AGENDA - BOARD OF DIRECTORS' MEETING

MEETING HELD IN PUBLIC

To be held at 1300 on Thursday 28 September 2023
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB100/23	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm meeting quoracy*	*Verbal*	Chair	**13:00**
TB101/23	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	**13:05** (15 mins)
TB102/23	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*Report + Verbal*	Chair	**13:20** (5 mins)
CORE BUSINESS				
TB103/23	**Minutes of the previous meeting held on 27 July 2023** *Purpose: To **approve** the minutes of the previous meeting*	*Report*	Chair	
TB104/23	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB105/23	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Verbal*	Chair	**13:25** (5 mins)
TB106/23	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13:30** (10 mins)

STRATEGY AND PERFORMANCE

TB107/23	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**13:40** (5 mins)
TB108/23	**Public Health Annual Report** *Purpose: To **receive** the Public Health Annual Report*	*Report + Presentation*	Director of Public Health	**13:45** (10 mins)
TB109/23	**Health Inequalities** *Purpose: To **receive** the Health Inequalities Update*	*Report*	COO	**13:55** (10 mins)
TB110/23	**Operational Update** a) Winter Plan b) Protecting and expanding elective capacity – Self certification checklist *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**14:05** (10 mins)
TB111/23	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance *Purpose: To **receive** the Integrated Performance Report*	*Report*	DCEO	**1415** (20 mins)
	COMFORT BREAK			**14:35**

QUALITY AND SAFETY

TB112/23	**Quality Assurance Committee Chair's Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**14:45** (5 mins)
TB113/23	**Initial response to the Countess of Chester inquiry** *Purpose: To **receive** the update on the initial response to the Countess of Chester inquiry*	*Report*	Chief Nurse	**14:50** (10 mins)

TB114/23	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update** *Purpose: To **receive** the CNST Scheme for Trusts Maternity Incentive Scheme Year 5 Update*	*Report*	DoM+ Chief Nurse	**15:00** (10 mins)
WORKFORCE				
TB115/23	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	PC Chair	**15:10** (5 mins)
TB116/23	**Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) Report** *Purpose: To **receive** the WRES/WDES Report*	*Report*	Chief People Officer	**15:15** (10 mins)
TB117/23	**Equality, Diversity & Inclusion Update** *Purpose: To **receive** the Equality, Diversity & Inclusion Update*	*Report*	Chief People Officer	**15:25** (10 mins)
TB118/23	**Revalidation Report** *Purpose: to **receive** the Revalidation Report*	*Report*	Medical Director	**15:35** (5 mins)
FINANCE				
TB119/23	**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)
TB120/23	**Charitable Funds Chair's Report** *Purpose: To **receive** the Charitable Funds Committee Chair Report*	*Report*	CF Chair	**15:45** (5 mins)

GOVERNANCE AND RISK				
TB121/23	**Audit Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	AC Chair	**15:50** (5 mins)
TB122/23	**Audit Committee Annual Report** *Purpose: To **receive** the Audit Committee Annual Report*	*Report*	AC Chair	**15:55** (5 mins)
TB123/23	**Fit and Proper Person's Update** *Purpose: To **receive** the update on changes to FPPT requirements*	*Report*	DCG	**16:00** (10 mins)
TB124/23	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*All*	**16:10** (10 mins)
CONSENT AGENDA				
TB125/23	**Complaints and Concerns Annual Report** *Purpose: to receive the Complaints and Concerns annual Report*	*Report*	*Chief Nurse*	
CONCLUDING BUSINESS				
TB126/23	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16:20** (2 mins)
TB127/23	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**16:22** (3 mins)
TB128/23	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16:25** (5 mins)

Date and time of next meeting: ***16:30***
Thursday 30 November 2023 ***close***

Chair: Dr Niruban Ratnarajah

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
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
Jackie **Njoroge**	Non-Executive Director	Director – Salford University	Financial Interest
		Deputy Chair HESPA (non-remunerated position)	Non-Financial Professional Interest

Name:	Position:	Interest Declared	Type of Interest
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		The Foundation Trust Network (Trustee NHS Providers)	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
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
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

Name:	Position:	Interest Declared	Type of Interest
Rae **Wheatcroft**	Chief Operating Officer	Nothing to declare	
Sharon **White**	Director of Strategy	Trustee at Fort Alice Bolton	Non-Financial Professional Interest
		Trustee George House Trust	Non-Financial Professional Interest
		Judge on She Inspire Awards	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

***Draft* Board of Directors Minutes of the Meeting**
Held on Microsoft Teams
Thursday 27 July 2023
(Subject to the approval of the Board of Directors on 28 September 2023)

Present

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

In Attendance

Name	Initials	Title
Ash Hussain	AH	Matron Acute Adult Division
Harni Bharaj	HB	Deputy Medical Director (on behalf of Francis Andrews)
Janet Cotton	JC	Director of Midwifery (for item 090)
Rachel Carter	RC	Associate Director of Communications and Engagement
Robyn Mcatee	RM	Trainee Nurse Associate
Tracey Garde	TG	Freedom to Speak Up Guardian (for item 86)
Victoria Crompton	VC	Corporate Governance Manager

There was one observer in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB076/23	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting. Apologies for absence were noted from Francis Andrews, Jackie Njoroge, Bilkis Ismail and Lynn Donkin.	
TB077/23	**Patient and Staff Story** The Chief Nurse introduced the recorded patient story relating to Arshad who shared his positive experience of attending A&E and subsequent treatment following a heart attack. TR advised the Board that Robyn Mcatee, Trainee Nurse Associate (TNA) would be sharing her staff story detailing her experience on the TNA nursing apprenticeship.	

Staff Story

RM advised Board members she commenced at the Trust 10 years ago as a Healthcare Assistant (HCA) and considered further progressing her career when she became aware of the Trainee Nurse Associate Apprenticeship, which she commenced in 2021. In her first year, she completed five placements in order to gain exposure to different fields of nursing. In the second year students arranged their own placements, RM had an interest in cardiology so spent time with the Heart Failure Specialist Nurses and at the Cardiac Rehab Exercise Programme.

Due to the pandemic, the cohort had experienced teaching sessions delivered on Zoom and placements cancelled due to staffing issues. Some students also found it hard to have their allocated learning time due to a lack of understanding of the role from their managers.

In response to a query from RG, RM confirmed there were seven students in her cohort who provided valuable support to each other; she has also had two managers whilst undertaking the apprenticeship both of whom have supported her alongside the nurses within the area she worked.

TR explained that the Nursing Associate role had now been reintroduced and sought to develop and educate staff to ensure they fully understood the capabilities of those in the position. There was already a strong workforce of Nursing Associates within community and the focus would be on promoting and enhancing the NA workforce.

It was noted that apprentices were guaranteed a role at the Trust and there was increased focus on the health and wellbeing of apprentices. However, whilst focus would be promoting and enhancing the NA workforce, the Trust would honour the commitment regarding NAs who had previously been offered the opportunity to continue training to become a Registered Nurse,

NR thanked RM for sharing her experienced adding that it would be beneficial to use feedback from NA apprentices in areas, which were struggling to develop the role.

Patient Story

The Board of Directors heard the story of Arshad who fell ill at New Year and continued to deteriorate. He contacted his GP who advised him to attend Accident and Emergency (A&E) whereupon he relayed his symptoms and was immediately placed on an ECG machine. Within 20 minutes of arriving in the department, he had been formally admitted and awaited an inpatient bed.

Arshad commended the staff for the good communication as they explained he had experienced a heart attack adding that the staff had been attentive to his needs that he felt as if they were only treating him. One member of staff took the time to ensure the toast was still warm every morning when served to patients, for their breakfast. Arshad stated his experience was positive from the moment he arrived until he was transferred.

Arshad was fully recovered and commented one of the things, which really benefitted him, was the information provided about what to expect post-surgery. He concluded by expressing thanks to all those who treated him including the cardio rehab nurses who were phenomenal.

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

TB078/23 Declarations of Interest

FN declared she was a member of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).

There were no other declarations relating to agenda items.

TB079/23 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 26 May 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 May 2023.

TB080/23 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

TB081/23 Chair's Update

The Chair advised that initial feedback had been received following the CQC inspection and was included on the agenda for the meeting.

NR advised that he had chaired his first Council of Governors meeting in July where discussions had focussed on progressing with the recruitment of two non-executive directors. The Trust would be assisting throughout the process by an external recruiter and expected the adverts to go live in August.

He added that he had held a good discussion and feedback session with staff governors as part of the drop-in sessions that were on offer to all governors.

NR extended thanks to the Bilkis Ismail and Jackie Njoroge whose tenures where coming to an end and advised that the next CoG meeting would be discussing succession plans for NEDs as well as the recruitment of two new non-executive directors to the Board. A detailed update would be presented at the next meeting.

TB082/23 Chief Executive Report

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

- Three nursing teams were recognised in the shortlist for the national Nursing Times Awards for their commitment to delivering excellent patient care.
- The Neonatal Unit had been awarded the highest level of FiCare (Family Integrated Care) status for the support provided to families.
- A new policy came to fruition, ensuring the safeguarding of patient's property whilst in the Trust's care. This was initiated because of work done to learn from loved ones during and after the pandemic.
- In July, the Trust celebrated NHS75, a day to reflect on everything the NHS had achieved in the past 75 years, and plans for the future.
- The Trust was reaccredited as Veteran Aware and received a Silver Award for the Employer Recognition Scheme.
- The Bolton Locality Plan would be refreshed to demonstrate how the Trust was meeting the health and care needs of communities.
- The Trust is in the process of electing nine members of the public and three members of staff to join the Council of Governors, each with a term length of three years.
- The Trust was appealing for the public to recognise members of the Bolton team who have made a difference to them as part of the annual FABB Awards.

RG commented the work completed by the Intravenous (IV) Nursing at Home Team who had been shortlisted for a Nursing Time Award, showed real benefit realisation and good patient experience.

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

TB083/23 Initial CQC Feedback

The Chief Executive presented the initial, informal feedback following the well-led inspection undertaken by the CQC between 07 to 09 June 2023. The feedback received remained subject to the post-inspection detailed data review and provision of further information. Many of the areas highlighted for improvement were known to the organisation and evidence had been provided on improvement plans. Where this was not the case, additional interventions were agreed.

The next stage would be to await the draft inspection report. Upon receipt, the Trust would be asked to check the factual accuracy and completeness of the information the CQC have used to reach their judgement and ratings. The draft report would also contain proposed recommendations and an action plan would be developed based on these and formalised on receipt of the formal report. It was important to note some actions were already in place of which some had also been completed. There had been no confirmations as to when the draft report would be received or the final report published.

MB asked when the draft report on the Children's and Young Peoples Services inspection was expected. FN advised it was believed the report would be received approximately two weeks prior to the well-led inspection report, but this was not confirmed.

RG asked what morale was like within the organisation following the inspection. FN explained it had been difficult and some of the CQC focus groups had a split of opinions from staff. Staff had been briefed throughout the CQC process and will continue to receive communications and updates.

RESOLVED:
The Board of Directors received the CQC Well-Led Inspection – initial feedback.

TB084/23 Operational Update

The Chief Operating Officer provided an overview of the operational performance and drew attention to the following points:

- There was a continued reduction in the number of patients with no criteria to reside. Community teams were working hard to support patients to be discharged as quickly as possible.
- A&E attendances overall were 3.7% down on the previous year. However, this had not translated into better A&E performance
- The Trust was currently at 68% for the four-hour target, which was almost 2% worse than the GM average.
- 12-hour performance had not made sufficient improvement and the organisation was just over 3% worse than the GM position.

- 32 patients waited more than 78 weeks for treatment, and 554 patients had waited more than 65 weeks to be treated or discharged from care. The waiting list continued to grow and the number of patients that waited more than a year had also grown.
- There were further periods of industrial action, which no doubt contributed towards the growth in the waiting list and backlog.
- The greatest cohort on the waiting list were aged between 19-64 years and represented the greatest proportion of longest waits. It was expected that the planned Know Your Patient's week would seek to improve recording of ethnicity, as around 25% of the waiting list have no ethnicity recorded.
- In June, 9.8% of patients did not attend their outpatient appointment. The national average, in May, was 9.7% with a North West median of 8.2%.
- The deterioration in the organisations ability to see and diagnose cancer patients within 28 days had raised concerns. The deterioration was linked to breast pathways and gaps within the Breast Radiology workforce. The team were working to reduce waiting times and performance had improved against the faster diagnosis standard.

AS queried whether the organisation overbooks appointments with the knowledge the Trust had a percentage of "did not attends" (DNAs). RW explained there are DNAs in each specialty, and some do overbook, but some do not. There was an improvement plan for DNAs, which each speciality is working on, and learning was being shared between divisions.

MN asked whether it would be beneficial to have a wider focus on productivity and identifying the top 10 measures, which could be most valuable to the organisation. AW advised the Finance and Intelligence Group (FIG) analyse the Model Hospital metrics and productivity. This group reports into the Strategy and Operations Committee.

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

TB085/23 Integrated Performance Report

Executive Directors presented the Integrated Performance Report for June 2023, and the following key points were highlighted:

- There were 27 pressure ulcers reported in June of which 21 were categorised as category two, demonstrating special cause variation with cause for concern and six were categorised as unstageable.
- The Trust remained under the local target on Falls as performance was 4.43 falls per 1000 bed days.
- Same sex accommodation breaches continued to be above trajectory with an astronomical point in month. The breaches occurred within the Critical Care Unit and were reflective of the constraints on the inpatient bed capacity.

- Four Serious Incident (SI) investigation reports were approved in June of which three were within the 60-day deadline. The fourth was finalised and scheduled for Exec sign off in July.
- Crude mortality was below Trust target and average for the period. HSMR was within control limits and below average for the timeframe. SHMI was above average for the time-period, but remained 'in control' for more than two years.
- Sickness reduced slightly in June to 4.71%. Turnover also reduced to 12.60% and was the fifth consecutive month to reduce.

In response to RG's comment relating to 60-day sign off on SI's, TR advised that there had been an improvement in the SI signing off process. Furthermore, the CQC had sampled six SI's during the inspection and had not raised any initial concerns.

MB added that previously there was a high number of outstanding SI actions and following the focussed work all actions plans were now SMART and there had been a significant reduction in the number of outstanding actions.

AS raised concern regarding the number of same sex accommodation breaches. TR confirmed at no point had there been any escalations of patients of the opposite sex sharing bathroom facilities, but that they may have had to walk past a member of the opposite sex. Such occasions are linked to demands on in-patient bed capacity and only ever made in the event of clinical priority and safety taking understandable precedence.

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

TB086/23 Freedom to Speak Up Annual Report

The Director of People introduced Tracey Garde, Freedom to Speak Up Guardian, who presented the Freedom to Speak Up (FTSU) Annual Report, which provided an update on activity within the Trust during the period 01 April 2022 – 31 March 2023. JM thanked TG for her continued work on Freedom to Speak Up and for completion of the Annual report. The report had previously been presented at People Committee who commended the report to the Board of Directors.

TG presented the report advising that:

- There were 186 FTSU cases within the reporting period, which was an increase of 32 from the previous year. The most common theme was around behaviour and nurses had raised the most concerns.
- 33 concerns were raised by BAME colleagues, which equates to 17.7%.
- 70% of concerns had an initial response within an hour of being received, 86.5% received an initial response within four hours and 94.6% within 48 hours.

- Feedback sought from those who had raised FTSU concerns was positive with the majority advising they felt they were taken seriously and were addressed appropriately.

The Staff Survey 2022 highlighted the Trust scored above the national average for staff feeling secure in raising a concern about unsafe clinical practice; however, this score had declined both within the Trust and nationally. There was also a decline in staff feeling confident the organisation would address any concerns raised.

MN raised concern regarding the decline in the number of staff who felt secure in raising a concern about unsafe clinical practice. TG advised this deterioration had also been seen nationally. There were two main barriers fear and futility and there is work to be done in order to build confidence back up. FTSU month is taking place in October and there will be a big focus on barriers.

RG queried how the survey results compared to the previous year. TG advised the results were as positive as last year, but it would be interesting to see the results from the current period and added it may be beneficial to complete a six-month review rather than wait for the annual survey.

It was noted that the uptake of the survey was quite high, as 50-60% of staff had completed the survey. In terms of issues raised, there had been concern around staff not feeling the process was confidential, however, the survey results indicated that those who had completed the survey felt it was a confidential process. TG added that whilst the results of the survey were included in the Annual Report, she would be communicating with staff and offering additional FTSU training in order to build up confidence in the FTSU process within the organisation.

JM advised that an internal audit review of FTSU was previously completed in 2020 and a further audit that would be completed this year. AS added that the new Internal audit providers also provide an audit provision for a number of other North West NHS Trusts, so it would be possible to obtain some benchmarking.

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

TB087/23 People Committee Chair Report

The Chair of the People Committee presented the Chair Reports from the meetings held on 20 June and 18 July. Key highlights from the June meeting were the Agency Update, Freedom to Speak Up Annual Report and Guardian of Safe Working Annual Q4 Report and Annual Report
The key points from the meeting held in July, included;

- The resourcing update highlighted the activity being undertaken across the Trust, focussing on turnover and recruitment analysis. The report outlined a strong resourcing/staffing position.

- The new Head of EDI was introduced and it was noted the Trust was also transitioning to a new interpretation and translation service to improve the experience for patients and colleagues.

RG queried the deep dive into the AHP staffing and AS advised, there were some areas within the organisation, which the Trust has difficulty recruiting and retaining staff in. The deep dive will use vacancy, turnover, agency, recruitment, and retention information to understand the challenges in the staff group.

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

TB088/23 Draft Clinical Strategy for Engagement

The Director of Strategy, Digital and Transformation and Deputy Medical Director delivered a presentation detailing the development and progress of the draft Clinical Strategy. This was the product of a great deal of work taking into account what the Trust had already achieved, as well as the refreshed aims and objectives, learning and research and, of course, the need to restore services following the pandemic.

It was noted that the Clinical Strategy would focus on the primary ambition to Improve Care and Transform Lives. The Board were asked to review the Clinical Strategy and approve the three priorities and the nine supporting themes. Following this, the Clinical Strategy will be refined and socialised with key stakeholders. Progress updates would continue to be brought to the Board of Directors.

JM queried how the Trust would ensure stakeholders knew the difference between the Clinical and Corporate Strategies. SW advised the Clinical Strategy was based on the ambition "Improving Care, Transforming Lives". The Corporate Strategy will be an evolution of the Clinical Strategy.

AS commented, it would be beneficial if both the Corporate and Clinical Strategies dates aligned so both were for the years 2024 – 2029. He added that it is imperative staff feel involved in the development of the Clinical Strategy to ensure they are connected to it. The draft Clinical Strategy had been presented at Strategy and Operations Committee on several occasions and feedback from divisions was that they felt far more engaged in the process of developing the Clinical Strategy than they did earlier on in the process.

RESOLVED:
The Board of Directors **approved** the Draft Clinical Strategy.

TB089/23 Strategy and Operations Committee Chair Report

The Chair of the Strategy and Operations Committee presented the Chair Reports from the meetings held on 26 June and 24 July 2023. The following key points from the July meeting were highlighted:

- A second delay noticed was received for Maternity EPR in April 2023. The project team sought procurement and legal advice and, met the providers in July. A proactive action plan was agreed with tight timescales, which will be monitored by the project Board.
- The committee received an update on the status of the GM Integrated Care Board (ICB) Business Intelligence (BI) Team. It was noted there is no Service Level Agreement (SLA) in place with GM as locality teams are employed by GM ICB. It had been agreed in principle the developers would be able to continue to work on the Trust's priorities.
- Winter Planning – committee members received the update on the approach to winter planning for 2023/24.
- The committee received the quarterly no criteria to reside (NCTR) update noting that the Trust achieved 90 NCTR patients in May; there were 84 NCTR patients as of June, evidencing a sustained improvement trajectory.

SW commented that Business Intelligence is relating to ICB staff not Foundation Trust staff and an SLA would be developed to ensure the Trust is not impacted by the reduction.

RESOLVED:

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

TB090/23 Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q1 Update

The Chief Nurse introduced the Director of Midwifery who presented the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 update. The new scheme was launched on 31 May 2023 to continue to support the delivery of safer maternity care. As in previous years, the scheme incentivises ten maternity safety actions.

Three CNST safety actions within the year 5 scheme continue to remain at risk namely:

- Safety Action 5 - attainment of 100% supernumerary status of the Delivery Suite Coordinator. The service had maintained compliance in month but the action remains at risk due to the ongoing staffing deficit of circa 50wte Registered Midwives.

- Safety Action 6 - collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset.
- Safety Action 8 - Attainment of the training requirements set out in the Core Competency Framework that require 90% attendance of relevant staff groups to be calculated as from January 2023.

Safety Action 2 has been flagged on the progress tracker as amber as 90% compliance for the submission of ethnicity data cannot yet be evidenced. Retrospective entry will be undertaken to improve compliance if required prior to submission.

15 of 26 actions within the Price Waterhouse Cooper audit action plan have been completed and the remaining actions will be completed following the approval of the standard operating procedure, receipt of the reporting cycle of business for the local maternity and neonatal system and receipt of three outstanding audits.

The service can evidence full compliance with 34/42 (80%) of the initial Ockenden recommendations and 24/31 (77%) of the recommendations highlighted in the Kirkup report.

In order to triangulate data the CNST reports were presented at the Family Care Division Clinical Governance and Clinical Governance and Quality Committee prior to presentation at Quality Assurance Committee and Board of Directors.

MB thanked JC for the work completed by herself and her team to make improvements and to ensure maternity services were safe for patients.

JM queried how the Board could be assured the RAG ratings are appropriate. JC advised there is an overarching tracker, 10 individual workstreams who complete the operational work, evidence was checked by the Director of Midwifery and then a final check will be completed by the Director of Governance prior to final submission of the declaration. The LMNS also require regular submissions for assurance.

RG asked what the implications were to not being 100% compliant with the Kirkup/Ockenden recommendations. JC explained there were no formal implications, but organisations were being held to account on compliance by the LMNS. All evidence over the last 12 month had been reviewed and therefore assurance can be given that if RAG rated green for compliance on the Kirkup/Ockenden recommendations then there is evidence to support this on file.

RG asked MN how he felt the department was working as the Maternity Champion. MN advised he felt the rapport was good and it was possible

from visiting the department to see the improvements that had been made, though there is still work to do and some cultural issues still to be resolved.

AS queried how the division fedback to staff and JC stated a Microsoft Teams Talk meeting was held with all Band 7 and 8 staff monthly, which provided an update on successes and areas of focus. The leaders then use the narrative Team Talk summary shared to cascade information down to their teams. The engagement culture within the department is now improving.

NR commented the next step to improve would be integrate medical support within the ongoing schemes further to ensure shared accountability.

RESOLVED:
The Board of Directors **received** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Q1 Update.

TB091/23 Quality Assurance Committee Chair Report

The Chair of the Quality Assurance Committee presented the Chair Reports from the meetings held on 21 June and 19 July 2023. The following key points from the July meeting were highlighted:

- Improvements had been made on pressure ulcers with no category three or four pressure ulcers for six months. There had also been improvements in C Diff infections.
- Call bell systems on wards continued to be replaced, and mitigations were in place for areas who were still awaiting the new system. TR added further work had been completed, so the work on this was almost complete.
- There had been agreement to proceed to withdraw the use of the Medical in Reach Team to answer 2222 calls to GMMH and SRFT. RW stated there was an existing SLA in place for this, but it lacked detail. Consideration would be given as to what service could be provided going forward.
- A working group had been established for clinical correspondence and JN would be the Non-Executive Director representative.

MB raised a personal experience he had encountered with regard to the lack of EPR within some areas. SW advised a review was being completed considering what was included in the business case originally, what had been delivered, and what was yet to be delivered. Although there are always risks, when relying on paper notes there continued to be risks when using electronic systems. Therefore, a considered process had to be followed when implementing a digital system to ensure a robust process is in place. AW added that as part of the review will consider what monies

had been spent and what was still required. There was some allowance within the capital plan as well.

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

TB092/23 Review of Financial Position

The Chief Finance Officer provided a presentation of the financial position and highlighted the following key points:

- Year to date deficit of £4.7m, off track by £1.5m. Probable deficit of £22.2m against a plan of £12.4m.
- Plan deficit is possible only with additional income or service reductions. The Trust will continue to forecast the plan on this basis and review the position monthly. A copy of the F&I report is submitted monthly to GM.
- GM had a year to date deficit of £87m against a break-even plan.
- Agency spending £4.1m year to date which is £1.1m overspent.
- £6m pressure on capital forecast.
- Cash forecast range of £1.7m to £24.6m.

RESOLVED:
The Board of Directors **received** the review of the financial position.

TB093/23 Finance and Investment Committee Chair Report

The Chair of the Finance and Investment Committee presented the Chair Report from the meeting held on 21 June and provided a verbal update from the meeting held on 26 July. The following key points from the July meeting were noted:

- GM ICS financial position is off track with a year to date deficit of £87m. All GM organisations had been requested to implement a range of standard financial controls.
- Month 3 position showed a year to date deficit of £3.2m. Unidentified cost improvements remained a significant issue.
- The Finance and Investment Committee received the IFM performance for May. The iFM Operating Model is due to be reviewed and the re-introduction of formal contract meetings and an annual shareholder meeting is under consideration. Any proposed changes to the Operating Model would be subject to Board of Directors approval.

AS advised, the Trust was £1.5m off track at the end of Quarter 1. AW explained there was some element of phasing and expected future cost pressures, it was envisaged £22.5m deficit is the worst-case scenario.

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

TB094/23 Board Assurance Framework

The Director of Corporate Governance presented the Board Assurance Framework (BAF). Since presentation at the last meeting, a review of the BAF was undertaken by Executive Directors to ensure the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level. There is no change in risk score and changes are highlighted as tracked changes within the report.

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

TB095/23 Audit Committee Chair Report

The Deputy Chair of the Audit Committee presented the Chair Report from the meeting held on 28 June 2023 and the key points were highlighted and noted.

AS thanked the finance team for their work on the audited annual accounts and quality account. He also advised Board members that the organisations internal auditors would be moving from PWC to Mersey Audit. AW added that Mersey Audit would commence as the Trusts internal auditors from September 2023.

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

TB096/23 Feedback from Board Walkabouts

MN advised he had visited theatres and noted the large amount of equipment required by the department. There was a requirement for additional staff rest facilities as the current provision was minimal. MN had also had a good visit to Day Care.

RG stated she had visited the Integrated Discharge Team who had advised it would make a huge difference to them if intermediate care was on site.

RG had also visited a ward where she met a patient who had spent 48 days medially optimised. The team had a high proportion of dementia and out of areas patients which impacted on discharging them home.

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

CONCLUDING BUSINESS

TB097/23 Questions to the Board

None.

TB098/23 Messages from the Board

The following key messages from the Board were agreed:

- Thank you for maternity for work on CNST and BoSCA
- Clinical strategy
- Finance pressures
- Patient and staff story
- Mortality
- FTSU – feedback from those who had gone through the process

TB099/23 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 28 September 2023.

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

Helen Lowey	✓	✓						
Rachel Tanner	✓	**A**	✓	✓	✓	✓	✓	**A**
Niruban Ratnarajah	**A**	✓	✓	✓	✓	✓	**A**	
Lynn Donkin			✓	✓	✓	✓	✓	**A**
✓ = In attendance A = Apologies							✓	✓

March 2022 actions

Code	Date	Context	Action	Who	Due	Comments
FT/23/06	26/05/2023	Staff Health and Wellbeing Report	Outside space rest facilities to be on the next Charitable Funds Committee agenda	SW	Sep-23	Work is ongoing and the Charitable Funds Committee will receive an application for funding when the statement of case has been fully developed.

Key

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	Thursday 28 September 2023		Discussion	
Exec Sponsor	Fiona Noden		Decision	

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

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

Previously considered by:
N/A

Proposed Resolution	To note the update.

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

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

Ambition 1
Provide safe, high quality care

During September, we held our third annual 'Know your Patient' week to highlight the importance of making sure we collect accurate data about our patients, through our electronic patient record, to support clinical decision making and care. The initial findings and feedback from the weeklong campaign indicate a successful impact with our data collection already improving since the campaign started.

Our neonatal unit has been recognised nationally in the British Association of Perinatal Medicine (BAPM) awards, which celebrate outstanding contributions in perinatal care, and individuals who go above and beyond to make things better for patients and colleagues. Senior neonatal nurse, Liz Howey has been shortlisted for the Outstanding Individual Award, whilst the antenatal team were also named as finalists in the Outstanding Team category.

A breast cancer survivor has spoken about how a letter inviting her to a mammogram appointment potentially saved her life, as she thanked staff at Bolton's Breast Unit for their phenomenal care and support. She described the process as being 'like clockwork' and appreciated the kindness from one of our porters, who avoided the route that passed the hospital canteen when transporting her, because he knew she had been unable to eat ahead of her scan.

To show her thanks and gratitude to staff, the patient has donated a Dyson fan through Our Bolton NHS Charity for the unit's waiting room to improve comfort for patients and staff.

We are one of only two Trusts in the UK to be recognised as a centre of excellence for advances in breast cancer care. We have teamed up with Endomag to use specialist technology to locate, remove and stage breast cancer, without the need for wires or nuclear medicine.

The technology is helping to improve surgical outcomes for patients and our surgeons are offering peer-to-peer education to clinicians around the world, who will go on to perform the advanced surgical techniques.

Hundreds of patients at risk of cancer have been referred for early tests since the introduction of our specialist rapid diagnostic clinic. The clinic recently cared for its 500th patient and treats people who have presented to their GPs with non-specific symptoms that could indicate cancer including unexplained weight loss, fatigue or nausea. As the service develops, the rapid diagnostic clinic team will be reviewing at what cancer stage patients are being referred, to enable a greater focus on early diagnosis.

We are officially a National Joint Registry (NJR) Quality Data Provider after meeting six ambitious registry targets that help hospitals reach high standards when it comes to patient safety for joint replacement operations.

The quality data provider monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations by collecting data to support patient safety, standards in quality of care, and overall cost-effectiveness in joint replacement surgery.

Ambition 2
To be a great place to work

This month there has been further industrial action, including some periods where both junior doctors and consultants have been exercising their right to strike at the same time. Our tried and tested contingency plans were adopted to support our patients and staff as best we can during this time.

Further routine appointments and procedures have been postponed to help us focus on keeping our sickest patients safe and we have been reminding the public of the importance of choosing the right service for their needs, when the pressure on services has been greater due to reduced staffing.

We have continued to welcome international recruits to our team, but feedback from some of our Internationally Educated Nurses (IENs) highlighted feelings of isolation, anxiety and stress during their first few months in the UK. In response we have developed a programme to help future new recruits familiarise themselves with living in Bolton, local systems and NHS processes.

The Trust has been shortlisted for this work in the Best Workplace for Learning and Development category, during a year which has seen a record-breaking number of entries submitted for the Nursing Times Awards. The annual awards are designed to highlight those making a difference in the key areas such as recruitment, staff retention, wellbeing and inclusion.

The first cohort of staff undertaking our new Health Care Assistant apprenticeship have started in their new roles. More than 100 applications were received when the pilot apprenticeship launched in March this year, with an offer of hands-on experience in a healthcare setting and monthly learning sessions with a tutor at Bury College.

Our revamped faith facilities at Royal Bolton Hospital are already supporting the wellbeing of staff, patients and their families, just six months since they opened. Since the mosque, temple, and community room were officially opened by Mr Mayor of Bolton, hundreds of worshippers have been able to make use of the new spiritual spaces for prayer and religious events, whilst the community hub has been used for staff meetings and network events. Most recently, staff and patients celebrated the birth of Lord Krishna with food and prayer in our Hindu temple.

A programme of staff engagement to inform the next iteration of our clinical strategy has taken place and been valuable in testing the priorities that were formed following the initial stages of the strategy development. A phased approach to engaging with our patients and public has also begun, starting with digital methods and due to progress to community engagement sessions over the coming months.

The longlist for our annual For a Better Bolton (FABB) Awards has been announced with a record number of nominations. 827 entries have been made across 12 categories. The People's Choice Award, which appealed for members of the public to highlight individuals and teams who have demonstrated dedication to delivering high quality care.

Twelve judging panels comprising a diverse range of staff and Governors will determine the shortlist and winners for each category. Details of how to get tickets to the awards, which will be held on 24 November, will be announced next month.

Ambition 3
To use our resources wisely

We have had a productive engagement event with the teams that will be working in our new community diagnostic centre (CDC), looking at opportunities to improve our pathways and provide even better care when the new facility opens, during the current financial year. In November the Board of Directors will have an opportunity to see the facility and understand the impact this will have for our patients.

A huge amount of focus across our teams and services continues to be on improving our financial position, and further work is planned to ensure that we reach our year-end deficit plan of £12.4million. Recent progress has included a significant, sustained reduction in the number of agency hours used across the organisation, and traction with the delivery of our cost improvement plan (CIP) with the leadership of our improvement and transformation team.

The Greater Manchester system has recently started to receive mandated support around its financial performance and we are expecting to see restrictions on our spend increasing as a result in the near future.

The Greater Manchester Integrated Care Board (GM ICB) has appointed a Turnaround Director, Stephen Hay, who is engaged to provide turnaround support to all providers within the Greater Manchester Integrated Care System (GM ICS). We welcome Stephen and his team's support, to help us improve our financial position, whilst continuing to maintain high quality care.

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

NHS England has outlined the actions that trusts should be taking to ensure as far as possible that reinforced autoclaved aerated concrete (RAAC) is identified and appropriately mitigated to keep patients, staff and visitors safe. Any trusts that identify the concrete are required to put robust management plans in place, in line with the IStructE guidance.

Our iFM team has previously undertaken audits that found no RAAC present but further reviews are taking place following updated national guidance and heightened public interest in the presence of RAAC in the NHS estate. Further updates will be provided to the Board of Directors throughout this process.

Work on our four new theatres is gaining momentum, with the ground floor of the new builds almost complete, and fixtures and fittings being installed. Work is ongoing on the top floor, with the planned completion date in just over two months. A number of staff involved in the move have had a tour of their new working environment and look forward to welcoming patients in the near future.

New Family Hubs are being set up across the locality to provide one-stop shops for early years' care. The hubs will be based in all areas of Bolton either on the site of Start Well Hubs, schools or other alternative centres, and will offer community midwifery, birth registrations, public health nursing, infant feeding facilities and infant and family mental health services. We are holding staff engagement events later this month, for staff across the system who

work in community family services, to find out more about the model and what the plans will mean for the people they support.

iFM Bolton, the Trust's wholly owned subsidiary, has been shortlisted for two categories in the Healthcare Estates IHEEM Awards 2023. Firstly, the team is up for the Estates and Facilities Team of the Year and secondly, the Diversity and Inclusion award for the part they played in the development of our new faith facilities and community hub. The full shortlist and further details are available on the awards website.

Ambition 5
To integrate care

Respiratory diagnostic tests are now being carried out at Bolton One thanks to a collaboration between local health services to reduce demand on hospital services and improve treatment for our patients.

Tests include Spirometry, which is the most commonly performed lung function test and provides basic information about a patient's airway function and vital capacity. The spirometry service was paused during the pandemic, due to the risk of potential aerosol generation but has since been providing vital tests to our local people.

As the service develops, the team plans to deliver a comprehensive joined up care package to include smoking cessation, inhaler techniques and other lifestyle choices, such as weight management. The ultimate aim is for the team to be based in primary care settings across the 49 GP practices across Bolton to enable care closer to home for our communities. We welcomed ITV Granada Reports to Bolton One earlier this month to showcase the service and the difference it's making to patients.

Work has continued to move from a 9 neighbourhood model to 6 to make it easier for teams to work together to support people at home and work more closely with our key partners. The boundaries of each of the six neighbourhoods has been refined and we are now looking at patient acuity and demand across the area to enable the right skill mix of staff across the caseloads for each area to be determined. The recruitment for six new roles who will be responsible for the development and delivery of neighbourhood working is currently underway with people expected to start in post before the end of the year.

Attendees of this month's Locality Board were joined by Sir Richard Leese, Chair of the Greater Manchester Integrated Care Board. The discussions included an update about Bolton's locality plan, our financial position and the Bolton Hospice recovery programme.

Ambition 6
To develop partnerships

Children staying in our hospital now have the opportunity to learn all about space, world exploration and dinosaurs thanks to a donation of free courses. The Trust and Our Bolton NHS Charity have teamed up with Centre of Excellence to give free access to 21 courses for children, which are tailored for children in both Key Stage 1 and 2 meaning children won't miss out on all of the learning they would be doing in school.

Thousands of pounds have been raised for Our Bolton NHS Charity during a six-hour Spinathon, with donations continuing to be made. Foundation Trust, Council and Public Health staff were all amongst the participants and Mr Mayor of Bolton, Councillor Mohammed Ayub, visited the studio to cheer on the teams as they entered their final hour of the event.

The charity will be funding 21 recliner chairs as a result of the Trust's fatigue working group designed to look further into the issues of fatigue in staff at Royal Bolton Hospital. The impacts of staff fatigue on patient safety, staff safety and wellbeing has been well documented and this has been recognised as a significant risk amongst our workforce.

In a recent survey of our staff, 59% of respondents felt they had been so tired after a shift, they felt unsafe to get home but there are currently no suitable areas (at ward level) for staff to rest during a shift, or sleep before travelling. Two recliner chairs have already been sourced free of charge and the charity funding will enable the repurposing of five on-call rooms within Musgrave House and create 'short stay rooms' and a further 18 recliner chairs for ward areas.

We have continued to receive entries from primary school children in Bolton who have created artwork for the competition that captures the historical NHS75 milestone. More than 60 designs have already been submitted ahead of the deadline, many of which say 'thank you' to NHS staff. The winning design will be selected later this year and placed on display at one of our sites.

A collection of mosques in Bolton have raised more than £18,000 in donations for Our Bolton NHS Charity to transform the wellbeing of staff patients, and communities. The Bolton Masjid Chanda Committee (BMCC), which represents 11 mosques, raised the money during Ramadan 2023. Their contributions have been donated to the 'general purposes fund', which gives the charity the flexibility to direct funds where they are needed most and will make a lasting and meaningful difference.

Gemma Atkinson and Gorka Marquez have been publicly praising our maternity service following the birth of their second child, Thiago, at Royal Bolton Hospital last month. A film crew has documented Gemma's pregnancy for a new documentary, Gemma and Gorka: Life behind the lens, which broadcast at the end of August, featuring our staff throughout.

Report Title:	Strategy and Operations Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 September 2023		Discussion	
Exec Sponsor	Sharon White and Rae Wheatcroft		Decision	

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

Summary:	The attached report from the Chair of the Strategy and Operations Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meeting held on 24 July 2023. Due to the timing of the September meeting, a verbal update will be provided at the meeting and will be included in the November meeting pack.

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

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

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

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

Strategy and Operations Committee Chairs Report

Name of Committee/Group:	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	24 July 2023	Date of next meeting:	25 September 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Alan Stuttard, Rae Wheatcroft, Sharon White, Tyrone Roberts. In attendance: Harni Bharaj, Louise Clarkson, Kelly Crumlin, Sharon Katema, Rachel Noble, Julie Ryan, Kate Smith, Jo Street, Lesley Wallace, Brett Walmsley, Judith Richardson (minutes)	Quorate (Yes/No):	Yes
		Apologies received from:	Francis Andrews, Sam Ball, Rachel Carter, Rayaz Chel, Andy Chilton, Jake Mairs, Lianne Robinson, Maddie Szekely

Key Agenda Items:	Lead	Key Points	Action/decision
Q1 Look Back/ Q2 Look Forward	R Noble	Received Q1 'look back' and Q2 'look forward' against the 5 priorities which are aligned to our strategic ambitions: • **Children & Young People** **Q1 look back** - Maternity, 0-19 Contract, SEND Offer **Q4 forward look** – Maternity, 0-19 Contract, Paediatric Services **Seeds to Saplings** – Go-live for Electronic Medication Administration Record prescriptions from Ward E5 to community nursing and medical teams. • **Data and Digital** **Q1 look back** - Commenced Community and Outpatients EPR, Continued deployment of equipment, creation of new operating model for ICB locality BI, commencement of MIYA patient flow project, IG Toolkit submission **Q2 forward look** – Microsoft Agreement, continued deployment of equipment, Go-Lives, continued work, collective prioritising • **Performance and Recovery** **Q1 look back** - Urgent Care, Virtual Wards, CDC and DM01 **Q2 forward look** - Delivery of Q2 milestone for treatment of patients within the 65week backlog cohort, mobilisation of Winter plan schemes, CDC and DM01 **Seeds to Saplings** – Robotic Process Automation, DaVinci Robot • **Recruitment and Retention** **Q1 look back** - Equality, Diversity and Inclusion, NHS Staff Survey, People Plan **Q2 forward look** – Community Diagnostics Centre Staffing, filling medical vacancies and reducing medical agency spend, Deep Dive into AHP recruitment and retention challenges **Seeds to Saplings** – refreshed approached to working with educational providers in Bolton • **System Transformation - Neighbourhoods** **Q1 look back** - Neighbourhood Mapping Completion and Implementation Plan, Establish Community of Practice for Asset Navigators/Social Prescribers in Neighbourhoods, Approval for Establishment of Neighbourhood Leadership **Q2 forward look** - Workforce engagement and OD requirement for 6 Neighbourhoods, Development of Neighbourhood profiles, Detailed assessment & finalisation of IT model and estate **Seeds to Saplings** – working across organisations to explore opportunities to improve connection.	The following actions and comments were noted: • Initial scoping exercise for Community and Outpatients EPR complete and currently with Altera for costings on a model for implementation. • The Committee welcomed the insight into new innovations - Seeds & Saplings - within the updates as part of further fostering a culture of risk managed innovation • The Chair acknowledged the fantastic Digital achievements during Q1 in light of current resource and capacity issues and wished to formally pass on her thanks to the Digital Team on behalf of the Committee. • Agreed that strategic risks needs a tighter focus for next look back, look forward. Action Consider how to integrate risk management more effectively in the quarterly review

Month 3 – Operational IPM	J Street	The Committee received the presentation of the operational element of the Trust Board's IPM. Key points to note: **Urgent Care:** • Small improvements in all metrics but considerably below the plan of 75% for 4-hour performance due to internal flow • Deterioration in Neck of Femur performance in comparison to last month due to capacity in trauma theatre and availability of specialist hip surgeons. **Elective Care:** • Continuing progress against 65-week milestone plan, delivered over 100% for outpatient first attendance and elective treatments in June despite industrial action • DM01 position improved by 7.3% in June, final position 85.8% with Colonoscopy now fully compliant **Cancer:** • Cancer performance for 2 week waits remains challenging due to Radiology capacity in Breast services. Failed the 62-day and faster diagnosis performance standards in June • Deep Dive into Radiology underway and improvements in faster diagnosis standard are expected. Full update on Cancer performance to come to next meeting. **Community Care – Children's** • SEND inspection date not known but Team remain prepared. • Key areas of service delivery now being prioritised for the 0-5 Health Visitor mandated contacts with antenatal visits now being recommenced which is expected to improve performance. • The EHCP compliance underperformance is due to delays in paperwork for out–of-area referrals /staffing challenges within AHP teams. Work on-going with ICB to improve processes.	Noted with the following comments received: • Any deviations/themes from the Neck of Femur 'Deep Dive' will be taken through speciality governance. • Discharge of one LoS patient had significant improvement in month for NCTR due to the large proportion of total lost bed days occupied but noted as exceptional case • The de-prioritisation of antenatal visits during Covid is now part of the prioritisation work. • The redevelopment of ward clinical boards and the development of UTC initiatives have now moved from pilot to sustainable model • Breast Radiologist recruitment is a national problem. Some organisations are splitting the start of the pathway to reflect achievement of the standard.
Winter Planning	J Street	The Committee received the update on the approach to Winter planning for 2023/24: • The Plan was developed in line with operational planning guidance which has elements for improving productivity in A&E waiting times so that no less than 76% of patients are seen, treated, admitted or discharged within 4 hours by March 2024 with further improvement in 2024/25; improving category 2 ambulance response times to an average of 30 minutes across 2023/24 and reducing and/or maintaining adult general and acute (G&A) bed occupancy to 92% or below. • Based on review of Winter 2022/23, Divisions developed transformation plans which have focussed on minimising risk of attendance, admission or reducing length of stay. Urgent Care Transformation Board will oversee and monitor progress against the Plan along with the identified cross-cutting projects, virtual ward and criteria-led discharge. • Bed modelling indicates that based on a super-high flu prevalence, without any reduction in admissions or length of stay, to achieve 92% occupancy we will require all beds to be open, plus an additional shortfall of 43 adult acute beds to manage this Winter. Length of Stay improvement plans are being tested to see if they support a length of stay reduction of 0.9 days.	Noted with the following comments received: • The planning approach is for focused efforts by the Divisions during the summer on those schemes that will have the biggest impact which will provide headroom going into Winter. • Plan will be enacted as described and nothing delayed in terms of waiting for additional monies being received. • Chair recommended that a paragraph is added for Board to contextualise the stretch challenge for the length of stay reduction target last year of 0.5 days compared to 0.9 this year along with bed occupancy target of 92% given we were at 94% in May.

Strategy and Operations Committee Chairs Report

NCTR Update	R Wheatcroft	The Committee received the quarterly update on the NCTR position: • The aim was to achieve the operational plan of 90 patients on the NCTR list by the end of Q2 and 360 lost bed days. This in itself was a stretch target, however, the Divisions were then challenged to improve this position further working towards reducing lost bed days due to NCTR to the target of 400 by the end of Q2. • Having achieved 90 NCTR patients in May, there were 84 patients with NCTR as of June, evidencing a sustained improvement trajectory.	The Committee acknowledged the positive traction and improved position. The following comments received: • Work has taken place to improve 'front door / back door' flow but more focus is now required on the middle pathway • Return of Wigan social workers has seen improvements in accelerating discharge of Out of Area patients. Avoidance of ambulance diverts will also bring improvements in avoiding patients being in the wrong place and unable to be discharged effectively. • The Chair noted the great work and continued focus and passed on her thanks to the Team.
Digital Performance and Transformation Board Chairs Report	B Walmsley	The Chair's report was presented and the following key points were noted: • Quorum of the meeting to be amended from 2 to 1 Executive Director in attendance • Risk 5400 remains the highest risk until recruitment to vacant posts is complete and the demand and capacity review carried out to identify any gaps. • Risk 5869 is being mitigated through robust cyber security processes. However, in light of the recent national cyber incidents at the University of Manchester and Barts Hospital which resulted in significant data loss, the risk scoring remains high. • The SLA with GM ICB is up for renewal at the end of March 2024 and the Locality is required to provide 6 months' notice of an intention to extend the contract • Digital Education Team attended Trust induction for the first time to represent Digital and provide a better experience for new starters. • Significant improvements noted in relation to the percentage of calls handled as the new Service Desk staff have been on-boarded with positive feedback received.	Noted with the following comments received: • Each organisation is now expected to have a Cyber Security Lead and a business case for this is being developed. • Risk 2956 relates to reputational damage from the Trust not knowing where all its data is being processed and passed to and from. • The Chair acknowledged the extension to the SLA contract with GM ICB and passed on her thanks to the Team for the effective system working with our Primary Care partners.
Maternity EPR	L Anton	The following key points on the status of the Maternity EPR implementation were noted: • A second delay notice was received from K2 in April 2023 which has clinical, reputational, operational, safety and financial implications. In addition to this the delay may impact on attainment of CNST Year 5 compliance. • Project team sought procurement and legal advice and an options paper was developed. Given the risks associated with the need to implement an EPR, the current financial landscape and the legal advice regarding terminating the contract, the Maternity Systems Implementation Project Board recommended pursuing Option 5 which was supported by the Executive Team. This option accepts the remedial action plan from K2, with caveats for timescales to facilitate an extended testing and training period for safe implementation. • Meeting with providers and parent company took place on 13.7.23 and progressive and proactive action plan agreed with tight timescales which will be monitored by the Project Board.	The following comments were received: • Of the other trusts using K2, only one has sought to pull out of the contract but there was very limited assurance around recuperating any monies already spent. • It is in the contract that K2 will not do more than one go-live at any one time • The Committee noted the parent guarantee being sought & suggested that, going forward, standard protocol should be to agree at what point a parent guarantee is necessary before we sign.

Strategy and Operations Committee Chairs Report

Update on GM Business Intelligence Consultation	J Ryan	The Committee received the update on the status of the GM ICB BI Team and service: • The second part of the consultation came to an end on 3.06.23. Communication out to staff on the final structure for all locality and GM functions due at the end of July. • GM data and intelligence service will be working in a temporary way over the next 6-8 weeks to deal with some urgent demands. For localities this means that some staff will be working solely within the delivery team within the central GM BI function and therefore in response to this all localities will be combined across GM to work as one locality team. • Work will continue on the delivery of key products for the locality including locality board reporting and neighbourhood intelligence profiles. • Bolton is well-placed with regards to the plans to bring the function together as a number of staff are staying in the Bolton area whilst other teams within GM have lost a majority of staff to the central teams. Careful prioritisation and planning will be needed over the next 8 weeks. The impact on staff of this level of change plus the additional temporary change should not be underestimated.	The following comments were received: • There is no SLA in place with GM as the locality teams are employed by GM ICB as well. • It has been agreed in principle with GM that the developers will be able to continue to work on the Trusts' priorities. Action: • Develop an internal SLA with GM for BI outcomes, so the Trust's priorities are appropriately supported
Clinical Strategy Engagement Update	H Bharaj/R Noble	The Committee received the engagement draft of the clinical strategy for review and approval of the three priorities and the nine supporting themes: • Progress updates will be brought to SOC on a monthly basis with updates to the Board as follows: – July Board – early draft – following this the Strategy will be refined and socialised with staff, the public and patients and our partners. – September Board – post-engagement draft – November Board – a concise, edited version of the document ready for final approval and publication. • Divisions are engaged and have far more confidence in the process and the output than have previously with positive feedback received from the Divisional DDOs.	The following comments were received: • 'I' statements are generic and need to brought to life with some examples of 'before/after' service user journey view • Risk rating and mitigations will be reviewed for major critical enablers e.g. Wi-Fi and BI • Engagement plan being developed along with specific development work programmes and targeted questions to lift teams ambitions around the strategy.
Board Assurance Framework	S Katema	BAF quarterly update received ahead of submission to the Board of Directors on 27th July 2023. • Risk appetite for 1.2 remains as 'Open' and following the review at the last SOC meeting 5 is now 'Seek' having been rated at 'Mature'. In relation to Ambition 5, it was clarified that the 'Lack of collaboration with system partners to understand and respond to the wider determinants of health' related to the lack of maturity within the system.	The Committee noted the BAF
Neighbourhoods Update	K Smith	The update was noted. • Neighbourhood mobilisation is in Phase 1 of 3 (each phase being of a year's duration) and is transitioning from 3 districts to 6 neighbourhoods. • It was noted there are 2 organisations working at neighbourhood level with different levels of digital maturity, which is being carefully navigated. • Phase 2 is when full integration will occur. • Community 'asset navigators & social prescribers' / community support workers are being mapped in June.	The following comments were received: • The detailed assessment and finalisation of IT model and estate rationalisation candidates will be delivered by the end of Q4 • Common approach on language e.g. 'asset navigators' to be considered going forwards so it is user friendly. • The Chair acknowledged progress within the Q1 Look Back/Q2 Look Forward review and passed on thanks to the team for the traction made in keeping on track during phase 1.

Strategy and Operations Committee Chairs Report

Strategy, Planning & Delivery Committee Minutes	S White	The Chairs report was taken as read.	The Chairs report was noted.
Performance and Transformation Board Chairs Report	R Wheatcroft	The Chairs report was taken as read.	The Chairs report was noted.

Items to note or be escalated to the Board:

- 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
- NCTR trajectory continues on an overall positive trend (84 patients in June versus a target of 90) 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.
- Maternity EPR - Meeting with providers and parent company took place on 13.7.23 and progressive and proactive action plan agreed with tight timescales which will be monitored by the Project Board to ensure safe implementation. A parent company guarantee is being sought.
- Winter plan preparations include stretch targets for occupancy and reducing length of stay with a forecast of being 43 beds short (81 beds short this time last year)
- Impact for BI of GM led changes to be mitigated by seeking an internal SLA for BFT priorities
- Due to the increasing risk around cyber attacks, a dedicated cyber lead will be required for the Trust.

Report Title:	Bolton Director of Public Health's Annual Report 2022

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 September 2023		Discussion	✓
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	The report presents updated information on the health and wellbeing needs of Bolton's resident population, providing information for decision-makers including in local health services and authorities on health gaps and priorities that need to be addressed.

Summary:	The Health and Social Care Act (2012) sets out the requirement for Directors of Public Health in England to produce an annual report on the health and wellbeing of their population. The latest Annual Report of the Director of Public Health for Bolton presents an updated picture of the health of people living in the borough. Three important topics are explored in this year's report: changing patterns of the population's demographics, trends in health and inequalities, and a focused look at mental health and wellbeing amongst the population. The analyses show worrying trends in health and wellbeing. Life expectancy, an overall summary indicator of the health of a population, has worsened, and there are marked inequalities in health between different groups of people and communities within the borough. Health inequalities are driven by a complex range of factors including the accessibility and quality of health and care services, individual behaviours and, most importantly, wider determinants such as housing and income, the physical, social and economic circumstances in which we live. The focus on mental health highlights that people with mental health conditions are at greater risk of lower life expectancy.

Previously considered by:
N/A

Proposed Resolution	The Board is asked to receive the Director of Public Health's Annual Report 2022.

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:	Lynn Donkin, Director of Public Health	**Presented by:**	Lynn Donkin, Director of Public Health

Director of Public Health's

Annual Report 2022

How are you Bolton?

Bolton Council

Editorial Team chaired by Kate Shethwood, with contributions from:
Shan Wilkinson, Munisha Savania, Phil Zarei, Chris Kirk, Lucy Heaton,
Leesa Hellings-Lamb, Karen Cassidy, Michael Kane, Tracy Lumer and many
members of the Public Health Directorate and partners beyond.

Contents

About this report

The Director of Public Health's Annual Report is a professional statement on the health and wellbeing of Bolton's population and includes independent recommendations on actions to improve and protect the health of residents in the borough.

The report is aimed at people who live, work, or have another connection to Bolton.

It aims to cover:

- What helps to look after our mental health
- Examples of what is going on in Bolton to support mental wellbeing and where to go for more information
- Some of what we know about how people are feeling and what is important to them
- The main changes in Bolton's population and some of the main things affecting our health
- Different experiences between people

Whilst it won't describe all the many things which affect people's mental health and wellbeing in Bolton, further detail on this will be available in the series of reports and information forming a Mental Health and Wellbeing section of the Bolton JSNA.

This and lots more information like it can be found on the JSNA webpage.
www.boltonjsna.org.uk

Director of Public Health's Annual Report 2022

At a glance...

The population has grown to nearly **300,000**

9.8% of respondents to the 2021 census in Bolton provide between one and 50 hours of unpaid care per week

91% of usual residents of Bolton identified with at least one UK National identity

Covid-19 now accounts for more than **10%** of the gap in life expectancy within Bolton

43% find it difficult to afford rent or mortgage costs

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

22% of children now live in relative poverty; significantly higher than the England average

26% of the Bolton population live in an area that is among the 10% most deprived nationally

Bolton's Big Wellbeing Conversation

30% of people with any long-term physical health condition also have a mental health condition.

24% of Bolton survey respondents reported low levels of happiness

23% of respondents reported a low level of life satisfaction

71% of Bolton's survey respondents reported high or very high anxiety

Over the last ten years between **20-30 people from Bolton** have died by suicide each year

We have heard directly from young people and parents about their challenges and worries around children missing out on learning and socialisation during the pandemic but also the opportunities and resilience they found

We have data on sexuality and gender identity for the first time, allowing us to better target services and recognise more fully our diverse population

Life expectancy has reduced. There is around 11 years difference between the most and least deprived groups

5 ways to wellbeing are evidence-based ways to help yourself and communities to keep well and protect and improve mental health

Summary

Inequalities are increasing:

- Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment.

- Life expectancy, an important indicator of our population's health, is lower in Bolton than the England average and has fallen in recent years, partly due to the Covid-19 pandemic. Inequalities in residents' health have widened, with life expectancy varying by 11 years between different areas within the borough.

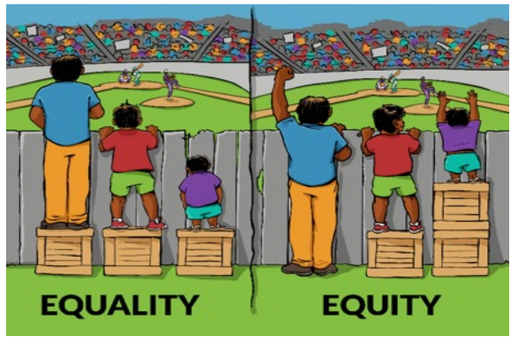
- The proportion of Bolton's children living in relative poverty (families whose income is 6-% or less than the UK median) has risen to 22%, an increase of 4.7% since 2014/15.

- We are moving out of the Covid-19 emergency response but the effects will live with us for many years; directly in life expectancy (Covid-19 now accounts for more than 10% of the gap in life expectancy within Bolton) and indirectly, through disruption to education, changes in how people use town centers and high streets, impact on mental health, changing job opportunities and reductions in preventative health care including screening and immunisations. These have not affected all people equally.

- The rising cost of living is affecting many of the people already disproportionately affected by Covid-19 pandemic.

- This level of inequality is not inevitable, there is evidence on what can be done. These are complex problems requiring coordinated action across partners. The Active Connected Prosperous (ACP) Board brings together public services and voluntary and community organisations to deliver the Vision 2030; Bolton's joint health and wellbeing strategy.

- New arrangements are developing across Greater Manchester to bring NHS, local authority services and wider place based services closer together. Greater



Source: https://interactioninstitute.org/illustrating-equality-vs-equity/

Manchester Integrated Care (Bolton Locality) are the commissioners for health and social care services and lead on reducing inequalities in people's experience of health and social care. GMIC Bolton and the wider Health and Social Care Partnership will continue to work on joined up approaches to tackling inequalities as key partners to the ACP Board.

- Some groups within society experience more risks from their physical and social environment or find it more difficult to access support. Some experience discrimination. Responding to this with universally available services that are able to respond differently to the level of need they see is called 'proportionate universalism.'[1]

Mental Health and Wellbeing:

- Our mental health influences our physical health and vice versa, with around 30% of people with any long-term physical health condition also having a mental health condition. Life expectancy is lower for people with mental health conditions.

- Bolton's Big Wellbeing Conversation highlighted:

o Nearly a quarter (24%) of Bolton survey respondents reported low levels of happiness – a much higher proportion than the national average (<5%).

o 23% of respondents reported a low level of life satisfaction compared to less than 5% nationally

o The proportion of people in Bolton reporting a low level of belief that their life is worthwhile was 22%, compared to less than 5% nationally

[1] Proportionate universalism and health inequalities (healthscotland.com); Macdonald W, Beeston C, McCullough S. Proportionate Universalism and Health Inequalities. Edinburgh: NHS Health Scotland; 2014.

o 71% of Bolton's survey respondents reported high or very high anxiety compared to less than 40% nationally

- Over the last ten years between 20-30 people from Bolton have died by suicide each year .

- Bolton's Children and Young People's Emotional Health and Wellbeing Joint Strategic Needs Assessment suggests the pandemic made it more difficult to get help but in 2020/21 for those who were assessed, more than double the number were referred on to receive further help and nearly 50% more young people required specialist mental health services.

- During the pandemic, local authority children's services across the country consistently reported to Department for Education increases in complexity, with mental health issues in children heightened throughout and existing mental illness in parents exacerbated. We have heard directly from young people and parents about their challenges and worries around children missing out on learning and socialisation during the pandemic but also the opportunities and resilience they found.

- Bolton Council worked with the University of Bangor[3], who interviewed 1,876 adults in Bolton about experiences of Adverse Childhood Experiences (ACEs). They found 52% of local adults had at least 1 ACE; 11% had 4 or more ACEs. People with more ACEs were found to be at higher risk of health, social and emotional problems. They were more likely to smoke, to report having been a victim of violence, and more likely to report having a mental health diagnosis. A programme of work to prevent ACEs and increase resilience and protective factors is now underway in Bolton.

- The '5 ways to wellbeing' are evidence-based ways to help yourself and communities to keep well and protect and improve mental health. There are lots of ways that people in Bolton are already connecting, giving, taking notice, being active and learning and helping others to do so.

Recommendations...

1. Build on the rapid partnership response to the cost of living pressures by producing a system-wide Poverty Strategy for Bolton
2. Provide energy bill, food bill and car fuel consumption advice and support
3. Continue to develop and promote the Joint Strategic Needs Assessment (JSNA)
4. Embed 'proportionate universalism'[4]; resourcing and delivering universal services at a scale and intensity proportionate to the degree of need
5. Deliver the Prevention Concordat for Better Mental Health Plan
6. Make every contact count – for staff and residents
7. Improve measurement of mental wellbeing using new Toolkit
8. Make it easy to access and navigate holistic mental health and wellbeing support

[2] ONS (2022) Suicides in England and Wales by local authority. https://bit.ly/3YdUJac
[3] Ford K, Hughes K, Bellis M. (2021). Adverse childhood experiences (ACEs) in Bolton Impacts on health, wellbeing and resilience. Bangor [4] University. https://bit.ly/3nM6OpL
[4]Proportionate universalism and health inequalities (healthscotland.com); Macdonald W, Beeston C, McCullough S. Proportionate Universalism and Health Inequalities. Edinburgh: NHS Health Scotland; 2014.

Foreword

This year's Annual Public Health Report for Bolton adds to our knowledge and understanding of the health and wellbeing of Bolton's residents and explores the differences in people's health and experience across the borough.

Lynn Donkin,
Director of Public Health

The report is in three sections

1. Considers the findings that have recently been released for the 2021 Census, showing how Bolton's population demographics are changing. It also reflects on the emerging impact of the rapid fall in disposable incomes since late 2021[5] ('cost of living crisis').

2. Presents analyses of recent trends in life expectancy and health inequalities amongst Bolton's residents.

3. Explores what we know about mental wellbeing in Bolton, including '5 ways to wellbeing' with examples of things going on in Bolton, with a final section for recommendations and where to get more information.

Last year's report discussed the impacts of the pandemic and the response in the borough. This captured the very significant direct and indirect consequences for health and wellbeing. The previous report also highlighted the incredible response from people and organisations across the borough. This was nationally recognised with a Gold Award for Community Focus at the national iESE Public Sector Transformation Awards.

Over the last year, we've all been learning to adapt to 'living with Covid'. Within the local authority public health team we have been adapting arrangements for protecting residents' health from covid and other infectious diseases and emergency events, by updating the Local Outbreak Management Plan and refocusing the work of the Health Protection Board.

But we now need to take the learning from Covid to help each other with recovery and pick up where we left off on creating environments that promote wellbeing and make Bolton a great place to live. There is a lot to deal with.

The cost of living forces people to make difficult choices and adds stress to daily lives. It is harder to live healthily and happily when money is tight and it is not good for any community to feel big differences between groups.

During the pandemic, people showed incredible resilience and support for others. We can build on this with asset-based community development (ABCD) that focuses on social connections and building on what is already good in Bolton.

The pandemic also took a real toll on many people's mental wellbeing[6]. For children and families the loss of education and time outside the home put pressure on relationships and added worries about the future. For those who were unwell it made accessing help harder and for others the isolation, loss, money worries and/or caring responsibilities made it harder to keep well mentally. That is why we have decided to focus on mental wellbeing this year.

We know that the impact of the pandemic was not equal and that is not new; often the same people experience multiple challenges and structural barriers to good health. We have to focus on reducing those differences – or inequalities – by improving things faster for those who are worst off so that everyone has the same opportunities to thrive.

Bolton is part of the Greater Manchester Marmot City Region and our own 2030 Vision for Bolton is structured around the Marmot Principles which set out an evidence-based strategy to address the things that determine our health; the conditions in which people are born, grow, live, work and age.

[5] Institute for Government. (2022). Cost of Living crisis: explainer. https://bit.ly/40Mkfns

[6] Local Government Association. (nd). Public mental health and wellbeing and COVID-19. https://bit.ly/3ztz9na

1. Bolton's population changes and cost of living

How Bolton's population has changed between 2011 and 2021

The census happens every 10 years and gives us a picture of all the people and households in England and Wales.

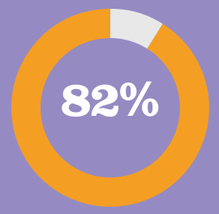
The most recent Census Day was Sunday 21 March 2021 and we are starting to see the results showing how Bolton's population has changed over the last 10 years. Whilst this is valuable data, it's also important to supplement this with other sources of information and through work with communities to understand findings in more depth.

The population has increased by 6.9%

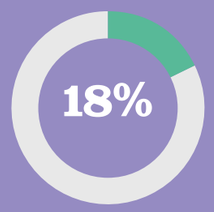
300,000

Bolton has a younger population than the NW and England – median age 38

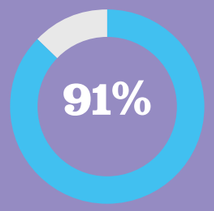
Bolton is a diverse town.



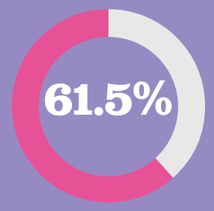
82% of the local population were born in England, with Pakistan the next most commonly represented country of birth (4.2%) and then India (2.7%).



18% Increase in the proportion of people in Bolton living in private rented properties.



91% of usual residents of Bolton identified with at least one UK National identity (English, Welsh, Scottish, Northern Irish, British and Cornish), similar to national figure.



61.5% own their home with or without a mortgage.

For breifings on census and links to national and local mapping and other tools, see New and notable – Bolton JSNA.

Director of Public Health's Annual Report 2022

The census shows some changes in people's home and work circumstances, but this may be influenced by the census being done in 2021 when lockdown restrictions were still in place or only recently lifted:

There are proportionately
fewer households without children
(single-adult or couples)

More people are working
30 hours or less

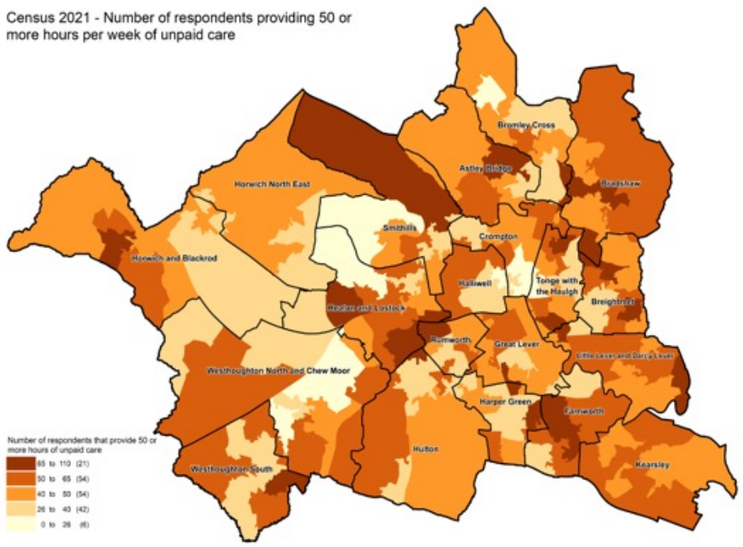
Reasons for people being out of the workforce have changed somewhat, with more people looking after their family or home. Bolton saw the third highest rise in the North West of people not in paid work for this reason.

5.4% of people are not in paid work due to being long-term sick or disabled. This has not changed since 2011.

Unpaid caring responsibilities have changed. This may have been affected by the pandemic. Some people appear to have done much more caring, possibly due to lack of support from others, and some did less, possibly due to avoiding contact.

9.8% (25,980) of respondents in Bolton said that they provide between one and 50 hours of unpaid care per week, with 3.3% (8601) providing 50+ hours of unpaid care per week. Caring responsibilities vary across Bolton:

Figure 1: Census 2021 - respondents providing 50 or more hours per week of unpaid care



Director of Public Health's Annual Report 2022

Bolton's population

295,963

26% of the Bolton population live in an area that is among the 10% most deprived nationally, while 56% of the population live in an area that is among the 30% most deprived nationally.

Gender:

men 49%

145,907

women 51%

150,056

Age:

0-15	**63,674**
15-24	**30,992**
25-64	**150,574**
65+	**50,721**

Pregnancy and maternity:

3,453 births in 2021, of which

32.8% of births in 2021 were by non-UK born mothers.

14,930 stay at home to look after family/home.

Race:

72% White

20% AsianAsian British

4% Black/Black British/ BlackWelsh/Caribbean/African

2% Mixed/Multiple ethnic groups

2% Other

28% are from communities facing racial inequality. Main languages include English, Gujarati, Panjabi, Polish, Arabic and Somali.

Marriage/Civil Partnerships:

105,505 married

362 civil partnerships

Sexual Orientation:

5,695 LGBT+ community

Gender Identity:

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

Religion:

No religion	**26%**
Christian	**47%**
Muslim	**20%**
Hindu	**2%**
Other	**1%**

Unpaid carers

25,980

Care leavers

190

Disability:

18% (16+)

9% have a long term health condition or disability which limits their day to day activities a lot

Armed forces veterans

7,345

All data was correct at the time of publication, gathered from **Office of National Statistics sources** and **Bolton JNSA**

Cost of living[7]

Bolton Council's recent cost of living survey heard from nearly 500 people:

- Just under one-third (29%) stated that they were really struggling with the rising costs and were unable to cope financially.
- 44% of respondents stated they were managing, but were finding the rising costs difficult
- Just under one-quarter (24%) stated they were currently managing the costs of living, but were concerned about future price rises.

A Greater Manchester residents[9] survey found similar rates of concern amongst Bolton respondents and also:

- 43% of respondents in Bolton say that they would not be able to afford an unexpected but necessary expense of £850
- Over half of respondents in Bolton say that it is hard to afford their energy costs (55%), with 43% saying that it is difficult to afford their rent or mortgage costs

These figures are similar to the Greater Manchester averages.

Some of the worst impacts are likely to be seen well into the future on a large scale:

- Almost one third of Greater Manchester respondents (30%) say they have borrowed more money or used more credit in the past month, compared to this time last year.
- Of this 30%, 1 in 5 estimate borrowing over £2,000 more than this time last year.
- Over half (53%) of those who have borrowed more money or taken out more credit are worried about being able to pay back this money.
- A quarter (24%) of Greater Manchester residents are seeking information or support for the first time

Worries about food:

- 45% of Bolton residents are experiencing low or very low food security, meaning they do not have enough food to facilitate an active and healthy lifestyle[10].
- Over half (58%) of Bolton respondents with children live in a food insecure household, similar to the GM average (56%). This is much higher if the adult is aged 16-24 years (86%), a renter (74%) or a lone parent (70%).
- A quarter (25%) of Bolton respondents have not eaten for a whole day because there wasn't enough money for food, higher than the GM average (21%).

This impacts directly on people's wellbeing, with certain groups showing a much higher rate of 'low life satisfaction' than the average across Greater Manchester (15%):

- Disabled respondents (30%) including those who have mental ill health (44 %), a mobility disability (30%), a sensory disability (26%) or a learning disability (25%)
- Those not in work due to ill health or disability (49%)
- Those who have been out of work for more than six months (36%)
- Those who have not eaten for a whole day due to lack of money (33%)
- Those who have got a loan from a friend, family member, neighbour or other personal connection (31%), or a loan from a bank / overdraft (29%)
- Those who live in a property rented from a housing association (27%)
- Those who are homemakers (27%)
- Those who find it difficult to afford their mortgage/rent (26%)

The rising cost of living is impacting on the health and wellbeing of Bolton residents.

Bolton Council's survey found...

89% of residents were cutting back on heating their homes

88% were changing shopping habits

78% were cutting down on socialising with others

These things can have a major impact on people's health and wellbeing.

Respondents wanted more information on energy bill support, how to reduce food bills and car fuel consumption, which may help people live more sustainably but must be done with the health risks in mind.

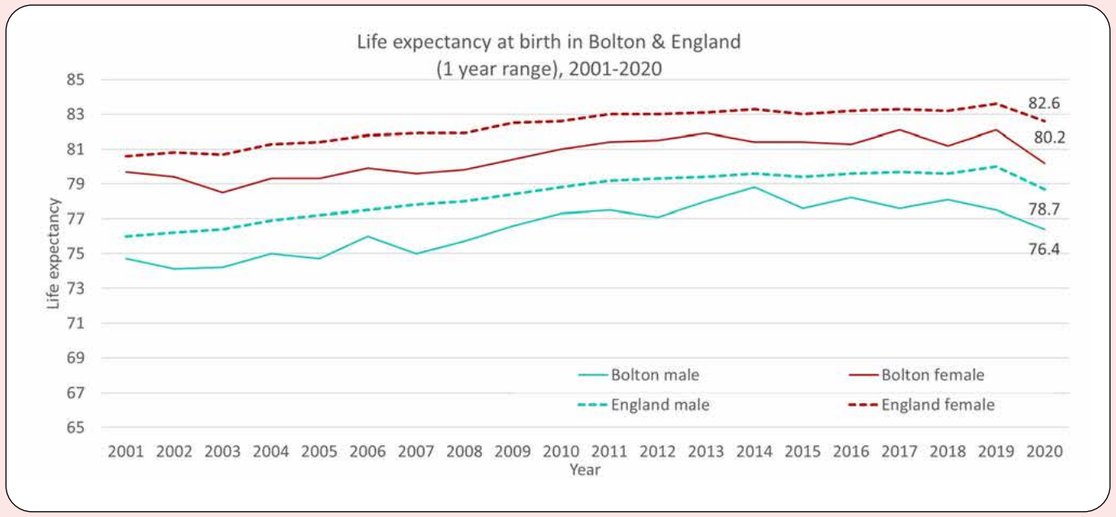
[7] 'cost of living crisis' refers to the fall in 'real' disposable incomes (that is, adjusted for inflation and after taxes and benefits) that the UK has experienced since late 2021, as described by: Institute for Government. (2022). Cost of Living crisis: explainer. https://bit.ly/40Mkfns
[8] Bolton Council Consultation & Engagement Team (2022). Cost of living – public findings.

[9] GMCA (2023). Greater Manchester Residents' Survey, wave 5. https://bit.ly/3X3n55e
[10] DWP (2023). Family resources survey: financial year 2021 to 2022. https://bit.ly/3KhJOYj The GM residents survey uses the same questions as in the family resources survey.

2. Life expectancy and inequalities within Bolton borough

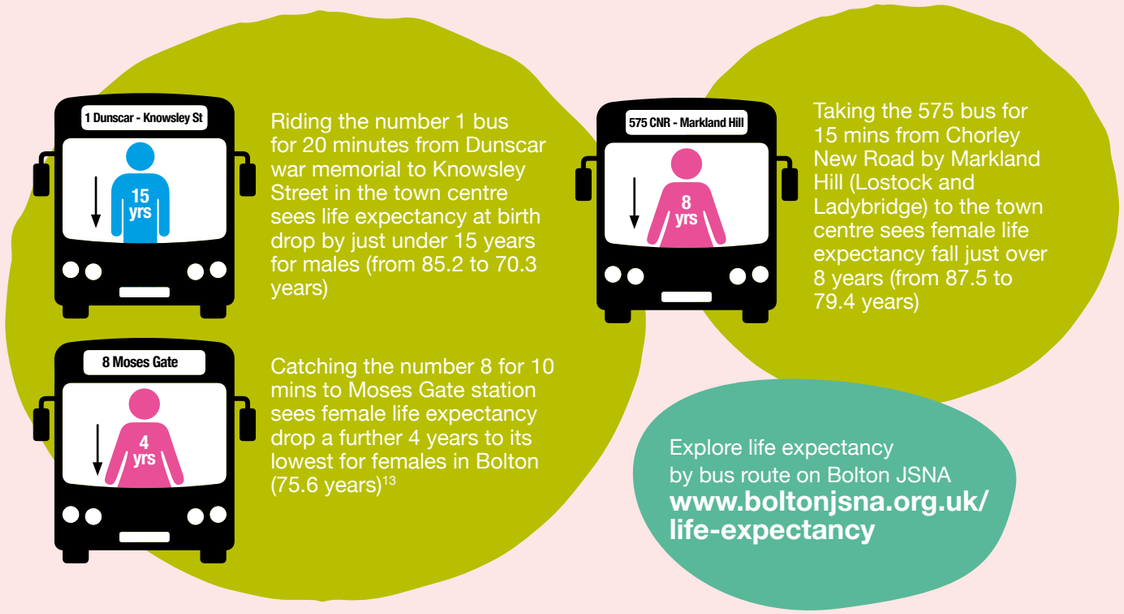
Life expectancy is reducing and gaps widening.

- Life expectancy is an important indicator of overall health and the differences between different groups of people.
- Improvements in life expectancy slowed between about 2014 and 2020 in Bolton and across England as a whole.
- Direct and indirect impacts of the Covid-19 pandemic appear to have contributed to a decrease nationally and within Bolton to levels not seen since 2009.
- Life expectancy in Bolton is persistently lower than in England as a whole and varies a lot within Bolton[11].
- Closing the gap and reversing these trends requires co-ordinated focused efforts.
- It also requires doing more for those groups whose life expectancy has reduced faster than average in Bolton.

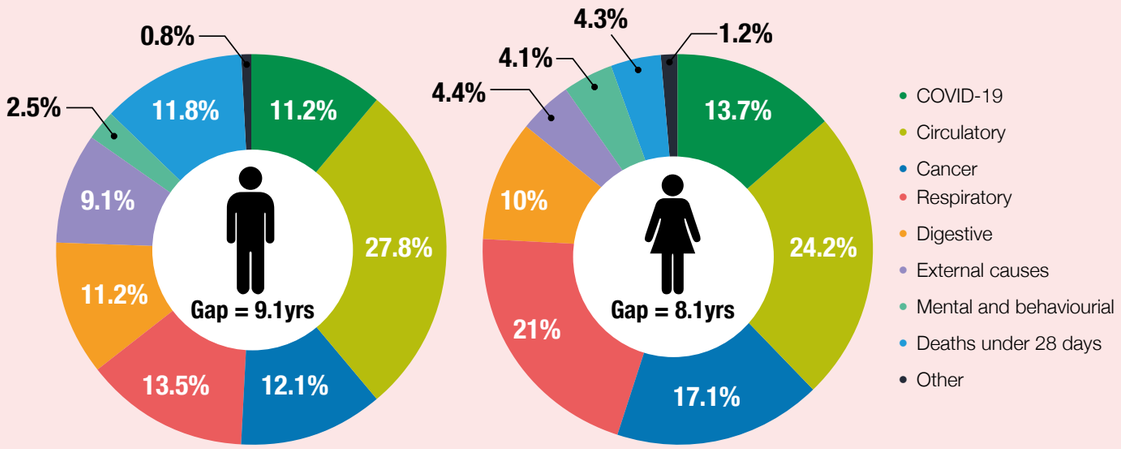


[11] Bolton JSNA – life expectancy https://www.boltonjsna.org.uk/life-expectancy

LLife expectancy varies within Bolton by 11 years for men and 10 years for women across the social gradient from most to least deprived part of the borough.[12].



In Bolton, the main causes of death that account for these differences in life expectancy are **circulatory disease, respiratory disease, cancer and Covid-19**.



[12] OHID (2022). Public health profiles. https://bit.ly/3ZuCMVK
[13] Male: Bolton 001, Dunscar & Egerton -> Bolton 016, Central Bolton
Female: Bolton 020, Lostock & Ladybridge-> Bolton 027, Farnworth North

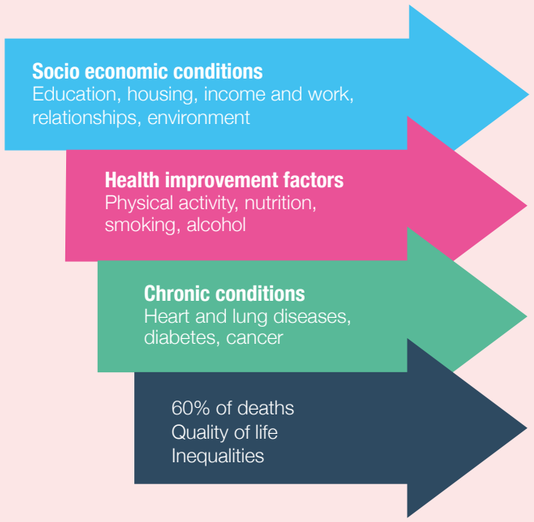
The differences in likelihood of experiencing these health conditions is determined by health-related behaviours; **smoking, physical activity, nutrition and excessive alcohol use**.

18% of Bolton residents smoke[14] (31% of those in routine and manual jobs[15])

32% of Bolton adults are physically inactive[16]

50% of Bolton adults eat 5-a-day (an indicator of a broader healthy diet)[17]

23% of Bolton adults drink over 14 units of alcohol a week[18]



These health behaviours in turn are determined by a complex interaction of the social, environmental and economic conditions in which people are born, grow, live, work and age (called wider or social determinants or 'the causes of the causes').[19]

For example; the quality of education, family support; income to support a good standard of living, suitable housing, and the relationships we are able to build. These things are not distributed evenly and this helps to account for different outcomes for different people.

Income inequality – a major driver

Evidence[20] from around the world highlights that it is not just the experience of very low income which impacts on health and wellbeing; it is also how different we feel to others on the social 'ladder' (relative income). This matters for self-esteem, stress and trust and ultimately drives health behaviours and therefore outcomes. We feel those differences more sharply if the differences are bigger.

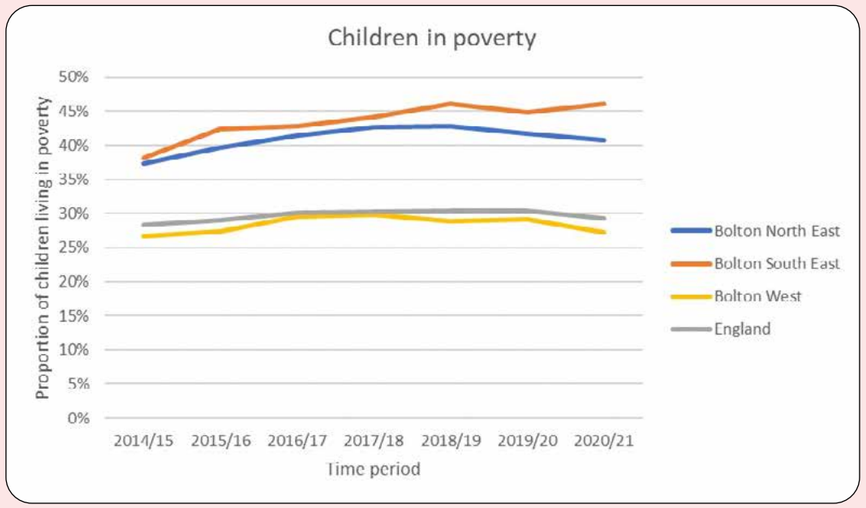
This matters particularly when children are young and forming perceptions about their place in society and relationships with others.

The proportion of Bolton's children who are living in poverty has risen 4.7% in Bolton between 2014/15 and 2020/21. 22% of under 16s now live in families whose income is 60% or less than the UK median (relative low income); that is 12,800 under 16s and is significantly higher than the England average.

The increase has been greatest in Bolton South East, where it continues to rise. Bolton West has child poverty rates slightly lower than the England rate, but even here there were an estimated 5000 children (27%) in relative poverty in 2020/21.

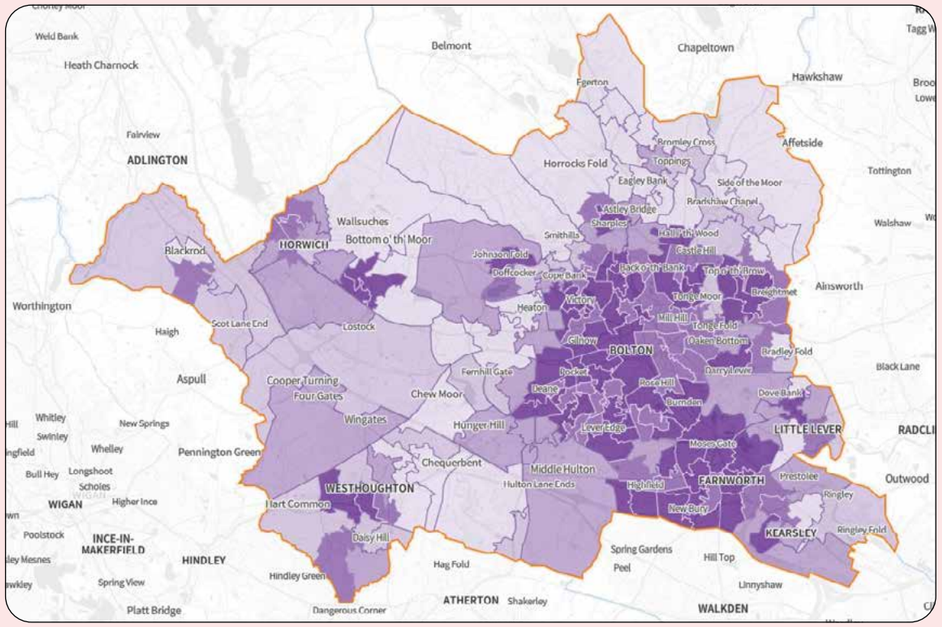
[14] OHID (2022). Public Health Outcomes Framework https://bit.ly/3Rrxo1W
[15] OHID (2022) Local Tobacco Control Profiles https://bit.ly/3wNFF71
[16] OHID (2022). Public Health Outcomes Framework https://bit.ly/3Hx6bGw
[17] OHID(2022) Public Health Outcomes Framework https://bit.ly/3Ya6l8a
[18] OHID (2021). Fingertips Public Health profiles. https://bit.ly/3yUu9l8

Figure 2: Children in poverty by constituency (after housing costs)[21]



Nationally, the latest data[22] shows children from Black and minority ethnic groups are more likely to be in poverty; 46%, compared with 26% of children in white British families. We can expect similar local variation in child poverty for different groups in Bolton.

Figure 3: Income Deprivation Affecting Children Index (IDACI) 2019 – a measure of relative child poverty, shown by quintile across Bolton MSOAs



[19] Representation of information from: The Vitality Institute (2016). Communicating Non-communicable Diseases: From 3Four50 to 4Four60. https://bit.ly/3nchaP5
[20] The Equality Trust (nd). Latest research: the most up to date research on the costs of economic inequality. https://bit.ly/3U6ftzk
[21] End Child Poverty Coalition (2022). Local child poverty rates, After Housing Costs https://bit.ly/3LKDlpN
[22] Child Poverty Action Group (2022). Official poverty statistics: government pulled children out of poverty - but universal credit cut will push them back again. https://bit.ly/3lZrQk9

Children who grow up in poverty may miss out on opportunities to thrive, including being disadvantaged at school or being frequently absent from school, missing out on the protective environment that can provide. Lower attendance in some schools since the since the pandemic is a cause for national concern.

In 2015 nationally there was a 28 per cent gap between children eligible for free school meals and their wealthier peers in achieving at least 5 A*-C GCSE grades. The Covid-19 pandemic has contributed to increasing educational inequalities, through differences in how families could adapt to virtual learning and pressures on family life at home.

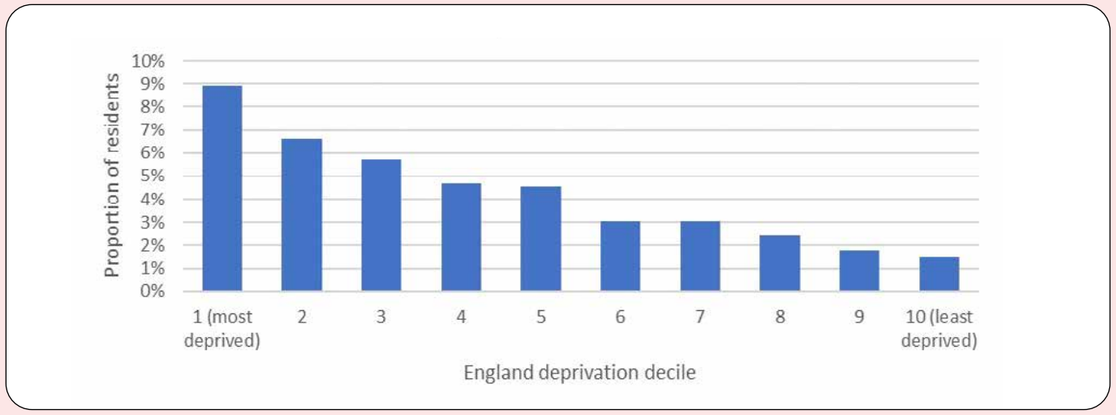
There are long-lasting effects of these differences in childhood; ONS longitudinal research published in 2022[23] shows that at age 25 years, 23.0% of free school meal (FSM) recipients in England had recorded earnings above the equivalent of Living Wage in comparison with 43.5% of those that did not. The rate for female FSM recipients was much lower (18.2%) compared to 39.3% who did not claim FSM.

We need to go further faster for these families, to tackle child poverty and to mitigate against its effects on health and social relationships. The answer is not simple; whilst individual support can help in times of crisis, if we are to reduce inequalities longer term, we need to support 'health for wealth', linking good work and ways to maximise income with promotion of health.

Nationally, in 2020/21, two thirds (65%) of children in poverty lived in households where at least one adult is in work. 40% of children in lone parent households were in poverty, compared to 24% of those in two parent households[24].

In more deprived[25] parts of Bolton higher proportions of residents said they were economically inactive because of long term illness or disability (see Figure 4). One may lead to the other; the causal relationship is unclear, but the impact is the same.

Figure 4: Proportion economically inactive (long term sick or disabled), by deprivation decile. Census 2021 (NB: The census was taken while some Covid-19 measures were still in place, which may affect results.)



[23] Education, social mobility and outcomes for students receiving free school meals in England - Office for National Statistics (ons.gov.uk)
[24] Child Poverty Action Group. (2023). Child Poverty facts and figures. https://bit.ly/3K3Cdv8
[25] All small areas in England are ranked on their level of deprivation, taking into account a number of factors. The areas are then split into 10 groups in order of deprivation, where 1 is the most deprived. Bolton has more areas that fall within the more deprived groups.

Bolton 2030 – our response

Bolton 2030 sets the framework for action to address inequalities and functions as Bolton's overarching joint local health and wellbeing strategy.

Key partners in Bolton come together at the Active Connected Prosperous Board to work together on key outcome aims, shown opposite. The Bolton 2030 framework uses the Marmot Principles, an evidence-based approach to address the wider determinants of health and reduce inequalities that was developed by Professor Sir Michael Marmot and his team at University College London (see various Marmot Review reports).

Bolton 2030 describes what we will focus on to improve the lives of everyone in Bolton and reduce the differences in quality and length of life between people in Bolton:

Reforms to the NHS and Social Care

Current government reforms are bringing together the NHS and local government to jointly deliver health and social care for local communities. In Bolton this is led by the Place-based Health and Care Lead and overseen by Bolton's Locality Board. This integration champions health and well-being and places a much greater emphasis on prevention and partnership working at a neighbourhood level to reduce inequalities in healthcare access, experience and outcomes.

That includes making it as easy as possible for different people to access and understand the help they need, for example by considering 'health literacy' for different groups[26]:

In Bolton

49% of people aged 16-64

would likely have difficulties in understanding or interpreting health information including about which health services to use, appointment letters and medicine instructions.

[26] University of Southampton/ Health Education England. (2019). Health Literacy. https://bit.ly/3K9hYMz

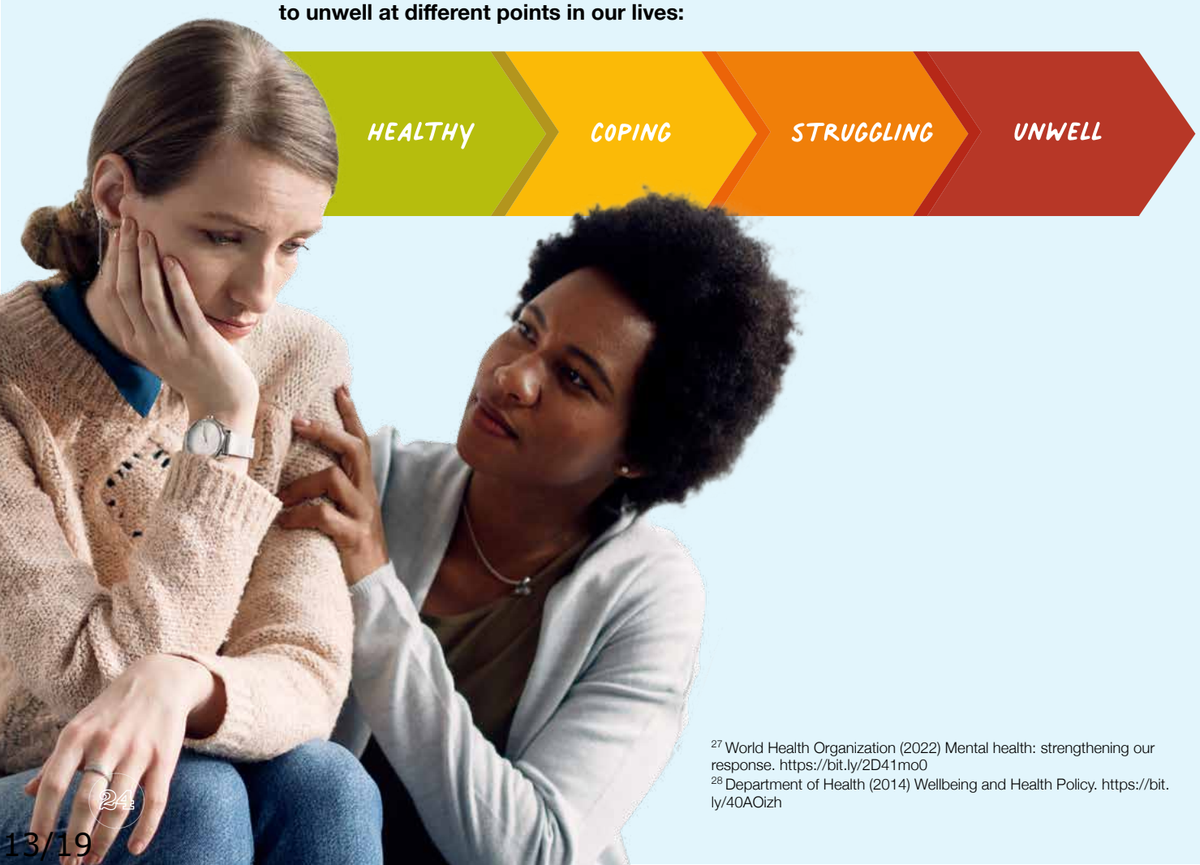
3. Focus topic: Mental health and wellbeing in Bolton

Although there are many inequalities to consider, for the 2022 annual report we have chosen to have a particular focus on mental health and wellbeing.

Our mental health influences our physical health and vice versa, with around 30% of people with any long-term physical health condition also having a mental health condition. Good mental health and wellbeing is about feeling good and functioning well[27].

It enables us to realise our abilities, cope with the normal stresses of life, work productively and fruitfully, and contribute to our community[28].

All of us have mental health which can vary on a spectrum from healthy to unwell at different points in our lives:



[27] World Health Organization (2022) Mental health: strengthening our response. https://bit.ly/2D41mo0
[28] Department of Health (2014) Wellbeing and Health Policy. https://bit.ly/40AOizh

Every year
one in four
adults experience at least one mental health problem.

People with severe mental illness on average have 15 to 20 years shorter life expectancy than the general population

Together with substance (drug and alcohol) misuse, mental illness accounts for 21% of the total burden of illness (morbidity) in England and is associated with many forms of inequalities, particularly for people living with severe mental illness (SMI).

Mental illness is often associated with distress and a sense of struggling to function in social, work or family activities. At its most tragic, people feel they have no option but to take their own life. Each year sadly between 20-30 Bolton people die by suicide[29]. All partners in Bolton are committed to suicide prevention including a regular audit of all suicides to identify opportunities to learn and themes that can help us improve people's lives and prevent anyone feeling this way.

More than 1,500 people took part in The Big Wellbeing Conversation in Bolton in 2021[30]. This included a survey for anyone over the age of 12 and focus groups with people whose voices are often not well heard.

It provided a powerful reminder of why we should focus on mental wellbeing:

24% of Bolton survey respondents reported low levels of happiness – a much higher proportion than the national average, which was less than 5%

A similar gap exists for life satisfaction, with **23%** in Bolton reporting a low level compared to less than 5% nationally

22% of people in Bolton reporting a low level of belief that their life is worthwhile was, compared to less than 5% nationally

71% of Bolton's survey respondents reported high or very high anxiety compared to less than 40% nationally

In addition, national data shows us that:

In Bolton an estimated **42,000** (around 19%) of residents aged 16 and over have a common mental health disorder (using 2017 data)

An estimated **9.8%** of children aged 5 to 16 years have a common mental health disorder

[29] ONS (2022) Suicides in England and Wales by local authority. https://bit.ly/3YdUJac
[30] Bolton Council (2021). Big Wellbeing Conversation. https://bit.ly/3ZiY4EF

BOLTON'S BIG WELLBEING CONVERSATION

The Big Wellbeing Conversation identified six themes to promote and improve people's wellbeing:

1. **Supporting the best start in life – preventing adverse childhood experiences and enabling children and young people to thrive**
2. **Enabling people to have enough money to enjoy a decent standard of living**
3. **Tackling discrimination**
4. **Creating physical environments that support access to free or genuinely affordable community amenities, green space and decent housing**
5. **Supporting good family and community relationships**
6. **Access to quality financial, health and other advice and services**

It was clear from responses that overall support to the community needed to be:

- Created with communities themselves in a way that involves people with lived experience to shape the support that is commissioned and provided
- Better communicated so that more people in the community and other services know what is available
- Joined up better with other sources of support – among the things mentioned were one-stop shops, alliance contracts that incentivise services to work together, better sharing of information about service users, and making it easier to refer between services

The findings were then discussed at a 'Let's Talk Bolton' co-production event to narrow down what we need to do and this has informed a full programme of work.

Population Mental Wellbeing and Suicide Prevention Programme

In response, partners around Bolton borough have signed up to the Prevention Concordat for Better Mental Health, with a detailed action plan, which has informed the recommendations in this report. This is aligned to Bolton's full Population Mental Wellbeing and Suicide Prevention Programme, led by a large and active Population Mental Wellbeing Partnership that includes organisations from across all sectors.

Public Perspectives are evaluating the Bolton Programme including local projects funded through the Better Mental Health Fund from Office for Health Improvement and Disparities (OHID).

The programme includes promoting better understanding of mental health with training tools for partners' staff, volunteers, community leaders and toolkits to improve measurement of mental wellbeing and understanding of how policies impact it.

> "OUR CLIENTS WERE REALLY STRUGGLING, AFTER COVID, AND SO WERE WE AS AN ORGANISATION TO SUPPORT THEM. THE FUNDING HELPED US INCREASE OUR CAPACITY AND PROVIDE DEDICATED SUPPORT. FOR SOME PEOPLE THIS HAS BEEN ABOUT SMALL THINGS, BUT FOR A FEW WE'VE BEEN ABLE TO HAVE A MASSIVE IMPACT ON THEIR LIVES, TO HELP THEM RE-CONNECT WITH THE WORLD AND PEOPLE, HELP THEM BE MORE ACTIVE AND REDUCE THEIR ISOLATION. WE KNOW HOW IMPORTANT SUCH SUPPORT IS AND WE'VE BEEN WORKING HARD TO FIND FUNDING AND OTHER WAYS TO KEEP DELIVERING THE SERVICE."
>
> *Project representative*

Giving children the best start

There is a legal and moral responsibility to create the best environments for children to grow up in and promote their safety, health and wellbeing, as well as responding when they do need help. Our Emotional Health and Wellbeing JSNA in 2021 looked at both quantitative data (eg. numbers you can count) as well as qualitative information (how people feel or their reasons for doing things) about young people's needs and experiences.

Hospital admissions for mental health concerns for under 25s and under 18s have increased since 2019/20, having reduced from a peak in 2014/15. It is not yet clear why there was such a large reduction since 2014/15 and whether this represents real change in need or service changes / referral patterns.

Figures from Bolton Children's Integrated Health and Wellbeing Service suggest that in 2020/21 far fewer children had a low health and wellbeing score than in 2019/20. But, for those who did, more than double the number were referred on to receive some help and about 50% more required specialist mental health services. This suggests the pandemic may have made it more difficult to get help, which may account for rises now.

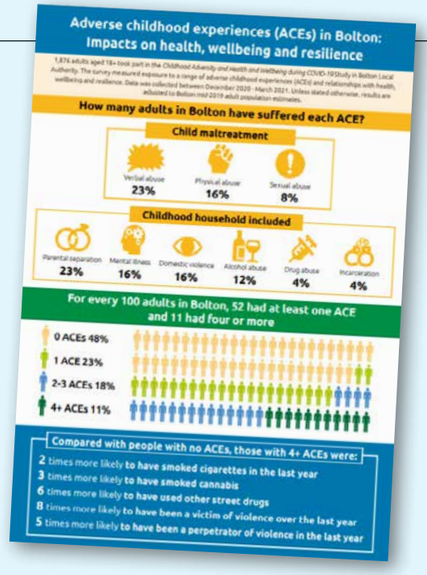
We will have to see how the impact of covid-19 on young people unfolds long term. During the pandemic, local authority children's services across the country consistently reported to Department for Education increases in complexity, with mental health issues in children heightened throughout and existing mental illness in parents exacerbated.

There have been some important messages coming directly from young people in Bolton. Creatives Now[31], for example, is an arts collective for social change led by young people aged 12-18 from secondary schools and colleges across Bolton who act as community champions. They undertook a range of arts projects and a creative consultation with peers. Young people they spoke to felt that Covid had affected their confidence and mental health (due to isolation from friends and outdoor activities) and their education. Some felt a lack of motivation and difficulty concentrating on school work.

However positive impacts included being able to spend more time with family, being able to focus more on artwork, developing new skills and making new/ international online friendships. Being involved in the community champion and creative arts project also had benefits for those involved, in terms of wellbeing, social skills and gaining other skills and paid work. These 'ways to wellbeing' are explored a little bit more in the next section.

In November 2021, Bolton Library and Museum Services began Create Wonder Play, a series of creative early years sessions to explore families' recent experiences of covid-19 lockdown restrictions. Over 31 sessions they spoke to around 600 people and ran an online survey and found:

- Socialisation, emotional development, along with speech language and communication were key parent/carer concerns for their children. This was also highlighted by educational professionals.
- Declining parental/carer mental health due to heavy restrictions during such a key family period was also evident for some families. The inability to see family and friends, the cancellation of EY provisions and limited EY health support contributed to many parents' negative emotional wellbeing.



ACEs and Protective Factors

Adverse Childhood Experiences (ACES) are traumatic events that occur whilst growing up. This includes exposure to direct abuse and indirect abuse, such as living in households with domestic violence, substance misuse, and mental illness. The effects of ACEs can disrupt child development and when there are several of these it can make it much harder to stay healthy mentally and physically.

Bolton Council worked with the University of Bangor[32], who interviewed 1,876 adults in Bolton. Our study found that that 52% of local adults had at least one ACE; 11% had four or more ACEs. People with more ACEs were found to be at higher risk of health, social and emotional problems. They were more likely to smoke, to report having been a victim of violence, and more likely to report having a mental health diagnosis. [see fig]

Many children who experience ACEs or trauma will go on to do well and that is because of 'protective factors' in their home, environment and relationships. Having a trusted adult, supportive friendship groups, activities to do and living in safe communities all help to reduce the impact of ACES and the risk of poor health and wellbeing later in life.

Through a priority programme of the Active, Connected and Prosperous Board (ACP) and Vision 2030, partners are working with residents and communities to recognise the importance of ACEs and build personal and collective resilience. This will help prevent future childhood adversity and support people who have experienced trauma in their past to recover.

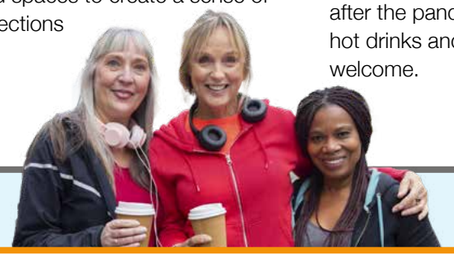
[31] Creatives Now (2022). Exec Summary. A working group project of the Bolton Cultural Education Partnership (BCEP), led by Housing Percent for Art (Bolton at Home) and Bolton School
[32] Ford K, Hughes K, Bellis M. (2021). Adverse childhood experiences (ACEs) in Bolton Impacts on health, wellbeing and resilience. Bangor University. https://bit.ly/3nM6OpL

Living Well through the 5 ways to wellbeing

The 5 Ways to Wellbeing describe things which research has shown we all can do to help us keep well mentally and emotionally. Our community engagement team and the partners to the Population Mental Wellbeing Partnership have been exploring ways that Bolton residents and organisations are creating these opportunities:

CONNECT

- Thousands of people told us why 'I love Bolton' and it was clear that our sense of community is really strong: we trust and care for each other. This kind of connection is shown to help keep people feeling positive about themselves and where they live and is an important way to tackle inequalities described above[33].
- Rebecca, a community facilitator, has been involved in supporting important community connections, using 'Asset-Based Community Development' (which means building on strengths including people and spaces to create a sense of belonging and connections between people):



"I managed to get access to a recently closed community space at Farnworth fire station. Now I facilitate an over 50's group which meets on a weekly basis to socialise and discuss our wellbeing and what we can do to improve it."

The community has access to a local asset which was previously run at a GM level. The involvement and sessions have improved the wellbeing of participants and brought together a sense of community to tackle other issues.

It's also brought older residents out of isolation after the pandemic and provided a warm space, hot drinks and snacks, which makes everyone feel welcome.

LEARN

- Team Bolton are developing a Skills Strategy this year to maximise the chances that people in Bolton have to learn, throughout their lives. Having a job or being involved in education and training can help to protect mental health and is especially important as young people are starting out. Although Bolton has a higher proportion of 16 and 17 year olds not in employment, education or training, we have been focusing on identifying who needs support and improving opportunities for them in Bolton so that we have seen a further reduction over the last 12 months.
- Learning can take place in many ways and places, including learning from meeting and working with others.

Demi has been involved in helping people learn new skills whilst sharing a warm space:

I facilitated the warm space at four seasons recently. I delivered educational activities such as transplanting and woodwork with others. Then we had the chance for a chat and snacks around a warm and cosy fire, lovely!

People are now visiting the space and enjoying their time there. People have expressed how they are happy to have learnt how to do things such as chicken husbandry and feel better within themselves.

[33] The Equality Trust (2009). The Spirit Level. https://bit.ly/3zxXVCw

ACTIVE

- Every year, leading an active life prevents 900,000 cases of diabetes and 93,000 cases of dementia (the leading cause of death in the UK), which also saves the UK economy £7.1 billion.
- People who get active have greater levels of happiness, life satisfaction and feeling worthwhile.
- Bolton's Active Lives Strategy has been developed with lots of input from residents and organisations working in Bolton to demonstrate a common purpose across the town, to help residents to move more everyday, supporting both emotional resilience and physical wellness.

Here are just a couple of examples:

ADAPTED CYCLE PROGRAMME

Wheels for All Bolton is a voluntary led group which is a corner stone boroughwide disability provider for people with disabilities in Bolton

The group provides activities for schools, community groups, residents, carers. Wheels for all have maintained their Bolton Mark Accreditation and will become a major component of the Leverhulme community Hub.

AJAYS MORRIS DANCE TROUPE is a local based voluntary led dance group that provides community focused dance sessions to young people.

Ajays have achieved the Bolton Mark and are a vital asset in the local Breightmet community. They provide friendship groups and community support to many families in the area.

GIVE

- Bolton has 58,259 volunteers giving 211 233 hours of their time each week
- Bolton has a thriving community, voluntary and social enterprise sector of over 1672 groups and organisations which provides a range of opportunities for people to both give and receive support from others, have fun and take part in something.
- Bolton's Community Fund continues to support many local groups and is contributed to by all sorts of partners locally as a way to reinvest in our communities.
- It has been a particularly hard few years for smaller groups and organisations, and many people who need them, so we must continue to connect and support those people who give their time and energy to others.
- Statutory services and the Community, Voluntary and Social Enterprise Sector work closely together in many forums. CVS are co-designing a model for making it easier to do this and we will work with them to make sure that the voice and experiences of different groups of people can influence policies and decisions including by providing as much information as possible to our public.

COMMUNITY KITCHEN HAVE BEEN SUPPORTING BOLTON RUGBY UNION CLUB, BY GROWING FRESH PRODUCE AND DONATING IT TO THE CLUB TO BE ABLE TO OFFER OUT A FREE MEAL TO MEMBERS OF THE COMMUNITY

The project has successfully provided many individuals with hot meals and brought the community together, showing one another that the support is there.

Volunteers who are with CVS have also described how it has changed their lives for the better.
www.boltoncvs.org.uk

NOTICE

- There is evidence that the arts help with mental health[34]. One arts-on-prescription programme designed to significantly reduce anxiety, depression and stress saw GP consultation rates drop by 37 percent and hospital admissions by 27 percent.
- There is also evidence of involvement with creative activities helping to manage long-term conditions, cancer and pain, which are significantly associated with mental ill-health[35].
- 'I love Bolton because…' work led to further discussions about what people want to see for Bolton in 10 or 20 years. So far, we have heard from young and older residents, investors and students that green spaces to enjoy are high on their list.

LITTER PICK & INSIGHT DAY ON THE CLARION HOUSING ESTATE IN BREIGHTMET

Residents and volunteers helped to clean up their green space and start to plan events and links to local provision. This brought the local community together and brought a sense of belonging to the estate. Some useful information given by residents was different to the residents' survey, providing the community lens.

DEAN AND DERBY CRICKET CLUB

In June 2022 using the residents of Rumworth with help from Community Facilitators identified the cricket club as an asset but not well used by the wider community. In September, the club was successful with bids to GMP, Bolton's Fund, Bolton at Home and GM Green Spaces.

By Dec 2022 several activities were running, keeping local residents active and mentally well, include women's keep fit, girls football, a walking group, arts and craft sessions and a friendly warm space. Two big events have run- a Winter Market attracted around 500 visitors and a Jobs/Volunteering Fair.

A lead volunteer has really taken on this asset and has plans now to work with other local partners including schools, Wave Adventure, Nuffield Health and others to develop further activities such as wellbeing drop-in and ESOL and a digital library.

[34] All Party Parliamentary Group on Wellbeing (2017). Creative Health: The Arts for Health and Wellbeing Report https://bit.ly/3ZC1rq9
[35] See: Bradt, J., Dileo, C., Grocke, D. & Magill, L. (2011). Music Interventions for Improving Psychological and Physical Outcomes in Cancer Patients. Cochrane Database of Systematic Reviews;
Bradt, J., Shim, M. & Goodill, S. W. (2015). Dance/Movement Therapy for Improving Psychological and Physical Outcomes in Cancer Patients. Cochrane Database of Systematic Reviews; and
Walker, J. Holm Hansen, C., Martin, P., Symeonides, S., Ramessur, R., et al. Prevalence, Associations, and Adequacy of Treatment of Major Depression in Patients with Cancer: A cross-sectional analysis of routinely collected clinical data. The Lancet Psychiatry, 1 (5), pp. 343–50

Age Well – Mental health and wellbeing of older people

The latest census data shows that the over 65 age group is the fastest growing age group nationally. Greater Manchester projections indicate by 2041 residents aged 65 and over will rise by 29.4% and those aged 75 and over is projected to increase by 46.2%. People are living longer but not all in good health or experiencing a good quality of life.

The Greater Manchester Older Peoples Mental Health Network launched on 2nd March 2023 and provide evidence and insight from older people's experiences.

THE PROMOTING ACTIVE LIVES STUDY (PALS) WAS CREATED TO ADDRESS ISOLATION AND REDUCED ACTIVITY AS WELL AS THE GAP IN MENTAL HEALTH PROVISION AND COMMUNITY ACTIVITIES FOR OLDER PEOPLE. IT AIMED TO IMPROVE INDEPENDENCE AND PROVIDE A LINK BETWEEN PEOPLE AND THEIR COMMUNITY THROUGH A 'BEFRIENDING PLUS' BUDDY SERVICE. THIS PROJECT HAS NOW BEEN EVALUATED AND WILL BE EXTENDED.

They have highlighted that:

Older people's mental health is not just about dementia, it can be affected by a number of things including loneliness and isolation.

Of 450,787 older people in Greater Manchester, over **100,000** have a serious mental illness, and over **60,000** will experience depression.

NHS stocktake in 2021 suggests depression has doubled in older people.

30% of carers also suffer from depression.

Left unaddressed the impacts of Adverse Childhood Experiences can lead to chronic health problems and condition, mental illness, and substance misuse in adulthood.

In 2020, the Centre for Ageing Better found that a third **36%** of 50-70 year old respondents said their mental health had deteriorated as a result of the pandemic. Individuals living alone were more likely to report increased stress and anxiety.

We know that it has been much harder for older people to 'bounce back' after covid as many have found their networks harder to engage digitally and groups have closed or moved. In many cases older people are not as strong or mobile as they were previously due to reduced activity, combined with lack confidence and fear of going outside of their home, known as deconditioning.

Money is a key source of worry for older people

Age UK research in March 2023 indicated that 9.6 million over 60's (60%) were worried about being able to heat their homes when they wanted to, and 7.2 million (45%) were worried about affording other essentials such as food.

Access to services for older people is important

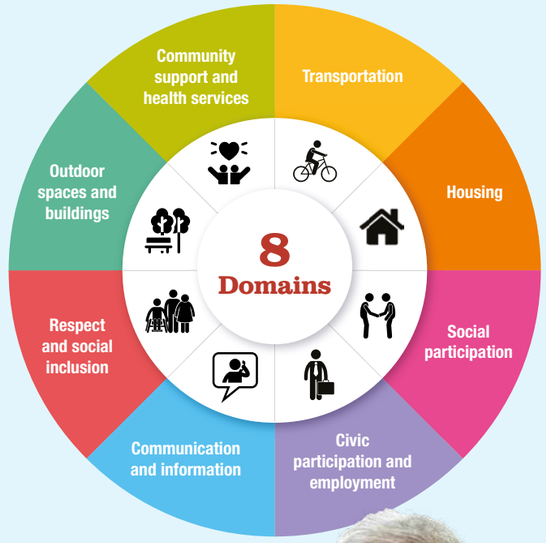
UK Network of Age Friendly Communities reports that older people are less likely to access help through IAPT (NHS talking therapies for anxiety and depression) and other mental health and wellbeing services. Bolton's Ageing Well Partnership has received feedback from older people indicating:

- Barriers to accessing services, a lack of awareness of what is available, uncertainty around how to access them, digital exclusion, language.
- Some people perceive that it is normal to feel down when you are older and describe trying to keep a 'stiff upper lip'.
- Fear of stigma and ageism
- Professionals in contact with older people misunderstanding signs e.g. thinking they are self-neglect, dementia, other physical illnesses or just ageing.

The newly developed Living Well Service in Farnworth and Kearsley has seen an increase in older people with issues such as hoarding and 'hard drinking'. The service has found it harder to engage with older men but have made progress by linking with community projects and partners such as Bolton at Home, Age UK and primary care Social Prescribers.

Developing strong partnerships to respond

Bolton's own Ageing Well Partnership is currently working to develop the Age Well theme of the Joint Strategic Needs Assessment (JSNA) to understand experiences, barriers, gaps and good practice. This will inform the co-production of Bolton's Age Friendly Strategy, with action under each of the WHO eight domains of Age Friendly Living.



Recommendations...

Supporting our changing population in the post-covid era:

1. Build on the rapid partnership response to the cost of living pressures by producing a system-wide Poverty Strategy for Bolton, with reference to the developing Economic Growth and Resilience Plan.

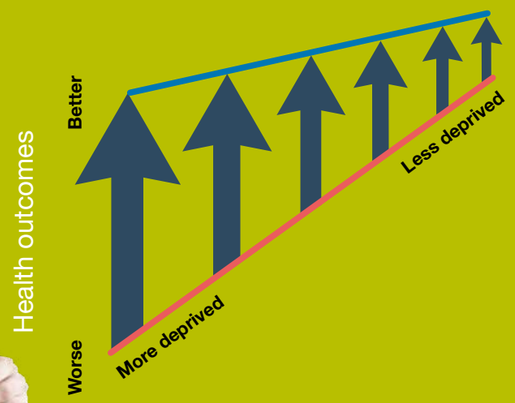
2. Provide energy bill support and information on how to reduce food bills and car fuel consumption to help people live more sustainably but with the health risks of these changes at the front of our minds.

3. Continue to develop and promote the Joint Strategic Needs Assessment (JSNA) resources to make intelligence about our population accessible so this is routinely used in policy and practice.

4. Embed 'proportionate universalism'[36]; resourcing and delivering universal services at a scale and intensity proportionate to the degree of need. Services and improvements are not only for the most disadvantaged or only 'open access' but recognise the different barriers and starting point for different people's health.

Proportionate universalism

Arrows indicates intensity (e.g. investment)



[36] Proportionate universalism and health inequalities (healthscotland.com); Macdonald W, Beeston C, McCullough S. Proportionate Universalism and Health Inequalities. Edinburgh: NHS Health Scotland; 2014.

Improving Mental Health and Wellbeing:

5. Deliver Prevention Concordat for Better Mental Health Plan

In Jan 2023 Bolton became a signatory to the national prevention concordat for better mental, including delivery of a 12-month detailed plan across the health, social care, and voluntary sector system.

This will require everyone to play their part, seeing mental wellbeing as their responsibility and embedding wellbeing into policies and practice. Done well, with real buy-in across partners, this plan provides a platform for achieving mental health equality for all, whilst reducing the inequality gap.

6. Make every contact count – for staff, volunteers and public

Collectively all organisations and services should promote and support key messages so everyone in Bolton can:

- Become mental health aware
- Know key triggers for poor mental health and wellbeing
- Know the key risk and protective factors for mental wellbeing
- Know how to engage in positive conversations to help themselves and others
- Know how to access timely and appropriate support

See 'Further Information'.

All workplaces and business should embed wellbeing into everyday practice, using the toolkits available, offering training and embedding policies and structures to create a wellbeing culture within the workplace.

7. Measure mental wellbeing to improve planning, implementation and review of decisions and services

Use the 'Measuring Mental Wellbeing: A Framework and Toolkit' to:

- decide which measures to use to assess the extent to which people's wellbeing has been impacted by activity or decisions
- better understand and monitor the local conditions that affect residents' wellbeing
- benchmark outcomes for Bolton against other local authorities, regional and national figures

8. Improve access to and information about holistic mental health and wellbeing provision and support

Resident responses from the Big Wellbeing Conversation highlighted the need for easy access to mental health and wellbeing support, including specialist services, self-help and alternative support options. This report has focused on non-medical interventions, though we know there are also gaps in provision and long waiting lists for specialist services.

The Let's Keep Bolton Moving resource aims to plug a gap in access to information about local activities and ways to positively change or enhance your life through the five ways to wellbeing. Local people can upload and find activities to Live Well, and come forward to volunteer, or become a community champion.

We must ensure this resource is sustainable and well-used by embedding it within other local efforts to bring together information and ensure it is a core part of any mental wellbeing training and information going forward.

Where can I find out more?

Connect, Keep Learning, Be Active, Take Notice, and Give
A web-resource to support and encourage the people of Bolton to positively change their lives through the five ways to wellbeing.

For specific information on mental health and wellbeing go to **letskeepboltonmoving.co.uk**

Bolton JSNA www.boltonjsna.org.uk
- This and previous Public Health Annual Reports are available on the home page
- **New and notable** - includes census information and latest updates
- **Our place** - includes maps and information on different areas of Bolton
- **Our people** - includes differences between people in Bolton and what people have told us

University of Bangor Research into ACEs prevalence and impact in Bolton

5 steps to mental wellbeing
www.nhs.uk/mental-health/self-help/guides-tools-and-activities/five-steps-to-mental-wellbeing/

More general information:
- Five ways to wellbeing - Mind
- Centre for Mental Health
- RSPH | MECC for Mental Health training programme

Report Title:	Health Inequalities Annual Report and 6 Month Delivery Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	✓
Exec Sponsor	Rae Wheatcroft		Decision	

Purpose	This paper and presentation provides Board of Directors with the Health Inequalities annual report and a 6-month update on delivery against our priorities for 2023-24.

Summary:	The Health Inequalities Annual Report is a long read and contains an executive summary for ease by Board of Directors members. The Annual Report was initially received by Strategy and Operations Committee in April 2023. A supplementary presentation is provided which updates on 6 month delivery against our priorities. The Health Inequalities Annual Report is produced by the Health Inequalities Enabling Group (HIEG). The HIEG is a sub-group of Performance and Transformation Board, which reports to Strategy and Operations Committee. The Annual Report was the culmination of the HIEGs first 12 months in existence and summarises work which took place to; • Spotlight the work going on across the Trust to tackle Health Inequalities. • Develop our organisational approach within the context of Bolton's 2030 Vision. • Analyse our data to understand inequalities in access to and experience of the services that we provide. • Map programmes of work which are contributing to our organisational approach to tackling Health Inequalities. These activities led to the identification of three key enabling priorities for the 2023-24 year, which are summarised as; 1. Education and awareness 2. Health equity impact assessment 3. Knowing our people A look back at the last 6 months and a look forward to the remaining half of the year for progress made with these priorities is provided.

	In the first 6 months of 2023-24 significant work has also been undertaken to develop our Bolton Locality Outcomes Framework. There is strongly focused on the health and well being of our population including reducing health inequalities. Finally, two examples are provided from our services of how health inequalities reduction work is being built into our improvement approaches.

Previously considered by:
Strategy and Operations Committee

Proposed Resolution	Board of Directors are asked to receive the update on the work underway to reduce health inequalities and note the progress against this years enabling priorities.

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:	Francesca Dean, Head of Strategy and Planning Julie Ryan, Chief Data Officer and Joanne Street, Director of Operations	**Presented by:**	Joanne Street, Director of Operations

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

HI	Health Inequalities
HIEG	Health Inequalities Enabling Group
JSNA	Joint Strategic Needs Assessment

Table of Contents

1. Executive Summary

1.1 Purpose and Background

This paper is to provide an update to Strategy and Operations Committee on the work undertaken by the Health Inequalities Enabling Group (HIEG) since its formation in March 2022 and to look forward at the plan of work for the next 12 months.

In its first 6 months of existence, the HIEG focused on spotlighting the work already underway within our operational and transformation programmes. Through this work, we found that that there were a lot of unanswered questions about how as a Foundation Trust we can best tackle Health Inequalities (HI) and also about how best to organise this complex work. In November 2022 we held a workshop with HIEG members plus other locality colleagues to move forward these issues.

As part of the workshop, we made sure that everyone had a common understanding of what HI are and why it is important for us to do work which helps to narrow them. In short, HI are unfair and they can be prevented. They are also costly, not just to individuals but also to health, care and economic systems; so its in our interest as a healthcare provider to focus on reducing HI.

1.2 Health Inequalities in Bolton

Bolton residents live disproportionately in the most deprived areas in comparison to the rest of the England population. Boltonians also experience wide disparities in life expectancy; 14.9 year difference between the best and the worst for men and 9.9 years difference for women. Working together, our localities business intelligence colleagues have created a bus tour concept to bring to life the health inequalities that exist within our town just a few short stops apart from each other. As a result of this work, a tool has been rolled out across Greater Manchester to allow all localities to benefit from this illustrative analysis. In this paper, you can read about the 501 bus route which comes right through Royal Bolton Hospital.

During the past year, considerable work has been undertaken to analyse our Trust data by ethnic group, deprivation, age and gender. We have used this to understand any statistically significant differences in, for example, waiting time. By doing this, we have been able to make specialties aware of any differences so that this is taken into account within recovery plans. It has also helped us to identify that in fact, any differences found, are typically only present at one snapshot in time. Frequent monitoring has allowed us to identify that differences at specialty level change frequently and are likely more to do with gaps in recording of demographic details. For example, in the Waiting List Minimum data set, we currently have around 27% of patients without a stated ethnicity.

To monitor health inequalities and ensure visibility, several inequalities indicators are being developed to go into the FT Board of Directors report, plus lower level indicators to be included at a variety of other groups. The key principle with monitoring is to ensure that health inequalities indicators are not seen as a separate entity and are an integral part of routine reporting. Work is also ongoing across the locality to bring together a range of outcome indicators, which will also highlight any inequalities, into the new and emerging governance structure.

1.3 Locality work to tackle Health Inequalities

The Bolton 2030 Vision contains the borough's place-based approach to tackling HI. Underpinning the Vision 2030 are 6 outcomes which provide the framework for action by a range of partners and sectors. These 6 outcomes map to the Marmot principles.

Bolton's Public Health team play a key role in providing a system strategic leadership role in public health matters including health inequalities reduction. This includes production and use of the Joint Strategic Needs Assessment (JSNA).

1.4 Bolton Foundation Trust approach to tackling Health Inequalities

Our approach as a Foundation Trust will be cognisant of the fact that universal access is not equally experienced and that for some of our services, universal access will have to be proportionally tailored. Use of our data, analysed by demographic splits will enable us to do this.

Our approach will also be to make simple, what can be extremely complex and confusing, even for those colleagues who work on HI issues regularly. This will be enabled by us focusing on being clear on which elements of the work we are leading on, which elements we are involved in but with another partner leading and which elements we are collaborating on equally.

The CORE 20+5 model will also help to guide our approach by providing a framework for focusing effort on tackling HI by healthcare organisations.

1.5 Our 12 Month Plan

A detailed programme map has been produced which identifies the matrix of work that is underway across the organisation which aligns to our approach to tackling HI. The HIEG will oversee the work and for its second year of existence has developed a structured workplan to ensure that all programmes are supported and scrutinised in their delivery.

The HIEG will also take a leading role in moving the dial on 3 key enabling priorities which have been identified through engagement with HIEG members, at the workshop and through review of gaps in the programme map. These priorities are;

- Education and awareness
- Health Equity Impact Assessment
- Knowing our patients

Due to the size and complexity of the work to be carried out there are risks to delivery which include the capacity to prioritise this in the midst of many competing priorities. The structured approach to overseeing the work by the HIEG will be a mitigation against this risk.

1.6 Recommendation

Strategy and Operations Committee are asked to note the work carried out so far and the plan for the next 12 months. SOC will receive regular updates on HI reduction work through the spotlight section on the agenda, for example the maternity spotlight in April will include information on the maternity HI reduction activities. An annual report on all HI work will be prepared by HIEG and presented next in March 2024.

2. Purpose

This paper provides an update to Strategy and Operations Committee on the work taking place across the organisation to tackle health inequalities. This includes the work which has been undertaken by the Health Inequalities Enabling Group since its formation in March 2022. The paper also provides a background to the context in which this work sits within our Trust strategy and locality plan. A view of our current position with regards to our known health inequalities experienced by our population and our patients is provided. The paper sets out the approach that we are taking to health inequality reduction in our organisation and takes a forward look at the planned work over the next 12 months.

3. Background and Context

In March 2022, the Health Inequalities Enabling Group (HIEG) was established to tackle the challenges surrounding Health Inequalities for the Trust. The group initially found that there were more questions than answers to these challenges, such as:

- what are health inequalities?
- do we really understand their prevalence in Bolton?
- why do they exist?
- what is already being done to address this in Bolton?
- and crucially, what is Trust's role in addressing health inequalities?
- What should be the Trust's overall approach to tackling health inequalities?

To address these questions, the HIEG held a workshop in November 2022 which brought together system partners with Trust colleagues. The workshop provided an opportunity to better understand health inequalities and identify the gaps and challenges in the Trust's approach. Through this process, the group identified the need to better distinguish between the Marmot principles (wider determinants of health) and the role of the locality in addressing these. However, more importantly it was clear there needed to be a distinction on the Trust's role in leading, collaborating, supporting, or simply being aware of HI-related initiatives.

The following sections will further detail the findings from the Health Inequalities Enabling Group, workshop and ongoing development of a Trust approach to addressing health inequalities and the supporting programme of work.

4. What are Health Inequalities and why are they important?

Health inequalities are about differences in the status of people's health. The term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives; both of which contribute to their health status. Health inequalities can therefore involve differences in:

- Health status
- Access to care

- Quality and experience of care
- Behavioral risks to health
- Wider determinants of health

Most poignantly, health inequalities are unfair, affect everyone and are avoidable.

"Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They are rooted deep within our society, and they are widening, leading to disparate outcomes, varied access to services, and poor experiences of care. This results in earlier deaths, lost years of healthy life, intergenerational effects from traumatic experiences, and has significant economic costs for society. Yet, health inequalities are often preventable." (Health Foundation)

4.1 Why should we be talking about Health Inequalities?

On average people are living longer but many people are being left behind. There are big differences in health outcomes of groups of people. In general, the worse someone's socioeconomic status the worse their health outcomes.

As well as the avoidable impact on the population there is also an avoidable impact on the NHS. People in deprived areas, such as many of those in Bolton, are more likely to smoke, to eat junk food, to be physically inactive, to be obese and to have type 2 diabetes – resulting in more years of ill health and a disproportionate consumption of NHS time and resource.

At any given age, poorer people are more likely to see their family doctor, have an outpatient appointment, visit accident and emergency, and stay in hospital. (Health Foundation).

4.2 What are the benefits to addressing Health Inequalities?

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in both human terms, lost years of life and active life; and in economic terms, the cost to the economy of additional illness.

If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely because of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability.

It is estimated that this illness accounts for:

- Productivity losses of £31-33 billion per year
- Lost taxes and higher welfare payments in the range of £20-32 billion per year and
- Additional NHS healthcare costs well in excess of £5.5 billion per year.
- If no action is taken, the cost of treating the various illnesses that result from inequalities in obesity alone will rise from £2 billion per year to £5billion per year in 2025.

Scaled down, there is still significant opportunity to reduce the social and economic impact of health inequalities in Bolton.

4.3 Understanding our role as a Foundation Trust?

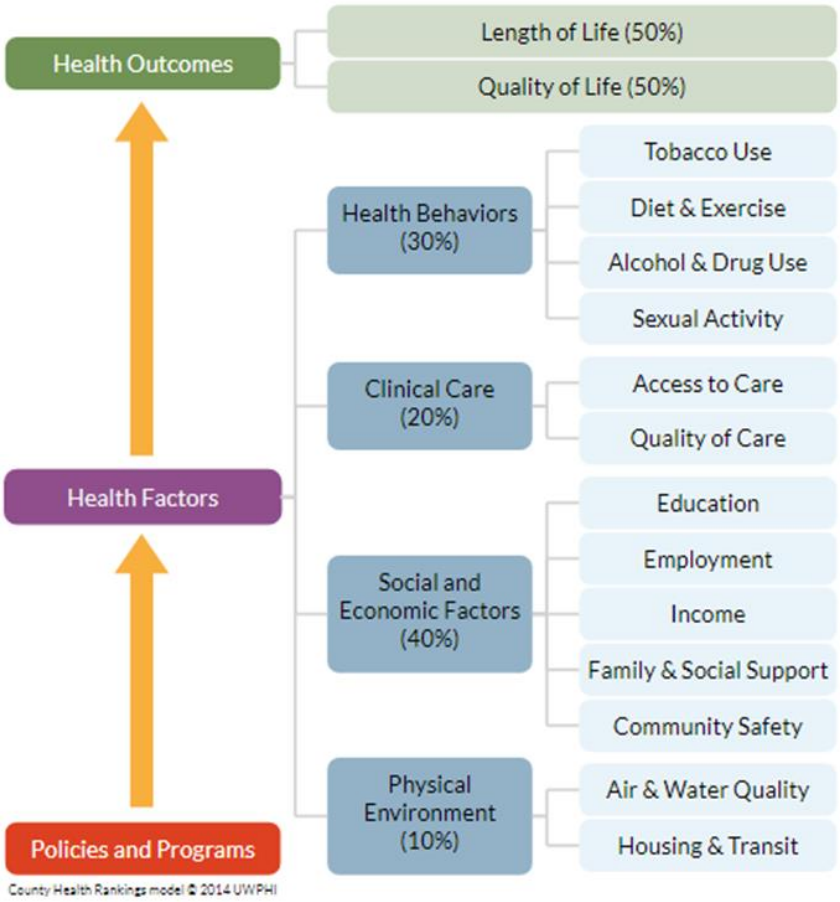
A former Chief Executive of the NHS identified in his 2020 book – Health is made at home, hospitals are for repairs. By the time most patients get to hospital, health inequalities will already be embedded in their lives, limiting what hospitals can reasonably be expected to achieve. (Crisp, 2020)

So if this point is true how do we tackle health inequalities as a Trust?

By firstly recognising that our health is shaped by a complex interaction between many factors. These include the accessibility and quality of health and care services, individual behaviours and, most importantly, wider determinants; such as housing and income.

Health inequalities exist because of systematic variations in these factors across a population, and this is why engagement with our system partners, and in particular public health colleagues, is crucial. Due to this complexity, tackling health inequalities can quickly become overwhelming and unfocused; it is therefore important we define what our role is and what it is not.

The County Health Rankings Model below breakdowns all the factors that impact health and helps us better understand where we can act.

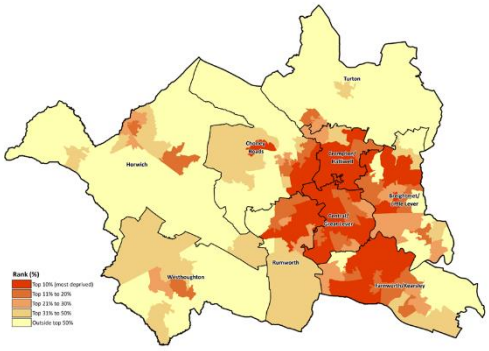


This model helps to narrow our focus; it is evident that as a Foundation Trust we can directly impact on clinical care, we can indirectly impact on health behaviours and we can influence with regards to social, economic factors and the physical environment.

5. What we know about Health Inequalities in Bolton

Using the 2020 Bolton population estimates we know that 26% of Bolton residents live in an area that is among the 10% most deprived nationally; 56% live in an area that is in the most deprived 30% and 4% in an area that is in the least deprived 10% .

Across the whole of Bolton, the life expectancy of our residents varies substantially. For example, in males there is a 14.9-year variation between Central Bolton (70.3 years) and Dunscar & Egerton (85.2 years) and in Females it's a 9.9 year variation between Breightmet North (77.1 years) and Dunscar & Egerton (87.0).



5.1 A Bus Tour of Bolton

To illustrate the differences in health inequalities across Bolton as a borough we have used the 501-bus route to show the changes that can occur in 50-minute journey across the Town. The 501-bus route runs from Johnson Fold to Farnworth, passing through the hospital site. In "real life" this route has 62 stops, however for the purposes of this example we will look at 4 stops, using personas built from feedback and data about our residents.

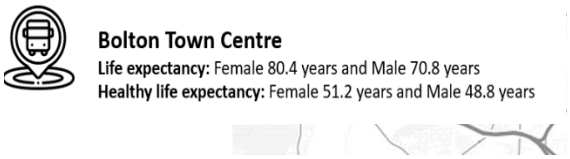
5.1.1 New Church Road

Is in the Doffcocker area of Bolton in the Chorley Roads neighbourhood.

The life expectancy in the area around this stop is 83.4 years for Females and 80.2 years for males. The healthy life expectancy is 65.7 years for females and 62.3 years for males.

5.1.2 Bolton Town Centre

The second stop is in Bolton Town Centre, a short drive from the last stop, however, life expectancy has decreased 3 years for females and 9 years males, health life expectancy decreased 15 years for females and 14 years for males.



4.1.3 Crescent Road

Moving through the town Centre and towards the hospital is the stop on Crescent Road. The life expectancy changes again to 77.9 years for Females and 74 years for Males. Healthy Life expectancy is 55.3 for Females and 54.9 years for Males.

5.1.4 Farnworth

the final stop is in Farnworth, where the life expectancy in this area is 76.9 years for females and 72.1 years for Males. The healthy life expectancy is 58.8 years for females and 55.0 years for males.

Throughout the whole of the 501-bus route, there was a 7-year difference in Female life expectancy and a 9-year difference in Male life expectancy. We see a bigger difference in healthy life expectancy which shows a variation of 14 years for females and 16 years for males along our route.

5.2 Knowing our patients - What we know about Health Inequalities in Bolton Foundation Trust

To effectively act on health inequalities, we need to be able to identify the areas and groups of patients that require additional focus. We hold a wealth of data as a Foundation Trust that can be "cut" at multiple various levels, including by ethnic group, age, sex and deprivation.

Our waiting list for example, is now routinely analyzed to show the waiting times by each of these characteristics, and whether any difference in wait is statistically significant. It should be noted that month on month, these figures can change and are impacted upon by the quality of the information recorded (see next section), without accurate and complete ethnicity data recording for example, it can be difficult to identify where a true inequality may lie.

Noting that this analysis is a snapshot in time, and as the waiting list moves and changes, so does the potential areas of interest, which is why it is important to continuously monitor and draw attention to those areas.

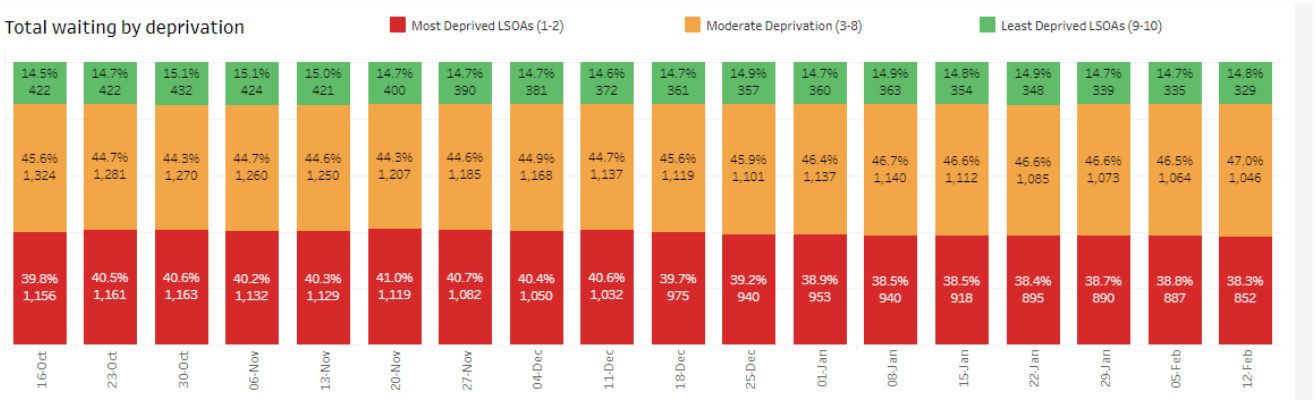
Using a snapshot from the 22nd of January 2023, analysis of our waiting list (RTT pathways, non-admitted routine only) shows potential statistically significant differences in the average time waiting between Black, Asian and Minority Ethnic groups and white groups in both Ophthalmology (in the 17-74 year old group and who are at the time of snapshot were at under 18 weeks wait on the waiting list) and in Gynaecology (for a cohort of patients who are over 17 year olds and whose wait at the snapshot was currently over 18 weeks).

Although, please note that improvement of recording of ethnic category may affect whether these differences are statistically significant, ophthalmology for example has 37% with ethnic group "not stated". A pattern which can be seen in other specialties to different extents and is a focus of data quality work to improve this.

When looking at the January snapshot for the most versus least deprived areas, the following specialties show potential differences – Cardiology and ENT (cohort of patients who at the snapshot date were over 17 year old and had been waiting for over 18 weeks) .

We can also use this data to look at positive changes, meaning specialties which did show a statistical difference in waiting times per group, are no longer showing a difference, such as:

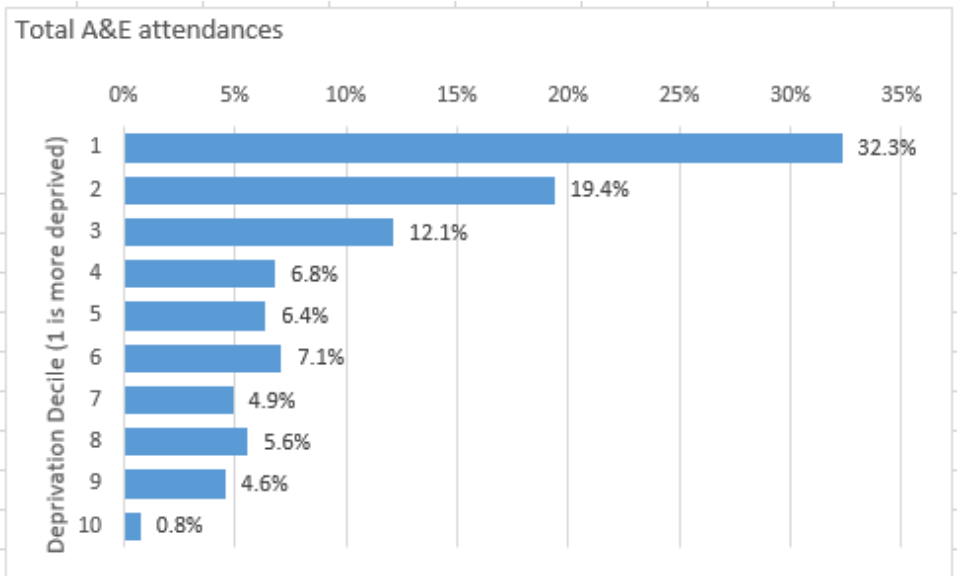
- Ophthalmology and Urology did have some difference between weeks waited for non admitted patients (cohort of patients who were aged over 17 years and who had been waiting over 18 weeks) for those is most and least deprived areas, but that difference is no longer significant on the last snapshot (example for ophthalmology shown below)



For Patient Initiated Follow ups we can split activity by deprivation, ethnic category and age group, and show this by specialty.

In January to March 23, most patients on an open PIFU waiting list are white (65.5%), although note that 19% of patients recorded on a PIFU waiting list have an “unknown” ethnic group. A substantial proportion of patients are within the most deprived areas (41%).

Focusing on our A&E attendances (April – December 22) we can see that 32.3% of our attendances are from patients in the most deprived areas. 0.8% of patients are from the least deprived areas. Although note, this is not weighted for population size.



Any of the Trust’s data that includes patient demographics can be split and analyzed in this way (see note 5.3 below on data quality). Other examples across the Trust include analyzing serious incidents and complaints by the neighbourhoods in which patients live, to identify potential differences.

Recent work taking place across the Bolton locality also involves looking at our community activity by neighbourhood and area, layering this with intelligence from our partners on the delivery of different services, to build a unique picture of service delivery per neighbourhood, to help with decision making.

Other planned events include a series of "data walks", which is a technique to look at data by theme or by neighbourhood, and bring intelligence together from all partners plus service users.

To monitor health inequalities and ensure visibility, several inequalities indicators are being developed to go into the FT Board of Directors report, plus lower level indicators to be included at a variety of other groups. The key principle with monitoring is to ensure that health inequalities indicators are not seen as a separate entity and are an integral part of routine reporting. Work is also ongoing across the locality to bring together a range of outcome indicators, which will also highlight any inequalities, into the new and emerging governance structure.

5.3 Gaps in recording

The 2021 Elective Recovery Fund guidance set out several "gateways" for assessment of adherence to the principles of Elective recovery. There was a strong emphasis on addressing health inequalities and being aware of the impact, this guidance specifically stated that as an organization we should be able to show our activity data split by age, disability, ethnicity and IMD across the following areas:

- Patient Initiated Follow Ups (PIFU)
- Advice and Guidance (A&G)
- Virtual Clinics
- Waiting List

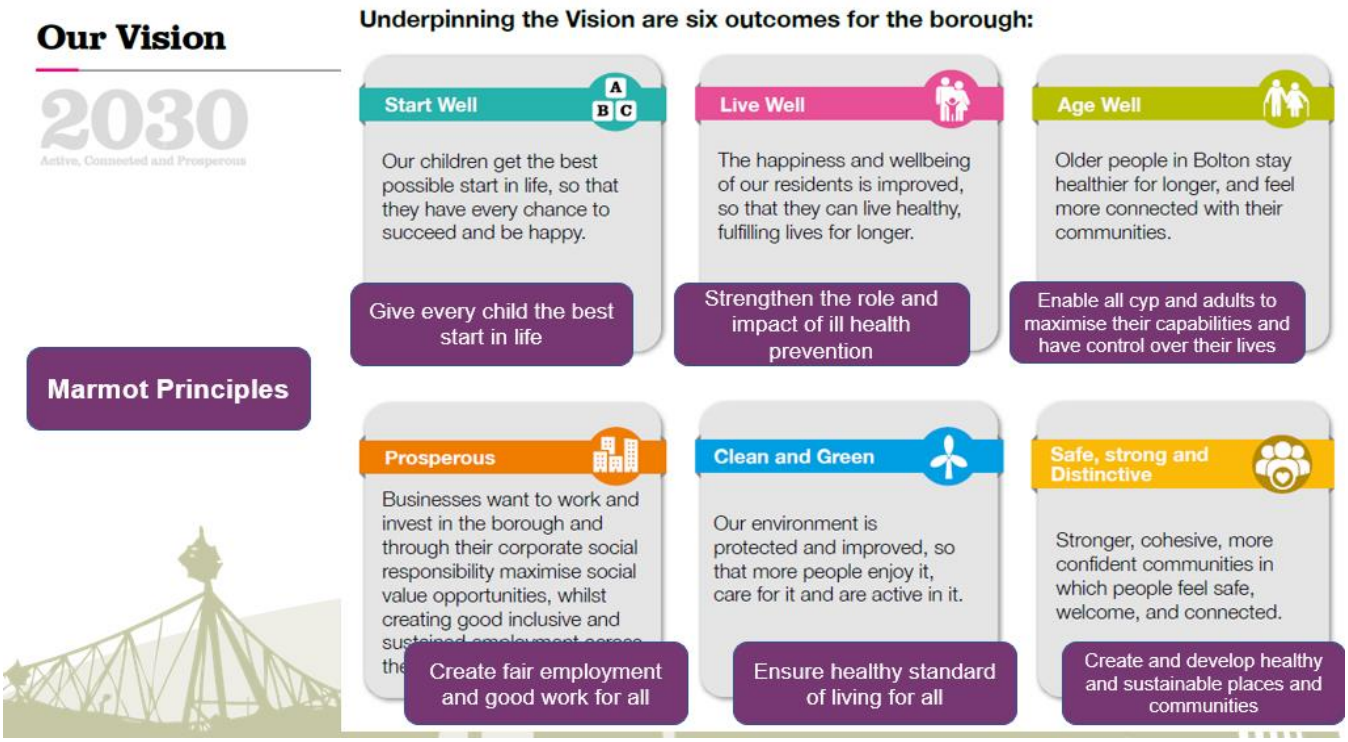
Ethnicity data completeness is one of the key indicators within the national Data Quality Maturity Index (DQMI). Bolton NHS FT as at the latest release in September 22, scored 90.2% completion against a national average of 77.2%. This index looks at all our activity for inpatient, outpatient, emergency care, maternity and community. Note that this could include where ethnicity has been given as "not stated". In the Waiting List Minimum data set for example, we currently have around 27% of patients without a stated ethnicity. The accurate recording of ethnicity has been the focus of our "Know Your Patient" educational campaign across the Trust, to highlight the importance of complete and correct patient information.

Another key focus is being able to analyze our data across key groups such as by disability, we want to improve our ability to capture and record this information as part of the "Know Your Patient" programme.

6. Tackling health inequalities across Bolton

In Bolton, our borough wide place-based approach to reducing health inequity is contained within the Vision 2030. Our Vision 2030 is for the borough to be Active, Connected and Prosperous. The Vision 2030 takes into consideration that health inequalities do not stem from one single issue, instead they are due to complex interactions between a range of environmental, social and economic factors. A

broad range of actions are needed from across different sectors within the borough to effectively tackle health inequity. Underpinning the Vision 2030 are six outcomes which provide the framework for action on health inequity across the borough. These outcomes map directly to marmot principles and can be seen in the figure below.



Bolton's Public Health Team play a key role in providing system strategic leadership for population health matters including health inequalities. The team do this through a wide range of activities including;

- Strategic evidence and intelligence, for example the Joint Strategic Needs Assessment.
- Facilitation of partnership working for prevention, for example the 'Keep Bolton Moving' campaign
- Health protection for our population, for example the Local Outbreak Management Plan (reducing excess deaths).

7. Our Bolton FT approach to tackling Health Inequalities

Tackling HI is complex and can be hard for individual practitioners and for individual organisations to gain clarity on our role and where to start. The approach considers complex change principles and recognises that this is a marathon and not a sprint. Our approach is focused on our people, making a cultural shift in how we think about equity from not just universal access to proportional universalism.

Our approach will also use evidence to drive our decision making and help us keep focused on what we can do in the short, medium and long term to reduce health inequality.

Our approach allows us to be clear on which parts of the work we are leading on, which parts other partners are leading on and what we are all collaborating on.

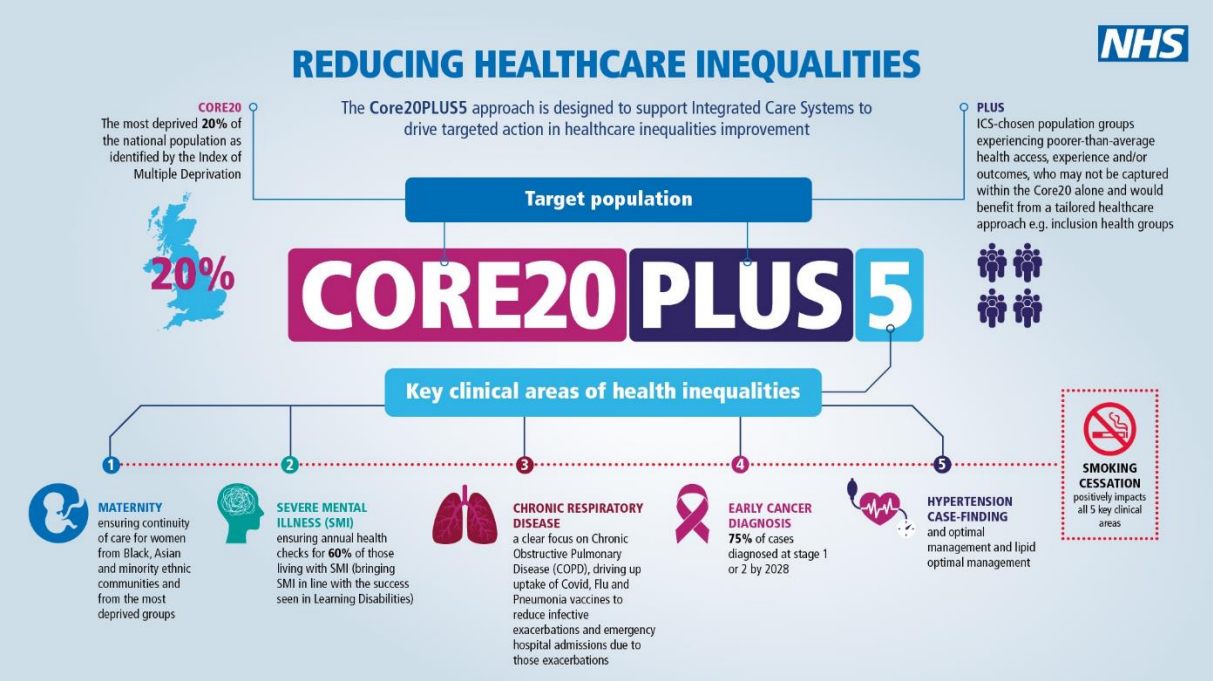
When considering the county healthcare model from section 3, we can then start to identify which areas we will naturally lead on within a health inequalities programme and areas that other partners will lead on.

Of course, these 3 components are not in silo, and instead we can influence our partners and they can influence us.

The diagram below identifies examples of how this relationship between leading on, collaborating on and allowing other partners to lead on areas works in practice:

For example, if we use the CORE20PLUS5 model, which is the national NHS England approach to informing the NHS contribution to reduce healthcare inequalities, there are areas by which we are directly responsible for and areas which we can contribute to.

In CORE20PLUS5, the "CORE20" defines the most deprived 20% of the population. The "PLUS" are for local population groups who are experiencing poorer-than-average health access and/or experience outcomes not captured elsewhere in the CORE20 model. The "5" in CORE20PLUS5, shows the 5 key clinical areas of health inequalities.



Within these 5 clinical areas, Bolton FT has overall leadership on some areas, but then for others we can collaborate with our partners to directly influence.

7.1 We Lead- Maternity

Our work to develop the cultural midwife role to specifically engage with a co-design maternity improvement with the underserved population in BL3 is an example of us leading work which tackles health inequalities. This has been done in collaboration with local faith and community groups such as Bolton Council of Mosques.

7.2 Partners Lead- Public Mental Health and Wellbeing

Bolton Council Public Health Team lead on development and delivery of the Prevention Concordat for Better Mental Health. They work in partnership with a range of providers to deliver a range of activities which promote better mental health outcomes.

7.3 We Collaborate- Tobacco Control

Bolton Council Public Health Team have overall responsibility for the Tobacco Control Strategy for the Borough, working with a broad range of providers and bodies The strategy is end to end ranging from enforcement action on sale of tobacco products to secondary prevention of ill health related to tobacco use.

Within this, we take a lead role in running the CURE program which aims to cure tobacco addiction through targeted interventions with people after ill health events such as stroke and heart attack which could have been contributed to by their smoking history.

8. Our plan for the next 12 months

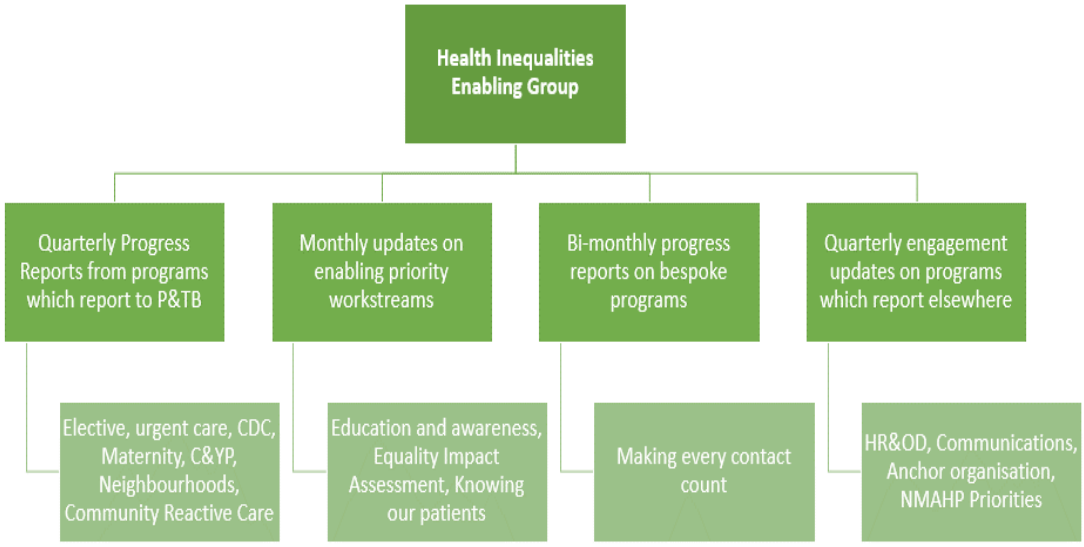
The Health Inequalities Enabling Group will oversee our plan for tackling health inequalities. Our plan for the next 12 months is best summarised as a matrix approach to programme management. A detailed programme map has been constructed which contains all the programmes which align to our approach to reducing health inequalities. This programme map is summarised in table 1 below. This shows the aligned programme of work, where it reports to within the organisation and in what way it contributes to tackling health inequalities. For example, the elective programme reports to Performance and Transformation Board and contributes through its work on access, clinical outcomes, health behaviours, patient experience and prevention.

Table 1: Summary of programme map for all programmes which contribute to tackling health inequalities

Program Name	Reports to	Contributes to improving							
		Access	Clinical outcomes	Experience	Health behaviours	Education & awareness	Physical environment	Prevention	Employment opportunities
Making every contact count	**HIEG**		x	x	x	x		x	
Elective recovery & transformation	**P&TB**	x	x	x	x	x		x	
Community Diagnostic centre	**P&TB**	x	x	x			x		x
Urgent care transformation	**P&TB**	x	x	x	x				
Locality transformation schemes	**Strategy, Plannin**	x	x	x	x	x		x	x

	g & Delivery								
Maternity transformation	**P&TB**	x	x	x	x	x		x	
C&YP transformation	**P&TB**	x	x	x	x	x		x	
Digital	**DP&TB**	x		x		x	x		
Anchor organisation ambitions	**TBC**			x	x		x	x	x
HR&OD schemes	**Workforce steering groups**				x	x	x		x
Communications	**Workforce steering groups**	x		x	x	x			x
BI & Data	**P&TB**	x	x	x	x	x		x	
NMAHP transformation	**CG&QC**	x	x	x	x	x		x	

The Health Inequalities Enabling Group will use a structured workplan to oversee these programmes through the year. The workplan is summarised in the figure below:



The HIEG will also lead on the delivery of work within three key enabling priorities. These enabling priorities have been identified through a range of engagement work within the HIEG, on our Health Inequalities workshop and through extensive review of the programme map. The enabling priorities align to our approach by focusing on our people, our culture and on enabling evidence-based decision making. The three enabling priorities are:

8.1 Education and awareness

We have recognised earlier in this paper that the landscape with regards to tackling health inequalities is complex and can be confusing even for those involved closely with the work. So for our wider organisational colleagues, we must not assume high levels of knowledge and understanding about the subject. However, for change to happen, we will rely on all our colleagues knowing about the subject and the small but impactful things that they can do. So, education on what HI are and how they can be positively influenced will be a key foundation of our plan over the next year.

Our approach to education and awareness will be multifaceted and will include;

- Introduction to the topic at Trust induction
- Development of online learning packages
- Promotion of bespoke training and development packages available externally

8.2 Health Equity Impact Assessment

Our culture change as an organisation will be underpinned by a different approach to how we assess equality impact in the things that we do. We will need to put health equity at the centre of our decision making and not as an add on, for example at the end of developing a business case. In this key enabling priority we will focus on changing our processes to build health equity consideration into the foundation of how we do business as an organisation. This will include;

- Refreshing the equality impact assessment process and document
- Refining our transformation programme initiation processes to ensure health equity impact assessment at the outset
- Building meaningful health equity impact assessment into our standard documents such as paper templates, business cases, quality impact assessments.

8.3 Knowing Our Patients

We have recognised the issues with gaps in recording earlier in section 5; this is our third foundational priority to shift the dial on in the next year. From our exploratory work in the first year of the HIEGs existence, it is evident that this issue with gaps in recording is one that we must change or we will not know precisely where to concentrate our improvement efforts and we will also not know whether changes we make lead to improvement.

Within this priority we will;

- Engage with stakeholders and staff to understand the barriers to asking about, declaring and recording demographics such as ethnic background
- Use the already established 'Know Your Patients' learning weeks to raise awareness amongst our patients and staff on the importance of knowing and recording demographic details correctly
- Monitor our progress with narrowing the gaps in recording

9. Risks to delivery

This programme of work is large and complex and hence holds inherent risk to delivery. Some of this is mitigated through the matrix programme mapping approach and the identification of key enabling priorities as detailed in section 8 above. The existence of our HIEG to oversee this programme is also a mitigation. However, the remaining risks to delivery which should be noted can be summarised as;

- Resource in clinical, operational, transformation and workforce teams to prioritise this work
- The interdependencies of our Bolton FT workplan with the locality approach which means that we are not always in direct control
- Real change will be dependent on culture which is notoriously slow and hard to impact upon
- Current gaps in recording are a risk to us knowing whether we have improved through the changes we have made because our baseline is not accurate.

10. Summary

This report is a long read and contains an executive summary for ease by committee members.
The Health Inequalities Group was formed 12 months ago to support the operational and

transformation programmes which report into Performance and Transformation Board. During this year it has done considerable work to spotlight the work going on across the Trust to tackle Health Inequalities. Work to develop our organisational approach, within the context of Bolton's Vision 2030 has also been carried out. We have also undertaken analysis of our data to understand inequalities in access to and experience of the services that we provide.

In the final quarter, work has been carried out to map all of the programmes of work which are contributing to our organisational approach to tackling Health Inequalities. This has shaped the workplan for the HIEG for 23/24. It has also led to the identification of three key enabling priorities for the next year, which are summarised as;

i. Education and awareness
ii. Health equity impact assessment
iii. Knowing our patients

11. Recommendation

Strategy and Operations Committee are asked to note the work carried out so far and the plan for the next 12 months. SOC will receive regular updates on HI reduction work through the spotlight section on the agenda, for example the maternity spotlight in April will include information on the maternity HI reduction activities. An annual report on all HI work will be prepared by HIEG and presented next in March 2024.

12. References

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Vision | Openness | Integrity | Compassion | Excellence

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Health Inequalities

Update to Board of Directors

September 2023

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NHS Bolton NHS Foundation Trust

Background and context

In March 2022, the Health Inequalities Enabling Group (HIEG) was established to tackle the challenges surrounding Health Inequalities for the Trust.

The group initially found that there were more questions than answers to these challenges, such as:

- what are health inequalities?
- do we really understand their prevalence in Bolton?
- why do they exist?
- what is already being done to address this in Bolton?
- and crucially, what is Trust's role in addressing health inequalities?
- what should be the Trust's overall approach to tackling health inequalities?

To address these questions a workshop was held in November 2022 involving HIEG members and system partners.

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Our approach to tackling health inequalities

We lead	We collaborate on	Partners lead
Access, outcomes and experience of our services	Making Every Contact Count	Economic regeneration
Providing high quality employment and education	Trauma aware organisations	Providing good quality housing
Chronic respiratory disease	Empowering communities	Clean, green and inviting environment

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Transformation Programmes

From December 2022 to February 2023 the HIEG undertook a review and mapping exercise across existing programmes of work within the Trust which were anticipated to connect to health inequality reduction in some way.

This evidenced that a vast amount of work was already underway.

In the mapping exercise we have categorised that contribution into the following benefits:

- Improving access
- Improving clinical outcomes
- Improving patient experience
- Improving health behaviors
- Improving education and awareness
- Improving physical environment
- Prevention
- Creating employment opportunities

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Priority workstreams for HIEG

In addition to existing transformation programmes, the HIEG identified three key enabling priorities
for this year, which are summarised as:

- Education and awareness
- Health inequality and equality impact assessment
- Knowing our people

Each priority has a lead and reports monthly on progress into HIEG.

Each division also reports into HIEG quarterly on the bespoke work which is underway
to tackle health inequalities in our services.

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Milestones achieved

Education and awareness

- CEO now includes HI in all Trust inductions
- Developed BOB page, infographic and educational posters
- Developed case studies on where we are addressing health inequalities
- Links made with several staff networks to promote correct and accurate demographic recording

Knowing Our People

- Data quality presentation as part of the Junior doctors induction
- Data quality included in the Trust wide induction
- Data quality session included in the Matron Leadership course
- KPIs developed for data monitoring and completeness of recording
- Know Your Patient education week to take place in September with educational activities and a stand in the main reception

Equality and health inequalities impact assessment

- EHIA process and screening tool developed to identify any changes or additional steps required to ensure equal access, experience and outcomes are achieved across all groups in the development of policies/services/projects.
- Pilot teams identified to trial the new process
- Agreement reached to include EHIA into business case and benefits realisation process

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Next step milestones

Education and awareness

- Develop public webpage on health inequalities
- Undertake a Trust wide 'What are health inequalities?' poll to develop an insight into our workforce's understanding and knowledge on health inequalities
- Plan a standalone Health Inequalities event day/week

Knowing Our People

- Exploration around possible recordings within LE2 to enrich our data
- Track data monitoring and completeness of recording KPIs
- Build on outputs from Know Your Patient Week and Trust wide poll to develop the our health inequalities programme plan and tailor our approach going forward
- Links made with the GM EDI team to look at other projects taking place around data recording

Equality and health inequalities impact assessment

- Complete pilots and plan full roll out
- Scope all other documents for changes to templates e.g. papers, QIA
- Work with Locality colleagues on standardising EHIA process

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Locality Outcomes Framework

- Given the need for a single approach to transforming Bolton's health and social outcomes, a Single Outcomes Framework is being developed to set out the outcomes we want to achieve in the town during the next decade; this will align with the Locality Plan
- The Outcomes framework is focused on improving the health and wellbeing of the population, reducing inequalities and enabling a sustainable system
- The use of this Single Outcomes Framework intends to support a system change, moving away from an activity and process approach to focusing on outcomes for people. This will also inform commissioning priorities and help focus activities and investment with wider partners such as voluntary sector, housing and police
- Due to the intractable Health Inequalities in Bolton, system partners agreed that in the first instance we would centre our outcomes framework around reducing health inequalities; using the Core20PLUS5 model
- The national CORE20PLUS5 model will assist the Locality in targeting efforts and resource in the areas evidence shows make a difference

CORE20PLUS5

- The Bolton Locality response to CORE20PLUS5 can be seen here
- This is still in development and the wider framework will detail the supporting outcomes and KPIs
- This is important as it not only sets the direction for the Locality, it aligns with our current clinical strategic priority of 'Improving the health of the population' and will help inform our future Health Inequalities programme and activities

Core10 - Deprivation

26% of the Bolton population live in an area that is among the 10% most deprived nationally, while 45% of the population live in an area that is among the 20% most deprived nationally. Due to the proportion affected, the Health and Care Partnership will focus on the Top 10% most deprived populations in Bolton, for at least the first year, and then expand to the Top 20%

PLUS – Local population groups

We have worked with Public Health to identify PLUS population groups. These are currently the same for adults and children and young people (0-17) but are subject to change

Clinical areas of focus

There are five clinical areas of focus for adults, and five for children and young people; which CORE20PLUS5 have identified as needing accelerated improvement.
Bolton will add a further two cross cutting areas for smoking and obesity

Local PLUS Groups

Adults and Children and Young People
People with drug and alcohol dependence
Asylum seekers and refugees
Gypsy, Roma, Traveller communities
Carers
LD

Clinical areas of focus

Adults	Children and Young People
Maternity	Asthma
Severe mental illness	Diabetes
Chronic respiratory disease	Epilepsy
Early cancer diagnosis	Oral health
Hypertension	Mental health
Obesity	
Smoking	

NHS Bolton NHS Foundation Trust

Rainbow badges assessment

- The Rainbow Badges Campaign has evolved and now assesses how organisations promote an open environment for LGBTQ+ patients and staff
- Assessment took place between February and May
- Service Reviews in Urgent Care, Outpatients and Family Care
- More than 100 staff and 50 patients contributed to the survey
- Each organisation receives a rating akin to other inspection regimes
- Trust rated at “INTIAL STAGE”
- More than 100 recommendations identified
- Several polices identified for review
- Other areas include estates and training of staff
- Action plan will be developed by the network by October
- Reassessment can be triggered at any stage

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Tackling health inequalities in cancer care

Our aim

- To identify patients on the 62-day cancer pathway who are more likely to breach the target by analysing patient demographics and exploring the impact of health inequalities on the pathway

What we expect to achieve

- To understand the barriers to timely access for patients with a suspected cancer and to enable remedial plans to be put into place to do this

How we plan to achieve it

- A provisional review of the data will be carried out to establish how demographics such as ethnicity and deprivation are affecting patients on the 62-day pathway
- Early analysis of the data shows roughly 30% of ethnicity data is not recorded and the BI team is currently carrying out a piece of work across the trust in order to help improve this. We are also exploring ways in which we can try and improve data capture locally within Cancer Services to assist in improving it
- Ethnicity and deprivation data will be analysed in order to establish which health inequalities are having the biggest impact on delays along the pathway, for example; patients experiencing delays due to requiring an interpreter if English is not their first language or patients living in the most deprived areas struggling with travel to and from the hospital to attend appointments

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Thank you.
Any questions?

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Report Title:	Winter Plan

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Rae Wheatcroft, Chief Operating Officer		Decision	

Purpose	To provide the Board of Directors with assurance on our preparedness for winter 2023/24.

Summary:	This paper describes the key actions and approach Bolton NHS Trust is taking to manage winter demand, whilst maintaining patient experience, meeting critical quality indicators, and ensuring the key deliverables for recovery are achieved. A review was undertaken of achievements, lessons learned and data analysis for winter 2022/23. Based on the review, Divisions developed transformation plans which have focussed on minimising risk of attendance, admission or reducing length of stay. Alongside the divisional plans, a series of cross cutting projects including virtual ward, and criteria led discharge report into the Urgent Care Transformation Board. In support, an updated bed modelling tool has been designed to allow different scenarios to be modelled in terms of bed numbers.

Previously considered by:
The Strategy and Operations Committee received the winter plan for scrutiny on 27 July and 25 September 2023 in order to recommend it to Board.

Proposed Resolution	The Board of Directors is asked to approve the trust's winter plan for 2023/24.

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:	Kelly Crumlin, Urgent Care Programme Manager Joanne Street, Director of Operations	**Presented by:**	Rae Wheatcroft, Chief Operating Officer

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

A&E	Accident & Emergency
G&A	General & Acute
OPAU	Older Persons Assessment Unit
ECIST	Emergency Care Improvement Support Team
ED	Emergency Department
ICPS	Integrated Community Paediatric Staff
IDT	Integrated Discharge Team
T&O	Trauma & Orthopedic
ENT	Ear Nose and Throat
HVAT	Homeless and Vulnerable Adult Team
SLT	Speech and Language Team
AAT	Admissions Avoidance Team
SAFER	Senior Review, All patients, Flow of patients, Early Discharge, Review
BoSCA	Bolton System of Care Accreditation
EPR	Electronic Patient Record
ACSC	Ambulatory Care Sensitive Condition
GM	Greater Manchester
NQ	Newly Qualified
ICB	Integrated Care Board
NHSE	NHS England

Bolton NHS Foundation Trust 2023/24 Winter Plan

Version control – sign off and changes from each group

V1	**First Draft**	**Queries in yellow to be discussed at UCTB**
V2	**Urgent Care Transformation Board**	**Change A&E to the National Operational planning priorities** **Changes to theme the schemes- remove division detail- this will be in the appendix** **Change monitoring to governance and add in division governance** **Finance section has been added**
V3	**Performance & Transformation Board**	**No changes**
V4	**Strategy and Operations Committee**	**Update to reflect NHSE winter planning priorities** **Update to the length of stay reduction**

1. Executive Summary Introduction

1.1 The purpose of this paper is to describe the key actions and approach Bolton NHS Trust is taken to manage winter demand, whilst maintaining patient experience, meeting critical quality indicators, and ensuring the key deliverables for recovery are achieved.

This year's Winter Plan has been formulated within the context of what is predicted to be a challenging winter, with a continuing increase in demand for urgent care services and continuing challenges in moving patients who no longer require hospital care to their discharge destination.

The plan has also been developed in line with operational planning guidance to recovery our core services and improving productivity within Urgent and Emergency Care:

- Improve Accident & Emergency (A&E) waiting times so that no less than 76% of patients are seen, treated, admitted or discharged within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24
- Reduce and/or maintain adult general and acute (G&A) bed occupancy to 92% or below

On 27th July 2023, NHS England wrote to system leaders with their plans for Winter 2023/24. The NHSE plan links to the following plans:

- recovering Urgent and Emergency Care (UEC) services
- Primary Care Recovery Plan
- Elective Recovery Plan

The plan details 10 high impact actions for systems to complete. These actions have been reviewed and are already included in the trust's winter plan.

1.2 Bolton NHS Foundation Trust winter plan sets out to:

- Ensure the best possible care, safety and experience for patients and service users
- Safely manage and protect patients from Flu and COVID-19 across all settings
- Deliver the Clinical Strategy for Urgent Care to make significant, sustainable improvement to urgent care services
- Deliver care in the right setting, close to home to support our population, through initiatives such as Home First, Admission Avoidance and Hospital at Home (Virtual Wards)
- Continue to progress our elective recovery
- Protect and support our staff, looking after staff wellbeing and protecting staff from COVID-19 and flu

2. Summary of Winter Planning Process and Priority Actions

2.1 The plan has been informed by a series of organizational and locality winter review and planning workshops. It reflects collaborative working across teams and takes account of lessons learnt from last winter.

2.2 A review of last winter has been carried out including:

- What was achieved against the 2022/23 transformation plans
- What could be improved/lessons learnt
- Review of winter bed modelling: capacity against demand
- COVID 19 and Flu impact assessment

The outcome of the review is summarised below;
Improvements made:

- The Older Persons Assessment Unit (OPAU) was launched in September and evaluated reduction in length of stay. For those patients who went through the unit then onto complex care wards, there has been a reduction of LoS by 2.8 days. Overall, across the complex care wards this is a reduction in length of stay of 0.6 days. This is as a result of early discharge planning and complex medical plans earlier in patient's journey.
- The virtual ward was launched in Frailty and Respiratory, over 670 patients to date, have either avoided admission or gone home from hospital early.
- The Same Day Emergency Care Re-design was completed prior to winter, and is being expanded into orthopaedics and surgery this summer. This has already started to demonstrate reduced occupied bed days compared to previous years.
- The ambulance handover project delivered improvements to handover times, and NWAS are linking with virtual ward admission avoidance to expand this summer the number of patients we can support at home

Challenges:

- Modelling demonstrated that at times there was insufficient bed capacity to meet the demand during winter; this resulted in high levels of bed occupancy in January and February. There is a direct correlation between high bed occupancy and waits in the Emergency Department.
- Outliers impacted on the risk of elective cancelled operations.
- High bed occupancy for last winter resulted in additional escalation beds being opened.
- A high prevalence of Flu impacted on capacity, the ability to isolate and/or cohort also reduced our overall available bed capacity.
- Overcrowding in A&E resulted in an increase in non-admitted breaches and delays in making decisions to admit.
- The number of patients who didn't meet the criteria to reside remained high leading to escalation beds remaining open, impacting on patient experience and pressure on workforce.

2.3 Divisional plans

Divisions have identified:

- Top transformational priorities that must be progressed in preparation for winter in order to create resilience
- Full detailed operational winter plan which describes all actions and interventions across the division for winter and will be agreed and managed through each Divisional Board
- Corporate plan to incorporate 3 trust wide schemes covering communication, workforce and Criteria Led Discharge
- Some of the divisional operational winter plans commenced in the summer to support a timely response to our winter planning process.

3. Winter Modelling and Intelligence

Analysis has been undertaken which is supported by bed modelling and Emergency Care Improvement Support Team (ECIST) recommendations. The aim of bed modelling is to ensure the number of beds available matches demand and seasonal variations to maintain occupancy levels at an optimum to support in hospital flow of patients.

This year's bed modelling indicates based on a super high flu prevalence, without any reduction in admissions or length of stay, to achieve 92% occupancy we will require all beds to be open, plus an additional shortfall of 43 adult acute beds to manage this winter at the worst point (January 2024). Occupancy for acute beds throughout summer months has run at circa 94-95%, and so it is likely that some of this shortfall will be made up through managing with higher occupancy rates than 92% during winter months also.

Based on Length of Stay improvement plans, we are aiming to achieve a length of stay reduction of 0.9 days and coupled with increased admission avoidance through Virtual Wards and SDEC, this would mean that the available bed capacity would meet demand in January.

It is acknowledged that the winter planning length of stay reduction of 0.9 days will be extremely challenging, this will be monitored closely by the urgent care programme manager and director operations who will implement the next line in the governance process. A check and challenge of our winter plan is being held in September in order to ensure that our plans are being mobilised effectively and to test our worst case scenario escalation plans.

The Divisions' transformational priorities ahead of winter are focused on admission avoidance, length of stay reduction and reducing Emergency Department attendances. Divisional team's plans are being translated into the benefits of reducing occupied bed days in order to monitor impact, track activity and support scenario planning.

4. Summary of Priority Actions

4.1 This section of the plan sets out a number of actions/schemes, which are supporting work to reduce attendances and avoid unnecessary admissions by managing care closer to home,

improving flow through the hospital to reduce length of stay and facilitating smoother transfer or discharge of patients on the health and care pathway.

4.2 Winter Resilience

- Bed Modelling
- Open Winter ward: October 2023 – April 2024
- Embed the new escalation policy and associated triggers and escalation meetings
- Deliver the deep clean and maintenance programme on wards between June – December 2023
- Workforce seasonal roster review
- Increase vaccination uptake campaign for flu and COVID across Bolton Locality and workforce
- Therapy winter escalation resource team
- Pharmacy operational efficiencies: pharmacy tracker, robot, ascribe upgrade, call direction service, change pharmacy opening hours- reviewing benefits realisation and impact of this service
- Inclusion of pharmacy staffing in urgent care Pre-op pharmacist to support planned elective surgery waiting lists
- Waiting list management - utilise all tools including digital Waiting List Validation (WLV) to ensure most effective waiting list management & capacity and demand management
- Mortuary Scanning to speed up release of patients

4.3 Reducing Emergency Department (ED) attendances

- Urgent Care Treatment Centre- education to be given at the end of each visit for self-management and use community pharmacy– standard 4 and standard 29
- Communication campaign, 'Keeping well for our Bolton patients', to include signposting to other services
- Gynae pathways: patients in ED longer than anticipated
- Paediatric community plans to reduce attendances and admissions
- Virtual Ward Step up: Increase number of Out-Patient Antibiotic Therapy patients to IV therapy
- Develop/ Expansion of GP Direct service
- Reduce overall wait times for surgery/treatment to reduce ED presentations and subsequent unscheduled admissions
- Deliver internal professional standards for specialty response to ED

4.4 Reducing Length of Stay

- Cross cutting LOS Improvement Projects:
    - Criteria led discharge to improve weekend discharges
    - Senior Review, All patients, Flow of patients, Early Discharge, Review – Bolton System of Care Accreditation (SAFER B0SCA) roll out
    - SAFER board on Electronic Patient Record (EPR) re-design to support flow

  - Discharge checklist to improve standards of discharge planning
  - 100 voices: involving patients in discharge planning
  - Expansion of Virtual Ward to deliver 100 beds by December
- Re-designed model for management of orthopedic outliers
- Older Persons Assessment Unit - phase 2
- Integrated Community Paediatric Staff (ICPS) to attend/contact F5, E5 and PED on a daily basis to facilitate early discharge and flow.
- Monitor LOS for patients receiving therapy on paeds and gynae ward
- Re-ablement improvement plan
- 7-day stroke therapy
- Ensure accurate and optimal Pre-op assessment - using digital tools to pre-op earlier in pathway and address any potential recovery issues as early as possible
- Reduce requirement for double handed care on discharge and develop confidence in single handed care strategies
- Continuation of 7 day enhanced social care weekend staffing model within Integrated Discharge Team (IDT)
- Implement Trauma & Orthopedic (T&O) and Ear Nose and Throat (ENT) pathways to SDEC
- Reduce unnecessary bed days due to preventable post-op complications to ensure accurate and optimal Pre-op assessment - using digital tools to pre-op earlier in pathway and address any potential recovery issues as early as possible
- Reduce unnecessary bed days by providing radiology imaging at point of need within turnaround time.

4.5 Reducing Admissions

- 7 day working in Homeless and Vulnerable Adult Team (HVAT)
- Expansion of 7 day working within Diabetes to include in reach to ED
- Outreach in community for Diabetes team (neighbourhood working)
- Stroke 7-day working
- Speech and Language Team (SLT) 7-day working
- Increase pathways in to Admissions Avoidance Team (AAT)

4.8 Trust Escalation Process

The new Trust Escalation process aligned to the National OPEL standards policy is live. Further work to launch this will happen in the coming months and the OPEL scores will be utilized fully on the new bed management system. The Trust escalation policy has clear lines of accountability to support trust and system partner actions.

5. Bolton Locality System-wide Winter Plan

Greater Manchester Integrated Care Bolton locality are supporting the trust with the delivery of their winter plans and the wider locality, having oversight of all the plans through the

Urgent and Emergency Care Board. The wider locality is reviewing the following schemes, which will support the trust in the delivery of their plans:

- Home Care Sector Stability
- Primary Care Hubs (Including but not limited to Respiratory)
- Primary Care Increased Capacity Bolton Tenancy Brokerage Scheme
- Greater Manchester Mental Health Trust Wide Schemes
- Primary Care Frailty Model – Frailty Registers & Rockwood Score Ambulatory Care Sensitive Condition (ACSC) Management in Primary Care
- Primary Care Access Audit
- High Intensity Users

6. Corporate Schemes

To support this year's winter planning approach, the following three corporate schemes have been prioritised:

- Criteria Led Discharge
- Communication – public and workforce
- Workforce

6.1 Criteria Led Discharge

- Testing phase for nurse-led discharge model on E4, Respiratory and Cardiology wards
- Roll out weekend discharge model in line with ECIST best practice

6.2 Communication

The communication team are supporting with the following schemes:

- Keep well campaign for our Bolton Residents
- Greater Manchester (GM) wide campaign
- Internal communication campaign to inform staff of our winter plans and how they can support

6.3 Workforce

Core to our successful delivery of the winter plan is our workforce. This is both in terms of:

- Having sufficient substantive staffing resource to run our services safely and to create extra capacity in our services and,
- Workforce health and wellbeing

In terms of workforce capacity, both effective recruitment and strong retention of our existing staff will be key to our success. We will ensure strong plans and activity are in place for both these areas.

In support of our staff, we will look after the health and wellbeing of our workforce through an enhanced corporate offer and personalised packages.

The provision of sufficient workforce is a significant challenge for the Trust and wider NHS in the context of a competitive jobs market, lack of enough clinical staff in the UK, NHS turnover rates running at high levels, on-going industrial disputes across a number of staffing groups, and a cost-of-living crisis. It is therefore important that we absolutely understand our data and areas of challenge with appropriate plans in place to recruit, retain and support; with the ability to report on activity and impact of that activity.

The three schemes being considered and explored are:

1. Filling vacancies: work underway with medical agency partners to recruit. On-going work with newly qualified nurses and midwives and strong expected September 2023 intake of Newly Qualified (NQ) new starters. Focus on AHP vacancies and promotion of roles through social media etc.
2. Retention and staff support activity: health and wellbeing support, promotion of financial and wellbeing advice and guidance, range of affordable salary sacrifice schemes in place, enhancement of staff facilities (e.g. food trucks on site, fruit and veg stall, new and improved staff break and rest facilities etc), opportunities to work flexibly etc.
3. Reduction of agency usage and expenditure: Efforts to fill our vacancies, go-live with NHS Professionals providing our temporary workforce needs from September 2023, grip and control and clear reporting etc.

7. Governance

The Urgent Care Transformation Board will oversee and monitor progress against plan which will be a standard agenda item. Sub groups report highlight reports into the board and include:

- Emergency Department Improvement Plan
- Same Day Emergency Care Group
- Length of Stay Group
- Frailty Steering Group
- Virtual Ward network board
- Stroke Improvement
- Diagnostic improvement
- Surgical Urgent Care
- Paediatric improvement
- No Criteria to Reside

The Urgent Care Programme Manager will monitor the winter plan and will escalate issues through to the Director of Operations via the weekly Divisional Director of Operations meeting. The winter plan reporting will be through the monthly through to the Urgent Care Transformation board.

To support the plans and provide further assurance to a check and challenge event has been organised for September, 4 areas and 12 questions are part of the Key Lines of Enquiry that the divisions have been asked to respond to prior to the session.

Timeline

8. Financial Implications

Funding has been allocated to localities via Greater Manchester Integrated Care Board (ICB) from the Urgent and Emergency Care Recovery fund. A prioritisation exercise was undertaken in March 2023 to identify schemes and allocate the resource across locality partners. Our winter plans have been based on assumptions of this funding plus existing baseline expenditure. Finance Business Partners are working with Divisions to identify the financial implications of all planned winter schemes. Expenditure for winter is set against a backdrop of significant deficit for Greater Manchester and further prioritisation of allocation of resource is ongoing.

9. Recommendation

The Strategy and Operations Committee (and subsequently Board of Directors) are asked to:

1. Review and scrutinise the approach to winter review and planning adopted this year
2. Accept the transformational priorities winter plans
3. Note the monitoring and escalation process for the winter plan
4. Note the financial implication

Report Title:	Protecting and expanding elective capacity – Self certification checklist

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 September 2023		Discussion	✓
Exec Sponsor	Rae Wheatcroft		Decision	✓

Purpose	To provide a response to the letter from NHSE ''*Protecting and expanding elective capacity*' with a proposed submission for self-certification to be submitted by 30 September.

Summary:	On the 04 August 2023, the Trust received a letter from NHSE '*Protecting and expanding elective capacity*.' See Appendix A for full letter. The letter sets out the expectation for Trust's to free up capacity and increase productivity, through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models. The Anaesthetic and Surgical Services division have led on the completion of the board self-certification below and this is to be presented to the Board of Directors for review and approval.

Previously considered by:
Strategy and Operations Committee

Proposed Resolution	It is requested that the Board of Directors, receives and approves the self-certification and assurance checklist below and that this is signed and submitted by the chair and chief executive by 30 September 2023.

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:	Alex Cottrell, Deputy Divisional Director of Operations ASSD Michelle Cox - Divisional Director of Operations ASSD	**Presented by:**	Rae Wheatcroft Chief Operating Officer

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

PIFU	Patient Initiated Follow Up
DNA	Did Not Attend
DMAS	Digital Mutual Aid System
PIDMAS	Patient initiated Digital Mutual Aid System
IPT	Inter Provider Transfer
PTL	Patient Tracking List

Background:

On the 4th August 2023, the Trust received a letter from NHSE '*Protecting and expanding elective capacity*.' See Appendix A for full letter.

The letter sets out the expectation for Trust's to create capacity and increase productivity, through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

The letter sets out further detail on three key actions that NHSE are asking Trust's to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.

- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will not be waiting for a first outpatient appointment after 31 October 2023

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

Trusts have been asked to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made in relation to outpatient transformation. Each Trust has been asked to review plans and to discuss and challenge these at Board level, through the undertaking of a board self-certification process, which is to be signed off by trust chairs and chief executives by 30 September 2023.

The Anaesthetic and Surgical Services division have led on the completion of the board self-certification below and this is to be presented to the Board of Directors for review and approval.

Recommendation:

It is requested that the Board of Directors, receives and approves the self-certification and assurance checklist below. This should be signed and submitted by the chair and chief executive by 30 September 2023.

Assurance Checklist

**RAG the letter from NHSE has not requested a RAG rating, but this has been added for ease for the board to review and can be removed if required. The request asks that the return is for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. This is then to be returned to our NHS England regional team.*

Assurance Area (set out in the letter)	Assured RAG *	Trust update and comments
1. Validation		
The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.		The trust has access to reports showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation. The trust has access to the national LUNA system and also has a local similar system.
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.		The Trust is utilising a digital system 'Health care communications,' to contact all patients waiting over 12 weeks to validate the PTL. To date, with the exception of four specialties, patients waiting over 18 weeks have been contacted using the health care communication systems. A detailed plan is in place for the remaining four specialities and to extend the contact down to patients waiting over 12 weeks.
C. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance		There is clear evidence through the trust PTL that the Access Policy is followed for long-waiting patients and those that are discussed as part of the PTL meeting and down to the point validated by specialties.

on operational implementation of the RTT rules and training can be found on the Elective Care IST Future NHS page. A clear plan should be in place for communication with patients.		
D. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.		The trust has an overdue undated follow-up report, which outlines the overall follow-up position across all specialties. All specialties discuss risks related to waiting lists as part of their specialty governance processes. Risks related to outpatient capacity and outpatient follow-up waiting lists are recorded on the trust's Operational Risk register. Some additional capacity for the follow-up waiting list was included in the Operational Planning Submission which noted our inability to deliver the mandated 25% reduction in outpatient activity as a result. Capacity for follow-up activity is balanced against capacity required for new and diagnostic activity and based on clinical need and demand.
2. First appointments		
The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.		As a trust there is a clear ambition to ensure that all patients within the 65 week cohort receive a first outpatient appointment by 31st October. Current modelling suggests we will deliver this with the exception of 4 specialties (Urology, Rheumatology, Paediatric Surgery & Paediatric Trauma & Orthopaedics)

b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net		The Trust has registered to use the DMAS system and a SRO has been identified and accessed the training. The Trust also makes use of available IS capacity and utilises LLPs
3. Outpatient follow-ups		
a. The board has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.		The trust is at 98.3% of the submitted plan for follow ups (year to date) which is an improved position.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.		The trust is consistently delivering the minimum 5% PIFU standard
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust		A plan is in place to reduce DNAs, looking at 2 key areas: - Improved communication with our patients through healthcare communications platform and our digital letters platform. - Working at specialty level to understand specific reasons causing patients to choose to not attend their appointment. This is looking specifically at health inequalities.

access policies to clinically review patients who miss multiple consecutive appointments.		
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking 6 data (via the Model Health System and data packs) to identify further areas for opportunity.		The trust has advice and guidance in place across 10 specialties and has a plan to increase this. The Trust utilises the OPRT and GIRFT checklist, national benchmarking 6 data (via the Model Health System and data packs) to identify further areas for opportunity.
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.		The Trust is actively working on improving pathway design and reducing inefficiency. Current areas of focus are straight to test model implementation across pathways where appropriate and reducing unnecessary follow-ups through a review of the new to follow-up ratios of specialties against the national best practice standards.
4. Support required		
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.		. Continuation of support from NHSE on Theatre and out-patient productivity.

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off	

Appendix 1: Letter from NHSE - Protecting and expanding elective capacity

Classification: Official

NHS England

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	✓
Exec Sponsor	James Mawrey, Director of People/ Deputy Chief Executive		Decision	

Purpose:	To present the Integrated Performance Report detailing high level metrics and performance against the Trust.

Summary:	The Integrated Performance Report provides the Board with an overview of the Trust's performance across a range of Quality, Operational, and Workforce and Finance metrics.

Previously considered by:	The IPR was previously discussed at Divisional IPMs and at all Board Committee meetings.

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

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

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

Bolton NHS Foundation Trust

Integrated Performance Report

August 2023

Guide to Statistical Process Control

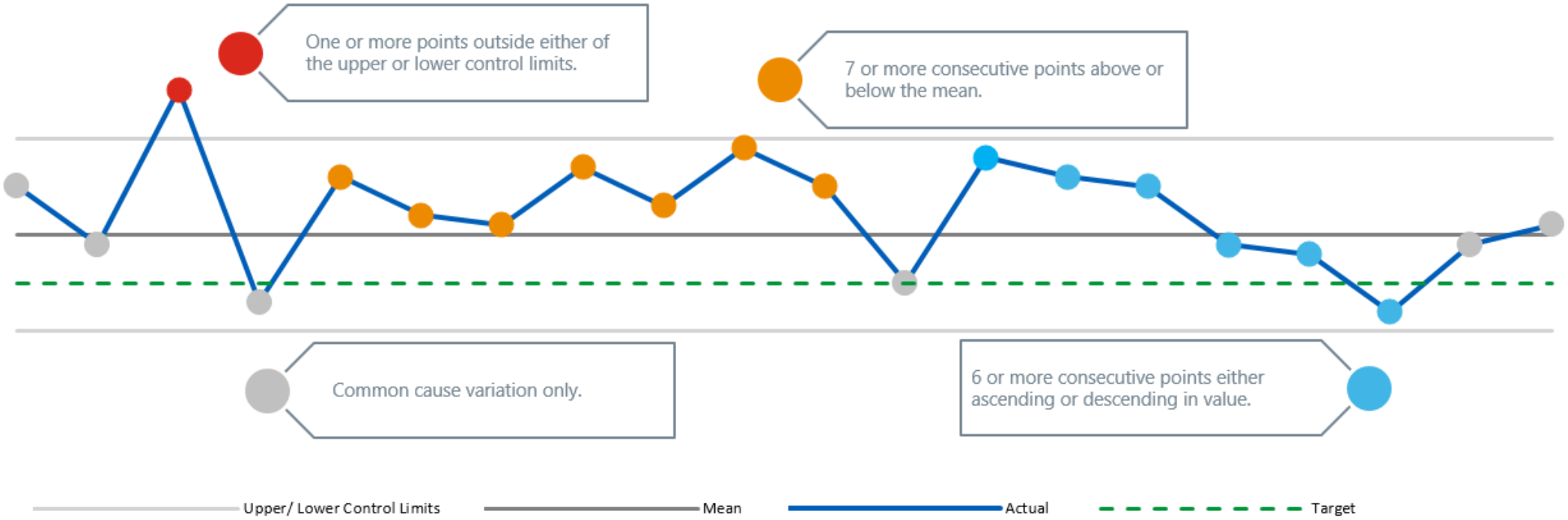
NHS Bolton NHS Foundation Trust

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	13	3	2	2	0	1	3	14
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	4	1	2	0	0	0	0	3
Patient Experience	10	6	0	0	0	2	0	14
Maternity	9	0	0	0	0	1	0	8
Operational Performance								
Urgent Care	4	1	1	2	2	1	3	5
Elective Care	3	1	1	2	1	1	2	4
Cancer	5	0	0	0	2	0	1	6
Community Care	2	0	0	1	1	0	1	3
Workforce								
Sickness, Vacancy and Turnover	2	0	2	0	0	0	1	2
Organisational Development	4	2	0	0	0	1	2	3
Agency	0	0	1	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.

Quality and Safety

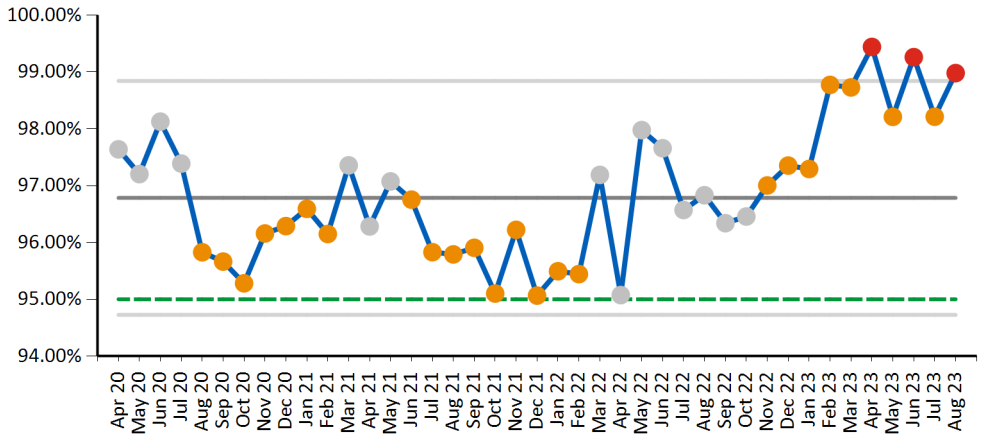
Harm Free Care

Pressure ulcers
In month reports special cause improvement (likely to have occurred due to an intervention as opposed to 'chance') in category 3 pressure ulcers in the hospital and community. Zero category 4 reported maintaining pressure ulcer collaborative aim of zero category 3 and 4 acquired in care from July 23. Category 2 hospital report astronomical (outside of control limit) reduction. PU collaborative and sustained leadership focus continues with learning session 3 due end Sep 23. Review of compliance with leading indicators for PU prevention completed and will report to Quality assurance committee October 23.

	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%	99.0%	Aug-23	H	>= 95%	98.2%	Jul-23	>= 95%	98.1%	?
9 - Never Events	= 0	1	Aug-23	H	= 0	0	Jul-23	= 0	1	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.94	Aug-23		<= 5.30	3.56	Jul-23	<= 5.30	4.06	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	Aug-23		<= 1.6	1	Jul-23	<= 8.0	6	?
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	6.0	Aug-23		<= 6.0	21.0	Jul-23	<= 30.0	72.0	?
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Aug-23	L	<= 0.5	0.0	Jul-23	<= 2.5	0.0	?
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Aug-23		= 0.0	0.0	Jul-23	= 0.0	2.0	?
515 - Acute Inpatients acquiring pressure damage (unstagable)		4	Aug-23			4	Jul-23		26	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	14.0	Aug-23		<= 7.0	10.0	Jul-23	<= 35.0	52.0	?

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	1.0	Aug-23		<= 4.0	0.0	Jul-23	<= 20.0	2.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Aug-23		<= 1.0	0.0	Jul-23	<= 5.0	2.0	
516 - Community patients acquiring pressure damage (unstagable)		5	Aug-23			7	Jul-23		27	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Aug-23			0	Jul-23		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Aug-23			0	Jul-23		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Aug-23			0	Jul-23		0	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	92.3%	Q1 2023/24		>= 90%	93.4%	Q4 2022/23	>= 90%	92.3%	
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q1 2023/24		>= 90%	100.0%	Q4 2022/23	>= 90%	100.0%	
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	4.0%	Q1 2023/24		>= 90%	32.0%	Q4 2022/23	>= 90%	4.0%	
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	0.0%	Q1 2023/24		>= 90%	100.0%	Q4 2022/23	>= 90%	0.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	67.1%	Aug-23		>= 95%	69.1%	Jul-23	>= 95%	71.9%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	85.6%	Aug-23		>= 95.0%	88.3%	Jul-23	>= 95.0%	82.3%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Aug-23		= 100%	100.0%	Jul-23	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	93.7%	Aug-23		>= 85%	94.6%	Jul-23	>= 85%	94.5%	
91 - SI Reports Signed off within 60 days	= 100%	100.0%	Aug-23		= 100%	66.7%	Jul-23	= 100%	75.0%	
8 - Same sex accommodation breaches	= 0	13	Aug-23		= 0	15	Jul-23	= 0	90	

6 - Compliance with preventative measure for VTE

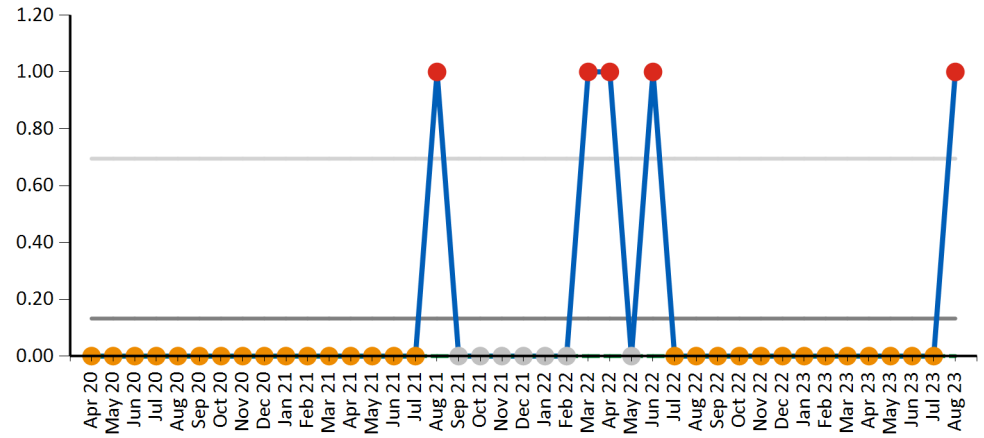


Abnormal variation. Target achieved.

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

6/6

9 - Never Events

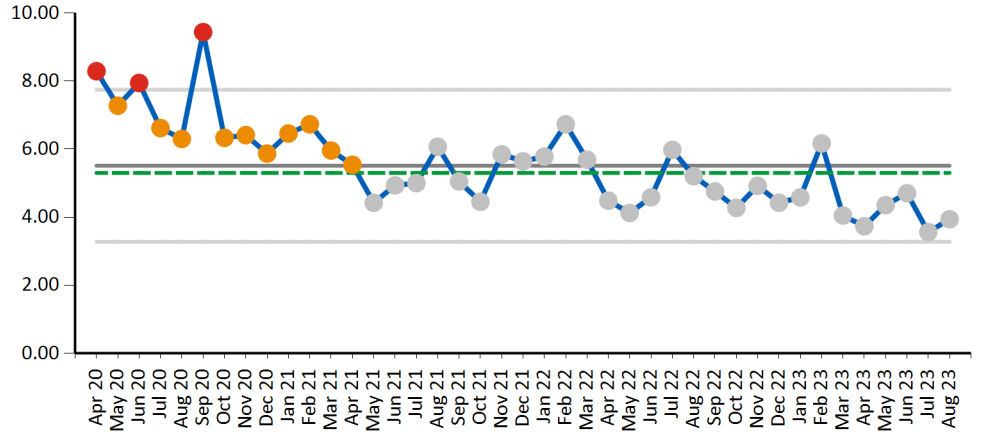


Abnormal variation. Target not achieved.

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

5/6

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

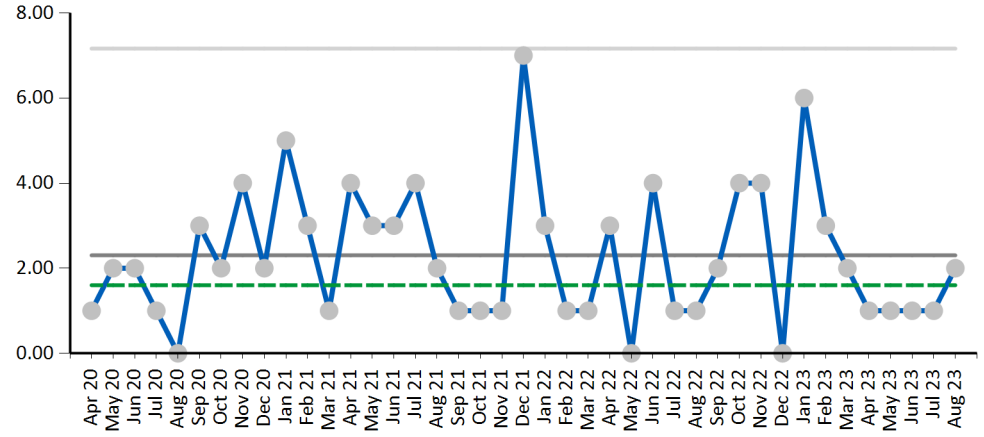


Normal Variation

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

6/6

14 - Inpatient falls resulting in Harm (Moderate +)

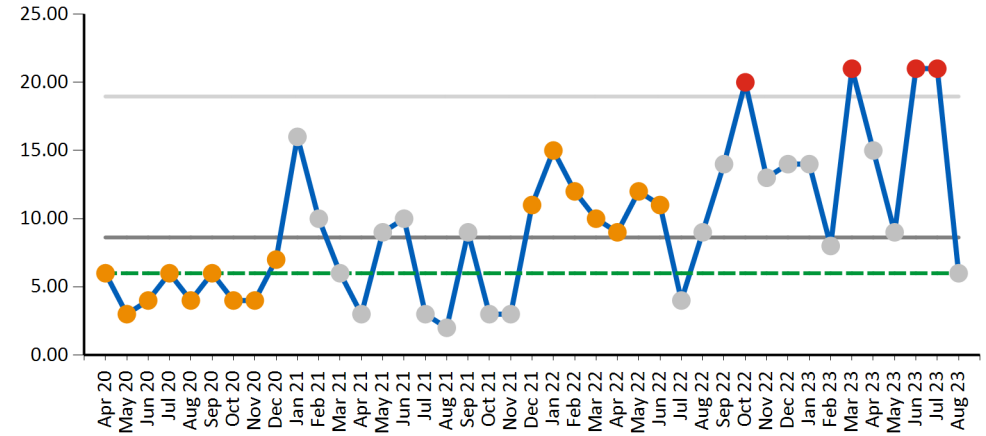


Normal Variation

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

4/6

15 - Acute Inpatients acquiring pressure damage (category 2)

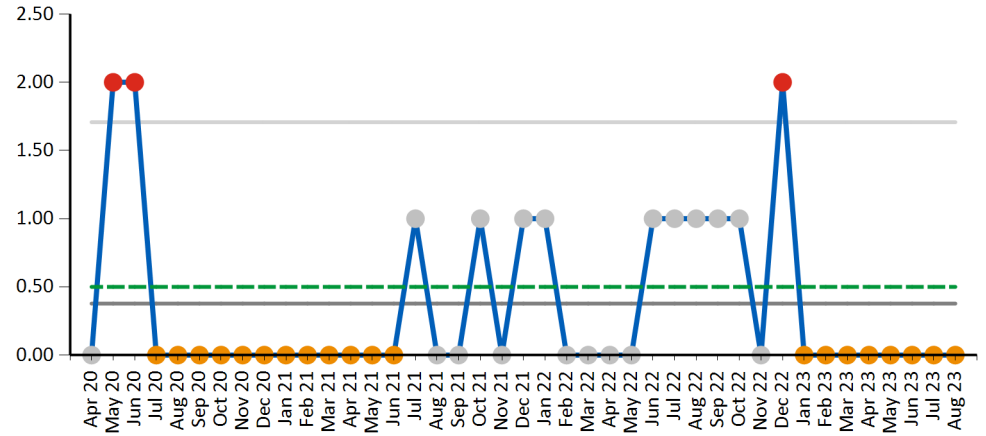


Normal Variation

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

1/6

16 - Acute Inpatients acquiring pressure damage (category 3)

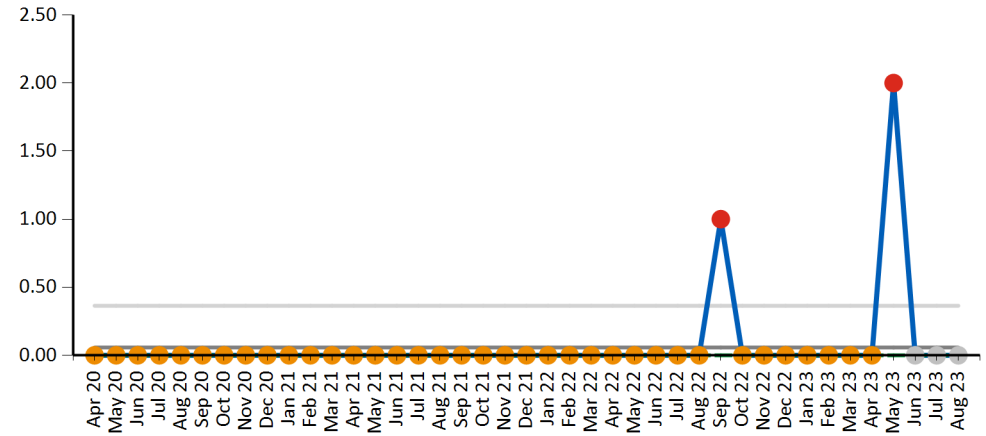


Abnormal variation. Target achieved.

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

6/6

17 - Acute Inpatients acquiring pressure damage (category 4)

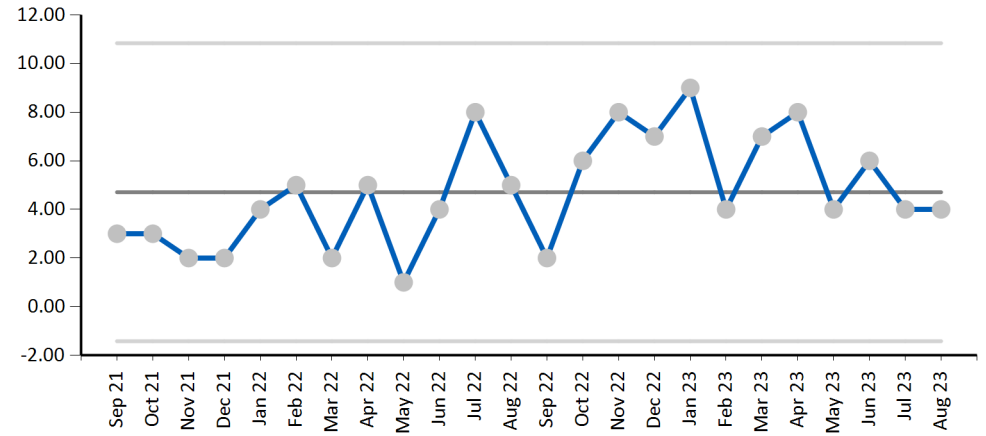


Normal Variation

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

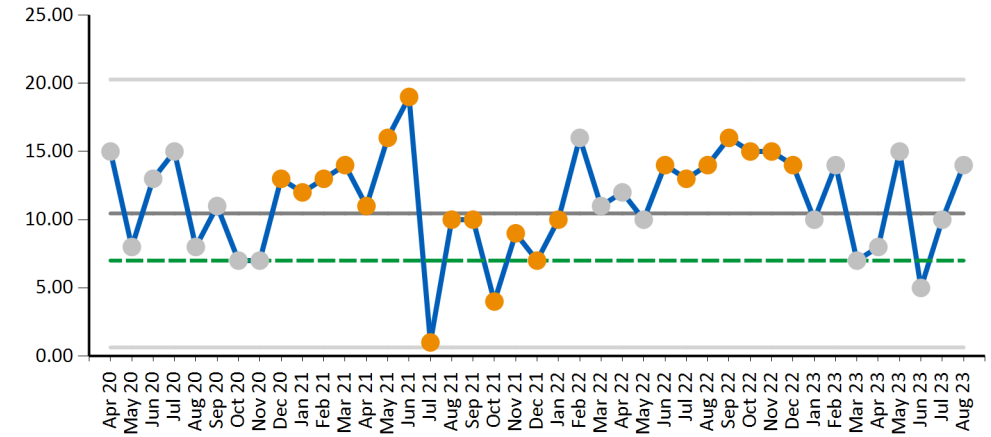
5/6

515 - Acute Inpatients acquiring pressure damage (unstagable)



Normal Variation

18 - Community patients acquiring pressure damage (category 2)

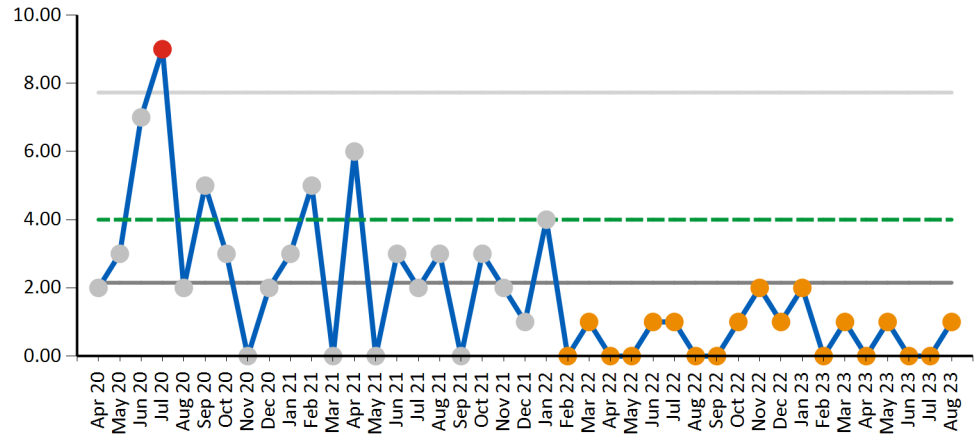


Normal Variation

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

2/6

19 - Community patients acquiring pressure damage (category 3)

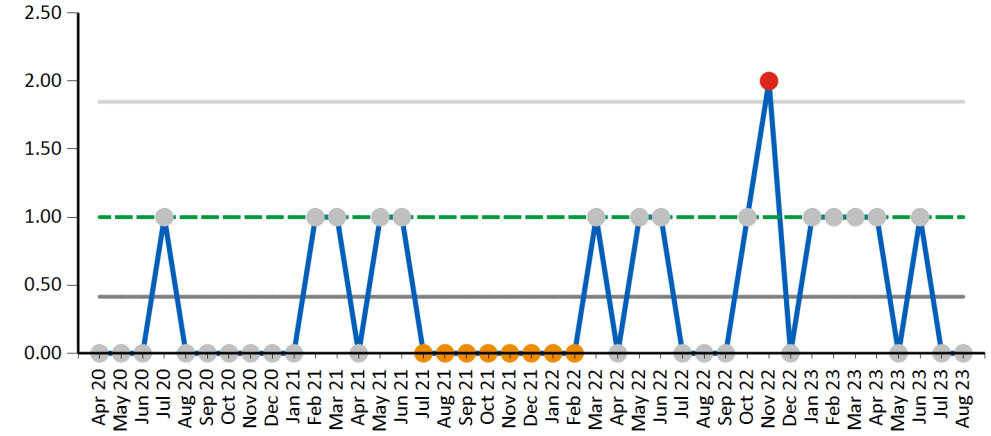


Abnormal variation. Target achieved.

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

6/6

20 - Community patients acquiring pressure damage (category 4)

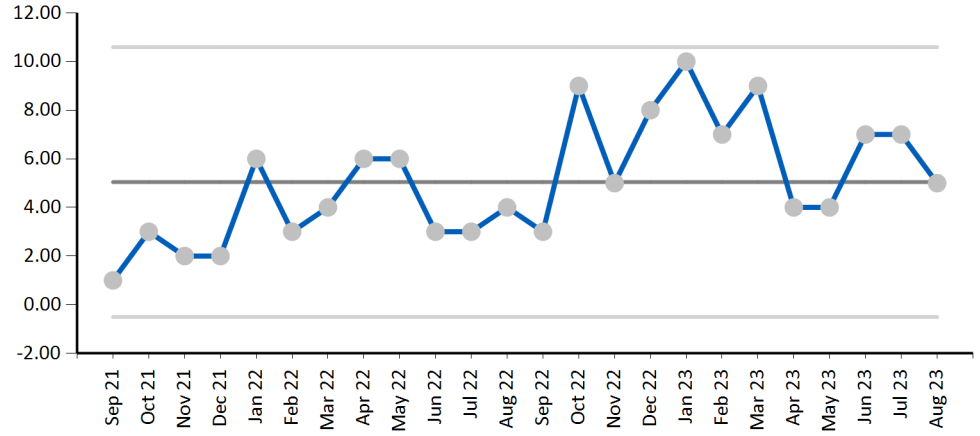


Normal Variation

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

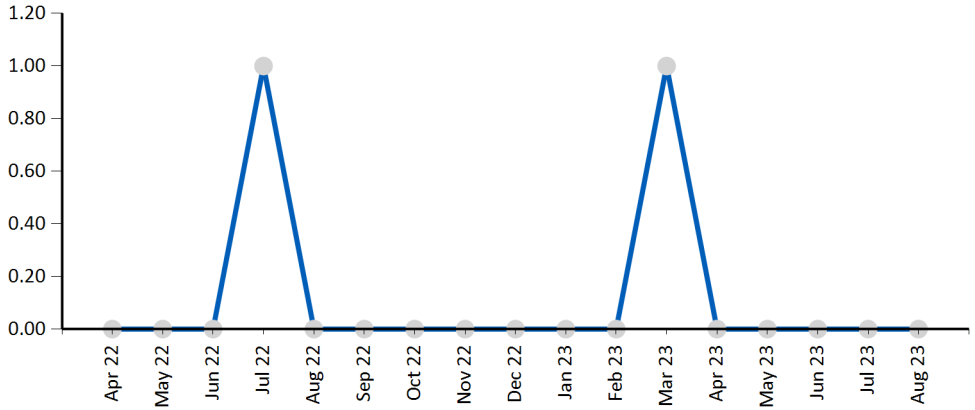
6/6

516 - Community patients acquiring pressure damage (unstagable)

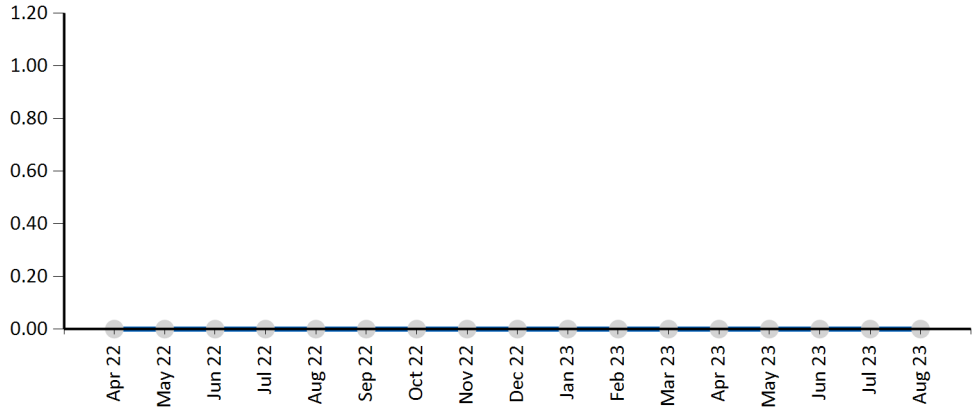


Normal Variation

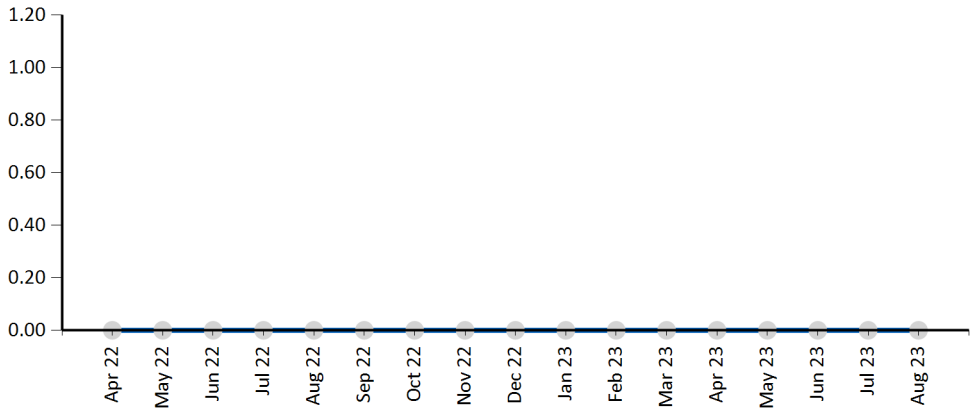
535 - Community patients acquiring pressure damage - significant learning category 2 - SPC data available after 20 data points



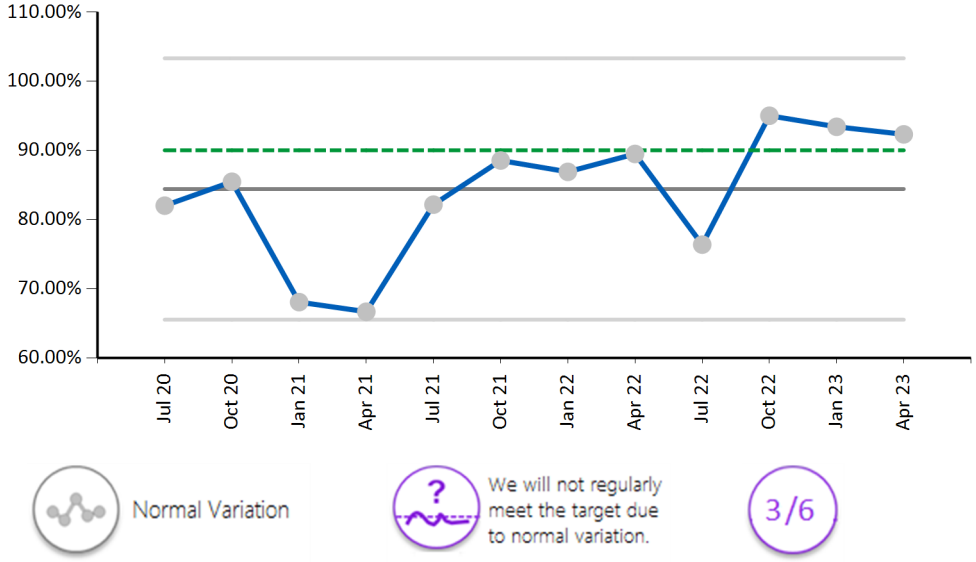
536 - Community patients acquiring pressure damage - significant learning category 3 - SPC data available after 20 data points



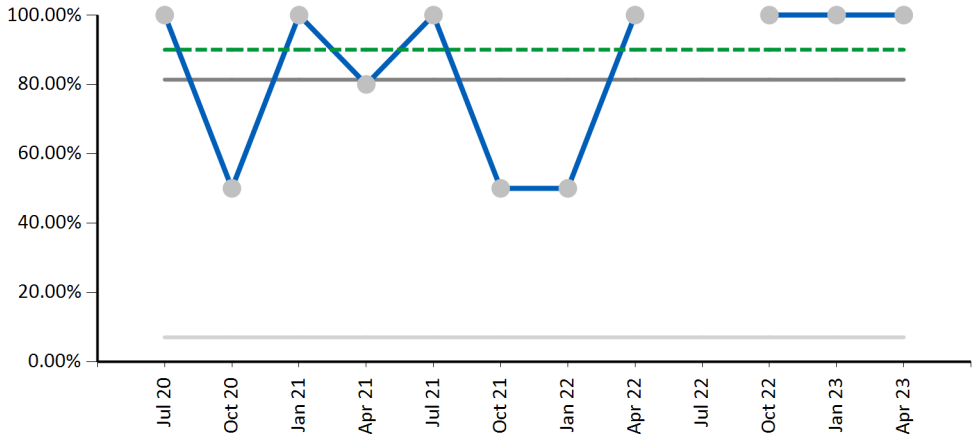
537 - Community patients acquiring pressure damage - significant learning category 4 - SPC data available after 20 data points



28 - Emergency patients - screened for Sepsis (quarterly)



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

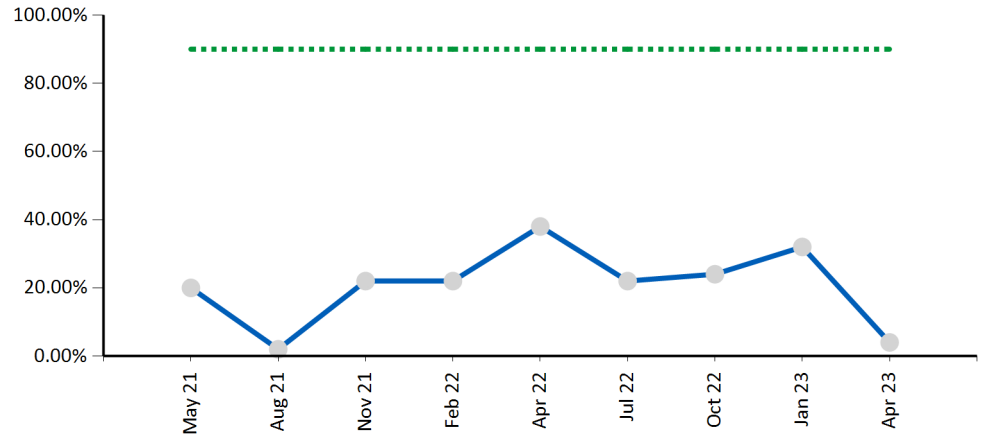


Normal Variation

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

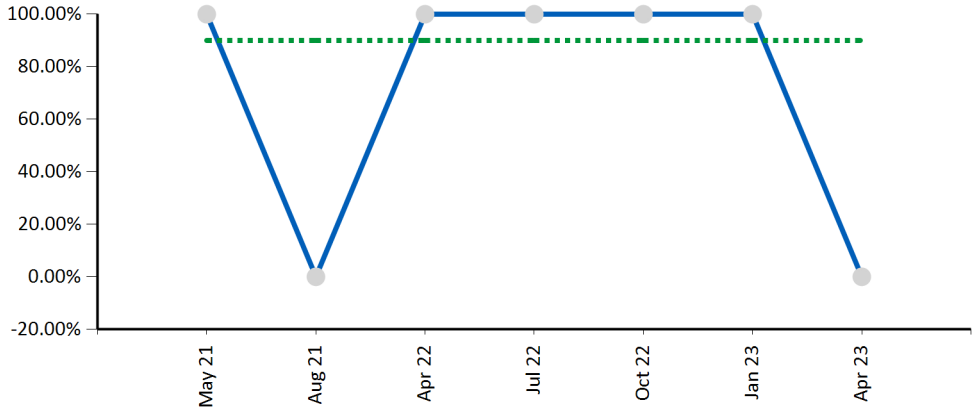
4/6

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



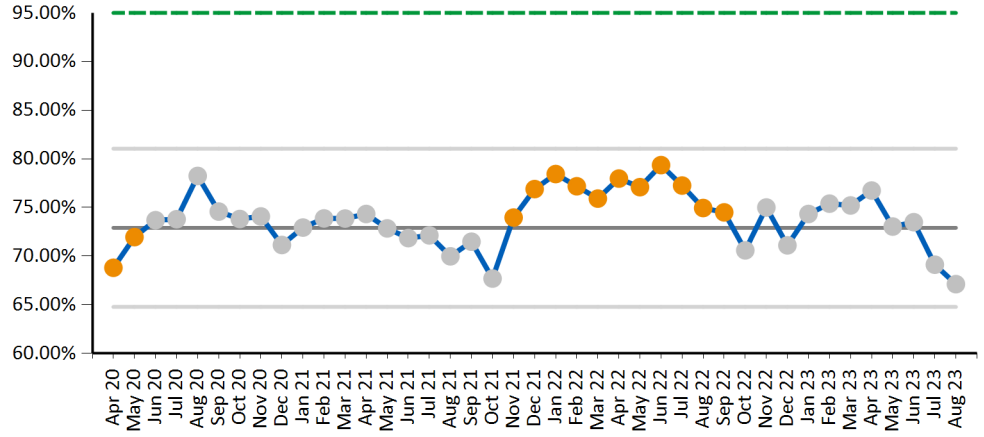
0/6

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



4/6

30 - Clinical Correspondence - Inpatients %<1 working day

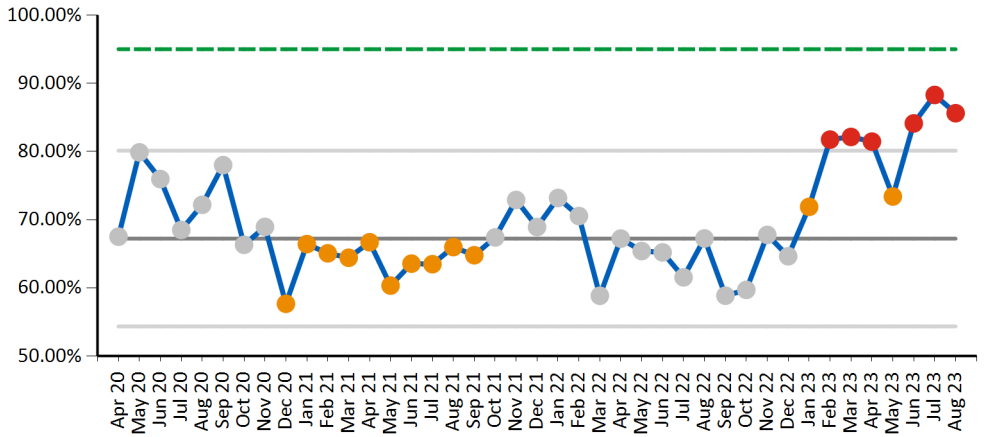


Normal Variation

We will regularly fail to meet the target.

0/6

31 - Clinical Correspondence - Outpatients %<5 working days

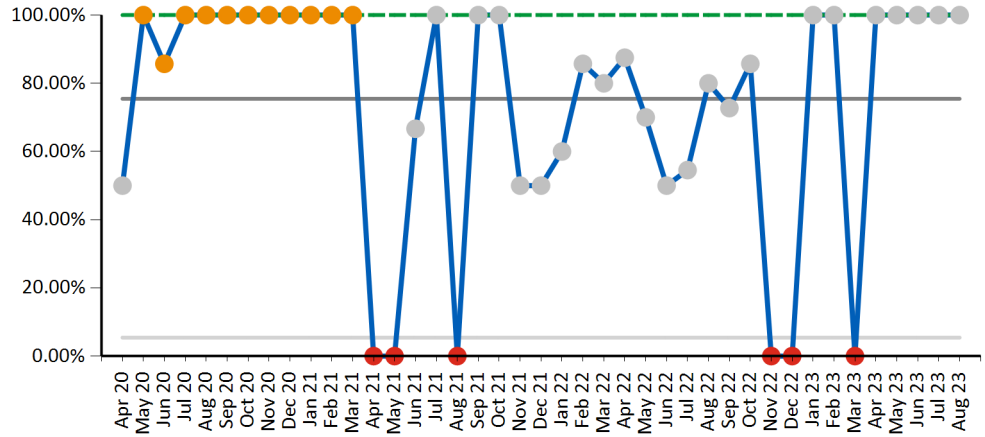


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

86 - Patient Safety Alerts - Trust position

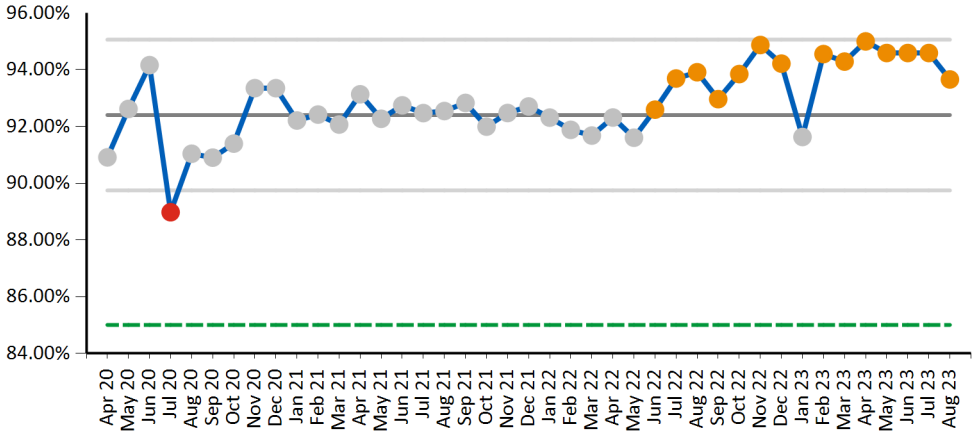


Normal Variation

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

5/6

88 - Nursing KPI Audits

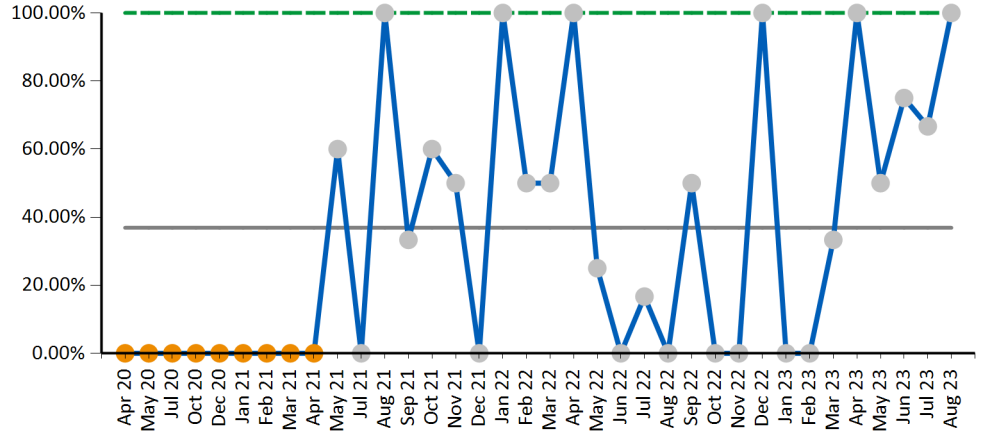


H Abnormal variation. Target achieved.

P Target will be regularly met.

6/6

91 - SI Reports Signed off within 60 days

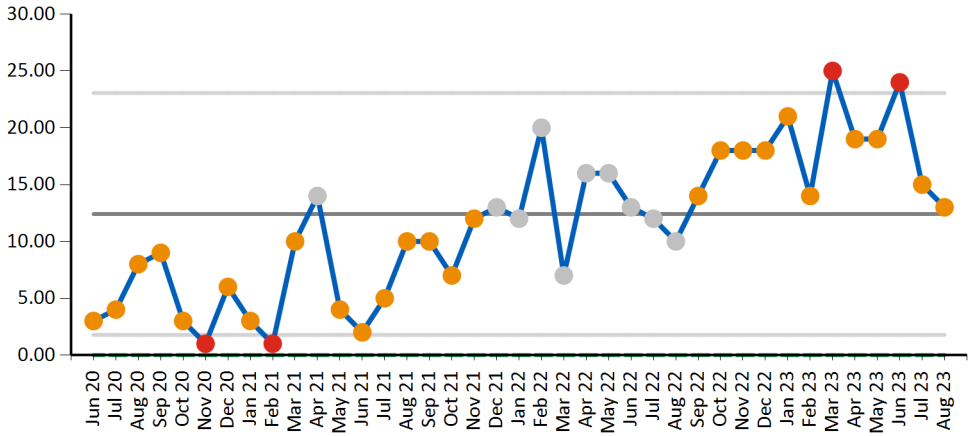


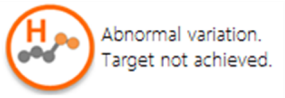
Normal Variation

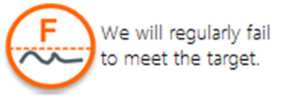
? We will not regularly meet the target due to normal variation.

2/6

8 - Same sex accommodation breaches







Infection Prevention and Control

There has been no statistically significant change in the number of Clostridium difficile cases but compared with 2022/23 there have been 10 fewer cases in 2023/24 at the same point. There has been a statistically relevant reduction in the number of patients who have tested positive for the Clostridium difficile toxin gene but who have tested negative for the toxin itself. This is suggestive of a reduction in the number of patients colonised rather than infected with Clostridium difficile which in turn reduces the likelihood of cross-transmission. The numbers who are gene positive only are not routinely reported to Board or externally as only the toxin positive cases – therefore with an active infection – are reportable externally.

This reduction will be in response to the improvements in timely isolation which has a special cause improvement as it reduces all spread of Clostridium difficile and reduces the number of patients who develop infections and the number of patients who become colonised due to exposure to a patient with symptoms. This becomes a virtuous cycle as there are then fewer patients with infection or colonised reducing exposure to other patients.

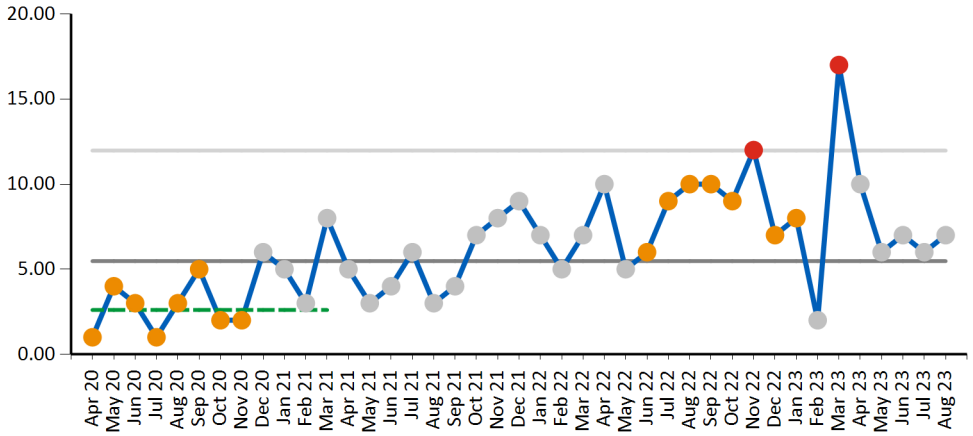
In 2023/24, by rate Bolton FT is the best performing provider for:
- Healthcare associated E. coli bacteraemia
- Healthcare associated Klebsiella spp. bacteraemia
- Healthcare associated Pseudomonas aeruginosa bacteraemia (albeit there are low numbers of these infections)

Bolton is the second best GM provider for hospital onset MSSA bacteraemia.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		7	Aug-23			6	Jul-23		36	
346 - Total Community Onset Hospital Associated C.diff infections		3	Aug-23			5	Jul-23		13	
347 - Total C.diff infections contributing to objective	<= 7	10	Aug-23		<= 7	11	Jul-23	<= 33	49	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Aug-23		= 0	0	Jul-23	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	5	Aug-23		<= 4	8	Jul-23	<= 21	26	
219 - Blood Culture Contaminants (rate)	<= 3%	2.3%	Aug-23		<= 3%	3.3%	Jul-23	<= 3%	2.9%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Aug-23		<= 1.0	1.0	Jul-23	<= 5.0	5.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	1	Aug-23		<= 1	0	Jul-23	<= 3	5	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Aug-23		= 0	1	Jul-23	= 0	1	

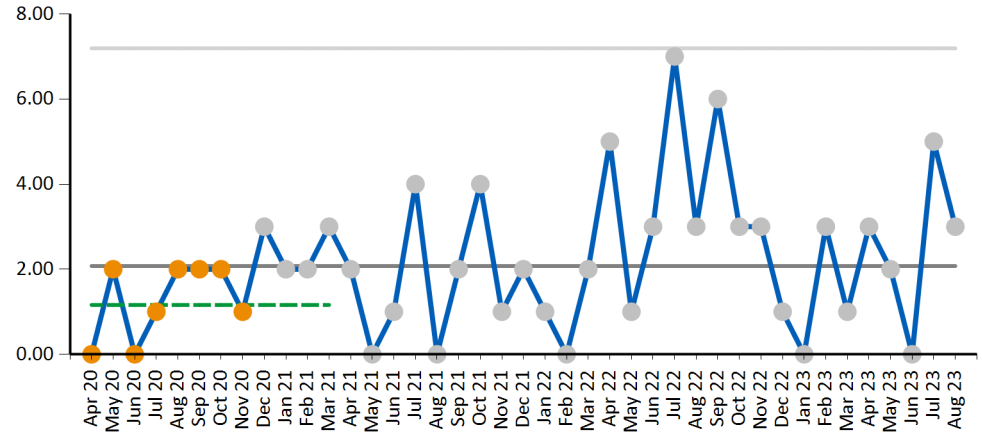
Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
491 - Nosocomial COVID-19 cases		15	Aug-23			9	Jul-23		93	

215 - Total Hospital Onset C.diff infections



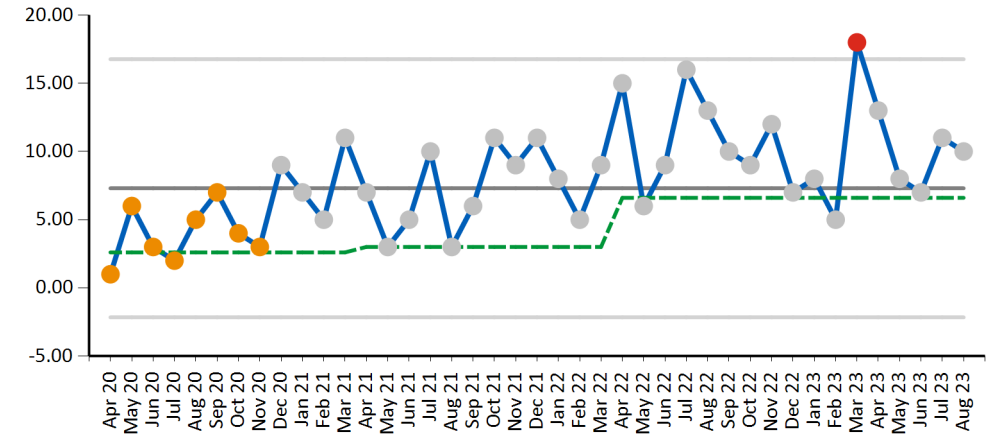
Normal Variation

346 - Total Community Onset Hospital Associated C.diff infections



Normal Variation

347 - Total C.diff infections contributing to objective

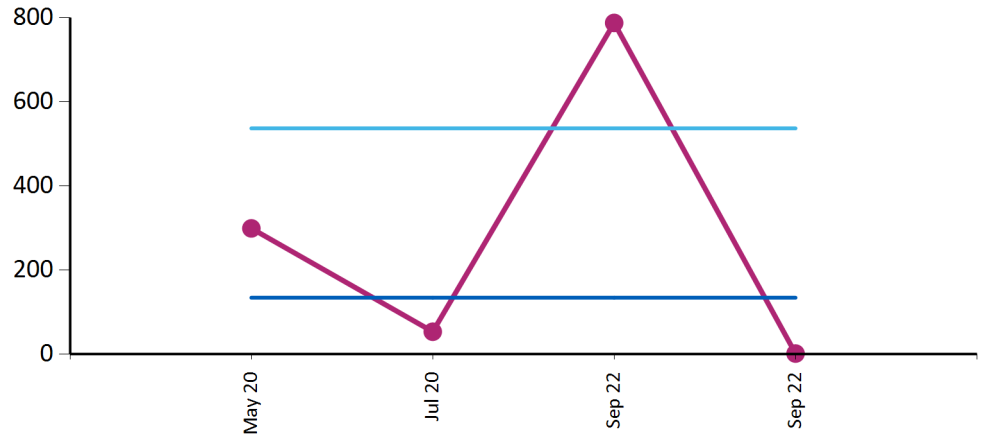


Normal Variation

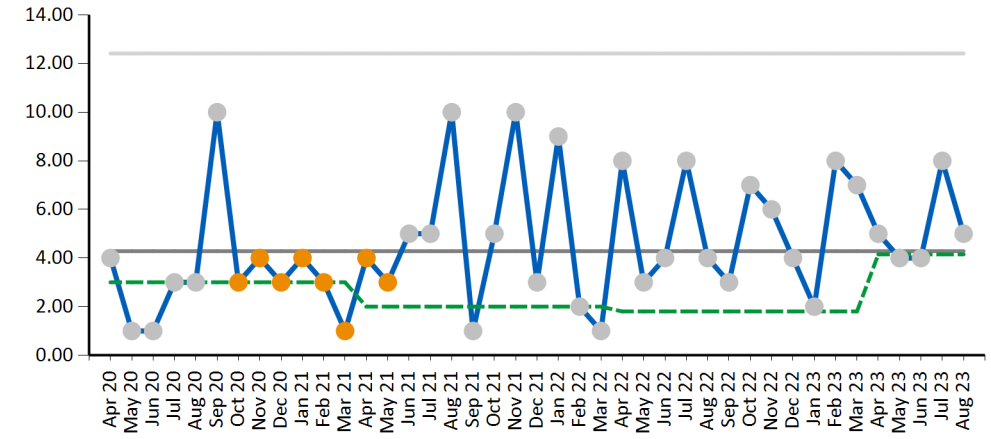
We will not regularly meet the target due to normal variation.

0/6

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



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

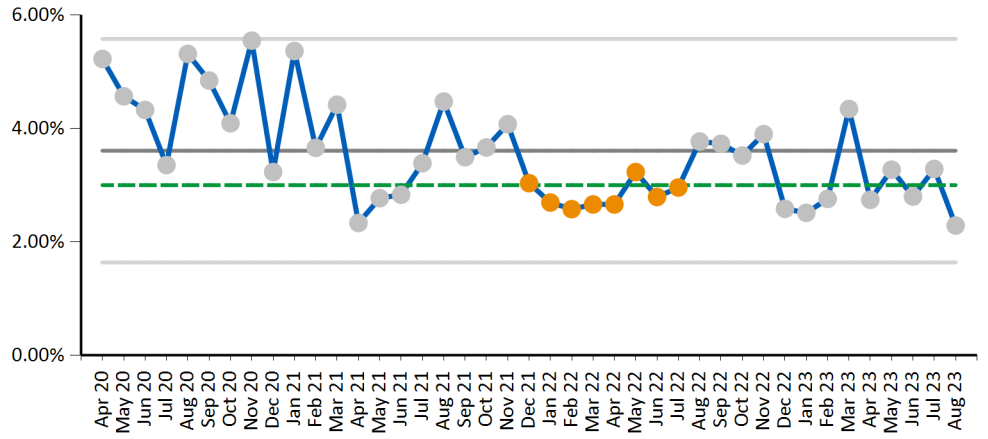


Normal Variation

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

2/6

219 - Blood Culture Contaminants (rate)

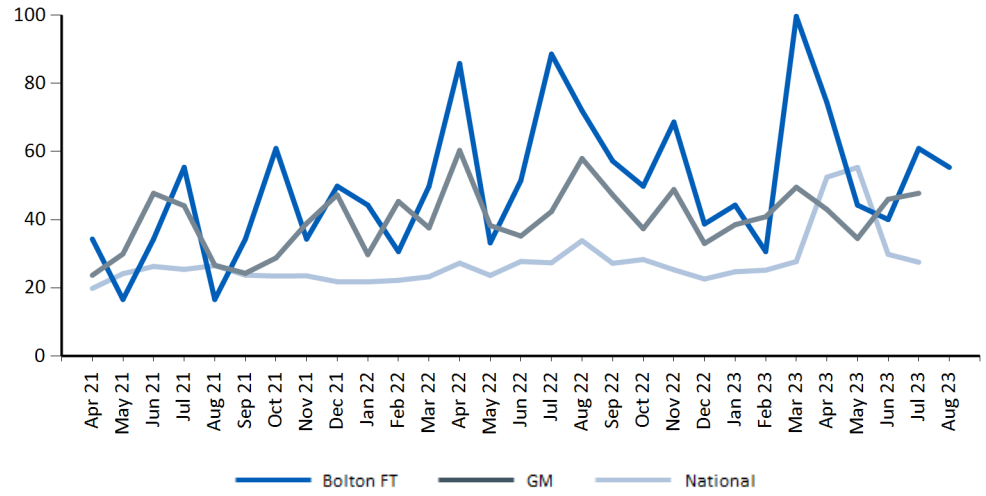


Normal Variation

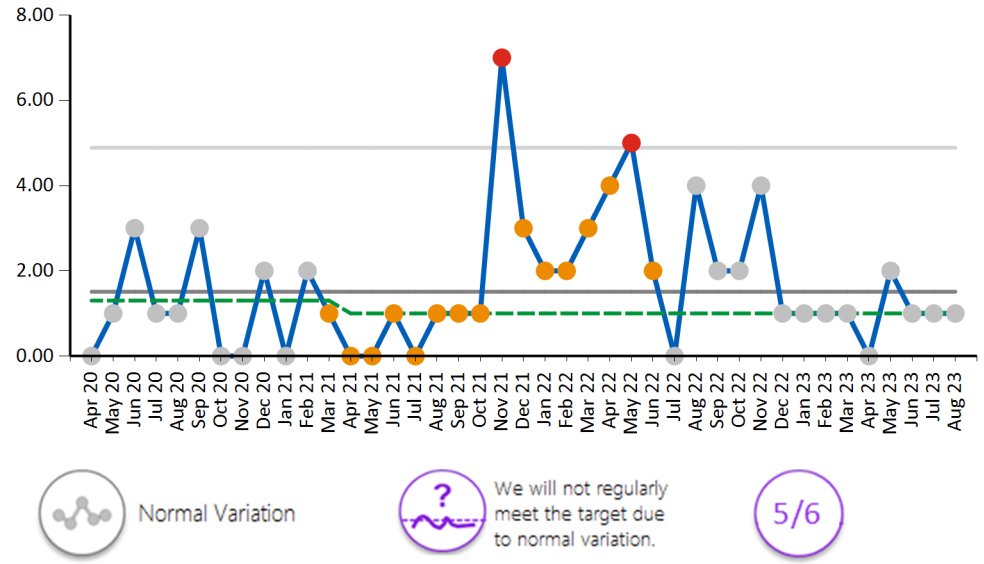
We will not regularly meet the target due to normal variation.

3/6

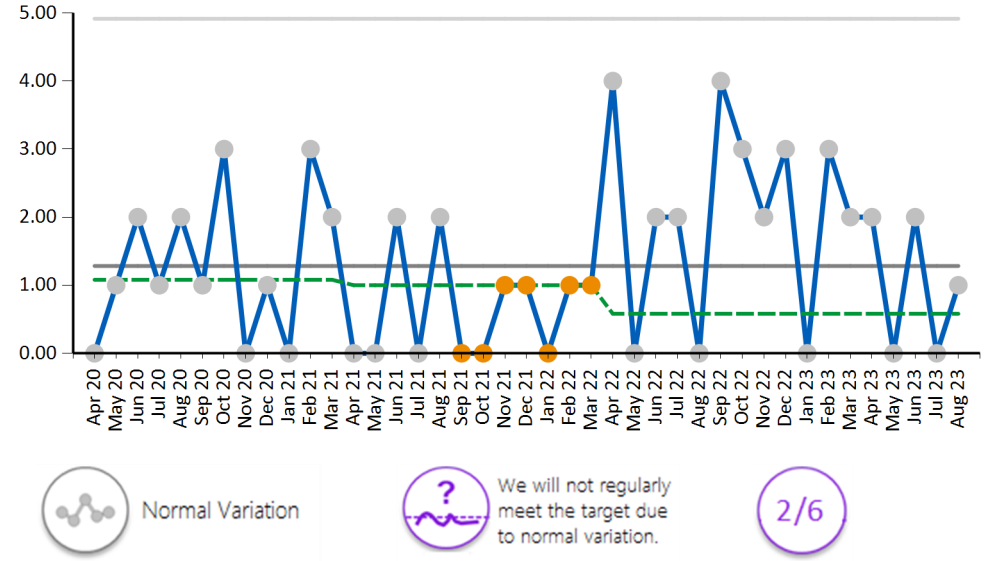
549 - C Diff Rate Comparison



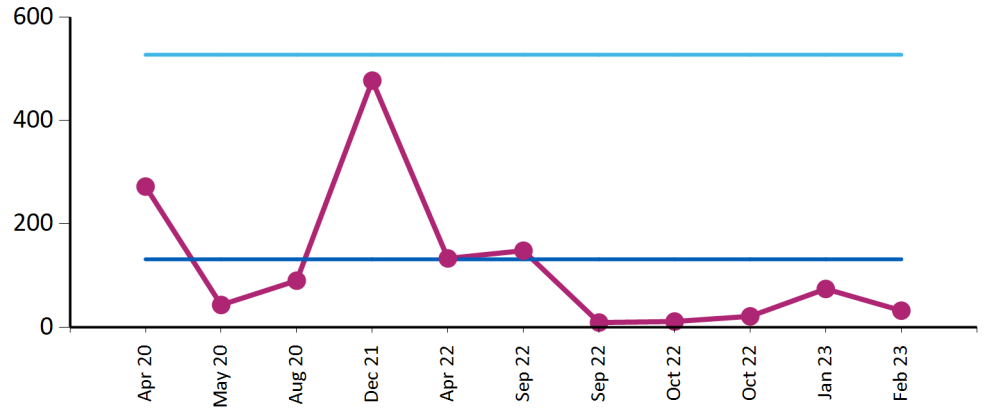
304 - Total Trust apportioned MSSA BSIs



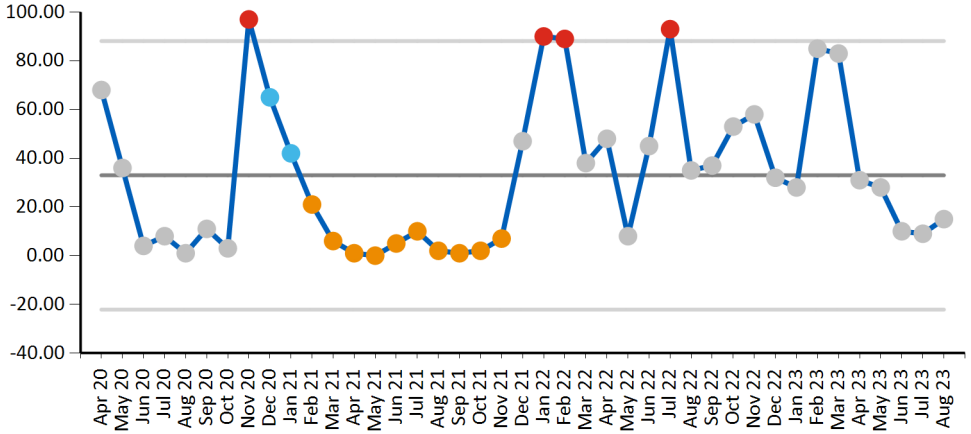
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

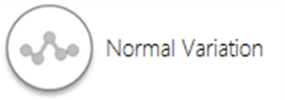


306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA) - G Chart (Days Between Cases)



491 - Nosocomial COVID-19 cases





Mortality

Crude – there has been a sustained period of the in-month figure continuing to be lower than the mean which is reflective of the seasonal period it covers. The crude rate has remained in control and has been for more than two years.

HSMR – in month figure is showing a sustained period of improvement with 8 consecutive points below the mean. This has helped keep HSMR down and the 12 month average to May 2023 is 106.22, this has remained as 'Green' (in the "as expected" range) when compared against other Trusts in England.

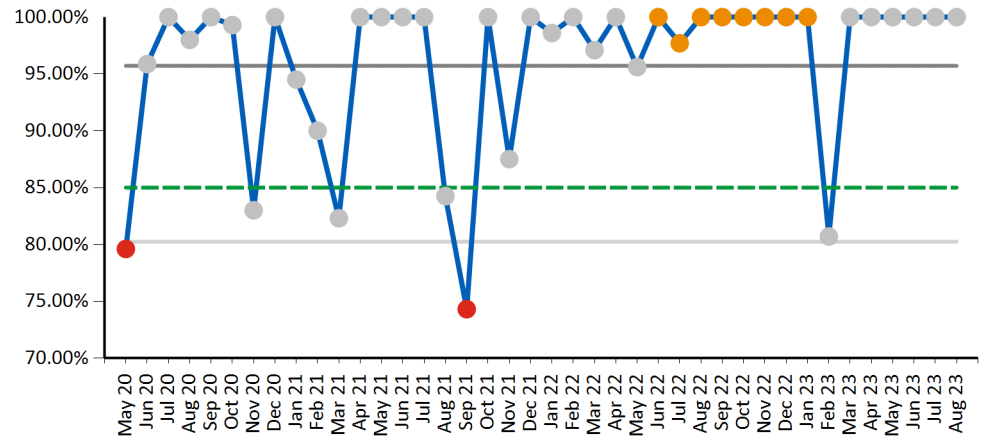
SHMI – In month figure is below the average and target for the time period and has remained 'in control' for more than two years. The published rolling average for the period May 2022 to April 2023 is 109.95, in the 'as expected' range.

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 period of 17 points above the mean since February 2022 indicating sustained improvement.

Analysis completed by BI around the recording of Charlson comorbidities has shown improved activity across the Trust over the period of May 2020 to May 2023, which has shifted the 12 month average of SHMI and HSMR to be back within range. Both the proportions of discharges without any comorbidities and the average Charlson score have improved. Education will continue via initiatives such as 'Know your Patient Week' and collaboration between BI and Divisional Medical Directors/Clinical leads is ongoing. Work is still required as these scores are still lower than national average, so there is scope for further 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%	Aug-23		>= 85%	100.0%	Jul-23	>= 85%	100.0%	
495 - HSMR		97.37	May-23	L		101.35	Apr-23		97.37	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	92.06	Mar-23		<= 100.00	95.40	Feb-23	<= 100.00		
12 - Crude Mortality %	<= 2.9%	2.3%	Aug-23	L	<= 2.9%	1.8%	Jul-23	<= 2.9%	2.2%	
519 - Average Charlson comorbidity Score (First episode of care)		4	May-23			3	Apr-23		7	
520 - Depth of recording (First episode of care)		6	May-23			6	Apr-23		12	
521 - Proportion of fully coded records (Inpatients)		98.7%	Jun-23	H		98.6%	May-23		98.6%	

3 - National Early Warning Scores to Gold standard

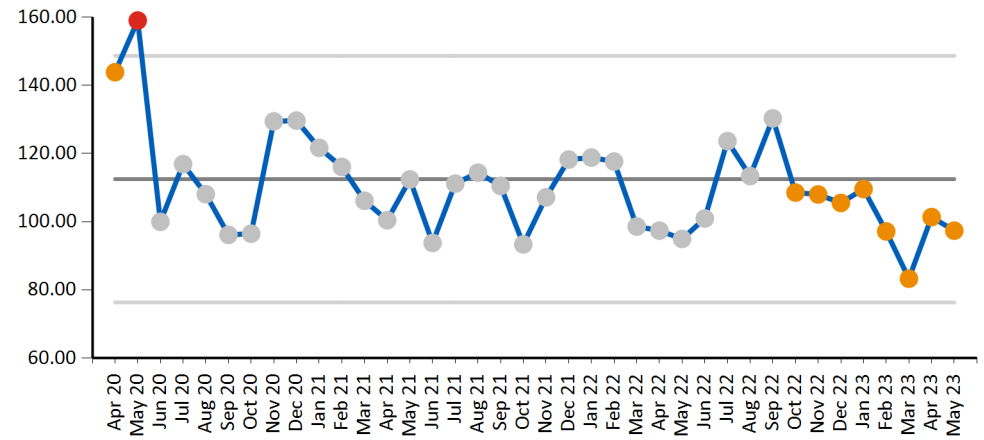


Normal Variation

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

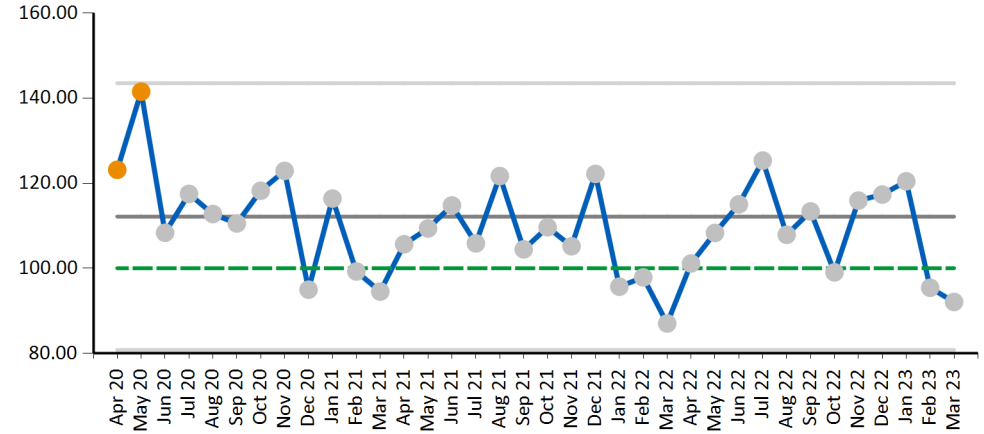
6/6

495 - HSMR



Abnormal variation. Target achieved.

11 - Summary Hospital-level Mortality Indicator (SHMI)

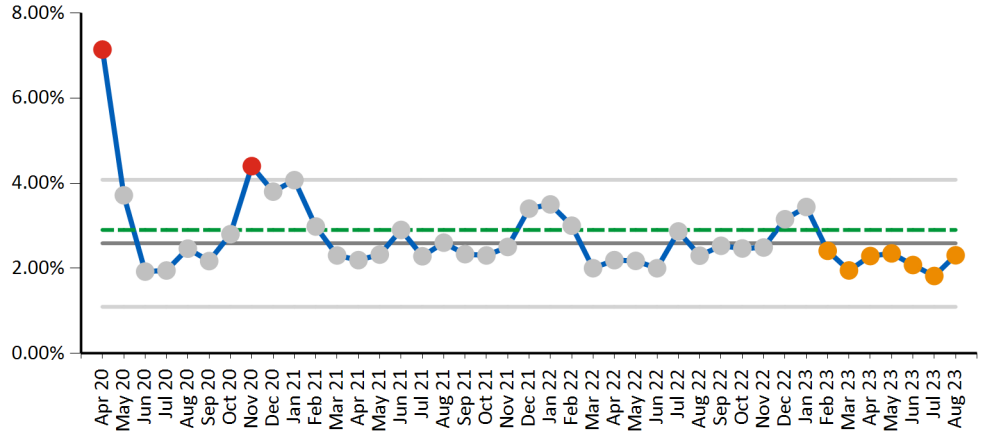


Normal Variation

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

3/6

12 - Crude Mortality %

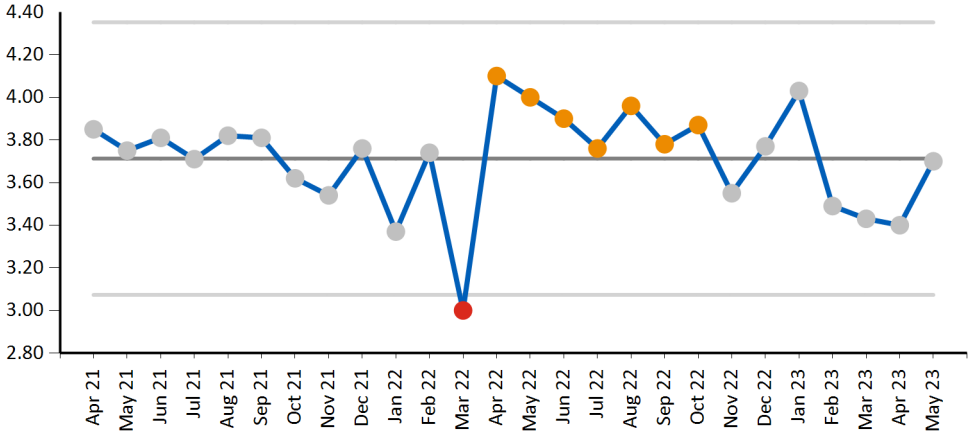


Abnormal variation. Target achieved.

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

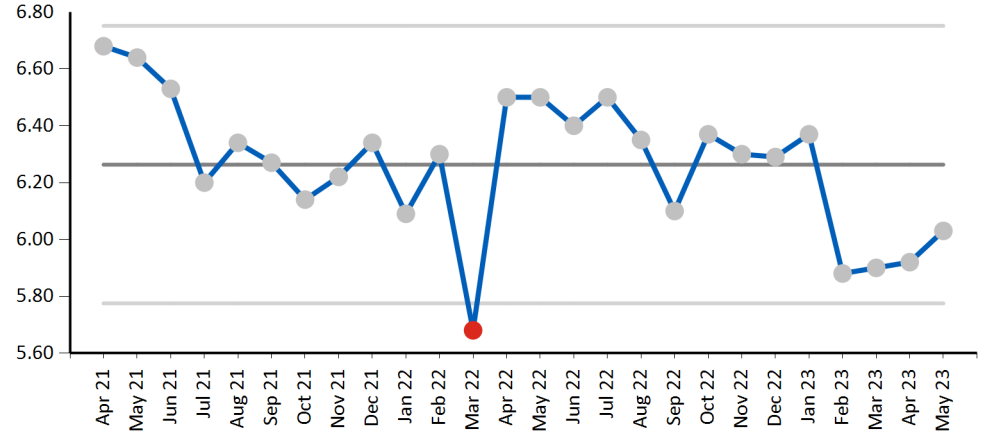
6/6

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



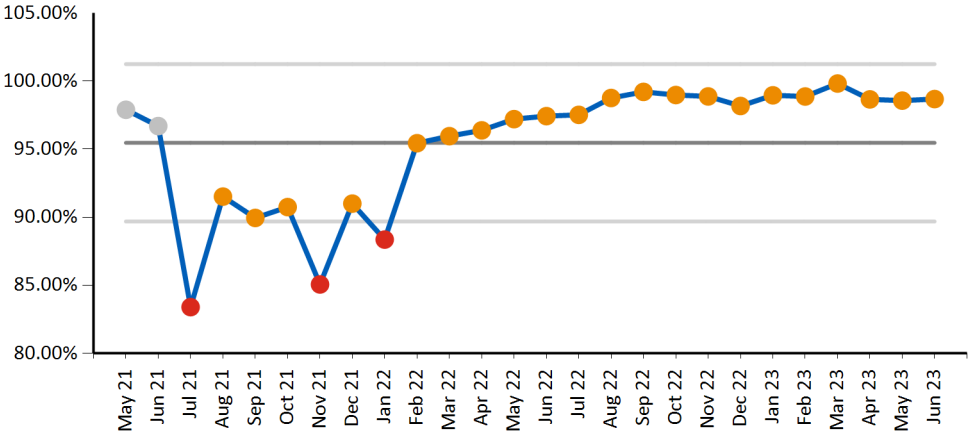
Normal Variation

520 - Depth of recording (First episode of care)



Normal Variation

521 - Proportion of fully coded records (Inpatients)



Abnormal variation.
Target achieved.

Patient Experience

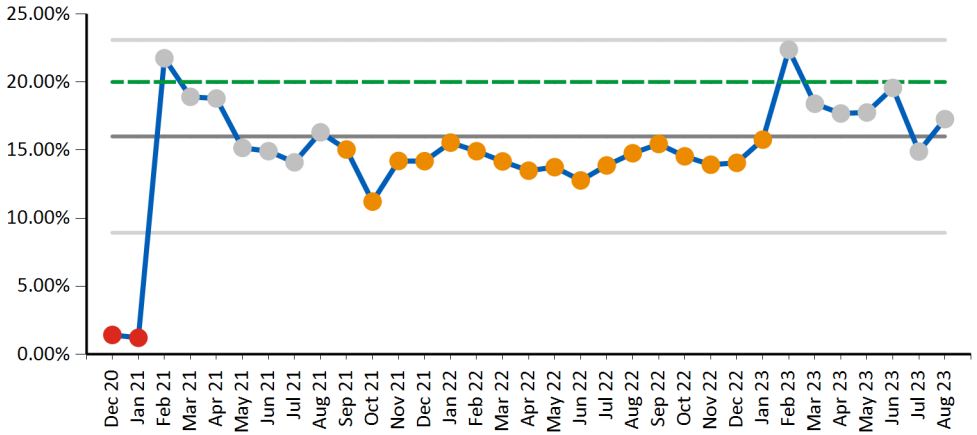
Complaint Response Rates
The trust target of 95% compliance was not achieved in August this is noted to be common cause variation. Compliance was within control limits, above the mean, and close to the upper control limit. The Trust had 16 responses due in August and 14 were provided within the set timeframe. Increased patient/complainant engagement at the start of the complaint process continues allowing more focus for complaints. There is now a fully embedded process of digital recording of complaint meetings with prompt collation of cover letters to ensure best practice and timely provision of response package to complainants. Complaint meetings are promoted, and Divisional team have embraced this approach. This has reduced the impact on divisional colleagues and has resulted in positive feedback on the outcome resolution meeting process as a whole.
Complaint training sessions continue to be offered to staff.

FFT Response and Satisfaction Rates
FFT response rates are within control limits with some positive special cause variation noted specifically across maternity. Hospital Postnatal satisfaction rates saw a slight reduction below the target of 90%. This remains within common cause variation and above the mean. A&E response and satisfaction rates were below the target but within control limits and above the mean. Continued work on sharing alternative methods to capture increased rates of information remains an ongoing piece of work with the sharing of QR codes and URLs.

	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%	17.3%	Aug-23		>= 20%	14.9%	Jul-23	>= 20%	17.5%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	85.9%	Aug-23		>= 90%	84.0%	Jul-23	>= 90%	86.1%	
80 - Inpatient Friends and Family Response Rate	>= 30%	30.9%	Aug-23		>= 30%	21.9%	Jul-23	>= 30%	27.5%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.1%	Aug-23		>= 90%	94.1%	Jul-23	>= 90%	95.9%	
81 - Maternity Friends and Family Response Rate	>= 15%	32.1%	Aug-23		>= 15%	38.8%	Jul-23	>= 15%	38.9%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	93.0%	Aug-23		>= 90%	94.2%	Jul-23	>= 90%	91.5%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	25.1%	Aug-23		>= 15%	21.8%	Jul-23	>= 15%	28.8%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	91.5%	Aug-23		>= 90%	97.1%	Jul-23	>= 90%	96.5%	
83 - Birth - Friends and Family Response Rate	>= 15%	44.8%	Aug-23		>= 15%	57.8%	Jul-23	>= 15%	46.3%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	94.4%	Aug-23		>= 90%	93.0%	Jul-23	>= 90%	91.9%	

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	36.9%	Aug-23	H	>= 15%	43.6%	Jul-23	>= 15%	54.7%	?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.4%	Aug-23		>= 90%	91.7%	Jul-23	>= 90%	84.1%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	24.1%	Aug-23		>= 15%	31.3%	Jul-23	>= 15%	28.5%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.7%	Aug-23	H	>= 90%	97.6%	Jul-23	>= 90%	97.0%	?
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Aug-23	H	= 100%	100.0%	Jul-23	= 100%	100.0%	?
90 - Complaints responded to within the period	>= 95%	87.5%	Aug-23		>= 95%	100.0%	Jul-23	>= 95%	80.0%	?

200 - A&E Friends and Family Response Rate

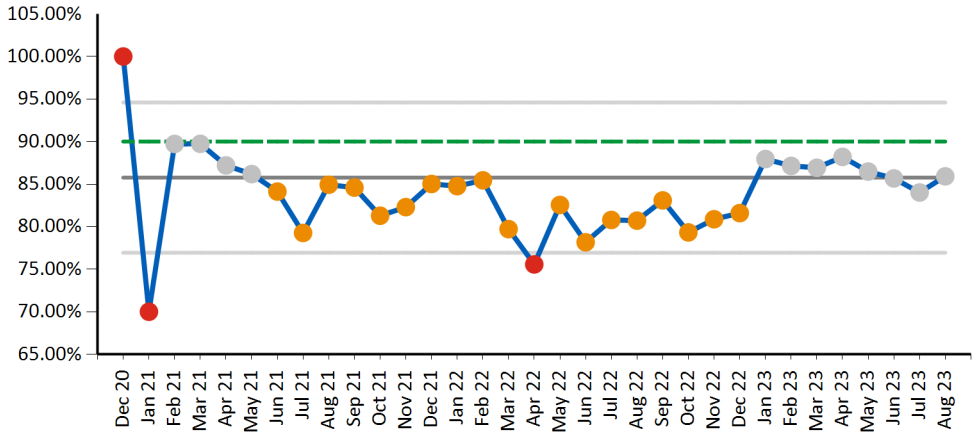


Normal Variation

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

0/6

294 - A&E Friends and Family Satisfaction Rates %

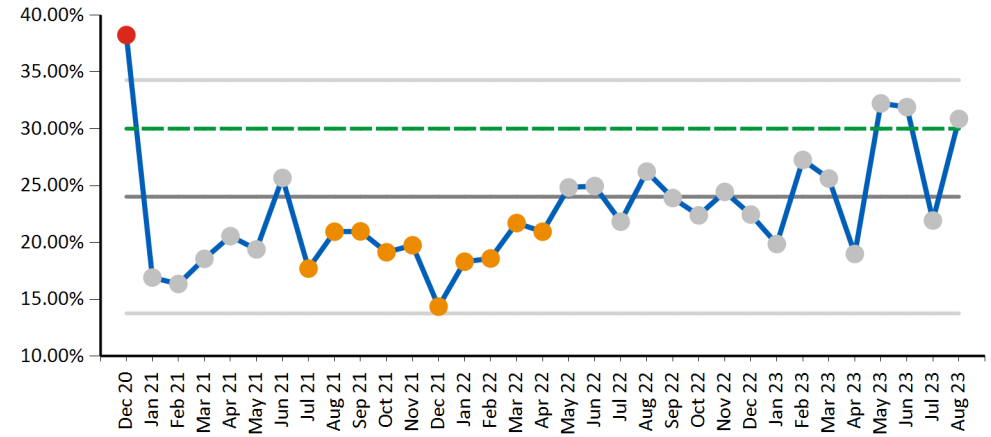


Normal Variation

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

0/6

80 - Inpatient Friends and Family Response Rate

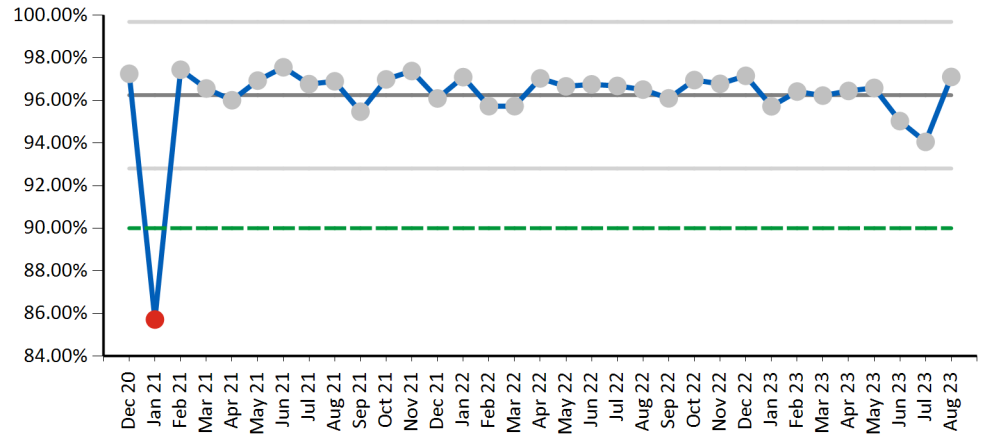


Normal Variation

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

3/6

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

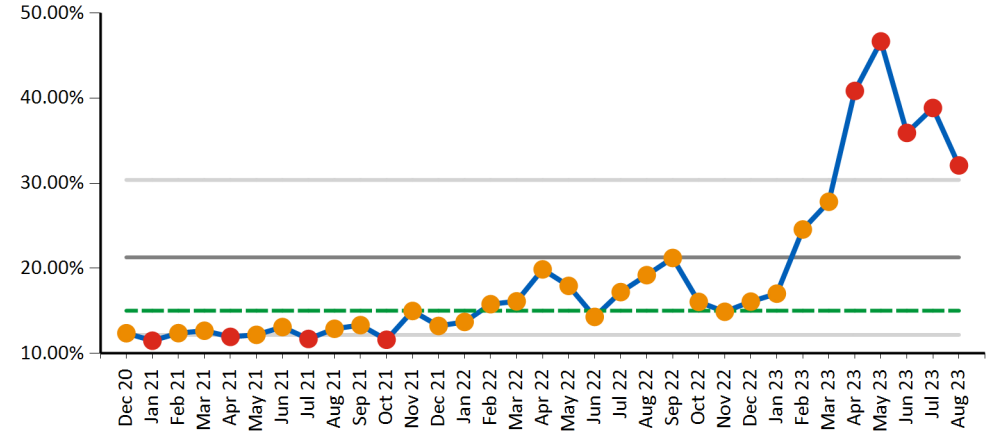


Normal Variation

Target will be regularly met.

6/6

81 - Maternity Friends and Family Response Rate

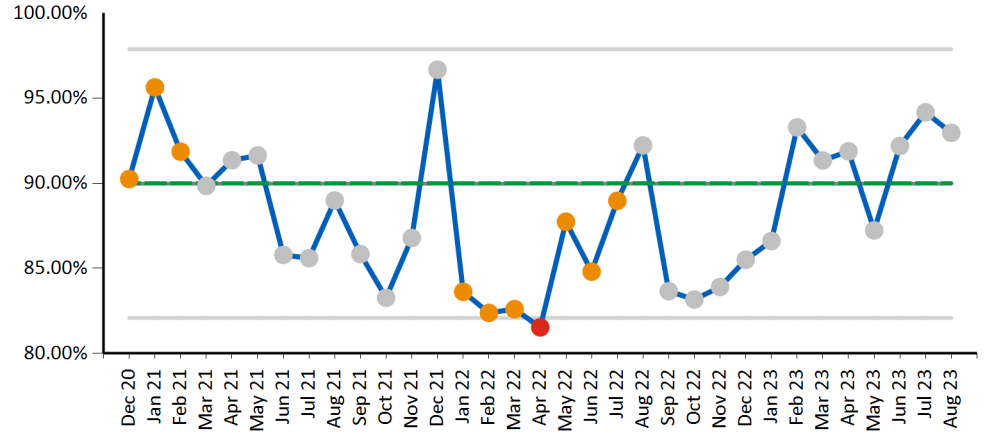


Abnormal variation. Target achieved.

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

6/6

241 - Maternity Friends and Family Test - Satisfaction %

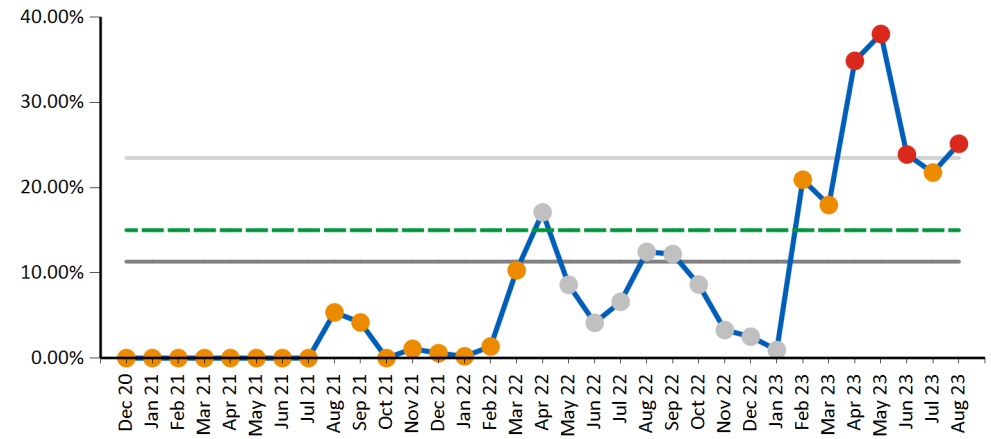


Normal Variation

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

5/6

82 - Antenatal - Friends and Family Response Rate

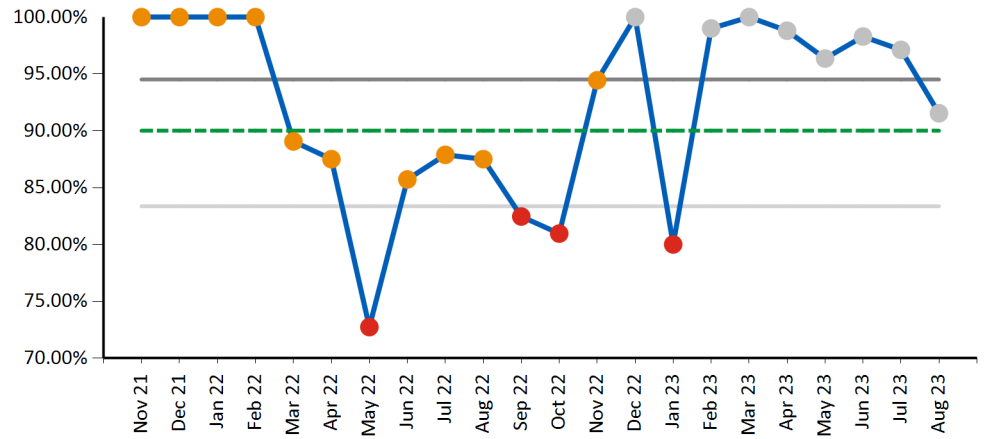


Abnormal variation. Target achieved.

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

6/6

242 - Antenatal Friends and Family Test - Satisfaction %

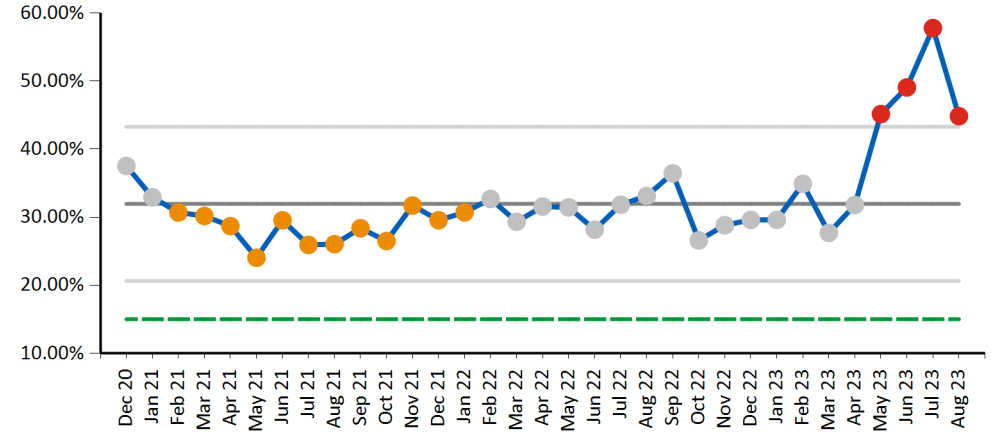


Normal Variation

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

6/6

83 - Birth - Friends and Family Response Rate

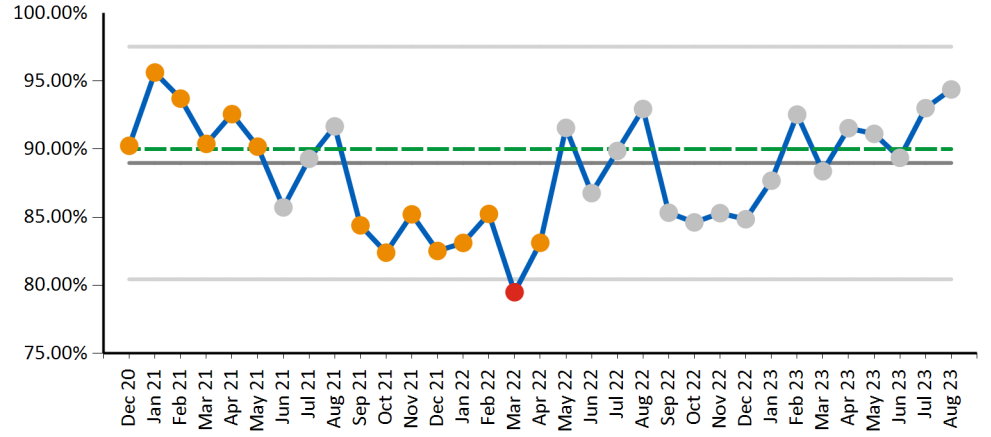


Abnormal variation. Target achieved.

Target will be regularly met.

6/6

243 - Birth Friends and Family Test - Satisfaction %

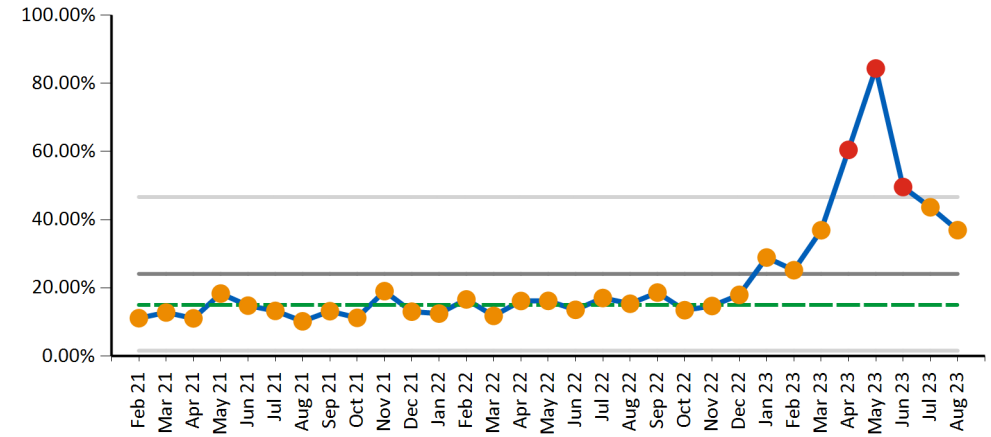


Normal Variation

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

4/6

84 - Hospital Postnatal - Friends and Family Response Rate

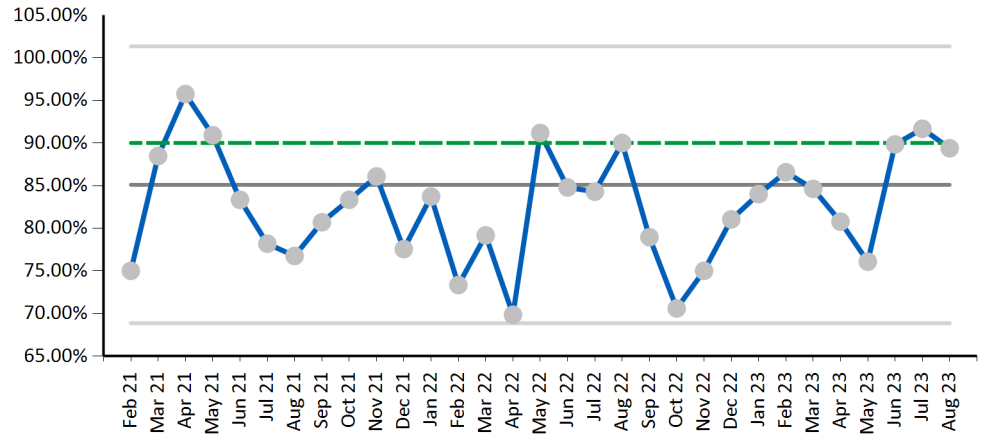


Abnormal variation. Target achieved.

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

6/6

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

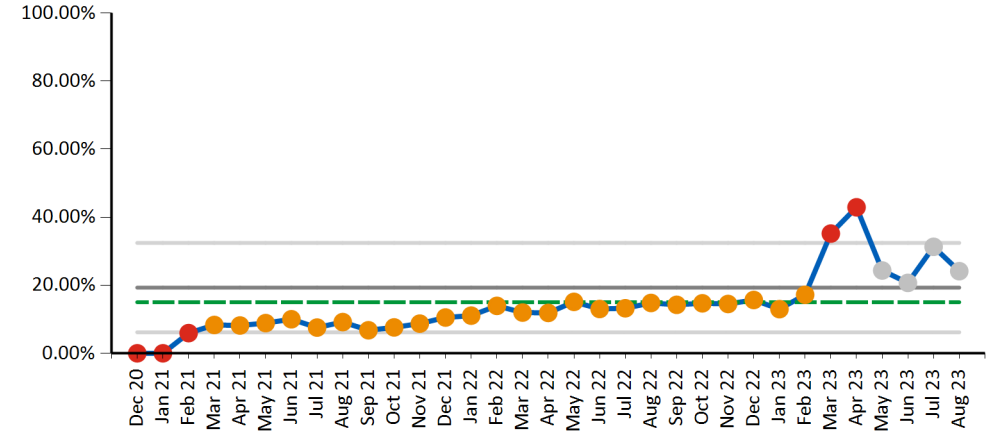


Normal Variation

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

1/6

85 - Community Postnatal - Friend and Family Response Rate

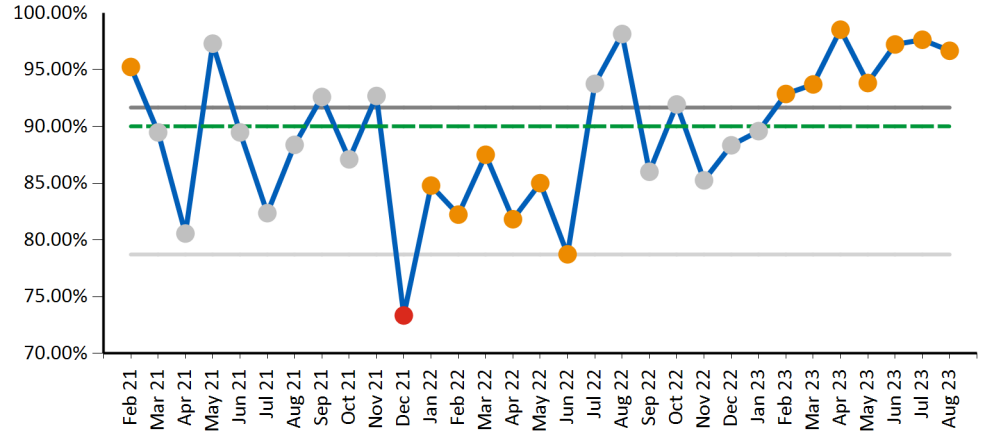


Normal Variation

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

6/6

245 - Community Postnatal Friends and Family Test - Satisfaction %

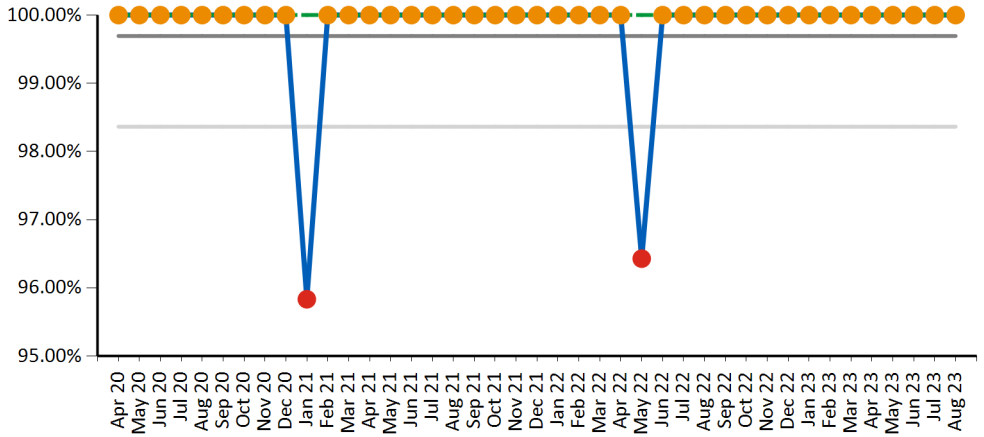


Abnormal variation. Target achieved.

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

6/6

89 - Formal complaints acknowledged within 3 working days

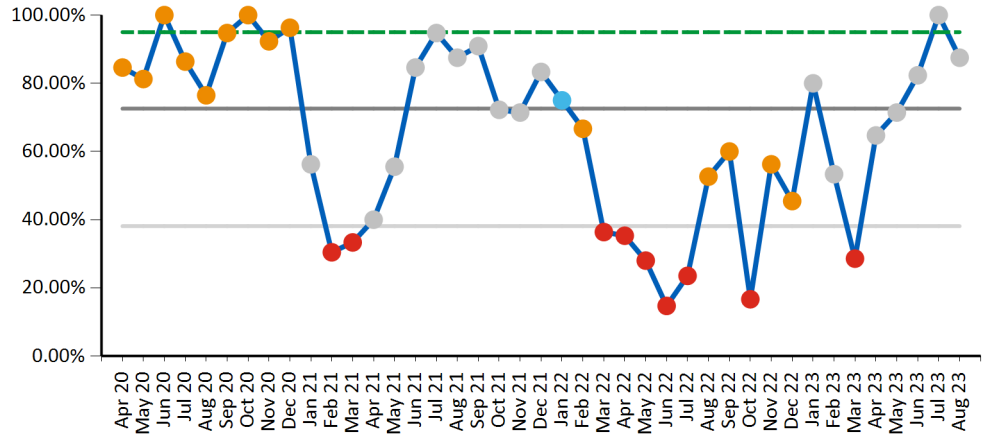


H Abnormal variation. Target achieved.

? 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.

1/6

Maternity

202 - 1:1 care in labour – Trust year to date incidence 89.89% lower than the rolling 12 month Greater Manchester and East Cheshire (GMEC) 2022 mean of 98.06% and peer average in similar sized providers (ie Oldham). Reflective of ongoing staffing deficit (50wte) and improvement anticipated from late September/October 2023 when overall staffing establishment predicted to improve. Incident reported as red flag and monitored on Birth Rate Plus acuity tool every 4 hours. Detailed action plan to recover position will be submitted to meet the CNST Year 5 scheme requirements.

23 – ¾ degree tears – Trust year to date incidence 3.40% slightly higher than rolling 12 month GMEC comparator mean of 2.60%. Meeting held with maternity team and local improvement event planned for January 2024 with educational intervention being provided during the interim months. Quarterly OASI review meeting held on 7 September 2023 and the quarterly clinical audit of all cases continues. Positive impact noted in response to physiotherapy pilot to assess impact of daily physiotherapy on maternal outcomes following a ¾ degree tear. Two initial significant trends noted in early date namely, 50% of the tears sustained were from patients that had been through the induction process and 90% of the tears sustained by from patients who had delivered their babies in lithotomy or semi-recumbent positions. The feedback from patients who have participated in the pilot has been overwhelmingly positive.

203 – Booked by 12+6 – Inconsistent trend in booking performance noted yet GMEC median aligns with Trust 12 month rolling data 88.19%. Performance target to be amended to 9+6 as per national standard which will remove impact of ultrasound date changes and associated impact upon compliance rate. Registered Midwifery staffing challenges continue within community settings which is impacting upon the staffing capacity to meet this target.

210 – Breastfeeding initiation – Sustained improvement again in performance noted in month. New leadership has been introduced to review current service offer and support Baby Friendly implementation within service. Trust year to date incidence 67.11% slightly higher than 2022 GMEC 12 months rolling rate of mean 64.64%.

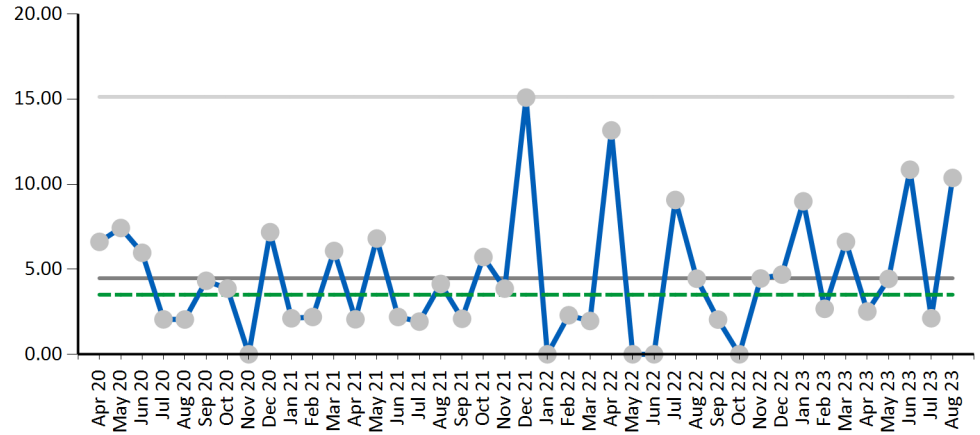
320 – Preterm birth – Elevated incidence in April 2023 noted on spc chart. No GMEC comparator data accessible on tableau to benchmark performance. Overview undertaken of April 2023 data by Clinical Director for neonates - admission rates higher in April, for the >36 week group admission rates (25/46) - joint obstetric audit now required to ascertain the reasons for delivery and whether delivery could have been delayed to after 37 weeks. Professional opinion indicates change associated with steroid administration practices. Joint medical / nursing audit requested and is being led by Dr Tahir. Recruitment to post of pre-term midwife in progress.

322 – Maternity Stillbirth Rate –Variation noted in rate this month. Trust year to date rolling 12mths rate 4.751/1000 slightly higher than GMEC rolling mean 4.307/1000 and lower than peer comparators ie Oldham 6.808/1000. Implementation of all of the revised saving babies lives care bundle elements continues as part of CNST year 5 implementation.

	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	10.36	Aug-23		<= 3.50	2.12	Jul-23	<= 3.50	6.00	
23 - Maternity -3rd/4th degree tears	<= 3.5%	4.4%	Aug-23		<= 3.5%	3.1%	Jul-23	<= 3.5%	3.6%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.0%	Aug-23		>= 95.0%	98.3%	Jul-23	>= 95.0%	98.8%	
203 - Booked 12+6	>= 90.0%	87.6%	Aug-23		>= 90.0%	87.9%	Jul-23	>= 90.0%	88.2%	
204 - Inductions of labour	<= 40%	39.2%	Aug-23		<= 40%	37.1%	Jul-23	<= 40%	36.3%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
210 - Initiation breast feeding	>= 65%	69.41%	Aug-23		>= 65%	69.89%	Jul-23	>= 65%	68.22%	
213 - Maternity complaints	<= 5	1	Aug-23		<= 5	2	Jul-23	<= 25	9	
319 - Maternal deaths (direct)	= 0	0	Aug-23		= 0	0	Jul-23	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.8%	Aug-23		<= 6%	9.1%	Jul-23	<= 6%	10.0%	

322 - Maternity - Stillbirths per 1000 births

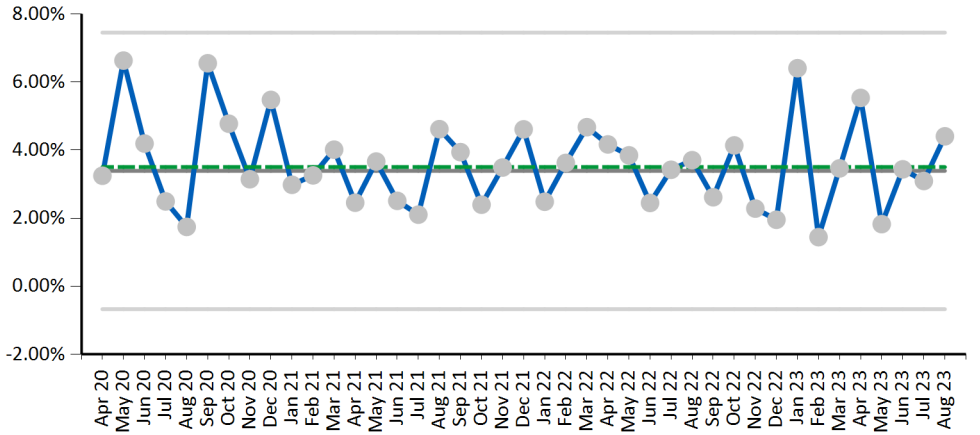


Normal Variation

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

2/6

23 - Maternity -3rd/4th degree tears

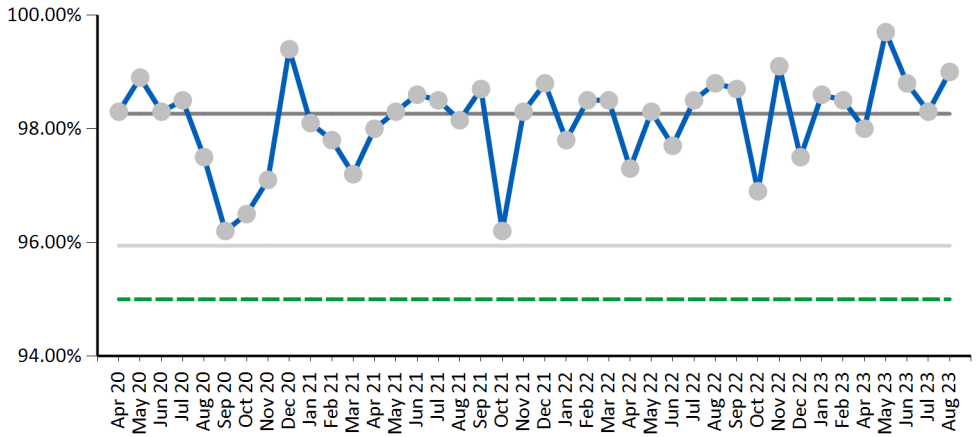


Normal Variation

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

4/6

202 - 1:1 Midwifery care in labour

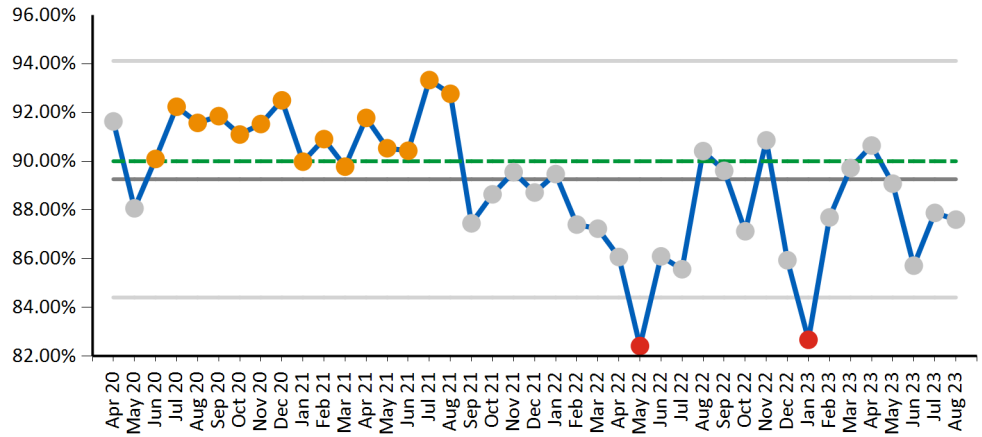


Normal Variation

Target will be regularly met.

6/6

203 - Booked 12+6

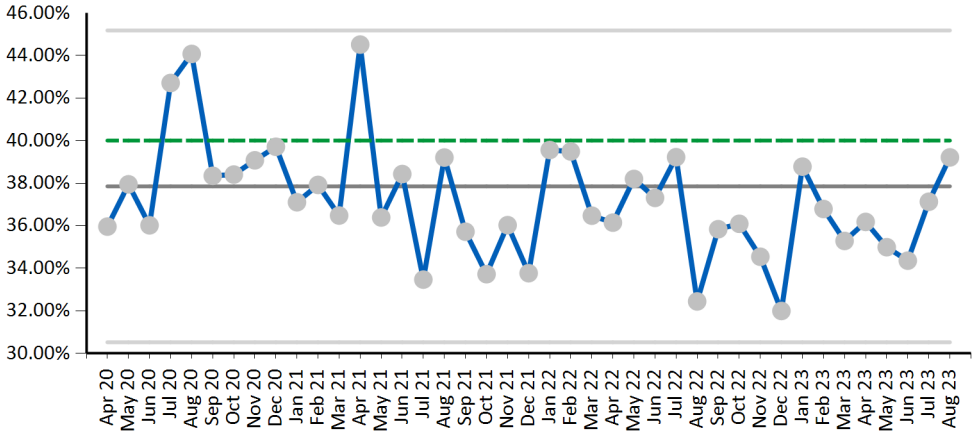


Normal Variation

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

1/6

204 - Inductions of labour

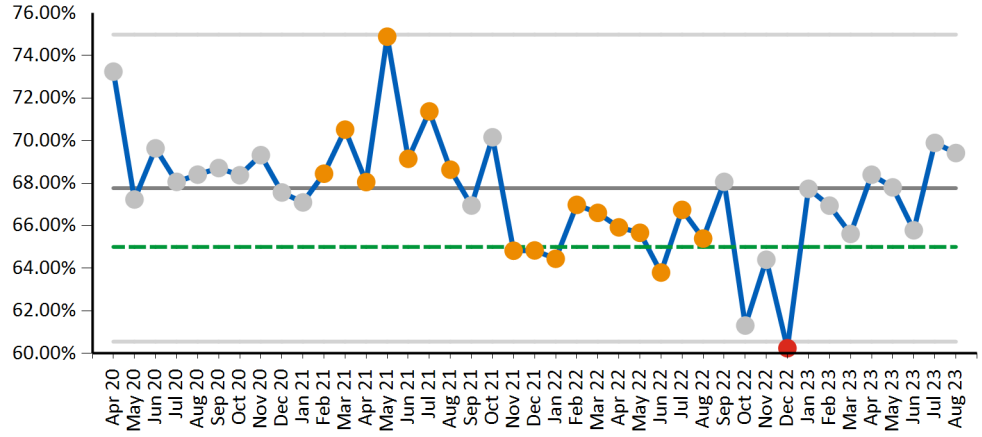


Normal Variation

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

6/6

210 - Initiation breast feeding

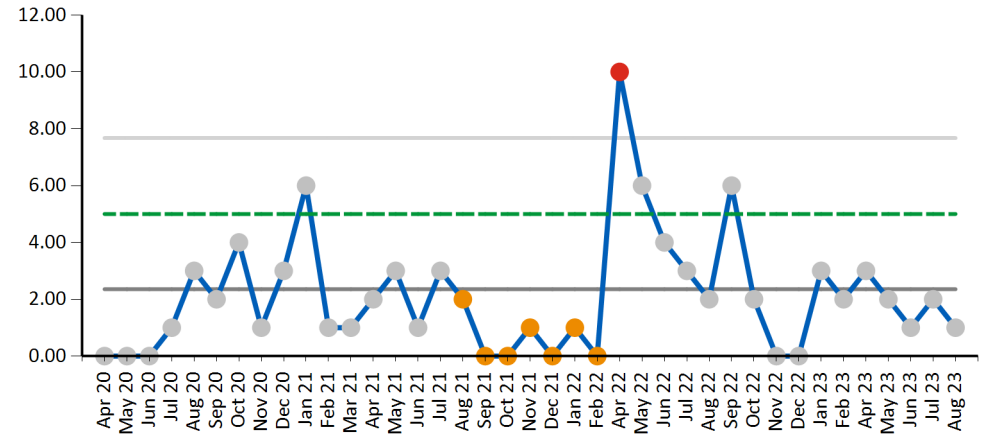


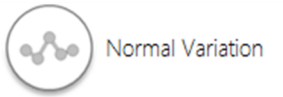
Normal Variation

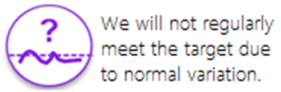
We will not regularly meet the target due to normal variation.

6/6

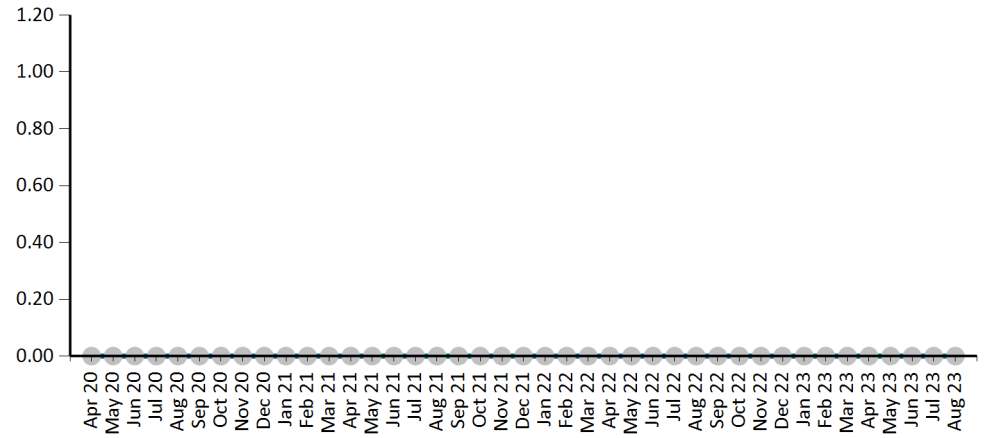
213 - Maternity complaints

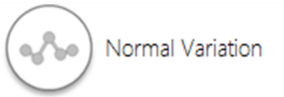


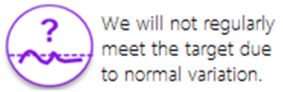




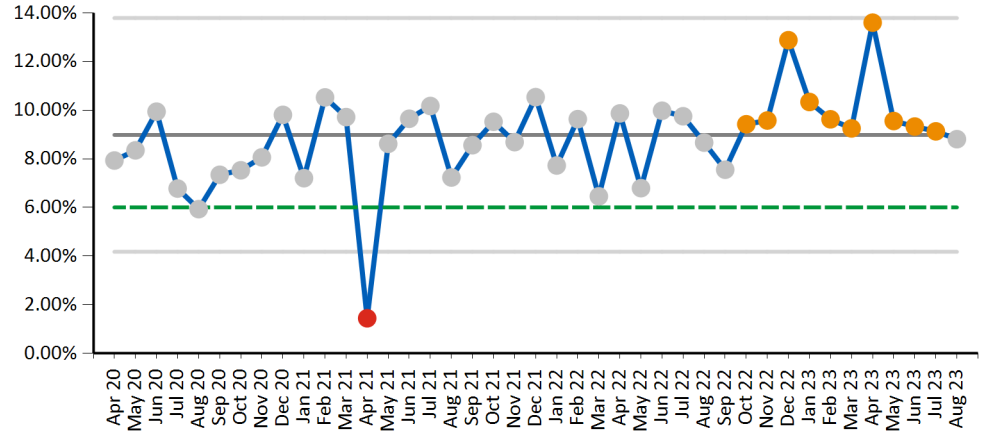
319 - Maternal deaths (direct)

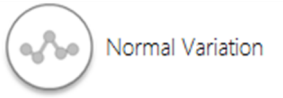


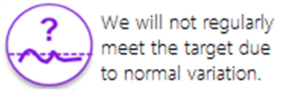




320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)







Operational Performance

Urgent Care

Urgent care saw a further decline in all metrics over the month, however 92.5% of patients who arrived via ambulance were handed over within 60 mins of arrival.
The driver for this position was predominantly flow with the number of stranded patients increasing as ED performance declines; this has a multi-factoral cause, with a large diagnostic underway to triangulate the root cause. This is examining:

- Attendances
- Admissions
- LOS
- Enhanced Care
- Time of discharges

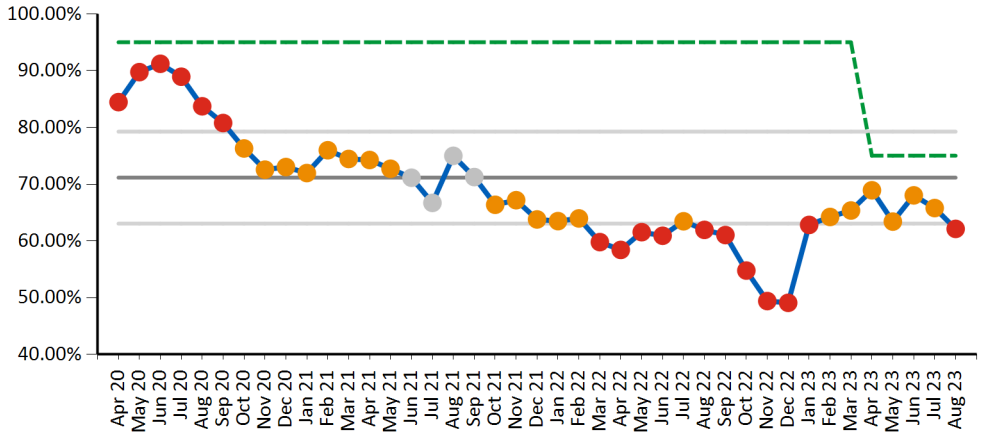
A number of initiatives continue across the Trust in order to improve the position:

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

	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%	62.1%	Aug-23		>= 75%	65.8%	Jul-23	>= 75%	65.6%	
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	51.9%	Aug-23		>= 65.0%	56.5%	Jul-23	>= 65.0%	57.9%	
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	80.8%	Aug-23		>= 95.0%	84.7%	Jul-23	>= 95.0%	84.7%	
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100.00%	92.55%	Aug-23		= 100.00%	95.19%	Jul-23	= 100.00%	94.94%	
545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes		7.5%	Aug-23			4.8%	Jul-23		5.0%	
539 - A&E 12 hour waits	= 0	1,207	Aug-23		= 0	1,121	Jul-23	= 0	5,407	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	75.0%	Aug-23		>= 75%	65.7%	Jul-23	>= 75%	62.4%	
56 - Stranded patients	<= 200	266	Aug-23		<= 200	260	Jul-23	<= 200	266	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	96	Aug-23	H	<= 69	107	Jul-23	<= 69	96	?
541 - Adult G&A bed occupancy	<= 92.0%	84.0%	Aug-23		<= 92.0%	84.2%	Jul-23	<= 92.0%	85.5%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.24	Aug-23		<= 3.70	3.78	Jul-23	<= 3.70	4.25	?
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.8%	Jul-23	L	<= 13.5%	9.4%	Jun-23	<= 13.5%	8.9%	P

53 - A&E 4 hour target

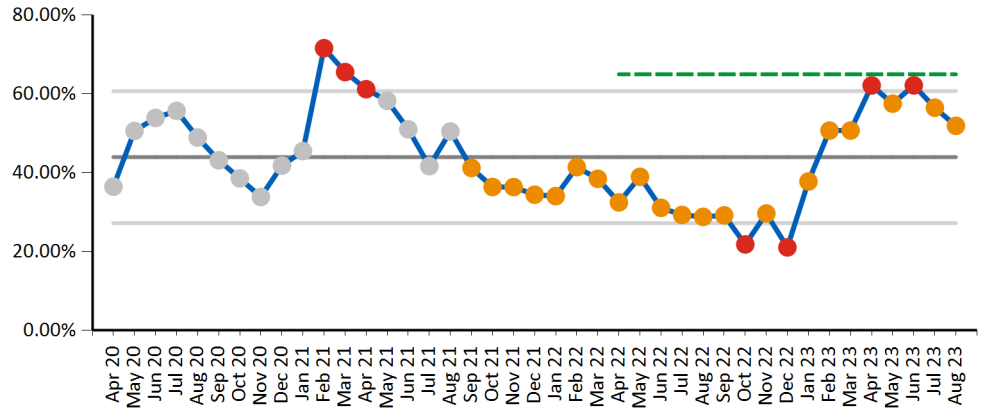


L — Abnormal variation. Target not achieved.

? — 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

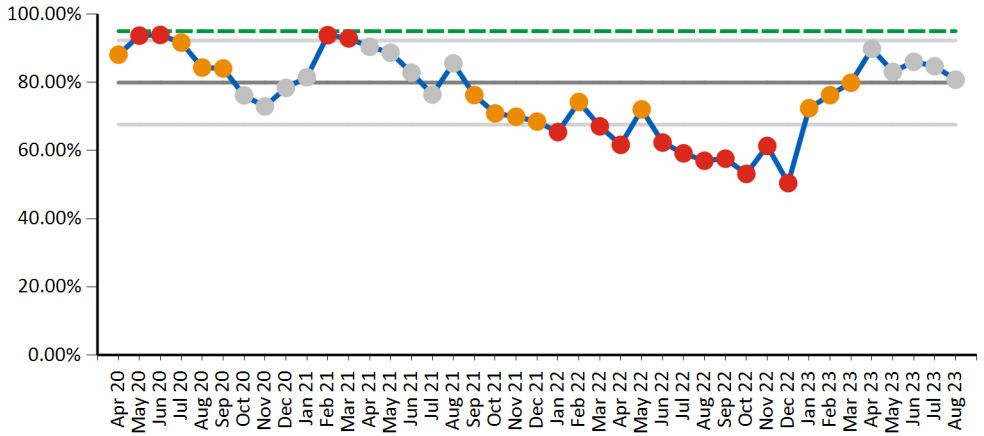


H — Abnormal variation. Target achieved.

F — We will regularly fail to meet the target.

0/6

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



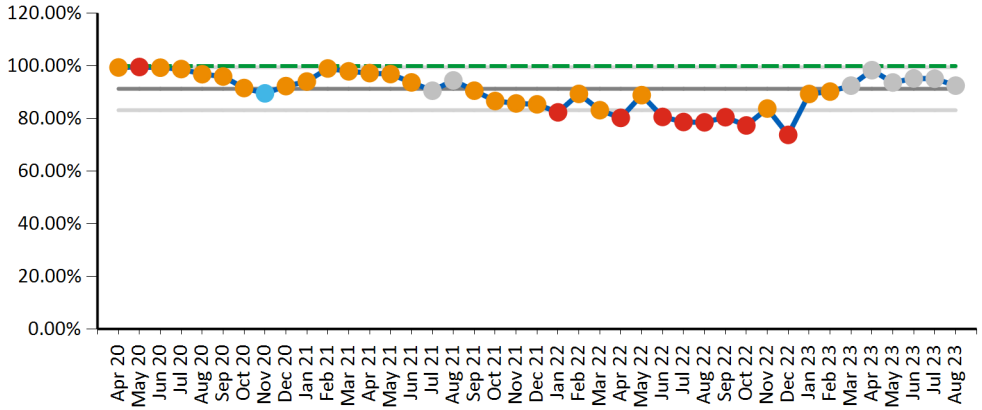
Normal Variation

F

We will regularly fail to meet the target.

0/6

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



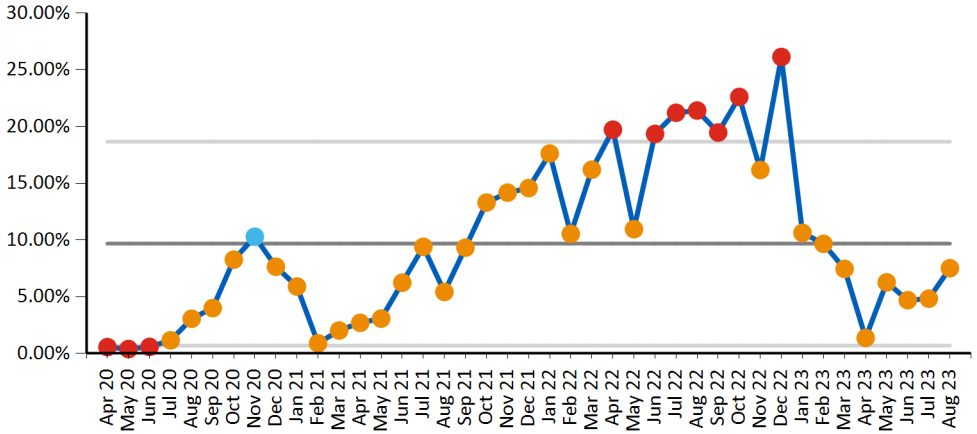
Normal Variation

F

We will regularly fail to meet the target.

0/6

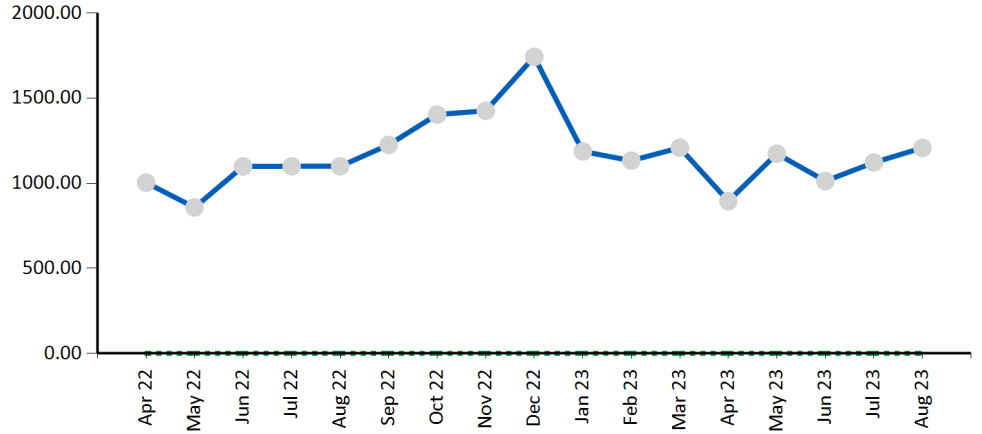
545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes



L

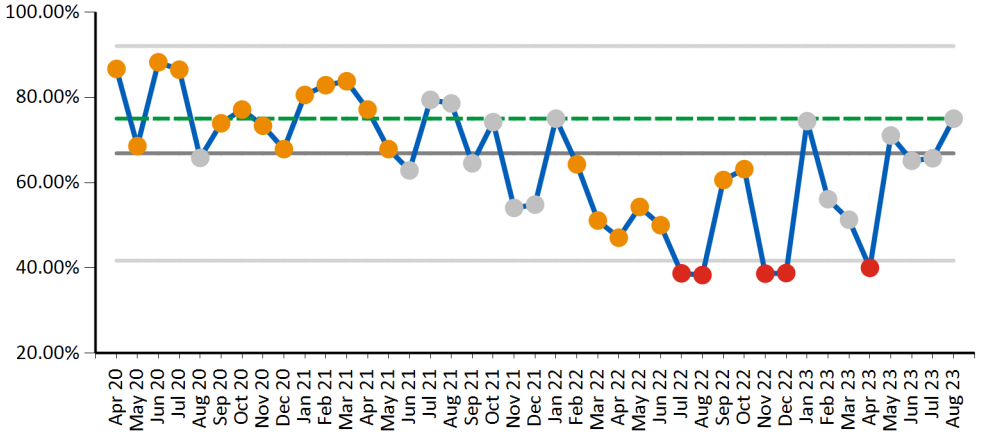
Abnormal variation. Target not achieved.

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

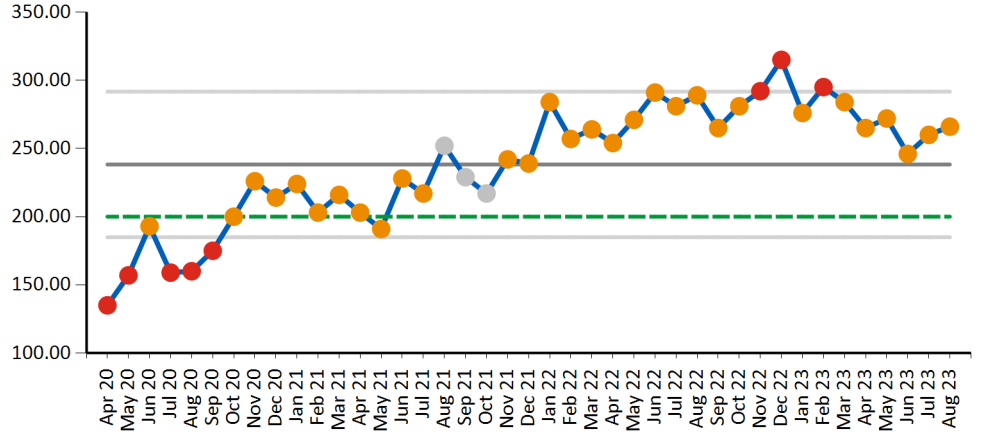


Normal Variation

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

1/6

56 - Stranded patients

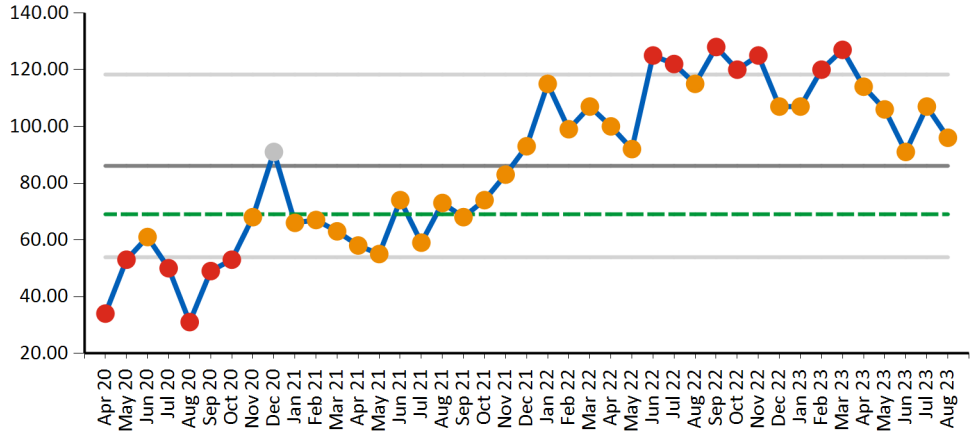


Abnormal variation. Target not achieved.

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

0/6

307 - Stranded Patients - LOS 21 days and over

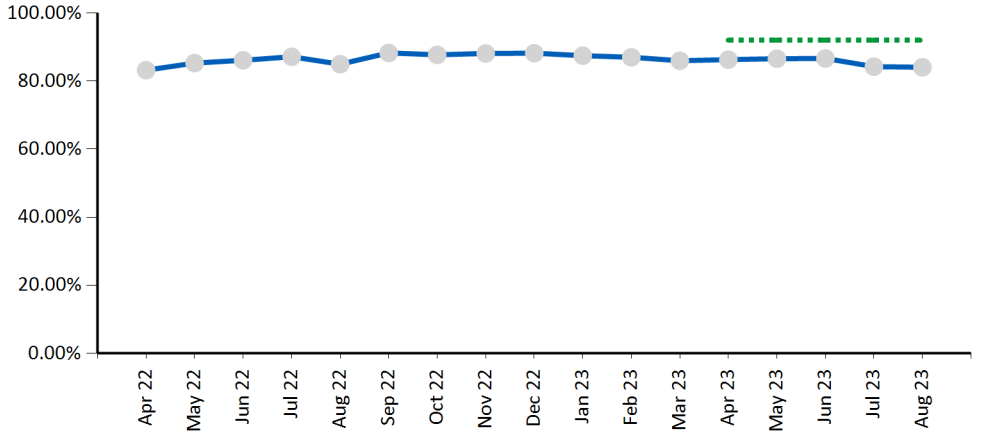


Abnormal variation. Target not achieved.

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

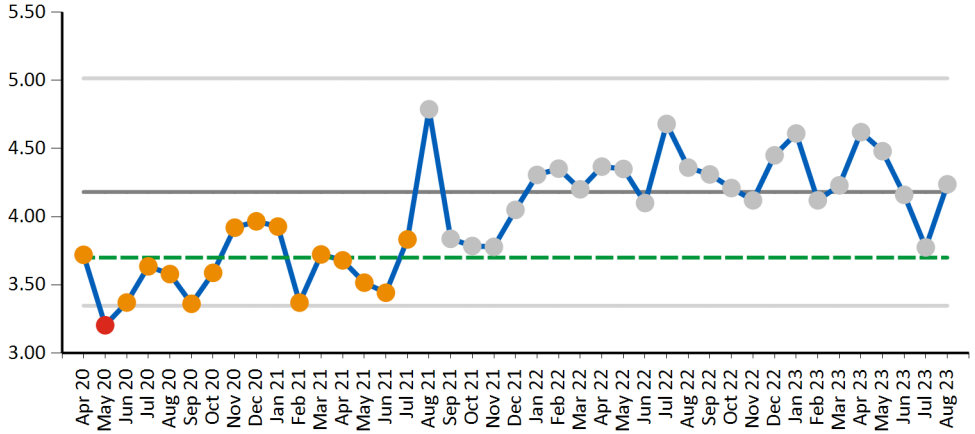
0/6

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



5/6

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

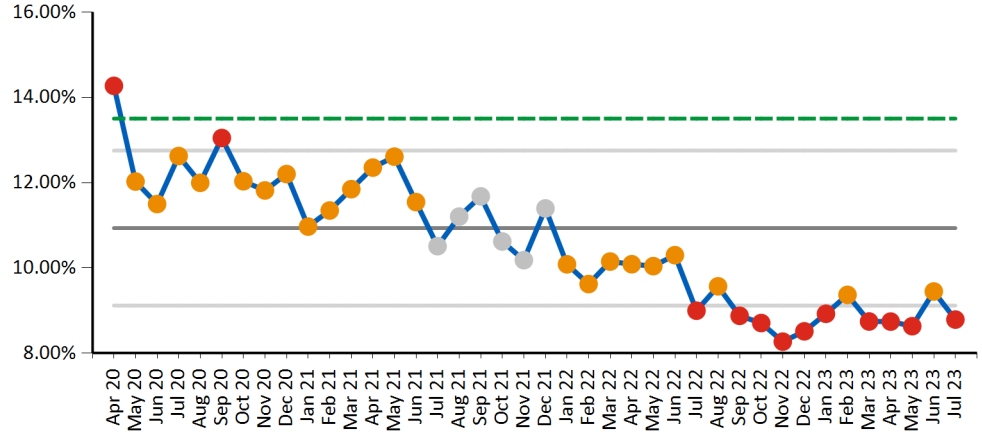


Normal Variation

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

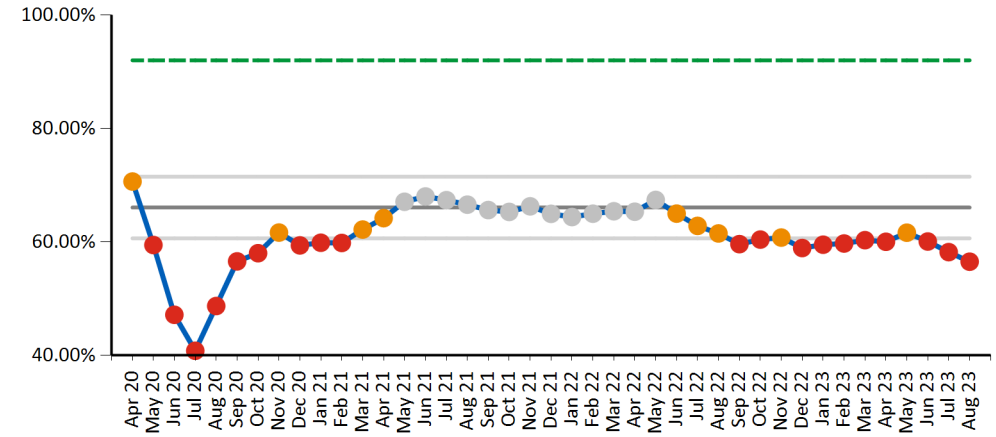
RTT
We finished August with 25 78-week breaches, of these, 8 were clinically complex, 5 chose to delay their treatment, 5 were corneal graft patients (one patient is over 104 weeks) awaiting tissue availability and 7 were due to capacity, in Urology, Paediatric Surgery, Ophthalmology and Gynaecology.

Our position against our initial trajectory for delivery of the 65-week wait target has improved this month, but remains off track. To recover the position we have requested mutual aid, are focusing on productivity in theatres and outpatients and are exploring delivery of additional theatre and outpatient sessions.

Diagnostics
Our overall position has deteriorated by 2.6% from the previous month with a final performance of 82.0%. This deterioration has been driven by the combination of Industrial Action challenges and the summer holiday period. The number of patients waiting over 6 weeks has increased by 100, and in total the PTL has increased by 189 patients from last month. There are a number of initiatives underway to increase capacity in September.

	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%	56.5%	Aug-23	L	>= 92%	58.2%	Jul-23	>= 92%	59.2%	F
314 - RTT 18 week waiting list	<= 28,664	43,698	Aug-23	H	<= 28,814	43,031	Jul-23	<= 28,664	43,698	?
42 - RTT 52 week waits (incomplete pathways)		2,326	Aug-23	H		2,275	Jul-23		10,641	
540 - RTT 65 week waits (incomplete pathways)	<= 664	663	Aug-23		<= 642	612	Jul-23	<= 3,112	2,851	
526 - RTT 78 week waits (incomplete pathways)	= 0	25	Aug-23		= 0	30	Jul-23	= 0	149	
527 - RTT 104 week waits (incomplete pathways)	= 0	1	Aug-23		= 0	0	Jul-23	= 0	1	
72 - Diagnostic Waits >6 weeks %	<= 5%	17.9%	Aug-23	L	<= 5%	15.4%	Jul-23	<= 5%	18.6%	F
489 - Daycase Rates	>= 80%	91.9%	Aug-23	H	>= 80%	92.8%	Jul-23	>= 80%	91.4%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.2%	Aug-23		<= 1%	1.4%	Jul-23	<= 1%	1.5%	?
62 - Cancelled operations re-booked within 28 days	= 100%	56.3%	Jul-23		= 100%	75.9%	Jun-23	= 100%	32.2%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.12	Aug-23		<= 2.00	2.72	Jul-23	<= 2.00	3.02	?

41 - RTT Incomplete pathways within 18 weeks %

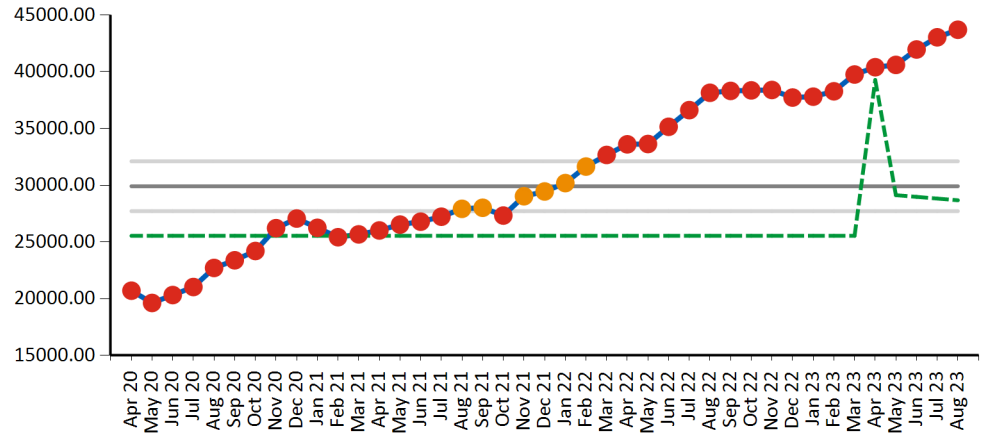


L — Abnormal variation. Target not achieved.

F — We will regularly fail to meet the target.

0/6

314 - RTT 18 week waiting list

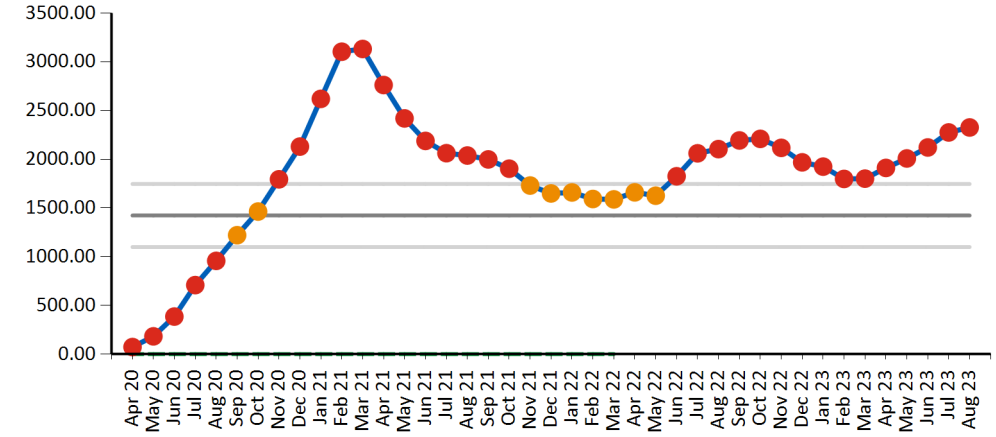


H — Abnormal variation. Target not achieved.

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

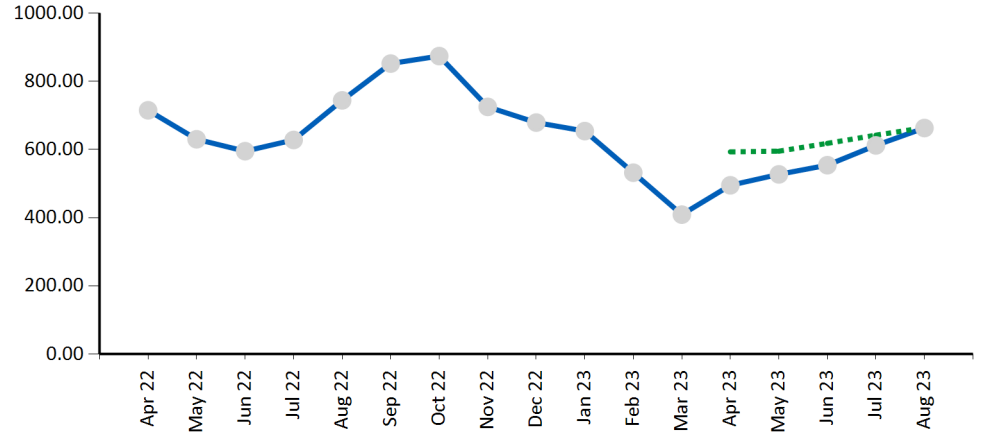
0/6

42 - RTT 52 week waits (incomplete pathways)



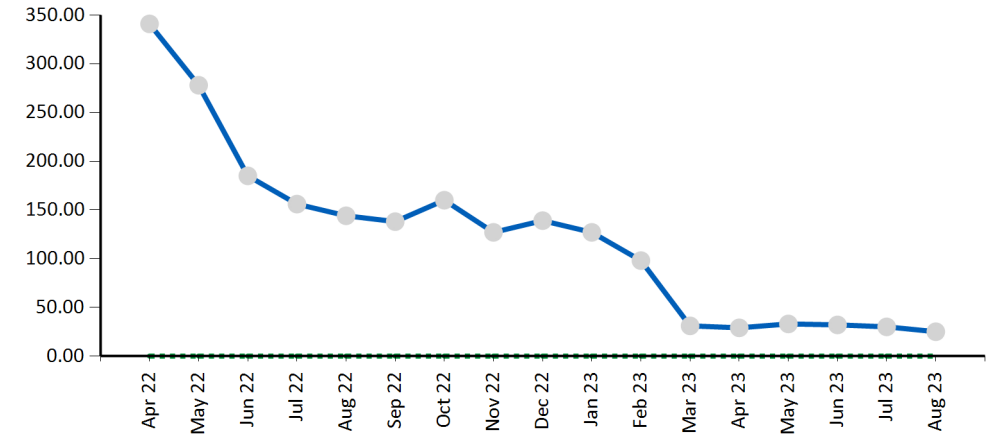
H — Abnormal variation. Target not achieved.

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



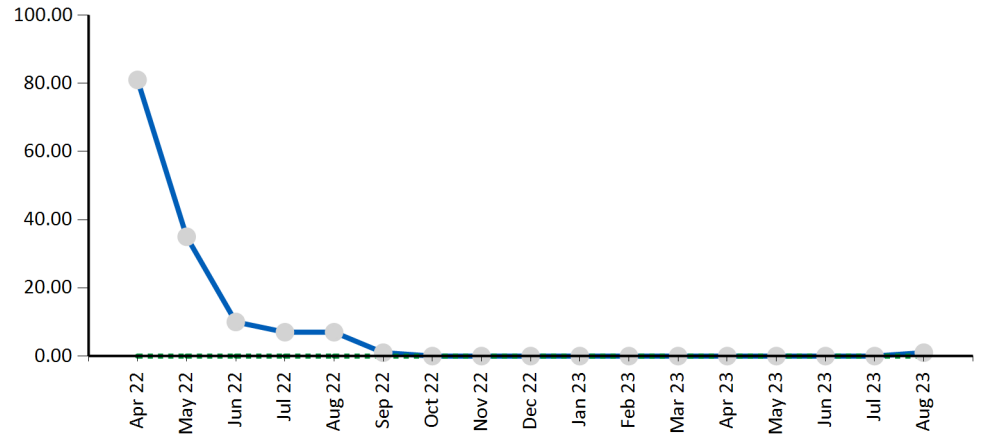
5/6

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



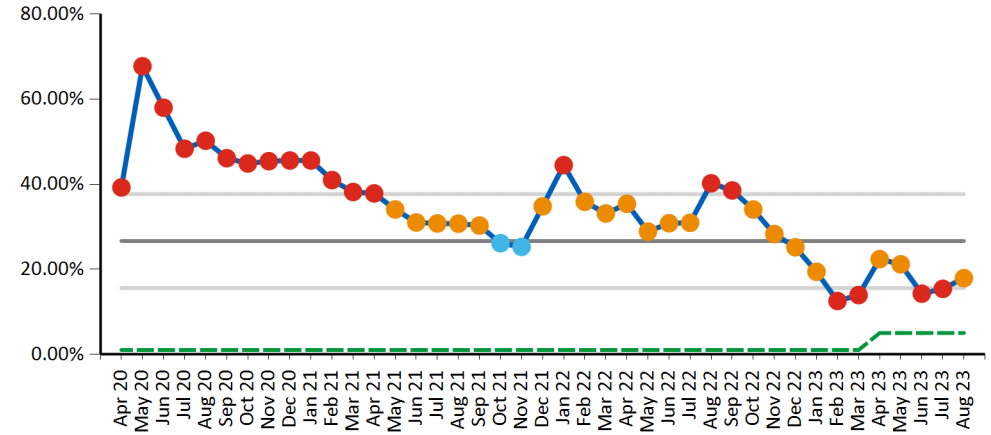
0/6

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



5/6

72 - Diagnostic Waits >6 weeks %

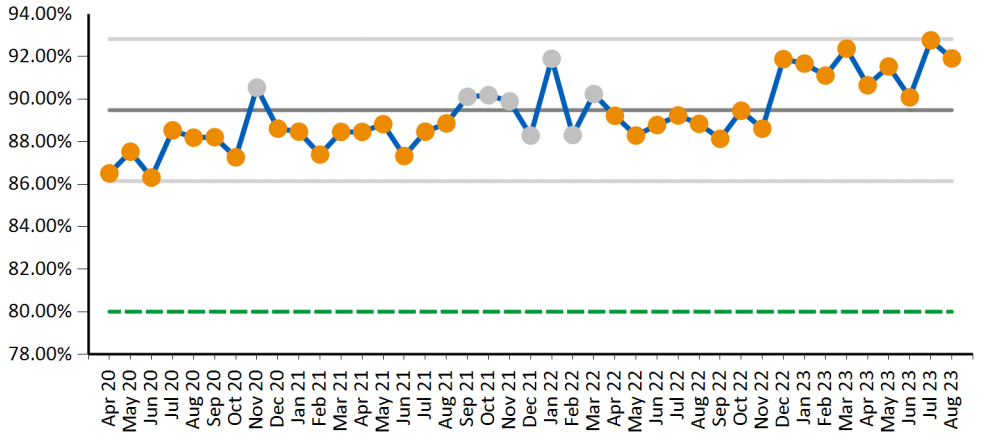


L Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

489 - Daycase Rates

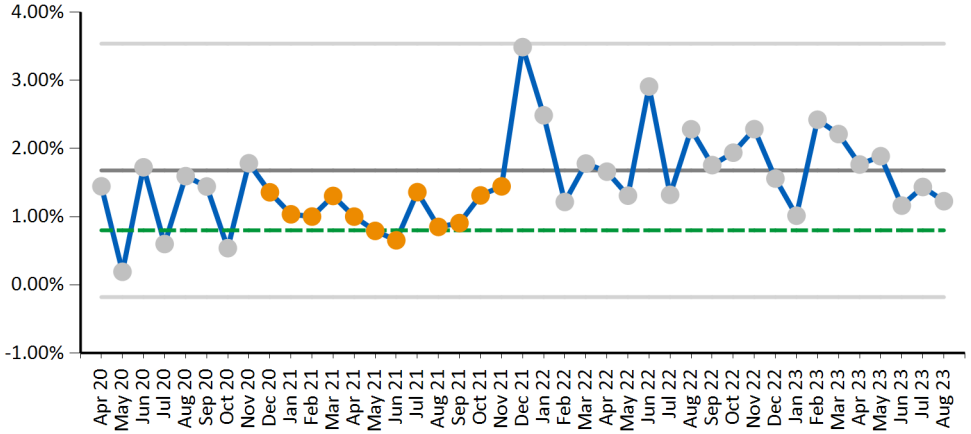


H Abnormal variation. Target achieved.

P Target will be regularly met.

6/6

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

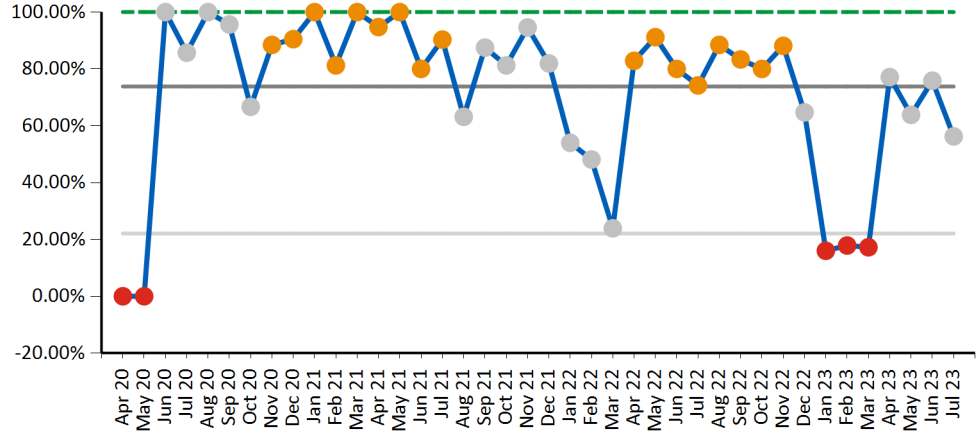


Normal Variation

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

0/6

62 - Cancelled operations re-booked within 28 days

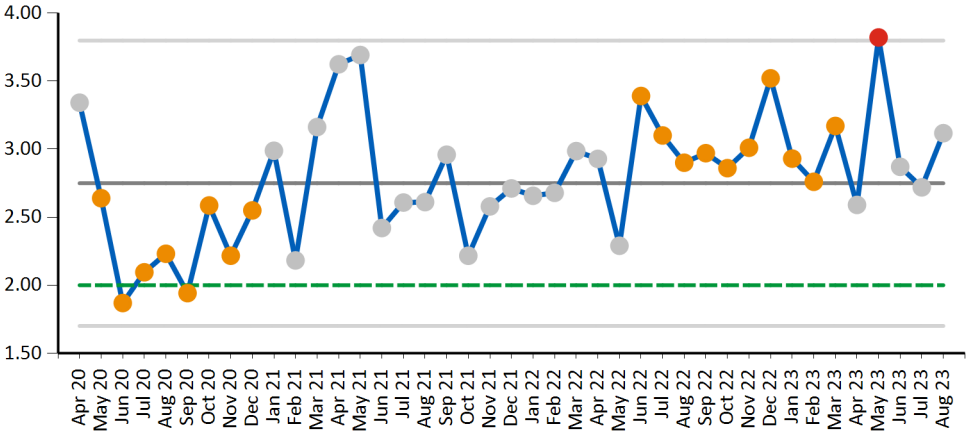


Normal Variation

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

Cancer
Our 2ww performance for July has seen a further deterioration. The main area of underperformance was Breast. There is a recovery plan in place and we expect performance to improve in the next two months. We are on track with the Breast cancer recovery plan and expect performance to improve over the next 2 months.

Our performance against the 62 day standard remains within normal variation and continues to be below the 85% target, breaches in July continue to be primarily due to delays in Breast and Urology.

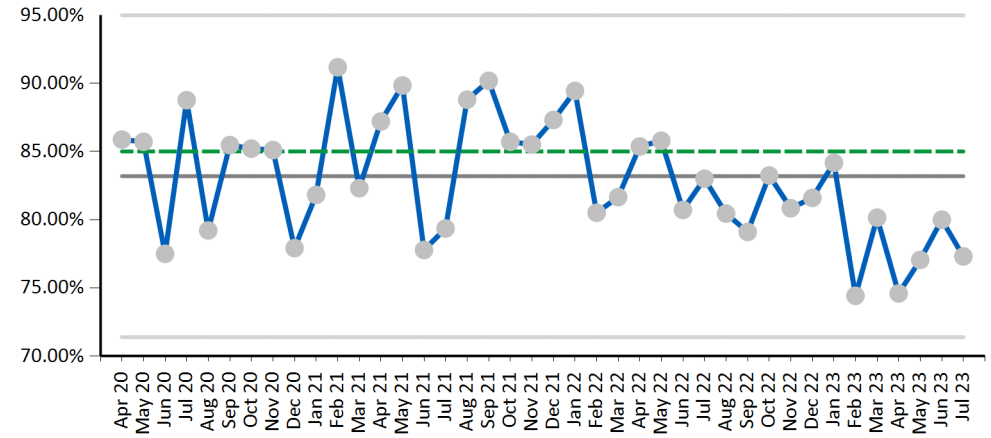
Faster Diagnosis performance has further improved this month at 82.3%.

We continue to achieve our Cancer 62 day backlog trajectory, having 29 patients on the PTL over 62 days against a planned position of 30.

Plans are in place to improve performance across all specialties and deliver the national best-timed pathways, and we are on track with our trust-wide cancer recovery plan.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	77.3%	Jul-23		>= 85%	80.0%	Jun-23	>= 85%	77.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	92.7%	Jul-23		>= 90%	89.5%	Jun-23	>= 90%	86.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Jul-23		>= 96%	96.0%	Jun-23	>= 96%	98.2%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Jul-23		>= 94%	100.0%	Jun-23	>= 94%	97.1%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Jul-23		>= 98%	100.0%	Jun-23	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	76.5%	Jul-23		>= 93%	77.8%	Jun-23	>= 93%	77.3%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	18.0%	Jul-23		>= 93%	20.0%	Jun-23	>= 93%	19.0%	
542 - Cancer: 28 day faster diagnosis	>= 75.0%	82.3%	Jul-23		>= 75.0%	76.8%	Jun-23	>= 75.0%	72.9%	

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

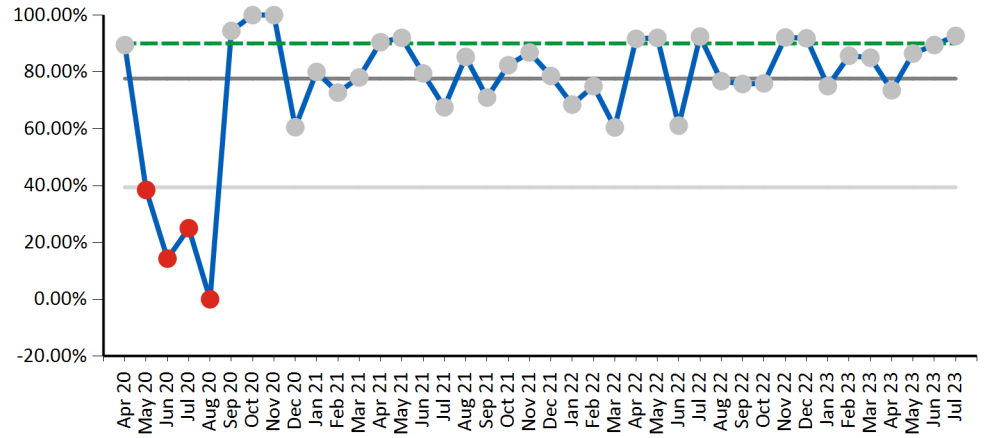


Normal Variation

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

0/6

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

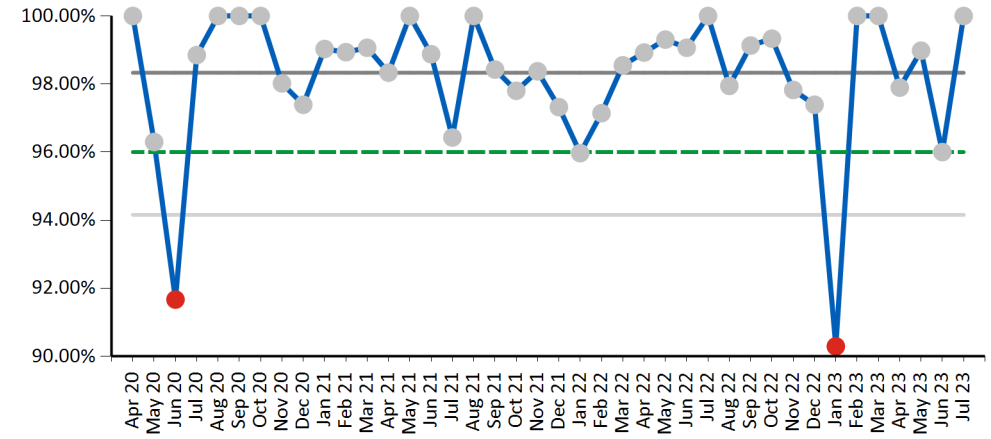


Normal Variation

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

1/6

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

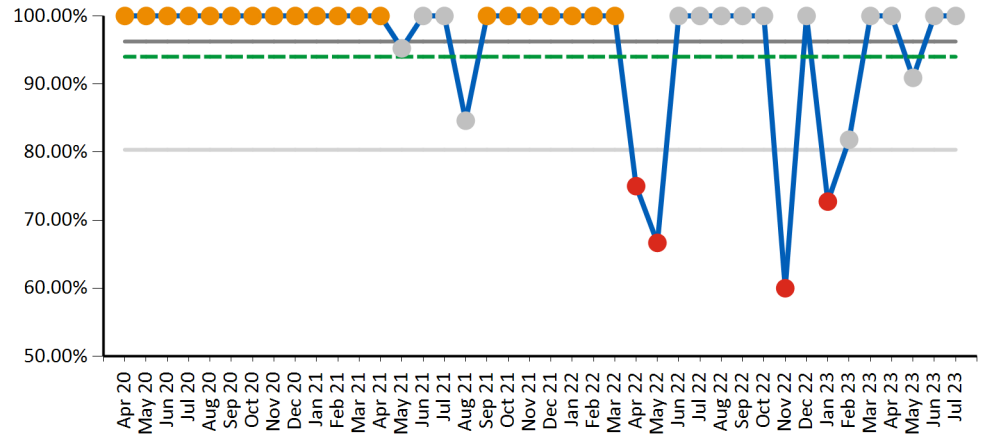


Normal Variation

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

6/6

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

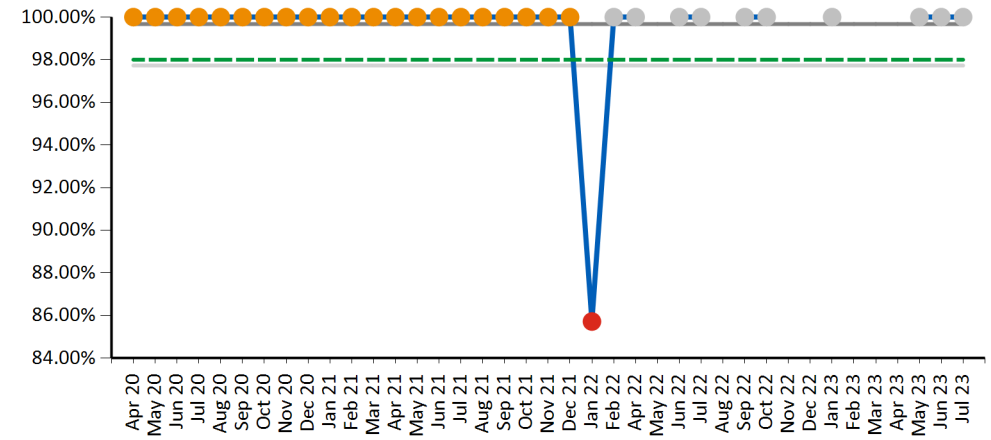


Normal Variation

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

4/6

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

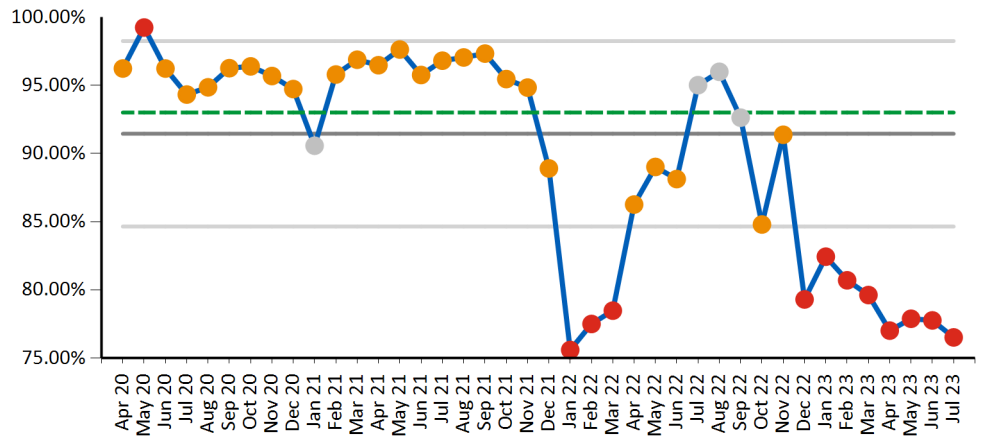


Normal Variation

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

3/6

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

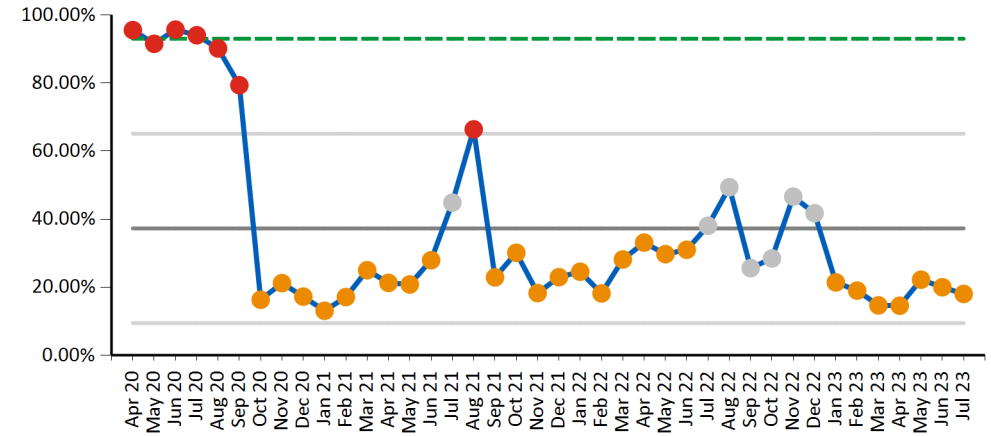


Abnormal variation. Target not achieved.

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

0/6

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

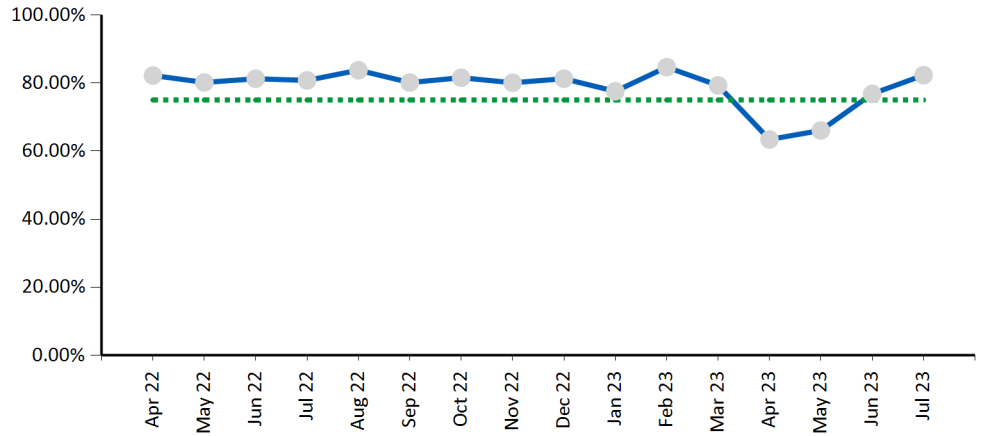


Abnormal variation. Target not achieved.

We will regularly fail to meet the target.

0/6

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



4/6

Community Care

ED deflections
ED deflections this month remain above plan of 400, at 454. This continues to be achieved through collaborative work between our Admission Avoidance and Home First teams. Our Admission Avoidance team have seen a further increase in the number of NWAS referrals since the go live of the direct NWAS access phone line into our Admission Avoidance team to support deflections.

Intermediate Tier LOS
We have seen a further slight reduction in month 5 to 5.32 weeks from the previous month at 5.58 weeks. Focused work is ongoing to support length of stay reduction across our service services.

NCTR
The number of patients with No Criteria to Reside (NCTR) has risen above the operational plan, with an average of 94 patients in hospital with no criteria to reside in month 5. Average occupied bed days has deteriorated in month to 868, and this is largely due to challenges in placement of patients on pathways 2 and 3. Actions being taken include:
• Focussed work with out of area colleagues to support timely discharge of patients who reside outside of Bolton, usually 20-25% of the total number of patient with NCTR
• Embedding home from hospital pilot from September as business as usual
• Work with system colleagues to support community capacity for more complex patients

0-5 Mandated Contacts
We have maintained underperformance against target, with staffing challenges continuing to be the key driver for this. In order to mitigate impact however possible, key areas of service delivery are being prioritised, and performance has remained satisfactory in our prioritised pathways.

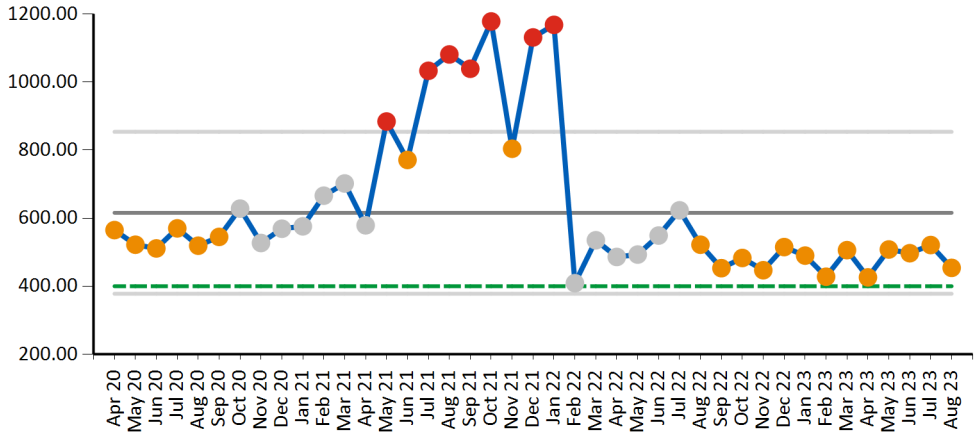
Looked After Children – Review Health Assessments by Health Visitor & School Nurse
With regards to review health assessments, for 0-5 years these are undertaken twice a year by health visitors, for 5 -18 years these are undertaken yearly by school nurses. Compliance for July was 88% - an improvement on July's 79% - 43 of 49 completed in time.

Looked After Children – Review Health Assessments for over 5s in Special Schools
100% performance for review health assessments due for children in Special Schools.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	454	Aug-23	L	>= 400	521	Jul-23	>= 2,000	2,406	?
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.32	Aug-23	H	<= 6.00	5.58	Jul-23	<= 6.00	5.32	?
493 - Average Number of Patients: with no Criteria to Reside	<= 93	94	Aug-23		<= 92	86	Jul-23	<= 93	94	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	868	Aug-23		<= 360	789	Jul-23	<= 1,800	3,838	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	85%	Aug-23		>= 95%	77%	Jul-23	>= 95%	79%	

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
269 - Education, health and care plan (EHC) compliance	>= 95%	88%	Aug-23		>= 95%	86%	Jul-23	>= 95%	85%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse		88.0%	Aug-23			79.0%	Jul-23			
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales		75.0%	Aug-23			90.0%	Jul-23			
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools		100.0%	Aug-23			67.0%	Jun-23			

334 - Total Deflections from ED

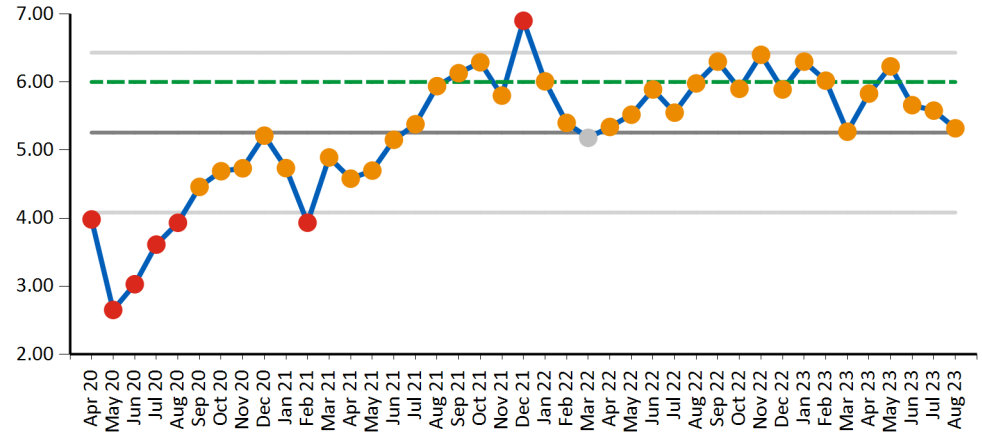


Abnormal variation.
Target not achieved.

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

6/6

335 - Total Intermediate Tier LOS (weeks)

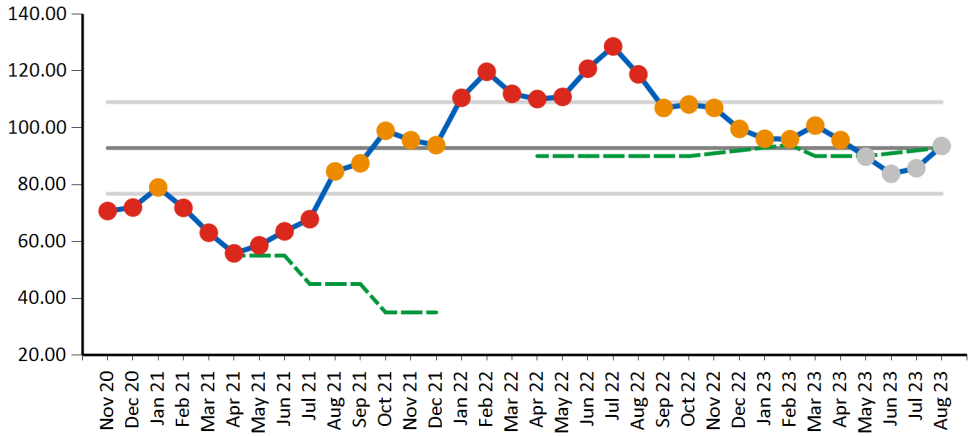


Abnormal variation.
Target not achieved.

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

5/6

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

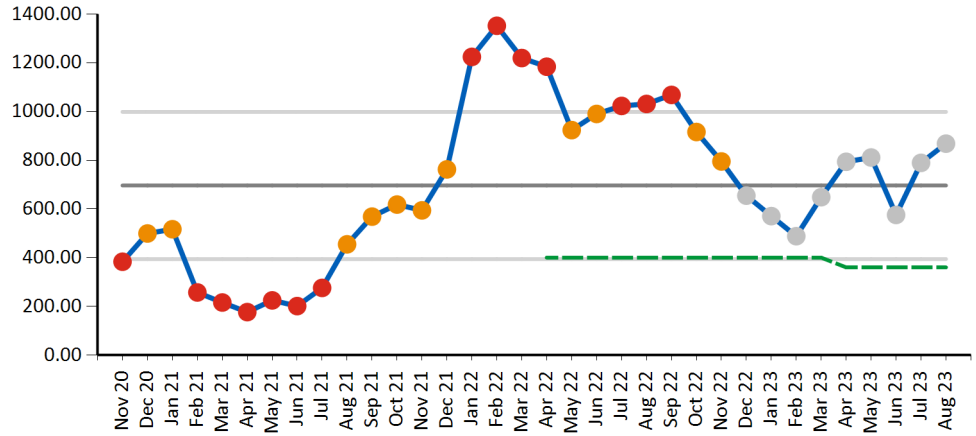


Normal Variation

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

3/6

494 - Average Occupied Days - for no Criteria to Reside

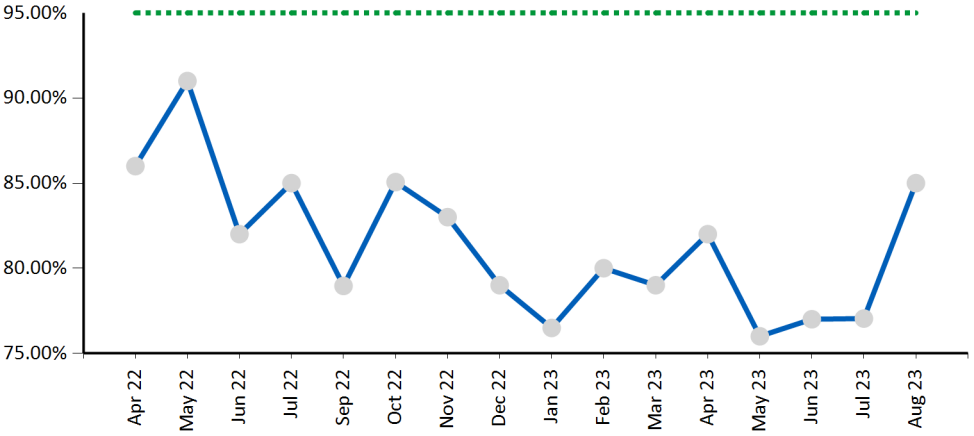


Normal Variation

We will regularly fail to meet the target.

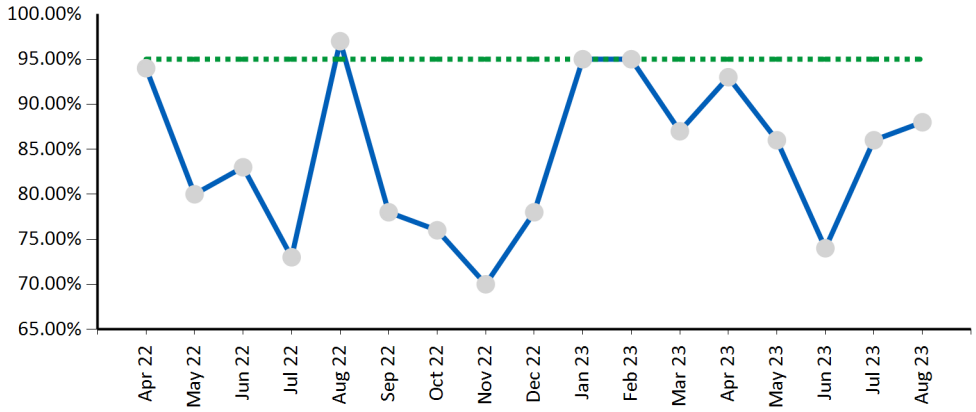
0/6

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



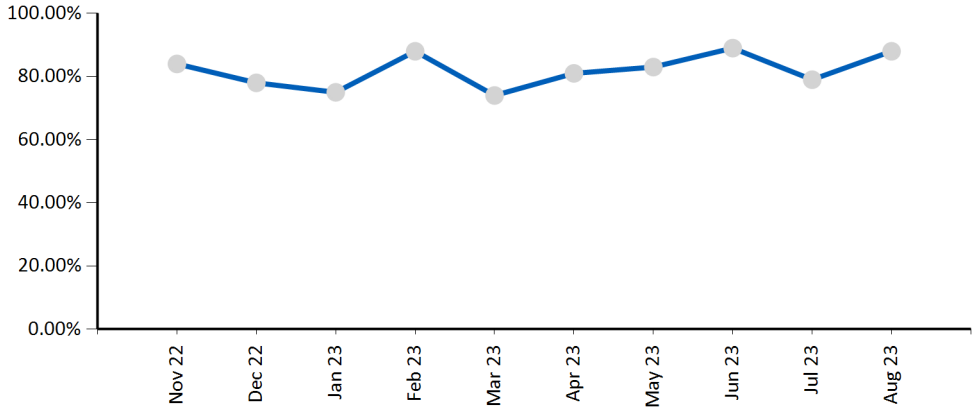
0/6

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

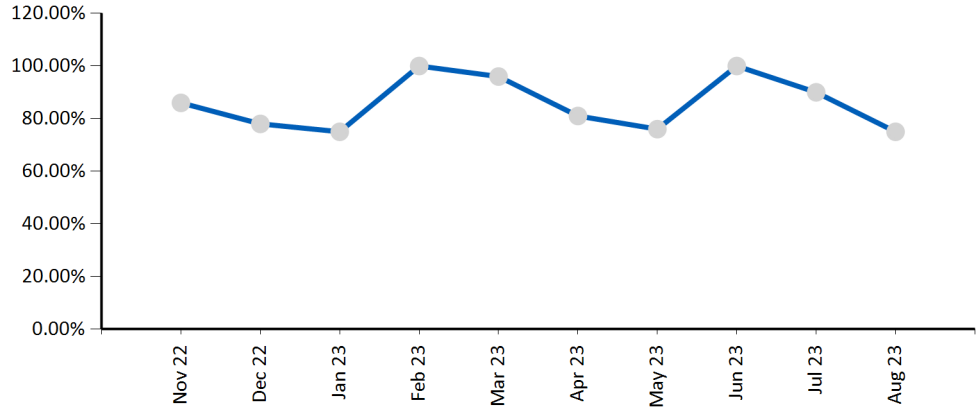


0/6

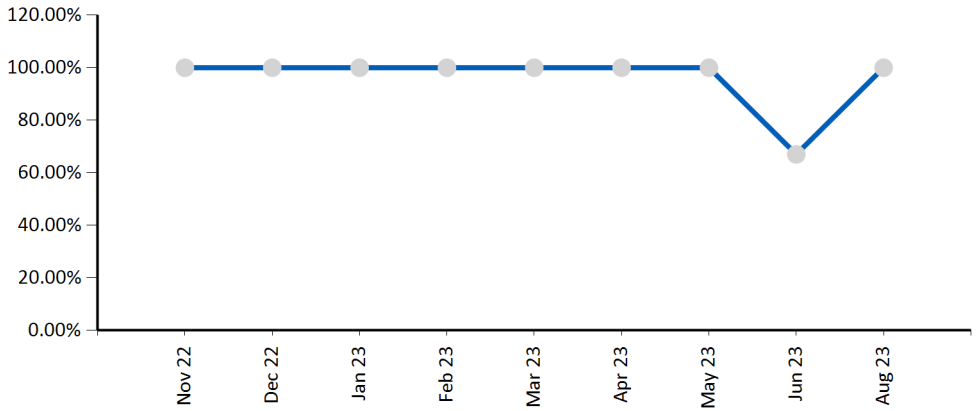
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse - SPC data available after 20 data points



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



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



Workforce

Sickness, Vacancy and Turnover

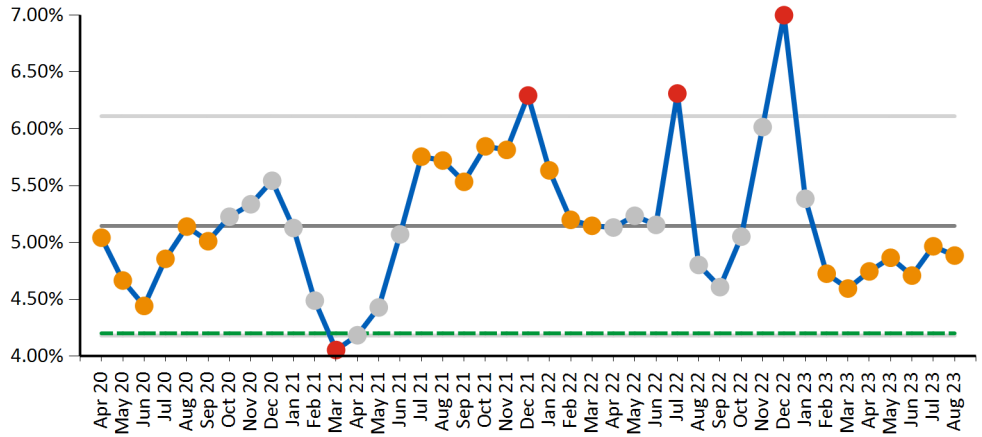
Sickness has decreased slightly in August 2023 to 4.88% from 4.97% in July 2023. The decrease in absence is driven largely by a reduction in sickness in the Anaesthetics and Surgery Division (a reduction of 0.38%), Family Care Division (a reduction of 0.54%) and Corporate teams showing a reduction across a number of teams. All sickness is reviewed monthly through unavailability meetings and HR input is provided to all necessary cases. The rates of Covid related absence however has increased across the Trust and stands at 0.21% compared to 0.13% in July 2023, this still remains low across previous spikes of Covid-19.

The Trust vacancy level remained under our plan (of 6%) at 5.64% in August 2023; maintaining our positive position in this regard when compared to July 2023. We are welcoming a large intake of newly qualified staff (Nursing, Midwifery, and AHP) in September 2023 so expect the vacancy position to continue to improve.

Turnover has remaining fairly static in August 23 at 12.21% from a rate of 12.19% in July 23, this slightly plateau of turnover comes on the back a reducing trends of turnover since January 2023.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.88%	Aug-23	L	<= 4.20%	4.97%	Jul-23	<= 4.20%	4.83%	?
120 - Vacancy level - Trust	<= 6%	5.64%	Aug-23		<= 6%	5.56%	Jul-23	<= 6%	5.94%	?
121 - Turnover	<= 9.90%	12.21%	Aug-23		<= 9.90%	12.19%	Jul-23	<= 9.90%	12.53%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Aug-23	L		2	Jul-23		3	

117 - Sickness absence level - Trust

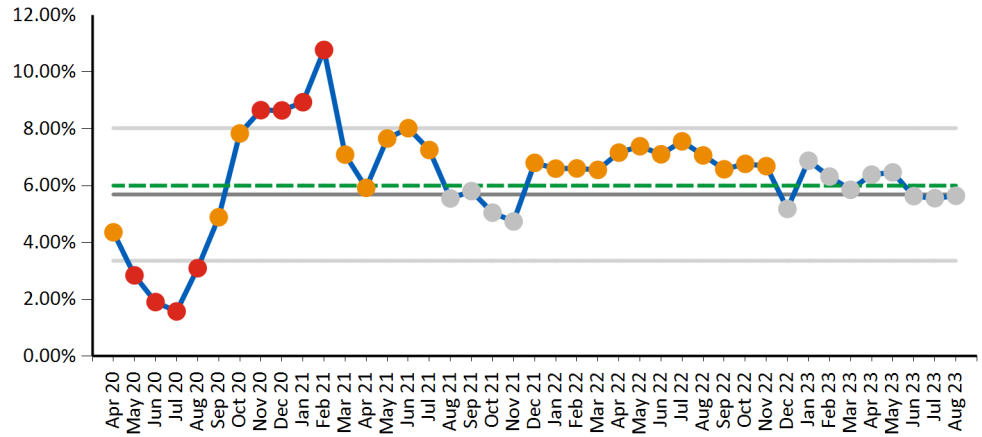


Abnormal variation. Target achieved.

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

0/6

120 - Vacancy level - Trust

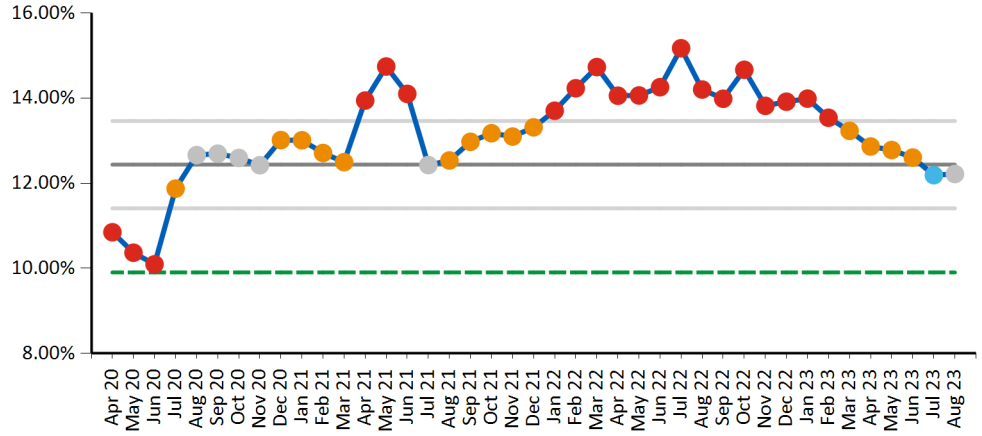


Normal Variation

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

4/6

121 - Turnover

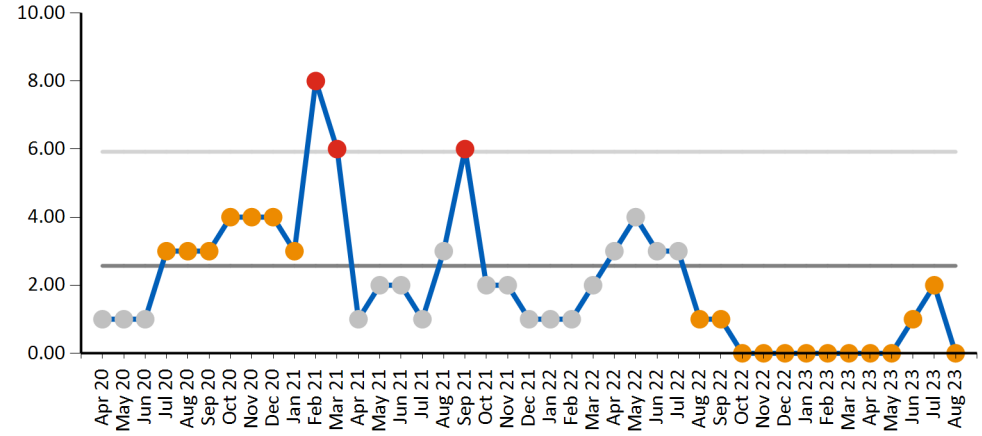


Normal Variation

We will regularly fail to meet the target.

0/6

366 - Ongoing formal investigation cases over 8 weeks



Abnormal variation. Target achieved.

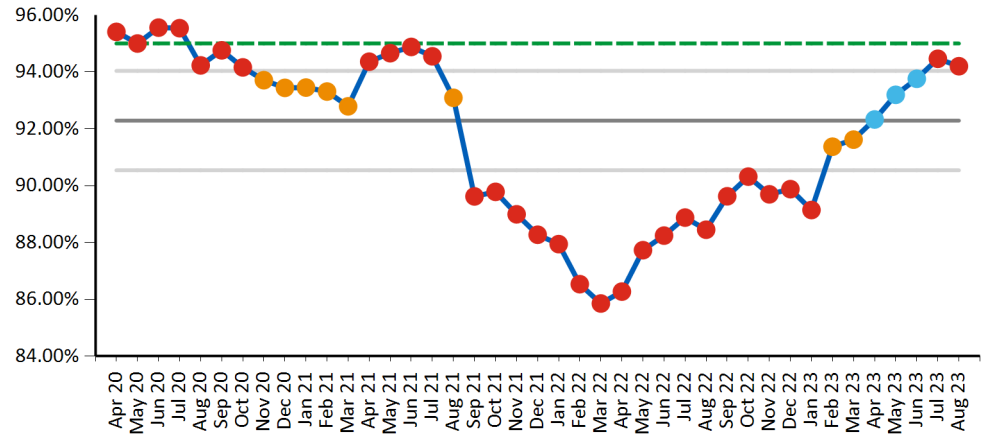
Organisational Development

Mandatory training compliance remains well above the present 85% target at 89.99%. Statutory training is at 94.2% against a target of 95%, almost at target. There was, however a slight dip in performance for both Mandatory and Statutory training compliance in August compared to July figures. This follows a similar pattern to last August and is likely to be linked to annual leave over the summer period.

Appraisal compliance rates have dipped from 86.35% to 85.83%.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	94.2%	Aug-23		>= 95%	94.5%	Jul-23	>= 95%	93.6%	
38 - Staff completing Mandatory Training	>= 85%	90.0%	Aug-23		>= 85%	90.1%	Jul-23	>= 85%	88.8%	
39 - Staff completing Safeguarding Training	>= 95%	94.74%	Aug-23		>= 95%	95.49%	Jul-23	>= 95%	94.70%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.8%	Aug-23		>= 85%	86.4%	Jul-23	>= 85%	86.4%	
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%		

37 - Staff completing Statutory Training

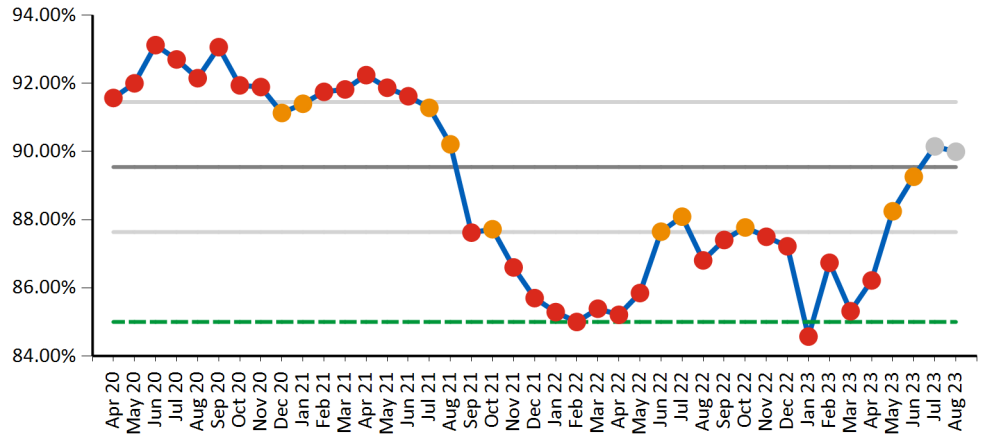


H Abnormal variation. Target achieved.

F We will regularly fail to meet the target.

0/6

38 - Staff completing Mandatory Training

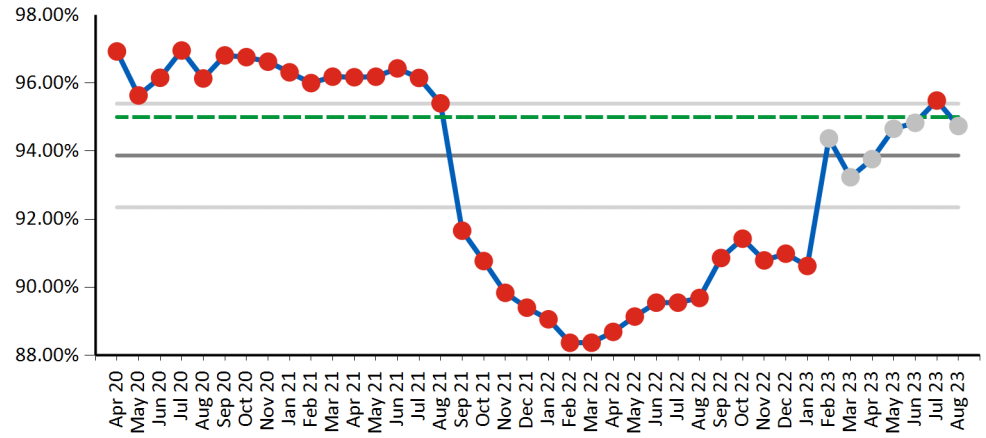


Normal Variation

P Target will be regularly met.

6/6

39 - Staff completing Safeguarding Training

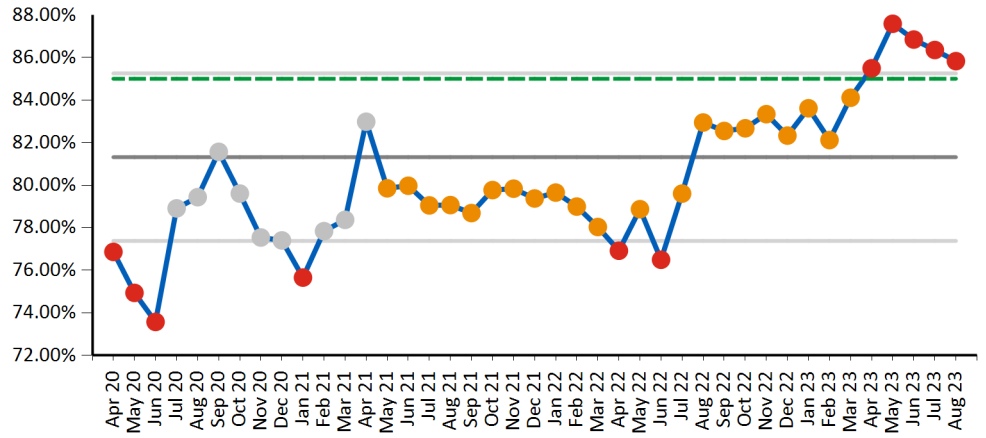


Normal Variation

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

1/6

101 - Increased numbers of staff undertaking an appraisal

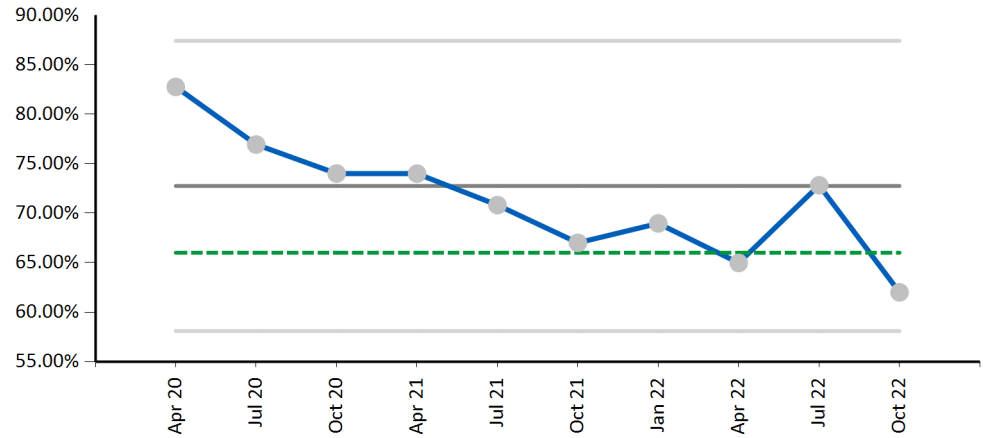


H Abnormal variation. Target achieved.

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

5/6

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

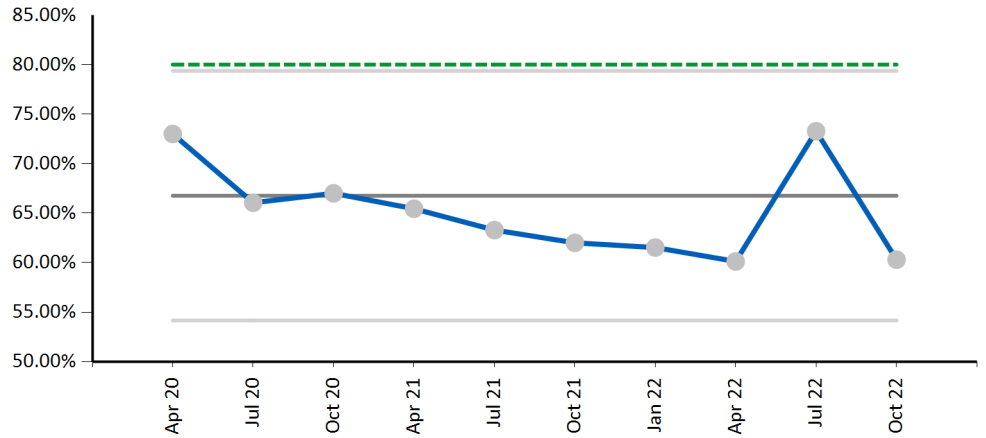


Normal Variation

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.

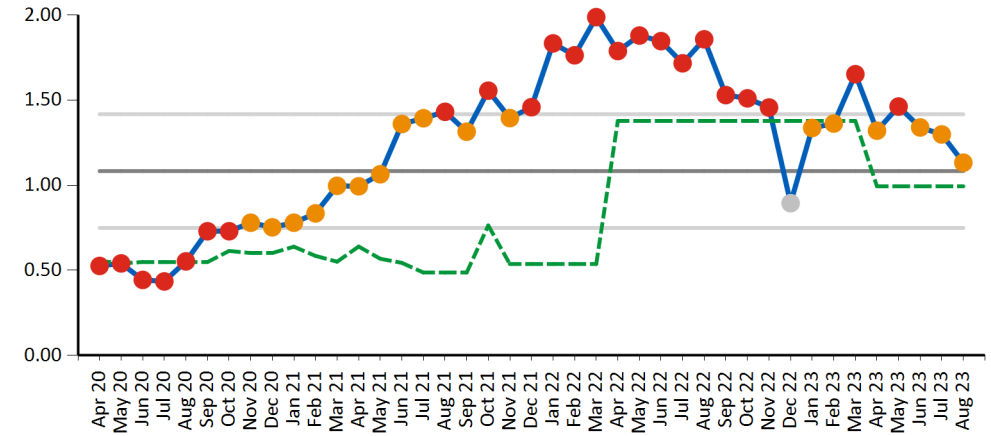
0/6

Agency

Agency expenditure reduced by £167k in August 2023, when compared to July 2023. This maintains a downward spend trend seen over the last quarter with agency spend significantly lower than the same period in 2022. At the end of August 2023 the Trust was £1.6m above our forecasted plan for agency spend, albeit that in-month performance in August 2023 was much closer to that forecast. Nursing agency spend is at its lowest level for the last two financial years thanks in the main to strong recruitment activity and grip and control. Medical agency spending remained static and this is influenced by industrial action, vacancies, and increased capacity.

	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	1.13	Aug-23	H	<= 0.99	1.30	Jul-23	<= 4.97	6.55	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.48	0.32	Aug-23	L	<= 0.48	0.39	Jul-23	<= 2.40	2.28	?
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.39	0.69	Aug-23	H	<= 0.39	0.78	Jul-23	<= 1.96	3.73	?

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

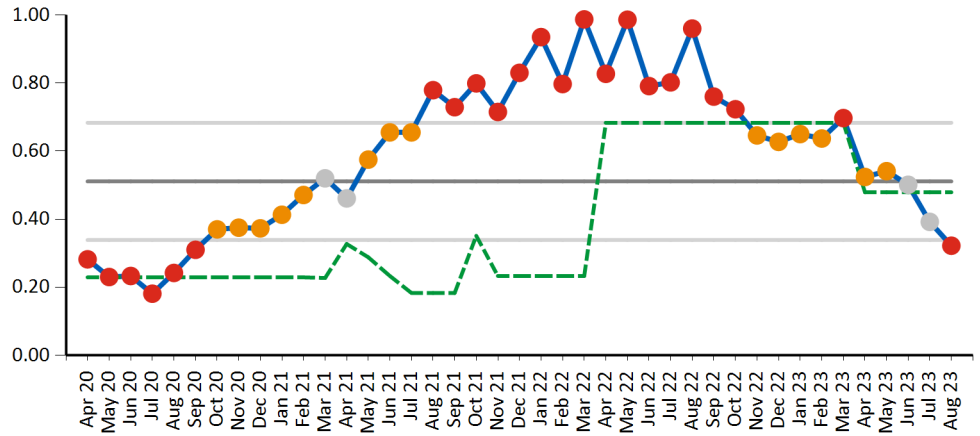


H — Abnormal variation. Target not achieved.

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

0/6

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

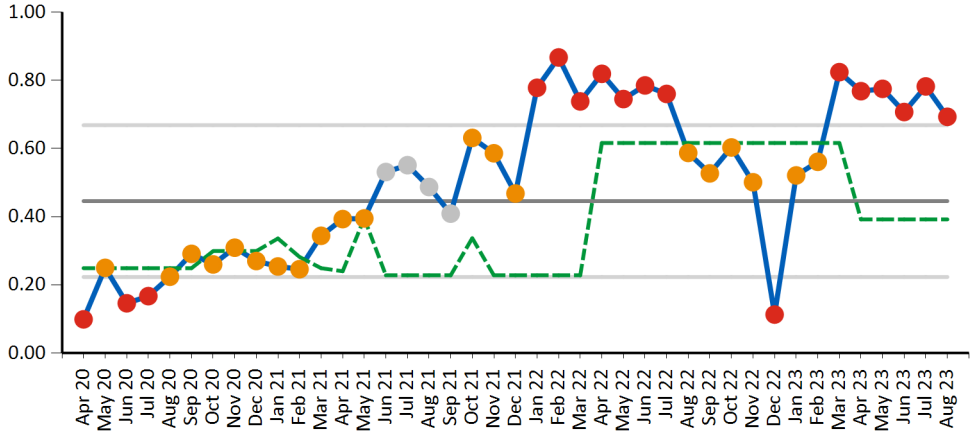


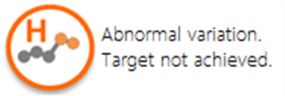
L — Abnormal variation. Target achieved.

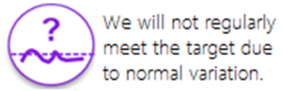
? — We will not regularly meet the target due to normal variation.

2/6

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







Finance

Finance

Revenue – In Month and Year to date
The Trust has a deficit plan of £12.5m for 2023/24. At month 5, the Trust recorded a year to date deficit of £6.6m compared to a planned deficit of £5.3m.

Revenue -Forecast
The probable forecast scenario by March 2024 is a deficit of £18.1m against a plan of £12.4m, which is an improvement from the previous month forecast. This assumes £16.3m of CIP savings against a target of £19.3m.
It is unlikely that the Trust will deliver its financial plan without additional income or reductions in service delivery.

Cost Improvement
The Trust has cost improvement target of 4% (£19.3m) for 2023/24.
CIP trackers currently show that £6m has been delivered against a year to date target of £8m.
£16.3m of CIP delivery is currently forecasted against a target of £19.3m with £13.5m of this rated 'Delivered' or 'Green'. £6m of this forecast delivery is central / technical CIP delivery.

Variable Pay
The Trust spent £4.5m on variable pay in month 5 compared to a monthly average of £4.1m in 2022/23.
The trust is required to spend no more than 3.7% of total pay costs on agency in 2023/24, which is £1.1m per month. A total of £1.1m was spent on agency in Month 5, representing 3.8% of total pay costs in month.

Capital
The Trust has a draft planned capital spend for 2023/24 of £20.8m. Year to date capital spend to the end of month 5 was £4.1m.
We are currently managing a potential capital overspend of up to £6m and working with divisions to reduce the risk.

Balance Sheet
Decrease in total assets employed of £6.6m due to the revenue deficit.
Total aged debt is £4.9m, which is £0.2k better than last month.
Loans outstanding of £35.7m.

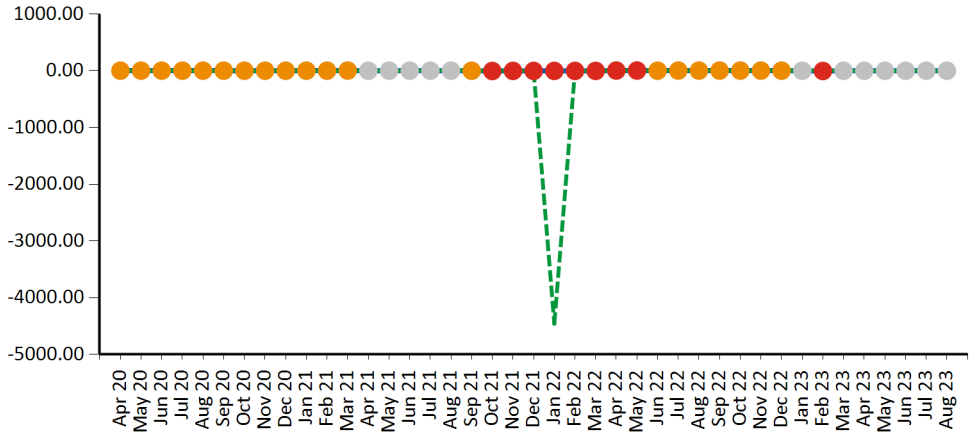
Cash Position
The month end cash balance was £28.7m, this is up on last month by £5.9m. The forecast scenarios indicate cash becoming an issue towards the end of 23/24.

Better Payment Practices Code
Performance of 93.1% in month against target of 95%. Year to date performance by value is 87.7%, which is a slight improvement from the previous month.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.2	-1.3	Aug-23		>= -1.0	-0.6	Jul-23	>= -5.3	-6.6	
222 - Capital (£ millions)	>= 1.4	2.2	Aug-23		>= 1.4	1.3	Jul-23	>= 5.0	4.2	

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
223 - Cash (£ millions)	>= 35.4	27.8	Aug-23		>= 35.9	21.9	Jul-23	>= 35.4	27.8	

220 - Control Total (£ millions)

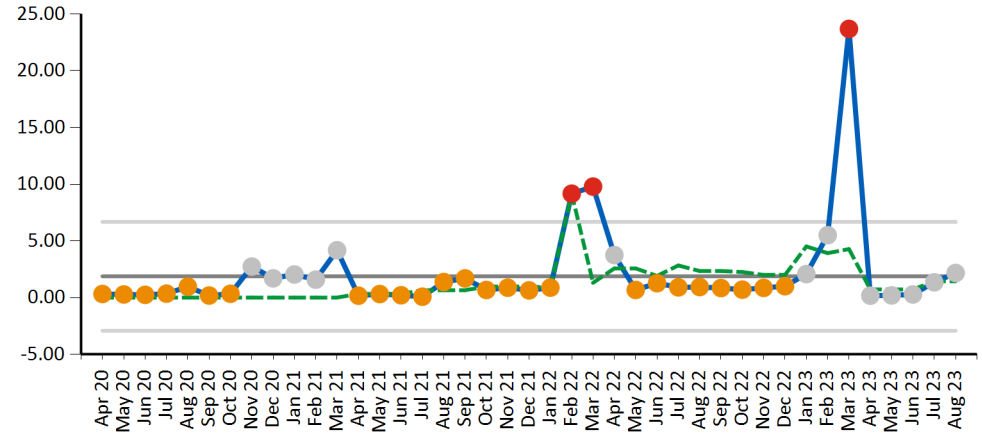


Normal Variation

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

1/6

222 - Capital (£ millions)

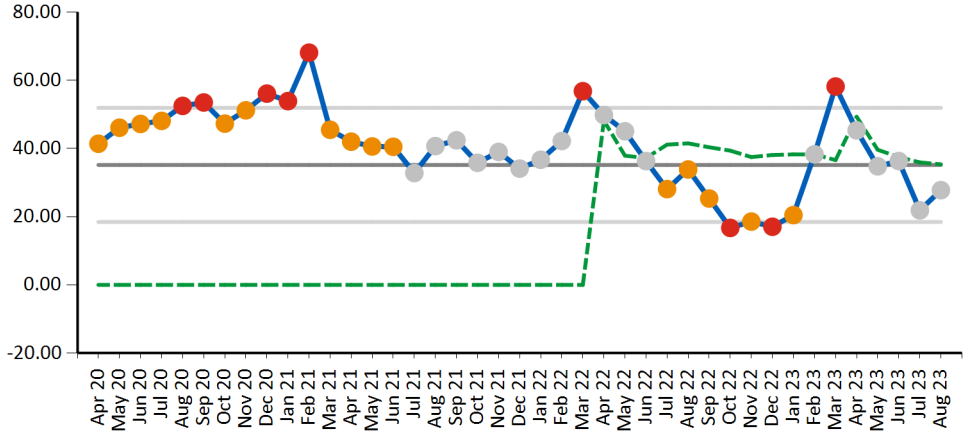


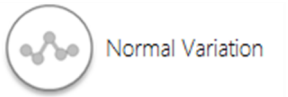
Normal Variation

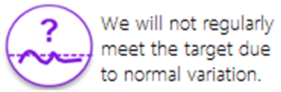
We will not regularly meet the target due to normal variation.

2/6

223 - Cash (£ millions)







Report Title:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Francis Andrews, Medical Director		Decision	

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

Summary:	The attached report from the Chair of the Quality Assurance Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed by the Quality Assurance Committee at their meeting held on 20 September 2023.

Previously considered by:	The report was discussed at the Quality Assurance Committee.

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

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

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

Committee/Group Chair's Report

(Version 4.0 October 2021, Review: October 2022)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	20 September 2023	Date of Next Meeting	October 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, Tyrone Roberts, Martin North, Sophie Kimber-Craig, Carol Sheard, Sharon White and Divisional Representation.	Apologies received from:	Francis Andrews, Harni Bharaj, Fiona Noden, Rae Wheatcroft, Nicola Caffrey, Rauf Munshi, Stuart Bates, Angela Volleamere and Rebecca Lennon.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report		CN / AMD	The paper was taken as read with the Committee noting the following: • There had been one never event which was in relation to a misplaced NG tube and this was being taken through the usual process. • PU Collaborative had seen over 8 months of no hospital acquired Cat 3 pressure ulcers resulting in a statistical special cause improvement, along with community caseload acquired pressure 3 ulcers, and 4 months of no hospital acquired Cat 4 pressure ulcers. • Serious Incident responses within 60 days is still improving. • There had been a focus on same sex accommodation breaches and had seen a reduction. • The Trust had been an outlier with regard to C-Diff for many years and is now looking to focus on process measures and have begun to see improvements in some areas. • 3rd/4th degree tears – there is a learning event being held in January 2024. • There is a deep audit underway to look into the pre-term birth rate and this will be reported back through the usual channels. • Mortality – Both SHMI and HSMR are within expected range, HSMR also now evidence of statistical special cause improvement. Noted to be due to the hard work of clinical teams for recording and the engagement from the coding team.	**Action:** SKC to ensure delivery of amended sepsis audit process by 31.10.23. **Decision**: The Quality Assurance Committee received and noted the report.

	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

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

Committee/Group Chair's Report

			• Sepsis was discussed and noted that the figures in the report are not a reflection of what happens on the wards and so cannot be used to assess performance. This is due to data issues and there is a fix to be addressed on EPR in October. Other indicators used to assess sepsis compliance does not give cause for concern, yet focus to remedy current data issue by end October 2023 • Education work is also vital to improve this further and ensure that the sepsis screening tool is embedded in all learning. JN asked if now that the response rate/target is being consistently achieved does this need to be reviewed to which TR confirmed that this is a nationally set target.	
Clinical Governance & Quality Committee Chairs Report		L Robinson	The chairs reports was received and the Deputy Chief Nurse noted: • Renal Unit and work with GMMH is ongoing and have started to manage/mitigate the risks identified and so will be transferred to the Risk Management Committee for oversight. • GMMH have purchased new equipment and so the Trust Resus Team have requested that full training support is provided. • Divisional Governance Chairs Report has seen an improvement in terms of quality. • ASSD Div Gov chairs report was noted as 'amber' given the outstanding SI actions and mixed sex accommodation breaches. • Procedural Document – There has been a large piece of work to ensure all policies/guidelines are up to date for uploading to the new intranet system. The Trust has 79% which are correct and in date with a further 21% which have expired and so are being addressed via a risk priority process. There was a discussion regarding the Renal Unit where it was noted that Jo Street had liaised with her counterparts at both GMMH and the Renal Unit to make clear the Trusts intentions and to put an appropriate plan in place. In relation to a query regarding oversight and assurance around policies remaining in date LR confirmed that CG&QC will receive a monthly update via the Learning Report and a full Quarterly Review.	**Decision**: The Quality Assurance Committee received the chairs report.

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Committee/Group Chair's Report

Annual Complaints Report 2022/23		Chief Nurse	The report was received and the Chief Nurse noted: • Between April 2022 and March 2023 there had been an increase of 12% in complaints and 45% in compliments. • The response rate to complaints was previously low but is consistently above 85% now. • There is a table showing what has been achieved in response to what was said needed to be done. • A focus has been put on resolution meetings and finding digital solutions for this so patients/ families can have a verbatim record of the discussion with a summary letter to follow. This has reduced the amount of time divisions are having to spend on responses and makes them more timely. There was a discussion regarding the recurring theme of communication being a concern and how this can be addressed and how this was generally in relation to decisions and treatment. SKC noted that 27% had not provided their ethnicity and that there is a need to understand if they were asked to do so and did not wish to or if as a Trust we did not ask the question. This could link in with the work being done by the Health Inequalities Group which is trying to improve how patients are supported and heard.	**Decision:** The Quality Assurance Committee received and noted the update.
NMAHPHCS Priorities Review		L Robinson	The Deputy Chief Nurse presented slides to the Committee and highlighted the following; • The priorities were discussed individually and the Committee noted the progress each one had made since the last review. • Work continues to improve these further and there were actions which needed to be delivered. • HCAs continue to have the highest turnover and so are looking into this to establish why and find ways of retaining these staff and provide development. MN discussed the importance of visibility of the AHP's and HCS's and that as a Board perhaps these areas needed to be seen as much as the wards are.	**Action:** SK to look into visits to AHPs and HCSs by Board of Directors. **Decision:** The Quality Assurance Committee received and noted the update.

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Committee/Group Chair's Report

BoSCA Quarterly Update		Chief Nurse	The report was received and noted: • Trust overall compliance has increased against 17 of the 19 BoSCA standards. • There has been an increase in awarded Silver status from 9 to 19 (111%) since June 22. • 6 Gold BoSCA status were awarded to the District Nursing Services. • Nutrition standard has improved across all bed based from 51.5% to 68.5%. • The report noted the progress made, next steps and transformation work that is underway to further develop the BoSCA accreditation. SW queried why the ICSD Division appeared to be performing higher than other divisions to which TR confirmed that this was due to the starting platforms.	**Decision:** The Quality Assurance Committee received the report.
Cultural Dashboard		C Sheard	The Deputy Director of People presented slides to the Committee and discussed the following; • Themes identified have been categorised into three areas: wellbeing, behaviour and feedback. • The Organisational Development Team is still developing the feedback category. • The gauge slide included in the presentation was not based on factual data and was for demonstration of how the divisions will be presented with their data. • Business Intelligence will be included in this work to provide support.	**Action:** It was agreed that a report is to be presented to the Quality Assurance Committee before transferring to People Committee. **Decision**: The Quality Assurance Committee received the report.
Clinical Coding Update		J Ryan & P Taylor	The report was presented and the Committee noted the following; • On average it can take a coder 10-40mins to complete a single episode of care, there are also 200-900 documents to be looked at in each episode of care. • The Coding Team is fully established with 12 coders and 6 trainees and within this team there are two clinical information leads and additional auditors. • The trainees are audited more frequently and move through all of the specialties via the robust training programme.	**Decision:** The Quality Assurance Committee received the report.

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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

			• The team have set up a clinical coding query facility where input on coding can be sought from clinicians which is showing to be well received. • There are plans to implement a one time code on EPR which means this code will remain with the patient and the team are also now able to access the Greater Manchester Care Records. • A pilot is being run to test a filter which will limit the amount of notes needed in a safe way and is then heavily audited to make sure that the quality of coding does not suffer. There was a discussion regarding the use of AI technology and how this could be of benefit to the coding team but JR expressed caution as the current AI technology in use performs basic coding skills which is the starting point for the trainees and so there needs to be a safe balance but the Trust is putting itself forward as pilot sites.	

Maternity Incentive Scheme Year 4 Progress Update (CNST)		Head of Midwifery	JC presented the report to the Committee noting the following key points:
			• Three CNST safety actions within the year 5 scheme continue to remain at risk namely:
			  ○ Safety Action 5 –The attainment of 100% supernumerary status of the Delivery Suite Coordinator however it was noted that the Trust will achieve 34 wte in Jan 2024.
			  ○ Safety Action 6 - Collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset. This is to be formally escalated to NHS Resolution with the support of the Board of Directors given the difficulties with the provider.
			  ○ Safety Action 8 - Attainment of the training requirements set out in the Core Competency Framework that require 90% attendance of relevant staff groups to be calculated as from January 2023.It was noted the competency requirements have been changed and the Trust is transitioning to the new version.
				Action: JC will share formal response to the items in 'red' on the Safety Champions Dashboard within the report.
				
				Decision: The Quality Assurance Committee received and approved the report.

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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

Committee/Group Chair's Report

			• 18/26 actions within the Price Waterhouse Cooper (PWC) audit action plan have now been completed and the remaining actions. TR highlighted the items flagged as 'red' within Table 2 – Safety Champions dashboard to which JC was unable to provide written narrative for assurance and so was asked to share a response with the Committee following the meeting. There was a discussion regarding Safety Action 6 and the data required and if the Trust had this in a different format than what was required to be submitted or if there was no data at all. JC confirmed that the EPR roll out is planned for Feb 2024 and needs to seek clarification on if this will allow enough time for submission to Year 5 as was not provided assurance last time this was asked.	
Group Health & Safety Committee Chairs Report		S Bates	The Group Health and Safety Committee chairs report was taken as read by the Committee with no escalations to note.	**Decision:** The Quality Assurance Committee received the chairs report.
Professional Forum Chairs Report		Chief Nurse	The Professional Forum chairs report was taken as read by the Committee with no escalations to note.	**Decision:** The Quality Assurance Committee received the chairs report.
Risk Management Committee Chairs Report		Chief Nurse	The Risk Management Committee chairs report was taken as read by the Committee with no escalations to note.	**Decision:** The Quality Assurance Committee received the chairs report.
For Escalation:				

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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

Report Title:	Response to the Countess of Chester Inquiry

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 September 2023		Discussion	✓
Exec Sponsor	Chief Nurse		Decision	✓

Purpose	To provide a briefing on initial national and local response to the Countess of Chester (CoC) Inquiry, with recommendations for next steps

Summary:	This paper provides an overview of the initial national and local discussions subsequent to a nurse being charged on the 18th August 2023, with the murder of seven babies and attempted murder of six others at the CoC neonatal unit. Included within the report are a recap of the presentation provided to the Board of Directors in 2022 following the tragic events reported by Panorama at the mental health unit Edenfield in Bury. Following attendance by CEO/Chairs or their deputies at a recent NHSE event, and discussions at a Safety congress in Manchester, this paper also provides a summation of emerging national recommendations for areas which organisation may wish to review. These include; • **Board governance** • **Freedom to speak up process** • **Flow of data** • **Escalation of concerns process (links to FTSU)** • **Mortality data** The paper also provides an update on various national and local work-streams, which are underway, all with the underlying driver of improving reliability in patient safety. The reports provides a recommendation for ongoing monitoring and reporting whilst also providing some key lines of enquiry for Board colleagues to consider.

Previously considered by:
N/A

Proposed Resolution	The Board of Directors are asked to discuss the contents of the report and to approve the recommendation.

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:	Chief Nurse	**Presented by:**	Chief Nurse

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

PSIRF	Patient Safety Incident Response Framework

Initial response to the Countess of Chester Hospital Inquiry

1. Introduction

On Friday, 18th August, 2023, a 33 year old nurse from the Countess of Chester (CoC) was charged with the murder of seven babies and attempted murder of six others at the CoC neonatal unit. A statutory public inquiry has been launched to understand, again, how tragic events such as these can happen.

In order to provide the Board with assurance on current systems and processes within Bolton FT, it is important to note that confidence levels of 100% are unlikely to be offered within any organization, as to offer such complete assurance would require 100% automation. There have sadly been numerous convictions over the years including; Niels Hogel, a nurse, charged in Germany with the murder of 6 people, Benjamin Green, a British nurse who murdered two patients, Beverley Allit, one of the UKs most infamous female nurse serial killers who murdered four children and who tried to murder a further 9. Nurse Victorino Chua was found guilty of murdering two patients at Stepping Hill Hospital and poisoning others in 2011. Finally Dr Harold Shipman whom, to date, is reported as murdering as many as 218 patients.

With all of these, there have been investigations and inquiries looking at what could have been done to prevent, what should have been done to prevent and what would be put in place going forward. In respect of the CoC inquiry, it is important to recognize that since the period in question (2015 – 2016), there have already been various national systems put in place which 'could / should' have highlighted concerns earlier if they were in place at the time. These include; the medical examiner role, comprehensive neonatal reporting requirements, saving babies' lives interventions and the clinical negligence scheme for trusts (CNST). More recently, the imminent launch of the Patient Safety Incident Response Framework (PSIRF) further builds upon fundamental patient safety work.

The purpose of this briefing is to provide the Board with an overview of the various intelligence sources that are in place to trigger 'alarms' and prompt further review. It will also provide an update on next steps in reviewing the organizations' response to the CoC inquiry.

2. Background

In 2022, the BoD received a presentation update in response to the devastating Panorama programme focused on the mental health unit in Bury, called Edenfield. This response highlighted the following as areas of focus;

- Culture; Boards are responsible for ensuring their organization develops a coherent, effective and forward looking collective leadership strategy
- That good cultural characteristics include; an inspiring vision and narrative, clear objectives at all levels, have supportive people management and leadership, high levels of staff engagement and learning / innovation seen as the responsibility of all
- Behavioral characteristics included; compassionate leadership, commitment to improving patient care, effective involvement of service users, making intelligent use of data, transparency

In responding to the question of 'how do we know?' the following was discussed;

- Collective leadership
- Walk-rounds (BoD programme)
- Clinical walk-rounds and 'work-withs'
- Positively encouraging and seeking the truth
- Joining up the dots; development of the quarterly learning report to pull in all learning in 'one place'
- Executive buddy system

- Tea with Fi (tea with the CEO)
- Partnerships with the trade unions
- Freedom to speak up processes and relationships
- Complaints data and themes
- Serious incident process and learning
- Helpline – 3 steps to the Exec rolled out across all areas of the organization (this line receives circa 50 calls a month – none have required escalation to an Executive as are resolved within a maximum of two conversations)
- Development of real-time feedback including those on a long term community caseloads (first data reports to Clinical and Quality governance October 2023)
- Health watch inclusion
- Extended visiting
- Regulatory involvement; both proactive and reactive
- Staff survey
- Staff networks (BAME, LGBTQ+ and more)
- Executive sponsor for each protected characteristic
- Development of a cultural dashboard – due Q3 23/24
- Focus on turnover hotspots

Currently, triangulation of all intelligent sources is largely reliant upon manual review of data and 'joining the dots' (see later section).

3. National and local emerging areas of focus

NHSE

Through attendance at NHSE and also Safety congress, there are emerging themes that are being given priority for focus. A letter from NHSE was received on the 18th August (see appendix A) and seeks assurance on 5 key areas;

- Staff access to information on how to speak up
- Relevant departments, such as human resources, and freedom to speak up guardians are aware of the national speaking up support scheme
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so
- That Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well
- Boards are regularly reporting, reviewing and acting upon available data

The letter also references the recent strengthening of the fit and proper person test.

A further event that was attended by CEOs, Chairs or their nominated deputies, highlighted the following areas for priority;

- Board governance
- Freedom to speak up process
- Flow of data from 'ward to Board'
- Escalation of concerns process
- Mortality data

- Visibility of unexpected results

Dr Aiden Fowler (National Director of Patient safety) has also re-iterated the following 3 points;

- Do not stop and re-start – instead build upon current systems and processes
- Avoid alienating 'fads'
- To not be tempted by magical thinking and false hope. The aspiration of zero harm is appealing yet potentially unrealistic. To focus instead on learning, learning, learning.

CQC

The revised Care quality commission (CQC) attempts to provide consistency and transparency with how judgements/assessments are achieved. To achieve this, the revised process will focus on 4 key areas; 5 key questions (safe, effective, caring, responsive, well-led), supported by 'we' statements in place of key lines of enquiry. Evidence to support assessment will come from 6 main categories such as patient and staff feedback (staff survey) plus service specific quality indicators (e.g. A&E).

Linking the revised CQC process to 'learning from incidents', an example would be that the CQC will focus on staff experience of reporting incidents, their involvement and the organization works with partners.

PSIRF

Finally, PSIRF (referenced earlier), intends to transform the current national serious incident framework by moving away from 'numbers of serious incidents' to thematic learning and hence positive impact. Quality assurance committee recently heard of the serious incidents reported for falls resulting in moderate+ harm during 21/22 – of all circa 10 serious incidents, the learning was the same across all. This illustrates a failure of the process, with too much time spent investigating with not enough focus on improving. Bolton FT has recognized this, and implemented tests of change, with current statistical process control charts indicating a downward trend (improvement) – to note no special cause improvement yet. PSIRF also focusses on family involvement and adoption of a range of learning / review tools, with the traditional serious incident framework reserved for cases whereby death is deemed to have been unexpected.

4. Next steps

In order to provide Board colleagues with a comprehensive oversight in relation to the areas highlighted, it is proposed that an action plan, developed by the Director of Quality Governance, and reported through Quality and Clinical Governance will be developed.

By way of summary, the action plan will include and monitor;

- **Board governance** (to note the current Good governance institute review of quality governance changes introduced in 22/23 and a review of divisional governance, and peer review of corporate governance led by Company secretary)
- **Freedom to speak up process** (to note also agreement with Bolton FT staff to access Wrightington, Wigan and Leigh's (WWL) FTSU in event that they wish to speak with someone outside of the organization)
- **Flow of data** from 'ward to Board'(links to Board governance)
- **Escalation of concerns process (links to FTSU)**
- **Mortality data**
- **Visibility of unexpected results***

There are also further 'process' measures (these focus on embedded systems and processes as opposed to 'person dependency' which add further reliability to monitoring of safety as follows;

*Current **data / intelligence monitoring** is largely a manual process, with the exception of Mortality data which provides 'alerts' for anomalies. The organization is currently scoping options to incorporate digital solutions that would enhance reliability of ability to detect trends / patterns and to review various differing forms of data input

To review the efficacy of the organization's **Safety management system** (SMS). SMS are widely reported in industries such as aviation, oil etc. yet less acknowledged within healthcare in the UK. The components are adopted within Bolton FT; hazard detection, risk management, monitoring of safety performance, management of change and promotion of safety (through various tools), yet their overall impact and 'joined up' framework requires review.

Patient safety incident response framework; the implementation plan is progressing well with updates due at Quality assurance committee and Board during Q3 23/24. The organization intends to prioritise establishment of a bespoke investigation team and deployment of alternative tools to review incidents. Quality assurance committee September 2023 received a thematic serious incident to cover pressure ulcer prevalence to ensure focus can be on implementation of learning.

The **Quality Improvement strategy**; already in draft and undergoing significant stakeholder engagement with final approval due at Board before the calendar year end. A key focus is Quality improvement capability building and will see various levels of training from 'ward to Board'.

Health inequities; a greater focus on differences in health inequities relating to patient safety has commenced but is in its infancy. Areas of focus in development include a focus on Maternity (previously reported to Quality assurance committee).

Staff engagement; in response to initial draft feedback from the CQC well led inspection in June 2023, the organization has reviewed its staff engagement process and is launching a CEO led engagement process which commences October 2023. Staff engagement cannot be underestimated in terms of its ability to help differentiate 'noise from signal**', supporting the presence of safe cultures across all corners of an organization. ***Noise and signal is often a term used by quality improvement science to differentiate between normal variation and special cause / astronomical (outside control limits) data points). This does not mean 'noise' should be ignored, yet important to recognize the difference*

Finally, other actions already underway in response to both the CoC Inquiry and the CQC draft well-led inspection include;

- Further development for 'middle management' leadership
- Recruitment for values; review and building upon current process
- Turnover; to incorporate case studies for wider organizational learning

5. Conclusion

This report highlights the various intelligence sources that are in place to detect anomalies in data and outcomes that may support detection of untoward systems, processes, or, in very rare events, intentional malpractice. It also highlights the additions already put in place and plans for further improvements to promote reliability of analysis.

6. Recommendations

The Board of Directors is asked to review the contents of this report and consider the following prompts;

- Is the BoD assured with current evidence 'form' available?
- Are any changes needed to ensure continued focus on data anomalies?
- Is there any evidence / intelligence not currently presented?
- Are there any areas that require more focus?

The BoD is also asked to approve the development of an overarching action plan with underpinning work-streams.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	✓
Exec Sponsor:	Tyrone Roberts, Chief Nurse		Decision	

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

Summary:	On the 31 May 2023 NHS Resolution launched year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. As in previous years the scheme incentivises ten maternity safety actions. Key highlights: Three CNST safety actions within the year 5 scheme previously identified as 'at risk' continue to remain at risk, albeit with improved confidence is some aspects: • Safety Action 5 - The attainment of 100% supernumerary status of the Delivery Suite Coordinator. The service has maintained compliance in month but this action remains at risk due to the ongoing staffing deficit of circa 50wte Registered Midwives. Recruitment of newly qualified midwives remains positive (26.09WTE due to commence by end of October 2023 and 6.34WTE due to start in January 2024) and, once supernumerary period achieved, will further facilitate improved confidence with this safety action. • Safety Action 6 - Collation and submission of digital datasets in the absence of a single maternity electronic patient record and digital dataset. The risk to compliance remains due to the current electronic systems not meeting functional requirements. The maternity services and business intelligence teams are working together to implement the required changes within the current systems to enable submission of the required data sets. Confirmation is awaited on 20 data fields currently with no viable solution yet to address.

	• Safety Action 8 - Attainment of the training requirements set out in the core competency framework require 90% attendance of relevant staff groups to be calculated as from January 2023. Current compliance remains below the required standard for all standards with the exception of emergency skills training. The compliance differs per training requirement and staff group with a range of 37% - 98% currently. The service has actively engaged with NHS Resolution to revise the training schedule to meet the year 5 scheme requirements and ensure optimal monitoring of compliance. Due to the additional training requirements and staffing pressures, this safety action remains at significant risk. Eighteen of the twenty-six actions within the Price Waterhouse Cooper audit action plan are now complete and the remaining actions will be complete following the approval of the standard operating procedure and collation of outstanding evidence.

Previously considered by:
Quality Assurance Committee

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

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

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

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

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

1. Introduction

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

2. CNST Year 5 Scheme Update

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

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

3. Price Waterhouse Cooper (PWC) Audit

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

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

3.2 As of 7 September 2023 18 of the 26 actions have been completed and the remaining actions will be completed following the approval of the standard operating procedure and collation of outstanding evidence.

4. Progress Tracker

A summary of progress to date with regard to the attainment of all MIS ten safety actions identified within the CNST year 5 scheme are summarised in the table 1 below. To date three of the safety actions, remain at risk and seven of the actions are on track. The table also shows compliance at indicator level. The report RAG rating has been adjusted in this report to reflect indicators delivered to date. The number of indicators has increased in this report following the publication of revised scheme details in July 2023.

Table 1 – CNST Progress Tracker

CNST Year 5 Progress Tracker						
Action No.	**Maternity Safety Action**	**RAG**	**Number of Indicators**	**Red (Failed)**	**Amber (Awaiting evidence)**	**Green (Achieved)**
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		12	0	11	1
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		11	0	8	3
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		21	0	8	13
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		32	0	32	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		5	0	4	1
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		48	0	48	0

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		13	0	10	3
8	Can you evidence the following 3 elements of local training plans and 'in house', one day multi professional training?		24	0	23	1
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		22	0	13	9
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		10	0	10	0
Total			198	0	167	31

5. Mandatory Updates

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

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

5.3 11 cases have been reported to MBRRACE using the perinatal mortality tool since 30 May 2023 and the required standard has been met for all cases to date (Appendix 1). 22 further cases have been completed during this period. All cases reported since 30 May 2023 are currently awaiting their final report.

5.4 CNST year 5 criteria requires Board to be informed of the deaths reviewed, any themes identified and the consequent action plans. Issues raised by the reviews completed during the year 5 reporting period are detailed within Appendix 1a.

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

5.6 Ensuring a valid ethnic category for at least 90% of women booked in the month of July 2023 is required to meet this standard. The service attained 93.4% compliance as of 1 September 2023 which meets the required standard.

5.7 The provisional indicative scorecard data indicates that the service has met all the required Clinical Quality Improvement Metrics (CQUIMs) submission criteria to date and this has been confirmed by an internal assurance check. Publication of the formal compliance scorecard is awaited on the 21 September 2023 to confirm this position.

5.8 The service can evidence the required sustained engagement with the data quality submission tool and this will be verified as part of the evidential submission.

5.9 A formal email was sent to NHS Resolution on 1 August 2023 detailing ongoing concerns with the Euroking maternity information system currently in the service. The concerns escalated related to the way that some information is being saved in Euroking, resulting in a potential risk that information recorded at one clinical contact in a pregnancy could be copied over to earlier contacts in a pregnancy or records of previous pregnancies, and as such overwrites information previously recorded by the clinician. The concern impacts upon the accuracy of the maternity service dataset and the data being submitted for CNST purposes.

5.10 An email response was received on 8 August 2023 and NHS Resolution advised they are escalating the concern and are working with NHS England to resolve the issue.

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

5.12 A robust process is in place that demonstrates a joint maternity and neonatal approach to the auditing of all admissions to the NNU of babies equal to or greater than 37 weeks is undertaken quarterly. The Q4 and Q1 transitional care and avoiding term admissions to neonatal unit (ATAIN) reports have now been published and shared with the local maternity and neonatal system. The focus of the ATAIN review is to identify whether separation could have been avoided and the action plan to address findings is detailed in Appendix 2.

5.13 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

5.14 An internal audit has been undertaken to confirm that the service is compliant with all requirements to date.

6. Safety actions at risk

6.1 The underpinning detail relating to three safety actions considered to be at risk of non-attainment is as follows:

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

6.3 Supernumerary Status of the Co-ordinator

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

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

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

There were no reported breaches of the supernumerary standard in July and August 2023 on the Birth Rate Plus tool whereby the Delivery Suite Co-ordinator was noted to have delivered 1:1 care to a woman and thus the safety action recommended standard has been maintained.

6.7 This action remains at risk due to the ongoing staffing deficit of circa 50wte Registered Midwives. Every effort continues to be made to mitigate this risk using formal escalation procedures. Recruitment of newly qualified midwives remains positive (26.09WTE due to commence by end of October 2023 and 6.34WTE due to start in January 2024) and, once supernumerary period achieved, will further facilitate improved confidence with this safety action. Recruitment to address the staffing deficit remains ongoing.

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

6.9 Submission of data for this safety action during the year 5 period needs to be made using a national implementation tool that will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle. The tool was published on the 4 July 2023 and is currently being populated with the required evidence prior to sharing with the integrated care board and Trust Board in due course.

6.10 The relevant data items for the required process indicators should already be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the Maternity Services Data Set (MSDS) submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. However due to the delay in the implementation of the end to end maternity digital system, collation and extraction of some of the required data fields has not been possible to date.

6.11 In response scoping work has been undertaken by the Trust business intelligence team in conjunction with the current maternity digital system provider E3 to verify the trust position.

6.12 To date on the E3 maternity system 8 evidential fields should be accessible following upcoming system amends and updates. Further detail is still awaited regarding outstanding 20 fields.

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

6.14 A copy of the current saving babies lives dashboard is detailed within Appendix 3 to illustrate progress to date.

6.15 Quarterly quality improvement sessions with the integrated care board are required during the year 5 reporting period to share the completed national implementation tool and ongoing quality improvements with the integrated care board. The first quality improvement meeting has been scheduled for the 22 September 2023.

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

6.17 The year 5 training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups to be attained in six specified training elements starting from the maternity incentive scheme in August 2021 and up to July 2024. Compliance will be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme. The year 4 submission was based upon the January 2023 dataset and therefore this will be the starting point of the 12-month consecutive period.

6.18 Due to staffing challenges profession specific training compliance has remained below the expected standard of compliance throughout the year 4 scheme and at the point the compliance was reported. The current compliance rate remains below the 90% standard as of September 2023 for 5 of the 6 indicators (Appendix 4). Work is underway to collate an improvement trajectory to recover performance.

6.19 The service has actively engaged with NHS Resolution to revise the training schedule to meet the year 5 scheme requirements and ensure optimal monitoring of compliance can be reported.

6.20 The current service training plan has now been aligned with the national core competency version 2 and GMEC guidance. This includes the introduction of an additional fetal monitoring training day from August 2023.

6.21 A locally held database continues to be used prior to the transfer of the data to the electronic staff record system, which requires significant manual oversight. There is an ongoing plan to transfer the data to the electronic staff record facilitated by the newly appointed substantive member of staff.

6.22 Monthly monitoring of training compliance is currently undertaken at speciality governance meetings with escalation to speciality leads to address non-compliance. Releasing staff to attend training sessions due to staffing challenges remains an ongoing pressure in addition to the revised training schedule that has increased the profession specific training requirements of each individual.

7. Ongoing performance oversight

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

7.2 In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance and will be included in all future reports. All serious incident reviews continue to be shared for the approval of Quality Assurance Committee when completed. Additional required datasets from staff feedback sessions are displayed in Appendix 5.

Table 2 – Safety Champions locally agreed dashboard

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

Indicator	Goal	Red Flag	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23
Quality & Safety								
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		374	454	398	451	461	472
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			1	3	1	2	5	1
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.2	4.6	3.8	4.1	5.1	4.5
HIE Grades 2&3 (Bolton Babies only)	0	1	1	0	0	0	0	0
1HIE (2&3) rate (12 month rolling)	<2	2.5	0.9	0.9	0.9	0.9	0.9	0.9
Early Neonatal Deaths (Bolton Births only)	Information only		1	2	1	1	2	1
END rate in month	Information only		2.7	4.4	2.5	2.2	4.3	2.1
END rate (12 month rolling)	2.4	>3.1	3.5	3.9	3.8	4.0	4.0	3.9
Late Neonatal deaths	Information only		0	0	0	1	0	0
Perinatal Mortality rate (12 month rolling)	7.5	8	8.5	9.1	8.1	8.9	9.8	9.2
Serious Untoward Incidents (New only)	0	2	1	2	0	0	1	1
HSIB referrals			0	0	0	0	0	1
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			1	1	0	0	1	3
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98.5%	96.7%	98%	99.7%	98.8	98.3
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	2	2	1	1	0	0
Saving Babies Lives Care bundle training – e learning	<90%	>90%				13.36%		11.89%
Fetal monitoring training compliance (overall)	<90%	>90%	77.00%	72.16%	78.00%	80.50%	86.46%	84.00%
PROMPT training compliance (overall)	<90%	>90%	82.34%	72.16%	78.00%	91.00%	92.14%	93.00%
Neonatal basic life support (defined cohort)	<90%	>90%						70.62%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:27.1	1:26.9	1:26.8	1:28.9	1:27.2	1:26.9
RCOG benchmarking compliance	Information only		86%	95.8%	100%	93%	100%	
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							

7.3 A review of the local training plan and training database has been undertaken to ensure all six-core modules of the Core Competency Framework can be monitored to demonstrate 90% compliance before July 2024. Currently not all data fields can be captured and work remains ongoing to migrate the training data onto the electronic staff record.

7.4 Training compliance as detailed in the local maternity and neonatal system quarterly submission is detailed in Appendix 4.

Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity serious incidents is required in the CNST criteria. All serious incidents are therefore presented to Quality Assurance Committee in full for oversight and scrutiny and metrics of quality are detailed in the safety champions dashboard. Additional metrics are also included in the monthly integrated performance dashboard published monthly and shared with Board colleagues. Staff feedback from Executive / Non-Executive engagement sessions is detailed in Appendix 5.

7.5 The Q4 triangulation of incident, complaint and scorecard data report was presented at Trust Clinical Governance and Quality Committee in July 2023 and the Family Care Divisional Governance meeting held on 13 July to meet the scheme requirements. Quarterly updates will continue to be provided

7.6 To be noted the maternity service is due to participate in the perinatal culture and leadership programme due to commence in October 2023.

7.7 In Q1 2023/2024 1 serious harm maternity incident was declared and 2 incidents were closed.

Table 3 – Serious harm incident Q1 2023/2024

Serious harm incidents declared – Q1 2023/24			
Incident No	**Cause Groups**	**Specialty**	**Summary of incident**
223575	Delayed/Cancelled Time Critical Activity	Maternity	A woman attended the antenatal day unit with symptoms of a urine infection. The urine culture report subsequently confirmed a urine infection with enterococcus (a bacteria), however this report was not reviewed and she was not commenced on appropriate antibiotics. The baby was born unexpectedly at 28 weeks + 2 days' gestation (pre-term labour).

7.8 Learning was also identified and actioned from a serious incident closed during this period

Table 4 – Learning from serious harm incident Q1 2023/2024

Incident no.	**Type of Incident**
212705	Fetal Loss Above 24 Weeks
	• A review of the fetal monitoring training curriculum, to include tailored direction on optimal principles of action and agreed

	means of escalation following CTG interpretation and management. • CTG training needs to include Dawes Redman interpretation. • The subject of CTG/fetal monitoring training should become a full day of training in itself. • Existing staff to be reminded of the principles of the antenatal monitoring guideline and its instruction in relation to optimal CTG interpretation and management. • New staff should receive an introduction in the interim of formal fetal monitoring training to relevant standing operating procedures that will mitigate the contributory factors highlighted by this investigation and ensure that in the absence of formal training that safety is maintained in response to CTG interpretation.

8. Patient Safety Incident Response Framework (PSIRF)

8.1 An update on the PSIRF framework was presented to Divisional Colleagues on the 23 August 2023.

8.2 Divisional data was triangulated to outline the top 10 cause groups.

NNU-Unexpected Admission	940
Communication Failure/Communication Failure with staff	720
Lack of suitably trained/skilled staff	454
Documentation - Wrong	262
Post Partum Haemorrhage	253
Documentation - Missing/Inadequate/Illegible/found	244
Undiagnosed Intrauterine Growth Retardation	242
Med - Administration	165
NNU Closed	141
Breach of Patient Confidentiality	75
Third and Fourth Degree Tears	75

8.3 The specialities are currently reviewing their local data to inform their speciality patient safety profile to inform the direction of future service development.

8.4 Bi-monthly maternity and neonatal safety champions meetings continue to be held bi-monthly attended by the Board level Safety Champion (Chief Nurse) and the Non-Executive Director to support the escalation of concern to the Board when required. The maternity and neonatal safety champions continue to visit and engage with the clinical areas to understand and support the cultural improvement work ongoing within the service.

9. NHS Resolution thematic review

9.1 On the 14 August 2023 the service was formally notified by NHS Resolution of thematic review which will include all Early Notification cases reported by the Trust, from 1 April 2017 to 31 March 2023: a review of medical notes and/or investigation reports from the Healthcare Safety Investigation Branch (HSIB) where available. It will also include non-Early Notification maternity claims brought against the Trust between April 1, 2013, and March 31 2023.

9.2 The review was commissioned due to the declared compliance with the CNST Year 4 submission in addition to 24% of claims brought against the Trust in the last 10 years pertaining to maternity services. The review is being undertaken to improve safety and learning and the timeline for completion of the thematic review is September 2023.

10. Risk

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

11. Financial

11.1 On the 9 June 2023 the Trust was received £221k discretionary non recurrent funds to support the delivery of the safety actions that were not attained in the CNST year 4 programme of works following approval of a detailed action plan. Recruitment will commence to recruit to the non–recurrent posts following approval at CRIG on 5 September 2023.

11.2 Approval has also been given to appoint to all recurrent posts identified in the Saving Babies Lives financial award to support the delivery of safety action 6.

12. Summary

12.1 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**.**

12.2 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.

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

13. Recommendations

It is recommended that the Board of Directors:

i. Receive the contents of the report

ii. Approve the actions plan detailed within this report

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

Appendix 1 – Cases reported to MBRRACE from 30 May 2023

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	1 month surveillance Deadline Date	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/concerns questions	Report to draft Deadline Date 4 months	Report published Deadline Date 6 months
87775	SB	26+6	1.6.23	2	1.7.23	1.8.23	31.5.23 15.7.23	1.10.23 **Draft done 31.8.23**	1.12.23
87828	SB	36+2	6.6.23	0	6.7.23	6.8.23	8.6.23 15.6.23	6.10.23 **Draft done 31.8.23**	6.12.23
88155	SB	32+2	24.6.23	5	28.6.23	28.6.23	28.6.23 19.8.23	24.10.23 **Draft 28.9.23**	24.12.23
88233	SB	24+3	30.6.23	3	30.07.2023	30.08.2023	30.06.2023	30.10.2023 **Draft 28.9.23**	30.12.2023
88360	SB	28+4	11.7.23	1	12.8.23 done 12.7.23	12.09.23 done 12.7.23	12.7.23	12.11.23 **Draft 05/10/23**	12.01.24
88409	SB	36+3	13.07.23	1	13.08.23 Done 14/7/23	13.09.23 Done 14/7/23	13.7.23	13.11.23 **Draft 05/10/23**	13.01.24
88621	ENND	23+3	23.7.23 26.7.23	0	26.8.23 done 27/7/23	26.8.23 done 31/7/23	1.8.23	26.11.23 **Draft 12.10.23**	26.01.24
88814	SB	25+2	7.8.23	1	7.9.23	7.10.23	7.8.23 10.8.23	7.12.23 **Draft completed 10.8.23**	7.2.24

88887	SB	41+1	13.8.23	1	Assigned to MFT	Assigned to MFT	15.8.23 17.8.23	13.12.23 **Draft 7.12.23**	13.2.24
89209	SB	27+6	31.8.23	1	30.9.23	31.10.23	1.9.23	31.12.23 **Draft 21.12.23**	29.2.24
89239	SB	39	4.9.23	0	4.10.23 Done 4.9.23	4.11.23	4.9.23	4.1.24	4.3.24

Appendix 1a – Extract from the PMRT database board summary report – actions planned in response to issues identified following completed reviews.

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
A full review of the CTG /fetal monitoring training curriculum is required to include tailored direction on optimal principles of action and agreed means of management and escalation following CTG interpretation when used in conjunction with Dawes Redman interpretation/ clear guidance relating to the Dawes Redman criteria management when the criteria is not met and the STV is >4	1	Review current training with Practice Education Facilitators and implement any changes to training identified
Advised to attend nearest hospital which does not have a maternity unit	1	Finalised SI report to be anonymised & shared with NWAS for their information & learning
Delay in ambulance transfer of 3 hours from Bury A&E to Bolton maternity unit	1	Finalised SI report to be anonymised & shared with NWAS for their information & learning
Delayed recognition of AKI	1	1.Case to be presented as a mortality & morbidity case at obstetric teaching session 2. To promptly order & chase blood results in case of reduced urine output
Existing staff must be reminded of the principles of the antenatal monitoring guideline and its instruction in relation to CTG interpretation and management.	1	Remind all staff of principles of antenatal monitoring guideline
Investigation findings to be shared with relevant professional and reflection to be requested.	1	Meeting to be held with staff members
New staff should receive an introduction in the interim of CTG/fetal monitoring training	1	Amend induction curriculum to include introduction to Fetal monitoring and the principles outlined in this incident
Share the lessons and learning with all midwives and doctors	1	Investigation findings to be shared with relevant professional and reflection to be requested. Share the lessons and learning with all midwives and doctors
This mother has a history of pregnancy induced hypertension and her antenatal care was not appropriate given this history	1	Community matron to cascade to community midwives of the importance of following pathway of AN schedule
To ensure there is reliable systems and processes in place to ensure etc. Escalation if suboptimal medical cover in ANDU to be included in escalation policy	1	No action entered

Appendix 2 ATAIN action plan

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

					on 11 July 2023		
		ICB	Director of Midwifery	1 February 2024			
		Trust Board	Director of Midwifery	1 February 2024	12.07.23 Action plan shared at QAC – delegated committee of Board		
3		Use national ATAIN for auditing purposes	Maternity Governance Lead	30 July 2023	12.07.23 National tool used for data collation and review.		
4		Add further detail to the ATAIN pro-forma to support identification of trends and contributory factors to unexpected Neonatal Admissions in Q1 2023-2024 audit proforma	Maternity Governance Lead	30 July 2023	07.09.23 GMEC ATAIN audit tool implemented for use in Q2		
5		Undertake a deep dive review of respiratory distress as the main cause of admission to NNU at term	Consultant Neonatologist	1 January 2024			
6	Potentially unavoidable admissions	Review Trust lactate guideline as a contributory factor for potentially avoidable admissions to Neonatal Unit	Consultant Neonatologist	1 Nov 2023			
7	Trusts should have or be working	Review and update the Transitional	Matron Complex Care	30 April 2023	03/03/2023 Guideline reviewed and		

	towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.			updated and awaiting ratification at guideline group. On agenda for Guideline Group March 2023. 12/07/23 Guideline updated May 2023	
8		Implement full the BAPM transitional care framework for practice	Postnatal Ward Lead Complex Care Matron	1 February 2024	07.09.23 Benchmarking in progress	

Appendix 3 – SBLV2 dashboard

Saving Babies Lives Care Bundle V3 Process Outcomes & Indicators Dashboard	Frequency of Audit/Assessment	Current performance	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep 23	Data indicator
Reduction in still births of 50%		National ambition - not currently being achieved.	By 2025							
Reduction in pre-term births to 6%		National ambition - not currently being achieved.	**6%**							
CNST Year 5 Target:	Annual	Demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. (Calculated within the national implementation tool once available)	**70%**	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		
1.a.i. CO measurement at booking appointment	Monthly	Non-compliant. Action plan in place	**95%**	71.96%	86.60%	86.08%	88.29%	Data not yet collected		Field in E3
1.a.ii. CO measurement at 36-week appointment	Monthly	Non-compliant. Action plan in place	**95%**	62.27%	56.53%	66.28%	65.19%	Data not yet collected		Field in E3
1.a.iii. Smoking status** at booking appointment	Monthly	Issues with data collection. Action plan in place	**95%**	Data not yet collected	Data not yet collected	Data not yet collected	100% (Collected via manual audit)	Data not yet collected		Field in E3

1.a.iv. Smoking status** at 36-week appointment	Monthly	Issues with data collection. Action plan in place	**95 %**	Data not yet collected	Data not yet collected	Data not yet collected	100 % (Collected via manual audit)	Data not yet collected		Field in E3
1b. Percentage of smokers* that have an optout referral at booking to an in-house tobacco dependence treatment service.	TBC	Non compliant with target	**95 %**	Awaiting data	Awaiting data	Awaiting data	Awaiting data	70.00%		E3 confirmed needs to add field
1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	TBC	Non compliant with target	**60 %**	Awaiting data	Awaiting data	Awaiting data	Awaiting data	50.00%		E3 confirmed needs to add field
1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks.	TBC	Non compliant with target	**TBC.**	Awaiting data	Awaiting data	Awaiting data	Data not yet collected	Data not yet collected		E3 confirmed needs to add field
1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks.	TBC	Non compliant with target	**60 %**	Awaiting data	Awaiting data	Awaiting data	Data not yet collected	Data not yet collected		E3 confirmed needs to add field
2a. Percentage of pregnancies where a risk status for FGR is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.)	Monthly	Compliant	**80 %**	99.30%	97.70%	99.40%	97.60%	Data not yet collected		Awaiting E3 to confirm field or new field
2b. Percentage of pregnancies where an SGA fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital.	Quarterly	Non-compliant. Data current collected via Perinatal Institute. Unable to collect data from current MIS(E3).	**43.8% (GAP Average)**	57.50%			Data not yet collected (Released October 23)			Awaiting E3 to confirm field or new field
2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	Annual	Data report required from MMBRACE. Collected annually.	**N/A**	Data not applicable to E3						
2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR).	Quarterly	Data not yet collected via MIS/BI	**As low as possible**	50.70%			Data not yet collected (Released October 23)			Awaiting E3 to confirm field or new field

2e. Percentage of babies >3rd birthweight centile born <39+0 weeks gestation	TBC.	Data not yet collected via MIS/BI	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Awaiting E3 to confirm field or new field
3a. Percentage of women who attend with RFM who have a computerised CTG.	TBC.	Data not yet collected via MIS/BI	**100 %**	100 %	100 %	Data not collected	100 %	Data not collected		Awaiting E3 to confirm field or new field
3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth.	TBC.	Data not yet collected via MIS/BI	**100 %**	100 %	100 %	Data not collected	100 %	Data not collected		Awaiting E3 to confirm field or new field
3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT.	Annual	Data report required from MMBRACE.	**N/A**	Data not applicable to E3						
3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.	TBC.	Data not yet collected via MIS/BI	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Awaiting data		Awaiting E3 to confirm field or new field
4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness.	TBC.	Non-compliant. Action plan in place	**90 %**	76.16%	Awaiting data	Awaiting data	Awaiting data	Awaiting data		Data not applicable to E3
4b. Percentage of staff who have successfully completed mandatory annual competency assessment.	TBC.	Non-compliant & challenges monitoring compliance accurately. Action plan in place.	**90 %**	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data		Data not applicable to E3
4c. Fetal monitoring lead roles appointed	TBC.	Appointed. However insufficient hours within job plan of obstetric lead.	**N/A**	Non Compliant	Non Compliant	Non Compliant	Non Compliant	Non Compliant		Data not applicable to E3
Outcome indicators										
4d. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor.	TBC.	Non-compliant in collecting data	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Data not applicable to E3

*Using the severe brain injury definition as used in Gale et al. 2018.										
5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)	Monthly	Data not yet collected via MIS/BI	**100 %**	100 %	100 %	100 %	100 %	Data not yet collected		Awaiting E3 to confirm field or new field
5b. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.	Monthly	Data not yet collected via MIS/BI	**40 %**	43%	50%	43%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5c. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth.	Monthly	Data not yet collected via MIS/BI	**80 %**	83%	100 %	60%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.	Monthly	Data not yet collected via MIS/BI	**No Target Set**	43%	25%	0%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.	Monthly	Data not yet collected via MIS/BI	**50 %**	79%	70%	86%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5– 37.5°C and measured within one hour of birth.	Monthly	Data not yet collected via MIS/BI	**65 %**	71%	100 %	71%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.	Monthly	Data not yet collected via MIS/BI	**No Target Set**	71%	90%	100 %	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)	Monthly	Data not yet collected via MIS/BI	**N/A**	66%	76%	66%	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field

5i. Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)	TBC.	Data not being collected by BI & SBL Lead no access to data - to review where this is collected.	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5j. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: a) Germinal matrix/ intraventricular haemorrhage b) Post haemorrhagic ventricular dilatation. c) Cystic periventricular leukomalacia	TBC.	Data not being collected by BI & SBL Lead no access to data - to review where this is collected.	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	TBC.	Data not being collected by BI & SBL Lead no access to data - to review where this is collected.	**As low as possible**	Data not yet collected	Data not yet collected	Data not yet collected	Awaiting data	Data not yet collected		Awaiting E3 to confirm field or new field
5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births:										Awaiting E3 to confirm field or new field
a) in the late second trimester (from 16+0 to 23+6 weeks).	TBC.	Review of data collection/submission methods required.	N/A	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Awaiting E3 to confirm field or new field
b) preterm (from 24+0 to 36+6 weeks).	TBC.	Review of data collection/submission methods required.	N/A	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Awaiting E3 to confirm field or new field

6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with preexisting diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc).	Annual	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant		Data not applicable to E3
6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	Annual	Evidence required.	N/A	Evidence required.	Evidence required.	Evidence required.	Evidence required.	Evidence required.		Data not applicable to E3
6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets.	Annual	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant		Data not applicable to E3
6d. Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes.	Annual	Provided by Diabetic Specialist Nurses - Evidence required.	N/A	Evidence required.	Evidence required.	Evidence required.	Evidence required.	Evidence required.		Data not applicable to E3
6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	Annual	Partially compliant. New Guideline being developed.	N/A	Evidence required.	Evidence required.	Evidence required.	Evidence required.	Evidence required.		Data not applicable to E3
6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the NPID dashboard (aiming for >95% of women). (Should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups).	TBC.	Non-compliant in collecting data	95 %	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Data not applicable to E3
6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). (Should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups).	TBC.	Non-compliant in collecting data	95 %	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected	Data not yet collected		Data not applicable to E3

Appendix 4

Name of Maternity Provider: Royal Bolton Hospital – 05.09.2023				
Time Period reporting on (please tick) January to April (Report in May) ☐ May to August (Report in September) x September to December (Report in January) ☐				
Core training as per core competency assessment	**Percentage of staff who are compliant with training**			
	Midwifery staff	Obstetric Staff	Anaesthetic Staff	Other Staff Groups
Percentage staff trained *Example: Fetal monitoring*		*90%*	*86%*	*82%*
Fetal Monitoring Training	***71%***	***80%***	*N/A*	*N/A*
Saving Babies Lives Care Bundle	***72%***	***37%***	*N/A*	*N/A*
Maternity Emergencies and multi-professional training *Please specify which topics under this heading you have undertaken for this period* • Breech Birth • Antepartum Haemorrhage • Impacted Fetal Head • Cord Prolapse/	***95%***	***98%***	***98%***	***86%***
Neonatal Life Support	***97%***	*N/A*	*N/A*	*N/A*
Care during labour and the immediate postnatal period *Please specify which topics under this heading you have undertaken for this period* • Management of epidural anesthesia • Recovery care after general anesthetic	***43%***	*N/A*	*N/A*	*N/A*
COVID-19 Specific training	*N/A*	*N/A*	*N/A*	*N/A*

Maternal Critical Care	*No data*	*No data*	*No data*	*No data*
Personalised Care *Please specify which topics under this heading you have undertaken for this period* *Safeguarding* *Mental Health*	***43%***	*N/A*	*N/A*	*N/A*
Targeted local learning	***43%***	*N/A*	*N/A*	*N/A*

Appendix 5

Feedback from Executive / Non-Executive Staff Walkabouts

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

Report Title:	People Committee Chair's Reports – September 2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

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

Summary:	The attached report from the Chair of the People Committee provide an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed by the People Committee at their meeting held on 19 September 2023.

Previously considered by:	The report was discussed at the People Committee.

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

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

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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	19 September 2023	Date of next meeting:	17 October 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Malcolm Brown, Paul Henshaw, Claire McPeake, Carol Sheard, Laura Smoult, Toria King, Sophie Kimber-Craig, Chris Whittam, Lianne Robinson, Lisa Rigby, Rachel Carter, Sharon White, Andy Chilton	Quorate (Yes/No):	Yes
		Apologies received from:	Fiona Noden, Jo Street, Francis Andrews, Tyrone Roberts, Annette Walker

Key Agenda Items:	RAG	Key Points	Action/decision
EDI Update and the Future of Bolton EDI (Equality, Diversity & Inclusion)		• The Committee considered the EDI Update. It was noted that there are new requirements following the publication of a Framework by NHSE. There are a number of other elements that are required to be actioned including the Trust's ambitions in this area. Overall there are c200 actions of which 100 are rated as Priority 1.However it was noted that action is already underway in some of the areas.	The EDI & Staff Experience meetings are currently combined and will be split going forward to ensure dedicated focus on EDI. The report is recommended to the Board of Directors for consideration and approval. The Committee recommends that EDI is included in the Board Assurance Framework as a Strategic Risk given the focus being given to this area.
Workforce Race Equality Standard (WRES), Bank WRES, Medical WRES and Workforce Disability Equality (WDES) Report		• The Committee considered the WRES and WDES. These are the Annual Reports which are submitted to NHSE. Overall the reports reflect areas of improvement but also areas where the results have fallen. The key issue will be the Action Plan referenced in the previous item.	The report is recommended to the Board of Directors for consideration and approval.
Agency Update		• Report demonstrated that agency expenditure has been on a downward trajectory over the reporting period (June 2023 to Aug 2023). In June 2023 Trust overall expenditure reduced by £123k in-month (when compared to May 2023), and expenditure reduced further by £41k in July 2023, and by a further £167k in August 2023, when compared to the previous month. • Trust agency expenditure position at the end of M5 (Aug 2023) was £1.6m above the forecast we submitted at the start of the financial year, although August 2023 spend was close to the forecasted spend for that month. • Good progress made with nursing agency spend (at its lowest level for a number of years); more work needed on medical agency which has been static for a number of months and the report included some medical pipeline reporting which demonstrated the impact of medical recruitment on medical agency.	Committee members noted the report.

	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

		• Report outlined the controls in place across the Trust; which include a clear instruction to cease usage of admin and estates agency, and enhanced approval processes in relation to agency placements expected to last for more than 28 working days. • The Committee noted that the transition to NHSP was currently taking place and would be operational from this month. This hopefully would also result in a reduction in Agency spend through the more effective use of the Bank.	
Absence Report/Attendance Management		• Sickness absence remains above Trust target, however comparatively this is lower than the previous year and has reduced from the levels in January 2023 (from a rate of 5.54% to 5.10% in July). • Covid related sickness has reduced however other sickness absence reasons (Gastro) has increased, with reasons for absence starting to mirror pre-covid position. • The Trust benchmarks well for sickness absence across GM Trusts – this data is to be reintroduced to the report.	• The Committee noted updates in the report. • Future reports to include formal policy management (included in a separate report) for wider context and analysis. • Additional triangulation of information to be brought to future reports and linked to wider culture dashboard work.
NHS Staff Survey – Staff Engagement Plan Update		• An update was provided on the Trust's high-level Staff Experience Plan, which addresses Trust-wide areas of concern and amplifies examples of good practice. • The actions are focused around the nine themes from the 2022 NHS staff survey and sets out the key priorities for 2023/24 include developing and launching our new BAME Leadership Programme, delivery of the various EDI requirements, 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. • The Staff Experience Steering Group will monitor the delivery of the Staff Experience Plan.	The Committee approved the Trust's high-level Staff Experience Plan and it was agreed that a presentation would be brought back to a future meeting on the Trust's Staff Listening Programme as a lot of activity is happening to bring together all Trust-wide colleague feedback, including the staff survey results, into an overarching Staff Listening Programme.
Mandatory & Statutory Training Update		• Divisional and Corporate teams have worked hard to support staff to complete Mandatory and Statutory training, leading to an improvement in compliance rates. As of the 5th September, Mandatory Training is reported as 89.99% (well above the current target of 85%) and Statutory at 94.20% (almost as the current target 95%).	Proposals 1 & 2 were agreed. After a detailed discussion it was agreed to postpone a decision on item 3 (targets), engage further with Divisions and bring a further update to the October meeting.

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	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

		• The Committee had previously agreed that a review of the Statutory and Mandatory training requirements would be undertaken and the report was presented to the Committee. The Committee considered a number of changes to the programme which had been reviewed by subject matter experts. It was noted that some requirements were role specific. Approval / decision was sought on the following 3 proposals: 1. Realigning the Trust's mandatory and statutory training requirements to the national Core Skills Training Framework (CSTF). 2. In relation to the above, renaming Statutory training 'Compulsory Training' and renaming Mandatory Training 'Trust Mandated'. 3. Refresh the compliance targets as a staggered, phased approach with a view to the target for both Compulsory and Trust Mandated Training gradually increasing to 95% for both by April 2025.	
Appraisal & Revalidation – Final Action Plan – Bolton & ABL Health		• The Committee received a report on the governance arrangements in place in relation to medical appraisal, revalidation and managing concerns. • Under the NHS England Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation, organisations are encouraged to report on their appraisal data via an Annual Board Report and Statement of Compliance. This report is the detailed response and sets out the achievements and challenges around appraisal and revalidation for medical staff. • Report also received for sign off for ABL Health, which is the Laser Clinic on site. This is due to Dr F Andrews being the Responsible Officer.	S Kimber-Craig to discuss with S Katema the process for signing off ABL Health. If agreement made, to be presented to Board in September. The Committee recommended approval of the reports by the Board of Directors subject to the query on ABL Health.
Locality Workforce Transformation Update		A brief update / presentation on the workforce priorities of the Bolton People & Culture Group was shared, however we were out of time and the Committee felt this item was too important to rush.	Agreed to bring an update and People & Culture programme to the November meeting.
Steering Group Chair Reports		Noted	
Divisional People Committee Chair Reports		Noted	
IPM Workforce & OD Dashboard		Noted, with a query raised on two of the metrics.	These metrics to be updated.

Matters for escalation to the Board: EDI/WRES/WDES

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	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

Title:	Workforce Race Equality Standard (WRES), Bank WRES, Medical WRES and Workforce Disability Equality Standard 2023 Reports

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	28 September 2023		Discussion	✓
Exec Sponsor:	James Mawrey, Director of People/ Deputy CEO		Decision	

Purpose:	The purpose of this report is to provide assurance on the Trust's commitment to becoming a great place to work ensuring there is no disparity between the experiences of our workforce.

Summary:	The annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are contractual national data collections, which promote equality of career opportunities and fairer treatment in the workplace. The experiences of BAME and disabled colleagues are measured against their counterparts. Bank WRES data is being collected for the first time this year, but responsibility for making improvements will shift over to NHS Professionals as they take over responsibility for day to day management of temporary staffing from the Trust. MWRES has changed from a national collection to a trust-level collection and the Trust have submitted data to the National Team. These raw data submissions are included in the Appendices. The Trust awaits the analysis report from the WRES national team for MWRES. Raw data submissions for all four frameworks were successfully submitted before the 30 June deadline. The associated action plans for WRES and WDES must be submitted by 31 October. This wider timeframe has allowed the BAME Staff Network and Disability and Health Conditions network to input into the development of the action plan, translating evidence into meaningful action. Some of the actions from these plans are summarised in this paper, and these are aligned with national mandatory frameworks. Within the report national comparisons have been offered although these are from previous years. The Trust has achieved an improved position for a number of indicators (5 out of 9 for WRES and 5 out of 10 for WDES.) All indicators are better than the national average, apart from one: staff having reasonable adjustment requests met (72.1% compared to 76%) nationally. This aspect of inclusion for our disabled staff is one of the top priorities to improve this year in the EDI plan. We recognise that more work is required to create a fully inclusive culture. Our WRES and WDES performance data will continue to inform our key annual EDI priorities.

Previously considered by:	The People Committee received and endorsed the report at the meeting held on 19 September 2023

Proposed Resolution:	The Board of Directors is asked to receive and approve the WRES and WDES Reports for 2023.

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

Prepared by:	Rahila Ahmed, EDI Lead	**Presented by:**	Toria King, EDI Programme Manager

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

BAME	Black, Asian and Minority ethnic
WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard
MWRES	Medical Workforce Race Equality Standard
CPD	Continued Professional Development

1. Introduction

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

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

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

1.4. Each year the Trust is required to publish the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports. This year saw the introduction of a Trust level Medical Workforce Race Equality Standard (MWRES) and mandated Bank Workforce Race Equality Standard (BWRES).

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

- **Workforce Race Equality Standard (WRES)** – First introduced in the NHS standard contract in 2016, it focuses on meeting requirements around ethnicity and hinges on nine race equality indicators. They relate to a combination of workforce data and results from the NHS national staff survey. A local action plan to take corrective action is required to be published by 31 October 2023.
- **Workforce Disability Equality Standard (WDES)** - A requirement of the CCG contract and NHS contract since 2018. The WDES is a set of ten specific metrics that will enable organisations to compare the employment experiences of disabled and non-disabled staff. By 31 October, an action plan to demonstrate progress must be published.
- **Medical Workforce Race Equality Standard (MWRES)** – First introduced in September 2020 and in 2023 became a mandated Trust level submission. It consists of eleven indicators focused on representation, awards, complaints, investigations and revalidations. The MWRES recognises doctors' opportunities for professional development, training, pay, appointments and leadership roles can be hindered by inequalities they may face. It helps to root out racism and discrimination among doctors working in the NHS and enables organisations to understand the challenges that exist. Data must be submitted for indicators 1 and 2 only whilst the national team will gather data for indicator 3-11.
- **Bank Workforce Race Equality Standard (BWRES) -** Builds on the work from the WRES, to improve the quality of bank provision as a flexible option for staff. It recognising that staff on bank contracts (those on NHS zero-hours contracts, this does not include permanent or fixed contract employees of the Trust who are signed up as bank workers) have different experiences and outcomes compared to the general workforce. It consists of nine indicators focused on fair disciplinary, treatment, value, recognition and career aspirations. Trusts are required to submit

data for indicators 1-3 only whilst 4 to 9 will be derived by the national team from the staff survey results.

1.5. The new NHS EDI Improvement plan sets targets for organisations that will help to improve WRES, WDES, MWRES and Bank WRES performance on the above frameworks. The Trust's WRES, WDES and wider consolidated EDI action plans will incorporate these measures. The latter action plans are out of the scope of this report.

2. WRES: Performance and Key Findings 2023

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

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

a) The overall headcount for the Trust is at 6104 (194 more staff than the previous year). 18% of staff are from BAME backgrounds (1097 staff). Over the past year, we have seen a positive 3% (208 additional employees) increase in the number of BAME staff employed by the Trust, and a 5.6% increase over the past 5 years.

b) We have reached the initial target of overall BAME representation set out in our EDI Plan. However, the new Census (2021) data reveals the BAME Bolton population has increased from 18.2% in 2011 to 28%, calling for a revision of the set target.

c) 5.3% of staff (322 individuals) have not revealed their ethnicity data with a small 0.7% improvement in declaration rates seen over the past the past 5 years.

d) Figure 1 shows that the majority of our BAME staff employed within clinical and non-clinical roles remain clustered in pay band 5. There has also been an overall reduction of BAME staff in band 7 Band 8b and 8c positions in the past year but an increase in Band 8a, 8d, band 9 positions and Band 2 to 6 positions.

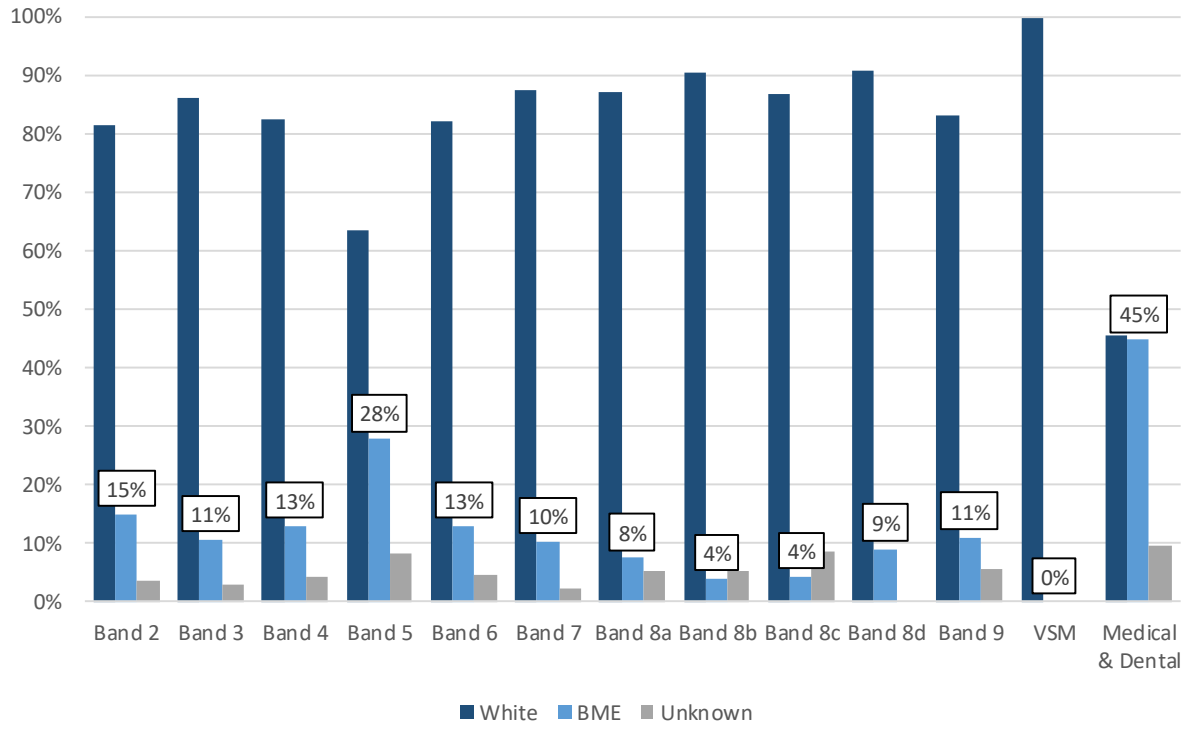


Fig 1: Distribution of BAME and white staff across AfC pay bands at Bolton FT.

e) Our national staff survey results during 2022- 23 show a high staff engagement score for BAME staff, in comparison to their White counterparts, as per Table 1:

Table 1: Overall Engagement Scores in the National NHS Staff Survey

Overall Engagement Score			
Year	**Trust Overall**	**BAME Staff**	**White Staff**
2022-23	7.0	7.2	6.9
2021-22	7.1	Not provided	

* Note: NHS national staff survey scores range from 1 to 10.

f) There has been a consistent improvement in BAME applicants being appointed for shortlisting when compared to white applicants and improved even further this year. Currently at 0.14 compared to 1.54 nationally. This is the result of partnership working between the Recruitment Team, BAME Staff Network and EDI Team, alongside the innovative work with our international recruits.

g) The National Staff survey shows a 4.5% reduction in BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public (8.8% reduction in the past 5 years). The Trust's figure at 23% is now lower than the national average at 29%.

h) Reports of bullying and harassment from staff also reduced by 2% (4.3% less than 5 years ago).The Trusts results at 24.7% remains lower than the national average at 27.6%.

i) National Staff Survey results show a marginal 0.6% increase of BAME staff that believe the Trust provides equal opportunities for career progression or promotion. Overall, only 48% of BAME staff compared to 61% of White staff agree with this statement. The Trusts score is better than the national average (44% and 58% respectively). This has declined by 27% over the past 5 years but also reduced by a higher 29% difference from 2019.

j) More BAME staff have raised concerns via the Trust's Freedom to Speak Up process compared to the previous year, rising from 24 to 33 concerns (17.7%). This shows that BAME staff feel safe to speak up about their concerns about patient safety and staff treatment. Currently 8 of the 55 FTSU champions (15%) are from a BAME background and more are looking to join.

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

a) The relative likelihood of BAME staff entering the formal disciplinary process has increased this year (now at 1.02 from 1) meaning that BAME staff now have a slightly higher chance than White staff of entering the disciplinary process. The overall figure has largely improved over the past 5 years when the score was 1.59 in 2019. This is lower than the national average at 1.14. However, a score of 0.8 to 1.25 indicates a non-adverse range. A score greater than 1.25 for BAME staff indicate they are more likely to be subject to formal process.

b) There has been a trend reversal where White staff for the first time are slightly more likely to access non-mandatory or statutory training than BAME staff, to support career progression, now at 1.02yet better than the national average at 1.12, and remains within the non-adverse range of 0.80 to 1.25.

c) National Staff Survey results show a 1.4% increase of BAME staff reporting they have personally experienced discrimination at work from manager/team leader or other colleague (17% compare to 5% White staff), now on par with the national average. The rates are almost the same as 5 years ago although a decline has previously been seen, but is now back on the rise.

d) The percentage of BAME board members has decreased by 2% (13%), but has doubled in percentage from 5 years ago (6.7%). Again, this is better than the national average at 9.6%.

3. WRES: Action Taken 2022-23

3.1. During 2022-23 the following actions have been taken with the aim of helping to improve the Trusts EDI practices in relation to race and ethnicity to create an inclusive work culture:

- Continued to support the BAME Staff Network. The Network have been pivotal in co-designing solutions to create a better Bolton such as reviewing recruitment practices, prayer facilities and external communication methods to reflect the diversity of Bolton. It also provides a safe space at each meeting to raise issues affecting staff. Socials have also been held to increase attendance and to ensure psychological safety.
- Stretch assignments/projects have been offered to BAME staff who had successfully completed the Trust's BAME leadership programme to advance their career, some of which have gone on to more senior positions (targeting indicators 1, 2, 4, 7).

- Recruited to the Northwest BAME Leadership programme. In addition, to further support growth further packages will be locally embedded, designed with active involvement of previous attendees and the BAME staff network. This includes reciprocal mentoring, EDI and management learning modules, completion of a workplace project and guaranteed interview scheme (targeting indicators 1, 2, 4, 7).
- Continued to embed our Freedom to Speak Up Approach and actively continued to recruit a number of FTSU champions from a diverse background (targeting indicators 3, 5, 6 & 8).
- EDI training for hiring managers has been rolled out to raise awareness of factors that affect ethnic communities and to disrupt biases of colleagues and recruiting managers (targeting indicators 1, 2 & 7).
- Rolled out Active Bystander Train the Trainer programme, offering training to a number of key officers. Over the coming months the training will be rolled out Trust wide (targeting indicators 5, 6 & 8).
- An anti –bullying and harassment communications video campaign is in action, to deter bullying and harassment and abuse by patients. A series of video screen slides showcasing diverse staff were created and displayed in the waiting areas (targeting indicators 5, 6 & 8).
- Development of new expanded Muslim and Hindu prayers facilities on the hospital site, as a direct result of feedback received and the support of the Bolton's Community of Mosques (targeting indicator 1).
- Began to embed inclusion considerations in Management and leadership development programmes (targeting indicators 5, 6 & 8).
- Implementation of the Trust's Inclusive Recruitment Framework to improve the Trust Race Disparity Ratio to ensure inclusion is at its heart. Action plans have been developed with a focus on ensuring policies and procedures are updated to support diverse talent to progress, improving where job roles are advertised, working closely with local communities and the BAME staff network to provide support to colleagues applying for roles. Examples include promotion of inclusion staff networks within recruitment packs (targeting indicators 1, 2 & 7).
- Continued to organise community voices involvement network meetings with local race and cultural community groups to co-design solutions and achieve the Trust's EDI plan ambitions. A review of the Trust's recruitment practices took place, leading to partnership outreach community solutions (targeting indicators 1, 2 & 7).
- Held an Islamophobia History Month Lunch and Learn which included staff stories. Staff are actively encouraged to avoid Friday afternoon prayer time meeting clashes (targeting indicator 1).
- Involvement in various events including Ramadhan awareness, Diwali celebrations, Black History month celebrations and South Asian Heritage Month, to increase awareness of cultures and needs (targeting indicator 1, 5, 6 & 8).
- Developed an annual Inclusion and wellbeing events calendar to increase celebration and better support staff in advance with requests for changes in working patters or leave during key festivals (targeting indicators 1, 5, 6 & 8).

4. WRES: Further In-Year Actions

4.1. Whilst some positive improvements have been made, we are fully committed to take further action to improve our WRES performance. These actions are particularly targeted around the indicators that we've identified should be priorities. These are indicators 1, 7 and 8.

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

- Improve self-declaration rates in ESR. Set up process with HR to ensure new starters are encouraged to declare (targeting indicator 1).
- Roll out the local elements of the wider BAME Leadership Programme, including Reciprocal Mentoring (targeting indicators 1, 2, 7).
- Continue to progress the Inclusive Recruitment Framework actions including interview preparation checklists, ensuring diverse interview panels are in place, organise further inclusive recruitment training and review the current process and content of sample EDI Interview questions (targeting indicators 1, 2 & 7).
- Implement NHS Northwest Anti-Racism campaign, for which Executive commitment has been achieved (targeting indicators 5, 6, 8).
- Develop a joint approach and process with Human Resources, Freedom to Speak Up Guardian, Unions and Staff Network Chairs, to analyse staff concerns and implement effective interventions (targeting indicators 3, 5, 6 & 8).
- A range of actions from the NHSE EDI Improvement Plan to ensure International Recruits and the teams they join are well prepared and feel supported in how to work well and integrate together. Actions within this point include onboarding, cultural competency training and talent progression (targeting indicators 1, 2, 4, 5, 6, 7, 8).
- Continue to work with the BAME Staff Network and implement their action plan objectives to reduce bullying & harassment. Objectives for this year are to achieve more inclusive recruitment and selection practices, flexible learning & development and career progression opportunities, Increase celebrations & awareness and reduce bullying and harassment.

5. WDES: Performance and Key Findings 2023

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

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

5.3. The following improvements have been made since the last reporting year and compared to the last four years where applicable (refer to Figure 2):

a) The proportion of disabled staff increased by 0.7% (53 staff) to 3.9% (now at 240 individuals) as recorded within the Electronic Staff Record (ESR) HR information system, now higher than the national average which stands at 3.7%.

b) A 6.8% reduction in the 'Unknown' category has been noted in the last five years, now similar to the national average at 21.7%. Almost 1 in 4 staff continue to not declare

whether they have a disability or health condition on ESR. This gap in data impacts on the analysis of experiences of staff with a disability or health condition.

c) Comparatively, a higher 25.5% (518) proportion of staff have declared they have a disability or health condition in the anonymous staff survey. This has risen from 1.5% the previous year showing increased awareness and confidence levels.

d) The highest proportion of disabled staff are represented at Band 8c and Band 9 senior positions (8% and 12% respectively). However, limitations with data prevent an in-depth analysis.

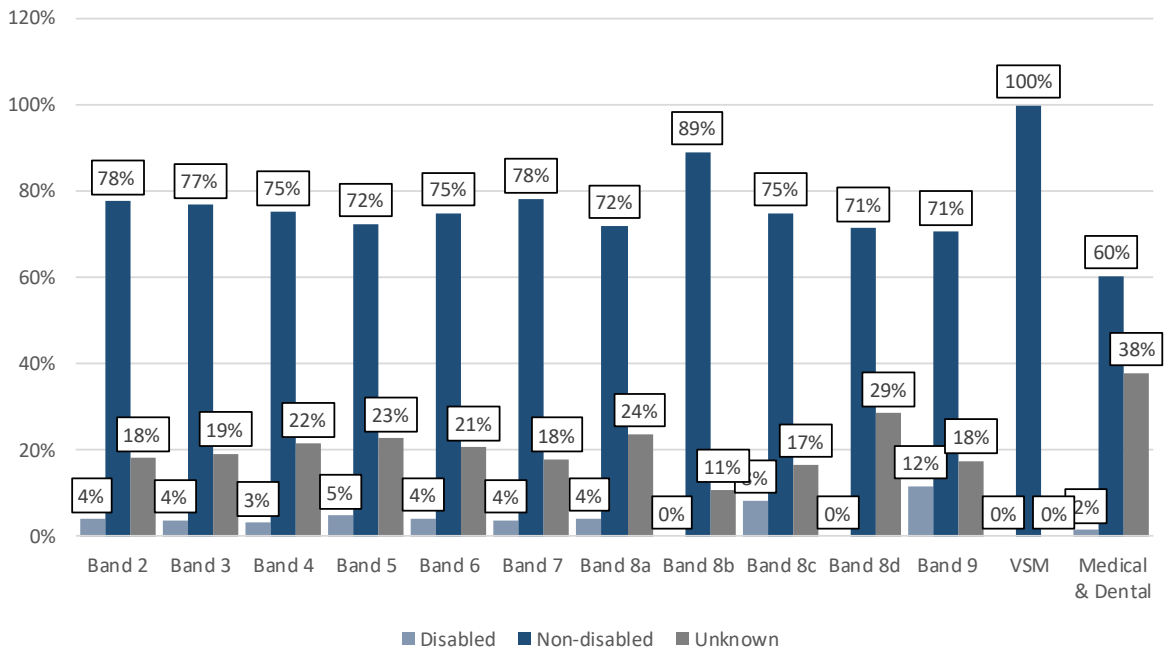


Fig 2: Distribution of disabled and non-disabled staff across AfC pay bands at Bolton FT.

e) The numbers of staff entering the capability process for both disabled and non-disabled staff have been proportionally so low that the relative likelihood is 0. Nationally, however the relative likelihood is 1.94, indicating disabled staff are nearly twice as likely to enter the capability process as their non-disabled colleagues.

f) The percentage of disabled staff who have experienced harassment, bullying or abuse from patients/service users/their relatives has reduced by 4.5% (29.2%) in the last year. This is lower than the national average at 31.9%.

g) Staff are increasingly confident to report experiences of harassment, bullying and abuse at work, increasing by 2.1% in the last year (51.1%, compared to 68% five years ago). This is also better than the national average at 50%. The FTSU Guardian is active in promoting the service including liaising with the international recruits to alleviate any additional fears and monthly drop-ins are held by the Disability and Health conditions staff network for staff.

h) More staff (2.6%) this year are agreeing that the Trust provides equal opportunities for career progression or promotion although over the past 5 years the figure has declined for both staff with a disability and without by more than 20%.

5.4. Areas for focus include:

a) **Indicator 2:** Similar to the previous year, non-disabled staff have a slightly higher likelihood of being appointed from shortlisting than those with a disability. There has been a positive shift in the past 4 years when the figure was at 1.57 to now at 1.04, still better than the national average at 1.11. (A figure above 1 denotes a higher likelihood of non-disabled staff being appointed from shortlisting).

b) **Indicator 4:** The percentage of disabled staff who have experienced harassment, bullying or abuse from Managers has increased by almost 1% (13.4% compared to 9.0% for non-disabled staff). Although this is better than the national picture at 19.8%, we must look at this as there is still a disparity between disabled and non-disabled staff.

c) **Indicator 4:** Reports of bullying, harassment and abuse from colleagues also increased by 2.2% (now at 22.6% compared to 14.4% of non-disabled staff). Again, while lower than the national average at 25.6%) and a considerable 7.3% improvement from 2020 when the rate was at its highest at 30%, it is still a large disparity that must be tackled.

d) **Indicator 6:** More staff report feeling pressure to come to work, despite not feeling well enough to perform their role (28% compared to 17% non-disabled staff). This has worsened over the past year. Although the rate is lower than the national average at 31%, this will be an area of focus as there is a big disparity ratio.

e) **Indicator 7:** Just over a third of Disabled staff feel valued by the Trust (37.5% compared to a higher 40% nationally). There has been a 3.2% reduction in this score over the last year and 9.5% reduction over past 5 years. This score is also disappointing as it differs from non-disabled staff by more than 10%.

f) **Indicator 8:** Nearly one in four disabled (28%) staff do not believe that they are getting the necessary equipment and support needed for them to perform their role as effectively as possible. The rates of disabled staff saying their employer has made reasonable adjustments to carry out their work has fallen 1.7% in the past year. This undoubtedly means a loss of productivity for these staff, and is worse than the national average at 76%. (Trust score 72.1%).

g) **Indicator 9:** A decrease of 0.1 in the engagement scores of disabled staff has been noted, as per the graph below and this is the lowest score for this group since before 2019. 518 staff members with a disability completed the staff survey. There is also a difference between disabled and non-disabled staff (Figure 3).

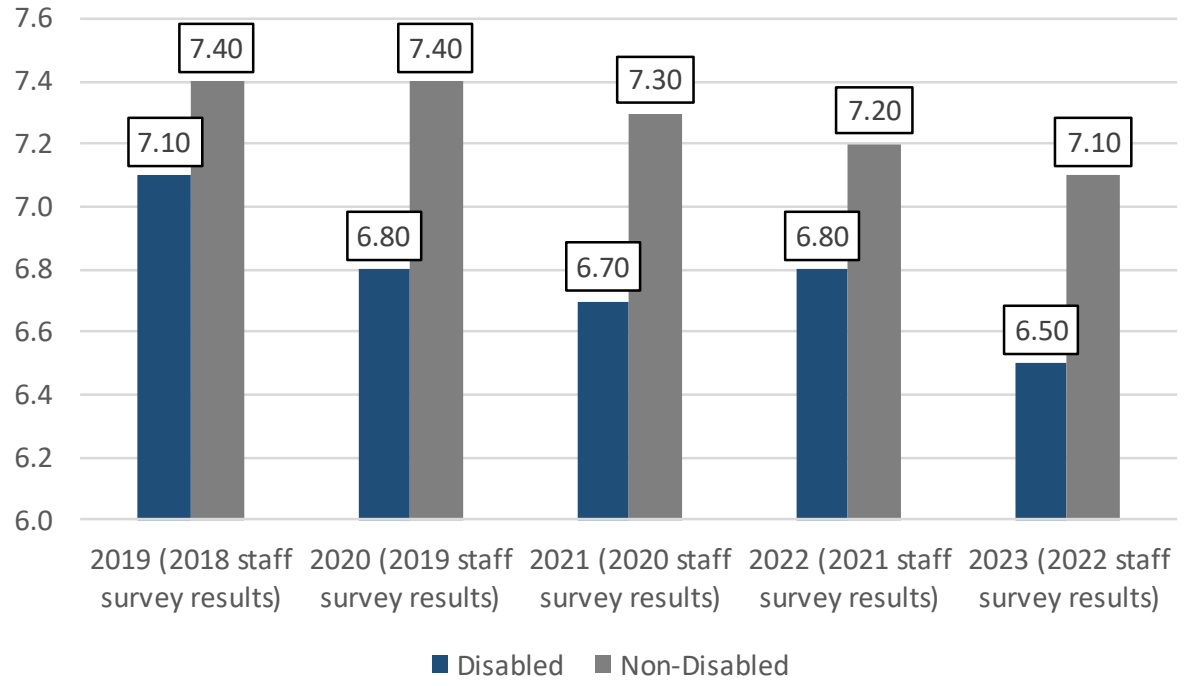


Fig 3: Overall engagement score of disabled vs non-disabled staff at Bolton FT in the National Staff Survey.

h) **Indicator 10:** There remains no disabled representation on the Board as on 2019 since the first WDES report was first published. Nationally 58% of Trusts are in the same position.

6. WDES: Action Taken 2022-23

a) The Disability and Health Conditions Staff Network has grown in strength, first established February 2022. Their role is to support the Trust to make improvements for staff and patients. A safe space is created for staff to raise concerns in a confidential manner complimented by monthly drop-ins are held with attendance by the Executive.

b) Raised the profile of disability equality and inclusivity through our annual calendar of diversity and inclusion campaigns and engagement activities such as Disability History Month, Deaf Awareness Week, Visual Impairments etc. (targeting indicators 7 & 9).

c) The Trust Health and Wellbeing offer has continued to expand including trained Mental First Aiders, Counselling services, Trauma & Risk Management (TRiM) assessors, Physiotherapy service, Occupational Health amongst others (targeting indicators 6 & 8).

d) The updated Workplace Health and positive Attendance Policy recognises disability leave is a reasonable adjustment under the Equality Act 2010 to enable employees who have a disability confirmed to manage appointments and treatment in relation to their condition. Employees who meet the criteria are entitled to a maximum of 6 days (pro-rata) per annum to manage their treatment plan. Leave can be taken in timeframes suitable to their conditions (hours, ½ days or full day) (targeting indicators 6 & 8).

e) Reasonable adjustment passport and guidance has very recently been developed and currently being trialled (targeting indicators 6 & 8).

f) Achieved level 2 of the Disability Confident 2 accreditation (targeting indicators 1, 2, 5 and 8).

g) Delivered Inclusive Recruitment training for hiring managers with a plan to roll out Trust wide (targeting indicators 1, 2 and 5).

7. WDES: Further In-Year Actions

7.1. Whilst some positive improvements have been made, it is clear that there is much more work to do in our approach to supporting our workforce who identify as having a disability or long term conditions. There are a number of actions which we are committing to which will ensure our disabled workforce receive the best experience of working for the Trust. These actions are particularly targeted around the indicators that we've identified should be priorities. These are 4, 5, 6, 7, 8 & 9.

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

- **Indicator 4:**
  a. Zero tolerance policy, process and communications campaign for patients, public & colleagues. Staff are supported to report people who verbally or physically abuse them.
  b. Psychological support for victims of bullying, harassment, discrimination or violence.
  c. Active bystander training rollout.
- **Indicator 5:**
  a. Discuss and agree actions with the staff network that would improve opportunities available for Disabled staff to advance their careers.
  b. Widen recruitment opportunities within local communities inc. apprenticeships, graduate management schemes.
  c. Explore use of skill based assessment tasks in recruitment.
- **Indicator 6:**
  a. Review attendance management policy and uptake of disability leave with the Staff network. Promote if necessary.
- **Indicator 7 & 9:**
  a. Launch an internal campaign to encourage staff to declare their disability within ESR to allow more meaningful analysis to be conducted to understand differences of experiences.
  b. Further strengthen the Disability and Health Conditions Network to increase membership, support, education and learning across the Trust.
  c. Develop a communication campaign focused on the benefits of employing Disabled people, aligning to the NHS People Plan. Include insight into what is defined as a disability so staff are more likely to relate/declare.
- **Indicator 8:**

a. Work is underway to strengthen the reasonable adjustment process to ensure timely support and access to aids and adaptations. Learning from other organisations, including Higher Education Institutions is taken on board.

b. Ensure the flexible working policy and procedure is well structured, easy to implement and is communicated widely.

8. Next Steps

8.1. The Trust's detailed WRES, WDES reports and action plans will be published on 31st October 2023. Meanwhile the Trust will await the MWRES and Bank WRES national reports, to offer a baseline from which to improve.

9. Recommendations

- The Board asked to note the contents of this report.

Appendix 1: WRES 2023 dashboard

	WRES indicator		2017	2018	2019	2020	2021	2022	2023	Difference between 2022 & 2023
1	Percentage of BME staff	**Overall**	11.00%	11.60%	12.40%	12.90%	14.10%	15.00%	17.97%	2.97% ↑
		VSM	0.00%	4.80%	6.30%	8.30%	0.00%	0.00%	0.00%	0% ↔
2	Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants		1.37	1.4	1.53	1.3	0.62	0.84	0.51	-0.33 ↑
3	Relative likelihood of BME staff entering the formal disciplinary process		2.34	1.87	1.59	1.64	0.93	1	1.21	0.21 ↓
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		0.97	0.95	0.91	0.9	0.99	0.99	1.02	0.03 ↓
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BME**	26.70%	20.00%	32.00%	28.80%	23.90%	27.70%	23.20%	-4.5% ↑
		White	26.80%	27.10%	31.00%	21.90%	25.70%	26.50%	25.90%	-0.6% ↑
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BME**	26.80%	20.00%	29.00%	25.00%	27.00%	26.70%	24.70%	-2% ↑
		White	23.90%	27.10%	16.00%	23.60%	19.80%	20.50%	20.10%	-0.4% ↑
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	**BME**	87.90%	79.20%	75.00%	67.50%	74.80%	47.40%	48.00%	0.6% ↑
		White	92.70%	90.00%	90.00%	86.50%	90.10%	62.30%	61.10%	-1.2% ↓
8	Percentage of staff personally experienced discrimination at work from manager/team leader or other colleague	**BME**	14.00%	20.00%	18.00%	21.20%	15.30%	16.30%	17.70%	1.4% ↓
		White	6.10%	4.53%	5.00%	5.30%	5.30%	4.60%	5.20%	0.6% ↓
9	BME board membership		0.00%	7.70%	6.70%	6.70%	8.30%	15.40%	13.33%	-2.07% ↓

Appendix 2: WDES 2023 Dashboard

WDES metric			2019	2020	2021	2022	2023	Difference between 2022 & 2023
1	Workforce representation of Disabled staff (AfC)	**Overall**	2.8%	2.6%	2.9%	3.3%	3.9%	0.57% ↑
		8c and above	0.0%	0.0%	0.0%	0.0%	0.0%	0% ↔
2	Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff		1.41	1.57	1.57	1.04	1.05	0.01 ↓
3	Relative likelihood of Disabled staff entering the performance management capability process compared to non-disabled staff		0	0	0	0	0	0 ↔
4(i)	Percentage of staff experiencing harassment, bullying or abuse in the last 12 months by patients/service users, their relative or other member of the public	**Disabled**	34.0%	26.1%	30.8%	33.7%	29.2%	-4.5% ↑
		Non-disabled	24.0%	21.9%	24.2%	24.2%	24.5%	0.3% ↓
4(ii)	Percentage of staff experiencing harassment, bullying or abuse from managers	**Disabled**	10.0%	19.1%	15.7%	12.5%	13.4%	0.9% ↓
		Non-disabled	11.0%	9.9%	9.4%	9.7%	9.0%	-0.7% ↑
4(iii)	Percentage of staff experiencing harassment, bullying or abuse from other colleagues	**Disabled**	20.0%	29.9%	23.3%	20.4%	22.6%	2.2% ↓
		Non-disabled	16.0%	14.6%	14.3%	15.2%	14.4%	-0.8% ↑
4(iv)	Percentage of staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	**Disabled**	68.0%	42.1%	54.0%	49.0%	51.1%	2.1% ↑
		Non-disabled	50.0%	41.3%	49.8%	46.0%	47.4%	1.4% ↑

WDES metric			2019	2020	2021	2022	2023	Difference between 2022 & 2023
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	**Disabled**	85.0%	76.6%	80.9%	55.0%	57.6%	2.6% ↑
		Non-disabled	89.0%	86.1%	89.6%	62.1%	59.3%	-2.8% ↓
6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled**	27.0%	31.7%	28.2%	25.0%	27.6%	2.6% ↓
		Non-disabled	19.0%	14.7%	21.4%	18.0%	17.1%	-0.9% ↑
7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work	**Disabled**	47.0%	43.2%	37.7%	40.7%	37.5%	-3.2% ↓
		Non-disabled	57.0%	55.4%	51.4%	47.5%	47.0%	-0.5% ↓
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	74.0%	69.4%	77.0%	73.8%	72.1%	-1.7% ↓
9	Staff engagement score (a composite based on several questions in the NHS Staff Survey)	**Disabled**	6.80	7.10	6.70	6.80	6.50	-0.3 ↓
		Non-disabled	7.40	7.40	7.30	7.20	7.10	-0.1 ↓

Appendix 3: Bank WRES

Introduction

- The Bank WRES builds on the work from the Workforce Race Equality Standard, recognising that staff on bank contracts (only) have different experiences and outcomes compared to the general workforce.
- A bank worker is a worker that does not have fixed hours contracts but pick up shift as and when the worker is available. While it is possible to be on a permanent or fixed contract employee of the Trust and work as a bank worker, this standard focuses on those with bank worker contracts only.
- All Trusts were invited to submit data for this standard in the summer of 2023
- There are over 150,000 bank workers across the NHS in England, representing a sizeable proportion of the workforce. For context, there are more NHS bank workers than the current total.
- The diversity of roles covered by bank workers is wide-ranging – including, but not limited to, nursing, midwifery, clinical and administrative support, medical, dental, estates and allied health professionals.
- Bank workers fulfil a vital function. They provide flexibility, help address staff shortages, offer skills and experience, contribute to organisational cost-effectiveness, and support our ability to undertake workforce planning. This enables our NHS to deliver high-quality healthcare services to the population, even during challenging circumstances.
- By understanding the experiences of bank workers, NHS leaders can make informed decisions, implement appropriate policies and practices, and continue to build supportive and inclusive work environments. This contributes to the wellbeing of the workforce, enhancing patient care and strengthening the performance of the NHS.

Bank WRES indicator 1

Key supportive data

Table 1 & 2

Bank Staff in Bolton FT by ethnicity: 2022 - 2023

The tables show the number of Bank only staff who were active in the 6 months prior to the 31 Mar 2023 by their ethnicity profile. There are two tables showing each category of clinical and non-clinical to mirror the Trust WRES return

Clinical Staff	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+	non AfC	Total
White	298	17	5	47	34	12	20	433
BAME	152	3		12	7	3	4	181
Unknown	21	2		4	5	2	13	47
Grand Total	**471**	**22**	**5**	**63**	**46**	**17**	**37**	**661**

Non-Clinical Staff	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+	non AFC	Total
White	111	12	3	2		5	2	135
BAME	25	2						27
Unknown	5		1				1	7
Grand Total	**141**	**14**	**4**	**2**	**0**	**5**	**3**	**169**

Within the clinical staff group BAME staff make up 27.3% of the total workforce compared to a lower 15.97% of staff in non-clinical groups.

Within clinical groups the majority of BAME staff are clustered within Band 2 positions (83%) and which is the largest group bank staff are recruited too (71% of all posts). 15% of BAME staff are recruited to higher positions including band 5 and above. 7% of ethnicity data is not recorded

Within non-clinical staff groups the majority of BAME staff are employed within Band 2 positions (92%) which makes up 83% of all positions. There is no representation at band 4 or above although these make up 8.2% of the non-clinical bank workforce.

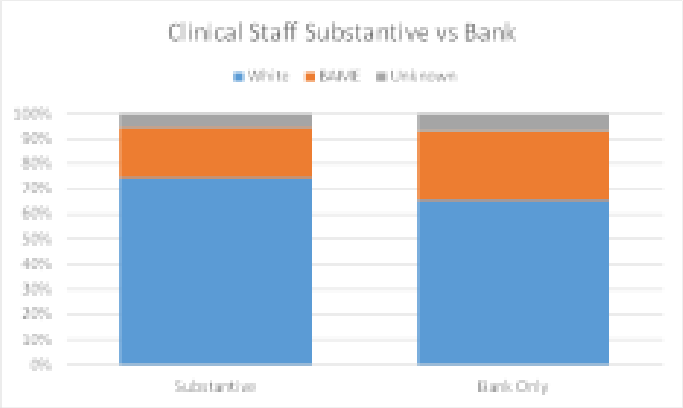
Bank WRES indicator 1

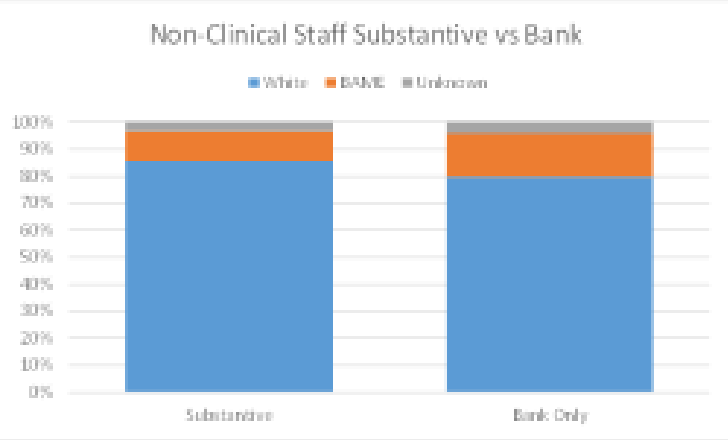
Key supportive data

Chart 1 & 2

The charts show the ethnicity profile of Bank only staff who were active in the 6 months prior to the 31 Mar 2023 compared with the ethnicity profile of substantive workers. There are two tables showing each category of clinical and non-clinical to mirror the Trust WRES return. There is a higher proportion of BAME staff in the bank only staff workforce in both clinical and non-clinical capacities.

Within the clinical staff group BAME staff make up a higher 27.4 % of the bank workforce compared to 19.7% of those within substantive post. Similarly within the non-clinical staff group BAME staff make up 16 % of the bank workforce compared to 11% of those in substantive posts





Bank WRES Indicator 2

Key supportive data

Bank Staff in Bolton FT by ethnicity: 2022 - 2023

The Bank WRES asks for the number of bank workers by ethnic grouping entering a formal disciplinary process over a 12 month period. This applies to bank only staff to the trust.

The was a nil return for this metric as bank staff are not subject to the same disciplinary process as substantive workers as the Trust. Bank staff are currently transferring to NHS Professionals (NHSP) form 31 July 23 so investigations into conduct of bank only workers will be carried out by NHSP.

Bank WRES Indicator 3

Key supportive data

Bank Staff in Bolton FT by ethnicity: 2022 - 2023

The Bank WRES asks for the number of dismissals by ethnic grouping for bank workers over a 12 month period (conduct and capability cases only)

White: 3

BAME: 2

5 Dismissals were upheld of which 40% (2 cases) relate to BAME staff.

Appendix 4: Medical WRES

Introduction

To highlight and address discrimination against BME staff, the MWRES now requires all NHS trusts and organisations locally that are subject to the Standard NHS contract to demonstrate progress against its eleven indicators. For the MWRES submission, Bolton FT had to submit data to the national team for indicator 1a (part), 1b and 2 by 30th June. The data for the remaining 9 indicators are derived from other sources by the national WRES team. The data the Trust submitted to the national WRES team is summarised on the following slides and we await our full analysis report from the National Team which will show how we perform across all 11 indicators.

In July 2021, the very first national MWRES was published. The report provided baseline evidence to quantify discrimination in the NHS trust-based medical workforce at the national level and hence identify the targets for organisations

BME doctors make up a substantial part of the NHS workforce with numbers growing by 40 per cent over the past five years. However, they often face a poorer experience in medicine than white colleagues, feeling less supported, less included and less able to progress. Evidence has shown that this disparity directly impacts patient experience and that there is a clear link between staff experience and patient satisfaction.

The 2021 national report showed:

- Underrepresentation in consultant, clinical director and medical director roles and overrepresented in other doctor grades and doctors.
- BME medical and dental staff earn, on average, 7% (£4,310) per year less than their white colleagues. The most significant gap is seen amongst consultants. This has implications for the lifetime earnings, pension and accumulated wealth over a lifetime.
- The proportion of BME clinical academics across all levels is not representative.
- Shortlisting and interview process discriminates against BME applicants for consultant appointments. Even when BME doctors become consultants, they report more significant discrimination and harassment.
- BME doctors reported a worse experience than their white colleagues when it comes to harassment, bullying, abuse and discrimination from staff and lower levels of inclusion and being involved at work.
- BME doctors have a worse experience when it comes to examinations (medical school and postgraduation examinations) and regulation (revalidation, referrals/complaints to GMC, Annual Review of Competence Progression). This discrimination begins early in their career, with BME students less likely to attain a place in medical school than white students. This is especially evident for international medical graduates and speciality and associate specialist (SAS) doctors.

For the year ahead, the national Workforce Race Equality Standard (WRES) team plan to support NHS trusts and systems to make improvements with the use of detailed analysis at the individual Trust level against five critical priorities.

MWRES indicator 1a

Key supportive data

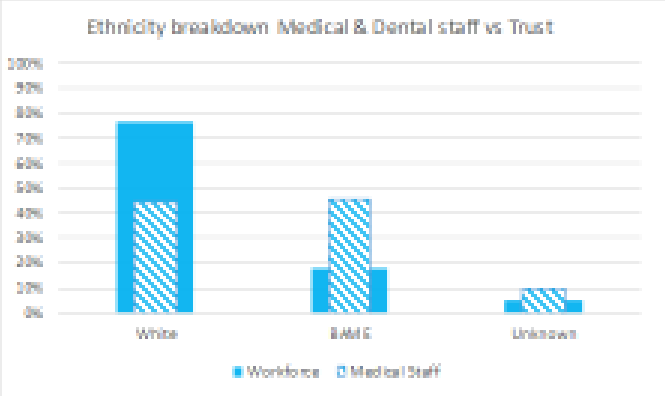
Table 1

Medical and Dental Staff in Bolton FT by ethnicity: 2022 - 2023

	Headcount			Percentage		
Year	White	BME	Unknown	White	BME	Unknown
2021	187	169	49	46.2%	41.7%	12.1%
2022	202	173	43	48.3%	41.4%	10.3%
2023	197	200	42	44.9%	45.6%	9.6%

Chart 1

Medical and Dental Staff in Bolton FT vs all staff in Bolton FT by ethnicity: 2023



BAME staff now make up the majority of the Medical and Dental (M&D) staff group at 45.6% compared to a significantly lower BAME Trust representation at 18% overall.

However 9. 6% of data remains unrecorded although there has been a 2.5% reduction in the proportion of 'ethnicity profile unknown' over the past 2 years by M&D staff.

The overall Medical and Dental headcount of BAME staff has increased between 2022 and 2023 (by 27 staff equating to a 4.2% increase).

MWRES indicator 1a

Key supportive data

The number of staff in each medical and dental sub group, disaggregated by ethnicity (based on the workforce as at 31st March in the reporting year)

	2022/23				
	White	Black	Asian	Other	Not Known
Medical Directors	5	0	1	0	2
Clinical Directors	16	0	0	2	3

Of the 8 Clinical Directors, 1 (12.5%) is of BAME background. 25% of data is 'ethnicity data is unrecorded'.

Of the 21 Clinical Directors, 2 (9.5%) are from a BAME 'Other' ethnicity group. 14% of ethnicity data is unrecorded.

The Census 2021 data shows that 28% of Bolton residents are from a BAME background with a recommendation targets should be set to reach similar levels of representation.

MWRES indicator 1b

Clinical Excellence Awards

Clinical Excellence Awards were distributed evenly amongst all eligible parties in 2023. There were 205 eligible staff, of which 75 (32.9%) were from a BAME background.

MWRES indicator 2

Consultant Recruitment

Table 3

	2022/23				
	White	Black	Asian	Other	Not Known
Applicants	30	3	57	20	1
Shortlisted	3	1	28	9	0
Appointed	3	0	2	1	0

6 applicants were appointed of which 3 (50%) were from a BAME background.

Report Title:	Equality, Diversity & Inclusion Update & Future of EDI at Bolton FT

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	✓
Exec Sponsor	James Mawrey, Director of People/ Deputy CEO		Decision	

Purpose	This paper has been commended to the Board of Directors by People Committee on 19 September 2023.

Summary:	The report provides an update on the past 12 months of Equality, Diversity & Inclusion (EDI) activity, an overview of two new national EDI mandatory frameworks, and presents the actions set out in the following frameworks as a consolidated EDI plan for 2023/24, with associated local recommendations: • NHSE EDI Improvement Plan • Equality Delivery System 2022 • WRES • WDES • Gender Pay Gap Action Plan • NW BAME Assembly Anti-racism framework • Rainbow Badges Phase 2 Action Plan

Previously considered by:
People Committee

Proposed Resolution	The Board of Directors is asked to: a. **Note** the EDI progress so far, the new priority areas for EDI set out, and the challenging associated deadlines to meet these obligations; b. **Support** these outcomes by ensuring that responsibility and accountability for the actions is accepted across wider workforce leadership and embedded in the wider work plans for the directorates; c. **Support** forthcoming changes to EDI governance, to establish a solid foundation for improvement; d. **Sponsor** EDI as a priority work stream for 2023/24.

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:	Toria King, EDI Programme Manager	**Presented by:**	James Mawrey, Director of People

1. Introduction

1.1. Equality, Diversity & Inclusion (EDI) remains 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 EDI is also rightly recognised by NHS England (NHSE) who have recently (July 2023) published the NHS England EDI Improvement Plan, providing a mandatory framework for EDI work in NHS Trusts.

1.3. This comes at the same time as the first mandatory reporting year that Trusts must use Equality Delivery System 2022 (EDS2022). This is a report that Trusts have published every year since 2011, which details how Trusts have met certain EDI objectives, and is scored. However, the objectives in the refreshed EDS2022 have changed and so the associated actions on the Trust's EDI action plan going forward must be aligned to these.

1.4. The Trust's current EDI action plan that was last presented to this Board in July reflects priorities related to the WRES, WDES, Gender Pay Gap and local actions. These remain important. However, it is important to note that the two new national frameworks add significant pressure and require additional resource to deliver, so a reprioritisation exercise has taken place, the results of which are reflected in the EDI consolidated framework action plan. This action plan is summarised in section 5 of this paper.

2. Key EDI achievements: 2022-23

2.1. You are reminded that in July, the Board was presented with an EDI update that highlighted achievements in Bolton's EDI journey. Some (but by no means all) of the achievements that the Trust should be proud of from the last 12 months are:

- The setting up of staff diversity networks, to be a consultative partner in co-designing a more inclusive workplace and place to receive care,
- Our staff attending the North West BAME leadership programme,
- Equality Impact Assessment process overhaul underway,
- Strong focus on patient health inequalities with a Health Inequalities Enabling Group working on key projects,
- Roll out of the new interpretation and translation contract,
- Active bystander train-the-trainer programme,
- Pronoun badges rollout,
- Rainbow Badges Assessment,
- Presence at Bolton Pride 2023.

3. Future focus: NHSE EDI Improvement Plan

3.1. The next section will aim to summarise the new NHSE EDI Improvement plan. The plan is organised under six high-impact actions:

1) Chief Executives, Chairs and Board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable;

2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity;
3) Develop and implement an improvement plan to eliminate pay gaps;
4) Develop and implement an improvement plan to address health inequalities within the workforce;
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff;
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

3.2. Underneath these themes, the plan comprises 45 actions in total, 37 of which have a deadline of March 2024 or sooner.

4. Future focus: EDS2022

4.1. The EDS is an accountable improvement tool which was created in 2011 to help NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010, including improving services and provide better working environments for those who work in the NHS.

4.2. An updated version of the EDS was commissioned by NHS England in Feb 2020 to incorporate feedback and take into consideration new NHS infrastructures and COVID-19. All NHS organisations are expected to implement the revised tool from April 2023.

4.3. The key differences between EDS2 which Bolton FT has completed before, and EDS2022, which is new, are:

- 11 New indicators (outcomes) with an increased demand to show proactive pursuit of equity for patients with protected characteristics by service leads, a new focus on health inequalities of the workforce, and a much greater focus on the accountability of leaders. The framework requires evidence from leaders and Board members of how they personally commit and contribute to the EDI and health inequalities agenda within their organisation.
- Scoring of NHS organisations against the indicators will no longer be completed by the Trust's EDI team. Instead it will be completed by stakeholders such as the EDI team at GM ICB, another NHS Trust (outside of GM), staff networks, Trade Union representatives, voluntary sector organisations, Healthwatch.

4.4. Actions that the Trust will need to pursue are therefore rated as priority 1 in the consolidated action plan and will be built into the appropriate timelines to achieve publication of the EDS2022 report by 28th Feb annually. The results of the EDS reviews will inform actions for the EDI work plan for 2024.

5. Bolton's consolidated EDI action plan.

5.1. Alongside the NHSE EDI Improvement Plan and EDS2022, we continue to be mandated to produce Workforce Race Equality System and Workforce Disability Equality System (WDES) reports, and Gender Pay Gap reports. Each of these results in an action plan.

5.2. Additionally, the Trust has committed to work on some non-mandatory EDI frameworks. These are: the North West BAME Assembly's Anti-racism framework, and the NHS Rainbow Badges Phase 2 scheme.

5.3. The North West BAME Assembly's Anti-racism framework is important to pursue and many of the actions on this framework link with those in the NHS England EDI Improvement Plan.

5.4. The Trust has been through an LGBTQ+ assessment framework called the Rainbow Badges Phase 2 this year. The resulting actions are added to the consolidated action plan and the LGBTQ+ Staff Network will be choosing actions to pursue this coming year, with the support from other key stakeholders.

5.5. It is noted that many actions of the two new frameworks (EDS2022, and the EDI Improvement Plan) do not focus on actions to improve conditions for disabled staff. This is noted but will not detract from our focus on improvements in this area. We will prioritise actions that work on WDES indicator improvements to ensure that we do not lose focus for this group.

5.6. Noting the large number of actions across the five frameworks, and the significant overlap of themes and actions across these, it was imperative to consolidate these into a single plan for EDI, across six themes. The plan also includes a small number of local recommendations to ensure the success and sustainability of the work and to address local-specific issues.

5.7. When overlaps and repeated actions were removed, the consolidated EDI action plan was left with 198 actions. These were arranged under the themes of:

- Workforce: 93
- Community & Partnerships: 42
- Governance and reporting: 25
- Learning and Development: 14
- Policies and Procedures: 17
- Awareness, Communications and Celebrations: 7

5.8. Actions were prioritised into

- priority 1 (mandated): 79
- priority 1 (non-mandated): 21
- priority 2 (non-mandated): 98

5.9. Of the 100 priority 1 actions, the main topics that the actions tackled are summarised by Figure 1 below.

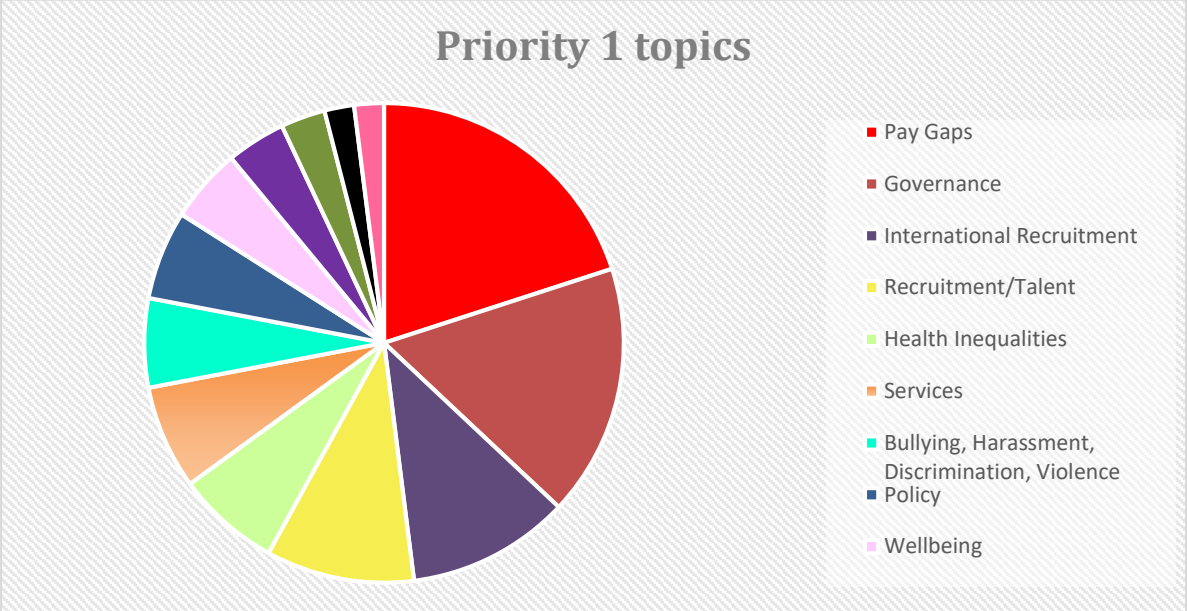


Fig. 1: Priority 1 topics from the EDI consolidated action plan

5.10. Some of the actions within the 6 themes are summarised below for interest:

5.11. Workforce: Actions in this category are widespread and cover everything from supporting internationally educated staff to thrive, to health inequalities of staff. From bullying, harassment, discrimination and violence to recruitment and supporting staff diversity networks. There are also many actions around eliminating gender pay gaps (and extending this to ethnicity and disability pay gaps).

5.12. Community and Partnerships: Actions in this category focus around improving accessibility of services in order to reduce health inequalities. There are also actions that focus on discovering if patient experience differs between patients who have a protected characteristic and those who do not.

5.13. Governance: A high priority area for improvement and a central theme in each of the frameworks is the need to ensure that EDI remains mission-critical for the organisation and core business for the Board. Here at Bolton FT, we are already doing many of the things that are listed below. There are, however, things that we could implement to be even better. With all of these improvements in place as a solid foundation, further EDI work is likely to progress faster and have greater impact for our communities. Note that high priority is given in the framework to:

- Establishing accountability and visibility for EDI at Board level, including embedding of EDI in the Board Assurance Framework (commended by the Chair at People Committee); establishment of EDI reviews in the Board schedule of business; establishment/review of Board leads for EDI, anti-racism and health equity;
- Create robust data-driven systems of accountability, assurance and escalation, including a review of EDI governance, development of an EDI

dashboard, and embedding impact measurement as standard for all EDI initiatives;

- Be ambitious and set clear targets and KPIs, including at least one stretch goal that goes beyond mandated minimums, and clear objectives for Executive Board members;
- Resource the work to ensure sustainability, considering the breadth of the work required as laid out in this paper.

5.14. Learning and Development: These actions are focussed on equity in talent development and opportunities, and in training in areas such as health inequalities, inclusive leadership and reciprocal mentoring.

5.15. Policies and Procedures: Policies/procedures that will be prioritised are those around recruitment, employee relations, reasonable adjustments processes, anti-racism and zero-tolerance policies, and family leave policies to ensure that they are inclusive.

5.16. Awareness, Communications and Celebrations: Actions under this theme will support the rollout of wider projects, to enable staff and patients to understand what EDI is and the important part that they can play in improving equality, diversity and/or inclusion for staff and/or patients.

6. Delivery of the plan

6.1. EDI is everyone's business. The acknowledgement of this in Bolton FT is evident in the breadth of stakeholders that attend the current Staff Experience and Inclusion Steering group. In the near future, this steering group will split into two, with an EDI Steering Group created. Terms of Reference and membership of this group is currently being carefully considered and will be brought to People Committee next month. It is imperative that the membership of this group, as well as wider staff across the Trust, understands that the delivery of the consolidated EDI action plan doesn't lie solely with the EDI team, or the Workforce & OD directorate. Instead, it involves a wide number of staff and it should be integrated into their work plans accordingly. Key stakeholders from all directorates will be identified against the mandated actions and will be engaged in work to make Bolton FT a more equitable, diverse and inclusive place to work and receive care.

6.2. The EDI Steering group will report quarterly updates on progress against the EDI action plan to People Committee for workforce actions, and to the other Committees as agreed with the relevant NED Chair and Executive leads – such Strategic Operational Committee and Quality Assurance Committee for patient/service actions.

6.3. Volunteers currently run and attend our staff diversity networks. These staff networks, if correctly supported and resourced, can become a vehicle for change in the Trust. Through not mandated in the NHSE EDI Improvement Plan, best practice recommendations are to facilitate the development, growth and ongoing sustainability of effective staff networks for addressing the needs, views and concerns of diverse minoritized staff. This should

include investing in facility time and developmental support to staff who run the networks, executive support and clear governance and structure including meaningful opportunities to review EDI data and improvement plans. I know that facility time has already been agreed for this purpose, and so operationalising this will be a priority alongside wider investment and support for our diversity staff networks.

6.4. There are 68 actions (48 of which are priority 1) that the EDI team are solely responsible for the delivery of, or will lead on with another stakeholder. The remaining actions, while sitting with others, will still be introduced by and overseen by the EDI team.

6.5. We cannot fill 100% of our time with the actions listed above or we will be inflexible to react to local pressures, issues and topics that are highlighted from our staff and patients via e.g. Freedom to Speak Up, HR, Staff Surveys, PALS etc.

6.6. While the EDI team is now resourced with three people as opposed to one, achieving all of the 48 priority 1 actions is still a challenge and there is a risk that some actions will not be achievable in the timeframes stated. If this becomes likely, these risks will be highlighted and a mitigation plan will be made.

7. Conclusion and next steps

7.1. The progress made so far on equality, diversity and inclusion at Bolton FT is something to be proud of. It is clear that the Trust recognises and is investing in the EDI agenda.

7.2. The EDI journey is an evolving one, and new nationally-mandated frameworks are to be taken into account, alongside those the Trust are already working alongside.

7.3. The new frameworks are challenging and pose a large number of actions with short deadlines. It is therefore very important to reprioritise existing actions from the EDI action plan.

7.4. The new consolidated action plan aims to do this, but remains a challenge to deliver.

7.5. The next step is to develop the action plan by plotting timescales with relevant stakeholders, and use these timescales to prepare relevant agendas for the new EDI steering group to monitor progress against the actions. The headline priorities from the action plan for quarter 3 of 2023/24 are:

- Equality and Health Inequality Impact Assessment improvements
- Diversity declaration rates and improving the reasonable adjustment process
- EDS2022 delivery
- Gender Pay Gap action plan development

7.6. Bolton FT's future is to go beyond being complaint with equality, diversity and inclusion, becoming strategic and integrating EDI into everything we do.

The ultimate goal is to be a leader in EDI practice, and to inspire others to emulate our success.

8. Recommendations:

8.1. The following actions have been commended by People Committee to the Board:

- **Note** the EDI progress so far, the new priority areas for EDI set out, and the challenging associated deadlines to meet these obligations;
- **Support** these outcomes by ensuring that responsibility and accountability for the actions is accepted across wider workforce leadership and embedded in the wider work plans for the Directorates
- **Support** forthcoming changes to EDI governance, to establish a solid foundation for improvement;
- **Sponsor** EDI as a priority work stream for 2023/24.

Report Title:	Appraisal & Revalidation Annual Report 2022-2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Francis Andrews, Medical Director		Decision	

Purpose	To provide assurance to the Board of Directors around governance arrangements in place in relation to medical appraisal, revalidation and managing concerns.

Summary:	Under the NHS England Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation, organisations are encouraged to report on their appraisal data via an Annual Board Report and Statement of Compliance. This report is our detailed response and sets out our achievements and challenges around appraisal and revalidation for medical staff. Included in Appendix A is the submission for ABL Health who are based on our site and deal with weight loss management and other health issues. The FT acts as the designated body and appraise the doctors employed by ABL.

Previously considered by:
People Committee

Proposed Resolution	The Board of Directors is asked to receive and note the Medical Appraisal & Revalidation Annual 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:	Joanne Warburton	**Presented by:**	

			Francis Andrews, Medical Director

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

A&R	Appraisal & Revalidation
AOA	Annual Organisational Audit
CLAR	Clinical Lead for Appraisal & Revalidation
CQC	Care Quality Commission
GMC	General Medical Council
LNC	Local Negotiating Committee
MAG	Medical Appraisal Guide
MPIT	Medical Practice Information Transfer
RO	Responsible Officer

Introduction:

The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General
2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Name of Organisation:	**Bolton NHS Foundation Trust**
What type of services does your organisation provide?	Acute district general hospital providing NHS health care services

	Name	**Contact Information**
Responsible Officer	Dr Francis Andrews	Francis.Andrews@boltonft.nhs.uk

Medical Director	Dr Francis Andrews	Francis.Andrews@boltonft.nhs.uk
Medical Appraisal Lead	Dr Wyn Price	Wyn.Price@boltonft.nhs.uk
Appraisal and Revalidation Manager	Joanne Warburton	Joanne.Warburton@boltonft.nhs.uk
Appraisal and Revalidation Officer	Rabeya Rashid	Rabeya.Rashid@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: ABL Health **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	319
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	301
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	2
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	16
Total number of appraisers as at 31 March 2023?	52

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	50
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	12
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	1
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	**1**
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**6**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	**1**

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
Appraisal & Revalidation Policy for Medical Staff	December 2018	Review in progress. Anticipated final sign off by LNC in Sept 2023.

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**

Capability and Conduct Policy (Medical & Dental Staff)	March 2022	March 2025
Complaints & Concerns Policy and Procedure	June 2020	July 2023 – under review
Supporting Staff Policy	June 2021	June 2024

Other relevant policies	**Implementation date**	**Review date**
Remediation Policy (Medical & Dental Staff)	October 2021	October 2024

How do you socialise your policies?
All policies are available on the Trust intranet.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes
The Medical Director was appointed as Responsible Officer in August 2018. The Responsible Officer is responsible for Bolton NHS Foundation Trust, Bolton Hospice and ABL Health Ltd.
Action for next year (1 April 2023 – 31 March 2024). No action required.

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
The Responsible Officer is supported by the CLAR, a part time A&R Officer (18 hours per week) and an A&R Administrator (30 hours per week). Funds are in place to support licences for the online appraisal and revalidation system (Premier IT).
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes

If yes, how is this maintained? The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. Induction registers and GMC connect notifications inform of new starters to the Trust.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). No action required.

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? We are in the process of organising a peer review with a neighbouring Trust for Autumn 2023. Terms of Reference for the review have been circulated between Trusts and final details are being confirmed. The last peer review took place in July 2017.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes Priming appraisals have been introduced for all new starters, including short term doctors, to ensure they are aware of appraisal requirements and to provide support with the process. Doctors are encouraged to attend the online training provided by Premier IT which gives them a step by step demonstration of the system and the opportunity to ask questions.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Short term doctors receive a study leave budget to support with their continued professional development. The MAG form has been used for appraisal purposes and the priming appraisals are used to highlight any learning needs and support required by the doctor.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes The Trust uses the Premier IT appraisal system. The appraisal portfolio is compliant with the latest national requirements and is based on the GMC framework for good medical practice.
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

Yes MAG forms have been used to appraise short term doctors.
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

With the discontinuation of the MAG form going forward we will be adding all our doctors to the Premier IT system.

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

Introduction of priming appraisals to ensure all new starters are aware of requirements and can navigate the online system. Standardisation of processes following appointment of new Clinical Lead for Appraisal and Revalidation.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

The newly appointed CLAR is looking to set up monthly online drop in sessions where new starters, or indeed any doctor, can ask questions about the A&R process. The peer review will take place to look at processes and share good practice. Continue to encourage and engage with senior medical staff to recruit new appraisers.

5.5 How do you train your appraisers?

Appraisers attend initial training through external providers which can be funded using the local study leave budget. An appraiser network meeting is held every 6 months and these meetings are aimed to provide continuous improvement in the quality and consistency of appraiser performance and an opportunity to discuss topical issues.

5.6 How do you Quality Assure your appraisers?

Appraiser performance is monitored by inspection of the appraisal outcome form by the clinical lead for appraisal. The electronic appraisal system provides the opportunity to provide appraiser feedback. This information is then collated and a report generated for each appraiser prior to their own appraisal meeting for discussion and reflection.

5.7 How are your Quality Assurance findings reported to the board?

Monthly meetings take place between the Medical Director/Responsible Officer, CLAR, A&R Officer and the Lead for Medical Education, where issues and concerns are discussed and where revalidation recommendations are signed off by the RO. An A&R action plan was produced following the last annual report and this is being monitored via the People Development Steering Group which feeds into the Trust People Committee with executive representation. Appraisal performance figures are also reported to the People Development Steering Group on a monthly basis as part of the Medical Education highlight report.

5.8 What was the most common reason for deferral of revalidation?

A lack of required supporting information, usually missing feedback, is the most common reason for a revalidation deferral. The RO will consider the circumstances before making a recommendation to defer.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The 'Failure to Engage Monitoring Pathway' is triggered for doctors who are not engaging in the appraisal and revalidation process. These doctors are also discussed at the monthly meetings with the RO, CLAR and administration team. All communications with the doctors by the A&R team are logged on the e-portfolio for accurate record keeping. Three failure to engage letters are sent at specified times with the GMC liaison officer and clinical lead being included in the 3rd letter should that stage be reached.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

The capability and conduct policy for medical staff outlines the procedure for handling concerns around doctors conduct, capability and health. It implements the framework set out in Maintaining High Professional Standards in the NHS. The MD/RO receives copies of all complaints concerning medical staff. Advise is sought from NHS Resolution Practitioner Performance Advisory Service on all cases of concern. Relevant information around complaints and involvement in serious incidents/never events is fed back to the appraisal lead to ensure they are included in appraisal discussions. All doctors complete a formal 360 degree and patient feedback process and reflect on outputs with their appraiser. Concerns regarding a doctor in training will be notified to the postgraduate dean. Where a concern involves a specialty doctor being hosted at the Trust we will inform the lead employer at the earliest opportunity.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

This information has been shared with a report on doctors in difficulty to people committee on a six monthly basis since 2022-2023

6.3 How do you ensure that any concerns are managed with compassion?

Where staff have been involved in a difficult or challenging complaint they will be supported within their relevant specialty in accordance with the Trusts Supporting Staff Policy. Peer support can be accessed through the KESS (Keeping Everyone Safe and Supported) team. KESS is run by a group of staff, including medical staff, who have been involved in an incident, complaint, claim or inquest and was set up to provide peer support. The patient experience team will provide training and education in relation to concerns and complaints to meet the needs of staff groups. Where a concern relates to a doctor in training the educational supervisor will always be notified to offer support and all doctors who are the subject of concerns are offered occupational health support.

6.4 How do you Quality Assure your system for responding to concerns?

All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document 'Principles of a good investigation'. However, there is currently no auditing of this to quality assure.

6.5 How is this Quality Assurance information reported to the board?

Not currently undertaken

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

MPIT forms are used to transfer information between RO and RO when a doctor leaves/commences employment. The RO is responsible for informing other organisations where a concern had been identified.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The capability and conduct for medical staff policy includes the NHS England Just Culture Guide which encourages managers to treat staff in a consistent, constructive and fair way.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

We now discuss monthly each doctor who has not complied with the appraisal process and ensure that they meet with the divisional medical director to formulate

an action plan that includes health. Whilst supporting any health concerns for such doctors, we will also hold doctors to account if they still fail to comply as appraisal is a contractual requirement

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

We will set up a system to independently audit how we respond to concerns. This will start by using the GMC 'principles of a good investigation' tool and will be reported through People Committee

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

The Trust uses an e-recruitment system (TRAC) which supports the completion of all pre-employment checks in line with NHS Employment Check Standards. The system is used to check all substantive staff, bank medical staff and foundation doctors before they commence employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements. The Trust receives confirmation that all appropriate checks are in place before work is permitted. NHS frameworks regulate agency partners on their frameworks with regular compliance audits.

Do you collate EDI data around recruitment and /or concerns information?

Yes/No (delete as applicable)
If yes, how do you use this information?'

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

We have a robust and mature appraisal and revalidation system in Bolton. Following the Covid Pandemic we have managed to get appraisals back on track for the majority of doctors. We have challenges in ensuring that we have sufficient appraisers (funding is not an issue). We aim to continue to improve our processes by undertaking a peer review process and auditing our investigation process.

Section 9: Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body:
……..…….

Name:
……

Role:
……..

Date:
……..

Appendix 1
Actions identified from the 2021-2022 AOA report and progress noted.

ISSUE	OWNER	DUE DATE	ACTION	RAG
BUSINESS CASE FOR INCREASED SUPPORT IN THE A&R TEAM To meet increasing demands and improve quality of A&R. Seeking to increase working hours of Band 5 to 0.8 WTE (30 hours p/w) to allow A&R Officer to provide service cover over longer and increased days.	CLAR (Clinical Lead for Appraisal and Revalidation)	Dec 2022	**Sept 2023** – Review requirements for A&R Team April 2023 – With CLAR being new in post this has been put on hold until A&R Officer returns from maternity leave.	
PRIMING APPRAISAL To discuss appraisal requirements will all medical new starters and offer support. Not in place due to staff pressures – being worked on.	A&R Officer	Nov 2022	**April 2023** – Template finalised and being sent out to new starters. Meetings organised to guide through appraisal process.	
RECRUITMENT OF APPRAISERS Revised and for submission to execs November 2022 for funding options. Delay due to working out funding model.	CLAR	Sept 2022	**July 2023** – Currently 41 appraisees without an appraiser allocated. April 2023 – Currently 43 appraisees without an appraiser allocated. In addition, 24 locally employed doctors on short term contracts without appraisers – being managed with support from ES/DME outside Premier IT system.	
PEER REVIEW NHS England encourages each designated body to conduct a peer review within each revalidation cycle. A&R Officer to liaise with neighbouring trusts to organise.	A&R Officer	Feb 2023	**July 2023** – Wigan A&R manager liaising with Bolton A&R Team to finalise. Terms of reference shared. April 2023- Wigan have agreed to conduct peer review with Trust – date to be finalised. Nov 2022 – made initial contact with Trusts of similar size.	

INCLUSION OF NEVER EVENTS AND SERIOUS INCIDENTS To be included in appraisal portfolios.	A&R Officer	Jan 2023	**Nov 2022** – Reporting system in place.	
A&R POLICY REVIEW/UPDATE Policy review was due December 2021.	CLAR/A&R Officer	Oct 2022	**July 2023** – With JLNC awaiting feedback. April 2023 – With JLNC awaiting feedback.	
CASE INVESTIGATOR & MANAGEMENT TRAINING FOR DMD TEAM	A&R Officer	Feb 2023	**April 2023** – Funding available via divisions as per study leave.	
AUDIT OF NEVER EVENTS & SERIOUS INCIDENTS Audit and feedback to educational supervisors.	A&R Officer	Jan 2023	Plan for Winter 2023	
DOCTOR CONCERNS Report to People Committee.	A&R Officer	6 monthly update	**April 2023** – Future reports to People Development Steering Group	

Appendix A – ABL Health Report

Introduction:

The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

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This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General
2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Name of Organisation:	**Bolton NHS Foundation Trust**
What type of services does your organisation provide?	Acute district general hospital providing NHS health care services

	Name	**Contact Information**
Responsible Officer	Dr Francis Andrews	Francis.Andrews@boltonft.nhs.uk
Medical Director	Dr Francis Andrews	Francis.Andrews@boltonft.nhs.uk
Medical Appraisal Lead	Dr Wyn Price	Wyn.Price@boltonft.nhs.uk

Appraisal and Revalidation Manager	Joanne Warburton	Joanne.Warburton@boltonft.nhs.uk
Appraisal and Revalidation Officer	Rabeya Rashid	Rabeya.Rashid@boltonft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: ABL Health **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	1
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	0
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	0
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1
Total number of appraisers as at 31 March 2023?	52 (Bolton FT)

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**0**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	**0**
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**0**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	**0**

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
Appraisal & Revalidation Policy for Medical Staff	December 2018	Review in progress. Anticipated final sign off by LNC in Sept 2023.

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**
Capability and Conduct Policy (Medical & Dental Staff)	March 2022	March 2025

Complaints & Concerns Policy and Procedure	June 2020	July 2023 – under review
Supporting Staff Policy	June 2021	June 2024

Other relevant policies	Implementation date	Review date
Remediation Policy (Medical & Dental Staff)	October 2021	October 2024

How do you socialise your policies?
All policies are available on the Trust intranet.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes
The Medical Director was appointed as Responsible Officer in August 2018. The Responsible Officer is responsible for Bolton NHS Foundation Trust, Bolton Hospice and ABL Health Ltd.
Action for next year (1 April 2023 – 31 March 2024). No action required.

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
The Responsible Officer is supported by the CLAR, a part time A&R Officer (18 hours per week) and an A&R Administrator (30 hours per week). Funds are in place to support licences for the online appraisal and revalidation system (Premier IT).
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained?

The Trust utilises the Premier IT appraisal and revalidation system to maintain accurate records. Induction registers and GMC connect notifications inform of new starters to the Trust.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). No action required.

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? We are in the process of organising a peer review with a neighbouring Trust for Autumn 2023. Terms of Reference for the review have been circulated between Trusts and final details are being confirmed. The last peer review took place in July 2017.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes Priming appraisals have been introduced for all new starters, including short term doctors, to ensure they are aware of appraisal requirements and to provide support with the process. Doctors are encouraged to attend the online training provided by Premier IT which gives them a step by step demonstration of the system and the opportunity to ask questions.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Short term doctors receive a study leave budget to support with their continued professional development. The MAG form has been used for appraisal purposes and the priming appraisals are used to highlight any learning needs and support required by the doctor.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes The Trust uses the Premier IT appraisal system. The appraisal portfolio is compliant with the latest national requirements and is based on the GMC framework for good medical practice.
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

Yes MAG forms have been used to appraise short term doctors.
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024). With the discontinuation of the MAG form going forward we will be adding all our doctors to the Premier IT system.

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

Introduction of priming appraisals to ensure all new starters are aware of requirements and can navigate the online system. Standardisation of processes following appointment of new Clinical Lead for Appraisal and Revalidation.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

The newly appointed CLAR is looking to set up monthly online drop in sessions where new starters, or indeed any doctor, can ask questions about the A&R process. The peer review will take place to look at processes and share good practice. Continue to encourage and engage with senior medical staff to recruit new appraisers.

5.5 How do you train your appraisers?

Appraisers attend initial training through external providers which can be funded using the local study leave budget. An appraiser network meeting is held every 6 months and these meetings are aimed to provide continuous improvement in the quality and consistency of appraiser performance and an opportunity to discuss topical issues.

5.6 How do you Quality Assure your appraisers?

Appraiser performance is monitored by inspection of the appraisal outcome form by the clinical lead for appraisal. The electronic appraisal system provides the opportunity to provide appraiser feedback. This information is then collated and a report generated for each appraiser prior to their own appraisal meeting for discussion and reflection.

5.7 How are your Quality Assurance findings reported to the board?

Monthly meetings take place between the Medical Director/Responsible Officer, CLAR, A&R Officer and the Lead for Medical Education, where issues and concerns are discussed and where revalidation recommendations are signed off by the RO. An A&R action plan was produced following the last annual report and this is being monitored via the People Development Steering Group which feeds into the Trust People Committee with executive representation. Appraisal performance figures are also reported to the People Development Steering Group on a monthly basis as part of the Medical Education highlight report.

5.8 What was the most common reason for deferral of revalidation?

A lack of required supporting information, usually missing feedback, is the most common reason for a revalidation deferral. The RO will consider the circumstances before making a recommendation to defer.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The 'Failure to Engage Monitoring Pathway' is triggered for doctors who are not engaging in the appraisal and revalidation process. These doctors are also discussed at the monthly meetings with the RO, CLAR and administration team. All communications with the doctors by the A&R team are logged on the e-portfolio for accurate record keeping. Three failure to engage letters are sent at specified times with the GMC liaison officer and clinical lead being included in the 3rd letter should that stage be reached.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

The capability and conduct policy for medical staff outlines the procedure for handling concerns around doctors conduct, capability and health. It implements the framework set out in Maintaining High Professional Standards in the NHS. The MD/RO receives copies of all complaints concerning medical staff. Advise is sought from NHS Resolution Practitioner Performance Advisory Service on all cases of concern. Relevant information around complaints and involvement in serious incidents/never events is fed back to the appraisal lead to ensure they are included in appraisal discussions. All doctors complete a formal 360 degree and patient feedback process and reflect on outputs with their appraiser. Concerns regarding a doctor in training will be notified to the postgraduate dean. Where a concern involves a specialty doctor being hosted at the Trust we will inform the lead employer at the earliest opportunity.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

This information has been shared with a report on doctors in difficulty to people committee on a six monthly basis since 2022-2023

6.3 How do you ensure that any concerns are managed with compassion?

Where staff have been involved in a difficult or challenging complaint they will be supported within their relevant specialty in accordance with the Trusts Supporting Staff Policy.

Peer support can be accessed through the KESS (Keeping Everyone Safe and Supported) team. KESS is run by a group of staff, including medical staff, who have been involved in an incident, complaint, claim or inquest and was set up to provide peer support.

The patient experience team will provide training and education in relation to concerns and complaints to meet the needs of staff groups.

Where a concern relates to a doctor in training the educational supervisor will always be notified to offer support and all doctors who are the subject of concerns are offered occupational health support.

6.4 How do you Quality Assure your system for responding to concerns?

All concerns raised with the RO are discussed with the deputy director of people and the PPAS to ensure a fair and proportionate response. We follow the 10 recommended practices in the GMC best practice document 'Principles of a good investigation'. However, there is currently no auditing of this to quality assure.

6.5 How is this Quality Assurance information reported to the board?

Not currently undertaken

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

MPIT forms are used to transfer information between RO and RO when a doctor leaves/commences employment. The RO is responsible for informing other organisations where a concern had been identified.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The capability and conduct for medical staff policy includes the NHS England Just Culture Guide which encourages managers to treat staff in a consistent, constructive and fair way.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

We now discuss monthly each doctor who has not complied with the appraisal process and ensure that they meet with the divisional medical director to formulate an action plan that includes health. Whilst supporting any health concerns for such doctors, we will also hold doctors to account if they still fail to comply as appraisal is a contractual requirement

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

We will set up a system to independently audit how we respond to concerns. This will start by using the GMC 'principles of a good investigation' tool and will be reported through People Committee

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

The Trust uses an e-recruitment system (TRAC) which supports the completion of all pre-employment checks in line with NHS Employment Check Standards. The system is used to check all substantive staff, bank medical staff and foundation doctors before they commence employment. All agency medical staff are sourced through accredited agency partners, through NHS framework agreements. The Trust receives confirmation that all appropriate checks are in place before work is permitted. NHS frameworks regulate agency partners on their frameworks with regular compliance audits.

Do you collate EDI data around recruitment and /or concerns information?

Yes/No (delete as applicable)
If yes, how do you use this information?'

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

We have a robust and mature appraisal and revalidation system in Bolton. Following the Covid Pandemic we have managed to get appraisals back on track for the majority of doctors. We have challenges in ensuring that we have sufficient appraisers (funding is not an issue). We aim to continue to improve our processes by undertaking a peer review process and auditing our investigation process.

Section 9: Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ABL Health Ltd

Name:
……

Role:
……..

Date:
……..

Appendix 1
Actions identified from the 2021-2022 AOA report and progress noted.

ISSUE	OWNER	DUE DATE	ACTION	RAG
BUSINESS CASE FOR INCREASED SUPPORT IN THE A&R TEAM To meet increasing demands and improve quality of A&R. Seeking to increase working hours of Band 5 to 0.8 WTE (30 hours p/w) to allow A&R Officer to provide service cover over longer and increased days.	CLAR (Clinical Lead for Appraisal and Revalidation)	Dec 2022	**Sept 2023** – Review requirements for A&R Team April 2023 – With CLAR being new in post this has been put on hold until A&R Officer returns from maternity leave.	
PRIMING APPRAISAL To discuss appraisal requirements will all medical new starters and offer support. Not in place due to staff pressures – being worked on.	A&R Officer	Nov 2022	**April 2023** – Template finalised and being sent out to new starters. Meetings organised to guide through appraisal process.	
RECRUITMENT OF APPRAISERS Revised and for submission to execs November 2022 for funding options. Delay due to working out funding model.	CLAR	Sept 2022	**July 2023** – Currently 41 appraisees without an appraiser allocated. April 2023 – Currently 43 appraisees without an appraiser allocated. In addition, 24 locally employed doctors on short term contracts without appraisers – being managed with support from ES/DME outside Premier IT system.	
PEER REVIEW NHS England encourages each designated body to conduct a peer review within each revalidation cycle. A&R Officer to liaise	A&R Officer	Feb 2023	**July 2023** – Wigan A&R manager liaising with Bolton A&R Team to finalise. Terms of reference shared. April 2023- Wigan have agreed to conduct peer review with Trust – date to be finalised.	

with neighbouring trusts to organise.			Nov 2022 – made initial contact with Trusts of similar size.	
A&R POLICY REVIEW/UPDATE Policy review was due December 2021.	CLAR/A&R Officer	Oct 2022	**July 2023** – With JLNC awaiting feedback. April 2023 – With JLNC awaiting feedback.	
CASE INVESTIGATOR & MANAGEMENT TRAINING FOR DMD TEAM	A&R Officer	Feb 2023	**April 2023** – Funding available via divisions as per study leave.	
DOCTOR CONCERNS Report to People Committee.	A&R Officer	6 monthly update	**April 2023** – Future reports to People Development Steering Group	

Report Title:	Finance & Investment Committee Chair's Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 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 Chair's report is attached from the Finance & Investment Committee Meeting held on the 26 July as assurance on the work delegated to the Committee by the Board. Due to the timing of the next meeting, a verbal update will be provided for the meeting to be held on 27 September 2023.

Previously considered by:
Discussed and agreed at the Finance and Investment Comittee

Proposed Resolution	The Board of Directors are asked to note the Finance & Investment Committee Chair's Report.

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

Prepared by:	Annette Walker Chief Finance Officer	**Presented by:**	Annette Walker Chief Finance Officer

Committee/Group Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	26 July 2023	Date of next meeting:	27 September 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rae Wheatcroft, Sharon Katema, James Mawrey, Rebecca Ganz, Rachel Noble, Sam Ball	Quorate (Yes/No):	Yes
		Apologies received from:	Bilkis Ismail, Andrew Chilton

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Board Assurance Framework		S Katema	The Committee received the updated Board Assurance Framework following review by the Chief Finance Officer regarding the gaps in control and assurance. All changes were highlighted. There is no proposed change in risk score.	Noted.
GM/National System Update		A Walker	The Committee received an update on the GM/National/System financial positon. The key points were noted as follows: • GM ICS has a combined has a year to date deficit of £87.0m which in the context of a break even plan by year is extremely challenging. • All NHS providers have year to date deficits. • PWC work has identified key drivers of GM's financial and operational challenges and 13 improvement opportunities, which are being worked on by all providers. • GM is ranked 41/42 for productivity levels, with the main driver being reduced activity.	Noted.
Standardised Financial Controls for GM ICS partners		A Walker	The Committee were advised of a letter written by Mark Fisher sent to Provider Chief Executives requesting that they implement a range of standard financial controls with immediate effect. Assurances were provided that work was underway to assess compliance and that an update would be provided in September.	Noted.

	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

Committee/Group Chair's Report

Month 3 Finance Report		A Chilton	The Committee received the Month 3 Finance Report. The following key points were noted: • In month 3, an NHSI reported year to date deficit of £4.7m compared with a planned deficit of £3.2m. Unidentified CIP remains a significant issue, as only £2.1m has been delivered against a target of £4.8m, leaving a shortfall of £2.7m. • Capital spend for month 3 2023/24 is £275k of which £35k relates to CDC. • Cash of £36.3m at the end of the month, which is an increase of £1.5m from Month 2 2023/2024. The Trust cash position will become challenging during 2023/24 and this has been flagged as a key concern during planning discussions with the ICB. • BPPC performance year to date is 84.1% due the processing of a late payment of £6m in month 2. A number of actions are underway to improve and maintain this performance. • Probable forecast scenario by March 2024 is a deficit of £22.2m against a plan of £12.4m which is an improvement from the previous month forecast.	Noted with associated risks around CIP.
Productivity Cost Improvement Update		S Ball	The Committee received an update on the Cost Improvement Programme and the Productivity Scheme of Work progress to date for 2023/24 which included a summary of the June CIP Position, the 2023/24 CIP Programme schedule and the Trust wide 'Dragon's Den' CIP challenge.	Noted with risk in delivery of CIP and unidentified CIP.
IFM Performance Report May 2023		A Walker	The Committee received the monthly IFM Performance Report for May. Each month IFM management meet with the Chief Finance Officer and Chief Operating monthly and present to the respective Divisional Directors of Operations and Nursing meetings as a means of holding to account as both a supplier to the Trust and as a wholly owned subsidiary. The IFM Operating Model is due to be reviewed and the re-introduction of formal contract meetings and annual shareholder meeting is under consideration. Any proposed changes to the Operating Model will be subject to FT Board approval.	Noted.

	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

Committee/Group Chair's Report

CHP Lease Extensions		A Walker	The Committee was asked to approve for recommendation to Trust Board the lease renewal for a period of 5-years at Breightmet and Bolton One The combined annual rent is £3.7m p.a with service charge of £0.9m; over the 5-year term, this would equate to £18.5m rent and £4.5m service charge. Rental charges increase in line with RPI in accordance with the head lease with the landlord.	Recommended for approval by the Board.
Chairs' Reports		A Walker	**Chairs' Reports** The Committee noted the following reports for information: **Capital Revenue & Investment Group** The Chair's report from the meeting held on the 4th of July was received for information. **Place Based Finance & Assurance Committee** The Minutes from the meeting on the 18th of July were received for information.	
Comments:				
Risks escalated: Delivery of CIP and unidentified CIP remains a significant issue				

	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

Report Title:	Charitable Funds Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide the Board of Directors with a summary of discussion and decisions made at the Charitable Funds Committee meeting on 28 July and 11 September 2023.

Summary:	The attached report from the Chair of the Charitable Funds Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meetings held on 28 July and 11 September 2023.

Previously considered by:
Discussed and agreed at the Charitable Funds Committee

Proposed Resolution	The Board of Directors is asked to note 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:	Sarah Skinner, Charity Manager	**Presented by:**	Martin North, Chair of the Charitable Funds Committee

Charitable Funds Committee Chair's Report

Name of Committee/Group:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	28 July 2023	Date of next meeting:	11 September 2023
Chair:	Martin North	Parent Committee:	Board of Directors
Members Present:	Sharon White, Alan Stuttard, Sharon Katema, Rachel Noble, Catherine Hulme (deputising for Annette Walker), Sarah Skinner and Abdul Goni	Quorate (Yes/No):	Yes (with deputies)
		Apologies received from:	Francis Andrews, Annette Walker, and Rachel Carter

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Our Bolton NHS Charity Q1 2023/24 highlight report		SS	The Charity Manager shared the Q1 2023/24 highlight report to provide an overview of activity against key themes: • Fundraising and grants • Communications, marketing and media • Charity-funded schemes • Events • Risks	The Charitable Funds Committee noted the highlight report.
NHS Charities Together update		RN SS	The Deputy Director of Strategy and the Charity Manager provided an update on the latest work with NHS Charities Together, including events, strategy development and the delivery of grant programmes.	The Charitable Funds Committee noted the NHS Charities Together update, acknowledging that investment in NHS Charities Together should be commensurate with the return in terms of grant-funding and other intangible benefits.
NHS 75		SS	The Charity Manager provided an update of events and activities that took place during NHS 75 and advised that the NHS' milestone birthday had provided an ideal opportunity to leverage support for Our Bolton NHS Charity.	The Charitable Funds Committee noted the update, acknowledging the breadth of activities organised aby the charity and communications teams, and the opportunities the celebration had provided.

	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

Finance report		CH	The Associate Director of Financial Services presented the finance report noting a net increase in funds of £1k for the 12 months to 31st March 2023, comprising of £712k in income and £711k in expenditure. The Associate Director of Financial Services advised that the charity had received £556k in legacies leaving five legacies outstanding (worth £2.6k). The Associate Director of Financial Services confirmed the call on funds now stands at £388k and the charity's fund balances totalled £1,050k.	The Charitable Funds Committee noted the finance report.
Audit report		CH	The Associate Director of Financial Services presented the audit report, advising that the auditors had issued a low risk rating with three findings (two low and one medium risk) and that recommendations were being actioned by the Charity Manager and Finance Manager.	The Charitable Funds Committee noted the finance report acknowledging the progress the team had made since the audit report back in 2019/20.
Comments				
Risks escalated There are no risks to be escalated to the Board of Directors.				

	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

Charitable Funds Committee Chair's Report

Name of Committee/Group:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	11 September 2023	Date of next meeting:	4 December 2023
Chair:	Martin North	Parent Committee:	Board of Directors
Members Present:	Sharon White, Alan Stuttard, Sharon Katema, Rachel Noble, Catherine Hulme (deputising for Annette Walker), Rachel Carter, Sarah Skinner and Abdul Goni	Quorate (Yes/No):	Yes (with deputies)
		Apologies received from:	Francis Andrews and Annette Walker

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Our Bolton NHS Charity Q2 2023/24 highlight report		SS	The Charity Manager shared the Q2 2023/24 highlight report to provide an overview of activity against key themes: • Fundraising and grants • Communications, marketing and media • Charity-funded schemes • Events • Risks	The Charitable Funds Committee noted the highlight report.
Our Bolton NHS Charity Q3 2023/24 outlook report		RN SS	The Deputy Director of Strategy introduced the new Q2 2023/24 outlook report to provide a state of the sector update and proposed/planned activity against key themes: • People and team development • Process and system development • Fundraising plans • Anticipated expenditure	The Charitable Funds Committee welcomed the new outlook report and noted its content.
NHS Charities Together funding update		RN SS	The Charity Manager shared the stage 3 impact (including supplementary evidence), noting that grant conditions had been fully met and our stage 3 grant programme had been formally closed by NHS Charities Together. The Charity Manager presented a Gantt chart setting out the work programme, which is being funded by the £30k development grant.	The Charitable Funds Committee noted the content of the impact report and Gantt chart.

	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

Application for charitable funds: fatigue project		HB	The Chief Registrar presented a statement of case requesting £39,821.46 from charitable funds to support with the purchase of 21 recliner chairs to encourage colleagues (particularly those on a night-shift) to rest/sleep during their allocated break or post-shift before travelling home. The Charity Manager advised that the application had passed the technical appraisal based on the three tests (enhancement, patient benefit and public perception) being met and confirmed sufficient funds were available.	The four voting members of the Charitable Funds Committee voted unanimously in support of the fatigue project and funding will subsequently be awarded to purchase the 21 recliner chairs.
Finance report		CH	The Associate Director of Financial Services presented the finance report noting a net increase in funds of £84k for the 4 months to 31st July 2023, comprising of £133k in income and £49k in expenditure. The Associate Director of Financial Services advised that the charity had received £80k in legacies leaving five legacies outstanding (worth £2.6k). The Associate Director of Financial Services confirmed the call on funds now stands at £360k and the charity's fund balances totalled £1,132k.	The Charitable Funds Committee noted the finance report.
Draft annual report and financial statements 2022/23		RN CH	The Deputy Director of Strategy shared the draft annual report and financial statements up to 31st March 2023. The financial statements are currently being audited by KPMG and are expected to be returned in September 2023. The final version will be brought to the Charitable Funds Committee meeting on 4th December 2023 for approval and the deadline for submission to the Charities Commission is the end of January 2024.	The Charitable Funds Committee noted the draft annual report and financial statements and agreed to provide any further comments via email by 31st October 2023.
Terms of reference: annual review		SS	The Charity Manager shared the Charitable Funds Committee's terms of reference, which had been updated following an annual review, noting the following changes: • Tightening of the wording around funding applications considered by the Charitable Funds Committee • Inclusion of the Outlook report as a quarterly standing agenda item	The Director of Corporate Governance suggested including the Chief Nurse as a voting member (alternating with the Medical Director) to ensure the clinical perspective is always represented. Subject to this change being made, the terms of reference were approved.

	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

Risk register		RN	The Director of Strategy introduced the risk register confirming the Q2 review had been completed, resulting in three new risks and one retired risk. The charity now has ten live risks, with two risks scoring 12 or above (before mitigation). Due to time constraints, it was agreed that the risk register would be brought back as a substantive item in December.	The Charitable Funds Committee noted the risk register and welcomed the suggestion of a 'deep dive' in December 2023.
Comments				
Risks escalated There are no risks to be escalated to the Board of Directors.				

	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

Report Title:	Audit Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 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:	Chairs' Reports attached from the Audit Committee Meeting held on the 13 September 2023.

Previously considered by:
Discussed and agreed at the Audit Committee.

Proposed Resolution	The Board of Directors are asked to note 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:**	Annette Walker Chief Finance Officer

Audit Committee Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	13 September 2023	Date of next meeting:	06 December 2023
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Martin North, Sharon Katema, Andrew Chilton, Catherine Hulme, Debra Chamberlain, Darrell Davies, Patrick Clark	Quorate (Yes/No):	Yes
		Apologies received from:	Malcolm Brown, Annette Walker

Agenda Items:	RAG	Key Points	Action/decision
Terms of Reference		The Committee were informed that the review of the Terms of Reference have been deferred until December to enable a number of changes to be made to them.	The Committee deferred the approval of the Terms of Reference to December 23.
Internal Audit Annual Report		The Committee considered the final Internal Audit Annual Report for 2022/23 from PWC. The Committee had previously seen a draft of the report. The final report confirmed the previous head of Internal Audit Opinion of Reasonable/Moderate Assurance for both the Trust and IFM. As previously reported this represents the second highest rating by PWC. This report concludes the tenure of PWC as Internal Auditors to the Trust.	Noted.
Internal Audit Plan 2023/24		The new Internal Auditors, MIAA presented the Internal Audit Plan for 2023/24. The rationale behind the plan was explained which comprised of a review of key risks from the risk register and Board Assurance framework together with discussions with the Executive and Non- Executive Directors. The plan set out details of the areas to be covered and the timetable for undertaking the reviews. The Committee also asked if there were any particular areas that MIAA felt needed to be reviewed, for example based on their work elsewhere these could also be brought to the Committee for consideration.	The Committee approved the Internal Audit Plan for 2023/24.
Internal Audit Progress Report 2023/24		MIAA presented a progress report on the 2023/24 plan. A number of audits had already commenced from the plan presented to the Audit Committee for approval at the meeting. The Committee noted that 4 reviews were underway and 2 were in the planning stage.	Noted.
Health Sector Update		KPMG presented the update noted by the Committee. The Committee asked about the audits for IFM Bolton Ltd and Charitable Funds. KPMG advised that these were	Noted.

	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

		underway with the intention to bring the audit reports to the next meeting in December.	
Local Counter Fraud Specialist Progress Report		The Local Counter Fraud Specialist provided an update on what had been a very busy period. A number of fraud alerts have been issued and a number of investigations have been undertaken. The Committee raised a number of questions regarding the investigations and it was pleasing to note that staff continue to be prepared to raise their concerns even if in some cases there is no evidence of fraud found. In some cases there may be further action required depending on the nature of the investigation.	Noted.
Register of Waiver for Bolton and iFM		The Associate Director of Finance presented the register of Waivers Report for the period 1st April to 31st August 2023 for the Trust and IFM. Overall, the number of waivers had reduced slightly. However, the value of the waivers had increased. The Committee questioned the number of retrospective waivers and it was felt that some of these could be dealt with more effectively through the contract process. It was noted that a number of the waivers were scheduled for review by the procurement team in terms of reducing the overall number of waivers. A query was also raised by the Committee in respect of the safeguarding checks undertaken in relation to taxi and ambulance usage.	Noted.
Losses and Special Payments Report Bolton FT and iFM		The Associate Director of Finance presented the Special Payments Report for the period 1st of April to 31st of August 2023 for the Trust and IFM. The main area of losses was from pharmacy relating primarily to out of date drugs. The Committee did ask for assurance that there were no potential risks in relation to the pharmacy losses.	Noted.
Comments:			
Risks Escalated : There were no risks to be escalated to the Board of Directors.			

	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

Report Title:	Audit Committee Annual Report 2022/23

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	

Purpose	To provide an overview of the work the Audit Committee has undertaken at formal meetings, including how it carried out the work, assurances it received and demonstrate compliance with its Terms of Reference.

Summary:	The production of an Audit Committee Annual Report represents good governance practice and ensures compliance with the HFMA Audit Committee Handbook. In line with statutory requirements, the Board formally established the Audit Committee whose role is to provide an independent and objective review of the Trust's internal controls. It seeks high-level assurance on the effectiveness of: • the Trust's governance (corporate and clinical) • risk management, • and systems of internal control

Previously considered by:	This report was presented to the Audit Committee who made final comments upon receipt and recommended the report for approval .

Proposed Resolution	The Board of Directors is asked to **approve** the Audit Committee Annual 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:	Victoria Crompton, Corporate Governance Manager Sharon Katema, Director of Corporate Governance	**Presented by:**	Alan Stuttard, Chair Audit Committee

Bolton
NHS Foundation Trust

Audit Committee Annual Report

2022/23

1. **Introduction**

The Audit Committee is a formal Committee of the Board established under Board delegation with approved terms of reference aligned with the NHS Audit Committee Handbook, published by the Healthcare Financial Management Association (HFMA). The Committee met on five occasions in the period covered by this report to discharge its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

Membership of the Committee consists of a Non-Executive Chair and two other Non-Executive Directors of the Trust. The Chair of the Trust and the Chair of the Finance Committee are specifically excluded from membership. The Chair of the Audit Committee is Alan Stuttard, Non-Executive Director and the two Non-Executive Directors are Malcolm Brown and Martin North. Attendance at the committee is shown in the table below.

	Meeting Date				
	04/05/22	15/06/22	05/10/22	07/12/22	15/2/23
Alan Stuttard (Chair)	✓	✓	✓	✓	Apologies
Malcolm Brown	✓	✓	✓	✓	✓
Martin North	✓	✓	Apologies	✓	✓

A number of officers are in regular attendance. These include the Director of Finance, the Head of Financial Services, the Director of Corporate Governance, Internal and External Auditors, and the Local Anti-Fraud Specialist. Other directors and managers attend at the request of the Committee. The Audit Committee Chair provides a summary report of the Committee's activities to the next meeting of the Trust Board of Directors. The Committee is assured that its members and regular attendees, have sufficient knowledge of the organisation's business to identify key risks.

The Committee's work predominantly focused upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives (the Assurance Framework). The Committee had a pivotal role to play in reviewing the disclosure statements from the organisation's assurance processes; in particular, the Annual Governance Statement, included in the Annual Report and Accounts. The Committee also has a key role in reviewing the reports of the External and Internal Auditors and their findings for the Trust.

In addition to the Trust the Audit Committee also considers all audit reports and findings in respect of IFM Ltd, the wholly owned subsidiary of the Trust.

2022/23 continued to be a challenging year for the Trust as it started to emerge from the Covid 19 pandemic. This still had a significant impact on the Trust and the staff and patients. During this period, however, the Audit Committee has continued in its role providing challenge and oversight of the underlying assurance processes to ensure compliance with organisational objectives and regulatory requirements.

2. **Purpose of the Report**

This Annual Report has been prepared for the attention of the Board of Directors and reviews the work and performance of the Audit Committee in satisfying its Terms of Reference.

The production of an Audit Committee Annual Report represents good governance practice and ensures compliance with the HFMA NHS Audit Committee Handbook, the principles of

integrated governance and the NHSI Compliance Framework.

The report covers the financial year 2022/23.

3. **Terms of Reference**

- The Terms of Reference of the Audit Committee are reviewed annually and were last reviewed by the Audit Committee in March 2022 (Appendix A)
- The Audit Committee met five times during the reporting period.
- All meetings were quorate (quorum is defined in the terms of reference as two Non-Executive Directors).
- A Chair's report from the Audit Committee is submitted to the next meeting of the Board of Directors.
- The Audit Committee members have the option to meet in private with the Internal and External Auditors if required although in this reporting period this option was not taken up.
- The Director of Finance, Deputy Director of Finance, Director of Corporate Governance, Head of Internal Audit and Internal Audit Manager, representatives of External Audit and the Local Counter Fraud Specialist have been in attendance.
- Executive Directors, Corporate Directors and other members of staff have been requested to attend the Audit Committee as required.
- Following receipt of the Adult Safeguarding Report which had limited assurance the Committee requested the presence of the Chief Nurse at the December 2022 meeting.

  The Adult Safeguarding Report had been considered by the Quality Assurance Committee and the Safeguarding Committee and the action plan would be taken forward by these committees. The Audit Committee discussed the level of assurance and whether this should be included on the Board Assurance Framework.

  The Maternity Incentive Scheme report highlighted three high risk and two medium risk findings and overall reported as high risk. All actions would be followed up diligently.

4. **Work and Performance of the Committee**

The Audit Committee agenda is formulated from the Annual Workplan and is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate, financial, clinical, and risk governance and management.

The Audit Committee agendas in the reporting period covered the following:-

- Review of the Board Assurance Framework
- External Audit reports
- Internal Audit reports
- Anti-Fraud reports
- Losses and special payments reports

- Tenders waived reports
- Declarations of interest
- Register of sealings

The Audit Committee also reviewed the draft Annual Governance Statement for the period 1 April 2022 to 31 March 2023 at its meeting in June 2023. The Annual Governance Statement described the system of internal control that supports the achievement of the Trust's policies, aims and key priorities.

5. Financial Reporting

During and in respect of the year, the Committee received, gained assurance and actioned the following:

- Recommended approval of the 2021/22 Annual Report and Annual Accounts to the Board of Directors following completed of the External Audit
- Approved the Annual Report & Quality Account 2022/23 timetables for production
- Reviewed the Draft Annual Accounts for 2022/23 prior to submission to the External Auditors
- Confirmed that the Accounts for 2022/23 be prepared on a going concern basis
- Reviewed the Annual Accounts following completion of the audit by the External Auditors and recommended the Accounts for approval by the Board of Directors
- Reviewed the Letter of Representation 2022/23 for approval by the Board of Directors and signing by the Accountable Officer
- Reviewed the Annual Report and recommended the Report for approval by the Board of Directors

6. External Audit

The External Auditors to the Trust are KPMG.

The Audit Committee received and approved the External Audit Plan for 2022/23. The Plan identified significant inherent audit risks related to:

- Valuation of Land and Buildings
- Fraud risk from expenditure recognition – completeness
- Management override of controls

The Plan identified key audit judgements relating to:

- Revenue recognition
- IFRS 16 Leases

The Committee received the 2022/23 External Audit Report (including the ISA 260 Report) in June 2023. The report confirmed that no significant audit issues had arisen in respect of the significant inherent audit risks and key audit judgements listed above. The report further confirmed that no audit adjustments or disclosure deficiencies had been identified. An Unqualified audit opinion was given on the Trust's accounts for 2022/23

As part of their Audit work the External Auditors also undertook the Value for Money risk assessment for the year ended 31 March 2023 as required by the Code of Audit practice the auditors reported that 'we have not identified any significant risks that there are significant weaknesses in your arrangements'.

Following the Committee meetings in June 2023, the Committee made recommendations to the Board of Directors to approve the Audited Accounts, Annual Report and Annual Governance Statement for 2022/23

KPMG provided regular progress reports and technical updates to the Audit Committee.

The External Audit Contract was due for re-tendering from 2023/24. The Audit Committee presented a report to the Council of Governors in February 2023 with a number of options. The Council of Governors approved an extension of 1 year to the contract to allow a period of time for all the options to be fully considered.

7. **Internal Audit**

Internal Audit during the reporting period has been provided by Pricewaterhouse Coopers (PwC).

The Committee worked with the Internal Auditor to consider the major findings of internal audit reports and the associated management responses and monitored the implementation of recommendations through regular progress reports.

The conclusions, as well as the findings and recommendations, of all Internal Audit reports finalised during the year were shared with the Audit Committee. The Committee challenged Internal Audit on assurances provided and, where appropriate, requested additional information, clarification and follow-up work if considered necessary. Progress towards the implementation of agreed recommendations was also reported (including full details of all outstanding recommendations) to the Executive Management Team. The Audit Committee reviewed and was satisfied by the progress reports.

The Head of Internal Audit Opinion for 2022/23 presented to the Audit Committee was "Generally satisfactory with some improvements required". PwC apply four assessments to their opinion and the one for Bolton is the second highest of those assessments.

The following Internal Audit Reports were received by the Audit Committee during the reporting period:

Audit Title (Final Reports)	**Report classificatio**	**Number of findings**			
		Critical	High	Medium	Low
IT Access Controls	Advisory				
IT EPR Deployment	Low			1	1
Procurement Tender/Waivers	Medium		1	1	
Data Security Protection Toolkit (DSPT)	Moderate				
Discharging – Criteria to Reside	Medium		1		1
Governance and Risk Management	Low			1	2

Key Financial Controls	Low				2
Finance Sustainability Review	N/A				
Green Plan Review	Medium			3	2
Adult Safeguarding	High		2	2	
CNST	High		3	2	
Workforce Equality Diversity and Inclusion	Medium			3	1
Sickness Absence, iFM Bolton	Medium			3	1
Assurance Framework and Risk Management	Low			1	2
Business Continuity/Emergency Planning (EPRR)	Low				1
Charitable Funds	Low			1	2

The Internal Audit Contract was due for renewal in 2023/24 and a tender exercise was undertaken by the Trust. The outcome of the tender was to award the contract to Mersey Internal Audit Agency with a contract term of two years to 16 May 2025, with two 12 months options to extend.

The Audit Committee would like to place on record it's thanks to PwC for the work undertaken under the current contract.

8. **Counter-Fraud**

Counter Fraud services have been provided through a Service Level Agreement with Wrightington, Wigan and Leigh NHS Foundation Trust. A nominated Counter Fraud Specialist (CFS) works with the Trust and regularly attends Audit Committee meetings.

The Audit Committee received regular progress reports and details of investigations carried out during the year.

During the reporting period the organisation has undertaken anti-fraud work as per the "Standard for Providers" document this is set out in four sections and covers corporate responsibilities and the three key principles for action. These are:

- Strategic governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

The Audit Committee acknowledged the pro-active work undertaken by the local CFS in providing training to staff and sending out anti-fraud awareness notices.

The Committee was pleased to see the openness and transparency with which staff are prepared to report on matters of potential fraud even though following investigation there may be no case to answer.

The Audit Committee approved the following Reports:

- Counter Fraud Annual Report 2022/23
- Counter Fraud Work Plan 2023/24

9. **Losses and Special Payments**

The Audit Committee was provided with regular information regarding the levels and values of losses and special payments within the Trust. There were no areas of concern noted with these payments.

10. **Tenders Waived**

A summary of all tenders waived above a £50k value was presented at each meeting of the Audit Committee. The key aspect here is for the Committee to review the explanations given for the waivers to ensure that there is effective control over the financial and procurement process with the overall aim of reducing the number of waivers.

The Audit Committee noted that as a consequence of the impact of Covid there was an increase in the number of waivers due to the impact on both suppliers and the speed at which purchasing had to be made to deal with the consequences. However this is expected to reduce as the impact reduces and will be closely monitored by the Committee.

11. **Effectiveness of the Audit Committee**

In December 2022, the Committee undertook a self-assessment of its effectiveness. This involved a range of questions covering different elements of the work of the Committee. This follows good governance practice in accordance with the NHS Audit Committee Handbook.

The results were generally positive and indicated the committee had continued to build on its effectiveness since the last review in 2020. This is evidenced by the absence of Strongly Disagree/Disagree responses to any of the questions. There were a number of neutral survey submissions and how to improve the overall effectiveness of the Committee will be subject to on-going review.

12. **Conclusion**

The Audit Committee has an important role in delivering good governance, providing challenge and oversight and in advising senior management on the effectiveness of risk management processes.

Committee members recognise that although progress has been made the Trust must not be complacent and must build on recent successes to embed strong and sustainable governance arrangements throughout the Trust.

The Audit Committee has an important role to play in ensuring appropriate governance and control arrangements are also in place for iFM Bolton. Going forward the scope of the Audit Committee will need to consider the arrangements in respect of the Local Care System and how this impacts on the Trust.

As Chair of the Audit Committee I would like to take this opportunity to thank the members of the Committee for their support and input to the work of the Committee and also to thank all

those who attend the Committee along with the Corporate Services team who provide us with all the administrative support.

Alan Stuttard
Chair of Audit Committee

Report Title:	Fit and Proper Person's Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Sharon Katema		Decision	

Purpose	This report provides an update to the Board of Directors following the are compliant with the regulatory requirements of the Fit and Proper Person Tests

Summary:	On 2 August 23, NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT as it applies under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review highlighted areas that needed improvement to strengthen the existing regime Notable changes to the FPP Framework include • Updates in the NHS Electronic Staff Record (ESR) to record the testing of relevant information about board members' qualifications and career history. • A new standard board member reference template for references for all new appointments and for those leaving the organisation. • Introduction of the NHS Leadership Competency Framework which will provide guidance for the competence categories against which a board member should be appointed, developed and appraised. • The annual assessment which will be submitted to NHS England.

Previously considered by:	N/A

Proposed Resolution	The Board is asked to **receive** this report detailing the changes to the Fit and Proper Person requirements

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

1. Introduction

1.1. The Care Quality Commission (CQC) introduced new requirements regarding the 'Fit and Proper Person Tests' for Directors in November 2014, which became law from 1 April 2015. This approach sought to ensure that providers meet Government regulations about the quality and safety of care, to ensure an open, honest and transparent culture within the NHS to ensure accountability of Directors to NHS Bodies.

1.2. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Person Regulations (FPPR).

1.3. The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights. The regulations place a duty on trusts to ensure that their directors are compliant with the FPPR and this report provides assurance to the board on this matter.

1.4. The Fit and Proper Person Test places a duty on providers to meet their obligations to only employ individuals who are fit for their role. The regulations also extend to individuals who are prevented from holding the office (for example, under a Director's disqualification order) and significantly, excluding people who:

> '*Have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity'.*

2. FPP Assessment Core Elements

2.1. Under the requirements, the Trust must not appoint to a post under the scope of the Regulated Activity Regulations without first satisfying itself that the individual:

- Is of good character
- Has the necessary qualifications, competence, skills and experience
- Has the appropriate level of physical and mental fitness
- Has not been party to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity
- Is not deemed unfit under the Regulated Activities Regulations provisions
- Can provide the personal information as set out in the regulations which must be available to be supplied to the CQC when required.

2.2. These requirements must be held at the point of commencing the role and on an ongoing basis. In the event that an individual ceases to be a fit and proper person, the individual may be summarily dismissed and the Trust will notify the individual and the trust's regulator.

3. Updates to FPP

3.1. In July 2018, Tom Kark KC was commissioned to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT). The review looked in particular at how effective the FPPT is in preventing unsuitable staff from being redeployed or re-employed in the NHS and follows the Kirkup report into Liverpool Community Health Trust in February 2018.

3.2. The Kark Review identified a range of problems with the FPPT and sought to improve its operation and effectiveness. It set out the following recommendations:

- All directors should meet specified standards of competence to sit on the board of any health providing organisation
- A central database should be created, holding relevant information about qualifications and history about each director (including NEDs)
- Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5
- The FPPT should be extended to all commissioners and other appropriate ALBs
- An organisation should be set up with the power to suspend and disbar directors who are found to have committed serious misconduct
- Further work is done to examine how the test works in the context of the provision of social care

4. Changes to the FPP Framework

4.1. On 2 August 23, NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to these recommendations as it applies under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review highlighted areas that needed improvement to strengthen the existing regime.

4.2. The Framework is effective from 30 September 2023 and should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework.

4.3. Notable changes to the FPP Framework include

- Updates in the NHS Electronic Staff Record (ESR) to record the testing of relevant information about board members' qualifications and career history.
- A new standard board member reference template for references for all new appointments and for those leaving the organisation.
- It is also expected that the NHS Leadership Competency Framework, once published will provide guidance for the competence categories against which a board member should be appointed, developed and appraised.
- The annual assessment which will be submitted to NHS England. The duty to store information relevant to the annual assessment will apply to existing directors as they will have to comply with the assessment each year, and not only new appointees/promotions.

5. Board Member Reference

5.1. A standardised board member reference has now been introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

5.2. The template is based on the standard NHS reference and includes additional requests for information (relevant to the FPPT).

5.3. The six competency domains outlined in the forthcoming NHS Leadership Competency Framework should be considered when the board member reference is written.

5.4. Board member references will apply as part of the FPPT assessment from 30 September 2023

- For any new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS.

- When any board member leaves an organisation for any reason. NHS organisations should use the board member reference template and maintain the accuracy of the reference where the board member departs, irrespective of whether there has been a request from another NHS employer for the reference. The completed
- ESR will be updated to ensure that the reference will be retained at a local level up to the age of 75.

6. Compliance and Oversight

6.1. NHS organisations must be able to demonstrate, annually, that they have carried out a formal assessment of the FPPT for each board member and should consider carrying out the assessment alongside the appraisal cycle.

6.2. The Trust has in place robust processes with regard to the appointment of directors. All checks for new directors were undertaken by the Workforce Team in collaboration with the Corporate Governance Team.

6.3. These processes include the following:

- Confirming the status of the specific qualifications as outlined within the relevant JD/Person Spec and status of qualifications listed on an individual's CV
- Identity and Right to work checks
- Qualification, registration and references checks
- DBS checks
- Search of insolvency/bankruptcy register and disqualified directors register
- Review of full employment history and explanation of any gaps in employment
- Health questionnaire and occupational health clearance
- A search of the individual through internet search engines to note any information in the public domain which the trust should be made aware of
- A self-declaration from the individual

7. Role of the Chair

7.1. The Chair has ultimate accountability for ensuring that the Trust conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role.

7.2. The Chair also needs to ensure that their organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be fit and proper

8. Recommendation

8.1. The Board is asked to receive this report on the changes to the FPPT requirements.

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Report Title:	Complaints and Concerns Annual Report 2022/2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 September 2023		Discussion	
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	To provide the Board of Directors with an annual report of the complaints and Patient Advice and Liaison Service (PALS) enquiries received in 2022/23.

Summary:	• An overall increase in formal complaints of 12% compared with 2021/22 • An increase in the Patient Advice and Liaison Service (PALS) enquiries of 16% compared with previous year • An increase in formal compliments received of 45% compared with previous year • The response compliance performance rate was 50% against the Trust internal target of 95%. • There were 50 local resolution meetings held • 52% complaints were made by the patient themselves • 55% PALS were received from the patient themselves • 72% of complaints were upheld or partially upheld • 10% of complaints were re-opened. Themes are highlighted in the report by division along with improvements, equality data of the patients related to the complaints and plans for improvements to the complaints process and support mechanisms in 2023/24.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	The Board of Directors is asked to receive the Complaints Annual Report 2022/23 for assurance purposes.

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:	Patient Experience Team Gina Riley Assistant Director of Clinical Governance	**Presented by:**	Tyrone Roberts, Chief Nurse

NHS
Bolton
NHS Foundation Trust

Complaints and Concerns Annual Report

April 2022 to March 2023

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EXECUTIVE SUMMARY

In 2022/23 we have seen:

- An overall increase in formal complaints of 12% compared with previous year
- An increase in Patient Advice and Liaison Service (PALS) enquiries of 16% compared with previous year
- An increase in formal compliments received of 45% compared with previous year
- Response compliance performance rate of 50% against our Trust internal target of 95%.
- No complaints fell outside of the six-month timeframe to resolve, as set out in the Local Authority Social Services and National Health Service, Complaints (England) Regulations 2009.
- One case from 2022/23 is currently being investigated by the Parliamentary and Health Services Ombudsman (PHSO)
- There were 50 local resolution meetings held
- 52% complaints were made by the patient themselves
- 55% PALS were received from the patient themselves
- 72% of complaints were upheld or partially upheld
- 7% of complaints were re-opened.
- A higher proportion of complainants in postcodes BL1, BL2 and BL3 were the patient themselves
- The majority of complainants were White British (88%)

FOREWORD

Bolton NHS Foundation Trust provides acute hospital services; specialist and general out-patients; Maternity and Women's Health; Emergency Department; and Community Services.

The Trust is required to publish an Annual Complaints report in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and this report sets out a detailed analysis of the nature and number of complaints and concerns received by Bolton NHS Foundation Trust from 1st April 2022 to 31st March 2023. It provides key information of our performance in responding to complaints and concerns; what learning has been identified as a result of investigations undertaken and how practice has changed in response to the issues raised through the complaints process.

PROGRESS in 2022/2023

A number of areas of focus were set from the 2021/22 report and the progress towards these is set out below:

What did we say we would do	How did we plan to do this	Progress report
Complete a review of the complaints process	Review each stage of complaint management process to measure value	Completed and approval process streamlined
Improve the quality of complaint responses	Embed full executive/senior management team oversight and scrutiny to work towards standardised high quality responses	The complaints process has been revised to include executive and senior management oversight
Increase number of outcome resolution meetings to improve engagement and communication with service users	Implement focused engagement on ensuring complainants are supported to attend a meeting with the aim of resolution	Increase in uptake of resolution meetings of 72% compared to 2021/22 data

OUR SERVICES - the Trust is made up of five Clinical Divisions

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

Acute Adult Care Services Division

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

Anaesthetics and Surgical Services Division

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

Diagnostic and Support Services Division

DSSD is a key support for Trust services and interacts with patients on many different inpatient and outpatient pathways.

The division operates services including Pharmacy, Laboratory Medicine, Radiology and Infection Prevention and Control.

Family Care Division

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

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

Integrated Community Services Division

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

ACTIVITY

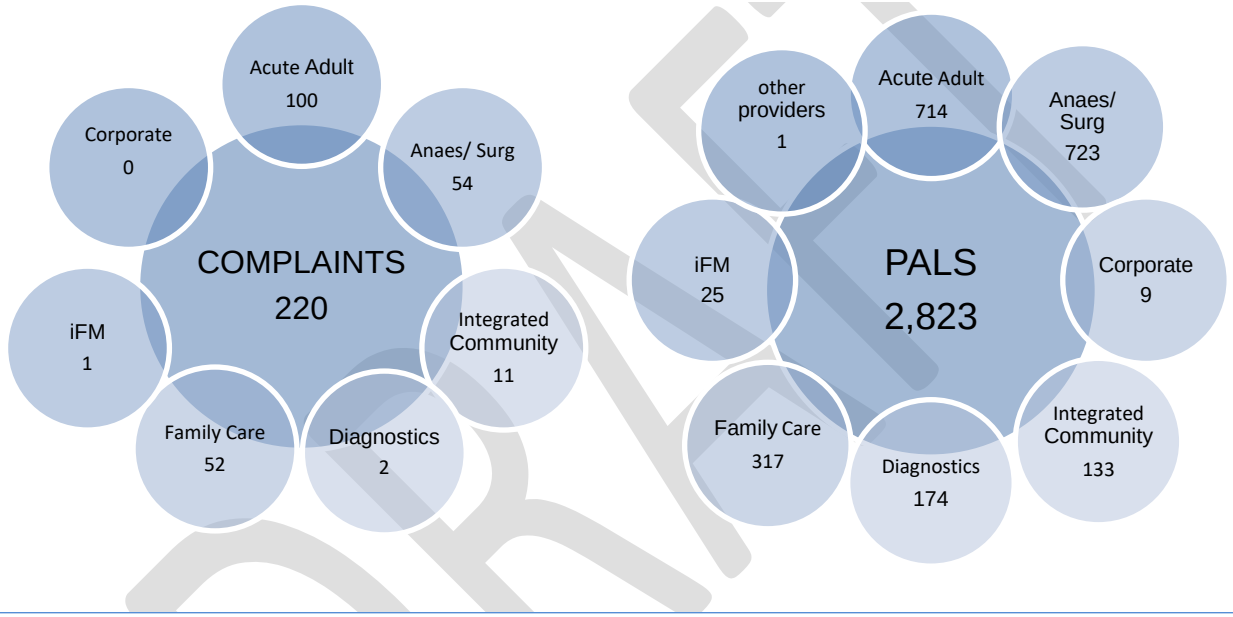
Who has contacted us to make a complaint?

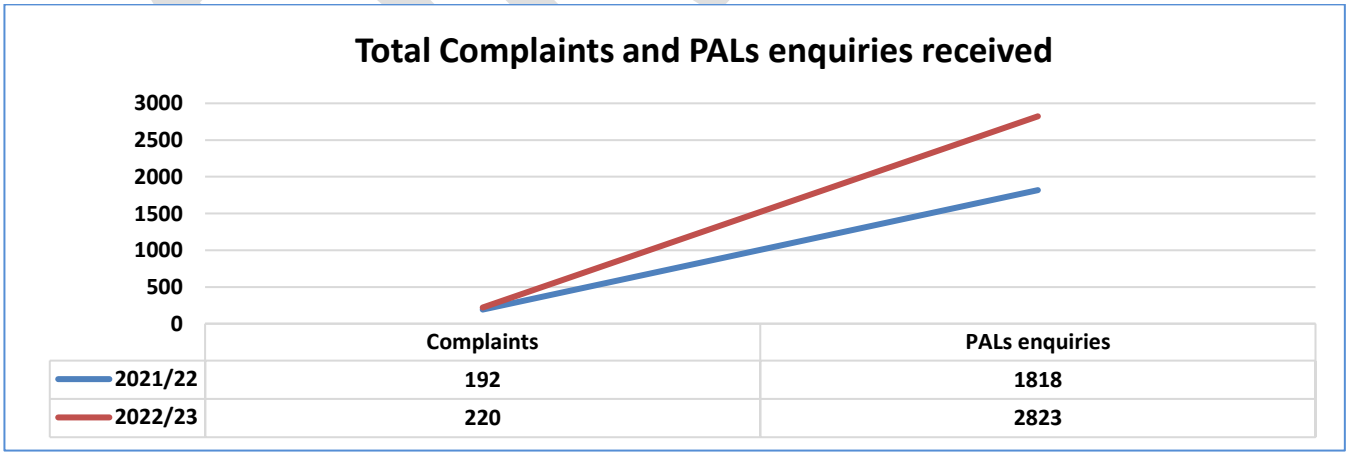
- 55% Patient
- 25% Relative/Carer
- 20% other advocate

Who have the PALS supported to resolve their concerns?

- 52% Patient
- 34% Relative/Carer
- 14% other advocate

DIVISIONAL BREAKDOWN





When comparing data from the previous year overall the total number of both complaints and PALs enquiries have increased. When compared with the previous year, a notable variance for complaints received by FCD demonstrated 53% increase.

THEMES FROM COMPLAINTS

The themes from complaints are regularly monitored throughout the year and action is taken to prevent recurrence. The information below shows the top themes for each of our five Divisions.

Communication is one of the top themes that features in every clinical division.

Decisions about clinical treatment relates to questions about the plan of care for the patient including prescribing of medication, care pathway, investigations and discharge.

The Trust also manages complaints on behalf of iFM Bolton and for non-clinical services including finance and information governance

Integrated Community Services

- Communication
- Decisions about clinical treatment
- Nursing Care
- Discharge Arrangements

Diagnostics & Support

- Delayed test results
- Cancelled appointments
- Delayed testing
- Communication

Family Care

- Decisions about clinical treatment
- Communication
- Lack of Information
- Nursing care
- Complications of treatment

Acute Adult Care

- Decisions about clinical treatment
- Communication
- Delayed treatment and tests
- Attitude of staff
- Long wait in ED

Anaesthetics & Surgical

- Decisions about clinical treatment
- Attitude of staff
- Complications of surgery
- Communication
- Delayed tests, operations, treatment

iFM

- Attitude of staff (Security)
- Allegations of physical abuse
- Parking issues

Other

- Communication
- Incorrect Information Noted

THEMES FROM PALS

In the same way we monitor themes from complaints, the themes from all concerns received by PALS are also reviewed regularly and actions taken. The top themes for each of our Divisions are provided here

The Trust also manages PALs on behalf of iFM Bolton and for non-clinical services including finance and information governance

Integrated Community Services

- Aids/appliances unavailable
- Decisions about clinical treatment
- Communication
- Delay in receiving appointment

Diagnostics & Support

- Cancelled appointments
- Attitude of staff
- Communication
- Issues with booking appointments

Family Care

- Decisions about clinical treatment
- Cancelled/delayed appointments Communication
- Delayed treatment, results, operations

Acute Adult Care

- Decisions about clinical treatment
- Appointments
- Attitude of staff
- Communication

Anaesthetics & Surgical

- Delay in receiving appointments
- Decisions about clinical treatment
- Communication Delayed operation, tests, results

iFM

- Parking issues
- Attitude of staff
- Communication
- Aids/appliances unavailable

Other

- Reimbursement requests
- Communication

HOW WE HAVE IMPROVED OUR SERVICES

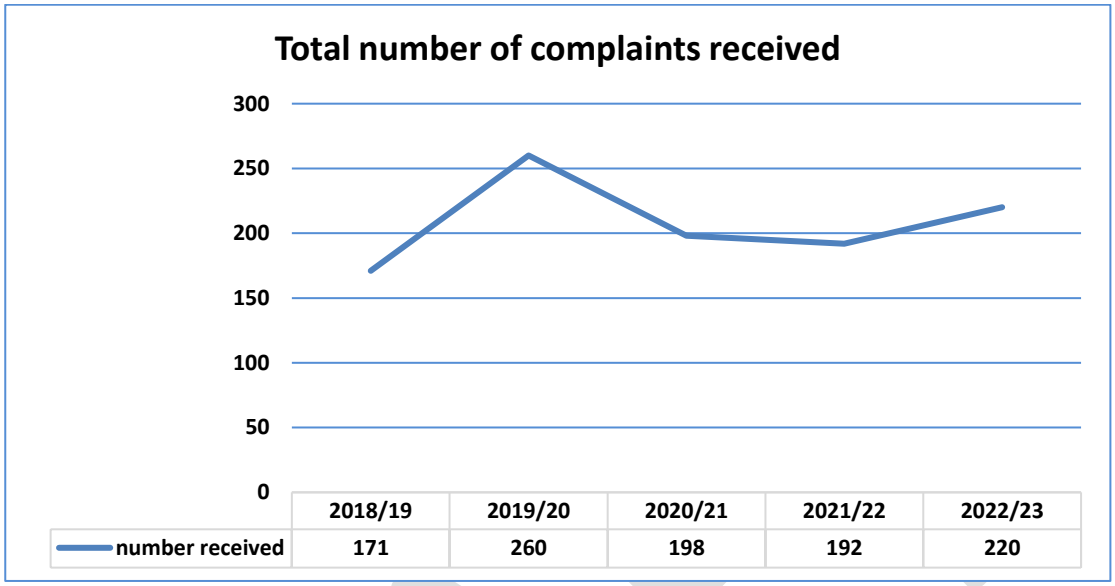
The Trust views all complaints as an opportunity to learn from the experience of our service users and are valuable in helping us to improve our services. All complaints are shared anonymously within speciality teams and are included in education and training programmes as standard practice. Safety huddles are used to share key information across all in-patient areas.

Examples of improvements made following complaints received:

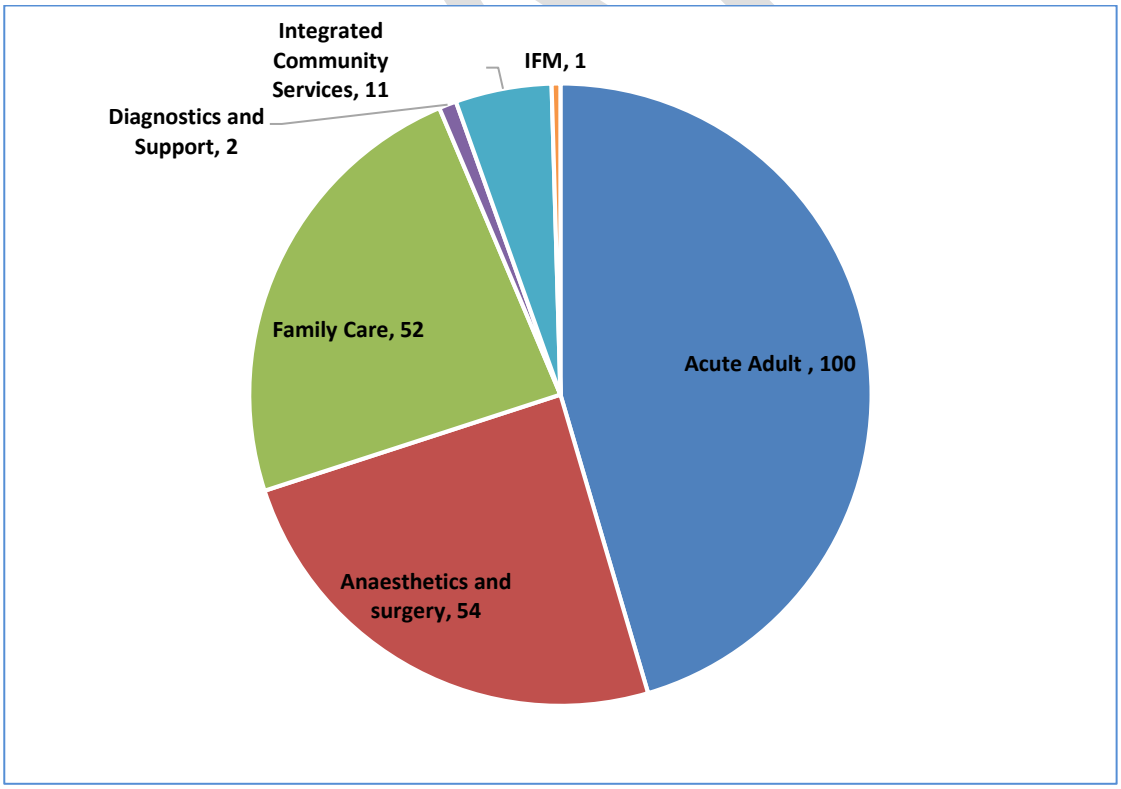
Our Acute Adult Care Division have implemented clinical improvements to our ED following complaints raised about attendance to the Emergency Department and waiting times. These include an allocated waiting room nurse who undertakes observations, assessments and provides nursing care for those in this area.
Other ED improvements related to patient comfort include refreshment rounds, the provision of more comfortable chairs, information boards, a television and a phone charging bank to enhance the experience of those who are in the waiting area.
Improvements following feedback from patient complaints and concerns about care and treatment include the planned addition of workflow manager into EPR which will support senior nurse oversight of compliance with care plans and risk assessments.
A complaint to the paediatrics emergency department highlighted that the ability for staff to monitor whether all sections of a new-born screening heel prick test had been carried out was not robust. The nursing handover sheet has now been updated to aid communication between shifts.
In the Family Care Division, it was found from a complaint to the Maternity department that the process for following up repeat samples was not robust, resulting in a urine sample not being followed up and actioned appropriately. **The antenatal clinic department now have an improved specimen sample recording system. This new system will enable the maternity team to monitor antenatal clinic specimen results on a daily basis. It also has a facility to ensure compliance, so no samples are overlooked.**

OUR PERFORMANCE

In 2022/2023 we received an increase of 28 (13%) complaints in comparison to the previous year 2021/2022.

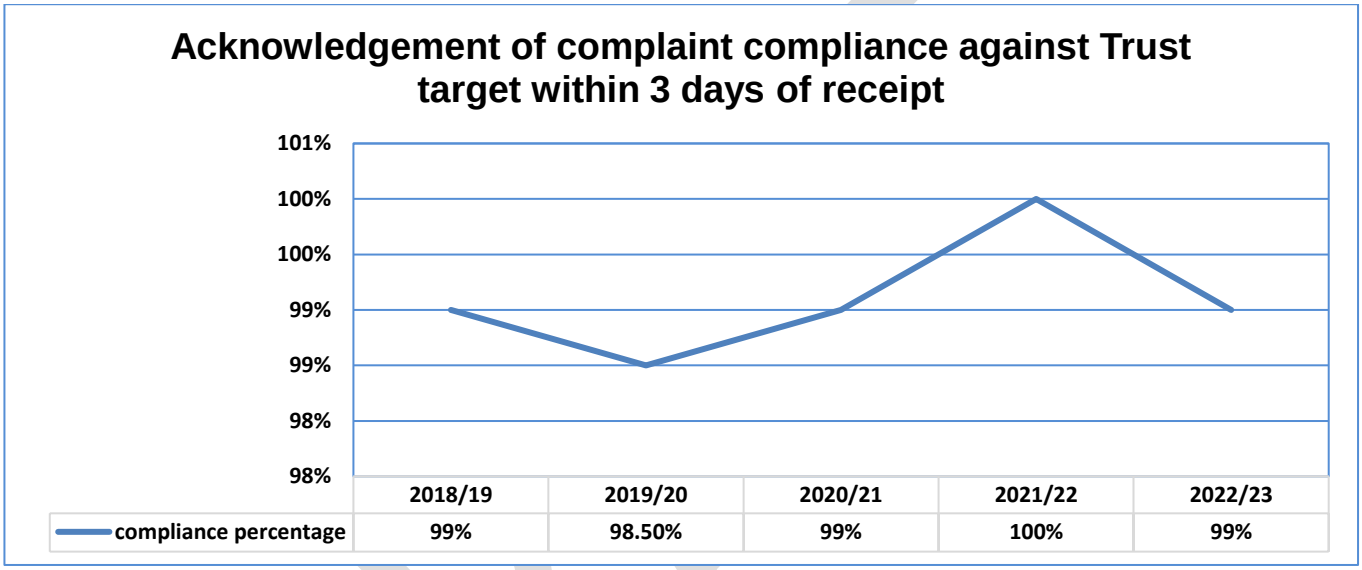


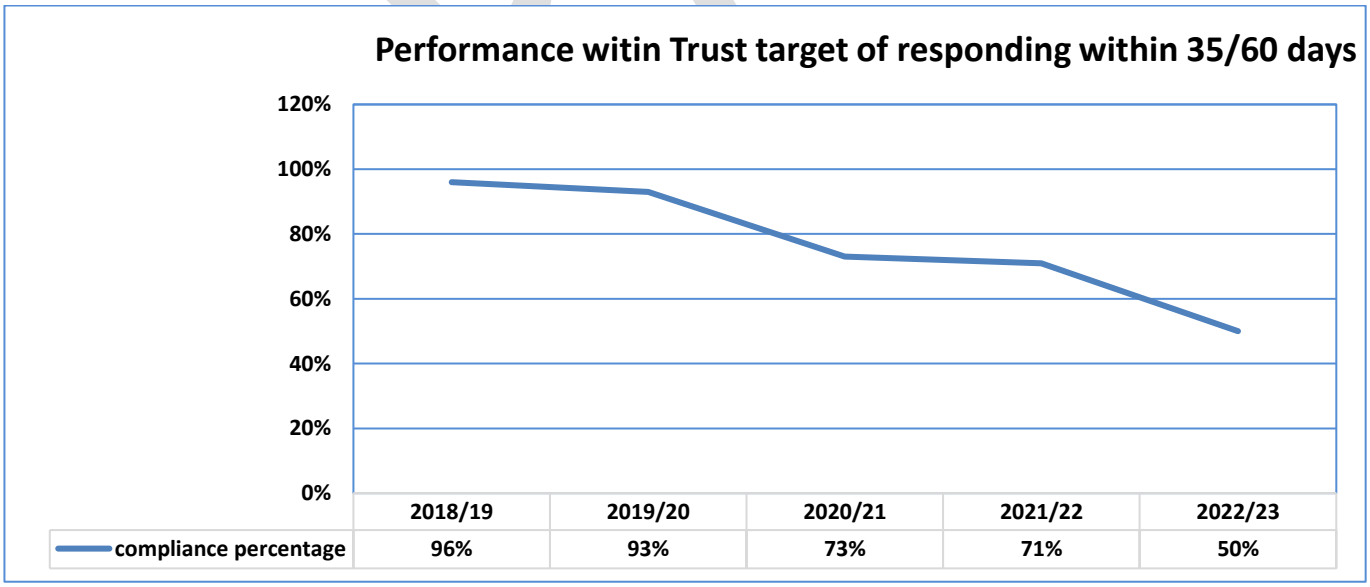
Number of complaints received by Division 2022/2023



Performance is measured by monitoring our complaint acknowledgment rates within three working days from the day of receipt of a complaint. During 2022/2023, 99% of complainants received an acknowledgement of their complaint within the three working days' target.

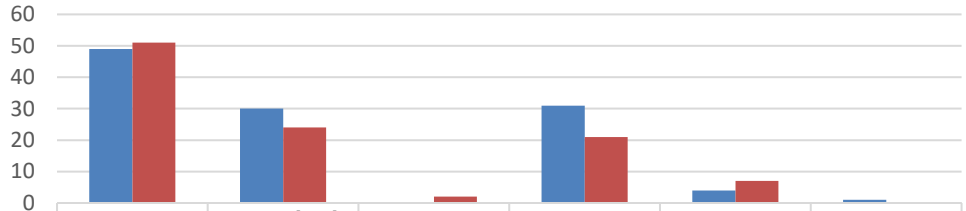
The response target rate is for 95% of complainants to receive a response by 35 working days or 60 working days if the complaint is complex and/or crosses multiple providers. In 2022/2023, 50% of our complainants received a response within this timeframe. In all cases where compliance with timescale was not achieved, the complainant was kept fully informed of progress and the cause of any delays throughout the complaints process. None of our complaints received a response outside of the six-month timescale set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.





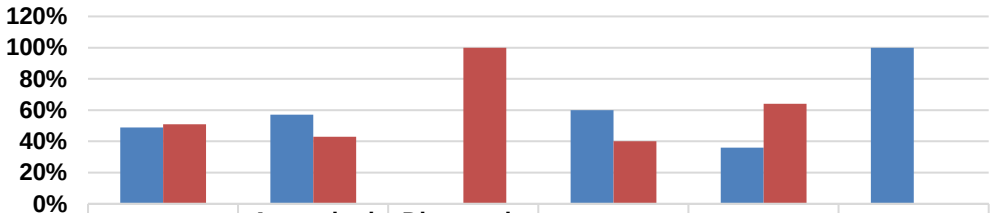
The reduction in performance has been as a result of an increased focus on the quality of our investigations and responses provided.

Complaints performance by Division by numbers Apr 22 - Mar 23

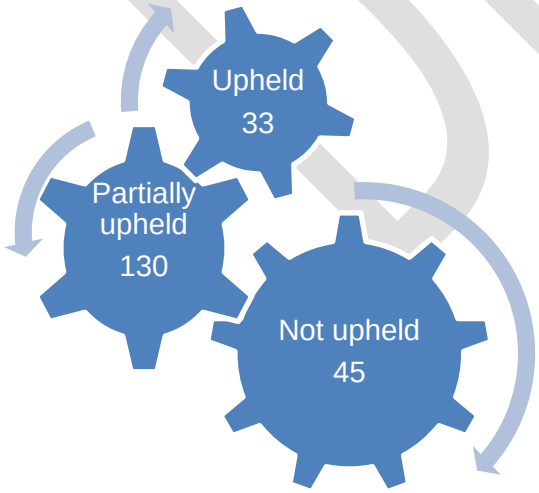


	Acute Adult Care	Anaesthetics and Surgery	Diagnostics and Support	Family Care	Integrated Community	IFM
Compliance with trust target	49	30	0	31	4	1
Breached Trust target	51	24	2	21	7	0

Complaints performance by Division by percentage Apr 22 - Mar 23



	Acute Adult Care	Anaesthetics and Surgery	Diagnostics and Support	Family Care	Integrated Community	IFM
Compliance with trust target	49%	57%	0%	60%	36%	100%
Breached Trust target	51%	43%	100%	40%	64%	0%



The Trust views all complaints as being justified accepting that the person complaining feels dissatisfied in some way. At the conclusion of an investigation, we record whether the investigation has found the main issue raised to have been upheld, partially upheld or not upheld.

Upheld – substantive evidence has been found to support the complaint.

Partially Upheld – if a complaint is made regarding more than one issue some of these are upheld (using the rationale for an upheld outcome).

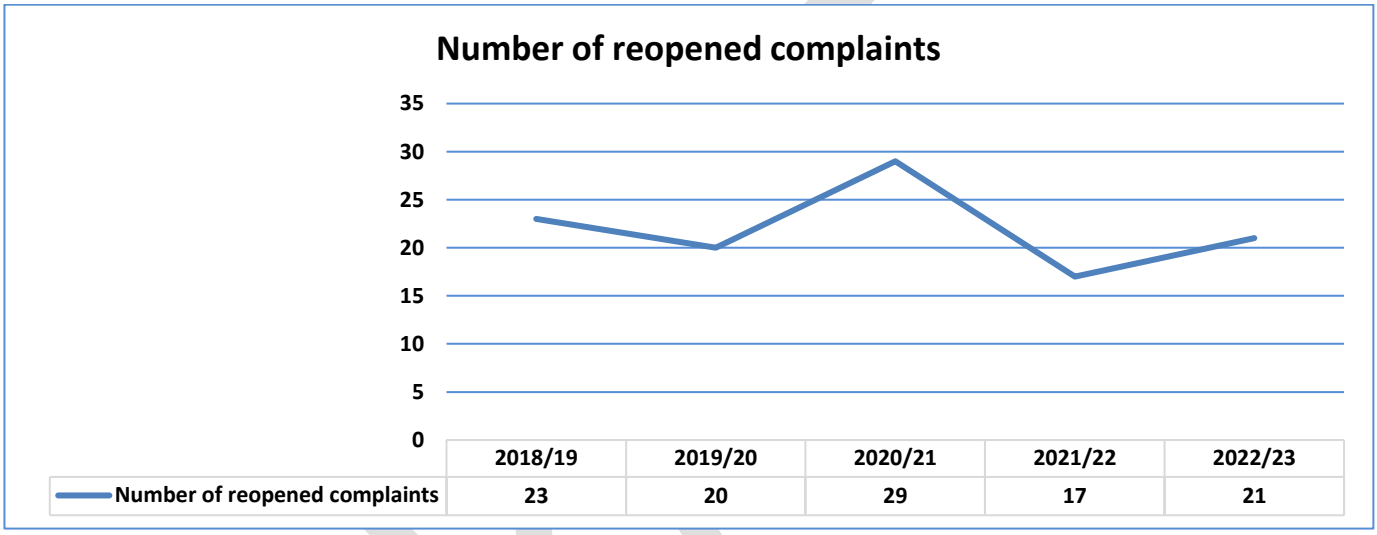
Not Upheld – no evidence to support any aspects of the complaint.

QUALITY MONITORING

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

21 (9.5%) cases were re-opened during 2022/23 compared with 17 (9%) in 2021/22 and 29 (15%) in 2020/21

There are a number of reasons for cases being re-opened. New/additional questions were the main reason for cases being re-opened (8). The next main reason was where the complainant requested a local resolution meeting to discuss disputed information provided.



	2018/19	2019/20	2020/21	2021/22	2022/23
Number of reopened complaints	23	20	29	17	21

The Trust encourages our staff to meet with complainants to discuss the findings from our investigations and to achieve a positive outcome for them.

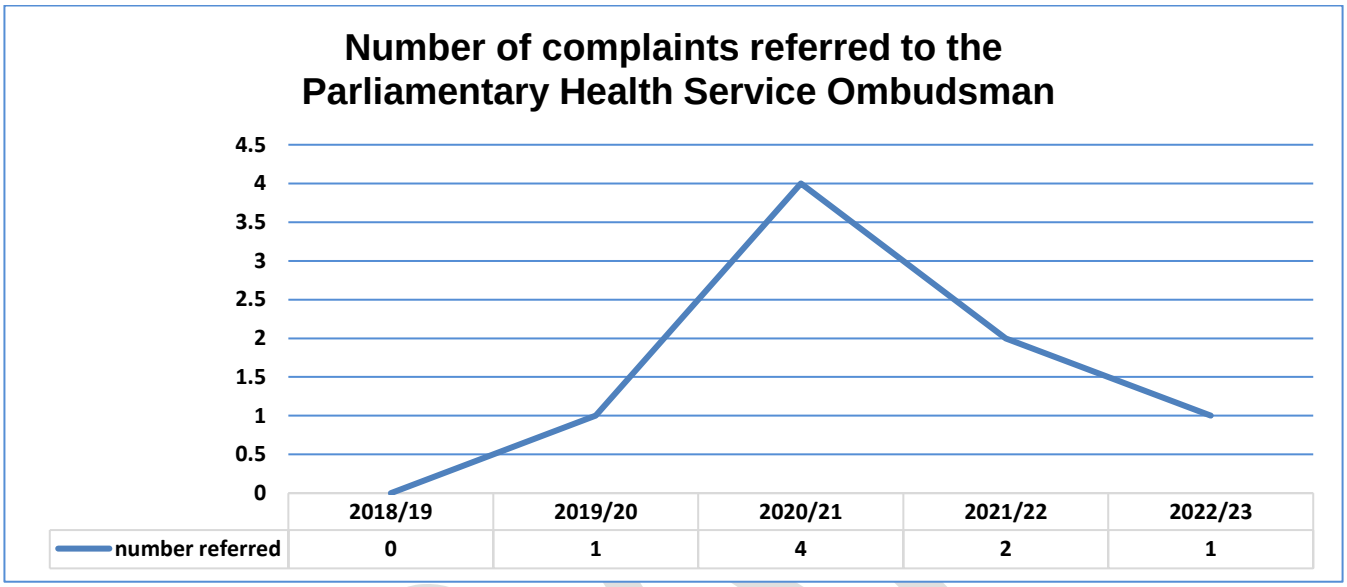
The Patient Experience Team facilitated 50 local resolution meetings with complainants and achieved positive outcomes in all meetings. This compares with 29 for 2021/2022

Parliamentary and Health Service Ombudsman

All of our complainants are provided with the opportunity to contact the Parliamentary and Health Services Ombudsman if they remain unhappy following receipt of our response to their complaint. The Parliamentary Health Services Ombudsman (PHSO) provide an independent complaint handling service and make final decisions on serious complaints that have not been resolved by the NHS in England and other UK government departments. Their findings are used to support Parliament's scrutiny of public service providers and to help drive improvements within these services.

We received one enquiry from the PHSO from complaints received in 2022/2023, and this is currently under investigation by the PHSO

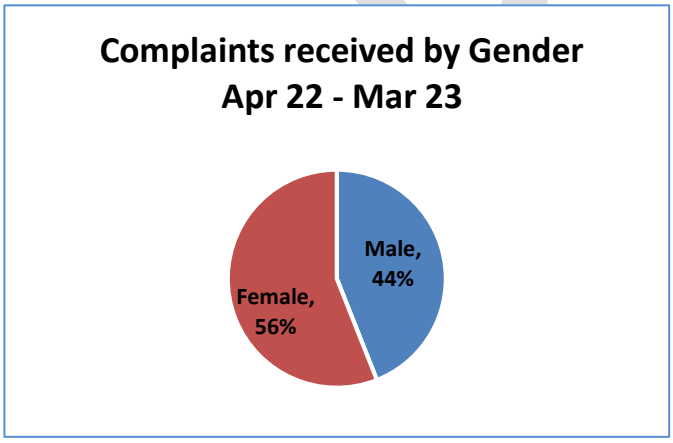
There are currently two cases under investigation by the PHSO from 2020/21. Two cases from 2021/22 that were referred to the PHSO, the PHSO has made the decision not to investigate further.

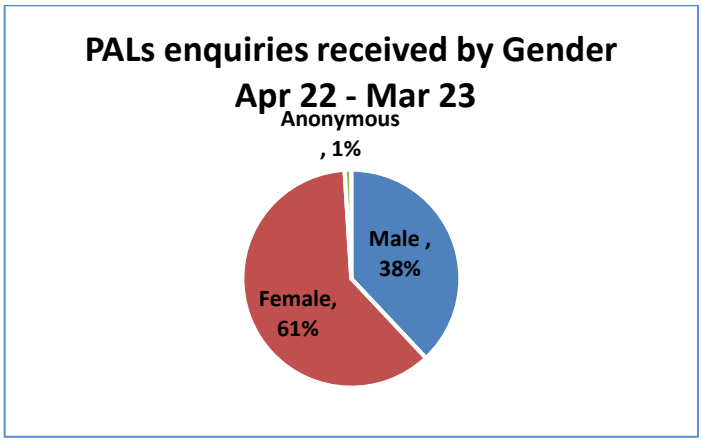


EQUALITY MONITORING

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

GENDER

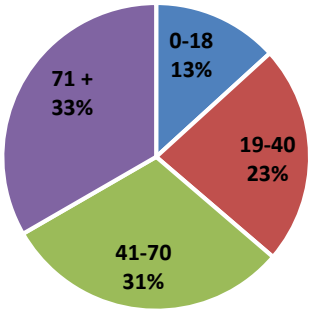




Age of patient

COMPLAINTS - There is a good representation across all age groups

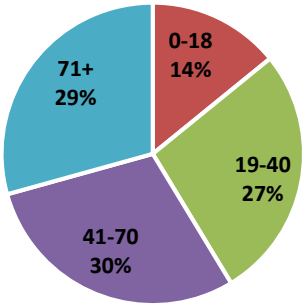
Percentage of Complaints received related to patient age Apr 22 - Mar 23



The majority of complainants were in relation to patients aged 71+ which is expected as they are the largest group accessing services

PALS - There is a good representation across all age groups

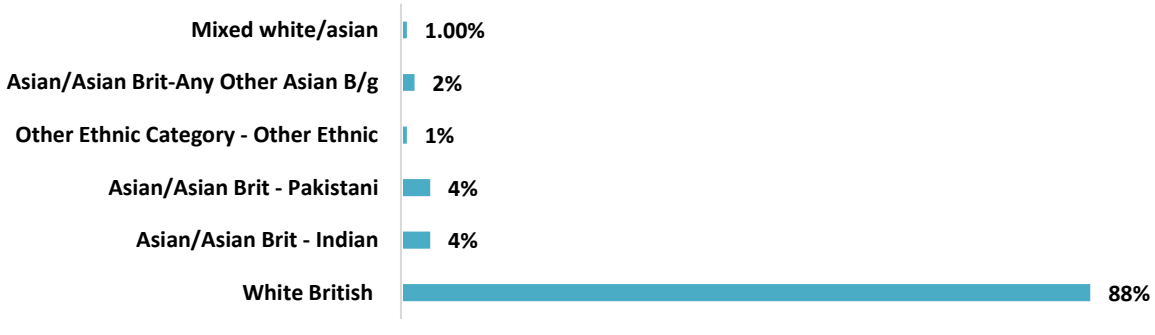
Percentage of PALS received related to patient age Apr 22-Mar 23



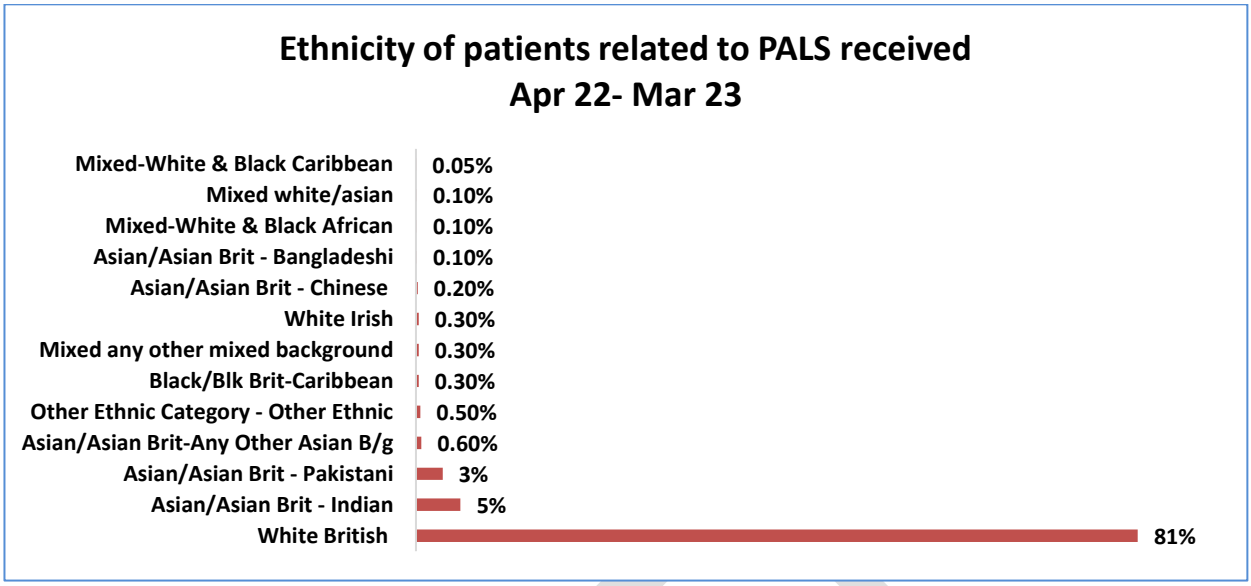
The age group raising the most PALs were those aged 41 - 70years (30%)

Ethnicity of patient

Ethnicity of patients related to Complaints received Apr 22 - Mar 23



Please note that 27% of patients did not provide details of their ethnicity when using our Complaints service.



Please note that 11% of patients did not provide details of their ethnicity when using our PALS service.

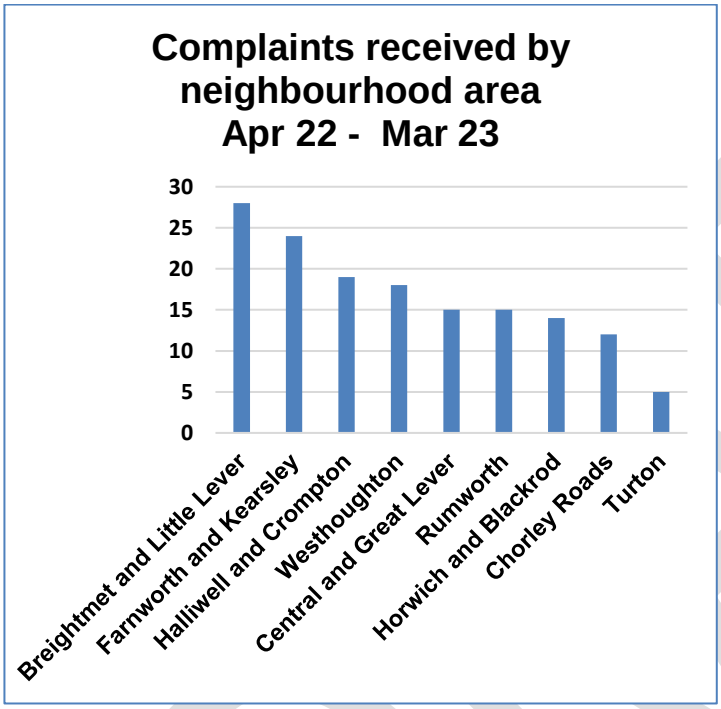
Of note, themes of complaints remain the same regardless of ethnicity.

What next?

- To explore how we can improve and promote equal access to the Complaints and PALs services the development of leaflets and posters in other languages will be undertaken.
- Collaborative working with the EDI Team to review and report on themes of complaints from our under represented communities.
- Collaborate with EDI Team for an awareness training session to be provided for PALS and Patient Experience Team to ensure best practice when understanding the needs of our BAME service users.

Neighbourhoods

Our data shows that in relation to formal complaints, 28% were received on behalf of patients who live/lived outside of the Bolton borough for example Manchester, Wigan, Salford, Preston and Oldham with the majority received from the Manchester area. This is due to the residents of nearby towns and boroughs being able to choose where they go to for treatment, maternity services and for emergency care in the region. The highest number of complaints in Bolton were related to patients living in the Breightmet/Little Lever neighbourhood. There are nine neighbourhoods that sit within Bolton postcodes but within some postcodes the deprivation levels and ethnicity can vary widely. Therefore, it may be useful to breakdown the data into those neighbourhoods to truly understand what this data means.



According to the Index of Deprivation for Bolton (2015) the most deprived areas of Bolton are: BL1 and BL2 (Halliwell and Crompton), BL3 (Town Centre) and a small area to the South of BL4 (Farnworth).

The least deprived areas of Bolton are: BL1 (Astley Bridge and Heaton/Lostock), BL2 (Bradshaw), BL3 (Little Lever and Darcy Lever), BL5 (Westhoughton), BL6 (Horwich and Blackrod), BL7 (Bromley Cross).

According to data taken from 2011 Census (2021 data not yet available) the largest BAME communities live in the following areas of Bolton: BL1 (Halliwell), BL2 (Crompton), BL3 (Rumworth and Great Lever).

BL1 – Chorley Roads

BL1/3 – Central/Great Lever

BL2/3 - Breightmet/Little Lever

BL2 – Halliwell/Crompton

BL4 – Farnworth/Kearsley

BL5 – Westhoughton

BL6 – Horwich/Blackrod

BL7 - Turton

OUR FOCUS FOR THE NEXT 12 MONTHS

FOCUS	OBJECTIVE
To have a sustained improvement in complaint response rates	• Work with complainants to ensure focused questions/concerns being responded to. • Use digital solutions to resolve concerns earlier.
To provide a quarterly overview of complaints performance to strengthen oversight and monitoring.	• To provide a Complaints quarterly report to Clinical Governance and Quality Committee
Increase the number of complaint outcome resolution meetings to increase service user satisfaction and support earlier resolution.	• Devise a new process for digital recording and sharing of complaint outcome resolution meetings to meet the expectations of services users and the PHSO • Work collaboratively with the Information Governance Team to find a solution that securely delivers recordings and saves these as per data requirements
Increase of PET input to support divisions in meeting target dates	• Ensure regular communication with divisional colleagues and oversight of cases to establish any issues at the earliest opportunity within the process
To understand the reason why a complaint may be reopened, and to ensure re-opened complaints are accurately recorded	• To perform a full review of any reopened cases to understand why a complainant feels their concerns have not been resolved and whether there are any improvement opportunities for the complaint process.
Support Divisions by providing training packages for complaint leads	• Develop and deliver regular training packages for complaints leads to ensure high standards of complaint responses are maintained.