture dashboard was and JM explained a tool was required to bring data together. This tool work through all soft and hard metrics to provide an early warning on both positive and negative culture.

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

TB043/23 Finance and Investment Committee Chair Report

JN presented the Finance and Investment Committee Chair Reports from the meetings held on 25 January and 22 February 2023 noting the Month 10 finance report and the Draft Financial Plan 2023/34

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

TB044/23 Audit Committee Chair Report

AS presented the Audit Committee Chair Report from the meeting held on 15 February 2023. The following key points were highlighted:

- Internal Audit Reports were received on the Maternity Incentive Scheme, Equality Diversity and Inclusion, and iFM Sickness Absence.
- Audit Committee Effectiveness Review results were generally positive and indicate the committee has continued to build on its effectiveness since the last report.
- New software for registering interests, gifts and hospitality was live. It will enable staff to make their declarations on-line and will improve the transparency of gifts and hospitality.
- The external audit contract is due to expire at the end of August. Governors had agreed to honour a one-year contract award to KPMG from the Procurement Framework. The Internal Audit contract is also up for renewal for which a plan is already in place.

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

TB045/23 Charitable Funds Committee Chair Report

MN presented the Charitable Funds Committee Chair Report from the meeting held on 06 March 2023. MN highlighted the committee were informed the delivery of the staff rest facilities programme was delayed beyond the adaption date meaning £36k underspend was at risk. The Deputy Director of Strategy had shared an alternative proposal to use the monies towards the community hub within the new faith facilities, which allowed the grant to be fully utilised by 31 March 2023, in line with the terms and conditions.

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

TB046/23 People Committee Chair Report

AS presented the People Committee Chair Report from the meeting held on 21 March 2023. The following key points were highlighted:

- The final draft of the People Plan 2023-26 was shared for feedback and review.
- The organisation remained the best Acute and Community Trust in GM for staff engagement in the 2022 National NHS Staff Survey.
- There continued to be a downward trajectory for agency, albeit agency spend remains at an unprecedented high.
- The committee received an update on Staffside and employee relations.
- The committee received the Equality, Diversity and Inclusion Annual Report and the Gender Pay Gap Update.

JN commented considering the operational pressures the staff survey results were a brilliant success. Concern was raised, however, that the results highlighted discrimination towards staff had increased by 8%. JN stated this should not be tolerated and should feature strongly within action plans. It was also important to consider whom staff are experiencing discrimination from whether this be from colleagues, patients or relatives JM advised this would be a focus for the Workforce Team.

FN added the staff survey is a reflection of what staff within the organisation perceive and if staff are happy and looked after within their work and feel able to raise concerns they will look after patients well.

RG asked whether the Engage surveys were still being completed. JM advised temperature checks continue to be completed, but the organisation has ceased to use the Engage surveys, as they were quite cumbersome.

Board members discussed the difference in pay between social care staff and AHPs with RT commenting the issue was beyond the locality to solve. Bolton sets the fees annual in order to pay the national living wage to social care staff and the issue needs to be dealt with nationally though the social care funding was not addressed in the most recent budget.

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

TB047/23 Board Assurance Framework

SK presented the Board Assurance Framework advising since presentation at the last meeting, a review of the BAF was undertaken by Executive Directors to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level.

The BAF had been discussed at the Strategy session in February and now includes Risk 1.3, which sits under the Chief Nursing Officer. At the end of March 2023, none of the strategic risks had seen any improvements in the current risk score. To ensure consistency in approach, all risks have been assessed in line with our Risk Management Policy and have been graded using the system highlighted below to generate a risk score: Severity (Consequence) x Likelihood = Risk Score.

RG challenged whether the organisation really has a mature risk appetite with regard to ambition five. SW agreed this was a fair challenge further discussion would take place at the Strategy and Operations Committee.

FT/23/03	Risk appetite for ambition five to be discussed at Strategy and Operations Committee.	**SW**

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

TB048/23 Feedback from Board Walkabouts

MN advised he had recently visited the Churchill Unit. An issue was raised that the Christie NHS Foundation Trust fund the Trust for the delivery of a number of chemotherapy session per month, but when the funding amount has been reached patients are then expected to travel to Christie NHS Foundation Trust for their treatment. This is a frustration for both patients and staff. RW advised this relates to the capacity and demand modelling and alongside AW, they would discuss the issue with the division.

FT/23/04 Capacity and demand modelling for Churchill Unit to be discussed with division

AS advised he had recently visited the Breast Radiology Unit and A&E and there were some estates issues which if rectified would benefit staff. Some areas within the unit were cramped and a new television has been fitted, but the power cable is not long enough so it cannot be used. The outside area could also benefit from some improvements.

JN advised she had visited Waters Meeting House and it was good to see multidisciplinary working. The staff within the Therapy Team had raised a concern regarding changes within the team. RW discussed this with the division and plans are in place, which RW has asked be shared with the team.

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

CONCLUDING BUSINESS

TB049/23 Questions to the Board

A question was raised querying what the trusts plans were for expanding their CDC network?

SW advised Bolton NHS Foundation Trust has an approved business case for a large model Community Diagnostic Hub. Any future expansions of the CDC provision will be considered in line with changes to referral pathways, demand and locality landscape.

The trust network for CDC system working consists of the following;

- Bolton Locality stakeholder group inclusive of locality system partners (trust, community, GP federation, ICB, primary care, voluntary sector)
- GM CDC Steering Group
- GM Cancer Alliance
- GM Imaging and Pathology Network
- GM Pharmacy Network
- Other regional Diagnostic Networks, LSC, Cheshire and Mersey
- Northwest Imaging Academy
- Higher Education Institutions
- IS providers
- Northwest Diagnostic Transformation Programme Team
- National Diagnostics Transformation Team
- National Imaging Transformation Team
- Health Education England

- National Screening Programmes

TB050/23 Messages from the Board

The following key messages from the Board were agreed:

- Staff Survey Results
- Capital Developments
- Board visit to Theatres
- Board patient food testing

TB027/23 Any Other Business

There being no other business, the chair thanked all for attending and brought the meeting to a close at insert time

The next Board of Directors meeting will be held on Thursday 25 May 2023.

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

March 2022 actions

Code	Date	Context	Action	Who	Due	Comments
FT/22/13	28/07/2022	Staff Story	Invite LS to a Board of Directors meeting in six months to provide an update	SK	Jan-23	Lauren attending May Board - complete
FT/22/22	24/11/2022	Midwifery Staffing Report	Forward view on maternity staffing to be provided through People Committee	CS	May-23	Nursing, Midwifery and staffing paper to be presented to People Committee in May. Complete
FT/22/20	29/09/2022	WRES/WDES	Updates from the BAME and Disability and Health Conditions Forums back in six months.	SK	May-23	Updates from staff networks provided at Staff Experience & EDI Steering Group. Chair Report from EDI Steering Group presented at People Committee and section included in EDI Report
FT/23/02	26/01/2023	Bolton Locality Update	It was agreed as part of Non-Executive Director walkabouts to include multi-working locations.	SK	May-23	Complete - all areas visited except Lever Chambers which will be added to the list.
FT/22/21	29/09/2022	Any other business	Chief Finance Officer to present the Estates Plan at a future Board Development Session.	AW	Jun-23	
FT/23/03	30/03/2023	Board Assurance Framework	Risk appetite for ambition five to be discussed at Strategy and Operations Committee.	SK/SW	Jul-23	
FT/23/04	30/03/2023	NED Walkabouts	Capacity and demand modelling for Churchill Unit to be discussed with division	RW/AW	Jul-23	

Key

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May, 2023		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Purpose	To outline key activity.

Summary:	The Chief Executive's report provides an update regarding key activity that has taken place since the last meeting, in line with our strategic ambitions.

Previously considered by:
N/A

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

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

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

Ambition 1
Provide safe, high quality care

We have updated our guidance on facemasks following a recent trial and other research that suggests it is safe to do so. Mask wearing outside of clinical settings, such as wards and departments, is now a personal choice for patients, staff and visitors. We support anyone whose personal choice it is to continue to wear a face mask in any setting.

A Clostridium difficile or C.Diff Improvement Collaborative launched in May to direct and focus improvement to reduce the number of C.Diff infections acquired at Royal Bolton Hospital. The first session focused on understanding the personal impact with a patient story, an introduction to quality improvement science and defining 'what good looks like' as a group of experts.

We are partnering with Age UK Bolton and Urban Outreach, as part of Bolton's Nutrition and Hydration Programme. Age UK Bolton's 'Home from Hospital' team will offer meal bags to people Royal Bolton Hospital identify as being at risk of malnutrition at the time of discharge. Each bag provides two days' worth of long shelf-life meals, which includes nutritional information for older people who are at risk of, or suffering from, malnutrition and dehydration. The 'Hearty Meal Bags' contains breakfasts, lunches, dinners and snacks to ensure people have the nutrients and supplies for when they return home to support a healthy recovery.

A new pharmacy prescription tracker has been launched on our hospital site, which allows outpatients to see in real time the progress of their prescription and when it's ready to collect. The tracking system, features a screen next to the pharmacy entrance and a screen in the hospital's restaurant, and has been developed to improve patient experience by reducing waiting times and congestion around the main entrance of the hospital.

Patients, service users and families are being invited to share their experiences in a short survey to understand how inclusive healthcare services are for LGBT+ communities. The anonymous two-minute questionnaire forms a vital part of the NHS Rainbow Badge scheme, which will support us to demonstrate our commitment to reducing barriers to healthcare for LGBT+ people and showcase work that has already taken place. The Rainbow Badge initiative will also see a survey sent to our staff and a review carried out of our policies, services and workforce.

Ambition 2
To be a great place to work

Our Midwives shared what inspired them to join Bolton and the NHS as the world celebrated their profession and their vital contribution to healthcare. International Day of the Midwife is an annual event that recognises the work of midwives, support workers and students for the positive difference they make to the lives of families. Our midwives have helped to deliver more than 5,000 babies in 2022. That's approximately thirteen babies every single day.

On International Nurses Day, our nurses shared why they love nursing, why they chose to be a nurse and a little bit about their specialist nursing areas. The day also saw numerous teams celebrating on their wards and other places of work, as well as a service in the hospital chapel and a dedicated event with poster competition and refreshments.

In May we celebrated Operating Department Practitioners day, where we recognised the incredible difference our ODP's make to people in situations which are often when a patient is at their most vulnerable, and our iFM colleagues celebrated World Facilities Management day, recognising and rewarding teams for the brilliant work they do.

Our relocated and refurbished multi-faith facility and community hub was officially opened at the Minerva Road site by the Mayor of Bolton. A huge thanks to generous donations and fundraising efforts from communities across Bolton.

At a cost of £430,000, the project has been funded by Our Bolton NHS Charity and an NHS Charities Together grant to support staff with their spiritual wellbeing whilst at work or patients during their time in hospital. Facilities include a newly refurbished bright and spacious mosque and temple that can welcome 100 worshippers, with prayer mats incorporated into the design of the mosque carpet.

Work is ongoing around dying matters, where our specialist colleagues have been having conversations with staff around how to access the support they need when they experience a bereavement.

We have been developing and improving the service we provide for our veterans and their families, and are proud to say we have been reaccredited as Veteran Aware by the Veterans Covenant Healthcare Alliance, achieving a Silver Award. We are fully committed to ensuring that those who serve, or have served, and their families are not at a disadvantage when using our services and that we can best support their needs. We will build on our silver award and continue to learn from our patients and their families so we can ensure we provide the highest quality of care to veterans.

As the 75th anniversary of the NHS approaches, we have hosted a session with our staff. This was part of an NHS75 country wide engagement exercise with staff, the public, patients and partners to understand the challenges that the NHS currently faces, and consider how the NHS should develop in the future.

Finally, I am delighted to be welcoming our new Chair of the Board of Directors, Dr. Niruban Ratnarajah, who will start in post on 12th June. Niruban is a practising GP and partner at Stonehill Medical Centre, and was also Clinical Lead and Chair in Bolton Clinical Commissioning Group, now part of the Greater Manchester Integrated Care Board. I look forward to how he helps us deliver even better healthcare for our people, build on the legacy of our previous Chairs and help us progress on our integration journey in the most meaningful way.

Ambition 3
To use our resources wisely

We have our finalised figures for the last financial year, and can confirm that we ended 2022/23 with a £1.5m deficit, and a total of £42.1m capital spend. This was our largest capital spend in the last 15 years. It was amazing work from everyone involved and will

bring improvements throughout the Trust, notably with the modular theatres build and the service moves, to help us to continue to deliver even better care for our patients.

Looking forward to this financial year however, we are expecting it to be much more challenging. We have a deficit plan of £12.4m. We will be constantly working on improving this situation to ensure we get to break even position by the end of the year and not have a deficit. Our obligation is to make the best use of the public pound, using it most effectively, efficiently and productively for our patients to help ensure they receive the care and service they deserve. All teams are being tasked with making 3% reductions, alongside an overall Trust target of 4%, to help with this.

Pricewaterhouse Coopers were commissioned by Greater Manchester to review the financial position of trusts. While their work indicates that we are in a comparatively reasonable position, there are still opportunities for us to improve. Despite the challenges we are facing with our finances, we are in a position to meet them, deliver our targets and provide efficient service for our patients.

At the beginning of the new financial year, we have set really challenging targets around our cost improvement programme. Alongside any efficiency savings identified within divisions and directorates, we will also be introducing productivity targets, to recognise financial gains as well as savings.

Ambition 4

To develop an estate that is fit for the future

We are really excited to have been successful in securing funding to build a Community Diagnostic Centre on the Minerva Road site, which should be ready to use by spring 2024.

To accommodate the new facility, we have transformed some of our existing estate and after a rigorous assessment process, the ground floor of J Black has been identified as the most appropriate location for the Diagnostic Centre. This allows us to link it up with our existing services and makes it easy as possible for our patients to access the service.

While the centre will generate lots of great benefits for staff and patients for years to come, in the short-term the development has meant relocation of some of the services in J Block and N Block. We have worked with those teams affected and their Divisional Management Teams to develop relocation plans which met patient and staff needs.

Our modular theatres build continues apace, with the first floor of the works starting to be installed, and work on the ground floor progressing well. The four theatres, as well as the creation of a bespoke day case paediatrics theatre hub by refurbishing our existing day case theatres, should significantly increase our theatre capacity.

Work continues on the Bolton College of Medical Sciences, with a steel signing ceremony taking place to mark the latest milestone in the build. I along with Professor George Holmes DL, President and Vice Chancellor of the University of Bolton, Sue Johnson, Chief Executive of Bolton Council, and Bill Webster, Principal of Bolton College had the opportunity to sign the steel.

Located on the hospital site, BCMS is due to open its doors in September 2024 and marks the single largest investment into healthcare and education in Bolton for decades. The facility aims to support up to 3,000 learners each year and give prospective students a direct route into clinical healthcare employment.

Ambition 5
To integrate care

In our neighbourhoods, we have been working with our workforce and partners about the move from nine neighbourhoods to six in the Bolton locality. This change is intended to make it easier for teams to work together to support people at home and work more closely with our key partners including primary care.

This development of our neighbourhoods will support and improve outcomes for the people and families we support whilst also ensuring minimal disruption to staff. We have been working with senior managers from social care and community services as well as workforce, estates and IT leads to understand what operating across six neighbourhoods means for teams currently working in our neighbourhoods.

The intention is to begin co-locating teams towards the end of this year so the next step is to work with teams to shape how we make this happen.

We are also working hard with our partners on how to ensure every patient contact counts, with a recent workshop taking place at Bolton Science and Technology Centre and including attendees from the Trust and Bolton's Public Health teams. The patient journey was looked at, as were the resources available (including CURE, ORCHA, Keep Bolton Moving and Well While You Wait), and table-top discussions took place looking at what we do well, how we improve and the challenges faced.

Ambition 6
To develop partnerships

Our new Strategic, People and Culture Group met for the first time to create shared workforce priorities across the locality. The group will make sure that workforce supports the delivery of our other key workstreams, and will be responsible for creating one workforce plan which addresses workforce challenges that are tricky to resolve in one organisation alone. This includes shared careers/recruitment campaigns for both health and social care, growing our future workforce with schools, colleges and universities, and our role as anchor organisations in Bolton to support the wider determinants of health and wellbeing such as employment, skills, housing and social connection.

Staff and students from Kings Leadership Academy have raised in total £2,800 for the Children's Ward at the Royal Bolton Hospital. The funds will be used to pay for the children's ward very first medical gaming cart. The gaming cart will be expected to benefit more than 2000 young patients each year, having a real sustainable and meaningful impact on our patients.

Areas of our children's ward have been transformed into garden scenes thanks to the talented designs of a Manchester-based artist. The 'parents room' now features bright and colourful hand-drawn flowers across the walls to create a more inviting space for the hospital's younger patients and their families. Whilst the 'quiet room' has been decorated in a calming landscape design.

As part of our five-year strategy refresh, we have started the process of refining our organisational ambitions. Following engagement, towards the end of last year, it is clear that our staff prioritise improving care above all else, so we have refined our ambitions to put this front and centre. We are proposing that the remaining ambitions will 'orbit' around and enable our central ambition to improve care and transform lives.

And finally, both Bolton and Salford Sexual Health contracts are being re-commissioned before the end of this calendar year. Previously, this was a joint commission between Bolton and Salford Public Health commissioners, however both services will be now tendering separately. We believe that we are in a position to develop a unique Bolton offer to meet the needs of the population in partnership with statutory and voluntary organisations as part of an integrated system, and look forward to hearing the outcome of the process.

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	26/05/2023		Discussion	X
Exec Sponsor	James Mawrey		Decision	

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

Previously considered by:	Divisional IPMs

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

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

Prepared by:	Emma Cunliffe	**Presented by:**	James Mawrey

Bolton NHS Foundation Trust

Integrated Performance Report

April 2023

Guide to Statistical Process Control

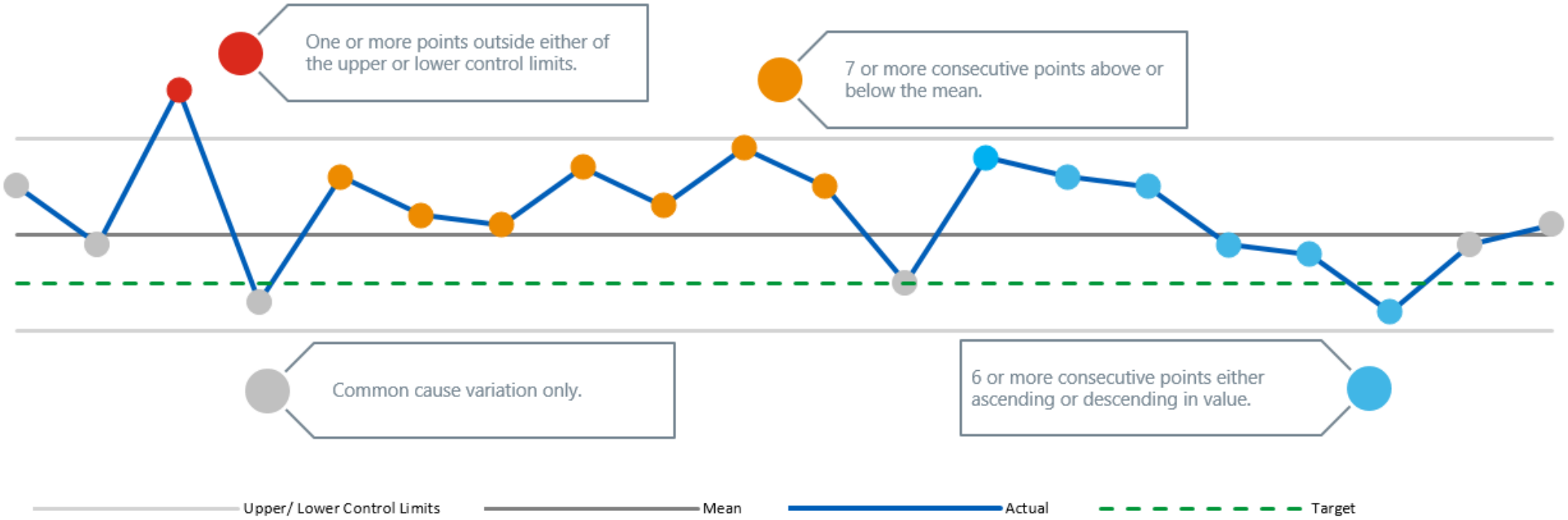
NHS Bolton NHS Foundation Trust

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	15	1	3	1	0	1	3	14
Infection Prevention and Control	9	0	1	0	0	0	0	7
Mortality	6	1	0	0	0	0	0	3
Patient Experience	11	5	0	0	0	2	0	14
Maternity	8	0	0	1	0	1	0	8
Operational Performance								
Urgent Care	3	2	1	2	2	1	3	5
Elective Care	4	0	0	2	2	2	2	3
Cancer	6	0	0	0	1	0	1	6
Community Care	1	0	0	2	1	0	1	2
Workforce								
Sickness, Vacancy and Turnover	2	0	1	1	0	0	1	2
Organisational Development	4	1	0	0	1	1	3	2
Agency	1	0	0	2	0	0	0	3
Finance								
Finance	3	0	0	0	0	0	0	3
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.

NHS
Bolton
NHS Foundation Trust

Quality and Safety

Harm Free Care

Patient Safety Alerts
In April 2023 Patient Safety Alerts compliance was at 100%. All alerts have been responded to within the specified timeframe.

Report to patient/family within 60 working days of incident declaration
In April 2023 there were two SI investigation reports due for approval. Both were approved and sent to the Patients/families by the 60-day deadline.
There are currently eight SI investigations ongoing with one being overdue and the remaining seven on track to be completed and approved within the 60-day timeframe.
There is no special cause variation noted however control limits ranged between 0 -100% and as such does not provide assurance in this respect.
Past performance has been variable. Process and practices have been strengthened to support improvement in this area.

Pressure Ulcers
Hospital
Twenty-three pressure ulcers were reported in April 2023, 15 were categorised as category 2; this demonstrated common cause variation. 8 of these were categorised as unstageable pressure ulcers and demonstrated common cause variation.

Community
13 Pressure Ulcers were reported in April 2023, 8 were categorised as category 2; this demonstrated common cause variation. 4 of these were categorised as unstageable pressure ulcers and demonstrated common cause variation.

Pressure Ulcer Collaborative
The system wide Quality improvement collaborative continues with focused visits by the QI Team focusing on test for change. The collaborative is scheduled to collude in July 2024. It is expected that reductions in pressure ulcer prevalence will be observed 23/24, and specifically Q2 onwards following the collaborative timeline and previous experience with improvement methodology outcomes.
Additionally, the Divisional nurse directors are implementing focussed interventions with clear expectations on objectives.

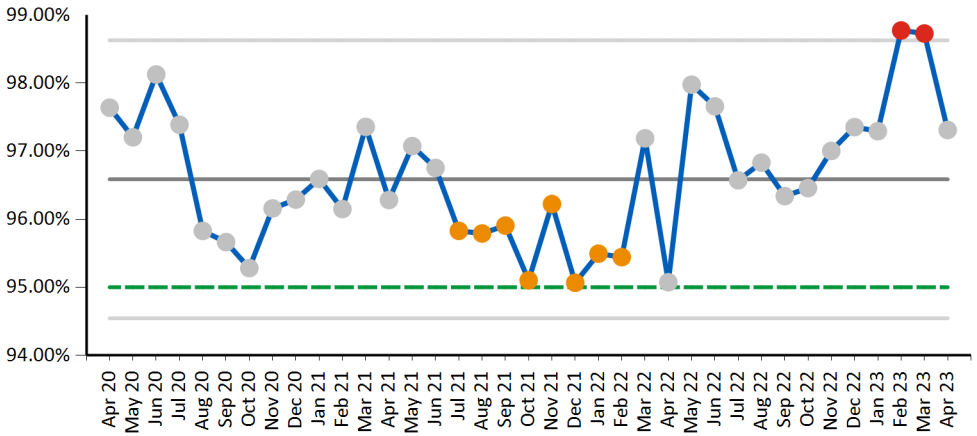
Falls
Our performance is currently at 3.75 falls per 1000 bed days. We continue to remain under our local target, which is 5.3 falls per 1000 bed days. Falls continue to demonstrate common cause variation.
We have had 1 fall with harm in April which fell below our monthly target of 1.6, a decrease from March of 2.

	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%	97.3%	Apr-23		>= 95%	98.7%	Mar-23	>= 95%	97.3%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
9 - Never Events	= 0	0	Apr-23		= 0	0	Mar-23	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.73	Apr-23		<= 5.30	4.05	Mar-23	<= 5.30	3.73	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Apr-23		<= 1.6	2	Mar-23	<= 1.6	1	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	15.0	Apr-23		<= 6.0	21.0	Mar-23	<= 6.0	15.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Apr-23		<= 0.5	0.0	Mar-23	<= 0.5	0.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Apr-23		= 0.0	0.0	Mar-23	= 0.0	0.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		8	Apr-23			7	Mar-23		8	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	8.0	Apr-23		<= 7.0	7.0	Mar-23	<= 7.0	8.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Apr-23		<= 4.0	1.0	Mar-23	<= 4.0	0.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Apr-23		<= 1.0	1.0	Mar-23	<= 1.0	1.0	
516 - Community patients acquiring pressure damage (unstagable)		4	Apr-23			9	Mar-23		4	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	93.4%	Q4 2022/23		>= 90%	95.0%	Q3 2022/23	>= 90%		
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2022/23		>= 90%	100.0%	Q3 2022/23	>= 90%		
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	32.0%	Q4 2022/23		>= 90%	24.0%	Q3 2022/23	>= 90%		
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2022/23		>= 90%	100.0%	Q3 2022/23	>= 90%		
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	76.7%	Apr-23		>= 95%	75.2%	Mar-23	>= 95%	76.7%	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	81.4%	Apr-23	H	>= 95.0%	82.1%	Mar-23	>= 95.0%	81.4%	F
86 - Patient Safety Alerts	= 100%	100.0%	Apr-23		= 100%	0.0%	Mar-23	= 100%	100.0%	?
88 - Nursing KPI Audits	>= 85%	95.0%	Apr-23		>= 85%	94.3%	Mar-23	>= 85%	95.0%	P
91 - Report to patient/family within 60 working days of incident declaration	= 100%	100.0%	Apr-23		= 100%	33.3%	Mar-23	= 100%	100.0%	?
8 - Same sex accommodation breaches	= 0	19	Apr-23	H	= 0	25	Mar-23	= 0	19	F

6 - Compliance with preventative measure for VTE

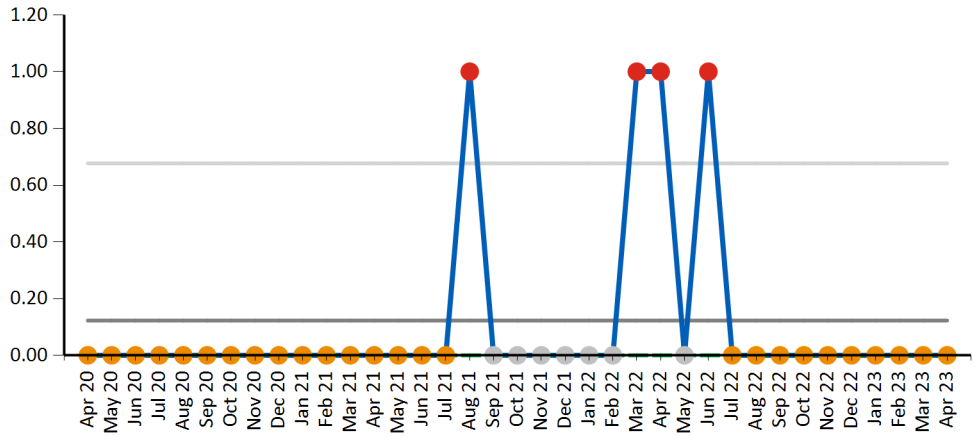


Normal Variation

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

6/6

9 - Never Events

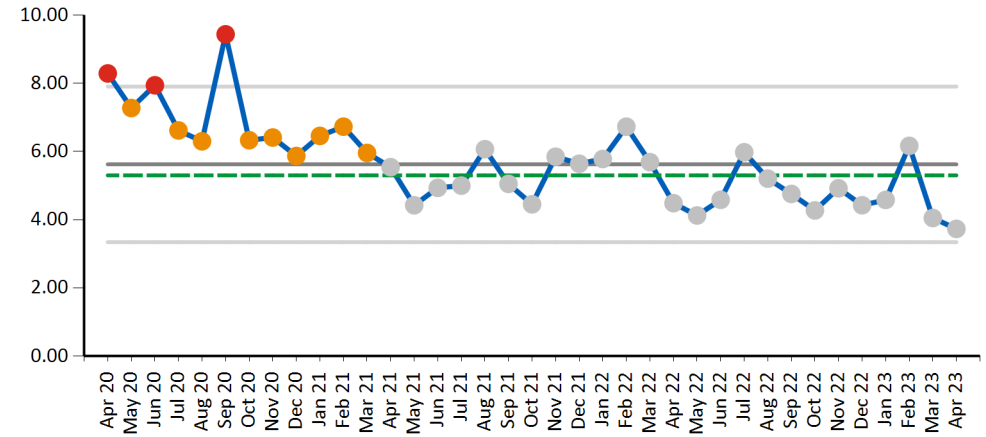


Abnormal variation. Target achieved.

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

6/6

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

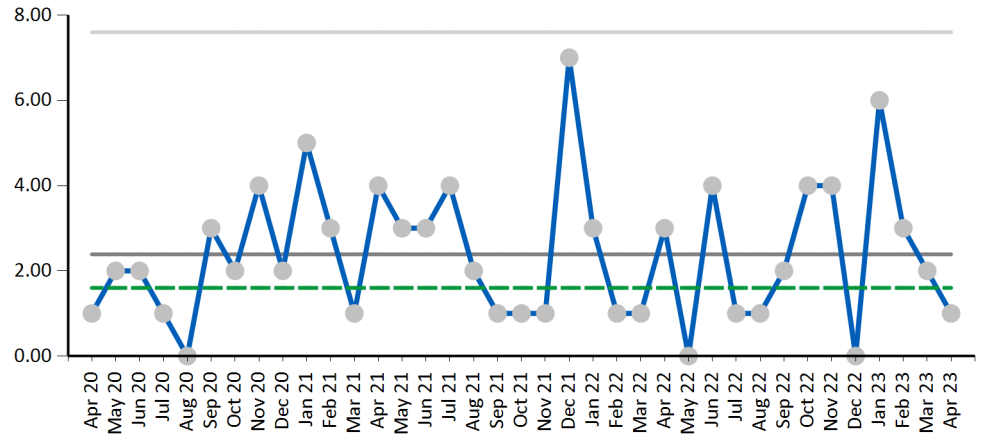


Normal Variation

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

5/6

14 - Inpatient falls resulting in Harm (Moderate +)

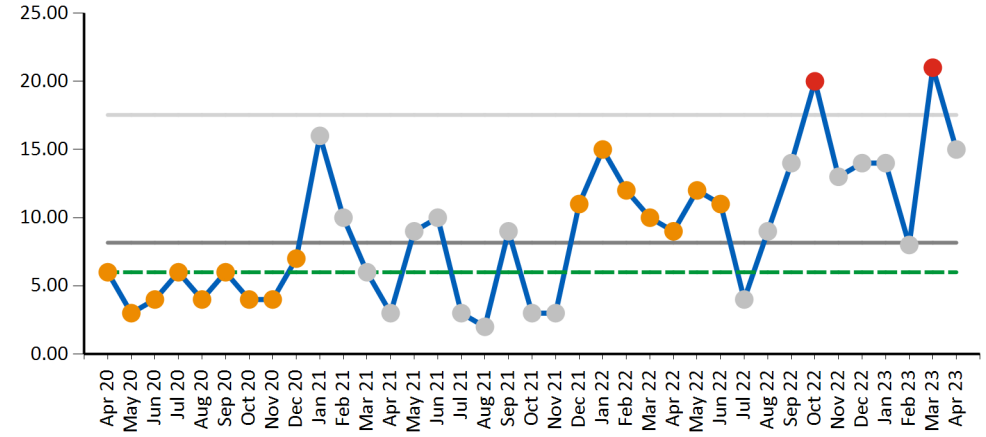


Normal Variation

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

2/6

15 - Acute Inpatients acquiring pressure damage (category 2)

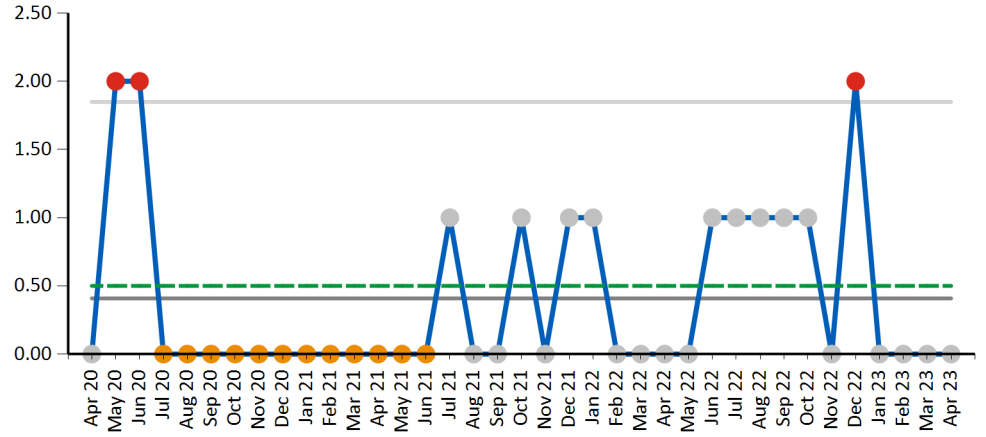


Normal Variation

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

0/6

16 - Acute Inpatients acquiring pressure damage (category 3)

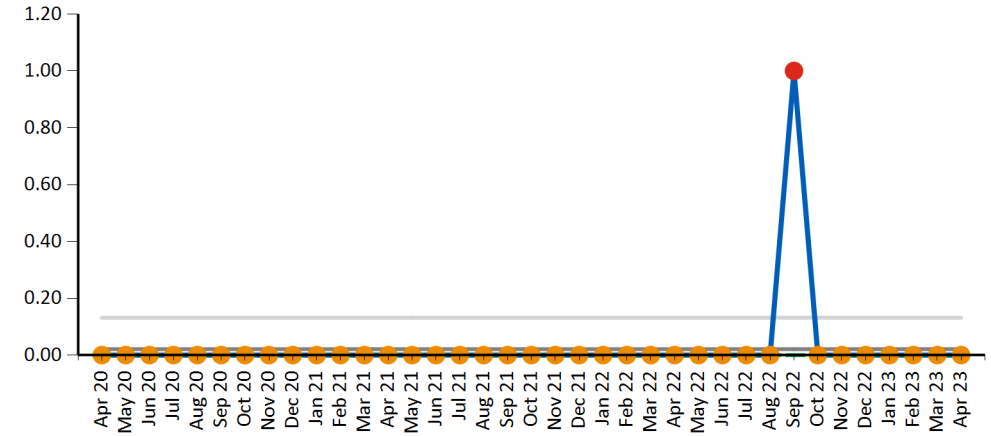


Normal Variation

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

5/6

17 - Acute Inpatients acquiring pressure damage (category 4)

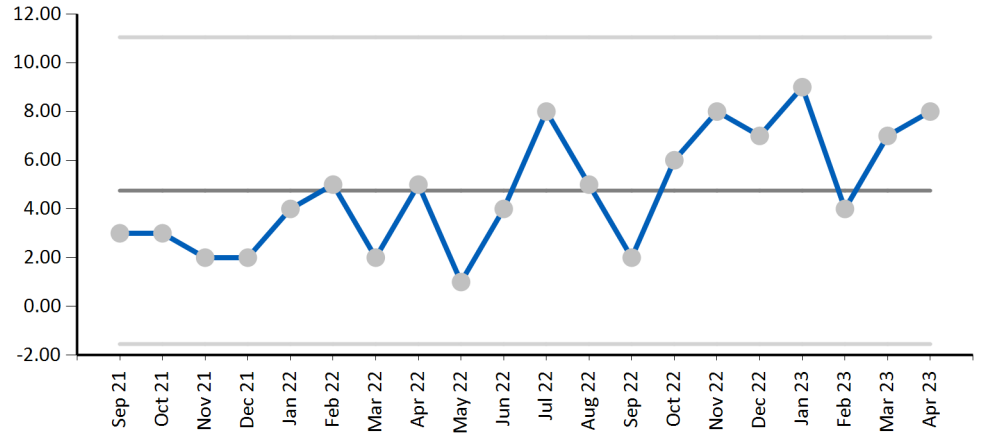


Abnormal variation. Target achieved.

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

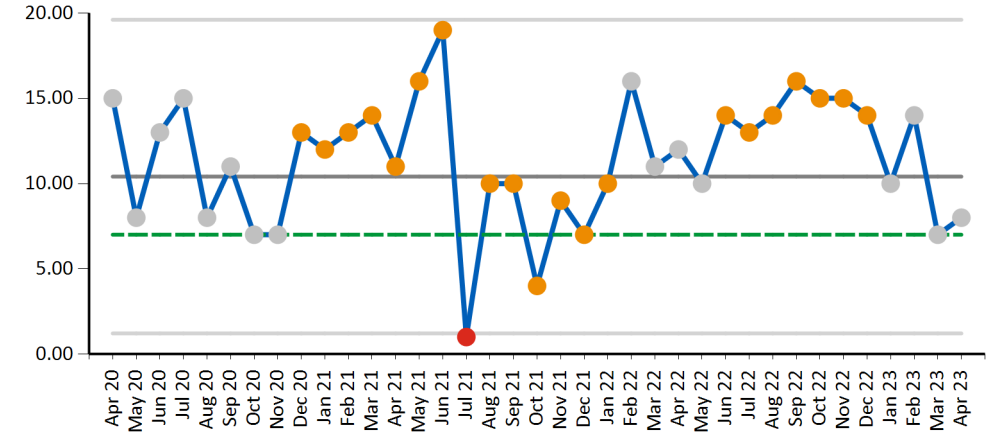
6/6

515 - Acute Inpatients acquiring pressure damage (unstagable)



Normal Variation

18 - Community patients acquiring pressure damage (category 2)

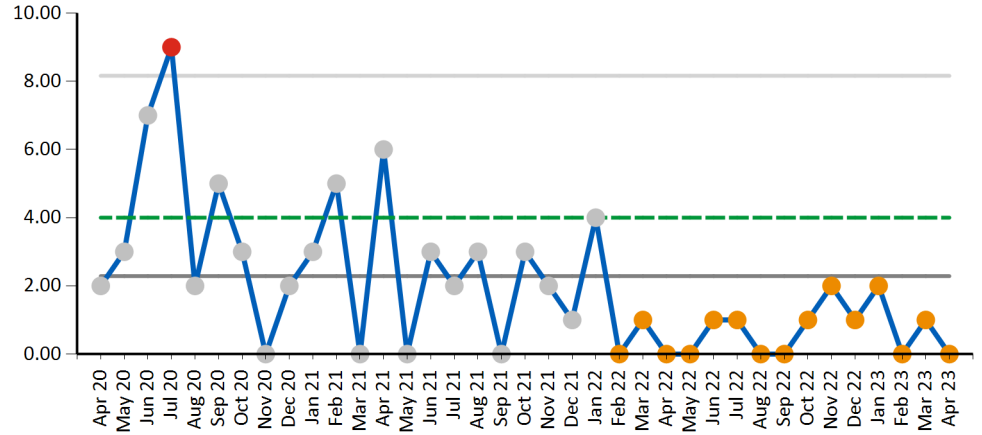


Normal Variation

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

1/6

19 - Community patients acquiring pressure damage (category 3)

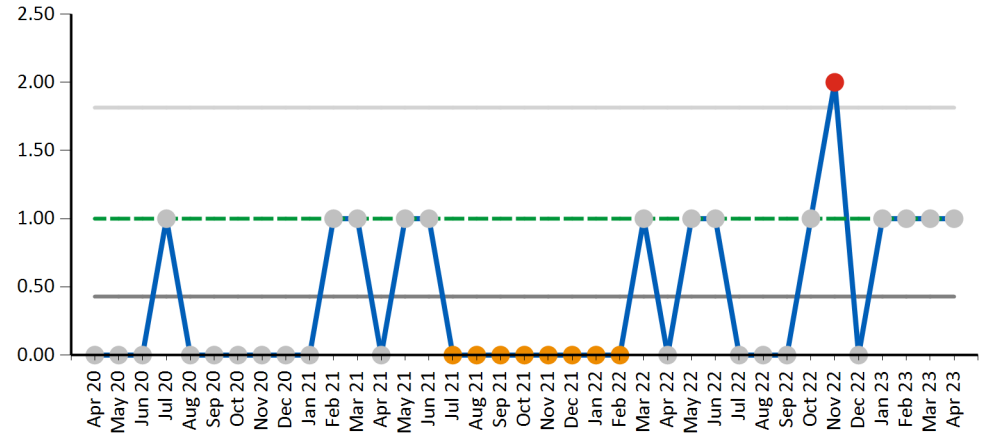


Abnormal variation. Target achieved.

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

6/6

20 - Community patients acquiring pressure damage (category 4)

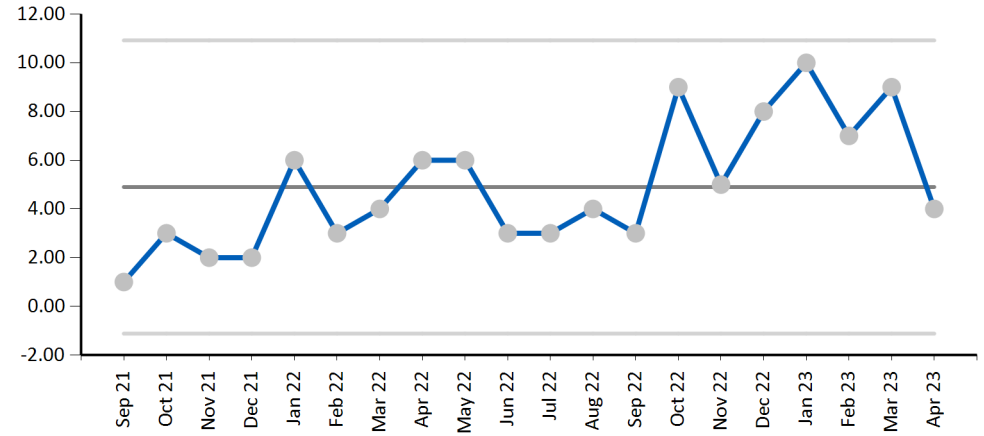


Normal Variation

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

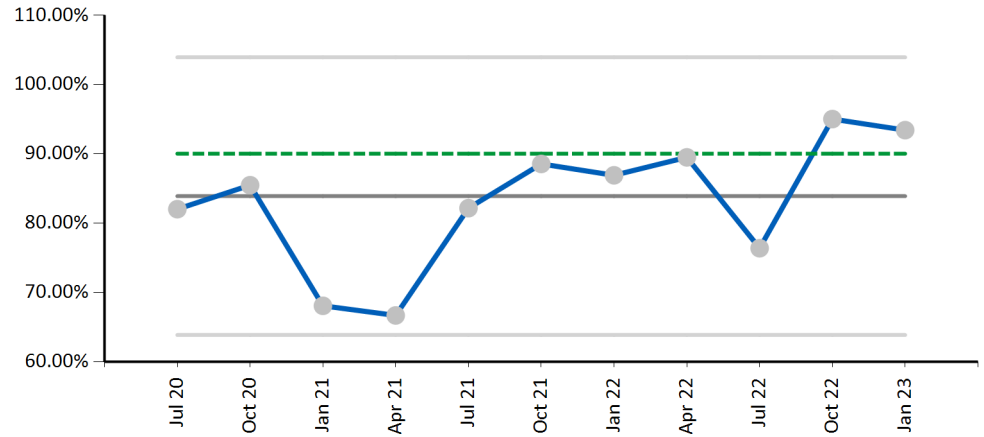
5/6

516 - Community patients acquiring pressure damage (unstagable)



Normal Variation

28 - Emergency patients - screened for Sepsis (quarterly)

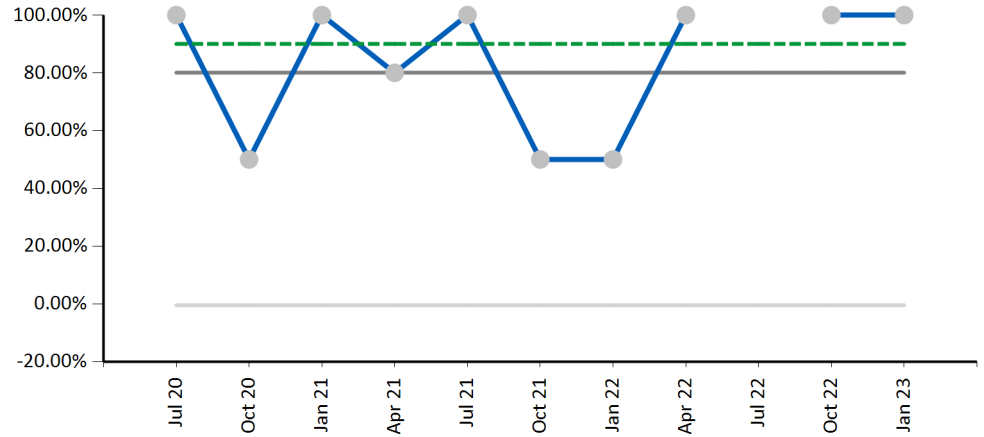


Normal Variation

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

2/6

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

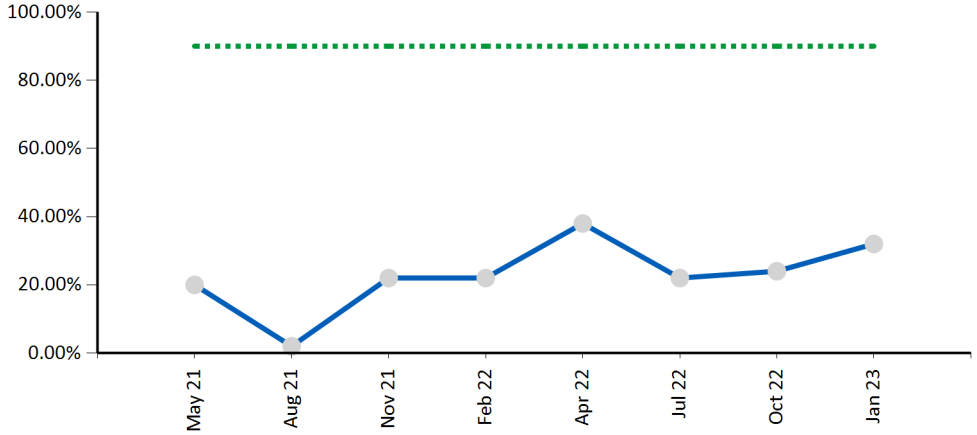


Normal Variation

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

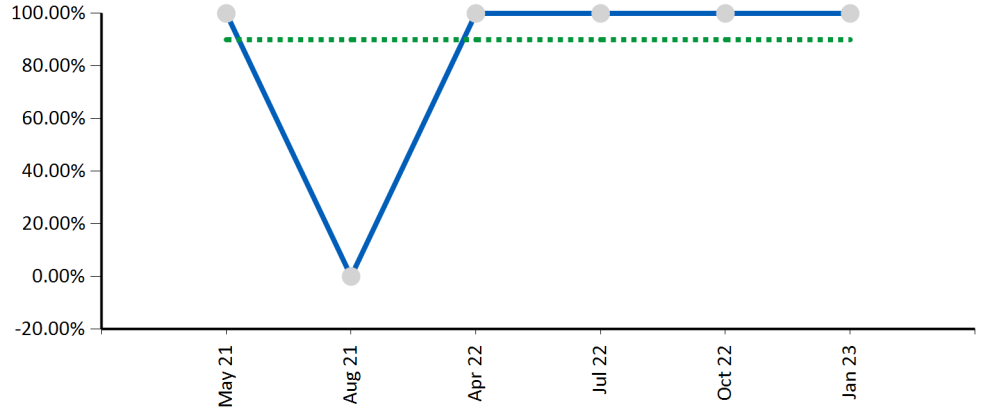
3/6

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



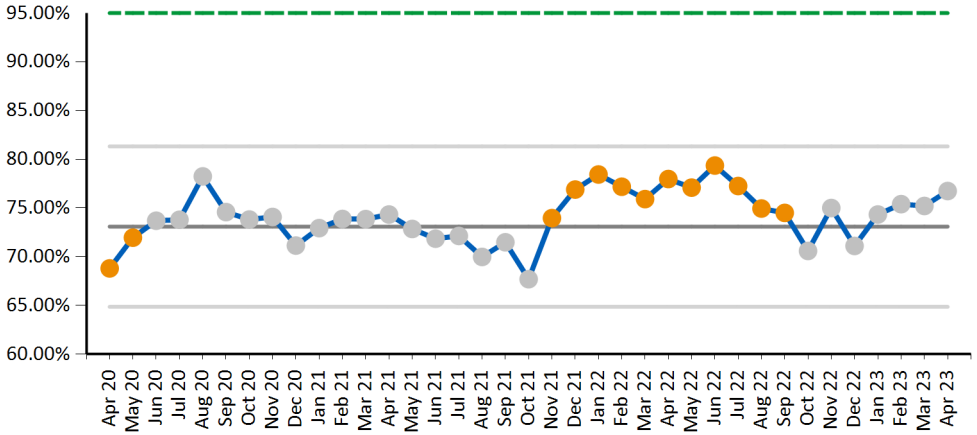
0/6

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



5/6

30 - Clinical Correspondence - Inpatients %<1 working day

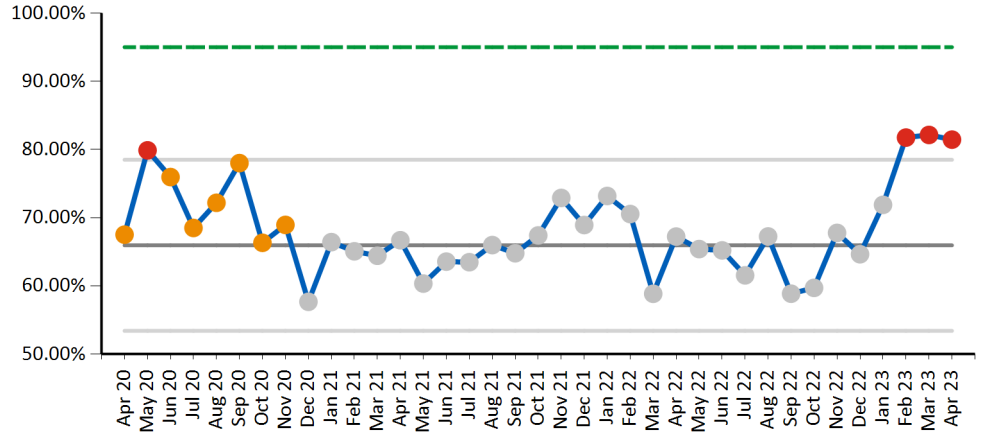


Normal Variation

F We will regularly fail to meet the target.

0/6

31 - Clinical Correspondence - Outpatients %<5 working days

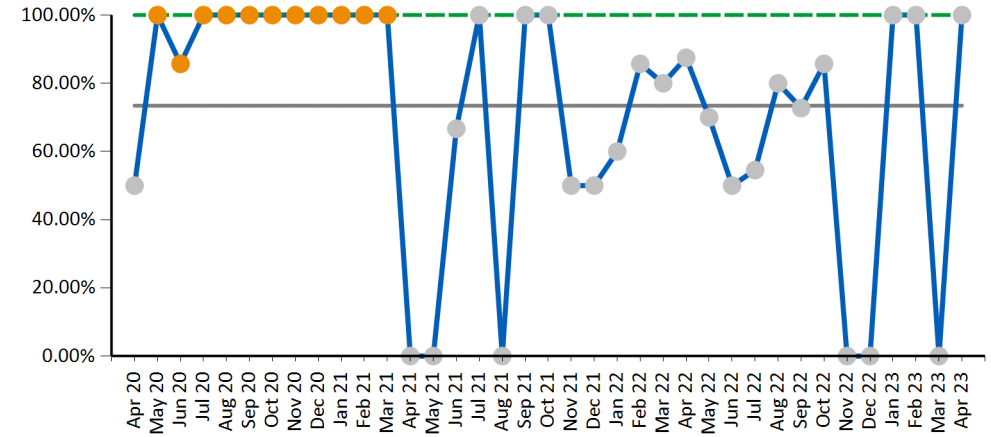


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

86 - Patient Safety Alerts

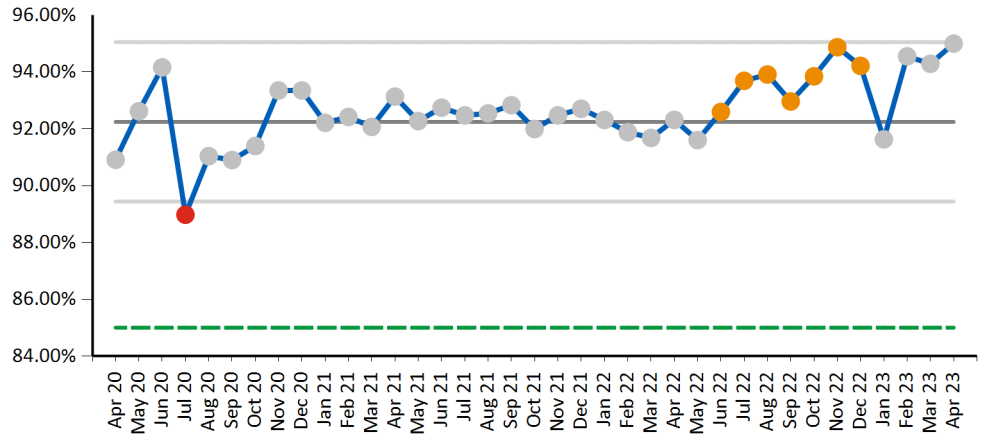


Normal Variation

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

3/6

88 - Nursing KPI Audits

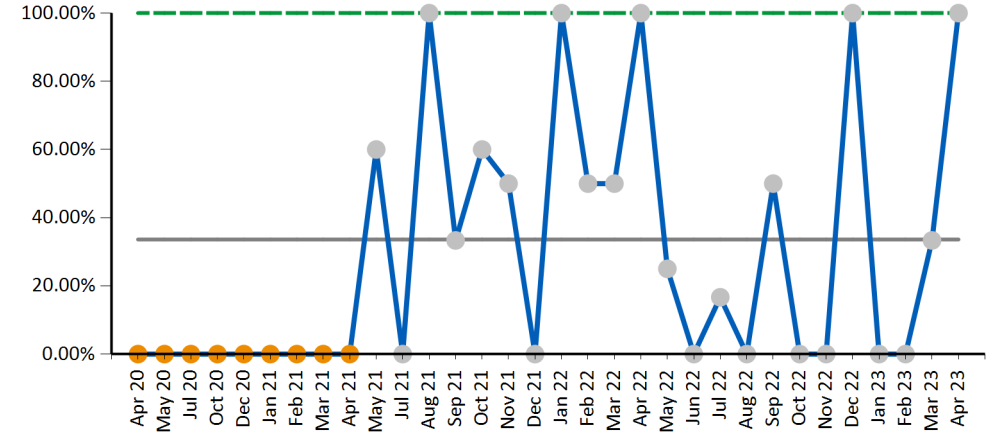


Normal Variation

Target will be regularly met.

6/6

91 - Report to patient/family within 60 working days of incident declaration

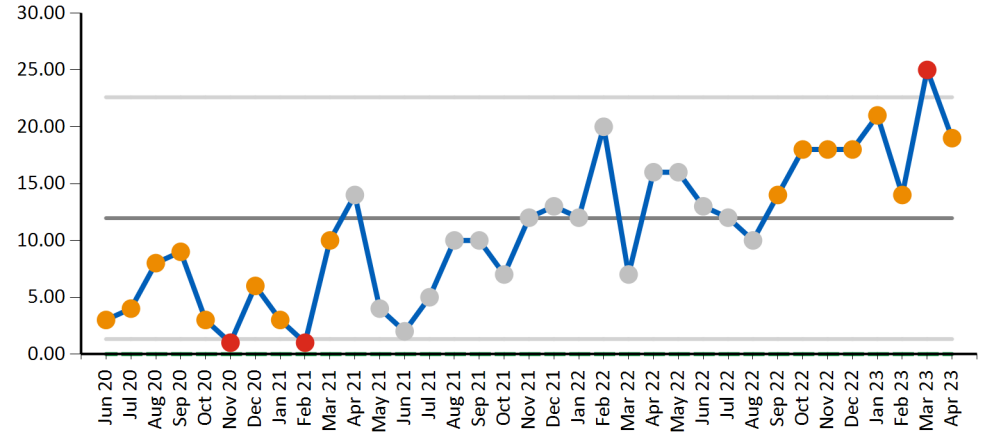


Normal Variation

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

2/6

8 - Same sex accommodation breaches



Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

Infection Prevention and Control

There have been 13 healthcare associated C. diff cases in April – This is a decrease on March but remains above the trajectory of no more than six cases (6.6 cases) per month. Two of these cases are part of a cluster that is being managed as an outbreak.

The first learning collaborative will take place on the 24th May with the aim of creating sustainable improvements in the management of patients with C. diff infection and diarrhoea. The intention of the collaborative will be to address long-standing issues related specifically to C. diff reduction – such as identifying and managing patients when symptomatic – but also to test change that will reduce the risk of the transmission of all healthcare associated infections – such as hand hygiene and personal protective equipment use.

There have been no healthcare associated MRSA, MSSA or Pseudomonas aeruginosa bloodstream infections in April. There have been two healthcare associated Klebsiella pneumonia bloodstream infections – both investigated with no common themes. There have been five healthcare associated E. coli bloodstream infections in April, all unrelated with no common themes.

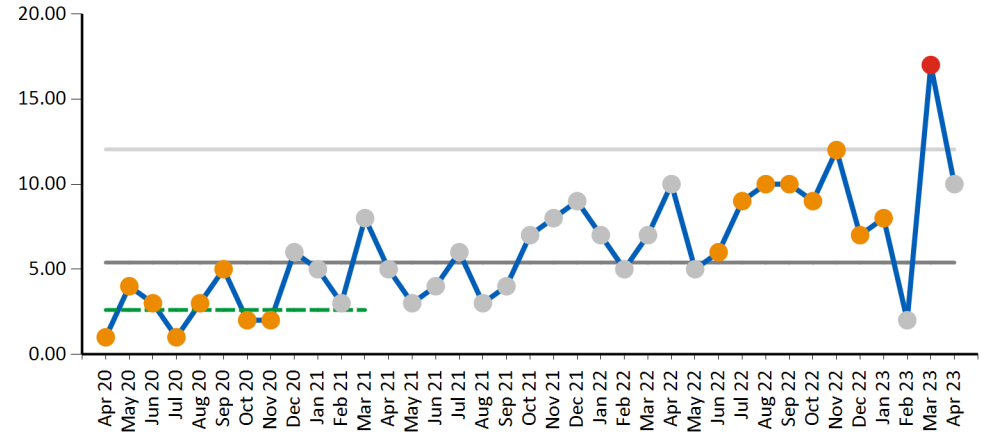
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

Chart 217 and 306 - These are SPC G Charts. These are time series charts that plot the time intervals between infrequent events such as MRSA bacteraemias. This chart demonstrates that the Trust is seeing progressively longer gaps between hospital onset MRSA bacteraemias.

	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		10	Apr-23			17	Mar-23		10	
346 - Total Community Onset Hospital Associated C.diff infections		3	Apr-23			1	Mar-23		3	
347 - Total C.diff infections contributing to objective	<= 7	13	Apr-23		<= 7	18	Mar-23	<= 7	13	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Apr-23		= 0	0	Mar-23	= 0	0	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	5	Apr-23		<= 2	7	Mar-23	<= 2	5	
219 - Blood Culture Contaminants (rate)	<= 3%	2.7%	Apr-23		<= 3%	4.3%	Mar-23	<= 3%	2.7%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	0.0	Apr-23		<= 1.0	1.0	Mar-23	<= 1.0	0.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Apr-23		<= 1	2	Mar-23	<= 1	2	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Apr-23		= 0	0	Mar-23	= 0	0	

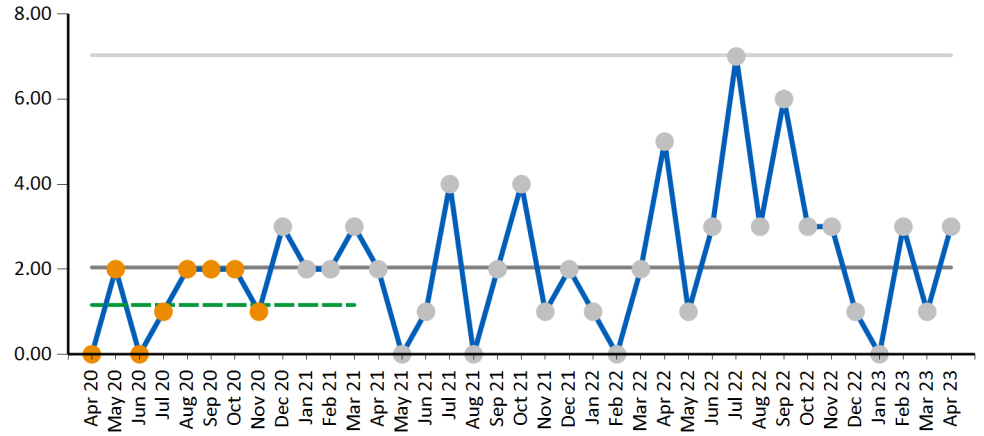
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
491 - Nosocomial COVID-19 cases		31	Apr-23			83	Mar-23		31	

215 - Total Hospital Onset C.diff infections



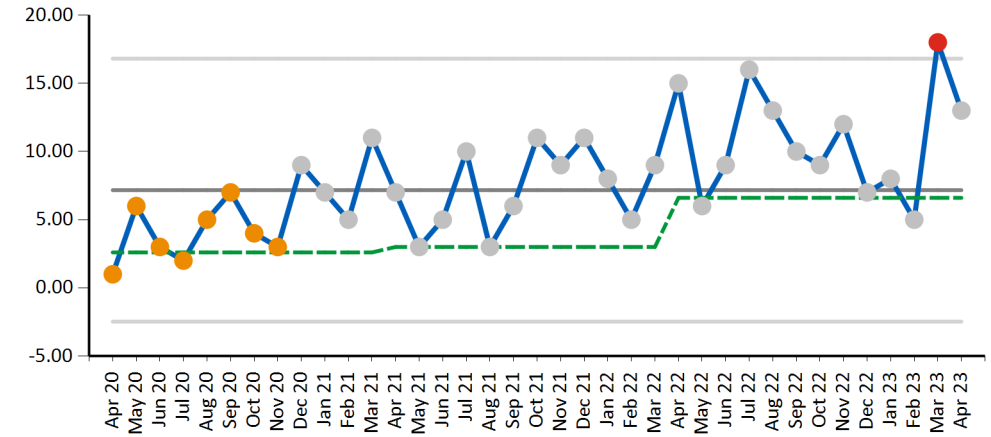
Normal Variation

346 - Total Community Onset Hospital Associated C.diff infections



Normal Variation

347 - Total C.diff infections contributing to objective

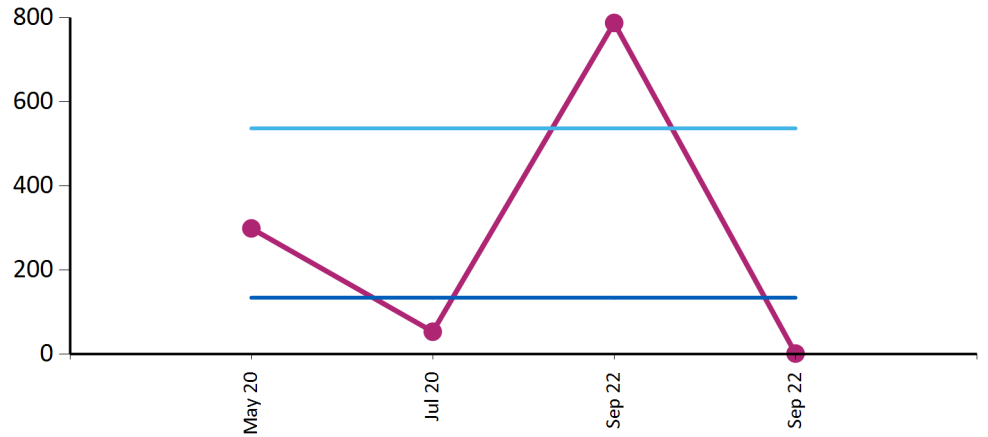


Normal Variation

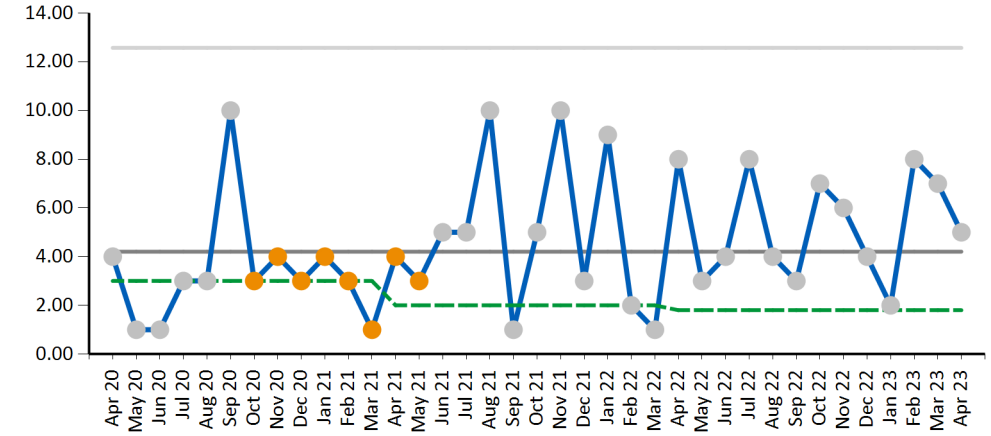
We will not regularly meet the target due to normal variation.

1/6

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



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

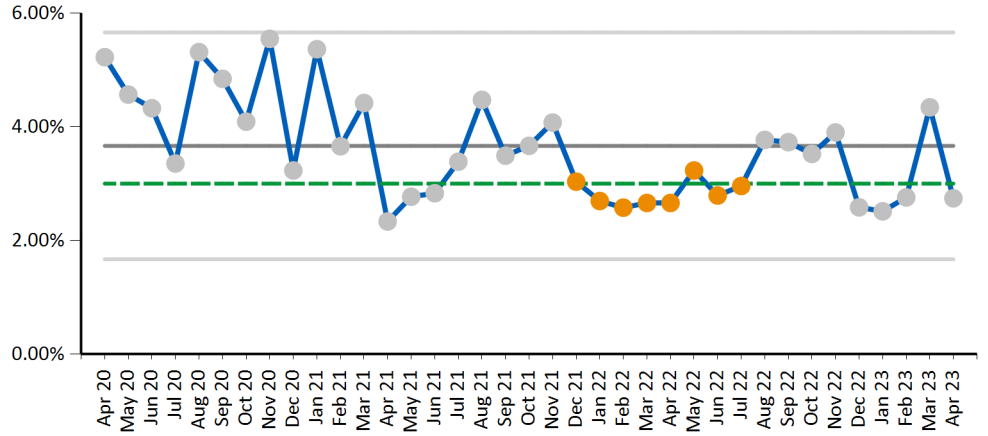


Normal Variation

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

0/6

219 - Blood Culture Contaminants (rate)

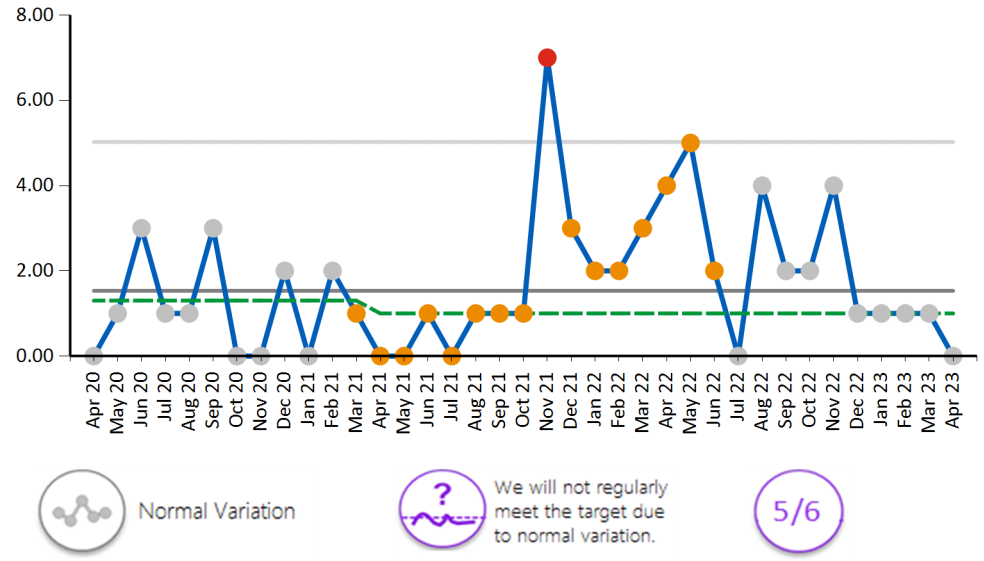


Normal Variation

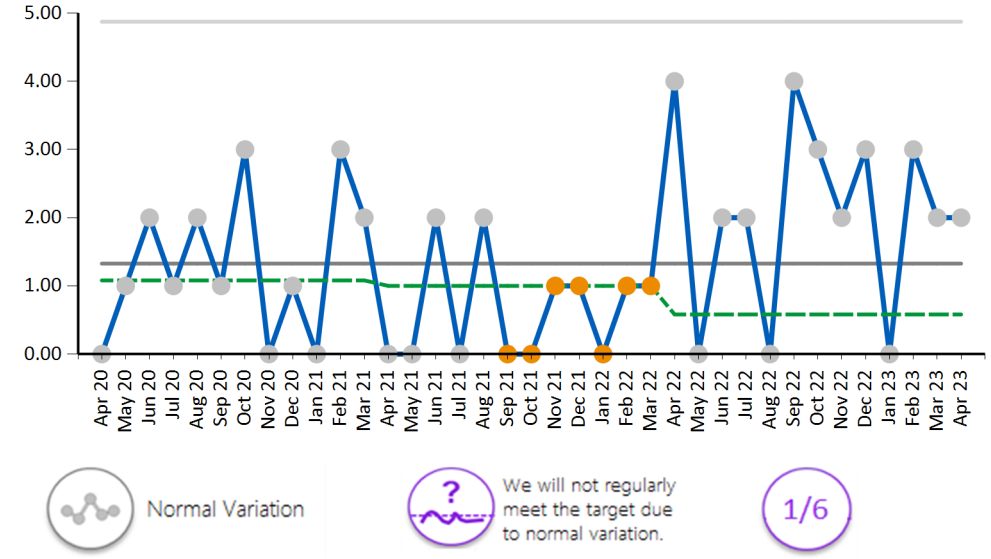
We will not regularly meet the target due to normal variation.

4/6

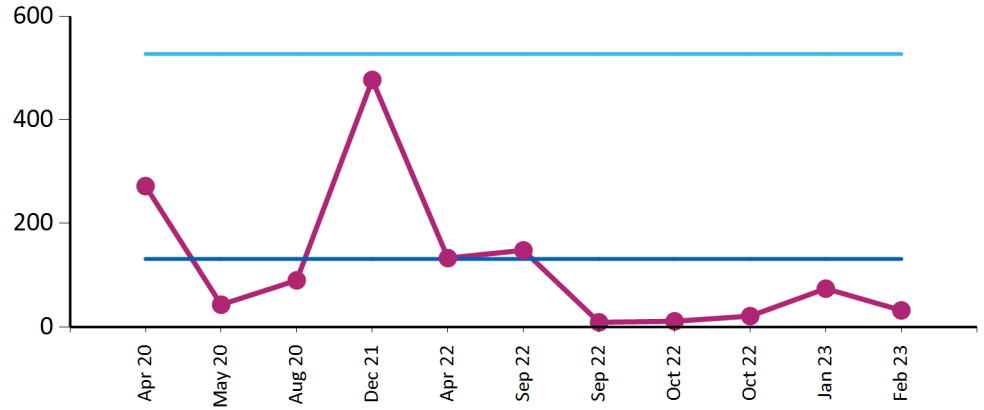
304 - Total Trust apportioned MSSA BSIs



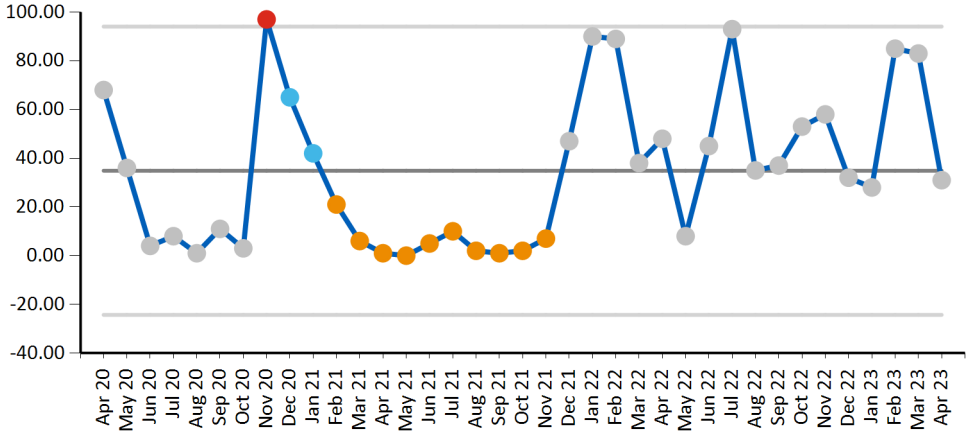
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

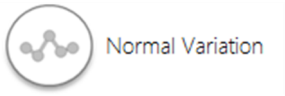


306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA) - G Chart (Days Between Cases)



491 - Nosocomial COVID-19 cases





Mortality

Crude – in month rate is below Trust target and average for the period. The crude rate has remained in control and has been for more than two years.

HSMR – in month figure is within control limits and below average for the time frame. The 12 month average to January 2023 is 111.35, this is a 'Red' alert. The risk adjustments within HSMR are being examined in detail by Business Intelligence as these are slightly different to SHMI, it is thought that this alert is more of a data issue than quality of care.

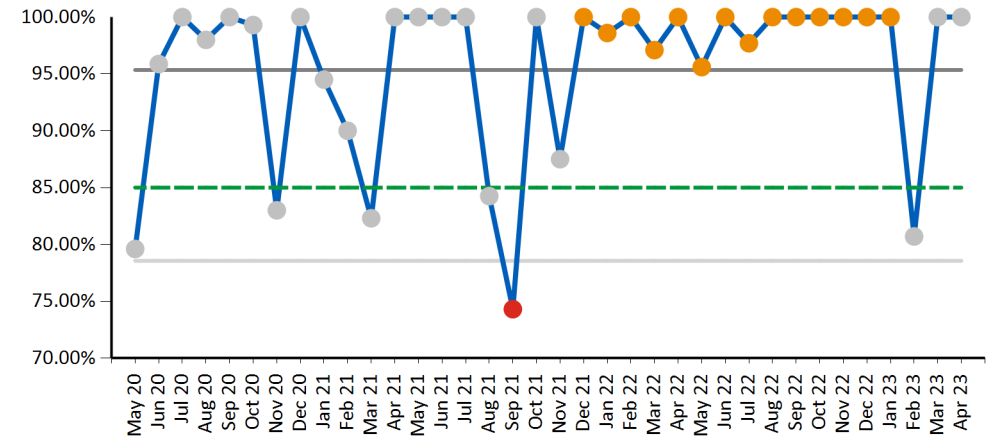
SHMI – In month figure is above the average for the time period but has remained 'in control' for more than two years. The published rolling average for the period January to December 2022 is 107.07 'as expected'.

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

The proportion of coded records at the time of the snapshot download is above the target and average for the time frame. There has been a sustained period of 7 points above the mean since August 2022 indicating sustained improvement.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Apr-23		>= 85%	100.0%	Mar-23	>= 85%	100.0%	
495 - HSMR		112.09	Jan-23			105.59	Dec-22			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	120.20	Nov-22		<= 100.00	100.02	Oct-22	<= 100.00		
12 - Crude Mortality %	<= 2.9%	2.1%	Apr-23		<= 2.9%	1.9%	Mar-23	<= 2.9%	2.1%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Jan-23			4	Dec-22			
520 - Depth of recording (First episode of care)		6	Jan-23			6	Dec-22			
521 - Proportion of fully coded records (Inpatients)		98.9%	Feb-23			99.0%	Jan-23			

3 - National Early Warning Scores to Gold standard

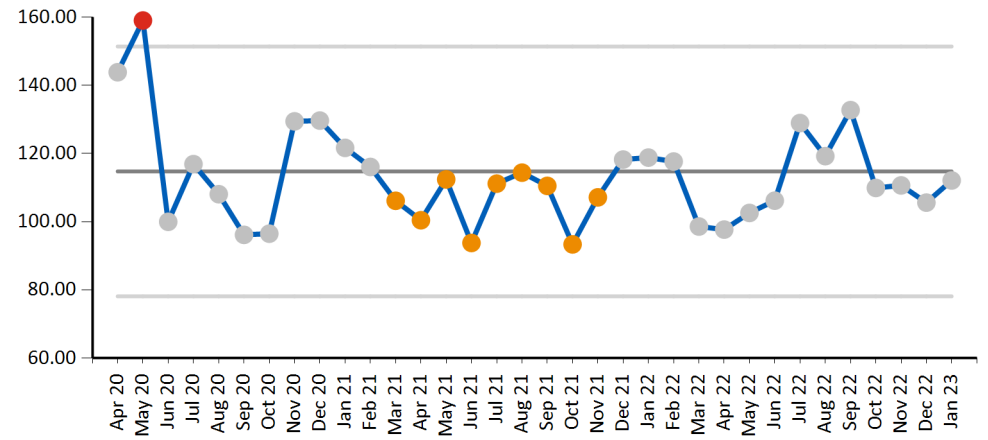


Normal Variation

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

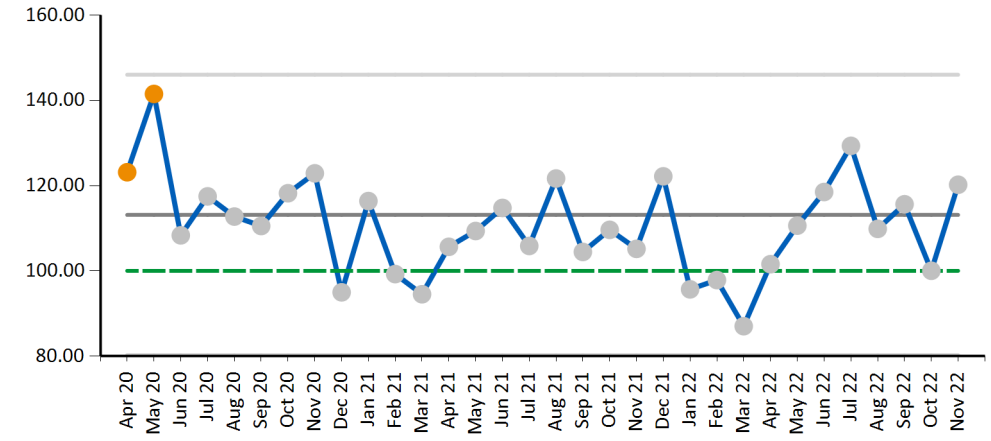
5/6

495 - HSMR



Normal Variation

11 - Summary Hospital-level Mortality Indicator (SHMI)

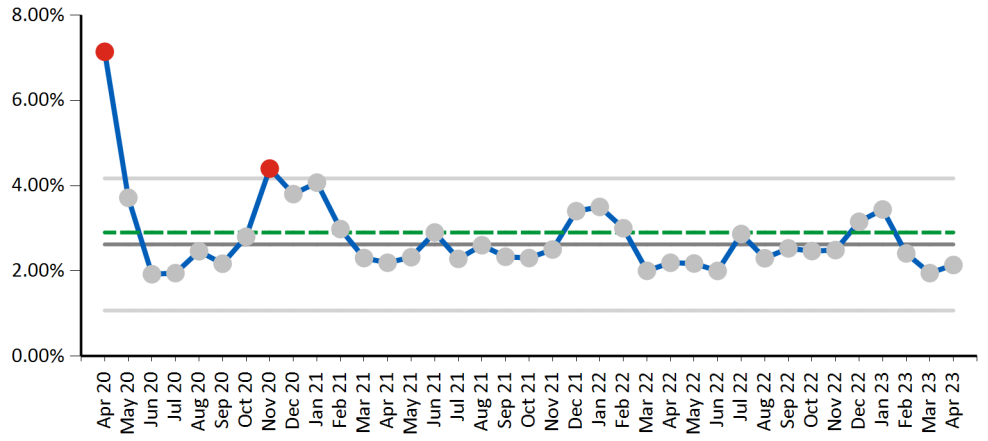


Normal Variation

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

0/6

12 - Crude Mortality %

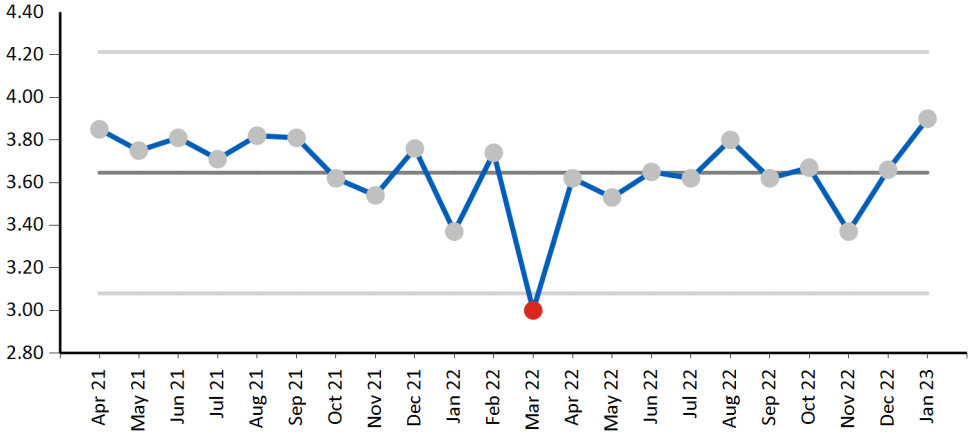


Normal Variation

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

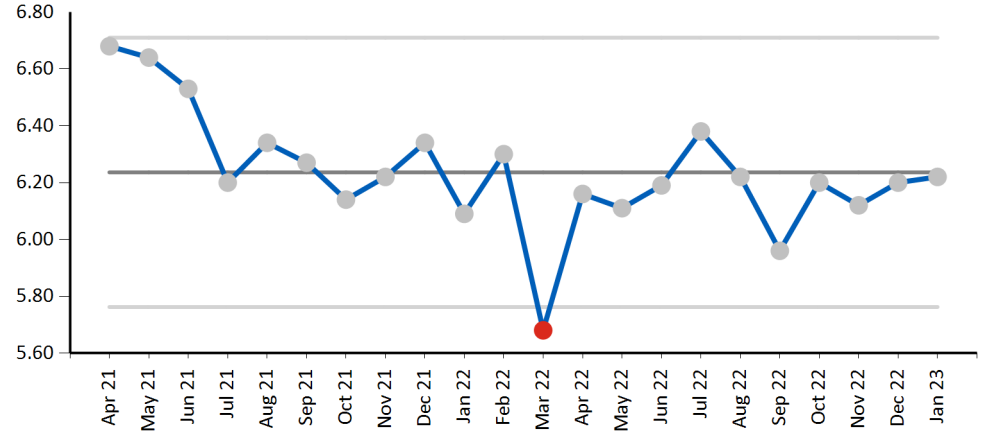
4/6

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



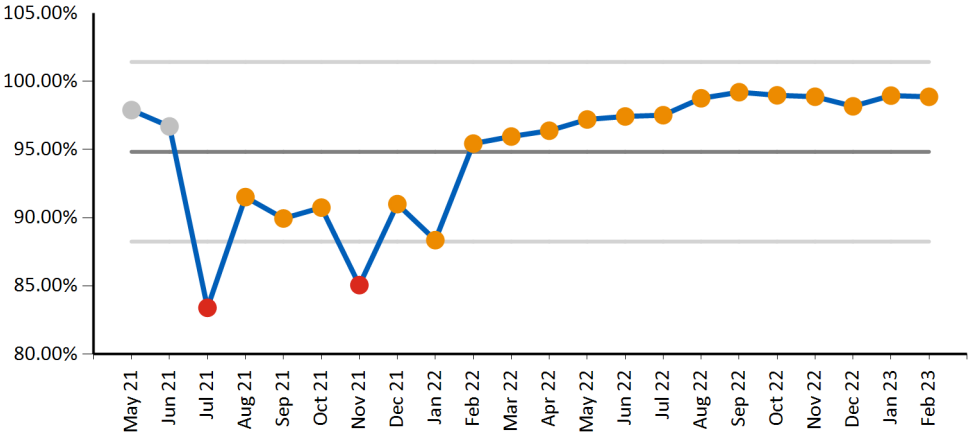
Normal Variation

520 - Depth of recording (First episode of care)



Normal Variation

521 - Proportion of fully coded records (Inpatients)



Abnormal variation.
Target achieved.

Patient Experience

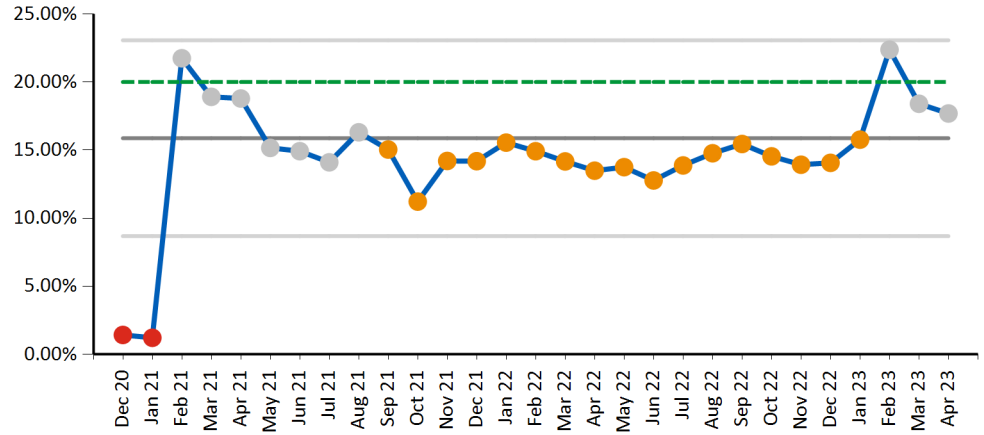
Complaint Response Rates
Following on from the implementation of an agreed list of specific questions between the Patient Experience Team and complainant, we have seen an increase in cases responded to within timescales. From a target of 95% we have been able to achieve 64.7% which is a substantial improvement on March 23 figures (28.6%). Despite initial concerns that the junior doctors strike would impact the investigation timeframes into April 23, the change in agreeing terms of reference has been successful and we anticipate that this will continue. Digital solutions for the sharing of meeting recordings is near completion and we anticipate this should be resolved in readiness for May 23 data.

FFT
We have commenced a focussed and planned collection of data and this is being input in a timely manner. As soon as we are in a position to obtain further log in opportunities for divisional staff, we will ensure that training is delivered rapidly to support speedy self-departmental inputting.

	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%	17.7%	Apr-23		>= 20%	18.4%	Mar-23	>= 20%	17.7%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	88.2%	Apr-23		>= 90%	86.9%	Mar-23	>= 90%	88.2%	
80 - Inpatient Friends and Family Response Rate	>= 30%	19.0%	Apr-23		>= 30%	25.6%	Mar-23	>= 30%	19.0%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.4%	Apr-23		>= 90%	96.2%	Mar-23	>= 90%	96.4%	
81 - Maternity Friends and Family Response Rate	>= 15%	40.8%	Apr-23		>= 15%	27.8%	Mar-23	>= 15%	40.8%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.9%	Apr-23		>= 90%	91.3%	Mar-23	>= 90%	91.9%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	34.9%	Apr-23		>= 15%	18.0%	Mar-23	>= 15%	34.9%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	98.8%	Apr-23		>= 90%	100.0%	Mar-23	>= 90%	98.8%	
83 - Birth - Friends and Family Response Rate	>= 15%	31.8%	Apr-23		>= 15%	27.7%	Mar-23	>= 15%	31.8%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	91.5%	Apr-23		>= 90%	88.4%	Mar-23	>= 90%	91.5%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	60.5%	Apr-23		>= 15%	36.9%	Mar-23	>= 15%	60.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	80.8%	Apr-23		>= 90%	84.6%	Mar-23	>= 90%	80.8%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	42.9%	Apr-23		>= 15%	35.2%	Mar-23	>= 15%	42.9%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.5%	Apr-23		>= 90%	93.7%	Mar-23	>= 90%	98.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Apr-23		= 100%	100.0%	Mar-23	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	64.7%	Apr-23		>= 95%	28.6%	Mar-23	>= 95%	64.7%	

200 - A&E Friends and Family Response Rate

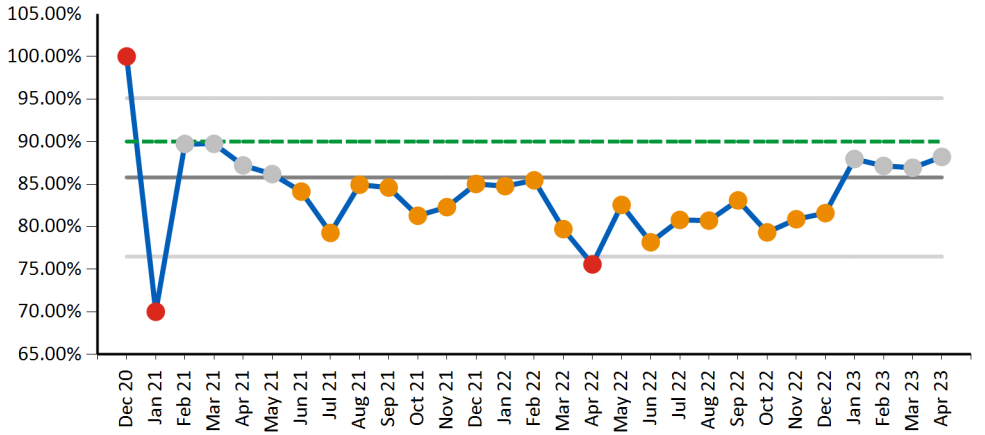


Normal Variation

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

1/6

294 - A&E Friends and Family Satisfaction Rates %

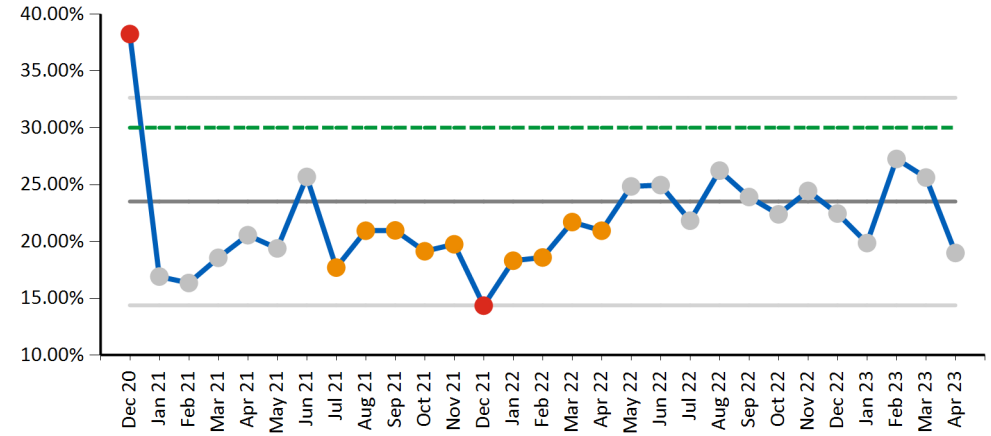


Normal Variation

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

0/6

80 - Inpatient Friends and Family Response Rate

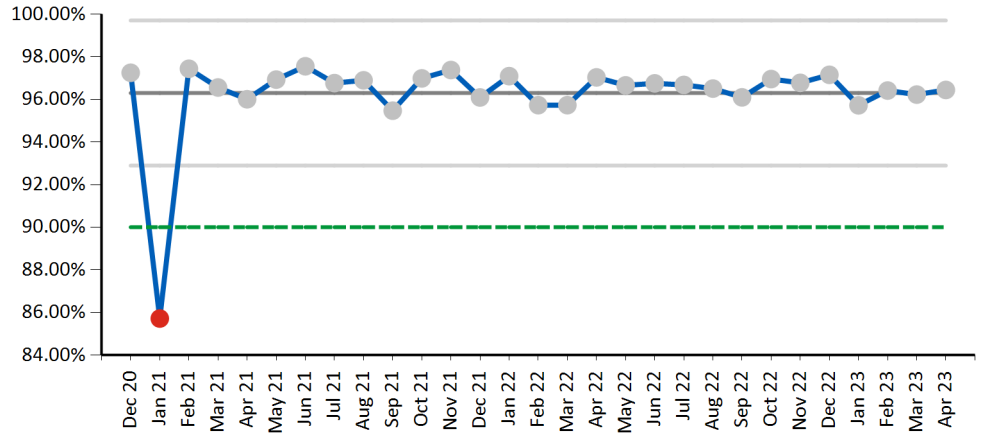


Normal Variation

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

0/6

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

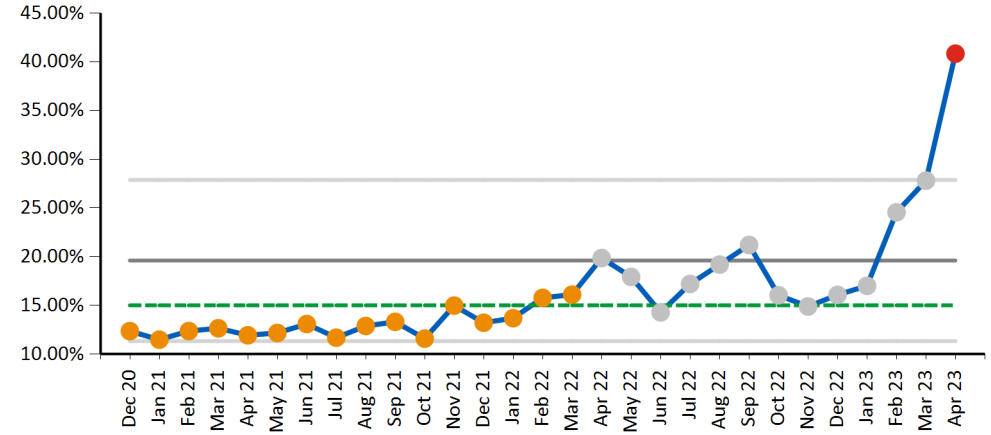


Normal Variation

Target will be regularly met.

6/6

81 - Maternity Friends and Family Response Rate

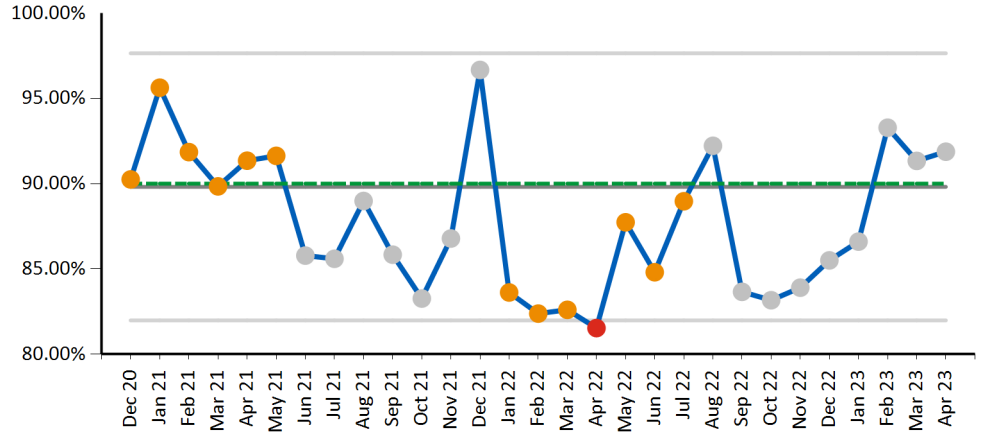


Abnormal variation. Target achieved.

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

5/6

241 - Maternity Friends and Family Test - Satisfaction %

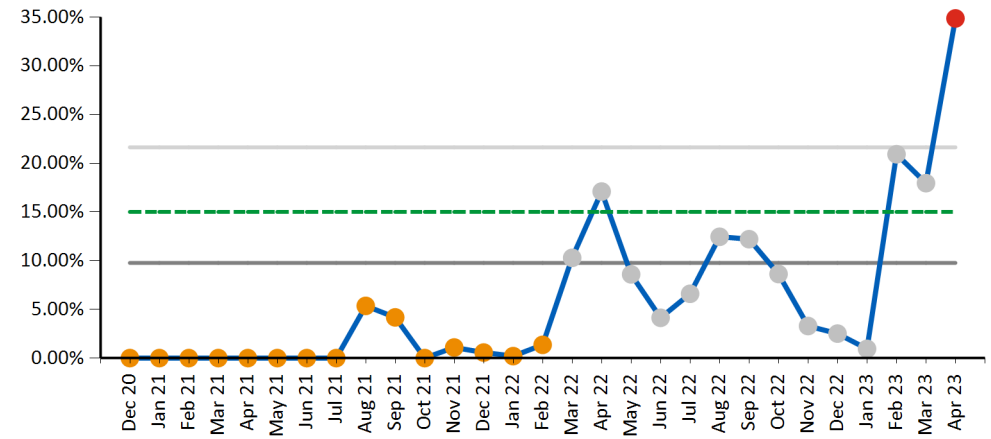


Normal Variation

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

3/6

82 - Antenatal - Friends and Family Response Rate

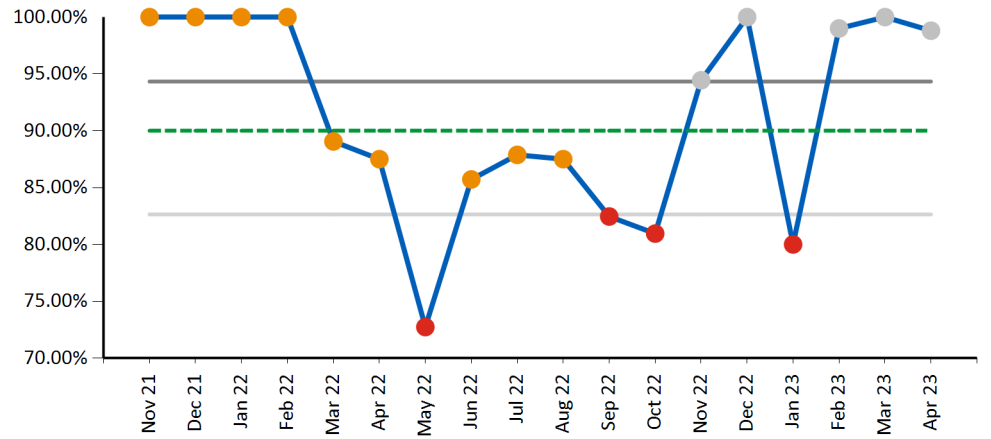


Abnormal variation. Target achieved.

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

3/6

242 - Antenatal Friends and Family Test - Satisfaction %

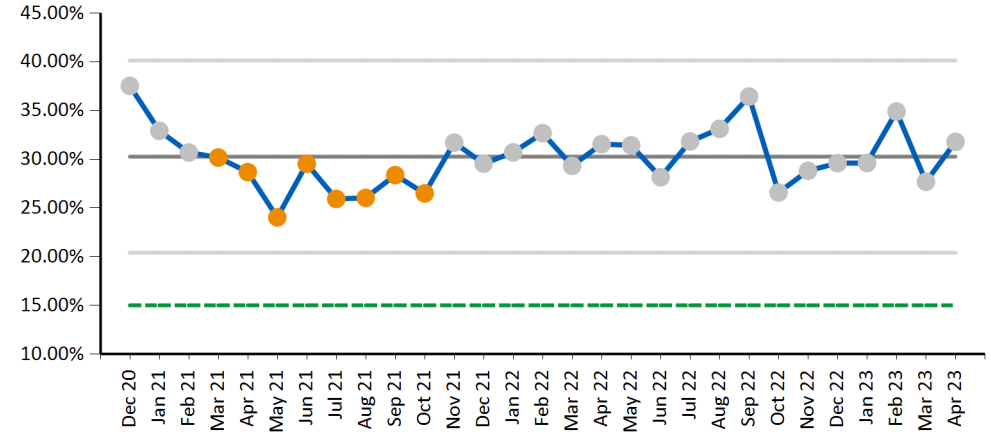


Normal Variation

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

5/6

83 - Birth - Friends and Family Response Rate

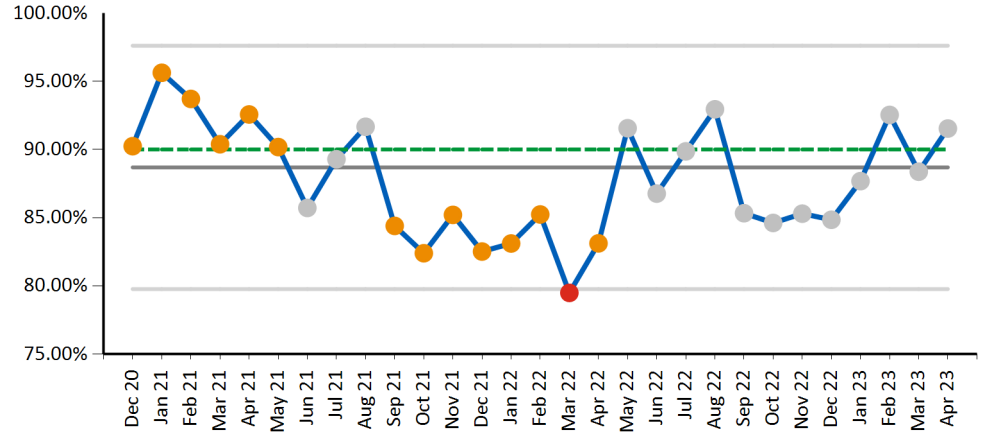


Normal Variation

Target will be regularly met.

6/6

243 - Birth Friends and Family Test - Satisfaction %

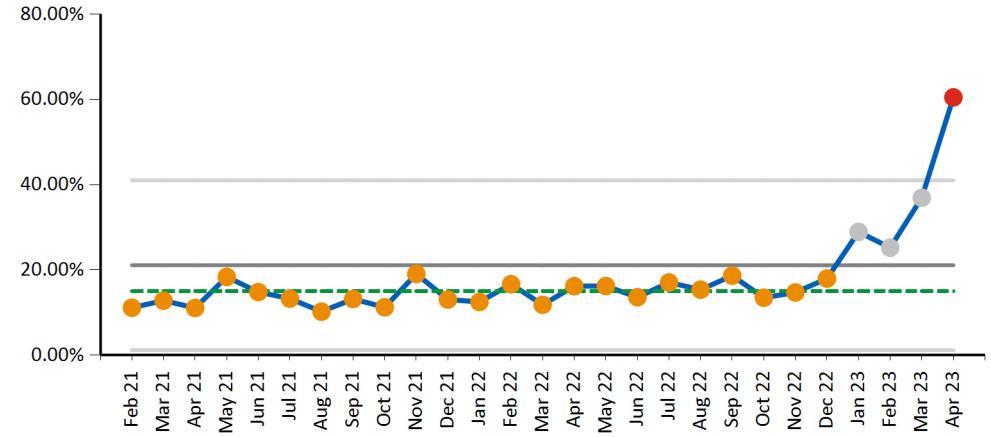


Normal Variation

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

2/6

84 - Hospital Postnatal - Friends and Family Response Rate

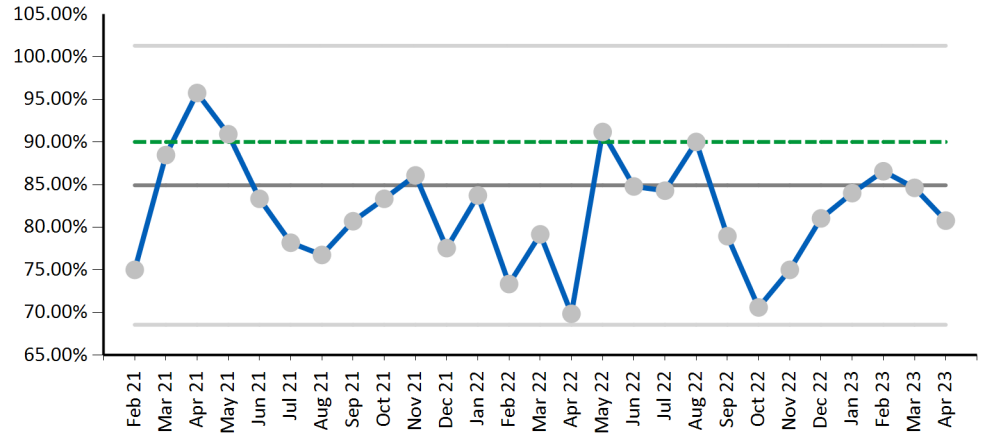


Abnormal variation. Target achieved.

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

5/6

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

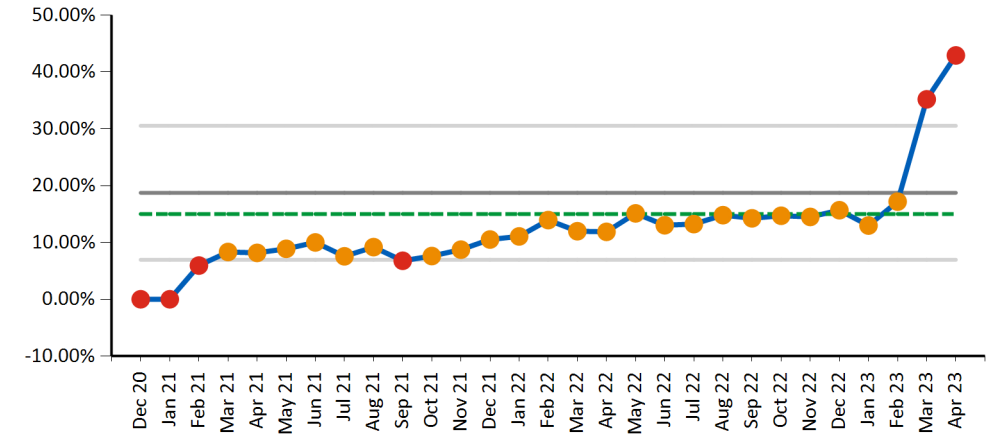


Normal Variation

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

0/6

85 - Community Postnatal - Friend and Family Response Rate

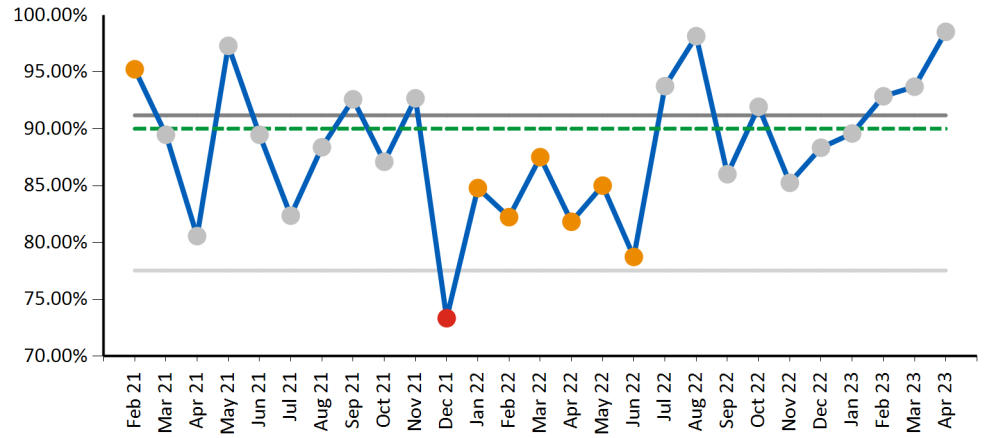


Abnormal variation. Target achieved.

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

4/6

245 - Community Postnatal Friends and Family Test - Satisfaction %

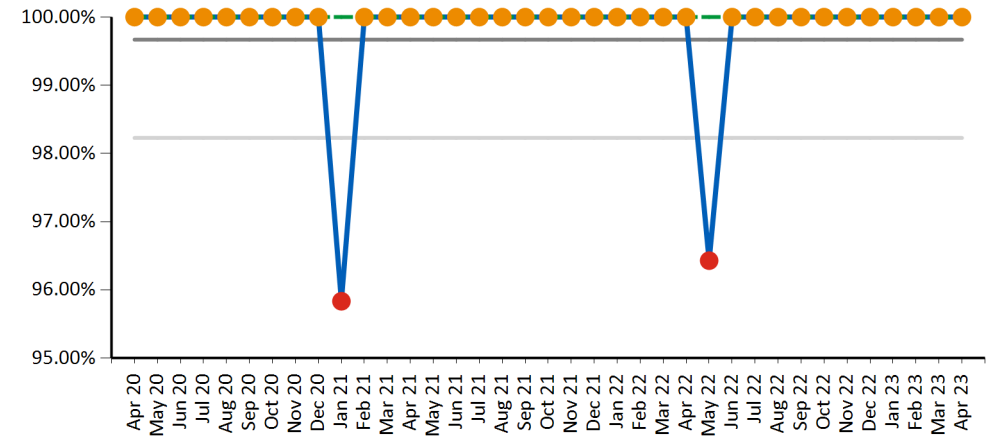


Normal Variation

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

3/6

89 - Formal complaints acknowledged within 3 working days

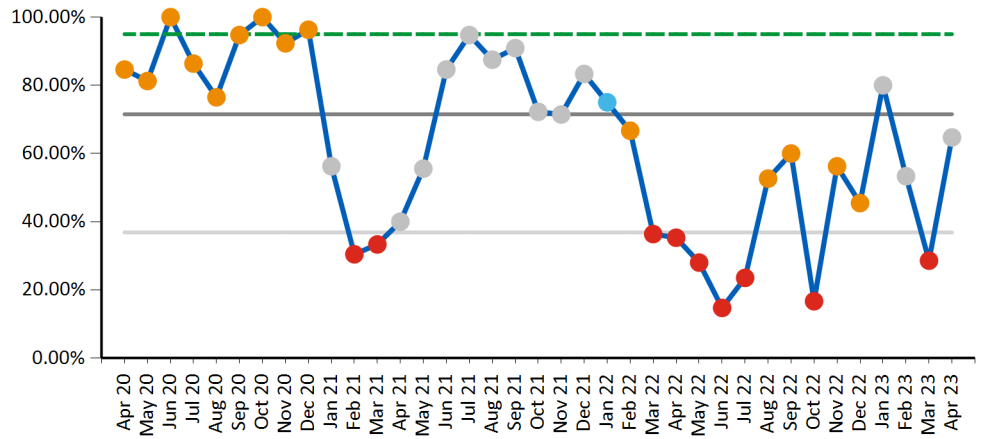


Abnormal variation. Target achieved.

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

6/6

90 - Complaints responded to within the period



Normal Variation

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

0/6

Maternity

81 Friends and Family Response Rate – Improving trend in response rate reported over past three consecutive months. Improvement noted following establishment of the friends and family task and finish group.

202 - 1:1 care in labour – Trust mean in Q4 2022/2023 89.62% is lower than the Greater Manchester and East Cheshire (GMEC) 2022 mean of 95.60% and peer average in similar sized providers (ie Oldham). Reflective of current staffing deficit (50wte) and improvement anticipated from September 2023 when overall staffing establishment predicted to improve following recruitment of 53wte Registered Midwives. Incident reported as red flag and monitored on Birth Rate Plus acuity tool every 4 hours.

23 – ¾ degree tears – Bolton incidence in Q4 2022/2023 2.88% slightly higher than GMEC incidence of 2.57%. OASI bundle 1 and OASI2 bundle previously launched at Bolton and relaunch of OASI2 bundle planned. Midwife allocated time to undertake role of OASI lead and support further staff training and development. Detailed analysis now shared monthly with breakdown of incidence per delivery type so trends can be identified and action taken where appropriate. Additional pairs of episcissors as interim measure whilst research review awaited due to conflicting results re impact of scissors on OASI and association with increased blood loss (Ayuk et al 2019).

203 – Booked by 12+6 – Improving trend in booking performance continued. New task and finish group to review the booking process commenced 18/04/2023 to streamline process. Trust mean Q4 2022/2023 88.77% aligns with GMEC 2022 mean of 89.90%.

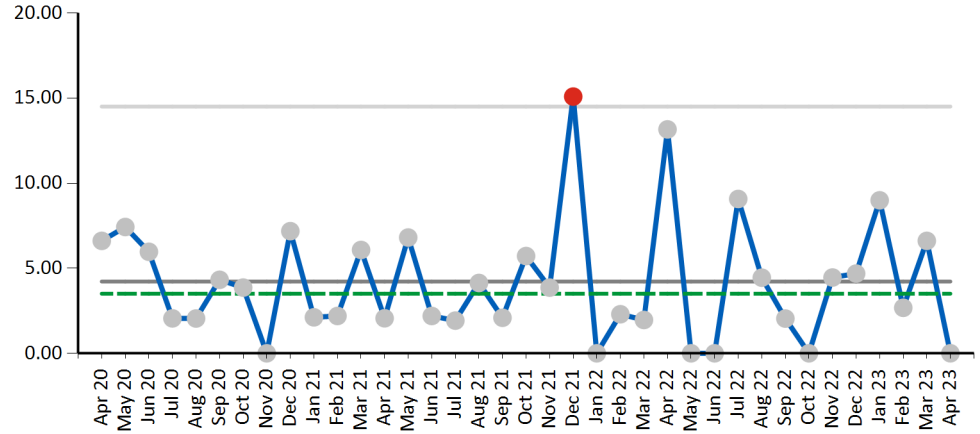
210 – Breastfeeding initiation – Infant feeding team continue to have reduced capacity as team members have been working clinically to maintain safe staffing levels in service. New leadership has been introduced to review current service offer and support Baby Friendly implementation within service. Trust mean in Q4 2022/2023 64.49% slightly higher than 2022 GMEC mean 64.31%.

322 – Maternity Stillbirth Rate – Fluctuating trend. Review of perinatal mortality tool process undertaken to strengthen governance and oversight. Trust 2022 rate Q4 2022/2023 5.00 compares favourably with GMEC mean 5.05/1000 and lower than peer comparators ie Oldham 8.63/1000. All cases reviewed individually. Review of PMRT cases has been undertaken within each provider in system and shared learning event planned for late May.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	0.00	Apr-23		<= 3.50	6.61	Mar-23	<= 3.50	2.51	
23 - Maternity -3rd/4th degree tears	<= 3.5%	5.5%	Apr-23		<= 3.5%	3.5%	Mar-23	<= 3.5%	5.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.0%	Apr-23		>= 95.0%	98.5%	Feb-23	>= 95.0%	98.0%	
203 - Booked 12+6	>= 90.0%	90.6%	Apr-23		>= 90.0%	89.7%	Mar-23	>= 90.0%	90.6%	
204 - Inductions of labour	<= 40%	36.2%	Apr-23		<= 40%	35.3%	Mar-23	<= 40%	36.2%	
210 - Initiation breast feeding	>= 65%	68.39%	Apr-23		>= 65%	65.61%	Mar-23	>= 65%	68.39%	
213 - Maternity complaints	<= 5	3	Apr-23		<= 5	2	Feb-23	<= 5	3	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
319 - Maternal deaths (direct)	= 0	0	Apr-23		= 0	0	Mar-23	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	13.6%	Apr-23		<= 6%	9.3%	Mar-23	<= 6%	13.6%	

322 - Maternity - Stillbirths per 1000 births

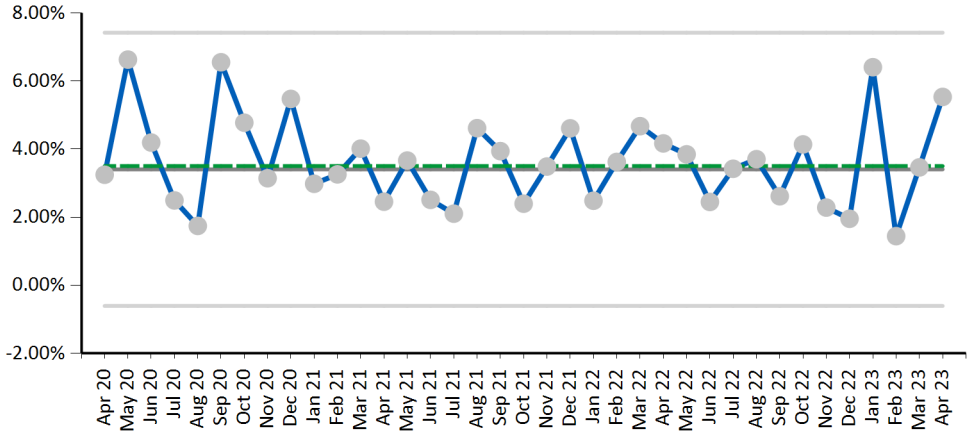


Normal Variation

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

2/6

23 - Maternity -3rd/4th degree tears

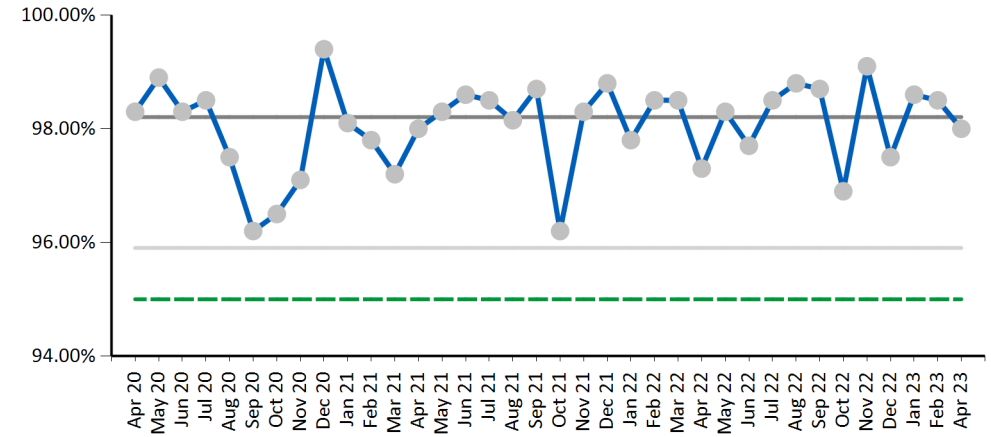


Normal Variation

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

4/6

202 - 1:1 Midwifery care in labour



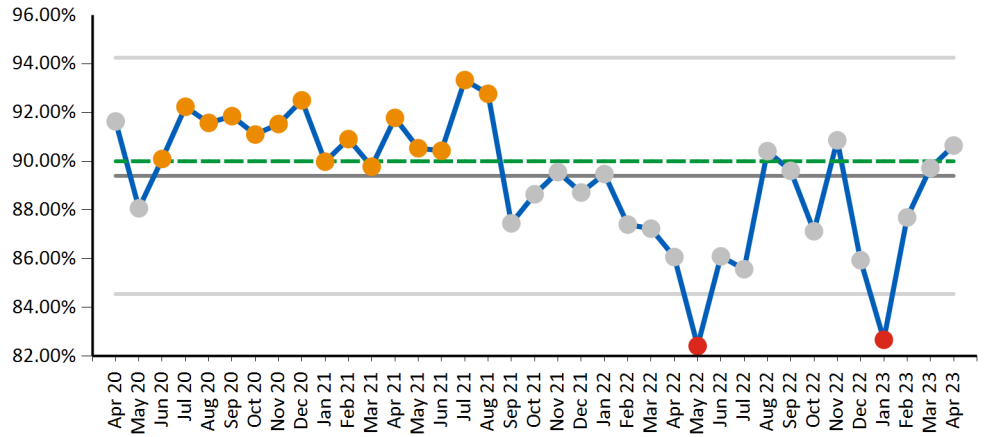
Normal Variation

P

Target will be regularly met.

6/6

203 - Booked 12+6



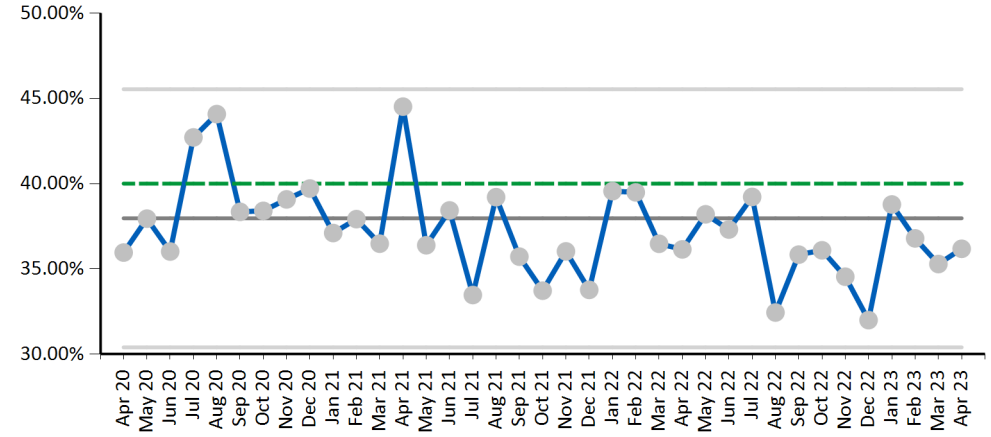
Normal Variation

?

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

2/6

204 - Inductions of labour



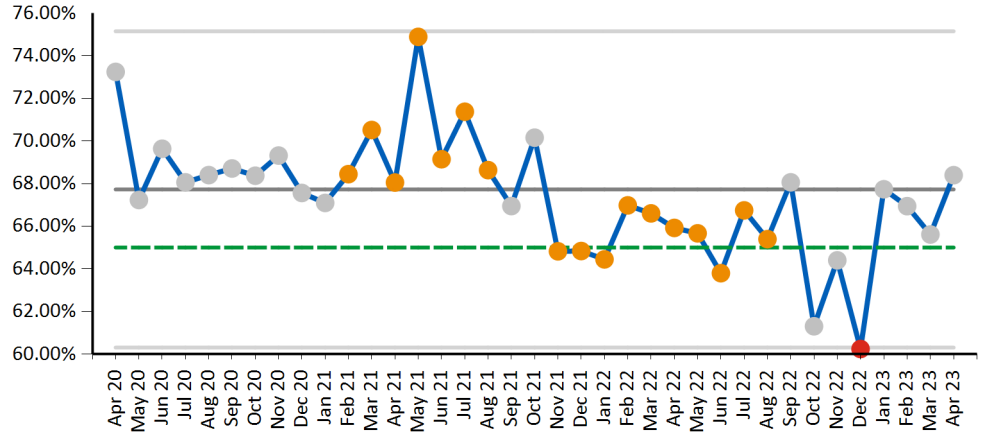
Normal Variation

?

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

6/6

210 - Initiation breast feeding



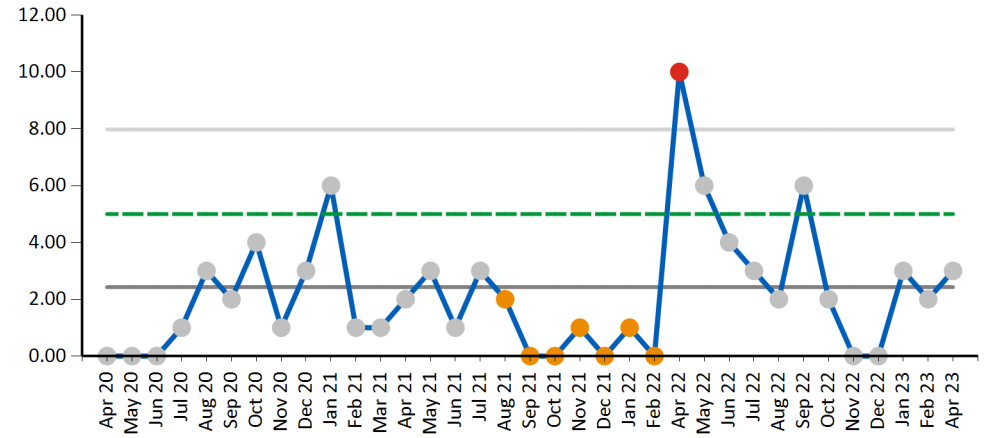
Normal Variation

?

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

4/6

213 - Maternity complaints

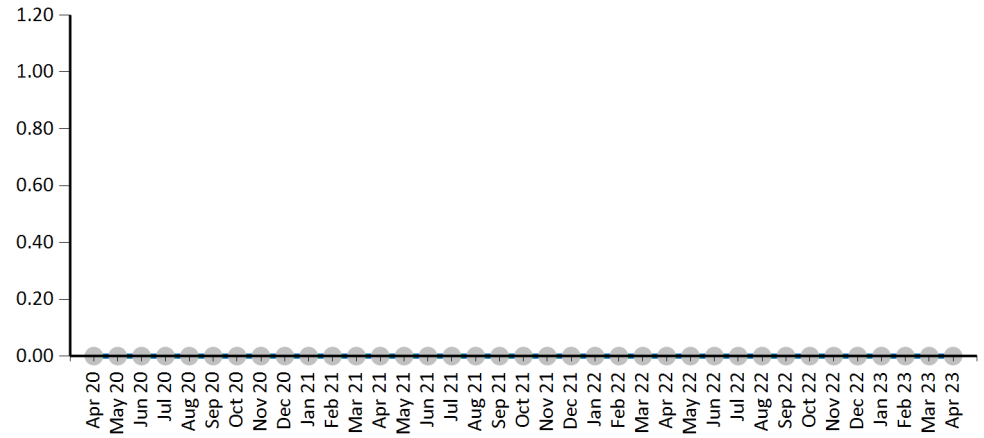


Normal Variation

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

6/6

319 - Maternal deaths (direct)

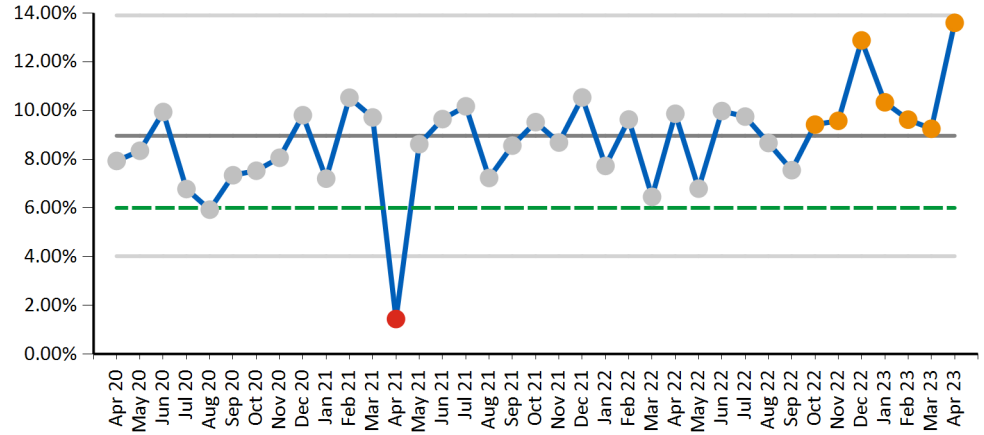


Normal Variation

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

6/6

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



Abnormal variation. Target not achieved.

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

0/6

Operational Performance

Urgent Care

Emergency Department
April saw a significant increase in urgent care pressure with challenges to patient flow across the organisation. However, we have seen an improvement in all ambulance handover metrics (15 mins, 30 mins and 60 mins); and whilst the 4 hour performance did not meet our improvement trajectory, performance was better than the previous month. This improvement was also seen in the number of patients more than 12 hours. May so far has been impacted by an increase in attendances and the two bank Holidays so far have had a further detrimental impact on flow across the organisation. Consequently, we are not predicting to be able to meet the May trajectory of 75%.

Fractured Neck of Femur
Performance has deteriorated further this month. The marked deterioration over the past year is being caused by an increase in the volume of patients who are being admitted with peri-prosthetic traumas (patients are living longer after having their hips replaced and then falling and having more complex fractures). This is reflective of a national picture. We have appointed an additional hip surgeon and have moved hip surgeon theatre sessions across the week to spread out capacity. High influxes of patient admissions during short periods, increased patient comorbidity and reduced theatre capacity due to industrial action have all contributed to delays in April.

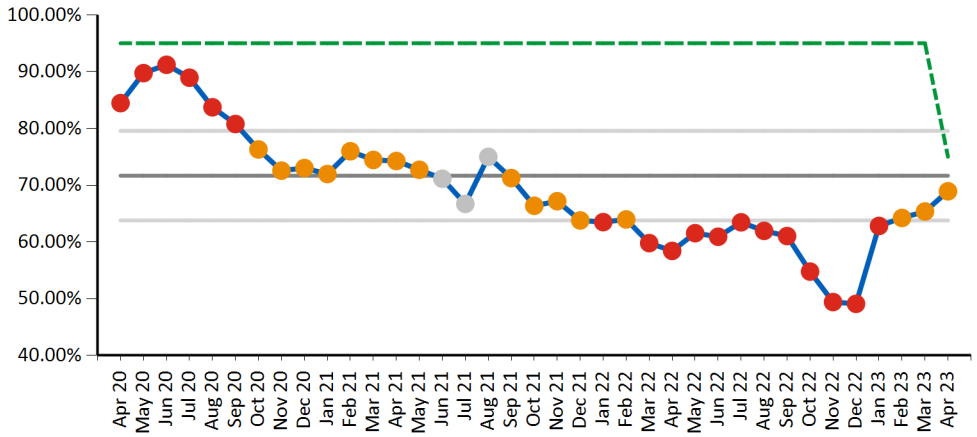
30 Day Readmission Rate
We are continuing to see low levels of readmission rates within 30 days after seeing a downward (improving) trend over the past 3 years. This improvement is likely to be linked to our long-term approach to development of our community proactive and reactive services. Our acute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

Please note: In line with NWAS the Ambulance handover metrics are calculated using only ambulance attendances where the handover was measurable, ie a time stamp is present on both NWAS and receiving Trust. Therefore not all ambulance attendances are included.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 75%	68.9%	Apr-23		>= 95%	65.4%	Mar-23	>= 75%	68.9%	
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	62.2%	Apr-23		>= 65.0%	50.7%	Mar-23	>= 65.0%	62.2%	
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	89.8%	Apr-23		>= 95.0%	79.9%	Mar-23	>= 95.0%	89.8%	
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100.00%	98.43%	Apr-23		= 100.00%	92.56%	Mar-23	= 100.00%	98.43%	
545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes		1.4%	Apr-23			7.4%	Mar-23		1.5%	
539 - A&E 12 hour waits	= 0	894	Apr-23		= 0	1,208	Mar-23	= 0	894	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	40.0%	Apr-23		>= 75%	51.3%	Mar-23	>= 75%	40.0%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	265	Apr-23		<= 200	284	Mar-23	<= 200	265	
307 - Stranded Patients - LOS 21 days and over	<= 69	114	Apr-23		<= 69	127	Mar-23	<= 69	114	
541 - Adult G&A bed occupancy	<= 92.0%	86.3%	Apr-23			86.0%	Mar-23	<= 92.0%	86.3%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.62	Apr-23		<= 3.70	4.23	Mar-23	<= 3.70	4.62	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.5%	Mar-23		<= 13.5%	9.4%	Feb-23	<= 13.5%		

53 - A&E 4 hour target

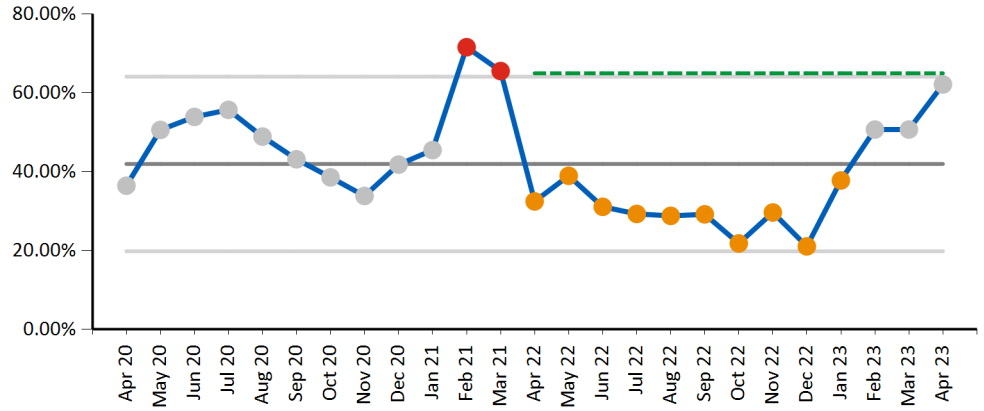


Abnormal variation. Target not achieved.

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

0/6

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

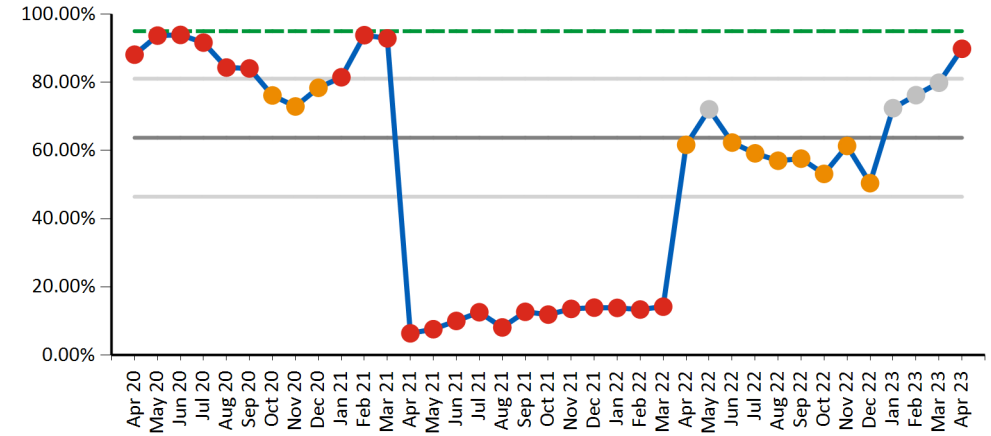


Normal Variation

We will regularly fail to meet the target.

0/6

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

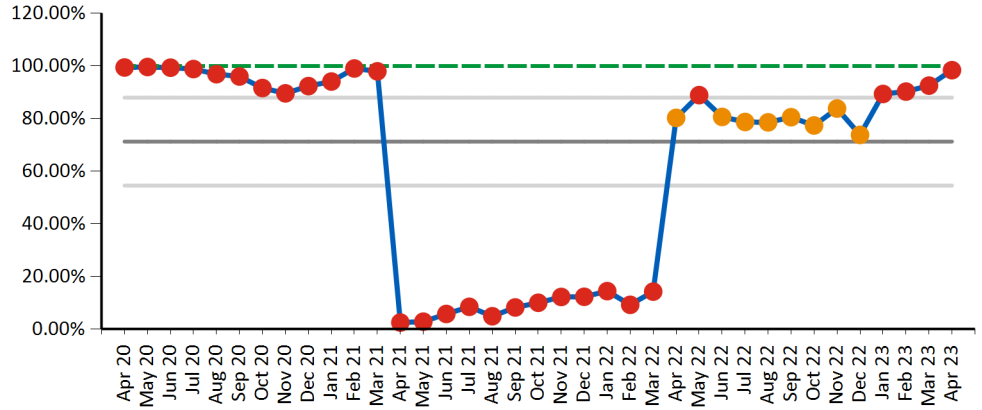


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

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

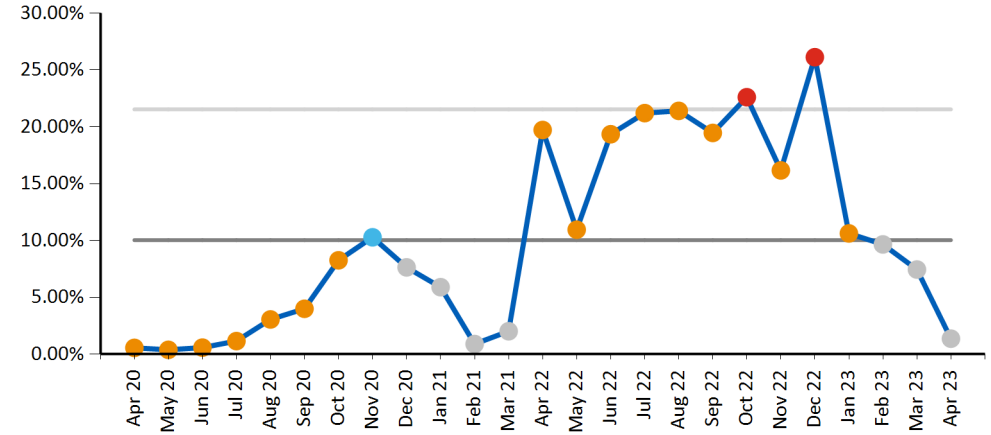


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

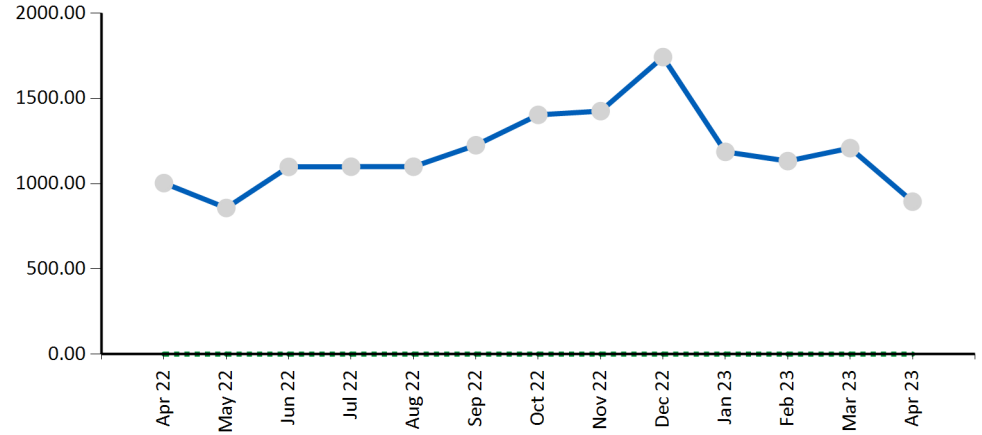
0/6

545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes



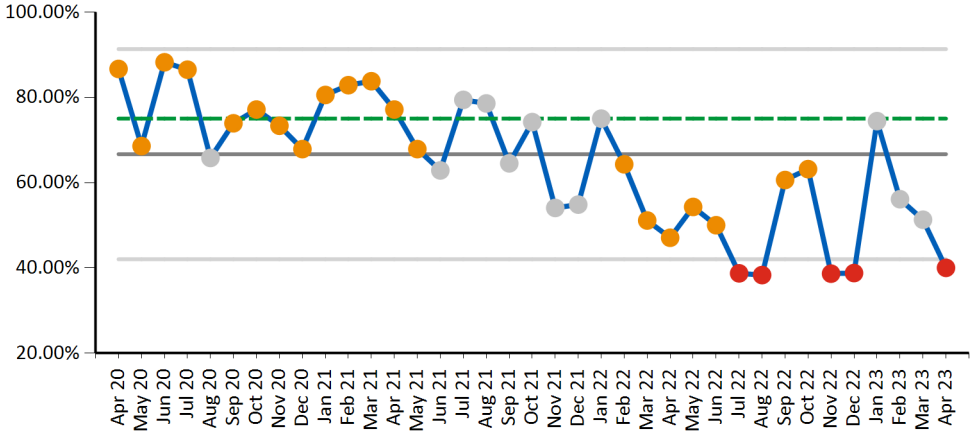
Normal Variation

539 - A&E 12 hour waits - SPC data available after 20 data points



0/6

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

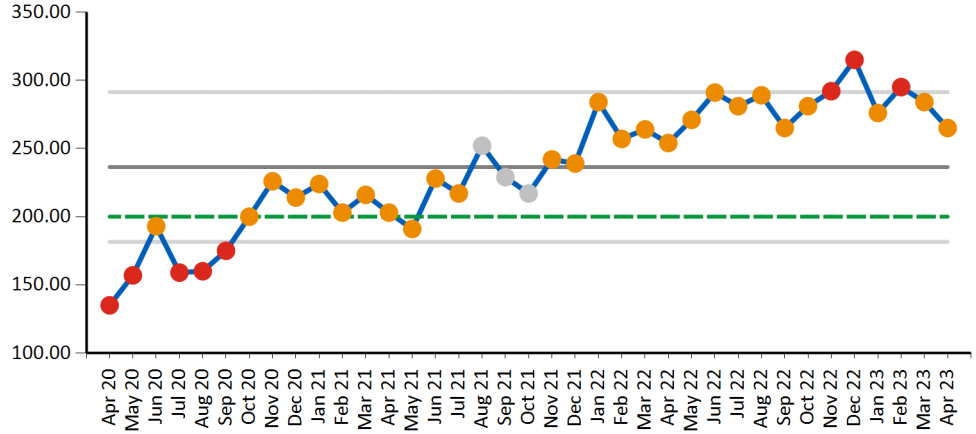


L — Abnormal variation. Target not achieved.

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

0/6

56 - Stranded patients

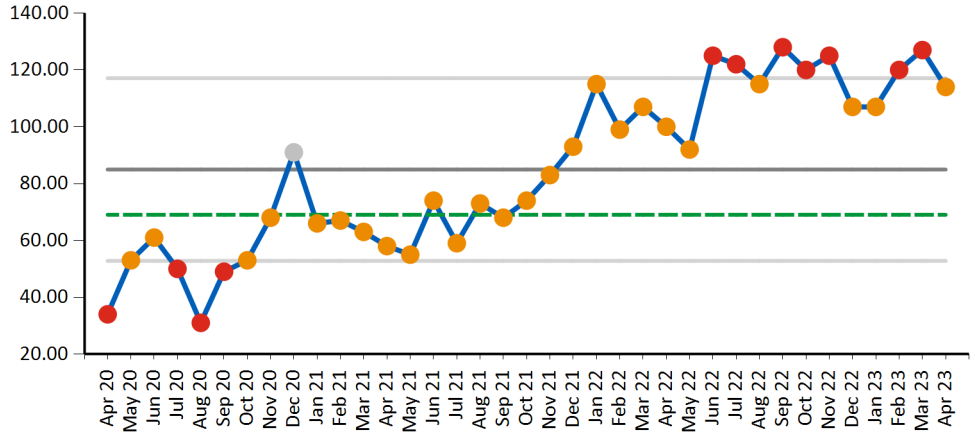


H — Abnormal variation. Target not achieved.

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

0/6

307 - Stranded Patients - LOS 21 days and over

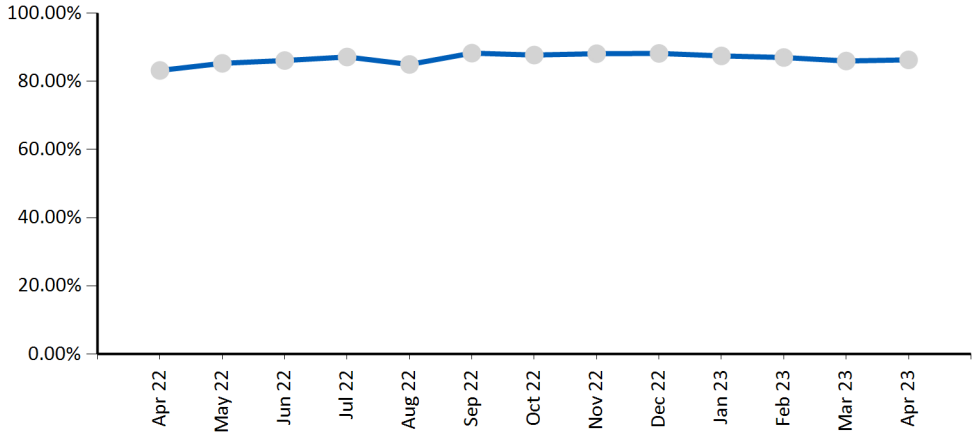


H — Abnormal variation. Target not achieved.

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

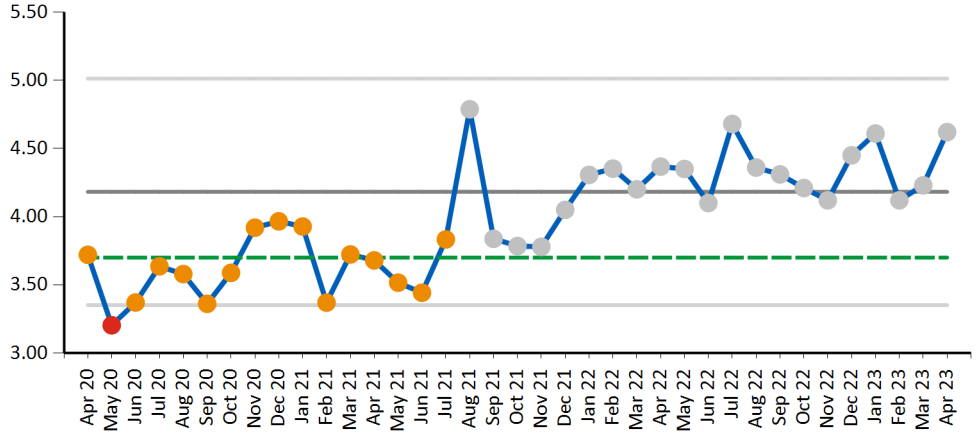
0/6

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



1/6

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

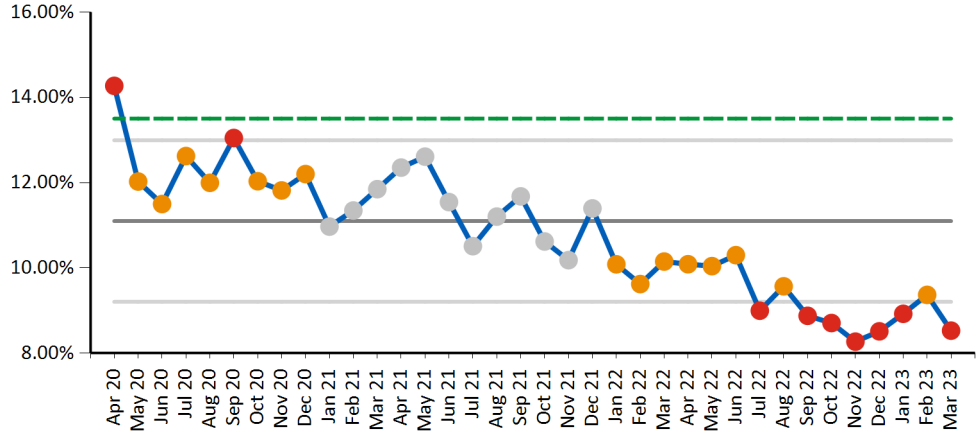


Normal Variation

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

0/6

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



Abnormal variation. Target achieved.

Target will be regularly met.

6/6

Elective Care

Referral to Treatment
In April there was a total of 29 78-week waiters, of these 6 were reportable 78 week breaches due to capacity (5 were due to reduced SLA provision from another provider for paediatric surgery and 1 was due to an incorrect clock-stop in ENT). A further 23 were within the national exclusion criteria (4 due to patient choice and 19 patients who were clinically complex).

The focus continues to be on working to achieve zero 65 week waiting patients by April 2024.
We have a monthly trajectory for theatre capacity to meet this standard and this is being monitored through the Performance and Transformation Board. This will be supported by plans to return theatre productivity to 19/20 levels. Theatre productivity and utilisation continues to be monitored through monthly performance governance processes alongside outpatient efficiency schemes such as PIFU and DNA reduction.

Our overall waiting list size has grown for the 4th consecutive month. This is due to an underlying increase in referrals with a reduction in clock stops over the past two months. The bank holidays plus the impact of the industrial action periods have contributed to reduction in clock stops.

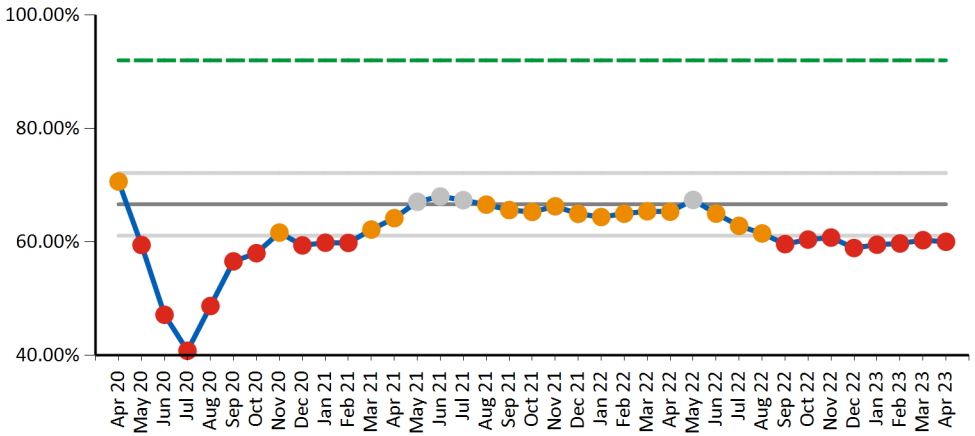
Diagnostics
The DM01 position for the trust has worsened by 8.4% with the final position for the trust standing at 22.3%. The waiting list has decreased by 261 and the number of breaches (775) can be attributed to the below:
• Endoscopy total 29.0%. The majority of the breaches are due to capacity issues in Cystoscopy. Additional clinics have been put in place to recover increase in PTL size in month.
• Physiological Measurements total 31.2% Audiology remains challenged with the additional pressures of 2x Audiologists currently absent exacerbating the capacity constraints. Recovery is pushed back even further to September 2023.
Imaging however has now achieved the target since September 2022.

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

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	60.0%	Apr-23		>= 92%	60.3%	Mar-23	>= 92%	60.0%	
314 - RTT 18 week waiting list	<= 39,264	40,392	Apr-23		<= 25,530	39,752	Mar-23	<= 39,264	40,392	
42 - RTT 52 week waits (incomplete pathways)		1,911	Apr-23			1,801	Mar-23		1,911	
540 - RTT 65 week waits (incomplete pathways)	<= 593	495	Apr-23			409	Mar-23	<= 593	495	
526 - RTT 78 week waits (incomplete pathways)	= 0	29	Apr-23		= 0	31	Mar-23	= 0	29	
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Apr-23		= 0	0	Mar-23	= 0	0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
72 - Diagnostic Waits >6 weeks %	<= 1%	22.4%	Apr-23		<= 1%	13.9%	Mar-23	<= 1%	22.4%	F
489 - Daycase Rates	>= 80%	91.7%	Apr-23		>= 80%	92.4%	Mar-23	>= 80%	91.7%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.8%	Apr-23		<= 1%	2.2%	Mar-23	<= 1%	1.8%	?
62 - Cancelled operations re-booked within 28 days	= 100%	17.2%	Mar-23	L	= 100%	17.9%	Feb-23	= 100%		?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.59	Apr-23		<= 2.00	3.17	Mar-23	<= 2.00	2.59	?

41 - RTT Incomplete pathways within 18 weeks %

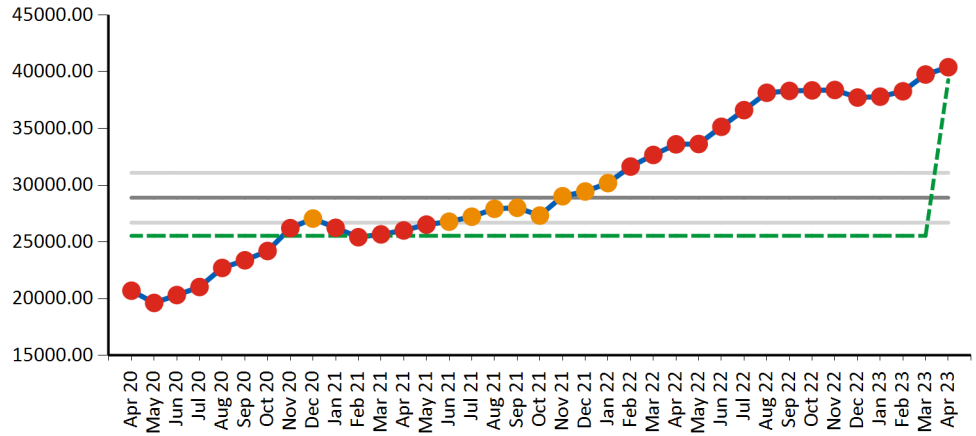


L — Abnormal variation. Target not achieved.

F — We will regularly fail to meet the target.

0/6

314 - RTT 18 week waiting list

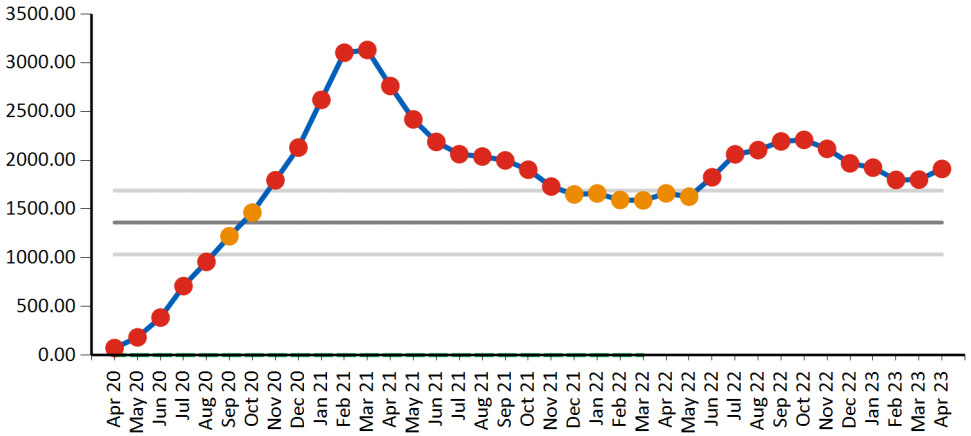


H — Abnormal variation. Target not achieved.

P — Target will be regularly met.

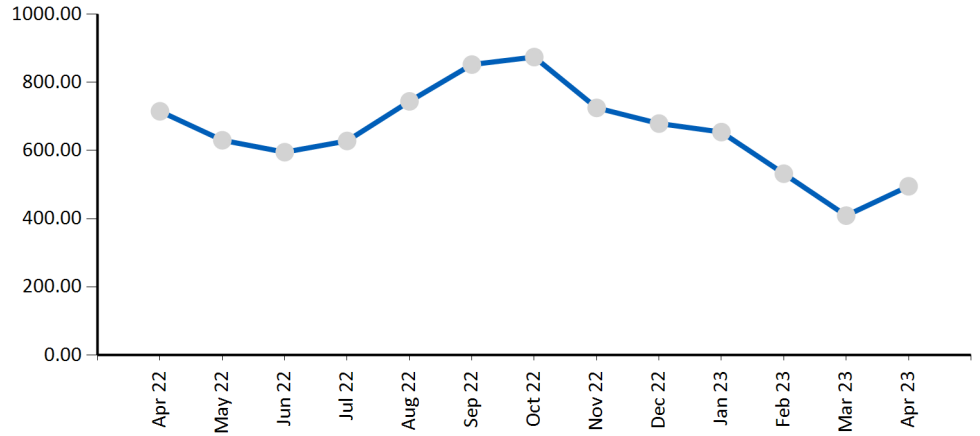
0/6

42 - RTT 52 week waits (incomplete pathways)



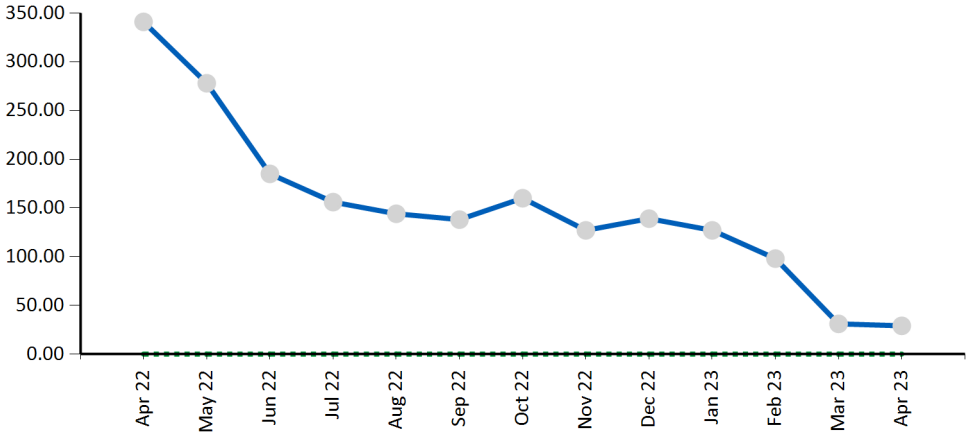
Abnormal variation.
Target not achieved.

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



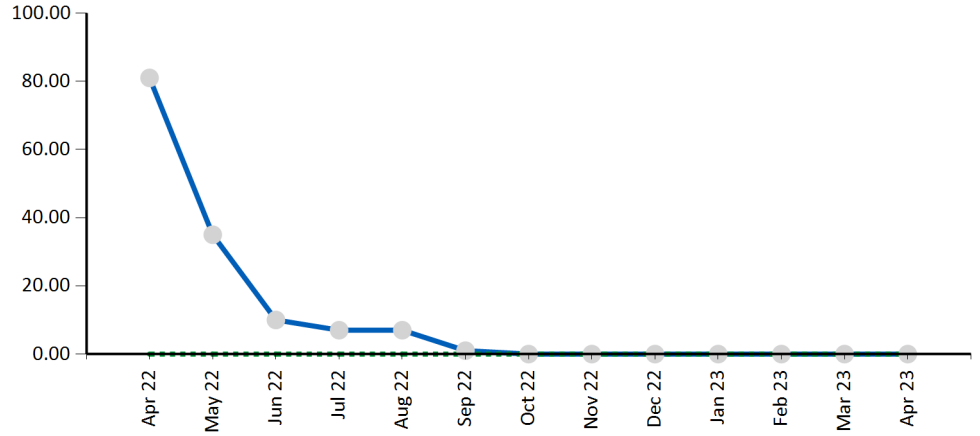
1/6

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



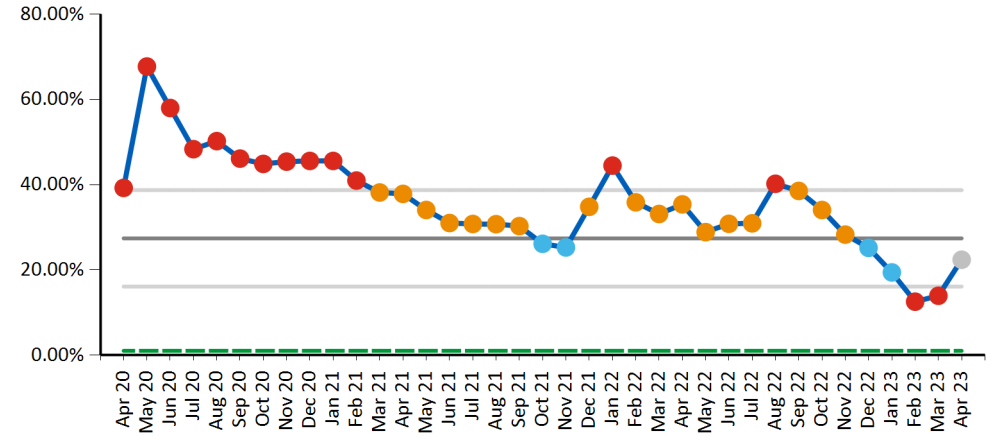
0/6

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



6/6

72 - Diagnostic Waits >6 weeks %

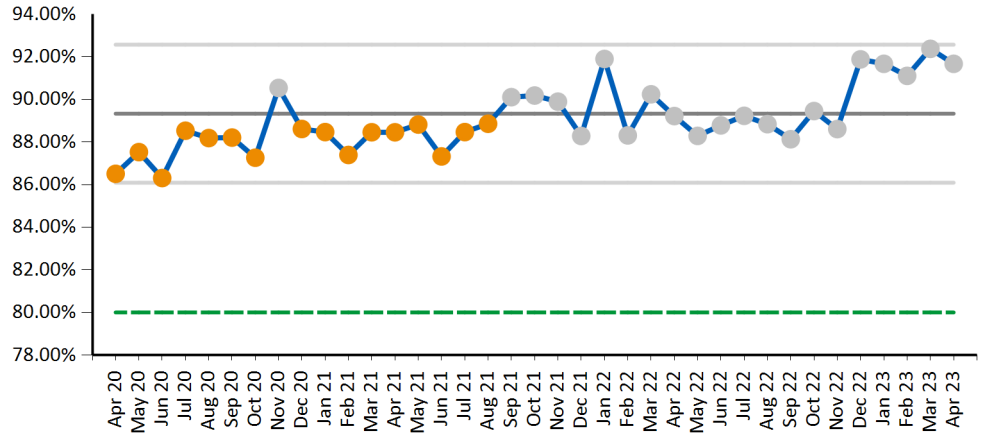


Normal Variation

F — We will regularly fail to meet the target.

0/6

489 - Daycase Rates

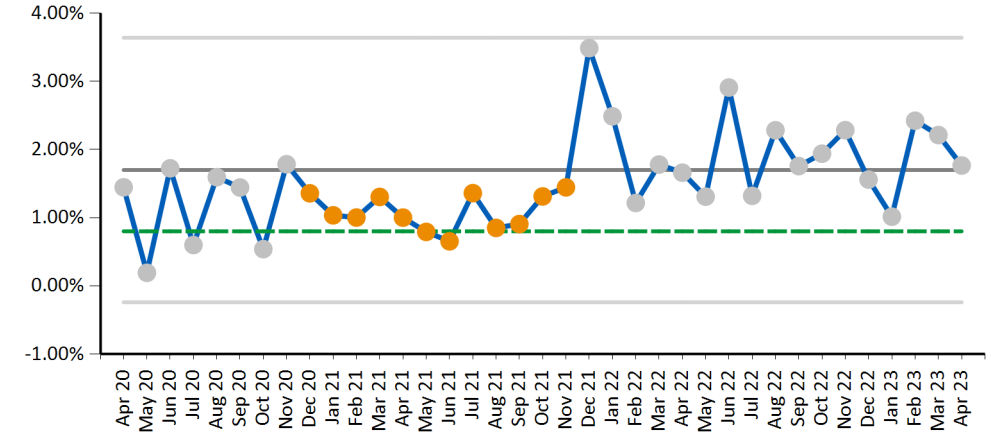


Normal Variation

P — Target will be regularly met.

6/6

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

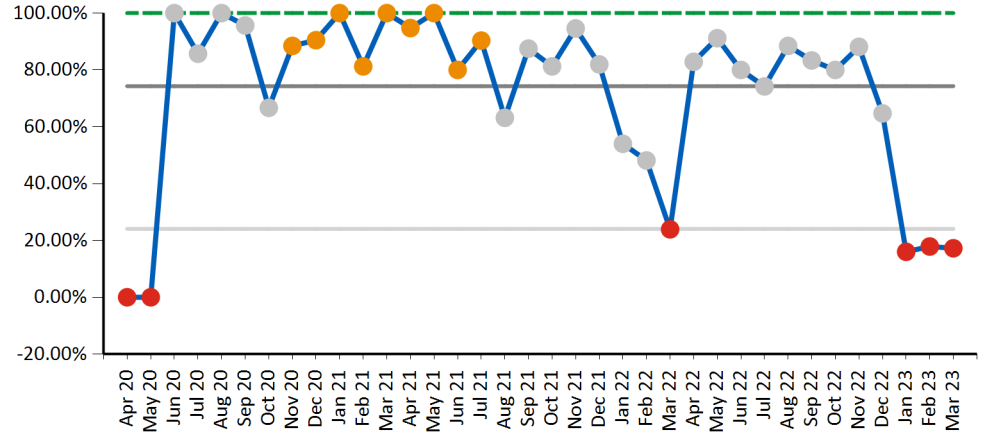


Normal Variation

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

0/6

62 - Cancelled operations re-booked within 28 days

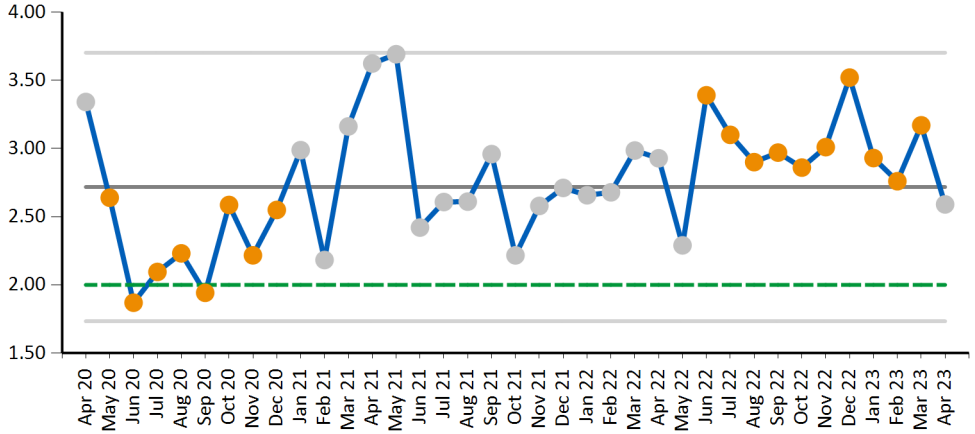


L — Abnormal variation. Target not achieved.

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

0/6

65 - Elective Length of Stay (Discharges in month)



Normal Variation

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

0/6

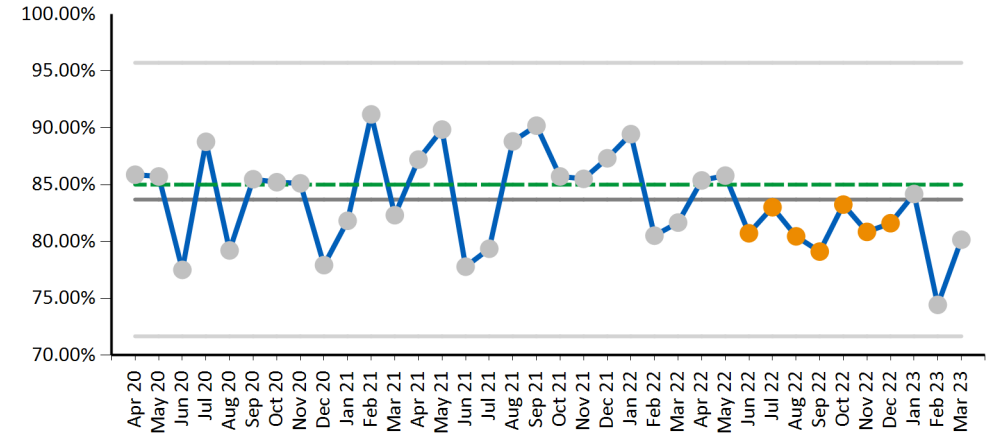
Cancer

Our 2 week wait performance for March was below target at 79.6% this continues to be due to Radiology capacity in Breast services.
We failed the 62 day standard for March with performance at 80.1%, breaches are largely in Urology and Breast. Urology breaches are due to diagnostic delays and a lack of outpatient capacity and Breast breaches are due to delays at the start of the pathway due to the length of wait time for first appointment.

We achieved the Faster Diagnosis standard in March with performance at 79.3%
We achieved our 62 day backlog target of 24 in April with a reduction to 20 patients.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	80.1%	Mar-23		>= 85%	74.4%	Feb-23	>= 85%		
47 - 62 day screening % (1 mth in arrears)	>= 90%	85.0%	Mar-23		>= 90%	85.7%	Feb-23	>= 90%		
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Mar-23		>= 96%	100.0%	Feb-23	>= 96%		
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Mar-23		>= 94%	81.8%	Feb-23	>= 94%		
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%		Mar-23		>= 98%		Feb-23	>= 98%		
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	79.6%	Mar-23	L	>= 93%	80.7%	Feb-23	>= 93%		
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	14.7%	Mar-23		>= 93%	19.0%	Feb-23	>= 93%		F
542 - Cancer: 28 day faster diagnosis		79.3%	Mar-23			84.7%	Feb-23			

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

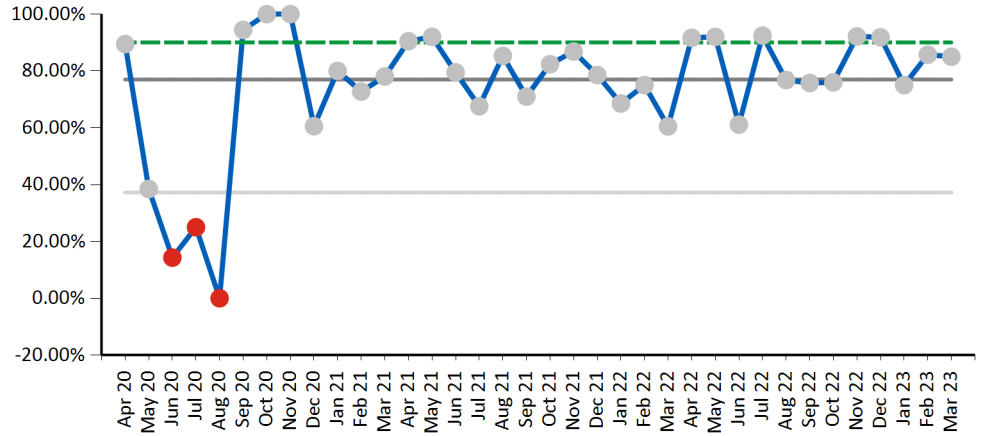


Normal Variation

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

0/6

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

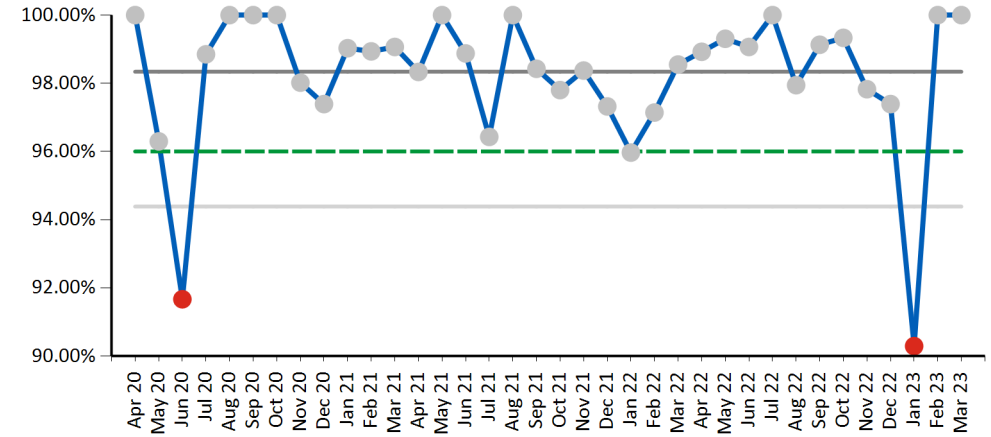


Normal Variation

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

2/6

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

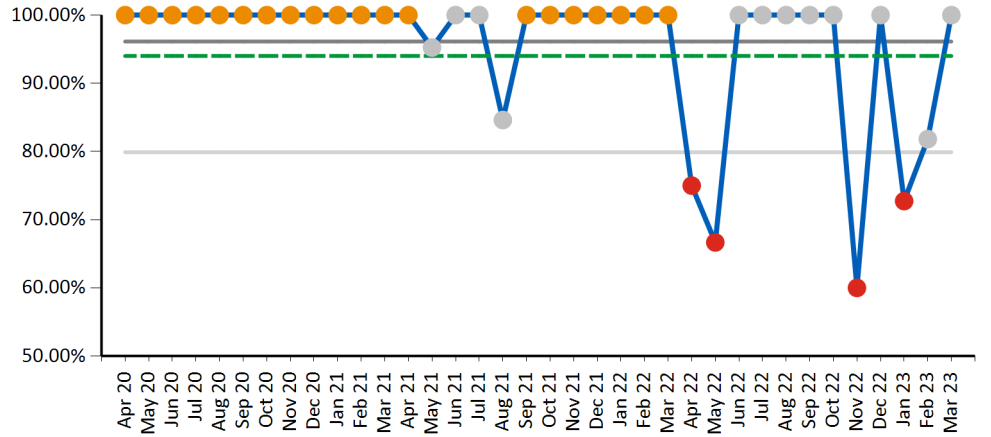


Normal Variation

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

5/6

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

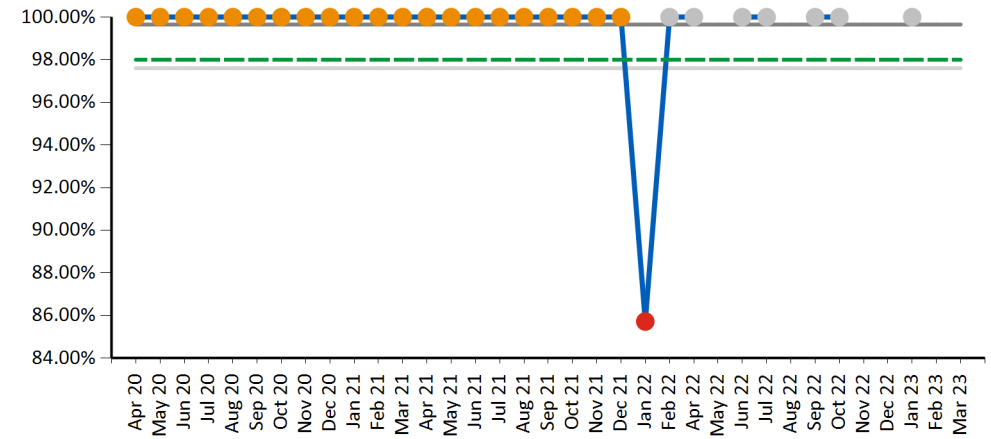


Normal Variation

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

3/6

50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)

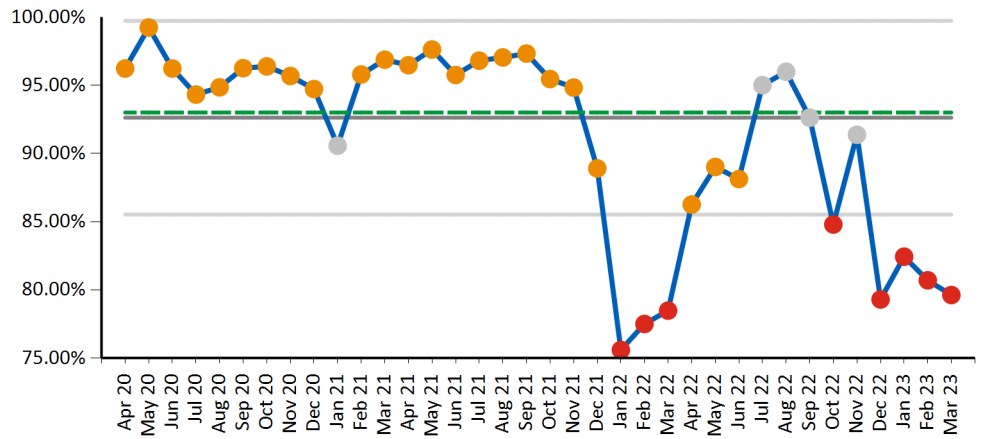


Normal Variation

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

2/6

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

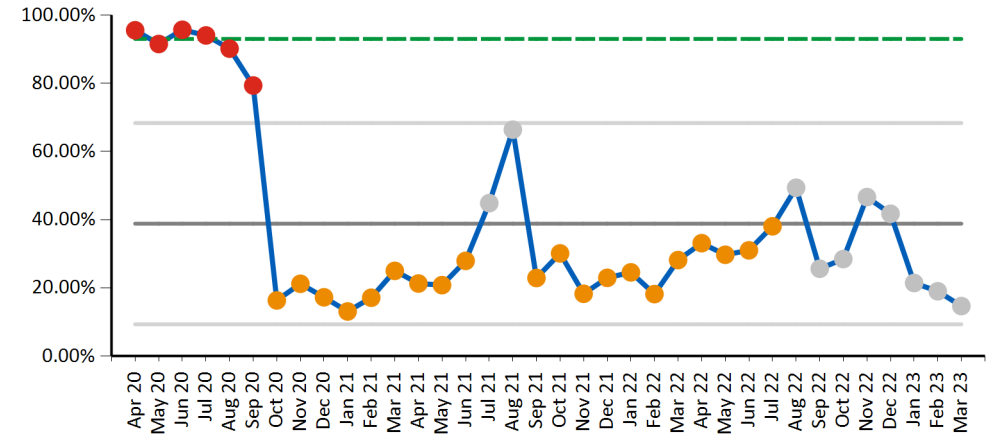


Abnormal variation. Target not achieved.

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

0/6

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

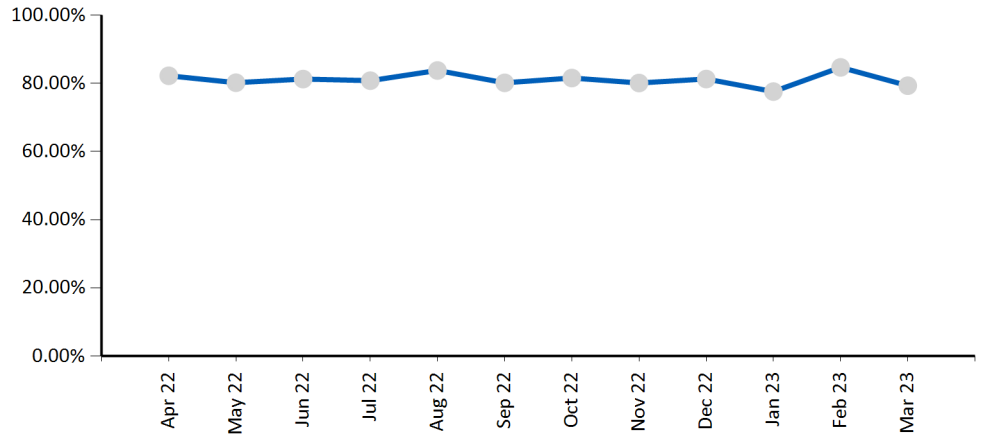


Normal Variation

We will regularly fail to meet the target.

0/6

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



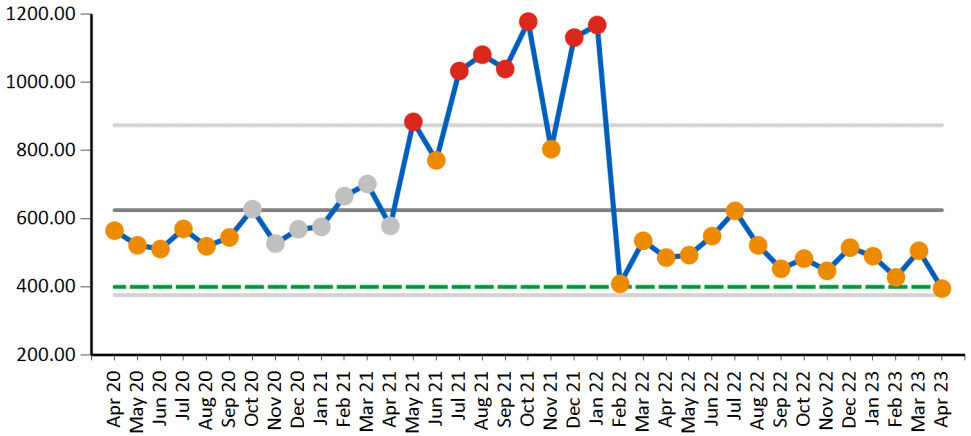
Community Care

Deflections from Emergency Department
We have seen decreased deflections in the emergency department in M1; there has been a noticeable increase in the acuity of patients attending the department which has provided challenges for the Home First Team to identify suitable patients to deflect and support to go home safely. Focused work continues in the admission avoidance team in relation to the urgent care performance with efforts to raise awareness with NWAS and the Primary Care Networks to Think Community First and access the admission avoidance team initially to try and prevent conveyance to the emergency department. A new falls pick up service is being piloted and it is anticipated this will also help prevent avoidable conveyance.

NCTR
We continue to experience pressure in relation to reducing the number of patients at any one time with no Criteria to Reside (NCTR); in M1 NCTR has decreased. Lost bed days in the month of April was an average of 794, a slight increase on M12. For the same time period last year there was an average of 1184 in the same time period; a 33% reduction. Work continues with system partners to support the improvement of this indicator and there is currently specific focus on pathway 1 patients with NCTR in order to support early discharge and also system escalation of those patients who have had NCTR for more than 7 days. Additionally, there has been daily 'super-stranded' meetings to focus on those complex patients with an extended stay with the aim to reduce lost bed days. The commissioned beds at Heathlands for the complex high needs dementia patients has also helped to discharge that cohort of patients for a period of assessment, in a more suitable environment, prior to sourcing a long term placement.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	395	Apr-23	L	>= 400	506	Mar-23	>= 400	395	?
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.83	Apr-23	H	<= 6.00	5.27	Mar-23	<= 6.00	5.83	?
493 - Average Number of Patients: with no Criteria to Reside	<= 55	96	Apr-23	H		101	Mar-23	<= 55	96	F
494 - Average Occupied Days - for no Criteria to Reside		794	Apr-23			648	Mar-23		794	

334 - Total Deflections from ED

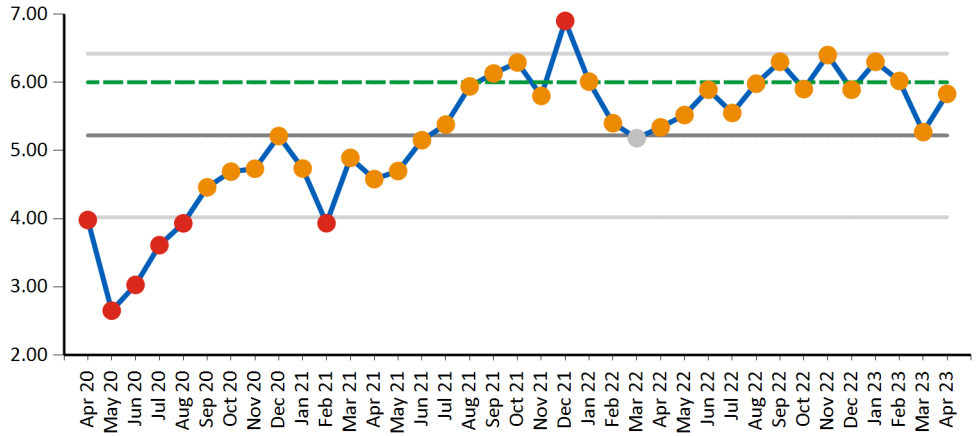


L — Abnormal variation. Target not achieved.

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

5/6

335 - Total Intermediate Tier LOS (weeks)

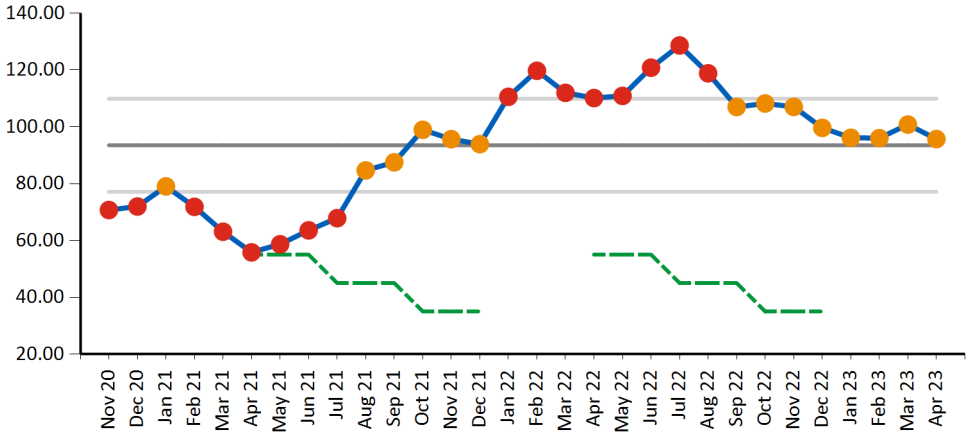


H — Abnormal variation. Target not achieved.

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

3/6

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

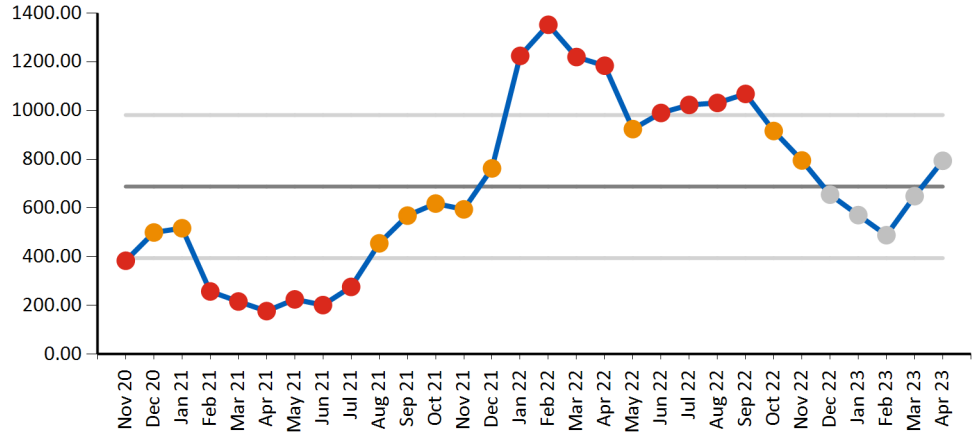


H — Abnormal variation. Target not achieved.

F — We will regularly fail to meet the target.

0/6

494 - Average Occupied Days - for no Criteria to Reside



Normal Variation

Workforce

Sickness, Vacancy and Turnover

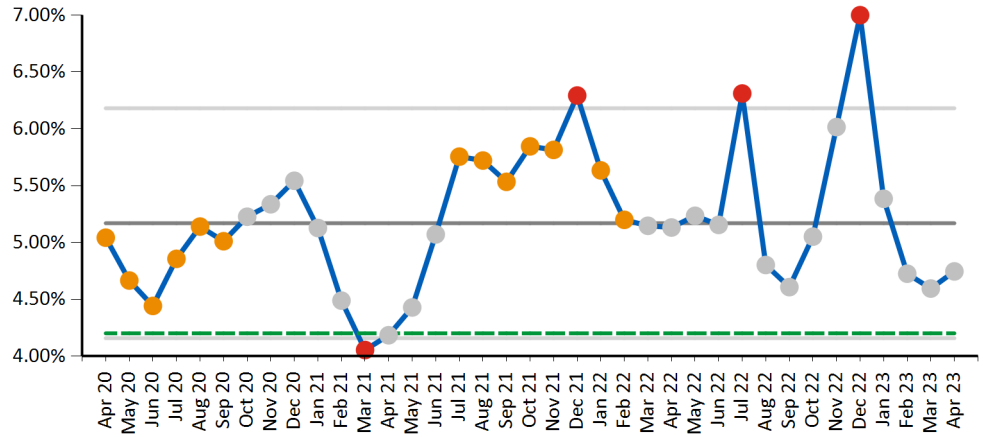
Sickness has increased slightly in April 2023 to 4.75% from 4.59% in March 2023. The DSSD and ICSD Divisions have seen a significant reductions in their levels of absence (1.59% and 0.77% reductions respectively) however this has been offset by increases in other Divisions. The rates of Covid related absence has reduced across all Divisions and now stands at 0.47% compared to 0.87% in March 2023.

Our vacancy levels are slightly above our plan and concerted action continues to ensure we have a full understanding of where our vacancies exist, with robust plans in place to fill these.

Turnover has reduced further in March at 12.86% from 13.23% in March 23, and is the third consecutive month of reducing turnover to the lowest level of turnover in the last 12 months. Turnover remains a focus with the Trust's new People Plan and Divisions will continue to support the reduction in turnover and increased retention of colleagues.

	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%	4.75%	Apr-23		<= 4.20%	4.59%	Mar-23	<= 4.20%	4.75%	?
120 - Vacancy level - Trust	<= 6%	6.39%	Apr-23		<= 6%	5.85%	Mar-23	<= 6%	6.39%	?
121 - Turnover	<= 9.90%	12.86%	Apr-23	H	<= 9.90%	13.23%	Mar-23	<= 9.90%	12.86%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Apr-23	L		0	Mar-23		0	

117 - Sickness absence level - Trust

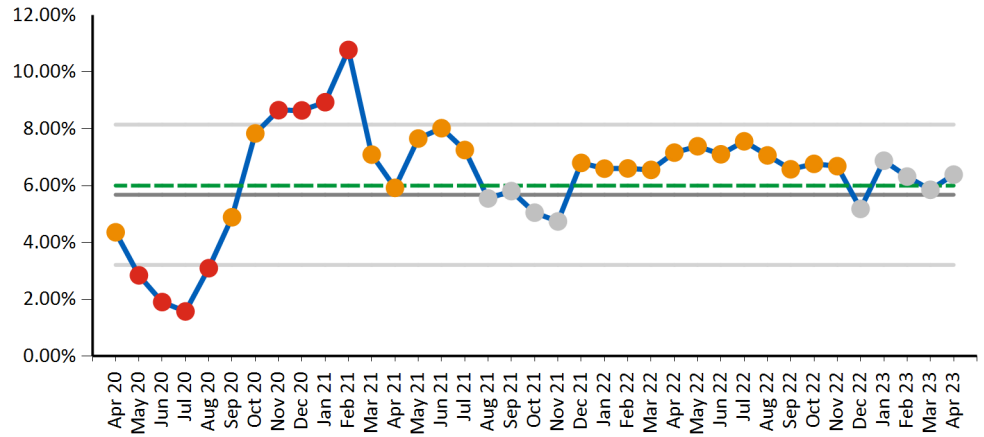


Normal Variation

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

0/6

120 - Vacancy level - Trust

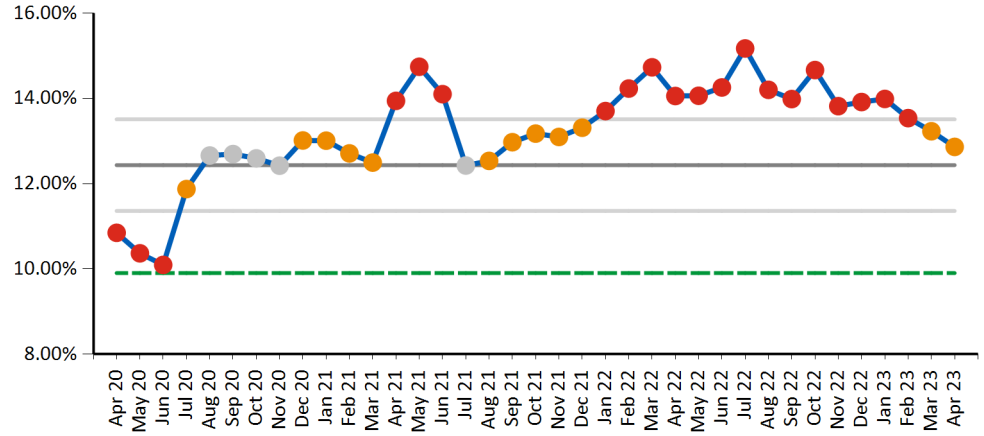


Normal Variation

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

2/6

121 - Turnover

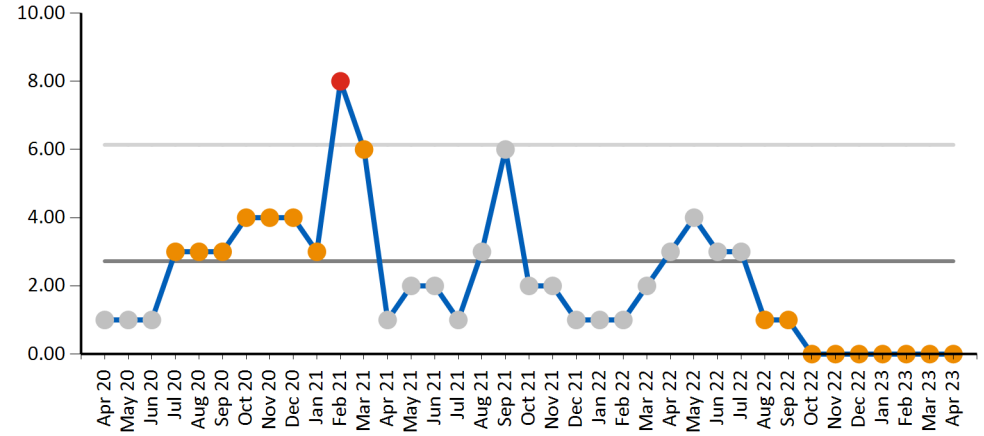


Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

366 - Ongoing formal investigation cases over 8 weeks



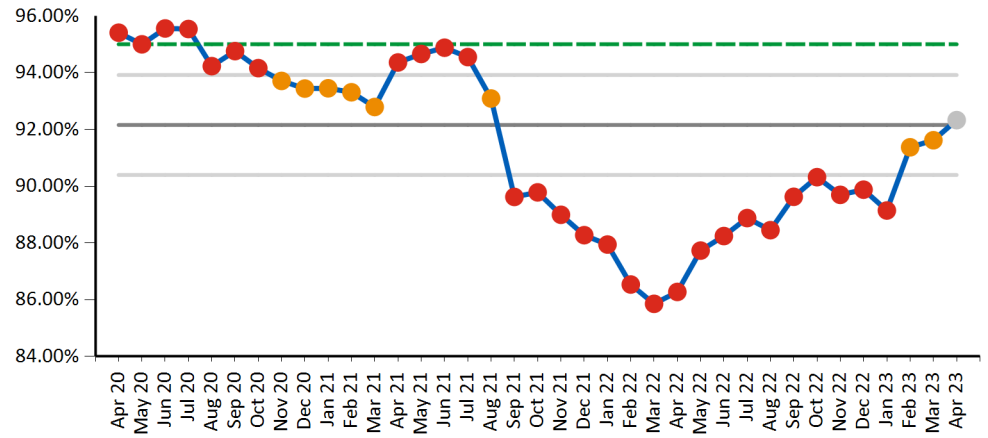
Abnormal variation. Target achieved.

Organisational Development

The Trust's overall compliance level for mandatory training was 86.2% (a 0.9% increase on last month and above our corporate target of 85%) and statutory training was 92.3% (a 0.7% increase from last month and below our corporate target of 95%). A comprehensive MaST Improvement Action Plan was agreed at People Committee on 16 May. Appraisal compliance has increased by 0.5% this month and is now at 85.5%, 0.5% above the 85% target.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	92.3%	Apr-23		>= 95%	91.6%	Mar-23	>= 95%	92.3%	F
38 - Staff completing Mandatory Training	>= 85%	86.2%	Apr-23	L	>= 85%	85.3%	Mar-23	>= 85%	86.2%	P
39 - Staff completing Safeguarding Training	>= 95%	93.76%	Apr-23		>= 95%	93.23%	Mar-23	>= 95%	93.76%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.5%	Apr-23	H	>= 85%	84.1%	Mar-23	>= 85%	85.5%	F
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	62.0%	Q3 2022/23		>= 66%	72.8%	Q2 2022/23	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	60.3%	Q3 2022/23		>= 80%	73.3%	Q2 2022/23	>= 80%		F

37 - Staff completing Statutory Training

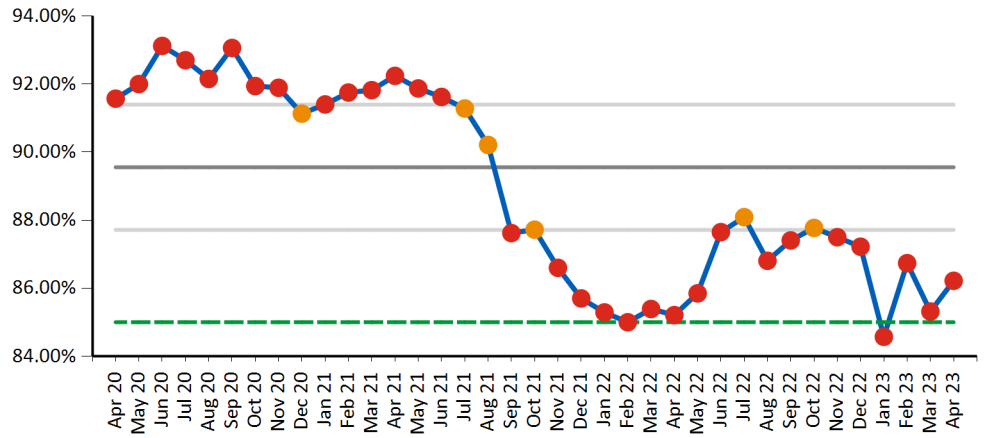


Normal Variation

F — We will regularly fail to meet the target.

0/6

38 - Staff completing Mandatory Training

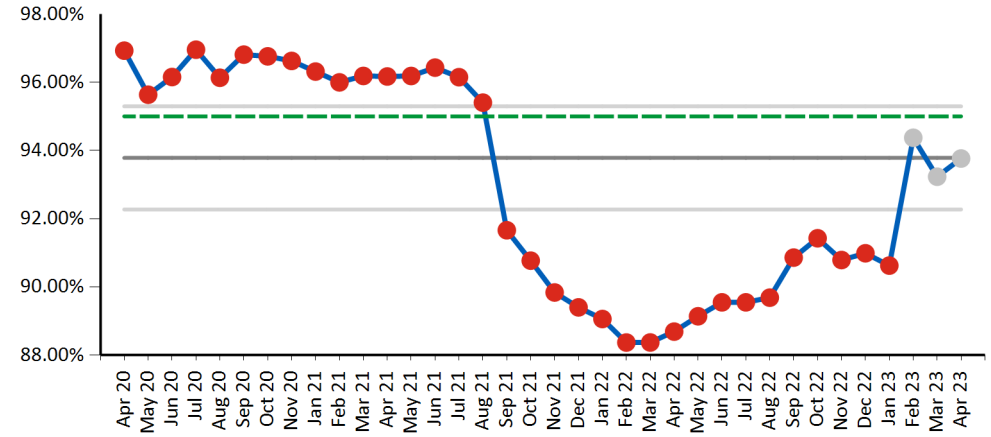


L — Abnormal variation. Target not achieved.

P — Target will be regularly met.

5/6

39 - Staff completing Safeguarding Training

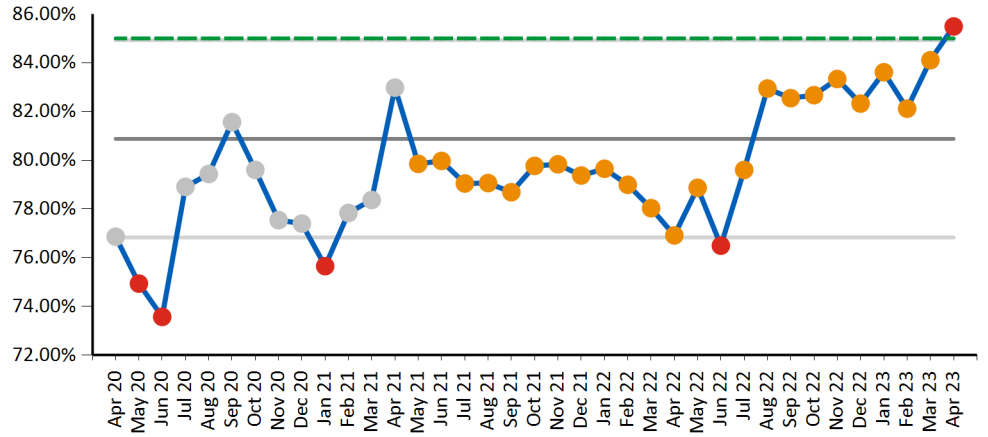


Normal Variation

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

0/6

101 - Increased numbers of staff undertaking an appraisal

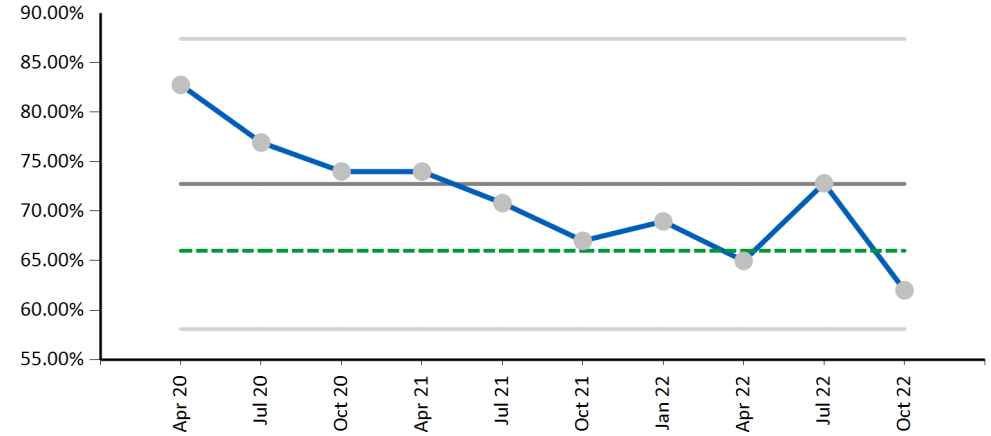


Abnormal variation. Target achieved.

We will regularly fail to meet the target.

1/6

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

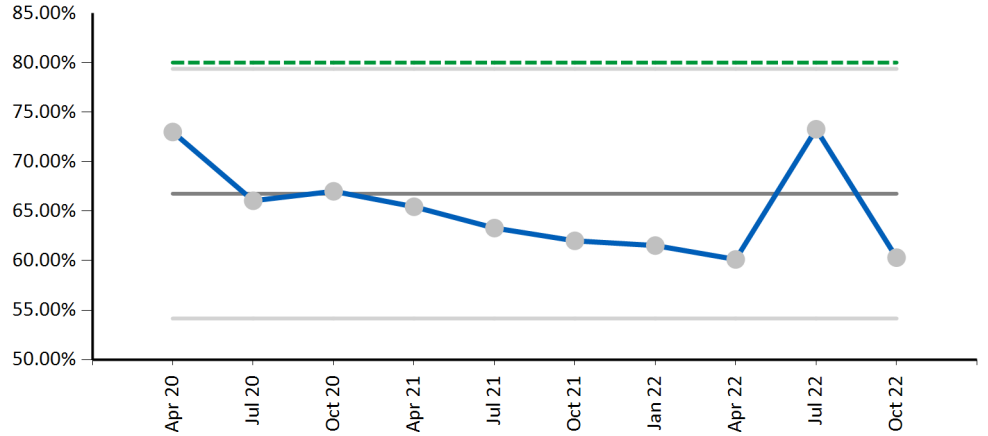


Normal Variation

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

4/6

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



Normal Variation

We will regularly fail to meet the target.

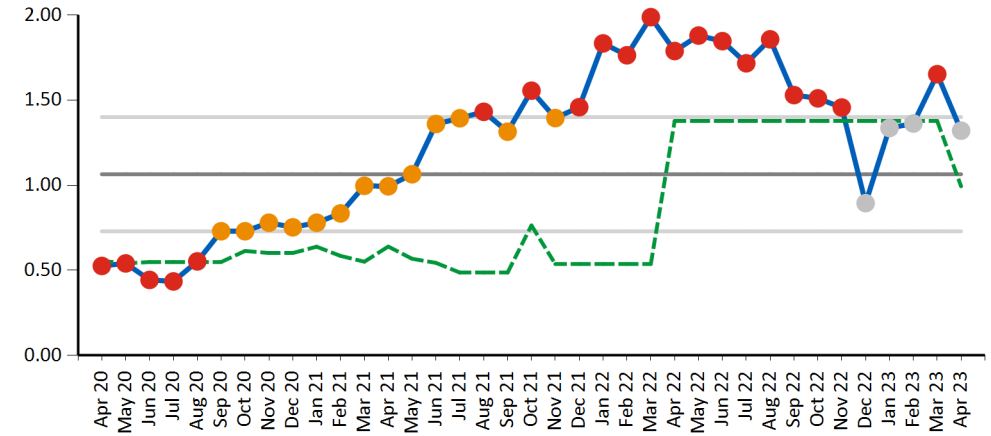
0/6

Agency

Agency spend was slightly above expectation in M1 2023/2024 and this was, in the main, driven by increased medical agency expenditure in support of the Trusts response to the Junior Doctors industrial action which took place between 11th and 15th April.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.99	1.32	Apr-23		<= 1.38	1.65	Mar-23	<= 0.99	1.32	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.49	0.52	Apr-23	H	<= 0.68	0.70	Mar-23	<= 0.49	0.52	?
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.39	0.77	Apr-23	H	<= 0.62	0.82	Mar-23	<= 0.39	0.77	?

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

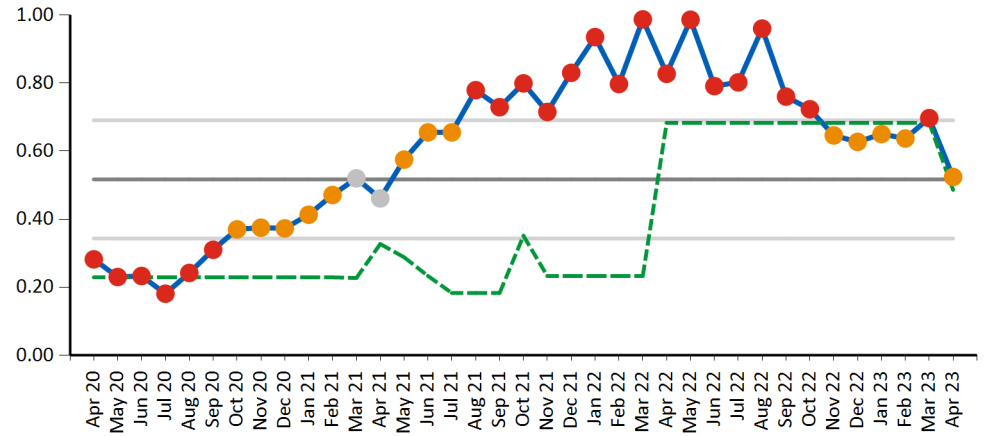


Normal Variation

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

3/6

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

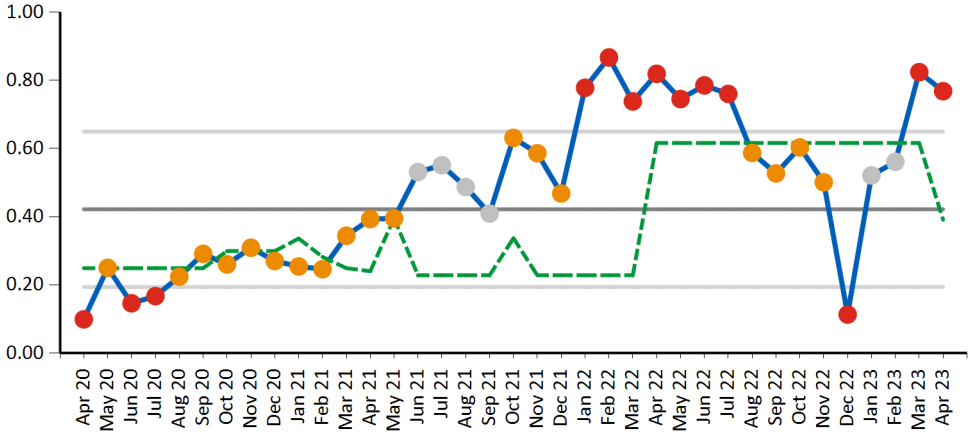


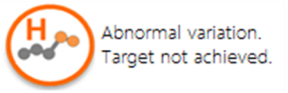
Abnormal variation. Target not achieved.

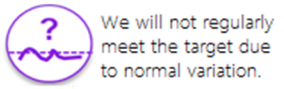
We will not regularly meet the target due to normal variation.

4/6

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







Finance

Finance

Revenue Performance
The Trust has a deficit plan of £12.4m for 23/24
In Month 1, the Trust recorded an actual deficit of £1.7m compared to a planned deficit of £1m. Arranging additional medical cover for the junior doctor industrial action contributed to this adverse variance.

Forecast
The probable forecast scenario suggests a deficit of £8.0m deficit against a plan of £12.4m.
This assumes £11m of CIP savings against a target of £19.3m.

Cost Improvement
The Trust has cost improvement of 4% of £19.3m for 23/24.
CIP trackers currently suggest savings of £10.4m have been identified.

Variable Pay
The Trust spent £4.6m on variable pay in Month 1 compared to a monthly average of £4.1m in 22/23.
The trust is required to spend no more than 3.7% of total pay costs on agency in 23/24 which is £1m per month. £1.4m was spent on agency in Month 1, representing 4.6% of total pay costs.

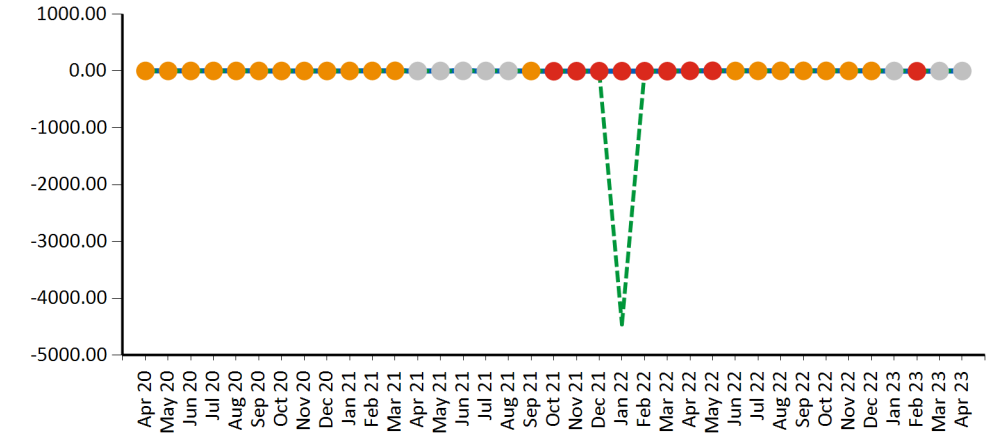
Capital Spend
The Trust has a planned capital spend for 23/24 of £21.6m
£0.2m of capital was spent in Month 2.

Cash Position
Month end cash balance of £45.3m

Better Payment Practices Code
Performance of 95.0% in month against target of 95%.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.0	-1.7	Apr-23		>= 1.0	-2.0	Mar-23	>= -1.0	-1.7	
222 - Capital (£ millions)	>= 0.7	0.2	Apr-23		>= 4.3	23.7	Mar-23	>= 0.7	0.2	
223 - Cash (£ millions)	>= 49.3	45.3	Apr-23		>= 36.6	58.2	Mar-23	>= 49.3	45.3	

220 - Control Total (£ millions)

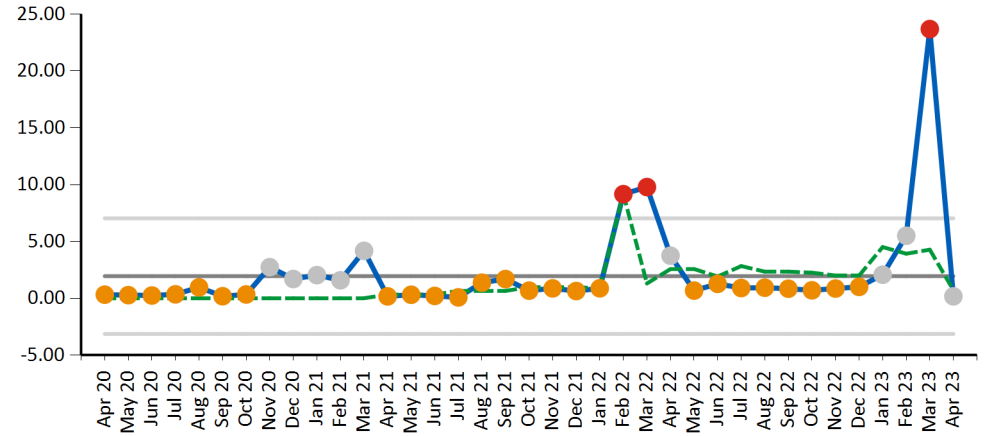


Normal Variation

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

0/6

222 - Capital (£ millions)

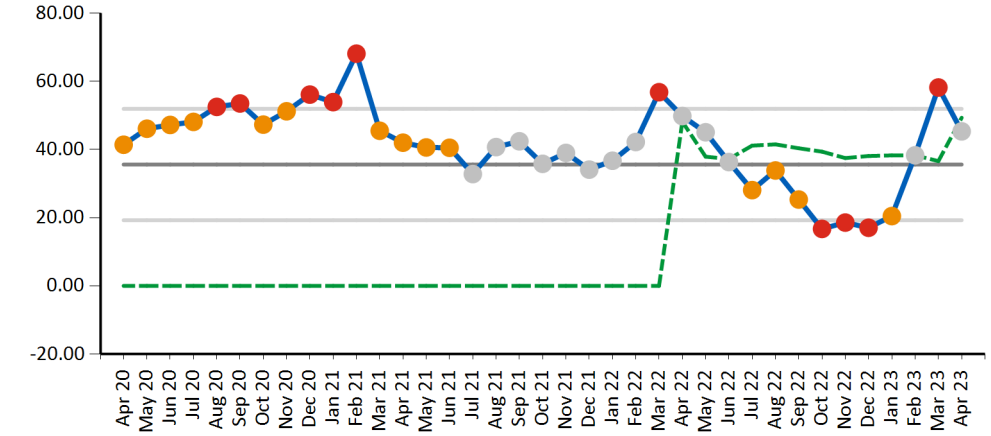


Normal Variation

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

2/6

223 - Cash (£ millions)



Normal Variation

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

2/6

Report Title:	2022 NHS Staff Survey Results and Staff Experience Action Plan

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	26 May 2023		Discussion	
Exec Sponsor	James Mawrey		Decision	

Purpose	To update the Board of Directors on the Trust's 2022 NHS national staff survey results and associated Trust-wide Staff Experience Action Plan.

Summary:	Bolton NHS FT has performed strongly in the 2022 NHS national staff survey, achieving for the fifth year running, the highest overall staff engagement score compared to other acute and acute and community Trusts in Greater Manchester. This report provides an overview of the Trust's 2022 NHS national staff survey results (the full benchmark report can be found online here). 2081 employees took part in the survey which equated to a 35.7% response rate (3.2% lower than last year) however, the sample size had also increased. Our results are overall positive and despite some declines; we remain largely above the comparator average. This is a testament to the work taking place at all levels across the organisation to continually improve our organisational culture and staff experience. We have scored above average on the seven elements of the People Promise and the two themes of staff engagement and morale when compared to our national benchmarking group (124 acute and acute & community Trusts). A high-impact communications plan is being implemented from March onwards with an emphasis on celebrating the results obtained, thanking staff for their hard work, and looking at ways to engage with colleagues to help the Trust become an even greater place to work for all. In addition, this report provides an update on the Trust's high-level Staff Experience Plan developed by the OD Team which addresses Trust-wide areas of concern and amplifies examples of good practice from the 2022 NHS national staff survey results. It is important that the staff survey results are viewed in the context of other HR metrics, workforce data and other plans and priorities at a local level however the Staff Experience Plan outlines the activity happening Trust-wide to continue to make Bolton NHS FT a great place to work.

Previously considered by:
This report was presented at the People Committee prior to submission at Board.

Proposed Resolution	The Board of Directors are asked to **receive** and note this report.

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

Prepared by:	Laura Smoult, Staff Experience Manager	**Presented by:**	James Mawrey, Director of People / Deputy Chief Executive

1. Background

1.1 Bolton NHS FT has performed strongly in the 2022 NHS national staff survey, achieving for the fifth year running, the highest overall staff engagement score compared to other acute and acute and community Trusts in Greater Manchester.

1.2 This report provides an overview of the Trust's 2022 NHS national staff survey results. 2081 employees took part in the survey which equated to a 35.7% response rate (3.2% lower than last year) however, the sample size had also increased.

1.3 Our results are overall positive and despite declines; we remain largely above the comparator average. This is a testament to the fantastic work undertaken by senior leaders, divisions and enabling services to improve our organisational culture and staff experience.

1.4 We have scored above average on the seven elements of the People Promise and the two themes of staff engagement and morale when compared to our national benchmarking group (124 acute and acute & community Trusts).

1.5 A high-impact communications plan is being implemented from March onwards with an emphasis on celebrating the results obtained, thanking staff for their hard work, and looking at ways to engage with colleagues to help the Trust become an even greater place to work for all.

1.6 In addition, this report provides an update on the Trust's high-level Staff Experience Plan developed by the OD Team which addresses Trust-wide areas of concern and amplifies examples of good practice from the 2022 NHS national staff survey results.

2. Key Survey Findings – Bolton NHS Foundation Trust vs. national position

2.1 The 2022 NHS national staff survey results are a fantastic achievement for the Trust and we largely sit in between the best and worst scores and above the benchmarking group average for all of the People Promise elements and themes. This is shown in **Figure One** below.

Figure One – Bolton NHS Foundation Trust People Promise elements and themes scores

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.4	6.0	6.9	6.0	5.6	6.1	6.9	7.0	5.9
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2076	2028	2022	2071	1995	2020	2069	2077	2077

2.2 The full benchmark report can be found online here where the results of the NHS national staff survey are measured against the seven People Promise elements and against the two themes of staff engagement and morale. The reporting also includes sub-scores, which feed into the People Promise elements and themes.

2.3 In summary, when we look at our Trust's scores across the NHS Staff Survey Co-ordination Centre benchmarking group, our Trust has scored higher than the average scores for the seven People Promise elements and against the two themes of staff engagement and morale as shown in **Figure Two** below.

Figure Two: Trust's overall elements and theme scores compared to our benchmarking group

People Promise Element	2022	2022 Benchmarking Group Average Score	Difference
We are compassionate and inclusive	7.4	7.2	+0.2
We are recognised and rewarded	6.0	5.7	+0.3
We each have a voice that counts	6.9	6.6	+0.3
We are safe and healthy	6.0	5.9	+0.1
We are always learning	5.6	5.4	+0.2
We work flexibly	6.1	6.0	+0.1
We are a team	6.9	6.6	+0.3
Theme	**2022**	**2022 Benchmarking Group Average Score**	**Difference**
Staff Engagement	7.0	6.8	+0.2
Morale	5.9	5.7	+0.2

2.4 Overall, these scores are impressive and evidences the increased focus the Trust has given to recognise and thank colleagues, our staff engagement plans to ensure that employee voice is listened to and action taken as a result and an ethos of great team working across the Trust.

2.5 When comparing our results nationally, we are positioned 21st out of 124 acute and acute & community Trusts (in the top 17%) which is slightly down on last year's position of 16th out of 122 acute and acute & community Trusts.

2.6 When looking at individual question scores, the table shown in **Figure Three** below shows our Trust's position when compared to our benchmarking group with the Trust having scored higher on 77% of questions (80 questions) and the Trust scoring lower on 12% of questions (13 questions).

Figure Three: Trust Performance vs. NHS Staff Survey Co-ordination Centre benchmarking group

Performance vs Survey Co-ordination Centre comparator group (124 Trusts)	
109 Questions	
Higher	77% (80 questions)
Same	11% (11 questions)
Lower	12% (13 questions)

2.7 A breakdown of the individual questions scores can be seen in the comparison chart in **Appendix One**. This shows the Trust variance from the benchmarking group as a whole at an individual question level and also shows which questions have deteriorated, improved or stayed the same when compared to our 2021 NHS national staff survey results.

3. Key Survey Findings – Bolton NHS Foundation Trust vs. position in GM

3.1 **Figure Four** below shows how we have performed against other NHS Trusts across Greater Manchester. Highlighted in yellow are the highest scores achieved for each of the elements and themes. It is really positive to see that we have achieved the best scores in six out of the nine NHS People Promise elements and themes.

Figure Four: 2022 NHS national staff survey elements and theme scores across Greater Manchester NHS Trusts

Trust	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Bolton FT	7.4	6.0	6.9	6.0	5.6	6.1	6.9	7.0	5.9
Tameside FT	7.2	5.9	6.7	6.0	5.4	6.2	6.7	6.8	5.8
Stockport FT	7.2	5.8	6.7	5.8	5.4	6.1	6.7	6.7	5.7
Northern Care Alliance	7.2	5.7	6.7	5.9	5.2	6.0	6.6	6.7	5.7
Wrightington, Wigan & Leigh FT	7.2	5.8	6.7	6.1	5.1	6.3	6.7	6.9	6.0
Manchester FT	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Overall Benchmark Group Score	***7.2***	***5.7***	***6.6***	***5.9***	***5.4***	***6.0***	***6.6***	***6.8***	***5.7***

3.2 As mentioned above, we have achieved for the fifth year running, the highest overall staff engagement score compared to other acute and acute and community Trusts in Greater Manchester. Although this is something we are very proud of, when we look at this trend over the past five years, we have seen a year on year decline of this score as shown in red in **Figure Five** below. We can also see in 2022 that the gap is closing with other Greater Manchester NHS Trusts not very far behind us.

Figure Five: Staff Engagement Theme Scores 2018-2022

	2018	2019	2020	2021	2022
Bolton FT	7.3	7.3	7.2	7.1	7.0
Tameside FT	7.1	7.0	6.8	6.6	6.8
Stockport FT	6.9	6.9	6.8	6.8	6.7
Northern Care Alliance	N/A	N/A	N/A	N/A	6.7
Wrightington, Wigan & Leigh FT	7.1	7.3	7.1	7.0	6.9
Manchester FT	7.1	7.1	7.0	6.7	6.5
Overall Benchmark Group Score	**7.0**	**7.0**	**7.0**	**6.8**	**6.8**

4. Key Survey Findings – comparison to Trust's 2021 results

4.1 Whilst we are really pleased that the Trust benchmarks well when compared to the national benchmarking group average, it is acknowledged that our scores have deteriorated when compared to our 2021 NHS national staff survey results. This can be seen in **Figure Six** below.

Figure Six: People Promise Elements and Themes – Trust's 2021 scores vs. Trust 2022 scores

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.5	2189	7.4	2076	Not significant
We are recognised and rewarded	6.2	2117	6.0	2028	Significantly lower
We each have a voice that counts	7.0	2158	6.9	2022	Not significant
We are safe and healthy	6.1	2171	6.0	2071	Not significant
We are always learning	5.5	2106	5.6	1995	Not significant
We work flexibly	6.2	2110	6.1	2020	Not significant
We are a team	6.9	2174	6.9	2069	Not significant
Themes					
Staff Engagement	7.1	2191	7.0	2077	Significantly lower
Morale	6.0	2190	5.9	2077	Significantly lower

4.2 It can be seen from **Figure Six** above that our scores relating to we are recognised and rewarded, staff engagement and morale are significantly lower when compared to the Trust's 2021 NHS national staff survey results. Within the People Promise element of we are recognised and rewarded, the largest question decrease is colleague satisfaction with level of pay (40% to 31%), although question scores have also decreased for the recognition colleagues get for good work, the extent to which the organisation values colleagues' work and immediate managers valuing colleagues' work. **Figure Seven** below summarises how many questions have improved, declined and stayed the same.

Figure Seven: We are recognised and rewarded elements and theme results

We are recognised and rewarded	
5 questions	
Higher	1 question
Same	0 questions
Lower	4 questions

4.3 When looking at the theme of Staff Engagement, we have seen decreases in all nine questions, which are categorised under three aspects of scores relating to Motivation, Involvement and Advocacy. As part of these scores, we have seen decreases to recommending as a place to work and happiness with the standard of care provided by the organisation.

4.4 When looking at the theme of Morale, we have seen increases to more colleagues thinking about leaving, negative decreases relating to work pressure and colleagues being involved in changes relating to their work area, team or department. In addition, there are decreases to question scores for colleagues having a choice in deciding how to do their work, relationships at work being strained, receiving respect from colleagues and immediate managers encouraging colleagues at work. **Figure Eight** below summarises how many questions have improved, declined and stayed the same.

Figure Eight: Morale elements and theme results

Morale	
13 questions	
Higher	1 question
Same	1 question)
Lower	11 questions

4.5 These declines in scores will be addressed and relevant actions developed as part of the Trust's Staff Experience Action Plan relating to more frequently recognising our colleagues and delivering tailored staff morale boosting initiatives/interventions with divisions and teams.

5. Key Survey Findings – what our staff survey results are telling us

5.1 In summary the top five areas of success and focus from the Trust's 2022 NHS national staff survey results are shown in **Figure Nine** below.

Figure Nine – Top five areas of success and top five areas of focus

	Top 5 Success:	Top 5 Focus:
1.	Trusted and empowered to do your job (91%)	Recommend as a place for care (62% which is a 6% decrease)
2.	My role makes a real difference (88%)	Experienced discrimination on the grounds of ethnic background (increase of 8% to 39%)
3.	Encouraged to report errors, near misses or incidents (88%)	Satisfied with opportunities to work flexibly (56% - same as 2021 but a 4% decrease from 2020)
4.	Enjoy working with colleagues in my team (83%)	Empowered to make improvements in my area (56% which is a 3% decrease)
5.	Staff Engagement – still best in GM for comparative Trusts (7.0)	Level of Pay satisfaction (down 9% to 31%).

5.2 When we compare our 2022 NHS national staff survey results to last year's results, **Figure Ten** below shows the two questions that have most improved and the two questions which have most deteriorated.

Figure Ten: Most improved and most deteriorated two questions when compared to our 2021 NHS national staff survey results

Theme	Question	2021 % score	2022 % score	Variance
Your Health, Wellbeing and Safety at Work	16c (02) 'On what grounds have you personally experienced discrimination at work – Gender'	31%	21%	↓ 10%
Your Personal Development	21b Regarding Appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review – 'It helped me to improve how I do my job'	18%	21%	↑ 3%
Your Job	4c 'My level of pay' (% of staff selecting 'Satisfied' or 'Very Satisfied')	39%	29%	↓ 10%
Your Health, Wellbeing and Safety at Work	16c (01) 'On what grounds have you experienced discrimination – Ethnic background'	31%	39%	↑ 8%

5.3 It can be seen from the above table where our Trust has made some real improvements around staff experience in some of the grounds relating to discrimination and an improved score relating to appraisals helping colleagues to improve how they do their jobs which is really positive to see. Areas for improvement are staff experiencing discrimination on the grounds of ethnic background and overall colleagues feeling unhappy with their level of pay.

5.4 When looking across the Divisions, **Figure Eleven** below shows the 2022 NHS national staff survey results People Promise elements and theme scores benchmarked against the national benchmarking group average. It can be seen across the Divisions that we are largely above or equal to our benchmarking group average with only Diagnostics and Support and Acute Adult Divisions having scored more than 0.2 below the national benchmarking group average.

Figure Eleven – Divisional 2022 NHS national staff survey results (People Promise elements and themes) vs. national benchmarking group average

Theme

Division	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale	Position
NATIONAL BENCHMARKING GROUP	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7	N/A
Integrated Community	7.6	6.2	7.0	6.3	5.7	6.0	7.1	7.0	6.0	1
Family Care	7.6	6.1	6.9	5.8	5.5	6.0	7.0	6.9	5.6	2
Anaesthetics & Surgery	7.3	5.7	6.8	5.9	5.4	6.0	6.7	7.0	5.9	3
Diagnostics & Support	7.1	5.6	6.6	5.9	5.2	5.6	6.3	6.6	5.6	4
Acute Adult	7.0	5.4	6.7	5.3	5.2	5.7	6.4	6.8	5.4	5

KEY:

Above National Benchmarking Group Average
Equal to or up to 0.2 below National Benchmarking Group Average
More than 0.2 below National Benchmarking Group Average

**Note: in line with the national benchmarking reports and statistical significance testing, a parameter of -0.2 difference has been used in the RAG ratings shown above*

5.5 **Figure Twelve** below shows the 2022 NHS national staff survey results People Promise elements and theme scores benchmarked against the Trust average. Whilst we have implemented a consistent approach in terms of the divisional results packs and action plans, the OD team will flex its' support to ensure we are responding to the Divisions who need it the most.

Figure Twelve – Divisional 2022 NHS national staff survey results (People Promise elements and themes) vs. Trust Average

Theme

Division	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale	Position
TRUST	**7.4**	**6.0**	**6.9**	**6.0**	**5.6**	**6.1**	**6.9**	**7.0**	**5.9**	**N/A**
Integrated Community	7.6	6.2	7.0	6.3	5.7	6.0	7.1	7.0	6.0	1
Family Care	7.6	6.1	6.9	5.8	5.5	6.0	7.0	6.9	5.6	2
Anaesthetics & Surgery	7.3	5.7	6.8	5.9	5.4	6.0	6.7	7.0	5.9	3
Acute Adult	7.0	5.4	6.7	5.3	5.2	5.7	6.4	6.8	5.4	4
Diagnostics & Support	7.1	5.6	6.6	5.9	5.2	5.6	6.3	6.6	5.6	5

KEY:

Above Trust Average
Equal to or up to 0.2 below Trust Average
More than 0.2 below Trust Average

*Note: in line with the national benchmarking reports and statistical significance testing, a parameter of -0.2 difference has been used in the RAG ratings shown above

6. Bolton NHS FT Staff Experience Action Plan – 2022 NHS national staff survey results

6.1 Along with our successes and areas of focus for the Trust following analysis of the 2022 NHS national staff survey results, we know there continues to be challenges for colleagues with increasing workload pressures, recovery from COVID-19 and making sure we are getting the basics right to make a positive difference to staff experience. It is so important that colleagues feel able to share their views of what it's like to work at our Trust, and to share their experience, feedback and ideas. It is even more important that the Trust can then translate this into action to ensure the priorities for the next 12 months are focused on the right things.

6.2 To capture this, the OD Team is developing the Trust's high-level Staff Experience Action Plan which will be presented to the Trust's People Committee next month to monitor progress. The actions are focused around the following themes from the 2022 NHS national staff survey:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff Engagement
- Morale

6.3 The Trust's Staff Experience Action Plan details the specific actions, who is responsible for delivery, when the actions will be completed by and how we will measure success.

6.4 Within the Trust's Staff Experience Action Plan, the key priorities for 2023/24 include developing and launching our new BAME Leadership Programme, delivery of the various EDI, Wellbeing and Staff Engagement Action Plans, a targeted approach to eliminating discrimination, undertaking a review of the Trust's Long Service Awards, enhancing the ways in which colleague voice can be heard and enabling colleagues to work flexibly in a hybrid way.

6.5 It will be crucial that the Staff Experience Action Plan is communicated and shared across the organisation and the Staff Experience Team will be working closely with the Communications and Engagement Team to help to celebrate and share our results and actions with colleagues. This provides a further opportunity to demonstrate to our employees that we listen and act upon their feedback and we continue to be fully committed to being a great place to work for a better Bolton.

7. Next Steps

7.1 The Staff Experience Team will be monitoring delivery of the Bolton NHS FT Staff Experience Action Plan overall. In addition, the Staff Experience Team is supporting divisions to maximise the insights gained from the 2022 NHS national staff survey at a local level. It is intended for the Trust-wide action plan to set the overall direction of travel with the Divisional action plans complementing and picking up the nuances within the Divisions for appropriate areas of focus needed for their teams.

7.2 The Trust-wide action plan and Divisional action plans will be monitored and reported on through the Staff Experience Steering Group and People Committee. The People Committee will receive updates in terms of progress of the actions contained within the Staff Experience Action Plan.

8. Conclusion

8.1 We are pleased with the results from the 2022 NHS national staff survey and that Bolton NHS Foundation is still the best place to work in Greater Manchester based on our staff engagement score. The delivery of the Bolton NHS FT Staff Experience Plan however is important to ensure that the Trust continues to make improvements on the priority areas of focus. This will ensure that the Trust continues to build on its successes, learns where things can be even better and most importantly takes action as a result of staff feedback to ensure that Bolton NHS Foundation Trust is a great place to work.

9. Recommendations

9.1 It is recommended that the Board of Directors:

- Consider and note the information contained within this report.

Staff Survey Results Comparison 2022

Survey Co-ordination Centre

Theme - Your job

	Trust Results			Average score for comparator group		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
2a	57%	56%	1%	52%	53%	3%
2b	74%	71%	3%	68%	67%	4%
2c	79%	76%	3%	73%	73%	3%
3a	88%	88%	0%	86%	86%	2%
3b	93%	91%	2%	91%	91%	0%
3c	76%	75%	1%	73%	73%	2%
3d	75%	74%	1%	70%	71%	3%
3e	57%	55%	2%	49%	50%	5%
3f	60%	57%	3%	53%	55%	2%
3g	47%	45%	2%	43%	43%	2%
3h	51%	50%	1%	55%	54%	4%
3i	30%	28%	2%	26%	25%	3%
4a	58%	56%	2%	51%	51%	5%
4b	47%	45%	2%	41%	41%	4%
4c	40%	31%	9%	32%	25%	6%
4d	56%	56%	0%	52%	53%	3%
5a	24%	24%	0%	22%	22%	2%
5b	59%	56%	3%	52%	52%	4%
5c	46%	46%	0%	43%	44%	2%
6a	91%	88%	3%	87%	87%	1%
6b	48%	46%	2%	43%	44%	2%
6c	55%	53%	2%	51%	52%	1%
6d	69%	68%	1%	65%	67%	1%

Theme - Your Team

Trust Results				Average score for comparator group		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
7a	76%	74%	2%	72%	72%	2%
7b	61%	63%	2%	56%	58%	5%
7c	75%	74%	1%	70%	70%	4%
7d	75%	74%	1%	71%	71%	3%
7e	86%	83%	3%	81%	81%	2%
7f	62%	61%	1%	57%	57%	4%
7g	61%	60%	1%	55%	56%	4%
7h	74%	73%	1%	68%	69%	4%
7i	71%	70%	1%	64%	64%	6%

Theme - Your Health, Well-Being and Safety at Work

	Trust Results			Average score for comparator group		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
10b	31%	35%	4%	38%	40%	5%
10c	55%	55%	0%	57%	56%	1%
11a	60%	56%	4%	56%	56%	0%
11b	27%	27%	0%	31%	31%	4%
11c	45%	43%	2%	47%	45%	2%
11d	54%	56%	2%	55%	57%	1%
11e	20%	21%	1%	26%	24%	3%
12a	35%	38%	3%	38%	37%	1%
12b	32%	34%	2%	35%	35%	1%
12c	37%	39%	2%	40%	40%	1%
12d	27%	30%	3%	32%	32%	2%
12e	42%	45%	3%	47%	47%	2%
12f	18%	21%	3%	22%	22%	1%
12g	30%	33%	3%	32%	32%	1%
13a	13%	15%	2%	14%	15%	0%
13b	0%	0%	0%	1%	1%	1%
13c	1%	1%	0%	2%	2%	1%
13d	71%	66%	5%	67%	68%	2%
14a	26%	25%	1%	27%	28%	3%
14b	10%	10%	0%	12%	12%	2%
14c	17%	17%	0%	20%	20%	3%
14d	45%	47%	2%	47%	47%	0%
15	60%	60%	0%	56%	56%	4%
16a	6%	6%	0%	7%	8%	2%
16b	6%	7%	1%	9%	9%	2%
16c (1)	31%	39%	8%	46%	49%	10%
16c (2)	31%	21%	10%	21%	20%	1%
16c (3)	3%	11%	8%	4%	4%	7%
16c (4)	2%	6%	4%	4%	4%	2%
16c (5)	11%	10%	1%	8%	9%	1%
16c (6)	17%	19%	2%	19%	19%	0%
16c (7)	33%	31%	2%	27%	24%	7%
17	n/a	35%	n/a	n/a	35%	0%
18a	n/a	63%	n/a	n/a	58%	5%
18b	n/a	88%	n/a	n/a	86%	2%
18c	n/a	72%	n/a	n/a	67%	5%
18d	n/a	67%	n/a	n/a	59%	8%

Theme - Your Personal Development

	Trust Results			Average score for comparator group		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
19a	79%	76%	3%	74%	71%	5%
19b	65%	62%	3%	58%	56%	6%
20	75%	73%	2%	69%	69%	4%
21a	89%	91%	2%	80%	81%	10%
21b	18%	22%	4%	20%	22%	0%
21c	28%	30%	2%	30%	32%	2%
21d	28%	30%	2%	29%	31%	1%
22a	74%	73%	1%	69%	70%	3%
22b	55%	54%	1%	52%	53%	1%
22c	68%	67%	1%	66%	68%	1%
22d	56%	54%	2%	51%	54%	0%
22e	56%	55%	1%	54%	56%	1%

Theme - Your Managers

	Trust Results			Comparator		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
9a	73%	72%	1%	69%	70%	2%
9b	66%	65%	1%	61%	62%	3%
9c	60%	60%	0%	56%	57%	3%
9d	70%	70%	0%	66%	67%	3%
9e	74%	74%	0%	70%	70%	4%
9f	70%	71%	1%	66%	66%	5%
9g	71%	73%	2%	68%	69%	4%
9h	71%	73%	2%	67%	68%	5%
9i	68%	68%	0%	63%	64%	4%

Theme - Your Organisation

	Trust Results			Comparator		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
23a	80%	77%	3%	75%	74%	3%
23b	77%	75%	2%	71%	68%	7%
23c	63%	60%	3%	58%	57%	3%
23d	68%	62%	6%	67%	62%	0%
23e	67%	67%	0%	61%	60%	7%
23f	55%	53%	2%	48%	47%	6%
24a	26%	30%	4%	31%	32%	2%
24b	20%	21%	1%	22%	23%	2%
24c	13%	15%	2%	16%	17%	2%

Theme - People in Your Organisation

	Trust Results			Comparator		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
8a	59%	56%	3%	52%	52%	4%
8b	75%	75%	0%	69%	70%	5%
8c	76%	75%	1%	70%	71%	4%
8d	72%	72%	0%	66%	67%	5%

Background Information

	Trust Results			Comparator		
Question	2021	2022	Variance	2021	2022	Trust Variance from comparator
30b	n/a	72%	n/a	n/a	72%	0%

Report Title:	Equality, Diversity & Inclusion update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	To provide an update on our Equality, Diversity & Inclusion agenda.

Summary:	Equality, Diversity & Inclusion (EDI) is a key priority for the Trust, including fostering a culture of inclusion and an environment where everyone feels they can bring their true selves to work. This report provides an update on the Equality, Diversity & Inclusion (EDI) agenda; including key achievements in the previous quarter and the focus areas for the next quarter.

Previously considered by:
This Equality, Diversity and Inclusion Report was presented at the People Committee prior to submission at Board.

Proposed Resolution	The Board of Directors are asked to **receive** and support the report.

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

Prepared by:	Rahila Ahmed, EDI Lead & Jake Mairs, Associate Director of OD	**Presented by:**	James Mawrey, Chief People Officer and Deputy Chief Executive

1. Introduction

1.1. Equality, Diversity & Inclusion (EDI) is a key priority for the Trust, including fostering a culture of inclusion and an environment where everyone feels they can bring their true selves to work.

1.2. The importance of inclusion is demonstrated in our EDI Plan 2022-2026 (Board approved), which can be found on our website. Our EDI Action Plan 2023 supports us in achieving our ambitions and priorities in improving EDI practice and health outcomes.

1.3. The report demonstrates that whilst strong progress has been made there remains significant work that needs to be undertaken to push forward this critical work programme further.

2. Background - Our current position on Equality, Diversity & Inclusion

As demonstrated by the latest Workforce Race Equality Standard: August 2022. Non-exhaustive overview:-

2.1. We are committed to ensuring that our workforce represents the demographic of the population we serve, and have seen a 3.4% increase over the last three years of BAME colleagues employed by the Trust (15%).

2.2. We were voted in the top 10 high performing Trusts nationally for shortlisting BAME applicants (by NHSE).

2.3. There was a marginal 0.3% decrease in the proportion of BAME staff (27%) experiencing harassment, bullying or abuse from staff in the last 12 months.

2.4. There has been a 3.8% increase in the percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (27.7% which is lower than the national average at 28.9%).

2.5. There is no difference in the relative likelihood of BAME staff entering the formal disciplinary process, when compared to white colleagues. This has reduced over the past 5 years when the score was 1.87.

As demonstrated by the latest Workforce Disability Equality Standard data: August 2022. Non-exhaustive overview:-

2.6. The proportion of staff recording their disability increased by 0.3% (20 staff) to 3.2% in 2021/2022 (187 staff in total) as recorded within the Electronic Staff Record (ESR) HR information system (national average at 3.7%). Of note sources such as the NHS Staff Survey, indicate that in the NHS then it is likely that circa 1 in 4 staff may have a disability but not declared on ESR. It is therefore recognised that this gap in data impacts on the analysis of experiences of staff with a disability or health condition.

2.7. Nearly one in four disabled staff in the NHS nationally do not believe that they are getting the necessary equipment and support needed for them to perform their role as effectively as possible.

2.8. The rates of disabled staff saying their employer has made reasonable adjustments to carry out their work has fallen nationally to 73% in 2022, Bolton is higher than the national average at 76%.

2.9. There has been a 3.4% reduction in the percentage of disabled staff saying they felt pressure to come to work and a 3% increase in feeling their work is valued.

*NHS England have announced changes to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data collection and submission timetables, with the data collection being completed May 2023. Our full WRES and WDES data for last year can be found on the EDI section of our website.

Our current position as demonstrated by the recent Staff Survey results 2022 for Equality, Diversity & Inclusion

2.10. Following our recent NHS Staff Survey results, we have completed a deep dive analysis of the EDI specific results – **appendix 1**.

2.11. From an overall picture, 94% of colleagues said they had not experienced any discrimination and the results reflect discrimination from either colleagues, managers and/or patients.

2.12. Of the 11 questions, we have scored favourably (better than, or on par with, the national average) in six questions and are below the national average in five questions.

2.13. We have provided a summary of the findings from appendix 1 below;

- 60% of our colleague feel we act fairly in relation to career progression / promotion, which is 4% higher than the national average. This score has remained the same since last year.
- 6% of our colleagues have experienced discrimination at work by members of the public, which is the same as last year and 2% lower than the national average.
- We have seen a 1% increase in colleagues experiencing discrimination by a leader or colleague to 7%, which is 2% lower than the national average.
- We have seen a 10% reduction in colleagues experiencing discrimination due to gender, and we are 1% above the national average at 21%
- The national average shows that 49% of colleagues experiencing discrimination due to ethnic background. In Bolton, we have seen an increase to 39%, so whilst this remains below the national average this is an increase from last year (31%).
- 11% of our colleagues have shared that they have experienced discrimination due to their religion, up 8% and 7% above the national average. In real terms, this equates to 21 colleagues experiencing discrimination due to their religion.

- We are 2% above the national average in colleagues experiencing discrimination due to their sexual orientation at 6%, which is also a 4% increase from last year.
- We have seen a 1% decrease in colleagues experiencing discrimination due to disability, but are still 1% behind the national average at 10%.
- We are on par with the national average for colleagues experiencing discrimination due to age at 19%, although this is 2% increase since last year at a Bolton level.
    - There has been a 2% decrease in experiencing discrimination due to 'other', which is 7% more than the national average.
    - We have seen a 2% decrease in "I think my organisation respects individual differences", to 73%. This is 4% above the national average.

3. High-level update on actions being taken across the organisation

3.1. An internal audit of EDI has been completed and a number of areas of good practice were highlighted;

- High level Executive Team and Board involvement in EDI Commitments
- Consolidated EDI Action tracker for 2023
- Communications and Engagement team involvement in EDI activities
- Wide range of mechanisms in place to gather insight from Trust's workforce, patients and local community
- Clear and established governance structure to oversee the Trust's commitment to their EDI agenda

3.2. The internal audit had four findings, three of which have successfully closed and the remainder is on-track to be closed in July 2023 and relates to EDI training.

3.3. Various learning and celebratory events have taken place and will continue; including LGBTQ+ History Month, Islamophobia Awareness lunch and learn, Disability History Month Quiz, Transgender Awareness and Ramadhan awareness and resources. Our Bolton NHS Charity also led our Share Ramadan campaign.

3.4. We hosted another successful Community Voices event in January with good representation. Following feedback, our next Community Voices event will be face-to-face and will focus on how community groups want to engage with us moving forward; rather than a focus on specific topics.

3.5. We have continued to drive a number of activities related to training and development, including a new cohort for our BAME leadership programme, ensuring all mandatory training is accessible, and also reviewing our coaching and mentoring model to ensure it better reflect the demographic of Bolton.

3.6. We have completed a review of our Interpretation & Translation service and will be moving to a new supplier from July, in line with others in Greater Manchester. This will enhance the patient experience and reduce the

number of complaints we have received in this space. It will also significantly improve our compliance to the Accessible Information Standard (AIS).

3.7. We have reviewed our Equality Impact Assessment and are currently working with the Health Inequalities Enabling Group on how we can embed and operationalise this.

3.8. We have developed an inclusive recruitment framework to improve the Trust Race Disparity Ratios which is monitored on a regular basis to ensure inclusion is at its heart. Action plans have been developed with a focus on ensuring policies are procedures are updated to support diverse talent to progress, improving where job roles are advertised, working closely with local communities and the BAME staff network to provide support to colleagues applying for roles.

3.9. We continue to embed our Freedom to Speak Up approach and increased the number of FTSU champions to 44. Seven of the current champions (15.9%) are from a BAME background, and the BAME Staff Network is currently supporting the FTSU Guardian in improving this position.

3.10. We launched our new faith facility, with support from our community and via Our Bolton NHS Charity.

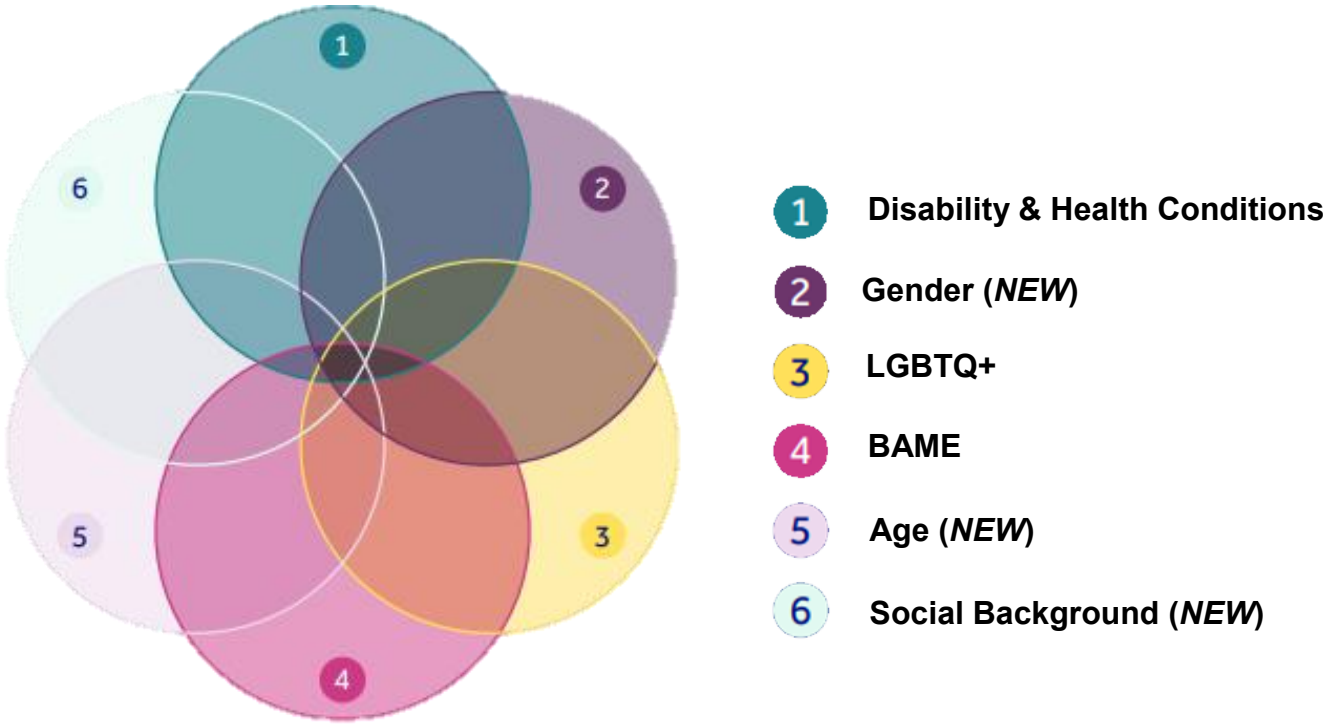
3.11. We continue to promote staff wellbeing initiatives including access to counselling, staff physiotherapy service, shiny minds app, vivup etc.

3.12. We have successfully appointed a new Equality, Diversity & Inclusion Manager and Officer, to support our existing EDI Lead in driving forward this agenda.

3.13. Our staff networks continue to be critical to delivery of our EDI agenda, and we have launched three new networks: Gender, Age and Social Background. They are still within their infancy and growing membership.

4. Actions being undertaken by our staff networks

4.1. We understand the importance of our networks in driving our inclusion agenda, but also in intersectionality and how we continue to strive to make Bolton a place where we all feel we belong. It is important that each network has their own agenda, but that we regularly come together to ensure we are thinking of the whole person.



4.2. Our BAME staff network achievements;

- Supporting with a review of our BAME leadership programme, including a reciprocal mentoring initiative, and goes live this month
- Initiated the process to receive the Muslim Friendly Employer accreditation. We have explored other religious accreditations but this is the first that exists.
- Provided pastoral and cultural support to our International nurses
- Led our inclusive recruitment action plan, which has included activity such as reviewing job advert wording, producing guidance questions for candidates on inclusion, and training for hiring managers
- Supported with recruiting FTSU Champions from a BAME background

4.3. Our BAME staff network focus areas for next quarter;

- Supporting and reviewing the active bystander campaign and training
- Review the bullying and harassment policy and procedure
- A deep dive review into ethnicity statistics to further understand the challenges our BAME colleagues face

4.4. Blandina Mutambirwa is the Chair of this network.

4.5. Our LGBTQ+ staff network achievements;

- Celebrated LGBT history month with a series of resources and events, including a 'lunch and learn' delivered by the LGBT Foundation.
- Leading on our rainbow badges campaign, including a staff and patient survey. The rainbow badges assessment reviews how inclusive our organisation is for LGBTQ+ people and will support us in driving this agenda further.
- Launched 'Hello my name is' gender pronoun badges for our colleagues, which will be delivered to colleagues this month.
- Produced guidance for colleagues undergoing gender reassignment.

4.6. Our LGBTQ+ staff network focus areas for next quarter;

- Finalise our work-plan following the results of the rainbow badges assessment.
- As part of a broader piece of work, looking at how we integrate gender identity into a patient's record.
- We also want to strengthen this network through increasing the number of members.

4.7. Imran Khan is the Chair of this network.

4.8. Our Disability & Health Conditions staff network achievements;

- Led on the renewal of our Disability Confident level 2 status

- Supported colleagues with additional needs with mandatory and statutory training
- Host regular drop-in sessions for colleagues, raising awareness of the support available and supporting colleagues with declaring their disability and/or health condition via the ESR system
- Work has begun on a reasonable adjustment passport, to support our colleagues in understanding what support available

4.9. Our Disability & Health Conditions staff network focus areas for next quarter;

- Pilot and test the reasonable adjustment passport
- Through a new task and finish group, review the process for declaring to simplify where possible
- A dedicated communications and awareness campaign to further promote the support available.

4.10. Catherine Binns is the Chair of this network.

5. Conclusion

5.1. As previously note the Equality, Diversity & Inclusion (EDI) is a key priority for the Trust, including fostering a culture of inclusion and an environment where everyone feels they can bring their true selves to work.

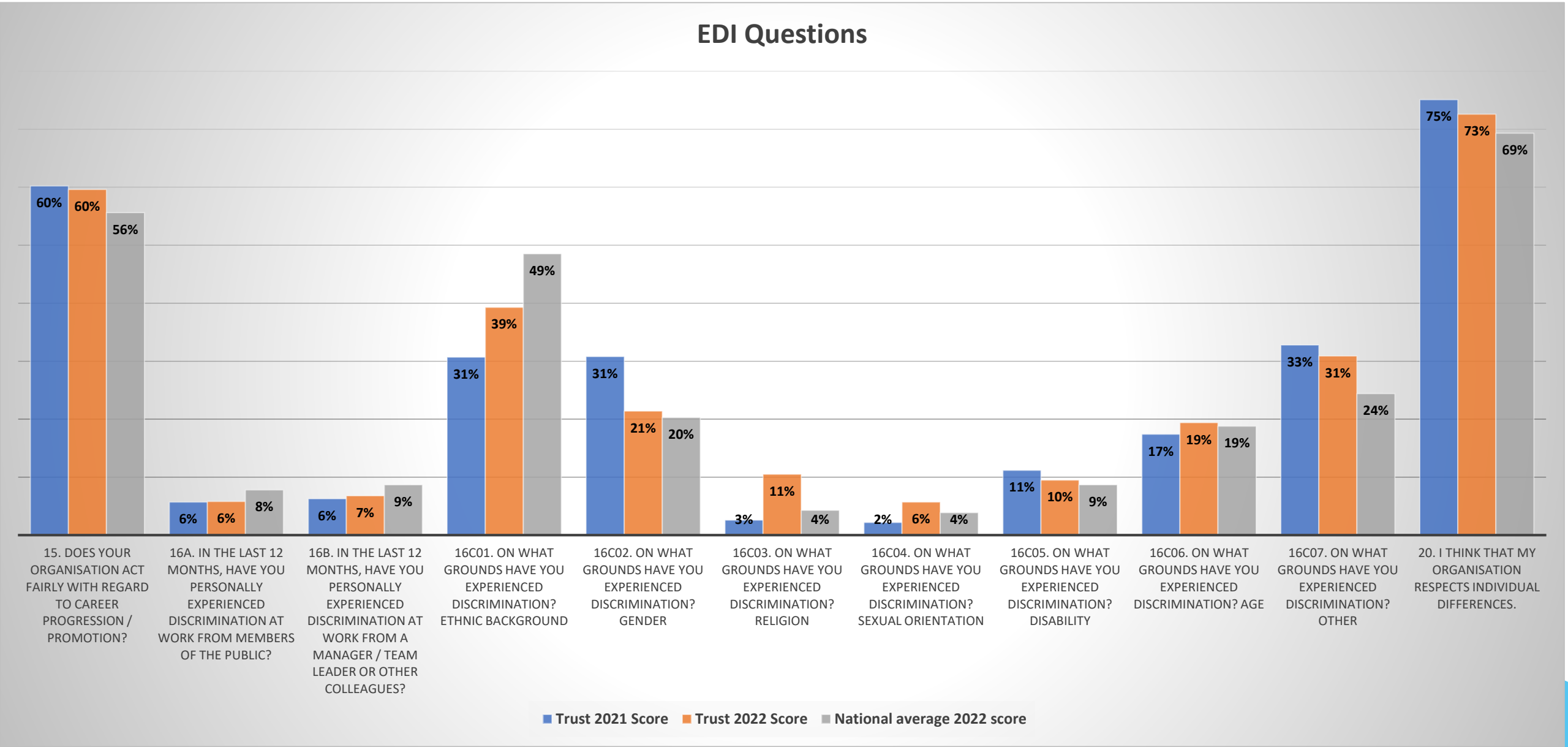
5.2. The report demonstrates that whilst strong progress has been made there remains significant work that needs to be undertaken to push forward this critical work programme further. This work will be in line with our EDI Plan 2022-2026 and the progress of our action plan will continue to be monitored on a monthly basis via the Staff Experience & Inclusion Steering Group and regularly by the People Committee.

6. Recommendation

6.1. We ask the Board to note the report. Further reports will come to the Board following the annual completion of the WRES and WDES.

NHS Bolton NHS Foundation Trust

NSS EDI Questions: 2021 - 2022 Comparison



Report Title:	Staff Health & Wellbeing Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	To provide an update on the Trust's wellbeing review, associated wellbeing action plan, and update on key initiatives in place to support colleagues to look after themselves in order to be best placed to look after our patients.

Summary:	Overall our sickness absence position remains good when benchmarked against GM organisations. A plethora of work programmes have been put in place to support our fantastic staff to be healthy and remain in work. Despite the work in place we acknowledge the added staffing and workload pressures and the impact that we know other challenges are having on colleagues, such as the cost of living crisis and recent industrial action, are all contributing to highly pressurised work environments and driving down overall wellbeing for colleagues. Following the staff wellness offer review in August 2022, it was recognised that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions. The Trust is therefore further enhancing its staff health and wellbeing offering at such a critical time and delivering key priority actions set out in the Trust's wellness review action plan.

Previously considered by:
This Staff Health and wellbeing report was previously discussed by the Executive Team and is routinely presented at People Committee.

Proposed Resolution	The Board of Directors are asked to: • Receive this report as assurance on the actions undertaken with regards to colleagues' wellbeing. • Note the progress with the Trust's enhanced staff health and wellbeing review action plan.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	

*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Laura Smoult, Staff Experience Manager	**Presented by:**	Laura Smoult, Staff Experience Manager

1. Background

1.1 This paper provides an update to the Board of Directors on the Trust's wellbeing review and associated wellbeing action plan, as well as an update on key initiatives to support colleagues to look after themselves in order to be best placed to look after our patients.

2 Overall our sickness absence position remains good when benchmarked against GM organisations. A plethora of work programmes have been put in place to support our fantastic staff to be healthy and remain in work.

2.1 Referrals through to Occupational Health are meeting current targets to support colleagues in a timely manner. We have seen an increase to calls to our Employee Assistance Programme in Quarter 4 and the highest presenting issues reflect what we are seeing as the main reasons for sickness absence in the Trust of anxiety and stress.

2.2 Despite the above we acknowledge the added staffing and workload pressures and the impact that we know other challenges are having on colleagues, such as the cost of living crisis and recent industrial action, are all contributing to highly pressurised work environments and driving down overall wellbeing for colleagues. Following the staff wellness offer review in August 2022, it was recognised that not as many colleagues are accessing the Trust's staff wellness offer as expected and/or not being released to participate in self-care interventions.

2.3 The Trust is therefore further enhancing its staff health and wellbeing offering at such a critical time and delivering key priority actions set out in the Trust's wellness review action plan.

2. Key Activity / Updates

2.1 During the past six months, and as we are now recovering from the COVID-19 pandemic, we know the impact on staff health and wellbeing continues to be immense and we know from listening to colleagues that they continue to feel fatigued and overwhelmed and some struggle to switch off when they finish work. We have significantly stepped up our efforts to enhance our staff wellness offer throughout this time and create a culture that promotes self-care through initiatives such as Menopause, Mental Health First Aid Training and support with OD interventions for teams.

2.2 The Trust's wellbeing review action plan was developed to focus on getting the basic right first with the wellbeing offer and we are already starting to see some positive results and progress. Key achievements include our work around cost of living and breakfast packs which hit the local news and across the whole wellbeing offer, we have seen an increase in usage (13% to 39%).

2.3 The wellbeing action plan has enabled the Staff Experience Team to make some great progress with priority initiatives and projects aimed at improving overall staff health and wellbeing. We are already seeing some good progress and the key activity that the wellbeing action plan has delivered for the Trust are set out below.

2.4 **Rest Facilities** – an initial walk-around has been undertaken with iFM to review staff break and rest facilities. Priority areas have been identified and we are exploring alternative funding opportunities from Our NHS Bolton Charity to support with ensuring consistency across staff break and rest facilities and the basics being in place.

2.5 **Wellbeing Offer Identity / Brand** – work is underway to develop a new look and feel of the Trust's staff health and wellbeing offer and an initial meeting has been held with the Communications & Engagement Team to develop this further. This will ensure that colleagues feel a connection to the Trust's staff health and wellbeing offer, as whilst lots of great work is being done locally within Divisions to support staff health and wellbeing, colleagues don't always associate this with the Trust's staff health and wellbeing offer and it will help to ensure consistency of approach.

2.6 **Wellbeing Offer 'Back to Basics'** – closely connected to the new look and feel of the Trust's staff health and wellbeing offer are the actions related to going 'back to basics,' as much of these initiatives and support mechanisms for colleagues need established processes and embedding as part of the staff health and wellbeing offer. These are all initiatives that are unique to Bolton NHS Foundation Trust and these staff support offers need to be better communicated and promoted so that colleagues are aware of the help and support available to them when they need it the most.

2.7 **Cost of Living Update** – this has been a priority for the Staff Experience Team, particularly throughout the winter months, to ensure that colleagues feel as supported as possible in such difficult and challenging times. Key actions included creating a cost of living staff support kit, 700 individual breakfast packs distributed to support colleagues who haven't had the opportunity to have their first meal of the day and two online Financial Wellbeing Sessions offering budgeting hints and tips receiving positive feedback from colleagues.

2.8 **Menopause** – a training module was launched on ESR in October 2022 and the refreshed Menopause Policy is due to go to PDOC for ratification in May 2023. A six month pilot for Menopause support sessions has been planned and rooms have been booked both on the Trust's main site and out in the Community. A communications campaign for the Menopause support sessions is due to launch this month and the Menopause Task and Finish Group meet monthly to progress actions ahead of a full menopause staff offer launch in June 2023.

2.9 **Fatigue** – a working group has been established with a number of colleagues and actions are focused on understanding colleagues' perception of the importance of sleep, education and awareness raising and launching a Sleep Campaign in June 2023. Videos are being created from senior leaders across the organisation highlighting the importance of sleep and the impact on patient care and a review of the usage of the on-call rooms is also underway.

2.10 **Wellbeing / OD Plans for Teams** – the Staff Experience Team have supported a number of teams with Wellbeing / OD Plans, including Theatres, Emergency Department and supporting actions during the recent Industrial Action strikes. The themes have generally been the same and have focused on supporting colleagues given the current operational pressures and demands in response to recognising the impact that this is having on wellbeing and staff morale. In the main, the actions have related to promoting the existing wellbeing support available, arranging for onsite presence from the GM Resilience Hub and Occupational Health to ensure formal psychological wellbeing support and providing 'keep me going moments' including distribution of thank you packs to colleagues.

2.11 **Wellbeing Champions** – in December 2023 we re-launched our Wellbeing Champions Network across the Trust where we now have 32 active Champions. The

role of the Wellbeing Champions Network is to provide two-way communications whereby Wellbeing Champions can provide their ideas and suggestions and can take actions forward in their own areas and we can share important updates and information about the Trust's wellbeing offer. The Wellbeing Champions Network is such an important part of what we do and ensures we can listen to the employee voice around wellbeing which influences our actions and priorities.

2.12 **Making Every Contact Count (MECC) for Mental Health & Mental Health First Aid Training** – we have launched two training sessions for colleagues with the MECC for Mental Health training starting in March 2023 and there is a plan to continue to offer these courses for colleagues throughout the year. We have also recently launched some Mental Health First Aid Training with the final courses due to be delivered in June and July 2023. We are receiving extremely positive feedback about this course and we will have approximately 80 Mental Health First Aiders trained as a result. Next steps will include how we develop and take this network forwards.

2.13 **Wellbeing Dashboard** – based on feedback we have created a Wellbeing Dashboard which includes data across all of our Wellbeing data metrics including the Employee Assistance Programme, sickness absence rates and reasons, gym data, TRiM, Menopause and Occupational Health Service, to name but a few. It also includes key wellbeing actions for the Quarter, top three achievements in the previous Quarter and top three areas of focus looking ahead to the next Quarter. It is intended that the finalised Wellbeing Dashboard template will be populated with full and complete data by the end of this month for Quarter 4 and we will then fall into a quarterly reporting cycle moving forwards. The key objective of the Wellbeing Dashboard is to be able to look across the various data sets at what the data telling us and to respond and take timely and appropriate action as a result relating to colleague wellbeing.

2.14 **Catering** – iFM have been making some great progress with the catering offer across the Trust. This includes successes of the fruit and veg stall and Carrs pasties on the main hospital site, a new menu launched with Elior and a coffee van attending the main hospital site for a six-week trial. On-going actions include the food available in the hot vending machines, the amount of available space for colleagues to eat their own lunches, completing a gap analysis of the dietary requirements across the site and ensuring a good balance between vegetarian and non-vegetarian options.

3. Next Steps / Areas of Focus

3.1 The areas of focus for the staff health and wellbeing offer, in line with the Wellbeing Review action plan, include further developing our Wellbeing Champions Network, refreshing our approach to TRiM and Schwartz Rounds, launching our wellbeing offer identity / brand, embed the role of the Wellbeing Guardian and progressing with actions in Phase Two of the wellbeing review action plan relating to psychological needs and support for colleagues.

3.2 The challenges that colleagues continue to face do not go underestimated or unnoticed and by implementing the actions outlined in the wellbeing review action plan will help to ensure that colleagues feel supported throughout these difficult times.

3.3 The wellbeing review action plan remains flexible and whilst the immediate priority actions are being delivered, more actions will be added to these throughout the coming months where needed. All of the actions are aligned to our broader activity around retention, ensuring we continue to be a great place to work.

4. Conclusion

4.1 Continuing to invest in our colleagues' health and wellbeing will ensure that they can in turn provide the best care to our patients. If we can continue to help and support our colleagues to look after themselves, and the things that may be impacting on their health and wellbeing at work, then we can make sure our colleagues are best placed to look after our patients and families at Bolton NHS Foundation Trust.

5. Recommendations

5.1 The Board of Directors are asked to:

- Receive this report as assurance on the actions undertaken with regards to colleagues' wellbeing.
- Note the progress with the Trust's enhanced staff health and wellbeing offering.

Report Title:	Our People Plan 2023-2026

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26 May 2023		Discussion	
Exec Sponsor	James Mawrey		Decision	✓

Purpose	To present our new People Plan with the Board of Directors for their support and approval.

Summary:	We are pleased to introduce our new People Plan 2023-2026, which has been created following the successful conclusion of our previous Workforce & Organisational Development strategy. Our People Plan 2023-2026 is structured under four pillars; - Attracting - Developing & Leading - Sustaining & Retaining - Including Each pillar has a list of activities we will deliver and key measures of success. The plan will be monitored via People Committee.

Previously considered by:
This report was previously presented at the People Committee held in April.

Proposed Resolution	To recommend our new People Plan 2023-2026 to the Board of Directors for their support and approval.

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

Prepared by:	Jake Mairs, Associate Director of OD & James Mawrey, Chief People Officer	**Presented by:**	James Mawrey, Deputy Chief Executive / Chief People Officer

1. Introduction

1.1. We are pleased to introduce our People Plan 2023-2026, which builds on our previous Workforce & Organisational Development strategy.

1.2. Our mission remains the same: to be a great place to work, and by looking after our people, they will provide the best care to our patients, families and the people of Bolton.

1.3. Our new People Plan sets out our commitment to our colleagues and is deliberately ambitious. It clearly documents agreed delivery dates and measures of success, so our colleagues and stakeholders can hold us to account on what we do for them.

1.4. The new People Plan is split into four pillars;

Attracting	The best people will want to join the Bolton team, because they know that working here is more than just a job.
Developing & Leading	Our staff will be encouraged to grow and feel inspired to be the best they can be.
Sustaining & Retaining	People will have long and happy careers in Bolton, and will not want to work anywhere else.
Including	Making Bolton a place where we all feel we belong.

2. Background

2.1. As part of our development of our new People Plan, it was important that we used the opportunity to 'take stock' of our current position and the progress we have made over the last few years, in addition to the continued improvements we wish to make and the opportunities we can leverage through our new People Plan.

2.2. Bolton NHS Foundation Trust continues to be a great place to work, with the highest score in Greater Manchester for staff engagement for the fifth year running. We also continue to be in the top 20% nationally for our NHS Staff Survey results.

2.3. The VOICE Behaviour Framework has successfully been embedded within the organisation and is aligned to a refreshed appraisal and 121 process (known as the 'For a Better Bolton Conversation Toolkit').

2.4. The Freedom to Speak Up approach continues to go from strength to strength. We now have over forty three FTSU Champions and two FTSU employed Guardians. The FTSU Guardian continues to meet on a monthly basis with Bilkis Ismail - NED, Malcolm Brown – NED, Fiona Noden – CEO and James Mawrey CPO and Deputy CEO.

2.5. Equality, Diversity & Inclusion (EDI) has and will remain a key priority for the Trust. Further information on this item is provided in the agenda papers. Colleagues will note from these papers that whilst strong progress has been made there remains significant work that needs to be undertaken to push forward this critical work programme further.

2.6. Our sickness levels remain in a relatively good position when benchmarking against neighbouring Greater Manchester organisations, however when looking wider than Greater Manchester it is evident that further improvements could be made. People Committee members have been briefed on the basket of approaches that have been taken across the organisation to support our staff to remain healthy and in work. Further information on this work programme is provided to wider Board members in the agenda papers.

2.7. Recruitment - Bolton continues to be able to attract staff to come and work for us. In the last year alone we recruited 1059 new colleagues and have been able to appoint in many hard to fill posts. We have successfully increased our international recruitment with 185 colleagues joining us from oversees. The Chief Nurse and Medical Director have overseen further developments of emerging roles e.g. Training Nurse Associates, Physician Associates, Advanced Nurse Practitioners, MTI Doctors, Trust Grade Associate Specialists. Despite the many recruitment success we do have some hard to fill posts and we continue to be dependent on agency spend which is unhelpful for a plethora of reasons.

2.8. We continue to focus on our retention activity, which is reflected in our turnover rates of circa. 13%. We favour well in comparison to other GM Trusts in this space, but this is a 3.29% increase since 2019 and pre-pandemic levels – turnover rates have increased across all sectors since COVID pandemic.

2.9. Our Leadership and Management Development Framework continues to be well received. This clearly articulates the internal and external training offered to our staff at all levels. In addition to this more focused leadership programmes have been developed where we have determined additional focus is required e.g. BAME Leadership Development Programme, Medical Leadership Programme and BAME reverse mentoring programme.

2.10. Colleagues will be aware that the Apprenticeship Programme was significantly impacted by the pandemic (regular discussion at People Committee). Very pleasingly the last 12 months has seen this position improve and we are now meeting our Apprentice target (currently 147 colleagues are undertaking an apprentice programme). This has been achieved by working collaboratively with divisions to implement a series of

enabling actions to re-invigorate apprenticeship activity within the context of increased operational pressures.

2.11. We have created a new Organisational Development (OD) model for partnering and supporting divisions and overseen a number of bespoke OD programmes across the organisation (as described in the last People Committee). Given the pressures on the organisation and wider NHS then it is anticipated that the need for this service will grow in the future.

2.12. Work has started on our integration agenda work provides an opportunity for us to work and collaborate differently across Bolton, including enhancing post-Covid ways of working for our workforce.

3. Approach to developing our new People Plan 2023-2026

3.1. Whilst strong progress has been made on the People & Culture agenda there remains a significant amount of work to do. therefore we have taken the opportunity to ensure our new People Plan has been a truly co-produced piece of work, with a great level of socialisation, feedback from colleagues at all levels of the organisation and some within the locality.

3.2. We have engaged the following as part of its creation;

- Our Staff Networks and Community Voices Forum
- Our frontline colleagues (via dedicated drop-in sessions)
- Our Executive Director and Deputy population
- A dedicated small team of senior nursing and clinical colleagues
- Our Workforce & OD leaders and broader team

3.3. You will note that our VOICE values remain unchanged as there was clear feedback, as part of the co-production, that these are well embedded within the organisation. The People Plan does, however, include some activity on how we can ensure our values are demonstrated consistently across the organisation.

3.4. As part of the creation of our People Plan, we fully reviewed the NHS People Promise and Greater Manchester People Plan and key elements have been reflected within our document.

3.5. It is also worth noting that our People Plan is for the Trust but that locality partners have also been involved and it does include some broader locality activity, as we progress with our integration agenda. Our colleagues in IFM Bolton have also been involved and will be producing their own version of the plan, utilising the same pillars, but with some amendments to ensure it addresses the specific challenges that effect their workforce.

4. Operationalising our new People Plan (following approval)

4.1. Subject to approval from the Board, we will ensure the People Plan is operationalised and launched across the organisation. It is crucial to its

delivery that colleagues understand and support our People Plan, especially those in leadership positions.

4.2. We will therefore complete the following steps, following approval;

- A dedicated communications plan, including launching within the organisation
- Finalise the supporting detailed action plan, which articulates owners, escalation points and governance / monitoring arrangements
- We will also revise our People governance structure, subject to approval by People Committee, through adapting our current steering groups to be aligned to the pillars within the plan; for example our current Resourcing & Talent Planning steering group will transition to the Attracting steering group.

4.3. The overall monitoring and oversight of the People Plan will be through our People Committee, with bi-annual dedicated updates and an annual report to Board to show progress and provide assurance.

4.4. The People Plan will underpin the workforce and people development ambition of our new Trust Strategy, due for publication later this year.

5. Conclusion

5.1. We are really proud of our People Plan 2023-2026 and the commitment we are making to the colleagues of our organisation. The plan has been fully endorsed by the People Committee.

5.2. We would like to formally recognise the colleagues who have fed into the creation of this plan for their contributions and support. It is a document created by our colleagues, for our colleagues.

5.3. We recommend the Board approve the People Plan 2023-2026.

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

People Plan

2023-2026

... for a better Bolton

Our People Plan: Our promise to you

Dear colleagues

It's our pleasure to introduce our People Plan, our commitment to supporting you, our fantastic staff, to develop and grow in your careers and yourselves.

You tell us that this is a great place to work – and that is all down to you, our people. We are working hard to continue to provide the right conditions and culture for this to stay a fantastic place to be.

This plan outlines how we will get there, defined by the four pillars we will use as our guiding framework. We will focus our attention on how we attract the best people, support them to develop as leaders in their field of expertise, provide the right environment so that they want to stay and grow their careers in Bolton, all whilst shaping an inclusive culture that allows everyone to bring their full and true selves to work every day.

It's really important to us that this isn't just words on a page. We will all play a part in making sure that the plans in these pages happen. We will continue to

work with our colleagues across the Bolton locality to make sure that Bolton remains the place to be, guided by our Board of Directors every step of the way.

I hope you see something in this plan for you. It is truly an honour to work alongside each and every one of you, every day.

Fiona Noden

Chief Executive and Place Based Lead for Bolton

James Mawrey

Deputy Chief Executive and Chief People Officer

The best people will want to join the Bolton team, because they know that working here is more than just a job.

We will get there by:

- Local jobs for local people, wherever possible.
- Developing new ways of attracting diverse talent to Bolton.
- Working with the education sector in Bolton to put career paths in place that welcome a steady pipeline of new talent into the organisation.
- Welcoming new members into the Bolton team by providing everything they need to do their jobs effectively.
- Offering competitive packages that enable people to have a happy life.
- Recognising our achievements and building on our reputation by consistently doing the right thing for our people.

Our people will be encouraged to grow and feel inspired to be the best they can be.

We will get there by:

- Planning our workforce for the future.
- Ensuring all our people have personalised development plans that outline their career paths of choice.
- Creating a talent management framework and measuring how many staff are promoted as a result.
- Investing in our people by developing leadership programmes for line managers at all levels.
- Create a multi-disciplinary skills model that ensures alignment and focus across personal, professional and clinical education.

Bolton NHS Foundation Trust VOICE Behaviours

Vision

Be Positive

We have strong plans and make decisions with Bolton's communities

Openess

Be Inclusive

We communicate clearly and encourage feedback

People will have long and happy careers in Bolton, and will not want to work anywhere else.

We will get there by:

- Looking after the health and wellbeing of our workforce.
- Embracing flexible working so that people don't have to choose between their personal and professional lives.
- Monitoring progress and continuing to really listen to feedback about the thing that mean the most to our people.
- Encouraging people to speak up when something isn't quite right.
- Recognising and rewarding the efforts of our staff.
- Simplifying HR systems and processes to make life easier for our staff.

Making Bolton a place where we all feel we belong.

We will get there by:

- Embedding equality, diversity and inclusion best practices into everything we do.
- Building a workforce that represents the communities we serve, at all levels.
- Create a multi-disciplinary skills model that ensures alignment and focus across personal, professional and clinical education
- Enhancing the process for our people to declare protected characteristics, so we have a better understanding of everyone across our organisation.
- Ensuring all our people have the tools, equipment and access to work that they require to be their best selves at Bolton.
- Be at the forefront of the diversity agenda and continue to celebrate this across Bolton.

Integrity

Be Honest

We are fair, show respect and empathy

Compassion

Be Kind

We have a caring person-centred approach

Excellence

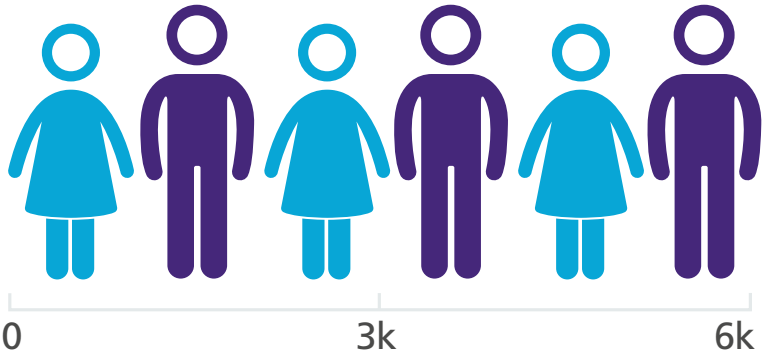
Be Bold

We prioritise quality, safety and continuous improvement

Our current workforce

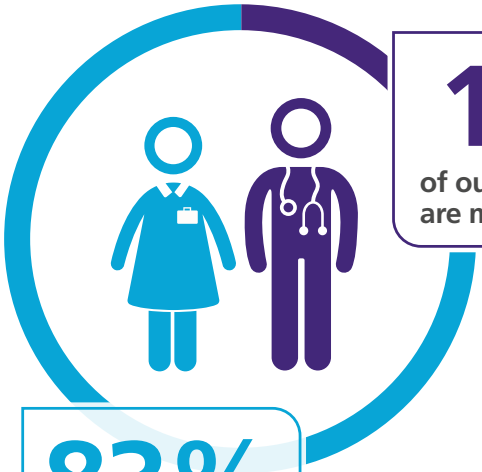
Total workforce circa

6000



15%

of our total workforce are BAME

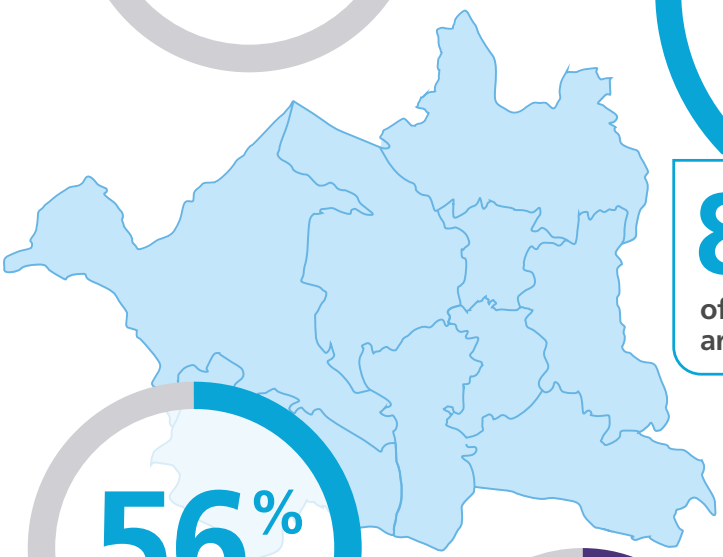


17%

of our workforce are male

83%

of our workforce are female



56%

of our workforce live in Bolton

4%

of our workforce declared a disability and/or health condition

Workforce age range

Age range	Percentage
20	0.42%
21-30	18.69%
31-40	25%
41-50	22.9%
51-60	24.77%
61-70	7.82%
71	0.39%

Data correct as of March 2023

Attracting

The best people will want to join the Bolton team, because they know that working here is more than just a job.

We will get there by:

- Recognising our achievements and building on our reputation by winning external awards.
- Working with the education sector in Bolton to put career paths in place that welcome a steady pipeline of new talent into the organisation.
- Developing new ways of attracting diverse talent to Bolton.
- Welcoming new members into the Bolton team by providing everything they need to do their jobs effectively and timely.
- Offering competitive packages that enable people to have a happy life.
- Promoting the important role our volunteers play in our organisation.
- Developing roles as a Bolton locality and in partnership with others, not with an organisational boundary.
- Develop a platform and framework for our alumni to keep connected to the Bolton community.
- Achieving our Armed Forces silver re-accreditation, with a clear plan to achieve Gold and refresh our Armed Forces Covenant.
- Local jobs for local people, wherever possible.
- Continue to welcome colleagues as part of our international recruitment activity, where appropriate.

We will know we have got there by:

- Recruitment data.
- Vacancy rates.
- Bank and agency usage data.
- E-Rostering key performance indicators.
- External recognition via HR and NHS Awards.
- Increase in International Recruitment numbers and Apprenticeships.
- Data on Bolton returners (i.e. those who come back to us).

Developing and leading

Our people will be encouraged to grow and feel inspired to be the best they can be.

We will get there by:

- Ensuring all our people have personalised development plans that outline their growth and careers paths of choice and align to our 'For a Better Bolton' appraisal model.
- Creating a multi-disciplinary skills model that ensures alignment and focus across personal, professional and clinical education.
- Developing and embed our Career Frameworks across the organisation, including showcasing the role that clinical and professional development play in this.
- Investing in our people by developing leadership programmes that are flexible with consistent themes across all levels of the organisation and locality.
- Creating a talent management framework that supports succession planning, with an 'internal first' mentality for senior and leadership roles across Bolton locality.
- Enhancing the planning of our workforce for the future, including skills changes.
- Establishing and developing rotational development programme across the locality, to support our people in operating as one team across the Bolton system.
- Maintaining and improving the quality and compliance levels of appraisal, mandatory training and statutory training.

We will know we have got there by:

- Equal opportunities for career progression question results within NHS staff survey.
- Workforce and skills profile and forecasting available.
- Continue to achieve and sustain appraisal rate of 85%.
- An achieved mandatory training rate of 92%.
- An achieved statutory training rate of 95%.
- Leadership and development data – including short / long term benefits realised as a result of L&D intervention.

Sustaining and retaining

People will have long and happy careers in Bolton, and will not want to work anywhere else.

We will get there by:

- Simplifying people / HR systems and processes to make life easier for our people.
- Looking after the health and wellbeing of our people across the organisation through an enhanced corporate offer and personalised packages.
- Embracing flexible working so that people don't have to choose between their personal and professional lives.
- Monitoring progress and continuing to really listen to feedback about the things that mean the most to our people – and act in a timely and effective manner.
- Encouraging people to speak up when something isn't quite right.
- Recognising and rewarding the efforts and commitment of all our people.
- Our people are advocates and champions for good health and wellbeing, supporting our focus on health inequalities.
- Our leaders will continue to be visible across the organisation and locality.
- Continuing to enhance our pro-active Occupational Health offering, such as weight management, smoking cessation, mindfulness and resilience programmes.
- Ensuring consultant job plans match service demand and support 24/7 delivery. Extend the use of job plans to other staff who manage caseloads, for example AHPs and nurse consultants.

We will know we have got there by:

- Remaining in the top 20% of NHS organisations for staff engagement scores (as measured by NHS staff survey).
- An achieved sickness rates of under 4.2%
- An achieved turnover rate of 8-10%
- Succession planning in place for key roles across the organisation
- Exit interview data
- Freedom to Speak Up and raising concerns data
- Well Led CQC Inspection feedback

Including

Making Bolton a place where we all feel we belong.

We will get there by:

- Building a workforce that represents the communities we serve, at all levels.
- Empowering our staff networks to have a voice that counts and drive activity that has the greatest impact for them.
- Enhancing the process for our people to declare protected characteristics, so we have a better understanding of everyone across our organisation.
- Ensuring all our people have the tools, equipment and access to work that they require to be their best selves at Bolton.
- Be at the forefront of the diversity agenda and continue to celebrate this across Bolton.
- Embedding equality, diversity and inclusion best practices into everything we do.
- Developing and enhancing our recruitment processes to ensure we are attracting diverse talent to the organisation and removing any barriers.
- Enhancing our learning and development opportunities for people in under-represented groups.
- Providing support for our people in dealing with challenging others, re-affirming our zero-tolerance policy to bullying, harassment and discrimination.

We will know we have got there by:

- We have a workforce which reflects the population that we serve – specifically ensuring that the organisation is as diverse as the population we serve (as measured by the Workforce Race Equality Standard) and Workforce Disability Equality Standard.
- Declaration rates for Disability & Health Conditions.
- Reporting of bullying and harassment in the national staff survey.
- Organisational development – including short / long term benefits realised as a result of OD and EDI intervention.
- Completion of Equality Impact Assessments.


shield

Attracting - Roadmap dates

What we will deliver	Dates	Level
Recognising our achievements and building on our reputation by winning external awards.	December 2026	Trust-wide
Working with the education sector in Bolton to put career paths in place that welcome a steady pipeline of new talent into the organisation.	September 2024	Divisional-level
Developing new ways of attracting diverse talent to Bolton.	February 2024	Targeted-level
Welcoming new members into the Bolton team by providing everything they need to do their jobs effectively and timely.	October 2023	Trust-wide
Offering competitive packages that enable people to have a happy life.	January 2025	Trust-wide
Promote the important role our volunteers play in our organisation.	October 2023	Divisional-level
Develop roles as a Bolton locality and in partnership with others, not with an organisational boundary.	November 2024	Locality
Develop a platform and framework for our alumni to keep connected to the Bolton community.	March 2024	Trust-wide
Achieve our Armed Forces convenant and enhance our support to Veterans.	September 2023	Targeted-level
Local jobs for local people, wherever possible.	December 2026	Locality
Continue to welcome colleagues as part of our international recruitment activity, where appropriate.	Ongoing	Targeted-level

Developing & Leading - Roadmap dates

What we will deliver	Dates	Level
Ensuring all our people have personalised development plans that outline their growth and careers paths of choice and align to our 'For a Better Bolton' appraisal model.	October 2024	Trust-wide
Create a multi-disciplinary skills model that ensures alignment and focus across personal, professional and clinical education.	January 2025	Divisional-level
Develop and embed our Career Frameworks across the organisation, including showcasing the role that clinical and professional development play in this.	July 2023	Divisional-level
Investing in our people by developing leadership programmes that are flexible with consistent themes across all levels of the organisation and locality.	September 2023	Targeted-level
Creating a talent management framework that supports succession planning, with an 'internal first' mentality for senior and leadership roles across Bolton locality.	January 2024	Trust-wide
Enhance the planning of our workforce for the future, including skills changes. Create an 'aspirational Non-Executive Director' programme for Bolton, to continue in our journey of having a diverse Board of Directors that represents our community.	November 2024	Targeted-level
Establish and develop rotational development programme across the locality, to support our people in operating as one team across the Bolton system.	March 2024	Locality
Maintain and improve the quality and compliance levels of appraisal, mandatory training and statutory training.	Ongoing	Trust-wide

Sustaining & Retaining - Roadmap dates

What we will deliver	Dates	Level
Simplifying people / HR systems and processes to make life easier for our people.	March 2025	Targeted-level
Looking after the health and wellbeing of our people across the organisation through an enhanced corporate offer and personalised packages.	October 2023	Trust-wide
Embracing flexible working so that people don't have to choose between their personal and professional lives.	Ongoing	Divisional-level
Monitoring progress and continuing to really listen to feedback about the things that mean the most to our people – and act in a timely and effective manner.	Ongoing	Divisional-level
Encouraging people to speak up when something isn't quite right.	Ongoing	Trust-wide
Recognising and rewarding the efforts and commitment of all our people.	Ongoing	Trust-wide
Our people are advocates and champions for good health and wellbeing, supporting our focus on health inequalities.	April 2024	Trust-wide
Our leaders will continue to be visible across the organisation and locality.	Ongoing	Locality
Continue to enhance our pro-active Occupational Health offering, such as weight management, smoking cessation, mindfulness and resilience programmes.	August 2024	Targeted-level
Ensure consultant job plans match service demand and support 24/7 delivery. Extend the use of job plans to other staff who manage caseloads, for example AHPs and nurse consultants.	September 2024	Targeted-level

Including - Roadmap dates

What we will deliver	Dates	Level
Building a workforce that represents the communities we serve, at all levels.	December 2025	Trust-wide
Empowering our staff networks to have a voice that counts and drive activity that has the greatest impact for them.	Ongoing	Trust-wide
Enhance the process for our people to declare protected characteristics, so we have a better understanding of everyone across our organisation.	September 2023	Targeted-level
Ensure all our people have the tools, equipment and access to work that they require to be their best selves at Bolton.	February 2024	Divisional-level
Be at the forefront of the diversity agenda and continue to celebrate this across Bolton.	Ongoing	Locality
Embed equality, diversity and inclusion best practices into everything we do.	Ongoing	Trust-wide
Develop and enhance our recruitment processes to ensure we are attracting diverse talent to the organisation and removing any barriers.	July 2023	Trust-wide
Enhance our learning and development opportunities for people in under-represented groups.	July 2023	Targeted-level
Provide support for our people in dealing with challenging others, re-affirming our zero-tolerance policy to bullying, harassment and discrimination.	Ongoing	Divisional-level

High-Level Strategic Targets

- To continue to remain in the top 20% of NHS organisations for staff engagement scores (as measured by NHS staff survey).
- To have a workforce which reflects the population that we serve – specifically ensuring that the organisation is as diverse as the population we serve (as measured by the Workforce Race Equality Standard & Workforce Disability Equality Standard).
- An achieved sickness rates of under 4.2%.
- An achieved turnover rate of 8-10%.
- Continue to achieve and sustain appraisal rate of 85%.
- An achieved mandatory training rate of 92%.
- An achieved statutory training rate of 95%.
- Reduction in agency spend as per the Trust's forecast.
- Overall Trust Vacancy rate lower than 5% by 2024, and lower by 4% by 2025.

Delivery of the People Plan and the above targets will be monitored via the People Committee, with an annual progress report presented to Trust Board.

Risks

It is important to note that there are workforce risks that could pose a risk to the delivery of business outcomes and outputs. These key workforce risks are included in the Trust's risk register and to avoid duplication are not included within this plan. The programmes and activities within this plan will aim to mitigate these risks as much as possible.

Concluding comments

People always come first at Bolton and we all have a part to play.

This is not just a strategy or work programme for the People & Organisational Development directorate – it requires real commitment and input from the whole organisation, particularly those in a leadership position.

Our People Plan demonstrates our determination and commitment to our colleagues to ensure we continue to provide the best possible care to the people, families and community we serve.


NHS

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust
Royal Bolton Hospital
Minerva Road,
Farnworth
Bolton, BL4 0JR

t| 01204 390390 w| boltonft.nhs.uk

Report Title:	People Committee Chair's Repors

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	The purpose of these reports is to provide an update and assurance to the Board.

Summary:	The attached reports from the Chair of the People Committee provide an overview of items discussed at the People Committee meetings held on 18 April and 16 May 2023.

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

Proposed Resolution	The Board is requested to receive the People Committee Chair's reports.

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

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

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	18 April 2023	Date of next meeting:	16 May 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Jake Mairs, Sharon White, Joanne Street, Tyrone Roberts, Andrew Chilton, Harni Bharaj, Fiona Noden, Carol Sheard, Victoria Crompton, Lisa Rigby, Michelle Cox, Rachel Carter, Kelly Hart, Malcolm Brown, Tracey Garde, Chris Whittam, Paul Henshaw, Angela Cain	Quorate (Yes/No):	Yes
		Apologies received from:	Bilkis Ismail, Lianne Robinson, Sharon Katema

Key Agenda Items:	RAG	Key Points	Action/decision
People Plan		• Presented with the finalised People Plan 2023-2026, following previous review by the Committee. • The People Plan focuses on four key pillars of delivery: Attracting, Developing & Leading, Sustaining & Retaining and Including.	The Committee strongly endorsed the People Plan to progress to BoD for approval.
Agency Update		• Trust agency spend increased in March 2023 by £290k when compared to previous month, majority of this increase was in relation to impact of junior doctors industrial action. • Trust finished the financial year 2022/23 with a total agency spend of £18.56m which was under/better than the forecast submitted to NHSEI at the start of the year by £1.6m; but above the internal 'stretch' target we set by £2m. • Total Variable Pay (including bank, overtime, and WLI) also increased in month by £700k and, again, it is felt industrial action impacted this. • Report outlined the controls and actions in place across the Trust to mitigate agency usage and expenditure • The Committee discussed and noted the report.	• The Committee asked if it was possible to report on the actual variable pay cost attributed to industrial action. Finance team will prepare this for the May 2023 meeting. • Discussion held on 'pipeline' reporting mentioned in the report and Head of Resourcing will include this in his Resourcing Report to the Committee in May 2023. • Next report to include internal agency projections, aligned to the financial plans submitted.
Sickness Review		• Covid related absence has been declining and now accounts for a lower proportion of total absence. • Bolton benchmarks well, at the lower end of sickness absence, compared to GM peer Trusts. • Stress/anxiety related absences remain largest volume of absence and remain a focus for support to staff. • Sickness absence has reduced in 2023 and is lower than same period in 2022.	• The Committee noted the report. • Discussion held on taking learning from other organisations in relation to post-covid sickness absence and best practice. • A further paper will include occupational health and broader wellbeing support and will be considered at the July meeting.

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

People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Freedom to Speak Up		• During the period from 1st January 2023 to 31st March 2023 a total of cases 47 were reported through the FTSU route. This is slight decrease compared to 51 the previous quarter but the highest number of cases in Q4 so far. The numbers of cases have almost doubled since Q4 2021-2022 . • Issues relating to behaviour that is unbefitting the values of the organisation are the biggest issue that staff speak up to the Guardians about. • During Q4 a total of 15 concerns (32%) were raised by workers from a Black, Asian or Ethnic Minority (BAME) background, which is an increase of 14% from last quarter (18%). Whilst it is positive that our workers from a BAME background are feeling confident to speak up this increase raises concerns as this percentage outweighs the demographics of the organisation.	The Committee challenged what activity has been done on the back of the results and themes – with two papers coming to next month's People Committee as part of this; 1. An update on the data triangulation to further understand the themes . 2. An update on the OD programmes within divisions and across the Trust to confirm what is being done about the FTSU themes / feedback . The Committee noted the report and continued to recognise the efforts of the FTSU Guardians.
Apprentice programme		• An update was provided on our end of year position on Apprenticeships, the ongoing plethora of work happening and proposed targets for the new 3 years. • We continue to be above target with the number of staff currently undertaking Apprenticeships. • Levy spend is similar to last year as per our forecast – as our wage bill increases each year so does the levy. Average levy under spend across all sectors in the UK is 55.6% - our figure is in line with this. • A workforce planning / prioritisation exercise is being undertaken to prioritise key areas of focus and enable creative solutions to unblock barriers such as time off the job and backfill. • National Apprenticeship Week campaign was a huge success, showcased success stories, generated lots of interest and appeared twice in the local press. • Innovate approach being trialled to recruited new HCA apprenticeships and links with partners to consider our future workforce for Bolton as a place are growing.	The Committee noted and supported the report and ongoing work .
EDI quarterly report		• The Committee was shared an update on our EDI activity over the last quarter, including an updated version of the EDI action plan which has been updated to	The Committee noted and supported the report.

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
		reflect the appropriate prioritisation and show where the requirement is legal/mandatory. • The Committee was updated about the new timescales for the data collation of the WRES/WDES, which has been brought forward to end of May – but with the publication of October remaining. The change is to allow more time to analysis results and develop robust action plans. • An update was provided that a triangulation exercise of data is underway, including FTSU, ER/HR, staff survey results, and others. This includes additional feedback sessions with colleagues across the organisation, specifically staff networks, and will help validate the prioritisation of the activity within our EDI Plan.	
Steering Group Chair Reports		Noted.	
Divisional People Committee Chair Reports		Noted.	
IPM Dashboard		Noted.	

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

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People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	16 May 2023	Date of next meeting:	20 June 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Tyrone Roberts, Sharon White, Malcolm Brown, Sharon Katema, Lisa Rigby, Michelle Cox, Chris Whittam, Paul Henshaw, Matthew Greene, Lianne Robinson, Ian Webster	Quorate (Yes/No):	Yes
		Apologies received from:	Bilkis Ismail, Fiona Noden, Jo Street, Andrew Chilton, Carol Sheard, Jake Mairs, Rachel Carter, Francis Andrews

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing Update		The Head of Resourcing presented his Resourcing update, which the People Committee receive bi-monthly. The report covered both turnover analysis and resourcing activity as follows:- Turnover: Turnover at Trust level, and across most Trust staffing groups, is still tracking above expectation but there are early indications of a reducing turnover trend and, while this is positive to see, we would like to see that trend continue over a longer period. The Trust benchmarks well in the majority of our staffing groups on turnover when compared to other NHS providers both regionally and nationally. Turnover across the UK has increased significantly across most employment sectors so is not exclusively an NHS or Healthcare challenge. Efforts to mitigate impact of turnover can be seen by the fact that the Trust recruited 1059 new starters in the year 2022/2023, but saw 843 individuals leave our employment over the same period. Recruitment: The Trust reported, in the April 2023 NHSEI Provider Workforce Return, a total number of 439.62 WTE vacancies at the end of M12 2022/2023, and the Committee received a breakdown of these vacancies. Reporting demonstrated that the Trust continues to have a healthy pipeline of candidates with confirmed start dates, or going through pre-employment checks. The report provided the Committee with some recruitment performance indicators against our expectations, and raised some concerns about timeliness of vacancy approval and shortlisting processes, which will be explored further in partnership between Workforce and Divisional teams. The report outlined that the Trust Resourcing and Talent Planning Steering Group had refreshed its Terms of Reference and Workplan and the group had received comprehensive updates on Nursing & HCA, AHP, Midwifery, and Medical recruitment and retention activity in its May meeting; these updates were summarised in the report.	The report was received and discussed. Actions: Head of Resourcing was asked if Foundation Doctors impact on Medical and Dental turnover rates and he confirmed he would clarify this at the June meeting. The committee asked for clarification on whether the 843 leavers were actual leavers or if they had transferred to another role in the organisation. Head of Resourcing to confirm and feedback. Performance against vacancy approval, and shortlisting, recruitment expectations will be analysed, and progress reporting will be provided by the Head of Resourcing. Future reporting will include headcount tracking analysis reporting by staff group.
Widening Participation		• A paper was shared which described our current provision and future ambitions to enhance and improve Widening Participation activity such as Work Experience, Employability / Pre-employment Programmes, Careers information, Education advice and guidance, T Levels, Volunteers & Clinical Attachments. • The focus is around working with partners and widening access for those who are underrepresented within our existing workforce and to provide support into employment for those people in our communities who need it most. • Next steps will include development of an action plan around priorities and consideration of what is needed across the Trust to deliver.	• The paper was supported with agreement to bring back a high level plan to the July 23 meeting. • It was suggested that a further paper is brought to the committee in 6 months' time highlighting success factors and lessons so far.

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Mandatory & Statutory Training Update		• A paper was shared which provided an update on the latest position. • The Trust's overall compliance level for mandatory training was 86.2% (a 0.9% increase on last month and above our corporate target of 85%) and statutory training was 92.3% (a 0.7% increase from last month and below our corporate target of 95%). • The paper also included Divisional compliance breakdown and a comprehensive MaST Improvement Action Plan.	• The update was noted and the Improvement Plan agreed. • It was agreed to undertake a comprehensive review of MaST requirements / content / targets. A progress update on the review will be brought to the September 23 meeting. • Actions taken to share good practice from Divisions with good compliance, explore availability of PEF's to support training, provide a divisional breakdown of safeguarding training and to develop a training programme to commence from the end of Q3.
Communications Update		The report highlights many of the areas of work in Quarter 4, including launching the new BOB and opening of the new Faith Facility. The report outlines priorities for Quarter 1, including leading on Communications and Engagement for the Bolton Locality; a Communications Audit will be undertaken; Staff Awards in November.	The Committee thanked the Communications Team for their continued support.
Guardian of Safe Working Quarterly Update		Deferred.	
Nursing, & Midwifery Staffing Report		The Chief Nurse presented the report to the Committee. Nursing: The report demonstrated that Trust adult inpatient wards are staffed safely and in line with national guidance. The report outlined actions that are being taken to further develop and enhance our staffing provision. Midwifery: A business case is being developed to bring Midwife staffing establishment in line with the Birth Rate Plus Review (Jan 2023). The report outlined some challenges but noted an improving picture, especially in relation to staffing with a positive shift in midwives returning to Bolton and a much stronger pipeline of NQ Midwives as a result of work undertaken in the Family Care Division.	

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People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
OD & Culture Paper		A paper was shared which provides some background on culture and ways to measure it, gives on overview of current OD programmes in place, summarises key current cultural themes and sets out areas of exploration.	The paper and areas of exploration were noted and agreed. Future updates on progress to be brought to the committee once the areas of exploration are considered and an action plan developed.
Steering Group Chair Reports		Noted.	
Divisional People Committee Chair Reports		Noted.	
IPM Dashboard		Noted.	

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

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Report Title:	Strategy and Operations Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Sharon White & Rae Wheatcroft		Decision	

Purpose	To provide an update from the Strategy and Operations Committee meetings held since the last Board of Directors meeting.

Summary:	The attached reports from the Strategy and Operations Committee Chairs Report provides an overview of items discussed at the meetings held on 27 March and 24 April 2023. Due to the timing of the May meeting, a late report will be provided by the Committee Chair to the Board reflecting discussions held on 22 May 2023, this will be included in July meeting papers.

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

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

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

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

Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	27 March 2023	Date of next meeting:	24 April 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Sharon White. In attendance: Sam Ball, Rachel Carter, Rayaz Chel, Andy Chilton, Francesca Dean, Sharon Katema, Jake Mairs, Rachel Noble, Julie Ryan, Kate Smith, Jo Street, Brett Walmsley, Judith Richardson (minutes)	Quorate (Yes/No):	Yes
		Apologies received from:	Francis Andrews, James Mawrey, Tyrone Roberts, Rachel Tanner.

Key Agenda Items:	Lead	Key Points	Action/decision
Terms of Reference	R Ganz	The Strategy and Operations Committee were asked to review the ToR as part of the six monthly review since its evolution in September 2022. Comments received: • time constraints of people having to attend so many committee meetings acknowledged but there is a need for rationalisation of meeting papers to different committees • The work of the system delivery and planning group will be included in the oversight of organisational transformation programmes section • The outcome of the committee effectiveness review survey will shape the ToR going forwards	• System delivery and planning group to be included in Transformation section of the ToR and agreed to provide the Director of Corporate Governance with appropriate wording

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Strategy and Operations Committee Chairs Report

Service Spotlight: Health Inequalities	Jo Street J Ryan	Update provided on the work undertaken by the Health Inequalities Enabling Group (HEIG) since its formation in March 2022 along with a look forward at the work planned for the next 12 months to tackle health inequalities: • Three key enabling priorities identified for 2023-24, Education and awareness; Health equity impact assessment and Knowing our patients • HI are unfair, can be prevented and are costly, not just to individuals but also to health, care and economic systems and therefore it is in our interest as a healthcare provider to focus on reducing HI • Bolton residents live disproportionately in the most deprived areas in comparison nationally along with population and experience-wide disparities in life expectancy • Business Intelligence have created a 'bus tour' concept to illustrate the health inequalities that exist within Bolton. As a result of this work, a tool has been rolled out across GM to allow all localities to benefit from this illustrative analysis • The Bolton 2030 Vision for the borough to be Active, Connected and Prosperous is underpinned by six outcomes which provide the framework for action by a range of partners and sectors. • Health is shaped by a complex interaction between many factors including accessibility and quality of health and care services, individual behaviours and, most importantly, wider factors such as housing and income. • To effectively act on HI, we need to be able to identify the areas and groups of patients that require additional focus. The Trust holds a wealth of data that can be "cut" at multiple various levels, including by ethnic group, age, sex and deprivation and as an example can be used to analyse waiting lists. • Work across the Bolton locality involves looking at our community activity by neighbourhood and area and layering this with intelligence from our partners on the delivery of different services, to build a unique picture of service delivery per neighbourhood and to help with decision making. A series of "data walks" is planned, which is a technique to look at data by theme/neighbourhood and brings intelligence together from all partners plus service users.	• Strategy and Operations Committee received the report as an excellent, comprehensive update noting the work to date and the plan for the next 12 months • 6 monthly summary update and an Annual report to be received by SOC on headline traction for 3 key priorities, Education and awareness; Health equity impact assessment and Knowing our patients • Strong OD element identified so need to ensure that the principles and priorities are also applied to our staff as well as our patients • Communication is part of proportional universalism across Bolton and is driving inequality and access to services. Future updates via the education and awareness priority will explicitly show how this is being tackled • Due to the size and complexity of the work to be carried out there are risks to delivery but the structured approach to overseeing the work by the HIEG will be a mitigation against this risk.

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Strategy and Operations Committee Chairs Report

Month 11 Operational IPM	J Street	**Access:** • Ambulance handovers over 60 mins show a slight improvement • The early focus of ED improvement has seen an increase in performance to 64.2% against an improvement trajectory of 60%, Feb 2022 at 63%. Feb 2023 we were third out of 6 in GM with Type 1 A&E with best at 66% worst at 59% • RTT - 78 week waiting patients continues to reduce and we are on target to achieve zero waiting patients by the end of March 2023. This was only slightly impacted by strike action. There are 2 breaches which will not fall within the criteria for the nationally agreed exemptions and there is a concentrated effort to resolve these in time. At 30.6.22 when focus moved from 104 week waits to 78 week waiting patients, we had 4098 patients and we have now treated almost all those patients. • DM01 position improved by a further 6.87% in February with a final position at 12.5%. Continued improvements with physiological measurements in echocardiography, paediatric audiology and urodynamics pathways and are still on track for full recovery by the end of March 2023. **Productivity:** • NCTR remains positive - still continuing to reduce along with a continued decrease in occupied bed days • Re-admission within 30 days of discharge remains positive. **Cancer:** • 2 week wait performance for January below target at 82.4%, due to Radiology capacity in Breast services and it is expected that this will continue to be impacted in the medium-term until it is resolved. Across GM we are mid-table with only 2 trusts achieving the standard in January, best at 83% and worst at 68%. • We failed the 62-day standard for January with performance at 84.2%, the deterioration in the 2 week wait standard for Breast services is now starting to impact delivery of the 62-day standard. • On track to meet our elective recovery milestones by the end of March 2023, with our 62 day backlog of patients recovered to 19 patients as of 27.3.23 against a trajectory of 20.	• Impact of strike action on public behaviours/attendances to A&E felt during the ambulance strikes but less so during the 72hr junior doctor strike due to planning. • National shortage of Breast Radiologists and we are using a whole range of options to increase capacity including international recruitment but no quick fix. An update will be provided in the Operational IPM report for Month 12 • COO and DoOp will carry out an analysis of the LoS and NCTR data to understand why LoS is going up but NCTR average days is going down. The Chair requested that this is included within the narrative of future Operational IPM reports • In relation to our internal flow measures for 12 midday and 4pm discharges, some positive outcomes have been identified from staff working in different ways/in different roles during the recent junior doctors strike. The learning from this is being captured by the Transformation Team led by Sam Ball to make sustainable changes that will contribute to improving our internal flow standards going forwards.

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Strategy and Operations Committee Chairs Report

Performance and Transformation Board Chairs Report	R Wheatcroft	**Urgent Care Transformation Programme:** • Detailed improvement plan requested to come to the next PTB meeting in relation to stroke performance **Finance and Intelligence Group** • This work of this Group is becoming an enabler to a wide range of other work and presents an opportunity as a provider of data/data quality and outcome analysis.	• Reviewed simultaneously with the Month 11 Operational IPM above
Digital Performance and Transformation Board Chairs Report	B Walmsley	• The meeting in March had been stood down due to the lack of availability of key members who were required to deal with the impact from the junior doctor strike action • B Walmsley provided a verbal update on the deployment of equipment in March – 100 Ormis Lone Working devices – 33 new clinical pack workstations – 66 new laptops for HR with docks – Community Wifi now in Farnworth, Great Lever, Egerton, Dunscar and Horwich • Now have an established IG SLA with GM • GP SLA making progress • On track for the Data Protection Toolkit submission with a reminder to staff needed to complete their IG training	• The key area of risk relates to the resources to carry out future projects as noted in the previous Digital & Data spotlight
GM ICB Business Intelligence Update	J Ryan	• The whole of GM is going out to a staff consultation including locality BI staff commencing on 29th March for 45 days • Locally the re-designed function will have 3 analytical staff down from 10 • Preparatory work currently taking place in readiness for the outcome of the consultation as we will have to work with the new way of working. In the process of reviewing all the reporting and analysis within ICB team across the whole of the locality to deliver ICB and FT objectives along with looking at how the centralised BI resource across GM can be used to deliver this as well • GM have not consulted with Bolton FT on their proposed new model. J Ryan, N Ledwith and S White are currently working through the mitigations to look at what can be done differently within Divisions to train and develop them to use the tools that are already in place.	• The Director of Strategy, Digital and Transformation advised that the risk of losing a cohort of highly skilled staff due to the consultation remains a significant risk to the Trust and GM. • The Chair advised of the need to have an appetite for being creative with our boundaries to make this work as the need for BI is growing not reducing.

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Strategy and Operations Committee Chairs Report

Operational Plan 2023-24	R Noble	• R Noble advised that the focus of the report related to the activity element. The Strategy and Operations Committee were asked to provide comments and input on the plan ahead of submission to Part 1 and 2 of the Board of Directors on 30.3.23. • There is a wider locality component to the delivery of the plan and therefore the approach this year will be different and will include a Locality Steering Group which is already in place and currently developing a locality narrative on how we will work collectively across the system to deliver the Plan • The Finance and Intelligence Group will monitor and oversee progress against key operational planning targets • GM will submit a system operational planning return, of which Bolton's return is a component part, and the North West region of NHS England will monitor the GM system's performance against operational planning targets. If GM does not achieve their targets, but Bolton do, we could still be negatively impacted in order to support the wider system • Granularity of the Plan is provided at speciality level with more rigour and engagement this year at specialty level to target where improvements are needed. • GM is one of the lowest performing regions in the country so is under much scrutiny	• The Strategy and Operations Committee approved the final operational activity template accepting the risk of underperformance against the 4 key targets to deliver 30% more elective activity (than before the pandemic); eliminate 65 week waits; reduce no criteria to reside (NCTR) to 60; reduce outpatient follow ups by 25% • It is anticipated that national scrutiny will push GM system to work together across GM more innovatively. • R Noble formally noted the high level of engagement with planning passed on her thanks to everyone involved in the production of the Plan
Clinical Strategy Update	R Chel	• Following the 3-month extension for the completion of the Clinical Strategy in January 2023, Archus have updated the programme which now runs from March to the beginning of July at which point the Clinical Strategy will be submitted to the Board of Directors for formal approval • First draft of the high level Clinical Strategy expected w/c 3rd April 2023 for initial review by the Programme Director, Associate Medical Director and Deputy Director of Strategy with Archus in advance of any circulation. • Significant engagement with Divisional triumvirates and cross divisional discussion to assess the impact of a divisions plan on another Division • The governance arrangements supporting the Clinical Strategy includes a project group and project board that meet on a monthly basis and a review against milestones of the programme will be a standing agenda item.	• The Strategy and Operations Committee noted the update • Draft documents will be shared with Strategy and Operations Committee and Board of Directors in May 2023 for discussion. • First draft to be received w/c 3 April enabling 14 weeks to ensure sufficient 'ambition' is embedded within the clinical strategy •

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Strategy and Operations Committee Chairs Report

Board Assurance Framework	S Katema	• The BAF was presented as a live document ahead of submission to the Board of Directors on 30.3.23 • Following the last iteration of the BAF to this Committee in November 2022 and January 2023, a review of the risk appetite for ambitions, 1.2, 5 and 6 has taken place with the Exec leads with no change to the risk scoring. • The Director of Strategy, Digital and Transformation advised of a couple of minor changes to Ambition 5 around 'transfer of adult social care teams into FT' and advised that this is no longer the plan but that this will be taken forward with integrated teams in the Neighbourhoods.	• The Chair agreed that she would discuss the suggestion for the 'Mature' risk appetite for ambition 5 to be updated to Seek at the BoD meeting along with the lines of defence for assurance of ambition 6 • The Committee accepted the proposal to amend the current risk appetite for ambition 1.2 from cautious to open
Strategy, Planning and Delivery Committee Minutes	S White	The Committee received the minutes of the last meeting held on 7th March, chaired by S White Deputy Chair: • Terms of Reference agreed • Voice of the Public – FT will lead on engagement and Council will lead on Marketing and will come together to lead on Communications. 3 priorities agreed – children, neighbourhoods and workforce • Locality Plan – presentation received on the Locality Plan 2020-24. Key priorities include Prevention and Early Intervention, Mental Wellbeing, Keep People Living Well in their Community, Develop our workforce and culture as a locality and Digital First approach. Plan will be finalised in June • Integrated Partnership and 7 x Enabler Group Plans - plan on a page methodology will be used and will come through to future SOC • Areas for escalation – Primary Care Commissioning Committee, main risks highlighted were regarding delivery of IT on a PCN footprint and Estates • Presentation received on the proposed Bolton Quality Contract for 2023/24 signed for recommendation to the Locality Board	• The Committee noted the Locality's SPDG Committee minutes • Due to the large membership, core group members will meet monthly with partnership leads attending a quarterly workshop. • Carer Strategy will be submitted to the next SOC meeting • The Committee noted 12 months extensions to 0-19 contract and S White will provide update to the Chair outside of the meeting

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Strategy and Operations Committee Chairs Report

Neighbourhoods Maturity Matrix	K Smith	K Smith, Co-chair of the Neighbourhoods Integrated Partnership shared the maturity matrix for information and welcomed feedback: • Further to Locality Board approval to move to a 6 neighbourhoods delivery footprint, the Maturity Matrix summarises how we expect to move towards fully enabled, integrated, place-based working across neighbourhoods over the coming years. • Part of a wider piece on how measure success and working with data leads on system wide measures. This year is about establishing teams in Neighbourhoods with clear leadership.	• The Committee received and noted the Maturity Matrix • The word 'culture' needs to be more at the forefront of the matrix as clear leadership enabled by strong cultural glue is necessary for a successful One Team n'hood approach. OD very much involved to enable this • Major risks requested to be highlighted as part of the Matrix

Items to note or be escalated to the Board:

- Cancer, 2 week wait performance for January below target at 82.4%. Radiology capacity in Breast services is a national issue and likely to continue into the medium-term given the backlog of patients.
- Cancer, failed 62-day standard for January with performance at 84.2%, the deterioration in the 2 week waits for Breast services is starting to impact 62 day delivery.
- 78-week wait, 2 breaches noted that are not exempted. Strikes had a minor impact and team working to meet the zero target by 31/2/23.
- Digital programme continuing at pace, however continues to be at risk due to resourcing available
- GM ICB Model means a reduction from 10 to 3 staff locally. Team focused urgently on different ways of working and a range of mitigations given increased BI demand
- Operational plan is extremely challenging with some targets not achievable within the context of GM being one of the lowest performing regions in the country
- Draft clinical strategy due w/c 3rd April with 14 weeks to finalise for approval by the Board
- Maturity Matrix formulated to support 6 neighbourhood's having a 'One Team' approach with high level measurable outcomes TBC

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Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	24 April 2023	Date of next meeting:	22 May 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Sharon White. In attendance: Sam Ball, Rachel Carter, Andrew Chilton, Sophie Kimber Craig, Rachel Noble, Jake Mairs, Lianne Robinson, Julie Ryan, Jo Street, Maddie Szekely, Brett Walmsley. Michelle McConvey (minutes)	Quorate (Yes/No):	Yes
		Apologies received from:	Francis Andrews, Rayaz Chel, Sharon Katema, James Mawrey, Tyrone Roberts.

Key Agenda Items:	Lead	Key Points	Action/decision
Service Spotlight: Quarterly Look back Look forward	R Noble	The Committee received the Quarterly look back/look forward for Q4 2022-23/Q1 2023-24 against the 5 organisational priorities of Children & Young People, Data & Digital, Performance & Recovery, Recruitment & Retention and System Transformation. The purpose of the look back/look forward is to note progress against key deliverables and look forward to aims and objectives for the next quarter. **Children & Young People:** • Q4: Maternity Improvement Group CNST T&F group stepped down through assurance, attendance at SEND inspection Exec steering group, with internal working group looking at learning from other sites that have been inspected. 0-19 service contract has been extended to March 2025 • Q1: Maternity CQC action plan to be progressed, continued anticipation of the SEND inspection and developing MDT offer to support young people in mainstream schools, 0-19 service working with partners on implementation of family hubs. • Lessons: difficulty of meeting competing demands in children's services; importance of linking new innovations with existing services; further focus needed on governance and assurance within maternity as identified in PwC audit • Hard choices: difficult decision anticipated on plan to reduce neighbourhoods from 9-6 given the current lack of alignment to the 0-19 commissioned offer/family hub model. Ingleside re-opening is delayed until at least Oct 2023.	The following actions were noted: • CYP – written confirmation of contract extension is required. • The Committee requested that the 'look back' slides highlight which of the targets were achieved versus a Work In Progress. • It was noted that the 'hard choices' section was a valuable addition to the presentation as this illuminated some otherwise unseen elements of the work to SOC members.

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		Data & Digital: • Q4: K2 Maternity EPR contract negotiations under discussion with Execs. Ward assessment kit audit completed and additional equipment is on order for delivery in Q1. Community WiFi rollout complete and safer working in place for over 700 lone-working staff. Additional, unplanned demand for Informatics to operationalise CDC and support moves. • Q1: commencement of community and outpatients EPR programme, continued deployment of equipment, creation of new operating model for ICB and locality BI, commencement of MIYA patient flow project, focus on data quality. • Lessons: working closely with divisions to ensure development of robust business cases with fully-understood impact to Informatics. Limitations of resources in the department and more prioritisation is needed, both within the team and across the organisation. • Hard choices: prioritisation of CDC and other projects over BAU. **Performance & Recovery:** • Q4: delivery of the 78ww milestone, recovery of the 62-week backlog to pre-pandemic levels, reset of urgent care footprint, review of community bed base model, 29 • specialties now offering PIFU and achieved 5% national milestone of 5% all outpatient appointments through PIFU. • Q1: collaborative delivery of revised UTC model, Step Up Care Home pilot initiative commenced and delivery of Pneumonia virtual ward pathway pilot, CDC and DM01 delivery. • Lessons: positive impact of booking deadline for 78ww, value and positive impact of delaying decisions to cancel patients during winter. • Hard choices: balance in when and how much we offer mutual aid to GM system, closure of community beds, funding the UTC pilot **Recruitment & Retention:** Reported through People Committee **System Transformation:** • Q4: completion of workforce and BI neighbourhood profiles, neighbourhood programme plan in place. • Q1: completion of neighbourhood mapping, Bolton Strategic Workforce & Culture Transformation Group established, Making Every Contact Count workshop arranged. • Lessons: importance of one 'Team Bolton' and alignment across the system • Hard choices: move to 6 neighbourhoods will be challenging in terms of estates and IT and the requirements of the health and care teams. Rollout of EPR and the fact that many services are still paper-based.	• Confirmation re. impact of team resource constraints for Digital deliverables to be reported in Q1 • An update on Maternity EPR will be brought to May's meeting following discussion with Execs. • Urgent Care funding for locality and FT implications to come to SOC in Q1 • Update on how Family Hub/0-19 Services to align with 6 Adult neighbourhoods in Q1

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Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Digital Performance and Transformation Board Chairs Report	M Szekely	The Chair's report was presented with the following key points noted: • Positive escalation shared regarding the rollout of 800 devices • Continued 100% coding completion by the Clinical Coding Team • Risks were shared for information only regarding resourcing in the Digital Team and also provision of smart cards for temporary staff; both have actions plans in place • A quarterly EPR report is submitted each month and will be included in the Digital Update going forward. There is a focus on how to develop a broader programme and project development report for key stakeholders. • The Digital Transformation Board agenda will align with the 4 themes of the Digital Strategy from next months which will be reflected in the next Chair's report.	The Chair's report was noted with the following actions: • To further understand the current status of resources within the Digital Team, over the next 2-3 months there will be a review of performance which will consider how the team benchmarks with other organisations for July meeting
GM ICB Business Intelligence update	J Ryan	Verbal update received on the status of this high priority workforce issue for Business Intelligence: • GM ICB staff are currently under consultation on organisational change. Further updates will be provided once outcomes from this consultation are known. This item will remain on the Committee's agenda.	The Strategy & Operations Committee noted the update.
Month 12 Operational IPM	J Street	The committee received the presentation of the IPM. Key points to note were; **Access:** • Both ambulance handovers over 60 minutes and A&E 4 hour access target demonstrates improvement for 3 months in a row. The Trust was a positive 3rd within the GM ranking for March. This is due to rapid improvement work over the months aligning into the Urgent Care Transformation and Improvement plan • With RTT, there are three 78 week breaches. Regarding the 65 week waits, there are more than 18000 patients require treatment. • Diagnostics deteriorated by 1.4% this month due to slower than anticipated recovery in Paediatric Audiology and breaches in urodynamics. **Cancer:** • Expecting to see a further deterioration before improvement due to capacity in Breast and the 2 week wait capacity. However, the Trust are in a good position compared to other Trusts within GM and did achieve the 62-day backlog recovery milestone at the end of March 2023; • There were 3 breaches of the 78-week RTT recovery milestone at the end of March 2023.	• It was noted that percentages on the performance reports do not reflect the number of number of patients. There is a need to recognise the actual number. A revised version of the board report will be provided next month. • Regarding the DM01 target, the standard is 99% of our patients should receive their diagnostic within 6 weeks. As part of the recovery milestones recovery should be at 95% at the end of March 2025. • The IPM was noted. The Director of operations will provide further information on 30-day readmission rates and also on cancer performance with breast performance excluded.

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Strategy and Operations Committee Chairs Report

Key Agenda Items:	Lead	Key Points	Action/decision
Performance and Transformation Board Chairs Report	R Wheatcroft	The Chair's report was taken as read with only 2 points highlighted to SOC members; • The Urgent Care Transformation Programme was stood down within the month but a performance report was submitted to Performance and transformation Board and the Committee was assured. • 2 presentations were provided on Virtual Activity from Integrated Services Division and Trust level. Further work is needed, there is an action plan for Rheumatology to action through Performance and Transformation. • The Finance & Intelligence group have had oversight of the operational plan and the group will monitor the plan. The Group will also take the lead on the PWC work through GM and will oversee on our organisation response to the PWC Diagnostic.	The Chair's report was noted.
NCTR (No Criteria to Reside) update	J Street	The quarterly update on our NCTR position was presented. • The plan is to have no more than 90 patients with 4 day 'stays' / 360 lost bed days on the NCTR list and reduce the number of bed lost days. Good progress has already been made. During March, there NCTR position was 101 versus (GM stretch target was 60) • There are 4 different discharge pathways, the proportions have not changed and the majority of patients are leaving on P1 • The average number of patients with NCTR and average days occupied, there has been a reduction. There was a slight rise in March due to not meeting the trajectory of 90 patients. Nevertheless, there is a positive picture of improvements. • Days delayed continue to reduce but did not meet the target. • Out of area patients that are not Bolton residents is a challenge, this links into the improvement work. The overall proportion of in patients has slightly improved. • The Bridging scheme continues to have success, 175 referrals were accepted and 164 care packages commenced. There is a focus piece work with locality partners to ensure user engagement in the long term. • Out of area residents are mostly from Wigan. Wigan colleagues have agreed to have some onsite dedicated social work presence to support these residents. • An additional workstream has commenced to review the current ward Multidisciplinary Team processes. • Age UK has supported more than 1615 patients to leave hospital. This winter Age UK will also include community. The Community Care Reactive Oversight Group monitor this and conducted a winter review scheme ahead of the notification that GM were releasing bids for the urgent care recovery and winter funding. • A target has been set for no more than 4 days for the NCTR list over the next 12 months	• P0 and P1 patients spend the least time on the NCTR list and average 2 days, whereas P3 patients within the complex bracket can stay significantly longer. • Out of area patients and none Bolton residents tend to stay the longest. • Further work is required regarding the weekend drop off discharge. • JS to check the timeline for the Bridging Service Review with engagement users and feedback • Noted good progress made with 90 patients and an average of 4 day 'stays' is a stretch target • Also noted that GM's stretch target for 23/24 is 60 NCTR patients

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Strategy and Operations Committee Chairs Report

Operational Plan update	R Noble	The Committee received an update on the 2023/24 operational planning round: • The planning round is ongoing following NHS England's request for an improvement to the submitted Greater Manchester plan • System DoFs are leading the development of a revised financial submission which would be presented to the Finance & Investment Committee prior to review and approval by the Board • There had been no request to review activity trajectories, thus the operational detail of Bolton's submitted plan remains the same • The final submission will be made on 2nd May 2023	The Strategy & Operations Committee noted the update.
Clinical Strategy Project Board Chairs Report	S Kimber Craig	The Committee received the Chair's report of the last meeting, held on 18th April, chaired by F Andrews: • A very early draft of the clinical strategy document has been circulated to the Project Board and a feedback meeting took place with the Programme Director, Associate Medical Director, Deputy Medical Director and Deputy Director of Strategy to inform the second draft • A number of key stakeholder meetings are scheduled for the next reporting period to further develop the draft and to feedback on the data exercise • The programme remains on track for delivery by the end of June	The Committee noted the update and in response to members' questions, the following themes were identified as of particular interest to the Committee: • Sustainability and interdependency of services: work is underway on this topic at a GM level and this should continue to form part of discussions at Trust-level so that any issues of vulnerability are identified and can be mitigated • The data aspect of the Clinical Strategy should inform future workforce planning
Strategy, Planning and Delivery Committee Minutes	S White	There had been no formal meeting of the Locality System, Planning & Delivery Committee (SPD) since the previous meeting of SOC. • S White provided a brief summary of the SPD workshop focused on aligning locality plan outcomes to the SPD priorities of Children & Young People, Neighbourhoods and Workforce. One of the outputs of the day will be the creation of a locality performance report which will support the work of SPD and the integrated partnership groups which report into it. • A further update will be presented at the next meeting.	The Strategy & Operations Committee noted the update.

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Strategy and Operations Committee Chairs Report

Strategy Review	R Noble	The draft 2021-23 Strategy Review paper was presented for discussion and comment. The draft stimulated significant discussion on the desired approach to be taken to conclude the current strategy and move to a refreshed strategy. • The Committee concluded that the review is a significant opportunity to celebrate, reflect and acknowledge challenges emerging during the review period. • Overall, it was agreed that further work was required to fully reflect successes and acknowledge challenges to ensure that the review was meaningful to the staff and the wider organisation. • Beyond this, it was agreed that the format should be changed to make the review more impactful and engaging.	The draft was received and the Committee requested that the following actions be taken: • That consideration is given to how the report is presented to ensure that it is accessible to staff • That clinical and corporate divisions are asked to provide their top three achievements from 2021-23 • That the number of 78ww was corrected • That further work is completed prior to the draft being shared with the Board

Items to note or be escalated to the Board:

- 78 week wait milestone largely met with 3 breaches at 31/3/23
- Cancer 2 week wait continues to deteriorate reflecting national trends around recruitment challenges. Focused work on mitigations ongoing
- 0-19 and Family Hub services alignment to 6 Neighbourhoods for Adult services under review during Q1
- Transition to 6 neighbourhoods has begun with completion expected by April 2024
- Approach to funding Urgent Care across locality underway and to be reported Q1
- NCTR good progress continues with stretch goal for 23/24 of 360 lost bed days versus a high of over 1,400 lost days in Jan 2022
- Clinical strategy work on track for July delivery with a core focus on sustainability of service design

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Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	22 May 2023	Date of next meeting:	26 May 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Sharon White. In attendance: Sam Ball, Rayaz Chel, Andrew Chilton, Janet Cotton, Sophie Kimber-Craig, Sharon Katema, Naomi Ledwith, Rachel Noble, Lisa Rigby, Tyrone Roberts, Lianne Robinson, Julie Ryan, Jo Street, Maddie Szekely, Judith Richardson (minutes)	Quorate (Yes/No):	Yes
		Key Members not present:	Francis Andrews, Rachel Carter, Jake Mairs, James Mawrey, Brett Walmsley

Key Agenda Items:	Lead	Key Points	Action/decision
Service Spotlight: Maternity	J Cotton	Update presented on the work being undertaken on Equality of Outcomes as part of the Maternity Transformation Programme. This is in line with the priorities within the NHS Long Term Plan to prevent and manage ill health in groups that experience health inequalities. The following areas were highlighted: • Why ethnicity matters – the national picture for childbirth outcomes • GMEC/BFT demographics • A deep dive and review of the GAP analysis against the 12 standards of the GMEC Black and Asian maternity standards is in progress • A deep dive into maternal and neonatal outcomes associated with deprivation indices and ethnicity is currently in progress as part of the wider work stream • Padlet developed to improve access to information and resources led by the BFT Cultural Liaison Midwife • On-going actions include, strengthening co-production to include BAME population and deprived groups in Maternity Voices Partnership (MVP); ensure inclusive language used in all guidelines, SOP and resources and cultural competency training for staff.	The Committee noted the update with the following responses to members' questions: • Previous data led work by the previous Community Midwife by has been paused due to challenges in the service but will be resumed • Team are doing everything they can to improve equity of outcomes across the whole of the population • Resources will also be available as printed leaflets as not everyone is digitally enabled to access QR codes • 2 day working week for the Cultural Liaison Midwife appropriate at this time due to staffing challenges. Work in progress to extend Community Midwives into 'Neighbourhoods' areas for joined up approach • Working with Digital Team to review Trust internet to make sure accessible for all • Director of Midwifery will provide update on GMEC and equality plan to June meeting.

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

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

Strategy and Operations Committee Chairs Report

Month 1 – Operational IPM	J Street	The Committee received the presentation of the operational element of the Trust Board's IPM in its revised format. Changes have been made to some metrics to bring them in line with the new operating plan. Key points to note were: **Urgent Care:** • Improvement in all ambulance handover metrics and although the 4 hour performance did not meet our improvement trajectory, performance was better than the previous month. May has seen significant pressures with the two Bank Holidays having an impact on flow and not predicting to meet the trajectory of 75% for this month for 4 hours. • Continuing to see low levels of readmission rates within 30 days linked to our long-term approach to development of our community proactive and reactive services. **Elective Care:** • RTT - 6 reportable 78 week breaches in April. Focus continues to be on working to achieve zero 65 week waiting patients by April 2024. The bank holidays and industrial action periods have contributed to the reduction in clock stops. • The DM01 position has worsened by 8.4% with the final position standing at 22.3% but confident that on track to meet nationally mandated milestone of 95% by March 25. **Cancer:** • Failed 2 week wait and 62-day standard for March with radiology capacity in Breast making up a significant proportion of failings but not exclusively. **Community Care** • Decreased deflections from emergency department in M1. The continued focus on admissions avoidance and the new falls pick up service are key to deflections • NCTR reducing gradually - the commissioned beds at Heathlands have helped to discharge complex high needs dementia patients to a more suitable environment, prior to a long term placement.	• The IPM was noted. The Director of Operations will provide a forecasted recovery paper to June's meeting in relation to Cancer performance • To evaluate the impact of breast on cancer performance it was noted that if the breast patients had not breached, cancer would have met targets 9 of the last 12 months. Urology is another significant contributor to non achievement • Capacity impact on diagnostic wait times of being short of 2 Audiologist to be confirmed in June meeting • Funding of Heathlands is temporary it investment to be covered within wider work on Urgent Care in the locality • The Chair formally thanked the BI Team for their achievement in the simplification of the format. • IPM is run through the Finance and Intelligence Group with a focus on triangulation and fed through to Performance & Transformation Board including a focus on productivity
Digital Performance and Transformation Board Chairs Report	M Szekely	The Chair's report was presented and the following key points were noted: • EPR - Altera scoping exercise commenced on 15th May for 8 weeks in acute and community outpatients • Overview of the new high level Digital department structure received for information • IT Service Desk Survey feedback for last quarter – 'were we polite' 97% and 'was your issue fixed' 91% • Significant amounts of equipment deployed in April 2023 with thanks received for support with CVDC project • First iteration of Digital Education performance provided to the meeting • Meetings are planned with the Deputy DDO's to review a number of legacy/orphaned requests in order to prioritise project management support	The Chair's report was noted with the following actions: • The Chair requested that the next iteration of the IT Service Desk survey includes harder questions • Update on Maternity EPR to be provided to next meeting as currently working through legal advice with regards to issues with supplier • To receive an update of resource / budget implications in July meeting

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Strategy and Operations Committee Chairs Report

Bolton Digital Partnership Group - Priorities	S White	Update presented on the priorities of the Bolton Digital Partnership Group. The following areas were highlighted: • Due to the many digital initiatives within organisations and services the creation of a Digital Partnership with representation from Bolton FT, Bolton Council, Bolton College, Bolton University, ICP, Bolton@Home, Bolton CVS, GMMH and GP Federation was developed to support organisations to share ideas and learning; co-design and support partner organisations' progress through their digital development and strategy implementation and identify strategies where digital can expedite integration initiatives. • Priority 1 – Childrens; Priority 2 – Neighbourhoods, Priority 3 – Workforce • Bolton College providing support to Bolton NHS Foundation Trust by promoting industry-based practical courses to fill skills gap in the field of Informatics. Bolton College have developed a Higher Technical qualification in Computing for prospective NHS employees and the video is being used nationally as best practice	The Committee noted the update. • The Committee noted the Digital Partnership Group as a strong example of maturing system working in the locality • It was confirmed that career opportunities in health in Bolton are being promoted into schools as part of the local talent pipeline strategy • Noted that neighbourhoods currently have improved the ability to access to 2 systems – FT and Council's – and that it will be reviewed if 'one system' is the way forward as further neighbourhood integration occurs
Urgent Care Strategy for Bolton	J Street N Ledwith	Update presented on the UTC development plan. The following areas were highlighted: • A full UEC review will run over a year to ensure that there are Urgent Care services in Bolton which meet the needs of population at Neighbourhood level • The review has a number of workstreams; population needs, assessment of current Health and Social Care service provision against national standards, co-production of ideal clinical model and determination of delivery and funding models • Need confirmation of funding from GM as the purpose of the review is to make sure that money is appropriately allocated and that we got services in the right place. Acknowledged that GM are holding line on no new spend • Review will be triangulated with Trust including its Clinical Strategy • Need digital connectivity and clinical operating model • Bolton FT, BARDOC, PCNS, GMMH and Community Pharmacy is required to deliver a successful affordable model.	The Committee noted the update. • Funding for UTC across the locality is yet to be confirmed. Sustainability being key with readiness to mobilise at pace noted • Work to clarify the 'flow' of patients across UC (UTC, SDEC and A&E) such that A&E serves volumes of circa 90K pa yet to be completed working with FT and Bardoc.
Clinical Strategy Update	R Chel	Verbal update received on progress: • Second draft strategy from Archus expected later this week which will be reviewed by the Programme Director, Associate Medical Director, Deputy Medical Director and Deputy Director of Strategy • Project Group and Project Board meetings continue to ensure that everyone is on the same page.	The Committee noted the update. • Draft strategy to come to Committee in June • Noted there is very active engagement with Divisions ongoing supported by weekly project meetings

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Strategy and Operations Committee Chairs Report

Strategy Development - Ambitions	R Noble	Proposed new ambitions were discussed at the Board Development Session in April and presented to SOC for discussion and agreement as the foundations of the new Trust Strategy: • The ambitions are the starting point for the Strategy and a development programme is underway to analyse internal and external data, national policy and our own internal plans to set the course for our new strategic objectives	The Committee ratified the ambitions as a starting point for our new Strategy and commended their compelling simplicity
Performance and Transformation Board Chairs Report	R Wheatcroft	The Chairs report was taken as read.	The Chairs report was noted. • The Chief Operating Officer will include a further update on the Benefits Realisation – IV Line Insertion Service to the next meeting.
Carer Strategy	R Noble	Update presented on the work being undertaken on the Carer Strategy. The following areas were noted: • Bolton Council has led the development of a partnership strategy with the aim of supporting and improving the lives of carers in Bolton. • As a partner in delivery, Bolton NHS FT has endorsed the strategy and will contribute to the achievement of its 5 core aims which are: to recognise and respect carers; support carers; reach unknown carers; create a culture of trust, and support young carers. • The Strategy is currently being overseen through the FT Health Inequalities Group	The Committee noted the update and the Deputy Director of Strategy will provide a 6 monthly update to the Committee going forwards.
Strategy, Planning & Delivery Committee Outcomes	S White	Deferred to June meeting	

Items to note or be escalated to the Board:

- 78 week wait milestone largely met with 6 breaches as at 30/4/23. Major focus is on 65 week waits.
- Cancer 2 week wait continues to deteriorate reflecting national trends. Noted that shortage of breast radiologists contributes circa 75% of 2 week wait target non-achievement, with urology being another area of significant challenge
- NCTR trajectory continues on an overall positive trend with sustainable funding of urgent care in the locality being key to continuing this trajectory and meeting the 90 people on the NCTR list and 400 bed days lost target throughout 2023/24.
- Resource based risk for achievement of Digital strategy with June update to tally resource with objectives and resultant implications
- Urgent Care Strategy funding yet to be confirmed reflecting GM challenges around investing in 'new' programmes without a corresponding pause/reduction elsewhere
- Clinical strategy draft due at June Committee with a view to finalisation in July

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Title:	Nurse Staffing Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	✓

Purpose:	The purpose of this report is to outline the findings of the Bi-annual review for the period July- December 2022.

Summary:	The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. The report provides assurance to the Board of Directors that adult in-patient wards are staffed in line with the national guidance and that where this falls below the standard the relevant mitigation is put in place. The report details a number of next steps and transformation work that is underway to further develop and enhance Registered Nurse staffing

Previously considered by:	This report was presented and received by the People Committee at the meeting held on16 May 2023

Proposed Resolution	The Board of Directors are asked to: • **Approve** the Bi-annual staffing report and recommendations. • **Note** the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

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

Prepared by:	L Robinson, Deputy Chief Nurse and Sonia Griffin, Assistant Director of Nursing	**Presented by:**	T Roberts, Chief Nurse

Introduction

1.2 This report details the findings of the Bolton Foundation Trust 2022 bi-annual staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the organisation.

1.3 The report fulfils the requirements outlined in the National Quality Board (NQB 2018), that recommends acute hospitals should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months. The review incorporates all national guidance relating to the provision of safe staffing levels, National Institute for Clinical Excellence (NICE) guidance 2016, National Quality Board (NQB) 2018.

1.4 The report provides assurance to the Board of Directors that adult in-patient wards are staffed in line with the national guidance and that where this falls below the standard the relevant mitigation is put in place.

1.5 This report covers a specific review of speciality areas against their specific national guidance and recommendations for safe staffing.

1. Background - Adult in-patient areas

2.1 In January 2018, the National Quality Board (NQB)[1] released updated guidance in respect of adult in-patient areas, defined as wards that provide overnight care for adult patients in acute hospitals.

Table 1; NQB's expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2. Current situation

[1] National Quality Board *Safe, sustainable and productive staffing* an improvement resource for adult inpatient wards in acute hospitals

3.1 Our approach & assessment to Expectation 1 – Right staff – *adult in-patient areas*

Table 2; Compliance against key recommendations all wards during the months of July- December 2022

Recommendation	Assessment		Variation
RN to Patient ratios not exceeding 1:8 day shifts	All adult in-patient areas achieve a maximum ratio of 1 RN to 8 patients on day shifts	✓	
Evidenced based Tool	The Organisation has deployed the Safer Nursing care tool	x	Lack of validity and reliability due to frequent ward case-mix changes during covid-19 pandemic plus a need for greater validity from enhanced mitigation of the inter-rated reliability
Headroom/uplift	Headroom/uplift is calculated at 23% - compliant	✓	
Skill Mix	Reviewed as part of bi-annual staffing review.	✓	Currently being reviewed as part of safe care roll out.
Professional judgement	All areas were reviewed as a table-top exercise by the Chief Nurse in April 2022 with a focus on RN to Patient ratios and overall shift numbers (budgeted) vs actual	✓	

3.2 The table below provides an example of RN to Patient Ratios throughout the reporting period. An in depth review has been undertaken and, across all wards in total, the average ratio each month has not exceeded the 1:8. On days overall, the average is 1:5.16, this is in line with NQB recommendations.

Table 3: Example RN to Patient Ratio for day shifts.

Ward/Team	Division	Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec-22	
		E	L	E	L	E	L	E	L	E	L	E	L
Ward B3 (0408)	AACD	1:5.92	1:6.8	1:5.88	1:6.91	1:5.9	1:6.69	1:5.87	1:6.52	1:5.75	1:6.33	1:5.24	1:6.14
Ward C2 [0109]	AACD	1:7.26	1:7.95	1:6.91	1:7.56	1:7.38	1:7.89	1:6.97	1:8.04	1:7.55	1:7.76	1:7.47	1:8.8
Ward E3 (1513)	ASSD	1:6.33	1:7.41	1:6.11	1:7.66	1:6.32	1:7.78	1:6.39	1:8.13	1:6.27	1:8.22	1:6	1:7.97
Ward G4 (0707)	ASSD	1:6.05	1:7.54	1:5.35	1:6.01	1:6.1	1:7.82	1:5.72	1:7.17	1:5.73	1:6.92	1:5.88	1:6.38

3.3 Process for review of safe staffing

3.4 A daily review of safeguard by each division and triangulation of data and information concerning patient harms, complaints, incidents and staff feedback is undertaken to ensure that we capture all emerging risks and can take appropriate action.

3.5 The trust utilises the Safer Nursing Care Tool (SNCT) and SafeCare (web based tools linked to allocate the e-rostering system) in order to review staffing on a daily basis. This is an evidenced based tool used widely across the NHS to assist organisations when reviewing staffing. This provides the ability to have a full overview of the organisation and the ability to review ward acuity and move staff around to balance and mitigate any risks to patient and staff safety.

3.6 Divisional Nurse Directors or their deputies undertake on a daily basis:

- A full safety walk round across all in patient areas.
- A full review of SafeCare ensuring each area has provided professional judgement in relation the safe staffing of that ward.
- A divisional staffing review with decisions made to move staff around according to greatest need and level of risk.
- Trust wide staffing meeting at 9:15 am and 15:00pm led by the Assistant Director of Nursing or Deputy Chief Nurse, with escalation to the Chief Nurse when there is evidence of potential red flag incidences.
- Matrons are clinically visible in their portfolio.
- Safe Staffing information is reported through the trust bed meetings at 9:00am, 1:00pm. 4:00pm and 7:30pm.

3.7 In addition, there is daily oversight undertaken by the Chief Nurses Senior Nursing Team with twice daily and weekly staffing meetings.

3.8 In instances where the staffing falls below the recommended establishment the following mitigation and actions put in place utilising all available nursing resource:

- Ward basing specialist nurses where possible.
- Ward managers to be included in staffing numbers.
- Matrons to be released from all none clinical duties to increase their visibility and clinical oversight of their areas.
- Consider use of pharmacy technicians and pharmacists to dispense medications on clinical areas.
- Non- ward based nurses to be redeployed to suitable ward environment.
- Stepping down none urgent clinical activity.
- Increased use of student nurses and utilisation of synergy model where possible with the oversight of the PEFs and educators.
- Utilising the skills within the full multidisciplinary team such as the skills of the Allied Health Professionals (AHPs)

3.9 In the out of hours' period there is a Late Matron, site manager and hospital at night team who are available for escalation of any staffing issues and are able to be redeployed to the ward to maintain safe staffing levels should they be required.

3.10 International Nurse Recruitment

3.11 Trust activity for international nurse recruitment has been partly supported/funded by NHSEI funding streams. These have been used to cover training and arrival costs for the nurses themselves, and our small international recruitment team (part of the Workforce function). The team have sourced, recruited, and supported our new nurses; with their pastoral support being recognised by NHSEI as an exemplar service to be replicated elsewhere across the NHS.

3.12 Through the funding streams, we have recruited the following nurse numbers:-
Table 4: International Nurse Recruitment numbers

Year	Numbers of IR nurse recruited
2021	21
2022	129
2023 (arrivals before the end of March 2023)	35 (includes 16 in-training at GTEC)

3.13 The Trust also successfully submitted a bid to NHSEI in early 2023 for 25 WTE nurses who NHSEI will expect to arrive before the end of November 2023. Recruitment activity for these 25 nurses has currently been paused whilst analysis of international nurse recruitment is undertaken.

3.14 Harm data per 1000 bed days

3.15 The organisation has not previously reviewed harm data using per 1000 bed days at ward level, work has been undertaken with Business Intelligence and this data will be included in the next Safer Staffing Report.

3.16 There are various indicators that are evidenced to be impacted positively by the presence of suitably qualified registered nursing staff. These are discussed below.

3.17 Falls

3.18 The breakdown of falls with moderate or above harm for July to Dec 2022 is included below. Bolton FT remains below the upper control limit for falls with harm and under the trust target for falls per 1000 bed days. See Table 5 and charts 1 and 2.

Table 5: Falls with Moderate Harm by Division

Month	Number of Falls with Harm	By Division
July 2022	1	AACD x1
August 2022	1	AACD
Sept. 2022	2	AACD
Oct. 2022	4	AACDx3 ICSDx1
November 2022	4	AACDx3 ICSDx1
December 2022	0	

Chart 1: Falls with Harm- The trust target is 1.6 falls with harm per month, the mean is 2.

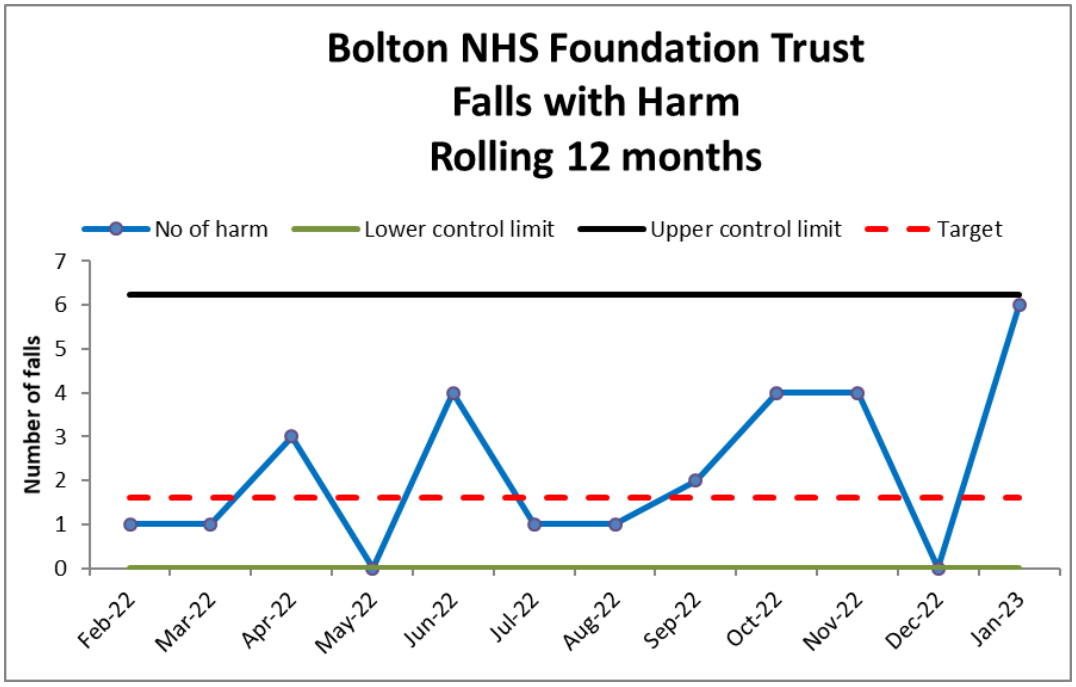
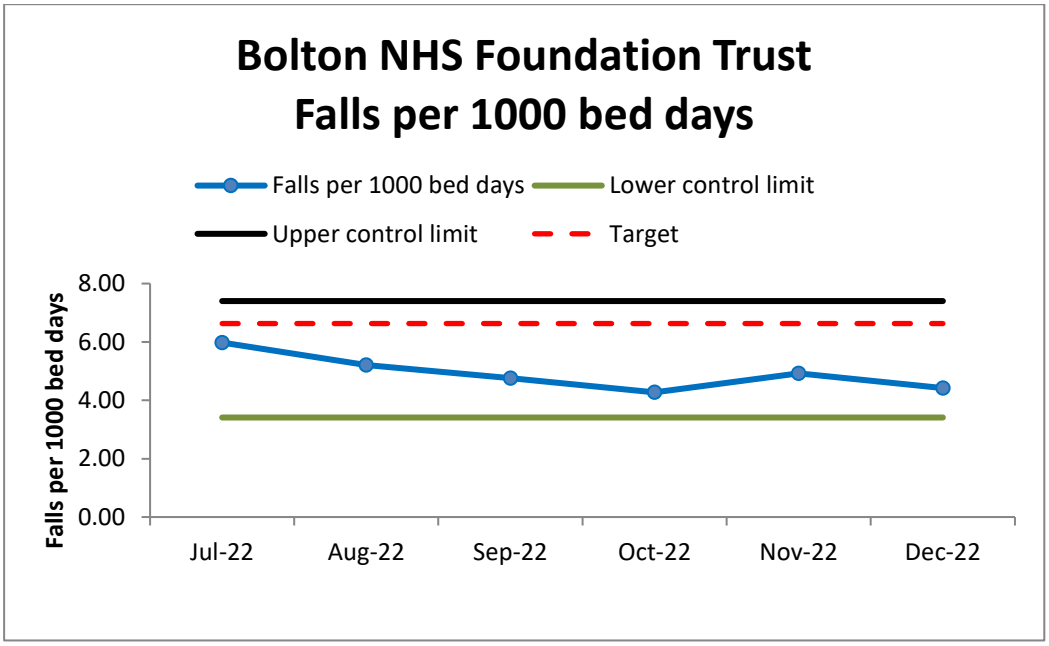


Chart 2: Falls per 1000 bed days.- The mean is 5.21



3.19 All falls with harm are reviewed at a trust wide Harm Free Care panel and key themes and learning are identified.

3.20 There have been no falls identified whereby a lack of registered nurses on duty was contributing factor.

3.21 Pressure Ulcers

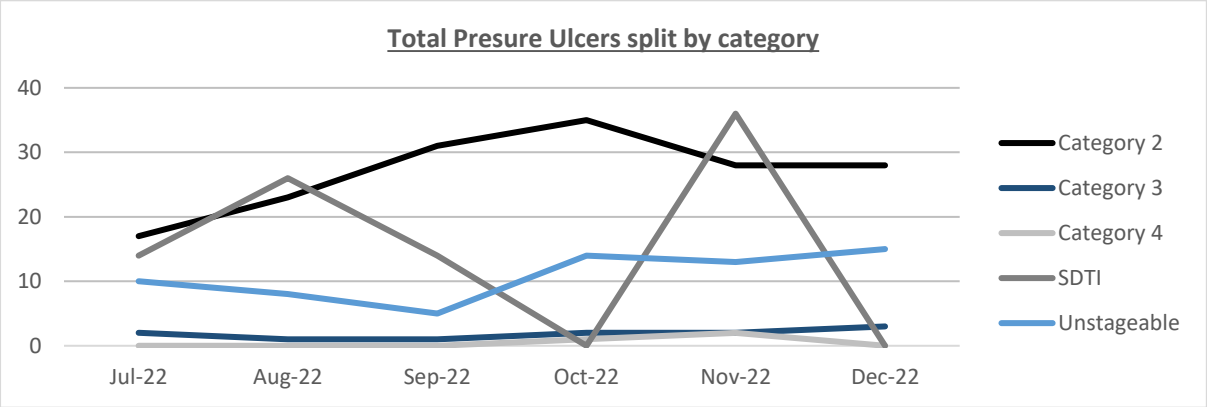
3.22 All pressure ulcers are reviewed at the Trust wide harm free care panel where key themes and learning are identified.

3.23 The number of deep tissue injuries have increased and peaked in the month of November 2022. The number of pressure ulcers has continued to increase from September 2022. A downward trajectory of category 4 pressure ulcers has been seen following peaks in May and June 2022.

3.24 Evidence to date gathered through harm free care panels, lends itself to failures in systems and processes as there remains significant variation between wards/ teams that is not accounted for by staffing levels.

3.25 A locality wide Pressure Ulcer Collaborative commenced in October 2022 ad is expected to conclude in July 2024. It is expected that reductions in pressure ulcer prevalence will be observed 23/24 and specifically Q2 onwards following the collaborative timeline and previous experience with improvement methodology outcomes.

Chart 3: Total number of pressure ulcers for Bolton FT.



3.26 Red Flags

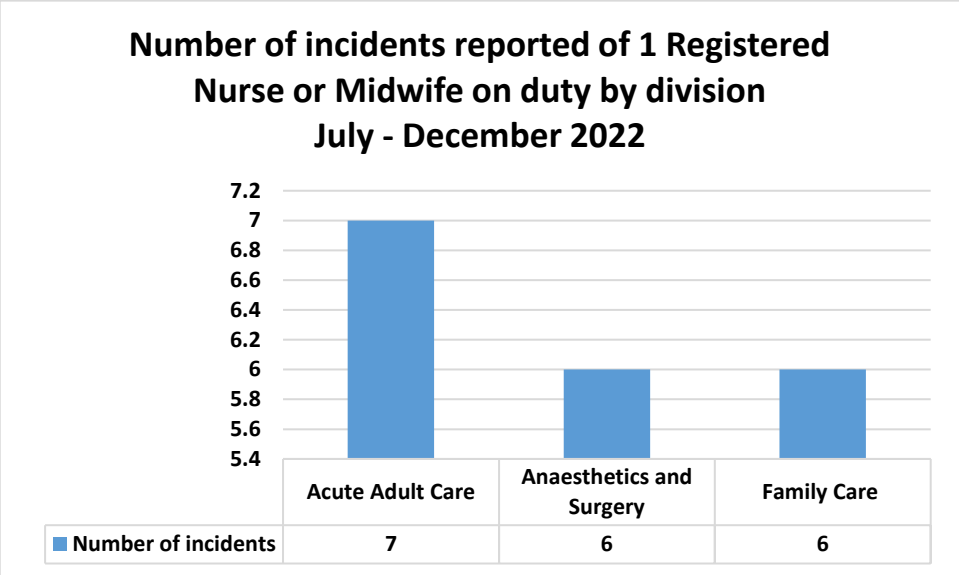
3.27 In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

- An unplanned omission in providing medications
- A delay in providing pain relief
- An incidence where vital signs have not been assessed or recorded
- Missed intentional rounding

- A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
- Less than two Registered Nurses or Midwives available on a shift.

3.28 Red flags for inpatient services are reported by clinical staff via Ulysses Safeguard system. As part of the SafeCare project there are future plans for these to also be recorded within the SafeCare system.

Chart 4, number of safe staffing incidents



3.29 Appropriate escalation was undertaken for all of the incidents reported and the mitigation taken included the following actions:

- Additonal staff were moved to support from other areas.
- Matron reviews were undertaken and a dynamic risk assessment and professional judgement was used to determine deployment of staffing.
- Escalation to Senior Divisional Management to review incidents.

3.30 Themes/trends

3.31 There are 714 incidents between July and December 2022 reported using the staffing cause group and all of the 23 incidents were reported under the cause group of only one Qualified Nurse/Midwife. Following analysis of these incidents 19 were reported correctly under this cause group and 4 incidents were incorrectly reported as the narrative demonstrated the incident was not due to having only one Qualified Nurse/Midwife on duty.

3.32 Sickness, vacancies and Trust pressures are cited as the cause of the areas left with one Qualified Nurse or Midwife in the narrative of the incidents when completed by Managers

3.33 A review was undertaken of the staffing Matron logs for the dates where incidents were reported. All logs documented actions taken to mitigate the areas that had been left with only registered member of staff.

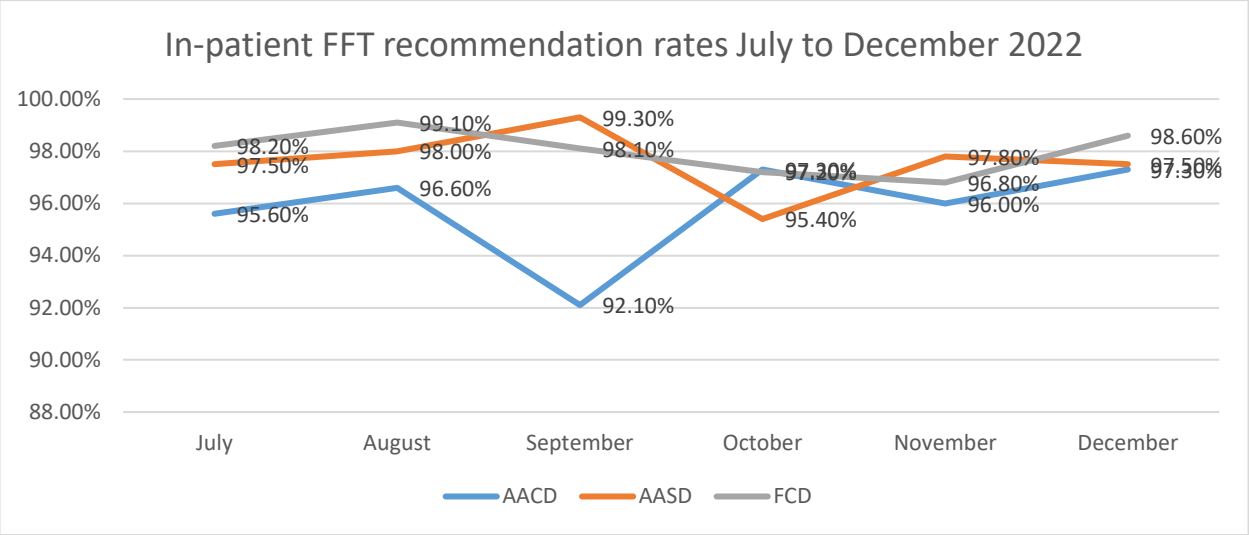
3.34 All incidents detailed appropriate escalation of the lack of Registered staffing. 16 incidents had no harm identified and 3 had low harm identified as the actual impact. The majority of incidents detail prioritising care to patients during the shifts to manage the situation.

3.35 National Adult Inpatient Survey November 2020 v November 2021

3.36 The 2022 National Adult In-Patient Survey is undertaken between January and March 2023 for those patients in our beds during November 2022. The embargoed report will be available in August 2023, ahead of its formal publication on the CQC website around September 2023

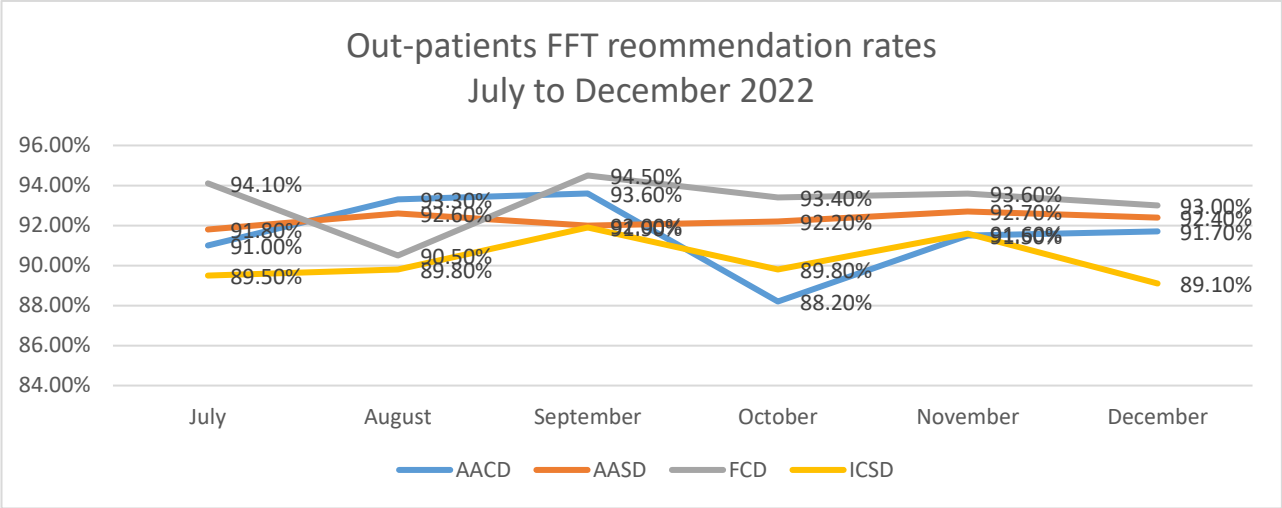
3.37 Friends and Family Test July to December 2022

Chart 5: In-patient FFT recommendation rates



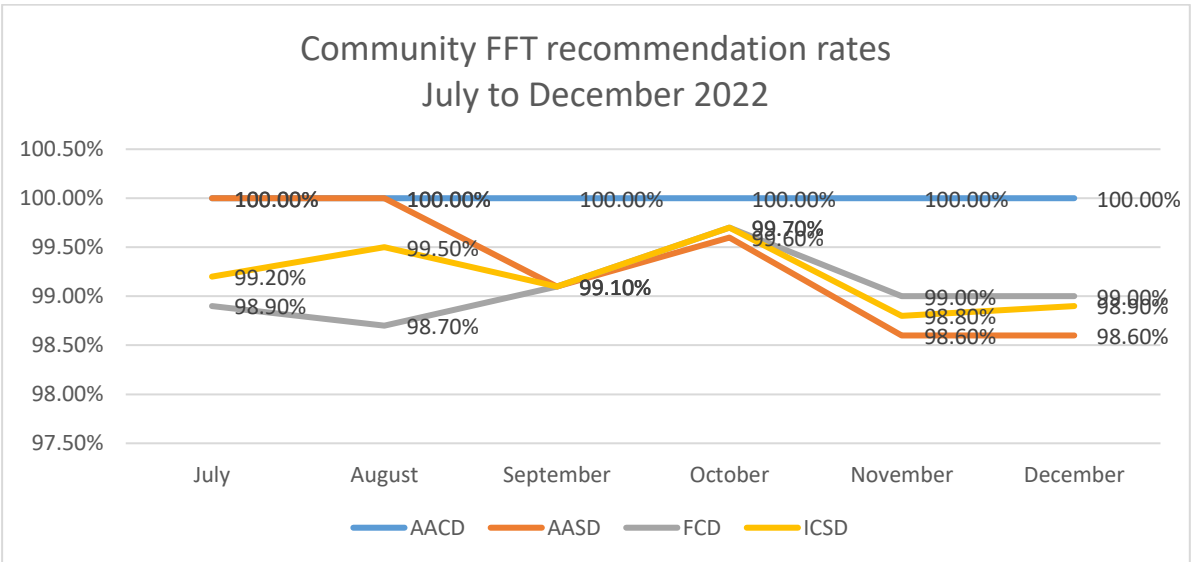
Top 5 positive themes	Top 5 negative themes
• Implementation of care • Staff attitude/staff • Patient mood/feeling • Environment • Communication	• Staff attitude/staff • Patient mood/feeling • Admission • Implementation of care • Waiting times

Chart 6: Out Patient Recommendation rates



Top 5 positive themes	Top 5 negative themes
• Staff attitude/staff • Patient mood/feeling • Implementation of care • Waiting • Admission	• Staff attitude/staff • Patient mood/feeling • Waiting • Communication • Admission

Chart 7: Community Recommendation rates



Top 5 positive themes	Top 5 negative themes

• Communication • Patient mood/feeling • Staff attitude/staff • Implementation of care • Waiting times	• Patient mood/feeling • Staff attitude • Environment • Food • Communication

3.38 PALS and Complaints

3.39 There are no categories captured on our database for PALS and complaints relating to safe staffing. On further analysis of the themes there was no correlation between care provided and staffing levels.

3.40 NHS website reviews

3.41 There were no reviews left on the NHS website in relation to staffing levels and impact on standards of care.

4.0 Expectation 2: Right skills

4.1 Leadership

4.2 A focused review has been undertaken regarding supervisory leadership time for ward managers. As per NQB standards all ward establishments are set to enable Ward Managers to be supervisory 5 days per week, this may change to accommodate, sickness, study leave, ward acuity and to provide general staffing support.

4.3 The allocation of supervisory time varies across wards and divisions. On the rostering template this is classified as a non-working day and can be utilised by the ward managers or allocated to another member of staff, for example to undertake the roster for the month.
This data is captured in the new Nursing and Midwifery staffing reports, to allow monitoring of this data and to ensure that leadership time is allocated (example in appendix 1 and 2).

4.4 Staff measures

4.5 Sickness

4.6 Staff sickness plays a substantial role in shortfalls on the majority of wards and results in temporary shifts being requested or staff redeployment occurring to maintain safety. This has a cumulative effect on the redeploying ward as pressures to maintain patient safety is increased. Sickness is managed by the Ward Manager, with Matron support, Human Resources monitoring and when required, input from Occupational Health. Sickness is managed actively, fairly and consistently balancing the needs of staff with the efficient running of a safe, clean and personal service. The target for sickness 4.2%

4.7 Retention

4.8 NHS Improvement (2019) advises the retention of staff is a key issue for the NHS and it is critical that Organisations focus on securing skilled and sustainable

workforce for the future. In addressing the challenges of workforce supply, organisations must focus not only on recruitment but also should ensure new and existing staff are supported and encouraged to remain in the NHS. Turnover within the Organisation is monitored via the People Committee and where high areas of turnover are noted the Divisional Management team and HR Business Partners undertake a deep dive to understand particular issues and agree a support plan. Additionally, all staff are encouraged to undertake exit interviews to aid managers in identifying themes and learning related to why staff are leaving.

4.9 The below tables show the HR metrics for each month July to December 2022. The turnover rates exclude internal staff moves.

Table 6: HR metrics

Measure Type	No.	No.	%	%	£	%	%	%	%	%
Period to Measure	In-month	In-month	In-month	12 months	In-month	12 months	12 months	12 months	12 months	In-month
Month	HC (Active)	WTE	Sickness Absence (includes Covid sickness)	Sickness Absence Rolling	Est. Sickness £ (in-month)	Labour Turnover %	Appraisal (excluding medical staff)	Statutory Training	Mandatory Training	RTW
Jul-22	5724	4978.44	6.31%	5.45%	£961,841.96	14.71%	79.60%	88.87%	88.09%	56.29%
Aug-22	6084	5255.19	5.46%	5.52%	£870,092.17	14.20%	82.94%	88.45%	86.81%	58.17%
Sep-22	5958	5183.40	5.30%	5.39%	£830,504.36	14.02%	82.55%	89.62%	87.40%	58.18%
Oct-22	5969	5196.37	5.97%	5.39%	£958,967.76	14.03%	82.67%	90.32%	87.77%	57.92%
Nov-22	6173	5343.04	6.02%	5.42%	£951,977.41	13.87%	83.34%	89.69%	87.66%	56.41%
Dec-22	5896	5121.16	7.00%	5.49%	£1,127,824.60	13.96%	82.33%	89.88%	87.22%	61.67%

5. Expectation 3 – Right place, right time

5.1 E-Rostering

5.2 E-Rostering and the production of rostering is closely monitored to ensure all rosters are fully optimised. Each division has a monthly meeting with a senior member of the corporate nursing team and workforce support in order to challenge and approve rosters. At this meeting the following KPIs are reviewed prior to rosters being approved:

- Safety: *% of roster unfilled, Charge cover, Skill mix*
- Effectiveness: *Review of unused hours, Additional hours, Wrong grade types*
- Annual Leave: *Ensuring annual leave is within KPI thresholds.*

5.3 Rostering KPIs have been fully reviewed with Senior Divisional Nursing and Maternity Leads. The rostering KPIs have been developed and are currently under review ready for a full roll out in May 2023. These KPIs will be monitored at a divisional level with exceptions also presented through the Resource and Talent Group. An example of the KPIs can be found in appendix 1

5.4 Flexible Working Policy

5.5 By ensuring staff have access to an equitable flexible working policy it will hopefully provide staff with the work life balance that is needed and help with preventing sickness and annual leave being used inappropriately. The policy outlines provisions for staff under the following categories:

- Balancing work and personal life
- Special leave provisions
- Caring for children and adults
- Flexible working arrangements

5.6 The policy allows for a partnership approach which is cooperative and which considers both individual and service needs.

5.7 Process for measurement and improvement

5.8 Dashboards per Division are currently in development called; “Nursing and Midwifery Staffing Report”. These reports will be produced monthly and will include triangulation of various data sources such as:

Vacancy, recruitment and leavers (pipeline)

- Finance (monthly, year-to-date and forecast spend)
- Planned vs. actual staffing and unused hours
- Unavailability
- Substantive filled and temporary staffing demand
- Temporary staffing fill performance (bank and agency)
- Safe staffing

5.9 A full roll out of these reports is currently underway and the first months data (March 2023) has been shared with divisions. Appendix 1 provides an overview of the reports for information purposes only.

5.10 Temporary staffing

5.11 Where a staffing shortfall is identified, the escalation process found in the rostering policy should be followed. However, Ward Managers or the Nurse-in-Charge must demonstrate that they have exhausted all potential options via the E-Roster or by using the safer nursing care tool prior to making a request.

5.12 The tables 7 & 8 below demonstrate the month by month breakdown of WTE hours for Registered and Unregistered Bank and Agency staff across the trust from July 2022 to December 2022. This is the culmination of all registered staff employed by the respective divisions including out-patient departments and specialist nursing services.

5.13 When reviewing the data it is important to recognise that a –red position demonstrates that the area is over staffing against the agreed establishment and this is due to sickness and absence (mainly covered in the agreed uplift), maternity leave, increased acuity and additional escalation areas that are open, with the latter being the key driving factor when budgets are reviewed monthly.

Table 7: Registered bank and agency usage (Worked WTE)

Qualified	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Funded	2,014	2,018	2,017	2,022	2,020	1,989
Substantive Worked	-1,685	-1,694	-1,693	-1,713	-1,725	-1,726
Overtime Worked	-6	-6	-3	-4	-5	-4
Bank Worked	-68	-97	-80	-77	-104	-100
Agency Worked	-123	-148	-102	-102	-87	-91
Sub Total Worked	-1,882	-1,946	-1,879	-1,896	-1,921	-1,921
Funded vs Worked	132	72	137	125	99	68

Table 8: Unregistered bank and agency usage (Worked WTE)

Unqualified	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Funded	1,214	1,224	1,225	1,226	1,227	1,227
Substantive Worked	-1,058	-1,073	-1,070	-1,075	-1,092	-1,108
Overtime Worked	-3	-2	-2	-2	-2	-2
Bank Worked	-138	-211	-186	-161	-201	-190
Agency Worked	-1	-1	-0	-0	-0	-0
Sub Total Worked	-1,199	-1,288	-1,259	-1,238	-1,295	-1,301
Funded vs Worked	14	-65	-33	-12	-68	-74

5.14 When reviewing staffing, in the absence of the required number of registered staff, additional unregistered staff will be utilised to ensure that patient care needs are met.

5.15 It is evident from the tables above that the number of registerd nurses is under establishment whereas this is offset by unregistered nurses being over

establishment. This is in line with the trusts plans to open additional ward areas to deal with winter pressures and increased acuity. The report does not cover the full winter period but on review of the data of beds open at midnight across the site it was evident that winter pressures began to affect the bed complement from the week commencing the 25th October 2022.

5.16 Enhanced care rates (Patient Observations)

5.17 Inpatients that require enhanced care through direct 1:1, bay tagging or co-horting are managed at ward level on a daily basis. This intervention is not built into existing clinical establishments and as a result we rely on bank staff for additional staffing. Up until recently there has been a lack of reliability in determining levels of care needed, a view formed following several ad hoc 'in person' checks by the Chief Nurse, and this was reinforced via audits undertaken by colleagues. The following Tables 10 & 11 detail the average number of patients requiring enhanced care provisions per division per month. Jan- Dec 2022.

5.18 The data from July – Dec 2022 demonstrates a gradual reduction in the level 3 (AMBER) and Level 4 (Red) Patients. In April 2022 the Enhanced Care and Support Team was implemented as a test for change within the trust and the team provide daily reviews of the enhanced care scores which includes a prescription of care for any level 4 Patient. This reduction in level 3 and level 4 continues to improve from Dec 22 since the ALHOA: (*Avoiding Levels of Harm Assessment*) tool has been adjusted on EPR creating a mandatory field on the flowsheet. This ensures staff complete the risk assessment accurately providing a rationale for the recommended level of Patient observation. This process historically has been inconsistent and the scores imputed have had limited rationale with inconsistent daily reviews of scores being completed. By changing the flowsheet to include a mandatory field and the introduction of the Enhanced Care and Support Team has created a streamline and structured approach providing an accurate picture of the enhanced care pressures within the trust.

Chart 8: Monthly Average Number of Enhanced Care Level 3 (AMBER) Patients

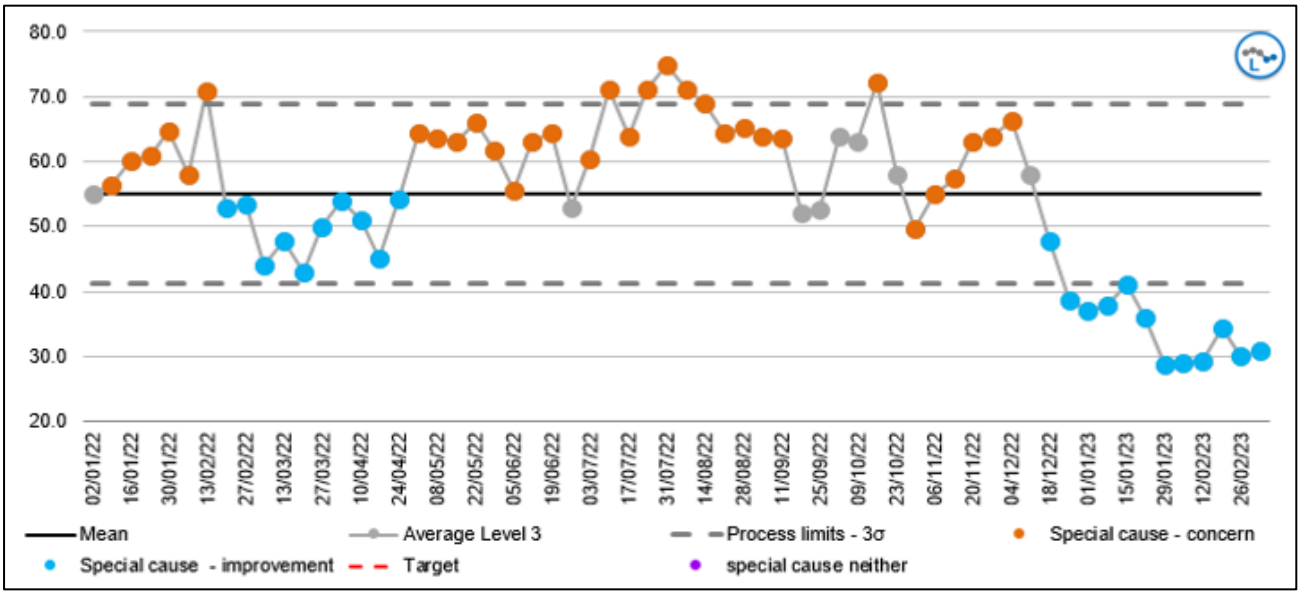
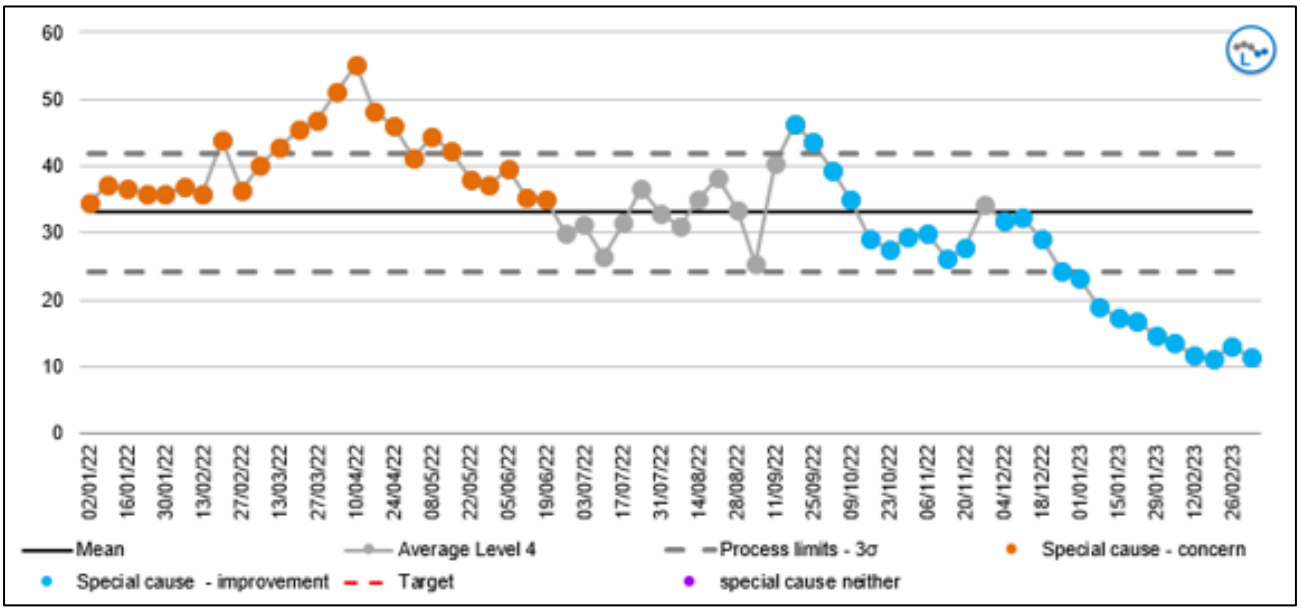


Chart 9: Monthly Average Number of Enhanced Care Level 4 (RED) Patients



5.19 Enhanced Care level 3 (AMBER): This level of enhanced care observation is required when a patient displays infrequent, unpredictable, unsafe behaviour towards themselves, others and/or the environment or is at avoidable risk of moderate levels of harm. Patients requiring amber (level 3) care will be kept within the line of sight of a clinical team member at all times. There may be a requirement for additional support for these patients above the nursing establishment numbers.

5.20 Enhanced Care level 4 (RED): Continuous enhanced observation is required when the patient requires continued regular therapeutic/clinical intervention or if the patient is likely to seriously harm themselves or others. Patients requiring this level of support will display frequent, unpredictable unsafe behaviours towards self, others and/or the environment or is at avoidable risk of significant levels of harm. Nursing establishments within some wards have been uplifted to reflect the increase in requirements for RED Level 4 care, and this should be considered prior to booking further staff.

5.21 Patients requiring Red level 4 care observations will be cared for within in a one to one situation by a clinical team member, by day and by night. The patient will need to be observed at all times, including personal care and toileting. Patients will be cared for on an individual basis.

6.0 Speciality areas

6.1 The Emergency Department (ED), Critical Care and Neo-Natal units plan and manage their staffing in line with relevant professional guidance.

6.2 This report will give a focused review of the speciality areas for the period July 2022-December 2022.

6.3 Acute Adult Care Division – Emergency Department

6.3.1 Current speciality and National guidance

6.3.2 NICE (The National Institute for Health and Care Excellence) developed evidence-based guidelines on safe staffing for ED nursing numbers published in 2015. NICE recommended 1 to 4 ratio of nursing to patients in ED Majors and 1 to 2 ratio of nursing to patient in ED Resuscitation. https://www.nice.org.uk/guidance/gid-sgwave0762/documents/accident-and-emergency-departments-draft-guideline2.

6.3.3 Compliance with guidance against establishment

6.3.4 During the COVID pandemic staffing levels were revised to deal with the change in attendances and patient acuity. The increase in staffing levels has largely been covered by temporary staffing. In response to these changes and the current demands and pressures on the ED a full staffing review was undertaken in October 2022. A business case has since been presented and approved requesting that these increases to the staffing levels were funded on a permanent basis**.** The department complies with the national guidelines of a staffing ratio of 1 to 4 nursing to patients in ED Majors and 1 to 2 ratio of nursing to patient in ED Resuscitation. Furthermore, the new uplift allows for additional staff to work in several areas of the department to support the increased demand on the department due to patient acuity and increased capacity.

6.3.5 The uplift in establishment also allows for the below additional roles;

Senior nurse floor manager to co-ordinate patients waiting for ambulance handover, ensure fit to sit is carried out, and provide senior nursing hands on support to the shift leader and staff.
A 2nd triage nurse to support patients being triaged in under 15 minutes as per NHS England Guidance
Corridor support for up to 10 patients, requiring 1:5 ratio 1 RN + 1 NA. This approach allows increased staffing matched to the nursing workload, therefore additional nursing has been added to ensure all necessary nursing care is provided safely and patient flow is maintained.

6.3.6 Compliance with guidance against fill rate

6.3.7 Staffing fill % continues to fluctuate month on month however Decembers fill % does show an improved position in ED (registered/non-registered). An improvement in fill % across all areas is forecasted following ongoing recruitment drive.

Table 9: ED fill rate

Ward/Team	Grade Type Category	Day/ Night	Jul-22 Fill %	Aug-22 Fill %	Sep-22 Fill %	Oct-22 Fill %	Nov-22 Fill %	Dec-22 Fill %
ED	Registered	Day	110.87%	105.85%	104.13%	106.61%	111.57%	111.23%
ED	Non-Registered	Day	106.66%	110.57%	102.37%	99.33%	96.23%	96.03%
ED	Registered	Night	108.76%	108.12%	105.31%	107.50%	104.29%	101.62%
ED	Non-Registered	Night	114.15%	113.61%	110.29%	101.36%	106.77%	107.94%

Green = between 90% and 110%
Amber = Between 80% and 90% or between 110% and 120%
Red = less than 80% or greater than 120

6.3.8 Recruitment and Retention issues

6.3.9 The table below demonstrates that registered nursing vacancy has gradually reduced to 5.47 WTE in December. This is also reflected in an improved position to fill rates. Non - Registered vacancy has fluctuated throughout the 6 months however rolling recruitment programmes are currently in place.

Table 10: ED vacancy rates

Ward/Team	Grade Type Category	Jul-22 Vacancy	Aug-22 Vacancy	Sep-22 Vacancy	Oct-22 Vacancy	Nov-22 Vacancy	Dec-22 Vacancy
ED	Registered	7.55	7.63	6.82	9.17	5.92	5.47
ED	Non-Registered	9.9	10.82	15.35	13.43	13.96	14.57

6.4 Anaesthetics & Surgical Division- Critical Care Unit

6.4.1 Current speciality and National guidance

6.4.2 The Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and UK Critical Care Nursing Alliance (UKCCNA), continue to recommend adherence to minimum critical care staffing levels as laid out in the Guidelines for the Provision of Intensive Care Services (GPICS).[1] These multi-professional consensus guidelines exist to provide standards and recommendations for safe and effective delivery of critical care to some of the sickest patients in hospital; the ratio of staff to patients is a central part of this. GPICS guidelines provide the best evidence currently available for providing a quality of critical care expected by patients and healthcare professionals.

6.4.3 Critical care staffing ratios are guided by GPICS standards and the unit must be staffed to these ratios at all times. Level 3 patients (multi organ support) require 1:1 care and Level 2 patients (single organ support) require 1:2 care.

6.4.4 The intensive care unit at Bolton is an 18 bedded unit which provides a combination of level 2 and 3 care. The unit has 2 areas which is considered when planning staffing alongside the national staffing guidance.

6.4.5 Compliance with guidance against fill rate

6.4.6 The unit has welcomed international nurses over the last twelve months to support the nursing establishment following staff retention following COVID and its impact on critical care staff. This is reflected in the data from July – Oct 2022 where the working hours above contract is shown as supervisory time for the oversees nursing programme.

6.4.7 Staffing within Critical Care is managed according to bed occupancy, when there are empty beds staff are flexed off and unworked hours are banked in the roster system. Staff then repay these hours when occupancy is increased in order to meet the demands of the unit. In addition staff from Critical Care will move to support the ED and other wards across the organisation.

6.4.8 The table below demonstrates the fill rate for critical care. A full detailed review has been undertaken and has confirmed that the standard of 1:1 and 1:2 has been met. Where the fill rate is recorded as red or amber, the occupancy of the unit was below the 18 available beds and therefore staff were 'flexed off' duty. This has therefore impacted on the fill rate.

Table 11: Critical Care fill rate

Ward/Team	Grade Type Category	Day/ Night	Jul-22 Fill %	Aug-22 Fill %	Sep-22 Fill %	Oct-22 Fill %	Nov-22 Fill %	Dec-22 Fill %
Critical Care Unit (1935)	Registered	Day	77.12%	79.49%	83.58%	84.26%	86.84%	79.06%
Critical Care Unit (1935)	Non-Registered	Day	87.19%	86.40%	110.53%	97.31%	109.93%	105.03%
Critical Care Unit (1935)	Registered	Night	78.40%	79.55%	83.97%	85.39%	88.16%	77.26%
Critical Care Unit (1935)	Non-Registered	Night	70.78%	67.39%	71.07%	70.13%	67.05%	77.27%

Green = between 90% and 110%
Amber = Between 80% and 90% or between 110% and 120%
Red = less than 80% or greater than 120%

6.5 Family Care Division- Neonatal Unit

6.5.1 Current speciality and National guidance

6.5.2 Staffing levels on the Neonatal Unit are monitored in line with the British Association of Perinatal Medicine (BAPM 2021, DOH 2019 and NICE 2018). The model indicates the staffing levels in relation to patient acuity i.e. 1:1 for Intensive Care, 1:2 for High dependency care and 1:4 for special care and a supervisory shift coordinator (band 7) in charge.
We aim to achieve 90% - 100% staffing as per BAPM.

Table 12: Average levels from July – Dec 22 of staffing as per BAPM incorporating all patient: staff ratios.

MONTH	July 2022	August 2022	Sept 2022	Oct 2022	November 2022	December 2022
BAPM COMPLIANCE	92.8%	89%	97.7%	83.3%	95.3%	96%

>95% Green 90-95% Amber < 90% Red

6.5.3 BAPM standards

6.5.4 The British Association of Perinatal medicine (BAPM) outlines Neonatal nurse staffing requirements for all Neonatal units. Workforce data is submitted quarterly to the network to review as part of the CRG Nursing workforce calculator, numbers submitted reflect direct patient care only. Compliance to the following standards are reported:

- A supervisory nurse in charge - Bolton are currently compliant.
- At least 70% staff of nurses should be QIS (qualified in speciality trained) in December 22 compliance was 67.5% - however the latter does not reflect nurses currently due to finish the training / currently on the course.
- For special care, registered nurse to non-registered staff ratios are calculated 70-30 – this allowing for skill mix flex. Bolton NNU are currently compliant.

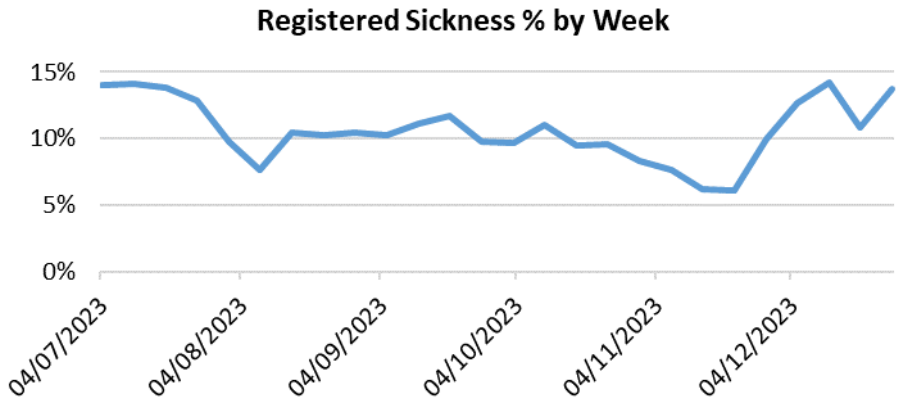
6.5.5 The Neonatal Unit

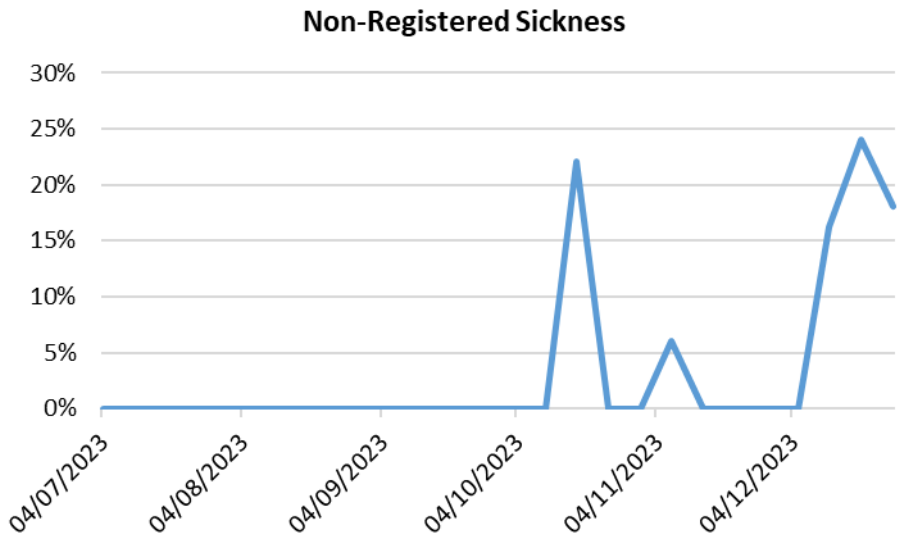
6.5.6 The NNU is a level 3 regional unit which consist of 36 cots. (9 Intensive care cots, 7 High dependency and 19 Special care cot) We provide care for extreme infants on the cusp of viability to sick Term infants requiring Neonatal input. Activity within Neonates is unpredictable – with staffing levels often reflecting the activity on the NNU and the acuity of infants on the unit, to maintain adequate skill mix to accommodate for any unexpected admissions, transfers etc.

6.5.7 Band 7 coordinators review staffing daily and manage in accordance with unit acuity. Where staffing levels are compromised nurses are transferred between NNU and the Children's ward (where appropriate) to alleviate staffing pressures and sustain a safe level of staff – patient ratio.

6.5.8 The Neonatal unit is currently experiencing a high level of long term sickness 5.81 WTE and high levels of Maternity leave are a common prevalence 3.75 WTE currently with a further 1WTE to commence Mat leave in the coming months. Maternity leave as per national guidance is not included in staffing uplift, however the NNU do endeavour to backfill during recruitment processes. Temporary staffing via bank and agency is used to support where possible.

Chart 10 and 11: Sickness rates.





6.5.9 As part of the Neonatal Critical care review, the Neonatal unit recently secured funding for 18 WTE new nurses, this as a reflection of actual direct cot side care against average activity over a 3-year period.

6.6 Family Care Division Acute Paediatrics Staffing Review

6.6.1 Current speciality and National guidance

Bolton NHS FT provides acute and community services for children under the Family Care Division. The Acute Paediatric children's unit includes –

- 28 bedded Medical Unit
- bedded Surgical day case unit
- 3 bedded Level 2 Critical Care Unit
- 9 Bedded Paediatric Assessment unit (F5)

6.6.2 *National Guidance*

6.6.3 In June 2018 the National Quality Board on behalf of NHS England, NHS Improvement and the CQC along with a range of national bodies produced Safe, Sustainable and Productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals. This guidance highlighted that no standard model for staffing on children and young people's inpatient wards existed. The guidance recognised that previous RCN guidance published in 2003, 2011 and 2013, recommended staffing ratios for age groups but did not focus specifically on safe staffing levels. The new guidance recognised that there is no 'one-size-fits-all' for staffing on acute paediatric units.

6.6.4 *Local /GM Guidance*

6.6.5 To ensure these standards are met, Bolton children's unit works as part of the Greater Manchester Network where an agreed nurse / patient ratio of 1:5 24 hours a day is the agreed standard for all age groups.

6.6.6 Compliance with guidance against establishment

6.6.7 The unit operates a seasonal staffing model which is reviewed twice a year in order to mitigate against seasonal variation. Below is the current guidance in place at Bolton:

- Staffing ratio of 1:4 (plus a supernumerary nurse in charge) Band 6 shift lead is supernumerary, Band 7 ward manager is supernumerary as per guidance.
- Minimum of 1 paediatric nurse per shift with the Advanced Paediatric Life Support course (APLS).
- The Paediatric Assessment Unit (F5) is staffed 24 hrs per day with at least one registered children's nurse.
- Play Specialists are available 7 days a week, to provide distraction or prepare children undergoing procedures.
- Staffing ratio of 1:2 in HDU as per Critical Care Network guidance.

Table 13: Compliance with standards

July 2022 – Dec 2022 Compliance	Supernumerary shift coordinator	APLS trained Band 6/7	7 day play team cover
July 2022	**100%**	**100%**	**100%**
August 2022	**94%**	**100%**	**97%**
Sept 2022	**90%**	**100%**	**100%**
October 2022	**91%**	**100%**	**100%**
Nov 2022	**90%**	**100%**	**100%**
Dec 2022	**86%**	**100%**	**100%**

Table 14: Registered nurse to child ratio

Ward/Team	Division	Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec-22	
		Early	Late	Early	Late	Early	Late	Early	Late	Early	Late	Early	Late
Ward E5 [2309]	FCD	1:1.79	1:2.58	1:1.76	1:2.39	1:2.45	1:3.42	1:2.52	1:3.48	1:3.1	1:4.4	1:2.05	1:3.0

6.6.8 Compliance with guidance against fill rate

6.6.9 In October, November and December 2022, there was approximately a 60% increase in children and young people admitted with Mental Health and social issues. This increased the number of HCA shifts required for 1:1 supervision. The decreased fill rates in July and August are as a direct result of decreased bed occupancy, requiring less staff on duty.

Table 15 - E5 Staffing Fill rates

Ward/Team	Grade Type Category	Day/ Night	Jul-22 Fill %	Aug-22 Fill %	Sep-22 Fill %	Oct-22 Fill %	Nov-22 Fill %	Dec-22 Fill %
Ward E5 [2309]	Registered	Day	79.68%	76.38%	82.13%	90.02%	91.17%	89.60%
Ward E5 [2309]	Non-Registered	Night	89.46%	64.87%	46.18%	95.22%	106.54%	94.95%
Ward E5 [2309]	Registered	Day	98.95%	84.77%	93.24%	92.93%	97.85%	93.78%
Ward E5 [2309]	Non-Registered	Night	136.96%	88.20%	147.28%	147.72%	189.06%	159.82%

6.7 Integrated Community Services Division- Bed Base & Community Nursing Teams

6.7.1 This report provides a high-level summary of the registered nurse staffing, focusing upon the bed base area and the community nursing teams within Integrated Community Nurses Services. Including an overview of the current staffing position and the work undertaken to ensure staffing levels are safe and sustainable.

6.7.2 National guidance and compliance with guidance against establishment

6.7.3 Investment in nursing establishments has been a priority within the community bed based inpatient areas and community nursing services. The workforce establishment within the bed base (Laburnum Lodge) has been agreed upon NICE guidelines, professional judgement and the consideration of quality indicators.

6.7.4 Laburnum Lodge delivers 24-hour nursing provision to a total of 16 patients at any one time; the current nursing establishment aligns with the Nursing Midwifery Council (NMC) and Royal College of Nursing (RCN) recommendation of 1:8. The Division uses Model Hospital to support establishment reviews alongside other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements, national staffing guidance and work continues to embed the safer nursing care tool (SNCT).

6.7.5 There is no national guidance available to determine the safe staffing levels for domiciliary-based community nursing services. The Queen's Nursing Institute (QNI) recently produced the Workforce Standards for the District Nursing Service. Maximum caseloads are not defined within the new QNI Standards, however a caseload of 150 patients per whole time equivalent (1 WTE) is recommended, with a maximum of 10 visits per day allocated per nurse per 7.5-hour working day.

6.7.6 Civica Scheduling (formerly Malinko) supports the allocation of domiciliary nursing visits; this software enables our community nursing services to operate with transparency and safety, providing real-time visibility of the distributed clinical capacity and patient demand for better, safer care within the nine neighbourhoods.

6.7.7 The Community Nursing Safer Staffing Tool (CNSST) is an evidence-based workforce-planning tool that has recently been introduced to support the establishment review process within the nine community nursing teams. This tool captures the patients care needs to ensure that the number of staff within each team is sufficient to provide optimal care.

6.7.8 Compliance with guidance against fill rate

6.7.9 The e-rostering system provides the off duty six weeks in advance to ensure the levels and skill mix of the nursing staff on duty are appropriate for providing safe and effective care. This allows contingency plans to be made where the roster falls short of the minimum requirement . Safe staffing levels continue to be monitored on a daily

basis by the Matron for that clinical area who will support with managing nurse staffing issues.

Table 16: ICSD fill rates

Ward/Team	Grade Type Category	Day/ Night	Jul-22 Fill %	Aug-22 Fill %	Sep-22 Fill %	Oct-22 Fill %	Nov-22 Fill %	Dec-22 Fill %
District Nursing	Registered	Day	87.52%	85.65%	86.92%	85.49%	89.21%	85.81%
District Nursing	Non-Registered	Day	114.33%	120.33%	132.34%	154.48%	137.00%	112.40%
District Nursing	Registered	Night	92.37%	95.65%	96.66%	99.84%	100.00%	100.00%
District Nursing	Non-Registered	Night	98.47%	100.00%	99.25%	99.68%	100.00%	98.95%
Laburnum Lodge (3818)	Registered	Day	106.27%	93.67%	103.46%	105.77%	89.96%	93.96%
Laburnum Lodge (3818)	Non-Registered	Night	80.01%	73.37%	84.05%	87.12%	86.49%	85.40%
Laburnum Lodge (3818)	Registered	Day	114.52%	103.23%	115.00%	114.45%	111.67%	116.13%
Laburnum Lodge (3818)	Non-Registered	Night	91.61%	76.72%	100.75%	90.09%	95.60%	90.32%

Green = between 90% and 110%
Amber = Between 80% and 90% or between 110% and 120%
Red = less than 80% or greater than 120%

7.0 Update on planned steps from last report

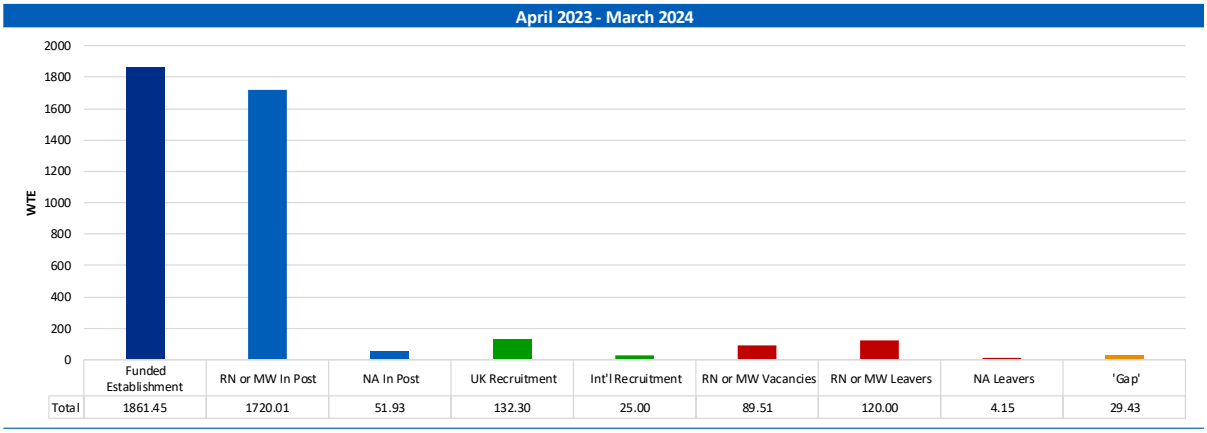
7.1 Following on from the previous report January 2022- June 2022, the table below demonstrates current progress against the identified project areas.

Table 17: Progress against projects

Project Number	Project Title	Progress Update	RAG rating
1	SNCT Inpatient areas	Three census collections have been completed on the adult in-patient wards and paediatric ward. Analysis of the data has taken place but issues with inter rater reliability were detected. A further data collection is planned for June 2023.	
	SNCT ED	The first data collection has taken place in the emergency department. Second collection date is planned for June 2023.	
	SNCT Community	Training of community nursing teams to Utilise the SNCCT has been undertaken and the first data collection is planned for March 2023	

2	Recruitment, the chart below (chart 11) demonstrates current recruitment activity and planned workforce gap.	Recruitment and retention plans are currently in place supported by a career pathway for all clinical staff.	
		A full international nurse recruitment plan is underway and is on track for delivery against numbers requested via NHSE	
3	Rota Management	Roster Management processes are embedded across divisions. The suite of rostering KPI's have been developed with workforce Business Intelligence colleagues and reviewed with Divisional Senior Nurses and will be utilised from May 2023 (appendix B). Further work is required regarding exception reporting and format for presentation.	
4	Trainee Nursing Associates	The Increasing capacity of Trainee Nursing Associates business case was approved in July 2022 this will increase number of TNAs over the next 2 years. Total number of NAs will equate to 15% of the RN headcount over the next 2 years.	
5	Bank and Agency	A full review of the processes for request temporary staffing has been undertaken and an SOP is in place. Weekly and monthly reporting is now available to track spend and evidence is available to demonstrate a reduction in variable pay.	
6	Leadership	A full review of the percentage of supervisory time that Ward Managers work against the NQB standards was undertaken and all ward managers are provided with 100% supervisory time	

Chart 12: Nursing and Nursing Associate establishment, in post, recruitment (UK and international), vacancies and leavers (turnover), demonstrating a forecast 'gap' by the end of financial year 23/24.



	Funded Establishment	RN or MW In Post	NA In Post	UK Recruitment	Int'l Recruitment	RN or MW Vacancies	RN or MW Leavers	NA Leavers	'Gap'
Total	1861.45	1720.01	51.93	132.30	25.00	89.51	120.00	4.15	29.43

8.0 Further transformation

8.1 Additional priorities for the next 12 months have been set out in below. These are monitored via the Chief Nurses Business Meetings and Professional Forum. In addition, updates are provided via the Resource and Talent Planning meeting.

- Review of International Nurse programme- to undertake a detailed review of the programme, including training, cost v benefit and relevant learning.
- Health Care Assistant retention- to review our current turnover rates and work with partners across Greater Manchester to review retention and reasons for leaving the NHS.
- Enhance and develop the Advanced Practice workforce.
- Fully roll out functionality of safecare- including ability to record red flags and live movement of staffing.
- Fully embed the new KPIs and Nursing, Midwifery and AHP workforce reports into practice.

8.2 In addition to the above work continues with the University of Bolton to develop partnerships and training and education programmes to develop and upskill our workforce.

9.0 Summary

9.1 This report provides a comprehensive review of the framework used to assess safe staffing levels, both in real-time, and bi-annually. The additional data provided and forensic review supports the recommendation that safe staffing levels were maintained during the periods of July to December 2022.

9.2 The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within Bolton FT.

10.0 Recommendations

10.1 It is recommended that the Board of Directors:

I. Approve the Bi-annual staffing report and recommendations.

II. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

Appendix A – NQB Recommendations

Detailed breakdown.

1.0 Expectation 1 - Right staff

1.1 The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months. The NQB references various tools that can be used.

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

1.4 The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for a maximum of 6-8 patients each during a day shift. There is no specific guidance regarding night duty. This is based on NICE[2] evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward Sr/CN should have supervisory capacity – the extent of which is subject to local Chief Nurse determinant **Headroom / Uplift**

1.5 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

1.6 The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. Current headroom/uplift provided is 23% with national ranges varying between 19% and 25%

1.7 Skill Mix

1.8 This is the ratio of RNs to unregistered staff such as healthcare assistants. Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

1.9 Professional judgement

1.10 The judgement of senior experienced nurses remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment

[2] NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals* July 2014

- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

1.12 NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were stated as specifically affected by the presence (and hence absence) of **registered** nursing staff. These indicators included;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

1.13 The NQB (2018) has highlighted that these indicators can be challenging to monitor consistently and recommends a thorough audit programme be agreed.

1.14 Patient reported outcome measures

1.15 NICE (2014) also recommend monitoring of the following;

- Adequacy of meeting patients' nursing care needs
- Adequacy of provided pain management
- Adequacy of communication with nursing team
- National in-patient survey

1.16 Staffing data & Training and education

- Appraisal, retention, vacancy, sickness
- Mandatory training, clinical training

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Appendix B – KPI Examples this is still not talking to the KPIs I requested before your time (last summer) and shared again recently. I think we need to show e roster KPIs as red

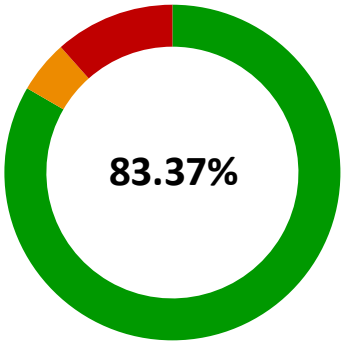
HealthRoster Rollout Progress

Key:	
	Yes
	Partially
	No

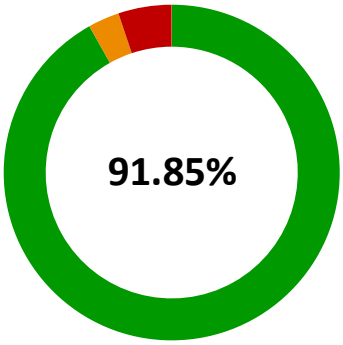
Parameters:

The report summarises the proprtion of the employee headcount
Includes only substantive, primary assignments

Actively Rostering in HealthRoster - Total



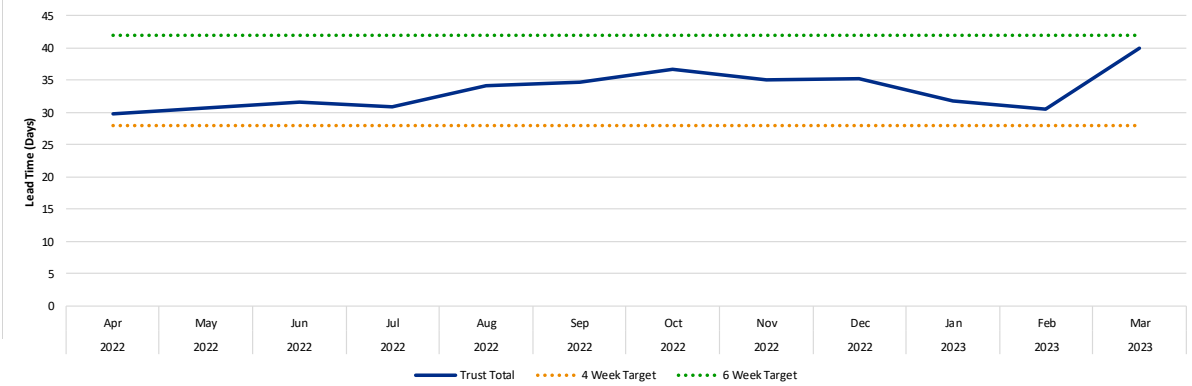
Record All Unavailability in HealthRoster - Total



241 L3 Acute Adult Care Division	241 L3 Anaesthetics & Surgical Division	241 L3 Diagnostics & Support Services Division	241 L3 Family Division	241 L3 Integrated Community Services Division
Adult ED (0419)	Critical Care Unit (1935)	Infection Control (5103)	Antenatal Clinic - ANDU [3009]	District Nursing - Avondale [3917]
CCU (Coronary Care Unit) [0121]	DCU Ward (1931)	Infection Control Community (4002)	Beehive (3010)	District Nursing - Breightmet [3918]
CDU (Clinical Decisions Unit) (0420)	Ward E3 (1513)	Nurse Led IV Access Service [5102]	Central Delivery Suite (CDS) [3011]	District Nursing - Crompton [3919]
Childrens ED (0419)	Ward E4 [1517]	OPD General Nursing (3205)	CM - Bluebell (3007)	District Nursing - Evenings & Nights (3
Discharge Lounge (0415)	Ward F3 (1529)	Pharmacists (6201)	CM - Daffodil (3007)	District Nursing - Farnworth [3921]
Minors ED (0419)	Ward F4 (1515)	Pre Op Assessment Outpatients (3207)	CM - Enhanced Midwives Team (3007)	District Nursing - Great Lever [3922]
SDEC (0404)	Ward F6 (0703)	Radiography (4303)	CM - Lavender (3007)	District Nursing - Horwich [3923]
Ward A4 (0214)	Ward G3 [0705]	Radiology Assistants (4303)	CM - Office (3007)	District Nursing - Pikes Lane [3924]
Ward B1 [0206]	Ward G4 (0707)	Ultrasound (4309)	CM - Sunflower (3007)	District Nursing - Waters Meeting [392
Ward B2 (0207)	Ward H2 (1003)		CM - Wildflower (3007)	District Nursing - Westhoughton [3926
Ward B3 (0408)			Maternity Triage (3011)	Laburnum Lodge (3818)
Ward B4 (0208)			Mental Health Midwives [3018]	
Ward C1 [0105]			Neonatal Unit [3013]	
Ward C2 [0109]			Specialist Midwives [3002]	
Ward C3 [0115]			Ward E5 [2309]	
Ward C4 (0216)			Ward M1 [3101]	
Ward D1 (0409)			Ward M2 - Obstetrics (3004)	
Ward D2 (0411)			Ward M4 - Post Natal [3005]	
Ward D3 [0117]			Ward M5 - Post Natal (3006)	
Ward D4 [0119]				
Ward H3 - Stroke [0204]				
Ward R1 (0309)				

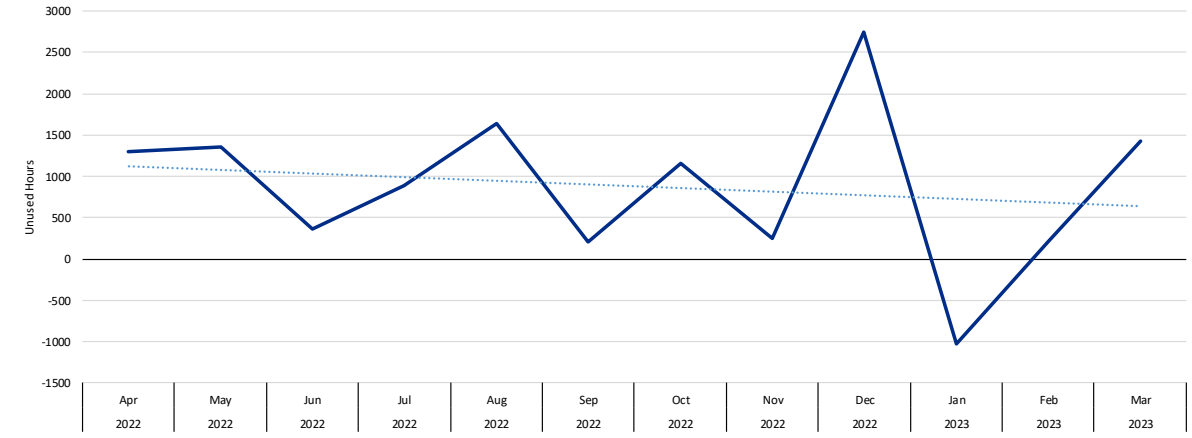
Roster Approval Lead Time KPI Performance					
Period	No. Rosters (Teams) in Scope	Average Lead Time (in Month)	No. Rosters Compliant (6 Weeks/42 Days or More)	No. Rosters Compliant (4 Weeks/28 Days or More)	No. Rosters Non-Compliant (Less than 4 Weeks/28 Days)
Mar 2023	75	40.02	42 (56%)	23 (30.67%)	10 (13.33%)

Roster Approval Lead Time Trend



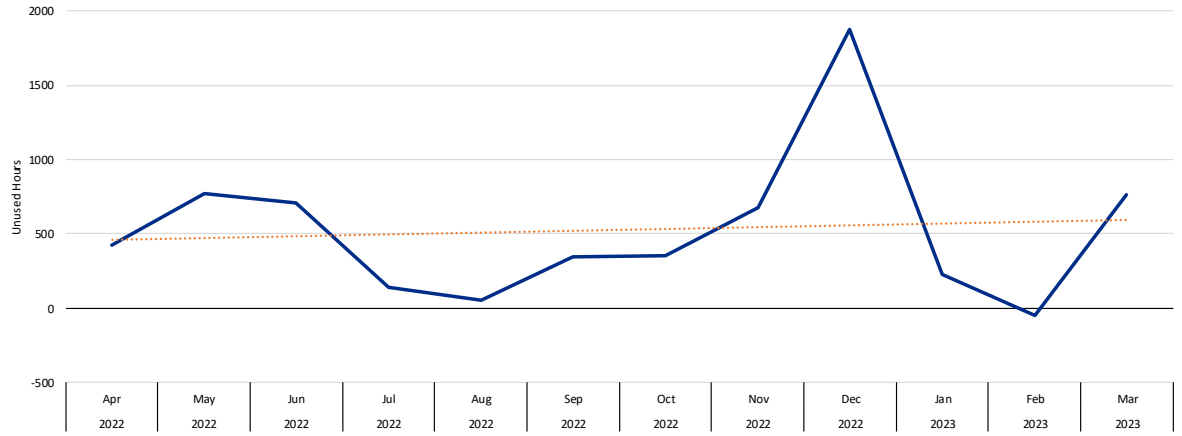
Unused Hours - Registered					
Period	Available Contracted Hours	Unused Hours	Unused WTE	Hours Filled Bank/Agency/OT	Avoidable Bank/Agency/OT
Mar 2023	194041	1425 (0.73%)	37.99	29379	1425 (4.85%)

Unused Hours per Month by Division - Registered



Unused Hours - Non-Registered					
Period	Available Contracted Hours	Unused Hours	Unused WTE	Hours Filled Bank/Agency/OT	Avoidable Bank/Agency/OT
Mar 2023	90592	767 (0.4%)	20.45	28574	767 (2.61%)

Unused Hours per Month by Division - Non-Registered

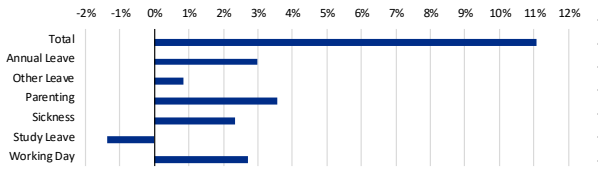


Unavailability In Month					
Period	Contracted Hours	Funded Unavailability Hours	Total Unavailability Hours	Hours Filled Bank/Agency/OT	Unfunded Bank/Agency/OT
Mar 2023	270656	62792 (23.2%)	92618 (34.22%)	57953	29825 (51.46%)

Registered

Type	Funded		Actual		Difference	
	Hrs	%	Hrs	%	Hrs	%
Total	42581	23.20%	62915	34.28%	20334	11.08%
Annual Leave	28816	15.70%	34291	18.68%	5476	2.98%
Other Leave	0	0.00%	1556	0.85%	1556	0.85%
Parenting	0	0.00%	6538	3.56%	6538	3.56%
Sickness	8259	4.50%	12533	6.83%	4274	2.33%
Study Leave	5506	3.00%	3000	1.63%	-2506	-1.37%
Working Day	0	0.00%	4996	2.72%	4996	2.72%

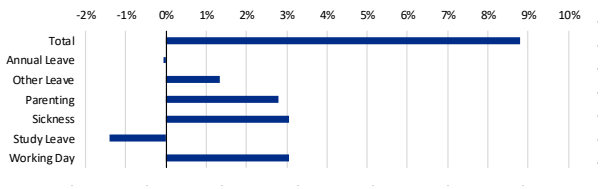
Unavailability Exceeding Funded - % by Type



Non-Registered

Type	Funded		Actual		Difference	
	Hrs	%	Hrs	%	Hrs	%
Total	20211	23.20%	27890	32.01%	7679	8.81%
Annual Leave	13677	15.70%	13634	15.65%	-43	-0.05%
Other Leave	0	0.00%	1177	1.35%	1177	1.35%
Parenting	0	0.00%	2446	2.81%	2446	2.81%
Sickness	3920	4.50%	6579	7.55%	2659	3.05%
Study Leave	2613	3.00%	1396	1.60%	-1218	-1.40%
Working Day	0	0.00%	2658	3.05%	2658	3.05%

Unavailability Exceeding Funded - % by Type



Appendix C – Example ASSD Staffing Data Pack

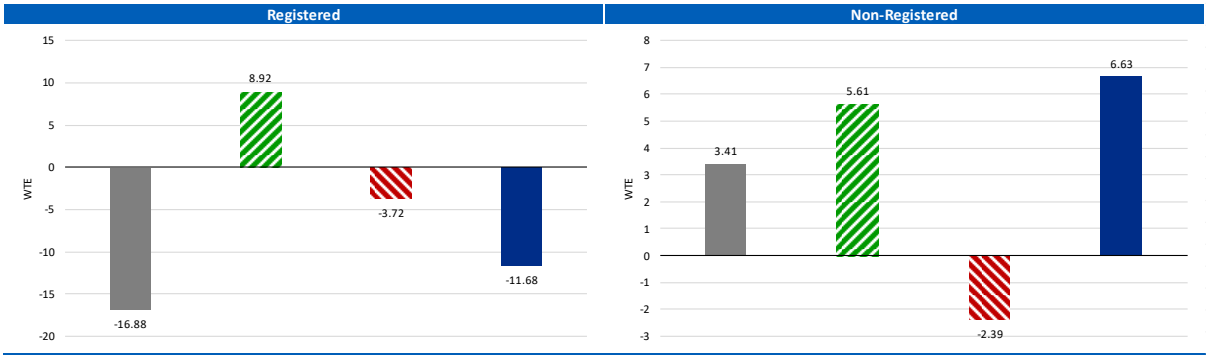
Ward (Unit)	Vacancy March 2023						Recruitment & Leavers As at 11/04/2023							
	WTE Budgeted Establishment		WTE In Post		WTE Difference		WTE Requested Recruitment		WTE Live Recruitment		WTE Starters (Final Offer)		WTE Leaving	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**265.41**	**174.40**	**248.53**	**177.81**	**-16.88**	**3.41**	**1.00**	**1.00**	**25.61**	**9.84**	**8.92**	**5.61**	**-3.72**	**-2.39**
Critical Care Unit (1935)	79.63	16.73	79.02	17.19	-0.61	0.46	0.00	1.00	7.55	0.92	2.00	0.00	-1.80	0.00
DCU Ward (1931)	20.92	11.83	24.99	10.64	4.07	-1.19	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
Ward E3 (1513)	19.57	18.59	18.25	19.38	-1.32	0.79	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
Ward E4 [1517]	16.93	13.28	12.59	17.36	-4.34	4.08	0.00	0.00	3.00	0.00	1.00	0.00	0.00	-0.61
Ward F3 (1529)	24.51	13.28	20.29	16.55	-4.22	3.27	0.00	0.00	7.53	0.00	1.00	0.00	0.00	-0.92
Ward F4 (1515)	19.57	15.92	12.76	14.11	-6.81	-1.81	0.00	0.00	6.61	2.00	3.92	1.00	0.00	0.00
Ward F6 (0703)	12.53	5.45	12.24	7.68	-0.29	2.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ward G3 [0705]	18.00	26.50	17.17	29.49	-0.83	2.99	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ward G4 (0707)	17.98	26.51	17.90	21.81	-0.08	-4.70	0.00	0.00	0.92	5.92	0.00	1.61	-0.92	0.00
Ward H2 (1003)	35.77	26.31	33.32	23.60	-2.45	-2.71	0.00	0.00	0.00	1.00	1.00	1.00	-1.00	-0.85

Key (Field/Column Descriptions):	
Budgeted Establishment	The Whole Time Equivalent (WTE), where 1 = 37.5 hours per week, of funded posts in the budget.
In Post	WTE of substantive employees in post - includes employees on career break, maternity leave, out on external secondment etc.
Difference	Establishment minus substantive staff in post, i.e. the 'true' vacancy. Note this may be different than the 'operating vacancy' which may be increased where employees are unavailable for long periods of time.
Requested Recruitment	WTE of requests to recruit in TRAC that are progressing through the authorisation stages (OBM/Finance/HRBM/ESC) and not yet advertised.
Live Recruitment	WTE that are either being advertised, at selection stage (shortlisting /interview) or have been conditionally offered a post and are undergoing pre-employment checks.
Starters (Final Offer)	WTE who have received and accepted a final offer and have a start date. They have not yet commenced in employment.
Leaving	WTE confirmed leavers in future, where a manager has submitted the SimpleSAF termination form and it has been processed by Payroll.

Key (RAG Status):		
Red		Outbound leavers from services with confirmed end date
Amber		Inbound on-going recruitment (various stages) without confirmed start dates
Green		Inbound recruitment with confirmed start dates

Key:

WTE Current Vacancy: WTE Starters (Final Offer): WTE Leaving: Forecast Vacancy:



Ward (Unit)	Finance March 2023 £000s Month Position		£000s YTD Position		£000s Forecast Position	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**51.24**	**-7.05**	**1640.05**	**-183.79**	**1691.30**	**-204.57**
Critical Care Unit (1935)	10.50	-0.00	183.92	-10.12	194.42	-12.73
DCU Ward (1931)	-9.48	0.00	-60.09	0.00	-69.57	0.00
Ward E3 (1513)	10.90	0.00	217.27	-11.52	228.17	-11.52
Ward E4 [1517]	18.98	-2.36	303.49	-50.71	322.48	-61.73
Ward F3 (1529)	12.77	-3.45	307.74	-59.34	320.51	-62.78
Ward F4 (1515)	1.80	-0.16	244.67	-10.04	246.46	-10.20
Ward F6 (0703)	3.92	-3.06	120.64	-39.21	124.56	-42.27
Ward G3 [0705]	-1.37	1.50	91.69	13.93	90.33	15.43
Ward G4 (0707)	-3.27	0.46	103.83	-7.71	100.56	-7.24
Ward H2 (1003)	6.50	0.00	126.90	-9.08	133.40	-11.53

Key (Field/Column Descriptions):	
Month Position	Pay budget minus pay spend (substantive, bank and agency) in month.
YTD Position	Pay budget minus pay spend (substantive, bank and agency) since the start of April.
Forecast Position	The annual pay budget minus the forecasted pay spend (substantive, bank and agency) by the end of March.

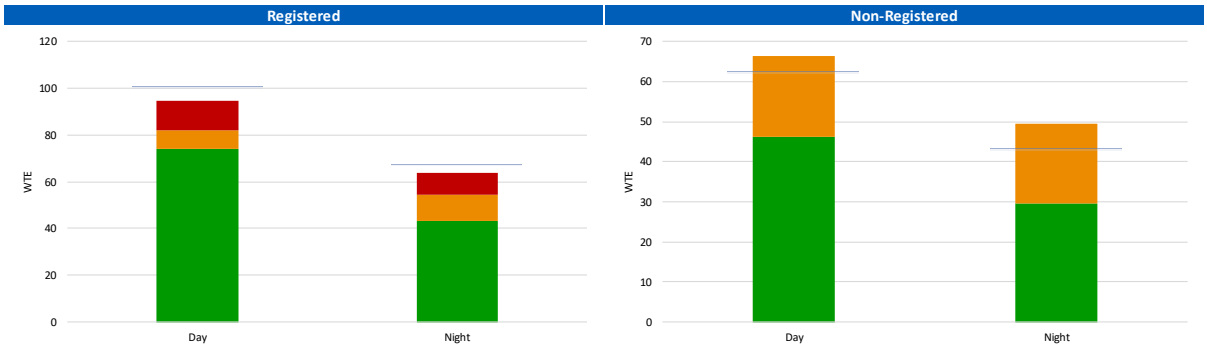
Ward (Unit)	Planned vs. Actual Staffing and Unused Hours March 2023												March 2023 WTE Unused Hours	
	WTE Planned Days		WTE Actual Days		% Fill Rate		WTE Planned Nights		WTE Actual Nights		% Fill Rate			
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**100.58**	**62.65**	**87.86**	**64.19**	**87.36%**	**102.47%**	**67.33**	**43.13**	**62.17**	**49.09**	**92.34%**	**113.82%**	**4.69**	**2.22**
Critical Care Unit (1935)	26.85	6.20	20.88	6.70	77.75%	108.13%	26.86	6.20	21.28	5.46	79.23%	87.99%	0.26	0.00
DCU Ward (1931)	11.00	5.13	9.17	4.74	83.32%	92.32%	0.00	0.00	0.00	0.00	*N/A*	*N/A*	0.02	0.06
Ward E3 (1513)	8.27	8.27	8.29	8.03	100.33%	97.16%	6.13	6.20	6.10	7.03	99.46%	113.43%	-0.09	0.17
Ward E4 [1517]	8.16	6.20	7.68	5.69	94.11%	91.78%	4.13	4.13	5.34	4.96	129.17%	119.92%	-0.03	-0.04
Ward F3 (1529)	9.93	6.20	9.32	6.61	93.83%	106.62%	8.27	4.13	7.98	4.94	96.46%	119.53%	0.71	0.32
Ward F4 (1515)	8.25	6.20	8.54	7.06	103.56%	113.91%	6.20	6.00	6.03	7.23	97.19%	120.53%	-0.06	0.06
Ward F6 (0703)	5.67	3.59	3.69	2.80	64.99%	78.06%	4.07	0.00	3.03	1.00	74.52%	*N/A*	1.07	0.01
Ward G3 [0705]	8.20	10.33	8.08	11.66	98.48%	112.80%	5.47	8.27	6.24	10.30	114.16%	124.61%	2.86	0.22
Ward G4 (0707)	8.29	10.35	8.15	10.90	98.27%	105.27%	6.20	8.20	6.17	8.17	99.58%	99.69%	-0.04	1.43
Ward H2 (1003)	5.94	0.17	4.07	0.00	68.43%	0.00%	0.00	0.00	0.00	0.00	*N/A*	*N/A*	-0.01	0.00

Key (Field/Column Descriptions):	
Planned Days	Based on the roster template 'required' day shifts (does not include 'optional' duties). Also does not include 'additional' duties added by managers. Should be aligned with budgeted establishment.
Actual Days	All rostered day shifts except those 'Excluded from SafeCare' calculations (e.g. ward clerk, housekeeper etc.) - includes 'optional' and 'additional' duties where rostered.
Planned Nights	Based on the roster template 'required' night and evening shifts (does not include 'optional' duties). Also does not include 'additional' duties added by managers. Should be aligned with budgeted establishment.
Actual Nights	All rostered night and evening shifts except those 'Excluded from SafeCare' calculations (e.g. ward clerk, housekeeper etc.) - includes 'optional' and 'additional' duties where rostered.
Fill Rate(s)	Actual days or nights divided by planned days or nights.
Unused Hours	Sum of contracted hours minus all work time and unavailability rostered - i.e. paid time with no allocated hours. A positive value indicates hours are owed to the Trust, and negative value indicates the Trust owes hours.

Key (RAG Status):		
Red		Fill rate is 20% or more above or below the planned
Amber		Fill rate is between 10% and 20% above or below the planned
Green		Fill rate is between 0% and 10% above or below the planned

Key:

Planned: Substantive: Bank: Agency:



Ward (Unit)	Unavailability March 2023															
	WTE Funded Headrom		WTE Difference		WTE Annual Leave		WTE Sickness		WTE Maternity		WTE Working Day		WTE Study Leave		WTE Other Leave	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**71.10**	**40.15**	**-21.00**	**-4.05**	**40.41**	**18.45**	**13.21**	**13.33**	**8.30**	**3.35**	**17.54**	**4.66**	**9.55**	**3.14**	**3.09**	**1.26**
Critical Care Unit (1935)	19.33	3.85	-9.99	0.46	14.94	2.47	3.75	0.73	0.87	0.00	7.19	0.00	2.30	0.18	0.26	0.00
DCU Ward (1931)	5.82	2.72	1.10	0.80	1.60	0.81	1.31	1.08	0.00	0.00	1.54	0.00	0.27	0.00	0.00	0.04
Ward E3 (1513)	5.51	4.28	-3.15	-3.57	3.99	3.14	1.77	0.27	1.95	1.82	0.70	1.69	0.24	0.53	0.00	0.40
Ward E4 [1517]	4.90	3.06	-5.51	0.51	2.88	1.50	0.47	0.89	0.87	0.00	1.91	0.00	4.22	0.13	0.07	0.02
Ward F3 (1529)	6.64	3.06	-1.68	-4.66	4.04	2.20	0.33	1.97	1.91	0.95	0.91	1.37	0.90	1.22	0.23	0.00
Ward F4 (1515)	5.51	3.66	-3.34	-0.10	2.77	2.92	2.05	0.65	1.18	0.00	2.41	0.00	0.28	0.17	0.15	0.02
Ward F6 (0703)	3.88	1.25	-2.86	0.63	2.97	0.33	1.53	0.00	0.52	0.00	1.13	0.03	0.53	0.20	0.07	0.07
Ward G3 [0705]	5.14	6.10	-0.80	-2.07	2.82	1.97	0.89	4.16	1.00	0.58	0.63	0.64	0.40	0.56	0.20	0.27
Ward G4 (0707)	5.14	6.10	-2.01	-2.11	3.54	3.10	0.99	3.58	0.00	0.00	1.11	0.93	0.39	0.15	1.10	0.44
Ward H2 (1003)	9.23	6.06	7.25	6.06	0.86	0.00	0.12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.01	0.00

Key (Field/Column Descriptions):	
Funded Headroom	The portion of the budgeted establishment included on top of the 'planned' hours to account for time expected to be unavailable due to annual leave, sickness, study and management. Other leave categories are not funded/budgeted for.
Total Difference	The funded headroom minus the sum total of all unavailability categories. The greater a negative value, the more of a roster gap which may result in the need for overtime, bank or agency fill.
Annual Leave	Includes 'normal' annual leave, bank holidays and 'bought' annual leave.
Sickness	Includes all sickness unavailability reasons aligned to ESR.
Maternity	Includes maternity, paternity and adoption unavailability reasons.
Working Day	Various reasons where an employee is in paid work time but not clinical, including; Audit/Inspection, Coroner's Court, Management Time, Meeting, Probationary (supernumary), Supervision, Time Accrued On Call, Training Facilitator, Union Duties, Working From Home.
Study Leave	Includes all paid time to complete study, including; Apprenticeship (Outside Study), Continuous Professional Development, Role/Post Specific Training, Statutory & Mandatory Training.
Other Leave	Includes all other reasons for unavailability, including; Armed Forces, Bereavement Leave -PAID, Career Break, Compensatory Rest, Consultant - Professional Leave, Disability Leave, Emergency Leave/Time Off for Dependants - Paid, Gone Home Sick, Medical Suspension Other, Not Authorised Leave - UNPAID, Other Leave - PAID, Out on External Secondment – Unpaid, Personal/General Commitments, Phased Return to Work, Special Leave - jury/interview/court/mags, Time Owing, Unpaid Leave - authorised.

Key (RAG Status):		
Red		Unavailability exceeds funded headroom per unavailability group and in total

Ward (Unit)	Substantive Fill March 2023						Temporary Staffing Demand March 2023							
	WTE Days		WTE Nights		WTE Total		WTE Vacancy		WTE Absence Over Headroom		WTE Increased Activity		WTE Total	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**74.06**	**46.19**	**43.23**	**29.59**	**117.29**	**75.79**	**25.74**	**16.83**	**19.13**	**17.20**	**5.77**	**14.97**	**50.63**	**49.00**
Critical Care Unit (1935)	25.16	6.33	21.38	5.13	**46.53**	**11.47**	1.45	0.14	2.25	0.61	0.04	0.11	**3.74**	**0.86**
DCU Ward (1931)	9.17	3.54	0.00	0.00	**9.17**	**3.54**	0.00	1.12	0.00	0.52	0.00	0.00	**0.00**	**1.64**
Ward E3 (1513)	5.21	5.60	3.13	3.61	**8.34**	**9.21**	2.64	3.32	4.40	2.39	0.07	1.56	**7.11**	**7.26**
Ward E4 [1517]	4.65	3.68	2.81	3.53	**7.46**	**7.21**	5.65	2.61	0.73	0.91	1.44	1.94	**7.82**	**5.46**
Ward F3 (1529)	7.61	4.25	4.87	2.33	**12.48**	**6.58**	1.97	1.05	3.34	3.21	1.06	0.87	**6.38**	**5.13**
Ward F4 (1515)	3.15	4.38	2.07	3.93	**5.22**	**8.31**	6.23	1.23	2.43	2.10	2.42	3.93	**11.08**	**7.26**
Ward F6 (0703)	3.43	3.01	1.34	0.00	**4.77**	**3.01**	1.98	0.83	2.28	0.07	0.40	1.38	**4.66**	**2.28**
Ward G3 [0705]	6.06	8.32	3.87	6.60	**9.93**	**14.92**	4.13	2.02	0.91	2.27	0.22	4.67	**5.25**	**8.96**
Ward G4 (0707)	6.54	7.09	3.77	4.45	**10.31**	**11.53**	1.55	4.51	1.81	5.12	0.12	0.51	**3.49**	**10.13**
Ward H2 (1003)	3.08	0.00	0.00	0.00	**3.08**	**0.00**	0.12	0.00	0.97	0.00	0.00	0.00	**1.10**	**0.00**

Key (Field/Column Descriptions):	
Substantive Fill - Days	WTE worked days by substantive staff in their contracted post - including any contractual overtime (but excludes all Bank).
Substantive Fill - Nights	WTE worked nights by substantive staff in their contracted post - including any contractual overtime (but excludes all Bank).
Temporary Staffing Demand - Vacancy	WTE active (not recalled) requests (both filled and unfilled) using reasons; Established vacancy not recruited into, Established vacancy recruited into but not in post.
Temporary Staffing Demand - Absence Over Headroom	WTE active (not recalled) requests (both filled and unfilled) using reasons; Short term sickness cover (unplanned cover), Long term sickness cover (planned cover), Urgent leave cover, Maternity cover.
Temporary Staffing Demand - Increased Activity	WTE active (not recalled) requests (both filled and unfilled) using reasons; Increased Activity, Escalation Area Open, Enhanced Care.
Temporary Staffing Demand - Total	Sum of Temporary Staffing Demand categories.

Ward (Unit)	Temporary Staffing Fill Performance March 2023													
	Average Days Request Lead Time		WTE Bank Requests WTE		WTE Bank Filled		% Bank Fill Rate		WTE Agency Requests		WTE Agency Filled		% Agency Fill Rate	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**20.25**	**16.04**	**23.62**	**51.59**	**19.20**	**40.21**	**36.63%**	**77.94%**	**28.80**	**0.00**	**21.76**	**0.00**	**41.50%**	**0.00%**
Critical Care Unit (1935)	4.24	2.40	3.67	0.86	2.95	0.69	**78.74%**	**80.34%**	0.07	0.00	0.00	0.00	**0.00%**	**0.00%**
DCU Ward (1931)	0.00	14.51	0.00	1.64	0.00	1.20	**0.00%**	**72.84%**	0.00	0.00	0.00	0.00	**0.00%**	**0.00%**
Ward E3 (1513)	24.04	32.71	2.70	7.30	2.29	5.89	**30.78%**	**80.61%**	4.74	0.00	3.83	0.00	**51.44%**	**0.00%**
Ward E4 [1517]	18.16	13.92	2.53	5.49	2.20	3.49	**27.21%**	**63.52%**	5.54	0.00	3.80	0.00	**47.09%**	**0.00%**
Ward F3 (1529)	42.39	17.17	4.40	5.94	3.41	5.10	**51.01%**	**85.92%**	2.27	0.00	1.54	0.00	**23.12%**	**0.00%**
Ward F4 (1515)	18.52	14.51	4.95	7.52	4.38	6.09	**39.13%**	**80.97%**	6.24	0.00	5.21	0.00	**46.55%**	**0.00%**
Ward F6 (0703)	32.11	26.68	2.49	2.36	1.43	1.27	**30.14%**	**53.78%**	2.24	0.00	1.00	0.00	**21.08%**	**0.00%**
Ward G3 [0705]	24.01	12.41	1.81	9.47	1.57	7.18	**26.94%**	**75.82%**	4.02	0.00	3.13	0.00	**53.69%**	**0.00%**
Ward G4 (0707)	30.52	26.10	0.88	11.00	0.81	9.30	**22.31%**	**84.53%**	2.75	0.00	2.43	0.00	**66.88%**	**0.00%**
Ward H2 (1003)	8.48	0.00	0.18	0.00	0.17	0.00	**15.87%**	**0.00%**	0.91	0.00	0.81	0.00	**74.07%**	**0.00%**

Key (Field/Column Descriptions):	
Days Lead Time	Average of the number of days before a shift that the request is made to fill by Bank or Agency - a longer lead time is more likely to result in fill by any source and also for fill by Bank.
Bank Requests	WTE of all active temporary staffing requests, not including those subsequently escalated to Agency.
Bank Filled	WTE of all Bank shifts filled.
Bank Fill Rate	Bank shifts filled divided by total of active Bank and Agency requests, i.e. the proportion of all Bank and Agency requests filled by Bank.
Agency Requests	WTE of all active temporary staffing requests escalated to Agency.
Agency Filled	WTE of all Agency shifts filled.
Agency Fill Rate	Agency shifts filled divided by total of active Bank and Agency requests, i.e. the proportion of all Bank and Agency requests filled by Agency.

Key (RAG Status):		
Red		Fill rate is less than 50%
Amber		Fill rate is between 50% and 60%
Green		Fill rate is greater than 60%

Title:	Maternity Bi-Annual Staffing Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Tyrone Roberts		Decision	

Previously considered by:	The purpose of this report is to outline the findings of the maternity bi-annual review for the period July – December 2022.
Summary:	The acuity based tool Birth rate + (NICE accredited) was completed in Jan 23 using caseload data from a 3-month period June to August 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. The report highlights: - That there has been a reported increase in acuity (as defined by obstetric, fetal and medical problems). This increase is noticeable across many providers over past 3-4 years - That as a consequence of this increased acuity, the midwife to patient ratio needs increasing leading to a revised establishment and subsequent reported gap against funded establishment of an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles - A revision of the current skill mix is required to ensure a 90:10 mix is deployed in postnatal clinical areas. Currently 97;3. - A review of safety indicators with potential to be impacted by staffing illustrate previously reported challenges with; bookings at 12+6 (due to reduced workforce capacity to offer weekend/evening clinics) and initiation of breast feeding. Our compliance is comparable and/or favourable when compared to Greater Manchester and East Cheshire (GMEC) - Mandatory and statutory staff training compliance during the period July – December 2022 remained below the Trust standard due to ongoing staffing pressures - A deficit in planned and actual hours worked for registered and non-registered staff was reported during the period July – December 2022 despite the offer of enhanced bank and agency pay to incentivise uptake. The report details the actions being taken to mitigate the risk within the service and improve training and key staffing related metrics. Further updates will be provided in quarterly Board reports for ongoing oversight and scrutiny. In summary, the report demonstrates the ongoing workforce challenges yet details mitigation and signs of improvement. Next steps include a request from regional colleagues to review Greater Manchester acuity data to understand if acuity increase is comparable. Plans to re-open current reduced capacity will only happen in parallel with discussions around the BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

Previously considered by:	The report was presented at the People Committee on 15 May 2023

Proposed Resolution	The Board of Directors are asked to **approve** the report and recommendations.

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

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

1. Introduction

1.1 This report details the findings of the Bolton Foundation Trust 2022 bi-annual maternity staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

1.2 The report fulfils the requirements outlined in the National Quality Board (NQB 2018) and the Clinical Negligence Scheme Trusts guidance (CNST 2022) that recommended maternity services should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months.

1.3 The review incorporates all national guidance relating to the provision of safe staffing levels within maternity services (Royal College of Obstetrician and Gynaecologists (RCOG) 2021), National Institute for Clinical Excellence (NICE) 2016, National Quality Board (NQB) 2018 workforce indicators, clinical outcome and activity measures, outcome measures reported by women, staff reported measures and findings of the formal Birth Rate Plus (BR+) assessment of the midwifery establishment staffing levels published in 2023.

2. Background

2.1 In January 2018, the National Quality Board (NQB) released updated guidance in respect of nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Table 1: NQB expectations for safe, sustainable and productive staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

3.0 Expectation 1 - Right staff

3.1 The NQB recommends that there is an annual strategic staffing review, with evidence that it is developed using a triangulated approach (accredited tools,

professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months.

3.2 The Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (2022) requires a midwifery staffing oversight report that covers staffing/safety issues to be submitted to the Board every 6 months.

3.3 Process for determining staffing levels

3.4 Birth Rate Plus - Evidence based workforce planning

3.5 Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The Birth Rate Plus assessment was last undertaken in January 2023 and included case mix data from June to August 2022.

3.6 The report acknowledged that the Beehive alongside birthing centre and the Ingleside freestanding birthing centre were closed to birthing activity at the time of the assessment

3.7 The report confirmed that there had been a noticeable change in the number of women in category V (highest acuity) category of case mix in the 2023 with the % increasing from 29.3% in 2019 to 51.4% in 2023. This increase in acuity had a significant impact upon the required staffing ratio.

3.8 The maternity service has seen an increase in the % of women with significant safeguarding needs which has added to the clinical workload. The service currently manages 600 significant safeguarding cases per year.

3.9 The 2023 Birth Rate Plus review highlighted

3.10 Findings of the Birth Rate Plus review confirmed that a total clinical staffing establishment of 283.07 Whole Time Equivalent (WTE) was required to deliver a safe midwifery service. This includes an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles. The breakdown as to how the staffing establishment has been calculated by Birth Rate Plus is detailed in Appendix 1.

3.11 A revision of the skill mix is required to ensure a 90:10 mix is deployed in postnatal clinical areas. Currently the skill mix for Registered Midwives: Support Workers is 97:3 – adjusting this skill mix will reduce the impact upon the Registered Midwife uplift required.

3.12 A business case will be submitted in June 2023 to seek funding for an additional uplift to the funded establishment to fulfil the 2023 Birth Rate Plus report recommendations. The current funded Registered Midwife establishment of 242.58WTE is not compliant with the report recommendations.

3.13 The required additional variance is -37.89WTE that includes a shortfall of 18.36WTE Registered Midwives for clinical, specialist and management roles and a 19.53WTE deficit in postnatal Maternity Support Workers when applying the 90/10 skill mix to the clinical total WTE.

3.14 Monthly establishment reconciliations are shared with the service that detail the funded and vacant positions within the funded establishment. The monthly reconciliation as of March 2022 is therefore detailed in Appendix 2. This reconciliation was based upon the current funded establishment defined in the 2019 Birth Rate Plus report.

3.15 Specialist Midwifery Roles

3.16 Specialist midwives support the delivery of the maternity service providing expert guidance and specialist support to the midwifery team. Currently 27.01WTE specialist midwives are currently employed within the maternity service undertaking a range of roles including infant feeding specialist, digital midwife and pastoral support. 1WTE post holder is awaiting appointment. (Appendix 3).

3.17 Birth Rate Plus advises that the additional workforce should equate to no more than 8-10% of the funded clinical midwifery establishment to provide specialist support for the delivery of a safe service. The current establishment (27.01WTE) is therefore within the recommended specialist midwifery requirements for the service.

3.18 A further revision of the current specialist funded establishment will be undertaken in response to the Birth Rate Plus recommendations. Any additional specialist roles to fulfil statutory requirements and support the delivery of the Year 5 CNST programme will be included in the upcoming business case.

3.18 Registered Midwife to birth ratio

3.19 A recommended Trust specific ratio for Bolton Foundation Trust of 1.27.5 births to 1WTE was recommended in the 2019 Birth Rate Plus report. This ratio was calculated using the case mix and acuity data.

3.20 The 2023 report suggests a revised ratio of 1:23 should be implemented based upon current activity / acuity data. Table 2 highlights the staffing ratio between July and December 2022 does not meet the required standard. Non-compliance with the standard was exacerbated by the significant staffing gap during this period (circa 45WTE).

3.21 Table 2 highlights the midwife to birth ratio in accordance with funded hours and actual hours worked when staffing levels have been supplemented with additional agency/bank staff to support acuity / activity. The Trust midwife/birth rate ratio mean of 1: 31.90 in December 2022 was slightly higher than the GMEC regional peer mean of 1:29 and reflective of the staffing pressures within the maternity service of circa 45WTE during this period.

Table 2: Midwife to birth ratio

Indicator	Goal	Red Flag	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:33.9	1:34	1:35	1:33.4	1:33.1	1:33.9
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		1:31.4	1:30.3	1:31.5	1:31.2	1:29.3	

3.22 Supernumerary Status

3.23 The Delivery Suite Coordinator is a supernumerary member of the team (defined as having no caseload of their own during their shift).

3.24 This indicator is a safety proxy indicator identified within the clinical negligence scheme for trusts guidance to ensure there is oversight of all birth activity within the service at all times.

3.25 Currently non-compliance is recorded on the Birth Rate Plus acuity tool when the Co-ordinator is the named person providing 1:1 care and is thus unable to retain the status of supernumerary co-ordinator.

3.26 CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. The plan to mitigate shortfalls at time of pressure is detailed in section 5.4.

3.27 Non-compliance with supernumerary status between July 2022 and December 2022 is detailed in Table 3. The Delivery Suite Co-ordinator establishment was uplifted at the end of December 2022 to ensure a second Co-ordinator was present to support activity 24 hours per day in response.

Table 3: Supernumerary status episodes of non-compliance (per shift)

Indicator	Goal	Red Flag	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
The Co-ordinator is the named person providing 1:1 care	100%	<100%	4	0	1	3	1	1

3.28 Headroom / Uplift

3.29 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

3.30 Current headroom/uplift provided within the Trust is 23% with national ranges varying between 19% and 25%.

3.31 Skill Mix

3.32 Birth Rate Plus advises a registered / non registered skill mix of 90/10 ratio within defined clinical areas such as the postnatal ward to support the delivery of care with unregistered staff. The skill mix calculation is integrated in the overall Birth Rate Plus recommendation and establishment recommendations. The service currently has a 97:3 distribution of clinical to non-clinical ratio in defined settings. A revision of the skill mix is required to ensure a 90:10 mix is deployed in postnatal clinical areas.

3.33 Professional judgement

3.34 The judgement of senior experienced midwives remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Acuity requirement
- Ward/dept leadership
- Ward/dept layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional

3.35 Safety outcome indicators

3.36 Maternity sensitive staffing metrics are displayed on the integrated performance maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and thus need investigation and prompt action.

3.37 The dashboard reflected in Table 4 highlights the staffing related key performance metrics for the period July - December 2022.

3.38 The dashboard reflects an increase in maternity diverts due to sustained staffing pressures within the service during this period.

3.39 The maternity dashboard indicators reflect a challenged service. One to one care in labour compliance rates continue to be below the standard, and remain an area of ongoing focus.

3.40 A business case for the provision of a second theatre staffing provision was approved in October 2022 that included a phased approach to implementation.

3.41 Inconsistent performance was noted on the dashboard with regard to the booking of women prior to 12+6 week gestation with peaks of elevated compliance noted in November 2022 yet not sustained in December 2022. Community midwifery staffing was a challenge at this time with a Registered Midwife vacancy of 13.92WTE reported within community midwifery teams. This deficit impacted upon the teams ability to flex availability and offer weekend/evening clinics for booking to positively influence the 12+6 compliance. To be noted the Trust mean for 12+6 booking compliance aligned with the Greater Manchester and Eastern Cheshire (GMEC) median of 87.68% during this period.

3.42 Decreased compliance of breastfeeding initiation was noted in December 2022. At this time the infant feeding team had reduced capacity as team members were working clinically to maintain safe staffing levels in service. In response authorisation was given for additional infant feeding support workers to be recruited to increase support being provided on wards. The Trust mean of 65.95% was slightly higher than GMEC mean 58.70% during this period.

3.43 The maternity stillbirth rate flagged as a concern during July – December 2022. A monthly review was undertaken using the data presented in the integrated performance dashboard using a statistical process analysis chart. In response a review of the outlier incidence peaks in the stillbirth rate that occurred in Dec 21, April 22 and July 22 was completed. The analysis identified the increase in cases appeared to be related to cases of medical terminations where women opted to continue with their pregnancy as such cases are not excluded. There were 2 cases in Dec 2021 and 1 case in April 2022 and 1 case in July 2022. In addition, growth restriction affected over half of the cases and 5 out of 7 cases had no known underlying pathologies and 4 out of 6 had known pathologies. Assurance can be provided that the increased incidence of critical safety indicator outcomes that have been reviewed such as the stillbirth rate do not appear to be related to staffing levels.

Table 4 -Critical Safety Indicators

Indicator	Target	Red flag	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Critical Safety Indicators								
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.7	4.8	4.8	4.3	4.3	3.4
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	0	0	1	3
ICU/ HDU Admissions	Information only		1	0	0	0	2	1
Post-Partum Hysterectomy	0	>1	0	0	0	0	1	1
2nd Maternity theatre requested to be opened but delay or unable to open changed to rag rate Aug 21	0	>=1	5	1	0	0	0	1
Admissions to Maternity CCU level 2 care	Information only		7	5	3	2	0	2

% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	12.84%	12.30%	11.25%	10.22%	13.77%	13.27%

3rd /4th Degree Tears (rate in month)	3%	>3.1%	3.42%	3.70%	2.60%	4.14%	2.28%	1.95%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.7%	3.6%	3.5%	3.7%	3.6%	3.4%
Breastfeeding Initiated within 48 Hours	65%	<65%	67.2%	65.4%	67.8%	63.0%	64.4%	60.2%
1:1 care in labour	95%	<90%	98.5%	98.8%	98.7%	96.9%	99.1%	97.5%
% Completed Bookings by 12+6 BI calculation	90%	<90	85.56%	90.4%	89.61%	88.80%	90.86%	86.30%
SUI'S (New only)	0	2	3	0	3	0	0	2
HSIB referrals	Information only		0	1	0	0	1	0
Access Standards								
Unit Closures	0	1	3	0	2	1	2	1

4.0 Expectation 2 – Right Skills

4.1 Improving the mandatory and statutory training compliance rates presented a challenge during the period July – December 2022 due to the ongoing staffing deficit of circa 45WTE Registered Midwives within the service. In response the service had to prioritise elements of training namely emergency skills training and fetal monitoring training within trained staff groups. This resulted in an improving trajectory of compliance as detailed in Table 5a.

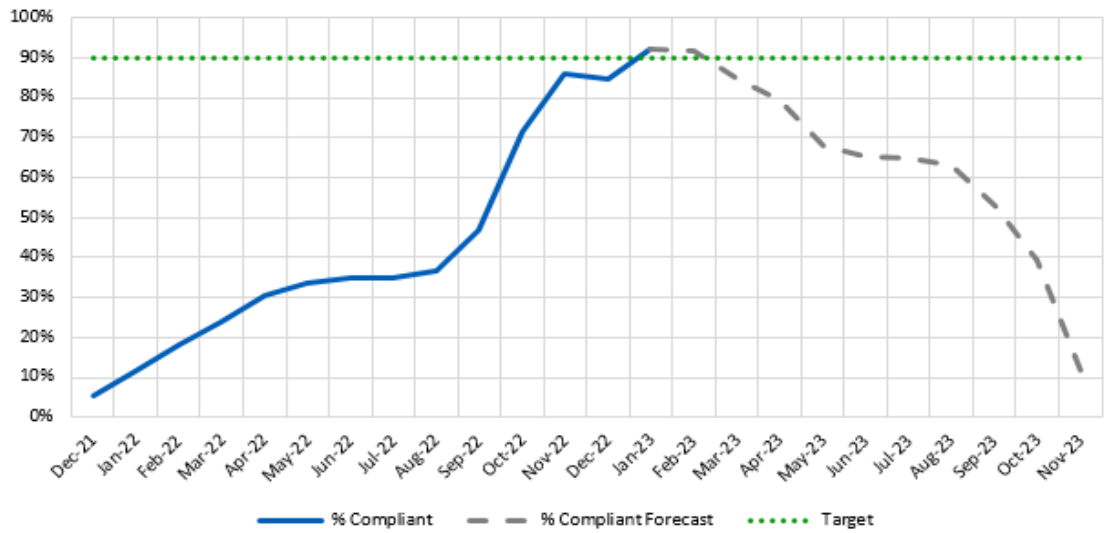
4.2 Professional specific training was not historically recorded on the performance dashboard and thus the addition was made in April 2023 for ongoing oversight and monitoring.

Table 5: Midwifery specific training matrix

Workforce			Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Shifts covered by NLS trained staff	Information only		77%		52%	53%	39%	71%
Medical Device Compliance Training Midwifery	95%	80%				11.00%		

Safeguarding compliance level 3	95%	80%	82.99%	81.59%	81.86%	83.05%	82.63%	84.85%
Safeguarding supervision outreach only	Information only		100.00%	100.00%		75.00%		40.00%
PROMPT training (added Oct 21)	90%	<90%				75.00%		86.50%
Return to work interview percentage completed (number due and completed in comments please)	Information only		33.00%	32.26%	33.00%	33.00%	20.00%	38.60%
Exit Interview percentage completed. (number due and completed in comments please)	Information only		0%	NA	14%	0%	0%	0%
Monthly attendance	Information only		93.42%	96.38%	95.45%	93.60%	93.55%	90.60%
Monthly percentage sickness	4%	>=4.75%	6.58%	3.62%	4.55%	6.40%	6.55%	9.40%
Statutory Training	95%	<95%	76.20%	77.96%	77.44%	76.21%	74.37%	74.76%
Mandatory Training	85%	<80%	78.81%	80.48%	78.67%	79.77%	78.26%	77.57%
Completed Staff Appraisals	85%	<=75%	83.75%	68.45%	69.93%	71.24%	68.46%	68.58%

Table 5a – PROMPT training trajectory December 2021 – December 2022



5.0 Expectation 3 – Right place, right time

5.1 Planned versus actual midwifery staffing levels

5.2 The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

5.3 The planned staffing levels outlined in Table 6 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff.

5.4 Table 6 and Table 7 both highlight a significant gap in the planned and worked hours for both registered and non-registered staff groups.

5.5 Assurance can be provided agency and bank shifts are offered to mitigate staffing gaps and pressures when indicated. Safety is maintained within the service by redeploying staff within the service and clinical areas on a daily basis to mitigate clinical risk.

Table 6: Planned versus actual staffing levels of registered staff (in hours) July – December 2022

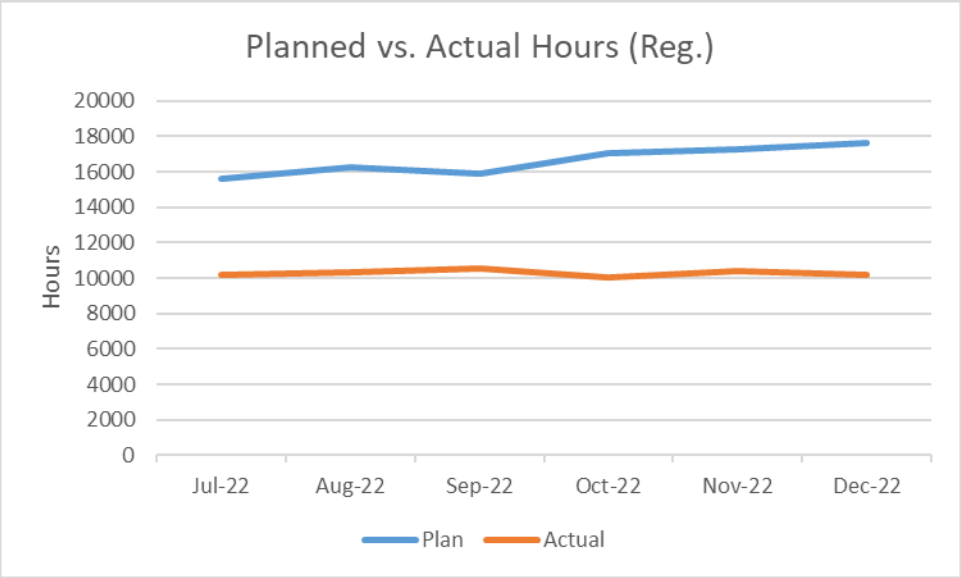
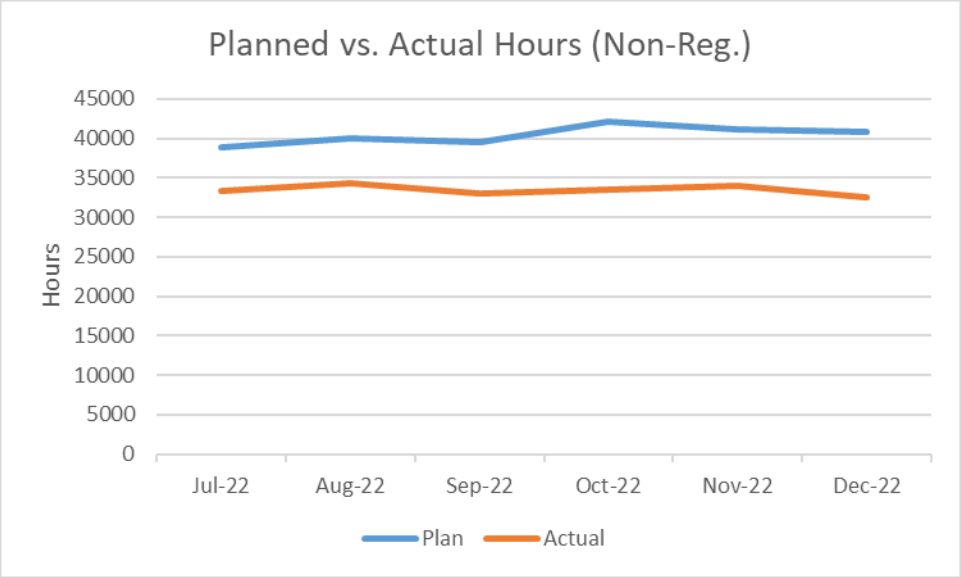


Table 7: Planned versus actual staffing levels of non-registered staff July - December 2022



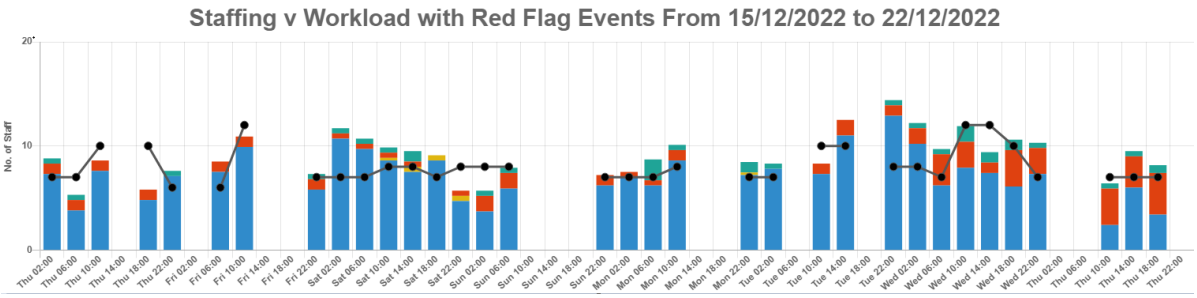
5.6 Mitigating actions

5.7 The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

- Incident reporting system is used to report staffing incidents.
- Regular reviews with ward managers, Matrons and the Director of Midwifery
- Daily operational staffing meetings led by matrons to assess and respond to changes in pressure and demand.
- Midwives move flexibly between delivery suite, maternity wards, birth centres and community to ensure women's needs are met.
- Ward managers work clinically as part of the clinical establishment with matrons, if required, to support patient care.
- Safety huddles occur in maternity twice daily to assess the activity and acuity
- Escalation guidelines are in place and used to respond to elevated demand, to preserve patient safety.
- The publication of rosters in a timely manner so staffing deficits can be safely managed.
- Approval of agency and bank usage to mitigate shortfalls in staffing levels

5.8 For additional oversight and scrutiny on a daily basis staffing figures and the acuity levels within the maternity intrapartum areas are input into an additional electronic Birth Rate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at twice daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. Table 8 details the acuity recorded on the intrapartum acuity tool in June, highlighting the 4hrly review of staffing levels undertaken by the Delivery Suite Co-ordinator and the periods of increased staffing pressure.

Table 8: Birth Rate Plus intrapartum acuity/staffing modelling tool – December 2022



5.9 Midwifery Continuity of Carer

5.10 In July 2022 a formal paper detailed the position to date relating to the provision of MCoC and confirmed that until the current midwifery vacancy rate was recruited to establishment, the service would be unable to implement and roll out MCoC safely.

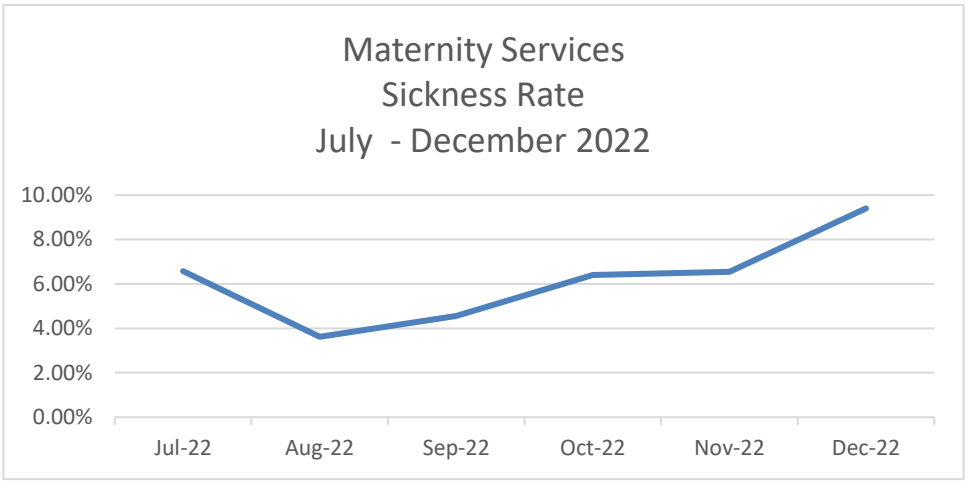
5.11 The maternity service received formal notification on 21 September 2022 thereafter from NHS England that there was no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders were advised to focus on retention and growth of the workforce, and develop plans that would work locally taking account of local populations and current staffing to support the maternity team to work to their strengths.

5.12 A detailed MCoC delivery plan was submitted to the Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (LMNS) in September 2022. Feedback received in March 2023 highlighted that the plan was 'almost' accepted. Further work was recommended to improve the sustainability of the workforce plan and engagement of the Maternity Voice Partnership with community groups.

5.13 Workforce Metrics

5.14 The sickness absence data for the period July - December 2022 demonstrated an increasing trend in sickness absence reported within the maternity service between July and December 2022**.** Matrons are supported by workforce partners to monitor absence and support staff members during their absence and following their return to work.

Table 9: Sickness absence per WTE July – Dec 2022



5.15 Red Flags

5.16 Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

5.17 Within the maternity service midwifery red flag events are monitored currently using the Birth Rate Plus acuity tool as detailed in Table 10. Alignment of the red flags with the nationally defined flags as per current NICE guidance is required with ongoing visibility at Trust level. Currently there is a discrepancy with Trust level reported data and the Birth Rate Plus level data and thus alignment of the datasets is required.

5.18 The table highlights a significant number of cases are delayed each month during the induction of labour process. Assurance can be provided that oversight of all induction cases is undertaken if delay is experienced and all cases are prioritised in accordance for need for transfer to Delivery Suite to minimise the risk.

Table 10: Number of red flag safe staffing incidents between July to December 2022 extracted from the Birth Rate Plus acuity tool.

Number & % of Red Flags Recorded

From 01/07/2022 to 31/12/2022

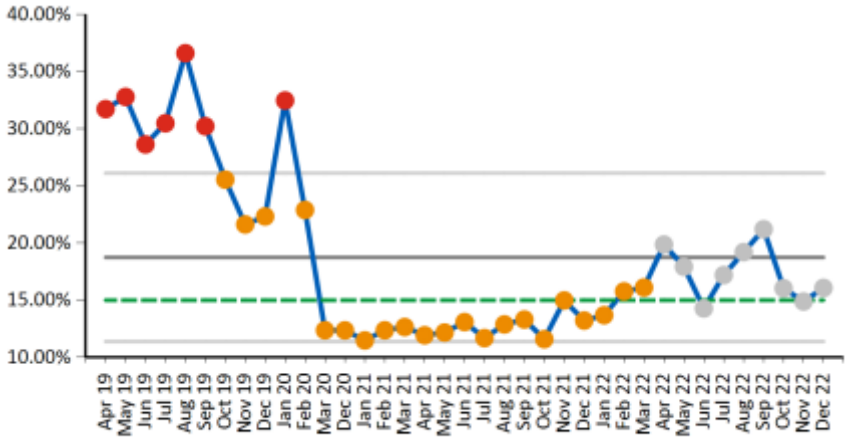
RF1	Delayed or cancelled time critical activity Medications as per prescribed times LSCS as per Trust guidelines Fresh eyes CTG review delayed	12	2%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) Suturing > 60 mins after delivery (where there is no clinical reason to delay this)	8	2%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	0%
RF5	Delay between presentation and triage	4	1%
RF6	The coordinator is the named midwife for a woman requiring 1:1 care	10	2%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	24	5%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) Timing as per Trust guidance	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	8	2%
RF10	Delay of 24 hrs in accessing CDS for continuation of IOL once identified as ready for transfer	421	86%
	Total	488	

6.0 Patient Experience

6.1. The maternity service over the last 12 months has actively sought feedback from service users. The friends and family test feedback can be evidenced in the maternity survey, feedback sought from the maternity voices partnership and the friends and family response rates illustrated below.

6.2 Further work has been undertaken to increase the uptake of responses within the antenatal setting and the use of posters with an accessible code is being trialled to increase the uptake. Table 11 demonstrates the compliance rate since April 2019.

Table 11: Friends and Family Response Rates



7.0 Maternity Survey

7.1 The NHS Maternity Services 2022 Maternity Care Survey was undertaken by the CQC in 2022. The survey sample was drawn from women aged 16 or over who had a live birth between the 1st and 28th of February 2022. Eligible women include those who had given birth using any unit managed by the Trust, or at home. Of the 413 surveys distributed, a total of 157 were completed (39% response rate).

7.2 Themes from the CQC Maternity Care Survey

Where mothers' experience is best

- ✓ Mothers receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.
- ✓ Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby.
- ✓ Mothers being given information about any changes they might experience to their mental health after having their baby.
- ✓ Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.
- ✓ Mothers being involved in decisions about their antenatal care.

Where mothers' experience could improve

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- Mothers discharge from hospital not being delayed on the day they leave hospital.
- Mothers being given enough information on induction before being induced.
- Mothers being given the information or explanations they needed while in hospital after the birth.

- Mothers being able to get a member of staff to help when they needed it while in hospital after the birth.

8.0 Complaints

8.1 Thematic analysis of all complaints is undertaken within the service to identify trends and actions to be undertaken on a monthly basis and a bi-annual triangulation review is undertaken to review themes from claims, incidents and complaints data.

8.2 The Q3 data highlighted that there were no explicitly shared themes within the claims scorecard, incident and complaints data presented. However, the overarching themes related to:

- Failure and delays in the treatment pathway
- Failure to recognise the complications of pathways of care
- Delay in the diagnosis

9.0 Conclusion

9.1 This report details the findings of the Bolton NHS Foundation Trust 2022 bi-annual maternity staffing review in order to provide assurance of safe staffing levels within the maternity service. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the maternity service.

9.2 This report provides assurance that a systematic evidence based process to calculate the staffing establishment has been undertaken that has highlighted a funded staffing establishment deficit.

9.3 The report provides evidence that the funded midwifery staffing budget does not meet the standard identified in the Birth Rate Plus review published in January 2023. This report confirms that the specialist midwifery establishment is within expected parameters.

9.4 The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with supernumerary status of the Delivery Suite Co-ordinator and one to one care in labour rates remain below the required standard, and remain an area of ongoing focus. Training metrics also highlight poor compliance with the Trust standard and reflect the registered midwifery staffing pressures (circa 45 WTE) within the maternity service during the period of review.

9.4 The report details the actions required to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny.

10.0 Recommendations

It is recommended that the Board of Directors:

I. Approve the bi-annual staffing report and recommendations

Appendix 1 – Birth Rate Plus summary of establishment – January 2023.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Princess Anne Maternity Unit Bolton NHSFT

Final version 23/01/2023

Annual period 2021/22

Combined births — Total births in service: 5922

June to Aug 2022	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	0.2	2.1	25.7	20.6	51.4
Generic %Casemix	1.7	5.1	24.5	19.7	49.0

	Annual Nos.	Required WTE	
Delivery Suite			
Births	5842	77.83	**77.83**
Other DS Activity			
Antenatal Cases	920	4.83	**6.00**
PN Readmissions	36	0.13	
Escorted Transfers OUT	23	0.12	
Non-viables	47	0.56	
Inductions (10%)	196	0.36	
Triage	8455	11.02	**11.02**
Beehive Birth Suite			
Service not fully operating so not assessed and activity within hospital total wte.			
M2 Ward			
Antenatal admissions	1680	16.53	**16.53**
Inductions (90%)	1768		
M4 and 5 Wards			
Postnatal women	5842	58.51	**64.21**
Postnatal Ward Attenders	0	0.00	
Postnatal Re-admissions	235	1.25	
NIPE Clinics		2.88	
Extra Care Babies	177	1.18	
Frenulotomies	775	0.39	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife Booking & Follow up clinics		5.27	**11.03**
Specialist Midwife clinics		1.59	
Obstetric clinics		1.46	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	11640	6.35	**6.35**
COMMUNITY SERVICES			
Home Births	80	2.36	**64.38**
Community Cases	5732	58.83	
Attrition cases	670	0.89	
Additional safeguarding		2.30	
INGLESIDE BIRTH & COMMUNITY CENTRE		257.34	
Service closed so not assessed and activity within community total.			
CLINICAL MIDWIFERY WTE REQUIRED			**257.34**
Additional Specialist and Management wte		**25.73**	
TOTAL WTE REQUIRED		**283.08**	

Appendix 2 – Birth Rate Plus establishment reconciliation as of December 2022

Row Labels	Funded	WTEC	Vacancy
241 L7 Antenatal Clinic - ANDU [3009]	12.97	9.39	3.58
241 L7 Birth Suite - Beehive [3010]	16.44	1.00	15.44
241 L7 Central Delivery Suite [3011]	70.56	68.80	1.76
241 L7 Community Midwives [3007]	59.73	45.81	13.92
241 L7 Divisional Management Family Care Division [2903]	1.00	1.00	0.00
241 L7 Ingleside Birth Centre [3020]	2.00	2.58	-0.58
241 L7 Maternity Smoking Cessation Team [3019]	0.64	0.64	0.00
241 L7 Midwifery Management [3003]	3.00	4.40	-1.40
241 L7 Perinatal Mental Health Team [3018]	4.45	3.40	1.05
241 L7 Specialist Midwives [3002]	19.27	18.97	0.30
241 L7 Ward M2 - Antenatal Ward [3004]	15.92	10.67	5.25
241 L7 Ward M4 - Post Natal Ward [3005]	16.00	14.62	1.38
241 L7 Ward M5 - Post Natal [3006]	16.00	11.05	4.95
Grand Total	237.98	192.33	45.65

Band 5/6 establishment	242.58
Band 5/6 vacancy rate	4.60

Appendix 3: Specialist Midwife establishment by role type.

ESR Position Title	ESR WTE @ Jan 23	WTEW @ Jan 23
Salford Smoking Cessation Midwife - Band 6	0.64	0.25
Specialist Mental Health Midwife - Band 6	0.80	0.80
Specialist Mental Health Midwife - Band 6	1.00	1.00
Specialist Mental Health Midwife - Band 6	0.60	0.60
Perinatal Mental Health Midwife - Band 7	1.00	1.00
33793772 Diabetes Specialist Midwife = Band 6	0.76	0.76
Screening Midwife - Band 6	0.92	0.92
Diabetes Specialist Midwife - Band 6	1.00	1.00
Safeguarding Midwife - Band 6	1.00	1.00
Specialist Midwife - Infant Feeding - Band 6	0.61	0.61
Cultural Liaison Midwife - Band 7	0.40	0.40
Diabetic Specialist Midwife - Band 7	1.00	1.00
Infant Feeding Co-ordinator - Band 7	0.80	0.80
Infant Feeding Midwife - Band 7	0.00	0.20
Practice Educator Midwife - Band 7	1.00	1.00
Practice Educator Midwife - Band 7	0.92	0.00
Saving Babies Lives & Neo Champion - Band 7	1.00	0.98
Antenatal Screening Midwife - Band 7	1.00	1.00
Practice Educator Midwife - Band 7	0.31	0.31
Infant Feeding Co-ordinator - Band 7	0.61	0.61
Bereavement Midwife - Band 7	0.80	0.80
Lead Midwife - Information Systems & EPR - Band 7	1.00	1.00
Lead Midwife for Safeguarding - Band 7	1.00	1.00
Specialist Midwife Clinical Standards - Band 7	0.64	0.64
Bereavement Midwife - Band 7	0.40	0.40
Infant Feeding Co-ordinator - Band 7	1.00	1.00
Practice Educator Midwife - Band 7	0.80	0.80
Practice Educator Midwife - Band 7	1.00	1.00

Advanced Midwifery Practitioner - Band 8a	1.00	1.00
Clinical Fellow (Midwifery)	0.00	0.31
Advanced Midwifery Practitioner - Band 8a	1.00	1.00
Interim Head of Midwifery - Band 8c	1.00	1.00
Screening Midwife - Band 6	1.00	1.00
Recruitment and Retention Midwife	1.00	1.00

Appendix 4 – NQB Recommendations
Detailed breakdown

1.0 Expectation 1 - Right staff

1.1 The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months. The NQB references various tools that can be used.

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

1.3 The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for a maximum of 6-8 patients each during a day shift. There is no specific guidance regarding night duty. This is based on NICE[1] evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward Sr/CN should have supervisory capacity – the extent of which is subject to local Chief Nurse determinant

1.4 Headroom / Uplift

1.5 Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered.

1.6 The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. Current headroom/uplift provided is 23% with national ranges varying between 19% and 25%

1.7 Skill Mix

1.8 This is the ratio of RNs to unregistered staff such as healthcare assistants. Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

1.9 Professional judgement

1.10 The judgement of senior experienced nurses remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical

[1] NICE *Safe staffing for nursing in adult inpatient wards in acute hospitals* July 2014

care). Professional judgement incorporates the experience of the registered Chief Nurse and senior colleagues and their judgement takes into consideration;

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

1.12 NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were stated as specifically affected by the presence (and hence absence) of **registered** nursing staff. These indicators included;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

1.13 The NQB (2018) has highlighted that these indicators can be challenging to monitor consistently and recommends a thorough audit programme be agreed.

1.14 Patient reported outcome measures

1.15 NICE (2014) also recommend monitoring of the following;

- Adequacy of meeting patients' nursing care needs
- Adequacy of provided pain management
- Adequacy of communication with nursing team
- National in-patient survey

1.16 Staffing data & Training and education

- Appraisal, retention, vacancy, sickness
- Mandatory training, clinical training

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

"ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Report Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q4 Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

Purpose	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and preparations being made in anticipation of the Year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Summary:	Key highlights of the report: • The Trust has received confirmation that a discretionary payment has been awarded by NHS Resolution (NHSR) in response to submission of the CNST Year 4 declaration in February 2023. All Trusts are due to receive correspondence from NHSR confirming their award status for MIS year 4 at the end of May 2023 with funds due to be released in early June. Notification of the award will be issued to the Director of Finance. • Extensive work remains ongoing to complete the outstanding actions identified in the Price Waterhouse Cooper action plan prior to the end of May 2023 to strengthen oversight and management of the CNST Year 5 Scheme. To date 5 of the actions have been completed and 20 actions remain in progress. • A recent benchmarking exercise to ascertain compliance with the recommendations from the initial Ockenden report published in December 2020 and The Morecambe Bay Investigation (Kirkup) report published in 2015 has been undertaken. The service can evidence full compliance with 31/42 (74%) of the initial Ockenden recommendations and 13/21 (61%) of the recommendations highlighted in the Kirkup report. The service is due to re-assess compliance on the 26 July 2023.

Previously considered by:
This report was presented at the Quality Assurance Committee

Proposed Resolution	The Board of Directors are asked to: i. Receive the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q4 Update ii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

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

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

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

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

1. Introduction

1.1 The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and preparations being made in anticipation of the Year 5 NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

2. CNST Year 4 Scheme Update

2.1 The CNST declaration confirming the Trust position with regard to compliance with the Year 4 CNST maternity incentive scheme was submitted to NHS Resolution in February 2023.

2.2 Further narrative was submitted on the 24 February 2023 to provide assurance of long term sustainability of the actions taken in response to the compliance position declared.

2.3 On the 5 April 2023 the Trust was informed via email the Trust request for the scheme's discretionary funding had been reviewed and approved.

2.4 The Trust has received confirmation that all Trusts are due to receive correspondence from NHSR confirming their award status for MIS year 4 at the end of May 2023 with funds due to be released in early June. Notification of the award will be issued to the Director of Finance.

2.5 The Trust has been advised not to share detail of the award widely or make any public announcements until NHS Resolution have published the national results of the scheme in full. NHS Resolution will contact the Trust in due course to confirm that this publicity embargo has been lifted.

2.6 Reporting of defined CNST elements will continue during the interim period between schemes to fulfil the ongoing monitoring requirements and oversight.

3. Price Waterhouse Cooper (PWC) Audit

3.1 In preparation for the CNST Year 5 scheme an internal audit was undertaken by Price Waterhouse Cooper (PWC) to assess and understand the processes that were in place to gather, review and analyse the data and evidence used to inform compliance against the defined safety actions within the CNST Year4 maternity incentive scheme.

3.2 The PWC audit findings highlighted that further improvements were required with regard to:

- Compliance with the scheme
- Roles and responsibilities
- Planning and oversight
- Clinical audit plan
- Working group

3.3 In response a detailed action plan (Appendix 1) has been collated for completion prior to May 2023 when commencement of the Year 5 scheme is anticipated.

3.4 Additional audit capacity has been secured within the funded establishment to support the audit requirements of the scheme.

3.5 Extensive work remains ongoing to complete the outstanding actions identified in the Price Waterhouse Cooper action plan prior to the end of May 2023 to strengthen oversight and management of the CNST Year 5 Scheme. To date 5 of the actions have been completed to date and 20 remain in progress.

3.6 A further review of the governance arrangements will need to be undertaken when the details of the CNST Year 5 scheme are released in order to ensure the clinical audit and reporting requirements implemented fulfil the requirements of the Year 5 scheme.

4. Performance oversight

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

4.2 In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance and will be included in all future quarterly reports.

4.3 Table 1 – Safety Champions locally agreed dashboard

Indicator	Goal	Red Flag	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
CTG Rating: Requires improvement								
Quality & Safety								
CNST attainment	Information only					30%		
Critical Safety Indicators								
Births	Information only		466	449	427	445	374	454
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			0	2	2	4	1	3
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.3	4.3	3.4	4.2	4.2	4.6
HIE Grades 2&3 (Bolton Babies only)	0	1	0	1	3	1	1	0
1HIE (2&3) rate (12 month rolling)	<2	2.5	0.2	0.4	0.9	0.9	0.9	0.9
Early Neonatal Deaths (Bolton Births only)	Information only		3	1	3	2	1	2
END rate in month	Information only		6.4	2.2	7.0	4.5	2.7	4.4
END rate (12 month rolling)	2.4	>3.1	2.8	2.9	3.3	3.5	3.5	3.9
Late Neonatal deaths	Information only		1	1	0	1	0	0
Perinatal Mortality rate (12 month rolling)	7.5	8	7.8	7.8	7.3	8.4	8.5	9.1
Serious Untoward Incidents (New only)	0	2	0	0	2	1	1	2
HSIB referrals			0	1	0	1	0	0

Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	1	1	2		
Workforce								
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	96.9%	99.1%	97.5%	98.6%	98.5%	96.7%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	3	1	1	3	1	1
Fetal monitoring training compliance (overall)						77.74%	77.00%	69.74%
PROMPT training compliance (overall)	<90%	>90%			86.50%	86.10%	82.34%	72.36%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:29.3	1:30.8	n/a	1:24.4	1:24	
RCOG benchmarking compliance	Information only		86%	53%	54%	100%	86%	n/a
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							

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4.4 The dashboard confirms a monthly review of RCOG compliance rate relating to attendance of the Consultant Obstetrician in defined clinical situations is being undertaken.

4.5 The dashboard highlights a decrease in PROMPT training compliance in March (72.36%) following the commencement of new starters within the service. The Practice Education Team capacity for both midwifery and obstetric leads has been increased to support the delivery of training of smaller training sessions in view of the ongoing staffing challenges. Alignment of the current training needs analysis with the Greater Manchester and Eastern Cheshire standard is underway.

4.6 An increase in the rate of stillbirth is notable on the dashboard in March 2023, with a rate of 4.6 per 1000 births reported. This incidence related to 3 cases of loss that are currently subject to a review using the perinatal mortality tool. Assurance can be provided that in Q4 2022/2023 the Trust rate of 3.0 stillbirths per 1000 births was lower than the GMEC regional rate of 5.05 per 1000 births. The Trust rate also broadly aligned with the regional rate during all previous quarters of 2022/2023.

4.7 Bi-monthly engagement sessions (e.g. staff feedback meeting, staff walk around sessions etc.) continue to be undertaken by the Chief Nurse and Non-Executive Lead and outcomes shared within the Division. Revisions were made to the support provided to Band 7 leads following a recent visit.

4.8 There is a requirement for the Trust's claims scorecard to be reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) on a quarterly basis. A report was presented at Quality Assurance Committee in March 2023 following consideration by Maternity Safety Champions at the meeting held on the 2 March 2023. The next report is due for presentation in June 2023.

4.9 Serious incident reports are now presented in the Trust learning from experience quarterly report for oversight and scrutiny as part of the required perinatal quality surveillance monitoring.

4.10 During Q4 three serious incidents (Table 2) were declared and a total of 3 serious incidents were closed. Three of the incidents closed were categorised as moderate harm. There were no Never Events declared throughout this period and no themes were identified due to the stark differences of the incidents.

4.11 Assurance can be provided that the Q3 Transitional Care and Avoiding Term Admission to Neonatal Unit (ATAIN) Audits have been published as per requirements of the CNST Scheme. Formal submission of both audit reports was made to the Local Maternity and Neonatal System on the 12 April 2023. Both reports were also shared on the agenda at the Maternity Safety Champions meeting held in May for oversight and detailed scrutiny.

4.12 CNST require the Trust Board / Delegated Committee to retain oversight of the Saving Babies Lives Dashboard for oversight and scrutiny. To meet this requirement the dashboard will be included in all future quarterly reports (Appendix 2).

Table 2: Serious harm incidents declared in Q4 2022-2023

Serious harm incidents declared – Q4 2022/23			
Incident No	**Cause Groups**	**Specialty**	**Summary of incident**
217493	Communication failure	ANC/Gynaecology	A woman experienced a 19-week late miscarriage. She had a history of previous miscarriage, and there was a failure to follow the preterm pathway. Possible delays have been identified and the investigation is ongoing.
217120	NNU/Unexpected admission	Maternity	On admission to hospital for induction of labour the baby was found to be having decelerations in heart rate. A category 2 Caesarean section was declared, with this subsequently being changed to Category 1. The fetal heart rate was not recorded in theatre during the spinal insertion prior to knife to skin commencement. Baby was born in poor condition. There was a possible failure to follow the antenatal CTG monitoring policy and the investigation is ongoing.
212705	Fetal loss above 24 weeks	Maternity	Woman was admitted complaining of abdominal pain and the scans confirmed there was no fetal heart seen. Due to the woman's medical history and her having 2 risk factors for pre-eclampsia it is felt that she should have been commenced on Aspirin. The woman was a high risk pregnancy with evidence of possible fetal compromise and further

			investigations were indicated as per guidelines.

5. Single Delivery Plan

5.1 The NHS England maternity three-year single delivery plan was launched on 30 March 2023 to make maternity care safer, more personalised and equitable by:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safe, more personalised and equitable care

5.2 Services have been asked to focus on delivery of the four high level themes over the next three-year period.

5.3 The plan clearly outlines the actions required of Trusts, Integrated Care Boards and NHS England to deliver the requirements of the four key themes.

5.4 The plan incorporates actions defined within both Ockenden reports, Equity reports and the Kirkup report and will be used to inform the direction of service transformation.

5.5 The Director of Midwifery will be supporting the Local Maternity and Neonatal System to review the plan as the nominated midwifery lead.

6. Ockenden and Kirkup benchmarking

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

6.2 Currently the service can demonstrate full compliance with 31/42 (74%) of the initial Ockenden recommendations and partial compliance with the remaining 11 recommendations.

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

Table 3 - Ockenden initial report compliance as of March 2023

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

6.4 Areas of further improvement relate to:

- IEA1 – Full implementation of perinatal surveillance model
- IEA 3&6 – Training requirements
- IEA4 – Audit of complex pregnancies and all Saving Babies Lives v2 elements
- IEA4 – Establishment of maternal medicine network
- Workforce – NICE benchmarking of new guidance and risk assessments if not compliant.

6.5 The service can evidence current compliance with 13 out of the 21 Kirkup recommendations (61%) and further evidence is required for 8 of the recommendations highlighted in the Kirkup report (Appendix 3). Areas of further improvement relate to:

- Review preceptorship package and induction package for locums
- Staff rotation plan
- Support for supernumerary learners and new starters
- Improvement of management of confidential enquiry reports within governance process in service

7. Maternity Regional Support Programme

7.1 Confirmation has been received from the regional Chief Midwife that the regional midwifery team will be supporting the maternity service on their improvement journey half a day per month as part of a regional maternity support offer. The offer of support has been made following the grading of requires improvement published in the recent CQC report.

7.2 In preparation for the visit a detailed maternity self-assessment document has been submitted that highlights the areas of service improvement required within the service.

7.3 The regional team are meeting with relevant leads on the 1 June to determine the support that can be provided and the scope of the support offer.

8. Risk

8.1 The loss of financial income related to non-delivery of the CNST Scheme is detailed within the risk register.

9. Financial

9.1 The Trust has received confirmation that a discretionary payment has been awarded by NHS Resolution (NHSR) in response to submission of the CNST Year 4 declaration in February 2023.

9.2 All Trusts are due to receive correspondence from NHSR confirming their award status for MIS year 4 at the end of May 2023 with funds due to be released in early June. Notification of the award will be issued to the Director of Finance.

10. Summary

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

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

10.3 A recent benchmarking exercise to ascertain compliance with the recommendations from the initial Ockenden report published in December 2020 and The Morecambe Bay Investigation (Kirkup) report published in 2015 has been undertaken. The service can evidence full compliance with 31/42 (74%) of the initial Ockenden recommendations and 13/21 (61%) of the recommendations highlighted in the Kirkup report.The service is due to re-assess compliance on the 26 July 2023**.**

11. Recommendations

It is recommended that the Board of Directors:

iii. Receive the contents of the report

iv. 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 – PWC Audit Action Plan

Rec 1	Compliance with the Scheme	Lead(s)	Completion date	Action	BRAG	Update 5/5/2023
1	A Maternity Incentive Scheme reporting format should be agreed to ensure that data is presented to all governance forums consistently.	JC / DT	May-23	Align with cycles of business for Maternity Specialty Governance / Divisional Governance Committee / Board level reporting Create papers timetable / year overview and template to support paper submission (put on shared teams channel)		05.05.23 Trust Board cycle of business updated to receive papers each quarter. Interim reports to be presented to Quality Assurance Committee as a Committee of the Board. Reporting requirements to be reviewed when CNST Year 5 scheme launched to ensure meets requirements of the scheme.
2	Ensure a PMRT procedural document is produced. It should clearly outline the end to end process, responsibilities for each phase and the overall collation, review and submission of data. The document should be approved by both Neonatal and Midwifery Quality Forums and disseminated to all stakeholders.	LM	May-23	Collation and approval of revised SOP		05.05.23 Revised PMRT SOP Finalised 4 May. For presentation at guideline group 11/5 Will then need to go to specialty governance and divisional governance for sign off
3	Consider the recruitment of a PMRT midwife or allocation of an equivalent individual to oversee the review, collation and reporting duties required.	SK/TGC	May-23	Allocate band 7 lead Midwife Recruit to band 6 post on TRAC		05.05.23 Band 6 Post is currently out to advert. Band 7 named lead allocated.
4	Ensure version 4 of the Transitional Care SOP is signed off by Maternity & Neonatal clinical leads.	LM	May-23	Approval of revised SOP		05.05.23 Revised SOP out for comments.
5	Include the criteria "the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues." within the format of the ATAIN review.	MD /AA	May-23	Gather ATAIN data to fulfil required criteria Ensure revised criteria is in the SOP		05.05.23 Q4 ATAIN report overdue.
6	Ensure that progress of the ATAIN/TC action plan is maintained and updated with findings from quarterly audits.	JC / MD	May-23	Ensure standalone action plan is collated that can be updated each quarter		05.05.23 Copies of both plans obtained. ATAIN/TC action plan to be merged and updated.
7	Ensure that there is sign off at Trust Board level acknowledging engagement with the RCOG document. Monthly audits of RCOG status should be undertaken and included in the clinical audit plan.	JC / LM	May-23	Ensure process is embedded in reporting arrangements and monitored.		05.05.23 RCOG audit data included in QAC and Board reports within dashboard.

9	Align the integrated performance dashboard and the relevant safety action performance indicators that are included in the scheme progress reporting. Ensure that dashboards have a clearly outlined review procedure.	JC / DT/ EB LG	May-23	CNST year 4 criteria to be added to IPM dashboard for appropriate fields.		05.05.23 Additional tab being added to the maternity IPM dashboard to collate the SBLV2 data. This can then be used for the Board reports.
10	Monthly reviews of supernumerary status red flags should be undertaken and quarterly audits should be undertaken.	EJ - if required for Y5	May-23	Ensure monthly red flag report collated and presented in a quarterly report to maternity speciality governance meeting Ensure quarterly audit added to clinical audit schedule.		05.05.23. Red flag report to be extracted from the Birth Rate Plus tool and presented at Maternity Quality Forum each quarter by the Intrapartum Matron.
11	Quarterly reviews of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation should be undertaken (inc additional requirements) and included in the clinical audit plan.	LG / EB	May-23	SBLV2 dashboard to be added to tab on maternity IPM dashboard		05.05.23 Audit undertaken in Q4 and update provided on the SBLV2 dashboard included in the Board report.
12	The Trust Board should sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. Evidence of 90% compliance with training should also be presented within Board papers.	LB /LG	May-23	Ensure training on CTG machines added to TNA		05.05.23 Training commenced on new Edan machines. Request made for compliance to be captured on local training database.
13	Review the approach taken to audit the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	LG / VP	May-23	Ensure audit undertaken fulfils requirements of CNST scheme. Increase audit capacity to support SBLV2 lead		05.05.23 Audit undertaken in Q4 and update provided on the SBLV2 dashboard included in the Board report. Action plan required as compliance 58%
Rec 2	Roles and Responsibilities					
1	Ensure that a document or a standard operating procedure (SOP) is produced which clearly outlines the roles and responsibilities in relation to scheme and required activities, linking to staff titles. Consider the incorporation of a RACI style matrix that outlines roles and governance channels required for the scheme. It should include the relevant version control, periodic review, ownership and approval information. It should be approved at Board level.	JC/DT	May-23	Collate overarching CNST oversight document and review content when CNST Year 5 scheme launched		05.05.23 Draft document in process of being collated.
2	Ensure that all staff involved with the scheme can access the document and are aware of their roles and responsibilities and the document is provided to them once approved.	JC/DT	May-23	Enable access to the information on a teams channel		05.05.23 Teams channel set up for document sharing. Document to be shared when finalised.
3	Where there are lower level SOPs produced for individual safety actions, make sure the roles and responsibilities align appropriately.	JC/DT	May-23	Ensure overarching SOP collates reflects individual work stream SOPS.		05.05.23 SOPS collated for PMRT, smoking cessation and transitional care. Guidance will inform overarching SOP.

Rec 3	Planning and Oversight		May-23			
1	Ensure that the business cycle for key governance channels are reviewed to include scheme updates and progress monitoring throughout the year and that an update on the scheme is reported to the Board at each sitting.	JC/DT	May-23	Collate cycle of business. Review when CNST Year 5 scheme launched.		05.05.23 Draft cycle of business collated. For review when Year 5 scheme launched.
2	Due to confirmation from NHS Resolution on the use of the Quality Assurance Committee (QAC) as a delegated assurance function of the Board, determine the role this Committee will have in relation to the scheme. Ensuring a format for reporting a summary of decisions and information sets is produced for Board papers.	JC/DT	May-23	Seek assurance from NHSR that reporting to QAC is accepted and confirm role of QAC in operating procedure.		05.05.23 Confirmation received from NHSR that delegated Committee of Board can receive papers. Terms of reference and copy of email saved as evidence.
3	Produce a Maternity Incentive Scheme Plan which outlines the requirements for each safety action and the evidence deliverables required. Ensure that there is appropriate consideration of periodic requirements and include reference to the date the information has been reviewed at required stakeholder and governance meetings. This should be reviewed and reiterated whenever new guidance is published to ensure an up to date understanding of compliance is maintained throughout the year.	JC/DT	May-23	Scheme of works to be collated when CNST Year 5 scheme released		05.05.23 Plan to deliver each action defined in SOP being collated. Scheme of works to be collated when CNST Year 5 launched.
4	Maintain a shared central storage location that allows for stakeholders to upload evidence and information in support of scheme compliance throughout the year. This should be reviewed to ensure appropriate access provisions. Consider linking to this from the central plan to produce one source of truth for evidence	JC/DT	May-23	Develop shared teams folder and allocate appropriate access		05.05.23 Shared teams file established.
Rec 4	Clinical Audit Plan		May-23			
1	As part of year five planning produce a clinical audit plan specific to the Maternity Incentive Scheme that outlines the audits and reviews required within the scheme period. Ensure that the audit plan aligns with periodic requirements and reporting arrangements (monthly/quarterly etc.). It should include required by, completion & reviewed dates as well as names of the individuals that perform and review the audits.	JC/DT	May-23	Revise clinical audit schedule to include all CNST requirements. Revise audit schedule following release of the CNST Year 5 scheme.		05.05.23 Cycle of business to be aligned with Trust format and audits prioritised.
2	Ensure that the date the audit information is presented at relevant govemance meetings is logged, this should include columns related to monitoring action plans such as Board sign-off and date last reviewed/updated etc.	JC/DT	May-23	Revise clinical audit schedule to include all CNST requirements. Revise schedule following release of the CNST Year 5 scheme.		05.05.23 Meeting with audit lead scheduled
3	Ensure that roles and responsibilities are understood for individuals responsible for monitoring the audit plan, performing and reviewing the audits as well as updating and submitting action plans to the relevant govemance channels.	JC/DT	May-23	Collate overarching CNST oversight document and review content when CNST Year 5 scheme launched		05.05.23 Draft document in process of being collated

4	Ensure that a review of this audit plan is undertaken at the safety champion or working group meetings	JC/DT	May-23	Ensure all relevant audits are presented on Maternity Safety Champions agenda		05.05.23 Audit plan to be shared at July Maternity Safety Champions meeting when requirements f CNST Year 5 scheme released. Currently ATAIN and transitional care audits presented at each meeting as per Year 4 scheme requirements.
Rec 5	Working Group		May-23			
1	Review the transformation group approach to determine if it functions appropriately as a working group	JC/DT		Need to wait for launch of MIS year 5		05.05.23 Group not launched as CNST Year 5 scheme details are awaited.
2	A working group should be maintained for year five and made up of key stakeholders responsible for organising and delivering on scheme requirements. The meeting frequency should be bi-weekly but also allow for flexibility and increased frequency at times of planning or periods of increased delivery.	JC/DT		Establish working group when CNST Year 5 Scheme requirements are released to include all relevant personnel.		05.05.23 Group not launched as CNST Year 5 scheme details are awaited.
3	Ensure that the working group reports into an appropriate monthly governance channel such as Divisional Governance Committee or Safety Champion Meeting.	JC/DT		Provide regular progress updates through safety champions and divisional governance meetings prior to and during the CNST scheme.		05.05.23 Regular updates presented to Divisional and Trust level committees until commencement of the Year 5 scheme

Appendix 2 - Saving Babies Lives Dashboard

Element	Indicator	% compliance	Target	Action plan required
Element 1 **Reducing smoking in pregnancy**				
	A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded	Average for Q4 - 93.92% (E3 Data) (100% from annual manual audit)	80%	Not required
	B. Percentage of women where CO measurement at 36 weeks is recorded	Average for Q4 – 61.05% (E3 Data) (80% from annual manual audit)	80%	Action plan in place to aim for >95%
Element 2 **Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)**	Process indicator: A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan	97.5%	80%	Not required
	Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Compliant		
	In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	Compliant		
	There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	Compliant. Q4 - 36 of 1281 = 2.81%	No Target	Not required

	The Trust have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).	Compliant	No Target	
	The risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.	Compliant		
Element 3 **Raising awareness of reduced fetal movement (RFM)**	Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.	100% (February 23 Audit)	80%	Not required
	Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).	100% (February 23 Audit)	80%	Not required
Element 4 **Effective fetal monitoring during labour**	There should be: Trust board sign off that staff training on using their local CTG machines that staff training on fetal monitoring in labour are conducted annually.	Training in progress in preparation for roll out of new Edan machines		Action plan in place

	The Trust board should specifically confirm that within their organisation: - 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.	70.69%	90%	Action plan required.
	A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest.	Compliant		
Element 5 **Reducing preterm birth**	A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	58%	80% *Does not fail CNST if less than 80%	Action plan in place
	B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	11%	No Target	Not required
	C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	95.33%	**80%**	Action plan in place
	D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	91.66%	**80%**	Not required
	They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention.	Compliant		

	Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided	Compliant		
	An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway	100%		Not required
	Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network	Compliant		

Appendix 3 – Compliance with Kirkup recommendations

Kirkup Action Number	Recommendation	No evidence collected to meet requirements	Requires updated evidence	Evidence collected to meet requirements
5	Review the current preceptorship programme	0	1	0
6	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	0	1	0
7	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	0	0	1
8	Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	0	0	1
9	Review the current induction programme for locum doctors	0	1	0
10	Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.	0	1	0
11	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	0	0	1
12	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	0	0	1
13	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	0	0	1
14	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	0	0	1
15	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.	0	1	0
17	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations	0	1	0
20	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	0	0	1
22	Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention	0	0	1
23	Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	0	0	1
26	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.	0	0	1
28	Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	0	1	0
36	Ensure that all staff are aware of how to raise concerns	0	0	1
37	Provide evidence of how we deal with complaints	0	0	1
38	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	0	0	1
41	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	0	1	0
	Total	**0**	**8**	**13**

Report Title:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Francis Andrews		Decision	

Purpose	To provide an update on the Quality Assurance Committee meetings held in April and May 2023.

Summary:	The attached reports from the Chair of the Quality Assurance Committee provide an overview of items discussed at the meetings held on 19 April and 17 May 2023.

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

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

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

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

Quality Assurance Committee Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	19 April 2023	Date of Next Meeting	17 May 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Martin North, Harni Bharaj, Francis Andrews, Rachel Noble, Carol Sheard, Rae Wheatcroft, Tyrone Roberts and Divisional Representation.	Apologies Received from:	Fiona Noden, Sharon White, Sophie Kimber-Craig, Sharon Katema, Gareth Hughes, Rebecca Lennon, Susan Moss, Rauf Munshi, Angela Volleamere

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report		TR/FA	The report was taken as read with the Committee noting the following; • Harm Free Care: Infection Control, C-Diff and Pressure Ulcers were noted and TR has discussed this with NMAHPs to look at improving leadership attention and focus. It was noted that whilst the approach to C-Diff had been mainly proactive, timely isolation remained a key area of focus. TR confirmed there were concerns the increase in category 2's since Dec 21 which is why the Trust is using this as one of the quality account priorities going for the upcoming year. • TR informed the Trust had put in place additional internal induction programmes to welcome international nursing colleagues and ensure familiarity with systems and processes. This means ongoing double-running until each international recruit is embedded. • Patient Experience – Improvements noted on Friends and Family response rates. Leadership attention needs to be maintained as the change to Complaints process means that the relevant DDO will approve the responses before they are submitted to the CEO for final approval. Maternity – There are no exceptions to note and this is the first heatmap to be shared with narrative.	**Action:** Agreed that future reports the expected national targets will be included for benchmarking purposes in the areas the Trust is most concerned with. **Decision:** The Committee received and noted the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Clinical Governance & Quality Committee Chair Report		TR	TR presented the report and noted the following items; • First time for the Committee to receive the Divisional Governance chairs reports, minutes and relevant IPR data together and was found to be useful. • Sepsis – There were concerns regarding the validity of the rescreening and frequency of the screening process, in that the electronic audit is measuring incorrect parameters. The manual audits demonstrate excellent compliance. There was a request to reconvene the Sepsis Steering Group and focus on moving this forward. • GIRFT – Confirmation of all planned deep dives has been requested as there is no true oversight. • Blood Transfusion – Assurance was provided but there is still work to be done until full roll out of the two phases is complete. In response to MN's concerns on sepsis, HB confirmed that this is due to the way in which staff have to report the recording on EPR and the management of triggers. It was also noted that when a patient scores NEWS 5 there is a requirement to carry out screening and then there are repeated observations every hour but there is no need to screen again if NEWS 5 however the system does not allow adjustments for this and so it is classed as a trigger when this is not carried out.	**Action:** The Committee were advised that a full report on Sepsis and NEWS will be presented to the Clinical Governance and Quality Committee in the coming months and so a detailed update will follow. **Decision:** The Committee received and noted the report.
Quality Improvement Model Update		DR	DR presented the report to the Committee noting the following key points; • All staff to be encouraged to use the same language when discussing quality improvement aims and objectives. • The Trust would be applying a collaborative approach which can take between 12 – 24 months to see sustained improvements. • Rushed improvement has been noted to have a negative impact as it is not sustainable and does not allow for the necessary change in culture. • The agreed quality accounts priorities for 2023/24 will be Pressure Ulcers, C-Difficile and the QI Fundamentals. With regards JN's query on building and thriving once the collaborative have run their course, DR advised that an Advanced Improvement Advisor was rolled out within the Acute Adult Care Division through a Quality Improvement Clinic.	**Decision:** The Committee received and noted the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Mortality Update		FA	FA presented the report to the Committee noting that SHMI is in 'expected range' and crude mortality has shown a similar level to the same period last year. It was noted that HSMR was showing as a 'red' alert after tipping over the confidence limit. However, this was not alarming as the ongoing work within Palliative Care will improve this position due to the investments in this area. The report also highlighted that the Trust was performing within expected range; however, the narrative implied that more needed to be done. FA confirmed that for cases such as liver disease, influenza etc. there is assurance that this is not due to clinical care provided but rather how these are categorised.	**Decision:** The Committee received the quarterly update.
Learning from Deaths Update		FA	FA took the report as read noting the following key items; • There were over 1000 deaths which have gone through the SJR process in the Trust since it began. 75 of these had been completed since the last quarterly report was presented. • This provides the Trust with a case completion rate of over 70% which is consistent with national average. • It was noted that there had been delays in discussing the reviewed cases, but this could be turned around as has been done before.	**Action:** Confirmed future reports would include information regarding the ongoing Palliative Care work, engagement with Primary Care and the refreshed End of Life Care Steering Group as these begin to gain traction. **Decision:** The Committee received the quarterly update.
Clinical Correspondence		FA	FA took the report as read and noted the following key items; • There was a decrease in both the longest turnaround time and the average turnaround time. there was a decrease in both the longest turnaround time and the average turnaround time. • A project group has been formed in order to monitor a detailed action plan and to engage further with primary care.	**Action:** It was agreed to have a further update in three months' time. **Decision:** The Committee received and noted the report.

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Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Maternity Incentive Scheme Year 4 Progress Update (CNST)		JC	JC presented the report and noted the following; • Trust received confirmation that a discretionary payment has been awarded by NHS Resolution in response to submission of the CNST Year 4 declaration in February 2023. Confirmation of the financial award allocation is awaited. • Extensive work remains ongoing to complete all outstanding actions identified in the PWC audit report prior to the end of May 2023. • A formal action plan update will be shared in the Board Report in May 2023. • The dashboard highlighted a decrease in PROMPT training compliance in March (72.36%) following the commencement of new starters within the service. • In response the Practice Education Team have increased capacity for both midwifery and obstetric leads to facilitate smaller training sessions. • NHS England maternity three-year single delivery plan was launched on 30 March 2023 and services have been asked to focus on delivery of the four high level themes.	**Decision:** The Committee received and noted the report.
Safeguarding Committee Chair Report		LR	LR took the chairs report as read with no items to be raised for escalation. JN queried the DBS checks referenced in the chairs report to which LR confirmed that this is a random sample taken for assurance as staff are required to have this refreshed every three years.	**Action:** Chair requested divisional assurance be rated as 'amber' given still assurance sought and include breakdown of concerns. **Decision:** The Committee received and noted the Chairs Report.
For Escalation: No additional concerns to be escalated to Board of Directors.				

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Quality Committee Chair's Report

(Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	17 May 2023	Date of Next Meeting	21 June 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Martin North, Fiona Noden, Sharon White, Sharon Katema, Gareth Hughes, Rebecca Lennon, Rauf Munshi, Tyrone Roberts and Divisional Representation.	Apologies received from:	Harni Bharaj, Francis Andrews, Sophie Kimber-Craig, Susan Moss, Angela Volleamere, Rachel Noble, Carol Sheard, Rae Wheatcroft.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report		Chief Nurse	The paper was taken as read with the Committee noting the following: • Harm Free Care: An incorrect Opthalmology procedure was carried out on the correct eye. There was no actual patient harm occurred, other than the patient to return to theatre to fully correct the procedure. This procedure has been discussed with Manchester ICB and as this does not meet the criteria, it will be removed as a never event. An ICS investigation will take place as appropriate. SB confirmed the safe systems and procedures were in place the procedure was based on the wrong assumption at the offset. As this was human error there is a specific exception within the never event giving a similar scenario where a procedure is performed. • Patient Experience: The Chief Nurse positively highlighted that Divisional colleagues have been focused on their activity and process. With the exception of post-natal, ED, in patients, maternity, antenatal, birth centre and community post-natal, there are increases around satisfaction which will also link with increasing response rate.	It was agreed that in future reports, updates will be provided from the midwifes. It was requested within the next quarter update, to show the difference between 3rd and 4th degree tears to enable to monitor and understand the issues. Include how many tears are associated with instrumental delivery and break down the factors that influence the 3rd and 4th degree tears, and if possible have the OASI training lead in attendance to present. Information on Pressure Ulcers will be provided on data linked to the collaborative around the drivers where we are performing against risk assessments.

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

Quality Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
			• 3rd and 4th degree tears: JC reported that OASI2 bundle was resized and remodified following actions queried of the OASI bundle. A review of the use of episiotomy scissors are being researched due to conflicting results. A further update will be provided in 2 months. • Maternity stillbirth rates are a fluctuating trend. A review of perinatal mortality tool process is undertaken to strengthen governance and oversight. The 3 cases from March and 1 in April are currently under review. • Pressure Ulcers are still under review and the target line has risen on Cdiff is due to the national target has also risen. The guidance has only recently been published for the next year therefore the target line will be the same for the external target.	
Clinical Governance & Quality Committee Chairs Report		TR	TR presented the report to the Committee noting the following key points: • Acute adult – the main issue is C-diff cases. The collaborative commences next Wednesday and there has been a flurry of activity with Quality Care including a process of UV cleaning. • Patient Safety Incident Report – No Serious Incident Investigations are currently overdue. • CQC Improvement Plan is progressing well, improvement actions are implemented and support progress. • Health Inequalities for Adults with Autism – this was an update to have oversight on how to support Out With Autism. This will now have a corporate approach; a detailed update will be provided at the next meeting.	

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Quality Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Quality Account Q4 – Priority 2 - Rheumatology		ICSD	The report was received and noted: • The main focus has been about implementation of transformation of ideas from the team. There has been successful recruitment of an additional specialist registrar from February to July 2023, the substantive consultant will start in September 2023, the 4th specialist nurse will start June 2023, and support from a locum consultant from March 2023. • Changes to improve the appropriateness of the referrals into the pharmacy clinic from other clinicians has been approved at the Steering Group. • There has been improvement with triage advice and guidance, adhoc medical support will cover any absences. • Fibromyalgia referrals have been forwarded to the Rheumatology Therapy Team, and exploring possible education sessions in diagnosing fibromyalgia with primary care colleagues. • Exploring potential for specialist follow up clinics and one stop shops with medical support.	Further work to be done with patients who are waiting a long time for appointments. TR suggested the quality and updates need to be made more smart in the presentations going forward.
Quality Account Q4 – Priority 4 – NEWS Improving Response to Escalation		ASSD	The report was received and noted: • ASSD and AACD will reduce the volume of patient safety incidents in relation to the failure to escalate a deterioration in the patients NEWS score by end March 2023 • In AACD, a further piece of work is required to support the streamlining of the escalation document process. • In ASSD, KPIs are now assed by the ward manager with matron oversight giving more insight into trends and concerns of staffing training required. The results do not triangulate into the quarterly sepsis report for both divisions.	Labelling of the tables and charts to be improved. Specific improvements on the KPIs to be made clearer

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Quality Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Draft Quality Account 2022/23		S Bates	The report was received and noted: • The timeframe for the publication of the document is end June. • Quality account priorities have been identified for the forthcoming year around Pressure Ulcer improvement, Cdiff infection reduction, and Enabling and empowering staff through development of QI skills. • Existing quality account priorities will continue and report through divisional governance structures, with the QI support when required.	
Trust Learning Report for Q4		S Bates	The report was received and noted: • Part 1 of the report is around the themes and trends, and learning from a number of different data sources be them complaints and incidents, and BOSCO results, CQC enquiries. • Themes identified are pressure ulcers, communication, review of pathways and procedures, and education and training. • Part 2 of the report is around the QI projects that the divisions are undertaking. A number of those projects address the themes and trends being identified.	
Maternity Incentive Scheme Year 4 Progress Update (CNST)		JC	JC presented the report to the Committee noting the following key points: • The Trust has been awarded a discretionary amount of money to help with improvements. This will be confirmed by end of May and payment released by June.	

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Quality Committee Chair's Report

			• Extensive work is ongoing with regards to the PWC actions following the audit undertaken on the CNST Year 4 scheme. The full action plan is detailed in Appendix 1 of the report. 5 actions have been completed and 20 actions are in progress. There has been a delay in issuing of the Year 5 programme. Aiming to have the draft policy written by end May/mid June 2023. • A recent benchmarking exercise have been done in regards to Ockenden and Kirkup recommendations report. Still not fully compliant with all recommendations but are 74% complaint with the initial Ockenden and 61% of the Kirkup report. Continuing to report on a system level every 2 months until achieved full compliance.	
Risk Management Committee Chairs Report		TR	The Chair's report was taken as read with the iFM Risk 1144 raised for escalation.	
Group Health & Safety Committee Chairs Report		S Bates	• The Fire Assurance paper is to be updated and presented to the next Risk Management Committee and GHSC. The Committee are seeking further assurance around the actual requirements and gaps within the paper. • Health and Safety National Alerts – there were 2 alerts and there was no assurance around the process and detail. • H&S Risk Report – there are a number of risks related to H&S and are being reviewed by the H&S Manager, evidence is being collated as BAU.	

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Quality Committee Chair's Report

			• Riddor Report – identified the process for reporting and recording incidents is not robust and a new process needs to be implemented. A recent HSE visit confirmed assurance with the systems and process in place to identify, monitor and support staff re dermatitis.	
Professional Form Chairs Report		TR	• Policy and Practice Group – assurance received on the progress against objectives, partial assurance on the outcomes of MCA/DoLS application. • Quality Patient Experience – assured on progress, partial assured on outcomes as data awaited. • Quality of Care – needs better inspection knowledge on the falls equipment. • Quality Governance – assurance on progress, partial assurance outcomes with complaints response timeframes. • Research, Innovation and Health Promotion – limited assurance on progress and outcomes. A New Lead in place from April 2023.	
Safeguarding Committee Chairs Report		LR	• Safeguarding Adults – further traction on the overarching safeguarding adults action plan. Capacity in the team is supported in the business case. Further assurance required within the content of the report. • Adult Acute Divisional update – due to the training compliance. Care in mind issues remain and DoLs referrals require accuracy and quality of the documentation. • Care in Mind issues have been picked up and a series of meetings are arranged with ICB with N Ledwith N Collier and M Toms. Updates will be provided when required. • There was no Medical representative at the meeting, this will be discussed with relevant leads going forward. LR has picked this up with F Andrews.	

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Quality Committee Chair's Report

For Escalation:
No additional concerns to be escalated to Board of Directors.

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Report Title:	Confirmation of Financial Plan 2023/24

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	This report provides confirmation of the final financial plan submitted to NHS England to ensure clarity.

Summary:	Following Board discussions in previous month, the final financial plan for 23/24 has been submitted. The headlines are:- **Bolton FT** Revenue deficit plan of £12.4m Year end cash balance of £24.0m Capital plan of £22.2m **GM ICS** GM revenue balance overall but with a system efficiency target of £123m GM capital overcommitted and discussion still ongoing to resolve. **Board Statement** GM ICB has requested that Boards confirm their support to a statement in relation to the system efficiency target.

Previously considered by:	
Discussed by the Executive Team and at the Finance and Investment Committee on 24 May 2023.	
Proposed Resolution	The Board is asked to:- 1. Confirm approval of the 2023/24 financial plan and their understanding of the consequences and the actions required to achieve break even. 2. Agree with the statement as requested by the ICB. 3. Note that the Cost Improvement Tracker has been submitted to GM ICB as requested.

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

Prepared by:	Annette Walker	**Presented by:**	Annette Walker Chief Finance Officer

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

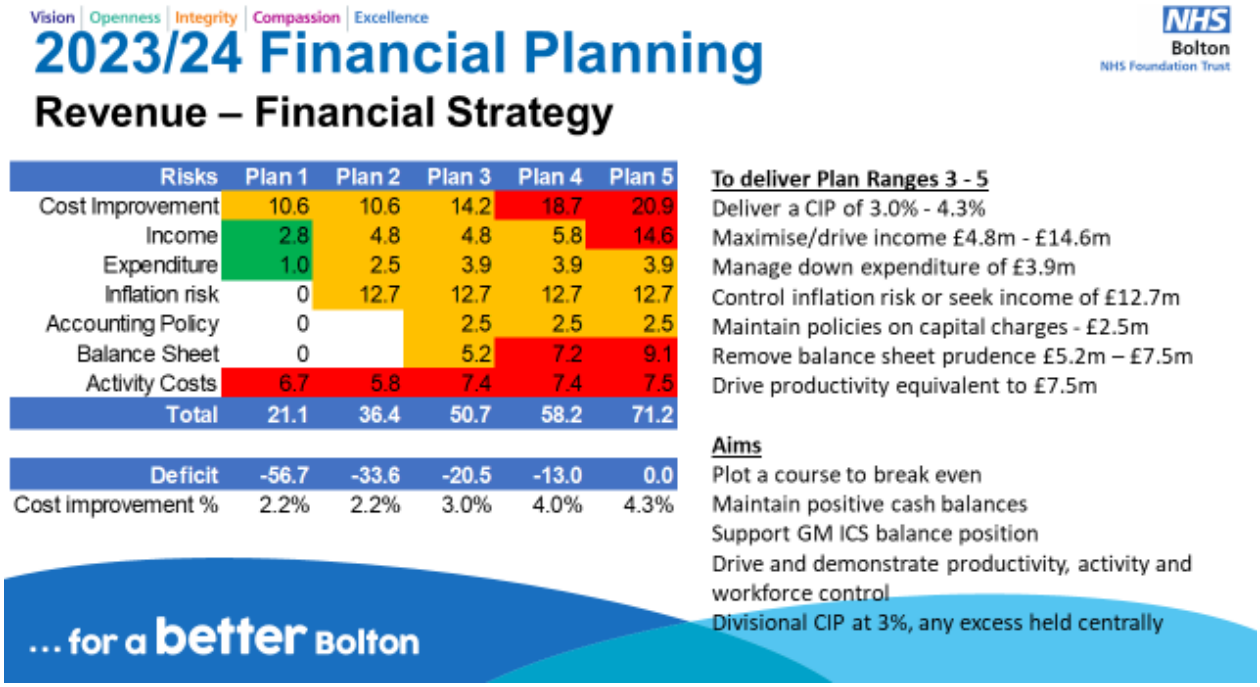
BAU	**Business As Usual**
CIP	**Cost Improvement Programme**
CDC	**Community Diagnostic Centre**
ICB/S	**Integrated Care Board/System**
LIMS	**Laboratory Information Management System**
SET	**System Efficiency Target**

Confirmation of Financial Plan 2023/24

Further to the presentations made to the Board in March and April, the Trust has now submitted a financial plan to NHS England as follows:-

FT Revenue Plan 23/24

Deficit plan of £12.4m which is in line with the plan 4 scenario that the board previously discussed using the slide below. Achieving this plan requires a CIP of £18.4m and the management of a range of risks and issues. The year-end cash balance if this plan is delivered is £24.0m.



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2023/24 Financial Planning

Revenue – Financial Strategy

NHS Bolton NHS Foundation Trust

Risks	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Cost Improvement	10.6	10.6	14.2	18.7	20.9
Income	2.8	4.8	4.8	5.8	14.6
Expenditure	1.0	2.5	3.9	3.9	3.9
Inflation risk	0	12.7	12.7	12.7	12.7
Accounting Policy	0		2.5	2.5	2.5
Balance Sheet	0		5.2	7.2	9.1
Activity Costs	6.7	5.8	7.4	7.4	7.5
Total	21.1	36.4	50.7	58.2	71.2
Deficit	-56.7	-33.6	-20.5	-13.0	0.0
Cost improvement %	2.2%	2.2%	3.0%	4.0%	4.3%

To deliver Plan Ranges 3 - 5

Deliver a CIP of 3.0% - 4.3%
Maximise/drive income £4.8m - £14.6m
Manage down expenditure of £3.9m
Control inflation risk or seek income of £12.7m
Maintain policies on capital charges - £2.5m
Remove balance sheet prudence £5.2m – £7.5m
Drive productivity equivalent to £7.5m

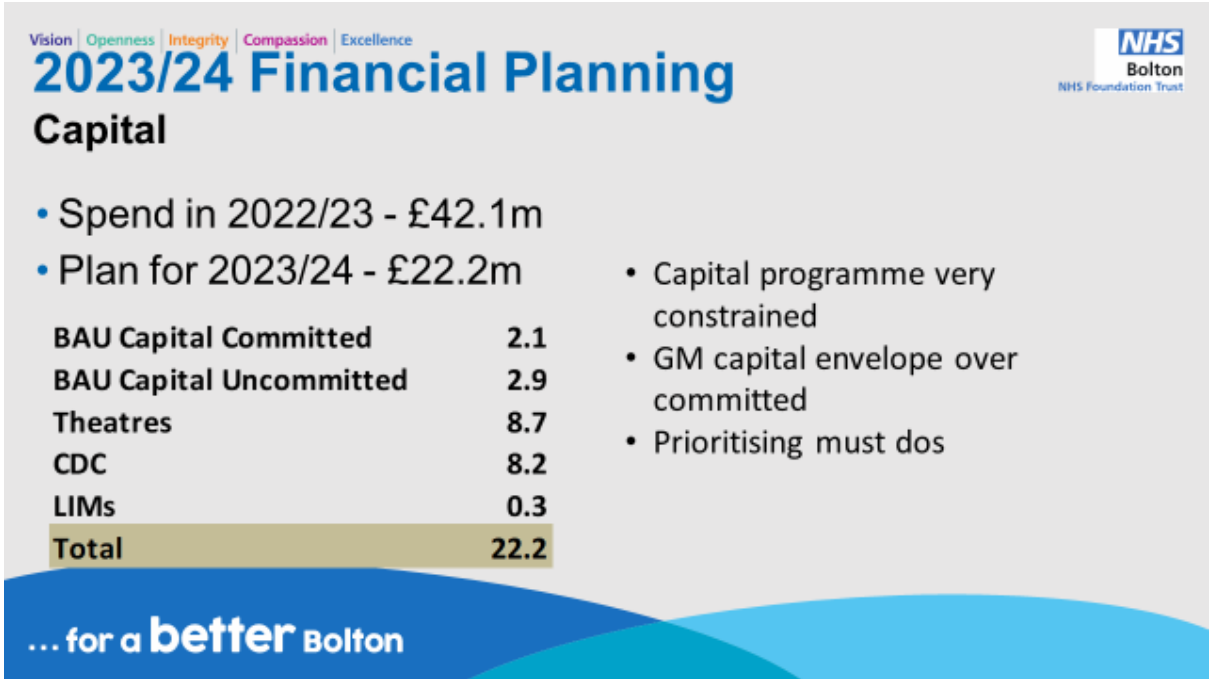
Aims

Plot a course to break even
Maintain positive cash balances
Support GM ICS balance position
Drive and demonstrate productivity, activity and workforce control
Divisional CIP at 3%, any excess held centrally

… for a better Bolton

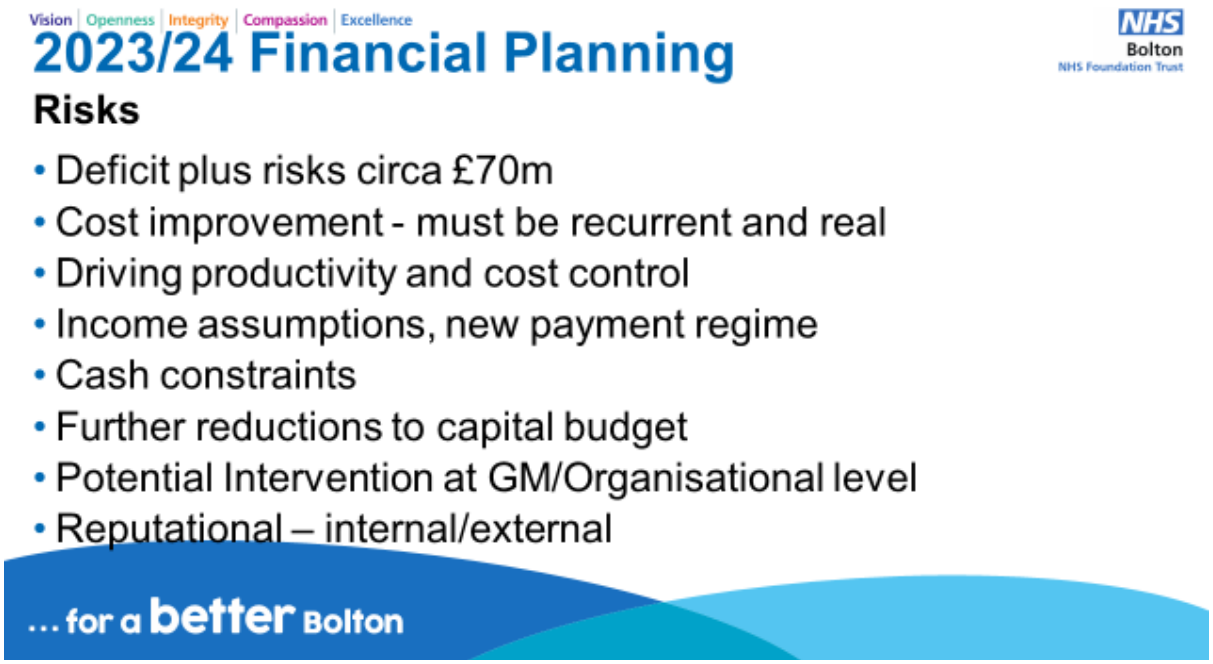
FT Capital Plan 23/24

We have set a capital budget of £22.2m as previously discussed using the slide below.



FT Financial Risks

The Board has discussed the risks inherent within the financial plan as per the slide below and mitigations are in development and will be reported to the Finance Committee from May onwards.



GM Financial Plan

GM has submitted a balanced revenue plan as follows:-

GM Providers	£
Manchester Foundation Trust	0.0
Christie Foundation Trust	-8.0
Northern Care Alliance	-32.0
Bolton Foundation Trust	-12.4
Tameside and Glossop Foundation Trust	-31.5
Wrightington Wigan and Leigh Foundation Trust	-6.5
Pennine Care Foundation Trust	0.0
Stockport Foundation Trust	-31.5
Greater Manchester Mental Health Foundation Trust	0.0
Gap on Inflation Funding	-8.0
Total	**-130.0**
Greater Manchester Integrated Care Board	0.0
System risk mitigations - unidentified	123.0
System risk mitigations - identified	7.0
Total	**130.0**

In order to submit a balance plan, GM ICB has submitted a surplus to offset provider deficits by creating a system risk 'reserve' with the expectation of system efficiencies being delivered to this level. A total of £123m as yet remains unidentified. This is in addition to required cost improvements across the ICS of £438m.

The overall GM Capital budget is over committed by circa £30m. Discussions continue between Providers and the ICB to identify how this is to be managed. There is a risk that provider capital budgets will be reduced as a consequence.

Board Statement

The ICB has requested that Providers agree the following statement around the delivery and ownership of the System Efficiency Target (SET).

Achievement of this plan is predicated on a number of assumptions and management of risk, and specifically requires the delivery of £123m system savings, which is in addition to the challenging efficiency targets already built into all organisational plans. For planning purposes, the £123m system target currently sits within the NHS GM plan, but all NHS organisations recognise that there is a collective responsibility of all organisations in the system to manage and mitigate this risk. To deliver savings at this level, all organisations and all parts of the system will be impacted.

Delivery of this level of savings needs to focus on cost reduction, rather than an expectation of new income, though every opportunity to mitigate will be explored. Current examples include:

- *Output from the PWC diagnostic and productivity opportunities identified both for the system and at an organisational level.*
- *Review of enduring costs resultant from COVID, examples include additional G&A and Critical Care beds as well as specific COVID services such as testing and Medicine Delivery Unit.*

- *Wider efficiencies and productivity measures, above CIP plans, which could include reviewing more sustainable commissioning of services including decommissioning.*

As a result of the findings from the Carnall Farrah review, governance in the GM system is expected to be revised. The current proposal to oversee not just the delivery of the £123m system savings, but also the wider underlying financial pressures and risks, is to develop a system wide PMO that will report into the NHS GM ICB Board via a Board Committee. The PMO will also ensure that GM has sufficient narrative to adequately articulate why the system has seen material increases in its workforce, but a corresponding reduction in activity when compared to pre-COVID levels. The PMO will facilitate the process and agree with system partners the impact on money, workforce, activity and performance metrics, and agree the changes on the impacted organisations.

Delivery of financial and wider performance indicators is not the sole responsibility of finance; leaders across all disciplines must by accountable, recognising that decisions ultimately may impact patients. Consequently, the system must undertake appropriate engagement and complete Quality Impact Assessments (QIA) to ensure there are no unintended consequences resultant from any proposed changes. The Joint Committee of the ICB will balance the QIA and financial benefits in making the decision to approve the implementation of any changes.

The GM system is facing a significant financial challenge, which has been building over several years, and will continue to increase unless recurrent savings are delivered at pace and at scale. It is expected that decisions taken that benefit the overall system could impact differentially on individual organisations. This might include cost reduction schemes that target specific organisations/ sectors as opportunities are identified and prioritised, or decisions about how income is allocated, recognising that whilst there will be engagement with partners, NHS GM has ultimate the responsibility and accountability for how resources allocated to the ICB are deployed."

Boards have also been asked to demonstrate that they are clear on the consequences of *'both approving a deficit plan along with what action would need to be taken to deliver a breakeven plan and what the consequences of this would be including quality and patient safety'.*

Providers have also been asked for a copy of their Cost Improvement Programme tracker to provide assurances to the ICB.

Recommendations

The Board is asked to:-

1. Confirm approval of the 2023/24 financial plan and their understanding of the consequences and the actions required to achieve break even.
2. Agree with the statement as requested by the ICB.
3. Note that the Cost Improvement Tracker has been submitted to GM ICB as requested.

Report Title:	Finance & Investment Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

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

Summary:	The attached reports from the Finance and Investment Committee Chair provides an overview of items discussed at the meetings held on 22 March and 26 April 2023. Due to the timing of the May meeting, a verbal report will be provided by the Committee Chair to the Board reflecting discussions held on 24 May 2023.

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

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

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

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

Finance and Investment Committee Chair's Report

Name of Committee/ Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	22 March 2023	Date of next meeting:	26 April 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Sharon White, Andrew Chilton, James Mawrey, Rebecca Ganz, Joanne Street, Sharon Katema, Matthew Greene, Adele Morton	Quorate (Yes/No):	Yes
		Key Members not present:	Fiona Noden, Rae Wheatcroft, Bilkis Ismail

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Review of Terms of Reference	NA	A Walker	The Committee agreed to the amendments made in March 2022 with one further amendment to be made to the Strategic Section with the following line to be added: To receive updates on the System/GM/National Financial Positon.	Approved subject to one minor addition.
Financial Plan 2023/24		M Greene	Key points from the presentation were noted as: **Revenue** • The Trust is to submit a financial plan of £34.8m post CIP, an improvement of £21.9m compared to the first submission. • Scenarios were explained including the route to break even and the Committee was asked to note all assumptions detailed in the presentation. • Planning to achieve 2.2% CIP in line with national guidance but set divisions a stretch target of 3% recurrently.	
Financial Plan 2023/24		M Greene	**Capital** • Total capital plan for 23/24 of £22.2m. • TIF, CDC and LIMS account for £17.3m of this planned spend. • £4.9m of CDEL for local capital schemes, of which £2m is committed. • The remaining £2.9m of uncommitted CDEL will be held for urgent safety/risk, meaning there will be very limited Capital investment next year. **CIP** • CIP remains a risk with various detailed revenue scenarios. • To break even CIP would need to be stretch to 6%. • Engaging with the divisions next week to look at where further savings can be made. Propositions include a variable pay challenge of £25m to half variable pay and a non-pay challenge of £5m across many areas.	Noted with associated risks.

	No assurance – WILL have a significant impact on quality, operational or financial performance of the organisation if left unaddressed within 1 month;
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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Elective Recovery Fund	NA	A Morton	The committee received an overview of how the elective recovery targets will affect the Trust in 23/24. Payment for activity from ICBs and Specialist Commissioners will change in 2023/24. An Aligned Payment & Incentive (API) payment mechanism is to be introduced, which allows for a variable element based on performance.	Noted.
Month 11 Finance Report		A Chilton	key points were noted as follows: • Year to date deficit of £3.5m compared with a planned deficit of £6.2m. The forecast outturn has been updated to a £1.5m deficit due to an additional £9.2m of income being forecasted from GM and Spec Comm. • Variable pay remains a significant issue for BFT averaging at £3.1m per month in 2022/23 compared with £1.7m per month in 2019/20. • Our year to date capital spend is £18.3m of which £7m relates to Theatres. Revised capital envelope of £42.2m, which must be fully spent by 31st March 2023. • We had cash of £21.7m at the end of the month, which is an increase of £1.2m from month 10. The Trust cash position will become challenging during 23/24 and this has been flagged as a key concern during planning discussions with the ICB. • Our BBPC performance year to date is now 90.5% and is improving overall. A number of actions are underway to improve and maintain this performance.	Noted with associated risk.
Renewal of Gas Contract	NA	A Walker	The Trust (via IFM) will enter into a 4 year contract with Inspired Energy for gas supplies, procured via the Countess of Chester NHS FT framework. This contract has an indicative cost for 2023/24 of £2.8m per year. This would represent an increase of approx. £1m compared with 22/23.	Approved.
Going Concern Submission	NA	A Walker	For a public sector organisation to prepare their accounts on a going concern basis there has to be an anticipated continuation of service. The Trust anticipates a continuation of service. It is recommended the accounts for 2022/23 are prepared on a going concern basis.	Approved.

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Procurement Quarterly Update		A Walker	Procurement savings of £4.78m have been secured for the period to January 2023, through cost avoidance (£2.7m), cash releasing (£1.7m) and inflation avoidance (£0.35m). This saving is an increase of £774K on prior year. Collaboration with the GM Procurement team and working closely with SCCL contributed to £1m of the saving. The remainder of the savings, have been achieved by the internal team working closely with the Divisions. The procurement team is forecasting to complete 64% of the projects identified on the work plan, the remainder will be rolled forward in to 23/24.	Noted.
Chairs' Reports	NA	A Walker	The Committee noted the following: • **Capital Revenue & Investment Group** Chair's Report - 7th March 2023 • **Place Based Finance & Assurance Committee -** Verbal update from the meeting held on 21st March 2023. AW reported on discussions, which took place around issues with Little Lever Health Centre which have been in the press and also with Horwich which have been resolved. A review is to be undertaken of the legal framework and Section 75's with a more co-ordinated savings plan approach. Working well with Local Authority and ICB.	Noted
Comments				
Risks escalated No items identified for escalation				

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Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	26 April 2023	Date of next meeting:	24 May 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rebecca Ganz, Rae Wheatcroft, Sharon Katema, James Mawrey, Rachel Noble, Andrew Chilton, Matthew Greene, Samantha Ball, Alison Lil	Quorate (Yes/No):	Yes
		Apologies Received from:	Bilkis Ismail

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Financial Planning 2023/24		A Walker	AW presented an updated on the 23/24 financial plan. The Committee noted that the presentation was a further iteration from the last position seen in March. The Committee noted the current plan submission, scenario ranges and risks and confirm the appetite to move to plan 4, meaning a deficit of £13m noting risks and further ICB changes. Final submission due 4 may 2023. Full CIP plan being finalised. It was noted that the capital plan was £22m but subject to change and that cash balances would be positive provided the plan was delivered. The plan was subject to Board agreement.	Noted
Cost Improvement Plan		S Ball	The Programme Director for Transformation presented the Cost Improvement Programme for 2023/24. The key points were noted as follows: • CIP Target of £14.2m with a stretch to £18.7m • £9.5m identified which is changing daily. • CIP and productivity overview presented in detail for assurance to the Committee. CIP has to be cashable. Total productivity and CIP required is £26.1m. • Programmes of work will be benchmarked to maximise identification of opportunity. • Divisional and Corporate CIPs already commenced and also working with Junior Drs and Chief Registrars. • CIP sprints approach underway to ensure progress. • Productivity and Efficiency Improvement Packs provided by the Transformation team. • Cross cutting schemes being scoped and planned covering areas such as digital, workforce, procurement and system prescribing efficiencies. • Robust governance in place. •	Noted.

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Month 12 Finance Report		A Chilton	The Operational Director of Finance updated the committee on the month 12 finance position. The key points were noted as follows: • We have a performance deficit of £1.5m compared with a planned deficit of £7.2m. The reported position in accounts is a surplus of £2.4m after technical adjustments have been made. These adjustments are not recognised by NHSI for measuring financial performance. Variable pay remains a significant issue for BFT averaging at £4.1m per month in 2022/23 compared with £1.7m per month in 2019/20. The trend is agency spend is reducing, though there was an increase in March due to the impact of industrial action. • Our capital spend for the year is £42.1m of which £14.6m relates to Theatres and £15.0m to CDC. £24m was spent in one month to hit the plan. • We had cash of £58.2m at the end of the month, which is an increase of £36.5m from month 11. Of this £32m relates to PDC capital funds. The Trust cash position will become challenging during 23/24 and this has been flagged as a key concern during planning discussions with the ICB. • Our BPPC performance year to date is now 91.3% and is improving overall. A number of actions are underway to improve and maintain this performance.	Noted with huge thanks to the Finance Department for the completion of the annual accounts within the deadline.
Group Banking Arrangements		M Greene	The committee received an update in relation to the Group Banking Arrangements. The Trust, IFM and Charitable Funds have separate bank accounts. The operation of the bank accounts is in line with the Standing Financial Instructions with two authorised signatories required to authorise a payment.	Approved.
Finance Department Business Plan Update		M Greene	Progress against deliverables in 2022/23 has been BRAG rated. Those shown as green 'implementation underway' and amber and thus not fully completed have been rolled into 2023/24. For 2023/24, the number of deliverables has remained narrow at 20 to ensure there is a focussed approach to the improvement opportunities that will deliver the greatest benefit.	Noted.

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Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
iFM Bolton – IFRS Implementation Paper		A Lil	Currently, the reporting framework utilised by iFM Bolton Limited to prepare their accounts is not consistent with the reporting framework utilised by Bolton NHS Foundation Trust. In order to ensure consistency across the Trust Group, it is proposed that iFM Bolton Limited adopt the same reporting framework with effect from 1 April 2021 and prepare their accounts in accordance with International Financial Reporting Standards.	Approved.
Contract Award: Data connection lines with Virgin Media		A Walker	Virgin Media are the current provider of the Data Line Connections. The contract commenced in 2017; the latest extension expired in February 2023 and is now on a rolling contract, subject to inflation. It is therefore the intention to enter into a new contract on the most economic and advantageous terms. Following a tender process undertaken via the Crown Commercial Services Framework, the most economical advantages solution is to award a contract to Virgin Media. Whilst the contract presents a cost pressure of £45K p.a, the contract incorporates data line connections for new projects such as CDC and the ICP Business Case and other value added items as noted below. The tender outcome meets our obligations under the Public Contract Obligations 2015.	Approved to go through Board.
Chairs' Reports		A Walker	The Committee noted the following reports: **Capital Revenue & Investment Group Chair's Report** – April's meeting stood down. **Place Based Finance & Assurance Committee Minutes** – Draft minutes from meeting held on 18th April.	Noted.
Comments				
Risks escalated No items escalated				

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Report Title:	Annual Governance Declarations

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	✓
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Purpose	The purpose of this report is to provide the proposed content of the self-certification against the NHS Provider Licence.

Summary:	This report and supporting appendices provides a contextual information and sources of assurance with regards to the Annual Trust Self-Certification against the NHS Provider Licence, Annual Self-Certification. As part of its annual reporting process, the Board is required to self-certify on its compliance with the following conditions of the NHS Provider Licence: 1. **General Condition 6 (3):** The provider has taken all precautions to comply with the licence, NHS Acts and NHS Constitution. 2. **Condition FT4 (8):** The provider has complied with all required governance standards and objectives. 3. **Continuity of service (CoS7):** The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of statement. 4. **Section 151(5) of the Health and Social Care Act 2012 Training of Governors:** Providers must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this. In addition, the NHS England Guidance on Good Governance and Collaboration requires the Trust to review its compliance against this guidance during 2022/23.

Previously considered by:
The Board considers this declaration on an annual basis.

Proposed Resolution	The Board of Directors are asked: 1. Approves the self-certification against the conditions provided by the Trust in relation to the NHS Provider Licence Conditions (Appendix 2)

	The Board is asked to **review** the evidence and **confirm** compliance with the NHS Self Certification for the NHS Provider Licence.

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

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1. Introduction

1.1. The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

1.2. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023. The conditions within the Licence are detailed at ***Appendix 3*** with assessment of compliance made against each condition.

1.3. All NHS foundation trusts and NHS trusts are required to hold a licence and self-certify that they can meet the obligations set out in the NHS provider licence.

1.4. The functions of the Trust are conferred by 2006 Act and the Trust will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

2. Changes to the NHS Provider Licence

2.1. NHS England (NHSE) has now modified and launched an updated NHS provider licence, to bring it in line with current statutory and regulatory requirements

2.2. The new provider licence applies from 1 April 2023 and aims to:

- support effective system working
- enhance the oversight of key services provided by the independent sector
- address climate change and
- make a number of necessary technical amendments.

2.3. **Supporting system working**

The new conditions listed below reflect expectations around collaboration and cooperation as prerequisites for system working, financial sustainability, fair and equitable access to skills and expertise across the local workforce.

- **WS1 Cooperation** – requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering NHS services, improving NHS services, delivering system financial plans and delivering system workforce plans.
- **WS2 The Triple Aim** – which requires NHS trusts, foundation trusts and NHS controlled providers to have regard for and consider the likely effects of their decisions on the Triple Aim and have regard to related guidance.
- **WS3 Digital Transformation** – which requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim

2.4. **Tackling climate change and delivering Net Zero**

NHS2 Governance arrangements paragraph 3(b) and CP1 Governance arrangements for NHS controlled providers' paragraph 3(b) – to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change.

2.5. **Importance of personalised care**

- Reframing **IC1 Provision of Integrated Care** – as a positive obligation that all providers take steps to integrate services and enable cooperation with other services to improve quality and reduce inequalities of access and outcomes.
- Expanding **IC2 Personalised care and Patient Choice** – to require providers to support the implementation and delivery of personalised care by having regard for relevant guidance and legislation, offering people control to manage their own health and wellbeing.

2.6. **Technical Amendments**

Shifting the focus of the costing conditions to support integration and improvement.

- Replace Pricing Condition 1 with new Costing Condition 1: Submission of costing information
- Replace Pricing Condition 2 with new Costing Condition 2: Provision of costing and costing related information
- Replace Pricing Condition 3 with new Costing Condition 3: Assuring the accuracy of pricing and costing information.
- Pricing Condition 4 (renamed as Pricing Condition 1) – to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.

2.7. **Conditions removed from the Licence**

The following conditions have been removed from the final modified licence:

- **Choice and Competition Condition 2:** Competition Oversight from the modified
- **Pricing Condition 5** (local modifications) from the licence.
- Removed reporting requirements from General Condition 6 (Systems for compliance), which requires licensees to self-certify against the licence,
- Removed Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the licence and to prepare a Corporate Governance Statement.
- The following obsolete conditions have been removed:
  - **General Condition 3**: Payment of fees to Monitor
  - **Foundation Trust Condition 2**: Payment to Monitor in respect of registration and related costs
  - **Foundation Trust Condition 3**: Provision of information to advisory panel.

2.8. **Other notable changes include:**

- Removal of redundant clauses from General Condition 9 (now G8)

- To allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers (*providers where their services may be of sufficient scale or complexity nationally or regionally that NHS England considers that their unavailability, due to the provider's insolvency or quality issues, would impact on patients)*

- To amend relevant CoS conditions to reference Hard to Replace Providers.

- Expanding the scope of CoS conditions (CoS 3 and CoS 6) to include quality governance standards given the importance of ensuring that NHS England can intervene as a regulator in the interest of patients

- **NHS2: Governance arrangements paragraph 3(c) and CP1:** Governance arrangements for NHS controlled providers' paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.

3. The Self-Certification requirements

3.1. The Trust is required to carry out self-certification as assurance that it complies with the conditions. Where the Trust is not compliant, it is required to explain why and develop an action plan to achieve compliance.

3.2. Whilst there is no requirement for the Trust to submit the Self-Certification to NHSE, the Trust is required to make the Self-Certification public on its website. NHSE will contact a select number of trusts to ask for evidence of self-certification.

3.3. The Trust is required to self-certify the following Licence Conditions after the financial year-end:

a) **General Condition G6** - The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution

b) **Continuity of Services Condition CoS7** - If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service

c) **Condition FT4** is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.

d) **Section 151(5) of the Health and Social Care Act 2012 Training of Governors** - NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles

Appendix 1 NHS Provider Licence - Self Certifications for 2022/23

Bolton NHS FT undertakes an annual assessment against each of the NHS Improvement Provider Licence requirements. Once approved, these declarations will be published on the Trust's website.

1. General Condition 6 - Systems for compliance with licence conditions

1.1. The Licensee should 'take all reasonable precautions against the risk of failure to comply with:

- the conditions of this Licence;
- any requirements imposed on it under the NHS Acts; and
- the requirement to have regard to the NHS Constitution'.

1.2. The steps the Trust is expected to take (paragraph 2(a) and 2(b) of the Licence) are:

- the establishment and implementation of processes and systems to identify risk and guard against their occurrence; and
- regular review of whether those processes and systems have been implemented and of their effectiveness.

2. **Evidence of Compliance**

2.1. The Board and supporting Committees (Audit Committee, Quality Assurance Committee, Finance and Investment Committee, People Committee, Strategy and Operations, and the Trust Risk Management Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

2.2. The Risk Management Strategy, including the Board Assurance Framework is reviewed by the Board and the Audit committee and the Risk Registers are reviewed through the Risk Management Committee.

2.3. The Trust has a comprehensive monthly dashboard, which on a monthly basis triangulates key performance indicators using Statistical Protocol Control (SPC) tools to understand whether change results in improvement and provides an easy way to track the impact of improvement. The Integrated Performance Report is presented to all committees prior to presentation at Board.

*Please see **Appendix 3** for a full break down of the assessment of compliance with the licence conditions*

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution

2.4. The Board is required to sign off on self-certification no later than: **G6: 31 May 2023.**

3. Continuity of Services Condition CoS7

3.4. Commissioner Requested Services CRS are defined as *"services that will be subject to regulation by NHSE in the course of a licensee's operations that, in the event of a provider failure, must be identified and kept in operation at that specific locality."*

3.5. The Board is asked to consider confirmation of the following statement:

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3.6. **Evidence of compliance**

The Going Concern report provides evidence that the Trust will continue to have the resources required to operate

4. Declaration of compliance with conditions of the NHS Provider Licence: Condition FT4

4.1. The standards set out in FT4 are similar to the standards of governance set out in the NHSE general objective.

4.2. There is no set approach to these standards and objectives but there is an expectation that any compliant approach will involve effective board and committee structures, reporting lines, performance and risk management systems.

4.3. NHSE will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

4.4. **Evidence of compliance**

The Board is required to provide a specific declaration with regard to Condition FT4(8) of the provider licence in the form of a **'Corporate Governance Statement'**. To support the self-certification against Condition FT4(8), the Board of Directors will be required to certify that they are satisfied with the risks and mitigating actions against each area listed.

Appendix 4 sets out the detail for the Corporate Governance Statement declaration

4.5. The Board is required to sign off on self-certification no later than: **FT4: 30 June 2023.**
The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time

5. Section 151(5) of the Health and Social Care Act 2012 Training of Governors

5.1. A Governor training programme has been in place since the election of the shadow council of Governors in 2008.

5.2. Whilst all face to face governor training had been postponed following the Covid-19 outbreak, all formal governor induction sessions have now resumed for any newly elected Governors.

5.3. The Trust has an established Governor Training Programme and Governor Induction Handbook both of which have been used to support new governors elected during 2022/23 and are undergoing a refresh ahead of the new term.

5.4. In addition, it is planned that there is a continuation at the Council of Governors meetings, for a presentation from a Non-Executive Director on their role and work of their Committee thus allowing Governors knowledge over the governance of the Trust to be enhanced.

6. Self-Certification Recommendation

6.1. Whilst the deadlines for self-certification are different, the Board is recommended to consider:

- Confirmation of self-certification against the requirements of General Condition 6 of the Licence.
- Confirmation of the continuity of services condition (CoS7)
- Each statement within the Corporate Governance Statement and confirms compliance.
- Approving the declaration of compliance with regard to Governor training

6.2. All Self-Certifications will be made public on the Trust's website by 30 June 2023.

6.3. The Board is asked to note and support the proposed declarations which will be published on the Trust website on **30 June 2023.**

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Appendix 2 – proposed declaration using a modified version of the template *(to be published on 30 June 2023)*

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

1 & 2 **General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)**

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

3 **Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Board reviewed a detailed paper providing assurance with regard to compliance with the provider licence.

The Going Concern report reviewed by the Board in June 2023 and included within the Annual Report and Accounts sets out the assurance provided to the Board to confirm that the management of the Trust are confident that the Trust will remain a Going concern and will therefore be able to continue the provision of Commissioner Requested Services with due regard to the NHS Constitution.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Appendix 3 - Checklist of Compliance to underpin self-certification against NHS Provider Licence Standard Conditions:

Licence Condition	Compliance	Evidence
Section 1 – Integrated care		
IC1: Provision of integrated care *'The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS is integrated'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition and played a full part in the development of Greater Manchester Integrated Care Board and within Bolton Locality.
IC2: Personalised Care and Patient Choice *'The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition as required. The ERS directory of services provides patients with easily accessible information by speciality
Section 2 – Trusts Working in Systems		
WS1: Cooperation *'The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.
WS2: The Triple Aim *"When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.
WS3: Digital Transformation *The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required.

Section 3 – General Conditions		
G1: Provision of information *'the Licensee shall provide NHS England with such information, documents, and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required. All information requested by NHS England is supplied in a timely manner in the format requested.
G2: Publication of information '*The Licensee shall comply with instruction from NHS England , issued for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services it provides for the purposes of the NHS.'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition as required Information is published as required in accordance with the Code of Governance and the Annual Reporting Manual.
G3: Fit and proper persons as Governors and Directors '*The Licensee must ensure that a person may not become or continue as a Governor of the Licensee' if that person is not fit and proper.* *'The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper'*	**Confirmed**. The Trust complies with this condition as required.	Trust Employment policies ensure compliance. There are robust pre-employment compliance checks for new directors and self-declarations and associate checks for existing directors to ensure ongoing compliance with FPPR. Governor eligibility and disqualification criteria and code of conduct ensures compliance. All Governors are also subject to DBS checks on appointment. CQC review Director files to test fit and proper person documentation
G4: NHS England guidance '*the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2)*	**Confirmed**. The Trust complies with this condition.	Self-assessment against Code of Governance, compliance with the Annual Reporting Manual, routine review and compliance with all directives issued by NHSI.
G5: Systems for compliance with licence conditions and related obligations	**Confirmed**. The Trust complies with this condition.	Risk Management system in place throughout the Trust including Board Assurance Framework and Risk Registers

G6: Registration with the Care Quality Commission	**Confirmed**. The Trust is fully registered, without conditions, with the Care Quality Commission (CQC). All sites are registered	An internal assurance process is in-place to minimise the risk of non-compliance with essential standards of quality and safety. The Trust is rated Good overall by the CQC with a rating of excellent for the Well Led review.
G7: Patient eligibility and selection criteria	**Confirmed**. The Trust complies with this condition.	There is an annual review of the contract is in place to agree eligibility criteria in accordance with Department of Health and Social Care guidance
G8: Application of Section 6 (Continuity of Services)	Refer to Section 6 below.	
Section 4 – Trust Conditions		
NHS1: Information to update the register *The Licensee shall ensure that NHS England has available to it written and electronic copies of the following documents:* *a) the current version of Licensee's constitution;* *b) the Licensee's most recently published annual accounts* c) *any report of the auditor on them, and the Licensee's most recently published annual report'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. The Annual Accounts, Annual Report, and Auditors opinion are submitted to NHSE annually in accordance with requirements. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.
NHS2: Governance arrangements *'The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. Please refer to **Appendix 3** and separate declaration

Section 5 – NHS Controlled Providers Conditions		
N/A		
Section 6 – Continuity of Services		
COS1: Continuing provision of Commissioner Requested Services *'The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service (CRS)…'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition
COS2: Restriction on the disposal of assets '*The Licensee shall establish, maintain and keep up to date, an asset register'* *'The Licensee shall furnish NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition
COS3: Standards of corporate governance and financial management and quality governance '*The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management…'*	**Confirmed**. No compliance issues identified	Outstanding in the CQC Well Led Review with "Good" for the *"use of resources review"* Position against Code of Governance regularly assessed and reviewed through the Audit Committee Monthly monitoring of quality governance, operational and financial performance and risks at monthly Committee meetings and Board

COS4: Undertaking from the ultimate controller **'***The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee'*	N/A	Not applicable (relates to non-FT whose ultimate controller may be a separate legal organisation).
COS5: Risk pool levy **'***The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public liability schemes.
COS6: Co-operation in the event of financial or quality stress **'***if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern…the Licensee will: provide such information as NHS England may direct to Commissioners, allow such persons as NHS England ay appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition The Trust is not in financial special measures, but would cooperate fully with NHS England should this ever be the case
COS7 Availability of resources **'***The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources'*	**Confirmed**. No compliance issues identified	The Trust complies with this condition. Robust plan and quarterly profile that is approved as part of the Operating Plan submission
Section 7 – Costing Conditions		

C1: Submission of costing information '*the Licensee shall obtain, record and maintain sufficient information about the costs which it expends in the course of*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition and produces cost information in relation to both the annual National Cost Collection submission (in line with the nationally prescribed costing methodology) and the annual accounts submission.
C2: Provision of costing and costing related information '*the Licensee shall furnish to NHS England such information and documents, and shall prepare or procure and furnish to NHS England such reports, as NHS England may require for the purpose of performing its functions'*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition.
C3: Assuring the accuracy of pricing and costing information *'Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition. Bolton NHSFT costing methodology aligns to nationally prescribed costing guidance and standards.
Section 8 – Pricing Conditions		
P1: Compliance with the NHS payment scheme '*the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable*	**Confirmed**. No compliance issues identified.	The Trust complies with this condition and produces cost information in relation to both the annual National Cost Collection submission (in line with the nationally prescribed costing methodology) and the annual accounts submission

Appendix 4: Corporate Governance Statement

Corporate Governance Statement	Compliant	Risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Yes	**Risk:** not adhering to accepted standards of corporate governance or best practice **Assurance and Mitigating actions:** • CQC rated as Outstanding for Well Led • Compliance with Monitor's Code of Governance for Foundation Trusts regularly assessed and reported through Audit Committee • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Director of Corporate Governance/Trust Secretary who has accountability for its maintenance. • There are no material conflicts of interest in the Board. • All governors elections and by elections held in accordance with election rules. • Director of Corporate Governance/Trust Secretary in post who holds responsibility for corporate governance. • Systems and controls assurances are obtained via the Audit Committee. • Further formal external governance review will take place every three years or as required by NHSE. • More complete explanations about systems of corporate governance are set out in the annual governance statement and the Trust's annual report
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Yes	**Risk**: non-compliance with Monitor's Code of Governance for foundation trusts and other governance guidance issued by the regulator **Assurance and Mitigating actions:** • Compliance with the Code of Governance assessed each year as part of the annual reporting process.

		• Any guidance requirements are routinely assessed and implemented as necessary. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Yes	**Risk**: Ineffective board and committee structures in place which are not reviewed and updated. Unclear reporting lines **Mitigating actions:** • CQC outstanding for Well Led domain • Board committees established with clear lines of reporting. • Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary? These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. • Standardised Chair reports to escalate assurance and concerns in line with reporting structure. • Clear delegation of actions to committees • Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
4. The Board is satisfied that the Licensee effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Yes	**Risk:** Lack of systems to assess compliance with Licensing requirements **Assurance and Mitigating actions:** • Risk Management Strategy in place and regularly reviewed. • Board Assurance Framework • Safeguard risk management system in place. • Use of internal and external audit services to investigate any areas of concern. • Inpatient and other CQC surveys utilised with action plans put in place where necessary.

c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		• External reviews undertaken where appropriate or necessary. • Contracts for services agreed with clinical commissioning groups. • Finance and Investment Committee considers detailed financial performance report at each meeting • Monthly performance report considered by Board, detailed performance discussed at monthly performance reviews. • Comprehensive agendas for Board meetings circulated to directors at least 3 days before each meeting • Cost Improvement Plans in place which are risk assessed for quality • Standing Financial Instructions and Standing Orders in place • Counter Fraud specialist reports to the Audit Committee • In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. The four areas are: quality and safety, finance, operations and governance • Points as set out in 1), 2) and 3) above apply. **Risk**: Potential loss of control through devolution of authority to the Trust's wholly owned subsidiary **Mitigating actions:** • Group Audit Committee and Risk Management Committee • Group Health and Safety Committee

5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Yes	• The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity • Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Clinical quality, patient safety & patient experience metrics are reported to the Board monthly. • Quality Assurance Committee – chaired by a NED – Terms of Reference include reporting from Clinical Governance Committee and reports from clinical divisions. • Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to Clinical Audit Committee. Full list included within the Quality Account • Learning from national reports with comparative reports undertaken and action plans devised and implemented. • National reports and benchmarking e.g. NICE guidelines – NPSA safety alerts managed via Clinical Governance Committee • Regular ward and department visits undertake by all Board members • PLACE • Ward to board heat map • Exec team ward buddies • Board go and see • Processes in place to escalate and resolve issues - risk management committee established with reporting line to the QA Committee
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel	Yes	• The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust).

on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		• All Executive Directors' performance and competencies are reviewed through annual appraisals. • Collective & individual skill-sets reviewed as part of board development • Chairman receives an annual performance appraisal from the Senior Independent Director, • NEDs receive an annual performance appraisal from the Chairman who advises the governors • NEDs have been appointed by the Council of Governors as advised by the governors' Nominations Committee. • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance, and, OD. Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. • Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. • NED progress is monitored by the Chair via one to one meetings including a formal appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. • This is supplemented by a number of Board development/strategy sessions to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. • Divisions are led by experienced and capable teams consisting of a Divisional Medical Director, a Divisional Director of Operations and a Divisional Director of Nursing. • Nursing levels on wards are reported to Board and are monitored and published on a daily basis on the ward staffing boards.

Report Title:	Audit Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Audit Committee meeting held since the last Board of Directors meeting.

Summary:	The attached report from the Audit Committee Chair, provides an overview of items discussed at the meeting held on 03 May 2023.

Previously considered by:
The Chair's report was discussed at Audit Committee.

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

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

Prepared by:	Annette Walker Chief Finance Officer	**Presented by:**	Alan Stuttard, Chair Audit Committee

Audit Committee Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	3 May 2023	Date of next meeting:	21 June 2023
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Malcolm Brown, Annette Walker, Sharon Katema, Othmane Rezgui, Debra Chamberlain, Imogen Milner, Collette Ryan, Catherine Hulme	Quorate (Yes/No):	Yes
		Apologies Received from:	Karen Finlayson

Key Agenda Items:	RAG	Key Points	Action/decision
Going Concern Report		The Committee considered the going concern assumptions for the 2022/23 accounts. The committee confirmed that the accounts should be prepared on an ongoing basis.	Approved.
Draft Annual Accounts 2022/23		The Committee considered the draft annual accounts for 2022/23. The Trust had a Year End surplus of £2,610k. However, the financial performance after various technical adjustments was a deficit of £1506k. It was noted that the accounts will show the surplus of £2610k. It was agreed that a reconciliation will be shown in the Annual Report. The Year End cash balance was £58.2m. It was noted that due to the volume of capital expenditure in March there were circa £23.0m of capital creditors which effectively reduced the cash balance to circa £35.0m. Capital expenditure for the year was £42.6m including donated and grant funded assets. The Committee commended the finance team for submitting the accounts by the due deadline of the 27th of April. The accounts are now with the auditors and will be presented back to the Audit Committee at the next meeting prior to adoption by the Trust Board of Directors.	Noted.
iFM Bolton – IFRS Implementation Paper			Approved.

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

Committee/Group Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
		The committee considered the paper prepared by the Head of Financial Accounts on the adoption of International Financial Reporting Standard (IFRS). Currently the iFM accounts are prepared under Financial Reporting Standard (FRS) 102. This change will bring iFM in line with the Trust accounting standards. The committee approved the change to the IFRS reporting standard.	
Draft Audit Committee Annual Report/ Annual Governance Statement 2022/23		The Director of Corporate Governance advised that due to the impact from current pressures this report has been delayed. With approval from the Committee it will be circulated by the end of May and then considered for approval at the next Audit Committee meeting in June.	Noted.
External Audit VFM Risk Assessment 2022/23		KPMG presented the External Audit Value for Money risk assessment findings from the procedures performed to date. The VFM risk assessment covers 3 domains; namely financial sustainability, governance and improving economy, efficiency and effectiveness. KPMG advised that they had not identified any significant risks for which there are not appropriate arrangements in place for as part of the procedures they have undertaken to date. KPMG advised that their work on financial sustainability is ongoing in relation to the 2023/24 financial plan. The Chief Finance Officer confirmed the financial plan of £12.4m deficit for which detailed information will be provided and asked the Committee to note the huge risk within this figure which is no different to any other organisation within GM. In relation to the risk management framework this is currently being reviewed with internal audit involvement and will feedback in May.	Noted.
Quarter 3 Benchmarking Report		KPMG presented the quarter 3 benchmarking report which compares over 40 Trusts across KPMG's portfolio. The Committee noted the report.	Noted.
Internal Audit Reports		The Internal Auditors PWC presented their internal audit update. Three final reports have been issued:	Noted.

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

Committee/Group Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
		• Assurance Framework and Risk Management (low risk) • Business continuity/Emergency Planning EPRR (low risk) • Charitable funds (low risk) It was noted with regards to Charitable Funds, the improvements that had been made since the previous review. PWC advised that four further reviews are in progress.	
Draft Internal Audit Annual Opinion		PWC presented their report which outlines the internal audit work carried out for the year ending 31 March 2023 and their associated conclusions and opinions for the year. It was noted that the opinion is still in draft and a final opinion will be presented to the June Audit Committee. The current opinion provides reasonable/moderate assurance which is the second highest assurance rating under the PWC methodology. It was noted that the opinion classifications have changed slightly.	Noted.
Counter Fraud Work Plan 2023/24		The Local Counter Fraud Specialist presented the Counter Fraud Work Plan for 2023/24. The committee approved the work plan noting the substantial scope of work which will be carried out across the Trust.	Noted.
Counter Fraud Annual Report 2022/23		The Counter Fraud Annual Report was presented by the LCFS. It was noted that the report has been approved by the Chief Finance Officer. The report sets out details of all the work carried out during 2022/23 and the positive approach taken by the Trust towards anti-fraud measures. The LCFS reported back on the attendance by the National Head of the Counter Fraud Service who had attended a previous Audit meeting.	Noted.
Risks Escalated : There were no risks to be escalated to the Board of Directors			

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

Report Title:	Bolton NHSFT Constitution

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	✓
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Purpose	To present the Constitution for ratification following periodic review.

Summary:	All NHS Foundation Trusts (FTs) are required to have a constitution that is in accordance with Schedule 7 of the 2006 Act. A Trust's initial constitution is scrutinised at the time of authorisation, future changes do not need to be approved by NHS England but should be submitted to NHSE. The Trust's Constitution was last revised in April 2021 to ensure compliance with the NHS Model Core Constitution. The changes set out in Appendix 1, are consequential to amendments by the Health and Care Act 2022 (the HCA) to the National Health Service Act 2006 (the NHSA).

Previously considered by:	This Constitution was presented and approved by both the Board of Directors and the Council of Governors.

Proposed Resolution	The Board of Directors are asked to **approve** the submission of the Trust Constitution to NHS England and publication on Trust website.

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

Appendix 1

Constitution reference	Amendment
3.4	Suggested provision to reflect s63 of the NHSA.
3.5 to 3.7	New provisions to reflect the new s63A NHSA duty to have regard to the wider effect of decisions.
3.8	Suggested provision to reflect s47(1) of the NHSA.
3.9	New provisions to reflect the new s63B NHSA duties in relation to climate change etc.
10.2	Updated to reflect change in name of Department of Health and Social Care
10.4	Suggested provision to reflect s60(1) of the NHSA.
17.1	Substitute NHS England for NHS Improvement.
20.4.1 and 20.4.2	No change but it should be noted that the Code of Governance for NHS - Provider Trusts reduces the period in these provisions to 2 years.
20.4.5	Suggested addition to reference holding of cross directorships to be consistent with the Code of Governance for NHS Provider Trusts
20.4.6	No change but requirements of Code of Governance for NHS Provider Trusts - should be noted where any term beyond 6 years is being considered.
21.2`	Updated to reflect that appointment of the Chair or of a non-executive director shall require the approval a majority governors present and voting on the question at a meeting of the Council of Governors
24.12	Substitute NHS England for clinical commissioning groups
27A	Insert new provision for exercise of powers for joint working and delegation arrangements under new ss65Z5 to 65Z7 of the 2006 Act
27B	Insert new provision for compliance with duties relating to ICS financial controls under new ss223L to 223N of the 2006 Act
31.2.6 37A5	Substitute NHS England for Monitor.
32.4 ; 34 ; 35	Substitute NHS England for NHS Improvement
37.2	Suggested additional wording to simply the sealing of documents.
38	Amendment to indemnity provision

42	Insert new definition of the Health and Care Act 2022 Insert new definition of the Code of Governance for NHS Provider Trusts Insert new definition of NHS ICB Delete definition of Monitor Delete definition of NHS Improvement Insert new definition of NHS England Delete definition of NHS FT Code of Governance
Para 1.4	To consider amendment of the LMC appointed governor. This provision for an LMC to appoint a governor is unusual. The LMC's statutory role is to represent GPs in relation to primary care services. -
	To be amended to substitute NHS England for Monitor. reviewed following update from NHS Providers.
Para 1.2	Updated reference to Code of Governance for NHS Provider Trusts
	Updated references from Monitor to NHS England and to Code of Governance for NHS Provider Trusts
	Annex updated throughout to reflect current NHS legislation
Introduction	Section updated to set out statutory framework for NHS foundation trusts
Interpretation	Definitions set out in the core constitution will apply to the SOs and can therefore be deleted from this section
2.8	Updated to reflect position set out in Code of Governance for NHS Provider Trusts
2.9	New provision for appointment of a deputy chair to reflect separation of SID and deputy chair roles.
2.9AA	Amended to reflect separation of SID and deputy chair roles. This paragraph also provides for the appointment of a deputy SID.
2.10	Updated so that these powers are those of the deputy chair rather than the SID.
5	Amended to be consistent with the requirement of the NHSA that all powers of the Trust are exercised by the Board, a committee of directors or an individual executive director.
5.8	Updated to include Strategy and Operations Committee and Charitable Funds Committee
8.11	Suggested amendment for clarity.
	Substitute NHS England for Monitor

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NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust Constitution

May 2023

... for a better Bolton

Bolton

NHS Foundation Trust

Version Control

April 2023	10	• Update to reflect Health and Care Act 2022 including changes to Code of Governance for NHS Providers
January 2021	9	• Major review
October 2016	8	• Change to areas of the public constituency • Reduction in number of governors from 39 to 35 • Change references to the regulator Monitor to NHS Improvement • Update to model election rules to include electronic voting
November 2015	7	• Membership age reduced to 14
Nov 2013	6	• Addition of version control section • Removal of reference to PCT • Change CRB to DBS • Removal of clauses to establish initial COG and Board • Removal of reference to the Audit commission • Monitor panel • Approval of significant transactions • Change to Constitution approval
Sept 2012	5	• The continuation of the body corporate known as Monitor; • Change from the 'Board of Governors' to the 'Council of Governors'; • Requirement for the principal purpose (i.e. provision of goods and services for the health service in England) to be stated in the constitution; • Introduction of the new legal duty to ensure that income of NHS funded goods and services is greater than income from other sources; • Introduction of additional oversight and scrutiny by the Council of Governors over activities generating non-NHS income; • Replacement of HM Treasury with Secretary of State as regards giving guidance over FT accounts
2011	4	• Name changed to Bolton NHS Foundation Trust • Reduced number of out of area governors from four to three
2010	3	• Change to allow flexibility to the number of Directors • Change to limit the number of elections to one per year • temporary addition of Community staff governor
2009	2	• Addition of a Governor to represent LINk • Change to quorum requirement for AMM
2008	1	• approved on authorisation 1st October 2008

BOLTON NHS FOUNDATION TRUST CONSTITUTION

CONTENTS

DEFINITIONS

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006.

- the **2006 Act** is the National Health Service Act 2006.
- the **2012 Act** is the Health and Social Care Act 2012.
- the **2022 Act** is the Health and Care Act 2022

In this Constitution:

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

Appointed Governor means the Local Authority Governors and the Partnership Governors

Authorisation Date means the date that the Trust's initial authorisation as an NHS Foundation Trust took effect.

Board of Directors means the Board of Directors as constituted in accordance with this Constitution and "Board" shall be construed accordingly.

Chair is the Chair of the Board of Directors appointed in accordance with paragraph 21 of this Constitution, interchangeable with the term Chairman.

Chief Executive means the Chief Executive and Accounting Officer of the Trust appointed in accordance with paragraph 23 of this Constitution.

Code of Governance for NHS Provider Trusts means the Code of Governance for NHS Provider Trusts published by NHS England in October 2022 or such similar or further guidance as NHS England may publish from time to time.

Constituencies means the Public Constituencies and the Staff Constituency.

Constitution means this Constitution of Bolton NHS Foundation Trust and all annexes to it.

Council of Governors means the Council of Governors of the Trust as constituted in accordance with this Constitution.

Financial Year means: (a) the period beginning with the date on which the Trust is authorised as a Foundation Trust and ending with the next 31 March; and (b) each successive period of twelve (12) months beginning with 1 April.

ICB means an integrated care board established under Chapter A3 of Part 2 of the 2006 Act.

the **Independence Criteria** means those criteria set out at paragraph 20.4 below

Local Authority Governor means a governor appointed by one or more local authorities in accordance with the provisions of this Constitution and as specified in Annex 3.

the **MHA** means the Mental Health Act 1983.

Model Rules for Elections means the model form rules for the conduct of elections published from time to time by NHS Providers.

NHS England is the body corporate known as NHS England, established under section 1H of the 2006 Act.

Partnership Governor means a governor appointed by a Partnership Organisation.

Partnership Organisation means those organisations that may appoint Partnership Governors as listed at paragraph 1.4 of **Annex 3**

Public Constituency means all those individuals who live in an area specified as an area for a public constituency in **Annex 1.**

Public Governor means a member of the Council of Governor elected by the members of a Public Constituency.

Secretary or Trust Secretary means the secretary of the Trust or any other person appointed by the Trust pursuant to paragraph 2.1 of Annex 7 to perform the duties of the secretary

Secretary of State means the Secretary of State for Health and Social Care.

Staff Constituency means that part of the Trust's membership consisting of the staff of the Trust and other persons as more particularly provided for in paragraph 7 of this Constitution and which is divided into the Staff Classes as specified in Annex 2;

Staff Governor means a member of the Council of Governor elected by the members of one of the classes of the Staff Constituency.

Statutory Transaction means a merger under section 56 of the 2006 Act, an acquisition under section 56A of the 2006 Act, a separation under section 56B of the 2006 Act, and dissolution under section 57A of the 2006 Act.

Trust means Bolton NHS Foundation Trust.

voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

Save as otherwise permitted by law, the Chair shall be the final authority for all purposes on the interpretation of this constitution (on which they should be advised by the Trust Secretary).

1. Name

The name of the foundation Trust is Bolton NHS Foundation Trust (the Trust).

2. Principal purpose

2.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3. The Trust may provide goods and services for any purposes related to –

2.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

2.3.2. the promotion and protection of public health.

2.4. The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3. Powers

3.1. The powers of the Trust are set out in the 2006 Act.

3.2. The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.3. Any of these powers may be delegated to a committee of directors or to an executive director.

3.4. The Trust shall exercise its functions effectively, efficiently and economically.

3.5. Subject to paragraph 3.6 below and having regard to any guidance published by NHS England, in making a decision about the exercise of its functions, the Trust shall have regard to all likely effects of the decision in relation to:

3.5.1. the health and wellbeing of the people of England;

3.5.2. the quality of services provided to individuals by relevant bodies, or in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; and

3.5.3. efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

3.6. The requirement to have regard to the wider effect of its decisions set out at paragraph 3.4 shall not apply to decisions about services to be provided to a particular individual for or in connection with the prevention, diagnosis or treatment of illness.

3.7. In paragraph 3.4 'relevant bodies' has the meaning set out in paragraph 63A(4) of the 2006 Act.

3.8. The Trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions, within the terms of its Authorisation and Provider Licence.

3.9. In exercising its functions, the Trust shall have regard to the need to contribute towards compliance with the UK net zero emissions target set out at section 1 of the Climate Change Act 2008 and the environmental targets set out at section 5 of the Environment Act 2021, and to adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008. In doing so, the Trust shall also have regard to guidance published by NHS England.

4. Membership and constituencies

4.1. The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1.1. the Public Constituencies

4.1.2. the Staff Constituency

4.2. The members of the Trust are those individuals whose names are entered in the register of members.

4.3. Members may attend and participate at members meetings, vote in elections for, and stand for election to the Council of Governors, and take such other part in the affairs of the Trust as is provided in this constitution.

4.4. The Trust shall hold members meetings in accordance with the provisions of Annex 8

5. Application for membership

5.1. An individual who is eligible to become a member of the Trust may do so on application to the Trust.

5.2. Subject to this constitution, membership is open to any individual who is entitled under this constitution to be a member of one of the Public Constituencies or one of the classes of the Staff Constituency, and who (unless they are a member

of one of the classes of the Staff Constituency) completes a membership application form in whatever form the Secretary specifies.

6. Public Constituencies

6.1. An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

6.2. Those individuals who live in an area specified as an area for any public constituency are referred to collectively as a Public Constituency.

6.3. The minimum number of members in each Public Constituency is specified in Annex 1.

7. Staff Constituency

7.1. Subject to paragraph 7.3 below an individual who is employed by the Trust under a contract of employment (which for the avoidance of doubt includes full and part time contracts of employment) with the Trust may become or continue as a member of the Trust provided:

7.1.1. they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2. they have been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2. Subject to paragraph 7.3 below individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

7.3. For the avoidance of doubt, the eligibility to be a member of the Staff Constituency described at paragraph 7.2 above does not include those who assist or provide services to the Trust on a voluntary basis.

7.4. Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.5. The Staff Constituency shall be divided into four (4) descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.6. The Trust Secretary shall make a final decision about the class of which an individual is eligible to be a member.

7.7. The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.8. An individual who is:

7.8.1. eligible to become a member of the Staff Constituency, and

7.8.2. invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

8. Restriction on membership

8.1. An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class of the Trust.

8.2. An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3. A member of any constituency must be fourteen (14) years of age or over

8.4. An individual who:

8.4.1. has threatened, harassed, harmed or abused staff, patients and/or visitors of the Trust or the Predecessor Trust; or

8.4.2. has been a vexatious complainant. For the purposes of this paragraph a vexatious complainant is an individual who is found by the Trust (applying the relevant Trust policy) to have abused or used inappropriately the Trust's or the Predecessor Trust's complaints procedure

shall be refused membership of the Trust or where an existing member shall have their membership of the Trust withdrawn.

8.5. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8.

8A Annual Members' Meeting

8A.1 The Trust shall hold an annual members' meeting. The annual members' meeting shall be open to the public.

8A.2 Further provisions for the annual members' meeting are set out in Annex 8.

9. Council of Governors – composition

9.1. The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

9.2. The composition of the Council of Governors is specified in Annex 3.

9.3. The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

10. Council of Governors – election of governors

Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time on the basis of [single transferable vote (STV)] polling and the Model Rules for Elections shall be construed accordingly

10.1. The Model Rules for Elections, as published from time to time by NHS Providers, form part of this constitution. The Model Rules for Elections current at the date of their adoption under this constitution are attached at Annex 4.

10.2. A subsequent variation of the Model Rules for Elections by the Department of Health and Social Care or NHS Providers or a successor body shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules for Elections.

10.3. An election, if contested, shall be by secret ballot.

10.4. A member of the Public Constituency may not vote at an election for a Public Governor unless within twenty-one (21) days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the Public Constituency. It is an offence to knowingly or recklessly make a declaration which is false in a material particular.

11. Council of Governors - tenure

11.1. An elected governor may hold office for a period of up to 3 years following each election that resulted in their election as a governor.

11.2. An elected governor shall cease to hold office if they cease to be a member of the constituency or class or area of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution. For the avoidance of doubt, this includes a Public Governor moving their principal residence from one Public Constituency to another.

11.3. An elected governor shall be eligible for re-election at the end of their term.

11.4. An elected governor may not, if re-elected for more than a single term of office hold office for more than nine (9) consecutive years in total.

11.5. The Trust shall conduct annual elections for elected governors during each year (being a period of 12 months commencing on an anniversary of the Authorisation Date) in respect of each governor whose term of office shall expire at the end of that year, with any governors elected pursuant to such an annual election taking office on the next anniversary of the Authorisation Date following such election.

11.6. An Appointed Governor shall hold office for a period up to three years.

11.7. An Appointed Governor shall be eligible for re-appointment after the end of that period; subject to paragraph 11.8 below;

11.8. An Appointed Governor may not hold office for longer than nine consecutive years.

11.9. An Appointed Governor shall cease to hold office if the appointing organisation terminates their appointment or if they are disqualified for any of the reasons set out in this Constitution.

11.10. For the purposes of this paragraph 11 years of office are consecutive unless there is a break of at least 12 months between them.

12. Council of Governors – disqualification and removal

12.1. The following may not become or continue as a member of the Council of Governors:

12.1.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

12.1.2. A person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

12.1.3. a person who has made a composition or arrangement with, or granted a Trust deed for, their creditors and has not been discharged in respect of it;

12.1.4. a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

12.2. Governors must be at least 16 years of age at the date they are nominated for election or appointment.

12.3. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

12A Council of Governors – duties of Governors

12A.1 The general duties of the Council of Governors are:

12A.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

12A.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

12A.2 The Trust must take steps to secure that the Council of Governors are equipped with the skills and knowledge they require in their capacity as such.

12A.3Further provision as to the roles and responsibilities of the Council of Governors is set out in Annex 5.

13. Council of Governors – meetings of governors

13.1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 20.1 or paragraph 21.1 below) or, in their absence the Deputy Chair (appointed in accordance with the provisions of paragraph 22 below), shall preside at meetings of the Council of Governors.

13.2. Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting for special reasons.

13.3. the Council of Governors may require one or more of the directors to attend a meeting for the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance),

13.4. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

14. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 6.

15. Council of Governors - conflicts of interest of governors

15.1. If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

15.2. Further provisions on disclosure of interests are listed in Annex 6.

16. Council of Governors – travel expenses

The Trust may pay travelling and other expenses to members of the Council of Governors as determined by the Trust.

17. Council of Governors – referral to the Panel

17.1. In this paragraph, the Panel means a panel of persons appointed by NHS England to which a governor of an NHS foundation Trust may refer a question as to whether the Trust has failed or is failing —

17.1.1. to act in accordance with its constitution, or

17.1.2. to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

17.2. A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

18. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5.

19. Board of Directors – composition

19.1. The Trust is to have a Board of Directors to manage the business of the Trust and to exercise all powers of the Trust (subject to any contrary provisions in the 2006 Act and/or this constitution) which shall comprise both executive and non-executive directors.

19.2. The Board of Directors is to comprise:

19.2.1. a non-executive Chair

19.2.2. a minimum of five (5) non-executive directors; and

19.2.3. a minimum of five (5) executive directors.

19.2.4. The number of executive directors will not exceed the number of non-executive directors excluding the Chair.

19.3. One of the executive directors shall be the Chief Executive.

19.4. The Chief Executive shall be the Accounting Officer.

19.5. One of the executive directors shall be the finance director.

19.6. One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

19.7. One of the executive directors is to be a registered nurse or a registered midwife.

19A Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

20. Board of Directors – qualification for appointment as Chair or another non-executive director

20.1. A person may be appointed as the Chair or another non-executive director only if – they are a member of the Public Constituency, and they are not disqualified by virtue of paragraph 24 below.

20.2. The Chair must on appointment for each and every term of office meet the Independence Criteria and may not have previously served as the chief executive of the Trust.

20.3. Every other non-executive director must on appointment and throughout their term of office meet the Independence Criteria.

20.4. The Independence Criteria are that the Chair on appointment for each and every term of office and every other non-executive director on appointment and throughout their term of office should;

20.4.1. not have been an employee of the Trust within the last five (5) years;

20.4.2. not have, or have had within the last three (3) years a material interest in any matter within the meaning of paragraph 5.3 of Annex 7;

20.4.3. not receive or have received additional remuneration from the Trust (apart from a director's fee), participate in the Trust's performance-related pay scheme (if any) or be or have been a member of the Trust's pension scheme;

20.4.4. not have any close family tie with any director, senior employee or professional advisor to the Trust;

20.4.5. not hold cross-directorships or have any significant business link with any other director of the Trust including through any involvement in any company or body; or

20.4.6. not have served on the Trust Board of Directors for more than nine (9) years from the date of their first appointment.

21. Board of Directors – appointment and removal of the Chair and/or other non-executive directors

21.1. The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and/or the other non-executive directors.

21.2. Appointment of the Chair or of a non-executive director shall require the approval of a majority of the members of the Council of Governors.

21.3. Removal of the Chair or any other non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

21.4. The procedures for the appointment and removal of the Chair and other Non-Executive Directors are set out in Annex 7.

22. Board of Directors – appointment of deputy Chair

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a Deputy Chair. If the Chair is unable to discharge their office as Chair of the Trust, the Deputy Chair shall be acting Chair of the Trust.

23. Board of Directors - appointment and removal of the Chief Executive and other executive directors

23.1. The Chair and the other non-executive directors shall appoint or remove the Chief Executive.

23.2. The appointment of the Chief Executive shall require the approval of the Council of Governors.

23.3. A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. The Chair shall act as Chair of such committee.

24. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

24.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

24.1A A person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

24.2. a person who has made a composition or arrangement with, or granted a Trust deed for, their creditors and has not been discharged in respect of it;

24.3. a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

24.4. a person who is a member of the Council of Governors or a governor of another NHS foundation Trust;

24.5. a person who is the spouse, partner, parent or child of a member of the Board of Directors (including the Chair) of the Trust;

24.6. a person who is a member of a committee which has, any role on behalf of a local authority to scrutinise and review health matters including a local authority's Overview and Scrutiny Committee covering health matters;

24.7. a person who is the subject of an unexpired disqualification order made under the Company Directors Disqualification Act 1986;

24.8. a person whose tenure of office as a Chair or as an officer or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for nondisclosure of a pecuniary interest;

24.9. a person who has within the preceding five (5) years been lawfully dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

24.10. in the case of a non-executive director, a person who has:

24.10.1. refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

24.10.2. refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

24.11. on the basis of disclosures obtained through an application to the Disclosure and Barring Service (DBS), they are not considered suitable by the Trust Secretary in consultation with the Trust's director responsible for Human Resources on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

24.12. they are a person who has had their name removed or been suspended from any list (including any performers list maintained by NHS England) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification reinstated.

24.13. they have within the preceding five (5) years been:

24.13.1. made subject to a Hospital Order under section 37 of the MHA whether or not subject to restrictions under section 41:

24.13.2. made subject to an interim Hospital Order under section 38 of the MHA;

24.13.3. made subject to a transfer direction under section 48 of the MHA whether or not subject to restrictions under section 49; and/or

24.13.4. made subject to an order under the Criminal Procedure (Insanity) Act 1964 as amended

24.14. they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation.

24A Board of Directors – meetings

24A.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

24A.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

25. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 7.

26. Board of Directors - conflicts of interest of directors

26.1. The duties that a director of the Trust has by virtue of being a director include in particular:

26.1.1. a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

26.1.2. a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

26.2. The duty referred to in paragraph 26.1.1 is not infringed if:

26.2.1. the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

26.2.2. the matter has been authorised in accordance with the Constitution.

26.3. The duty referred to in paragraph 26.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

26.4. In paragraph 26.1.2, “third party” means a person other than:

26.4.1. the Trust; or

26.4.2. a person acting on its behalf.

26.5. If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

26.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

26.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

26.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

26.9. A director need not declare an interest:

26.9.1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

26.9.2. if, or to the extent that, the directors are already aware of it;

26.9.3. if, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered:

26.9.3.1. by a meeting of the Board of Directors; or

26.9.3.2. by a committee of the directors appointed for the purpose under the Constitution.

26.10. Further provisions as to conflicts of interests are in Annex 7.

27. Board of Directors – remuneration and terms of office

27.1. The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

27.2. The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

27.3. The Trust may reimburse executive directors' travelling and other costs and expenses incurred in carrying out their duties as the remuneration committee of non-executive directors decides. These are to be disclosed in the annual report.

27.4. The remuneration and allowances for directors are to be disclosed in bands in the annual report.

27A Joint working and delegation arrangements

27A.1 Subject to paragraph 27A.2 the Trust may arrange in accordance with s65Z5 of the 2006 Act for the joint exercise of functions with any one or more of the following bodies:

27A.1.1 a relevant body;
27A.1.2 a local authority;
27A.1.3 a combined authority.

12A.2 Where the Trust has entered into arrangements for the joint exercise of functions with one or more bodies in accordance with paragraph 27A.1, it may make arrangements for:

27A.2.1 the function to be exercised by a joint committee of theirs
27A.2.1 for one or more of them, or a joint committee of them, to establish and maintain a pooled fund.

27A.3 The Trust must have regard to any guidance published by NHS England under s65Z7.

27A.4 In this paragraph 27A the following terms have the following meanings:

27A.4.1 'Relevant body' has the meaning set out in section 65Z5(2) of the 2006 Act
27A.4.2 'Local authority' means a local authority within the meaning of section 2B of the 2006 Act
27A.4.3 'Combined authority' has the meaning set out in s275 of the 2006 Act

27A.4.4 'Pooled fund' has the meaning set out in s65Z6(3) of the 2006.

27B Duties relating to Integrated care system financial controls

272B.1 The Trust must seek to achieve financial objectives that apply to it under section 223L of the 2006 Act.

27B.2 The Trust must exercise its functions with a view to ensuring that it complies with its duties:

27B.2.1 under s223LA of the 2006 Act to limit expenditure

27B.2. under s223M and s223N of the 2006 Act to limit local capital resource use and local revenue resource use.

28. Registers

The Trust shall have:

28.1. a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes or areas within it, the class or area to which they belong;

28.2. a register of members of the Council of Governors;

28.3. a register of interests of governors;

28.4. a register of directors; and

28.5. a register of interests of the directors.

29. Admission to and removal from the registers

29.1. The Secretary shall add to the register of members the name of any individual who is accepted as a member of the Trust under the provisions of this constitution.

29.2. The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

30. Registers – inspection and copies

30.1. The Trust shall make the registers specified in paragraph 28 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

30.2. The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

30.3. So far as the registers are required to be made available:

30.3.1. they are to be available for inspection free of charge at all reasonable times; and

30.3.2. a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

30.4. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

31. Documents available for public inspection

31.1. The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

31.1.1. a copy of the current constitution;

31.1.2. a copy of the latest annual accounts and of any report of the auditor on them;

31.1.3. a copy of the latest annual report; and

31.1.4. a copy of the latest information as to its forward planning.

31.2. The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

31.2.1. A copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act;

31.2.2. A copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;

31.2.3. A copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

31.2.4. A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

31.2.5. A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

31.2.6. A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J

(power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

31.2.7. A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

31.2.8. A copy of any final report published under section 65I (administrator's final report);

31.2.9. A copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

31.2.10. A copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

31.3. Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

31.4. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

32. Auditor

32.1. The Trust shall have an auditor and is to provide the auditor with every facility and all information, which they may reasonably require for the purposes of their functions under Schedule 10 of the 2006 Act.

32.2. A person may only be appointed as the auditor if they (or in the case of a firm, each of its members) is a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

32.3. The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

32.4. The auditor shall be required to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS England on standards, procedures and techniques to be adopted.

33. Audit committee

The Trust shall establish a committee of non-executive directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

34. Accounts

34.1. The Trust must keep proper accounts and proper records in relation to the accounts.

34.2. NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

34.3. The accounts are to be audited by the Trust's auditor.

34.4. The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

34.5. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

34.6. In preparing its annual accounts, the Accounting Officer shall require the Trust to comply with any directions given by NHS England with the approval of the Secretary of State as to:

34.6.1. the methods and principles according to which the accounts are to be prepared; and

34.6.2. the information to be given in the accounts.

34.7. The annual accounts, any report of the auditor on them, and the annual report are to be presented to the Council of Governors at a meeting of the Council of Governors.

34.8. The Trust shall lay a copy of the annual accounts, and any report of the auditor on them, before Parliament and once it has done so, send copies of those documents to England.

35. Annual report and forward plans

35.1. The Trust shall prepare an Annual Report and send it to NHS England.

35.2. Each Annual Report is to contain:

35.2.1. information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituencies and of the classes of the Staff Constituency are representative of those eligible for such membership; and

any other information NHS England requires.

35.3. The Trust is to comply with any decision NHS England makes as to:

35.3.1. the form of Annual Reports;

35.3.2. when the reports are to be sent to it;

35.3.3. the periods to which the Annual Reports are to relate.

35.4. The Trust shall give information as to its forward planning in respect of each financial year to NHS England.

35.5. The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

35.6. In preparing the document, the directors shall have regard to the views of the Council of Governors.

35.7. Each forward plan must include information about –

35.7.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

35.7.2. the income it expects to receive from doing so.

35.8. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 35.7.1 the Council of Governors must –

35.8.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

35.8.2. notify the directors of the Trust of its determination.

35.9. A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

36. Meeting of Council of Governors to consider annual accounts and reports

36.1. The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

36.1.1. the annual accounts

36.1.2. any report of the auditor on them

36.1.3. the annual report.

36.2. The documents shall also be presented to the members of the Trust at the annual members' meeting by at least one member of the Board of Directors in attendance.

36.3. The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 36.1 with the annual members' meeting.

37. Instruments

37.1. The Trust shall have a seal.

37.2. The seal shall not be affixed except under the authority of the Board of Directors. Attestation by any two Directors shall be deemed to constitute affixing the seal under the authority of the Board of Directors.

37.3. A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

37A Amendments to the Constitution

37A.1 The Trust may make amendments of this Constitution only if:

37A.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments; and

37A.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

37A.2 Amendments made under paragraph 37A.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as this Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

37A.3 Where an amendment is made to this Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

37A.3.1 at least one member of the Council of Governors must attend the next annual members' meeting and present the amendment; and

37A.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

37A.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

37A.5 Amendments by the Trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not this Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

38. Indemnity

The Trust shall provide an indemnity to any member of the Council of Governors, the Board of Directors or the Secretary that if any such person acts honestly and in good faith such person will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Council of Governors and the Board of Directors and the Secretary.

39. Not used

40. Mergers etc. and significant transactions

40.1. The Trust may only apply for a Statutory Transaction with the approval of more than half of the members of the Council of Governors.

40.2. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

40.3. For the purposes of paragraph 40.2, "Significant transaction" means amounts equal to or greater than 25% of:-

40.3.1. in relation to assets, the gross assets (being the sum of fixed assets and current assets) subject to the transaction whether contingent or not, divided by the gross assets of the foundation Trust

40.3.2. in relation to income, the income attributable to the assets or the contract associated with the transaction whether contingent or not, divided by the income of the foundation Trust

40.3.3. in relation to acquisitions or divestments whether contingent or not, the gross capital (being the market value of the target's shares and debt securities plus the excess of current liabilities over current assets) of the company being acquired or divested, divided by the total capital (being the total taxpayers' equity) of the Trust following completion, or the effects on the total capital of the Trust resulting from a transaction.

40.4. In assessing the value of any contingent liability for the purposes of paragraph 40.3, the directors:

40.4.1. Must have regard to all circumstances that Directors know, or ought to know, affect or may affect, the value of the contingent liability; and

40.4.2. May rely on estimates of the contingent liability that are reasonable in the circumstances; and

40.4.3. May take account of the likelihood of the contingency occurring.

40.5. A Statutory Transaction under paragraph 40.1 is not a significant transaction for the purposes of paragraph 40.2.

41. Validity of actions

No defect or deficiency in the appointment or composition of the members or the Council of Governors or the Board of Directors shall affect the validity of any decision or action taken by them.

ANNEX 1 - THE PUBLIC CONSTITUENCIES

(Paragraphs 6.1 and 6.3)

Areas comprising a Public Constituency	Electoral Wards	Minimum number of Members	Number of Governors to be elected
Bolton North East	Astley Bridge Bradshaw Breightmet Bromley Cross Crompton Halliwell Tonge with the Haulgh	250	6
Bolton South East	Farnworth Great Lever Harper Green Hulton Kearsley Little Lever & Darcy Lever Rumworth	250	6
Bolton West	Atherton Heaton & Lostock Horwich & Blackrod Horwich North East Smithills Westhoughton North & Chew Moor Westhoughton South	250	6
Out of Area	All electoral divisions in England not falling within an area detailed above in this table as being a Public Constituency	100	2

ANNEX 2 - THE STAFF CONSTITUENCY

Staff Class	Minimum number of Members	Number of Governors to be elected
Nurses and midwives who are registered with their regulatory body to practise	20% of the total number of employees who are eligible for membership of the class	2
Doctors and dentists who are registered with their regulatory body to practise	20% of the total number of employees who are eligible for membership of the class	1
Allied health professionals and scientists who are registered with their regulatory body to practise in a clinical capacity	20% of the total number of employees who are eligible for membership of the class	1
All other staff	20% of the total number of employees who are eligible for membership of the class	2

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1 The Council of Governors shall comprise thirty four (34) governors composed as set out below and as illustrated in the following table:

1.1 Twenty (20) Public Governors which must be more than half the total membership of the Council of Governors elected by members of the Trust from the Public Constituencies as set out in Annex 1.

1.2 Six (6) Staff Governors elected by the Staff Classes set out in Annex 2.

1.3 Two (2) Local Authority Governors appointed by Bolton Metropolitan Borough Council or any successor local authority for an area which includes the whole or part of an area forming part of the Public Constituencies set out at Annex 1.

1.4 Six (6) Partnership Governors:

(a) Two (2) Governors appointed by educational institutions from the further and/or higher education sector which shall be: one (1) governor appointed by the University of Bolton and one (1) by Salford University.

(b) Two (2) Partnership Governors appointed by voluntary organisations which shall be appointed by the Council for Voluntary Services (CVS).or a successor organisation

(c) One (1) Partnership Governor appointed by the Bolton LMC (Local Medical Committee), who must be a practising GP.

(d) One (1) Partnership Governor appointed by Bolton Healthwatch or a successor organisation

1.5 Members of the Public Constituencies may elect any of their number to be a Public Governor and members of the Staff Classes may elect any of their number to be a Staff Governor.

Composition of the Council of Governors:

Public Constituency	**Number of seats**
Bolton West	**6**
Bolton North East	**6**
Bolton South East	**6**
Out of Area	**2**
Sub Total	**20**

Staff Constituency	**Number of seats**
Nurses and midwives who are registered with their regulatory body to practise	**2**
Doctors and dentists who are registered with their regulatory body to practise	**1**
Allied health professionals and scientists who are registered with their regulatory body to practise in a clinical capacity	**1**
All other staff	**2**
Sub Total	**6**

Appointed Governors Constituency	**Number of seats**
Bolton Metropolitan Borough Council	**2**
University of Bolton	**1**
Salford University	**1**
Council for Voluntary Services	**2**
Bolton Local Medical Committee	**1**
Bolton Healthwatch	**1**
Sub Total	**8**
TOTAL	**34**

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1 Roles and responsibilities of the Council of Governors

1.1 The statutory duties of the Council of Governors are provided in paragraph 12A of the constitution.

1.2 Each governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the Code of Governance for NHS Provider Trusts and the Code of Conduct for Governors.

1.3 All governors shall comply with the Code of Conduct for Governors, as agreed by the Board of Directors and the Council of Governors.

2 Appointed Governors

Local Authority Governors

2.1 The Trust Secretary, having consulted with Bolton Metropolitan Borough Council or any successor local authority for an area which includes the whole or part of an area forming part of the Public Constituency, is to adopt a process for agreeing the appointment of Local Authority Governors with that local authority.

Partnership Governors

2.2 The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Trust Secretary

General Provisions

2.3 Appointed Governors:

2.3.1 shall normally hold office for a period of three (3) years commencing on the date such election is to have effect;

2.3.2 are eligible for re-appointment subject to paragraph 2.3.3;

2.3.3 may not where reappointed hold office for longer than nine (9) consecutive years

3 Eligibility to be a Governor

3.1 A person may not become a governor of the Trust, and if already holding such office will immediately cease to do so, if:

3.1.1 they are a director of the Trust, or a governor of another foundation Trust or a director (or equivalent) of a health service organisation

(unless they are an appointed governor appointed by the health service organisation for which they are a governor or director);

3.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors (including the Chair) of the Trust;

3.1.3 they are a member of a committee which has, any role on behalf of a local authority to scrutinise and review health matters including a local authority's Overview and Scrutiny Committee covering health matters;

3.1.4 being a member of the Staff Constituency they have a current and unexpired written warning which has been imposed following disciplinary action by the Trust arising out of their employment with the Trust. if a Staff Governor is suspended from duties for any reason they will also be suspended from their role as a Staff Governor for the duration of their suspension. Whilst a Staff Governor is under suspension, the Staff Governor cannot attend meetings of the Council of Governors as a member of the Council of Governors, but missing any meetings of the Council of Governors will not count as failure to attend for the purposes of paragraph 4.1.2 of this Annex 5. Spent disciplinary warnings will not preclude eligibility to be a Governor;

3.1.5 they refuse to sign a declaration in the form specified by the Secretary that they are a member of a Public Constituency or the Staff Constituency as the case may be and that they are not prevented from being a member of the Council of Governors;

3.1.6 they are a vexatious complainant within the meaning of paragraph 8.4.2;

3.1.7 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, they are not considered suitable by the Trust Secretary and the Trust's director responsible for Human Resources;

3.1.8 they have within the preceding five (5) years been lawfully dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service organisation;

3.1.9 they are a person whose tenure of office as the Chair or as a member or director of a health service organisation has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

3.1.10 they are a person who has had their name removed or been suspended from any list (including any performers list maintained by a primary care Trust) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been

suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification reinstated;

3.1.11 they have within the preceding five (5) years been:

(i) made subject to a Hospital Order under section 37 of the MHA whether or not subject to restrictions under section 41;

(ii) made subject to an Interim Hospital Order under section 38 of the MHA;

(iii) made subject to a transfer direction under section 48 of the MHA whether or not subject to restrictions under section 49; and/or

(iv) made subject to an order under the Criminal Procedure (Insanity) Act 1964 as amended.

3.1.12 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation;

3.1.13 any of the grounds contained in paragraph 12 of the Constitution apply to that person;

3.1.14 in the case of an elected Public Governor, they cease to be a member of the Constituency by whom they were elected;

3.1.15 they have previously been removed as a governor of the Trust or removed as a governor or expelled from membership of another foundation Trust;

3.1.16 in the case of an Appointed Governor, the appointing organisation terminates the appointment, or they leave, retire or are suspended from their employment. If an Appointed Governor is suspended from their duties for any reason by the appointing organisation they will also be suspended from their role as Governor for the duration of their suspension. Whilst an Appointed Governor is under suspension, the Appointed Governor cannot attend meetings of the Council of Governors as a member of the Council of Governors, but missing any meetings of the Council of Governors will not count as failure to attend for the purposes of paragraph 4.1.2 of this Annex 5;

3.1.17 they are a person who is not a fit and proper person as defined by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or condition G4 of the Trust's provider licence;

3.1.18 they are subject to a direction made under the Education Act 2011 or the Safeguarding Vulnerable Groups Act 2006;

3.1.19 they have failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act;

3.1.20 their term of office was terminated pursuant to paragraph 4.2 of this Annex 5;

3.2 Where a person has been elected or appointed to be a Governor and that person becomes disqualified from that appointment that individual shall notify the Trust in writing of such disqualification as soon as practicable and in any event within fourteen days of first becoming aware of those matters which rendered the individual disqualified.

3.3 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare Governor disqualified and shall give the Governor notice in writing to that effect as soon as practicable.

3.4 Upon the giving of notice under paragraphs 3.2 and 3.3 of this Annex, that person's tenure of office as a Governor shall thereupon be terminated and the individual shall cease to be a Governor and the individual's name shall be removed from the Register of Governors.

4 Termination of office and removal of Governors

4.1 A person holding office as a governor shall immediately cease to do so if:

4.1.1 they resign by notice in writing to the Secretary;

4.1.2 they fail to attend three (3) consecutive meetings, unless the Council of Governors is satisfied that:

4.1.2.1 the absences were due to reasonable causes; and

4.1.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the Council of Governors considers reasonable.

4.1.3 in the case of an elected governor, they cease to be a member of the constituency or class by which they were elected;

4.1.4 in the case of an appointed governor, the appointing organisation terminates the appointment, the appointing organisation ceases to exist or they withdraw themselves as the Appointed Governor representative;

4.1.5 they have refused without reasonable cause to undertake any training which the Council of Governors requires all governors to undertake;

4.1.6 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for governors;

4.1.7 they cease to fulfil the requirements of paragraph 3.1 above;

4.2 A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting at a meeting of the Council of Governors on the grounds that:

4.2.1 They have committed a material breach of the Code of Conduct for Governors; and/or

4.2.2 They have acted in a manner detrimental to the interests of the Trust; and/or

4.2.3 The Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor. Circumstances where it may not be appropriate for an individual to continue as a Governor include the circumstances set out in paragraph 4.3;

4.3 The Council of Governors may remove a Governor in accordance with paragraph 4.2.3 where the Council of Governors finds that their continuing as a Governor would or would be likely to:

4.3.1 Prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

4.3.2 Prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

4.3.3 Adversely affect public confidence in the goods and services provided by the Trust; or

4.3.4 Otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

4.3.5 Not in the best interests of the Trust for that person to continue in office as a Governor; or

4.3.6 Fail to comply in a material way with the values and principles of the NHS or the Trust.

4.4 Upon a Governor resigning under paragraph 4.1.1 of this Annex or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions that Governor shall cease to be a Governor and their name shall be removed from the register of Governors.

4.5 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until the later of:

4.5.1 Seven days after the date of decision; or

4.5.2 Where the Governor applies for the decision to be referred to an independent assessor, the date on which the independent assessor determines the matter.

4.6 The Governor in question will be permitted to appeal any decision of the Council of Governors to terminate that Governor's tenure of office made in accordance with paragraph 4.2 in writing, within 28 days of the date upon which notice of the decision is received, for that decision to be referred to an independent assessor.

4.7 On receipt of an application under paragraph 4.6 above the Council of Governors and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on the identity of the independent assessor within twenty-one days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Chartered Institute of Arbitrators to nominate an independent assessor.

4.8 The independent assessor will consider the evidence and conclude whether the decision to remove the Governor was reasonable or otherwise.

4.9 The independent assessor's decision will be binding on the parties. If the independent assessor finds that the decision of the Council of Governors to remove the Governor was not reasonable, the decision of the Council of Governors will be rescinded.

4.10 The Trust shall bear the independent assessor's costs unless the independent assessor determines that such costs shall be shared between the Trust and the Governor.

4.11 A Governor:

4.11.1 Who resigns or whose tenure of office is terminated under paragraph 4.1 of this Annex shall not be eligible to stand for re-election for a period of six years from the date of their resignation or removal from office; or

4.11.2 Whose tenure is terminated under paragraph 4.2 of this Annex shall not be eligible to stand for re-election for a period of nine years from the date of their removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later.

4.11.3 Not less than twenty percent of the Governors may, where the process leading to the possible removal of a Governor has been initiated, require the appointment of an independent assessor to

consider the evidence and advise as to the appropriateness of removal. It will also be available to the Chair to initiate any such independent assessment at any time.

4.12 A Governor may resign from office at any time during the term of office by giving notice in writing to the Trust Secretary save that if in the opinion of the Trust Secretary the Governor's conduct and tenure are or may become subject to review or investigation which may lead to his or her removal under paragraph 4.2, then any such notice of resignation will not be effective without the agreement of the Chair or (if the Chair is conflicted) the Deputy Chair.

4.13 The Chair or (if the Chair is conflicted) the Deputy Chair may suspend a Governor whose conduct and tenure are subject to review or investigation if in the opinion of the Chair or the Deputy Chair such review or investigation may lead to the Governor's removal under paragraph 4.2.

5 Vacancies amongst Governors

5.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply:

5.1.1 where the vacancy arises amongst the appointed governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

5.1.2 where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:

5.1.2.1 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and be subject to election for any unexpired period of the term of office of the governor who is being replaced.

5.1.2.3 If there is no other candidate available the governors may choose to leave the seat vacant until the next elections are held unless to do so would mean that there is no longer a majority of public governors on the Council of Governors.

5.2 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

6 Expenses and Remuneration of Governors

6.1 The Trust may reimburse governors for travelling and other costs and expenses incurred in carrying out their duties as the Board of Directors decides.

6.2 The Trust may at their discretion decide to reimburse the cost and expense of a governor's carer arrangements necessarily and reasonably incurred in such governor carrying out their duties as the Board of Directors decide.

6.3 In respect of a Staff Governor who is an employee of the Trust, the Board of Directors shall seek to facilitate such employee's reasonable participation as a Staff Governor during normal working hours to the extent reasonably necessary for the performance of their duties as a Staff Governor (including reasonable time off from their contracted duties) and shall not make any corresponding deduction from salary.

6.4 Governors are not to receive remuneration from the Trust otherwise than as set out in paragraphs 6.1 and/or 6.2 and/or 6.3 above of this Annex 5.

7 Governors Code of Conduct

The Trust may from time to time publish a governors' code of conduct and each governor shall be required to follow and observe such code of conduct's provisions.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1 Meetings of the Council of Governors

Calling meetings

1.1 The Council of Governors is to meet a minimum of four (4) times in each Financial Year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen (14) days' written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will also be published on the Trust's website.

1.2 Meetings of the Council of Governors may be called by the Secretary, or by the Chair.

1.3 Meetings of the Council of Governors may be called by ten (10) governors (including at least two (2) elected governors and two (2) appointed governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all governors as soon as possible after receipt of such a request.

1.4 The Secretary shall call a meeting on at least fourteen (14) but not more than twenty eight (28) days' notice.

1.5 If the Secretary fails to call such a meeting following notice pursuant to paragraph 1.3 of Annex 6 above then the Chair or ten (10) governors, whichever is the case, shall call such a meeting.

Quorum

1.6 Subject to paragraph 1.7 of Annex 6 below, fifteen (15) governors including no fewer than ten (10) Public Governors, no fewer than two (2) Staff Governors and no fewer than one (1) appointed governor shall form a quorum for the Council of Governors.

1.7 The Council of Governors shall not be quorate unless a majority of governors present are Public Governors.

1.8 The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the auditor or other advisors to attend a meeting of the Council of Governors.

1.9 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

1.9A A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the Meeting. The meeting must then proceed to the next business.

Voting

1.10 Except as provided for in this constitution or the 2006 Act and the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes of the Governors present and voting on the question.

1.10A At the meeting of the Council of Governors a vote shall be decided on a show of hands, the result being declared by the Chair and recorded in the minutes. The entry in the minutes shall confirm the result without recording the number in favour or against the motion unless a request is made under Standing Order 2.17.

1.10B A paper ballot may be used if a majority of the Governors present so request. If a paper ballot is used, it shall be taken at such time and place and in such a manner as the Chair of the meeting shall direct and the result of the ballot shall be deemed to be the resolution of the meeting at which the ballot was demanded. The demand for a ballot shall not prevent the continuance of a meeting for the transaction of any business other than the question on which a ballot has been demanded.

1.10C If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

1.10D No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

1.11 Not used

Committees

1.12 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. The Council of Governors may appoint governors and may invite directors and other persons to serve on such committees. The Council of Governors may, through the Secretary

request that external advisors assist them or any committee they appoint in carrying out its duties.

1.13 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the governors attending the meeting.

2 Disclosure of interests

2.1 Any governor who has a material interest in a matter as defined below shall declare such interest to the Council of Governors and shall withdraw from the meeting and play no part in the relevant discussion or decision and shall not vote on the issue (and if inadvertently they do remain and vote, their vote shall not be counted).

2.2 Any governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a not less than two thirds of the remaining governors.

Subject to the exceptions below, a material interest in a matter is where a governor:

2.2.1 holds any directorship of a company;

2.2.2 holds any interest or position in any firm or company or business;

2.2.3 has any interest in an organisation providing health and social care services to the National Health Service; or

2.2.4 holds any position of authority in a charity or voluntary organisation in the field of health and social care;

2.2.5 receives research funding/grants either as an individual or to their department;

2.2.6 holds interests in pooled funds that are under separate management.

and such organisation is, in connection with the matter, trading with the Trust or entering into a financial arrangement with the Trust, or is likely is to be considered as a potential contractor to the Trust. In the case of two persons living together as a couple (whether married or not) the interest of one shall be deemed to be also an interest of the other

2.3 The exceptions which shall not be treated as material interests are as follows:

2.3.1 shares held in any company where the value of those securities does not exceed £10,000 or the number of shares held does not

exceed 2% of the total number of issued shares in a company whose shares are listed on any public exchange;

2.3.2 an employment contract with the Trust held by a Staff Governor;

2.3.3 an employment contract with a local authority held by a Local Authority Governor;

2.3.4 an employment contract with a partnership organisation held by a Partnership Governor.

3 Declaration

An elected governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Council of Governors. An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected governors.

4 Agendas and Papers

4.1 An agenda, copies of any questions on notice and/or motions on notice to be considered at the relevant meeting and any supporting papers shall be sent to each Governor so as to arrive with each Governor normally no later than 7 days in advance of each meeting. Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item.

4.2 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

4.3 A Governor desiring a matter to be included on the agenda shall make his request in writing to the Trust Secretary at least 14 days before the meeting. Requests made less than 14 clear days before a meeting may be included on the agenda at the discretion of the Chair.

4.4 The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Receipt of such matters via electronic means is acceptable.

5 Admission of the Public

5.1 All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public

from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

5.2 Nothing in these Standing Orders shall require the Council to allow members of the public or press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceeding as they take place without the prior agreement of the Council of Governors

6 Chair of Meetings

6.1 The Chair of the Trust, or in that person's absence, the Deputy Chair is to preside at meetings of the Council of Governors. If the Chair is absent from a meeting or temporarily absent on the grounds of a declared conflict of interest the Deputy Chair shall preside. If the Chair and Deputy Chair are absent from the meeting or absent temporarily on the grounds of a declared conflict of interest, such non-executive director as the Governors present shall choose shall preside.

6.2 The Chair of the Trust is not a member of the Council of Governors but the Chair of the Trust or, in their absence, the Deputy Chair of the Trust is to preside over meetings of the Council of Governors.

7 Chair's Ruling

7.1 Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

7.2 Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which that person should be advised by the Trust Secretary).

8 Minutes

8.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it. The approved minutes will be conclusive evidence of the events of the meeting and retained by the Trust Secretary.

8.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

9 Standards of business conduct

9.1 In relation to their conduct as a Governor of the Trust, each Governor must comply with the Constitution, the Code of Conduct for Governors, the Code of Governance for NHS Provider Trusts, the requirements of the law and any guidance issued by NHS England.

9.2 Governors will confirm their agreement to adhere to the Code of Conduct for Governors by signing a copy annually and returning it to the Trust Secretary.

9.3 Canvassing of Directors or Governors or of any members of any committee of the Trust directly or indirectly for any appointment by the Trust shall disqualify the candidate for such appointment.

9.4 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10 Suspension of Standing Orders

10.1 Except where this would contravene any statutory provision or any direction made by NHS England, any one of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present, including one Public Governor and one Staff Governor, and that a majority of those present vote in favour of suspension.

10.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

10.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and the members of the Council of Governors.

10.4 No formal business may be transacted while Standing Orders are suspended.

10.5 The Trust's Audit Committee shall review every decision to suspend Standing Orders.

11 Variation and Amendment of Standing Orders

These Standing Orders may only be amended in accordance with paragraph 37A of the Constitution.

12 Review of Standing Orders

These Standing Orders shall be reviewed annually by the Council of Governors. The requirement for review extends to all documents having effect as if incorporated in these Standing Orders.

13 Interpretation and definitions

13.1 These Standing Orders are the standing orders referred to in paragraph 14 of the Constitution. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

13.2 Terms defined in the Constitution shall have the same meaning in these Standing Orders.

ANNEX 7– STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

STANDING ORDERS

April 2023

FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt a "Schedule of matters reserved" and a "Scheme of Delegation". Which, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

It is acknowledged within these Standing Orders and the Standing Financial Instructions of the Trust that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the Trust Board meets its obligation to perform its functions within the financial resources available.

P*rovisions within the Standing Orders which are not subject to suspension under SO 3.32 are indicated in italics.*

CONTENTS

INTRODUCTION

Statutory Framework

Bolton NHS Foundation Trust (the Trust) is a Public Benefit Corporation which was established which came into existence on 1 October 2008 as Royal Bolton Hospital NHS Foundation Trust pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003. The name of the Trust was changed to Bolton NHS Foundation Trust in 2011.

The principal place of business of the Trust is:

Royal Bolton Hospital, Minerva Road, Bolton, BL4 0JR

The functions of the Trust are conferred by 2006 Act and the Trust will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The constitution requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. This document, together with Standing Financial Instructions (SFIs) and Scheme of Delegation set out the responsibilities of individuals.

Delegation of Powers

All business shall be conducted in the name of the Trust. The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any contrary provisions of the 2006 Act given effect by the Constitution.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Scheme of Reservation and Delegation of Powers'. Those powers which it has delegated to Directors are also contained in the Scheme of Reservation and Delegation of Powers.

1 INTERPRETATION

1.1 Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made thereunder or in paragraph 42 of the constitution shall have the same meaning in these Standing Orders and in addition:

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"COMMITTEE" shall mean a committee appointed by the Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

“CONSTITUTION” shall be the Constitution of Bolton NHS Foundation Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution.

Directors for the purpose of SO/SFI and Scheme of Delegation are those board members reporting directly to the Chief Executive.

"DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

The expression “the Chair of the Trust” shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

2. THE BOARD OF DIRECTORS

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in Trust shall be in the name of the Trust as corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has the functions conferred on it by the 2006 Act and its terms of authorisation.

2.4 Directors acting on behalf of the Trust as a corporate Trustee are acting as quasi-Trustees. Accountability for charitable funds held on Trust is to the Charity Commission. Accountability for non-charitable funds held on Trust is only to NHS England.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6 **Composition of the Board of Directors** - In accordance with the 2006 Act and the constitution, composition of the Board of Directors of the Trust shall be:

The Chair of the Trust

At least 5 non-executive directors

At least 5 executive directors including:

- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

The number of Executive Directors must not be greater than the number of Non-Executive Directors

2.7 **Appointment of the Chair and Directors** - *The Chair and non-executive directors are appointed in accordance with paragraph 21 of the constitution*

The Chair and Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years and may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

2.8 **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair and directors will be in accordance the constitution.

The Chair and Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to rigorous review and NHS England approval. Such appointments beyond six years shall be subject to annual re-appointment and external competition if recommended by the Board and approved by the Council of Governors.

Any re-appointment after the second term of office (irrespective of tenure duration), for the Chair and Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence.

2.9 Appointment of Deputy Chair

Subject to paragraph 22 of the constitution, the Council of Governors, on recommendation of the Trust Chair, may appoint a non-executive director to be Deputy Chair for such a period, not exceeding the remainder of his/her term as non-executive director of the Trust, as they may specify on appointing him/her.

Any non-executive director so appointed may at any time resign from the office of Deputy-Chair by giving notice in writing to the Chair and the Council of Governors may thereupon appoint another Non-Executive Director as Deputy-Chair in accordance with this Standing Order.

2.9A **Appointment of Senior Independent Director** – *the Board of Directors shall, following consultation with the Council of Governors, appoint one of the non-executive directors to be the senior independent director and one of the non-executive directors to be the deputy senior independent director.*

In accordance with a process to be agreed between the Chair and Council of Governors, the senior independent director will lead in the process for evaluating the performance of the Chair.

The senior independent director shall lead a meeting of the Non-Executive Directors at least annually without the Chair to evaluate the Chair's performance, as part of the process agreed with the Council of Governors for appraising the Chair.

The expression "senior independent director" shall be deemed to include the deputy senior independent director of the Trust if the senior independent director is absent from the meeting or is otherwise unavailable.

2.10 **Powers of Deputy Chair** - *Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.*

2.11 **Joint Directors** - *Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an*

executive director jointly, and shall count for the purpose of Standing Order 2.6 as one person.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Admission of the Public and Press** – The public shall be admitted to all formal meetings of the Board, but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

3.2 The Board may treat the need to receive or consider recommendations or advice from sources other than Directors, Committees or Sub-Committees of the Board as a special reason why publicity would be prejudicial to the public interest.

3.3 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner.

3.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5 *The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented, or if, the Chair does not call a meeting within seven days after such requisition has been presented,* at the Trust's Headquarters*, one third or more directors may forthwith call a meeting.*

3.6 **Notice of Meetings** - *Before each meeting of the Board of Directors, a notice of the meeting, shall be delivered to every director, at least three clear days before the meeting.*

3.8 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.9 Public notice of the time and place of any meeting of the Board (open to the public) will be posted on the Trust's web site at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. Such notice, together with a copy of the agenda, will be supplied, on request to the press.

3.10 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.11 A director desiring a matter to be included on an agenda should make this request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.12 **Chair of Meeting** - *At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they are present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.*

3.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.14 **Annual Public Meeting** - The Trust will publicise and hold an annual public meeting in accordance with the constitution and the Act.

3.15 **Notices of Motion** - A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.8.

3.16 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.17 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if considered appropriate.

3.18 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.19 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.20 **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final.

3.21 **Voting** - *Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.*

3.22 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.23 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.24 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.25 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.26 An officer who has been appointed formally by the Board of Directors to act up for an executive director will have the voting rights of that executive director. An officer attending the Board of Directors to represent an executive director without formal acting up status may not exercise the voting rights of the executive director.

3.27 **Non – Voting Directors** - Non Voting Directors are ones who Board members have determined should attend the Board in order to provide it with particular expertise on a continuing basis. They may be expected to attend some or all Board meeting whether held in public or private.

They will receive all board papers for agenda items against which their contributions are required. They will have the opportunity to participate in all board discussions but may not take part in any voting and may be excluded from any part of a Board meeting at the request of the Chair.

All matters discussed or witnessed by attendees shall be regarded as confidential to the board save for those where actions are agreed otherwise.

In order that they do not become liable for decisions made, the Chair will make clear that they are being invited to comment upon items for debate but not take part in any vote should one occur

3.28 **Minutes** - *The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting.*

3.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

3.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.31 **Joint Directors** - *Where a post of executive director is shared by more than one person:*

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of SO 3.38 (Quorum).

3.32 **Suspension of Standing Orders** - Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least half (normally six) of the Board of Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.33 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.34 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

3.35 No formal business may be transacted while SOs are suspended.

3.36 The Audit Committee shall review every decision to suspend SOs.

3.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall not be revoked, varied or amended except upon:

a) A report to the Board by the Chief Executive or the Director of Corporate Governance acting on their behalf.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the Chair) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.38 **Record of Attendance** - *The names of the directors present at the meeting shall be recorded* in the minutes.

3.39 **Quorum** - *No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.*

3.40 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.41 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter,

that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 , The Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by an executive director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or subcommittee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions to perform personally and shall nominate officers to undertake the remaining functions for which the CEO will still retain an accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance and Commissioning or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

5. COMMITTEES

5.1 **Appointment of Committees** - *The Board of Directors may appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust.*

5.2 *A committee appointed under SO 5.1 may, subject to such directions as may be given by the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee.*

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

5.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. .

5.7 Not used

5.8 The committees formally established by the Board of Directors are:

- Audit and Risk Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People Committee
- Nomination and Remuneration
- Strategy and Operations Committee
- Charitable Funds Committee

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Pursuant to paragraph 28 of the constitution, a register of Director's and Governor's interests must be kept by the Trust

6.1 **Declaration of Interests** - The constitution requires board directors (including for the purposes of this document Non-executive Directors) and Governors to declare interests, which are relevant and material. All existing board directors should declare relevant and material interests. Any board directors or governors appointed subsequently should do so on appointment or election.

6.2 All employees of the Trust who have a direct financial interest in a private company of any description which may be engaged in the provision of goods or services to the NHS, must declare that interest in in accordance with the "*Standards of Business Conduct Policy"* at the time of appointment or commencement of any such interest**.**

6.3 Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should include in the register are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.4 If board directors or governors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Governance.

6.5 Any changes in interests should be declared at the next Board of Directors' meeting following the change. It is the obligation of the director or governor to inform the Director of Corporate Governance in writing within seven days of becoming aware of the existence of a relevant or material interest.

6.6 The names of directors holding directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.7 During the course of a Board of Directors meeting or a governor meeting, if a conflict of interest is established, the director or governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

6.8 Register of Interests - The details of directors' and governors' interests recorded in the Register will be reviewed on a quarterly basis by the Audit and Risk Committee.

6.9 In accordance with paragraph 30 of the constitution, the Register will be available for inspection. The Chair will take reasonable steps to bring the existence of the

Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 *Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they will at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

7.2 Not used.

7.3 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

7.4 *Any remuneration, compensation or allowances payable to a director by virtue of their position as a director of the Trust shall not be treated as a pecuniary interest for the purpose of this Standing Order.*

7.5 For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) *they or a close associate* of theirs, is a director of a company or other body, not being public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or*

b) *they or a close associate* of theirs is a business partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;.*

7.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) *of membership of a company or other body, with no beneficial interest in any securities of that company or other body;*

b) *of an interest in any company, body or person as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.*

7.7 *Where a director:*

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class and the total nominal value of shares of any one class does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to the duty to disclose an interest.

7.8 Standing Order 7 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee as it applies to a director of the Trust.

For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:

- *Married persons and those in Civil partnerships or cohabiting. In which case, the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** – The Trust has adopted a Standards of Business Policy and staff must comply with this guidance and guidance in the Bribery Act 2010. The following provisions should be read in conjunction with these documents.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare any other employment or business or other relationship of theirs or a close associate as previously defined, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9 Prior to acceptance of an appointment directors should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

8.11 Any Board member or member of staff who receives or is offered hospitality in excess of £50.00 must decline that hospitality and is required to enter the details of the hospitality in the Trust's Hospitality Register.

8.12 The Board recognise the offences set out in the Bribery Act:

- to give, promise or offer a bribe,
- to request, agree to receive or accept a bribe either in the UK or overseas
- A corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place in accordance with arrangements approved by the Board.

9.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board of Directors, a Board Committee or where the Board of Directors has delegated its powers.

9.3 On approval by the Board, or by the Chair or the Chief Executive under delegated powers, to a transaction in pursuance of which the Common Seal of the Board is required to be affixed to appropriate documents, shall be deemed also to convey authority for the use of the Common Seal.

9.4 Where approval to the sealing of a document has been given specifically in pursuance of a resolution of the Board or in accordance with Standing Order No.9.3 above, the Seal shall be affixed in the presence of the Chair, or other Officer duly authorised and an Executive Director of the Trust, and shall be attested by them.

9.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

10. SIGNATURE AND INSPECTION OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

10.3 A Director of the Board may for purposes of their duty as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, provided that the Director shall not knowingly inspect ore request a document relating to a matter in which they are professionally interested or in which they have directly or indirectly any pecuniary interest.

This Standing Order shall not preclude the Chief Executive from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

10.4 Nothing in the above paragraphs of this Standing Order 10 shall be interpreted as giving the right to Directors to have access to confidential patient records.

11. MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within the Standing Orders and SFIs.

11.2 **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

ANNEX 8 MEMBERSHIP AND MEMBERS MEETINGS

1 Members Meetings

1.1 The Trust is to hold a members meeting (called the annual members meeting) within nine (9) months of the end of each Financial Year.

1.2 All members meetings other than annual meetings are called special members meetings.

1.3 Members meetings are open to all members of the Trust, governors and directors, and representatives of the auditor. Annual members meetings are also open to all members of the public who are not members of the Trust, but only in the capacity as an observer (which for the avoidance of doubt does not include any right to address the meeting, speak, be heard or vote at such meeting). Special members meetings should not be open to members of the public unless the Council of Governors decides otherwise.

1.4 The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a members meeting.

1.5 All members meetings are to be convened by the Secretary by order of the Council of Governors.

1.6 The Council of Governors may decide where a members meeting is to be held and may also for the benefit of members arrange for the annual members meeting to be held in different venues each year.

1.7 The Council of Governors shall also fix an appropriate quorum for each venue provided that the aggregate of the quorum requirements shall not be less than the quorum set out below at the annual members meeting.

1.8 At each annual members meeting the Board of Directors shall present to the members:

1.8.1 the annual accounts

1.8.2 any report of the auditor on the annual accounts

1.8.3 the annual report

1.8.4 forward planning information for the next financial year

1.9 At each annual members meeting the Council of Governors shall present to the members:

1.9.1 a report on steps taken to secure that (taken as a whole) the actual membership is representative of those eligible for such membership;

1.9.2 the progress of the membership strategy

1.9.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

1.10 At any members meeting the results of the election and appointment of governors and the appointment of non-executive Directors that have occurred since the preceding members meeting will be announced.

1.11 Notice of a members meeting is to be given:

1.11.1 by notice to all members;

1.11.2 by notice prominently displayed at the head office and at all of the Trust's places of business; and

1.11.3 by notice on the Trust's website at least fourteen (14) clear days before the date of the meeting.

1.12 The notice of a members meeting must:

1.12.1 be given to the Council of Governors and the Board of Directors, and to the auditor;

1.12.2 state whether the meeting is an annual or special members meeting;

1.12.3 give the time, date and place of the meeting; and

1.12.4 indicate the business to be dealt with at the meeting.

1.13 Before a members meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is at least ten members present from the public constituencies and at least ten members present from the staff constituency.

1.14 The Trust may make arrangements for members to vote by post, or by using electronic communications.

1.15 It is the responsibility of the Council of Governors, the Chair of the members meeting and the Secretary to ensure that at any members meeting:

1.15.1 the issues to be decided are clearly explained;

1.15.2 sufficient information is provided to members to enable rational discussion to take place.

1.16 The Chair of the Trust, or in their absence the Deputy Chair of the Board of Directors, or in their absence one of the other non executive Directors shall act as Chair at all members meetings of the Trust.

1.17 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the

start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

1.18 A resolution put to the vote at a members meeting shall be decided upon by a poll.

1.19 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second or casting vote.

1.20 The result of any vote will be declared by the Chair of the members meeting and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

1.21 The ruling of the Chair on a point of order shall be final.

1.22 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the agenda shall be considered at a Members' meeting unless specifically agreed by the Chair.

2 Termination of Membership

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this constitution;

2.1.4 they cease to be entitled under this constitution to be a member of the Public Constituencies or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors they fail to demonstrate that they wish to continue to be a member of the Trust;

2.1.6 they are disqualified from membership by paragraph 8 of the Constitution or paragraph 4 of this Annex 8;

2.2 A member may be expelled by a resolution of the majority of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:

2.3 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

2.4 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.4.1 subject to the disputes procedure set out at Annex 9, paragraph 1 dismiss the complaint and take no further action; or

2.4.2 for a period not exceeding twelve (12) months suspend the rights of the member complained of to attend members meetings and vote under this constitution;

2.4.3 arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

2.5 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one (1) month before the meeting with an invitation to answer the complaint and attend the meeting.

2.6 At the meeting of the Council of Governors the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.7 If the member complained of fails to attend the meeting of the Council of Governors without due cause the meeting may proceed in their absence.

2.8 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting of the Council of Governors that the resolution to expel them is carried.

2.9 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a meeting of the Council of Governors.

3 Representative membership

The Trust shall take steps to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end the Trust shall at all times have in place a membership strategy which shall be approved by the Council of Governors, and which shall be reviewed by them from time to time.

4 Disqualification from membership

A person may not become or continue as a member of the Trust:

4.1 If, in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust, or;

4.2 If they are subject to a direction made under the Education Act 2011 or the Safeguarding Vulnerable Groups Act 2006;

4.3 If they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003 or other relevant legislation; or

4.4 If they have been removed as a member of the Trust or removed as a member of another NHS foundation Trust.

ANNEX 9 FURTHER PROVISIONS

1 Dispute Resolution Procedures

1.1 In the event of any dispute about the entitlement to membership the dispute shall be dealt with as follows:

1.1.1 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

1.1.2 The Chief Executive (or a nominated representative) shall:

(a) Review the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

(b) Then either confirm the original decision or make some other decision as appropriate based on the evidence which the Chief Executive has considered; and

(c) Communicate his decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

1.1.3 Notwithstanding paragraph 2.2 of Annex 8 and paragraph 1.1.2 of this Annex 9 an independent assessor may be appointed (as if it had been a possible removal pursuant to and using the process set out in 1.1.2 of this Annex 9) to consider the evidence and advise on whether this justified disqualification under the terms of the Constitution.

1.1.4 In the event that the independent assessor appointed pursuant to paragraph 1.1.3 advises that the evidence justifies the disqualification, the original decision to disqualify shall stand. If however the independent assessor advises that there is at least reasonable doubt that the evidence justified disqualification, the matter shall be put to the Council of Governors to decide whether to uphold the disqualification or not (such decision requiring support of not less than three quarters of the Governors present and voting at a meeting of the Council of Governors convened for that purpose). If the Council of Governors does not uphold the disqualification, then such disqualification shall not stand and the individual subject to the proposed disqualification shall remain a member of the Trust.

1.1.5 Pending a decision of the independent assessor or the Council of Governors as referred to in paragraph 1.1.4, the individual shall

(without prejudice to the outcome of such review process) not be able to exercise any right or powers of member.

1.2 In the event of any dispute about the eligibility and disqualification of a Governor the dispute shall be referred to the Council of Governors whose decision shall be final.

1.3 In the event of dispute between the Council of Governors and the Board of Directors:

1.3.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

1.3.2 if the Chair is unable to resolve the dispute they shall refer the dispute to the Trust Secretary who shall appoint a joint special committee constituted as a committee of the Board of Directors and a committee of the Council of Governors, both comprising equal numbers, to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute;

1.3.3 if the recommendations (if any) of the joint special committee are unsuccessful in resolving the dispute, either constituent may resolve to refer the dispute for resolution by NHS England.

1.4 On the satisfactory completion of this disputes process the Board of Directors or Council of Governors, as appropriate, shall implement any agreed actions.

1.5 The existence of the dispute shall not prejudice the duty of the Board of Directors in the exercise of the Trust's powers on its behalf.

1.6 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors and that the Trust is not meeting the conditions of its provider licence.

Title:	Quality Account 22/23 Annual report – Working document

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

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

Previously considered by:	The 2022/23 Draft Quality Account was previously reviewed by the Clinical Governance & Quality Committee and the Quality Assurance Committee in May 2023.

Proposed Resolution	The Board of Directors are asked to: • **Receive** the Quality Account annual report 22/23 production and approval timeline and **receive** the Draft Quality Account document

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

Prepared by:	Debbie Redfern & Stuart Bates	**Presented by:**	Tyrone Roberts, Chief Nurse

Quality Account 2022/23 Annual Report

Introduction:

This paper seeks to provide:

- A time frame for the production and approval of the Quality Account 22/23 document
- A working version of the Quality Account Annual Report 2022/23 is included at Appendix 1

Quality Account annual report 22/23 – Remaining Review and Approval Schedule:

Committee	Date	Actions Required
Exec Directors	May 2023	• To receive Draft Quality Account for comment
Quality Assurance Committee	May 2023	• To receive Draft Quality Account for comment
GM ICB	May 2023	• To receive Draft Quality Account for comment
Board of Directors	May 2023	• To receive Draft Quality Accounts
Board of Directors (extraordinary)	June 2023	• To sign off Final Quality Account
Audit Committee	June 2023	• To receive Final Quality Account
Publish & Communicate	30th June 2023	• As a standalone document to NHS Choices

A WORKING version of the Quality Account Annual Report 2022/23

Please see appendix 1 for the current WORKING version of the Quality Account Annual Report 2022/23.

In line with previous years, there are a number of sections that are in draft – awaiting final year end/Q4 progress submission. These will be updated throughout May.

Summary and Recommendations

The Board of Directors is asked to:

- Note final **Remaining Review and Approval Schedule for the Quality Account Annual Report 222/23**
- Receive and review the current WORKING version of the Quality Account for assurance purposes
- Note that an number of sections of the Quality Account annual report are in draft awaiting final year end/Q4 update

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NHS
Bolton
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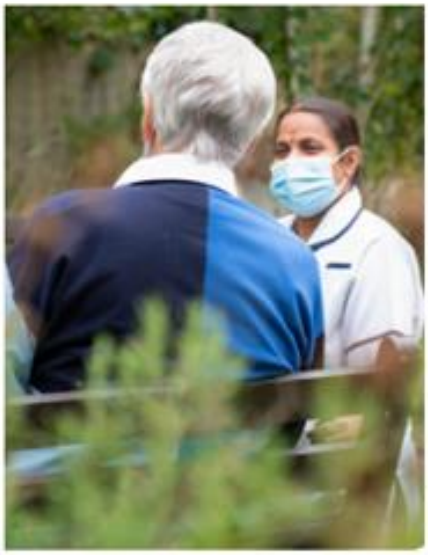
Bolton NHS Foundation Trust

Quality Account

2022/23





... for a better Bolton

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Part 1

Statement on the Quality of Services from the Chief Executive

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Statement on Quality from the Chief Executive

CEO statement on quality achievements and challenges in 2022/23 in progress by communications team – due end of April

A summary of achievements from all our 2022/23 quality account improvement priorities can be found in part two of this report, in addition to a summary of our aims for our 2023/24 improvement priorities, which are as follows:

- Pressure Ulcer Improvement
- C'difficile infection reduction
- Enabling and empowering our staff through the development of quality improvement skills

To the best of my knowledge, the information we have provided in this Quality Report is accurate. I hope that this report provides you with a clear picture of how important quality improvement, patient safety and experience are to us at Bolton NHS Foundation Trust.

Fiona Noden,
Chief Executive

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation *trust annual reporting manual 2022/23* and supporting guidance *Detailed requirements for Quality Reports 2020/21*
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to (the date of this statement)
    - papers relating to quality reported to the board over the period April 2022 to (the date of this statement)
    - feedback from commissioners
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
    - the 2022 national patient survey
    - the 2022 national staff survey
    - latest CQC inspection report dated 17/02/2023
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Chairman Chief Executive

Xx/xx/2023

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Part 2

How quality initiatives are prioritised in the Trust

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How quality initiatives are prioritised in the Trust

This Quality Report identifies the progress made against the quality and safety agendas in 2022/23 and identifies the quality improvement priorities for 2023/24. Quality initiatives are chosen and prioritized based on quality, safety and experience data to ensure we focus improvement activities in the area of greatest need and that decisions are made based on robust data.

Key quality improvement priorities for 2023/24

Following consultation with our stakeholders we would like to highlight the following as our quality account improvement priorities for 2023/24:

1. Pressure Ulcer improvement
2. C'difficile infection reduction
3. Enabling and empowering our staff through the development of quality improvement skills

Outline of aims and plans for the 2023/24 priorities are summarised on the following pages.

Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and where applicable commissioning for quality and innovation (CQUIN) payments.

Quality Performance in 2022/23:

In our Quality Account for 2021/22 we set ourselves a series of key priorities for improvement for 2022/23, these were:

- Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score (continuation from 2021/22)
- Antibiotic prescribing standards
- Rheumatology
- Improving information for patients
- Accessible Information Standards (AIS)

Progress against each priority and next steps is summarised on the following pages.

Quality Account Improvement Priorities 2022/23 - Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score

Improving the response to escalation from clinical teams following a deterioration in a patient's National Early Warning Score has been a key focus of the Anaesthetic and Surgical Support Division since 2020. Following improvements and learning we decided to continue with this priority, but widening the scope to include the Acute Adult Care Division in 2022/2023.

This priority focusses on the primary escalation of concern and the response from the medical and surgical teams in order to prevent harm and reduce mortality, therefore highlighting areas for learning and training across these divisions. This work supports the planned trust wide standardisation of the initial response to patient deterioration through the introduction of the RRSAFER care bundle

<table>
<tr><td>AIM: The overarching outcome aim was to:</td><td>Outcome – Partially Achieved</td></tr>
<tr><td>Improve the following KPI metrics to achieve 95% and above
• Observations are carried out in line with trust policy
• There is documented evidence that a sepsis screening tool has been completed for any patient with a NEWS score of 5 or more
• There is documented evidence that the nurse has recognized the significance of the news score and actioned an appropriate response</td><td><table><tr><td>AACD</td><td>ASSD</td></tr><tr><td colspan="2">(22/23 average)</td></tr><tr><td>90%</td><td>91%</td></tr><tr><td>91%</td><td>86%</td></tr><tr><td>90%</td><td>97%</td></tr></table></td></tr>
<tr><td>Other measures we will monitor and report include:</td><td>Outcome – Achieved</td></tr>
<tr><td>• Deterioration and admission to critical care (Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions –as measured by CQUIN 22/23 target 60%</td><td>CQUIN 22/23 target 60%
• Q1 – 50%
• Q2 – 86%
• Q3 – 96%
• Q4- 92.3%</td></tr>
</table>

What we have done:
The key drivers and interventions and progress made in 2022/23 are summarised below:

a) Analyse the monthly KPI figures and patient safety incidents in relation to failure to escalate.

- Incident report meetings weekly are now embedded in divisions to show shared learning across the division.
- NEWS steering group established across both divisions and QI template agreed and ward manager's feedback findings each month.
- KPI's reviewed in both Divisions and actions carried forward into QI template for the next month.

b) Review and analyse escalation process within the divisions and make recommendations for improvement

- Ward round improvement group established and work streams identified in ASSD.
- NEWS group reviewing the process for escalation and embedding escalation from patient track and embedding policy

c) Improve education and training programme across divisions in NEWS score training.

- In addition to NEWS training there is wide offer of training for staff in order to improve the respond to the deteriorating patient.
- Face to face Sepsis Training sessions to support the early recognition and response to the patient with potential sepsis. These sessions are available to Medical, Nursing, Midwifery, Allied Health Professionals, Band 3 and Band 4 HCA/Nursing Associates who perform clinical observations, patient assessment and escalation.
- A full learning needs assessment (LNA) has been completed and outlines each staff member required and training in relation to the deteriorating patients for all clinical staff. The LNA signposts the clinical development of all staff responsible for taking, recording and calculating observations and NEWS score to improve recognition and response to the deteriorating patient. The education within the LNA reinforces a deeper understanding of common clinical manifestations of patient deterioration by building on frameworks to support an effective response to the deteriorating patient.

d) Response to the Acutely Unwell Patient and reduction in transfers to Critical care due to failure to escalate

- This driver is now part of the Deterioration and admission to critical care CQUIN – focusing on compliance with Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- Compliance against recording of observations, escalation and response of Critical care team is captured within this data and reported via EPR and into the ICNARC data collection.
- Manual support alongside BI data is capturing the appropriate escalation and ability to plan Critical care admissions. Manual review provides feedback for referring teams.
- Achieved CQUIN target of above 60% - quarter 4 performance 92.3%

Next Steps:
This work will continue to be progressed at a divisional level via the AACD and ASSD divisional governance meetings and will feed into:

- Clinical Governance and Quality Committee
- Quality Assurance Committee

Key areas of focus being:

- Continue to drive sepsis screen via EPR work towards a single solution
- Continue to embed learning from incidents within both divisions
- Review data and decision to be made re Patient track recording of Sepsis screen.
- Critical Care Outreach Team link nurse role for the Deteriorating Patient to include sepsis and AKI to be embedded.

Quality Account Improvement Priorities 2022/23: Antibiotic Prescribing Standards

The appropriate use of antimicrobial agents is crucial for patient safety and public health, particularly in view of increasing antimicrobial resistance and complications of clostridium rates associated with inappropriate antibiotic use.

The areas of focus that stakeholders felt would lead to better patient outcomes and experience were:

- Objective 1: overall reduction in the use of antibiotics
- Objective 2: appropriate antibiotic in line with indication and trust guidance

AIM: *The overarching outcome aim was to:*	**Outcome – Partially Achieved**
• *10% increase in antibiotics stopped at the review date (72 hours from initiation of antibiotics on admission) by 31/03/23*	• *25% of patients on antibiotics stopped at 72 hours*
• *95% compliance or above with antibiotic prescribing standards by 31/03/23*	• *Compliance at 70% (excludes family care division).*
Other measures we will monitor and report include:	
• Antibiotic audits • Rate of clostridium infections associated with inappropriate antibiotic use	

What we have done:

We planned to meet the two objectives by:

- Objective 1 - implementation of ARK (antibiotic review kit) designed to support the reduction of antibiotic use through risk stratifying the probability when prescribing antibiotics into high or low, which has shown to encourage doctors reviewing antibiotics to stop at 72 hours.
- Objective 2 - introduction of order sets advising on the correct antibiotic to use as per guidance based on the indication rather than choosing the indication based on the antibiotic

The key drivers and interventions to progress these objectives are summarised below:

a) Understanding the barriers to delivering the standards

- Benchmark audits for objective 1 and objective 2 completed – no data available for objective 2 from family care division.
- MDT focus groups of antibiotic prescribers to understand the barriers to good practice complete
- Thematic analysis from prescribers – action plan pending
- Understanding and targeting areas for non-compliance with guidance – feedback through divisional governance structures. Data on individual consultant performance to be sent out again once QA completed

b) Education and training in prescribing standards

- Objective 1:
    - Benchmark data and intelligence regarding current education and awareness completed
    - Scoped implementation of ARK in EPR
    - Development of training package for ARK to be created once process approved and implemented in EPR

- Objective 2:
  - Testing and of the order sets and feedback to the EPMA team on going
  - Infographic informing clinical staff about Antimicrobial order sets created and published
  - Attendance at clinical staff departmental/lunchtime meetings to discuss the antimicrobial order sets
  - Inclusion of antimicrobial order sets in local inductions for next rotation – induction information package to be created in next 2 months prior to August changeover of doctors.
  - Ensure consultants are aware of the new process of prescribing using order sets
  - Increased awareness about antibiotic suitability based on indication rather than perceived efficacy of broader spectrum antibiotics

c) implementation and embedding proposed changes

- Objective 1 :
  - process for ARK agreed – change request form submitted
  - Plan for ARK EPR implementation – agree design and implementation plan with stakeholders
- Objective 2:
  - Antibiotic prescribing order sets created in EPR
  - Process change shared as outlined above.

d) monitor compliance

- Divisional performance monitored and fed into antibiotic stewardship committee for oversight and support with improvement
- Scope the automation of audit data collection with Business Intelligence
- Re-audit in the next 6 months – once the EPR changes have been made
- Monitor percentage of antibiotics prescribed through order sets

e) identify and feedback on clostridium cases attributable to inappropriate antibiotic use

- Established feedback mechanism from root cause analysis and Harm Free Care panels related to antibiotic prescribing through divisional governance structures for learning and monitoring compliance.

Next Steps:

This work will continue to be progressed and monitored by divisional and Trust IPMs, the Trust Antimicrobial Stewardship Group, which will report into:

- Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2022/23: Rheumatology – awaiting Q4 update

Rheumatology faced challenges in relation to management of newly referred and existing patients' caseloads. In association with this, the service was unable to deliver the care

recommendations as advocated within “Rheumatoid Arthritis in over 16s NICE Quality Standard QS33”. This therefore highlighted the need to review systems and processes within the Rheumatology service, to prioritise actions to address the concerns that have been highlighted.

There was a clear opportunity and desire to focus on wider multidisciplinary team building and associated organisational development; with an expectation of developing a collaborative team vision and identity, to harness the full potential and skills of the staff involved to deliver quality care to Rheumatology patients.

AIM: *The overarching outcome aim was to:*	**Outcome – TBC**
in line with “ Rheumatoid Arthritis in over 16s NICE Quality Standard QS 33” we will offer (and maintain that offer) patients with suspected early inflammatory arthritis (EIA) a specialist assessment within 3 weeks of referral by 31/03/23	
Other measures we will monitor and report include:	
Caseload: • Overdue follow up waiting list • Numbers and longest waiters • PTL incomplete performance • Patients triaged as suspected EIA • Numbers of discharges across the department Number of patients added to PIFU list	

What we have done:
We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Capacity enablement:

- Service redesign and transformation has been supported by the deployment of a Transformation manager to focus on the redesign of pathways to ensure patients are able to access the service quickly and appropriately.
- Review of previous and redesign of new “Directory of Services” to ensure appropriate patients are referred into the service or elsewhere as required i.e. EIA, GCA, Fibromyalgia, Osteoporosis
- “Straight to test” blood diagnostics prior to appointment to support timely treatment intervention.
- Clinic validation of new and follow up waiting lists
- Standardisation of PIFU pathways to ensure no medical vs non-medical discrepancy
- Rheumatology Physiotherapist undertaking steroid injection competencies which will release medical capacity
- Short and medium term capacity gains are being realised by focusing on leaner pathways and faster diagnosis / treatment:
    - fibromyalgia educational pathway implementation
    - increased Nurse follow up and Pharmacy outpatient capacity

- Increased PIFU implementation.

b) Implementation of self-management strategies in patients with inflammatory arthritis

- Redesign of fibromyalgia pathway - transferring referred patients with a confirmed diagnosis of fibromyalgia onto therapy based, educational pathway as opposed to medical pathway
- Positive feedback from patients due to immediate access via the remote educational Fibromyalgia support.

c) Improve waiting list management

- Weekly ICSD escalation meeting in place, with focus on capacity, 52 week and forecasted 78 week breaches and actions to address - 78-week RTT potential breach potential for 23/24 (April – September) reduced by 70%
- Booking / escalation guidance in place for urgent demand.
- BI led capacity vs demand analysis completed
- Digital validation of new and follow up waiting lists
- Exploration of pathways that can be supported by advice and guidance as opposed to automatic referral

d) Expand and develop patient initiated follow up (PIFU) for stable patients.

- Medical roll out of PIFU implementation
- Full team PIFU meeting to emphasise PIFU pathways and standardised approach requirement.

Next Steps:

This work will continue to be progressed at a divisional level via the Integrated Community Services Divisional Governance meeting. Key areas of focus being:

- Straight to test “blanket/generic” blood diagnostic tests as a standard
- New hypermobility pathway - patients booked direct to AHP for assessment
- GP education to enable Fibromyalgia diagnosis within primary care setting.
- Job planning engagement with incoming consultant to incorporate a dedicated EIA clinic to fast track EIA referrals.
- One stop clinic for Consultant and Pharmacist as well as Therapist and Nurse, enabling less appointments and faster treatment.
- Criteria requirements for drug starts to reduce inappropriate internal referrals to Pharmacy
- Consideration of medical triage of medical referrals into the service to reduce risk averse decision making which will enhance capacity.
- Implementation of Rheumatology Advice and Guidance Service
- On-line portal for remote access to information, FAQs etc.
- Scope Denosumab patient self-administration

Quality Account Improvement Priorities 2022/23 - Improving Information to Patients

Information is an essential element of communication with patients, and lack of information has been noted to be a strong contributing factor in a number of complaints within the family

care division. The CQC patient surveys, which make up a large part of the Caring section of their Insight report, also concentrates heavily on the amount of information given to patients and families throughout their admission and at discharge.

AIM: *The overarching outcome aim was to:*

We will improve scores on the information survey by 20% by 31/03/23

1. *On admission, did you know what was going to happen to you?*
2. *During the admission, were you always given the information you needed?*
3. *During admission, if you had a question was someone available to answer it?*
4. *During admission, were you ever left feeling uncertain about what was going on?*
5. *At discharge, did you know what would happen next?*

Outcome – Not Achieved

Baseline %		*Current*		
Maternity	*Paeds*	*Maternity*	*Paeds*	*Gynae*
89	*100*	*57*	97	67
85	*100*	*89*	93	93
100	*100*	*67*	93	100
64	*100*	*93*	97	87
100	*100*	*96*	93	100
N = 19	*N = 20*	*N = 45*	*N = 30*	*N = 16*

Other measures we will monitor and report include:

- *Friends and family test*
- *Complaints and PALS related to information and communication*
- *National patient survey*
- *National children and young peoples' survey*

What we have done:
The key drivers and interventions for 2022/23 are summarised below:

a) Set up survey as measurement and use as feedback mechanism

- Development of survey in maternity and acute paediatrics via face to face interview
- Baseline survey - initial results were generally positive whilst highlighting areas for improvement particular during the admission process
- Data collection expanded to Gynaecology

b) Set up on-going data monitoring

- Pilot study proved survey workable and collected some early benchmarking data confirming improvement opportunity in maternity.

c) Strengthen QI groups within clinical teams

- Engagement with clinical teams around the project
- Project lead appointed who will lead and monitor the progress.
- Leadership teams from each area support collation and monitoring of the data and co-design of PDSA cycles.
- Improvement group for Induction lead by Consultant Obstetrician and Ward manager (M2)
- Audit of wait times between induction and transfer to Central Delivery Suite
- Review of patient Information leaflet to explain possible waiting times

- Introduction of out patient induction for low risk women

Next Steps:
This work will continue to be progressed at a divisional level via Family Care Divisional Governance Meeting and reporting into:
  - Clinical Governance and Quality Committee
  - Quality Assurance Committee

Key areas of focus being:
- Updating women waiting for induction when delivery suite is busy.
- Aim for at least 10 responses per week from each area, which can then be plotted on SPC charts.
- Free text from the survey will allow us to get richer feedback that will also feed into the improvement work.

Quality Account Improvement Priorities 2022/23 - Accessible Information Standards

In August 2016, the Care Quality Commission (CQC) instructed that all providers of NHS care must meet the Accessible Information Standard (AIS). The AIS outlines what communication or information needs should be identified, recorded, flagged, shared and met for patients and includes additional needs caused by disability, impairment or sensory loss. The Trust as a whole is currently working toward achieving these standards and this project is led by the Equality, Diversity and Inclusion (EDI) team. Centralised Support Services (CSS) have recognised their position in supporting the Trust to work toward these standards and that Centralised Reception, Health Records and Access Booking and Choice (ABC) will play a key part in achieving the standards. The Diagnostics and Support Services Division is working closely with Trust Leads to support the Trust in meeting the standards, and a working group was established to drive this forward across the Trust, building on the work achieved within this Quality Account.

AIM: *The overarching outcome aim is to:*	**Outcome – Partially Achieved**
In line with legislation (Equality Act 2010 improve compliance with the Equality Diversity and Inclusion agenda by incorporating fundamental Accessible Information Standards in relation to Text reminders and digital letters for outpatient and/or elective care(AIS) by 31/03/23.	Co-ordinated working with the Trust's Equality , Diversity and Inclusion team has enabled the following: • GM wide single provider of Interpretation and Translation services – implementation in Q2 23/24 • A review of provision against communication professional, communication support and written information required by patients with a disability, sensory impairment and sensory loss • Trust central budget for all interpretation and translation charges - swifter access to provision and timely payments • Review and ongoing audit of booking process:

	• Communication prompt/flag in PAS to identify communication needs and advanced booking of provision. • Patient information leaflets in a variety of formats.

What we have done:
The key drivers and interventions for 2022/23 are summarised below:

a) Ask people if they have any information or communication needs, and find out how to meet their needs.

- Working with the Trust EDI Lead to carry out a gap analysis of available communication mediums across the Trust, and identify additional suppliers to meet current gaps. A communications card has been designed and will be rolled out once all AIS mediums are identified for offer.
- Multiple language options and audio options are available via digital letters service.
- Expansion of translation services between Language Line, DRC and DA Languages as new provider, and comprehensive services are offered to the Trust by RNIB/Action of hearing loss.
- The DSSD Division has implemented multiple written and audio translation options via the digital letter service; the use of yellow paper; large font; and opt out from digital letters, with blanket solutions for ophthalmology patients receiving appointment letters on yellow paper as standard and digital letters with a yellow background.

b) Record those needs clearly and in a set way.

- Co-ordinated working with IT, ABC Manager, Records Manager and Receptions Manager to ensure implementation of consistent and most effective recording of communication needs, and define communication pathways within the IT system.

c) Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs.

- Stickers implemented to identify communication needs on patient hard copy records.
- Define reporting/progress measures
- Scope and progress towards the implementation of an electronic solution

d) Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.

- Agree on where data needs to be shared and progress through AIS working group and integrated services model

e) Take steps to ensure that people receive information, which they can access and understand, and receive communication support if they need it.

- Gap analysis complete and all mediums implemented within current scope – digital letters with translation options, audio options with translation, yellow paper, large font, opt out of digital letters, etc.…

- All ophthalmology patients receiving appointment letters on yellow paper as standard and digital letters with a yellow background.
- AIS communications leaflet designed following consultation across GM
- EDI team leading on establishing future plans for additional service provision and contracting to fill gaps in services
- Implementation of digital solution for recording communication needs to ensure that all specialties follow the same approach to meeting patient AIS needs.
- Patient consultation to ensure collaboration around accessible information.

Next Steps:
This work will continue to be progressed and reported via the following groups:

- Clerical Support Services Governance Board Meeting
- Diagnostic and Support Services Divisional Governance Meeting
- Record Keeping Committee

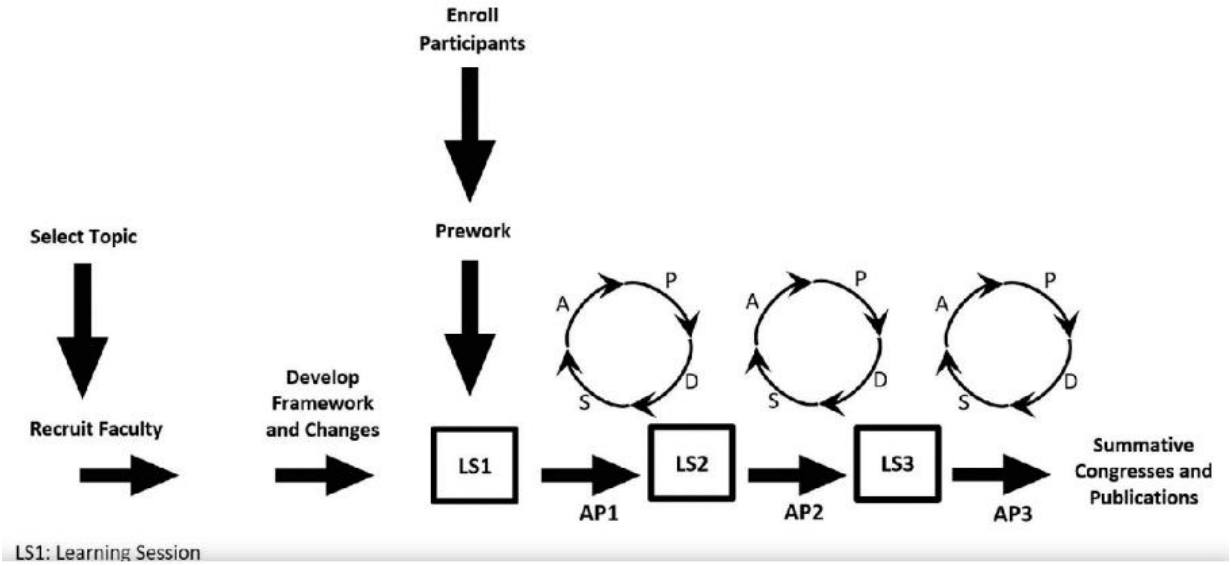
Quality Account Improvement Priorities 2023/24:

Following quality, safety and experience data review and stakeholder engagement, the chosen Quality Account Improvement Priorities for 2023/24 are:

1. Pressure Ulcer Improvement
2. Clostridium Difficile Infection Reduction
3. Enabling and empowering our staff through the development of quality improvement skills and knowledge

As Pressure Ulcers and C'*difficile* has significant impact on patient safety, outcomes and experience across the organization and system wide, we have decided to apply an Improvement Collaborative approach to the management and facilitation of these priorities.

An improvement collaborative is a short to medium-term (12-24 month) learning system that brings together teams to learn from each other and from recognised experts in topic areas where they want to make improvements. Over that period, change is tested and refined and if successful, a change package is created to be rolled out to the wider organisation/system.



The power of an improvement collaborative is:

- Staff empowerment – involving front line subject experts to define their own ideas for change and empowering them to influence improvement for the benefits of their patients and colleagues.
- Improved knowledge – learning from subject experts around best practice
- Improved QI skills and capacity - learning about QI, the framework and how to test change
- Networking and support – building organisation and system wide networks and support from peer group regarding implementing change
- Ability to prove (or disprove) if an idea works in practice – through the use of measurement strategies
- Culture change – shifting the perception around quality improvement and organisational change to engagement, empowerment and "the way we do things here"

Priority 1 - Pressure Ulcer Improvement

Pressure ulcers are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods. Pressure ulcers can affect any part of the body that is put under pressure. They are most common on bony parts of the body, such as the heels, elbows, hips and base of the spine. They often develop gradually, but can sometimes form in a few hours.

In Bolton, we have a system-wide problem with pressures ulcers – not just in hospital, but also in the community and nursing and residential care settings. Pressure ulcers are a challenge for the person who develops them and the health and social care professionals involved in their prevention and management. They can cause pain, affect a person's body image and lead to social isolation and immobility. For some people, the development of a pressure ulcer can lead to severe life limiting or life-threatening complications and treatment, such as blood poisoning, surgery/amputation, and severe disability.

The treatment of pressure ulcers is also costly and resource intensive and it estimated that treating pressure ulcers costs the NHS more than £1.4 million every day

Why a Collaborative:
We have chosen to run an improvement collaborative on pressure ulcer improvement for the above reasons and there are a number of interventions, which have been proven to reduce pressure ulcers within care settings – a collaborative will help us to test and implement these changes and provide the potential and opportunity to make significant improvements.

AIM: *The overarching outcome aim is to:*
To reduce Hospital acquired category 2 pressure ulcers by 31/07/24 *To reduce Community acquired category 2 pressure ulcer by 31/07/24*
Other measures we will monitor and report include:
• *Pressure ulcer count and rate for category 2s, 3s and 4s* • *Pressure Ulcer point prevalence* • *Pressure Ulcer risk assessment – Purpose T – completion within 6 hours of admission and ongoing review* • *% of Pressure Ulcers where wound assessment is completely correctly* • *Time to pressure relieving device* • *SSkin bundle*

What we will do
The primary drivers and interventions for the pressure ulcer improvement are summarised below:

- Data analysis and focussed tests of change
    - Use of measurement for improvement methodology e.g. SPC charts
    - Stratification of data to understand problems and their root cause:
        - Data split be category, site of body, location of acquisition, ward/dept/unit
    - Development of interactive pressure ulcer dashboard

- Pressure Ulcer Prevention:
    - PU risk assessment at admission –the use of Purpose T
    - Re-assessment of risk

    - Immediate access to pressure relieving devices
    - SSKIN Bundle - (Surface, Skin. Keep moving. Incontinence, Nutrition)

- Management of Pressure Ulcers:
    - Current best practice
    - National guidance
    - NICE guidance
    - EPUAP
    - Stage 3 and 4 = Never events
    - Learning from pressure ulcers, in line with PSIRF principles

- Leadership, staff and Patient Education and Ownership
    - Intentional rounding
    - Pressure Ulcer champions
    - Staff training and education
    - Patient education
    - Safety calendar

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress

The forums and governance committees which will provide progress, oversight and accountability for pressure ulcer improvements are summarised below:

- Pressure Ulcer Improvement Collaborative and Faculty
- Divisional Governance meetings
- Divisional and Trust IPM
- Patient Quality Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 2 - Clostridium Difficile Infection Reduction - DRAFT

Clostridium difficile (also known as “C. difficile” or “C. *diff*”) is a bacterium that can be found in people’s intestines (their “digestive tract” or “gut”). However, it does not cause disease by its presence alone; it can be found in healthy people, about 3% of adults and two-thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which C. difficile competes, are disadvantaged, usually by someone taking antibiotics, allowing the C. difficile to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease.

Bolton is an outlier for the rate of Healthcare Associated C’diff cases in GM, the Region and Nationally for provider services. Thematic review of C’diff cases highlighted common themes of delays to stool sampling, delays to isolation once a C’diff case has been confirmed, poor documentation of the detection and management of C’diff and fundamental standards in terms of hand hygiene and the ward environment.

Why a Collaborative:
We have chosen to run an improvement collaborative on c’diff infection reduction for the above reasons and there are a number of interventions which have been proven c’diff – a collaborative will help us to test and implement these changes and provide the potential and opportunity to make significant improvements.

AIM: *The overarching outcome aim is to:*
Reduce Healthcare associated C’*diff* Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024
Other measures we will monitor and report include:
• Total number of healthcare associated C'*diff* cases • Hand Hygiene and PPE spot checks by IPC • % CDT care plan completed • % Altered Bowel Habit Chart completed • Diarrhoea audit • Time from detection to sample being sent to lab • time from confirmation of a CDI to the start of treatment • Time from diagnosis to isolation • IPC mandatory training • Patient hand and environmental hygiene prior to meal times • % Antibiotic review within 72 hours

What we will do
The primary drivers and DRAFT interventions for C’diff infection reduction are summarised below*:*

- Data analysis and focussed tests of change
  - Use of measurement for improvement methodology e.g. SPC charts
  - Stratification of data to understand problems and their root cause:

- Documentation and communication

- Suspicion of infection and isolation
  - Escalation of loose stool between HCAs and registered nurses
  - Timely Sampling when patients have sign/symptoms
  - Isolation escalation of C'Diff patients

- Antibiotic treatment
  - Prescription supported by diagnostic test
  - Compliance with Trust guidelines
  - Proportion of ward patients on abx

- Environment

- Staff education and practice
  - Harm Free Care case reviews – in line with PSIRF

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress

The forums and governance committees which will provide progress, oversight and accountability for C'difficile reduction are summarised below:

- C'Diff Collaborative and Faculty
- Divisional Governance meetings
- Divisional and Trust IPM
- Infection Prevention Control Committee
- Patient Quality Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 3 - Enabling and empowering our staff through the development of quality improvement skills and knowledge

Quality Improvement – a definition
At Bolton we have adopted the National Quality Board's "Shared Single View of Quality", outlining systems should deliver care that is:
- Safe
- Effective
- Positive experience – responsive, personalised and caring
- Well-led
- Sustainably-resourced
- Quality care is also equitable

QI is the continual actions by staff and service users to improve outcomes (in line with the above key areas) for the benefits of our patients, whilst also engaging and empowering the workforce that supports those using systematic methods. Bolton NHS Foundation Trust has made a commitment to using quality improvement as THE method for all improvement and as a result are investing in our workforce, so our experts (our staff) are empowered and equipped with the knowledge, skills and permission to create tangible and sustained

improvements in their area of work.

AIM: *The overarching outcome aim is to:*
25% increase in Bolton NHS Foundation Trust Staff who have an awareness of the fundamentals of Quality Improvement by 31/03/24 (through QI fundamental training, improvement collaborative involvement, BoSCA QI involvement)
Other measures we will monitor and report include:
• *Contacts for QI assistance* • *Library of QI projects in the organisation* • *Hits on website* • *Contacts via social media*

What we will do

The key drivers and interventions for 2023/24 are summarised below:

- Establishing the vision:
  - Development of QI Strategy with stakeholder engagement
  - Development of QI infrastructure – central team of QI expertise to support the organization

- QI Skills learning and development academy
  - QI Fundamentals
  - Test QI Improvement Advisor
  - Test QI coaching clinics
  - QI incorporated into leadership programmes – Bridging the Gap
  - Focus on our future workforce – QI for Doctors in training and student nurses/midwives etc.

- Incorporating QI into operational delivery
  - Trust/system wide improvement collaboratives
  - Divisional specific QI projects linked to quality and safety metrics in divisional IPM – test concept of improvement advisor
  - BoSCA
    - White to Silver – QI test of change with QI Team support
    - Gold Teams – test clinical microsystems (team based problem solving coaching) on a QI project up to 12 months

- Establishing the standards
  - Utilisation of trust system to track QI engagement – ESR
  - QI workbook
  - Creation on central library of QI activities for tracking and shared learning purposes
  - Registering your improvement project mechanism

- QI Comms and Engagement
  - Development of QI comms and engagement plan
  - Social media promotion and networking
  - Internal electronic promotion, media and resources – intranet, team brief, staff bulletin
  - Signposting of QI opportunities both internal and external

- Case study development to share learning
- QI showcase events to celebrate and share learning

- Working with our partners/horizon scanning
  - National and local changes and strategies in relation to QI
  - Collaboration with the Bolton wide Quality Improvement Network

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress

The forums and governance committees which will provide progress, oversight and accountability for Enabling and empowering our staff through the development of quality improvement skills are summarised below:

- Patient Quality Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Statement of assurance from the board

Review of services
During 2022/23 Bolton NHS Foundation Trust provided and/or sub-contracted 13 relevant health services. (as defined by the CQC) across 41 specialties.

Bolton NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100 % of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust for 2022/23.

Participation in Clinical Audits and Research Activity
The NHS published a list of 68 Quality Accounts (*of which several fall under the same programme of work) in 2022/23.

During that period Bolton NHS Foundation Trust participated in 50 out of 50 (100%) national clinical audits and 100 % national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Trust did not participate in the following audits:

Not Applicable

- Cleft Registry and Audit NEtwork (CRANE)
- Mental Health Clinical Outcome Review Programme
- Muscle Invasive bladder cancer
- National Audit of Cardiovascular Disease Prevention
- National Audit of Pulmonary Hypertension
- National Bariatric Surgery Registry
- National Congenital Heart Disease Audit
- National Audit Cardiac Surgery

- National Clinical Audit of Psychosis
- National Obesity Audit
- Neurosurgical National Audit Programme
- Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
- Prescribing Observatory for Mental Health
- National Acute Kidney Injury Audit
- UK Cystic Fibrosis Registry
- National Audit of Percutaneous Coronary Intervention
- Paediatric Intensive Care Audit (PICANet)

Did not participate

- Fracture Liaison Service Database

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2022/23 are as follows:

	Project Name	Additional Information/Individual Studies/Data Range	No. of cases submitted
1	Breast and Cosmetic Implant Registry	Data Range: January 2022 to December 2022	11
2	Case Mix Programme (CMP) ICNARC	Data Range: 1st April - 30th September 2022	266
3	Elective Surgery National PROMs Programme	Data Range: April 2022 to February 2023 Hip Knee	 178 155
4 5 6 7	Royal College of Emergency Medicine QIPs	1. Infection Control 2. Pain in Children 3. Consultant Sign-Off Data Range: October 2021 – October 2022) 4.Mental Health self-harm Data Range: 3 October 2022 – 3 October 2024	273 160 74 0
8 9	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls National Hip Fracture Database Data Range: 2022/2023 continuous	6 420
10	Learning Disabilities Mortality Review Programme (LeDeR)	Please see narrative below	n/a
11	Medical and Surgical clinical outcome review programme (NCEPOD)	Please see narrative below	n/a
12	Maternal and New-born Infant Clinical Outcome Review Programme	Please see narrative below	n/a
13 14 15 16	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Children's Asthma Secondary Care COPD Adult Asthma Pulmonary Rehab Data Range: 2022/2023 continuous	177 301 84 45
17	National Audit of Breast Cancer in Older Patients (NABCOP)	Data Range: 2022/2023 continuous	351

18	National Audit of Cardiac Rehabilitation (NACR)	Data Range: 2022/2023 continuous	348
19	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) Published Nov 2022	Data Range: December 2019 and 30 November 2020	67
20	National Cardiac Arrest Audit (NCAA)	Data Range: 2022/2023 continuous	63
21 22 23	National Cardiac Audit Programme (NCAP)	Cardiac Rhythm Management Heart Failure MINAP Data Range: 2022/2023 continuous	273 461 215
24 25 26	National Diabetes Audit – Adults	NaDIA Harms Foot Care Inpatient Safety (Local data) Data Range: 2022/2023 continuous	23 226 115
27	National Emergency Laparotomy Audit (NELA)	Data Range: 2022/2023 continuous	135
28 29	National Gastro-intestinal Cancer Programme	National Bowel Cancer Audit National Oesophago-gastric Cancer Data Range: April 2022 – February 2023	210 56
30	National Joint Registry	Data Range: April 2022 – January 2023	259
31	National Lung Cancer Audit (NLCA)	Data Range: 2022/2023 continuous	151
32	National Maternity and Perinatal Audit	Latest data available -	Requested via email to NMPA
33	National Neonatal Audit Programme (NNAP)	Data Range: 2022/2023 continuous	52
34	National Paediatric Diabetes Audit (NPDA)	Data Range: 2022/2023 continuous	145
35	National Prostate Cancer Audit (NPCA)	Data Range: 2022/2023 continuous	207
36	National Vascular Registry	lower limb angioplasty Data Range: January 2022 – July 2022	10
37	Sentinel Stroke National Audit Programme (SSNAP)	Data Range: 2022/2023 continuous	207
38	Serious Hazards of Transfusion Scheme (SHOT) – Haemovigilance Scheme	Data Range: January 2022 - December 2022	32
39	The Trauma Audit & Research Network (TARN)	Data Range: 2022/2023 continuous	114
40	UK Renal Registry Chronic Kidney Disease Audit	*Note: Data for Royal Bolton Hospital is included within the Royal Salford Hospital submission as one of its satellites.*	17

42	Inflammatory Bowel Disease National Audit Project	IBD Registry Data Range: 2022/2023 continuous	45
42	National Early Inflammatory Arthritis Audit (NEIAA)	Data Range: 2022/2023 continuous	Michelle Info Requested
43	Society for Acute Medicine Benchmarking Audit (SAMBA)	Data Range: 23rd June 2022 - 19th August 2022	71
44 45	British Thoracic Society – Adult Respiratory BTS – Smoking cessation (Maternity & Mental Health) National Respiratory Support Audit is planned to begin on 1 February 2023. Tobacco Dependency/Smoking Cessation within Maternity and Mental Health Services Pilot Audit: Both pilots are on pause but are planned for later 2022/early 2023.	**Adult respiratory support Audit** Data Range: 1 February 2023- 31 March 2023 (national audit period) 1 February 2022- 31 January 2023 (local audit period) **Smoking cessation Maternity and MH service** Data Range: 1 September 2021- 31 August 2022 (Local Audit) 1 July 2021- 31 August 2021 (National Period)	0 (commenced Feb 2023) 0 0 84
46	National Audit of Care at the End of Life (NACEL)	Case reviews Staff Surveys Hospital Site overview Data Range: 6TH June to 7th October 2022	50 (100%) 24 1 (100%)
47	National Audit of Dementia (NAD)	Case note Reviews Patient Questionnaires Carer Questionnaires Organisational Proforma Data Range: 19 September – 14 October	58 32 4 1
48	National Ophthalmology Database	Adult Cataract Surgery Audit Data Range: 2022/2023 continuous	1703
49	Perioperative Quality Improvement Programme	Data Range: March 2022-February 2023	53
50	UK Parkinson Disease	Occupational therapy Physiotherapy	10 11

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
List applicable NCEPOD Studies and current status

Testicular Torsion
Date Publication: Winter 2023

	Requested	Submitted
Case notes	6	6 (100%)
Organisational Proforma	1	1 (100%)
Clinical Questionnaire	6	4

Community Acquired Pneumonia
Date Publication: Winter 2023

	Requested	Submitted
Case notes	8	8 (100%)
Organisational Proforma	1	1 (100%)
Clinical Questionnaire	8	3

Crohns Disease
Date Publication: Spring 2023

	Requested	Submitted
Case notes	1	1 (100%)
Organisational Proforma	1	1(100%)
Clinical Questionnaire	6	1

Maternal, New born and Infant Programme (managed by MBRRACE UK)
Results of the October 2022 MBRRACE Report (based on 2020 data) are:

The results concern stillbirths and neonatal deaths among the 5,779 babies born within Bolton Hospital NHS Foundation Trust in 2020, EXCLUDING births before 24 weeks' gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Type of death	Number	Crude rate	Stabilised and adjusted rate	Comparison to the average for similar Trusts & Health Boards
Stillbirth	20	3.46	3.70 (2.84 to 4.75)	Up to 5% higher or up to 5% lower
Neonatal death	6	1.04	1.54 (0.99 to 2.38)	More than 5% and up to 15% lower
Extended perinatal	26	4.50	5.25 (4.25 to 6.72)	Up to 5% higher or up to 5% lower

The crude mortality rate is the observed rate for the Trust and is a snapshot of mortality for births in 2020. The stabilised & adjusted mortality rate gives a more reliable estimate of the underlying mortality rate taking into account key factors known to increase the risk of stillbirth and neonatal mortality as well as the effects of chance variation, particularly where the number of deaths was small.

While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within Bolton NHS Trust in 2020.
The stabilised & adjusted mortality rates for Bolton Hospital NHS Foundation Trust were similar to, or lower than, those seen across similar Trusts and Health Boards.

Comparing 2019/2020 data

Type of death	Crude rate 2019	Crude rate 2020	Stabilised and adjusted rate 2019	Stabilised and adjusted rate 2020
Stillbirth	4.04	3.46	4.01 (3.42 to 4.81)	3.70 (2.84 to 4.75)
Neonatal death	1.35	1.04	1.60 (1.02 to 2.55)	1.54 (0.99 to 2.38)
Extended	5.39	4.50	5.59 (4.84 to	5.25 (4.25 to 6.72)

perinatal			7.02)	

Comparison data 2019/2020 demonstrates an overall reduction in stillbirth, neonatal and extended perinatal death rates at Bolton Hospital NHS Foundation Trust during this period of time.

Births at Bolton Hospital NHS Foundation Trust in 2020

- The proportion of mothers aged 35 years old or older is lower than that of the UK as a whole: 19.7% versus 23.8%.
- The mothers were more likely to live in areas of high deprivation than those giving birth across the UK as a whole.
- The proportion of babies of non-White ethnicity is higher than that of the UK as a whole: 30.5% versus 22.8%.
- 24 babies (0.4%) were born at 24 to 27 week's gestational age, similar to the 0.4% seen in the UK as a whole. The percentage of babies born at 28 to 31 weeks is also similar to the national average: 0.8% versus 0.8%. In addition, 101 babies (1.9%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.9%.
- There were 5,779 births in the Trust at 24 week's gestational age or later, excluding terminations of pregnancy. The number of births puts Bolton in the highest third of all Trusts and Health Boards in the UK.

The overall stillbirth rates continue to benchmark well against regional (Greater Manchester & East Cheshire) rates.

Year	Bolton per 1000 births	GMEC per 1000 births
2020	4.50	4.55
2021	4.31	4.57
2022	3.46	4.38

The overall early neonatal death rates continue to benchmark well against regional (Greater Manchester & East Cheshire) rates.

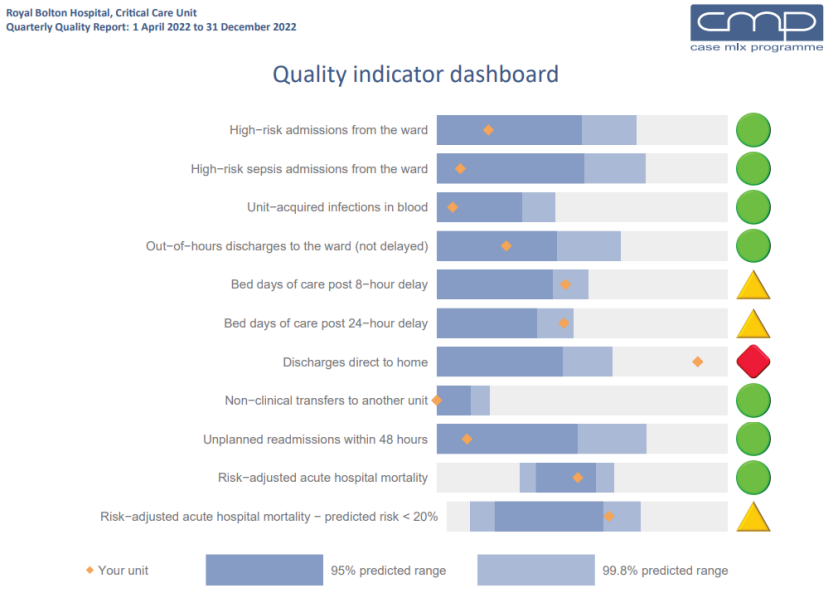
Year	Bolton per 1000 births	GMEC per 1000 births
2020	0.87	1.78
2021	1.21	1.63
2022	0.73	2.21

The Division continues with all of the national maternity quality and safety initiatives designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths:

- Saving Babies Lives Care Bundle
- Ockenden repport
- NHS resolution maternity incentive scheme
- Maternity and Neonatal Safety collaborative
- Each Baby Counts
- Kirkup Report
- Improving Equity and Equality in maternity and neonatal care.
- Tommy's app

National Clinical Audits: Actions to Improve

The reports of 29 national clinical audits were reviewed by the provider in 2022/23 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Project Name	Actions
Case Mix Programme (CMP) ICNARC	This programme has 11 Quality indicators; the trust is within or below the 95% predicted range for 7 of the Quality indicators. For 3 of the Quality indicators the Trust is above the 95% predicted range but within the 99.8% predicted range. For 1 of them the Trust is above the 99.8% predicted range. 
Royal College of Emergency Medicine QIPs	There were 3 RCEM publications in 2022 for the following audits: **Infection Control (March 2022):** Compliant with all three standards, no action required. **Pain in Children (March 2022):** Compliant with all three standards, performing above national average – QI project followed and increased performance further. **Fractured Neck of Femur (June 2022):** Compliant with three of the four standards, slightly below compliance with the third standard: *Standard 3: Patients should have an X-ray at the earliest opportunity* Average time to x-ray104 minutes 48% within 90 minutes National average time 94 mins National average within 90 minutes 56% (43% in 120 minutes) Action required: Below the national average but not by much, crowding and radiology delays contribute to this. Nurses have been trained to order from triage hence improvements in the last 3 years Huge gains from 2017/2018 The audits below have recently closed QA 21/22; the national reports from RCEM are awaited: • **Infection Control** (October 2021 – October 2022) • **Pain in Children** (October 2021 – October 2022) • **Consultant Sign-Off** (October 2021 – October 2022) The audits below are ongoing/not yet started nationally:

	• **Assessing for cognitive impairment in older people** (April 2023 – October 2023 • **Mental Health self-harm** (3 October 2022 – 3 October 2024)
Falls and Fragility Fracture Audit Programme (FFFAP)	**FFFAP Inpatient Falls** **Specific actions from this national audit include;** • Ensure your trust or health board participates in NAIF by registering and providing audit data. • Do not use screening tools to identify people at high risk of falls. • Instead, offer a multi-factorial falls risk assessment (MFRA) to those over 65, and others over 50 who may be at higher risk. • Assessment and provision of appropriate walking aids must be available for all newly admitted patients, 7 days a week • Ensure availability on all sites of equipment to safely move patients with suspected spinal injury or hip fracture from the floor. • Record inpatient hip fractures as 'severe harm' in national reporting and learning systems. • Ensure your trusts or health board has a patient safety group which: o includes falls prevention in its remit o is overseen by a member of the executive and non-executive team o regularly reviews data on falls, harm and deaths o assesses their practice against the trends in falls, harm and death rates from falls and reports and discusses these outcomes with the board. • Ensure training in the assessment, prevention and management of inpatient falls is provided for relevant staff groups. The Trust is compliant against all of the above recommendations.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **- Children and young people asthma combined clinical and organisational audit**	Local Actions for this National Audit Include; • **Identify improved ways of sharing smoking cessation information and keeping this up to date.** The CURE Team review all smokers identified by Nurse or Doctor on admission/clerking document, and offer support to patients who want temporary abstinence from smoking which is established on first contact with patient. The team also discuss harm reduction if the patient declares they want to reduce the amount of cigarettes they smoke, ensure all smokers are offered and provided with Pharmacotherapy to help with nicotine withdrawal and or temporary abstinence. • **Feed back to the ward the need to improve sending patients home with personalised action plans and documentation around this**. The CURE Team ensure Nicotine Replacement Therapy is prescribed when they are inpatients, and are referred for support on discharge. • **Local work to improve asthma discharge bundle**. The CURE Team undertake a 4-week follow-up after the quit date via telephone, unable to facilitate NICE Guidance recommendation for

	the use of a carbon monoxide test post 4-week follow-up at the present. Child and Young Person Asthma 2021 Organisational Audit: Summary report published September 2022. Gap Analysis completed and received and shared with all relevant– ongoing local CYP asthma workshops to address particular points, pre-existing QI work for some points; discussion in Acute Paediatric Specialty Governance meeting.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **- Adult Asthma & COPD** **- Pulmonary Rehabilitation Audit**	**Adult Asthma & COPD Secondary Care:** The recommendations from the latest report (Adult asthma and COPD 2021 organisational audit report) are for both of the national audits. Gap analysis for the Adult asthma and COPD 2021 organisational audit report received on 15/03/2023 - of the seven recommendations in the report, four of the recommendations are applicable to the Trust and the Trust is compliant with these. Gap analysis attached to Safeguard as evidence of compliance. Recommendations: • R2: Make 7-day respiratory specialist advice available to all patients admitted with an asthma/COPD exacerbation. This recommendation is for service providers and clinical teams - COMPLIANT • R3: Have designated clinical leads in place for both asthma and COPD. This recommendation is for service providers - COMPLIANT • R6: All centres which accept transfers of care from paediatric services should put in place all five components of a transition service. This recommendation is for commissioners, service providers and clinical teams - COMPLIANT • R7: All services reviewing patients with severe asthma, and commissioners of these services, who are not already members of a regional network must develop referral pathways to a commissioned severe asthma service to ensure that all patients have access to a severe asthma MDT. Leadership for this should come from regional respiratory networks in England. In addition, the NHS Accelerated Access Collaborative consensus pathway in England is working to define clinical standards for pathways of care that span primary, secondary and tertiary care for patients with suspected severe asthma, as well as improving access to diagnostics for patients with suspected asthma. - COMPLIANT **Pulmonary Rehab:** Pulmonary Rehab has restarted after COVID, and the respiratory admin team are awaiting the audit forms that have been completed for the last few cohorts. This has been delayed due to sickness, but should be getting them across to input shortly. The National Asthma and COPD Audit Programme (NACAP) has published its latest report into pulmonary rehabilitation. There are 7 recommendations. A gap analysis was completed and returned o

	15/03/2023, the Trust's current compliance with the recommendations are detailed below: Recommendations: • R1: To drive improvement in care, NACAP urges commissioners, service providers and clinicians to review the way in which they provide pulmonary rehabilitation and work together to effect service-level change by implementing the individual recommendations highlighted in this report. - NOT COMPLIANT: Service not currently not meeting waiting time targets – plan to cleanse waiting list and increase assessment/class capacity. • R2: Provide PR to all people with a COPD self-reported exercise limitation (MRC grade 3–5) This recommendation is for service providers and clinical teams - COMPLIANT • R3: This recommendation is for service providers Service providers offering home-based pulmonary rehabilitation should ensure that the intervention is guided by the best available evidence and includes comprehensive initial and discharge assessments (including exercise capacity). For recent guidance on delivering PR, read the American Thoracic Society (ATS) paper Defining modern pulmonary rehabilitation - NOT COMPLIANT: Service currently only offering centre based rehabilitation due to current staffing resource. Future plans include offering homebased rehab option in addition to centre based rehab. Once staffing resource is available we would ensure that current evidence based guidelines are followed. • R4: If a 6MWT (6-minute walk test) is being used to measure exercise capacity, use a 30-metre course to adhere to technical standards This recommendation is for service providers and clinical teams - NOT APPLICABLE: We are using the ISWT. • R5: This recommendation is for service providers and clinical teams Include provision of a written exercise plan as a key element of discharge. To facilitate this: build designated time into discharge assessments for provision of an exercise plan develop a standardised exercise plan that can be customised for each person with COPD - COMPLIANT • R6: All service providers must ensure time for leadership activities is built into job plans for clinical leads, and work with commissioners to identify and assign additional resources where necessary to enable this. - NOT COMPLIANT: Meeting to review team structure and staffing planned for 16/03/23. • R7: Ensure all PR services have an agreed standard operating procedure (SOP) This recommendation is for service providers and clinical teams - COMPLIANT: SOP currently in draft form, aim to submit via clinical governance meeting next month.
National Pregnancy in Diabetes Audit	Local actions from National Recommendations <u>Pre-conception care</u> 1. Better utilization of the pre-conception clinics at BDC. 2. Better glycaemic control (HbA1c < 48 mmol/mol) before conceiving. 3. Better provision of contraceptives 4. Asking patients about their plan for pregnancy at every contact and directing them to appropriate services:

<table>
<tr><td></td><td>a. Primary care: Meeting due tomorrow.
b. Secondary care: EPR documentation already in place.
<u>Antenatal Care</u>
1. Deal with the rising number of pregnant women with Type 2 DM
2. Identify factors leading to LGA babies and address them earlier in pregnancy if possible</td></tr>
<tr><td>National Audit of Breast Cancer in Older Patients (NABCOP)</td><td>The Healthcare Quality Improvement Partnership Benchmarks results by key metrics. Out of the a total of 18 metrics the trust was higher than 90% of Trust in 9 metrics. The Trust was classed as Amber in three metrics when compared to other Trusts;
• Proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit [50-69 years]
• Percentage of patients with NABCOP Fitness Assessment Form data items recorded: Clinical Frailty Scale [70+ years]
• Percentage of patients with NABCOP Fitness Assessment Form data items recorded: Abbreviated Mental Test Score. [70+ years]
The Trust has an action plan in place to improve the three amber metrics.</td></tr>
<tr><td>National Audit of Cardiac Rehabilitation (NACR)</td><td>Assessment Breakdown Summary Report for Bolton QA 22/23 below-
Number Starting Core Rehab: 212
Number Valid Assessment 1 (before Rehab): 211
Percentage of Started with Assessment 1: 100%
Number Valid Assessment 2 (after Rehab): 164
Percentage of Started with Assessment 2: 77%

Following the publication of the NCP_CR 2022/23 report, Bolton's cardiac rehabilitation programme has been certified as Green and has been awarded National Certification. It will retain this status until the date of publication of the next (2023/24) NCP_CR results.</td></tr>
<tr><td>National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td><td>The last data published for Epilepsy12 was 2021and a summary of the Bolton issues and lessons learnt was received in February 2022.
Actions included:
Actions
• Restart QOL clinics (nurse led virtual)
• revamp transition clinics to include YP clinic
• introduce epilepsy passport (care plan)
• improve school IHP system
• Revisit BPT
• further info re ECG / 1st paediatric assessment data</td></tr>
<tr><td>National Cardiac Arrest Audit (NCAA)</td><td>Total number of team visits recorded for QA 22/23 is 63, please see breakdown of monthly denominator data below:

<table><tr><td>Quarter 1-
April 2022: 5
May 2022: 3
June 2022: 6</td><td>Quarter 2-
July 2022: 8
August 2022: 3
September 2022: 8</td></tr><tr><td>Quarter 3-
October 2022: 5</td><td>Quarter 4-
January 2023: 5</td></tr></table></td></tr>
</table>

	The November 2022: 8 December 2022: 7 February 2023: 5 March 2023: 1 number of team visits recorded also correlates with the total number of 2222 calls solely for cardiac arrest, which means that all team visits recorded were for cardiac arrests. Latest report data from NCAA (period of the latest report only covers 01/04/2022 - 30/09/2022, figures will be updated when more complete data is published) Reported number of admissions to your hospital: 37,262 Reported number of 2222 calls solely for cardiac arrest: 33 Number of team visits recorded: 33 Number of individuals: 33 Number of team visits to the ward recorded: 19 Number of individuals: 19 Number of potential non-arrests: 1 All 2222 calls that result in a patient having chest compressions has a RCA undertaken by the parent team as well as the incident itself being included in the NCAA. The RCA is then reviewed a panel of clinicians at a validation clinic. These findings are demonstrated above in the Annual Totals. The Monthly data is presented to the organisation via the Clinical Governance committee and also the Mortality Reduction Committee. Areas of concern are as follows and these have been identified following RBH Cardiac Arrest Data: Patients who in-spite of their complexity and multiple co morbidities were to be resuscitated, were for CPR And those whom had an appropriate DNA – CPR decision in place and were resuscitated / had chest compressions. The common theme is communication. • Reluctance to undertake DNA- CPR discussions • Lack of understanding of the DNA – CPR policy - Understanding this is a medical decision • Difficulty in identifying that patients are approaching end of life. • Poor communication within teams that patient in their care were not for CPR.
National Cardiac Audit Programme (NCAP) **-Myocardial Ischaemia National Audit Project (MINAP)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 215. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 30 June 2023. There is a backlog of MINAP forms that need to be entered, going back to admissions in Sept 2022. An extension was requested from NICOR on behalf of cardiac rehab team on 27/01/2023; response received 30/01/2023 advising that an extension cannot be given, but

	encouraged to input missing data so that it will show next year. Cardiac rehab team have been informed. Management of Heart Attack 2022 Summary report [MINAP] was published with 9 recommendations. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1. In the management of STEMI, staff in hospitals where Call-To-Balloon time standards are not being met should work with partner Ambulance Trusts, emergency departments, neighbouring non-interventional hospitals and cardiologists to better understand delays in provision of primary PCI. This may include making improvements to the hospital response to the arrival of a patient but may also focus on ways to improve pre-hospital Call-To-Door times. Since the end of the present annual audit cycle significant pressures on the ability of Ambulance Trusts to hand over care of patients upon arrival at hospital may further adversely affect this metric. 2. In the management of both STEMI and NSTEMI, staff in hospitals with lower rates of provision of an echocardiogram should undertake a review of data collection processes – to ensure that the reported rate accurately reflects practice – and then review the patient pathway to identify opportunities for echocardiography during the index admission. Consideration should be given to performing a limited 'bedside' echocardiogram if there are difficulties obtaining timely detailed 'departmental' studies. Where patients are discharged early to another hospital before an echocardiogram can be performed there must be a clear request to perform the test at the receiving hospital. 3. Those hospitals not reaching recommended levels for admitting patients with heart attack to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those nursed outside cardiac facilities. 4. Those hospitals with low rates of cardiology involvement in the care of patients with heart attack should undertake a review of their data collection processes – to ensure that the submitted data reflects practice. If it does, there should be consideration of improved provision of cardiac care during admissions. This might require increased staffing or more flexible use of members of the cardiology team – for example Nurse Specialists and Physician Associates. 5. Those hospitals with low rates of angiography in eligible NSTEMI patients should perform a review of their systems of data collection and submission, and their systems for managing acute coronary syndromes (ACS). 6. In those hospitals where the 72-hour quality standard for angiography following admission with NSTEMI is not met, commissioning groups, managerial and clinical leaders should engage

	in a process of system review, economic appraisal and quality improvement. This may require changes within hospitals, across referral networks and/or in the overall commissioning of services. There should be an emphasis on early reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals; this may involve weekend angiography lists for such patients. Anecdotal reports suggest that since the end of the present annual audit cycle the improvements seen here have not been maintained. Any lessons regarding more timely care that have been learned during the pandemic should be incorporated within plans for post COVID recovery of services. 7. In the management of both STEMI and NSTEMI, staff in hospitals not meeting the standard for prescription of all secondary prevention medication prior to discharge should first explore data completeness and ensure that their data are a valid representation of practice. If suboptimal performance is confirmed quality improvement programmes should be implemented. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or 'ACS nurse specialists'. 8. Staff in those hospitals with lower rates of prescription of aldosterone antagonists should ensure that patients with impaired LV function are identified by echocardiography (or some other reliable assessment method) and that such patients are considered for appropriate treatment. This might require the use of discharge pro-forma or checklists and the direct involvement of specialist cardiac pharmacists, 'ACS nurse specialists' and specialist sonographers. 9. Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI should review the provision of services and identify early patients who might benefit. This could include routine distribution of cardiac rehabilitation information/invitation leaflets to all patients admitted to cardiac facilities, and the inclusion of such information in discharge checklists. All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices.
National Cardiac Audit Programme (NCAP) **-National Heart Failure Audit (HF)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 461. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 8 June 2023. National Heart Failure Audit 2022 Summary report was published with 5 recommendations. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1. Hospitals not achieving the recommended standard of the use of in-patient echocardiography for patients with acute heart failure should

	urgently review their clinical pathways and ensure that echocardiography is performed and ideally within the first 48 hrs of admission. 2. Hospitals should ensure that high-risk cardiac patients have access to a cardiology ward. Heart failure patients are often those in the highest risk groups. 3. Hospitals not achieving the standards for ensuring a patient with acute heart failure is managed on a cardiology ward or seen by a heart failure team should review their pathways of care and consider a quality improvement programme to improve on their current performance. Hospitals that do not have a clinical lead for Heart Failure should appoint one: ideally a consultant cardiologist with sub-specialty training in heart failure. Hospitals that do not have access to specialist heart failure nurses within their hospital team or in the community should urgently seek to appoint them. 4. Greater attention is needed to ensure all patients with HFrEF receive the disease-modifying drugs that they should be on unless there is a contraindication. This can be increased by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made. 5. More attention to follow-up arrangements is required so that patients are referred for Cardiology & Specialist Heart Failure Nurse follow-up, ideally leaving hospital with their first appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for heart failure patients.
National Cardiac Audit Programme (NCAP) **-National Audit of Cardiac Rhythm Management (CRM)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 273. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 30 June 2023. National Audit of Cardiac Rhythm Management 2022 Summary report was published with 1 recommendation. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1-The fall in procedure numbers has been largely a result of the pandemic, and not within the control of specialists. However, doctors who have become de-skilled should consider undertaking procedures jointly with colleagues, especially for complex or high-risk cases. Those persistently undertaking very small volumes of procedures should examine whether this is sustainable, as should their hospitals. No new recommendations for catheter ablation procedures, the fall in implant rates has not been within the control of the hospitals. In recent

<table>
<tr><td></td><td>years, few NHS Adult hospitals have been significantly below the standards.</td></tr>
<tr><td>National Diabetes Audit – Adults</td><td>National Diabetes Continuous Harms database
Monthly submissions to NDHARMS
Since the Audit commenced there have been a totals of n77 harms. This figures were 57 2021/2022

There were 21 harms in 2021
There were 23 harms in 2022.
(Hypos – 19, Hhs – 2,) Dka -2

National Diabetes Foot care Audit (NDFA)
Monthly submissions to NDFA
226 new entries (i.e. new diabetic foot ulcers assessed by the diabetes podiatry team) between 01/04/2022 – 01/04/2023.</td></tr>
<tr><td>National Emergency Laparotomy Audit (NELA)</td><td>The Healthcare Quality Improvement Partnership Benchmarks results by key metrics. Out of the a total of 6 metrics the trust was higher than 85% of Trust in 3 metrics. The Trust was classed as Amber in 2 metrics when compared to other Trusts;
Crude proportion of high-risk cases (≥5% predicted mortality) with consultant surgeon and anaesthetist present in theatre AND admitted to critical care post-operatively
Crude proportion of patients aged 80 and over OR aged 65+ and frail (CFS>=5) who were assessed by a consultant geriatrician</td></tr>
<tr><td>National Gastro-intestinal Cancer Programme</td><td>The National Oesophago-Gastric Cancer Audit report published on in January 2023 made 7 recommendations. Of the 7 recommendations made 5 where applicable to the Trust.
<table>
<tr><th>n</th><th>Recommendation</th><th>Compliant</th><th>Comment</th></tr>
<tr><td>1</td><td>Review patients diagnosed with stage 4 disease to identify opportunities for earlier detection</td><td>Y</td><td>During the Surgical Multi-Disciplinary meetings (SMDT) previous investigations are always checked as part of our learning</td></tr>
<tr><td>2</td><td>Review patients diagnosed after emergency admission and undertake root cause analysis where appropriate to identify opportunities to reduce rates of emergency diagnosis.</td><td>Y</td><td>Reviews are a routine part of SMDT discussion</td></tr>
<tr><td>3</td><td>Review the oesophago-gastric cancer care pathway and identify ways to reduce the proportion of patients waiting more than 104 days from referral to first treatment.</td><td>Y</td><td>All 104 breachers go through detailed review with Trust Cancer Lead</td></tr>
<tr><td>6</td><td>In regions with high rates of surveillance or non-treatment, review whether patients with high grade dysplasia are being considered for endoscopic treatment, in line with current BSG recommendations.</td><td>Y</td><td>This is part of our SMDT</td></tr>
<tr><td>7</td><td>Review data collection practices for NOGCA and improve case ascertainment in regions where this is low.</td><td>Y</td><td>This is part of our AGM every 12 months</td></tr>
</table></td></tr>
<tr><td>National Joint Registry</td><td>The National Joint Registry Centre Website on the Surgeon and Hospital Profile page for the Trust highlights 5 Quality Measures. The Trust preformed 'Better than expected' in 2 measures and 'As Expected' in the remaining 3. The building of two new modular theatres will improve the experience for our patients, by cutting wait times & increase clinical capacity.</td></tr>
</table>

National Maternity and Perinatal Audit	Gap Analysis received 03/02/2022- Complaint with R1 - R4 Lead Responsibility Lisa Hall BI Senior analyst/Sharon Lord Digital Midwife Data items come from E3 Euroking Digital MIS (maternity information system) There is also some neonatal data items on BADGER NET. NIS (Neonatal information system) R1 Maternity service providers, NHSE&I and national organisations responsible for collating and managing maternity datasets in England should work together to identify how to support individual NHS trusts to meet the criteria for complete monthly data submissions to MSDS. R2 National organisations across England, Scotland and Wales that are responsible for collating and managing maternity datasets should work with NHSE&I, maternity information system suppliers and maternity services, as well as with organisations responsible for neonatal datasets, to improve capture and recording of maternal and neonatal data items. Where data sources have been insufficiently complete to report results, or where results suggest there may be data quality issues, maternity service providers, maternity information system suppliers, NHSE&I and those responsible for collating and managing maternity datasets should work together to improve completeness and accuracy of the data items required for these measures: - birth without intervention - smoking at booking and at the time of giving birth - breast milk at first feed, and at discharge - skin-to-skin contact at birth and for these data items used in the case-mix adjustment (English data only): - previous caesarean birth - BMI - smoking at booking and at the time of giving birth Organisations responsible for collating and managing maternity datasets in England (NHS Digital) and Scotland (Public Health Scotland Data and Intelligence) should use the 'NMPA Measures - Technical Specification for births from 1 April 2017' to align data items (to 0-500 ml, 500-1000ml, 1000-1500 ml, >1500 ml) for postpartum blood loss to enable measurement of the rate of major postpartum haemorrhage of over 1500 ml
National Neonatal Audit Programme (NNAP)	The Team regularly discuss the key quality indicators from NNAP audit in their monthly neonatal Quality forum meetings and via dashboard at the iPM meetings. Update 19.10.2022 NNAP 2020 Report published 10.03.2022 What we have done in response to our NNAP 2020 data results: Improve our data entry on Badger: We have created a monthly focus on data entry into badger and have created an Optimisation multi-

	disciplinary team This has significantly improved our data and our figures for 2021 show above average results for most indicators (see our 2021 data displayed). We discuss the monthly badger data in our teaching sessions with trainee doctors, medical staff and ANNPs to ensure correct data entry A focus of Optimal cord management along with temperature control at delivery has improved the thermal support provided to preterm babies at birth so that their temperature on admission is within the normal range. Early breast milk feeding and improving breast feeding at discharge: A new quality improvement project lead by a band 7 on NNU along with breast feeding support team and mhas significantly improved our early breast milk feeding rates. Work is ongoing to sustain this through to baby's discharge from NICU. We have presented our work on breast feeding support to other units in the country through regional and national study days To optimise the respiratory support provided to preterm babies and improve the rates of BPD, we have introduced an alternate way of administering surfactant to preterm babies (Less Invasive Surfactant Administration – LISA) since March 2020 and we are looking into expand this into early use in delivery suite soon after baby's birth (something along these lines) Our current areas of quality improvement focus are: BPD QI project: Guideline on early respiratory management for babies <32 weeks in progress (in keeping with NICE guideline); October 2022 Delivery room CPAP along with LISA (Less Invasive Surfactant Administration – LISA) on delivery suite project to start in November 2022 Discussion on Postnatal steroids in grand rounds for babies ventilated in the second week of life Early breast milk feed project: Monthly dashboard to monitor progress 2 year follow up data: join the network meetings set up by NWODN to improve our 2 year follow up and data collection
National Paediatric Diabetes Audit (NPDA)	The latest report NPDA Parent and Patient Reported Experience Measures (PREMs) 2021 was published in September 2022. Fully compliant with all 8 recommendations. Paediatric Team have discussed the recommendation in their MDT away day and plan to present at the governance meeting. The outcomes were very good and generally above national and regional averages and also above our own data from 3 years ago. The Team have a poster produced and will try and put this up in outpatients. The only issue it has highlighted is a lack of awareness around who is present in MDT clinics and what support can be

	requested. The Team are making plans to have a board up in the initial nurse review room, in addition, also making plans to improve access to the survey next time as the numbers were quite low for our patients, whilst parents were adequate.
Perinatal Mortality Surveillance Report (PMSR)	New report published 2022. Report and gap analysis sent to Neeraja Singh to complete within the 3-month deadline A sample of Gap Analysis compliance results below: **Recommendation:** Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist. Trust Compliance: Partially compliant **Action:** Update guideline to include placental histology for all babies admitted to NNU. Updated guideline to be discussed at CDS staff huddles **Recommendation:** Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population Trust Compliant: No **Action:** Add to 22/23 audit plan and complete audit **Recommendation:** Develop public health initiatives to address issues linked to high risk populations Trust Compliance: Yes **Comments:** The following are embedded in process - Smoking cessation services and BMI guideline in place. Vaccine administration, BCG complaint. Proposal to implement public health midwifery team to include: Bariatric clinic, Parent craft sessions, Alcohol drug service **Recommendation:** Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are monitoring their impact on reducing preterm birth. Trust compliance: Yes **Comments:** Saving Babies lives care bundle fully implemented and audited. Lead Consultant and Midwife for pre term prevention. Specialist pre term clinic in place **Recommendation:** Ensure that there is a multi-agency targeted approach affecting women living in areas of high socio- economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway. Trust Compliance: Yes – multiagency approach across all points of pathway as appropriate.

	Recommendations: Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision. Trust Compliance: Yes **Comments:** Cultural Liaison Midwife in post
Sentinel Stroke National Audit Programme (SSNAP)	National Average Overall Audit Compliance Band: A National Average Overall Audit Compliance Score: 92.8 From the Sentinel Stroke Audit Programme Annual Report 2022, which uses recommendations from NICE NG128 (Stroke and transient ischaemic attack in over 16s: diagnosis and initial management), the Trust is compliant with all recommendations as per the completed baseline assessment tool provided by Dr G Halstead. This also includes the updated guidance for NG128 regarding the new recommendations related to hypertension management, which we follow and are also being incorporated in the new guidelines for stroke prescribing.
The Trauma Audit & Research Network (TARN)	Data quality report for Quality Accounts 2022-23: Case ascertainment percentage for this time period: 24 - 29% Number of cases submitted: 110 Data completeness is the percentage of cases submitted to TARN compared to the expected number derived from the HES dataset. Accreditation percentage for this time period: 74.5% Patients with chest wall injuries- Number of patients: 33 Number of >3 Rib Fractures: 5 (15.2%) Number of Operations: 0 (0.0%) Number of chest wall fixations: 0 (0.0%) Number of Over 65s: 23 (69.7%) Seen by pain team: 0 (0.0%) Risk 4836 update: TARN staff member having to support with 12-hour breach analysis so this will remain as a risk until the new breach process is in place. TARN staff member needs to undertake training from TARN courses, awaiting new TARN course dates. Risk target completion date is 01/03/2023, currently flagging as overdue on the risk register.
Inflammatory Bowel Disease National Clinical Audit Project	The latest quarterly report (published October 2022) shows that 87% of patients whose disease activity was assessed as severe at the start of their biologic treatment had improved at three months, whereas smaller proportions of patients whose disease was less severe showed improvement (71% and 50% respectively for those with moderate and mild activity). Audit Summary 2019 - 2022 for Royal Bolton Hospital KPI trends from the report published on 20/04/2023, below- (% = Performance) KPI 1: Was the patient screened before starting on a biological therapy? (For KPI 1, only biologic naïve patients are reported, so the numbers represent a subset of all biologics starters)

	2019: Bolton 98% - National Average 69% 2020: Bolton 99% - National Average 71% 2021: Bolton 99% - National Average 74.2% 2022: Bolton 99.1 - National Average 76.7% KPI 2: Was a formal assessment of disease activity recorded at the point the decision was made to commence a biological therapy? (Physician Global Assessment - PGA - not included) 2019: Bolton 40% - National Average 40% 2020: Bolton 55% - National Average 40% 2021: Bolton 58.5% - National Average 37.4% 2022: Bolton 58% - National Average 36% KPI 3: Was a formal assessment of disease activity recorded at the point the decision was made to commence a biological therapy? (PGA included) 2019: Bolton 96% - National Average 64% 2020: Bolton 98% - National Average 67% 2021: Bolton 93.2% - National Average 63.1% 2022: Bolton 91.5% - National Average 61.9% KPI 4: Did a post induction review take place? 2019: Bolton 43% - National Average 39% 2020: Bolton 47% - National Average 41% 2021: Bolton 49.5% - National Average 41% 2022: Bolton 49.8% - National Average 41.6% KPI 5(a): Was a formal assessment of disease activity recorded at the post-induction review? (PGA not included) 2019: Bolton 83% - National Average 42% 2020: Bolton 87% - National Average 40% 2021: Bolton 87.1% - National Average 38.7% 2022: Bolton 88.2% - National Average 38.3% KPI 5(b): Was a formal assessment of disease activity recorded at the post-induction review? (PGA included) 2019: Bolton 96% - National Average 63% 2020: Bolton 96% - National Average 64% 2021: Bolton 96% - National Average 62.3% 2022: Bolton 96.4% - National Average 61.6% KPI 6: Did a 12-month review take place? 2019: Bolton 62% - National Average 34% 2020: Bolton 65% - National Average 36% 2021: Bolton 61.9% - National Average 35.2% 2022: Bolton 57.7% - National Average 34% KPI 7(a): Was a formal assessment of disease activity recorded at the 12-month review? (PGA not included) 2019: Bolton 83% - National Average 46% 2020: Bolton 84% - National Average 46% 2021: Bolton 77.1% - National Average 40.1% 2022: Bolton 77.3% - National Average 38.8%

	KPI 7(b): Was a formal assessment of disease activity recorded at the 12-month review? (PGA included) 2019: Bolton 91% - National Average 65% 2020: Bolton 92% - National Average 67% 2021: Bolton 84.3% - National Average 60.8% 2022: Bolton 83.5% - National Average 59.4%
National Early Inflammatory Arthritis Audit (NEIAA)	Bolton NHS trust have been listed as an outlier for the National Inflammatory Arthritis Audit for NICE Quality Standard 2 which is that 'the patients with suspected inflammatory arthritis need to be seen within 3 weeks of referral via the GP'. There is improvement work within Rheumatology of which EIA is part and is currently on the risk register. •The Rheumatology Team are continuing to recruit to the NEIA - Medical clinicians are recruiting suitable patients in clinic if/when time permits. The time constraint in clinic has been highlighted in Rheumatology meetings, and enquiry & response re potential support from Clinical Audit is pending. MP to meet with Rheumatology Steering Group to discuss (November 2022). •Identified EIA/urgent slots (3 per substantive consultant post/week) Since around Aug/Sept'21 new template set up to improve waiting time - Protected EIA slots in place within medical job plans, but currently insufficient capacity (October 2022) •Current waiting time for EIA appointment is 10 weeks as of 18/3/22 (National guideline - 3 weeks) - As of 19/10/2022, length of wait has increased to 14 weeks. •New Consultant business case for EIA service –- ICSD is currently working with BI to undertake an in depth capacity vs demand analysis for Rheumatology to highlight establishment shortfalls if any (medical, nursing etc.) to support the identification of true staffing requirements. Separately, as part of the Rheumatology QAC steering group, work is being undertaken by team stakeholders that will review current service provision and potentials for increasing existing medical capacity through redesign. Request made to clinical lead October 2022 to consider increasing overall capacity as well as swapping existing routine capacity for additional EIA capacity.
Society for Acute Medicine Benchmarking Audit (SAMBA)	SAMBA22 data collection started 23rd June 2022 and ended on 19th August 2022. Bolton submitted 71 cases total for this national audit. Bolton's report was produced on 17 October 2022 and is attached to Safeguard. It shows that Bolton's service is compliant with the national average. Report findings below- PATIENT POPULATION: Percentage of unplanned admissions with NEWS2 score of 3 or more: Average: 29% Bolton: 32%

	Percentage of unplanned admissions aged 70 years or older: Average: 50% Bolton: 44% Referral source for unplanned admissions: Average percentage GP referrals: 20% Bolton: 22% Percentage of unplanned admissions who had been in hospital in prior 30 days: Average: 20% Bolton: 22% EARLY WARNING SCORES: Percentage of unplanned admissions with Early Warning Score recorded within 30 minutes of hospital arrival Median unit performance: 75% Bolton: 86% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 80% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% FIRST CLINICIAN REVIEW: Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival Median unit performance: 82% Bolton: 81% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 73% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% Percentage of unplanned admissions with consultant review (if required) within the target time Median unit performance: 52% Bolton: 50% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 38% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% Percentage of unplanned admissions arriving during the daytime (08:00-20:00) with consultant review within the target time (6 hours) Median unit performance: 41% Bolton: 47% Percentage of unplanned admissions arriving overnight (20:00-08:00) with consultant review within the target time (14 hours) Median unit performance: 80% Bolton: 57% Percentage of unplanned admissions discharged without overnight admission Median unit performance: 28% Bolton: 41%

British Thoracic Society	National Improvement Objectives: 1. A validated risk stratification score should be recorded in the notes of all patients managed on an OP PE pathway. Target 90% Each centre should ensure a validated risk score (most commonly PESI or sPESI) is mandated in their PE management guideline. PESI/sPESI should be easily accessible and visible within EDs/AMUs, and the scoring system should be added, where possible, to clerking proformas. 2. Initial anticoagulation should be administered within 1 hour of clinical suspicion of PE, unless diagnostic investigations occur within the first hour. Target 90% Each centre should ensure that this timescale is mandated in their PE management guideline. Electronic radiology requesting systems should include guidance to administer initial anticoagulation unless imaging will be performed within the hour. 3. All patients should receive written information including emergency contact details and follow-up within 7 days of going home. Target 90%. Each centre should ensure that easily accessible printed patient information including emergency contact details is available. Follow-up (face to face or remote) within 7 days of going home should be booked. Timeline: 18 months from report publication - February 2024.
National Audit of Care at the End of Life (NACEL)	Fourth round of the audit (2022/23) bespoke dashboard was received in February 2023. Action Development of a business case to add 8a to the team to move from advice/liaison service to a proactive decision making service and see these patients early and role model AC – **Completed recruitment underway March 2023** Lack of complete holistic individualised assessments - Re-develop an electronic record of Care
National Audit of Dementia (NAD)	This national audit (Round 5) has now been completed, as of 06/02/2023. It is on the QA 2023-24 list and is due to recommence (as Round 6) in August 2023. Details from Round 5 below- Case-note Audit Part 1: There were 58 patients submitted for the auditing period 19th Sept 2022-14th Oct 2022. Case-note Audit Part 2: information about assessment and planning was completed ahead of the deadline of 3 January 2023. The annual dementia statement has also been completed, which also had the same deadline. Case-note Audit Part 3: details of the patient's discharge date/date of death, the deadline was 24 March 2023, this has been completed on 06/02/2023. Carer Questionnaires: 4 questionnaires were completed by carers who posted them back to the Royal College of Psychiatrists.

	Patient Feedback Questionnaires: 32 total questionnaires submitted to the NAD Patient Feedback Tool.

Local Clinical Audits

216 local clinical audits were registered and reviewed by the provider in 2022/23 and Bolton NHS Foundation. The breakdown is as follows:

Topic	Count of Request Date
Clinical Interest	14
Clinical Outcome Reviews	4
CQC	3
External Audit	1
Incident (Divisional Review)	3
Incident (SI Review)	11
Inquest	1
Local Standard	18
Monitoring	10
National Regulations	16
NICE Clinical Guidelines (CG)	9
NICE Guidance (NG)	9
NICE Quality Standards (QS)	1
Patient Satisfaction	4
Quality Account Requirement	27
Quality Improvement	58
Record Keeping/Documentation/L	5
Royal College	11
Trust Policy	11
Grand Total	**216**

Local Clinical Audits, examples of learning and actions to improve

Below are some examples of the Trusts completed Local Audits which have taken place throughout the year with identified learning and actions.

Audit title	Learning/Actions
Perinatal mental health	PMH problems carry significant health and social burden for the UK society and timely identification and treatment of these can help reduce the long-term human and economic cost associated with PMH. This fact should constitute an important focus point for policy makers, commissioners, and health care providers. Locally, more attention should be paid to PMH with more resources channeled to provide adequate care for at risk women especially in the current COVID-19 climate associated with worsening PMH indices. Healthcare professionals who work with pregnant women should ensure the promotion of physical and emotional wellbeing of these women in perinatal period.

Ongoing vision care in hearing aided children	**Actions include:** The current questionnaire needs to be amended to obtain more information about vision -Discuss with Regional Audit group re amending the form 2 children not referred for O testing after diagnosis due to Covid-related disruption in clinic -Refer those not tested and those with possible Ophthalmology issues a/c questionnaire
Risk assessment at each Ante natal appointment	The majority of women had a full risk assessment undertaken at booking, however some improvements need to be made particularly around anesthetic assessment, manual handling assessment. **Actions include:** • Findings to be shared with the AN matron, ANC manager, team leaders to be disseminated to midwives • Intended place of birth to be included in E3 antenatal contact section • Formal risk assessment to be included in E3 antenatal contact section
Consultant attendance at difficult births	The audit has identified that consultant attendance in all of the RCOG recommended scenarios is not in line with RCOG recommendations. • Overall there were 2 cases where HDU care was required and both had consultant presence. • 5/7 (71%) of cases of caesarean births <28 weeks' gestation had consultant presence. • 9/10 (90%) of cases of PPH >2 litres had consultant presence. • All cases of twins <30 weeks had consultant presence. There were no cases of: caesarean section for major placenta praevia/abnormally invasive placenta, BMI >50, 4th degree tear, unexpected intrapartum stillbirth or eclampsia in the audit period of time. Whilst evidence was found that in all cases consultant discussion took place, improvement in attendance in C/S<28 weeks and PPH>2 litres is required in order to ensure that optimal clinical standards are provided and to be compliant with RCOG recommendations.
Do we meet the NICE quality standards for a diagnosis and management of headaches in young people <12yrs?	The audit looks at our compliance with NICE guidelines for headaches in the over 12s. Due to numbers, this also included some patients under 10.The main areas that need improvement, highlighted in the initial audit, are documentation around analgesia over-use and documenting the use of the (very good) headache leaflet.
Use of IBD Control PROM to improve post induction follow	The IBD Control results gave a quick PROM result on day of infusions highlighting to staff need for further investigations/review.

up in biologic patients	Results show a good correlation with already established DAS Using the IBD Control highlights patients struggling early, we were able to quickly intervene and switch/optimise treatment quickly. Implementation of the IBD-Control Questionnaire proved feasible and acceptable to patients and staff, with high rates of response and completeness. Using adverse scores to trigger ad hoc reviews allowed treatment interventions that would otherwise have been delayed until clinic follow-up.
Royal Bolton Hospital Trust compliance to NICE and Trust guidance on assessment of stroke/bleeding risk and the choice of anticoagulation newly diagnosed non-valvular Atrial Fibrillation	Edoxaban is now the 1st line recommendation for DOAC in new NVAF (within clinical context) Improvements needed for inpatient documentation regarding: Management strategy- RATE VS RHYTHM CHADSVASC and ORBIT/HASBLED Be careful of UNDERdosing with Apixaban (need two of the outlined criteria) Communication with primary care needs improvement: CHADSVASC/ORBIT AF registry Use opportunities to offer lifestyle advice to AF patients- e.g. lots of documentation of 'high BMI' but no explanations given to the patient as to the implications of this Planning to present it to the acute medical team (date tbc)- see attached summary of data. We will re-audit in December/January.
Dermatology toolkit for Advanced Clinical Practitioners working on ambulatory care unit	55% of these patients were female and 45% were male. Age and gender are important contributions to skin health due to the hormonal status affecting the skin function and structure; after menopause female skin becomes noticeably thinner (Mvitzrovitz er al.,2016). Approximately 94% of the patients referred to dermatology required a follow-up appointment. We can identify positive downward trends in waiting times for appointments pre and post-intervention and although this may be multi-faceted it hopefully reinforces that the referral was required and appropriate.
Improving Headache Assessment on the Ambulatory Care Unit	• Reduction in proportion of females in post-intervention audit reflects a fall in suspected idiopathic intracranial hypertension referrals over Christmas period. This, together with fall in GP and rise in A&E referrals during same period, are potential confounding factors. • Good baseline neurology and red flag assessment. Fundoscopy, however, undertaken infrequently by ACPs and others clerking. COVID, and need to avoid unnecessary close contact, may have been a factor. Further work required to explore issue and improve use. • 8 Significant findings out of 59 patients with red flags suggests good pre-test probability assessment and a reminder that some

	headache presentations may point towards a serious underlying pathology. • 11 red-flag negative patients underwent neuroimaging, with no significant findings – suggesting headroom for greater adherence to guidelines and reduction in non-indicated neuroimaging. • Educational and guideline tool aimed at ACPs was associated with improved knowledge and confidence in headache assessment, indications for neuroimaging and reduced length of stay.
Audit on quality of discharge summaries post percutaneous coronary intervention in patients with acute coronary syndrome	• Among 56 discharge summary, 70 % (n=39) had detail ECG findings and ECG findings were missing in 30% (n=17) of discharge letters. • Results of Trop I were mentioned in 77% (n=43) of discharge letters whereas 23% (n=13) discharge letters didn't have Trop I results. • Echo findings in detail were described in 84% (n=47) of discharge letters and 16% (n=9) of letters were missing Echo Results. • Angiogram findings in detail were written in 86% (n=48) of discharge summary, whereas 14% (n=8) of letters were missing that information. • Out of 57 patients, 79% had PCI and PCI was not indicated in 21% (n=12) people. However, description of PCI was written in 59% (n=33) of letters, whereas 20% (n=11) letters were missing that information. • DVLA advice was given in only 11% (n=6) of people and 89% (n=50) of discharge letters did not include that important information. • Among 57 patients 96% received Dual Anti-Platelets Therapy (DAPT) on discharge. However, DAPT regime was mentioned in 73% (N=41) of letters and 23% (n=13) letters were missing that information. DAPT were not indicated for 4% (n=2) of people. • Only 4% (n=2) people received written advice on secondary prevention and there was no mention of secondary prevention in 49% (n=26). However, 39% (n=21) of people were advised to register on IHD register and 4% (N=2) people were referred to secondary prevention clinic. Secondary prevention was not relevant/applicable in 4% (n=5) of people. • Further stage procedures were mentioned in 7% (n=4) discharge letters and no mention of further stage procedure in 4% (n=2) letters. This is because further stage procedure was not indicated in 89% (n=50) of patients.

A&E Cauda Equina Referrals	Out of 108 referrals from A&E there was 6 confirmed cases which is 5.6% positive rate for Cauda Equina Out of the 108 referrals all the patients had their scan performed and reported within 24 hours All patients were scanned and had report available within 24 hours No breaches Low positive rate of CES Takes approximately 30 mins to scan 51 hours a year scanning where CES was not present A more thorough physical examination is required from referring consultants A study conducted by zusman et al, (2022) concluded a combination of physical examination findings of lower sacral function is an effective means of ruling out CES and with further study, may eliminate the need for MRI is many patients reporting back pain or bladder dysfunction. Offering a 24/7 service for certain types of emergency scan (CES and MSCC) Including bank holidays Implication: Tele-radiologist service will be required Offering a on-call service Needing more MR trained staff Re-audit yearly Audit all routes of referrals for Cauda Equina Syndrome Audit on if physical examination is carried out prior to referral for MRI Follow a standardise referral procedure for MRI CES scans which specifically mentions information about physical examinations that needs to be carried out in clinic. Continue to achieve a 100% standard in scanning all A&E? cauda equina scan within 24 hours as according to the local policies. Re-audit in a year to see the standard is being kept up of scanning all ? cauda equina within 24 hours. In the next audit try to include all ? cauda equina from across the hospital instead of just one area of the hospital.
dignity and care after death	Where we can improve • 88% of patients appeared clean and washed as no distinctive body odour was detected and/or food debris identified. 6/52 patients were identified to have a distinctive body odour. • 23% of patients were a delayed transfer to the mortuary. • Patients hair not combed, 14 Patients were identified to have had their hair combed. 60% had not had their combed. Good practice • 96% of patients were transferred to the mortuary wearing either their own clothes or shroud as per trust policy. • 100% of plastic split sheets were used correctly on our deceased patients.

	• 90% of patients had their arms by their side. • 96% of patients were identified correctly with wrist bands in situ. • 98% of patients were transferred to the mortuary with the appropriate slide sheet in place (orange). • 96% of patients were identified as having no leakage from the cannula site. • 98% of patients had the Notice of Death form completed appropriately. • All of the patients audited across all specialities were checked and identified if they had a pacemaker or ICD. The findings of this report will be fed back and shared at the End of Life Steering Group and discussed with the End of Life Care Educator with how to move forward with training of Care after death and continue to support staff. Share results with ward managers and matrons and Bereavement Ambassadors Mortuary staff will contact the ward/department directly, if the patient appears to have not had care after death completed as per hospital policy or if any concerns are identified i.e. no orange slide sheet in place. The mortuary staff will then inform the bereavement nurse who can offer further training and support if required to the staff and/or ward area. An incident form to be completed for all patients transferred to the mortuary not achieving the standard of the policy. Care after Death training sessions will continue. Discussions with EOLC Steering Group executives to ensure Care after Death stays on the Care Certificate Training Programme.
Abdominal Radiographs : Learning by our practice	Improvements could be made to our practice as radiographers. This could be achieved by: -Simply asking patients if they are able to transfer to the table for imaging due to higher doses associated with images taken on trolleys (free detector). -By achieving better centred 1st images, ideally including Symphysis Pubis to avoid re-radiation over this sensitive area. -CPD given in the form of a presentation/ email slides to radiographers to help understand where we could do better, particularly of the need to palpate patients when centring. -A poster on abdominal technique within the department demonstrating essential image criteria. Further work 1.A re-audit in a year to see if there has been a significant change in the quality of images/ greater compliance to DRL's, addressing some of the limitations of this audit. 2.For example, a separation of data for ?Perforation /?

	Obstruction where an erect chest is also performed, look at the effect this has on the data for image analysis. 3.Further audit of LMP documentation to see if the results found in this audit are representative. Standard 1: Results within National Dose Reference Levels -70.9% of examinations were within the National DRL of 250uGycm2. -Of the 29.1% above the standard, 56% had a BMI >25 or evident excessive soft tissue on imaging reinforcing the relationship between patient BMI and dose. -Overall average dose has improved on previous years. The average dose for this sample in 2022 was 218.80 uGycm2 as oppose to 214.98uGycm2 (2020) and 266.91 uGycm2 (2021). -Reasons for examinations being above the National DRL include patients imaged on trolleys, rather than on the x-ray examination table, poor centring and cutting off anatomy and subsequent repeats. Standard 2: Image Analysis • Only 2/117 (1.7%) fulfilled all image criteria on 1 film, both of these were within the local DRL. • Looking as standalone images, 14 of the 117 (11.97%) patients completely fulfilled all image criteria • 23% non-compliance for LMP form scanned onto CRIS. • 101/117 images were of adequate exposure • 4 over exposed, 11 under exposed, 1 examination (2 images was a combination of adequate and over exposed) • And only 4/117 had patient artefact. This is positive due to patients attending fully clothed, especially from A&E, and the placement on metal fastenings on hospital pyjamas. • 65% demonstrated the Symphysis Pubis, although less successful demonstrating lateral margins and diaphragm. However, a discussion could be had about how vital these are. For example, if the request is for ? Perforation ? Obstruction, the diaphragm would be included on the accompanying chest film. This is a limitation to the study in terms of image analysis and would be addressed in further audit. • Another example, requests for KUB, or Stents, if the image is diagnostic and Kidneys or Stents can be visualised, is there a need to include the lateral margins of the abdomen or the diaphragm? Standard 2: Image Analysis • Only 2/117 (1.7%) fulfilled all image criteria on 1 film, both of these were within the local DRL. • Looking as standalone images, 14 of the 117 (11.97%) patients completely fulfilled all image criteria • 23% non-compliance for LMP form scanned onto CRIS. • 101/117 images were of adequate exposure • 4 over exposed, 11 under exposed, 1 examination (2 images

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Are we compliant with our Lateral Lumbar Spine DRL's?	Radiographers are not compliant with the national DRL when AECs are used. This can be seen on both AP and Lateral projections. However, compliancy is met when AECs have not been used (on both projections). To deliver CPD sessions to revisit optimum imaging techniques with regards to lumbar spine examinations. This can be done over a lunch break as it will act as a revision session and so should not take too long. This CPD session can held as soon as possible to ensure immediate learning can take place. To re-audit in 12 months to re-assess compliance as this will demonstrate if effective learning has taken place.
Adequacy of images for Skeletal Survey Imaging for Suspected Physical Abuse in Children	It is felt that engagement with our Paediatric colleagues will improve our image quality and reduce the amount of artefact caused by holders anatomy. The production of a departmental guide to skeletal survey imaging may benefit staff and raise awareness of the importance of the image quality for such examinations. Re-iteration of the need to aim for excellent quality imaging regardless of examination length time. Generally, image quality has improved for skeletal survey examinations. However, we failed to meet the target of 80% in 3 of the 4 areas of assessment, and of 75% for overall image quality.
An evaluation into the voice and upper airway profiles of those living with Long COVID	The complexities of SLT needs described highlights the essential requirement of embedded multi-disciplinary working not only to provide the best care for patients, but to critically support the professionals working with individuals with post-COVID voice, swallowing, communication, and upper airway symptoms. The clinical complexities also call for appropriate staffing provision, skill, and training to fulfil the needs of this population. It is acknowledged that nationally there are inconsistencies and inequalities regarding the access and service provision of Long COVID services. It is therefore essential that speech and language therapy is recognised within Long COVID commissioning guidelines that guide service managers and clinicians of the multi-faceted nature of voice, swallowing, communication, and upper airway symptoms.

An evaluation into the voice and upper airway profiles of those living with Long COVID	The complexities of SLT needs described highlights the essential requirement of embedded multi-disciplinary working not only to provide the best care for patients, but to critically support the professionals working with individuals with post-COVID voice, swallowing, communication, and upper airway symptoms. The clinical complexities also call for appropriate staffing provision, skill, and training to fulfil the needs of this population. It is acknowledged that nationally there are inconsistencies and inequalities regarding the access and service provision of Long COVID services. It is therefore essential that speech and language therapy is recognised within Long COVID commissioning guidelines that guide service managers and clinicians of the multi-faceted nature of voice, swallowing, communication, and upper airway symptoms.
Audit of the MAGSEED system in localizing non-palpable breast lesions at Royal Bolton Hospital	Three patients who needed re-excision Two had Magseed placed within tumour or adjacent One had Magseed placed >5mm away from tumour All were IDC with associated DCIS • 100% of impalpable lesions identified at first operation (ABS) • 93.8% of lesions removed completely (6.2% re-excision rate) • 92% of Magseeds placed within/adjacent to tumour • Magseed localization appears to be used safely and effectively in Bolton
Obstetric analgesia response times	Response times overall are good Overnight sometimes there was a solo anaesthetist which occasionally delayed response to requests where they were in theatres or busy with another patient. Documentation in some instances was not accurate
Trial of Magtrace®. in Royal Bolton Hospital as an alternative method to radioactive isotope in sentinel node biopsy in axillary breast cancer surgery.	• Magtrace worked well in small inner tumour more dissection than isotope and needed to be close for signal. However, 2 hot and blue nodes. Need more babcock/thinner retractors/smaller probe • Magtrace provided an alternate option in case where radio isotope was not available (patient DNA, High BP) but was unsuccessful • Lack of focal signal until very close to node, mainly guided by blue dye. • There is a steep learning curve it was acknowledged that the number of cases performed was small and that greater numbers needed to be performed by those clinicians not familiar with the technique before any conclusions could be reached. Mr Pardo suggested that the learning curve for the technique is quite steep and offered to provide support in theatre.
Retrospective Review of Naevus Clinic since it started in Feb 2021	• Standardised care and follow up now undertaken for all patients with a naevus. • More patients being discharged to the care of their own Optometrist with copies of their images as they are low risk and do not need to be reviewed in the HES.

	• Clinicians gaining more experience so fewer low risk naevi being sent for opinions to Liverpool. • Inform High Street Optometrists of the new guidelines so they can monitor more patients and only refer in the ones with MOLES scores of 1 or over for assessment. (Already completed) • Organise meeting with the Chair of Bolton Local Optical Committee to discuss the new guidelines and the possibility of organising a training session next year.
Compliance and Effectiveness of the Tinnitus Handicap Inventory	1We are maintaining high compliance. Continue active monitoring, on-going scores guide treatment and management plans, this will however be carried forward to next audit to ensure compliance and treatment plans booked as appropriate. Post THI not completed. Implementing Evaluation form or when audit base is upgraded implementing TFI (tinnitus functional index to capture date) 2Over the last three months there have been 5 patient's DNA tinnitus follow-up appointments, these patients had not received a letter and were subsequently re-appointed, however there had been no phone call prior to the appointment which was agreed to be implemented in a previous audit. Tinnitus staff to mirror follow-up appointment in the rota prior to appointment to ring patient to remind. 3Capacity for appointment to be increased MA to devise fitting symbol for tinnitus fitting. Implement In-house training for interested Audiology staff in tinnitus THI conclusion We are maintain high compliance with initial THI to implement effective management plan No measure of effectiveness at follow-up. THI part 2 being completed, no measure of data to ensure we are delivering an effective service not capturing Actions Evaluation to be created to be given at follow -up to monitor any changes needed for service delivery Re-audit for effectiveness 2023 DNA Conclusion to many DNA impacting on capacity and cost Actions Audiologist when booking follow-up appointments in the department to improve DNA rate, put shadow alert 3 days prior to ring patient to confirm attendance Re-audit 2023 Good compliance with severe/catastrophic being appointed within 2 weeks Actions Severe/Catastrophic to continue to be given an appointment within 2 weeks to issue hearing aid/combination device. MA to create new tinnitus symbol for capacity with tinnitus staff, role out staff training in house identify audiologist who wish to

	deliver a more formal tinnitus service peer review/appraisal Beaumont patient to have triage appointment within a week a receiving referral letter On staff meeting for office staff. LK to monitor fitting waiting list Re-Audit 2023

Participation in Clinical Research

52 National Institute for Health Research (NIHR) Portfolio Research studies with Health Research Authority (HRA) / Research Ethics approval, were open to recruitment at Bolton NHS Foundation Trust in 2022/23. 2004 patients receiving relevant health services provided or sub-contracted by Bolton NHS Foundation Trust were recruited to participate in research during that period.

Goals agreed with Commissioners: use of the CQUIN payment framework

A proportion of Bolton NHS Foundation Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2022/23 Bolton NHS Foundation Trust received £3.2m of its CQUIN target agreed with commissioners

The operation of CQUIN for Trusts was suspended in 2021/22; the Trust therefore did not to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data.

Further details of the agreed goals for 2022/23 and for the following 12-month period are available on request

Care Quality Commission Registration

Bolton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Bolton NHS Foundation Trust during 2022/23.

Bolton NHS Foundation Trust participated in an unannounced visit to the urgent care centre and medical wards and an announced inspection of maternity services in December 2022.

The CQC inspection report for the unannounced visit to the urgent care and the medical wards was published on 17 February 2023. This report contained three 'Must Do' actions and five 'Should Do' actions.

The Trust has also received the inspection report for maternity services. The report contained six 'Must Do' recommendations.

A trust wide CQC improvement plan has been developed to monitor a number of recommendations and actions following the CQC inspection visits and the internal quality and safety assessment sand the improvement sprints. All recommendations and are included in one trust wide improvement plan that is overseen and monitored at Clinical Governance and Quality Committee on a monthly basis. As at 31/03/23 all actions were either complete or in progress. No actions are overdue.

Data Quality
Bolton NHS Foundation Trust submitted records during 2022/23, at the Month 11 inclusion date to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- **which included the patient's valid NHS number was:**
  - *99.9 %* for admitted patient care;
  - *99.9 %* for outpatient care; and
  - *95.5 %* for accident and emergency care. (ECDS dataset 1 April 2022 to 11 April 2023)

- **which included the patient's valid General Medical Practice Code was:**
  - *100.0 %* for admitted patient care;
  - *100.0 %* for outpatient care; and
  - *98.2 %* for accident and emergency care. (ECDS dataset 1 April 2022 to 11 April 2023)

Action to Improve Data Quality
Bolton NHS Foundation Trust will be taking the following actions to improve data quality:

- Daily validation continues to be undertaken by the Data Quality team with a focus on the use of correct NHS numbers, GP details and responsible CCG. This also includes ethnicity to ensure our services meet the needs of the population we serve
- The Data Quality team continues to provide advice and guidance to other users
- The Data Quality team are involved in discussions regarding how activity should be recorded in line with the National definitions
- Anomalies and issues are dealt with as they arise and users are made aware of errors to prevent further errors occurring
- Bespoke reports have been created, and continue to be created as necessary, to identify DQ issues as early as possible so that they can be rectified before activity is reported on or submitted to national bodies
- Users are signposted to the relevant training
- All training manuals have recently been reviewed by the team and updated as and where necessary
- The RTT validation team is under the management of the Deputy Head of Business Intelligence (Data Quality). There is now an RTT data lead in post who delivers face to face RTT awareness sessions not only within our own team but across the wider organisation.
- Face to face training has been, and continues to be, delivered to Ward Clerks to ensure the accuracy of inpatient data
- The team support numerous projects across the organisation to ensure that data is recorded correctly and in line with national definitions
- We undertake regular internal audits, carried out by the Validation Team Leader focussing on known or suspected data quality issues
- Data Quality is a standard item on various Trust group agendas
- Senior managers from within the organisation have sat with the DQ validation team to gain more of an understating of the role the Data Quality team play in ensuring accurate data

- The data quality strategy is now embedded within the Informatics strategy. This will assist the team in moving forward and by raising the importance of quality data will ultimately lead to improvements

Information Governance
The Data Security and Protection toolkit which is mandated for all Trusts and measures organisations against the National Data Guardian measure. The Trust can evidence compliance against all mandated standards.

Clinical Coding Audit
Bolton NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Learning from Deaths
During 2022/23 1628 of Bolton NHS Foundation Trust patients died in hospital.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 344 in the first quarter;
- 405 in the second quarter;
- 453 in the third quarter;
- 426 in the fourth quarter.

In 2022/23, 187 structured judgement case record reviews and 60 cardiac arrest root cause analysis investigations (where the patient did not survive) have been carried out in relation to 1628 of the deaths included above.

Out of 187 Structured judgement cases recorded, in 3 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 92 Case record reviews in the first quarter; Investigations = 2
- 48 Case record reviews in the second quarter; Investigations = 0
- 33 Case record reviews in the third quarter; Investigations = 0
- 14 Case records reviews in the fourth quarter; Investigations = 1

27% (6 avoidable cardiac arrests, 187 deaths audited by Structured Judgement Review) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 19 representing 5% for the first quarter;
- 20 representing 5 % for the second quarter;
- 7 representing 2 % for the third quarter;
- 6 representing 1 % for the fourth quarter.

These numbers have been estimated using the data provided within the cardiac arrest root cause analysis reports and learning from deaths process.

All Divisional Reviews and Serious Investigations which are generated via an avoidable cardiac arrest are identified timely by using the cardiac arrest validation clinic and have

specific individual actions generated which remain the responsibility of the Division. Learning from deaths is disseminated through specialty mortality and morbidity meetings and individual feedback to the clinicians concerned.

Learning Disabilities Mortality Review (LeDeR)

There have been significant changes to the LeDeR process in the past 12 – 18 months. Since January 2022, the programme has changed to Learning from Lives and Deaths; People with a Learning Disability and Autistic People (LeDeR) and notifications should now be made for people aged 4+ with a learning disability and for autistic people. Across Greater Manchester, the reviews are now completed by a regional review team, however, the learning and action from reviews remains the responsibility of each locality. The external review arrangements help to ensure reviews are completed objectively and within the required timescales.

From April 2022 to date, there have been 10 Bolton death notifications made to the LeDeR platform, all previously known to specialist learning disability services. We have a cause of death recorded for 7 as some reviews are still in progress. Of the 7 who do have a recorded cause of death, 57.1% (four people) had pneumonia listed as primary issue. One person died of cancer, one pulmonary embolism and one as a result of surgical complications. The average age of death is 58.4 years of age and 90% died in hospital with one person dying at home.

There is continued concern about notifications to the LeDeR platform; only one of the notifications has been made by a GP, all the others were alerted by LD specialist staff. This is a continuing trend and raises concern that we are not notified of the deaths of people who are not in receipt of specialist learning disability services. Of additional concern, is a lack of any child death notifications, whilst these would be subject to the CDOP process, the death should still be alerted to the LeDeR platform for collation of data. There are also no notifications for adults with autism only, despite the change to the process in January.

The Bolton locality continues to deliver a multi-agency LeDeR steering group to ensure appropriate governance and any learning from deaths is reported and actioned across all relevant organisations.

Seven day services

Seven day services review was put on hold for the duration of the COVID pandemic as per NHS Improvement's request – the recommencement of the audit is currently being reviewed.

Raising Concerns

Following the recommendations of Sir Robert Francis QC's Freedom to Speak Up (FTSU) report, it was recommended that all NHS organisations should have a FTSU Guardian in place, to support workers to speak up about anything that gets in the way of providing quality patient care or staff safety and well-being. In October 2018, the Trust appointed a FTSU Guardian working 0.6WTE and this was increased in July 2022 to 1.2 WTE. The Guardians are supported by a Network of FTSU Champions who reflect the diversity of our workforce. Although the FTSU Champions are unable to manage individual cases- they are able to promote speaking up and support/ signpost workers appropriately.

The Guardians take the lead in supporting workers to speak up safely, to thank them for speaking up, to listen to their concerns and to help resolve issues satisfactorily and fairly at the earliest stage possible ensuring workers receive regular feedback and support. Importantly, the role is independent and impartial. The Guardians work in partnership with the communications team in utilising different methods of promoting the freedom to speak up approach. The Guardians meet regularly with the CEO, Executive Director of People and

the Non-Executive Lead for FTSU to discuss concerns raised by workers whilst protecting staff confidentiality. The Guardians request feedback from every individual that speaks up to ensure that the process has met their expectations and that they have not faced any detriment from speaking up. The themes and feedback from individuals is collated in quarterly reports to the people Committee and Divisions and an annual report delivered by the Guardians to the Trust Board. The Guardians also provide quarterly data to the National Guardian Office.

Guardian of Safeworking – NHS Doctors in Training

The safety of our patients is the Trust's key priority, and it is widely acknowledged that staff fatigue is a hazard to both patients and the staff themselves. As such, there are safeguards in place for staff to ensure that working hours and rest periods are regulated and that these are adhered to. The Trust has appointed a Guardian of Safeworking. The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The GOSW identifies and either resolve or escalate problems, and acts as a champion of safe working hours for junior doctors. The guardian provides assurance to the Workforce Assurance Committee (quarterly) and to the Trust Board (annually), that issues of compliance with safe working hours are addressed, as they arise. The guardian reports to the Executive Medical Director and is accountable to the Trust Board.

Reporting against core indicators – *latest published data to 20/04/23*

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital. An overview of the indicators is provided in the table. It is important to note that whilst these indicators must be included in the Quality Report the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (12/21 – 11/22) latest published data available	SHMI Value = 1.0817 (12/21 – 11/22 Band 2 (As expected)	SHMI value = 1.00	SHMI Value = 0.7173 Chelsea and Westminster Hospital NHS Foundation Trust Band 3	SHMI Value = 1.2219 Norfolk and Norwich Hospital NHS Foundation Trust Band 1	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and to ensure the quality of its services by: • Monthly Mortality Reduction Group meetings to scrutinise the quality of care against the mortality metrics • Structured judgement review on patients who died, feeding into the learning from deaths process • Review of recording process across the trust	SHMI value = 1.1533 (12/20 to 11/21) Band 1	SHMI value = 1.1030 Band 2
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (12/21 – 11/22) Latest published data	33% (12/21 – 11/22	40%	66% Isle of Wight NHS Trust	13% Sherwood Forest Hospitals NHS Foundation Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • The Clinical Coding team receive weekly information on any patients who have had a palliative care or contact with the palliative care team, so that this can be reflected in the clinical coding	34% (12/20 to 11/21)	31 %
Patient reported outcome scores for hip replacement surgery	In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMS-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at the present time. This has resulted in a pause in the current publication reporting series for PROMs at this time.						
Patient reported outcome scores for knee replacement surgery							

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
28 day readmission rate for patients aged 0 – 15 *	*The latest available published national data for 28-day readmission rate provided for these measures is for 2011/12. Local data for Bolton NHS Foundation Trust readmission rate is 9.4% for discharges in February 2023 *(based on PBR national guidance, exclusions apply)*						
28 day readmission rate for patients aged 16 or over *							
Responsiveness to inpatients personal needs – measured by Overall experience whilst in hospital: Adult Inpatient survey 2021	8.0 (2021) (Best and worst performer included for reference as calculated by CQC) Most up to date available is 2021 Adult Inpatient Survey.	8.1 (2021)	9.4 (2021)	7.4 (2021)	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Adult Inpatient Survey programme. Due to a national change in questions and methodology results for the Adult Inpatient 2020 survey are not comparable with results from previous years. Therefore, no historic performance included. Overall experience used as closet measure to responsiveness. Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Review and refining of the Concerns and complaints policy • Receipt of real time patient stories and analysis • Lived Experience Panel • Development of Local Surveys • Carer Involvement • Patient Safety Plan	8.2 (2020)	
National Quarterly Pulse Survey – staff engagement score	6.99 (Quarter 4 2022/23)	6.99 (Quarter 4 2022/23)	7.49 (Quarter 4 2022/23) University College London Hospitals NHS Foundation Trust	4.54 (Quarter 4 2022/23) North Bristol NHS Trust	The National Quarterly Pulse Survey (NQPS) provides a consistent and standardised approach, nationally and locally, to listening to staff at more regular intervals with a robust data set. NQPS focuses on the core set of nine questions which make up the engagement theme from the NHS Staff Survey that provide insight into motivation, involvement and advocacy.	The Staff FFT collection was suspended during Covid and not reinstated Results for the National Pulse Survey by Trust started in Quarter 4 2022/23 so no previous data is available.	

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
The percentage of admitted patients risk-assessed for Venous Thromboembolism (Mar-23)	96.94% (04/22 to 03/23)	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • VTE Nurse Champion • Nurse-led DVT Clinic • VTE database • Staff Awareness campaign • RCA of patients developing clots for continuous learning and improvement	97.19%	97.34%
Rate of C.Difficile per 100,000 bed days (Hospital onset Healthcare associated amongst patients 2 of over) Rate published by Public Health England, Source *HCAI Mandatory Surveillance Data*	32.7	18.3	59.0 Wye Valley NHS Trust	5.6 East Cheshire	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Rate as published on the Public Health Profiles. National data published September each year. Therefore, latest available published data is 2020/21 Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Continuation of an annual deep cleaning programme. • Investment in more efficient Hydrogen Peroxide Vapour. • More scrutiny in the application of SIGHT. • Hand hygiene awareness campaigns. • Harm Free Care Panels for each CDT case to identify root cause and review prescribing practices. • Regular audits of antibiotic prescribing practices. • Investment in estate in conjunction with the deep clean programme. • C'diff Improvement Collaborative • Revised guidance and policy. • IPC link nurse development programme.	23.8 (20/21)	18.7 (19/20)
Number/Rate of patient safety incidents per 1000 bed days Apr/21 to Mar/22 latest data available (NRLS)	61.5 per 1,000 bed days N = 12,420 Apr/21 to Mar/22	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the National Reporting and Learning System (NRLS) National data published September each year. Therefore, latest available published data is 2021/22 Bolton NHS Foundation Trust Risk & Assurance team have	64.9 per 1,000 bed days N = 10,882 20/21	60.4 per 1,000 bed days N = 6,224 19/20

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
Number of above patient safety incidents that resulted in severe harm or death Apr/21 to Mar/22 latest data available (NRLS)	N = 33 10 deaths 23 Severe harms Apr/21 to Mar/22	n/a	n/a	n/a	undertaken: • Preparation for the Implementation of new national Learning from Patient Safety Events Service, replacing NRLS • Preparation for the Implementation of new national Patient Safety Incident Response Framework (PSIRF)	N = 24 8 deaths 16 Severe harms 20/21	. N= 10 3 deaths 7 Severe harms 19/20
Inpatient Friends and Family Test (Feb-23)	96.4% (Feb-23)	95.03%	100% The Royal Orthopaedic Hospital NHS Foundation Trust	66.07% Ashford and St. Peter's Hospital NHS Foundation Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health and Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Increased use of Friends and Family Test – available in a variety of formats • Communicating the process to the public Implementation of the 'you said' 'we did' process for feedback	96.1%	96.6%
Accident and Emergency Friends and Family Test (Feb-23)	87.1% (Feb-23)	79.2%	94.74% Torbay and South Devon NHS Foundation Trust	37.5% University Hospital Southampon NHS foundation Trust		85.0%	89.7%

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Part 3

Performance against Trust selected metrics

... for a better Bolton

Performance against Trust selected metrics

This section of the report is provided to give an overview of the quality of care across a range of indicators covering patient safety, clinical effectiveness and patient experience. We have chosen to use the same indicators as used in previous years

	Indicator/Measure	2022/23	2021/22	2020/21
Patient Safety Outcomes	Mortality - SHMI	See page xx		
	C.Diff – number of cases	See page xx		
	Pressure ulcers by category: • Cat 2 • Cat 3 • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	304 16 8	248 50 3	210 46 3
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally and published by NHS England*	25.6% 96.2% (Mar-23)	21.7% 95.7%	31.2% 96.6%
	Lessons Learnt	See below		
	Dementia Training* * *HEE Tier 1 Dementia Awareness* *Data source – captured via local training and development system (Moodle and ESR)*	Suspended and not reinstated	Suspended	90.8%
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally and published by NHS Digital*	4.6% (Mar-23)	5.1%	4.1%
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	84.1% (Mar-23)	78%	78.4%
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	85.3% (Mar-23)	85.4%	91.8%

The above data is reflective of 2022/23 performance; national comparable benchmarking data for the same period was not available at time of Quality Account publication. Where applicable/available the above indicators are governed by national standard definitions.

Lessons Learnt:
The Trust has over the course of 2022/23 used a variety of methods to ensure that learning is captured, shared and embedded in a timely manner.

Capture: Incidents, complaints, claims, audits and Inquests provide us with the opportunity to reflect when our practice could have been better, the Governance Team are central to ensuring that the intelligence gleaned from such events is accurate and focused on learning.

Shared: The Trust ensures that lessons learnt are shared with appropriate audiences across the organisation in formats that are engaging, helpful and easy to appreciate. The key example of this is the use of SBARS (Situation, Background, Recommendations, Situation) a single slide, covering an important topic that will improve patient safety. In the period 1st April 2022 – 31st March 2023, xx SBARS were published. In addition to this learning intelligence was shared in a variety of formats at the Clinical Governance and Quality Committee from the Governance Team for distribution across divisions.

Embedded: SBARS, once published are monitored in terms of demonstrating embeddedness via a measure in BoSCA (our in-house ward and departmental accreditation scheme) which ensures that staff in clinical settings have been made aware of the SBAR. Furthermore, the Governance Team meet with divisions to discuss progress with the completion of actions associated with complaints and incidents on a regular basis, reporting if necessary to the Clinical Governance & Quality Committee.

Performance against the relevant indicators and performance thresholds (Risk Assessment Framework and Single Oversight Framework)

Indicator for disclosure (limited to those that were included in both RAF and SOF for 2016/17)	**Apr 22-Mar 23**	**Target**	**Achieved**	**Apr 21-Mar 22**	**Apr 20-Mar 21**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2023)	60.29%	92%		65.4%	62.2%
A&E: Maximum waiting time of four from arrival to admission, transfer or discharge (average for the year)	59.48%	95%		66.84%	80.0%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/22 – 02/23)	81.85%	85%	tbc	85.35%	83.47%
• NHS Cancer Screening Service referral (04/22 – 02/23)	82.63%	90%	TBC	77.28%	74.45%
Clostridium difficile - meeting the C. difficile objective *National data published September each year. Therefore latest available published data is 2021/22*	66	N/A		40 (2020/21)	38 (2019/20)
Summary Hospital-level Mortality Indicator included in "**Reporting against core indicators" section**					
Maximum 6 week wait for diagnostic procedures *Definition – proportion of patients referred for diagnostic tests who have been waiting less than 6 weeks* (as at 31/03/2022)	86.1%	99%		66.9%	61.8%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"**					

Bolton NHS Foundation Trust Quality Account 2022/23 – Statement from Greater Manchester Integrated Care Partnership

Dr Jane Bradford - Clinical Director for Governance and Safety
xx - Associate Director of Governance and Safety