BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1300 on Thursday 30 November 2023
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB129/23	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm quorum*	*Verbal*	Chair	**13:00**
TB130/23	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	
CORE BUSINESS				
TB131/23	**Declaration of Interests** *Purpose: To record interests relating to items on the agenda.*	*Report + Verbal*	Chair	**13:15** (5 mins)
TB132/23	**Minutes of the previous meeting held on 28 September 2023** *Purpose: To **approve** the minutes of the previous meeting*	*Report*	Chair	
TB133/23	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB134/23	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Report*	Chair	**13:20** (5 mins)
TB135/23	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13:25** (15 mins)

STRATEGY AND PERFORMANCE				
TB136/23	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**13:40** (5 mins)
TB137/23	**Clinical Strategy** *Purpose: To **receive** the Clinical Strategy*	*Report*	MD	**13:45** (15 mins)
TB138/23	**Operational Update** *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**13:55** (10 mins)
TB139/23	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance *Purpose: To **receive** the Integrated Performance Report*	*Report*	DCEO	**14:05** (20 mins)
QUALITY AND SAFETY				
TB140/23	**Quality Assurance Committee Chair's Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**14:25** (05 mins)
TB141/23	**Nurse, AHP and Midwifery Staffing Report** *Purpose: To **receive** the Nurse, AHP and Midwifery Staffing Report*	*Report*	Chief Nurse	**14:30** (10 mins)
TB142/23	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update** *Purpose: To **receive** the CNST Year 5 Update*	*Report*	DoM+ Chief Nurse	**14:40** (10 mins)
TB143/23	**In-Patient Survey** *Purpose: To **receive** the In-Patient Survey Report*	*Report*	Chief Nurse	**14:50** (10 mins)

WORKFORCE				
TB144/23	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	PC Chair	**15:00** (5 mins)
TB145/23	**Staff Health and Wellbeing Report** *Purpose: To **receive** Staff Health and Wellbeing Report*	*Report*	Chief People Officer	**15:05** (10 mins)
	COMFORT BREAK			**15:15**
FINANCE				
TB146/23	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	**15:25** (5 mins)
TB147/23	**Financial Controls Committee Chair's Report** • Terms of Reference *Purpose: To ratify the establishment and TOR of the FCC*	*Report*	FCC Chair	**15:30** (5 mins)
TB148/23	**Green Plan** *Purpose: To **receive** the Green Plan*	*Report*	CFO	**15:40** (10 mins)
GOVERNANCE AND RISK				
TB149/23	**Board Assurance Framework** *Purpose: To **receive** the Board Assurance Framework*	*Report*	*DCG*	**15:50** (10 mins)
TB150/23	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*All*	**16:00** (10 mins)
CONSENT AGENDA				
TB151/23	**EPRR Core Standards Report** *Purpose: To **receive** the EPRR Core Standards Report*	*Report*	COO	**16:10**

TB152/23	**PSIRF Policy** *Purpose: To **receive** the PSIRF*	*Report*	Chief Nurse	
CONCLUDING BUSINESS				
TB153/23	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16:20**
TB154/23	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	
TB155/23	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	
				16:30
	Date and time of next meeting: Thursday 25 January 2024			***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
Seth **Crofts**	Associate Non-Executive Director	External Academic, Appointed Representative, The Open University, Academic Quality and Governance Committee	Non-Financial Professional 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
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest
		Director, Harriss Interim and Advisory	Financial Interest
		Family member works for Astra Zeneca	Non-Financial Personal Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	

Name:	Position:	Interest Declared	Type of Interest
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
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		The Foundation Trust Network (Trustee NHS Providers)	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
		Egerton Pre School Committee Chair	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of 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	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
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
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 28 September 2023
(Subject to the approval of the Board of Directors on 30 November 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
Jackie Njoroge	JN	Non-Executive Director
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
Sophie Kimber-Craig	SKC	Consultant Anaesthetist & Associate Medical Director for Clinical Governance (for Francis Andrews)
Janet Cotton	JC	Director of Midwifery (for item 114)
Rachel Carter	RC	Associate Director of Communications and Engagement
Jenni Makin	JMa	Specialist Physiotherapist, Community Learning Disability Team (for item 101)
Liz O'Donnell	LOD	Specialist Physiotherapist, Community Learning Disability Team (for item 101)
Victoria Crompton	VC	Corporate Governance Manager
Toria King	TK	Equality Diversity and Inclusion Manager (for item 116 and 117)
Lynn Donkin	LD	Director of Public Health

There was one observer in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		

TB100/23 Chair's Welcome and Note of Apologies

The Chair welcomed everyone to the meeting. Apologies for absence were noted from Francis Andrews, and Naomi Ledwith.

TB101/23 Patient and Staff Story

The Chief Nurse shared a patient story about Conor, who has Pallister-Killian syndrome, highlighting the positive impact of providing specialist equipment. Conor's health and family's well-being declined due to his inability to access previous facilities after outgrowing his postural care equipment. The Adult Community Learning

Disability Team (CLDT), including physio and OT, assessed his needs and sourced a new, appropriately sized buggy to help him access the countryside.

Securing funding for the buggy was challenging due to the Specialist Equipment Funding Panel's reluctance to fund specialist seating, often viewed as "double funding" alongside wheelchairs. However, after the Lead Nurse Assessor met with Conor's family and understood their challenges, the panel approved the funding. The CLDT helped set up the buggy, which Conor uses regularly, significantly improving the family's quality of life. Conor's mother expressed the life-changing impact of the buggy, which accommodates Conor's medical equipment, is easy to handle, and has been customised with programmable wheel lights for events.

During a discussion, it was noted that while funding from charities is an option but it is a difficult process. The organisation recognised a need for improved communication between departments to better understand and meet patient needs.

Staff Story

Jenni Makin, a Specialist Physiotherapist from the Community Learning Disability Team, shared the story of her work with Linda, a 62-year-old with stage 4 ovarian cancer, a learning disability, and schizophrenia. Linda was referred to Jenni after hospital discharge, and Jenni provided comprehensive support, including addressing concerns, facilitating appointments, co-working with Social Services for respite care, and arranging wheelchair access for Linda's mobility and leisure activities, such as attending Bolton Wanderers Football Club games.

Jenni also supported Linda’s husband, Chris, who also had learning difficulties, and their daughter. Jenni accompanied Chris to A&E during Linda's acute illness and provided support until Linda's unfortunate passing in January 2023. Jenni's personal experience with her mother's similar cancer diagnosis helped her empathise with Linda and Chris's struggles. Jenni felt she made a difference in their lives by offering support and enabling Linda to enjoy her last Christmas and visit her caravan.

The Chair acknowledged the team's efforts, and on behalf of the Board of Directors thanked Jenni and the team for sharing the patient and staff story.

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

TB102/23 Declarations of Interest

There were no declarations relating to agenda items.

TB103/23 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 27 July 2023 and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors **approved** the minutes from the meeting held 27 July 2023.

TB104/23 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

TB105/23 Chair's Update

The Chair informed Board members the agenda included the Public Health Annual Report and Health Inequalities update which would provide an overview of the wider impact the organisation can have on the Bolton population.

Significant financial challenges were being seen within GM and locally within the Trust and this was an area of priority focus. The Trust was working with system partners and other partner trusts within GM. Members of the Board had recently attended the Bolton Finance and Recovery Meeting.

The Non-Executive Director recruitment campaign was progressing well. A shortlisting meeting had been held and there was a strong pool of candidates who wished to join the Trust and help shape the strategy. Interviews would be held on 11 and 12 October.

The Annual Members Meetings was scheduled for Monday 16 October. The meeting was an opportunity for the organisation to showcase performance in 2022-23 and the plans for the future.

Finally, NR welcomed the new governors and gave a special thank you to those whose tenures had concluded. Governors have a key role within a Foundation Trust and bring the community voice, and diversity of thought and experience.

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

TB106/23 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:

- The Neonatal Unit was recognised nationally in the British Association of Perinatal Medicine awards.
- Further periods of industrial action had taken place and contingency plans were adopted to support patient and staff.

- The Greater Manchester system had started to receive mandated support around financial performance. The Trust expected restrictions around spending to increase as a result.
- iFM Bolton had undertaken an audit which found no reinforced autoclaved aerated concrete (RAAC) present. Further reviews would be completed following updated national guidance.
- Work continued in the locality to move from nine neighbourhood models to six to make it easier for teams to work together to support people at home and work more closely with key partners.

AS queried, whether RAAC surveys were being completed on those premises the Trust leased from other organisations. AW confirmed all premises that the organisation provided services from were being checked.

In response to a query from RG, FN confirmed despite the changes made in the locality moving from nine neighbourhoods to six there would be no increase in workforce or financial pressures and would therefore remain within the financial envelope previously agreed.

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

TB107/23 Strategy and Operations Committee Chair Report

The Chair of the Strategy and Operations Committee provided a verbal update from the meeting held on 25 September 2023. The following key points were noted:

- A health inequalities presentation had been received with the committee acknowledging it was an excellent piece of work that linked to the Clinical Strategy and draft Locality Outcomes Framework.
- An update had been provided on the continued development of the Clinical Strategy.
- The Winter Plan update was presented which outlined the key activities that had been undertaken in preparedness for winter.
- Four key areas of risk were outlined to committee members which included; maternity EPR, cyber risks, Service Level Agreement with Greater Manchester for Business Intelligence and 0 – 19 services.
- The committee noted that cancer two-week wait recovery was on track for best case.

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

TB108/23 Public Health Annual Report

The Director of Public Health provided a presentation on the Public Health Annual Report 2022. The following key points were highlighted:

- The Public Health Annual Report was a statutory publication by the Director of Public Health. The contents highlighted the changes in the Bolton population and cost of living insight, left expectancy and inequalities within the borough and it had a focus on mental health.
- The Bolton population was growing and had been significantly impacted by the cost of living crisis. In the more deprived regions of the town, life expectancy was around a decade or more earlier than those who lived in the more affluent areas.
- To create a society where everyone thrives, the right building blocks were required. The social and economic conditions people are born into and live in determine how easy it is to have a healthy lifestyle.
- Universal services and policies are the foundation for population health, but in order to reduce the social gradient in health outcomes these need to be resourced and delivered at a scale and intensity proportionate to need.
- CORE20PLUS5 is an NHS England approach to reducing healthcare inequalities for key population groups.
- The report included eight recommendations to improve the health and wellbeing of the population of Bolton.

The Chair thanked the Director of Public Health for sharing the Public Health Annual Report and presentation.

RESOLVED:
The Board of Directors **received** the Public Health Annual Report

TB109/23 Health Inequalities

The Director of Operations provided an update advising the Health Inequalities Enabling Group was established in 2022, to tackle the challenges around health inequalities for the Trust. The organisation leads and collaborates on a number of approaches to tackling health inequalities, whilst system partners also lead on some approaches.

A review and mapping exercise completed across existing programmes of work within the Trust had highlighted a vast amount of work was already underway. The three key enabling priorities identified were;

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

Each priority had a lead and provided a monthly update on progress.

The achievements made and the next step milestones were outlined whilst noting the national CORE20PLUS5 model would assist the locality in targeting efforts and resources in the areas which evidence showed would have the most impact.

JN commented due to the significant variations across the borough it was important to place support where it was most required. SW suggested it would be beneficial to invite the Locality Board to present at a future Board meeting

FT/23/07 SW Locality Board to a future meeting. **VC**

FN stated the organisation was privileged to have system partners in attendance to discuss items such as health inequalities across the town.

SKC advised there was substantial evidence, which confirmed work to improve health inequalities would save the NHS money in the long term, and a change in narrative is required for how patients are treated.

Board members thanked the Director of Operations for the presentation.

RESOLVED:
The Board of Directors **received** the Health Inequalities update.

TB110/23 Operational Update

The Chief Operating Officer thanked staff for their continued efforts over what had been a very challenging period and provided an overview of the operational performance, highlighting several points:

- A&E deflections remained stable and the intermediate tier length of stay was lower than expected due to improvements in Integrated Services Division.
- Patient delays increased in August but decreased in September, despite a steady number of patients.
- Ambulance handover times worsened in August, with a slight rise in A&E attendances compared to the previous year, and ongoing challenges in meeting the 4-hour performance target.
- The Winter Plan aims to keep patients safe amid risks such as workforce challenges and financial constraints.
- The elective waiting list is growing, with an expected increase in patients waiting over 65 weeks for treatment by the end of March.
- Industrial action is causing cancellations and reduced capacity, affecting operational performance.
- Cancer treatment timeliness has declined for the two-week wait standard but improved for the 28-day faster diagnosis standard, with three consecutive months of meeting the diagnosis standard.
- Staff efforts were acknowledged during a challenging period.

MN inquired about data management for executives, and RW mentioned the use of software for immediate access to operational data, supplemented by weekly updates and tracking through the Strategy and Operations Committee.

RG raised a point about reviewing the length of stay, with RW emphasizing the need for self-challenge to avoid impacting the A&E department. Four key themes for review include staff well-being, a robust Patient Flow Team, a comprehensive Escalation Plan, and funding.

AS's question about mortuary scanning was addressed, noting it would help patient flow. RW also mentioned ongoing work to improve productivity in theatres and clarified that introducing seven-day working wouldn't require new hires but flexible scheduling of current staff.

NR observed that despite reduced A&E activity, wait times were increasing. RW indicated that a new urgent treatment centre workstream should positively impact A&E by November 2023.

FT/23/08 It was agreed to include an update on the Urgent Care Treatment Centre workstream in the November 2023 Operational Update. **RW**

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

TB111/23 Integrated Performance Report

Executive Directors presented the Integrated Performance Report for August 2023, and the key points were highlighted.

JN commented that the Integrated Performance Report was discussed, at length, in the Board subcommittee meetings, which resulted in some discussions in Board of Directors being repetitive. NR advised the challenge raised in the subcommittee meetings would be evidenced in the Chair Reports.

TR advised there had been a special cause variation noted for maternity stillbirths, and the Director of Midwifery would be completing a review to attain assurance around this.

AS commented that there had been a deterioration in the number of staff who would recommend the Trust as a place to receive treatment and work. JM advised the 2023 NHS Staff Survey had been launched which would provide updated responses to these questions.

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

TB112/23 Quality Assurance Committee Chair Report

The Chair of the People Committee presented the Chair Reports from the meetings held on 20 September. The key highlights from the meeting were outlined:

- The Annual Complaints Report had been received with the committee raising concerns that 27% of complainants had not provided their ethnicity data. Investigative work was required to ascertain whether they did not want to provide this information or if they had not been asked. This work would link in with the actions being undertaken by the Health Inequalities Group.
- The BoSCA quarterly update was received with the committee noting that overall compliance had increased against 17 of the 19 BoSCA standards. Work had commenced to further develop the BoSCA accreditation.

The Quality Assurance Committee had also received a detailed update on the Cultural Dashboard, CNST and Clinical Coding. SKC thanked the Clinical Coding Team for the work they had completed around mortality and highlighted it was important that they were recognised for this.

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

TB113/23 Initial Response to the Countess of Chester Inquiry

The Chief Nurse provided an overview of the initial national and local discussions subsequent to a nurse being charged with the murder of seven babies and attempted murder of six others at the Countess of Chester neonatal unit.

The update also included a recap of the presentation provided to the Board of Directors following the tragic events reported by Panorama at the mental health unit in Edenfield in Bury.

The papers outlined a summary of emerging national recommendations for areas that organisations may wish to review, which included:

- Board governance
- Freedom to speak up processes
- Flow of data
- Escalation of concerns process (links to Freedom to Speak Up)
- Mortality data

The Board of Directors were asked to discuss the contents of the report and approve the recommendation for ongoing monitoring and reporting whilst also providing some key lines of enquiry for Board colleagues to consider.

RG queried whether the use of Artificial Intelligence (AI) would assist with any of the recommendations made around data. TR advised work against the recommendations was in the very early stages and it was important each stage was worked through appropriately. TR suggested that data and AI be a focus for a future Board Development Day.

FT/23/09 Data and AI to be a focus for Board Development Day **VC/RN**

MB asked whether there were any additional actions, which could be undertaken by the Trust. NR stated there would be some national guidance, which organisations will need to await.

TR advised data did not highlight any anomalies within the Trust and FN commented the Board were assured on information which was available to a point but consideration should be given as to how all of the evidence was brought together.

RESOLVED:
The Board of Directors **approved** the Initial Response to the Countess of Chester Inquiry

TB114/23 Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year Five Update

The Director of Midwifery presented the report advising 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

Work is being completed on the early neonatal death rate, which was recommended, by check and challenge, which took place last month.

AW queried whether the organisation would achieve all ten standards considering the improvements that had been made. JC advised that training compliance remained low and continued to be challenging in some areas. TR explained some of the issues around training compliance were part of a legacy issue. AW added there was a substantial financial incentive to achieving the standards.

RESOLVED:

The Board of Directors **received** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.

TB115/23 People Committee Chair Report

The Chair of the People Committee presented the Chair report from the meeting held on 19 September 2023. The following key points were highlighted:

- The agency update demonstrated that expenditure was on a downward trajectory over the reporting period. Good progress had been made on nursing agency spend, but more work was required on the medical agency spend, which had been static for a number of months. The transition to NHSP was being completed.
- The WRES and WDES Annual Reports were received and reflected areas of improvement but also areas where the results had fallen.

- The mandatory and statutory training update showed an improvement in compliance rates. In early September, mandatory training compliance was 89.99% and statutory training was 94.20%.

MN queried whether it was possible to identify which areas were continuing to spend on medical agency staffing. AS advised the Medical Director had been supplied with this data, but consideration needed to be given to the implications to a service if agency spend was stopped.

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

TB116/23 Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES) Report

The EDI Programme Manager reported on the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), which aim to ensure equality in career opportunities and treatment in the workplace. The raw data for these standards were submitted on time, and action plans are due by October 31, with input from the BAME Staff Network and Disability and Health Conditions network. The Trust outperformed the national average on most indicators but needs to improve on meeting staff's reasonable adjustment requests, which is a key priority.

There is ongoing work to foster a fully inclusive culture, with WRES and WDES data informing EDI priorities. Concerns were raised about staff with disabilities feeling undervalued and difficulties in accessing adjustments. A Reasonable Adjustments Passport is being introduced to streamline the process. There were also concerns about accurate disability data capture, which will require system improvements to ensure comprehensive record-keeping.

Additionally, efforts were being made to increase BAME representation on the Board of Directors.

FN queried whether the WRES data was based on the information available on the Electronic Staff Record (ESR) raising concern that if staff had not declared a disability how would the organisation be aware of this. TK advised the Trust needed to ensure systems were not only capable of recording the required information but that they linked with other systems. The organisation would need to ensure the project to roll out the Reasonable Adjustments Passport was comprehensive so all staff were aware and knew what actions to take when they were presented with the passport.

NR commented on the number of BAME colleagues on the Board of Directors stating the Non-Executive Director recruitment campaign had sought to widen the search for professionals, as it was important the challenge was taken forward as a Board.

RESOLVED:
The Board of Directors **received** the Workforce Race Equality Standards (WRES) and Workforce Disability Standards (WDES) report.

TB117/23 Equality Diversity and Inclusion Update

The EDI Programme Manager reported on the organization's progress in Equality, Diversity, and Inclusion over the past year and presented a consolidated EDI plan for 2023/24. This plan aligns with two new national EDI frameworks and includes various local recommendations from multiple sources like the

- 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.

The next steps involve finalizing the action plan with stakeholders and using it to guide the new EDI Steering Group in monitoring progress. The organization aims to embed EDI strategically in all its activities, going beyond mere compliance. Board member JN asked about the Board's role in supporting these actions, to which TK responded that more specific actions will be presented to the Board once further detailed work is conducted..

RESOLVED:
The Board of Directors **received** the Equality, Diversity and Inclusion update.

TB118/23 Revalidation Report

The Consultant Anaesthetist & Associate Medical Director for Clinical Governance presented the appraisal and revalidation report, which provided assurance to the Board of Directors around governance arrangements in place in relation to medical appraisal, revalidation and managing concerns.

The report sets out the achievements and challenges around appraisal and revalidation for medical staff. Appendix A is the submission for ABL Health who are based on the Trust site and deal with weight loss management and other health issues. The organisation acts as the designated body and appraise the doctors employed by ABL.

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

TB119/23 Finance and Investment Committee Chair Report

The Chief Finance Officer advised the Finance and Investment Committee had met the previous day and discussed the month five position and forecast.

The Board of Directors were advised the Siemens Maintenance Contract paper had been discussed and supported at the Finance and Investment Committee. A question was raised by RG on the trajectory of Consumer Price Index (CPI) and it was noted the information is available until 2026. CPI was due to fall to around 5% by the end of 2023 and will reach a target of 2% by 2025/2026. Therefore, on this basis the prices would remain fixed as the compounded interest would not exceed 2.5% after the initial three-year terms.

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

TB120/23 Charitable Funds Committee Chair Report

The Chair of the Charitable Funds Committee presented the Chair reports from the meetings held on 28 July and 11 September 2023.

The reports were received and it was noted there were no risks to be escalated.

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

TB121/23 Audit Committee Chair Report

The Chair of the Audit Committee presented the Chair report from the meeting held on 13 September 2023. The following key points were highlighted:

- Approval of the Terms of Reference was deferred to the meeting due to be held in December 2023.
- The new Internal Auditors, MIAA presented the Internal Audit Plan for 2023/24, which was approved.
- MIAA presented a progress report on the 2023/24 plan. It was noted that a number of audits had already commenced.

No risks were escalated to the Board of Directors.

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

TB122/23 Audit Committee Annual Report

The Chair of the Audit Committee presented the Audit Committee Annual Report, which provided an overview of the work the committee had undertaken at formal meetings, including how it carried out the work, assurances it received and demonstrated compliance with its Terms of Reference.

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

TB123/23 Fit and Proper Person Update

The Director of Corporate Governance presented the Fit and Proper Person Update to provide assurance the organisation was compliant with the regulatory requirements of the Fit and Proper Person Tests.

RESOLVED:
The Board of Directors **received** the Fit and Proper Person update.

TB125/23 Complaints Annual Report

The Chief Nurse presented the Complaints Annual Report noting there was an overall increase in formal complaints of 12% compared with 2021/22 and an increase in Patient Advice and Liaison Service (PALS) enquiries of 16% compared with previous year.

There was also an increase in formal compliments received of 45% compared with previous year. Themes were 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.

RESOLVED:
The Board of Directors **received** the Complaints Annual Report.

TB124/23 Feedback from Board Walkabouts

MN advised he had visited Opthalmology and noted that a number of different services lead into this department. Staff fed back that if additional space was available the service would be able to provide additional RTT services.

SW advised she had completed two walkabouts with MB to C2 and B3. They noted that improvement had been seen in digital support within the areas. SW and JN had visited D1, D2 and the new pharmacy locker on D1, which she commented was amazing and a huge benefit. The staff rooms on the wards required improvement which had had raised with the Our Bolton Charity.

NR advised he had visited B1 who advised they had been through the BoSCA but the process had not been followed. It was good to see good medical leadership on the support on the ward.

AS advised he had sat on a FABB Awards Judging panel and it was good to see so many nominations.

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

CONCLUDING BUSINESS

TB125/23 Questions to the Board

None.

TB126/23 Messages from the Board

The following key messages from the Board were agreed:

- Financial challenges facing the organisation and GM and how the Trust is working, to mitigate.

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 30 November 2023.

Meeting Attendance 2022/23									
Members	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**	**May**	**July**	**Sept**
Donna Hall	✓	✓	✓	✓	✓	A			
Niruban Ratnarajah								✓	✓
Fiona Noden	✓	✓	✓	✓	✓	✓	✓	✓	✓
Francis Andrews	✓	✓	✓	✓	✓	✓	A	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	A
Niruban Ratnarajah	A	✓	✓	✓	✓	✓	A		
Lynn Donkin			✓	✓	✓	✓	✓	A	✓
✓ = In attendance A = Apologies							✓	✓	✓

November 2023 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/23/08	30/09/2023	Operational Update	Include an update on the Urgent Care Treatment Centre worstream in the November 2023 Operational Update	RW	Nov-23	
FT/23/09	30/09/2023	Initial response to the Countess of Chester Inquiry	Data and AI to be a focus for a future Board Development Session	VC/RN	Nov-23	**Added to Board Development workplan**
FT/23/07	30/09/2023	Health Inequalities	Bolton Locality Board to be invited to present at future Board of Directors meeting on health inequalities.	VC	Jan-24	

Key

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	Fiona Noden		Decision	

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

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

Previously considered by:	N/A

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

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

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

Ambition 1
Provide safe, high quality care

The CQC report following the inspection of our children and young people's services in May, and the well-led inspection in June, has now been published.

The safety rating for children's services was upgraded to 'good', while the rating for 'well-led' was downgraded to 'requires improvement' reflecting the challenges the Board has experienced in relation to governance, leadership and relationships between former Board members. The Trust's overall ratings remain good in all other areas; safe, effective, caring and responsive.

We have thoroughly reviewed the report and have taken on board all of the recommendations. All actions are already either in progress or in development and we'll continue to report on our progress, through our existing governance structures, and at our public Board meetings.

We are so proud of our services for children and young people for achieving a good rating across all areas and improving their rating for safety, and continuing to provide safe, high quality care for the people of Bolton.

Since forming in November 2022, our nursing-led intravenous line (IV) access team has supported hundreds of patients who require medication and fluids. The team uses ultrasound technology to identify whether a patient has a suitable access point to receive medicine or fluids directly into a vein. Previously, patients with complex vascular access needed to wait for theatre slots to receive an IV line; however, the new service allows for bedside care and has reduced the average wait in hospital by four days.

A new Enhanced Care Lounge has opened at Royal Bolton Hospital to support vulnerable patients who are waiting for discharge to a care or nursing home. The dedicated care lounge on Ward B4 provides physical and mentally stimulating activities away from the busy ward environment in a comfortable setting to prepare patients for a safe discharge.

Areas created in the lounge including a living room, arts and crafts zone, kitchen and hairdressers. During a six-month trial, the Enhanced Care Lounge will aim to reduce length of stay in hospital, support complex discharges, and allow patients with cognitive impairments such as dementia, the opportunity to leave the ward.

Investing in digital technology is allowing us to enhance capacity in our phlebotomy service. A survey of patients who have used our 24/7 online booking system for blood tests since April 2023, showed that in August this year, 100% of patients who had a pre-booked appointment for the hospital service were seen within five minutes.

Data also shows that in the first six months of the online system being live, there has been an increase in pre-booked appointments, making up more than 75% of attendances. The system reduces the amount of time patients have to spend waiting whilst enabling our phlebotomy team to manage demand and align staffing levels to the bookings made.

The Parallel held an open morning on 6th October to celebrate 20 years of supporting young people in Bolton since opening its doors in October 2003. Staff joined the event to share their memories of working for The Parallel over the past two decades, and people were able to walk in to find out more about the service.

The needs of children and young people continue to be at the heart of the service in line with their mission which remains to improve the welfare and wellbeing of children and young people in Bolton.

Work is ongoing to implement Martha's Rule, named after 13-year-old Martha, who tragically died of sepsis after falling off her bicycle while on holiday with her family in 2021. Her family has campaigned ever since for patients to be able to formally request a review of their, or their family members' records by a senior nurse or doctor, if the patient is deteriorating and they feel their concerns are not being listened to. We are working closely with Martha's mum, Merope, to mobilise this approach at pace and make a longstanding difference for future families in Bolton.

Our annual vaccination programme is underway to protect our staff and in turn, their families and patients over the winter months. This year's offer includes a COVID-19 booster vaccine, as well as the vaccine for flu, and staff are encouraged to book via a number of routes including our vaccination champions, through Occupational Health or by accessing one of our drop in clinics.

Ambition 2
To be a great place to work

Our new 'Our Voice Change Programme' has officially launched and will focus on the key themes that when addressed, will have the biggest impact on our workforce. The themes have been determined by feedback our staff have given via a number of mechanisms including focus groups and our NHS staff survey. The current programmes are digital systems and equipment, car parking, working environments, flexible working and living our values. Each theme is led by an Executive sponsor and will be driven forward by a change team of volunteers across the organisation.

Some of our longest service staff were honoured for their commitment and dedication to serving Bolton communities at the 2023 Long Service Awards. The event celebrated staff who have 25 and 40 years' service and in total, attendees had more than 1,600 years of service between them. The event involved hearing stories about the history of the NHS in Bolton, including pictures from the archives of former nursing staff and hospital buildings from over the years.

Our hospital chaplain conducted a remembrance service for staff, patients and visitors on 10th November followed by the raising of the Union flag, a two-minute silence and the Last Post. There was a great turn out for the service, arranged by the Armed Forces team and supported by veterans who work at the trust, both of whom have been working tirelessly throughout the year to improve the support provided to veterans and armed services personnel, for both staff and patients alike.

Back in April, we received our Veteran Aware reaccreditation making us one of 147 NHS accredited providers across England, having met the standards laid down by the Veterans Covenant Healthcare Alliance (VCHA). To build on this and coincide with Armistice Day, we launched some new armed forces and veteran information packs, that will be given to every identified veteran or serving armed forces member, when they are admitted to the hospital. This provides vital information and support services for them to access, including links to the Armed Forces Charity the SSAFA, counselling support and the Ministry of Defence.

Our staff networks and teams continue to use awareness days as an opportunity to celebrate important topics and make tangible differences to our staff and patients.

October was Freedom To Speak Up month which allowed us to recognise the importance of continuing to create the right conditions across our organisation where people feel safe to speak up, without fear or detriment. Our Freedom To Speak Up Guardians and champions network held events throughout the month and continue to support our staff to speak up whenever they need to. During quarter two of this year, a record number of concerns were raised in comparison to previous quarters and years.

Our processes will continue to evolve based on staff feedback. We have recently introduced an alternative arrangement for staff who feel unable to raise their concerns internally, and would prefer to do so via NHS Greater Manchester.

October was also Black History Month with a theme of 'Saluting our Sisters' highlighting the crucial role that black women have played in shaping history, inspiring change, and building communities. Our Black, Asian and Minority Ethnic (BAME) staff network held a drop in celebration for all staff which included welcoming guest speaker Foluke Ajayi, the Chief Executive at Airedale NHS Foundation Trust, to hear about her career journey to inspire others.

We are currently recognising Disability History Month, with a series of events and plans to highlight the support we have in place for colleagues that have a disability or long-term health condition. This includes launching our reasonable adjustment passport for staff, our first neurodiversity support group and launch of the neurodiversity toolkit, a visual impairments learning lunch and 'access to work' support.

We recently welcomed three new Non-Executive Directors and an Associate Non-Executive Director to our Board of Directors. Tosca Fairchild, Fiona Taylor, Sean Harriss, and Seth Crofts will all play an important role in ensuring the Trust works effectively, efficiently, and economically to deliver high quality and safe services. We look forward to benefiting from their experience and working together in the coming months and years.

Our workforce systems and theatres teams have been recognised as highly commended for the Innovative Award for Quality Improvement at the RLDatix Awards 2023.The Trust's project 'Driving Down Waiting Lists with an Innovative Staff Rostering System' was implemented as an initiative to address staffing pressures and support elective surgery waiting lists. Staff now receive their rosters approximately 30 days in advance, allowing for better work-life balance and planning. The system also ensures that the right staff with specific skill sets are assigned to each shift, improving patient and staff experiences.

Our research teams have been celebrated at the Greater Manchester Health and Care Research Awards 2023 for their work in helping to improve patient care in the future. The Bolton REDUCE 2 Trial Collaborative Delivery Team were awarded the 'Collaborative Working Accomplishment' prize for the work between the Hospital Liver Team, Community Nursing Services and Bolton Hospice. Our Neonatal Unit Research Delivery Team also came as a runner-up in the 'Outstanding Achievement by a Team' through their work recruiting to a study on RSV immunisation named HARMONIE and the teams increased commitment to studies running on the Unit.

Ambition 3
To use our resources wisely

Financial turnaround and recovery for the whole NHS element of the integrated care system, including NHS Greater Manchester, is a key priority for the rest of this financial year. A team from Pricewaterhouse Coopers (PwC), led by Stephen Hay, is supporting this process.

Across Greater Manchester, there is a £606 million financial gap that must be closed during this financial year. £356 million of this is the responsibility of provider organisations, including ourselves in Bolton. This recovery is only going to be possible with a concerted effort, and all organisations and teams playing their part. Decisions taken will not be made on finance considerations alone - quality, safety, performance and tackling inequalities will be central to this programme of work.

A financial recovery sub-committee has been established to oversee delivery of the financial turnaround and recovery, reporting to the regional finance committee and the NHS Greater Manchester Board. Turnaround meetings have now taken place with all NHS provider organisations over the last few months to gain assurance that each has a robust Cost Improvement Plan (CIPs) in place to ensure the overall £356 million target is achievable and on track for delivery. A 'grip and control' review has also identified opportunities to further tighten financial grip and control across all providers.

While this year's plans are being delivered, a longer term strategic financial framework, to sit alongside and support delivery of the health outcomes in the Integrated Care Partnership (ICP) strategy and joint forward plan, is being developed. NHS Greater Manchester is in the process of scoping a plan to begin a public conversation in relation to our system financial pressures and what this may mean for our people and communities.

In Bolton, we already have longstanding processes in place to monitor and manage our finances. In addition our cost improvement programme enables us to work together to proactively identify areas in which we think we could make efficiencies and reduce our spend, without compromising quality or safety. In addition to this, we have established a Financial Improvement Group (FIG) with Executive leadership and representation from all divisions and corporate services to consider how these savings will be met.

Every option presented to the financial improvement group will continue to be carefully considered and balanced against the impact that it would have on patient safety, experience and outcomes.

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

Our Integrated Facilities Management (iFM) team has been undertaking some work across our hospital site in preparation for the winter months. This has included the refurbishment of several boilers in the boiler house, and a drone survey of the roofs across our hospital site to understand the extent of the repairs required. As a result, some repair work has been undertaken on Musgrave House and targeted work is underway to investigate some additional areas in further detail.

Construction work has continued on our state of the art school of medicine building located on our Royal Bolton Hospital site. The development is the first of its kind in Greater Manchester thanks to a collaboration between the University of Bolton, Bolton College, Bolton NHS Foundation Trust and Bolton Council.

The development is set to transform the way people are trained and employed in the healthcare sector, offering learners a direct route into healthcare careers, new training and apprenticeship opportunities for a range of clinical roles, including nursing, midwifery and physiotherapy. Courses at the Institute of Medical Sciences will be co-delivered and assessed by senior clinicians at the trust, ensuring that learners have the necessary skill-set to immediately step into clinical roles.

On 18th October, a public consultation event enabled attendees to voice their views on the development and what it will mean for our town.

Ambition 5
To integrate care

A scoping exercise has been undertaken to understand how we are delivering urgent care in Bolton, with the aim of supporting our communities to access the right urgent care service, in the right place at the right time. Urgent primary and community services are in scope for the review and this work supports to delivery of our Locality Plan which recognises the impact working together, across organisational boundaries can have on patient care.

A programme of engagement is underway to understand 'what matters most' to our patients and communities. Engagement has included a social media campaign, targeted work with community groups and hyperlocal engagement led by Bolton Council's community champions. The intelligence gathered will help shape the future of Bolton's health and care services by informing the priority areas identified in the Trust's clinical strategy, as well as Bolton's Health and Care Partnership refreshed Locality Plan which is currently underway.

Sally McIvor stepped down in her role as chair of the Bolton locality Strategy, Planning and Delivery Committee. I will now chair this group as Placed Based Lead for Bolton and will continue to report on progress for assurance purposes to our Locality Board. Sally has been recognised for her commitment and contribution to the committee and we look forward to continuing to work with her on an ad-hoc basis.

Work has continued to co-design an engagement framework for Bolton, led by the Voice of the Public Enabler Group. The group is chaired by Dawn Yates-Obe, chief executive of Bolton CVS and recently held a workshop for partners across our town, to understand where we engage with our communities well, and where there is room to learn from good practice and strengthen our approach. A Greater Manchester plan is in development and the group is working closely with them to align and work together where possible.

Ambition 6
To develop partnerships

Landmarks across Greater Manchester were lit up pink to mark Breast Cancer Awareness Month including Bolton Town Hall and the Royal Bolton Hospital site. Our Bolton NHS Charity has funded this October's Breast Cancer Awareness campaign, which includes external lighting outside the breast unit and the main entrance, and a handcrafted ribbon of support at the main roundabout. Alongside the Trust's awareness campaign, a fundraiser has been launched to raise funds for Breast Services at the hospital.

We provide a wide-range of high quality services for all patients with breast problems and we are the centre for Bolton, Bury and Rochdale Breast Screening Programme. 2023 has seen the us named a centre of excellence in breast cancer care as one of only two Trusts in the UK to be recognised in this way for the use of specialist technology to locate, remove and stage breast cancer, without the need for wires or nuclear medicine.

A pilot scheme to fund bespoke counselling for parents who sadly experience baby loss is seeing a reduction in levels of anxiety and depression. The therapy service is available to those who have experienced baby loss in later pregnancy at more than sixteen weeks, during birth, and in the weeks shortly after birth.

Seventeen couples or individuals have benefitted from 69 counselling sessions since Our Bolton NHS Charity started funding the pilot with Lighthouses Therapy Services in February 2023. Feedback from those who have accessed the counselling has found 71% reported a positive change to their relationship following counselling and a significant reduction in their levels of depression and anxiety.

In addition this this support, on Sunday 15th October, we hosted our annual 'Wave of Light' event at Royal Bolton Hospital's Baby Memorial Garden, inviting people who have experienced loss to light a candle and take a moment to reflect with poems and music.

Our anaesthetic department has been reaccredited under the prestigious Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) scheme, demonstrating the hospital's commitment to patient safety and excellence of care. ACSA is the RCoA's peer-reviewed scheme that promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, departments are required to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership.

Stroke patients also known as the 'stroke warriors', came together to take on a special walking challenge that celebrated their recovery and the progress they have made. The sponsored walk on the 400m race track at Leverhulme Park raised more than £7,000 which through Our Bolton NHS Charity, will support our community stroke team at Breightmet Health Centre by funding rehabilitation equipment to enhance patient recovery.

Our staff and public members attended our Annual Members Meeting on 16th October to reflect on the challenges our organisation has faced and achievements during 2022-2023 whilst also looking at exciting new plans to better support Bolton residents. The Executive team gave progress updates on the last twelve months and attendees were offered the opportunity to ask questions and further discuss our services.

Report Title:	CQC Well-Led Improvement Plan – Management & Oversight Process

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	The purpose of this report is to present an update on the trust wide CQC improvement plan has been developed in response to the announced and unannounced CQC inspections.

Summary:	The CQC inspection report for Children and Young Peoples Services and the Well-Led assessment was published on 18 October 2023. The core services subject to inspection have been; Urgent Care, Medical Services, Maternity, Children and Young People Services, along with a Well-Led inspection. Children's and Young Person's Services remains rated as "good" overall, with an improvement in the rating of the "safe" domain to "good". This has resulted in Children's and Young People services being rated "good" in all CQC domains. The Well-Led inspection resulted in a rating of "requires improvement". The published CQC report contains seven must do recommendations; all related to the Well-Led inspection and four should do recommendations; two related to Well-Led and two related to Children and Young People Services. The existing CQC Improvement Plan following the Urgent Care, Medical Services and Maternity Services inspection has been updated to include these subsequent recommendations. The Children and Young Person recommendations will be managed and overseen in line with the existing process for Urgent Care, Medical Services and Maternity Services. This will be via reporting of progress, risks, and barriers to completion to Clinical Governance & Quality Committee and via Chairs report to Quality Assurance Committee. The approach to oversight of the Well-Led recommendations is different as these recommendations relate largely to overall organisational leadership and management. The focus of a Well-Led inspection is on: ▪ the leadership and governance at trust board and executive team-level ▪ the overall organisational vision and strategy ▪ organisation-wide governance, management, improvement ▪ organisational culture and levels of engagement The recommendations have been assigned to a responsible Executive Director and oversight assigned to an appropriate sub board assurance committee. Executive Directors deputies are responsible for updating and reporting through to the relevant committee. See Appendix 1 for details. Board of Directors will be updated on progress or risks via the respective sub board committee Chairs reports. This reporting process will commence from December 2023 onwards

Previously considered by:

The report has been reviewed by executive directors and will be presented to the Board committees for progress updates.

Proposed Resolution	The Board of Directors is asked to receive and note the update provided in relation to management and oversight of the CQC recommendations, particularly those recommendations related to the Well-Led assessment.

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:	Stuart Bates, Director of Quality Governance	**Presented by:**	Fiona Noden, Chief Executive Officer

Appendix One: Well Led CQC Improvement Plan 23.11.2023

overdue	on track
due in next month	completed

Must Do/ Should Do	Recommendation	Actions	Date due for completion	Responsible Executive Director	Oversight Committee	Current Rag Rating
Must Do	The trust must ensure staff feel supported to speak up without fear of retribution by seeking and acting on feedback from relevant persons or other persons on the service provided in the carrying on of the regulated activity, for the purpose of continually evaluating and improving such services.	A reciprocal approach has been agreed with NHS GM FTSU Guardian that if staff do not feel able to raise concerns with Bolton FTSU Guardians, then they will be able to access the NHS GM FTSU service. Signposting of these arrangements will be made clear.	Completed	James Mawrey Director of People/Deputy CEO	People Committee	
		FTSU process is subject to internal audit assessment.	Nov 23		People Committee	
		To scope a leadership programme that supports leaders at all levels to better understand the crucial role they play in driving values and culture.	Dec 23		People Committee	
Must Do	The trust must ensure that the board and council of governors	In person Board of Director meetings resumed on 30th March 2023.	Completed	Dr Niruban Ratnarajah	N/A	

	are working effectively together to create constructive relationships and governance arrangements at this level.	In person Council of Governor meetings resumed 25th April 2023.	Completed		N/A	
Must Do	The trust must ensure it aligns relevant policies and procedures and that all policies are up to date.	Reviewed effectiveness of corporate procedural document oversight. (procedural documents; policies, clinical guidelines, SOP)	Dec 23	Tyrone Roberts Chief Nurse	Quality Assurance Committee	
		All procedural documents to be in date 95% (current 75%)	Mar 24	Tyrone Roberts Chief Nurse	Quality Assurance committee	
		Develop quarterly Procedural Document assurance report to improve oversight and monitoring.	Oct -23	Tyrone Roberts, Chief Nurse	Quality Assurance Committee	
Must Do	The trust must ensure the disciplinary and grievance / resolution procedures fully meet	Workforce Partnership formal sessions identified to undertake lessons learnt in conjunction with staff side colleagues.	Dec-23	James Mawrey Director of	Workforce Partnership Forum	

	the current required legislative standard and are fair to the person involved, follow correct procedure and are consistently operated effectively.	Investigation skills training to be included in the refreshed People Skills training offer.	Mar-24	People/Deputy CEO	People Committee	
		Internal Audit recommendations are actioned in line with timescales agreed.	Dec-23		People Committee	
		Assurances sought regarding fairness and consistency of disciplinary process. Scheduled on internal audit plan for Q3 2023/24.	Dec-23		People Committee	
Must Do	The trust must ensure that records relating to care and treatment of each person using the service are accessible to authorised people as necessary to deliver people's care through improved IT connectivity.	Investment in clinical equipment replacement programme deployed from March 2023 and continues.	Dec-23	Sharon White Director of Strategy and Transformation	Digital Transformation Board	
		Review of current digital strategy to ensure implementation plan is delivered at pace.	Nov-23		Digital Transformation Board	
		Community Wi-Fi upgrade complete, acute upgrade being deployed alongside	Mar-24		Digital Transformation Board	

		ward cleaning decant programme to minimise disruption.				
		Review of progress against the EPR business case implementation complete with a clear costed plan to complete deployment within 2 years.	Oct-23		Executives and Finance and Investment Group	
		Continue to test staff perception through the Trusts Listening programme.	Mar-24		Our VOICE TMC Reviews	
Must Do	Development and investment in workforce and systems must be prioritised to make sure clinical pharmacy services including medicines reconciliation rates are improved across the trust.	Review of Pharmacy workforce to determine service efficiencies to be delivered and further staff investments required to be presented at CRIG.	Mar-24	Francis Andrews Medical Director	Quality Assurance Committee	
		Compliance with the NICE Quality Standard 120, quality statement 4 for Medicines Reconciliations - all medicines reconciliations completed within 24 hours of admission. BI report being developed to provide real time data for medicines reconciliations compliance.	Mar-24		Quality Assurance Committee	

		This is to be reported through IPM and CG&QA.				
		Pharmacy T&F group for medicines reconciliations action plan identifies areas for improvement and is reported through DSSD divisional governance.	Mar-24		Quality Assurance Committee	
Must Do	The trust must continue with plans to strengthen the trust position on equality, diversity and inclusion are managed and monitored in a timely way and that all reasonable steps are taken to make reasonable adjustments to enable people to carry out their role in line with the requirements for employees under the Equality Act 2010.	HR Leads for each staff network identified to strengthen corporate support. Following review the socio economic group is not progressing. Neuro diversity staff network to be launched 29th November 2023.	Dec-23	James Mawrey Director of People/Deputy CEO	People Committee and Equality, Diversity and Inclusion Steering Group.	

Should Do	The trust should ensure the review of the trust strategy is completed in a timely way, ensuring clear aims and objectives are supported by current and relevant enabling strategies to turn them in to action.	Produce a summary report which is explicit on progress against strategic ambitions and objectives to provide assurance on progress. Additionally, to inform the development of the new strategy and ensure that incomplete actions that remain a priority are carried forward into the 2024-29 strategy.	Mar-24	Sharon White Director of Strategy and Transformation	Strategy & Operations Committee	
Should Do	The trust should promote and communicate relevant strategies via different means to make them meaningful to all staff. Staff should be provided with the opportunity to comment and contribute where appropriate.	Action is to continue to communicate about our strategies and plans through a range of channels and methods, including internal communications, through our intranet (including the opportunity to provide anonymous feedback through surveys), at open forum engagement events and through attendance at team meetings across the organisation. To do this regularly through the life of the strategy.	Ongoing	Sharon White Director of Strategy and Transformation	Strategy & Operations Committee	

Should Do	The trust should continue to improve governance processes in particular the senior oversight of risk, policy governance and the management of risk.	Good Governance Institute have reviewed our divisional quality governance systems and processes. To focus on supporting implementation of recommendations.	Mar-24	Tyrone Roberts Chief Nurse	Quality Assurance Committee	
		Peer review of Board Governance scheduled to commence in October 2023.	Dec-23	Sharon Katema, Director of Corporate Governance	TBC	
		Development of a corporate risk register to ensure Board oversight of high scoring risks.	Dec-23	Sharon Katema, Director of Corporate Governance	Quality Assurance Committee	
Should Do	The trust should ensure that the networks for staff from ethnic minority groups; Disabled staff and LGBTQ+ staff, have suitable corporate support to improve their effectiveness and that the	HR Leads for each staff network identified to strengthen corporate support. Following review the socio-economic group is not progressing. Neuro diversity staff network to be launched 29th November 2023.	Nov-23	James Mawrey Director of People/Deputy CEO	People Committee	

	socio-economic, age and gender networks, currently in developmental stages, are supported to develop in a timely way.					

Report Title:	Strategy and Operations Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 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 23 October 2023.

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 Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	25 September 2023	Date of next meeting:	23 October 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	M North, R Wheatcroft, S White, F Andrews. In attendance: A Chilton, L Clarkson, R Noble, L Rigby, L Robinson, J Ryan, J Street, M Szekely, C Trenchard, L Wallace, J Richardson (minutes)	Quorate	Yes
		Apologies received from:	S Ball, H Bharaj, R Carter, R Chel, S Katema, T Roberts, A Stuttard, B Walmsley

Key Agenda Items:	Lead	Key Points	Action/decision
Service Spotlight Theme: Health Inequalities	J Street	6 month progress update received on delivery against the three enabling priority workstreams: **Education and Awareness** Milestones achieved: • Significant traction achieved including the CEO now incorporates HI in all Trust inductions and links made with several staff networks to promote correct and accurate demographic recording Next step milestones: • 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. **Equality and Health Inequalities Impact Assessment (EHIA)** Milestones achieved: • Good progress secured including EHIA process and screening tool developed to identify any changes or additional steps required to ensure that equal access, experience and outcomes are achieved across all groups in the development of policies, services and projects & pilot teams identified to trial the new process Next step milestones: – 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.	The following actions and comments were noted: • The update presentation was well received and acknowledged as an exceptional piece of work led by JS and which also links with the clinical strategy and the draft locality outcomes framework. • The resourcing around data will be secured by making accurate, complete data everyone's business through consistent messaging. • Alongside CORE20PLUS there is a focus on the underlying health inequalities and other factors that contribute to the super users of FT services to reduce HI. • Recognition that Bolton has a CORE10 rather than CORE20 deprivation profile as 26% of the population live in the 10% most deprived nationally.

	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

Key Agenda Items:	Lead	Key Points	Action/decision
		• Knowing our People **Milestones achieved:** • Solid traction on embedding the importance of data quality including a presentation as part of the Junior doctors induction and the Trust wide induction. Know Your Patient education week to take place in September with educational activities and a stand in the main reception. **Next step milestones:** • 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 'Our Health Inequalities Programme Plan' to tailor the approach going forward • Links made with the GM EDI team to look at other projects taking place around data recording. • The Trust's internal work on enabling priorities and the clinical strategic priority of 'Improving the health of the population' links with the work across the Locality in the development of a single Bolton locality outcomes framework. The framework uses the national CORE20PLUS5 model • The Rainbow Badges Assessment and Tackling Health Inequalities in Cancer Care are two examples of how health inequalities reduction work is being built into our improvement approach at service level	• This is the foundation year to understand the work needed, make improvements to our data quality to enable us to be able to move into next year more robustly to monitor and measure outcomes. The Committee encouraged target setting for Year 2 onwards to clearly track progress. • It was acknowledged that this is a system-wide programme of work and not just with the Trust to achieve. • Noted this is an evolving landscape, such that as the quality of the data improves, it will provide an understanding of more groups to identify and target combined with softer intelligence to inform which groups we need to look at. As a result, KPI's will likely change over time as the programme develops. • The Committee **recommended** the HIEG update to the Board
Digital Performance and Transformation Board Chairs Report	M Szekely	• Risk 5400 - Workforce constraints remain the highest risk across the Digital portfolio with a number of projects remaining on hold due to resourcing issues • Terms of Reference ratified for the newly established Digital Clinical Governance Committee, as mandated by NHSE to identify and review potential hazards associated with the deployment and use of any health Information Technology systems • Bolton IM&T Primary Care Board - Wendy Hughes appointed as the new Digital Primary Care Lead with oversight of the digital primary care service • The Strategy and Operations Committee approved the recommendation of M Szekely as Deputy Senior Information Risk Officer (Deputy SIRO) for the Trust and Chair of the IG Committee going forwards. • Cyber Security Group now includes clinical representation with a robust assurance report provided up to the IG Committee. A second wave of cyber security training for Board members is being arranged. The governance reporting arrangements for IG into Audit Committee and Board are currently being reviewed. • Maternity EPR – received final release of software from the Provider on schedule and have now commenced testing of the functionality. Push back with supplier on original go-live in November 2023 to February 2024 to ensure robust and safe testing cycle.	The following actions and comments were noted: • Business case for EPR in Outpatients and Community is going to CRIG on 3.10.23 with a proposal for next steps. • The SLA for the GP IT Service with the ICB is currently being progressed through the ICB approval processes as planned. • GM ICB Business Intelligence Update – post filling protocol is now complete and the SLA can now be progressed within the in late October. • While the Maternity EPR project plan is on track there is a significant risk to CNST being achieved with a £1M impact. • Cyber risk recommended for inclusion in the BAF

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Month 5 – Operational IPM	J Street	The Committee received the presentation of the operational element of the Trust Board's IPM. Urgent Care: • 12 hour wait performance is persistently at the bottom of GM and has attracted recent media attention. • To rectify performance there are plans underway for the Urgent Treatment Centre (UTC) which include moving some of the services at the front door to the back door to co-exist with the UTC to free up additional capacity at the front door pathway and help improve assessment times. • Improving flow out of ED will be key to 12 hour performance and a large diagnostic is underway to triangulate the root cause. A substantial update paper will come to this meeting next month. Elective Care: • RTT – end of August at 25 78-week breaches with one patient over 104 weeks. • 65-week wait target has improved this month, but remains off track. To recover the position we have requested mutual aid • Diagnostics - Overall position has deteriorated by 2.6% from the previous month with a final performance of 82.0%. Community Care: • The number of patients with No Criteria to Reside (NCTR) has risen above the operational plan (90 patients), at 94 patients in hospital with no criteria to reside in month 5 and significant deterioration in lost bed days. GM stretch target of 65 NCTR patients was noted. • Currently in GM SPRINT led by ICS Division and have been set a further stretch trajectory of 65 patients on the NCTR list • 0-5 Health Visitor Mandated Contacts – Have seen improvements and key areas of service delivery are being prioritised and performance has remained satisfactory in our prioritised pathways.	Noted with the following comments received: • Significant challenge balancing activity and performance in relation to elective recovery and 65 week waits, in light of the current financial scrutiny being experienced by the Trust noted. • Internal Winter planning check and challenge session taking place including ensuring that we are doing everything possible to improve the position with 12 hour wait performance. • While NCTR performance is higher than expected, the number of patients with NCTR is better than at this time last year. It was noted August is always a challenging month due to annual leave- despite that ED is performing more or less in line with Aug 22. • The delivery of the 65 week wait target has improved at 663 against a target of 664 for August, but we remain off track against the re-based local plan where the phasing is less linear.
Winter Planning	J Street	Update received on the key activities undertaken in the Trust's preparedness for Winter, since it was last presented to this Committee in July 2023. • NHS England plans for Winter 2023/24 have now been received and reviewed against the Trust plan • Review of the bed modelling confirms that the planning assumptions remain correct. • Current plans are in the forecasted position, however, if the check and challenge identifies any increased expenditure, the ability to deliver this will be very challenging and presents a potential risk from an operational and financial perspective. • The delivery of the 92% bed occupancy target by reducing length of stay to 0.9 days will be extremely challenging and the check and challenge session will ensure that our plans are being mobilised effectively and test our worst case scenario escalation plans.	Noted with the following comments received: • Once the check and challenge is complete the outcomes from the scenario planning will inform the narrative for the Board update. • The GM financial constraints will have a significant impact on the workforce schemes from a recruitment and retention perspective • The nurse led discharge model was welcomed by the Committee. Action: The Committee approved the Winter Plan for Board consideration

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Cancer Recovery Performance Update	R Wheatcroft J Street	Update received on the current position against the cancer performance recovery trajectory since last presented to this Committee in June 2023. • The recovery plan for Cancer 62-day performance has no new risks to delivery identified at this point and is on track to achieve the best case scenario, which forecasts recovery in January 2024 (likely being February 2024 and worst case being April 2024 onwards) • An increase in clinical capacity in the Urology and Breast pathways and a reduction in the number of breaches in other tumour pathways have brought the required improvements to achieve the best case scenario • The new streamlined Cancer waiting time standards come into effect in October 2023 with the following 3 core measures and our recovery plans have been reviewed to fully take account of these changes: – The 28-day Faster Diagnosis Standard (75%) – One headline 62-day referral to treatment standard (85%) – One headline 31-day decision to treat to treatment standard (96%). • Achievement of best case rather than likely case is attributed to all the plans having had an incremental marginal impact on all pathways leading to an overall reduction in breach numbers • The Breast & Radiology teams have worked collaboratively to increase capacity safely, improve clinic scheduling and ensure effective use of locum activity to reduce the backlog. • Cross-divisional forensic focus has provided the ability to re-align job plans and admin and clerical systems across two divisions/services to improve pathways.	Noted with the following comments received: • The assurance regarding being on track for a January 24 return to 62-day Cancer performance was noted. • The Committee discussed the increased clinical capacity being from agency and locum as a risk to sustainability from a financial perspective and noted, everything possible will be done to protect the cost implications relating to Cancer performance due to the significant quality and outcome impacts. • A fifth Consultant Urologist is now in post substantively creating greater capacity. • Capacity has been maintained through use of IT such that a member of the team having returned to India recently with DPIA/IT processes being put in place has been able to continue to report whilst overseas • A continued huge amount of work to actively encourage people to apply for Breast Radiologist posts is underway.

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Protecting and Expanding Elective Capacity – Self-Certification Checklist	J Street	The Committee received the self-assessment document which is in response to a letter received from NHSE in August entitled ''Protecting and expanding elective capacity'. • 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-ups where appropriate, following clinically-informed access policies and implementing new ways of working. The following areas were RAG rated red and amber: • 1b Amber - has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023. Currently rated amber as the 'Health care communications' digital system used to contact all patients waiting over 12 weeks has not yet been rolled out to all specialties • 1d Red - 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 Limited capacity to achieve this due to challenges in delivery of cancer performance and 65 week clearance priorities, on-going industrial action and financial challenges. • 2a Amber - has signed off the Trust's plan with an ambition that no patient in the 65 week 'cohort' will be waiting for a first outpatient appointment after 31 October 2023. There is a gap in terms of the ability to meet the target in 4 specialties.	Noted with the following comments received: • The Committee noted the risks and supported the realism of the RAG rating. • Also approved the self-certification for onward sign off by the Board of Directors by 30th September 2023
Clinical Strategy Update	R Noble	Update received on progress towards the completion of the Clinical Strategy • Since the last update to this Committee in July, work has focussed on the three key elements of work; data and insight; engagement and drafting. • Successful staff engagement sessions have taken place with participation from over 100 staff members who had not contributed previously with good feedback received on the priorities and minor changes made from this. However the actual number of staff who have engaged with the strategy is much higher and the level of staff engagement received is consistent with participation on other Trust strategies previously. • A data pack and clinical drivers document has been received from Archus. Following initial review, the Chief Data Officer is working to refine the data, with a particular focus on aligning this with the Trust's approach to bed modelling along with further work to understand likely demand and bed requirements at specialty-level by 2033. • A number of public meetings have been identified to progress public engagement, which includes some condition specific groups. This along with some wider alignment with the locality plan engagement will bring together locality and clinical strategy objectives for testing with the public. The information from previous locality engagement exercises will be utilised to provide useful data.	The following comments were received: • The support from the Medical Director team in helping to shape the strategy to its current iteration was acknowledged. • FA wished to pass on his thanks to the team for their efforts to date and endorsed the momentum to deliver the strategy. • Achieving the deadline in light of the additional expectation from clinical divisions on financial recovery, will be challenging in addition to industrial action. However, a high level, pithy clinical strategy with overarching outcomes will be ready for approval in November as planned. • The detailed clinical implementation plan to be launched in April 2024 . Work will also take place with the Transformation Team to review 'what good looks like' for the Trust.

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Locality Urgent Care Strategy Update	C Trenchard	The Committee received on the purpose, workstreams and approach for the full urgent care review. • The UEC Board have supported a full urgent care review to ensure that there are Urgent Care services in Bolton which meet the needs of population at Neighbourhood level. • UTC compliant model – FT-led project board in place that includes ICS colleagues, meeting weekly and with full mobilisation plan in place, currently rated green (on track) • The review has a simple and ambitious purpose to design a easy to navigate joined up primary and community urgent care offer. The services in scope of the review are everything that sits before an attendance in ED. • The review has the following 4 workstreams: Population needs, assessment of current Health and Social Care service provision against national standards, co-production of Ideal clinical model and determination of delivery and funding models. • The review will be cost neutral; value adding, cognisant of inter-dependencies, draw on and sharing of best practice, engagement with clinicians and communities and be data informed. • An update on the triangulation of the review with the CORE20PLUS5 model will be provided to the next meeting	The following comments were received: • ED data analysis showed that a high percentage of 'No diagnosis' coding. FA highlighted that this is an issue with SNOMED which will not allow a diagnosis to be entered. This will be captured as one of the barriers to progress. • The Committee encouraged forming a panel with diverse input from across the system e.g. primary, secondary, voluntary and local authority partners. • The data analysis will inform the potential alternatives for a 24 hour emergency care system to mitigate A&E pressure. • The timeframe for completion of the review by the end of March 2024 will be manageable if efforts are focussed on where there will be the biggest impact.
0-19 Children's Services Update	M Cox	Update received on the current position with regards to the extension of the 0-19 contract and the Family Hubs programme. • In June 2023, a deed of variation was received to apply an extension to the 0-19 contract from April 2024 until March 2025 and to set out delivery elements required for the Family Hubs programme over the lifetime of the current 0-19 contract. Following review of the financial envelope for the 0-19 contract and the Family Hubs element, there are some concerns about the forecasted financial loss for the Trust due to increases in pay and associated costs. • The forecasted financial loss for 23/24 is £1.7m and for 24/25 £2.3m. However, there are plans in place with the Council to start to reduce those gaps. • The Family Hubs Programme is a new programme from the Department for Education which is linked to the 0-19 contract but is stand alone and due to run until March 2025. The business case was approved at CRIG and for the Trust to proceed with recruitment. • The contract is as yet unsigned while negotiations are underway given the financial pressures.	The following comments were received: • Immediate actions have already been taken to work towards the financial savings and a quarterly update will be provided to this meeting in December showing the evolution and quantification to streamline the service to breakeven. • Committee noted the services need to fit the financial envelope available given the current GM and national backdrop. • Need to be mindful of the impact of a review on nationally mandated outcomes, which the contract stipulates we have to achieve. • Lessons learnt, that any future contracts with the local authority should cover off the inflationary impact of pay and non-pay. • The financial element is on the risk register with oversight being triangulated with this Committee and the Risk Management Committee.

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Strategy, Planning and Delivery Committee – Outcomes Framework	S White	Update received on the draft Locality Outcomes Framework. • A Single Locality Outcomes Framework is being developed to document the outcomes we want to achieve in Bolton during the next decade. • The Framework centres on the NHS England CORE20PLUS5 model which breaks down as: Core20 - The most deprived 20% of the national population. 45% of the Bolton population are in the 20% most deprived boroughs nationally our approach will be to look at the top 10% which is still 26% of the Bolton population. PLUS - Population groups to be identified at a local level. Our PLUS groups have been identified with support from Public Health and BI 5 - Set of five clinical areas of focus, for both adults and children and young people (0-17), which require accelerated improvement. Oral Health for children has been updated from addressing the backlog of tooth extractions to improving the oral health of children and reduce tooth extractions due to decay. • Smoking and Obesity have been added as two cross-cutting areas of focus	The following comments were received: • The smoking and obesity cross-cutting areas of focus do not include children with the national model only including adults. The systems does have a separate children's model to include. • Public Health will help in relation to providing the evidence base to underpin the achievement of the interventions • SW supported JS taking the draft framework through two of the meetings that she chairs, the Health Inequalities Enabling Group and the Locality Planning Care Group. • The Committee noted the outcomes would be monitored annually at Locality Board with progress reviewed based on quarterly KPI tracking.
Performance and Transformation Board Chairs Report	R Wheatcroft	The Chair's report was received for information and assurance	• Noted

Items to note or be escalated to the Board:

- The challenge in balancing activity and financial pressures given the GM and national context were highlighted throughout the agenda
- 12 hour wait performance is persistently at the bottom of GM and has attracted recent media attention – significant work underway to mitigate this
- NCTR patients increased to 94 (Trust target is 90, GM stretch target is 65) but better than August 2022 and reflects usual August annual leave challenges.
- 65 weeks waits on track at with target at 663 but off track against locality targets, where the phasing is less linear in the run up to Winter than Trust targets
- Winter plan is recommended for Board approval
- Maternity EPR CNST risk – go live in Feb 24 is a challenge. To meet CNST requirements it must be live by March 24 (£1M at risk).
- Cyber risk recommended to be considered for inclusion in the Trust BAF.
- SLA with GM ICB so BI is able to support Trust priorities to be initiated late October
- 0-19 Children service renegotiation ongoing to pursue break even given forecast loss of £1.7m (23/24) and £2.3m (24/25).
- Cancer 2-week wait recovery on track for best case – January 24
- High level clinical strategy with overarching outcomes on track for finalisation – November 24.

	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

Strategy and Operations Committee Chair's Report

Name of Committee	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	23 October 2023	Date of next meeting:	30 November 2023
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	M North, A Stuttard, R Wheatcroft, S White, F Andrews, S Katema, T Roberts In attendance: A Blackburn, L Clarkson, M Cox, N Ledwith, C McPeake, R Noble, L Rigby, J Riley, L Wallace, B Walmsley, S Ashley, J Richardson (minutes)	Quorate	Yes
		Apologies received from:	S Ball, R Carter, R Chel, A Chilton, J Ryan, J Street

Key Agenda Items:	Lead	Key Points	Action/decision
Q2 Look Back/ Q3 Look Forward	R Noble	Received Q2 'look back' and Q3 'look forward' against the 5 priorities aligned to our strategic ambitions: Focus on risks rather than innovation with a six monthly rotation alongside the 'look back' approach. Recruitment and Retention priority will be tracked through the People Committee Q2 challenges; workforce availability, high demand and financial challenges. The anticipated challenges for Q3 relate to further planned industrial action, entering the Winter period, launch of the new operational planning guidance and the programme of financial improvements. • **Children & Young People and Maternity** **Q2 look back** - Maternity Improvement Group, 0-19 Evaluation, SEND and Sexual Health **Q3 forward look** – Maternity, 0-19 Evaluation, SEND and Sexual Health • **Data and Digital** **Q2 look back** - On-going work, Ward assessment kit audits, Go-Lives, Data **Q3 forward look** – On-going work/Go-Lives, EPR, IT Service Improvement, Data • **Performance and Recovery** **Q2 look back** - Delivery of 78 week milestone, UC business case and sustainable delivery of UTC, PIFU review to determine improvement actions for specialties with only a small number of patients on a PIFU list, 62 day backlog should return to pre-pandemic level, Urgent community response **Q3 forward look** – UEC, Cancer recovery trajectory, NCTR, 65 week wait 1st outpatient appointment, Cancer best timed to pathways • **System Transformation** **Q2 look back** - Neighbourhood Mapping and commencement of Workforce Implementation Plan, Final approval for Establishment of Neighbourhood Leadership, Assessment and shortlist of Neighbourhood Estate and Informatics options **Q3 forward look** - Workforce engagement, staff allocation and OD requirement for 6 Neighbourhoods, Development of Neighbourhood profiles/Insights, Detailed assessment & finalisation of IT model and estate.	The following actions and comments were noted: • The high-level review of strategic risks did not suggest any likely impact to delivery against the priorities. • The link with Digital into the 'Our Voice Programme' will be picked up through the Trust Management Committee and the Comms Team are working to ensure that positive messages relating to Data and Digital outputs are recognised in the organisation. • The aspirations around the opening of the on-site Bolton Birthing Unit are achievable and important from a flow perspective. • A full review on the status of completion of CNST is underway along with a paper to CRIG for the IT solution and financial implications • A business case to take the UTC from pilot to BAU is being considered aligned to the wider locality urgent care planning underway • Kit roll out will be expressed as a percentage in future milestone updates – current 50% roll out • The highest Digital risk relates to capacity and overlapping projects. • TMC to review if the level of 'green' ratings are fully representative of current status • The Chair acknowledged the level of traction and assurance from the look back/look forward

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Trust EPR Business Case	B Walmsley L Clarkson	• The Committee was asked to note the progress on deployment of the EPR project against the original business case and to approve an additional capital investment of £1.52m (exc VAT) for the roll out of Phase 2 of EPR into Outpatients and Adult Community Services which service the vast majority of patient contacts for the Trust • The next phase of EPR is essential for the development of the Trusts' digital maturity and is key for the delivery of quality, safe and efficient care. Based on the risk and key benefits highlighted by the Divisions, work has been undertaken with Altera Digital Health to develop an ambitious deployment plan to deliver outpatient and community EPR by April 2024.	The following actions and comments were noted: • Business case supported from a Locality perspective and the interoperability with Primary Care as an important next step for Community and Neighbourhoods. • The project has been well phased with a large amount of preparatory work carried out by the Digital Team to be in a position of ready to go. Finances have also been phased with capital monies separated in the event of any delays. • The Committee approved the business case in principle for recommendation to Finance and Investment Committee
Digital Performance and Transformation Board Chairs Report	B Walmsley	• No chairs report provided as the meeting on 9th October was stood down due to Opel 4 status impacting on quoracy of the meeting	• Noted
Urgent care – Length of Stay	C McPeake	• The Urgent Care Transformation Board (UCTB) had requested the LOS workstream to review the main schemes that had been implemented to improve patient flow and bed occupancy: - Same Day Emergency Care (SDEC) - Older Persons Assessment Unit (OPAU) - Introduction of Virtual Wards • The areas identified for improvements to flow relate to decision to admit; bed request to bed availability and timeliness of discharges from wards • The Team have developed a full workstream plan that takes into account the elements that will contribute to better performance and have also volunteered to be part of the Missed Opportunity Programme with NHS England NW which is taking place through October with results expected at the beginning of the New Year. This external scrutiny, advice and assurance will ensure we are focussing on the areas of improvement that matter.	The following comments were noted: • In relation to timeliness, the standard process for conducting a ward round 'shop model' is implemented on every ward. • The data quality issue for reporting of bed occupancy for BFT referred to in the report is being picked up by Business Intelligence • A full plan is in place for timeliness of discharge letters and TTO's from Pharmacy and an update will be brought to this Committee (date to be confirmed by RW). • The new SDEC pathway has removed zero length of stay patients leaving more complex patients in the bed base which is causing issues around performance. The next update to this Committee will provide the key actions needed to make the difference that is now required in the middle pathway.

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
NCTR Update	J Riley	• Average of 90 patients on the NCTR list has been maintained through Q2 which is in line with the Trust's Operational Plan. A stretch target of 60 on the NCTR list is also being worked towards • Bed days lost remains challenging at around 800 with a target of 400 • In the latter half of Q2 a Sprint was initiated by GM ICB inQ2 and as part of this a refreshed target of 65 to be achieved by 1 October 2023 was proposed. Whilst this stretch target was not achieved there was a reduction from 99 in August to 68 by 1 October • Bolton continues to benchmark well across GM having shown a considerable improvement against the GM average for patients with NCTR, as a percentage of total occupied beds • The focus going into Q3 will be to sustain the improvements already put in place and to develop processes to identify and plan for patients likely to have the most complex needs to avoid delays later which will impact on the bed base • Outstanding challenges relate to complexity of patients, needing the system to work together on user capacity across the whole of the system, intermediate care and care home capacity specifically in relation to infection prevention and control and driving down the bed days going forwards.	The following comments were noted: • The GM Sprint was not recognised as a 'Sprint' locally but it provided the focus needed on the improvement schemes already up and running and achievement of the reduction in NCTR to 68. The daily focus was very labour intensive and micro-managed and is not sustainable going forwards. Therefore, a structure is needed that will make these processes work without the need to have daily meetings drawing on large numbers of staff. • The Reablement and the Discharge to Assess at Home service has been merged to create the Hospital to Home test for change which enables patients on pathway 1 to return home on day zero of NCTR allowing assessment of patients' needs in their own homes, and reducing dependency for on-going care support by avoiding de-conditioning caused by delays. The Committee acknowledged the significant achievement in reducing the NCTR position to 68.
Finance and Intelligence group (FIG) Update	R Noble	• The Group reports into the Performance and Transformation Board on the following areas of work – Elective Recovery Fund (ERF); Counting and Recording; Contracting Update; PLICS Implementation; Capacity and Demand; Operational Planning; Tableau; Productivity and benchmarking • The Terms of Reference for the Group are currently being refreshed in order to align with GM Productivity and financial constraints to support the delivery of the trust financial and operational plan and the Committee was asked to provide feedback/constructive challenge • The main priorities and objectives of the Group relate to intelligence; optimisation and performance and financial efficiency • The Group provides targeted actions in relation to operational planning performance and is a critical interface for corporate and clinical decision making • Current key areas of focus relate to Trust income position; Counting and Recording and Productivity Next steps include focus on analysis of GM Planning and Implementation Group (PIG); Triangulated operating plan and Productivity focus	The following comments were noted: • The Committee recognised that FIG is a key strategic and operational group within the organisation that feeds into the Performance and Transformation Board and the strengthening of productivity should be added to the Terms of Reference going forwards • The Terms of Reference demonstrated good grip and would be a good example of sharing good practice within the Provider Collaborative • Benefits realisation is reported by CRIG up to F&I Committee with an efficient tracking mechanism in place by the PMO for reporting financial and non-financial benefits to CRIG. A regular FIG update will be provided to this Committee going forwards

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Month 6 – Operational IPM	M Cox	The Committee received the presentation of the operational element of the Trust Board's IPM. **Urgent Care:** **Fractured Neck of Femur** - target did not meet the standard in month. An action plan is in place to improve the hip fracture performance focussing on improved trauma theatre productivity, improved clinical pathway and improved data reporting Elective Care: • **RTT** – end of September at 38 78-week breaches. • **65-week wait** target has deteriorated in month and remains off track. To recover the position we will continue to request mutual aid • Diagnostics - Overall position has improved by 0.6% from the previous month **Cancer:** • 2ww performance for August improved to 79.87%. • Remain on track with the Breast cancer recovery plan and achieved the 62 day standard this month • Faster Diagnosis performance has improved this month and continue to achieve our Cancer 62 day backlog trajectory, having 29 patients on the PTL over 62 days against a planned target of 30. **Community Care:** • **0-5 Mandated Contacts** – small increase in month from 85 to 88% with underperformance being due to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors. • **EHCP compliance** - Reduced performance in-month due to 14 overdue reports from previous month. Requests for new EHCP plans have increased significantly, up from 41 in August to 74 in September • **Looked After Children** - Compliance for August was 88% with a drop in performance in September to 82%. The services have a recovery plan in place to recover performance to 90% target.	Noted with the following comments received: • The Chair acknowledged the improved DM01 position. • From an Elective Care perspective 65 weeks performance is a significant risk as we are not achieving the necessary clock stops to achieve the target by the end of March and we are therefore seeking help for mutual aid. • The main concerns relate to waiting list growth with no progress in reducing this Acknowledged that system working with primary care will help with admission avoidance along with linking up with referrals from GP practices. • The Chair welcomed the exec summary provided by RW and requested this to future meetings as part of the IPM update. **Action**: Exec summary of IPM 'helicopter' view to be included going forward
Clinical Strategy Update	R Noble	Update received on progress towards the completion of the Clinical Strategy: • Positive progress has been made against the four key tasks presented to Board in July and the project remains on track for sharing with SOC in November ahead of submission to the Board of Directors for final approval. The draft will not include detailed divisional plans to all Divisions time to work through against the set outcomes • Once approved the Strategy will be launched into the organisation supported by the Strategy Team to deliver divisional plans.	The following comments were received: • The Chair advised that the Board of Directors had received this version of the strategy the week previous due to the Board meeting being scheduled ahead of other committees this month. The Board of Directors were supportive of the direction of the Strategy, acknowledged the amount of work done to date and had provided positive feedback

	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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
GM Digital Strategy	B Walmsley	The Committee received the outline of the GM Health and Care Digital Transformation Strategy and received assurance that there is alignment with the Bolton Digital Strategy 2022-2025 to ensure the Trust has capabilities for joined up healthcare across the ICS. • Almost all of the key priorities in the GM Strategy are in the Trust Strategy and have either already been completed, in progress or due to be completed in 2023/24 with 29 of the 47 digital and data capabilities within the GM strategy already completed - In order to ensure that we continue to align with the GM Digital strategy we will need to continue engagement with GM, continue to invest and deliver what is in our Digital Strategy 2022-2025 with EPR deployment across outpatients and community being a priority action item and continue evaluation of our Digital Strategy. Bolton is behind on its EPR deployment as noted by the CQC.	The following comments were received: • The synergies with the GM Strategy were welcomed by the Committee which provided assurance on our digital journey and despite the delays with EPR rollout to Outpatients and Community outlined the excellent work achieved to date. • Health Innovate Manchester underpins the GM Strategy from a resources perspective • Open Eyes EPR has stalled due to the company going into administration and we now have support from a different company • NHS at home devices were distributed by GM without updating Bolton, hence there's a catch up on understanding what devices are being deployed at home
GM Draft Operating Model	N Ledwith	An overview of the GM operating model was provided covering all partners and their roles; key functions and how they operate in a placed based delivery approach and KPIs to be monitored at a headline level across PC; Community Services; MH; LD & Autism; SC and Use of resource	The Committee noted the report and the greater clarity on the GM operating model. It was also discussed that this summary would have been very welcome at the inception of the ICS in July 22.
Locality Plan	S White	The current Locality Plan is valid until March 2024 and the plan refresh articulates how the Locality will improve the health related outcomes for our population. • A project group has been working together to develop the draft key strategic aims which are based on information and insight gathered locally, regionally and nationally with 6 strategic aims • Launch will be in March 2024	• Noted
Strategy, Planning and Delivery Committee Minutes	S White	The Chair's report was received for information and assurance	• Noted
Performance and Transformation Board Chairs Report	R Wheatcroft	The Chair's report was received for information and assurance	• Noted

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

Strategy and Operations Committee Chair's Report

Key Agenda Items:	Lead	Key Points	Action/decision
Sexual Health Tender Update	R Wheatcroft	• Sexual Health is one of the services being considered from a loss making perspective by GM. • N Ledwith advised that there is work on-going at Locality level around service line reviews to support those loss making services and this is being discussed at GM on 30th October. N Ledwith will make sure ensure that the Stephen Hay finance work and the GM service line reviews come together at that meeting and that the work happens at pace to ensure that sexual health services are provided to the people of Bolton but not at any cost.	• Noted

Items to note or be escalated to the Board:

- Phase 2 of the Trust EPR programme was wholeheartedly supported and recommended for F&I approval
- LOS of stay improves but Decision to Admit is significantly worse than 22/23 likely to due complexity of the bed base as zero day case numbers increase
- An NCTR average of 90 patients was maintained for Q2 versus a GM stretch target of 60. Bed days are challenging at around 800 versus a target of 400
- 65 week wait performance is at significant risk and the Trust is seeking mutual aid to mitigate this
- Clinical strategy is on track for November 23 finalisation

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

Report Title:	Clinical Strategy

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	30 November 2023		Discussion	
Executive Sponsor	Francis Andrews		Decision	✓

Purpose	To provide the Board with a final draft of the Clinical Strategy for approval

Summary:	This paper introduces the final draft of the Clinical Strategy. It outlines progress made following Board review in October and answers the questions posed in the October review. Following October Board, the document has been circulated for final review and comment internally and shared with members of the Clinical Strategy Project Board, which recommended it to Strategy and Operations Committee, and the Board of Directors.

Previously considered by:
The paper has been formulated through a series of consultations and engagement with the internal and external stakeholders, Clinical Strategy Project Board, Executive Directors and the Strategy and Operations Committee.

Proposed Resolution	The Board is asked to approve the final draft of the Clinical Strategy.

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:	Dr Harni Bharaj, Nicola Caffrey, Rayaz Chel, Francesca Dean, Dr Sophie Kimber-Craig & Rachel Noble	**Presented by:**	Dr Francis Andrews

1. Purpose

This paper introduces a final draft of the Clinical Strategy for review and approval.

At the Board's previous review of the Strategy in October, feedback was provided and clarifications were sought across the following key themes:

- Engagement
- Document content
- Strategic alignment
- Risk
- Strategy launch and delivery
- Next steps

Accordingly, this paper answers the points raised at October Board and highlights the changes made to the document following further work and engagement with clinical teams, stakeholders and the public which took place after changes proposed by the Board were made.

2. Engagement

Following commencement of the clinical strategy programme in 2022, engagement has been ongoing to develop a document that describes the aspirations of our clinical and operational teams, encapsulates what is important to our service users, and critically, identifies how we can best meet the increasing demand for our services over the next five years. Our engagement spans staff (both clinical and non-clinical), local stakeholders and partner organisations, and members of the public and patient groups. In summary:

- 36 specialty-specific meetings took place at the outset of the programme, with subsequent divisional triumvirate meetings to validate and develop information gathered
- An anonymous survey was published on the staff intranet and a total of 23 responses were received
- Updates were provided through regular staff communications and the draft document was publish on the intranet
- The project team conducted a review of patient feedback and complaints received between 2021-23
- The clinical strategy project team attended almost 30 virtual and in-person events including town council meetings and patient support groups. Around 100 members of the public were reached through these meetings
- The draft strategy was shared with stakeholder organisations and presented at meetings including the Bolton Locality Board, Primary Care Network and Strategy, Planning and Delivery Committee

2a) Organisational feedback following October Board

Following refinements made to the document after discussion in October, the final draft document was issued across the organisation at the start of November for review and comment. Feedback was received from clinical divisions and from individual clinicians, and offered broad support for the document, along with some suggested additions to the clinical themes which have been incorporated. Of note are the changes made to the Community Care and Diagnostics themes to articulate the vision to deliver the 'Home First' approach for our population, and to embed technology and innovation at the heart of our diagnostics services. Several clinicians noted the importance of the

completion of this document, and its importance for the organisation, which is a positive milestone.

All feedback received was reviewed by the Medical Director prior to inclusion in the document.

2b) Public Feedback

The feedback received throughout public engagement can be summarised into three core themes; access, experience, and communication. The following points were raised through our engagement:

- **Access** – desire for access to records (digital) and information to manage care including test results, appointment booking, access to the right people at the right time. Access to the site with parking raised as an issue. Members of the public said they want choice on how they access care, services and appointments. Too many touch points and hand-offs between departments. A feeling that Trust processes are complex and could be simplified
- **Experience** – members of the public want to know we are doing our best to improve care, that we understand and respond to their diverse needs as individuals, family members and carers, and that we treat people with compassion and respect
- **Communication** – there was a strong theme that people want to be communicated with openly and provided with as much information as they feel they need. Two-way communication is important, especially for carers, people with long-term conditions and people undergoing a longer course of treatment

This feedback predominantly influenced our priorities as described in the October Board paper.

2c) Stakeholder feedback

To ensure that the strategy aligns to local priorities, it has been presented to several Bolton system meetings including the Locality Board, Strategy, Planning and Delivery Group, and the Primary Care Network. Partners have endorsed the document, suggesting only minor changes which have been incorporated.

3. Document content

Following the October Board discussion and final organisational feedback, the clinical strategy document has been further refined to:

- Reflect home first and prevention, rather than community
- Re-frame the Community section to better articulate the aspirations of the organisation and embed the 'Home First' approach
- Ensure alignment between Trust Health Inequalities Programme
- Ensure that the document reflected divisional priorities as described at the June Service Review Day
- Expand the description of and rationale behind the three priorities
- Develop the approach to delivery
- Strengthen the impact outcomes by providing some example measures
- Include staff wellbeing in our catalysts

The Board raised a question about the 'three service user groups' which were included in an earlier draft of the document. Recent analysis on user groups in the Emergency Department

has identified *seven* categories of users, and it is clear that service user groupings will continue to change based on access trends. As part of the delivery of the clinical strategy, it is proposed that we continue to review access trends to seek opportunities to do things differently, and to address the specific challenges that some of these cohorts encounter. Further work will be done on this and will be shared with the Board in due course.

4. Strategic alignment

Ensuring that the clinical strategy is aligned to local, regional and national priorities is critical to assure us that our priorities and ambitions connect to and support the achievement of wider NHS aspirations.

- At a local level, our critical alignments are to the corporate strategy (and its ambitions), and the Bolton locality plan. The clinical strategy will support the delivery of our new central Trust ambition which is to 'Improve Care, Transform Lives'
- At a Greater Manchester level, we have a responsibility to ensure our strategy connects to GM and regional ambitions and priorities, with a specific focus on how it supports the delivery of the GM strategy. The GM vision outlines the following priorities which are reflected in our strategy:
    - Everyone experiences high quality support and care when they need it
    - Everyone has the opportunity to live a good life
    - Everyone has improved health and wellbeing
    - Health and care services are integrated and sustainable
- In turn, the ongoing delivery of our strategy will inform wider GM transformation programmes such as Sustainable Services, and as we identify scope for transformation of our models of care and delivery, we will encounter opportunities to work more closely with neighbouring Trusts to deliver more resilient services to the population of GM. The Trust will feed into this work through the GM Executive sub-groups of the Trust Provider Collaborative
- At a national level, the document embeds the targets and ambitions outlined in the NHS Long Term Plan I.e. target to increase the number of cancers diagnosed at Stage I/II to 75%. Pursuit of these targets will – in time – begin to support the delivery of our locality outcomes by improving health through the early identification and treatment of disease

5. Risk

At its meeting in October, the Board requested further detail on the anticipated primary risks linked to the delivery of the Clinical Strategy. Our primary risks fall into the following categories:

- Financial
- Estates
- Culture and capacity to deliver

5a) Finance

The activities described under each of the clinical themes are the aspirations of our clinical teams which are likely to deliver an improvement in access, experience and outcomes for our service users, but they will come at a cost.

It is important to note that the priorities outlined in the paper are a set of aspirations and their impact needs to be assessed, costed, and prioritised. Investment should only be made once we are assured that we:

- have maximised productivity
- are confident that the identified aspiration is the best course of action
- are clear on cost, affordability and understand the outcomes that will flow from the investment and the return it will deliver

In Q4, the Strategy team will work with clinical divisions, Finance and IFM to develop the Year 1 delivery plan for the clinical strategy which will be linked to the development of our financial recovery plan. Year 1 and 2 of the delivery programme is likely to focus predominantly on productivity and efficiency gains that will lay a solid foundation for future transformation. This approach will mitigate the risk of pursuing investment that will not yield anticipated returns.

5b) Estates

Our estate is ageing and our bid for New Hospital Programme funding was unsuccessful. Government has no plans for a future round of funding and therefore, we need to develop a credible, alternative plan for our estate that seeks to make the best use of what we have.

The clinical strategy programme began the important work of defining our likely growth in demand over the next five years, and this modelling will be developed as part of the delivery programme.

Building on the financial point above, a focus on productivity and efficiency is essential before we make investment decisions to expand our acute and community estate/bed base.

In parallel to the productivity focus, we will commence – through the delivery plan work – a programme to identify strategic transformation opportunities. This programme will flag services where new, innovative models of care, technology, reconfiguration, collaboration, or another form of transformation could enhance our capacity/reduce demand. These schemes will be worked up against the clinical themes and developed in a way that responds to local need.

5c) Culture and capacity to deliver

There are potential challenges in executing the clinical strategy due to organisational maturity, skills and capacity for implementing large-scale innovation, transformation and collaboration.

We will need to develop our workforce through targeted organisational programmes to enhance skills, foster a culture of curiosity and provide the workforce with the capacity and opportunity to expand their thinking.

Although a limiting factor is finance, we do have other opportunities to create space for innovation through Our Bolton NHS Charity, and the newly-launched QI programme which fosters the basis for innovation by embedding the cycle of continuous improvement, and strong leadership.

In addition, the Health Innovation Bolton strategic partnership provides us with a forum to pursue innovation with our system partners, seeking opportunities to attract investment to support innovation and the development of our infrastructure, to evolve our approach to research and development in partnership with the University of Bolton, and to embed a culture of innovation across the Bolton system.

Alignment to our people plan, OD teams and Communications and Engagement team are also crucial.

6. Launch and delivery

6a) Launch

Launching the clinical strategy will be a pivotal moment for the Trust. A well-executed launch sets the tone for successful implementation and ensures that all stakeholders are actively on board with the journey ahead.

Although we acknowledge the current challenges, the clinically strategy should stand as a document of hope and optimism, describing the desired clinical future for our organisation as described by our service users and staff. This optimism will guide the tone of the launch, which will be planned and delivered by our Communications team.

The document will be launched in mid-December, following completion of proofing, editing, and application of Plain English guidance. The document will be full designed prior to launch.

6b) Deployment and Delivery

A comprehensive deployment and delivery framework is crucial in ensuring we turn our strategic aspirations into tangible and sustainable outcomes for the organisation.

This approach will be developed and agreed during December with implementation beginning in January 2024. It builds on the revised Strategy into Action section within the document. The core components of this approach include

Area	Description
Organisational level deployment	Ensuring alignment to other strategies and plans, embedding strategic priorities through the appraisal process and through inductions, and agreement on the sub-Strategy and Operations Committee governance to ensure robust monitoring, reporting and delivery
Resource allocation	Addresses alignment of finances, value for money, development and prioritisation of business cases. Utilising partnerships such as academic and research partners, as well as Our Bolton NHS Charity, to progress innovation
Outcomes/KPI development and deployment	Ensures we are focusing on the measurable changes we are trying to achieve over the course of the strategy, alongside the plans for delivery. Includes a review of current KPIs and reporting mechanisms.
Portfolio Management	Ensures complete oversight of delivery from our strategic thematic plans to Divisional level delivery plans and identification of golden threads.
Evaluation/ progress reviews	Annual evaluation of the high-level outcomes. Progress and suitability review against strategy goals. Consistent evaluation and review at a Divisional level; informed by analysis.
Culture and OD piece	Identifies and addresses where support is required to support delivery I.e. move towards more innovative practice
Comms and Engagement	Focuses on organisational updates, overall engagement and addresses plans for continued public, partner engagement and individual responsibility. Supports communication of priorities, and links closely to culture and OD

Delivery will be overseen by Strategy & Operations Committee (SOC) and a paper will be brought forward in the new year on planned reporting and review.

7. Next steps

Following Board discussion, the clinical strategy will be designed and launched as described. A paper on development of the delivery plans will be brought to SOC as outlined.

8. Recommendation

The Board is asked to approve the Clinical Strategy

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Clinical Strategy

2024-2029

... for a better Bolton

NHS Bolton NHS Foundation Trust

Introduction

About Bolton

Bolton NHS Foundation Trust is an Integrated Care Provider located in the borough of Bolton in Greater Manchester. We provide more than 100 different health and wellbeing services to a catchment population across Bolton and Greater Manchester of around 337,000. Our services include:

- Care in the community and in people's homes
- General and specialist medical and surgical services
- Maternity care in the community and in hospital
- Neonatal, paediatric and community services for children and young people
- Urgent and Emergency Care

We have over 20 community facilities and the hospital has approximately 600 inpatient beds. We are one of the busiest ambulance receiving site in Greater Manchester. At the time of writing in 2023, the Trust employs around 5,800 staff.

The purpose of our clinical strategy is to:

- Evaluate our current status and define our future goals.
- Provide the blueprint for the Trust's clinical future over the next 5 years.
- Serve as the foundation for all clinical priorities and decisions, ensuring delivery of safe, high quality, clinically effective, sustainable and financially sound services.
- Guide us to adapt to the evolving healthcare needs of our population.
- Ensure that clinical activities contribute to the achievement of our organisational objectives.

Our Clinical Priorities

NHS Bolton NHS Foundation Trust

Priority

Improving people's experience

Priority

Innovating and collaborating for the future

Priority

Playing our part in improving people's health

...for a better Bolton

Following an extensive period of engagement, we've identified three priorities for our Clinical Strategy.

Our three priorities describe what we want to achieve over the next five years to improve the services we provide and the outcomes we deliver.

By focusing on these priorities, we will change how we deliver care. We will be more effective, create a more rewarding environment for our dedicated teams and ultimately, get better results for our service users.

"However difficult life may seem, there is always something you can do and succeed at."
- Stephen Hawking

Our case for change

NHS Bolton NHS Foundation Trust

1. Changing demand

Bolton's population is growing, aging and increasing in diversity. Increased health complexities and socio/economic issues are placing additional pressure on many of our services and resources; in particular, urgent and emergency care, care of the older person (dementia, stroke), Frailty and care for people with long term conditions (diabetes, cardiovascular and respiratory diseases).

2. Health inequalities

There are significant variations in life expectancy, reported wellbeing, rates of preventable illnesses and maternal and neonatal mortality across different population groups in Bolton. 45% of Bolton's population meet the criteria for inclusion in the CORE20PLUS5 programme, meaning they experience significant health inequalities. These differences are avoidable and unfair and result in poorer outcomes.

3. Late diagnosis

In Bolton, medical conditions and illness, especially cancers and long-term conditions, are often identified at a more advanced and less treatable stage. This leads to poorer health outcomes, increased treatment complexity, higher healthcare costs and in some cases, a reduced likelihood of successful recovery.

4. Reactive care

Our healthcare services are often reactive, where treatment is provided after the problem has already developed, worsened or the condition is under recognised. We are seeing an increase in disease severity, reduced service user wellbeing and greater pressure on our healthcare resources.

5. Holistic care

By not always offering or coordinating care that addresses the physical, mental and emotional needs of service users we are seeing fragmented care, unmet health needs and reduced overall wellbeing.

6. Workforce

A shortage of healthcare professionals is adding significant pressures to the workforce and impacting our ability to provide timely care. We have excellent skills and experience in our organisation, and we need to maximise our use of people's professional skills and experience.

7. Clinical and technology advances

Clinical and technological advances, such as those found through research, artificial intelligence, robotic surgery and mobile technology are important not only for improving outcomes and efficiency, but also for meeting the evolving expectations of service users who seek more personalised, convenient and accessible healthcare.

8. Infrastructure and partnerships

Many of our community and acute site buildings and technology systems are ageing, outdated, inefficient and unsuitable to meet the evolving needs of our population, service users and workforce.

9. Sustaining quality through budget constraints

Limited funding and budget constraints mean we can't do everything we want and need to do straight away. We therefore have to think differently about what we are doing, making sure that we are working to be as productive and efficient as possible, and we are clear on where investment will have the biggest return to deliver improvements in quality, safety and experience.

10. Service user experience

Through listening to our service users, we know there are areas where we can improve their experience, including communication, long wait times, co-ordination challenges, safety concerns, access to care and involvement in decision-making. The people who use our services want to feel part of their care, and want their diverse needs to be considered as part of the patient pathway.

Our case for change incorporates the requirements of the GM Joint Forward Plan and The Long Term Plan.

Our case for change in Bolton numbers

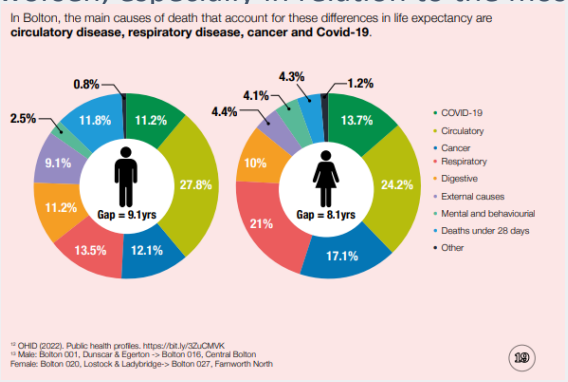
NHS Bolton NHS Foundation Trust

Where we are now:

- The population has increased by 6.9%, 300,000, between 2011 and 2021 and we anticipate it will continue to rise by 4.3% per year.
- 26% (295,963) of the Bolton population live in an area that is among the 10% most deprived nationally.
- 28% are from communities facing racial inequality. Main languages include English, Gujarati, Panjabi, Polish, Arabic and Somali.
- 32.8% of births in 2021 were by non-UK born mothers.
- Bolton's Foundation Trust catchment population has a high prevalence of diabetes at 8.4%. In England this is 7.3% and Greater Manchester ICB is 7.5%.
- Circulatory, respiratory and digestive diseases, along with cancer, account for over 60% of the life expectancy gap in Bolton.
- 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.

What might happen if we don't adapt:

- By 2043, it is predicted that around a third of the Bolton population will be aged 55+, around a fifth will be aged 65+, and around a tenth aged 75+. Care and support needs generally increase in older age groups. Services are under great pressure currently, and this will grow with our ageing population. We need to prepare for the older age group who are likely to be more dependent in the next 5-10 years.
- Insufficient healthcare services to support a local population growth, on average of 4.3% per year, and with increased complexity.
- By 2029, demand for acute care has risen and – if we don't transform – we could need 3 additional wards.
- Late diagnosis means we do not achieve targets such as diagnosing 75% of cancers at Stage I/II.
- Inequalities worsen, especially in relation to the most common causes of death, as below:



...for a better Bolton

https://www.boltonjsna.org.uk/downloads/file/189/phar-2022

NHS Bolton NHS Foundation Trust

Outcomes

We will create a comprehensive outcomes framework, covering short-, medium- and long-term outcomes, reinforced by precise targets that will be defined as part of the delivering planning exercise. This framework will be established to oversee and guarantee the realisation of our objectives.

Over the next 5 years we will achieve:

- Seamless transitions for all service users I.e. ensuring 100% of young people have a managed supportive transition from paediatric to adult services
- More people supported to live well at home, in the community or in the best-suited locations for them, enabled by a shift to place-based and neighbourhood-focused delivery of care
- Improved service performance to the highest benchmarking quartiles in Model Hospital and GIRFT, enhancing overall quality of care and productivity
- A year-on-year reduction in avoidable harm and mortality
- Decreased acute demand by embedding the 'Home First' approach across the organisation, resulting in reduced avoidable admissions, re-admissions and extended hospital stays
- Realising innovation, collaboration and transformation by supporting the workforce to drive positive change and developing our strategic partnerships
- Enhanced clinical decision-making accuracy and efficiency through the effective utilisation of technologies such as AI, predictive analytics and decision-support
- Expanded research collaboration and provision, providing service users with increased access to clinical trials and supporting our workforce to take part in research
- People confidently taking charge of their health decisions and managing their care independently, empowered by user-friendly technology i.e remote technology, digital care records
- Understanding, addressing and reducing health inequalities in access, experience and outcomes; aligned with the CORE20PLUS5 model and Bolton Locality Plan
- Optimisation of health outcomes for cancer and chronic conditions with earlier diagnosis and specific interventions, including diagnosing 75% of cancers at Stage I/II by 2028
- Providing more personal and timely response by anticipating and addressing needs before they escalate and minimising hospital visits
- Contributing to a reduction in disparities in Bolton's healthy life expectancy

NHS Bolton NHS Foundation Trust

Priority

Improving people's experience

What we heard

Our service users are at the heart of everything we do. Quality, safety and experience must come first.

Communication is one of the most important things for our service users; how we communicate, when we communicate and where we communicate.

We repeatedly heard about the need for us to coordinate care across the whole pathway for people to gain the most benefit from the time people spend in our care; whether that's transition from paediatrics to adult services or between community and acute services.

We want to treat people in the best place for them – whether that is at home, in the community, at the hospital or with another organisation. If we focus on this then we not only improve service user experience, but we also better protect acute resources for those who need it most.

Our Objectives

Establishing and building on strong foundations
Optimising our services and continually striving for clinical excellence.

Building seamless services
Creating a healthcare system where services are seamlessly integrated and coordinated.

Evolving how, where and when we deliver care
Delivering care in the most suitable setting and transforming services so that they are responsive to current and future needs of our service users.

NHS Bolton NHS Foundation Trust

Priority

Innovating and collaborating for the future

What we heard

While there's a strong drive for innovation, our workforce currently feels limited by challenges in recovery, changing demand, financial constraints and infrastructure.

We have significant opportunities to cultivate and educate our future workforce through our system partnerships and those with academic and research institutions, and embed innovation in everything that we do.

Collaboration and partnerships are essential to help us meet the changing needs of our population, and make sure that capacity is sufficient to meet demand. As a Trust, we can only solve so many problems alone, so we must work together with our partners to plan develop, inform, transform and influence the services of the future.

There is significant appetite for more insight from data, to help us identify areas of challenge and opportunities, and areas where collaboration could help improve the services we provide.

Utilising novel technologies and therapies was a consistent theme throughout, with some of the most promising prospects lying within diagnostics, where technology, automation and artificial intelligence are rapidly advancing.

Our Objectives

Enabling a culture of innovation
Creating the space for our teams to innovate and explore novel approaches and technologies to improve what we do, with an increased emphasis on research.

Strengthening our collaborations
Enhancing and expanding collaborative partnerships with healthcare providers, local communities and external organisations.

Evidence based decision making
Harnessing advanced technologies, such as artificial intelligence, decision-support and predictive analysis to enhance decision-making, prioritisation and targeting of care.

NHS Bolton NHS Foundation Trust

Priority

Playing our part in improving people's health

What we heard

The impact of worsening health can be overwhelming for individuals, their loved ones and for the workforce that cares for them.

There are many drivers of poor health that we can't address alone. We have a great opportunity to work closer with our locality and system partners , especially public health, on initiatives that respond to population health needs and to help prevent illness and chronic disease in the first place.

If we catch issues before they become major concerns, then this not only helps us live well for longer but ensures healthcare resources are used wisely.

Improving people's health is not just about the things we do, but how we all work together to respond to need and give everyone the tools they need to support their needs.

There was a clear and consistent theme on the importance of understanding and addressing the diverse needs and challenges experienced by people using our services and the wider population.

Our Objectives

Prevention and early identification of disease
Reduce the risk and impact of disease through screening, early diagnosis and proactive management of care.

Addressing health inequalities
Ensuring everyone has equitable access to quality care, while actively working to improve health outcomes for underserved populations.

Promoting good health and wellbeing
Actively promoting positive health choices amongst our workforce, service users and wider population while working with partners on wider public health initiatives.

NHS Bolton NHS Foundation Trust

Strong foundations

To achieve our clinical priorities and outcomes, we must first ensure strong foundations for the future. The Trust is committed to establishing a solid, stable base on which to build our clinical priorities and aspirations. We will:

Make the best use of our collective skill mix, developing our staff and embedding a multi-professional, multi-disciplinary approach. This not only improves experience and outcomes for the people who use our services, but means staff skills are utilized to their best effect.

Use our data, insight and intelligence to identify trends in access, changes in our population and how we can better meet and manage demand.

Horizon scan for the latest evidence, developments and innovations to stay informed about opportunities to improve our services or do things differently.

Learn from and implement best practice including adopting *Getting it right first time (GIRFT)* recommendations to ensure we are working to the highest standards of quality and safety.

Establish and develop the neighbourhood delivery model with system partners, to provide integrated care in the places where people live.

Engage and work with our service users and population to understand and respond to what is important to people.

Implement quality improvement methodology as a framework to deliver improvements.

Drive productivity to maximize our existing capacity and make the best use of the resources we have.

Deliver efficiencies to ensure we are using our resources to their best effect and focus on delivering sustainable models of care.

Maximise existing technology and systems to deliver care virtually as far as possible i.e. PIFU, A&G, Virtual wards.

Utilise benchmarking tools such as Model Hospital to enable us to identify opportunities where we can improve what we do.

Building strong foundations is crucial for a stable financial environment. It involves everyone and ensures we use our resources wisely and make smart investments.

…for a better Bolton

NHS Bolton NHS Foundation Trust

Our Clinical Themes

Through our engagement process, our clinical teams and divisions shared their vision and aspirations for their services against each of our three priorities and across the following clinical themes:

- Maternity, Neonates and Women's Health
- Children and Young People
- Urgent and Emergency Care
- Care of the Older Person
- Community Care
- Cancer Care
- Elective Care
- Long Term Conditions
- Diagnostic and Support Services
- End of Life Care

These clinical themes intend to focus us on the user experience, prioritising their journey over organisational structures and helps us pinpoint areas for enhanced collaboration and co-ordination.

This next section begins to describe our aspirations to support the achievement of our three clinical priorities, so that we:

- Improve people's experience
- Innovate and collaborate
- Play our part in improving people's health

Theme: Children & Young People (CYP)

We provide acute and community-based health care and preventative services for CYP, with the aim of getting the right start in life for a better future.

Our ambition is to co-produce services with our CYP to ensure they have something that is truly accessible for them, where we care for them as they transition from childhood, through adolescence into adulthood, recognising the impact of ill health, from a social, psychological and long-term perspective. We will reduce health inequalities for CYP using the Core20PLUS5 approach.

To improve people's experience, we will…

- Align to the priorities of the NHS Long Term Plan for children which includes asthma, end of life and inequalities
- Collaboratively design clinical services with CYPs living with chronic conditions– with a focus on diabetes, improving transition to adulthood and empowering CYP, and their families, to self-care
- Increase access to remote care options, such as virtual wards and remote monitoring, allowing healthcare services to be tailored to CYPs lives and homes
- Ensure neuro-developmental pathways and service offers keep pace with the increased demand
- Improve timely and comprehensive expert assessments that address emotional and wellbeing needs, alongside their physical needs
- Expanding and enhancing paediatric surgical services to Bolton and Greater Manchester
- Use technology to enhance safeguarding processes with an alert to identify CYP in need during every contact

To innovate and collaborate, we will…

- Ensure we have a robust adolescence service offer
- Explore the use of rapid diagnostics, new patient testing and decision support to prevent avoidable admissions and intervene before condition worsen i.e. Use Ribonucleic acid (RNA) technology to diagnose infection in children
- Continuously assess opportunities to enhance the paediatric surgical hub
- Work with partners to ensure accessible and integrated mental health services for CYPs

To play our part in improving people's health, we will…

- Eliminate inequalities in access, experience and outcomes for CYP
- Deliver our aspirations around children's hubs and the new healthy child programme
- Implement the CYP NHS England Core20PLUS5 model
- Work with public health and schools on improving health for CYP
- Reinforce education on supportive dental hygiene and health behaviours for CYP attending the hospital for tooth extraction
- Utilise modern media methods to educate and inform CYPs on positive behaviour choices
- To embed an informed, compassionate approach to adverse childhood events and wider safeguarding issues to improve longer-term health outcomes
- Improve where and how we employ diverse languages and alternative communication styles to effectively engage with CYPs and their families

Theme: Maternity, Neonates and Women's Health

We are busy maternity unit with approximately 6000 babies delivered each year and we are a tertiary unit for neonates. Our maternity population is growing in complexity and often have higher care needs that influence their pregnancy care. We serve a very diverse population and it is recognised that this can cause variation in outcomes.

Our ambition is to provide an equitable offer of birth options that mean people have the experience they want with the best and equal outcomes for families and babies.

To improve people's experience, we will…

- Full choice in birth locations and family-centred caesarean birth
- Reduce induction wait times
- Empower women to take control of their health and address changing demands, such as menopause.
- Improve the effectiveness of clinical risk assessment and triage at every contact; focusing on reducing maternal and neonatal mortality.
- Increase provision of enhanced recovery for same-day discharge for caesarean birth
- Seamless perinatal care, from pre-conception, antenatal through to postnatal care - with a focus on early diagnostics
- Provide culturally-appropriate support to those whose babies have died
- Enhance the provision of Maternity and Neonatal triage safety systems
- Improve rates of same-day discharge for surgery to improve access for inpatients and outpatients

To innovate and collaborate, we will…

- Develop our academic research offer in women's health and maternity care
- Invest in infrastructure and create central areas for a more supportive MDT (Multidisciplinary Team) environment
- Implement user-friendly health records for women
- Expand the use of evidence-based, minimally invasive gynaecological surgery techniques.
- Increase home monitoring for pregnancy-related conditions, such as foetal heart rate,
- Reduce preterm birth through novel tests predicting the course of pre-eclampsia, diabetes etc.
- Extend our partnership pathways across GM for gynaecology services
- Implement an end-to-end maternity EPR
- Deliver the Maternity Transformation and Saving Babies Lives programmes

To play our part in improving people's health, we will…

- Eliminate differential maternal mortality and morbidity rates
- Earlier diagnosis and management of perinatal conditions (e.g. gestational diabetes, anaemia)
- Improve and maintain cancer diagnostic timeframes
- Improve access to mental health support in maternity and gynaecology services.
- Increase in access to and utilisation of pre-conception counselling for individuals with chronic health conditions to improve congenital outcomes
- Culturally-appropriate maternity care to reduce inequity
- Collaboration with therapeutic services to improve overall health and reduce need for surgery
- Ensure high rates of screening and early detection for gynaecological cancers, such as cervical cancer, particularly for under-served groups.
- Targeting prevention and management of chronic conditions affecting women, such as heart disease, diabetes and osteoporosis
- Improve healthy behaviours like smoking cessation during and after pregnancy
- Achieving higher rates of initiation and continuation of breastfeeding
- Provide continuity of carer in pregnancy line with Core 20 Plus 5 targets

Theme: Urgent and Emergency Care

Our UEC services see 130,000 attendances per year and we have the most ambulances attending for any hospital in GM. Often people who attend the hospital may be better served by other health, social or mental health care providers.

Our ambition is to ensure that people get the right care from the right people in the right place. For those that do need our services, they will receive the very best care and experience while with us and are supported to get home safely as quickly as possible.

To improve people's experience, we will…

- Use novel technologies to reduce diagnostic time
- Integrate mental health assessments and responses into routine physical examinations conducted by healthcare professionals in urgent and emergency care
- Place a senior clinical decision maker at the Emergency Department entrance to ensure patients are directed to the right services, like the Urgent Treatment Centre and Same Day Emergency Department
- Increase speed of access to specialities for service users in the Emergency Department to ensure optimum and timely treatment
- Increase the use of specialist teams such as Pharmacy, the Home First team, Virtual Wards and Specialist Palliative care to ensure clinical care is provided in the most appropriate setting
- Improve recognition and response to deterioration, including the appropriate introduction of patient and families/carer assessed wellness score and risk assessment
- Improve pathways with primary care for the referral of service users with urgent care requirements to ensure the most timely and appropriate provision of care
- Implement electronic referral pathways from primary care for direct streaming into specialities i.e. Ophthalmology model
- Increase the use in the Emergency Department of validated systems such as those used to reduce falls, pressure ulcers and Clostridium difficile to ensure patients are safely managed

To innovate and collaborate, we will…

- Establish a 24/7 command centre of multi-professional experts dedicated to proactively managing healthcare resources, data and patient flows, aiming to reduce unnecessary hospital admissions and support people in the community
- Introduce the use of AI in clinical decision making to aid and support timely diagnosis, treatment and management
- Use personalised medicine and biomarkers to identify patients who are likely to benefit from personalised clinical approaches in the identification of sepsis and other clinical conditions
- Explore development of a same day elderly emergency care unit to better support elderly patients
- Collaborate with the ambulance services to improve management of people in the community and prevent attendance or admission to hospital where avoidable
- Regularly review data to identify opportunities to better manage and respond to the needs of people who access urgent and emergency care

To play our part in improving people's health, we will…

- Conduct additional screening while service users wait or when they are in our care. Ie wellbeing, diabetes, cholesterol, chlamydia, high blood pressure
- Enhance care navigation services to help individuals understand and navigate the healthcare system, particular in emergency situations

Theme: Diagnostic and Supportive Care

Our diagnostic, Pharmacy and support services are mainly focused on the hospital site and Bolton One; people often stay in hospital awaiting their needs to be met.

Our ambition is to improve our diagnostic offer and accessibility, using advancing technology to ensure quicker diagnosis and that people get their treatment more rapidly. This will achieve better outcomes. We will coordinate diagnostic services alongside others to make them more efficient and less burdensome for patients to access them. We will deliver more therapies in people's own homes and help them to take charge of their own care more.

To improve peoples experience, we will…

- Provide laboratory support nearer the patient's home with further development of IV therapy team services and delivery of point of care testing for the admission avoidance team
- Provide "drive through phlebotomy" service to improve access and convenience, focus on prevention of pre-analytical issues in blood sciences to reduce unnecessary repeats and admissions and explore self-sampling strategies for monitoring conditions
- Scope the development of the Cardiac CT service
- Empower people to manage their own medicines, with the support of Pharmacy and local delivery options
- Provide clinical reasons for medicine
- Use novel devices for IV therapy teams to increasingly deliver treatments in patient's own homes
- Develop pathways for multi-disciplinary professionals such as First Contact Practitioners and GPs to request appropriate diagnostics
- Develop 24 Hour Blood culture testing

To innovate and collaborate, we will…

- Enhance and expand our community diagnostics hub and laboratory testing offer
- Implement new genomic technologies for improved diagnoses across all disciplines working with genomic hubs to deliver this where required for example molecular PCR for enteric and respiratory pathogens, NIPT for trisomy screening, POCT genomic tests and histopathology cancer genetic testing for personalised treatment
- Implement digital pathology and Increase the use of AI to support diagnosis and increase efficiency to deliver faster and more accurate image and histopathology interpretation
- Develop bloods sciences workflow to further improve turn-around times
- Develop the delivery of non-invasive post-mortem examinations through CT scanning in collaboration with the NW sector.
- Scope and support how we can innovate in diagnostic technologies and minimally invasive tests such as ingestible sensors, liquid biopsies and hair and breath sampling to improve patient experience and outcomes
- Develop better access to the Genomic Hub to support cancer work, and enhance and expand the use of Advanced Nurse Practitioners for diagnostic capability
- Continue to collaborate with GM partners on the Pathology and Radiology networks

To play our part in improving people's health, we will…

- Develop an equitable patient centred radiology offer where patients can receive all the imaging they need in a single visit with quick and accurate reporting, including overnight and at weekends and shared appropriately across treating clinical teams
- Support and develop the (Commission) faecal transplant service for patients with recurrent C-Diff, implement enteric molecular technologies to improve diagnosis and prevent unnecessary procedures
- Deliver new testing strategies and risk algorithms for improved patient care e.g. pre-eclampsia risk prediction, liver and renal risk predictors to identify conditions sooner

Theme: Care of the Older Person

We are seeing rising numbers of older people with increasingly complex health and social care needs; we know the impact that frailty can have on outcomes. People can often have protracted stays in hospital, which means their ability to recover from their illness is affected, so it takes more time to get them back to their homes.

Our ambition is to help people to age well. We will have a joined up service across the Trust, and in the community, that manages the needs of older people, minimising any time spent in hospital and by supporting them more effectively in their own homes, thereby reducing the impact of ill health.

To improve people's experience, we will

- Expand virtual community wards for older people to facilitate appropriate early discharge
- Establish a new model of care in the community for elderly care that includes a geriatric physician proactively addressing needs
- Enhance ED referrals directly into the Frailty service
- Ensure every appropriate person has a frailty assessment
- Targeting evidence-based assessments, such as Surgical liaison, on those aged over 65 to improve individual and service-level outcomes for older people.
- Improve the identification of risk factors associated with delirium to ensure appropriate prevention and treatment is provided
- Ensure all clinical staff are appropriately trained to recognise frailty indicators and use standardised tools to identify individual frailty status and manage required clinical response
- Ensure appropriate management in the first 24 hours of admission for people living with frailty so optimal clinical care can be established
- Cares and family members are empowered with the knowledge and access needed to understand and actively participate in the management of healthcare

To innovate and collaborate, we will…

- New model and approach to care of the elderly in acute and community – roles, pathways, delivery
- Implement a fracture liaison service
- Collaborative work on Dementia diagnosis and management
- Using the expertise of our community geriatrician to expand and enhance our out of hospital care model for care homes
- Deliver an enhanced community frailty pathway, including in reach to the emergency department
- Work with partners on increasing the number of advanced care planning conversations and plans
- Ensure that every appropriate person has a structured medication review to address polypharmacy and improve the identification of risk factors for falling in hospital

To play our part in improving people's health, we will…

- Improve the diagnosis and management of Delirium
- Taking steps to ensure there is effective and equitable recuperative rehabilitation for older people on all wards in hospital and in linked community services
- Develop equitable routine screening for risk of malnutrition across health and social services for people at risk of developing frailty and to provide targeted nutritional education and support
- Develop an accessible and recognised rapid crisis response service for older people and those living with severe frailty
- Promote healthy eating habits to improve nutritional health and reduce malnutrition amongst older people

Theme: Community Care

We are an integrated care provider, working with local authority, social care, mental health and voluntary sector, colleagues, to provide care and improve health outcomes for our local population.

Our ambition is to support people to live well at home. We recognise our part to play in addressing healthcare inequalities across the borough, and we are committed to delivery of place- based care within the six neighbourhoods as our vehicle to do this. We will provide proactive care to support people to manage their own care needs and access preventative services.

To improve people's experience, we will…

- Deliver integrated care across health and social care at a neighbourhood level, to support people to stay well at home
- Improve information sharing and working across hospital and community-based services
- Ensure community-based staff can access investigations and point of care testing in the community, to avoid hospital attendances for diagnostic tests
- Develop clinical practices to support the community-based management of appropriate orthopaedic and MSK conditions by First Contact Practitioners
- Further develop the IV Therapy service for wider clinical practice such as inserting lines, zometa at home and home transfusion
- IV Biologics provided in the community, including service user administration

To innovate and collaborate, we will…

- Work across acute, community and social care to identify and transform pathways to avoid unnecessary hospital attendances and admissions
- Expand the virtual ward offer to support both admission avoidance and earlier discharge from hospital
- Improve advice, transition and support between acute and community teams, using the hub at Castle Hill to enhance this
- Earlier discharge facilitated by 7-day therapies and social care services, with therapy delivered closer to home
- Develop the service for clinical rotation between community and hospital-based services to ensure full integrated provision, develop understanding of care delivery and strength of offer in the community
- Leverage non-medical prescribing to provide wider and timely access to medication such as anti-coagulation
- Develop a community-based clinical pathway for osteomyelitis treatment

To play our part in improving people's health, we will…

- Take a place-based approach to delivering services, working in neighbourhoods to understand community issues and assets, recognising that answers to health inequalities may lie beyond formal health and care delivery
- Embed 'no decision about me, without me' across all community care service
- Support wider health and wellbeing services through our Health Improvement Practitioner offer
- Maximise opportunities in the community to actively screen or encourage screening for disease

Theme: Cancer Care

We provide cancer screening, diagnosis and treatment for the people of Bolton and beyond. We do perform well with regards to our cancer targets, but we are predicting increasing rates of some cancers and our patients often have to attend the hospital for multiple different appointments to manage their cancer.

Our ambition is to improve the accessibility and uptake of screening services and to ensure early diagnosis of cancer by developing "One-Stop Shops." We will work as a multi-professional team using the most up-to-date techniques to both identify and treat cancer, getting people the best outcomes.

To improve people's experience, we will…

- Provide a more seamless and integrated clinical and therapeutic services after cancer treatment closer to home
- Develop Community Diagnostic Centre and one-stop shops for cancer diagnosis and management planning including the scope of patient self referral to diagnostics (increase scope of self referrals and diagnostics and screening)
- All eligible people to receive enhanced recovery for surgery to help service users of their treatment journey more quickly
- Develop Endoscopic Ultrasound (EUS) and Positron emission tomography (PET) provision for patients with alignments to the single queue diagnostics programme for Cancer care within Greater Manchester
- Increase the use of the Christie@Bolton for more patients we will provide more cancer care closer to home – such as lung biopsy
- Promote wider single queue in GM
- Diagnose 75% cancers at stage 1 and 2 by 2028

To innovate and collaborate, we will…

- Utilise novel screening and diagnostic techniques, such as MR screening for prostate cancer
- Scope the use of robotic surgery to reduce complications and improve surgical recovery time for patients with cancer
- Provide personalised chemotherapy, in collaboration with Christies based on genetics and individual disease
- Targeted implementation of AI to achieve more rapid diagnosis for patients with cancer and pre-cancerous conditions
- Use of personal biopsy data for patients, and by securing links with the Genomic Hub we will ensure personalised cancer treatment continues to develop
- Utilise novel biomarkers of cancer as they are developed
- Further develop our homecare service provision
- Support the development of endocrine therapy improvement programme (ETIP) within Cancer services such as breast, prostate and thyroid.

To play our part in improving people's health, we will…

- Work with communities to understand barriers to the uptake of screening offers
- Provide the best personalised cancer care, treatment and follow up to ensure equitable outcomes for all patients
- Collaborate with system partners to understand, recognise and react to early diagnosis of cancer through screening initiatives
- Provide expert support to the wider system to address rising incidence of skin cancer in Bolton and GM
- Increase the use of appropriate anaesthesia as requested for diagnostic tests (e.g. hysteroscopy)
- Maximise initiatives to provide smoking cessation support for patients and staff
- Increase the provision of psychological and holistic compassionate support for patients during their cancer journey with system partners such a Macmillan and the Wellbeing Hub at Bolton Hospice
- Adopt the Prehab4Cancer programme for Bolton
- Understanding and targeted approach to late diagnostics – focus on high-risk groups i.e. prostate
- Focus on prevention and health behaviours

Theme: Elective care

We are progressing in reducing our elective surgical waiting lists, but it is an ongoing challenge to ensure people get their surgery in a timely way.

Our ambition is to use evidence-based techniques, such as robotic surgery, to reduce complications and get the best outcomes. We will take a holistic approach to ensuring people are ready for surgery and recover rapidly, spending as little time away from their own homes as possible. We will reduce variation in outcomes by actively targeting those most at need for earlier intervention.

To improve people's experience, we will…

- Use nurse associates and appropriate clinical skill mix to improve access and support i.e. delivery of specialised Ophthalmology services such as injecting eyes and pre-operative management
- Use innovative approaches such as rapid diagnostics at first appointment and direct to test pathways to continue to support the waiting list management
- Develop community-based pre- and rehabilitation outreach and patient-initiated follow-up services included clinically managed virtual wards
- Increase the number of treatment procedures which are delivered as outpatients appointments, day case surgery and laparoscopic
- Streamline the pre-operative assessment pathway for investigations and diagnostics
- Increase the use of specialist teams such as pharmacy to improve pre- and post-op medication assessments improving patients understanding of their medicines, reduce delays and improve discharges

To innovate and collaborate, we will…

- Develop the use of robotics and AI to provide minimally-invasive surgery options to support enhance recovery i.e. for joint arthroplasty surgery
- Use more camera-based technology, such as those in ENT services, to reduce infection risk, improve outcomes and experience
- Scope the provision of post operative medications at the pre op assessments to improve patients understanding, reduce delays and facilitate discharge
- Develop wider outpatient department swabbing and pre op provision prior to surgical admission to reduce the need for re-attendance to specialist pre-op clinics

To play our part in improving people's health, we will…

- Provide equitable clinically led waiting well services for patients awaiting surgery including appropriate input from Allied Health Professionals, e.g. dietetics, pain management, physiotherapy and occupational therapy where appropriate
- Develop clinically led and equitable management of patients not on national targeted pathways, such as the management of pre-malignant conditions and secondary breast cancer

Theme: Long term conditions (LTCs)

We successfully manage people with LTCs, but with the growing numbers of people with multiple medical problems and an ageing population, we will see the need for greater coordination of care.

Our ambition is to provide people the option to be managed differently, with the use of things like virtual wards and wearable technology, to facilitate remote monitoring to reduce the need to attend the Trust's sites. We will deliver care closer to home and help people to take control of their own conditions. Overall, we will aim to deliver the best recommended care that reduces complications in those with long term conditions.

To improve peoples experience, we will…

- Reintroduce one stop shop for TIA patients to improve patient experience and clinical outcomes
- Scope wider support provision for stroke patients including clinical psychology, speech and language therapies
- Increase the provision of Patient-initiated follow up (PIFU) across wider clinical specialities to improve patient access and experience
- Develop the delivery of IV diuretics for heart failure patients at home
- Develop an early Inflammatory arthritis service with an effective referral management system aligned to best practice as seen in GIRFT to support affected patients
- Develop the pain management service to provide a teenage pain management programme and a paediatric-to-adult transition service in addition to a specific provision for older people

To innovate and collaborate, we will…

- Develop the use of wearable technology, virtual wards and novel digital solutions for remote monitoring and management of patients' conditions, linking directly to the EPR
- Use AI to assess clinical information such as skin lesions
- Use Tele-derm, advice and guidance and develop the use of AI and Biologics within the dermatology service to clinically support patients
- Develop virtual reality provision for stroke survivors to reduce the risk of falls and to support physiotherapeutic rehabilitation through Virtual reality (VR) with the provision of virtual environments and multisensory inputs to train balance
- Scope the use of closed loop systems for patients with Type 1 diabetes

To play our part in improving people's health, we will…

- Develop robust equitable access and provision of vaccinations for people with LTC , for example TB and Pneumococcal pneumonia
- Develop a clinically led pain management self-care programme that reflect the culture and language of the patients and population
- Address health inequalities specific to long term conditions
- Introduce an annual health check for LTCs

Theme: End of Life Care

We are committed to providing the best care at the end of people's lives and working collaboratively with colleagues across the locality to help people die comfortably in the place of their choosing.

Our ambition is to help people recognise when they are approaching the end of their lives and plan in advance for that, giving time to discuss with their families what they might want. We will provide culturally-appropriate palliative care support where people need it, addressing the holistic needs of people as they reach the end of their lives, keeping them comfortable as they die.

To Improve people's experience, we will…

- Enhance specialist psychological support for dying patients and their families and carers to help in the management of anxiety and depressive symptoms
- Further develop pathways associated with condition-specific triggers and risk factors associated with the dying person to enable access to appropriate clinical care
- Improve palliative and end of life care in reach into the emergency department

To Innovate and Collaborate, we will…

- Use digital tools to connect technologies that could have direct and immediate impact on dying people and their experiences, including appropriate remote monitoring of symptom assessment and management
- Consider use of AI to better understand and identify the optimal time to put in place advance care planning needs and wishes
- Develop specialised services
- Avoid unnecessary acute admission through round the clock access to community palliative care expertise and care

To playing our part in improving people's health, we will…

- Ensure barriers to end of life care are recognised and managed to provide equitable access for all to hospice care, specifically including people with dementia and learning disabilities – place of death
- Provide specialist and multi-disciplinary clinical support to address and meet the needs associated with symptom control and management for the dying person in both hospital and community settings

NHS Bolton NHS Foundation Trust

Catalysts

In driving our clinical strategy, we have pinpointed certain catalysts that play a crucial role in enabling delivery.

- Our cross cutting catalyst are essential for driving and implementing the clinical strategy effectively.
- They are overarching, connecting various aspects of our clinical priorities and serve as catalysts for positive change.
- They help align efforts and ultimately contribute to successful delivery of the clinical strategy.

People	Research and Technologies	Workforce, Skills and Culture	Infrastructure	Relationships and Partnerships	Finance and Efficiencies
Prevention	Research provision	New skills	Digital system integration	Academic	Best practice and benchmarking
Supporting people to live independently for as long as possible	Predictive analytics	Time and space	Place based delivery and neighbourhood models	Locality System	Using data to target resources
Focus on wellbeing with physical needs	Artificial Intelligence	Inter professional teams and roles	Community and home based care	Community and neighborhood integration	
Workforce wellbeing and equality	Decision support	New roles	24/7 hub models	Commercial and private sector partnerships	
	Service user led technology	Proactive, preventative and personalised care culture	‘One stop shops’		
	Remote technology				

NHS Bolton NHS Foundation Trust

Our Strategy into action

Our strategy provides the blueprint for the Trust's clinical future over the next 5 years. To ensure delivery, we will:

1. Define our short, medium and long term outcomes with supporting measures
2. Develop Divisional level delivery plans to support the achievement our clinical strategy priorities and objectives over the next 5 years
3. Establish robust oversight and assurance through a clearly defined governance structure; from Board through to delivery teams
4. Align approval of internal business cases to the clinical strategy; investments must deliver significant benefit or savings
5. Embed and deploy the clinical strategy priorities through the Trust appraisal process
6. Align to the aims and goals of our corporate strategy and other strategic plans
7. Continuously review and monitor plans and progress
8. Celebrate success

Recognising the healthcare landscape is constantly changing and evolving, we will review the strategy goals every 6 months. This allows us to respond effectively to those emerging changes and refine our objectives and plans accordingly.

We will also undertake an annual evaluation of the overall strategy to ensure progress and to stay aligned with national, regional and local context.

At a divisional level we will consistently assess the needs of our services, workforce and service users while actively monitoring our environment for opportunities and innovations.

A plan is nothing without the people who drive it, and every member of our workforce has a role to play in helping us achieve the ambitions of our clinical strategy and to deliver high quality services for the people we serve.

…for a better Bolton

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	30 November 2023		Discussion	X
Exec Sponsor	James Mawrey, Director of People		Decision	

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

Previously considered by:	Divisional IPMs

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

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

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey

Bolton NHS Foundation Trust

Integrated Performance Report

October 2023

Guide to Statistical Process Control

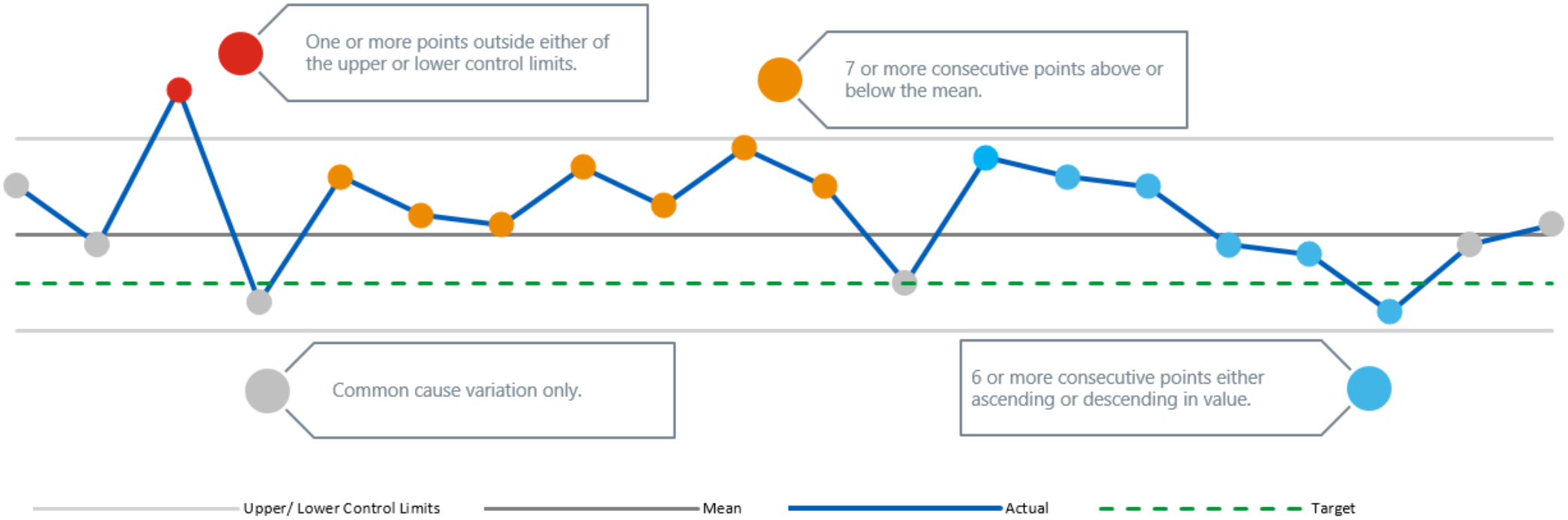
NHS Bolton NHS Foundation Trust

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

Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	10	5	2	1	0	2	3	11
Infection Prevention and Control	8	0	2	0	0	0	0	7
Mortality	3	2	2	0	0	0	0	3
Patient Experience	11	4	0	0	1	2	0	14
Maternity	9	0	0	0	0	1	0	8
Operational Performance								
Urgent Care	5	0	1	2	2	1	4	4
Elective Care	6	1	1	3	1	0	4	5
Cancer	6	1	0	0	0	0	1	6
Community Care	2	0	0	0	1	0	1	2
Workforce								
Sickness, Vacancy and Turnover	2	0	2	0	0	0	1	2
Organisational Development	5	1	0	0	0	1	2	3
Agency	0	0	2	1	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

Bolton NHS Foundation Trust

Falls
Common cause variation continues with reported falls with an increase in month in falls with moderate harm. All are subject to full Patient safety incident analysis, which are underway.

Pressure Ulcers:
Continue to see common cause variation in the number of category 2 and unstageable pressure ulcers with divisional action plans underway consolidating learning from previous SIs and thematic analysis.
Report zero Category 3 pressure ulcers for 10th consecutive month and zero 4 pressure ulcers for 5th consecutive month.
Community continues to see common cause variation in pressure ulcer incidents with zero ulcers demonstrating significant new learning.
This performance demonstrates a continually improving picture and is in direct response to the significant amount of work, education and improvement across the pressure ulcer collaborative and DND accountability.

Report to patient/family within 60 working days of incident declaration
In October 2023, and for the first time in over four years, there was special cause variations with improving performance for responding to SIs within the 60 day timeframe. In month there were five SI investigation reports due for approval. Three were approved by the 60-day deadline. One was approved two days after the deadline and one was approved eight working days after the deadline.
There are currently eleven ongoing internal SI investigations with one report overdue. This investigation is due for sign off on the 29th November 2023. The remaining eight are on track to be completed and approved within the 60-day timeframe. One of the SI's is a never event regarding wrong route for a medication administration.

Same sex accommodation breaches, astronomical point in month with 24 reported breaches. All have been reviewed and occurred in Critical Care. A new flow chart for escalation has been produced and this is being led by ASSD. A full paper was submitted at Risk Management Committee where updates will be reported.

	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%	98.4%	Oct-23	H	>= 95%	97.4%	Sep-23	>= 95%	98.0%	?
9 - Never Events	= 0	0	Oct-23		= 0	0	Sep-23	= 0	1	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.76	Oct-23	L	<= 5.30	3.90	Sep-23	<= 5.30	3.99	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	3	Oct-23		<= 1.6	2	Sep-23	<= 11.2	11	?
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	18.0	Oct-23		<= 6.0	14.0	Sep-23	<= 42.0	104.0	?

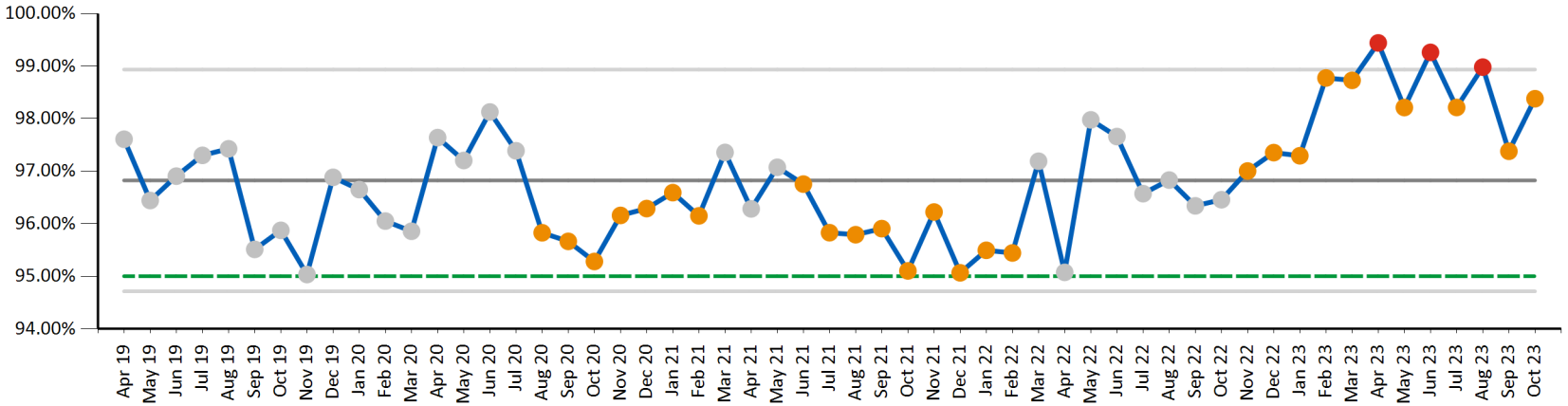
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Oct-23		<= 0.5	0.0	Sep-23	<= 3.5	0.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Oct-23		= 0.0	0.0	Sep-23	= 0.0	2.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		3	Oct-23			7	Sep-23		36	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	14.0	Oct-23		<= 7.0	9.0	Sep-23	<= 49.0	75.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Oct-23		<= 4.0	0.0	Sep-23	<= 28.0	2.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Oct-23		<= 1.0	1.0	Sep-23	<= 7.0	3.0	
516 - Community patients acquiring pressure damage (unstagable)		8	Oct-23			3	Sep-23		38	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Oct-23			0	Sep-23		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Oct-23			0	Sep-23		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Oct-23			0	Sep-23		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	71.1%	Oct-23		>= 95%	69.7%	Sep-23	>= 95%	71.4%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	71.1%	Oct-23		>= 95.0%	72.3%	Sep-23	>= 95.0%	79.1%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Oct-23		= 100%	100.0%	Sep-23	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	94.2%	Oct-23		>= 85%	94.2%	Sep-23	>= 85%	94.4%	
91 - SI's 60 day turnaround performance	= 100%	60.0%	Oct-23		= 100%	85.7%	Sep-23	= 100%	75.0%	
8 - Same sex accommodation breaches	= 0	24	Oct-23		= 0	14	Sep-23	= 0	128	

6 - Compliance with preventative measure for VTE

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 95%	98.4%	Oct-23

Previous

Plan	Actual	Period
>= 95%	97.4%	Sep-23

Year to Date

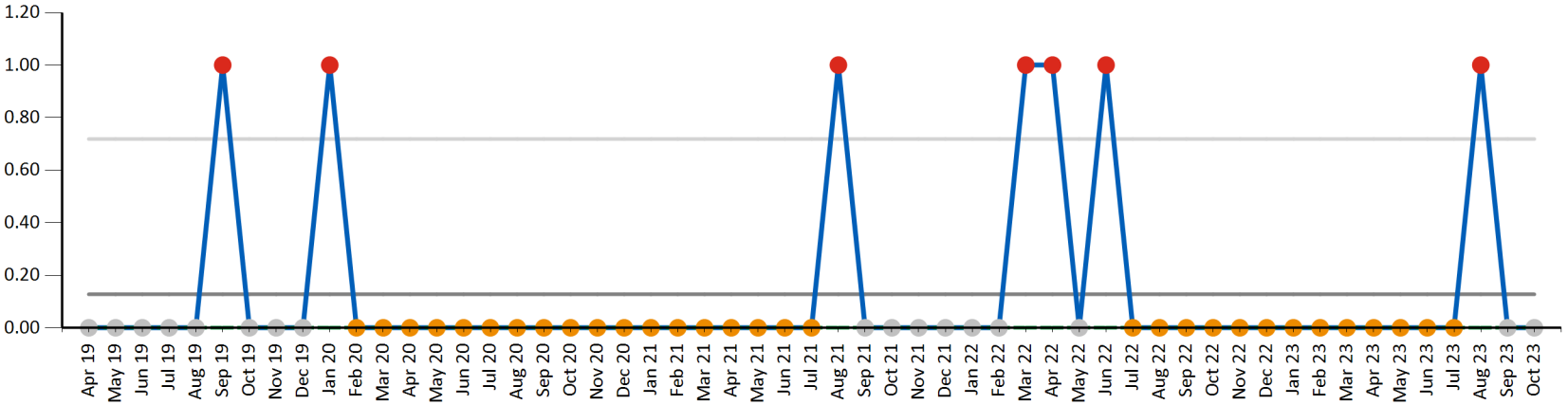
Plan	Actual
>= 95%	98.0%

9 - Never Events

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Oct-23

Previous

Plan	Actual	Period
= 0	0	Sep-23

Year to Date

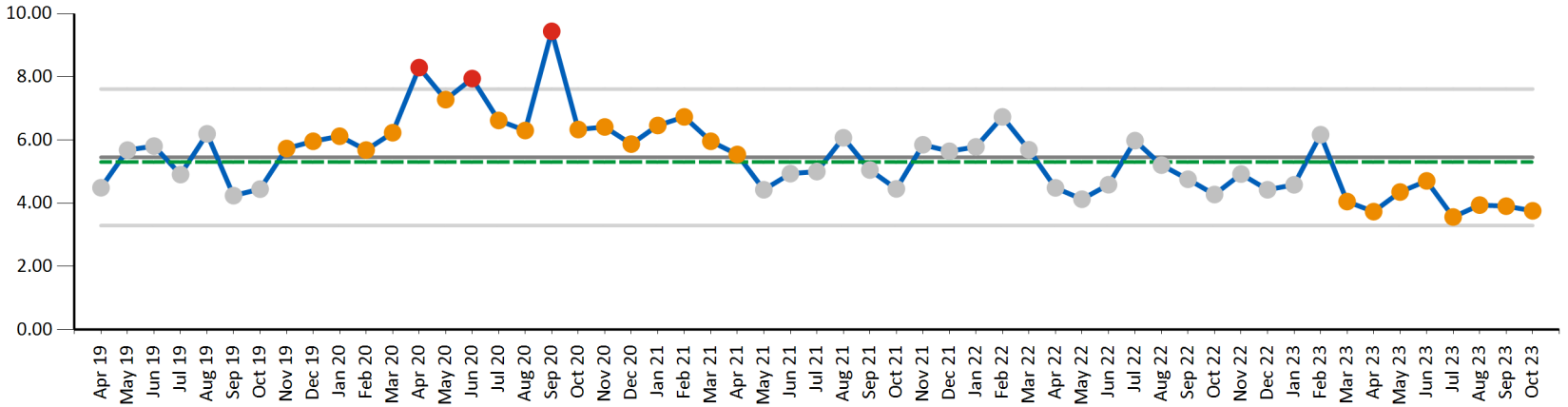
Plan	Actual
= 0	1

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 5.30	3.76	Oct-23

Previous

Plan	Actual	Period
<= 5.30	3.90	Sep-23

Year to Date

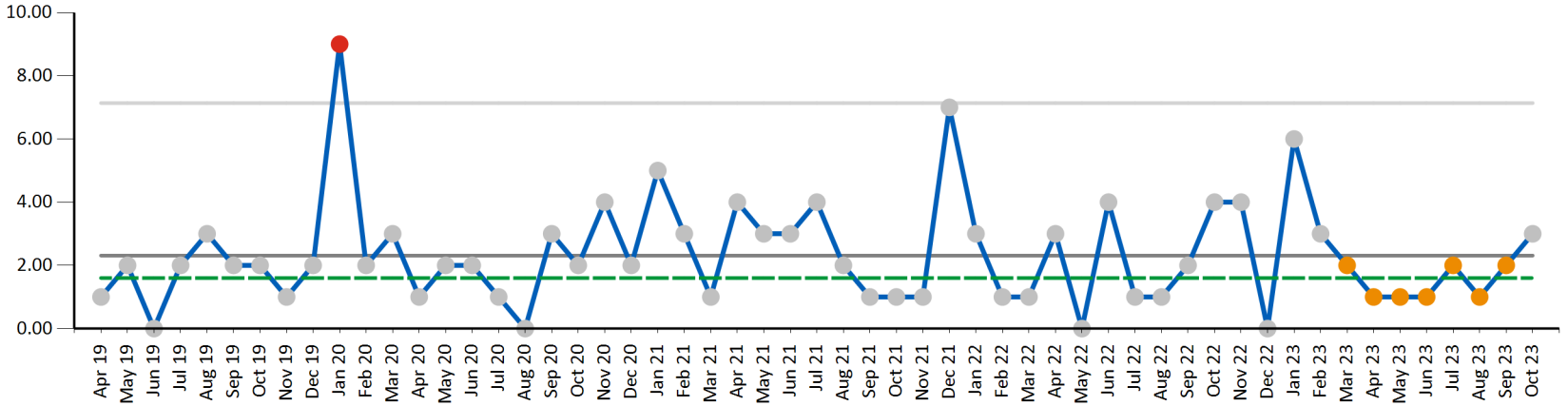
Plan	Actual
<= 5.30	3.99

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.6	3	Oct-23

Previous

Plan	Actual	Period
<= 1.6	2	Sep-23

Year to Date

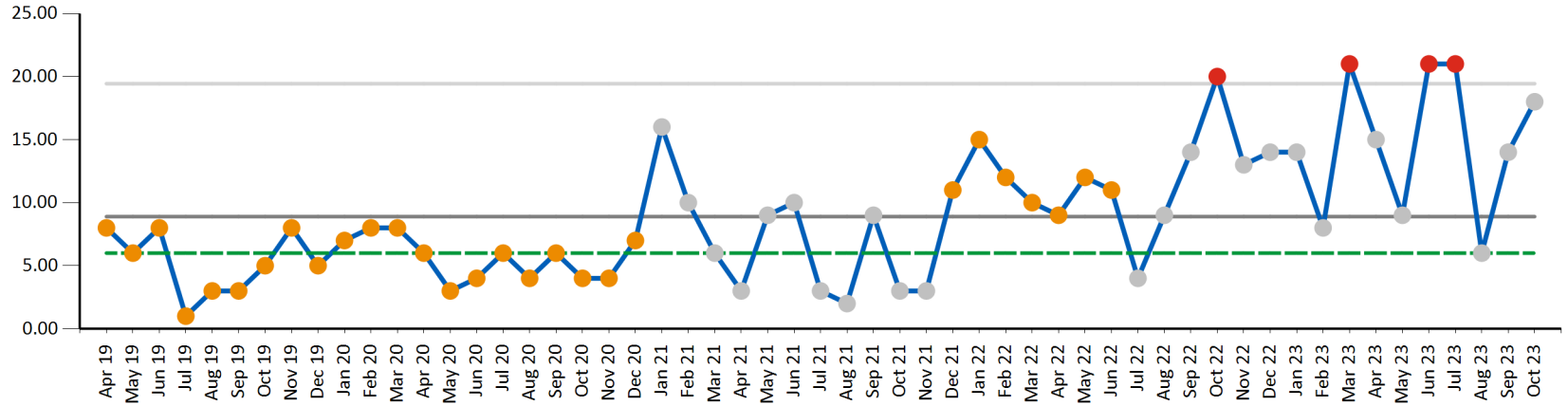
Plan	Actual
<= 11.2	11

15 - Acute Inpatients acquiring pressure damage (category 2)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 6.0	18.0	Oct-23

Previous

Plan	Actual	Period
<= 6.0	14.0	Sep-23

Year to Date

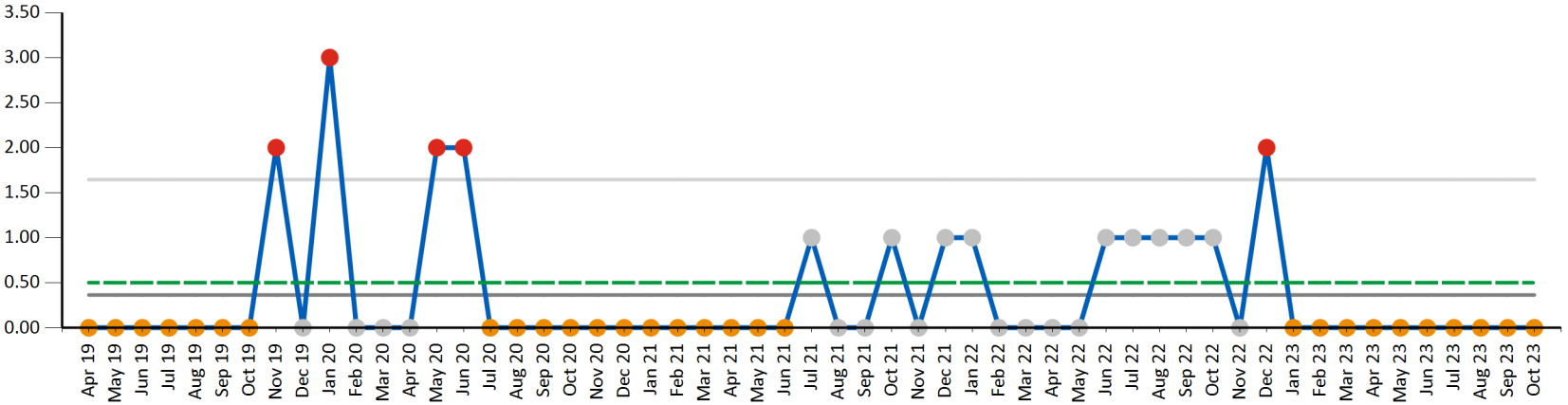
Plan	Actual
<= 42.0	104.0

16 - Acute Inpatients acquiring pressure damage (category 3)

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 0.5	0.0	Oct-23

Previous

Plan	Actual	Period
<= 0.5	0.0	Sep-23

Year to Date

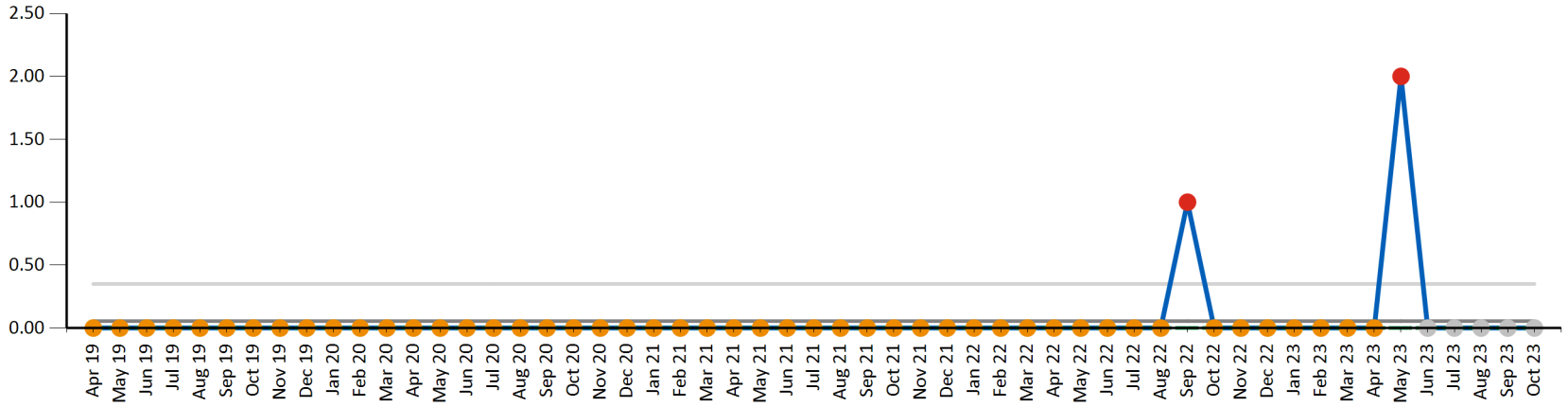
Plan	Actual
<= 3.5	0.0

17 - Acute Inpatients acquiring pressure damage (category 4)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0.0	0.0	Oct-23

Previous

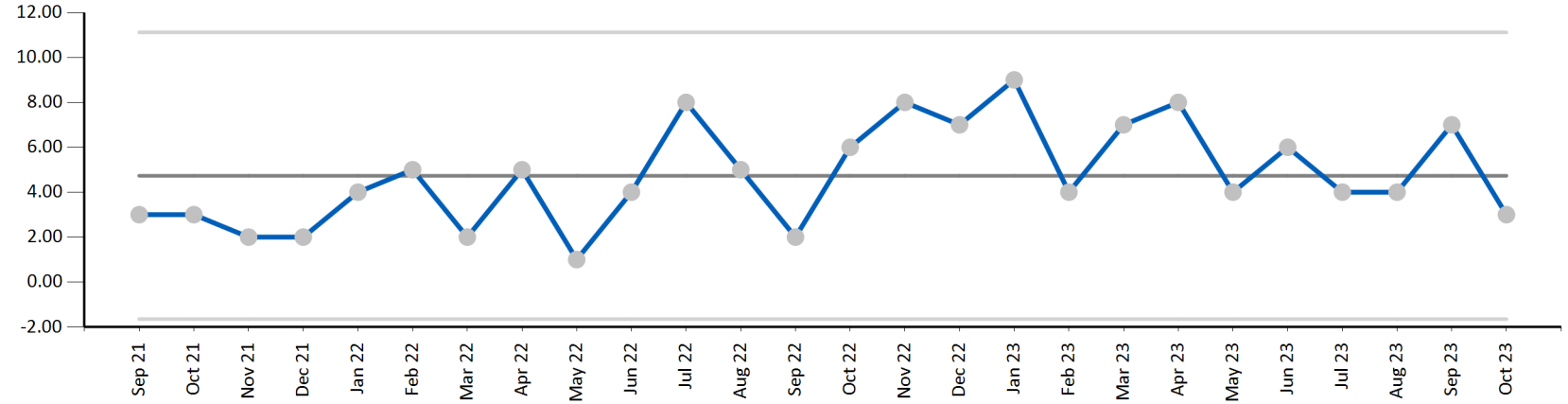
Plan	Actual	Period
= 0.0	0.0	Sep-23

Year to Date

Plan	Actual
= 0.0	2.0

515 - Acute Inpatients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	3	Oct-23

Previous

Plan	Actual	Period
	7	Sep-23

Year to Date

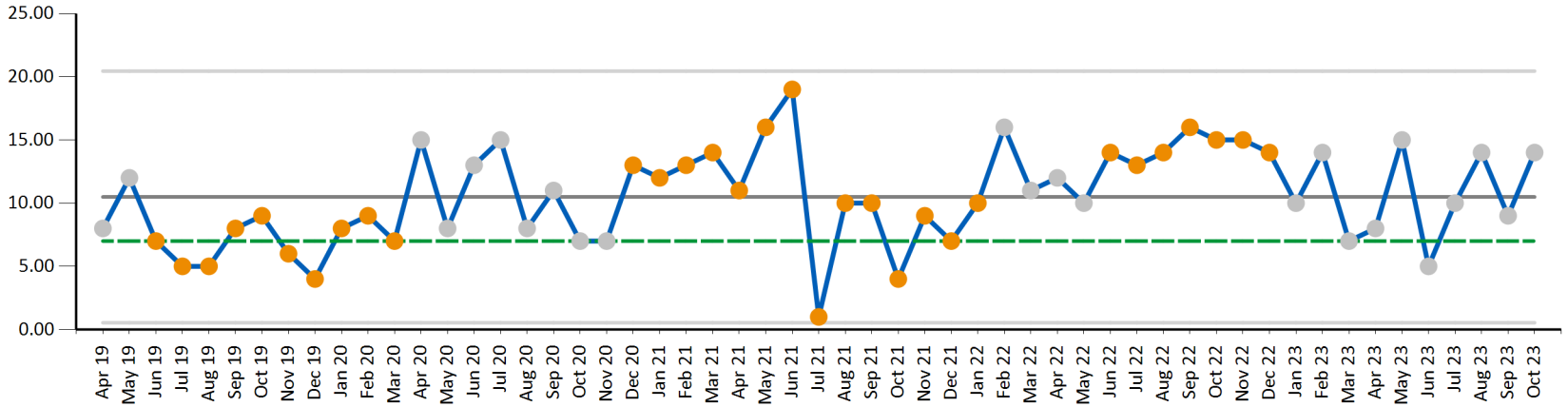
Plan	Actual
	36

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 7.0	14.0	Oct-23

Previous

Plan	Actual	Period
<= 7.0	9.0	Sep-23

Year to Date

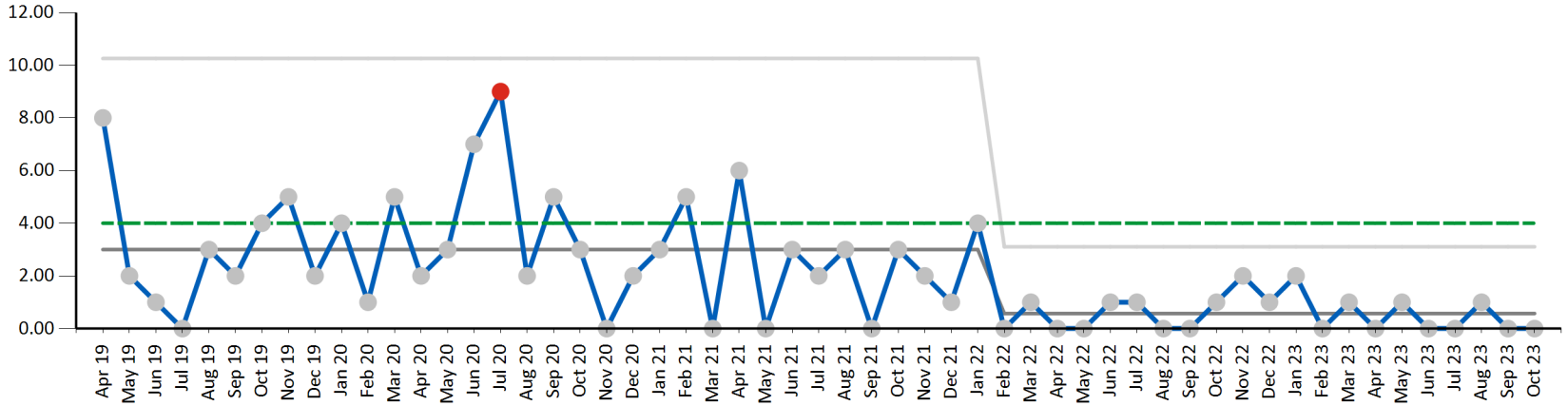
Plan	Actual
<= 49.0	75.0

19 - Community patients acquiring pressure damage (category 3)

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 4.0	0.0	Oct-23

Previous

Plan	Actual	Period
<= 4.0	0.0	Sep-23

Year to Date

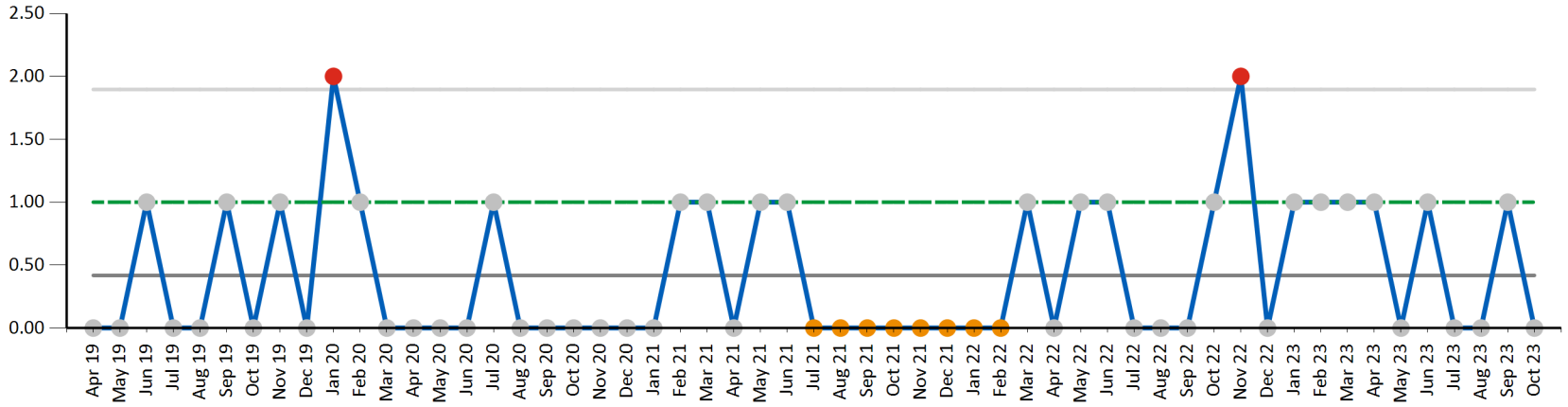
Plan	Actual
<= 28.0	2.0

20 - Community patients acquiring pressure damage (category 4)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 1.0	0.0	Oct-23

Previous

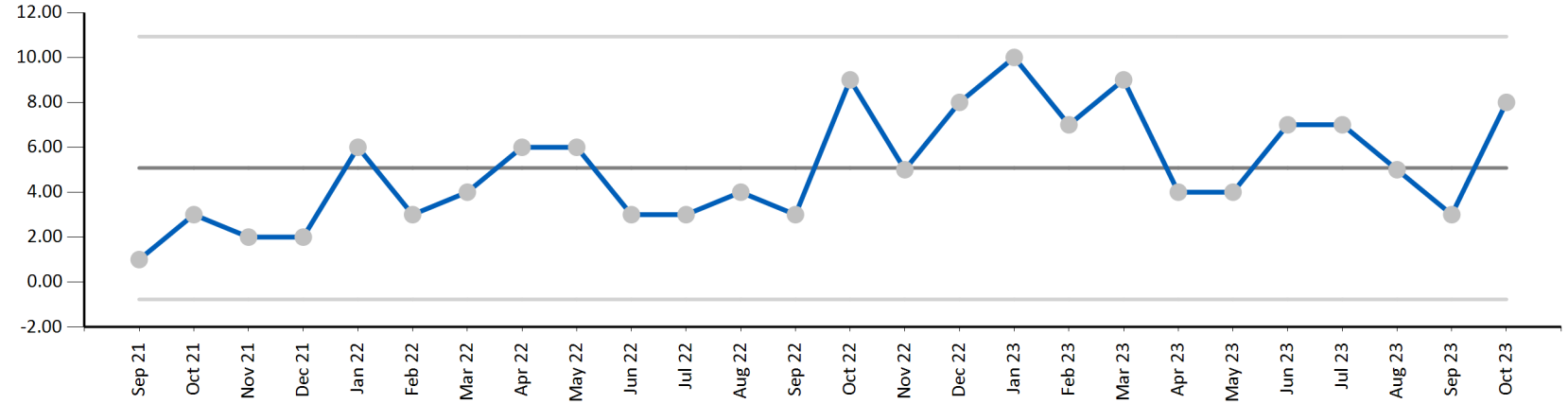
Plan	Actual	Period
<= 1.0	1.0	Sep-23

Year to Date

Plan	Actual
<= 7.0	3.0

516 - Community patients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	8	Oct-23

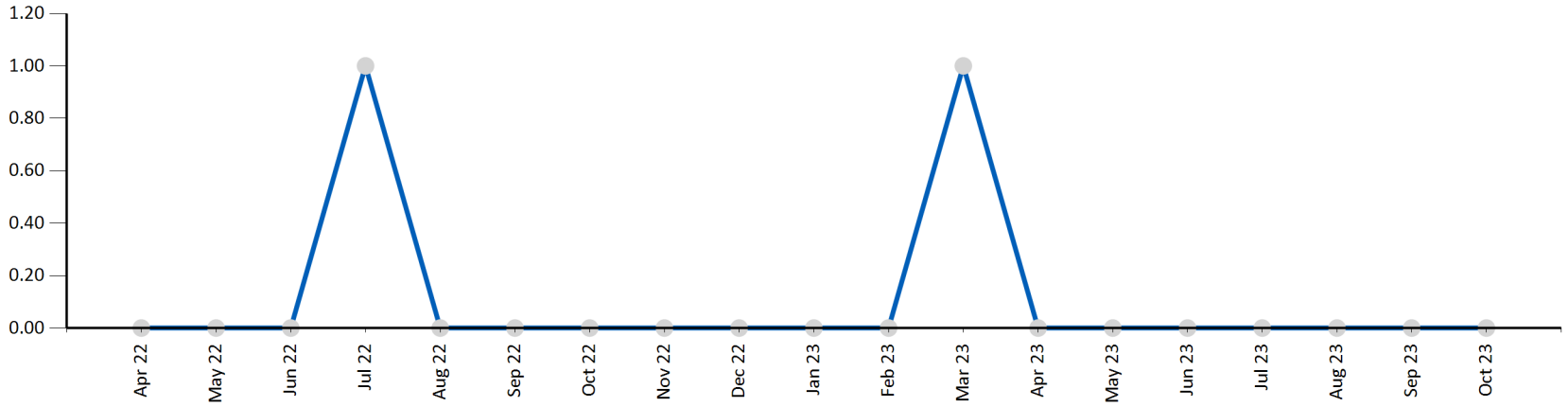
Previous

Plan	Actual	Period
	3	Sep-23

Year to Date

Plan	Actual
	38

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



Latest

Plan	Actual	Period
	0	Oct-23

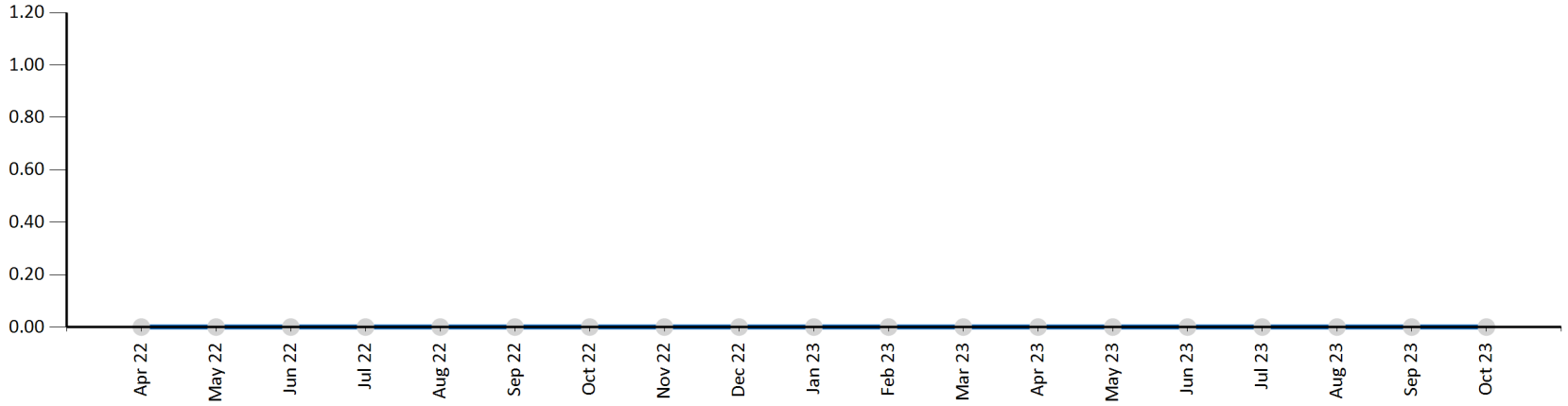
Previous

Plan	Actual	Period
	0	Sep-23

Year to Date

Plan	Actual
	0

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



Latest

Plan	Actual	Period
	0	Oct-23

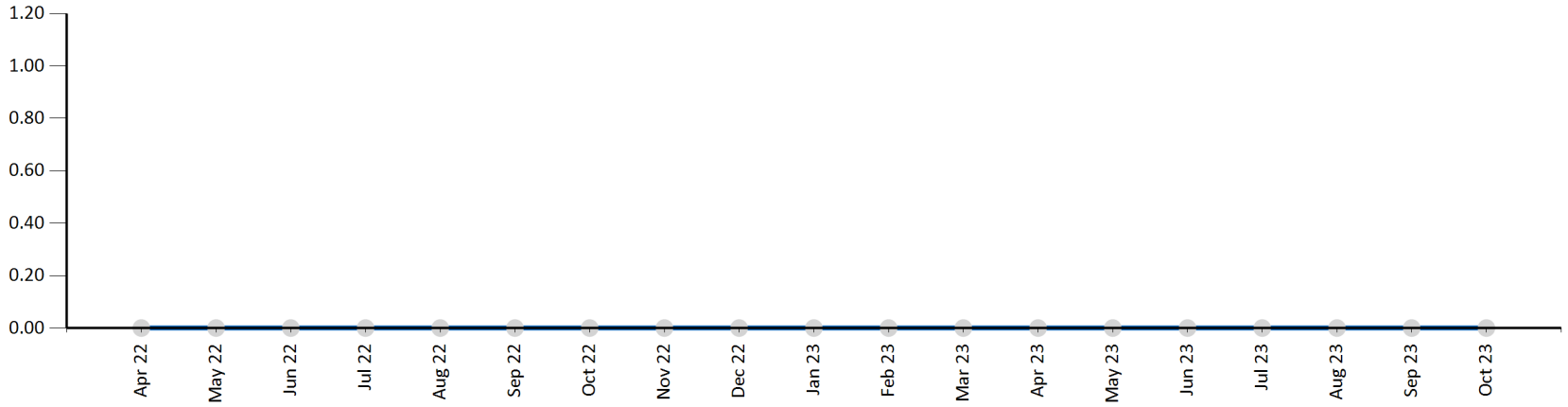
Previous

Plan	Actual	Period
	0	Sep-23

Year to Date

Plan	Actual
	0

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



Latest

Plan	Actual	Period
	0	Oct-23

Previous

Plan	Actual	Period
	0	Sep-23

Year to Date

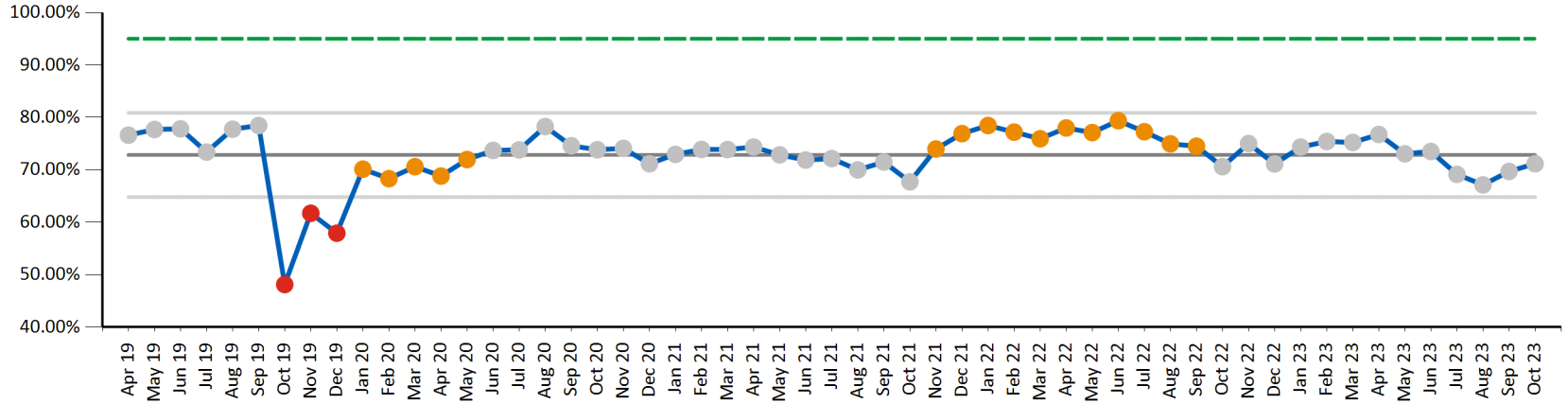
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	71.1%	Oct-23

Previous

Plan	Actual	Period
>= 95%	69.7%	Sep-23

Year to Date

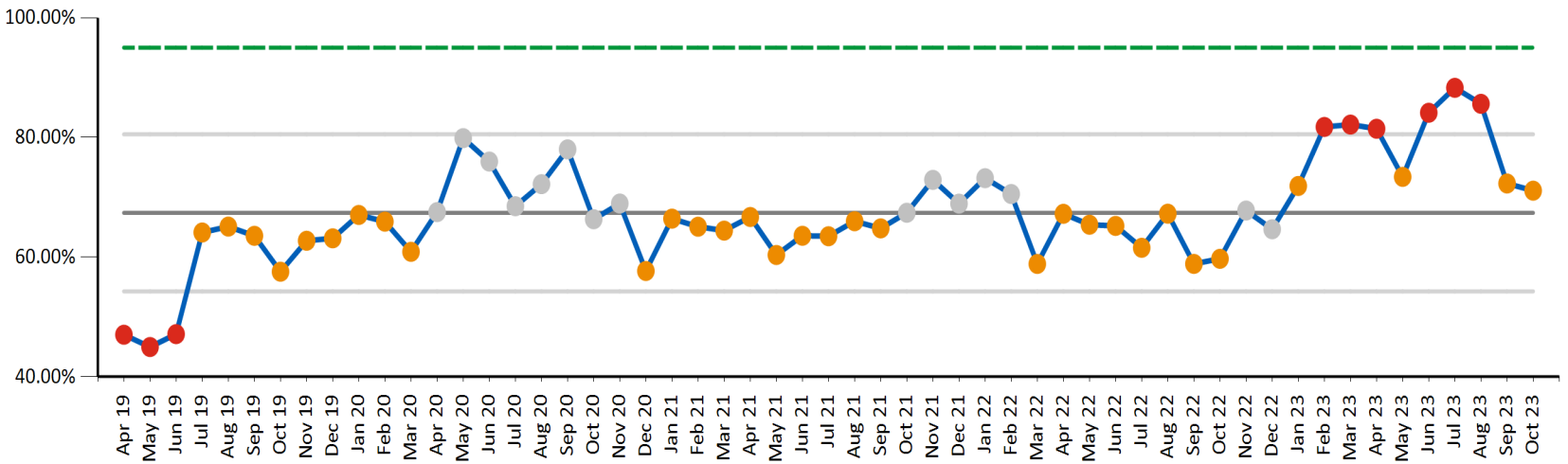
Plan	Actual
>= 95%	71.4%

31 - Clinical Correspondence - Outpatients %<5 working days

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	71.1%	Oct-23

Previous

Plan	Actual	Period
>= 95.0%	72.3%	Sep-23

Year to Date

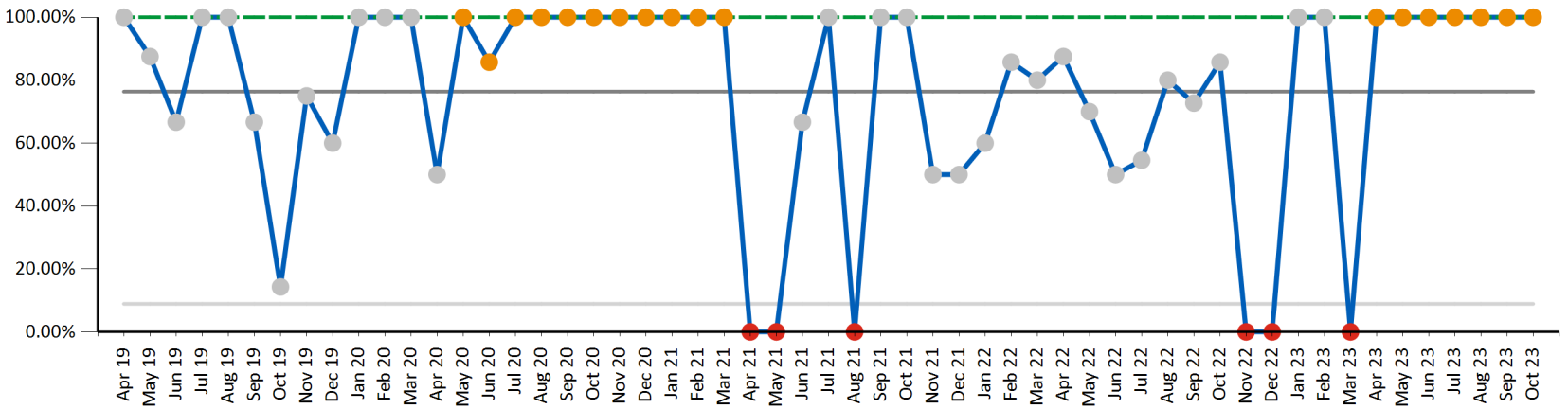
Plan	Actual
>= 95.0%	79.1%

86 - Patient Safety Alerts - Trust position

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Oct-23

Previous

Plan	Actual	Period
= 100%	100.0%	Sep-23

Year to Date

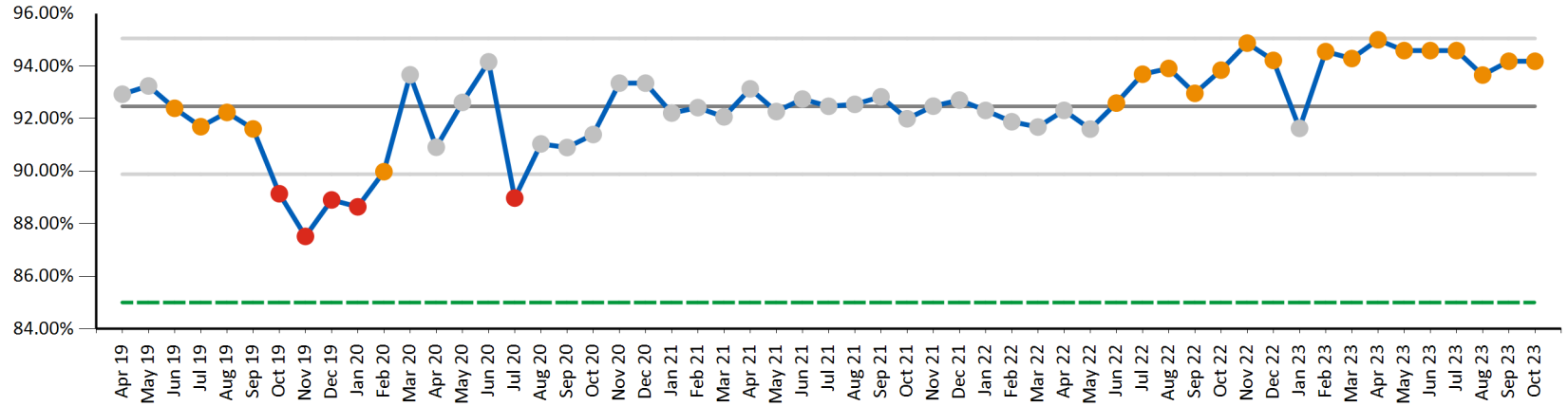
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	94.2%	Oct-23

Previous

Plan	Actual	Period
>= 85%	94.2%	Sep-23

Year to Date

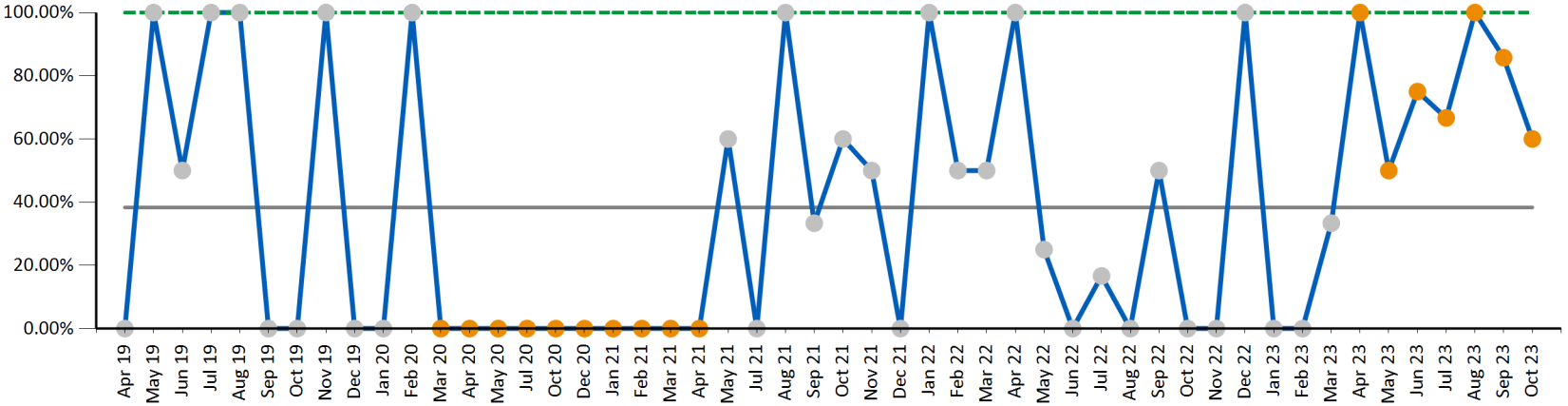
Plan	Actual
>= 85%	94.4%

91 - SI's 60 day turnaround performance

Special cause variation with improving performance

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

1/6



Latest

Plan	Actual	Period
= 100%	60.0%	Oct-23

Previous

Plan	Actual	Period
= 100%	85.7%	Sep-23

Year to Date

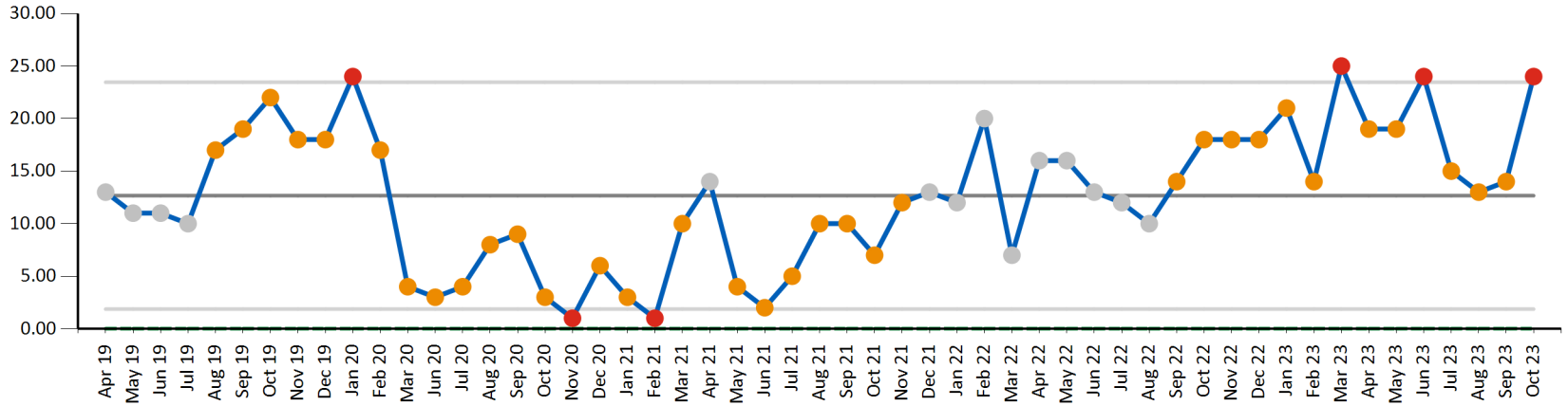
Plan	Actual
= 100%	75.0%

8 - Same sex accommodation breaches

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	24	Oct-23

Previous

Plan	Actual	Period
= 0	14	Sep-23

Year to Date

Plan	Actual
= 0	128

Quality and Safety - Infection Prevention and Control

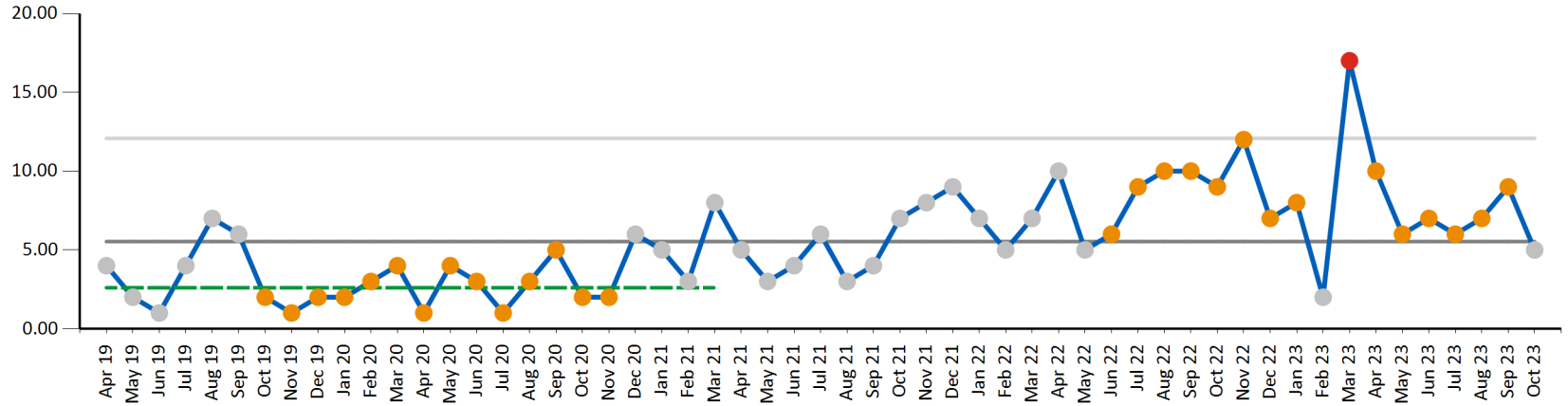
Bolton NHS Foundation Trust

There has been no statistically significant change in the number of Clostridium difficile cases, however this month has seen the lowest number of hospital onset-healthcare associated case year to date and there have been 10 fewer healthcare associated cases than at the same point in 2023/24.
The Trust remains the best provider in GM for E. coli bacteraemia by rate and second for Klebsiella spp. and Pseudomonas aeruginosa cases.
Blood culture contaminant rate is above target in month, however statistically with 7 points below the mean, there is a special variation with an improving picture and year to date average remains below target at 2.8%

	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		5	Oct-23			9	Sep-23		50	
346 - Total Community Onset Hospital Associated C.diff infections		3	Oct-23			2	Sep-23		18	
347 - Total C.diff infections contributing to objective	<= 7	8	Oct-23		<= 7	11	Sep-23	<= 46	68	?
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Oct-23		= 0	0	Sep-23	= 0	1	?
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	5	Oct-23		<= 4	5	Sep-23	<= 29	36	?
219 - Blood Culture Contaminants (rate)	<= 3%	3.3%	Oct-23	L	<= 3%	2.2%	Sep-23	<= 3%	2.8%	?
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Oct-23		<= 1.0	1.0	Sep-23	<= 7.0	8.0	?
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Oct-23		<= 1	3	Sep-23	<= 4	10	?
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Oct-23		= 0	2	Sep-23	= 0	3	?
491 - Nosocomial COVID-19 cases		30	Oct-23	L		23	Sep-23		146	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Oct-23

Previous

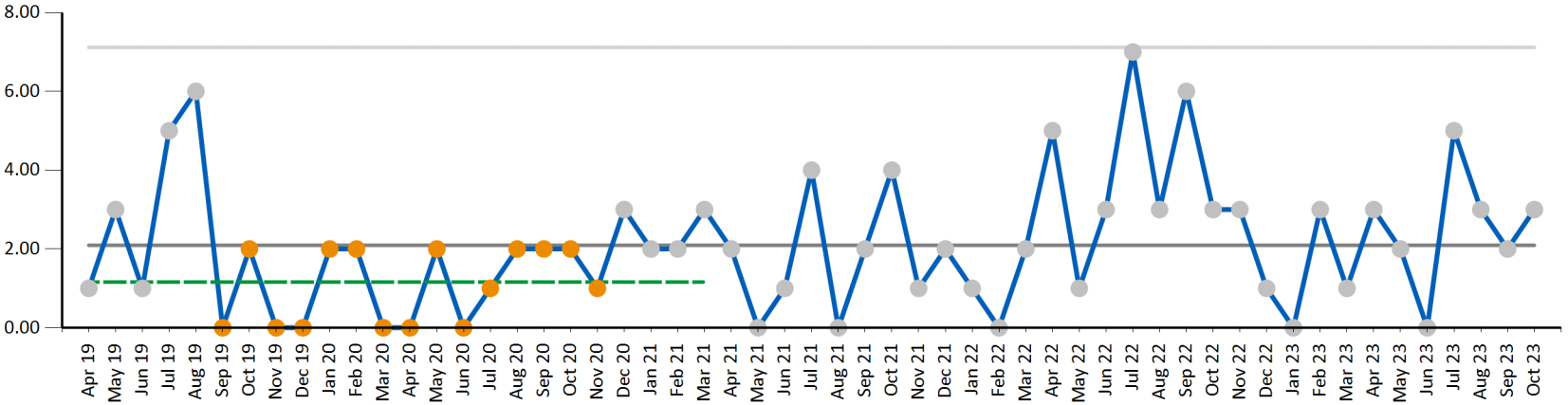
Plan	Actual	Period
	9	Sep-23

Year to Date

Plan	Actual
	50

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	3	Oct-23

Previous

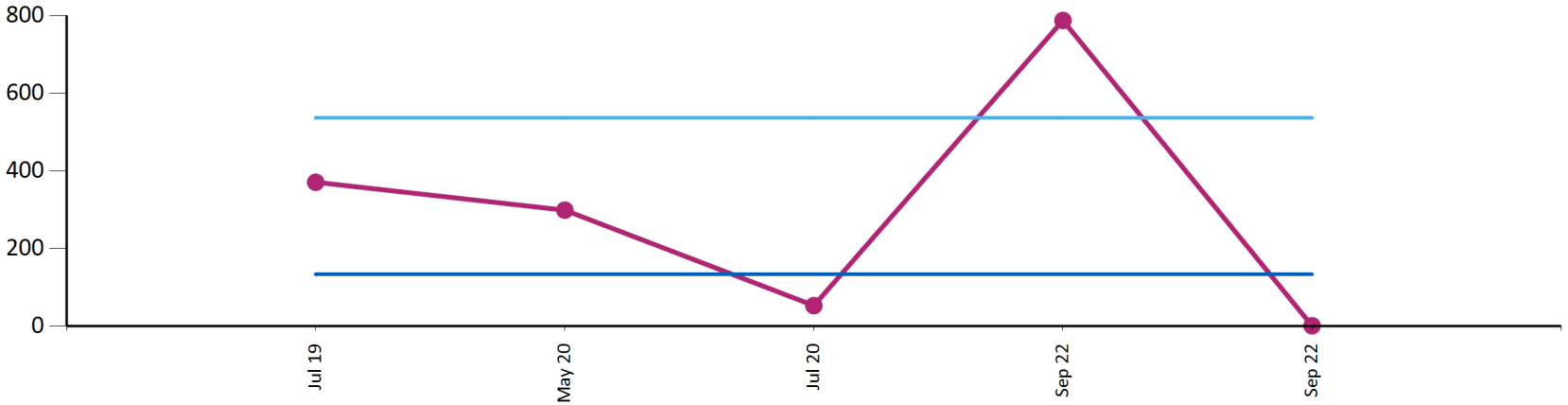
Plan	Actual	Period
	2	Sep-23

Year to Date

Plan	Actual
	18

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Oct-23

Previous

Plan	Actual	Period
	0	Sep-23

Year to Date

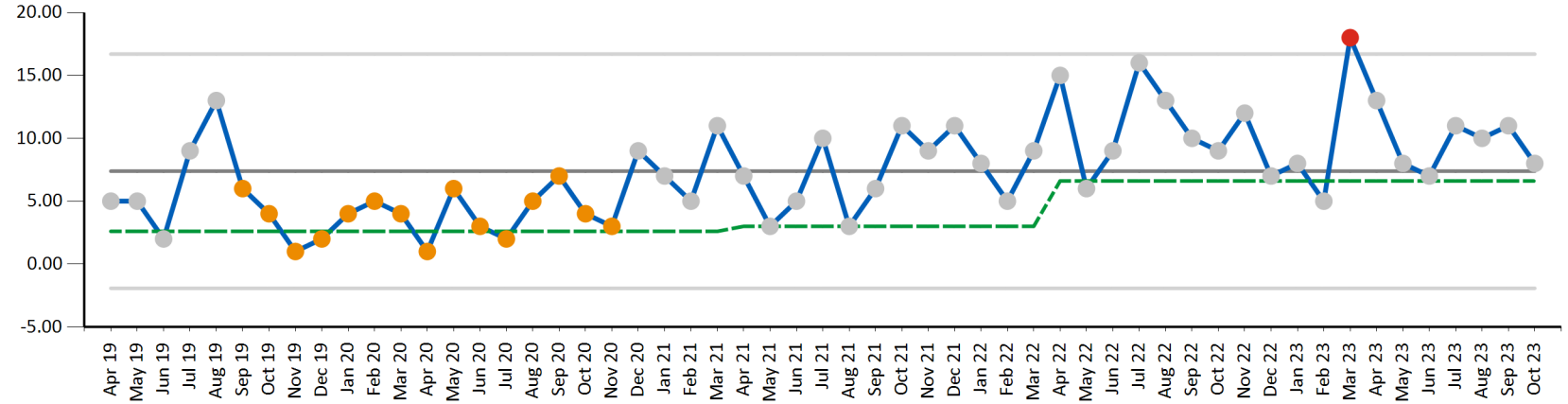
Plan	Actual

347 - Total C.diff infections contributing to objective

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 7	8	Oct-23

Previous

Plan	Actual	Period
<= 7	11	Sep-23

Year to Date

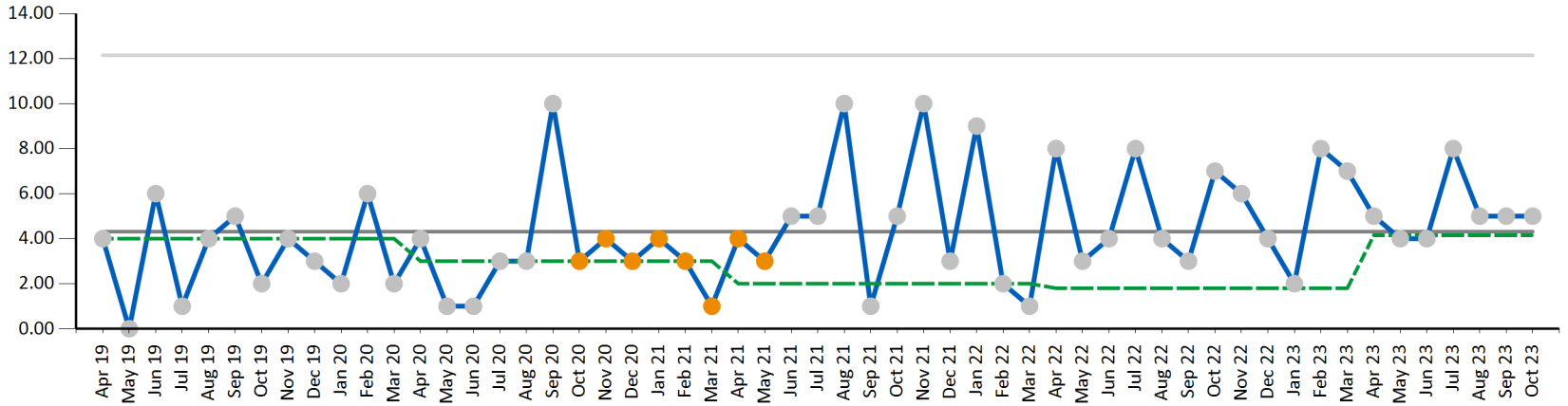
Plan	Actual
<= 46	68

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 4	5	Oct-23

Previous

Plan	Actual	Period
<= 4	5	Sep-23

Year to Date

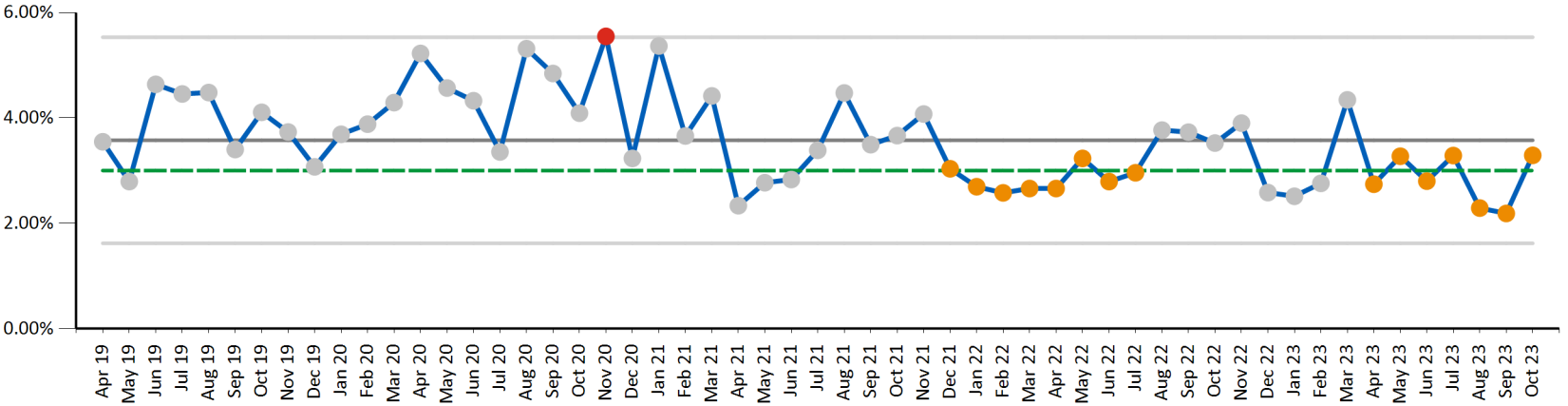
Plan	Actual
<= 29	36

219 - Blood Culture Contaminants (rate)

Special cause variation with improving performance

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

3/6



Latest

Plan	Actual	Period
<= 3%	3.3%	Oct-23

Previous

Plan	Actual	Period
<= 3%	2.2%	Sep-23

Year to Date

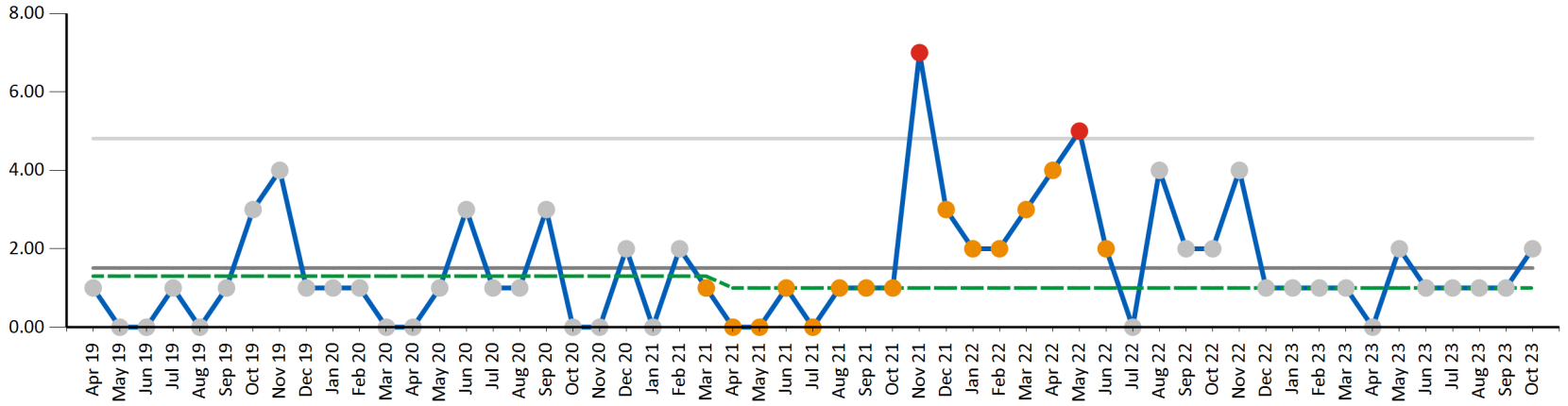
Plan	Actual
<= 3%	2.8%

304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Oct-23

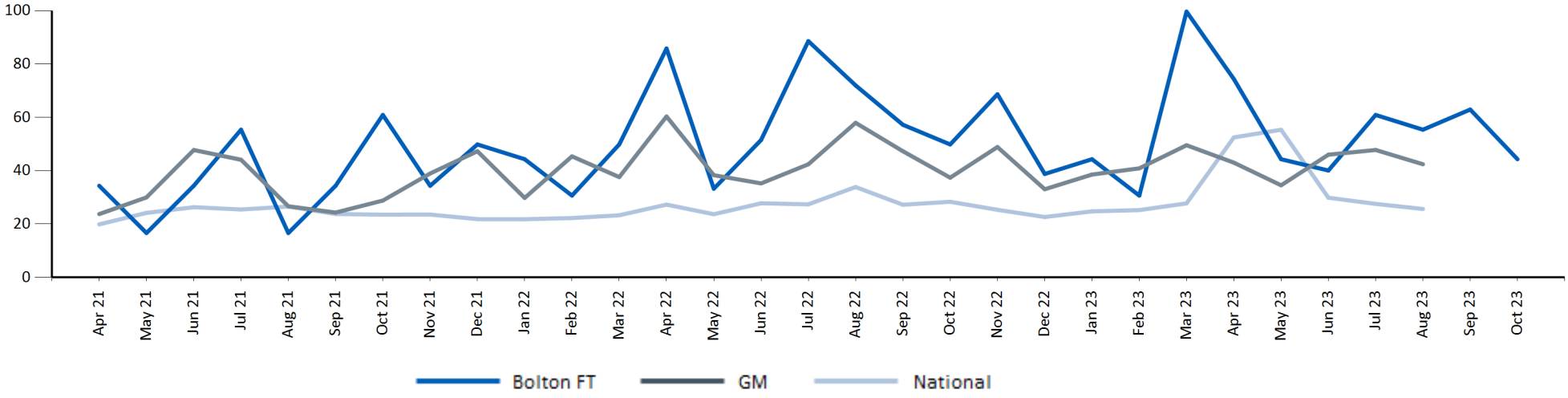
Previous

Plan	Actual	Period
<= 1.0	1.0	Sep-23

Year to Date

Plan	Actual
<= 7.0	8.0

549 - C Diff Rate Comparison

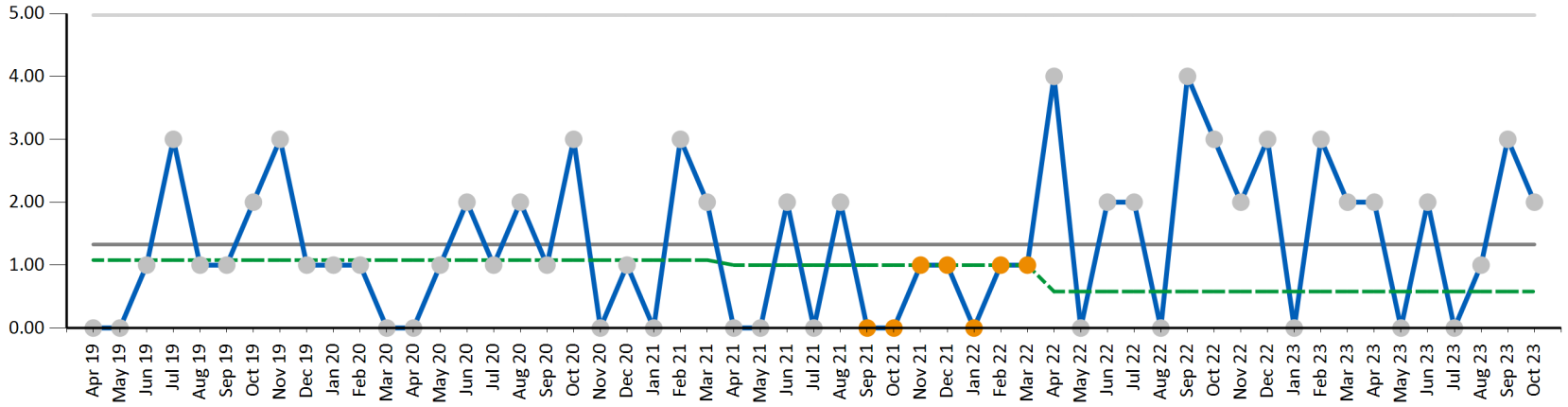


305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	2	Oct-23

Previous

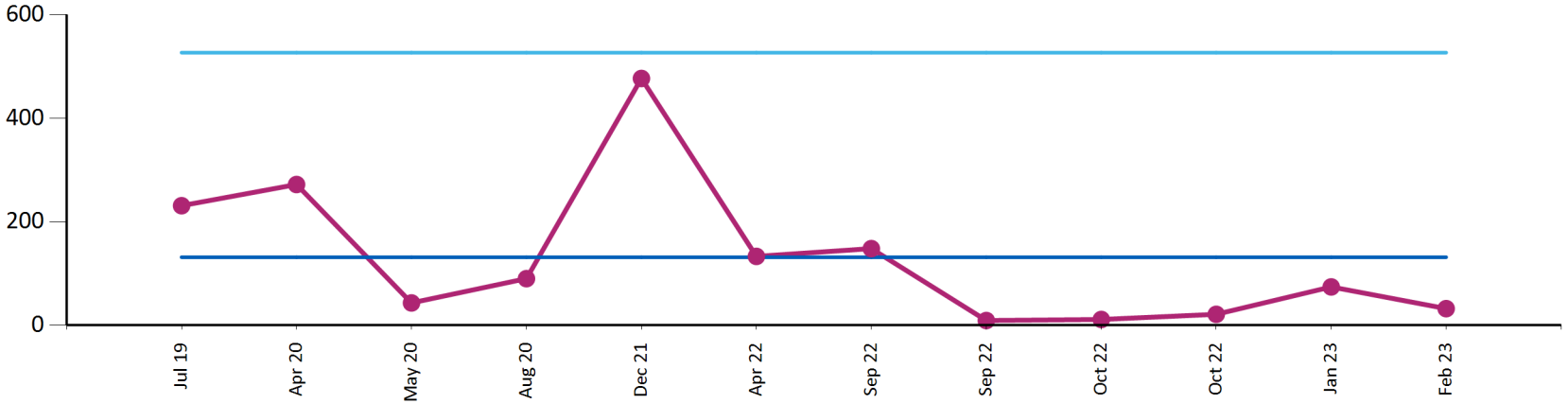
Plan	Actual	Period
<= 1	3	Sep-23

Year to Date

Plan	Actual
<= 4	10

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

0/6



Latest

Plan	Actual	Period
	0	Oct-23

Previous

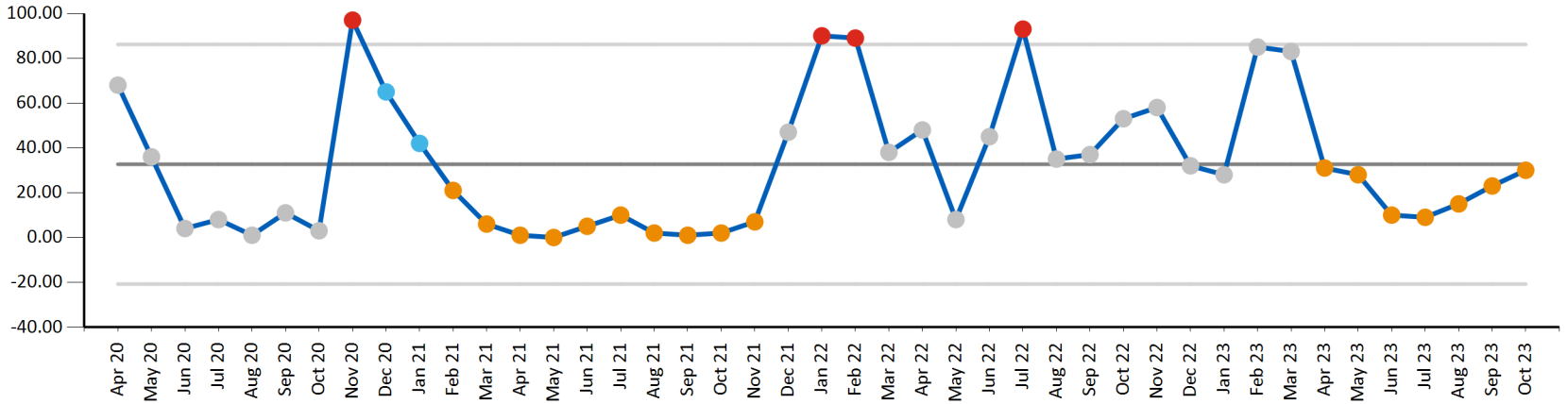
Plan	Actual	Period
	0	Sep-23

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Special cause variation with improving performance



Latest

Plan	Actual	Period
	30	Oct-23

Previous

Plan	Actual	Period
	23	Sep-23

Year to Date

Plan	Actual
	146

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the period. There are nine consecutive points below the mean and the rate has been in control for more than two years.

HSMR – in month figure is showing a sustained period of improvement with ten consecutive points below the mean. This has helped push the HSMR down and the 12 month average to July 2023 is 104.29 remaining as 'Green' when compared against other Trusts.

SHMI – In month figure is below the average for the time period and has remained 'in control' for more than two years. The published rolling average for the period July 2022 to June 2023 is 108.93 'as expected'.

The proportion of Charlson comorbidities and the Depth of Recording remain in control and have done for 12 months. However, both are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot download is above the target and average for the time frame. There has been a sustained period of 19 points above the mean since February 2022 indicating sustained improvement.

Sustained education and improvement in the recording of Charlson comorbidities over the previous two years has improved the expected deaths in both SHMI and HSMR keeping both indicators within range.

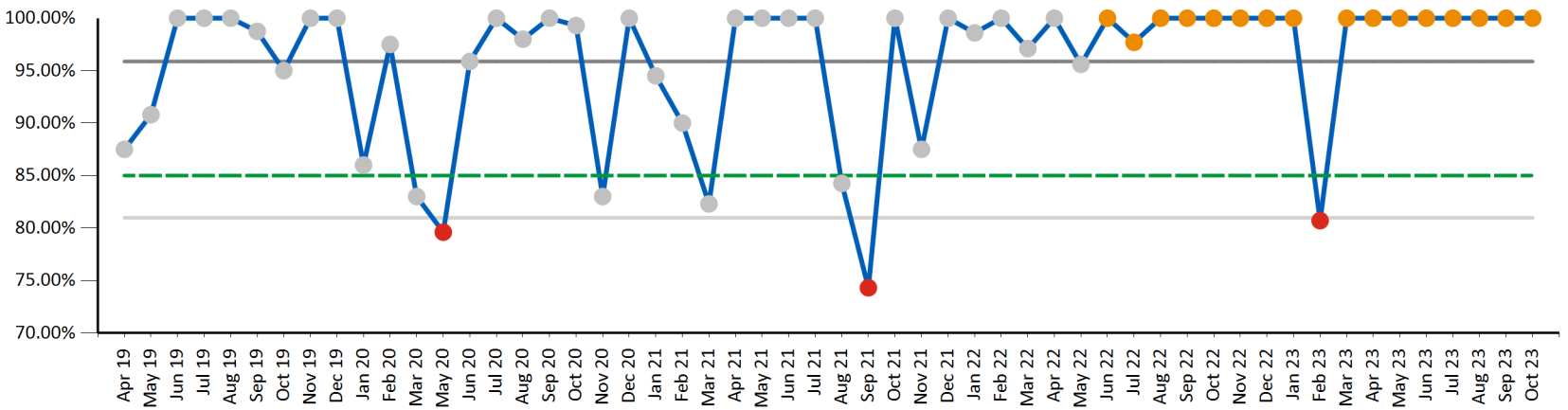
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Oct-23	H	>= 85%	100.0%	Sep-23	>= 85%	100.0%	?
495 - HSMR		92.72	Jul-23	L		99.08	Jun-23		92.72	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	108.82	May-23		<= 100.00	104.17	Apr-23	<= 100.00	108.82	?
12 - Crude Mortality %	<= 2.9%	2.3%	Oct-23	L	<= 2.9%	1.9%	Sep-23	<= 2.9%	2.2%	?
519 - Average Charlson comorbidity Score (First episode of care)		4	Jul-23			4	Jun-23		14	
520 - Depth of recording (First episode of care)		6	Jul-23			6	Jun-23		24	
521 - Proportion of fully coded records (Inpatients)		97.9%	Aug-23	H		98.0%	Jul-23		98.4%	

3 - National Early Warning Scores to Gold standard

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 85%	100.0%	Oct-23

Previous

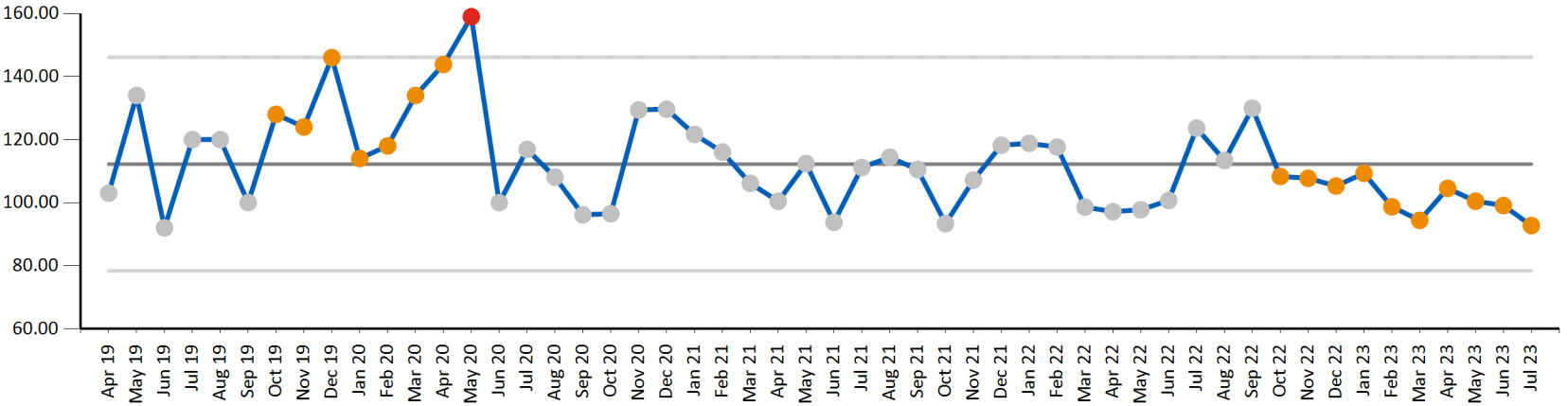
Plan	Actual	Period
>= 85%	100.0%	Sep-23

Year to Date

Plan	Actual
>= 85%	100.0%

495 - HSMR

Special cause variation with improving performance



Latest

Plan	Actual	Period
	92.72	Jul-23

Previous

Plan	Actual	Period
	99.08	Jun-23

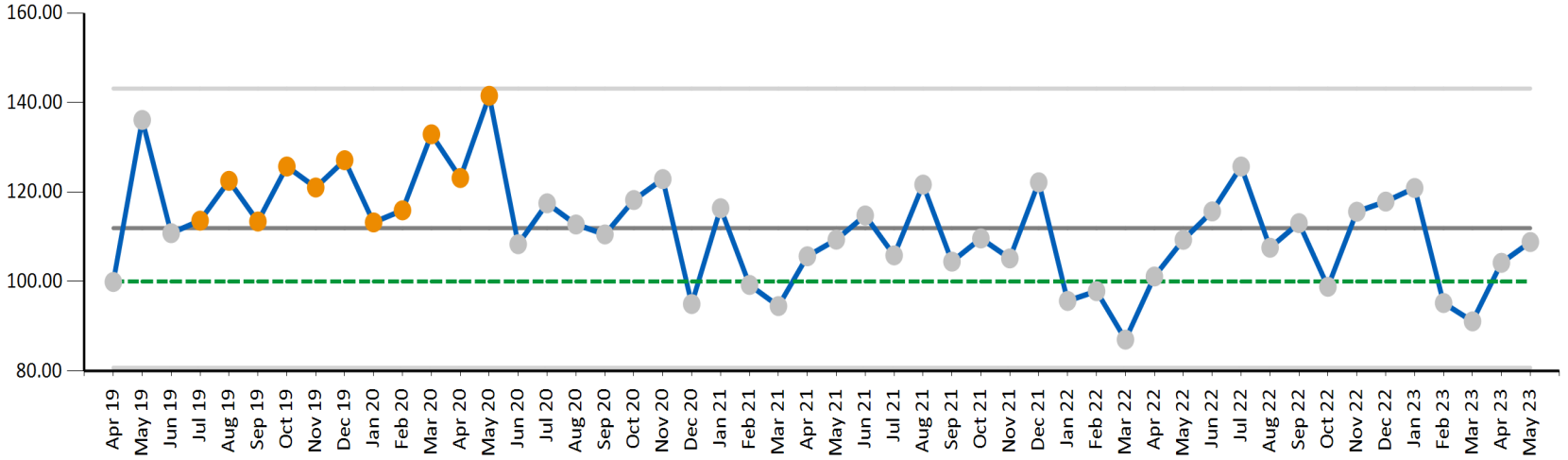
Year to Date

Plan	Actual
	92.72

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

We will not regularly meet the target due to normal variation. 2/6



Latest

Plan	Actual	Period
<= 100.00	108.82	May-23

Previous

Plan	Actual	Period
<= 100.00	104.17	Apr-23

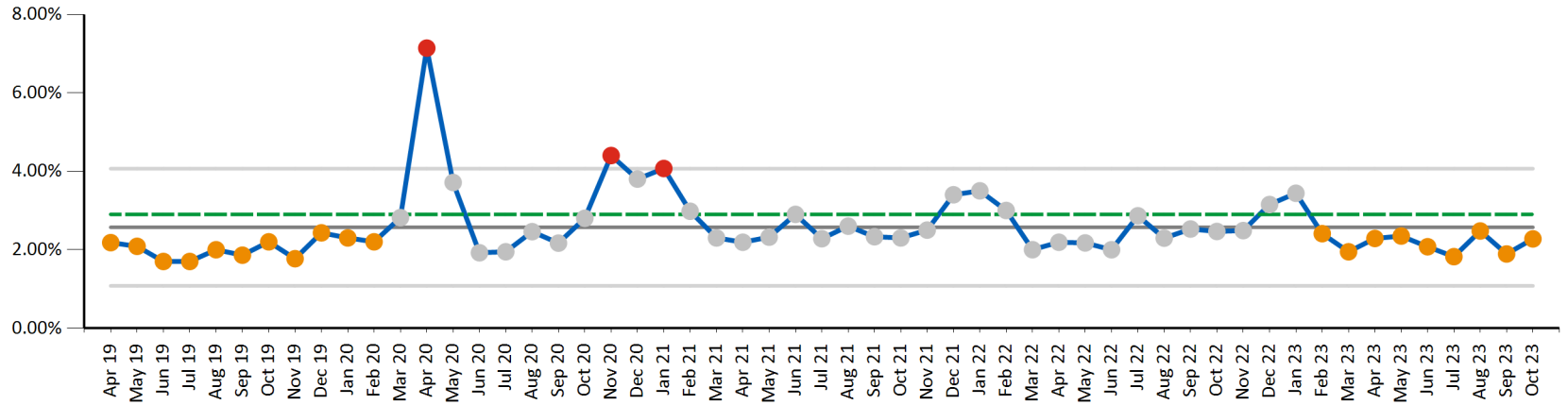
Year to Date

Plan	Actual
<= 100.00	108.82

12 - Crude Mortality %

Special cause variation with improving performance

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



Latest

Plan	Actual	Period
<= 2.9%	2.3%	Oct-23

Previous

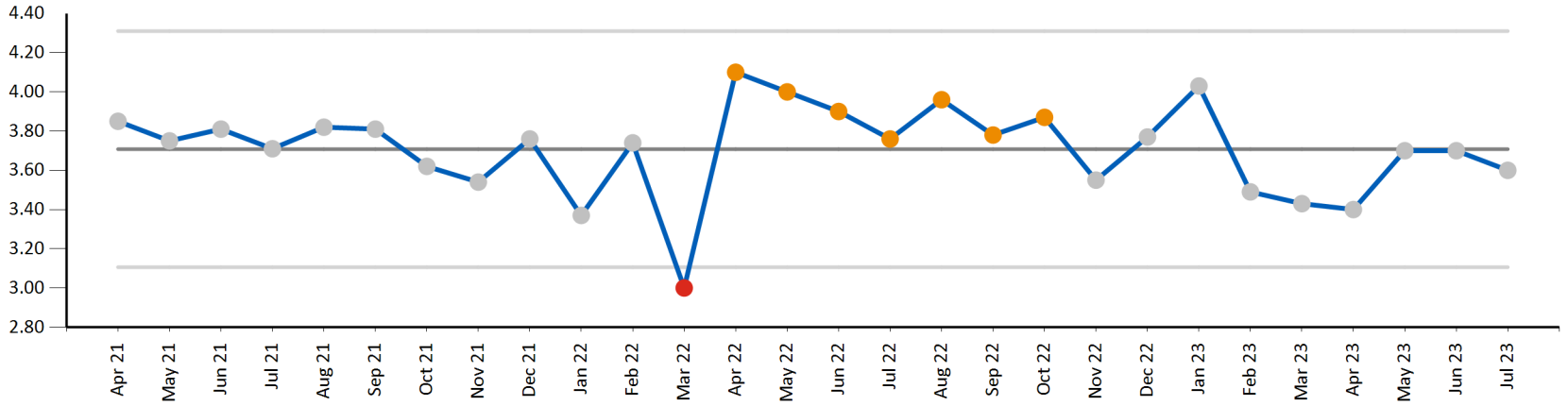
Plan	Actual	Period
<= 2.9%	1.9%	Sep-23

Year to Date

Plan	Actual
<= 2.9%	2.2%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Jul-23

Previous

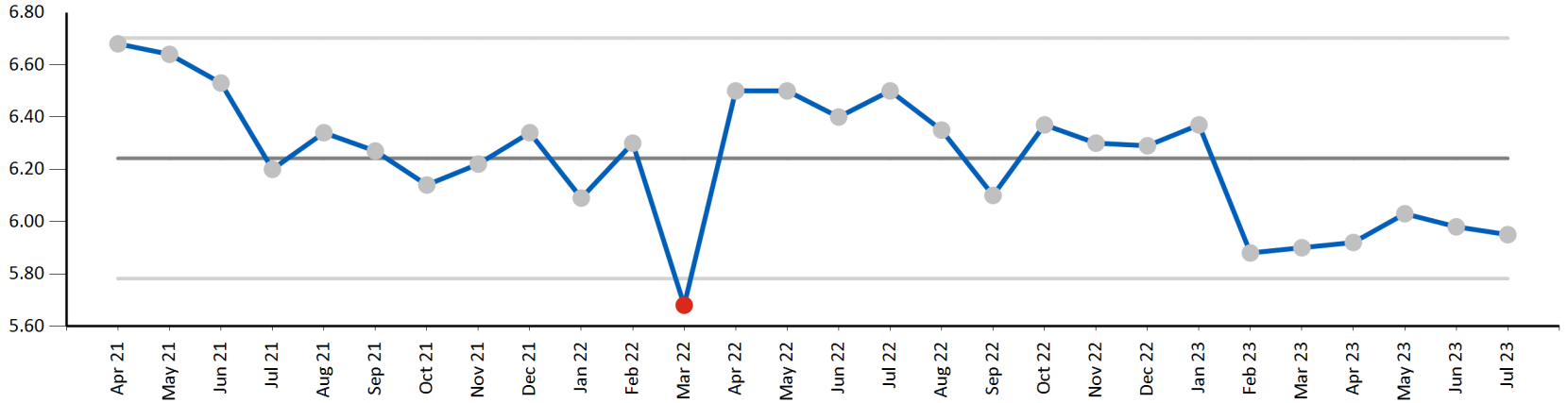
Plan	Actual	Period
	4	Jun-23

Year to Date

Plan	Actual
	14

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	Jul-23

Previous

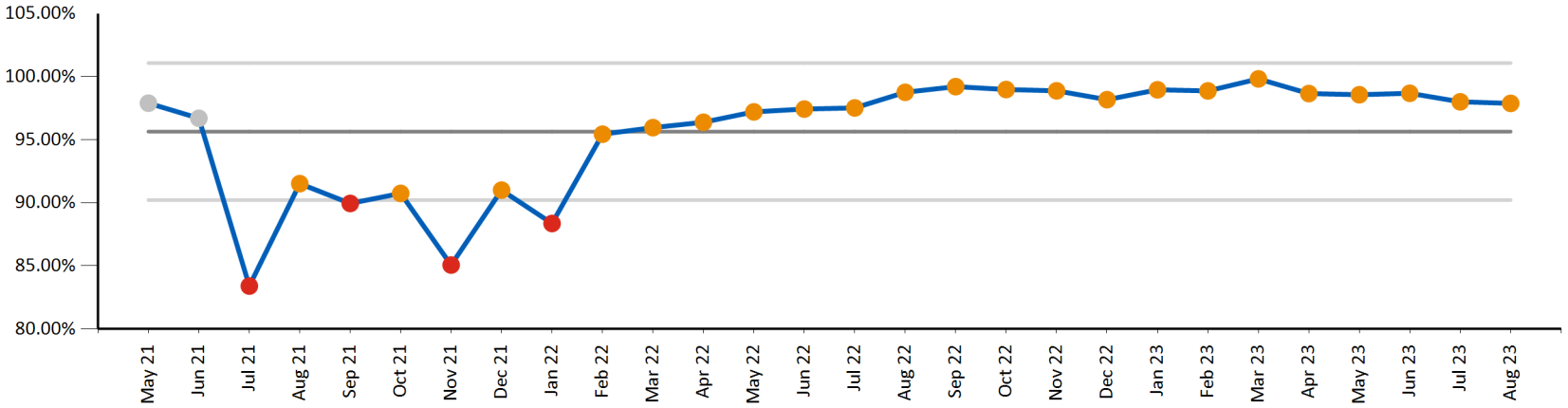
Plan	Actual	Period
	6	Jun-23

Year to Date

Plan	Actual
	24

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	97.9%	Aug-23

Previous

Plan	Actual	Period
	98.0%	Jul-23

Year to Date

Plan	Actual
	98.4%

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

Complaint Response Rates
Compliance rates remain within normal variation.
Ten responses had an October target date. All ten have been responded to; eight in October and two in September. Eight were within the timeframe.
A total of 18 responses were issued in October. One overdue from September. Eight ahead of target with due dates of November and early December.
Complaint meetings remain a positive best practice resolution outcome and this continues to be encouraged to improve service user engagement.
Complaint training sessions continue to be offered to staff at all levels.

FFT
All response and satisfaction rates remain within common cause variation except for one astronomical point in Antenatal indicating deterioration in relation to satisfaction rates. This is despite response rates being above the target and within normal variation.
FCD have reinstated their FFT task and finish group to address the issues of poor satisfaction and PET to support recording when acuity is high to sustain the improved response rates

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	15.9%	Oct-23		>= 20%	16.7%	Sep-23	>= 20%	17.1%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	81.8%	Oct-23		>= 90%	82.3%	Sep-23	>= 90%	85.0%	
80 - Inpatient Friends and Family Response Rate	>= 30%	30.4%	Oct-23		>= 30%	29.1%	Sep-23	>= 30%	28.2%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.4%	Oct-23		>= 90%	96.5%	Sep-23	>= 90%	95.9%	
81 - Maternity Friends and Family Response Rate	>= 15%	26.8%	Oct-23	H	>= 15%	27.1%	Sep-23	>= 15%	35.5%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	87.0%	Oct-23		>= 90%	95.2%	Sep-23	>= 90%	91.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	19.8%	Oct-23		>= 15%	6.0%	Sep-23	>= 15%	24.3%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	76.9%	Oct-23	L	>= 90%	92.9%	Sep-23	>= 90%	93.9%	
83 - Birth - Friends and Family Response Rate	>= 15%	37.6%	Oct-23		>= 15%	53.1%	Sep-23	>= 15%	45.8%	

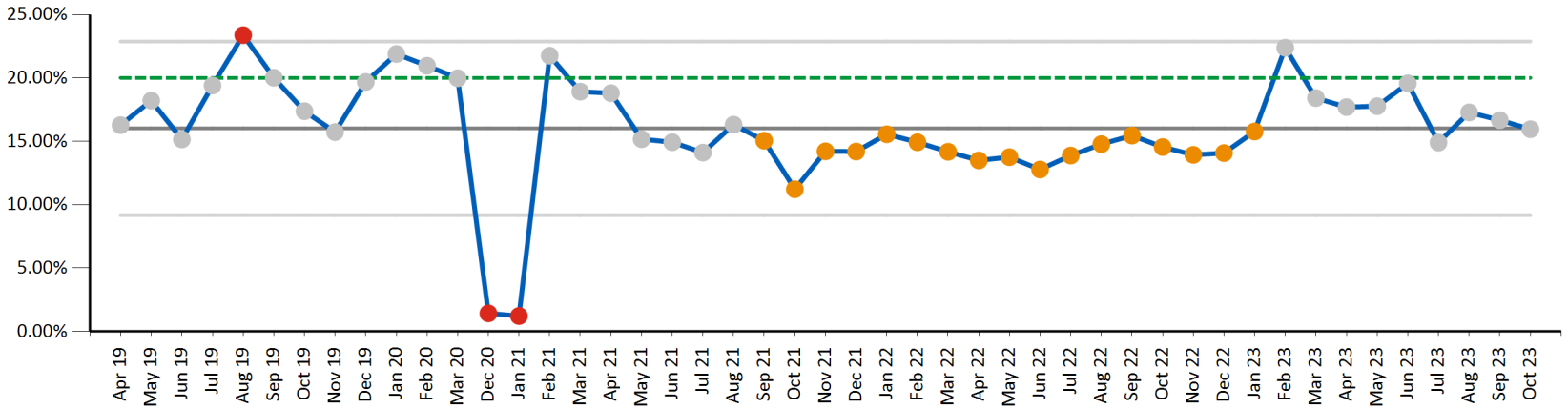
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.6%	Oct-23	H	>= 90%	95.1%	Sep-23	>= 90%	92.1%	?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	39.6%	Oct-23	H	>= 15%	40.1%	Sep-23	>= 15%	50.6%	?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	92.5%	Oct-23		>= 90%	96.9%	Sep-23	>= 90%	86.5%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	8.7%	Oct-23		>= 15%	10.6%	Sep-23	>= 15%	23.5%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	82.1%	Oct-23		>= 90%	91.2%	Sep-23	>= 90%	96.0%	?
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Oct-23	H	= 100%	100.0%	Sep-23	= 100%	100.0%	?
90 - Complaints responded to within the period	>= 95%	80.0%	Oct-23		>= 95%	92.9%	Sep-23	>= 95%	81.7%	?

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	15.9%	Oct-23

Previous

Plan	Actual	Period
>= 20%	16.7%	Sep-23

Year to Date

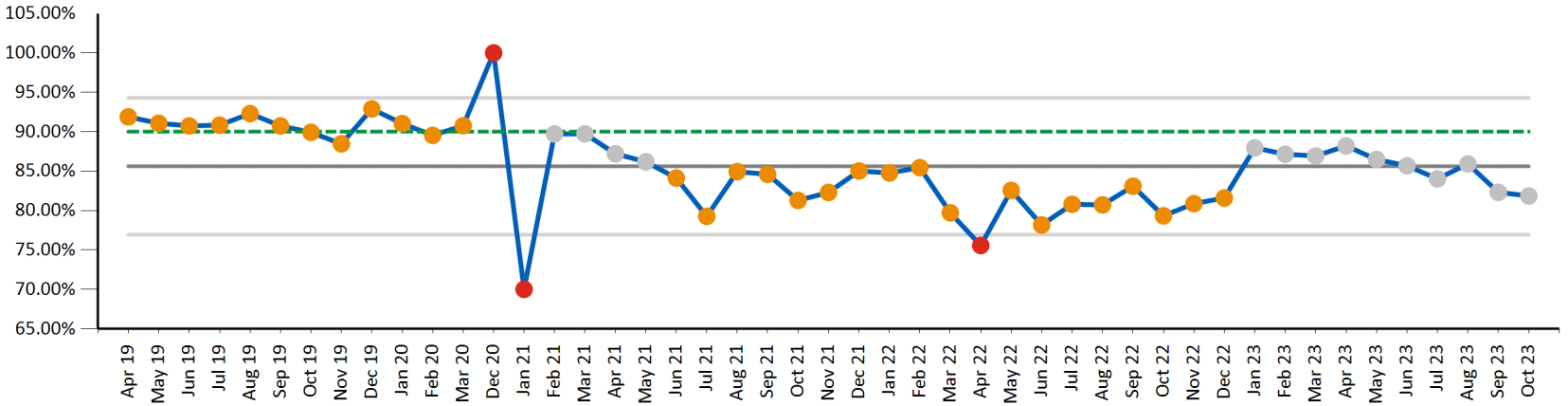
Plan	Actual
>= 20%	17.1%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90%	81.8%	Oct-23

Previous

Plan	Actual	Period
>= 90%	82.3%	Sep-23

Year to Date

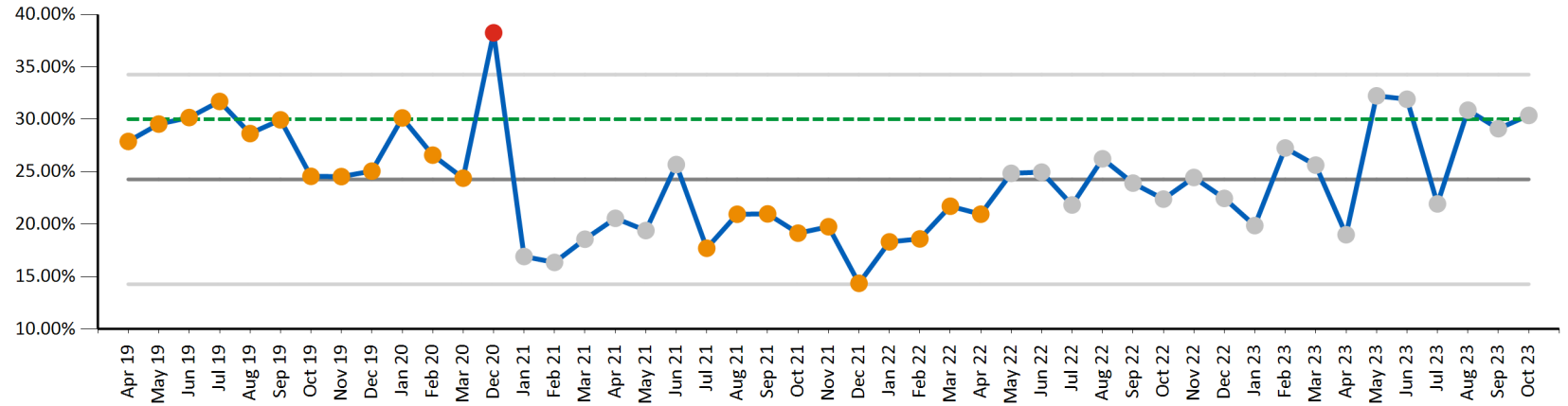
Plan	Actual
>= 90%	85.0%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 30%	30.4%	Oct-23

Previous

Plan	Actual	Period
>= 30%	29.1%	Sep-23

Year to Date

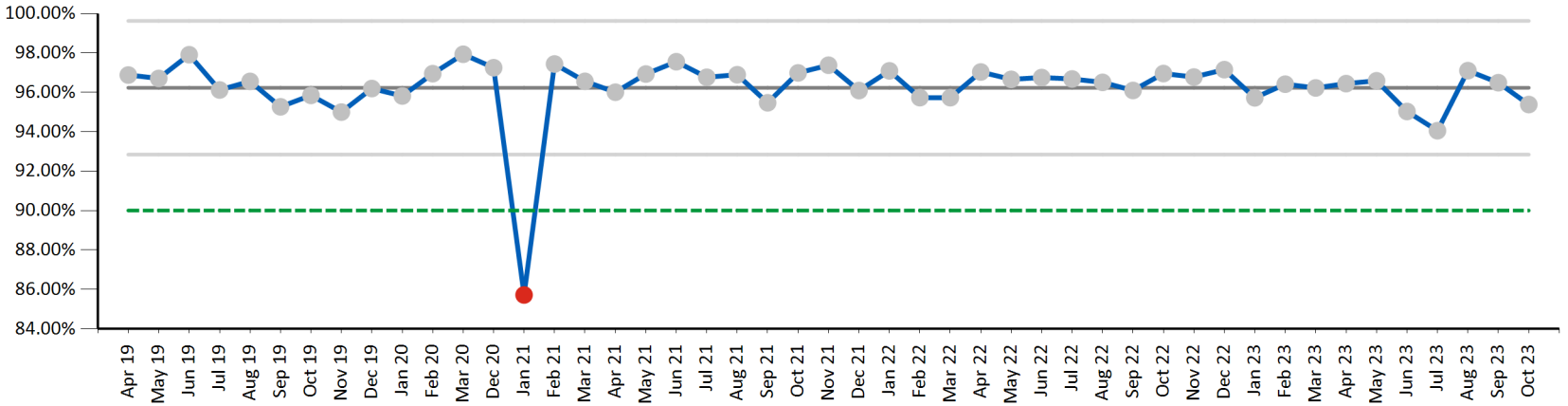
Plan	Actual
>= 30%	28.2%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	95.4%	Oct-23

Previous

Plan	Actual	Period
>= 90%	96.5%	Sep-23

Year to Date

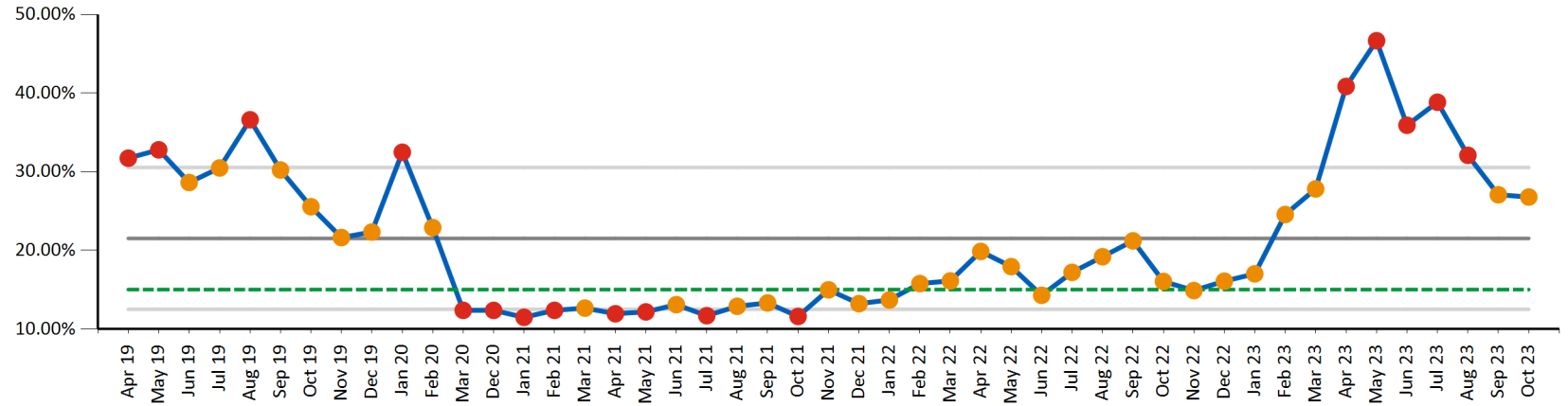
Plan	Actual
>= 90%	95.9%

81 - Maternity Friends and Family Response Rate

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 15%	26.8%	Oct-23

Previous

Plan	Actual	Period
>= 15%	27.1%	Sep-23

Year to Date

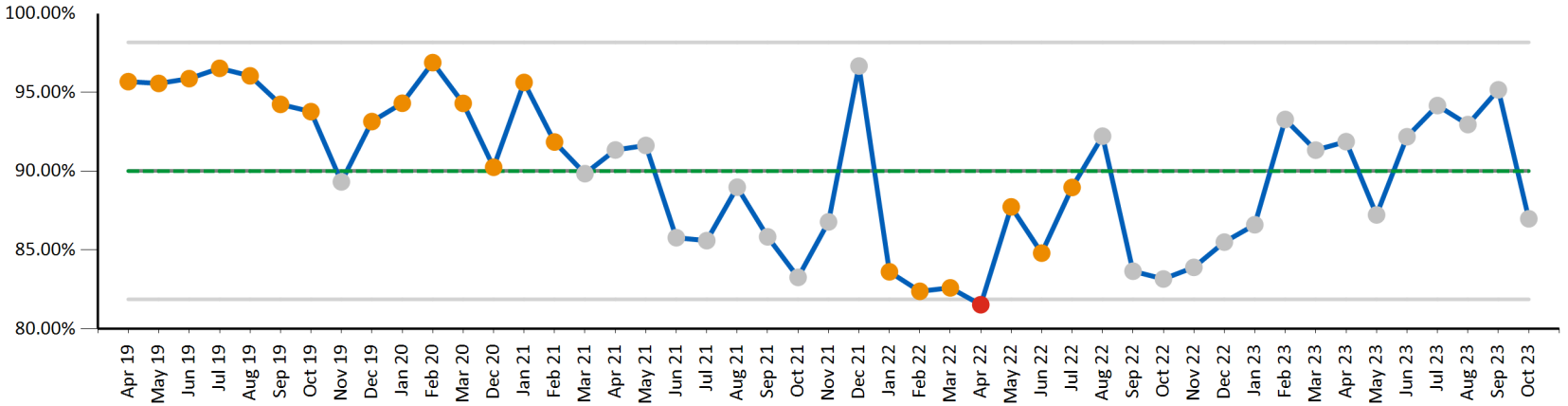
Plan	Actual
>= 15%	35.5%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 90%	87.0%	Oct-23

Previous

Plan	Actual	Period
>= 90%	95.2%	Sep-23

Year to Date

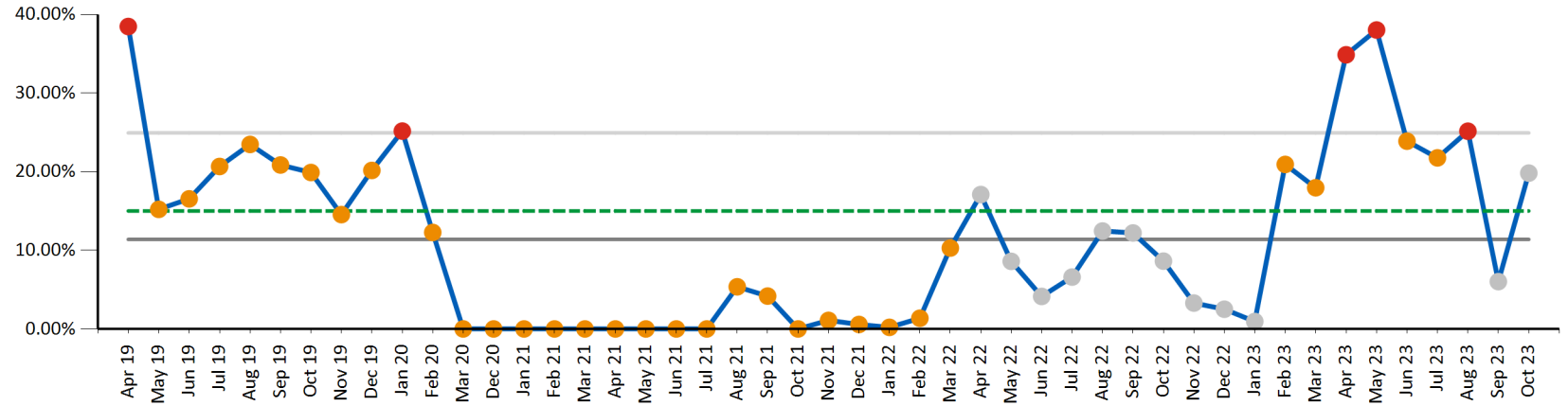
Plan	Actual
>= 90%	91.3%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	19.8%	Oct-23

Previous

Plan	Actual	Period
>= 15%	6.0%	Sep-23

Year to Date

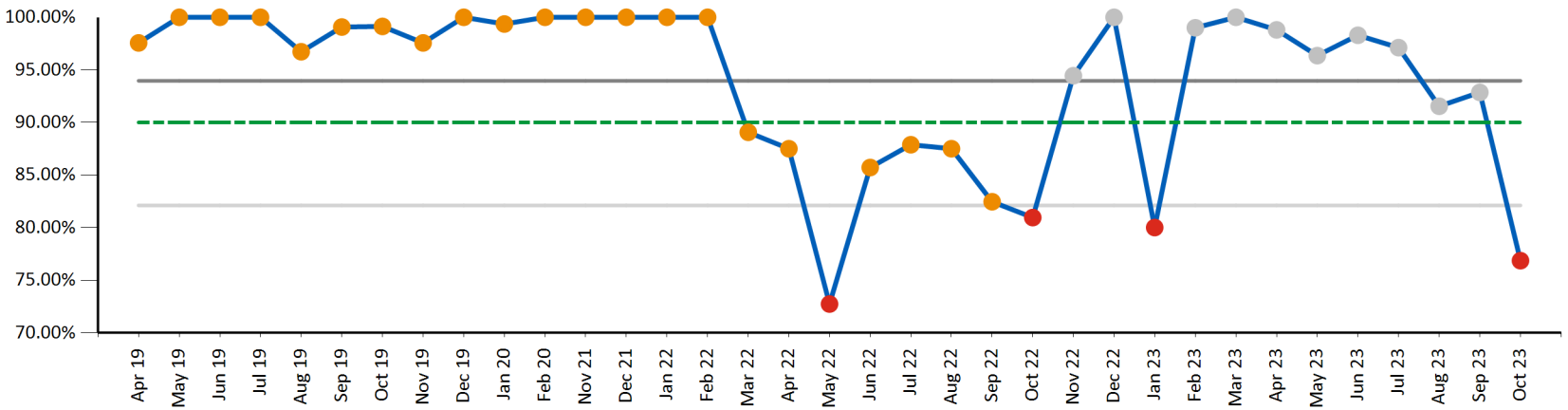
Plan	Actual
>= 15%	24.3%

242 - Antenatal Friends and Family Test - Satisfaction %

Special cause variation with deteriorating performance

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

5/6



Latest

Plan	Actual	Period
>= 90%	76.9%	Oct-23

Previous

Plan	Actual	Period
>= 90%	92.9%	Sep-23

Year to Date

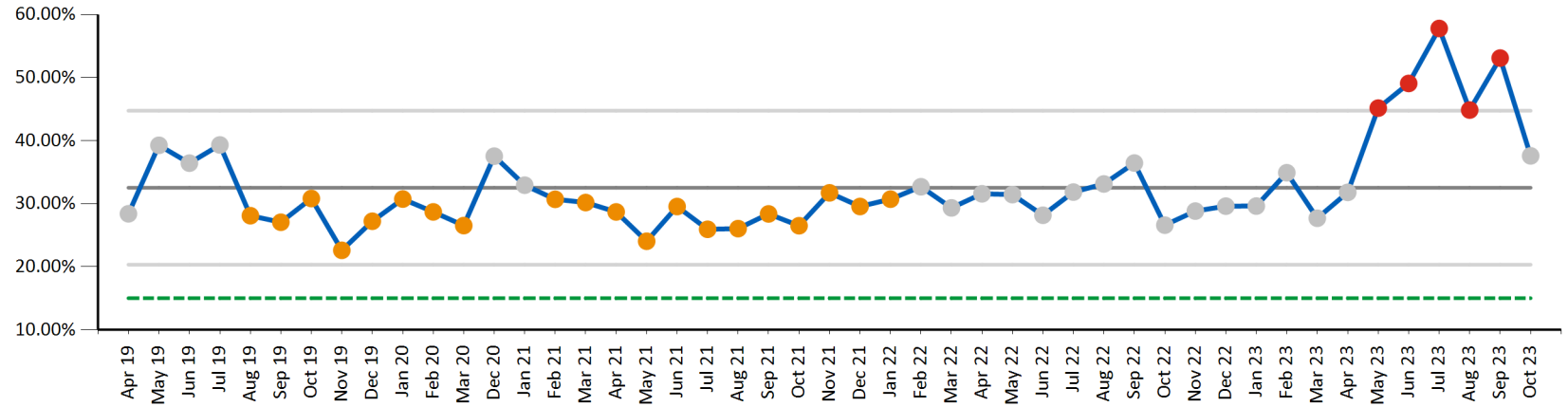
Plan	Actual
>= 90%	93.9%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	37.6%	Oct-23

Previous

Plan	Actual	Period
>= 15%	53.1%	Sep-23

Year to Date

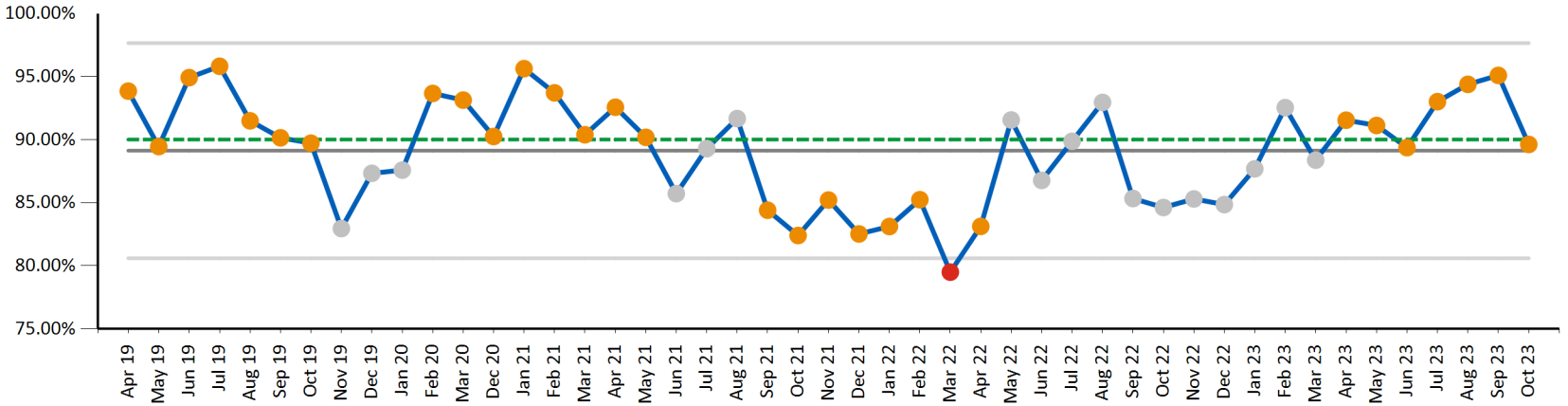
Plan	Actual
>= 15%	45.8%

243 - Birth Friends and Family Test - Satisfaction %

Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
>= 90%	89.6%	Oct-23

Previous

Plan	Actual	Period
>= 90%	95.1%	Sep-23

Year to Date

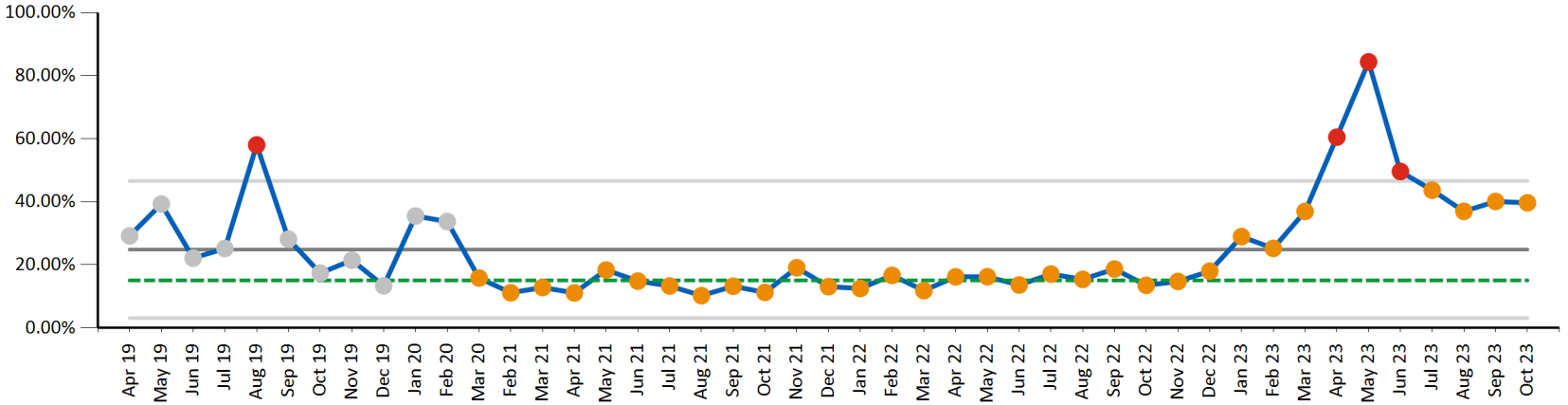
Plan	Actual
>= 90%	92.1%

84 - Hospital Postnatal - Friends and Family Response Rate

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 15%	39.6%	Oct-23

Previous

Plan	Actual	Period
>= 15%	40.1%	Sep-23

Year to Date

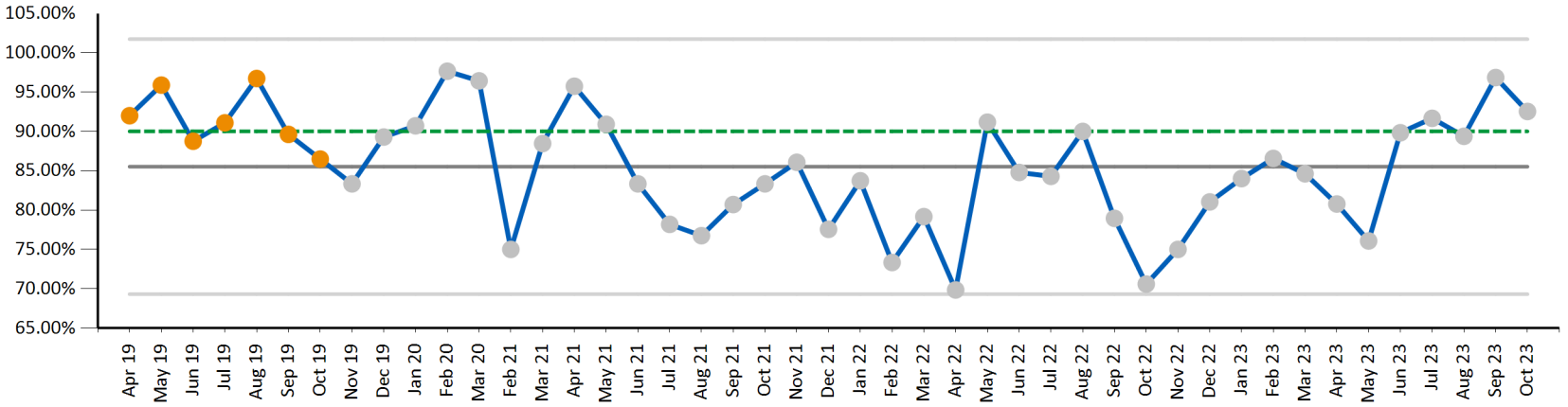
Plan	Actual
>= 15%	50.6%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90%	92.5%	Oct-23

Previous

Plan	Actual	Period
>= 90%	96.9%	Sep-23

Year to Date

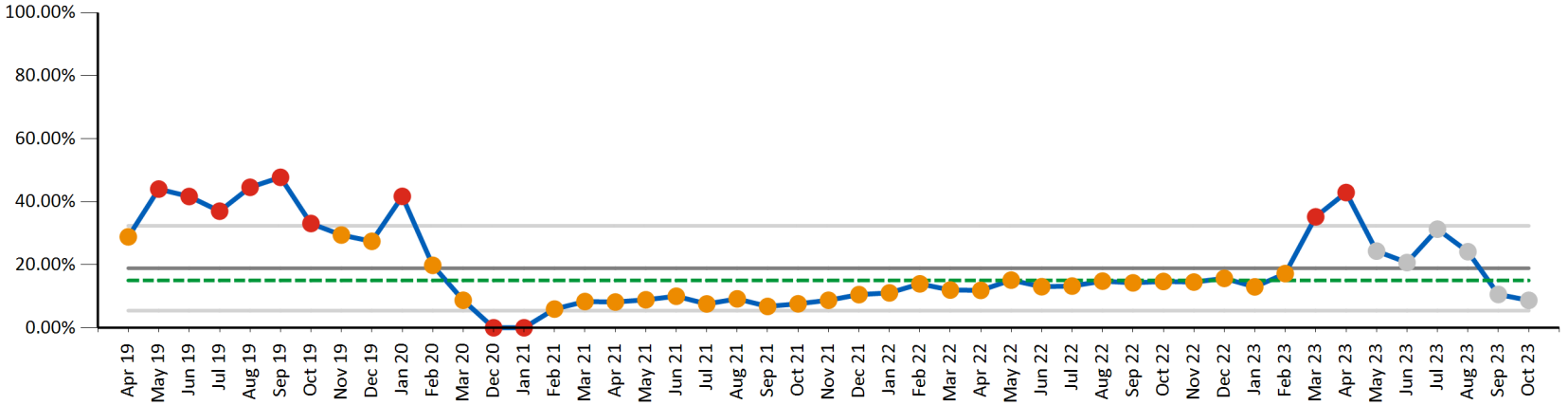
Plan	Actual
>= 90%	86.5%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	8.7%	Oct-23

Previous

Plan	Actual	Period
>= 15%	10.6%	Sep-23

Year to Date

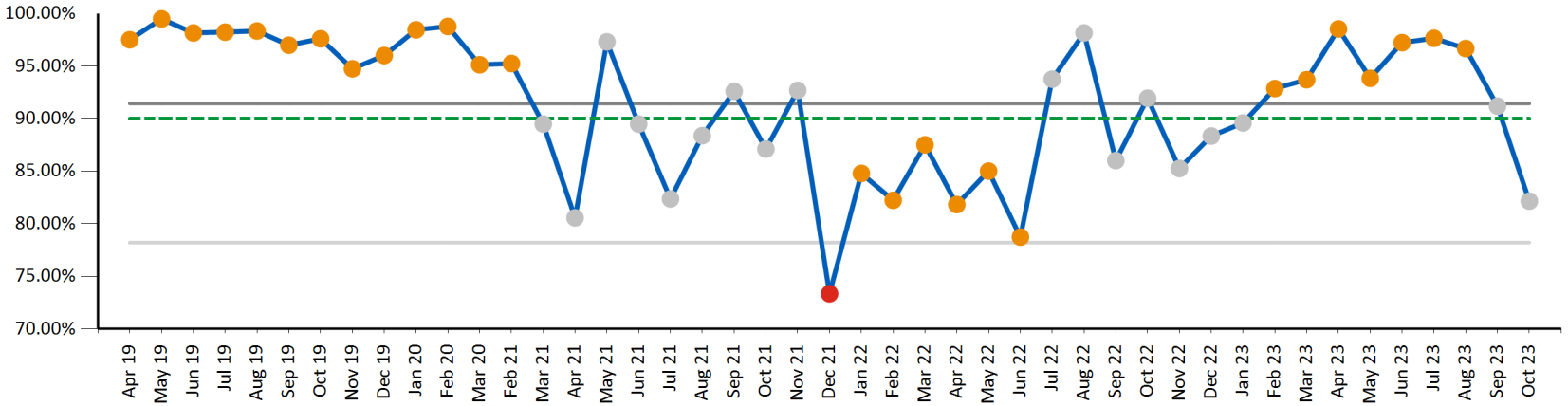
Plan	Actual
>= 15%	23.5%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	82.1%	Oct-23

Previous

Plan	Actual	Period
>= 90%	91.2%	Sep-23

Year to Date

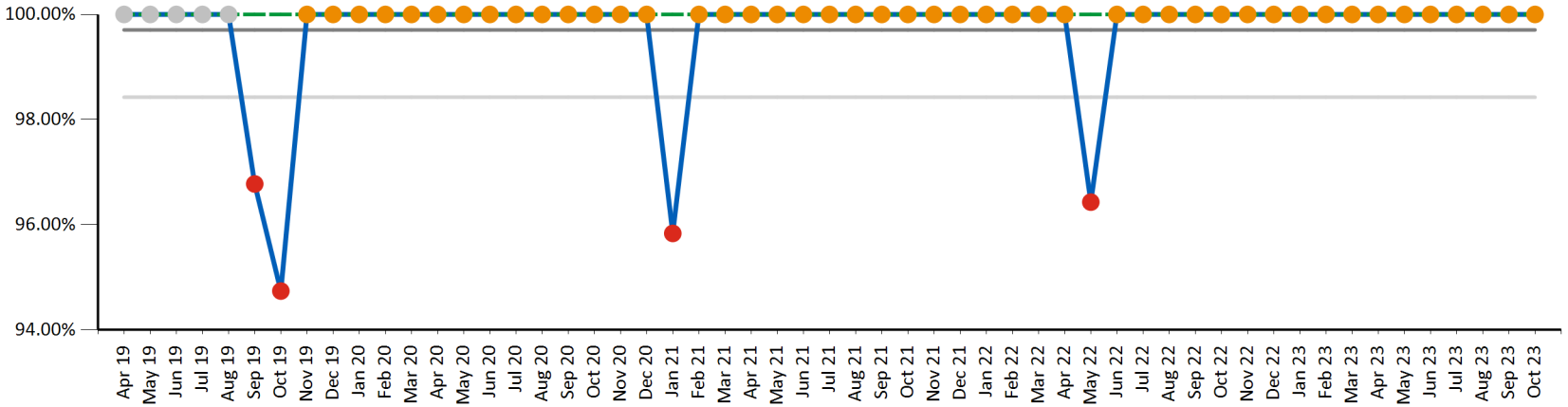
Plan	Actual
>= 90%	96.0%

89 - Formal complaints acknowledged within 3 working days

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Oct-23

Previous

Plan	Actual	Period
= 100%	100.0%	Sep-23

Year to Date

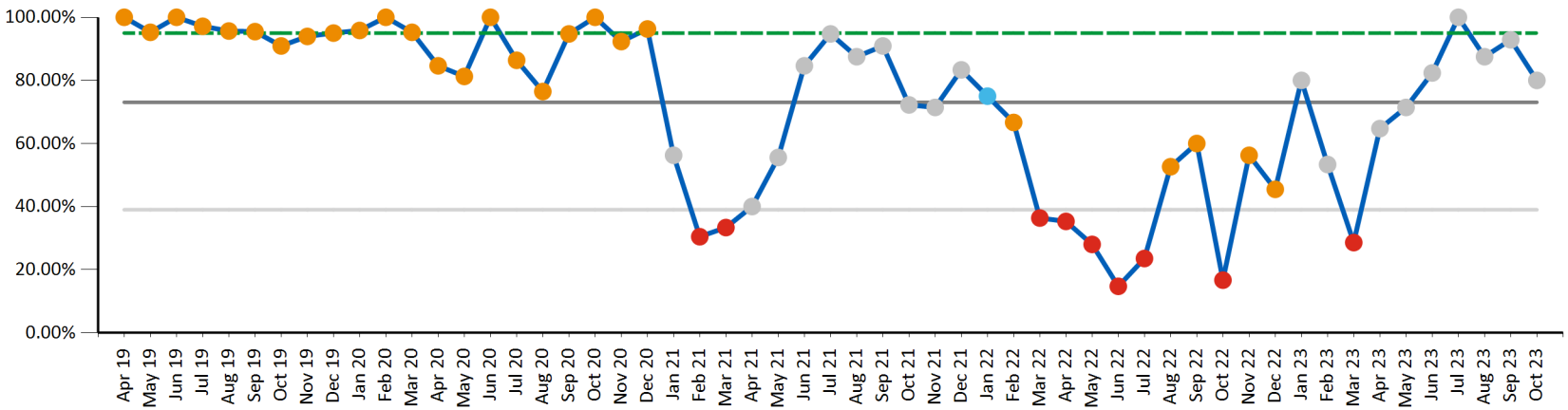
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 95%	80.0%	Oct-23

Previous

Plan	Actual	Period
>= 95%	92.9%	Sep-23

Year to Date

Plan	Actual
>= 95%	81.7%

Quality and Safety - Maternity

NHS Bolton NHS Foundation Trust

81 Friends and Family Response Rate – Stabilisation in the maternity friends and family response rate in month to 26.8% with a slight decrease in satisfaction rate noted (87%). Recovery noted within antenatal care response rate this month and sustained response rate in birth and postnatal areas.

202 - 1:1 care in labour – Trust year to date incidence 89.03% lower than the rolling 12 month Greater Manchester and East Cheshire (GMEC) rate of 93.22% and peer average in similar sized providers (ie Oldham). Recovery plan in place as per CNST requirements. Detailed review of each cases of non-compliance undertaken and summarised in quarterly red flag report for assurance. No breaches of supernumerary status as per CNST classification reported.

23 – ¾ degree tears – Trust year to date incidence 3.41% slightly higher than rolling 12 month GMEC comparator rate of 2.55%. Local relaunch of OASI planned for January 2023 and access granted to OASI implementation toolkit for educators. Q2 audit of compliance delayed as PEF reallocated to support CNST training delivery.

203 – Booked by 12+6 – Continued inconsistent trend in booking performance noted yet GMEC median 82.59% aligns with Trust 12 month rolling rate 87.91%. 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 as newly qualified staff are unable to work in community until induction has been completed with a risk assessment as per Ockenden requirements. Additional specialist staff allocated to support in month from other clinical specialities to reduce ongoing staffing deficit. Rotation of new preceptees being considered to mitigate the staffing gap.

210 – Breastfeeding initiation – Sustained improvement again in performance noted in month to 68.61%. Baby Friendly implementation within service timeframe to be delayed until 2024. Trust year to date incidence 67.75% slightly higher than GMEC 12 months rolling rate of 62.41%.

320 – Preterm birth – Elevated incidence in April 2023 noted on spc chart. Trust 12mths rolling data 9.73% slightly higher than GMEC rolling 12mth rate 9.335% but less than peer Tier 3 comparators Oldham (11.95%) and MFT (10.63%). Recruitment to post of pre-term midwife ongoing.

322 – Maternity Stillbirth Rate – Rate 2.14 per 1000 within month. Trust rolling rate 4.66/per1000 slightly higher than GMEC rolling 12mth rate 4.47/1000 but less than peer comparators Oldham (6.31/1000) and MFT (7.207/1000). Implementation of all of the revised saving babies lives care bundle elements continues as part of CNST year 5 implementation. LMNS review of cases Jan-August 2023 requested and due for submission in December 2023.

	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	2.14	Oct-23		<= 3.50	2.45	Sep-23	<= 3.50	4.93	
23 - Maternity -3rd/4th degree tears	<= 3.5%	5.5%	Oct-23		<= 3.5%	2.2%	Sep-23	<= 3.5%	3.7%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.6%	Oct-23		>= 95.0%	98.6%	Sep-23	>= 95.0%	98.7%	

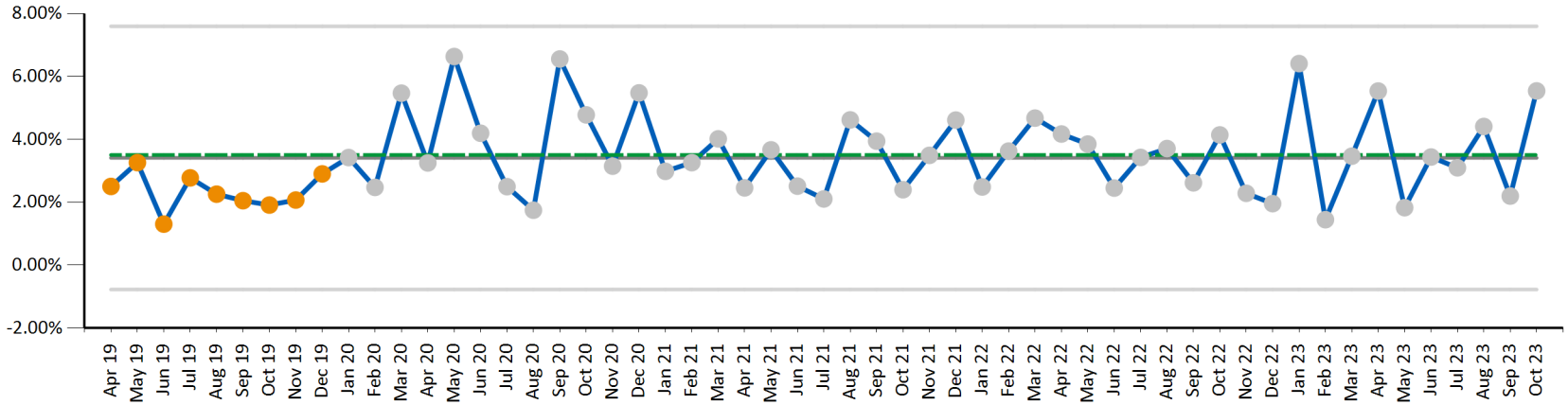
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
203 - Booked 12+6	>= 90.0%	85.9%	Oct-23		>= 90.0%	83.5%	Sep-23	>= 90.0%	87.2%	
204 - Inductions of labour	<= 40%	32.2%	Oct-23		<= 40%	34.0%	Sep-23	<= 40%	35.3%	
210 - Initiation breast feeding	>= 65%	68.61%	Oct-23		>= 65%	68.91%	Sep-23	>= 65%	68.38%	
213 - Maternity complaints	<= 5	1	Oct-23		<= 5	2	Sep-23	<= 35	12	
319 - Maternal deaths (direct)	= 0	0	Oct-23		= 0	0	Sep-23	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.4%	Oct-23		<= 6%	11.0%	Sep-23	<= 6%	10.1%	

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	5.5%	Oct-23

Previous

Plan	Actual	Period
<= 3.5%	2.2%	Sep-23

Year to Date

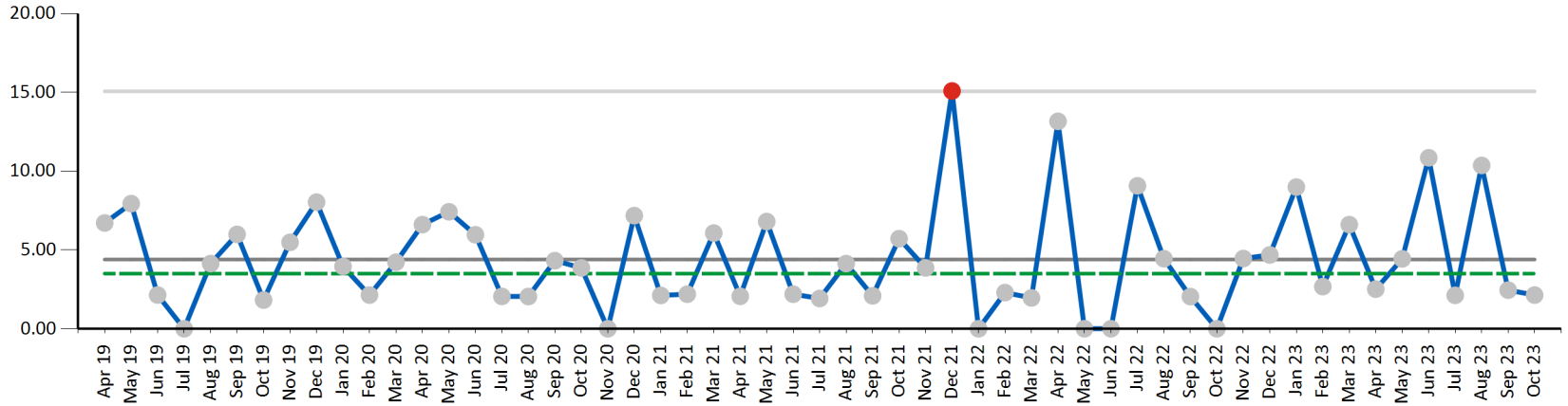
Plan	Actual
<= 3.5%	3.7%

322 - Maternity - Stillbirths per 1000 births

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3.50	2.14	Oct-23

Previous

Plan	Actual	Period
<= 3.50	2.45	Sep-23

Year to Date

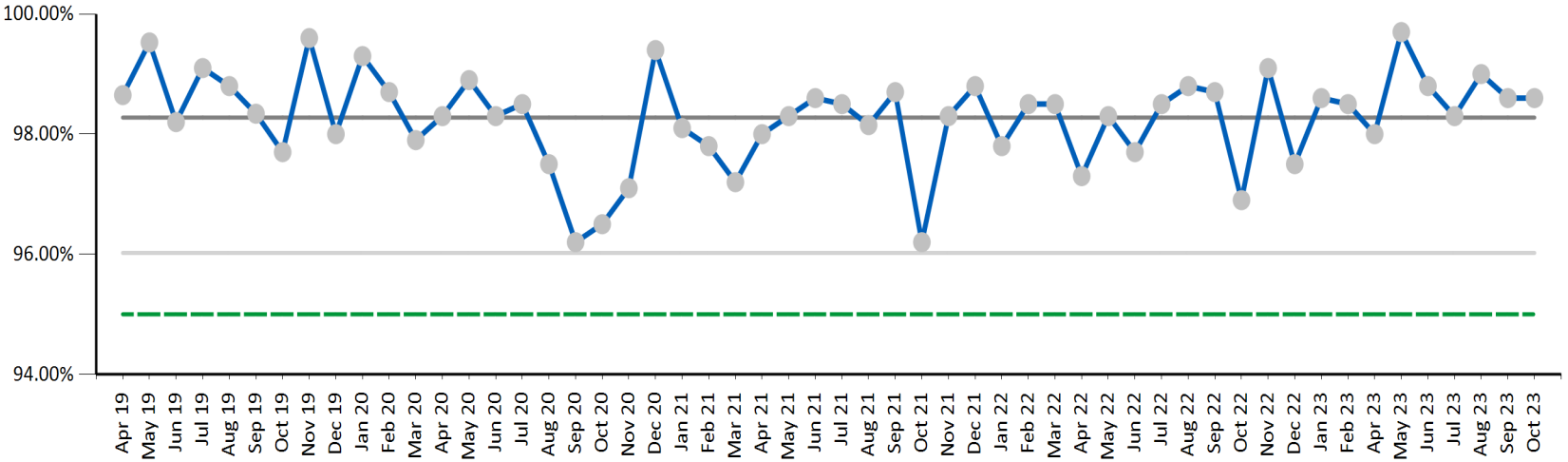
Plan	Actual
<= 3.50	4.93

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	98.6%	Oct-23

Previous

Plan	Actual	Period
>= 95.0%	98.6%	Sep-23

Year to Date

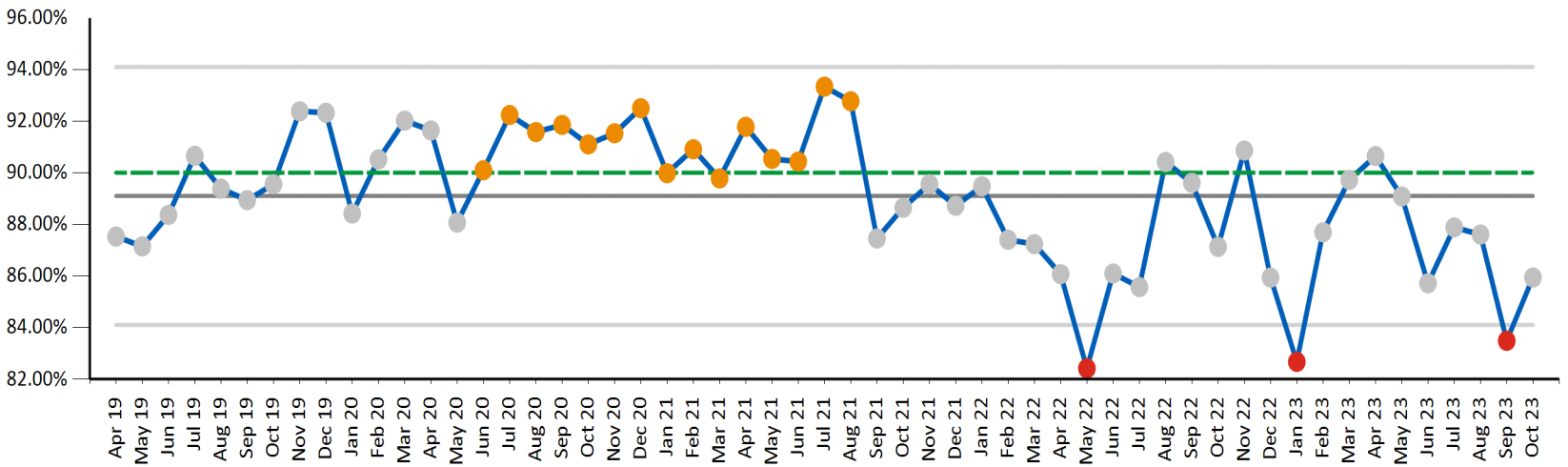
Plan	Actual
>= 95.0%	98.7%

203 - Booked 12+6

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90.0%	85.9%	Oct-23

Previous

Plan	Actual	Period
>= 90.0%	83.5%	Sep-23

Year to Date

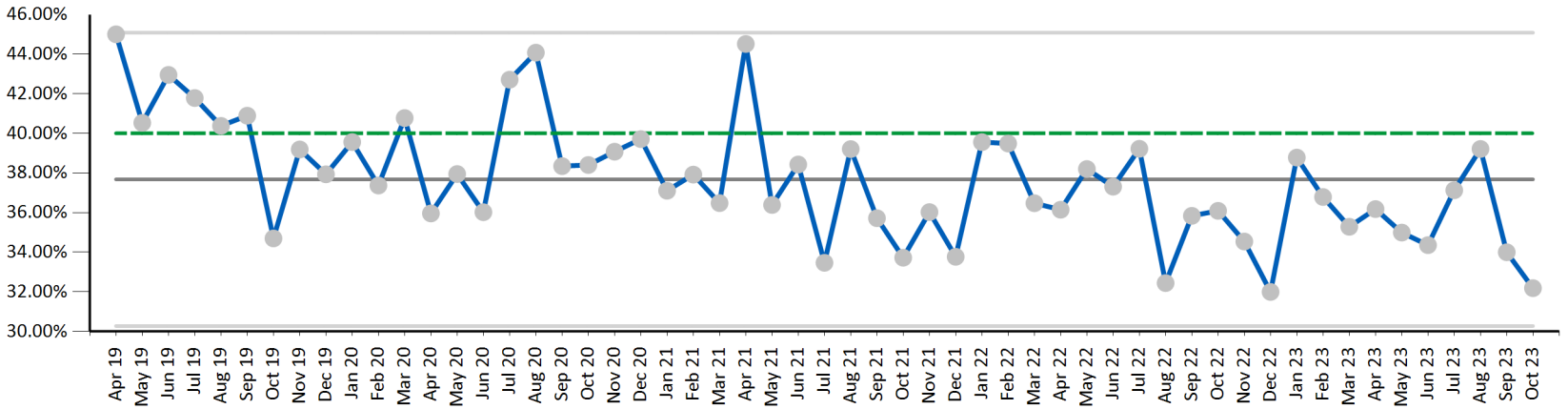
Plan	Actual
>= 90.0%	87.2%

204 - Inductions of labour

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	32.2%	Oct-23

Previous

Plan	Actual	Period
<= 40%	34.0%	Sep-23

Year to Date

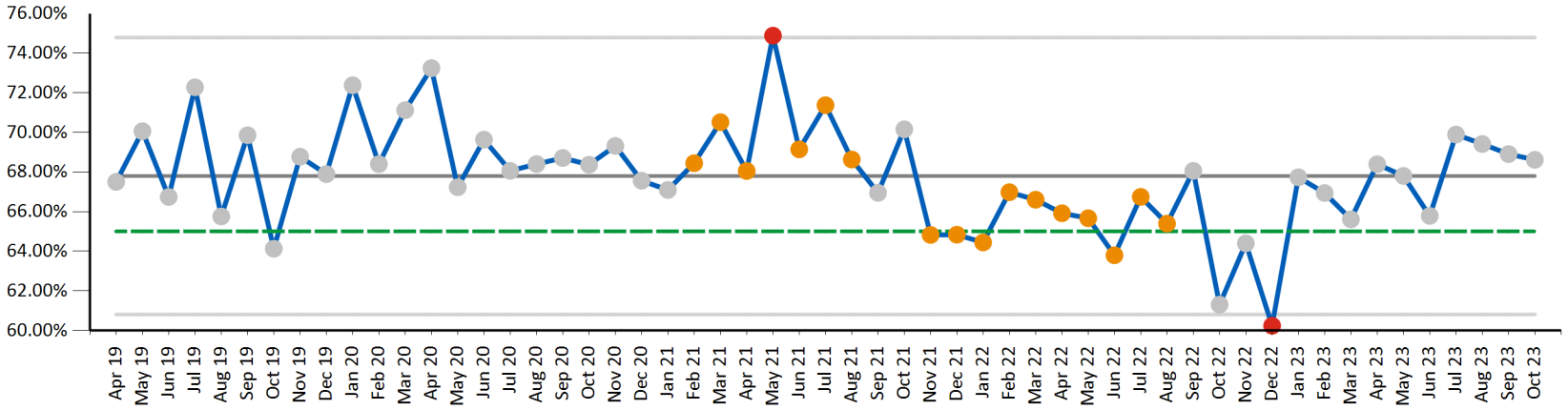
Plan	Actual
<= 40%	35.3%

210 - Initiation breast feeding

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	68.61%	Oct-23

Previous

Plan	Actual	Period
>= 65%	68.91%	Sep-23

Year to Date

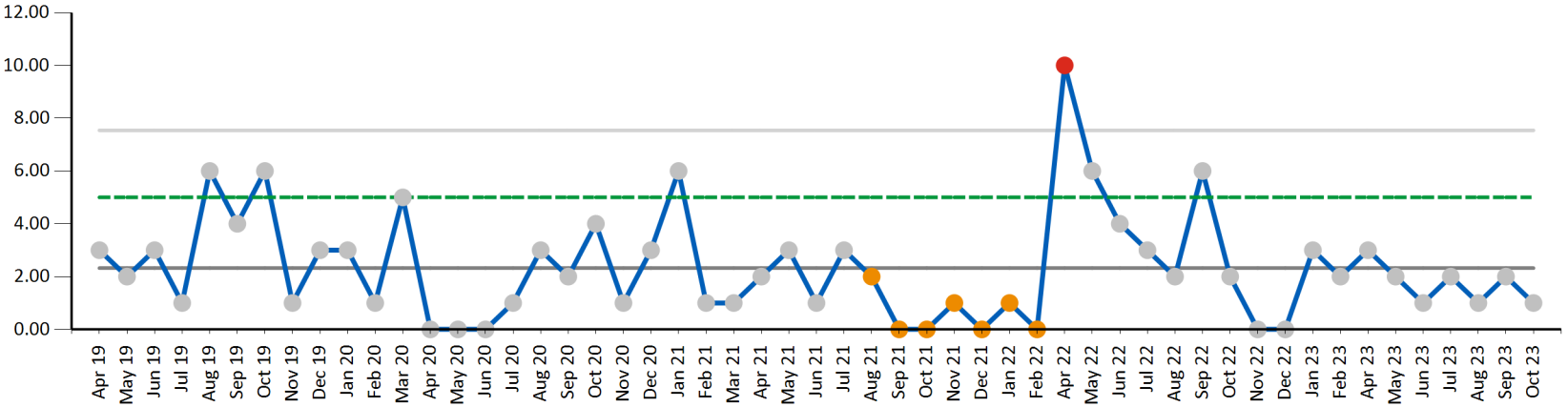
Plan	Actual
>= 65%	68.38%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	1	Oct-23

Previous

Plan	Actual	Period
<= 5	2	Sep-23

Year to Date

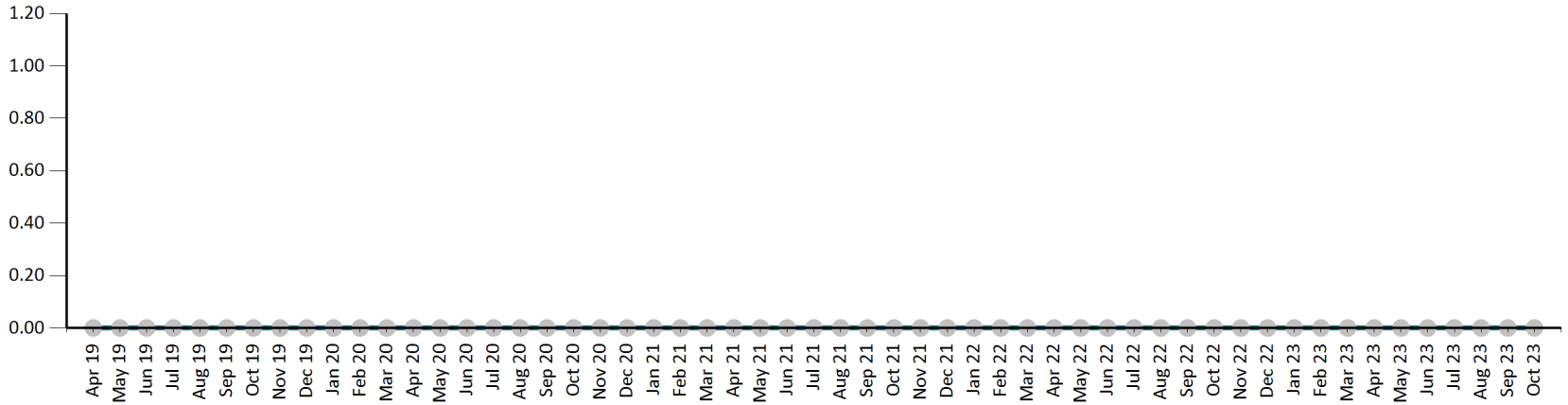
Plan	Actual
<= 35	12

319 - Maternal deaths (direct)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 0	0	Oct-23

Previous

Plan	Actual	Period
= 0	0	Sep-23

Year to Date

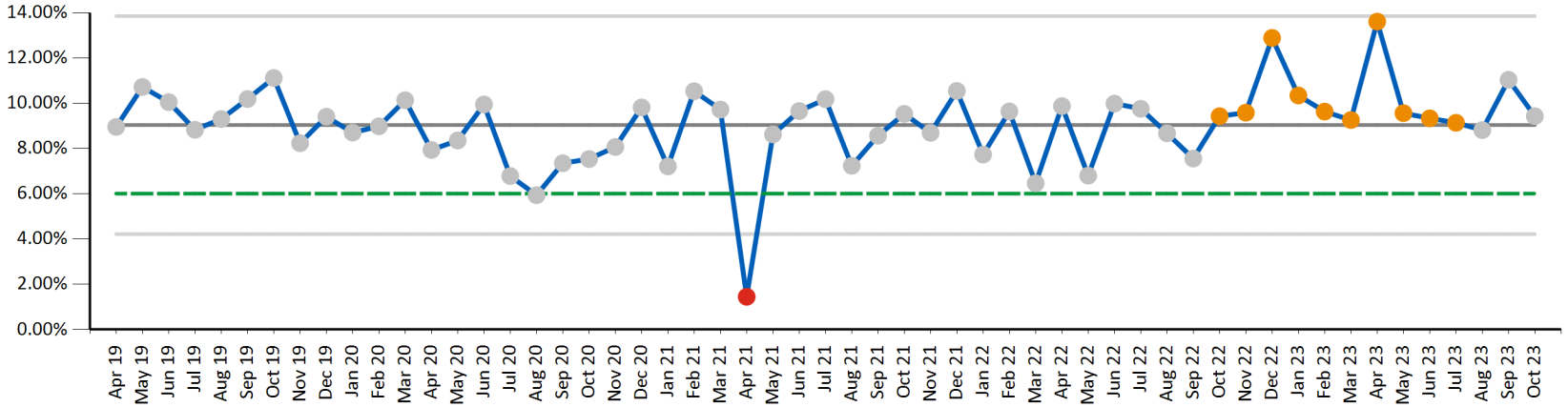
Plan	Actual
= 0	0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6%	9.4%	Oct-23

Previous

Plan	Actual	Period
<= 6%	11.0%	Sep-23

Year to Date

Plan	Actual
<= 6%	10.1%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Emergency Department

Performance remain below the improvement trajectory and represents a 4th consecutive month of decline in performance against the 4 hour standard. Whilst ambulance performance saw a further deterioration in October this is in line with other providers across Greater Manchester and performance remains above the corresponding month in 2022. October also started to see an increase in paediatric attendances and admissions which represented a 4% decline in performance against the previous month. Type 3 performance also saw a reduction of 4% from the previous month though from the 1st November the new Urgent Treatment model has been implemented. The ED medical team are in the process of developing a recovery plan for the time to be seen metric.

In Hospital Flow

Flow during October was challenging across Greater Manchester, in Bolton to ensure that we maintained safe care, a command and control approach was instigated as part of escalation plan to enable us to provide the best possible care and work as a team to reduce the number of patients in hospital. This month the BOSCA standards and associated training was launched, this is an MDT approach to impact on the number of stranded patients and timeliness of discharges.
Virtual ward/hospital at home achieved 80% occupancy meaning more patients are being managed in their own home as an alternative to hospital.

NOF

October's performance for fractured neck of femur reduced to 38.5%. Key reasons for underperformance against the target were a lack of theatre capacity and medical complexity of the patients resulting in necessary delay for optimisation.
An improvement plan is in place, with a deep dive ongoing into the variable performance, including how theatre capacity can be optimised to reflect admission patterns.

	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%	57.7%	Oct-23		>= 75%	60.0%	Sep-23	>= 75%	63.6%	
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	43.3%	Oct-23		>= 65.0%	53.0%	Sep-23	>= 65.0%	55.1%	
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	70.8%	Oct-23		>= 95.0%	80.4%	Sep-23	>= 95.0%	82.1%	
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	84.61%	Oct-23		= 100%	92.55%	Sep-23	= 100%	93.13%	
545 - Percentage of Ambulance handovers - Proportion of patients waiting over 60 minutes		15.4%	Oct-23			7.4%	Sep-23		6.9%	
539 - A&E 12 hour waits	= 0	1,417	Oct-23		= 0	1,192	Sep-23	= 0	8,016	

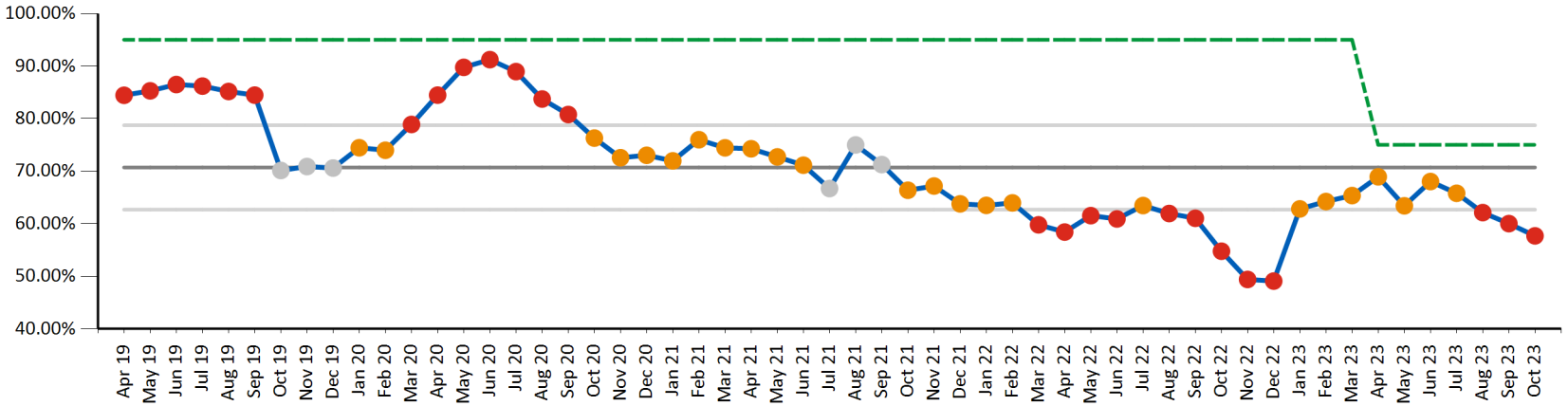
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	38.5%	Oct-23	L	>= 75%	54.8%	Sep-23	>= 75%	57.1%	?
56 - Stranded patients - over 7 days	<= 200	268	Oct-23	H	<= 200	251	Sep-23	<= 200	268	?
307 - Stranded Patients - LOS 21 days and over	<= 69	112	Oct-23	H	<= 69	97	Sep-23	<= 69	112	?
541 - Adult G&A bed occupancy	<= 92.0%	89.9%	Oct-23		<= 92.0%	87.3%	Sep-23	<= 92.0%	86.4%	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.39	Oct-23		<= 3.70	6.15	Sep-23	<= 3.70	6.13	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.0%	Oct-23	L	<= 13.5%	8.7%	Sep-23	<= 13.5%	8.7%	P

53 - A&E 4 hour target

L — Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	57.7%	Oct-23

Previous

Plan	Actual	Period
>= 75%	60.0%	Sep-23

Year to Date

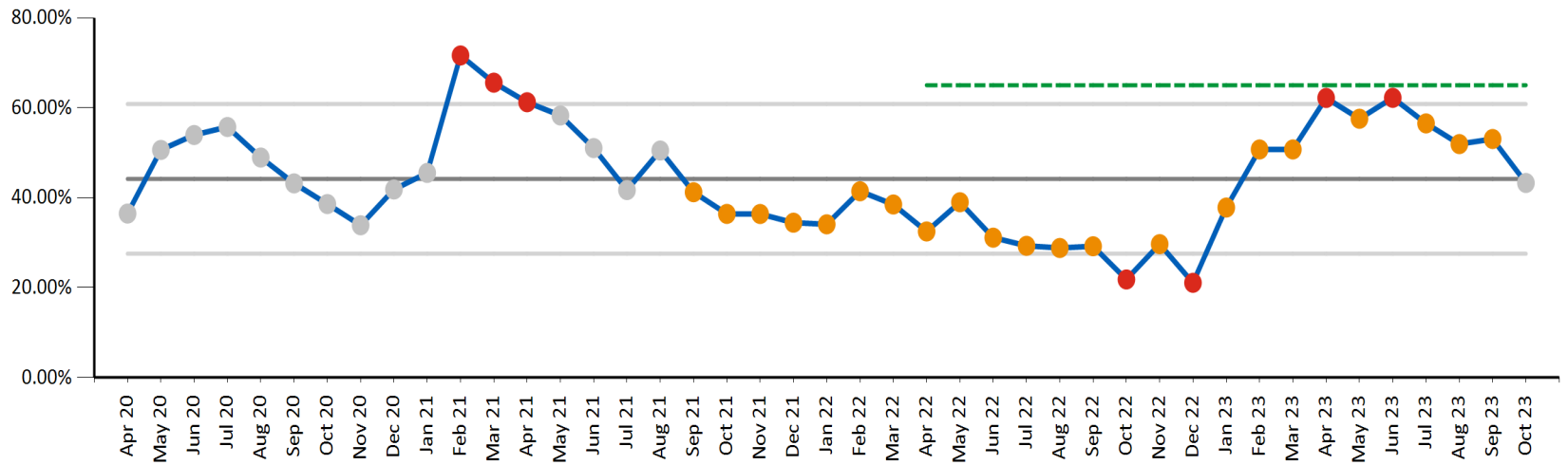
Plan	Actual
>= 75%	63.6%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 65.0%	43.3%	Oct-23

Previous

Plan	Actual	Period
>= 65.0%	53.0%	Sep-23

Year to Date

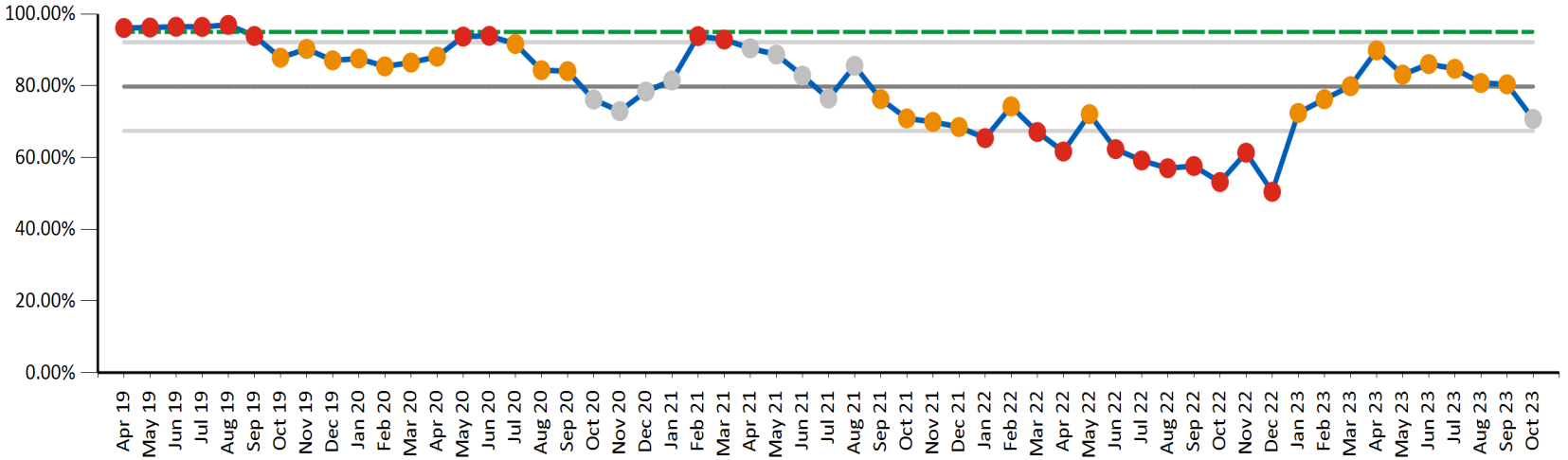
Plan	Actual
>= 65.0%	55.1%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	70.8%	Oct-23

Previous

Plan	Actual	Period
>= 95.0%	80.4%	Sep-23

Year to Date

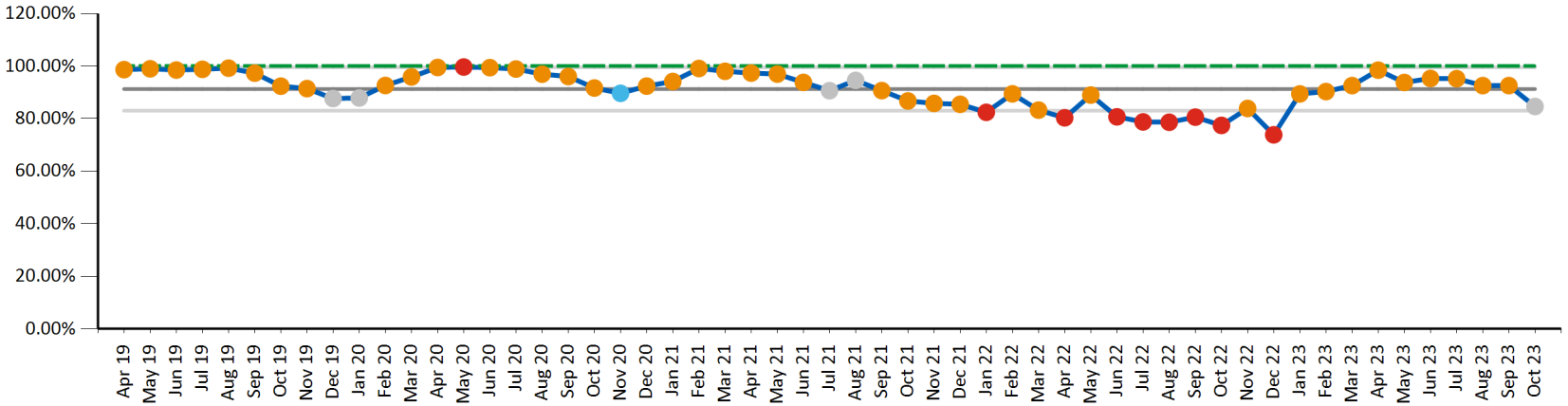
Plan	Actual
>= 95.0%	82.1%

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

Common cause variation.

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	84.61%	Oct-23

Previous

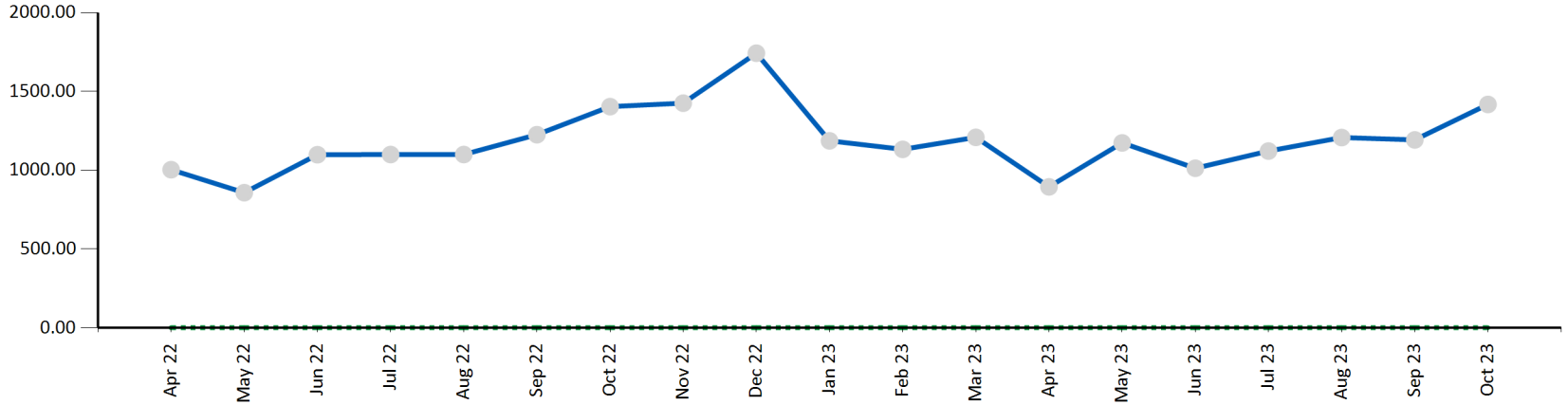
Plan	Actual	Period
= 100%	92.55%	Sep-23

Year to Date

Plan	Actual
= 100%	93.13%

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

0/6



Latest

Plan	Actual	Period
= 0	1,417	Oct-23

Previous

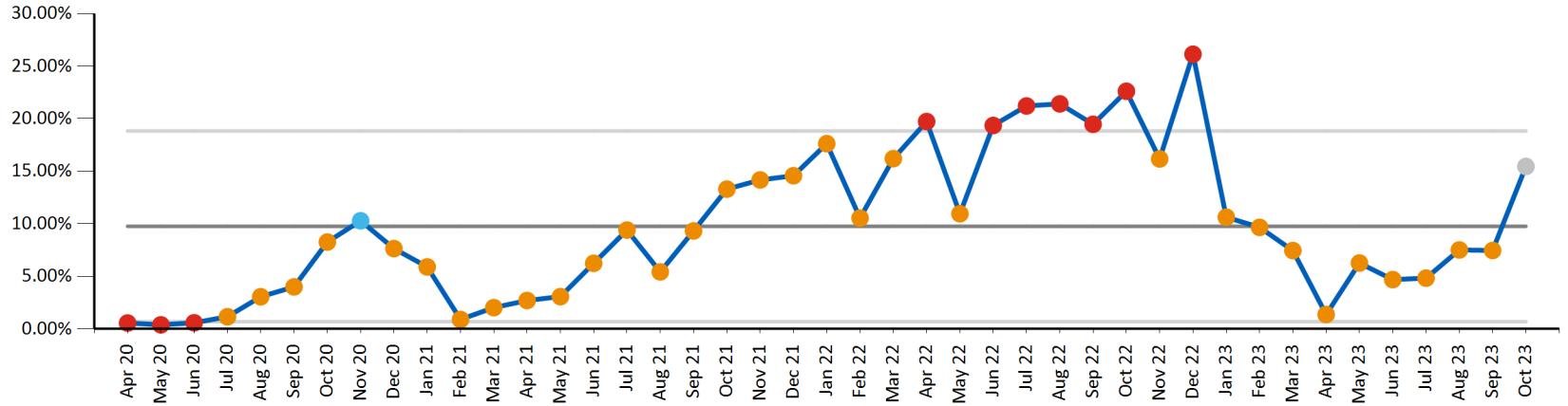
Plan	Actual	Period
= 0	1,192	Sep-23

Year to Date

Plan	Actual
0	8,016

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

Common cause variation.



Latest

Plan	Actual	Period
	15.4%	Oct-23

Previous

Plan	Actual	Period
	7.4%	Sep-23

Year to Date

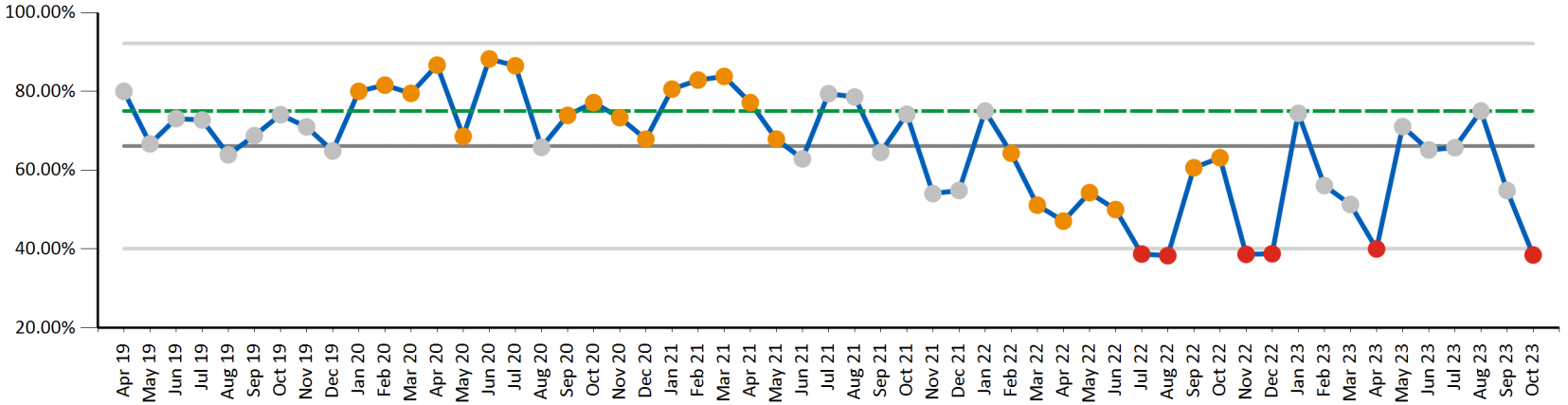
Plan	Actual
	6.9%

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

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
>= 75%	38.5%	Oct-23

Previous

Plan	Actual	Period
>= 75%	54.8%	Sep-23

Year to Date

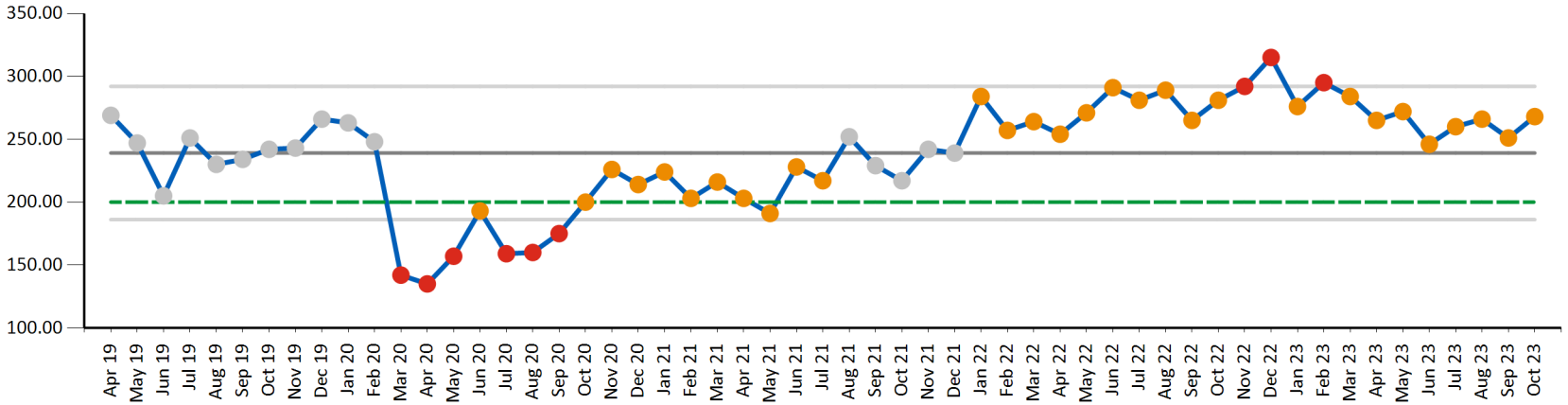
Plan	Actual
>= 75%	57.1%

56 - Stranded patients - over 7 days

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 200	268	Oct-23

Previous

Plan	Actual	Period
<= 200	251	Sep-23

Year to Date

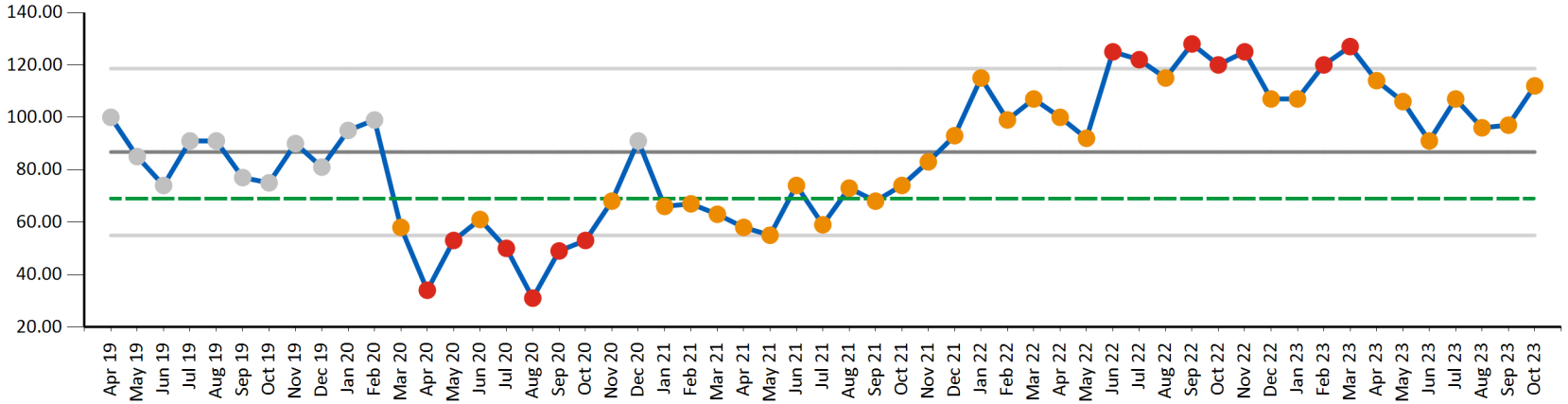
Plan	Actual
<= 200	268

307 - Stranded Patients - LOS 21 days and over

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 69	112	Oct-23

Previous

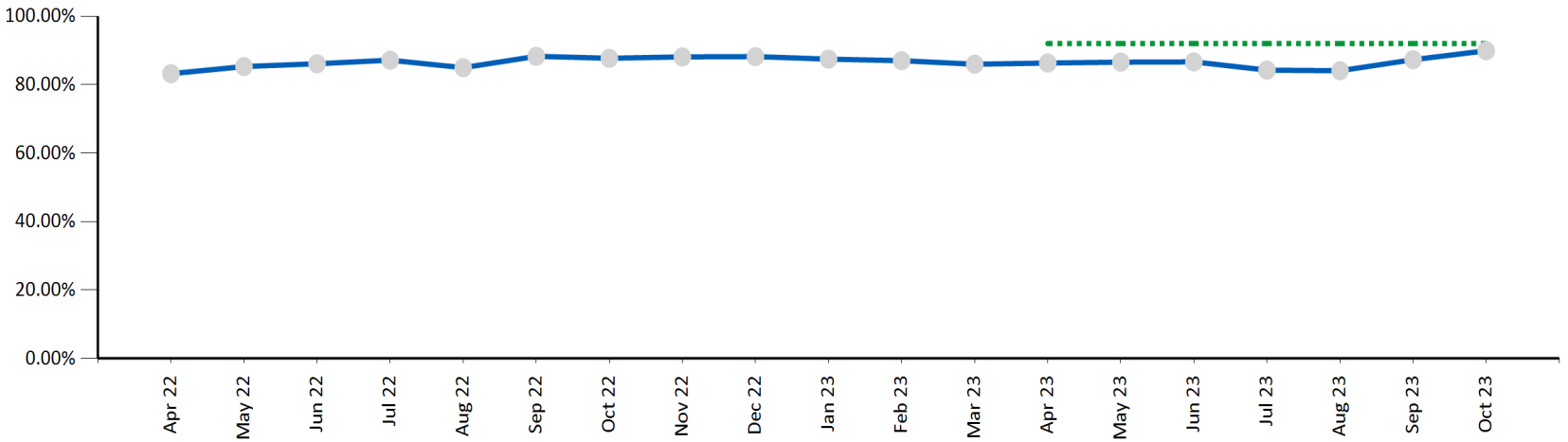
Plan	Actual	Period
<= 69	97	Sep-23

Year to Date

Plan	Actual
<= 69	112

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

6/6



Latest

Plan	Actual	Period
< = 92.0%	89.9%	Oct-23

Previous

Plan	Actual	Period
< = 92.0%	87.3%	Sep-23

Year to Date

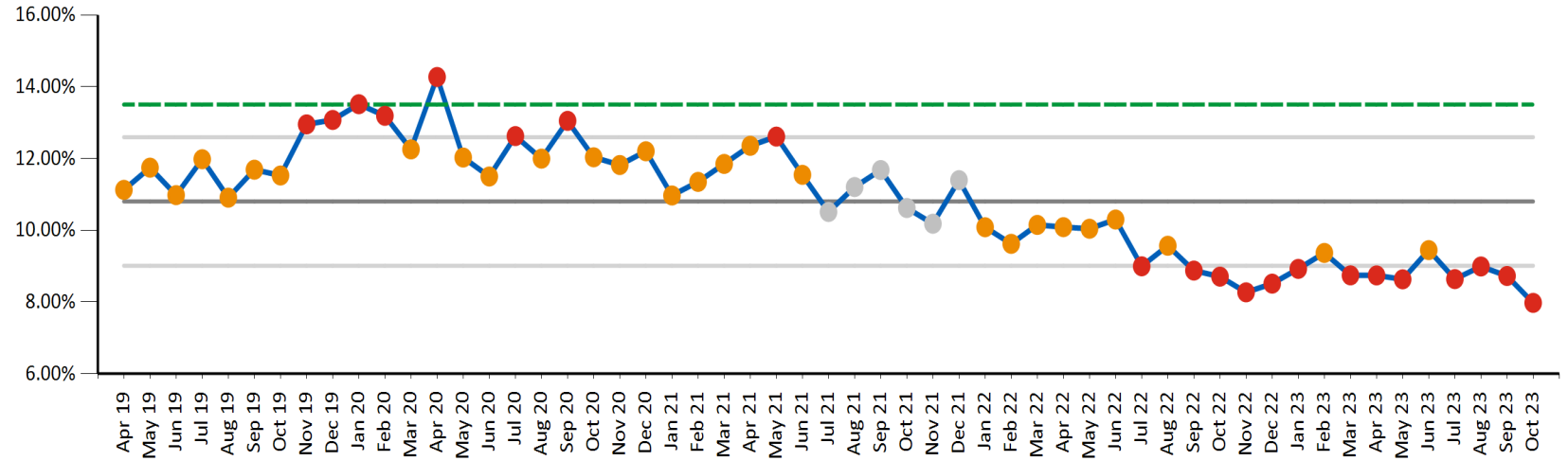
Plan	Actual
0.92	86.4%

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

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
< = 13.5%	8.0%	Oct-23

Previous

Plan	Actual	Period
< = 13.5%	8.7%	Sep-23

Year to Date

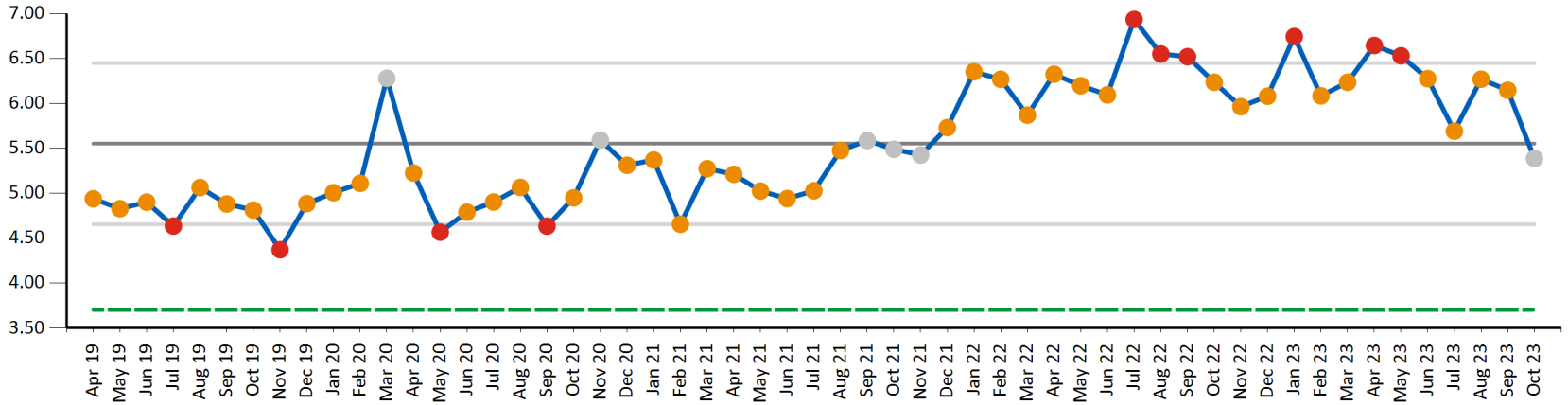
Plan	Actual
< = 13.5%	8.7%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	5.39	Oct-23

Previous

Plan	Actual	Period
<= 3.70	6.15	Sep-23

Year to Date

Plan	Actual
<= 3.70	6.13

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We continue to see the total waiting list increase and this is significantly above plan. Using a scenario where we see no further industrial action for the remainder of 2023/24, we expect to see this stabilise, but we will not be able to recover this to achieve the year end planned position.

We finished September with 47 patients having experienced a wait of longer than 78 weeks. Reasons for these breaches includes clinical complexity, patient choice to delay treatment, corneal graft tissue availability and capacity in Paediatric Surgery. A plan is in place with MFT to increase paediatric surgical capacity, but it is anticipated that the Paediatric Surgery position will deteriorate into December due to the Paediatric Winter Pressures.

We have seen an increase in the number of patients experiencing a wait longer than 65 weeks for the 6th consecutive month and this is above our submitted plan. Our forecasted number of patients breaching 65 weeks at the end of March 2024 does continue to reduce however, which is due to efforts being undertaken to book and treat these patients before year end. We do now though have low degrees of confidence that we will get sufficient mutual aid to reduce this number to zero and are predicting that we will have circa 700 patients remaining.

Diagnostics

The trust position has improved this month by a significant 5.3%, taking performance to 12%. The trust has seen a decrease in the volume on the waiting list by 137, and there were 178 fewer people waiting over 6 weeks. Cystoscopy, Cardiology and Urodynamics are now the main pathways requiring further recovery work and plans are in place to support this, in month improvement of 10.8% for Cardiology & 9.1% for Urodynamics. We remain on track to recover diagnostic performance by the end March 2024, which is ahead of the nationally set recovery milestone.

	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%	53.9%	Oct-23		>= 92%	55.0%	Sep-23	>= 92%	57.8%	
314 - RTT 18 week waiting list	<= 28,364	43,982	Oct-23		<= 28,514	44,204	Sep-23	<= 28,364	43,982	
42 - RTT 52 week waits (incomplete pathways)		2,514	Oct-23			2,459	Sep-23		15,614	
540 - RTT 65 week waits (incomplete pathways)	<= 706	735	Oct-23		<= 687	728	Sep-23	<= 4,505	4,314	
526 - RTT 78 week waits (incomplete pathways)	= 0	48	Oct-23		= 0	38	Sep-23	= 0	235	
527 - RTT 104 week waits (incomplete pathways)	= 0	1	Oct-23		= 0	1	Sep-23	= 0	3	
72 - Diagnostic Waits >6 weeks %	<= 5%	12.9%	Oct-23		<= 5%	17.3%	Sep-23	<= 5%	17.6%	

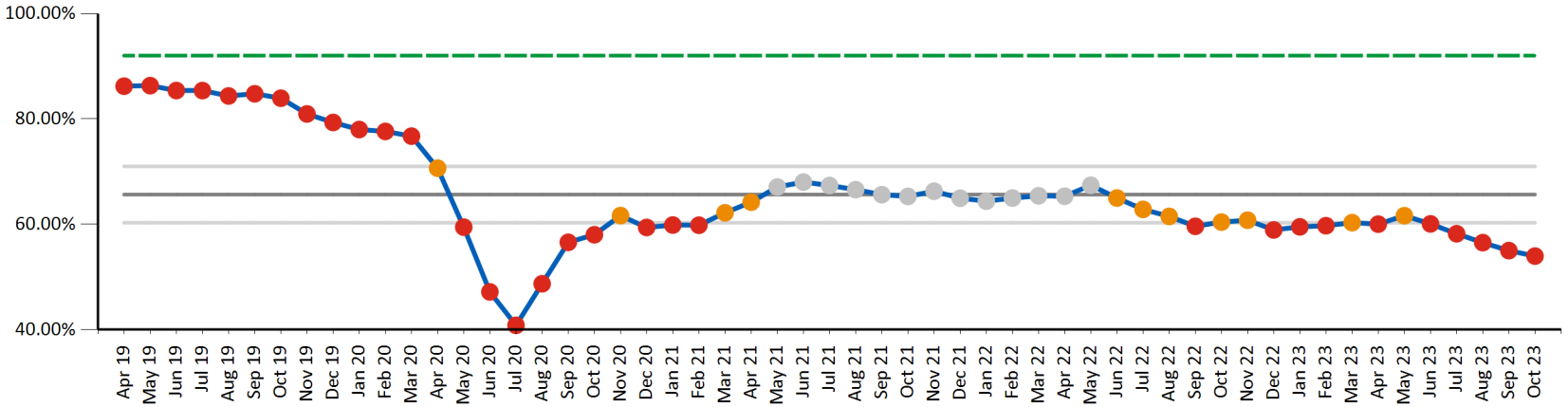
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
489 - Daycase Rates	>= 85%	84.0%	Oct-23	H	>= 85%	85.2%	Sep-23	>= 85%	84.8%	?
582 - Theatre Utilisation - Capped		78.3%	Oct-23			74.6%	Sep-23		74.8%	
583 - Theatre Utilisation - Uncapped		82.1%	Oct-23			80.2%	Sep-23		79.9%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.8%	Oct-23		<= 1%	1.9%	Sep-23	<= 1%	1.6%	?
62 - Cancelled operations re-booked within 28 days	= 100%	61.9%	Sep-23		= 100%	85.7%	Aug-23	= 100%	31.0%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.78	Oct-23		<= 2.00	2.78	Sep-23	<= 2.00	2.95	?
309 - DNA Rate - New	<= 6.3%	9.7%	Oct-23	H	<= 6.3%	9.5%	Sep-23	<= 6.3%	9.8%	F
310 - DNA Rate - Follow up	<= 5.0%	9.0%	Oct-23		<= 5.0%	8.9%	Sep-23	<= 5.0%	9.2%	F

41 - RTT Incomplete pathways within 18 weeks %

L Special cause variation with deteriorating performance

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	53.9%	Oct-23

Previous

Plan	Actual	Period
>= 92%	55.0%	Sep-23

Year to Date

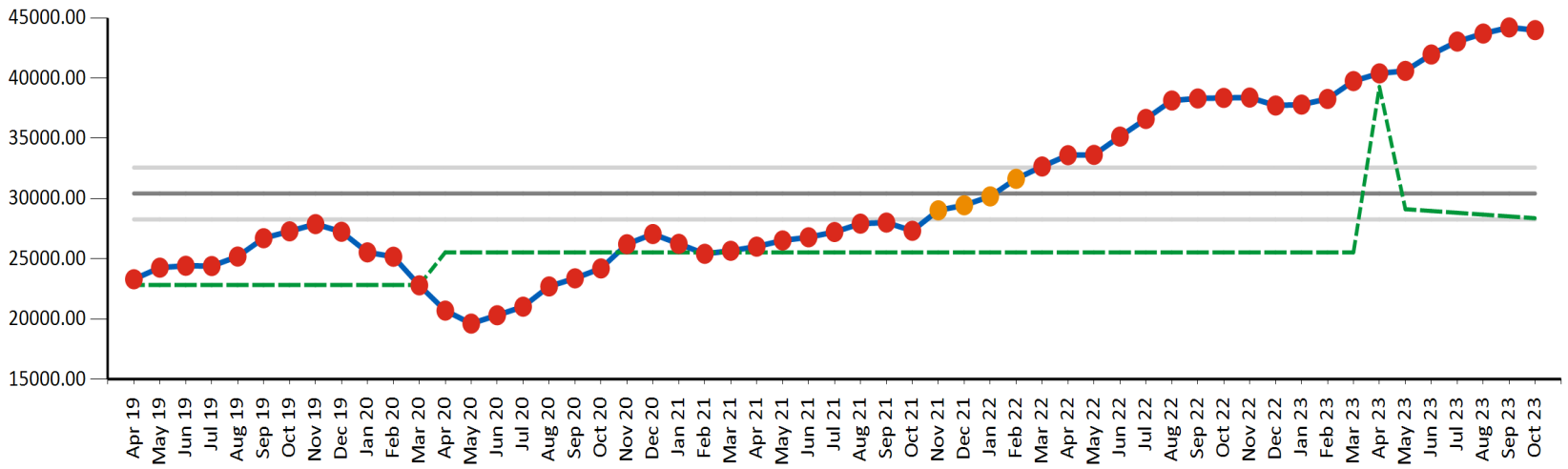
Plan	Actual
>= 92%	57.8%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 28,364	43,982	Oct-23

Previous

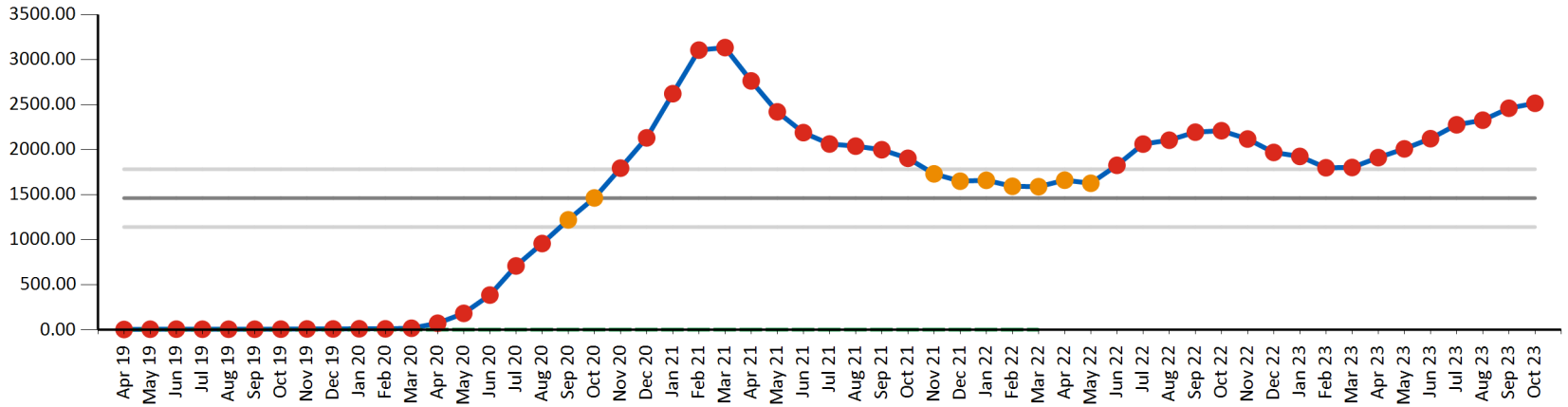
Plan	Actual	Period
<= 28,514	44,204	Sep-23

Year to Date

Plan	Actual
<= 28,364	43,982

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	2,514	Oct-23

Previous

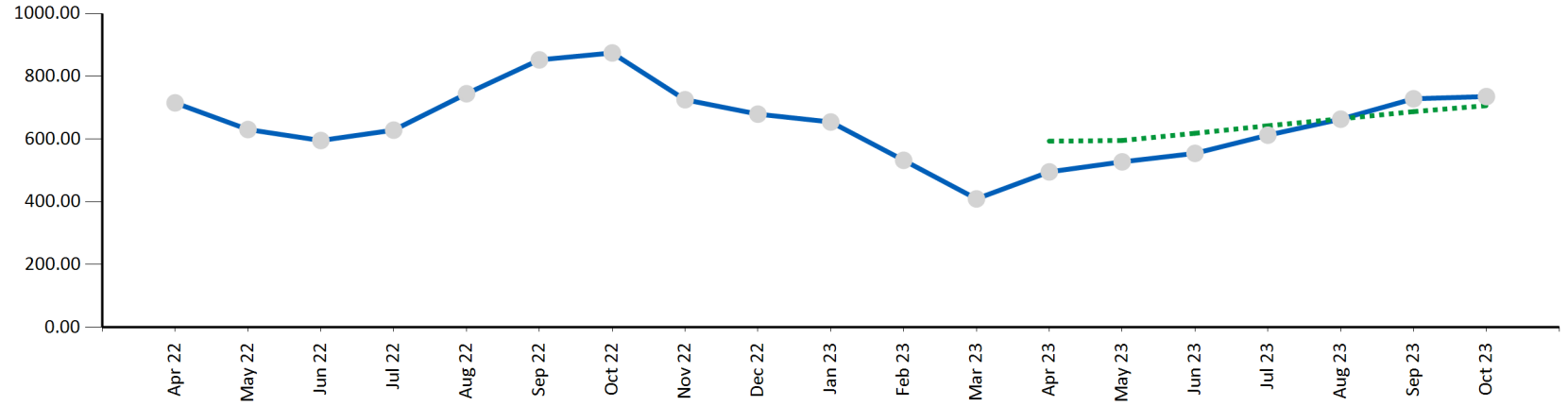
Plan	Actual	Period
	2,459	Sep-23

Year to Date

Plan	Actual
	15,614

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

4/6



Latest

Plan	Actual	Period
<= 706	735	Oct-23

Previous

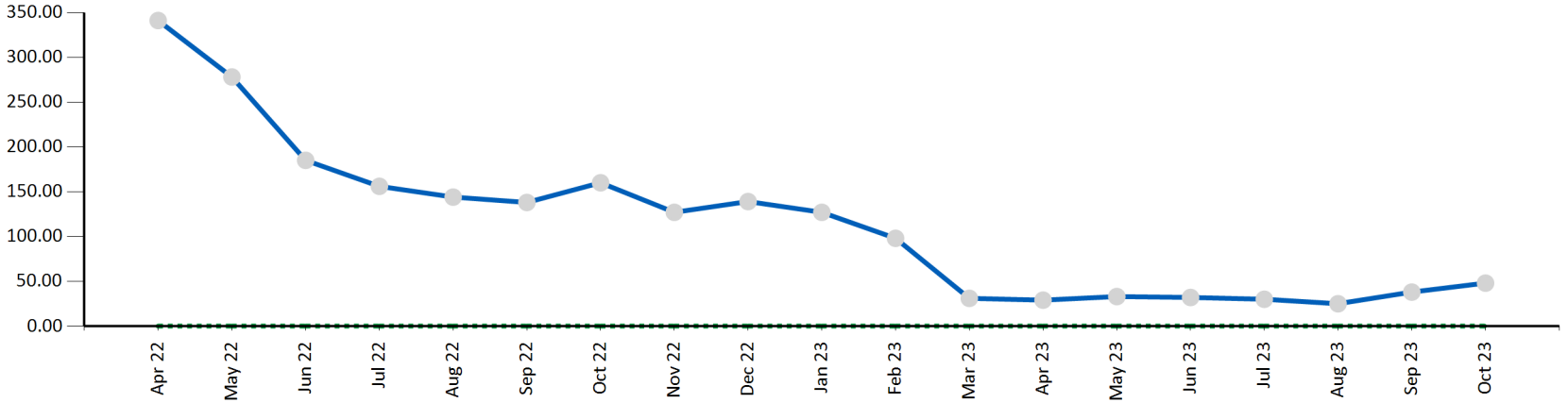
Plan	Actual	Period
<= 687	728	Sep-23

Year to Date

Plan	Actual
4505	4,314

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

0/6



Latest

Plan	Actual	Period
= 0	48	Oct-23

Previous

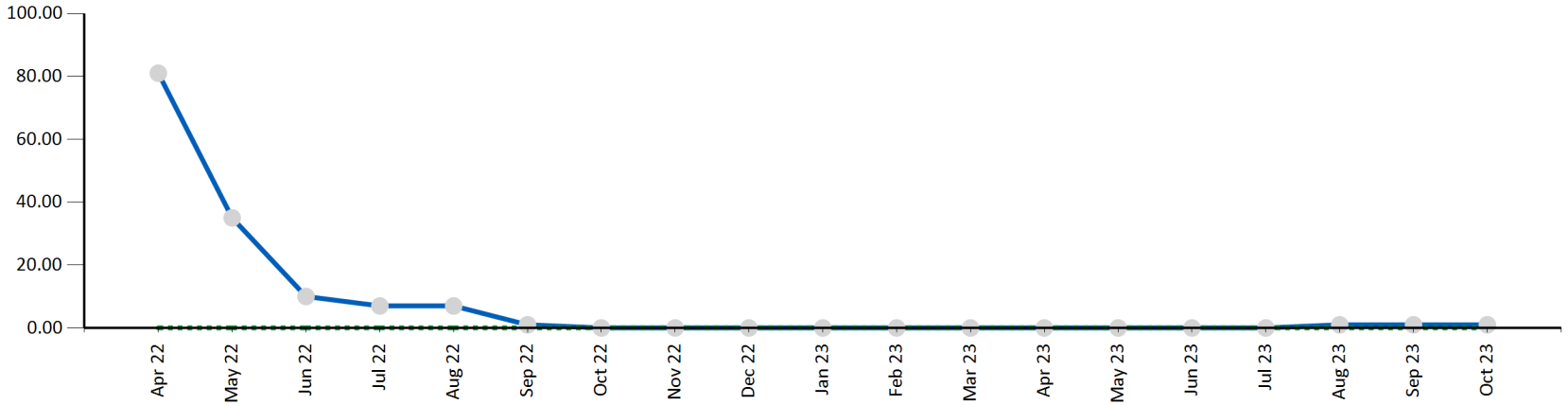
Plan	Actual	Period
= 0	38	Sep-23

Year to Date

Plan	Actual
0	235

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

3/6



Latest

Plan	Actual	Period
= 0	1	Oct-23

Previous

Plan	Actual	Period
= 0	1	Sep-23

Year to Date

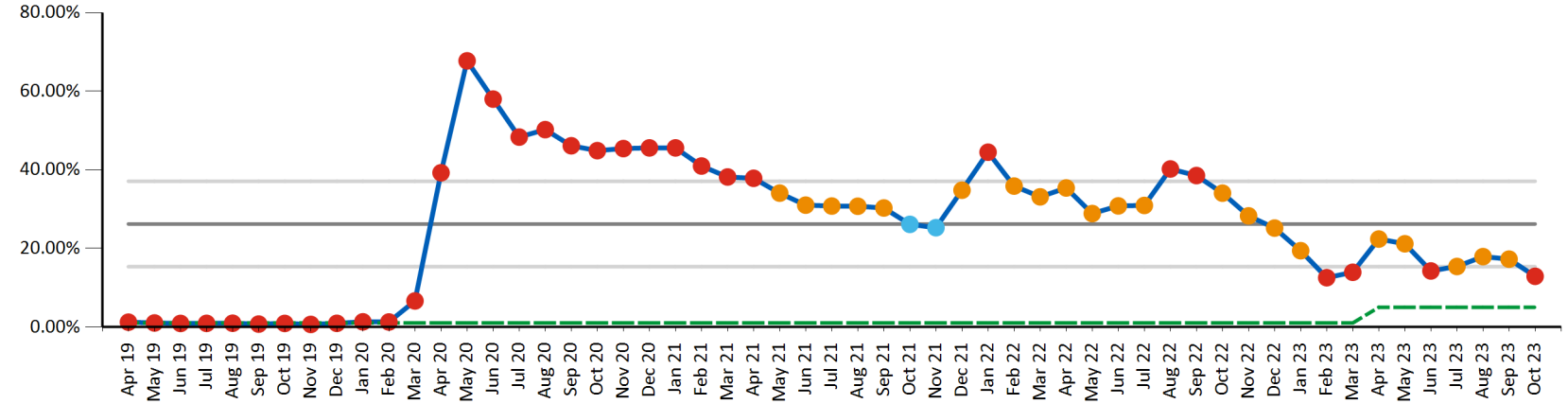
Plan	Actual
0	3

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5%	12.9%	Oct-23

Previous

Plan	Actual	Period
<= 5%	17.3%	Sep-23

Year to Date

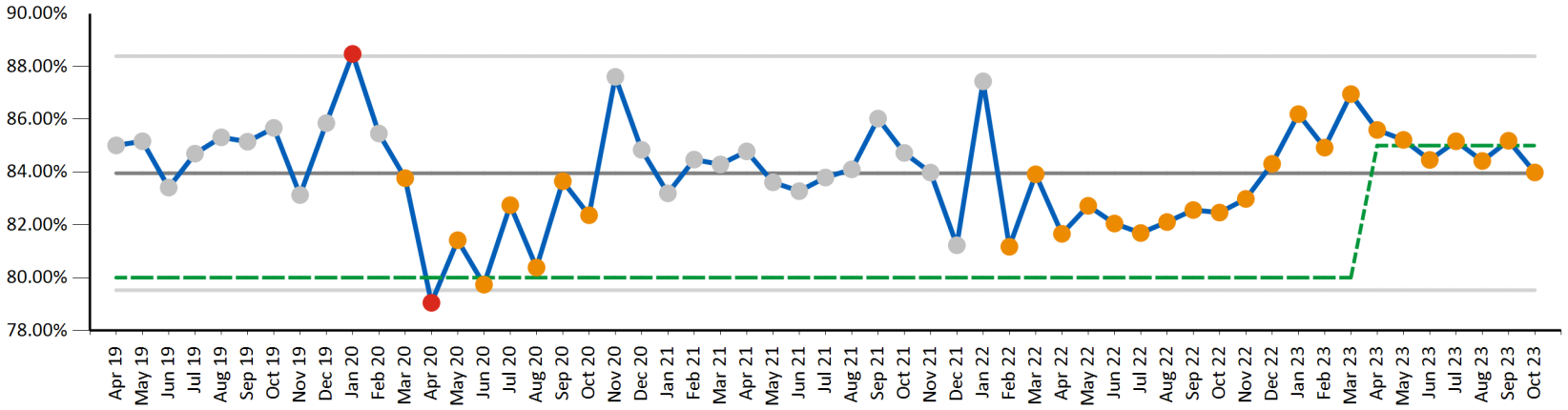
Plan	Actual
<= 5%	17.6%

489 - Daycase Rates

Special cause variation with improving performance

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

3/6



Latest

Plan	Actual	Period
>= 85%	84.0%	Oct-23

Previous

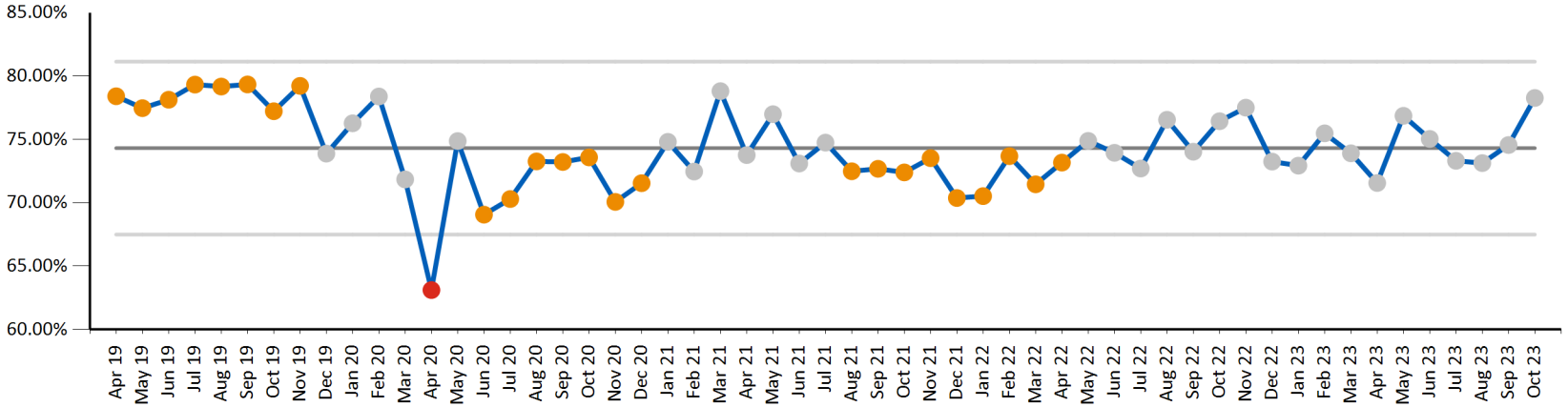
Plan	Actual	Period
>= 85%	85.2%	Sep-23

Year to Date

Plan	Actual
>= 85%	84.8%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	78.3%	Oct-23

Previous

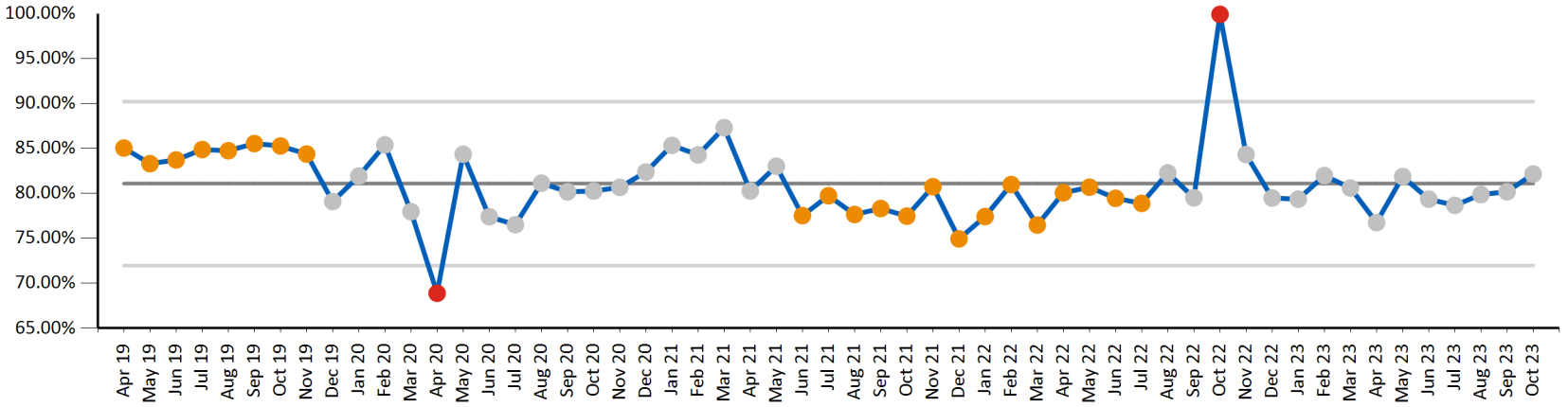
Plan	Actual	Period
	74.6%	Sep-23

Year to Date

Plan	Actual
	74.8%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	82.1%	Oct-23

Previous

Plan	Actual	Period
	80.2%	Sep-23

Year to Date

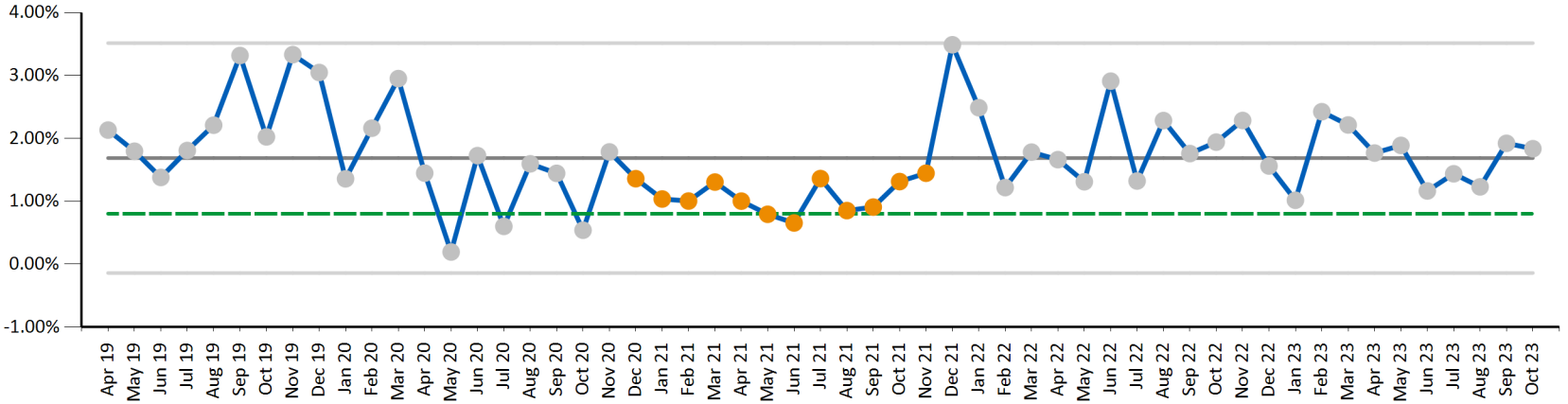
Plan	Actual
	79.9%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1%	1.8%	Oct-23

Previous

Plan	Actual	Period
<= 1%	1.9%	Sep-23

Year to Date

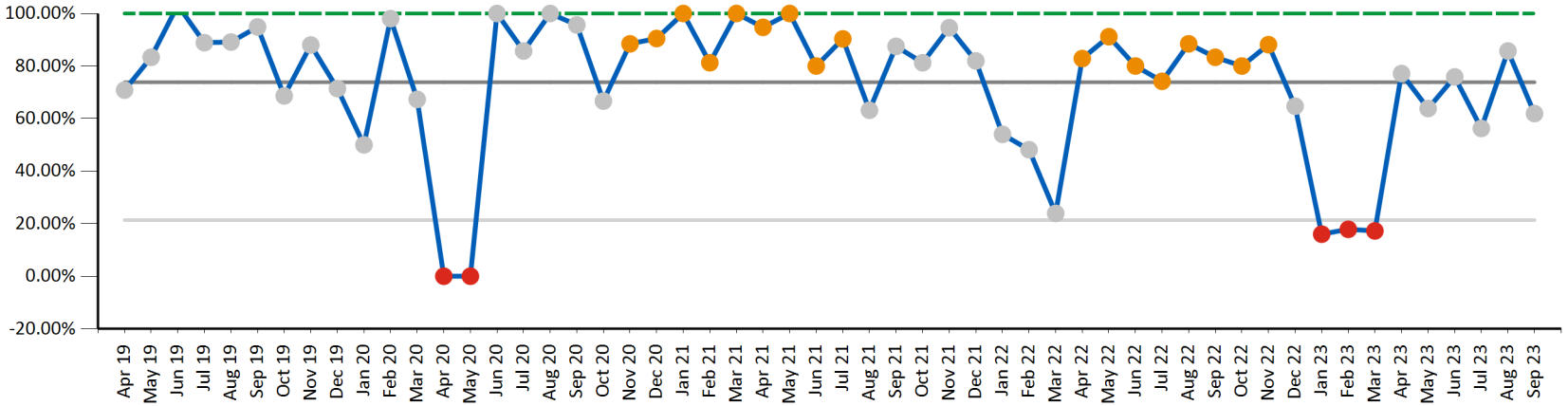
Plan	Actual
<= 1%	1.6%

62 - Cancelled operations re-booked within 28 days

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	61.9%	Sep-23

Previous

Plan	Actual	Period
= 100%	85.7%	Aug-23

Year to Date

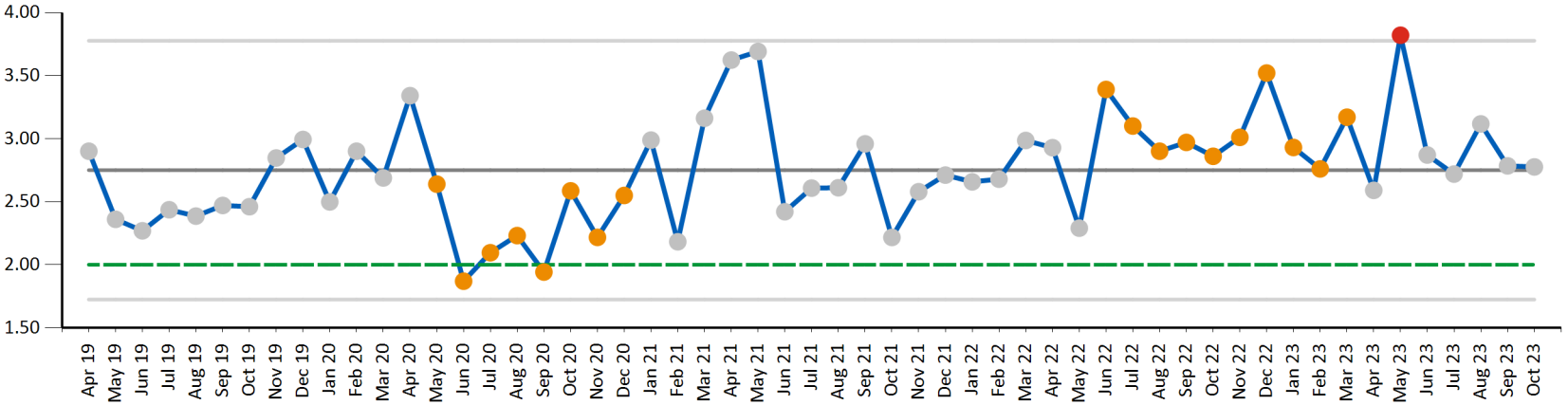
Plan	Actual
= 100%	31.0%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	2.78	Oct-23

Previous

Plan	Actual	Period
<= 2.00	2.78	Sep-23

Year to Date

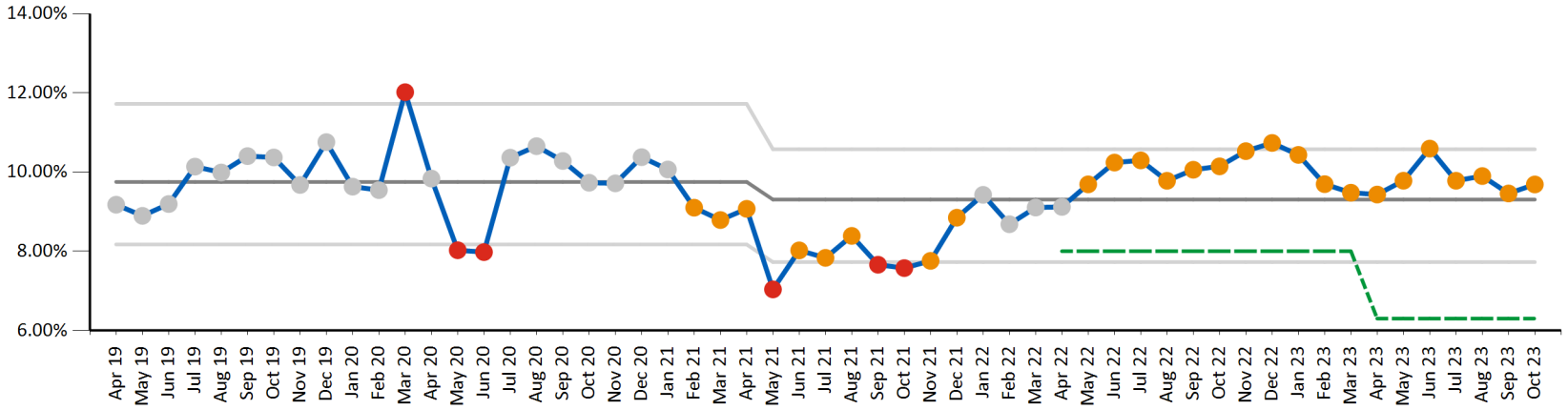
Plan	Actual
<= 2.00	2.95

309 - DNA Rate - New

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.7%	Oct-23

Previous

Plan	Actual	Period
<= 6.3%	9.5%	Sep-23

Year to Date

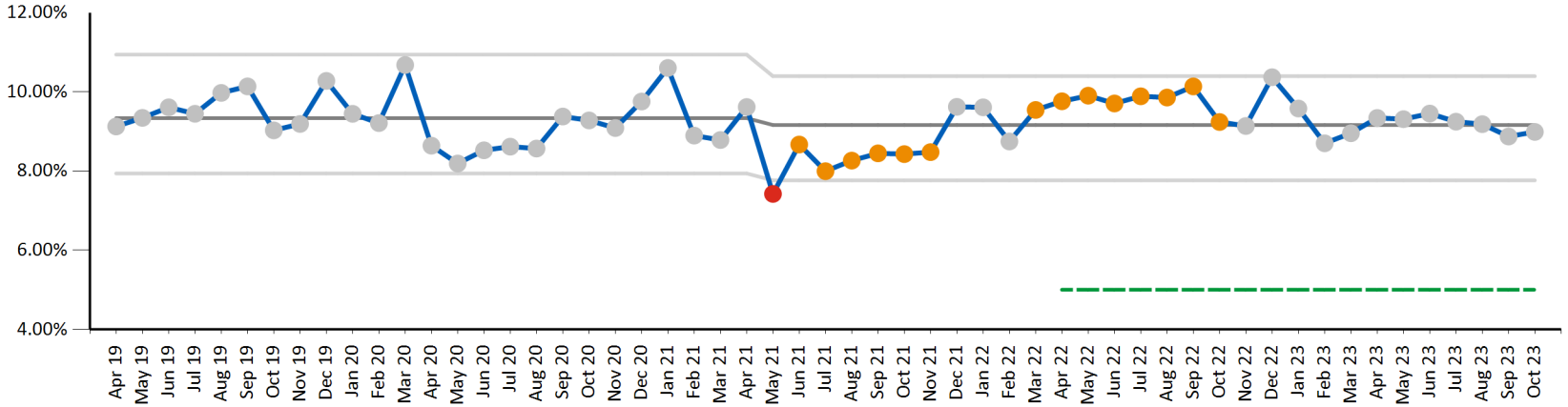
Plan	Actual
<= 6.3%	9.8%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.0%	Oct-23

Previous

Plan	Actual	Period
<= 5.0%	8.9%	Sep-23

Year to Date

Plan	Actual
<= 5.0%	9.2%

Operational Performance - Cancer

NHS Bolton NHS Foundation Trust

Our two week wait performance for September improved again to 92.1% against a target of 93%. Our areas of underperformance were primarily in Breast and Gynaecology and both services have improvement plans in place, with improved performance for both expected for October's performance.
Performance against the 62-Day standard deteriorated in September to 80.0% against a target of 85%. Our key areas of underperformance were Breast and Urology. 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.
Performance against our Cancer 62-Day backlog trajectory worsened in September; we had 35 patients on the PTL over 62 days against a planned position of 32, but expect to see full recovery to target for October.
Faster Diagnosis performance improved again in September to 84.06%.

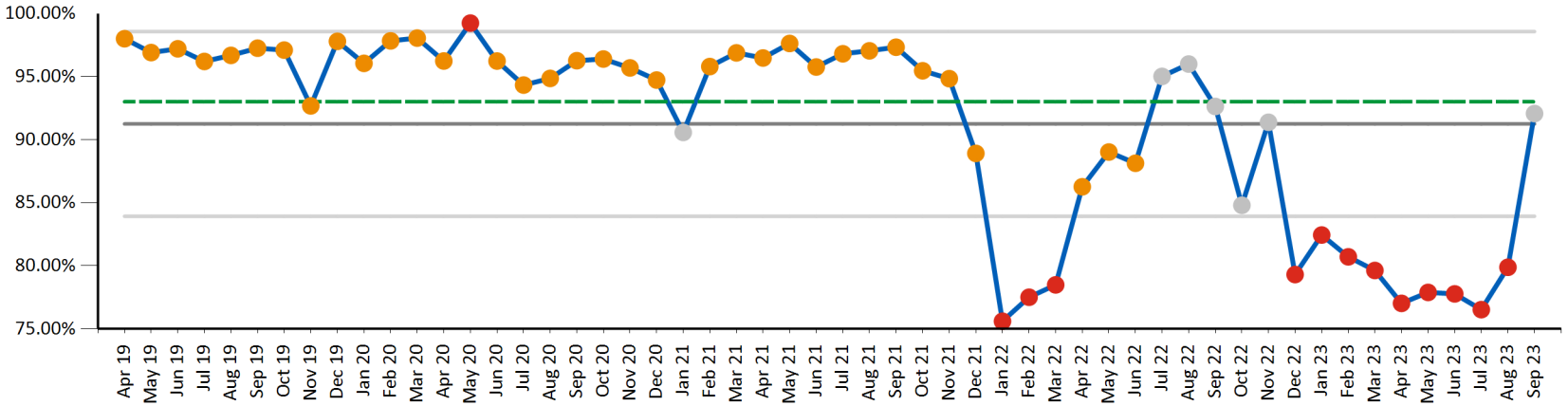
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	92.1%	Sep-23		>= 93%	79.9%	Aug-23	>= 93%	80.3%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	69.0%	Sep-23		>= 93%	30.0%	Aug-23	>= 93%	30.6%	
542 - Cancer: 28 day faster diagnosis	>= 75.0%	84.1%	Sep-23		>= 75.0%	82.7%	Aug-23	>= 75.0%	76.6%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Sep-23		>= 96%	99.2%	Aug-23	>= 96%	98.7%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Sep-23		>= 94%	100.0%	Aug-23	>= 94%	97.8%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%		Sep-23		>= 98%		Aug-23	>= 98%	100.0%	
46 - 62 day standard % (1 mth in arrears)	>= 85%	80.0%	Sep-23		>= 85%	85.4%	Aug-23	>= 85%	79.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	87.8%	Sep-23		>= 90%	85.0%	Aug-23	>= 90%	86.1%	

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 93%	92.1%	Sep-23

Previous

Plan	Actual	Period
>= 93%	79.9%	Aug-23

Year to Date

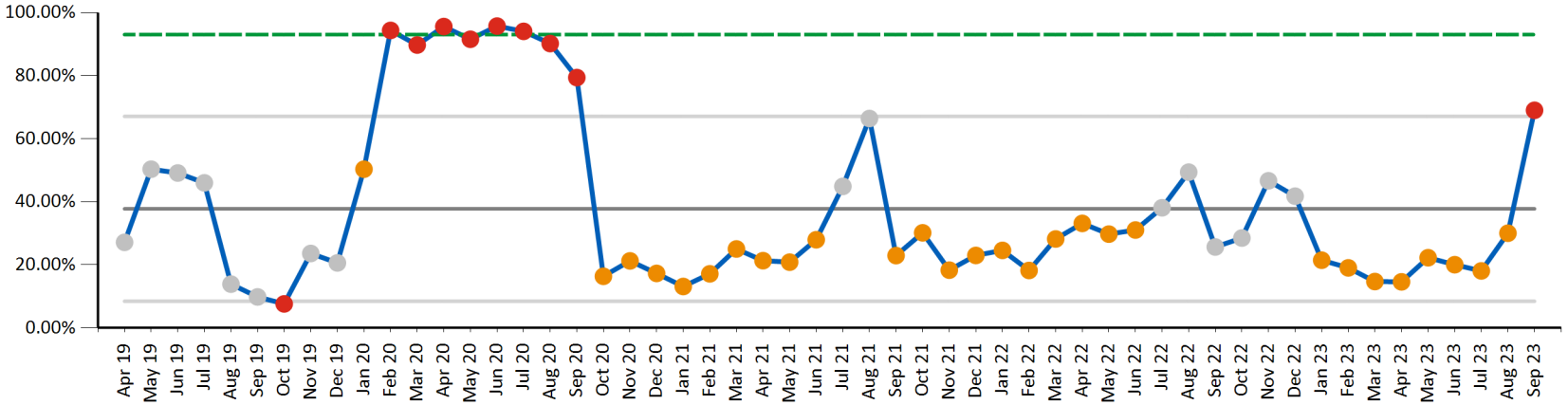
Plan	Actual
>= 93%	80.3%

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

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 93%	69.0%	Sep-23

Previous

Plan	Actual	Period
>= 93%	30.0%	Aug-23

Year to Date

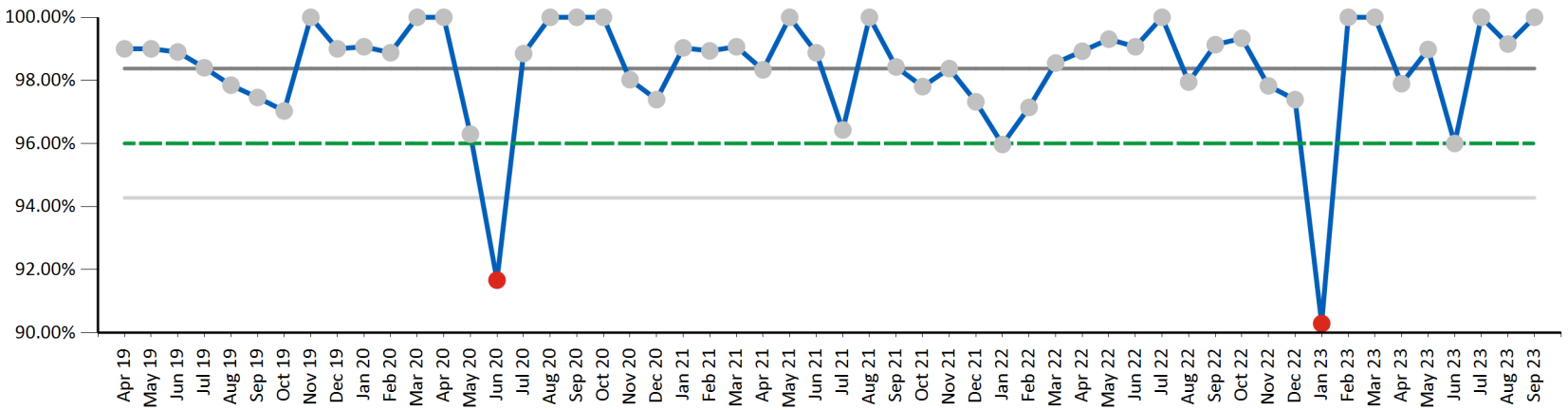
Plan	Actual
>= 93%	30.6%

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 96%	100.0%	Sep-23

Previous

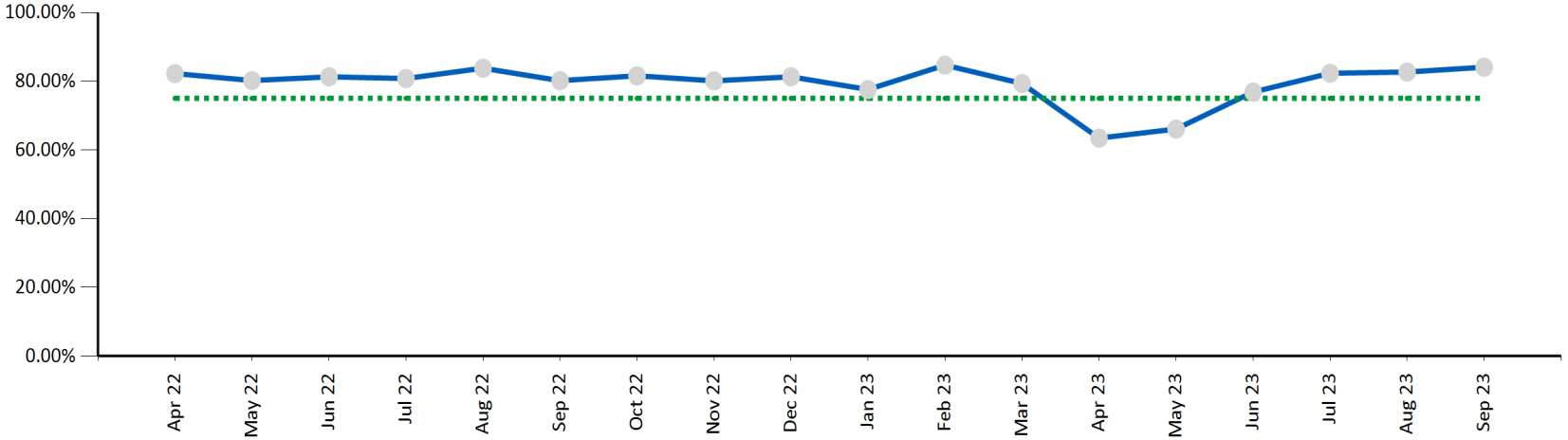
Plan	Actual	Period
>= 96%	99.2%	Aug-23

Year to Date

Plan	Actual
>= 96%	98.7%

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

4/6



Latest

Plan	Actual	Period
>= 75.0%	84.1%	Sep-23

Previous

Plan	Actual	Period
>= 75.0%	82.7%	Aug-23

Year to Date

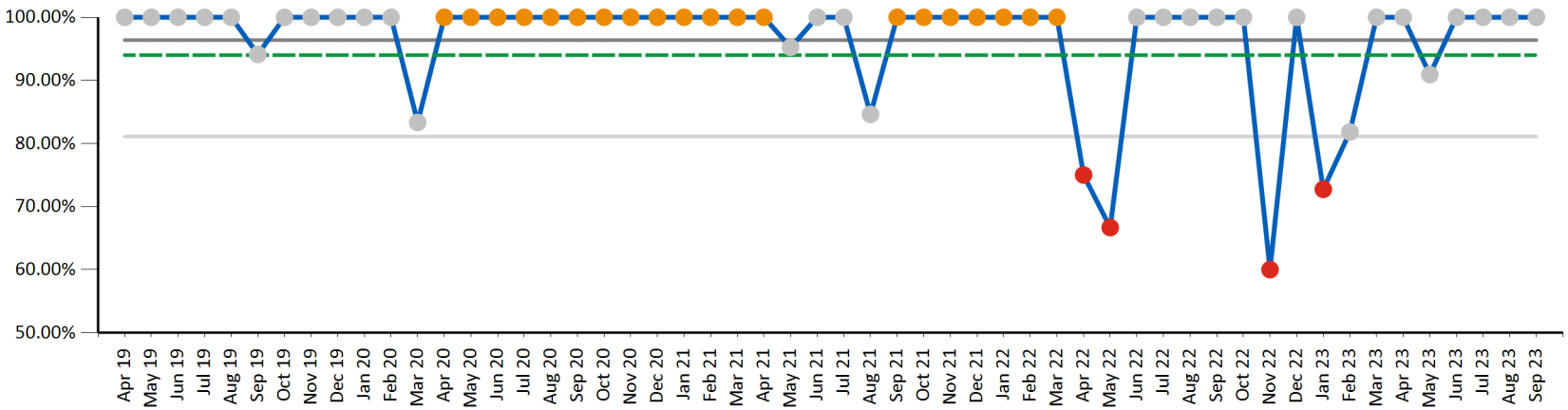
Plan	Actual
0.75	76.6%

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

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 94%	100.0%	Sep-23

Previous

Plan	Actual	Period
>= 94%	100.0%	Aug-23

Year to Date

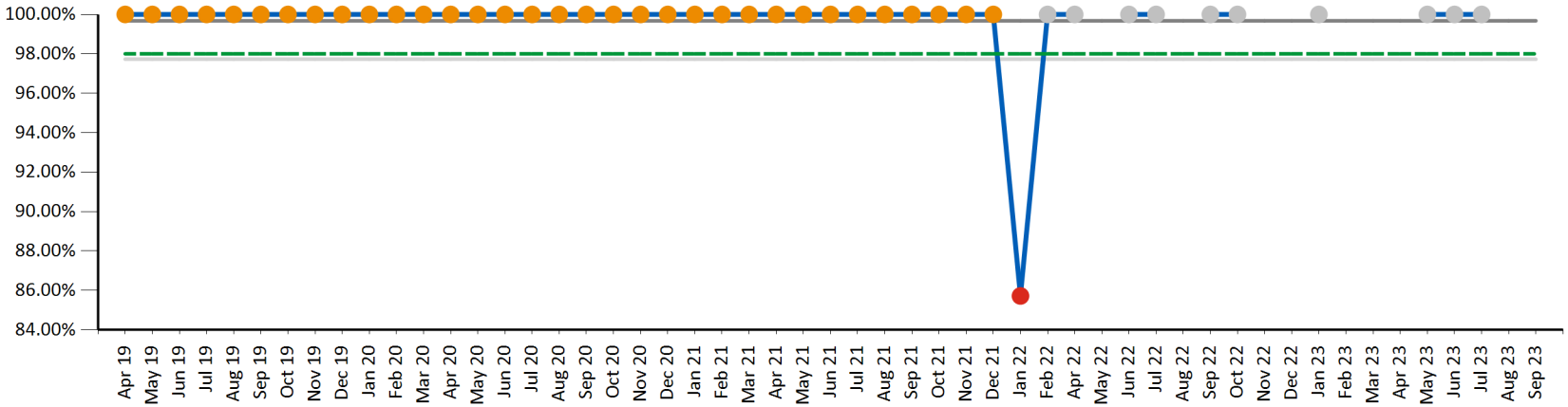
Plan	Actual
>= 94%	97.8%

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 98%		Sep-23

Previous

Plan	Actual	Period
>= 98%		Aug-23

Year to Date

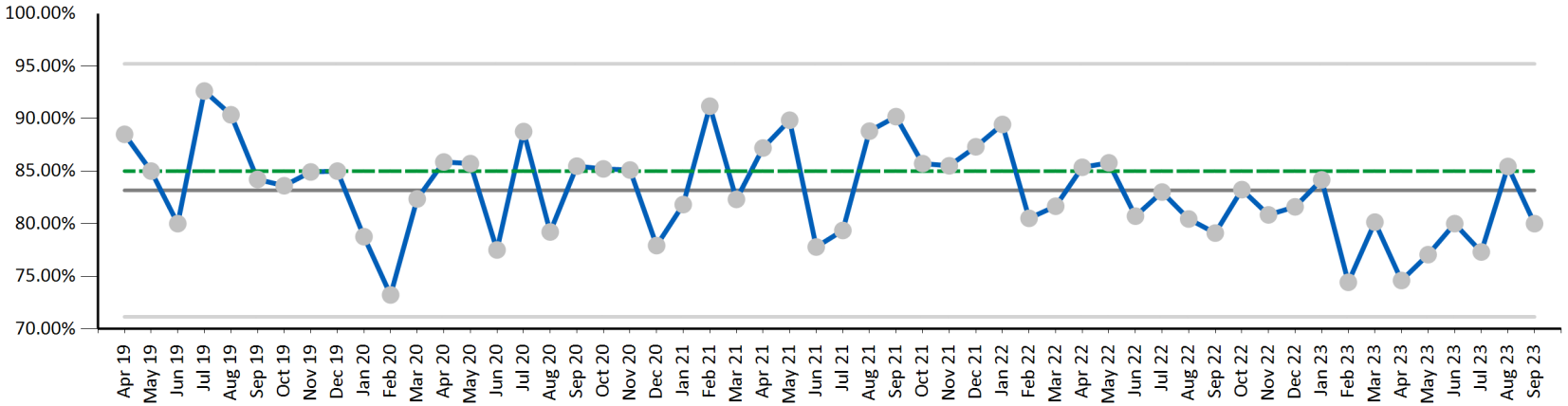
Plan	Actual
>= 98%	100.0%

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 85%	80.0%	Sep-23

Previous

Plan	Actual	Period
>= 85%	85.4%	Aug-23

Year to Date

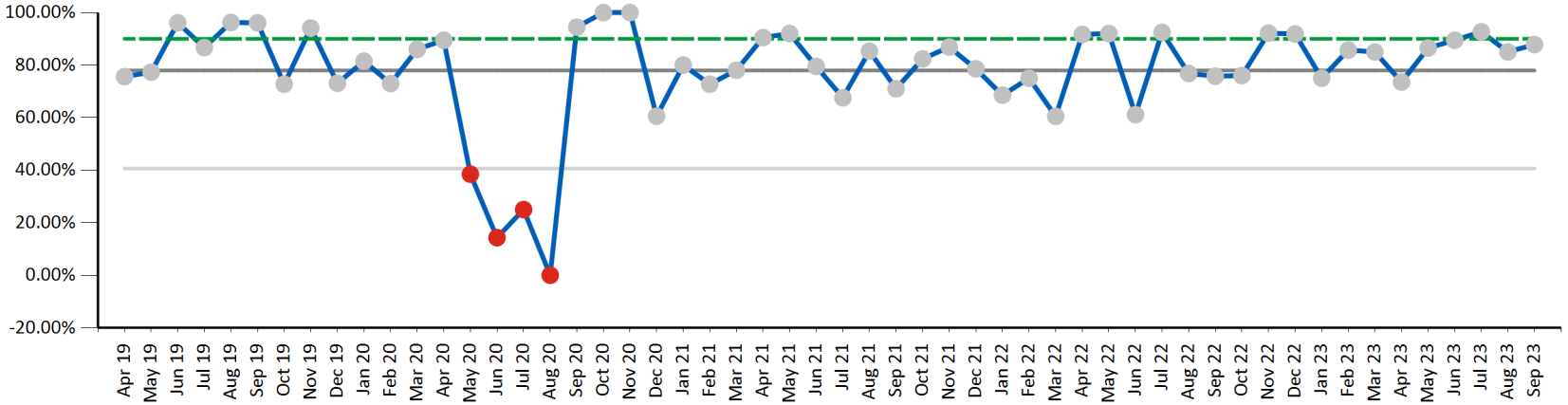
Plan	Actual
>= 85%	79.4%

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 90%	87.8%	Sep-23

Previous

Plan	Actual	Period
>= 90%	85.0%	Aug-23

Year to Date

Plan	Actual
>= 90%	86.1%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

ED deflections

ED deflections this month continue to increase and remain above plan of 400, at 552. 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.

NCTR

The number of patients with No Criteria to Reside (NCTR) continues to be in line with the operational plan, with an average of 90 patients in hospital with no criteria to reside in month 7. Average occupied bed days has remained consistent at 819, and this remains higher than intended. This is largely due to challenges in placement of a small number of complex 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 as business as usual
- Work with system colleagues to support community capacity for more complex patients

0-5 Mandated Contacts

Underperformance due to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors (nationally). In order to mitigate the impact, key statutory and mandatory contacts are being prioritised by the service team and performance is closely monitored by the Divisional team. Performance in prioritised pathways:
New Birth Visits within 14 days – 89.6% October.
6-8 week health review - 91.8% October.
8-12 month review - 97.2% October. Above compliance level of 95%.
2 -2.5 year Review – 93.8% October.

EHCP compliance

Demand has increased significantly since return to school in September (74 requests in September, 56 in October), APNP appointment capacity limited leading to breaches of the 6-week timescales. The service completed 48 reports in October (following high demand in September). The Trust is working with the ICB to see if the pathway can be streamlined to increase capacity for EHCPs including admin process reviews.

Looked After Children

Performance for review health assessments this month has improved to 91% (target 90%) up from 82% in September. In total, 45 RHA's were due in month and 42 were completed. The three RHA's not completed were due to: 1 COVID cancellation, 1 late change in provider and 1 young person refused.
We achieved 100% performance maintained in month for review health assessments for children over 5 in special schools.
We have seen significant improvement in performance for initial health assessments completed within 4 weeks. This is due to changes made to clinic capacity in October leading to 100% compliance, compared to 61.5% in September.

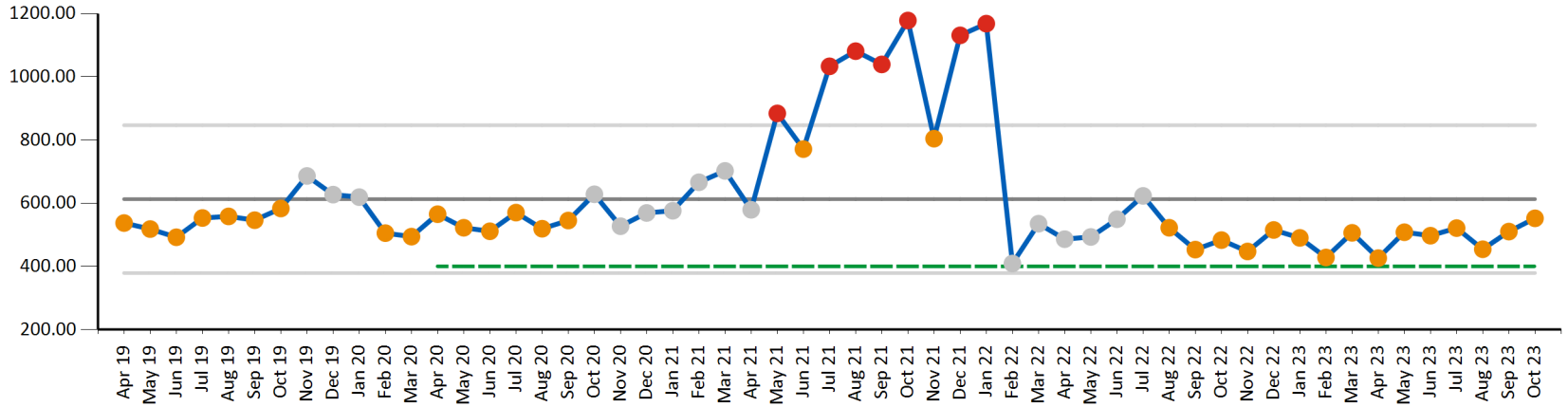
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	552	Oct-23		>= 400	510	Sep-23	>= 2,800	3,468	
493 - Average Number of Patients: with no Criteria to Reside	<= 95	90	Oct-23		<= 94	90	Sep-23	<= 95	90	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	819	Oct-23		<= 360	818	Sep-23	<= 2,520	5,474	
267 - 0-5 Health Visitor mandated contacts	>= 95%	79%	Oct-23		>= 95%	88%	Sep-23	>= 95%	81%	
269 - Education, health and care plan (EHC) compliance	>= 95%	67%	Oct-23		>= 95%	72%	Sep-23	>= 95%	81%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	91.0%	Oct-23		>= 90.0%	82.0%	Sep-23	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	100.0%	Oct-23		>= 90.0%	61.5%	Sep-23	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Oct-23		>= 90.0%	100.0%	Sep-23	>= 90.0%		

334 - Total Deflections from ED

Special cause variation with deteriorating performance

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

6/6



Latest

Plan	Actual	Period
>= 400	552	Oct-23

Previous

Plan	Actual	Period
>= 400	510	Sep-23

Year to Date

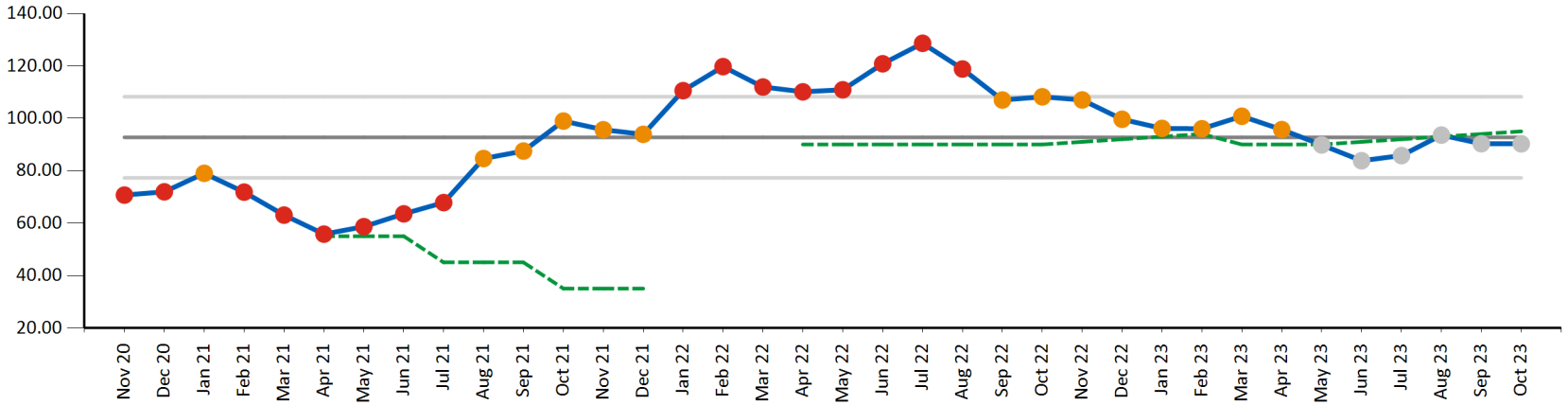
Plan	Actual
>= 2,800	3,468

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

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 95	90	Oct-23

Previous

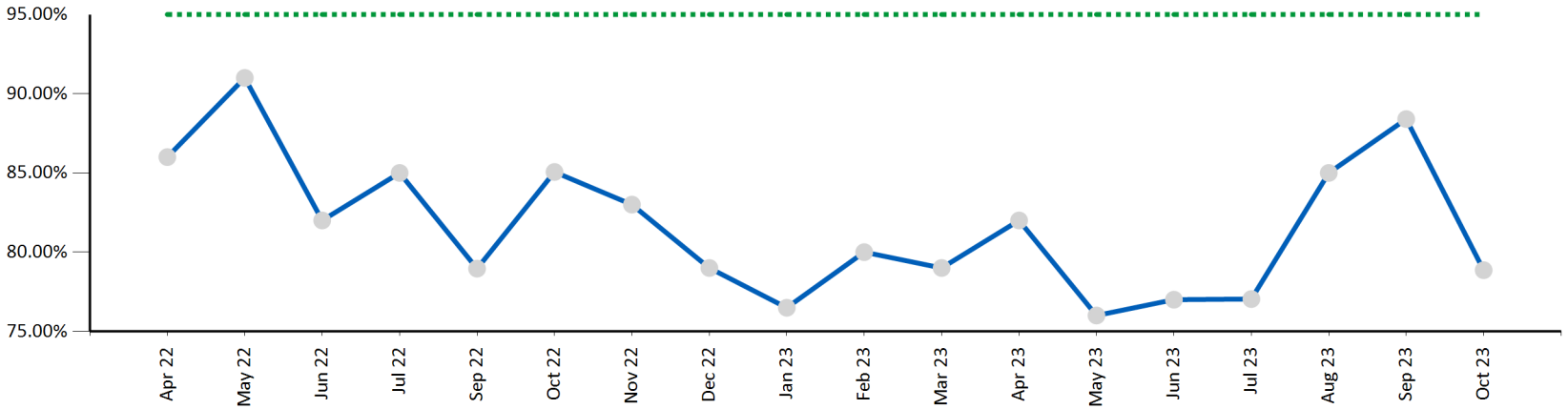
Plan	Actual	Period
<= 94	90	Sep-23

Year to Date

Plan	Actual
<= 95	90

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

0/6



Latest

Plan	Actual	Period
>= 95%	79%	Oct-23

Previous

Plan	Actual	Period
>= 95%	88%	Sep-23

Year to Date

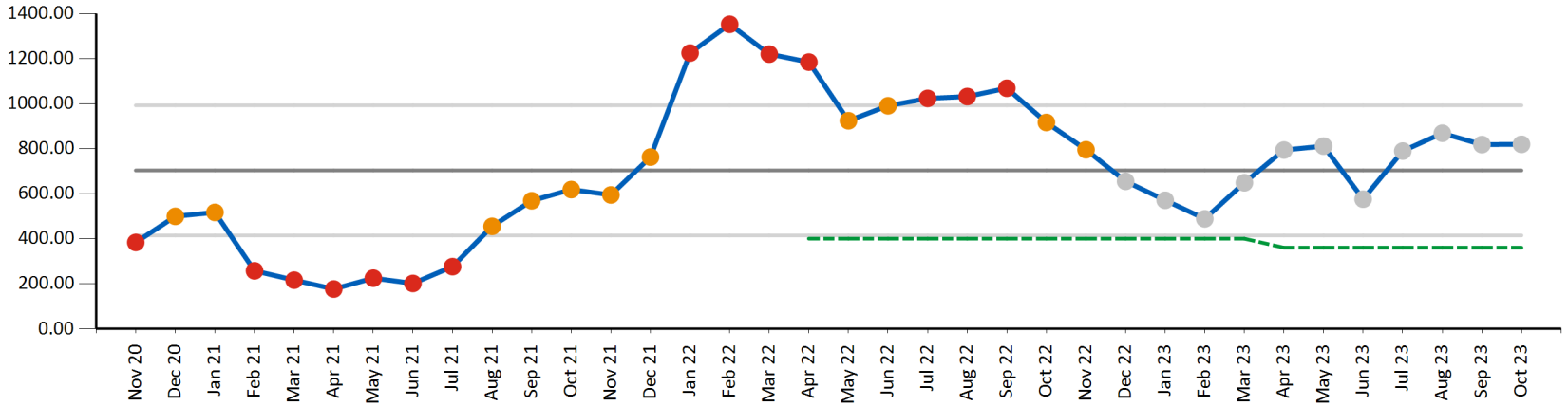
Plan	Actual
0.95	81%

494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	819	Oct-23

Previous

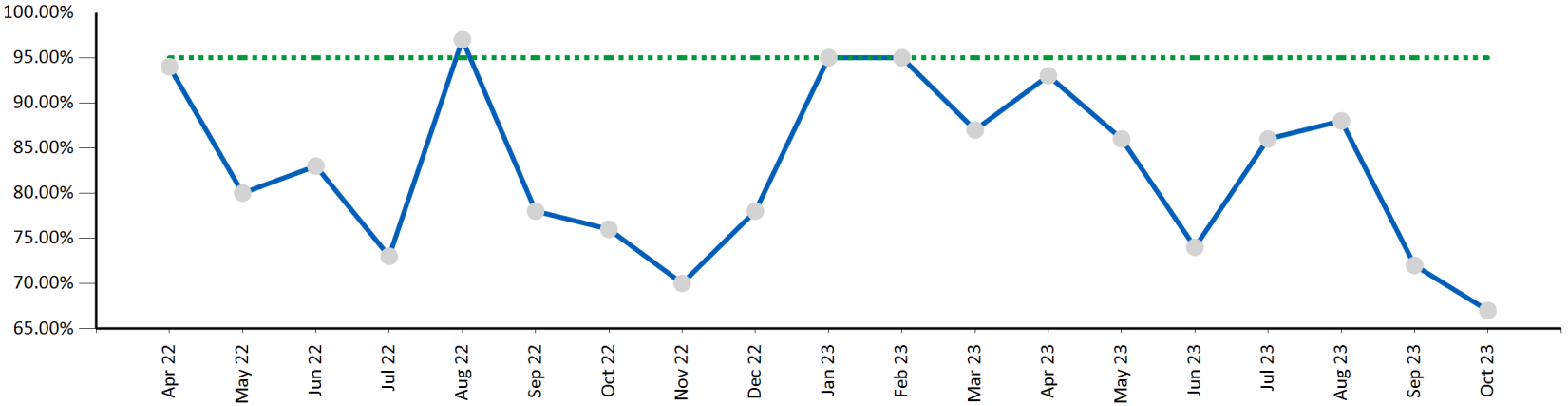
Plan	Actual	Period
<= 360	818	Sep-23

Year to Date

Plan	Actual
<= 2,520	5,474

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

0/6



Latest

Plan	Actual	Period
>= 95%	67%	Oct-23

Previous

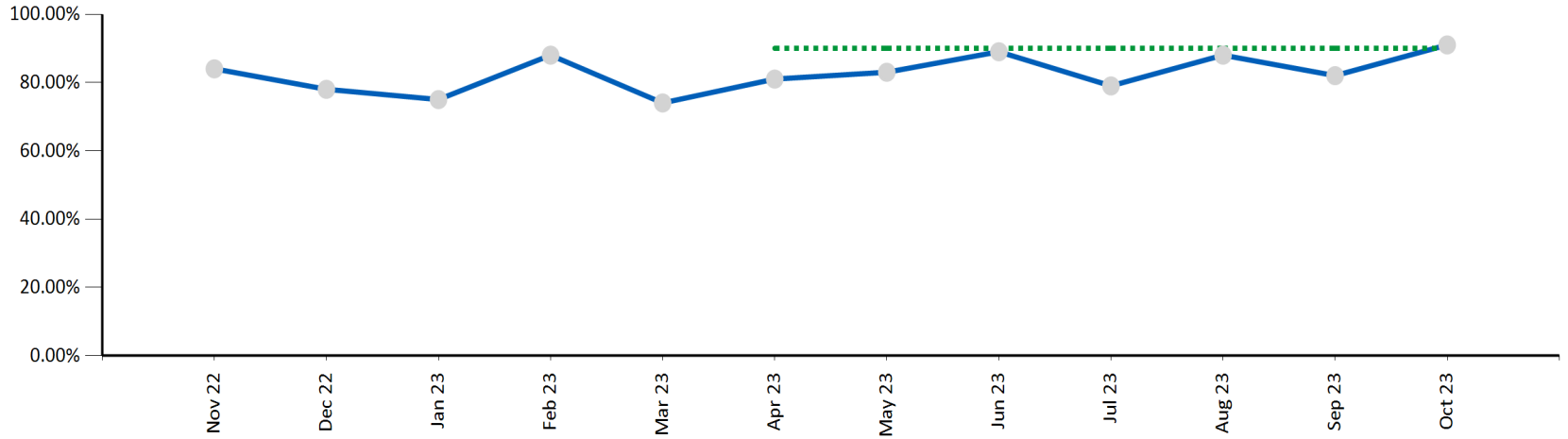
Plan	Actual	Period
>= 95%	72%	Sep-23

Year to Date

Plan	Actual
0.95	81%

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

1/6



Latest

Plan	Actual	Period
> = 90.0%	91.0%	Oct-23

Previous

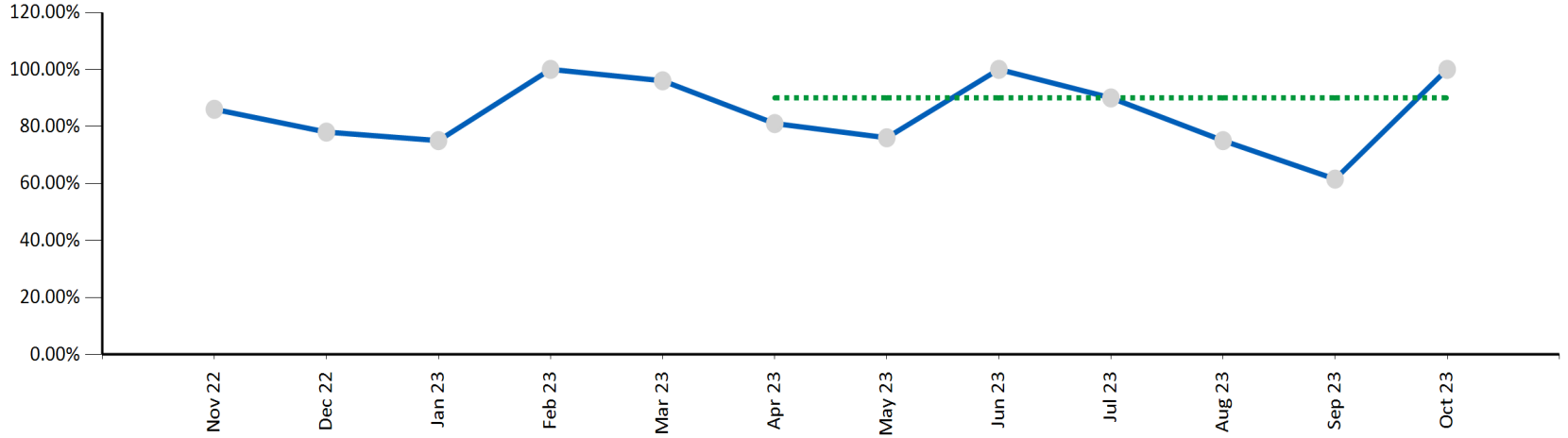
Plan	Actual	Period
> = 90.0%	82.0%	Sep-23

Year to Date

Plan	Actual
0.9	

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

3/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Oct-23

Previous

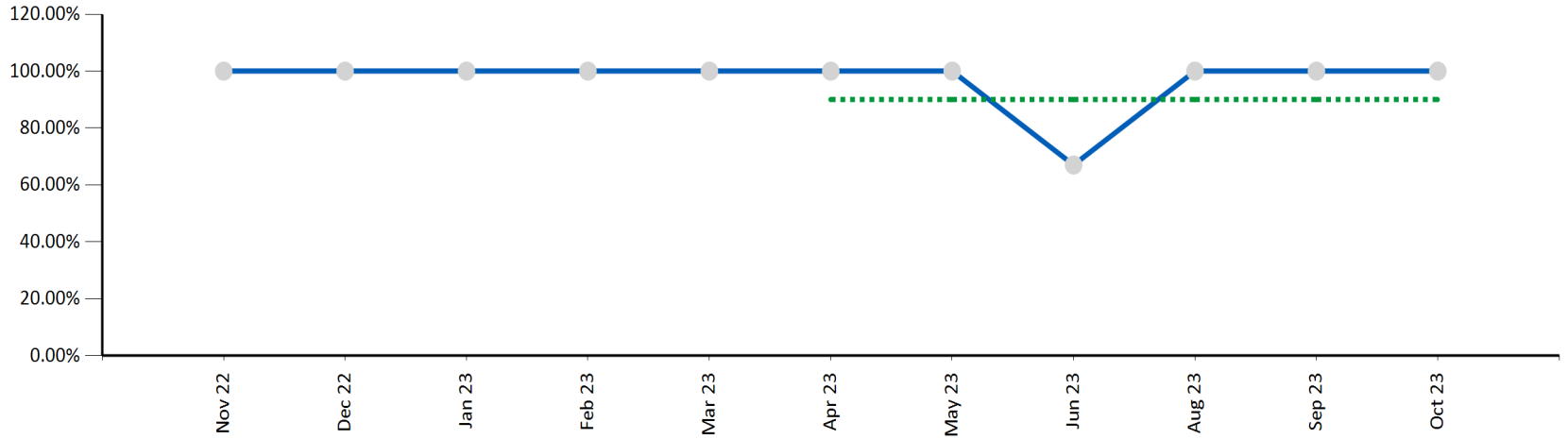
Plan	Actual	Period
> = 90.0%	61.5%	Sep-23

Year to Date

Plan	Actual
0.9	

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

5/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Oct-23

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Sep-23

Year to Date

Plan	Actual
0.9	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness has increased in October 2023 to 5.08% from 4.76% in September 2023. The increase in absence is observed largely across the Trust with notable increases occurring in ICSD (Increase of 1.55%) and ASSD (increase of 1.17%) compared to September 2023. The main absence cause of this increase is due to Cold & Flu related sickness, which increased significantly in October 2023. The rates of Covid related absence has also increased across the Trust again and stands at 0.58% compared to 0.32% in September 2023. The Trust continues to offer Flu and Covid-19 vaccines to support staff during this seasonal period.

Trust vacancy level improved to 4.25% in-month, which is better than plan. This related in the main to clinical recruitment of nursing, midwifery, AHP, and medical staff into the Trust and reflects the concerted and focussed efforts across the Trust to ensure safe and sustained clinical staffing – with a corresponding reduction in reliance on temporary staffing (agency and bank workers).

Turnover has reduced slightly in October 23 at 11.86% from a rate of 11.97% in September 23, and continues the reducing trend of turnover since January 2023 from a high of 13.99%.

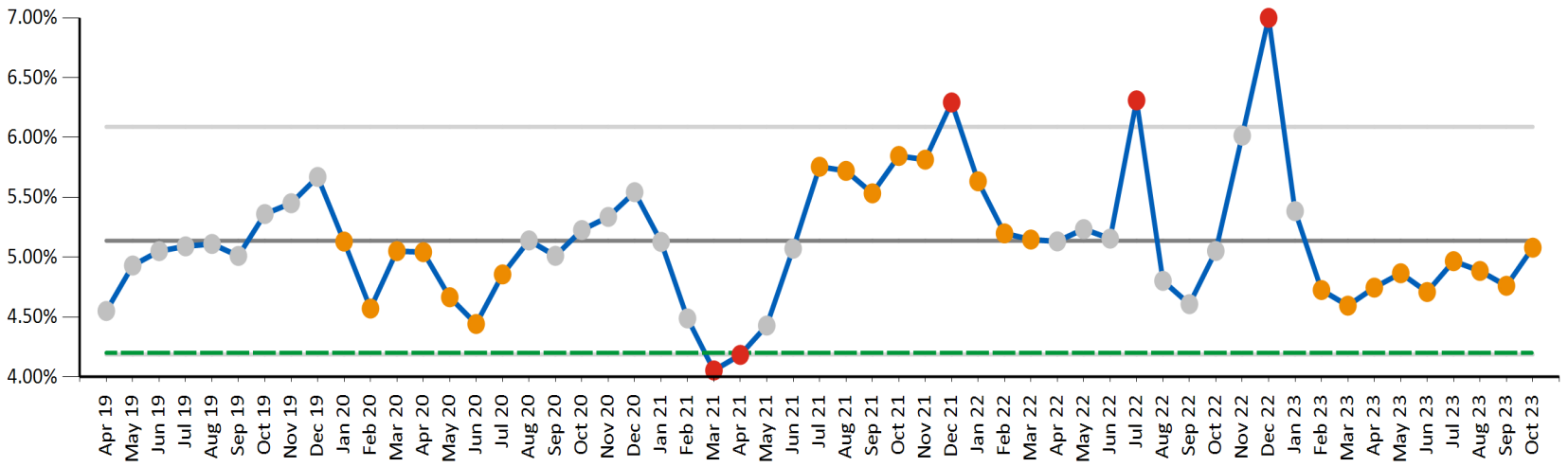
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.08%	Oct-23	L	<= 4.20%	4.76%	Sep-23	<= 4.20%	4.86%	?
120 - Vacancy level - Trust	<= 6%	4.25%	Oct-23		<= 6%	4.74%	Sep-23	<= 6%	5.52%	?
121 - Turnover	<= 9.90%	11.86%	Oct-23		<= 9.90%	11.97%	Sep-23	<= 9.90%	12.35%	F
366 - Ongoing formal investigation cases over 8 weeks		2	Oct-23	L		1	Sep-23		6	

117 - Sickness absence level - Trust

Special cause variation with improving performance

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

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.08%	Oct-23

Previous

Plan	Actual	Period
<= 4.20%	4.76%	Sep-23

Year to Date

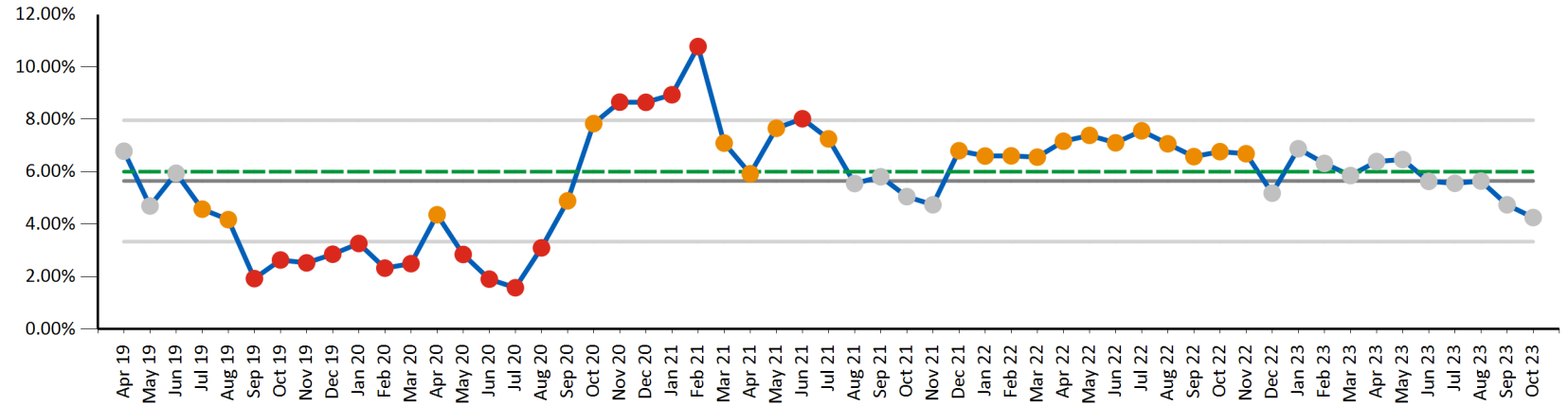
Plan	Actual
<= 4.20%	4.86%

120 - Vacancy level - Trust

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 6%	4.25%	Oct-23

Previous

Plan	Actual	Period
<= 6%	4.74%	Sep-23

Year to Date

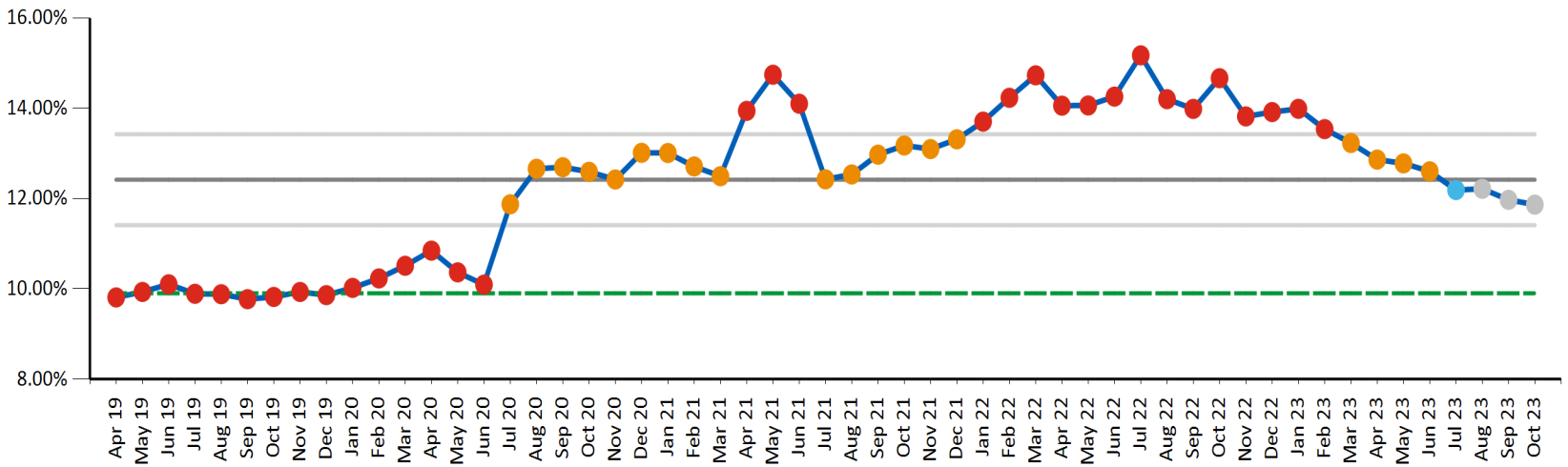
Plan	Actual
<= 6%	5.52%

121 - Turnover

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.86%	Oct-23

Previous

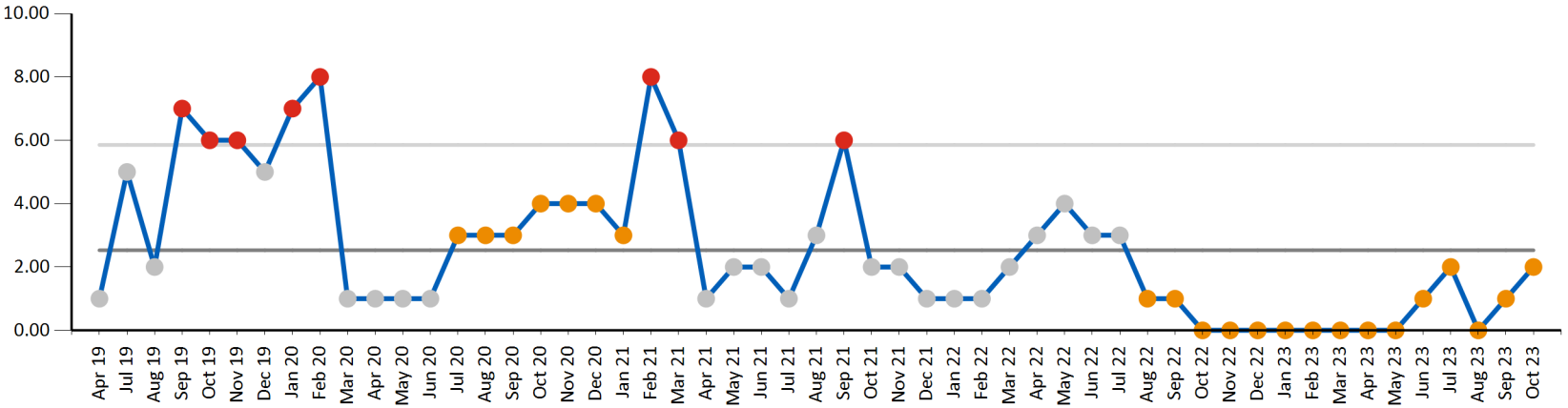
Plan	Actual	Period
<= 9.90%	11.97%	Sep-23

Year to Date

Plan	Actual
<= 9.90%	12.35%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	2	Oct-23

Previous

Plan	Actual	Period
	1	Sep-23

Year to Date

Plan	Actual
	6

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

This month is the first month we have reported in line with the Core Skills Training Framework for the 11 Compulsory subjects and the additional Trust Mandated subjects. The overall Trust position for Compulsory training is 93.85% against a target of 95%. It was anticipated there would be a drop as a result of the way the reports have been aligned with Information Governance/ Conflict Resolution and Resuscitation (BLS) moving from Mandatory to Compulsory training. The DNDs have all been involved with discussion as to the changes and accept there is additional work required in particular for Basic Life support as the % compliance target has increased from 85% to 95% in month.

The overall position for Trust Mandated subjects is very encouraging. All divisions and directorate teams have exceeded the target of 85% supporting the overall % compliance figure of 90.33%.

The appraisal rate has seen a slight reduction in month to 83.97% against a target of 85%. A plan is underway to support divisions to increase this

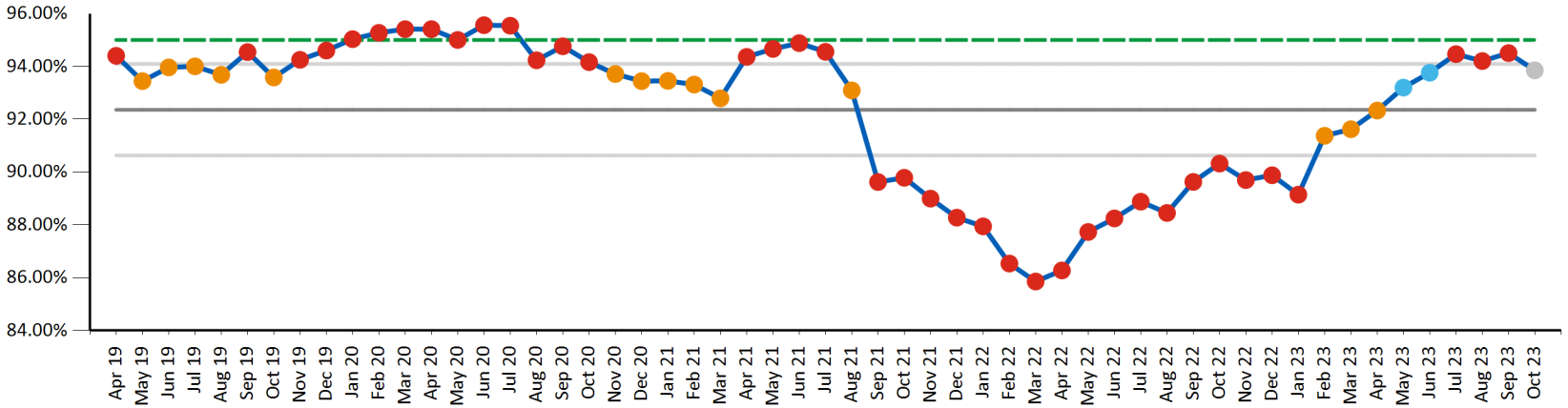
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.8%	Oct-23		>= 95%	94.5%	Sep-23	>= 95%	93.8%	F
38 - Staff completing Trust Mandated Training	>= 85%	90.3%	Oct-23		>= 85%	90.5%	Sep-23	>= 85%	89.2%	P
39 - Staff completing Safeguarding Training	>= 95%	95.16%	Oct-23		>= 95%	95.30%	Sep-23	>= 95%	94.85%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.0%	Oct-23	H	>= 85%	85.4%	Sep-23	>= 85%	85.9%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	62.0%	Q3 2022/23		>= 66%	72.8%	Q2 2022/23	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	60.3%	Q3 2022/23		>= 80%	73.3%	Q2 2022/23	>= 80%		F

37 - Staff completing Compulsory Training

Common cause variation.

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	93.8%	Oct-23

Previous

Plan	Actual	Period
>= 95%	94.5%	Sep-23

Year to Date

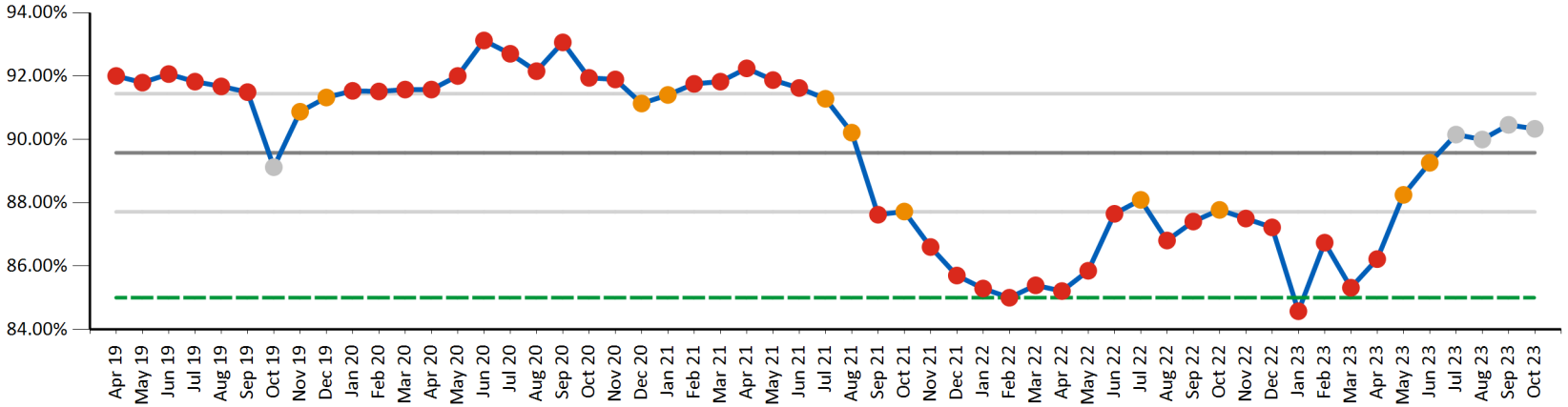
Plan	Actual
>= 95%	93.8%

38 - Staff completing Trust Mandated Training

Common cause variation.

P Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.3%	Oct-23

Previous

Plan	Actual	Period
>= 85%	90.5%	Sep-23

Year to Date

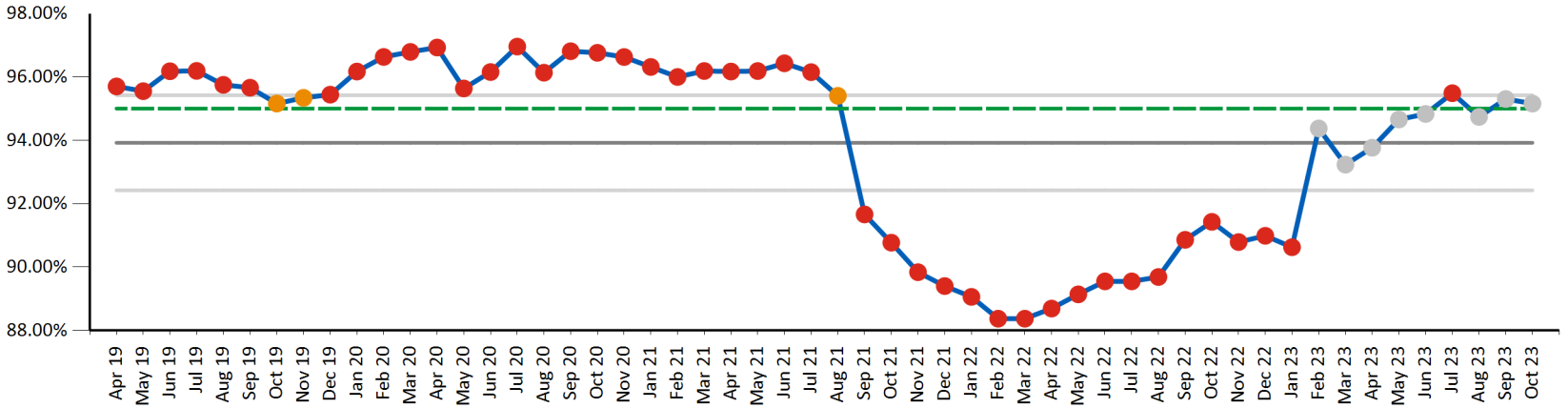
Plan	Actual
>= 85%	89.2%

39 - Staff completing Safeguarding Training

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 95%	95.16%	Oct-23

Previous

Plan	Actual	Period
>= 95%	95.30%	Sep-23

Year to Date

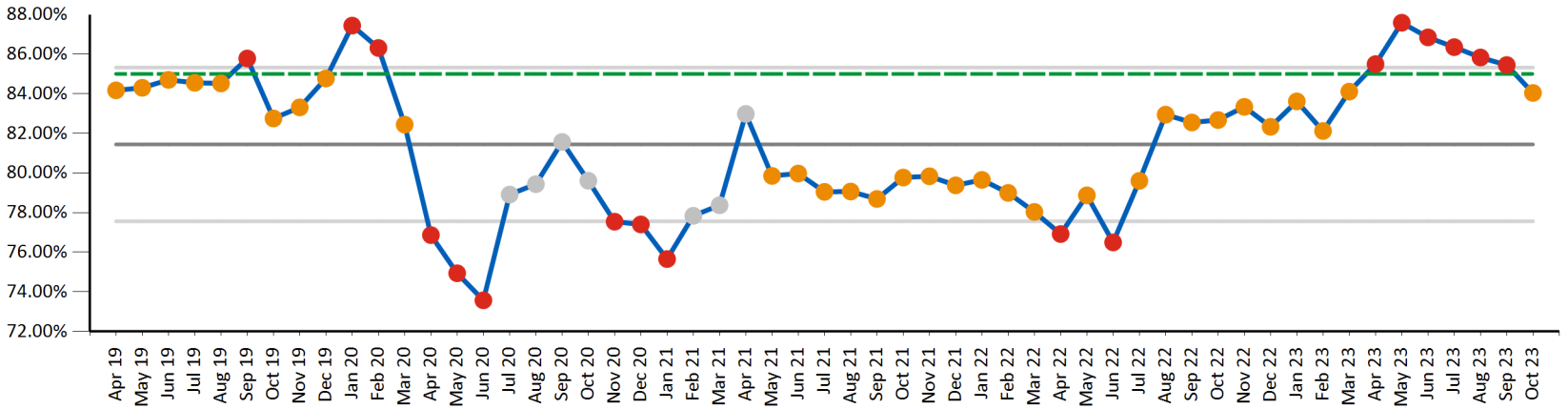
Plan	Actual
>= 95%	94.85%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
>= 85%	84.0%	Oct-23

Previous

Plan	Actual	Period
>= 85%	85.4%	Sep-23

Year to Date

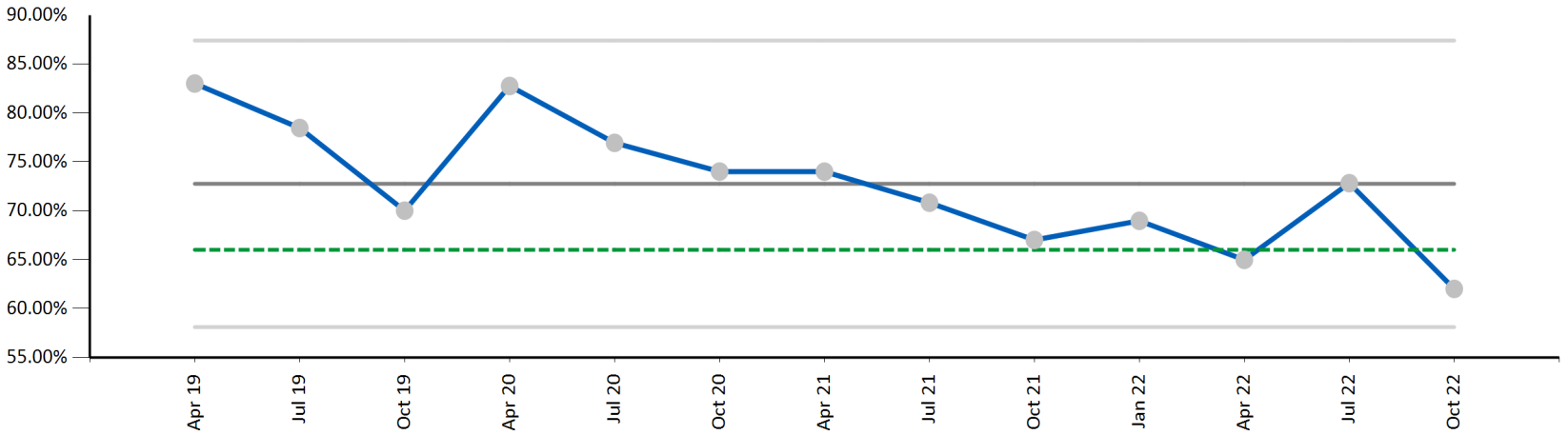
Plan	Actual
>= 85%	85.9%

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 66%	62.0%	Q3 2022/23

Previous

Plan	Actual	Period
>= 66%	72.8%	Q2 2022/23

Year to Date

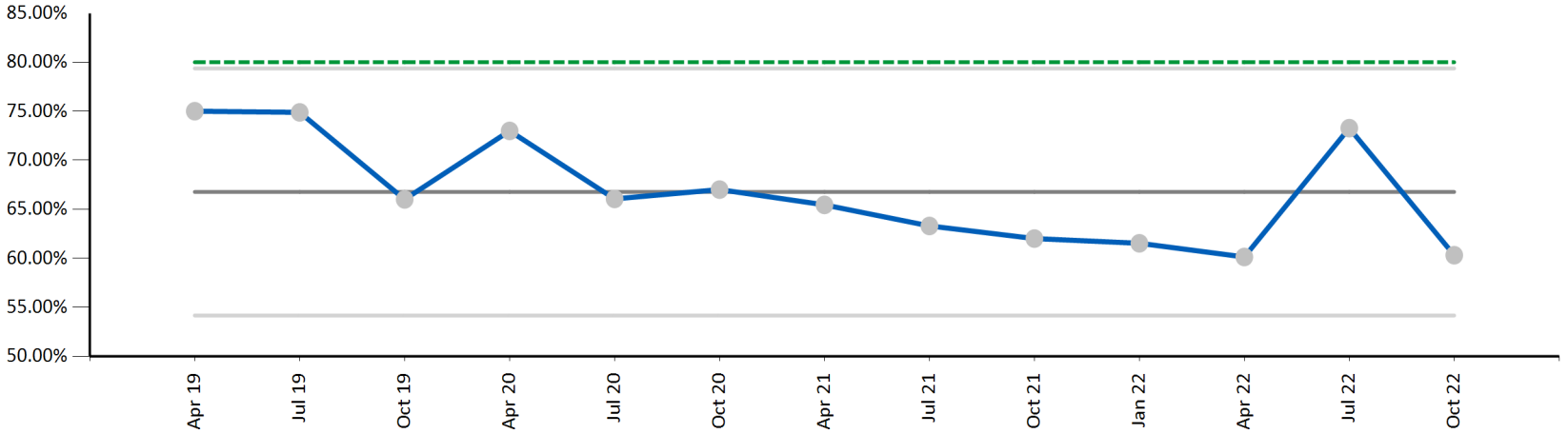
Plan	Actual
>= 66%	

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	60.3%	Q3 2022/23

Previous

Plan	Actual	Period
>= 80%	73.3%	Q2 2022/23

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Trust agency spend in October 2023 continued on the downward trend seen for the last five months and was under the Trust internal plan in-month (the second month in a row this has happened). Agency spend was at its lowest level for three years. If agency spending continues at the levels shown in October 2023 then the Trust would finish the financial year 2023/2024 with a total spend of approximately £11.7m, which would be just inside our submitted forecasted spend of £11.8m. We would hope to see continuation of the improving spend picture though which would put us in a much stronger position against forecast.

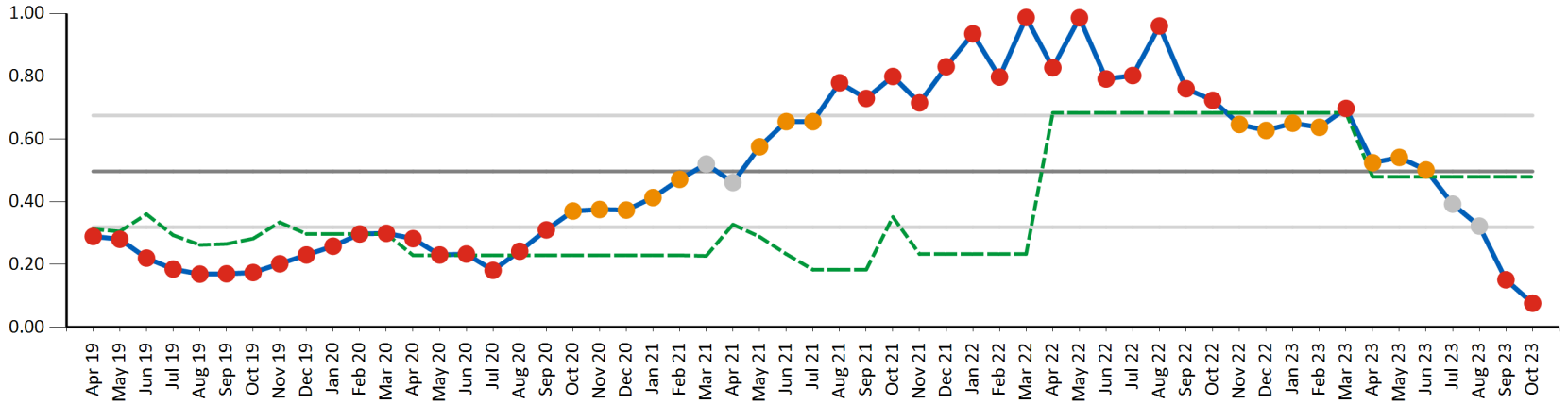
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.99	0.71	Oct-23	L	<= 0.99	0.87	Sep-23	<= 6.95	8.13	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.48	0.08	Oct-23	L	<= 0.48	0.15	Sep-23	<= 3.35	2.51	?
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.39	0.53	Oct-23	H	<= 0.39	0.54	Sep-23	<= 2.74	4.80	?

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

L — Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
<= 0.48	0.08	Oct-23

Previous

Plan	Actual	Period
<= 0.48	0.15	Sep-23

Year to Date

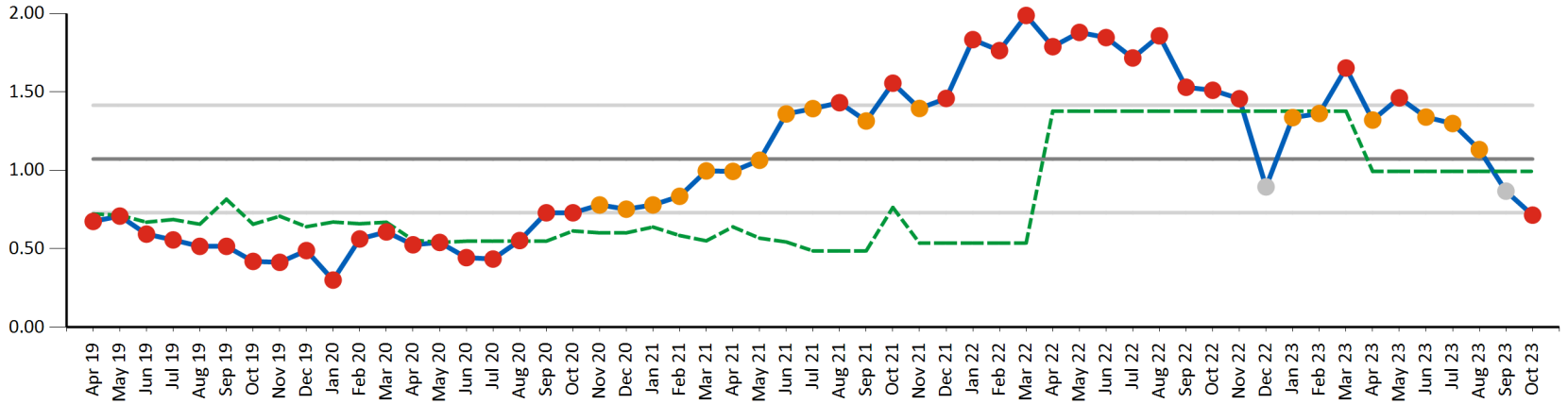
Plan	Actual
<= 3.35	2.51

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

Special cause variation with improving performance

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

2/6



Latest

Plan	Actual	Period
<= 0.99	0.71	Oct-23

Previous

Plan	Actual	Period
<= 0.99	0.87	Sep-23

Year to Date

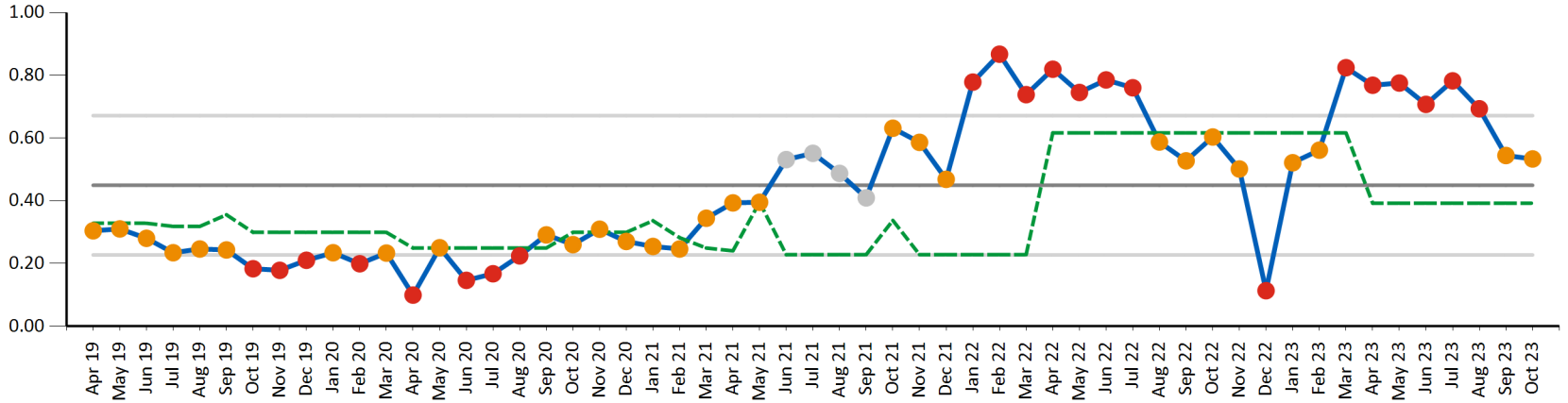
Plan	Actual
<= 6.95	8.13

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 0.39	0.53	Oct-23

Previous

Plan	Actual	Period
<= 0.39	0.54	Sep-23

Year to Date

Plan	Actual
<= 2.74	4.80

Finance - Finance

Bolton NHS Foundation Trust

Revenue – In Month and Year to date
The Trust has a deficit plan of £12.5m for 2023/24. At month 7, the Trust recorded a year to date deficit of £7.7m compared to a planned deficit of £7.3m.

Revenue -Forecast
In the 'Likely' forecast scenario, the Trust will deliver the planned deficit of £12.5m. The current worst-case scenario suggests a deficit of £23.4m.

Cost Improvement
The Trust has cost improvement target of 4% (£19.3m) for 2023/24.
CIP trackers currently show that £12.2m has been delivered against a year to date target of £11.2m.
£23.7m of CIP delivery is currently forecast against a target of £19.3m with £19.9m of this rated 'Delivered' or 'Green'. £11.6m of this forecast delivery is central / technical CIP delivery.

Variable Pay
The Trust spent £3.1m on variable pay in month 7 compared to a monthly average of £3.7m 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 £0.7m was spent on agency in Month 7, representing 2.5% of total pay costs in month.

Capital
The Trust has a draft planned capital plan for 2023/24 of £19.5m. Year to date capital spend to the end of month 7 was £10.0m against a plan of £8.6m.
We are currently managing a potential capital overspend of up to £6m and working with divisions to reduce the risk.

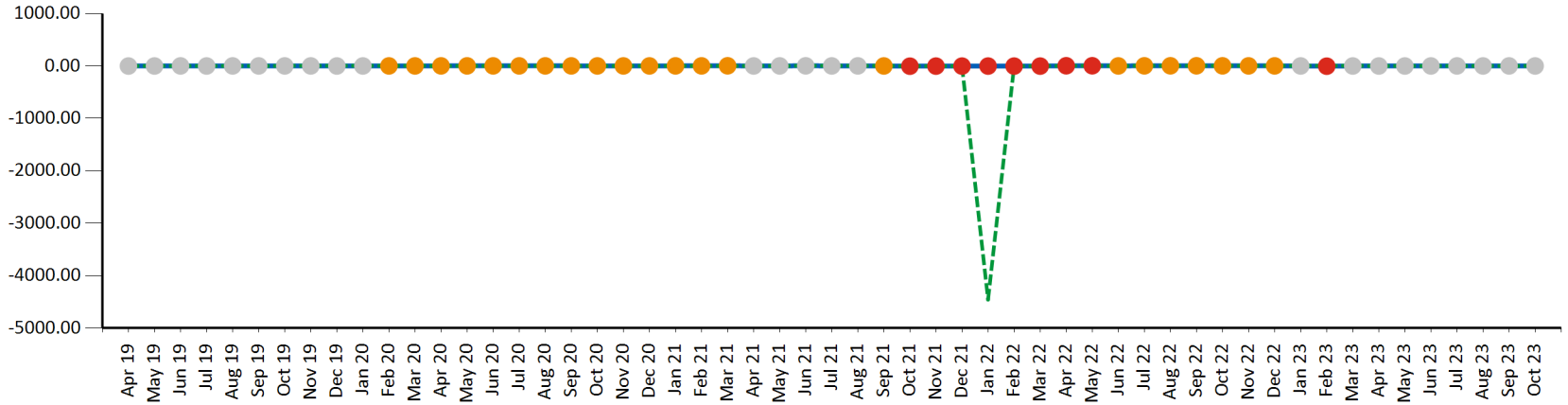
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.0	-0.9	Oct-23		>= -1.0	-0.2	Sep-23	>= -7.4	-7.7	
222 - Capital (£ millions)	>= 2.2	1.8	Oct-23		>= 1.4	4.0	Sep-23	>= 8.6	10.0	
223 - Cash (£ millions)	>= 31.1	25.1	Oct-23		>= 32.8	17.4	Sep-23	>= 31.1	25.1	

220 - Control Total (£ millions)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= -1.0	-0.9	Oct-23

Previous

Plan	Actual	Period
>= -1.0	-0.2	Sep-23

Year to Date

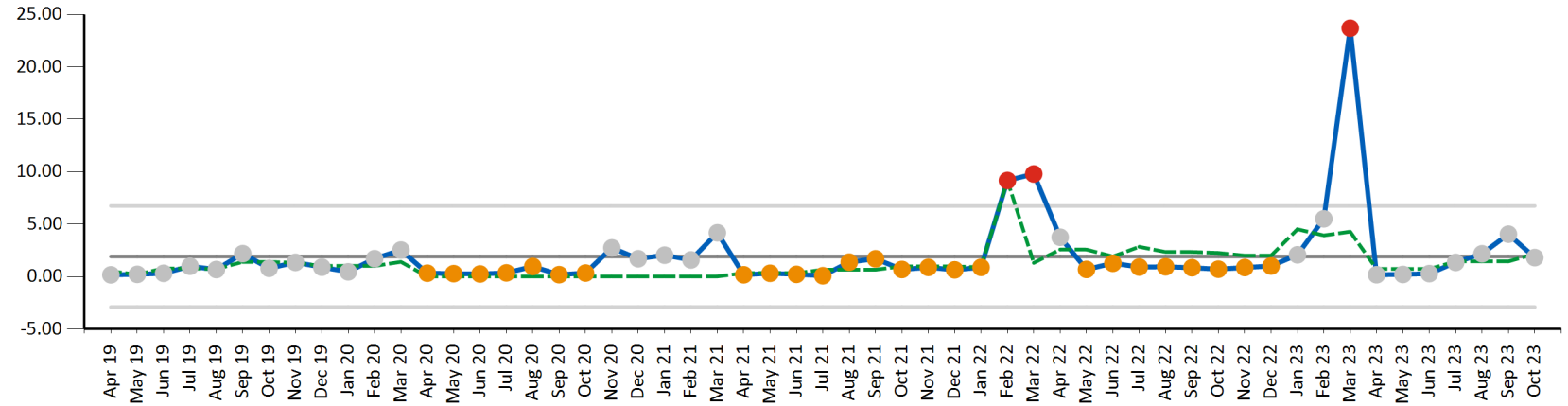
Plan	Actual
>= -7.4	-7.7

222 - Capital (£ millions)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 2.2	1.8	Oct-23

Previous

Plan	Actual	Period
>= 1.4	4.0	Sep-23

Year to Date

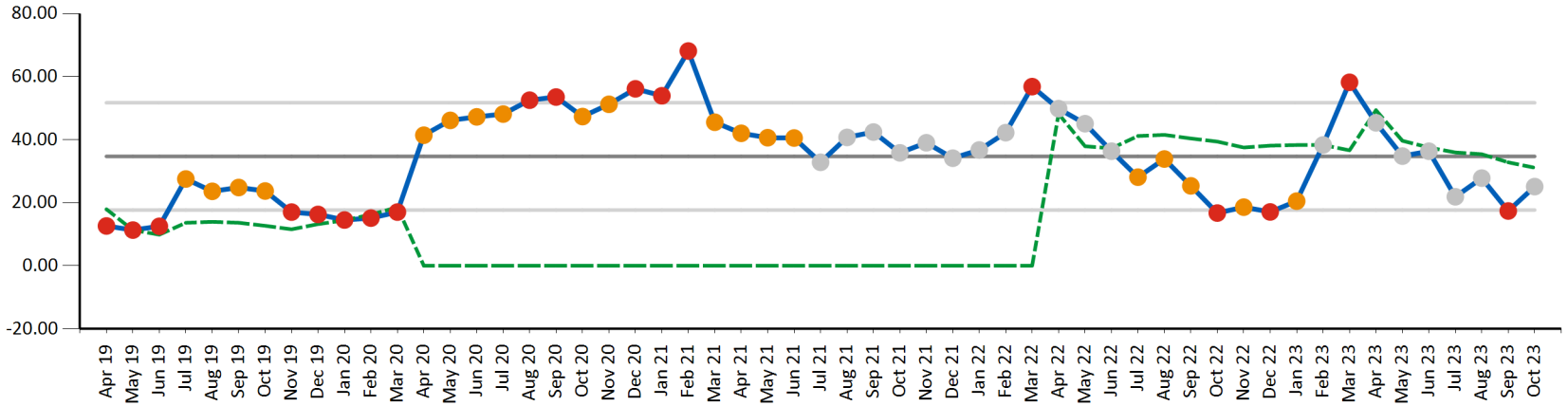
Plan	Actual
>= 8.6	10.0

223 - Cash (£ millions)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 31.1	25.1	Oct-23

Previous

Plan	Actual	Period
>= 32.8	17.4	Sep-23

Year to Date

Plan	Actual
>= 31.1	25.1

Heatmap Narrative – Trust Overview

Infection Prevention and Control

AACD
Mandatory training compliance
Infection Prevention and control – Level 1 93.92% (slight increase), Infection Prevention and control – Level 2 92.39% (slight increase)
3 x cases of C.Diff within Division – A4/ B1/ C3
A4 – presented at panel, no learning identified. Multiple antimicrobials prescribed/administered in different trust
B1 – presented at panel, noted SIGHT principles missed, delayed sample collection
C3 – presented at panel, appropriate antimicrobial prescribing throughout admission. Isolated appropriately
2 x MSSA on wards A4 & C1 – learning identified with gaps in cannula care this is being addressed at ward level. A4 RCA not yet present at panel
1 X E.coli – A4
The division continues to engage in the C.Diff collaborative with continued engagement with the QI team; weekly IPC audits remain in place
ASSD
Three areas with low handwashing results Critical care, day case and H2. All areas have action plans and we are working closely with the MDT to raise IPC standards. These action plans are reviewed monthly in divisional IPC meeting.
CDT x 1 case no causal lapses reported on RCA.
FCD
1 C Diff case reported on M4 – RCA completed. Low risk cases. Managed in accordance with guidance.

Harm Free Care

AACD
Pressure ulcers - 2 x unstageable pressure ulcers – B1 / B4
17 occurrences of category 2 pressure damage identified on the divisional heat map however following review of the data this is incorrect.
Following review the divisions has had 10 x occurrences of Category 2 pressure ulcers – 5 x ED / 1 x A4 / 1 X B1 / 1 X C3 / 1 X D1 / 1 X D3
Increase seen within ED this is being actioned by matron team with ADND oversight to ensure shared learning and improved compliance with pressure ulcer prevention and care processes
Falls - 3 x falls with harm - Ward D2, Ward B3, Ward C4
Continued divisional engagement with the trust falls task and finish group with delivery and implementation of falls quality improvement work streams
Continued senior nursing presence to promote/champion high standards of nursing practice
ICSD
Pressure Ulcers
14 x Category 2 pressure ulcers; 8 x unstageable pressure ulcers.
SBARs completed for all pressure ulcers above cat 2, of those processed, none deemed as meeting the SI criteria.
Falls
Laburnum Lodge reported 5 inpatient falls in M7. One fall resulted in a moderate harm. A PSIA is currently underway.
ASSD
Pressure ulcers - G4 blister noted on admission to Laburnum Lodge. Area for improvement noted is in relation to inconsistencies in body mapping.
Unstageable: Theatre toe 4th patient returned to fracture clinic following surgery on greater toe, pop removed
Falls - Work on E3 due to slight increase linking in with increased EHC.
C diff - 1x E3 No lapses in care noted
FCD
C diff
1x M4 No lapses in care noted

Audit, Patient Experience and Governance

AACD
KPI's - 8 x ward areas have achieved trust target of 95% with KPI audits – this is an increase from previous month (6 areas)
Complaints - The division has received 11 complaints in October, which is an increase in the number received last month where there was six and a decrease to the number received during the same period last year where there was 14.
The division's performance is 50% in October 2023, compared to 100% in September 2023
Incidents - 66 outstanding incidents > 14 days, not signed off. This is an improved position on previous month (sept 89 outstanding incidents)

ICSD
KPI'S - One teams recorded below 95% compliance in KPI's audit. The team have submitted an action plan to outline improvements required.
Incidents > 14 days, not yet signed off; the division had 28 breaching incidents at the end of M7; however 8 were exempt due to PU process.
Complaints - ICSD received one complaint in M7. One response was due in M7; this breached trust target date.
FFT - ICSD FFT response rate for Month 7 remains above target at 49% equating to a total of 373 responses against a target of 757. We achieved 99.2% recommendation rate with 0% not recommended rate.
Top three positive themes were staff attitude, implementation of care and patient mood/feeling, which remained unchanged from month 6 and no negative themes identified. Due to service changes we now have a number of unused titles within envoy, which are negatively impacting our response rate.
Arrangements for corrections within envoy are being made with support from the patient experience team.

ASSD
KPI - F6 low response for mouth care assessment: plan in place with ward manager
H2 care planning in relation to pain control needs improvement.
Outstanding incidents R1: ward manager now covering R1 as it is surgical and trajectory in place to improve via weekly incident meeting
FFT - A decline noted in satisfaction for day case and F3. The division is working to improve this via divisional patient experience group.

FCD
Good progress has been made with increasing patient experience response rates at 23.3% for October compared with 12% for September. Ward level initiatives continue to ensure all parents receive a FFT to complete before discharge. Recommended rate continues to be excellent at 98.6%.
Maternity: Reduced rate of friends and family response on M5 – ward closed as continues to be merged with M4 – likely reporting error.

Heatmap Narrative – Trust Overview

Staff Development, Staffing and Workforce

AACD
Appraisals: 85.2%, Mandatory Training: 88.6%

FCD
Appraisals: 79.2%, Mandatory Training: 92.2%, Statutory Training: 93.5%
Appraisal compliance is impacted by short term sickness; there is a plan in place to support an increase in appraisal rates while recruitment of the ward manager is underway

Increase in agency usage is noted in M5 which is reflective of the ongoing vacancies. Temporary staffing is reviewed on a daily and weekly basis and staff are allocated to the most relevant area depending on skill mix and acuity.
Ingleside staffing sickness 16.65% - reconfiguration of roster undertaken to include all community midwifery areas going forward as Ingleside closed.

ICSD
Appraisals: 84.19%, Mandatory Training: 96.99%, Statutory Training: 95.06%
Appraisal compliance remains a focus at divisional IPM to increase completion.

Overall sickness absence has increased to 7.18%, with 4.99% is attributed to long term sickness and 2.19% to short term sickness. Service-based sickness clinics are being planned to identify any further interventions that may reduce sickness absence. Labour Turnover has reduced to 12.05% across the division.

ASSD
Appraisals: 86%, Mandatory Training: 91.4%, Statutory Training: 94.5%

oard Assurance Heat Map - Hospital

	Indicator	Target	Council	Acute Division																			Elective Division												Families Division									
			Lab Lodge	AED-Adults	AED-Paeds	A4	B1	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1	D2	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	SDEC	Critical Care	DCU (daycare)	E3	E4	F3	F4	F6	G3/TSU	G4/TSU	H2 (daycare)	R1	UU (daycare)	CDS	E5	F5	Ingleside	M2 (AN)	M3 (Birth)	M4 (PN)	M5 (PN)	M6	NICU	Overall
	Average Beds Available per day	*N/a*	32			23	24	0	21	22	25	26	27	25	10	13	24	22	25	28	12	5	24	44	18	25	25	25	25	26	16	26	26	11	9	4	15	38	9	4	26	5	22	22	17	38	864
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%	60.0%	85.0%	100.0%	100.0%	N/R	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		90.0%	65.0%	100.0%	100.0%	100.0%	95.0%	95.0%	90.0%	85.0%	85.0%	N/R	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	90.0%	95.2%
	C - Diff	*Target = 0*				1	1	0	0	0	0	1	0	0	0	0	0	0	0	0		0	0		0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		1	0	0	0	5
	MSSA BSIs	*Target = 0*				1	0	0	0	0	1	0	0	0	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	2
	E.Coli BSIs	*Target = 0*				1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0		0	0	0	0	3
	MRSA acquisitions	*Target = 0*				0	0	1	0	0	0	0	0	2	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	3
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	6	3	0	4	8	0	5	3	1	3	7	5	0	3	3	1	3	3		1	4	0	1	0	3	0	2	1	0	1	1	0	2	0	0	0	0	0	0	0	0	1	0	75
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	VTE Assessment Compliance	*Target = 95%*				100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	95.8%	100.0%	100.0%	93.1%	100.0%	97.7%	98.6%	100.0%	94.0%			100.0%	97.0%	100.0%	100.0%	100.0%	97.8%	96.2%	100.0%	100.0%	100.0%	100.0%	99.3%		96.0%	89.5%				100.0%		96.3%	100.0%	98.9%	100.0%	98.4%
	New pressure Ulcers (Grade 2)	*Target = 0*	0	7	0	1	2	0	0	0	0	0	1	0	0	0	1	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	18
	New pressure Ulcers (Grade 3)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New pressure Ulcers (Grade 4)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New pressure Ulcers (unstageable)	*Target = 0*	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Audit	Monthly KPI Audit %	*Target = 95%*	99.5%	91.5%	96.3%	93.2%	91.9%	N/R	87.8%	90.7%	93.5%	92.2%	89.2%	87.7%	96.4%	97.2%	95.2%	95.6%	92.1%	96.1%			96.6%		97.3%	100.0%	92.3%	91.5%	98.4%	95.9%	89.6%	95.6%	95.0%	91.3%	N/R	98.7%	100.0%	98.5%	98.5%	100.0%	97.8%	N/R	97.1%	N/R	99.5%	N/R	95.0%
	BoSCA Overall Score %	*w=<55,b>55, s>75*	84.7%			75.2%	66.7%	54.7%	81.1%	76.3%	83.9%	71.0%	77.9%	68.3%	88.1%	78.0%	76.6%	78.5%	78.3%	87.4%			76.5%		86.3%		74.2%	80.9%	84.4%	86.4%	92.5%	81.2%	76.5%				86.9%				91.5%		76.6%	75.3%	76.9%		79.1%
	BoSCA Rating		silver			silver	bronze	white	silver	silver	silver	silver	bronze	silver	bronze	silver	silver	silver	silver	silver	silver	silver		silver																									
																									silver		bronze	silver	silver	silver	gold	silver	silver							gold		silver	silver	silver		silver
Patient Experience	FFT Response Rate	*Target = 30%*		18.4%	9.9%	142.9%	75.0%	30.4%	59.4%	36.1%	31.7%	45.0%	42.4%	25.8%	50.0%	157.8%	72.2%	69.8%	89.4%	50.7%		30.3%	56.8%	16.9%	89.5%	26.0%	10.0%	15.6%	36.8%	8.8%	53.4%	31.9%	35.5%	26.5%		40.0%		23.3%	0.0%		19.8%	37.6%	39.6%	8.7%	16.5%	61.5%	30.4%
	FFT Recommended Rate	*Target = 97%*		81.2%	84.7%	97.5%	19.0%	100.0%	89.5%	84.6%	92.3%	100.0%	96.0%	100.0%	100.0%	100.0%	97.4%	97.3%	98.3%	89.2%		98.3%	100.0%	97.6%	100.0%	92.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%		100.0%		98.6%			76.9%	89.6%	92.5%	82.1%	95.5%	100.0%	95.4%
	Number of complaints received	*Target = 0*	0	5	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	1	0	0	0	0	1	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	1	0	1	15
Gover-nance	Serious Incidents in Month	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	3	0	0	0	1	0	0	0	0	5
	Incidents > 14 days, not yet signed off	*Target = 0*	0	9	3	1	2	5	1	2	3	2	7	10	0	0	8	0	1	9	0	2	0	1	0	3	4	2	1	1	1	3	2	4	14	1	5	2	1	0	2	1	6	2	6	8	135
	Harm related to Incident (Moderate+)	*Target = 0*	1	1	0	0	2	0	1	0	0	0	7	1	0	0	0	1	0	7	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	23
Staff Dev - elopme nt	Appraisals	*Target = 85%*		83.33%	77.42%		76.9%	100.0%	91.3%	92.9%	76.9%	87.2%	71.8%	91.5%	93.1%	94.4%	93.9%	91.7%	90.0%	97.4%	75.0%	98.1%	85.4%	93.5%	91.0%	89.7%	93.2%	71.9%	75.6%	100.0%	66.7%	92.0%	81.4%	50.0%		94.1%	92.6%	79.2%		100.0%	96.0%		92.9%	75.0%		72.0%	86.5%
	Statutory Training	*Target = 95%*		93.93%	95.83%		88.05%	79.17%	90.76%	93.02%	93.98%	91.62%	92.27%	94.27%	96.65%	98.75%	91.13%	95.31%	96.64%	95.03%	91.67%	97.01%	91.98%	96.22%	96.15%	97.41%	92.59%	95.42%	97.96%	95.04%	93.89%	88.94%	95.24%	97.14%		98.04%	87.0%	93.5%		88.2%	89.5%		81.9%	87.1%		89.03%	92.7%
	Mandatory Training	*Target = 85%*		96.01%	95.04%		85.8%	80.0%	88.6%	93.6%	87.3%	88.7%	94.2%	89.7%	95.8%	95.4%	89.7%	93.2%	90.6%	95.0%	86.1%	96.5%	85.4%	97.0%	97.7%	98.3%	89.0%	91.5%	98.2%	94.6%	93.4%	81.7%	92.2%	73.9%		96.2%	88.6%	92.2%		87.5%	79.7%		78.0%	70.0%		91.3%	89.6%
Staffing & Workforce	% Qualified Staff (Day)					104.5%	105.6%	101.1%	106.3%	101.7%	100.0%	98.0%	102.4%	97.0%	100.5%				99.0%	99.3%			101.4%		81.4%		100.0%	100.8%		108.3%	80.2%	101.3%	100.3%				92.0%	80.8%			102.6%		63.3%			91.4%	96.8%
	% Qualified Staff (Night)					100.7%	99.8%	104.8%	100.9%	106.7%	98.7%	132.5%	118.0%	110.6%	100.0%				100.0%	100.5%			103.2%		79.9%		100.0%	121.5%		105.8%	87.3%	101.2%	100.0%				74.6%	91.2%			97.2%		53.5%			97.0%	99.4%
	% un-Qualified Staff (Day)					92.9%	123.1%	118.9%	94.5%	96.2%	87.5%	100.0%	96.6%	124.7%	93.1%				93.5%	95.3%			109.4%		103.8%		104.9%	85.6%		112.9%	75.2%	103.7%	112.1%				90.2%	98.7%			191.3%		52.6%			119.8%	103.1%
	% un-Qualified Staff (Night)					109.8%	146.4%	135.2%	100.0%	123.1%	103.4%	115.2%	113.0%	139.9%	97.2%				115.4%	101.2%			141.8%		65.9%		130.1%	98.4%		124.1%		112.8%	105.7%				94.5%	266.0%			100.8%		55.5%			74.7%	115.4%
	Registered Agency % (Day)					0.8%	1.6%	40.0%	0.8%	0.0%	0.0%	0.8%	5.5%	0.2%	0.0%				2.0%	0.8%			0.0%		0.0%		2.0%	0.4%		11.4%	0.8%	2.3%	1.2%				0.5%	3.4%			0.0%		5.9%	10.6%		0.0%	3.5%
	Registered Agency % (Night)					0.0%	4.9%	40.0%	4.7%	3.2%	4.9%	0.0%	1.6%	9.2%	0.0%				2.1%	0.0%			4.7%		0.0%		5.4%	10.6%		2.0%	6.2%	4.3%	3.2%				1.1%	10.5%			1.7%		6.7%	0.0%		0.5%	4.9%
	Sickness (%)	*Target < 4.2%*		6.61%	6.98%		2.89%	3.96%	9.08%	7.41%	9.04%	8.06%	5.37%	4.41%	3.72%	5.00%	5.98%	7.95%	3.91%	6.68%	0.00%	10.04%	6.88%	2.92%	7.27%	10.67%	3.84%	5.66%	8.03%	8.36%	11.01%	3.64%	6.04%	9.14%		10.17%	3.45%	6.00%		16.64%	2.20%		6.83%	1.08%		8.28%	6.43%

Data Legend

No data returned	N/R
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists or Doctors.
BOSCA Colours - white, bronze, silver, gold, platinum

Board Assurance Heat Map - District Nursing Domiciliary & ICS Services

			ICS Services															DN Teams										Treatment Rooms			
	Indicator	Target	Admission Avoidance	Acute Therapies	Anti-coagulant Team	Asylum & Refugee/ Homeless & Vunerable	Bladder & Bowel Service	Community IV Therapy	Diabetes & Endo	Dietetics	Falls	Home First	Neurology & LTC	Podiatry	Rheum-atology	SLT	Stroke	Wheel-chair Service	Avondale	Breightmet & Little Lever	Crompton	Farnworth	Great Lever	Horwich	Pikes Lane	Waters Meeting	West-houghton	Evening Service	North	West	South	Overall
Infection Control & Harm Free Care	Hand Washing Compliance %	100%	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
	Monthly New pressure Ulcers (Grade 2)	7	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	2	2	4	0	0			14
	Monthly New pressure Ulcers (Grade 3)	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
	Monthly New pressure Ulcers (Grade 4)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
	Monthly New pressure Ulcers (Unstageable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	2	0	2	1	0	0	0			6
Audit	Monthly KPI Audit %	95%	98.1%			98.7%	100.0%	98.1%		98.6%		95.9%	98.3%	95.7%		95.1%		96.5%	N/R	98.0%	98.6%	95.6%	99.0%	98.8%	987.7%	96.1%	98.4%	97.7%	97.4%		96.4%	98.00%
	BoSCA Overall Score %	w=<55%, B>55%, S>75%, G>90%																	94.00%	92.40%	97.60%	95.20%	92.90%	79.30%	92.20%	95.70%	93.20%	93.70%				92.6%
	BoSCA Rating																		gold	gold	gold	gold	gold	silver	gold	gold	gold	gold				gold
Patient Experience	Friends and Family Response Rate %	30%	100.0%		100.0%	40.0%	100.0%	100.0%	25.0%	0.0%	75.0%		90.0%	0.0%	6.7%	100.0%	100.0%	85.7%	24.5%											40.0%			49.30%
	Friends and Family Recommended Rate %	97%	100.0%		97.5%	100.0%	100.0%	96.8%	100.0%		100.0%		100.0%		100.0%	100.0%	100.0%	100.0%	98.1%											100.0%			99.20%
	Number of Complaints received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1										0			1
Staff Development	Sickness (%)	8.25%	15.3%	7.8%	0.0%	0.00%	18.2%	6.5%	15.4%	3.26%	11.1%		9.8%	7.5%	1.8%	0.2%	6.3%	10.0%	5.9%	15.6%	8.6%	11.6%	1.5%	10.3%	5.2%	6.2%	6.4%	0.4%		13.0%		7.60%
	Substantive Staff Turnover Headcount (rolling average 12 months)	11.76%	9.2%	16.0%	11.8%	12.5%	0.0%	28.6%	16.7%	48.5%	7.5%		6.3%	10.1%	4.5%	29.4%	31.3%	0.0%	20.0%	5.9%	14.3%	0.0%	0.0%	7.1%	0.0%	0.0%	17.4%	5.8%		13.8%		12.18%
	Appraisals	85.71%	72.5%	72.4%	100.0%	75.0%	75.0%	83.3%	61.9%	53.8%	94.5%		100.0%	94.4%	90.5%	92.9%	96.0%	75.0%	75.0%	81.3%	93.8%	93.3%	92.3%	100.0%	84.6%	83.3%	81.8%	94.4%		82.8%		84.61%
	Statutory Training	97%	97.5%	95.7%	100.0%	98.8%	100.0%	96.4%	95.9%	99.2%	98.2%		97.6%	97.7%	99.2%	95.0%	98.2%	100.0%	94.4%	94.2%	96.9%	93.8%	100.0%	92.3%	97.4%	95.8%	99.4%	96.8%		95.9%		97.17%
	Mandatory Training	97%	93.9%	95.7%	100.0%	89.5%	94.7%	98.6%	95.4%	100.0%	95.4%		97.2%	94.9%	98.7%	94.6%	97.5%	100.0%	92.3%	93.2%	96.8%	93.7%	100.0%	93.8%	88.9%	92.9%	100.0%	97.1%		96.4%		95.82%

Data Legend

No data returned	N/R
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists, Relief Team or Doctors & so will not marry up with the community performance report.
Home visits on this report excludes Groups so will not marry up with the community performance report.

BOSCA Colours - white, bronze, silver, gold, platinum

Report Title:	Quality Assurance Committee Chairs Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 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 at the meetings held in October and November 2023.

Previously considered by:
N/A

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

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

Prepared by:	Malcolm Brown Non-Executive Director	**Presented by:**	Malcolm Brown Non-Executive Director

Quality Assurance Committee Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	18 October 2023	Date of Next Meeting	15 November 2023
Chair	Malcolm Brown	Quorate (Yes/No)	Yes
Members present	Francis Andrews, Jackie Njoroge, Martin North, Sharon Katema, Tyrone Roberts, Sharon White, Rae Wheatcroft and Divisional Representation.	Apologies received from:	Janet Cotton, Harni Bharaj, Michelle Cox and Carol Sheard.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Mortality Quarterly Update		S Kimber-Craig	The report was taken as read and SKC highlighted the following; • SHMI (NHS Digital published figures, not HED) shows Bolton at 109.95, which is in the 'Expected' range. • The trend in HSMR has fallen to 'Green' (within 'Expected' range) at 106.22 • The crude rate has remained at a similar level as compared to last year. • Significant reductions in the number of discharges where patients have 0 comorbidities over the past 3 years has been fundamental in the movement of SHMI and more recently HSMR back into expected range. • The Clinical Coding Team continue to achieve the >98% coding completeness at the data freeze point. • A review of alerting groups has highlighted recording issues and collaboration between Coding, BI and AACD DMD have identified ways to improve this. In relation to a query around coding and ensuring everything is captured SKC was able to assure that the Trust is performing to the correct standard as cases are readily audited and the use of GMCR ensures that there is much more data that can be captured.	**Decision**: The Quality Assurance Committee received 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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision

Learning from Deaths Quarterly Update		S Kimber-Craig	The report was taken as read and SKC highlighted the following;
			• 8 cases were discussed at the committee, with 2 being referred for scoping as a potential Serious Incident –both were deemed not to meet the threshold for SI and therefore local investigation has been undertaken.
			• There is a backlog of cases still to be reviewed and so additional training sessions are being put in place to increase the number of reviewers in order to clear this backlog.
			• Key themes from the cases included:
			  ○ The importance of undertaking and appropriately documenting mental capacity assessments and Best Interest meetings, using an IMCA where required, particularly for those with learning disabilities.
			  ○ The need to stop and reflect when patients are in-patients for prolonged periods or when considering transfer to another Trust (i.e. are they still fit enough for the proposed intervention/management).
			  ○ The details for patients on "high risk medications" (e.g. antiretroviral for HIV, antirejection therapies for transplants) that are not prescribed by the GP may not be held on the GMCR thus initiation may be delayed.
			• A thematic review from the Palliative Care team on the deaths in August 2022 highlighted that there was little pattern in when patients were admitted to the Trust, nor where they came from across the locality. 60% of the patients had an active DNACPR order, but in 87% of patients despite this, there was no EPaCCS (Electronic Palliative Care Coordinating System) plan in place. There is an opportunity to promote this.
			
			The LFD Committee has considered how to ensure that operational pressures the organisation may be facing that can impact on patient outcomes is understood; a change to the input form is being made to reflect this query.
			The Committee had a discussion regarding high risk medications and the processes that are in place noting that there are systems in place but there is no consistency across all of them and hence there are gaps in the data available.
			SKC commented on the cases reviewed with mental health diagnoses and emphasised the need to review the definition of mental health in terms of the thematic analysis as this is too broad and needs to focus on those with psychiatric conditions which SKC and Business Intelligence are working towards.
				Decision: The Quality Assurance Committee received 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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Integrated Performance Report		CN / MD	The Chief Nurse and Medical Director presented the report and highlighted the following: • Clinical Correspondence has made some progress in relation to Outpatients but work is still required for Inpatients. A project group has been established and await the results to come to fruition. • Quality Improvement benefits are being seen following the investment to expand through the collaborative work as there has been a special cause improvement in all falls for the first time in over three years. • Pressure Ulcers – There had been zero Cat 4 declared however there was an increase in Cat 2 which may be due to early detection and the focus of the collaborative. • Sepsis – The change to EPR system has been finalised but the 'go live' date is yet to be confirmed so timely data should be available once this has been launched. • Serious incident reports have maintained 85%+ compliance. • IPC measures – Improvement has been noted within ASSD in terms of timely isolation and further focus is needed within AACD. There was a query in relation to c-difficile cases and the work being done around isolation as the figures did not appear to be going down. TR commented that there are more measures being put in place by RC and the team alongside the isolation work not least the antimicrobial stewardship programme and the real time data being captured.	**Decision**: The Quality Assurance Committee received and noted the report.
Clinical Governance & Quality Committee Chairs Report		Chief Nurse	The Chief Nurse highlighted one area of escalation which was in relation to the Care In Mind Pathway which had been escalated to the Deputy Place Based Leads as immediate action is required and this will continue to be tracked through the Committee. The Chair queried the 13 neonatal deaths in 2021 and if this would affect the Year 5 CNST. TR agreed to check this with JC but it was SM who confirmed that to review all of the cases would be a significant task given the timeframe for Year 5 CNST. The claims update regarding no executive oversight was noted by the Committee with FA advising that learning is shared with the division's but an update will be brought to the Committee for assurance.	**Action:** Medical Director to provide an update in relation to Claims and the Executive oversight and shared learning. **Decision**: The Quality Assurance Committee received the chairs 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

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Inpatient Survey 2022/23		Chief Nurse	The Chief Nurse presented the report and highlighted the following key points; • The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2022, who had had a stay of at least one night in hospital. • There were 33 patients excluded from the survey where they had either died or moved address leaving a sample size of 1,217. • 403 completed questionnaires were returned which provided an overall response rate of 33%. This was the same percentage response rate as in 2021. • The results for the 2022 survey indicate a broadly stable picture for Bolton NHS Foundation Trust, with the majority of scores sitting in the intermediate-60% range of Trusts surveyed. • There were seven scores in the top-20% range and three scores in the bottom-20% range.	**Decision**: The Quality Assurance Committee received the report.
			• In comparing the 2022 survey results positive progress can be seen against the 2021 themes of noise at night, food and cleanliness. There was discussion regarding the theme of communication and what is being done to understand what good communication looks like from the viewpoint of patients. RC confirmed through the use of iPads on wards patients are being asked in an open way for their feedback and the live data being captured allows issues to be addressed quickly rather than awaiting the results of an annual survey.	

	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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
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. Recruitment of newly qualified midwives remains positive (26.09WTE will have commenced 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 - The Local Maternity and Neonatal System has validated manual audit data in the absence of a single maternity information system to support the evidential submission. To date the service has achieved the overall target compliance score of 70% with all actions. Further work now required to recover element one that currently has an overall compliance score of 20% the audit actions of which relate to reducing smoking in pregnancy and monitoring of defined metrics. ○ 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	**Action:** Medical Director to present the Committee with an expansion paper focussing on Neonatal Mortality in February. **Decision:** The Quality Assurance Committee received and approved 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

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
			January 2023. Current compliance is below the required standard and has been impacted by a non-attendance rate of 60% due to clinical pressures. There have been multiple revisions to the training standards undertaken over the past twelve months to align the training needs analysis with revised core competency standards and the GMEC standard. This work has now been completed and a request has been made to the workforce team for the local excel database to be realigned to reflect the updated TNA as an interim measure prior to the transfer of all the training data onto ESR to aid future reporting. Following a query regarding the level of assurance around stillbirths and that the investigation process are robust the Medical Director agreed to present the Committee with an expansion paper focussing on Neonatal Mortality and will share this in three months' time. The Committee noted that the Trust had received its regional review and the decision was taken for the Trust not to be on the support programme and praised for candidness	
Risk Management Committee Chairs Report		Chief Nurse	The Chair's report was taken as read with no items noted for escalation. Improvements in relation to IT were noted by the Committee as part of the Our Voice programme and the importance of making sure EPR is fully rolled out in all areas to avoid duplication.	**Decision:** The Quality Assurance Committee received the chairs report.
Safeguarding Committee Chairs Report		Deputy Chief Nurse	The Chair's report was taken as read with no items noted for escalation. JN noted the escalation in the number of children referred and queried if there is enough capacity to which the team confirmed there are some concerns regarding capacity and demand but there is full oversight of this and the cases are dealt with on a prioritisation basis.	**Decision:** The Quality Assurance Committee received the chairs 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

Quality Assurance Committee Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	15 November 2023	Date of Next Meeting	20 December 2023
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Francis Andrews, Stuart Bates, Seth Crofts, Tyrone Roberts, Joanne Street, Carol Sheard, Fiona Taylor and Divisional Representation.	Apologies received from:	Jackie N, Martin N, Sharon K, Fiona N, Niruban R, James M, Sharon W and Rae W.

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Committee Effectiveness Review		S Katema	The Committee took the report as read with no further comments raised.	**Decision:** The Quality Assurance Committee noted the report.
Clinical Governance & Quality Committee Chairs Report		Chief Nurse	The Chairs Report was received and taken as read by the Committee. • AACD are making good progress in terms of pressure ulcers and have had no Cat 4 since July 2023. • ASSD remain focussed on reducing pressure ulcers and narrative has been provided regarding the concerns around unstagable pressure ulcers. • There is currently one SI Report that is overdue and the Trust is achieving 8.4 days from incident to declaration of SI. • CQC Improvement Plan – Update on improvement plan observations actions to be detailed in next month's update. • Delayed/Omitted Medications - Compliance with delayed and omitted doses of medicines will become part of the Divisions internal performance metrics.	**Decision**: The Quality Assurance Committee received the chairs report.
Board Assurance Framework		S Katema	The BAF was presented following periodic review. The following changes were proposed: • Ambition 1.1 - Due to a reduction in Likelihood from 4 to 3 the overall risk was now rated 12 and was now at the 'Target' risk rating. • Ambition 1.3 - Risk had reduced from 12 to 9 and remains a Significant Risk. • There was no proposed change to Risk Appetite.	**Decision:** The Quality Assurance Committee received the report.
Patient Safety Incident Report Policy and Plan		S Bates	The following key points were noted: • Organisations must produce a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan. The Framework will replace the current Serious Incident Framework. • The Trust has started to move to using PSIRF already with further monitoring conducted through the Clinical Governance & Quality Group	**Decision**: The Quality Assurance Committee received the report and approved the policy.

	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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision

Annual Health and Safety Report		S Bates	The report was presented and the following points were noted;
			• At the conclusion of the reporting period the Trust was 'Green' against the Health and Safety Legal Compliance.
			• Against the agreed seven Health and Safety key objectives, the following was confirmed;
			  ○ Successful in completing 2 (green)
			  ○ Provided some assurance on 1 (amber)
			  ○ Unsuccessful in completing against 4 (red)
			• PMVA Training compliance figures surpassed the Trust 85% compliance target every month through the period Apr 22 to March 23.
			• The Group Health and Safety Committee will be receiving a report to absorb the Sharps Safety Committee following the refresh of the TOR.
				Action: SBates to provide an update regarding PMVA/ Conflict Resolution training at the next meeting.
				Decision: The Quality Assurance Committee received the report.

Maternity Incentive Scheme Year 4 Progress Update (CNST)		Chief Nurse	TR 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 has been attained up to end September 2023. One reported breach of the standard on the 11 October 2023 at 0600hrs is currently under review.
			  ○ Safety Action 6 - To date the service has achieved an overall target compliance score of 67% with all actions. The current service focus is on the completion of carbon monoxide monitoring at every contact to meet the 80% standard. Our last assessed rate of compliance at 36 weeks gestation was 65% and improvement work remains ongoing. A revision of the standards for safety action 6 was undertaken on the 8 November 2023 by the LMNS, 3 interventions were suspended and some compliance thresholds were reduced to facilitate the attainment of the overall standard. The next formal validation of performance by the LMNS will be undertaken in January 2024.
			  ○ Safety Action 8 - The CNST training requirements were revised on the 23 October 2023 and 80% compliance by the 1 December 2023 for three defined elements will now be accepted if there is an action plan approved by Trust Board. This safety action is now on track to attain 80% compliance with the three required training elements by the 1 December 2023.
				Decision: The Quality Assurance Committee received and approved 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

Quality Assurance Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Risk Management Committee Chairs Report		Chief Nurse	The Chair's report was taken as read with no items noted for escalation. There was a discussion regarding the risks around iFM and of as a Trust they should be held accountable from a contractual point of view. It was agreed that further clarity would be useful on this at the next meeting.	**Action:** iFM accountability to be confirmed. **Decision:** The Quality Assurance Committee received the chair's report.
Safeguarding Committee Chairs Report		L Robinson	The Chair's report was taken as read with no items noted for escalation. The Committee noted the vacant Named Midwife for Safeguard and that this is being undertaken by someone alongside their other duties but needs to be a standalone role.	**Decision:** The Quality Assurance Committee received the chairs report.
Mortality Reduction Group Chairs Reports		S Kimber-Craig	The Chair's reports for September and October were taken as read with no items noted for escalation. The Committee noted the focus on Neonatal/Perinatal deaths and the processes in place to review these and assess data. SKC discussed the SHMI Influenza report which confirmed the Trust is seeing 3x more patients between ages 0-4 than other Trusts. This was confirmed by Bridget T as being due to all patients being tested which is not standard at other Trusts.	**Decision:** The Quality Assurance Committee received the chairs reports.
Professional Forum Chairs Report		Chief Nurse	The Chair's report was taken as read with no items noted for escalation. It was noted that the pressure ulcer panels are to be transitioned into Divisional panels as per the PSIRF policy and will include triumvirate attendance.	**Decision:** The Quality Assurance Committee received the chairs report.
Group Health and Safety Committee Chairs Report		S Bates	The Chair's report was taken as read by the Committee. Level 2 Manual Handling training compliance is noted to be below the Trust target and there had been an increase in manual handling incidents recently. Divisions had reported difficulty releasing staff to attend training due to clinical pressures/ off site venues.	**Decision:** The Quality Assurance Committee received the chairs 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

Report Title:	Bi-Annual Safer Staffing Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	✓
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	The purpose of this report is to outline the findings of the Bi-annual review for the period January - June 2023.

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

Previously considered by:
The report was presented at the People Committee meeting held on 22 November 2023 who received the report and endorsed the recommendations.

Proposed Resolution	It is recommended that the Board of Directors: I. Approve the Bi-annual staffing report and recommendations. II. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

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:	Sonia Griffin, Assistant Director of Nursing Lianne Robinson, Deputy Chief Nurse	**Presented by:**	Tyrone Roberts Chief Nurse

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

NQB	National Quality Board
RN	Registered Nurse
NA	Nursing Associate
HCA	Health Care Assistant
AHP	Allied Health Professional
HCS	Health care Scientist
SNCT	Safer Nursing Care Tool
IR	International Recruitment
KPI	Key Performance Indicators
BAPM	British Association Perinatal Medicine

1. Introduction

1.1 This report details the findings of the Bolton Foundation Trust January to June 2023 bi-annual staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels within the organisation.

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

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

2. Background - Adult in-patient areas

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

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

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

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

3. Current situation

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

Table 2; Compliance against key recommendations all wards during the months of January-June 2023.

Recommendation	Assessment		Variation
RN to Patient ratios not exceeding 1:8 day shifts	All adult in-patient areas achieve a maximum ratio of 1 RN to 8 patients on day shifts	✓	
Evidenced based Tool	The Organisation has deployed the Safer Nursing care tool	✓	
Headroom/uplift	Headroom/uplift is calculated at 23% - compliant	✓	
Skill Mix	Reviewed as part of bi-annual staffing review.	✓	
Professional judgement	All areas were reviewed with a focus on RN to Patient ratios and overall shift numbers (budgeted) vs actual	✓	

3.2 The RN to patio is measured as part of daily staffing reviews utilising safecare and captured as part of establishment reviews. Any incidence where staffing breaches, the ratio of 1:8 in daylight hours is reviewed by the Divisional Nurse Directors and appropriate mitigation and action takes place.

3.3 Process for review of safe staffing

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

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

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

- A full safety walk round across all in patient areas.
- A full review of SafeCare ensuring each area has provided professional judgement in relation the safe staffing of that ward.
- A divisional staffing review with decisions made to move staff around according to greatest need and level of risk.
- Matrons are clinically visible in their portfolio.

- Safe Staffing information is reported through the trust bed meetings at 9:00am, 1:00pm. 4:00pm and 7:30pm.

3.7 In addition, there is daily oversight undertaken by the Chief Nurses Senior Nursing Team with twice daily and weekly staffing meetings with escalation to the Chief Nurse when there is evidence of potential red flag incidences.

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

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

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

3.10 International Nurse Recruitment

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

3.12 Through the funding streams, we have recruited the following nurse numbers:-

Table 3: International Nurse Recruitment numbers up until June 2023

Year	Numbers of IR nurse recruited
2021	21
2022	129
2023 (arrivals before the end of March 2023)	35

3.13 International Nurses have been provided with a full bespoke educational programme ensuring they are equipped with the correct skills once they have passed their OSCE. Nurses are counted in the RN safe staffing figures once they have demonstrated the required level of competence and completed their supernumerary period**.**

3.14 Harm data per 1000 bed days

3.15 Falls

3.16 The breakdown of falls with moderate or above harm for January to June 2023 is included below. Bolton FT remains below the upper control limit for falls with harm and under the trust target for falls per 1000 bed days. See Table 5 and charts 1 and 2.

Table 4: Falls with Moderate Harm by Division

Month	Number of Falls with Harm	By Division
Jan 2023	6	AACD x5 AASD x1
Feb 2023	3	AACD x3
March 2023	2	AACD x1
April 2023	1	AACD x1
May 2023	1	AACD x1
June 2023	1	AACD x1

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

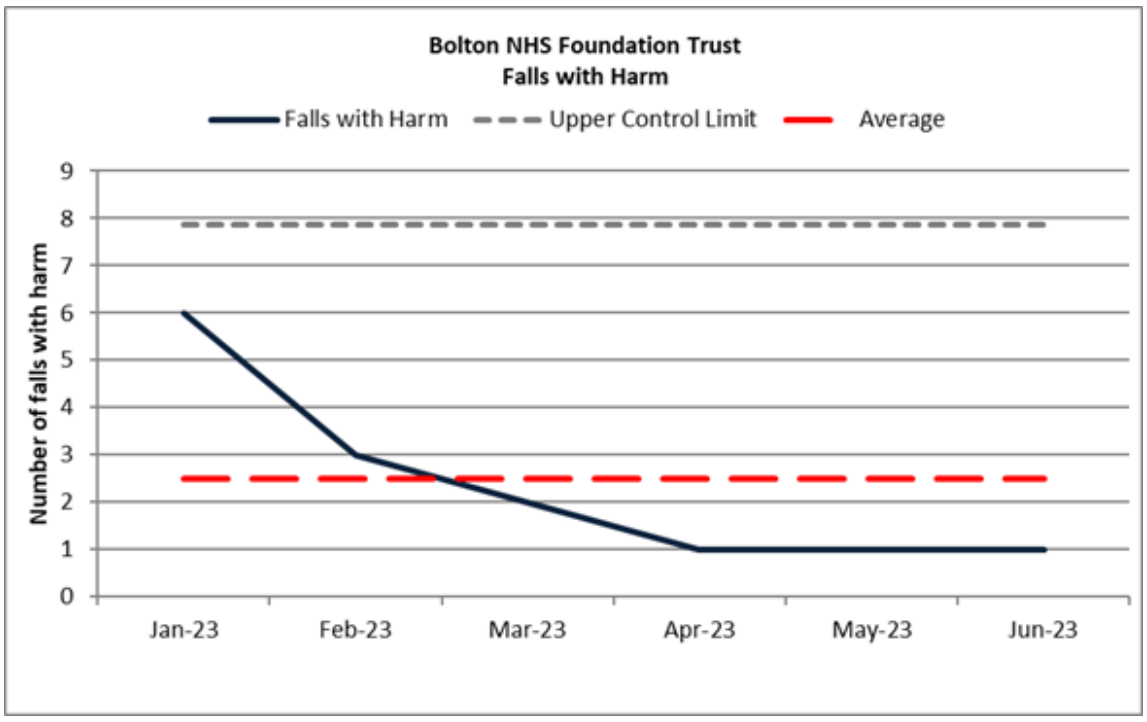


Chart 2: Falls per 1000 bed days.- The mean is 5.21

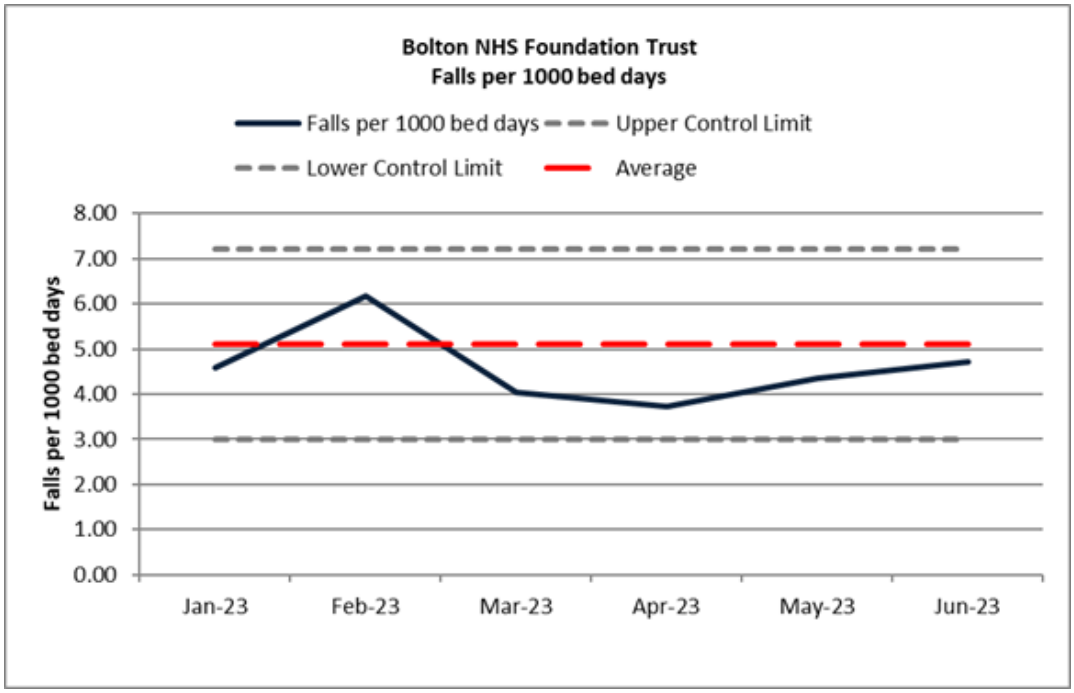


Chart 3: Total number of Falls

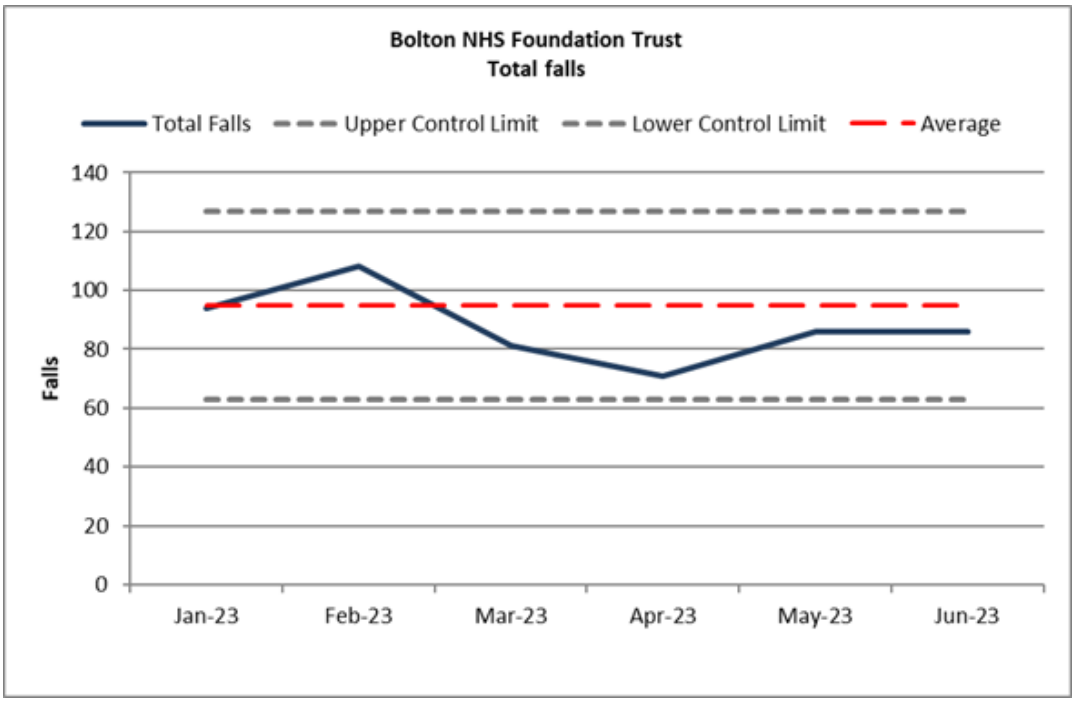
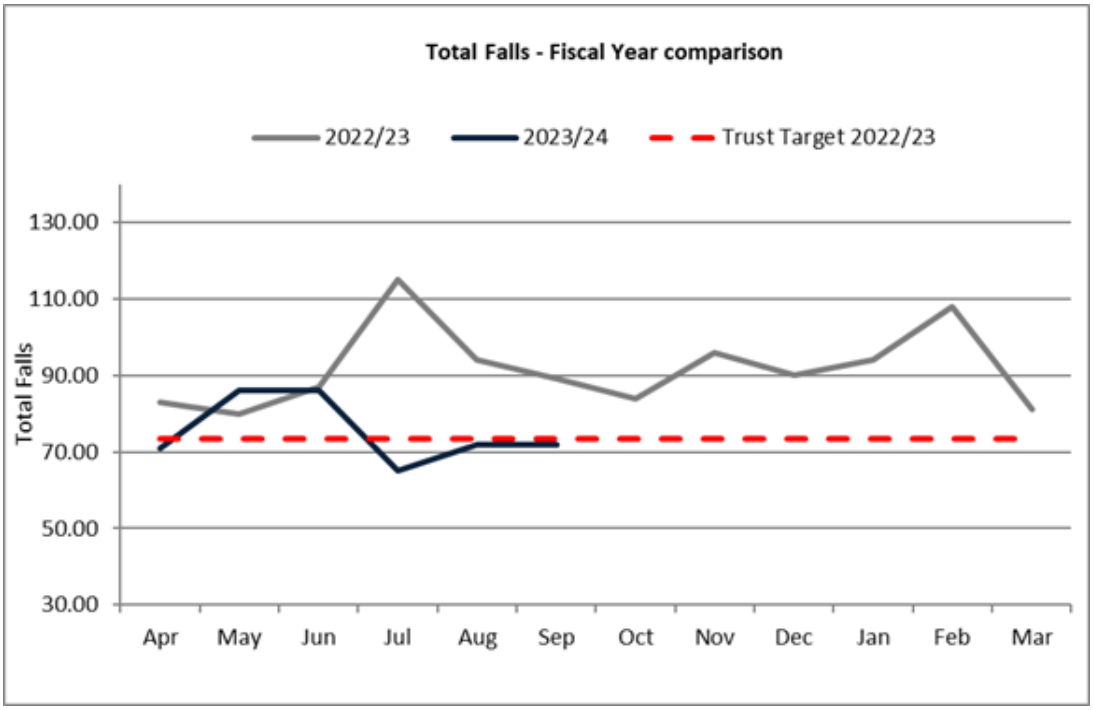


Chart 4: Total Falls- Fiscal year comparison



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

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

3.21 Pressure Ulcers

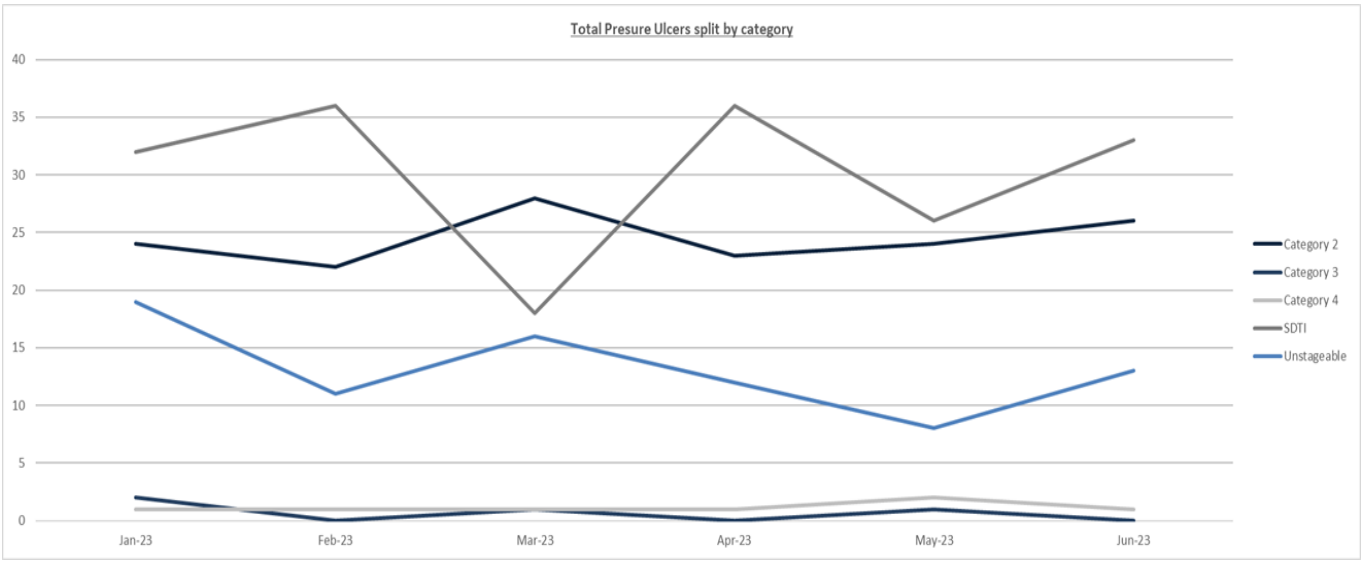
3.22 Pressure Ulcer prevalence is monitored via IPM and is reported monthly to Trust Board of Directors via the Integrated Performance Report.

3.23 Until the month of June 2023 all pressure ulcers were reviewed at the Trust wide harm free care panel where key themes and learning were identified. In June 2023 in line with PSIRF recommendations, swarm huddles for all category 2 pressure ulcers commenced and completed by Matrons, Ward Managers and District Nurse Team leaders.

3.24 Evidence gathered through harm free care panels, has identified failures in systems and processes, and there remains significant variation between wards / teams. Swarm huddles have mirrored the findings of harm free panels.

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

Chart 5: Total number of pressure ulcers for Bolton FT.



3.26 Red Flags

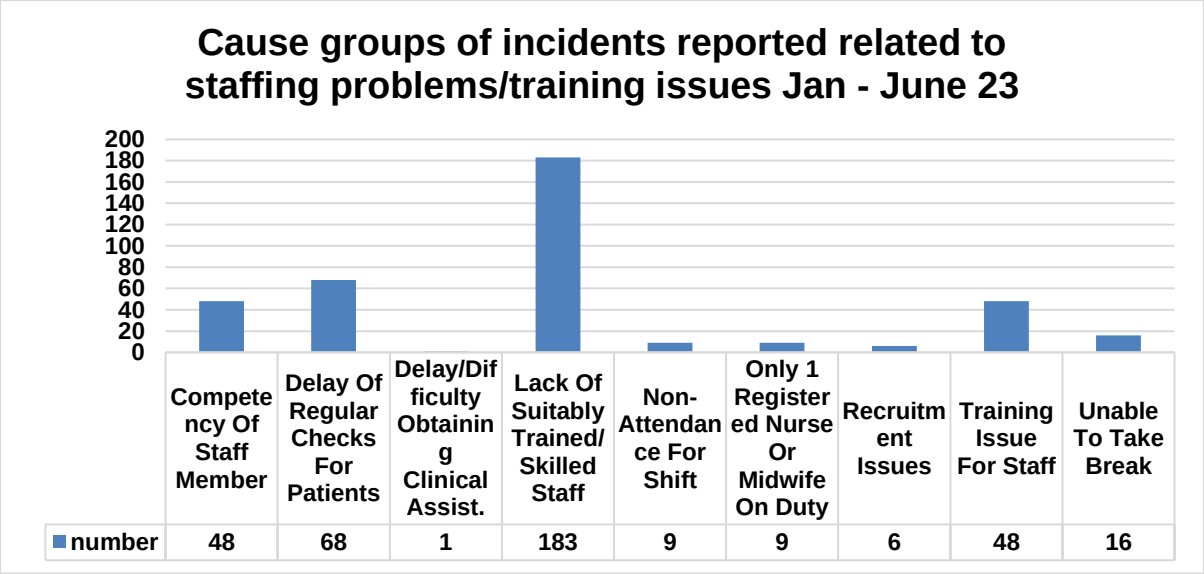
3.27 In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

- An unplanned omission in providing medications
- A delay in providing pain relief
- An incidence where vital signs have not been assessed or recorded
- Missed intentional rounding
- A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
- Less than two Registered Nurses or Midwives available on a shift.

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

The number of incidents reported under the Cause Staffing problems/training issues are below:

Chart 6: Incidents reported realted to staffing problems/ training issues Jan-Jun 2023

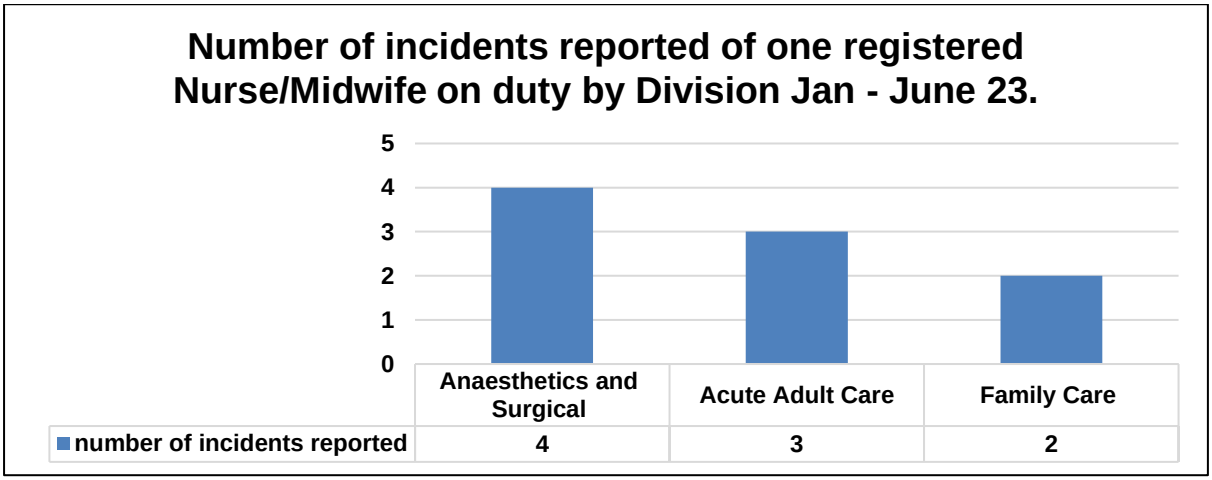


3.29 Appropriate escalation was undertaken for all of the incidents reported and the mitigation taken included the following actions:

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

3.30 In total there are 413 incidents reported between January and June 2023 which is a significant reduction compared to 714 incidents reported between July and December 2022. The actual impact of the incidents reported was 349 no harm, 59 low harm and 5 have yet to be given a final actual impact.

Chart 7: Number of incidents reported of one Registered Nurse/ Midwife on duty



3.31 Nine incidents were reported under the cause group of one Registered Nurse/ Midwife on duty. This is a significant decrease in the number of incidents reported in this cause group compared to the 23 incidents reported during July to December

2022. In all cases where only one registered Nurse/ Midwife is on duty these are escalated to the Chief Nurse

3.32 Of the nine incidents submitted with a cause group of only one Registered Nurse/ Midwife was on duty, six were reported correctly. The remaining three were incorrectly reported, as the narrative demonstrated there was not only one Registered Nurse/ Midwife on duty.

3.33 For the six reported correctly, appropriate escalation took place with support provided by staff from other areas in three of the incidents. For the remaining three, Matron reviews were undertaken and a dynamic risk assessment and professional judgement was used to determine deployment of staffing and escalation to Senior Divisional Management to review incidents. A review was undertaken of the staffing Matron logs available for the dates where incidents were reported. All logs reviewed documented actions taken to mitigate the areas that had been left with only registered member of staff.

3.34 All incidents detailed appropriate escalation of the lack of registered staffing. Of the six incidents with one Registered Nurse/Midwife, all had no harm identified as the actual impact. The majority of incidents detail prioritising care to patients during the shifts to manage the situation.

3.35 Sickness, vacancies and trust pressures are cited as the cause of the areas left with on Registered Nurse or Midwife in the narrative of the incidents when completed by managers.

3.36 National Adult Inpatient Survey November 2020 v November 2021

3.37 The 2022 National Adult In-Patient Survey was undertaken between January and March 2023 for those patients in our beds during November 2022.

3.38 There are two questions in the National Adult In-Patient Survey relating to staffing.

Chart 8: National In-patient survey

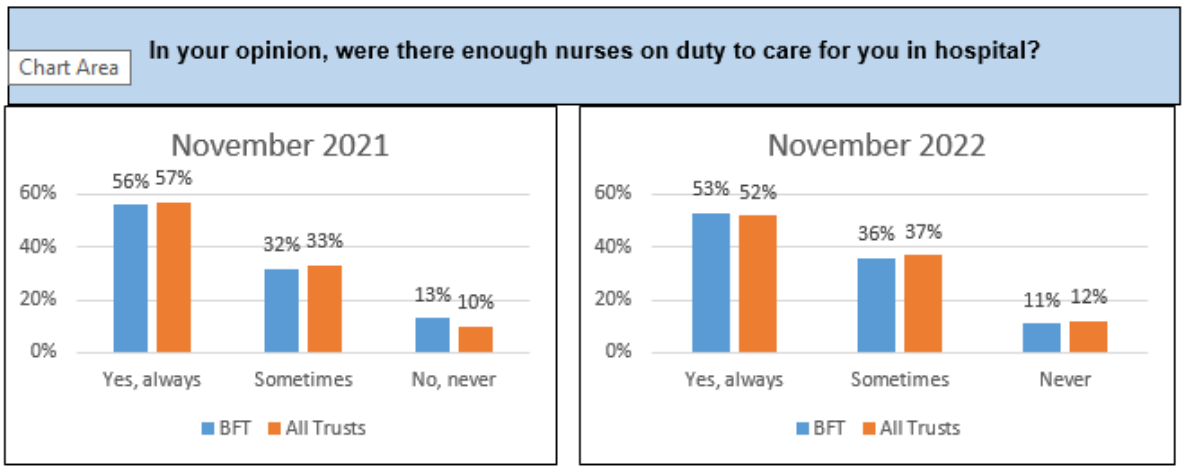
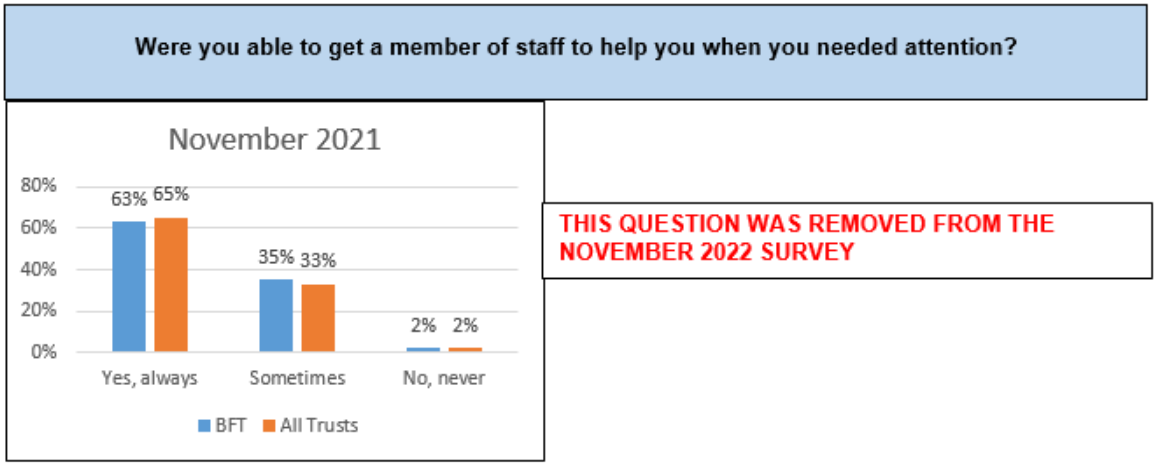
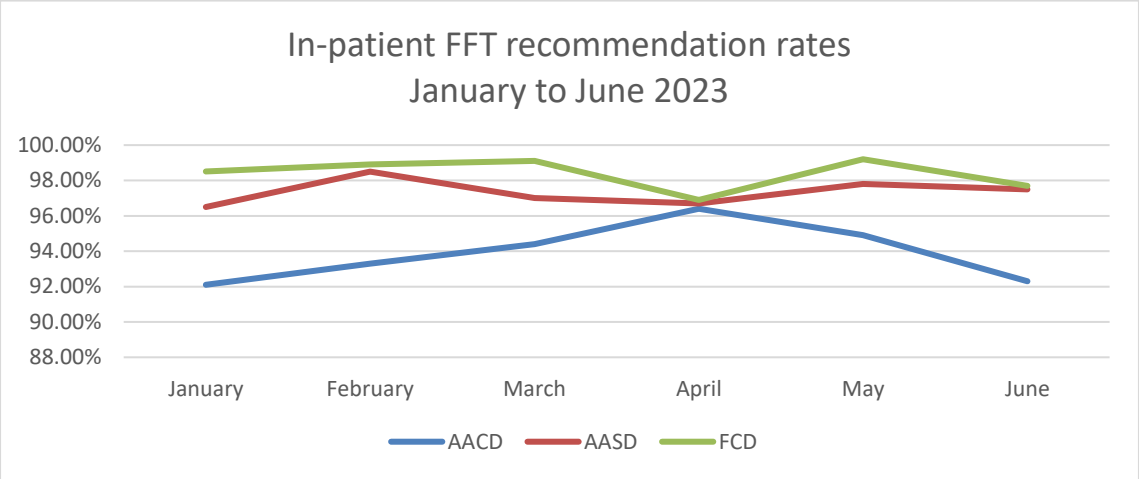


Chart 9: National In-patient survey



3.39 Friends and Family Test January to June 2023

Chart 10: In-patient FFT recommendation rates



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

3.40 PALS and Complaints

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

3.42 NHS website reviews

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

4.0 Expectation 2: Right skills

4.1 Leadership

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

4.3 Following the review all ward managers across the in-patient bed base are now supervisory. On the rostering template this is classified as a non-working day and can be utilised by the ward managers or allocated to another member of staff, for example to undertake the roster for the month, to undertake audit or to provide further leadership and managerial support.

4.4 Staff measures

4.5 Sickness

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

4.7 Retention

4.8 The below tables show the HR metrics for each month January to June 2023. The turnover rates exclude internal staff moves

4.9 The data is provided on a monthly basis to all divisions who review their headcount and monitor staffing unavailability. This is used in combination with the workforce staffing scorecards in order to triangulate workforce information and take action to drive down sickness absence and increase performance for mandatory and statutory training.

Table 5: HR Metrics January – June 2023

Measure Type	No.	No.	%	%	£	%	%	%	%	%
Period to Measure	In-month	In-month	In-month	12 months	In-month	12 months	12 months	12 months	12 months	In-month
Month	HC (Active)	WTE	Sickness Absence (includes Covid sickness)	Sickness Absence Rolling	Est. Sickness £ (in-month)	Labour Turnover %	Appraisal (excluding medical staff)	Statutory Training	Mandatory Training	RTW
Jan-23	5952	5171.54	5.77%	5.52%	£896,620.94	13.99%	83.61%	90.31%	85.75%	54.75%
Feb-23	5993	5203.63	5.29%	5.53%	£778,923.62	13.54%	82.12%	91.37%	86.74%	67.72%
Mar-23	6000	5212.61	5.47%	5.56%	£901,721.98	13.23%	84.11%	91.62%	85.32%	56.50%
Apr-23	5983	5192.47	5.21%	5.56%	£813,349.92	12.90%	85.49%	92.33%	86.22%	64.16%
May-23	5985	5195.61	5.22%	5.54%	£861,447.60	12.83%	87.59%	93.20%	88.25%	66.77%
Jun-23	5933	5173.47	4.83%	5.51%	£788,643.67	12.60%	86.84%	93.76%	89.26%	61.40%

RAG KPI's	RED	AMBER	GREEN
Sickness	>=4.75%	>4.20% & <4.75%	<=4.20%
Turnover	>=10%	-	<=10%
Appraisal	<=75%	>75% & <85%	>=85%
Stat Training	<=94.99%	-	>=95%
Mand Training	<=79.99%	>=80% & <85%	>=85%
RTW	<100%	-	100%

5. Expectation 3 – Right place, right time

5.1 E-Rostering

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

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

5.3 Rostering KPIs have been fully reviewed with Senior Divisional Nursing and Maternity Leads. These rostering KPIs have been further developed and are now issued monthly to each Divisions' Nursing and Operational Directors. Trend analysis will commence once sufficient months' data is available in a consistent format. These KPIs will be monitored at a divisional level with exceptions also presented through the Resource and Talent Group. An example of the KPIs can be found in appendix 1

5.4 Flexible Working Policy

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

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

5.6 The policy allows for a partnership approach which is cooperative and which considers both individual and service needs. All flexible working requests are reviewed on an annual basis by the Divisional Nurse Directors and relevant individuals.

5.7 Process for measurement and improvement

5.8 Dashboards per Division, known as; "Nursing and Midwifery Staffing Reports" are also issued monthly, in addition to the rostering KPIs. These reports include triangulation of various data sources such as:

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

5.9 A full roll out of these reports is now complete which are issued monthly. Appendix 2 provides an overview of the reports for information purposes only.

5.10 Both the rostering KPIs and staffing reports are under development on the Trust data-warehouse. The project, which is at its discovery stage, forms part of a wider objective of the Workforce directorate to provide increasing real-time, self-service access to workforce information.

5.11 Temporary Staffing

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

5.13 The tables 7 & 8 below demonstrate the month by month breakdown of WTE hours for Registered and Unregistered Bank and Agency staff across the trust from January to June 2023. This is the culmination of all registered staff employed by the respective divisions including out-patient departments and specialist nursing services.

5.14 When reviewing the data it is important to recognise that a –red position demonstrates that the area is over staffing against the agreed establishment and this is due to sickness and absence, maternity leave, increased acuity and additional escalation areas that are open.

Table 6: Registered bank and agency usage

Qualified	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Funded	2,096	2,095	2,096	2,104	2,096	2,082
Substantive						
Worked	-1,768	-1,790	-1,820	-1,817	-1,831	-1,828
Overtime Worked	-2	-2	-2	-4	-4	-2
Bank Worked	-103	-135	-121	-125	-118	-114
Agency Worked	-89	-87	-99	-74	-73	-69
Sub Total Worked	-1,962	-2,014	-2,042	-2,020	-2,026	-2,013
Funded vs Worked	134	80	54	84	70	68

Table 7: Unregistered bank and agency usage

Unqualified	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Funded	1,257	1,257	1,256	1,227	1,227	1,202
Substantive						
Worked	-1,132	-1,151	-1,157	-1,134	-1,106	-1,108
Overtime Worked	-2	-3	-3	-4	-2	-2
Bank Worked	-213	-236	-203	-198	-201	-194
Agency Worked	-0	-0	0	-0	-0	-0
Sub Total Worked	-1,348	-1,390	-1,363	-1,336	-1,310	-1,304
Funded vs Worked	-90	-133	-108	-109	-82	-102

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

5.16 It is evident from the tables above that the number of registerd nurses is under establishment whereas this is offset by unregistered nurses being over establihsment. This is in line with the trusts plans to open additional ward areas to deal with winter

pressures and increased acuity as well as international nurse working as supernumerary. It is anticipated that this shortfall will reduce again in the next reporting period.

6.0 Speciality Areas

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

6.2 This report will give a focused review of the speciality areas for the period January 2023- June 2023.

6.3 Acute Adult Care Division – Emergency Department
Current speciality and National guidance

6.31 NICE developed evidence-based guidelines on safe staffing for ED nursing numbers published in 2015. NICE recommended 1 to 4 ratio of nursing to patients in ED Majors and 1 to 2 ratio of nursing to patient in ED Resuscitation.

6.32 Compliance with guidance against establishment

6.33 A full staffing review was undertaken in October 2022. A business case has since been approved requesting that increases to the staffing levels in response to continued demand, and delays in bed allocation, were funded on a permanent basis**.** The department complies with the national guidelines of staffing ratios in all specified areas of ED, plus staffing for additional capacity utilised.

6.34 The uplift in establishment also allows for additional roles;
Senior nurse floor manager - to co-ordinate patients waiting for ambulance handover, ensure fit to sit is carried out, and provide senior nursing hands on support to the shift leader and staff.

2nd triage nurse- to support patients being triaged in under 15 minutes as per NHS England Guidance

Corridor support- for up to 10 patients, requiring 1:5 ratio 1 RN + 1 NA (the NA currently backfilled with an RN due to NA recruitment difficulties) and 1 waiting room nurse. This approach allows increased staffing matched to the nursing workload, therefore additional nursing have been added to ensure all necessary nursing care is provided safely and patient flow is maintained.

6.35 Compliance with guidance against fill rate

6.36 Staffing fill % continues to fluctuate month on month.

Table 8: ED fill rate

Ward/Team	Grade Type Category	Day/Night	Jan-23 Fill %	Feb-23 Fill %	Mar-23 Fill %	Apr-23 Fill %	May-23 Fill %	Jun-23 Fill %
A&E Majors (0419)	Registered	Day	109.75%	92.13%	90.02%	89.35%	91.18%	91.08%
	Non-Registered	Day	93.21%	93.96%	98.98%	95.19%	97.93%	96.43%
	Registered	Night	104.91%	92.28%	91.15%	89.01%	88.17%	88.22%
	Non-Registered	Night	95.81%	92.01%	114.02%	97.56%	96.93%	99.49%
A&E Minors (0422)	Registered	Day	112.70%	114.98%	107.74%	109.56%	102.03%	96.86%
	Non-Registered	Day	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
	Registered	Night	117.79%	118.13%	114.03%	104.20%	101.02%	98.80%
	Non-Registered	Night	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
A&E Paeds (0423)	Registered	Day	109.50%	112.03%	106.33%	109.38%	110.69%	111.67%
	Non-Registered	Day	93.72%	77.73%	92.78%	98.33%	100.00%	100.00%
	Registered	Night	114.29%	129.21%	121.26%	115.58%	125.30%	121.56%
	Non-Registered	Night	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

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

6.37 Recruitment and Retention issues

6.38 The table below demonstrates that registered nursing vacancy has gradually reduced.

Table 9: ED Vacancy Rate

Ward/Team	Grade Type Category	Jan-23 Vacancy	Feb-23 Vacancy	Mar-23 Vacancy	Apr-23 Vacancy	May-23 Vacancy	Jun-23 Vacancy
A&E Majors (0419)	Registered	-14.64	-12.57	-10.87	-10.02	-6.74	-8.23
	Non-Registered	-5.64	-3.64	-5.87	-12.78	-11.78	-16.69
A&E Minors (0422)	Registered	#N/A	#N/A	#N/A	0.46	0.46	0.46
	Non-Registered	#N/A	#N/A	#N/A	5.76	5.76	6.68
A&E Paeds (0423)	Registered	#N/A	#N/A	#N/A	-3.16	-3.16	-1.1
	Non-Registered	#N/A	#N/A	#N/A	0.56	0.56	1.56

6.4 Family Care Division- Neonatal Unit

6.5 Current speciality and National guidance

6.51 Staffing levels on the Neonatal Unit are monitored in line with the British Association of Perinatal Medicine (BAPM 2021, DOH 2019 and NICE 2018). The model indicates the staffing levels in relation to patient acuity i.e. 1:1 for Intensive Care, 1:2 for High dependency care and 1:4 for special care and a supervisory shift coordinator (band 7) in charge.
We aim to achieve 90% - 100% staffing as per BAPM.
Where staffing falls below 90% this is escalated to the Director of Midwifery where relevant mitigation and action is put in place. The outcome of this could be the temporary closure of the unit.

Table 10: Average levels from January –June 23 of staffing as per BAPM incorporating all patient: staff ratios.

MONTH	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023
BAPM COMPLIANCE	93%	82%	92%	87%	96.2%	92.2%

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

6.52 British Association of Perinatal Medicine (BAPM) standards

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

Table 11: Compliance against BAPM standards.

Standard	Bolton FT compliance
Supervisory Nurse in charge	Compliant
70% all nurses should be QIS (qualified in speciality)	Compliance currently 49.7%
Special Care Nursing ratio RN to Non-registered 70-30	Compliant

6.54 The compliance of nurses QIS, does not reflect those currently in training or due to finish. This level of compliance is not unique to Bolton and is a reflection of the national shortage of Neonatal Nurses. This has been added to the unit risk register and has been highlighted at network level. A full network wide training needs assessment is currently underway in order to provide network wide education provision and consolidation.

6.55 The table below demonstrates the Neonatal Unit staffing fill rates.

Table 12: Neonatal unit fill rates

Ward/Team	Grade Type Category	Day/Night	Jan-23 Fill %	Feb-23 Fill %	Mar-23 Fill %	Apr-23 Fill %	May-23 Fill %	Jun-23 Fill %
Neonatal Unit [3013]	Registered	Day	99.59%	99.62%	99.38%	101.38%	100.52%	83.91%
	Non-Registered	Night	121.14%	83.93%	124.71%	115.94%	83.21%	90.29%
	Registered	Day	99.00%	97.07%	98.83%	98.89%	98.08%	86.03%
	Non-Registered	Night	110.71%	118.01%	113.83%	118.17%	106.60%	90.00%

6.56 As part of the Neonatal Critical care review, the Neonatal unit secured external funding in November 2012 for 18 WTE (including 25% uplift) additional nurses, this as a reflection of actual direct cot side care against average activity over a 3-year period. To date recruitment is ongoing to establish the 18 WTE. All vacancies are out to advert.

Table 13: Neonatal Unit vacancy rates including increased establishment.

Ward/Team	Grade Type Category	Jan-23 Vacancy	Feb-23 Vacancy	Mar-23 Vacancy	Apr-23 Vacancy	May-23 Vacancy	Jun-23 Vacancy
Neonatal Unit [3013]	Registered	-23.35	-23.41	-23.74	-22.82	-25.94	-27.02
	Non-Registered	-1.78	-1.78	-0.78	-0.16	-0.16	-0.16

7.0 Update on planned steps from last report

7.1 Following on from the previous report July to December 2022, the table below demonstrates current progress against the identified project areas.

Project Number	Project Title	Progress Update	RAG rating
1	SNCT Inpatient areas	Three census collections have been completed on the adult in-patient wards and paediatric ward. Issues were raised in all 3 censuses with inter rater reliability. A further census was completed in July 2023 with revised inter-reliability and data analysis. This will be reported on in the staffing report covering July-December 2023. Further data collection planned for February and September 2024	
	SNCT ED	The first data collection has taken place in the emergency department. A second census is planned for July 2023 with revised inter-reliability and data analysis. Further data collection planned for February and September 2024	

	SNCT Community	Training of community nursing teams to Utilise the CNSST has been undertaken and the first data collection is planned for March 2023 and October 2023	
2	Recruitment, the chart below (chart 11) demonstrates current recruitment activity and planned workforce gap.	Recruitment and retention plans are currently in place supported by a career pathway for all clinical staff.	
		A full international nurse recruitment plan is underway and is on track for delivery against numbers requested via NHSE. Full review of International recruitment undertaken and recruitment was paused due to vacancy fill.	
3	Rota Management	Roster Management processes are embedded across divisions. The suite of rostering KPI's have been further developed with workforce Business Intelligence colleagues and reviewed with Divisional Senior Nurses. These are now issued monthly to Divisional Nursing and Operational Directors. Where exceptions arise these are reported through the Resource and Talent Group.	
4	Trainee Nursing Associates	The Increasing capacity of Trainee Nursing Associates business case was approved in July 2022 this will increase number of TNAs over the next 2 years. Total number of NAs will equate to 159. We are off trajectory with currently 57 on the programme. This is due to a lack of supply via our HEE partners which we are working with to address.	
5	Bank and Agency	A full review of the processes for request temporary staffing has been undertaken and an SOP is in place. Weekly and monthly reporting is now available to track spend and evidence is available to demonstrate a reduction in variable pay.	
6	Leadership	A full review of the percentage of supervisory time that Ward Managers work against the NQB standards was undertaken and all ward managers are provided with 100% supervisory time	
7	HCA Retention	A full review of leaver data and common themes, oversight within division and standardisation of divisional processes	
8	Advanced Practice Workforce	Development of trustwide engagement plan for HCS, CNS and ACPs.	

8.0 Further transformation

8.1 As part of the Nursing, Midwifery, Allied Health Professionals and Health Care Scientist priorities through until 2024 further workforce transformation continues to take place.

8.2 In line with the NHS Long Term Workforce Plan a review of the nursing, midwifery, AHP and HCS response, specific to Bolton, has commenced

8.3 The trust has committed to engaging with NHS Professionals to provide the temporary staffing function. The monitoring off this is via the workforce function and is being undertaken in partnership with The Chief Nurse Senior Nursing Team. It is anticipated that this will increase fill rates for temporary staffing, whilst also decreasing variable pay spend.

9.0 Summary

9.1 This report provides a comprehensive review of the framework used to assess safe staffing levels, both in real-time, and bi-annually. The additional data provided and forensic review supports the recommendation that safe staffing levels were maintained during the periods of January and June 2023.

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

10.0 Recommendations

10.1 It is recommended that the Board of Directors:

I. Approve the Bi-annual staffing report and recommendations.
II. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

Appendix A – NQB Recommendations
Detailed breakdown.

1.0 Expectation 1 - Right staff

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

1.2 Process for determining staffing levels

1.3 Registered Nurse to Patient ratio

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

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

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

1.7 Skill Mix

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

1.9 Professional judgement

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

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties

- Multi-professional working
- Shift patterns

1.11 Safety outcome indicators

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

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

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

1.14 Patient reported outcome measures

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

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

1.16 Staffing data & Training and education

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

1.17 Process measures

- Hand hygiene, documentation standards

1.18 Comparison with peers

1.19 Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

2.0 Expectation 2 – Right Skills

2.1 The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role

- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place.
- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

- Recruitment and retention – strategies should be in place

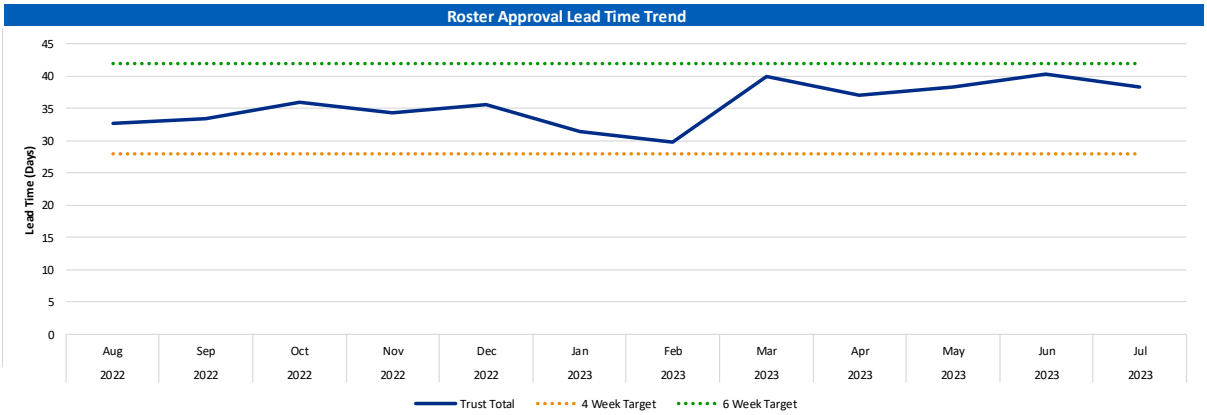
3.0 Expectation 3 – Right place, right time

3.1 The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise. Recommendations to support this include;

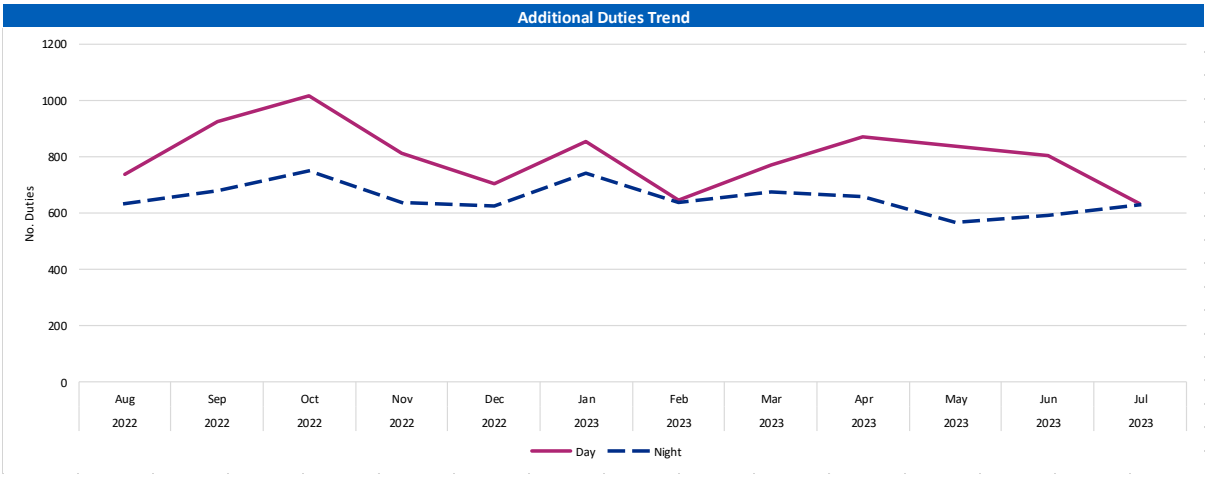
- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Appendix 1 – KPI Examples

Roster Approval Lead Time KPI Performance					
Period	No. Rosters (Teams) in Scope	Average Lead Time (in Month)	No. Rosters Compliant (6 Weeks/42 Days or More)	No. Rosters Compliant (4 Weeks/28 Days or More)	No. Rosters Non-Compliant (Less than 4 Weeks/28 Days)
Jul 2023	78	38.32	42 (53.85%)	22 (28.21%)	14 (17.95%)

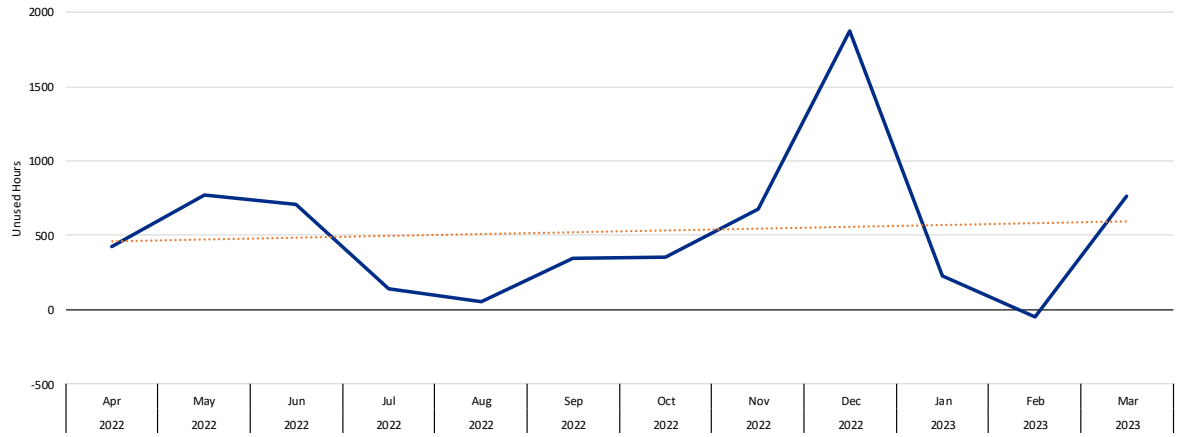


Additional Duties				
Period	Total	Registered	Non-Registered	Other
Jul 2023	1266	344	903	19



Unused Hours - Non-Registered					
Period	Available Contracted Hours	Unused Hours	Unused WTE	Hours Filled Bank/Agency/OT	Avoidable Bank/Agency/OT
Mar 2023	90592	767 (0.4%)	20.45	28574	767 (2.61%)

Unused Hours per Month by Division - Non-Registered

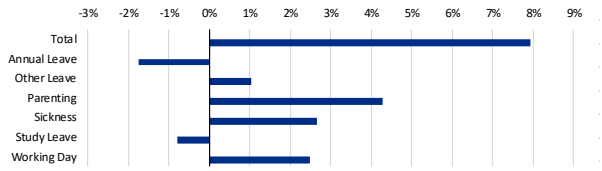


Unavailability In Month					
Period	Contracted Hours	Funded Unavailability Hours	Total Unavailability Hours	Hours Filled Bank/Agency/OT	Unfunded Bank/Agency/OT
Jul 2023	274929	63783 (23.2%)	82331 (29.95%)	49681	18548 (37.33%)

Registered

Type	Funded Hrs	Funded %	Actual Hrs	Actual %	Difference Hrs	Difference %
Total	43561	23.20%	58458	31.13%	14897	7.93%
Annual Leave	29479	15.70%	26204	13.96%	-3275	-1.74%
Other Leave	0	0.00%	1926	1.03%	1926	1.03%
Parenting	0	0.00%	8065	4.30%	8065	4.30%
Sickness	8449	4.50%	13449	7.16%	4999	2.66%
Study Leave	5633	3.00%	4166	2.22%	-1467	-0.78%
Working Day	0	0.00%	4649	2.48%	4649	2.48%

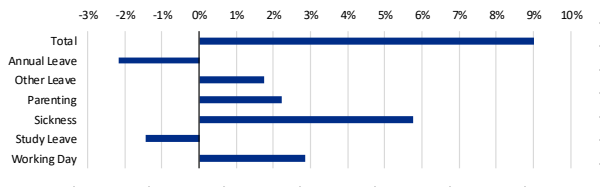
Unavailability Exceeding Funded - % by Type



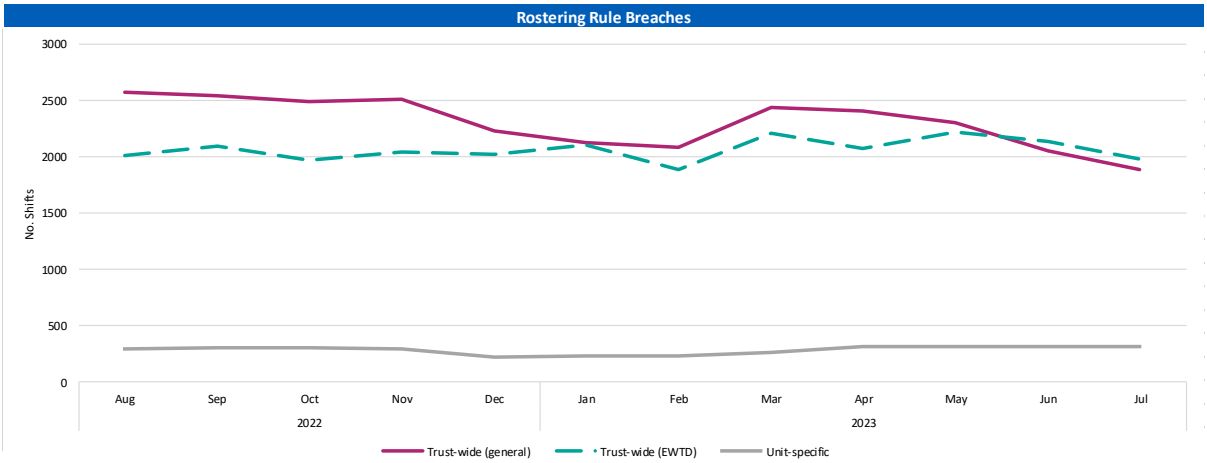
Non-Registered

Type	Funded Hrs	Funded %	Actual Hrs	Actual %	Difference Hrs	Difference %
Total	20223	23.20%	28077	32.21%	7854	9.01%
Annual Leave	13685	15.70%	11810	13.55%	-1875	-2.15%
Other Leave	0	0.00%	1521	1.75%	1521	1.75%
Parenting	0	0.00%	1939	2.22%	1939	2.22%
Sickness	3923	4.50%	8944	10.26%	5022	5.76%
Study Leave	2615	3.00%	1371	1.57%	-1244	-1.43%
Working Day	0	0.00%	2491	2.86%	2491	2.86%

Unavailability Exceeding Funded - % by Type



Rostering Rule Breaches					
Period	Trust-Wide (General)	Trust-Wide (EWTD)	Unit-Specific		
Jul 2023	1885	1985	314		



Appendix C – Example ASSD Staffing Data Pack

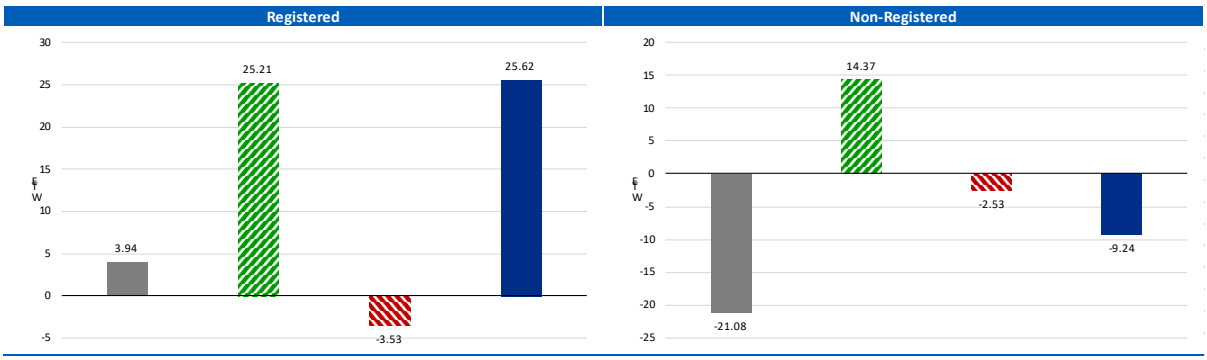
Ward (Unit)	Vacancy July 2023						Recruitment & Leavers As at 21/08/2023							
	WTE Budgeted Establishment		WTE In Post		WTE Difference		WTE Requested Recruitment		WTE Live Recruitment		WTE Starters (Final Offer)		WTE Leaving	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**437.58**	**360.10**	**441.52**	**339.02**	**3.94**	**-21.08**	**5.92**	**4.80**	**35.84**	**79.26**	**25.21**	**14.37**	**-3.53**	**-2.53**
A&E Majors (0419)	89.65	47.30	79.00	30.15	-10.65	-17.15	0.00	0.00	12.00	10.26	6.84	6.45	0.00	0.00
CCU (Coronary Care Unit) [0121]	18.55	7.95	20.96	6.75	2.41	-1.20	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00
CDU (Clinical Decisions Unit) (0420)	14.55	5.76	11.60	6.16	-2.95	0.40	0.00	0.00	2.00	0.00	1.53	0.00	0.00	0.00
A&E Paeds (0423)	17.42	7.25	17.12	6.25	-0.30	-1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Discharge Lounge (0415)	5.29	4.28	3.81	3.61	-1.48	-0.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A&E Minors (0422)	21.50	0.00	22.96	6.68	1.46	6.68	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
SDEC (0404)	22.19	13.65	21.93	12.68	-0.26	-0.97	0.00	0.00	2.00	0.00	0.92	0.00	-0.92	0.00
Ward A4 (0214)	16.58	17.39	19.13	23.42	2.55	6.03	0.00	0.00	1.00	1.00	0.00	0.00	0.00	-0.92
Ward B1 [0206]	16.79	21.24	18.62	17.72	1.83	-3.52	0.00	4.00	2.00	1.00	4.92	0.00	0.00	0.00
Ward B2 (0207)	3.00	0.01	1.61	2.61	-1.39	2.60	0.00	0.00	1.92	0.00	0.00	0.00	0.00	0.00
Ward B3 (0408)	16.79	22.12	21.66	19.43	4.87	-2.69	0.00	0.00	0.92	1.00	2.00	1.00	0.00	0.00
Ward B4 (0208)	17.53	29.56	16.00	27.48	-1.53	-2.08	0.00	0.00	1.00	61.00	0.00	6.92	-1.00	0.00
Ward C1 [0105]	16.79	16.92	19.37	14.96	2.58	-1.96	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00
Ward C2 [0109]	16.79	24.44	20.61	22.02	3.82	-2.42	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00
Ward C3 [0115]	16.79	25.90	16.00	25.08	-0.79	-0.82	0.00	0.00	1.00	1.00	0.00	0.00	0.00	-1.61
Ward C4 (0216)	16.79	20.04	25.24	26.01	8.45	5.97	0.00	0.00	0.00	0.00	3.00	0.00	-1.00	0.00
Ward D1 (0409)	29.22	21.60	26.95	19.12	-2.27	-2.48	3.00	0.00	3.00	1.00	1.00	0.00	-0.61	0.00
Ward D2 (0411)	26.22	14.08	23.73	14.85	-2.49	0.77	1.92	0.00	6.00	0.00	2.00	0.00	0.00	0.00
Ward D3 [0117]	18.60	21.52	17.40	18.18	-1.20	-3.34	1.00	0.00	1.00	1.00	1.00	0.00	0.00	0.00
Ward D4 [0119]	18.60	21.48	19.52	19.46	0.92	-2.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ward H3 - Stroke [0204]	17.94	17.61	18.30	16.40	0.36	-1.21	0.00	0.80	0.00	0.00	0.00	0.00	0.00	0.00
Ward R1 (0309)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Key (Field/Column Descriptions):	
Budgeted Establishment	The Whole Time Equivalent (WTE), where 1 = 37.5 hours per week, of funded posts in the budget.
In Post	WTE of substantive employees in post - includes employees on career break, maternity leave, out on external secondment etc.
Difference	Establishment minus substantive staff in post, i.e. the 'true' vacancy. Note this may be different than the 'operating vacancy' which may be increased where employees are unavailable for long periods of time.
Requested Recruitment	WTE of requests to recruit in TRAC that are progressing through the authorisation stages (OBM/Finance/HRBM/ESC) and not yet advertised.
Live Recruitment	WTE that are either being advertised, at selection stage (shortlisting /interview) or have been conditionally offered a post and are undergoing pre-employment checks.
Starters (Final Offer)	WTE who have received and accepted a final offer and have a start date. They have not yet commenced in employment.
Leaving	WTE confirmed leavers in future, where a manager has submitted the SimpleSAF termination form and it has been processed by Payroll.

Key (RAG Status):		
Red		Outbound leavers from services with confirmed end date
Amber		Inbound on-going recruitment (various stages) without confirmed start dates
Green		Inbound recruitment with confirmed start dates

Key:

WTE Current Vacancy: WTE Starters (Final Offer): WTE Leaving: Forecast Vacancy:



Ward (Unit)	Finance July 2023 £000s Month Position		£000s YTD Position		£000s Forecast Position	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**66.03**	**15.21**	**121.42**	**60.36**	**862.90**	**182.01**
A&E Majors (0419)	48.08	35.09	-20.58	121.22	364.08	401.90
CCU (Coronary Care Unit) [0121]	-6.26	0.00	0.19	0.00	-49.85	0.00
CDU (Clinical Decisions Unit) (0420)	10.20	0.00	0.15	3.85	81.79	3.85
A&E Paeds (0423)	2.76	0.00	34.34	-7.59	54.83	-7.59
Discharge Lounge (0415)	0.87	0.00	5.84	0.00	12.80	0.00
A&E Minors (0422)	1.75	-23.04	33.41	-89.68	47.45	-274.01
SDEC (0404)	21.49	-4.96	83.31	-14.60	255.24	-54.26
Ward A4 (0214)	-1.23	0.00	-3.01	3.84	-14.77	3.84
Ward B1 [0206]	2.54	0.00	5.53	1.92	25.85	1.92
Ward B2 (0207)	6.20	0.00	15.87	0.00	285.31	0.00
Ward B3 (0408)	-4.90	0.00	3.58	-3.01	-35.63	-3.01
Ward B4 (0208)	6.49	0.00	39.34	1.92	91.31	1.92
Ward C1 [0105]	-11.18	0.00	-26.88	0.00	-116.32	0.00
Ward C2 [0109]	-7.51	0.00	-21.08	0.00	-81.18	0.00
Ward C3 [0115]	6.20	0.00	20.73	0.00	70.30	0.00
Ward C4 (0216)	-13.08	0.00	-44.09	0.00	-148.75	0.00
Ward D1 (0409)	6.75	0.00	38.07	1.57	88.97	1.57
Ward D2 (0411)	10.24	0.04	20.77	0.14	102.71	0.42
Ward D3 [0117]	3.01	2.23	1.22	10.82	25.26	28.69
Ward D4 [0119]	-11.41	5.85	-45.19	20.36	-136.46	67.15
Ward H3 - Stroke [0204]	-2.71	0.00	-11.94	9.60	-33.61	9.60
Ward R1 (0309)	-2.28	0.00	-8.18	0.00	-26.45	0.00

Key (Field/Column Descriptions):	
Month Position	Pay budget minus pay spend (substantive, bank and agency) in month.
YTD Position	Pay budget minus pay spend (substantive, bank and agency) since the start of April.
Forecast Position	The annual pay budget minus the forecasted pay spend (substantive, bank and agency) by the end of March.

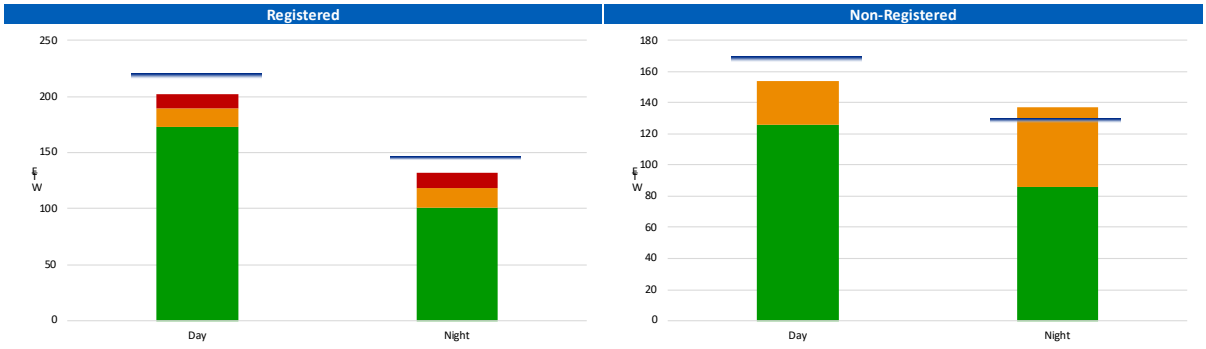
Ward (Unit)	Planned vs. Actual Staffing and Unused Hours July 2023												July 2023 WTE Unused Hours	
	WTE Planned Days		WTE Actual Days		% Fill Rate		WTE Planned Nights		WTE Actual Nights		% Fill Rate			
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**230.24**	**177.62**	**207.72**	**157.03**	**90.22%**	**88.41%**	**152.89**	**135.66**	**138.42**	**143.71**	**90.53%**	**105.93%**	**2.22**	**3.33**
A&E Majors (0419)	40.73	15.84	36.65	15.13	89.97%	95.50%	42.21	15.84	36.48	15.40	86.42%	97.19%	0.64	0.20
CCU (Coronary Care Unit) [0121]	6.72	2.26	6.67	2.24	99.24%	99.16%	4.53	2.26	4.53	2.27	100.00%	100.42%	-0.37	0.03
CDU (Clinical Decisions Unit) (0420)	6.75	2.99	6.88	4.40	101.86%	147.14%	4.53	2.26	4.60	4.35	101.61%	192.19%	-0.07	0.09
A&E Paeds (0423)	4.48	2.26	4.74	2.25	105.81%	99.93%	6.41	2.12	7.29	2.38	113.77%	112.59%	0.12	-0.04
Discharge Lounge (0415)	3.54	3.54	3.47	3.07	98.07%	86.65%	3.07	0.00	0.00	0.00	0.00%	*N/A*	-0.13	-0.02
A&E Minors (0422)	13.57	0.00	14.45	0.41	106.49%	*N/A*	8.82	0.00	9.46	0.29	107.23%	*N/A*	-0.07	0.00
SDEC (0404)	14.96	8.31	15.00	7.57	100.27%	91.16%	0.00	0.00	0.16	0.00	*N/A*	*N/A*	-0.30	-0.19
Ward A4 (0214)	8.98	9.05	8.93	9.31	99.39%	102.87%	4.53	9.05	4.54	10.73	100.21%	118.55%	0.31	-0.50
Ward B1 [0206]	9.01	11.28	9.59	11.55	106.43%	102.41%	4.53	6.79	5.09	11.94	112.38%	175.81%	-0.06	0.06
Ward B2 (0207)	8.98	11.32	0.03	0.00	0.39%	0.00%	4.31	9.05	0.00	0.00	0.00%	0.00%	-0.01	0.00
Ward B3 (0408)	8.91	8.93	8.94	10.22	100.41%	114.36%	4.45	9.05	4.67	12.12	104.92%	133.87%	-0.39	1.33
Ward B4 (0208)	9.06	11.32	3.98	3.80	43.96%	33.55%	4.53	9.05	2.70	4.38	59.68%	48.39%	0.24	0.84
Ward C1 [0105]	8.91	6.75	9.10	6.92	102.20%	102.40%	4.53	6.79	4.53	7.52	100.00%	110.75%	0.36	0.16
Ward C2 [0109]	9.05	11.33	8.96	11.26	98.93%	99.41%	4.53	9.05	4.60	12.54	101.61%	138.48%	0.12	0.55
Ward C3 [0115]	9.07	11.35	8.79	11.33	96.97%	99.77%	4.53	9.05	5.59	9.13	123.56%	100.81%	-0.56	0.58
Ward C4 (0216)	8.98	11.36	9.57	12.09	106.55%	106.45%	4.53	6.79	5.00	11.03	110.48%	162.41%	0.90	0.15
Ward D1 (0409)	13.35	9.08	13.69	9.02	102.49%	99.29%	11.32	6.79	11.18	8.31	98.79%	122.37%	0.62	0.26
Ward D2 (0411)	11.30	9.05	11.66	10.09	103.22%	111.45%	9.00	6.79	8.54	9.64	94.80%	142.03%	0.78	-0.17
Ward D3 [0117]	9.05	8.98	8.80	8.87	97.19%	98.78%	6.79	6.79	6.94	7.00	102.15%	103.02%	-0.05	-0.44
Ward D4 [0119]	9.02	9.05	8.73	8.43	96.81%	93.06%	6.71	6.79	6.40	7.08	95.27%	104.30%	-0.13	0.02
Ward H3 - Stroke [0204]	9.03	9.06	8.87	8.92	98.26%	98.48%	4.53	6.79	4.53	7.01	100.00%	103.23%	0.27	0.43
Ward R1 (0309)	6.79	4.49	0.22	0.15	3.23%	3.25%	4.53	4.53	1.61	0.58	35.48%	12.90%	0.00	0.00

Key (Field/Column Descriptions):	
Planned Days	Based on the roster template 'required' day shifts (does not include 'optional' duties). Also does not include 'additional' duties added by managers. Should be aligned with budgeted establishment.
Actual Days	All rostered day shifts except those 'Excluded from SafeCare' calculations (e.g. ward clerk, housekeeper etc.) - includes 'optional' and 'additional' duties where rostered.
Planned Nights	Based on the roster template 'required' night and evening shifts (does not include 'optional' duties). Also does not include 'additional' duties added by managers. Should be aligned with budgeted establishment.
Actual Nights	All rostered night and evening shifts except those 'Excluded from SafeCare' calculations (e.g. ward clerk, housekeeper etc.) - includes 'optional' and 'additional' duties where rostered.
Fill Rate(s)	Actual days or nights divided by planned days or nights.
Unused Hours	Sum of contracted hours minus all work time and unavailability rostered - i.e. paid time with no allocated hours. A positive value indicates hours are owed to the Trust, and negative value indicates the Trust owes hours.

Key (RAG Status):		
Red		Fill rate is 20% or more above or below the planned
Amber		Fill rate is between 10% and 20% above or below the planned
Green		Fill rate is between 0% and 10% above or below the planned

Key:

Planned: Substantive: Bank: Agency:



Ward (Unit)	Unavailability July 2023															
	WTE Funded Headroom		WTE Total Difference		WTE Annual Leave		WTE Sickness		WTE Maternity		WTE Working Day		WTE Study Leave		WTE Other Leave	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**117.73**	**82.90**	**-68.42**	**-23.68**	**62.95**	**48.15**	**25.00**	**29.02**	**21.79**	**6.11**	**53.25**	**9.47**	**19.26**	**5.59**	**3.89**	**8.23**
A&E Majors (0419)	20.64	10.89	-9.71	2.31	9.33	4.70	4.09	1.18	2.90	0.66	10.52	0.51	2.71	0.22	0.80	1.31
CCU (Coronary Care Unit) [0121]	5.27	1.83	-3.52	-0.39	4.10	0.72	0.07	1.50	1.55	0.00	2.06	0.00	0.93	0.00	0.07	0.00
CDU (Clinical Decisions Unit) (0420)	4.35	1.33	-1.47	-0.53	2.45	0.76	0.51	0.00	0.00	0.00	1.72	0.61	1.09	0.49	0.05	0.00
A&E Paeds (0423)	4.01	1.67	-3.09	0.24	2.60	0.77	0.51	0.44	1.67	0.00	1.33	0.05	0.95	0.17	0.04	0.00
Discharge Lounge (0415)	1.22	0.99	-0.33	0.02	0.39	0.55	1.12	0.15	0.00	0.00	0.00	0.00	0.05	0.05	0.00	0.22
A&E Minors (0422)	4.95	0.00	-3.87	0.00	4.50	0.00	2.56	0.00	0.00	0.00	1.41	0.00	0.35	0.00	0.00	0.00
SDEC (0404)	5.11	3.14	-6.13	0.28	2.68	1.38	2.00	1.39	3.73	0.00	2.10	0.00	0.66	0.09	0.07	0.00
Ward A4 (0214)	4.82	4.00	-4.64	-4.81	2.16	3.21	1.32	2.46	0.22	0.95	4.93	1.73	0.63	0.07	0.21	0.40
Ward B1 [0206]	4.87	4.89	-2.28	-1.17	3.34	2.68	0.37	2.18	1.03	0.00	1.64	0.57	0.73	0.63	0.05	0.00
Ward B2 (0207)	1.69	0.00	0.53	-0.63	0.00	0.00	0.00	0.00	0.66	0.63	0.44	0.00	0.00	0.00	0.06	0.00
Ward B3 (0408)	4.87	5.09	-4.61	-0.52	3.19	3.92	1.53	0.73	0.00	0.00	3.56	0.39	1.06	0.42	0.15	0.15
Ward B4 (0208)	5.04	6.80	-0.64	-0.49	1.70	2.94	0.00	1.36	0.00	1.31	2.74	0.55	0.99	0.20	0.26	0.94
Ward C1 [0105]	4.87	3.89	-3.75	-3.93	2.59	2.51	1.58	2.98	1.03	0.00	2.27	0.69	0.85	0.41	0.29	1.23
Ward C2 [0109]	4.87	5.63	-5.51	-4.54	3.23	3.20	1.87	3.84	0.00	1.10	3.71	0.51	1.20	0.60	0.37	0.91
Ward C3 [0115]	4.87	5.96	-1.73	0.17	2.35	3.86	0.00	1.39	2.12	0.00	1.31	0.00	0.65	0.20	0.16	0.34
Ward C4 (0216)	4.87	4.61	-5.56	-3.13	3.59	3.82	1.04	1.65	1.48	0.00	2.59	0.49	0.73	0.71	1.00	1.07
Ward D1 (0409)	7.73	4.97	-3.28	-2.56	3.33	3.28	1.94	2.19	1.24	0.22	3.25	0.65	1.18	0.61	0.07	0.57
Ward D2 (0411)	7.04	3.24	0.02	0.46	2.47	2.31	1.00	0.07	1.61	0.00	0.70	0.00	1.17	0.18	0.07	0.22
Ward D3 [0117]	5.28	4.95	-3.06	-0.95	2.19	2.09	0.60	1.63	2.03	0.00	2.31	1.43	1.15	0.37	0.07	0.38
Ward D4 [0119]	5.28	4.94	-1.84	-2.26	3.09	3.90	1.33	1.71	0.55	0.80	1.06	0.44	1.04	0.18	0.04	0.17
Ward H3 - Stroke [0204]	5.13	4.05	-4.93	-1.25	3.69	1.52	1.57	2.17	0.00	0.44	3.59	0.84	1.14	0.00	0.07	0.33
Ward R1 (0309)	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Key (Field/Column Descriptions):	
Funded Headroom	The portion of the budgeted establishment included on top of the 'planned' hours to account for time expected to be unavailable due to annual leave, sickness, study and management. Other leave categories are not funded/budgeted for.
Total Difference	The funded headroom minus the sum total of all unavailability categories. The greater a negative value, the more of a roster gap which may result in the need for overtime, bank or agency fill.
Annual Leave	Includes 'normal' annual leave, bank holidays and 'bought' annual leave.
Sickness	Includes all sickness unavailability reasons aligned to ESR.
Maternity	Includes maternity, paternity and adoption unavailability reasons.
Working Day	Various reasons where an employee is in paid work time but not clinical, including; Audit/Inspection, Coroner's Court, Management Time, Meeting, Probationary (supernumary), Supervision, Time Accrued On Call, Training Facilitator, Union Duties, Working From Home.
Study Leave	Includes all paid time to complete study, including; Apprenticeship (Outside Study), Continuous Professional Development, Role/Post Specific Training, Statutory & Mandatory Training.
Other Leave	Includes all other reasons for unavailability, including; Armed Forces, Bereavement Leave -PAID, Career Break, Compensatory Rest, Consultant - Professional Leave, Disability Leave, Emergency Leave/Time Off for Dependants - Paid, Gone Home Sick, Medical Suspension Other, Not Authorised Leave - UNPAID, Other Leave - PAID, Out on External Secondment – Unpaid, Personal/General Commitments, Phased Return to Work, Special Leave - jury/interview/court/mags, Time Owing, Unpaid Leave - authorised.
Key (RAG Status):	
Red	Unavailability exceeds funded headroom per unavailability group and in total

Ward (Unit)	Substantive Fill July 2023						Temporary Staffing Demand July 2023							
	WTE Days		WTE Nights		WTE Total		WTE Vacancy		WTE Absence Over Headroom		WTE Increased Activity		WTE Total	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**181.02**	**131.83**	**105.64**	**90.23**	**237.63**	**201.83**	**35.39**	**36.70**	**34.34**	**31.08**	**8.33**	**39.13**	**49.27**	**94.69**
A&E Majors (0419)	25.90	11.07	23.14	9.16	49.04	20.23	19.66	8.95	7.32	3.11	1.80	0.16	28.78	12.22
CCU (Coronary Care Unit) [0121]	8.62	2.87	4.53	1.83	13.15	4.70	0.00	0.00	0.67	0.87	0.00	0.00	0.67	0.87
CDU (Clinical Decisions Unit) (0420)	5.67	3.28	3.65	2.26	9.32	5.55	1.61	0.51	0.75	0.00	0.13	3.61	2.50	4.12
A&E Paeds (0423)	4.45	2.85	5.56	2.19	10.00	5.04	0.24	0.05	0.36	0.42	3.29	0.08	3.89	0.55
Discharge Lounge (0415)	2.67	2.74	0.00	0.00	2.67	2.74	0.24	1.25	0.71	0.20	0.00	0.05	0.95	1.50
A&E Minors (0422)	13.99	0.00	7.99	0.00	21.98	0.00	1.45	0.41	2.26	0.33	0.00	0.00	3.71	0.75
SDEC (0404)	12.95	6.62	0.08	0.00	13.02	6.62	0.12	0.00	2.45	1.56	0.16	0.00	2.73	1.56
Ward A4 (0214)	8.42	8.11	3.22	7.45	11.64	15.56	0.48	1.37	1.42	1.73	0.16	3.01	2.06	6.11
Ward B1 [0206]	9.04	8.53	4.94	4.90	13.98	13.43	0.40	3.77	0.36	1.43	0.00	6.45	0.75	11.65
Ward B2 (0207)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.00	0.04	0.00
Ward B3 (0408)	8.69	8.51	4.60	8.83	13.29	17.35	0.08	0.83	0.40	0.36	0.00	6.53	0.48	7.73
Ward B4 (0208)	3.61	3.58	2.48	3.72	6.10	7.30	0.63	0.67	0.24	0.75	0.00	0.71	0.87	2.14
Ward C1 [0105]	6.82	3.99	3.58	4.89	10.40	8.88	1.04	2.04	2.55	4.16	0.00	1.19	3.59	7.39
Ward C2 [0109]	8.41	9.29	3.65	7.16	12.06	16.44	0.88	3.32	1.15	1.98	0.12	4.22	2.15	9.52
Ward C3 [0115]	8.24	10.86	4.67	7.08	12.92	17.95	0.08	2.06	0.56	1.68	1.19	0.16	1.83	3.90
Ward C4 (0216)	9.42	11.23	4.63	7.89	14.05	19.12	0.04	0.44	0.36	1.30	0.00	3.31	0.40	5.05
Ward D1 (0409)	10.74	8.29	7.01	4.02	17.75	12.30	0.67	0.40	7.25	4.13	0.00	2.21	7.92	6.74
Ward D2 (0411)	9.40	7.05	6.98	5.56	16.38	12.60	1.85	3.41	2.44	0.79	0.08	4.58	4.37	8.78
Ward D3 [0117]	7.21	8.07	5.11	3.72	12.32	11.79	2.58	2.06	1.31	2.13	0.30	0.63	4.19	4.83
Ward D4 [0119]	7.59	7.54	5.01	5.48	12.60	13.02	1.85	1.71	1.27	1.90	0.19	1.03	3.31	4.64
Ward H3 - Stroke [0204]	8.73	7.19	3.94	3.94	12.67	11.13	1.41	3.43	0.52	2.22	0.00	0.32	1.92	5.97
Ward R1 (0309)	0.44	0.15	0.88	0.15	1.31	0.29	0.08	0.00	0.00	0.00	0.87	0.87	0.95	0.87

Key (Field/Column Descriptions):	
Substantive Fill - Days	WTE worked days by substantive staff in their contracted post - including any contractual overtime (but excludes all Bank).
Substantive Fill - Nights	WTE worked nights by substantive staff in their contracted post - including any contractual overtime (but excludes all Bank).
Temporary Staffing Demand - Vacancy	WTE active (not recalled) requests (both filled and unfilled) using reasons; Established vacancy not recruited into, Established vacancy recruited into but not in post.
Temporary Staffing Demand - Absence Over Headroom	WTE active (not recalled) requests (both filled and unfilled) using reasons; Short term sickness cover (unplanned cover), Long term sickness cover (planned cover), Urgent leave cover, Maternity cover.
Temporary Staffing Demand - Increased Activity	WTE active (not recalled) requests (both filled and unfilled) using reasons; Increased Activity, Escalation Area Open, Enhanced Care.
Temporary Staffing Demand - Total	Sum of Temporary Staffing Demand categories.

Ward (Unit)	Temporary Staffing Fill Performance July 2023													
	Average Days Request Lead Time		WTE Bank Requests WTE		WTE Bank Filled		% Bank Fill Rate		WTE Agency Requests		WTE Agency Filled		% Agency Fill Rate	
	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.	Reg.	Non-Reg.
Total	**17.52**	**15.37**	**40.25**	**100.51**	**35.88**	**82.75**	**47.90%**	**82.33%**	**34.64**	**0.00**	**27.17**	**0.00**	**36.28%**	**0.00%**
A&E Majors (0419)	33.50	28.90	10.19	11.26	9.78	10.42	36.13%	92.54%	16.87	0.00	14.31	0.00	52.87%	0.00%
CCU (Coronary Care Unit) [0121]	30.31	14.48	0.29	0.80	0.29	0.73	46.51%	90.91%	0.33	0.00	0.33	0.00	53.49%	0.00%
CDU (Clinical Decisions Unit) (0420)	11.63	5.14	1.53	3.97	1.45	3.21	63.06%	80.71%	0.78	0.00	0.70	0.00	30.60%	0.00%
A&E Paeds (0423)	48.56	5.92	2.04	0.51	1.76	0.41	48.75%	80.00%	1.57	0.00	0.20	0.00	5.46%	0.00%
Discharge Lounge (0415)	15.02	42.97	0.80	1.42	0.73	1.09	80.00%	76.82%	0.11	0.00	0.07	0.00	8.00%	0.00%
A&E Minors (0422)	33.22	37.48	3.49	0.70	1.93	0.70	55.27%	100.00%	0.00	0.00	0.00	0.00	0.00%	0.00%
SDEC (0404)	21.40	11.81	1.95	1.43	1.70	0.95	66.96%	66.70%	0.58	0.00	0.43	0.00	17.18%	0.00%
Ward A4 (0214)	16.32	10.68	1.24	5.88	1.20	4.49	58.82%	76.40%	0.80	0.00	0.62	0.00	30.44%	0.00%
Ward B1 [0206]	1.77	9.94	0.37	11.56	0.26	10.06	28.10%	87.05%	0.54	0.00	0.43	0.00	47.82%	0.00%
Ward B2 (0207)	-2.13	0.00	0.03	0.00	0.03	0.00	100.00%	0.00%	0.00	0.00	0.00	0.00	0.00%	0.00%
Ward B3 (0408)	1.32	2.59	0.18	7.14	0.15	4.99	30.77%	69.84%	0.29	0.00	0.18	0.00	38.46%	0.00%
Ward B4 (0208)	5.37	3.00	0.73	2.01	0.55	0.88	65.28%	43.64%	0.11	0.00	0.04	0.00	4.34%	0.00%
Ward C1 [0105]	25.04	20.14	1.81	6.80	1.70	5.55	50.31%	81.73%	1.57	0.00	1.53	0.00	45.37%	0.00%
Ward C2 [0109]	6.64	7.12	1.06	8.88	0.80	7.40	36.07%	83.33%	1.17	0.00	0.69	0.00	31.15%	0.00%
Ward C3 [0115]	17.61	25.17	0.69	3.59	0.66	2.72	37.33%	75.61%	1.07	0.00	0.81	0.00	46.08%	0.00%
Ward C4 (0216)	0.64	1.61	0.11	4.91	0.00	4.00	0.00%	81.41%	0.52	0.00	0.52	0.00	82.65%	0.00%
Ward D1 (0409)	25.30	14.31	4.87	6.27	4.62	5.07	59.71%	80.79%	2.86	0.00	2.50	0.00	32.26%	0.00%
Ward D2 (0411)	24.28	32.68	3.05	7.97	2.94	7.13	67.93%	89.47%	1.28	0.00	0.88	0.00	20.26%	0.00%
Ward D3 [0117]	29.64	26.41	2.63	4.59	2.41	4.18	60.24%	91.24%	1.37	0.00	1.01	0.00	25.16%	0.00%
Ward D4 [0119]	23.10	19.96	1.64	4.27	1.46	2.96	45.28%	69.23%	1.58	0.00	1.07	0.00	33.22%	0.00%
Ward H3 - Stroke [0204]	17.98	19.01	1.33	5.61	1.26	5.39	71.07%	96.09%	0.44	0.00	0.33	0.00	18.60%	0.00%
Ward R1 (0309)	-1.12	-1.19	0.22	0.95	0.22	0.44	21.43%	46.15%	0.80	0.00	0.51	0.00	50.00%	0.00%

Key (Field/Column Descriptions):	
Days Lead Time	Average of the number of days before a shift that the request is made to fill by Bank or Agency - a longer lead time is more likely to result in fill by any source and also for fill by Bank.
Bank Requests	WTE of all active temporary staffing requests, not including those subsequently escalated to Agency.
Bank Filled	WTE of all Bank shifts filled.
Bank Fill Rate	Bank shifts filled divided by total of active Bank and Agency requests, i.e. the proportion of all Bank and Agency requests filled by Bank.
Agency Requests	WTE of all active temporary staffing requests escalated to Agency.
Agency Filled	WTE of all Agency shifts filled.
Agency Fill Rate	Agency shifts filled divided by total of active Bank and Agency requests, i.e. the proportion of all Bank and Agency requests filled by Agency.

Key (RAG Status):		
Red		Fill rate is less than 50%
Amber		Fill rate is between 50% and 60%
Green		Fill rate is greater than 60%

Title:	Maternity Bi-Annual Staffing Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose:	The purpose of this report is to outline the findings of the maternity bi-annual review for the period January – June 2023.

Summary:	The acuity based tool Birth rate + (NICE accredited) was completed in January 23 using caseload data from a 3 month period June to August 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. Key report highlights: - The current funded Registered Midwife establishment of 242.58WTE is compliant with the 2019 Birth Rate Plus report recommendations that is being used to model current roster templates. The funded establishment is not yet compliant with the 2023 report recommendations. A business case to seek an uplift to the funded establishment to meet the Birth Rate Plus recommendations is currently in progress. - The specialist midwifery establishment is within expected parameters. - The 2023 Birth Rate Plus report highlighted that Bolton FT has the highest level of case-hold acuity (as defined by obstetric, fetal and medical problems) within all providers in Greater Manchester and Eastern Cheshire with 72% of cases in the highest classification categories. This reflects an increase from 63% in 2019. As a consequence of this an uplift in the funded establishment of an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles is recommended. In summary, the report demonstrates the ongoing workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance. The risk to safety during the period of review has been mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICB colleagues.

Previously considered by:	The report was presented to the People Committee who endorsed the recommendations.

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

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

Prepared by:	J Cotton – Director of Midwifery / DND T Roberts, Chief Nurse	**Presented by:**	J Cotton – Director of Midwifery / Divisional Nurse Director T Roberts, Chief Nurse

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

BR+	Birth Rate Plus (Staffing Review)
CNST	Clinical Negligence Scheme for Trusts
NICE	National Institute for Clinical Excellence
NQB	National Quality Board
RCOG	Royal College of Obstetricians and Gynaecologists

1. Introduction

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

The report fulfils the requirements outlined in the National Quality Board (NQB 2018) and the Clinical Negligence Scheme Trusts guidance (CNST 2023) that recommended maternity services should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months.

The review incorporates national guidance relating to the provision of safe staffing levels within maternity services (Royal College of Obstetrician and Gynaecologists (RCOG) 2021), National Institute for Clinical Excellence (NICE) 2016, National Quality Board (NQB) 2018 workforce indicators, clinical outcome and activity measures, outcome measures reported by women, staff reported measures and findings of the formal Birth Rate Plus (BR+) assessment of the midwifery establishment staffing levels published in 2023.

2. Background

In January 2018, the National Quality Board (NQB) released updated guidance in respect of nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Table 1: NQB expectations for safe, sustainable and productive staffing

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

3. Expectation 1 - Right staff

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

The Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) (2023) requires a midwifery staffing oversight report that covers staffing/safety issues to be submitted to the Board every 6 months.

The CNST year 5 scheme requires the Trust Board to evidence that the midwifery staffing budget reflects the establishment as calculated in a systematic, evidence based process.

3.1 Birth Rate Plus - Evidence based workforce planning

Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The Birth Rate Plus assessment was last undertaken in January 2023 and included case mix data from June to August 2022.

The report acknowledged that the Beehive alongside birthing centre and the Ingleside freestanding birthing centre were closed to birthing activity at the time of the assessment. The re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

The report confirmed that there had been a noticeable change in the number of women in category V (highest acuity) category of case mix in the 2023 with the % increasing from 29.3% in 2019 to 51.4% in 2023. This increase in acuity had a significant impact upon the required staffing ratio.

Within Greater Manchester and Eastern Cheshire, Bolton has the highest number of women in the highest acuity with 72% in the Cat IV and V classification. This has increased from 63% in 2019. To be noted a rise in acuity has been noted in most maternity services over the last 3-4 years. This increase has been discussed with regional colleagues and a request made by GM ICB Chief Nurse for LMNS Birthrate+ lead to attend a Chief Nurse discussion to discuss the findings, specifically to explain how one locality report can highlight such a significant increase in acuity.

The majority of maternity services have seen an increase in the % of women with significant safeguarding needs which adds to the clinical workload and additional staffing is included in the community staffing for 600 women with significant safeguarding needs in the 2023 report in response to the assessment undertaken.

Findings of the Birth Rate Plus 2023 review confirmed that a total clinical staffing establishment of 283.07 Whole Time Equivalent (WTE) was required to deliver a safe midwifery service. This includes an additional 18.36WTE Registered Midwives and 19.53WTE support worker roles. The breakdown as to how the staffing establishment has been calculated by Birth Rate Plus is detailed in Appendix 1.

A revision of the skill mix is ongoing to ensure a 90:10 mix is deployed in postnatal clinical areas and this will be completed by March 2024. Currently the skill mix for Registered Midwives: Support Workers is 97:3 – adjusting this skill mix to 90:10 will reduce the impact upon the Registered Midwife uplift required. Without this adjustment there is an overall shortfall of 31.30wte of which 30.44WTE (97%) of

current clinical WTE are RMs and 3% (0.86WTE) maternity support workers providing postnatal care.

The current funded Registered Midwife establishment of 242.58WTE is compliant with the 2019 Birth Rate Plus report recommendations that is being used to model current roster templates. The funded establishment is not yet compliant with the 2023 report recommendations as the required uplift to the funded establishment has not yet been considered by the Trust. A business case to seek an uplift to the funded establishment to meet the Birth Rate Plus recommendations is currently in progress.

Monthly establishment reconciliations continue to be shared with the service that detail the funded and vacant positions within the funded establishment. The monthly reconciliation as of June 2023 is detailed in Appendix 2. The reconciliation undertaken in June 2023 was based upon the total funded clinical WTE establishment defined in the 2019 Birth Rate Plus report of 219.90WTE as alignment to the 2023 Birth report recommendations had not been completed in June 2023.

3.2 Specialist Midwifery Roles

Specialist midwives support the delivery of the maternity service providing expert guidance and specialist support to the midwifery team. Currently 26.68WTE specialist midwives are currently employed within the maternity service undertaking a range of roles including infant feeding specialist, digital midwife and pastoral support. (Appendix 3).

Birth Rate Plus advises that the additional workforce should equate to no more than 8-10% of the funded clinical midwifery establishment to provide specialist support for the delivery of a safe service. The current establishment (26.68WTE) is therefore within the recommended specialist midwifery requirements of the service at 9 %.

The specialist workforce calculation as of June 2023 does not include the appointment of all recurrently funded roles required to support the implementation of the saving babies lives care bundle and the CNST scheme requirements due to a lag in recruitment. The additional posts will be reflected in the next bi-annual staffing report.

3.3 Registered Midwife to birth ratio

An overall recommended ratio of 1.23 births to 1WTE was highlighted in the 2023 Birth Rate Plus report. This ratio was calculated using the case mix and acuity data. Differing ratios are applicable to hospital and community areas as the acuity of the patients differs i.e. community midwifery ratio 1:92.4.

The report advised the overall ratio that should be applied to the service at Bolton based upon activity and acuity in all areas is to 1:23.

On a monthly basis the birth rate plus midwife to birth ratio is calculated to provide assurance that staffing levels (including bank and agency usage broadly align with the recommended standard). Fluctuation in the ratio is notable at times of low shift fill.

Table 2 highlights that the mean staffing ratio (calculated to include all worked hours) between February – June 2023 meets the required 2023 Birth Rate standard when bank and agency usage is taken into account.

Table 2: Midwife to birth ratio

Indicator	Goal	Red Flag	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:28.9	1:27.5	1:27.1	1:26.9	1:26.8	1:27.2
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		n/a	1:24.4	1:24	1:23.2	1:22.8	1:23.4

3.4 Supernumerary Status

The Delivery Suite Coordinator is a supernumerary member of the team (defined as having no caseload of their own during their shift).This indicator is a safety proxy indicator identified within the clinical negligence scheme for trusts guidance to ensure there is oversight of all birth activity within the service at all times. Currently non-compliance is recorded on the Birth Rate Plus acuity tool when the Co-ordinator is the named person providing 1:1 care and is thus unable to retain the status of supernumerary co-ordinator. CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status. The service can evidence 100% compliance with the supernumerary standard from May 2023.

Since April 2023 quarterly red flag reports have been collated to provide assurance that the Delivery Suite Co-ordinator was not allocated as the named midwife for a woman requiring 1:1 care. All cases of non-compliance are reviewed by the Intrapartum Matron on a monthly basis. An inputting training issue identified in the May 2023 dashboard data and has now been rectified.

Table 3: Supernumerary status episodes of non-compliance (per shift)

Indicator	Goal	Red Flag	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	3	2	2	1	1	0

3.5 Headroom / Uplift

Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered. Current headroom/uplift provided within the Trust is 23% with national ranges varying between 19% and 25%.

3.6 Skill Mix

Birth Rate Plus advises a registered / non registered skill mix of 90/10 ratio within defined clinical areas such as the postnatal ward to support the delivery of care with

unregistered staff. The skill mix calculation is integrated in the overall Birth Rate Plus recommendation and establishment recommendations. The service currently has a 97:3 distribution of clinical to non-clinical ratio in defined settings. A revision of the skill mix is in progress to ensure a 90:10 mix is deployed in postnatal clinical areas.

3.7 Professional judgement

The judgement of senior experienced midwives remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). The last professional judgement review was undertaken in August 2023.The review included the Director of Midwifery, Maternity Matrons, workforce, and finance colleagues and considered:

- Acuity requirement
- Ward/dept leadership
- Ward/dept layout and environment
- Additional specific training requirements
- Support of carers/patients

3.8 Safety outcome indicators

Maternity sensitive staffing metrics are displayed on the integrated performance maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and thus need investigation and prompt action. The dashboard reflected in Table 4 highlights the staffing related key performance metrics for the period January – June 2023.The dashboard reflects an increase in maternity diverts in June 2023 due to staffing pressures within the service during this period.

The maternity dashboard indicators reflect a challenged service. One to one care in labour compliance rates continue to be below the 100% standard, and remain an area of ongoing focus. Recruitment continues to address the current vacancy rate with 28WTE Registered Midwives recruited in October 2023 to negate the 50WTE deficit identified in June 2023.

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with the 1:1 care in labour standard and an action plan if the standard cannot be demonstrated. The action plan to recover performance is detailed in appendix 4.

A business case for the provision of a second theatre staffing provision was approved in October 2022 that included a phased approach to implementation. Approval was given for an additional 1.64WTE to be added to the Registered Midwifery funded establishment in autumn of 2023 as part of the initial recruitment phase.

Inconsistent performance with regard to the booking of women prior to 12+6 week gestation has continued due to the ongoing registered midwifery staffing deficit within the community setting during the period of review. Community midwifery staffing was a challenge at this time with a Registered Midwife vacancy of 13.13 WTE reported within community midwifery teams in June 2023. This deficit impacted upon the team’s ability to flex availability and offer weekend/evening clinics for booking to positively influence the 12+6 compliance. To note the Trust mean or median (as

GMEC states median) for 12+6 booking compliance aligned with the Greater Manchester and Eastern Cheshire (GMEC) median of 87.68% during this period.

The maternity stillbirth rate flagged as a concern during June 2023. A review of perinatal mortality tool process was undertaken in response to strengthen governance and oversight and the introduction of a revised standard operating procedure. The Trust year to date incidence as of June 2023 was 4.24/1000 which compared favourably with GMEC mean 5.60/1000 and lower than peer comparators i.e. Oldham 9.13/1000. Assurance can be provided that the increased incidence in the stillbirth rate in June 2023 did not appear to be related to staffing levels.

Table 4 - Critical Safety Indicators

Indicator	Goal	Red Flag	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Critical Safety Indicators								
Still Birth rate (12 month rolling)per thousand	3.5	≥4.3	4.2	4.2	4.6	3.8	4.1	5.1
HIE Grades 2&3 (Bolton Babies only)	0	1	1	0	0	0	0	0
% Completed Bookings by 12+6 BI calculation	90%	<90	82.70%	87.75%	90.10%	90.58%	90.40%	85.81%
ICU/ HDU Admissions	Information only		1		1	0	0	0
Post Partum Hysterectomy	0	>1	0		1	0	0	1
2nd Maternity theatre requested to be opened but delay or unable to open changed to rag rate Aug 21	0	>=1	0	0	0	0	0	0
Admissions to Maternity CCU level 2 care	Information only		1	0	2	6	4	5
1:1 Midwifery Care in Labour	95%	<90%	98.6%	98.5%	96.7%	98.0%	99.7%	98.8%
% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	11.34%	9.81%	12.11%	12.08%	10.81%	7.44%
3rd /4th Degree Tears (rate in month)	3%	>3.1%	6.41%	1.44%	3.45%	5.51%	1.82%	3.42%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.7%	3.6%	3.5%	3.5%	3.3%	3.4%
Breastfeeding Initiated within 48 Hours	65%	<65%	67.7%	66.9%	65.5%	68.6%	68.6%	65.8%
SUI'S (New only)	0	2	1	1	2	0	0	1
HSIB referrals	Information only		1	0	0	0	0	0
Access Standards								
Unit Closures	0	1	1	2	0	0	0	3

4. Expectation 2 – Right Skills

Mandatory and statutory staff training compliance during the period January – June 2023 remained below the Trust standard due to ongoing staffing pressures and a staffing deficit of 50WTE during this period. In response the service had to prioritise elements of essential training namely emergency skills training and fetal monitoring training within the service.

Professional specific training was not historically recorded on the performance dashboard and thus the addition was made in April 2023 for ongoing oversight and monitoring. Following the launch of the CNST year 5 maternity incentive scheme in May 2023 the professional specific training requirements were revised to align with the national core competency framework version 2 and the GMEC standards.

Table 5: Midwifery profession specific training matrix

Workforce								
Shifts covered by NLS trained staff	Information only			84%		78%	81%	84%
Medical Device Compliance Training Midwifery	95%	80%	11.70%			39.00%	41.00%	
Safeguarding compliance level 3	95%	80%	81.33%	84.38%	84.38%	81.94%	83.33%	85.28%
Safeguarding supervision outreach only	Information only			100.00%	90.00%		100.00%	90.00%
PROMPT training (added Oct 21) (CNST requirement)	90%	<90%	86.10%	82.34%	72.16%	78.00%	91.00%	92.14%
Fetal monitoring training compliance (overall) (CNST requirement)	90%	<90%			77.74%	77.00%	72.16%	78.00%
Return to work interview percentage completed (number due and completed in comments please)	Information only		30.77%	32.75%	30.00%	40.00%	68.18%	50.00%
Exit Interview percentage completed (number due and completed in comments please)	Information only		25%	0%	0%	25%	0%	50%
Monthly attendance	Information only		94.55%	95.48%	93.89%	93.70%	93.63%	93.89%
Monthly percentage sickness	4%	>=4.75%	5.45%	4.52%	6.11%	6.30%	6.37%	6.11%
Statutory Training	95%	<95%	74.92%	74.15%	76.68%	79.63%	82.45%	84.35%
Mandatory Training	85%	<80%	70.71%	68.73%	69.48%	68.23%	76.39%	79.31%
Completed Staff Appraisals	85%	<=75%	73.46%	67.60%	77.85%	84.33%	88.85%	91.82%

Expectation 3 – Right place, right time

5.1 Planned versus actual midwifery staffing levels

The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels. The planned staffing levels outlined in Table 6 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff. Table 6 highlights a significant gap in the planned and worked hours for both registered and non-registered staff groups within M4 and M5 inpatient wards. This gap in fill is reflective of the staffing deficit during this period.

Assurance can be provided agency and bank shifts were and continue to be offered to mitigate staffing gaps and pressures when indicated. Safety risks are mitigated within the service by redeploying staff within the service and clinical areas on a daily basis.

Table 6: Planned versus actual fill for maternity ward inpatient areas.

Ward/Team	Grade Type Category	Day/Night	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
			Fill %	Fill %	Fill %	Fill %	Fill %	Fill %
Ward M2 - Obstetrics (3004)	Registered	Day	98.69 %	96.43 %	102.50 %	105.44 %	98.90 %	101.18 %
	Non-Registered	Night	102.10 %	93.63 %	97.97 %	140.58 %	171.67 %	181.93 %
	Registered	Day	100.11 %	84.01 %	93.16 %	93.89 %	96.84 %	92.54 %
	Non-Registered	Night	99.86 %	86.02 %	93.83 %	93.33 %	96.21 %	90.00 %
Ward M4 - Post Natal [3005]	Registered	Day	121.75 %	98.32 %	96.85 %	91.37 %	90.23 %	92.88 %
	Non-Registered	Night	64.24 %	60.09 %	57.87 %	61.05 %	58.12 %	59.04 %
	Registered	Day	108.78 %	87.56 %	98.16 %	91.64 %	87.42 %	80.43 %
	Non-Registered	Night	53.92 %	51.79 %	50.53 %	49.15 %	49.19 %	51.92 %
Ward M5 - Post Natal (3006)	Registered	Day	43.08 %	58.17 %	55.07 %	56.58 %	74.18 %	70.03 %
	Non-Registered	Night	41.05 %	38.14 %	51.31 %	46.46 %	47.41 %	50.78 %
	Registered	Day	22.34 %	57.87 %	40.01 %	73.88 %	83.73 %	80.14 %
	Non-Registered	Night	41.18 %	36.27 %	39.23 %	40.57 %	41.44 %	39.47 %

5.2 Mitigating actions

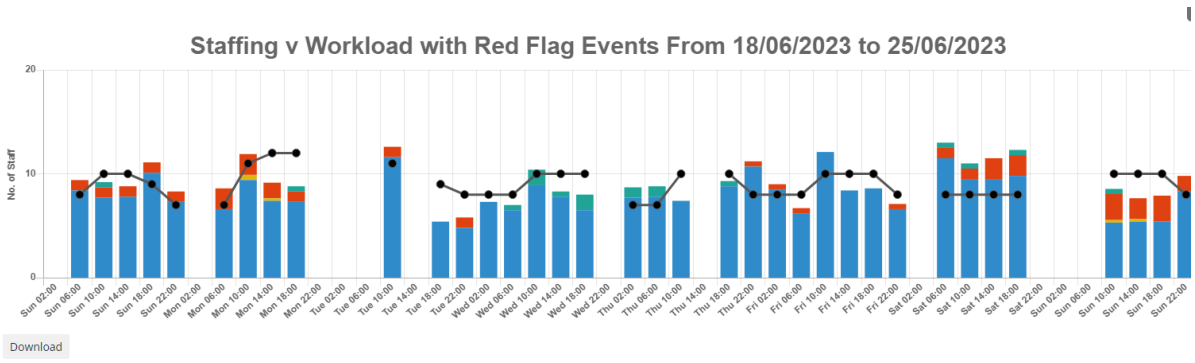
The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

- Incident reporting system is used to report staffing incidents and all red flag incidents are audited on a quarterly basis.
- Regular reviews with ward managers, Matrons and the Director of Midwifery

- Daily operational safety huddle meetings are held by matrons to assess and respond to changes in pressure and demand.
- Midwives move flexibly between delivery suite, maternity wards, birth centres and community to ensure women's needs are met.
- Ward managers work clinically as part of the clinical establishment with matrons, if required, to support patient care.
- Safety huddles occur in maternity twice daily to assess the activity and acuity
- Escalation guidelines are in place and used to respond to elevated demand, to preserve patient safety.
- The publication of rosters in a timely manner so staffing deficits can be safely managed.
- Approval of agency and bank usage to mitigate shortfalls in staffing levels

For additional oversight and scrutiny on a daily basis staffing figures and the acuity levels within the maternity intrapartum areas are input into an additional electronic Birth Rate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. Table 7 details the acuity recorded on the intrapartum acuity tool in June, highlighting the 4hrly review of staffing levels undertaken by the Delivery Suite Co-ordinator and the periods of increased staffing pressure.

Table 7: Birth Rate Plus intrapartum acuity/staffing modelling tool example - June 2023



5.3 Midwifery Continuity of Carer

In July 2022 a formal paper detailed the position to date relating to the provision of MCoC and confirmed that until the current midwifery vacancy rate was recruited to establishment, the service would be unable to implement and roll out MCoC safely. The maternity service received formal notification on 21 September 2022 thereafter from NHS England that there was no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders were advised to focus on retention and growth of the workforce, and develop plans that would work locally taking account of local populations and current staffing to support the maternity team to work to their strengths.

A detailed MCoC delivery plan was submitted to the Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (LMNS) in September 2022. A further

update was submitted in September 2023 that confirmed that Bolton Hospital NHS Foundation Trust was not currently in the position to implement of MCoC as the default model of maternity care due to the registered midwifery deficit.

5.4 Workforce Metrics

The sickness absence data for the period January - June 2023 demonstrated a sustained trend in sickness absence reported within the maternity service**.** The main cause of absence related to stress and anxiety. Matrons continue to be supported by workforce partners to monitor absence and support staff members during their absence to return to work.

Table 8: Sickness absence per WTE January – June 2023

Indicator			Jan 23	Feb 23	Mar 23	April 23	May 23	June 23
Monthly percentage sickness	4%	>=4.75%	5.45%	4.52%	6.11%	6.30%	6.37%	6.11%

5.5 Red Flags

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Within the maternity service midwifery red flag events are monitored currently using the Birth Rate Plus acuity tool as detailed in Table 9. Alignment of the red flags with the nationally defined flags as per current NICE guidance is required with ongoing visibility at Trust level.

Table 9 highlights a significant deficit in the provision of the 2nd Delivery Suite Co-ordinator during this period that was addressed following the appointment of additional Band 7 Co-ordinators on a fixed term basis as an interim measure. Substantive recruitment to the posts is in progress as of October 2023.

Table 9: Number of red flag safe staffing incidents between January – June 2023 extracted from the Birth Rate Plus acuity tool.

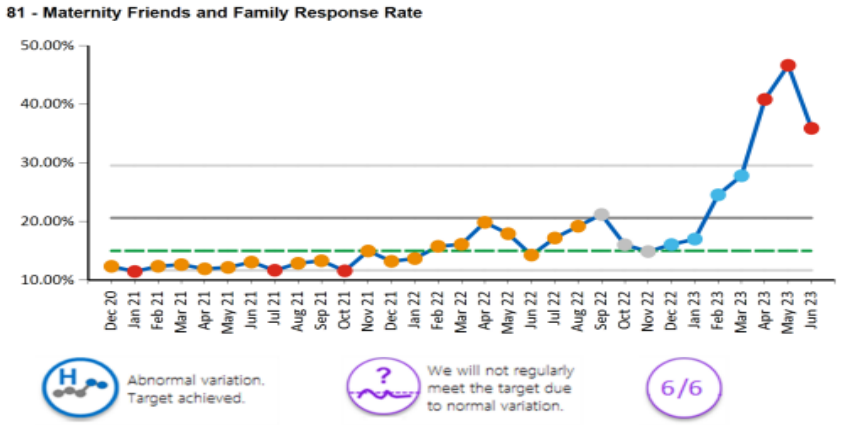
Number & % of Staffing Factors Recorded
From 01/01/2023 to 30/06/2023

SF1	Unexpected staff absence	240	20%
SF2	Unable to fill vacant shifts	636	52%
SF3	MW on transfer	5	0%
SF4	Staff redeployed to another area	84	7%
SF5	MW scrubbed in theatre	0	0%
SF6	Ward clerk not available	22	2%
SF7	Support staff not at rostered numbers	36	3%
SF8	>25% Band 5 on duty	80	7%
SF9	No 2nd coordinator on shift	122	10%
	Total	1225	

6.0 Patient Experience

Over the last 12 months, the maternity service has actively sought feedback from service users. The friends and family test feedback can be evidenced in the maternity survey, feedback sought from the maternity voices partnership and the friends and family response rates illustrated below. The service established a task and finish group to improve the response rate in January 2023. The result of which has been a sustained and significant improvement in the overall response rate peaking in May 2023. Table 10 demonstrates the improvement in compliance rate since December 2020.

Table 10: Friends and Family Response Rates



6.1 Maternity Survey

The Experience of Maternity Care Survey was undertaken by IQVIA between May and August 2023. The survey sample was drawn from women aged 16 or over who had a live birth between the 1st of January and 31st of March 2023. Eligible women include those who had given birth using any unit managed by the Trust, or at home. The survey provides information on women's experiences during all aspects of their maternity care, including antenatal care, postnatal care, and the care received during labour and birth. 217 surveys were completed by service users reflecting a 35% response rate.

6.2 Themes from the CQC Maternity Care Survey

The majority of the Trust's scores were in the intermediate - 60% range of all Trusts surveyed by IQVIA. 4 scores were in the top 20% range, with the best score being achieved in "During your antenatal check-ups, did your midwives listen to you?". However, 22 scores were in the bottom 20% range and these are spread across the sections "Your labour and the birth of your baby" and "Care in the ward after birth". However, since 2022, 30 scores have improved whereas 19 have declined. The detailed recommendations highlighted in the survey report are currently being used to populate an action plan.

6.3 Complaints

Thematic analysis of all complaints is undertaken within the service to identify trends and actions to be undertaken on a monthly basis and a quarterly triangulation review is undertaken to review themes from claims, incidents and complaints data. The Q1 2023 data highlighted that there were no explicitly shared themes within the claims

scorecard, incident and complaints data presented. However, the overarching themes related to:

- Decisions regarding clinical treatment
- Communication

7. Conclusion

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

This report provides assurance that a systematic evidence based process to calculate the staffing establishment has been undertaken that has highlighted a funded staffing establishment deficit when compared to the 2023 Birth Rate Plus recommendations. The report provides assurance that the funded midwifery staffing establishment as of June 2023 met the 2019 Birth Rate Plus report recommendations. Alignment to the 2023 Birth Rate Plus recommendations has not yet been undertaken. This report confirms that the specialist midwifery establishment is within recommended Birth Rate Plus expected parameters.

The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with one to one care in labour rates remains below the required standard and an area of ongoing focus. Training metrics also highlight sub-optimal compliance with the Trust standard and reflect the registered midwifery staffing pressures (circa 50 WTE) within the maternity service during the period of review.

The report details the actions required to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny.

The risk to safety during the period of review has been mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

8. Recommendations

It is recommended that the Board of Directors:

I. Approve the report and recommendations.

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

Appendix 1 – Birth Rate Plus summary of establishment – January 2023.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Princess Anne Maternity Unit Bolton NHSFT

Final version 23/01/2023

Annual period 2021/22

Combined births — Total births in service: 5922

June to Aug 2022	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	0.2	2.1	25.7	20.6	51.4
Generic %Casemix	1.7	5.1	24.5	19.7	49.0

	Annual Nos.	Required WTE	
Delivery Suite			
Births	5842	77.83	**77.83**
Other DS Activity			
Antenatal Cases	920	4.83	**6.00**
PN Readmissions	36	0.13	
Escorted Transfers OUT	23	0.12	
Non-viables	47	0.56	
Inductions (10%)	196	0.36	
Triage	8455	11.02	**11.02**
Beehive Birth Suite			
Service not fully operating so not assessed and activity within hospital total wte.			
M2 Ward			
Antenatal admissions	1680	16.53	**16.53**
Inductions (90%)	1768		
M4 and 5 Wards			
Postnatal women	5842	58.51	**64.21**
Postnatal Ward Attenders	0	0.00	
Postnatal Re-admissions	235	1.25	
NIPE Clinics		2.88	
Extra Care Babies	177	1.18	
Frenulotomies	775	0.39	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife Booking & Follow up clinics		5.27	**11.03**
Specialist Midwife clinics		1.59	
Obstetric clinics		1.46	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	11640	6.35	**6.35**
COMMUNITY SERVICES			
Home Births	80	2.36	**64.38**
Community Cases	5732	58.83	
Attrition cases	670	0.89	
Additional safeguarding		2.30	
INGLESIDE BIRTH & COMMUNITY CENTRE		257.34	
Service closed so not assessed and activity within community total.			
CLINICAL MIDWIFERY WTE REQUIRED			**257.34**
Additional Specialist and Management wte		**25.73**	
TOTAL WTE REQUIRED		**283.08**	

Appendix 2 – Birth Rate Plus establishment reconciliation as of June 2023

Midwives		Excluded						
Grade	Sum of Clinical WTE	Sum of Management WTE (Excl)	Sum of Specialist WTE	**Funded Ledger WTE**	**WTEC Included M3**	**WTEW Included M3**	WTEW Bank M3	WTEW Agency M3
Antenatal Clinic - ANDU	8.74			12.97	**8.74**	**8.74**	2.67	
Birth Suite - Beehive	0			16.44	**0**			
Central Delivery Suite	66.31	0	0	70.56	**66.31**	**62.69**	5.79	2.36
Community Midwives	45.57			59.73	**45.57**	**45.3**	7.75	
Divisional Management Family Care Division		2		2	**0**			
Ingleside Birth Centre	2.58			2	**2.58**	**2.58**		
Maternity Smoking Cessation Team	1			1	**1**	**1**		
Midwifery Management		4.53		3	**0**			
Perinatal Mental Health Team	2.8		0.6	4.45	**3.4**	**3.4**	0.27	
Specialist Midwives	8.3	2	11.78	19.27	**20.08**	**20.08**		
Ward M4 - Post Natal Ward	15.32			16	**15.32**	**13.02**	0.49	0.63
Ward M2 - Antenatal Ward	14.13			15.92	**14.13**	**13.76**	2.56	
Ward M5 - Post Natal Ward	7.69			16	**7.69**	**6.05**	2.18	5.07
	172.44	**8.53**	**12.38**	**239.34**	**184.82**	**176.62**	**21.71**	**8.06**

Appendix 3: Specialist Midwife establishment by role type.

Specialist Post	EST	Clinical	Non Clinical
Cultural Liaison Midwife - Band 7	0.40		0.40
Diabetic Specialist Midwife - Band 7	1.00	0.60	0.40
Infant Feeding Co-ordinator - Band 7	1.80	1.00	0.80
Practice Educator Midwife - Band 7	2.30		2.30
Antenatal Screening Midwife - Band 7	1.00		1.00
Bereavement Midwife - Band 7	1.20	1.00	0.20
Lead Midwife - Information Systems & EPR - Band 7	1.00		1.00
Lead Midwife for Safeguarding - Band 7	1.00		1.00
Specialist Midwife Clinical Standards - Band 7	0.64		0.64
Saving Babies Lives & Neo Champion - Band 7	0.40		0.40
Interim Specialist Midwife for Education and Clinical Skills - Band 7 (RS)	1.00		1.00
Screening Midwife - Band 6	0.92	0.92	
Safeguarding Midwife - Band 6	1.00	0.20	0.80
Specialist Midwife - Infant Feeding - Band 6	0.61	0.61	
Diabetes Specialist Midwife - Band 6	1.76	1.76	
Transitional Care Lead - Band 7	0.60		

Perinatal Mental Health Midwife - Band 7	1.00	0.40	0.60
Specialist Mental Health Midwife - Band 6	3.45	3.45	0.00
Salford Smoking Cessation Midwife - Band 7	1.00	1.00	0.00
Enhanced Midwifery Team - Band 6	4.60	4.60	0.00
Specialist Sub Total	**26.68**	**17.94**	**11.14**

Appendix 4 – Action plan to improve 1:1 care in labour compliance.

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

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Ensure service is recruited to funded establishment**	Continue regular recruitment events to recruit to full establishment	Recruitment and Retention Lead	October 2024	26.10.23 Provisional date for autumn recruitment event planned for November 2023.	
		Increase post registration student places within service	Director of Midwifery	March 2024	26.10.23 Intention expressed to University of Salford to increase post registration training numbers on January 2024 cohort.	

Report Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	23 November 2023		Discussion	x
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 with regards to safety actions 6 and 8: • Safety Action 5 - The attainment of 100% supernumerary status of the Delivery Suite Coordinator had been attained up to end September 2023. One reported breach of the standard on the 11 October 2023 at 0600hrs is currently under review. • Safety Action 6 – The local maternity and neonatal system has validated manual audit data in the absence of a single maternity information system to support the evidential submission. To date the service has achieved an overall target compliance score of 67% with all actions. Further work is ongoing to recover element one that currently has an overall compliance score of 20%, the audit actions of which relate to reducing smoking in pregnancy and monitoring of defined metrics. The current service focus is on the completion of carbon monoxide monitoring at every contact to meet the 80% standard. Our last assessed rate of compliance at 36 weeks gestation was 65% and improvement work remains ongoing. A revision of the standards for safety action 6 was undertaken on the 8 November 2023 by the LMNS, 3 interventions were suspended and some compliance thresholds were reduced to facilitate the attainment of the overall standard which will make the attainment of the safety action more feasible. The next formal validation of performance by the LMNS will be undertaken in January 2024.

	• Safety Action 8 - The CNST training requirements were revised on the 23 October 2023 and 80% compliance by the 1 December 2023 for three defined elements will now be accepted if there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. This safety action is now on track to attain 80% compliance with the three required training elements by the 1 December 2023. In summary, attainment of the required elements within the ten safety actions are progressing well. Three CNST safety actions within the year 5 scheme continue to remain at risk albeit with an increased confidence that safety action 8 and safety action 6 will now be attained.

Previously considered by:
Quality Assurance Committee

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

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

The purpose of this report is to provide an overview of the safety, 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. As in previous years, the scheme incentivises ten maternity safety actions.

2. 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 is detailed in table 1 below. To date three of the safety actions remain at risk, one has been met and six of the actions are on track.

The report RAG rating has been adjusted in this report to reflect the compliance indicators that will be reported in the final Trust declaration document submitted in February 2024.

Table 1 – CNST Progress Tracker

Action No.	Maternity safety action	At risk? (Y/N)	Met	Ongoing	Not Met
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	2	6	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	No	6	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	No	6	1	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No	13	2	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	1	0
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	1	3	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	No	7	1	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	17	9	0

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?	No	11	1	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	No	6	2	0
Total recommendations attained to date			74	26	0

3. Assurance Updates

Safety action 1 - Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

14 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 reported to date (Appendix 1).

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.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

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.

The NHS e-scorecard data received on the 30 October 2023 confirmed that the service has fulfilled all the required Clinical Quality Improvement Metrics (CQUIMs) submission criteria for the year 5 submission.

A copy of the scorecard for board approval is detailed in appendix 2.

Safety action 3 Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

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 multidisciplinary team meet each weekly to review the cases and to determine if the cause of admission was avoidable. The focus of the ATAIN review is to identify whether separation could have been avoided.

The action plan to address findings of the recent reviews has been shared with the quadrumvirate and is included in this report for board approval (Appendix 3).

The Q1 transitional care and avoiding term admissions to neonatal unit (ATAIN) reports have been published and shared with the local maternity and neonatal system.

The service is working towards revising the transitional care pathway in alignment with the BAPM transitional care framework for practice for both late preterm and term babies. An action plan detailing the steps to be taken to implement this change is shared in this report for approval (Appendix 3a).

All relevant action plans related to this safety action were shared with the ICB/LMNS as part of the CNST assurance check undertaken on the 25 October 2023.

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

Obstetric workforce

The obstetric service has introduced a standard operating procedure to outline the roles and health provider responsibilities when employing short and long-term locums on Tier 2 or 3 (middle grade) rotas in obstetrics and gynaecology that aligns with the RCOG guidance for short and long term locums published in 2022.

Trusts are advised to implement the guidance relating to long term engagement of locums and provide assurance that they have evidence of compliance or an action plan to address any shortfalls in compliance in compliance. An initial audit of compliance with the standard been undertaken in response that provided limited assurance that the service has implemented all of the health provider requirements. A further audit is planned and an action plan has been collated in response to improve compliance (Appendix 4)

The service has implemented a standard operating procedure that includes the RCOG guidance on compensatory rest for obstetric consultants and senior speciality and specialist SAS doctors following non-resident on-call activity. Trusts are advised to implement the guidance and provide assurance that they have evidence of compliance or an action plan to address any shortfalls in compliance.

As the service has recently implemented the guidance, the recommendations have been shared at a consultant meeting on the 13 October 2023 and compliance will be monitored using the number of incidents reported when compliance with the standard has not been attained. This will be added to the future Safety Champions dashboard for oversight.

The service continues to monitor compliance with consultant attendance at defined clinical situations as detailed in the RCOG workforce document ‘Roles and responsibilities of the consultant providing care in obstetrics and gynaecology. Findings are reported monthly on the maternity safety champions dashboard (Table 3).

Anaesthetic medical workforce

The service can demonstrate compliance that a duty anaesthetist is immediately available 24 hours per day and a review of six months of roster data has been received to demonstrate compliance with the standard.

Neonatal medical workforce

The service has assessed compliance with regard to the British Association of Perinatal Medicine (BAPM) national standards of medical staffing published in 2021.

Currently the service is unable to demonstrate compliance with BAPM Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers) due to an unfunded 2WTE deficit in the Tier 3 rota.

Progress has been made since the action plan was shared as part of the CNST year 4 submission following the recruitment of 1WTE. Sunmission of a business case to uplift the funded establishment to meet the Tier 3 requirement is highlighted within the ongoing action plan (Appendix 4a) .

Submission of the action plan collated in response to the assessment undertaken has been shared with the NWODN and the LMNS as part of the evidential submission.

Neonatal nursing workforce

The service has assessed compliance with regard to the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing published in 2021.

The neonatal nursing staffing establishment currently does not meet the BAPM recommendations due to a current staffing deficit of 12.62WTE that includes recent vacancies. Progress has been made since the action plan (Appendix 4b) was shared as part of the CNST year 4 submission yet recruitment to fill all posts remains ongoing.

Recruitment is due to commence for a funded clinical psychologist funded vacancy.

Submission of the action plan collated in response to the assessment undertaken has been shared with the NWODN and the LMNS as part of the evidential submission.

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

Supernumerary Status of the Co-ordinator

The bi-annual maternity staffing report will be presented to Board of Directors in November 2023 for board oversight and review.

One reported breach of the standard that occurred on the 11 October 2023 during a maternity divert at 0600hrs is currently under detailed review.

This action remains at risk due to the ongoing staffing deficit of circa 30.wte Registered Midwives and the need for the Delivery Suite Co-ordinator to negate risk to clinical safety at times of extremis and provide care in labour to a woman on a 1:1 basis.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.

One to one care in labour

One to one care in labour compliance rates continue to be below the 100% standard, and remain an area of ongoing focus. Recruitment continues to address the current vacancy rate that will impact upon future attainment of the standard.

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with the 1:1 care in labour standard and an action plan if the standard cannot be demonstrated. The action plan to recover performance is detailed for approval in appendix 5.

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?

This safety action consists of six defined elements and compliance is monitored using a national tool with evidence uploaded to an external Future Collaborations website. Providers are required to use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board.

In October 2023, compliance with regard to attainment of the required standard was externally reviewed by the local maternity and neonatal system leads using evidence submitted by the service. The service achieved a validated overall target compliance score of 67%. Further work is required to attain the required 70% standard and achieve at least 50% compliance against each standard. Progress with regard to attainment of all the six elements is detailed in appendix 6.

Work is ongoing to recover element one that currently has an overall compliance score of 20% with the audit actions of which relate to reducing smoking in pregnancy and monitoring of defined metrics.

It was noted in June 2023 that the carbon monoxide monitors in use were not all functioning, and this was impacting upon the recording of carbon monoxide levels for pregnant women at 36 weeks of pregnancy. Replacement monitors were delivered in October 2023, relevant training has now commenced and this is due to be completed by the end of November. The service is on track to exceed the 50% recommended training compliance rate for the submission. The current service focus remains on the completion of carbon monoxide monitoring at every contact to meet the 80% standard. The last assessed rate of compliance at 36 weeks gestation was 65% and improvement work remains ongoing.

Recruitment to the funded pre-term post remains ongoing, which is a defined requirement of this action.

The first quarterly quality improvement sessions with the integrated care board to review this indicator and defined elements was held on the 10 October 2023 and a further session has been planned for the 9 January 2024 as per CNST requirements.

A revision of the standards for safety action 6 was undertaken on the 8 November 2023 by the LMNS, 3 interventions were suspended and some compliance thresholds were reduced to facilitate the attainment of the overall standard which will make the attainment of the safety action more feasible.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

The service has a funded user led maternity and neonatal voices partnership in line with current guidance

An action plan has been co-produced with the MNVP following the maternity survey data publication and the plan was submitted to the LMNS as part of the October 2023 assurance check and was shared with safety champions at the November 2023 meeting.

Feedback from staff and service users and actions taken in response is detailed in appendix 7.

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

Assurance can be provided that the maternity training plan has been aligned with core competency framework version 2 requirements and includes all six defined elements.

The CNST training requirements were revised on the 23 October 2023. NHSR have confirmed they will now accept 80% compliance for the three required elements namely, neonatal life support, emergency skills training and fetal monitoring training if attained by the 1 December 2023. Trusts need to evidence that there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. This action plan will be included in the November Board report. Compliance to date is detailed in table 2.

The service is now on track achieve the required compliance target subject to staff being released to attend the required sessions prior to the 1 December 2023.

There is currently difficulty resourcing qualified trainers who are NLS / GIC trained to deliver the neonatal life support training and this is acknowledged in the CNST document. The service continues to lead on the delivery of external neonatal life support training and refer staff for the formal training as required. It is acknowledged that as a minimum, training must be delivered by a lead who is up to date with their NLS training.

Table 2: Current position with defined training elements

Course Compliance by 'Staff Group'											
Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW /HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
Total		**33.33 %**	**40.28%**	**31.85%**	**50.69 %**	**#VALUE!**	**88.89 %**	**28.57%**	**54.02%**	**82.14 %**	**72.22 %**
PROMPT	**85.19 %**	NA	**88.89%**	**71.43%**	**78.87 %**	**88.24%**	NA	NA	NA	**86.36 %**	**88.00 %**
Fetal Monitoring Core Competency Stds.	**78.39 %**	NA	**83.33%**	**58.82%**	NA	**81.00%**	NA	NA	NA	NA	NA
Neonatal Life Support	**0.90%**	**71.4%**	NA	NA	NA	**85.97%**	**90%**	**90%**	**66.36%**	NA	NA

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Booard on maternity and neonatal safety and quality issues?

The service has submitted their priorities for inclusion in the patient safety incident response framework action plan.

Members of the neonatal and obstetric teams commenced the perinatal quadrumivirate training as part of a national initiative. The training provided so the team can deliver the SCORE cultural survey early in February 2024 to support the development of the local culture.

The claims scorecard triangulation report was presented to the Trust Clinical Governance and Quality Committee in November 2023 in a revised format in response to feedback from the Board Safety Champion and usage of the Future Collaboration tool where examples of exemplar practice are shared. The scorecard was presented at the Divisional Governance and Quality Committee on the 9 November 2023.

The Board Safety Champions continue to meet with the perinatal quadrumvirate members at bi-monthly intervals.

Safety action 10: 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?

All actions are on track for this safety action. Ongoing monitoring of compliance will continue until the 7 December 2023.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the ‘Implementing a revised perinatal quality surveillance model’ guidance published in 2020. In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff and service user feedback sessions are displayed in Appendix 7.

Discrepancies in the mortality and Hypoxic – Ischaemic Encephalopathy (HIE) data presented on the integrated performance dashboard have been highlighted. In response the HIE data has been aligned on the safety champions dashboard with the Badgernet system report and a revision of the remaining mortality fields is in progress.

The revised HIE data highlighted an increased number of babies that require cooling and therefore a thematic review has commenced to identify themes and opportunities for learning. This will be completed in January 2024.

Table 3 – 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	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Quality & Safety								
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		398	451	461	472	386	408
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			1	2	5	1	4	1
Still Birth rate (12 month rolling) per thousand	3.5	≥4.3	3.8	4.1	5.1	4.5	4.9	5.0
HIE Grades 2&3 (Bolton Babies only)	0	1	1	0	1	1	3	2
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	1	2	1	0	5
END rate in month	Information only		2.5	2.2	4.3	2.1	0.00	12.3
Late Neonatal deaths	Information only		0	1	0	0	0	0
Serious Untoward Incidents (New only)	0	2	0	0	1	1	0	
HSIB referrals			0	0	0	1	1	3
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	0	1	3	3	3
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98%	99.7%	98.8	98.3	99.0	98.6%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	1	1	0	0	0	0
Fetal monitoring training compliance (overall)	<80%	>80%	78.00%	80.50%	86.46%	84.00%	85.92%	83.00%
PROMPT training compliance (overall)	<80%	>80%	78.00%	91.00%	92.14%	93.00%	93.94%	86.00%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:26.8	1:28.9	1:27.2	1:26.9	1:27.1	1:25.5
RCOG benchmarking compliance	Information only		100%	93%	100%	100%	100%	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							

Morbidity Data

The safety champions dashboard highlights an elevated rate of stillbirth in September 2023.In September 2023. This was also flagged at the local maternity and neonatal system board meeting and a review of the 2023 data is now underway and due to be presented in December 2023. The Trust rate of 5.48 per 1000 aligns with the GMEC mean of 5.10 per 100birth and that other comparative providers ie Oldham who reported a rate of 6.99 per 1000.

Serious harm incidents Q2 2023/2024

There were three serious incidents declared during this period, and one serious incident closed. The summary of incidents is detailed in table 3.

Table 3 Serious harm incidents declared – Q2, 2023/24

Serious harm incidents declared – Q2 2023/2024			
Incident No	**Cause Groups**	**Specialty**	**Summary of incident**
223573/5	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).
226376	Fetal Loss above 24 weeks.	Maternity	A woman, at 36 weeks gestation, telephoned maternity triage with a history of uterine tightening and period type pain. Incorrect advice was given to stay at home instead of being invited to attend for assessment. The woman was invited to attend when she called the following day, but was not admitted for observation, which was warranted, due to her history. The woman then attended the following day with ruptured membranes, pain and absent fetal movements. An emergency caesarean section took place and the baby was born with no signs of life.
229651	Maternity	Maternity	The woman has a low risk pregnancy. Patient had a history of reduced fetal movement (RFM) and telephoned the Maternity Unit at 38 weeks and 3 days gestation. She attended the Antenatal Day Unit on at 38 weeks and 5 days with history of reduced movement for 24 hours. On arrival, the abdomen was hard (which can indicate a fetal death in utero) and the midwife was unable to find the fetal heart on cardiotocograph (CTG). Two doctors performed an ultrasound scan and sadly, intra-uterine death was confirmed.

Table 4 - . Highlighted below is the learning from incidents during Q2.

Highlighted below is the learning for those incidents during Q2.

Incident no.	Type of Incident
217120	NNU Unexpected Admission

Learning	The review-highlighted episodes where the management of the fetal heart recording was not in accordance with the antenatal fetal monitoring guideline and earlier transfer to Central Delivery Suite was indicated. This led to delays in the decision to undertake an emergency caesarean section. • Speciality wide and multidisciplinary reinforcement of the principles of the antenatal fetal monitoring guideline and importance of correct CTG interpretation and the potential serious effects that incorrect interpretation, classification and escalation of CTGs can have on both maternal and fetal morbidity and mortality. • A full review of the processes and systems in conjunction with the findings of this incident (relating to the management of fetal monitoring) with a view to enhancing efficacy, maintaining safety and the way we work to ensure safety is maintained in the current climate of high acuity and often compromised staffing levels. • Evidence of completion of fetal monitoring training is being recorded on a speciality database and assurance compliance reports are presented at speciality governance meetings on a monthly basis. • To explore the possibility of the modification of the electronic system for classifying CTG readings for women not in labour, to include additional features. • Reflection for all staff involved.

5. Risk

The review of the year 5 scheme requirements undertaken by the Director of Midwifery has highlighted that limited assurance can be provided that full compliance will all ten standards will be attained. 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.

6. Summary

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**.**

In summary, attainment of the required elements within the ten safety actions are progressing well. Three CNST safety actions within the year 5 scheme continue to remain at risk albeit with an increased confidence that safety action 8 and safety action 6 will now be attained.

One reported breach of the supernumerary standard that occurred on the 11 October 2023 during a maternity divert at 0600hrs is currently under detailed review and ongoing monitoring of the supernumerary status of the co-ordinator continues.

7. Recommendations

It is recommended that the Board:

i. Receive the contents of the report

ii. Approve the action plans detailed within this report

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

Appendix 1 – Cases reported to MBRRACE from 30 May 2023 (included in report as per CNST standards)

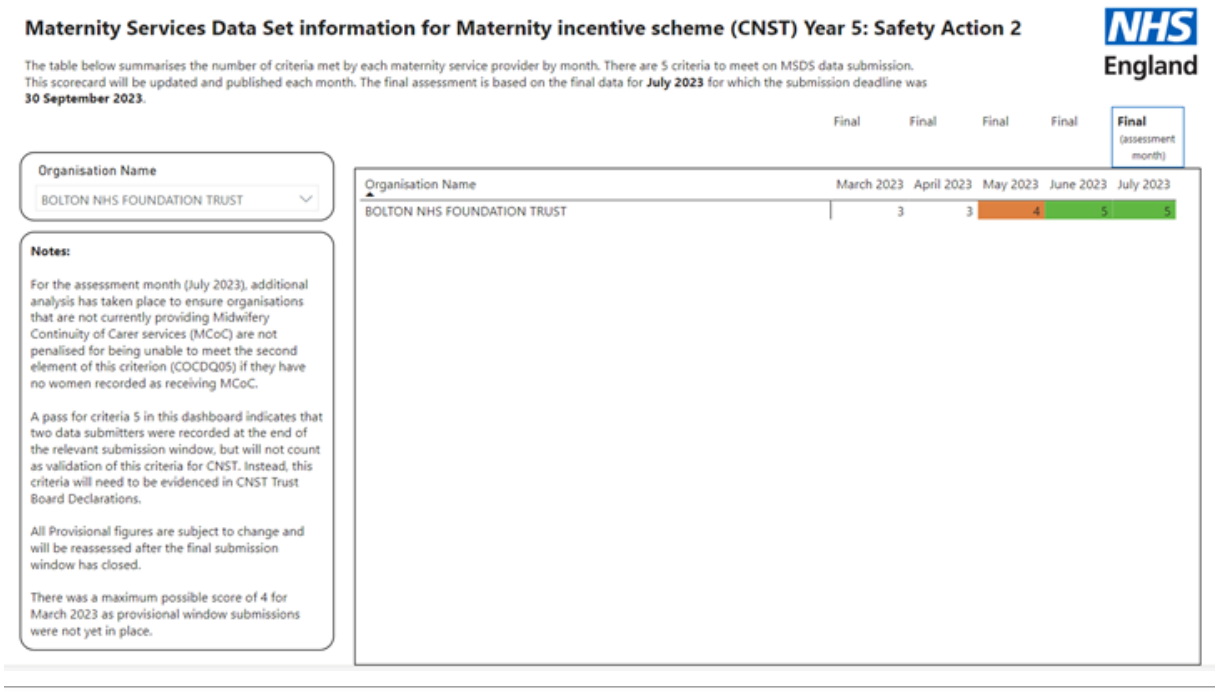
Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	1 month surveillance Deadline Date	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/concerns questions	Report to draft Deadline Date 4 months	Report published Deadline Date 6 months
87775	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 Done 02.11.23
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 Done 02.11.23
88155	SB	32+2	24.6.23	5	28.6.23	28.6.23	28.6.23 19.8.23	24.10.23 **Draft done 28.9.23**	24.12.23
88233	SB	24+3	30.6.23	3	30.07.2023	30.08.2023	30.06.23 13.07.23	30.10.2023 **Draft done 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 done 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 done 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 completed 19.10.23**	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 Done 7.9.23	4.9.23	4.1.24 **Draft 21.12.23**	4.3.24
89592	ENND	40	26.9.23	0	26.10.23 Done 27.9.23	26.11.2023 Done 27.9.23	26.9.23	26.1.24 **Draft 26.01.24**	26.3.24
89669	ENND	23+2	30.09.23	0	30.10.23 Done 19.10.23	30.11.23 Done 2.10.23	30.09.23	30.01.24 **Draft 28.12.23**	30.03.24
89813	SB	27+6	11.10.23	0	11.11.23 Done 12.10.23	11.12.23 Done 13.10.23	11.10.23	11.02.24 **Draft 18.1.24**	11.04.24

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 – NHS digital scorecard



Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 5: Safety Action 2

The table below summarises the number of criteria met by each maternity service provider by month. There are 5 criteria to meet on MSDS data submission. This scorecard will be updated and published each month. The final assessment is based on the final data for **July 2023** for which the submission deadline was **30 September 2023**.

NHS England

Organisation Name: BOLTON NHS FOUNDATION TRUST

Notes:

For the assessment month (July 2023), additional analysis has taken place to ensure organisations that are not currently providing Midwifery Continuity of Carer services (MCoC) are not penalised for being unable to meet the second element of this criterion (COCDQ05) if they have no women recorded as receiving MCoC.

A pass for criteria 5 in this dashboard indicates that two data submitters were recorded at the end of the relevant submission window, but will not count as validation of this criteria for CNST. Instead, this criteria will need to be evidenced in CNST Trust Board Declarations.

All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

There was a maximum possible score of 4 for March 2023 as provisional window submissions were not yet in place.

Organisation Name	March 2023 (Final)	April 2023 (Final)	May 2023 (Final)	June 2023 (Final)	July 2023 (Final (assessment month))
BOLTON NHS FOUNDATION TRUST	3	3	4	5	5

Organisation Name: BOLTON NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

Notes: The most recent available reporting period is based on the final July 2023 data for the final assessment. For the purposes of CNST the CQIMs are measured only on a single month's data, see the FAQs on page 5 in this scorecard for more information.

1. **CQIMApgar**

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	385			Passed
CQIMDQ14	455	490	92.9		Passed
CQIMDQ15	450	450	100.0		Passed
CQIMDQ16	415	450	92.2		Passed
CQIMDQ24	385	415	92.8		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	190	460	41.3	Passed
CQIMDQ08	460	460	100.0	Passed
CQIMDQ09	455	490	92.9	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	455	490	92.9		Passed
CQIMDQ11	205	455	45.1		Passed
CQIMDQ12	20	455	4.4		Passed
CQIMPPH	20	455		42	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	455	490	92.9		Passed
CQIMDQ22	450	450	100.0		Passed
CQIMDQ23	415	450	92.2		Passed
CQIMPreterm	30	450		71	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	455	490	92.9		Passed
CQIMDQ15	450	450	100.0		Passed
CQIMDQ16	415	450	92.2		Passed
CQIMDQ18	280	445	62.9		Passed
CQIMDQ20	5	270	1.9		Passed
CQIMTears	5	270			Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	455	490	92.9	Passed
CQIMDQ15	450	450	100.0	Passed
CQIMDQ16	415	450	92.2	Passed
CQIMDQ18	280	445	62.9	Passed
CQIMDQ26	445	450	98.9	Passed
CQIMDQ27	380	380	100.0	Passed
CQIMDQ28	145	380	38.2	Passed
CQIMVBAC	10	40	25.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	455	490	92.9	Passed
CQIMDQ31	460	460	100.0	Passed
CQIMDQ32	420	460	91.3	Passed
CQIMDQ33	455	460	98.9	Passed
CQIMDQ34	285	455	62.6	Passed
CQIMDQ36	455	455	100.0	Passed
CQIMDQ37	190	455	41.8	Passed
CQIMDQ38	460	460	100.0	Passed
CQIMDQ39	445	455	97.8	Passed
CQIMRobson01	5	60	8.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	60	105	57.1	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	50	65	76.9	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	380	490	77.6	Passed
CQIMDQ04	335	380	88.2	Passed
CQIMDQ05	35	335	10.4	Passed
CQIMSmokingBooking	35	335	10.4	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	450	455	98.9	Passed
CQIMSmokingDelivery	40	450	8.9	Passed

2. **EthnicityDQ**

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	355	380	93.4	Passed

3. **MCoC i**

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	330	430	76.7	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	15	15	100.0	Passed

4. **Provisonal Window Submission**

Indicator	Result
Provisional Submission	Passed

5. **Submission Portal Registration**

Indicator	Result
Registered Submitters	Passed

Appendix 3 – ATAIN/TC 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. 10.10.23 National data quality tool to be used to audit admissions from Q2	
		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	10.10.23 Q4 and Q1 audits submitted to LMNS – email evidence	**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				**Q4**

			Director of Midwifery	1 February 2024	10.10.23 Q4 and Q1 audits submitted to LMNS – email evidence	**Q1** **Q2** **Q3**	
		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 08.11.23 Action plan shared at QAC		
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	10.10.23 National ATAIN proforma now in use		
5		Undertake a deep dive review of avoidable admissions as per themes identified (delay in transfer to CDS for induction and delay in delivery)	Audit Team	1 February 2024	08.11.23 Action allocated		

6	Potentially unavoidable admissions	Review Trust lactate guideline as a contributory factor for potentially avoidable admissions to Neonatal Unit	Consultant Neonatologist	1 February 2024	10.10.23 Lactate guideline already updated and ratified at neonatal quality forum in July 2023	
7	Trusts should have or be working 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.	Review and update the Transitional care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.	Matron Complex Care	30 April 2023	03/03/2023 Guideline reviewed and 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	09.10.23 Action plan for the introduction of preterm infant 34+4 to transitional care draft developed and shared for comments 08.11.23 Action plan included in QAC paper – November 2023 for sign off	

Appendix 3a - Safety Action 3 - Expansion of transitional care action plan to include preterm infants from 34+4 weeks

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

Version	Date
1	*03/10/23*
2	*09/10/23*

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	Transitional Care Lead	Appoint a Transitional Care Lead	Complex Care Matron	03/01/2024	03.10.23 Transitional care lead appointed – awaiting start date	
2	Workforce Funding	Seek additional funding for staffing to ensure 24/7 cover	Director of Midwifery / Operational Business Manager	03/03/2024	03.10.23 Business case to be submitted to seek additional funding to expand the care provision to 24/7 for preterm infants	
3	Training	Ensure all staff are appropriately trained to provide safe and effective care to neonates from 34 weeks gestation requiring nasogastric tube feeding.	Practice Education Team	31/03/2024	03.10.23 Training plan to be developed to include a training passport that incorporates NG tube feeding management.	
5	Clinical Governance	Ensure accessible and evidence	TC Lead/Rachael Flynn	31/03/2024	03.10.23 Current transitional	

		based guidance to underpin clinical practice and a robust audit cycle			care guideline to be updated in accordance with BAPM standards. Ensure audit schedule is revised in accordance with amended guidance	

Appendix 4 - Safety Action 4 – Action plan to improve compliance with RCOG guidance relating to the implementation of long and short term locums.

Action	Responsibility	Timeline	Status
Develop Standard Operational Procedure	JK, NAR, LM	October 2023	Complete
Update Competency Checklist	JB, BW, JK	October 2023	Complete
Appoint Consultant Named Supervisor for Locums	NAR	October 2023	Complete
Ensure all consultants understand their responsibility in induction	All consultants	November 2023	Complete
Repeat compliance Audit	NAR, JK, Medical Staffing	April 2024	

Appendix 4a – Neonatal medical action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve BAPM Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	1. Assess compliance with the BAPM standard for medical staffing published in 2021. 2. Identify gaps in compliance	Operational Business Manager – Neonates	June 2024	17.10.23 – Service not compliant with standard. 1 WTE consultant recruited in September to cover existing gaps but a further 2 WTE consultants (minimum) required to ensure 12 hour consultant presence on all days of the week on the Tier 3 rota.  RBH - NIB Neonat Medical Workforc  Workforce Actio Plan Version V6 F	
		3. Collate a business case for the additional Consultan	Operational Business Manager –	January 2024	17.10.23 – Job planning underway for consultants	

		t Neonatologists	Neonates Clinical Director		to understand current position then a business case will be created.	
		4. Secure funding to appoint to the vacancies	Operational Business Manager – Neonates Clinical Director	February 2024		
		5. Recruit to vacant positions	Operational Business Manager - Neonates	June 2024		

Appendix 4b – Neonatal Nursing action plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Achieve neonatal nursing staffing requirements as per Clinical Reference Group workforce tool.	1. Ensure 12.63 WTE (Band 5 and Band 6 inclusive) staffing deficit reported in bi-annual staffing review and escalated to the Chief Nurse.	Divisional Nurse Director Neonatal Matron	October 23	08.11.23 Staffing deficit calculated using the BAPM tool – current vacancies added. Bi-annual staffing report detail submitted.	
		2. Secure funding to appoint to the vacancies	Neonatal Matron	March 24	08.11.23 All posts funded within current establishment and within NCCR allocation	
		3. Recruit to vacant Psychology position	Divisional Nurse Director OBM Neonatal Matron	March 24	08.11.23 Funding secured as part of NCCR monies May 22 to support Allied Health and Psychology presence on the Neonatal unit to support CNST, Ockenden and NCCR recommendations.Support sought from Lead Psychologist within GM ODN to	

					support with the recruitment of 0.5WTE psychology. Post to be filled by March 24 to avoid monies being revoked.	

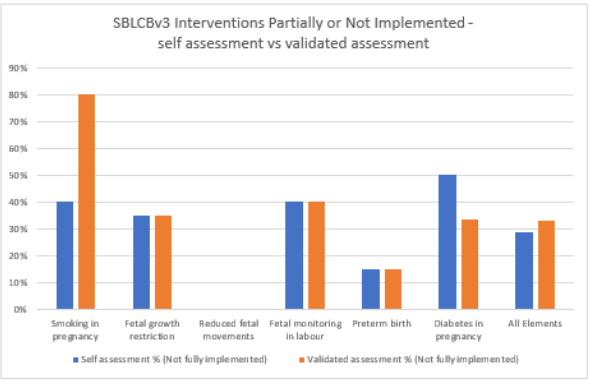
Appendix 5 – Action plan to recover one to one midwifery compliance rate.

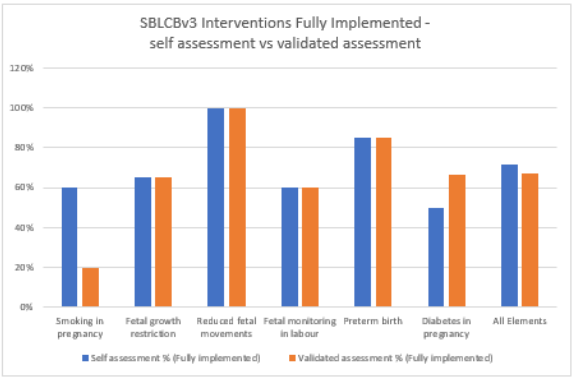
Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions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

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Ensure service is recruited to funded establishment**	Continue regular recruitment events to recruit to full establishment	Recruitment and Retention Lead	October 2024	26.10.23 Provisional date for autumn recruitment event planned for November 2023.	
		Increase post registration student places within service	Director of Midwifery	March 2024	26.10.23 Intention expressed to University of Salford to increase post registration training numbers on January 2024 cohort.	

Appendix 6 - Safety Action 6 – SBLV3 validated compliance.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	20%
Element 2	Fetal growth restriction	Partially implemented	65%	Partially implemented	65%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%
Element 6	Diabetes	Partially implemented	50%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	71%	Partially implemented	67%





Appendix 7 - Feedback from Executive / Non-Executive Walkabouts undertaken including service user and staff feedback

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
September 2023	
Benches are needed for families outside of the maternity unit	Charitable funding approved
New kitchen required on M4	Charitable funding approved for replacement of M4 kitchen
November 2023	
A storage area is required on M4 for the storage of medical devices not in use	Estates floor plan to be requested and repurposing of estate capacity to be undertaken to allow space for storage

Report Title:	Adult Inpatient Survey 2022

Meeting:	Board of Directors meeting	**Purpose**	Assurance	X
Date:	30 November 2023		Discussion	
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	This paper summarises the recent National Adult Inpatient Survey 2022 Management Report for Bolton NHS Foundation Trust by providing an overview of the survey process, findings for BFT and benchmarking against other Trust's surveyed by IQVIA.

Summary:	The results for the 2022 survey indicate a broadly stable picture for Bolton NHS Foundation Trust, with the majority of scores sitting in the intermediate-60% range of Trusts surveyed: • Seven scores are in the top-20% range • Three scores in the bottom-20% range: *How long do you feel you had to wait to get a bed on a ward after you arrived at the hospital?* *Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?* *Thinking about any medicine you were to take at home, were you given any information?* • Progress can be seen when compared with the findings of the 2021 Adult Inpatient Survey, specifically in relation to noise at night, food and cleanliness. • Recommendations have been provided by IQVIA following their analysis of the findings – these are contained in Appendix 1. • The report along with recommendations will be reviewed and discussed via the Quality and Patient Experience Forum (QPEF). This forum will oversee action to respond to the recommendations and report progress through to CG&QC.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	The Board of Directors are asked to receive and note the content of 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:	Stuart Bates, Director of Quality Governance. Richard Catlin, Divisional Director of Nursing (Chair of QPEF).	**Presented by:**	Tyrone Roberts Chief Nurse

1.0 Background

Bolton NHS Foundation Trust commissions IQVIA UK&I Healthcare to undertake the National Inpatient Survey.

The preparation for the survey completion is supported by the Trust's Business Intelligence Unit with regards to data extraction and data cleansing. The survey was undertaken between January 2023 and April 2023.

The benchmarking provided is based on those Trusts surveyed by IQVIA. 29 Trusts were surveyed by IQVIA for the 2022 Adult Inpatient Survey.

The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2022, who had had a stay of at least one night in hospital. There were 33 patients excluded from the survey where they had either died or moved address leaving a sample size of 1,217.

403 completed questionnaires were returned which provided an overall response rate of 33% this was the same percentage response rate as in 2021.

There will also be a national publication with the key results for each organisation which will be published around August 2023 which is undertaken by the CQC Coordination Centre who publishes the national results on the NHS Inpatient Survey website. Until such times, Bolton NHS Foundation Trust is asked to embargo the publication of the 2022 survey results which uses the benchmarked analysis included in the feedback reports.

2.0 Results

The top and bottom five scoring questions across the entire survey for Bolton NHS Foundation Trust were:

Top 5 Questions	Score
Q27. Were you given enough privacy when being examined or treated?	95.0%
Q15. During your time in hospital, did you get enough to drink?	94.2%
Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	91.2%
Q17. Did you have confidence and trust in the doctors treating you?	91.1%
Q38. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	90.7%

Bottom 5 Questions	Score
Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	14.5%
Q39. Thinking about any medicine you were to take at home, were you given any information?	38.7%
Q5f. Were you ever prevented from sleeping at night by any of the following? None of these.	46.3%
Q4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	54.8%
Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	55.4%

3.0 Benchmarking

The table below shows the scores for BFT highlighted by IQVIA with comparative data for the previous three years. In 2022, 29 Trusts took part in the survey with IQVIA.

	2019 survey	2020 survey	2021 survey	2022 survey
Highest 20%	7 questions	4 questions	2 questions	7 questions
Intermediate 60%	53 questions	34 questions	43 questions	36 questions
Lowest 20%	4 questions	8 questions	10 questions	3 questions

Lowest related questions

- How long do you feel you had to wait to get a bed on a ward after you arrived at the hospital?
- Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?
- Thinking about any medicine you were to take at home, were you given any information?

None of the questions scoring in the bottom 20% of scores was in the bottom 20% of scores in 2021.

Highest related questions

- Were you ever prevented from sleeping at night - Hospital lighting
- Did the hospital staff explain the reasons for changing wards during the night in a way you could understand
- Were you offered food that met any dietary needs or requirements you had
- Did you get enough help to eat your meals
- Beforehand, how well did the hospital staff answer your questions about the operations or procedures
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital*
- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition*

**Indicates a questions that was reported in the top 20% of responses in the 2021 adult in patient survey also.*

Bolton NHS Foundation Trust (BFT) was not the lowest or highest scoring Trust against any of the questions.

4.0 Findings from 2022 Survey

Analysis of the 2022 survey report has identified that leaving hospital was the area where the Trust scored in the bottom 20% for two questions. However also, scores in the top 20% for two questions in relation to leaving hospital. A number of other questions about leaving hospital were close to the threshold for either the lowest scoring 20% or highest scoring 20% of trusts.

Comparing the 2022 survey result themes with the 2021 survey result themes, positive progress can be seen against the 2021 themes of noise at night, food and cleanliness.

Noise at night

This is assessed whether patients were prevented from sleeping at night due to:

- noise from other patients,
- noise from staff,
- noise from medical equipment,
- hospital lighting, or
- something else

In all categories there was a reduction in the percentage of patients stating they were prevented from sleeping. Overall 47% of patients stated they were not prevented from sleeping compared with 39% in the 2021 survey. Although progress is indicated, this still indicates that over half of our patients are prevented from sleeping during their hospital admission. Noise from other patients was the leading cause patients reported that prevented them from sleeping (39%).

Food

Out of four food related questions, two questions had responses in the top 20% of all responses in relation to the specific question. The two remaining questions were close to the threshold for top 20% and lowest 20%.

The question; “were you able to get hospital food outside of set meal times” scored 59.3% against a highest 20% threshold of 61.7%.

The question; “how would you rate the hospital food” scored 68.9% against a lowest 20% threshold of 68.6%. 68% of respondents rated food as either very good or fairly good.

Cleanliness

The Trust scored 90.6% for cleanliness against a top 20% threshold of 91.3%. 73% of respondents reported that the hospital room or ward they were in was “very clean”.

5.0 Progress following 2021 Adult Inpatient Survey

The data from the 2022 survey demonstrates that improvements have been made on four of the five previous workstreams:

1. Quality of food
2. Hospital cleanliness
3. Patient communication
4. Discharge communication

The exception to this is noise at night which remains a concern for patients.

Each of these has a formal workstream with set objectives which were met. This is not an indication that improvements are not still being seen or determined but that these have been addressed through existing forums and groups:

1. Quality of food – nutritional steering group, Patient-Led Assessments of the Care Environment (PLACE), ongoing contractual reviews undertaken by Bolton iFM
2. Hospital cleanliness – Infection Prevention and Control (IPC) Committee following the introduction of the revised NHS Cleaning Standards, Cleaning Charter and audit methodology
3. Patient communication – creation of a simple process for patients/service users to escalate any of their concerns to a senior nurse
4. Discharge communication – ICSD now host a care home forum that allows care home staff to report concerns or suggestions regarding patient discharge as well as a revised (and now mandated) discharge checklist

In addition, the QPEF membership has been expanded to include representatives from Healthwatch every month, Maternity Voice Partnership (MVP) and Bolton Community and Voluntary Services (CVS).

For the response to the 2022 Inpatient Survey, QPEF has agreed that a new approach will be adopted. Rather than these previous large workstreams that try to address issues Trustwide, there will be some focussed work within the divisions based on small tests of change following QI methodology to diagnose the cause and make improvements. The areas of focus selected from the 2022 survey are:

1. How long patients felt they had to wait to get a bed on a ward after they arrived at the hospital
2. Staff discussing the need for additional equipment at home or adaptations after leaving the hospital
3. Medication information for discharge drugs
4. Patients being asked about their views on the quality of their care whilst inpatients
5. Involving patients, their family or carers in discussions about leaving hospital

The exception to this was Noise at Night which will continue as a standalone project and will be led by the Acute Adult Care Division.

6.0 Recommendations

The Committee is asked to note the content of the 2022 National Adult Inpatient Survey.

The Committee/Forum are asked to consider the above themes and proposal for focused tests of change using QI methodology in individual wards/departments. Note continued focus on noise at night and to identify additional projects/work streams to support an improvement in these areas.

Appendix 1

Observations and Recommendations by IQVIA

Admission to Hospital	**Examine reasons why many patients reported long waiting times to get a bed on a ward and take appropriate action where possible**	
Related question(s)	Recommendation	RAG
Q.4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital? 26% responded that they had to wait far too long 13% responded that they had to wait a bit too long 27% responded that they had to wait, but not for a long time	Look particularly at patients who are most at risk.	

The Hospital & Ward	**Address the issues of noise that are preventing patients from sleeping at night.**	
Related question(s)	Recommendation	RAG
Were you prevented from sleeping at night, due to: Noise from other patients (39%) Noise from staff (18%) Hospital Lighting (13%)	Look at the lighting on wards and surrounding areas at night, and monitor noise levels to ensure that staff are aware of actual levels and can take action where needed.	

The Hospital & Ward	**Look at why some patients rate food as only fair or poor.**	
Related question(s)	Recommendation	RAG
How would you rate the hospital food: Very poor – 5% Fairly poor – 9% Neither good nor poor – 18%	Look at food quality, temperature, timing of food arriving, and the operation of the catering contract.	

Doctors & Nurses	Further ensure that patients are acknowledged and included in all conversations which are around them and their care.	
Related question(s)	Recommendation	RAG
Q.18. When doctors spoke about your care in front of you, were you included in the conversation? Yes, always – 75% Sometimes – 21% No, never – 4% Q.21.When nurses spoke about your care in front of you, were you included in the conversation? Yes, always – 73% Sometimes – 23% No, never 4%	Look at reasons why some patients think this is not the case.	

Doctors & Nurses	Look to understand why some patients did not have confidence and trust in the nurses treating them.	
Related question(s)	Recommendation	RAG
Q.20. Did you have confidence and trust in the nurses treating you? Yes, always – 80% Sometimes – 16% No, never – 4%	Look at the scores around patients getting understandable answers and being included in decisions about their care, as these could impact on this score.	

Your care and treatment	Look at ways of improving privacy for patients when they are being examined or treated	
Related question(s)	Recommendation	RAG
Q.27 Were you given enough privacy when being examined or treated? Yes, always – 92% Sometimes – 7% No, never 1%	Look at ways of improving privacy for patients when they are being examined or treated	

Your care and treatment	Review reasons why some patients say they are not always able to get a member of staff to help them when they need attention.	
Related question(s)	Recommendation	RAG
Q29. Were you able to get a member of staff to help you when you needed attention? Yes, always – 61% Sometimes – 36% No, never – 3%	Review reasons why some patients say they are not always able to get a member of staff to help them when they need attention.	

Operations and procedures	Take steps to encourage staff to clearly communicate how an operation/procedure has gone to the patient shortly afterwards.	
Related question(s)	Recommendation	RAG
Q32. After the operation or procedures, how well did hospital staff explain how the operation or procedure had gone? Very well – 61% Fairly well – 29% Not very well – 4% Not at all well – 2% I did not discuss this with staff – 5%	This made need to be repeated later if the patient was still recovering from anaesthetic at the time of the explanation.	

Leaving hospital	Make sure hospital staff address patients' family and home situation when planning their discharge	
Related question(s)	Recommendation	RAG
Q35. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital? Yes – 77% No, but I would have liked them to – 23%	This should also include any additional equipment or adaptions they may need at home after leaving hospital.	

	Review the extent to which patients are given clear printed information about medicines.	
Related question(s)	Recommendation	RAG
Q39. Thinking about any medicine you were to take home, were you given any information? 46% - An explanation of the purpose of the medicine 17% - An explanation on the side effects 37% - An explanation of how to take the medicine 21% - Written information about your medicine 15% - I was given medicine but no information	Review the extent to which patients are given clear printed information about medicines.	

Report Title:	People Committee Chair Report – October/November 2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

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

Summary:	The attached report from the Chair of the People Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meetings held in October and November 2023.

Previously considered by:
N/A

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

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	17 October 2023	Date of next meeting:	21 November 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Malcolm Brown, Sharon White, Andrew Chilton, Fiona Noden, Francis Andrews, Joanne Street, Sharon Katema, Chris Whittam, Paul Henshaw, Carol Sheard, Laura Smoult, Lisa Rigby, Lianne Robinson, Tracey Garde, Louise Cartin, Hannah Baird	Quorate (Yes/No):	Yes
		Apologies received from:	Tyrone Roberts, Annette Walker

Key Agenda Items:	RAG	Key Points	Action/decision
Chief Registrar		Hannah Baird attended the meeting to reflect on her first year in post as Chief Registrar. The post has been extended for another year. It is the first time this post has been created in Bolton, but there are a 5-6 Trusts in the region that also have a Chief Registrar. Hannah went through some of the projects she has been working on, in particular the successful Fatigue campaign, which has resulted in recliner chairs now available for staff funded through Charitable Funds. Hannah highlighted the Junior Doctor Leadership Group that she has established and the creation of the Green ED Group.	Noted
Staff Experience/Our Voice Change Programme		The Our Voice – Change Programme, aims to build on the Trust's existing approaches by enabling us to focus on the things which colleagues have told us matter most, and make the changes that will have the biggest impact. The aim of the Our Voice – Change Programme is to enhance and grow our culture by empowering our workforce to make changes that matter the most to them and to the people that use our services. Five key themes have been identified: • Digital systems and equipment • Flexible Working • Your working environments • Car Parking • Living Our Values The first Trust-wide Change Programme Event will be held on the 30th October and will focus on a progress update on the five key themes. It will also give colleagues an opportunity to share any further thoughts or ideas.	Noted
Resourcing & Recovery Update		• Trust Turnover was noted to be on a clear reducing trend since January 2023 – and was running at 11.97% in September 2023. • Turnover by staffing group was also presented and the two areas of concern noted were Additional Clinical Services (Sept 2023 turnover for that group was 13.17%), and Allied Health Professionals (Sept 2023 turnover for that group was 14.92%). Further analysis on those groups will follow in future reporting. • Reporting on Trust WTE movement was provided; evidence of an increasing trend Trust-wide, and across the majority of our staff groups demonstrated the robust and effective recruitment activity undertaken by the Trust . • Report summarised delivery of some of the key recruitment pipelines, including Newly Qualified Nurses, Midwives, and AHPs.	Noted (also to be discussed at Finance Committee as part of the Financial Recovery Plan)

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

People Committee Chair's Report

Key Agenda Items:	RAG	Key Points	Action/decision
Agency Update		• Agency expenditure continued on a downward trajectory in September 2023 and, at a total spend of £867k in-month, is at its lowest monthly level for a number of years and is below the Trust 's forecasted plan for the first time this financial year (this report provides analysis of overall performance against forecast). The two biggest staffing groups that drive agency spend (Nursing & Midwifery, and Medical) both have expenditure reductions in-month. However other agency expenditure increased. Overall agency spend reduced by £264k in September 2023 when compared to August 2023. • Spending on Trust internal bank workers increased in September 2023 by £126k in-month when compared to August 2023. • Medical Waiting List Initiatives, and Extra Sessions, spending increased slightly in-month by £28k when compared to August 2023. • Overtime expenditure reduced by £32k in-month. • The report summarised the range of enhanced controls which had been introduced across the Trust to ensure all spending on vacancies and variable pay are closely scrutinised.	Noted (also to be discussed at Finance Committee as part of the Financial Recovery Plan)
Employee Relations Update		• Volume of formal HR casework has increased, predominantly an increase in Disciplinary cases and the Resolution of cases. • Additional outcomes included in the report and themes regarding disciplinary cases noted – behaviours in work, concerns regarding use of resources and information governance. • Themes regarding resolution cases demonstrate processes regarding relationships between colleagues and relationships with managers. This mirrors findings through FTSU. • Updates provided on Tribunal cases – There is an increase in number of ET claims being undertaken however some cases are being closed through resolution or withdrawal of claims. • Additional oversight of cases involving professional registration added to the report for committee oversight.	The committee noted the findings in the report To understand wider national picture regarding tribunal caseload for context To provide updated position in next quarter regarding Trade Union links and developments
Freedom to Speak Up Q2 Update		• Louise Cartin has been appointed as Interim Freedom to Speak Up Guardian and will be working 2 days a week in the role. • Quarter 2 had been a very busy quarter, with 54 concerns raised, which is an increase of 20 on the last quarter. It was noted that 8 concerns in one area all related to the same issue but are recorded separately. • Behaviour is noted as the highest theme, with 15 management, 11 colleagues and 5 both. • HCAs are the largest group to raise concerns. • There has been a significant decrease in cases raised by BAME colleagues and the Guardians are working with the Head of HR and the EDI Lead to ensure these staff members are aware of the routes they are able to take to raise concerns. • It is Freedom to Speak Up Month and the theme this year is 'Breaking Barriers'.	FTSU Internal Audit to be brought to the next meeting.
Annual Self-Assessment for Placement Providers		Francis Andrews brought the Self-Assessment to the Committee for information and sign off. The report covers medics, nurses and AHPs. It highlights the challenges with IT and supervision and outlines the achievements and good practice. Overall the self-assessment represented a very open and honest appraisal. There was a degree of uncertainty over what happens to the report once it has been sent to NHS England.	Approved for sign off by the People Committee Chair.

	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

Key Agenda Items:	RAG	Key Points	Action/decision
Steering Group Chair Reports		Noted	
Divisional People Committee Chair Reports		Noted	
IPM Workforce & OD Dashboard		Noted	Staff Survey metrics to be updated.

Matters for escalation to the Board:

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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21 November 2023	Date of next meeting:	19 December 2023
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Sean Harriss, Seth Crofts, Paul Henshaw, Carol Sheard, Chris Whittam, Lianne Robinson, Tyrone Roberts, Rahila Ahmed, Jo Street, Dawn Grundy, Lisa Rigby, Malcolm Brown, Sharon Katema, Sharon White, Amy Blackburn, Andrew Chilton	Quorate (Yes/No):	Yes
		Apologies received from:	Fiona Taylor, Rachel Carter, Fiona Noden

Key Agenda Items:	RAG	Key Points	Action/decision
CQC Workforce/Well Led Actions		The Trust overall rating is 'Good' and the well led rating is 'requires improvement'. There were 7 x must do's and 6x should do's identified in the well led inspection report. Of these 3 must do's and 1 should do directly relate to workforce actions. Many of the areas highlighted for improvement were already known to the organisation. Immediate actions were underway following the initial high level verbal and written feedback following the inspection, which took place between the 7th and 9th June 2023. The People Committee will provide oversight of the workforce actions and will receive monthly updates on progress. The Committee received an update on progress against the 4 areas highlighted in the CQC Report.	The Committee agreed that the narrative will be expanded to ensure it demonstrates all actions that have been and will be undertaken in relation to workforce, culture and leadership.
Board Assurance Framework		Since presentation of the BAF in July 23 the BAF was reviewed by the Director of People as part of the quarterly review. There is no proposed change in risk score and Risk Appetite. However, as the Trust approaches the conclusion of its 2019 to 2024 Strategy, it is expected that the BAF will be refreshed and realigned to the new Trust Ambitions. The balance of the current BAF was felt to be more Operational than Strategic and this would be addressed as part of the refresh.	• Noted.
Committee Effectiveness Survey		In line with good practice, the People Committee Effectiveness reviews are a regular exercise of self-assessment with the aim of providing assurance on the effectiveness of the committee and identifying areas requiring specific focus and development. A survey was issued to all People Committee members the results of which have been used to inform aspects of this review. Overall the results from this survey, are generally positive. The number of responses was low but the main themes were the balance of Operational and Strategic items on the agenda and a focus going forward on culture. The suggestion was made that each of the Operational Reports should include a link/reference to the appropriate Strategic objective .	• Noted

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

NHS Bolton NHS Foundation Trust

Key Agenda Items:	RAG	Key Points	Action/decision
Agency/Resourcing Update		The presentation highlights the relatively strong substantive staffing position, and a reduction in the usage and expenditure overall of temporary staffing because of this. Overall, worked whole time equivalent (including both substantive and variable staffing) reduced by 41.85 WTE in-month when compared to M6 2023/2024. Substantive staffing increased by 47.24 WTE in-month, with the majority of increases relating to clinical staffing groups. Agency usage reduced by 5.45 WTE in-month; with bank usage reducing by 82.84 WTE. It was noted that Agency spend for the second month running was below the monthly plan and if it continued with this trend would meet the overall target for the year. Overtime expenditure increased by £33k in-month. Medical variable pay (WLIs/Extra Sessions & Medical Bank work) reduced in-month by £101k. The presentation also provides Committee members with a summary of actions taken, and controls implemented, in support of financial improvement. With regards to resourcing, turnover and vacancy rates across the Trust continue to decrease (Vacancy = 4.25%, Turnover = 10.77%) which is positive news. The report also highlights delivery of recruitment activity and increased usage of volunteers across the Trust. However it was noted that there were workforce challenges with AHPs and Pharmacy. The Committee sought and were provided with assurance from the Executive Members of the Committee that the workforce reductions/changes were reflected in the finance position and that there were no issues of patient safety arising from the impact.	• The Committee welcomed the improving workforce position and the assurances provided on finance and patient safety
Guardian of Safe Working Q2 Update		The Exception Reporting process gives trainees the opportunity to highlight variations from their contractually agreed service requirements and educational activities. The system has been implemented to allow issues to be addressed in real time. The GOSW has oversight of all Exception Reports and is responsible for monitoring compliance to the process. Safety issues identified in these reports are escalated to the responsible Divisional Medical Director and Medical Director. An electronic system is in place in the Trust to report instances where hours are worked outside of safe working; limits as determined by the TCS; where breaks are missed; where there are deficiencies in service; and missed educational opportunities. The report contains details of the Exception Reports by department, grade and type with outcomes reached for 1st July to 30th September 2023, together with activities and issues arising during the reporting period.	• The Guardian of Safe Working is working with the DMDs in ASSD and AACD to ensure sustainability of the rota. • The Annual Report will include objective and subjective feedback.

	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

Key Agenda Items:	RAG	Key Points	Action/decision
		In this quarter 76 exception reports were submitted. It was noted that concerns previously raised in General Surgery were being addressed and improvements were being made. The GOSW has continued to attend local and regional meetings. The Medical Education team continue to support the GOSW with the process of chasing up supervisors, to respond to exception reports in a timely manner.	
Freedom to Speak Up Internal Audit		The Committee received the first of the Internal Audit Reports following the CQC Report . The report concluded that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. The overall rating of the report was **Substantial Assurance**.	The Audit Report will be submitted to the Audit Committee. The actions arising from the Audit will be monitored through the People Committee and Audit Committee.
EDI Annual Report/Action Plan		This report provides an analysis of the diversity profile of our workforce and service users at Bolton NHS Foundation Trust, during the period 1 April 2022 to 31 March 2023.) The report demonstrates the impact of our equality, diversity and inclusion (EDI) policies, procedures and practices as follows: • Celebrating our achievements in advancing EDI. • Monitoring usage of services and employment practices to measure whether access reflects the local population demographics. • Setting EDI priorities and measuring progress. The Annual Report is due for submission to NHSE by 31 March 2024.	The EDI Steering Group will monitor and align with the Action Plan. The People Committee approved the Annual Report for submission to NHSE
Bi-Annual Staffing Update (Nursing)		The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. The report provides assurance to the Board of Directors that adult in-patient wards are staffed in line with the national guidance and that where this falls below the standard the relevant mitigation is put in place.	

	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

Key Agenda Items:	RAG	Key Points	Action/decision
		The report details a number of next steps and transformation work that is underway to further develop and enhance Registered Nurse staffing.	
Bi-Annual Maternity Staffing Update		The report outlines the findings of the maternity bi-annual review for the period January – June 2023. The most recent acuity based tool Birth rate + (NICE accredited) was completed in January 23 using caseload data from a 3 month period June to August 2022. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators in order to provide assurance of safe staffing levels. **Key report highlights:** - The current funded Registered Midwife establishment of 242.58WTE is compliant with the 2019 Birth Rate Plus report recommendations that is being used to model current roster templates. The funded establishment is not yet compliant with the 2023 report recommendations. - The specialist midwifery establishment is within expected parameters. In summary, the report demonstrates the ongoing workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance. The risk to safety during the period of review has been mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICB colleagues.	
Steering Group Chair Reports		Noted	• EDI Steering Group RAG to be amended.
Divisional People Committee Chair Reports		Noted	
IPM Workforce & OD Dashboard		Noted	

Matters for escalation to the Board: There were no significant matters to escalate to the Board. The key issues are captured in the report above.

	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

Title:	Staff Health & Wellbeing Update

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor:	James Mawrey, Director of People/ Deputy Chief Executive Officer		Decision	

Purpose:	To provide an update to the Board of Directors on the Trust's staff health and wellbeing offering and associated actions to support colleagues to look after their own wellbeing in order to be best placed to look after our patients.

Summary:	The Health & Wellbeing plan forms a key part of the People Strategy and is referred to in the Board Assurance Framework - Ambition 2 - Great place to work. The report is intended to provide assurance to the Board of Directors that all possible actions are being taken at this difficult time for colleagues and are asked to note the update on progress with the Trust's staff health and wellbeing offering.

Previously considered by:	Board of Directors – 26 May 2023

Proposed Resolution:	To provide assurance that all possible actions are being taken at this difficult time for colleagues and to note the update on progress with the Trust's Wellbeing Review Action Plan.

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

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

1. Introduction

1.1 This paper provides an update to the Board of Directors on the Trust's staff health and wellbeing offering and associated actions to support colleagues to look after their own wellbeing in order to be best placed to look after our patients.

1.2 The Health & Wellbeing plan forms a key part of the People Strategy and is referred to in the Board Assurance Framework. Ambition 2 - Great place to work.

1.3 As a reminder the purpose of the Health & Wellbeing Plan is to ensure all possible support, advice and tools are in place to support our staff to flourish and remain in the best possible health. The plan includes tools for the social, physical and psychological aspects of wellbeing.

1.4 Overall our sickness absence position remains good when benchmarked against GM organisations. Sickness rates across GM are averaging 5.9% for September 2023, the Bolton sickness rate in September 2023 was 4.76%.

1.5 Colleagues will be sighted from previous papers the plethora of work programmes that have been put in place to support our fantastic staff to be healthy and remain in work. This paper provides a non-exhaustive overview of these work programmes.

1.6 It is important we continue to help and support our colleagues to look after themselves, and the things that may be impacting on their health and wellbeing at work, then we can make sure our colleagues are best placed to look after our patients and families at Bolton NHS Foundation Trust.

2. Wellbeing Update

2.1 A **Wellbeing Dashboard** template was created and presented at May's Staff Experience & EDI Steering Group. The Wellbeing Dashboard includes data across all of our Wellbeing data metrics including VIVUP, the Employee Assistance Programme, sickness absence rates and reasons, gym data, TRiM, Menopause and Occupational Health Service, to name but a few. The purpose of this dashboard is to ensure that the services we are promoting is getting increased 'footfall'. Board are advised that 'take up is improving,' in particular when we look at the number of calls made to the Employee Assistance Programme during Quarter Two (47) when compared to Quarter One (38). In addition, we have seen 114 colleagues access the Employee Assistance Programme online portal during Quarter Two, an increase from the same period in 2022 from 85 colleagues. We have also seen an increased number of colleagues joining the staff gym with 192 members in October 2023, when compared to around 125 members that time last year.

2.2 The refresh of the Trust's **Employee Assistance Programme and VIVUP** has been completed as well as some increased promotion throughout the year and reporting processes having been established. As at September 2023, 756 colleagues were registered users on the Vivup platform, with 897 active visits in the last three months. **Appendix One** shows the range of services provided by ViVUP our Employee Assistance Programme provider.

2.3 In November 2023, the **Reasonable Adjustments Passports** was launched which aim to support colleagues with long term conditions to stay in and be at their most productive in work through proactive support. This was a key action arising out of the CQC report and the Workforce Disability Equality Standard.

2.4 The Trust now has 40 active **Staff Health & Wellbeing Champions**. The role of the Wellbeing Champions Network is to provide two-way communications whereby Wellbeing Champions can provide their ideas and suggestions and can take actions forward in their own areas and we can share important updates and information about the Trust's wellbeing offer. The Wellbeing Champions Network is such an important part of what we do and ensures we can listen to the employee voice around wellbeing which influences our actions and priorities.

2.5 This year has seen the successful launch of the **Menopause** campaign (this is an increasing reason for absence) and actions which have included the Trust becoming a Menopause Friendly organisation. Colleagues can continue to access the training module launched on ESR in October 2022. The Trust's Menopause Policy was launched in June 2023 and a six-month pilot for Menopause peer support sessions commenced in June 2023 on the Trust-site and out in the Community and are anecdotally being well received.

2.6 The team continues to support the Trust's **Schwartz Rounds** and based on feedback received these have been held at a more local level throughout this year to support teams across the Trust. Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare. These have been found to be a really effective way of bringing teams together to listen and reflect and share experiences to help with overall team wellbeing. There is a Trust-wide Schwartz Round planned in November 2023 which is focused on Fatigue and exploring the impact that the recent strikes and increased workload pressures are having on colleagues. In addition, a cohort of colleagues have completed a Train the Trainer Programme on **Active Bystander** and a pilot session took place in October 2023 with the Trust's Freedom to Speak Up Champions. Being an active bystander means being aware of when someone's behaviour is inappropriate or threatening and choosing to challenge it. If you do not feel comfortable doing this directly, then get someone to help you such as a friend or someone in authority. Plans are being developed as to how we can bring this rollout together with the **Civility Saves Lives** campaign activity. Civility Saves Lives is a self-funded, collaborative project with a mission to promote positive behaviours and share the evidence base around positive and negative behaviour.

2.7 A working group was established for the **Fatigue** workstream and actions to take this agenda forwards in conjunction with the Trust's Lead Registrar are on-going. Actions are focused on understanding colleagues' perception of the importance of sleep, education and awareness raising. A successful sleep campaign was launched in October 2023 to highlight the importance of sleep to colleagues as well as the Group successfully securing funding from the Charitable Funds Committee for some recliner chairs for some clinical areas. Videos are being created from senior leaders across the organisation highlighting the importance of sleep and the impact on patient care and a review of the usage of the on-call rooms is also underway.

2.8 The team continues to provide support to Divisions with **Wellbeing weeks** and providing the relevant communications and awareness raising on relevant days throughout the year. In addition, the team has also continued to work closely with the **GM Resilience Hub** to support individuals and teams with wellbeing support. The team is also supporting Divisions with **winter wellbeing plans** and additional activity including looking at increased support from Boo Coaching as we head into winter pressures.

2.9 It should be recognised that the main priority within the wellbeing improvement action plan related to the **cost of living** actions. This included developing a cost of living communications toolkit which includes the Trust's current support offers (Vivup Employee Assistance Programme, Occupational Health, Chaplaincy etc.) and also signposting to other debt advice and resources. We also worked closely with colleagues in iFM to create videos and other resources to include cheap recipe ideas and cleaning tips. We created individual breakfast packs to support colleagues which were made available for colleagues to confidentially access from the Chaplaincy Team who also offered support and a listening ear to colleagues. In addition a Fruit & Veg stall was made available as well as financial wellbeing sessions for colleagues to attend.

2.10 Referrals through to Occupational Health are now meeting current targets to support colleagues in a timely manner. The Human Resources Divisional teams continues to work within their Divisions to ensure policies are consistently applied (audits / case management work) to support our staff to remain in work.

3. Next Steps / Areas of Focus

3.1 The areas of focus for the staff health and wellbeing offer, in line with the Wellbeing Review action plan, include reviewing the 'your working environment' theme as part of the Trust's Our Voice Change Programme. In addition, priorities will focus on refreshing our approach to TRiM and Schwartz Rounds, launching our wellbeing offer identity / brand, embedding the role of the Wellbeing Guardian and progressing with actions in Phase Two of the wellbeing review action plan relating to psychological needs and support for colleagues. With these measures being taken then it is anticipated that our staff will continue to look after their own health and wellbeing. In so doing this should positively impact the Trust's sickness absence rates and thereby supporting more staff to stay in work.

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

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

4. Recommendations

4.1 The Board is asked to receive assurance that all possible actions are being taken at this difficult time for colleagues and they are asked to note the update on progress with the Trust's staff health and wellbeing offering.

Report Title:	Finance & Investment Committee Chairs' Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 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 reports from the Finance & Investment Committee meetings held on the 27 September and 25 October 2023 are attached, for assurance. A verbal update will be provided for the meeting held on 22 November 2023.

Previously considered by:
NA

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

Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	27 September 2023	Date of next meeting:	25 October 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Rae Wheatcroft, Sharon Katema, James Mawrey, Andrew Chilton, Rebecca Ganz, Rachel Noble, Lesley Wallace, Adele Morton, Sam Ball	Quorate (Yes/No):	Yes
		Apologies received from:	Fiona Noden

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM/National System Update		A Walker	The Committee received an update on the financial position across the GM ICS which is a deficit ranging between £299m and £173m compared to a break-even plan. Financial Recovery and Improvement meetings have commenced. It was noted that financial grip and control measures were implemented in Bolton from July. Following the first Financial Recovery Meeting on the 21 of September a further letter is due from GM which is expected to set out actions to be addressed and governance processes which will address the Trust's approach to recovery and improvement.	Noted. GM Letter to be circulated to the members of the Committee.
Month 5 Finance Report		A Chilton	Key points were noted as follows: • We have an NHSE reported year to date deficit of £6.6m compared with a planned deficit of £5.3m. • Unidentified CIP remains an issue as only £6m of savings have been delivered year to date against a target of £8m. • The Trust spent £4.5m on variable pay in month 5, which is an increase of £0.4m compared to month 4. • Capital is challenged with a year to date spend at the end of Month 5 of £4.1m. • We had cash of £28.7m at the end of the month, which is an increase of £5.9m from Month 4 2023/2024. The Trust cash position will become challenging during 2023/24 and this was flagged as a key concern during planning discussions with the ICB. • Our BPPC performance year to date is 87.7%.	Noted. Report to be produced on Head Count to be brought to this Committee and Board.

	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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Implied Productivity		A Chilton	The national finance team now produce a monthly analysis which shows 'Implied Productivity' metrics for provider organisations. These metrics compare provider performance in the current financial year to previous financial years. Trust performance across all metrics is better than the Greater Manchester provider average and the North-West average. However, the metrics show that the Trust has experienced real terms cost growth but has not been able to leverage these expenditure increases into associated productivity improvements. Future monthly finance reports the Committee receives will include updated implied productivity metrics. The finance team is working to develop local productivity metrics, which can be broken down by division / specialty and will be available alongside month end finance information. This is planned for Month 9 23/24.	Noted.
Productivity to Cost Improvement Programme 2023/24		S Ball	The Committee received an update on the CIP position. Key points were noted as follows: • £16,322 CIP has been identified against a target of £19,325. • There needs to be improved pace and momentum and there is a need for more formal meetings in this area. • Targeted support for areas struggling will be provided. • Collaboration is taking place with GM peers and neighbouring trusts to support idea generation.	Commercial CIP figures and more detail around breakdown of delivery and timescales to be included in the next update.
Procurement Update		L Wallace	The Committee received a Procurement Update. Key points noted were: • Procurement savings of £2.86m have been secured for the period to August 23, through cost avoidance (£0.98m), cash releasing (£1.49m) and inflation avoidance (£0.39m). This saving is an increase of £0.44m on the same period of the prior year. • Collaboration with the GM Procurement team and working closely with NHSSC contributed to £1m of the saving. • The remainder of savings, have been achieved by close working with the Divisions. • The Procurement Team are focusing immediate efforts on 8 key priority areas from the strategy to enable maximum financial efficiencies and qualitative benefits. • The team continue to work on the inventory management project with a business case being developed for October CRIG in partnership with the transformation team to explore and articulate the full Group wide benefits a new system will deliver.	Noted. The Committee asked for their thanks to be passed onto the Procurement Team for their efforts.

	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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Service Contract – CDC radiology equipment		L Wallace	The Community Diagnostic Hub is due to open in March 2024. As part of the approved business case, radiology diagnostic equipment was purchased from Siemens, including 1 MRI, 2 CT scanners, 1 X-Ray and 2 Ultrasound. The equipment is currently held in storage by Siemens pending completion of the refurbishment of J Block. Siemens have offered a long-term service contract to maintain the equipment.	Approved for recommendation to Board. To be circulated to Finance & Investment Committee members following Board.
Costing Update		A Morton	NCCI for the Trust for the financial year 21/22 was 93. A score lower than 100 suggests the Trust is more efficient that the national average. The submission for 22/23 cost data has been delayed a few times, but a date has now been set, guidance has been issued and the Costing Team are working through the changes with the Managed Service Provider.	Noted.
Update on Finance Staff Development		A Morton	The Committee received an update on the Finance Department objections relating to finance staff development, spend on education and training within the year 2022/23 and examples of all the great work ongoing to ensure our staff have the ability to gain the skills/knowledge required to do their roles to the best of their ability.	Noted. Congratulations to be passed onto the Finance Team for their achievements.
Contract Award for a Blood Transfusion Managed Service		A Walker	This paper sought the approval for the contract award of a Blood Transfusion Managed Service.	Approved.
Tender Update		A Walker	As discussed at the previous meeting of Finance & Investment Committee, a decision was taken to develop a bid for the Adult Sexual Health Service, which was submitted on 13th September. An update on this tender will be provided at the next meeting. The Family Conferencing Service was not considered a viable opportunity given the low value attached to the contract, and a decision was taken not to bid for the service.	Noted.
Comments:				
Risks escalated:				

	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

Finance and Investment Committee Chair's Report

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	25 October 2023	Date of next meeting:	22 November 2023
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rae Wheatcroft, Sharon Katema, James Mawrey, Andrew Chilton, Matthew Greene, Rebecca Ganz, Rachel Noble	Quorate (Yes/No):	Yes
		Apologies received from:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM/National System Update		A Walker	The Committee received an update on the financial position across GM National and the PWC support. Key points noted were as follows: • GM revenue position is £187.7m deficit year to date (M6) which is significantly off the break even plan set for 23/24.Capital budgets are still not in balance though GM spend year to date is well below plan. • PWC are working on the in year financial recovery whilst Carnall Farrar are focusing on the medium term and a strategic financial framework. The latter has been paused to ensure enough capacity to complete the PWC work.	Noted.
Month 6 Finance Report		M Greene	The Committee received an update on the Month 6 Financial positon. Key points noted were as follows: • In month 6, we have an NHSE reported year to date deficit of £6.8m compared with a planned deficit of £6.3m. The adverse variance to plan is in the main driven by the costs of covering medical industrial action, which has cost the Trust £1m year to date. • Capital spend for month 6 is £4m of which £0.9m relates to TIF and £2.3m relates to CDC. • We had cash of £17.3m at the end of the month, which is a decrease of £10.4m from Month 5. 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. • Our BPPC performance year to date is 89.4%. This is expected to continue to improve due to having one invoice for NHSP in future months.	Noted. Planned FTE figures to be included in future reports.

	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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Cost Improvement Programme		S Ball	The Committee received an update on the CIP. Key points noted were as follows: • There is a slight increase in forecasted CIP. • Work has begun on the 24/25 programme to improve identification of recurrent schemes to support financial sustainability. • Question was raised around CIP from IFM. SB confirmed IFM are being pushed in relation to CIP and it will be seen on the tracker.	Noted. CIP from IFM to be addressed.
EPR Phase 2 Implementation Proposal		B Walmsley	The Committee received the EPR Phase 2 Implementation proposal to seek approval for an additional capital investment of £1.52m (exc VAT) for the roll out of Phase 2 of the EPR in to Outpatients and Adult Community Services. Key points noted were as follows: • The next phase of EPR is essential for the development of the Trusts digital maturity and is key for the delivery of quality, safe and efficient care. • The Committee and all the Executive Directors fully support the case but unanimously agree the benefits of the scheme need to be clearly tracked and realised. • Concern was raised around affordability this financial year. LW suggested a phased approach. • BW thanked the Committee for their support and noted the phased approach.	The Finance & Investment Committee **approved** the EPR Phase 2 Implementation Proposal subject to timing and profiling with clearer benefits realisation plan owned by the Division.
Comments:				
Risks escalated:				

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

Report Title:	Financial Controls Committee Chairs' Reports and Terms of Reference

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	Annette Walker		Decision	✓

Purpose	To ratify the establishment and Terms of Reference of the Financial Controls Committee and provide an update from the meeting held on 25 October 2023.

Summary:	The Terms of Reference from the Financial Controls Committee are attached for ratification alongside the Chair report from the Financial Controls Committee Meeting held on the 25 October 2023 for assurance. A verbal update will be provided for the meeting to be held on the 22 November 2023.

Previously considered by:
The attached Terms of Reference were presented to the newly established Financial Controls Committee and are recommended for ratification.

Proposed Resolution	The Board of Directors are asked to approve the Terms of Reference for the Financial Controls Committee and receive the 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

Financial Controls Committee Chair's Report

Name of Committee/Group:	Financial Control Committee	Report to:	Board of Directors
Date of Meeting:	25 October 2023	Date of next meeting:	22 November 2023
Chair:	Alan Stuttard for Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Alan Stuttard, Annette Walker, Fiona Noden, Rae Wheatcroft, Sharon Katema, James Mawrey, Francis Andrews, Matthew Greene	Quorate (Yes/No):	Yes
		Apologies received from:	Andrew Chilton

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Draft Terms of Reference		S Katema	The Committee received the draft Terms of Reference for consideration. The Terms of Reference were approved subject to the following changes: • The inclusion of a Non-Executive Director to quorum • Programme Director for Transformation added as a Member of the Committee.	Approved with minor amendments.
Grip and Control Review – PWC		A Walker	The Committee received an update on the outputs from the PWC GRIP and Control Review undertaken as part of the GM Financial Recovery Process. Key points noted included: • Bolton FT have been asked to focus on 8 out of the 19 controls that required either implementation or strengthening. • MIAA (our Internal Auditors) to complete a rapid piece of work around the controls in place, which PWC have asked for prior to December. • AW reported on implementing a change to the Standing Financial Instructions in that any non-pay spend greater than £10k will now require Executive Director approval.	Noted.
Finance and Performance Recovery meetings – Key Issues		A Walker	The Committee received an update on the key issues identified by PWC during the September round of FPRMs when PWC identified 13 issues, commonly found across the 9 providers in GM, which list the issue, the implication and the key consideration for Boards.	AW asked SB to look at the considerations with SK to cross check for governance actions.

	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

Financial Controls Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Vacancy and Variable Pay Spend		J Mawrey	The Committee received a presentation around Variable Pay and Vacancy Financial Controls and the impact. Although these enhanced controls had been in for only one month, it was agreed that these were having an impact and that a large range of actions were underway. The impact would be tracked in the Finance Committee.	Noted.
Gold Financial Improvement Group Update		J Mawrey	The Committee received an update on the key issues discussed within the last Gold Financial Recovering meeting held on the 13th of October. Discussion took place on two loss making services and the action being taken. The main focus of the update was on pay and the Chief Finance Officer confirmed that work on non pay would come through mext month.	Noted.
Comments: The Chair asked for a co-ordination piece to take place with SK, AW, JM AS and JN to agree the agendas for the various additional meetings taking place.				
Risks escalated:				

	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

Financial Controls Committee

Terms of Reference Document Control Sheet

MEETING	**Financial Controls Committee**
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance
ASSOCIATED DOCUMENTS:	Trust Constitution Standing Financial Instructions Scheme of Delegation
REPORTING GROUPS	Vacancy Control Panel Financial Improvement Group
RATED FORA **(COMMITTEES /GROUPS)**	Audit Committee Finance and Improvement Committee Quality Assurance Committee People Committee Strategy and Operations Committee

Terms of Reference of the Financial Controls Committee

1. Authority

1.1 The Financial Controls Committee is established as a time limited committee of the Bolton NHSFT Board until March 24.

1.2 The Financial Controls Committee (Committee) operates within the Trust's Constitution and Standing Financial Instructions.

1.3 The Committee has no delegated powers other than those specified in these Terms of Reference.

1.4 The Committee is authorised to investigate any activity within its Terms of Reference and obtain, within the limits set out in the Trust Scheme of Delegation, outside professional advice. All Trust employees are directed to co-operate with any request made.

2. Purpose

The purpose of the Committee is to receive assurance on the implementation of the framework for robust governance and accountability arrangements for delivery of the Financial Improvement Programme.

3. Principal Duties

In order to achieve its purpose, the Financial Controls Committee will:-

- Receive assurance on the delivery of the Trust's Financial Improvement Programme and grip and control mechanisms
- Receive assurance on progress of the actions required following each Financial Performance and Recovery Meeting with PWC and GM ICB.
- To have responsibility to the Board for oversight with regard to the Financial Improvement Plans and grip and control
- To embed and maintain a challenging and supportive culture in relation to the financial improvement agenda
- To promote and support the development and implementation of projects to enhance productivity and efficiency in the Trust's operations
- The Committee will work and liaise as necessary with other Board committees on matters deemed by other committees as relevant for their attention.
- To receive regular Chairs' reports from the Vacancy Control Panel and the Financial Improvement Group.

4. Reporting

4.1. The Financial Controls Committee will be accountable to the Board.

4.2. The Chair of the committee will escalate items to the Board using a Chair's report and shall draw to the attention of the Board any issues that require disclosure to the full Board, or require action by the Trust Executive.

4.3. The output from the Committee may be reviewed by the Audit Committee at any given time.

5. Chair

5.1. The Committee will be chaired by the Chair of the Finance and Investment Committee and in their absence, the Audit Chair will automatically assume the authority of the Chair.

6. Membership

6.1. The Financial Controls Committee membership will consist of:

- Two Non-Executive Directors
- Chief Finance Officer
- Chief Operating Officer
- Chief Nurse or Medical Director
- Deputy Chief Executive / Director of People
- Director of Corporate Governance
- Director of Digital, Transformation and Strategy
- Programme Director for Transformation

The Trust Chair and Chief Executive can attend the meeting as ex officio members

6.2. The following members will ordinarily be in attendance

- Operational Director of Finance
- Head of Financial Management

7. Quorum

A quorum will be no less than 5 members of which one must be the Chief Finance Officer or their nominated deputy and one Non-Executive Director.

8. Organisation and Frequency of Meetings

8.1. The Financial Controls Committee will meet on a monthly basis.

8.2. The minutes of Committee meetings shall be formally recorded by the Secretary.

8.3. The agenda and supported meeting papers will be issued two days before the meeting.

9. Review and Assessment of the Committee

9.1. A review of the Committee and these Terms of Reference shall be conducted at the end of the 2023/24 financial year. It is anticipated that this committee will cease in March 24.

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by (Insert Committee Name)**
Version No.	Initial Draft ToR	Executive Directors Group (*23.10.23)*	
1	Amended following meeting discussion with Audit and FCC chairs 6/11	FCC	

Report Title	Green Plan Update

Meeting	Board of Directors	**Purpose**	Assurance	✓
Date	30 November 2023		Discussion	✓
Exec Sponsor	Annette Walker		Decision	

Purpose	The purpose of the paper is to give an overview of the progress made on the Green Plan and Associated Targets.

Summary	In summary, the paper provides summative points of the progress of the Green Plan and status of all Targets. 79% of the Targets within the Green Plan are completed or on track to maintain compliance. 17% of the Targets are in progress, the majority of these Targets are low risk and progress has been made to ensure these Targets remain on track. The remaining 4% of targets are pending review of the Green Group and a request to the Group has been made to postpone these targets.

Previously considered by	Finance & Investment Committee 22 November 2023.

Proposed Resolution	The Board of Directors is asked to receive and note the Green Plan 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:	Adrian Wrigley QSHE Associate Director	**Presented by:**	Annette Walker Chief Finance Officer

Green Plan Introduction:

As a large and busy acute hospital with ageing buildings and infrastructure, Bolton NHS Foundation Trust consumes a significant quantity of resources and consequently has a large carbon footprint contributing to climate change and its associated impacts on a local and global scale.

Bolton NHS Foundation Trust aspires to make substantial improvements to the sustainability of its operations. We recognise the impact we have on the environment and our responsibility to integrate sustainability within our core business. Our Green Plan provides an organisation-wide strategy that outlines the Trust's plan of action for 2022-2025, in line with our vision and objectives.

This plan aims to deliver more sustainable healthcare; improving the quality of care while enhancing our resilience, sustainability and wellbeing in preparation for future pressures and challenges.

Green Plan Targets:

The Plan aims to address the Greener NHS aspirations for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments. The Trust strives to deliver brilliant care outcomes through brilliant people and be a leading partner within an integrated system of health and social care, providing a patient experience without boundaries.

The Green Plan has 12 categories with 71 targets; the plan is published and available to the public on the Bolton NHS website

Categories	No. Targets Per Categories
Corporate	8
Estates & Facilities	10
Travel & Transport	5
Supply Chain & Procurement	6
Food & Nutrition	5
Medicines	4
Sustainable Models of Care	6
Digital Transformation	4
Workforce & Leadership	6
Greenspace & Biodiversity	6
Use of natural resource	6
Climate Adaptation	5

The Green Plan targets are tracked with an Target status and in terms of our current status, we have either completed or are in progress with our Targets, additionally there are 3 pending review detailed in the Targets requiring review below.

Status of the listed 71 targets, as of 10Th September 2023

Target Status		
Targets requiring Review	4%	3
In Progress	17%	12
On track	61%	43
Complete	18%	13

Targets requiring review (4% - 3 Targets):

The most recent review of the Green Plan identified three Targets that are requiring review.

Those Targets are:

Number	Category	Target
2.6	Estates & Facilities	Comply with the zero carbon standards for buildings
2.8	Estates & Facilities	Achieve a minimum BREEAM excellent for new builds and very good for refurbishment
3.2	Travel & Transport	Convert the fleet vehicles to electric vehicles

- **Green Plan Target 2.6 – Comply with the zero carbon standards for buildings:**

The request is for the Group to make a decision on whether we can postpone this Target until the Green Plan is reviewed in time for 2025 republication

To meet these requirements, it is expected to cost over £1m more than the standard approach, due to the building materials and contractor expertise involved to meet the standard.

The HDP will however identify all the major projects required to reach a carbon net zero building and heating management system, including costs and timeframes.

IFM have currently provided 5 contractors a scope of works to determine indicative costs.

The indicative costs will cover the identification of all building works that will be necessary to meet the carbon net-zero requirement of 2040, as well as providing their guidance on what steps to take and in what order.

- **Green Plan Target 2.8 – Achieve a minimum BREEAM excellent for new builds and very good for refurbishment:**

The request is for the Group to make a decision on whether we can suspend this Target until the Green Plan is reviewed in time for 2025 republication.

This Target also relates to Target 2.6, with BREEAM being an assessment undertaken by independent licensed assessors to gain accreditation in the building standard. To hire and audit the building to gain accreditation will include additional costs in contractor fees. (In Addition to associated cost with Target 1 Comply with the zero carbon standards for buildings)

This Target would require and independent contractor to review and report on the site/project, with an expected cost upwards of £10,000, and £30,000 to receive external accreditation and registration.

This Target does not provide any direct investment returns, with any investment recouped through associated costs e.g., savings made through the installation of windows that meet the BREEAM standard.

- **Green Plan Target 3.2 – Convert the fleet vehicles to electric vehicles (EV):**

The conversion to EV will require a suitable electrical infrastructure to be in place. The current proposal is to replace the fleet with hybrid vehicles.

This does support the sustainability agenda of reduced emissions, and ensures the Trust can remain operational as standard and will also allow the Trust to pick from a greater range of EVs when the new lease agreements end. Currently, the Trust requires the use of 4-tonne vehicles but these are not available in the EV range.

Additionally, the cost of going completely EV would be an additional £150,000 on our current costs. Furthermore, the Trust does not have any EV chargers available on site, adding further complication to the use and recharging of an EV fleet.

Targets that are identified as '"In progress" (17% - 12 Targets):

Number	Category	Target	Cost	Progress
1	Corporate	Recognise and reward staff for sustainability behaviours and Targets	£0	The annual reward category will be reviewed in January 2024 between the Sustainability Manager and Comms team. The monthly recognition needs reviewing and the Sustainability Manager is waiting on a response from the Staff Experience Manager
2	Corporate	Revise our business case template and assessment tools to ensure that sustainability is embedded into business decisions	£0	A recommendation of amendments were proposed on the current document, alongside an in-depth version attached to the Finance department as part of their review. Further discussions are required to have sustainability added to the business case template
3	Estates & Facilities	Purchase 100% renewable energy tariff	£90,000+	Details noted below
4	Estates & Facilities	Complete the programme for LED lighting across the site	£250,000	Details noted below

5	Estates & Facilities	Establish an environmental monitoring reporting system to measure and report on key environment aspects	£0	The areas for monitoring carbon emissions have been established: • Energy, waste & water • Fleet • Anaesthetics gases & inhalers • Business Travel Processes are required to ensure this data is received by the Sustainability Manager
6	Estates & Facilities	Energy audits to produce an investment roadmap for short term investments and to meet NHS Climate Change reduction goals	£0	An overview and understanding of the energy management system will be established in the completion of the HDP Once that is completed, an internal audit to maintain an understanding of the energy management will be implemented
7	Estates & Facilities	Develop a sustainable guidance to integrate sustainability within the design of schemes for both new builds and refurbishments	£0	The Sustainability Manager needs to work with the Capital Team to ensure they are following the Health Technical Memorandum 07-07
8	Supply Chain & Procurement	Procure 100% certified renewable grid electricity **(note that this is a reworded duplicate of point 3)**	£90,000+	Details noted below
9	Digital Transformation	Introduce sustainability into corporate staff induction and job descriptions. Provide flexible policies and roles to provide staff with flexible careers and a better work/life balance	£0	The Sustainability Manager needs to liaise with the Learning and Development department to identify how sustainability can be embedded into induction and training.
10	Workforce & Leadership	Introduce sustainability into corporate staff induction and job descriptions. Provide flexible policies and roles to provide staff with flexible careers and a better work/life balance **(Note that this is a duplicate of point 9)**	£0	The Sustainability Manager needs to liaise with the Learning and Development department to identify how sustainability can be embedded into induction and training.
11	Climate Adaptation	Establish climate change adaption working group	£0	This will be established once Target 12 is approved
12	Climate Adaptation	Develop a Climate Change Risk Assessment (CCRA) and maintain a Climate Change Adaptation Plan to highlight risks to continuity and resilience of services, which will be reviewed annually or after an event or near miss	£0	The Sustainability Manager has worked with the GM ICS sustainability team to establish a GM wide consensus to the CCRA. The documents need to be internally agreed before we can initiate a roll out

The majority of these Targets continue to be internally managed (without capital investment), as they are in-house expenditure without the need for additional investment, the cost is simply absorbed through the standard business hours.

The Targets with known capital investment requirements are as follows:

Green Plan Target 2.1 – Purchase 100% renewable energy tariff (Non supportive of this Target)

Green Plan Target 4.6 – Procure 100% certified renewable grid electricity(Non supportive of this Target)

These Targets stem from the NHS England sustainability strategy and at the time of the released REGO report, would have cost the Trust approximately £5,000 per year.

However, for the last financial year of 2022/23, it would have cost over £40,000.

For this financial year, current costs are £93,000 on top of our annual electricity, with costs expected to continue to rise.

There are currently no known repercussions on NHS Trusts in refusing to purchase renewable energy tariffs. A number of Greater Manchester Trusts have refused to purchase the renewable energy certificates and this will have been reported through Estates Return Information Collection (ERIC).

A request to the Green Group has been made to make a decision on whether we can suspend this Target until the Green Plan review in time for 2025 republication or if we proceed with the purchase of renewable energy.

Target 2.2 – Complete the programme for LED lighting across the site

A request to the Green Group has been made to make a decision on the options available for this Target, or to propose any additional course of Target. This Target is 80% complete as reported on ERIC, however, to finalise the Target, the issues associated with the removal or management of asbestos to allow access to the light fittings will need to be resolved.

The maternity wards still to be complete and these were missed on the original scheme on the basis that it was under review for the Hospital Improvement Programme, whereby, funding was requested from the government to demolish and rebuild the building. This funding request was denied.

The NHS Estates strategy is no longer use the florescent tube lighting that is in place within the maternity wards, and this is determined by legislative change that has banned the ongoing installation and production of T5 / T8 florescent tubing within the UK from September 2023.

The Trust is legally required to replace the lighting in place with LED lighting once they fail.

The options available are:

1. Do nothing
    a. If we accept the 80%, we can postpone the monthly reviews of the Target and review the Target on the Green Plan in 2025
    b. We accept a breach in using the florescent tubes and continue to use existing stock until all available supplies are depleted
    c. We will then accept the associated hazard and risks of the Lux levels of lighting available

2. Begin a new scheme that aims to remove or encapsulate the asbestos and complete the roll out of the LED lighting
    a. This will require a capital investment, but will meet our sustainability goals
    b. This will also have the benefit of reducing energy costs and over a period offer a return on investment. It is recommended that prior to commencing the scheme (for option 2) a verification to include all costs is undertaken to better understand the timeframe of any returns and the reduction in carbon emissions

3. Replace the light fittings as and when each light fails
    a. This will impact on services as once a light has failed, an individual asbestos survey will need completing before any light fitting can be replaced. This is also likely to be more time consuming and will be more expensive over the course of the programme.

Summary:

In summary, the paper provides summative points of the progress of the Green Plan and status of all Targets.

- 79% of the Targets within the Green Plan are completed or on track to maintain compliance.
- 17% of the Targets are in progress additionally, the majority of these Targets are low risk and progress has been made to ensure these Targets remain on track.
- The remaining 4% of targets are pending review of the Green Group and a request to the Group has been made to postpone these targets.

Appendix 1:

Green Programme Plan (last updated 27/04/2022)			
Number	Task / Action	Priority	Action Status R - Not on track/ at risk A - In Progress/ behind schedule G - On track B - Complete
Corporate			
1.1	Establish the Green Champion network which will allow the organisation to increase colleagues' engagement with the sustainability plan	Med	G - On track
1.2	Recognise and reward staff for sustainability behaviours and actions	High	A - In Progress/ behind On track
1.3	Review sustainability and net zero progress and benchmark performance against other NHS Trusts	Med	G - On track
1.4	Undertake an annual sustainability awareness survey for staff and patients	High	G - On track
1.5	Revise our business case template and assessment tools to ensure that sustainability is embedded into business decisions	High	A - In Progress/ behind On track
1.6	Review our procurement strategy to ensure sustainability is embedded within the tender evaluation process.	Low	B - Complete
1.7	Work collaboratively and share best practice with the Bolton Family in order to achieve the targets	Low	G - On track
1.8	Support the Bolton £ to ensure locality spend and investment within small business	Low	G - On track

Estates &			
2.1	Purchase 100% renewable energy tariff	Med	A - In Progress/ behind On track
2.2	Complete the program me for LED lighting across the site.	Med	A - In Progress/ behind On track
2.3	Review sustainability and net zero progress and benchmark performance against other NHS Trusts	Med	G - On track
2.4	Establish an environmental monitoring reporting system to measure and report on key environmental aspects Energy (Building) Energy (Transport Scope 1) Energy (Transport Scope 3) Water use Waste and Recycling Carbon Footprint & Scope 1,2 and part 3 Emissions	Med	A - In Progress/ behind On track
2.5	Energy audits to produce an investment roadmap for short term investments and to meet NHS Climate Change reduction goals. The reviews will provide a detailed investment business case that would be produced for a five-year investment plan which includes the below: Renewable building technology (e.g. solar PV, wind generation , heat pump systems) Heat network improvements (e.g. thermal insulation) Review of performance of CHP Investment plan will be aligned to NHS grant funding and Salix public funding.	High	A - In Progress/ behind On track
2.6	Comply with the zero carbon standard for buildings	High	R - Not on track/ at risk
2.7	Provide procurement guidance to suppliers on the expected level of Environmental Management systems for new capital schemes.	Med	G - On track
2.8	Achieve a minimum BREEAM excellent for new builds and very good for refurbishment	High	R - Not on track/ at risk
2.9	Consider all aspects of sustainability by accounting for whole life costings for capital projects	High	G - On track
2.10	Develop a sustainable guidance to integrate sustainability within the design of schemes for both new builds and refurbishments	High	A - In Progress/ behind On track

Travel &			
3.1	Promote virtual meeting technology to reduce the requirement for staff to travel	Med	G - On track
3.2	Convert the fleet vehicles to electric vehicles.	High	R - Not on track/ at risk
3.3	Collect data on staff and patient travel through a staff / patient survey	Med	B - Complete
3.4	Develop a green travel plan – including a review of the business travel policy to ensure sustainable transport where possible Business mileage for cycle use Encourage walking to work Collaborate with GMPT for a sustainable travel plan	Med	G - On track
3.5	Install EV charging points in staff and patient parking areas	Med	G - On track

Supply Chain & Procureme			
4.1	Include sustainable procurement into our social value agenda	Low	B - Complete
4.2	Embed within tenders a sustainable procurement process with weighted scores (10%)	Low	B - Complete
4.3	Work collaboratively with GM on local tenders	Low	G - On track
4.4	Reduce single use plastics	low	B - Complete
4.5	Paper usage Volume reduction Use of recycled paper	Low	B - Complete
4.6	Procure 100% certified renewable grid electricity. This will significantly reduce carbon emissions	Med	A - In Progress/ behind On track

Food & Nutrition			
5.1	Reduce food waste by implementing digital menus	Med	G - On track
5.2	Recycled food waste – all food waste now sent for anaerobic digestion which produces biogas for electricity generation	Med	B - Complete
5.3	Work collaboratively with GM on local tenders	Low	G - On track
5.4	Endeavour to deliver highly nutritional menu that suits the patients' needs.	Med	G - On track
5.5	Remove single-use plastic crockery and cutlery	low	B - Complete

Medicines			
6.1	Investment in new anaesthetic machines which allow digital dosing	Med	B - Complete
6.2	Reduce any wastage of medicines with optimal care plans	Med	G - On track
6.3	Ensuring appropriate prescribing including lower carbon alternatives where appropriate	Med	G - On track
6.4	Avoid / minimise medicines with high Global Warming Potentials. GMMMG approved Management Plan for COPD that incorporates CO2 equivalents to guide prescribing choices	Med	G - On track

Sustainable Models of			
7.1	Work closely with our Clinical Commissioning Group colleagues and across the STP to identify and deliver joint sustainable initiatives	Low	G - On track
7.2	Maintain relationships with experts who support the delivery of quality improvement and cultural change through regular communications and monthly meetings	Low	G - On track
7.3	Develop and implement a sustainable anaesthesia programme	Med	G - On track
7.4	Provide training to staff on how we can embed sustainable practice into our care models.	Med	G - On track
7.5	Establish a sustainable workforce through a focused and targeted recruitment plan	Med	G - On track
7.6	Involve and engage with patients in the redesign of services through open discussion sessions	High	G - On track

Digital Transforma			
8.1	Provide our community based staff with Wi-Fi enabled devices to avoid unnecessary travel	Med	B - Complete
8.2	Increased activity of the virtual wards and clinics – reducing travel for both staff and patients	Med	G - On track
8.3	Reduce the use of paper Electronic paper records (EPR) Text reminder service	Med	G - On track
8.4	Introduce sustainability into corporate staff induction and job descriptions. Provide flexible policies and roles to provide staff with flexible careers and a better work/life balance	Med	A - In Progress/ behind On track

Workforce & Leadership			
9.1	Develop and implement a sustainability communications strategy	Low	G - On track
9.2	Promote and run at least 6 meetings per year to provide opportunities for colleague discussions and feedback on sustainability initiatives	Med	G - On track
9.3	Staff awards to encourage and recognise sustainable staff behaviours	High	G - On track
9.4	Introduce sustainability into corporate staff induction and job descriptions. Provide flexible policies and roles to provide staff with flexible careers and a better work/life balance	Med	A - In Progress/ behind On track
9.5	Conduct an annual staff survey to gain an understanding of staff satisfaction	High	G - On track
9.6	Promote health and wellbeing through staff and patient comfort, access to greenspace and sharing best-practice	High	G - On track

Greenspace & Biodiversity			
10.1	Undertake an air quality audit to establish a baseline	Med	G - On track
10.2.	Promote, establish and safeguard the greenspace on site including grass stands, trees and gardens	High	G - On track
10.3	Undertake a feasibility study for urban greenspace within the estate	Low	G - On track
10.4	Encourage the use of greenspace to staff and patients through walking maps and outdoor education and therapy session	Low	G - On track
10.5	Compost and biodegradable and food waste	Med	G - On track
10.6	Plant Trees	Low	B - Complete

Use of natural resource			
11.1	Develop and implement digitalisation initiatives to reduce paper use	Med	G - On track
11.2	Identify and progress opportunities for repair and reuse, such as furniture re-use schemes and donations	Low	G - On track
11.3	Switch to 100% recycled content paper for all office-based functions	Low	B - Complete
11.4	Continue to drive sustainability in catering through open discussion groups and the green champions network	Med	G - On track
11.5	Develop and implement a site-wide plastic reduction campaign	Low	G - On track
11.6	Work with our suppliers to reduce waste in the supply chain, especially packaging	Low	G - On track

Climate Adaptation			
12.1	Maintain business as usual adaptation plan	Low	G - On track
12.2	Review redevelopment options for changes to the estate to mitigate climate change risk	Low	G - On track
12.3	Ensure climate change risks are included on the Trusts risk register.	Low	B - Complete
12.4	Establish climate change adaption working group	Low	A - In Progress/ behind On track
12.5	Develop a Climate Change Risk Assessment (CCRA) and maintain a Climate Change Adaptation Plan to highlight risks to continuity and resilience of services, which will be reviewed annually or after an event or near miss	Low	A - In Progress/ behind On track

Title:	Board Assurance Framework

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	✓
Exec Sponsor	Sharon Katema		Decision	

Purpose:	The Board Assurance Framework provides assurance that the principal risks to achieving the Trust's Ambitions are identified, regularly reviewed, and systematically managed

Summary:	The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. Since presentation at the last meeting, a review of the BAF was undertaken by the executive directors and committees to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level. There are proposed changes in risk score for Ambition 1.1; 1.3 and 4.

Previously considered by:	Executive Directors and Board Committees

Proposed Resolution	The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

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. DEFINITIONS

- **Strategic risk**: Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors.
- **Linked risks:** The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
- **Controls:** The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the Ambition
- **Gaps in controls:** Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
- **Assurances:** The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively.
- **Gaps in assurance**: Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
- **Risk Treatment**: Actions required to close the gap(s) in controls or assurance, with timescales and identified owners.

2. INTRODUCTION

2.1. The Board Assurance Framework (BAF) provides a structured process that is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact the delivery of the strategic objectives.

2.2. This year the BAF has continued to reflect the existing Trust Strategy as a result it has been subject to periodic review. However, as the Trust approaches the conclusion of its 2019 to 2024 Strategy, it is expected that the BAF will be refreshed and realigned to the new Trust Ambitions in the new financial year.

2.3. The BAF has been considered by respective Executive Director Leads prior to presentation at Committees to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level

2.4. There are no changes to the assessment of assurance.

3. RISK MANAGEMENT

3.1. To ensure consistency in approach, all risks have been assessed in line with our Risk Management Policy and have been graded using the system highlighted below to generate a risk score: **Severity (Consequence) x Likelihood = Risk Score**.

Severity		Likelihood		
1	Insignificant	2	Rare	Difficult to believe that this will happen / happen again
2	Minor	2	Unlikely	Do not expect it to happen / happen again but it may.
3	Moderate	3	Possible	It is possible that it may occur/ reoccur.

4	Major	4	Likely	It is likely to occur / recur but is not a persistent issue
5	**Catastrophic**	5	**Certain**	Will almost certainly occur / reoccur and could be a persistent issue

Severity / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	8	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Key

15+	High
8 - 12	Significant
4 - 6	Moderate
1-3	Low

3.2. The following changes in risk score were presented and approved by respective committees.

- Ambition 1.1 due to a reduction in Likelihood to 3. Overall the risk is now rated 12 and is now at the Target risk rating.
- Ambition 1.3 risk has reduced from 12 to 9 and remains a Significant Risk.
- Ambition 4 score is increased in 20 so it reflects the highest scoring risk on the risk register regarding Estates which is currently scoring 25.

4. RISK APPETITE

4.1. Risk appetite can be broadly defined as the amount of risk that an organisation is willing to take or the total amount of risk an organisation is willing to accept in order to meet its strategic objectives.

4.2. Risk exists in all environments, and the Trust recognises that it is impossible to achieve its aims and objectives without taking risks. Whilst the amount of risk that the Trust is willing to accept will vary, this will be captured in each of the strategic risks and may change as we move forward.

4.3. The Risk appetite for each Strategic goal (Ambition) of the Trust is reviewed quarterly and discussed at Committees and Board.

4.4. There is no proposed change in risk score for each of the ambitions

5. CONTROL OF THE RISK.

5.1. This sets out how the Strategic Risk impacts the organisation and how it aligns with the Trust risk appetite.

5.2. Once a risk has been assessed, there are four main responses to managing a risk as outlined in diagram below. It is proposed that the Trust continue to ***Treat*** the risk.

6. CONCLUSION.

The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

Board Assurance Framework Explanatory Notes

- The ambitions for the Trust have been agreed in consultation with the Board and wider stakeholders. The ambition description used within this BAF is as set out in the summary Strategic Plan 2019 – 2024
- For each objective the Executive team consider the risks and issues that could impact on the achievement of the ambition, the BAF is then populated with these risks/issues, the controls in place and the assurance that the controls are having the desired impact. Actions to address gaps in controls and assurance are identified.
- Actions should be SMART and should include an expected date of completion.
- The “oversight” column is used to provide details of the key operational and assurance committee.
- The RAG column is used to indicate the level of assurance the Executive has that the risk is being managed.

	• No or limited assurance– could have a significant impact on the achievement of the objective;
	• Moderate assurance – potential moderate impact on the achievement of the objective
	• Assured – no or minor impact on the achievement of the objective

- The full BAF should be reviewed at least once a year at Board and twice a year at the Audit Committee
- The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF;

Ambition 1
Provide safe, high quality care

LEAD DIRECTOR	**Medical Director**	**1.1**
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Consequence	Likelihood	Score	Consequence	Likelihood	Score	Consequence	Likelihood	Score
November 2023	4	4	16	4	3	12	4	3	12

Linked Risks

No linked risks

PRINCIPAL RISK: IF THE TRUST DOES NOT GIVE THE BEST CARE EVERY TIME THEN THIS MAY RESULT IN INCREASED MORTALITY IN HOSPITAL AND IN THE 30 DAYS FOLLOWING DISCHARGE

Overall Assurance Level

Amber

RISK APPETITE:

1	2	3	4	5
Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

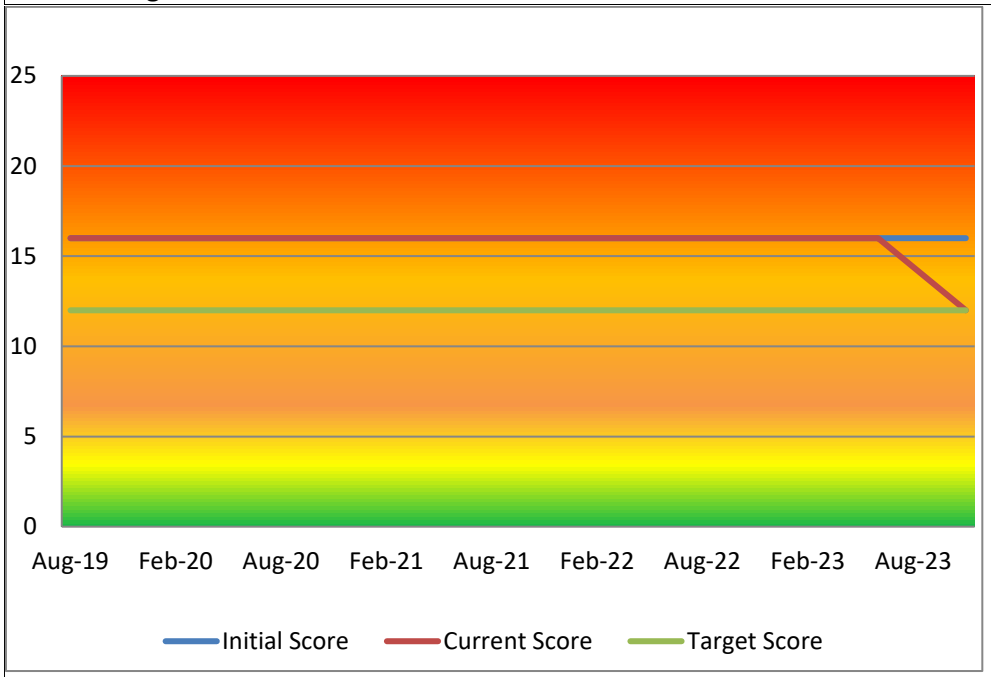
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
MORTALITY METRICS •HSMR and SHMI at risk of going outside of expected range DIAGNOSIS AND COMORBIDITY RECORDING •Recording of diagnosis done using terminology that cannot be coded •Failure to record all relevant Comorbidity	•HED used to alert Trust to areas of clinical concern - monitored monthly and reviewed with clinical teams for triangulation with other data sources regarding quality of care; presented at Trust Mortality Reduction Group (MRG) •MRG monitoring and maintaining the achievement of >98% Coding completeness with accuracy confirmed	•DQ issues mean expected deaths under-predicted – lack of time for clinical validation of data •Clinical time & lack of consistent EPR solution •Awaiting approval for automated	***1st Line of Defence (Operational Management)*** •Local BI monitoring on HED •Review of Monthly monitoring of HED SHMI & HSMR, mean Charlson comorbidity score & depth of coding plus at Mortality Review Group •Learning from Deaths Committee reports to MRG: •Quarterly Quality Account updates to CG&QA committee (on NEWS and antibiotic prescribing compliance)	•Mortality metric variations may reflect recording and data quality issues, rather than a true care concern •Performance data limited by systems and processes for recording and/or reporting (e.g. Sepsis screening and NEWS compliance); being rectified	•~~**Mortality Action Plan**~~ - ~~Supporting Clinical and Coding plan (**30 September 2023). Completed**~~ - Amend EPR to facilitate improved comorbidity recording and depth and consistency of coding ~~(**30 June 2023**~~ **Revised completion -Mar 24** •**MRG**: Continued adoption of new workplan and reporting methodology to ensure

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Comorbidity recording inconsistent between admissions QUALITY OF CARE • Care delivery concerns identified through Learning from Deaths process not fully addressed • Compliance with NEWS observation policy and escalation algorithm not at ~~compliance currently under~~100% ~~90%~~ consistently • Failure by individuals/teams to recognise or respond to a deteriorating patient (identified via Serious Incident Reports and Structured Judgement Review • Sepsis screening and Sepsis 6 performance not at 100% • Patients waiting longer in ED for inpatient beds which may impact on outcome • Patients admitted to hospital when nearing end of life/dying, when may be better cared for/more appropriately placed in other care facilities/at home	annually through external assessor. • Diagnoses and comorbidity education at induction • ~~Revised fluid balance charts on EPR~~ • RR-SAFER implementation and AIMS training • ~~Deteriorating Patient Lead in post~~ • EoL committee actions to improve ACP • Resuscitation Committee monitoring Cardiac Arrest RCAs • Educational programme to improve communication with patients, families and carers • Quarterly Sepsis KPIs reported to MRG • ~~Daily flow meetings~~ • ~~SAFER process to improve patient ADT~~ • ~~Procedural Document Oversight Committee reviews all documents related to evidence-based care~~ • Use of EPACCs system to document and define EOL plans • Ongoing QI Collaborative inc Pressure Ulcer	solution to comorbidity recording in EPR • IT kit access to record data (roll out in progress) • No digital solution for Coding Team to identify missing codes from previous admissions • Training compliance not at 100% for nursing and medical staff • Improving mandatory resuscitation and AIMs training sessions • Coordination between NEWS, sepsis and recognition of deterioration work required to ensure consistency across Trust • Quarterly sepsis KPIs pulled from only one system; data recorded in >1	***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Reports to QAC and Board • Reports on IPC, transfusion, Medicines Safety, Safeguarding • Quarterly MRG and LfD reports to QAC • Mortality reports to QAC and Board ***3rd Line of Defence (Independent or Semi-independent assurance)*** • Trust HED benchmarking against national acute trusts' data • Regional benchmarking and peer review (e.g. Critical Care peer review, Ockenden Insight report, PMRT) • National reporting and benchmarking (e.g. NELA, national hip fracture database) • AQuA audits of care (e.g. sepsis, pneumonia) • GIRFT reviews into care provision (e.g. cancer services, CIAD) • External assessments and accreditation (e.g. RCOA ACSA assessment, RCS reviews) • CNST MIS assessment	• Cases reviewed in arrears with reports collated quarterly – risks delay in sharing learning HED data published nationally in arrears – system does allows some early identification	identification and improvement in triangulation with other KPI and quality metrics (~~**30 September 2023**~~) **Ongoing** • Review of AQuA, GIRFT and other care reviews (March 24) - Increase trained assessors and improvement in response time and case identification processes (Dec 23) - Thematic analysis of existing database of LfD cases.(Dec23) • **Patient Quality Group**: • Enact changes to reduce inappropriate resuscitation attempts, by improving compliance with DNACPR and MCA documentation. • ~~QI collaboratives:~~ ~~- Pressure ulcer collaborative to reduce harm from skin damage **(September 2023)**~~ • **Recognition of deterioration:** - Complete TNA and develop educational training plan - Implement RR-SAFER by training RNs from wards & ratification of PGDs for fluid bolus • Improve sepsis screening & management: Ongoing

1.1	Ambition - To give every person the best care every time – reducing deaths in hospital

Risk tracking



Background

Mortality reduction remains a key strategic and operational ambition for the Trust; delivering high quality, evidenced-based healthcare will reduce.

Our observed deaths, mirrored by crude mortality, are within the expected range and are frequently below national average.

Committee Feedback

Approved change in risk score.

Date	Comments
05/11/20	Risk narrative updated
29/06/21	Narrative updated
01/11/21	Narrative updated
30/06/22	The narrative has been updated and reviewed. This remains a high risk with no change in risk score.
16/11/22	Narrative reviewed and updated. Risk persists due to the need for continued actions to provide controls.
13/03/23	Full review with dates for all actions
July 23	Coding is now at establishment with excellent performance on final coding completeness. This is no longer an issue and has been deleted from issues column. No change to Risk Score
Nov 23	Risk reviewed and reduced to 12 due to improvement in coding and is now at Target Rate

Ambition 1
Provide safe, high quality care

Lead Director	**Chief Operating Officer**
Lead Committee	**Strategy and Operations Committee** The SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

1.2

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
November 2023	**4**	**5**	**20**	**4**	**4**	**16**	**4**	**3**	**12**

Linked Risks

Risk ID:
5630 - scored 16
5588 - scored 15
5599 - scored 16

Principal Risk: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

Overall Assurance Level

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

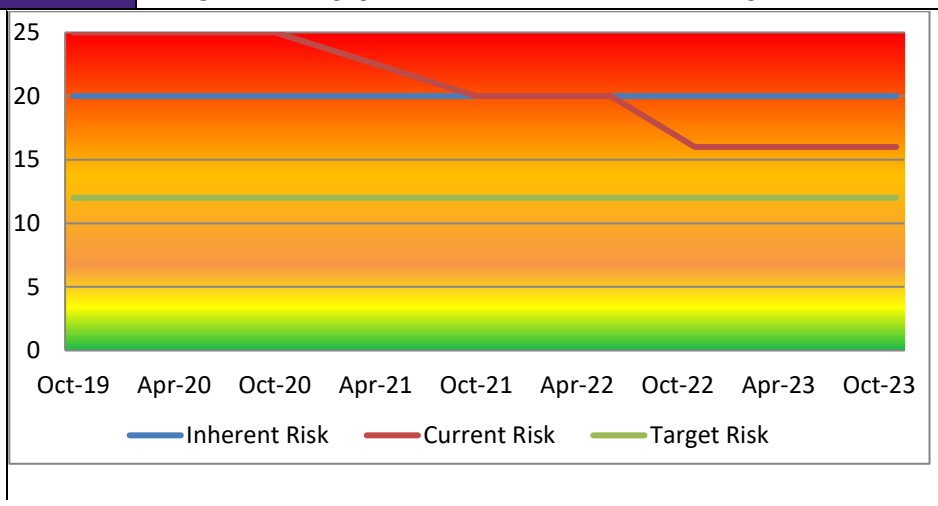
RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Failure to admit, treat or discharge patients from our services in a timely manner **Key Causes** • Increased waiting list size since 19/20 baseline • Increased cancer backlog size since 19/20 baseline • Insufficient theatre capacity to meet current demand • Insufficient diagnostic capacity within cancer pathways • Insufficient capacity within the Emergency Department to deal with the demand • Lack of a sustainable Urgent Treatment Centre model • Failure to reliably meet the SAFER ward standards • Discharge capacity frequently does not meet demand **Impact** • Failure to deliver against nationally mandated performance targets	• Trust policies including (Escalation, Access, Discharge) • ~~Flow meetings and reports (four a day)~~ • Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge • System Operational Response Taskforce (SORT) • ~~Cancer and RTT Patient treatment list management meetings~~ • ~~Theatre Scheduling meetings~~ • ~~Detailed capacity and demand management reviews~~ Joint working with GM on cancer pathways Joint working with GM to ensure equality of access across GM Regular validation of waiting lists Development of the Urgent Treatment Centre Pilot Refreshed Integrated Performance Report (IPR) dashboard ~~Attendance and monitoring at~~ • ~~System Urgent Care Integrated Partnership Group~~ • ~~Planned Care Board Integrated Partnership Group~~ • ~~System Strategy, Planning & Delivery Committee~~	Lack of monitoring of the effectiveness of policies Weak monitoring of the implementation of ward SAFER principles Lack of a robust Capacity & Demand planning cycle	1st Line of Defence (Operational Management) • Regular performance monitoring at Divisional level. • Monthly Integrated Performance Management (IPM) meetings to review performance data • Divisional Risk Registers at RMC • Urgent Care and Community workstream reports at Performance &Transformation Board. • Monthly review of assurance programmes at Performance & Transformation Board 2nd Line of Defence (reports and metrics monitored at Board/Committees • Review of Integrated performance report at Strategy and Ops Committee • Spotlight service reviews at Strategy and Ops • Bi-monthly presentation to Board of the refreshed IPR and Operational Update • Monitoring of performance at GM meetings 3rd Line of Defence (Independent Assurance) • NHSE Oversight framework • NHS benchmarking data including Model Hospital Dashboard and North West performance data • Getting it right first time (GIRFT) programme. • Monitoring and scrutiny of performance targets by GM ICB & PFB teams • Internal Audit reviews • External Peer Reviews by expert groups • Regionally arranged ECIST visits & reviews	~~Review and refresh of IPR dashboard~~ GM ICS Performance meetings	~~Updated IPM dashboard to be developed and available to Board of Directors **(May 2023)** **Action Completed**~~ Review of Escalation Policy, Access Policy & Discharge Policy monitoring to be undertaken and implemented **(September 2023)** Robust audit of ward SAFER principles to be undertaken and reported ~~**(June 2023)**~~ This remains ongoing and is additionally monitored through BOSCA**. Ongoing** Capacity & Demand cycle **(Target Completion Date March 2024)** ~~Review of OPD and Theatre capacity and transformation~~ Development of a workplan following conclusion of the Internal Audit review of waiting list management. **(Target Completion Date March 2024)** Deliver the 2023/24 winter plan to maintain access to urgent and emergency care across the Trust (March 2024) ~~Productivity Improvement Groups~~

1.2 To give every person the best care every time – Delivery of Operational Performance



The pandemic has had an impact on waiting times and has increased demand for our services. This has resulted in increased backlogs and a comprehensive recovery plan is now in place.

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update.

20.02.20	Risk updated to reflect challenges to RTT and cancer performance
16 Nov 22	Review of BAF. No change in risk score, Risk remains High at 16.
30 March 23	No proposed change in risk score following review.
July 23	No proposed change in risk score.
Nov 23	Risk has been reviewed. There is no proposed change in risk score. However, it is proposed that the overall assurance is reduced from Red to Amber given the mitigations in place to address the risk

Ambition 1
Provide safe, high quality care

LEAD DIRECTOR	**Chief Nursing Officer**	**1.3**
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
November 2023	3	4	**12**	3	3	**9**	3	2	6

Linked Risks

Risk 5192 - Scored 12
Risk 5535 – Scored 12
Risk 5536 – Scored 12
Risk 5638 – Scored 12

PRINCIPAL RISK: if the trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

Overall Assurance Level: Amber

RISK APPETITE:

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

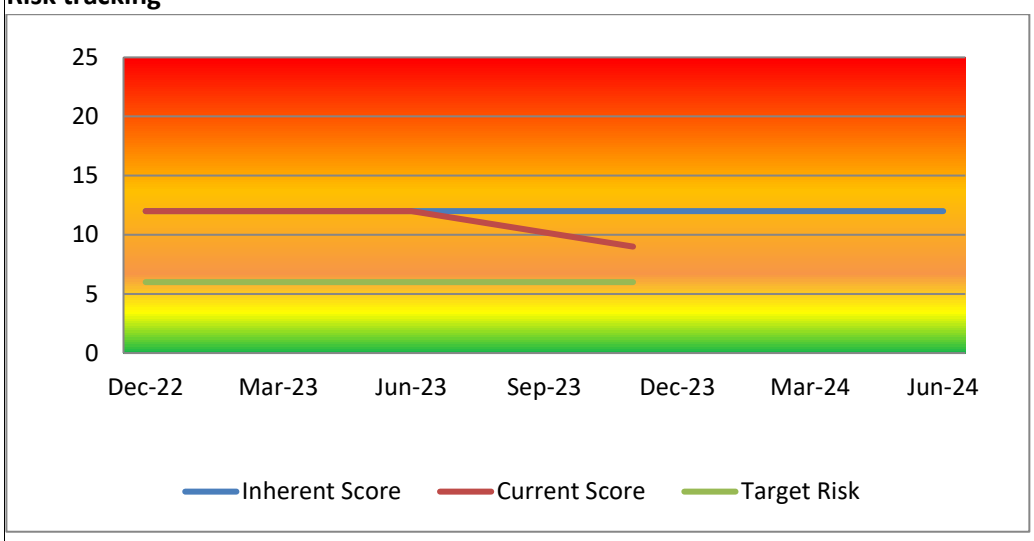
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Sustained achievement and visibility of safe staffing levels / skill mix • Demand for services exceeding capacity • Inconsistency with divisional governance processes • Regulatory breaches • Unreliable application of quality improvement science methodology • Leadership inconsistency with application of required standards • Financial health fragility impacting on service provision	• Quality Account Priorities now overseen by QI team with reporting to CG&QC committee quarterly • Two QI collaborative to support embedding of QI methodology around priority areas • QI training available to all staff. • Internal audit process (PWC, mock CQC) • Accreditation process (BoSCA) • Statistical process control charts for key indicators and split by division and overall organisation monthly • Daily / weekly reports to divisional teams in relation to governance performance metrics • 2:1 meeting with Director of Quality Governance and Divisional Governance teams • Revised serious incident process and policy • Revised being open policy (includes duty of candour) • Phase 1 implementation of changes to QG & CG with removal of 'reassurance' reports & replaced with data driven outcomes • Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS), reviewed every 6 months • Objective setting against agreed corporate priorities for senior NMAHP&HCS • Enhanced accreditation (BoSCA) escalation framework agreed and in place • Regular programme of senior practitioner work-withs and reality rounding in place • Quality impact assessments for service changes / non-medical staffing changes, requiring approval from Chief Nurse and Medical Director • Quarterly Nurse, Midwife, AHP & HCS (NMAHPHCS) development days • Annual NMAHPHCS leadership event • 6 weekly Chief Nurse 'focus groups' with all NMAHPHCS leaders band 7 • Programmed listening events with student non-medical learners to hear feedback	• Revised Quality Governance Dashboard and performance reporting • Development of a Risk management framework/strategy • Junior doctor listening events	***1st Line of Defence (Operational Management)*** • IPM meetings • Reports to Clinical Governance & Quality Governance committee including underpinning sub-group chairs report • Daily operational staffing reviews • Professional observations / reality rounding formal calendar planned & ad hoc • Risk management committee • Chief Nurse visibility of overall staffing provision including vacancies/ ratios • Monthly workforce score cards per division to provide chief nurse and divisional visibility • Monthly safe staffing report produced in line with CHPPD and shared on organisation website • Reports through safeguarding committee detailing actions of PWC review • safeguarding improvement plan • Midwifery safety dashboard in alignment with national requirements • Real-time patient experience with addition of key questions for all in-patients and community long term caseloads – data reports from 10.23 • Chief Nurse programmed interactions with Neighbourhood teams x 6 at 4-6 weekly intervals (digital) and weekly programme of community visits ***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Report at Quality Assurance Committee and Board • Quality Account • Mandatory training compliance • Bi-annual Nurse & Midwifery establishment reviews • CNST & other Maternity related specific reports to Clinical Governance & Quality & QAC and Board • Patient safety report monthly to Clinical Governance & Quality Committee (from 07.22) • Quarterly learning report to Clinical Governance & Quality Committee and Quality Assurance Committee (from 12.22)	• Assurance of ward to Board 'golden thread' through clinical assurance governance standardised framework • Sub-optimal assurance from safeguarding committee chairs reports, quarterly report required. • Implementation of Internal PWC audit of clinical negligence scheme for trusts (CNST) systems and processes within Families division • Implementation of recommendations from PWC internal audit of risk management process • Good governance institute (GGI) review of Quality Governance processes • Implementation of actions from CQC well-led inspection – final report published Sep 2023 •	• Implementation of serious incident process and revisions – **31.7.23 completed but reliability remains fragile within FCD & ASSD** • Commission and review of all Clinical Divisional governance processes against best practice – **31.08.23 completed – work-plan to implement improvements in development** • Finalise QG&CG work-plan to align with domains quality and CQC KLOE – **31.07.2023 delayed due to CQC inspections x 5. Aim 31.12.23** • Quality Governance dashboard and performance reporting – delayed - **Revised Target Completion 31.12.2023** • Refresh of Quality improvement strategy with all stakeholders – **Target Completion end Q3 23/24** • Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.24** • Enhanced Quarterly safeguarding reports to Clinical governance and quality to be developed for assurance **Target completion date 30.8.23 delayed – due end Q3 23/24** • Development of Risk management framework with stakeholder engagement **Target Completion Date 30.12.2023** • Well-led CQC inspection actions reporting to relevant sub-board committee as well as overall cqc improvement plan **– by 12.23** • Review of key lines of enquiry from Countess of Chester (Thirlwall inquiry) to be aligned with appropriate committee / work-plan – by **12.23** • Scope opportunities to enhance safety reliability through deployment of digital / artificial intelligence & linking with deputy national patient safety lead – **09.24** • In partnership with Medical Director, scope junior doctor focus group viability **– 03.24**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
			3rd Line of Defence (Independent or Semi-independent assurance) • Internal audit reviews • CQC inspection reports • CQC inspection visits, Insight reports, • National audits • Peer reviews and accreditation. • Internal audit review of safeguarding systems and processes concluded • Internal audit review of risk management process	•	

1.3 Ambition - To help our staff improve services making sure everyone has a good experience when using our services

Risk tracking



Background

If the Trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

Committee Feedback

The Committee approved the reduction in Risk Sore to 9.

Date	Comments
13.3.23	New risk for inclusion onto the BAF
12.07.23	Risk reviewed. No change to risk score.
Nov 23	Following review of risk, the risk has now been **reduced to 9** which is a Significant risk on the matrix. Risk Appetite risk unchanged and will be considered as part of the refresh of the BAF to ensure it's aligned to the new Ambitions

Ambition 2
To be a great place to work

Lead Director	**Director of People**	**2**
Lead Committee	**People Committee** can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 23	**4**	**5**	**20**	4	4	**16**	4	3	12

Linked Risks

Principal Risk: If the Trust is not a great place to work then it will be unable to recruit, retain and support people to maximise their potential.

Overall Assurance Level

Amber

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

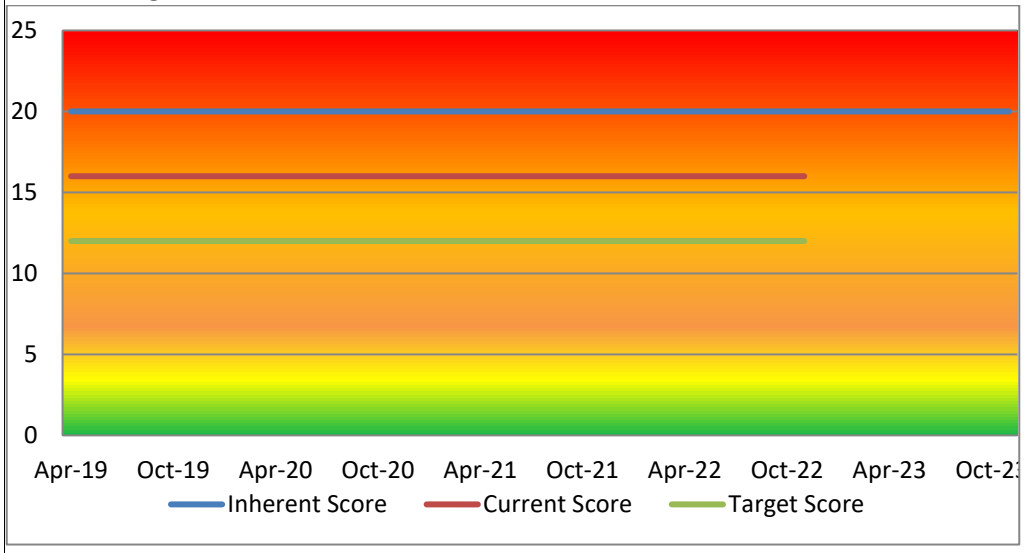
Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
• Health and Wellbeing of workforce – If the Trust does not reduce sickness absence rates there will be a service delivery and financial impact • Staff Engagement/Staff satisfaction – if levels of staff engagement are low there will be a potential impact on improvement initiatives,	• Staff Health and Wellbeing Plan • Our People Plan. • Occupational Health Provision • Staff Experience and Inclusion Steering Group • Staff Health and Wellbeing programme • Great Place to Work Plan	Identified and actioned from Internal Audit of identified key areas. EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (Gaps in control also identified through	***1st Line of Defence (Operational Management)*** • Attendance KPI • NHS Staff survey (annual) • HR Policies and Procedures • Friends and Family • Pulse Survey Staff Survey • Divisional People Committees reports to People Committee • IPM meetings with Divisions • Resourcing and Talent reports to PC	EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee	• Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **New Policy to be launched in the New Year.** • Review of Trust Well Being offer and financial well-being in light of cost of living pressures and

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
discretionary effort and attendance • Recruitment and retention – if the Trust does not recruit and retain staff with the right skills and values the delivery of all other objectives will be at risk. • Agency use – failure to reduce reliance on agency staff has a financial impact but also a potential impact on the wellbeing of substantive staff and the care of our patients • Inclusion – if the Trust workforce does not represent the diversity of the population we serve this can impact on care provision, reputation and future recruitment and retention • Education and Development – if the Trust does not provide opportunities for education and development this will impact on retention, engagement and wellbeing of staff and the future capability of the workforce • Failure to maximise digital HR systems could lead to lost opportunities for increased efficiency and effectiveness • Workforce Transformation – failure to support and enable the workforce to adapt, modernise and transform how	• Weekly / Monthly Safe Staffing meeting • Consultants Job planning • EDI Plan & 2023 specific action plan • Staff Network groups • Revalidation • Appraisals • Mandatory and Statutory Training • ESR Benefits realisation plan • Agile Working policy • Workforce and OD Strategy • Trust Health and Financial Wellbeing • Our People Plan • EDI Plan • Attendance and membership of Bolton wide People and culture group. • Vacancy Control Panels • NHS Workforce Plan	corporate check and challenge process Bolton response to NHS England newly published Workforce Plan to be presented at People Committee Vacancy Control Panel Meetings	***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Report to People Committee and Board. Includes • recruitment and retention • Temporary staffing • Sickness • Staffing report, • HR reports on vacancies • Ward to Board heat map • Staff Story included as a standing item in Board • EDI Plan monitored at People Committee quarterly • Bolton Integrated Partnership locality plan ***3rd Line of Defence (Independent or Semi-independent assurance)*** • WRES, • WDES, • Annual Gender Pay gap report • Annual Quality report • NHS Staff Survey • Local, Regional & national Benchmarking • Internal Audit reviews	Reports from Vacancy Control Panel Meetings	national issues on pay. **November Board Update.** • and vacancy control panel meeting. **Target Nov 23.** • Commence Listening into Action with regular reports to People Committee on a bi-monthly basis. **Target Sep 23** • Regular meeting and expansion of Community voices group. **Ongoing** • Trust's response to the NHS Workforce Plan to be presented at People Committee for ongoing monitoring. **Target September 23**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
we do things and embrace a locality Team Bolton culture / approach will impact our ability to address critical health & social care system wide workforce challenges					

2	Ambition - To be a great place to work

Risk tracking



Background

Maintaining safe staffing levels through recruitment and retention and reducing sickness absence is a key objective to ensure delivery of the Trust's strategy.

The People Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of being a great place to work.

The risk has been reviewed in light of ongoing industrial action and the cost of living challenge. Whilst there are mitigations in place should this be crystallised, there in no proposed change in score.

Date	Comments
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy
05.11.20	Risk reviewed – no changes made
06.01.21	Risk reviewed, minor changes made to content and to summary
28/06/21	Risk reviewed, minor changes to narrative
30/06/22	Risk reviewed, no proposed changes to score
09/11/22	No change in risk score proposed. General refresh of BAF
30/03/ 23	No change in risk score proposed
July 23	Risk reviewed, no change in score

Ambition 3
To use our resources wisely

LEAD DIRECTOR	**Chief Finance Officer**
LEAD COMMITTEE	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

3

RISK ASSESSMENT

Linked Risks

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 23	4	4	16	4	4	16	4	3	12

Principal Risk: If the Trust does not use its resources effectively, and operate within agreed financial limits, this may impact the sustainability and quality of services

Overall Assurance Level

Amber

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

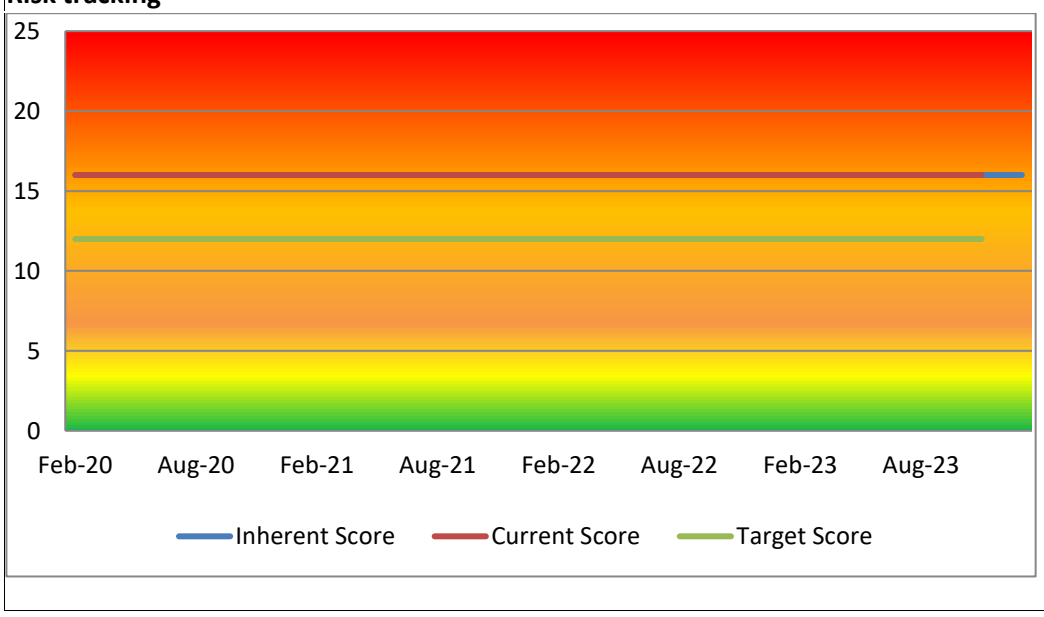
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Delivery of year on year cost improvements. Cost control and managing inflation effects. Shortage of revenue and capital funding Meeting NHS England Productivity requirements Working within GM ICB (jointly responsible and reliant on others results) Achieving the System Efficiency Target	• Executive / CRIG approval of business cases • Improvement and Transformation Team coordination of PCIP • Monthly financial reporting to budget holders • Divisional accountability through IPM • Annual budget setting and planning processes • Finance department annual business planning process • Development of annual procurement savings plans • Monthly accountability reporting to DOF • Standing Financial Instructions • Scheme of Delegation • Establishment of Pay / Vacancy Control Group • Representation at Place Based Finance and Assurance Committee • Establishment of the Financial Controls Committee and the Vacancy Control Panel	GM ICB overarching strategy and financial strategy. Disparate access to GM Provider Performance Productivity Reporting	**1st Line of Defence (Operational Management)** Capital Revenue Investment Group (CRIG) reports Reports to Integrated Performance Management Meetings Monthly cash flow forecast Reports to Finance and Intelligence Group (FIG) Finance Improvement Group **2nd Line of Defence (**reports and metrics monitored at Board/Committee) Reports to F&I including • Monthly Finance Reports • PLICs reporting • Cost improvement progress reports • Quarterly benchmarking • Procurement report • Monthly Chair's Report from CRIG to F&I SFI breach report to Audit committee Variable Pay Group reports to People Committee Monitoring of FPRM Action Log at the FCC **3rd Line of Defence (independent/ semi-independent assurance)** • Internal and External audit reports • System Reports to Greater Manchester ICS and NHS England • Costing returns • National Agency Team reports • **PWC 'Turnaround' Teams Review** • **Monthly FPRM Meetings with ICB Turnaround Director**	Model Hospital benchmarking reporting to F&I Committee	Development of place based approach to service and financial planning ~~April 22~~ *July 23* Understand cost and income base through active use of patient level and roll out throughout organisation. ~~osting December 2~~1 Ongoing 5 year financial strategy refresh subject to clarity on financial regime from 22/23 onwards and ICS Financial Strategy ~~June 21 Dec 22 April 23~~ Mar 24 Closer / joint local working in Bolton System. **Ongoing** Develop overarching GM PMO Productivity reporting. **Target completion December 23** FIG reviewing Provider Performance and benchmarking **December 2023** Clarity on GM Financial Strategy which would inform local Strategic Planning. **Target Completion December 23** Progress actions against 'PWC Grip & Control Checklist' Develop 'WAU' based internal productivity reporting

3 **Ambition - To use our resources wisely**

Risk tracking



Background

The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of Using our resources wisely.

The Trust has now established a Finance and Controls Committee which has the overall responsibility for the Improvement Plan and is supported by the Vacancy Pay Panel chaired by CEO and the Finance Improvement Group.

Date	Comments
20.02.20	Full update to risk
May 20	Risk narrative updated
Nov 20	General Update – risk score reduced
Jan 21	Review to focus on strategic risks
Nov 22	Full review and revision of the timescales for completing the actions. There is no change in risk score
Mar 23	No change in risk score
Jul 23	The Ambition and Principal risk has been reviewed and this remains a high risk at 16.
Nov 23	No change in risk score

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

Lead Director	**Chief Finance Officer**	**4**
Lead Committee	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
November 2023	4	3	12	4	5	**20**	4	2	8

Linked Risks

5958 (25) Estates Backlog
4060 (16) Electrical Distribution boards
5944 (16) K Block water main diversion
1670 (16) Steam and condense services

Principal Risk: If the Trust does not sufficient capital resource to to deliver a building fit for the future, then this will impact the investment in a sustainable estate.

Overall Assurance Level

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

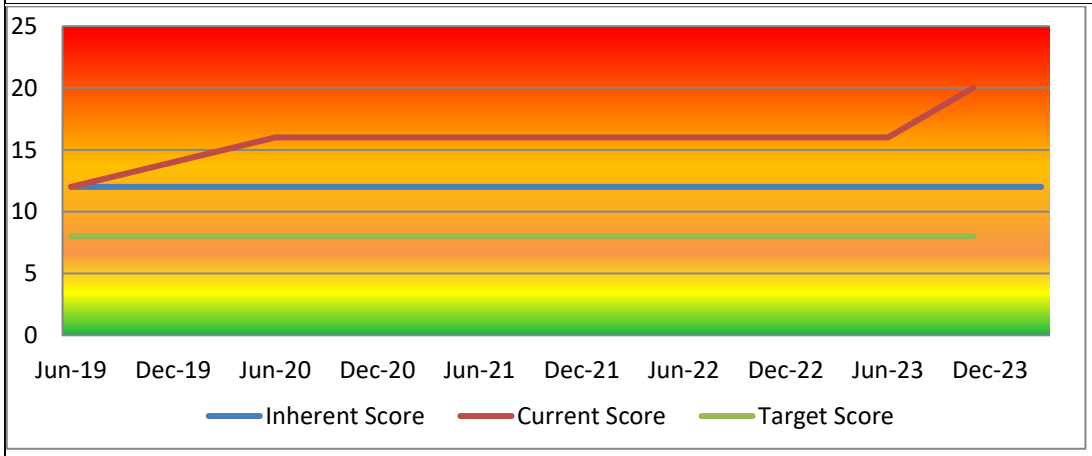
Treat. The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• shortage of capital and revenue funding • Changes to capital regime • High levels of backlog maintenance • Planning, traffic constraints to the site • Controllability of community estates not owned by BFT	• Estates Strategy and supporting Business Cases to make the case for external capital. • Established links to GM and NHSI • Capital processes to ensure correct prioritisation • Links with local partners including LA, University	Digital Performance Management Framework being developed PDC bids / funding not linked to Strategy	**1st Line of Defence (Operational Management)** • Monthly review of business cases at CRIG and Executive Directors. • Reports into 6 Facet Survey to Strategic Estates Group with output tracker presented at Execs • Monthly review performance data IPM meetings to • Reports to the Digital performance and transformation Board which reports into sub-committees of the Board	Periodic reports from Bolton Strategy Estates Groups	Developing dynamic 5 year Estates Strategy. **Ongoing** 6 facet survey reporting to Board annually. **December 23** ~~Clinical Strategy, May 2023~~ **~~September 23~~** Digital Performance Management Framework being developed ~~January 2023~~ July 2023 Digital Project Management Officer oversight of all programmes

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Constraints around capital and revenue funding • Lack of urgent capital investment to restore the estate to a suitable condition • If the Trust does not have a robust digital transformation and delivery plan, the organisation will be unable to function • Availability of investment for Digital programmes against need and expectations. • PDC bids/funding not linked to Strategy	• Membership of Bolton Strategic Estates Group • Premises Assurance Model • Enterprise Asset Management. • Backtrac system • Agile Working Programme • Working with LA and other partners • Our Green Plan • Demolition and Disposal Strategy • IFM asset management • Digital Plan that maps back to the Trust strategy • Clinical Strategy	Re-establishment of Space Utilisation Group	**2nd Line of Defence (reports and metrics monitored at Board/Cttees** Monthly review of Integrated performance report at F&I. Digital performance and transformation Board which reports into sub-committees of the Board **3rd Line of Defence (Independent Assurance)** • ERIC reports • Model Hospital estates and facilities metrics • Use of resources benchmarking • Locality Board oversight • Management Framework • NHS England IG Toolkit • Cyber Security national assessments		Introduce quarterly reporting from Bolton Strategy Estates Groups. **October 23** Re-establishment of Space Utilisation group. **September 23** Develop a capital backlog program of work with a view to prioritise key schemes which will reduce risk profile**. Jan 2024** Manage the estates backlog capital program **April 2024** Monitor and manage the aging estate and escalate urgent issues with the estates**. Ongoing**

4 To develop an estate that is fit for the future

Risk Tracking



Background

The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of developing an estate that is fit for the future.

Committee Feedback

Committee approved change in risk score.

Date	Comments
25/02/20	Full page risk description added
15/05/20	Narrative updated
16/11/20	Update – risk score increased
06/01/2021	Review to focus on strategic risks/issues
30/06/22	Risk reviewed - no changes proposed
March 23	No change in risk score
July 23	There are no changes proposed to the Risk Score which remains at 12.
Nov 23	Risk reviewed in light of new risk relating to Estates that currently has a risk score of 25. **It is proposed that Committee approve the increase in risk score to 20.**

Ambition 5
To integrate care

LEAD DIRECTOR	**Director of Strategy, Digital and Transformation**
LEAD COMMITTEE	**Strategy and Operations Committee** SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

5

RISK ASSESSMENT

Linked Risks

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 2023	4	4	**16**	4	3	**12**	4	2	**8**

Principal Risk: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

Overall Assurance Level

Amber

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

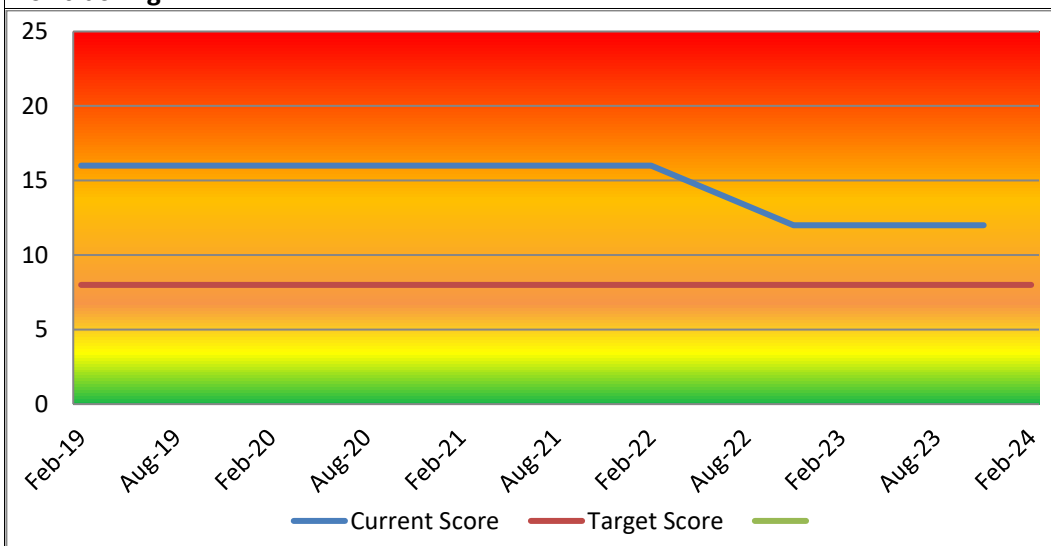
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
If the organisation does not cooperate with its partners to understand, respond to and seek to improve population health, then the people of Bolton will not experience improved health outcomes, and demand for acute and community services will remain high in future **Causes** • Not understanding the impact of changes to the Health and Care Act 2022 • Impact of organisations financial Cost Improvement Programmes on the development of the ICP • If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development • Lack of collaboration with system partners to understand and respond to the wider determinants of health **Consequences** • Changes in the wider health economy may destabilise our organisation • the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future • potential fragment integration and slow development	• Community engagement plan developed for Bolton Locality • *Accountability for delivery of through the Place Based Lead* • Bolton Alliance Agreement to support the governance of the partnership • Representation at Locality Board and System Finance Board on use of the of the Bolton £ . • ICB Locality Delegation agreement with GM in place with *Governance model for delivery in place.*	• Refreshed Locality Strategy and delivery plans in development • System transformation plan to transform services and drive integration being developed • System finance plan in development	***1st Line of Defence (Operational Management)*** Monthly report to Performance and Transformation Board on Community Transformation Report to Bolton Strategy Planning and Delivery Committee from 7 Transformation workstreams delivering against key priorities **2nd Line of Defence (Reports to board and Committees)** • Reports to the Strategy and Operations Committee including oversight of indicators through IPR • Spotlight on service transformation of the Neighbourhoods to SOC • Oversight of system finance and any impact to the FT through F&I and the Financial Controls Committee. • Oversight of Workforce Transformation through People Committee 3rd Line of Defence (independent and semi-independent assurance) Reports to Bolton Locality Meetings Reports to Bolton Health Overview and Scrutiny Committee Reports to GM scrutiny and oversight •Reports to Locality Board with engagement from key partners Reports to Locality Board and System Finance Board on use of the of the Bolton £ .	• New/immature structures – ongoing development including collaborative workshops across the system • Lack of agreed locality strategy, plans and approach to delivery (though these are in development and will be available in Q4 2023/24) • Fully functioning neighbourhood Teams in place **Q4 2023** • System transformation plans to transform services and drive integration are being developed and agreed • Locality workforce strategy being developed	• Revision and refresh of the Trust Strategy. **Q4 2023/4** • Locality strategy development by **Q4 2023/24** • Work with the ICB to agree the model for delivery under the Place Based Lead. **Sept 2023 - complete** • Development of a System Financial recovery Plan. Now superseded and enhanced by PWC Financial Recovery and Performance Committee. **Ongoing** • Development of System transformation plan to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the system to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.**Q.1 2024** • Refresh and embed the Locality Strategy and ensure delivery (TBC)

5 **Ambition - To join up services to improve the health of the people of Bolton**

Risk tracking



Background

The Strategy and Operations Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition join up services to improve the health of the people of Bolton.

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update

Date	Comments
10/5/20	Inherent risk score 16 as of Feb19. Risk Narrative Reviewed
16/11/20	Risk Narrative Reviewed
16/11/21	Reviewed
17 May 22	Risk reviewed and updated following changes to national and local policies
16 Nov 22	No change to risk score as Risk remains Significant
March 23	Risk Reviewed, no change to risk score
July 23	Risk reviewed No Change to score Risk Appetite reduced to Seek from Mature. Approved at Strategy &Ops Committee 26.06.23
Nov 23	Risk reviewed No Change to score

Ambition 6
To develop partnerships

Lead Director	**Director of Digital, Strategy and Transformation**
Lead Committee	**Strategy and Operations Committee** *SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge*

6

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
November 2023	4	4	16	4	3	**12**	4	**2**	**8**

Linked Risks

Principal Risk: If the Trust fails to develop partnerships that support the achievement of our strategic ambitions, then this could result in a negative impact to the services we provide, our infrastructure and our financial position.

Overall Assurance Level

RISK APPETITE

1	2	3	4	5
Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

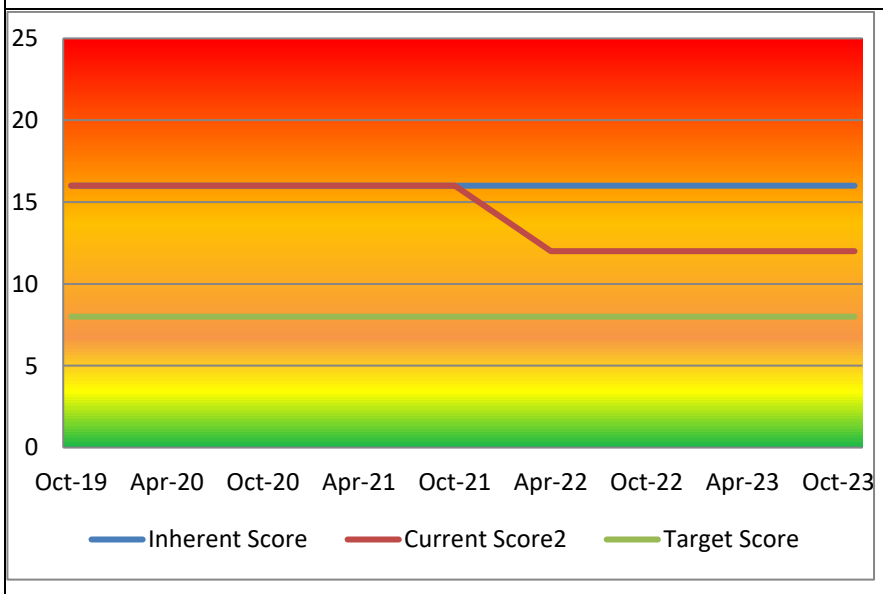
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Demand on services across Greater Manchester and workforce shortages are resulting in resilience issues in some services and requires different partnership approached to mitigate risk and could change the services we provide **Causes** • Resilience of GM clinical services • Increasing demand for services • Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services • Develop Provider Collaborative across GM • Sustainable Workforce Pipeline • Lack of relationships with neighbouring landowners and developers. • Missed opportunity for strategic partnerships **Consequences** • Inadequate workforce to deliver safe, effective care. • strategic partnership opportunities will be missed • adjacent land may be developed in a way that negatively impacts the Trust estate, meaning that our ambitions to improve our estate may be limited • Impact to access, experience and outcomes for the people of Bolton	• Strong Educational partnership through Bolton Health and Academic Partnership Board to support workforce development • Strong Private sector partnerships through Health Innovation Bolton Partnership • Attendance at Greater Manchester (GM) Trust Provider Collaborative (TPC)and its work streams • Participation in the GM Sustainable Services programme • Engagement through GM Exec Director Forums/ TPC • Reporting structure for Bolton Academic Partnership and Programme Management/Support • GM Joint Forward Plan	~~Continue to strengthen partnerships with local academic providers~~ Substantive membership and participation in service transformation programmes within GM. ~~through Directors of Strategy and other Exec Director Forums~~ Development of Local pathology, radiology and pharmacy clinical service strategies	***1st Line of Defence (Operational Management)*** Engagement with senior leaders on Strategy at Trust Provider Collaborative meetings (TPC) Health economics to understand future changes in demand which will influence our clinical Strategy Reports to Place Based Leadership Team ***2nd Line of Defence (Reports at Board and Committee Level)*** • Reports into People Committee • Reports into Strategic Operations Committee • Reports to Board and discussion at informal board meeting. ***3rd Line of Defence (Independent or Semi-independent assurance)*** Membership and attendance at GM Provider Collaborative Board and other Joint Leadership Group • Attendance at GM Director Forums • Membership of Health Innovation Bolton group • Report to the Bolton Health and Academic Partnership • Reports to the Bolton Health Innovation Partnership	• GM Sustainable Services work programme at an early stage though conversations ongoing through Directors of Strategy and Executive Medical Directors • Finalisation of GM network agreements • ~~Finalisation of GM Forward Plan~~	• Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **ongoing during 2023/24** • Continued participation in GM working group to shape and influence the developing programme - **ongoing** • Implementation of GM PACs and LIMS procurements **- Ongoing** • Finalisation of GM network agreements ~~July 2023~~ **Ongoing** • Development of Local pathology, radiology and pharmacy clinical service strategies • Phase 2 of the CDC programme – Building Commenced • Completion Financial Plan and Digital Plan **- Ongoing** • Working group to move towards medical school **Ongoing** • Expansion of clinical courses and programmes mapped to workforce demand **November 2023** • Development of new programmes to fulfil recruitment issues e.g. health informatics **November 2023** • Production of a shared vision for the site and neighbouring land – **Q4ongoing**

6 **To develop partnerships across GM to improve services**

Risk Tracking



Background

As a partner in the Greater Manchester Health and Social Care Partnership and the Bolton Locality we have prioritised the key actions we must take to achieve a sustainable Health and Social Care System.

We recognise there are services where the best solution to the challenge of limited resource is to work in partnership with other organisations.

As a foundation trust we have a duty to the public of Bolton to ensure their access to essential services is not compromised

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update

Date	Comments
21/10/19	c/f and aligned to new strategy
20/02/20	Risk reviewed
05/11/20	Risk reviewed
08/01/21	Risk reviewed
16/11/21	Risk Reviewed
17/05/22	Risk Reviewed and Likelihood reduced to 3
16/11/22	Risk reviewed no change to risk score
March 23	Risk reviewed no change to risk score
July 23	Risk reviewed no change to risk score
Nov 23	Risk reviewed and no proposed change to risk score.

Report Title:	EPRR Core Standards Annual Statement of Compliance

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	Rae Wheatcroft		Decision	

Purpose	To provide assurance to Board of Directors on the process and outcome of the 2023 EPRR Core Standards self-assessment and to present the statement of compliance made by the Accountable Emergency Officer with accompanying action plan for the coming year.

Summary:	• NHS England require all health organisations participating in the 2023 EPRR Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period. • The organisations self-assessment process has been undertaken by the Emergency Planning Manager and Officer with support and scrutiny by the Director of Operations and the Chief Operating Officer who is the Trust's Accountable Emergency Officer (AEO). • This year there has been an additional step to the EPRR core standards assessment with a tabletop check and challenge undertaken by NHSE Regional EPRR Team. • The outcome of the check and challenge has been duly considered and has resulted in some adjustment to our self-assessment outcome and associated action plan. Dialogue has also been conducted via the Local Health Resilience Forum regarding consistency of self-assessment approach with other Greater Manchester Trusts. • The final outcome of the Trust's self-assessment and corresponding AEO's statement of compliance is that we remain substantially compliant with the EPRR Core Standards Framework.

Previously considered by:
Strategy and Operations Committee

Proposed Resolution	Board of Directors is asked to receive the 2023 EPRR Core Standards self-assessment paper.

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 Street (Deputy AEO), Jimmy Tunn (EPRR Manager) and Mark Pickard (EPRR Officer)	**Presented by:**	Rae Wheatcroft (Accountable Emergency Officer)

Background and Purpose

NHS England require all health organisations participating in the 2023 EPRR Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period.

This year the process of EPRR self-assessment and statement of compliance, has changed to include a check and challenge process undertaken by the NHSE Regional EPRR Team.

The purpose of this paper is to provide assurance to Strategy and Operations Committee and subsequently to Board of Directors on the process and outcome of the 2023 EPRR Core Standards self-assessment and to present the statement of compliance made by the Accountable Emergency Officer with accompanying action plan for the coming year.

Self-assessment and check and challenge process and outcomes

As per our usual practises, the EPRR team undertook the self-assessment which includes a full review of all available evidence against the 62 standards contained within the EPRR Core Standards Framework. This resulted in a compliance rating of 'substantial' which is in accordance with previous years:

Self-Assessment assurance rating	Substantially	Percentage compliance	94%
Core standard position after organisation self-assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	58	4	

It is worth noting that this assessment is supported by a recent PWC internal audit of our EPRR compliance against 20 of the 62 Core Standards. The audit report was classified as low risk and contained 1 finding with a low risk recommendation.

Following this, our self assessment outcome and supporting evidence were submitted to the NHSE EPRR Regional team who conducted a tabletop check and challenge. Following the trust initial submission the regional team returned a score for the trust of 6% overall which is a compliance outcome of non-compliant. Following a brief window to resubmit additional evidence, a revised check and challenge outcome was returned with an outcome of 10% overall, which remained non-compliance for the trust:

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	6	56	

Greater Manchester Local Health Resilience Forum Engagement

The EPRR Team, Director of Operations and Accountable Emergency Officer have engaged with other Greater Manchester organisations (Trusts and ICB) via the Local Health Resilience Forum (LHRF) on the differences between the Trust self-assessment and the check and challenge by the NHSE Regional EPRR Team. All Trusts and the ICB have experienced a similar disparity between the two assessments.

Following detailed exploration of the issue, all GM AEOs, on behalf of their Board of Directors, remain autonomous in their assessment of the organisation's compliance with the EPRR Core Standards

Framework. On this basis, a further internal review of the self-assessment evidence has been undertaken, which has taken on board feedback provided by the regional team. This has resulted in our final self-assessment and statement of compliance.

Through the LHRF, we have committed to collaborative learning to take place this year following the feedback received through the check and challenge process.

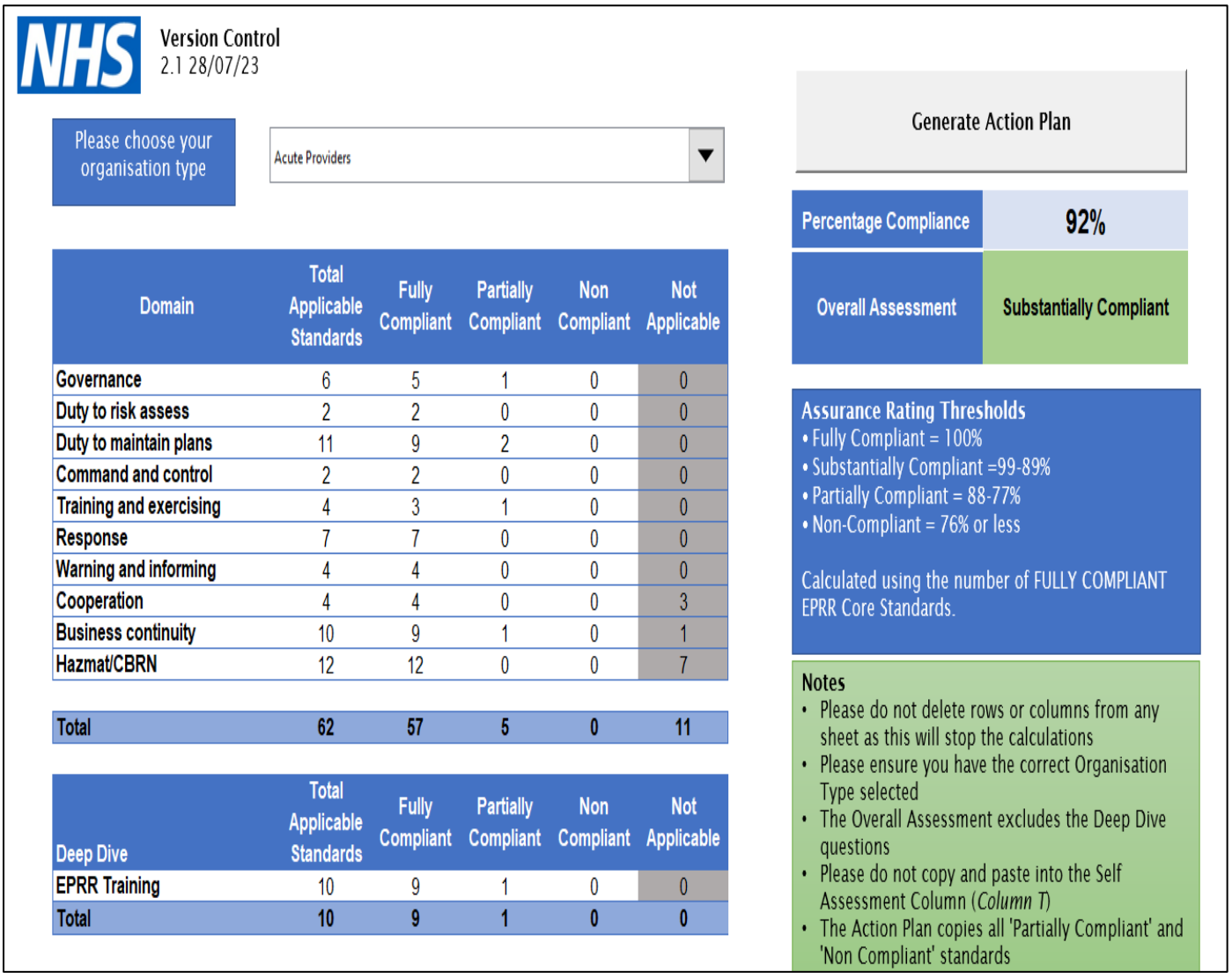
Annual statement of compliance

Following self-assessment, the organisation has been assigned an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Detail of the compliance level is identified in the dashboard below and where areas require further action, this is detailed in appendix A below.

Compliance Dashboard:



NHS Version Control 2.1 28/07/23

Please choose your organisation type: Acute Providers

Generate Action Plan

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	9	1	0	1
Hazmat/CBRN	12	12	0	0	7
Total	**62**	**57**	**5**	**0**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	9	1	0	0
Total	**10**	**9**	**1**	**0**	**0**

Percentage Compliance	92%
Overall Assessment	Substantially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

Summary and Recommendation

The annual process of self-assessment against the EPRR Core standards Framework has been undertaken, with the addition this year of a check and challenge step by the NHSE Regional EPRR Team.

Feedback from the check and challenge process was taken into consideration within the final internal review of the self-assessment and statement of compliance.

The Accountable Emergency Officer's statement of compliance remains that we are substantially compliant against the EPRR Core Standards. An action plan has been developed to address areas which are not fully compliant.

Strategy and Operations Committee are asked to accept the statement of compliance and recommend it to Board of Directors

Action Plan				Overall Assessment	#REF!					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Structured de briefs are facilitated following any significant incident or exercise with reports and actions forwarded to divisional leads and governance groups. • EPRR 1-1 papers with Dep AEO (Horizon Scan) • Risk paper evidence / impact of Ukraine conflict • Safeguard screen shots identifying EPRR Risk. • Trust Risk Mgt Policy • Community Risk Register • Greater Manchester Community Risk Register • CBRN RA • ERprr policy	Partially Compliant	Confirm arrangements for de brief actions to be completed	EPRR Manager	01/06/2024	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust Outbreak plan is currently in place and used as a framework to respond to the current Covid-19 Outbreak. This plan will be reviewed and updated in 2023 / 2024 • CBRNE SOP V4 2022 • Trust Covid-19 Vaccination arrangements. • Nat Countermeasures requesting and receipt arrangements • Countermeasures hyper-links. • Nat Counter measures arrangements Letter • Major Incident Plan • Outbreak Plan (Live Working Draft) submitted. To be reviewed 2023 following stand down of current Covid response. • ERT Policy • GM Outbreak Plan • cbrne	Partially Compliant	Current oubreak plan (Pandemic) will be shared with stakeholder for review to include any lessons leanrt from COVID -19 pandemic	EPRR Manager	01/06/2024	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Each ward has specific evacuation plans in place. Whole site evacuation plan is currently in Draft. It has been agreed in principle by Dir of Ops and all DDO`s. Awaiting further consultation and sign off by RM committee. • Example Ward Evacuation Plan / Action Card • DRAFT RBH Evacuation and Shelter plan awaiting final consult and sign-off • GM Response guidance • NHS Shelter and Evac guidance (May 2023) • BoSCA Awareness Letter Re Evacuation Action cards (line 508) • SMoC Awareness training session. • Fire Warden Check list. • NNU MT Evac Training • ERT Policy • ICU Evac Exercise • ICU Evac Exercise Report • Radio Comms Instructions For Integrity of Communications • 2023 EPRR Work Programme • Evacuation Exercise Report. • Comms EPRR Plan	Partially Compliant	Plan is now in final draft awaiting ratification	EPRR Manager	01/06/2024	Plan will be put through trust document control process
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	EPRR Manager maintains a record of all testing and exercising.portfolios to be rolled out in due course • 2023 EPRR Work Programme • EPRR SMoC Training Matrix • PHC Portfolio / TNA • SMoC Scan Document • On Call Policy • ED Staff Maj Inc and CBRN training Record • SMoC Incident Response Training	Partially Compliant	PHC Training (strategic and tactical) is ongoing as per NHS NW dates upto and including December 2023	EPRR Manager	01/06/2024	EPRR Manager to encourage all Strategic and tactical managers to attend NHSE course by December 2023

Action Plan				Overall Assessment	#REF!					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation	The trust BC policy outlines a corporate BIA, in addition each division was tasked to complete a BIA to identify critical services and staffing which was last updated during the Operational Covid-19 response. A formal BIA has also been developed for each Division to take forward • Service BIA (Business Impact Analysis) • Overarching Trust BC Policy document • Completed examples of BIA • Bcp sop	Partially Compliant	workshop to be delivered by the EPRR team to divisional leads outlining Divisional Business Continuity approach to ensure the trust is alligned to BS22301	EPRR Manager	01/06/2024	EPRR Manager to contact divional leads to agree suitable dates going forward
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Compliance is monitored by the EPRR team and can be made availbale to the board on request any actions in relation to complaince will be escalted via the EPRR line manager process • EPRR SMoC Training Matrix • NOS briefing email • Trust Annual report • EPRR Programme	Partially Compliant	Report to director of Ops on level of complaince with EPRR training	EPRR Manager	01/06/2024	

Title	Patient Safety Incident Response Policy and Plan

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	30 November 2023		Discussion	
Exec Sponsor	Chief Nurse		Decision	✓

Purpose:	The purpose of this report is to present the Patient Safety Policy for approval following the introduction of the Patient Incident Response Framework (PSIRF) in August 2022.

Summary:	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The Framework will replace the Serious Incident Framework and organisations have been asked to have their policy and plan in place by Autumn 2023 Organisations must produce a ***Patient Safety Incident Response Policy*** and a ***Patient Safety Incident Response Plan*** The following Draft Patient Safety Incident Response Policy describes our planned overall approach to responding to and learning from patient safety incidents for improvement and identifies the systems and processes in place to integrate the four key aims of PSIRF. The draft Patient Safety Incident Response Plan specifies the methods we intend to use to maximise learning and improvement and how these will be applied to different patient safety incidents. It is based on a thorough understanding of the organisation's patient safety incident profile, ongoing improvement priorities, available resources and the priorities of stakeholders.

Previously considered by:	Quality Assurance Committee – 15 November 2023 Clinical Governance & Quality Committee – 01 November 2023

Proposed Resolution	The Board is asked to formally agree receipt of the draft Patient Safety Incident Response Policy and Plan and to approve their content for final sign off.

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:	Emily Harrison, Patient Safety Specialist	**Presented by:**	Tyrone Roberts Chief Nurse

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

PSIRF	**Patient Safety Incident Response Framework**
PSI	**Patient Safety Incidents**

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Patient Safety Incident Response Policy

November 2023

... for a better Bolton

Patient safety incident response policy

Effective date: 01 December 2023

Estimated refresh date: 01 December 2024

	NAME	TITLE	SIGNATURE	DATE
AUTHOR	Emily Harrison	Patient Safety Specialist		
REVIEWER	Stuart Bates	Director of Quality Governance		
AUTHORISER				

Version Control

Version	Type of change	Date	Revisions
1	New document		

Contents

Glossary

Definitions for technical terms and acronyms used within this document

PSI or Patient Safety Incident	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient
PSIRF	Patient Safety Incident Response Framework. The Framework supports the development and maintenance of an effective patient safety incident response system across the NHS
SEIPS	Systems Engineering Initiative for Patient Safety. A framework for understanding complex socio-technical systems. A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.
LRT	Learning response tool. A toll or method used to learn from an incident that uses a systems based approach to learning
AACD	Adult Acute Care Division
ASSD	Anaesthetic and Surgical Services Division
ICSD	Integrated Care Services Division
FCD	Family Care Division
NHS Greater Manchester (NHS GM)	NHS GM is the Integrated Care Board for Greater Manchester. A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
AIS	Accessible Information Standard. This directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care.
CQC	Care Quality Commission. The independent regulator of health and adult social care in England.
CNST	The Clinical Negligence Scheme for Trusts is a payment made to NHS Resolution who then handle all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995. There is a specific incentive scheme for maternity services that supports the delivery of

	safer maternity care through an incentive element to trust contributions to the CNST.
C.Diff / CDT	Clostridium Difficile or Clostridioides Difficile. A type of bacteria that can infect the bowel and cause diarrhoea. It commonly affects people who have been recently treated with antibiotics but can spread easily to others. CDT is a binary toxin frequently observed in Clostridium difficile strains associated with increased severity of C. difficile infection
NPSIPs	National Patient Safety Improvement Programmes. National priorities because of their potential to enable the most significant impact on patient safety.
PSII	Patient Safety Incident Investigation. An in-depth review of a single patient safety incident or cluster of events to understand what happened and how
LeDeR	LeDeR is a service improvement programme for people with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care a person received that may have been relevant to their overall health outcomes.
DHR	Domestic Homicide Review. A review into the circumstances around a death of your friend or family member following domestic abuse.
MHRA	Medicines and Healthcare products Regulatory Agency. MHRA regulates medicines, medical devices and blood components for transfusion in the UK.
ICO	Information Commissioner's Office. the UK's independent body set up to uphold information rights.
HTA	Human Tissue Authority. The independent regulator of organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. The HTA also give approval for organ and bone marrow donations from living people.
SWARM Huddle	A type of learning response tool designed to start as soon as possible after a patient safety incident occurs to identify learning. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk
MDT Reviews	A type of learning response tool. An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done.
After Action Reviews (AAR)	A type of learning response tool. A structured, facilitated discussion of an event, the outcome of

	which gives the individuals involved in the event understanding of why the outcome differed from the expected and the learning to assist improvement.

1. Purpose

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF). It sets out how Bolton NHS Foundation Trust will respond to patient safety incidents (PSI) to learn and improve patient safety.

1.2 The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds PSI response within a wider system of improvement. It prompts a significant cultural shift towards systematic patient safety management.

1.3 This policy supports development and maintenance of an effective PSI response system. It integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

1.4 This policy also links with the Trust's Incident Reporting Policy, Being Open Policy, Risk Management Framework and Quality Improvement Strategy. These documents are available for staff on the Trust's intranet.

2. Scope

2.1 Responses under this policy follow a systems-based approach. The Trust will use the Systems Engineering Initiative in Patient Safety Framework (SEIPS). An overview of SEIPS is available in Appendix 1.

2.2 A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.

2.3 The PSI response policy and plan do not include non-patient safety incidents. These could include information governance, health and safety or estates and facilities incidents. Agreed processes are in place for reporting and responding to non-patient safety incidents. Details are available in the Incident Reporting Policy.

2.4 The learning response methods described in this policy can support learning and improvement from other non-patient safety incidents. However, their use must comply with any wider requirements.

2.5 There is no remit to apportion blame or determine liability, preventability or cause of death in a patient safety incident learning response. Other processes exist for that purpose. These include:

- claims handling human resources investigations into employment concerns
- professional standards investigations
- coronial inquests
- criminal investigations

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

2.7 Other processes should not influence the remit of a PSI response. However, it is possible to share information from a PSI response with those leading other types of responses.

3. Our patient safety culture

3.1 All staff can report incidents via the Safeguard system on the intranet. This includes bank and agency staff. The incident reporting system must focus on what needs to change rather than punitive actions. Using the NHS Improvement 'Just Culture Guide' will support consistent, constructive and fair evaluation of the actions of staff involved in incidents.

3.2 Staff must feel supported to report incidents and raise safety concerns. This is fundamental to developing and supporting a positive safety culture. The Trust's Raising Concerns Policy sets out the process for staff members to raise concerns confidentially.

3.3 The Trust has already adopted the 'Just Culture Guide' as part of its learning response and investigation processes. We will continue to develop and embed a restorative Just Culture approach at all levels of the organisation to ensure that learning focuses on wider systems and processes. See Table 1 (sidneydekker.com)

Table 1.

A **restorative just culture** asks: Who is hurt? What do they need? Whose obligation is that?	Accountability is *forward* looking. Together, you explore what needs to be done and who should do it.	An account is something you tell and learn from.
A **retributive just culture** asks: What rule is broken? How bad is the breach? What should the consequences be?	Accountability is *backward* looking, finding the person to blame and imposing proportional sanctions	An account is something you settle or pay.

3.4 The Trust's 2022 NHS Staff Survey results compare well when benchmarked against the other 124 Trusts in the same category (Acute and Acute & Community Trusts). Bolton scored better than the national average for all seven People Promise elements. However, results also highlighted some key areas for improvement including:

- Improving response rates
- Improving confidence levels that concerns will be addressed when they are raised.

The Trust has developed an overarching survey action plan. Each Division also an action plan tailored to their specific results and key areas of focus.

3.5 A range of workstreams are underway to support further development of a restorative Just Culture including:

- Staff can sign up to the Civility Saves Lives campaign.
- The Active Bystander project – This is a training programme that came about from work done by Medical, Dental and Public Health trainees in NW Region who formed an EDI Network- North West Trainee Equality, Diversity and Inclusion Allyship Network. It was led by Dr Naomi Fleming (Consultant Anaesthetist at Manchester Foundation Trust) and Mrs Clare Inkster (Consultant Ophthalmologist here at Bolton). The group provided peer support and shared lived experiences and the Active Bystander training grew from these discussions. The trainers have provided sessions at Bolton (2.5 hours) and facilitated Train the Trainer sessions (2 days). Discussions are now in progress to develop further rollout. This training is part of a bigger piece of work around behaviours and our culture. It aims to support staff to challenge poor behaviour and create a safe and inclusive work environment.
- Our Voice Change Programme - A schedule of listening events planned to engage and empower staff to make the changes and improvements that matter the most. Our Head of People Development is leading the programme.

Following the events, the intention is to set up change teams, empowered driven and sponsored by the senior leadership team to deliver. These will be up and running by mid-November 2023. We will then agree clear measures of success for each theme and the overall programme.

4. Patient safety partners

4.1 Bolton NHS Foundation Trust recognises that Patient Safety Partners (PSPs) can support effective safety governance at all levels in the organisation. The benefits of PSP involvement include:

- Promoting openness and transparency
- Supporting the organisation to consider how processes appear and feel to patients
- Helping the organisation know what is important to patients
- Helping the organisation identify risk by hearing what feels unsafe to patients
- Supporting the prioritisation of risks that need to be addressed and subsequent improvement programmes
- Supporting the organisation in developing an action plan following an investigation so that actions address the needs of patients
- Helping the organisation to produce patient information that patients understand and can access.

4.2 The role of PSPs in Bolton is currently under development. The long-term aim is to have a pool of PSPs representative of the community we serve. PSPs will be involved in:

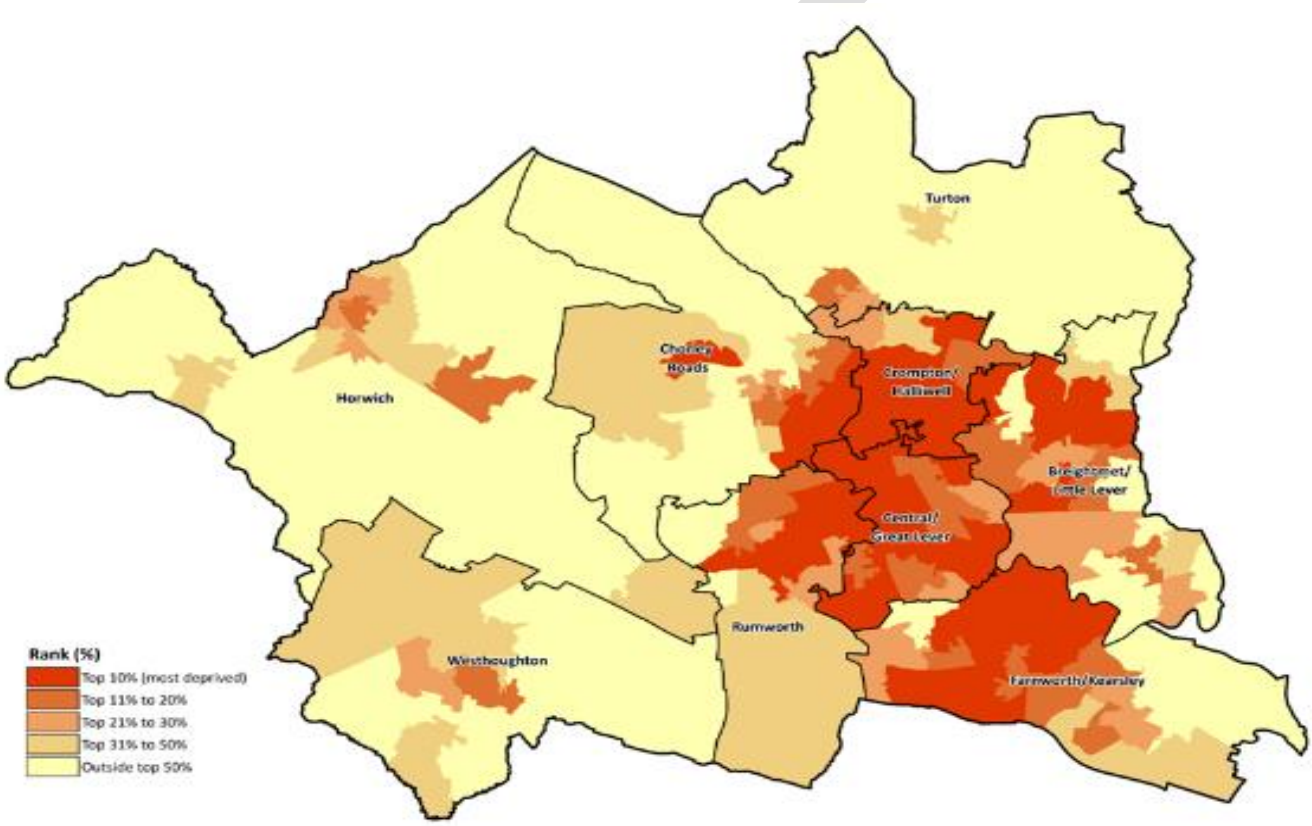
- Development of the organisation's PSI Response policy, profile and plan going forward
- Development of incident response processes including improved patient engagement and involvement
- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- Patient safety improvement projects
- Working with our board to consider how to improve safety
- Staff patient safety training
- PSI investigation oversight and review.

4.3 The first step in this process is to recruit two PSPs and this will be a priority area of focus for Q4 2023/24. As a result, PSPs will play a key role in the continued development of this policy, our annual PSI Response Plan and the development of robust PSI response processes.

4.4 We have consulted with existing Trust patient representatives along with members of local Healthwatch during the development of this PSI Response Policy and Plan to ensure we take account of patients' views.

5. Addressing health inequalities

5.1 Bolton currently has a population of around 284,000. The Bolton Locality Plan estimates that it will grow to 300,000 by 2025. While the number of people in some age groups will reduce over this period, growth will be driven, in large part, by significant increases in the secondary school-age population and in the over 75s (a 19% increase in 11-15s and a 42% increase in the 75+ group).



5.2 Greater Manchester has some of the poorest health outcomes in the UK. There is a significant gap between the wealthiest and poorest neighbourhoods. Bolton experiences higher-than-average early deaths from cardiovascular disease and cancer when compared with the rest of England. Life expectancy of those in areas that are more affluent is around nine years longer than in deprived communities. The healthy life expectancy in the most deprived communities in Bolton is 12 years below the England average. Our population has higher-than-average levels of alcohol-related harm, smoking-related deaths, deaths from drug misuse and higher rates of hospitalisation for self-harm.

5.3 Bolton has a diverse population, with 17.7% belonging to a non-white ethnic group. Census data shows that 20% of people assessed themselves as experiencing

some form of long-term illness, health problem or disability that limits their daily activities or the work they can do. This is higher than the England and Wales figure of 18%.

5.4 Work to tackle health inequalities is complex. In the past year, the Trust's Health Inequalities Enabling Group has "*undertaken considerable work to analyse Trust data by ethnic group, deprivation, age and gender. They have used this information to understand any significant differences. For example, in waiting times. As a result, specialties can take account of any differences within recovery plans. It has also helped to identify that any differences found, are typically only present at one snapshot in time. Frequent monitoring has identified that differences at specialty level change and are more likely to do with gaps in recording of demographic details. For example, in the Waiting List Minimum data set, around 27% of patients are without a stated ethnicity*.

Several inequalities indicators are being developed for the FT Board of Directors report. This will enable better monitoring of health inequalities and ensure visibility. Lower level indicators will be included at a variety of other groups. The key aim is to ensure that health inequalities indicators are not seen as a separate entity. Instead, they are an integral part of routine reporting. Work is also ongoing across the locality to bring together a range of outcome indicators. This will also highlight any inequalities in the new and emerging governance structure" (Health Inequalities Annual Report, April 2023)

5.5 Going forward the work of this group will feed into the patient safety incident response plan updates. The patient safety specialist will also provide a patient safety update to the group every three months. Updates will focus on PSIRF to avoid silo working and ensure shared learning. The group has provided information where possible to assist with the development of this policy and the PSI Response Plan. However, gaps in monitoring data have been a significant barrier in drawing robust conclusions in relation to patient safety incident themes and health inequalities/affected groups.

5.6 Applying a more flexible approach and intelligent use of data can help identify any disproportionate risk to patients with specific characteristics. The monthly PSI report includes information related to locality and is presented to the Clinical Governance and Quality Committee. Information from this report has also been used in the development of this policy and the PSI Response Plan. Again, gaps in the completion of monitoring data for reported incidents has hindered further progress. We will undertake a review to understand how we can strengthen aspect of incident reporting.

5.7 We will use the tools recommended by NHS England to learn from patient safety incidents. These tools adopt a systems based approach. A system-based approach looks at the components of a system and tries to understand how they influence each other. The aim is then to understand how they may contribute to patient safety.

Examples of a component would be: person(s) involved and any specific characteristics, tasks, tools and technology, the environment and the wider organisation. The four main tools that the Trust will use to learn from patient safety incidents will be:

- SWARM Huddles
- After Action Reviews
- MDT Reviews
- Patient Safety Incident Investigations

5.8 This does not exclude the use of other learning response tools if they are more appropriate provided they fulfil the following criteria:

1. All learning responses must use a systems based approach
2. Involve those affected including patients, families and staff
3. Understand everyday work
4. Define areas for improvement – Develop safety actions – Monitor & adapt – Demonstrate improvement

This will be judged on a case-by-case basis.

6. Engaging and involving patients, families and staff following a patient safety incident

6.1 You should read this section should in conjunction with the Trust's Being Open policy. This is available on the Trust intranet. People who use our services can find more information here: Add link

6.2 The PSIRF recognises that supportive systems and processes must be in place to achieve learning and improvement following a patient safety incident. It supports the development of a response system that prioritises compassionate engagement and involvement of those affected (including patients, families and staff). This involves working with those affected to understand and answer any questions they have in relation to the incident and signpost them to support as required.

6.3 The term 'engagement' describes everything an organisation does to communicate with and involve people in a learning response. This may include the Duty of Candour notification or discussion. It also includes seeking the input of patients, families, and healthcare staff to develop a shared understanding of what happened (NHS England 2022).

6.4 The Trust recognises the importance of meaningful and compassionate engagement and involvement. We will achieve this by:

- Managers and Leaders showing their commitment to compassionate engagement and leadership through their words and actions. This includes fostering an open and just culture that recognises the impact of patient safety incidents on staff, as well as patients and families.
- Ensuring those responsible for leading on engagement are trained and competent in line with NHS England expectations.
- Working with PSPs, staff and people who use our services to design systems and processes that are inclusive and recognise individual needs.
- Providing those affected by a patient safety incident with clear information about the purpose of a learning response including what to expect from the process.
- Signposting those affected by a patient safety incident to relevant support services.
- Working with PSPs, staff and people who use our services to design and develop ways to engage and involve those affected, using feedback to improve.
- Providing open and honest feedback if processes and/or outcomes from a learning response do not meet the expectation of those affected.

6.5 The statutory Duty of Candour requirements are unaffected by PSIRF. The Trust will continue to uphold these in line with the organisation's Being Open Policy (available on the Trust intranet).

6.6 The lead clinician, Duty of Candour Lead or Family Liaison Officer may undertake engagement with families. In line with our Being Open policy, a Family Liaison Officer must be appointed within the Division to keep in contact with the family regarding updates about an investigation a minimum of every 3 weeks. We will continue with this process, ensuring anyone responsible for leading engagement with families has received appropriate training and is supported to maintain competence in line with the NHS England expected standards. This will form part of our Trust PSIRF Implementation Plan.

7. Patient safety incident response planning

7.1 PSIRF supports organisations to respond to patient safety incidents in a way that maximises learning and improvement. Under PSIRF, responses are not based on arbitrary and subjective definitions of harm. Nor does PSIRF define set thresholds. Beyond national requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve.

7.2 Resources and training to support patient safety incident response

7.2.1 At present, a clinician that has completed training usually undertakes the role and responsibilities of the PSI investigator. Aqua* provides the training over three days. Learning Objectives for the training are:

- Apply a systems approach to human factors
- Describe the principles of human factors
- Recognise methods of intelligence gathering
- Apply programme learning to develop investigation recommendations and write the report
- Develop investigation techniques and apply them to a case study example

**Aqua stands for the Advancing Quality Alliance. Aqua is an NHS health and care quality improvement organisation*

7.2.2 To date, 38 members of staff have completed this training. The Divisions allocate their investigations to one or two of these individuals on a case-by-case basis.

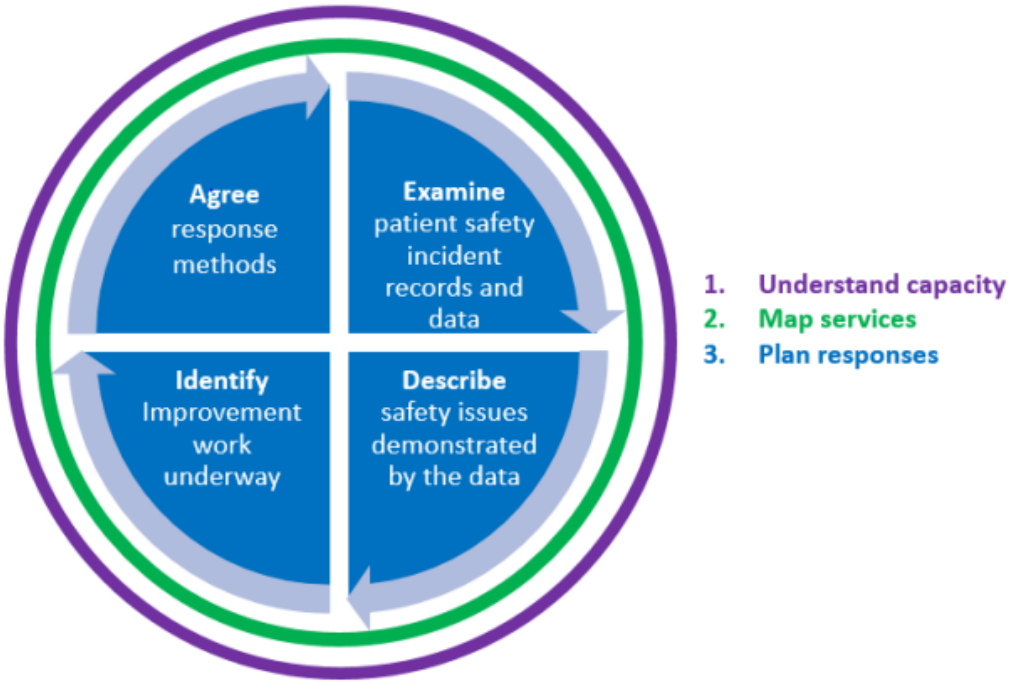
7.2.3 The Trust will continue with this process, ensuring anyone responsible for leading an investigation has the necessary dedicated time to do so and is supported to maintain competence in line with the NHS England expected standards. This will form part of our Trust PSIRF Implementation Plan.

7.2.4 This plan also includes the development of a support package for staff on how to use learning response tools as part of a wider rollout programme.

7.3 Our patient safety incident response plan

7.3.1 Our plan sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 months. Responding proportionately to balance learning and improvement efforts requires a thorough understanding of the local PSI profile and ongoing improvement work.

Figure 1. Patient safety incident response planning process (NHS England 2022)



7.3.2 We have developed our plan over a period of 12 months following review of information from a range of data sources including:

- Patient safety incidents reported via Safeguard 2020-2023
- Falls data 2021/2022 and 2022/2023
- Complaints data 2020-2023
- Claims data 2020-2023
- CNST Scorecard
- Pressure ulcer data 2021/2022 and 2022/2023
- Divisional review report of top 10 cause groups for incidents 2020-2023
- Quality Improvement Strategy
- Audits and NICE compliance
- Quality Improvement – local initiatives
- Learning from Deaths quarterly reports Q1-3 2022/23
- Integrated Performance Monitoring Reports Q1-3 2022/23
- Serious Incident investigation reports and action plans 2022-2023
- Divisional organisation and governance charts
- NHS Staff Survey 2022 Benchmarking Report and Breakdown Report

We have also engaged with multiple key stakeholders:

- Divisions via Divisional Governance meetings
- Family Care Division development session
- Monthly PSIRF Implementation Group meetings
- Bolton ICB (now NHS GM)
- Greater Manchester ICB (now NHS GM)
- Specialist nursing teams (Pressure ulcers, Enhanced care, Admiral nurse, learning disabilities)
- Staff experience manager
- Equality, diversity and inclusion programme manager
- BoSCA Lead
- North West Ambulance Service
- Greater Manchester Mental Health NHS Trust
- Healthwatch
- Patient representatives
- Director of Operations/Chair of the regional health inequalities enabling group
- Locality Systems Quality Group
- Divisional stakeholder workshop to stratify key themes

7.3.3 We undertook a service mapping exercise to ensure that the shape and structure of our plan reflects patient safety concerns for the range of services we offer.

7.3.4 Following collation and review of data, we were able to identify the top 15 most significant patient safety themes. By reviewing the current improvement work underway and engaging with stakeholders, we were able to narrow the list down to the top five patient safety themes.

7.3.5 To ensure this approach was consistent, measurable and comparable, we asked Divisions to rank the top 15 themes using the following matrix:

1. Are there any surprises?
2. Are there any themes you would add?
3. Using the matrix below give each theme a score from 1 to 5* (incl any themes you would add)
4. Rank the themes in order of priority/concern (1 being the highest priority)
5. Give each theme a total score

Level of harm**	Likelihood of harm**	Confidence in existing safety measures/ improvement work	Potential for new learning	Ranking	Total score

***Using the Trust matrix as per risk register*

7.3.6 We held a further workshop with key stakeholders from each Division across the Trust including relevant specialists. From this workshop, we were able narrow down the top five themes even further to identify specific areas. The Trust will focus PSI investigations on these areas in the next 12 months.

7.3.7 As part of the consultation process, we engaged with patient representatives and Healthwatch to gain feedback from people who use our services. We asked for their views on the top five themes and what they felt should be included in our plan.

7.3.8 There was a two-week stakeholder consultation period for the draft policy and plan in line with the Trust's procedural document development and management processes. We reviewed feedback and amended the draft documents accordingly. The final draft policy and plan were presented to Clinical Governance and Quality Committee and Quality Assurance Committee before finally being submitted to Trust Board for approval.

7.3.9 We have developed a specific chapter within the plan for Families services. This is to ensure the plan reflects some of the specific nuances of these services.

7.3.10 The plan aims to support the Trust to use resources effectively and enhance opportunities for learning and improvement. However, it is not a permanent set of rules and can be changed if appropriate. As well as the plan, we will remain flexible and consider the specific circumstances in which patient safety incidents occur and the needs of those affected.

You can find our full plan here: ADD LINK

7.3.11 The Trust recognises there will always be a reactive element in responding to incidents. We will always consider a response for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement. Even if they fall outside the issues or specific incidents described in the Trust's plan.

7.4 Reviewing our patient safety incident response policy and plan

7.4.1 Our patient safety incident response plan is a 'living document' that we will amend and update as we use it. We will review the policy 12 months from sign off to ensure our focus remains up to date. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

7.4.2 We will publish updated plans on our website, replacing the previous version.

7.4.3 A rigorous planning exercise will be undertaken at least every four years and more frequently if appropriate (as agreed with our NHS GM) to ensure efforts continue

to be balanced between learning and improvement. This more in-depth review will include:

- reviewing our response capacity
- mapping our services
- a wide review of organisational data (for example, PSI investigation reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data)
- wider stakeholder engagement

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

8.1.1 The Trust's Incident Reporting Policy clearly describes internal and external notifications requirements for the reporting of patient safety related incidents. A copy of this policy is available for staff on the Trust's intranet.

8.2 Patient safety incident response decision-making

8.2.1 Determining level of patient safety incident responses

(See Appendix 2 for full process flowchart and Appendix 3 for an overview of the PSII escalation and decision making process)

8.2.2 Staff should use the flowchart in Appendix 2 along with the definitions below to determine the appropriate level of response to a patient safety incident. Appendix 3 provides an overview of the PSI escalation and decision making process.

LEVEL 1
Patient Safety Incident Investigation = Meets national requirement or local PSI plan priority. Present to weekly PSI Investigation Review Group to identify Investigation Lead and Engagement Lead. If an incident does not meet these criteria but represents a significant concern and/or new/emerging risk then escalate incident to weekly PSI Review Group meeting.
Method: SEIPS methodology/National report template, Full involvement of those affected (including staff).
Outcome: Informs new and ongoing safety/quality improvement work.

LEVEL 2
Divisional Patient Safety Learning Response = Incidents where contributory factors are not fully understood, Limited ongoing safety/quality improvement work, concerns raised by patient/family/other, areas of increasing reporting/concerns.
Method: Learning response toolkit, Local patient safety response, Lead appointed by Division.
Outcome: informs organisational safety/quality improvement work or leads to development of local safety improvement plan.

LEVEL 3
Service/specialty incident review = Low/no harm incidents not identified as a PSI response plan priority/ limited concerns, moderate harm incidents where contributory factors are fully understood and are linked to improvement work.
Method: local service/speciality to have oversight/review. Duty of candour process should still be followed in line with Being Open policy.
Outcome: Service/specialty improvement actions identified, informs ongoing improvement work

Acknowledgements: With thanks to East Lancashire NHS Trust

8.2.3 Patient Safety Incident (PSI) Review Group

8.2.4 The PSI review group meets weekly to review any patient safety incidents that have been triaged as either:

i) A national reporting priority

ii) A local priority as per the Patient Safety Incident Response Plan

iii) Incidents that do not meet these criteria but do represent a significant concern/a new or emerging risk.

8.2.5 The group is responsible for:

- Identifying any immediate risks and/or actions in response to escalated incidents.
- Monitoring emerging risks and triangulating with other known intelligence from risks, complaints, inquests, structured judgement reviews etc. to inform any required investigations, learning responses or improvement work.
- Making an evidence based decision as to whether an incident meets the criteria for a PSI investigation or alternative patient safety learning response

- Keeping a clear record of decision making rationale
- Keeping a log of possible future local priorities.

8.2.6 The group will provide a quarterly update to the Clinical Governance and Quality Committee

8.2.7 Responding to broad patient safety issues

8.2.8 We will allocate resources on a case-by-case basis to support responses to emergent issues that are not in the PSI Response Plan. Where we already have a good understanding of an incident type, it may be better to direct resources at improvement work rather than repeat investigation (or other type of learning response). For example, there have been thorough investigations into previous incidents of this type and/or we are implementing national or local improvement plans and monitoring for effectiveness.

8.2.9 PSI response planning may identify risks or broader patient safety issues that could benefit from focused improvement efforts. In such instances, we will consider other methods such as a thematic review to inform the development of safety improvement plans. Alternatively, we may perform a 'horizon scan' where we identify or predict pathway issues regardless of whether an incident has occurred.

8.2.10 Assessment to determine if a learning response is required

8.2.11 If it is not clear where an incident 'fits' in relation to our plan (i.e. whether a learning response is required), we will perform an assessment to determine whether there were any problems in care that require further exploration and potentially action. This may take the form of a case note review, rapid review and/or structured judgement review. We will assess these incidents on a case-by-case basis.

8.3 Responding to cross-system incidents/issues

8.3.1 Work with NHS GM is ongoing to ensure an agreed process is in place to identify and report cross-system issues. This way, the organisation can initiate and/or support the relevant response as required at the most appropriate level of the system.

8.4 Timeframes for learning responses

8.4.1 We will undertake a learning response as soon as possible after the incident is identified in line with the process described in section 8.2.

8.4.2 We will agree learning response timeframes in discussion with those affected, particularly the patient(s) and/or their families/carer(s), where they wish to be involved in such discussions.

8.4.3 Depending on discussions with those involved, we will complete MDT reviews and Patients Safety Incident Investigations within one to three months. PSI Investigations will take no longer than six months.

8.4.4 SWARM Huddles will be completed as close to the incident as possible (and no later than 5 working days)

8.4.5 After Action Reviews will be completed within 5 working days of an incident occurring (and no later than 10 working days).

8.4.6 Timeframes for any other learning responses must be agreed on a case-by-case basis in line with principles outlined in this policy.

8.5 Safety action development and monitoring improvement

8.5.1 We will develop safety actions following a learning response using a SMART* approach to allow monitoring.

8.5.2 Learning from improvement work will be shared at divisional or organisational level through established internal quality and safety processes. Learning will also inform quality improvement work reported through internal governance systems including via Quality Accounts monitoring and reporting.

**SMART = Specific. Measurable. Achievable. Relevant. Time specific*

8.6 Safety improvement plans

8.6.1 A variety of safety improvement plans will be adopted based on context (local, organisational, system), other ongoing safety actions and sphere of influence (control, influence, escalate). Approaches will include:

- Organisation-wide safety improvement plan summarising improvement work
- Individual safety improvement plans that focus on a specific service, pathway or location
- Safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).
- Thematic safety improvement plan following review of learning responses from single incidents where there is sufficient understanding of the interlinked, underlying system issues/repeated themes.

8.6.2 There are no thresholds for when to develop a safety improvement plan. For example, after completing a certain number of learning responses. We will use knowledge gained through the learning response process and other relevant data to decide when a safety improvement plan is required.

8.6.3 To support alignment of safety improvement efforts across the Trust, Quality Improvement and Patient Safety sit centrally in the Trust's Governance Team. This ensures that the highest risks and themes are key quality improvement priorities. In

turn, patient safety will mutually inform the deliverables of the quality improvement strategy (and vice versa). There is evidence of this in the work of Trust wide collaborative work on key aspects of harm free care such as pressure ulcers, falls and infection prevention and control.

9. Oversight roles and responsibilities

9.1 The Trust Board

9.1.1The trust board (or those with delegated responsibility, including members of board quality sub-committees), is responsible and accountable for effective patient safety incident management in the organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations where required.

9.1.2 The 'oversight mindset' principles described in the *Oversight Roles and Responsibilities Guidance* (NHS England, 2022) underpin our approach to oversight. However, further work is required to embed and sustain these principles throughout the organisation.

9.2 Executive Lead for Patient Safety and PSIRF Implementation

9.2.1 The Chief Nurse and Medical Director hold delegated executive responsibility for quality and patient safety, with the Chief Nurse designated as Executive PSIRF lead. In line with NHS England Oversight Roles and Responsibilities guidance, are responsible for:

- Ensuring the organisation meets national Patient Safety Incident Response Standards.
- Ensuring PSIRF is central to overarching safety governance arrangements
- Quality assuring learning response outputs

9.2.2 To support the Board and its Executive Leads in fulfilling the requirements of PSIRF, a gap analysis of the incident response standards has highlighted areas for development and strengthening as follows:

- Rollout of this policy and the PSI Response Plan will support staff to understand the roles and responsibilities in relation to PSI response. We will provide further training in the PSIRF approach and supporting methodologies.
- Learning responses, particularly PSI investigations, are currently undertaken by staff as part of their existing job role. The Trust will continue to use appropriately trained staff to complete investigations with support from experts/clinicians/staff where possible. However, we will also ensure anyone responsible for leading an investigation has the necessary dedicated time to

do so and is supported to maintain competence in line with the NHS England expected standards.

- Similarly, we will ensure anyone responsible for leading engagement with families has received appropriate training and is supported to maintain competence in line with the NHS England expected standards.
- Mechanisms are in place to support staff affected by patient safety incidents and enable them to take part in learning responses but our approach is inconsistent. We will develop a standard support package for staff.
- Staff knowledge and application of the different learning response tools is inconsistent and training is variable. In addition to general PSIRF training, we will provide a series of workshops and troubleshooting clinics as part of the PSI response plan and policy rollout.
- Whilst subject matter experts with relevant knowledge and skills are involved throughout the learning response process, there is no consistent approach. Involvement of subject matter experts is usually limited to those with specific clinical knowledge as opposed to broader patient safety/human factors expertise. Rollout of the National Patient Safety Syllabus and dedicated human factors training will raise awareness of these areas.
- All learning response leads will have to complete level one (essentials of patient safety) and level two (access to practice) of the patient safety syllabus as part of their mandatory training. At present, completion of this training is voluntary and is therefore not in line with the expected standards.
- In line with expected standards, we must ensure that learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.

9.2.3 A Trust PSIRF Implementation action plan will support rollout of this policy and our PSI Response Plan. The plan identifies the actions required to develop and embed PSIRF principles and was submitted to the Board for approval along with this policy and the PSI Response Plan. Completion of this action plan will be monitored via quarterly Patient Safety Specialist updates to Clinical Governance and Quality Committee.

9.3 Integrated Care Boards

9.3.1 The Trust will work in collaboration with NHS GM to develop, maintain and review this policy and our PSI Response Plan.

9.3.2 We will also work closely with NHS GM, LMNS, GMEC plus any other networks/groups identified through the ongoing development of the plan to support cross-system learning responses, effectiveness of systems and achieve improvement following a patient safety incident.

9.4 Care Quality Commission and Other Regulatory Bodies

9.4.1 The Trust will continue to inform the CQC of high profile and complex incidents, as well as complying with all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

10. Complaints and appeals

10.1 As described in section 6, the Trust recognises the importance of compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). As such, we will assign an engagement lead as part of the PSI response process. Their role is to liaise with the patient and/or their representative, families and staff and:

- Provide those affected with clear information about the purpose of a learning response and what to expect from the process.
- Ensure those affected by a patient safety incident are signposted to relevant support services as needed.
- Adopt a flexible approach to the individual and changing needs of those affected. Ensure those affected are listened to, share their experience, have the opportunity to ask questions and inform the terms of reference of a learning response.

10.2 Those affected by a patient safety incident should raise any complaints or concerns regarding the PSI response process with the Engagement Lead initially where possible.

10.3 However, if attempts to resolve any issues are unsuccessful or if a patient wishes to make a formal complaint, patients can do so via the Trust's complaints process.

11. References

Patient Safety Incident Response Framework, NHS England 2022: NHS England » Patient Safety Incident Response Framework

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients 2019: Report template - NHSI website (england.nhs.uk)

Bolton Locality Plan, Bolton Council, 2016: Local plan – Bolton Council

Our Strategy: For a Better Bolton 2019-2024, Bolton NHS Foundation Trust, 2019: Our strategy - Bolton NHS FT (boltonft.nhs.uk)

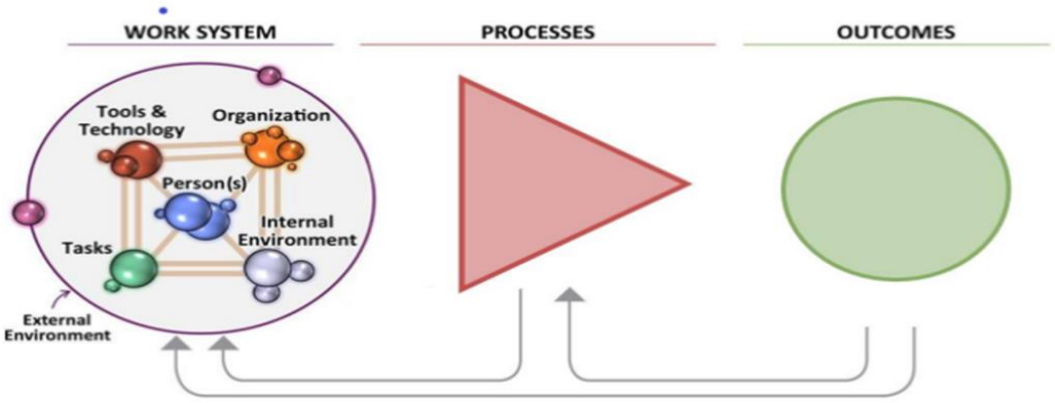
Bolton NHS Foundation Trust: Our Quality Account 2022/23: Bolton-NHS-Foundation-Trust-Quality-Account-2022-23.pdf (boltonft.nhs.uk)

Restorative Just Culture: Home - Sidney Dekker

Appendix 1 Systems Engineering Initiative for Patient Safety (SEIPS) Overview

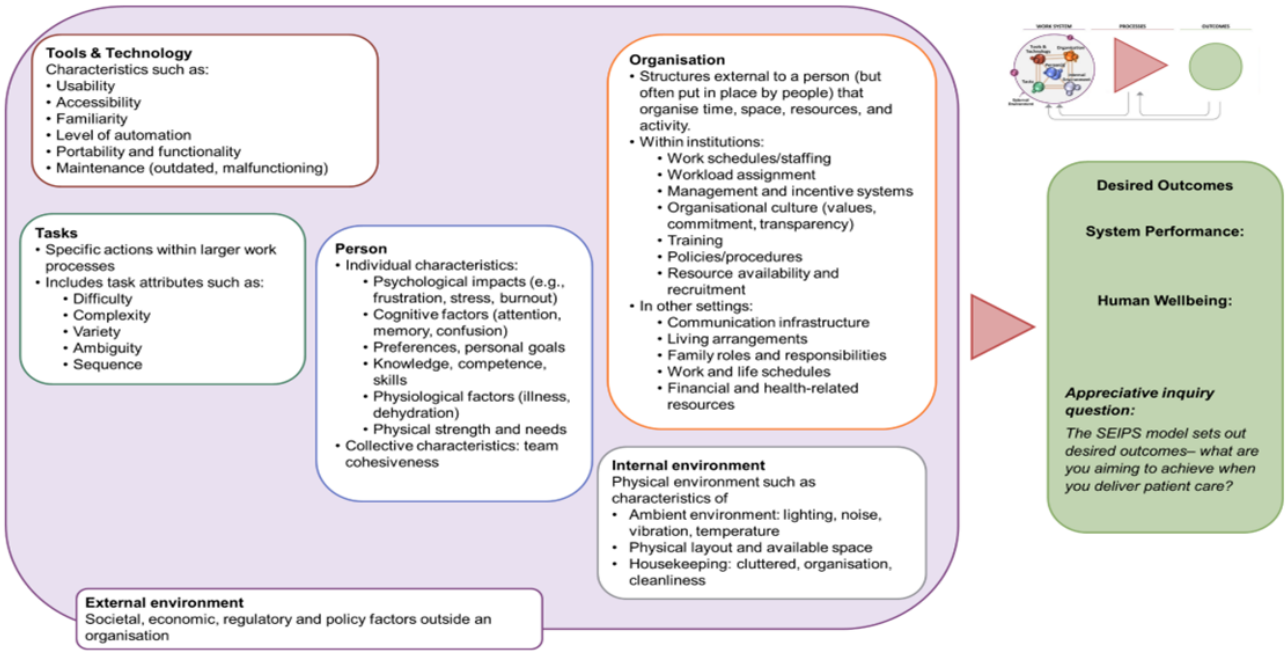
SEIPS is a Framework for understanding complex socio-technical systems. The figure below shows how a work system (or socio-technical system) can influence processes ('work done') which in turn shapes outcomes.

Figure 1. Overview of the SEIPS framework



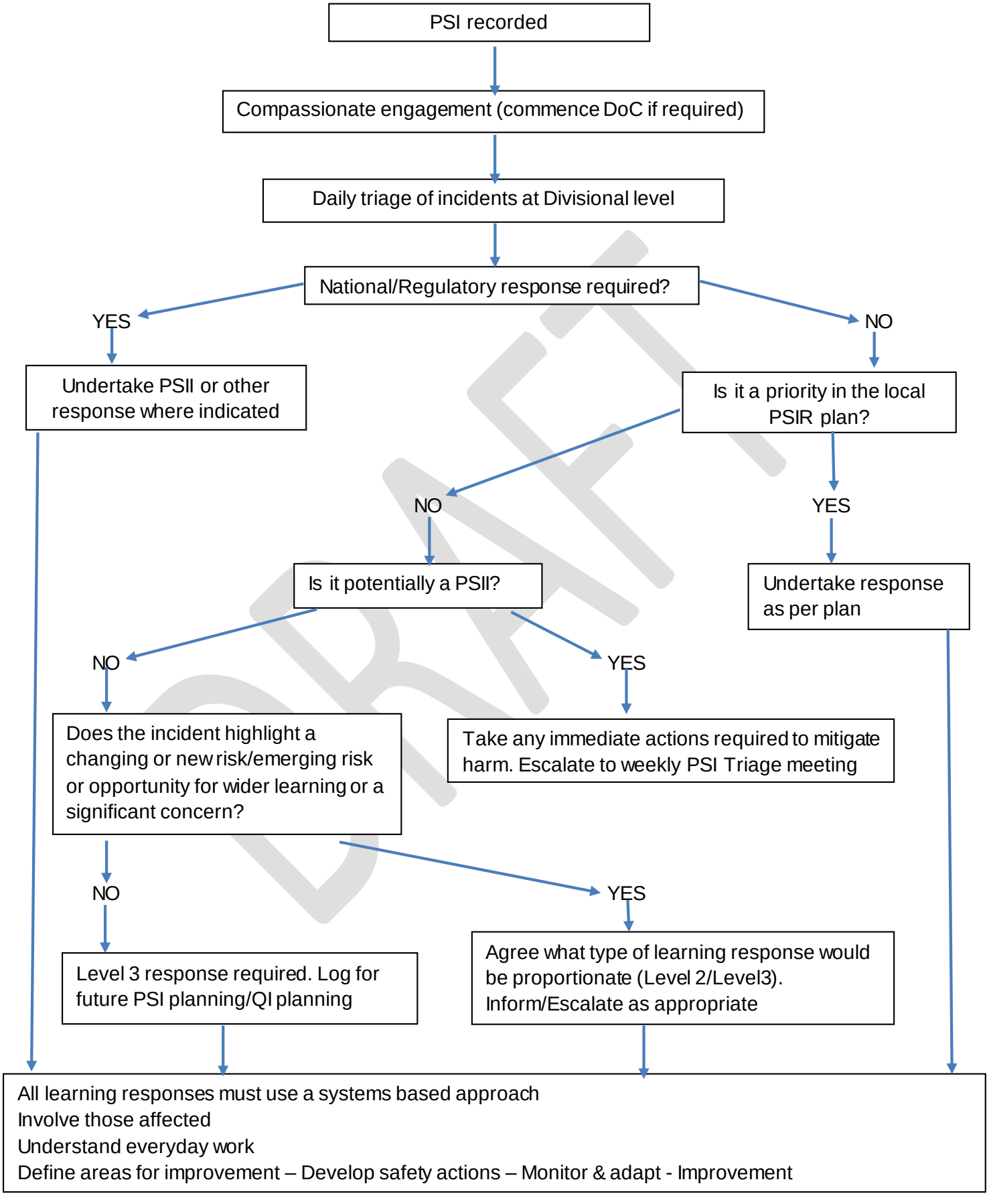
People cannot be separated from the work system; their deliberate placement at the centre emphasises that design should support – not replace or compensate – people. A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s).

Figure 2. Overview of the SEIPS work system

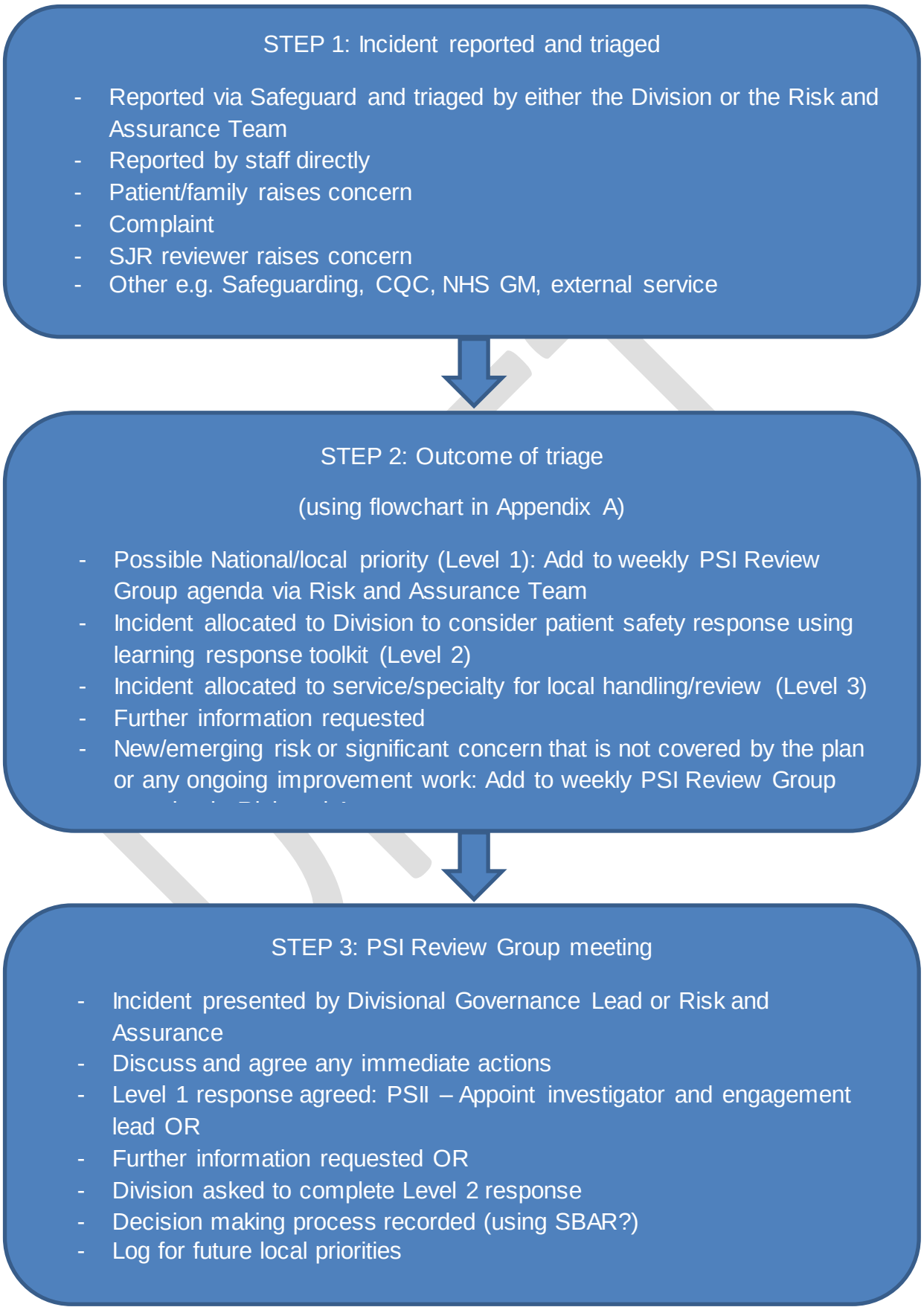


NHS England has produced guidance along with a 'works system' blank template to record findings and learning. Copies of both documents can be found in the Learning Resources Toolkit on the Trust Intranet.

Appendix 2 Determining the level of patient safety incident response required



Appendix 3 PSI Escalation and Decision Making Process



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

t| 01204 390390 w| boltonft.nhs.uk

Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	Possibly	Document will be published in the four languages most commonly spoken in the Bolton area.
	• Nationality	No	
	• Gender (including gender reassignment)	No	
	• Culture	Possibly	Access to policy must be available by several means not just internet
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Possibly	An easy read version will be available. Access to Braille and large print copy will also be available
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	N/A	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	N/A	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	

7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Manager together with any suggestions as to the action required to avoid/reduce this impact.

Document Development Checklist – Document Control Policy

Section 1	To be completed by Lead Author
Type of document :	Patient Safety Incident Response Policy
Lead author:	Emily Harrison, Patient Safety Specialist
Is this new or does it replace an existing document?	New
What is the rationale/ Primary purpose for the document	Nationally mandated by NHS England to improve the way the NHS learns from patient safety incidents.
What evidence/standard is the document based on?	NHS Patient Safety Strategy 2019 NHS Patient Safety Incident Response Framework 2022 (PSIRF)
Is this document being used anywhere else, locally or nationally?	This document is specific to the needs of Bolton but all NHS Trusts are required to produce a policy and supporting plan in line with the PSIRF. We are also required to use the template NHS England have provided.
Who will use the document?	All staff
Staff/stakeholders consulted:	Range of stakeholder from clinical, non-clinical and corporate divisions across the Trust, all services within each clinical division, Healthwatch, ICB, patient representatives, NWAS and GMMH
What is the implementation and dissemination plan? (How will this be shared?)	Gradual rollout to commence 1st December. Implementation plan in place to support. Rollout via comms and though divisions supported by a series of training workshops and clinics led by the patient safety specialist
Are there any service/resource implications? (How will any change to services be met? Resource implications?)	Possible resource implications in relation to training, roles and responsibilities. Training needs analysis

	and options appraisals completed as part of implementation plan.
Are there any additional training requirements? If so have these been discussed as part of the implantation plan?	As above
How will the document be reviewed? (When, how and who will be responsible?)	The document will be reviewed initially in 12 months' time (unless an earlier need is identified). The Patient Safety Specialist with input from key stakeholders will review the document.
Keywords (Include keywords for the document controller to include to assist searching for the policy on the Intranet)	Patient safety, PSIRF, incidents, learning, just culture
Any document that gives an instruction to prescribe or administer a medicine should have that instruction reviewed by the senior divisional pharmacist before it goes for ratification.	Signature of Pharmacist: N/A
Signed and dated by Chair of validating committee/group	Signed: Designation: Date:
Signed and dated By Chair of Approving Committee/Group *PDOC Chair (approval for submission to Execs). Leave blank for guidelines or where there have been minimal changes to policies.*	Signed: Designation: Date:
Final Sign off Signed and dated *Executive Director meeting Chair (or PDOC chair for guidelines or where there have been minimal changes to policies)*	Signed: Designation: Date:

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Patient Safety Incident Response Plan

... for a better Bolton

Patient Safety Incident Response Plan

Effective date: 01 December 2023

Estimated refresh date: 01 December 2024

	NAME	TITLE	SIGNATURE	DATE
AUTHOR	Emily Harrison	Patient Safety Specialist		
REVIEWER	Stuart Bates	Director of Quality Governance		
AUTHORISER				

Version Control

Version	Type of change	Date	Revisions
1	New document	November 2023	NA

Contents

Glossary

Definitions for technical terms and acronyms used within this document

PSI or Patient Safety Incident	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient
PSIRF	Patient Safety Incident Response Framework. The Framework supports the development and maintenance of an effective patient safety incident response system across the NHS
SEIPS	Systems Engineering Initiative for Patient Safety. A framework for understanding complex socio-technical systems. A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.
LRT	Learning response tool. A toll or method used to learn from an incident that uses a systems based approach to learning
AACD	Adult Acute Care Division
ASSD	Anaesthetic and Surgical Services Division
ICSD	Integrated Care Services Division
FCD	Family Care Division
NHS Greater Manchester (NHS GM)	NHS Greater Manchester is the Integrated Care Board for Greater Manchester. A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
AIS	Accessible Information Standard. This directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care.
CQC	Care Quality Commission. The independent regulator of health and adult social care in England.
CNST	The Clinical Negligence Scheme for Trusts is a payment made to NHS Resolution who then handle all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995. There is a specific incentive scheme for maternity services that supports the delivery of

	safer maternity care through an incentive element to trust contributions to the CNST.
C.Diff / CDT	Clostridium Difficile or Clostridioides Difficile. A type of bacteria that can infect the bowel and cause diarrhoea. It commonly affects people who have been recently treated with antibiotics but can spread easily to others. CDT is a binary toxin frequently observed in Clostridium difficile strains associated with increased severity of C. difficile infection
NPSIPs	National Patient Safety Improvement Programmes. National priorities because of their potential to enable the most significant impact on patient safety.
PSII	Patient Safety Incident Investigation. An in-depth review of a single patient safety incident or cluster of events to understand what happened and how
LeDeR	LeDeR is a service improvement programme for people with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care a person received that may have been relevant to their overall health outcomes.
DHR	Domestic Homicide Review. A review into the circumstances around a death of your friend or family member following domestic abuse.
MHRA	Medicines and Healthcare products Regulatory Agency. MHRA regulates medicines, medical devices and blood components for transfusion in the UK.
ICO	Information Commissioner's Office. The ICO is the UK's independent body set up to uphold information rights.
HTA	Human Tissue Authority. The independent regulator of organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. The HTA also give approval for organ and bone marrow donations from living people.
SWARM Huddle	A type of learning response tool designed to start as soon as possible after a patient safety incident occurs to identify learning. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk
MDT Reviews	A type of learning response tool. An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done.

After Action Reviews (AAR)	A type of learning response tool. A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from the expected and the learning to assist improvement.

1. Introduction

1.1 The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The main aim being to support learning and improve patient safety. It is a key part of the NHS patient safety strategy. Published in 2019, the NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients describes how the NHS will improve patient safety over the next five to ten years.

1.2 The Bolton Locality Plan, produced in 2016 by Bolton Clinical Commissioning Group, aspires to:

- Improve health outcomes, increase healthy life expectancy and reduce inequalities through targeted interventions. Including:
  - Reducing the number of people who have heart disease, a stroke, or diabetes
  - Reducing the number of people, especially older residents, who are injured due to falls.
- Support behavioural change with more people successfully managing their own health and wellbeing, supported by knowledgeable and skilled teams of integrated health and social care professionals.
- Reduce pressure on GPs, freeing up their time to support the management of people who have a higher level of clinical need.
- Reduce hospital-based care by improving access to local specialist health services, reducing ambulance call outs and emergency admissions to hospital (including from care homes).

1.3 Our aspirations are closely aligned with those of our commissioners and informed the development of our Trust Strategy. We will continue to work in partnership with them to achieve our shared ambitions. Our 2019-2024 Strategy describes our vision 'to be recognised as an excellent provider of health and care services, and a great place to work'. It has been created around 5 core ambitions:

1. Improving care, transforming lives
2. Working together for a better future
3. A skilled, healthy, thriving workforce
4. Financial and operational strength
5. Infrastucture, technology and innovation

1.4 Considering these factors, this Patient Safety Incident (PSI) Response Plan sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents over the next 12 months to improve patient safety and quality of care, in line with PSIRF principles. The plan is not a permanent rule that cannot be changed. We will

remain flexible and consider the specific circumstances in which patient safety incidents occurred and the needs of those affected.

2. Our services

2.1 Bolton NHS Foundation Trust provides a range of hospital and community health services in the Northwest Sector of Greater Manchester. We deliver services from the Royal Bolton Hospital site in Farnworth, in the Southwest of Bolton, close to the boundaries of Salford, Wigan, Blackburn and Bury as well as providing a wide range of community services from locations within Bolton.

2.2 The Royal Bolton hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric service for women, children, and babies. The Integrated Community Services Division consists of domiciliary, clinic and bed-based services across the Bolton footprint to GP registered population.

2.3 In total, we have 598 general and acute beds, 78 maternity beds and 35 critical care beds

2.4 The Trust has an estimated catchment population of 1,000,000 compared with a resident Bolton population of 285,000

2.5 In 2022/23 Bolton NHS Foundation Trust provided and/or sub-contracted 13 relevant health services (as defined by the CQC) across 41 specialties.

2.6 The services provided by the organisation have been mapped using profiling information from the Trust's intranet, divisional governance charts, the Trust's website and the most recent available CQC Inspection Report (October 2023)

2.7 Acute Adult Care Services Division (AACD)

2.7.1 The emergency department is a type 1 service. This means it is a consultant-led 24-hour service with full facilities for resuscitating patients. There are separate adult and paediatric emergency areas, a minors area, a same day emergency care unit (SDEC) which was re-launched (September 2022) and an urgent treatment centre.

2.7.2 Royal Bolton Hospital is the second busiest ambulance-receiving site in Greater Manchester.

2.7.3 The medical services consist of:

- 17 in-patient wards

- 54 respiratory beds with a ward based non-invasive ventilation service
- Coronary Care Unit
- 35 cardiology beds as well as
- Diabetes, gastroenterology, haematology, acute stroke, acute frailty, medical assessment, three care of the elderly and three escalation wards.

2.8 Anaesthetics and Surgical Services Division (ASSD)

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

2.8.2 We also offer both elective and non-elective surgery, as well as specialist clinical services delivered both at Royal Bolton Hospital and in the community.

2.8.3 In 2021/2022, we delivered more than 190,000 Outpatient appointments and performed 3,500 emergency surgeries in our theatres.

2.8.4 Our Critical Care department provides life sustaining treatment to patients with severe life-threatening illnesses and to patients after major surgical procedures.

2.8.5 The Critical Care Unit is a 19-bedded unit providing both high dependency and intensive care capacity.

2.8.6 We care for almost 1,400 patients a year, and are the third busiest critical care unit in Greater Manchester.

2.9 Diagnostic and Support Services Division (DSSD)

2.9.1 DSSD is a key support for Trust services and interacts with patients on many different inpatient and outpatient pathways.

2.9.2 The division operates a range of support services including Pharmacy, Laboratory Medicine, Radiology and Infection Prevention and Control.

2.10 Family Care Division (FCD)

2.10.1 The Family Care Division delivers a range of services including:

- Maternity
- Neonatal
- Sexual health
- Early pregnancy
- Gynaecology services
- 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.

2.10.2 More than 6,000 babies are delivered under our care and we carry out around 1,500 gynaecological procedures each year.

2.10.3 We also have a tertiary level Neonatal Intensive Care Unit and a level 2 Paediatric High Dependency service working in collaboration with Greater Manchester Acute paediatric services.

2.10.4 There is a range of options for where people can choose to give birth including:

- at home with support from our midwifery team
- at Ingleside Birth and Community Centre, our midwife led unit in Salford
- at the Beehive Unit our midwife led unit at Royal Bolton Hospital
- at the Royal Bolton Hospital delivery suite, our doctor led unit at the hospital

2.11 Integrated Community Services Division (ICSD)

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

2.11.2 We have more than 940 staff who help to deliver 40+ services, including district nursing, IV therapy, diabetes and homeless and vulnerable adults services

2.11.3 We also have staff working during the day at Wilfred Gere and 24 hours a day at Laburnum Lodge, intermediate care services run by Bolton Council.

2.11.4 The subsequent plan has been developed in collaboration with each of the divisions and relevant stakeholders (including patient representatives) to ensure it reflects the variety of services the organisation offers.

3. Defining our patient safety incident profile

3.1 Stakeholder Engagement

3.1.1 We have engaged with a range of stakeholders to create a list of PSI types that are jointly identified as areas of interest in terms of risk and potential learning and improvement. As part of the profile development process, we engaged with the following groups/stakeholders:

- Divisions via Divisional Governance meetings
- Family Care Division development session
- Monthly PSIRF Implementation Group meetings
- Bolton ICB (now NHS GM)

- Greater Manchester ICB (now NHS GM)
- Specialist nursing teams (Tissue viability, Enhanced care, Admiral nurse, learning disabilities)
- Staff experience manager
- Equality, diversity and inclusion programme manager
- BoSCA Lead
- Director of Operations/Chair of the regional health inequalities enabling group
- North West Ambulance Service
- Greater Manchester Mental Health NHS Trust
- Healthwatch
- Patient representatives
- Locality systems quality group
- Divisional stakeholder workshop to stratify key themes

3.2 Data Sources

3.2.1 Discussions with our stakeholders were underpinned by a review of both qualitative and quantitative data from a range of sources covering the last 1-3 years

- Patient safety incidents reported via Safeguard 2020-2023
- Falls data 2021/2022 and 2022/2023
- Complaints data 2020-2023
- Claims data 2020-2023
- CNST Scorecard
- Pressure ulcer data 2021/2022 and 2022/2023
- Divisional review report of top 10 cause groups for incidents 2020-2023
- Quality Improvement Strategy
- Audits and NICE compliance
- Quality Improvement – local initiatives
- Learning from Deaths quarterly reports Q1-3 2022/23
- Integrated Performance Monitoring Reports Q1-3 2022/23
- Serious Incident investigation reports and action plans 2022-2023
- Divisional organisation and governance charts
- NHS Staff Survey 2022 Benchmarking Report and Breakdown Report

3.2.2 Following the review of data, we were able to identify the top 15 most significant patient safety themes. By reviewing the current improvement work underway and engaging with stakeholders, we were able to narrow the list down to the top five patient safety themes.

3.2.3 To ensure this approach was consistent, measurable and comparable, Divisions were asked to rank the top 15 themes using the following matrix:

1. Are there any surprises?
2. Are there any themes you would add?
3. Using the matrix below give each theme a score from 1 to 5* (incl any themes you would add)
4. Rank the themes in order of priority/concern (1 being the highest priority)
5. Give each theme a total score

Level of harm**	Likelihood of harm**	Confidence in existing safety measures/ improvement work	Potential for new learning	Ranking	Total score

***Using the Trust matrix as per risk register*

3.2.4 As part of the consultation process, we engaged with patient representatives and Healthwatch to gain feedback from people who use our services. We asked for their views on the top five themes and what they felt should be included in our plan.

3.2.5 We held a separate workshop with the Families division to explore and understand the main safety themes specific to that division. As a result, we have developed a specific chapter within the plan for Families services. This is to ensure the plan reflects some of the specific nuances of these services.

3.2.6 There was a two-week stakeholder consultation period for the draft policy and plan in line with the Trust's procedural document development and management processes. We reviewed feedback and amended the draft documents accordingly. The final draft policy and plan were presented to Clinical Governance and Quality Committee and Quality Assurance Committee before finally being submitted to Trust Board for approval.

3.2.7 The plan aims to support the Trust to use resources effectively and enhance opportunities for learning and improvement. However, it is not a permanent set of rules and can be changed if appropriate. As well as the plan, we will remain flexible and consider the specific circumstances in which patient safety incidents occur and the needs of those affected. We have also developed a PSI Response Policy to support implementation of the plan.

A copy of the policy is available here: ADD LINK

4. Defining our patient safety improvement profile

4.1 In order to identify and agree our patient safety improvement profile it was important to understand what improvement and transformation work is planned or already underway across the Trust, locally and nationally.

4.2 Quality Account Priorities 2022/2023

4.2.1 In our Quality Account for 2021/22 we set ourselves a series of key priorities for improvement for 2022/23, these were:

- Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score (continuation from 2021/22)
- Antibiotic prescribing standards
- Rheumatology
- Improving information for patients
- Accessible Information Standards (AIS)

4.2.2 Full details regarding our aims and progress against these priorities can be found in the Bolton NHS Foundation Trust Quality Account 2022-23 which can be found here: https://www.boltonft.nhs.uk/app/uploads/2023/07/Bolton-NHS-Foundation-Trust-Quality-Account-2022-23.pdf

4.3 Quality Account Priorities 2023/2024

4.3.1 Following consultation with our stakeholders, the following were highlighted as our quality account improvement priorities for 2023/24:

1. Pressure Ulcer Improvement

Aims:

- To reduce Hospital acquired category 2 pressure ulcers by 50% by 31/07/24
- To reduce Community acquired category 2 pressure ulcer by 30% by 31/07/24
- To eradicate category 3 and 4 pressure ulcers by 31/07/24

2. C.difficile infection reduction

Aim:

- Reduce Healthcare associated C.diff Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024

3. Enabling and empowering our staff through the development of quality improvement skills

Aim:

- 25% increase in Bolton NHS Foundation Trust Staff who have an awareness of the fundamentals of Quality Improvement by 31/03/24 (through QI fundamental training, improvement collaborative involvement, BoSCA* QI involvement)

**BoSCA stands for Bolton System for Care Accreditation. It is an internal accreditation programme that supports all inpatient areas to provide safe, effective, consistent, compassionate care to our patients and their families.*

4.3.2 Trust-wide Quality Improvement work reflects these priorities.

4.4 Trust-wide Quality Improvement Work

Name of QI project/Area of focus	Status
Quality improvement skills capability building	In progress
Standardising nursing handover	In progress
Pressure ulcer collaborative	In progress
C.Diff collaborative	In progress
Sepsis	Scoping - Bringing together NEWS, Sepsis and deteriorating patients workstreams together
Improving the learning from deaths process	Scoping
End of life care – staff education, access to side rooms, information sharing with patient and relatives	In progress
Noise at night	In progress
Nursing documentation optimisation	In progress

4.4.1 Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and where applicable commissioning for quality and innovation (CQUIN) payments. (See Service Transformation section)

4.5 National Patient Safety Improvement Programmes (NPSIPs)/Priority Areas of Focus

4.5.1 The NHS Patient Safety Strategy 2019 identifies four national priorities because of their potential to enable the most significant impact on patient safety along with ongoing work in three key priority areas.

4.6 NPSIPs

- Preventing deterioration and sepsis
- Medicines safety
- Maternal and neonatal safety
- Mental Health Safety

4.7 Ongoing national priority areas of focus

- Antimicrobial Resistance and Healthcare Associated Infections
- Safety and learning disabilities
- Safety issues affecting older people

4.8 Divisional Quality Improvement Work

Name of QI project/Area of focus	Status
ICSD – Community Nursing and Treatment rooms: Purpose T risk assessment mandatory as part of all initial assessments. Increase team knowledge around pressure damage management and pressure ulcer related issues.	In progress
ICSD – Community nursing safety huddle alignment	Established
ICSD – Introduction of patient information card (Rheumatology)	Established
ICSD –Neuro epilepsy maternity pathway	In progress
DSSD – Accessible Information Standards in relation to text reminders and digital letters for outpatient and/or elective care	In progress
Pharmacy – Prescription tracking system	In progress
DSSD – Nurse-led PICC and midline insertion service	Well established
Pharmacy – Assembly of medications for discharge	In progress
AACD – Learning from falls	In progress
ASSD – Discharges (F4)	Scoping
ASSD - THR/TKR ambulatory care pathway	In progress
ASSD – Breast cancer end of treatment summaries	Well established
AACD – Standardising acuity measures in the emergency department	In progress
AACD – Enhanced Care Lounge	In progress
AACD – New Inpatient flow system	In progress
AACD – Productive ward	Established
AACD – Criteria led discharge	In progress
AACD – Ward welcome packs	In progress
AACD – Staff information cue cards	In progress
Speech and Language Therapy services - Improving patient experience and mouth care in long term nil by mouth patients using Biozoon	In progress
Speech and Language Therapy services - Improving functionality and experience in patients with muscle strength weakness –using EMST	In progress

The clinical audit reports for 29 national clinical audits and 216 local clinical audits were reviewed by the Trust in 2022/23. Full details of the actions being taken to improve the quality of healthcare provided can be found in the aforementioned Bolton NHS Foundation Trust Annual Quality Account 2022-2023.

4.9 Service Transformation

Please see Appendix 1 for a full list of the service transformation and improvement work underway with an impact on patient safety

5. Our patient safety incident response plan: national requirements

5.1 Some events in healthcare require a nationally mandated response. The table below summarises the guidance on nationally mandated responses to certain categories of event and sets out whether that mandated response needs to be a PSII or another response type, including referring the event to another organisation to manage.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Mental health-related homicides	Referred to the NHS England Regional Independent	Dependent on RIIT decision. Respond to

	Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	recommendations as required and feed actions into the quality improvement strategy
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	Create local organisational actions and feed these into the quality improvement strategy
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Dependent on Panel review outcome. Respond to recommendations as required and feed actions into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Dependent on LeDeR Review. Respond to recommendations as required and feed actions into the quality improvement strategy
Safeguarding incidents in which - babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence - adults (over 18 years old) are in receipt of care and support needs from their local authority	Refer to local authority safeguarding lead The Trust must contribute towards domestic independent inquiries, joint targeted area	Dependent on Local Authority line of enquiry/action/review

- the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	Create local organisational actions and monitor for effectiveness/ safety improvement
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and	Dependent on police and CSP review

	Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	
Incidents meeting 'Each Baby Counts' and maternal deaths criteria: - Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. - Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). - Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. - Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).	Referred to Healthcare Safety Investigation Branch (or Special Healthcare Authority when in place) for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy
Also to consider:		
Incidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 and Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R.	Refer to Health and Safety Executive. Locally-led learning response may be required/requested.	Create local organisational actions and monitor for effectiveness/

		safety improvement
Radiation Exposure Incidents – IR(ME)R	Incidents are reportable to CQC. Locally led learning response may be required/requested.	Create local organisational actions and monitor for effectiveness/ safety improvement
Medicines and Healthcare products Regulatory Agency (MHRA) reportable incidents All transfusion-transmitted infections (TTI) must be reported to MHRA. MHRA Yellow Card reporting Any adverse incident involving a medical device should be reported to the MHRA, including problems with the instructions for use, packaging or the use of the device itself, particularly if the incident has led, or might have led to death, life-threatening illness or injury.	Refer to MHRA. Locally led learning response may be required.	Respond to recommendations as required. Create local organisational actions and monitor for effectiveness/ safety improvement
Serious Hazards of Transfusion (SHOT) reportable incidents Serious adverse reactions and events related to blood components, including any novel components such as convalescent plasma and whole blood. Serious adverse reaction: an unintended response in a patient that is associated with the transfusion of blood or blood components that is fatal, life-threatening, disabling or incapacitating or which results in or prolongs hospitalisation or morbidity Serious adverse events: Any untoward occurrence associated with the collection, testing, processing, storage and	Refer to MHRA Where blood components are being used in clinical trials this must be recorded in the SHOT submission. Locally led response required.	Respond to recommendations as required. Create local organisational actions and monitor for effectiveness/ safety improvement

distribution of blood or blood components that might lead to death or life threatening, disabling, or incapacitating conditions for patients or which results in, or prolongs, hospitalisation or morbidity.		
Human Tissue Authority (HTA) reportable incidents Establishments licensed in the Post Mortem sector must notify the HTA within five working days of a serious incident or near miss occurring or being discovered.	Refer to HTA Locally led response required	Create local organisational actions and monitor for effectiveness/ safety improvement
Independent Commissioners Office (ICO) reportable incidents GDPR breaches to be reported to ICO within 72 hours.	Refer to ICO Locally led response required	Create local organisational actions and monitor for effectiveness/ safety improvement

6. Our patient safety incident response plan: Local focus

6.1 Themes identified for local focus with the tools we aim to use in each situation. We know these tools support learning from past events but we will also combine this approach with tools that allow us to learn from what is happening in real time. This may include tools such as process mapping, observation and horizon scanning. Section 7 provides information about our toolkit.

6.2 Plan for all Divisions (as applicable)

Patient safety incident type or issue	Planned response	Anticipated improvement route
Cancer patient or Management of patient with pre-malignant condition lost to follow up	Patient Safety Incident Investigation – the first four that result in any level of harm and/or themed investigation of 6 near misses.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate

	Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	
Tests/Scan results/reports – Delay/failure to undertake or review	This is a complex issues with multiple known challenges that would benefit from a quality improvement focus	Put forward for quality improvement project 2024/25.
Discharge/Transfers of care (Patients 75 yrs +) – Failure to provide adequate information, referrals process to other services	Inform current quality improvement work and escalate to NHS GM for locality focus/response	Engagement with all relevant stakeholders to inform and develop ongoing improvement efforts
Violent/Aggressive behaviour involving patients with Dementia/LD/Cognitive impairment	SWARM Huddle or after action review with specialist nurse input and annual review of themes	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
VTE – Failure to reassess within 24 hours and/or subsequent reassessment following changes to a patient's condition.	Patient Safety Incident Investigation – one per quarter / four per year Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Medication administration – Missed administration of critical medication in the Emergency Department or Community with failure to escalate	Patient Safety Incident Investigation – one per quarter / four per year Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Category 3 & 4 Pressure Ulcers	SWARM Huddles feeding into Trust wide/locality	Inform ongoing improvement efforts as

	Quality Improvement Collaborative	per 2023/24 Quality Account Priorities
Category 2 Pressure Ulcers	SWARM Huddles and quarterly thematic analysis feeding into Trust-wide/locality Quality Improvement Collaborative	Inform ongoing improvement efforts as per 2023/24 Quality Account Priorities
Falls with severe harm	SWARM Huddles and quarterly thematic analysis	Inform ongoing improvement efforts
Falls – repeat falls 3+ in a single inpatient period	SWARM Huddles and quarterly thematic analysis	Inform ongoing improvement efforts
TTOs – Patients sent home without medication	Monthly audits/Quarterly thematic review	Inform ongoing improvement efforts
Hospital Acquired C.Difficile	SWARM Huddles feeding into Trust wide/ locality Quality Improvement Collaborative	As per Quality Account priorities 2023/24
Recognition of deteriorating patient/delay in escalation	Divisional After Action Review feeding into Trust wide Quality Improvement work (currently at scoping stage) and wider NPSIPs	Build case for new improvement plan / Inform ongoing Quality Improvement work
Advanced care planning, recognition of dying patient, DNACPR	Learning from Deaths process feeding into Trust wide Quality Improvement work (currently at scoping stage)	Build case for new improvement plan / Inform ongoing Quality Improvement work

6.3 Plan for Families Division

6.3.1 The Families Division continues with all of the national maternity quality and safety initiatives designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths:

Patient safety incident response plan

- Saving Babies Lives Care Bundle
- Ockenden report 2022
- NHS resolution maternity incentive scheme
- Maternity and Neonatal Safety Collaborative
- Each Baby Counts
- Kirkup Report 2022
- Improving Equity and Equality in maternity and neonatal care.
- Tommy's app

In addition, the Division has identified the following key patient safety themes they will be focusing on in the next 12 months:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Neonatal Unit – Unexpected Admission, identification and management of sepsis	After Action Review with escalation to PSII if further in-depth review/ learning identified.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Neonatal unit closures due to staffing/skill mix and capacity issues	SWARM Huddle with actions feeding into CNST action plan	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required.
Neonatal, Maternity & Gynaecology Communication- conflicting information from staff, mis-communication	SWARM Huddle to aid prompt identification of issues. Annual thematic review Each baby counts behavioural toolkit is being rolled out across maternity by the Saving Babies Lives midwife, includes escalation which often features in incidents	Create local safety actions and monitor via Divisional Governance to identify possible themes that may require more in-depth improvement work
Neonatal & Gynaecology Medication – prescribing/ administering	SWARM Huddles and bi-annual thematic review	Inform ongoing improvement efforts and feed into Trust safety improvement action as per Trust-wide plan above.

Neonatal & Gynaecology Failure to follow processes (guidelines/ policies)	After Action Reviews where incident results in harm along with quarterly thematic review to understand broader system issues.	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required. Potential to put forward for quality improvement project 2024/25.
Neonatal, Gynaecology and Maternity Documentation – failure to document all clinical care	Quarterly audit to identify key issues and themes	Create local safety actions and monitor via Divisional Governance, feeding into local improvement projects if appropriate.
Gynaecology Tests/Scan results/reports – Delay/failure to review results	After action reviews with findings feeding into wider Trust improvement work	Create local safety actions and monitor via Divisional Governance. Identified issues and safety actions to inform broader Trust QI projects (in line with Trust-wide plan)
Gynaecology Discharge/ Transfers of care – Failure to complete timely discharge correspondence	SWARM Huddle or After Action Reviews with findings feeding into wider Trust improvement work	Create local safety actions and monitor via Divisional Governance. Identified issues and safety actions to inform broader Trust QI projects (in line with Trust-wide plan)
Gynaecology Aggressive/violent behaviour involving patients with mental health issues	Annual thematic review with input from specialist nursing staff/teams	Create local safety actions and monitor via Divisional Governance.
Gynaecology Delayed diagnosis/Missed diagnosis: Missed cancer, delayed	Incidents involving cancer patients lost to follow up managed as per Trust-wide plan. All other incidents managed by the Division through MDT or after action	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate

diagnosis of cancer, ectopic pregnancy	review with escalation to PSII panel if indicated as appropriate in line with escalation processes.	
Maternity Post- partum haemorrhage: Failure to identify/escalate and management of antenatal anaemia	Thematic review	Create local safety actions and monitor via Divisional Governance. Possibly escalate for PSII if indicated.
Acute paediatrics and integrated community paediatric service Medication prescribing and administration errors	Quarterly thematic review	Inform ongoing improvement efforts and feed into Trust safety improvement actions as appropriate
Acute paediatrics, Integrated community paediatric service & sexual health service Medical devices/ equipment – Availability, fit for purpose	SWARM Huddles	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required. Expand the Divisional Medical Devices taskforce into a monthly meeting with extended Terms of Reference that review incidents and share learning.
Integrated community paediatric service and Allied Health Professionals Service Referrals process	Quarterly thematic reviews feeding into Divisional/ Trust /North West forums	Inform Divisional/Trust and Regional safety improvement plans. Create referral forms and examples where required e.g. Tertiary hospitals to

		community care. Discuss at network meetings.
Acute Paediatrics & 0-19/25yrs services Lack of suitably trained staff	Quarterly audit and undertake review of evidence based models for paediatric acute care.	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required.
All paediatric community services Did not attend/ was not brought	SWARM Huddles	Create local safety actions and monitor via Divisional Governance. Put forward for quality improvement project.

7. Learning Response Toolkit

7.1 A learning response toolkit based on NHS England recommended tools and guidance is available for staff to use when undertaking a learning response. The toolkit is available on the Trust intranet. We will continuously review and develop the toolkit based on best practice guidance.

8. References

Patient Safety Incident Response Framework, NHS England 2022: NHS England » Patient Safety Incident Response Framework

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients 2019: Report template - NHSI website (england.nhs.uk)

Bolton Locality Plan, Bolton Council, 2016: Local plan – Bolton Council

Our Strategy: For a Better Bolton 2019-2024, Bolton NHS Foundation Trust, 2019: Our strategy - Bolton NHS FT (boltonft.nhs.uk)

Bolton NHS Foundation Trust: Our Quality Account 2022/23: Bolton-NHS-Foundation-Trust-Quality-Account-2022-23.pdf (boltonft.nhs.uk)

Saving Babies' Lives: A care bundle for reducing stillbirths, NHS England, 2016: saving-babies-lives-car-bundl.pdf (england.nhs.uk)

Ockenden Report - Final: Final findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS

Trust, Crown Copyright 2022: Final report of the Ockenden review - GOV.UK (www.gov.uk)

Each Baby Counts, Royal College of Obstetricians and Gynaecologists, 2020: Each Baby Counts | RCOG

Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation, Kirkup, 2022: Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation (publishing.service.gov.uk)

The Tommy's App, Tommy's National Centre for Maternity Improvement, 2023: Tommy's National Centre for Maternity Improvement | RCOG

Improving equity and equality in maternity and neonatal care, NHS England: NHS England » Improving equity and equality in maternity and neonatal care

Appendix 1: Transformation and Improvement Work

Title	Description	Status
Cost Improvement Plan	A co-ordinated Trust led approach to delivering the organisation's financial plan that integrates with the financial plans of Bolton's Integrated Care Board and Greater Manchester.	Well established and ongoing
Productivity Improvement Plan	A co-ordinated Trust led approach to delivering the organisation's productivity plan that integrates with the stra tegy of Bolton's Integrated Care Board and Greater Manchester.	In progress. On-track
Workforce Transformation Programme	- Mapping our workforce - Locality wide so hospital, community, primary care, ICP, care homes and social services - MECC Pilot - Collaboration opportunity with voluntary sector - Management of People and Culture Group which will inform and define transformational priorities across the locality	In progress. On-track
Outpatients Transformation Programme	A Trust wide delivery programme informed by a number of key national drivers. The programme will drive a Trust wide approach to implementing key OP deliverables and monitor developed KPIs to ensure achievement of the outcomes & benefits	Well established
Urgent care Programme	Locality wide programme comprising several workstreams to improve performance, productivity, efficiency, patient experience and staff experience	Established
Theatre (Admitted) Improvement Programme	Programme including multiple workstreams to improve elective recovery, operational planning targets, productivity and efficiency, patient experience and staff experience	Well established
Maternity Transformation Programme	3-year plan with 4 key themes: Theme 1: Listening to and working with women and families with compassion Theme 2: Growing, retaining and supporting our workforce Theme 3: Developing & sustaining a culture of safety, learning and support Theme 4: Standards and structures that underpin safer, more personalised and more equitable care	Well established

Patient safety incident response plan

Children and young people transformation programme	Programme including multiple workstreams to improve SEND and JTAI assessments, equitable outcomes, productivity and efficiency, patient experience and staff experience	Scoping
Community Diagnostic Centre	Aims to improve elective recovery, operational planning targets, productivity and efficiency, patient experience, staff experience	Well established
Health Inequalities Programme	Supports Health Inequalities Enabling Group and Oversight of the Programme Plan. Programme has 4 parts; - Education and Awareness - Development of Health Inequalities Impact Assessment - Know our patients and staff - Inclusion of HI on key trust documents (such as business case template and benefits realisation tracker)	Established
Making Every Contact Count	Leadership and oversight of MECC programme working collaboratively with system partners to improve patient experience, improve patient outcomes, reduce health inequalities, improve population health	Established
Think before you tick project	Clinically led project to reduce the number of tests ordered unnecessarily in order to improve patient experience, improve productivity and efficiency, improve performance.	Well established with plans to expand to primary care
Mortality and recording of co-morbidities	Oversight across the mortality work of which focus is around improving clinical recording which then allows accurate depth of coding (in particular comorbidities), training and education, coding review, clinical review, EPR optimisation, and Know Your Patient.	Well established
GIRFT	Oversight of annual national programme	Well established
CQUIN Schemes	- Appropriate antibiotic prescribing for UTI in adults aged 16+ - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions - Compliance with timed diagnostic pathways for cancer services - Treatment of community acquired pneumonia in line with BTS care bundle - Anaemia screening and treatment for all patients undergoing major elective surgery	Established

Patient safety incident response plan

	- Timely communication of changes to medicines to community pharmacists via the discharge medicines services - Supporting patients to drink, eat and mobilise after surgery - Cirrhosis and fibrosis tests for alcohol dependent patients - Malnutrition screening in the community - Assessment, diagnosis, and treatment of lower leg wounds - Assessment and documentation of pressure ulcer risk - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	
ORCHA	Implementation of ORCHA (digital care apps) working with specialities to keep patients well at home.	Ongoing – review of contract
LIMs	Project management of LIMs upgrade (Lab system)	2-year programme commenced April 2022.

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

t| 01204 390390 w| boltonft.nhs.uk

Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	Possibly	Document will be published in the four languages most commonly spoken in the Bolton area.
	• Nationality	No	
	• Gender (including gender reassignment)	No	
	• Culture	Possibly	Access to plan must be available by several means not just internet
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	An easy read version will be available. Access to Braille and large print copy will also be available
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	N/A	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	N/A	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	

7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Manager together with any suggestions as to the action required to avoid/reduce this impact.

Document Development Checklist – Document Control Policy

Section 1	To be completed by Lead Author
Type of document :	Patient Safety Incident Response Plan
Lead author:	Emily Harrison, Patient Safety Specialist
Is this new or does it replace an existing document?	New
What is the rationale/ Primary purpose for the document	Nationally mandated by NHS England to improve the way the NHS learns from patient safety incidents.
What evidence/standard is the document based on?	NHS Patient Safety Strategy 2019 NHS Patient Safety Incident Response Framework 2022 (PSIRF)
Is this document being used anywhere else, locally or nationally?	This document is specific to the needs of Bolton but all NHS Trusts are required to produce a policy and supporting plan in line with the PSIRF. We have also used the template NHS England have provided to ensure all requirements of PSIRF are covered.
Who will use the document?	All staff
Staff/stakeholders consulted:	Range of stakeholder from clinical, non-clinical and corporate divisions across the Trust, all services within each clinical division, Healthwatch, ICB, patient representatives, NWAS and GMMH
What is the implementation and dissemination plan? (How will this be shared?)	Gradual rollout to commence 1st December. Rollout plan in place to support. Rollout via comms and through divisions supported by a series of training workshops and clinics led by the patient safety specialist

Are there any service/resource implications? (How will any change to services be met? Resource implications?)	Possible resource implications in relation to training, roles and responsibilities. Training needs analysis and options appraisals completed as part of rollout plan.
Are there any additional training requirements? If so have these been discussed as part of the implantation plan?	As above
How will the document be reviewed? (When, how and who will be responsible?)	The document will be reviewed initially in 12 months' time (unless an earlier need is identified). The Patient Safety Specialist with input from key stakeholders will review the document.
Keywords (Include keywords for the document controller to include to assist searching for the policy on the Intranet)	Patient safety, PSIRF, incidents, learning, just culture
Any document that gives an instruction to prescribe or administer a medicine should have that instruction reviewed by the senior divisional pharmacist before it goes for ratification.	Signature of Pharmacist: N/A
Signed and dated by Chair of validating committee/group	Signed: Designation: Date:
Signed and dated By Chair of Approving Committee/Group *PDOC Chair (approval for submission to Execs). Leave blank for guidelines or where there have been minimal changes to policies.*	Signed: Designation: Date:
Final Sign off Signed and dated	Signed: Designation: Date:

Executive Director meeting Chair (or PDOC chair for guidelines or where there have been minimal changes to policies)	