NHS Bolton NHS Foundation Trust

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1300 on Thursday 25 January 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref Nº.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB001/24	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm quorum*	*Verbal*	Chair	**13:00**
TB002/24	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	
CORE BUSINESS				
TB003/24	**Declaration of Interests** *Purpose: To record interests relating to items on the agenda.*	*Report + Verbal*	Chair	**13:15** (5 mins)
TB004/24	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the previous meeting held on 30 November 2023.*	*Report*	Chair	
TB005/24	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB006/24	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Verbal*	Chair	**13:20** (5 mins)
TB007/24	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13:25** (10 mins)

STRATEGY AND PERFORMANCE				
TB008/24	**2024/25 Operational Planning** *Purpose: To **receive** the 2023/25 Operational Planning*	*Presentation*	SSDT	**13:35** (20 mins)
TB009/24	**Operational Update** *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**13:55** (20 mins)
TB010/24	**Integrated Performance Report** a) Quality and Safety b) Operational Performance c) Workforce d) Finance *Purpose: To **receive** the Integrated Performance Report*	*Report*	DCEO	**14:15** (20 mins)
TB011/24	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**14:35** (05 mins)
QUALITY AND SAFETY				
TB012/24	**Quality Assurance Committee Chair Reports** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**14:40** (05 mins)
TB013/24	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update** *Purpose: To **receive** the CNST Year 5 Update*	*Report*	DoM+ Chief Nurse	**14:45** (10 mins)
WORKFORCE				
TB014/23	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	PC Chair	**14:55** (05 mins)
COMFORT BREAK				**15:00**

FINANCE				
TB015/24	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	**15:15** (05 mins)
TB016/24	**Financial Controls Committee Chair's Report** *Purpose: To **receive** the Financial Controls Committee Chair Report*	*Report*	FCC Chair	**15:20** (05 mins)
TB017/24	**Charitable Funds Committee Chair Report** *Purpose: To **receive** the Charitable Funds Committee Chair Report*	*Report*	CFC Chair	**15:25** (05 mins)
TB018/24	**Our Bolton NHS Charity Annual Report and Accounts for year ending 31 March 2023** *Purpose: To **receive** the Our Bolton NHS Charity Annual Report and Accounts*	*Report*	CFC Chair	**15:30** (05 mins)
GOVERNANCE AND RISK				
TB019/24	**Audit Committee Chair Report** *Purpose: To **receive** the Audit Committee Chair Report*	*Report*	*AC Chair*	**15:35** (05 mins)
TB020/24	**Board Workplan** *Purpose: To **receive** the Board Workplan*	*Report*	*DCG*	**15:40** (05 mins)
TB021/24	**Committee Effectiveness Report** *Purpose: **To receive** the Committee Effectiveness Report*	Report	DCG	**15:45** (05 mins)
TB022/24	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*All*	**15:50** (10 mins)
CONSENT AGENDA				
TB023/24	**Safeguarding Adult, Children and Looked After Children Annual Report 2022/23**	*Report*	CN	

	*Purpose: To **receive** the Safeguarding Annual Report*			
TB024/24	**Standing Financial Instructions and Scheme of Delegation** *Purpose: To **receive** the Standing Financial Instructions and Scheme of Delegation*	*Report*	*CFO*	
TB025/24	**Standing Orders** *Purpose: To **receive** the Standing Orders*	*Report*	*DCG*	
TB026/24	**Audit and Risk Committee Terms of Reference** *Purpose: To **receive** the Committee Terms of Reference*	*Report*	*DCG*	
CONCLUDING BUSINESS				
TB027/24	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16:00** (02 mins)
TB028/24	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**16:02** (03 mins)
TB029/24	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16:05** (05 mins)
	Date and time of next meeting: Thursday 28 March 2024			**16:10** ***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
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	
Tosca **Fairchild**	Non-Executive Director	Chief of Staff – South East London Integrated Care Board	Financial Interest
		Trustee – South East London ICB Charity	Non-Financial Professional Interest
		Client Executive (Consultancy) – Bale Crocker Associates	Financial Interest
		Partner is Consultant in Emergency Care / Deputy Medical Director – University Hospitals of Derby NHS Foundation Trust	Non-Financial Interest
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest

Name:	Position:	Interest Declared	Type of 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	
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
	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest

Name:	Position:	Interest Declared	Type of Interest
Martin **North**		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
		Egerton Pre School Committee Chair	Non-Financial Personal Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
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	
Fiona **Taylor**	Non-Executive Director	Chair of Governors St Georges CE Primary & Nursery School	Non-Financial Personal Interest
		Trustee St Ann's Hospice	Non-Financial Personal Interest
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	
	Director of Strategy	Trustee at Fort Alice Bolton	Non-Financial Professional Interest

Name:	Position:	Interest Declared	Type of Interest
Sharon **White**		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 30 November 2023
(Subject to the approval of the Board of Directors on 25 January 2024)

Present

Name	Initials	Title
Niruban Ratnarajah	NR	Chair
Alan Stuttard	AS	Non-Executive Director
Annette Walker	AW	Chief Finance Officer
Fiona Noden	FN	Chief Executive
Fiona Taylor	FLT	Non-Executive Director
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
Seth Crofts	SC	Associate Non-Executive Director
Sean Harriss	SH	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
Victoria Crompton	VC	Corporate Governance Manager
Janet Cotton	JC	Director of Midwifery (for items 141 and 142)
Rachel Carter	RC	Associate Director of Communications and Engagement
Amy Blackburn	AB	Head of Communications
Lauren Brett	LB	Operating Department Practitioner (for item 130)
Beth Johnson	BJ	Anaesthetic Nurse (for item 130)
There were four observers in attendance.		

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB129/23	**Chair's Welcome and Note of Apologies**	
	The Chair welcomed the Board and observers to the meeting and introduced the new Non-Executive Directors who were attending their first Board of Directors meeting since commencing in office. It was noted this was Dr Malcolm Brown's last meeting and last day as a Non-Executive Director. Malcolm joined the organisation in September 2018 and had held roles including as chair of People Committee, Quality Assurance Committee and also Deputy Senior Independent Director and Deputy Freedom to Speak Up Non-Executive Director.	

	The Board of Directors thanked MB for his service and wished him well for the future. Apologies for absence were noted from Tosca Fairchild and Rachel Tanner.	
TB130/23	**Patient and Staff Story**	
	The Chief Nurse introduced the recorded patient story of Ann who waited more than a year to have a hip operation. She described her experience and her gratitude for everything the staff did for her and her family and the relief following the operation. Ann could not thank the staff enough from those who assisted her whilst waiting for the operation to those who provided her aftercare. Ann expressed she felt safe due to how well she was looked after. In response to JN's query regarding the 18 month wait for the hip operation, RW commented that a whole range of actions were in place to reduce the wait time.	
	Staff Story Lauren joined the Board to deliver the Staff Story and highlighted that she had worked at the Trust for several years and was offered an opportunity to complete an apprenticeship which on completion would make her a qualified Operating Department Practitioner (ODP) ODP. The apprenticeship was difficult, but she felt fully supported by her team Lauren undertook her apprenticeship during the Covid pandemic which meant some training opportunities were not available, but this did not hinder or affect her training as she was able to be placed in alternative departments. She also had a personal issue during her training which meant she was sensitive to being placed within a certain department, but her team and the education team were very supportive and arranged for her placements to be in other areas. The Education Team at the Trust also offered her additional training and facilitated her completing ILS prior to commencing her role as an ODP. Following qualification Lauren was placed on the preceptorship scheme and was fully supported for the first 12 months in her role. She highly commended the education team and advised they had a vast amount of resources available for both staff and students within the organisation. MB queried what actions the Trust could take to encourage more staff to undertake such apprenticeships. LB suggested it would be beneficial for staff to fully understand the qualifications available, what roles they could obtain and ensure they had a full understanding of what the roles entailed.	

	JN queried what update there had been of apprenticeships across the organisation. JM advised the target had been 137 apprenticeships and this had been exceeded. A quarterly update on apprenticeships was provided to People Committee. **RESOLVED:** The Board of Directors **received** the patient and staff story.	
TB131/23	**Declarations of Interest**	
	There were no declarations relating to agenda items.	
TB132/23	**Minutes of the previous meetings**	
	The Board reviewed the minutes of the meeting held on 28 September 2023 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board of Directors ***approved*** the minutes from the meeting held 28 September 2023.	
TB133/23	**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		
TB134/23	**Chair's Update**	
	The Chair advised that the finance challenges with Greater Manchester (GM) and locally remained an area of priority. The Trust continued to work with system partners and other trusts within GM on the challenges whilst also ensuring the continuation of good patient care. There had been national directive to minimise the focus on the elective recovery programme, but the Trust felt it was important this remained a priority to improve patient's lives. The Chair advised that the Trust had held its Annual Members Meeting on 16 October with governors and public in attendance. The AMM provides an opportunity for the Trust to review performance across all areas of the Trust and share this with members of the Trust. The NHS Provider Conference was held in November and was a successful event with systems and partners in attendance. Finally, the FABB Staff Awards took place on Friday 24 November 2023. **RESOLVED:** The Board of Directors ***received*** the Chair Update.	

TB135/23	**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 CQC had published the final report following the inspection of children and young people's services in May, and the well-led inspection in June. • An Enhanced Care Lounge opened at Royal Bolton Hospital to support vulnerable patients awaiting discharge to a care home. • The 'Our Voice Change Programme' launched which would focus on key themes that sought to improve the experience of staff working across the Trust. • The Trust celebrated Freedom to Speak Up month in October with a view to promote and highlight the importance of continuing to create the right conditions for people to feel safe to speak up. The Trust also celebrated Black History Month in October with a theme of 'Saluting our Sisters' which highlighted the crucial role black women played in shaping history, inspiring change, and building communities. • A series of events including the launch of the Reasonable Adjustment passport, were held in November to mark Disability History Month. These highlighted the support in place for colleagues who have a disability or long-term health condition. • An exercise was undertaken to understand how urgent care was delivered in Bolton, with the aim of supporting communities in accessing the right urgent care service, in the right place at the right time. • Landmarks across GM were lit up pink to mark Breast Cancer Awareness Month. Our Bolton NHS Charity funded October's Breast Cancer Awareness campaign. RG queried whether the Reasonable Adjustment Passport would assist disabled colleagues to access the equipment they needed. JM advised the passport was a first step and a commitment from the organisation that disabled staff would be supported and provided for, he added the passport had been well received by all staff. AS queried the accuracy of the CQC report which stated there were 522 policies and procedures within the Trust. TR confirmed the figure was accurate and related to a variety of documents which included policies and clinical documentation. SH commented the CQC action plan response appeared transactional and raised concern the organisation was possibly not highlighting the substantial work which was being undertaken as well as it could. FN stated the report was quite transactional and the plan was focussed on what would be completed but could be updated. **RESOLVED:** The Board of Directors **received** the Chief Executive Report.	
TB136/23	**Strategy and Operations Committee Chair Report**	
	The Chair of the Strategy and Operations Committee provided a verbal update from the meeting held on Monday 27 November 2023. The following key points were highlighted:	

	• An update was received on the 2023/24 operational plan performance noting as a consequence of industrial action there was a national request for all trusts to review their performance trajectories. The Trust had submitted 65% which was a realistic position that it would fail to deliver a 76% four hour wait target. A further request was received from GM to submit a revised four hour performance submission and the Trust response was an aspirational one to deliver 76% which would require national support from ECIST to achieve. • An update was received on ambitions one, two, five and six of the Board Assurance Framework (BAF) which remained aligned to the Trust Strategy. • The Maternity EPR project had a status of 'red' due to a significant reduction in resource. The March deadline for CNST reporting for Maternity EPR continued to be worked towards, but this would be difficult with little scope for any further delays. **RESOLVED:** The Board of Directors ***received*** the Strategy and Operations Committee Chair Report.	
TB137/23	**Clinical Strategy**	
	The Medical Director presented the Clinical Strategy which outlined the progress made following previous review by the Board and consultation with different stakeholders. The Strategy was shared with members of the Clinical Strategy Project Board and was endorsed for by the Strategy and Operations Committee. FA highlighted that this Clinical Strategy is a first for the Trust, outlining the clinical direction moving forward. A detailed implementation plan for the first year, with specific deliverables, will be presented to the Board upon approval of the strategy. RG noted the evolution of the strategy, which sparked extensive debate at the Strategy and Operations Committee (SOC) about its nature whether it was merely an aspirational document or a concrete strategy. It was ultimately decided that the Trust requires an aspirational strategy complemented by a yearly execution plan. JN was pleased with the strategy's progression and advocated for a sensible approach in light of the current NHS environment. She raised the possibility of the strategy evolving to become the clinical framework for the local area. NL acknowledged the need for both clinical and wellbeing strategies in the locality, suggesting the practitioner group as the ideal forum for developing these strategies. FA expressed gratitude to the Board of Directors for their constructive feedback and credited the extensive team effort involved in the strategy's development, with significant support from the LMC. He added that the strategy has the support of the staff, who felt engaged and saw their contributions reflected in the final document, unlike the initial draft where staff felt disconnected.	

	SH inquired about the integration of this strategy with the broader trust strategy. SW responded to SH's query, stating that the Corporate Strategy's aims are being updated and a revised version will be presented to the Board of Directors in January, as the current Strategy concludes in March 2024. The Clinical Strategy is designed to align with and support the renewed objectives of the Corporate Strategy. It was noted that the Trust was introducing its inaugural Clinical Strategy to guide clinical direction, with plans for annual deliverables post-approval. The strategy evolved to balance aspiration with practical planning, and there remains potential for it to inform wider local healthcare strategies. The Board acknowledged the collaborative effort behind the strategy, which has garnered staff support. An update on how the Clinical Strategy aligns with the overarching Corporate Strategy would be presented at a future Board meeting.	
FT/23/08	Update on how Clinical Strategy aligns with the overarching Corporate Strategy to be presented at a future Board meeting.	**SW**
	RESOLVED: The Board of Directors ***received*** the Clinical Strategy	
TB138/23	**Operational Update**	
	The Chief Operating Officer reported on the Trust's operational performance, highlighting the following issues: • Paediatric emergency department visits were slightly down compared to the previous year, but admissions to the paediatric ward were higher. • Ambulance handover times within 15 minutes worsened, although November showed some improvement. Handovers within 60 minutes also deteriorated, reflecting the pressure on the organisation. • Overall attendances at the end of October showed a slight decrease from the previous year, but a 2.4% increase compared to the same period last year. • The opening of the Urgent Treatment Centre in November led to a shift in attendance types, with type 1 (most urgent) decreasing and type 3 (minor) increasing. • The Trust struggled with four-hour and 12-hour performance standards and remained among the poorest performers in the North West. An aspirational plan was submitted to meet the standards, and support from the Emergency Care Intensive Support Team (ECIST) was requested. • The elective recovery waiting list and the number of patients waiting over 78 and 65 weeks continued to grow. • Cancer two-week wait standard performance improved, and the 28-day faster diagnosis standard exceeded the 75% target. • Despite operational challenges, teams across clinical, operational, digital, and facilities domains collaborated on a series of patient and staff improvements.	

	In response to SC's question, RW stated that while working with ECIST to establish objectives, capacity issues might arise due to national pressures. NL commented that performance issues extended beyond the Trust and involved the wider Locality, mentioning the importance of the "Living Well Programme" and an ongoing Urgent Care Review to assess population needs and service suitability, with results expected in March 2024. It was noted that Local Authority deficits were likely to impact the scope of achievable work, but efforts would be made to maximise available resources. SH thanked RW for the detailed update and inquired about A&E patient volumes. RW indicated a year-to-date decrease in attendance but noted potential complexities in patient care. ECIST's review would assess the effectiveness of current systems. TR advised that the temporary staff allocations in Accident and Emergency had been converted to permanent positions to better support the department. **RESOLVED:** The Board of Directors ***received*** the Operational Update.	
TB139/23	**Integrated Performance Report**	
	Executive Directors presented the Integrated Performance Report for October 2023, and the key points were highlighted. • TR advised there continued to be common cause variation for the number of reported falls and category two pressure ulcers. There had been zero reported category three pressure ulcers for the tenth consecutive month and zero category four pressure ulcers for the fifth consecutive month. • Clostridium Difficile remained a concern and there would be a focus on the timely isolation of patients. • Complaint response rate compliance remained within normal variation. • FA advised clinical correspondence was below target and a working group were considering a number of actions. **RESOLVED:** The Board of Directors ***received*** the Integrated Performance Report	
TB140/23	**Quality Assurance Committee Chair's Report**	
	The Chair of the Quality Assurance Committee presented the Chair Reports from the meetings held on 18 October and 15 November 2023. The highlights from the November meeting were outlined: • The Board Assurance Framework was presented and amendments proposed to ambition 1.1 – due to a reduction in Likelihood from four to three the overall risk was now rated 12 and was at the 'target' risk rating. Ambition 1.3 – risk had reduced from 12 to nine and remained a Significant Risk. There were no proposed changes to the Risk Appetite. • The Annual Health and Safety Report was presented. At the conclusion of the reporting period the Trust was rated 'Green' against the Health and Safety Legal Compliance.	

	Board members thanked MB for the comprehensive Chair Reports. **RESOLVED:** The Board of Directors **received** the Quality Assurance Committee Chair's Report.	
TB141/23	**Nurse, AHP and Midwifery Staffing Report**	
	The Chief Nurse presented the Safer Staffing Report, which combined workforce data with safety, patient experience, and clinical effectiveness indicators to assure that staffing levels were safe. The report confirmed that adult in-patient wards met national staffing guidelines, with appropriate measures in place when standards were not met. It outlined steps to improve Registered Nurse staffing. The Director of Midwifery reported on Maternity Staffing, noting compliance with the 2019 Birth Rate Plus recommendations but not yet with the 2023 update. A business case for additional funding to meet the new recommendations was underway. The latest report indicated a high level of case-hold acuity in the organisation, with an increase in cases classified in the highest categories since 2019, leading to a recommendation for additional Registered Midwife and support worker roles. It was noted that workforce challenges were persisting, with actions in place to mitigate clinical safety risks and improve training compliance. Temporary service closures and staff reallocations have been necessary to maintain safety. The reopening of any closed services was dependent on achieving safe staffing levels, with ongoing reviews and collaboration with regional partners. FLT asked for clarification on compliance with the 2019 versus 2023 Birth Rate Plus recommendations. JC responded that the current CQC inspection standards are based on 2019, but updates are expected in 2024, and the Trust has submitted a business case for staffing increases. FLT also inquired if there were enough midwives to fill vacancies. JC indicated that the reliance on agency midwives has reduced as permanent roles are filled, and the Trust is successfully attracting new staff. **RESOLVED:** The Board of Directors ***received*** the Nurse, AHP and Staffing Report	
TB142/23	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year Five Update**	
	The Director of Midwifery presented a report on the progress of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, focusing on the following three safety actions at risk in the fifth year of the scheme, with improved confidence in meeting all safety actions following validation in January 2024. • Safety Action 5: Achievement of the Delivery Suite Coordinator being 100% supernumerary was maintained until September 2023, with one breach on	

	October 11, 2023, which was deemed non-reportable according to CNST guidelines. • Safety Action 6: In the absence of a unified maternity information system, manual audit data was validated by the local maternity and neonatal system (LMNS). The service reached a 67% compliance score and will be reassessed on January 9, 2024. Efforts are focused on carbon monoxide monitoring compliance, with a recent LMNS revision of standards to aid in meeting the action, though a national team has advised against lowering thresholds as the goal is to demonstrate improvement. A local assessment indicated the Trust is on track to meet minimum standards, with the caveat that performance may decline as stretch targets are introduced in April 2024. • Safety Action 8: CNST revised training requirements on October 23, 2023, allowing for 80% compliance by December 1, 2023, with an approved Board action plan to reach 90% within 12 weeks from the MIS compliance period's end. It was noted that overall, attainment of the required elements within the 10 safety actions was progressing well. The three CNST safety actions within the year 5 scheme continued to remain at risk albeit with an increased confidence they would be attained. The Trust was on course to meet the 80% compliance requirement by the deadline. **RESOLVED:** The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.	
TB143/23	**National Adult In-Patient Survey**	
	The Chief Nurse presented the National Adult Inpatient Survey 2022 Management Report advising that the survey indicated a broadly stable picture for the Trust, with the majority of scores sitting in the intermediate-60% range of Trusts surveyed. Notably, seven aspects were rated in the top-20% range whilst three were in the bottom-20% range: Progress could be seen when compared with the findings of the 2021 Adult Inpatient Survey, specifically in relation to noise at night, food and cleanliness. The report and its recommendations will be reviewed and deliberated upon in the Quality and Patient Experience Forum (QPEF). This forum will oversee the actions to respond to the recommendations and report progress through to Clinical Governance and Quality Committee. In response to a query regarding the reporting process for local surveys assessing patient experience, TR explained that the results of these surveys would be communicated through the Quality Assurance Committee and included in the Chair's Report. **RESOLVED:** The Board of Directors ***received*** the Adult In-Patient Survey Report.	

TB144/23	**People Committee Chair Report**	
	The Chair of the People Committee presented the report summarising proceedings from the meetings held on 17 October and 21 November 2023. The following key points were highlighted: • An agency and resourcing update was received which highlighted a relatively strong substantive staffing position and a reduction in the usage and expenditure overall of temporary staffing. • The Guardian of Safe Working for Q2 report was received noting there were 76 exception reports within the period. It was noted that previous concerns raised in General Surgery were being addressed and improvements were being made. • The EDI Annual Report was received which provided an analysis of the diversity profile of the workforce and service uses at the Trust during the period 01 April 2022 – 31 March 2023. The EDI Steering Group would monitor and align the action plan. **RESOLVED:** The Board of Directors ***received*** the People Committee Chair Report.	
TB145/23	**Staff Health and Wellbeing Report**	
	The Director of People presented the Staff Health and Wellbeing Report which provided an update 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 patients. JM highlighted that the Health & Wellbeing plan formed a key part of the People Strategy and was referred to in the Board Assurance Framework - Ambition 2 - Great place to work. The report provided assurance that all possible actions were being taken at a difficult time for colleagues. SH queried whether the absence rate included iFM colleagues and raised concern if it did not that iFM absence could be higher. JM confirmed it did not and could obtain the attendance data and build this into a future People Committee Report.	
FT/23/09	iFM absence data to be included in future People Committee Report	**JM**
	JN queried whether this was included on Trust Induction. JM confirmed it was and staff can access the document on the staff intranet. **RESOLVED:** The Board of Directors ***received*** the Staff Health and Wellbeing Report.	

TB146/23	**Finance and Investment Committee Chair Report**	
	The Chair of the Finance and Investment Committee presented the Chair Reports from the meetings held on 27 September and 25 October 2023. A meeting was held on 22 November and a verbal update was provided advising that an additional £800m had been added to the NHS Together with a relaxation in activity targets, as a result of industrial action and additional pressures. GM had received £46m of these monies of which Bolton Foundation Trust had received £2.2m. The month seven finance report had been received which indicated a year to date deficit of £7.7m compared with a planned deficit of £7.3m. Capital expenditure for month seven was £1.8m and it was noted the cash position would become challenging during 2023/24 and this had been flagged a key concern during planning discussions with the ICB. The Chief Finance Officer advised the GM ICB position continued to forecast a deficit of £200m. **RESOLVED:** The Board of Directors ***received*** the Finance and Investment Committee.	
TB147/23	**Financial Controls Committee Chair Report**	
	The Chair of the Financial Controls Committee presented the Chair's Report and the Committee Terms of Reference which had been approved on [add date] It was noted that the FCC was a time limited committee that had been introduced to provide additional and targeted focus on the financial plans for the Trust given the financial challenges that the Trust was facing. RG thanked the finance team for their continued work to respond to a difficult position. **RESOLVED:** The Board of Directors ***received*** the Financial Controls Committee Chair Report and Terms of Reference.	
TB148/23	**Green Plan**	
	The Chief Finance Officer presented the Green Plan which provided summative points of the progress of the Green Plan and the status of all the targets. 79% of the targets were completed or on track to maintain compliance. 17% of targets were in progress, the majority of these were low risk and progress had been made to ensure these remained on track. The remaining 4% of targets were pending a review of the Green Group and a request to the Group had been made to postpone these. RG queried target 4.6 to procure certified renewable grid electricity. AW advised the target had been paused as it was a cost pressure. Target 2.2 to complete the	

	programme for LED lighting across the site would be completed as work went along. When a refresh of the plan is undertaken it will be established which targets are achievable. FLT asked how the Green Plan linked with the partner organisations plans. AW stated the Climate Group ensure there is an overarching approach and each organisation had a Green Plan in place. FA queried the target around developing a Climate Change Risk Assessment and maintaining a Climate Change Adaption Plan to highlight the risks to continuity and resilience of services. AW advised this action was progressing. **RESOLVED:** The Board of Directors ***received*** the Green Plan.	
TB149/23	**Board Assurance Framework**	
	The Director of Corporate Governance presented the Board Assurance Framework (BAF) advising that since the last presentation a review of the BAF had been undertaken by the executive directors and committees to ensure the process of identifying the main sources of risk continued to be balanced against the controls and assurances that were in place to enable discussion and scrutiny at the Board level. There were proposed changes in risk score for Ambition 1.1; 1.3 and 4. The Board were asked to note that the BAF would be presented at the Audit Committee in December and MIAA the Trust Internal Auditors were undertaking a review of the BAF. JN queried ambition five and the gap in assurance around the neighbourhood teams. FN advised the neighbourhood teams were being redefined and were not fully embedded. Although they were functioning well there would need to be consideration around how this was measured. **RESOLVED:** The Board of Directors ***received*** the Board Assurance Framework.	
TB150/23	**Feedback from Board Walkabouts**	
	AS advised he had visited General Surgery and theatres and each area displayed good team work and staff were enthusiastic. Each ward commented on delayed discharges due to the length of the process, AS spoke with an FY1 who advised the delay was usually due to workload. One of the wards commented they had a lot of food waste due to patients ordering their meals the previous day and then being discharged but a solution was being developed.	

	AS asked staff about the CQC report and was advised that this had little impact on the staff on the ground. AS also spoke with two overseas nurses who were very enthusiastic. RG advised she had visited D4 and had a good first impression. Staff stated in an ideal world it would be beneficial to have a specialist respiratory unit for part of the year, but they understood this was not possible and therefore made their own improvements to the ward. The ward were in the process of recruiting seven Nurse Associates and were undertaking events for their international nurses. Staff also commented they had developed an income opportunity as there was a training gap for respiratory professionals which they could provide. RG stated she had also visited Castle Hill Centre and spoke with the Homeless Team and the Admission Avoidance Team who have around 1000 patient contacts per month. NR advised he had visited Business Intelligence where he heard about the process to cleanse the data and also the team also told him about the training they complete with colleagues throughout the Trust. NR had also visited E4 and E5 were the biggest issue was around medical outliers. The team work on the wards was evident. SH queried how the information from the walkabouts was captured and how all quality information was measured. JN commented there was a high level of complexity within the NHS with data being required to meet both statutory and regulatory requirements. There is a need for the Board to be able to triangulate this information. SK added consideration could be given to how the themes from walkabouts could be captured.	
FT/23/10	SK to consider how themes from walkabouts could be captured.	**SK**
	RESOLVED: The Board of Directors ***received*** the Board Walkabout Update.	
TB151/23	**EPRR Core Standards Report**	
	The EPRR was received which provided 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. **RESOLVED:** The Board of Directors ***approved*** the EPRR Core Standard Report.	

TB152/23	**PSIRF Policy**	
	The PRIRF Policy was received for approval following the introduction of the Patient Incident Response Framework (PSIRF) in August 2022. **RESOLVED:** The Board of Directors ***approved*** the PSIRF Policy.	
CONCLUDING BUSINESS		
TB153/23	**Questions to the Board**	
	None.	
TB154/23	**Messages from the Board**	
	The following key messages from the Board were agreed: • Finance • Elective recovery continued whilst also focussing on finance • Data quality	
TB155/23	**Any Other Business**	
	There being no other business, the chair thanked all for attending and brought the meeting to a close at insert time The next Board of Directors meeting will be held on Thursday 25 January 2024.	

Meeting Attendance 2022/23										
Members	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**	**May**	**July**	**Sept**	**Nov**
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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sean Harriss										✓
Fiona Taylor										✓
Seth Crofts										✓
Tosca Fairchild										**A**
In Attendance	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**	**May**	**July**	**Sept**	**Nov**
Sharon Katema	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Lowey	✓	✓								
Rachel Tanner	✓	**A**	✓	✓	✓	✓	✓	**A**	**A**	**A**
Niruban Ratnarajah	**A**	✓	✓	✓	✓	✓	**A**			
Lynn Donkin			✓	✓	✓	✓	✓	**A**	**A**	✓
Naomi Ledwith									✓	✓
✓ = In attendance A = Apologies							✓	✓	✓	✓

November 2023 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/23/09	30/11/2023	Staff Health and Wellbeing Report	iFM absence data to be sent to SH and both iFM and Trust data would be reported to People Committee	JM	Jan-24	Complete
FT/23/11	20/11/2023	Sexual Health Tender	Family Care Division to ascertain whether Sexual Health service operating within financial budget and broader consideration to be given to whether all services were operating within financial envelope	AW	Jan-24	Complete - added to Finance and Investment committee 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	Mar-24	
FT/23/08	30/11/2023	Clinical Strategy	Update on how Clinical Strategy aligns with the overarching Corporate Strategy to be presented at a future Board meeting.	SW	Mar-24	
FT/23/10	20/11/2023	Feedback from Board Walkabouts	SK to consider how themes from walkabouts could be captured.	SK	Mar-24	

Key

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		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	To note the update.

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

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

Ambition 1
Provide safe, high quality care

Our new clinical strategy has now been published, setting out our five-year plan for how we will provide the best possible clinical services by adapting to the evolving healthcare needs of our population whilst balancing the delivery of safe, high quality and financially sustainable services.

The strategy comprises three goals - improving people's experience, innovating and collaborating for the future and playing our part in improving people's health, all of which have been shaped by the knowledge, experience and ambition of our expert staff who deliver and support our services. Our divisions and corporate teams are in the process of developing the delivery plans that will make our clinical strategy and goals a reality.

The longest period of industrial action in NHS history took place across six days, starting at 7am on Wednesday 3 January and finishing at 7am on Tuesday 9 January 2024. Our junior doctors are such a valued and integral part of our workforce. It has been brilliant to see how teams have worked together to do everything they could to maintain patient safety over the affected periods, as well as to support colleagues through this difficult time.

During the strike period, our Emergency Department welcomed Channel 5 for a short interview with Matron Laura Wells, and Medical Director Dr Francis Andrews, to help the public understand the impact and all that NHS services were doing to minimise disruption.

Our booking teams continued to support patient queries throughout the industrial action, with an average of 500 phone calls per day, and are currently working closely with clinicians to reschedule appointments and ensure our patients are seen as quickly as possible.

The industrial action, seasonal illnesses such as viruses and sickness bugs, and an increase in people coming forward for help over the festive period have all had a significant impact on our services. As a result during December and January, we have continued to appeal to the public and remind them of the most appropriate places to go for treatment.

The Trust has been recognised as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits. The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement procedures to improve clinical outcomes for the benefit of patients, but also to support and give performance feedback to orthopaedic clinicians and industry manufacturers.

Our research team works across our acute and community settings to support the delivery of important health research to improve the delivery and quality of care for people in Bolton both now and in the future. The Trust has been named the highest recruiting Trust in the country for an innovative study that uses a urine test to support with the diagnosis of womb cancers.

Ambition 2
To be a great place to work

On Friday 24 November, the 18 winners of this year's FABB (for a better Bolton) Awards were revealed after judges had the difficult job of reading through a record 827 nominations that had been submitted by staff and patients. It is with huge thanks to our sponsors including Core to Cloud, Altera Health and the University of Bolton for making the event possible. Over 300 people attended the event and more than £1,600 was raised for Our Bolton NHS Charity through a raffle packed with prizes.

Disability History Month took place between 16 November and 16 December 2023, enabling us to highlight the progress we have made towards inclusivity for our colleagues with disabilities, long-term health conditions and neurodivergence. During this time, we launched a brand new colleague support group, a neurodiversity toolkit, and a reasonable adjustments passport for all staff who need adaptations or considerations to be made to do their job to the best of their ability.

Figures from the 2021 Census revealed that more than 7,000 veterans were living in Bolton and since then, we have been working to improve the support provided to veterans and armed services personnel, for both staff and patients. Back in April 2023, we received the Veteran Aware reaccreditation, which makes us one of 147 NHS accredited providers across England, having met the standards laid down by the Veterans Covenant Healthcare Alliance (VCHA). We also have Armed Forces and Veteran information packs in place that are available for identified veterans or serving armed forces members following admission to hospital.

In addition to the support we have put in place for Armed Forces veterans, NHS England has rolled out an expanded mental health support service, after a survey found that more than half of respondents find it difficult to speak up about mental health issues. The Op COURAGE increased service has been designed by veterans, for veterans and accepts referrals from individuals, family member or friends, and health professionals.

Progress with Our Voice Change programme has continued with the formation of five change teams to define measurable outcomes and implement the changes that will make the biggest difference to our staff, over the coming months. All staff are invited to join a team based on their interest in the current themes identified by our workforce, which are digital systems and equipment, car parking, working environments, flexible working and living our values.

Ambition 3
To use our resources wisely

Along with all other NHS organisations in Greater Manchester, we continue to operate in a period of financial recovery and improvement to address the significant deficit we are dealing with across the region.

Financial recovery at this scale is only going to be possible with a concerted effort, with 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.

Locally in Bolton, our Financial Improvement Group (FIG) with representatives from our Executive Team, divisions and corporate teams is in place to identify and deliver plans that will improve the Trust's financial position, whilst maintaining the delivery of safe and effective services.

Action to date has included establishing a vacancy control panel to manage the advertising of posts, ramping up our cost improvement programme across the Trust, reviewing all spend and our enhanced rates of pay have been standardised to align with the rest of Greater Manchester.

The next twelve months will continue to be a challenge for financial improvement and the focus over the next three months will be to ensure cost improvement plans are in place and ready to implement from April 2024.

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

Since identifying reinforced autoclaved aerated concrete (RAAC) on our hospital site in November 2023 we have taken the necessary action make sure that our staff, patients and visitors remain safe in our buildings. This has included an ongoing programme of inspection of the identified RAAC planks, propping the known affected areas whilst we do detailed surveys of the department and areas, and safely decanting the affected areas to allow us to commence essential works.

A full survey of the hospital site is now underway. In order to carry out the inspections and any remedial work there may be some unavoidable disruption, including ward and service moves. We will continue to communicate the detail of this to patients and service users who are attending appointments in a different area as a result. We continue to work with the national NHS RAAC experts to ensure the right steps are being taken to manage any issues to ensure the safety of our patients, visitors, and staff.

The safety of our staff and patients remains our utmost priority and we thank patients, visitors and our staff for their patience and understanding while these vital works are being carried out.

Some of the key developments on our Royal Bolton Hospital site are coming to fruition. Our four new theatres officially opened on 15 January and is being utilised by our staff and patients. Our Community Diagnostic Centre is progressing well and remains on track to open on 18 March. Finally, the Institute of Medical Sciences, previously called the Bolton College of Medical Sciences, remains on course to open for the next educational year in September 2024. We look forward to the difference and impact our new developments will have on our communities and current and future workforce.

Ambition 5
To integrate care

A new initiative between the Trust and care homes across the town has seen a significant reduction in the number of people arriving at Royal Bolton Hospital. The pilot scheme took

place between July and October 2023, and encouraged care homes to contact the Trust's Admission Avoidance Team for patients at risk of urgent hospital admission, instead of emergency ambulance crews.

It forms part of the two-hour urgent community response (UCR) service, a national project to provide older people with fast access to care whilst taking pressure off hospital and ambulance services.

During the trial period, data shows an increase in referrals to the Admission Avoidance Team and a reduction in the number of calls to North West Ambulance Service. There was also a significant reduction in the number of attendances to the Emergency Department, with figures from one care home recording a fall of 68% and a 65% reduction in the number hospital admissions.

We have been supported by a nursing led funded care team which is in place to support hospital discharges across Greater Manchester. The team has been supporting colleagues across our hospital and community services to improve timely discharges and care, especially when a patient has complex circumstances and needs additional support finding the right funded place to go to once they leave hospital.

The team has an increasing number of complex packages to arrange, review and monitor due to the number of patients transitioning from children's to adult care, and as more patients with long term conditions require nursing care in community.

Ambition 6
To develop partnerships

In Bolton, we are working together as one team to make improvements for our local people. Together, we call ourselves the Bolton Health and Care Partnership which is a commitment to working closely together to solve problems and improve the lives of our population. As a partnership, we have developed a five year Locality Plan, which describes our collective ambition and commitment to working across our place to meet the needs of our communities. The plan will be published in the coming months and shared with all staff, partners and our communities.

Our valued partners and communities have continued to make donations through Our Bolton NHS Charity, to make a difference to our patients and staff. Hundreds of gifts were donated to lift the spirits of patients who were staying in hospital over Christmas and the staff who were caring for them.

Donors included Bolton Wanderers who made a surprise visit to our children's wards and paediatric Emergency Department, Overbury who visited our Enhanced Care Lounge, and Apogee Corporation who donated gifts to be distributed over the Christmas and New Year period.

Tesco kindly donated 1,500 children's and adult's books for patients to use during their stay at Royal Bolton Hospital. The supermarket's Oakwood Distribution Centre have made use of surplus stock to donate items to organisations where it can make a difference to the experience of others.

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	✓
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, Director of People

Bolton NHS Foundation Trust

Integrated Performance Report

December 2023

Guide to Statistical Process Control

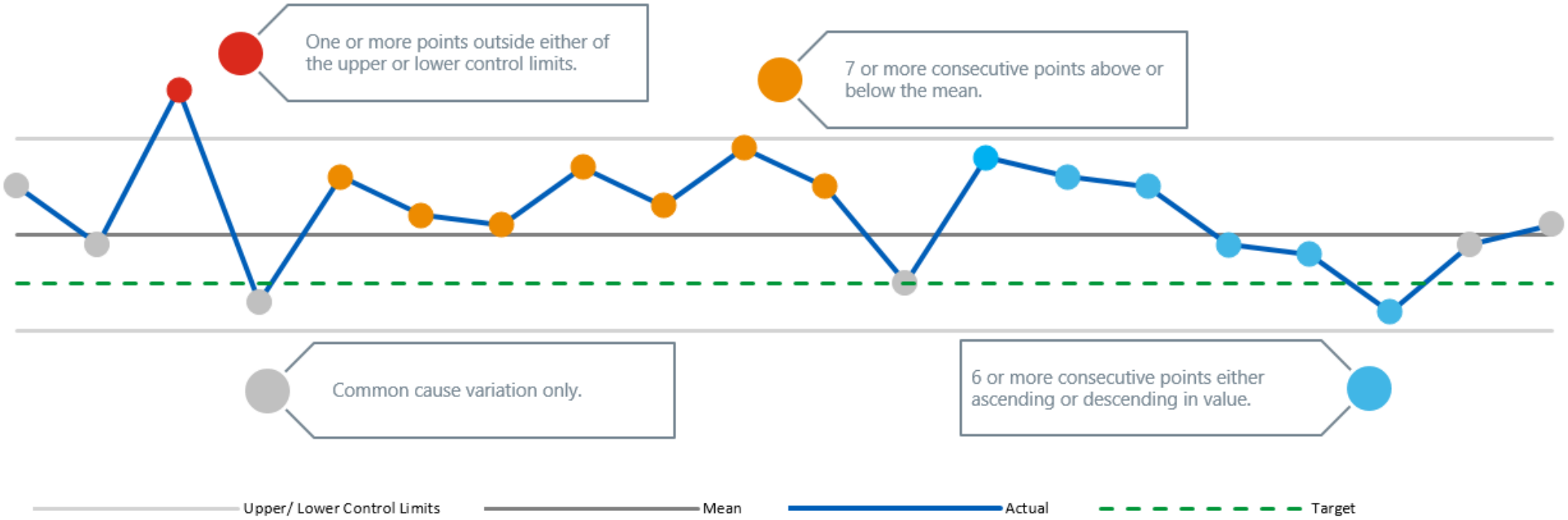
NHS Bolton NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	4	4	1	0	2	3	11
Infection Prevention and Control	6	0	3	1	0	0	0	7
Mortality	3	2	1	0	1	0	0	3
Patient Experience	10	6	0	0	0	2	0	14
Maternity	8	0	0	0	1	1	0	8
Operational Performance								
Urgent Care	7	0	1	2	1	2	5	4
Elective Care	7	0	3	4	1	1	6	5
Cancer	1	0	0	0	0	0	0	1
Community Care	3	0	0	0	2	0	2	3
Workforce								
Sickness, Vacancy and Turnover	3	0	1	0	0	0	2	1
Organisational Development	2	3	0	0	1	1	2	3
Agency	0	0	2	1	0	0	0	0
Finance								
Finance	2	1	0	0	0	0	0	0
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

Continued special cause improvement category 3 pressure ulcers in-patient, and zero category 4 in-patient.
Category 2 pressure ulcer improvement and zero unstageable ulcers reported in month, whilst this is not a statistical improvement, this is the first time we have reported zero in over 12 months. Work continues to drive down the number of overall pressure ulcers through the collaborative.

Four falls with harm reported in month, all subject to full investigation in line with PSIRF framework. No immediate learning identified.

Same sex accommodation breaches continue to remain high, breaches reviewed and all reported from critical care due to inability to step down

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	97.4%	Dec-23	H	>= 95%	97.9%	Nov-23	>= 95%	98.0%	?
9 - Never Events	= 0	0	Dec-23		= 0	1	Nov-23	= 0	2	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.12	Dec-23	L	<= 5.30	3.77	Nov-23	<= 5.30	3.98	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	4	Dec-23		<= 1.6	0	Nov-23	<= 14.4	15	?
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	7.0	Dec-23		<= 6.0	9.0	Nov-23	<= 54.0	120.0	?
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Dec-23	L	<= 0.5	0.0	Nov-23	<= 4.5	0.0	?
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Dec-23	L	= 0.0	0.0	Nov-23	= 0.0	2.0	?
515 - Acute Inpatients acquiring pressure damage (unstagable)		0	Dec-23			2	Nov-23		38	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	9.0	Dec-23		<= 7.0	11.0	Nov-23	<= 63.0	95.0	?
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	1.0	Dec-23		<= 4.0	0.0	Nov-23	<= 36.0	3.0	P
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Dec-23		<= 1.0	0.0	Nov-23	<= 9.0	4.0	?

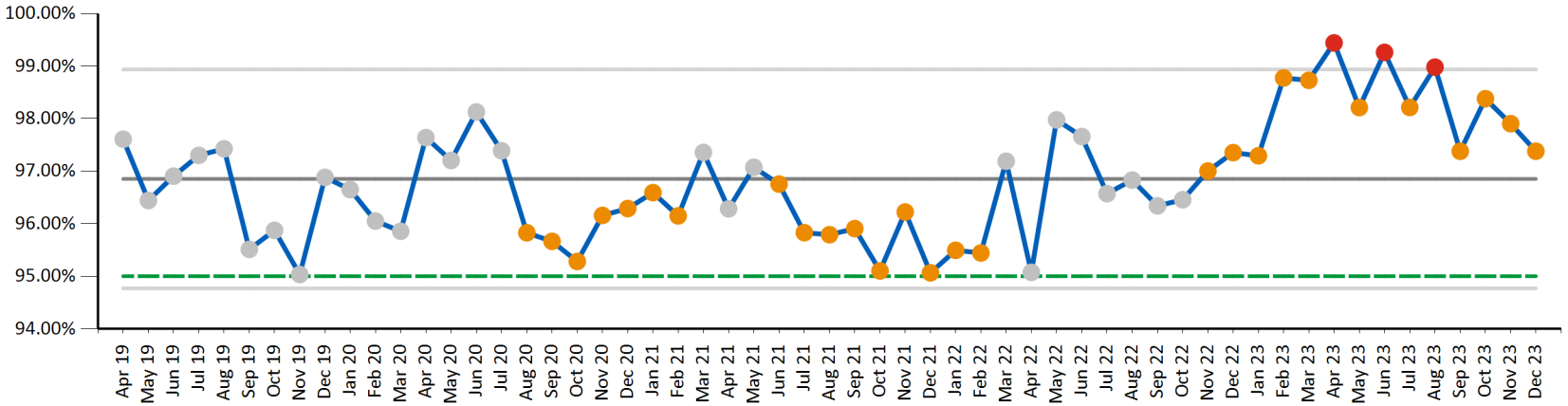
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
516 - Community patients acquiring pressure damage (unstagable)		7	Dec-23			9	Nov-23		54	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Dec-23	L		0	Nov-23		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Dec-23			0	Nov-23		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Dec-23			0	Nov-23		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	73.9%	Dec-23		>= 95%	74.7%	Nov-23	>= 95%	72.0%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	66.5%	Dec-23		>= 95.0%	75.7%	Nov-23	>= 95.0%	77.5%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Dec-23	H	= 100%	100.0%	Nov-23	= 100%	100.0%	?
88 - Nursing KPI Audits	>= 85%	95.7%	Dec-23	H	>= 85%	95.6%	Nov-23	>= 85%	94.8%	P
91 - SI's 60 day turnaround performance	= 100%	100.0%	Dec-23	H	= 100%	100.0%	Nov-23	= 100%	76.9%	?
8 - Same sex accommodation breaches	= 0	20	Dec-23	H	= 0	20	Nov-23	= 0	168	F

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%	97.4%	Dec-23

Previous

Plan	Actual	Period
>= 95%	97.9%	Nov-23

Year to Date

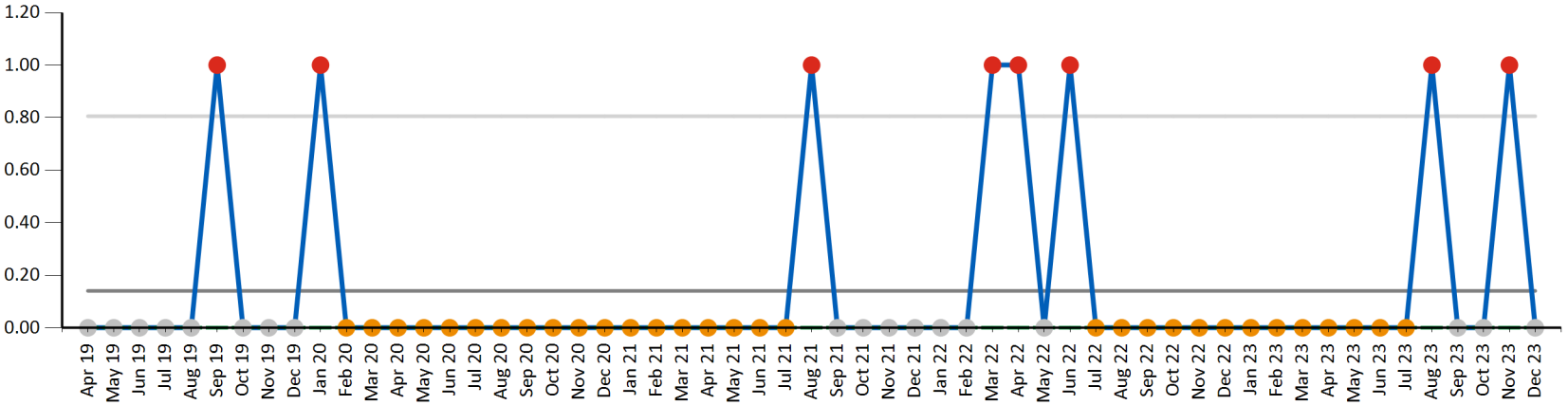
Plan	Actual
>= 95%	98.0%

9 - Never Events

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 0	0	Dec-23

Previous

Plan	Actual	Period
= 0	1	Nov-23

Year to Date

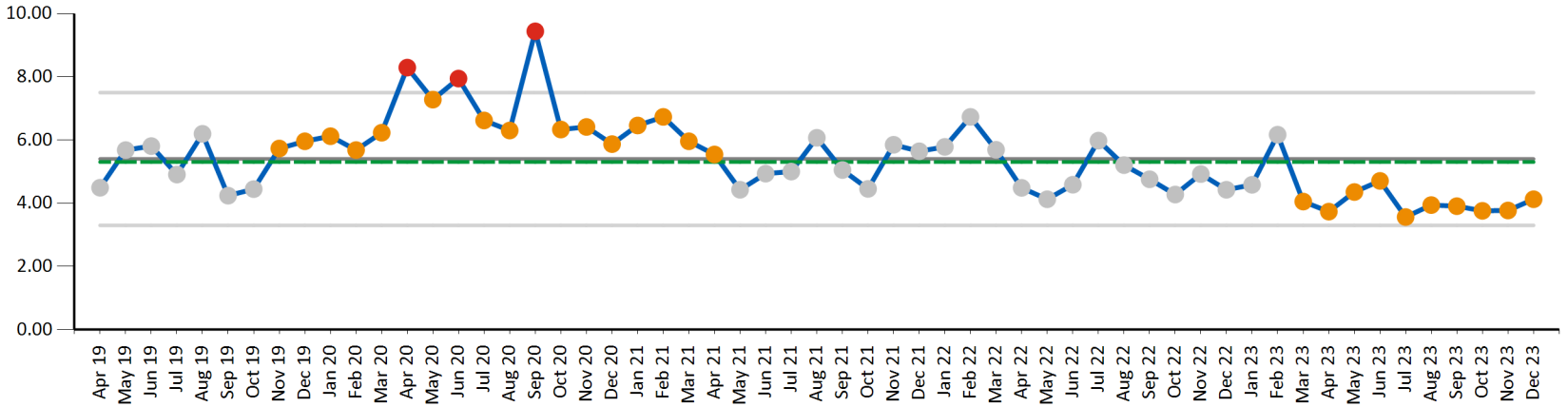
Plan	Actual
= 0	2

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 5.30	4.12	Dec-23

Previous

Plan	Actual	Period
<= 5.30	3.77	Nov-23

Year to Date

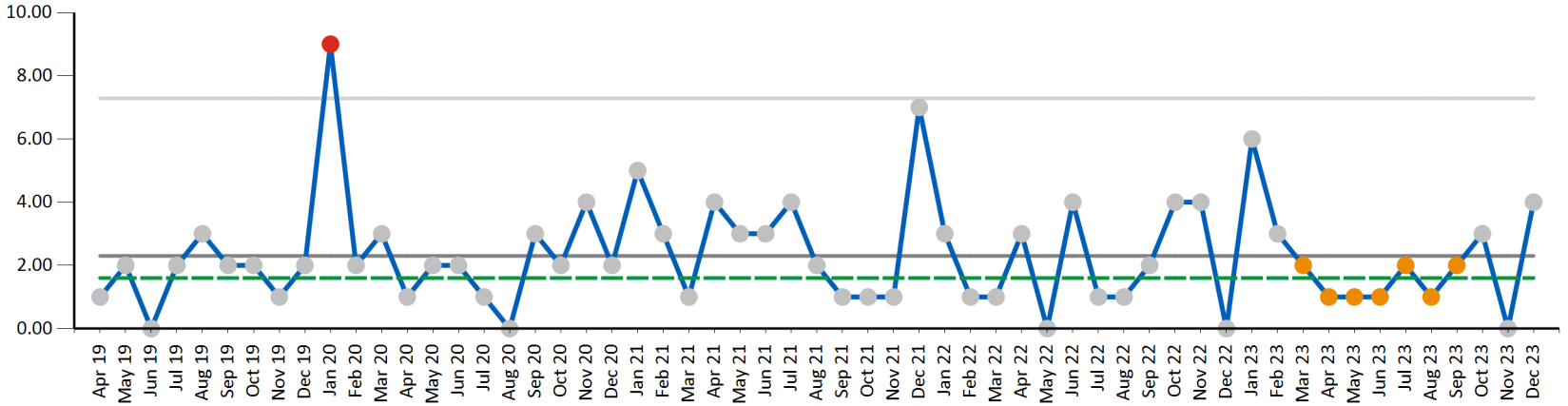
Plan	Actual
<= 5.30	3.98

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1.6	4	Dec-23

Previous

Plan	Actual	Period
<= 1.6	0	Nov-23

Year to Date

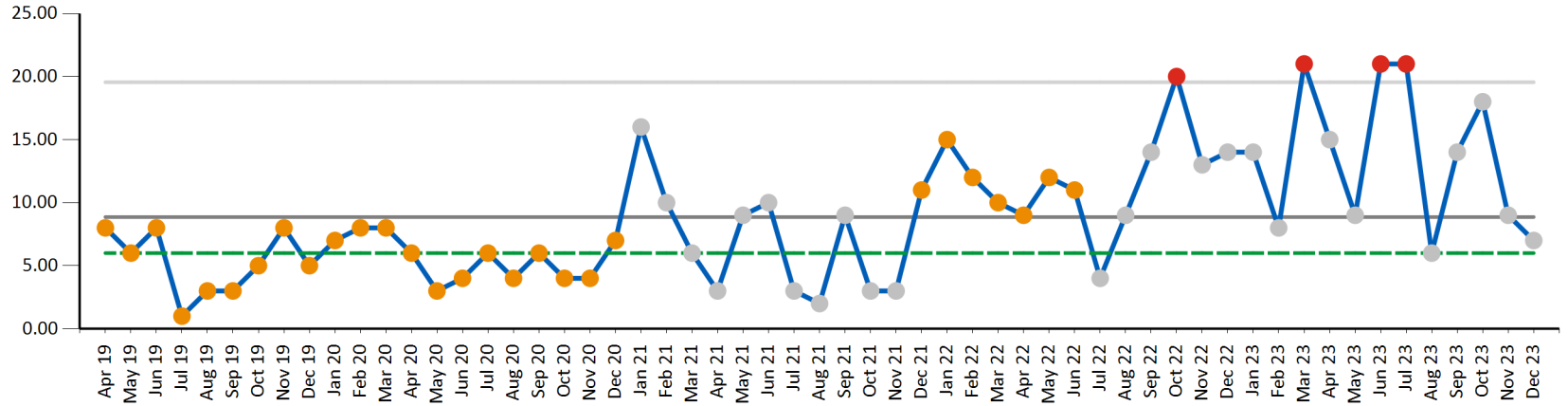
Plan	Actual
<= 14.4	15

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	7.0	Dec-23

Previous

Plan	Actual	Period
<= 6.0	9.0	Nov-23

Year to Date

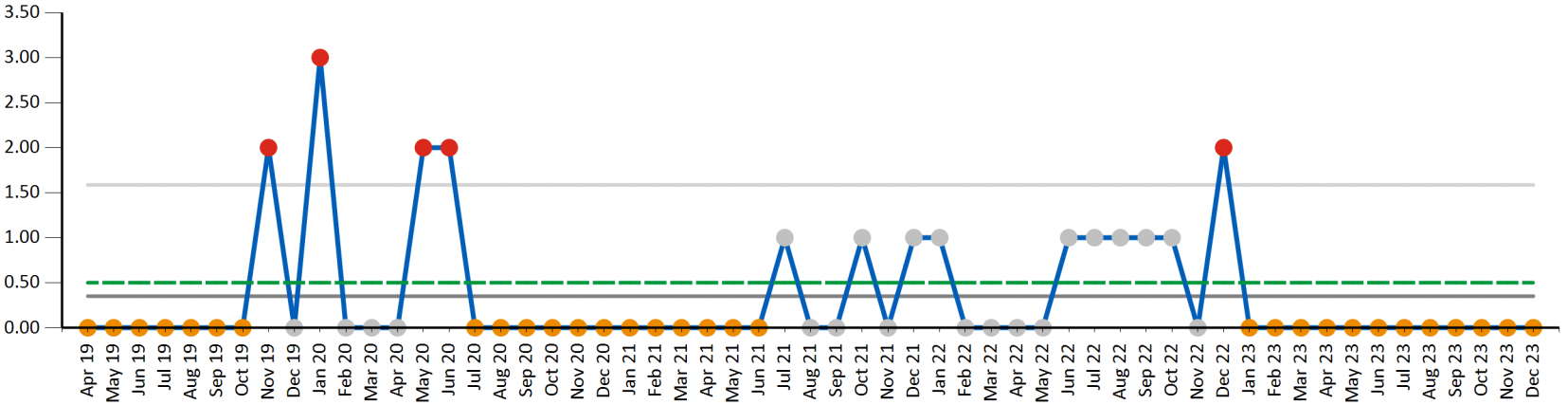
Plan	Actual
<= 54.0	120.0

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	Dec-23

Previous

Plan	Actual	Period
<= 0.5	0.0	Nov-23

Year to Date

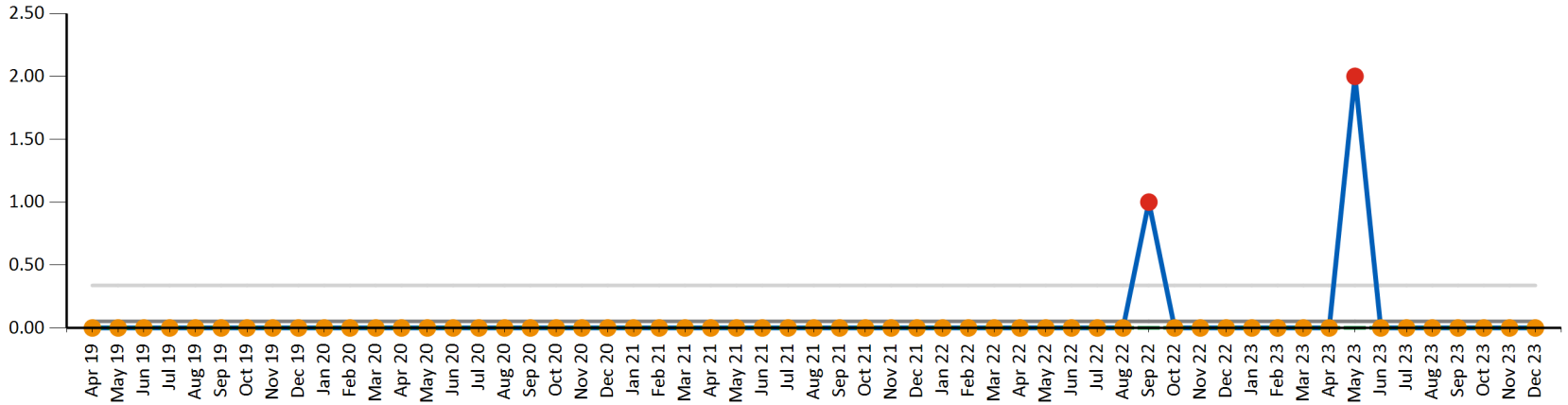
Plan	Actual
<= 4.5	0.0

17 - Acute Inpatients acquiring pressure damage (category 4)

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 0.0	0.0	Dec-23

Previous

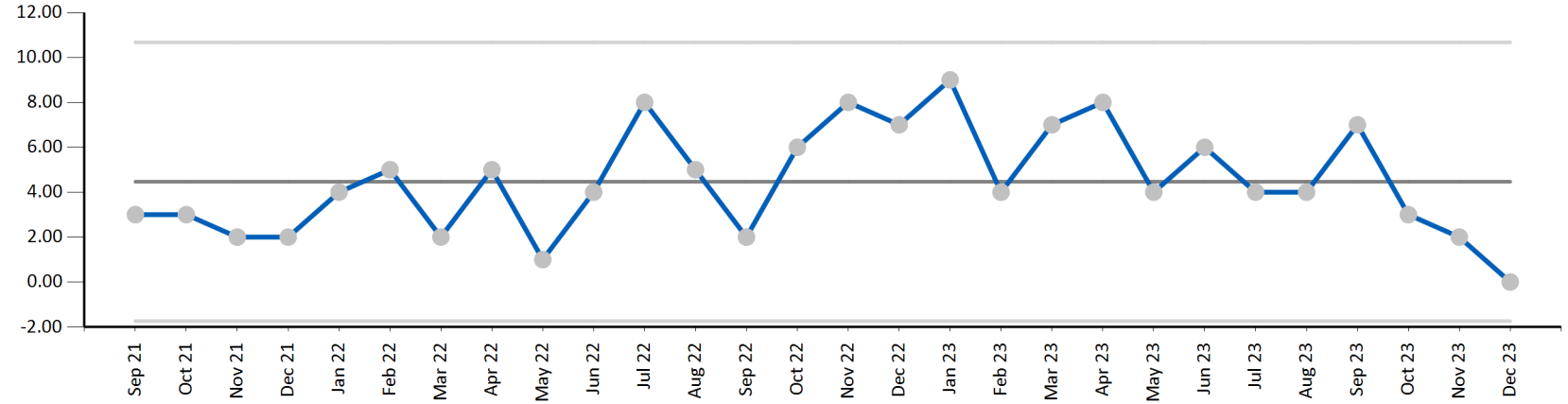
Plan	Actual	Period
= 0.0	0.0	Nov-23

Year to Date

Plan	Actual
= 0.0	2.0

515 - Acute Inpatients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-23

Previous

Plan	Actual	Period
	2	Nov-23

Year to Date

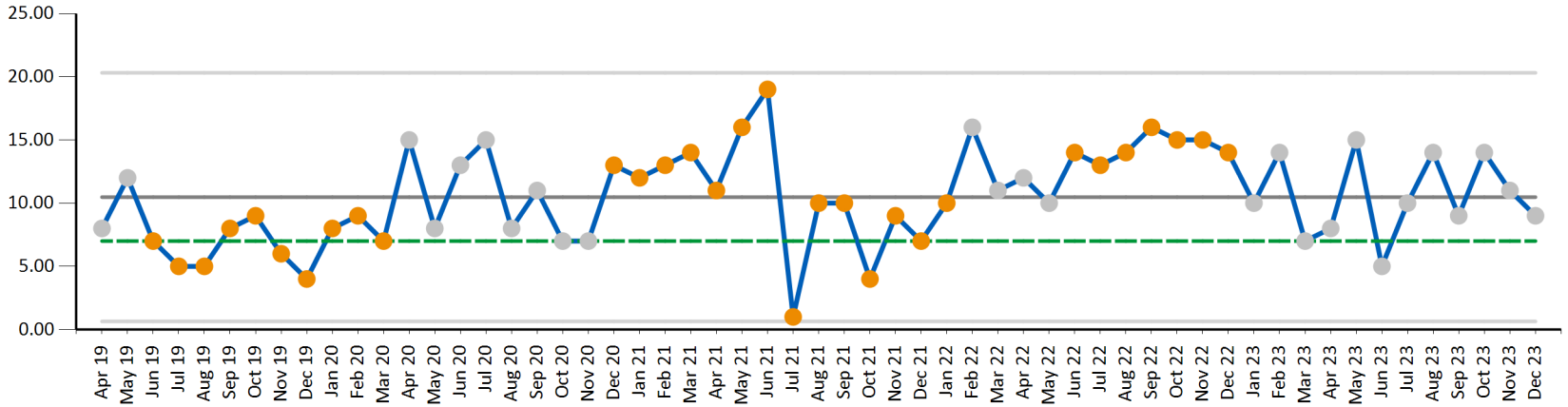
Plan	Actual
	38

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 7.0	9.0	Dec-23

Previous

Plan	Actual	Period
<= 7.0	11.0	Nov-23

Year to Date

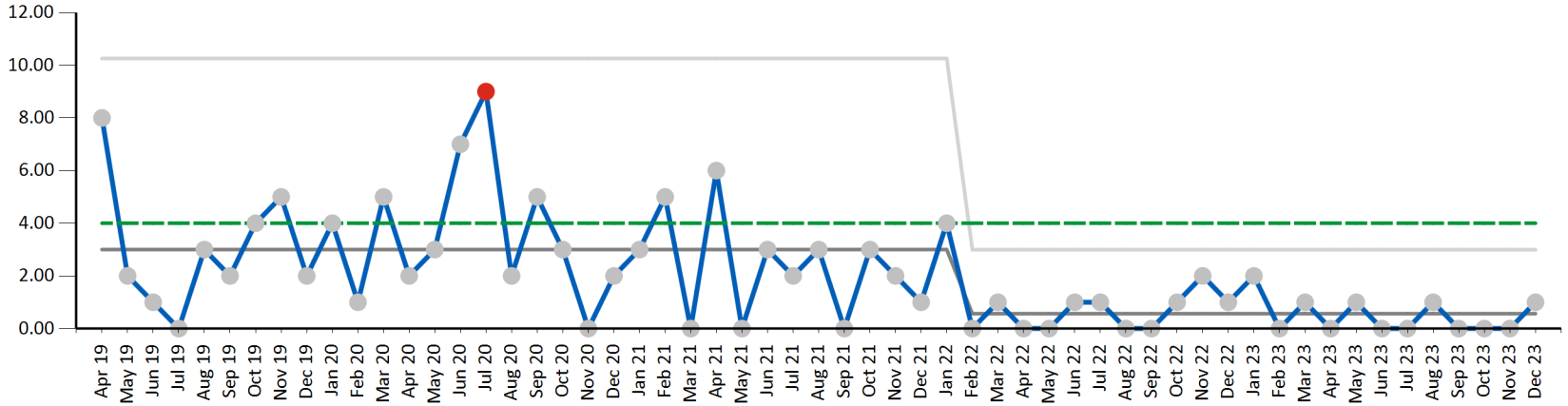
Plan	Actual
<= 63.0	95.0

19 - Community patients acquiring pressure damage (category 3)

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 4.0	1.0	Dec-23

Previous

Plan	Actual	Period
<= 4.0	0.0	Nov-23

Year to Date

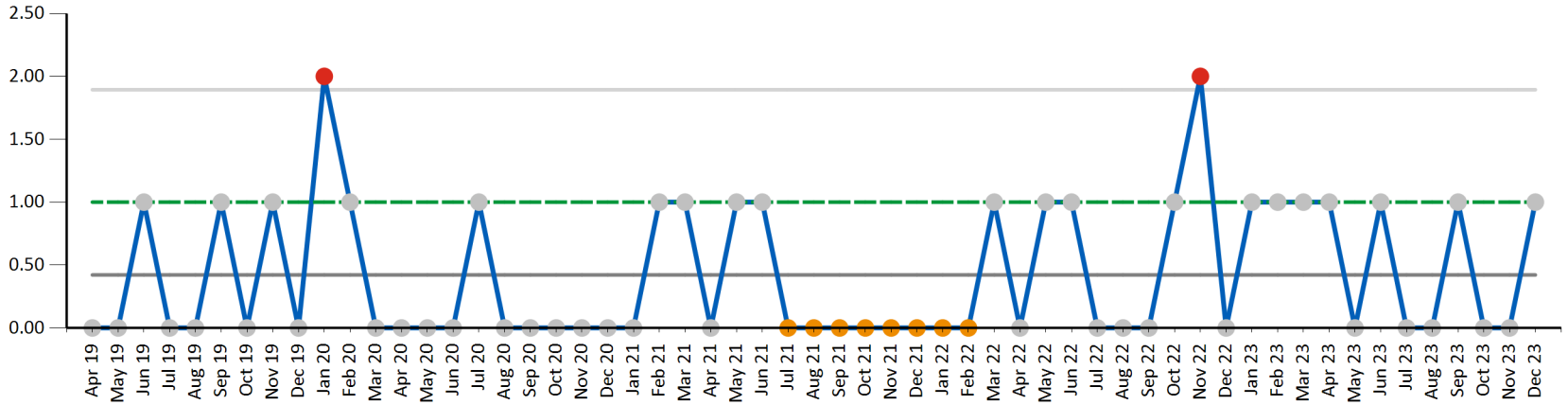
Plan	Actual
<= 36.0	3.0

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	1.0	Dec-23

Previous

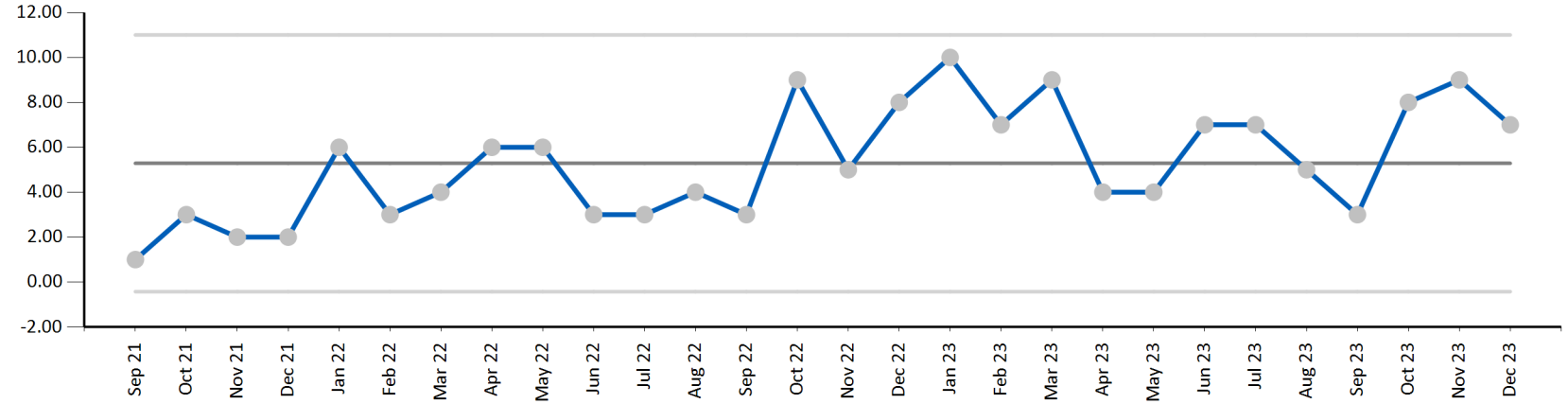
Plan	Actual	Period
<= 1.0	0.0	Nov-23

Year to Date

Plan	Actual
<= 9.0	4.0

516 - Community patients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	7	Dec-23

Previous

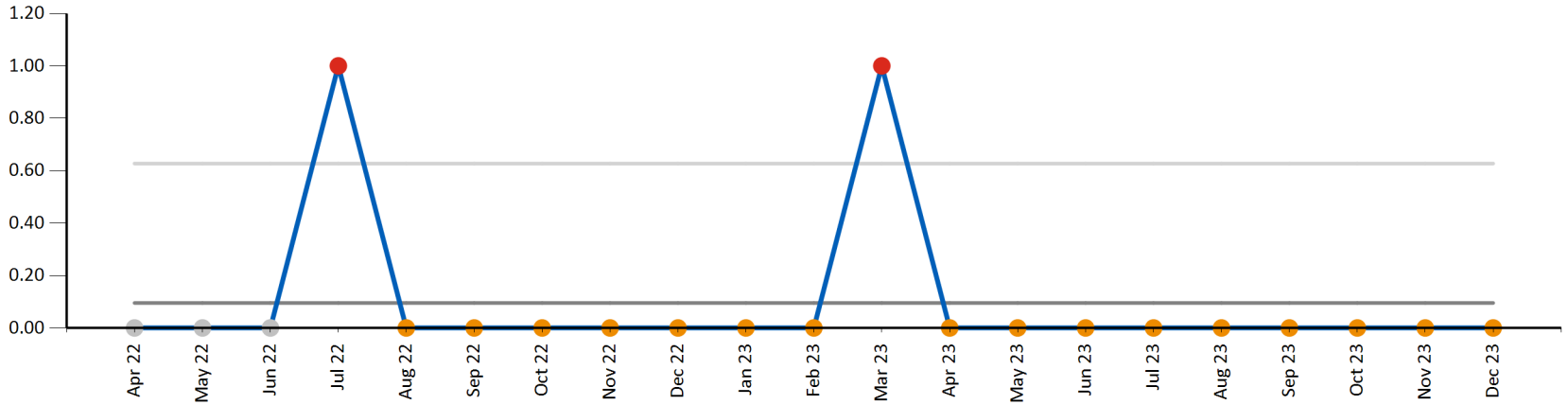
Plan	Actual	Period
	9	Nov-23

Year to Date

Plan	Actual
	54

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Dec-23

Previous

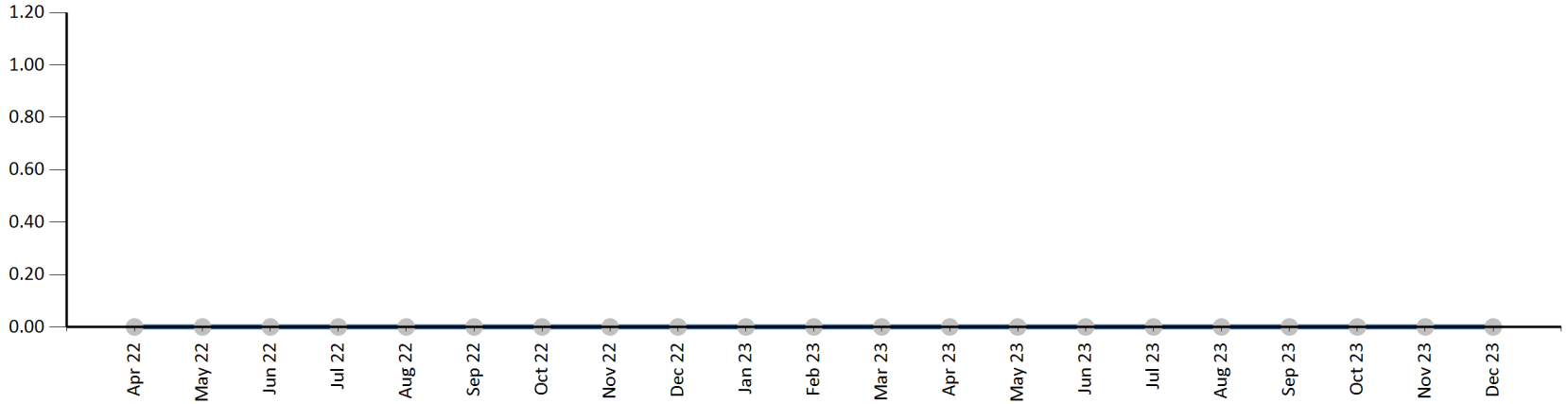
Plan	Actual	Period
	0	Nov-23

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-23

Previous

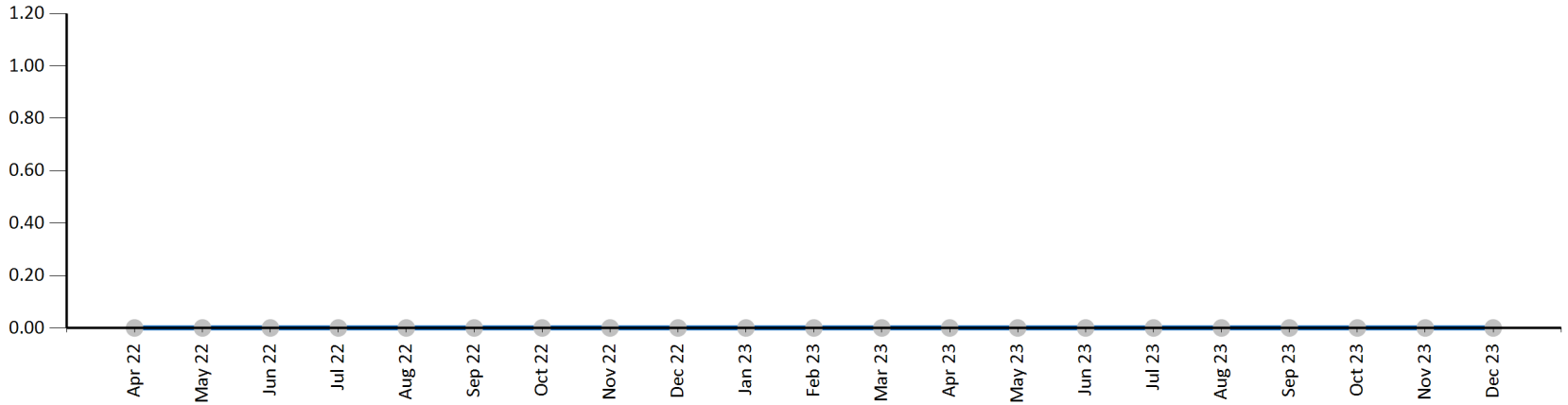
Plan	Actual	Period
	0	Nov-23

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-23

Previous

Plan	Actual	Period
	0	Nov-23

Year to Date

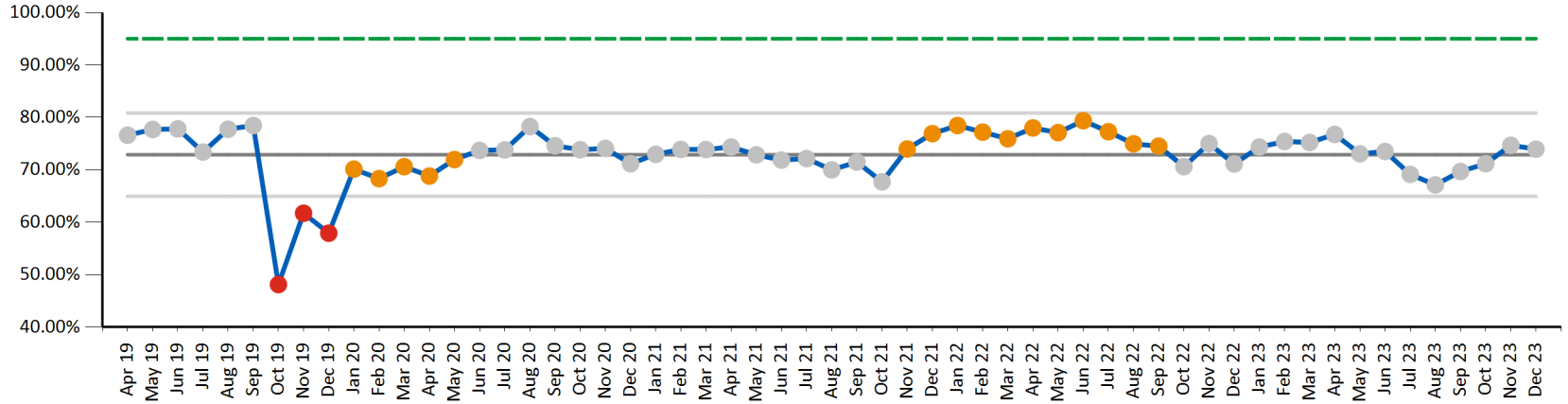
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Common cause variation.

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	73.9%	Dec-23

Previous

Plan	Actual	Period
>= 95%	74.7%	Nov-23

Year to Date

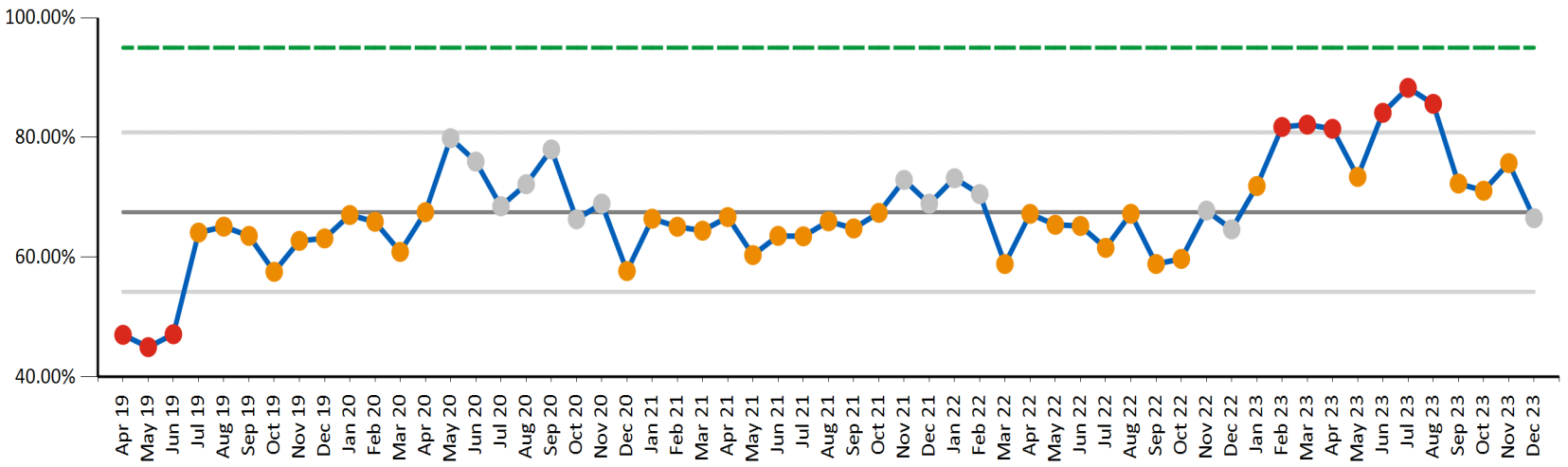
Plan	Actual
>= 95%	72.0%

31 - Clinical Correspondence - Outpatients %<5 working days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
> = 95.0%	66.5%	Dec-23

Previous

Plan	Actual	Period
> = 95.0%	75.7%	Nov-23

Year to Date

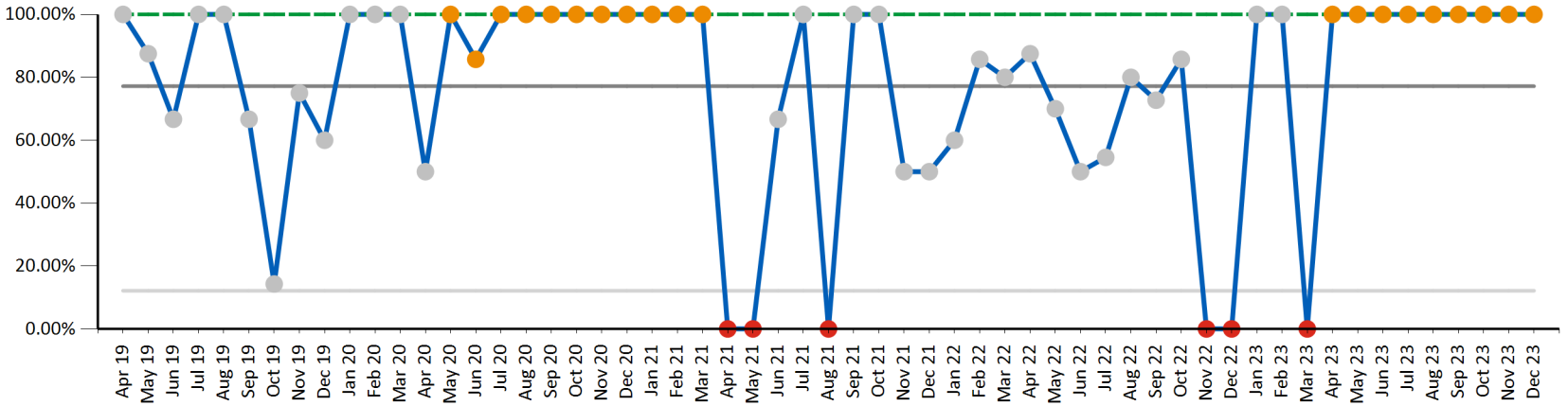
Plan	Actual
> = 95.0%	77.5%

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%	Dec-23

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-23

Year to Date

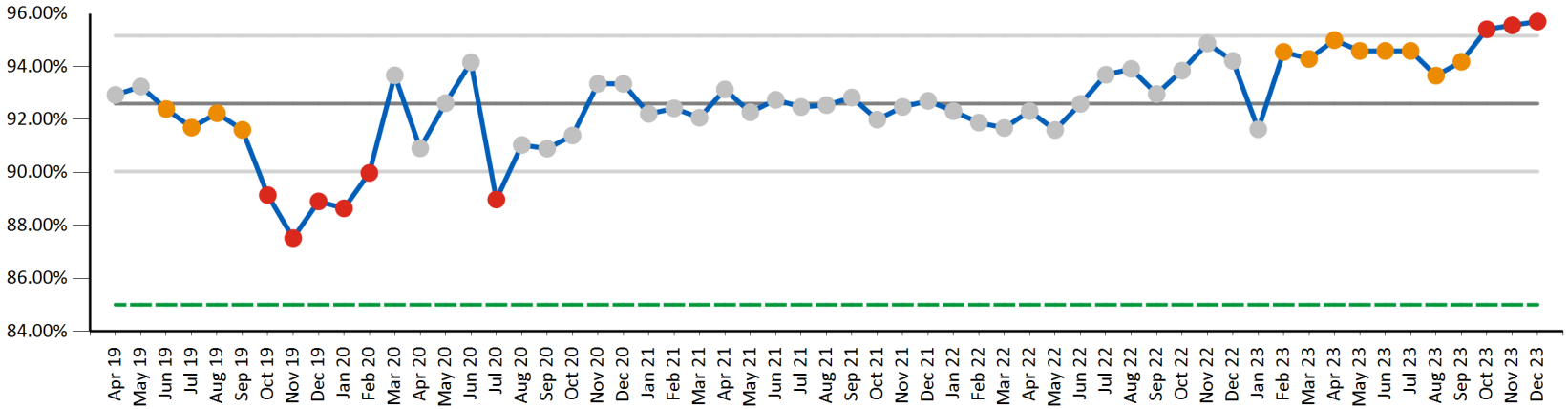
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.7%	Dec-23

Previous

Plan	Actual	Period
>= 85%	95.6%	Nov-23

Year to Date

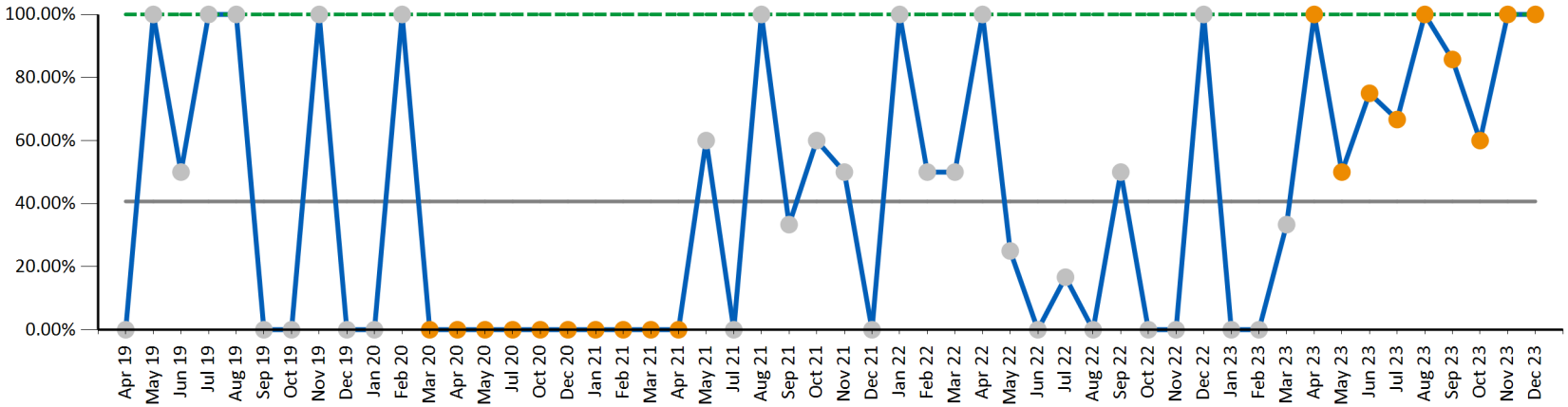
Plan	Actual
>= 85%	94.8%

91 - SI's 60 day turnaround performance

Special cause variation with improving performance

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

3/6



Latest

Plan	Actual	Period
= 100%	100.0%	Dec-23

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-23

Year to Date

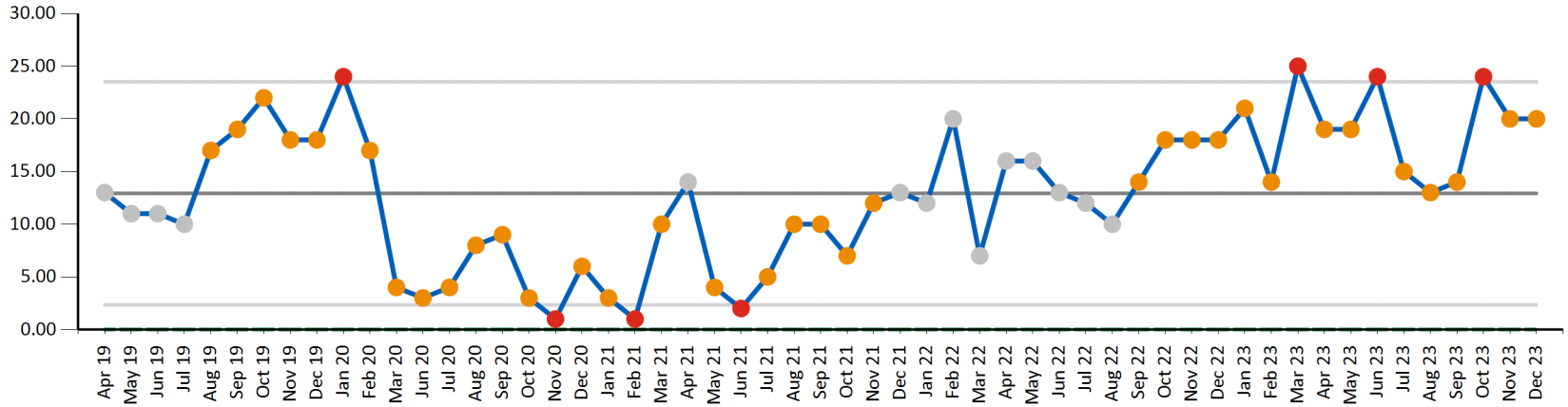
Plan	Actual
= 100%	76.9%

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	20	Dec-23

Previous

Plan	Actual	Period
= 0	20	Nov-23

Year to Date

Plan	Actual
= 0	168

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

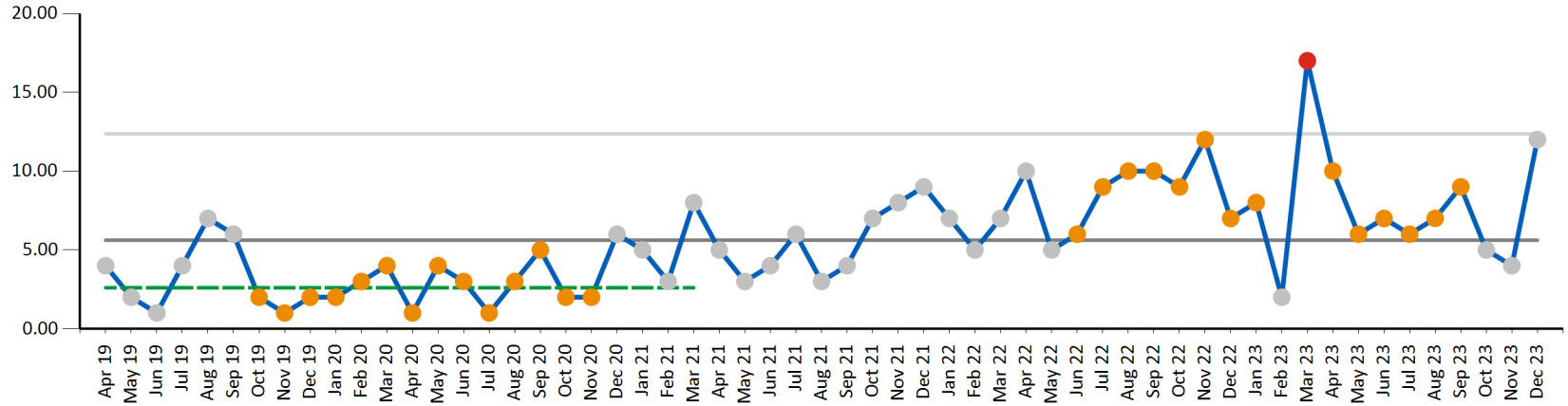
There were 17 Clostridium difficile cases in December counting towards the Trust objectives – 12 hospital onset and 5 from patients with a community onset where the patient has been an inpatient at Bolton in the previous 28-days. This is the highest number of hospital onset cases in 22/23. The Trust has been under operational pressures due to bed availability and this will have had an impact on the speed for isolating patients and there has also been a significant amount of norovirus. Often these two issues are related with more patients with loose stool, more samples sent and more Clostridium difficile cases identified. That does not appear from an initial review to have been the case. Proposals are being developed to identify how we can further amend our pathways to control the number of cases and protect patients from infection.
There have been improvements across the other measured metrics in month and for MSSA in particular, there have been 13 fewer cases in 23/24 year-on-year.

The Trust has been impacted by influenza infections but to a lesser degree than in 22/23 with 189 cases of flu to the end of December 2023 compared to 877 cases at the same point in 2022.

	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		12	Dec-23			4	Nov-23		66	
346 - Total Community Onset Hospital Associated C.diff infections		5	Dec-23			4	Nov-23		27	
347 - Total C.diff infections contributing to objective	<= 7	17	Dec-23	H	<= 7	8	Nov-23	<= 59	93	?
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Dec-23	L	= 0	0	Nov-23	= 0	1	?
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	5	Dec-23		<= 4	8	Nov-23	<= 37	49	?
219 - Blood Culture Contaminants (rate)	<= 3%	2.4%	Dec-23	L	<= 3%	2.6%	Nov-23	<= 3%	2.8%	?
304 - Total Trust apportioned MSSA BSIs	<= 1.0	0.0	Dec-23		<= 1.0	1.0	Nov-23	<= 9.0	9.0	?
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	1	Dec-23		<= 1	0	Nov-23	<= 5	11	?
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Dec-23		= 0	1	Nov-23	= 0	4	?
491 - Nosocomial COVID-19 cases		16	Dec-23	L		5	Nov-23		167	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	12	Dec-23

Previous

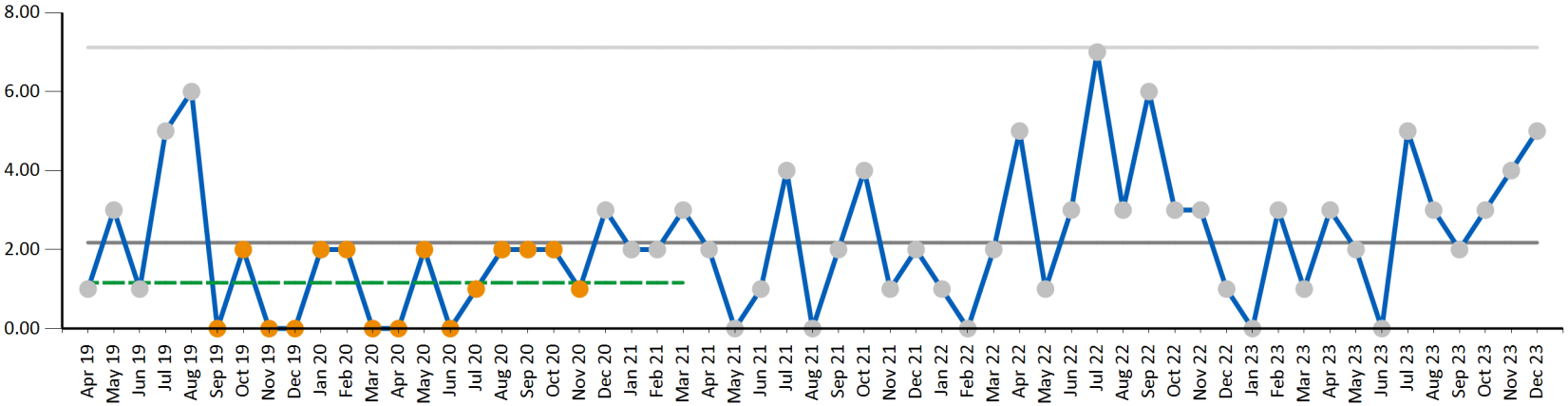
Plan	Actual	Period
	4	Nov-23

Year to Date

Plan	Actual
	66

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Dec-23

Previous

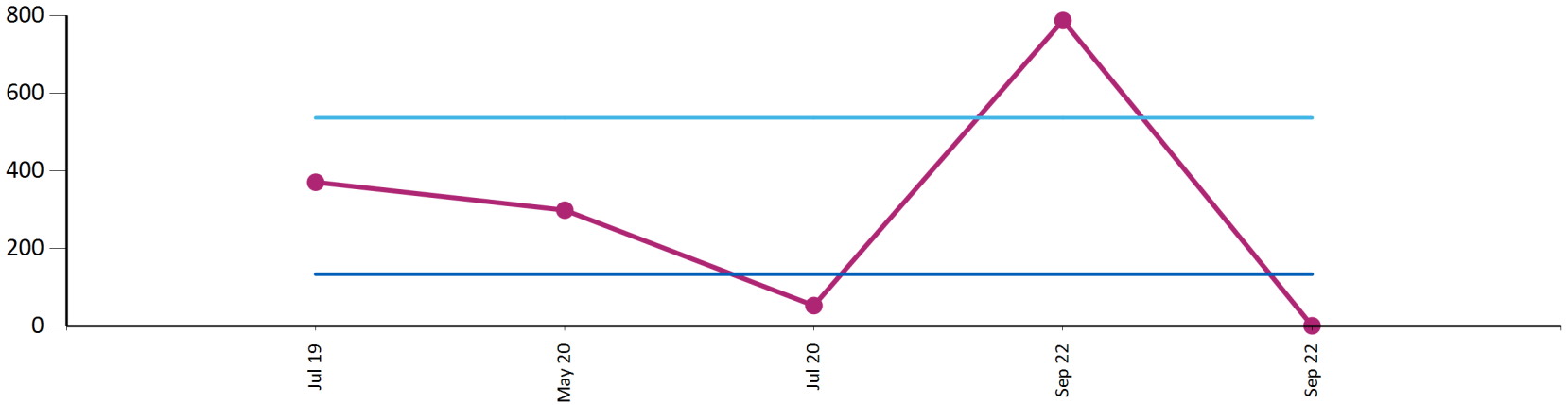
Plan	Actual	Period
	4	Nov-23

Year to Date

Plan	Actual
	27

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Dec-23

Previous

Plan	Actual	Period
	0	Nov-23

Year to Date

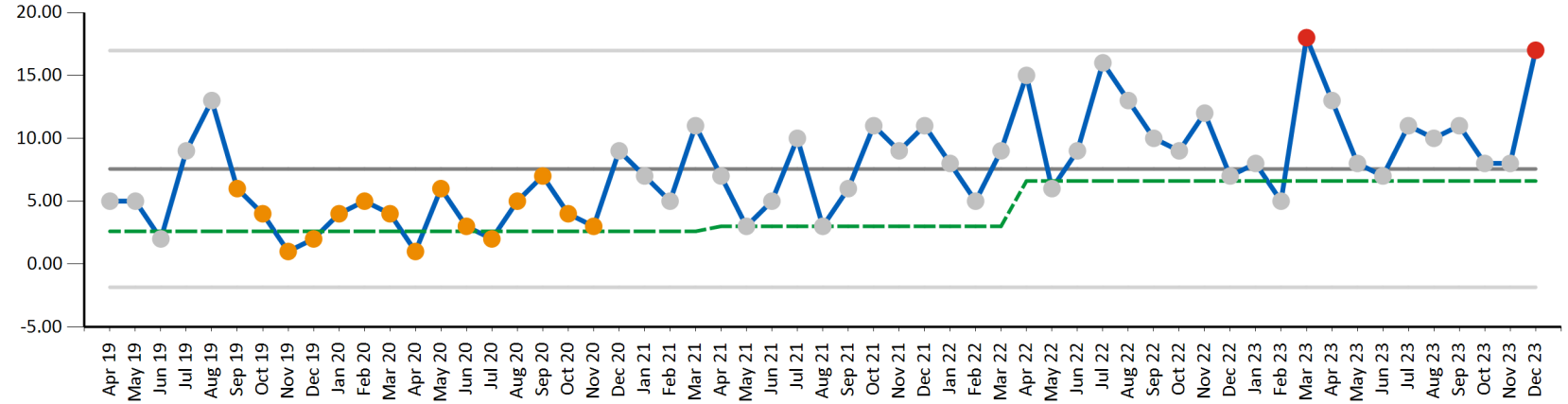
Plan	Actual

347 - Total C.diff infections contributing to objective

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 7	17	Dec-23

Previous

Plan	Actual	Period
<= 7	8	Nov-23

Year to Date

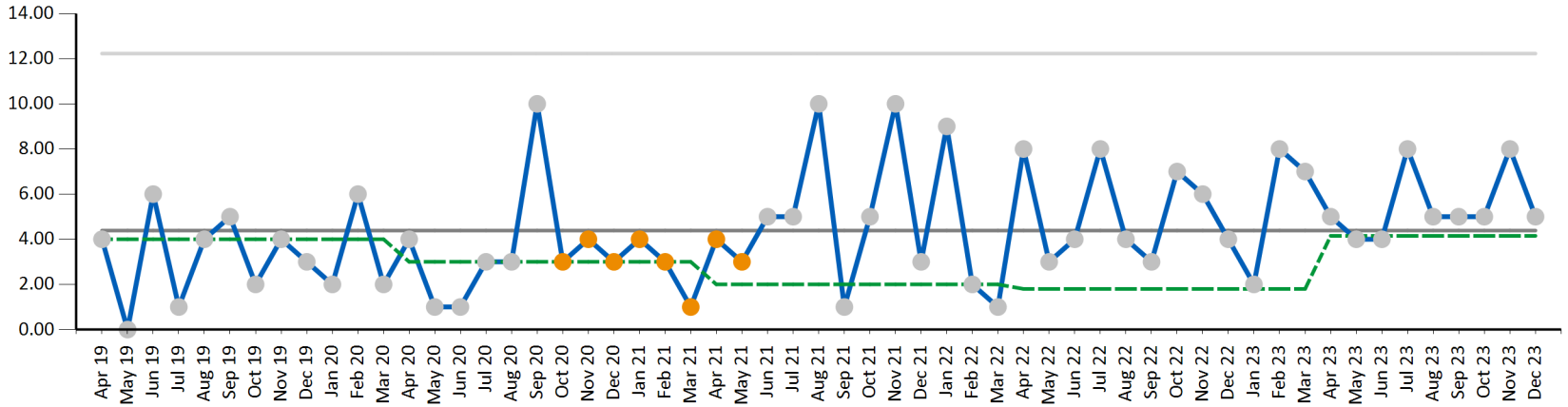
Plan	Actual
<= 59	93

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 4	5	Dec-23

Previous

Plan	Actual	Period
<= 4	8	Nov-23

Year to Date

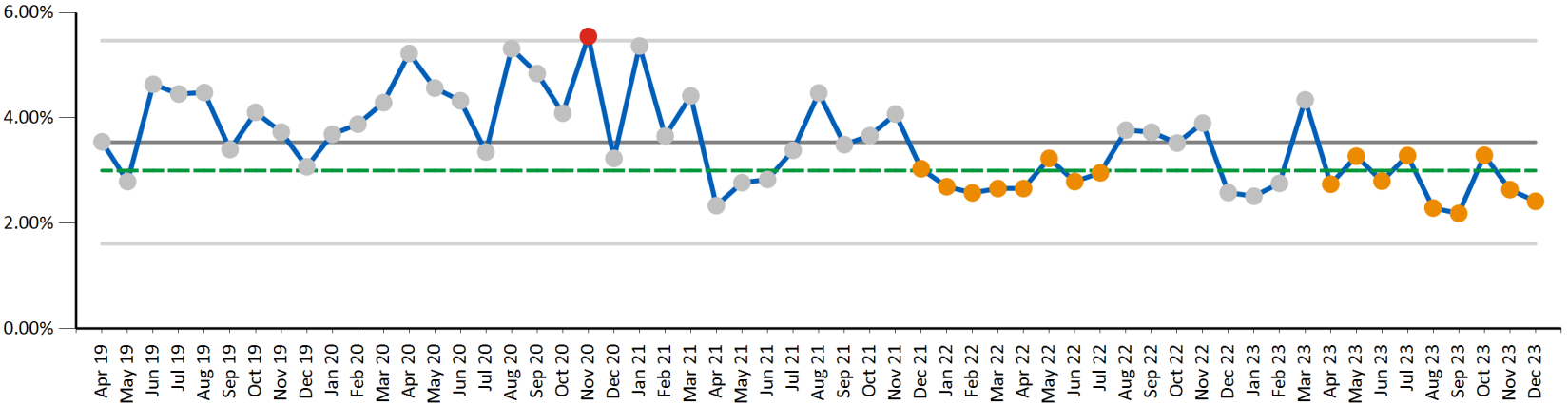
Plan	Actual
<= 37	49

219 - Blood Culture Contaminants (rate)

Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
<= 3%	2.4%	Dec-23

Previous

Plan	Actual	Period
<= 3%	2.6%	Nov-23

Year to Date

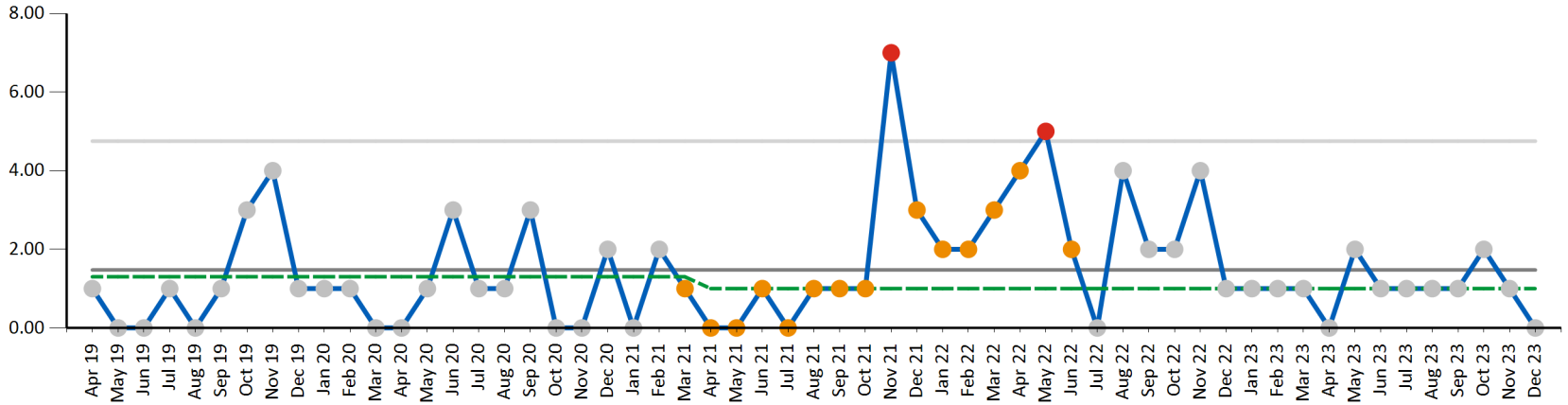
Plan	Actual
<= 3%	2.8%

304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 1.0	0.0	Dec-23

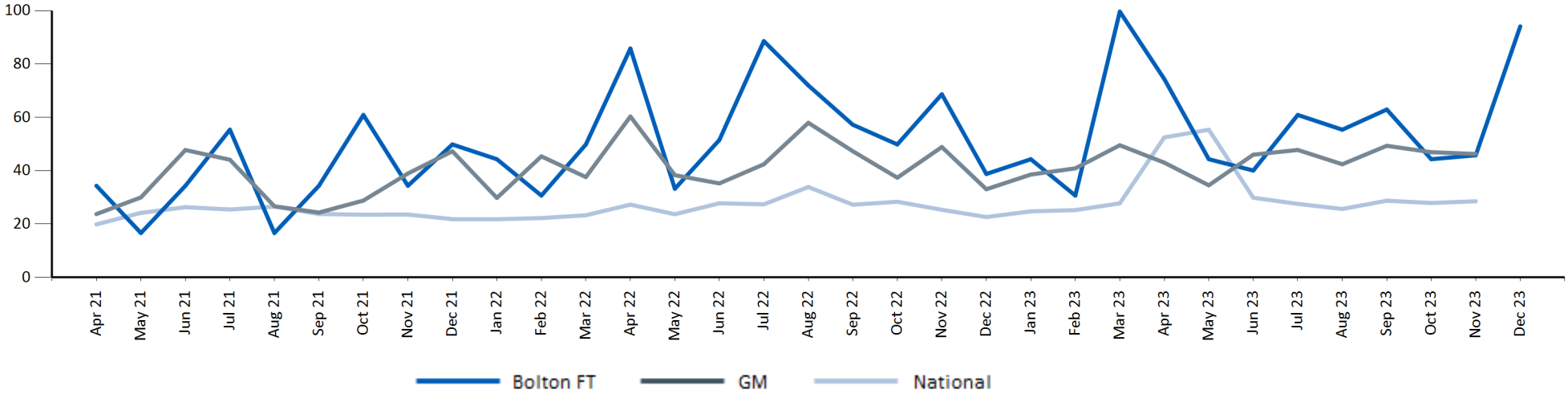
Previous

Plan	Actual	Period
<= 1.0	1.0	Nov-23

Year to Date

Plan	Actual
<= 9.0	9.0

549 - C Diff Rate Comparison

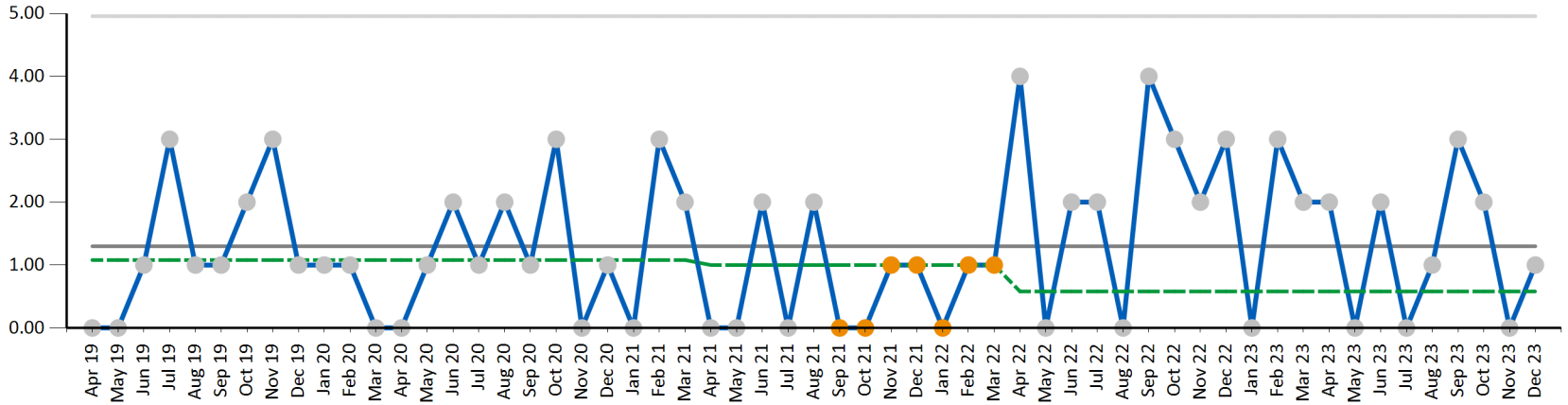


305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	1	Dec-23

Previous

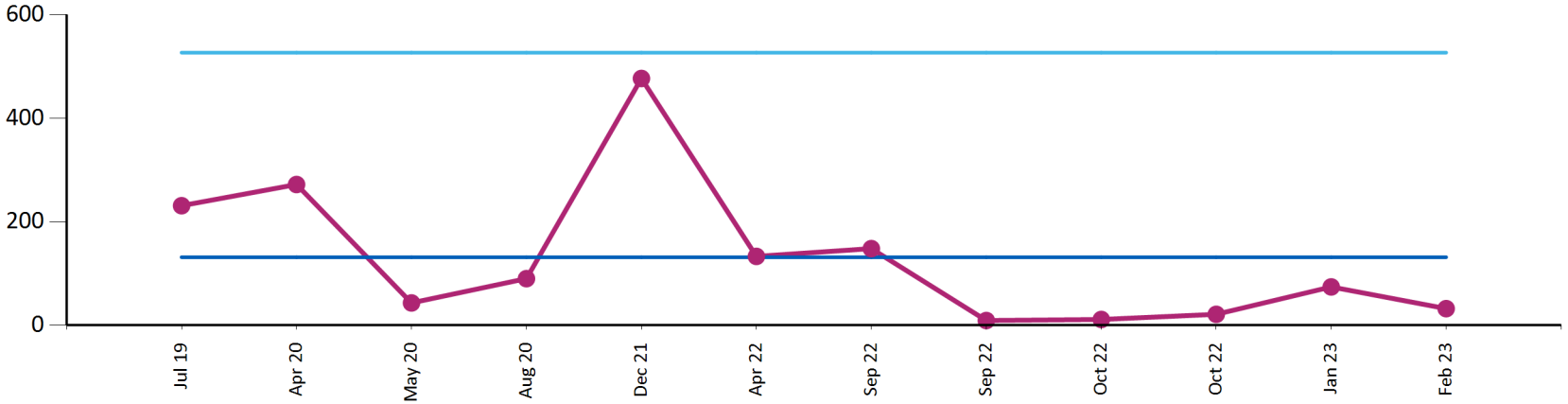
Plan	Actual	Period
<= 1	0	Nov-23

Year to Date

Plan	Actual
<= 5	11

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

0/6



Latest

Plan	Actual	Period
	0	Dec-23

Previous

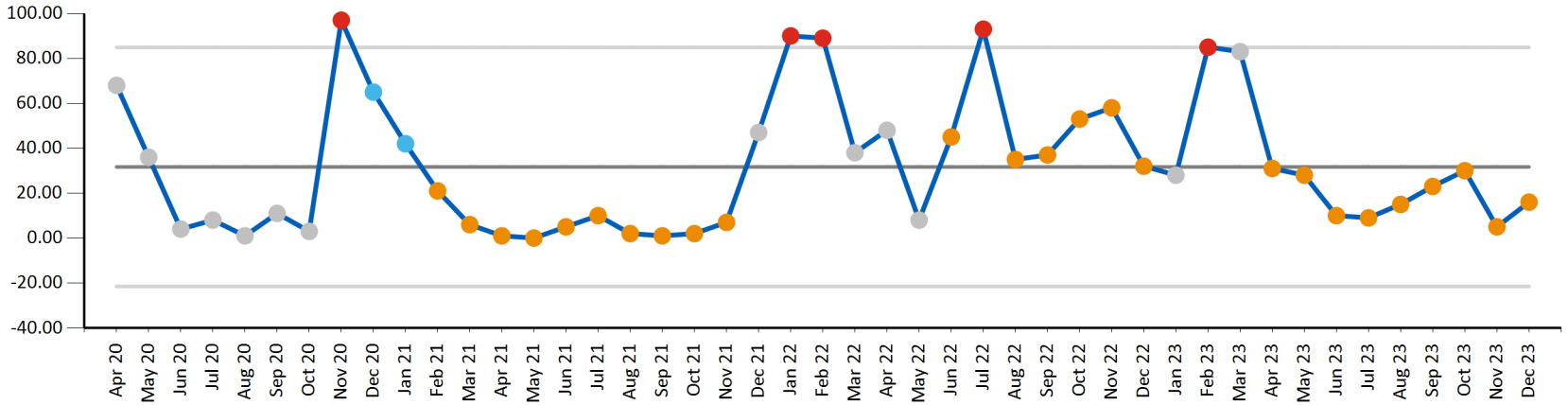
Plan	Actual	Period
	0	Nov-23

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Special cause variation with improving performance



Latest

Plan	Actual	Period
	16	Dec-23

Previous

Plan	Actual	Period
	5	Nov-23

Year to Date

Plan	Actual
	167

Quality and Safety - Mortality

Bolton NHS Foundation Trust

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

HSMR – in month figure is below the average for the period and remains in control. The 12 month rolling average to September 2023 is 102.22 remaining as 'Green' when compared against other Trusts.

SHMI – In month figure is below the average and target for the time period and has remained 'in control' for more than two years. The published rolling average for the period September 2022 to August 2023 is 108.06 'as expected'.

The proportion of Charlson comorbidities remains in control and has been since April 2022. The depth of recording has shown eight consecutive points below the mean since February 2023. 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 21 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.

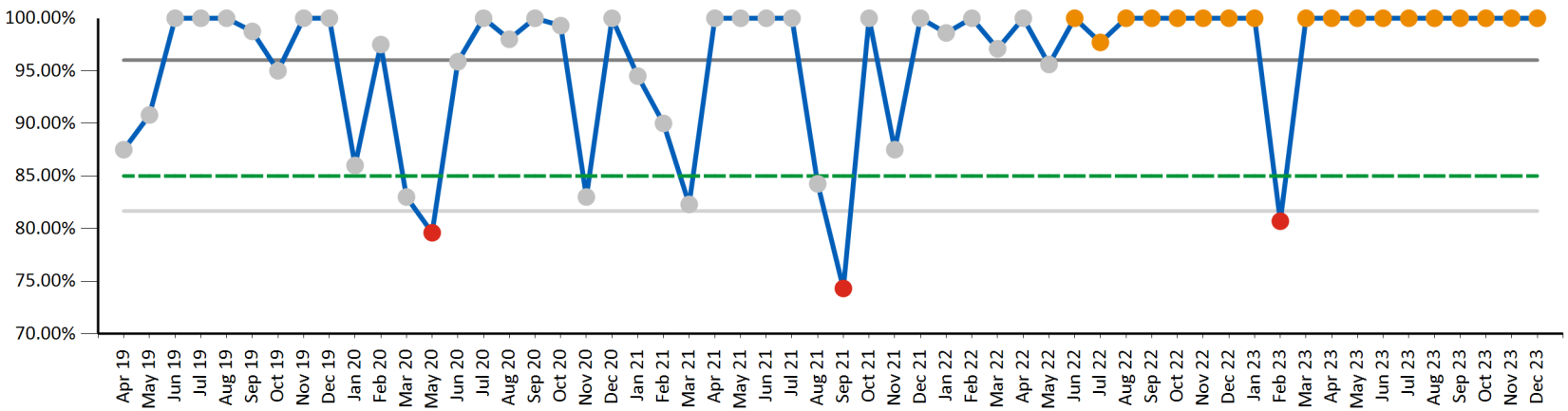
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Dec-23	H	>= 85%	100.0%	Nov-23	>= 85%	100.0%	?
495 - HSMR		87.38	Sep-23			114.55	Aug-23		87.38	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	96.00	Jul-23		<= 100.00	96.00	Jun-23	<= 100.00	96.00	?
12 - Crude Mortality %	<= 2.9%	2.5%	Dec-23	L	<= 2.9%	1.7%	Nov-23	<= 2.9%	2.2%	?
519 - Average Charlson comorbidity Score (First episode of care)		4	Sep-23			4	Aug-23		22	
520 - Depth of recording (First episode of care)		6	Sep-23	L		6	Aug-23		36	
521 - Proportion of fully coded records (Inpatients)		98.2%	Oct-23	H		97.7%	Sep-23		98.2%	

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%	Dec-23

Previous

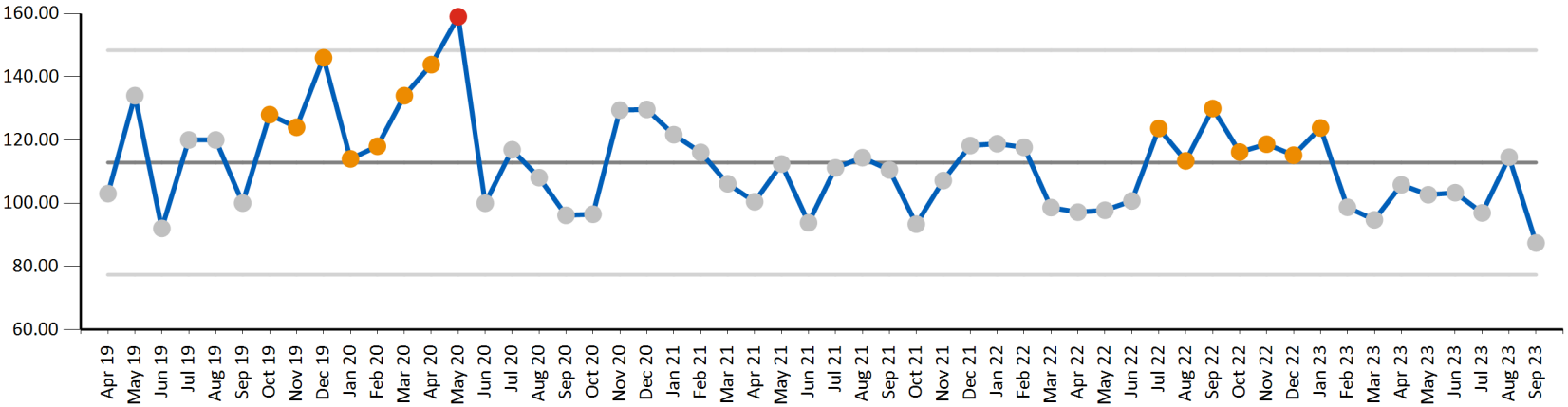
Plan	Actual	Period
>= 85%	100.0%	Nov-23

Year to Date

Plan	Actual
>= 85%	100.0%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	87.38	Sep-23

Previous

Plan	Actual	Period
	114.55	Aug-23

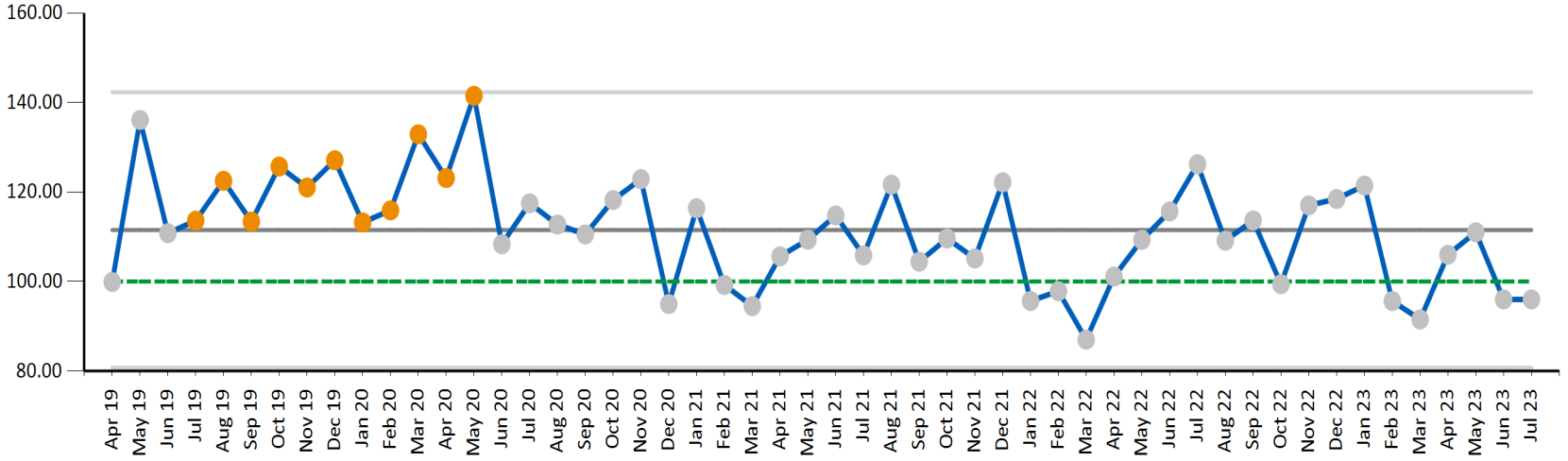
Year to Date

Plan	Actual
	87.38

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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



Latest

Plan	Actual	Period
<= 100.00	96.00	Jul-23

Previous

Plan	Actual	Period
<= 100.00	96.00	Jun-23

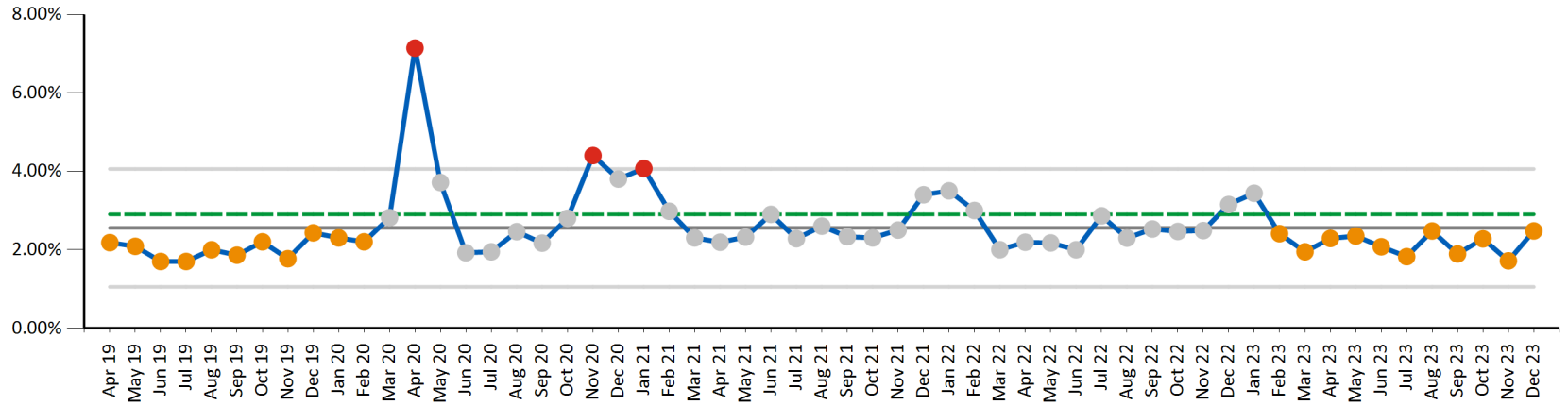
Year to Date

Plan	Actual
<= 100.00	96.00

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%	2.5%	Dec-23

Previous

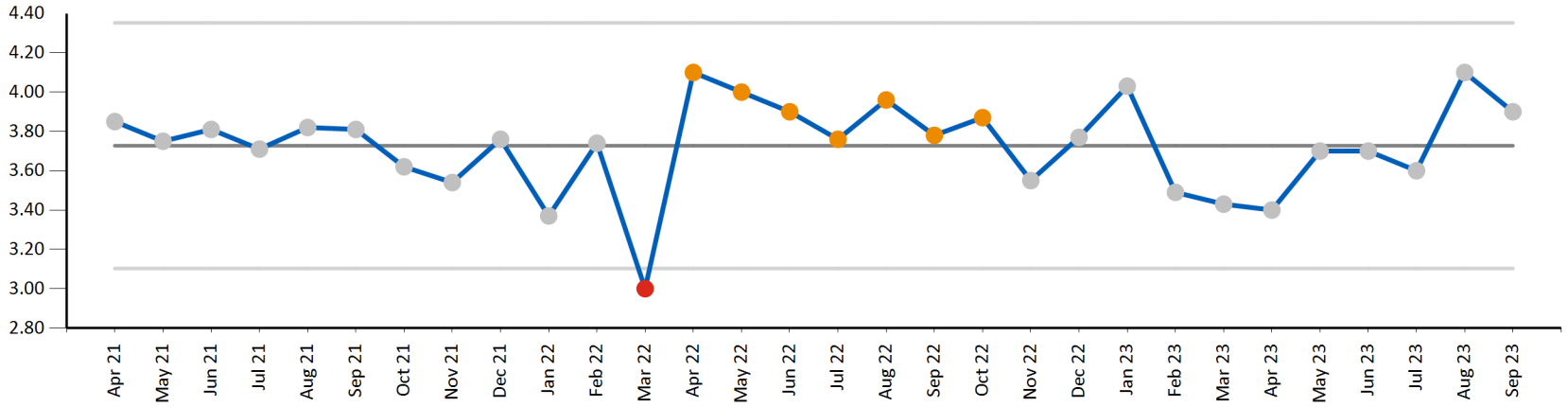
Plan	Actual	Period
<= 2.9%	1.7%	Nov-23

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	Sep-23

Previous

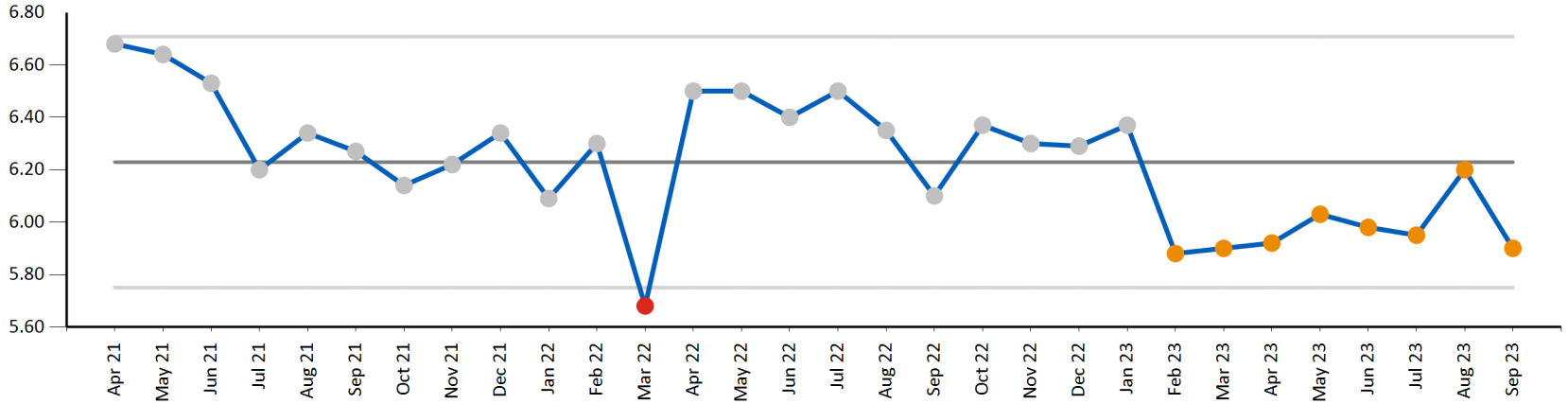
Plan	Actual	Period
	4	Aug-23

Year to Date

Plan	Actual
	22

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Sep-23

Previous

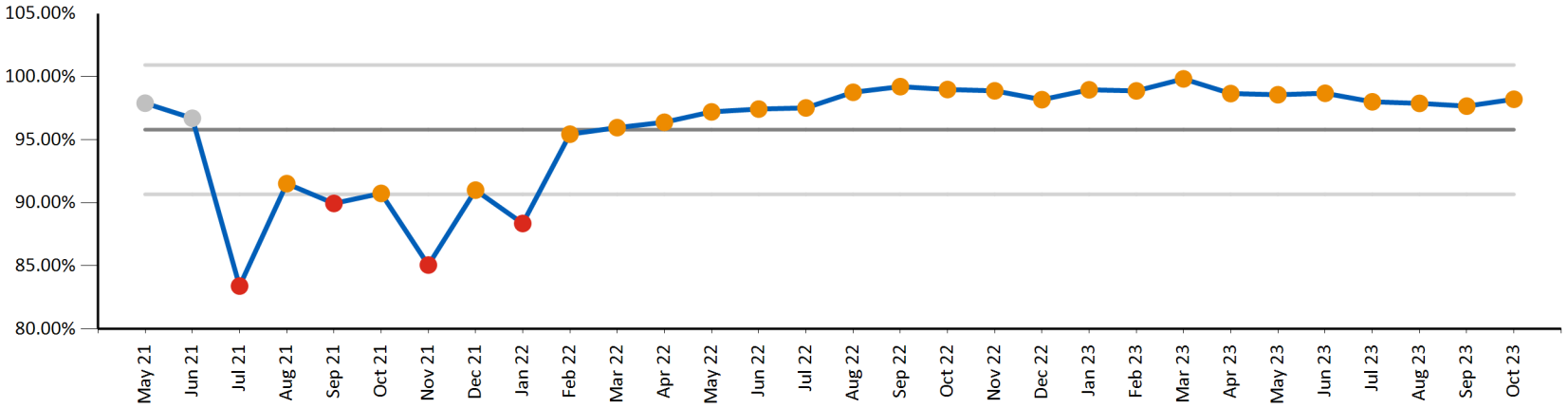
Plan	Actual	Period
	6	Aug-23

Year to Date

Plan	Actual
	36

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	98.2%	Oct-23

Previous

Plan	Actual	Period
	97.7%	Sep-23

Year to Date

Plan	Actual
	98.2%

Quality and Safety - Patient Experience

Bolton NHS Foundation Trust

Complaint Response Rates
The Trust had 10 responses due in December and nine responses were provided within timeframe. This resulted in 90% compliance rate for the month against the Trust target of 95%. For the first time in three years the Trust has seen sustained special cause improvement for complaint response rates.
Outcome resolution meetings remain our best practice offer to complainants, which continues to demonstrate engagement and a positive method of Trust learning from complaints.
Complaint training sessions continue to be offered to staff at all levels.

FFT Response and Satisfaction Rates
Both response and satisfaction rates remain within common cause variation.
Accident and Emergency Department response and satisfaction rates remain below target. AACD review response and recommendation rates at their Divisional Quality and Patient Experience Forum and are exploring options to improve response rates for Paediatric ED and reviewing the narrative for all negative responses to identify themes and learning.
Inpatient response rates are below the target however remain within common cause variation. Inpatient satisfaction rates however are above the target and are also within common cause variation.
Antenatal response rates are below target however are within common cause variation. Satisfaction rates however remain above the target and indicate special cause improvement.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.7%	Dec-23		>= 20%	14.8%	Nov-23	>= 20%	16.6%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	81.5%	Dec-23		>= 90%	82.4%	Nov-23	>= 90%	84.4%	
80 - Inpatient Friends and Family Response Rate	>= 30%	24.1%	Dec-23		>= 30%	29.6%	Nov-23	>= 30%	27.9%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.5%	Dec-23		>= 90%	97.8%	Nov-23	>= 90%	96.2%	
81 - Maternity Friends and Family Response Rate	>= 15%	28.5%	Dec-23		>= 15%	29.8%	Nov-23	>= 15%	34.1%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.8%	Dec-23		>= 90%	93.7%	Nov-23	>= 90%	91.6%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	9.8%	Dec-23		>= 15%	30.5%	Nov-23	>= 15%	23.5%	

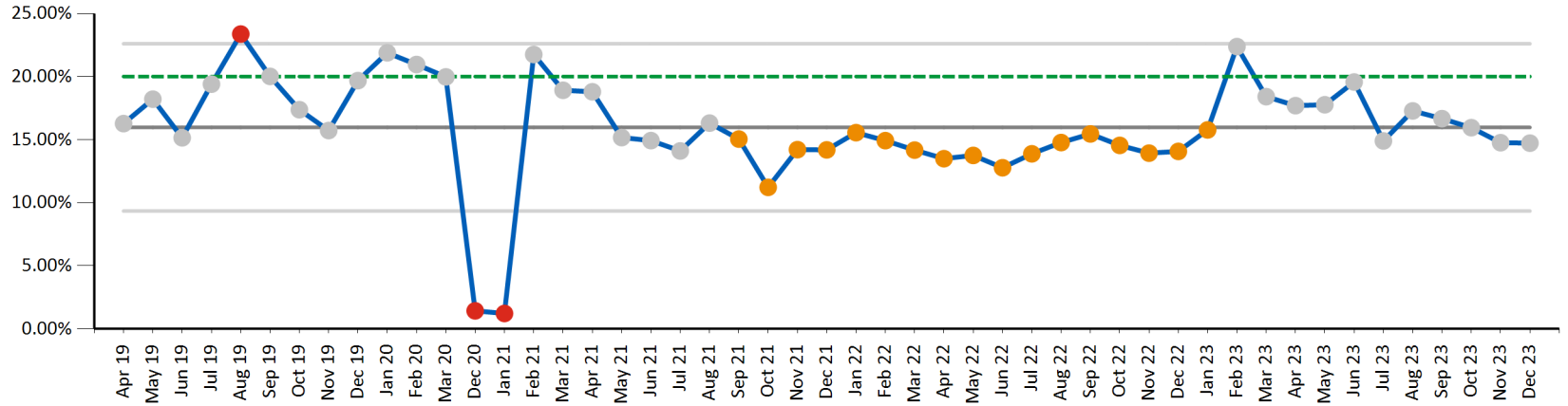
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	97.7%	Dec-23		>= 90%	98.6%	Nov-23	>= 90%	94.7%	
83 - Birth - Friends and Family Response Rate	>= 15%	41.8%	Dec-23		>= 15%	30.9%	Nov-23	>= 15%	43.7%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	91.8%	Dec-23		>= 90%	89.7%	Nov-23	>= 90%	91.8%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	32.1%	Dec-23		>= 15%	31.9%	Nov-23	>= 15%	46.6%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	91.4%	Dec-23		>= 90%	91.8%	Nov-23	>= 90%	87.2%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	32.5%	Dec-23		>= 15%	26.0%	Nov-23	>= 15%	24.8%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.9%	Dec-23		>= 90%	94.5%	Nov-23	>= 90%	94.8%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Dec-23		= 100%	100.0%	Nov-23	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	90.0%	Dec-23		>= 95%	81.8%	Nov-23	>= 95%	82.3%	

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	14.7%	Dec-23

Previous

Plan	Actual	Period
>= 20%	14.8%	Nov-23

Year to Date

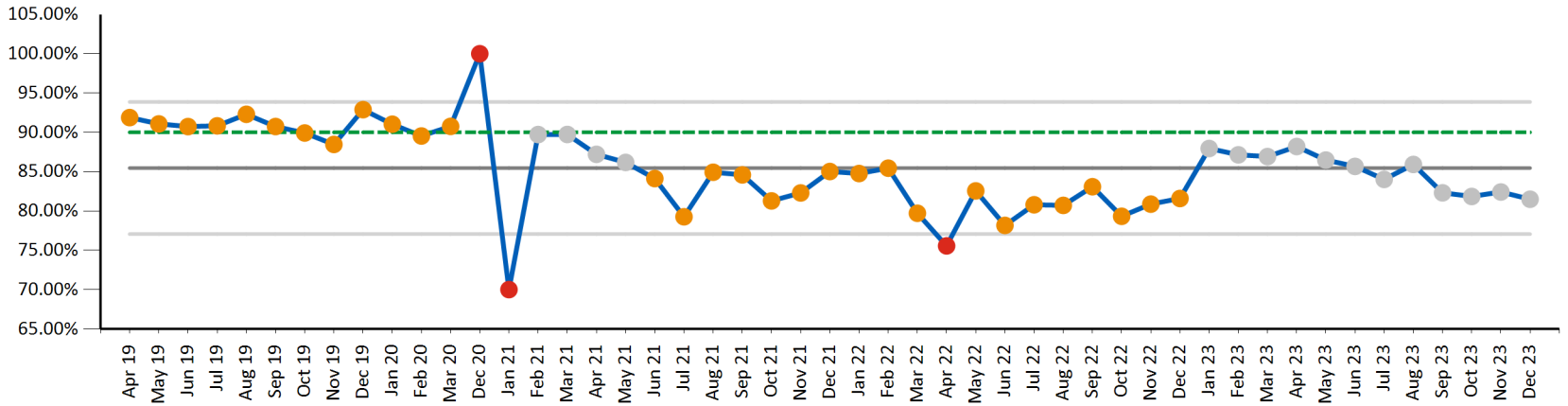
Plan	Actual
>= 20%	16.6%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90%	81.5%	Dec-23

Previous

Plan	Actual	Period
>= 90%	82.4%	Nov-23

Year to Date

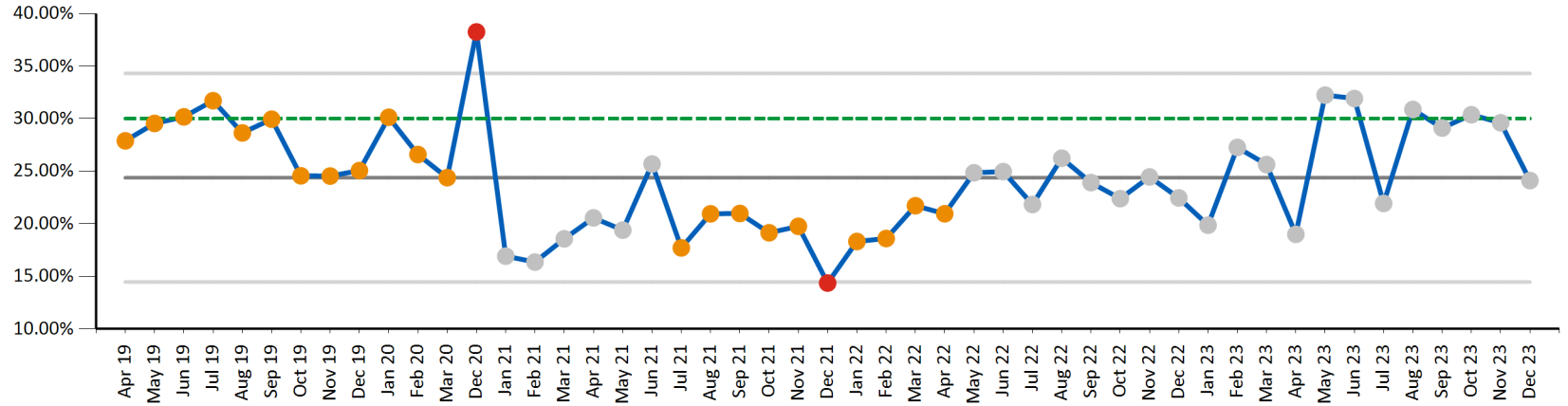
Plan	Actual
>= 90%	84.4%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 30%	24.1%	Dec-23

Previous

Plan	Actual	Period
>= 30%	29.6%	Nov-23

Year to Date

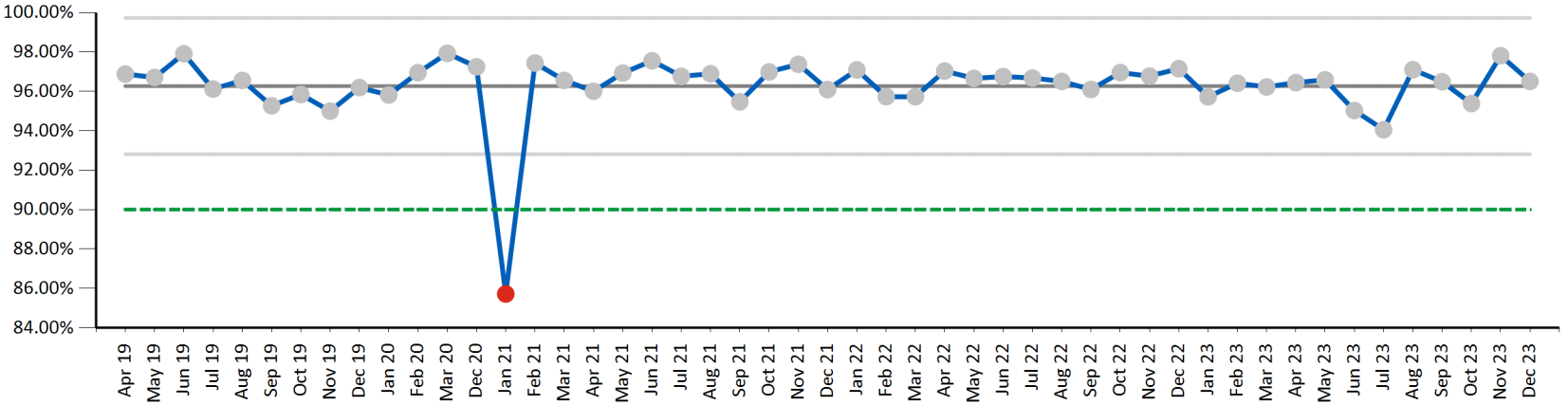
Plan	Actual
>= 30%	27.9%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

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

Previous

Plan	Actual	Period
>= 90%	97.8%	Nov-23

Year to Date

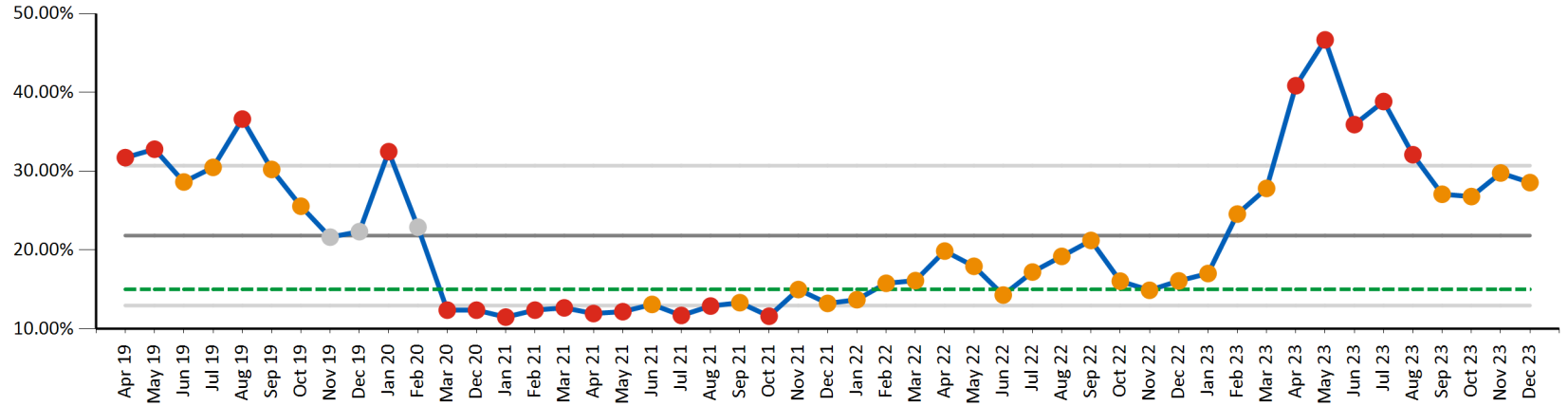
Plan	Actual
>= 90%	96.2%

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%	28.5%	Dec-23

Previous

Plan	Actual	Period
>= 15%	29.8%	Nov-23

Year to Date

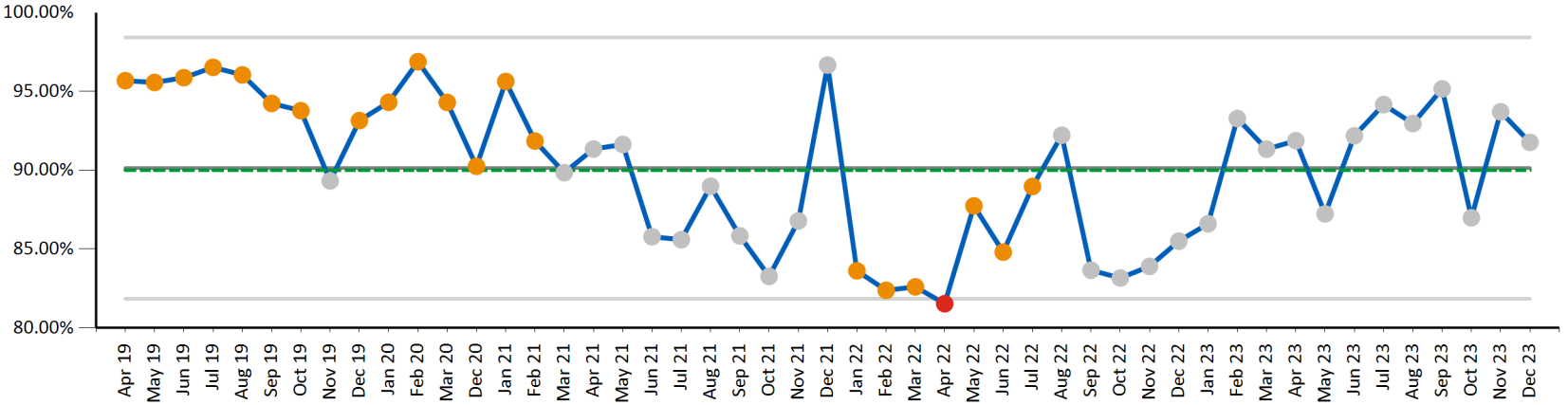
Plan	Actual
>= 15%	34.1%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	91.8%	Dec-23

Previous

Plan	Actual	Period
>= 90%	93.7%	Nov-23

Year to Date

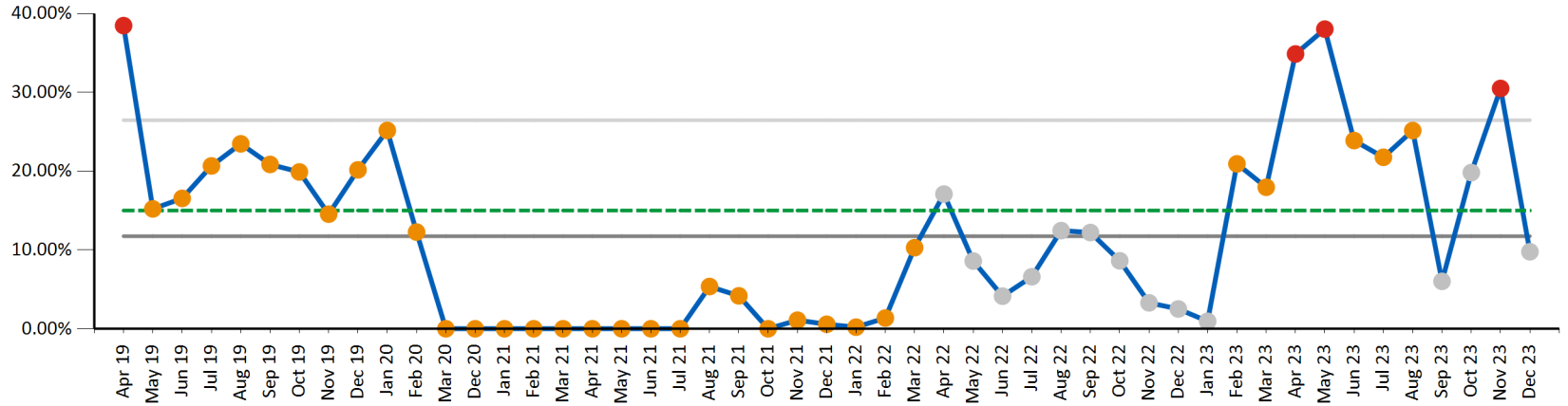
Plan	Actual
>= 90%	91.6%

82 - Antenatal - 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
>= 15%	9.8%	Dec-23

Previous

Plan	Actual	Period
>= 15%	30.5%	Nov-23

Year to Date

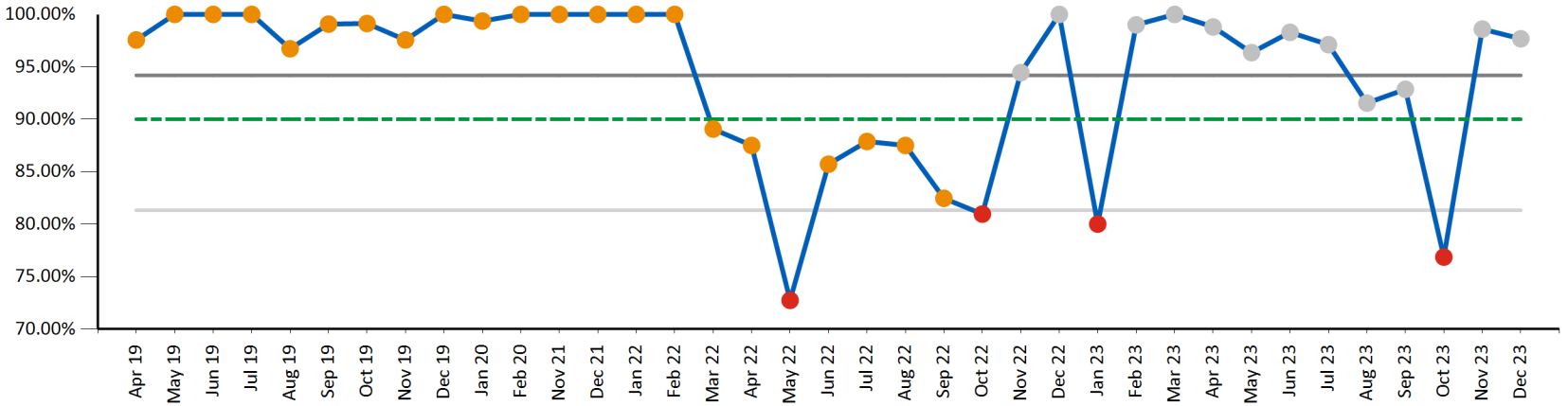
Plan	Actual
>= 15%	23.5%

242 - Antenatal 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%	97.7%	Dec-23

Previous

Plan	Actual	Period
>= 90%	98.6%	Nov-23

Year to Date

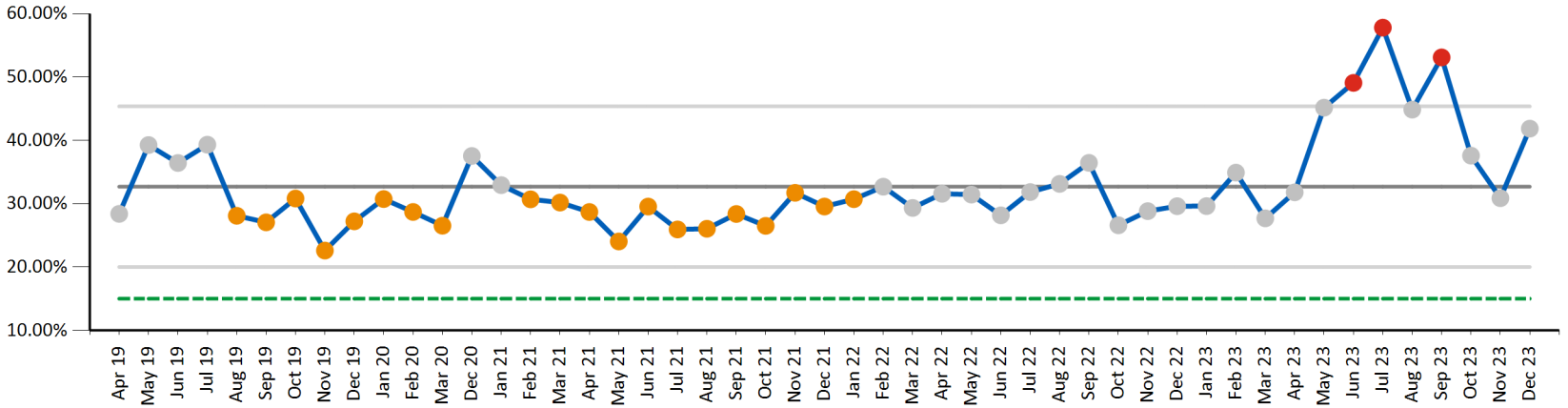
Plan	Actual
>= 90%	94.7%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	41.8%	Dec-23

Previous

Plan	Actual	Period
>= 15%	30.9%	Nov-23

Year to Date

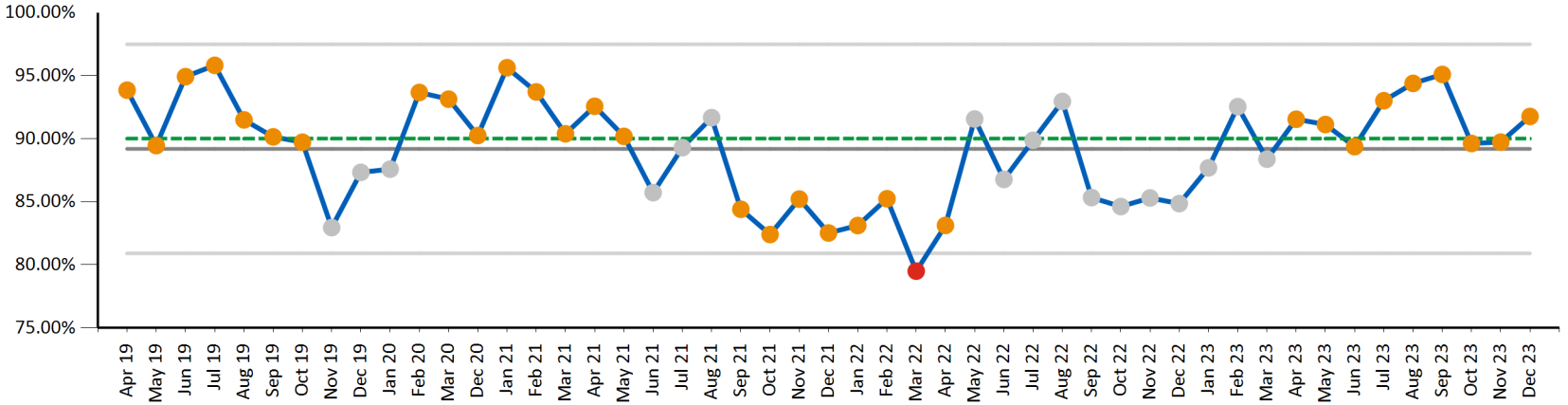
Plan	Actual
>= 15%	43.7%

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%	91.8%	Dec-23

Previous

Plan	Actual	Period
>= 90%	89.7%	Nov-23

Year to Date

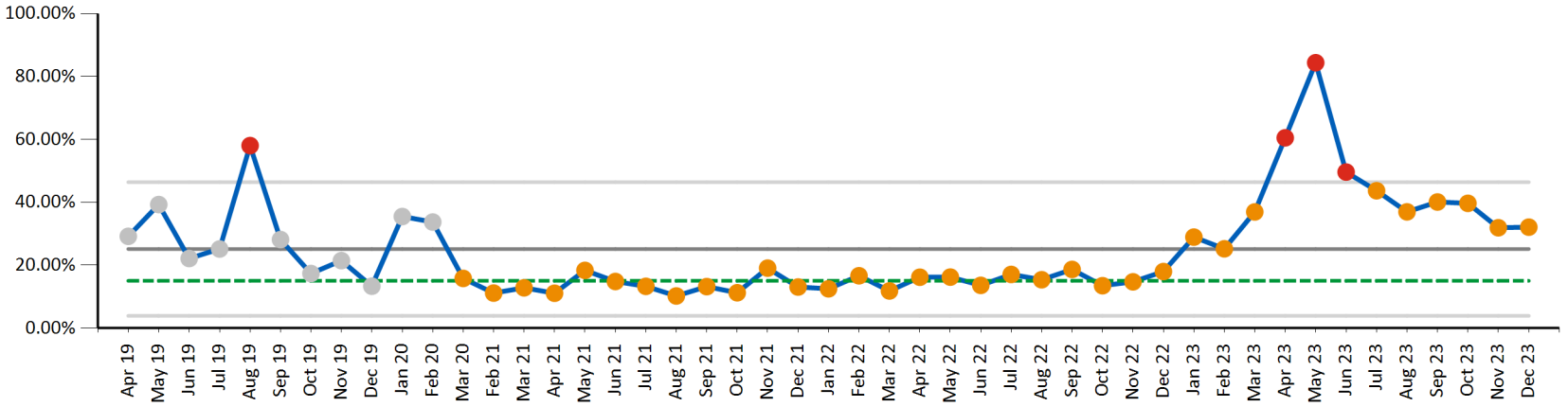
Plan	Actual
>= 90%	91.8%

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%	32.1%	Dec-23

Previous

Plan	Actual	Period
>= 15%	31.9%	Nov-23

Year to Date

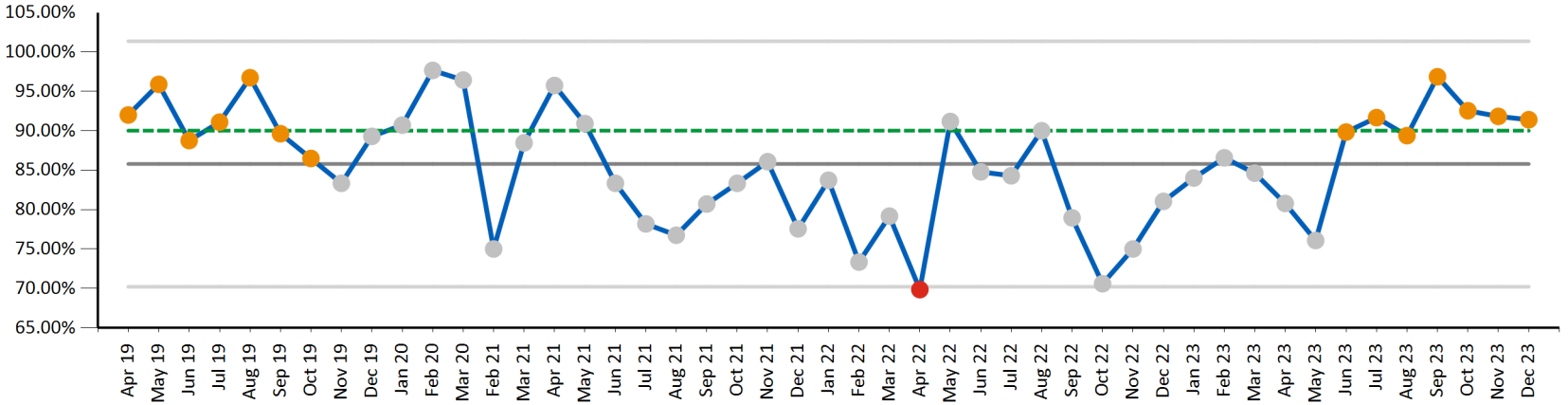
Plan	Actual
>= 15%	46.6%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
>= 90%	91.4%	Dec-23

Previous

Plan	Actual	Period
>= 90%	91.8%	Nov-23

Year to Date

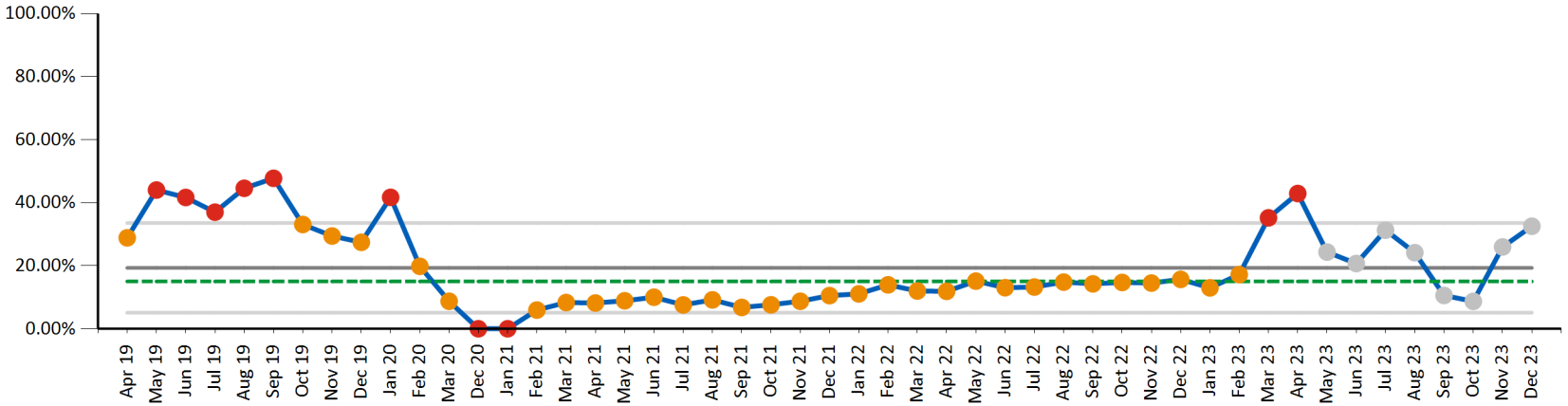
Plan	Actual
>= 90%	87.2%

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%	32.5%	Dec-23

Previous

Plan	Actual	Period
>= 15%	26.0%	Nov-23

Year to Date

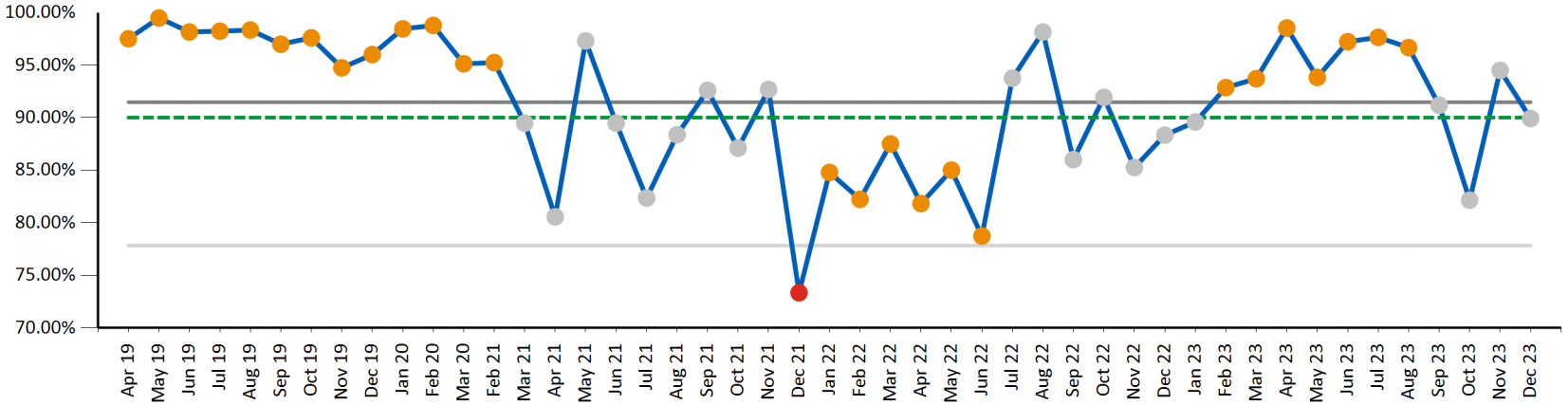
Plan	Actual
>= 15%	24.8%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 90%	89.9%	Dec-23

Previous

Plan	Actual	Period
>= 90%	94.5%	Nov-23

Year to Date

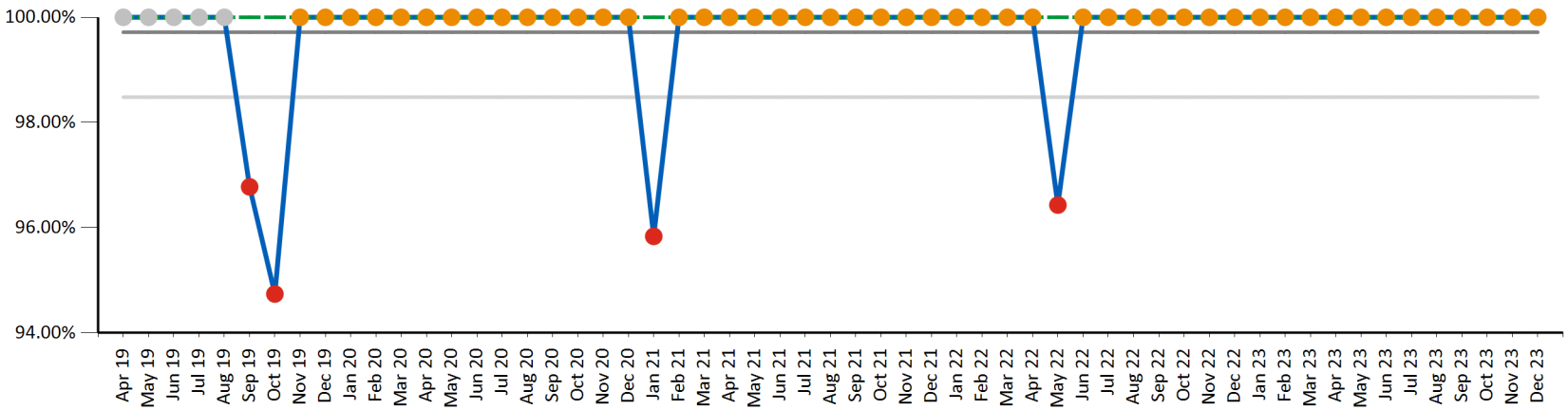
Plan	Actual
>= 90%	94.8%

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%	Dec-23

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-23

Year to Date

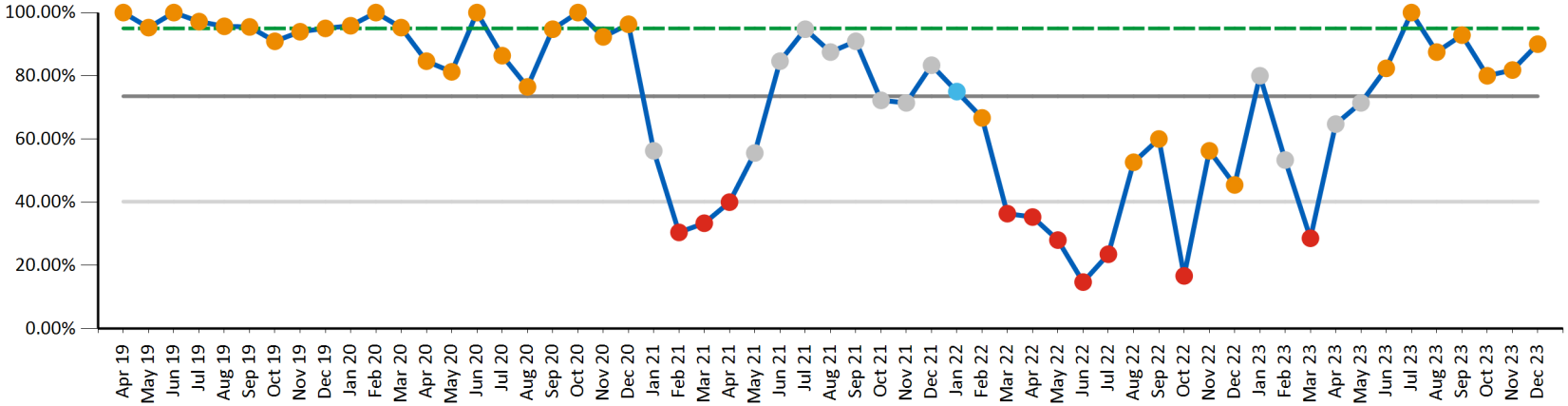
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Special cause variation with improving performance

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

1/6



Latest

Plan	Actual	Period
>= 95%	90.0%	Dec-23

Previous

Plan	Actual	Period
>= 95%	81.8%	Nov-23

Year to Date

Plan	Actual
>= 95%	82.3%

Quality and Safety - Maternity

81 Friends and Family Response Rate – Stabilisation in the maternity friends and family response rate continues at 28.5% with a slight variation in satisfaction rate noted (91.8%). Inconsistent performance again within antenatal care response rate this month and sustained response rate in birth and postnatal areas. Task and finish group reinstated fortnightly.

202 - 1:1 care in labour – Trust year to date incidence 88.74% lower than the rolling 12 month Greater Manchester and East Cheshire (GMEC) rate of 92.97% and peer average in similar sized providers (ie Oldham). Recovery plan in place as per CNST requirements. No breaches of supernumerary status as per CNST classification reported. New staff in probationary period do not appear to be included in staffing figures and thus may be negatively impacting upon the overall rate – issue being addressed with roster team.

23 – ¾ degree tears – Trust year to date incidence 3.65% slightly higher than rolling 12 month GMEC comparator rate of 2.60%. Local relaunch of OASI delayed due to CNST training prioritisation in January 2024. Elevated incidence of 3rd and 4th degree tears flagged at GMEC safety assurance panel and peer support requested from LMNS with wider sharing of learning as sustained increase also noted in another provider.

203 – Booked by 12+6 – Continued poor trend in booking performance noted Trust 12 month rolling rate 87.02% which exceeds GMEC performance median of 82.76%. Performance target amended to 10+0 as per national standard which will remove impact of ultrasound date changes and associated impact upon compliance rate and thus provide an enhanced reflection of community midwifery booking performance. GMEC detail relating to new standard of 10+0 highlights Trust is performing above GMEC mean for revised indicator (Trust performance 56.54% compared to GMEC median 51.74%). Assurance requested from Diagnostics & Support Services regarding capacity to undertake booking scans within required timeframe.

210 – Breastfeeding initiation – Sustained improvement again in performance noted in month to 66.99%. Baby Friendly implementation within service timeframe to be delayed until 2024. Trust year to date incidence 68.65% slightly higher than GMEC 12 months rolling rate of 62.35%.

320 – Preterm birth –Trust 12mths rolling data 9.64% slightly higher than GMEC rolling 12mth rate 9.10% but less than peer Tier 3 comparators Oldham (11.08%) and MFT (10.76%). Recruitment to post of pre-term midwife ongoing.

322 – Maternity Stillbirth Rate – Rate 0.00 per 1000 in month. Trust rolling rate 4.66/per1000 slightly higher than GMEC rolling 12mth rate 4.56/1000 but less than peer comparator MFT (7.24/1000). Implementation of all of the revised saving babies lives care bundle v3 elements continues as part of CNST year 5 implementation. LMNS review of cases Jan-August 2023 now completed and awaiting ratification at mortality meeting this month. Requested IPM Stillbirth data capture to align with GMEC reporting metrics and clearly highlight rate including termination of pregnancy and without.

Robson criteria – The service now has access to Robson group data at Trust and GMEC level for all of the 10 robson groups. Data trends are starting to develop in the newly collated data (4 months data) and early trends indicate that the Trust has a higher rate of caesarean section 32.46% compared to the GMEC median 27.168% for women who experience a subsequent single term baby and who had a previous caesarean section. The data also indicates that the Trust has a slightly higher rate than peers of women who have a caesarean section following a single term pregnancy following induction. The initial findings align with the BR+ report finding that BFT has a higher acuity of women than other providers in GMEC. Ongoing monitoring of trends will continue.

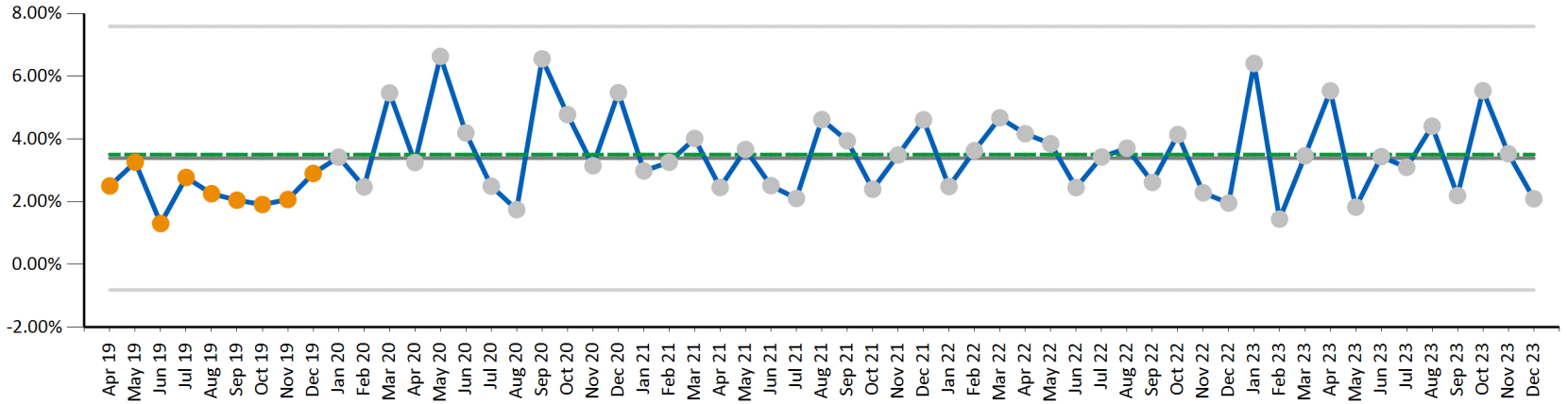
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (as per GMEC methodology)	<= 3.50	0.00	Dec-23		<= 3.50	2.20	Nov-23	<= 3.50	3.83	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.1%	Dec-23		<= 3.5%	3.5%	Nov-23	<= 3.5%	3.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	97.7%	Dec-23		>= 95.0%	98.1%	Nov-23	>= 95.0%	98.5%	
203 - Booked 12+6	>= 90.0%	84.9%	Dec-23		>= 90.0%	82.6%	Nov-23	>= 90.0%	86.5%	
586 - Booked 10+0		44.4%	Dec-23			49.0%	Nov-23		54.8%	
204 - Inductions of labour - over 24 hours	<= 40%	36.2%	Dec-23		<= 40%	36.2%	Nov-23	<= 40%	35.5%	
210 - Initiation breast feeding	>= 65%	66.99%	Dec-23		>= 65%	69.14%	Nov-23	>= 65%	68.32%	
213 - Maternity complaints	<= 5	1	Dec-23		<= 5	3	Nov-23	<= 45	16	
319 - Maternal deaths (direct)	= 0	0	Dec-23		= 0	0	Nov-23	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	11.2%	Dec-23		<= 6%	8.4%	Nov-23	<= 6%	10.0%	

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3.5%	2.1%	Dec-23

Previous

Plan	Actual	Period
<= 3.5%	3.5%	Nov-23

Year to Date

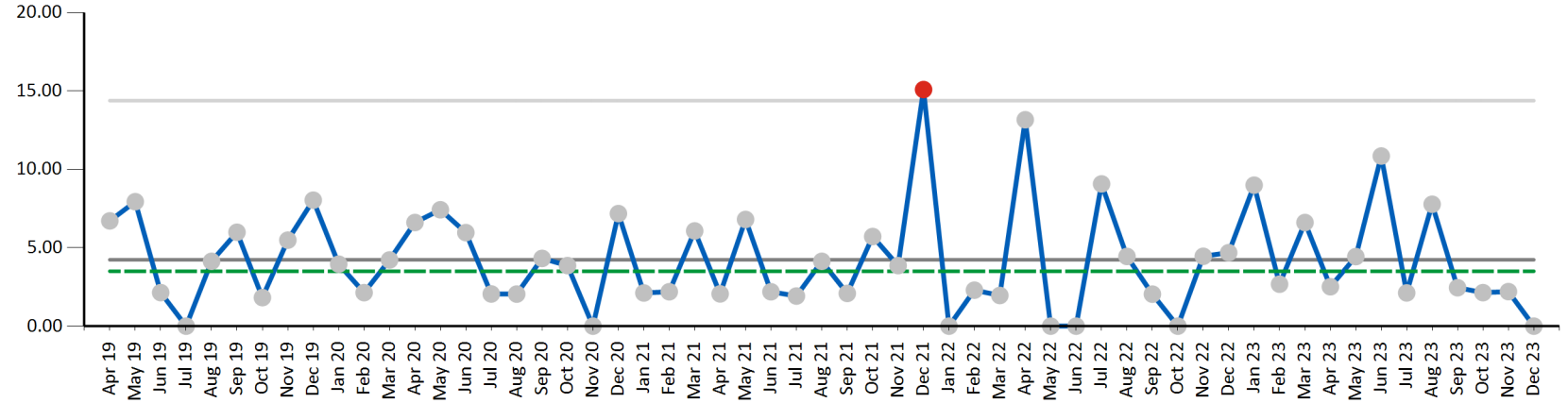
Plan	Actual
<= 3.5%	3.5%

322 - Maternity - Stillbirths per 1000 births (as per GMEC methodology)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 3.50	0.00	Dec-23

Previous

Plan	Actual	Period
<= 3.50	2.20	Nov-23

Year to Date

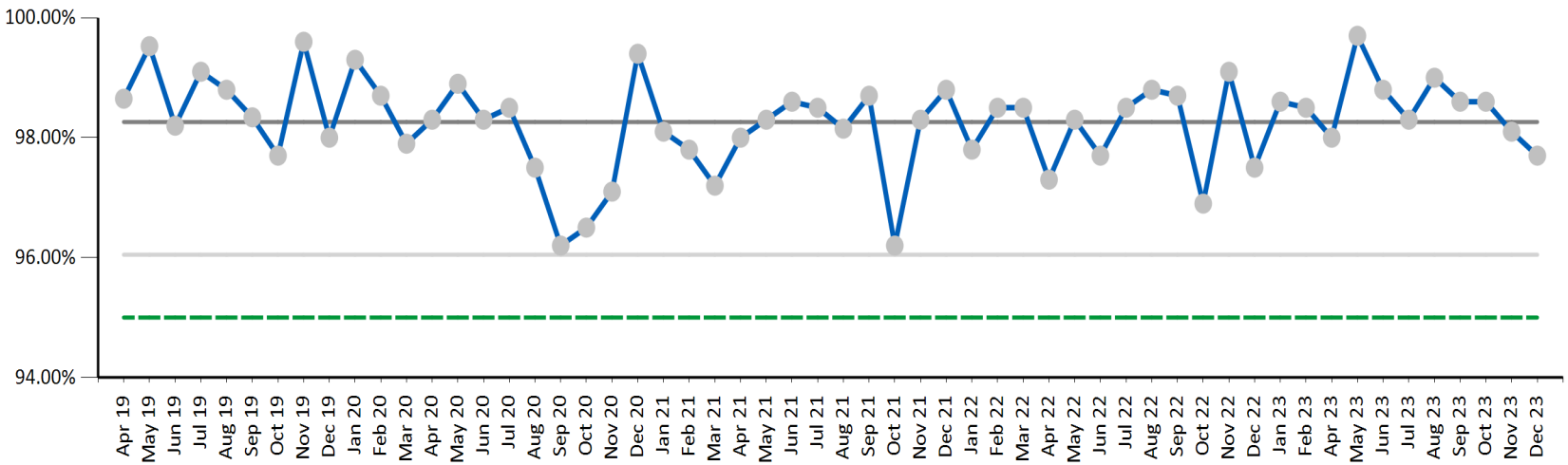
Plan	Actual
<= 3.50	3.83

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	97.7%	Dec-23

Previous

Plan	Actual	Period
>= 95.0%	98.1%	Nov-23

Year to Date

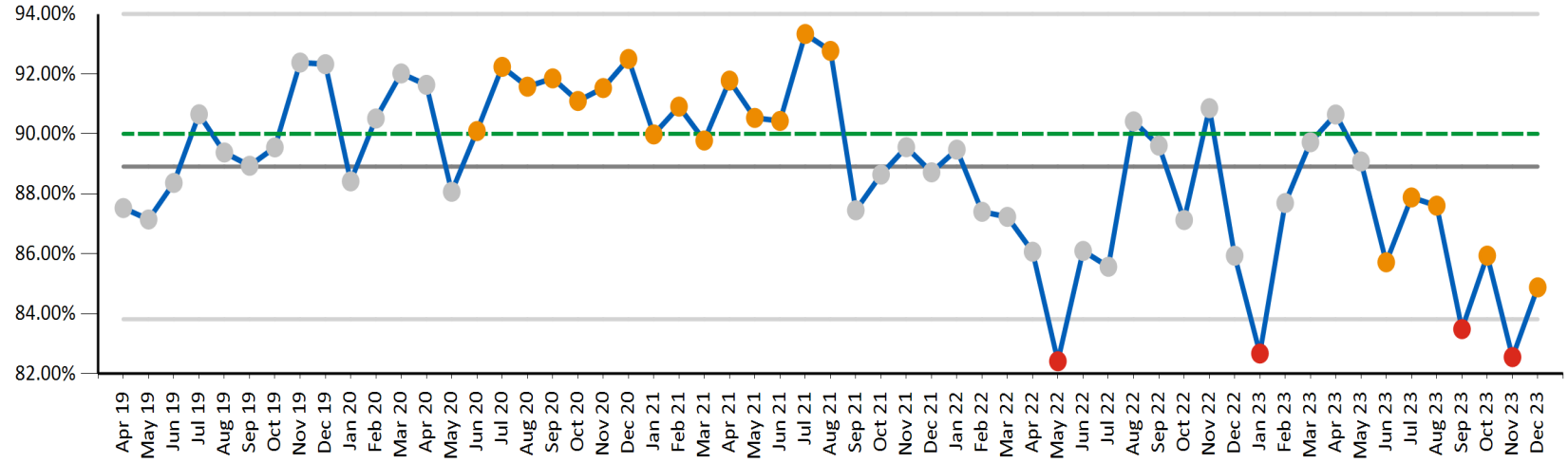
Plan	Actual
>= 95.0%	98.5%

203 - Booked 12+6

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 90.0%	84.9%	Dec-23

Previous

Plan	Actual	Period
>= 90.0%	82.6%	Nov-23

Year to Date

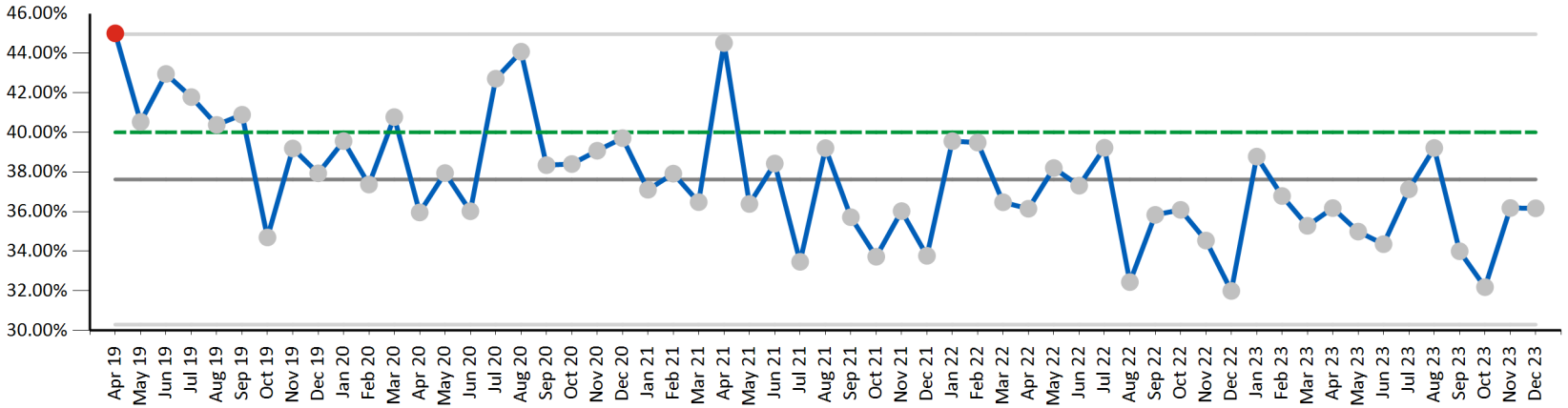
Plan	Actual
>= 90.0%	86.5%

204 - Inductions of labour - over 24 hours

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	36.2%	Dec-23

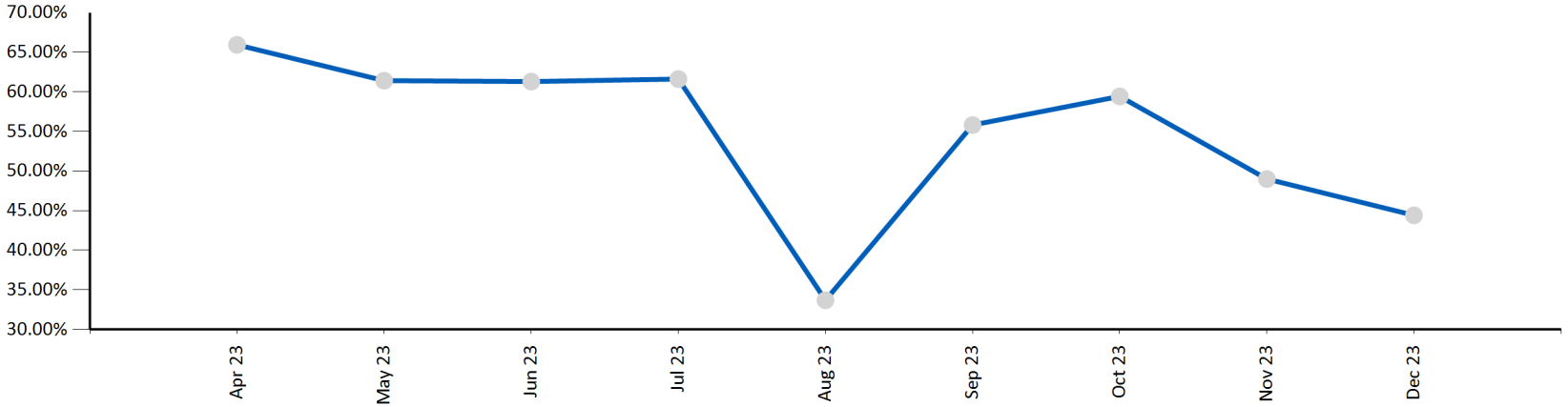
Previous

Plan	Actual	Period
<= 40%	36.2%	Nov-23

Year to Date

Plan	Actual
<= 40%	35.5%

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



Latest

Plan	Actual	Period
	44.4%	Dec-23

Previous

Plan	Actual	Period
	49.0%	Nov-23

Year to Date

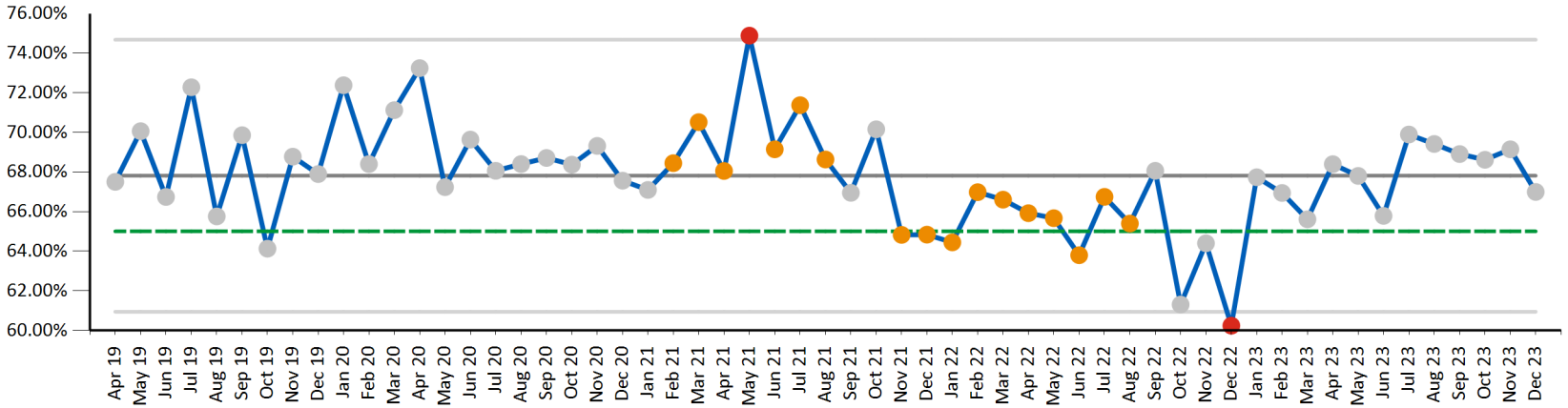
Plan	Actual
	54.8%

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%	66.99%	Dec-23

Previous

Plan	Actual	Period
>= 65%	69.14%	Nov-23

Year to Date

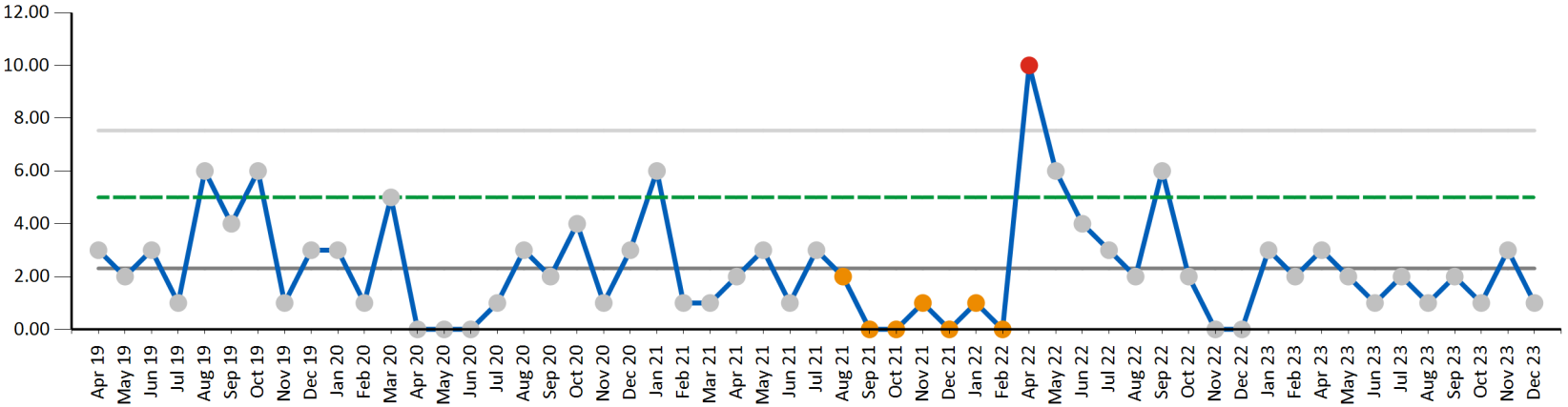
Plan	Actual
>= 65%	68.32%

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	Dec-23

Previous

Plan	Actual	Period
<= 5	3	Nov-23

Year to Date

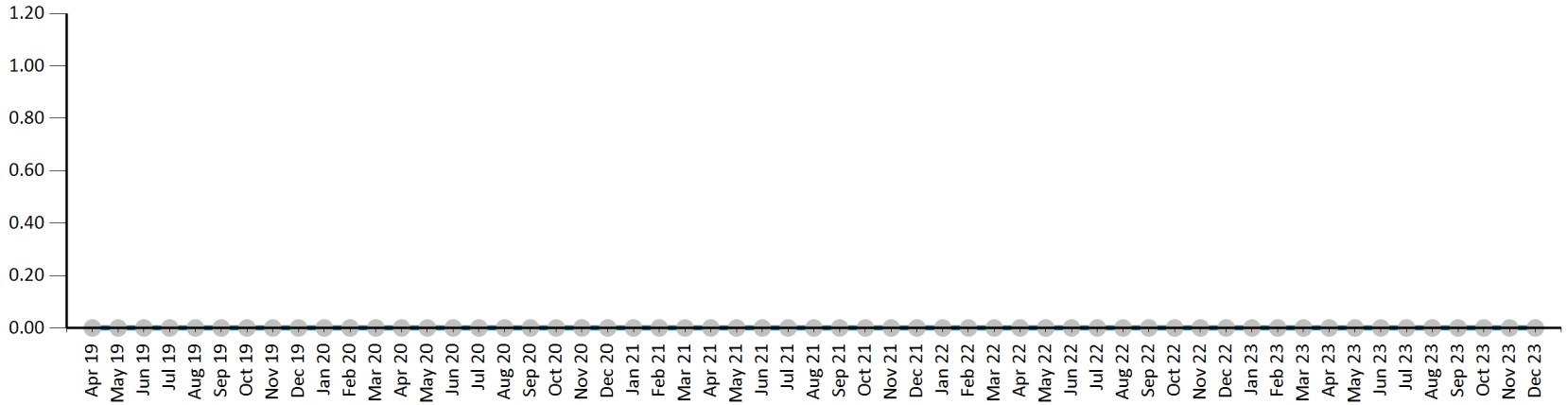
Plan	Actual
<= 45	16

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	Dec-23

Previous

Plan	Actual	Period
= 0	0	Nov-23

Year to Date

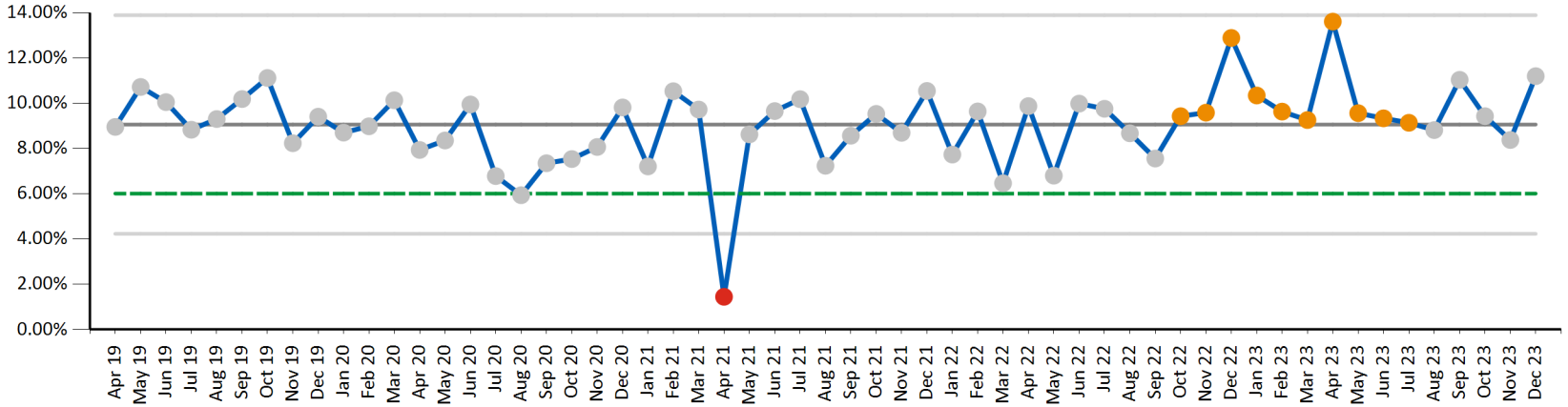
Plan	Actual
= 0	0

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%	11.2%	Dec-23

Previous

Plan	Actual	Period
<= 6%	8.4%	Nov-23

Year to Date

Plan	Actual
<= 6%	10.0%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

The number of patient ambulance handovers within 30 and 60 mins has seen a deterioration in month. Whilst it is a small decline there are a number of actions that are being taken in order to improve flow through the ED.

1) Forensic reviews of every patient is occurring twice a day in order to ensure there are no delays in the patient pathway, providing alternative solutions to in patient care
2) A modified continuous flow model of movement from ED to wards where we know patients will be discharged from. This occurs after the 9am bed meeting and if necessary at the 1pm bed meeting

There have been a number of benefits already seen and some areas for further improvement.

1) Discharges before 12pm and 4pm have significantly improved in AACD (12pm improved from 17.7% to 23.6%, and 4pm improved from 47.8% to 57.4%)
2) There has been a small improvement in non elective LOS from 10.18 days to 9.12 days
3) The number of patients who are readmitted has reduced month on month since Feb '20
4) The number of patients admitted to a virtual ward remains above 80

However the number of stranded and super stranded patients has continued to increase which remains an area for focused improvement through the length of stay group

Patients going to theatre within 36 hours of a Fractured Neck of Femur
December's performance for fractured neck of femur reduced to 41.7%. 28 of the 48 eligible patients breached the 36-hour target; of these 10 were due to lack of theatre capacity, 14 were due to medical complexity, 2 due to medical emergencies and 2 were due to delays in listing / referral.
An improvement plan is in place, with a full action plan to be brought through Performance & Transformation Board in February.

	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%	56.8%	Dec-23	L	>= 75%	58.2%	Nov-23	>= 75%	62.3%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	47.8%	Dec-23		>= 65.0%	51.3%	Nov-23	>= 65.0%	53.9%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	72.9%	Dec-23		>= 95.0%	79.7%	Nov-23	>= 95.0%	80.8%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	86.02%	Dec-23		= 100%	92.55%	Nov-23	= 100%	92.27%	F
539 - A&E 12 hour waits	= 0	1,320	Dec-23		= 0	1,277	Nov-23	= 0	10,613	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	41.7%	Dec-23		>= 75%	67.6%	Nov-23	>= 75%	56.8%	?

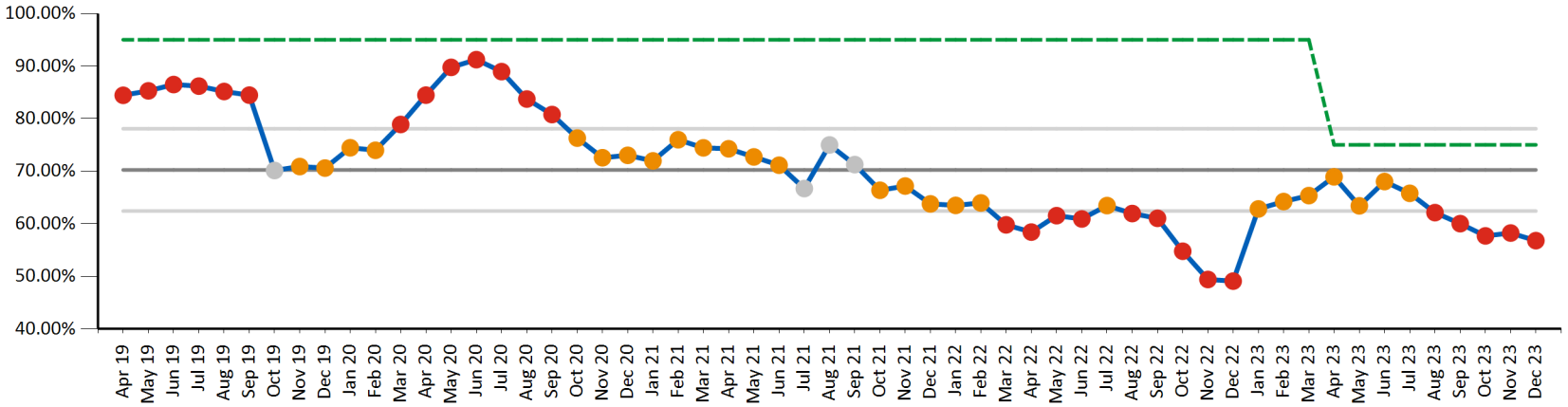
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
56 - Stranded patients - over 7 days	<= 200	275	Dec-23	H	<= 200	261	Nov-23	<= 200	275	?
307 - Stranded Patients - LOS 21 days and over	<= 69	108	Dec-23	H	<= 69	98	Nov-23	<= 69	108	?
541 - Adult G&A bed occupancy	<= 92.0%	88.9%	Dec-23		<= 92.0%	89.7%	Nov-23	<= 92.0%	87.1%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.26	Dec-23		<= 3.70	5.38	Nov-23	<= 3.70	5.95	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	7.9%	Nov-23	L	<= 13.5%	7.7%	Oct-23	<= 13.5%	8.6%	P

53 - A&E 4 hour target

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	56.8%	Dec-23

Previous

Plan	Actual	Period
>= 75%	58.2%	Nov-23

Year to Date

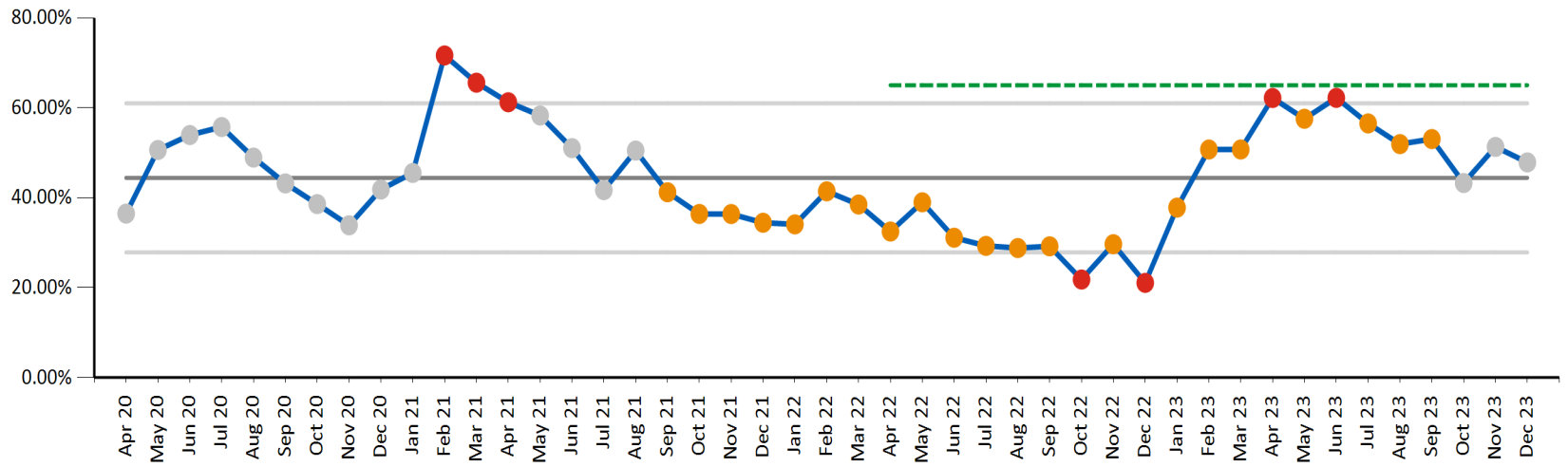
Plan	Actual
>= 75%	62.3%

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%	47.8%	Dec-23

Previous

Plan	Actual	Period
>= 65.0%	51.3%	Nov-23

Year to Date

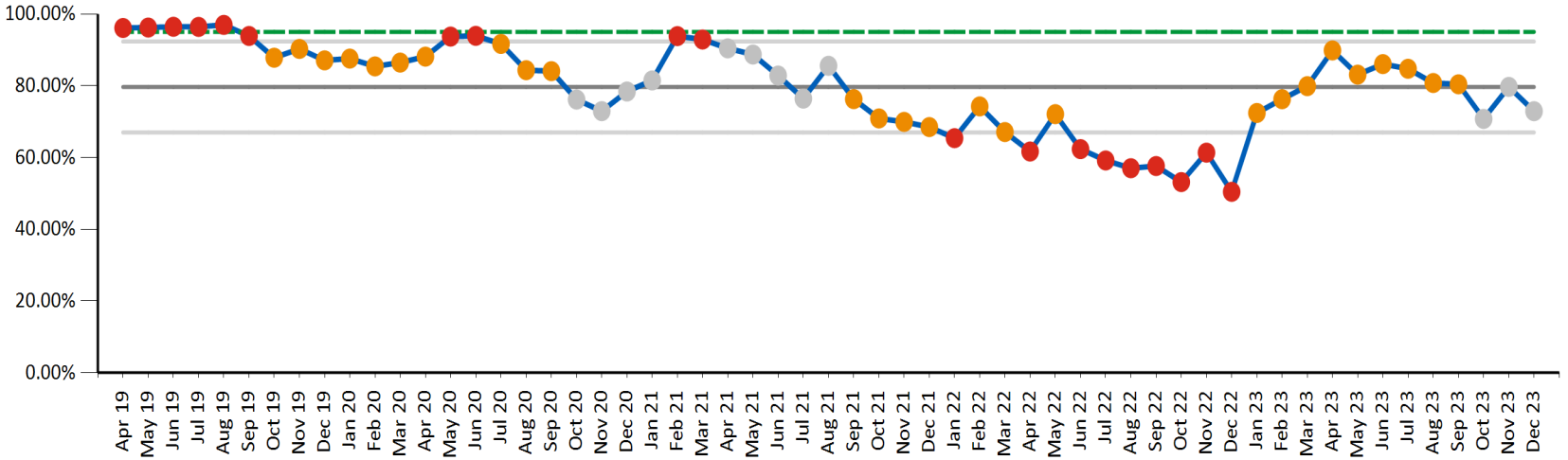
Plan	Actual
>= 65.0%	53.9%

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%	72.9%	Dec-23

Previous

Plan	Actual	Period
>= 95.0%	79.7%	Nov-23

Year to Date

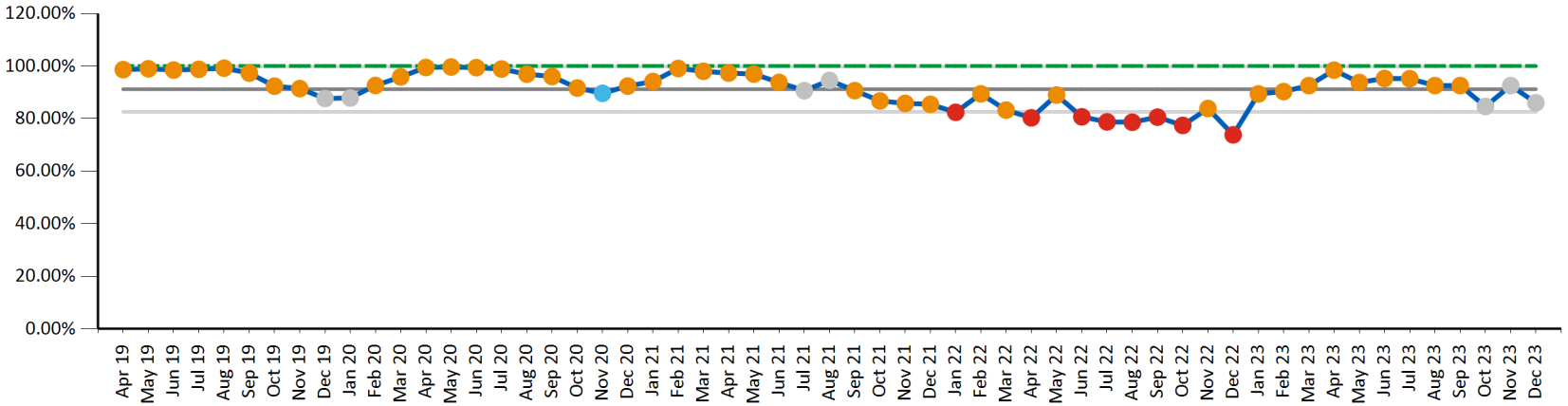
Plan	Actual
>= 95.0%	80.8%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	86.02%	Dec-23

Previous

Plan	Actual	Period
= 100%	92.55%	Nov-23

Year to Date

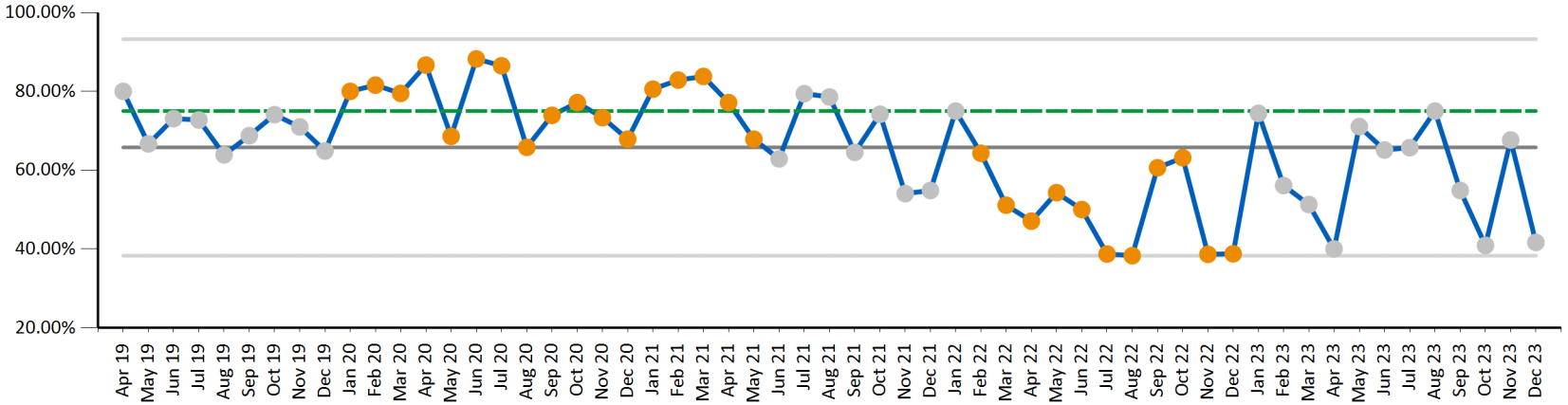
Plan	Actual
= 100%	92.27%

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 75%	41.7%	Dec-23

Previous

Plan	Actual	Period
>= 75%	67.6%	Nov-23

Year to Date

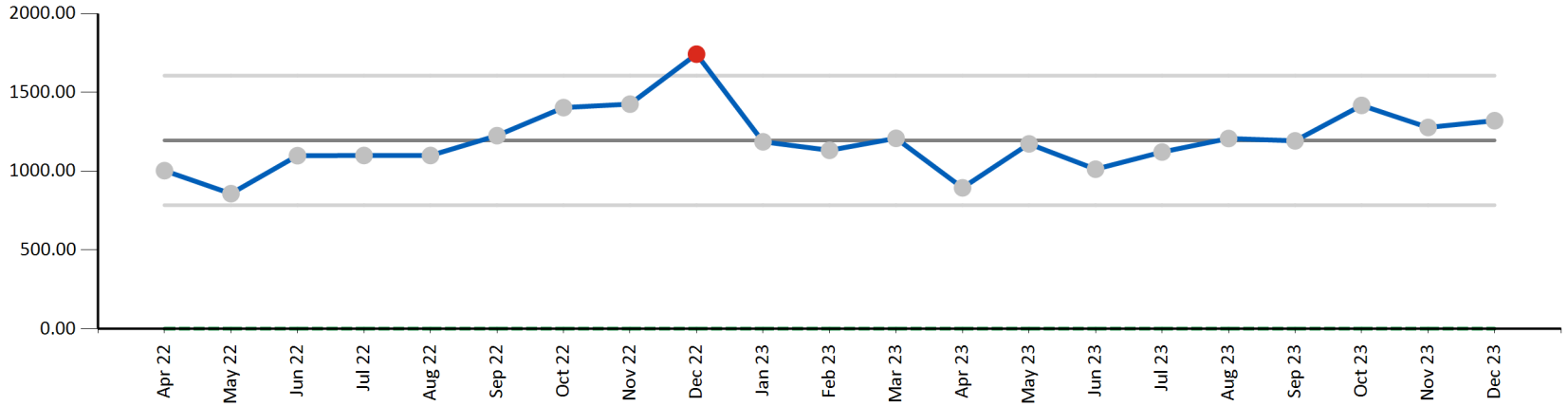
Plan	Actual
>= 75%	56.8%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,320	Dec-23

Previous

Plan	Actual	Period
= 0	1,277	Nov-23

Year to Date

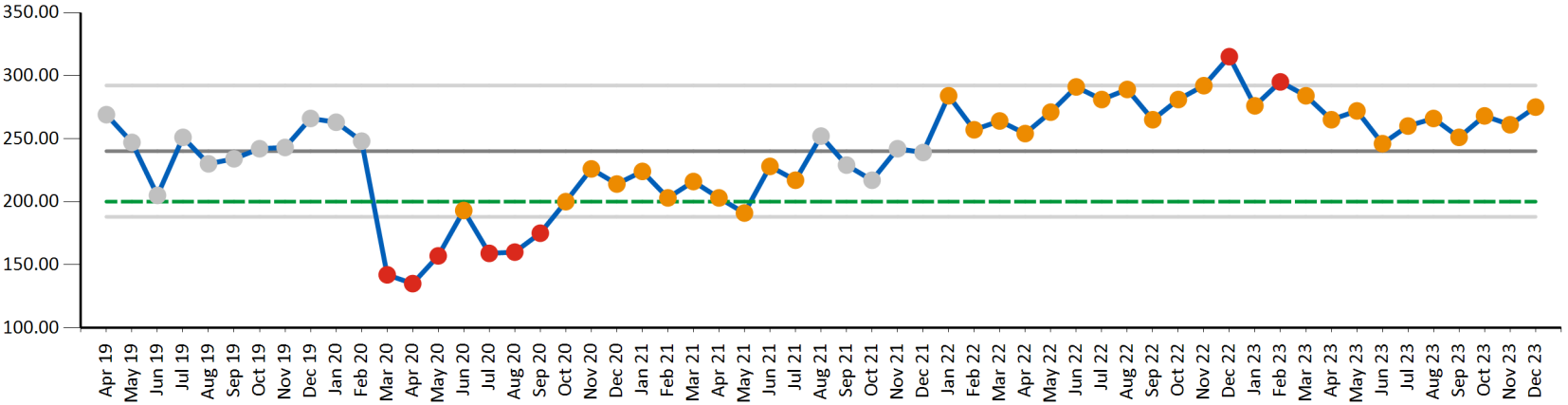
Plan	Actual
= 0	10,613

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	275	Dec-23

Previous

Plan	Actual	Period
<= 200	261	Nov-23

Year to Date

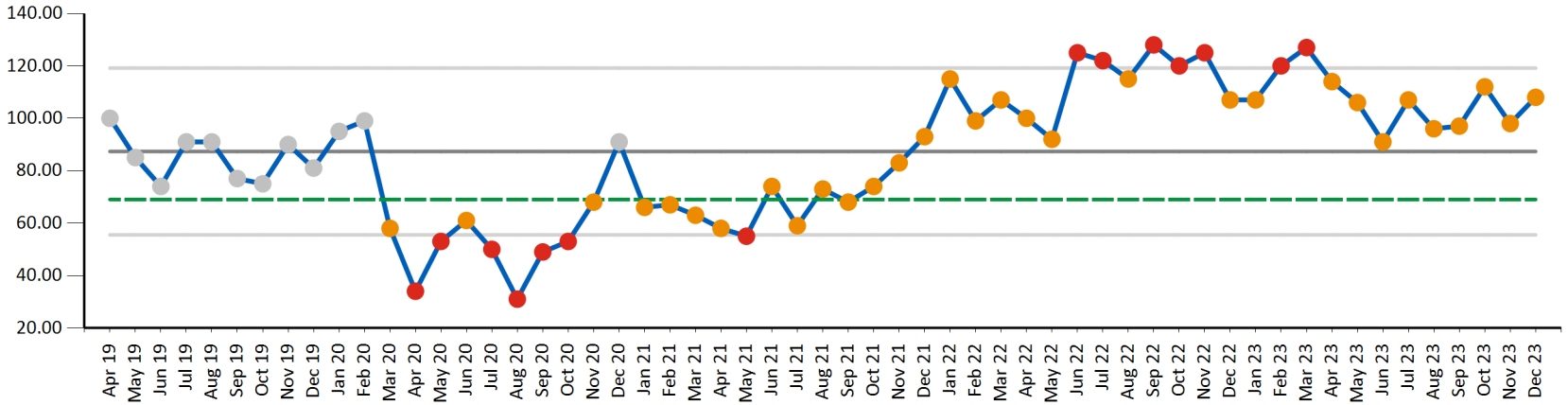
Plan	Actual
<= 200	275

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	108	Dec-23

Previous

Plan	Actual	Period
<= 69	98	Nov-23

Year to Date

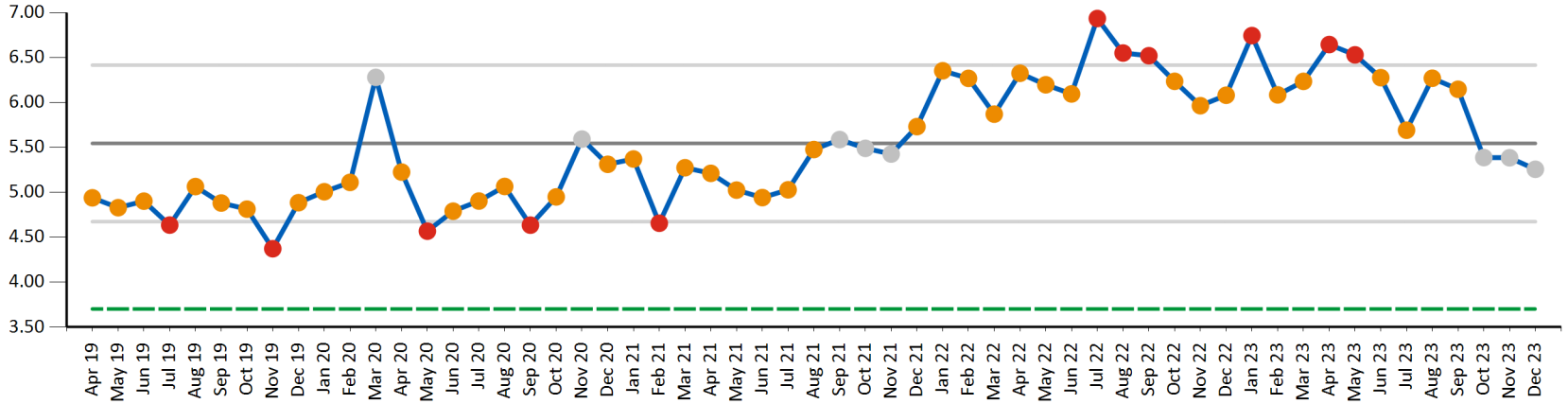
Plan	Actual
<= 69	108

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	5.26	Dec-23

Previous

Plan	Actual	Period
<= 3.70	5.38	Nov-23

Year to Date

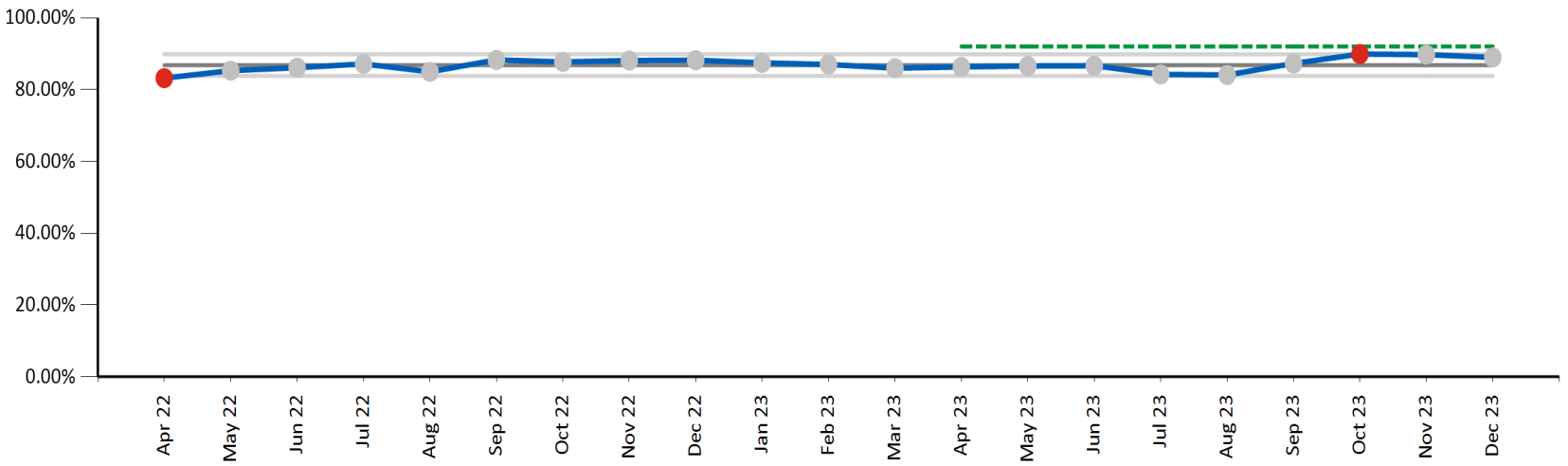
Plan	Actual
<= 3.70	5.95

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	88.9%	Dec-23

Previous

Plan	Actual	Period
<= 92.0%	89.7%	Nov-23

Year to Date

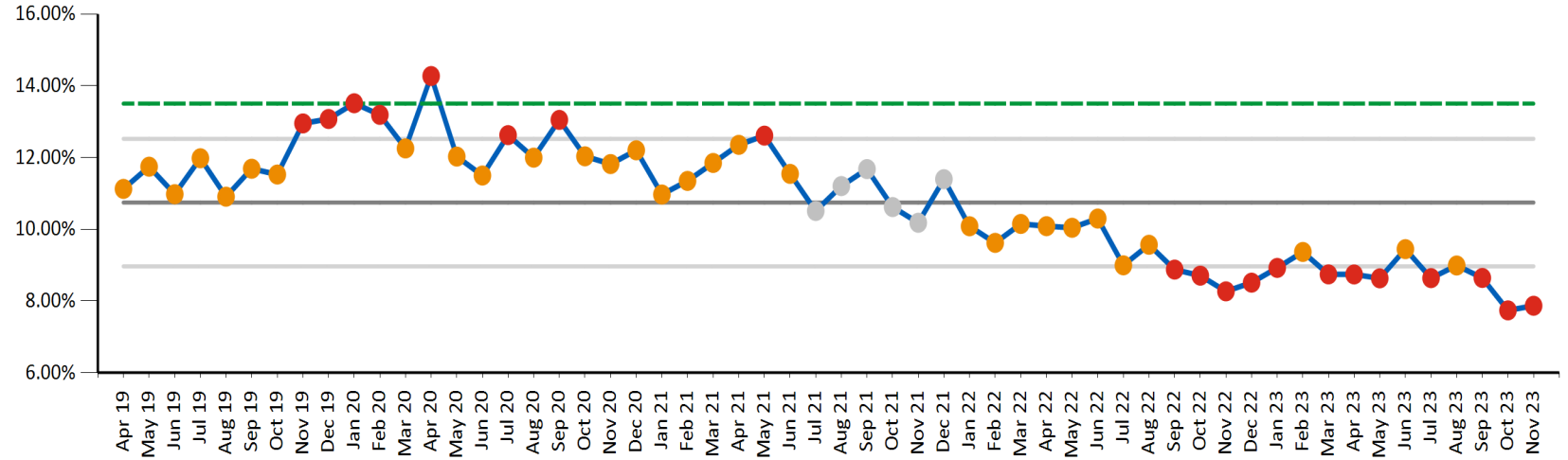
Plan	Actual
<= 92.0%	87.1%

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%	7.9%	Nov-23

Previous

Plan	Actual	Period
<= 13.5%	7.7%	Oct-23

Year to Date

Plan	Actual
<= 13.5%	8.6%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

We finished December with 84 patients having waited longer than 78-weeks. Off these, 11 patients were clinically complex, 33 patients chose to delay their treatment, 6 patients required corneal graft tissue which is not yet available and 34 patients were delayed due to capacity.
Key areas where we do not have capacity to treat patients within the standard remain Paediatric specialties, which was impacted by the Paediatric Winter Pressures in November / early December. We also saw a significant impact upon performance from the industrial action period in December.
We finished December with 2 patients having waited longer than 104 weeks. Both will have been treated by the end of January.

Our position against our trajectory for delivery of the 65-week wait target deteriorated in December, impacted upon by the industrial action.
Work continues to maximise our opportunities to benefit from mutual aid available from partners within GM. Key specialties predicted to have 65-week breaches at the end of March have developed action plans to mitigate the position wherever possible.

DM01
The trust position has deteriorated slightly this month, however this was expected due to the combination of Industrial Action, annual leave, and multiple bank holidays all affecting the capacity to offer diagnostics tests across the festive period. At 12.6% however, we remain on track to meet the recovery milestone of less than 5% of patients breaching 6 weeks for their diagnostic by March 2025. The DM01 waiting list decreased in month by 284 patients, but 86 more people were waiting over 6 weeks. Cystoscopy and Audiology continued their recovery work and despite the challenges mentioned above, managed to maintain their position. Urodynamics was able to continue to improve their overall position from 50% to 29.2% and reduce their number of patients waiting over 6 weeks by half.

	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%	51.1%	Dec-23		>= 92%	53.7%	Nov-23	>= 92%	56.6%	
314 - RTT 18 week waiting list	<= 38,064	44,526	Dec-23		<= 38,214	44,404	Nov-23	<= 38,064	44,526	
42 - RTT 52 week waits (incomplete pathways)		2,816	Dec-23			2,653	Nov-23		21,083	
540 - RTT 65 week waits (incomplete pathways)	<= 757	843	Dec-23		<= 731	705	Nov-23	<= 5,993	5,862	
526 - RTT 78 week waits (incomplete pathways)	= 0	84	Dec-23		= 0	69	Nov-23	= 0	388	
527 - RTT 104 week waits (incomplete pathways)	= 0	2	Dec-23		= 0	3	Nov-23	= 0	8	
72 - Diagnostic Waits >6 weeks %	<= 5%	12.6%	Dec-23		<= 5%	11.5%	Nov-23	<= 5%	16.4%	

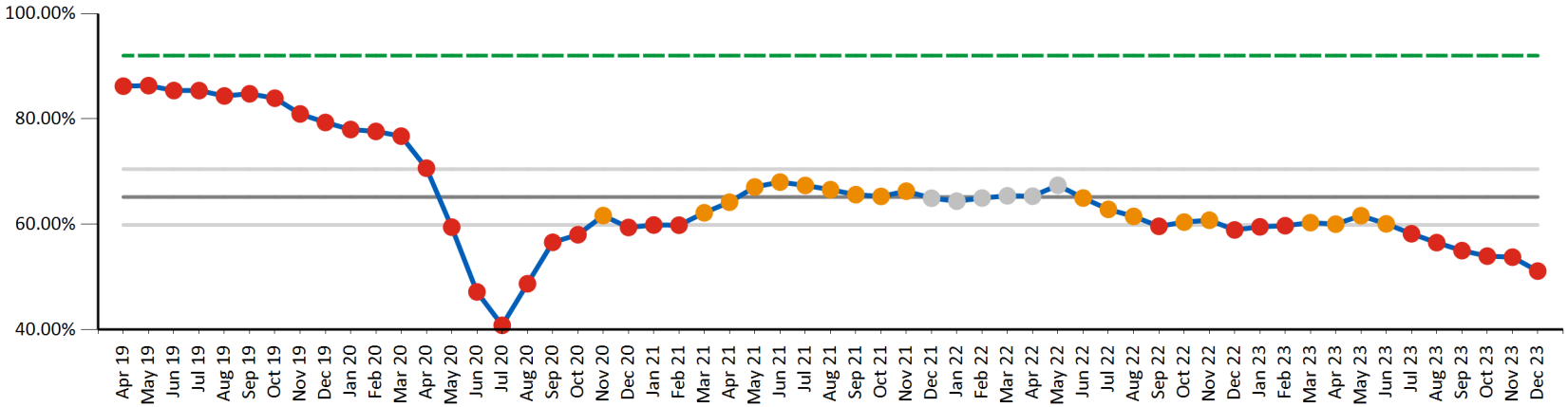
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
489 - Daycase Rates	>= 85%	83.5%	Dec-23		>= 85%	82.8%	Nov-23	>= 85%	84.5%	?
582 - Theatre Utilisation - Capped		75.3%	Dec-23			77.7%	Nov-23		75.1%	
583 - Theatre Utilisation - Uncapped		79.1%	Dec-23			83.2%	Nov-23		80.1%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.5%	Dec-23		<= 1%	1.3%	Nov-23	<= 1%	1.6%	?
62 - Cancelled operations re-booked within 28 days	= 100%	81.8%	Nov-23		= 100%	79.5%	Oct-23	= 100%	27.8%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.29	Dec-23		<= 2.00	2.59	Nov-23	<= 2.00	2.95	?
309 - DNA Rate - New	<= 6.3%	9.5%	Dec-23	H	<= 6.3%	9.5%	Nov-23	<= 6.3%	9.8%	F
310 - DNA Rate - Follow up	<= 5.0%	9.1%	Dec-23		<= 5.0%	8.6%	Nov-23	<= 5.0%	9.1%	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%	51.1%	Dec-23

Previous

Plan	Actual	Period
>= 92%	53.7%	Nov-23

Year to Date

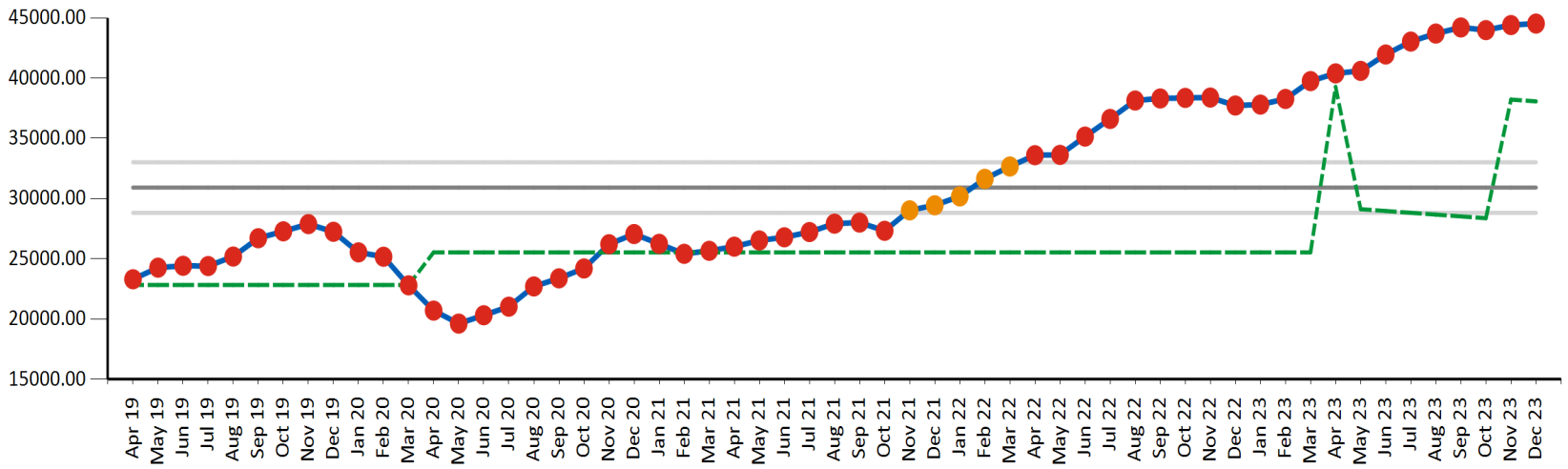
Plan	Actual
>= 92%	56.6%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
< = 38,064	44,526	Dec-23

Previous

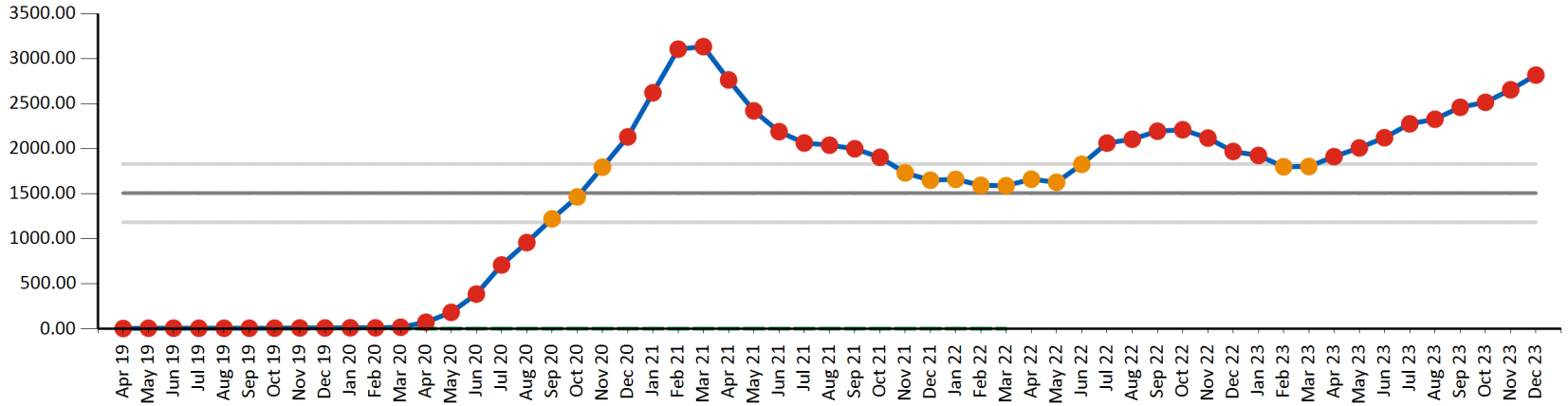
Plan	Actual	Period
< = 38,214	44,404	Nov-23

Year to Date

Plan	Actual
< = 38,064	44,526

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	2,816	Dec-23

Previous

Plan	Actual	Period
	2,653	Nov-23

Year to Date

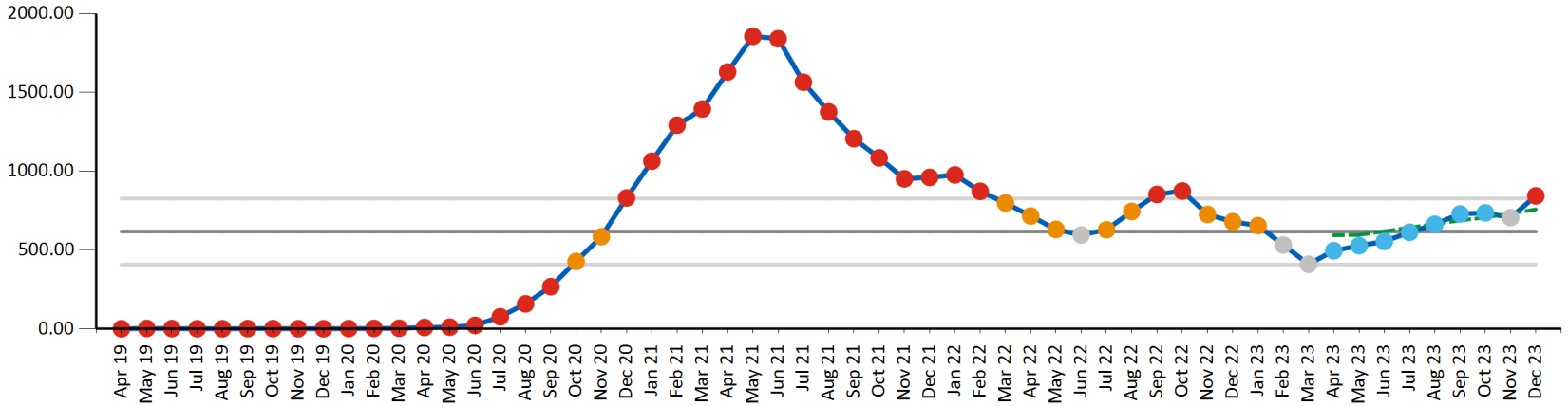
Plan	Actual
	21,083

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with deteriorating performance

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

3/6



Latest

Plan	Actual	Period
<= 757	843	Dec-23

Previous

Plan	Actual	Period
<= 731	705	Nov-23

Year to Date

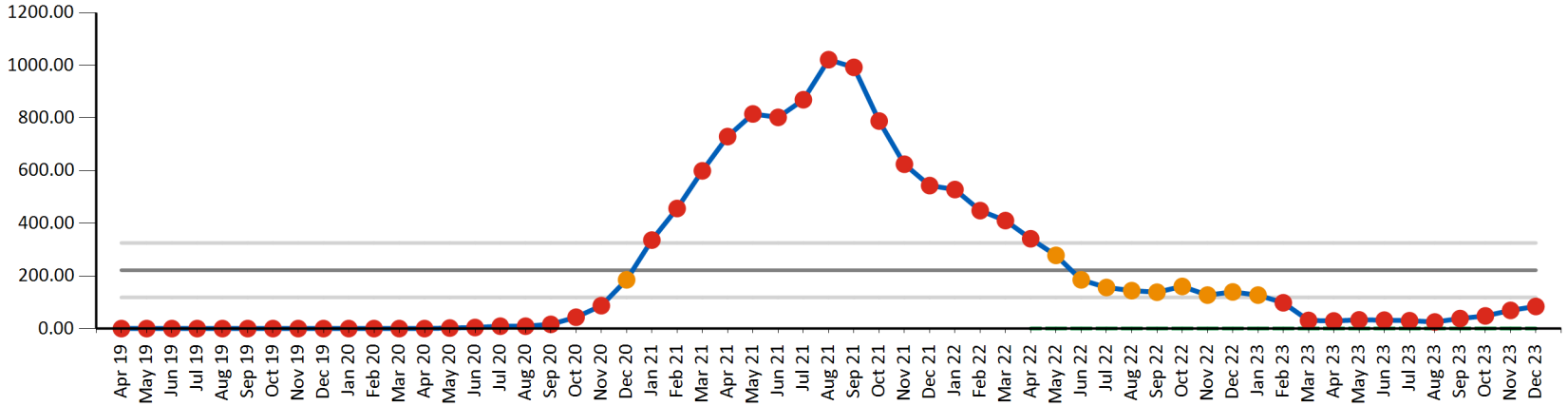
Plan	Actual
<= 5,993	5,862

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	84	Dec-23

Previous

Plan	Actual	Period
= 0	69	Nov-23

Year to Date

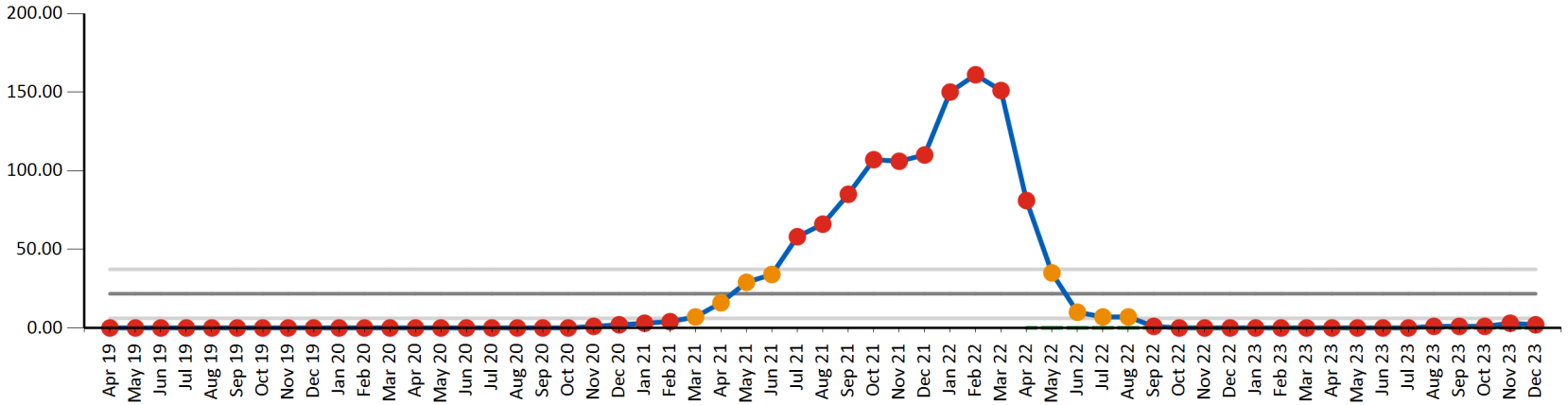
Plan	Actual
= 0	388

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
= 0	2	Dec-23

Previous

Plan	Actual	Period
= 0	3	Nov-23

Year to Date

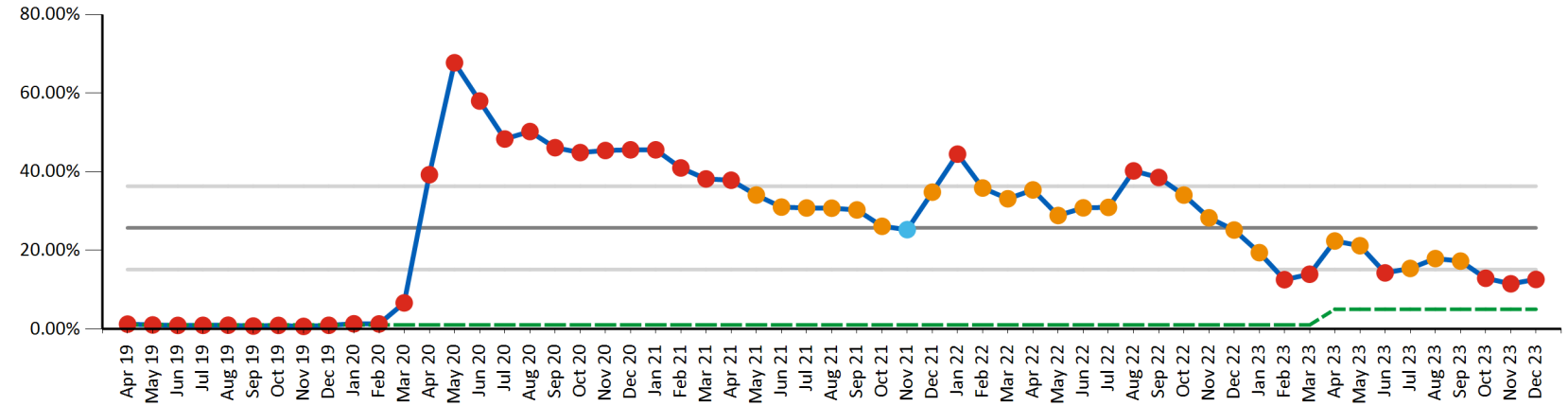
Plan	Actual
= 0	8

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%	12.6%	Dec-23

Previous

Plan	Actual	Period
<= 5%	11.5%	Nov-23

Year to Date

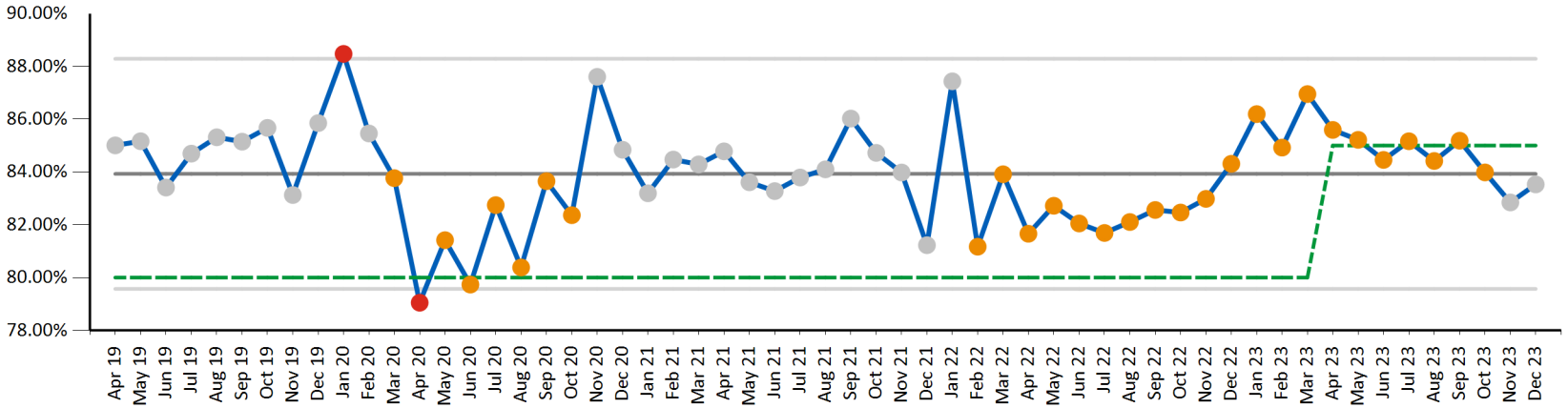
Plan	Actual
<= 5%	16.4%

489 - Daycase Rates

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 85%	83.5%	Dec-23

Previous

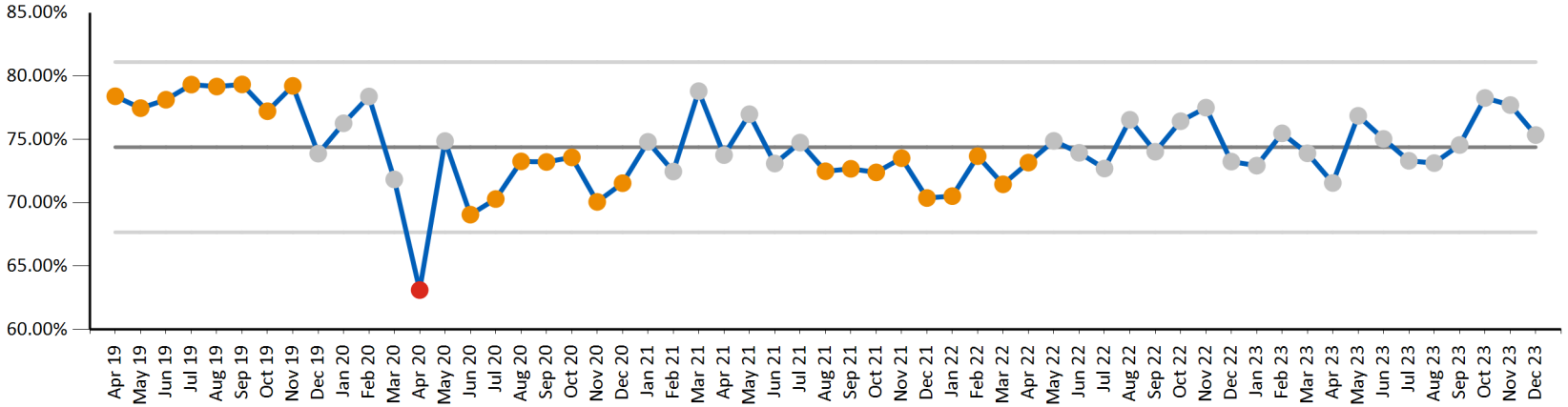
Plan	Actual	Period
>= 85%	82.8%	Nov-23

Year to Date

Plan	Actual
>= 85%	84.5%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	75.3%	Dec-23

Previous

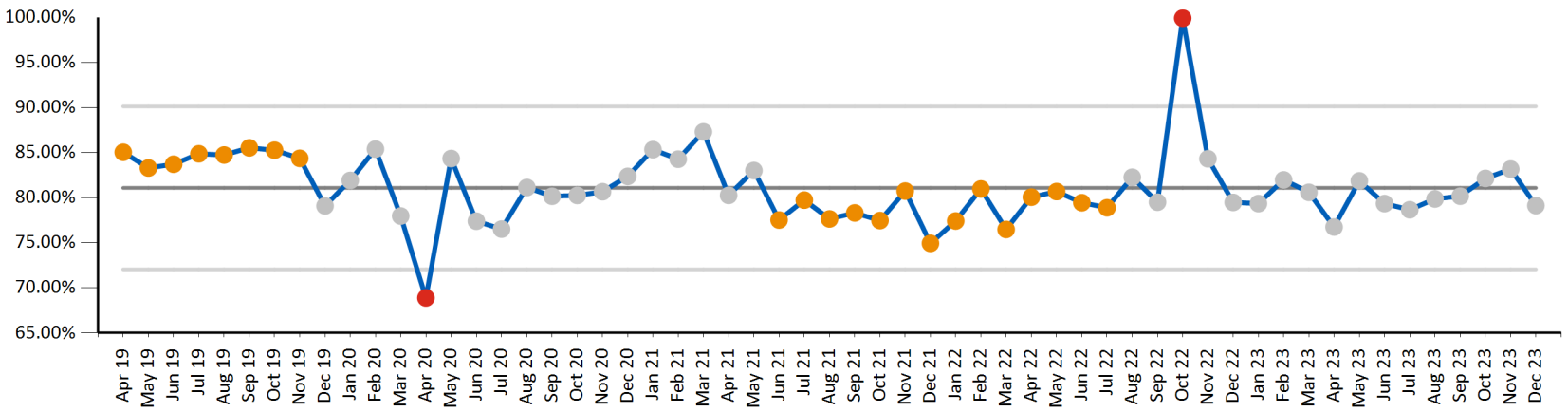
Plan	Actual	Period
	77.7%	Nov-23

Year to Date

Plan	Actual
	75.1%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	79.1%	Dec-23

Previous

Plan	Actual	Period
	83.2%	Nov-23

Year to Date

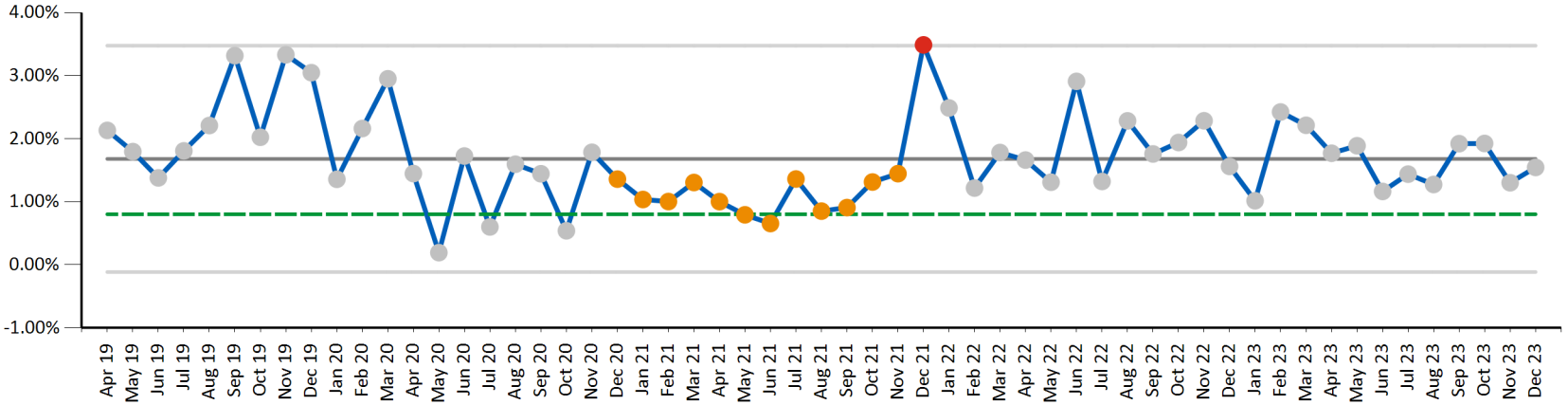
Plan	Actual
	80.1%

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%	1.5%	Dec-23

Previous

Plan	Actual	Period
<= 1%	1.3%	Nov-23

Year to Date

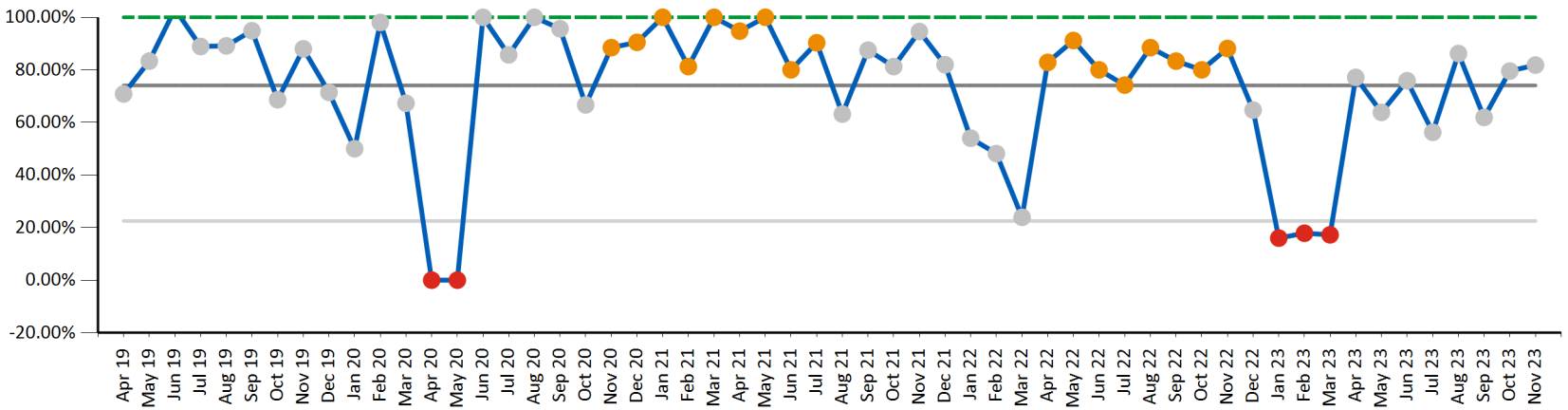
Plan	Actual
<= 1%	1.6%

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%	81.8%	Nov-23

Previous

Plan	Actual	Period
= 100%	79.5%	Oct-23

Year to Date

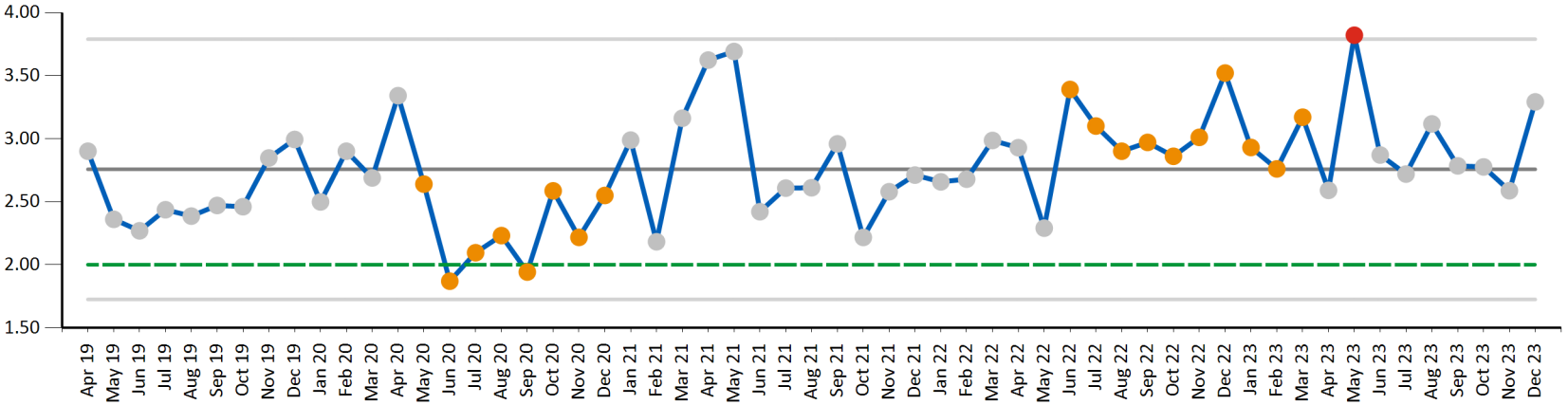
Plan	Actual
= 100%	27.8%

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	3.29	Dec-23

Previous

Plan	Actual	Period
<= 2.00	2.59	Nov-23

Year to Date

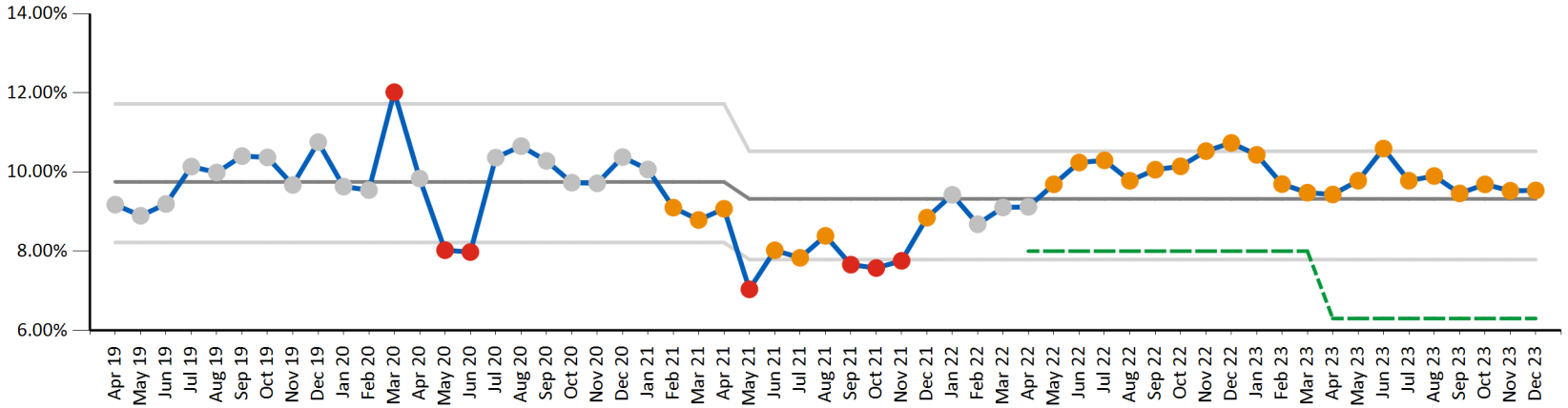
Plan	Actual
<= 2.00	2.95

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%	9.5%	Dec-23

Previous

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

Year to Date

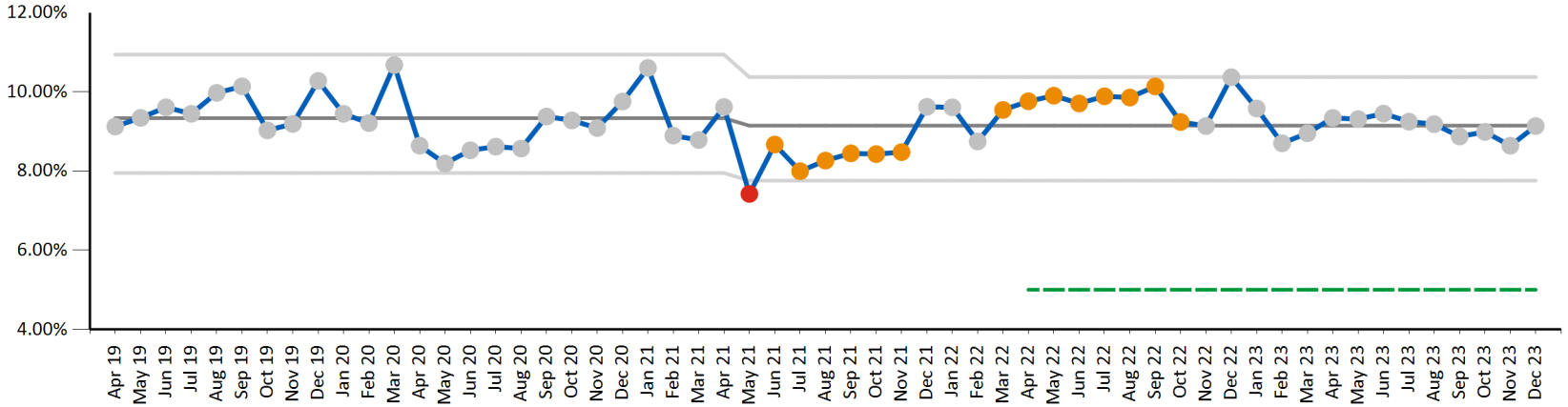
Plan	Actual
<= 6.3%	9.8%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.1%	Dec-23

Previous

Plan	Actual	Period
<= 5.0%	8.6%	Nov-23

Year to Date

Plan	Actual
<= 5.0%	9.1%

Operational Performance - Cancer

Bolton NHS Foundation Trust

Performance against the Faster Diagnosis standard was maintained in November at 80.43% against a target of 75%.
Performance against the 31-Day standard improved to 99.24% against a target of 96%.
Performance against the 62-Day standard improved in November to 81.55% against a target of 85%. Our key areas of underperformance were Breast, Colorectal, and Lung. 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 was off-track slightly in November; we had 28 patients on the PTL over 62 days against a planned position of 26 patients. We expect to see recovery for December's performance.

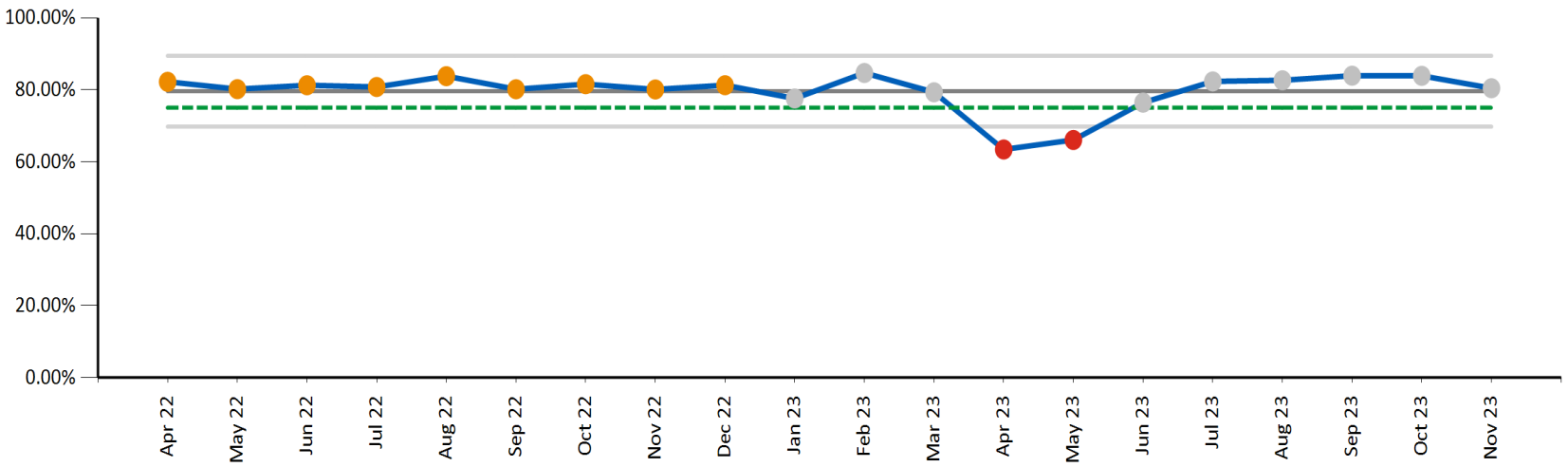
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	80.4%	Nov-23		>= 75.0%	83.9%	Oct-23	>= 75.0%	78.0%	
584 - 31 Day General Treatment Standard	>= 96%	99.2%	Nov-23		>= 96%	97.8%	Oct-23	>= 96%	98.5%	
585 - 62 Day General Standard	>= 85%	81.5%	Nov-23		>= 85%	77.7%	Oct-23	>= 85%	79.6%	

542 - Cancer: 28 day faster diagnosis

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	80.4%	Nov-23

Previous

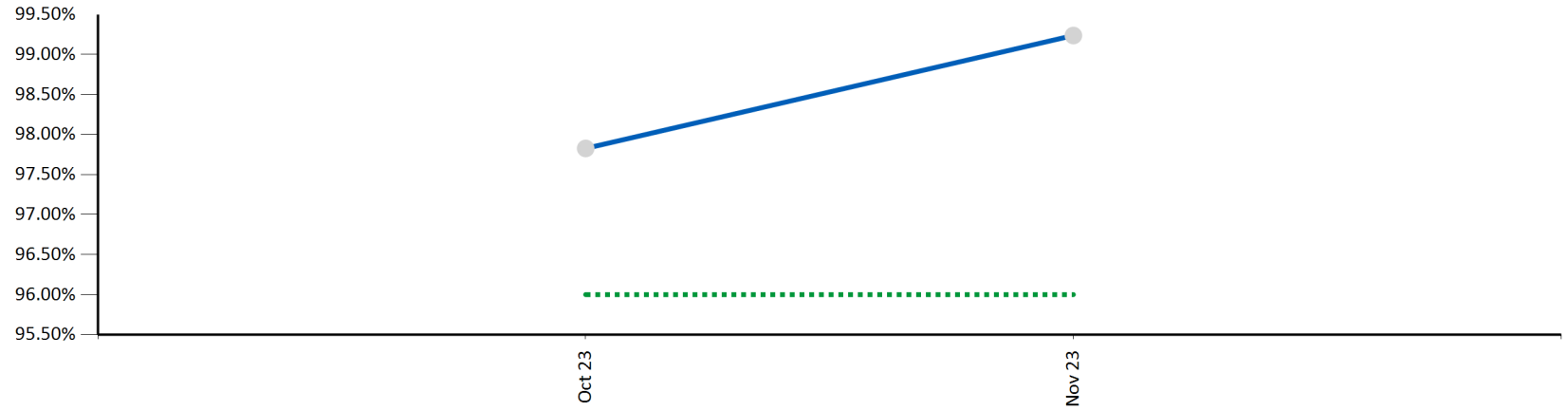
Plan	Actual	Period
>= 75.0%	83.9%	Oct-23

Year to Date

Plan	Actual
>= 75.0%	78.0%

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

2/6



Latest

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

Previous

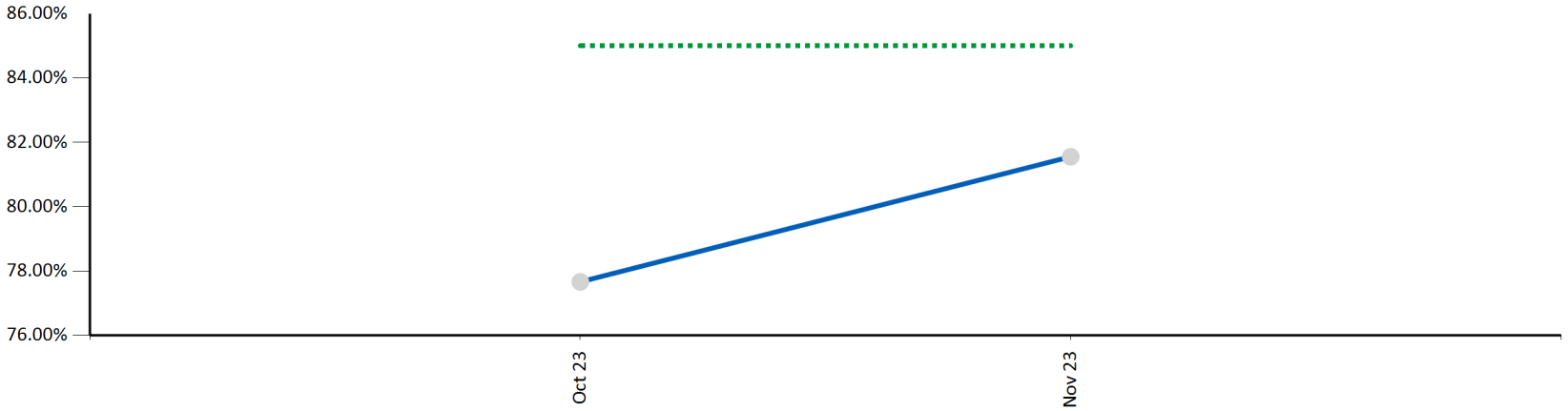
Plan	Actual	Period
>= 96%	97.8%	Oct-23

Year to Date

Plan	Actual
0.96	98.5%

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

0/6



Latest

Plan	Actual	Period
>= 85%	81.5%	Nov-23

Previous

Plan	Actual	Period
>= 85%	77.7%	Oct-23

Year to Date

Plan	Actual
0.85	79.6%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

ED deflections
ED deflections for Month 9 have increased to 593, remaining above plan of 400. Collaborative work and daily proactive interface between our Admission Avoidance and Acute Frailty teams to support deflections, together with a recent care home pilot led by AAT with two of our highest conveyance care homes, have supported increased deflections. Further work to roll this pilot out wider is ongoing. Our Home First team continue to support deflections working collaboratively across our wider Community teams.

NCTR
The number of patients with No Criteria to Reside is below our operational plan of 90, an average of 85 patients in Month 9.
We have seen a reduction in occupied bed days at 653. No closures in Month 9 across our Intermediate Tier beds together with senior caseload review of patients with 5-10 delayed bed days supported an overall reduction in lost bed days.The team are working to embed senior caseload reviews as business as usual.

0-5 Mandated Contacts
Our continued underperformance is 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.

EHCP compliance
There has been a special cause deteriorating variance in performance this month. The major cause of which is currently identified as APNP appointment capacity being limited in December. A new pathway has now been agreed with the ICB and signed off and comes into effect in January 2024. This will mean that patients do not need a medical appointment/review unless indicated rather than as standard. The new pathway will have a significant impact on APNP capacity and reduce delays. The second largest factor in breaches was due to children not being brought to appointments. There is an improvement workstream in place regarding was not brought rates which is taking a particular focus on socio-economic factors and is linked to our wider work on health inequality reduction.

Looked After Children
We met the standard for Review Health Assessments by Health Visitor & School Nurse and for Review health Assessments for over 5's in special schools.
For initial health assessments, we failed the standard in month and this is due to 2 breaches one of which was due to a child not being brought and the other was due to the child being transferred out of area.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	593	Dec-23		>= 400	468	Nov-23	>= 3,600	4,529	
493 - Average Number of Patients: with no Criteria to Reside	<= 97	85	Dec-23		<= 96	91	Nov-23	<= 97	85	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	653	Dec-23		<= 360	662	Nov-23	<= 3,240	6,789	

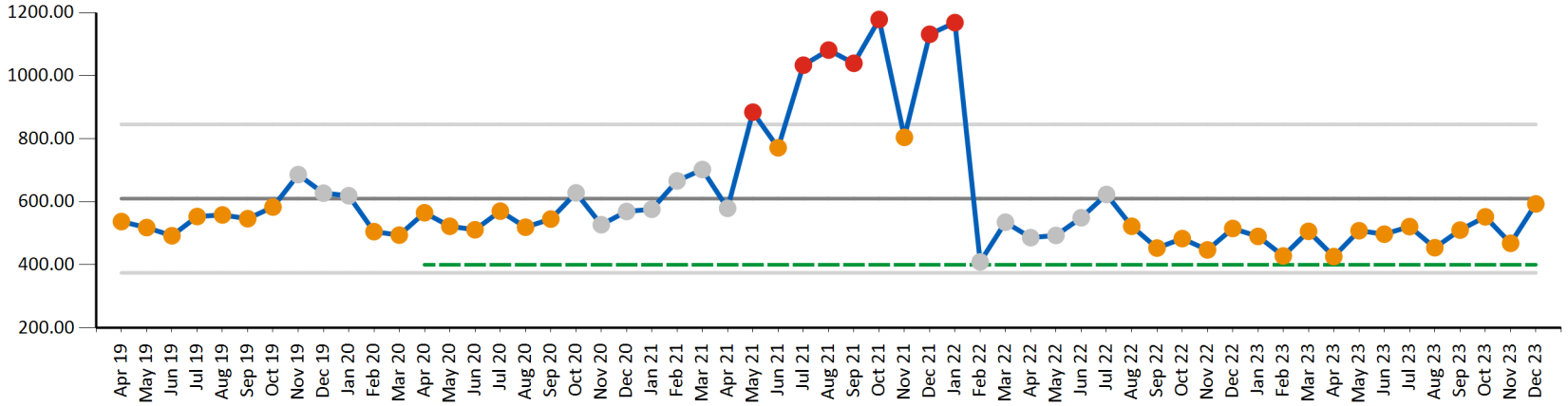
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
267 - 0-5 Health Visitor mandated contacts	>= 95%	81%	Dec-23		>= 95%	80%	Nov-23	>= 95%	81%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	53%	Dec-23	L	>= 95%	71%	Nov-23	>= 95%	77%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	90.0%	Dec-23		>= 90.0%	92.0%	Nov-23	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	82.0%	Dec-23		>= 90.0%	88.0%	Nov-23	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Dec-23		>= 90.0%	100.0%	Nov-23	>= 90.0%		

334 - Total Deflections from ED

L — Special cause variation with deteriorating performance

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

6/6



Latest

Plan	Actual	Period
>= 400	593	Dec-23

Previous

Plan	Actual	Period
>= 400	468	Nov-23

Year to Date

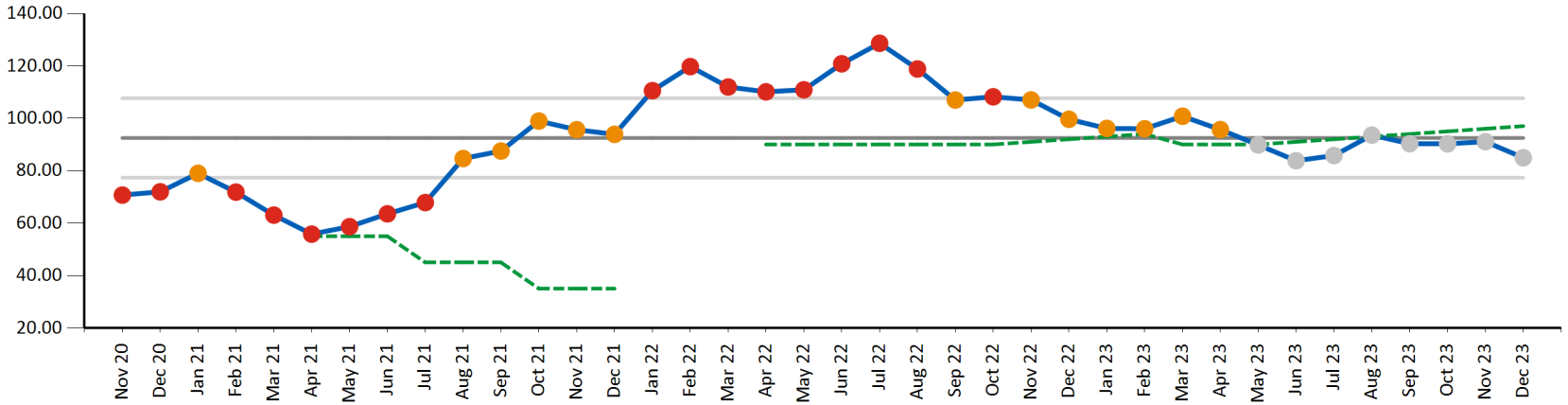
Plan	Actual
>= 3,600	4,529

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
<= 97	85	Dec-23

Previous

Plan	Actual	Period
<= 96	91	Nov-23

Year to Date

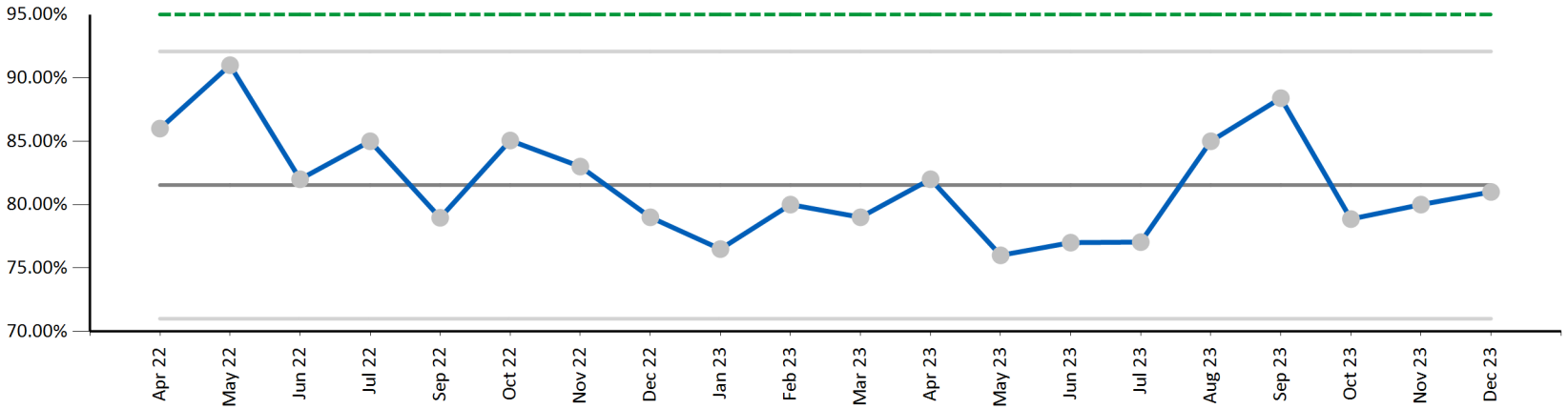
Plan	Actual
<= 97	85

267 - 0-5 Health Visitor mandated contacts

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	81%	Dec-23

Previous

Plan	Actual	Period
>= 95%	80%	Nov-23

Year to Date

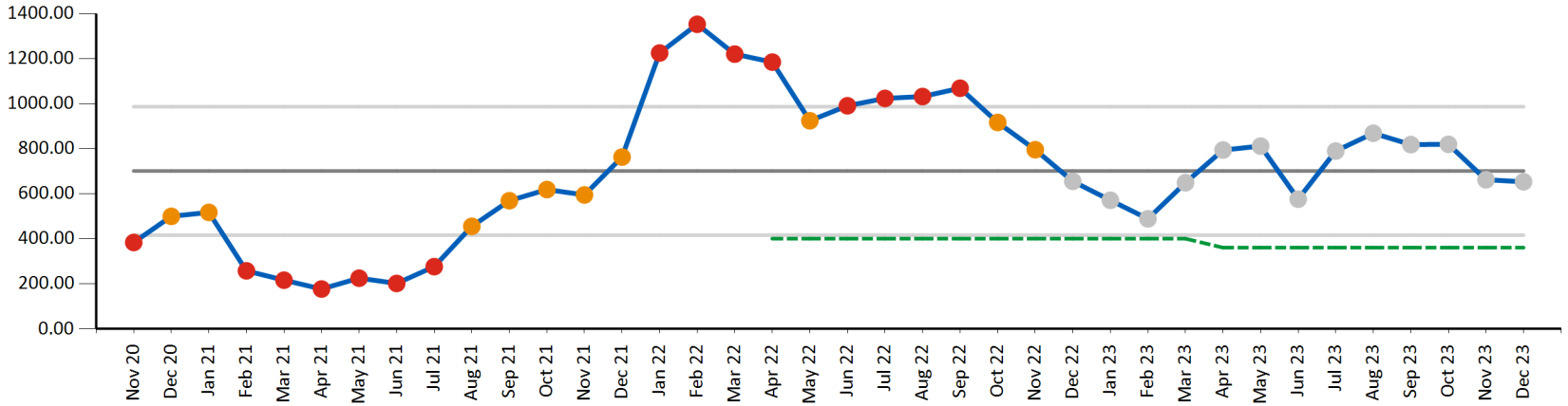
Plan	Actual
>= 95%	81%

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	653	Dec-23

Previous

Plan	Actual	Period
<= 360	662	Nov-23

Year to Date

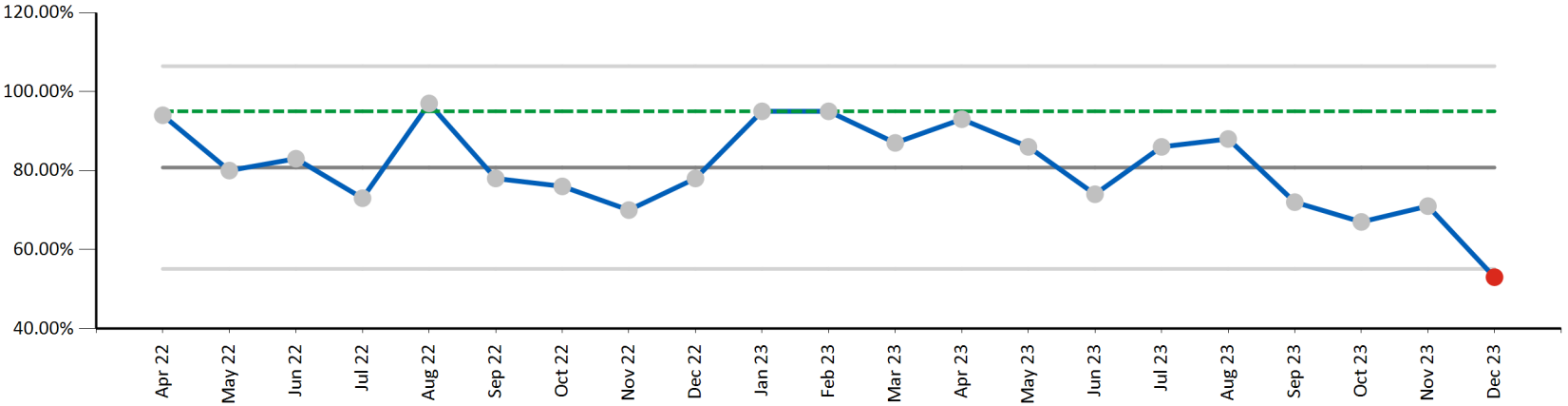
Plan	Actual
<= 3,240	6,789

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 95%	53%	Dec-23

Previous

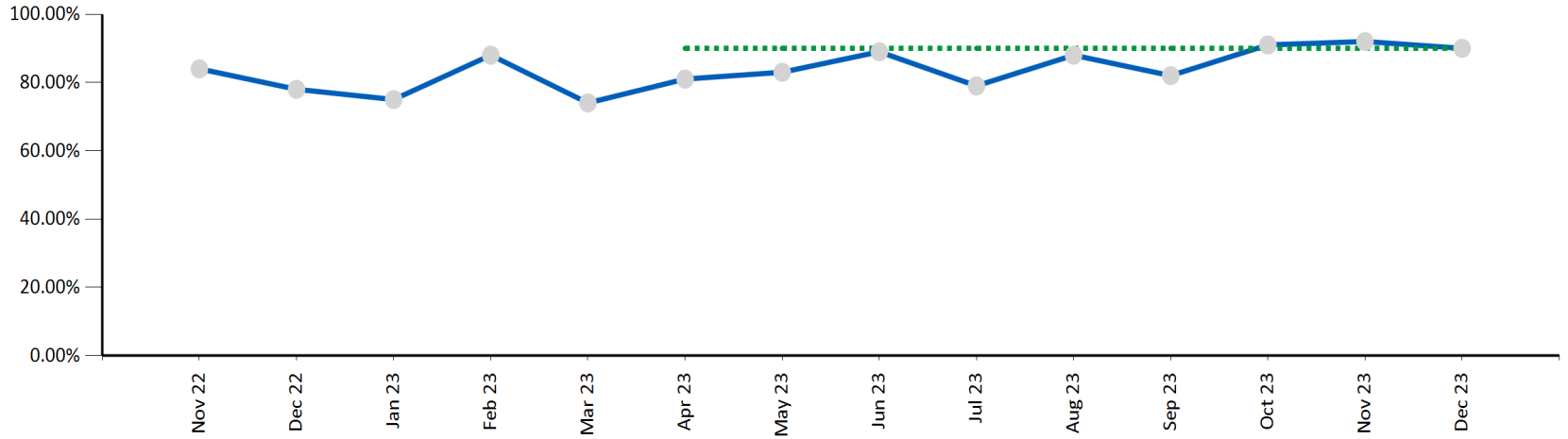
Plan	Actual	Period
>= 95%	71%	Nov-23

Year to Date

Plan	Actual
>= 95%	77%

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

3/6



Latest

Plan	Actual	Period
> = 90.0%	90.0%	Dec-23

Previous

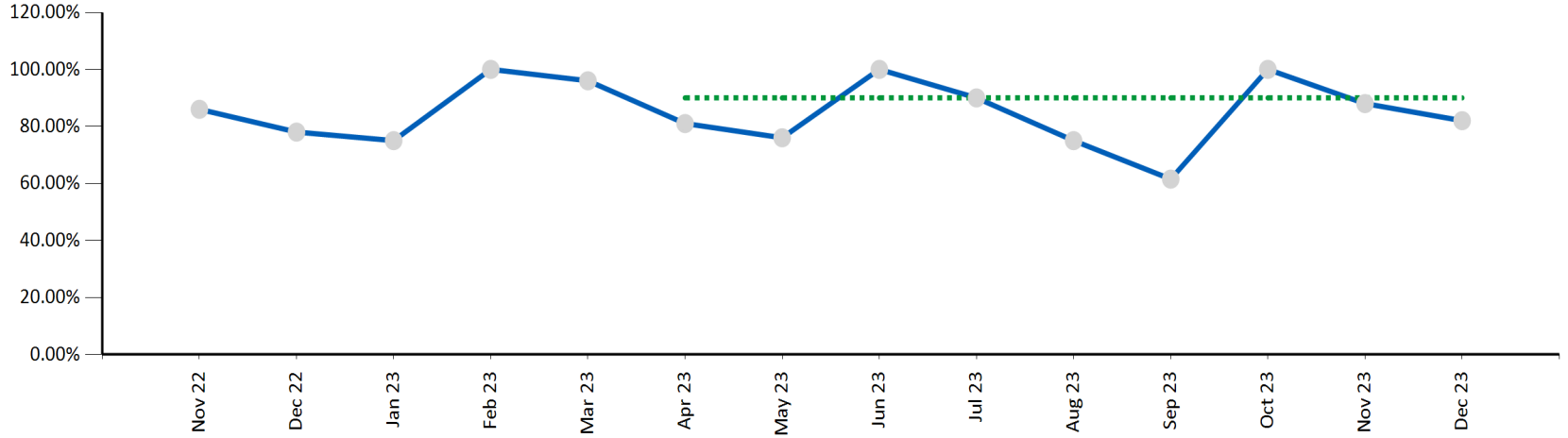
Plan	Actual	Period
> = 90.0%	92.0%	Nov-23

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

2/6



Latest

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

Previous

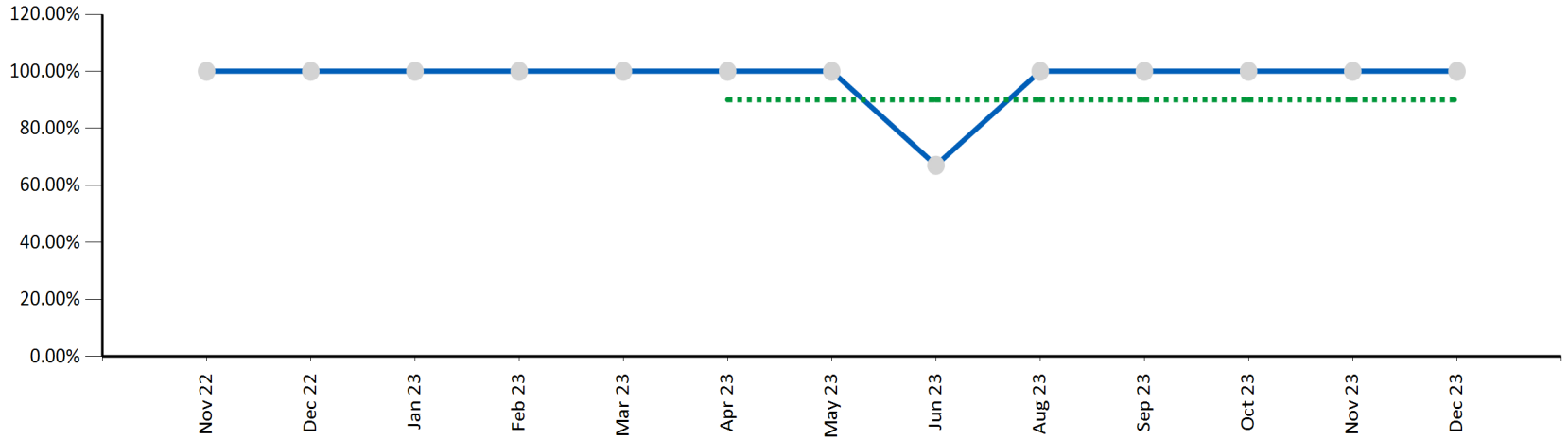
Plan	Actual	Period
> = 90.0%	88.0%	Nov-23

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%	Dec-23

Previous

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

Year to Date

Plan	Actual
0.9	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness has increased in December 2023 to 5.62% from 5.33% in November 2023. The increase in absence is observed largely across the Trust with notable increases occurring in DSSD (Increase of 1.78%) compared to November 2023. The main absence cause of continues to be Cold & Flu related sickness, which remains high during the seasonal period. The rates of Covid related absence has remained fairly static across the Trust and stands at 0.15% compared to 0.21% in November 2023. The Trust continues to offer Flu and Covid-19 vaccines to support staff during this seasonal period.

Trust vacancy rate increased in December 2023 but is still running under plan (6%) at 5.59%. The Trust benchmarks positively in this regard when compared to other providers across GM.

Turnover has reduced slightly in December 23 at 11.69% from a rate of 12.03% in November 23, and this reflects the reducing trend of turnover since January 2023 from a high of 13.99%.

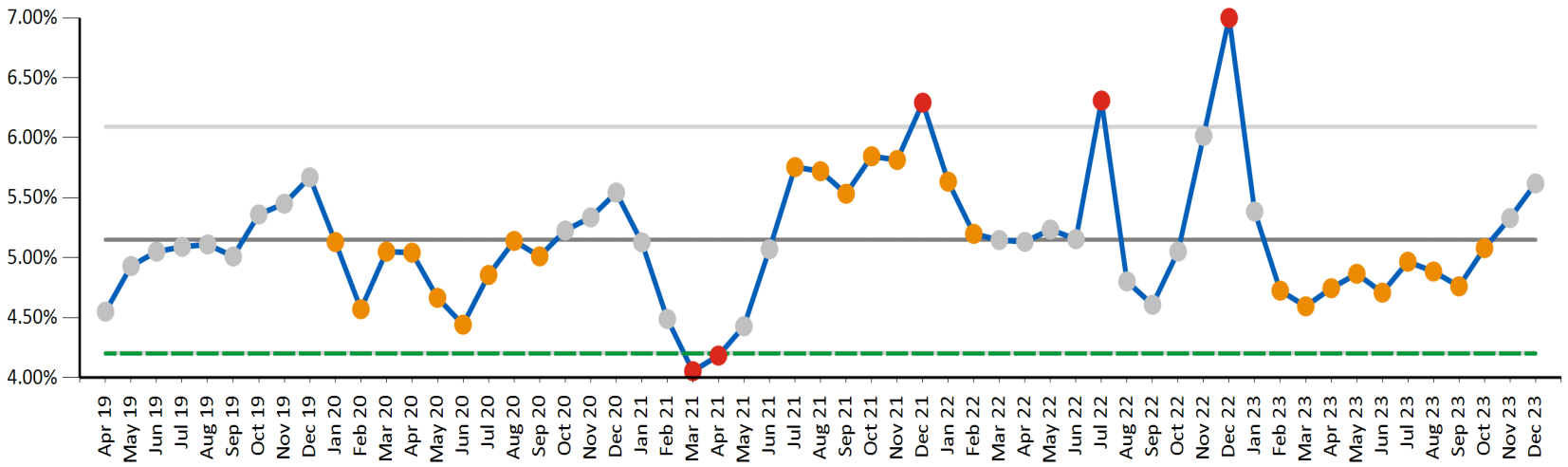
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.62%	Dec-23		<= 4.20%	5.33%	Nov-23	<= 4.20%	5.00%	F
120 - Vacancy level - Trust	<= 6%	5.59%	Dec-23		<= 6%	4.57%	Nov-23	<= 6%	5.43%	?
121 - Turnover	<= 9.90%	11.69%	Dec-23		<= 9.90%	12.03%	Nov-23	<= 9.90%	12.24%	F
366 - Ongoing formal investigation cases over 8 weeks		1	Dec-23	L		1	Nov-23		8	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.62%	Dec-23

Previous

Plan	Actual	Period
<= 4.20%	5.33%	Nov-23

Year to Date

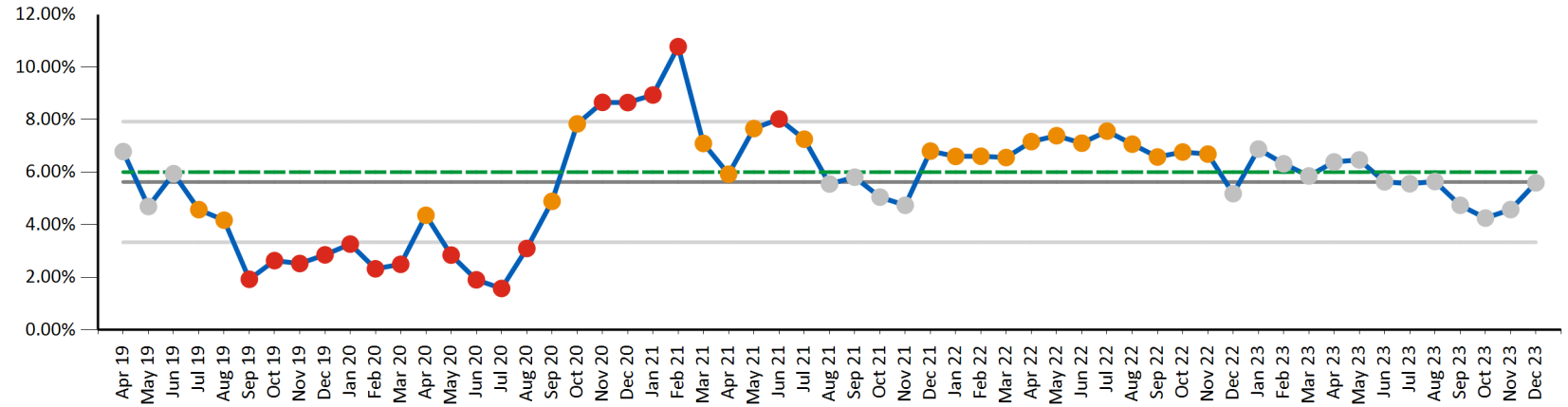
Plan	Actual
<= 4.20%	5.00%

120 - Vacancy level - Trust

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 6%	5.59%	Dec-23

Previous

Plan	Actual	Period
<= 6%	4.57%	Nov-23

Year to Date

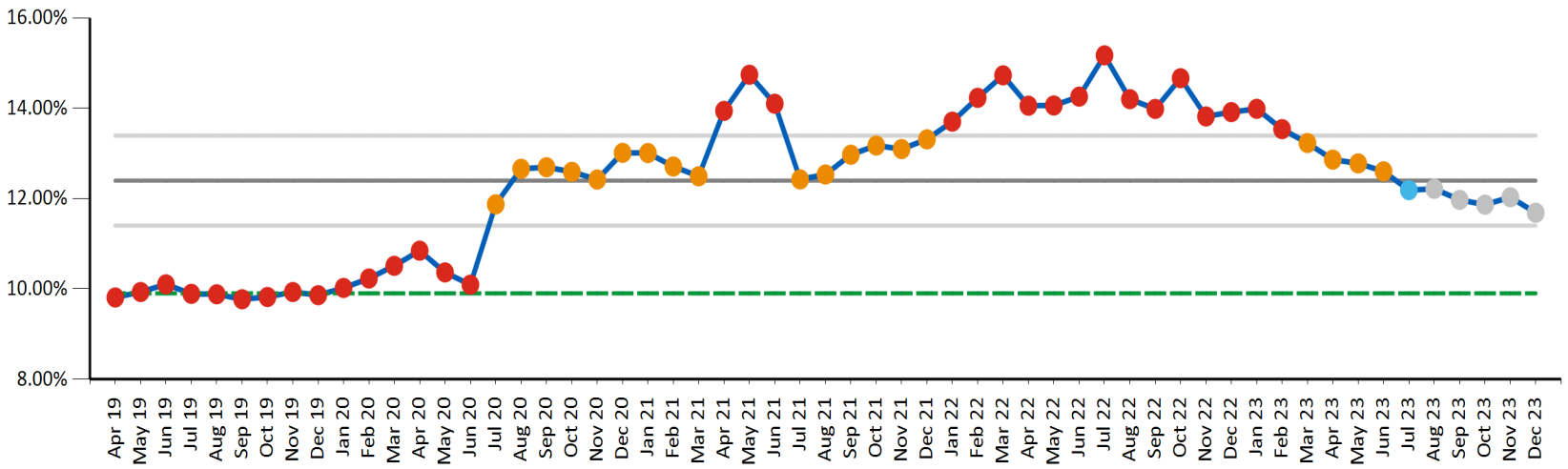
Plan	Actual
<= 6%	5.43%

121 - Turnover

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.69%	Dec-23

Previous

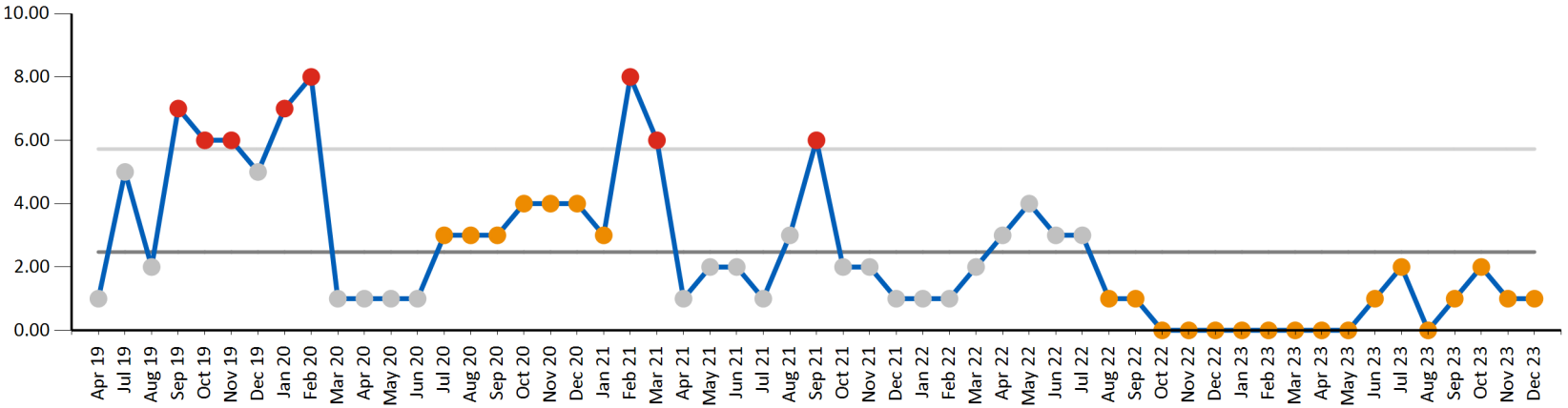
Plan	Actual	Period
<= 9.90%	12.03%	Nov-23

Year to Date

Plan	Actual
<= 9.90%	12.24%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1	Dec-23

Previous

Plan	Actual	Period
	1	Nov-23

Year to Date

Plan	Actual
	8

Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory and Trust Mandated (CaTM) Training
The Trust recorded a 0.14% deterioration in compliance this month for Compulsory training reporting a compliance rate of 93.84%.
Moving and Handling (85.11%) / Basic Life Support (83.07%) and Safeguarding level 3 (85.33%) are the subjects that require Divisional focus to support improvement. The challenge is that these three subjects require attendance at a face to face training sessions.
The remaining subjects achieved 92% or above.

The Divisions / Directorates are to be congratulated as they have improved on the compliance target for Trust Mandated training achieving 90.80% against a target of 85%.

Appraisals
There has been a slight improvement in month which has seen the Trust overall position improve by 0.35% to 85.17% and therefore meeting the 85% target.

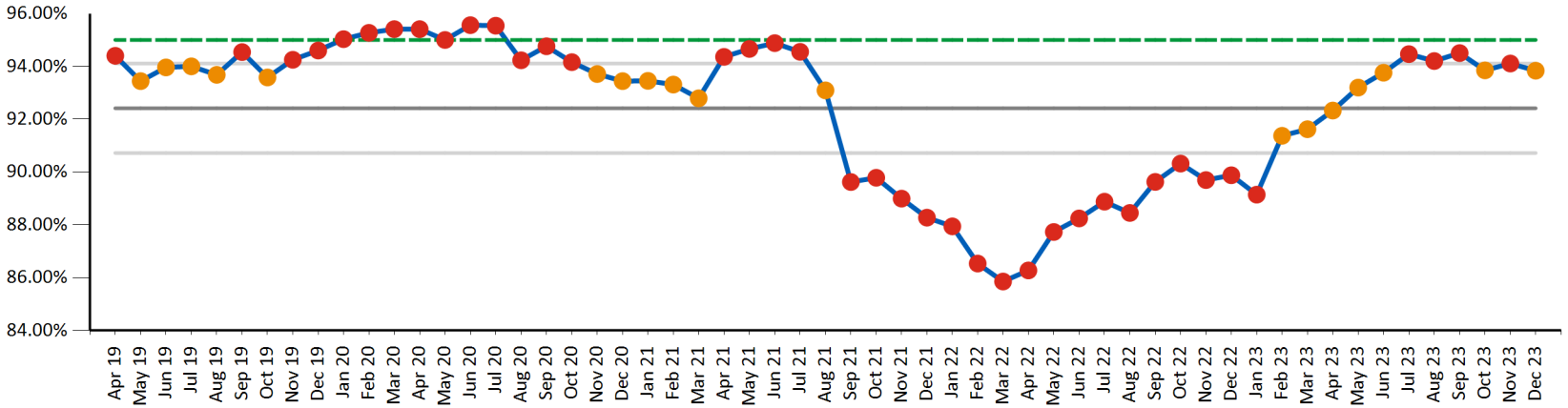
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.8%	Dec-23		>= 95%	94.1%	Nov-23	>= 95%	93.8%	
38 - Staff completing Trust Mandated Training	>= 85%	90.8%	Dec-23		>= 85%	90.8%	Nov-23	>= 85%	89.6%	
39 - Staff completing Safeguarding Training	>= 95%	94.93%	Dec-23		>= 95%	95.20%	Nov-23	>= 95%	94.90%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.2%	Dec-23		>= 85%	84.8%	Nov-23	>= 85%	85.7%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	51.1%	Q2 2023/24		>= 66%	58.3%	Q1 2023/24	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	57.8%	Q2 2023/24		>= 80%	61.8%	Q1 2023/24	>= 80%		

37 - Staff completing Compulsory Training

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

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

Previous

Plan	Actual	Period
>= 95%	94.1%	Nov-23

Year to Date

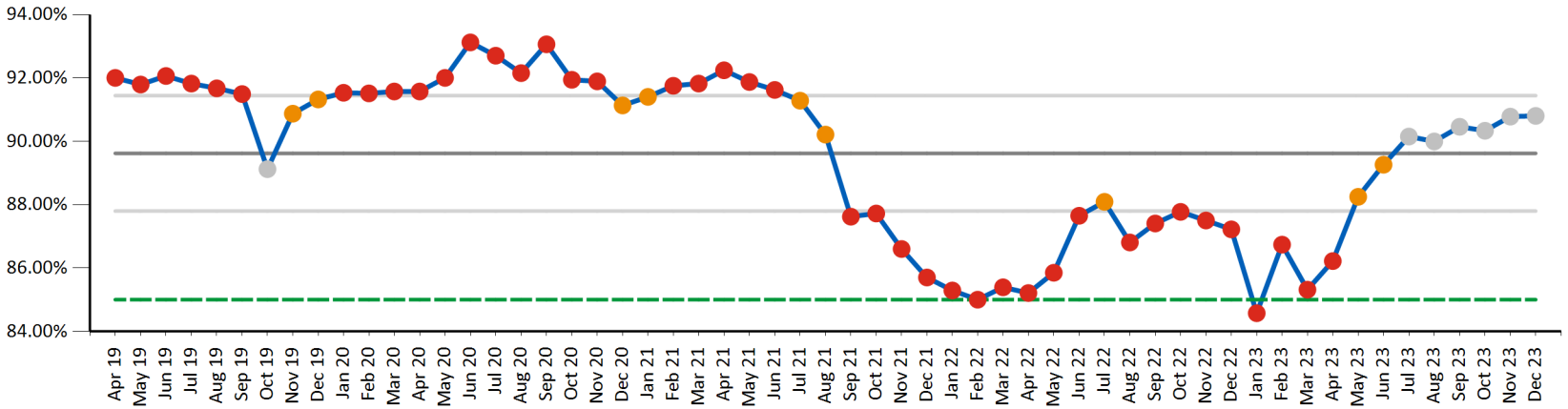
Plan	Actual
>= 95%	93.8%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.8%	Dec-23

Previous

Plan	Actual	Period
>= 85%	90.8%	Nov-23

Year to Date

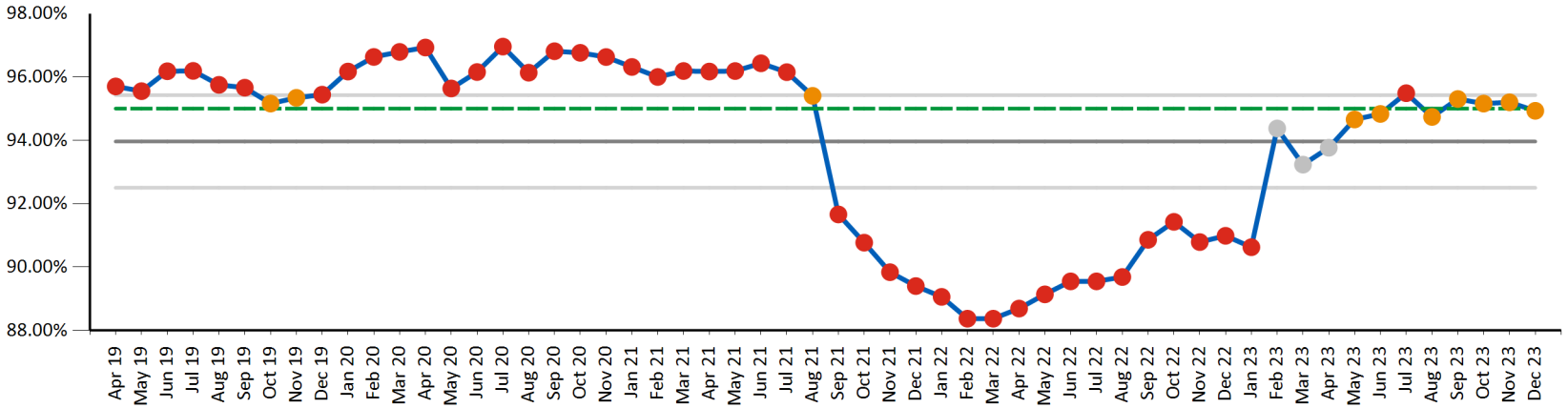
Plan	Actual
>= 85%	89.6%

39 - Staff completing Safeguarding Training

Special cause variation with improving performance

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

4/6



Latest

Plan	Actual	Period
>= 95%	94.93%	Dec-23

Previous

Plan	Actual	Period
>= 95%	95.20%	Nov-23

Year to Date

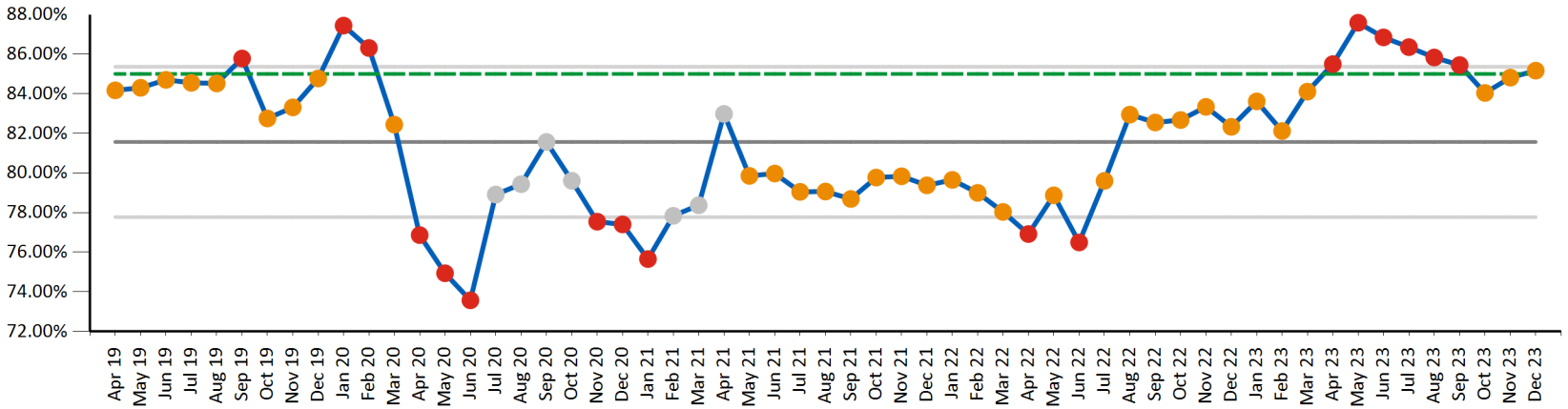
Plan	Actual
>= 95%	94.90%

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.

4/6



Latest

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

Previous

Plan	Actual	Period
>= 85%	84.8%	Nov-23

Year to Date

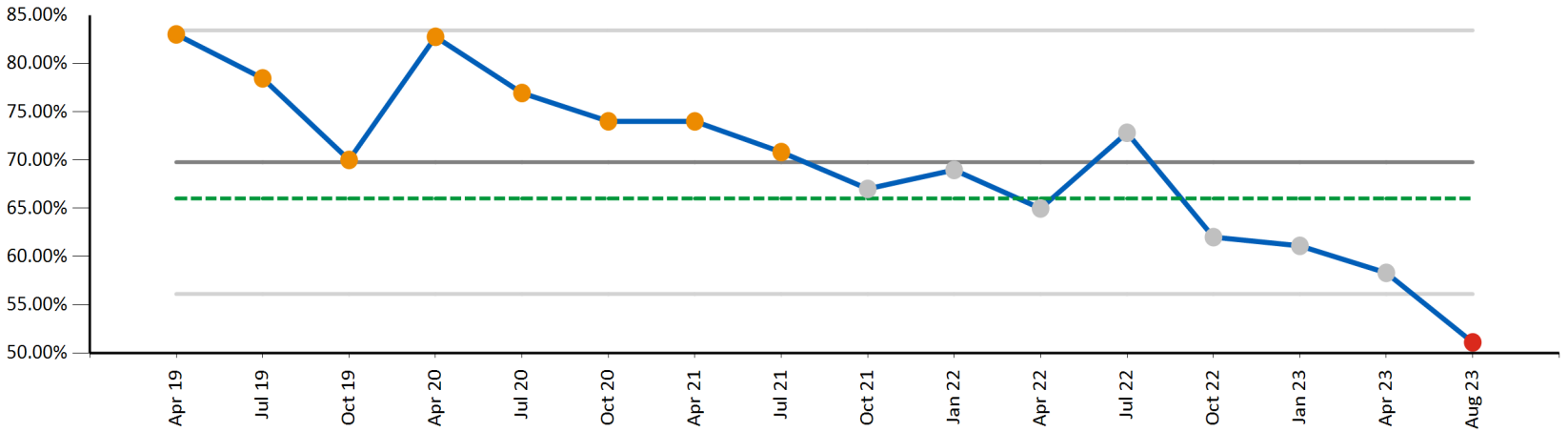
Plan	Actual
>= 85%	85.7%

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

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
>= 66%	51.1%	Q2 2023/24

Previous

Plan	Actual	Period
>= 66%	58.3%	Q1 2023/24

Year to Date

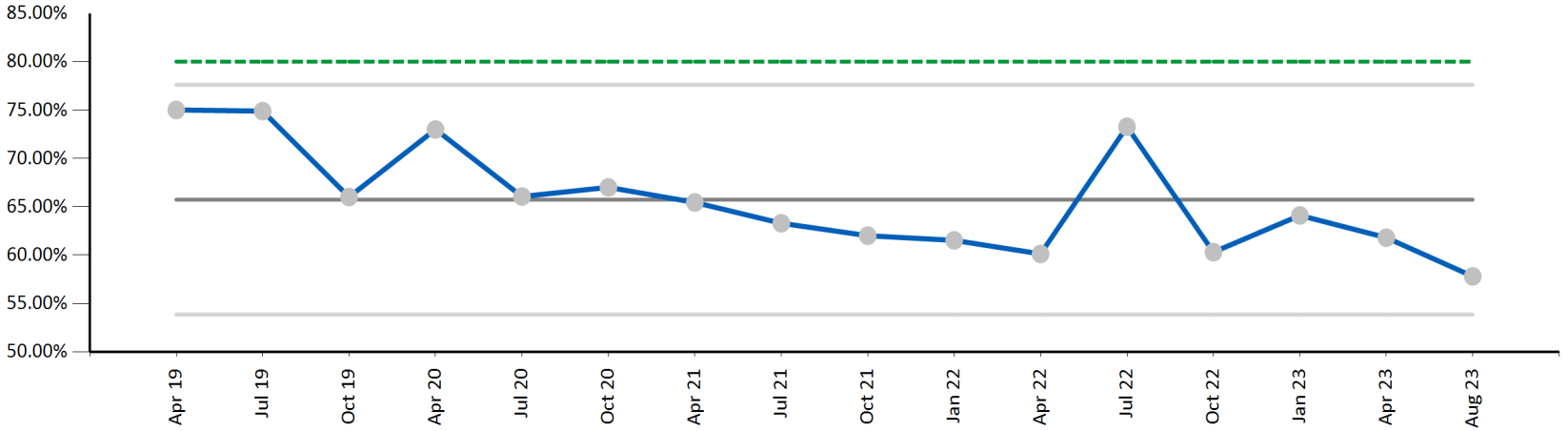
Plan	Actual
>= 66%	

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%	57.8%	Q2 2023/24

Previous

Plan	Actual	Period
>= 80%	61.8%	Q1 2023/24

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

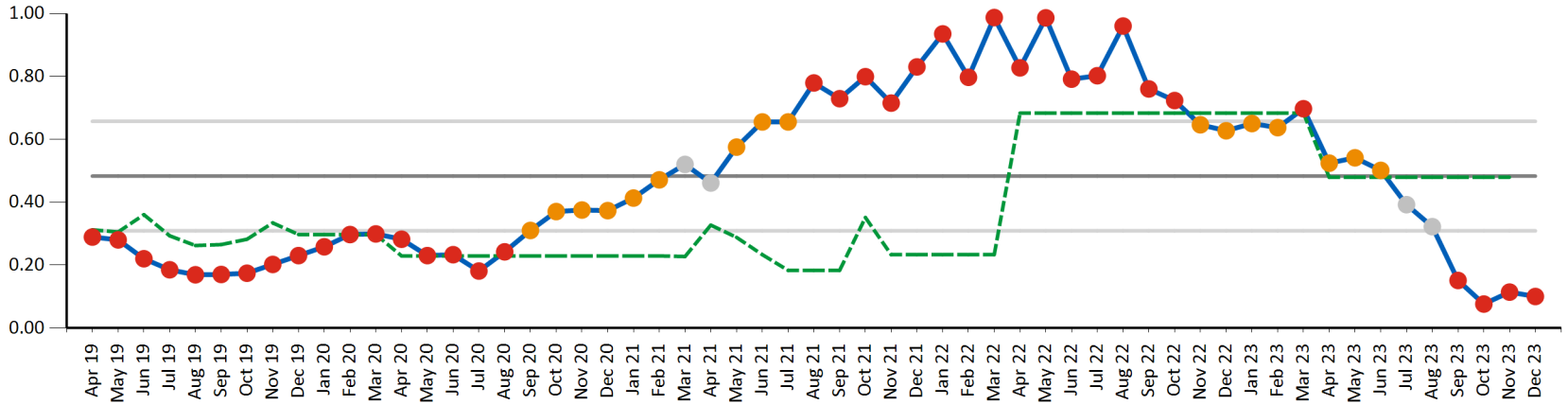
Agency spend reduced by £41k in December 2023 and is on a clear downward spend trend, focused efforts over previous months means there is confidence of hitting our forecast for 23/24. Significant progress made on reduction of nursing agency. GM benchmarking shows us in a positive position on agency (in relation to both spend and usage) when compared to most others.

	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)		0.72	Dec-23	L	<= 0.99	0.76	Nov-23	<= 7.94	9.61	
111 - Annual ceiling for Nursing Staff agency spend (£m)		0.10	Dec-23	L	<= 0.48	0.11	Nov-23	<= 3.83	2.72	
112 - Annual ceiling for Medical Staff agency spend (£m)		0.56	Dec-23	H	<= 0.39	0.55	Nov-23	<= 3.14	5.91	

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

Special cause variation with improving performance

5/6



Latest

Plan	Actual	Period
	0.10	Dec-23

Previous

Plan	Actual	Period
<= 0.48	0.11	Nov-23

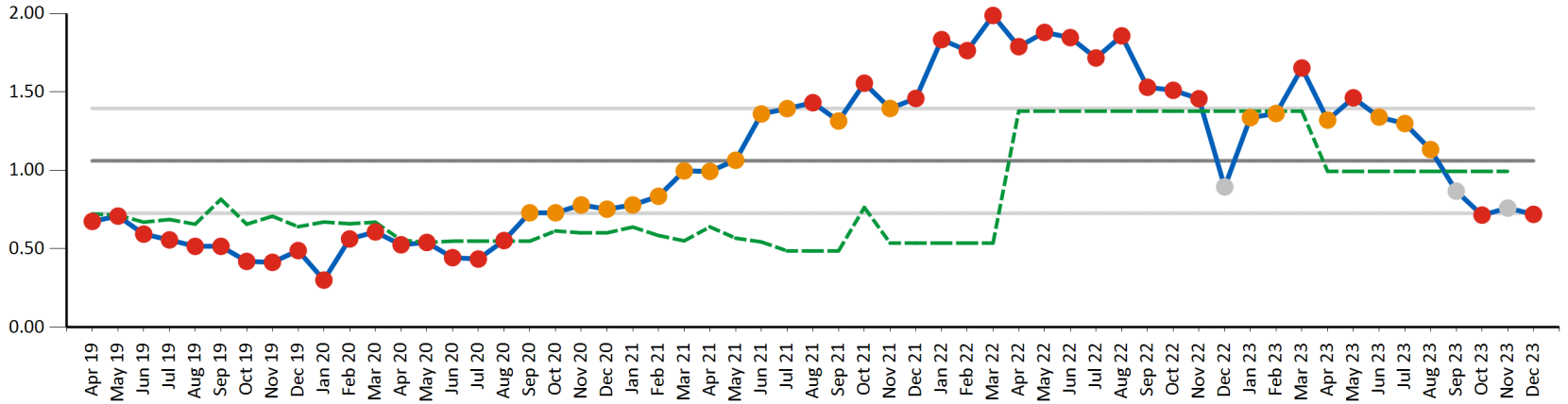
Year to Date

Plan	Actual
<= 3.83	2.72

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

Special cause variation with improving performance

3/6



Latest

Plan	Actual	Period
	0.72	Dec-23

Previous

Plan	Actual	Period
<= 0.99	0.76	Nov-23

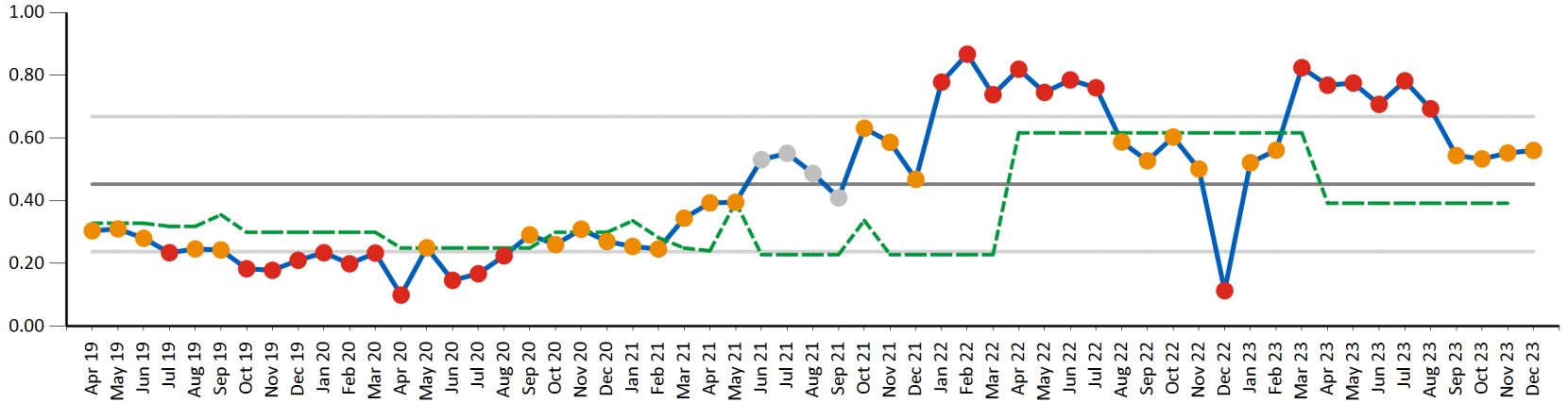
Year to Date

Plan	Actual
<= 7.94	9.61

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

Special cause variation with deteriorating performance

0/6



Latest

Plan	Actual	Period
	0.56	Dec-23

Previous

Plan	Actual	Period
<= 0.39	0.55	Nov-23

Year to Date

Plan	Actual
<= 3.14	5.91

Finance - Finance

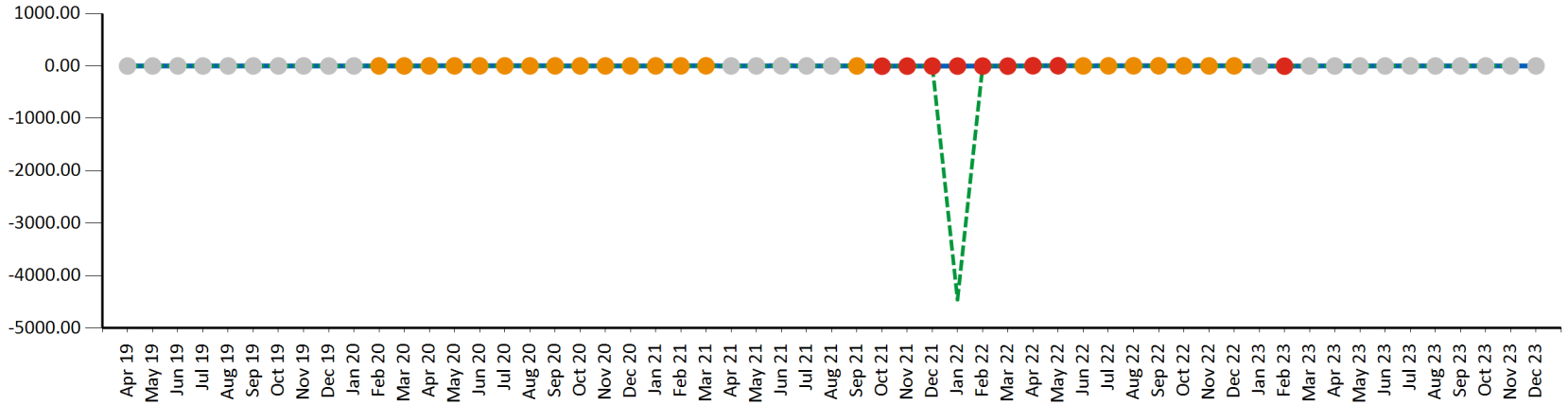
NHS Bolton NHS Foundation Trust

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)		-0.8	Dec-23		>= -1.0	-0.8	Nov-23	>= -8.4	-9.3	
222 - Capital (£ millions)		2.4	Dec-23		>= 2.2	2.9	Nov-23	>= 10.8	15.3	
223 - Cash (£ millions)		17,084.0	Dec-23		>= 28.5	19.5	Nov-23		17,084.0	

220 - Control Total (£ millions)

Common cause variation.

4/6



Latest

Plan	Actual	Period
	-0.8	Dec-23

Previous

Plan	Actual	Period
>= -1.0	-0.8	Nov-23

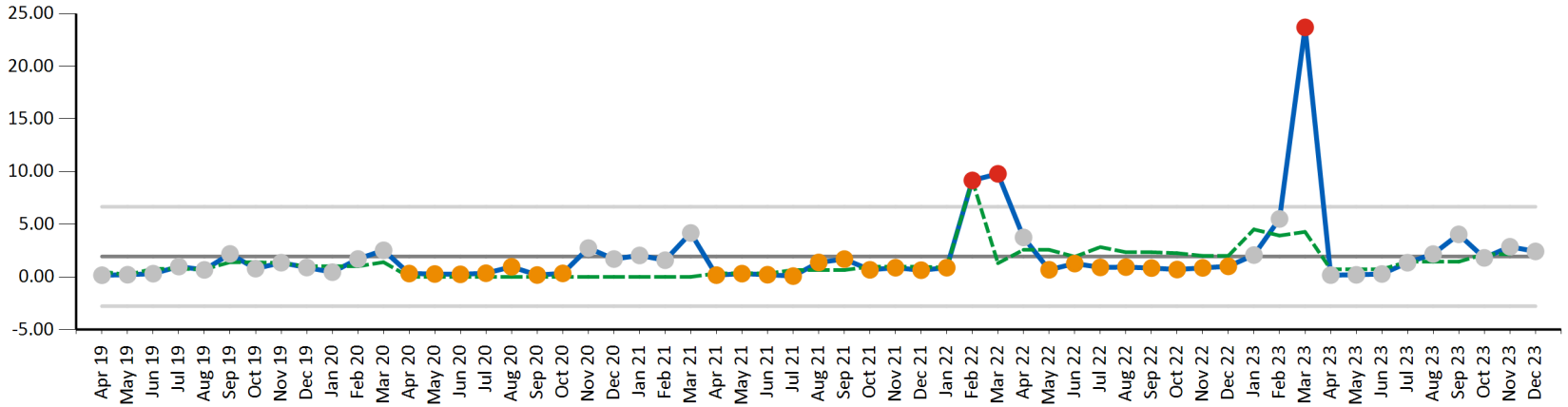
Year to Date

Plan	Actual
>= -8.4	-9.3

222 - Capital (£ millions)

Common cause variation.

3/6



Latest

Plan	Actual	Period
	2.4	Dec-23

Previous

Plan	Actual	Period
>= 2.2	2.9	Nov-23

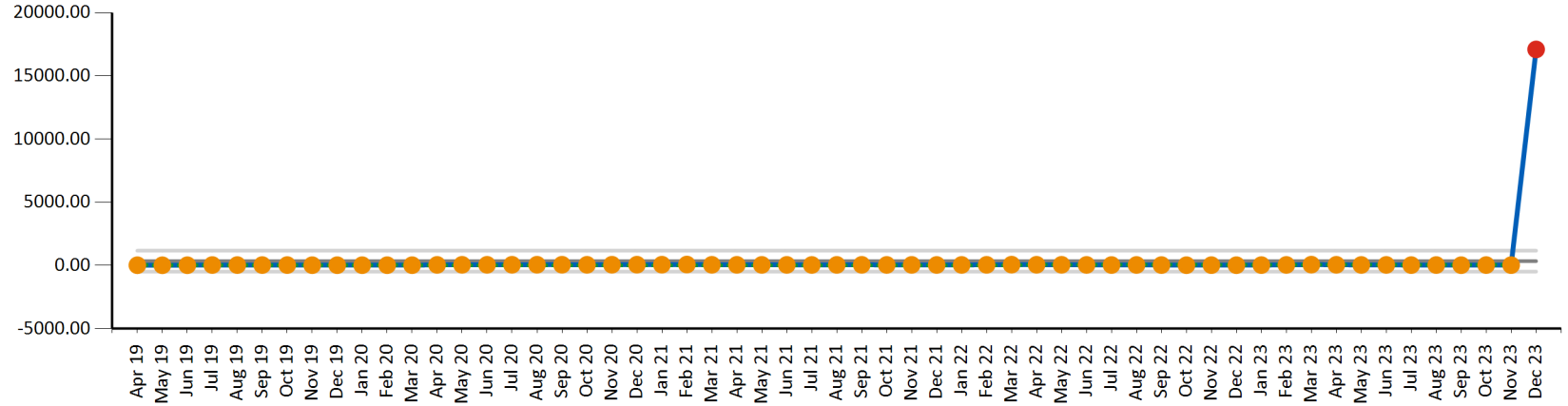
Year to Date

Plan	Actual
>= 10.8	15.3

223 - Cash (£ millions)

Special cause variation with improving performance

0/6



Latest

Plan	Actual	Period
	17,084.0	Dec-23

Previous

Plan	Actual	Period
>= 28.5	19.5	Nov-23

Year to Date

Plan	Actual
	17,084.0

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

IPM Summary

James Mawrey
Deputy Chief Executive/Director of People
January 2024

... for a better Bolton

Introduction – James Mawrey

- New IPM report launched, each month further metrics are added as per requests from each area. This month's version are the change to the new national cancer indicator set, which now focuses on the 28 day faster diagnosis standard, the 31 day general treatment standard and the 62 day general standard.
- Tableau version of the report will hopefully be launched in March. This will enable further interaction with all of the metrics.
- A 'where to look' version of the report will launch in March, highlighting key areas of improvement and challenge as evidenced in the data.

NHS Bolton NHS Foundation Trust

Quality – Francis Andrews, Medical Director & Tyrone Roberts, Chief Nurse

What's going well	Even better if…
• Continued special cause improvement rate category 3 pressure ulcers in-patient, and zero category 4 in-patient • Category 2 and un-stageable pressure ulcers improvement 'in month' (not statistical) • Patient safety incident response framework (PSIRF) live from 1.1.24 • Maintained HSMR & SHMI below mean (lower is better) • FFT satisfaction rates remain positive • Complaints performance (timeliness) maintained	• Clinical correspondence in-pt & out-pt lacks reliability • Same sex accommodation breaches reduced • C-difficile – reliability required in time from escalation to isolation of patient • Inductions of labour (IOL) amended to greater than 24 hours going forward • Antenatal bookings at 12+6 had reliability in performance. Indicator changing to reflect GMEC 10+0. In both scenarios Bolton higher than GMEC mean. Impacted by workforce challenges & so improvement expected as vacancies reduce

Operational – Rae Wheatcroft, Chief Operating Officer

What's going well	Even better if…
1. We have continued to achieve the Cancer faster diagnosis and 31 day treatment standards. We are also on track to recover the 62 day standard in line with our plan. 2. The number of patients on the No Criteria to Reside list remained below the plan of 90 in December. 3. We increased the number of people being deflected to an appropriate community service as an alternative to ED. 4. We achieved the standards for review health assessments for Looked After Children 5. Readmissions within 30 days continue to be improving and are well below the plan.	1. Our 65 week trajectory is off track, having been impacted by industrial action and other capacity challenges. 2. We have not been able to meet our stretch target of 60 patients on the NCTR list and have not been able to reduce days delayed to the target of 360. 3. We have not met the recovery trajectory for urgent care in December and have seen a deterioration in ambulance handover performance.

Workforce – James Mawrey, Director of People

What's going well	Even better if…
• Significant reducing agency spend trend noted and confidence that, due to this, we will meet/beat our forecasted agency spend for 2023/2024 • Reduction of 'worked whole time equivalent' of 39 WTE noted in December 2023 • We benchmark well against other GM providers on key metrics such as vacancy rate, turnover, apprenticeships, compulsory and trust mandated training, appraisal, engagement levels, sickness, agency usage etc.	• Stronger oversight of medical staffing needed and we will be implementing e-roster for this staff group in 2024 • High level of HCA vacancies noted across site (being filled by bank) so concerted efforts will be required to fill these • Turnover trend is down but we have some staffing groups with high levels (e.g. AHP) and are working to understand and address this • Strategic programme development in relation to engagement, leadership, talent & culture to deliver strategic ambitions – now being developed • Further development of widening participation opportunities

NHS Bolton NHS Foundation Trust

Finance – Annette Walker, Chief Finance Officer

What's going well	Even better if…
• Forecast revenue position on track to deliver better than planned deficit • Capital spend ahead of plan • PwC meetings progressing well • CIP forecast to be fully delivered • Additional capital secured for 2023/24	• CIP needs to be recurrently identified • Trust needs to be returning to surpluses in future years to restore cash position • Capital funding position is extremely constrained and forecast envelope not yet finalized

Report Title:	Strategy and Operations Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Rae Wheatcroft, Chief Operating Officer Sharon White, Director of Strategy, Digital and Transformation		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 18 December 2023. Due to the timings of the January meeting, a verbal update will provided at the Board meeting and will be included in the March boardpack.

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

Proposed Resolution	The Board of Directors are 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:	Rebecca Ganz Non-Executive Director	**Presented by:**	Rebecca Ganz Non-Executive Director

Name of Committee	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	18 December 2023	Date of next meeting:	25 January 2024
Chair:	Rebecca Ganz, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	M North, A Stuttard, S Harriss, R Wheatcroft, S White, T Roberts, S Katema, S Crofts. In attendance: S Ball, H Bharaj, R Calderbank, A Cottrell, R Carter, R Noble, L Rigby, J Ryan, M Szekely, L Wallace, B Walmsley, J Richardson (minutes)	Quorate	Yes
		Apologies received from:	R Chel, A Chilton, L Robinson, F Andrews

Key Agenda Items:	Lead	Key Points	Action/decision
Spotlight- Theme: Productivity Improvement Group (PIG) Update	R Calderbank	GM created the Productivity and Improvement Group (PIG) which focusses on a broad range of productivity metrics covering activity, finance and workforce. Internally, the scope and remit of our original FIG group has now changed to cover internal operational and performance support and assurance to productivity and efficiency measures. Update received on the operational metrics covered by the GM Productivity and Improvement Group (PIG), Remote Outpatient Attendances, PIFU, Outpatient DNA, Specialist Advice and Guidance, Outpatient First to Follow up ratios, Capped Theatre Utilisation and Day Case Rates	The following actions and comments were noted: • Our biggest productivity opportunities relate to PIFU, DNA rates and theatre utilisation • Committee responsibilities is an item planned for discussion at January Board to remove any overlap/duplication of responsibilities from an activity, finance and workforce perspective • Trust decision taken that Remote Outpatient Attendances would not be prioritised as there were other local priorities to focus on. • Clinical engagement crucial to productivity • The Trust continues to keep abreast of other areas outside of GM for benchmarking in relation to clinical productivity and this will also be explored for non-clinical • PTB has overall responsibility for this work with the mapped dependencies being inter-linked and interdependent • Reset on digital inclusion needed as 49% of the Bolton population are living in the top 25% of deprived boroughs to avoid increasing inequalities for virtual consults. • The Committee acknowledged that the Trust Productivity Group, under the chairmanship of R

	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

			Calderbank, was bringing value and benefit to the organisation. • The Chair acknowledged the comprehensive update provided by R Calderbank and J Ryan.
Digital Resourcing Update	B Walmsley	Overview on Digital Resource provided on recruitment and progress to date, project prioritisation and next steps • Project requests from Divisions will be prioritised for oversight by SOC • Once this is finalised the message to staff will then need to be managed appropriately as 'Access to Digital' has been highlighted as one of the top concerns from staff through the Our Voice Programme. • Recruitment was confirmed as all within budget • The team manages circa 20 projects at a time and has 167 project requests, which by the time of SOC had grown to 177 projects • Prioritisation by Divisions gave all projects a priority 1 or 2 (none rated with a lower priority of 3 or 4)	• Digital workforce constraints remains the highest risk with continued inability to meet SLA KPI's and a number of projects remaining on hold • The suggested process of chunking the projects down into units of work was not a process that Digital are mature enough to carry out at this stage but the project prioritisation list will be socialised more widely across the organisation ahead of submission to DPTB and SOC in February • **Action**: bring updated Divisional priorities given capacity constraints to Feb SOC
Maternity EPR Update	M Szekely	• Considerable amount of progress over the last month and now have a viable and deliverable product • Testing has identified a few areas in terms of gaps in process mapping and education. There are also challenges in relation to staffing and resource mainly due to sickness absence and mitigations have been put in place. • The main challenges relate to resourcing and timeline but work is continuing to progress and mitigating risks with movement and re-purposing of resource from elsewhere within the project • A one week delay has been agreed but the target go live date of 31/3/24 is still on track to support CNST compliance and securing of the 1M funding.	• There is a separate EPR for Maternity as most core EPR suppliers as yet do not deliver specialised maternity functionality. • Taking the learning from other organisations who have chosen to phase the go-live date. • On behalf of the Committee the Chair passed on thanks to the Digital Team in light of such a challenging project which is now coming to fruition

	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

Trust EPR Implementation Plan	M Szekely	• Update provided following approval of the business case by F&I Committee on 25th October 2023 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 • Goal is to deliver as much functionality as part of initial rollout (April 24) so every service has benefit as soon as feasible with more specialist modules in place by July 24.	• The rigorous benefits realisation process will be considered by F&I with a spotlight on EPR which is one of our biggest transformational investments to ensure that there is a return on investment both qualitatively and quantitively. • The embedding of the learning from other organisations on phasing the go-live provided the Committee with assurance for the roll out of Phase 2 of EPR. • **Action**: Review the capacity of the team for the scale of change management support for Phase 2
Operational Performance Update	J Street	Indicative tracking on Urgent Care, NCTR and Elective Care provided as it was too early to receive the operational IPM. **Urgent Care:** November validated position is 58.32%. The ambulance performance metrics failed for all 3 standards but improved in comparison to October **NCTR:** Finalised November position is average of 91 patients in hospital with no criteria to reside with the average occupied bed days at 662 which is an improvement of circa 150 days v October. **Elective Care:** Currently working with colleagues across GM to maximise mutual aid offers and provide mutual aid to help us to reduce 65ww and eradicate 78ww. Mutual aid will provide a modest benefit to the forecasted position, however, there is a new level of risk to this position pertaining to the BMA industrial action.	The following actions and comments were noted: • No additional funding from GM has been confirmed yet to support a reduction in 740 x 65 week waiting patients

	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

Cancer Recovery Update	A Cottrell	Update provided on the forecasted improvement in the cancer 62-day performance position • 62-day performance up to and including October 2023 has been better than the predicted best case scenario and predicted to achieve the trajectory again in November. • Recovery of the 62-day position is reliant on the continued recovery in Breast and Urology. • The main contributing factor to the deterioration in 62-day performance for Breast has been the increased waiting time for first outpatient appointment and the Breast and Radiology teams have worked collaboratively to increase capacity safely, improve clinic scheduling, and ensure effective use of locum activity to reduce the backlog from 36 clinics to 0. • Urology position is now the key area for continued achievement of the trajectory and has seen a significant increase in demand and projecting a 45% increase in referrals to the service • Since the last update to this meeting, there has been a deterioration in Gynaecology performance and a recovery plan is in place	• A member of the Urology Specialist Nurse Team undertaking additional training in order to be able to deliver Nurse-led prostate biopsies and improving performance is an example of the learning that can be used in other areas. • Although the improvements seen in Breast were partly attributed to the effective use of locum activity, from a sustainability perspective, the appointment of a consultant mammographer at a senior level to independently run clinics along with an advanced mammography practitioner post to take lower acuity referrals from consultants demonstrates the use of skill mix in the AHP workforce and driving the use of medical workforce to reduce the reliance on locums going forwards. • On behalf of the Committee, the Chair wished to formally pass on congratulations to everyone involved in being on track for the best case scenario to date of January 2024
Clinical Strategy	R Noble	• Latest version received with amendments from review by SOC in November now included • The comms for the launch of the Strategy in January are currently being finalised with a soft publication at the end of December ahead of the official launch in January. There will also be an animation to support the launch and Team Brief in January will be focussed on the Strategy	• Noted • **Action**: Update on soft launch in December and hard January launch to SOC in January
Operational Plan Update	R Noble	Update received on the operational planning approach for 2024/25 • The approach this year in comparison to the expectation by GM last year for a break even submission will be to make the best informed decision with honest realism on what can be achieved Some major concerns around the GM approach this year have been escalated and this Committee will be provided with honest appraisals going forward. • In relation to Digital being key to success going forwards, this can only be achieved if Digital is put into a system that delivers efficiencies.	• The Committee noted the report and supported an honest approach to Operational Plan submissions, while recognising wider system factors may impact the final parameters of the 24/25 Operational 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

Strategy, Planning and Delivery Committee Minutes	S White	The minutes were received for information and assurance. • The Bolton Locality Outcomes Framework was signed off by the Bolton Locality Board on 12th December. This work will now be delegated for delivery to the sub-groups that feed into the Strategy, Planning and Delivery Committee. J Ryan has already completed work on the KPI's and we will start to see what the sub-groups are contributing and an update on this will be provided to this Committee in April/May 2024.	• **Action**: Bring Locality outcomes framework to Jan SOC and Locality progress update to April or May SOC
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 Digital Programme is circa 8x oversubscribed in terms of the number of high rated projects on 'the list' versus average team capacity. Divisions preforming a further review to mitigate this and understand what needs to be paused/stopped and the implications
- Maternity EPR Go Live in Feb 24 is still on track but with increasing challenge due to resource. 1M CNST funding at risk if not in place by 31/3/24
- An NCTR average of 91 patients was maintained with a significant reduction in bed days at 662 compared with October bed days of 819
- 65 week wait performance is at significant risk and the Trust is seeking mutual aid to mitigate this with 740 patients expected to remain on the list at 31/3/24
- Cancer recovery on track for best case scenario of January 2024 for 62 day performance
- Clinical strategy is on track for 'soft' launch in December and 'hard' launch in January

	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:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	✓
Exec Sponsor	Francis Andrews, Medical Director		Decision	

Purpose	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 meeting held on 22 December 2023. The Board is asked to note that due to winter pressures and in line with previous years, the QAC meeting for January was deferred to February 2023.

Previously considered by:
Discussed and agreed at the Quality Assurance Committee.

Proposed Resolution	The Board of Directors are 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:	Fiona Taylor Non-Executive Director	**Presented by:**	Fiona Taylor Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	**Quality Assurance Committee**	Report to:	**Board of Directors**
Date of Meeting:	20 December 2023	Date of next meeting:	28 February 2024
Chair:	Fiona Taylor, NED	Meeting Quoracy: (Y/N)	Yes
Attendees:	Francis Andrews, Jackie Njoroge, Lianne Robinson, Martin North, Seth Crofts, Nicola Caffrey Niruban Ratnarajah, Rae Wheatcroft Sharon Katema, Sharon White, Sophie Kimber-Craig, Tyrone Roberts,	Apologies received:	Fiona Noden Carol Sheard Stuart Bates Harni Bharaj Sean Harriss.

AGENDA ITEMS DISCUSSED AT THE MEETING

- Annual Terms of Reference and Work-plan
- Integrated Performance Report
- Clinical Governance & Quality Committee Chairs Report
- Quality Improvement Plan
- Safeguarding Adult, Children and Looked After Children Annual Report 2022/23
- CQC Improvement Plan
- Quarter 2 Learning Report
- Maternity Incentive Scheme Year 5 Progress Update (CNST)
- Serious Incident Report – SI 223575
- Serious Incident Report – SI 226376
- Risk Management Committee Chairs Report
- Safeguarding Committee Chairs Report
- Mortality Reduction Group Chairs Report
- Group Health & Safety Chairs Report

ALERT

- Safeguarding Adult, Children and Looked After Children Annual Report 2022/23 – Report received and challenges noted by Committee in particular with lack of some statutory posts and increased demand noted. Requested interim report every six months for assurance and opportunity to ask for additional support. Re-looking into shared posts with ICB and LAC but not applicable to all vacancies.

ADVISE

- Integrated Performance Report – Noted the key points highlighted by Chief Nurse and Medical Director with lengthy discussion regarding Clinical Correspondence for which an assurance paper is being presented in February 2024.
- Clinical Governance & Quality Committee Chairs Report – Received and noted the comments around Sepsis/NEWS mitigations in place and report for BoSCA being deferred to evidence the areas of concern and plans to address them.

- CQC Improvement Plan – Report received and noted some recommendations are outstanding but action plans are in place.
- Quarter 2 Learning Report – Report was received and detailed narrative was noted with an ask to evidence in future reports what progress is being made and next steps.

ASSURE

- Annual Terms of Reference and Work-plan – Approved the revised Terms of Reference and proposed work-plan for 2024. Revision to the Terms of Reference included a streamlined membership of Directors and Non-Executive Directors in order to improve governance and provide assurance.
- Quality Improvement Plan – Approved by the Committee and will be shared with Board of Directors. Committee to receive update on implementation of methodology in other areas.
- Maternity Incentive Scheme Year 5 Progress Update (CNST) – All 10 Safety Actions are on track for completion in Year 5. Submission date is 1st February 2024 and J Cotton is confident evidence will meet compliance threshold.
- Serious Incident Report SI 223575 – Received and action plan noted. No further comments.
- Serious Incident Report SI 226376 - Received and action plan noted. No further comments.
- Chairs Reports from Risk Management, Mortality Reduction and Group Health & Safety – These were received and taken as read with no further comments. Going forward these will no longer be received by the Committee as will be monitored through Clinical Governance & Quality Committee.

New risks identified at the meeting:
None.

Review of the Risk Register:
Not reviewed.

Report Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	✓
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	The purpose of the report is to confirm the final compliance position with regard to attainment of the ten safety actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Year 5 Scheme (MIS), prior to formal submission of the declaration to NHS Resolution by 01 February 2024.

Summary:	On 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. This report provides assurance that the maternity service has attained all recommendations defined within the ten safety actions of the CNST year 5 maternity incentive scheme. Key highlights: • Verification of all evidence used to inform the current position was undertaken by the Director of Midwifery and Director of Clinical Governance on the 09 January 2023. • Assurance can be provided that the service successfully met the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint reviews undertaken in October 2023 and January 2024. • Quarterly review of the evidence relating to Safety Action 6 undertaken by a LMNS panel in January 2024 and the service attained an overall compliance score of 97%. • The declared position assumes that all evidence submitted to the Local Maternity and Neonatal System (LMNS) within the defined timeframes will be presented to the relevant integrated care system quality surveillance committees on behalf of the Trust. • This report provides assurance that the service has not received any external reports that may contradict the maternity incentive scheme declaration and confirms that the final position has been shared with commissioners prior to submission to the Trust Board. This report confirms that compliance with all requirements of the CNST year 5 maternity incentive scheme can be evidenced in accordance with the requirements detailed in the declaration form. In response, the Board are asked to approve the signing of the completed declaration form by the Chief Executive prior to submission to NHS Resolution by the 01 February 2024.

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. Authorise the signing of the declaration form by the Chief Executive prior to submission to NHS Resolution.* *iv. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.*

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 report purpose is to confirm the final compliance position with regard to attainment of the ten CNST maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

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 as reflected in the Trust declaration document.

Table 1 – CNST Progress Tracker

Action No.	Maternity safety action	Action met? (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?	Yes	10	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	15	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	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	4	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0	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?	Yes	12	0	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?	Yes	8	0	0
Total recommendations attained to date			103	0	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?

17 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 within the reporting period up to and including the 7 December 2023. (Appendix 1).

CNST year 5 criteria requires the 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 therefore detailed within Appendix 1a.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The NHS e-scorecard data (Appendix 2) 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.

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 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 Q2 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 relating to this safety action were shared with the ICB/LMNS as part of the CNST assurance checks undertaken on 25 October 2023 and 8 January 2024.

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. An initial audit of compliance with the standard has been undertaken which provided limited assurance that the service has implemented all of the health provider requirements. An action plan has been collated in response to improve compliance, and a repeat audit will be conducted (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.

Compliance is now being monitored on the maternity champions' dashboard (Table 4) with no breaches reported since monitoring commenced in November 2023.

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'. Compliance is included in the maternity safety champion's dashboard (Table 4).

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. Submission 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 North West Neonatal Operational Delivery Network (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 for a clinical psychologist funded vacancy remains ongoing.

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 latest bi-annual maternity staffing report was presented to the Board of Directors in November 2023 for board oversight and review.

One reported breach of the standard was reported on the 11 October 2023 during a maternity divert at 0600hrs. A review of the incident has been undertaken and as the Co-ordinator was not providing care to a woman in established labour this is not regarded as a breach of the standard as per CNST guidance.

Attainment of 100% supernumerary status of the Delivery Suite Coordinator has been achieved throughout the monitoring period 30 May 2023 until 7 December 2023 and can be evidenced on the Birth Rate Plus acuity tool.

One to one care in labour

One to one care in labour compliance rates continue to be below the 100% standard, and remains an area of ongoing focus. Recruitment continues to address the current vacancy rate that will affect 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?

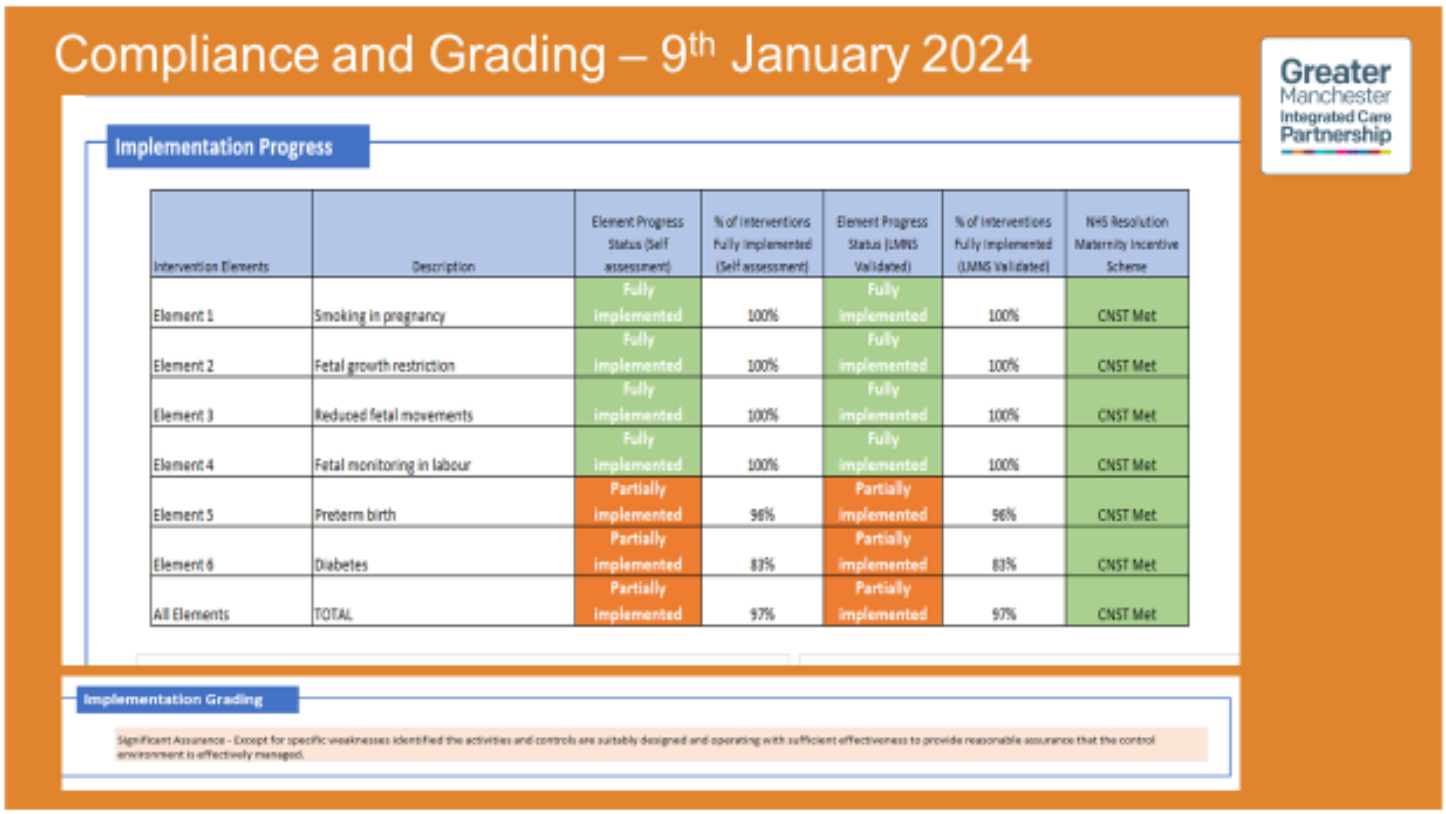
Due to the delay in the implementation of the maternity electronic patient record within the service a local agreement was approved by GMEC LMNS during the year 5 period to receive manual audit data to supplement the Trust position.

During the CNST year 5 period GMEC LMNS introduced a quarterly LMNS assurance panel to provide additional external scrutiny of the evidence submitted, oversight of progress and the opportunity for support to be provided to Trusts if needed.

On the 9 January 2024 the Trust attended the quarterly external assurance panel and received a grading of significant assurance that the evidence submitted fulfilled all the requirements for Safety Action 6. The Trust was awarded an overall compliance score awarded of 97% (Table 2).

A detailed action plan has been completed to attain full compliance with all elements and this includes ongoing recruitment to specific posts that are funded recurrently by the LMNS to support the delivery of the care bundle.

Table 2: Trust validated position with regard to Safety Action 6 as of 9 January 2024



Compliance and Grading – 9th January 2024

Greater Manchester Integrated Care Partnership

Implementation Progress

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	97%	Partially implemented	97%	CNST Met

Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

The Board are advised that the overall compliance position may deteriorate in the subsequent quarter of 2024 following the implementation of the stretch targets (which are higher) from April 2024.

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 Maternity and Neonatal Voice Partnership (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 6. Shared collaborative achievements to date in response to staff and service user feedback have included the upgrading of the waiting room in the Triage area that was identified in a service user 15 steps review of the service and the upgrading of the kitchen on M4 to facilitate partner involvement in care identified during a safety champions walk about. The service is grateful to the hospital charities fund for their timely and supportive response to improvements identified by the MNVP.

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 the core competency framework version 2 requirements and includes all six defined elements.

The CNST year 5 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.

The service attained the required 80% standard by the 1 December 2023 for all required metrics and the declared position is detailed in Table 3 below:

Table 3: CNST training compliance as of 1 December 2023

Course compliance by staff group										
Course	Advanced Neonatal Practitioners	Consultant Obs	Obstetric Medical Doctors	MSW/ HCA	Midwives	Neonatal Con	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	NA	**94.74%**	**93.55%**	**81.16 %**	**92.66 %**	NA	NA	NA	**86.36%**	**88.46 %**
Fetal Monitoring Core Competency Stds.	NA	**89.47%**	**80.56%**	NA	**83.03 %**	NA	NA	NA	NA	NA
Neonatal Life Support	**86.67%**	NA	NA	NA	**82.57 %**	**90.00 %**	**100.00%**	**85.57 %**	NA	NA

Trusts need to evidence there is an action plan approved by Trust Boards to recover the position to 90% within a maximum 12-week period from the end of the MIS compliance period. Current compliance position and ongoing action plan is included in appendix 7.

There is currently difficulty resourcing qualified trainers who are Newborn Life Support (NLS) / Generic Instructor Course (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. Staff have booked to attend the required training early in 2024 to meet this requirement.

Safety action 9: Can you demonstrate there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

The Board Safety Champion (Chief Nurse) has continued to meet with perinatal quadrumvirate members at bi-monthly intervals during the CNST year 5 period. Escalation to the Board during this period has been undertaken via the bi-monthly Board reports and also by the attendance of the maternity safety champion and the Board level Safety Champion at Board.

CNST requirements stipulate that any support required of the Board is identified and implemented.

During the CNST year 5 period in response to feedback from the safety champions, the Board have revised the board reporting schedule to improve oversight of CNST compliance, have facilitated the transition of training data onto the electronic staff record and have supported the release of transformational project support the delivery of the CNST scheme. The Board safety champion has also continued to provide professional support to the Director of Midwifery throughout the past year.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the 'Implementing a revised perinatal quality surveillance model' guidance published in 2020. In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022 as detailed in table 4. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff and service user feedback sessions are displayed in Appendix 6.

The recent HIE data highlighted an increased number of babies that require cooling and therefore a thematic review has been undertaken to identify themes and opportunities for learning. This thematic review is awaiting ratification at Divisional level.

The Trust rolling stillbirth rate 5.00/per1000 is slightly higher than GMEC rolling 12mth rate 4.56/1000 but less than the peer tertiary comparator (7.24/1000). Implementation of all of the revised saving babies lives care bundle v3 elements continues as part of CNST year 5 implementation. The LMNS review of cases Jan-August 2023 is now completed and awaiting ratification at mortality meeting in January 2024. The integrated performance dashboard stillbirth data will be revised from February 2024 to align with GMEC reporting metrics in order to clearly highlight the rate of stillbirth and illustrate the incidence including and excluding termination of pregnancy.

Table 4 – Safety Champions locally agreed dashboard

CQC rating	Overall	Safe	Effective	Caring	Well -Led	Responsive
Regional Support Programme	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Indicator	Goal	Red Flag	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23
Quality & Safety									
CNST attainment	Information only								
Critical Safety Indicators									
Births	Information only		451	461	472	386	408	468	454
Maternal deaths direct	0	1	0	0	0	0	0	0	0
Still Births			2	5	1	4	1	1	1
Still Birth rate (12 month rolling) per thousand	3.5	≥4.3	4.1	5.1	4.5	4.9	5.0	5.2	5.0
HIE Grades 2&3 (Bolton Babies only)	0	1	0	1	1	3	2	1	0
1HIE (2&3) rate (12 month rolling)	<2	2.5	1.5	1.5	1.5	2.1	2.5	2.7	2.5
Early Neonatal Deaths (Bolton Births only)	Information only		1	2	1	0	5	0	1
END rate in month	Information only		2.2	4.3	2.1	0.0	2.3	0.0	2.2
Late Neonatal deaths	Information only		1	0	0	0	0	0	0
Serious Untoward Incidents (New only)	0	2	0	1	1	0	0	1	1

HSIB referrals			0	0	1	1	3	1	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0	0
Moderate harm events			0	1	3	3	3	3	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	99.7%	98.8	98.3	99.0	98.6%	98.6%	98.1%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0	0
Fetal monitoring training compliance (overall)	<80%	>80%	80.50%	86.46%	84.00%	85.92%	83.00%	83.00%	86.73%
PROMPT training compliance (overall)	<80%	>80%	91.00%	92.14%	93.00%	93.94%	86.00%	83.00%	88.59%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:28.9	1:27.2	1:26.9	1:27.1	1:25.5	1.24.3	1:23.2
RCOG benchmarking compliance	Information only		93%	100%	100%	100%	100%	100%	100%
Compensatory rest breaches								0	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual								
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual								

5. Risk

Verification of all evidence used to inform the current position was undertaken by the Director of Midwifery and Director of Clinical Governance on the 9 January 2023. The service has also passed all external verification checkpoints undertaken by the LMNS.

6. Summary

This report confirms the final compliance position with regard to attainment of the ten safety actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Year 5 Scheme (MIS), prior to formal submission of the declaration to NHS Resolution.

This report confirms that compliance with all requirements of the CNST year 5 maternity incentive scheme can be evidenced in accordance with the requirements detailed in the declaration form. In response, the Board are asked to approve the signing of the completed declaration form by the Chief Executive prior to submission to NHS Resolution by the 1 February 2024.

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. Authorise the signing of the declaration form by the Chief Executive prior to submission to NHS Resolution.

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

Appendix 1 – Cases reported to MBRRACE from 30 May 2023 – 7 December 2023

Case ID no	SB/NND / TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	1 month surveillance Deadline Date	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/ concerns questions	Report to draft Deadline Date 4 months	Report published Deadline Date 6 months
87775	SB	26+6	1.6.23	2	1.7.23	1.8.23	31.5.23 15.7.23	1.10.23 **Draft done 31.8.23**	1.12.23 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 Done 23.11.23
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 Done 23.11.23
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	26.9.23 done 31/7/23	1.8.23	26.11.23 **Draft completed 19.10.23**	26.01.24 Done 4.1.24
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 7.12.23 Sent back to MFT for more input - HM**	13.2.24

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
89209	SB	27+6	31.8.23	1	30.9.23	31.10.23	1.9.23	31.12.23 **Done 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 **Done 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 done 28.12.23**	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 done 28.12.23 sent back to Burnley for completion of actions**	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
90290	ENND	23+	08.11.23	1	08.12.23 Done 10.11.23	08.01.24 Done 10.11.23	**09.11.23**	08.03.24 **Draft 15/2/24**	08.05.24
90317	SB	26	09.11.23	1	09.12.23 Done 10.11.23	09.01.24 Done 10.11.23	09.11.23	09.03.24 **Draft 15/2/24**	09.05.24
90319	Late Misc	23+6	09.11.23	1	09.12.23 Done 10.11.23	09.01.23 Done 10.11.23	09.11.23	09.03.24 **Draft 22/2/23 Sent for OUTSTANDING DETAILS for completion to WWL 10.11.23**	09.05.24

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 not relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	2	Disseminate to all staff
		Disseminate to all staff
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	2	No action entered
		No action entered
Delay in chase of bloods - 7 days	1	Process reviewed - electronic database now in use ti improve process.
Documentation of care on CDS	1	No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	1	No action entered
Patient discharged with hypertension +++ proteinuria - PET	1	Dissemination of GMEC Guidance
The test used to screen for gestational diabetes does not follow national guidance	1	No action entered
There is no evidence in the notes that this mother was asked about domestic abuse at booking	1	To be disseminated by Community Matron.
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered
This mother booked late. Did this affect her care?	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Appendix 2 – NHS digital scorecard

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 5: Safety Action 2

NHS England

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**.

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

Appendix 3 – ATAIN/TC action plan

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.	1a. Review current data collection process to enable capture and validation of future data in digital format and identify trends and themes	Business Intelligence Lead Sumeet Tuteja Consultant Obstetrician Dev Kumar Consultant Neonatologist Sam Whelan Governance Matron Melanie Durkin Advanced Midwife Practitioner /Governance Support	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	4
	1b. Complete quarterly reviews of term admissions to NeoNatal Units with the aim being on identifying if separation could be avoided	Sumeet Tuteja Consultant Obstetrician Dev Kumar Consultant Neonatologist Sam Whelan Governance Matron Melanie Durkin Advanced Midwife Practitioner	As per LMNS schedule	10.10.23 Q4 and Q1 audits submitted to LMNS – email evidence 27.11.23 Q2 audit submission to LMNS	**Q4** **Q1** **Q2** **Q3**
	1c. Ensure action plan is shared when approved with the quadrumvirate	Janet Cotton Director of Midwifery	1 February 2024	12/07/23 Action plan sent for inclusion on Divisional Board agenda	4

				27.11.23 Action plan sent for inclusion on Divisional Board agenda	
	1d. LMNS	Janet Cotton Director of Midwifery	1 February 2024	10.10.23 Q4 and Q1 audits submitted to LMNS – email evidence 27.11.23 Q2 audit submitted to LMNS	**Q4** **Q1** **Q2** **Q3**
	1e. ICB	Janet Cotton Director of Midwifery	1 February 2024	27.11.23 Audit evidence submitted as part of formal checkpoint 08.01.24 Audit evidence submitted as part of LMNS checkpoint	4
	1f. Trust Board	Janet Cotton Director of Midwifery	1 February 2024	12.07.23 Action plan shared at QAC – delegated committee of Board 27.11.23 Action plan shared at QAC – delegated committee of Board	4
	1g. Use national ATAIN for auditing purposes.	Melanie Durkin – Advanced Midwife Practitioner – Governance Support	30 July 2023	12.07.23 National tool used for data collation and review. 10.10.23 New ATAIN proforma in use via electronic data collection tool . 27.11.23 New audit proforma for ATAIN used for Q2 submission. New proforma for TC to be used for Q3	4
2. Potentially unavoidable admissions	1h. Add further detail to the ATAIN pro-forma to support identification of trends and contributory factors to unexpected Neonatal	Melanie Durkin – Advanced Midwife Practitioner – Governance Support	30 July 2023	10.10.23 National ATAIN proforma now in use 27.11.23 New audit proforma for ATAIN used for Q2	**4**

	Admissions in Q1 2023-2024 audit pro-forma			submission. New proforma for TC to be used for Q3	
	2a. Undertake a deep dive review of all 'avoidable admissions' with respiratory distress as the main cause of admission and cooled babies' admissions	Elizabeth Dean Antenatal Ward Manager Sumeet Tuteja Consultant Obstetrician Dev Kumar Consultant Neonatologist Sam Whelan Governance Matron Melanie Durkin Advanced Midwife Practitioner /Governance Support Rachel Flynn Matron Emma Jones CDS/ triage Matron	30 March 2024	10.10.23 To undertake a deep dive relating to delay in induction of labour and delay in transfer to CDS. 10.10.23 Perform a deep dive into avoidable admissions to identify any themes 27.11.23 Themes identified from Q2 report and actions included on ATAIN audit proforma – triage review, streamline ANDU and triage pathways 11.01.24 Review of cooled babies completed awaiting ratification.	3
	2b. Review Trust lactate guideline as a contributory factor for potentially avoidable admissions to Neonatal Unit	Dev Kumar – Consultant Neonatologist	Complete	10.10.23 Lactate guideline already updated and ratified at neonatal quality forum in July 2023	4
3. 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	3a.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.	Rachel Flynn Matron Complex Care Amanda Rigby – Postnatal Ward Manager	Complete	03/03/2023 Guideline reviewed, updated, and awaiting ratification at guideline group. On agenda for Guideline Group March 2023. 12/07/23 Guideline updated May 2023	**4**
	3b. Implement full the BAPM transitional care framework for practice	Rachel Flynn Matron Complex Care Amanda Rigby – Postnatal Ward Manager	1 February 2024	09.10.23 Action plan for the introduction of preterm infant 34+4 to transitional care draft	**4**

term babies. There should be a clear, agreed timescale for implementing this pathway.				developed and shared for comments	
4. The division has identified there are 4 work streams that require particular focus to avoid term admissions to NICU	4a. Maternal Diabetes – antenatal education required to ensure woman are aware of the likelihood of admissions to NICU	Andrew Muotune Consultant Obstetric Lead Diabetes Practice Education Midwife Team Michelle John -Diabetes Team Manager	30 March 2024	10.10.23 information relating to management of the neonate and possible admission to neonatal unit is within the Diabetes in pregnancy orange notes.	**4**
	4b. Maternal Sepsis - recognition education of maternal sepsis and fetal monitoring presentation in relation to fetal monitoring	Lauren Goddard - Fetal Monitoring Lead Practice Education Midwife Team Naheed Tahir –Obstetric CTG Lead All Matrons	30 April 2024	10.10.23 Included in Obstetric Training 10.10.23 Case presentation in Audit Meetings 10.10.23 CTG training to include Sepsis and impact on fetal wellbeing 27.11.23 MOEWS guidance to be cascaded via huddle to all staff.	**3**
	4c. Hypoglycaemia and hypothermia - increase skin to skin rates post birth and first feed within 1st hour	Emma Jones CDS Matron Kathryn Bolton CDS Manager Naheed Tahir CDS Lead Sara Blakeway/Paula O'Reilly Breast Feeding Lead Rachel Flynn Matron	30 March 2024	10.10.23 Audits in progress monitoring skin to skin, first feed and temperature within 1 hour of birth. This is also captured in the ATAIN case reviews. 27.10.23 Awaiting ratification of Management of Hypoglycaemia and hypothermia in the neonate	**4**

	4d. Antenatal and Intrapartum CTG classification and escalation	Lauren Goddard Fetal Monitoring Lead Naheed Tahir Obstetric Fetal Monitoring Lead Practice Education Team	30 March 2024	31.08.2023 GMEC CTG Training full day commenced for all staff in August 2023. 10.10.23 Include Antenatal CTG training on MET Days 27.11.23 monitor training compliance, introduce CTG sticker to aid antenatal classification. 11.01.24 Antenatal CTG ratified for use.	**4**

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 11.01.24 Postholder date confirmed wc 15.01.24	
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 based guidance to underpin clinical practice and a robust audit cycle	TC Lead/Rachael Flynn	31/03/2024	03.10.23 Current transitional 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.	
		3. Collate a business case for the additional Consultant Neonatologists	Operational Business Manager – Neonates Clinical Director	January 2024	17.10.23 – Job planning underway for consultants 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 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

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 - 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
7 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
2 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. Area allocated in vacant ward footprint
4 January 2024	
Staff requested the frequency of communications relating to the presence of Reinforced Aerated Autoclaved Concrete (RAAC) to be increased to alleviate staff concern	Virtual call scheduled for 11 January 2024 Staff briefing shared at team meetings and via corporate channels Trust website details current RAAC update Session held for Union representatives

Appendix 7 – Current position with defined training elements as of 11 January 2024 and mandatory training plan to recover performance to 90% by the end of February.

Course compliance by staff group										
Course	Advanced Neonatal Practitioners	Consultant Obs	Obstetric Medical Doctors	MSW / HCA	Midwives	Neonatal Con	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetis t
PROMPT	NA	89.47%	90.32%	82.86%	89.36%	NA	NA	NA	100%	84.62%
Fetal Monitoring Core Competency Stds.	NA	94.74%	86.11%	NA	87.66%	NA	NA	NA	NA	NA
Neonatal Life Support	86.67%	NA	NA	NA	85.96%	90.00%	100.00 %	84.54%	NA	NA

Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
PROMPT Ensure 90% compliance achieved in each staff group by end of February 2024	1.Identify staff who require training, including those who will become non-compliant during the CNST reporting period 2.Liaise with relevant managers / leads to allocate staff to attend 3. Update training database following training session, reallocate any DNA as a priority 4.Report training compliance monthly	Laura Higgs/ Lauren Booth	Feb 2024	Staff group trajectories created. Highlights that all staff groups will be >90% except for Anaesthetic Doctors (3 did not have training booked.) 3 x Anaesthetists recently rotated to Maternity/ or are new starters. Dates now provided for training.	3
Fetal monitoring training - Ensure 90% compliance achieved in each staff group by end of February 2024	1.Identify staff who require training, including those who will become non-compliant during the CNST reporting period 2.Liaise with relevant managers / leads to allocate staff to attend 3. Update training database following training session, reallocate any DNA as a priority	Laura Higgs/ Lauren Booth	Feb 2024	Staff groups trajectories created and provide assurance that all groups will be > 90% compliant.	3

	4. Report training compliance monthly				
Neonatal resuscitation- En sure 90% compliance achieved in each staff group end of February 2024.	1.Identify staff who require training, including those who will become non-compliant during the CNST reporting period 2.Liaise with relevant managers / leads to allocate staff to attend 3. Update training database following training session, reallocate any DNA as a priority 4.Report training compliance monthly	Laura Higgs/ Lauren Booth	Feb 2024	For Midwifery staff trajectory at present demonstrates 88%. Plan to mitigate risk = drop in training session with those that missed 2 x sessions. This is underway and will increase compliance to >90%. The trajectory for Neonatal Advanced practitioners is currently 87%. 1 more training update required to meet >90%. Plan in place to address. Trajectory for Neonatal consultants and Neonatal Doctors >90% this will not change.	3
Additional Neonatal resuscitation training- All trainers to hold GIC qualification from 31st March 2024.	1. Identify staff to be trained 2.GIC training booked June 2024 3.Approval of bank or zero hours contract req for April-July	Laura Higgs/ Lauren Booth	March 2024	Staff booked x 4 to attend 2 day course in June. Bank and honorary contracts approved if required.	3

Maternity incentive scheme - Guidance

Trust Name	**Bolton NHS Foundation Trust**
Trust Code	**T264**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within each condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - **safety action summary sheet** - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2022/23 financial year or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 1 February 2024.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on 1 **February 2024** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2024

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) 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. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, 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.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	No

8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	Yes

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	Yes
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	N/A
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	No
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	Yes
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	N/A
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A

Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes

4	d) Have all women in active labour received one-to-one midwifery care?	No
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	Yes
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

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

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided 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. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes

14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	Yes
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	Yes

Safety action No. 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?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes

8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 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?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	15	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	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	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0	1	0	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?	Yes	12	0	0	0	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?	Yes	8	0	0	0	0

NHS Resolution

Section B : Action plan details for Bolton NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity Incentive Scheme - Board declaration form

Trust name	**Bolton NHS Foundation Trust**
Trust code	**T264**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Bolton NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	Bolton NHS Foundation Trust
Name:	
Position:	
Date:	

Board of Directors

CNST Year 5 Progress Update

25 January 2024

Summary

		Safety actions	Action plan		Funds requested
Q1 NPMRT		Yes	No		-
Q2 MSDS		Yes	No		-
Q3 Transitional care		Yes	No		-
Q4 Clinical workforce planning		Yes	No		-
Q5 Midwifery workforce planning		Yes	No		-
Q6 SBL care bundle		Yes	No		-
Q7 Patient feedback		Yes	No		-
Q8 In-house training		Yes	No		-
Q9 Safety Champions		Yes	No		-
Q10 EN scheme		Yes	No		-
Total safety actions		**10**	**-**		-

Highlights

- ✓ 10 safety actions achieved
- ✓ Transformational project support received throughout programme
- ✓ Recruitment ongoing to posts recurrently funded by GMEC SBLV3 monies
- ✓ Local agreements with GMEC LMNS have supported the success of the programme
- ✓ External LMNS checkpoints have supplemented the evidential verification process

Detailed position

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	15	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	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	4	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0	1
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	12	0	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?	Yes	8	0	0

Themes

- **Frequent oversight of evidence for approval of Board or Committee**
  - Board cycle of business updated to bi-monthly presentation
  - Regular oversight ensured timely escalation and provision of support
- **Training & education**
  - Transfer of training data to ESR ongoing – monthly report will evidence progress
  - Training has been aligned with the GMEC standard
- **Audit compliance**
  - Audit capacity increased
  - GMEC LMNS templates introduced in year 5
- **Project support**
  - Transformational support provided to work stream leads by project lead
  - Dedicated tracker and teams channel established
  - LMNS checkpoints and dedicated external support for Safety Action 6 has supplemented the verification process.

Next Steps

- Board presentation and presentation of declaration due 25 January 2024
- Final CEO sign off and submission of declaration form to LMNS after Trust Board
- LMNS will submit the completed form to the Accountable Officer for the Integrated Care Board and then return to the Trust
- Trust submission of the declaration form by the Chief Executive Officer by the 1 February 2024

Report Title:	People Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Purpose	To provide an update and assurance to the Board on the work delegated to the People Committee.

Summary:	The attached report from the Chair of the People Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meetings held on 19 December 2023 and 16 January 2024

Previously considered by:
People Committee

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

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

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

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	19 December 2023	Date of next meeting:	16 January 2024
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Fiona Noden, Sharon White, Andrew Chilton, Francis Andrews, Jo Street, Sharon Katema, Sean Harriss, Seth Crofts, Tyrone Roberts, Tosca Fairchild, Fiona Taylor	Quorate (Yes/No):	Yes
		Apologies received from:	

Key Agenda Items:	RAG	Key Points	Action/decision
Agency/Resourcing Update		The update highlights the strong substantive staffing position, and a reduction in the usage and expenditure of agency workers, and medical variable pay, because of this. Overall, in-month there was an increase of 'worked WTE' (WWTE) of 34 WTE in November 2023, with this driven by substantive and bank work and mitigated slightly by reduced agency. Substantive staffing increased by 32 WTE in-month, with the majority of increases relating to clinical staffing groups. Agency usage reduced by 14 WTE in-month; with bank usage increasing by 17 WTE. Overtime usage continued on a reducing trend with 10 WTE in month. Medical variable pay (WLIs/Extra Sessions & Medical Bank work) reduced in-month by £132k a continuation of the reducing trend seen in October 2023. 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 across the Trust. Areas not included in the report: • CDC is an area of concern, there is a lot to do, but there is a lot of activity being undertaken.	To be included in future reports: • Summary of the analysis • Benchmarking • Turnover period of time • Detailed analysis on Medical Sciences • Detailed forecast 23/24 and 24/25

	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

		• Bank spend has increased in November, but is expected to reduce in December. The reason for this is that the Trust had recruited a number of newly qualified midwives and nurses in September but that there was a period of mentoring/double running for the new recruits resulting in the need for additional bank staff. This will reduce once the new recruits become fully operational which was expected to be in December. • Medical Recruitment – there are some concerns, but work is ongoing. The Operational Director of Finance assured the committee that contingency plans have been included in the CDC budgets, noting that activity needs to be delivered to receive the tariff. A certain amount of funding has been allocated for pre-recruitment, but it was not as much as was requested. The national team are also working on recruitment. The Chief Nurse noted the reducing trend in agency spend in the Acute Adult Division, which was massively supported by the international recruitment. It was also noted that the Division are continuing to eradicate the increase to their establishment which had grown during Covid.Grip and Control measures were led by Lianne Robinson, Deputy Chief Nurse, and are now embedded within the Divisions. The Chief Nurse also informed the Committee that Elaine Chesworth, Assistant Director of AHPs, is doing a piece of work on AHP establishment.	
Culture & Leadership Update		The Our Voice Change Programme has been launched with a number of sessions being held with staff across the organisation. The themes have had an executive lead assigned to lead improvements: • Digital systems and equipment – Exec lead Sharon White • Flexible working – Exec lead James Mawrey • Your working environments – Exec lead Rae Wheatcroft • Car parking – Exec lead Annette Walker • Living our values – Exec lead James Mawrey	• KPI examples to be included in the next update. • Additional session for HR/OD Senior Team and NEDs.

	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

		Plans were outlined for building our leadership capability and capacity to drive culture – developing our current leaders at all levels and inspiring future leaders. Further updates will be brought to the Committee on a quarterly basis. A key requirement would be to include measurable outcomes for what is a very exciting programme. Members of the Committee agreed a further session focussing on this area should be held.	
Steering Group Chair Reports		Noted	
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

People Committee Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	16 January 2023	Date of next meeting:	20 February 2024
Chair:	Tosca Fairchild	Parent Committee:	Board of Directors
Members present/attendees:	Alan Stuttard, James Mawrey, Fiona Noden, Sharon White, Andrew Chilton, Francis Andrews, Jo Street, Sharon Katema, Sean Harriss, Seth Crofts, Tyrone Roberts, Niruban Ratnarajah, Paul Henshaw, Carol Sheard, Lisa Rigby, Lianne Robinson, Rachel Carter, Louise Cartin, Elaine Chesworth, Chris Whittam	Quorate (Yes/No):	Yes
		Apologies received from:	

Key Agenda Items:	RAG	Key Points	Action/decision
Agency/Resourcing Update		Agency: Agency spend reduced by £41k in December 2023 and is on a clear downward spend trend, focused efforts over previous months means there is confidence of hitting our forecast for 23/24. Significant progress made on reduction of nursing agency. GM benchmarking shows us in a positive position on agency (in relation to both spend and usage) when compared to most others and we have improved further since GM comparator data set. Bank: increased spend in December to support clinical activity, but that increase did also prevent additional agency spend. Discussion took place regarding spike in HSCW bank spend and rationale. Other variable pay: Small reduction in medical variable pay in-month but evidence of a reducing medical spend trend when compared to earlier in 2023. Vacancy Rate: We benchmark positively compared to most GM providers when looking at the October 2023 comparator data set, and have improved since then to sub 5% vacancy rates. Turnover: We have improved since October 2023 to sub-12% turnover rates. Regional turnover rates indicates that most (not all) Trusts have seen a similar reducing turnover trend in 2023/2024. It was raised that AHP turnover spiked and the Committee would like to understand more as to the drivers and the actions being taken. Resourcing: Good activity on nursing, midwifery, AHP, and Medical recruitment. Focussed efforts needed on recruitment to the new Trust Community	**Action agreed:-** 1. The report was noted. 2. Resourcing steering group to undertake focus work on AHP and raise up to Committee via the Chairs report. 3. Include forecasts in next meeting, along with projected confidence levels.

	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
		Diagnostics Centre to support opening of that centre in 2024. Staffing the Community Diagnostic Centre is being closely monitored. The Committee were informed that the recent MIA Recruitment report provided substantial assurance of application within the organisation,	
Our Voice Change Programme Update		The committee discussed the Our Voice Programme – the Change Programme which works on the top themes that matter to our staff (which works alongside our wider staff engagement actions). The five being Digital, Flexible working, working environment, living our values and car parking) The Committee discussed the measures of success and highlighted that this should include both qualitative and qualitative measures. The Committee welcomed the update and agreed a further update be helpful in three months' time.	**Action agreed:-** 1. The report was noted. 2. Agreed quarterly updates would be received, alongside the wider staff engagement updates
Freedom To Speak Up Q3 Update		The report provided an update on Freedom to Speak Up activity within the Trust during the 2023/24 quarter 3 reporting period from 1 October 2023- 31 December 2023. Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement. The Trust's FTSU approach continues to be embedded to support the organisation to develop an inclusive and transparent culture and deliver the ambitions set out in our People Plan. A total of 55 cases were raised this quarter, which is a slight increase from last quarter (54). The Acute Division had the largest number of concerns raised and behaviour being the theme most concerns were raised about. 31% of concerns were raised from colleagues with a BAME heritage. The Committee requested further work be undertaken as this appeared to be an increase from previous quarter. The Committee were informed that the recent MIA FTSU report provided substantial assurance of application within the organisation, The Committee requested that further work be undertaken on the actions arising out of the report for learning.	**Action agreed:-** 1. The report was noted 2. Requested that future reports provide advice on any cross cutting themes that should be taken as a result of the FTSU findings.

	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
Employee Relations Update		This report provided an update of employee relations activity that took place between October and December 2023, including disciplinary, grievance and tribunal cases. It also provides an update on the recent feedback from an external audit following the recent CQC visit, as well as details on the current round of industrial action and RAAC position (impact on our staff). The Committee noted the comments from the staff side Chair that positive partnership arrangements were in place across the organisation. Further work was requested on whether the levels of employee relations activity were considered normal for an organisation of this size. The Committee supported the proposal to sign up for NHS Sexual Safety Charter. The Committee were informed that the recent MIA Disciplinary Process report provided substantial assurance of application within the organisation,	**Action agreed:-** 1. Next report to provide further information on any cross cutting themes that are being taken forward as a result of the ER activity. 2. Further information on whether the levels of employee relations activity are normal for an organisation of this size
Steering Group Chair Reports		All stood down in December/January.	
Divisional People Committee Chair Reports		Noted – AACD, FCD and DSSD stood down in December.	
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

Report Title:	Finance & Investment Committee Chairs' Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Annette Walker, Chief Finance Officer		Decision	

Purpose	To provide an update and assurance to the Board on the work delegated to the Finance & Investment Committee.

Summary:	The attached report from the Chair of the Finance and Investment Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meeting held on 22 November 2023. The next meeting is scheduled on 24 January 2024 and as such a verbal update will provided at the Board meeting and will be included in the March boardpack.

Previously considered by:
Discussed at Finance and Investment Committee.

Proposed Resolution	The Board of Directors are asked to **receive** 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:**	Jackie Njoroge, Chair Finance and Investment Committee

Finance and Investment Committee Chair's Report

Name of Committee:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	22 November 2023	Date of next meeting:	24 January 2024
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Rae Wheatcroft, Sharon Katema, James Mawrey, Andrew Chilton, Rachel Noble, Lesley Wallace, Catherine Hulme, Fiona Taylor, Sean Harris, Seth Crofts, Niruban Ratnarajah	Quorate (Yes/No):	Yes
		Apologies received from:	Rebecca Ganz

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
GM/National System Update		A Walker	The Chief Finance gave a verbal update on the GM/National financial position. Key points to note included: • The NHS has been notified additional funding of £800m to support the costs of industrial action and other pressures. • Out of the £800m, GM have been allocated £46m of which Bolton FT have received £2.2m. • The overall GM system is still considerably off track to the financial plan for 2023/24 and work is now underway to plan for 24/25. PWC are supporting both Trusts and the ICB on the financial improvement and planning.	The Finance & Investment Committee **noted** the GM/National System Update.
Month 7 Finance Report		A Chilton	The Operational Director of Finance gave an update to the Committee on the Month 7 financial position. Key points noted were as follows: • Year to date deficit of £7.7m compared with a planned deficit of £7.3m. The adverse variance to plan is mainly due to the costs of covering medical industrial action, under delivery on CIP offset by non-recurrent measures. • Capital spend for month 7 is £1.8m of which £0.5m relates to TIF and £1m relates to CDC. Year to date spend is £10m. • Cash of £25.1m at the end of the month, which is an increase of £7.8m from Month 6. The Trust cash position will become challenging during 2023/24 and this has been flagged as a key concern during discussions with the ICB. • BPPC performance year to date is 89.8% by number of invoices and 88.6% by value of invoices. • The Committee approved an improvement to the forecast outturn by £1.2m, bringing the deficit to £11.2m.	The Finance & Investment Committee **noted** the Month 7 Finance Report and **approved** the decision to accept an improved target of £1.2m.

	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
3 Year Financial Strategy		A Chilton	The Operational Director of Finance shared with the Committee an early draft of a 3-year financial strategy. It is proposed that the headlines be shared with PWC in early December. Key points to note were as follows: • Underlying deficit of £25m - £35m. • Gap in 24/25 expected to be circa £37m but this is subject to change. • Potential to take up to 3 years to resolve. • Consequences in relation to cash and capital need to be considered. • Drivers of the deficit work being undertaken over the next two months. • CIP big ticket items being developed. • PWC expected to support 24/25 planning round. • A review is being undertaking of any loss making services.	Noted.
Cost Improvement Update		S Ball	The Programme Director for Transformation presented the Cost Improvement Update. Key points to note included: • Slight increase in forecasted CIP following financial validation and identification of schemes to transfer to the pipeline for 2024/2025. • Delivered CIP remains on track year to date. • Additional £1.64m transacted recurrently in month. • Cross cutting theme actions have been incorporated as part of rapid actions in the financial recovery programme. • Progress of financial recovery actions are monitored weekly through the Financial Improvement Group. • Sprint sessions have been taking place for all divisions to plan for 2024/25. • A list of Bold CIP opportunities have been identified which are being evaluated with Executive leads to assess feasibility and scope.	Noted.
Revised Debt Collection Policy		C Hulme	The Associate Director of Finance outlined the Debt Management procedure to be put in place to ensure the Trust collects cash on a timely basis and that processes are in place for regular debt reviews to avoid/reduce debt write offs. The Debt Collection Procedure is to be discussed with Internal Audit as part of their review of the Key Financial Controls. Bad debt provision is currently just under £900k. AW advised that there is a review of where we are in relation to recovering income, which will be built into future plans. The plan is to be more proactive around chasing overdue debt and as a result, the bad debt provision should reduce.	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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Board Assurance Framework		S Katema	The Director of Corporate Governance updated the Committee on the Board Assurance Framework (BAF) last presented in July 23. SK highlighted that the Estates risk had been added and following the outcome of the 6 facet survey further related risks had been coupled together within Ambition 4. It was proposed that Ambition 4 score is increased from 4 to 20, which the Committee is asked to approve.	The Committee **approved** the increase in risk score for Ambition 4.
Estates Backlog Plan		L Wallace	The Commercial Director of Finance updated the Committee on the 3 Year Estates Capital Plan developed to undertake the most critical of works to ensure that the estate can continue to function and not impact on patient safety previously presented at CRIG in October and at the Executive Board on the 13th of November. Key points to note included: • A 6-facet survey was carried out in 2022, this identified backlog maintenance of £79.6m. Of the backlog maintenance £47.7m was identified to be undertaken by 2025/26 with a further £9.9m by 2027/28 and the balance in the following 5 years. • Five areas of works have been prioritised from the survey, which require a further investment of £6.9m. The costs have been formulated from the results of the survey and the designs are currently at RIBA stage 1; iFM are currently preparing a business case to undertake these works. Subject to approval and scheme design iFM would like to commence works in 2023/24 and complete by 2025/26. It is planned £1.45m will be required for 2023/24.	Noted.
Capital Plan		L Wallace	The Commercial Director of Finance gave an update on the Capital position. Key points noted included: • The capital envelope for 2023/24 in total is £32.2m of which £19.9m is CDEL / PDC and £12.3m iFRS16. Both allocations remain subject to final approval by GM/NHSE as the GM programme is currently significantly oversubscribed. • The current spend profile of business cases approved is £21.8m for 2023/2024 however further business cases have been submitted which total £8.4m with £1.89m of spend within 2023/2024. Should this profile be maintained, this would result in an overspend of £3.76m. It is proposed that this expenditure would be managed into the new financial year unless further capital becomes available. • Month 7 capital spend is £10.0m	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

Finance and Investment Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/Decision
Green Plan		F McDonnell	The Managing Director of IFM provided a summary of the progress made within the Green plan and the status of all targets. Key points noted included: • 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.	Noted.
Committee Effectiveness Report		S Katema	SK presented the Committee effectiveness report that had been circulated during October and November to members and regular attendees. It was noted that overall the results from this survey were generally positive as evidenced by the responses. The report will be used to support the production of the Report to the Board. The Chair thanked SK for this piece of work which is helpful feedback.	Noted.
Chairs' Reports		A Walker	The Committee noted the following reports for information: **Capital Revenue & Investment Group** – 7th of November **Place Based Finance & Assurance Committee** – 21st of November. The Chief Finance Officer highlighted that a paper concerning 0-19 services contract will be brought to the Board of Directors on the 29th of November.	Noted.
Comments:				
Risks escalated:	There were no risks to be 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

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	25 January 2024		Discussion	
Exec Sponsor	Annette Walker		Decision	

Purpose	To provide an update from the Financial Controls Committee meetings held since the last Board of Directors meeting.

Summary:	The Chairs' reports are attached from the Financial Controls Committee Meetings held on the 22 November and 13 December 2023 for assurance. A verbal update will be provided for the meeting to be held on the 17 January 2024.

Previously considered by:
NA

Proposed Resolution	The Board of Directors are asked to note the Financial Controls 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

Financial Controls Committee Chair's Report

Name of Committee/Group:	Financial Control Committee	Report to:	Board of Directors
Date of Meeting:	22 November 2023	Date of next meeting:	13 December 2023
Chair:	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, Andrew Chilton	Quorate (Yes/No):	Yes
		Apologies received from:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Terms of Reference		A Walker	The Financial Controls Committee Terms of Reference were approved at the last Finance & Investment Committee. However, since then further changes have been recommended and have been brought back to the Committee today for discussion and approval. Changes have been made to the principal duties focusing on financial control.	The Financial Controls Committee **approved** the minor changes made to the Terms of Reference.
October Financial Performance & Recovery Meeting		A Walker	The Chief Finance Officer shared with the Committee the letter and month 6 finance pack following the October meeting with Stephen Hay and Mark Fisher to provide assurance around actions. The Trust met with NHS GM and colleagues from PWC on 23 October to discuss the month 6 financial position and actions from the September meeting. The Trust is preparing a slide deck to respond to all the actions set to provide evidence and information for the next meeting with is scheduled for 5th December. The Trust has agreed to stretch target of £1.2m and now forecasting a deficit of £11.2m. The GM system is forecasting a £200m deficit.	Noted.
Financial Improvement Group Update		F Andrews	The Committee received the Chair's report from the Financial Improvement Group (FIG) meeting held on 15th November 2023 for information. SK explained that four FIG meetings have taken place, which have been set up predominantly as an oversight of the financial plan. The challenge of 7% CIP is difficult to achieve. The group has proposed a range of bold actions and identified savings ideas of £20m to date. It was noted however, the majority of the ideas were still red rated for risk.	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

Financial Controls Committee Chair's Report

Vacancy and Variable Pay Spend		J Mawrey	The Director of People presented an update on Vacancy and Variable Pay Spend. Key points noted included: • The presentation highlights the relatively strong substantive staffing position, and a reduction in the usage and expenditure overall of temporary staffing. Overall, worked whole time equivalent (including both substantive and variable staffing) reduced by 41.85 WTE in-month when compared to M6 2023/2024. • The presentation also provides Committee members with a summary of actions taken, and controls implemented, in support of financial improvement. • AS asked for it to be documented that the figures presented went through the People Committee yesterday and there has clearly been in a reduction in variable pay on Agency spend, this month and last and that we may come under the target which was set by NHSE.	Noted.
Grip and Control - PWC		A Walker	As part of the wider financial improvement work across GM, PwC has reviewed the grip and control mechanisms in place at each trust to identify opportunities and provide recommendations to improve the in-year financial position. This sub-report is the Bolton extract of the Greater Manchester Integrated Care System wide review of Grip and Control. The intention of this report is to support Bolton in: • understanding how Bolton's own assessment of their Grip and Control mechanisms compared to the PwC assessment; and, • identifying the opportunities to strengthen Grip and Control across both pay and non-pay spend areas based upon our findings and recommendations In response to this, the recommended controls are in the process of being implemented and we have commissioned MIAA to conduct an internal audit to determine how robustly those controls have been implemented.	Noted.
Comments:				
Risks escalated: There were no risks to be 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 Chair's Report

Name of Committee/Group:	Financial Control Committee	Report to:	Board of Directors
Date of Meeting:	13 December 2023	Date of next meeting:	17 January 2024
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Fiona Noden, Sharon White, Rae Wheatcroft, Sharon Katema, Andrew Chilton, Paul Henshaw, Sam Ball	Quorate (Yes/No):	Yes
		Apologies received from:	James Mawrey, Francis Andrews, Tyrone Roberts, Jackie Njoroge

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
December Finance & Performance & Recovery meeting		A Walker	The Trust met with NHS GM and colleagues from PWC on the 5th of December to discuss the month 7 financial position and actions from the October meeting. The month 7 finance pack was shared with the Committee but the letter is currently awaited and will be shared once received. • The month 7 position was discussed with a number of questions raised. • PWC suggested that their view was the Trust could push to improve further by £3m-4m. • Discussion also took place around next year's financial plan and the headline deficit. • All CIP needs to be coded green by March. • AW informed the Committee that the risk around deferred tax credit was raised at the meeting. AW is to meet with Alex Kirkpatrick and also discuss with Tim Cutler.	The Deputy Chair thanked everyone for the work pulled together for the meetings.
Financial Improvement Group Update		S White	The Committee received the Chair's report from the Financial Improvement Group (FIG) meeting held on 06 December 2023 for information. A further meeting was held today from which the Director of Strategic Operations gave an update. Key points highlighted were as follows: • CIP schemes identified for 2024/25 is £23m which is a reduced figure due to double counting in some areas. • The PwC recommendations and audit from grip and control were reviewed.	Noted.
			• The operating plan is discussed every week. Arrangements are now in place for speciality level meetings to discuss their plans for next year.	

	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		P Henshaw	The Head of Employee Resourcing presented an update on Vacancy and Variable Pay Spend for Month 8. Key points highlighted were as follows: • The presentation highlighted the strong substantive staffing position, and a reduction in the usage and expenditure of agency workers, and medical variable pay, because of this. Overall, in-month there was an increase of 'worked WTE' (WWTE) of 34 WTE in November 2023, with this driven by substantive and bank work and mitigated slightly by reduced agency. • Agency usage reduced by 14 WTE in-month; with bank usage increasing by 17 WTE. The increase in bank usage was due to the impact of the recruitment of newly qualified midwives and nurses who were supernumerary for a period of three months resulting in double running costs. • The CEO emphasised the need for the Trust to have a clear story regarding the workforce numbers.	Noted.
Statement of Financial Position - PwC		A Walker	The Chief Finance Officer updated the Committee on the most recent PwC report which provides a review of the Trust's Statement of Financial Position (SoFP). All the recommendations in the report have been accepted and actioned. The work undertaken has supported the FT to improve the forecast outturn to a deficit of £11.2m. There is still concern around the GM position on cash.	Noted.
Comments:				
Risks escalated: There were no risks to be 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:	Charitable Funds Committee Chair Report			
Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide the Board of Directors with a summary of discussion and decisions made at the Charitable Funds Committee meeting on 04 December 2023

Summary:	Chair's report from the Charitable Funds Committee meeting, covering the following items: • Screening of Our Bolton NHS Charity video • Finance report • Update on the draft annual report and accounts 2022/23 • Risk register deep dive • Management fee review • Our Bolton NHS Charity Q3 2023/24 highlight report • Our Bolton NHS Charity Q4 2023/24 outlook report

Previously considered by:
Charitable Funds Committee

Proposed Resolution	The Board of Directors is asked to **receive** and note the report.

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

Prepared by:	Sarah Skinner, Charity Manager	**Presented by:**	Martin North, Chair of the Charitable Funds Committee

Charitable Funds Committee Chair's Report

Name of Committee/Group:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	04 December 2023	Date of next meeting:	04 March 2024
Chair:	Martin North, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Sharon White, Francis Andrews, Alan Stuttard, Sharon Katema, Rachel Noble, Catherine Hulme (deputising for Annette Walker), Rachel Carter, Sarah Skinner and Abdul Goni	Quorate (Yes/No):	Yes (with deputies)
		Apologies received from:	Annette Walker

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Screening of Our Bolton NHS Charity video		SS	SS introduced the new Our Bolton NHS Charity video, which was funded by the NHS Charities Together development grant. https://www.youtube.com/watch?v=OAcKtH9jvQg	Charitable Funds Committee noted the video. **Action: Explore feasibility of incorporating the video into corporate induction and on digital screens across the Trust footprint.**
Finance report		CH	The charity's fund balances totalled £1,098k at 31 October 2023. There was a net decrease in funds of £101k for the seven months to 31 October 2023. The charity had received £81k in legacies to date in 2023/24, with just five legacies outstanding (totalling £2.6k). Work continued to streamline the call on funds, which stood at £209k (down from £360k as at 31 July 2023).	The Charitable Funds Committee noted the finance report.
Update on the draft annual report and accounts 2022/23		CH	The Committee received an update on the annual report and accounts for 2022/23. The Finance team had received the draft ISA260 and were reviewing the content. The Associate Director of Financial Accounts advised that the auditors had recommended some funds – currently deemed unrestricted – should be reclassified as restricted. The deadline for filing the accounts with the Charity Commission was 31 January 2024.	The Charitable Funds Committee noted the update.
Risk register deep dive		RN	The Committee received the Q3 review of the risk register with key changes to the register outlined. The charity continues to monitor ten live risks, with two risks scoring 12 or above (before mitigation).	The Charitable Funds Committee noted the risk register. **Action: Update risk register based on discussion.**

	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

Charitable Funds Committee Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Management fee review		RN	The Committee received an overview of the work programme to review the Charity management fee, setting out: • Confirmed costs for 2023/24 • The scope of the review for 2024/25 • Work undertaken to date • Progress reporting mechanism through the monthly Charity Senior Management Team meetings • Timescales and next steps	The Charitable Funds Committee noted the presentation and scope of the management fee review. **Action: Bring forward the management fee proposal to the Committee in March 2024.**
Our Bolton NHS Charity Q3 2023/24 highlight report		SS	The Committee received the Q3 2023/24 highlight report noting: • Fundraising and grants • Communications, marketing and media • Charity-funded schemes • Events • Risks	The Charitable Funds Committee noted the highlight report.
Our Bolton NHS Charity Q4 2023/24 outlook report		RN SS	The Committee received: • A 'state of the sector' update • An overview of work underway to align the investment of charitable funds with the Trust's capital plan • Confirmation of the introduction of grant round for charitable funding applications • Information on plans for networking through Greater Manchester Chambers of Commerce • A summary of key fundraising dates in Q4	The Charitable Funds Committee noted the outlook report.
Comments				
Risks escalated There are no risks to be escalated to the Board of Directors.				

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

Report Title:	Our Bolton NHS Charity's Annual Report and Accounts for year ending 31 March 2023

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	✓

Purpose	To provide the Board of Directors with a copy of Our Bolton NHS Charity's annual report and accounts and the letter of representation.

Summary:	The annual report and financial statements describe the structure, governance and management of the Charity; provide a breakdown of income and expenditure; outline some of our key priorities for 2023/24 and set out the financial position for the year ending 31 March 2023. The annual report and accounts will be submitted to the Charity Commission by the deadline of 31 January 2024.

Previously considered by:
Charitable Funds Committee

Proposed Resolution	The Board is asked to ratify Our Bolton NHS Charity's annual report and accounts to 31 March 2023

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

Prepared by:	Sarah Skinner, Charity Manager and Karen Sharples, Finance Manager	**Presented by:**	Sharon White, Director of Strategy, Digital and Transformation Annette Walker, Director of Finance

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

BMCC	Bolton Masjids Chanda Committee
CIC	Community Interest Company
FICare	Family Integrated Care
FRS	Financial Reporting Standard
ISA	International Standard on Auditing
LED	Light-Emitting Diode
NICU	Neonatal Intensive Care Unit
RBH	Royal Bolton Hospital
RBS	Royal Bank of Scotland
SIBA	Specialist Interest Bearing Account
SORP	Statement of Recommended Practice
UK GAAP	UK Generally Accepted Accounting Practice
VAT	Value-Added Tax

Annual Report and Financial Statements

Year ending 31st March 2023

Contents

Chair's statement 3
Reference and administrative details 5
Structure, governance and management 7
Our objectives and activities 8
Income analysis 10
Expenditure analysis 12
Looking ahead to 2023/24 14
Statement of the Corporate Trustee's responsibilities 15
Statement of financial activities for the year ended 31st March 2023 16
Balance sheet for the year ended 31st March 2023 17
Statement of cash flow for the year ended 31st March 2023 18
Notes on the accounts 19

Chair's statement

It is my pleasure to present the annual report and audited financial statements for Our Bolton NHS Charity for the year ending 31st March 2023.

As the official NHS charity partner of Bolton NHS Foundation Trust, we go over and above what the NHS is expected to provide to make a lasting and meaningful difference to the people of Bolton. Our mission is to invest in the latest technology and research; make improvements to the care environment and experience so patients feel comfortable and at ease, and fund specialist training and wellbeing support so our staff provide the highest standard of care to our patients.

Throughout 2022/23, we continued to receive valued support from the local Bolton community with £556,000 in legacy donations and £19,000 from gifts in kind. In this first year without Covid-19 restrictions, we were delighted to see the return of community fundraising, which contributed to £141,000 in donations, and continue to be humbled by the reasons our supporters fundraise in aid of Our Bolton NHS Charity.

Acting on behalf of the Corporate Trustee, we have a legal duty to ensure that money received is used appropriately and responsibly. In 2022/23, we invested £669,000 in a range of schemes designed to improve staff wellbeing and the patient experience at Bolton NHS Foundation Trust. A full breakdown of direct charitable expenditure can be found on page 12, but a particular highlight is the complete refurbishment of the faith facilities at Royal Bolton Hospital.

The revamped faith facilities include a bright and spacious mosque, temple and community hub, which offers a versatile space for communities to come together as well as a place to host staff network and support events. The project – costing £426,000 – was funded through donations to Our Bolton NHS Charity and a grant from NHS Charities Together. The facilities are intended to support the spiritual wellbeing of staff, patients and visitors, and were officially opened by the Mayor of Bolton in March 2023, coinciding with the start of Ramadan.

"This charitable investment is a really unique and impressive way of improving staff and patient experience through spiritual wellbeing and valuing cultural diversity. We're really proud to have been a part of this, and having listened to staff and various community groups in Bolton, there is no doubt this will be a very special space for years to come."

Ellie Orton OBE, CEO at NHS Charities Together

Looking ahead to 2023/24, the NHS' 75th birthday will provide a special opportunity to reflect on our achievements, but we will continue to build on our progress with the launch of our three-year strategy (delayed from 2021/22) and plans for investment in Our Bolton NHS Charity thanks to further grant-funding from NHS Charities Together.

On behalf of the Charitable Funds Committee, I would like to take this opportunity to thank our incredible donors, volunteers and supporters, without whom, none of the above would have been possible. We have exciting and ambitious plans for 2023/24, but we cannot deliver them on our own so please get involved and help us make a lasting and meaningful difference to the people of Bolton.

Martin North
Chair of the Charitable Funds Committee

Reference and administrative details

Our Bolton NHS Charity, registered charity number 1050488, is administered and managed by the corporate trustee – Bolton NHS Foundation Trust. The Bolton NHS Foundation Trust Board of Directors has delegated responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the corporate trustee.

The Charity's annual accounts for the year ended 31st March 2023 have been prepared by the Corporate Trustee in accordance with the Charities Act 2022 and Statement of Recommended Practice (SORP): Accounting and Reporting by Charities published in 2015. The Charity's accounts include all the separately established funds for which the Bolton NHS Foundation Trust is the sole beneficiary.

The main charity, Our Bolton NHS Charity, was entered on the central register of charities on 20th October 1995, as Bolton Hospitals NHS Trust Endowment Fund and renamed by supplemental deeds on 5th October 2005, 5th June 2009, 13th September 2011 and 27th July 2021.

Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

The principal office for the Charity is:

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

Principal staff (employed by Bolton NHS Foundation Trust):

- Sharon White, Director of Strategy, Digital and Transformation
- Rachel Noble, Deputy Director of Strategy
- Sarah Skinner, Charity Manager
- Karen Sharples, Finance Manager
- Abdul Goni, Charity Engagement Coordinator

The following services were retained by the Charity during 2020/21:

Bankers
Royal Bank of Scotland,
Bolton Central Branch,
46-48 Deansgate,
Bolton,
BL1 1BH

Solicitors
Hempsons Solicitors
City Tower,
Piccadilly Plaza,
Manchester,
M1 4BT

External Auditor
KPMG
One St Peter's Square
Manchester
M2 3AE

Structure, governance and management

Structure of funds

The Charity currently has three special purpose trusts/funds.

As at March 2023, the Trust had 61 individual funds relating to individual wards and departments. Ward Managers and Heads of Department manage funds at a local level and all expenditure is authorised in accordance with the Trust's standing financial instructions, standing orders and charitable fund procedures.

Charitable Funds Committee

The Charitable Funds Committee acts on behalf of the Corporate Trustee and is responsible for the overall management of the Charity. Key duties of the Charitable Funds Committee include:

- Controlling, managing and monitoring the use of funds
- Providing support, guidance and encouragement for fundraising activities
- Ensuring that 'best practice' is followed in the conduct of all is affairs
- Providing updates to the Board of Directors on the activity, performance and risks of the charity

Risk management

The major risks to which the Charity is exposed have been identified and considered. Internal audit reviews will continue to take place on a cyclical basis to ensure controls are appropriate. The Corporate Trustee is satisfied that systems are in place to mitigate exposure to identified risks and will review on an annual basis as per the Charitable Funds Committee terms of reference.

Investment policy

The majority of funds are held in the Specialist Interest Bearing Account (SIBA).

Reserves policy

The policy of the Corporate Trustee is to apply, wherever possible and without delay, all funds to charitable purposes within the Trust. Expenditure is approved only where sufficient funds are available.

Our objectives and activities

Objective

Our objective is not to fund patient care, but to enhance and improve it, providing funding for projects that are over and above those served by NHS funding.

We aim to increase both income and expenditure of funds for the primary purpose of enhancing the patient experience within the Trust, which includes:

- Improvements to the internal and external environments
- Providing additional services
- Enhanced staff training and development
- Purchasing new equipment
- Research and development

In setting the objectives and activities of the Charity, the Corporate Trustee has given due consideration to the Charity Commission's published guidance on public benefit.

Mission statement

Through the receipt of donations, legacies, fundraising activities and appeals, Our Bolton NHS Charity will further improve the provision of high quality patient care, specialist training and education for staff and the provision of amenities for both patients and staff, which are not fully covered or supported by central NHS funds.

Activities

We continue to be supported by individuals, community groups, charities and institutions. A range of individuals and groups have held events to raise funds for their chosen cause.

Where our funds came from

In 2022/23, the Charity received £141,000 from donations, £556,000 from legacies, and £19,000 from gifts in kind.

The year in review

Following two incredibly challenging years at the hands of the Covid-19 pandemic, 2022/23 marked the start of the post-pandemic era with the cessation of all Covid-19 restrictions and a firm focus on recovery and future resilience. However, while the pandemic has undoubtedly heightened public awareness of the contribution that charities (including NHS charities) make to society, optimism for income generation and financial stability has been tempered by rising inflation, resulting in a cost of living crisis that has seen demand for charities increase significantly but financial support from some donors and funders decrease.

Charity strategy and development

We are delighted to have written our first charity strategy, which sets out our objectives for 2023 to 2026 and describes how we will:

- Raise our profile and become the charity of choice for the people of Bolton
- Increase our charitable income and make the best use of our resources
- Make a lasting and meaningful difference to the people of Bolton

2022/23 has been a foundational year ahead of the launch of the strategy in April 2023 and – as such – our focus has been on building relationships within Bolton NHS Foundation Trust, across our community and nationally with our charity partners, including NHS Charities Together.

NHS Charities Together development grant

A one-off grant of up to £30,000 per NHS member charity is available through NHS Charities Together development grants programme. The objective of the development grant programme is to empower the NHS charity sector to be high performing, effective and impactful and grants awarded must:

- Be used on the charity itself, not the wider NHS Trust
- Build capacity, not fund existing resources
- Demonstrate impact, sustainability and value for money

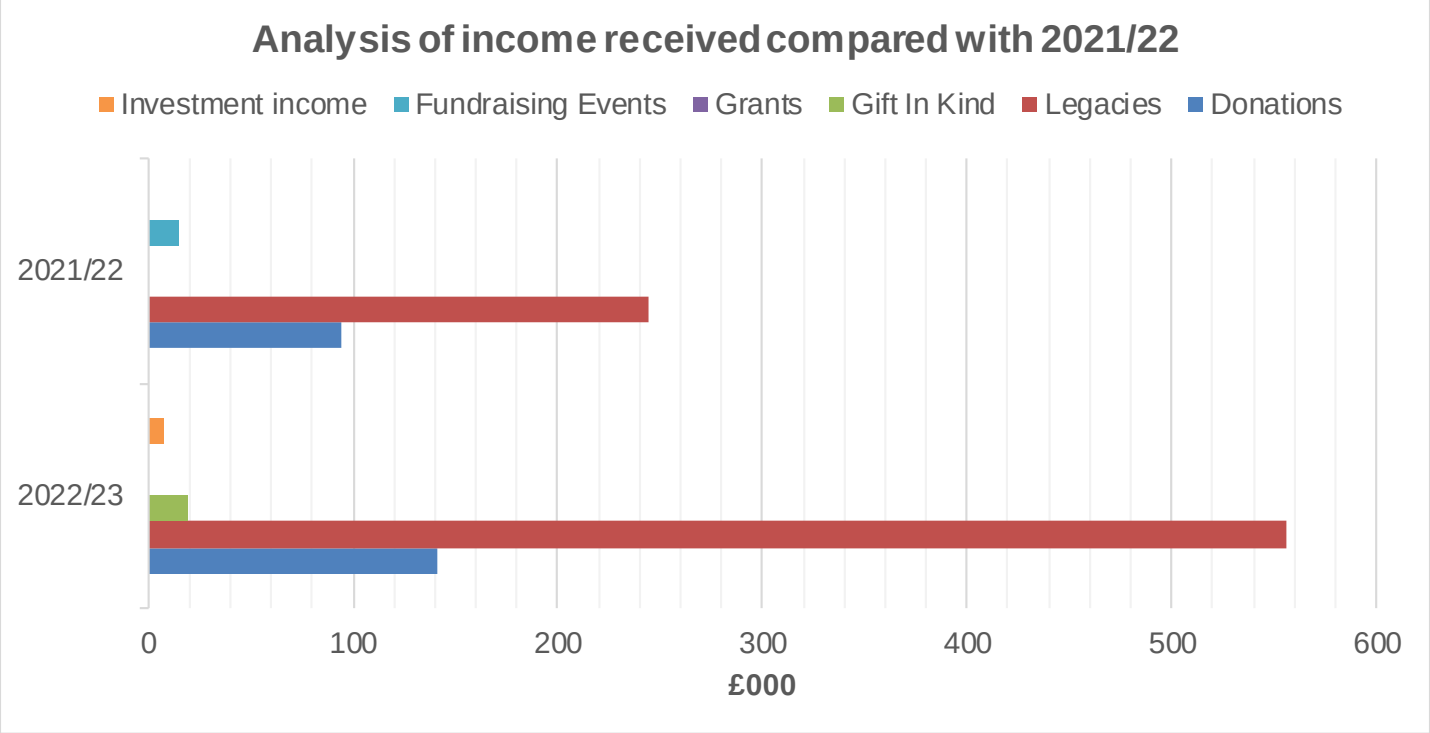
Following appropriate consultation with key stakeholders, we submitted our application for the £30k grant in December 2022, which focused on three key areas: operations, fundraising and influencing. Assuming we are successful, the development grant will equip the charity team with the knowledge, skills and materials required to deliver the three-year strategy.

Award nominations

Our Bolton NHS Charity's winter appeal: The Small Things was shortlisted in the 'Best Charity Campaign' category of the NHS Communicate 2022 awards. The award – sponsored by NHS Charities Together – recognises charitable campaigns that have delivered exceptional engagement and impact across the NHS, galvanising stakeholders and communities to create tangible and lasting benefits for staff, patients and carers. Unfortunately, Our Bolton NHS Charity did not win; however, it was wonderful to be recognised amon gst much larger, independent NHS charities, including the Royal Free Charity and the Addenbrook Charitable Trust.

Income analysis

The total income for 2022/23 was £724,000 compared with £353,000 in 2021/22. The majority of income came from donations (including funds raised through 'in aid of' events) and legacies, which increased by 50% and 127% respectively when compared with 2021/22.



Fundraising highlights

Fundraising by Bolton NHS Foundation Trust employees

Bolton NHS Foundation Trust employees raised more than £10,880 for Our Bolton NHS Charity across three separate fundraising events during May and June 2022. The Breast Services team organised a glitter ball, which raised £7,930 and helped to fund mastectomy bras so women who undergo a mastectomy can leave hospital with a greater degree of confidence. The Health Improvement Nursing team cycled the 218.4 virtual miles between the Royal Bolton Hospital and the Florence Nightingale Statue in London in under 12 hours, raising £2,060 to enhance patient and relatives' facilities on the children's ward. And members of the Strategy and Transformation team took on the Yorkshire Three Peaks and completed the 24 miles (including 1,585 metres of ascent) in 13.5 hours, raising £790 for the Small Things appeal.

Fundraising by former patients and their families

The mother and grandmother of twins, who were cared for by staff on Bolton Neonatal Unit back in 2019, organised their third World Prematurity Day charity ball and raised over £19,000 split equally between Our Bolton NHS Charity, Bliss Charity and Ronald McDonald House Charity. Funds raised will contribute towards Bolton Neonatal Unit's efforts to become an accredited FICare provider and empower parents to become confident in caring for their baby, through staff education and support; parent education, NICU environment and psychosocial support.

Fundraising by the local business community

In September 2022, Gareth Price took on the Italian Alps and Dolomites in recognition of the care his partner received from maternity staff when she gave birth to their daughter at Royal Bolton Hospital in 2018. Gareth – Director of Bolton Spin Studio and Founder of Tunity CIC – set himself the ambitious target of cycling 10,000 metres elevation in six days. Despite challenging weather conditions, Gareth finished with half a day to spare and raised more than £600. Gareth has since pledged to support Our Bolton NHS Charity for the next 12 months with another three endurance challenges planned, including the Yorkshire 3 Peaks.

Fundraising by the local school community

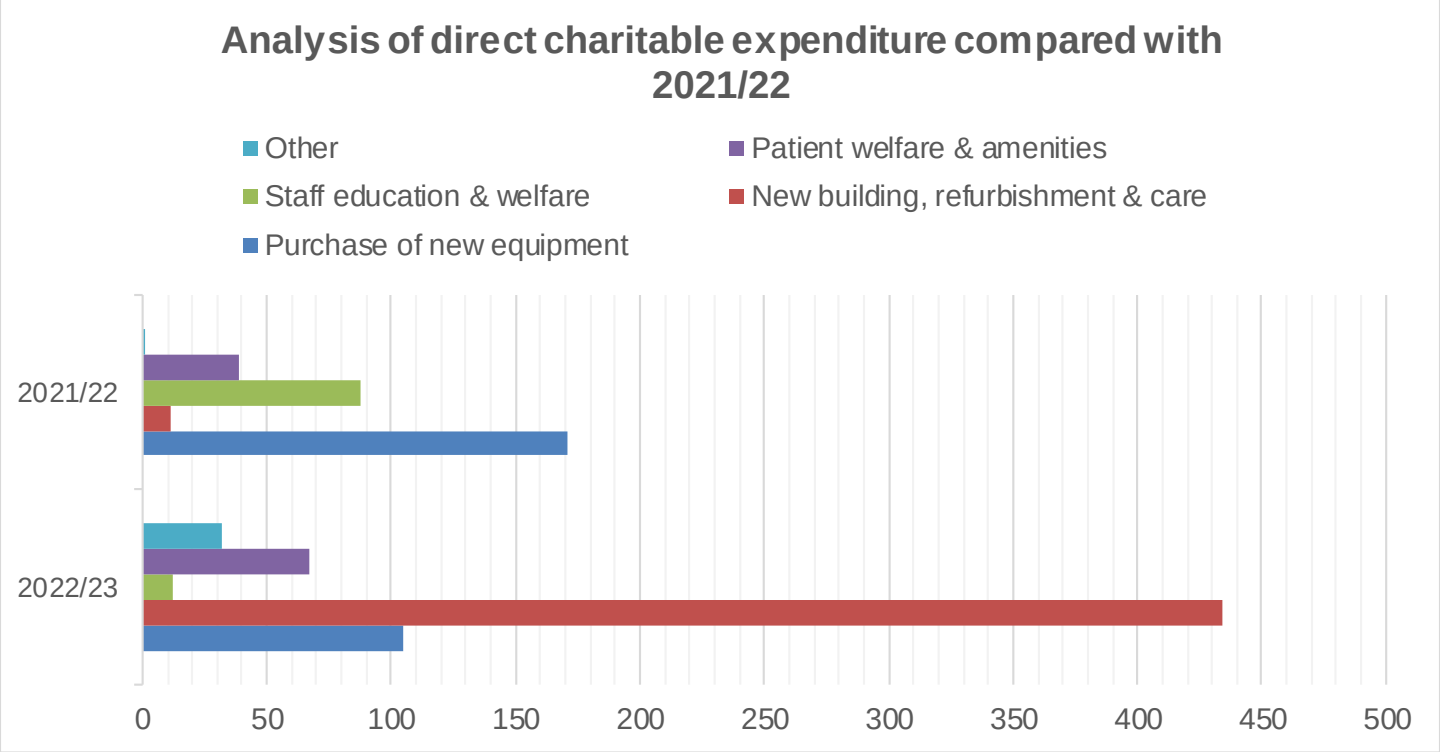
Kings Leadership Academy approached us with a proposal to raise £2,000 to buy presents for children in hospital over Christmas. Following discussion with the Charity Manager about the sustainable impact of one-off gifts versus equipment that could distract and entertain hundreds of paediatric patients every year, the organisers agreed to donate the £2,800 raised and create a lasting legacy at Royal Bolton Hospital. The funds will be used to purchase the children's ward's first medical gaming cart, which is anticipated to benefit more than 2,000 young patients each year.

Fundraising by the local faith communities

Bolton Masjids Chanda Committee and Bolton Council of Mosques invited donations from the local Muslim community during Ramadan 2022 and raised £38,240.34, which contributed towards the relocation and refurbishment of faith facilities at the Royal Bolton Hospital. The aim of this project is to increase the footprint and capacity of the existing Mosque and Temple so they better meet the needs of our Muslim and Hindu colleagues, volunteers and patients, as well as providing a multi-functional community space that can be used for bereavement support as well as meetings, conferences and events.

Expenditure analysis

Of the £753,000 total expenditure (£387,000 in 2021/22), £650,000 (£310,000 in 2021/22) was on direct charitable activities across a range of programmes, for the benefit of patients, service-users and the local health community. The remaining £103,000 is attributed to gifts in kind (£19,000) for the benefit of patients, and governance costs (£84,000), which relate to statutory external audit and staffing costs.



Charity-funded schemes and expenditure highlights

Improvements to staff, patient and visitors' facilities

Thanks to grant-funding from NHS Charities Together and the support of the local Muslim and Hindu community, Our Bolton NHS Charity funded the complete refurbishment of the faith facilities at the Royal Bolton Hospital. The enhanced facilities (including a new community hub) supports the Trust to better meet the religious, spiritual and pastoral needs of patients and service-users, which is understood to improve health outcomes. Similarly, the quality of staff rest facilities (including faith and prayer rooms) is a strong contributor to employee health and well-being, which – in turn – contributes to the provision of high-quality patient care.

Purchasing new equipment and supporting research

We have funded a CMAC video laryngoscope, which has been used with great success to facilitate neonatal intubation in babies from 500g up to 4kg. The video laryngoscope also facilitates a process called 'less invasive surfactant administration' (LISA) in pre-term infants with respiratory distress syndrome, without the need for mechanical ventilation, which can reduce the risk of death or chronic lung disease. The video laryngoscope is also supporting Bolton NHS Foundation Trust's participation in SurfON, which is a multicentre, randomised controlled trial, designed to determine how best to treat babies born two to six weeks prematurely with breathing problems. To date, 20 patients from Royal Bolton Hospital have been recruited to participate in the national trial, which has just received a 26-month extension and will now run until 2025.

Supporting staff wellbeing, training and development

Thanks to a legacy bequeathed to Our Bolton NHS Charity in support of staff training and development, we have funded a range of resources to facilitate restorative supervision sessions for colleagues at Bolton NHS Foundation Trust. Restorative supervision is a form of psychological support that helps colleagues manage the emotional demands of their role, while encouraging innovation to shape and improve services for the benefit of patients. Evaluation of the model shows professionals who engage with restorative supervision are more clinically effective, are less likely to be off sick, and develop better workplace relationships (Wallbank, 2012).

The small things that make a big difference

As part of our ongoing commitment to equality, diversity and inclusion, we funded Ramadan packs (including organic dates, Miswak and prayer beads) and Eid cards for Muslim patients, and Lakshmi shadowdiyas, LED tea lights and Diwali cards for Hindu patients, so those of faith can continue to observe and celebrate religious festivals even though they are in hospital or recuperating in intermediate care. This items are in addition to the Christmas presents we fund every year and will complement the new faith facilities that are now open at Royal Bolton Hospital.

Looking ahead to 2023/24

2023/24 will be another important year for Bolton NHS Foundation Trust as it will see the launch of a refreshed corporate strategy and the new clinical strategy. We know the Trust is focused on becoming a truly impactful 'anchor institution' in Bolton, supporting people to stay healthy and well for as long as possible; to be a fantastic employer and educational partner, and – over the long term – to reduce the health and societal inequalities that are sadly faced by many people in Bolton. As the Trust broadens its focus to improve health and outcomes across Bolton, Our Bolton NHS Charity will be a key partner in delivery of the Trust's vision.

Launch of Our Bolton NHS Charity's three-year strategy

2023/24 will see the launch of our three-year strategy. We will be focussing on 'high-return' activities that will raise the profile of Our Bolton NHS Charity while driving fundraising income so we can continue to improve the NHS experience for patients:

- Developing our staff (through the NHS Charities development grant) to ensure we have the knowledge and skills to deliver the strategy
- Developing a visual presence for the charity across all of the organisations buildings, livery and into Bolton
- Telling the story of Our Bolton NHS Charity through human interest pieces on all of our channels
- Engaging with staff through the corporate induction process and informal drop-ins so colleagues can learn more about Our Bolton NHS Charity and share their ideas
- Automating our processes to offer a frictionless giving experience for our donors and fundraisers
- Recruiting internal Charity Champions to act as advocates for our work
- Engaging and networking with the local businesses, education organisations and community groups
- Developing a donor stewardship programme with the aim of increasing the volume of regular donors

NHS 75 celebrations and leveraging support for Our Bolton NHS Charity

5 July 2023 marks the 75th anniversary of the NHS, and NHS 75 will provide a year-long opportunity to thank all NHS staff and volunteers, past and present, who have made the organisation what it is.

NHS England is encouraging members of the public to get involved with NHS 75 in a number of ways, including supporting their local NHS charity. We believe there is a lovely synergy between the local community working in partnership with Our Bolton NHS Charity, given many residents are born at the Royal Bolton Hospital; work for Bolton NHS Foundation Trust, or access the many services we provide across the conurbation. As such, NHS 75 presents a very special opportunity to raise the profile and leverage support for Our Bolton NHS Charity with local businesses, education organisations and local community groups.

Statement of the Corporate Trustee's responsibilities

Under the Trust deed of the charity and charity law, the Corporate Trustee is responsible for preparing a Trustees' Annual Report and the financial statements in accordance with applicable law and regulations. The Corporate Trustee is required to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees: select suitable accounting policies and then apply them consistently:

- make judgements and estimates that are reasonable and prudent
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so

The Corporate Trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. It is responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the Corporate Trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2022, those statements of accounts comply with the requirements of regulations under that provision.

It is responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities. These financial statements were approved by the Corporate Trustee on 25th January 2024 and were signed on its behalf by:

Martin North
Chair of the Charitable Funds Committee

Annette Walker
Director of Finance

Sharon White
Director of Strategy, Digital and Transformation

Statement of financial activities for the year ended 31st March 2023

	Note	Restricted Funds £000	Un-Restricted Funds £000	Endowment Funds £000	Total Funds 2023 £000	Total Funds 2022 £000
Incoming Resources:						
Incoming resources from generated funds:						
Voluntary income:	3					
Donations		60	81	0	141	94
Legacies		0	556	0	556	244
Gift In Kind		0	19	0	19	0
Grants		0	0	0	0	0
Sub total voluntary income		**60**	**656**	**0**	**716**	**338**
Activities for generating funds:						
Fundraising Events	9	0	0	0	0	15
Investment income	4	1	7	0	8	0
Total incoming resources		**61**	**663**	**0**	**724**	**353**
Resources Expended						
Costs of generating funds:						
Fundraising Cost	9	0	0	0	0	1
Sub total cost of generating funds		**0**	**0**	**0**	**0**	**1**
Charitable activities:	5					
Purchase of new equipment		32	92	0	124	171
New building, refurbishment & care		167	267	0	434	11
Staff education & welfare		9	3	0	12	88
Patient welfare & amenities		2	45	0	47	39
Other		0	32	0	32	1
Sub total direct charitable expenditure		**210**	**439**	**0**	**650**	**310**
Other resources expended						
Gift In Kind	5	0	19	0	19	0
Governance Costs	6	7	77	0	84	76
Total resources expended		**217**	**535**	**0**	**753**	**387**
Net incoming/(outgoing) resources before transfers		(156)	127	0	(29)	(34)
Net incoming/(outgoing) resources before other recognised gains and losses		**(156)**	**127**	**0**	**(29)**	**(34)**
Net movement in funds		**(156)**	**127**	**0**	**(29)**	**(34)**
Reconciliation of Funds						
Total Funds brought forward		610	785	42	1,437	1,471
Total Funds carried forward		**454**	**912**	**42**	**1,408**	**1,437**

Balance sheet for the year ended 31st March 2023

	Note	Restricted Funds £000	Un-Restricted Funds	Endowment Funds £000	Total Funds 2023 £000	Total Funds 2022 £000
Current assets:	10					
Debtors		0	6	0	6	8
Cash and Cash Equivalents		458	952	42	1,452	1,464
Total current assets		**458**	**958**	**42**	**1,458**	**1,472**
Liabilities	11					
Creditors falling due within one year		(3)	(47)	0	(50)	(35)
Net current assets or liabilities		**455**	**911**	**42**	**1,408**	**1,437**
Total assets less current liabilities		455	911	42	1,408	1,437
Net assets or liabilities		**455**	**911**	**42**	**1,408**	**1,437**
The funds of the charity:						
Endowment funds		0	0	42	42	42
Restricted Income Funds		455	0	0	455	610
Un-Restricted income funds		0	911	0	911	785
Total charity funds		**455**	**911**	**42**	**1,408**	**1,437**

The notes at pages 19 to 27 form part of these accounts.

Signed:

Name: Annette Walker

Date:

Statement of cash flow for the year ended 31st March 2023

	2023 £000	2022 £000
Net movement in funds for the reporting period (as per the statement of financial activities)	**(29)**	**(34)**
Adjustments for:		
(Increase)/decrease in debtors	2	(4)
Increase/(decrease) in creditors	15	2
Net Cash provided by (used in) operating activities	**(12)**	**(36)**
Cash Flows from investing activities:		
Dividends, interest and rents from investments	0	0
Net cash provided by (used in) investing activities	**0**	**0**
Change in Cash and cash equivalents in the reporting period	**(12)**	**(36)**
Cash and cash equivalents at the beginning of the reporting period	**1,464**	**1,500**
Cash and cash equivalents at the end of the reporting period	**1,452**	**1,464**

Notes on the accounts

1. Accounting Policies

a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011.

The trust constitutes a public benefit entity as defined by FRS 102.

Going Concern

The financial statements have been prepared on a going concern basis, which the Corporate Trustee considers to be appropriate for the following reasons. The business model of the charity is such that its charitable activities are limited to those which it has sufficient funds to support from the excess of funding received over the cost of administering the charity. The charity therefore has no specific commitments and no committed costs beyond its fixed costs of operation, which are detailed in note 6.

The Corporate Trustee has reviewed the cash flow forecasts for a period of 12 months from the date of approval of these financial statements, which indicate that the charity will have sufficient funds to meet its liabilities as they fall due for that period.

b) Income and Endowments

All income is recognised once the charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

Donations, are recognised when the Charity has been notified in writing of both the amount and settlement date. In the event that a donation is subject to conditions that require a level of performance before the charity is entitled to the funds, the income is deferred and not recognised until either those conditions are fully met, or the fulfilment of those conditions is wholly within the control of the charity and it is probable that those conditions will be fulfilled in the reporting period.

Gifts in kind are valued at estimated fair market value at the time of receipt.

Legacy gifts are recognised on a case-by-case basis following the granting of probate when the administrator/executor for the estate has communicated in writing both the amount and settlement date. In the event that the gift is in the form of an asset other than cash or a financial asset traded on a recognised stock exchange, recognition is subject to the value of the gift being reliably measurable with a degree of

reasonable accuracy and the title to the asset having been transferred to the charity.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield ofthe investment portfolio.

c) Expenditure Recognition

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

All expenditure is accounted for on an accruals basis. All expenses including support costs and governance costs are allocated or apportioned to the applicable expenditure headings. For more information on this attribution refer to note (e) below.

Grants payable are payments made to third parties in the furtherance of the charitable objects of the Charity. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grants awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Charity.

Provisions for grants are made when the intention to make a grant has been communicated to the recipient but there is uncertainty as to the timing of the grant or the amount of grant payable.

The provision for a multi-year grant is recognised at its present value where settlement is due over more than one year from the date of the award, there are no unfulfilled performance conditions under the control of the Charity that would permit the Charity to avoid making the future payment(s), settlement is probable and the effect of discounting is material. The discount rate used is the average rate of investment yield in the year in which the grant award is made. This discount rate is regarded by the trustees as providing the most current available estimate of the opportunity cost of money reflecting the time value of money to the Charity.

Grants are only made to related or third party NHS bodies and non-NHS bodies in furtherance of the charitable objects of the funds. A liability for such grants is recognisedwhen approval has been given by the Trustee. The NHS Foundation Trust has full knowledge of the plans of the Trustee, therefore a grant approval is taken to constitute a firm intention of payment, which has been communicated to the NHS Foundation Trust, and so a liability is recognised.

d) Allocation of overhead, support and governance costs

Overhead and support costs have been allocated as a direct cost or apportioned on an appropriate basis (see note 6) between Charitable Activities and Governance Costs. Once allocation and/or apportionment of overhead and support costs has been made the remainder is apportioned to funds on a transactional basis.

Governance costs comprise of all costs incurred in the governance of the Charity. These costs include costs related to statutory audit together with an apportionment of overhead and support costs.

e) Expenditure on raising funds

The costs of raising funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the Charity's objects. The expenditure on raising funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for events and the costs for the fundraiser's salary, this is recharged to the Charity by the Foundation Trust.

f) Expenditure on charitable activities

Costs of charitable activities include grants made, governance costs and an apportionment of overhead and support costs as shown in note 6.

g) Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it is incurred.

h) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified as an endowment fund, where the donor has expressly provided that only the income of the fund may be applied, or as a restricted income fund where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The major funds held within these categories are disclosed in note 14.

i) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later). Realised and unrealised gains and losses are combined in the Statement of Financial Activities.

j) Going concern

In preparing these accounts the Corporate Trustee has considered the future activities of the Charity and consider it to be a going concern.

k) Transfer of Funds from NHS Bodies

There have been no transfers in 22/23 from NHS bodies.

2. Related party transactions

The Bolton NHS Foundation Trust receives grants from Our Bolton NHS Charity; the Foundation Trust is the Corporate Trustee of the Charity (note 7). During the year, the following were members of the Foundation Trust Board of Directors:

Fiona Noden, Chief Executive
Annette Walker, Chief Finance Officer
Rae Wheatcroft, Chief Operating Officer
Francis Andrews, Medical Director
Sharon White, Director of Strategy
James Mawrey, Director of Workforce and OD
Donna Hall, Chair of Bolton NHS Foundation Trust
Tyrone Roberts, Chief Nurse
Malcolm Brown, Non-Executive Director
Bilkis Ismail, Non-Executive Director
Jackie Njoroge, Non-Executive Director
Martin North, Non-Executive Director
Alan Stuttard, Non-Executive Director
Zada Ali Shah Non-Executive Director
Rebecca Ganz, Non-Executive Director
Sharon Katema, Director of Corporate Governance

None of the above has received honoraria, emoluments or expenses from the Charity for the year ended 31st March 2023.

During the year, no member of the key management staff or parties related to them has undertaken any material transactions with Our Bolton NHS Charity.

3. Analysis of voluntary income

	Restricted Funds £000	Un-Restricted Funds £000	Total Funds 2023 £000	Total Funds 2022 £000
Donations				
Breast Fund	8	10	18	10
Neonatal & Paediatric Services Fund	8	20	28	15
General Purposes Fund	42	24	66	39
Cancer Services	0	3	3	4
Critical Care Fund	0	4	4	4
Special Care for Special Babies	1	0	1	0
Other Funds (55)	1	20	21	22
Sub total	**60**	**81**	**141**	**94**
Gift In Kind				
General Purpose Fund	0	19	19	0
Sub total	**0**	**19**	**19**	**0**
Legacies				
General Purpose Fund	0	258	258	242
Cardiology	0	283	283	1
Ophthalmology	0	14	14	1
Stroke	0	1	1	0
Sub total	**0**	**556**	**556**	**244**
Total	**60**	**656**	**716**	**338**

4. Analysis of investment income

Gross income earned from:	2023 Held in UK £000	2022 Held in UK £000
Interest from Bank Account	8	0
Total	**8**	**0**

5. Analysis of charitable expenditure

The charity undertook direct charitable activities and made available grant support to Bolton NHS Foundation Trust in support of physical and cash donated assets.

	Activities undertaken directly £'000	Grant Funded activity £'000	Support Costs £'000	Gift In Kind £'000	2023 Total £'000	2022 Total £'000
Purchase of new equipment	100	24	16	0	140	212
New building, refurbishment & care	0	434	54	0	488	15
Staff education & welfare	12	0	1	0	13	110
Patient welfare & amenities	48	0	8	19	75	48
Other	32	0	4	0	36	2
Total	**192**	**458**	**84**	**19**	**753**	**387**

6. Allocation of support costs and overheads

Allocation and apportionment to Governance Costs	Allocated to Governance £'000	Residual for Apportionment £'000	2023 Total £'000	2022 Total	Basis of Apportionment
Salaries & related costs	77	106	183	158	Fixed and transactional
Statutory External Audit (inc VAT)	7	0	7	7	Governance
Total	**84**	**106**	**190**	**165**	

7. Analysis of grants

The Charity does not make grants to individuals. All grants are made to Bolton NHS Foundation Trust in the form of donated assets.

During the year, a cash grant of £425k was made to Bolton NHS Foundation Trust for the new Multi-Faith Centre on RBH site.

	Restricted £'000	Unrestricted £'000	Total 2023 £'000
Grant made available to Bolton NHS Foundation Trust in the form of cash	167	258	425
Total	**167**	**258**	**425**

8. Transfers between funds

There have been no transfer between funds during the year.

9. Analysis of fundraising events

There have been no fundraising events during the year.

10. Analysis of current assets

Debtors under 1 year	2023 Total £000	2022 Total £000
Accrued Income and Aged Debt	6	8
Total	**6**	**8**

Analysis of cash and deposits	2023 Total £000	2022 Total £000
R.B.S. Special Interest Bearing Account	1,442	1,454
R.B.S. Current Account	10	10
Total	**1,452**	**1,464**
Total Current Assets	**1,458**	**1,472**

11. Analysis of current liabilities and long term creditors

Creditors under 1 year	2023 Total £000	2022 Total £000
Other creditors	19	15
Accruals	31	20
Total	**50**	**35**

12. Contingencies

The Trust has no contingent liabilities or assets.

13. Commitments

The Corporate Trustee recognises that it has commitments for goods or services that have yet to be received for £283,152.66.

14. Analysis of charitable funds

Material Funds	Balance b/fwd £000	Income £000	Resources Expended £000	Gains & Losses £000	Fund c/fwd £000
RBH General Purposes	696	343	(550)	0	489
Cancer Services	78	4	(6)	0	76
Cardiology	101	289	(81)	0	309
Elderly Medicine	13	0	(2)	0	11
Special Care for Special Babies	66	1	(23)	0	44
Community Funds	97	1	(12)	0	86
Breast Unit	52	19	(8)	0	63
Eye Unit	31	15	(7)	0	39
Other Funds	261	52	(64)	0	249
Total	**1,395**	**724**	**(753)**	**0**	**1,366**

The General Purposes Fund receives donations from donors who have not expressed a preference as to how the funds should be spent, these funds are used by the Corporate Trustee for any charitable purpose(s) related to Bolton Hospital.

During the year, the General Purposes fund has received donations in the form of a legacy and general donations. The General purpose fund has funded the Multi Faith Centre in the form of a grant to Bolton NHS Foundation Trust.

The Cancer Services Department receives many donations from grateful patients, funds are mainly used to purchase equipment for the department.

The Cardiology Department receives many donations from grateful patients and also from legacies, funds are mainly used to purchase equipment for the department. This year the department has purchased a stress test system with treadmill.

The Elderly Medicine Department receives many donations from grateful patients and also from legacies, funds are mainly used to purchase equipment for the department.

The Special Care for Special Babies campaign was launched in 2017 and the funds will be used to create a spacious and calm environment for families to be with their babies. This year the department has purchased furniture for the parental accommodation.

The Community Services Department receives many donations from grateful patients and also from legacies, funds are mainly used to purchase medical equipment for community services.

The Breast Unit receives many donations from grateful patients and also from legacies, funds are mainly used to purchase equipment for the department. Funds are used mainly used to purchase medical equipment and post op kits.

15. Post balance sheet events

There have been no post balance sheet events that require disclosure.

Registered as a charity number: 1050488

Debra Chamberlain
Director
KPMG LLP
15 Canada Square
London
E14 5GL

25th January 2024

Dear Debra,

This representation letter is provided in connection with your audit of the financial statements of Our Bolton NHS Charity ("the Charity") for the year ended 31 March 2023, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at year and of its surplus or deficit for the financial year then ended;

ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and

iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities, the Statement of Cash Flow and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Corporate Trustee confirms that the Charity meets the definition of a qualifying entity and meets the criteria for applying the disclosure exemptions with FRS 102.

The Corporate Trustee confirms that the Charity is exempt from the requirement to prepare consolidated financial statements.

The Corporate Trustee confirms that the representations made in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Corporate Trustee confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

Financial statements

1. The Trustee has fulfilled its responsibilities, as set out in the terms of the audit engagement dated 15th March 2022, for the preparation of financial statements that:

    i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;

    ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and

    iii. have been prepared in accordance with the Charities Act 2011. The financial statements have been prepared on a going concern basis.

2. The methods, the data and the significant assumptions used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this representation letter.

Information provided

5. The Corporate Trustee has provided you with:

    - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Trustee for the purpose of the audit; and
    - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Corporate Trustee confirms the following:

    i. The Corporate Trustee has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

ii. The Corporate Trustee has disclosed to you all information in relation to:

a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:

- management;
- employees who have significant roles in internal control; or
- others where the fraud could have a material effect on the financial statements; and

b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators, or others.

In respect of the above, the Corporate Trustee acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Corporate Trustee acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error, and we believe we have appropriately fulfilled those responsibilities.

8. The Corporate Trustee has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Trustee has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Trustee has disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

    Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in FRS 102.

11. The Corporate Trustee confirms that:

    a) The financial statements disclose all of the matters that are relevant to the Charity's ability to continue as a going concern, including the key risk factors, assumptions made and uncertainties surrounding the Charity's ability to continue as a going concern as required to provide a true and fair view and to comply with FRS 102.

    b) No material uncertainties related to events or conditions exist that may cast significant doubt upon the ability of the Charity to continue as a going concern.

This letter was shared with the Corporate Trustee on Thursday 25th January 2024.

Yours faithfully,

Martin North
Chair of Charitable Funds Committee

Appendix to the Board Representation Letter of Our Bolton NHS Charity: Uncorrected audit differences

The following uncorrected audit differences have been presented as part of the Audit Report to those charged with governance and are considered by management to be immaterial to the Charity's financial statements:

Uncorrected audit differences (£m)				
No	**Detail**	**SOCI Dr/(Cr)**	**SOFP Dr/(Cr)**	**Comments**
1	Dr Cash Cr Other Payables	£1,294.15 -	- £(1,294.15)	We noted that the charity had not cancelled the cheques older than 6 months and had been carrying forward the same reconciling item every month.
2	Dr Debtors Cr Expenditure	£8,750 -	- £(8,750)	An invoice was overpaid during year 22-23. (Refund received in 23-24). As a result expense was overstated and debtors/cash was understated at the year end.

Appendix to the Trustee's Representation Letter of Our Bolton NHS Charity: Definitions

Criteria for applying the disclosure exemptions within FRS 102

- The Charity discloses in the notes to its financial statements:
  a) A brief narrative summary of the disclosure exemptions adopted; and
  b) The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained

Financial Statements

A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- a Balance Sheet as at the end of the period;
- a statement of financial activities for the period;
- a statement of cash flows for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters

Certain representations in this letter are described as being limited to matters that are material. FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and

b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Qualifying Entity

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and surplus or deficit) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
   i. has control or joint control over the reporting entity;
   ii. has significant influence over the reporting entity; or
   iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.

b) An entity is related to a reporting entity if any of the following conditions apply:
   i. has control or joint control over the reporting entity;
   ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
   iii. Both entities are joint ventures of the same third party.
   iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
   v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
   vi. The entity is controlled, or jointly controlled by a person identified in (a).
   vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
   viii. The entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Audit Committee Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	6 December 2023	Date of next meeting:	14 February 2024
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Annette Walker, Martin North, Sharon Katema, Fiona Taylor, Catherine Hulme, Debra Chamberlain, Patrick Clark, Lesley Wallace	Quorate (Yes/No):	Yes
		Apologies received from:	Darrell Davies

Agenda Items:	RAG	Key Points	Action/ decision
Internal Audit Reports		MIAA presented an update on progress of the Audit Plan for 2023/24. Reports on Freedom to Speak Up (FTSU) and Patient Safety and Incident Response Framework (PSIRF) had been completed and both were rated as substantial assurance. MIAA also reported on their work on follow up actions following the handover from PwC. Good progress had been made on these and the intention was to conclude the outstanding items by the next meeting. A discussion was held on the FTSU which confirmed the assurance on the processes and procedures. However, the Committee were concerned to ensure that the full context of the issues raised by the CQC were addressed by the Trust in the CQC action plan. A number of reviews are also underway or in the process of being finalised.	Noted
PFR Benchmarking Report Quarter 2		KPMG advised that this report will be circulated separately.	Noted
Local Counter Fraud Specialist Progress Report		The Local Counter Fraud Specialist presented the update on Counter Fraud matters. Particular reference was made to a meeting that was held with IFM on counter fraud matters and a number of actions have been agreed. The LCFS made reference to a meeting held with the National Counter Fraud Authority who are developing a number of themes in terms of counter fraud matters which will be brought to the next Audit Committee. The LCFS also provided an update on a number of cases that were being investigated. It was noted that the main theme was around HR/payroll matters and she advised that in addition to the LCFS element these cases might also involve HR disciplinary action or referral to the professional bodies.	Noted
Standing Financial Instructions and Scheme of Delegation		The Chief Finance Office presented the updated SFIs and scheme of delegation for consideration by the Committee prior to approval by the Trust Board. It was noted that there were two temporary amendments to the SFI's arising from the financial review by GM ICB/PwC.	Recommended to Board for approval

	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

Audit Committee Chair's Report

Agenda Items:	RAG	Key Points	Action/ decision
IFM Bolton Statutory Accounts Year ended 31st March 2023		The Associate Director of Finance presented the IFM Bolton Statutory Accounts for 2022/23. These were nearing completion however a significant issue had been raised in respect of deferred taxation. The Auditors KPMG explained that although the accounts had included this issue for the previous two years an issue had been raised by the their tax advisers. This was currently under consideration but could have a significant impact on the Trust Group Accounts. The Chief Finance Officer advised that the GM ICB/PwC had been advised of the issue. A decision was expected from KPMG the following day.	To be escalated as required to the Trust Board
Standing Orders and Matters Referred to the Board		The Director of Corporate Governance presented the updated Standing Orders and Matters referred to the Board. The Standing Orders are scheduled to be presented at the Trust. Board in January following discussion at this Audit Committee. There were no changes proposed by the Audit Committee.	Recommended to Trust Board for approval
Board Assurance Framework		The Director of Corporate Governance presented the Board Assurance Framework covering the five ambitions setting out the Trust principle objectives. These have been reviewed by the Executive Directors and each of the Committees to ensure that the process of identify the main source of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at Trust Board level. The Audit Committee commended the work that had been undertaken with a general comment on the amount of detail being too much and in some cases quite operational. It was also recognised that the BAF would be refined with the new Trust Corporate Strategy.	Noted
Audit Committee Effectiveness		The Director of Corporate Governance reported on the Audit Committee Effectiveness Survey. Overall the survey was positive however, there were some areas where 'strongly disagree' had been noted. The Effectiveness Surveys had been undertaken across all Committees and the full results will be collated by the DCOG with an action plan.	Noted
Review of Audit Committee Terms of Reference and Annual Work Plan		The Director of Corporate Governance presented the updated Terms of Reference for the Audit Committee. There were two main changes to the ToR which now included Information Governance and Risk Management. It was also proposed that the Committee be retitled Audit and Risk Committee. The Committee approved the ToR with a couple of minor amendments. The main issue was to review the attendees to ensure that the new areas were represented.	Recommended to Board for approval.
Comments:			
Risks Escalated: The main risk to be escalated to the Board is in respect of the deferred taxation and the impact on the Trust Group Accounts**.**			

	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:	Audit Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Annette Walker		Decision	

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

Summary:	The attached report from the Chair of the Audit Committee provides an overview of significant issues of interest to the Board, key decisions taken, and key actions agreed at the meeting held on 06 December 2023.

Previously considered by:
Discussed and agreed at the Audit Committee

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

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

Prepared by:	Annette Walker Chief Finance Officer	**Presented by:**	Alan Stuttard, Chair Audit Committee

Report Title:	2024 Board Arrangements and Workplan

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	25 January 2024		Discussion	
Exec Sponsor	Director of Corporate Governance		Decision	✓

Purpose	This report seeks to set out the arrangements for Board of Directors meetings during 2024 and the Cycle of Business for approval.

Summary:	It is essential that the Board of Directors has an annual workplan to determine the flow and reporting of information in a timely way and in accordance with the Board's cycle of meetings. This Workplan details items to be presented throughout the calendar year to ensure that the Trust meets all its regulatory, statutory duties. It is intended that this Workplan will be used to inform the work plans of the committees. The Board workplan has been produced for consideration and approval by the Board. It provides a structured and streamlined approach when setting the Board agendas which ensures that the governance and strategic aspect of Board business is covered. The Board agenda will be drawn from the Workplan and will be reflective of changes in the national and local issues from a strategic, quality, performance and assurance perspective. The draft agenda is routinely reviewed by the executive team and as part of agenda setting meetings with the Chair and Chief Executive prior to issue.

Previously considered by:	Executive Directors

Proposed Resolution	The Board is asked to **receive** the Board Arrangements for 2024 and approve the Annual Workplan.

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

1. Introduction

1.1. The Board of Directors sets the strategic direction for the Trust, takes corporate responsibility for all Trust activity, and monitors performance across the organisation. These duties are discharged in the Board of Director's meetings.

1.2. The Board of Director's Meetings are held on the last Thursday of each alternate month. It is proposed that this this schedule of bi-monthly meeting will continue during 2024/25.

1.3. In line with its regulatory duties, meetings of the Board of Directors are held in public with members of the public encouraged to attend and or submit questions to the Board before each meeting. The majority of the Trust's business is conducted in these meetings.

1.4. In addition to these meetings, closed sessions known as Part 2, are held at the conclusion of the formal board meetings. Items discussed in closed sessions are restricted to matters, which are commercial in confidence or matters that would otherwise be inappropriate to discuss with members of the public present. The presumption is that business will be discussed in public unless there is a good reason why it should not be.

1.5. In those months where a Board meeting is not scheduled, discrete sessions focussing on Strategy or Board development are usually held. For 2024, it is proposed that these sessions will be held as follows:

- 29 February Board Strategy Session
- 25 April Board Development Session
- 26 June Annual Service Review Day
- 8 August Board Development Session
- 17 October Board Strategy Session
- 19 December Board Strategy Session

2. Annual Workplan

2.1. The Board maintains an Annual Workplan which details items to be presented throughout the calendar year to enable the Trust to delivers its objectives. It is essential that the Board of Directors has an annual workplan to determine the flow and reporting of information in a timely way and in accordance with the Board's cycle of meetings.

2.2. The workplan enables a structured and streamlined approach when setting the Board agendas and ensures that all the statutory and regulatory business is submitted to the meetings in a timely manner. The workplan also ensures the governance and strategic aspect of Board business is covered.

2.3. The following will be standing agenda items at all formal meetings of the Board of Directors:

- Declarations of Interest
- Patient Story and or a staff story
- Minutes of the previous meeting
- Actions and matters arising
- Integrated Performance Report
- Chair reports from the Board Committees

2.4. To avoid duplication, the committees will conduct an in-depth review of the relevant elements of the performance reports and escalate as required. It is intended that this Workplan, included in **Appendix A**, will be used to inform the work plans of the committees.

3. **Board Development Programme and Strategy Sessions for 2024/25**

3.1. All Board members are provided with opportunities to attend externally facilitated seminars and networking sessions such as those held through NHS Providers or Greater Manchester Non-Executive Director forum.

3.2. During 2023, an external facilitated Board Development Session held in December. It is proposed that a similar session is also held this year.

4. **Board Effectiveness**

4.1. Effective boards depend on having the right information at the right time. Information needs to be focused on the right issues, pitched at the right level of detail and presented clearly.

4.2. Board agenda setting meeting reviews are held with the Chair and Chief Executive before each meeting.

4.3. The annual board effectiveness review will be conducted during October and November with a report presented at the November meeting. The Workplan could be amended as a result of the responses received or in light of any new statutory or regulatory requirements.

4.4. To support good governance across the Trust, a suite of templates necessary for the effective management of meetings, was introduced in 2023 and is now widely used across the organisation. This has ensured that there is standardisation of templates and consistency on how meetings are managed.

4.5. A new approach to the Chair's report is now in place which focusses on the Advise, Alert and Assure methodology. This format of template, widely used across the NHS, ensures that key discussion points and matters escalated from the committee discussions are presented in a format that is easy to digest thus improving on meeting efficiency. The template will be divided into the following sections.

- **Alert** the reporting Group on any areas of non-compliance or matters that need addressing urgently.
- **Advise** on any areas of on-going monitoring where an update has been provided to the sub- committee AND any new developments that will need to be communicated or included in operational delivery
- **Assure** the reporting group on any matters of assurance that the meeting received.

5. Conclusion

The Board is asked to receive the Board Arrangements for 2024 and approve the Annual Workplan

Board of Director's Annual Workplan 2024

	Agenda Item/Report	Purpose		Mar	May	July	Sep	Nov	Jan
STANDING AGENDA ITEMS									
Chief Nurse	Patient Story	To Receive							
Director of People	Staff Story	To Receive							
All	Board Visits / Walkabouts	To Receive							
Chair	Chair's Report / Update	To Note							
CEO	Chief Executive's Report	To Note							
All Executives	Integrated Performance Report	To Receive	All Committees						
Committee Chairs	Committee Chairs' Reports	To Receive	All Committees						
QUALITY AND SAFETY		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Chief Nurse	Quality Account Objectives	To Receive	QAC						
	Nurse, AHP and Midwifery Staffing Reports	To Approve	People Cttee						
	Health and Safety Annual Report	To Receive	QAC						
	2022/23 Quality Account	To Approve	QAC						
	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (Quarterly)	To Receive	QAC						
	In Patient Survey	To Receive	QAC						
	Complaints Annual Report	To Receive	QAC						
	Infection Prevention and Control Annual Report	To Receive	QAC						
	Safeguarding Annual Report	To Receive	QAC						
Medical Director	Quality Account Objectives	To Receive	QAC						
	Guardian of Safe Working Hours Annual Report	To Receive	People Committee						
	Learning from Deaths / Mortality Report	To Receive	QAC						
	Revalidation Report	To Approve	People Committee						
STRATEGY AND OPERATIONAL PERFORMANCE		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Chief Operating Officer	Operational Plan	To Receive	Strategy & Ops						
	Winter Plan	To Receive	Strategy & Ops			Draft			
	EPRR Core Standards Report	To Receive	Strategy & Ops						
Director of Strategy Digital and Transformation	Operational Plan	To Receive	Strategy & Ops						
	SIRO / IG Report	To Receive	Strategy & Ops						
	Strategy Review and Update	To Receive	Strategy & Ops						
	Digital Strategy	To Receive	Strategy & Ops						
	Charity Annual Report	To Receive	Strategy & Ops						
FINANCE AND WORKFORCE		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Chief Finance Officer	Financial Plan	To Receive	F&I Committee						
	Annual Accounts	To Receive	F&I Committee						
	Review of Financial Position	To Receive	F&I Committee						
	Green Plan	To Receive	F&I Committee						
	Approval of High Value Contracts	To Receive	F&I Committee						
	Estates Plan	To Receive	F&I Committee						
	SFIs and SOD	To Approve	F&I Committee						
	iFM Report	To Receive	F&I Committee						
Director of People	Staff Survey Report 22/23 Results	To Receive	People Committee						
	Staff engagement – Our Voice Change Programme	To Receive	People Committee						
	Freedom to Speak Up Annual Report	To Receive	People Committee						
	Staff health and wellbeing	To Receive	People Committee						
	Gender pay gap report	To Receive	People Committee						
	Workforce Race Equality Standard and Workforce Disability Equality Standard Reports	To Approve	People Committee						
	EDI Plan and Annual Report	To Receive	People Committee						
	Leadership Development Programme	To receive	People Committee						
GOVERNANCE AND RISK		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Director of Corporate Governance	Register of Interests	To Receive	Audit Committee						
	Fit and Proper person declarations	To Approve	Audit Committee						
	Board Assurance Framework	To Approve	**All Committees**						
	Annual Report	To Approve	Audit Committee						
	Annual Governance declarations	To Approve	Audit Committee						
	Board evaluation/Well Led review	To Receive	Audit Committee						
	Standing Orders	To Approve	Audit Committee						
	Anti-Slavery statement	To Approve	Audit Committee						
	Board workplan	To Approve	Audit Committee						

Title:	Committee Effectiveness Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	✓
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	

Purpose:	This report seeks to provide assurance on the efficacy of the committees and demonstrate alignment with best practice and Trust Ambitions.

Summary:	Efficient Board and committee meetings are necessary components of a robust governance framework. It is therefore important to ensure that the Trust's organisational governance aligns with best practice, statutory and regulatory guidance. An annual committee effectiveness review was undertaken in November 2023 to ensure the committees are demonstrating good governance and identifying areas of improvement an effectiveness review. This report reflects the key points arising from those reviews and seeks to inform the planned discussions by the Board of Directors of the committee performance and provide assurance on the efficacy of the committees. The committees also reviewed their Terms of Reference as part of the reviews. These are include elsewhere on the agenda.

Previously considered by:
N/A

Proposed Resolution	The Board of Directors are asked to **receive** this report as assurance that its committees are working effectively and in line with agreed Terms of Reference.

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

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon Katema, Director of Corporate Governance

1. Introduction

1.1. As part of the Board of Directors' corporate governance and performance management arrangements, committees that the Board has established undertook an annual review of their performance and Terms of Reference.

1.2. The reviews aimed at enabling committees to review their governance arrangements, check they have appropriate systems in place and identify areas where they could improve.

1.3. This paper reflects the key points arising from the committee annual reviews undertaken during 2023 to inform planned discussion by the Board of Directors of its performance and that of the Committees that it has established.

2. Board Committees

2.1. The Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, the Trust Board has formally established the following Committees and delegated authority to these through agreed Terms of Reference:

- Audit and Risk Committee
- Remuneration Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People Committee
- Charitable Funds Committee

2.2. This report includes reviews from all assurance committees namely: People Committee, Quality Assurance and the Strategy and Operations Committee.

2.3. There was minimal uptake on the Charitable Funds Committee as this was the first review for the Committee. These responses will be used to benchmark future reviews.

2.4. The Audit Committee review was undertaken in November 2023 and presented to the Audit Committee. This review was based on the recommended checklist from the HFMA Audit Committee handbook (2014).

2.5. A survey was issued to all Audit Committee members and regular attendees. The results from the survey were positive and indicated an uptick in scores compared to the previous year. There were notable areas of improvement which will be categorised into themes and distributed as short periodic surveys to ensure that the committee builds on its effectiveness and address the areas that have shown progress based on the feedback received.

2.6. The Audit Effectiveness report will be used to inform the Audit Committee Annual Report to the Board and is included in *Appendix 3*.

3. Changes to the Governance Structure and membership of Committees

3.1. In October 2023, the Board approved the establishment a time limited committee whose role was to implement the framework for robust governance with oversight of accountability arrangements for delivery of the Financial Improvement Programme. An updated governance framework is included in *Appendix 1*.

3.2. There were also some changes to the composition of committees and the structure of their meetings. It is worth noting that whilst there were gaps in membership, these changes did not adversely impact delivery of work programmes or the ability to meet quorum requirements, which remained good throughout the period.

4. Committee Effectiveness Reports

4.1. Committee Effectiveness reviews are an exercise of self-assessment with the aim of reflecting on areas requiring specific focus and development. These annual reviews of performance and effectiveness were completed in November 2023, using questionnaires drawn from discussions with the respective Chairs and Executive Director Leads.

4.2. The Director of Corporate Governance coordinated and presented the findings from the surveys. A summary of the responses is included in *Appendix 2*

4.3. The reviews focussed on

- Membership
- Role of scope of the Committee
- Extent to which the Committee is achieving objectives
- Meeting the ToR and work undertaken by the Committee

4.4. Despite a low response rates across all committees, the results were generally positive. This positive trend was underscored by the lack of any "Strongly Disagree" responses to the questions posed.

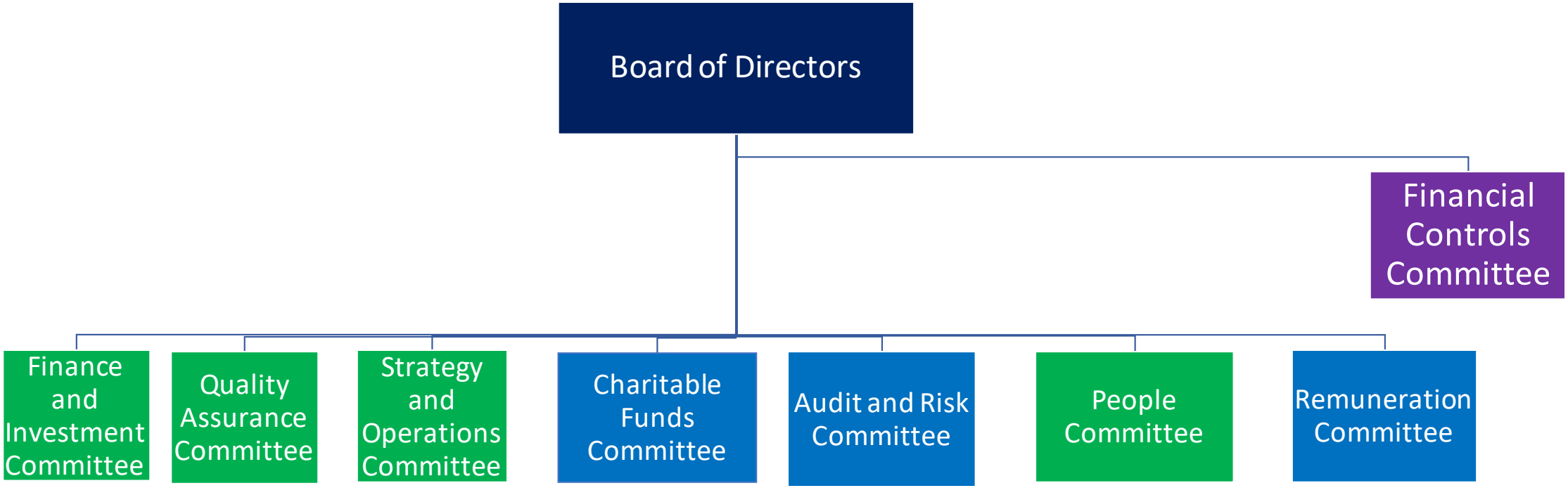
4.5. It is intended that future reports will maintain the same style of inquiry to promote consistency and facilitate the identification of both advances and areas needing enhancement.

5. Conclusion

5.1. The Board of Directors are asked to receive this report as assurance that its committees are working effectively and provides information to support with the Board's annual review of performance and effectiveness.

Trust Organisation Structure

NHS Bolton NHS Foundation Trust



Key

- Statutory Committee
- Assurance Committee
- Time limited committee

Appendix 2 – Summary of responses

	Charitable Funds	People Committee	Quality Assurance Committee	Strategy & Operations Committee	Finance & Investment Committee
The role and scope of the committee					
The committee understands the Trust operating environment and the associated risks	*87%	90%	93%	93%	95%
The committee critically challenges and reviews both the strategic and operational issues with an appropriate balance between the two	N/A	77%	90%	87%	85%
At meetings there is a good balance on quality, operational challenges, finance, governance and risk management	N/A	83%	90%	87%	90%
The Committee meets is purpose as set out in the Terms of Reference	100%	N/A	N/A	N/A	95%
Achieving Objectives					
The Chair ensures all committee members have an opportunity to participate in the debate	N/A	96%	95%	97%	95%
The secretariat circulates meeting documents in good time before each meeting	90%	93%	90%	77%	100%
The committee is a useful forum for Trust leaders	*100%	83%	95%	N/A	100%
The correct level of detail is provided /presented at the committee to fulfil its remit	*95%	80%	N/A	90%	85%
The committee has sufficient membership, authority and resources to perform its role effectively and independently	100%	N/A	N/A	N/A	80%
The Committee meets sufficiently frequently to deal with planned matters and enough time is allowed for questions and discussions	100%	*N/A*	*N/A*	*N/A*	100%
Are there any gaps in the information being provided to the Committee	N/A	80%	N/A	N/A	70%
Overall, the committee works well	95%	77%	90%	87%	100%

N/A indicates question not asked

****Indicates question rephrased to align with Charitable Funds***

This summary report shows total scores, total percentage scores and a breakdown of responses by category and by individual statement.

Key and Scoring

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

Audit Committee Effectiveness Review October 2023

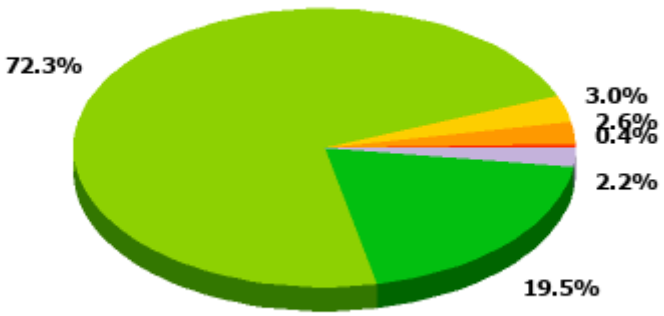
Number of respondents: 7
Number of statements: 33

Table 1

							Score	%age
Audit Committee Effectiveness Review October 2023	1 [0.4%]	6 [2.6%]	7 [3%]	167 [72.3%]	45 [19.5%]	5 [2.2%]	927/1130	82%

Display 1

Audit Committee Effectiveness Review October 2023



Breakdown of report by category

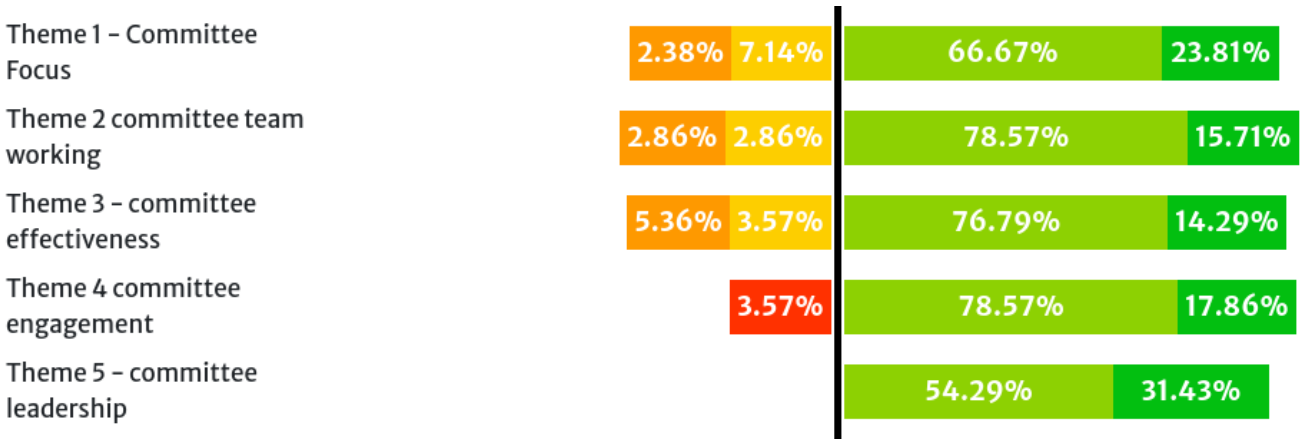
Table 2

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

Audit Committee Effectiveness Review October 2023							Score	%age
Theme 1 – Committee Focus	0	1	3	28	10	0	173/210	82%
Theme 2 committee team working	0	2	2	55	11	0	285/350	81%
Theme 3 – committee effectiveness	0	3	2	43	8	0	224/280	80%
Theme 4 committee engagement	1	0	0	22	5	0	114/140	81%
Theme 5 – committee leadership	0	0	0	19	11	5	131/150	87%

Display 2

The following diverging stacked barchart has a common baseline allowing for easy comparison of the data by the length of each bar.



Breakdown of report by individual statements

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

	Audit Committee Effectiveness Review October 2023								Score	%age
Theme 1 - Committee Focus										
1	The committee has set itself a series of objectives for the year.	0	0	0	6	1	0		29/35	83%
2	The committee has made a conscious decision about the information it would like to receive.	0	0	0	5	2	0		30/35	86%
3	Committee members contribute regularly to the issues discussed.	0	0	0	5	2	0		30/35	86%
4	The committee is aware of the key sources of assurance and who provides them.	0	0	0	5	2	0		30/35	86%
5	The committee receives assurances from third parties who deliver key functions to the organisation - for example, NHS Shared Business Services or private contractors.	0	0	3	2	2	0		27/35	77%
6	Equal prominence is given to both quality and financial assurance.	0	1	0	5	1	0		27/35	77%
Theme 2 committee team working										
7	The committee has the right balance of experience, knowledge and skills to fulfill its role.	0	0	0	5	2	0		30/35	86%
8	The committee has considered the internal audit plan based on risk assessment for its agendas.	0	0	0	5	2	0		30/35	86%
9	The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.	0	1	0	5	1	0		27/35	77%
10	Management fully briefs the committee on key risks and any gaps in control.	0	0	0	7	0	0		28/35	80%
11	Other committees provide timely and clear information in support of the audit committee.	0	1	1	5	0	0		25/35	71%
12	The committee environment enables people to express their views, doubts and opinions.	0	0	0	5	2	0		30/35	86%
13	Committee members understand the messages being given by external audit, internal audit and counter fraud specialists.	0	0	0	6	1	0		29/35	83%

Audit Committee Effectiveness Review October 2023									Score	%age
14	Internal audit contributes to the debate across the range of the agenda.	0	0	0	6	1	0		29/35	83%
15	Members hold their assurance providers to account for late or missing assurances.	0	0	1	5	1	0		28/35	80%
16	Decisions and actions are implemented in line with the timescale set down.	0	0	0	6	1	0		29/35	83%
Theme 3 - committee effectiveness										
17	The quality of committee papers received allows committee members to perform their roles effectively.	0	0	0	5	2	0		30/35	86%
18	Members provide real and genuine challenge - they do not just seek clarification and/or reassurance.	0	0	0	6	1	0		29/35	83%
19	Debate is allowed to flow, and conclusions reached without being cut short or stifled.	0	0	0	5	2	0		30/35	86%
20	Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored.	0	0	0	7	0	0		28/35	80%
21	At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	0	2	1	4	0	0		23/35	66%
22	The committee provides a written summary report of its meetings to the governing body.	0	0	0	5	2	0		30/35	86%
23	The governing body challenges and understands the reporting from this committee.	0	0	1	6	0	0		27/35	77%
24	There is a formal appraisal of the committee's effectiveness each year.	0	1	0	5	1	0		27/35	77%
Theme 4 committee engagement										
25	The committee challenges management and other assurance providers to gain a clear understanding of their findings.	0	0	0	5	2	0		30/35	86%
26	The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.	0	0	0	6	1	0		29/35	83%

Audit Committee Effectiveness Review October 2023								Score	%age
27	The committee receives clear and timely reports from other governing body committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	1	0	0	6	0	0	25/35	71%
28	We can provide two examples of where we as a committee have focussed on improvements to the system of internal control as a result of assurance gaps identified.	0	0	0	5	2	0	30/35	86%
Theme 5 - committee leadership									
29	The committee chair has a positive impact on the performance of the committee.	0	0	0	4	2	1	26/30	87%
30	Committee meetings are chaired effectively.	0	0	0	3	3	1	27/30	90%
31	The committee chair is visible within the organisation and is considered approachable.	0	0	0	4	2	1	26/30	87%
32	The committee chair allows debate to flow freely and does not assert his/her own views too strongly.	0	0	0	4	2	1	26/30	87%
33	The committee chair provides clear and concise information to the governing body on committee activities and gaps in control.	0	0	0	4	2	1	26/30	87%

Report Title:	Safeguarding Adult, Children and Looked After Children Annual Report 2022/23

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	25 January 2024		Discussion	✓
Exec Sponsor	Tyrone Roberts, Chief Nurse		Decision	

Purpose	The report is intended to provide an overview of safeguarding related activity as per the NHSE safeguarding assurance framework.

Summary:	The report provides an overview of safeguarding adults, children and looked after children at Bolton Foundation Trust from April 2022- March 2023. In 2022/23, there were no significant changes to statutory requirements for safeguarding, and the trust continues to work within the same legislation and statutory frameworks guidance. 2022/23 has seen some challenges in both the children and adults safeguarding teams with an increase in the volume and complexity of safeguarding work. During this time, the ability to deliver on our statutory responsibilities has been challenging and there are some areas of concern with regards to capacity to deliver. **Key Findings:** The trust has achieved compliance (95%) for safeguarding training across all metrics with the exception of safeguarding children level 3 which finished the year at 87%. Referrals to the trust safeguarding teams have increased over the last 12 months without any corresponding increase in capacity to respond or deliver. The trust remains in breach of its statutory responsibilities against the NHSE safeguarding assurance framework for three key posts, Named Midwife, Named Nurse Looked After Children and Mental Capacity Lead. There are temporary mitigations in place, monitored via the safeguarding committee reporting into Quality Assurance Committee in order to balance this risk. A business case will be presented to Capital Revenue and Investment Group in February to request additional investment in these key posts.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	The Board of Directors is asked to **receive** the report recognising the increase in activity across the service and the non-compliance with NHSE safeguarding assurance framework.

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:	Bridget Thomas, DND Sheila Mooney, Named Nurse Safeguarding Adults Fiona Farnworth, Named Nurse Safeguarding Children and LAC Lianne Robinson, Deputy Chief Nurse	**Presented by:**	Tyrone Roberts, Chief Nurse

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

LAC	**Looked After Children**
DoLS	**Deprivation of Liberty Safeguards**
MCA	**Mental Capacity Act**
IHA	**Initial Health Assessment**
RHA	**Review Health Assessment**
BSAB	**Bolton Safeguarding Adults Board**
BSCP	**Bolton Safeguarding Children's Partnership**

Bolton NHS Foundation Trust

Safeguarding Adult, Children and Looked After Children Annual Report 2022/23

Authors:

Bridget Thomas, Divisional Nurse Director, Family Care Division

Fiona Farnworth, Named Nurse Safeguarding and Looked after Children

Sheila Mooney, Named Nurse for Adult Safeguarding

Lianne Robinson, Deputy Chief Nurse

Contents

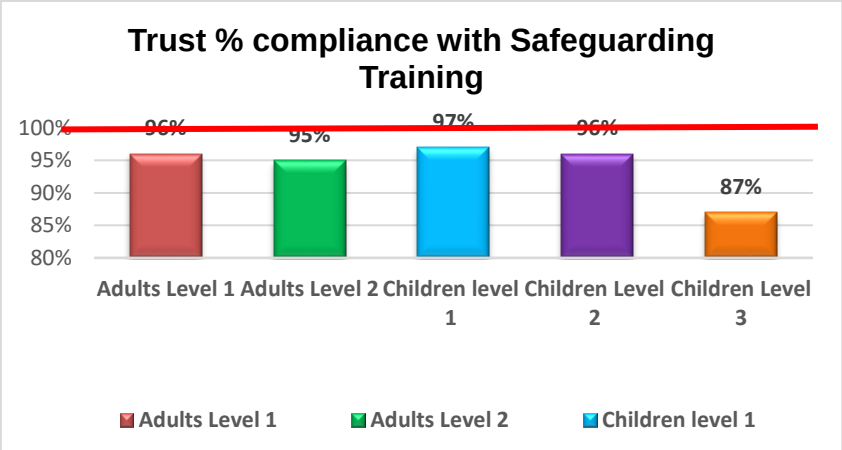
1	**Introduction**	**4**
2	**Safeguarding Frameworks**	**4**
3	**Governance Arrangements for Safeguarding**	**6**
4	**Training**	**11**
5	**Safeguarding Adults**	**14**
6	**Safeguarding Children**	**18**
7	**Looked after Children (LAC)**	**27**
8	**Domestic Abuse**	**28**
9	**Learning from Reviews**	**31**
10	**Conclusion**	**34**
11	**Next Steps**	**34**
	Appendix 1 Underpinning Legislation /Statutory Guidance	**36**
	Appendix 2 Definitions	**37**

Safeguarding Activity at a glance 2022/2024

Training

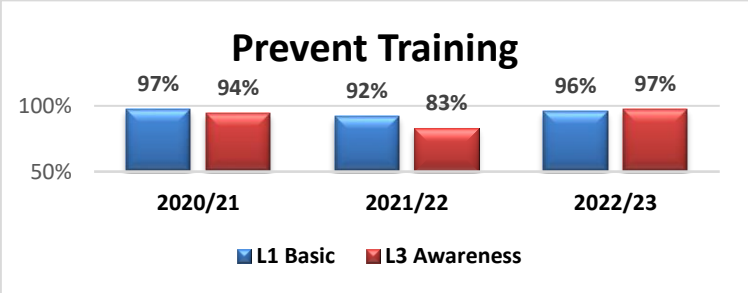
The trust target for safeguarding training is 95% across all areas.

Performance as of March 2023:



The trust target for PREVENT training is 95%

Performance as of March 2023:



Safeguarding Referrals

Adults:

Safeguarding Referrals from Emergency Department **INCREASE of 125%**

All other safeguarding referrals **INCREASE of 16%**

Deprivation of Liberty Safeguard applications **INCREASE of 46.7%**

Children:

Number of children being referred via Emergency Department **INCREASE of 7.9%**

Key Risks:

None compliance with NHSE Safeguarding Assurance Framework across for the following statutory posts:

- Named Midwife
- Named Nurse Looked After Children
- Mental Capacity Lead.

1. Introduction

The safeguarding annual report provides an opportunity to reflect on the achievements of 2022/23 and focus on priorities for 2023/24. The is year's annual report will provide an update to the Trust Board on compliance against statutory safeguarding requirements and will focus on key work streams and achievements of adults, children and looked after children during 2022/23. The report will also highlight some themes from the Bolton Safeguarding Children Partnership (BSCP) and the Bolton Safeguarding Adult Board (BSAB).

In 2022/23, there has been no significant changes to statutory requirements for safeguarding, and the trust continues to work within the same legislation and statutory frameworks guidance for both children and adults.

We continue to see the impact of Covid-19 on our patients and service users of all ages, we prioritise our most vulnerable to ensure they are protected, and their health needs are met.

2022/23 has seen some challenges in both the children and adults safeguarding teams with an increase in the volume and complexity of safeguarding work. During this time, the ability to deliver on our statutory responsibilities has been challenging and there are some areas of concern with regards to capacity to deliver. A full service review has been undertaken and a business case developed in order to request an increase in capacity.

This report will provide an overview of the trusts position in fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers. This is in line with the trust's statutory responsibilities and required regulatory and contractual standards.

2. Safeguarding Frameworks

2.1 Legislation

Legislation and regulatory requirements governing adult and children safeguarding remains unchanged since the previous annual report, with the overarching legislation –

- **Children Act 1989/2004 (Children)**

- **Care Act 2014 (Adults)**

Trust safeguarding policies, procedures and training are underpinned by this legislation and include definitions and arrangements as to how Bolton NHS FT discharges it's statutory safeguarding duties.

In 2022/23, Working Together to Safeguard Children guidelines were updated to reflect legislative changes that have been passed in the UK and will directly impact the care of children in the country. The main context of the statutory guidance has not changed, and the updates reflect changes in commissioning arrangements in the NHS, changes to GDPR legislation and changes in the Domestic Abuse Act 2021. Bolton FT have incorporated these new guidelines in policy, procedures and training.

An outline of the changes are as follows –

- **Integrated Care Boards (ICB)** - The guidance replaces clinical commissioning groups (CCG) with ICB and updated to reflect the role of ICBs
- **Public Health England** - Replaced by the Health and Security Agency and office for Health Improvement and Disparities (OHID). This new department is part of the Dept of Health and Social Care.
- **Domestic Abuse Act 2021** - Outlines changes in ways victims of domestic abuse are protected, and instances that can be considered domestic abuse in the UK. Working Together has been changed to reference the Domestic Abuse Act 2021.
- **UK GDPR** - Since the UK left the EU, reference to EU law has been removed. References to GDPR has changed to read UK GDPR instead. The UK GDPR legislation sits alongside the Data Protection Act 2018.

Assurance and monitoring:

The trust self assesses against the NHSE Safeguarding Assurance Framework on a yearly basis and submits the outcome of this to the CCG (ICB). This is then monitored on a quarterly basis to provide assurnace that the organsation is compliant with its regulatory and statutory duties.

In addition the Royal College of Nursing Intercollegiate guidance sets out the expectations for the dellivery of safegurding activity and has a suite of standards that the organsation aso benchmarks on.

The below table provides an overview of the trusts position against the NHSE assurnace framework for statutory posts:

Role	NHSE assurance requirement/ Statutory Role	Trust Compliance
Named Nurse Adult Safeguarding	Yes	Yes
Named Nurse Children's Safeguarding	Yes	Yes
Named Nurse Children in Care/Looked after child	Yes	Role combined with Named Nurse Children, no dedicated resource
Named Midwife	Yes	No
Designated MCA lead	Yes	No
Named Doctor Children in Care/ Looked after Child	Yes	Yes
Named Doctor, Safeguarding Children	Yes	Yes

To date the Named Midwife and Named Nurse Children in Care/ LAC posts have been combined with other roles within the organisation in order to provide some oversight. However, this is not in line with the assurance framework nor the Intercollegiate Guidance and the trust is in breach of its statutory responsibility.

The designated MCA lead is a new addition to the assurance framework in July 2022 in recognition of the changes made to Mental Capacity Assessments and changes made to the DoLS process.

The focus in 2023/2024 will be to undertake a further service review and self-assessment against the NHSE assurance framework and present a business case to request additional funding and capacity to deliver against our statutory responsibilities.

3. Governance Arrangements for Safeguarding

Bolton NHS FT has robust governance processes in place to ensure that safeguarding children and adults is everyone's responsibility across the trust. In addition, assurance is provided via the safeguarding committee that policies, procedures and training are in place to ensure the trust fulfils its statutory and regulatory requirements. All staff, regardless of role, should be able to identity and escalate concerns, and ask for advice and guidance when a safeguarding concern arises.

The trust board executive lead for safeguarding children, looked after children and adults at risk is the Chief Nurse, who represents the trust at the Bolton Safeguarding Children Partnership. The Deputy Chief Nurse represents the trust at the Bolton Safeguarding Adult Board, is responsible for the management of the safeguarding teams in the trust, and chairs the safeguarding committee.

The trust safeguarding teams provide an integrated and consistent approach to safeguarding and the safeguarding committee meets monthly to ensure there are robust arrangements in place, which are regularly reviewed. In addition to monthly meetings, a wider safeguarding assurance meeting takes place on a quarterly basis where all divisions present evidence of compliance with adult and children safeguarding.

The safeguarding committee monitors compliance and benchmarking against regulatory standards and key clinical effectiveness indicators (including Regulation 13 Care Quality Commission (CQC) requirements. The safeguarding committee reports to the Quality Assurance Committee on a quarterly basis, which informs the Trust Board.

The safeguarding structure outlined below shows the reporting and accountability framework for the trust with the Chief Executive having overarching accountability and the Chief Nurse with delegated responsibility as Executive Board Lead for safeguarding.

3.1 Safeguarding structure

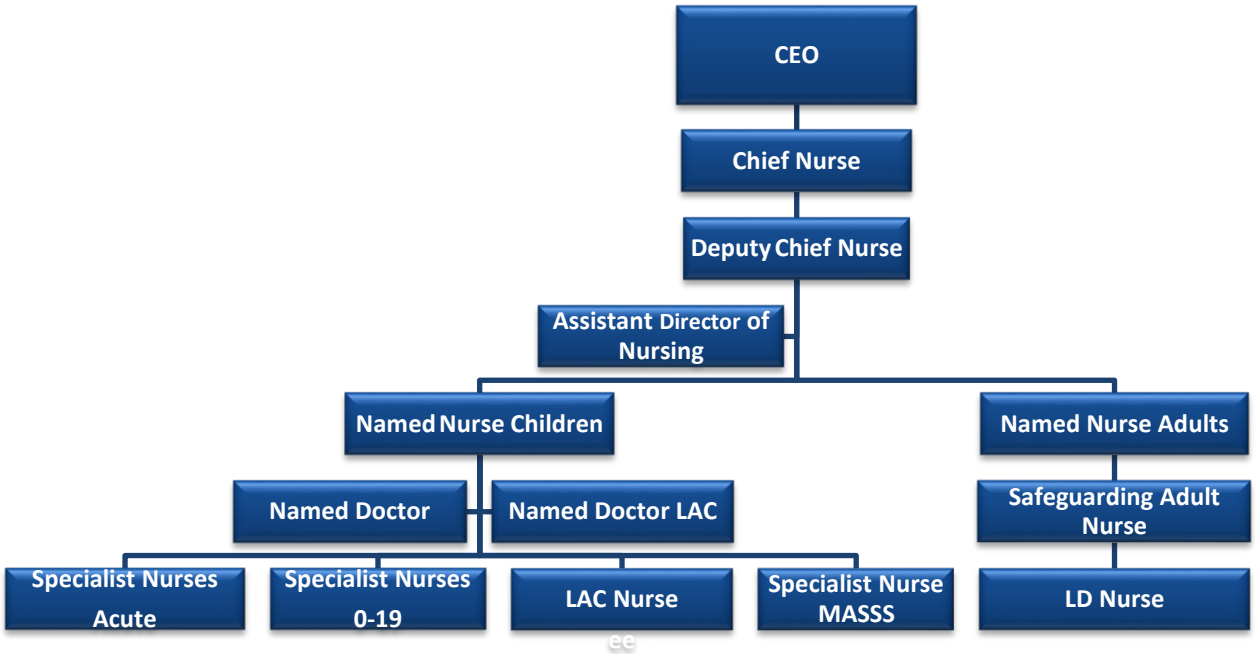


Figure 1: Safeguarding structure

3.2 Governance Reporting Structure

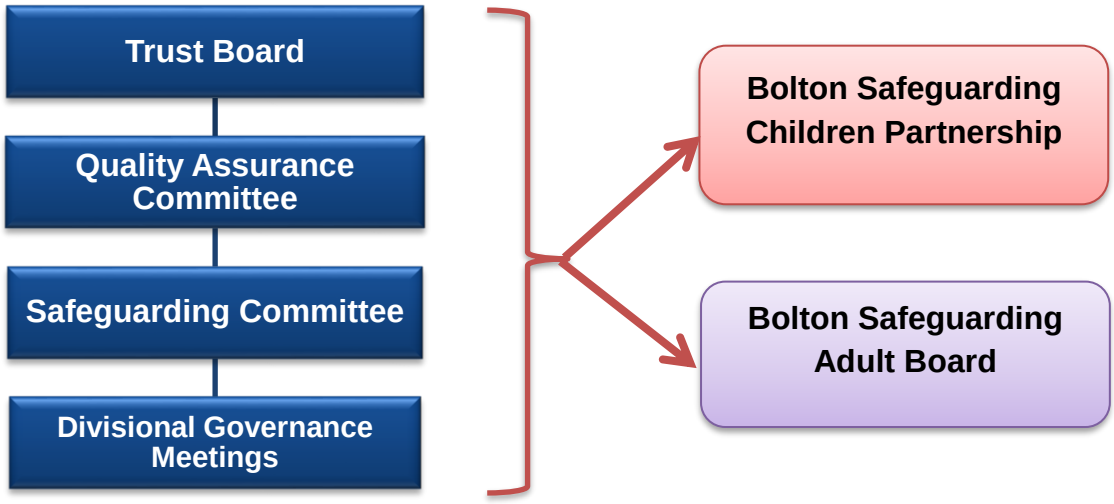


Figure 2: Safeguarding reporting structure

3.3 Risks

There are 3 risks on the Patient Safety and Experience risk register scoring 12+ within the timeframe of this report, which reflect the capacity and staffing in the teams to deliver the increasing complexity of the service.

The risks cover:

- Capacity within the current safeguarding teams and compliance against the NHSE assurance framework
- The trusts statutory responsibilities to provide and ensure compliance against training standards.
- The ability to undertake an MCA assessment and apply for a Deprivation of Liberty Safeguard (DoLS)

These risks are monitored at trust safeguarding committee, risk management committee and reviewed regularly to reflect the actions taken and revised level of risk identified. Work has been undertaken to reduce these risks throughout the year and we are able to report improvement in the safeguarding training figures which follow in section 4.
Compliance with the NHSE Safeguarding Assurance Framework still remains challenging due to the lack of statutory posts for Named Midwife, Mental Capacity lead and a Named Nurse for Looked After Children. This also has an impact on the ability to appropriately educate the workforce on DoLs and Mental Capacity Act. This education is currently being provided via the existing safeguarding workforce, however this requires specialist skills and knowledge.

3.4 Audit

During 2022/23, both adult and children's teams undertook a number of safeguarding audits. Learning and recommendations reported to teams, managers, and services and progress is monitored via the trust safeguarding committee.

3.4.1 Adult Safeguarding Audits

The safeguarding team have undertaken a number of point prevalence studies in relation to Mental Capacity and DoLS. This has led to the development of an audit programme for 203/24 from issues identified in the point prevalence.

These include the following –

Local programme/audit name	2023/24 Audit Period	Completion due	Lead Clinician
MCA/DoLS Audit	September 2023	January 2024	Lead Nurse adult safeguarding
Community safeguarding adult referrals	January 2024	January 2024	Lead Nurse adult safeguarding

Safeguarding adult team incidents and alerts Audit (against policy)	November 2023	January 2024	Lead Nurse adult safeguarding

Joint Audit for Adult and Children Safeguarding

Local programme/audit name	2023/24 Audit Period	Completion due	Lead Clinician
DVA risk check list	January 2024	April 2024	Lead Nurse adult Safeguarding Named Nurse Children's Safeguarding

3.4.2 Looked After Children Audit

The safeguarding Children team have completed a Looked after Children audit in 2022/23 as capacity and activity has meant that audit activity had not been prioritised. **10** cases of LAC have been audited by the LAC specialist nurse and named nurse for safeguarding.

Audit Questions and Findings

Domains	Findings
Voice of the child is evident	• Strong evidence - 9 cases • Adequate -1 cases
There is a thorough assessment covering physical health, development, emotional health and behavior and health promotion/ lifestyle advice	• Strong evidence - 5 cases • Good evidence - 3 cases • Adequate -1 cases • Poor/none - 1 cases
There is a concise summary which has evidence of good analysis of health needs and a review of previous health actions as appropriate	• Strong evidence - 6 cases • Good evidence - 2 cases • Adequate -1 cases • Poor - 1 case
That the health care plan has evidenced all relevant actions with timescales and is focused on the needs of the child	• Strong evidence - 3 cases • Good evidence - 4 cases • Adequate - 2 cases • Poor - 1 case
That actions from the previous health assessments have been met leading to positive outcomes for the child	• Strong evidence - 3 cases • Good evidence -1 case • Adequate -1 case • Poor- 5 cases

Recommendations from audit.

- All health assessments were reviewed and scored individually with a collaborative discussion with the practitioner to determine benchmarking against the domains.

- General feedback provided to 0-19 service Matron with direct feedback in 2 cases where the health assessment is of excellent quality and 2 that require improvement/further details.
- It is recommended that a more up to date approach is taken in writing up the assessments to include and address the child/young person directly to ensure the assessment is child friendly.

A full revised audit schedule is required in order to assess and improve on our current services and this will form part of the safeguarding committee work plan for the coming year.

4. Training

Key Highlights

- **Above 95% compliance in all training except L3 safeguarding children**
- **Level 3 safeguarding training recommenced face to face**
- **Plan for increased L3 safeguarding children compliance**
- **Training Needs Analysis for adult safeguarding**
- **Above 95% compliance with both levels of Prevent training.**

4.1 Safeguarding training

By the end of 22/23, the trust was compliant in all adult and children's safeguarding apart from level 3 safeguarding Children. While there is no national target for this level of safeguarding training, the target is set by the organisation. This target ranges across organisations from 80% to 95%. Bolton FT target for compliance is 95% and the data shows compliance at 87% across the Trust. All other safeguarding training finished the year at 95% or above.

CQC requirements for safeguarding training is not target driven but triangulated with staff knowledge and how this is applied in practice to keep service users safe and recognise and responds at the appropriate levels to abuse in line with Intercollegiate guidance.

All training is three yearly and delivered in line with intercollegiate requirements. In early 2022/23 face-to-face level 3 training was reintroduced post COVID.

- **Adults** - A Training Needs Analysis (TNA) was undertaken for compliance with adult intercollegiate guidance. Further embedding of the TNA will continue in 2023/24 with increased accuracy of data.

- **Children** - Demand to deliver face-to-face level 3 children's training outstripped capacity therefore this is reflected in the level 3 children figures. This has been addressed during 2022/23 with more places offered and a proactive approach to non-attendance. Additional mop up sessions were arranged and these will continue in 2023/24.

Figure 3 demonstrates trust compliance with safeguarding children and adult training at the end of this reporting period. Compliance is consistently high with ongoing work to increase compliance with level 3 safeguarding children's training as it transitions from eLearning to face-to-face post COVID.

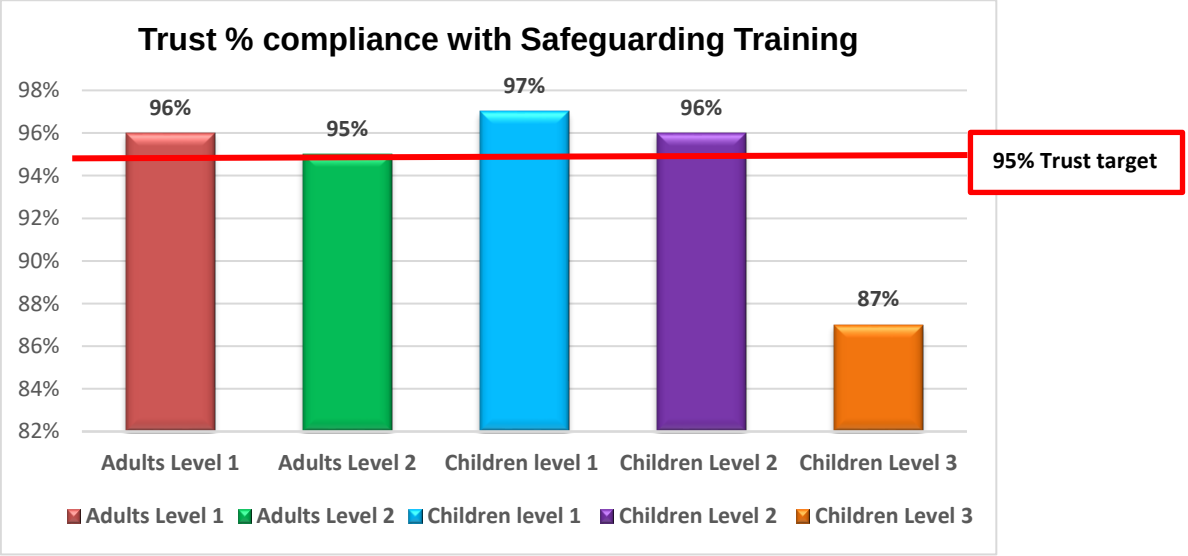


Figure 3: Trust Safeguarding compliance 31st March 2023

Figure 4 shows a breakdown of safeguarding training across all services in the same timeframe and compliance is good and consistent across the Trust.

KEY

GREEN – Meets Trust 95% target

AMBER – Within 10% of Trust target and improving

RED – Below 85%

	Adults L1	Adults L2	Children L1	Children L2	Children L3
AACD	97%	95%	97%	95%	89%
ASSD	97%	97%	97%	97%	88%
Board	100%	100%	100%	100%	Not Required
DSSD	97%	96%	97%	97%	75%
DDOs/Ops	75%	Not Required	75%	Not Required	Not Required
FCD	93%	93%	96%	96%	88%

Finance	97%	Not Required	95%	Not Required	Not Required
Informatics	92%	67%	94%	67%	Not Required
ICSD	97%	97%	97%	97%	Not Required
Medical Education	100%	100%	100%	100%	Not Required
Patient Safety & Experience	91%	92%	98%	94%	67%
Strategy & Transformation	95%	Not Required	95%	Not Required	Not Required
Workforce	95%	91%	95%	50%	Not Required

Figure 4: Divisional/service safeguarding compliance at 31st March 2023

4.2 Prevent Training

Prevent sits alongside safeguarding duties of professionals to protect people from a range of harm such as substance abuse, involvement in gang activity and physical and sexual exploitation. Prevent is one part of the government's overall counter-terrorism strategy, CONTEST.

The aim of Prevent is to:

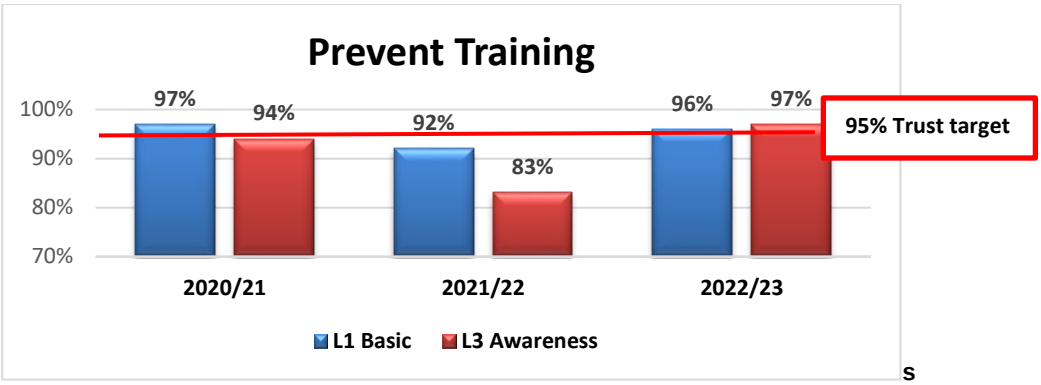
Tackle the ideological causes of terrorism.	**Intervene early to support people susceptible to radicalisation.**	**Enable people who have already engaged in terrorism to disengage and rehabilitate.**

All professionals working in the following sectors are covered by the Prevent duty, such as:

4.2.1 Bolton FT Compliance with PREVENT Training

Bolton FT complies with 2 levels of prevent training and the data shows a significant increase in compliance from previous years.

Figure 5 shows the year on year compliance increase, while figure 6 provides a breakdown of the divisional and departmental compliance across the trust.



s

Figure 5: Prevent training comparison with previous year

	WRAP Basic Awareness	Prevent
AACD	99%	95%
ASSD	99%	96%
Board	100%	100%
DSSD	97%	97%
DDOs/Ops	87%	Not Required
FCD	95%	94%
Finance	98%	Not Required
Informatics	94%	100%
ICSD	97%	99%
Medical Education	100%	100%
Patient Safety & Experience	98%	94%
Strategy & Transformation	95%	Not Required
Workforce	96%	100%

Figure 6: Prevent compliance at 31st March 2023

5. Safeguarding Adults

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. This is underpinned by six principles of safeguarding.

Empowerment.	**Prevention.**	**Proportionality.**

Protection	Partnership	Accountability

The Department of Health defines a vulnerable adult as -

A person aged 18 or over who may need community care services because of a disability (mental or other), age, or illness.

5.1 Safeguarding Referrals 2022/23

The data below demonstrates the numbers of safeguarding referrals received into Bolton FT safeguarding team for 2022/23.

	2020/21	2021/22	2022/23
Safeguarding referrals from Adults ED	No data available	925	2085 increase of 125%
All other Safeguarding referrals for Adults	No data available	834	1017 increase of 16%

Figure 7: Safeguarding Adult referral figures

The data presented demonstrates the significant increase in the number of referrals especially from the Emergency Department. Reasons for increasing numbers are:

- Increased number of safeguarding concerns
- New electronic system for referrals
- Embedded systems and processes for referrals.

Prior to May 2023 adult safeguarding referrals was a manual data capture therefore accurate data reporting cannot be guaranteed. Since May 2023 a new system and process has been developed to ensure data accuracy, which will provide greater ability to benchmark for the following year.

5.2 Section 42 Enquiries 2022/23

This relates to the duty of the Local Authority under the Care Act 2014 to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect and cannot protect himself

or herself or has care and support needs. This happens whether or not the authority is providing any care and support services to that adult. The following chart provides a comparison with the number of safeguarding adult concerns in Bolton and Nationally.

Concerns/S42	2020/21	2021/22	2022/23		
	England	England	England	Bolton LA	Bolton FT
Number of Section 42 Investigations	152,270	161,925	173,280	875	81 (10% of all S42 have health involvement)

Figure 8: Number of S42 Enquiries

5.2.1 Analysis of section 42 enquiries – Bolton FT

The evidence in figure 8 demonstrates the year on year increase in section 42 investigations nationally and Bolton is following the same trend.

Data from 2020- 2022 demonstrates that Bolton FT (health) involvement previously accounted for between 4-5% of all Bolton LA activity. This has doubled over the last 12 months resulting in increased demand on the trusts safeguarding team, increased attendance at meetings and ability to contribute toward investigations.

The safeguarding adult team undertook an analysis of Section 42 enquiries to Bolton FT from January 2023 to April 2023.

10 section 42 enquiries were analysed which had been opened between January 2023 and April 2023 for recurring themes.

The analysis found the following themes:

Themes	Outcomes of S42 Enquiry
• **60%** related to unsafe discharge. • **10%** staff allegations. • **10%** Self Neglect. • **20%** Neglect from a Nursing/residential home.	• **80%** ongoing. • **10%** Fully substantiated. • **10%** partially substantiated.

An action plan has been developed with clinical areas to address findings and planned re audit in 2023/24.

The team continue to input into Section 42 enquires currently ongoing and will develop action plans for learning once concluded.

5.3 Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards procedure is designed to protect a patient's rights if the care or treatment they receive in a hospital means that the patient is or may become, deprived of their liberty, and lack mental capacity to consent to those arrangements.
DoLS is an amendment to the Mental Capacity Act (MCA) 2005. They apply in England and Wales only. The Mental Capacity Act allows some restraint and restrictions to be used – but only if they are in a person's best interests and necessary and proportionate.

5.3.1 DoLS in Bolton FT

Significant work has taken place to increase knowledge across all services of the process for applying for a DoLS to ensure our patients are not being deprived of their liberty while in our care.
Systems and process for the accurate data collection and recording of DoLS applications is currently still in progress however, figure 9 demonstrates a near 50 % increase in the number of DoLS applications to the local authority in comparison with previous years.

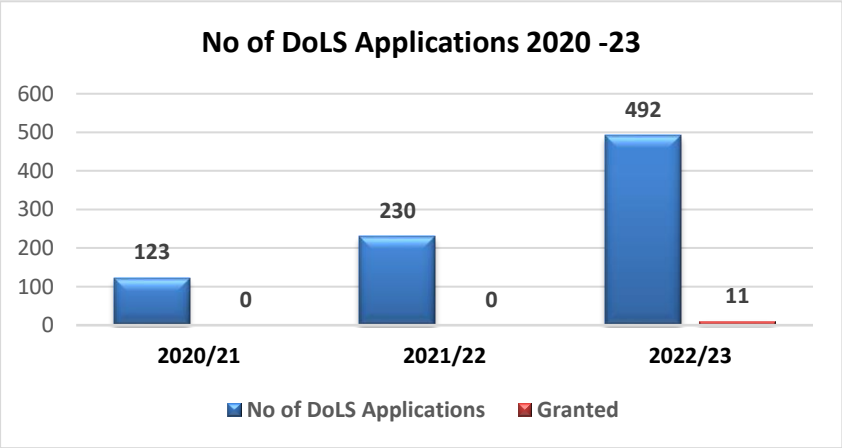


Figure 9: Bolton FT DoLS applications

The trust is currently working with the Local Authority to review the number of DoLS granted. There is an absence of process for tracking DoLS once received by the local authority that the trust can view and monitor. All referrals and subsequent information are sent back to the original referrer resulting in the safeguarding team having no awareness of DoLS granted or declined. This is manual search and data review with individual wards.
This has been discussed at BSAB and will remain an area of focus for 2023/2024.

5.4 Bolton Safeguarding Adult Board

Bolton FT are committed to supporting the BSAB in ensuring that there is joined up work streams across all services to keep vulnerable adults safe. Also, to ensure the BSAB achieves its strategic objectives for 2022/23 and set its priorities for 23/24.

Priority 1 - Domestic Violence and Abuse

- Bolton FT have updated the Domestic Abuse policy and are working with partners to ensure robust training is available for staff and procedures are in place to recognise, respond and escalate Domestic Abuse Cases.
- Bolton FT are fully represented at MARAC meetings and details will be further in the report.

Priority 2 - Reduce the prevalence of self-neglect

- Self-Neglect is included in training and well embedded across the Trust to ensure professional curiosity regarding living circumstances.
- Bolton FT are represented on the Self-Neglect and Hoarding task, finish group, and supports the development of a Bolton Wide strategy.

Priority 3 - Raise the profile of Safeguarding in Bolton

- Across the Trust to ensuring, the voice of the adult at risk and their carers is central in all we do.
- Member of the Communication and Engagement Sub-Group convened as part of the new board structure.

6. Safeguarding Children

In May 2022, two government-commissioned reviews were published about the child protection system in England:

1. The National review into the murders of Arthur Labinjo-Hughes and Star Hobson looked at how and why the services intended to protect children were not able to do so (Hudson and Child Safeguarding Review Panel, 2022).
2. The independent review of children's social care looked at the changes needed to better protect and support children and young people (MacAlister, 2022).

As a result of these reviews, in England, changes have been made to the way people working with children are expected to report concerns about a child's welfare to the relevant agencies. The key guidance for child protection remains ***Working Together to Safeguard Children (Department for Education, 2018)*** which states -

Everyone who works with children has a responsibility for keeping them safe. Everyone who comes into contact with children and families has a role to play in sharing information and identifying concerns.

Working Together 2018 has been updated in 2022, however because of recent reviews, in 2023, a consultation for a new version was shared and this is expected to be published in 2024.

In addition, section 11 of the Children Act 2004 places a statutory duty on certain agencies to co-operate to safeguard and promote the welfare of children. This includes NHS services and trusts.

6.1 Safeguarding Children in Bolton

Bolton FT works closely with Bolton Safeguarding Children Partnership's (BSCP) to promote our children to have the best possible start in life, so that they have every chance to succeed, be safe and be happy.

The Chief Nurse who is accountable for safeguarding across the trust represents Bolton FT on the BSCP.

The partnership supports and enables local organisations and agencies to work together to –

- **Ensure children are safeguarded, and their welfare promoted.**
- **Achieve improved outcomes for vulnerable children.**
- **Organisations challenge appropriately and hold one another to account effectively.**
- **Early identification and analysis of new safeguarding issues and emerging threats.**
- **Learning is promoted and embedded.**
- **Information is shared effectively.**
- **Tackling disadvantage and promoting equality for all children.**

6.1.1 Snapshot Children in Bolton

Children aged 0-17 years make up almost a quarter of Bolton's population with almost a third of children living in low-income families. This affects the outcomes for children and makes them more vulnerable to bullying but also to being at risk of gangs and crime where money can be plentiful.

The snapshot below gives a small insight into the Bolton children's population and aligns to the need to adapt services and work in partnership to protect children and young people.

71,391

0-17 yr olds

(24% population of Bolton)

278

16-17 yrs olds

not in education, training or work

31.5%

Low income families Bolton

(18.7% in England)

29.5%

BME in Bolton

(24.6% England)

3,359

Domestic Abuse incidents where child present

2,132

Childen with SEND

(Special Educational Needs and Disbility)

6.2 Voice of the Child

Bolton FT work collaboratively across the Bolton partnership to ensure the voice of children shapes service provision. The BSCP have asked children about working with BSCP, they were positive about the role of the partnership and their work with youth groups.
In 2023/24 Bolton FT will continue to progress this work to seek the views of children and young people in a meaningful way.

Bolton FT have participated in two BEE COUNTED inspections of services in 2022/23. This is a group of 12 young people from across Greater Manchester (GM) who have taken part in training to inspect health services across the city region. Both professionals and young people, with the aim for young people to feel that health services across GM support their needs, created the Greater Manchester Youth Agreement in 2018. The Greater Manchester Health and Social Care Partnership support this.

Comments from youth inspectors on their visit to Bolton FT children's services include -

Staff seem to know what to do when it comes to having support for young people, which is great because it educates the young people and they get to be open with others.
The staff seemed thoughtful and introspective with deeply thought out answers and a genuine curiosity for any possible

- **Access/Location Ease: Green**
- **Quality of Care: Green**
- **Communication: Green**
- **Staff Training: Green**
- **Advertising/ Marketing: Green**
- **Specific support for young people: Green**
- **Patient Comfort: Green**
- **Youth Participation: Amber**

In 2023/24 the work with Harper Green School will be extended to consider developing a youth forum. This will be a focus for the safeguarding children team and the Family Care division to ensure the voice of the child and young person is heard and counted.

6.2.1 BEE COUNTED Findings

All findings were positive with the recommendations to considering developing a youth forum to further understand the voice of children and young people, particularly those that are vulnerable, to shape services around their needs**.**

The information below provides a snap shot of the main themes that we plan to address in 2023/2024.

- **Wheelchair accessible services**
- **Well-trained professionals who provided excellent care**
- **Texts and letters if patients do not have a mobile device.**
- **Surveys for parents and carers**
- **Services advertised on Facebook, Twitter and Instagram**
- **Nurses in every SEND school in Bolton,**
- **15 step challenge with Harper Green School.**
- **Privacy and confidentiality for young people**
- **Staff are trained to understand and respect religious needs**

6.3 Child Protection Plans

A child protection plan sets out what action needs to be taken, by when and by whom (including family members), to keep the child safe from harm and to promote their welfare. The plan is reviewed at regular child protection conferences until the child is no longer considered at risk of significant harm or until they are taken into care.

In 2022/23, the numbers of children subject to a child protection plan has remained consistent throughout the year, however in early 2023 these numbers have increased significantly, prompting analysis by the Local Authority and the BSCP. Work is ongoing to look at the Early Help offer and link with the developments of Family Hubs in 2023/24 to try and intervene at an earlier stage to avoid escalation to statutory intervention to keep children safe.

Whilst the numbers of Children on Child Protection Plans has increased, the capacity within the safeguarding teams has not, this results in a higher case load for practitioners and a decrease in the level of support that we are able to offer to these vulnerable children and young people.

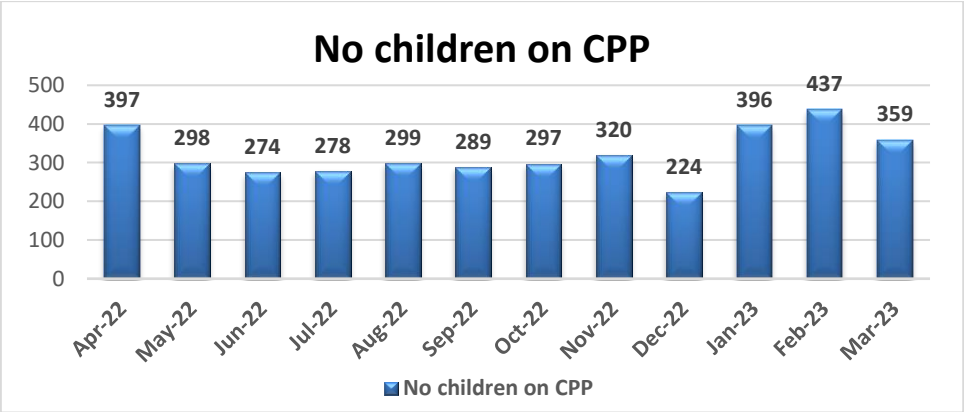


Figure 10: Number of children on a CPP in Bolton 2022/23

6.3.1 Categories of Abuse in Bolton

The categories of abuse can fluctuate depending on current socio economic factors. Figure 11 is an over view of the categories of abuse seen in 2022/23 and comparisons.

- **Emotional Abuse** continues to be the category with the highest numbers of referrals and in many cases is a consequence of domestic abuse where a child or children are present.

- **Neglect** also features as a high level across Bolton and can be linked to low levels of intervention at an Early Help level and deprivation related to unemployment and cost of living crisis.
- **Physical and sexual abuse** are the lower categories and are known to be under reported locally and nationally.

Child Protection Plan at 31st October 2021		Category of Abuse			
Year	Total CPP	Neglect	Physical	Sexual	Emotional
2023	379	160	21	16	182
2022	349	152	22	18	157
2021	494	214	30	33	205
2020	381	180	20	28	136
2019	325	147	21	24	126

Figure 11: Demonstrates the categories of abuse for children in Bolton at 31st March each year

6.4 Referrals to Safeguarding Children Team from the Emergency Department

The numbers of safeguarding referrals to the Children's safeguarding team continues to increase. The majority of referrals come from the Emergency Department. The 0-19 Public Health Nurses, as Specialist Practitioners, manage their own safeguarding caseloads and receive advice and case supervision from the safeguarding team.

In 2022/23, the Safeguarding Children Team received daily referrals for –

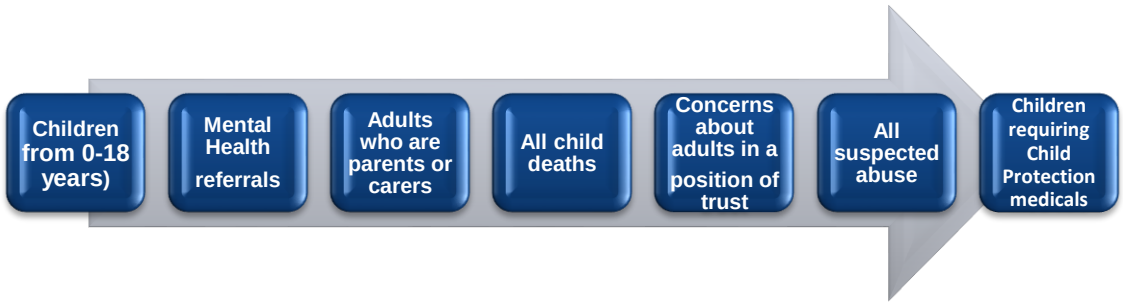


Figure 12 outlines the number of referrals from the Emergency Deparment and the referrals relating to children, adults with caring responsibilities for children and mental health assessments where there are safeguarding children concerns.

Month	Children (under 18)	Adults who are parents/carers or in a position of trust	Mental Health (adults who are carers and children)	Total
2021/2022 Total	2859	634	1587	5080
2022/2023 Total	3107	627	1279	5013

Figure 12: Referrals to safeguarding Children team 2022/23

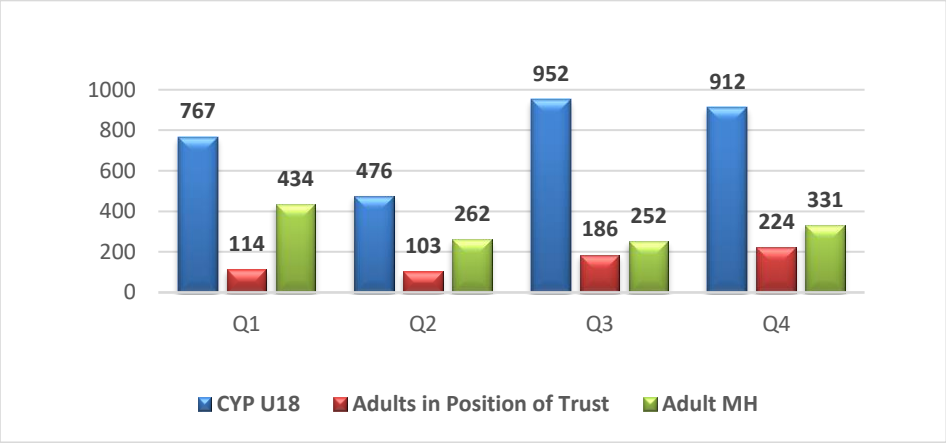


Figure 13: Referrals by quarter 2022/ 2023

Analysis

- Referral numbers from the emergency Department remain static throughout 2022/23, however seasonal variation is noted in line with previous years.
- Significant increase in number in Quarter 3 from A/E, with a fluctuating pattern of reasons for referral. This includes, issues of safety and supervision such as –
    - Dog bites,
    - Falls
    - Ingestion of toxic substances.
- While there are smaller numbers of presentations with Mental Health concerns and for adults with caring responsibilities for children, these are often long standing and complex for both adults and children including those who live out of area but access Bolton FT services.

6.5 Safeguarding team Activity 2022/23

In 2022/23, the safeguarding team represent the trust on the following meetings –

Meetings	Frequency
SUDC (Sudden Unexplained Death in Childhood)	5 meetings
Professional's meetings	8 meetings
Strategy Meeting	9 meetings
Discharge Planning Meetings	5 meetings
Child Action Meetings	3 meetings
CEAM (Child Exploitation and Missing)	9 meetings
Channel Panel	3 meetings
MARAC(Multi Agency Risk Assessment Conference)	13 meetings
Child Safeguarding Review Panel (chair)	2 meetings
Domestic Homicide Review Panel	4 meetings

Figure 14: Safeguarding team attendance at meetings

These meetings are often complex and require significant report writing and actions for implementation. The attendance at these meetings places increased activity on the Named Nurse for Children and Looked After as she holds a dual role. This is not in line with the NHSE Safeguarding Assurance Framework, where these two roles should be independent of each other.

In addition to the meetings outlined, the team also responded to **234** CP-IS (Child Protection Information Sharing) alerts and are required to attend and represent the trust at the below:

MARAC Steering Group	**Designated and Named Professionals meeting**	**CYP Emotional Health and Well Being Transformation Group**	**Neglect Steering Group**
Health Economy LAC	**NICE Guidelines meeting**	**Trust Mental Health Act Meeting**	**Divisional Safeguarding Meeting**
Bolton and GM LAC meeting	**Exploitation Audit and Assurance Meeting**	**Domestic Abuse and Violence Partnership Board**	**Trust Sleep Safe meeting**

In addition to writing reports there is a requirement to meet with staff who have provided services to the child and family. Providing support, education and safeguarding supervision is a fundamental role of the team and unfortunately, due to service capacity, is not always a priority. Throughout 2022/2023 the safeguarding team have supported complex cases for Young People out of area acting as their advocate and ensuring the trust is fulfilling its

safeguarding duties. Work continues building relationships with external stakeholders and the Integrated Care Board to further strengthen these and ensure the trust workforce is supported throughout.

6.6 Bolton Safeguarding Children Partnership Priorities (BSCP)

The following priorities for the BSCP are aligned to and supported by the work streams across Bolton FT children's services.

Priority 1 - Complex safeguarding

Bolton FT is fully involved in Complex Safeguarding and are represented on all groups across Bolton. Complex safeguarding is included in training and the Trust has forged good relationships with GMP to further develop this work in 2023/24.

Priority 2 - Neglect

Bolton FT have contributed to the Bolton Neglect Strategy. Neglect is increasing with the cost of living crisis and its impact on families.

Priority 3 - Safeguarding Thresholds

Bolton FT have a nurse co-located at the integrated font door service, which is the gateway for referrals into children's social care. This allows a health voice in high-level decision making regarding high-risk children.

Bolton FT have been involved in reviewing these thresholds to ensure they are fit for purpose and support all practitioners.

Priority 4 - A Safe Workforce

Abuse and neglect can occur within the workplace, therefore clear, consistent and timely arrangements must be in place to respond to any allegation of abuse made against practitioners working with children. Bolton FT have procedures in place to manage allegations made against staff and have good relationships with the LADO (Local Authority Designated Officer) to share information and support any investigation.

LADO processes are followed where one or more of the following criteria is met, if a person working with children has –

- Behaved in a way that has harmed or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates that they may pose a risk of harm to children.
- Behaved or may have behaved in a way that indicates they may be unsuitable to work with children.

7. Looked After Children

In Bolton FT the Named Nurse for Safeguarding Children also undertakes the role of Named Nurse for Looked After Children (LAC) with a Specialist Nurse to support as part of the 0-19 team. Named Nurse for LAC is a statutory post and standalone role; therefore, the trust is not aligned with statutory requirements for LAC.

The Named Nurse and Doctor support multi-agency working along with advice to adoption and fostering panels and attendance at Corporate Parenting and Permanency Panel and other multi agency meetings and forums. The trust LAC group has a distinct action plan based on the safeguarding standards and this feeds into the trust safeguarding committee.

7.1 Looked After Children Performance

LAC data is collated on a monthly basis to monitor compliance with timescales for statutory health assessments for children in care. Compliance data provides evidence of the effectiveness of agreed LAC pathways.

The majority of LAC in Bolton are placed in Bolton; however, there are children who are placed in Bolton from other areas and responsibility for the provision of health assessments for these children lies with Bolton FT.

The service is proud that despite high levels of activity all children who reside in Bolton are treated equitably for health assessments. For Bolton children placed in other Local Authority areas, this is not always the case, and this has been escalated to the Designated Nurse in the ICB for discussion within GM.

The numbers of children entering care fluctuates from week to week therefore the pressure on services to be responsive to needs within statutory time frames is positive.

Statutory Time Frames:

- **Initial Health Assessments** – Are required to be completed by a doctor within 20 working days of a child becoming LAC
- **Review Health Assessments** – Are required to be completed every 6 months for under 5s and yearly for over 5s.

7.2 LAC Data

The following charts demonstrate Bolton FT performance against statutory requirements for Initial and Review Health Assessment in 2022/23.

7.2.1 Initial Health Assessments (IHA)

IHA	2021/2022	2022/2023
Number of Initial Health Assessments due	158	162
Number completed in 20 working days	106 (69%)	141 (87%)
Number completed of out time scales	52	21

Figure 15: Initial Health Assessment Compliance.

Despite sickness in the medical team requiring locum cover, performance has improved on last years.

7.2.2 Review Health Assessments (RHA)

RHA	2021/2022	2022/2023
0-5 Review Health Assessments due	550	564
Number completed in 20 working days	461 (84%)	486 (86%)
Number completed of out time scales	89	42

Figure 16: Review Health Assessments

The majority of RHA are undertaken by the 0-19 Public Health Nurses. There has been significant vacancies and sickness in the 0-19 team in 2022/23 affecting capacity and the ability to meet timescales. This will continue to be monitored and reviewed into the next year.

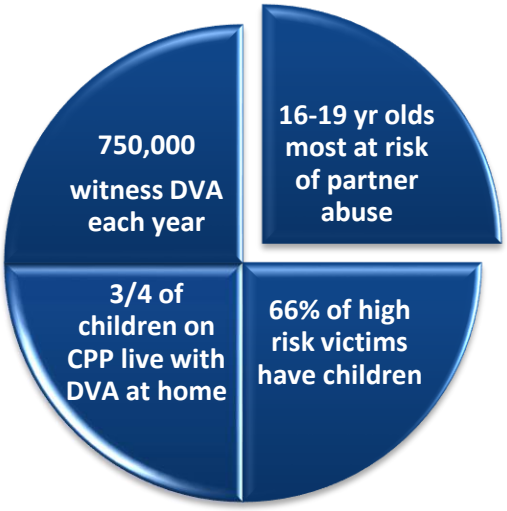
8. Domestic Abuse

Domestic abuse is a priority area for both children and adult safeguarding across Bolton FT. Bolton FT are represented on the Bolton Community Safety Partnership and its Domestic Abuse and Violence (DAV) Steering Group, to tackle Domestic Abuse and Violence in Bolton. For children living with this issue there can be a range of impacts, which often affect them throughout their childhood and into adulthood.

Bolton has adopted the national definition of Domestic Abuse and Violence (DAV), which covers:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse; psychological, physical, sexual, financial, and emotional. This also includes so-called honour based violence, female genital mutilation and forced marriage.

National Data tells us that:



This mirrors the picture seen across Bolton and is driving the current priorities for BSCP and BSAB with a focus on domestic violence for 2023/2024

7.1 MARAC (Multi Agency Risk Assessment Conference)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may

have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

In Bolton, the number of MARAC referrals have significantly increased with the need to go to weekly meetings from fortnightly from 1st April 2022. Bolton FT safeguarding specialist nurse attends all MARACs and shares health information as appropriate to protect the victims and any children who may have been present.

The figure below shows the numbers of MARAC cases discussed in 2022/23 and the categories included in relation to children, which are –

- Total number of cases heard.
- Number of cases where children present
- Number of children present
- Pregnant woman present

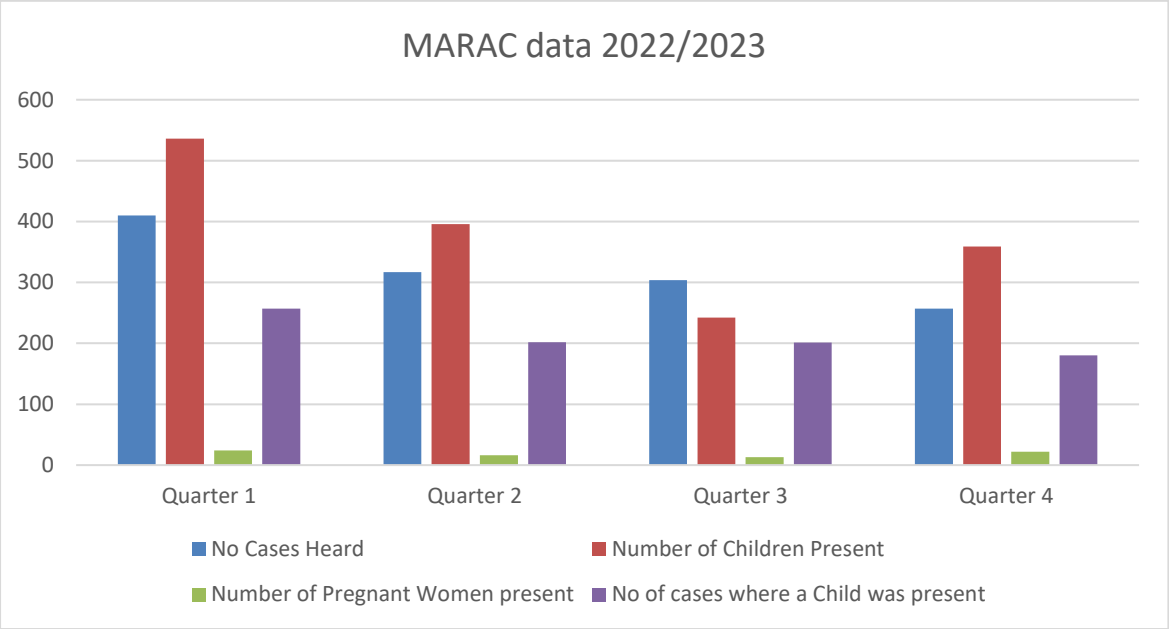


Figure 17: MARAC Data 2022/2023

A full data set is unavailable for 2021/2022 however as a comparison, quarter 1 and quarter 2 data is below for total number of cases only.

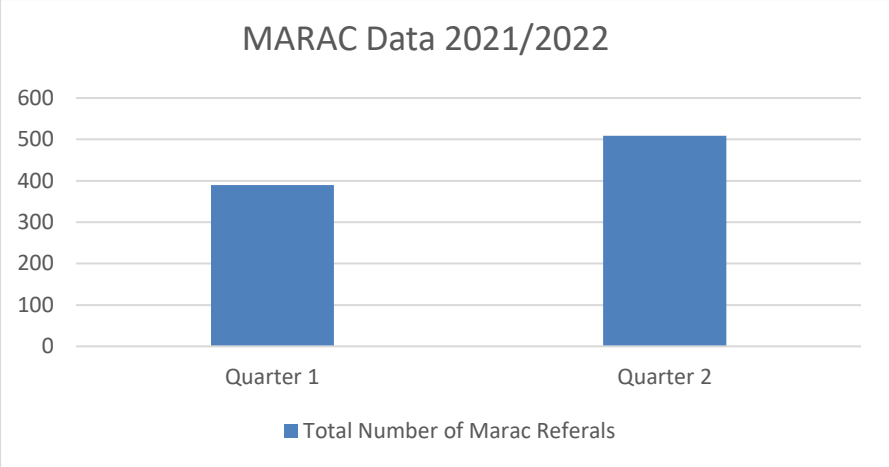


Figure 18: MARAC Data 2021/2022

Outcomes from MARAC cases are in line with the national picture and demonstrate:

- Increase in abuse of older people.
- Increased self harm and anxiety.
- Increase in domestic violence in same sex relationships.

The safeguarding teams are working in partnership with Fort Alice BSCP and BSAB to further identify key themes and equip staff with the necessary skills to be able to respond to concerns.

9. Learning from Reviews

8.1 Child Safeguarding Reviews

A serious child safeguarding case review is one in which abuse or neglect of a child is known or suspected and the child has died or been seriously harmed. Learning from local and national child safeguarding practice reviews is vital to share good practice but also to learn from incidents and makes changes to practice and services prevent reoccurrence.

8.2 Learning from Reviews

8.2.1 Bolton Children Reviews published 2022/23

Type of Review	Overview	Learning Themes
Thematic Safeguarding Practice Review **Commissioned 2020** **Published 2022**	• Infant who suffered serious non-accidental injuries	• Impact of Covid-19 on practice • Information sharing • Child Protection Processes • Delivering Best Practice • Partnership working • Effective safeguarding Supervision

Serious Case Review **Commissioned 2020** **Published 2022**	• 2 children who died aged three and one year old respectively. • Died as a result of being given poisonous substances by their mother, who then took her own life.	• Domestic abuse, harassment • Exploitation; • Mental health; • Engaging suspicious and avoidant parents; • Care experienced parents; • Right support at the right time; • **Filicide-suicide.**
Serious Case Review	• Death of a baby within a week of birth. • The pregnancy, birth, death and burial concealed by both parents. • Neither parent was involved with services until after the death.	• Coercive Control • Concealed pregnancy • Early Intervention • Post adoption support
Rapid Review	• 16 years at the time of the review. Child of Asian heritage. Child exposed to significant adverse childhood experiences and made • Allegations of sexual grooming leading to mental health issues.	• Timely multi-agency discharge planning at the point of admission, • Support for carers • Early CAMHS consultation to provide strategies for carers. • Continuity of Care • Ensure that a child's cultural, religious and gender identity is explored, understood and promoted by all agencies.
Practice Review	• 15 years old at the time of the review and was LAC • Diagnosis of ASD and OCD • Presentation of 'self-neglect' • Significant decline in his mental health and sectioned under the Mental Health Act.	• Opportunities for multi-agency early help were missed. • Need for regular MDT's understanding family dynamics and history. • At times the health offer lacked coordination

8.2.2 Ongoing Safeguarding Reviews 2022/23

Type of Review	Overview	Updates
Child Safeguarding Practice Review	**Child 1**	• 3rd Panel Meeting held • Practitioner event held • Awaiting further panel meeting and draft report for comments
Single Agency Review	**Child 2**	• Referred to Children's Safeguarding Partnership who have requested a single agency review • Completed by the Safeguarding Children team with Divisional and Corporate Services contribution.
Rapid Review **Awaiting final report**	**Child 3**	**Emerging learning** • Practice was effective in providing a specialist health practitioner and service to assess and provide interventions to child when the Social Worker raised concerns about sexual activity and risks of exploitation.

		• The health assessment includes risk indicator questions that are used at each contact and child engaged with the assessment. • Sexual activity and the law was considered and reported to the police as appropriate. • Good senior practitioner oversight and joint decision making in view of the age and concerns. • Learning shared regarding cases where under 13-year-old access contraception or sexual health screening as per Sexual Offences Act 2003.
Rapid Review	**Child 4**	**Emerging learning** • To share key messages to staff about features of familial sexual abuse based on Tri X Guidance • Requirement for accurate recording of family/household members at each contact • The importance of puberty and healthy relationships work within 0-19 service as this may support a child to make a disclosure

8.2.3 Domestic Homicide Review (DHR)

There has been one DHR in the timeframe of this report; although the DHR is not yet completed, there has been learning for Bolton FT as a single agency as follows -

Sensitive enquiry in A/E

- There are a range of indicators to suggest that a patient may be experiencing domestic abuse and staff need to listen, persist and enquire about signs and subtle cues.

Professional curiosity

- The health records did not include details of how other agencies were working with the family. This may be because staff did not ask or that the information was not disclosed. This is a potential missed opportunity by A/E staff.
- Where patients mention arguments, asking further questions about what was meant by an “argument” may have provided the opportunity to disclose domestic abuse and this would have supported further actions.

8.2.4 Organisational learning

The outcome of all safeguarding reviews is presented in the trusts safeguarding committee where discussion takes place on what organisational learning can be taken. Throughout 20223/2024 this now requires further development to track actions in order to demonstrate changes in practice, process and that learning has been embedded.

10. Conclusion

This annual report has provided an overview of the complex and diverse work undertaken by the adult, children and LAC safeguarding services. 2022/23 has been a difficult year with both teams experiencing staffing issues and unprecedented levels of vulnerability and risk across all age groups.

The safeguarding teams have seen an impact, by the volume of referrals and despite being pressured, have managed to maintain performance, monitor and manage complex safeguarding situations, continue to develop and deliver policy guidelines and training, and have moved practice forward. In addition, the safeguarding teams have been key members of partnership meetings, representing the trust and being a voice and advocate for vulnerable children and adults.

Safeguarding priorities align with partnership strategic objectives, and this will continue to strengthen in 2023/24 as further partnerships evolve as part of an Integrated Care System to ensure the people of Bolton are afforded the best care and protection when in our care. 2023/24 will bring more pressures in safeguarding with the impact of the cost of living crisis on families, the increasing complexity of safeguarding and the increasing demands for training and supervision. The teams will rise to this challenge to ensure that safeguarding remains the golden thread through all services.

11. Next steps

Safeguarding activity and protecting our vulnerable patients and service users remains a key focus for the trust in 2023/2024. In line with the priorities from Bolton Safeguarding Childrens Partnership (SCP) and Bolton Safeguarding Adults Board (SAB) our focus for the next 12 months are:

- Further develop the governance framework for Safeguarding including committee reporting structures.
- Develop a quarterly safeguarding assurance report
- Undertake a full service review in line with NHSE Safeguarding Assurance Framework
- Develop a safeguarding audit schedule.

- Identify a trajectory for Level 3 Children safeguarding training for achievement by the end of 2023/2024.
- Commence monitoring and reporting of safeguarding adults level 3 training as per training needs analysis.
- Further develop the DoLs process in partnership with Local Authority.

Appendix 1

Underpinning Legislation /Statutory Guidance
• Children Act 1989/2004 • Working Together (2018) Statutory Guidance • Promoting the Heath of Looked After Children (2015) Statutory Guidance • Safeguarding Children and Young People Roles and Competencies for Health Care staff (2019) • Safeguarding Adults Roles and Competencies for Health Care staff (2019) • Looked After Children, Skills and Competencies for healthcare Staff (2015) • Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) • Lampard Inquiry (2015) • Children Act 1989/2004 • Working Together (2018) Statutory Guidance • Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) • General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. • Working Together (2018) • Children Act 1989/2004 • Working Together (2018) Statutory Guidance • Female Genital Mutilation Act 2003 • Mental Capacity Act 2005 • Serious Crime Act 2015 • Mental Health Act 2007 • Children and Families Act 2014 • Modern Slavery Act 2015 • The Crime and Disorder Act 1998 • Sexual Offences Act 2003 • Domestic Abuse Act 2021

Appendix 2 – Definitions

Child	Having not reached 18 years, up to 19/25 years if SEND (Special Educational Needs and Disability)
Safeguarding Children	Protection from maltreatment, preventing impairment of health or development; growing up with safe, effective care to enable best outcomes.
Child Protection	Part of safeguarding refers specifically to children who are suffering, or at risk of significant harm.
Looked After Child	In the care of the Local Authority for more than 24 hours. Also often referred to as children in care
Adult Safeguarding	Protecting an adult's right to live in safety, free from abuse and neglect, while at the same time making sure that the adult's wellbeing is promoted and having regard to their views, wishes, feelings and beliefs
Deprivation of Liberty Safeguards (DoLS)	DoLS is part of the MCA and is a legal framework for individuals over 18 years who lack the capacity to consent to be accommodated in a hospital or care home in order to receive care and treatment
The Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Report Title	Standing Financial Instructions and Financial Scheme of Delegation			
Meeting	Board of Directors	**Purpose**	Assurance	✓
Date	25 January 2024		Discussion	✓
Exec Sponsor	Annette Walker, Chief Finance Officer		Decision	

Purpose	To present the Standing Financial Instructions and Financial Scheme of Delegation following periodic review.

Summary	The **Standing Financial Instructions (SFIs)** are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. The **Financial Scheme of Delegation (FSOD)** sets out the powers and financial levels of authority or the Board, its Committees and the Executive. The Board is asked to note that temporary changes to variable pay control (pay control panel) and non-pay expenditure (expenditure above £10k requires exec approval) have been introduced.

Previously considered by
The Audit Committee reviewed the SFIs and FSOD in December 2023. There were no changes to these documents.

Proposed Resolution	The Board of Directors is asked to approve the Standing Financial Instructions and Financial Scheme of Delegation.

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:	Catherine Hulme Associate Director of Finance – Financial Services	**Presented by:**	Annette Walker, Chief Finance Officer

Bolton
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

November 2022

CONTENTS

1.	**INTRODUCTION**	**Page 1**
1.1	Use and application	Page 1
1.2	Failure to comply	Page 1
1.3	The Role of the Board	Page 2
1.4	The Role of the Chief Executive	Page 2
1.5	The Role of the Director of Finance	Page 2
1.6	The Role of the Board and Employees	Page 3
2.	**AUDIT**	**Page 3**
2.1	Audit Committee	Page 3
2.2	Internal Audit	Page 3
2.3	External Audit	Page 4
2.4	Counter Fraud and Security Management	Page 5
2.5	Financial Reporting	Page 6
2.6	Scrutiny of Waivers and Registers	Page 6
2.7	Raising Concerns	Page 6
2.8	Access to Records and Information	Page 7
3.	**FINANCIAL PLANNING AND MANAGEMENT**	**Page 7**
3.1	Annual Financial Plans	Page 7
3.2	Delegation to Budget Holders	Page 7
3.3	Budgetary Control and Reporting	Page 8
3.4	Capital Planning	Page 8
4.	**ANNUAL ACCOUNTS AND REPORTS**	**Page 9**
5.	**BANK AND GBS ACCOUNTS**	**Page 9**
5.1	Operation of Accounts	Page 9
5.2	Banking Procedures	Page 9
5.3	Tendering and Review	Page 10
6.	**CONTRACTING AND INCOME**	**Page 10**
6.1	Contracting for Income	Page 10
6.2	Income	Page 10
6.3	Fees and Charges	Page 10
6.4	Debt Recovery	Page 11
6.5	Security of Cash, Cheques, Payable Orders	Page 11
7.	**TENDERING PROCEDURES**	**Page 11**
7.1	Compliance	Page 11
7.2	Formal Tendering	Page 12
7.3	Exceptions Where Formal Tendering Need Not Be Applied	Page 12
7.4	Tendering Procedures	Page 13
7.5	Financial Standing and Technical Competence	Page 13
8.	**PAY EXPENDITURE**	**Page 13**
8.1	Remuneration and Nomination Committee	Page 13
8.2	Funded Establishment	Page 13
8.3	Staff Appointments	Page 14
8.4	Payroll	Page 14
8.5	Contracts of Employment	Page 14

9.	**NON-PAY EXPENDITURE**	**Page 14**
9.1	Delegation of Authority	Page 14
9.2	Requisitioning of Goods and Services	Page 15
9.3	Payment of Invoices	Page 15
9.4	Expenditure Contracts	Page 15
9.5	Prepayments	Page 15
9.6	Official Orders	Page 15
9.7	Budget Holders	Page 15
10.	**EXTERNAL BORROWING AND INVESTMENTS**	**Page 16**
10.1	Borrowing and Public Dividend Capital	Page 16
10.2	Investments	Page 16
11.	**CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**	**Page 17**
11.1	Capital Investment	Page 17
11.2	Capital Asset Registers	Page 18
11.3	Security of Capital Assets	Page 18
12.	**STORES AND RECEIPT OF GOODS**	**Page 19**
12.1	General Position	Page 19
12.2	Control of Stores, Stocktaking, Condemnations and Disposal	Page 19
12.3	Goods Supplied by NHS Supply Chain	Page 19
13.	**DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**	**Page 20**
13.1	Disposals and Condemnations	Page 20
13.2	Losses and Special Payments	Page 20
14.	**INFORMATION TECHNOLOGY**	**Page 21**
15.	**PATIENTS' PROPERTY**	**Page 21**
16.	**CHARITABLE FUNDS (FUNDS HELD ON TRUST)**	**Page 22**
16.1	Corporate Trustee Arrangements	Page 22
16.2	Administration of Charitable Funds	Page 22
16.3	Accountability to Charity Commission	Page 22
16.4	Applicability of Standing Financial Instructions to Funds Held on Trust	Page 22
17.	**DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT**	**Page 22**
17.1	Policy	
17.2	Declaration of Interests	
17.3	Register of Interests	
18.	**RETENTION OF RECORDS**	**Page 23**
19.	**RISK MANAGEMENT AND INSURANCE**	**Page 23**
19.1	Risk Management	Page 23
19.2	Insurance	Page 23

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1.1 Use and Application

1.1.2 These Standing Financial Instructions are issued by the Board of Bolton NHS Foundation Trust (the Trust). They will have effect as if incorporated in the Standing Orders.

1.1.3 These Standing Financial Instructions detail the financial regulations adopted by the Trust. They are designed to ensure that financial matters are carried out in accordance with the law and relevant Government policy in order to achieve probity, accuracy, and value for money. The Standing Financial Instructions should be used in conjunction with the Financial Scheme of Delegation which sets out powers and financial limits of the Board, its Committees and the Executive.

1.1.4 These Standing Financial Instructions apply to all employees, agency, locum or temporary staff working for the Trust. They also apply to wholly owned subsidiaries, hosted functions and organisations and the Trust Charity unless separate arrangements have been agreed by the Board. Standing Financial Instructions do not provide detailed advice or policies and should therefore be used in conjunction with financial procedure notes.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought.

1.1.6 Wherever the title Chief Executive or Director of Finance is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them.

1.2 Failure to Comply

1.2.1 Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter.

1.2.2 Deliberate failure to comply with Standing Financial Instructions could constitute fraud or theft and result in criminal action being taken.

1.2.3 If for any reason these Standing Financial Instructions are not complied with, full details should be reported to the Director of Finance who will advise on the appropriate course of action. This will include deciding whether to report to the Audit Committee and/or the Board if the breach is significant.

1.2.4 All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.3 The Role of the Board

1.3.1 The Board exercises financial supervision and control by:-

(a) approving the financial strategy;

(b) approving of budgets within overall income;

(c) approving important financial policies and systems;

(d) approving the Financial Scheme of Delegation; and

(e) receiving regular assurance on financial strategy and performance.

1.4 The Role of the Chief Executive

1.4.1 The Chief Executive may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.4.2 By law, the Chief Executive of an NHS Foundation Trust is the Accounting Officer. The responsibilities of the Accounting Officer are contained in guidance issued by the Regulator and include the requirement to ensure that:-

(a) there is a high standard of financial management in the NHS Foundation Trust as a whole;

(b) there is efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation; and

(c) financial considerations are fully taken into account in decisions by the NHS Foundation Trust.

1.4.3 It is a duty of the Chief Executive to ensure that the Board and all employees understand their responsibilities within these Standing Financial Instructions.

1.5 The Role of the Director of Finance

1.5.1 The Director of Finance will carry out duties and responsibilities where delegated by the Chief Executive under these Standing Financial Instructions.

1.5.2 The Director of Finance may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.5.3 The Director of Finance is accountable for:-

(a) design and implementation of financial policies;

(b) maintaining an effective system of internal financial control;

(c) ensuring that sufficient financial records are maintained;

(d) the provision of strategic financial advice to the Board and employees; and

(f) the preparation and maintenance of accounts, certificates, estimates, records and reports as required.

1.6 The Role of the Board and Employees

1.6.1 The Board and employees must act in the interests of the Trust by:-

(a) avoiding loss of property and valuables;

(b) exercising economy and efficiency in the use of resources; and

(c) conforming with the requirements of these Standing Financial Instructions and the Financial Scheme of Delegation.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with the NHS Foundation Trust Code of Governance, the Board will formally establish an Audit Committee of non-executive directors.

2.1.2 The Board will satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 The Audit Committee will have clearly defined terms of reference and follow guidance from the NHS Audit Committee Handbook.

2.1.4 The Audit Committee will meet a minimum of four times a year.

2.2 Internal Audit

2.2.1 The Audit Committee will ensure that there is an effective internal audit function established by management that meets mandatory audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

2.2.2 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(a) an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives; and

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.2.3 The Head of Internal Audit will provide to the Audit Committee:-

(a) a risk-based plan of internal audit work, agreed with management and approved by the Audit Committee;

(b) regular updates on the progress against plan;

(c) reports of management's progress on the implementation of actions agreed as a result of internal audit findings;

(d) an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This opinion is used by the Board to inform the Annual Governance Statement; and

(e) additional reports as requested by the Audit Committee.

2.2.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.2.5 The Head of Internal Audit will be accountable to the Director of Finance.

2.2.6 The Director of Finance is responsible for ensuring that:-

(a) there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the accountable officer;

(c) an annual Internal Audit report is prepared for the consideration of the Audit Committee;

(d) an annual Internal Audit Plan is produced for consideration by the Audit Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year; and

(e) ensuring that a medium-term Internal Audit Plan (usually three years) is prepared for the consideration of the Audit Committee and the Board.

2.3 External Audit

2.3.1 The Audit Committee will review the findings of the external auditor and consider the implications and management responses.

2.3.2 In accordance with the relevant legal requirements the governors of the Trust appoint the External Auditor. The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council of Governors will need to ensure they have the skills and knowledge to choose the right External Auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the External Auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

2.3.3 The Audit Committee should make recommendations to the council of Governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

2.3.4 The Trust and the Council of Governors must ensure compliance with requirements of the relevant Acts as to who may be an auditor for an NHS Foundation Trust.

2.3.5 While the Council of Governors may be supported by the Audit Committee in running the process to appoint the external auditor, the Council of Governors must have ultimate oversight of the appointment process.

2.3.6 In appointing and monitoring the External Auditor, the Council of Governors should ensure that the audit firm and audit engagement leader have an established and demonstrable standing within the healthcare sector and are able to show a high level of experience and expertise.

2.3.7 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practice.

2.4 Counter Fraud, Corruption and Bribery and Security Management

2.4.1 The Audit Committee will satisfy itself that the organisation has adequate arrangements in place for countering fraud. NHS organisations must have appropriate counter fraud arrangements.

2.4.2 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

2.4.3 The Director of Finance will monitor and ensure compliance with the conditions of the NHS Contract Fraud Standards.

2.4.4 The Director of Finance is responsible for deciding at what stage to involve the police in cases of theft, fraud, misappropriation and any other irregularities.

2.4.5 The Director of Finance will appoint a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud, Corruption and Bribery Manual and guidance.

2.4.6 The Local Counter Fraud Specialist will report to the Director of Finance and will work with staff in NHS Protect in accordance with the NHS Fraud, Corruption and Bribery Manual.

2.4.7 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. A Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.4.8 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

2.4.9 The Act:-

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

2.4.10 The Trust will produce an annual statement to satisfy the compliance requirements of the Bribery Act.

2.4.11 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS Security Management.

2.4.12 The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Executive Director with lead responsibility for Security Management and a Local Security Management Specialist (LSMS).

2.4.13 The LSMS shall regularly report progress to each meeting of the Health and Safety Committee and upwards to the Trust Executive Committee at least quarterly.

2.5 Financial Reporting

2.5.1 The Audit Committee will assure the integrity of the annual financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.6 Scrutiny of Waivers and Registers

2.6.1 The Audit Committee will be responsible for:-

(a) scrutinising waivers approved by chief Executive and/or Director of Finance and approving waivers above £1m;

(b) scrutinising regular reports on losses and compensations; and

(c) scrutinising the registers of interests.

2.7 Raising Concerns

2.7.1 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, non-compliance with Standing Financial Instructions, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

2.7.2 The Audit Committee should review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action.

2.8 Access to Records and Information

2.8.1 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:-

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust; and

(d) explanations concerning any matter under investigation.

3. FINANCIAL PLANNING AND MANAGEMENT

3.1 Annual Financial Plans

3.1.1 Prior to the start of the financial year the Director of Finance will prepare and submit an annual financial plan for approval by the Board. The financial plan will:-

(a) reflect the Trust's annual plan in terms of developments, workforce, performance etc.;

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the context of available income;

(d) identify potential financial risks;

(e) include a cash flow forecast;

(f) identify an opening capital plan; and

(g) include details of the required level of cost improvement.

3.1.2 The financial plan will be submitted to the Regulator in the required format.

3.1.3 The Director of Finance will monitor financial performance against the plan and report to the Finance Committee and/or Board and the Regulator.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Delegation to Budget Holders

3.2.1 Budgets will be delegated in accordance with the Financial Scheme of Delegation.

3.2.2 Budget holders must ensure that plans are in place to prevent expenditure budgets from being exceeded.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the control of the Director of Finance unless virement is agreed.

3.2.4 Non-recurrent budgets should not be used to finance recurrent expenditure without the authority in writing of the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:-

(a) monthly financial reports to the Board and/or Finance Committee;

(b) timely and accurate financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from the budget or plan;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers;

(f) determination of budget control totals prior to the start of the financial year; and

(g) a requirement for a monthly report from Divisional Directors to provide an account of their financial performance and forecast outturn.

3.3.2 Budget Holders are responsible for ensuring that:-

(a) any overspending or reduction of income which cannot be met by an approved virement is not incurred;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised;

(c) no permanent employees are appointed without the approval of the Director of Finance other than those provided for within the available resources and manpower establishment as approved by the Board; and

(d) they take responsibility for the delivery of savings targets in accordance with the requirements of the annual plan.

3.4 Capital Planning

3.4.1 The Board will approve the capital plan as part of the overall financial plan prior to the start of the financial year.

3.4.2 The Board may delegate decision making to the Finance Committee and the Capital Revenue & Investment Group (CRIG) in line with the Financial Scheme of Delegation.

3.4.3 The Director of Finance will provide monthly reports to the Finance Committee monitoring progress against the capital plan.

4. ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Trust must prepare annual accounts in accordance with the requirements of the Regulator. The Director of Finance will make arrangements to:-

(a) prepare and submit annual accounts in accordance with the Regulator's requirements, accounting policies and generally accepted accounting practice;

(b) prepare and submit annual accounts to the Board and an audited summary to an annual members meeting convened by the Council of Governors; and

(c) lay a copy of the annual accounts before Parliament.

4.1.2 The annual report should include an Annual Governance Statement in accordance with the relevant requirements.

4.1.3 The annual accounts must be audited by the external auditor and be presented at the annual members' meeting.

4.1.4 The Trust will prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's requirements.

5. BANK AND GBS ACCOUNTS

5.1 Operation of Accounts

5.1.1 The Director of Finance is responsible for:-

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) ensuring separate bank accounts for charitable funds;

(c) ensuring accounts are not overdrawn except where arrangements have been made; and

(d) making arrangements for overdrafts if required.

5.1.2 All accounts will be held in the name of the Trust. No officer other than the Director of Finance will open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.2 Banking Procedures

5.2.1 Monies belonging to the Trust or its Charity must only be deposited in bank accounts authorised by the Director of Finance. All bank accounts must be in the name of the Trust or its Charity.

5.2.2 The Director of Finance will ensure that detailed procedures are in place for the operation of bank and GBS accounts.

5.2.3 The Director of Finance will advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3 Tendering and Review

5.3.1 The Director of Finance will ensure that banking arrangements are reviewed at regular intervals to ensure they reflect best practice and represent best value for money. This will be through local or national competitive tendering exercises.

6. CONTRACTING AND INCOME

6.1 Contracting for Income

6.1.1 The Director of Finance is responsible for negotiating, approving and signing contracts with CCGs and other NHS bodies.

6.1.2 The Trust will contract its services in line with either national tariff arrangements or local price agreements.

6.1.3 The Director of Finance will ensure that the appropriate contractual arrangements and documentation are in place for all services provided.

6.1.4 The Director of Finance will ensure that reports are produced detailing contract performance and income levels.

6.1.5 The Director of Finance will ensure the production of reports to show the profitability of services compared to income generated.

6.2 Income

6.2.1 The Director of Finance is responsible for designing and maintaining systems for recording, invoicing, collection and coding of income due.

6.2.2 Private patient and overseas visitors paying for their treatment, are required as far as possible, to make a pre-payment equal to the estimated cost of treatment prior to admission.

6.3 Fees and Charges

6.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges.

6.3.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is received, the Trust's policy on Standards of Business Conduct and Conflict of Interest must be followed.

6.3.3 All employees must inform the Director of Finance promptly of money due from agreements, including provision of services, leases, private patient undertakings and other transactions.

6.4 Debt Recovery

6.4.1 The Director of Finance is responsible for ensuring arrangements are in place to recover outstanding debt.

6.4.2 Where income is written off, this should be dealt with in accordance with losses procedures and reported to the Audit Committee.

6.4.3 All overpayments (including salary) should be recovered wherever possible.

6.5 Security of Cash, Cheques, Payable Orders

6.5.1 The Director of Finance is responsible for:-

(a) approving all means of officially acknowledging or recording cash, cheques and payable orders received;

(b) controlling stationery used for receipting funds;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash;

(d) authorisation and provision of safes or lockable cash boxes;

(e) ensuring that policies are in place for the operation of safes including key holding;

(f) systems and procedures for handling cash, postal orders and cheques; and

(g) authorising the use of charitable giving platforms such as Just Giving, Amazon Wish Lists etc and ensuring that there is appropriate oversight and monitoring.

6.5.2 Trust cash will not be used to cash private cheques or "I Owe You's" (IOUs).

6.5.3 All cheques, postal orders, cash etc., will be banked promptly and intact. This means that disbursements (payments) will not be made from cash received prior to banking.

6.5.4 The holders of safe keys will not accept unofficial funds or items for depositing in their safes.

6.5.5 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy & Response Plan& Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures. will comply with the requirements of the law and relevant national guidance and European law as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7. TENDERING PROCEDURES

7.1 Compliance

7.1.1 Trust will comply with the requirements of the law and relevant national guidance and contract regulations as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7.2 Formal Tendering

7.2.1 The Trust will ensure that a minimum of three competitive tenders are invited for:-

(a) the supply of goods, materials and manufactured articles;

(b) the receipt of services;

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) health care services supplied by non NHS providers.

7.3 Exceptions Where Formal Tendering Need Not Be Applied

7.3.1 Formal tendering procedures need not be applied:-

(a) where total estimated annual expenditure with a supplier is expected to be below £15k, at least one written quote is needed;

(b) where total estimated annual expenditure with a supplier is not expected to exceed £50k but is above £15k, a minimum of three written or electronic quotations must be obtained; or

(c) where a competitive process or direct award (where permissible) has been undertaken through a public sector framework agreement co-ordinated by the procurement team.

7.3.2 Formal tendering procedures **may be waived** in the following circumstances:-

(a) in very exceptional circumstances formal tendering procedures would not be practical;

(b) where the timescale genuinely precludes a competitive process; or

(c) where specialist goods/services are required and available from only one source.

7.3.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

7.3.4 All waivers with supporting reasons should be fully documented and approved by the Director of Finance or the Chief Executive and reviewed by the Audit Committee at each meeting.

7.3.5 Where contract expenditure subsequently breaches a tender threshold, advice from the procurement team will need to be sought and the matter reported to the Audit Committee.

7.4 Tendering Procedures

7.4.1 All invitations to tender will be compliant with the Trust procurement policies and procedures which ensure a full audit trail is maintained.

7.4.2 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Clarifications may be made regarding qualitative aspects of the tender prior to the award of a contract providing there is a full audit trail of communications and information relevant to all bidders and shared.

7.4.3 Contracts should be awarded based on achieving the best value for money, from both quality and cost perspectives.

7.4.4 Contracts should not be awarded if they exceed the budget allocated.

7.4.5 All tenders should be treated as confidential and should be retained for inspection.

7.4.6 The Director of Finance will ensure that a register of tenders is maintained.

7.5 Financial Standing and Technical Competence

7.5.1 The Director of Finance will ensure that procurement processes include the necessary checks on the financial standing, technical competence, legal and regulatory compliance and suitability of contractors/suppliers.

8. PAY EXPENDITURE

8.1 Remuneration and Nomination Committee

8.1.1 The Board will establish a Remuneration and Nomination Committee, with clearly defined terms of reference, specifying which posts and issues fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will report in writing to the Board the basis for its recommendations. The Board will use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

8.1.3 The Trust will remunerate the Chair and non-executive directors of the Board in accordance with resolutions of the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 Remuneration in terms and conditions of other employees will follow nationally negotiated settlements unless otherwise agreed by the Remuneration Committee.

8.2.3 The funded establishment of any department may not be varied except in accordance with the Financial Scheme of Delegation.

8.3 Staff Appointments

8.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration beyond the limit of their approved budget and funded establishment.

8.4 Payroll

8.4.1 The Director of Finance will arrange the provision of a payroll service and will be responsible for:-

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment;

(e) ensuring internal controls and audit review; and

(f) ensuring separation of duties.

8.4.2 Managers have responsibility for:-

(a) completing and submitting time records, termination forms and other notifications in accordance with agreed timetables; and

(b) notifying payroll if an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.

8.5 Contracts of Employment

8.5.1 The Director of People will have responsibility for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) making arrangements to deal with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis as part of the annual financial plan.

9.1.2 Authority to incur spend and enter into expenditure contracts will be set in accordance with the Financial Scheme of Delegation.

9.2 Requisitioning of Goods and Services

9.2.1 The requisitioner should use electronic catalogues for the procurement of goods or services. Where this is not possible the procurement team should be consulted to advise on the appropriate route to market.

9.3 Payment of Invoices

9.3.1 The Director of Finance will ensure arrangements are in place for prompt payment of invoices and claims. Payment of invoices will be in accordance with contract terms.

9.4 Expenditure contracts

9.4.1 Advice should be sought from the procurement team before signing expenditure contracts of any value. The 'value' of the contract is over its duration rather than per annum. Authority to sign contracts is set out in the Financial Scheme of Delegation.

9.5 Prepayments

9.5.1 Prepayments will only be permitted where this is normal commercial practice or provides a financial advantage to the Trust and the financial standing of the company has been assessed along with the associated financial risk.

9.5.2 In all cases the budget holder is responsible for ensuring that goods and services due under a prepayment contract are received.

9.6 Official Orders

9.6.1 Official orders must be used for all non pay expenditure and contracts unless there is an agreed exception approved by the procurement team. The Trust operates a no purchase order no pay policy. This means that there is no obligation to pay for supplies delivered or work carried out without a purchase order.

9.7 Budget Holders

9.7.1 Budget holders must adhere to the delegated limits specified in the Financial Scheme of Delegation.

9.7.2 Orders should not be issued to any supplier that has made an offer of gifts, reward or benefit to directors or employees, or has in any other way breached the Bribery Act (2010).

9.7.3 Requisitions/orders must not be placed where there is no budget or insufficient budget, unless authorised by the Director of Finance or the Chief Executive.

9.7.4 Verbal orders must only be issued very exceptionally and an official order must be obtained as soon as practically possible.

9.7.5 Orders must not be split to circumvent financial thresholds.

9.7.6 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

9.7.7 Changes to the list of employees and officers authorised to certify invoices will be notified to the Director of Finance.

9.7.8 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Director of Finance.

9.7.9 Petty cash records will be maintained in a form as determined by the Director of Finance.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1 Borrowing and Public Dividend Capital

10.1.1 All loans and overdrafts must be approved by the Board. Any draw-down against working capital facilities must be authorised by the Director of Finance and reported to the Board.

10.1.2 Draw down of Public Dividend Capital should be authorised in accordance with the Financial Scheme of Delegation.

10.1.3 The Trust will pay a dividend on its Public Dividend Capital at a rate determined by the Secretary of State.

10.1.4 The Director of Finance will report on loans, overdrafts and Public Dividend Capital to the Finance Committee.

10.1.5 The Director of Finance will prepare applications for loans and overdrafts for approval by the Finance Committee in accordance with the Regulator's requirements.

10.2 Investments

10.2.1 The Director of Finance will prepare a Treasury Management Policy which sets out the Trust's approach to cash management including investments for approval by the Board.

10.2.2 The Treasury Management Policy will seek to obtain competitive rates of interest with minimal exposure to risk.

10.2.3 Cash balances and investments must only be held by banking institutions approved by the Board as part of the Treasury Management Policy.

10.2.4 The Director of Finance is responsible for advising and reporting to the Finance Committee on any Treasury Management activities.

10.2.5 The Director of Finance will prepare detailed procedural instructions on the operation of Treasury Management activities.

11. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The Director of Finance:-

(a) will ensure that there is an adequate process in place for determining capital expenditure priorities;

(b) is responsible for ensuring that monitoring arrangements are in place for capital schemes and that budgets are adhered to;

(c) will put arrangements in place to manage the capital programme within the overall budget available; and

(d) will ensure that the capital investment is not undertaken without the necessary capital financing and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For all capital expenditure the Director of Finance will ensure that that a business case has been produced and approved in accordance with the Financial Scheme of Delegation.

11.1.3 The Director of Finance will assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.4 The approval of a capital plan will not constitute approval for expenditure on any scheme unless:

(a) the funding has been confirmed in the annual capital budget for the year;

(b) the cost of the scheme remains within the sum allocated whilst still delivering the benefits identified in the business case; and

(c) the supporting Business Case has been approved.

11.1.5 Where the forecast of costs of any scheme rises above the sum allocated in the capital budget, the Director of Finance must immediately be notified and an updated business case prepared for the Capital, Revenue and Investment Group approval.

11.1.6 Contractual commitments should not be entered into unless the scheme is approved.

11.1.7 Business cases requiring Board approval under the Financial Scheme of Delegation will be considered and scrutinised by the Finance Committee.

11.1.8 All business cases will be considered by the Capital, Revenue and Investment Group irrespective of the value and either approved or recommended for approval by the Finance Committee or Board according to the Financial Scheme of Delegation.

11.1.9 The Director of Finance will approve procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Capital Asset Registers

11.2.1 The Chief Executive is responsible for the maintenance of registers of capital assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Chief Executive is also responsible for the maintenance of a register identifying land and/or buildings owned or leased by the Trust.

11.2.3 Capital assets must not be sold, scrapped, or otherwise disposed of without prior approval of the Director of Finance. Their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The Director of Finance will approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.5 Capital assets will be valued and depreciated in accordance with current accounting and reporting standards.

11.3 Security of Capital Assets

11.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.3.2 Capital asset control procedures must be approved by the Director of Finance. This procedure will make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical location of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded; and

(f) identification and reporting of all costs associated with the retention of an asset.

11.3.3 All discrepancies revealed by verification of physical assets to fixed asset register will be notified to the Director of Finance.

11.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and employees in all disciplines to apply appropriate routine security practices in relation to NHS property. Any breach of security practices must be reported in accordance with agreed procedures.

11.3.5 Any theft, loss or damage to premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the Director of Finance.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Assets must not be used for private purposes unless agreed in advance by the Director of Finance.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores should be:

(a) kept to a minimum;

(b) subjected to annual stock take or a program of rolling stock takes and

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 The day-to-day responsibility for stock control is delegated to departmental employees and stores managers/keepers. The control of Pharmaceutical stocks is the responsibility of the Chief Pharmacist.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations will be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The Director of Finance will ensure systems are in place to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 The Director of Finance will ensure there are adequate checks on items in stores at least once a year.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 The Director of Finance will identify those authorised to requisition and accept goods from the store. The authorised person will check receipt against the delivery note and notify any discrepancies to Procurement who will pursue correction of delivery or a credit note.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 Land and buildings may not be sold or otherwise disposed of without the approval of the Board.

13.1.2 The Director of Finance must ensure procedures are in place for the disposal of assets.

13.1.3 When it is proposed to dispose of a Trust asset, the Head of Department or Divisional Director of Operations will liaise with Procurement and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 The method of all asset disposals will be recorded and confirmed by a countersignature authorised by the Director of Finance.

13.2 Losses and Special Payments

13.2.1 Any employee discovering a suspected fraud should report the matter to their line manager, Local NHS Counter Fraud Specialist or Director of Finance in accordance with the Fraud, Corruption and Bribery Policy.

13.2.2 Any employee discovering or suspecting any other loss or theft must immediately inform their head of department, security team and the Director of Finance.

13.2.3 Special payments e.g. payments not under legal obligation (or ex gratia) may only be made in line with the Financial Scheme of Delegation.

13.2.4 The Director of Finance will be authorised to take any necessary steps to safeguard against the impact of bankruptcies and company liquidations.

13.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

13.2.6 The Director of Finance will maintain a Losses and Special Payments Register.

13.2.7 All losses and special payments must be reported to the Audit Committee on a regular basis.

14. INFORMATION TECHNOLOGY

14.1.1 The Trust must comply with relevant legal and regulatory requirements in relation to IT and information.

14.1.2 The Trust will nominate one of the Executive Directors to act as the Senior Information Risk Officer (SIRO) to ensure controls over data entry, processing, storage, transmission and output to achieve security, privacy, accuracy, completeness, and timeliness.

14.1.3 The Senior Information Risk Officer (SIRO) will ensure that risks arising from the use of IT are identified and mitigated. This will include the preparation and testing of disaster recovery plans.

14.1.4 The Director of Finance will ensure that financial systems are implemented, developed and maintained to achieve accuracy and timeliness of data.

14.1.5 The Trust will publish and maintain a Freedom of Information (FOI) Publication Scheme.

14.1.6 The Trust IT strategy will be approved by the Board.

15. PATIENTS' PROPERTY

15.1.1 The Trust has a duty to provide safe keeping of money and other personal property belonging to patients.

15.1.2 The Trust will not accept responsibility or liability for patients' property unless it is handed in for safe keeping and a copy of an official patients' property record is obtained as a receipt.

15.1.3 The Director of Finance will ensure that procedures are in operation for the collection, recording, safekeeping and disposal of patients' property.

15.1.4 Where property of a deceased patient exceeds £5,000, the production of Probate or Letters of Administration will be required before release. Where the total value of the property is less than £5,000, this will be released to the next of kin provided forms of indemnity are obtained.

16. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

16.1 Corporate Trustee Arrangements

16.1.1 The Board is the Corporate Trustee of the Trust Charity which is responsible for the management of funds held on trust.

16.1.2 The Board's discharge of Corporate Trustee responsibilities is distinct from its responsibilities for exchequer funds. There must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

16.1.3 The Corporate Trustee may delegate functions as it determines to a Charitable Funds Committee subject to approved written terms of reference. The Board must receive and adopt the annual accounts of the Charity.

16.1.4 The Corporate Trustee will authorise the Chief Executive to make arrangements for the executive leadership and day to day running of the Charity.

16.1.5 The Director of Finance will approve the financial governance arrangements of the Charity.

16.2 Administration of Charitable Funds

16.2.1 The Director of Finance will oversee the preparation of the annual accounts and the annual audit.

16.3 Accountability to Charity Commission

16.3.1 The Corporate Trustee responsibilities must be discharged separately from the Board and full recognition given accountability to the Charity Commission for charitable funds.

16.4 Applicability of Standing Financial Instructions to Funds Held on Trust

16.4.1 The Charity will apply these Standing Financial Instructions where relevant. Any breaches will be notified to the Director of Finance and reported to the Charity Committee.

17. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT

17.1 Policy

17.1.1 The Director of Finance will ensure that all staff are made aware of the Trust policy on Managing Conflicts of Interest Standards of Business Conduct which includes guidance on a range of issues including gifts, outside employment and managing conflicts of interest. This policy will incorporate best practice guidance issued by the Regulator and will take effect as if incorporated into these Standing Financial Instructions.

17.2 Declaration of Interests

17.2.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes. Staff members will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

17.2.2 If a staff member comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any interest, direct or indirect, they must make a declaration.

17.2.3 If a staff member has any doubt about the relevance of an interest, this should be discussed with their line manager or the Director of Corporate Governance.

17.2.4 Staff should be asked to declare interests at the start of meetings and recorded in the minutes.

17.2.5 During the course of a meeting, if a conflict of interest arises, the staff member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

17.3 Register of Interests

17.3.1 The Director of Corporate Governance will ensure that all staff and governors are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

17.3.2 The Director of Corporate Governance will ensure that a Register of Interests is maintained to record formal declarations of interests of staff in accordance with the Trust policy.

17.3.3 The Register will be available to the public on request.

17.3.4 The Trust operates a zero tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Local Counter Fraud Specialist and/or the Director of Finance.

17.3.5 Gifts of cash and vouchers to staff should always be declined.

18. RETENTION OF RECORDS

18.1.1 The Chief Executive will be responsible for maintaining archives for all paper and digital records required to be retained in accordance with guidelines and the Trust's Record Management Policy.

19. RISK MANAGEMENT AND INSURANCE

19.1 Risk Management

19.1.1 The Chief Executive will ensure that risk management arrangements are in place in accordance with relevant requirements, which must be approved and monitored by the Board.

19.1.2 Risk management arrangements will be reported in the Annual Governance Statement within the Annual Report and Accounts.

19.2 Insurance

19.2.1 The Chief Executive will be responsible for ensuring adequate insurance cover is in place in accordance with risk management policy approved by the Board.

19.2.2 The Director of Finance should be notified of any changes to risks or property which require insurance.

19.2.3 The Director of Finance will ensure that insurance arrangements are regularly reviewed and provide the necessary assurances to the Finance Committee and / or Board.

19.2.4 The Director of Finance will authorise claims to be made and these will be reported to the Finance Committee and / or Board.

19.2.5 The Trust will insure for clinical negligence, employers' and public liability claims through the risk pooling schemes administered by the NHS Resolution.

FINANCIAL SCHEME OF DELEGATION

1. Financial Scheme of Delegation – Reservation of Financial Powers and Limits to Board, Committees and Directors

includes non-recoverable VAT

Trust Board The Board reserves to itself the following powers:-	**Committees** Powers reserved to specific Committees unless delegated:-	**Directors** Powers reserved to specific Directors:-
All financial powers emanate from the Board and are delegated according to this Scheme which is incorporated as part of the Trust's Standing Financial Instructions. This scheme can be amended by the Board as required. Powers Approval of the Standing Financial Instructions and Financial Scheme of Delegation Approval of business cases for capital schemes above **£2m** Approval of business cases for revenue expenditure and income impact above **£2m** per annum Approval of invoices and contract values (total life over the contract) above **£2m** Approval of working capital facilities and loans Approval of Annual Financial Plan Approval of Capital Programme and Annual Capital Budget Approval of sale or acquisition of land or buildings Approval of sale or disposal of items on the capital asset register above **£1m** Approval of demolition of buildings Approval of waiver of competition requirements over **£1m** Approval of ex gratia payments above **£100k** Approval of Annual Accounts / Annual Report The Board will authorise the appropriate Executive Director as signatories to execute its decisions e.g. contracts, invoices, requisitions. The Operational Director of Finance transacts items on behalf of the Board in the ledger system.	Audit Committee Approval of the appointment of Internal Auditor Approval of Internal & External Audit Plans Recommending the External Auditor appointment to the governors Scrutiny of the Annual Accounts / Annual Report Review of waivers of competition Review and scrutiny of losses and ex gratia payment registers Review of SFI breaches Finance Committee Approval of business cases for capital schemes up to **£2m** Approval of business cases for revenue expenditure or income impact up to **£2m** per annum Approval of invoices and contract values (total life over the contract) up to **£2m** Approval of the appointment of Measured Term Contractors Approval of the Treasury Management Policy Approval of ex gratia payments up to **£100k** Approval of waivers of competition requirements above **£250k and up to £1m** The Finance Committee will authorise the Director of Finance or other relevant officer as signatory to execute its decisions as appropriate Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Approval of sale or disposal of equipment on the capital asset register up to **£1m** Approval of requisitions, invoices and contract values (total life over the contract) up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events e.g. alcohol Remuneration Committee Approval of Executive Directors' Pay Awards and other variations to their terms and conditions of employment Approval non-contractual severance payments Approval of Pay and Terms and Conditions of senior managers on local pay arrangements Approval of significant variations to national Terms & Conditions	Chair Approval of Chief Executive travel expenses and study leave Chief Executive/Deputy Chief Executive Approval of travel expenses and study leave of Directors Chief Executive or Director of Finance Approval of capital or non-recurrent revenue spend up to **£100k** Approval of requisitions, invoices and contract values (total life over the contract) within approved budget up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events Director of Finance Final interpretation of Standing Financial Instructions Authorising the opening/closing of bank accounts Approval of financial procedures and financial signatories Authorisation of the use of charitable giving platforms, wish lists etc. Authorisation of the use of safes Approval of pricing strategies, fees and charges in relation to income Deciding when to involve the police in matters of fraud or theft Approval of financial systems and controls including cash handling Approval of sale or disposal of equipment on the capital asset register up to **£100k of the NBV** Approval of financial governance arrangements of charitable funds Approval of changes to the Financial Scheme of Delegation below **£50k** Approval of PDC draw down signatories Approval of insurance claims Access to records to progress financial investigations Deputy Chief Executive Assumes powers and limits in the absence of the Chief Executive Operational Director of Finance Assumes powers and limits in the absence of the Director of Finance Capital Revenue & Investment Group - sub group of Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Review of all capital business cases and capital expenditure

2. Financial Scheme of Delegation – Authorised Powers and Limits to the Executive including non-recoverable VAT

Executive Directors Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Deputy Director of Operations** **Divisional Directors of Operations** **Operational Director of Finance** **Deputy Director of Finance** Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Other Deputy Directors** **General Managers** **Professional Leads** Powers and Approval Limits within Departmental Approved Budget:	**Departmental Managers** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**Matrons** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**"Ward / Unit Managers" or equivalent** Powers and Approval Limits within Ward/Departmental/Unit Approved Budget:	**Non Budget Holding Manager** Powers and Approval Limits within Ward/Department/Unit Approved Budget:
Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets (not including overtime or internal bank hours) and scheduling of annual leave
Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£250k**	Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£50k** (Operational Director of Finance **£150k**)	Revenue or capital requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£10k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£2.5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£1k.**	
Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	
Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	
Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	
Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories		
Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget			
Recruitment to posts within pay budget	Recruitment to posts within pay budget	Recruitment to posts within pay budget				
Ex gratia payments up to **£5k**	Ex gratia payments up to **£5k**	Ex-gratia payments up to **£1k**				
Approval of changes to Directorate/Divisional Control Total	Approval of changes to Directorate/Divisional Control Total	<u>Chief Pharmacist</u> Drugs expenditure up to **£50k**				

3. Financial Scheme of Delegation – Financial Limits by Type of Approval (£) including non recoverable VAT

Type of Approval	Board	Finance Comm	Execs	CRIG	CEO	DoF	ED	DDOs	Other Deputy Directors	Dep't managers	Matrons	Ward managers
Approval of business cases for capital schemes	>2m	<2m	<1m	<1m	<100k	<100k						
Approval of business cases for revenue expenditure and income impact per annum	>2m	<2m	<1m	<1m	<100k Non rec	<100k Non rec						
Approval of invoices and contract values (total life over the contract) within approved budget	>2m	<2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of requisitions or orders within approved budget	>2m	>2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of sale or disposal of items on the capital asset register	>1m		<1m			<100k						
Approval of ex gratia payments	>100k	<100k	<50k		<50k	<50k	<50k	<5k	<1k			
Approval of waiver of competition requirements	>1m	<1m	<250k		<250k	<250k						
Changes to Financial Scheme of Delegation	>50k					<50K						

Key SFIs – breaches are reported to the Audit Committee

1.2.4	If you become aware of a breach of SFIs, then seek advice from the Director of Finance
3.2.4	Do not use one off monies to fund ongoing expenditure
5.1.2	Do not open a bank account in the name of Trust, only the Director of Finance can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Director of Finance
6.5.1	You must seek permission from the Director of Finance to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Director of Finance has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the Director of Finance
13.2.1	Suspected fraud must be reported to line management, Local Counter Fraud lead or the Director of Finance
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.4	Do not accept personal gifts of cash or vouchers

Report Title:	Board Standing Orders and Matters Reserved for the Board

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	

Purpose:	To provide assurance on the integrity and effectiveness of the Trust's governance processes.

Summary:	The Board Standing Orders are a set of rules and procedures that govern the operations of the Board, including the conduct of board meetings, decision-making processes, and the roles and responsibilities of board members and committees. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents and, where necessary, be familiar with the detailed provision. The Standing Orders fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. The Standing Orders were revised and approved by the Board in May 2023. Since then, a review has taken place and there are no proposed changes.

Previously considered by:
The Standing Orders were reviewed and endorsed by the Audit Committee at the meeting held on 6 December 2023.

Proposed Resolution	The Board of Directors is asked to **approve** the attached Standing Orders.

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

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Board of Directors
Standing Orders
January 2024

... for a better Bolton

STANDING ORDERS

November 2023

FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt a "Schedule of matters reserved" and a "Scheme of Delegation". Which, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

It is acknowledged within these Standing Orders and the Standing Financial Instructions of the Trust that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the Trust Board meets its obligation to perform its functions within the financial resources available.

P*rovisions within the Standing Orders which are not subject to suspension under SO 3.32 are indicated in italics.*

CONTENTS

FOREWORD

INTRODUCTION

Statutory Framework 1

Delegation of Powers 2

1. INTERPRETATION 3

2. THE BOARD OF DIRECTORS 5

Composition of the Board of Directors 5

Appointment of the Chair and Directors 5

Terms of Office of the Chair and Directors 5

Appointment of Deputy-Chair 6

Powers of Deputy-Chair 6

Joint Directors 6

3. MEETINGS OF THE BOARD OF DIRECTORS 7

Admission of the Public and Press 7

Calling Meetings 7

Notice of Meetings 7

Setting the Agenda 8

Chair of Meeting 8

Annual Public Meeting 8

Notices of Motion 8

Withdrawal of Motion or Amendments 8

Motion to Rescind a Resolution 8

Motions - right of reply 9

Chair's Ruling 9

Voting 9

Non-Voting Directors 10

Minutes 10

Joint Directors 10

Suspension of Standing Orders 11

Variation and Amendment of Standing Orders 11

Record of Attendance 11

Quorum 11

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION 13

Emergency Powers 13

Delegation to Committee 13

Delegation to Officers 13

5. COMMITTEES 14

Appointment of Committees 14

Confidentiality 15

6. DECLARATIONS OF INTEREST AND REGISTER OF INTEREST 16

Declaration of Interest 16

Register of Interests 17

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST 18

8. STANDARDS OF BUSINESS CONDUCT POLICY 20

Interest of Officers in Contracts 20

Canvassing of, and Recommendations by, Directors in Relation to Appointments 20

Relatives of Directors or Officers 20

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS 22

Custody of Seal 22

Sealing of Documents 22

Register of Sealing 22

10. SIGNATURE OF DOCUMENTS 23

11. MISCELLANEOUS 24

Standing Orders to be given to Directors and Officers 24

Review of Standing Orders 24

INTRODUCTION

Statutory Framework

Bolton NHS Foundation Trust (the Trust) is a Public Benefit Corporation which was established which came into existence on 1 October 2008 as Royal Bolton Hospital NHS Foundation Trust pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003. The name of the Trust was changed to Bolton NHS Foundation Trust in 2011.

The principal place of business of the Trust is:

Royal Bolton Hospital, Minerva Road, Bolton, BL4 0JR

The functions of the Trust are conferred by 2006 Act and the Trust will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The constitution requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. This document, together with Standing Financial Instructions (SFIs) and Scheme of Delegation set out the responsibilities of individuals.

Delegation of Powers

All business shall be conducted in the name of the Trust. The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any contrary provisions of the 2006 Act given effect by the Constitution.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Scheme of Reservation and Delegation of Powers'. Those powers which it has delegated to Directors are also contained in the Scheme of Reservation and Delegation of Powers.

1 INTERPRETATION

1.1 Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made thereunder or in paragraph 42 of the constitution shall have the same meaning in these Standing Orders and in addition:

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"COMMITTEE" shall mean a committee appointed by the Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

“CONSTITUTION” shall be the Constitution of Bolton NHS Foundation Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution.

Directors for the purpose of SO/SFI and Scheme of Delegation are those board members reporting directly to the Chief Executive.

"DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

The expression “the Chair of the Trust” shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

2 THE BOARD OF DIRECTORS

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in Trust shall be in the name of the Trust as corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has the functions conferred on it by the 2006 Act and its terms of authorisation.

2.4 Directors acting on behalf of the Trust as a corporate Trustee are acting as quasi-Trustees. Accountability for charitable funds held on Trust is to the Charity Commission. Accountability for non-charitable funds held on Trust is only to NHS England.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6 **Composition of the Board of Directors** - In accordance with the 2006 Act and the constitution, composition of the Board of Directors of the Trust shall be:

The Chair of the Trust

At least 5 non-executive directors

At least 5 executive directors including:

- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

The number of Executive Directors must not be greater than the number of Non-Executive Directors

2.7 **Appointment of the Chair and Directors** - *The Chair and non-executive directors are appointed in accordance with paragraph 21 of the constitution*

The Chair and Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years and may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

2.8 **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair and directors will be in accordance the constitution.

The Chair and Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to rigorous review and NHS England approval. Such appointments beyond six years shall be subject to annual re-appointment and external competition if recommended by the Board and approved by the Council of Governors.

Any re-appointment after the second term of office (irrespective of tenure duration), for the Chair and Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence.

2.9 Appointment of Deputy Chair

Subject to paragraph 22 of the constitution, the Council of Governors, on recommendation of the Trust Chair, may appoint a non-executive director to be Deputy Chair for such a period, not exceeding the remainder of his/her term as non-executive director of the Trust, as they may specify on appointing him/her.

Any non-executive director so appointed may at any time resign from the office of Deputy-Chair by giving notice in writing to the Chair and the Council of Governors may thereupon appoint another Non-Executive Director as Deputy-Chair in accordance with this Standing Order.

2.9A **Appointment of Senior Independent Director** – the Board of Directors shall, following consultation with the Council of Governors, appoint one of the non-executive directors to be the senior independent director and one of the non-executive directors to be the deputy senior independent director.

In accordance with a process to be agreed between the Chair and Council of Governors, the senior independent director will lead in the process for evaluating the performance of the Chair.

The senior independent director shall lead a meeting of the Non-Executive Directors at least annually without the Chair to evaluate the Chair's performance, as part of the process agreed with the Council of Governors for appraising the Chair.

The expression "senior independent director" shall be deemed to include the deputy senior independent director of the Trust if the senior independent director is absent from the meeting or is otherwise unavailable.

2.10 **Powers of Deputy Chair** - *Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.*

2.11 **Joint Directors** - *Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 2.6 as one person.*

3 MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Admission of the Public and Press** – The public shall be admitted to all formal meetings of the Board, but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

3.2 The Board may treat the need to receive or consider recommendations or advice from sources other than Directors, Committees or Sub-Committees of the Board as a special reason why publicity would be prejudicial to the public interest.

3.3 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner.

3.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5 *The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented, or if, the Chair does not call a meeting within seven days after such requisition has been presented,* at the Trust's Headquarters*, one third or more directors may forthwith call a meeting.*

3.6 **Notice of Meetings** - *Before each meeting of the Board of Directors, a notice of the meeting, shall be delivered to every director, at least three clear days before the meeting.*

3.8 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.9 Public notice of the time and place of any meeting of the Board (open to the public) will be posted on the Trust's web site at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. Such notice, together with a copy of the agenda, will be supplied, on request to the press.

3.10 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.11 A director desiring a matter to be included on an agenda should make this request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.12 **Chair of Meeting** - *At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they are present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.*

3.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.14 **Annual Public Meeting** - The Trust will publicise and hold an annual public meeting in accordance with the constitution and the Act.

3.15 **Notices of Motion** - A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.8.

3.16 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.17 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if considered appropriate.

3.18 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.19 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.20 **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final.

3.21 **Voting** - *Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.*

3.22 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.23 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.24 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.25 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.26 An officer who has been appointed formally by the Board of Directors to act up for an executive director will have the voting rights of that executive director. An officer attending the Board of Directors to represent an executive director without formal acting up status may not exercise the voting rights of the executive director.

3.27 **Non – Voting Directors** - Non Voting Directors are ones who Board members have determined should attend the Board in order to provide it with particular expertise on a continuing basis. They may be expected to attend some or all Board meeting whether held in public or private.

They will receive all board papers for agenda items against which their contributions are required. They will have the opportunity to participate in all board discussions but may not take part in any voting and may be excluded from any part of a Board meeting at the request of the Chair.

All matters discussed or witnessed by attendees shall be regarded as confidential to the board save for those where actions are agreed otherwise.

In order that they do not become liable for decisions made, the Chair will make clear that they are being invited to comment upon items for debate but not take part in any vote should one occur

3.28 **Minutes** - *The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting.*

3.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

3.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.31 **Joint Directors** - *Where a post of executive director is shared by more than one person:*

a) both persons shall be entitled to attend meetings of the Trust:

b) either of those persons shall be eligible to vote in the case of agreement between them:

c) in the case of disagreement between them no vote should be cast;

d) the presence of either or both of those persons shall count as one person for the purposes of SO 3.38 (Quorum).

3.32 **Suspension of Standing Orders** - Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least half (normally six) of the Board of Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.33 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.34 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

3.35 No formal business may be transacted while SOs are suspended.

3.36 The Audit Committee shall review every decision to suspend SOs.

3.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall not be revoked, varied or amended except upon:

a) A report to the Board by the Chief Executive or the Director of Corporate Governance acting on their behalf.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the Chair) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.38 **Record of Attendance** - *The names of the directors present at the meeting shall be recorded* in the minutes.

3.39 **Quorum** - *No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.*

3.40 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.41 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 , The Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by an executive director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or subcommittee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions to perform personally and shall nominate officers to undertake the remaining functions for which the CEO will still retain an accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance and Commissioning or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

5 COMMITTEES

5.1 **Appointment of Committees** - *The Board of Directors may appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust.*

5.2 *A committee appointed under SO 5.1 may, subject to such directions as may be given by the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee.*

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

5.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. .

5.7 Not used

5.8 The committees formally established by the Board of Directors are:

- Audit and Risk Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People Committee
- Nomination and Remuneration
- Strategy and Operations Committee
- Charitable Funds Committee

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Pursuant to paragraph 28 of the constitution, a register of Director's and Governor's interests must be kept by the Trust

6.1 **Declaration of Interests** - The constitution requires board directors (including for the purposes of this document Non-executive Directors) and Governors to declare interests, which are relevant and material. All existing board directors should declare relevant and material interests. Any board directors or governors appointed subsequently should do so on appointment or election.

6.2 All employees of the Trust who have a direct financial interest in a private company of any description which may be engaged in the provision of goods or services to the NHS, must declare that interest in in accordance with the "*Standards of Business Conduct Policy"* at the time of appointment or commencement of any such interest**.**

6.3 Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should include in the register are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of authority in a charity or voluntary organisation in the field of health and social care.
e) Any connection with a voluntary or other organisation contracting for NHS services.
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.4 If board directors or governors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Governance.

6.5 Any changes in interests should be declared at the next Board of Directors' meeting following the change. It is the obligation of the director or governor to inform the Director of Corporate Governance in writing within seven days of becoming aware of the existence of a relevant or material interest.

6.6 The names of directors holding directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.7 During the course of a Board of Directors meeting or a governor meeting, if a conflict of interest is established, the director or governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

6.8 Register of Interests - The details of directors' and governors' interests recorded in the Register will be reviewed on a quarterly basis by the Audit and Risk Committee.

6.9 In accordance with paragraph 30 of the constitution, the Register will be available for inspection. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

7 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 *Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they will at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

7.2 Not used.

7.3 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

7.4 *Any remuneration, compensation or allowances payable to a director by virtue of their position as a director of the Trust shall not be treated as a pecuniary interest for the purpose of this Standing Order.*

7.5 For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) *they or a close associate* of theirs, is a director of a company or other body, not being public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or*
b) *they or a close associate* of theirs is a business partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;.*

7.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) *of membership of a company or other body, with no beneficial interest in any securities of that company or other body;*
b) *of an interest in any company, body or person as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.*

7.7 *Where a director:*

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
c) if the share capital is of more than one class and the total nominal value of shares of any one class does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to the duty to disclose an interest.

7.8 Standing Order 7 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee as it applies to a director of the Trust.

For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:

- *Married persons and those in Civil partnerships or cohabiting. In which case, the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

8 STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** – The Trust has adopted a Standards of Business Policy and staff must comply with this guidance and guidance in the Bribery Act 2010. The following provisions should be read in conjunction with these documents.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare any other employment or business or other relationship of theirs or a close associate as previously defined, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9 Prior to acceptance of an appointment directors should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

8.11 Any Board member or member of staff who receives or is offered hospitality in excess of £50.00 must decline that hospitality and is required to enter the details of the hospitality in the Trust's Hospitality Register.

8.12 The Board recognise the offences set out in the Bribery Act:

- to give, promise or offer a bribe,
- to request, agree to receive or accept a bribe either in the UK or overseas
- A corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place in accordance with arrangements approved by the Board.

9.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board of Directors, a Board Committee or where the Board of Directors has delegated its powers.

9.3 On approval by the Board, or by the Chair or the Chief Executive under delegated powers, to a transaction in pursuance of which the Common Seal of the Board is required to be affixed to appropriate documents, shall be deemed also to convey authority for the use of the Common Seal.

9.4 Where approval to the sealing of a document has been given specifically in pursuance of a resolution of the Board or in accordance with Standing Order No.9.3 above, the Seal shall be affixed in the presence of the Chair, or other Officer duly authorised and an Executive Director of the Trust, and shall be attested by them.

9.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

10 SIGNATURE AND INSPECTION OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

10.3 A Director of the Board may for purposes of their duty as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, provided that the Director shall not knowingly inspect ore request a document relating to a matter in which they are professionally interested or in which they have directly or indirectly any pecuniary interest.

This Standing Order shall not preclude the Chief Executive from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

10.4 Nothing in the above paragraphs of this Standing Order 10 shall be interpreted as giving the right to Directors to have access to confidential patient records.

11 MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within the Standing Orders and SFIs.

11.2 **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Report Title:	Audit and Risk Committee Terms of Reference

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	25 January 2024		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Purpose	The purpose of this report is to present the revised Audit and Risk Committee Terms of Reference for ratification following annual review.

Summary:	The Audit and Risk Committee has overall responsibility for the establishment and maintenance of an effective system of internal control by means of independent and objective review of financial and corporate governance, and risk management arrangements, including compliance with statutory and regulatory rules governing the NHS. These Audit and Risk Committee Terms of Reference set the remit and responsibilities of the Committee and have been revised in line with HFMA Audit Committee Handbook. The Committee is a statutory committee with membership consisting of non-executive directors has been realigned and now includes within its remit, information governance and risk management.

Previously considered by:
The Terms of Reference were approved at the Audit Committee held on 06 December 2023

Proposed Resolution	The Board of Directors are asked to ratify the Audit Committee Terms of Reference and Annual Workplan

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

Terms of Reference Document Control Sheet

MEETING	Audit and Risk Committee
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER:	Director of Corporate Governance Chief Finance Officer
REVIEW:	December 2023
RELATED FORA **COMMITTEES /GROUPS:**	Board of Directors Council of Governors Finance and Investment Committee Quality Assurance Committee People Committee Risk Management Committee

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by Board**
Nov.23	Periodic revision of ToR, Committee responsibilities refreshed to reflect changes in relation to Risk Management and Information Governance	6 December 2023	

Terms of Reference of the Audit and Risk Committee

1. Authority

1.1 The Board of Bolton NHS FT hereby resolves to establish a Committee to be known as the Audit and Risk Committee ('the Committee')

1.2 The Committee is constituted as a standing committee of the Trust Board and operates within the Trust's Constitution, Standing Orders and Standing Financial Instructions.

1.3 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to seek any information it requires from any employee. All employees are directed to co-operate with any requests made by the committee.

1.4 The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1. The Committee has overall responsibility for the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

2.2. The Committee is responsible for reviewing the effectiveness and receiving assurance on the Trust's system of internal control, by means of independent and objective review of financial and corporate governance, risk management across the whole of the Trust's activities, and compliance with statutory and regulatory requirements.

3. Duties and Responsibilities

3.1. The Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities, including Integrated Facilities Management (iFM) the Trust's wholly owned subsidiary, both generally and in support of the statement of internal control.

3.2. In addition the Committee shall:

- Ensure independence of external and internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Committee; and
- Monitor corporate governance (e.g. compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests)

4. Principal Duties

In order to achieve its purpose, the Audit and Risk Committee will undertake duties which can be categorised as follows:

4.1. **Governance, Risk Management and Internal Control**

4.1.1. Review the establishment and maintenance of an effective system of governance, risk management and internal control, across the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives.

4.1.2. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority

4.1.3. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.1.4. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

4.2. **Internal Audit**

4.2.1. The Audit and Risk Committee shall ensure that there is an effective internal audit function established by management that meets mandatory *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors.

4.2.2. This will be achieved by:

- Considering the provision of the internal audit service, the costs involved and any questions of resignation and dismissal.
- Reviewing and approving the annual internal audit workplan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Ensuring that the internal audit function is adequately resourced and has appropriate experience and standing within the organisation.
- Overseeing the continuing independence of the internal auditor.
- Monitoring the effectiveness of internal audit and carrying out an annual review

4.3. **External Audit**

4.3.1. The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work.

4.3.2. This will be achieved by

- Considering the appointment and performance of the External Auditor, in accordance with the Trust specification for an external audit service, informed by *Code of Audit Practice published by the National Audit Office*.
- Discussing and agreeing with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan.
- Discussing with the External Auditors their local evaluation of audit risk and assessment of the Trust and associated impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance, (before submission to the Board and/or the Council of Governors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

4.4. **Other Assurance Functions**

4.4.1. The Audit and Risk Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, any reviews by the Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. NHS England, Care Quality Commission and NHS Resolution), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

4.4.2. The Committee shall have responsibility for :

- Scrutinising waivers approved by the Chief Executive and Chief Finance Officer and approving waivers of £250,000 - £1m
- Approving changes to the Trust's Standing Financial Instructions
- Receiving regular reports on losses and compensations and review the appropriateness thereof.
- Receiving regular reports on variations to terms and conditions of service and review the appropriateness thereof.

4.4.3. The Committee shall satisfy itself that there are adequate arrangements in place to manage the Register of Interests in line with the Managing Conflicts of Interests Policy and consider any breaches and action taken.

4.4.4. The Committee shall review every decision by the Council of Governors or the Board of Directors to suspend their respective Standing Orders.

4.4.5. The Committee shall satisfy itself that there are adequate arrangements in place to manage clinical and non-clinical Data Quality in line with the Trust's Data Quality Policy and other related policies.

4.5. **Counter Fraud**

4.5.1. The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.

4.5.2. In accordance with 3.2 of the *NHS Counter Fraud Authority's Fraud Commissioners Standards*, the Committee has:

'*Stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHS Counter Fraud Authority's quality assurance programme'*.

4.5.3. The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority

4.6. **Management**

4.6.1. The Audit Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.7. **Financial Reporting**

4.7.1. The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial position.

4.7.2. The Committee should ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.7.3. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas;
- significant adjustments resulting from the audit;
- Letter of representation
- Explanations of significant variances

4.8. **Information Governance**

4.8.1. To receive regular updates on IG compliance (including uptake and completion of data security training), data breaches and any related issues and risks.

4.8.2. To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security and Protection Toolkit and relevant reports and action plans.

4.8.3. To receive reports on audits to assess information and IT security arrangements, including the annual Data Security and Protection Toolkit.

4.8.4. To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

4.9. **Whistleblowing**

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently through the Trust's procedures eg Freedom to Speak Up Guardian or Local Counter Fraud Specialist.

5. Membership

5.1. The Committee will be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board.

5.2. At least one of the members of the Committee will have recent and relevant financial experience

5.3. The Chair of the Trust shall not be a member of the Committee.

6. Quorum

6.1. The quorum necessary for the transaction of business shall be two Non-Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

7. Attendance at Meetings

7.1. On invitation from the Chair of the Committee, meetings will normally be attended by the:

- Chief Finance Officer

- Commercial Director of Finance
- Associate Director of Finance
- External Auditors
- Internal Auditors
- Counter Fraud Specialist
- Director of Corporate Governance
- Director of Quality Governance
- Information Governance representative

7.2. The Accounting Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accounting Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

7.3. Other executive directors/managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

7.4. The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

7.5. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.6. If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. The Committee Chair will also be required to bring to the attention of the Chair or Chief Executive if they feel that lack of attendance has not enabled adequate discussion or decision making.

8. Reporting Arrangements

8.1. The Audit and Risk Committee will be accountable to the Board of Directors of Bolton NHS FT including matters within the scope of services provided by the subsidiary.

8.2. The Chair of the Committee shall produce a Chair's Report to draw the attention of the Board of Directors any issues that require disclosure to the full Board or require executive action

8.3. The Committee will refer to the other Committees of the Board matters deemed relevant for their attention and will also consider matters referred to it by other Board Committees.

8.4. The Audit and Risk Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and "embeddedness" of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC.

9. Frequency of Meetings

9.1. The group will meet no less than five times per year at appropriate times in the reporting and audit cycle.

9.2. The Trust Board, Accounting Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

9.3. At least once a year, the Committee will meet in private with the internal and external auditors.

10. Organisation

10.1. The agenda and papers for the meeting shall be distributed 4 days in advance of the meeting.

10.2. The Committee will be supported by the PA to the Chief Finance Officer, whose duties in this respect will include:

- Agreement of the agenda with Chair, Director of Finance and Director of Corporate Governance and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forwards

10.3. Minutes of the meeting will be approved by the committee members.

11. Review and Assessment of Performance and Effectiveness

11.1. These Terms of Reference will be reviewed annually or in light of changes in practice or legislation.

11.2. The Audit and Risk Committee will undertake an annual review of its performance against its annual work plan, in order to evaluate the achievement of its duties

Approved by: **Audit Committee**

Ratified by Board: [Date]

Date of approval: **6 December 2023**

Date for review: 30 November 2024