NHS Bolton NHS Foundation Trust

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1300 on Thursday 28 March 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB030/24	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm quorum*	*Verbal*	Chair	**13:00**
TB031/24	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*	CN + DoP	
CORE BUSINESS				
TB032/24	**Declaration of Interests** *Purpose: To record interests relating to items on the agenda.*	*Report + Verbal*	Chair	**13:15** (5 mins)
TB033/24	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the previous meeting held on 25 January 2024.*	*Report*	Chair	
TB034/24	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included on agenda, review outstanding and **approve** completed actions.*	*Report*	Chair	
TB035/24	**Chair's Update** *Purpose: To **receive** the update from the Chair*	*Verbal*	Chair	**13:20** (5 mins)
TB036/24	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report*	*Report*	CEO	**13:25** (10 mins)
STRATEGY AND PERFORMANCE				
TB037/24	**Operational Update (including dashboard)** *Purpose: To **receive** the Operational Update*	*Presentation*	COO	**13:35** (20 mins)

TB038/24	**Strategy Review and Update** *Purpose: To **receive** the Strategy review and Update*	*Report*	DoSDT	**13:55** (15 mins)
TB039/24	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	SoC Chair	**14:10** (5 mins)
TB040/24	**Operational Plan** *Purpose: To **approve** the Operational Plan*	*Report*	CFO	**14:15** (10 mins)
QUALITY AND SAFETY				
TB041/24	**Quality Assurance Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	QAC Chair	**14:25** (5 mins)
TB042/24	**Quality Account Objectives** *Purpose: To **receive** the Quality Account Objectives*	*Report*	Chief Nurse	**14:30** (10 mins)
TB043/24	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme*	*Report*	Chief Nurse	**14:40** (10 mins)
TB044/24	**Mortality Report** *Purpose: To **receive** the Morality Report*	*Report*	Medical Director	**14:50** (10 mins)
TB045/24	**Learning from Deaths Report** *Purpose: To **receive** the Learning from Deaths Report*	*Report*	Medical Director	**15:00** (10 mins)
WORKFORCE				
TB046/24	**People Committee Chair's Report**	*Report*	PC Chair	**15:10** (05 mins)

*Purpose: To **receive** assurance on work delegated to the Committee*

COMFORT BREAK **15:05**

FINANCE

TB047/24	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	F&I Chair	**15:20** (05 mins)
TB048/24	**Financial Controls Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	FCC Chair	**15:25** (05 mins)
TB049/24	**Charitable Funds Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	CFC Chair	**15:30** (05 mins)

GOVERNANCE AND RISK

TB050/24	**Audit Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the Committee*	*Report*	*AC Chair*	**15:35** (05 mins)
TB051/24	**Board Assurance Framework** *Purpose: **To approve** the Board Assurance Framework*	Report	DCG	**15:40** (10 mins)
TB052/24	**Fit and Proper Declaration** *Purpose: To **approve** the Fit and Proper Declaration*	Report	DCG	**15:50** (10 mins)
TB053/24	**Anti-Slavery Statement** *Purpose: To **approve** the Anti-Slavery Statement*	Report	DCG	**16:00** (05 mins)
TB054/24	**Feedback from Board Walkabouts** *Purpose: to **note** the feedback following the Non-Executive Walkabouts*	*Verbal*	*All*	**16:05** (10 mins)

CONSENT AGENDA				
TB055/24	**Gender Pay Gap Report** *Purpose: To **receive** the Gender Pay Gap Report*	*Report*	DoP	**16:15**
CONCLUDING BUSINESS				
TB056/24	**Questions to the Board** *Purpose: To discuss and respond to any questions received from the members of the public*	*Verbal*	*Chair*	**16:15** (02 mins)
TB057/24	**Messages from the Board** *Purpose: To agree messages from the Board to be shared with all staff*	*Verbal*	*Chair*	**16:17** (03 mins)
TB058/24	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16:20**
	Date and time of next meeting: Thursday 30 May 2024			**16:30** **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
Tosca **Fairchild**	Non-Executive Director	Chief of Staff – South East London Integrated Care Board	Financial Interest
		Trustee – South East London ICB Charity	Non-Financial Professional Interest
		Client Executive (Consultancy) – Bale Crocker Associates	Financial Interest
		Partner is Consultant in Emergency Care / Deputy Medical Director – University Hospitals of Derby NHS Foundation Trust	Non-Financial Interest
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest
		Director, Harriss Interim and Advisory	Financial Interest
		Family member works for Astra Zeneca	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	
James **Mawrey**	Chief People Officer / Deputy CEO	Trustee at Stammer	Non-Financial Personal Interest
Jackie **Njoroge**	Non-Executive Director	Director – Salford University	Financial Interest
		Deputy Chair HESPA (non-remunerated position)	Non-Financial Professional Interest
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		The Foundation Trust Network (Trustee NHS Providers)	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
		Egerton Pre School Committee Chair	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Chair – Atlas BFH Management Ltd (wholly owned subsidiary of Blackpool NHS FT)	Financial Interest
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	
Sharon **White**	Director of Strategy	Trustee at Fort Alice Bolton	Non-Financial Professional Interest
		Trustee George House Trust	Non-Financial Professional Interest
		Judge on She Inspire Awards	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

NHS Bolton NHS Foundation Trust

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

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

Types of Interests:

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

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

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

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

***Draft* Board of Directors Minutes of the Meeting**
Held in the Boardroom
Thursday 25 January 2024
(Subject to the approval of the Board of Directors on 28 March 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
Jackie Njoroge	JN	Non-Executive Director
James Mawrey	JM	Director of People and Deputy CEO
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
Tosca Fairchild	TF	Non-Executive Director
Tyrone Roberts	TR	Chief Nurse

In Attendance

Name	Initials	Title
Carolyn Williams	CW	Consultant Clinical Scientist/Clinical Lead for Laboratory Medicine (for item 002)
Cassie Hesketh	CH	Healthcare Science Practitioner (for item 002)
Janet Cotton	JC	Director of Midwifery (for item 013)
Nadia Ali-Ross	NAR	Clinical Lead for Obstetrics and Gynaecology (for item 013)
Rachel Carter	RC	Associate Director of Communications and Engagement
Victoria Crompton	VC	Corporate Governance Manager

There were six observers in attendance.

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB001/24	**Chair's Welcome and Note of Apologies**	
	The Chair welcomed everyone to the meeting of the Board and introduced Tosca Fairchild, Non-Executive Director who was attending her first Board of Directors meeting since commencing in office. Apologies for absence were noted from Fiona Taylor.	
TB002/24	**Patient and Staff Story**	
	The Chief Nurse introduced Carolyn Williams, Consultant Clinical Scientist and Clinical Lead for Laboratory Medicine and Cassie Hesketh, Healthcare Science Practitioner who would be presenting the patient and staff stories.	

	CW presented the pregnancy story of Tina and Jay and how healthcare scientists were involved from the very start of their patient journey by providing pre-conception fertility testing to the couple. During pregnancy healthcare scientists were involved in pregnancy screening and also conducted placental function blood tests when Tina complained of headache and had raised blood pressure at 32 weeks. These tests indicated a chance of pre-eclampsia and at 33 weeks Tina delivered baby Sam who spent time in the Neonatal Unit where his condition was monitored. An infection was noted and it was queried whether this was meningitis. A CSF sample was sent for Biofire analysis and a result produced in less than two hours. Tina and Sam could then be discharged home when both were ready. The story highlighted the importance of the healthcare scientist's role within a patient's journey and how the results provided were key in urgent treatment decisions.	
	Staff Story CH advised she worked in the Antenatal Screening Department who provided screening for 50 sites whilst ensuring results were received in a timely manner and accurate. The importance of this was evidenced when a pregnant lady was called for a test re-check which led to her becoming extremely distressed, therefore in order to save any further upset to the patient the department worked to provide the test results within one hour. CH acknowledged that despite the role not being patient facing, it was important to remember there was always a patient at the end of the pathway. CW advised that the department employed 10 whole time equivalents (WTE) and commenced screening for Greater Manchester (GM) and Lancashire in the early 2000's, which developed further and led to the team providing a nationwide service including completing second trimester testing for Scotland. SW queried whether the laboratory medicine role was showcased in schools and colleges, to encourage children to consider a job role within laboratories. CW advised that engagement events are conducted with local universities the team would like to undertake more engagement events with younger students, but there was minimal resource available within the team to complete this work. AS asked whether the department had mitigations in place in case of equipment failure. CH explained the Trust had three analysers and in the event of a major issue laboratory staff could undertake testing from other hospitals. Finally, FA commented the innovation and research completed by the team in laboratory medicine was worthy of highlighting and the work of the department should be celebrated. **RESOLVED:** The Board of Directors ***received*** the patient and staff story.	

TB003/24	**Declarations of Interest**	
	There were no declarations relating to agenda items.	
TB004/24	**Minutes of the previous meetings**	
	The Board of Directors reviewed the minutes of the meeting held on 30 November 2023 and approved them as a correct and accurate record of proceedings subject to the following amendment: Tosca Fairchild was shown as apologies, but had not yet commenced in post. **RESOLVED:** The Board of Directors ***approved*** the minutes from the meeting held 30 November 2023, subject to the amendments.	
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		
TB006/24	**Chair's Update**	
	The Chair commented on the significant pressures which faced the Trust and commended staff who had taken all of the necessary actions to ensure the safety of patients. Despite the financial issues within Greater Manchester (GM) the work completed by staff within the organisation had made a real improvement on the financial position. **RESOLVED:** The Board of Directors ***received*** the Chair's Update.	
TB007/24	**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: • Disability History Month took place between 16 November and 16 December 2023, enabling the Trust to highlight the progress made towards inclusivity for colleagues with disabilities, long-term health conditions and neurodivergence. • Progress with the Our Voice Change Programme continued with the formation of five change teams to define measurable outcomes and implement changes that would make the biggest difference to staff.	

	• Alongside other NHS organisations in GM, the Trust continued to operate in a period of financial recovery and improvement to address the significant deficit across the region. • Since identifying reinforced autoclaved aerated concrete (RAAC) on the hospital site the necessary actions had been undertaken to ensure staff, patients and visitors remained safe whilst on Trust premises. • The new theatres officially opened on 15 January 2024 and the Community Diagnostic Centre was progressing well and remained on track to open on 18 March 2024. The Institute of Medical Sciences, remained on course to open for the next educational year in September 2024. An initiative between the Trust and care homes across the town has seen a significant reduction in the number of people arriving at the hospital. The pilot 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. FN added that the Institute of Medical Sciences building would be handed over to the University of Bolton, in February 2024 for the first fit and at that point there would be further details on what would be included the building. JN commented it would be beneficial to provide an update at a future Board of Directors on the Admission Avoidance Pilot.	
FT/24/01	Admission Avoidance Pilot Update to be brought back to Board of Directors	**RW**
	RESOLVED: The Board of Directors ***received*** the Chief Executive's Report.	
TB008/24	**2024/25 Operational Planning**	
	The Director of Strategy, Digital and Transformation delivered the presentation advising that whilst the 2024/25 Operational Planning guidance was yet to be published, GM Integrated Care Board (ICB) had published a set of provisional assumptions for performance modelling. Internal preparation for this began in October 2023, the Trust had affirmed its ability to meet all but two of the 11 GM assumptions by March 2025. These were: • Zero 52 week waits – this was related to the extent of the backlog, the impact of industrial action and the balance of achieving activity targets vs financial balance. The discovery of RAAC had further put the achievement at risk. • 80% A&E four hours – the organisation was expected to improve the position, but to close the gap would be challenging.	

	The Operational Plan submission to NHS England would be completed at a GM level and the Trusts activity, finance and workforce returns would be developed in partnership with GM ICB (Bolton), to ensure local system oversight, where appropriate. A draft timeline was received by GM on 19 January 2024, but this was subject to change following release of the national guidance. AS queried the implications of submitting a 'no' response to two of the assumptions. SW advised that although there were no implications, GM as a whole were putting themselves under pressure to achieve all of the assumptions as they related to good patient care. **RESOLVED:** The Board of Directors ***received*** the 2024/25 Operational Planning.	
TB009/24	**Operational Update**	
	The Chief Operating Officer reported on the Trust's operational performance, highlighting the following issues: • The winter season posed significant challenges due to , IPC measures concerning flu, Covid-19 and norovirus alongside the added complexity of industrial action and the identification of Reinforced Autoclaved Aerated Concrete (RAAC) • Ambulance handover performance under 15 minutes remained a challenge although this was shown to be common cause variation. The same applied for ambulance handovers within 60 minutes which provided a clear indication of the pressure the organisation was under. • The Urgent Treatment Centre opened in November 2023, type three attendances had been fairly consistent since the opening unfortunately performance was not as required as the Trust were aiming to achieve at least 93% within four hours through the center. • The four hour performance for December was 56.8% against the revised plan of 58%. The submitted plan for January was 68% and unfortunately the Trust was a significant distance away from that at around 55%. • 12 hour performance continued to track the same as the GM position. However, the Trust remained around 2% worse than GM, which was due to congestion in the department and bed availability. • Industrial action had a negative impact on elective recovery progress, the revised planning submission was to have no patients waiting more than 78 weeks by the end of March and no more than 557 patients waiting more than 65 weeks in March. The Trust was not on track to achieve these targets and had a deteriorating position for both. • The Trust continued to achieve 28 day faster diagnosis standard for patients on a cancer pathway. This was due to robust planning and the great work of clinical teams, MDT coordinators and everyone involved in cancer pathways. • Performance against the new 62 day standard, remained on track to be achieved.	

	TF queried whether there were any incidents as a result of the delayed ambulance handovers and wait times in the Emergency Department. RW advised that when there were delays staff worked to mitigate and balance any risks to patients, but at times the department had been overwhelmed. A proportion of patient who had experienced delays were mental health patients and were the responsibility of the trust when on site and are cared for appropriately. TF asked how delays to the elective recovery plan were impacting patients. RW explained there was a small cohort of patients who had been waiting over 18 months for treatment and the Trust continued to take actions to improve the elective recovery position. The Trust was in a similar position to other organisations within GM. RG queried when the Emergency Care Improvement Support Team (ECIST) report would be received. RW confirmed ECIST had completed a two day diagnostic and the report was expected in February. In response to a query from SH, RW advised the Trust was already challenged despite the periods of industrial action and therefore it was difficult to predict what the position would be should these have not taken place. The pressures seen in the Emergency Department were due to usual winter pressures and not linked to industrial action. FN commented the pressures which had been faced by the Trust had been relentless, but it was important to recognise that staff had continued to provide compassionate care to patients. **RESOLVED:** The Board of Directors ***received*** the Operational Update	
TB010/24	**Integrated Performance Report**	
	The Director of Workforce/Deputy Chief Executive introduced the Integrated Performance Report from December 2023. The report included the change to the national cancer indicator set which now focussed on the 28 day faster diagnosis standard, the 31 day general treatment standard and the 62 day general standard. The Chief Nurse advised there continued to be a special cause improvement rate for category three pressure ulcers, and there had been zero category four pressure ulcers. Quality could be improved if same sex accommodation breaches were reduced and clinical correspondence for inpatients and outpatients was improved. The Medical Director advised that HSMR and SHMI had been maintained below the mean and complaints timeliness had also been maintained. Quality could be improved if antenatal books at 12+6 had reliability in performance. The Director of Workforce stated there had been a significant reduction in agency spend and it was expected the Trust would meet the forecasted spend for 2023/24.	

	Workforce could be improved if there was stronger oversight of medical staffing and if the high level of HCA vacancies were filled. The Chief Finance Officer advised the forecasted revenue position was on track to deliver a better than planned deficit and the capital spend was ahead of plan. The Cost Improvement Programme (CIP) was forecast to be fully delivered, but it would be better if CIP was recurrently identified. AW added that the main focus was to bring the revenue position back within plan and the Trust had been challenged to improve the forecast by a further £2m. Discussions were also being held with GM regarding funding for the required work on RAAC. SC queried the Clostridium Difficile rates which were out of comparison with other GM organisations. TR confirmed the Trust tracked higher than GM and the North West for C Difficile, but there was increased oversight on this. One of the key challenges for the trust was the timely isolation of patients. JN commented the key performance indicator relating to the number of staff who would recommend the Trust for treatment was on a declining trend. JM confirmed this would be updated and the latest NHS Staff Survey results would be presented once the embargo had been lifted. He added the first iteration of the new Cultural Dashboard would be presented to the People Committee in March. In response to a query from RG, AW advised there was a slightly improved position with regard to productivity. The organisation was not seeing improvements as quickly as other organisations and the reasons behind this were quite complex. Board members agreed the new IPR presentation was beneficial, and JM commented there was still work required to bring the Operational Update and IPR presentation together. JN stated the operational update covered the key areas which the Board needed to be appraised of, but the Board pack, however, did not always represent the good discussions and challenge which was held at the sub-committee meetings. **RESOLVED:** The Board of Directors ***received*** the Integrated Performance Report	
TB011/24	**Strategy and Operations Committee Chair Report**	
	The Chair of the Strategy and Operations Committee presented the report from the meeting held on 18 December 2023 and provided a verbal update from the meeting held on 22 January 2024, the key points highlighted were: • The planned go live date for Maternity EPR would not be achievable without posing increased clinical risk to the service, it was proposed the go-live date be moved to May/June 2024. • The Business Intelligence Team had strengthened internal architecture and improved efficiency and productivity which included bringing the Commissioning Data Set translation in-house, which would speed up production, save time, allow for easier cross matching of data and give the	

	Trust full control over the timeline. The organisation would be one of only a handful of Trusts across the country who were able to do this in-house. • The committee received oversight of the CQC actions which related to its portfolio. Assurance was received on the actions being undertaken against the three strategy and digital recommendations. • The implementation of the six neighbourhood's model in Bolton had progressed significantly with neighbourhood leads appointed. It was anticipated the deadline of implementing all six neighbourhoods would be met. **RESOLVED:** The Board of Directors ***received*** the Strategy and Operations Committee	
TB012/24	**Quality Assurance Committee Chair's Report**	
	Seth Crofts presented the Chair Report from the meeting held on 20 December 2023. The Safeguarding Adult, Children and Looked After Children Annual Report 2022/23 was highlighted as there were challenges around statutory posts and an increase in demand. Six monthly interim reports had been requested for assurance and to provide an opportunity to request additional support. **RESOLVED:** The Board of Directors **received** the Quality Assurance Committee Chair's Report.	
TB013/24	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year Five Update (CNST)**	
	The Director of Midwifery and Clinical Director for Obstetrics and Gynaecology presented the report which provided assurance that the maternity service has attained all recommendations defined within the ten safety actions of the CNST year 5 maternity incentive scheme. The key highlights: • Verification of all evidence used to inform the position was undertaken by the Director of Midwifery and Director of Clinical Governance on the 09 January 2023. • Assurance 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. • A quarterly review of the evidence relating to Safety Action 6 undertaken by an LMNS panel in January 2024, and the service attained an overall compliance score of 97%. • The report provided assurance that the service had not received any external reports that may contradict the maternity incentive scheme declaration and confirmed the final position has been shared with commissioners prior to submission to the Trust Board. The report confirmed that compliance with all requirements of the CNST year 5 maternity incentive scheme could be evidenced in accordance with the requirements detailed in the declaration form. The Board were 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. The Board thanked the whole team and in particular the Director of Midwifery for the transformation of the department and the achievement of the year five CNST. RG commented that the Board were grateful for the transparency over the last 12 months and asked what the ambition was going forward. JC advised that the baseline had been risen over the last 12 months and the team would continue to build on that momentum. The aim going forward was to achieve year six of the CNST, reinstate Ingleside Birth Centre and continue to recruit to full establishment within the service. AS queried whether there would be further scrutiny from the LMNS as the organisation had gone from only achieving three standards to ten. JC advised that the LMNS had supported the organisation over the last 12 months and the Trust had already requested external validation to ensure complete compliance and transparency. In response to TF's query regarding the level of confidence in achieving the amber rated actions, the action plan. JC advised the action plan would continue to be monitored by the Quality Assurance Committee and any concerns would be escalated via that committee. JN queried whether there was any best practice that could be shared across the organisation. JC advised that retaining vigilance of all workstreams was imperative with adequate governance oversight and any learning would be shared at professional forum. FA commented that GM had an ambition to reduce still births and asked what needs to happen to reduce. JC advised the organisation has implemented the Saving Babies Lives Version Three bundle which is a bundle to reduce perinatal mortality. To date the service has implemented 97% of the elements with further work ongoing and this should have an impact on outcomes in the medium to longer term. TF asked how the Trust was assured that women with a BAME origin did not have a high mortality rate. JC advised that there had been one case of indirect maternal death within the service within the last year in a women that was not of BAME origin and when a recent review of still births was undertaken the results concluded that the highest rates of still birth were in those patients of a white origin. JC acknowledged the sample reviewed in the stillbirth review was only small (19 cases) adding that the Trust would be working with towards the implementation of the equity and equality measures as per LMNS strategy to improve outcomes for BAME women. **RESOLVED:** The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.	

TB014/24	**People Committee Chair Report**	
	Alan Stuttard, Non-Executive Director presented the Chair Report from the meeting held on 19 December 2023 and highlighted the key points. The Chair of the People Committee presented the report from the meeting held on 16 January 2024 advising that in December 2023 agency spend had reduced by £41k and was on a clear downward trajectory. The committee had also discussed the Our Voice Change Programme and the measures of success. **RESOLVED:** The Board of Directors ***received*** the People Committee Chair Report.	
TB015/24	**Finance and Investment Committee Chair Report**	
	The Chair of the Finance and Investment Committee presented the Chair Report from the meeting held on 22 November 2023 and provided a verbal update from the meeting held on 24 January 2024. It was noted that the Trust were maintaining the trajectory to meet the targets set by GM. **RESOLVED:** The Board of Directors ***received*** the Finance and Investment Committee Chair Report.	
TB016/24	**Financial Controls Committee Chair Report**	
	The Chair of the Financial Controls Committee presented the reports from the meetings held on 22 November and 13 December 2023, the key points were highlighted. **RESOLVED:** The Board of Directors ***received*** the Financial Controls Committee Report.	
TB017/24	**Charitable Funds Committee Chair Report**	
	The Chair of the Charitable Funds Committee introduced the Our Bolton NHS Charity Video which was shared with members of the Board. The video had been funded by the NHS Charities Together development grant. The Charitable Funds Committee Chair also presented the report from the meeting held on 04 December 2023, highlighting the charity's fund balance totalled £1,098k at 31 October 2023. Work continued to streamline the call on funds, which stood at £209k. **RESOLVED:** The Board of Directors ***received*** the Charitable Funds Committee Chair Report.	

TB018/24	**Our Bolton NHS Charity Annual Report and Accounts for year ending 31 March 2023**	
	The Director of Strategy, Digital and Transformation advised the Our Bolton NHS Charity Annual Report and Accounts described the structure, governance and management of the Charity; provided a breakdown of income and expenditure; outlined some of the key priorities for 2023/24 and set out the financial position for the year ending 31 March 2023. The annual report and accounts would be submitted to the Charity Commission by the deadline of 31 January 2024. **RESOLVED:** The Board of Directors ***received*** the Our Bolton NHS Charity Annual Report and Accounts for year ending 31 March 2023.	
TB019/24	**Audit Committee Chair Report**	
	The Chair of the Audit Committee presented the Chair Report from the meeting held on 06 December 2023, the following key points were highlighted: • The Freedom to Speak Up (FTSU) and Patient Safety and Incident Response Framework (PSIRF) audit reports had been completed and both were rated as substantial assurance. • The Audit Committee Terms of Reference (TOR) had been updated with two main changes to note. It was also proposed the committee be retitled the Audit and Risk Committee. The TOR were approved subject to minor amendments. • A significant issue had been raised regarding the iFM Statutory Accounts for 2022/23 in respect of the deferred tax asset. AW commented that the issue had been discussed in the Finance and Investment Committee who had agreed a potential way forward and a further meeting would be held with KPMG to discuss. **RESOLVED:** The Board of Directors ***received*** the Audit Committee Chair Report.	
TB020/24	**Board Workplan**	
	The Director of Corporate Governance presented the 2024 Board Arrangements and Workplan advising the Board of Directors agenda would be drawn from the Workplan and would be reflective of the changes in the national and local issues from a strategic, quality, performance and assurance perspective. It was noted there were had been some minor changes to the draft Workplan following submission in that the Infection Prevention and Control and Health and Safety Annual Reports would be delivered at the end of quarter one.	

	TF queried that a number of items highlighted as being 'to receive" and commented it was important to consider the role of the Board to ensure discharging duties correctly. **RESOLVED:** The Board of Directors ***received*** the Board Workplan.	
TB021/24	**Committee Effectiveness Report**	
	The Director of Corporate Governance presented the report advising an annual committee effectiveness review was undertaken in November 2023, to ensure the committees were demonstrating good governance and identifying areas of improvement. The report reflected the key points which arose from the reviews and sought to inform the planned discussions by the Board of Directors of the committee performance and provide assurance on the efficacy of the committees. **RESOLVED:** The Board of Directors ***received*** the Committee Effectiveness Report.	
TB022/24	**Feedback from Board Walkabouts**	
	SC advised he had visited the Emergency Department, SDEC and the Urgent Treatment Centre, all of which were very busy. The staff were working tirelessly and the Trust Chaplain was also there to support them. RG stated she had visited the Critical Care Unit, ward C1, cardiac rehab and the cardiac investigation unit. The staff were amazing and worked together well. MN advised that he had visited the maternity department who were moving to G Block due to the identification of RAAC within maternity. The staff commented the areas within G Block were better and the move had provided them with an opportunity to consider how they could reconfigure their usual ward. **RESOLVED:** The Board of Directors ***received*** the Feedback from Board walkabouts.	
TB023/24	**Safeguarding Adult, Children and Looked After Children Annual Report 2022/23**	
	The Chief Nurse presented the report advising there were no significant changes to statutory requirements for safeguarding during this timeframe. The Trust continued to work to the same legislation and statutory frameworks guidance. 2022/23 had seen challenges in both the children and adults safeguarding teams with an increase in the volume and complexity of safeguarding work. The ability to deliver on the statutory responsibilities had been challenging and there were some areas of concern with regards to capacity to deliver.	

	AS queried the organisation being in breach of its statutory responsibilities against the NHSE safeguarding assurance framework for three key posts. TR advised that was in relation to the three statutory posts and temporary mitigations were in place which were monitored by the Safeguarding Committee. A business case would be presented to the Capital Revenue and Investment Group in February to request additional investment in these key posts. **RESOLVED:** The Board of Directors ***approved*** the Safeguarding Adult, Children and Looked After Children Annual Report 2022/23.	
TB024/24	**Standing Financial Instructions and Scheme of Delegation**	
	The Chief Finance Officer presented the report and asked Board members to note that temporary changes to variable pay control (Pay Control Panel) and non-pay expenditure (expenditure above £10k requires exec approval) had been introduced. **RESOLVED:** The Board of Directors ***approved*** the Standing Financial Instructions and Scheme of Delegation.	
TB025/24	**Standing Orders**	
	The Director of Corporate Governance presented the report advising that the Standing Orders were revised and approved by the Board in May 2023. Since then, a review had taken place and there were no proposed changes. **RESOLVED:** The Board of Directors ***approved*** the Standing Orders.	
TB026/24	**Audit and Risk Committee Terms of Reference**	
	The Director of Corporate Governance presented the Audit and Risk Committee Terms of Reference which had been revised following annual review. The Terms of Reference had been approved at the Audit Committee on 06 December 2023. **RESOLVED:** The Board of Directors ***approved*** the Audit and Risk Committee terms of Reference.	
CONCLUDING BUSINESS		
TB027/24	**Questions to the Board**	
	None.	

TB028/24	**Messages from the Board**	
	The following key messages from the Board were agreed: • Acknowledged the hard work and dedication of staff during challenging times. • CNST • Opening of new theatres	
TB029/24	**Any Other Business**	
	There being no other business, the chair thanked all for attending and brought the meeting to a close at 16:30. The next Board of Directors meeting will be held on Thursday 28 March 2024.	

Meeting Attendance 2024						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓					
Fiona Noden	✓					
Francis Andrews	✓					
James Mawrey	✓					
Tyrone Roberts	✓					
Annette Walker	✓					
Rae Wheatcroft	✓					
Sharon White	✓					
Rebecca Ganz	✓					
Jackie Njoroge	✓					
Martin North	✓					
Alan Stuttard	✓					
Sean Harriss	✓					
Fiona Taylor	**A**					
Seth Crofts	✓					
Tosca Fairchild	✓					
In Attendance						
Sharon Katema	✓					
✓ = In attendance	A = Apologies					

November 2023 Actions

Code	Date	Context	Action	Who	Due	Comments
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	Board Development Sesssion 29 February 2024
FT/23/10	20/11/2023	Feedback from Board Walkabouts	SK to consider how themes from walkabouts could be captured.	SK	Mar-24	A new feedback form has been developed which will be used following all walkabouts to ensure consistency. This will be captured as part of the wider cultural dashboard.
FT/24/01	25/01/2024	Chief Executive Report	Admission Avoidance Pilot Update to be brought back to Board of Directors	RW	Mar-24	Update included in March 2024 Operational Update

Key

Report Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Fiona Noden		Decision	

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

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

Previously considered by:
N/A

Proposed Resolution	The Board is asked to **receive** the Chief Executive's report

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

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

Ambition 1
Provide safe, high quality care

Our urgent and emergency care services continue to operate under considerable pressure and this is affecting our ability to provide timely care to our patients and their loved ones. In line with other NHS organisations across the country, we are working towards ensuring that 76% of our patients are either admitted, transferred, or discharged within four hours of their arrival to our Emergency Department (ED). Unfortunately, we are not on track to deliver this performance standard by the end of March, but have plans in place to improve our performance during 2024/25.

We have established the Urgent Care Improvement Group to expedite the recommendations made by the clinically led national NHS Emergency Care Improvement Support Team (ECIST), following their review of our services. The newly formed group comprises representatives from the Trust and across the Bolton locality, to increase our shared focus on areas including care outside of the ED, acute medicine and same day emergency care (SDEC), flow through our wards and discharge.

In response to an outbreak of measles in other areas of the country, we have put plans in place to support our staff and the public in the event of cases more locally. Our 0-19 immunisation and vaccinations team have been running extra sessions in local schools, offering the opportunity for children who have not been vaccinated to take up the opportunity. Our Occupational Health Team are running daily vaccine clinics for MMR (Measles, Mumps, and Rubella) to help create a healthy working environment for all our staff, and to prevent the spread of contagious disease.

One of our complex care wards has trialed a new inclusive finger food menu, designed specifically for people who are living with conditions such as dementia, to allow them to maintain their nutritional intake without a time limit. The new menu is available upon request for patients across the hospital thanks to a collaboration between the iFM catering colleagues, our Speech and Language Therapy team and Senior Admiral Nurse.

Bereaved parents and families attended our Baby Remembrance Service on Sunday 17th March 2024. The annual event, held at the Bridge Church, is an opportunity for people to come together and remember the lives of babies who are sadly no longer with us. The service included multi-faith prayers and readings, as well as poems and music to support reflection.

Our community midwives have been delivering information sessions at Ingleside Birth and Community Centre to enable parents to make informed choices about their birth. The sessions are open to the public and include insight from parents who have recently given birth at home, based on their lived experiences.

On 9th February the findings of the Care Quality Commission's latest national maternity survey was published and captured what people using maternity services in 2023 felt about the care they received. The survey is designed to build an understanding of maternity care and highlights women's views on all aspects of their journey from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby.

We have already made improvements to our postnatal environment to improve the care provided after birth, which has been well received by families and we will continue to listen and make improvements based on our service user's feedback.

Ambition 2
To be a great place to work

Our NHS staff survey results have now been published and can be found here. Some of the results confirm to us that we have more work to do when it comes to things like fair career progression, feeling safe to raise concerns and people feeling burnout or emotionally exhausted.

The immeasurable sense of teamwork we see and feel in Bolton every single day is reflected in some of the feedback. In particular, the strong personal attachment our staff feel to their team and the support they get from their line managers.

Our results reflect a decrease in the number of staff who would recommend our organisation as a place to work or receive treatment and we are giving this our urgent attention to understand more and address this as a priority.

We want our organisation to be the one where every single person has a good experience. To enable this aspiration we have started a series of engagement sessions for colleagues to discuss the future actions that we will need to put in place through the Our Voice Change Programme.

Inspirational women across the Trust shared stories about their careers in healthcare to mark International Women's Day. Each year individuals and organisations mark the day to celebrate women's achievements, raise awareness about discrimination, and take action to drive gender parity. The theme for 2024 was 'Inspire Inclusion', which called on everyone to create a better world with a sense of belonging, relevance and empowerment.

Healthcare staff are in a privileged position to help women and girls make informed decisions about their health and inspire others to consider a career where they can make a difference in the lives of others.

Our apprentices shared their stories during National Apprenticeship Week in celebration of the work the Trust is doing to develop a skilled and diverse workforce. We currently have more than 180 employees taking part in apprenticeship qualifications which range from Level 2 (GCSE) to Level 7 (Degree).

The invaluable work of our healthcare scientists was highlighted this month during Healthcare Science Week. Healthcare science strives to improve patient outcomes by using science, engineering and technology to prevent, diagnose and treat many different medical conditions.

We have 143 scientists working across a range of specialties, including audiology, cardio-respiratory, and laboratory medicine. The week gave us an opportunity to raise awareness internally and showcase the range of job roles on offer in Bolton.

Waheeda Abbas, our Specialist Liaison Midwife and Lead Midwife at North West Genomic Medicine Service Alliance, was awarded the Silver Chief Midwifery Officer Award for her significant and outstanding contribution in everyday work.

Waheeda was nominated for developing a midwifery network across the North West to share the value of genomics across their wider workforce communities. Genomics is the study of the genes in our DNA, and Waheeda's remit has been to educate midwives across the North West about using genomics and its benefits in current medicine.

Our Divisional Director vacancies have now been appointed to, with interim arrangements in place until post holders are able to take up their roles on a substantive basis:

- Ryan Calderbank has moved over to his new role in our Adult Acute Division.
- Steph Clarke will be joining our Diagnostics and Support Services Division.
- Alex Cottrell will be taking up the role in Anesthetics and Surgical Services Division.
- Michelle Cox remains in post for our Family Care Division.

A new Divisional Director has been appointed for our Integrated Community Services Division and we look forward to welcoming Mike Chew who will be joining us from Blackpool Teaching Hospitals NHS Foundation Trust in May.

Ana Freitas has been appointed as our new Chief Pharmacist and is look looking forward to collaborating with colleagues across Bolton to contribute to the well-being of our community.

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 in across the region.

NHS Greater Manchester colleagues are in the process of developing an annual plan for 2024/25 which will be overseen by Chief Executives, Place Based Leads and NHS GM Chief Officers.

The plan will ensure there is a clear collaborative approach to recovery; and a longer-term plan to move as swiftly as possible into long-term sustainability, recover performance standards, and improve population health.

Our Financial Improvement Group (FIG) continues to oversee the programmes of work that will enable us to continue to improve our financial position, with Executive leadership and representation from all divisions and corporate services coming together weekly to plan how these savings will be met. The group continues to proactively identify areas for efficiency, without compromising patient quality or safety.

From this month, patients and visitors attending the Royal Bolton Hospital site will experience a slight increase to the amount they will need to pay for parking. We have tried to keep the increase as low as possible and will continue to offer free parking for blue badge holders, cancer patients, relatives of end of life patients, parents/carers of children admitted overnight and relatives of critically ill patients admitted long term. We have managed to preserve the cost for our monthly pass for people who attend our hospital site on a regular basis.

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

In February, the Department of Health and Social Care and NHS England updated their published list of Trusts who have on boarded onto the national RAAC programme. The list has increased from 42 to 55 sites, including Royal Bolton Hospital site.

As part of our ongoing action to address the reinforced autoclaved aerated concrete (RAAC) on our hospital site, we continue to undertake inspections and daily monitoring of the props in the affected areas. The majority of our maternity and women's healthcare services have now been relocated from M Block, with just one ward remaining in this area until it is operationally possible to move.

Our new theatres are officially open and in use for our inpatient and day case adult patients. Day case surgeries includes ear nose and throat, oral, urology and general specialities. The first three patients treated in the new centre had surgery for breast cancer, ear, nose and throat surgery and oral surgery. As well as the four new theatres, two integrated wards have also been built as part of the development.

Construction work on the brand new Community Diagnostic Centre (CDC) for people in Bolton is now complete. Once the centre is fully operational, thousands of people will benefit from quicker and easier access to vital tests and scans to help diagnose and treat a range of conditions sooner.

Around 80,000 diagnostic tests will be carried out each year, ranging from phlebotomy and fibroscan to MRI and X-ray, to support patients on elective care journeys and those referred for cancer diagnosis. The first patients to be treated have shared their feedback about the new facilities, and the difference the centre will make to our communities.

Ambition 5
To integrate care

Our neighbourhood teams will be fully co-located in their new areas and operational soon after the Easter bank holiday.

Each of the six neighbourhoods will have a designated team lead in place, whose role will be to coordinate activity across each neighbourhood, including multi-disciplinary team meetings and partnership working. They will be responsible for relationship building and developing collaboration within their neighbourhood, to ensure the delivery of its vision and long-term strategy.

Throughout March the teams have been getting together for a series of meet and greet events, which has been an opportunity for leads to meet the different professionals who will form their teams and understand more about how they will connect.

Once the neighbourhoods are up and running they will be hosting partnership events in each area, which will be an opportunity for the wider partners within the Bolton locality to come together and understand each other's parts of the jigsaw and how we can work together better for Bolton people.

The updated Locality Plan for Bolton has been shared with partners across the system, and is representative of everyone's feedback so that the final plan is reflective of our shared goals. The plan articulates our six strategic aims, developed with colleagues in the system and Bolton communities, which will shape our future delivery plans. The final document will be implemented from 1st April, and will be used to guide partners over the next five years and beyond.

Ambition 6
To develop partnerships

This month to mark the beginning of the holy month of Ramadan, our equality, diversity and inclusion lead Rahila Ahmed shared her insightful reflections and personal experiences with our staff. Our clinical colleagues and chaplains have also been sharing advice for staying healthy and well during Ramadan.

Through our partners, the Bolton Council of Mosques (BCOM), we have arranged for the breaking of the fast with donated dates, fruit and water for those who may need to attend hospital. We also held an open iftar event at the hospital, to give colleagues the opportunity to celebrate Ramadan together, and encourage people from all faiths to learn more about Ramadan.

We hosted our first non-medical research and genomics conference for all health, care and voluntary, community and social enterprise (VCSE) colleagues across Bolton. During the last twelve months, we recruited 2087 people to join 55 different research studies and aim to build on this, to better support the needs of our communities. Throughout the day attendees heard from some inspirational speakers and case studies about the many ways research improves patient care and outcomes and there was a shared commitment to further build research into our every day practice.

Parents in Bolton with babies that were born early or had difficulties around birth are being invited to take part in a new study that is aiming to find out if a nutritional supplement can help child development. Our researchers have recently joined the DOLFIN study (Developmental Outcomes of Long-term Feed Supplementation in Neonates), which looks at whether the food supplement helps with how children think, communicate and play.

A community of women in Bolton called the Ladies Empowerment Circle has raised more than £4,000 in the last twelve months for the Trust's official charity partner, Our Bolton NHS Charity. Through a range of fundraising including a fashion show, NHS 75 raffle, a Christmas lunch and shopping event donations to Breast Services have been used to fund a new patient garden at the front of the Evergreen Unit, post-surgery bras for woman who have had a mastectomy, and a series of information videos designed to improve patient understanding before treatment.

Our Breast Unit is trialling new animated videos to improve patient information about surgical procedures for breast cancer. Funded by Our Bolton NHS Charity, the twelve-month trial will provide patients with access to online videos by 'explain my procedure', which explain different breast operations, their benefits and risks, and any alternative management options. The animations are not meant to replace communication between patients and their medical team, but to be an additional information tool for patients to use at home.

Each year, an average of 450 patients are diagnosed with breast cancer at Bolton Breast Unit and undergo mastectomy (removal of the breast) or wide local excision (removal of part of the breast). The animations will play an important role in ensuring patients and their families have the information they need to fully under understand their treatment options.

Bolton Wanderers fans benefitted from a host of cancer advice and information at the Toughsheet Stadium, thanks to a Bolton-wide collaboration of organisations who want to 'tackle cancer together'. Supporting organisations included the Trust, Bolton GP Federation, Bolton Wanderers in the Community, Bolton Macmillan Cancer and Support Services, Bolton Hospice and Healthwatch Bolton. The event aimed to build awareness of cancer screening programmes, provide opportunities for fans to access information and support, and offer free health checks.

The winning designs for our NHS 75 children's artwork competition have been revealed as part of the organisation's celebrations for the historic milestone. Primary school-aged children across Bolton sent in more than 150 entries to say 'thank you' to the NHS and the thousands of our staff who provide care to the town's communities. Designs included landscape paintings of Royal Bolton Hospital, portraits of some of our nursing staff, and picture collages of what the NHS means to Bolton's young people. The competition was so tough that judges were unable to settle on only one winner and after careful consideration chose six winners to have their incredible designs displayed at the hospital for people to enjoy for years to come.

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	✓
Exec Sponsor	James Mawrey, Deputy Chief Executive/Director of People		Decision	

Purpose:	To present the Month 11 Integrated Performance Report

Summary:	The Integrated Performance report provides an overview of the Trust's performance in February 2024, against the reported metrics. The narrative describes issues that are affecting performance and any mitigating actions to improve performance.

Previously considered by:	This report was previously discussed at Divisional Integrated Performance Meetings.

Proposed Resolution	The Board of Directors are asked to receive the Integrated Performance 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:	Liza Scanlon (BI)	**Presented by:**	James Mawrey, Deputy Chief Executive/Director of People

Bolton NHS Foundation Trust

Integrated Performance Report

February 2024

Guide to Statistical Process Control

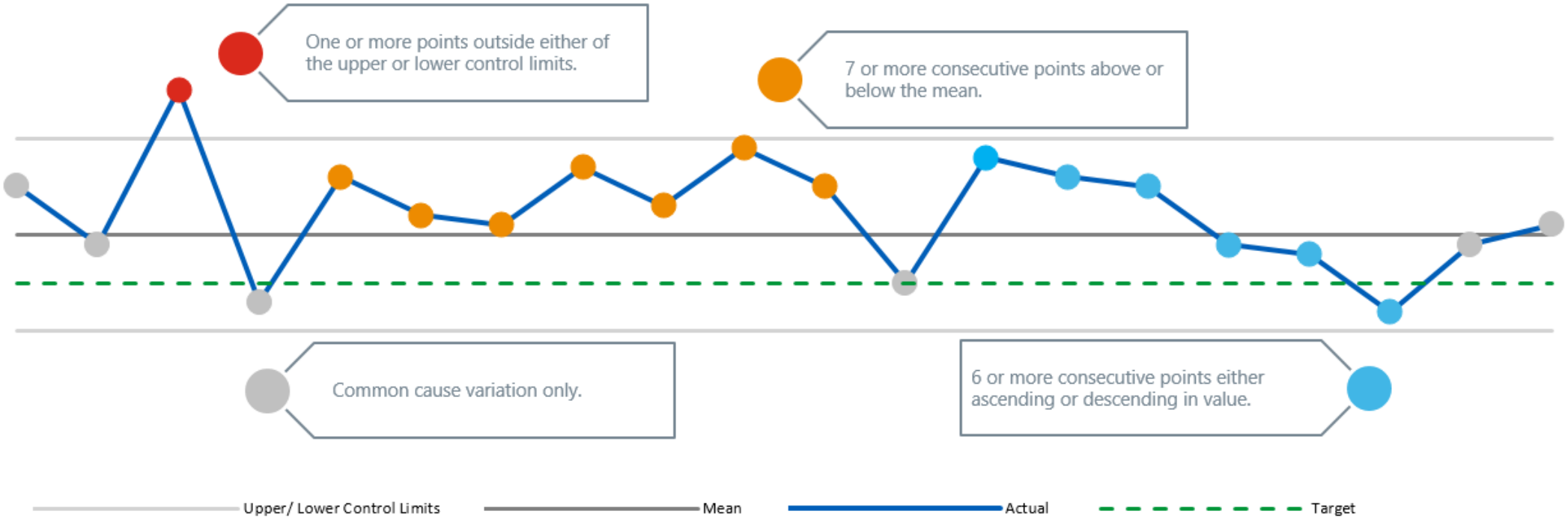
NHS Bolton NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	5	3	0	0	2	3	11
Infection Prevention and Control	7	0	2	1	0	0	0	7
Mortality	5	1	0	0	1	0	0	3
Patient Experience	12	4	0	0	0	2	0	14
Maternity	8	0	0	0	1	1	0	8
Operational Performance								
Urgent Care	5	0	1	2	3	2	5	4
Elective Care	8	0	3	3	1	1	6	5
Cancer	0	1	0	0	0	0	0	1
Community Care	4	0	0	0	1	0	2	3
Workforce								
Sickness, Vacancy and Turnover	3	0	1	0	0	0	2	1
Organisational Development	1	4	0	0	1	1	2	3
Agency	0	0	2	1	0	0	0	3
Finance								
Finance	2	0	0	0	1	0	0	3
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

Pressure Ulcers

There has been a reduction in category 2 pressure ulcers in month with the review of these now being led by the divisions through the PSIRF framework.

There have been no reported unstageable, category 3 or category 4 pressure ulcers acquired in hospital.

Following after action reviews, the category 3 pressure ulcer reported as hospital acquired in month 10 has been identified to have developed after discharge and will therefore be removed from these figures. In addition, one of the unstageable pressure ulcers reported in month 10 was identified as developing after discharge from hospital and will also be removed from the data.

Learning from pressure ulcer ulcers in the community continues through the PSIRF process, with no significant learning identified.

Falls

Falls per 1000 bed days remains below target and within normal variation.

Falls with harm continue to be investigated via the PSIRF framework with further work to be undertaken regarding how learning is disseminated across divisions.

	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%	97.9%	Feb-24	H	>= 95%	97.9%	Jan-24	>= 95%	97.9%	?
9 - Never Events	= 0	0	Feb-24		= 0	0	Jan-24	= 0	2	?
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.79	Feb-24	L	<= 5.30	3.46	Jan-24	<= 5.30	3.92	?
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Feb-24		<= 1.6	0	Jan-24	<= 17.6	16	?
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	10.0	Feb-24		<= 6.0	13.0	Jan-24	<= 66.0	143.0	?
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Feb-24		<= 0.5	1.0	Jan-24	<= 5.5	1.0	?
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Feb-24	L	= 0.0	0.0	Jan-24	= 0.0	2.0	?
515 - Acute Inpatients acquiring pressure damage (unstagable)		0	Feb-24			3	Jan-24		41	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	6.0	Feb-24		<= 7.0	8.0	Jan-24	<= 77.0	109.0	?

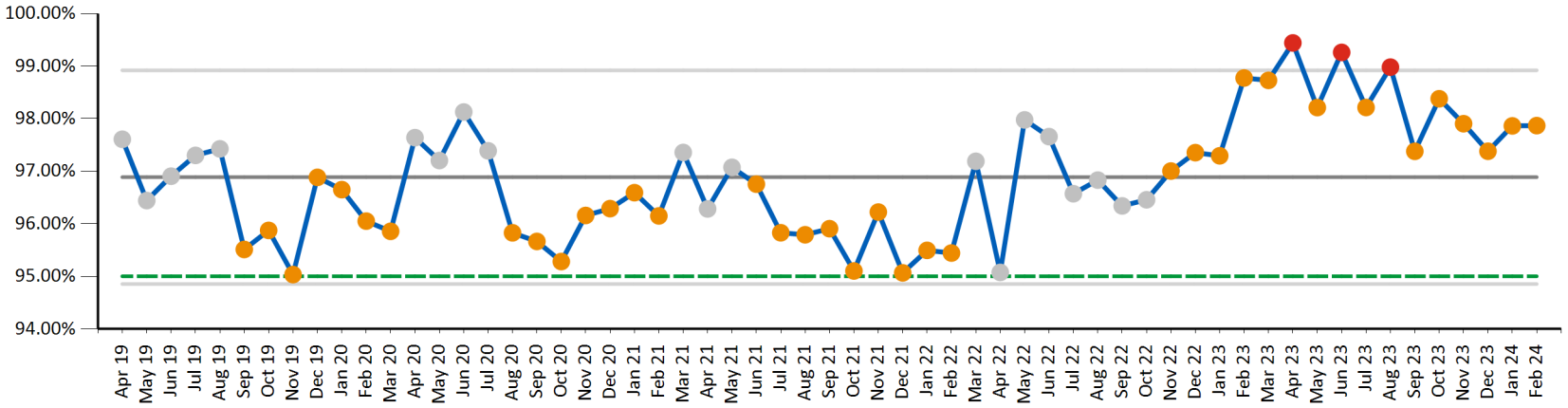
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Feb-24		<= 4.0	0.0	Jan-24	<= 44.0	3.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Feb-24		<= 1.0	0.0	Jan-24	<= 11.0	4.0	
516 - Community patients acquiring pressure damage (unstagable)		12	Feb-24			7	Jan-24		73	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Feb-24			0	Jan-24		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Feb-24			0	Jan-24		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Feb-24			0	Jan-24		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	75.8%	Feb-24		>= 95%	74.4%	Jan-24	>= 95%	72.6%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	70.7%	Feb-24		>= 95.0%	76.6%	Jan-24	>= 95.0%	76.7%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Feb-24		= 100%	100.0%	Jan-24	= 100%	100.0%	
88 - Nursing KPI Audits	>= 85%	94.9%	Feb-24		>= 85%	94.7%	Jan-24	>= 85%	94.8%	
91 - SI's 60 day turnaround performance	= 100%	100.0%	Feb-24		= 100%	57.1%	Jan-24	= 100%	73.5%	
8 - Same sex accommodation breaches	= 0	14	Feb-24		= 0	26	Jan-24	= 0	208	

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%	97.9%	Feb-24

Previous

Plan	Actual	Period
>= 95%	97.9%	Jan-24

Year to Date

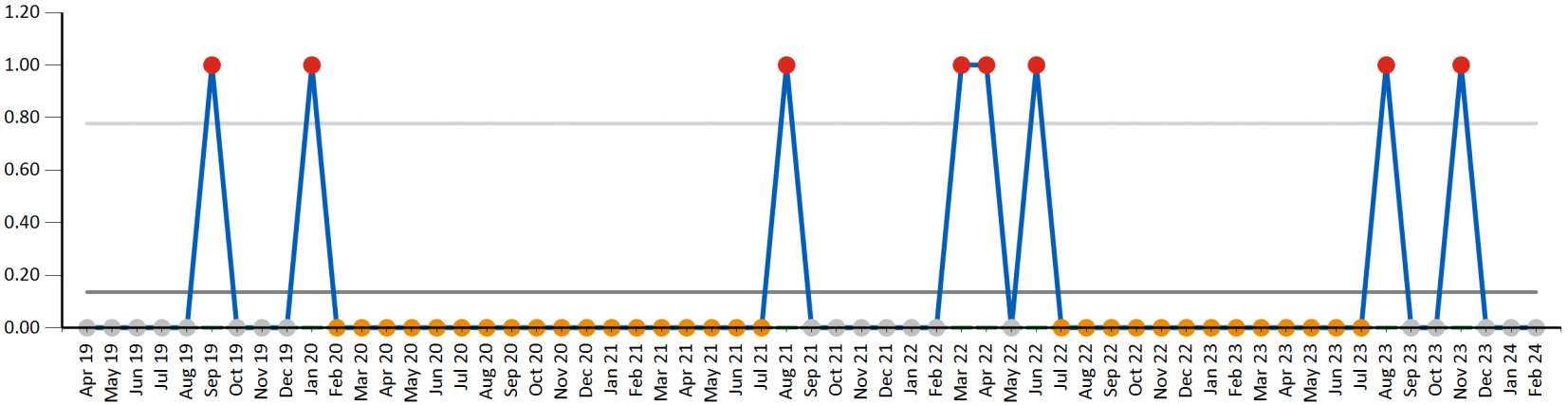
Plan	Actual
>= 95%	97.9%

9 - Never Events

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Feb-24

Previous

Plan	Actual	Period
= 0	0	Jan-24

Year to Date

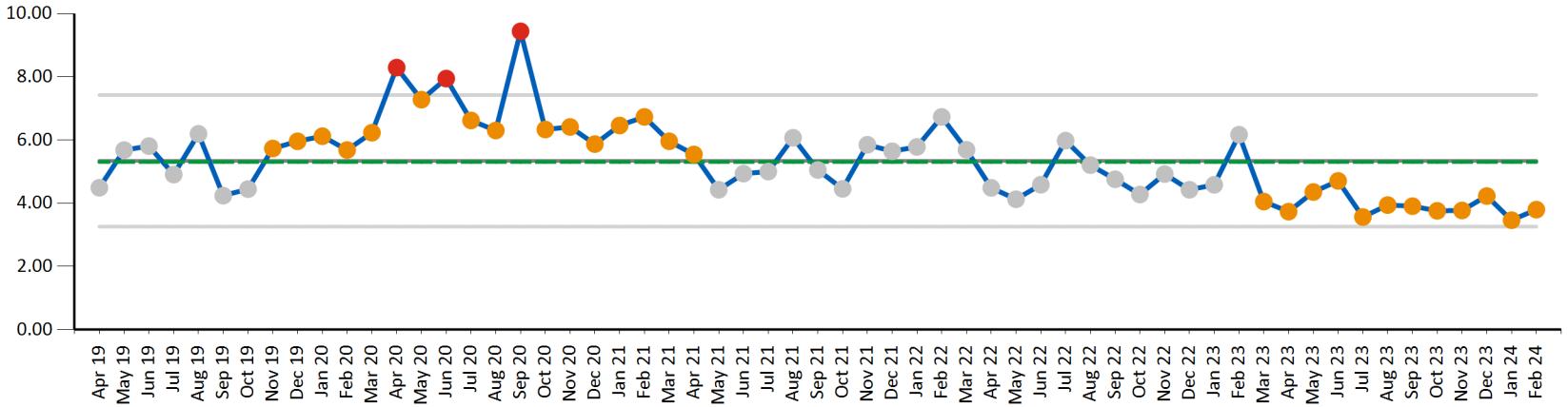
Plan	Actual
= 0	2

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	3.79	Feb-24

Previous

Plan	Actual	Period
<= 5.30	3.46	Jan-24

Year to Date

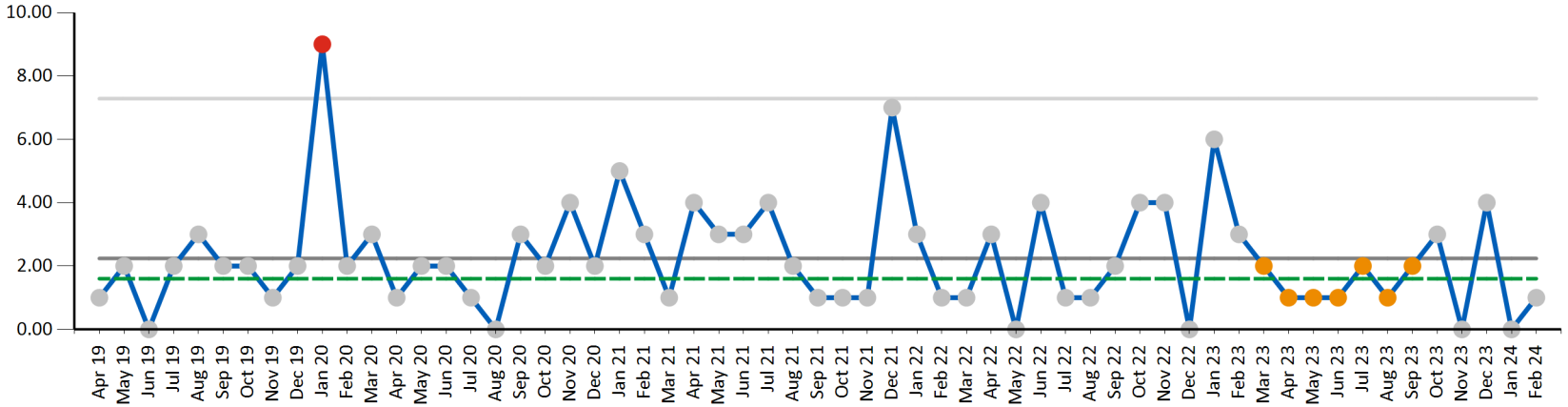
Plan	Actual
<= 5.30	3.92

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.6	1	Feb-24

Previous

Plan	Actual	Period
<= 1.6	0	Jan-24

Year to Date

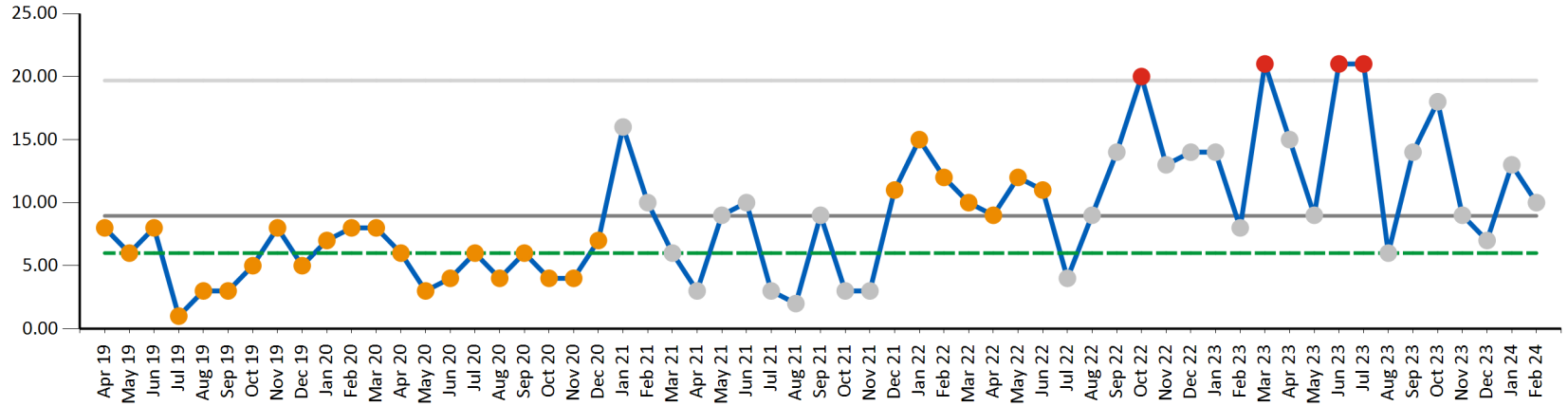
Plan	Actual
<= 17.6	16

15 - Acute Inpatients 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
<= 6.0	10.0	Feb-24

Previous

Plan	Actual	Period
<= 6.0	13.0	Jan-24

Year to Date

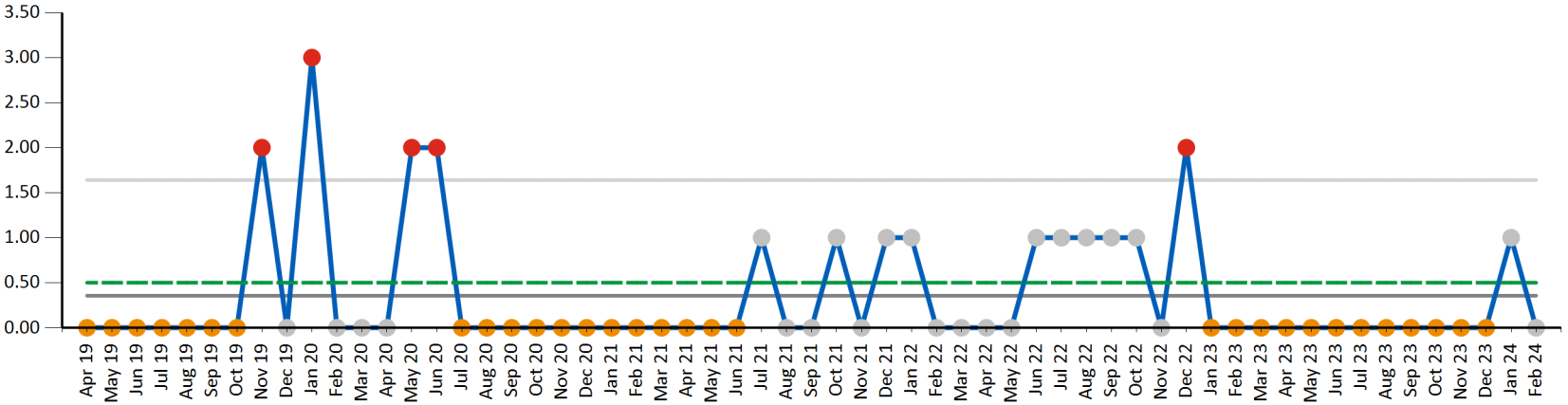
Plan	Actual
<= 66.0	143.0

16 - Acute Inpatients acquiring pressure damage (category 3)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 0.5	0.0	Feb-24

Previous

Plan	Actual	Period
<= 0.5	1.0	Jan-24

Year to Date

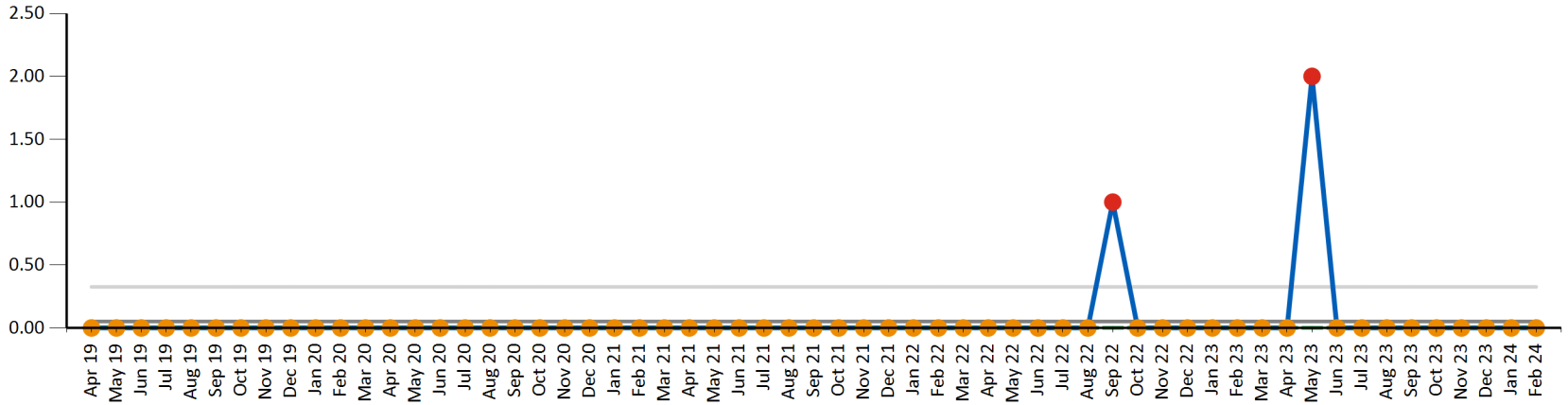
Plan	Actual
<= 5.5	1.0

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	Feb-24

Previous

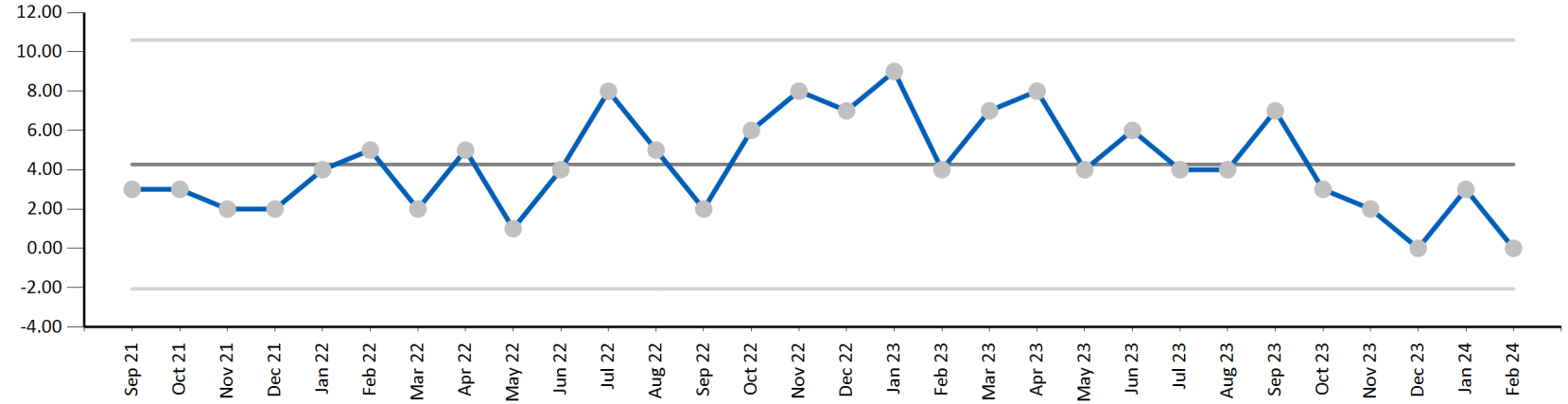
Plan	Actual	Period
= 0.0	0.0	Jan-24

Year to Date

Plan	Actual
= 0.0	2.0

515 - Acute Inpatients acquiring pressure damage (unstagable)

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-24

Previous

Plan	Actual	Period
	3	Jan-24

Year to Date

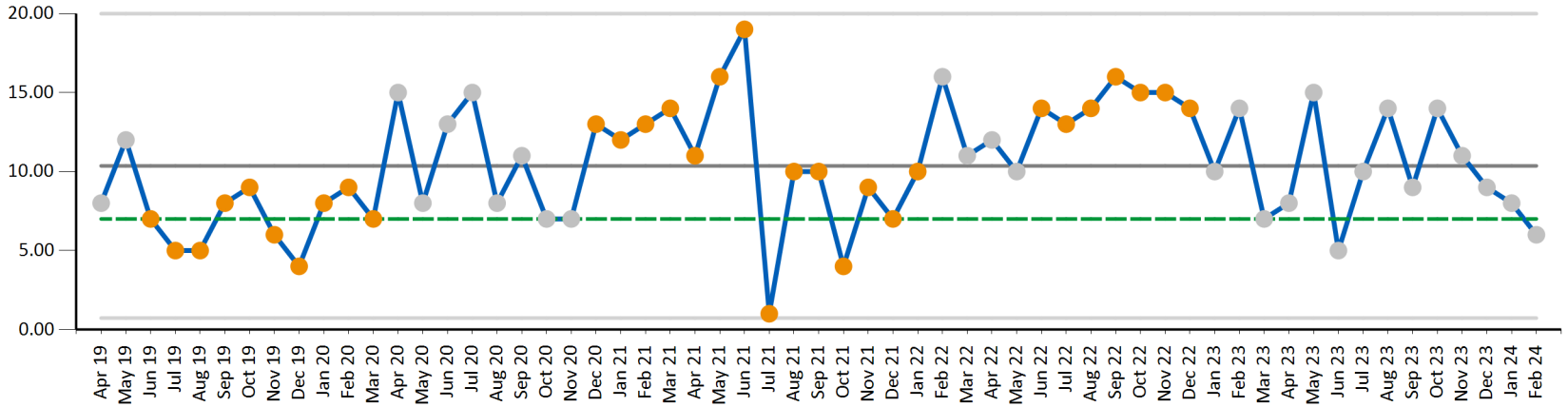
Plan	Actual
	41

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 7.0	6.0	Feb-24

Previous

Plan	Actual	Period
<= 7.0	8.0	Jan-24

Year to Date

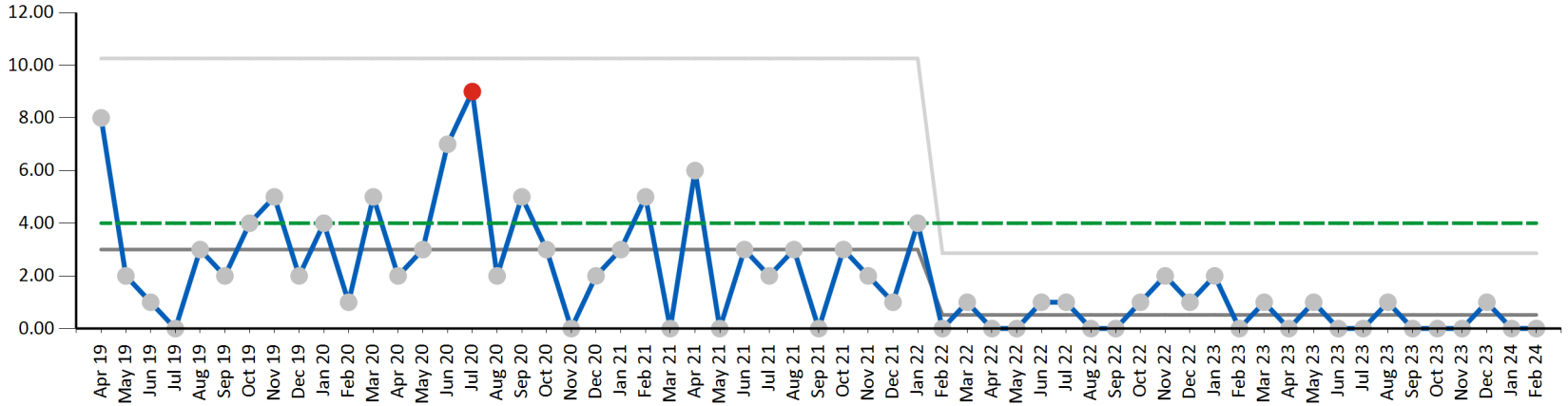
Plan	Actual
<= 77.0	109.0

19 - Community patients acquiring pressure damage (category 3)

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 4.0	0.0	Feb-24

Previous

Plan	Actual	Period
<= 4.0	0.0	Jan-24

Year to Date

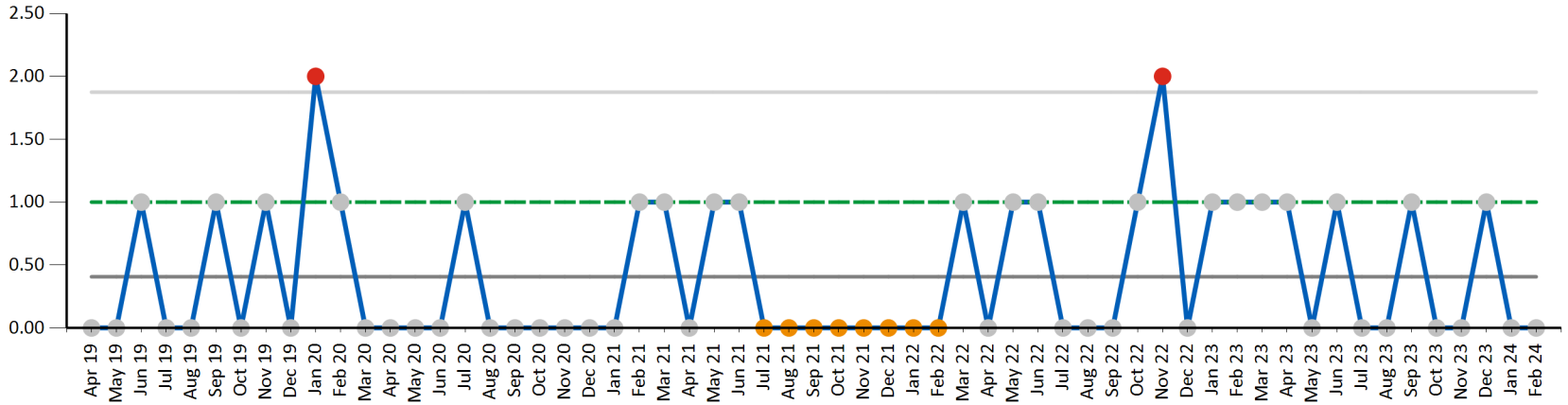
Plan	Actual
<= 44.0	3.0

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	0.0	Feb-24

Previous

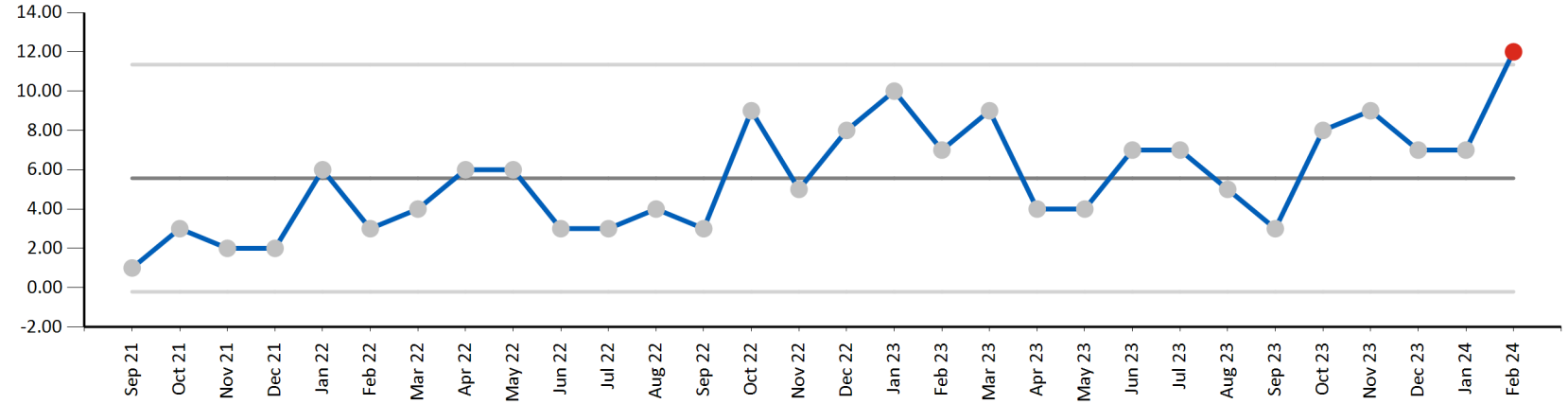
Plan	Actual	Period
<= 1.0	0.0	Jan-24

Year to Date

Plan	Actual
<= 11.0	4.0

516 - Community patients acquiring pressure damage (unstagable)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	12	Feb-24

Previous

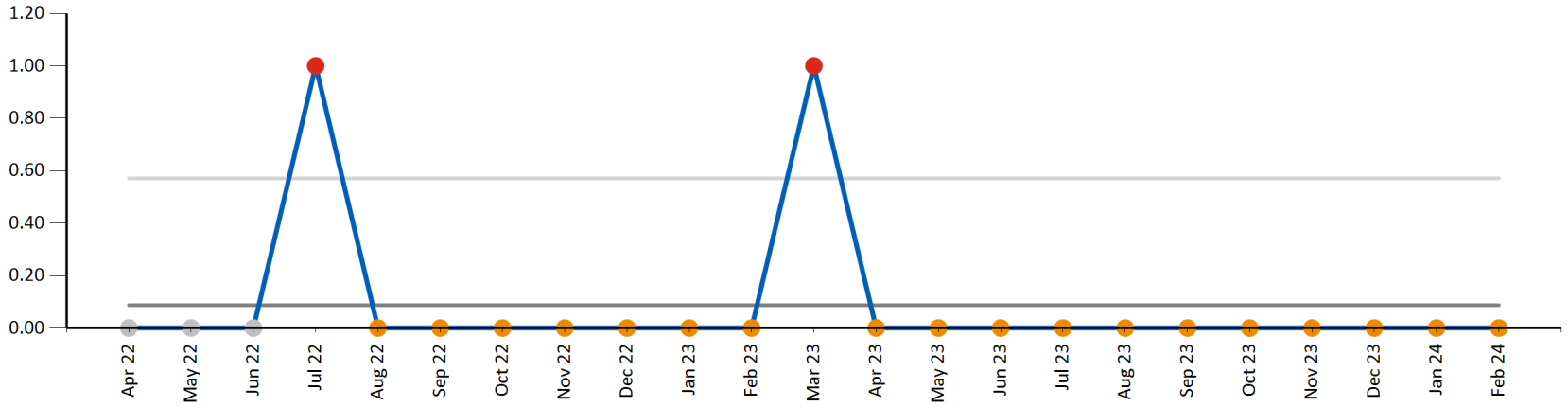
Plan	Actual	Period
	7	Jan-24

Year to Date

Plan	Actual
	73

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Feb-24

Previous

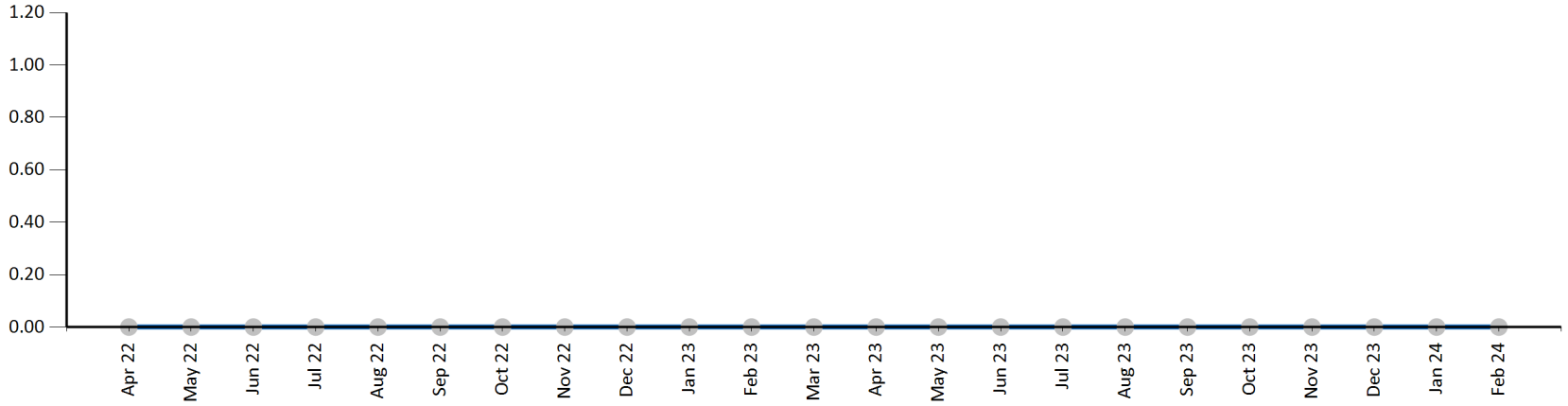
Plan	Actual	Period
	0	Jan-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-24

Previous

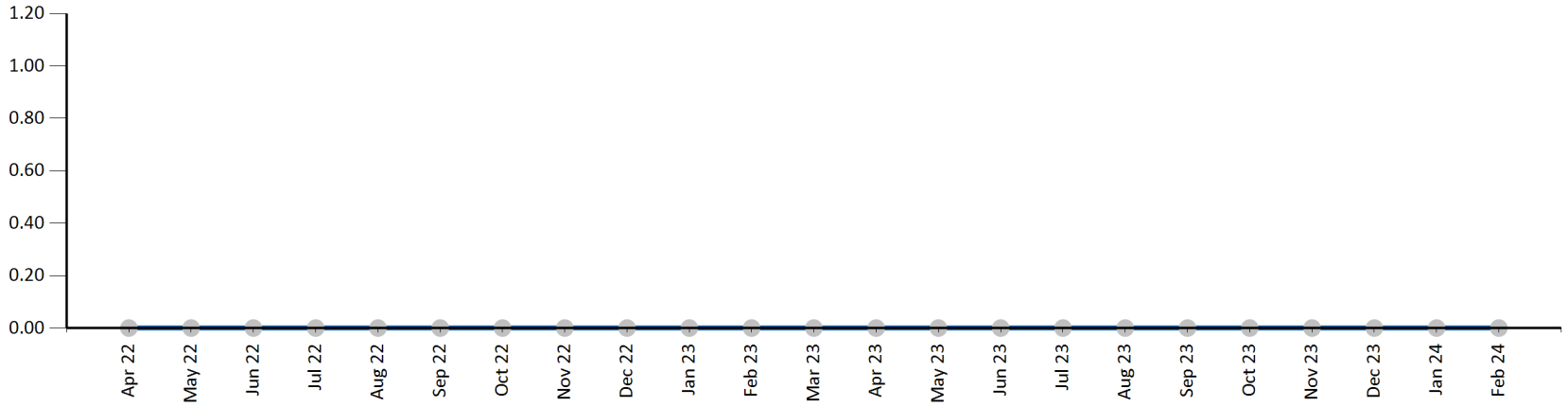
Plan	Actual	Period
	0	Jan-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Feb-24

Previous

Plan	Actual	Period
	0	Jan-24

Year to Date

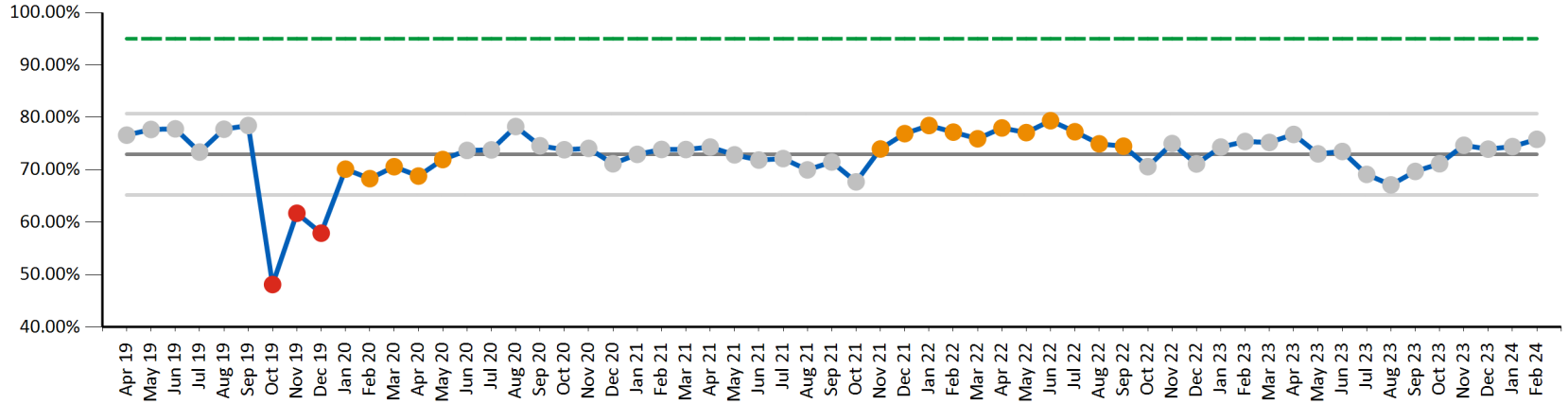
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	75.8%	Feb-24

Previous

Plan	Actual	Period
>= 95%	74.4%	Jan-24

Year to Date

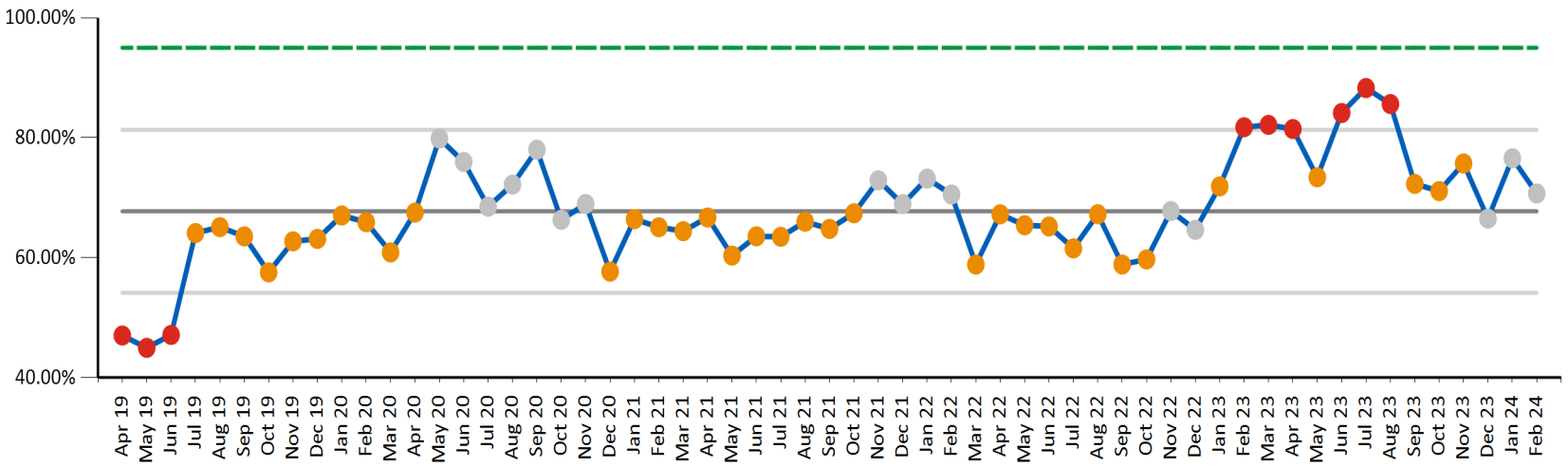
Plan	Actual
>= 95%	72.6%

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%	70.7%	Feb-24

Previous

Plan	Actual	Period
>= 95.0%	76.6%	Jan-24

Year to Date

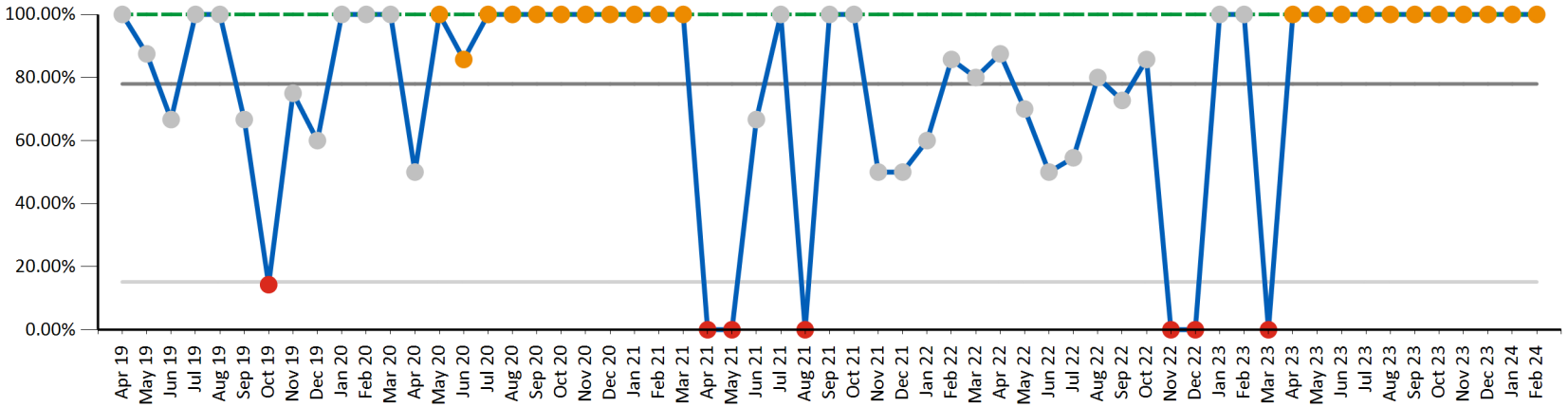
Plan	Actual
>= 95.0%	76.7%

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%	Feb-24

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-24

Year to Date

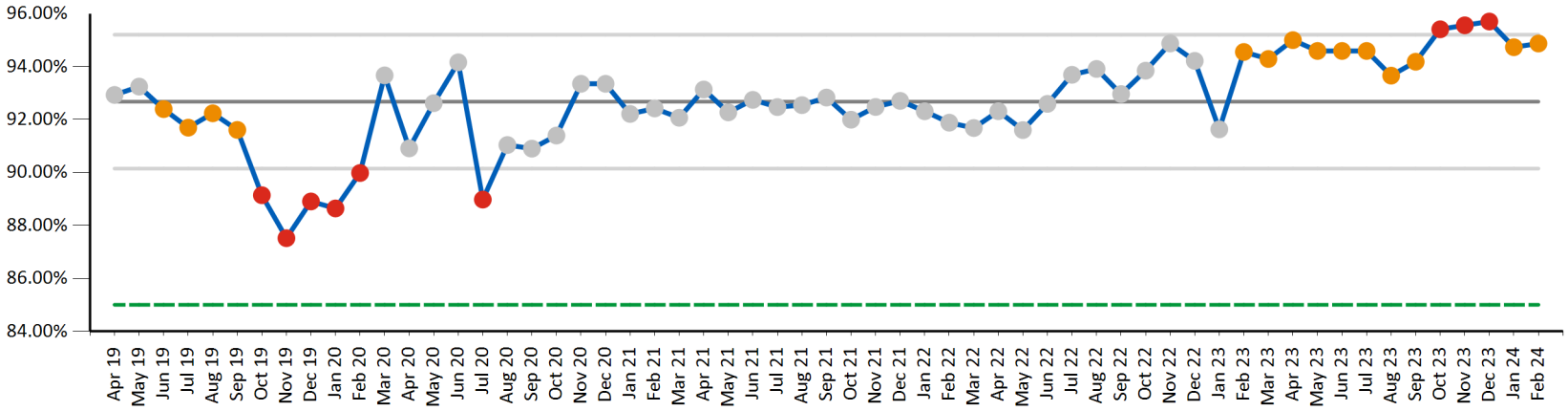
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	94.9%	Feb-24

Previous

Plan	Actual	Period
>= 85%	94.7%	Jan-24

Year to Date

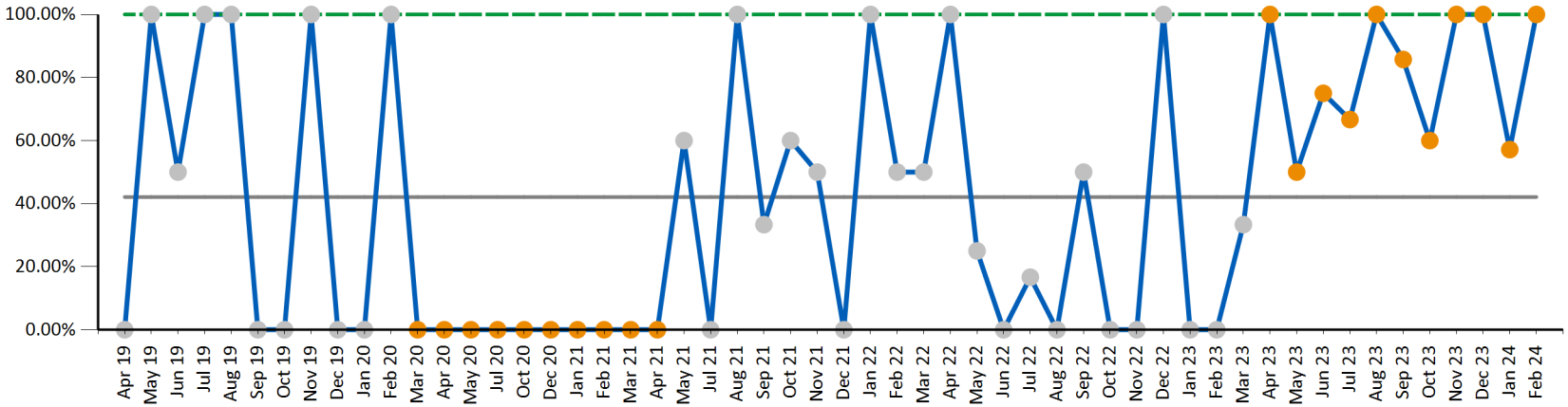
Plan	Actual
>= 85%	94.8%

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%	Feb-24

Previous

Plan	Actual	Period
= 100%	57.1%	Jan-24

Year to Date

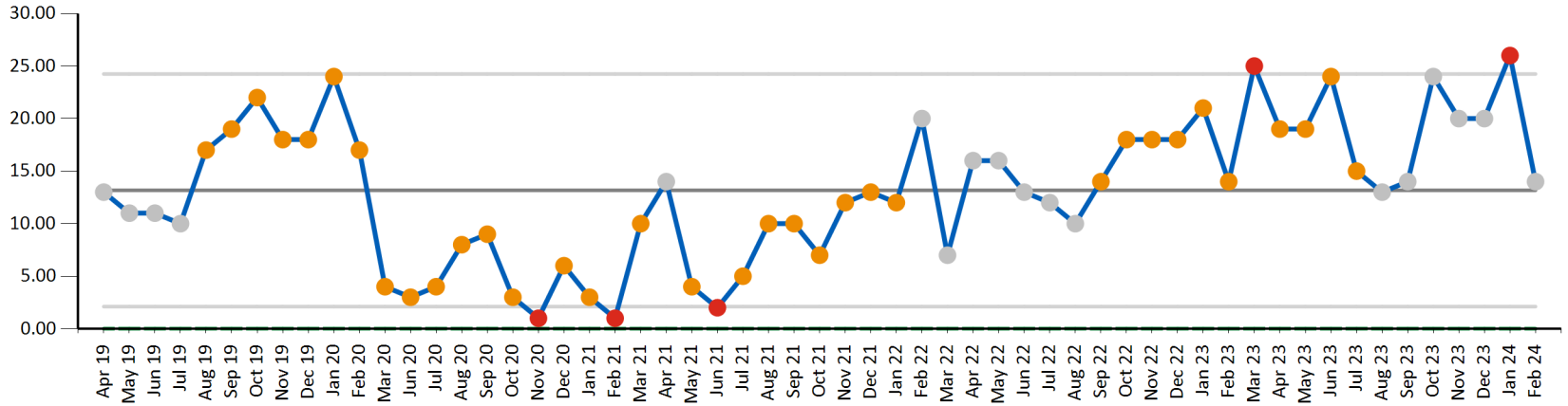
Plan	Actual
= 100%	73.5%

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	14	Feb-24

Previous

Plan	Actual	Period
= 0	26	Jan-24

Year to Date

Plan	Actual
= 0	208

Quality and Safety - Infection Prevention and Control

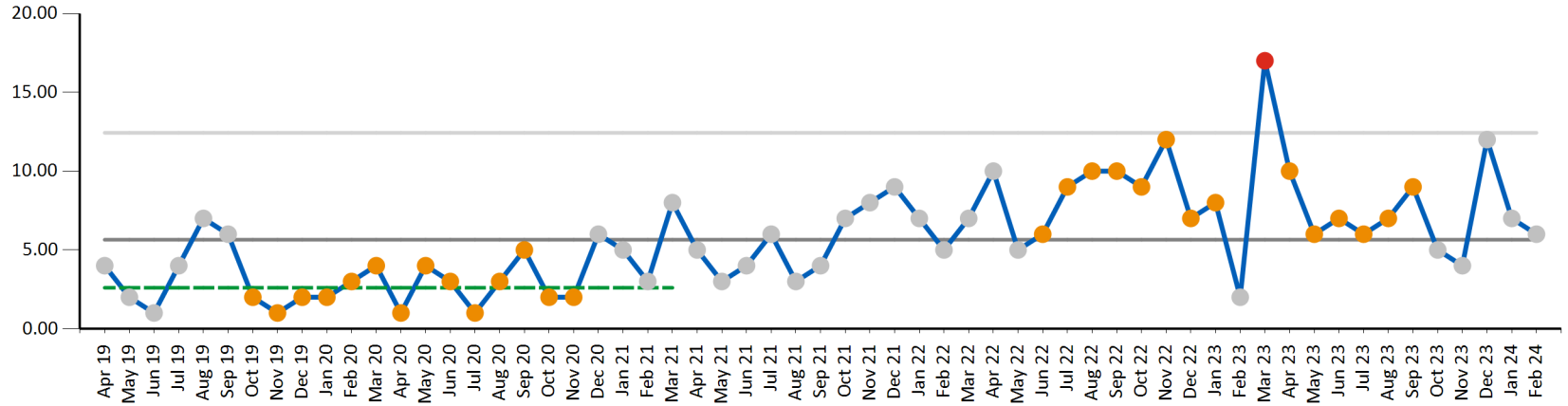
NHS Bolton NHS Foundation Trust

The CDT position has not changed and shows a deteriorating special cause variation. A draft operational plan for a cohort facility is now being scrutinised by the related stakeholders. A live dashboard for antibiotic prescribing has been developed and it is planned that this will report into the IPR from May 2024.

	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		6	Feb-24			7	Jan-24		79	
346 - Total Community Onset Hospital Associated C.diff infections		2	Feb-24			2	Jan-24		31	
347 - Total C.diff infections contributing to objective	<= 7	8	Feb-24	H	<= 7	9	Jan-24	<= 73	110	?
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Feb-24	L	= 0	0	Jan-24	= 0	1	?
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 4	3	Feb-24		<= 4	5	Jan-24	<= 46	57	?
219 - Blood Culture Contaminants (rate)	<= 3%	4.0%	Feb-24		<= 3%	3.2%	Jan-24	<= 3%	2.9%	?
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Feb-24		<= 1.0	3.0	Jan-24	<= 11.0	13.0	?
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Feb-24		<= 1	3	Jan-24	<= 6	16	?
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Feb-24		= 0	0	Jan-24	= 0	4	?
491 - Nosocomial COVID-19 cases		18	Feb-24	L		31	Jan-24		216	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	6	Feb-24

Previous

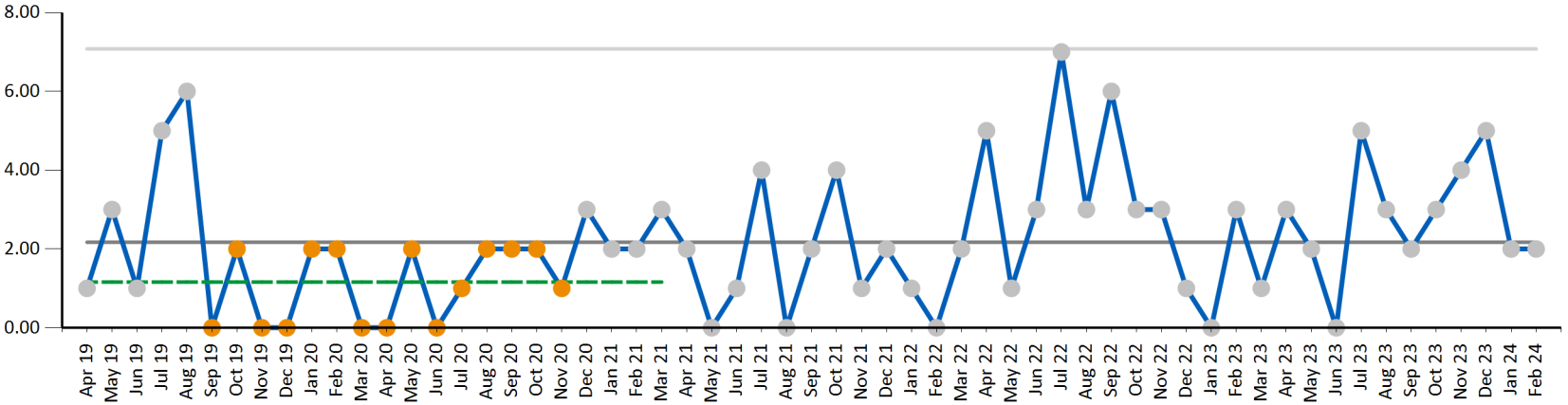
Plan	Actual	Period
	7	Jan-24

Year to Date

Plan	Actual
	79

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	2	Feb-24

Previous

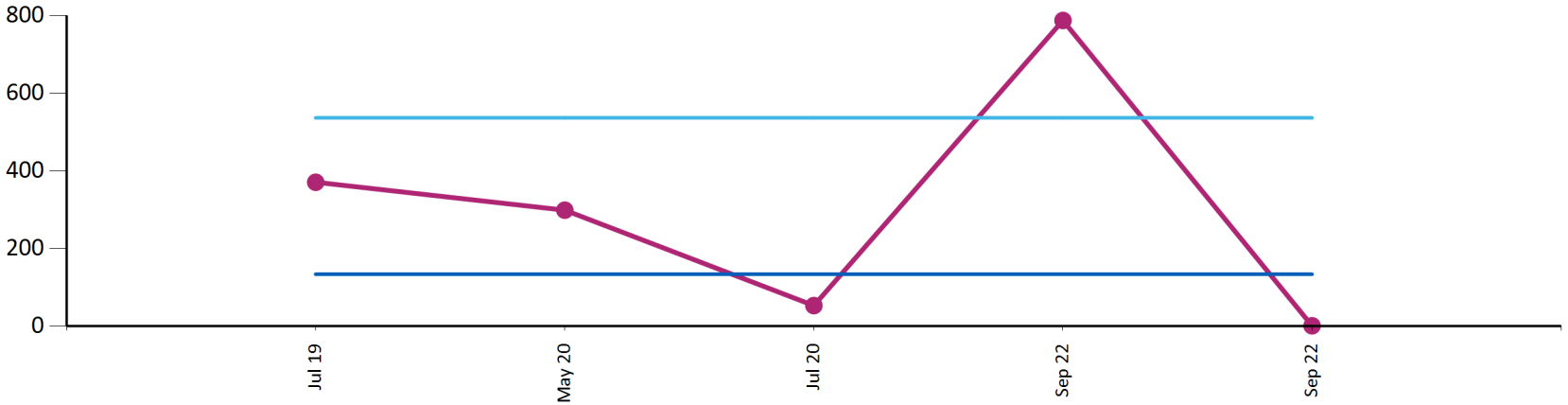
Plan	Actual	Period
	2	Jan-24

Year to Date

Plan	Actual
	31

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Feb-24

Previous

Plan	Actual	Period
	0	Jan-24

Year to Date

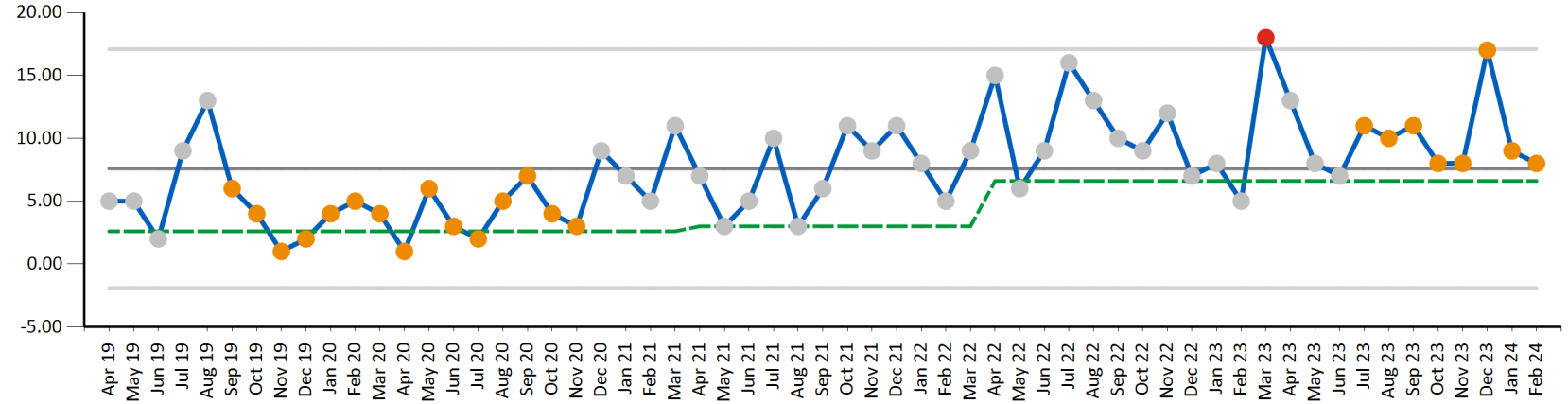
Plan	Actual

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	8	Feb-24

Previous

Plan	Actual	Period
<= 7	9	Jan-24

Year to Date

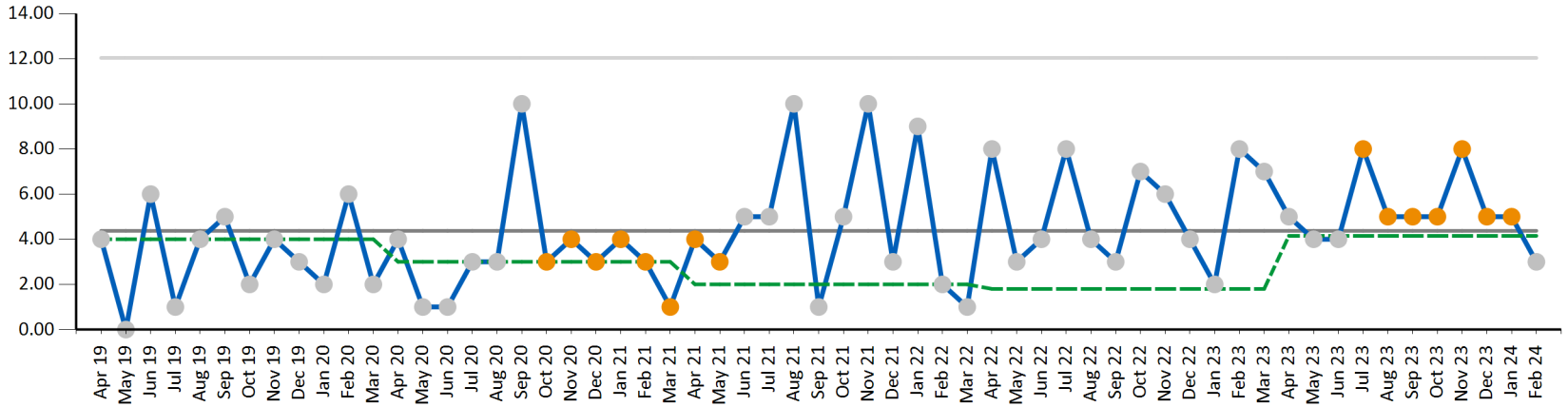
Plan	Actual
<= 73	110

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 4	3	Feb-24

Previous

Plan	Actual	Period
<= 4	5	Jan-24

Year to Date

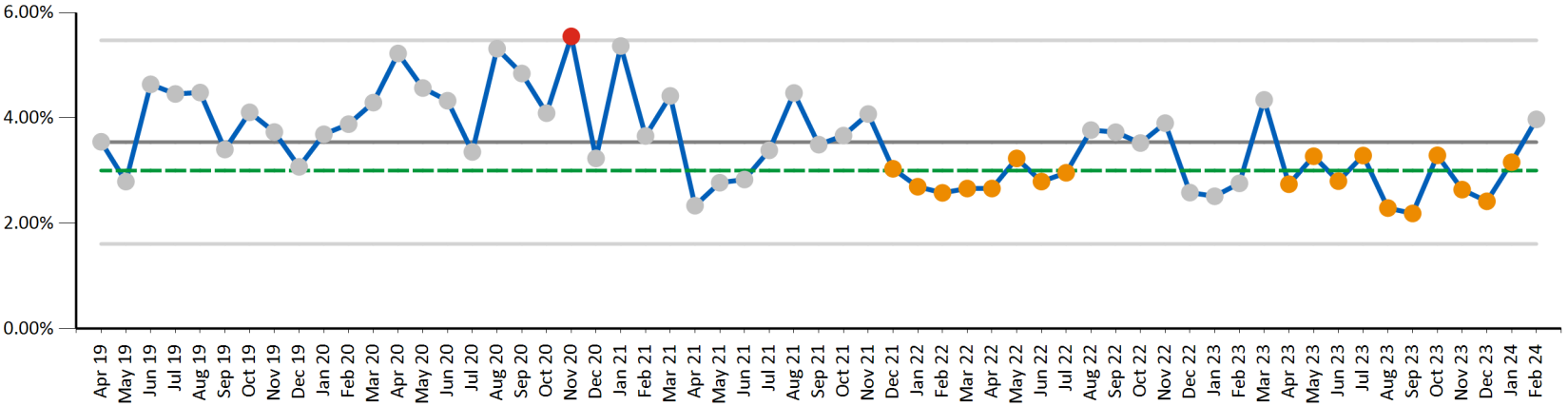
Plan	Actual
<= 46	57

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3%	4.0%	Feb-24

Previous

Plan	Actual	Period
<= 3%	3.2%	Jan-24

Year to Date

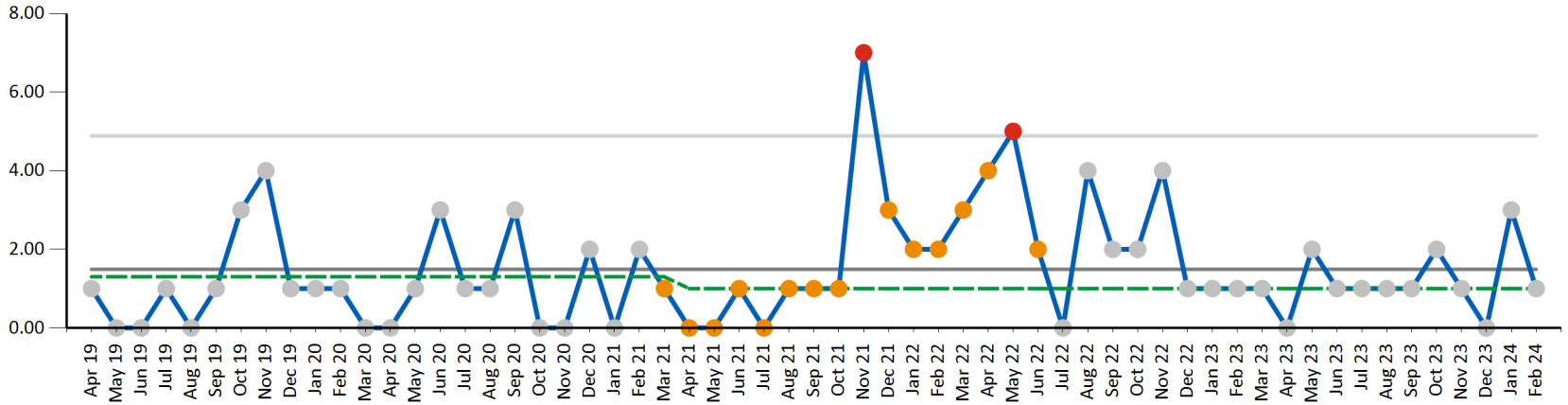
Plan	Actual
<= 3%	2.9%

304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Feb-24

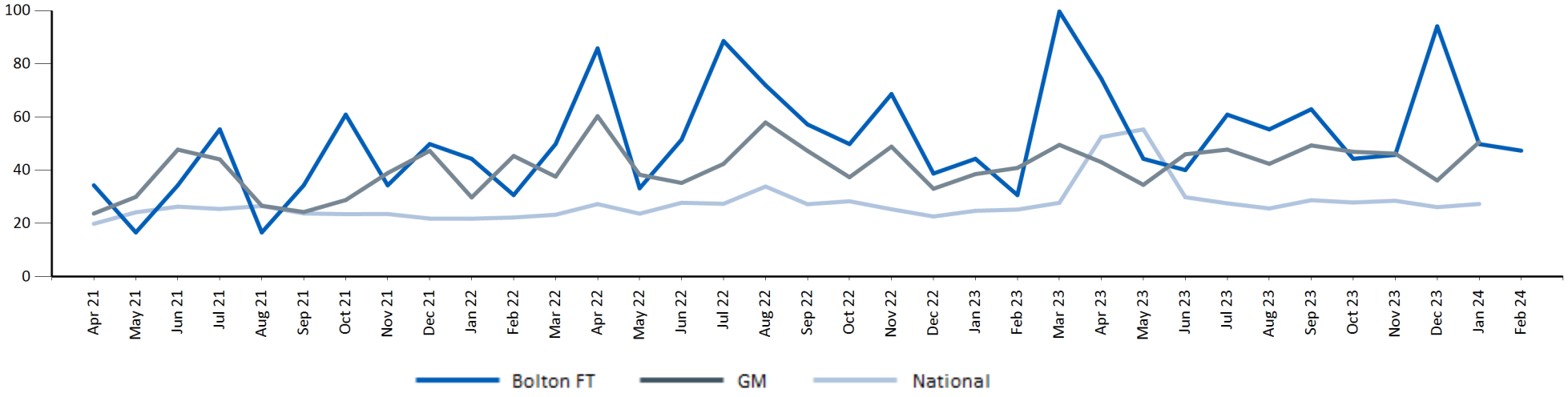
Previous

Plan	Actual	Period
<= 1.0	3.0	Jan-24

Year to Date

Plan	Actual
<= 11.0	13.0

549 - C Diff Rate Comparison

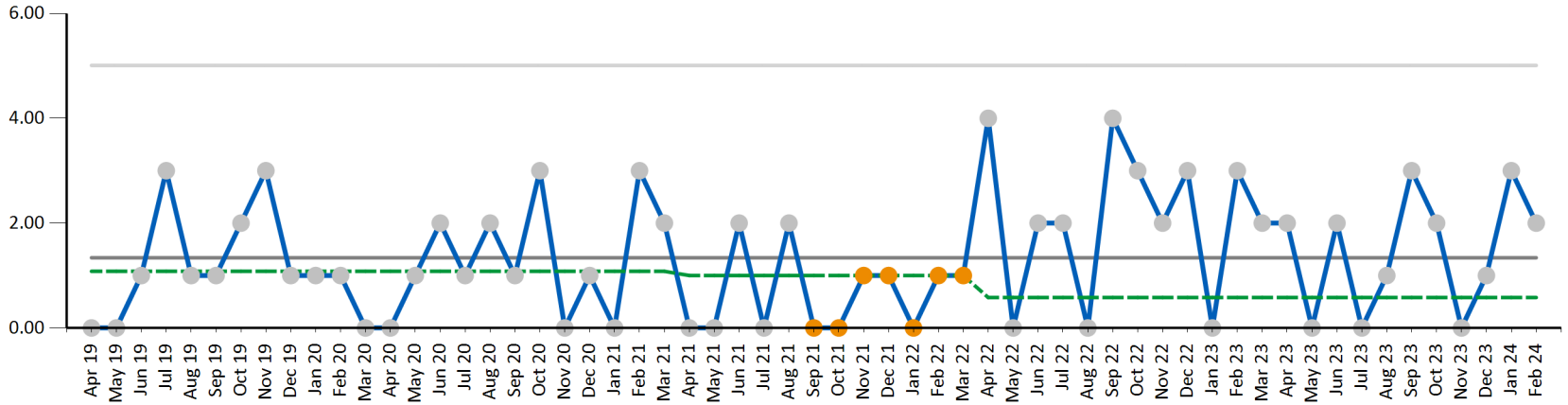


305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 1	2	Feb-24

Previous

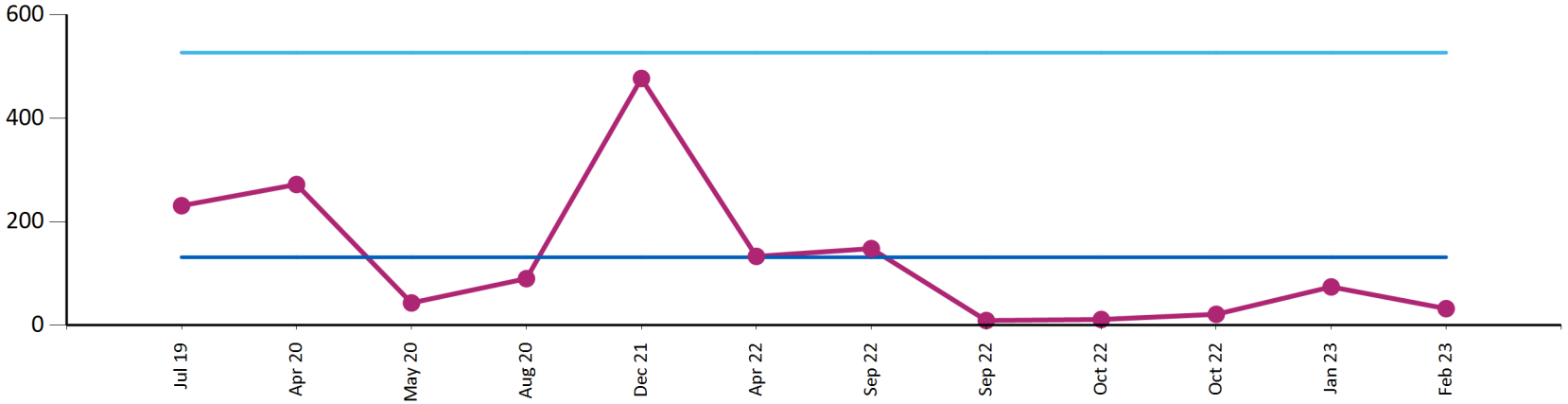
Plan	Actual	Period
<= 1	3	Jan-24

Year to Date

Plan	Actual
<= 6	16

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

0/6



Latest

Plan	Actual	Period
	0	Feb-24

Previous

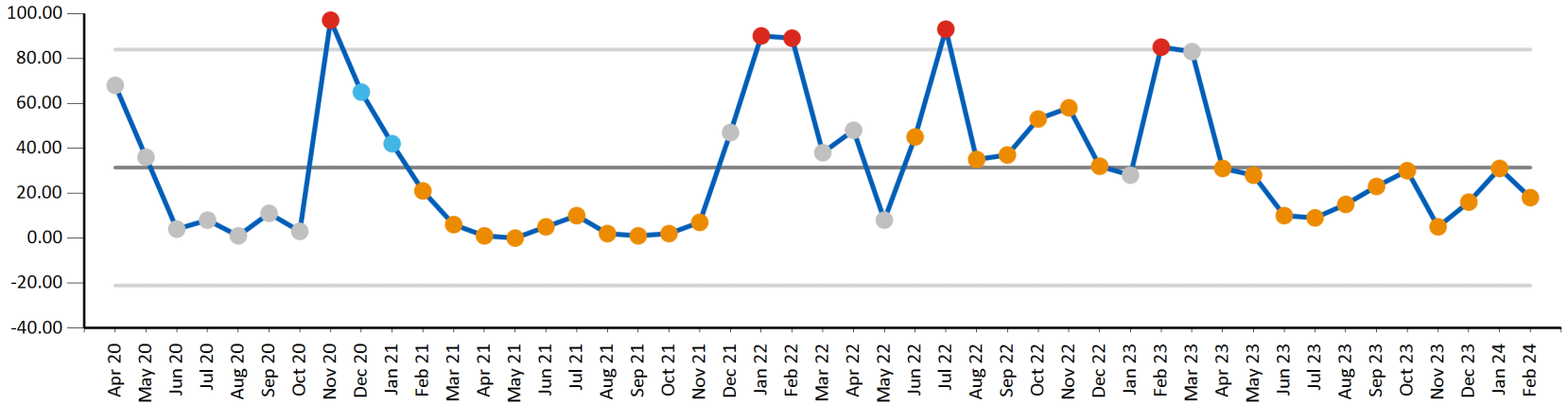
Plan	Actual	Period
	0	Jan-24

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Special cause variation with improving performance



Latest

Plan	Actual	Period
	18	Feb-24

Previous

Plan	Actual	Period
	31	Jan-24

Year to Date

Plan	Actual
	216

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is slightly below Trust target and average for the period and has now remained in control for more than 3 years.

HSMR – in month figure is below average for the period and remains in control. The 12 month rolling average to October 2023 is 103.06 remaining as 'Green' when compared against other Trusts.

SHMI – In month figure is just below the target and average for the time period and remains in control. The published rolling average for the period November 2022 to Or 2023 is 109.43 'as expected'.

The proportion of Charlson comorbidities remains in control and has been since April 2022. The depth of recording has remained as an outlier in November 2023. This risk adjustment does not impact as much as the recording of Charlson's and a new recording process to record such comorbidities was released in February 2024. However, any improvements from this will not be seen for some time due to the time lag in data. Both are still lower when benchmarked against the England average of all Acute Trusts, but the mortality metrics remain in range despite this.

The proportion of coded records at the time of the snapshot download is above average for the time frame. There has been a sustained period of 23 points above the mean since February 2022 indicating sustained improvement.

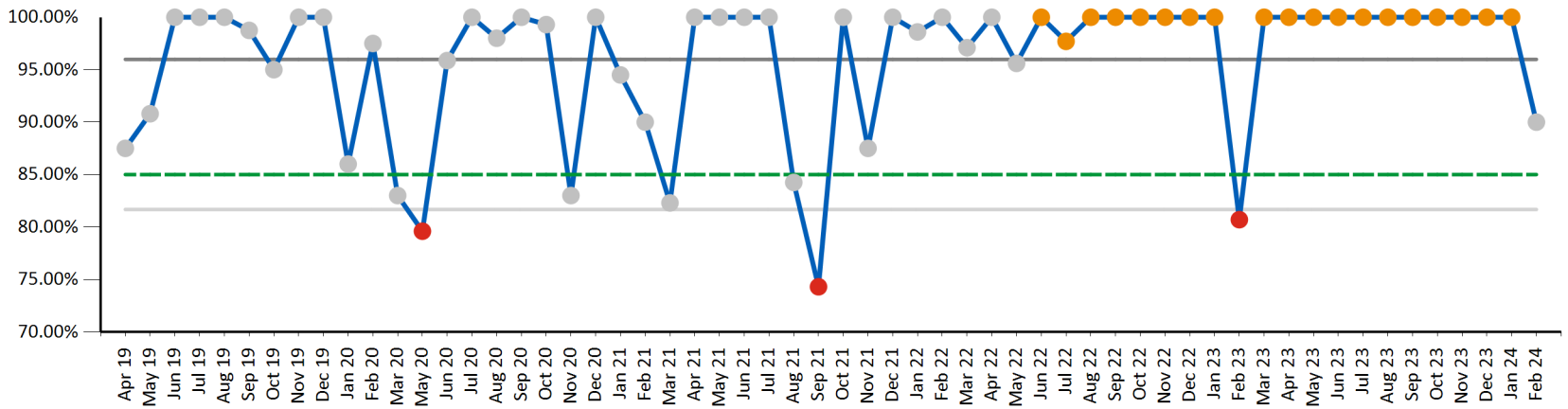
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	90.0%	Feb-24		>= 85%	100.0%	Jan-24	>= 85%	99.1%	
495 - HSMR		82.26	Nov-23			120.25	Oct-23		82.26	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	98.32	Sep-23		<= 100.00	113.56	Aug-23	<= 100.00	98.32	
12 - Crude Mortality %	<= 2.9%	2.5%	Feb-24		<= 2.9%	3.2%	Jan-24	<= 2.9%	2.3%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Nov-23			4	Oct-23		30	
520 - Depth of recording (First episode of care)		6	Nov-23	L		6	Oct-23		47	
521 - Proportion of fully coded records (Inpatients)		97.7%	Dec-23	H		98.0%	Nov-23		98.1%	

3 - National Early Warning Scores to Gold standard

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 85%	90.0%	Feb-24

Previous

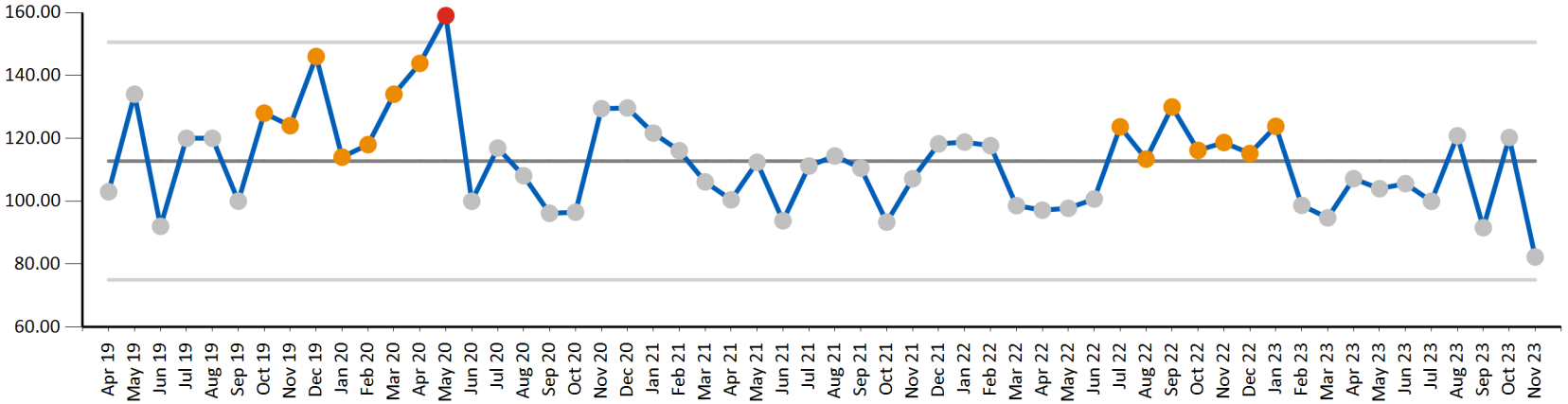
Plan	Actual	Period
>= 85%	100.0%	Jan-24

Year to Date

Plan	Actual
>= 85%	99.1%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	82.26	Nov-23

Previous

Plan	Actual	Period
	120.25	Oct-23

Year to Date

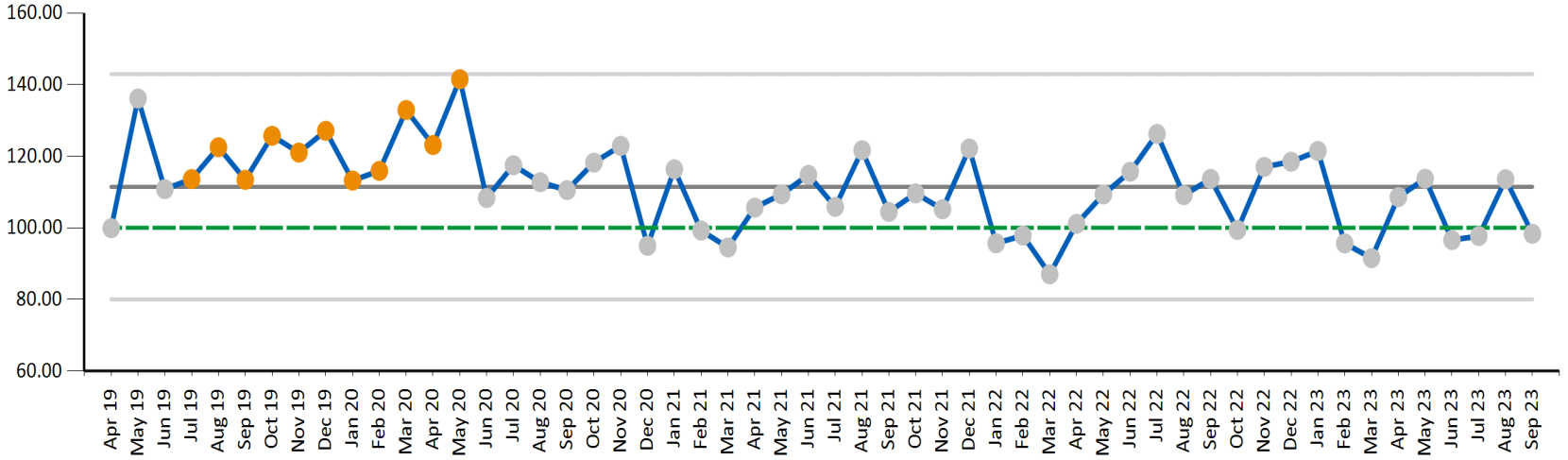
Plan	Actual
	82.26

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 100.00	98.32	Sep-23

Previous

Plan	Actual	Period
<= 100.00	113.56	Aug-23

Year to Date

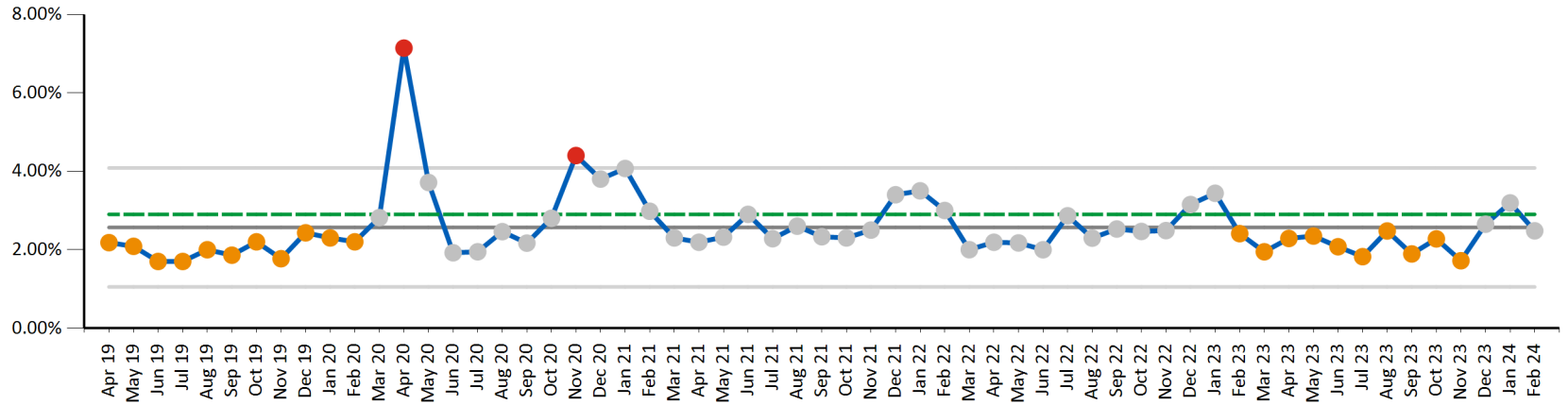
Plan	Actual
<= 100.00	98.32

12 - Crude Mortality %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 2.9%	2.5%	Feb-24

Previous

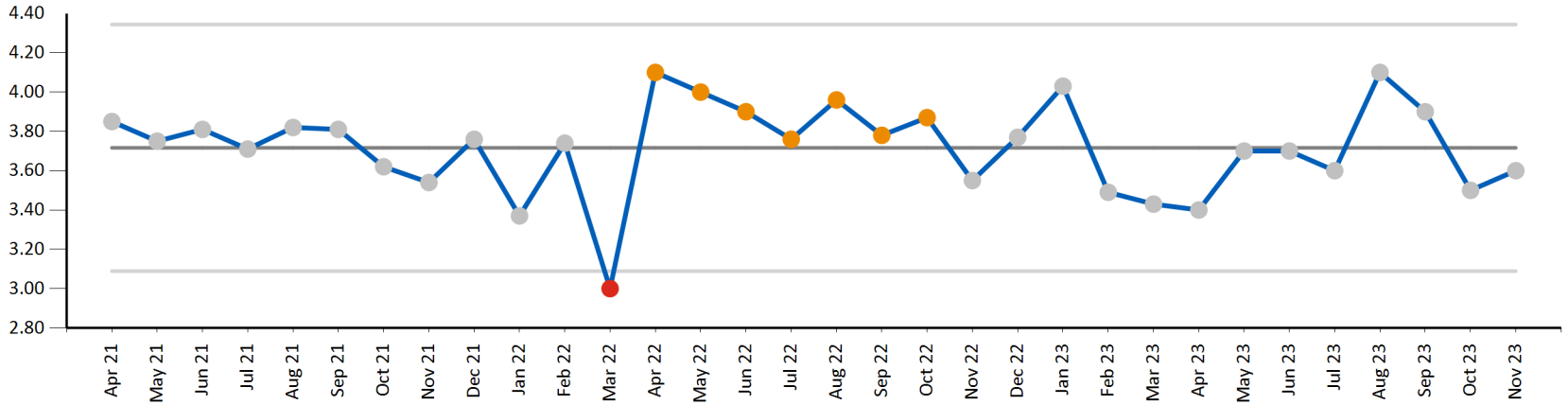
Plan	Actual	Period
<= 2.9%	3.2%	Jan-24

Year to Date

Plan	Actual
<= 2.9%	2.3%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Nov-23

Previous

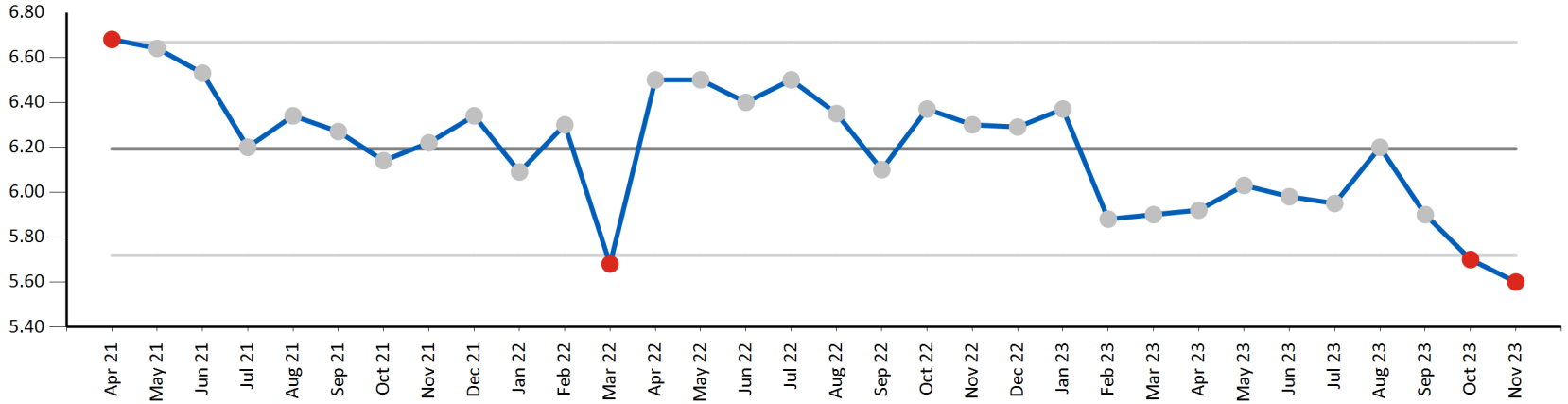
Plan	Actual	Period
	4	Oct-23

Year to Date

Plan	Actual
	30

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Nov-23

Previous

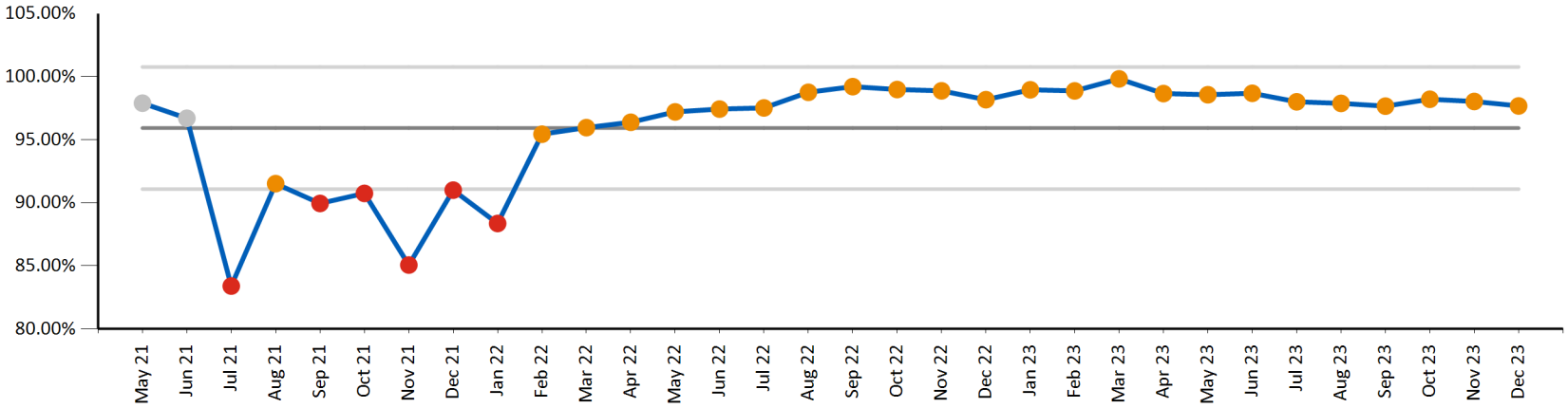
Plan	Actual	Period
	6	Oct-23

Year to Date

Plan	Actual
	47

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	97.7%	Dec-23

Previous

Plan	Actual	Period
	98.0%	Nov-23

Year to Date

Plan	Actual
	98.1%

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction Rates February 2024
Accident and Emergency Department response and satisfaction rates remain below target however are within common cause variation.
AACD review response and recommendation rates at their Divisional Quality and Patient Experience Forum (QPEF) and are exploring a number of options with the Patient Experience Team to improve response rates for the Paediatric Emergency Department. The division continue to review the narrative for all negative responses to identify themes and learning.
Antenatal response rates remain below target but within common cause variation. The maternity matrons are reviewing collection methods and considering a number of options to improve response rates. This is being monitored at Divisional QPEF and at Trust QPEF.

Complaint Response Rates February 2024
Compliance rates remain within common cause variation, however below the mean.
In February there were 14 complaints due a response. Seven were provided within timeframe. All of the complaints have been responded to; 2 in January, 9 in February and 3 in March.
Complaint meetings remain a positive best practice resolution outcome and this continues to be encouraged to improve service user engagement.
Complaint training sessions continue to be offered to staff at all levels.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	15.1%	Feb-24		>= 20%	16.1%	Jan-24	>= 20%	16.4%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	78.3%	Feb-24		>= 90%	80.9%	Jan-24	>= 90%	83.6%	
80 - Inpatient Friends and Family Response Rate	>= 30%	30.1%	Feb-24		>= 30%	27.3%	Jan-24	>= 30%	28.0%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.1%	Feb-24		>= 90%	97.3%	Jan-24	>= 90%	96.4%	
81 - Maternity Friends and Family Response Rate	>= 15%	26.3%	Feb-24		>= 15%	27.2%	Jan-24	>= 15%	32.8%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.9%	Feb-24		>= 90%	93.9%	Jan-24	>= 90%	91.8%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	6.2%	Feb-24		>= 15%	10.4%	Jan-24	>= 15%	20.7%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Feb-24		>= 90%	98.2%	Jan-24	>= 90%	95.0%	

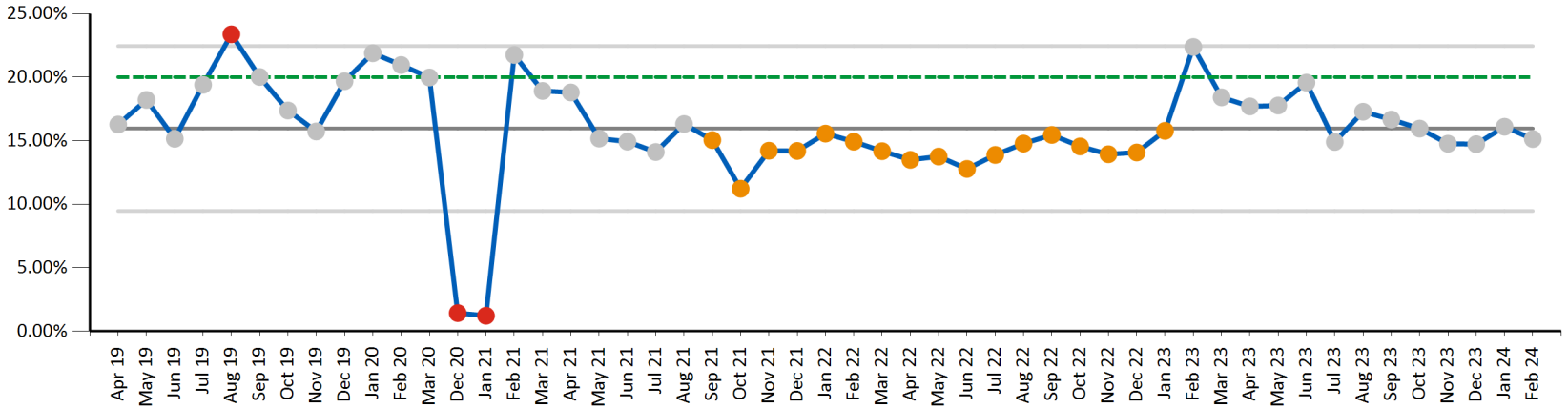
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
83 - Birth - Friends and Family Response Rate	>= 15%	42.7%	Feb-24		>= 15%	46.8%	Jan-24	>= 15%	43.9%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	90.2%	Feb-24	H	>= 90%	94.0%	Jan-24	>= 90%	91.9%	?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	34.2%	Feb-24		>= 15%	24.9%	Jan-24	>= 15%	43.9%	?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	93.5%	Feb-24	H	>= 90%	93.1%	Jan-24	>= 90%	87.9%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	27.5%	Feb-24		>= 15%	28.5%	Jan-24	>= 15%	25.4%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	91.3%	Feb-24		>= 90%	92.2%	Jan-24	>= 90%	94.2%	?
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Feb-24	H	= 100%	100.0%	Jan-24	= 100%	100.0%	?
90 - Complaints responded to within the period	>= 95%	50.0%	Feb-24		>= 95%	70.6%	Jan-24	>= 95%	78.5%	?

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	15.1%	Feb-24

Previous

Plan	Actual	Period
>= 20%	16.1%	Jan-24

Year to Date

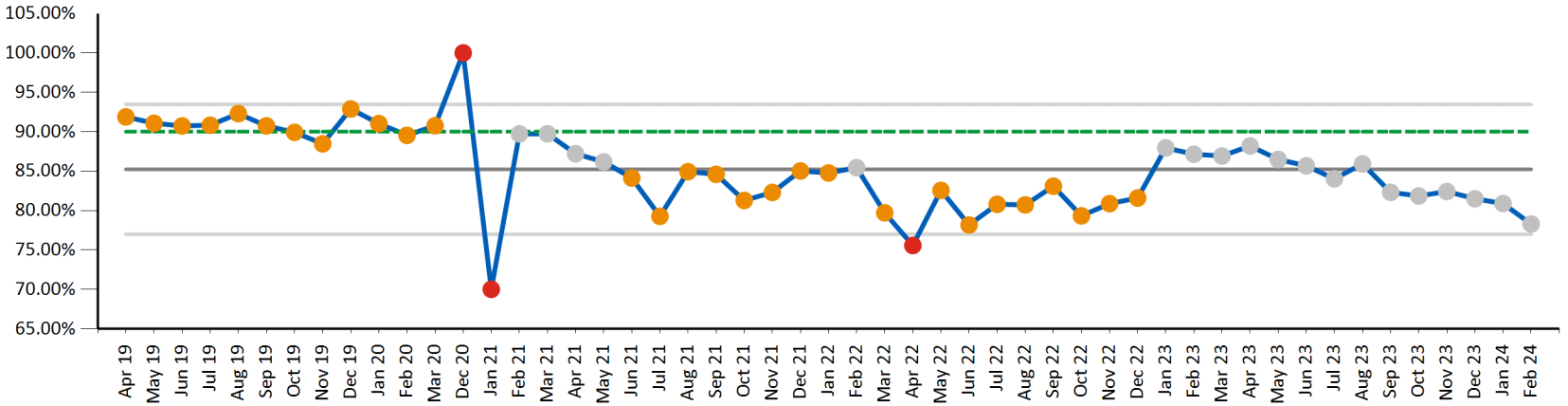
Plan	Actual
>= 20%	16.4%

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%	78.3%	Feb-24

Previous

Plan	Actual	Period
>= 90%	80.9%	Jan-24

Year to Date

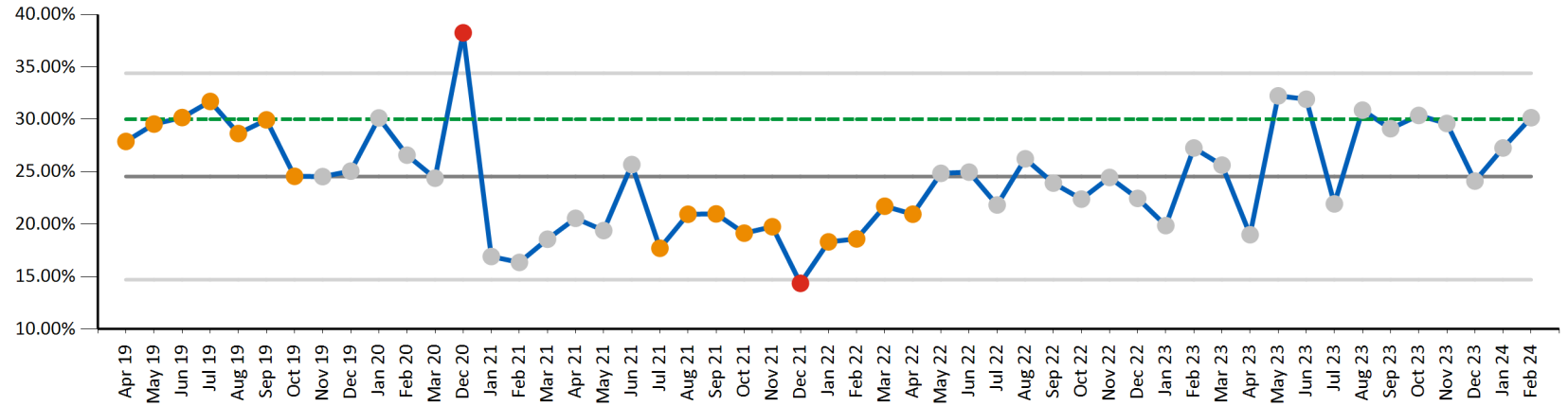
Plan	Actual
>= 90%	83.6%

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%	30.1%	Feb-24

Previous

Plan	Actual	Period
>= 30%	27.3%	Jan-24

Year to Date

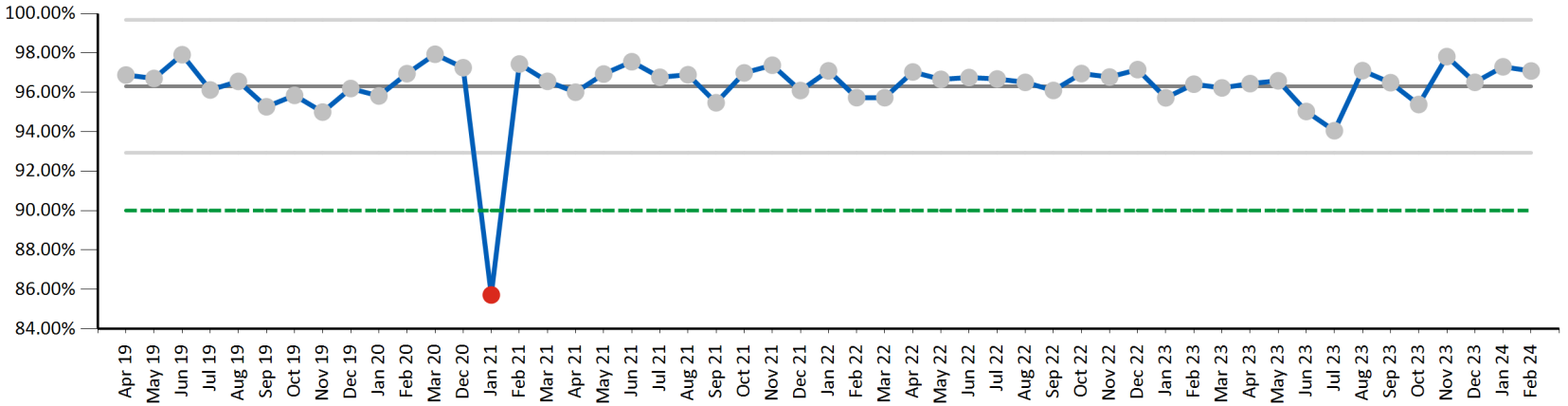
Plan	Actual
>= 30%	28.0%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	97.1%	Feb-24

Previous

Plan	Actual	Period
>= 90%	97.3%	Jan-24

Year to Date

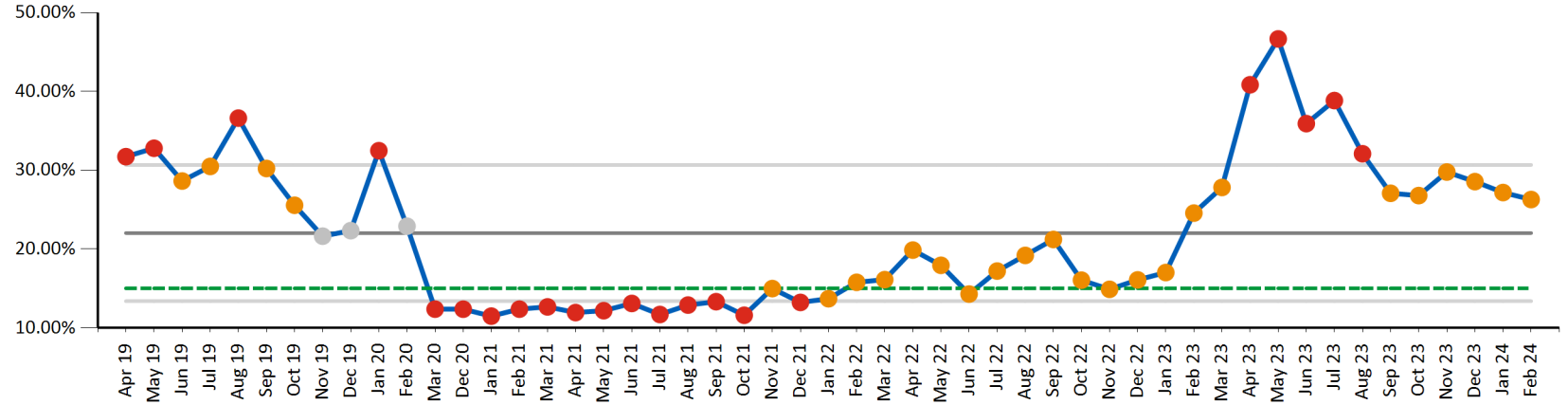
Plan	Actual
>= 90%	96.4%

81 - Maternity Friends and Family Response Rate

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 15%	26.3%	Feb-24

Previous

Plan	Actual	Period
>= 15%	27.2%	Jan-24

Year to Date

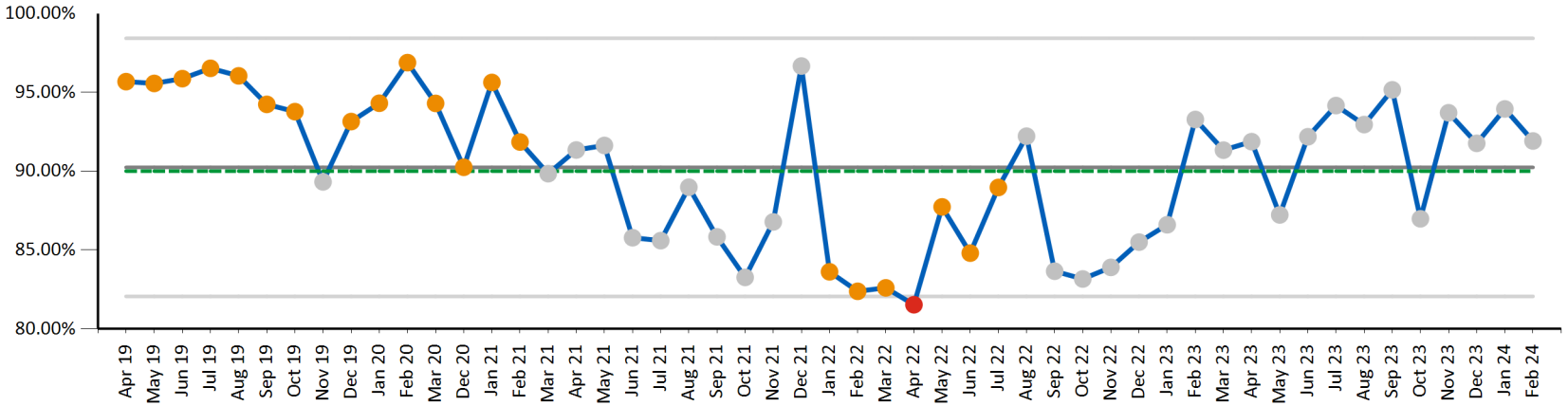
Plan	Actual
>= 15%	32.8%

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%	91.9%	Feb-24

Previous

Plan	Actual	Period
>= 90%	93.9%	Jan-24

Year to Date

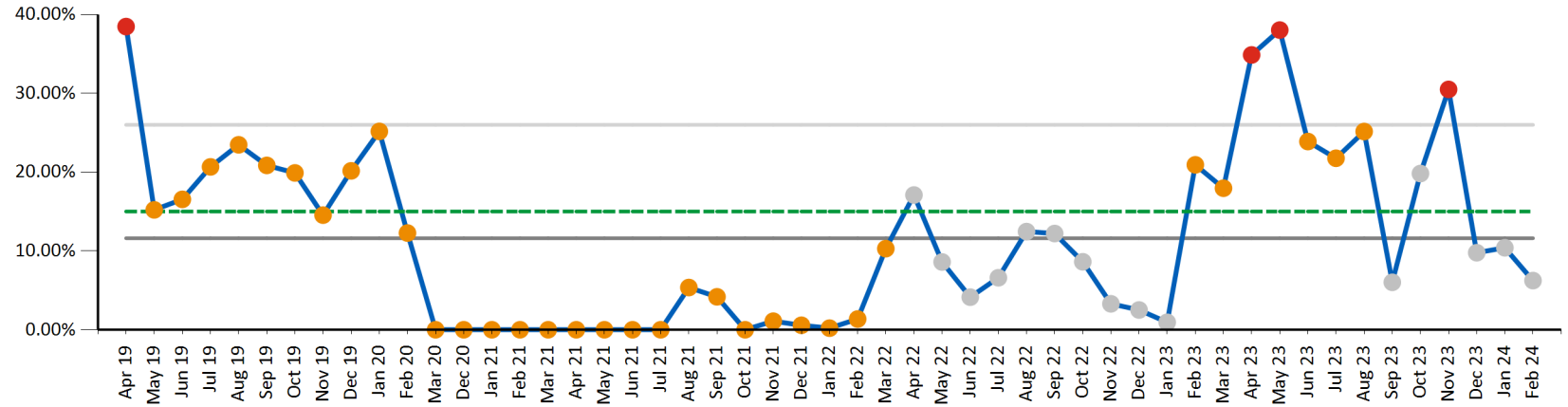
Plan	Actual
>= 90%	91.8%

82 - Antenatal - 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
>= 15%	6.2%	Feb-24

Previous

Plan	Actual	Period
>= 15%	10.4%	Jan-24

Year to Date

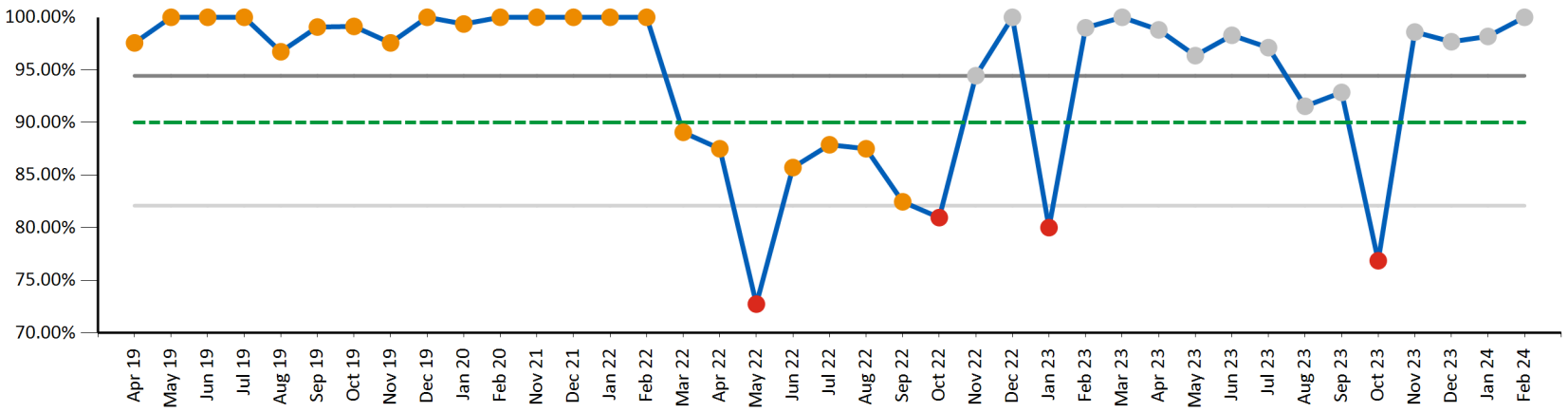
Plan	Actual
>= 15%	20.7%

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%	100.0%	Feb-24

Previous

Plan	Actual	Period
>= 90%	98.2%	Jan-24

Year to Date

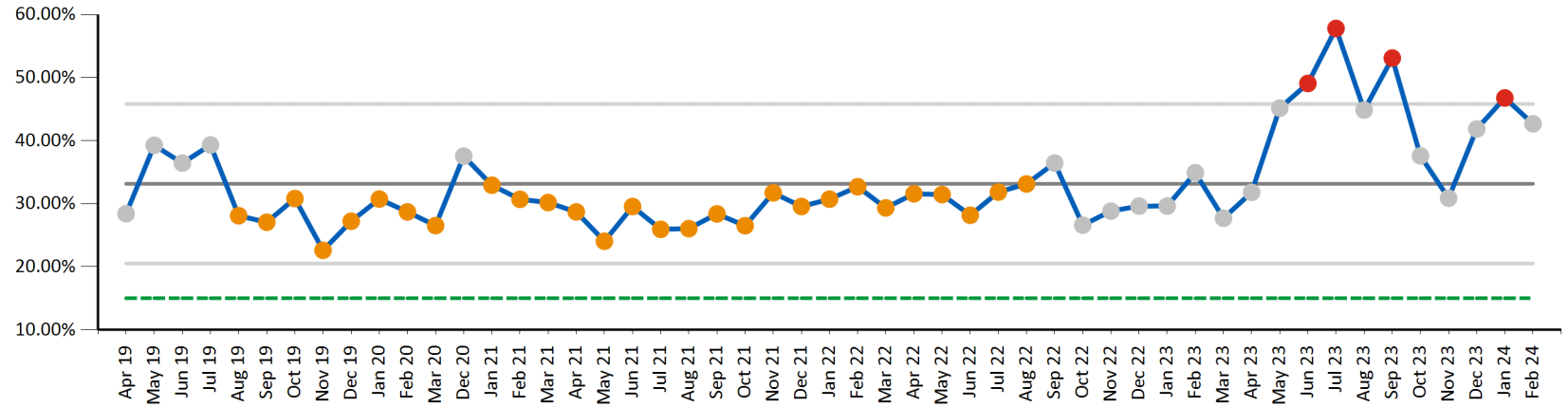
Plan	Actual
>= 90%	95.0%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	42.7%	Feb-24

Previous

Plan	Actual	Period
>= 15%	46.8%	Jan-24

Year to Date

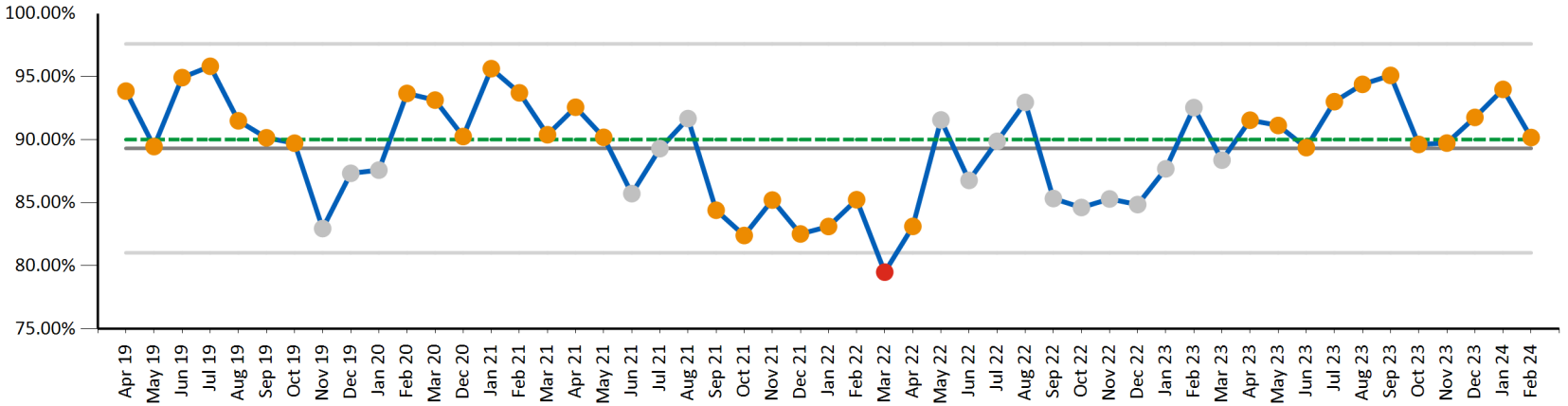
Plan	Actual
>= 15%	43.9%

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%	90.2%	Feb-24

Previous

Plan	Actual	Period
>= 90%	94.0%	Jan-24

Year to Date

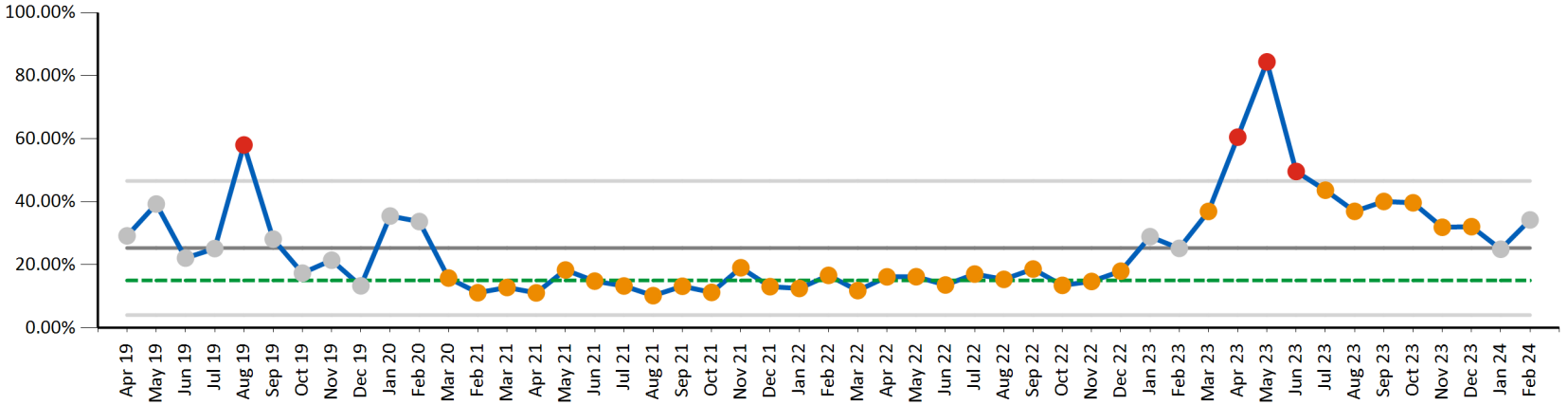
Plan	Actual
>= 90%	91.9%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 15%	34.2%	Feb-24

Previous

Plan	Actual	Period
>= 15%	24.9%	Jan-24

Year to Date

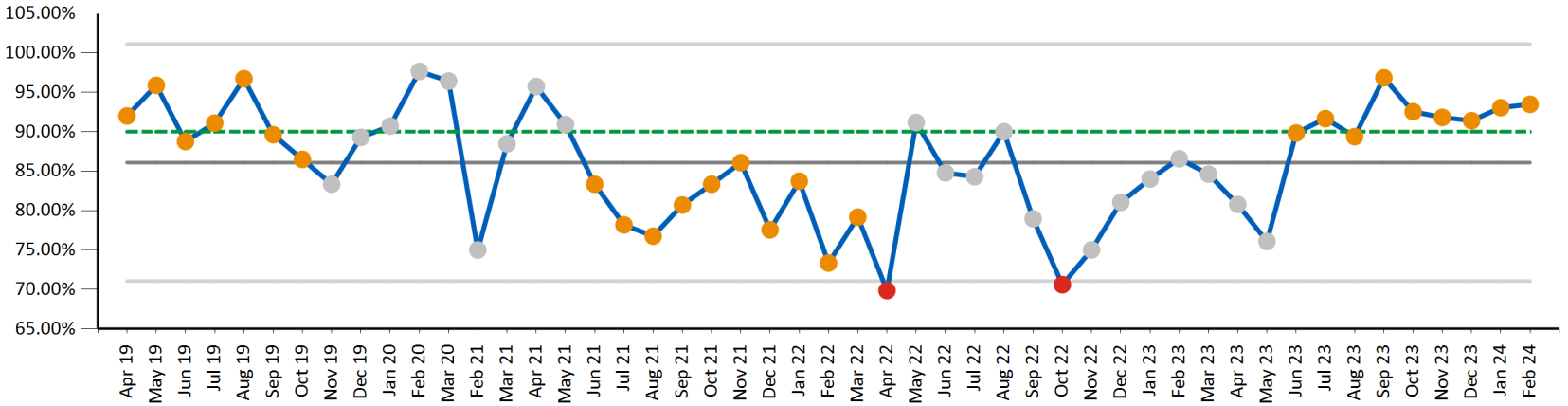
Plan	Actual
>= 15%	43.9%

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.

6/6



Latest

Plan	Actual	Period
>= 90%	93.5%	Feb-24

Previous

Plan	Actual	Period
>= 90%	93.1%	Jan-24

Year to Date

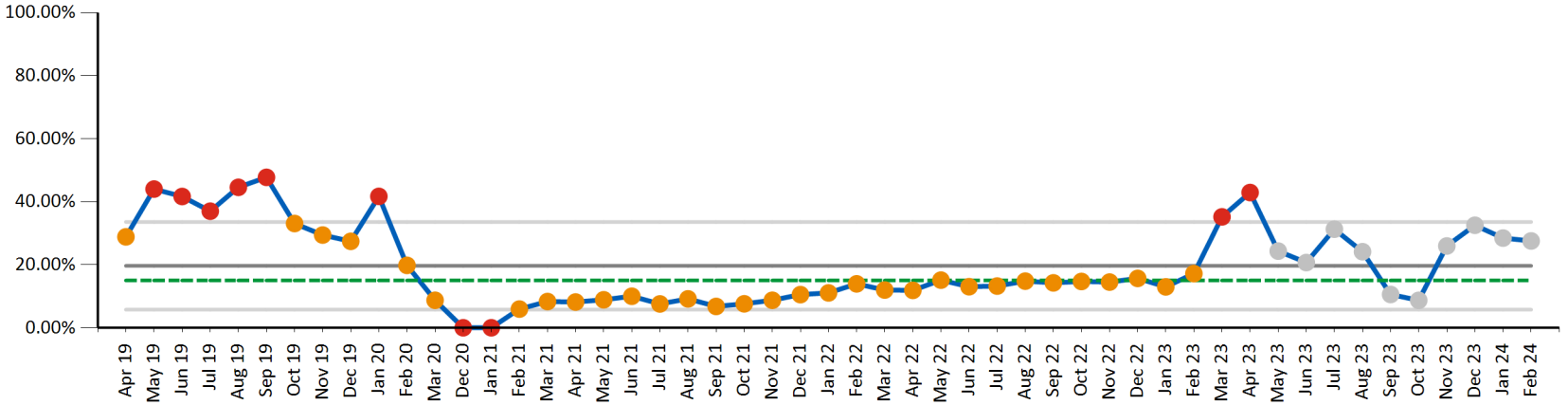
Plan	Actual
>= 90%	87.9%

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%	27.5%	Feb-24

Previous

Plan	Actual	Period
>= 15%	28.5%	Jan-24

Year to Date

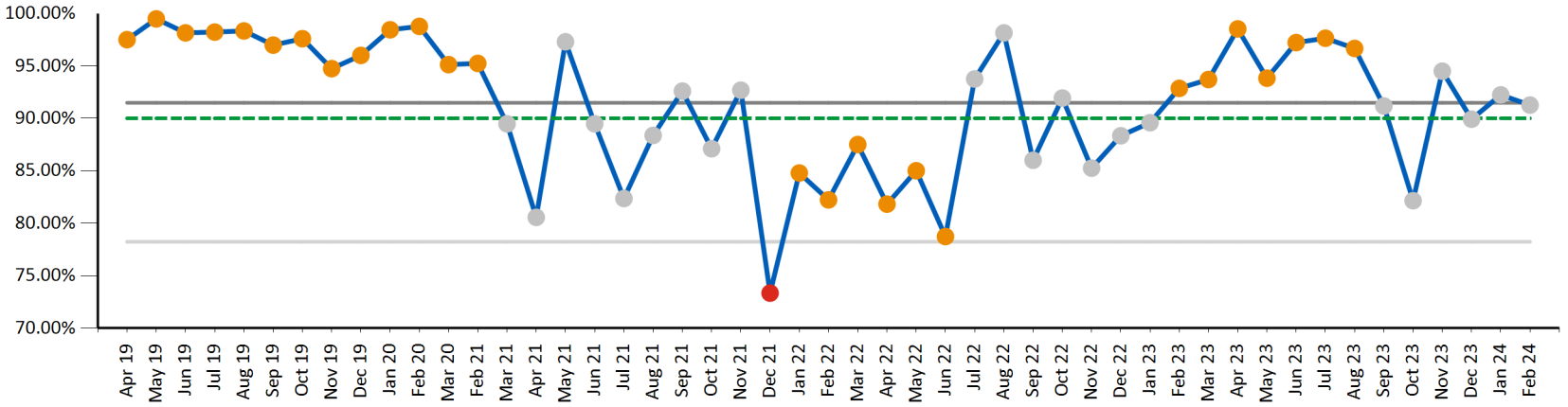
Plan	Actual
>= 15%	25.4%

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%	91.3%	Feb-24

Previous

Plan	Actual	Period
>= 90%	92.2%	Jan-24

Year to Date

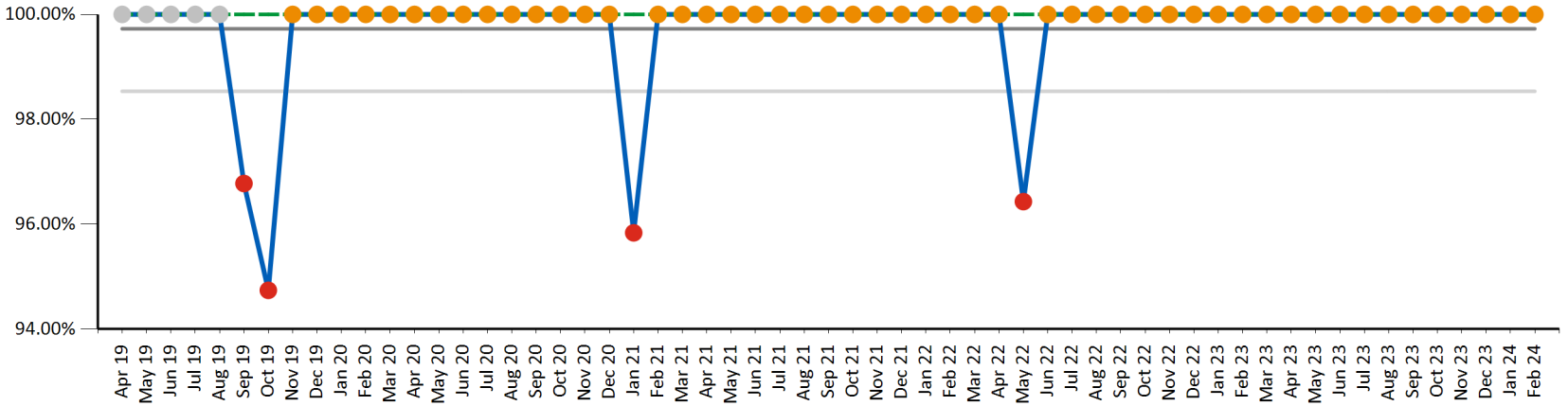
Plan	Actual
>= 90%	94.2%

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%	Feb-24

Previous

Plan	Actual	Period
= 100%	100.0%	Jan-24

Year to Date

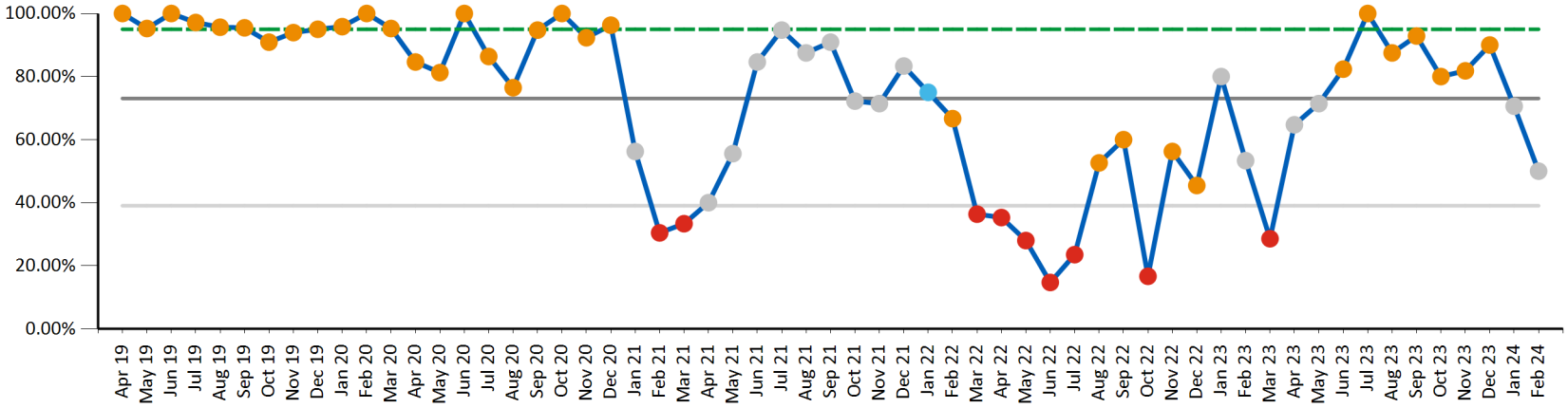
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	50.0%	Feb-24

Previous

Plan	Actual	Period
>= 95%	70.6%	Jan-24

Year to Date

Plan	Actual
>= 95%	78.5%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family Response Rate – Stabilisation in the overall maternity friends and family response rate continues at 26.3 %. Further improvement required in antenatal response rate. Support being provided following a change in leadership within clinical area.

¾ degree tears – Lower than average incidence of 2.6% for second consecutive month. Year to date incidence 3.34% slightly higher than rolling 12 month GMEC comparator average of 2.59% -flagged at Greater Manchester & East Cheshire (GMEC) safety assurance panel and system wide learning event being planned for May 2024 to share learning across providers. Regional team contacted to seek access to national maternity dashboard to elicit which provider has the best rate in UK then contact can be made to share good practice. No response received as yet.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Trust peak variation in incidence 7.32/1000 in month of February 2024. (3 cases including one transfer from another provider and including 2 early gestation cases) Trust 2024 rolling median rate 2.96 /per1000 slightly higher than GMEC rolling 12 months rate 2.88/1000. Implementation of all of the revised saving babies lives care bundle v3 elements continues. Perinatal mortality review of all eligible cases in progress. For assurance, 2022 Mothers and babies; reducing risk through audit and confidential enquiries, reports trust rate as 'around the average for similar Trusts & Health Boards'

1:1 care in labour – Decrease noted in Trust rate to 96.4% in February 2024. Trust incidence 88.61% lower than the rolling 12 month Greater Manchester and East Cheshire (GMEC) rate of 92.90% and peer average in similar sized providers (ie Oldham). No breaches of supernumerary status as per Clinical negligence scheme for trusts (CNST), classification reported. New staff in probationary period not included in staffing figures in February 2024 and thus negatively impacting upon the overall rate

Booked by 12+6 – Notable deteriorating trend in booking performance noted. Detailed review undertaken and data suggests that 2.4% of the breaches related to scan issues and 16.8% related to late presenters (predominantly in white population). Ongoing work continues to revise the booking process as women are being added onto the LE 2.2 Trust patient management system and given a booking appointment when they will have already breached the 12+6 timeframe. This was reported last month with update provided illustrating the importance of separating the ultrasound date from the first appointment with midwife (see standard below).

Booked by 10 weeks (new standard)– Target reflects bookings by 10+0 as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact upon compliance rate. An action plan has been collated that has identified booking delays are influenced by duplication of process epr/paper, lack of digital devices (18 laptops outstanding) and lack of wifi access in community estate. Operational support has been provided to address the issues identified. Trust performance 52.1% above GMEC median of 52.71%. As reported last month, an improvement plan is underway and a trajectory for improvement will follow once all key drivers have ben identified.

Inductions of labour – New metric on dashboard indicates that 36.1% of induction of labour cases by 24 hours were delayed in February 2024, such cases can be associated with poor outcomes for mother and baby. This equated to 52 cases in total. Issue relates to lack of bed flow capacity within the maternity unit due to RAAC reconfiguration. In response, a discharge lounge is being developed on Ward G3 to address the issue.

Breastfeeding initiation – Sustained improvement again in performance noted in month to 69.55%. Trust year to date incidence 69.22% slightly higher than GMEC 12 months average of 62.73%.

Preterm birth –Trust 12mths rolling data 9.42% slightly higher than previous GMEC rolling 12mth rate 8.92%. 8.0% incidence within month reported. Pre term lead appointed.

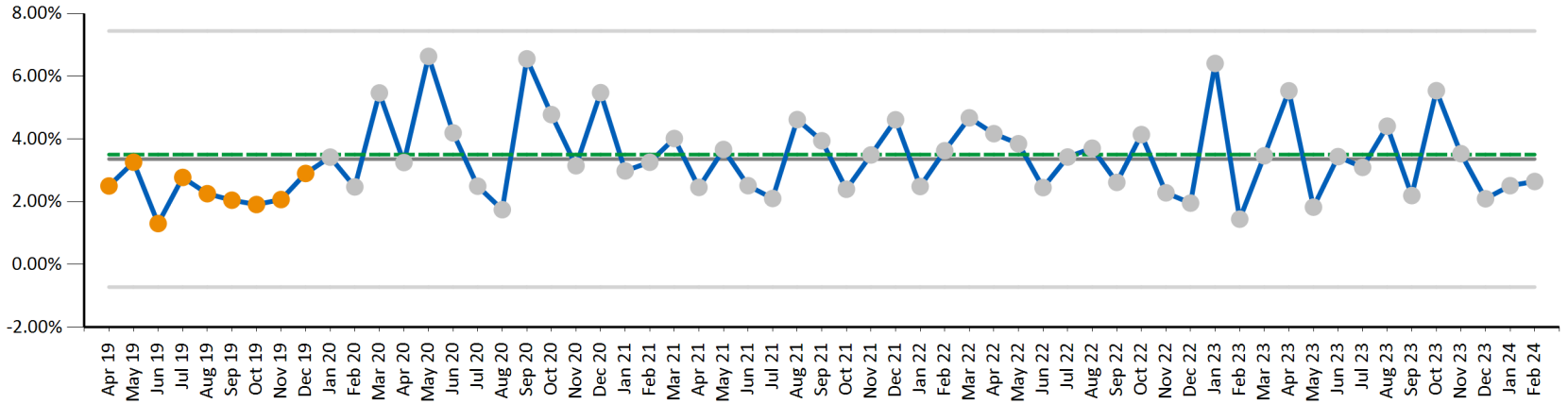
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (as per GMEC methodology)	<= 3.50	7.32	Feb-24		<= 3.50	4.39	Jan-24	<= 3.50	4.18	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.6%	Feb-24		<= 3.5%	2.5%	Jan-24	<= 3.5%	3.4%	
202 - 1:1 Midwifery care in labour	>= 95.0%	96.4%	Feb-24		>= 95.0%	97.7%	Jan-24	>= 95.0%	98.3%	
203 - Booked 12+6	>= 90.0%	80.6%	Feb-24		>= 90.0%	78.9%	Jan-24	>= 90.0%	85.2%	
586 - Booked 10+0		44.4%	Feb-24			44.4%	Jan-24		52.4%	
204 - Inductions of labour - over 24 hours	<= 40%	36.1%	Feb-24		<= 40%	33.0%	Jan-24	<= 40%	35.3%	
210 - Initiation breast feeding	>= 65%	69.55%	Feb-24		>= 65%	67.56%	Jan-24	>= 65%	68.35%	
213 - Maternity complaints	<= 5	1	Feb-24		<= 5	0	Jan-24	<= 55	17	
319 - Maternal deaths (direct)	= 0	0	Feb-24		= 0	0	Jan-24	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.0%	Feb-24		<= 6%	9.4%	Jan-24	<= 6%	9.8%	

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	2.6%	Feb-24

Previous

Plan	Actual	Period
<= 3.5%	2.5%	Jan-24

Year to Date

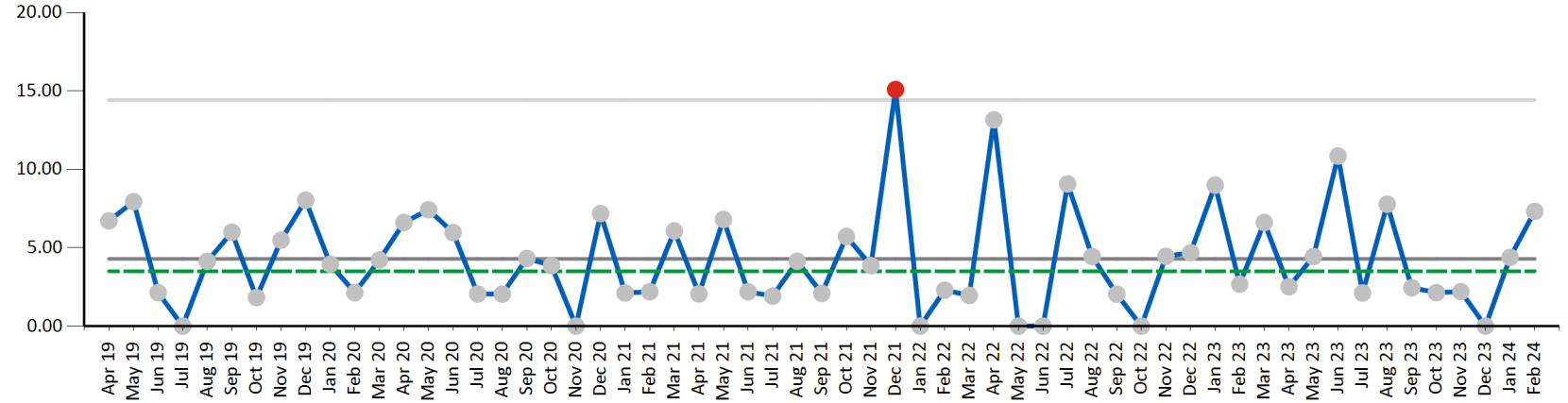
Plan	Actual
<= 3.5%	3.4%

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.50	7.32	Feb-24

Previous

Plan	Actual	Period
<= 3.50	4.39	Jan-24

Year to Date

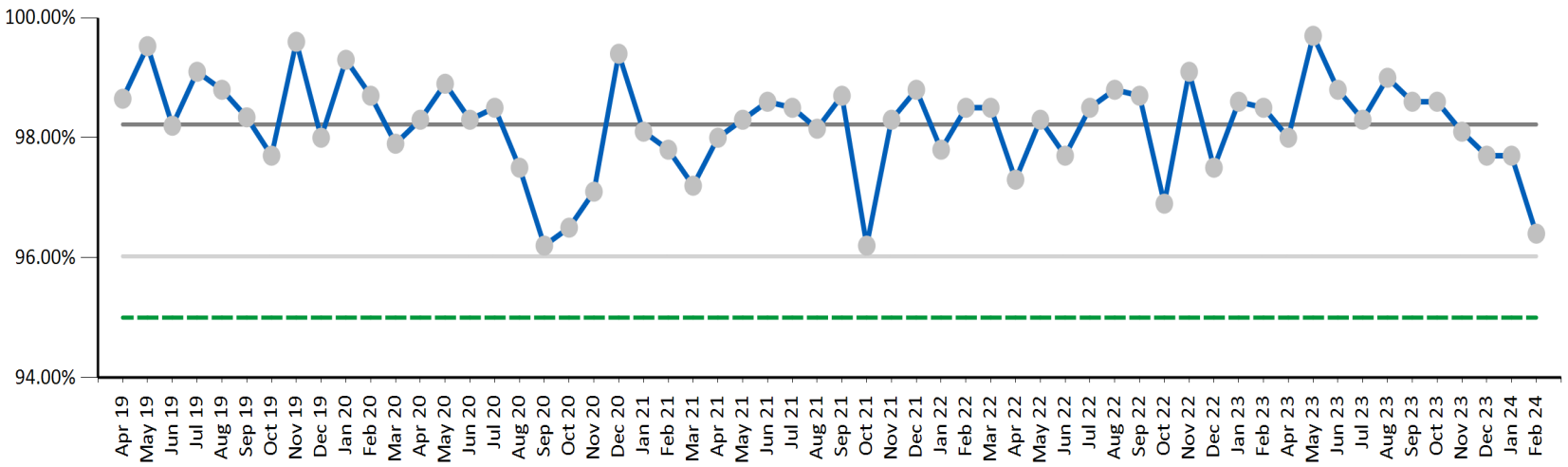
Plan	Actual
<= 3.50	4.18

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	96.4%	Feb-24

Previous

Plan	Actual	Period
>= 95.0%	97.7%	Jan-24

Year to Date

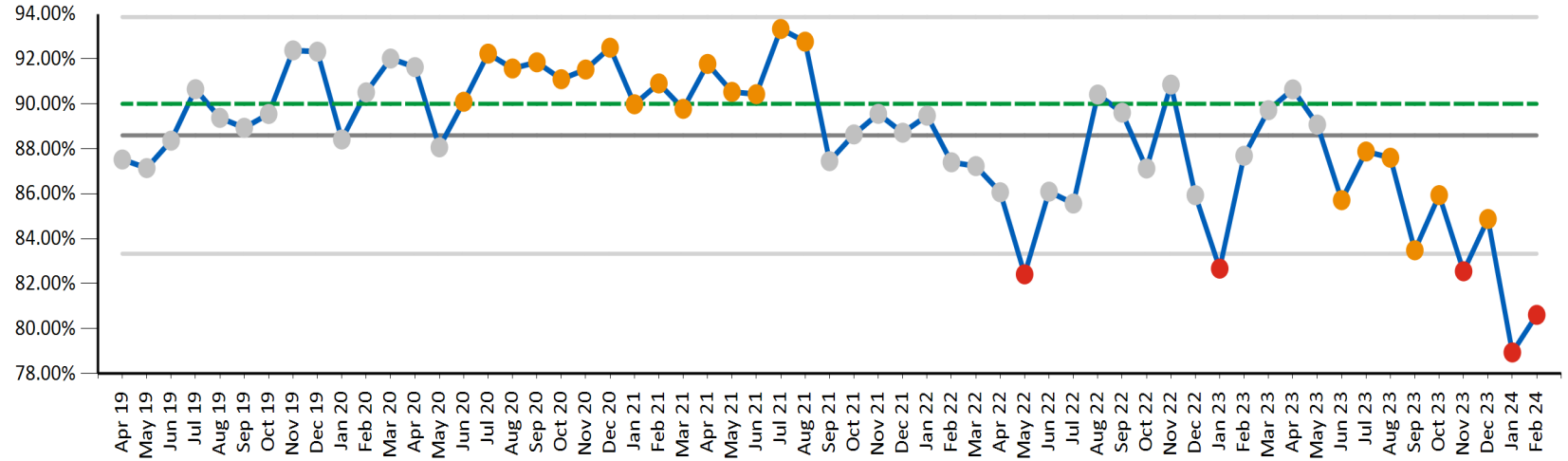
Plan	Actual
>= 95.0%	98.3%

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%	80.6%	Feb-24

Previous

Plan	Actual	Period
>= 90.0%	78.9%	Jan-24

Year to Date

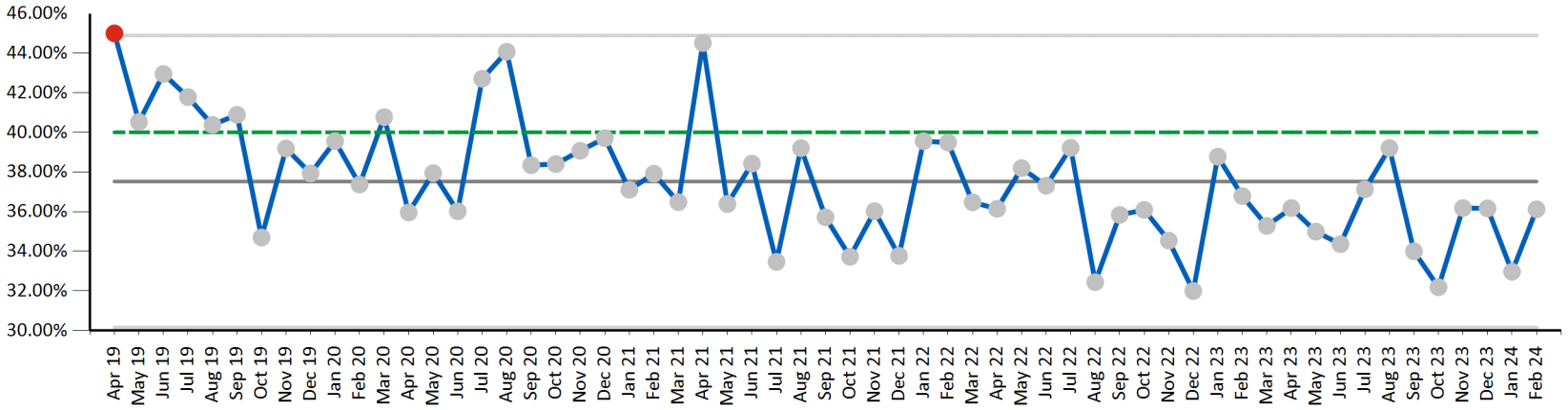
Plan	Actual
>= 90.0%	85.2%

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%	36.1%	Feb-24

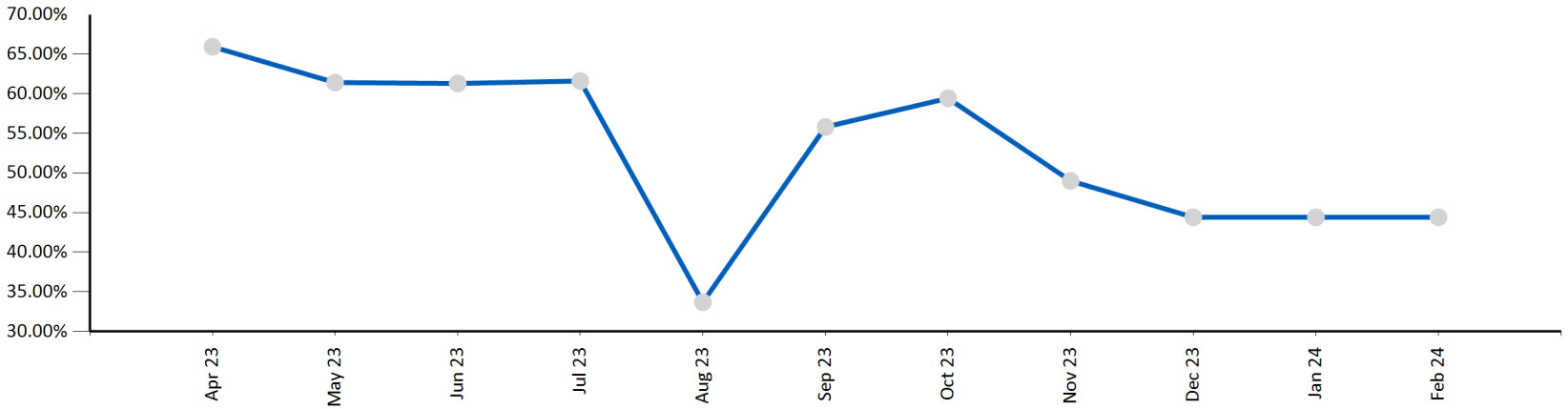
Previous

Plan	Actual	Period
<= 40%	33.0%	Jan-24

Year to Date

Plan	Actual
<= 40%	35.3%

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



Latest

Plan	Actual	Period
	44.4%	Feb-24

Previous

Plan	Actual	Period
	44.4%	Jan-24

Year to Date

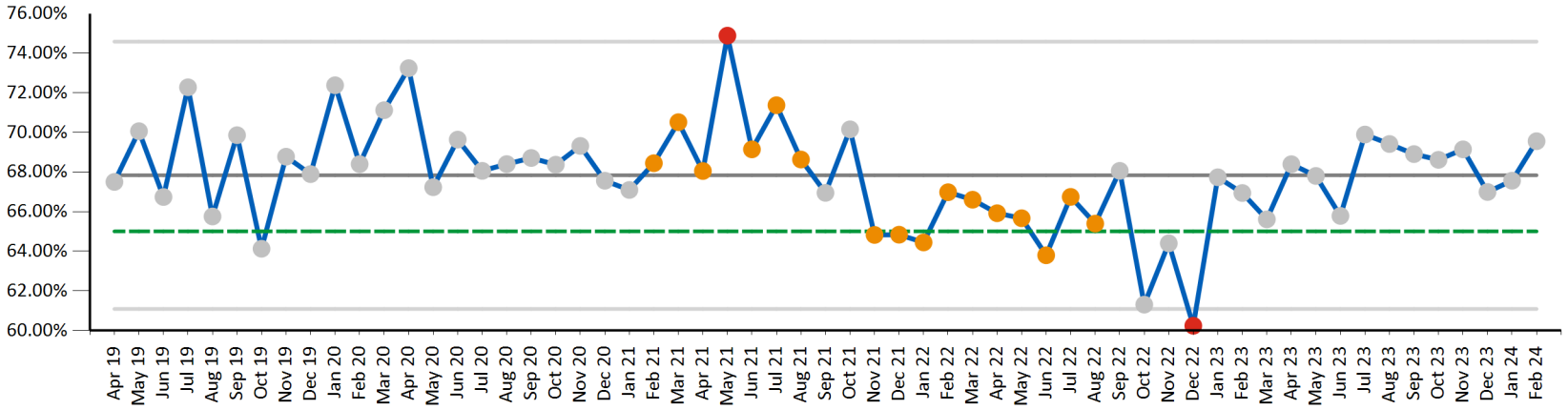
Plan	Actual
	52.4%

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%	69.55%	Feb-24

Previous

Plan	Actual	Period
>= 65%	67.56%	Jan-24

Year to Date

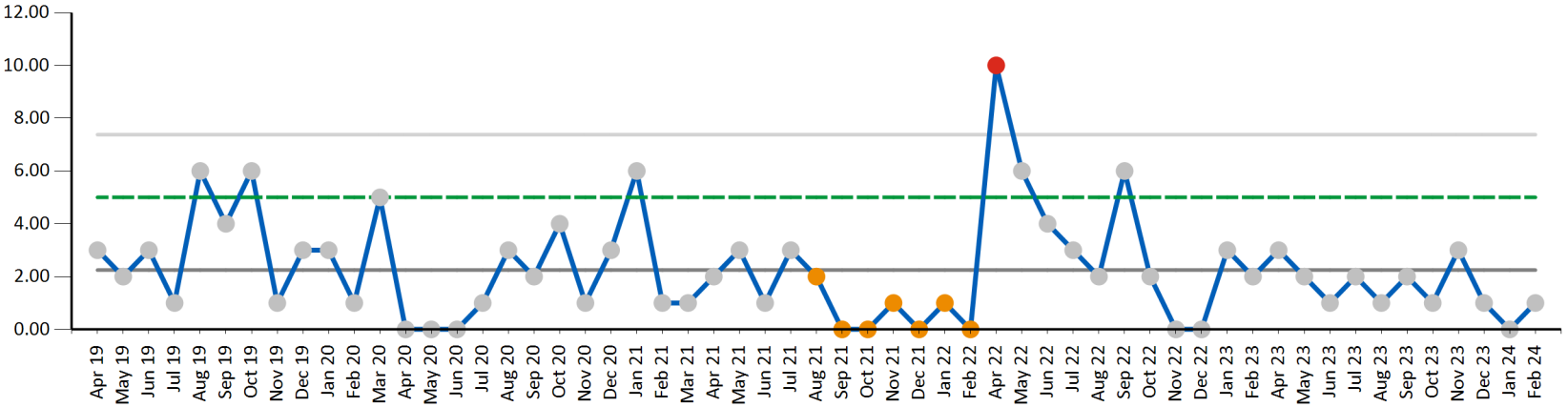
Plan	Actual
>= 65%	68.35%

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	Feb-24

Previous

Plan	Actual	Period
<= 5	0	Jan-24

Year to Date

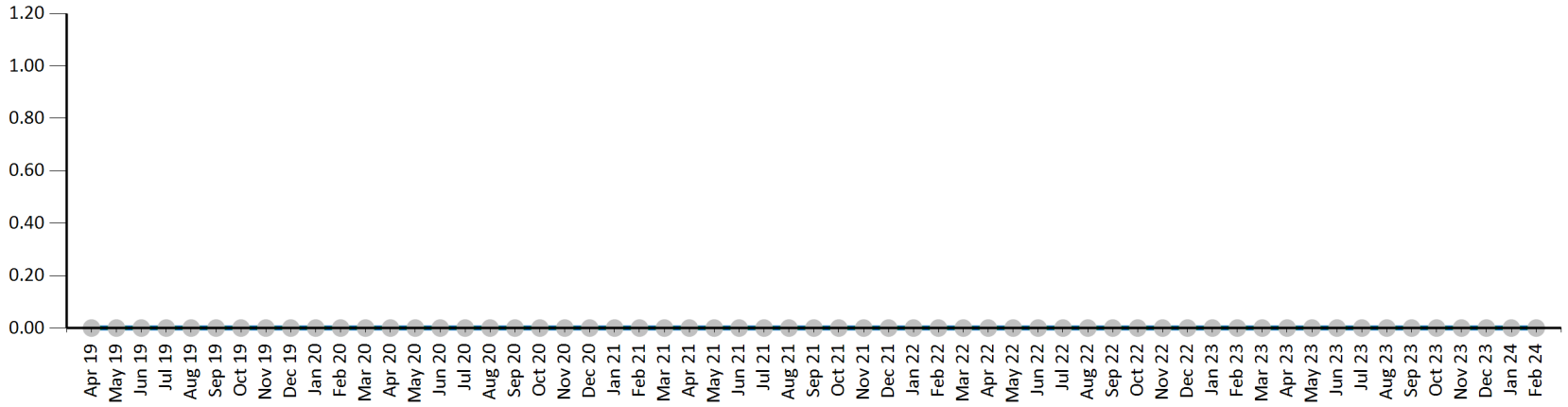
Plan	Actual
<= 55	17

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	Feb-24

Previous

Plan	Actual	Period
= 0	0	Jan-24

Year to Date

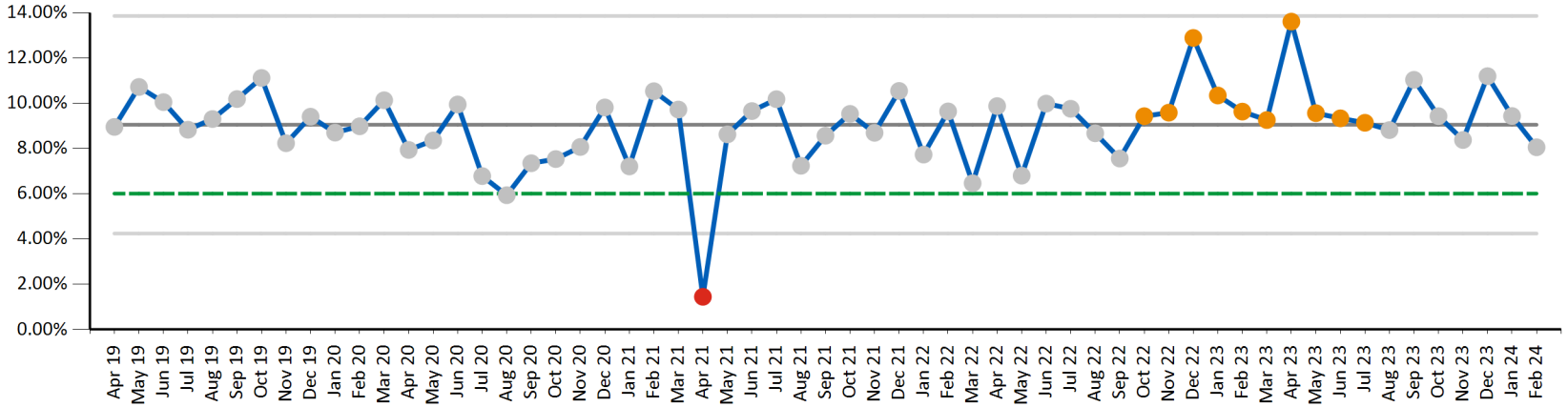
Plan	Actual
= 0	0

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%	8.0%	Feb-24

Previous

Plan	Actual	Period
<= 6%	9.4%	Jan-24

Year to Date

Plan	Actual
<= 6%	9.8%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

A&E 4 Hour

Performance in February was a further deterioration and has now been on an overall downward trend since June 2023. We have now translated the ECIST recommendations into a revised urgent care improvement plan, delivery of which is being overseen through an executive led improvement group. We are forecasting an improvement in March

Ambulance

Performance across the suite of ambulance handover standards has deteriorated. This has been linked mainly to overcrowding in the emergency department and consequently we have seen an increase in the number of ambulances held outside the department. A daily performance meeting has been in place throughout March which is reviewing these breaches alongside other performance metrics.

NOF

Our fractured neck of femur performance remained largely static again this month, at 40.5%.

The majority of breaches (18) continue to relate to challenges with theatre capacity, with other breaches relating to complex pathways and patients not being medically optimised. Work is ongoing against the identified action plan to improve performance, including a review of trauma capacity to enable sufficient capacity across the week, and to continue to enable the separation of elective and non-elective capacity which is supported by GIRFT.

	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%	51.8%	Feb-24	L	>= 75%	55.0%	Jan-24	>= 75%	60.7%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	32.4%	Feb-24		>= 65.0%	37.0%	Jan-24	>= 65.0%	50.3%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	59.5%	Feb-24	L	>= 95.0%	65.4%	Jan-24	>= 95.0%	77.4%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	75.56%	Feb-24	L	= 100%	80.80%	Jan-24	= 100%	89.62%	F
539 - A&E 12 hour waits	= 0	1,638	Feb-24		= 0	1,577	Jan-24	= 0	13,828	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	40.5%	Feb-24		>= 75%	47.1%	Jan-24	>= 75%	54.6%	?
56 - Stranded patients - over 7 days	<= 200	288	Feb-24	H	<= 200	298	Jan-24	<= 200	288	?
307 - Stranded Patients - LOS 21 days and over	<= 69	119	Feb-24	H	<= 69	120	Jan-24	<= 69	119	?

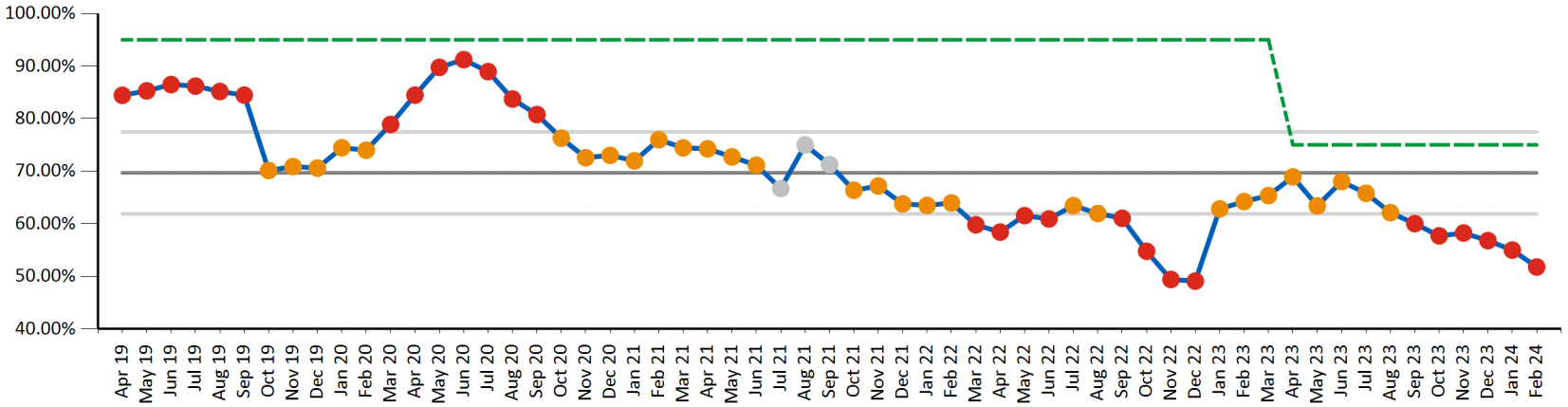
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
541 - Adult G&A bed occupancy	<= 92.0%	89.7%	Feb-24		<= 92.0%	90.4%	Jan-24	<= 92.0%	87.6%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.76	Feb-24		<= 3.70	5.87	Jan-24	<= 3.70	5.93	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.5%	Jan-24	L	<= 13.5%	8.7%	Dec-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%	51.8%	Feb-24

Previous

Plan	Actual	Period
>= 75%	55.0%	Jan-24

Year to Date

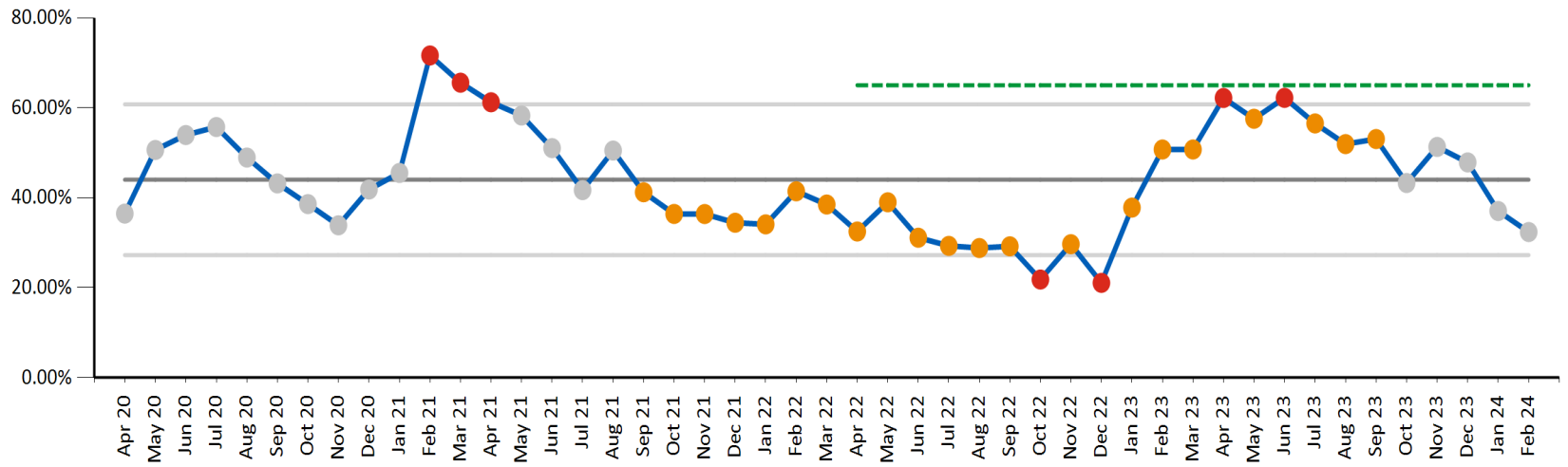
Plan	Actual
>= 75%	60.7%

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%	32.4%	Feb-24

Previous

Plan	Actual	Period
>= 65.0%	37.0%	Jan-24

Year to Date

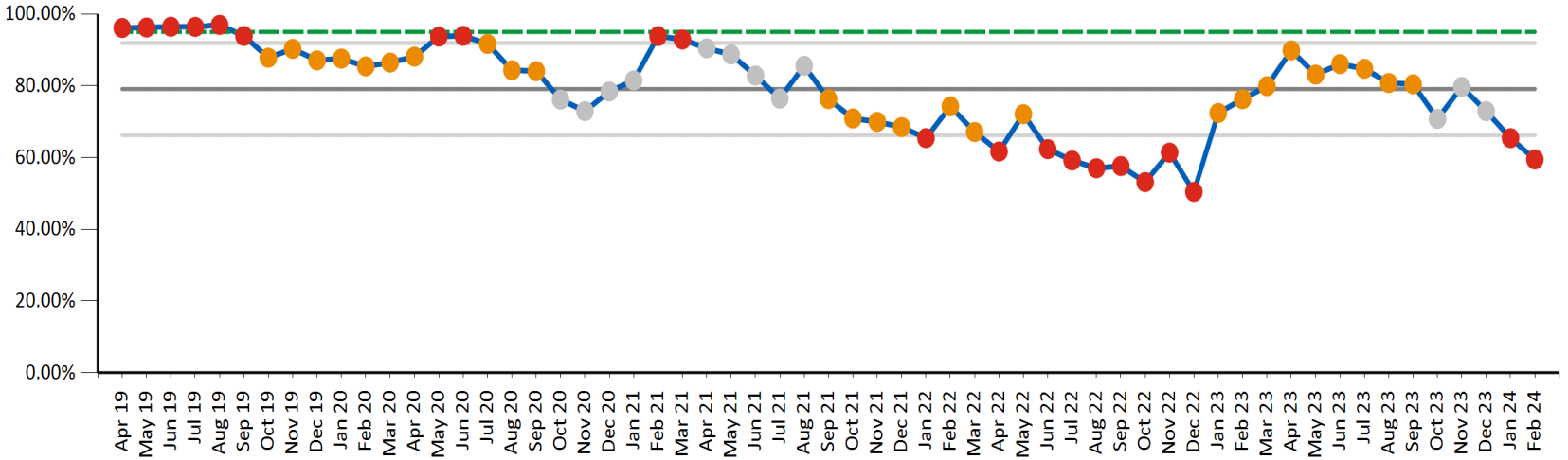
Plan	Actual
>= 65.0%	50.3%

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

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	59.5%	Feb-24

Previous

Plan	Actual	Period
>= 95.0%	65.4%	Jan-24

Year to Date

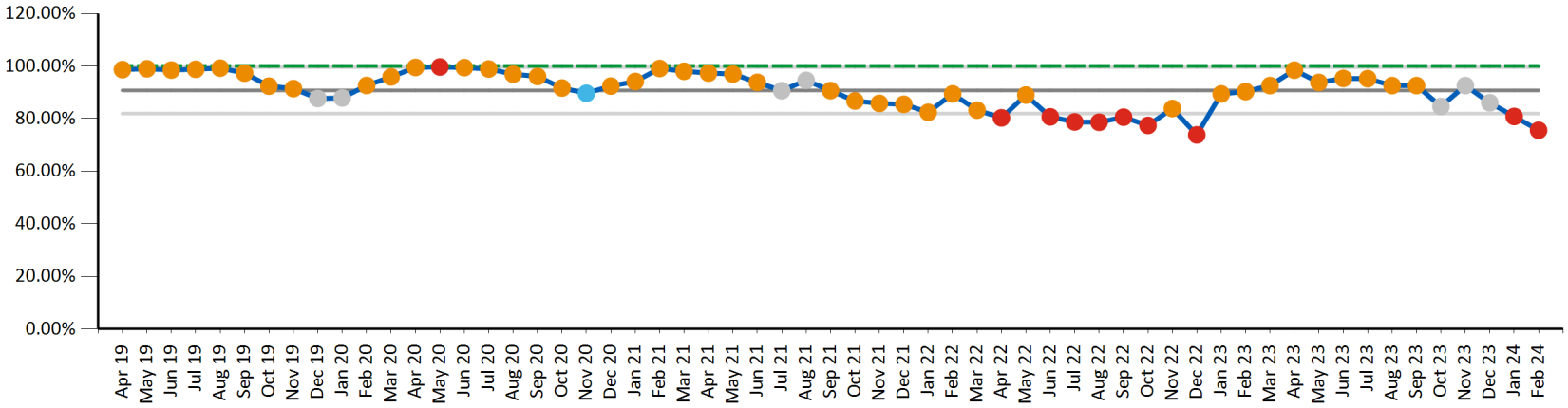
Plan	Actual
>= 95.0%	77.4%

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

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	75.56%	Feb-24

Previous

Plan	Actual	Period
= 100%	80.80%	Jan-24

Year to Date

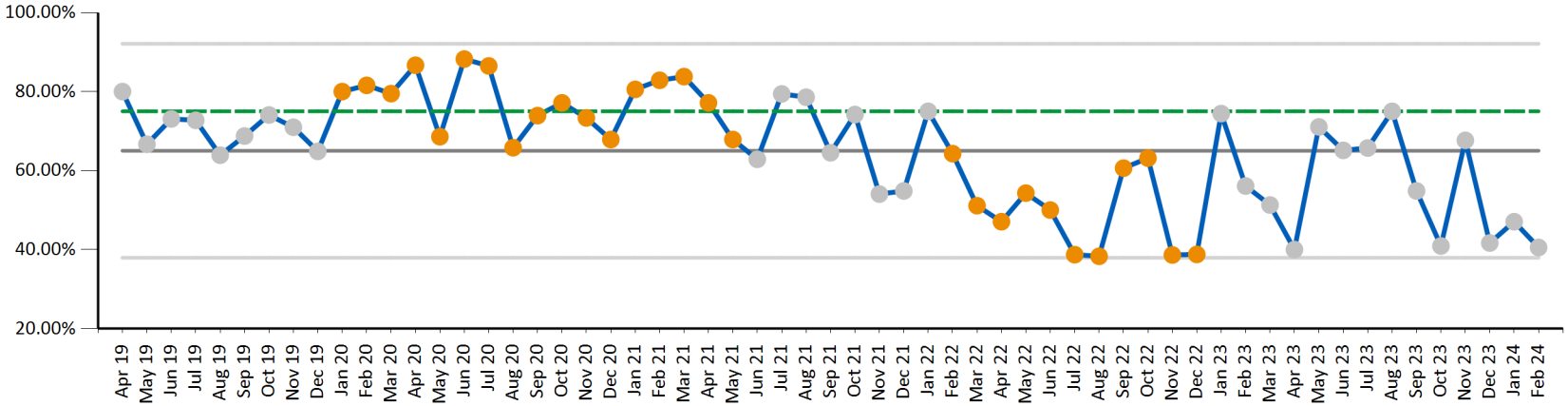
Plan	Actual
= 100%	89.62%

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.

0/6



Latest

Plan	Actual	Period
>= 75%	40.5%	Feb-24

Previous

Plan	Actual	Period
>= 75%	47.1%	Jan-24

Year to Date

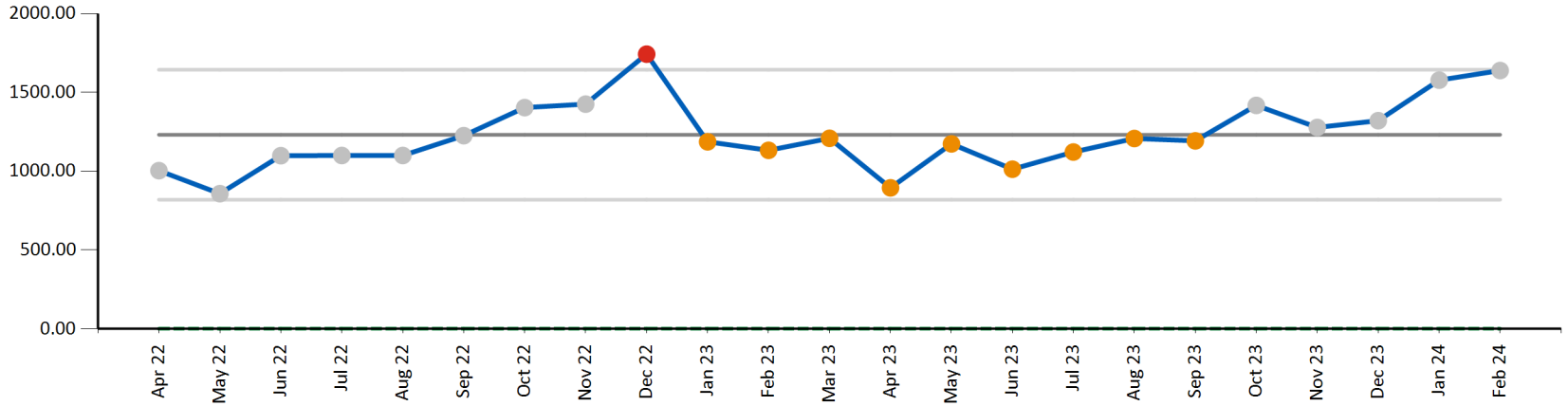
Plan	Actual
>= 75%	54.6%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,638	Feb-24

Previous

Plan	Actual	Period
= 0	1,577	Jan-24

Year to Date

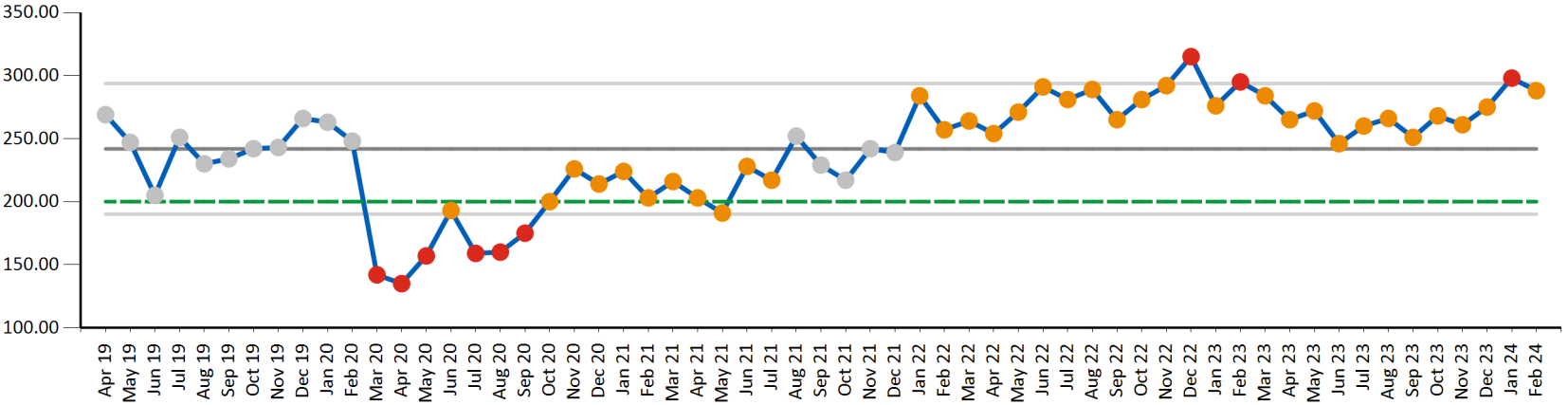
Plan	Actual
= 0	13,828

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	288	Feb-24

Previous

Plan	Actual	Period
<= 200	298	Jan-24

Year to Date

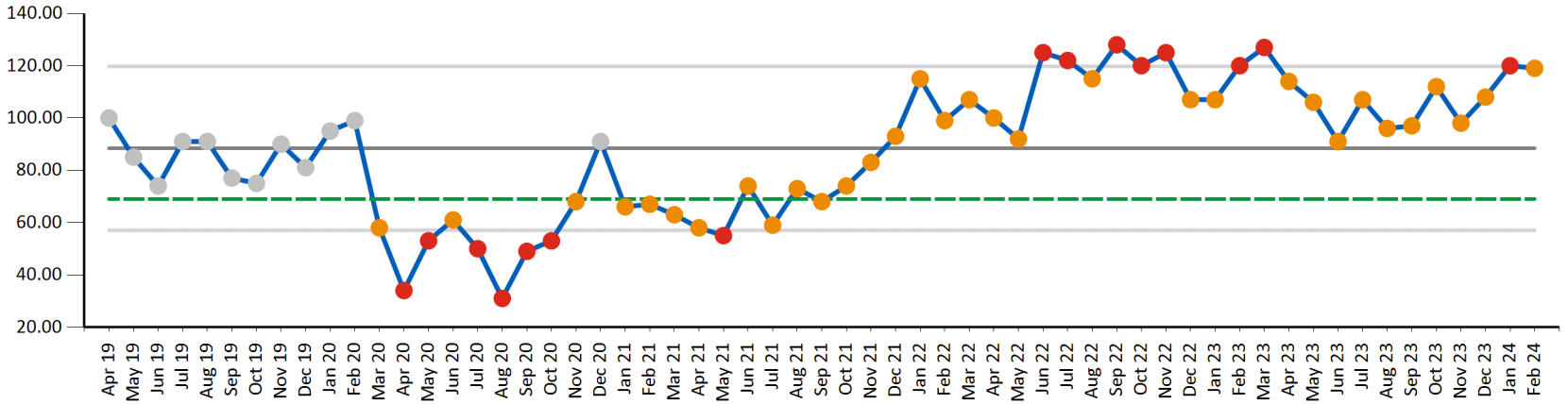
Plan	Actual
<= 200	288

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	119	Feb-24

Previous

Plan	Actual	Period
<= 69	120	Jan-24

Year to Date

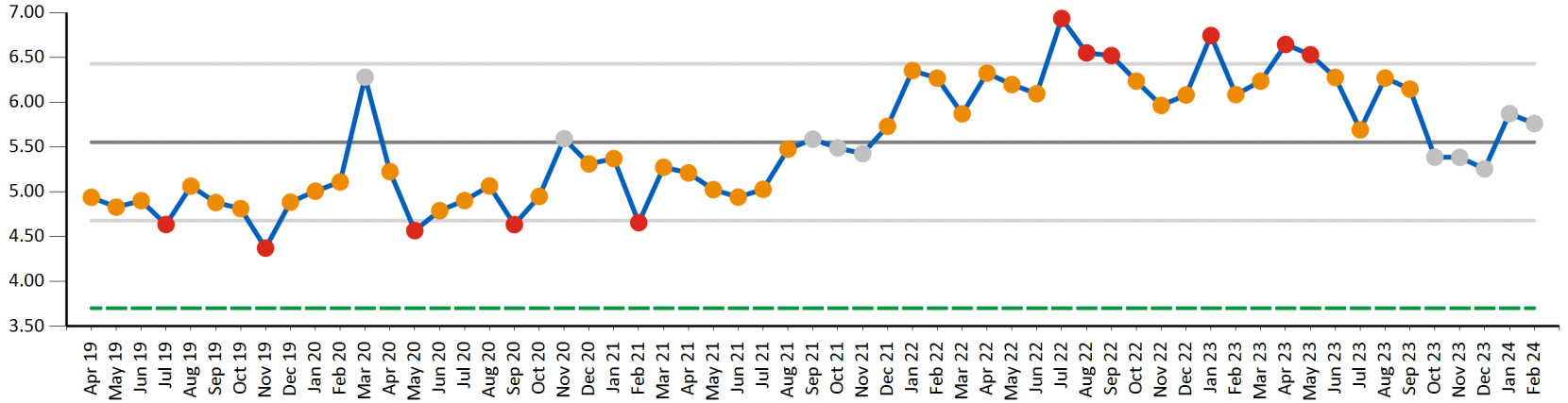
Plan	Actual
<= 69	119

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	5.76	Feb-24

Previous

Plan	Actual	Period
<= 3.70	5.87	Jan-24

Year to Date

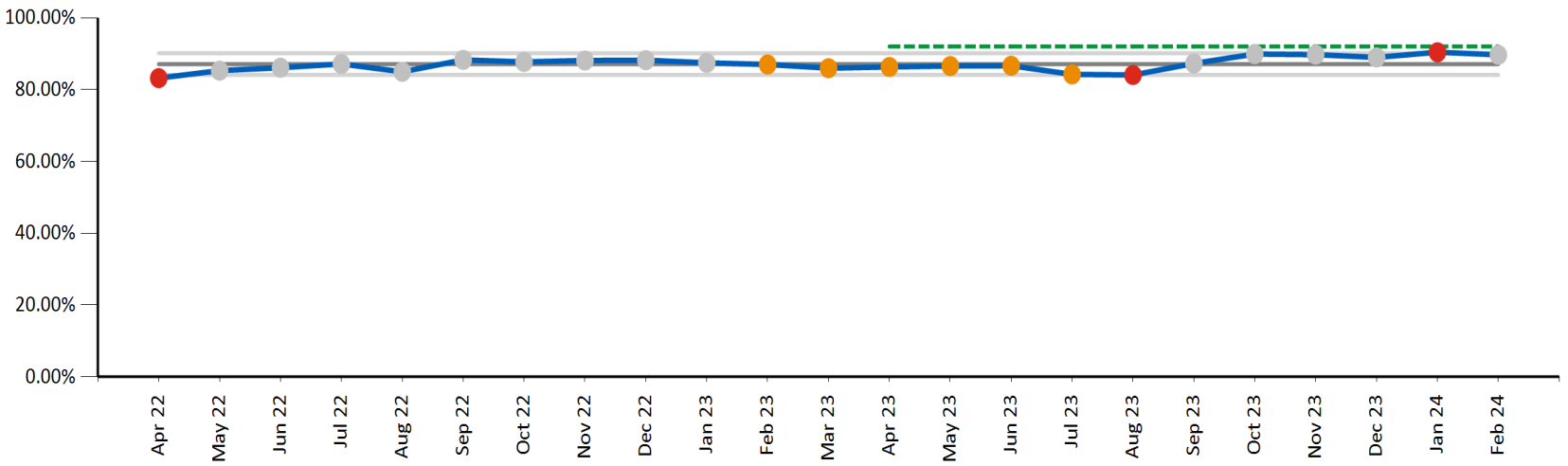
Plan	Actual
<= 3.70	5.93

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	89.7%	Feb-24

Previous

Plan	Actual	Period
<= 92.0%	90.4%	Jan-24

Year to Date

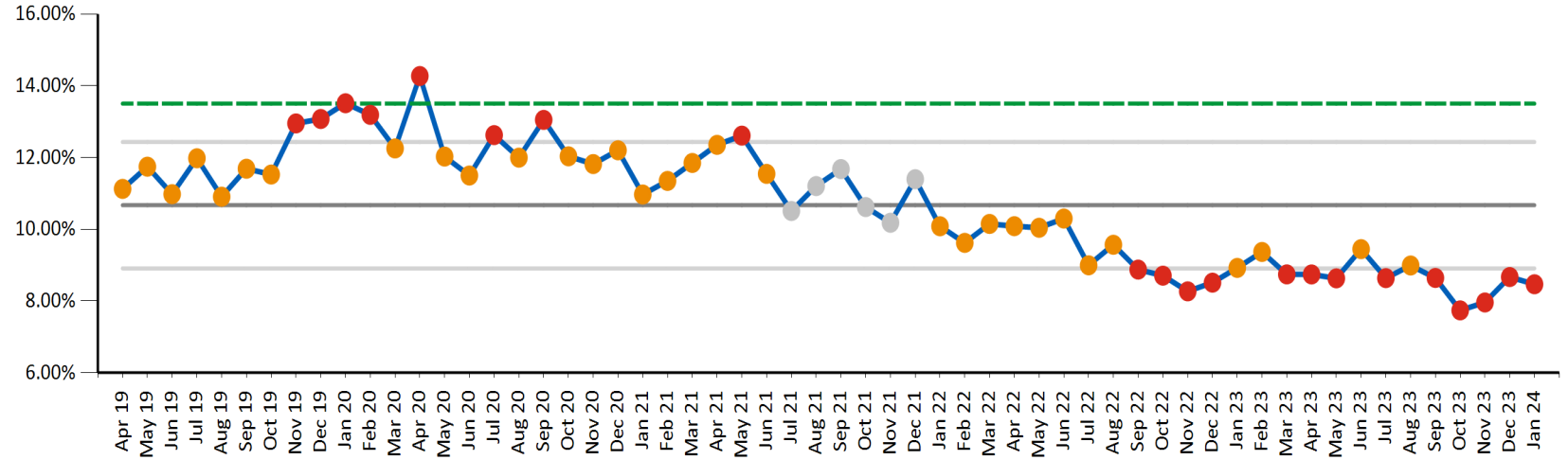
Plan	Actual
<= 92.0%	87.6%

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

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	8.5%	Jan-24

Previous

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

Year to Date

Plan	Actual
<= 13.5%	8.6%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished February with 90 78-week breaches. Breaches due to capacity challenges are mainly within our paediatric specialties, and we are working with RMCH to identify additional capacity. We are also experiencing capacity pressures within Urology as a result of increased cancer demand. We continue to work to ensure that there are no patients waiting longer than 78-weeks at the end of March 2024 (other than patients waiting for corneal graft materials. There is currently a high level of risk with this due to patients wishing to defer their treatment until after April, and due to patients who may be not clinically fit for treatment before the end of April 2024.

We remain on track with our re-forecasted end-of-year position for 65-weeks following February's industrial action.

DM01

The trust position has improved again this month by 3.7% with a final position of 7.6%. In particular Cardiology has completed their recovery plans and is now compliant with the 5% target, reporting at 2.1% The trust has seen an increase in the total number of patients on the waiting list by 579 but still managed to reduce the number of patients waiting over 6 weeks for their diagnostic tests by 69 patients. The forecasted dip in Imaging performance has reached 5.5% as expected due to a planned step down of additional outsourced capacity in preparation for the opening of the new state of the art Community Diagnostics Centre which will begin to absorb some of these work streams in March. This transfer has been carefully planned and recovery plans are expected to start in April 2024 for this speciality.

	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%	49.7%	Feb-24	L	>= 92%	50.0%	Jan-24	>= 92%	55.3%	F
314 - RTT 18 week waiting list	<= 37,764	44,219	Feb-24	H	<= 37,914	43,947	Jan-24	<= 37,764	44,219	P
42 - RTT 52 week waits (incomplete pathways)		3,113	Feb-24	H		2,971	Jan-24		27,167	
540 - RTT 65 week waits (incomplete pathways)	<= 648	949	Feb-24	H	<= 784	889	Jan-24	<= 7,425	7,700	?
526 - RTT 78 week waits (incomplete pathways)	= 0	90	Feb-24	L	= 0	94	Jan-24	= 0	572	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Feb-24	L	= 0	3	Jan-24	= 0	11	F
72 - Diagnostic Waits >6 weeks %	<= 5%	7.6%	Feb-24	L	<= 5%	11.3%	Jan-24	<= 5%	15.0%	F
489 - Daycase Rates	>= 85%	82.1%	Feb-24		>= 85%	85.3%	Jan-24	>= 85%	84.3%	?

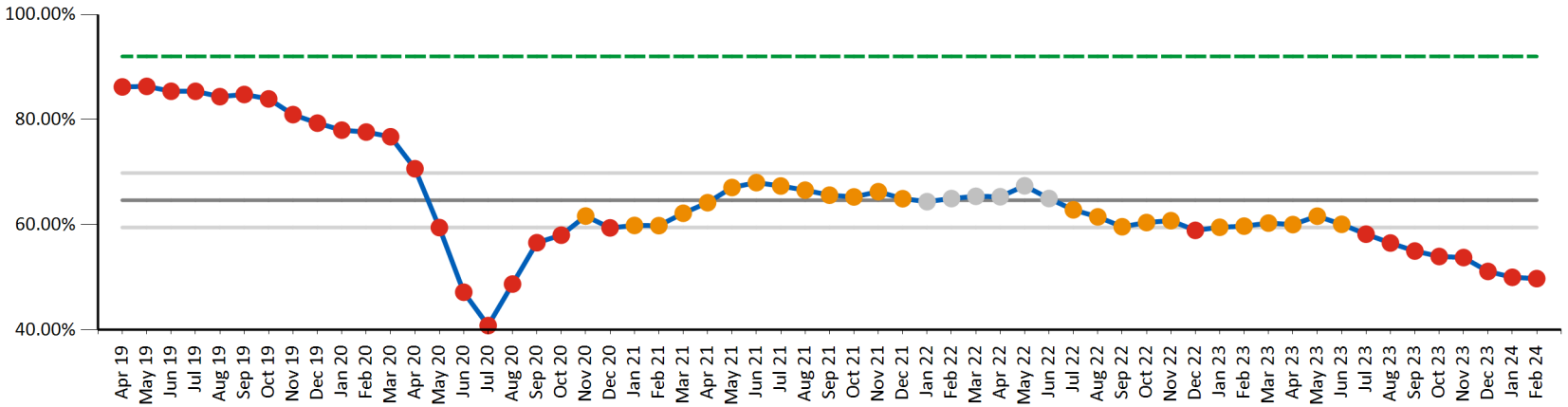
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
582 - Theatre Utilisation - Capped		74.7%	Feb-24			75.9%	Jan-24		75.1%	
583 - Theatre Utilisation - Uncapped		79.2%	Feb-24			78.9%	Jan-24		79.9%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.0%	Feb-24		<= 1%	1.6%	Jan-24	<= 1%	1.6%	?
62 - Cancelled operations re-booked within 28 days	= 100%	86.8%	Jan-24		= 100%	71.9%	Dec-23	= 100%	26.3%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.82	Feb-24		<= 2.00	2.86	Jan-24	<= 2.00	2.93	?
309 - DNA Rate - New	<= 6.3%	8.8%	Feb-24		<= 6.3%	9.4%	Jan-24	<= 6.3%	9.6%	F
310 - DNA Rate - Follow up	<= 5.0%	8.9%	Feb-24		<= 5.0%	9.3%	Jan-24	<= 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%	49.7%	Feb-24

Previous

Plan	Actual	Period
>= 92%	50.0%	Jan-24

Year to Date

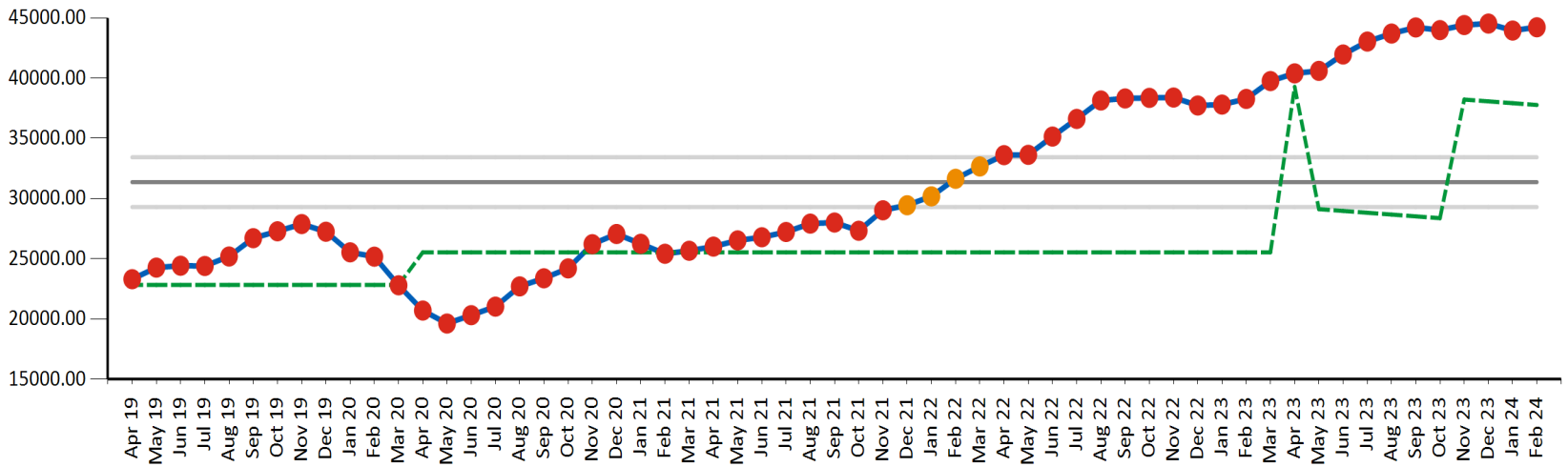
Plan	Actual
>= 92%	55.3%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
<= 37,764	44,219	Feb-24

Previous

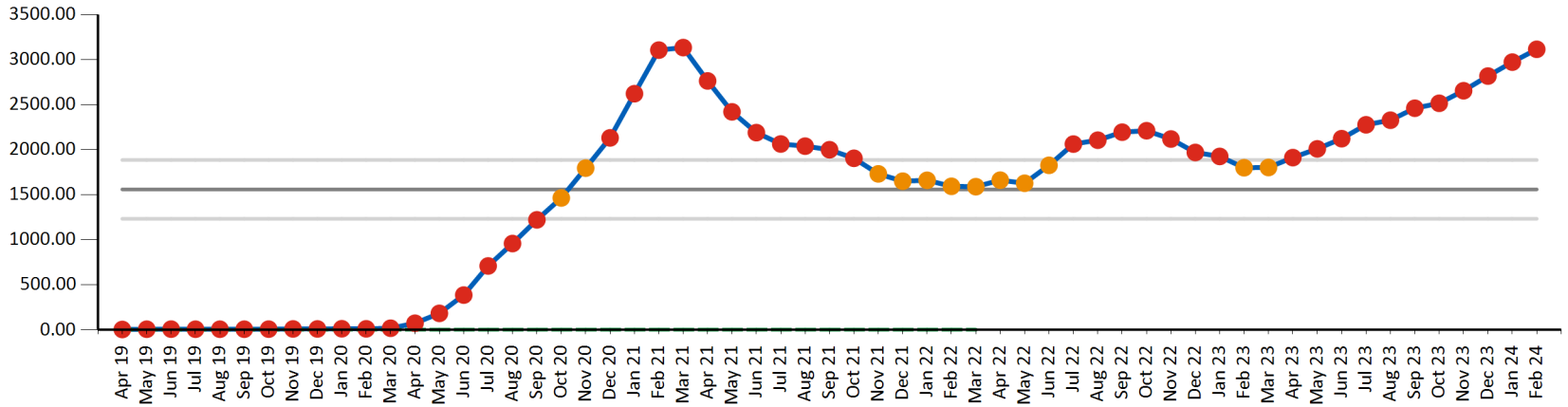
Plan	Actual	Period
<= 37,914	43,947	Jan-24

Year to Date

Plan	Actual
<= 37,764	44,219

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	3,113	Feb-24

Previous

Plan	Actual	Period
	2,971	Jan-24

Year to Date

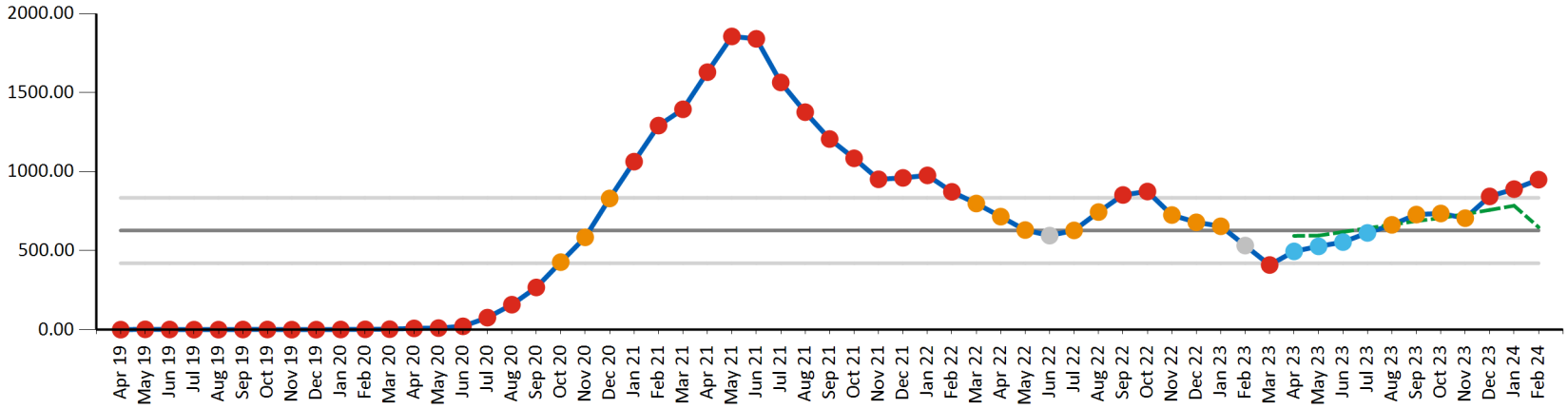
Plan	Actual
	27,167

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with deteriorating performance

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

1/6



Latest

Plan	Actual	Period
<= 648	949	Feb-24

Previous

Plan	Actual	Period
<= 784	889	Jan-24

Year to Date

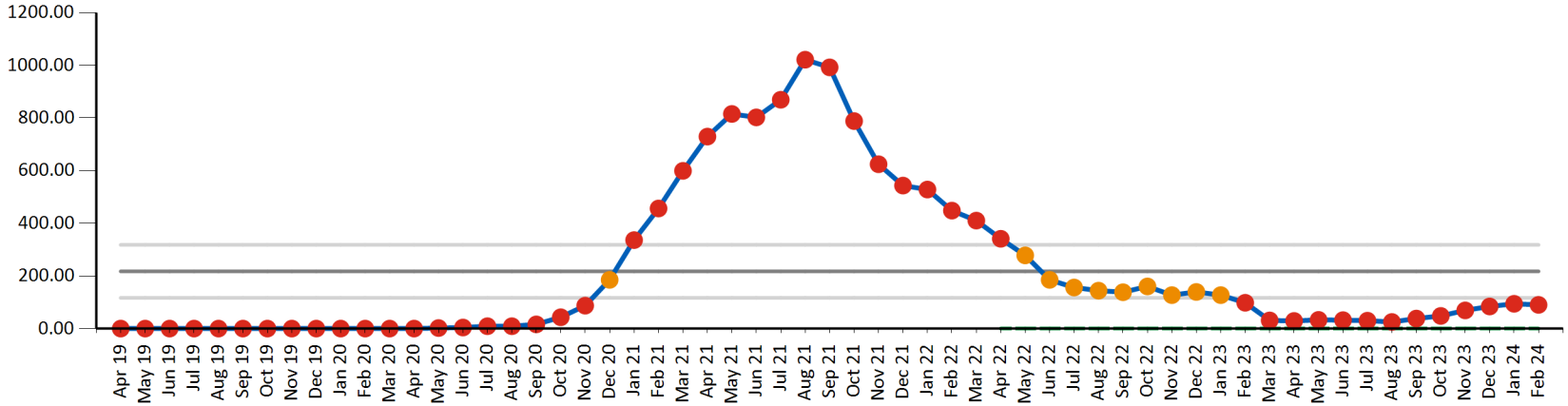
Plan	Actual
<= 7,425	7,700

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	90	Feb-24

Previous

Plan	Actual	Period
= 0	94	Jan-24

Year to Date

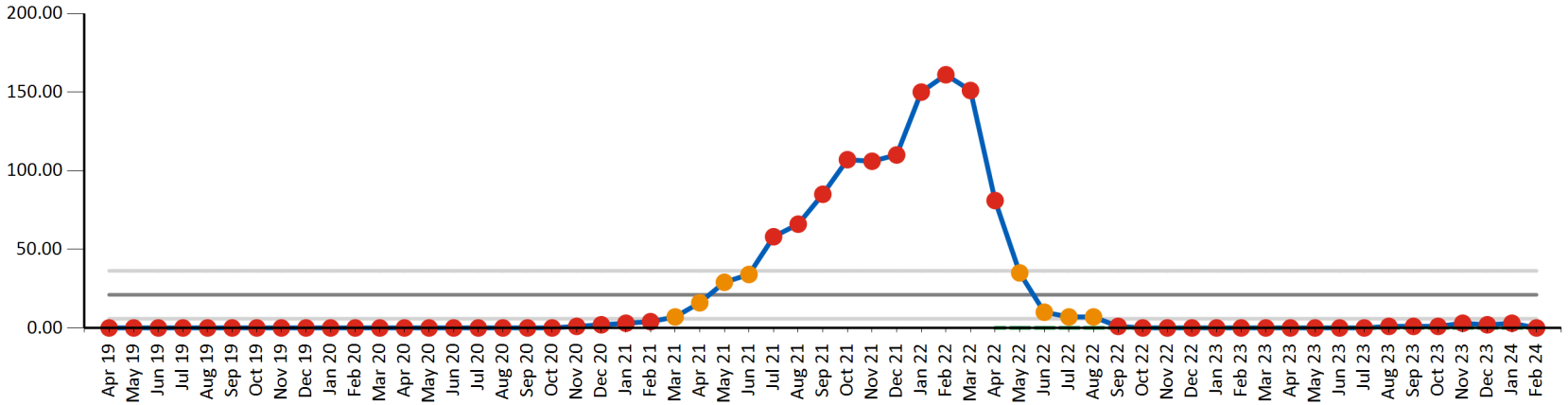
Plan	Actual
= 0	572

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	0	Feb-24

Previous

Plan	Actual	Period
= 0	3	Jan-24

Year to Date

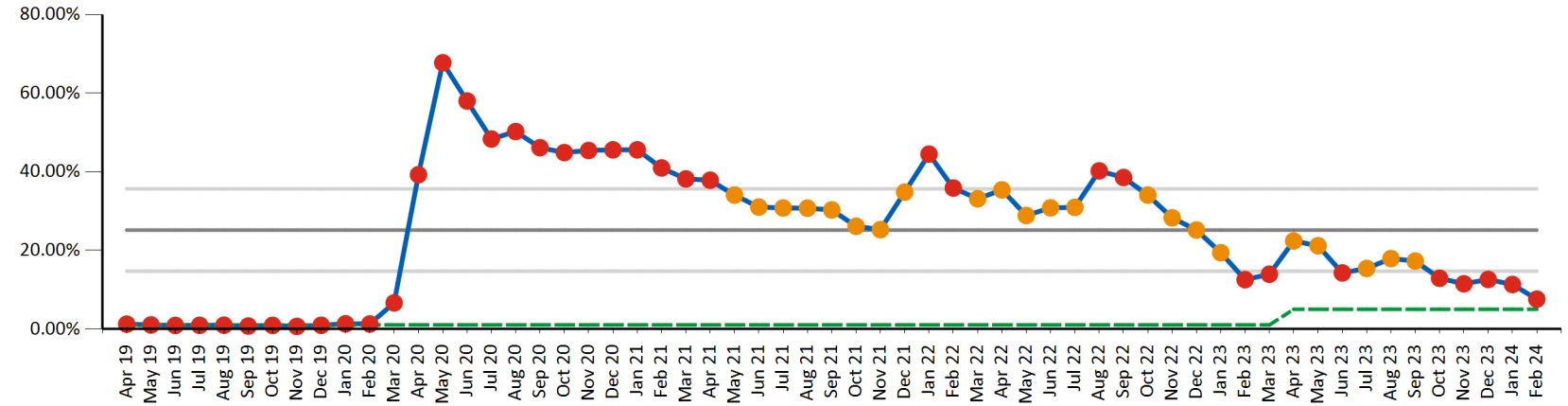
Plan	Actual
= 0	11

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%	7.6%	Feb-24

Previous

Plan	Actual	Period
<= 5%	11.3%	Jan-24

Year to Date

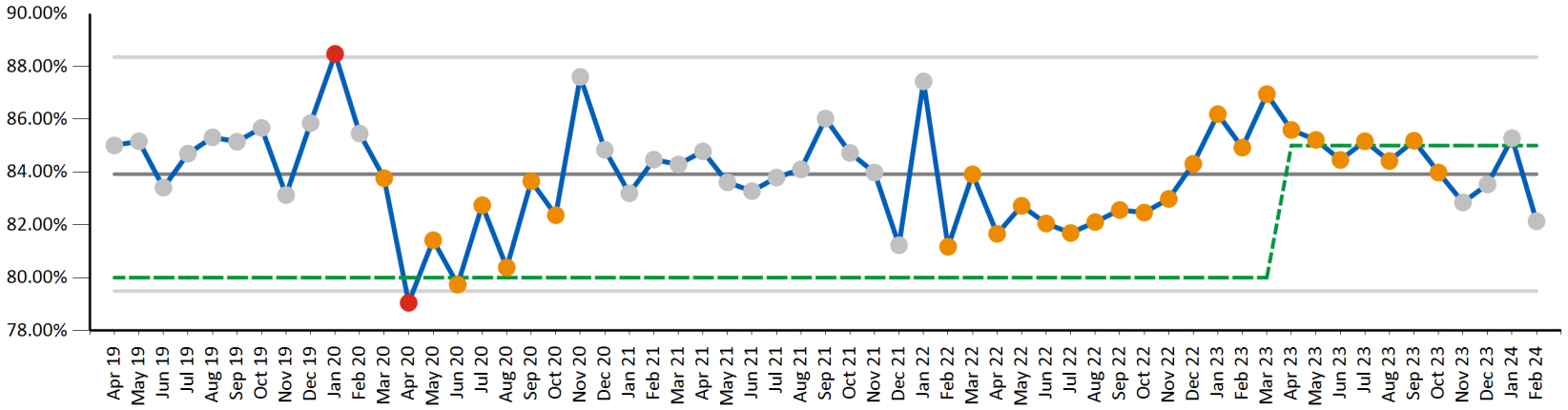
Plan	Actual
<= 5%	15.0%

489 - Daycase Rates

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 85%	82.1%	Feb-24

Previous

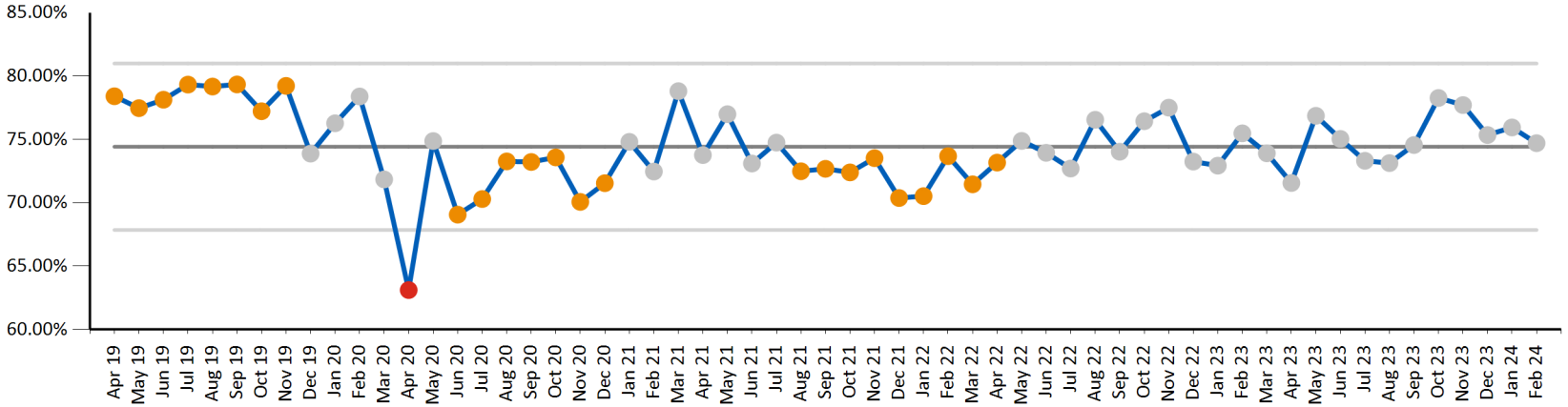
Plan	Actual	Period
>= 85%	85.3%	Jan-24

Year to Date

Plan	Actual
>= 85%	84.3%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	74.7%	Feb-24

Previous

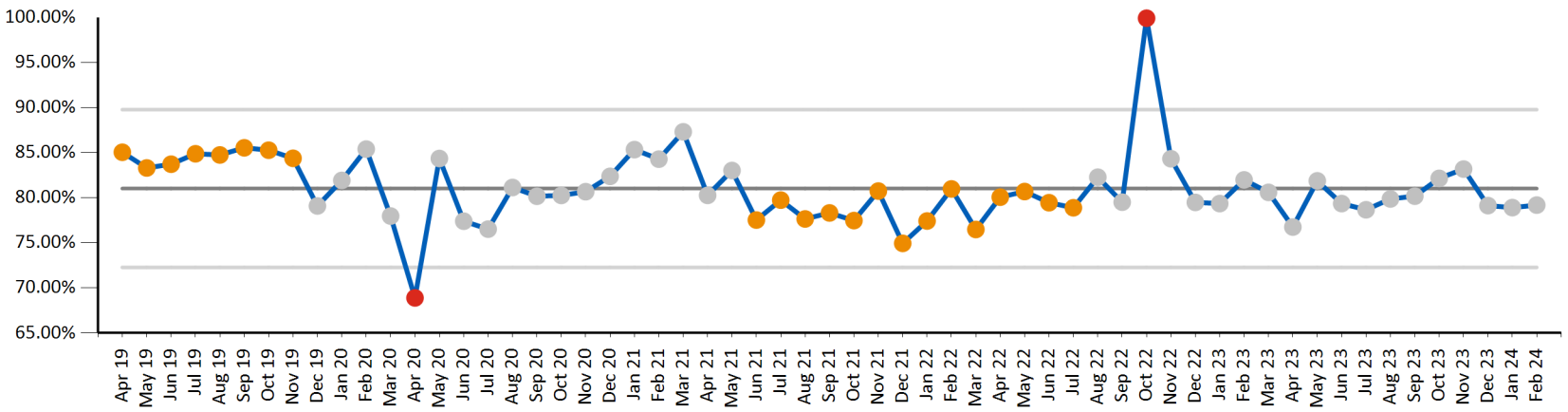
Plan	Actual	Period
	75.9%	Jan-24

Year to Date

Plan	Actual
	75.1%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	79.2%	Feb-24

Previous

Plan	Actual	Period
	78.9%	Jan-24

Year to Date

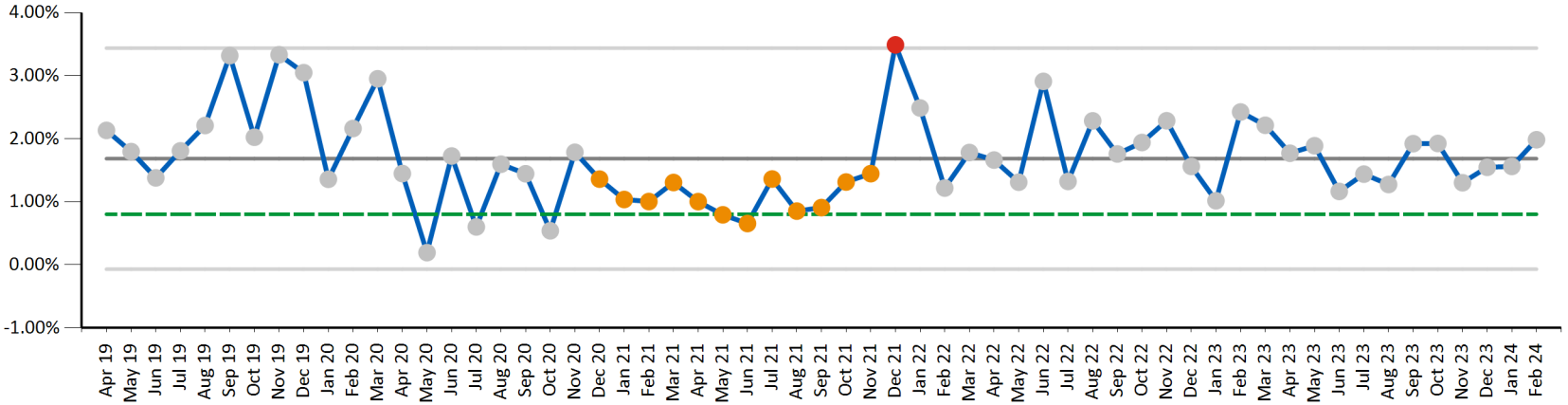
Plan	Actual
	79.9%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1%	2.0%	Feb-24

Previous

Plan	Actual	Period
<= 1%	1.6%	Jan-24

Year to Date

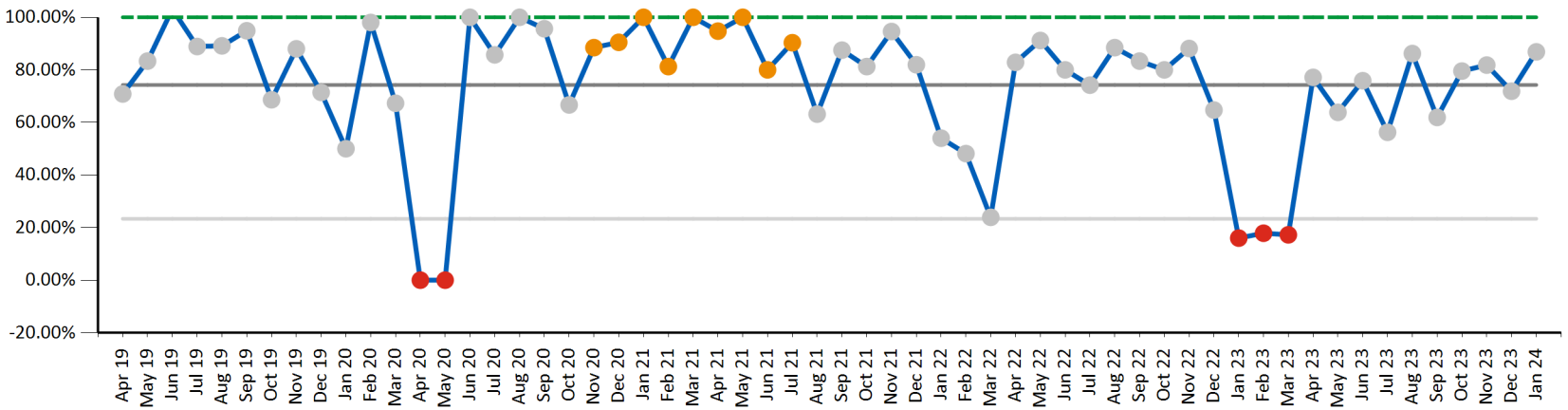
Plan	Actual
<= 1%	1.6%

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%	86.8%	Jan-24

Previous

Plan	Actual	Period
= 100%	71.9%	Dec-23

Year to Date

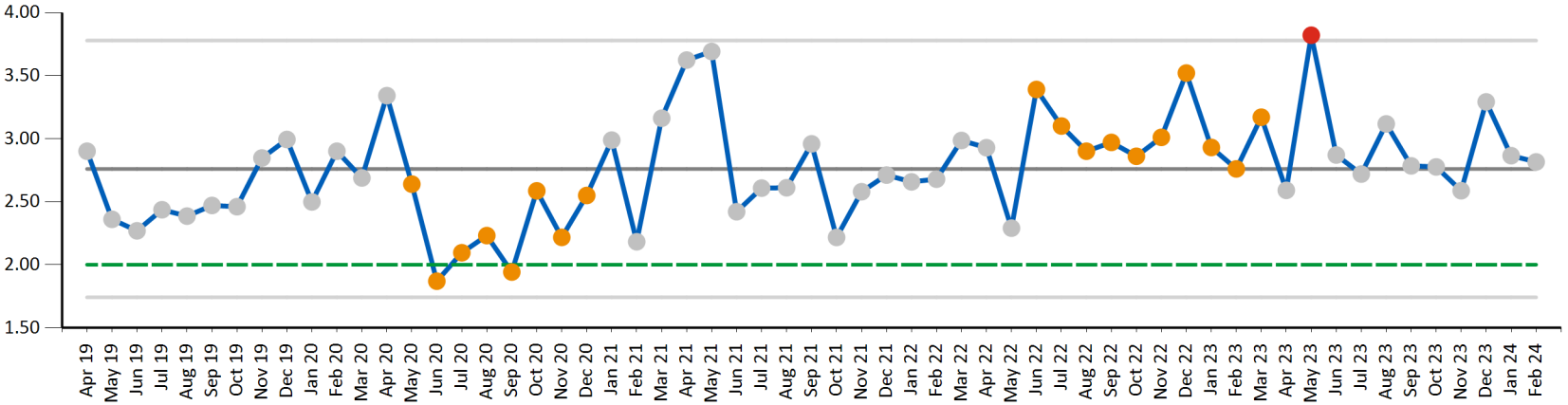
Plan	Actual
= 100%	26.3%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	2.82	Feb-24

Previous

Plan	Actual	Period
<= 2.00	2.86	Jan-24

Year to Date

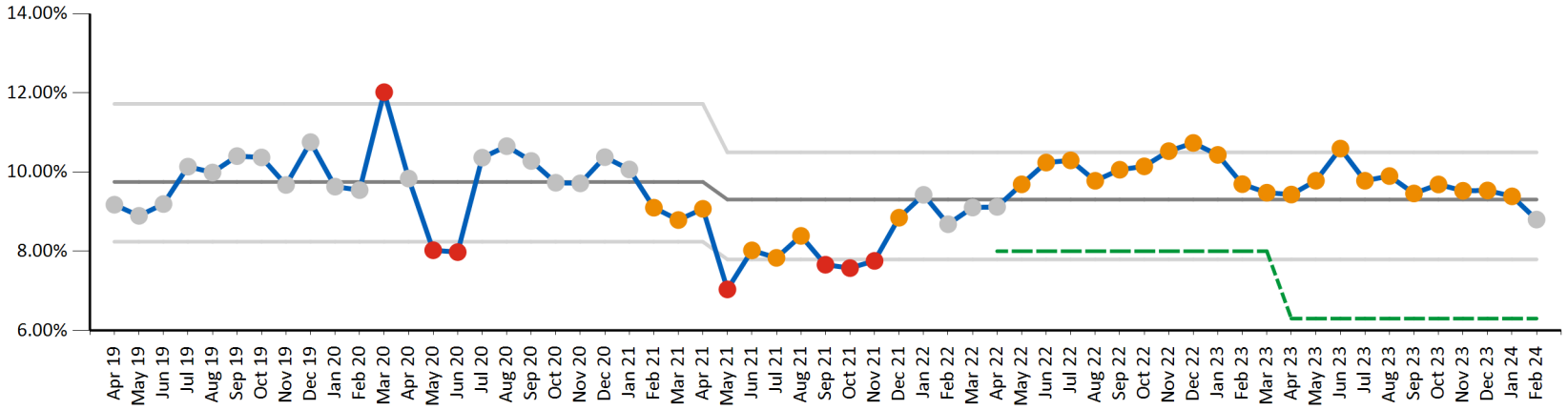
Plan	Actual
<= 2.00	2.93

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	8.8%	Feb-24

Previous

Plan	Actual	Period
<= 6.3%	9.4%	Jan-24

Year to Date

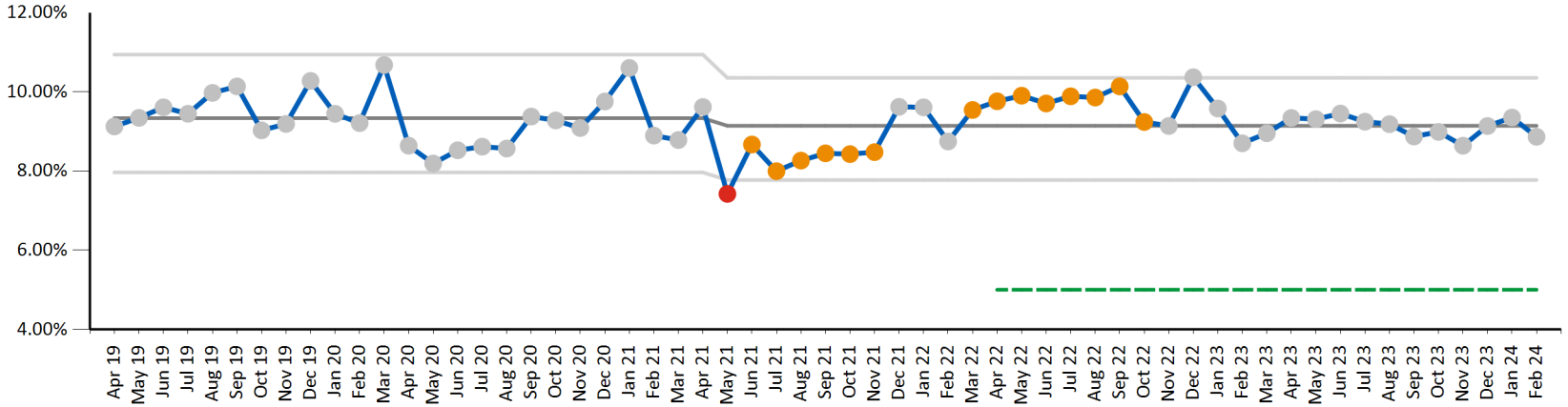
Plan	Actual
<= 6.3%	9.6%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.9%	Feb-24

Previous

Plan	Actual	Period
<= 5.0%	9.3%	Jan-24

Year to Date

Plan	Actual
<= 5.0%	9.1%

Operational Performance - Cancer

Bolton NHS Foundation Trust

Cancer

For January, we achieved the faster diagnosis standard, and the 31-day treatment standard.

We did not achieve the 62-day standard; areas of underperformance were Colorectal, Breast, and Urology. Performance was impacted by the industrial action at the start of January and the resultant loss of capacity.

As a result of January industrial action and significantly increased demand in lung, we are off track with our cancer recovery trajectory and have set a revised trajectory for recovery of May 2024. We are continuing to progress plans to implement best-timed pathways across our tumour sites.

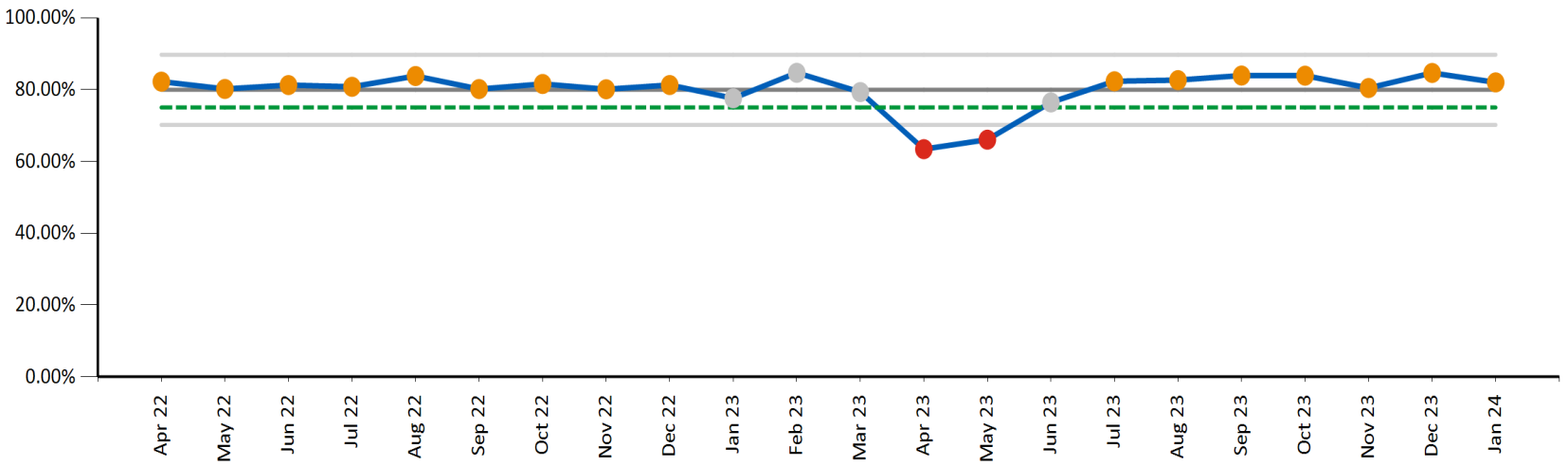
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	82.0%	Jan-24		>= 75.0%	84.6%	Dec-23	>= 75.0%	79.0%	
584 - 31 Day General Treatment Standard	>= 96%	97.1%	Jan-24		>= 96%	100.0%	Dec-23	>= 96%	98.4%	
585 - 62 Day General Standard	>= 85%	76.1%	Jan-24		>= 85%	79.7%	Dec-23	>= 85%	78.7%	

542 - Cancer: 28 day faster diagnosis

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	82.0%	Jan-24

Previous

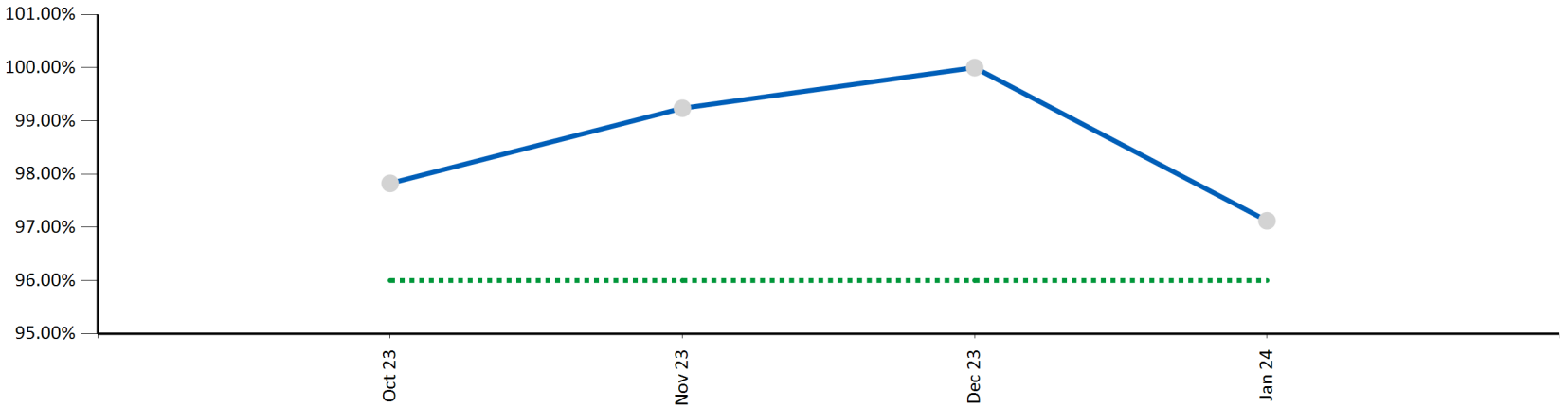
Plan	Actual	Period
>= 75.0%	84.6%	Dec-23

Year to Date

Plan	Actual
>= 75.0%	79.0%

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

4/6



Latest

Plan	Actual	Period
>= 96%	97.1%	Jan-24

Previous

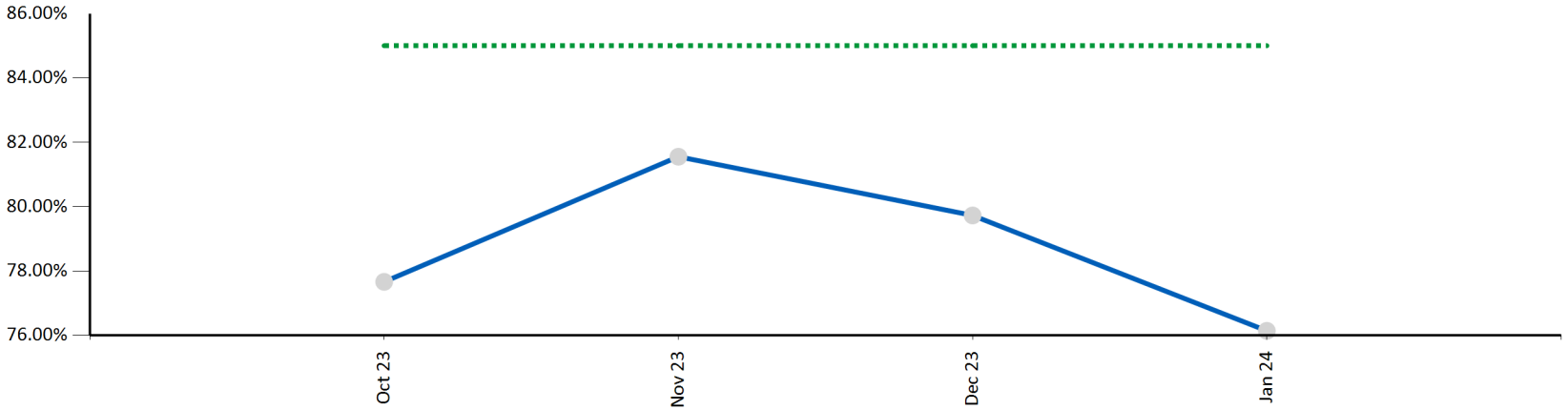
Plan	Actual	Period
>= 96%	100.0%	Dec-23

Year to Date

Plan	Actual
0.96	98.4%

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

0/6



Latest

Plan	Actual	Period
>= 85%	76.1%	Jan-24

Previous

Plan	Actual	Period
>= 85%	79.7%	Dec-23

Year to Date

Plan	Actual
0.85	78.7%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

ED deflections
ED deflections for month 11 have decreased to 464, remaining above plan of 400. ED deflections are in line with usual variation over the last two years in month 11. AAT identified a reduction in 2hr UCR referrals and have continued to work collaboratively with NWAS and Care Homes to promote deflection pathways in month 12.

NCTR
The number of patients with No Criteria to Reside has slightly reduced in month but remains above our operating plan at an average of 104. The number of additions to the NCTR list were in line with usual variation however there were reduced discharges back off the list in the period immediately around the February industrial action resulting in a higher backlog during month 11. Recovery of this has been through continuation of the 'fire break' methodology and additionally a Multi-agency Discharge Event (MADE) is planned in March.
Occupied bed days have increased from the previous month of 894 to 900 in month 11. The increase has been due to social work capacity within IDT, closures across our care home and intermediate tier bed base. Local Authority partners have worked with us to prioritise social work capacity across the borough.

0-5 Mandated Contacts
Performance has remained largely static and is below the target level due to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors (nationally). We continue to be struggling with retention of Health visitors. Work is underway to create stability in the 0-19 contract and service.

EHCP compliance
EHCP compliance continues to improve following the implementation of the new pathway. The service completed/finalised 31 EHCP's in February. In month, there were 3 breaches in total due to late notification (outside of FT control).

Looked After Children – Review Health Assessments by Health Visitor & School Nurse
Decrease from last month from 94% to 87%. 38 due and 33 completed within timescale. Exceptions: 1 Young person refused although review attempted 4 times, 1 delay in paperwork from OOA, 2 due to sickness/cancellation due to sickness and 1 due to paperwork being submitted late (but review completed within timescale)

551 Looked After Children – Initial Health Assessments completed within 4 weeks
52.9% in month – 8 breaches in total, 6 due to clinical availability/capacity issues, 1 due to late paperwork, 1 placed out of area and 1 was not brought.

552 Looked After Children – Review Health Assessments for over 5s in Special Schools
100% - no breaches.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	464	Feb-24		>= 400	557	Jan-24	>= 4,400	5,550	

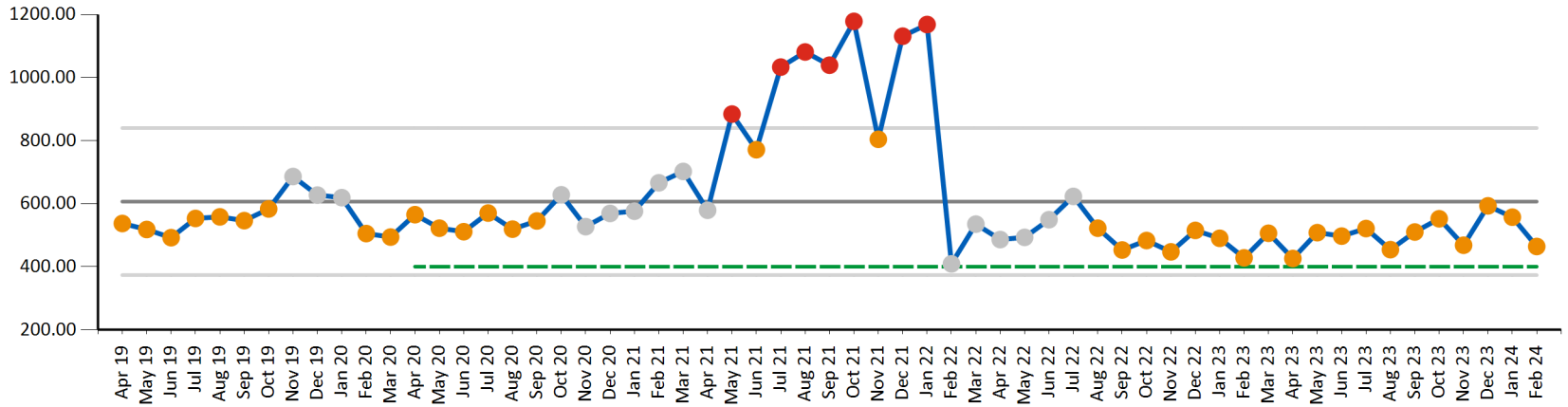
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
493 - Average Number of Patients: with no Criteria to Reside	<= 99	104	Feb-24		<= 98	106	Jan-24	<= 99	104	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	900	Feb-24		<= 360	894	Jan-24	<= 3,960	8,582	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	74%	Feb-24		>= 95%	73%	Jan-24	>= 95%	79%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	90%	Feb-24		>= 95%	75%	Jan-24	>= 95%	78%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	87.0%	Feb-24		>= 90.0%	94.0%	Jan-24	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	53.0%	Feb-24		>= 90.0%	86.0%	Jan-24	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Feb-24		>= 90.0%	67.0%	Jan-24	>= 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	464	Feb-24

Previous

Plan	Actual	Period
>= 400	557	Jan-24

Year to Date

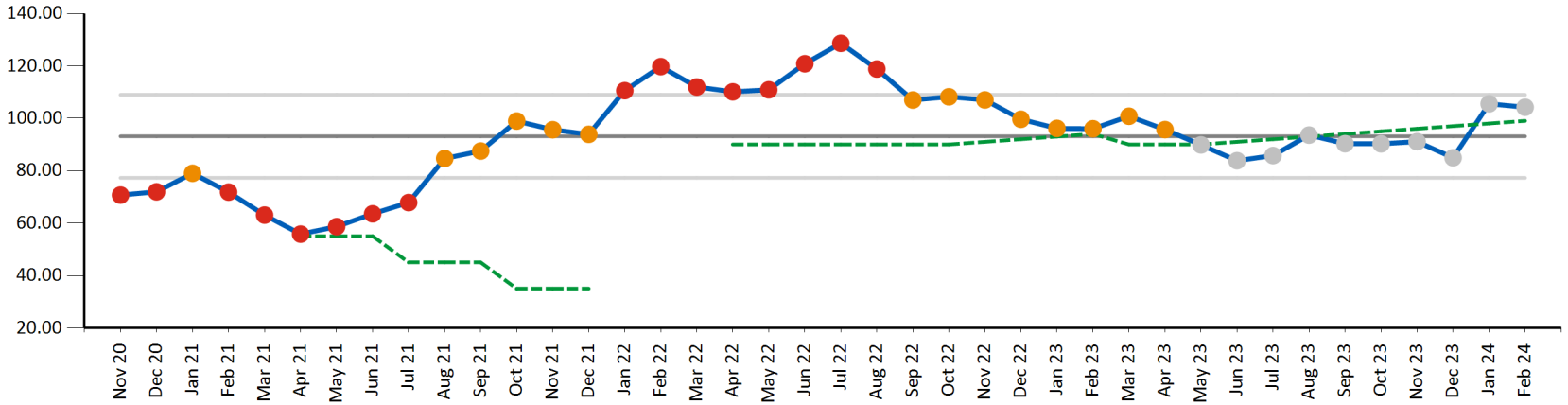
Plan	Actual
>= 4,400	5,550

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 99	104	Feb-24

Previous

Plan	Actual	Period
<= 98	106	Jan-24

Year to Date

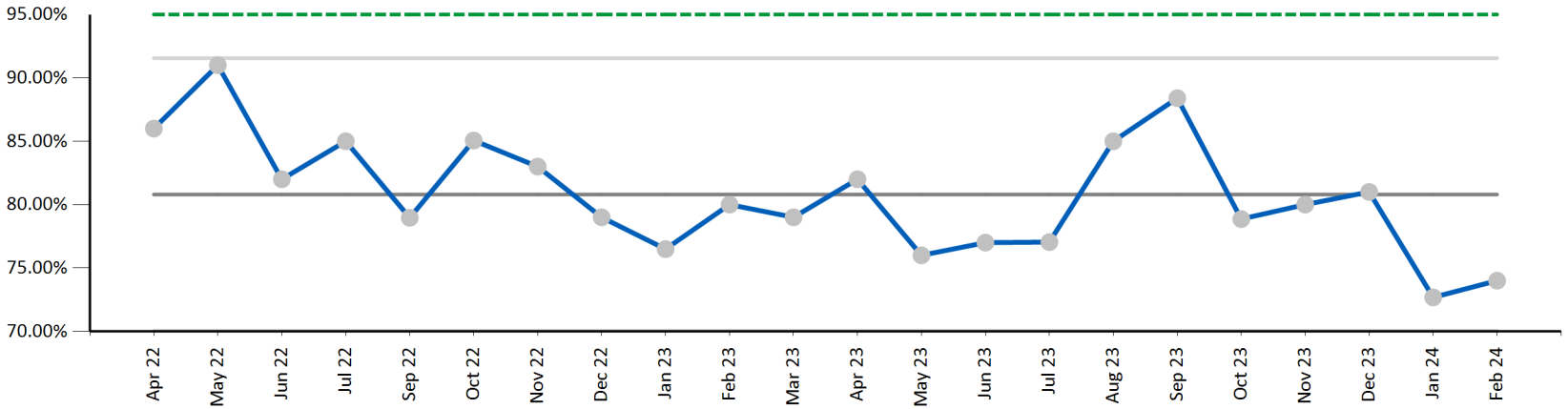
Plan	Actual
<= 99	104

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%	74%	Feb-24

Previous

Plan	Actual	Period
>= 95%	73%	Jan-24

Year to Date

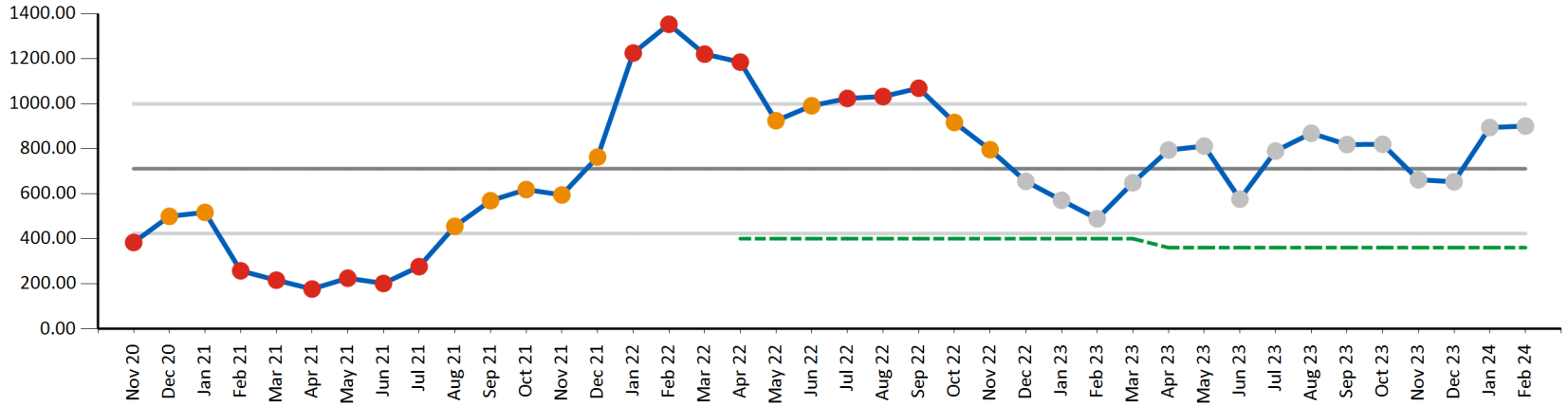
Plan	Actual
>= 95%	79%

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	900	Feb-24

Previous

Plan	Actual	Period
<= 360	894	Jan-24

Year to Date

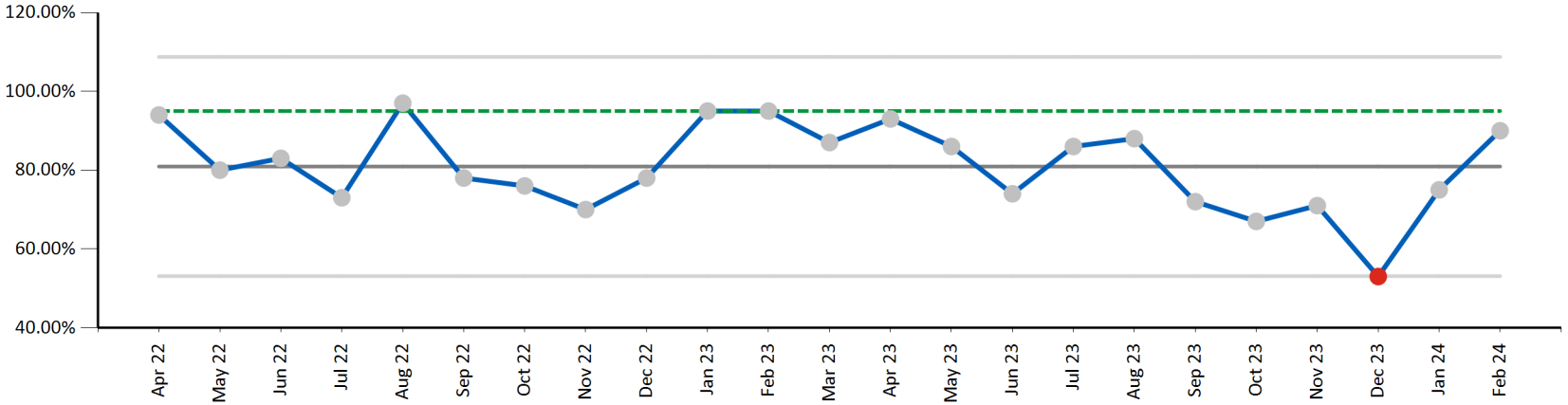
Plan	Actual
<= 3,960	8,582

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	90%	Feb-24

Previous

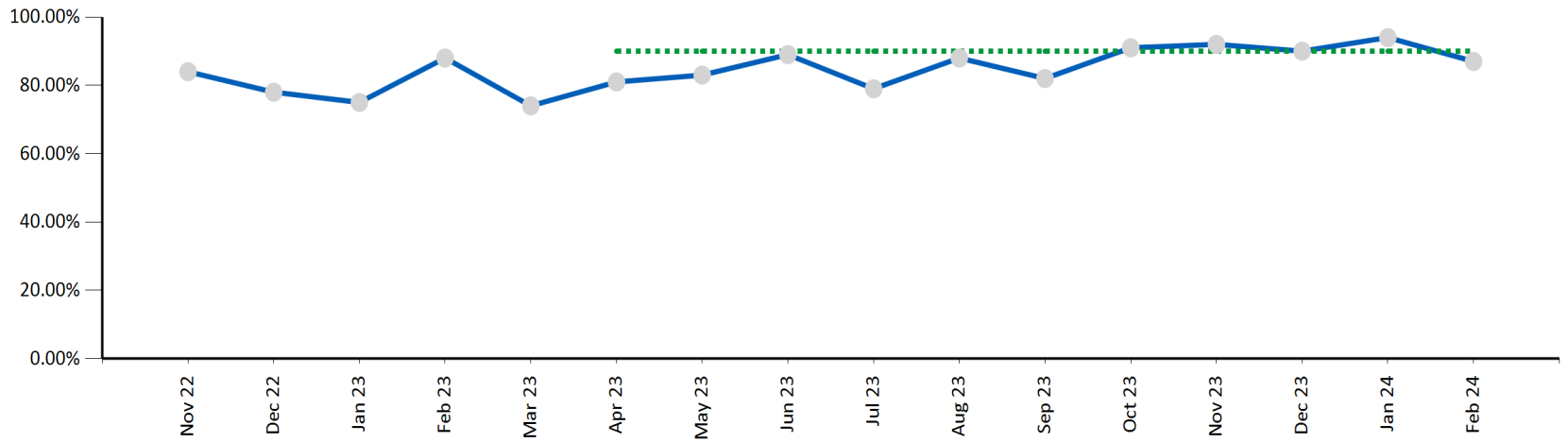
Plan	Actual	Period
>= 95%	75%	Jan-24

Year to Date

Plan	Actual
>= 95%	78%

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	87.0%	Feb-24

Previous

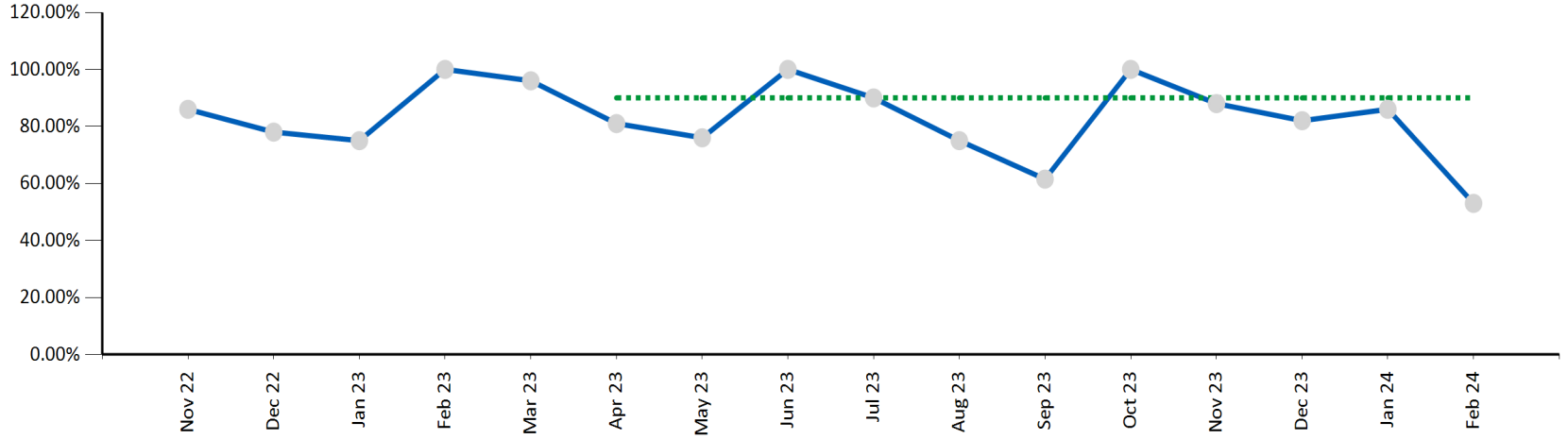
Plan	Actual	Period
> = 90.0%	94.0%	Jan-24

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

1/6



Latest

Plan	Actual	Period
> = 90.0%	53.0%	Feb-24

Previous

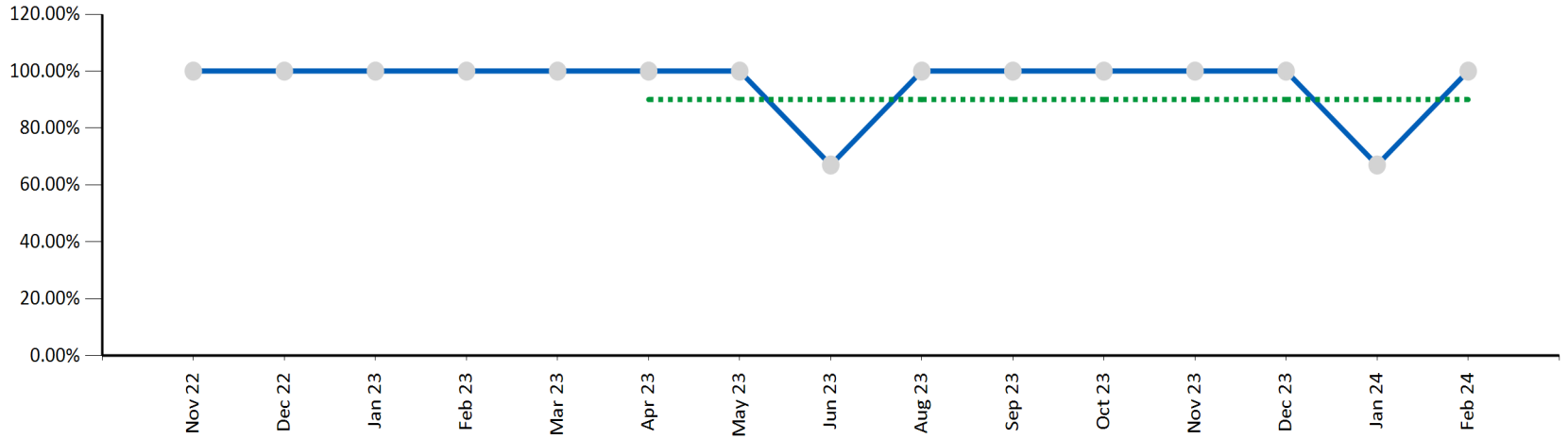
Plan	Actual	Period
> = 90.0%	86.0%	Jan-24

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%	Feb-24

Previous

Plan	Actual	Period
>= 90.0%	67.0%	Jan-24

Year to Date

Plan	Actual
0.9	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness has decreased in February 2024 to 5.33% from 5.86% in January 2024. The decrease in absence is observed largely across the Trust with notable decreases occurring in DSSD (decrease of 1.29%) and ACCD (decrease of 0.94%) compared to January 2024. The rates of Covid related absence have remained fairly static across the Trust and stands at 0.12% compared to 0.21% in January 2024.

Vacancy level:
Trust vacancy level reduced in-month to 5.03%, which is under our target (of 6%) and a continuation of our strong performance in this regard since June 2023. The improved in-month position is due to strong and effective clinical recruitment activity, with good activity on nursing, midwifery, HCA, and medical recruitment noted.

Turnover:
Turnover increased slightly in-month to 11.57%; despite this there has been a clear reducing trend seen across the year 2023/2024.

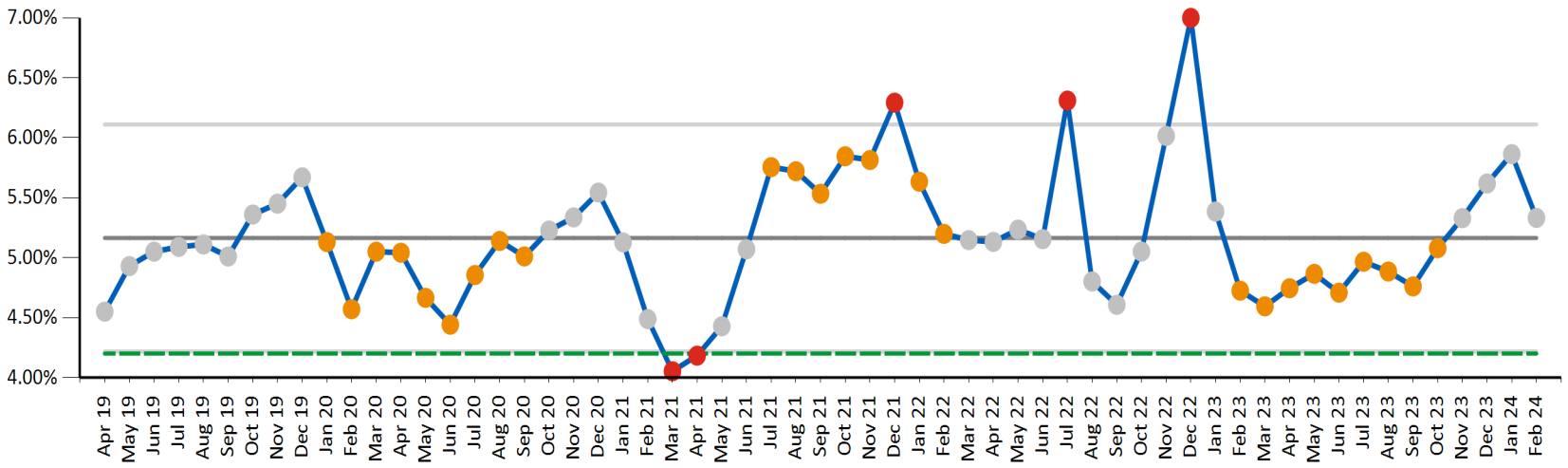
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.33%	Feb-24		<= 4.20%	5.86%	Jan-24	<= 4.20%	5.10%	F
120 - Vacancy level - Trust	<= 6%	5.03%	Feb-24		<= 6%	5.37%	Jan-24	<= 6%	5.38%	?
121 - Turnover	<= 9.90%	11.57%	Feb-24	L	<= 9.90%	11.33%	Jan-24	<= 9.90%	12.10%	F
366 - Ongoing formal investigation cases over 8 weeks		3	Jan-24			1	Dec-23		11	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.33%	Feb-24

Previous

Plan	Actual	Period
<= 4.20%	5.86%	Jan-24

Year to Date

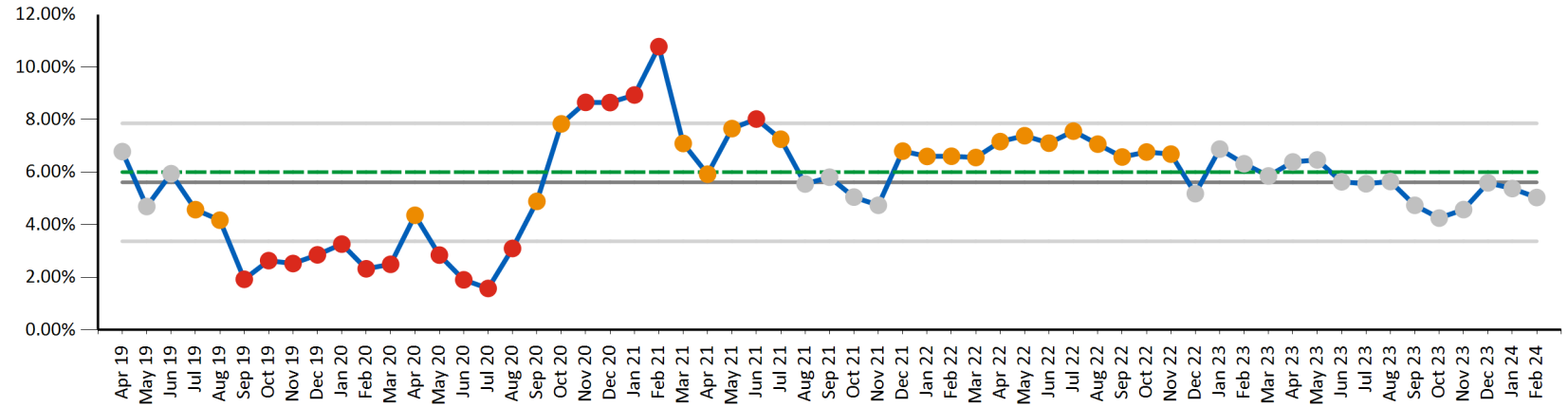
Plan	Actual
<= 4.20%	5.10%

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%	5.03%	Feb-24

Previous

Plan	Actual	Period
<= 6%	5.37%	Jan-24

Year to Date

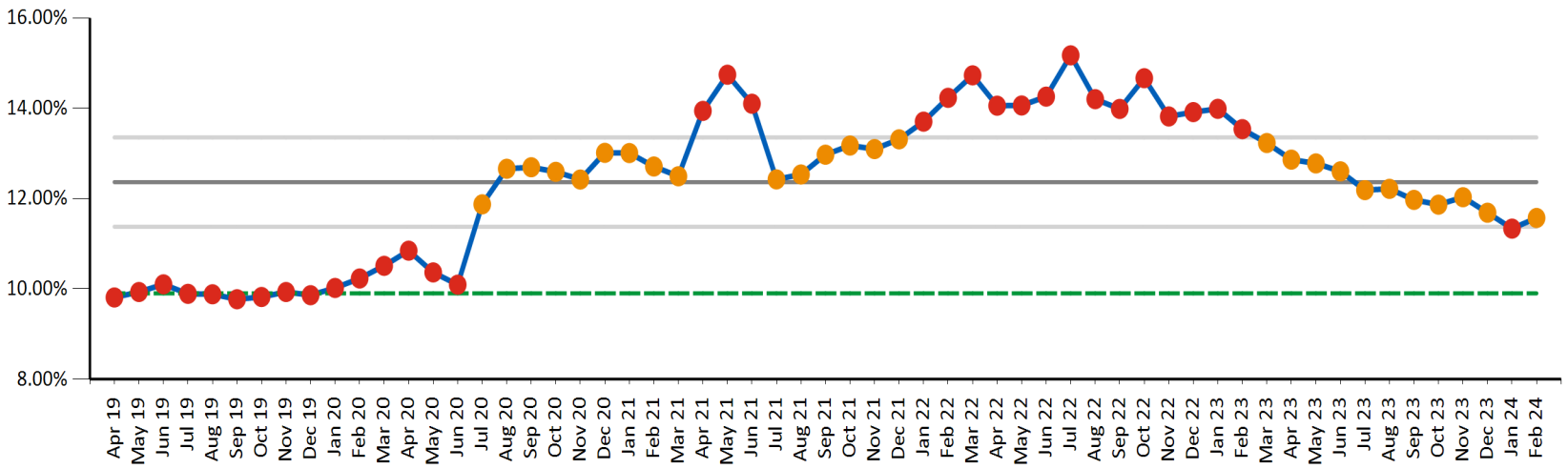
Plan	Actual
<= 6%	5.38%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.57%	Feb-24

Previous

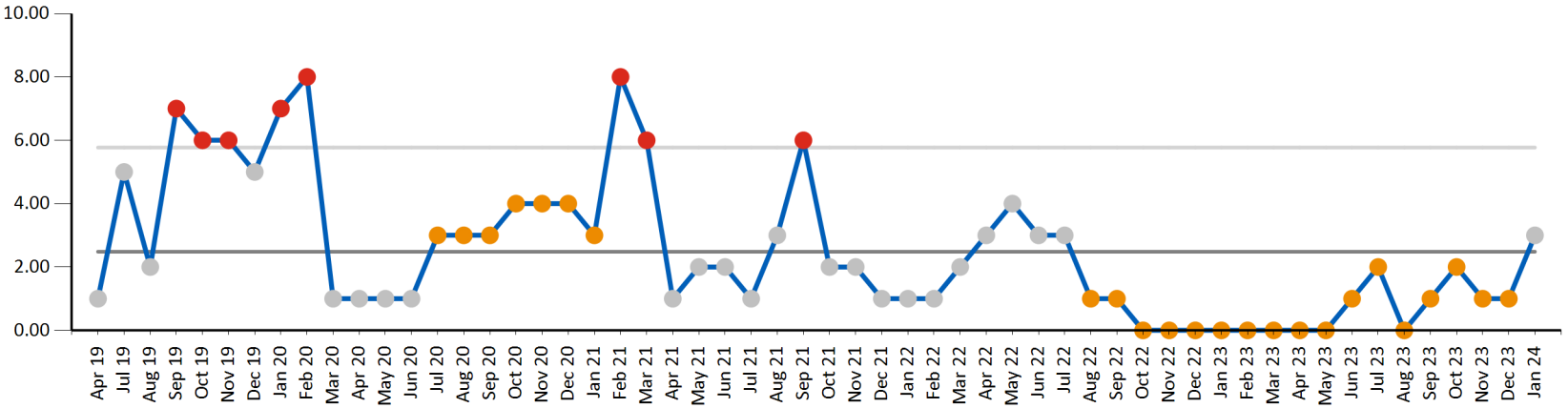
Plan	Actual	Period
<= 9.90%	11.33%	Jan-24

Year to Date

Plan	Actual
<= 9.90%	12.10%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	3	Jan-24

Previous

Plan	Actual	Period
	1	Dec-23

Year to Date

Plan	Actual
	11

Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory and Trust Mandated Training (CaTM)
The Trust CaTM compliance is reported as 93.12%. This is a deteriorating position in month. It can be evidenced that the overall position has been as a result of % reduction for the 3 subjects that require face to face training (Basic Life Support / Moving and handling and to a lesser extent Safeguarding Children level 3). The data shows that although staff are booking to attend these training sessions, there is a large number of staff cancelling on the day or not attending (DNA)

Appraisal
Appraisal compliance has shown a 0.4% improvement to reach 85.28%. This is an encouraging position, putting us just above the target of 85%

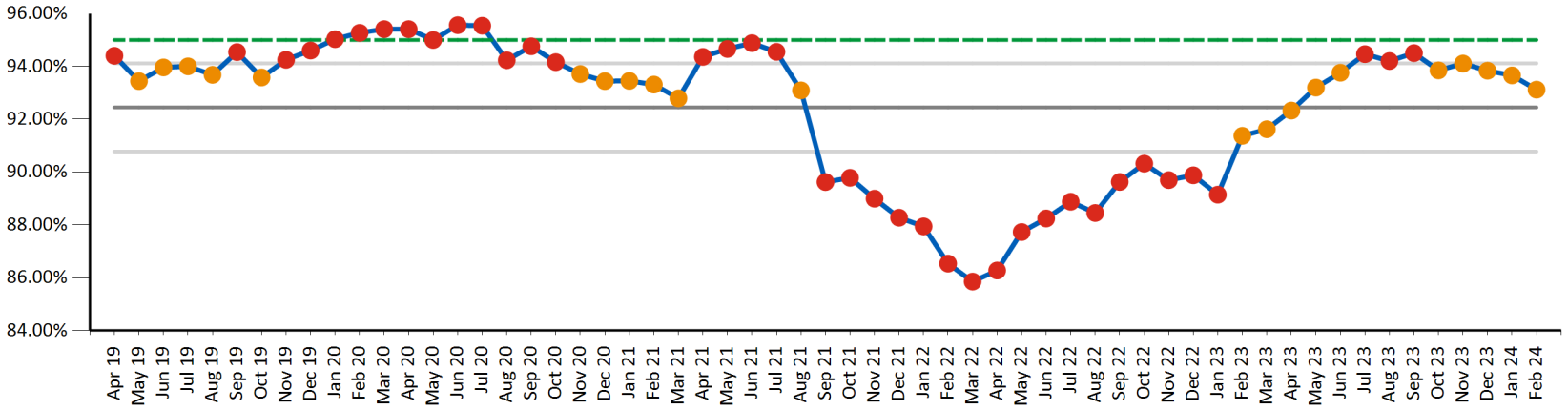
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.1%	Feb-24	H	>= 95%	93.7%	Jan-24	>= 95%	93.7%	F
38 - Staff completing Trust Mandated Training	>= 85%	90.7%	Feb-24	H	>= 85%	90.9%	Jan-24	>= 85%	89.8%	P
39 - Staff completing Safeguarding Training	>= 95%	94.20%	Feb-24	H	>= 95%	94.63%	Jan-24	>= 95%	94.81%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.3%	Feb-24	H	>= 85%	84.8%	Jan-24	>= 85%	85.6%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	51.1%	Q2 2023/24	L	>= 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%		F

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%	93.1%	Feb-24

Previous

Plan	Actual	Period
>= 95%	93.7%	Jan-24

Year to Date

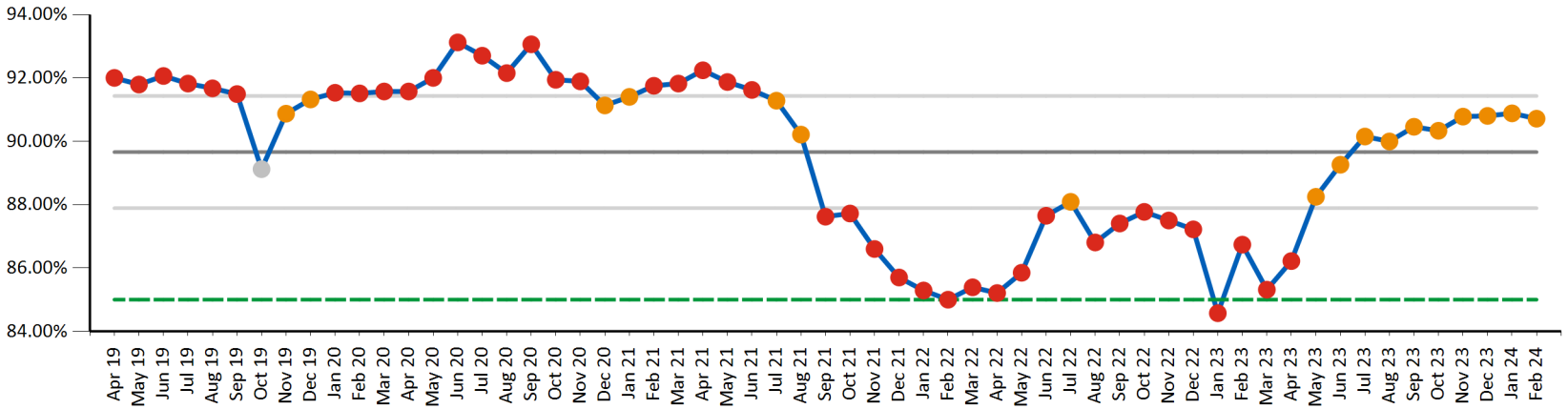
Plan	Actual
>= 95%	93.7%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.7%	Feb-24

Previous

Plan	Actual	Period
>= 85%	90.9%	Jan-24

Year to Date

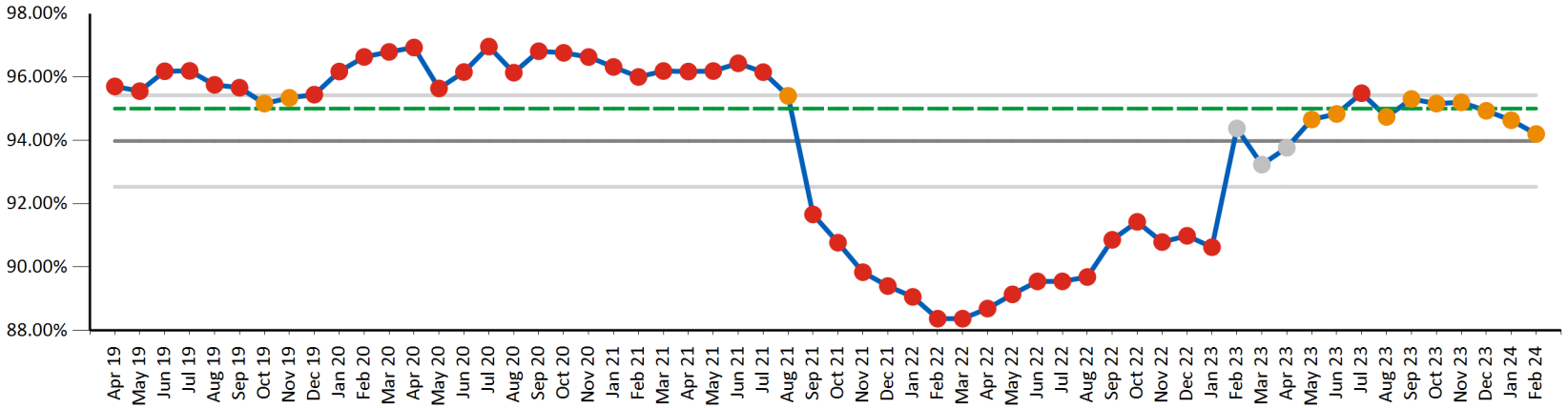
Plan	Actual
>= 85%	89.8%

39 - Staff completing Safeguarding Training

Special cause variation with improving performance

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

3/6



Latest

Plan	Actual	Period
>= 95%	94.20%	Feb-24

Previous

Plan	Actual	Period
>= 95%	94.63%	Jan-24

Year to Date

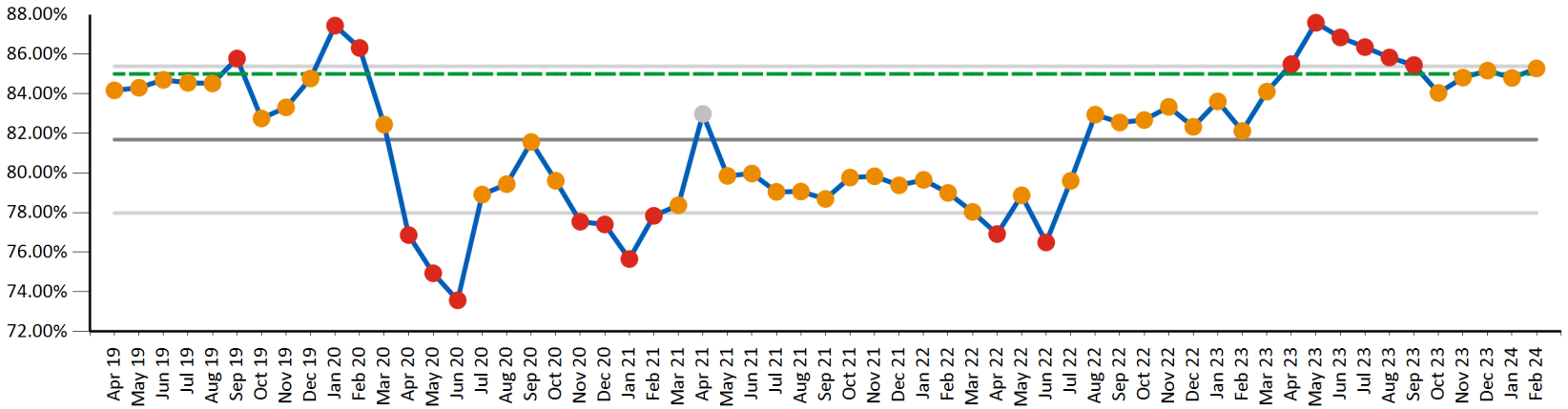
Plan	Actual
>= 95%	94.81%

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.

3/6



Latest

Plan	Actual	Period
>= 85%	85.3%	Feb-24

Previous

Plan	Actual	Period
>= 85%	84.8%	Jan-24

Year to Date

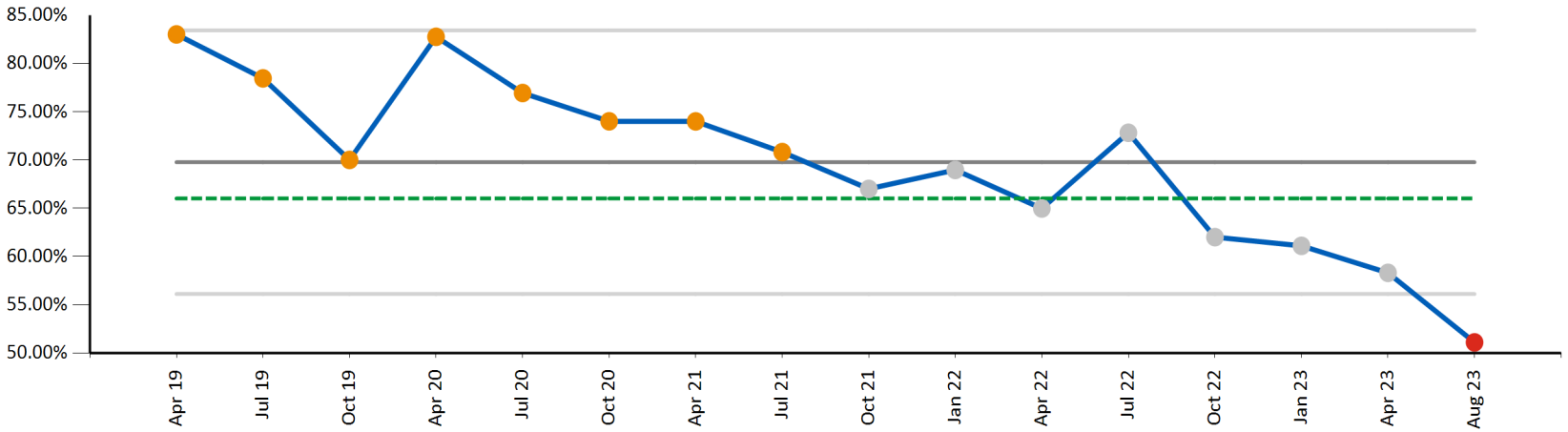
Plan	Actual
>= 85%	85.6%

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

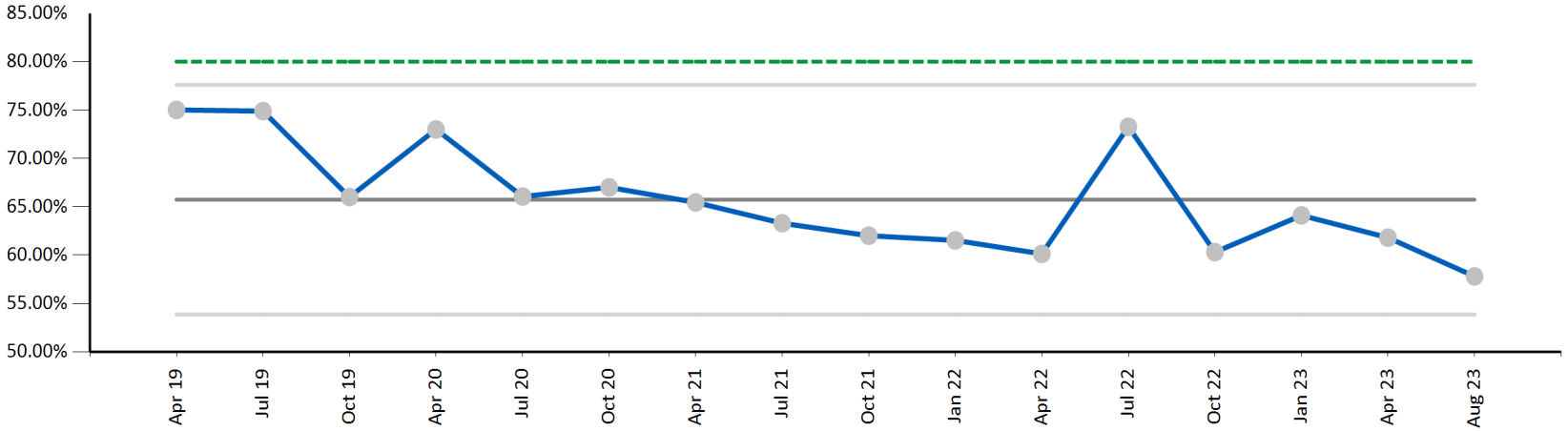
Plan	Actual
>= 66%	

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 increased by £86k in Feb 2024. This is the first month where an increase has been noted since May 2023. Despite the increase agency spend in-month was still under the forecast monthly spend submitted by the Trust to NHSE at the start of the year, and we are still on track to meet the forecast for the year if we remain at current spend levels.

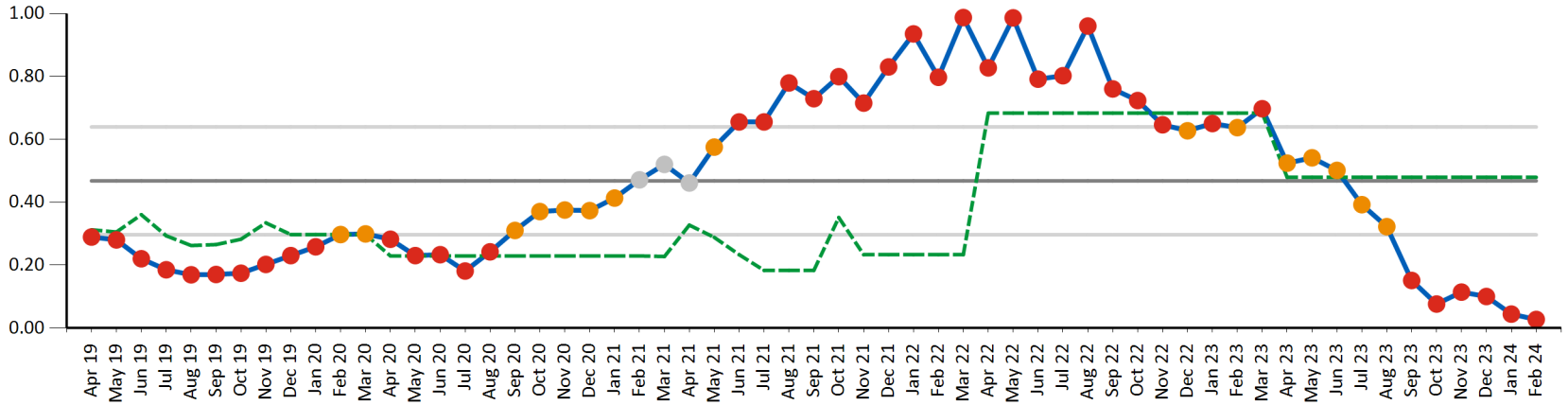
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.99	0.63	Feb-24	L	<= 0.99	0.54	Jan-24	<= 10.92	10.78	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.48	0.03	Feb-24	L	<= 0.48	0.04	Jan-24	<= 5.27	2.79	?
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.39	0.54	Feb-24	H	<= 0.39	0.49	Jan-24	<= 4.31	6.95	?

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

L — Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 0.48	0.03	Feb-24

Previous

Plan	Actual	Period
<= 0.48	0.04	Jan-24

Year to Date

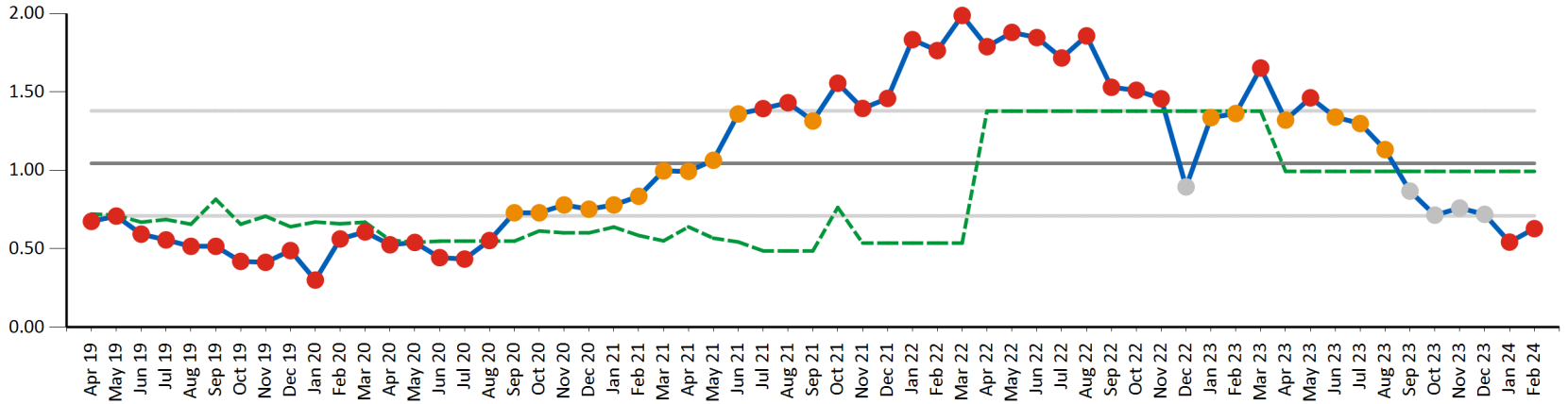
Plan	Actual
<= 5.27	2.79

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

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 0.99	0.63	Feb-24

Previous

Plan	Actual	Period
<= 0.99	0.54	Jan-24

Year to Date

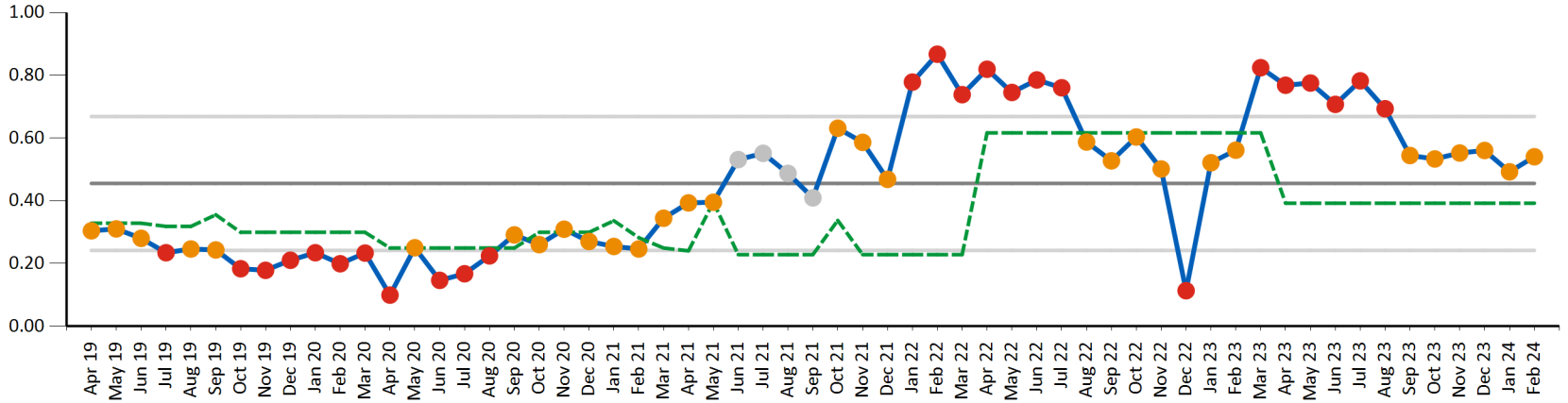
Plan	Actual
<= 10.92	10.78

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 0.39	0.54	Feb-24

Previous

Plan	Actual	Period
<= 0.39	0.49	Jan-24

Year to Date

Plan	Actual
<= 4.31	6.95

Finance - Finance

Revenue – In Month and Year to date - Green
At month 11, the Trust recorded a year to date deficit of £9.3m compared to a planned deficit of £11.5m.
We have rated this domain green due to the year to date favourable variance.

Revenue -Forecast - Green
In the 'Likely' forecast scenario, the Trust will finish the year with a deficit of £9.3m, which is £3.1m better than the plan of £12.4m. The current worst-case scenario suggests a deficit of £10.6m.
We have rated this domain green recognising £10.6m is significantly better than the original planned deficit of £12.4m.

Cost Improvement - Green
The Trust has a cost improvement target of 4% (£19.3m) for 2023/24.
CIP trackers currently show that £22m has been delivered (£7.3m recurrent) against a year to date target of £17.7m.
£24.6m of CIP delivery is currently forecast against a target of £19.3m of which £23.2m of this is rated 'Delivered' or 'Green'. £13.8m of this forecast delivery is central / technical CIP delivery.
The FYE of the recurrent schemes is £11.1m.
We have rated this domain green due to the forecast being in excess of the target. It is noted however that not all of the delivery is recurrent.

Variable Pay - Green
The Trust spent £3.5m on variable pay in month 11 compared to a monthly average of £3.7m in 2022/23.
The Trust is required to spend no more than 3.7% of total pay costs on agency in 2023/24, equating to £1.1m per month. A total of £0.6m was spent on agency in Month 11, equating to 2.2% of total pay costs. YTD agency spend is currently 3.4% of the Trusts total pay cost.
This domain has been rated green as the Trust is now compliant with the NHSE agency spend target.

Capital - Amber
The Trust has a revised capital plan for 2023/24 of £23.2m (£13.3m for CDEL and £9.9m for PDC). Additional CDEL of £2.85m has been received from Cheshire & Mersey ICB to improve the revenue position by £1.5m and bring forward schemes of £1m from 2024/25. Additional PDC of £1.9m has been received.
Year to date capital spend to the end of month 11 was £18.8m (£10.9m for CDEL and £7.9m for PDC) against a plan of £18.6m
This domain is rated amber given the risks around the achievement of the capital envelope.

Balance Sheet - Amber
Decrease in total assets employed of £0.3m due to the revenue deficit offset by additional PDC drawn down.
Total aged debt overdue is £4.2m a reduction from previous month. The total debt including that not yet due is £5.4m.
Loans outstanding of £33.7m.
We have rate this domain amber due to the revenue deficit position.

Cash Position - Red
The month end cash balance was £15.6m, which is £9.0m lower than the planned cash balance of £24.7m. Cash has increased by £0.8m from Month 10. The forecast scenarios

indicate a year-end cash balance of £12.3m.
We have rated this domain red due to the risks around cash and the lower than expected levels.

Better Payment Practices Code - Amber
Performance of 96.7% in month against target of 95%. Year to date performance by value is 98.8%, which is above the target of 95%.
We have rated this domain amber, as we are achieving the target in month but not cumulatively.

Implied Productivity - Amber
The Trust's implied productivity has improved from last month, by 0.6% when comparing to 19/20 and 0.2% when comparing to 22/23. The Trust's rate of improvement when comparing with 22/23 is significantly lower than the GM improvement of 1.9%
We have rated this domain amber due to the level of organisational improvement compared to that seen at GM and nationally.

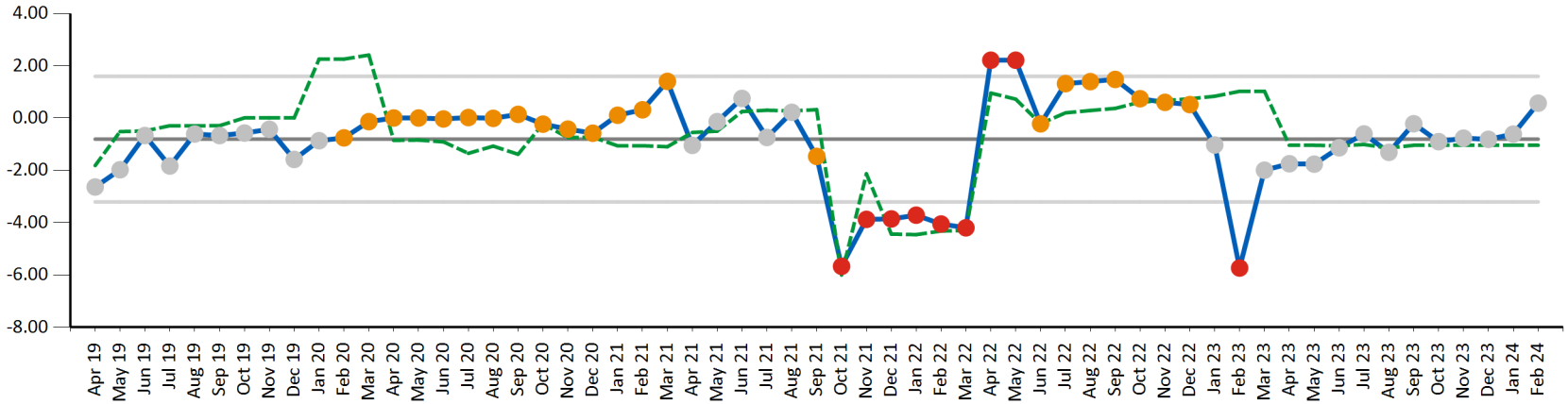
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.0	0.6	Feb-24		>= -1.0	-0.6	Jan-24	>= -11.6	-9.3	
222 - Capital (£ millions)	>= 2.9	0.9	Feb-24		>= 2.9	2.6	Jan-24	>= 18.7	18.8	
223 - Cash (£ millions)	>= 24.7	15.6	Feb-24		>= 26.1	14.8	Jan-24	>= 24.7	15.6	

220 - Control Total (£ millions)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= -1.0	0.6	Feb-24

Previous

Plan	Actual	Period
>= -1.0	-0.6	Jan-24

Year to Date

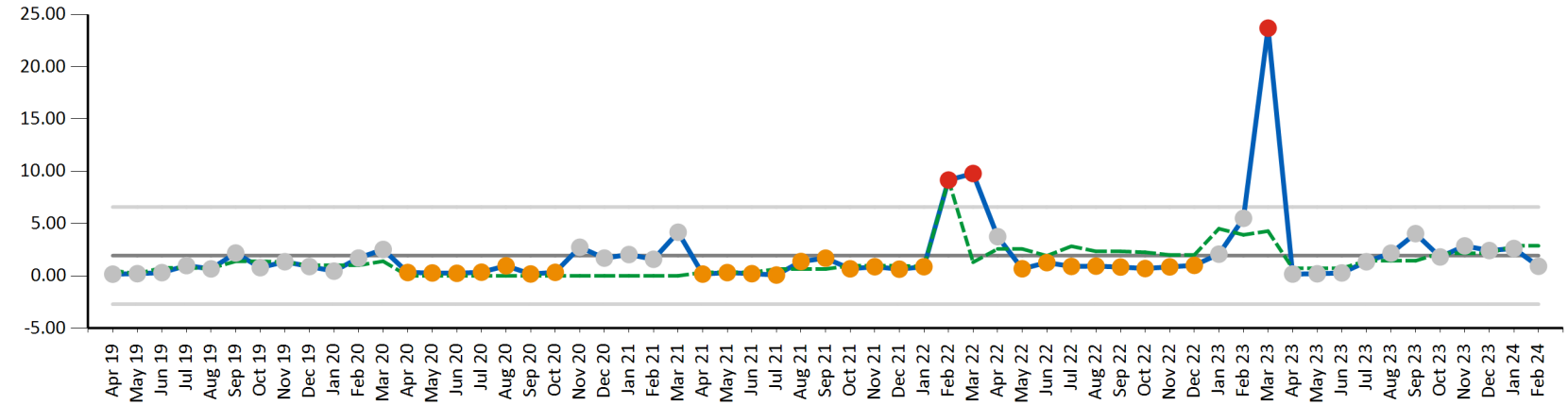
Plan	Actual
>= -11.6	-9.3

222 - Capital (£ millions)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 2.9	0.9	Feb-24

Previous

Plan	Actual	Period
>= 2.9	2.6	Jan-24

Year to Date

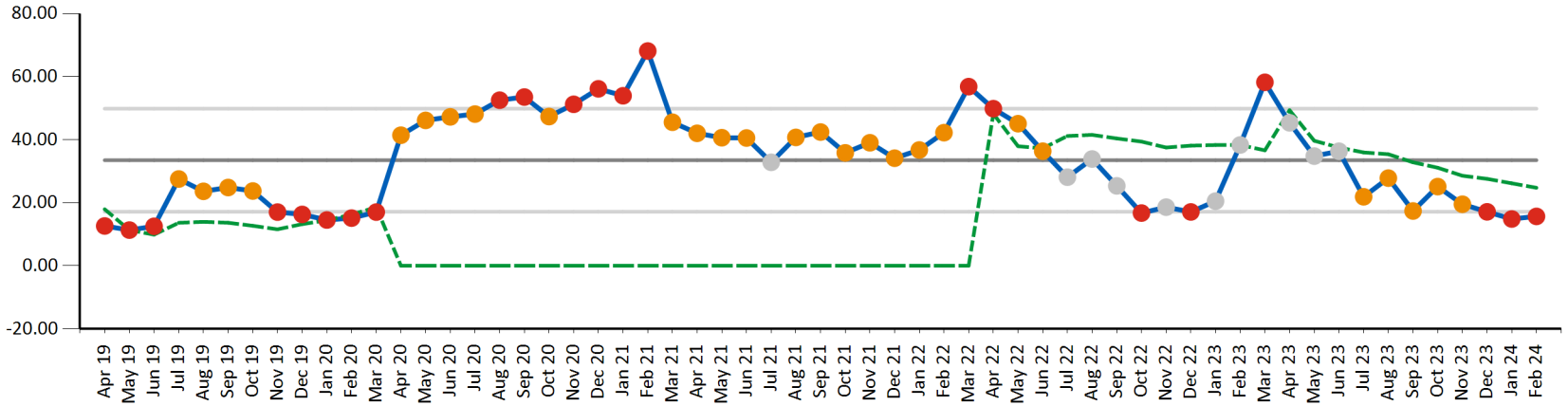
Plan	Actual
>= 18.7	18.8

223 - Cash (£ millions)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 24.7	15.6	Feb-24

Previous

Plan	Actual	Period
>= 26.1	14.8	Jan-24

Year to Date

Plan	Actual
>= 24.7	15.6

Report Title:	Strategy 2024-29: Engagement Draft

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	✓
Exec Sponsor	Sharon White, Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide an update to the Board on the progress of the new Trust Strategy.

Summary:	An engagement draft of the new Trust Strategy 2024-29 is shared with the Board for assurance. This draft document will be shared with staff and stakeholders, and for public engagement in late March. An associated set of KPIs is in development. Following Board discussion in March, the Committees of the Board will receive the Strategy and KPIs for detailed review and sign-off. The final iteration of the Strategy and KPIs will then be brought to the Board for review and approval in May.

Previously considered by:
N/A

Proposed Resolution	The Board is asked to review and comment on the engagement draft.

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:	Rachel Noble, Deputy Director of Strategy	**Presented by:**	Sharon White, Director of Strategy, Digital and Transformation

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Our Trust Strategy

2024-2029

... for a better Bolton

Where we are now

When we developed our previous five-year strategy in 2019, we wanted to improve the outcomes and experience for the patients we serve. Whilst we have seen major progress in these areas over the last few years, a lot has changed in the last five years, and our world looks very different.

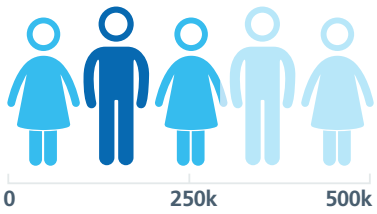
A growing population means that demand for our services is rising, but without the central funding to support it. We know that our communities experience significant health inequalities compared to other parts of the country – and compared to other parts of the town.

Our recovery from the pandemic has meant that some people in Bolton are waiting longer than they should to be supported with health conditions that have been impacted by delays to care.

Alongside this, our ageing estate and increasing responsibility to the green agenda are impacting on our ability to provide services in the way we want to.

What we know about our communities

Bolton's population is approaching **300,000**



28% are from communities facing racial inequality

9.8% of Bolton's population provide between **1 and 50 hours** of unpaid care per week

49% of Bolton's adults would have difficulty understanding health information

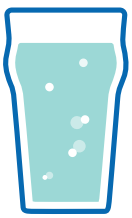
5.4% of people are not in paid work due to being long-term sick or disabled

The percentage of people aged 16+ have a disability **18%**

Main languages spoken English, Gujarati, Punjabi, Polish, Arabic and Somali

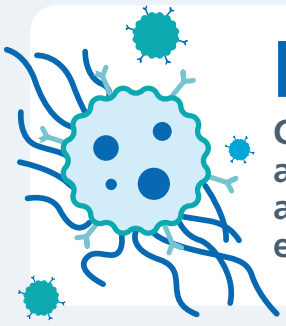
11 Years

Difference in life expectancy between our communites



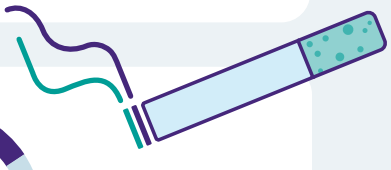
Alcohol

23% of Bolton's adults drink over **14 units** of alcohol per week



Diseases

Circulatory, respiratory, cancer and digestive diseases together account for over **60%** of the life expectancy gap within Bolton



14% of Bolton's adult population are smokers

32% of Bolton's adults are physically inactive

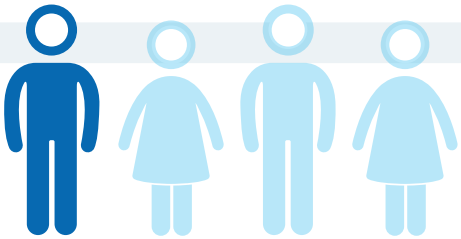
50% of Bolton's adults are eating the recommended 5-a-day

24.7% Primary school pupils eligible for free school meals

England average **24%**

60+ **17%** of people currently on the Housing Register are aged 60+

72,458 the number of children in Bolton



1 in 4 adults in Bolton experience at least one mental health problem

71% Of people surveyed in 2022 that reported high or very high anxiety

National average **40%**

5,695 LGBTQ+

Data collected for the first time tells us that there are 5,695 LGBTQ+ people

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

26% live in an area that is among the **10%** most deprived nationally

56% of the population live in an area that is among the **30%** most deprived nationally

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

The proportion of Bolton's children living in relative poverty **22%**

5,368 Number of babies born in Bolton this year

10,444 adults receiving care and support from the local authority

4,331 adults in Bolton are receiving long-term support

Where do we want to be

In five years' time, we want to be providing high quality and safe services across Bolton, making sure we are meeting the needs of our diverse population.

We want to have a happy, skilled and diverse workforce that is reflective of the people we care for, and that feels like they belong.

We will innovate, develop research, and continually evolve so that we can be the best we can possibly be.

We will work with our partners and our communities to deliver the best services, as close to the people that need them as possible.

What people told us was important to them

Our patients and population told us that:

- They want services to be easy to access when they need them
- They want to be treated with compassion and respect, and to be involved in decisions about their care
- Those with caring responsibilities and those who are cared for said that they want to be listened to and supported to access healthcare in ways that work for them

Our staff told us that:

- They want to be supported to do their best for the people we care for
- They want to contribute to clear, shared goals that reflect their top priorities
- They want to provide personalised care, supporting their patients to best use services and take control of their own care
- They want to expand clinical areas, being aspirational for ourselves and our patients

Our ambitions

Ambitions

- Improving Care, Transforming Lives
- A Great Place to Work
- A High Performing, Productive Organisation
- An Organisation that's Fit for the Future
- A Strong System Partner

Outcomes

Quality Safety and Effectiveness	Improved Staff Experience	Efficient and Productive	Digitally Enabled and Inclusive	Improving Health, Reducing Inequalities
Improved patient experience	Unlocking Potential	Delivering Constitutional Standards	Improving our Estate	Delivering Locality Outcomes
Delivering Innovation	Reflecting our Population	Financially Sustainable	Environmentally Sustainable	Maximising Partnerships For Local Benefit

Our five core ambitions

Our strategy focuses on five core ambitions that will help us to get to where we want to be. They are:

Improving Care, Transforming Lives

A Great Place to Work

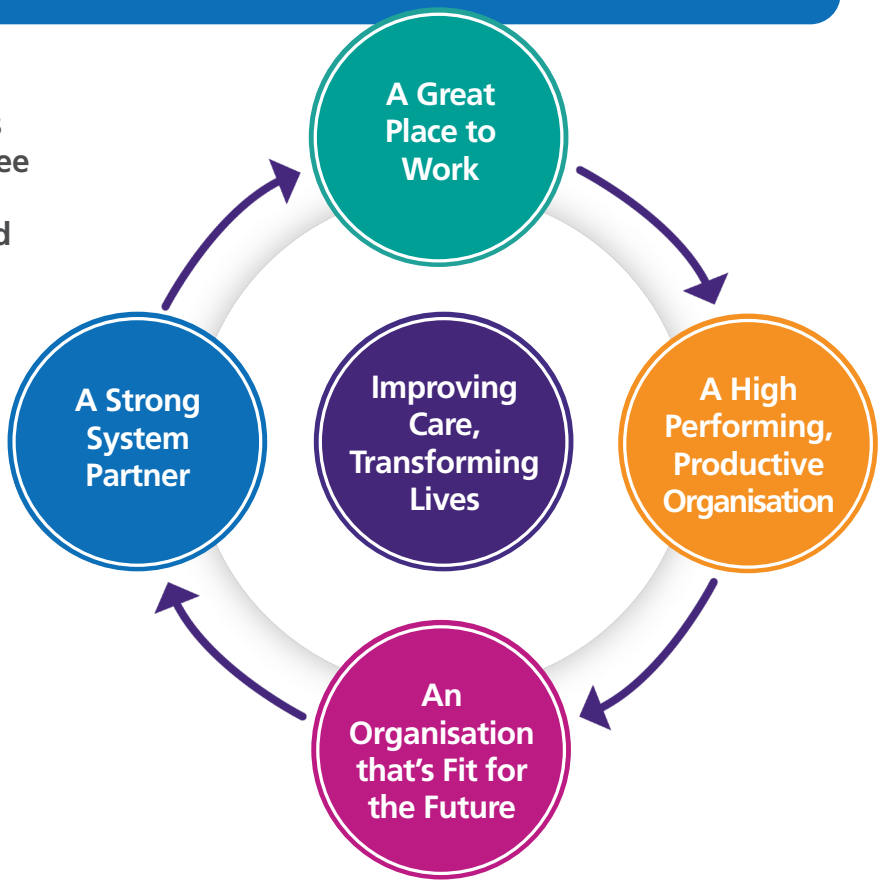
A High Performing, Productive Organisation

An Organisation that's Fit for the Future

A Strong System Partner

Underneath these ambitions are the things that we will see if we achieve our goals, and these will make a lasting and meaningful difference to the people of Bolton.

As a Trust, and as part of a wider health and care system, we will support the greatest possible improvements in health, wellbeing and outcomes for everyone.



Ambition 1: Our care will improve and transform lives

We will continuously improve the care that we provide, and will transform the lives and outcomes of the people of Bolton.

What will this look like?

- Quality, safety and effectiveness
- Our patients will have a better experience
- Continuous innovation

Why is this important?

We want the people who use our services to have a positive experience of the care that we provide, and to achieve the outcomes that are important to them. Over the next five years, we want to be known as an organisation that pursues and delivers the highest standards of care and experience, achieves the right outcomes for the people who use our services, and acts with care and compassion in everything we do.

What will we achieve over the next five years

- Improved pathways across primary, community, secondary and social care.
- A shift from "what is the matter" to "what matters most to me" – actively engaging our patients and service users in service improvements and design.
- Continued and sustained improvement of our ward and departmental standards.
- Reviewed our services to make sure that they are sustainable and delivered in a way that best meets the needs of the people who use them.
- Embedded a culture of continuous quality improvement that provides our people with the time and tools they make positive changes.
- Listened to and acted on feedback and complaints.
- Created the conditions for research to flourish, piloting and collaborating on new initiatives, and implementing new technologies and innovations.

Ambition 2: Our organisation will be a great place to work

We will work together to create an environment where every staff member feels skilled and supported to provide the best care.

What will this look like?

- Improved staff experience
- Our staff will be skilled and have development opportunities
- A workforce that reflects the population we serve

Why is this important?

We know that to achieve our goals, our people must have the skills and support to be the best they can be. We want to create a positive experience of work so that our people feel included, able to speak up and safe to be themselves, because we know that this in turn improves patient care.

What will we achieve over the next five years

- Work will be a place where everyone feels consistently valued, and they feel the work they do is worthwhile.
- Everyone has the skills and confidence to champion the best possible quality of patient care.
- A more inclusive workplace, promoting equality, celebrating diversity, and challenging discrimination.
- A culture where everyone is supported and accountable for the work that they do, and can aspire to excellence.
- Set clear standards, behaviours and values and our managers and leaders have the right skills and behaviours to help them lead effective, high-performing teams.

Ambition 3: Our services will be high performing and productive

We will challenge ourselves to identify opportunities to improve, to work together with our partners across the system, and maximise productivity so that our patients will have shorter waits and better access to services.

What will this look like?

- Efficient, effective and productive services
- Delivery of our constitutional standards
- Financially sustainable

Why is this important?

As our population grows, rates of ill-health rise, and funding continues to be restricted, we need to make sure we can meet future demand. Waiting lists are at record highs and we know we need to be more productive so that we improve both the patient journey, and our financial position.

What will we achieve over the next five years

- A year-on-year reduction in waiting times for planned care and in our ED.
- Improved discharge so that fewer people stay in hospital beds when they could be at home or another place of residence.
- 75% of cancers diagnosed at stage 1 or 2 by 2028.
- Implemented our clinical strategy.
- Achieved the targets in our financial recovery plan.
- Every staff member will have a clear understanding of the part they play in making improvements and the impact it has.

Ambition 4: Our organisation will be fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings enable us to provide the best care. We will look for opportunities to reduce the environmental impacts of the business we run.

What will this look like?

- We will be digitally enabled and inclusive
- An improved estate
- We will be a greener organisation

Why is this important?

We need to improve patient and colleague satisfaction by making sure we have digital infrastructure that is fit for purpose, so that people can do their jobs to the best of their ability, and patients can access our services more easily. We need our building and estates to be able to meet the needs of our growing population, whilst improving health and wellbeing now and for future generations through reducing our carbon footprint.

What will we achieve over the next five years

- An increase in the number of co-located services with other public bodies in neighbourhoods, towards our vision of one public estate across Bolton.
- Our health and care records will be digitised and integrated with our partners.
- A reduced carbon footprint.
- Patients will be empowered with the data and tools to manage their own health and wellbeing.
- A new Estates strategy that describes our long-term vision for how we will invest in and maintain our buildings and environment.

Ambition 5: Our partners and communities will work as one team

As the largest employer in town, we will make sure that we do more for Bolton in addition to the healthcare we provide, by widening access to work, working with local partners and buying locally where possible.

What will this look like?

- A healthier Bolton
- Delivering the outcomes in our Locality Plan
- Working together to benefit local people

Why is this important?

Bolton experiences higher-than-average rates of diabetes, cancer, respiratory and cardiovascular disease, and some of the starkest disparities in health outcomes between the wealthiest and most deprived communities in our town. We need to work in partnership to make it easier for our communities to use our services and ensure we are proactive in targeting care to people who need our services the most.

What will we achieve over the next five years

- Strong partnerships with existing and new stakeholders.
- Integrated services, which will improve outcomes for Bolton people.
- Evolved our partnerships with academic institutions to develop research and education capability, moving towards becoming a Teaching Hospital by 2025.
- Delivered clinically-led collaboration with health and care partners to redesign pathways of care based on a person-centred approach.
- A thriving Trust charity that benefits patients, supports staff and improves facilities.

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

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

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Report Title:	Strategy and Operations Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Sharon White and Rae Wheatcroft		Decision	

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

Summary:	The attached report from the Chair of the Strategy and Operations Committee provides an overview of matters discussed at the meeting held on 26 February 2024. This report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors Due to the timing of the March Strategy and Operations Committee, a verbal update will be provided at Board.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the Strategy and Operations Committee held in February.

Proposed Resolution	The Board of Directors are asked to **receive** the Strategy and Operations 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:	Martin North Non-Executive Director	**Presented by:**	Martin North Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee	Strategy and Operations Committee	Report to:	Board of Directors
Date of Meeting:	26 February 2024	Date of next meeting:	28 March 2024
Chair	Martin North, Non-Executive Director	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Minutes of the previous meetings
- Matters Arising and Action Log
- Spotlight – Theme: EPR Implementation (inc EPR Jigsaw)
- Digital Performance and Transformation Board Chairs Report
- Maternity EPR Risk of Implementation
- Trust Strategy and Outcomes
- Month 10 Operational IPM
- 78-Week and 65-Week Position Update
- Operational Planning Update
- Bolton Strategy, Planning and Delivery Committee Minutes
- Carers Strategy
- Performance and Transformation Board Chairs Report

ALERT

Spotlight – Theme: EPR Implementation (inc EPR Jigsaw)

- Associated risks relate to the inability to deliver the current proposed programme of work and maintain on-going development of the system in areas that are already live if the current staffing resource allocated to the project remains in place. In addition if funding is not allocated for the remaining phases of EPR then this will result in the inability to deploy the solution in key areas or reduced pace of deployment.

Maternity EPR risk of Implementation

- There have been a number of issues affecting the project including; lack of resources, lack of supplier availability to respond to issues, further updates to the product and the impact of the activities needed to mitigate the RAAC situation in Maternity. As a result of this the current planned EPR go-live will move back to June 2024 to enable robust testing along with compliance with CNST data collection

Digital Performance and Transformation Board Chairs Report

- Resourcing remains the highest risk to deployment of projects

Month 10 Operational IPM

- **Urgent Care** - The key recommendations for improvement from ECIST are being triangulated with our urgent care plans. The key 'take home' from ECIST is around simplifying our urgent care improvement

work into three main theme areas; Emergency Department, Acute Medicine and the Back Door. These have been pulled out into a revised plan which will be launched on 27th February along with a series of 'grip and control' meetings being rolled out. As a result of current under performance we are receiving additional external scrutiny • A revised performance trajectory has been submitted to GM to deliver 65% by the end of March 2024 with a week by week trajectory for improvement • **Neck of Femur** - An action plan is in place for improving performance against the national standard, with a focus on reviewing the theatre timetable to ensure there is sufficient trauma capacity across the week
Operational Planning Update • The 2024-25 planning guidance is yet to be released and we are still working to assumed targets
ADVISE
Spotlight – Theme: EPR Implementation (inc EPR Jigsaw) • As of February 2024, Adult Community Services, Adult Outpatients and Maternity have now commenced. Theatres and Anaesthetics are included in the Digital capital plan for 2024/25 and subject to business case approval.
Digital Performance and Transformation Board Chairs Report • Service Desk Report – improvements to the Service Desk are progressing as part of the Service Improvement programme and feedback from the Our Voice Programme
Trust Strategy and Outcomes • A slide will be added to the presentation to provide clear sight on where we will need to make investment in order to take the Strategy forwards along with the milestones that need to be achieved over each of the five years so that there is a detailed delivery plan ready for the end of April 2024 to be deployed into the Trust for consultation.
Month 10 Operational IPM • **Elective Care** - The DM01 position improved in January by 1.3% with a final position of 11.3%. In particular the additional capacity as part of recovery plans in Cardiology and Urodynamic testing has had a significant impact on the DM01 performance in these areas • **NCTR** - The number of patients with No Criteria to Reside has increased and above our operating plan in month at an average of 106. Occupied bed days has increased from the previous month of 653 to 894 in Month 10. In response to the increases, a rapid improvement week called 'Firebreak 40' was held at the beginning of February which did result in an additional 36 patients being discharged from the NCTR list within that week. This concept is being continued, however, the increase was expected to continue into February
78-Week and 65-Week Position Update • We are currently above our likely case trajectory for 78-weeks, however remain confident that we will achieve the projected end of March position. • We are currently below our likely case trajectory for 65-weeks and remain confident that we will achieve this trajectory based on current circumstances.

ASSURE
Spotlight – Theme: EPR Implementation (inc EPR Jigsaw) • Change management and benefits realisation are embedded in the project and logged and tracked through CRIG • The Chief Clinical Information Officer (CCIO) and Clinical Nurse Information Officer (CNIO) roles will work with Digital to bridge the current gap between digital implementation and the workforce to ensure the workforce are able to maximise the benefits of using such a transformational programme
Maternity EPR risk of Implementation • With the current product, we are compliant with the data collection requirements included within CNST
Month 10 Operational IPM • **Cancer -** The Faster Diagnosis standard and the 31 day treatment standard were both achieved
Bolton Strategy, Planning and Delivery Committee Minutes • The recommendations from the Carnall Farrar review of population health opportunities across GM have already been built into the Locality Outcomes Framework.
New Risks identified at the meeting: None
Review of the Risk Register: Resourcing remains the highest risk in relation to deployment of projects and business as usual

Report Title:	Operational Plan submission – 2024/25

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide the Board with a summary of the 2024/25 draft operational planning submission

Summary:	The Trust has submitted a first draft of its operational plan for 2024/25 which describes the Trust's projected performance against activity, finance and workforce. Our submission will be consolidated into a single Greater Manchester return and submitted to NHS England for consideration, and feedback is expected in early April.

Previously considered by:
Executive Directors Finance and Investment Committee March 2024

Proposed Resolution	The Board is asked to note the draft Operational planning submission

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 Andy Chilton Francesca Dean Rachel Noble	**Presented by:**	Sharon White, Director of Strategy, Digital & Transformation

NHS Bolton NHS Foundation Trust

2024/25 Operational Plan Submission

Draft

NHS Bolton NHS Foundation Trust

Draft Operational Plan 24/25

Key Headlines & Assumptions

- Deficit of £9.3m, CIP of 5% - £24.3m, of which £8.6m unidentified
- Financial risk of £15.5m
- Sickness rate of 4.8%, agency rate of 3.2%
- No unplanned workforce growth
- 7/8 performance targets planned to be met
- Capital plan of £13m

Performance Target Headlines

NHS Bolton NHS Foundation Trust

Theme - Target	Target	BFT submission as of 23/02/24	Expected submission for 15th	Achievement
Elective – RTT 65ww Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Zero	1186	Zero	
Beds Maintain the peak increase in capacity agreed through operating plans in 2023/24. This includes acute G&A beds, virtual ward beds, intermediate care (rehabilitation, reablement and recovery services that are either bedded and non-bedded) and ambulance service capacity.	Maintain	Reduced	Reduced	
Beds Reduce adult, paed and critical care general and acute (G&A) bed occupancy to 92% or below.	92%	92%	92%	
Diagnostics – 6ww Increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24	95%	95%	95%	
UEC – A&E 4 hour waits Improve on 2023/24 performance, with a minimum of 77% of patients seen within 4 hours in March 2025	77%	80%	80%	
Cancer Improve performance against the headline 62-day standard to 70% by March 2025	70%	86.5%	86.5%	
Cancer Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025	77%	83.62%	83.62%	
Weighted activity System specific value weighted activity targets are the same as those agreed at the start of 2023/24, consistent with a national value weighted activity target of 107% for 2024/25. *Bolton target TBC	TBC%*	N/A	TBC%*	

Report Title:	Quality Assurance Committee Chairs Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Francis Andrews		Decision	

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

Summary:	The attached report from the Chair of the Quality Assurance Committee provides an overview of matters discussed at the meeting held on 26 February 2024. This report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the March Quality Assurance Committee, a verbal update will be provided at Board with a written report presented to the subsequent Board meeting

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee held in February.

Proposed Resolution	The Board of Directors are asked to **receive** the Chair's report from the 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, Chair Quality Assurance Committee

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

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	28 February 2024	Date of next meeting:	27 March 2024
Chair:	Fiona Taylor, Chair Quality Assurance Committee	Meeting Quoracy: (Y/N)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Patient Story - ASSD Division
- Integrated Performance Report
- Trust Mortality Quarterly Report
- Learning from Deaths Quarterly Report
- Clinical Correspondence Update
- Claims Analysis April 2013 – March 2023
- Maternity Incentive Scheme Year 5 Progress Update (CNST)
- CQC Improvement Plan
- CQC Well Led Recommendation Update – Chief Nurse
- CQC Well Led Recommendation Update – Medical Director
- 8x Serious Incident Reports
- Clinical Governance & Quality Committee Chairs Report

ALERT

Agenda Item	Action required
Clinical Correspondence Update: The report was received by the Committee and it was noted that the 95% is still consistently being missed for inpatients however this could also be due to not being measured correctly. Work is ongoing to align all of the data available and engaging with Primary Care to agree a proposal.	A variation report to be presented in May including divisional data oversight and timelines/action plan

ADVISE

- Integrated Performance Report: Noted the key points highlighted by Chief Nurse and Deputy Medical Director with lengthy discussion regarding Clinical Correspondence and the Urgent Care performance following unprecedented demand in ED/Elective Care.
- Trust Mortality Quarterly Report: The report was received and the Committee noted the challenges identified with regards to influenza and aspiration pneumonia and the steps being taken to address these. The Trust remains within expected range for mortality indicators which was also noted as a positive.
- Learning from Deaths Quarterly Report: The Committee noted the need for more reviews to be undertaken to reduce backlog and it was also confirmed that only 1% of cases that had been reviewed were rated as ‘very poor’ which was positive. Work is ongoing to increase the number of

reviewers and to find solutions to issues identified across the system in relation to DNACPR and ceiling of care as these are not always conveyed across all systems.

- Claims Analysis April 2013 – March 2023: The Committee received the report and noted the themes identified through the ten year period. It was confirmed that there is an annual report and review presented to the Committee and that there are quarterly updates shared with the Quality Safety Committee for oversight. It was agreed that following receipt of the report the Committee would like a deep dive exercise into the medical aspects to identify any learning.
- Maternity Incentive Scheme Year 5 Progress Update (CNST): Assurance was provided to Board of Directors on the 25 January 2024 that all requirements of the CNST year 5 maternity incentive scheme could be evidenced and the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint reviews undertaken in October 2023 and January 2024 had been met. The Committee noted that publication of the CNST year 6 scheme is due in April 2024.
- CQC Well Led Recommendation Update – Chief Nurse: The report was received by the Committee and it was noted that all of the 'must' do recommendations have been completed and the remaining 'should do' is on track for completion by the deadline. Policy assurance is only partially complete as there is a need to remove the dependency on person reliance. A quarterly update on Well Led actions will be presented to the Committee going forward.
- CQC Well Led Recommendation Update – Medical Director: A verbal update was provided noting that two of the three actions were complete and that the one remaining action required a business case approval and will increase headcount which needs to be discussed further given the GM challenges. A written report will be shared at the next meeting for assurance.
- 8x Serious Incident Reports: Multiple reports were received by the Committee and the actions plans were approved.

ASSURE

- Patient Story - ASSD Division: The Committee heard the patients story and how this was the first patient with zero length of stay following a new quality improvement method for knee/hip replacements. It was agreed that a review of the service and lessons learned will be presented to the Committee in one year.
- CQC Improvement Plan: The report was received and it was noted that of the 28 recommendations from various inspections 18 of these were complete, 7 were on track for completion, 2 were set for completion within month and one was overdue. There was a discussion around progress in completing the actions but also ensuring that changes are in place and embedded as business as usual. This may require further actions to be allocated in some circumstances.
- Clinical Governance & Quality Committee Chairs Report: The Committee received the chair report and were pleased to note the level of debate held in sub-committees.

New risks identified at the meeting:
None.

Review of the Risk Register:
Not reviewed.

Report Title:	Quality Account Update

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 March 2024		Discussion	✓
Exec Sponsor	Chief Nurse		Decision	✓

Purpose	To provide the Board of Directors with the Quality Account priority proposals for 24/25 and timeline for QA Annual report 23/24

Summary:	The National guidance for the Quality Account annual report is yet to be released. The 23/24 Quality Account publication timeline will follow the assumed timeline, based on previous years' timeframes. Final publication being 30 June 2024. The Proposed Quality Account improvement priorities for 24/25 are: ○ Deteriorating Patient Collaborative – new for 24/25 ○ C.*diff* Collaborative – continuation ○ QI skills capability building – continuation

Previously considered by:
Discussed at Clinical Governance & Quality Committee on 7 February 2024. To be discussed at Quality Assurance Committee on 27 March 2024.

Proposed Resolution	The Board of Directors are asked to **note** timeline for publication of the 23/24 Quality Account report and **approve** the proposed Quality Account improvement priorities 24/25.

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

Prepared by:	Stuart Bates, Director of Quality Governance Debbie Redfern, Quality Improvement Programme Manager	**Presented by:**	Tyrone Roberts, Chief Nurse

Quality Account Annual Report 23/24:

National guidance for the Quality Account annual report is yet to be released. Appendix one offers a schedule of committees where the report will be approved based on previous years (subject to change).

The Director of Quality Governance, Assistant Director of Clinical Governance and Quality Improvement Programme Manager will lead on the collation and governance of the Quality Account annual report. All contributors have been informed the 23/24 cycle is due to start.

Proposed 24/25 Quality Accounts Improvement Priorities

The Quality Account annual report requires organisations to select three improvement priorities for the forthcoming financial year and to publish progress in these areas in the following year's report. Priorities must demonstrate a clear link to quality improvement/patient safety. The following priorities have been suggested for 24/25:

1. **Recognition and Response to the Deteriorating Patient–** The Clinical Governance and Quality Committee supported the commissioning of an improvement collaborative in December 2023. The scope of the collaborative will be agreed by and progress reported to the newly formed Recognition and Management of Deterioration Group.

2. **C.dificile Reduction** – the C.*diff* improvement collaborative is not due to end until December 2024, followed by the launch of a trust-wide change package. Therefore, due to the complexities and amount of work still required C.*diff* reduction is proposed to remain as a QA improvement priority for 24/25.

3. **Quality Improvement Skills Capability Building** – The trust has made a commitment to support and empower its' staff to use QI methodology as the way to improve and transform its' services. Although good progress has been made in laying the foundations for QI skills capability building; the review of the NHS IMPaCT maturity matrix baseline has highlighted further work is required. Therefore, QI skills capability building is proposed to remain as a QA improvement priority for 24/25, but will not be taken forward as a QA improvement priority in 25/26. QI skills and capability building will remain in place and offered to all staff following the 24/25 QA cycle.

Summary:

The Board is asked to note:

- No national guidance has been published in respect of the drafting or required content of the 23/24 Quality Account and therefore this will follow the assumed timeline in appendix one (subject to change), based on previous years timeframes.

- Quality Account contributors have been informed the 23/24 cycle is due to commence

Recommendations:

The Board is asked to approve the following proposed Quality Account improvement priorities for 24/25:

a. Deteriorating Patient Collaborative – new for 24/25
b. C.*diff* Collaborative – continuation (see rationale above)
c. QI skills capability building – continuation – but will not go beyond 24/25

Appendix One – Quality Account 23/24 annual report approval timeline

Revised arrangements from 2019/20 and 20/21 will continue – these being:

- NHS foundation trusts are no longer required to include a quality account/report in their annual report. This will continue for 2021/22 and beyond

- NHS foundation trusts are not required to commission assurance on their quality report for 2020/21 and beyond

Committee	Date	Actions Required
Clinical Governance and Quality	February 2024	• To note assumed timeframes for 23/24 Quality Accounts annual report production and changes to governance arrangements • To note/approve proposed approach to the 24/25 Quality Account priorities
Audit Committee	February 2024	• To note commencement of Quality Account 23/24
Quality Assurance Committee	March 2024	• To note assumed timeframes for 23/24 Quality Accounts annual report production and changes to governance arrangements • To note/approve proposed approach to the 24/25 Quality Account priorities
Clinical Governance and Quality	April 2024	• To receive a draft Quality Account 23/24 for sign off
Quality Assurance Committee	April 2024	• To receive a draft Quality Account 23/24 for sign off
Healthwatch Bolton	May 2024	• To receive Draft Quality Account for comment
GM ICB	May 2024	• To receive Draft Quality Account for comment
Audit Committee	May 2024	• To review Final Quality Account
Board of Directors	May 2024	• To sign off the Final Quality Accounts
Publish & Communicate	30th June 2024	• As a standalone document to NHS Choices

Report Title:	Clinical Negligence Scheme for Trusts Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	✓
Exec Sponsor	Tyrone Roberts		Decision	

Purpose	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Summary:	Key highlights: • The CNST declaration confirming the Trust position with regard to compliance with the Year 5 CNST maternity incentive scheme was submitted to NHS Resolution on 29 January 2024. Notification of the financial award is anticipated by the 30 April 2024 • Publication of the CNST year 6 scheme is due on 02 April 2024 • This report confirms that the service has attained the required >90% compliance in all staff groups • On the 09 February 2024 the CQC Maternity survey was published, reflecting feedback from women who gave birth between January – March 2023. Actions are in place. To note the survey shows that **57% of responses have improved** compared to 2022 (responses linked specifically to care) • A Local Maternity Neonatal System (LMNS) visit was undertaken on 19 February 2024. Assurance was provided during the visit that that the service is now compliant with all immediate and essential Ockenden actions and progress to evidence delivery of the single delivery plan was presented. The formal LMNS visit report is awaited which will also advise whether Bolton FT can be removed from the regional support programme • At the February 2024 Quality Assurance Committee, assurance was provided that alignment of the speciality and Trust dashboard to Greater Manchester and East Cheshire (GMEC) in relation to stillbirth data was in progress. The data for the aligned stillbirth metric (that excludes termination of pregnancy cases) highlights the Trust stillbirth rate of 4.39 /1000 in January 2024. This rate is marginally higher than the GMEC median of 4.35 in January 2024. A brief review of 2 cases in January has been undertaken in response and both cases related to 25 and 26 week gestation babies. A detailed perinatal mortality review of both cases is now in progress to identify whether there is any learning from the cases. Implementation of all of the revised saving babies lives care bundle v3 elements to reduce perinatal mortality continues within the service.

	This paper has been discussed at the Clinical Governance and Quality Governance Committee where further clarification was required in relation to the still birth data. It was confirmed that the results from the 2022 'Mothers and babies; reducing risk through audit and confidential enquiries' report (MBRACE) show that the organisational stabilised & adjusted stillbirth rate, excluding deaths due to congenital anomalies, is 3.26 per 1,000 total births. This is around the average for similar Trusts & Health Boards. A further response in relation to the MBRACE report will follow in due course. In summary, CNST year 5 has been submitted and passed through all LMNS gateways. Official confirmation of 100% achievement is awaited. Previous queries in relation to stillbirth have been discussed and narrative provided with support of the now released 2022 MBRACE report.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	*It is recommended that the Committee:* *i. Receive the contents of the report.* *ii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.*

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

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

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
LMNS	Local maternity and neonatal system
GMEC	Greater Manchester and East Cheshire
MBRACE	Mothers and babies; reducing risk through audit and confidential enquiries

1. Introduction

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) year 5 Maternity Incentive Scheme (MIS).

2. CNST year 5 update

Assurance was provided to Board of Directors on the 25 January 2024 that all requirements of the CNST year 5 maternity incentive scheme could be evidenced and the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint reviews undertaken in October 2023 and January 2024 had been met.

The CNST declaration confirming the Trust position with regard to compliance with the Year 5 CNST maternity incentive scheme was then submitted to NHS Resolution on 29 January 2024.

In March 2024 a detailed action plan was approved by Trust Board to recover the training compliance position to 90%, within a maximum 12-week period from the end of the MIS compliance period as per CNST scheme requirements.

Extensive work has been undertaken in response to attain the 90% training compliance for the PROMPT (emergency skills), newborn life support and fetal monitoring training elements prior to the 24 February 2024.

This report confirms that the service has attained the required >90% compliance in all staff groups.

Notification was received on the 4 March 2024 that the year 6 scheme requirements will be published on the 2 April 2024 and the scheme will run until the 30 November 2024.

Table 1 – CNST training compliance as of 11 February 2024

Course compliance by staff group									
Course	Advanced Neonatal Practitioners	Consultant Obs	Obstetric Medical Doctors	MSW/HCA	Midwives	Neonatal Con	Neonatal Doctors	Neonatal Nurses	Obstetr Anaesth Consul
PROMPT	NA	94.74%	96.77%	90.41%	95.76%	NA	NA	NA	100%
Fetal Monitoring Core Competency Stds.	NA	94.74%	96.77%	NA	91.95%	NA	NA	NA	NA
Neonatal Life Support	100%	NA	NA	NA	92.377%	90.00%	90.91%	90.72%	NA

3. 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 2. 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 1.

At the February 2024 Quality Assurance Committee assurance was provided that alignment of the speciality and Trust IPM dashboard stillbirth dataset was in progress to align with the GMEC tableau datasets to facilitate performance benchmarking with peers.

The data for the aligned stillbirth metric (that excludes termination of pregnancy cases) highlights the Trust stillbirth rate of 4.39 /1000 in January 2024. This rate is marginally higher than the GMEC median of 4.35 in January 2024. A brief review of the 2 cases has been undertaken in response and both cases related to 25 and 26 week gestation babies. A detailed perinatal mortality review of both cases is now in progress to identify any learning from the cases. Implementation of all of the revised saving babies lives care bundle v3 elements to reduce perinatal mortality continues within the service.

The results from the 2022 'Mothers and babies; reducing risk through audit and confidential enquiries' report (MBRACE) show that the organisational stabilised & adjusted stillbirth rate, excluding deaths due to congenital anomalies, is 3.26 per 1,000 total births. This is around the average for similar Trusts & Health Boards. A further response in relation to the MBRACE report will follow in due course.

Table 2 – Safety Champions locally agreed dashboard

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

Indicator	Goal	Red Flag	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
CNST attainment	Information only							100%	
Critical Safety Indicators									
Births	Information only		472	386	408	468	454	422	456
Maternal deaths direct	0	1	0	0	0	0	0	0	0
Still Births			1	4	1	1	1	0	2
Still Birth rate per thousand (excluding termination of pregnancy cases)	3.5	≥4.3							4.39
HIE Grades 2&3 (Bolton Babies only)	0	1		3	2	1	0	0	0
HIE (2&3) rate (12 month rolling)	<2	2.5	1.5	2.1	2.5	2.7	2.5	1.9	1.5
Early Neonatal Deaths (Bolton Births only)	Information only		1	0	5	0	1	1	2
END rate in month	Information only		2.1	0.0	2.3	0.0	2.2	2.4	4.4
Late Neonatal deaths	Information only		0	0	0	0	0	0	0
Serious Untoward Incidents (New only)	0	2	1	0	0	1	1	0	1
HSIB referrals			1	1	4	2	0	0	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0	0
Moderate harm events			3	3	3	3	0	0	1
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98.3	99.0	98.6%	98.6%	98.1%	97.7%	97.7%

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%	84.00%	85.92%	83.00%	83.00%	86.73%	91.38%	93.40%
PROMPT training compliance (overall)	<80%	>80%	93.00%	93.94%	86.00%	83.00%	88.59%	94.84%	95.56%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:26.9	1:27.1	1:25.5	1.24.3	1:23.2	1:23.4	1:23.2
RCOG benchmarking compliance	Information only		100%	100%	100%	100%	100%	100%	100%
Compensatory rest breaches						0	0	0	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual								59.4%
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual								

4. CQC Maternity Survey

On 9th February 2024, the CQC published their annual maternity survey results as part of the NHS Patient Survey Programme. The NHS Patient Survey Programme (NPSP) is commissioned by the CQC to collect feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

All eligible individuals, who had a live birth between 1 January and 31 March 2023 were invited to participate in the maternity survey. The Trust had a 35% response rate from the 628 individuals invited to take part.

Comparison with 2022 survey data

- Overall, compared to the 2022 date, there was no statistically significant change in 96% of the scores.
- Two scores (4%) had statistically significant increase in scores. No scores had a statistically significant decrease.
- Overall, **57% of questions had an improved score** – this includes some of the questions in the bottom 20% of scores
- 18% of these improved by 10% or more (including confidence in staff /post-natal care/ reduction in being 'left worried alone')
- 21% of these improved by 5 - 9% (including being allowed to be with partner)
- 61% of these improved by between 1-4% (including continuity of midwife)
- Four scores in the 2023 survey were in the top 20% range, with the best score achieved in "During your antenatal check-ups, did your midwives listen to you?"
- Deteriorated from 2022 data
- 35% of the responses deteriorated by up to 5% (including feeding information, and visiting intra-partum)
- 2% deteriorated of the responses by 6% (This equated to one question relating to: Would you have liked to have seen or spoken to a midwife, in the care after birth section).

Areas of strength

✓ Maternity service users receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.

- ✓ Maternity service users discharge from hospital not being delayed on the day they leave hospital.
- ✓ Maternity service users feeling that if they raised a concern during their antenatal care it was taken seriously.
- ✓ Maternity service users having confidence and trust in the staff caring for them during their antenatal care.
- ✓ Maternity service users being given information about their own physical recovery after the birth.

Areas of further improvement

- The cleanliness of the hospital room or ward maternity service users were in during their stay at the hospital.
- Partners or someone else close to the service user were involved in their care as much as they wanted to be during labour and birth.
- Maternity service users feeling that if they raised a concern during labour and birth it was taken seriously.
- Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.

The report highlighted no statistical change in the response to 47 questions when compared with the 2022 survey findings and a slight statistical increase in 2 questions.

The report reflects the overall service challenges in early 2023, the decrease in place of birth choice at Bolton since 2022 and the staffing pressures at the time of the survey (circa 53 WTE Registered Midwives) that impacted upon the quality of the care provided to families.

Since January 2023 significant work has been undertaken within the service to address staffing pressures with a reduction in the Registered Midwife vacancy from 53WTE to 13WTE in January 2024. This has enabled the provision of the supernumerary Delivery Suite Co-ordinator role to be implemented within the Delivery Suite environment supporting the oversight of clinical care, timeliness of resolution of concern and provision of professional support for staff and patients when required. Ongoing work is in progress to review delays in induction of labour pathways and improve the information presented to families to inform decision making.

5. LMNS Assurance Visit

Since 2023, the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity & Neonatal System (LMNS) has taken on the role of assurance and oversight of maternity services for the ICB. In response a LMNS assurance was undertaken the 19 February 2024.

The visit was undertaken to seek assurance that the provider was compliant with all Ockenden Immediate and Essential Actions (IEA's) (Appendix 2) and ensure the guidance was embedded in practice. The visit was also be used as an opportunity to review implementation of the three year delivery plan for maternity and neonatal

services published in 2023 and seek assurance with regard to wider national and local pieces of work and care standards.

The Trust provided assurance during the visit that all immediate and essential recommendations have been implemented within the service (Appendix 2) and progress to evidence delivery of the single delivery plan was presented.

Feedback was also received from the maternity voice partnership and relevant staff groups.

The initial LMNS feedback highlighted a positive improvement in the team culture and leadership of the service. The LMNS acknowledged that the service was on an improvement journey and commended the work undertaken to date. Further assurance was requested regarding the current maternity triage arrangements and the team were advised that the service has an ongoing action plan to improve the current service offer.

The Trust is awaiting a summary report following the visit and this will be shared at a future Committee meeting.

6. Summary

This report provides an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

The report provides assurance that all standards for the CNST maternity scheme have been fulfilled and confirms the formal declaration was submitted to NHS Resolution on the 29 January 2024. It also provides additional assurance re stillbirth rate subsequent to recept of the 2022 MBRACE report.

This report outlines the key findings of the CQC 2023 maternity survey and confirms the initial feedback received in response to the recent LMNS assurance visit. The Trust is awaiting the formal LMNS visit report and this will be shared at a future Committee meeting.

7. Recommendations

It is recommended that the Committee:

i. Receive the contents of the report.

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

Appendix 1 - 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 2 – Ockenden immediate and essential actions compliance

IEA number	Immediate and Essential Action	Required Standard	Number of questions in action	No of questions with no evidence collected to meet requirements	No of questions that require updated evidence	No of questions with all evidence collected to meet requirements
1	**Enhanced Safety**	Trusts must work collaboratively to ensure serious incidents are investigated thoroughly and Trust Board must have oversight of these	**7**	**0**	**0**	**7**
2	**Listening to Women and Families**	Maternity Services must ensure women and their families have their voices heard	**5**	**0**	**0**	**5**
3	**Staff Training and Working Together**	Staff who work together must train together and MDT Ward Round Twice Daily	**6**	**0**	**0**	**6**
4	**Managing Complex Pregnancy**	There must be robust pathways in place for managing women with complex pregnancies	**6**	**0**	**0**	**6**
5	**Risk Assessment Throughout Pregnancy**	Staff must ensure that women undergo risk assessments in pregnancy at each contact	**3**	**0**	**0**	**3**
6	**Monitoring Fetal Well-being**	Dedicated leads for Fetal Monitoring who champion best practice in fetal surveillance	**4**	**0**	**0**	**4**
7	**Informed Consent**	Women must have access to accurate information to enable informed choice	**6**	**0**	**0**	**6**
WF	**Workforce and compliance with NICE guidelines**		**5**	**0**	**0**	**5**
		Total	**42**	**0**	**0**	**42**

Report Title:	Trust Mortality Quarterly Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Francis Andrews, Medical		Decision	

Purpose	This report provides an update on recent mortality metrics and details of key actions and priorities for improving these metrics.

Summary:	**Key indices**
	• SHMI (NHS Digital published figures, not HED) shows Bolton at 108.06, which is in the 'Expected' range.
	• The trend in HSMR has remained at 'Green' (within Expected range) at 102.22
	• The crude rate has remained at a similar level as compared to last year.
	Key challenges and achievements
	• Improving our comorbidity and diagnosis recording
	  ○ Significant reductions in the number of discharges where patients have 0 comorbidities over the past 3 years has been fundamental in the movement of SHMI and more recently HSMR back into expected range.
	• Maintaining clinical coding completeness
	  ○ The Clinical Coding Team continue to achieve the >98% coding completeness at the data freeze point
	• Clinical scrutiny of mortality data
	  ○ Influenza, Aspiration pneumonitis and other perinatal conditions have been reviewed with learning from these is reported here.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	The Board of Directors are asked to receive and note the Trust Mortality Quarterly report.

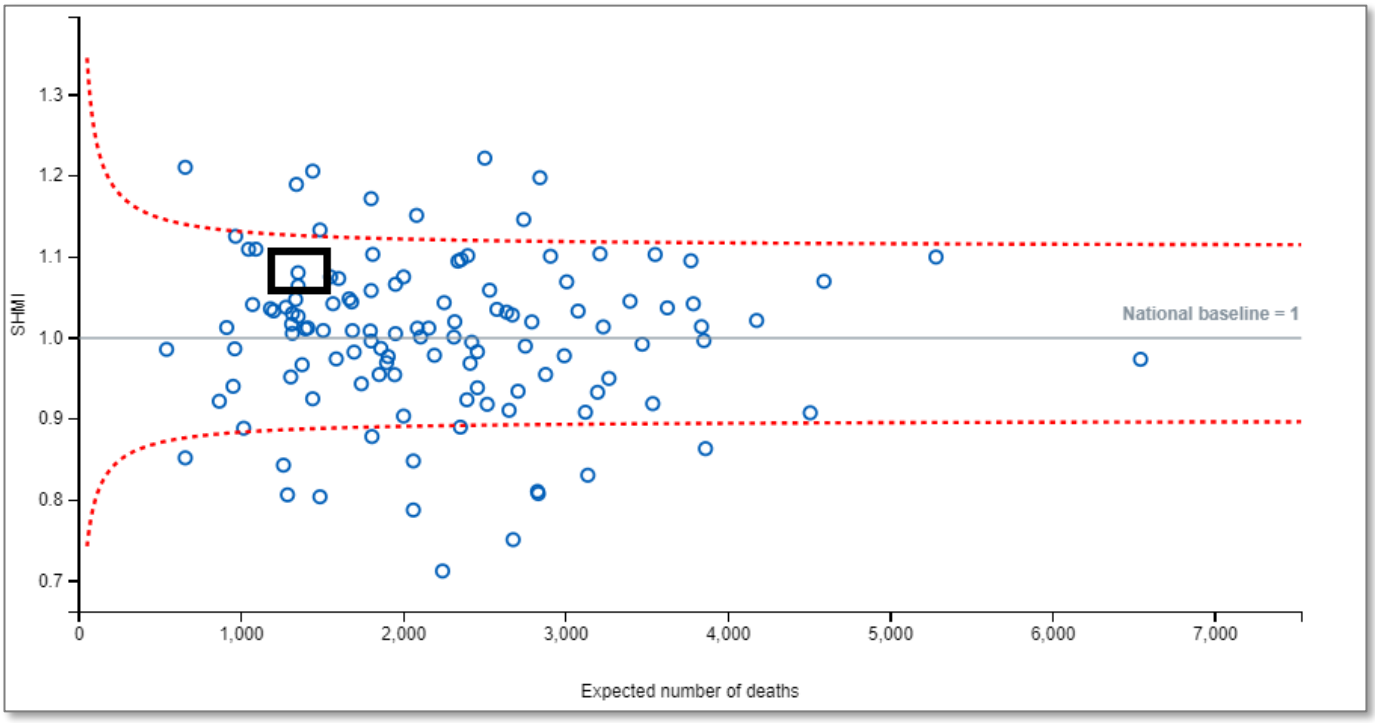
This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** 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:	Liza Scanlon (BI) and Sophie Kimber Craig (AMD)	**Presented by:**	Francis Andrews, Medical Director

1. Current key mortality metrics for Bolton

1.1 Summary Hospital-level Mortality indicator – SHMI

NHS Digital data for SHMI (September 2022 to August 2023) shows Bolton at 108.06, which is in the 'Expected' range. This rate has remained stable since the last reported figure of 109.96[1].



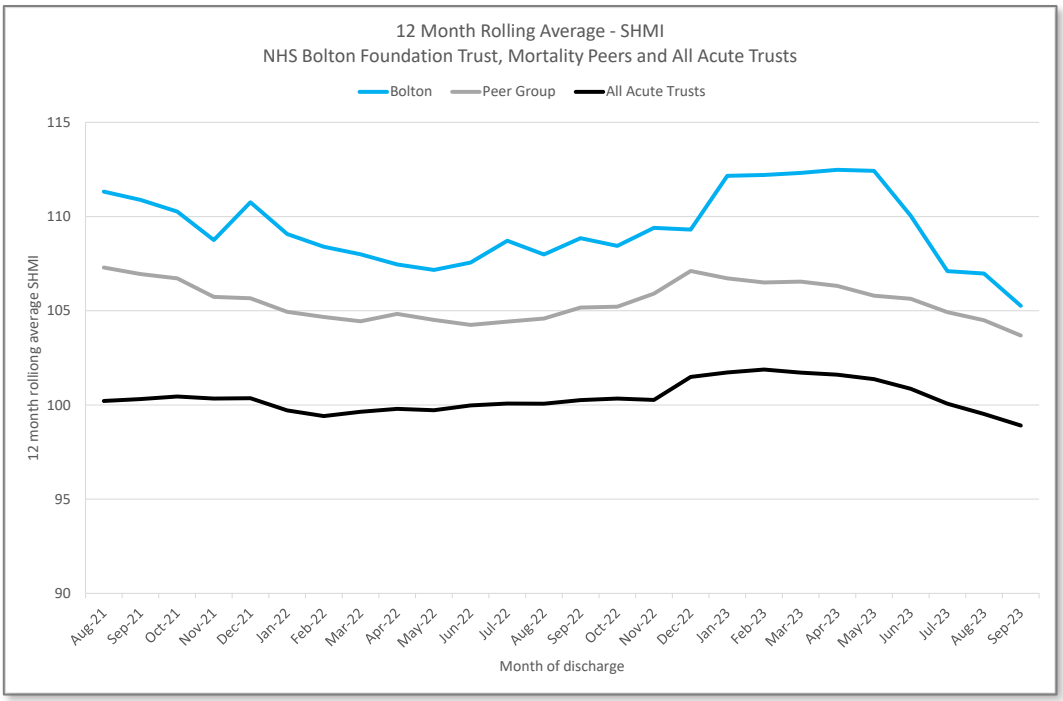
Time series to September 2023[2]

The rolling average for Bolton (light blue) has shown a rise in January 2023 increasing the gap between Bolton and peers but has since fallen again with a reduced gap to peers seen across the timeframe. It also remains higher than the average compared to mortality peers (grey) and all acute trusts (black)***.[3]***

[1] Patients with Covid are excluded from the SHMI calculation (ie the spell is removed in its entirity regardless of whether the patient died or not).

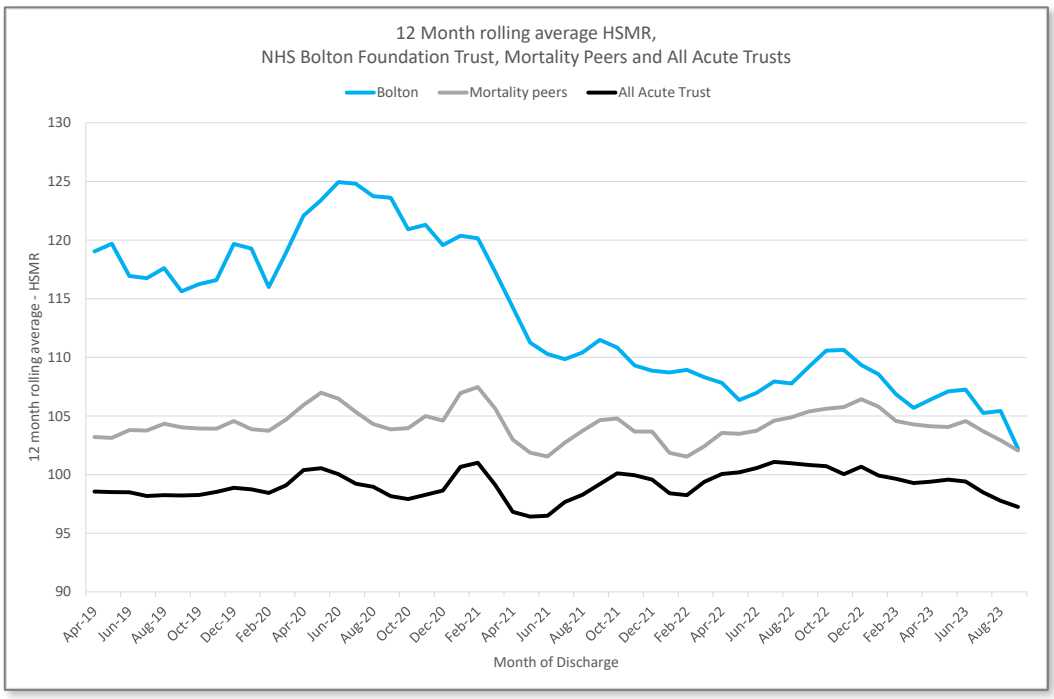
[2] The rest of the report uses the SHMI figures as calculated using HES and ONS linked datasets via the HED system and is therefore more up to date than NHS Digital published figures to give an earlier indication of the indicator.

[3] Data excludes any patients who have 'opted out' of their data being shared for research purposes. As this data is calculated ahead of the published data (where they are included) this is causing the rolling average to be inflated when compared to the published data. The average opt out rate nationally is around 5%, Bolton is currently at 6.4% so causes a substantial shift in the data.



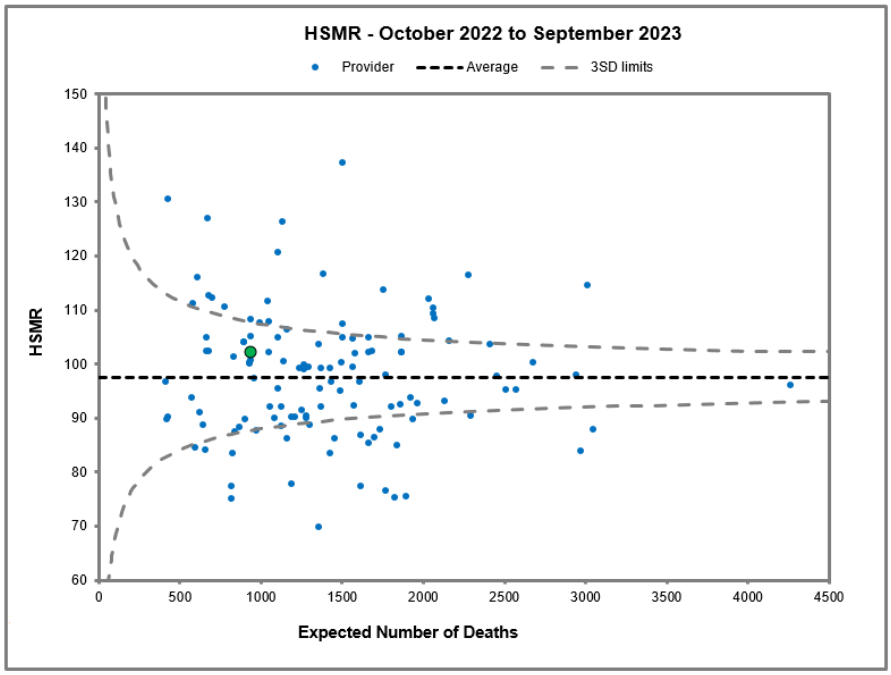
1.2 Hospital Standardised Mortality Ratio (HSMR)

The HSMR ratio is 102.22 for the 12 months to September 2023 (shown as a 12 month rolling average in the graph); Bolton (light blue) is higher than the average of mortality peers (grey) and all Acute Trusts (black). However, the gap has significantly reduced from the earlier part of the timeframe and is only just above that of the peer group in September 2023.[4]



[4] HSMR calculations exclude patients with a primary diagnosis of Covid. HSMR is adjusted for Covid according to the following: *Patients with a primary diagnosis of Covid-19 (in the first episode or second episode if the first contains a primary diagnosis of a sign or symptom) are placed in CCS group '259 - Residual codes unclassified' and will therefore be excluded from the HSMR. If the Covid-19 coding appears elsewhere in the spell or in subsidiary diagnoses the patient may be included in the HSMR.*

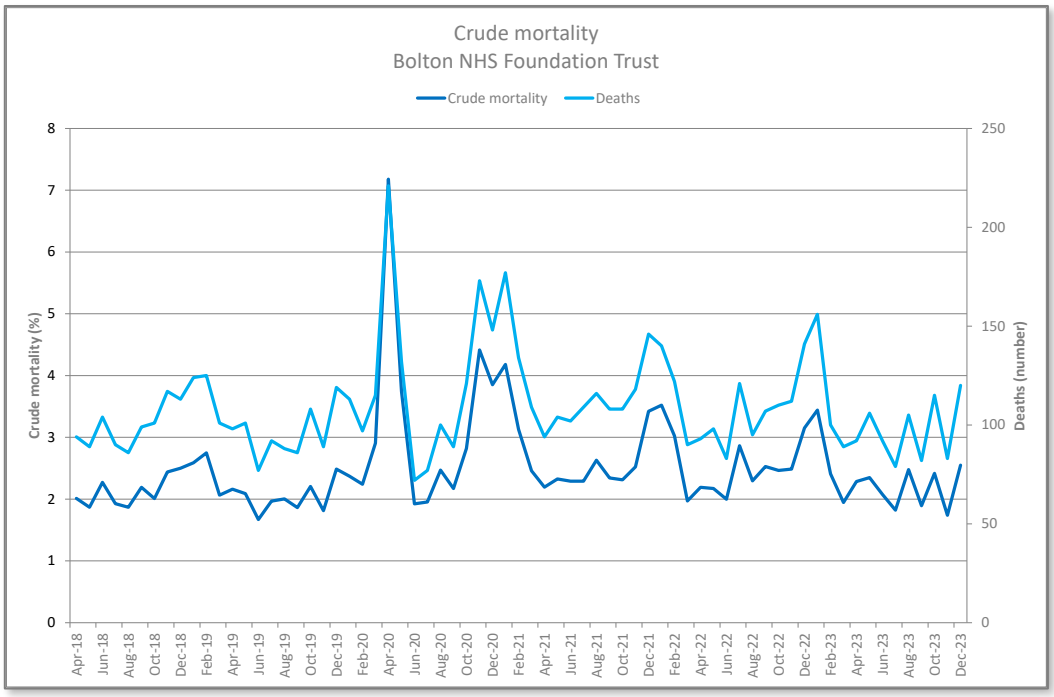
Bolton has remained at 'Green' which is the expected range for HSMR, as indicated by a green circle on the chart below. The HSMR has remained stable and remained in range since the previous report.



1.3 Crude mortality (excluding day case patients)

In hospital crude mortality has shown a similar level to the same period last year. There was a slight spike over winter due to an increased number of in month deaths, but this is not out of any control limits when analysed via statistical process control (SPC).

The crude rate is not adjusted for Covid mortality or spell activity, which is seen with spikes coinciding with the pandemic waves (in April and November 2020 and again in January 2021). The normal cyclical winter increasing pattern occurred over winter 2021/22 and 2022/23, worsened by the Covid spike and more recently the bad flu season. Nationally, crude mortality fell in Summer 2020 (following the impact of Covid on the death rates before then). We now need to be mindful of the mortality rate and the causes of death we see at times where Covid is not peaking, as it may be that we will see the impact of the pause on other work during the pandemic and its effects on patients' outcomes.



1.4 Comment on mortality indices

SHMI has been consistently within the expected range for a number of months now and our HSMR is also back within range in the most recently available data. Our crude mortality rate sits below national average, which given the population of Bolton and the link between deprivation and health, could actually be an unexpected finding (i.e. where there are higher levels of deprivation and poorer health, one would expect a higher number of observed deaths). It is worth considering the differences between the two main risk-adjusted metrics; a table showing the different data included in the calculations in shown on the last page of this report.[5] We reported in the last quarter that we have seen a significant improvement in the recording of Charlson comorbidities, which is one of the main risk adjustments for both SHMI and HSMR; this improvement persists and is expected to further improve once the proposed EPR changes are implemented.

2. Dashboard views

2.1 Mortality Indicators

The HED dashboard is shown this includes the NHS Digital published information and a more up to date externally calculated SHMI using HES and ONS data.[6] [7]

Indicator	Current	Previous	Change	Peer	National	Position
SHMI - NHS Digital (12 mth rolling) NHS Digital SHMI Dataset (Jan 2024)	108.06 (Sep 2022 - Aug 2023)	108.02 (Aug 2022 - Jul 2023)	0.04 ↑	104.32	100.00	Within expected range
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Dec 2023)	105.26 (Oct 2022 - Sep 2023)	106.98 (Sep 2022 - Aug 2023)	-1.72 ↓	101.84	99.25	Within expected range

[5] Further information can also be found at: CHKS_Mortality measures compared_Dec2018.pdf

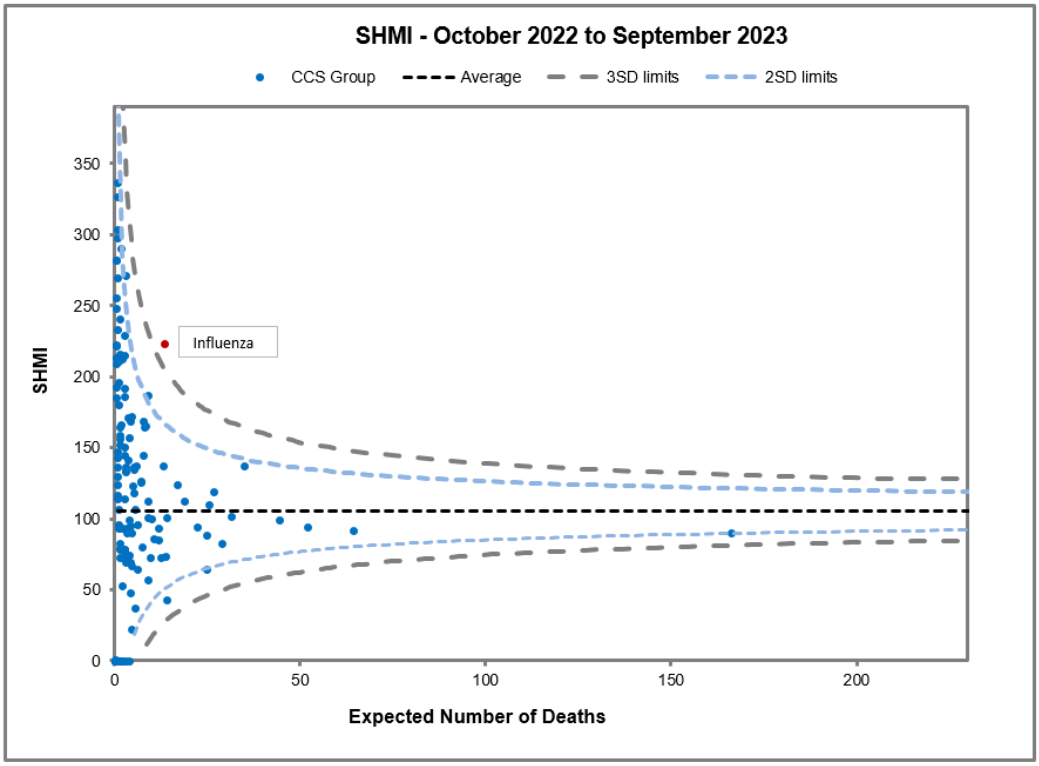
[6] Important note: HSMR has not been included in the dashboard as this is created using the 'Flex' position of SUS data. This is not viable to use for Bolton until the coding is completed at the 'Freeze' position as it bases the HSMR on incomplete records which skews the indicator.

[7] Please note there is a time lag in the data compared to the rest of this report

3. Diagnostic groups

3.1 SHMI red alerts by diagnosis group (12 months to September 2023)

SHMI can be split by CCS diagnosis group. Outlying diagnostic groups falling outside of the 99.8% control limits for SHMI are indicated as 'red' alerts. Influenza is flagging as red for the 12 months to September 2023.



This is a legacy alerting group. There have been no deaths in this group since February 2023 but as it is a rolling 12 months these months are still alerting due to the bad flu season over winter 2022/23. The disease group was reported upon in the previous report.

3.2 SHMI Amber alerts by diagnosis group (12 months to September 2023)

Any CCS diagnostic groups that sit outside the 95% control limits, but within the 99.8% limits are classed as an Amber alert.

There are no disease groups alerting as Amber in the time period.

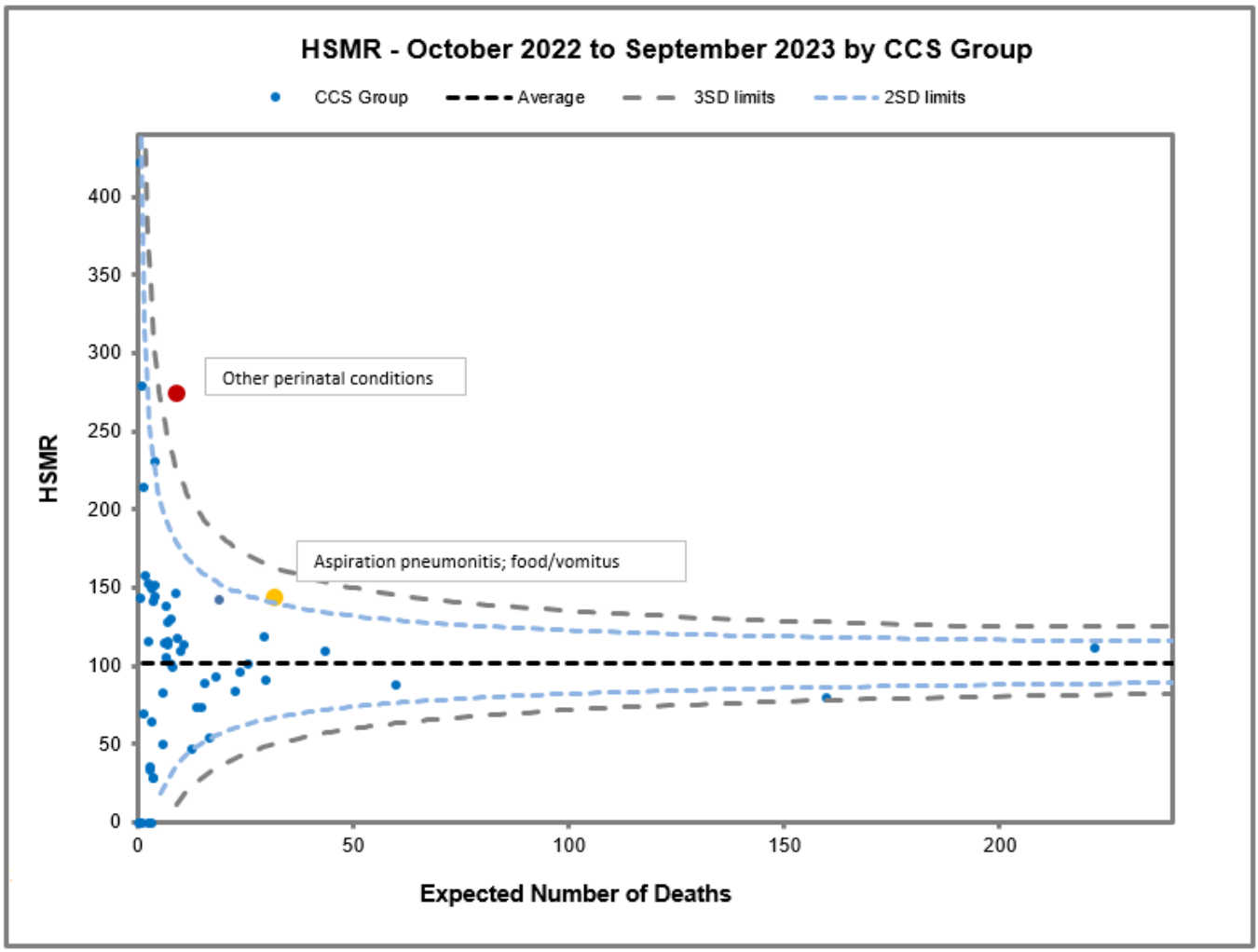
3.3 HSMR Red alerts by diagnosis group (12 months to February 2023)

Other perinatal conditions is flagging as a red alert, as shown in the next graph.

3.4 HSMR Amber alerts by diagnosis group (12 months to September 2023)

Aspiration pneumonitis is flagging as an Amber alert in the 12 months to September 2023.

It is important to note that any small change to either the numerator or denominator of these alerting groups will substantially shift HSMR as the numbers are so low, causing fluctuations in the data.



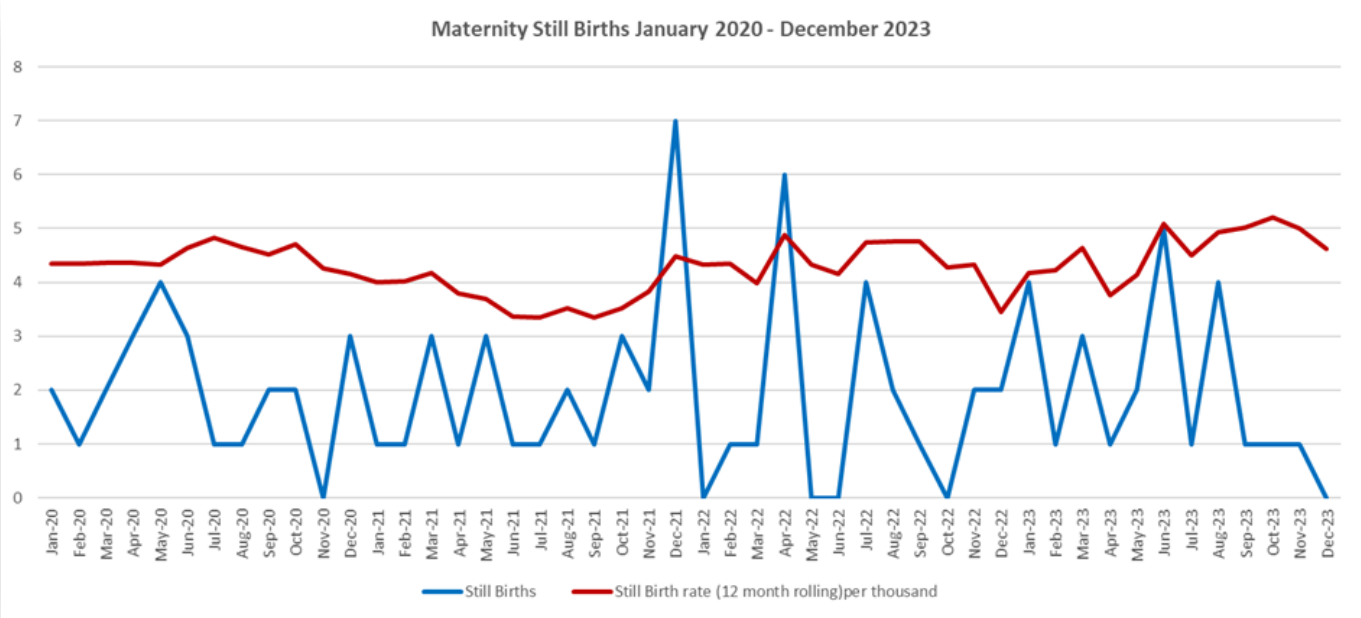
Other perinatal conditions

Any slight change in the number of deaths would shift this group out of alerting – which from the patients that were reviewed is to likely to be the case. However, the legacy coding and 12-month rolling average will cause this to continue to alert for some time.

Part of this is known to be due to the incorrect data entry around some stillbirths, which were incorrectly identified in the discharge method which is affecting the risk score. A comprehensive Action Plan has been developed by the Divisional Medical Director for Families covering aspects of audit and process to fully understand the data recording. This is still being worked on and has been extended to include all systems used across maternity and neonates. A full report on neonatal deaths will be presented in March by the divisional team at CGQ committee. The current Trust rates are shown here for information and relevant available data to articulate the variation across various recording systems is provided.

The stillbirth cases reported during the period January – August 2023 are shown in this table and graph provided in the Trust IPR, as per our local KPI data. On the next page, the GMEC data is provided for comparison, where it can be seen that we benchmark reasonably across the system.

2023	Goal	Red Flag	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Stillbirth cases			4	1	3	1	2	5	1	4
Stillbirth rate (12 month rolling per thousand)	<3.5	≥4.3	4.2	4.2	4.6	3.8	4.1	5.1	4.5	4.9



GMEC dashboard - stillbirth cases per 1000 births:

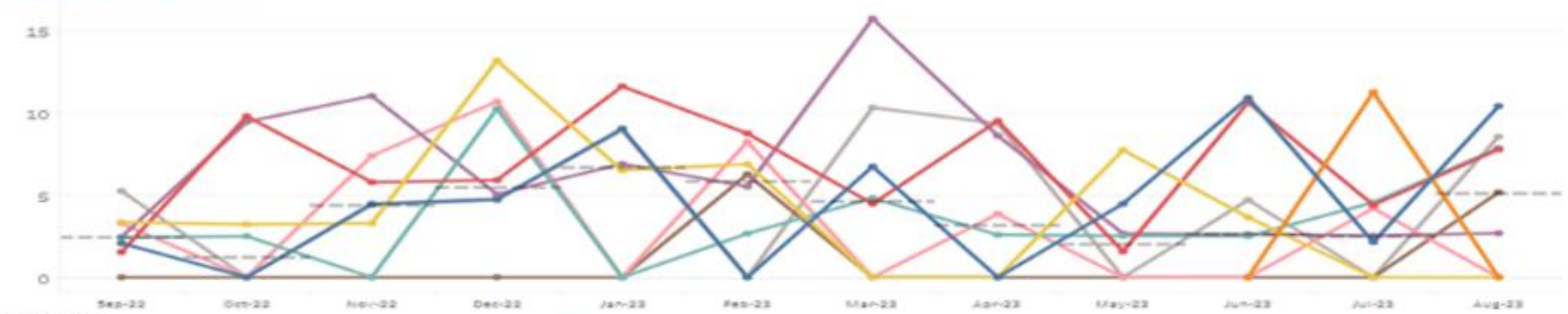
SCN Maternity Dashboard

Front Page | Activity Data | Maternity (Rate) | Maternity (%) | Perinatal (Rate) | Perinatal (%)

Perinatal Rate (Month) - (per 1,000)

GM: (All) | Period Selection: Month | Perinatal Rate - Select a Measure: Stillbirth Rate (per 1,000)

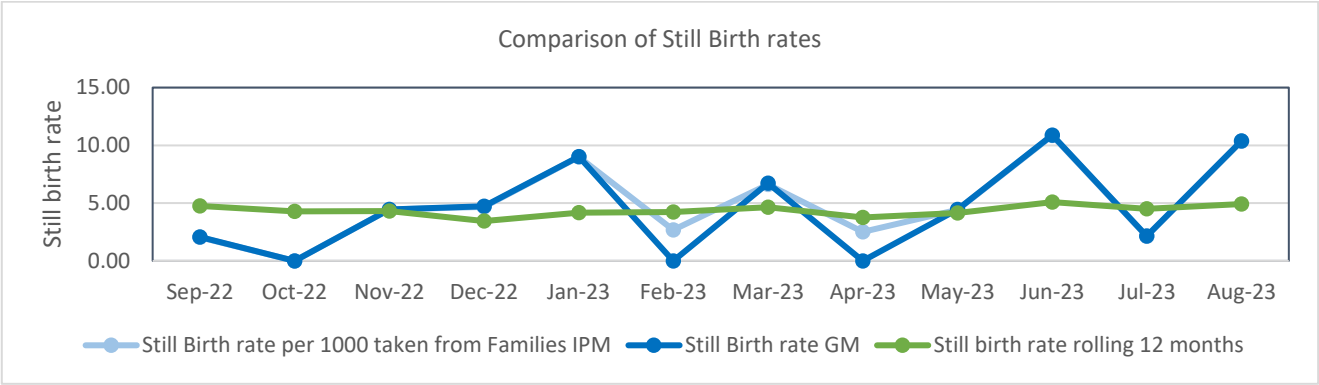
Stillbirth Rate (per 1,000)



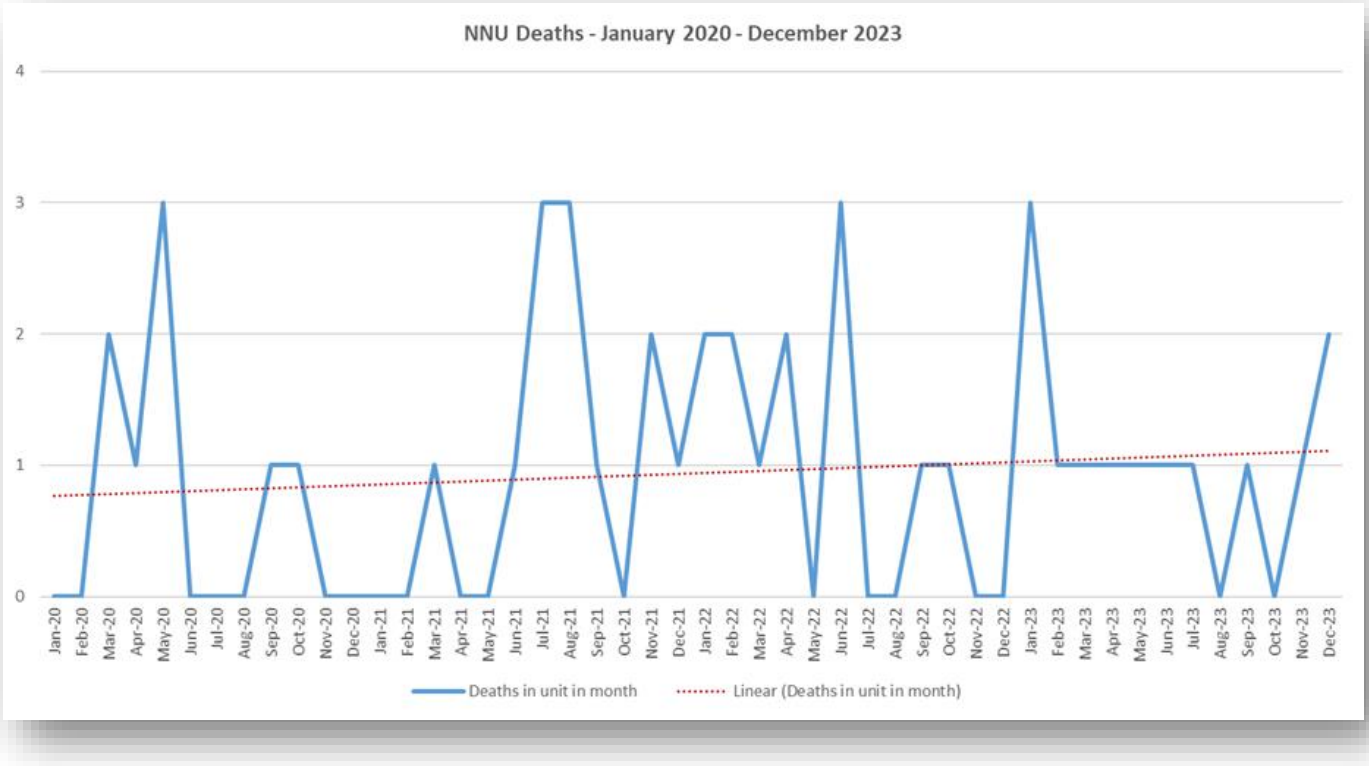
Hospital Name
Bolton
East Cheshire
MFT - North Manchester
MFT - Oxford Road
MFT - Wythenshawe
NCA Oldham
Stockport
Tameside
WWL

Hospital Name	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Bolton	2.07	0.00	4.46	4.74	9.03	0.00	6.73	0.00	4.46	10.89	2.14	10.39
East Cheshire										0.00	11.24	0.00
MFT - North Manchester	3.34	3.22	3.28	13.16	6.49	6.87	0.00	0.00	7.72	3.65	0.00	0.00
MFT - Oxford Road	1.53	9.77	5.77	5.90	11.59	8.73	4.46	9.49	1.57	10.62	4.39	7.76
MFT - Wythenshawe	2.42	2.49	0.00	10.23	0.00	2.66	4.81	2.58	2.52	2.50	4.55	7.85
NCA Oldham	2.44	9.43	11.01	5.05	6.88	5.51	15.71	8.60	2.66	2.61	2.53	2.68
Stockport	3.27	0.00	7.38	10.68	0.00	8.23	0.00	3.85	0.00	0.00	4.18	0.00
Tameside	0.00	0.00	0.00	0.00	0.00	6.25	0.00	0.00	0.00	0.00	0.00	5.15
WWL	5.24	0.00	4.39	4.69	8.93	0.00	10.31	9.35	0.00	4.69	0.00	8.55
MEDIAN	2.43	1.25	4.43	5.48	6.69	5.88	4.64	3.22	2.05	2.61	2.53	5.15

This next table highlights that there is considerable variation in stillbirth rates using the differing reporting methods and that the rate is fairly static over the last 18 months.



Neonatal unit deaths are shown here for information. A comprehensive review of cases is completed regularly and a summary report will come to the next committee meeting, as stated.



The data here shows that while there is a very slow gradual trend upwards, this still represents a very low rate of neonatal mortality, at a time when we are admitting babies with much lower gestational ages (i.e. born more prematurely).

Aspiration pneumonitis

An initial review of the data within this group was undertaken between BI and the Clinical Lead for Respiratory Medicine. Clinically, Aspiration Pneumonia is not always the primary pathology as it can be secondary to another progressive pathologies/diseases, or there is evidence of a decision already made to “feed at risk” due to an irreversible underling disease (e.g. worsening dementia, stroke). A careful history is key to correctly diagnose aspiration pneumonia; in up to a quarter of patients, CXR failed to diagnose aspiration pneumonia as compared to CT scan.

Certain themes emerged from case note reviews:

- The majority of the patients had extensive co-morbidities and other health issues such as significant learning difficulties, being tube fed, tracheostomy, refrectory epilepsy, etc. This makes aspiration more likely due to the nature of these conditions. These patients are more complex and may not be differentiated in the coding, as there did not appear to be appropriate risk adjustment in the SHMI for them.
- Patients with dementia and progressive frailty may be reaching the end of their lives and therefore are admitted to hospital. In the majority of these patients, a decision was made to "feed at risk" which recognises that it may lead to aspiration pneumonia, but for patient comfort and experience, it is done. We need to make sure all such decisions are promptly and clearly made by clinical teams, appropriately documented in the EPR and are captured somehow in coding/mortality and cause of death. This will be achieved by ensuring that "aspiration pneumonia" does not appear as an unqualified cause of death, with no other contributing factors.
- There were cases of cardiac arrest with secondary aspiration and progressive cancer resulting in secondary aspiration pneumonitis, which highlights that the aspiration is a sequelae of another condition, which warrant being considered as the main condition being treated, which would therefore lead to it falling into a different diagnositic group for the purposes of the mortality metrics.

4. Key KPIs

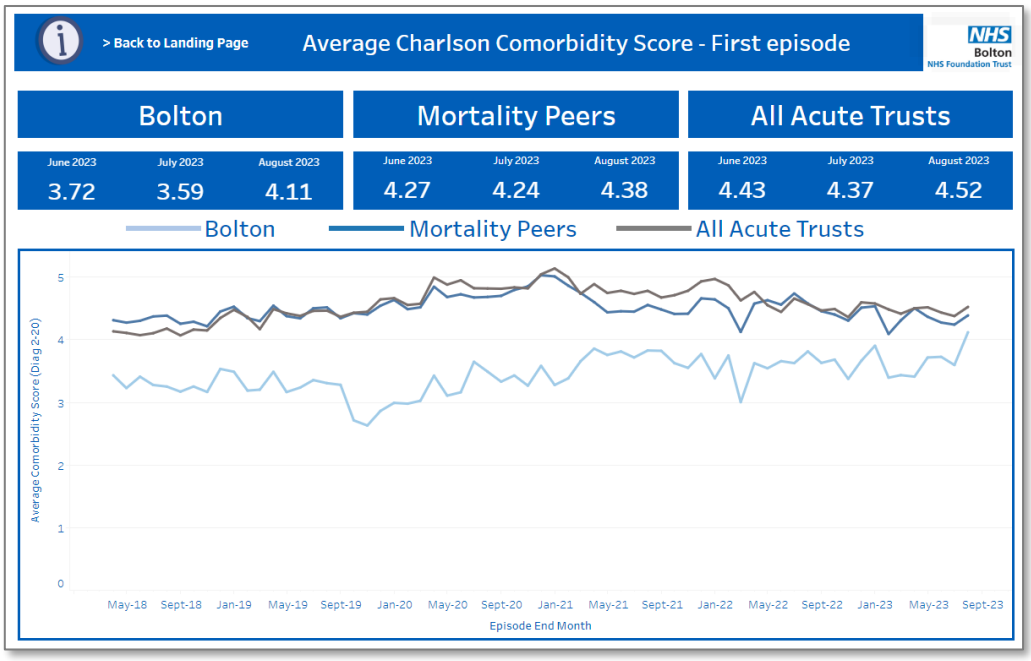
The key KPIs for tracking progress in improving the mortality data are improved Charlson comorbidity scoring (in line at least with national average), overall depth of recording and final coding completeness. These are associated with a more accurate prediction of the number of expected deaths

4.1 Average Charlson score

On average, Bolton patients have a recorded Charlson average score around 1 lower than peers and the national average: this has slowly improved with the gap between peers and the national average reducing. This suggests our patients are *healthier* than those in the rest of the country, which does not equate with what we know about our patient population and the deprivation in the local area.

Despite improvements in the recording there remains a gap to Mortality Peers and All Acute Trusts.

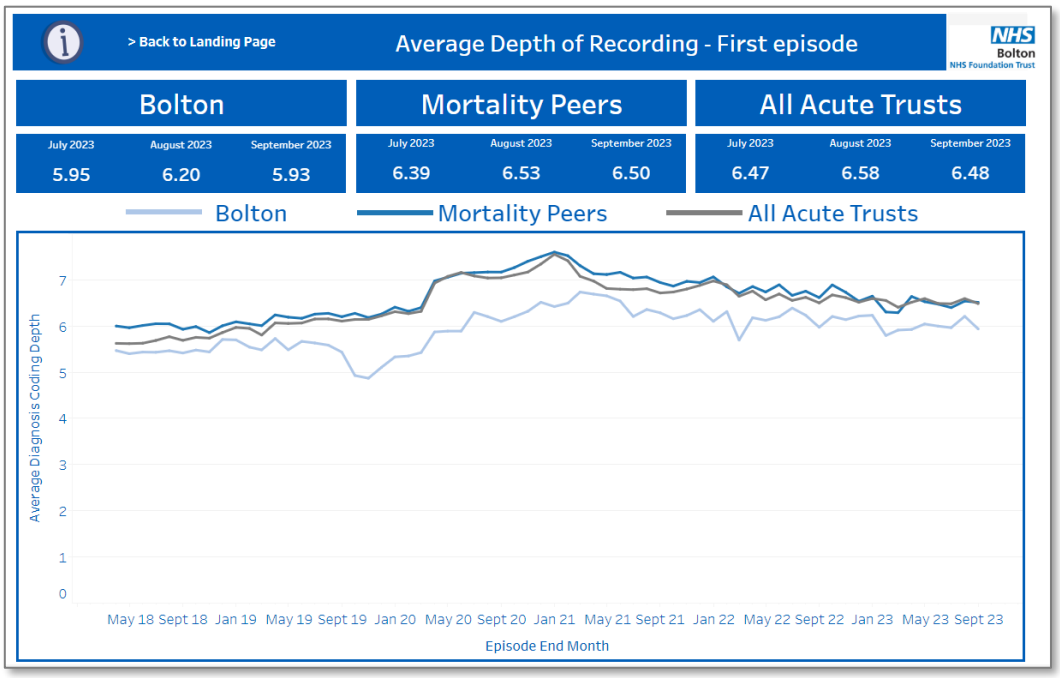
The successful inclusion of mandatory comorbidity recording with autopopulation of the Health Issues section of our EPR should result in an improvement in this metric in the coming months.



4.2 Average depth of recording

Depth of recording indicates the extent of the patients' health issues; this again currently suggests that compared to average, people in Bolton are healthier. The gap between peers and the national average has reduced but has stagnated for the last couple of years.

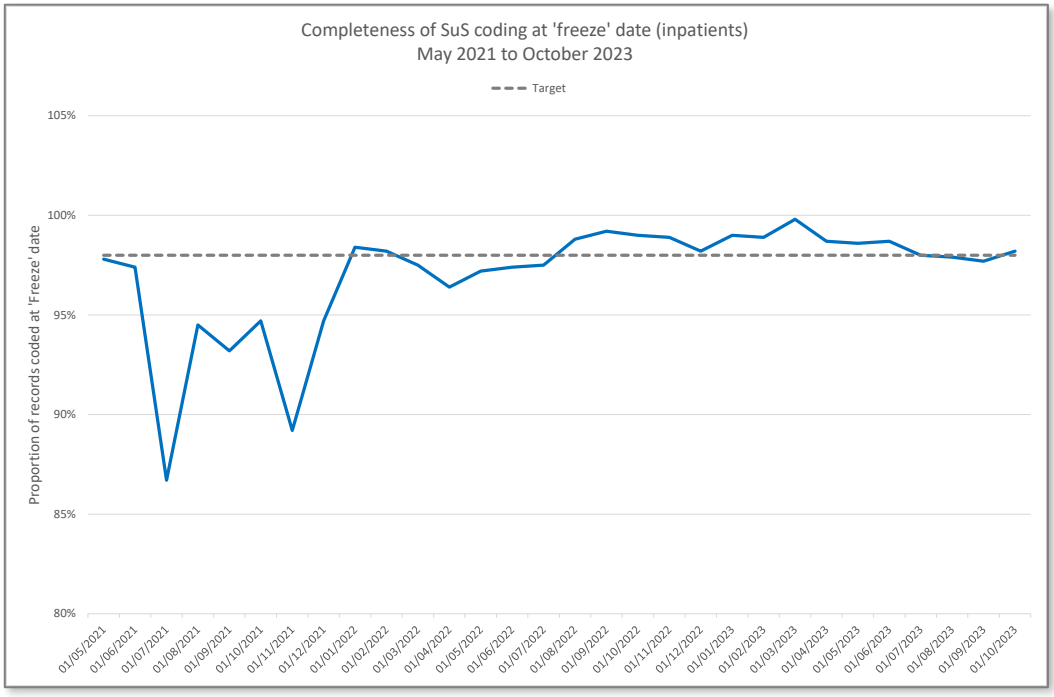
This risk adjustment creates less impact on the expected level of deaths than the amount of Charlson comorbidity recording. The Charlson scoring has improved slightly over time which caused the reduction in both SHMI and HSMR and has offset any slight reduction in depth of recording.



Although lower than other organisations, the trends at Bolton map those of elsewhere. The actions taken to improve automation within the EPR should also help with this, as data will be carried through between admissions, which we know does not happen consistently at this time.

4.3 Completeness of coding at 'Freeze' date (12 months to November 2022)

The Clinical Coding team are consistently meeting the Trust target of >98% of inpatient records to be fully coded at SUS 'Freeze' date, which has impacted positively on SHMI and HSMR.



5. Narrative on the mortality data

As highlighted in paragraph 1.4, we are 'within expected range' for both SHMI and HSMR. This is the first time in a number of years that both indicators are in range and is due to the increased recording of secondary diagnoses by clinicians, fully coded information at the deadline dates and improved data quality within certain specialties.

Given that our patient population is in a high deprivation area, it would be reasonable to expect our crude mortality would be high. This is not the case and suggests that we are not observing unexpected deaths. As both SHMI and HSMR are measures of the *observed* deaths over those that are *expected*, any drift outside of normal range suggests that it is primarily a problem with our prediction of the *expected* deaths, which is down fundamentally to our data quality around diagnostic recording and comorbidity scoring. The action plan is designed to address this with improvement in the key KPIs.

Work across the organisation continues to be done on ensuring high quality of care and we have robust systems now in place to review clinical cases when they alert on our metrics, such as with acute kidney failure.

6. Ongoing work to maintain and improve the mortality indices

6.1 Comorbidity recording

Planned amendments are being made to the EPR to automate the recording of key comorbidities:

- The new feature for the EPR that allows the clinician to record comorbidity directly into the coded Health Issues part of the system has completed testing and is expected to go live imminently, after due governance processes have been completed.
- The impact of this will be audited via the Mortality Action Plan, to ensure that it is being completed accurately and consistently as expected. As the field has a mandatory compoentent, we expect this there to be good compliance.

6.2 Assurance on our quality of care

We have made real progress in getting clinical engagement with the mortality data for divisions and departments and are able to much better understand our metrics. We have better comprehension on how best to record data to optimise the mortality metrics. We have objective evidence of improved data quality, which reflects improved ownership of the data. Teams are also working collaboratively with the BI team to triangulate SHMI and HSMR data against other care metrics that explain the quality of the care we deliver and how we benchmark both regionally and nationally.

The queries raised around the data with regards to aspiration pneumonia did not highlight a failure in our care, but showed that how we record information and decision making is essential.

We await the neonatal data full report, but we have reassurance that the process of case review is working effectively now with key staff members having dedicated time for the work.

Work on recognition of deterioration, NEWS and sepsis is being addressed through the newly formed group combining various previous forums to ensure we respond appropriately to patients when they deteriorate. This work is being fed back to the Mortality Reduction Group and CGQ committee.

Feedback from the End of Life Steering Group and Palliative Care Team has provided reassurance that progress is being made on our provision of end of life care. Where we provide specialist palliative care or support patients who are nearing the end of their lives to avoid admission, this wiill impact on our mortality metrics, as we see patients in hospital or who die within 30 days of discharge who would have been better served by being kept at home or admitted to a place that can support them better as they die.

6.3 Clinical coding

The Clinical Coding Team continue to achieve excellent compliance with their standards for completeness. Our CIALs are continuing to test filters to reduce the number of different documents that must be accessed while coding a patient's record to optimise their time. The process is under constant internal audit to ensure we are not losing vital patient information, nor breaching coding standards.

6.4 Education and training

Since the last report:

- Sepsis study days continue in the Trust and there are Sepsis Link Workers for many wards now, working collabarotively with the Critical Care Outreach Team.
- There was a successful “Deteriorating Patient” conference held in December, which received good feedback.

7. Recommendation

The committee is asked to note the contents of this report for assurance.

8. Appendix – Glossary

CCS and SHMI groupings available from (see SHMI specification):

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data

See below for mortality rates explanation and comparison table.

'As Expected' mortality: This is usually expressed as a funnel chart, using confidence intervals. Using the 'official' SHMI definitions, 'as expected' mortality is explained within the 95% confidence intervals. Outside of the 'as expected' grouping means an organisation is either an outlier in terms of mortality performance.

Common Cause Variation: is fluctuation caused by unknown factors resulting in a steady but random distribution of output around the average of the data. It is a measure of the process potential, or how well the process can perform when **special cause variation** removed. A common characteristic is to be stable and "in control". We can make predictions about the future behaviour of the process within limits. When a system is stable, displaying only common cause variation, only a change in the system will have an impact.

Control Limits: indicate the range of plausible variation within a process. They provide an additional tool for detecting special cause variation. A stable process will operate within the range set by the upper and lower control limits which are determined mathematically (three standard deviations above and below the mean).

Crude Mortality Rate: The crude mortality rate is based on actual numbers. It is calculated by the number of deaths divided by the number of discharges (not including day cases, still births and well born babies). A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in a specific time period and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. It tells you how a Trust's mortality rate changes over time; however, it cannot be used to compare or contrast between hospitals. This differs from SHMI, which features adjustment based on population demographics and related mortality expectations.

CUSUM: CUSUM statistical process control techniques are commonly applied to mortality monitoring to detect changes in mortality rates over time. The CUSUM value increases when patients die and decreases when they survive. They are calibrated with a 'trigger' value, and if a CUSUM exceeds its trigger, it should be investigated. A CUSUM chart is 'reset' after each trigger and continues monitoring. A trigger value of 5.48 is used for all of the 56 disease groups within the aggregated CUSUM and has been confirmed by CQC. The chart will rest to zero after a trigger. When the CUSUM drops it is showing less deaths than the previous month compared to expected.

HED: Healthcare Evaluation Data is an online benchmarking tool, designed to deliver intelligence to enable healthcare organisations to drive clinical performance improvement and financial savings. It allows the organisation to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets.

Hospital Standardised Mortality Rate (HSMR): The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for all diagnostic (CCS) groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. The HSMR is a method of comparing mortality levels in different years, or between different hospitals. Thus, if mortality levels are higher in the population being studied than would be

expected, the HSMR will be greater than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking

HSMR methodology: Collated via Healthcare Evaluation Data (HED), HSMR information is calculated using the 'lagged' model. This ensures a more stable rate despite the model being calculated on the 10 years to three months behind the most recent in HED. This removes any skewing caused by inconsistencies or incomplete data at SUS 'Flex' deadline.

Rolling average: The most recent months' performance with the previous 11 months included thus providing an annual average. This is an effective way of presenting monthly performance data in a way that reduces some of the expected variation in the system i.e. seasonal factors providing a much smoother view of performance allowing trends to be more easily discerned.

National Peer Group: All other UK NHS acute Trusts (i.e. not including specialist, community or mental health trusts), enabling the Trust to benchmark itself against all other UK hospitals.

Peer group: The comparison peer group identifying the most similar (overall) Trusts to Bolton. The activity with other trusts has been compared and those identifying as most similar using the distribution of activity by HRGs are as below:

- Airedale NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Pennine Acute Hospitals NHS Trust
- Rotherham NHS Foundation Trust
- Stockport NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Wye Valley NHS Trust

Summary Hospital-Level Mortality Indicator (SHMI): The nationally developed mortality ratio designed to be used to allow comparison between NHS organisations. This indicator also includes mortality within 30 days of discharge, so represents in hospital and out of hospital (within 30 days) mortality. The SHMI is the NHS 'Official' marker of mortality and is Glossary Directorate of Performance Assurance, published on a quarterly basis. Because of its inclusion of mortality data within 30 days of hospital discharge, when published, the most recent information available is quite historic, sometimes up to 6 months behind present day.

Sigma: A sigma value is a description of how far a sample or point of data is away from its mean, expressed in standard deviations. A data point with a higher sigma value will have a higher standard deviation, meaning it is further away from the mean.

Special Cause Variation: the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather recently experienced) can result in special cause variation. Systems which display special cause variation are said to be unstable and unpredictable. When systems display special cause variation, the process needs sorting out to stabilise it. There are usually two types of special cause variation, trends and outliers. If a trend, the process has changed in some way and we need to understand and adopt if the change is beneficial or act if the change is deterioration. The outlier is a one-off condition which should not result in a process change. These must be understood and dealt with on their own (i.e. response to a major incident).

Standard Deviation: Standard deviation is a widely used measurement of variability or diversity used in statistics and probability theory. It shows how much variation or "dispersion" there is from the "average" (mean, or expected

value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data are spread out over a large range of values.

Understanding Mortality Rates – CRUDE, HSMR and SHMI

	Crude	SHMI	HSMR
Numerator	Actual number of deaths	Total number of observed deaths in hospital and within 30 days of discharge from the hospital	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England
Denominator	Number of discharges	Expected number of deaths	Expected number of deaths
Adjustments		• Sex • Age group • Admission method • Co-morbidities based on Charlson score • Year index • Diagnosis group No adjustment is made for palliative care. Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summar y-hospital-level-mortality-indictorshmi	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge
Exclusions	Excludes day cases, still births and well born babies.	Excludes specialist, community, mental health and independent sector hospitals; Stillbirths, Day cases, regular day and night attenders. Palliative care patients not excluded.	Excludes day cases and regular attendees. Palliative care patients not excluded
Whose data is included		All England non-specialist acute trusts except mental health, community and independent sector hospitals via SUS/HES and linked to ONS data for out of hospital deaths. Deaths that occur within 30 days are allocated to the last hospital the patient was discharged from.	England provider trusts via SUS/HES

Report Title:	Learning from Deaths Quarter 3 Report 2023/24

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Francis Andrews, Medical Director		Decision	

Summary:	During this quarter, 39 cases were reviewed. Three have been escalated for secondary review. At the committee meetings, seven cases were reviewed that were previously escalated for further assessment. None of these required referral as a serious incident, as any areas of concern around care did not impact on outcome. Data presented from the full database shows that over the last five years, on average 1% of cases are rated by the first reviewer as very poor – and this has been consistent over that time. Key themes from the cases included: • Decisions made by clinical teams (e.g. DNACPR or ceilings of care) are not always easily conveyed through our own EPR or between it and external systems, which may influence care • Surgical Liaison Physicians are a vital resource for our patients, given their increasing comorbidity and acuity • Pressure ulcers can required surgical assessment and intervention, therefore medical input to the QI work in this area may confer some benefit The actions to address and understand these issues is described in the report. An improved case definition means we are now able to better recognise people with mental health conditions which would warrant inclusion in the review process. More case reviewers have been trained, which will help us improve our completion rate for both primary and secondary reviews.

Previously considered by:
Quality Assurance Committee

Proposed Resolution	The Board of Directors are asked to receive and note the Learning from Deaths Quarter 3 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:	Michelle Parry, Clinical Effectiveness Manager Sophie Kimber Craig, AMD	**Presented by:**	Francis Andrews, Medical Director

1. Background

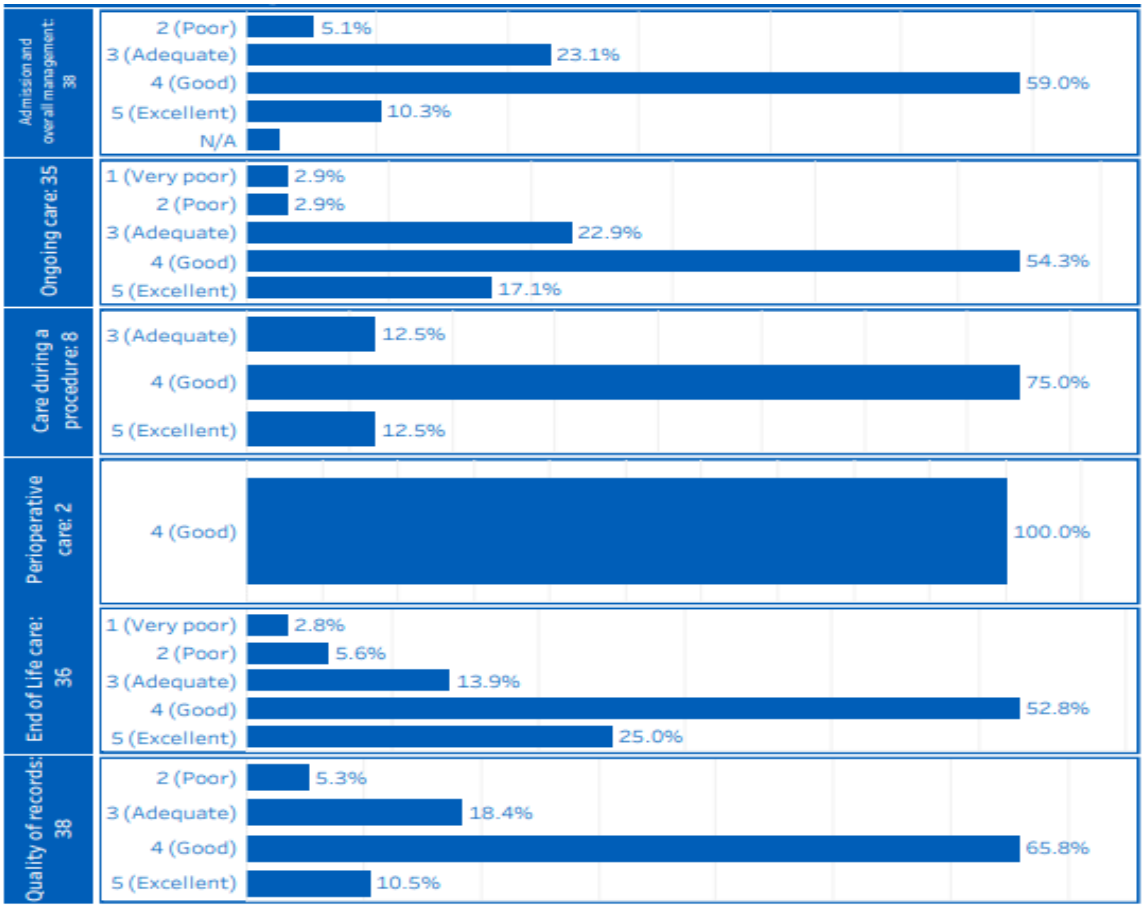
A glossary of terms used in the paper is included in Appendix 1. The SJR process is outlined in detail in Appendix 2.

A summary of data from the adult inpatient learning from deaths process can be found in Appendix 3. Business Intelligence supply Clinical Effectiveness details of the adult inpatient deaths one month in arrears (currently the November 2023 deaths have just been circulated for review). SJR reviewers have four weeks for completion; after this, if not completed, an escalation process is followed.

2. Summary of progress in Q3 2023/24:

Case Reviews

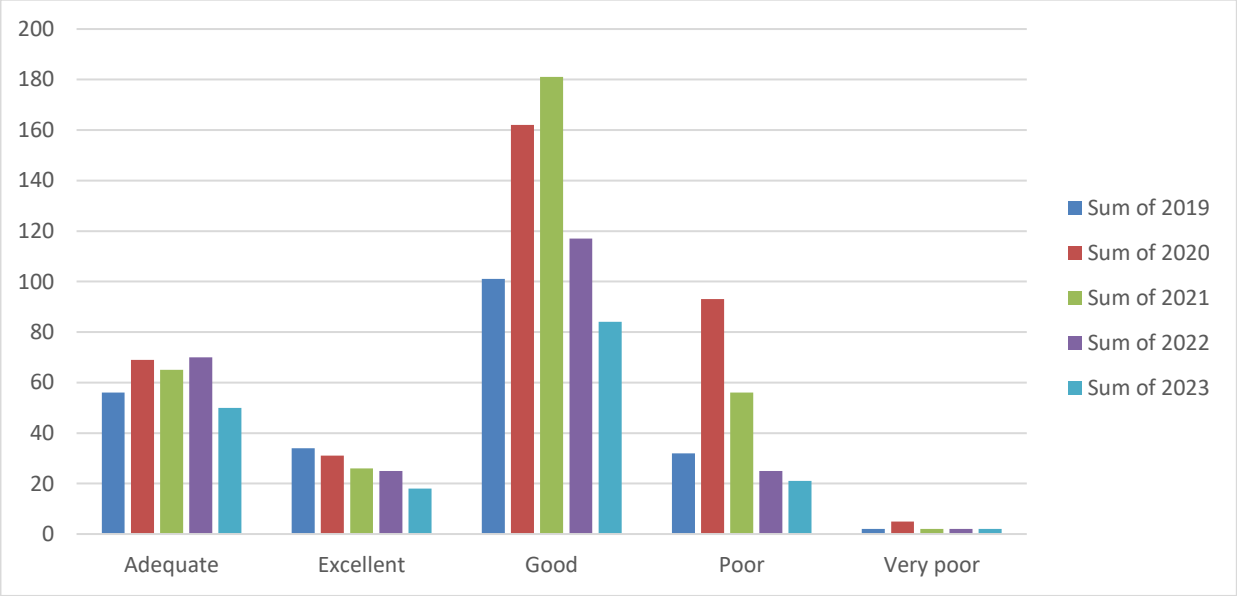
- 39 SJRs have been completed in this quarter; three have been referred for secondary review – consistent with previous quarters' data.
- Care for each phase of care (where applicable) and the quality of the documentation was rated by the first reviewer as follows:



- This quarter's data can be considered in relation to the total rating for overall care from 2019, as shown here:

1st overall rating	2019	2019 % of total	2020	2020 % of total	2021	2021 % of total	2022	2022 % of total	2023	2023 % of total
Very poor	2	1%	5	1%	2	1%	2	1%	2	1%
Poor	32	14%	93	26%	56	17%	25	10%	21	12%
Adequate	56	25%	69	19%	65	20%	70	29%	50	29%
Good	101	45%	162	45%	181	55%	117	49%	84	48%
Excellent	34	15%	31	9%	26	8%	25	10%	18	10%
Total cases	225		360		330		239		175	

Represented here in graphical form:



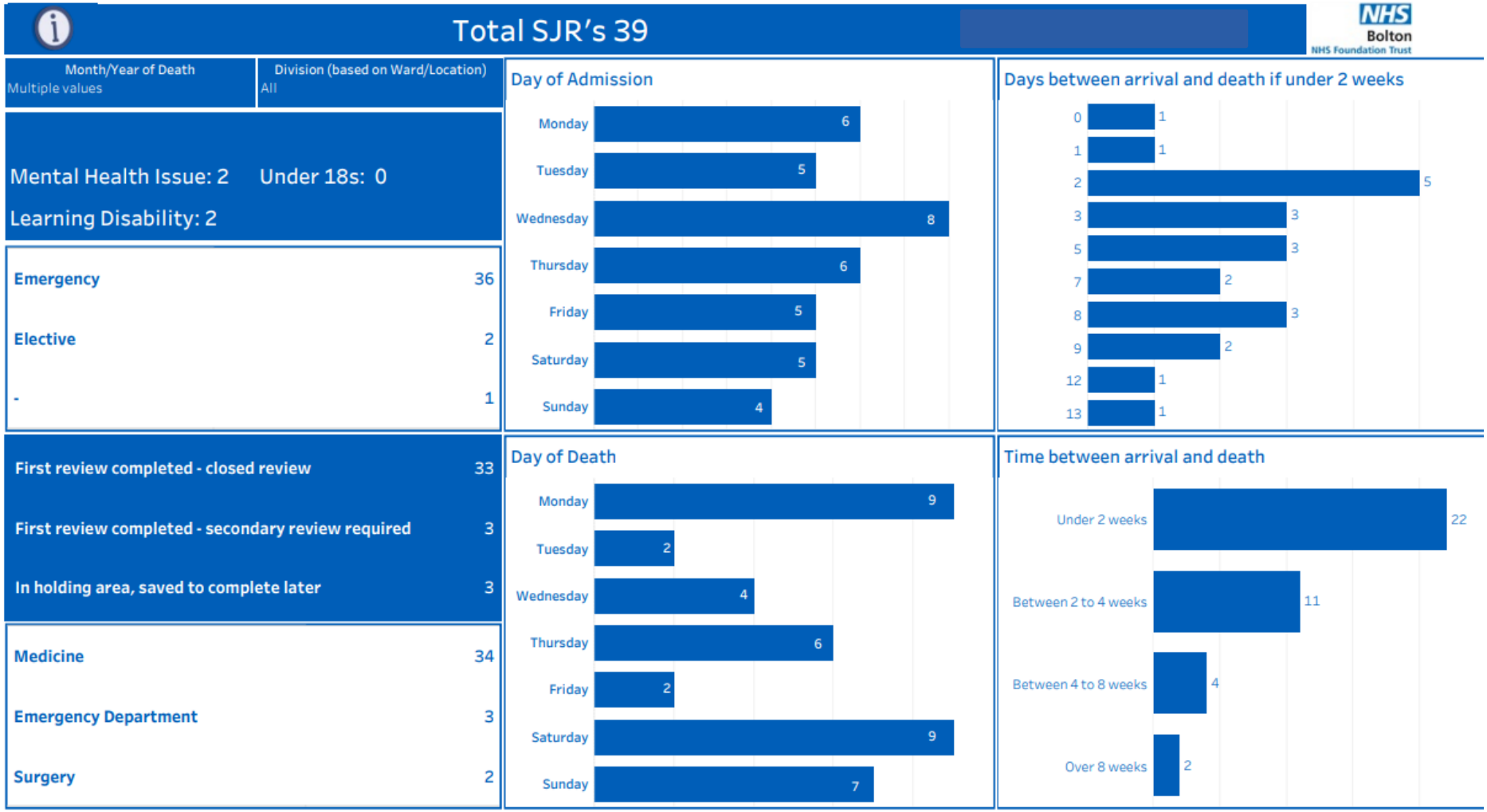
Which shows that the vast majority of cases fall into adequate, good or excellent, and on average only 1% of cases are considered to represent poor care. All cases where the care is rated poor or very poor are referred for secondary review, so are seen by another reviewer and the MDT LFD committee.

Of the 7 cases reviewed at the two committee meetings held during the quarter, none were escalated for further evaluation due to concerns about care impacting on outcome.

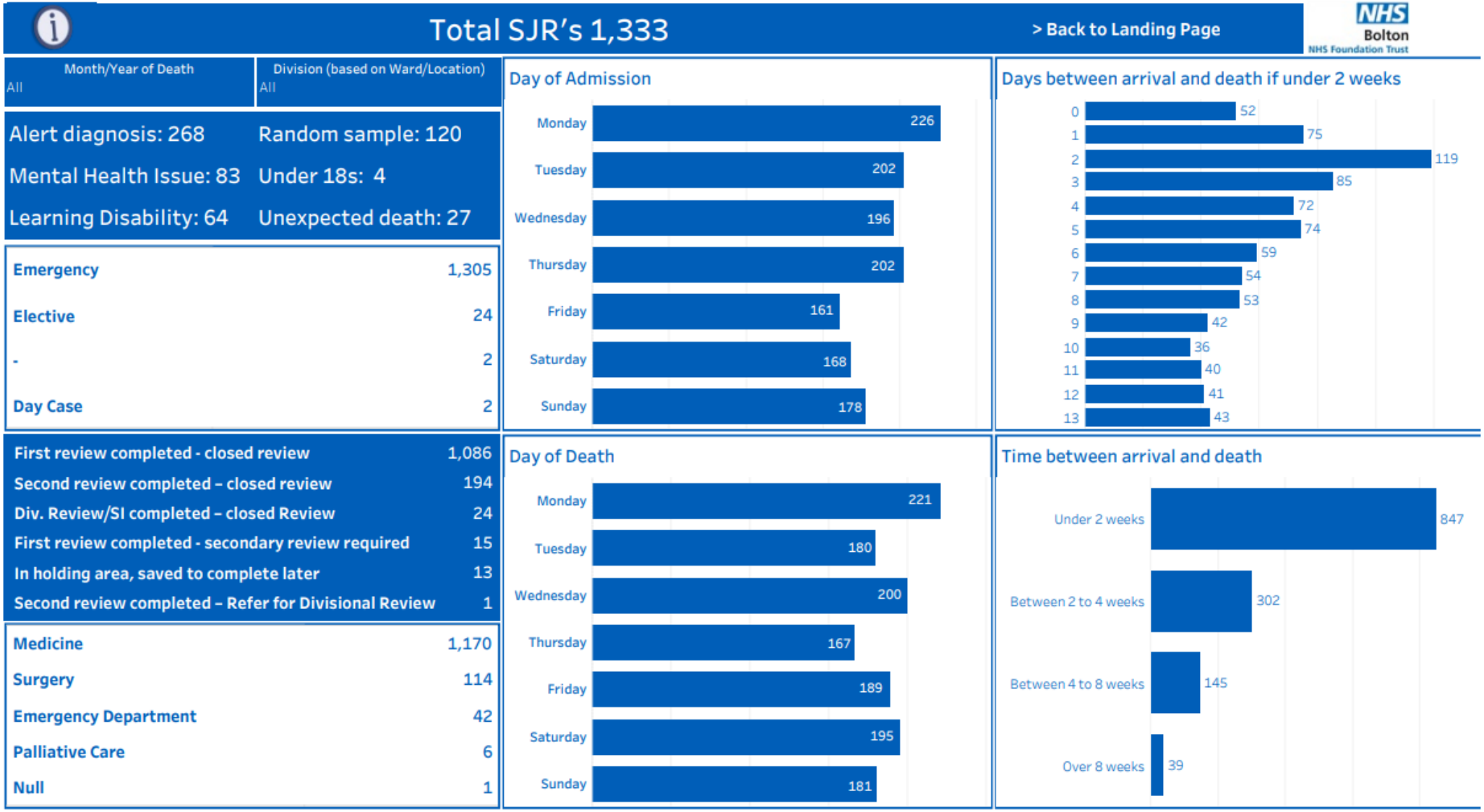
3. SJR Dashboards

These dashboards show this quarter's case reviews since the last report, with that for the full database provided for benchmarking.

SJR Dashboard – Cases for October to December 2023 (Q3 23/24)



Totals for full database inclusive of all cases for comparison with this quarter



Completion rate

- The completion rate for reviews has dipped to 39% for this quarter from 45%, which is lower than national average. This does tend to improve over the course of the year, as cases are undertaken in arrears, but there is a backlog of reviews to be completed and reviewer numbers have been expanded to address this.
- Further training has been completed in this quarter; 17 new reviewers have been added to the team, taking us to 41 reviewers across the Trust. This should help address the completion rate in a more timely fashion.
- There are 12 outstanding secondary reviews, which is consistent with average quarterly numbers. There has been a push to reduce those waiting a long time for a review, with good success, but there will be further work done to reduce this.

Case mix of reviews

- Previous changes to the mental health case definitions (that are a mandated group for review) had not been appropriately enacted. These have once again been reviewed, ensuring compliance with the national recommendations for whom should be included, and that has allowed better focus on those with a significant MH history. This can be seen in Appendix 3, which shows the drop in case reviews in the MH group. (Prior definitions included anyone with any history of depression and/or who used any addictive substance).

4. Committee case review in Q3

No cases were escalated as Serious Incidents in this quarter. Cases were shared with departmental and/or divisional teams for local learning, where applicable.

From the secondary reviews, the committee learned:

- A patient deteriorated after being declared medically fit for discharge; this should have prompted a review of the clinical situation around appropriateness for escalation of care.
- Plans of care (particularly when it involves a ceiling of care) are not always taken into account or clear from the records. A patient had a scan when it had already been determined they were not fit for any form of surgery and died very soon after returning to the ward. This is time they could have spent with their family if that had been communicated to the out of hour's team more effectively.
- Similarly, the DNACPR in the GMCR does not pull through to the EPR.
- There is no medical input in to the Pressure Ulcer collaborative, which given the nature of the condition, may confer some benefit when considering management.
- There is reduced medical cover on Ward D2 currently.

- The Surgical Liaison Physicians (i.e. orthogeriatricians, general surgery geriatricians) provide a vital service to patients, particularly as we are seeing increasing complexity and acuity in our patient cohort. It is apparent in cases when they have not had input into the patients' care.

Excellence reports

No cases of excellence were presented at committee in this quarter.

Thematic reviews

A review of ICU deaths was presented, which illustrated that there was possible sub-optimal care in 20% of those patients admitted to ICU. This case review will now be an ongoing process of audit and the committee will review the next dataset to consider actions.

Analysis was undertaken by the BI team to determine whether reviewers' ratings have changed over the years the process has been in place, to determine whether operational pressures may be impacting on rating of care. No significant issue was found.

5. Confirmation of completion of cases escalated for review

There is no new data to present.

6. Themes identified in LFD case reviews and actions taken

Since the last report, we have identified and escalated/acted upon concerns around:

- **End of life care, recognition of dying and DNACPR decision-making** – Cases where care at the end of life could have been better are often seen at the LFD committee, and this quarter was not unusual in that. This learning is escalated to the EOL steering group via the Palliative Care team members that attend the committee meetings. A plan to provide a thematic review on this phase of care for the EOL group is underway. Positive feedback has been provided from that group as to progress around some of the key issues, including an agreed DNACPR policy and new TOR for the Resuscitation Committee, which is supporting improvement work.
- **High risk medication medicines reconciliation** – Work commenced in the last quarter continues within the Trust, locality and system to address how high-risk critical medicines are recorded in the GMCR to ensure appropriate prescription when patients are admitted to secondary care. The Chair of the committee is liaising with the Prescribing Lead at Manchester University too, to ensure that students are trained in this important area.

- **Consistent process for reviewing cases and sharing learning** – Our QI partner for the SJR and LFD process is continuing to work on our training offer for new reviewers and how we effectively communicate with teams and staff across the Trust to appropriately share the learning from the committee meetings and to ensure reviewers understand the value of their work. A new LFD newsletter[1] has been developed to share the learning across the Trust and with reviewers.
- **Medical representation at the Pressure Ulcer Collaborative** – An offer of medical input into the work on pressure ulcers was made following this committee meeting to the QI team. Some cases of PU require surgical intervention and this may provide a valuable addition to the management process in the future.
- **Bereavement team, Regulation 28 and Medical Examiner reports** – It has been agreed with these teams that we will work collaboratively to triangulate all data regarding deaths both within the Trust, the locality and nationally, to ensure we optimise our capacity for learning and improvement.

7. Recommendation

The Committee is asked to receive the content of the report for assurance purposes.

[1] BoB - Learning-from-Deaths-Newsletter.pdf - All Documents (sharepoint.com)

Appendix 1 – Glossary of terms

LFD	Learning from Deaths
SJR	Structured Judgement Review
LeDeR	Learning Disabilities Mortality Review Programme
RCP	Royal College of Physicians
NQB	National Quality Board
LFDC	Learning from Deaths Committee
QAC	Quality Assurance Committee
NCDRP	Nosocomial Covid Deaths review panel
GMMH	Greater Manchester Mental Health Trust

Appendix 2 – Learning from Deaths methodology (adult inpatient only)

The process involves using a validated 'Structured Judgement Review' tool to assess the quality of care from a sample of adult inpatient deaths, in addition to mandated categories of deaths, which are those with a learning disability, mental health issue or where a family concern has been raised. The trust can also designate particular alert diagnostic groups for investigation (e.g. nosocomial Covid-19 cases) and the Medical Examiners can refer for a review. The aim is to provide tangible evidence of learning from deaths.

Initial (primary) reviews are conducted by a trained reviewer; individual components of care are scored on a 5-point scale and an overall score is also determined. For any patient who is scored as 1 or 2 (very poor or poor) overall, the LFDC members collectively undertake a secondary review to determine whether the primary reviewer's scores, especially the overall score, are justified. Each case is also reviewed to determine whether, on balance, the death was more likely than not to have resulted from problems in care, and if so, it is referred for scoping as a Serious Incident. If after the secondary review, the overall score is 1 (very poor) or 2 (poor) then the case is referred for further investigation via corporate and/or divisional governance teams.

Cases deemed to be uniformly excellent are also reviewed at LFDC and any actions and learning points are captured are shared.

The benefits realised by this approach include:

- Targeting of reviews to areas of mortality concern to improve patient care e.g. Pneumonia, COVID-19
- Use of a validated judgement tool
- Mutual support for reviewers
- Use of an electronic form that can be stored on a new database with easy retrieval for audit purposes
- Learning from good practice in care as well as learning from practice where things could have been better

Appendix 3 - Learning from Deaths Adult inpatients for 23/24

(Note that the system runs in arrears for case notification, therefore deaths in this quarter have only been distributed for review up to November.)

	Quarter 1			Quarter 2			Quarter 3	
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Number of In-patient Deaths	90	105	90	77	105	78	114	83
Number Cases (Sample)	31	32	33	26	27	36	43	42
COMPLETED	16	18	14	8	9	19	18	9
Outstanding Cases								
Not Yet Received - Within Deadline	0	0	0	0	0	0	0	33
Outstanding -Supassed Deadline	15	16	19	18	18	17	25	0
Missing notes unable to find	0	0	0	0	0	0	0	0
Cases requiring reallocation	1	0	1	2	3	1	2	1
%	52	56	42	31	33	53	42	21
Source								
Mandated Death (Alert Diagnosis)	3	5	3	0	1	2	2	2
LD Death	0	0	3	1	0	0	2	1
Mental Health Death / In-Patient MH	26	26	26	25	26	18	35	3
sample	2	0	0	0	0	15	4	33
Requested by cons/matron/Other	0	1	0	0	0	0	0	0
Diabetes Death	0	0	0	0	0	0	0	0
NELA Death	0	0	0	0	0	0	0	0
Medical Examiner	0	0	1	0	0	1	0	3
30 Days PEG Mortality	0	0	0	0	0	0	0	0
BAME + COVID Death	0	0	0	0	0	0	0	0
	31	32	33	26	27	36	43	42
Overall Score								
1 (Very Poor)	0	0	1	0	0	0	0	0
2 (Poor)	2	2	5	1	1	1	1	2
3 (Adequate)	4	7	3	4	4	6	3	2
4 (Good)	8	8	3	3	4	10	12	4
5 Excellent	2	1	2	0	0	2	2	1
	16	18	14	8	9	19	18	9

Report Title:	People Committee Chair Report – February and March 2024

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

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

Summary:	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held in February and March 2024. These reports also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the People Committee.

Proposed Resolution	The Board of Directors are asked to **receive** the People 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:	James Mawrey, Director of People	**Presented by:**	Tosca Fairchild, Chair People Committee

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

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	20 February 2024	Date of next meeting:	19 March 2024
Chair	Tosca Fairchild, Chair People Committee	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Leadership Development Programme
- Resourcing & Retention Update
- EDI Update Q3
- Gender Pay Gap
- Guardian of Safe Working
- CQC Well Led – Workforce Actions
- Terms of Reference
- Steering Group Chair Reports
- Divisional People Committee Chair Reports
- IPM Workforce & OD Dashboard

ALERT

Agenda items	Action Required
The Committee noted that IFM was not included in group reports to the People Committee such as Gender Pay Gap and Leadership Development Programme, which were on the agenda. It was agreed that consideration should be given on how the information pertaining to IFM is captured in Group reports.	Committee to agree how IFM are captured in future workstreams of the Committee.

ADVISE

- **Refreshed Leadership Development Programme** – The People Committee welcomed the opportunity to feed into how this programme will be shaped. It was noted that this is programme forms part of the Our Voice Change programme and is focused on ensuring deep alignment to our values and behaviours throughout our leadership structures. .
- **Resourcing & Retention Update –** key areas highlighted:
  - Agency spend reduced by £177k in January 2024 and continues on a downward spend trend.
  - Bank increased by £202k as a result of clinical pressures, absence and vacancies, but that increase di also prevent additional agency spend.
  - Other variable pay – medical variable pay increased by £330k in month drive by consultant, SAS and SpR.
  - Vacancy Rate – Trust vacancy rate reduced in-month and currently stands at 5.37%.
  - Turnover – Turnover reduced in-month t0 10.85%. There is a reduction in AHP turnover in-month, but is still high and People Committee will receive a detailed update at the next meeting.
  - Resourcing – good activity on nursing, midwifery, AHP and medical recruitment. More work needed to fill HCA vacancy levels, although it was noted a number of appointments have recently been made (52).

- **EDI Update Q3 –** The report outlines the progress made in against the EDI Action Plan 2023/24. Measures of success will continue to be evidence via the key statutory reports, along with the findings of the NHS Staff Survey. Progress of the action plan will continue to be monitored via the EDI Steering Group.
- **Gender Pay Gap –** This paper is included on the Board of Directors meeting so no narrative if provided in this section.
- **Guardian of Safe Working -** this report highlights the progress of the Guardian of Safe Working and the Exception Reporting system. 34 exception reports were submitted in this quarter. The GOSW continues to attend local and regional meetings. The Medical Education Team continue to support the GOSW with the process to respond to exception reports in a timely manner.

ASSURE

- **CQC Well Led Inspection – Workforce Actions** – Whilst progress was discussed on the 'People elements' it was noted that the Quality Assurance Committee will have oversight of all the actions for all the 'must do' and 'should do' requirements. The report confirms that the majority of workforce actions are closed and one remaining action is on track providing positive assurance that the 'must do' and 'should do' CQC requirements relating to workforce have been met.

New Risks identified at the meeting:

- None

Review of the Risk Register:

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

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	19 March 2024	Date of next meeting:	21 May 2024
Chair	Tosca Fairchild	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- NHS Staff Survey Findings and Next Steps
- Resourcing & Retention Update
- Cultural Dashboard
- Recruitment & Retention Audit Report
- Disciplinary Processes Audit Report
- Mandatory & Statutory Training Update
- Staff Health & Wellbeing Report
- Board Assurance Framework
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

ALERT

Agenda items	Action Required
1. NHS Staff Survey. The Committee welcomed a detailed discussion on the NHS Staff Survey, along with the actions that are being taken to ensure we meet our strategic aim of Bolton being a great place to work. 2. The Committee does not receive updates from IFM Bolton with regard to their People Agenda. It was noted that this would be helpful as IFM is a key part of the Group Model.	

ADVISE

NHS Staff Survey

- This year 42% of our workforce completed the NHS Staff Survey which is a 6% increase on last year's completion rate.
- The immeasurable sense of teamwork we see and feel in Bolton every single day is reflected in some of the feedback. The results tell us that a large proportion of our staff feel a strong personal attachment to teams, feel supported by managers and leaders, and have opportunities to show initiative and get involved in change. We improved scores compared to 2022 relating to staffing levels and effectiveness, the amount of additional hours staff work both paid and unpaid and access to learning and development opportunities. Feedback like this will help us understand what's making a difference and support others to do more of this in their teams.
- Some of the results confirm to us that we have more work to do when it comes to things like fair career progression, inclusion, feeling safe to raise concerns and people feeling burnout or emotionally exhausted. We have been taking action in some of these areas but will be doing some further work to understand what more we could be doing, in line with our People Plan.

- Of particular note, we have seen a continued decrease in the number of staff who would recommend the Trust as a place to work or receive treatment and we are giving this our urgent attention to understand more with a view to address this as a priority.
- The Committee noted the priority work will be done to address the following key areas:-
  1. Increasing the number of people recommending the Trust as a place to work or receive treatment. Our Chief Nurse and Medical Director already lead a number of patient care workstreams and these will be reviewed against these findings. Similarly the recommending as a place to work workstream will be reviewed by our Chief People Officer to consider if any further measures are required
  2. Improving our culture. This work stream will be led by the Chief People Officer. It is clear that whilst our VOICE values remain important to our staff there remains pockets in the organisation where a refocus in this area would be beneficial. The organisation has recently embarked on the 'Our Voice Change programme' which sets out how we will deeper engage with our workforce on the key matters that affect them. Furthermore the People Committee will now receive a cultural dashboard which will provide a helicopter view of any cultural matters throughout our organisation to enable us to quickly identify and address them.
  3. Accelerating our equality, diversity and inclusion programme.
  4. Accelerating our flexible working opportunities.

Resourcing & Retention Update

- The key point to note is that the Trust saw an overall increase of 'worked WTE' (WWTE) of 7 WTE in February 2024 (when compared to the previous month); this was driven by increases in agency working in-month (agency expenditure increased by 10 WWTE).
- Agency expenditure increased by £86k in-month (the first increase noted since May 2023. However agency spend levels are still under forecasted expectation and there is a high level of confidence that we will end the financial year under our submitted NHSE forecast for agency expenditure. Agency has accounted for 3.4% of our total pay bill in the financial year-to-date which is under the NHSE expectation/threshold (of 3.7%).
- Bank expenditure reduced by £87k in-month; and spending on medical variable pay remained static.
- Hotspot areas where hard to recruit roles are driving agency spend were discussed at the Committee. It was requested that this form part of the regular update.

Mandatory & Statutory Training Update

- The report provides an update of the present compliance against the current targets of 95% for Compulsory Training and 85% for Trust Mandated Training (to avoid duplication Board members can see performance in the dashboard).
- A discussion took place on the measures that are being taken to improve performance, although it was noted the difficulties in this in ensuring appropriate release due to organisational pressures.
- It was agreed that the Professional Development Group would make a recommendation to move all Training KPI's to one measure rather than the existing two. This recommendation will be made at the next People Committee.

Staff Health & Wellbeing Report

- The Committee were informed on the current levels of sickness absence across the Trust; an outline of the current trends relating to sickness absence and action being taken to support and address absences across the Trust. Discussion then ensued regarding the support packages available to our staff and whether our offering for mental health related supported had been reviewed. It was confirmed

that additional support was being put in place though the demand on the Occupational Health services remains high (in areas outstrips demand).

ASSURE

Cultural Dashboard

- The Committee welcomed the first iteration of the cultural dashboard and agreed for its wider roll out. It was noted that measuring 'culture' within any large organisation is notoriously difficult. There is no single metric which indicates whether an organisation has a good, bad or indifferent culture. This dashboard has been designed to combine multiple data sources which can be considered to be signifiers of the organisations' culture.

Recruitment & Retention Audit Report/Disciplinary Processes Audit Report

- The Committee received the findings of the MIAA internal audit reviews that received of Substantial Assurance. for
  1. Disciplinary Processes and Procedures
  2. Recruitment Processes and Procedures.

- It was noted that all actions will be completed and reported back to MIAA. The Audit Committee did not agree with one of the management responses regarding unsigned contracts, this is currently being resolved and will be reported back to MIAA.

Board Assurance Framework

- The Committee reviewed the BAF and supported that the risk rating remained unchanged at 16 against an agreed Target score of 12. It was also agreed that the narrative should be updated to provide a more balanced overview of the current position. .

New Risks identified at the meeting: None

Review of the Risk Register: None

Report Title:	Finance and Investment Committee Chair's Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Annette Walker, Chief Finance Officer		Decision	

Purpose	To provide an update from the Finance & Investment Committee meetings held since the last Board of Directors meeting.

Summary:	The attached report from the Chair of the Finance and Performance Committee provides an overview of matters discussed at the meetings held on 24 January and 28 February 2024. This report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the March Finance and Investment Committee, a verbal update will be provided at Board with a written report presented to the subsequent Board meeting.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the Finance and Investment Committee held in February

Proposed Resolution	The Board of Directors are asked to **receive** the Finance and 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 F&I Committee

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	24 January 2024	Date of next meeting:	28 February 2024
Chair	Jackie Njoroge, Chair F&I Committee	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- GM National System Update
- Month 9 Finance Report
- Draft Financial Report 2024/25
- Deferred Tax Asset
- Cost Improvement Programme 2024/25
- IFM Half Year Report

ALERT

Agenda items	Action Required
Deferred Tax Asset The Commercial Director of Finance updated the Committee in relation to the deferred tax asset with the IFM accounts and the options available. The Committee supported option 3 to continue with the current approach with a further meeting to be held with KPMG.	

ADVISE

Cost Improvement Programme 2024/25

The Chief Finance Officer gave an update on the cost improvement programme 2024/25, on behalf of the Programme Director for Transformation. 141 schemes have been identified at a value of £20,969k of which £2.5m have been rag rated green or delivered. A number of schemes have been moved to a black category following scoping after being considered not to be realistic opportunities. Black schemes are to be reviewed by the Executives and brought to the Committee for information and assurance.

ASSURE

GM National System Update

The Chief Finance Officer gave an update on the GM/National System position. Key points to note included:

- GM forecast revenue deficit now £180m in total.
- BFT forecast deficit is now £10.6m + £1m further IA costs.
- Further pressure to improve but forecast still high risk.
- Capital position across GM finely balanced.

- BFT have requested £2m additional CDEL cover from GM to help manage 23/24 spend – decision pending.
- The current message is that deficits are repayable.

Month 9 Finance Report

The Operational Director of Finance gave an update on the Month 9 financial position. Key points included:

- The Trust's 'likely' case forecast scenario suggests a deficit of £11.6m including the latest IA costs of circa £1m.
- Capital spend for month 9 is £2.4m of which £1.2m relates to TIF and £1m relates to CDC. YTD £15.3m has been spent.
- We had a closing cash position of £17.1m, which is a decrease of £2.4m from Month 8. The Trust cash position will become challenging toward the end of 2023/24 and start of 2024/25.
- Our BPPC performance year to date is 90.4% by number of invoices and 90.7% by value of invoices.

Draft Financial Plan 2024/25

The Operational Director of Finance presented the Draft Financial Plan for 2024/25. Key points to note included:

- There has been no new guidance for 2024/25 planning issued by NHSE. GM have issued some interim assumptions to enable a high-level review of issues.
- Bolton FT 2023/24 exit run rate is c£27m. Using GM assumptions, we have in year pressures of £11m, giving a gap to be addresses of £38m.
- 5 scenarios have been developed for recovering the gap over a number of years to demonstrate the scale of the challenge and guage views.

IFM Half Year Report

The Divisional Director for Estates and Facilities presented the Estates Plan on behalf of the Managing Director of IFM. The report has been to IFM Board for scrutiny and sign off. A full year report will be ready in July. The Key areas covered in the report include health and safety, finance, estates and facilities, RAAC update and Capital, Strategy and Specialist Services.

New Risks identified at the meeting:

None.

Review of the Risk Register:

Not reviewed.

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

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	28 February 2024	Date of next meeting:	27 March 2024
Chair	Jackie Njoroge, Chair Finance and Investment Committee	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- 2024/25 Planning Update
- Month 10 Finance Report
- Key Financial Transactional Processing Controls
- Capital Plan 2024/25
- Cash Management Plan
- Cost Improvement Programme 2024/25
- Finance System – Integra - Upgrade & Collaboration
- Procurement Update
- NHS Professionals Update

ALERT

Agenda items	Action Required

ADVISE

2024/25 Planning Update

The Operational Director of Finance provided an update. The main points were noted as follows:

- The start point on the first iteration of the plan for 2024/25 was a gap of £38m, as reported at the last meeting.
- Several assumptions have been included in the plan
- The revenue position as at 23rd February 2024 was for a 2024/25 planned deficit of £20.8m.
- There are significant risks of capital funding shortfalls.
- Cash is forecast to run out in July 2024 based on a deficit of £21.9m for 2023/24
- The Chief Finance Officer provided an update from a meeting that she had attended earlier in the day with PWC in which the bridge had been reviewed in detail. At the end of this meeting it was suggested that Providers will be expected to deliver at least 5% and that as Bolton has delivered a significant proportion of CIP this year non recurrently then a year of catch up will be expected, meaning a minimum of 5% but possibly 6% CIP. PWC will be working with the Trust to get the deficit figure more in line with a figure of £9m, subject to Board sign off and approval. The national teams' expectations is that the outer limit for 2023/24 will be the upper limit of the deficit for 2024/25.

Month 10 Finance Report

The Operational Director of Finance updated on the financial position for month 10. He advised that the Trust has an NHSE reported year to date deficit of £9.9m compared with a planned deficit of £10.4m. The Trust is forecasting a likely case year end deficit of £10.6m (excluding the costs of industrial action) which

is £1.8m better than the original planned deficit of £12.4m. The Trust continues to strive to achieve the best case which is a deficit of £9.3m. Capital spend for month 10 was £2.6m of which £0.2m relates to TIF and £1.4m relates to CDC. Year to date £17.8m has been spent.
The Trust had a closing cash position of £14.8m, which is a decrease of £2.2m from month 9. It was noted that the Trust cash position will become challenging early in 2024/25 and this has been flagged as a key concern during planning discussions with the ICB.

Key Financial Transactional Processing Controls

The Chief Finance Officer presented this report advising that it had been through Audit Committee on 14th February 2024 where it had been suggested that it also be brought through this committee for further review. The report highlights seven recommendations around the management of debt. Four of these were medium risk and three low risk. A meeting has been arranged to review the likely implication on the financial position. Following this meeting an assessment will be made.

Capital Plan 2024/25

The Chief Finance Officer updated on the capital plan for 2024/25. She advised that the capital envelope for 2023/24 is currently £22.3m of which £13.2m is CDEL and £9m is PDC. This is forecast to be spent in full. It was noted that this excludes the envelope for IFRS16. It was noted that, since the report was prepared, additional RAAC funding of £975k has been secured and that additional capital of £0.9m is being allocated to us to assist the overall GM position. £21m of capital was requested for 2024/25 but, having received a request to review this, the request has now been reduced to £14m.

Cash Management Plan

The Chief Finance Officer updated on the cash management plan for 2024/25 and asked the committee to approve the recommendation to the Board that the Trust start the process of securing cash support of £800k in quarter one of 2024/25 with the expectation of this continuing for each of the remaining three quarters.

She advised that a year-end deficit position of £12m is forecast. This equates to 9.3 days of cover for operating expenditure. The latest version of the plan is a deficit of £21m and on this basis it is anticipated that the Trust will run out of cash in July 2024 and that cash would dip below the minimum cash balance, which for Bolton is calculated at £1.6m, in May 2024.

The Finance & Investment Committee approved this recommendation to Board.

Cost Improvement Programme 2024/25

The Programme Director for Transformation updated on the Cost Improvement Programme for 2024/25, advising that CIP opportunities totalling £25.9m, risk rated down to £12.6m, have been identified on the tracker. She advised that the report is reviewed regularly at Executive Directors and also weekly at the Financial Improvement Group. The number of schemes has increased most weeks

Finance System – Integra - Upgrade & Collaboration

The Deputy Director of Finance updated on an upgrade to the main finance system which will be done in collaboration with Manchester University Foundation Trust (MFT). It was noted that this had been approved by Executive Directors.

Procurement Update

The Commercial Director of Finance updated that procurement savings of £6.28m have been secured for the period from April 2023 to January 2024. This has been achieved through cost avoidance (£3.37m), cash releasing (£1.87m) and inflation avoidance (£1.05m). This saving is an increase of £1.83m on the same period of the prior year. These savings offset costs pressures of £0.5m through NHS Supply Chain.

ASSURE

NHS Professionals Update

The Deputy Director of Finance provided an update on NHS Professionals who the Trust have engaged for a fully managed bank and agency service. In September 2023 agenda for change staff transferred over. The original business case included medical and iFM staffing also moving to NHSP. Medical staffing has been paused whilst some internal work is done on the Healthroster system. iFM staff will transfer when all the terms and conditions are up to date.

It was noted that this has been successful and the Trust has seen an increase in bank fill and a reduction in agency fill across all shifts, however, it was noted that this was done in conjunction with other grip and control measures across the Trust around variable pay

New Risks identified at the meeting:

None identified.

Review of the Risk Register:

There were no risks reviewed.

Report Title:	Financial Controls Committee Chairs' Reports

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	28 February 2024		Discussion	
Exec Sponsor	Annette Walker, Chief Finance Officer		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 17 January and 21 February 2024 for assurance. A verbal update will be provided for the meeting to be held on the 20 March 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

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

Name of Committee/Group:	Financial Controls Committee	Report to:	Board of Directors
Date of Meeting:	17 January 2024	Date of next meeting:	21 February 2024
Chair	Jackie Njoroge	Meeting Quoracy (Yes / No)	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- December Month 9 FPRM Outcome Letter
- Month 8 FPRM Update
- Financial Improvement Group Update
- Vacancy and Variable Pay Spend

ALERT

Agenda items	Action Required

ADVISE

ASSURE

December Month 9 FPRM Outcome letter

The Chief Finance Officer gave an update from the FPRM outcome letter received on the 29 December 2023 which contained 6 actions raised during the meeting and one ongoing action to develop the plan for 2024/25.

Month 8 FPRM Update

The Chief Finance officer informed the Committee that the formal meeting with PwC to discuss month 8 was stood down and the next meeting was scheduled for the 18 January to work through month 9. The Programme Director for Transformation reported on the Draft Financial Control Audit completed by MIAA. The recommendation was of substantial assurance.

Financial Improvement Group Updated

Key points from the meeting held on the 6th of December and the meeting held today were highlighted as below:

- 49 schemes in total on red which is an improvement.
- Total risk rated CIP is £9.8m with a total of £20,969k.
- Review of WTE has taken place with a focus underway on medical agency.
- Locum usage has been reviewed and is producing savings.
- 2 QIAs approved today.

Vacancy and Variable Pay Spend

The Director of People presented an update on Vacancy and Variable Pay spend for month 8. Key points highlighted were as follows:

- The Trust saw an overall reduction of 'worked WTE' (WWTE) of 39 WTE in December 2023.
- Agency spend reduced by £41k in December 2023 and is on a clear downward trend.
- Significant progress made on reduction of nursing agency.
- Bank showed increased spend in December to support clinical activity, but that increase did also prevent additional agency spend.
- Small reduction in medical variable pay in-month but evidence of a reducing medical spend trend when compared to earlier in 2023.
- Our vacancy rate benchmarks very positively compared to most GM providers when looking at the October 2023 comparator data set, and has improved since then.
- Turnover reduced slightly in-month and benchmarking demonstrates that the Trust is in a positive position.

New Risks identified at the meeting:

None.

Review of the Risk Register:

Not reviewed.

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

Name of Committee/Group:	Financial Controls Committee	Report to:	Board of Directors
Date of Meeting:	21 February 2024	Date of next meeting:	20 March 2024
Chair	Jackie Njoroge	Meeting Quoracy (Yes / No)	

AGENDA ITEMS DISCUSSED AT THE MEETING

- January FPRM Month 10 meeting outcome letter
- Financial Improvement Group Update
- Vacancy and Variable Pay Spend
- Grip and Control Internal Audit Report

ALERT

Agenda Item	Action Required

ADVISE

January FPRM Month 10 meeting outcome letter

- The Chief Finance Officer gave an update from the FPRM outcome letter received on the 9th of February which contains 6 actions raised during the meeting and one ongoing action to develop the plan for 2024/25. The next meeting is scheduled for the 28th of February and the actions will be completed and evidenced in a slide deck submitted to the ICB in advance.

Financial Improvement Group Update

Key points to note:

- Overarching PID given for admin review. Francis Andrews to be Exec Sponsor. Linking in with EPR has enabled monies for a clinical lead.
- Lesley Wallace is working through Level 3 iFM work which is in its early stages.
- Approved QIA to close the weekend phlebotomy service approved.
- CIP continues to improve - £25.8m identified, after risk rating £12.5m identified with a total of 187 schemes and there is a continued push.
- WTE reduction identified as 214 submitted with the operational plan.

Vacancy and Variable Pay Spend

Key points to note:

- The Trust saw an overall increase of 'worked WTE' (WWTE) of 20 WTE in January 2024 compared to December 2023 driven by increases in bank working in-month (bank expenditure increased by £202k in January 2024).

• Agency spend reduced by £177k in January 2024 (in-month spend was the lowest spend level in 2023/24) and continues on a downward spend trend. • Spend increased in Jan 24 by £202k as a result of clinical pressures, absence, and vacancies (evidenced by increases in HCA, Nursing, AHP staff groups), but that increase did also prevent additional agency spend. • Medical variable pay increased by £330k in-month driven by consultant, SAS, and SpR spend. • Trust vacancy rate reduced in-month and currently stands at 5.37%. Vacancy rates have been broadly tracking downwards (positively) throughout 2023/24. • Turnover reduced in-month, to a sub-11% position (10.85%). This is a continuation of the reducing trend seen throughout 2023/24.
ASSURE
Grip & Control Internal Audit Report • Two recommendations received in terms of monitoring to take back to the GM ICB.
New Risks identified at the meeting: • None identified
Review of the Risk Register: • There were no risks reviewed.

Report Title:	Charitable Funds Committee Chair's Report			
Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Director of Strategy, Digital and Transformation		Decision	

Purpose	To provide the Board of Directors with a summary of discussion, decisions made and issues raised at the Charitable Funds Committee meeting on 11 March 2024

Summary:	Chair's report from the Charitable Funds Committee meeting, covering the following items: • Q4 Highlight report • Year in review 2023/24 • Outlook report – Q1 2024/25 • Management fee review • Finance report • Training phantoms for radiology modalities

Previously considered by:
Charitable Funds Committee

Proposed Resolution	The Board of Directors are asked to receive the Charitable Fund's 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:	Sarah Skinner, Charity Manager	**Presented by:**	Martin North, Chair of the Charitable Funds Committee

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

Name of Committee/Group:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	11 March 2024	Date of next meeting:	28 March 2024
Chair	Martin North, Non-Executive Director	Meeting Quoracy	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Q4 Highlight report
- Year in review 2023/24
- Outlook report **– Q1 2024/25**
- Management fee review
- Finance report
- Training phantoms for radiology modalities

ALERT

Agenda Item	Action Required

ADVISE

Management fee review

A review of the Charity's core costs has taken place, resulting in a proposed 6% reduction in the Charity's management fee. Work will continue into 2024/25 to deliver on the full scope of the review. The Committee approved the proposed fee for 2024/25 and noted that further updates will be provided to the Committee later in 2024.

Finance report

Two losses were highlighted: one for £1k for lost bedding and the other for £300 for a duplicate staff lottery winner's payment. The Committee noted the losses and requested an update on revised security measures.

Training phantoms for radiology modalities

The Committee received a presentation regarding a forthcoming funding application for training phantoms in Radiology. The Committee noted the presentation and acknowledged the full bid would be sent via email for consideration.

ASSURE

Highlight report

The Committee received the Q4 2023/24 highlight report noting updates on: fundraising and grants; communications, marketing and media; charity-funded schemes; events; and risks.

The Committee noted the report.

2023/24 year in review

The Committee received an overarching review of 2023/24 performance, including (but not limited to) operational, income and expenditure highlights, and areas of growth and focus for 2024/25.

The Committee noted the report.

Outlook Report – Q1 2024/25

The Outlook report covered key planning activities scheduled to take place in Q1 2024/25. The Committee received a 'state of the sector' update highlighting key issues, risks and opportunities, and an overview of proposed /planned activity for Q1 2024/25.

The Committee noted the report.

Finance report

The charity's fund balances totalled £1,009k at 31 January 2024. There was a net decrease in funds of £219k for the ten months to 31 January 2024, made up of income of £223k and expenditure of £442k.The charity has received £81k in legacies to date in 2023/24, with just four legacies outstanding (totalling £2.6k). Work continues on streamlining the call on funds, which now stands at £180k.

The Committee noted the report.

New risks identified at the meeting:

None identified

Review of the Risk Register:

Following the Q4 review of the risk register, no new risks have been identified or retired, meaning the charity continues to monitor ten live risks, with two risks scoring 12 or above (before mitigation).

Report Title:	Audit Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Chief Finance Officer		Decision	

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

Summary:	The attached report from the Chair of the Audit and Risk Committee provides an overview of matters discussed at the meeting held in February 2024. This report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

Previously considered by:
The matters included in the Chair's report were discussed and agreed at the Audit and Risk 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 and Risk Committee

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of committee/Group:	Audit and Risk committee	Report to:	Board of Directors
Date of Meeting:	14 February 2024	Date of next meeting:	08 May 2024
Chair	Alan Stuttard	Meeting Quoracy (Yes / No)	Yes
Attendees	Annette Walker, Tosca Fairchild, Martin North, Sharon Katema, Catherine Hulme, Collette Ryan, Imogen Milner, Chris Paisley, Darrell Davies, Stuart Bates.	Apologies received from	Fiona Taylor, Patrick Clark, Debra Chamberlain.

AGENDA ITEMS DISCUSSED AT THE MEETING

- Chair's notes and updates
- Health Technical Update
- External Audit Plan
- Internal Audit Reports
- Local Counter Fraud Specialist Progress Report
- Accounting Update
- Arrangements for the Annual Report 23/24
- Register of Interests, Gifts and Hospitality
- Register of Waivers Bolton FT & iFM
- Losses and Special Payments Bolton FT & IFM
- Standing Financial Instructions Breach Report Bolton FT and iFM

ALERT

Agenda Item	Action

ADVISE

Chair's notes and Updates
The committee were advised of the change in name of the Audit Committee to the Audit and Risk Committee and that risk management and information governance are now included in the Terms of Reference, all of which were approved by the Board of Directors in January 2024.

Health Technical Update
KPMG provided their quarterly technical update.

External Audit Plan
KPMG presented the External Audit Plan for the 2023/24 accounts. The committee expressed concern at the increase in fees for the Trust accounts. KPMG explained that this was due to an increase in costs and market forces. The committee advised that the Trust will be considering the option to change the Auditors for the iFM accounts and the Charitable Fund Accounts for 2023/24.

The committee also advised as previously discussed that the Trust would be undertaking a full tender exercise for the audited accounts for 2024/25.

The committee discussed the issue of the deferred tax affecting the closure of the iFM accounts. The deadline for submission of the accounts of the 31 January had been missed. The deferred tax issue was currently under discussion between the Trust, the Trust Tax Advisors and the External Auditors. It was hoped that a resolution would be agreed by the end of February.

Accounting Update
The committee noted the update.

Arrangements for the Annual Report 2023/24
The Director of Corporate Governance presented the timetable and actions for completion of the Annual Report for 2023/24.

Register of Interests, Gifts and Hospitality
The Director of Corporate Governance presented an update on the reporting arrangements for the registers. The committee discussed how this will be presented to the committee as the reports were now generated on line. This will be taken up outside of the meeting.

ASSURE

Internal Audit Reports
Mersey Internal Audit Agency introduced their update on the completed internal audit reports and the audit reports where fieldwork was currently being undertaken. There were 7 completed Internal Audit reports;

- **Recruitment and Retention** – substantial assurance. The committee considered the report and asked that follow up work from previous audits undertaken by MIAA. These had been inherited from the previous Internal Auditors. The committee were pleased to see that of the 51 outstanding items 40 had been completed, 2 had been one of the management responses be referred back to the HR Team for reconsideration. The committee also recognised that part of the review should be reported to the Council of Governors as it referred to the Non-Executive Directors.

- **Disciplinary Process** – substantial assurance. The committee asked that this report and the Recruitment and Retention report be referred to the People Committee for consideration. Both reports had arisen following external scrutiny by the CQC and PwC. The committee asked that the People Committee review the reports for assurance purposes and review the actions contained in the reports.

- **Digital Plan** – moderate assurance. The committee noted that there were a number of recommendations and actions within the report. Concern was expressed at the pressure on the digital team and the scale of the work that they were currently undertaking. The committee referred the report back to the Strategy and Operations committee for consideration.

- **Assurance Framework phase 1.** The committee noted the update from this review and the actions which had been agreed by management.

- **Key Financial Transactional Processing Controls** – moderate assurance. The committee considered the report and expressed concern over the findings in relation to aged debt. It was noted that the aged debtors had not been reviewed for some time although a new procedure had been introduced. There was a risk that some of the aged debtors would need to be written off and this could potentially impact on the bad debt provision and the Trust financial position. The committee referred the report to the Finance & Investment committee for further assurance on the process with regard to the aged debtors.

- **Grip and Control Action Plan** – substantial assurance. This review had been undertaken in response to the financial scrutiny being undertaken by GM ICB and PwC. The review was positive in its outcome and the review would be referred back to the Financial Controls committee for consideration and onwards submission to GM ICB/PwC.

- **Follow up quarter 4** - The committee considered the follow up work from previous audits undertaken by MIAA. These had been inherited from the previous Internal Auditors. The committee were pleased to see that of the 51 outstanding items 40 had been completed, 2 had been superseded as a result of changes and there were 9 outstanding, each of which had a timetable for completion.

Local Counter Fraud Specialist Progress Report
The Local Counter Fraud Specialist presented the report and highlighted a number of events, updates and cases over the last quarter. The committee were pleased to see the proactive approach to counter fraud measures and the actions being taken.

Register of Waivers for Bolton FT and iFM
The Chief Finance Officer presented the register of waivers for the Trust and iFM. The committee noted that the number of waivers had been reduced although the value remains broadly the same. It was recognised that in a number of cases the items were purchased from a single source supplier. It was pleasing to see that a number of the waivers going forward would be subject to the normal procurement and tendering arrangements. The committee did raise concern over one of the items which the Chief Financial Officer confirmed was under review.

Losses and Special Payments Report for Bolton FT and iFM
The Associate Director of Finance presented the report. The main item related to pharmacy write offs which were primarily due to out of date drugs. However it was noted that this was a very small percentage (less than 1%) when considered alongside the total value of drugs in stock and dispensed.

Standing Financial Instructions Breach Report for Bolton FT and iFM
There were no material breaches to report.

New Risks identified at the meeting:

1. The risk relating to the completion of the iFM accounts and the deferred taxation.
2. Consideration of the arrangements for the 2023/24 audit of the iFM accounts and the charitable funds accounts.
3. The risk related to aged debtors and the potential write off of any outstanding debts.
4. Consideration of the recommendations and actions arising from the digital plan review in the context of the pressure on the digital team.

Review of the Risk Register:
There were no changes made to the risk register.

Title:	Board Assurance Framework

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	✓
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	

Purpose:	The Board Assurance Framework provides assurance that the principal risks to achieving the Trust's Ambitions are identified, regularly reviewed, and systematically managed

Summary:	The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. Since presentation at the last meeting, a review of the BAF was undertaken by the executive directors and committees to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level.

Previously considered by:	Executive Directors and Board Committees

Proposed Resolution	The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

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

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

1. DEFINITIONS

- **Strategic risk**: Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors.
- **Linked risks:** The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
- **Controls:** The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the Ambition
- **Gaps in controls:** Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
- **Assurances:** The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively.
- **Gaps in assurance**: Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
- **Risk Treatment**: Actions required to close the gap(s) in controls or assurance, with timescales and identified owners.

2. INTRODUCTION

2.1. The Board Assurance Framework (BAF) provides a structured process that is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact the delivery of the strategic objectives.

2.2. This year the BAF has continued to reflect the existing Trust Strategy as a result it has been subject to periodic review. However, as the Trust approaches the conclusion of its 2019 to 2024 Strategy, it is expected that the BAF will be refreshed and realigned to the new Trust Ambitions in the new financial year.

2.3. The BAF has been considered by respective Executive Director Leads prior to presentation at Committees to ensure that the process of identifying the main sources of risk continues to be balanced against the controls and assurances that are currently in place to enable discussion and scrutiny at the Board level

2.4. There are no changes to the assessment of assurance.

3. RISK MANAGEMENT

3.1. To ensure consistency in approach, all risks have been assessed in line with our Risk Management Policy and have been graded using the system highlighted below to generate a risk score: **Severity (Consequence) x Likelihood = Risk Score**.

Severity		Likelihood		
1	Insignificant	2	Rare	Difficult to believe that this will happen / happen again
2	Minor	2	Unlikely	Do not expect it to happen / happen again but it may.
3	Moderate	3	Possible	It is possible that it may occur/ reoccur.

4	Major	4	Likely	It is likely to occur / recur but is not a persistent issue
5	**Catastrophic**	5	**Certain**	Will almost certainly occur / reoccur and could be a persistent issue

Severity / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	8	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Key

15+	High
8 - 12	Significant
4 - 6	Moderate
1-3	Low

3.2. The following changes in risk score were presented and approved by respective committees.

- Ambition 1.1 due to a reduction in Likelihood to 3. Overall the risk is now rated 12 and is now at the Target risk rating.
- Ambition 1.3 risk has reduced from 12 to 9 and remains a Significant Risk.
- Ambition 4 score is increased in 20 so it reflects the highest scoring risk on the risk register regarding Estates which is currently scoring 25.

4. RISK APPETITE

4.1. Risk appetite can be broadly defined as the amount of risk that an organisation is willing to take or the total amount of risk an organisation is willing to accept in order to meet its strategic objectives.

4.2. Risk exists in all environments, and the Trust recognises that it is impossible to achieve its aims and objectives without taking risks. Whilst the amount of risk that the Trust is willing to accept will vary, this will be captured in each of the strategic risks and may change as we move forward.

4.3. The Risk appetite for each Strategic goal (Ambition) of the Trust is reviewed quarterly and discussed at Committees and Board.

4.4. There is no proposed change in risk score for each of the ambitions

5. CONCLUSION.

The Board is asked to **receive** the Board Assurance Framework and assurance on the work undertaken to achieve the Trust's Ambitions.

Board Assurance Framework Explanatory Notes

- The ambitions for the Trust have been agreed in consultation with the Board and wider stakeholders. The ambition description used within this BAF is as set out in the summary Strategic Plan 2019 – 2024
- For each objective the Executive team consider the risks and issues that could impact on the achievement of the ambition, the BAF is then populated with these risks/issues, the controls in place and the assurance that the controls are having the desired impact. Actions to address gaps in controls and assurance are identified.
- Actions should be SMART and should include an expected date of completion.
- The “oversight” column is used to provide details of the key operational and assurance committee.
- The RAG column is used to indicate the level of assurance the Executive has that the risk is being managed.

	• No or limited assurance– could have a significant impact on the achievement of the objective;
	• Moderate assurance – potential moderate impact on the achievement of the objective
	• Assured – no or minor impact on the achievement of the objective

- The full BAF should be reviewed at least once a year at Board and twice a year at the Audit Committee
- The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF;

Ambition 1
Provide safe, high quality care

LEAD DIRECTOR	**Medical Director**	**1.1**
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

Linked Risks

No linked risks

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Consequence	Likelihood	Score	Consequence	Likelihood	Score	Consequence	Likelihood	Score
March 2024	4	4	16	4	3	12	4	3	12

PRINCIPAL RISK: IF THE TRUST DOES NOT GIVE THE BEST CARE EVERY TIME THEN THIS MAY RESULT IN INCREASED MORTALITY IN HOSPITAL AND IN THE 30 DAYS FOLLOWING DISCHARGE

Overall Assurance Level

RISK APPETITE:

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

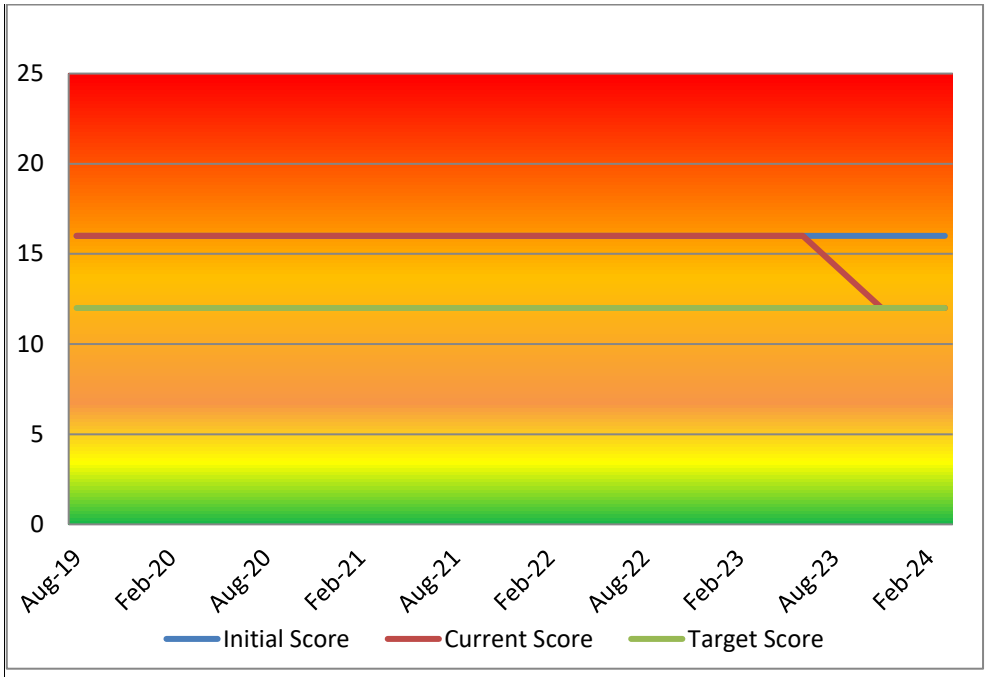
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Amber

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Causes **a) MORTALITY METRICS** • HSMR and SHMI at risk of going outside of expected range **b) DIAGNOSIS AND COMORBIDITY RECORDING** • Recording of diagnosis done using terminology that cannot be coded	• HED used to alert Trust to areas of clinical concern - monitored monthly and reviewed with clinical teams for triangulation with other data sources regarding quality of care; presented at Trust Mortality Reduction Group (MRG) • MRG monitoring and maintaining the achievement of >98% Coding completeness	• DQ issues mean expected deaths under-predicted – lack of time for clinical validation of data • Clinical time & lack of consistent EPR solution • Awaiting approval for automated solution to	***1st Line of Defence (Operational Management)*** • Local BI monitoring on HED • Monthly monitoring of HED SHMI & HSMR, mean Charlson comorbidity score & depth of coding plus at Mortality Review Group • Learning from Deaths Committee reports to MRG: • Quarterly Quality Account updates to CG&QA committee (on NEWS and antibiotic prescribing compliance)	• Performance data limited by systems and processes for recording and/or reporting (e.g. Sepsis screening and NEWS compliance); being rectified	- Amend EPR to facilitate improved comorbidity recording and depth and consistency of coding ~~(30 June 2023~~ **Revised completion -Mar 24** • **MRG**: Continued adoption of new workplan and reporting methodology to ensure identification and improvement in triangulation with other KPI and quality metrics (~~30~~

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Failure to record all relevant Comorbidity • Comorbidity recording inconsistent between admissions **c) QUALITY OF CARE** • Care delivery concerns identified through Learning from Deaths process not fully addressed • Compliance with NEWS observation policy and escalation algorithm not at 100% consistently • Failure by individuals/teams to recognise or respond to a deteriorating patient • Sepsis screening and Sepsis 6 performance not at 100% **Effects** • Patients waiting longer in ED for inpatient beds which may impact on outcome • Patients admitted to hospital when nearing end of life/dying, when may be better cared for/more appropriately placed in other care facilities/at home • Mortality metric variations may reflect recording and data quality issues, rather than a true care concern	with accuracy confirmed annually through external assessor. • Diagnoses and comorbidity education at induction • RR-SAFER implementation and AIMS training • EoL committee actions to improve ACP • Resuscitation Committee monitoring Cardiac Arrest RCAs • Educational programme to improve communication with patients, families and carers • Quarterly Sepsis KPIs reported to MRG • Use of EPACCs system to document and define EOL plans • Ongoing QI Collaborative inc Pressure Ulcer	comorbidity recording in EPR • IT kit access to record data (roll out in progress) • No digital solution for Coding Team to identify missing codes from previous admissions • Training compliance not at 100% for nursing and medical staff • Improving mandatory resuscitation and AIMs training sessions • Coordination between NEWS, sepsis and recognition of deterioration work required to ensure consistency across Trust • Quarterly sepsis KPIs pulled from only one system; data recorded in >1	***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Reports to QAC and Board • Reports on IPC, transfusion, Medicines Safety, Safeguarding • Quarterly MRG and LfD reports to QAC • Mortality reports to QAC and Board ***3rd Line of Defence (Independent or Semi-independent assurance)*** • Trust HED benchmarking against national acute trusts' data • Regional benchmarking and peer review (e.g. Critical Care peer review, Ockenden Insight report, PMRT) • National reporting and benchmarking (e.g. NELA, national hip fracture database) • AQuA audits of care (e.g. sepsis, pneumonia) • GIRFT reviews into care provision (e.g. cancer services, CIAD) • External assessments and accreditation (e.g. RCOA ACSA assessment, RCS reviews) • CNST MIS assessment	• Cases reviewed in arrears with reports collated quarterly – risks delay in sharing learning HED data published nationally in arrears – system does allows some early identification	~~**September 2023**~~).**Ongoing and progressing into 2024** • Review of AQuA, GIRFT and other care reviews (March 24) - Increase trained assessors and improvement in response time and case identification processes ~~(Dec 23)~~ revised target completion date Q.1 24 - Thematic analysis of existing database of LfD cases.(Dec23) revised completion date Q.1 24 • **Patient Quality Group**: • Enact changes to reduce inappropriate resuscitation attempts, by improving compliance with DNACPR and MCA documentation. • **Recognition of deterioration:** - Complete TNA and develop educational training plan Ongoing - Implement RR-SAFER by training RNs from wards & ratification of PGDs for fluid bolus Target completion date Q.1 24 • Improve sepsis screening & management: Ongoing and progressing into 24

1.1	Ambition - To give every person the best care every time – reducing deaths in hospital		
Risk tracking	**Background**	**Date**	**Comments**
		05/11/20	Risk narrative updated



Mortality reduction remains a key strategic and operational ambition for the Trust; delivering high quality, evidenced-based healthcare will reduce.

Our observed deaths, mirrored by crude mortality, are within the expected range and are frequently below national average.

Committee Feedback

Mar 24:

29/06/21	Narrative updated
01/11/21	Narrative updated
30/06/22	The narrative has been updated and reviewed. This remains a high risk with no change in risk score.
16/11/22	Narrative reviewed and updated. Risk persists due to the need for continued actions to provide controls.
13/03/23	Full review with dates for all actions
July 23	Coding is now at establishment with excellent performance on final coding completeness. This is no longer an issue and has been deleted from issues column. No change to Risk Score
Nov 23	Risk reviewed and reduced to 12 due to improvement in coding and is now at Target Rat. QAC approved change in risk score.
Mar 24	Risk reviewed no change in risk score

Ambition 1
Provide safe, high quality care

Lead Director	**Chief Operating Officer**	**1.2**
Lead Committee	**Strategy and Operations Committee** The SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
March 2024	**4**	**5**	**20**	**4**	**~~4~~ 5**	**~~16~~ 20**	**4**	**3**	**12**

Linked Risks

Risk ID:
5630 - scored 16
5599 – (16) *Escalation spaces in ED Majors*
6072 – (16) *ED Cohorting in non-clinical areas*
5588 – (15) *ED Waiting Room*

Principal Risk: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

Overall Assurance Level

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

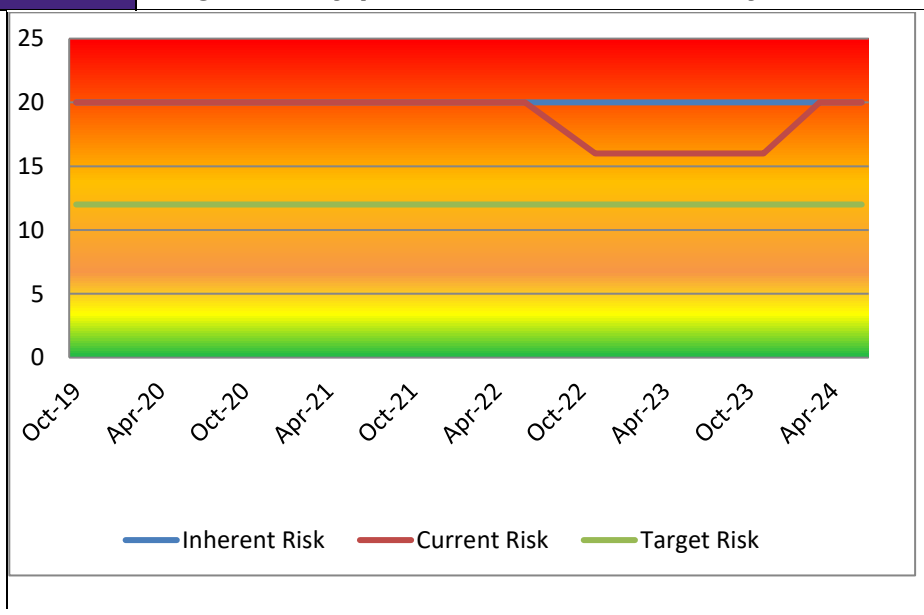
RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Failure to admit, treat or discharge patients from our services in a timely manner **Key Causes** • Increased waiting list size since 19/20 baseline • Increased cancer backlog size since 19/20 baseline • Insufficient theatre capacity to meet current demand • Insufficient diagnostic capacity within cancer pathways • Insufficient capacity within the Emergency Department to deal with the demand • Lack of a sustainable Urgent Treatment Centre model • Failure to reliably meet the SAFER ward standards • Discharge capacity frequently does not meet demand **Impact** • Failure to deliver against nationally mandated performance targets	• Trust policies including (Escalation, Access, Discharge) • Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge • System Co-ordination Centre Meetings previously (SORT) • Joint working with GM on cancer pathways • Joint working with GM to ensure equality of access across GM • Regular validation of waiting lists • Implementation of the Urgent Treatment Centre • Refreshed Integrated Performance Report (IPR) dashboard • Escalation Policy, Access Policy and Discharge Policy now refreshed and implemented.	Lack of monitoring of the effectiveness of policies Weak monitoring of the implementation of ward SAFER principles Lack of a robust Capacity & Demand planning cycle	1st Line of Defence (Operational Management) • Regular performance monitoring at Divisional level. • Monthly Integrated Performance Management (IPM) meetings to review performance data • Divisional Risk Registers at RMC • Urgent Care and Community workstream reports at Performance &Transformation Board. • Monthly review of assurance programmes at Performance & Transformation Board • Weekly Operational Update at Execs with regular Urgent Care Performance reviews 2nd Line of Defence (reports and metrics monitored at Board/Committees • Review of Integrated performance report at Strategy and Ops Committee • Spotlight service reviews at SOC • Bi-monthly presentation to Board of the refreshed IPR and Operational Update • Monitoring of performance at GM meetings 3rd Line of Defence (Independent Assurance) • NHSE Oversight framework • NHS benchmarking data including Model Hospital Dashboard and North West performance data • Getting it right first time (GIRFT) programme. • Monitoring and scrutiny of performance targets by GM ICB & PFB teams • Internal Audit reviews • External Peer Reviews by expert groups • Regionally arranged ECIST visits & reviews	Development and review at SOC of the implementation of Emergency Care Intensive Support Team (ECIST of action log. GM ICS Performance meetings	~~Review of Escalation Policy, Access Policy & Discharge Policy monitoring to be undertaken and implemented (September 2023)~~ • Robust audit of ward SAFER principles to be undertaken and reported **(~~June 2023~~)** This remains ongoing and is additionally monitored through BOSCA**. Ongoing** • Capacity & Demand cycle **(~~Target Completion Date March~~ Revised target completion date December 2024)** • Development of a workplan following conclusion of the Internal Audit review of waiting list management. **(Target Completion Date March 2024)** • Deliver the 2023/24 winter plan to maintain access to urgent and emergency care across the Trust (March 2024 Ongoing) • Emergency Care Intensive Support Team (ECIST) review and implementation of action log. (Ongoing and subject to periodic review at SOC)

1.2 To give every person the best care every time – Delivery of Operational Performance



The pandemic has had an impact on waiting times and has increased demand for our services. This has resulted in increased backlogs and a comprehensive recovery plan is now in place.

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update.

20.02.20	Risk updated to reflect challenges to RTT and cancer performance
16 Nov 22	Review of BAF. No change in risk score, Risk remains High at 16.
30 March 23	No proposed change in risk score following review.
July 23	No proposed change in risk score.
Nov 23	Risk has been reviewed. There is no proposed change in risk score. However, it is proposed that the overall assurance is reduced from Red to Amber given the mitigations in place to address the risk
Mar 24	The risk has been reviewed and based on current performance, **it is proposed that the risk is increased to 20.**

Ambition 1
Provide safe, high quality care

LEAD DIRECTOR	**Chief Nursing Officer**	**1.3**
LEAD COMMITTEE	**Quality Assurance Committee** QAC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

RISK ASSESSMENT

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
March 2024	3	4	**12**	3	3	**9**	3	2	6

Linked Risks

There are no Risks scoring Catastrophic for impact on the Risk Register

Risk 5192 - Scored 15 Inadequate level of staff in specialist and Named safeguarding roles

PRINCIPAL RISK: if the trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

Overall Assurance Level: Amber

RISK APPETITE:

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

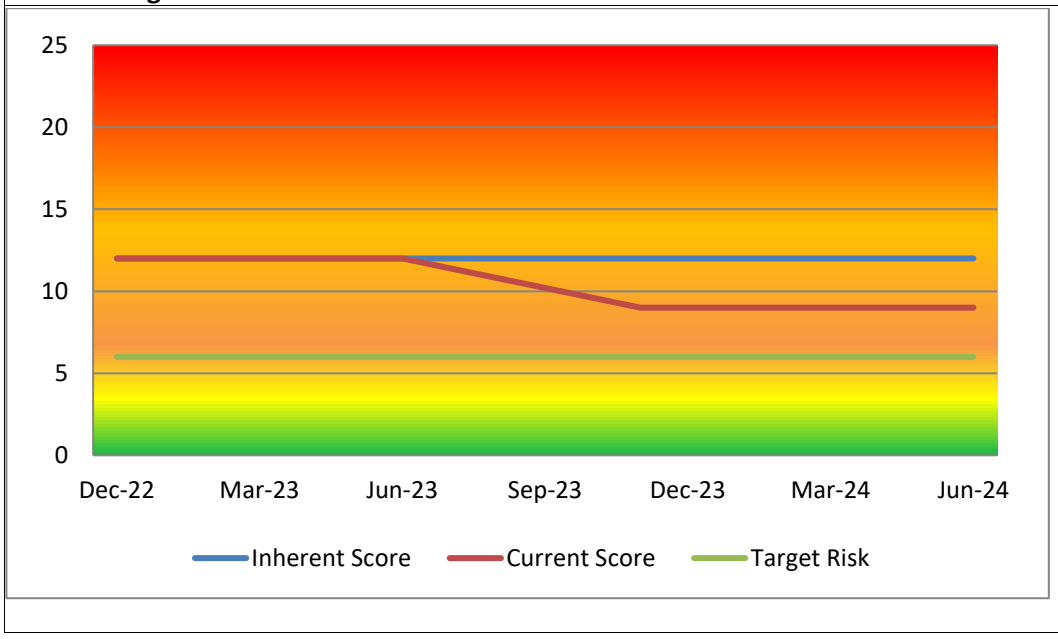
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Causes • Sustained achievement and visibility of safe staffing levels / skill mix • Demand for services exceeding capacity • Inconsistency with divisional governance processes • Regulatory breaches • Unreliable application of quality improvement science methodology • Leadership inconsistency with application of required standards • Financial health fragility impacting on service provision **Effect** • Insufficient staffing levels and an inadequate skill mix • increased stress and burnout • potential adverse impact on patient outcomes • Inconsistent delivery of patient care • Missed Opportunities for Improvement or implementation of evidence based interventions • Inefficiency and waste of resources	• Quality Account Priorities now overseen by QI team with reporting to CG&QC committee quarterly • Refreshed Quality Improvement Strategy • Two QI collaborative to support embedding of QI methodology around priority areas • QI training available to all staff. • QI Plan has been finalised and is in place. • Internal audit process (PWC, mock CQC) • Accreditation process (BoSCA) • Implemented Patient Safety Incident Response Framework • Revised being open policy (includes duty of candour) • Phase 1 implementation of changes to QG & CG with removal of 'reassurance' reports & replaced with data driven outcomes • Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS), reviewed every 6 months • Enhanced accreditation (BoSCA) escalation framework agreed and in place • safeguarding improvement plan • Regular programme of senior practitioner work-withs and reality rounding in place • Quality impact assessments for service changes / non-medical staffing changes, requiring approval from Chief Nurse and Medical Director • Programmed listening events with student non-medical learners to hear feedback • Implementation of Workplan from Good governance institute (GGI) review of Quality Governance processes	• Revised Quality Governance Dashboard and performance reporting • Development of a Risk management framework/strategy • Junior doctor listening events	***1st Line of Defence (Operational Management)*** • Performance metrics reviews by divisional governance teams • Risk Registers reviewed at Risk Management Group • Reports through safeguarding committee detailing actions of PWC review • Real-time patient experience with addition of key questions for all in-patients and community long term caseloads – data reports from 10.23 • Chief Nurse programmed interactions with Neighbourhood teams x 6 at 4-6 weekly intervals (digital) and weekly programme of community visits **Reports to Clinical Governance & Quality Governance Group** • Patient safety report • Monthly workforce score cards • Monthly safe staffing reports produced in line with CHPPD • Midwifery safety dashboard in alignment with national requirements • Quarterly learning report ***2nd Line of Defence (Reports at Board and Committee Level)*** **Reports to Quality Assurance Committee and Board, namely:** • Integrated Performance Report • Quality Account Priorities • Mandatory training compliance • Bi-annual Nurse & Midwifery establishment reviews • CNST & other Maternity related specific reports • Patient safety report monthly • Quarterly learning report • CQC Improvement Plan reporting/oversight to CG&QC and QAC. Well led recommendations reported through to appropriate committees of the board. ***3rd Line of Defence (Independent or Semi-independent assurance)*** • Internal audit reviews • CQC inspection reports • CQC inspection visits, Insight reports, engagement meetings • National audits • Peer reviews and accreditation. • Internal audit review of safeguarding systems and processes concluded.	• Assurance of ward to Board 'golden thread' through clinical assurance governance standardised framework • Sub-optimal assurance from safeguarding committee chairs reports, quarterly report required. • Implementation of Internal PWC audit of clinical negligence scheme for trusts (CNST) systems and processes within Families division • Implementation of recommendations from PWC internal audit of risk management process • ~~Good governance institute (GGI) review of Quality Governance processes~~ • ~~Implementation of actions from CQC well-led inspection – final report published Sep 2023 –~~ • Monthly safe staffing report to board in line with NQB recommendations. •	• ~~Implementation of serious incident process and revisions~~ – **31.7.23 completed but reliability remains fragile within FCD & ASSD.** Implemented PSIRF. (SI Framework no longer being followed). • ~~Commission and review of all Clinical Divisional governance processes against best practice –~~ **31.08.23 Completed ongoing oversight at QAC** • Finalise QG&CG work-plan to align with domains quality and CQC KLOE – ~~31.07.2023 delayed due to CQC inspections x 5. Aim 31.12.23.~~ **Completed and will continue in 24/25 as review of wider governance reporting structure.** • Quality Governance dashboard and performance reporting – delayed - ~~Target Completion 31.12.2023~~**.** Dashboard in place but has limitations. Target completion date for new dashboard. May 2024 • ~~Refresh of Quality improvement strategy with all stakeholders~~ – **Target Completion end Q3 23/24 Completed.** • Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.24 Currently on track and working with GM on full roll out programme. Ongoing** • Enhanced Quarterly safeguarding reports to Clinical governance and quality to be developed for assurance ~~Target completion date 30.8.23 delayed~~**. Revised date of end of Q1 24/25.** • Development of Risk management framework with stakeholder engagement **Target Completion Date ~~30.12.2023~~. Revised to May 24.** • ~~Well-led CQC inspection actions reporting to relevant sub-board committee as well as overall CQC improvement plan –~~ **by 12.23 - completed** • Review of key lines of enquiry from Countess of Chester **Completed** • Scope opportunities to enhance safety reliability through deployment of digital / artificial intelligence & linking with deputy national patient safety lead – **09.24 - Ongoing. Procurement exploring GM wide opportunities. If none, will explore local opportunities.** • In partnership with Medical Director, scope junior doctor focus group viability **– 03.24 Ongoing and progressing into 23/24** • Develop a monthly Nursing and Midwifery safe staffing report to be submitted to Board of Directors**. Target due date 30.06.2024**

1.3	Ambition - To help our staff improve services making sure everyone has a good experience when using our services

Risk tracking



Background

If the Trust does not deliver reliable compliance with regulatory quality standards then this will result in sub-optimal outcomes

Committee Feedback

Due to the timing of the Quality Assurance Committee, any feedback follwing review will be provided verbally.

Date	Comments
13.3.23	New risk for inclusion onto the BAF
12.07.23	Risk reviewed. No change to risk score.
Nov 23	Following review of risk, the risk has now been **reduced to 9** which is a Significant risk on the matrix. Risk Appetite risk unchanged and will be considered as part of the refresh of the BAF to ensure it's aligned to the new Ambitions
Mar 24	Risk reviewed. No change to risk score.

Ambition 2
To be a great place to work

Lead Director	**Director of People**	**2**
Lead Committee	**People Committee** can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
March 2024	**4**	**5**	**20**	4	4	**16**	4	3	12

Linked Risks *(Scoring 16+ or Catastrophic for impact / 5 Severity on Risk Register)*

There are no risks rated 15 and above or scoring Catastrophic for Impact to include.

Principal Risk: If the Trust is not a great place to work then it will be unable to recruit, retain and support people to maximise their potential.

Overall Assurance Level

Amber

RISK APPETITE

1	2	3	4	5
Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

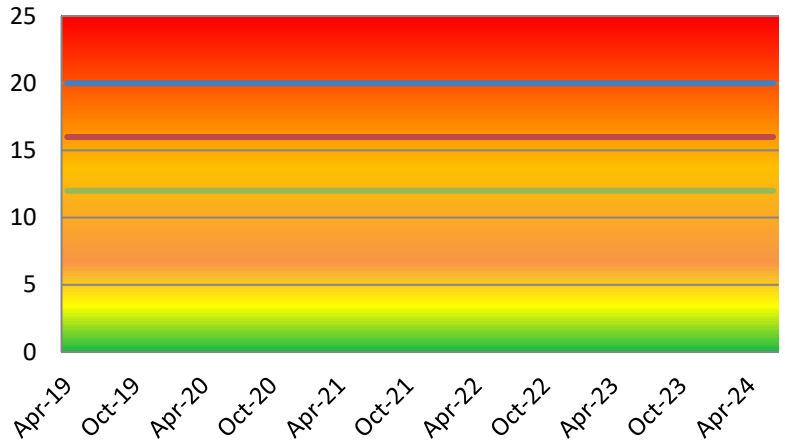
Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
Causes • Failure to provide health and wellbeing support to staff • increase in sickness absence rates • Low Staff Engagement/Staff satisfaction levels • Low recruitment and retention of staff with the right skills and values • Failure to reduce reliance on agency staff	• Staff Health and Wellbeing Plan • Our People Plan. • Occupational Health Provision • Staff Experience ~~Inclusion~~ Steering Group • Equality Diversity and Inclusion Steering Group • Staff Health and Wellbeing programme • Great Place to Work Plan	Identified and actioned from Internal Audit of identified key areas. EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (Gaps in control also identified through corporate check and challenge process	***1st Line of Defence (Operational Management)*** • Attendance KPI • ~~NHS Staff survey (annual)~~ • Friends and Family • Pulse Survey Staff Survey • Divisional People Committees reports to People Committee • IPM meetings with Divisions • Resourcing and Talent reports to PC • Reports to Vacancy Control Panels	EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee	• Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Ongoing** • Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Ongoing** • Our Voice Programme commenced with regular reports to People Committee and Executive Directors Group on a bi-monthly basis. **Ongoing**

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions or opportunities to improve controls/assurance
• Failure to have an inclusive and diverse workforce representative of the population • Failure to provide education and development opportunities • Failure to maximise digital HR systems • Failure to deliver workforce transformation • Failure to support and enable the workforce to adapt, modernise and transform **Consequences** • Impact on improvement initiatives and attendance • Lost opportunities for increased efficiency and effectiveness • Reduced ability to recruit and retain staff • Impact on future capability of the workforce • Decrease in diversity of our workforce • impact on the staff wellbeing and future workforce capabilities • Impact of service delivery • Impact on our ability to address critical health & social care system wide workforce challenges • Widening health inequalities impacting on care provision, reputation and future recruitment and retention	• Weekly / Monthly Safe Staffing meeting • Consultants Job planning • Staff Network groups • Revalidation • Appraisals • Mandatory and Statutory Training • ESR Benefits realisation plan • Agile Working policy • Workforce and OD Strategy • Trust Health and Financial Wellbeing • Our People Plan and Bolton interpretation of the NHS Workforce Plan • Attendance and membership of Bolton wide People and culture group. • Vacancy Control Panels • NHS Workforce Plan • NHSE EDI Improvement Plan • EDI Strategy • Equality Impact Assessments / Equality analysis • Health Inequalities Enabling group	Bolton response to NHS England newly published Workforce Plan to be presented at People Committee Vacancy Control Panel Meetings Refresh and revise EDI Plan	***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Report to People Committee and Board. • Staff Story included as a standing item in Board • EDI Action Plan monitored at People Committee quarterly • Report and attendance at Bolton Locality Workforce Group • Reports to Financial Controls Committee ***3rd Line of Defence (Independent or Semi-independent assurance)*** • WRES, WDES, • Gender Pay Gap report • Annual Quality report • NHS Staff Survey • Local, Regional & national Benchmarking • Internal Audit reviews • Equality Delivery System (EDS) 2022 • ICB EDI contract monitoring	Reports from Vacancy Control Panel Meetings	• Regular meeting and expansion of Community voices group. **Ongoing** • *Trust's response to the NHS Workforce Plan to be presented at People Committee for ongoing monitoring. Target September* 23 **Completed** • EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date December 2024**

2	Ambition - To be a great place to work

Risk tracking



	Apr-19	Apr-20	Apr-21	Apr-22	Apr-23	Nov-23	Mar-24	Jun-24
Inherent Score	20	20	20	20	20	20	20	20
Current Score	16	16	16	16	16	16	16	16
Target Score	12	12	12	12	12	12	12	12

Inherent Score Current Score Target Score

Background

Maintaining safe staffing levels through recruitment and retention and reducing sickness absence is a key objective to ensure delivery of the Trust's strategy.

The People Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of being a great place to work.

The risk has been reviewed in light of ongoing industrial action and the cost of living challenge. Whilst there are mitigations in place should this be crystallised, there in no proposed change in score.

Date	Comments
21.10.19	Risk from 2018 BAF carried forward on new BAF aligned to new strategy
05.11.20	Risk reviewed – no changes made
06.01.21	Risk reviewed, minor changes made to content and to summary
28/06/21	Risk reviewed, minor changes to narrative
30/06/22	Risk reviewed, no proposed changes to score
09/11/22	No change in risk score proposed. General refresh of BAF
30/03/ 23	No change in risk score proposed
July 23	Risk reviewed, no change in score
Nov 23	Risk reviewed, no change in score
Mar 24	Risk Remains High at 16. No proposed change in risk score

Ambition 3
To use our resources wisely

LEAD DIRECTOR	**Chief Finance Officer**
LEAD COMMITTEE	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

3

RISK ASSESSMENT

Linked Risks *(scoring 16+ or Catastrophic for impact / 5 Severity on Risk Register)*

5773 (15) Capital Funding 23/24
5770 (15) Revenue Deficit 23/24

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
March 2024	4	4	16	4	4	16	4	3	12

Principal Risk: If the Trust does not use its resources effectively, and operate within agreed financial limits, this may impact the sustainability and quality of services

Overall Assurance Level

Amber

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

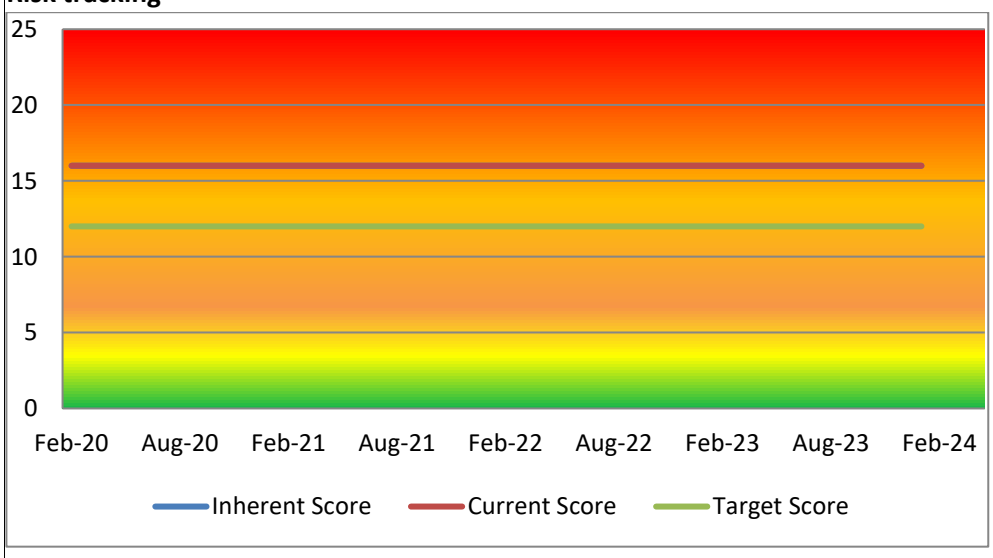
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Delivery of year-on-year cost improvements. Cost control and managing inflation effects. Shortage of revenue and capital funding. Meeting NHS England Productivity requirements. Working within GM ICB (jointly responsible and reliant on others results). ~~Achieving the System Efficiency Target~~	• Executive / CRIG approval of business cases • ~~Improvement and~~ PMO ~~Transformation Team~~ coordination of CIP • Monthly financial reporting to budget holders • Divisional accountability through IPM • Annual budget setting and planning processes • Finance department annual business planning process • Development of annual procurement savings plans • Monthly accountability letters ~~reporting~~ to DOF • Standing Financial Instructions • Scheme of Delegation • Establishment of Pay / Vacancy Control Group • Representation at Place Based Finance and Assurance Committee • Weekly Financial Improvement Group • Tracking of wte and headcount through Committees and Executive Groups • Weekly review of CIP programme through Executive and Financial Improvement Group • Finance and Intelligence Group reviews of productivity and actions to improve • ~~Establishment of the Financial Controls Committee and the Vacancy Control Panel~~	GM ICB overarching strategy and financial strategy.	**1st Line of Defence (Operational Management)** Capital Revenue Investment Group (CRIG) and Executive reports Reports to Integrated Performance Management Meetings Monthly cash flow forecast Reports to Finance and Intelligence Group (FIG) Review of Cost Improvement Programme at Finance Improvement Group **2nd Line of Defence (**reports and metrics monitored at Board/Committee) Reports to F&I including ○ Monthly Finance Reports ○ PLICs reporting ○ Cost improvement progress reports ○ Quarterly benchmarking ○ Procurement report ○ Monthly Chair's Report from CRIG to F&I SFI breach report to Audit committee Increased financial scrutiny at Financial Controls Committee Oversight from GM Financial Performance Review Meetings (FPRM) Action Log, Variable Pay Panel Report to People Committee from Vacancy and Variable Pay Panel Executive Director review and monitoring of FPRM Action Log and Financial Controls Committee (to be disestablished on 1 Apr) **3rd Line of Defence (independent/ semi-independent assurance)** • Internal and External audit reports • System Reports to Greater Manchester ICS and NHS England • Costing returns • National Agency Team reports • **PWC 'Turnaround' Teams Review** • **Monthly FPRM Meetings with ICB Turnaround Director**	Model Hospital benchmarking reporting to F&I Committee	Understand cost and income base through active use of patient level and roll out throughout organisation. ~~December 21~~ Ongoing and progressing into 2024 3-year financial strategy refresh subject to clarity on financial regime and ICS Financial Strategy ~~June 21 Dec 22 April 23~~ May 24 Closer / joint local working in Bolton System. Ongoing and progressing into 2024 ~~Develop overarching GM PMO Productivity reporting.~~ **Target completion December 23** Clarity on GM Financial Strategy which would inform local Strategic Planning. ~~December 23~~ **Target Completion May 24** ~~Progress actions against 'PWC Grip & Control Checklist' monitored through Financial Controls Committee.~~ **Completed**

3 **Ambition - To use our resources wisely**

Risk tracking



Background

The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of Using our resources wisely.

The Trust has now established a Finance and Controls Committee which has the overall responsibility for the Improvement Plan and is supported by the Vacancy Pay Panel chaired by CEO and the Finance Improvement Group.

Committee Feedback

Due to the timing of the Quality Assurance Committee, any feedback follwing review will be provided verbally.

Date	Comments
20.02.20	Full update to risk
May 20	Risk narrative updated
Nov 20	General Update – risk score reduced
Jan 21	Review to focus on strategic risks
Nov 22	Full review and revision of the timescales for completing the actions. There is no change in risk score
Mar 23	No change in risk score
Jul 23	The Ambition and Principal risk has been reviewed and this remains a high risk at 16.
Nov 23	No change in risk score
Mar 24	Risk reviewed - no change in risk score.

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

Lead Director	**Chief Finance Officer**	**4**
Lead Committee	**Finance and Investment Committee** F&I can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge	

Risk Assessment

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	Severity	Likelihood	Score	Severity	Likelihood	Score	Severity	Likelihood	Score
March 24	4	3	12	4	5	**20**	4	2	8

Linked Risks *(Scoring 16+ or Catastrophic for impact / 5 Severity on Risk Register)*

5958 (25) Estates Backlog
4060 (16) Electrical Distribution boards
1670 (16) Steam and condense services
5747 (15) Substation 10 Air circuit breaker replacements
6054 (15) Reinforced Autoclaved Aerated Concrete (RAAC)

Principal Risk: If the Trust does not sufficient capital resource to to deliver a building fit for the future, then this will impact the investment in a sustainable estate.

Overall Assurance Level

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

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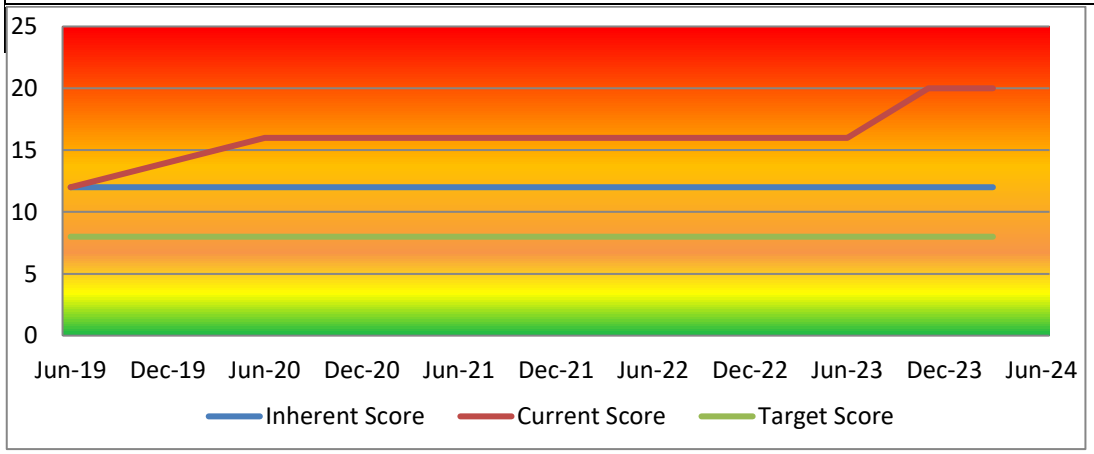
Treat. The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Shortage of capital and revenue funding • Changes to capital regime • High levels of backlog maintenance • Planning, traffic constraints to the site • Controllability of community estates not owned by BFT • Constraints around capital and revenue funding	• Estates Strategy and supporting Business Cases to make the case for external capital to CRIG, F&I, Board • Established links to GM and NHSI • Capital processes to ensure correct prioritisation • Links with local partners including LA, University • Membership of Bolton Strategic Estates Group	Digital Performance Management Framework being developed PDC bids / funding not linked to Strategy	**1st Line of Defence (Operational Management)** • Monthly review of business cases at CRIG and Executive Directors. • Estates Reports into Executive and Strategic Estates Group • Critical estates priorities presented to F&I and Trust Board • Monthly review performance data IPM meetings through Execs and DDO • Reports to the Digital performance and transformation Board which reports into sub-committees of the Board	Periodic reports from Bolton Strategy Estates Groups to	Developing dynamic 5-year Estates Strategy. **Ongoing** ~~6 facet survey reporting to Board annually.~~ ~~**December 23**~~ **Completed** ~~Digital Performance Management Framework being developed January 2023~~ ~~**July 2023**~~ **Completed** Introduce quarterly reporting from Bolton Strategy Estates Groups (**October 23 F&I** Revised target completion date to Q.1 24

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Lack of urgent capital investment to restore the estate to a suitable condition • If the Trust does not have a robust digital transformation and delivery plan, the organisation will be unable to function • Availability of investment for Digital programmes against need and expectations. • PDC bids/funding not linked to Strategy	• Premises Assurance Model • Enterprise Asset Management CAFM • Backtrac system • Agile Working Programme • Our Green Plan • Demolition and Disposal Strategy • IFM asset management • Digital Plan that maps back to the Trust strategy • Clinical Strategy • National RAAC team support	Re-establishment of Space Utilisation Group	**2nd Line of Defence (reports and metrics monitored at Board/Cttees** • Monthly review of Integrated performance report at F&I and Board • Annual Estates Report at Board **3rd Line of Defence (Independent Assurance)** • ERIC reports, Premises Assurance Model • Model Hospital estates and facilities metrics • Use of resources benchmarking • Locality Board oversight • Management Framework • NHS England IG Toolkit • Cyber Security national assessments		Re-establishment of Space Utilisation group. ~~September 23~~ Ongoing and continuing into Q.1 2024 ~~Develop a capital backlog program of work with a view to prioritise key schemes which will reduce risk profile~~. Jan 2024 Completed Manage the estates backlog capital program ~~April 2024~~ Ongoing and continuing into 2024 Monitor and manage the aging estate and escalate urgent issues with the estates. Ongoing and continuing into 2024

4 To develop an estate that is fit for the future

Risk Tracking



Background

The Finance and Investment Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition of developing an estate that is fit for the future.

Committee Feedback Due to the timing of the Quality Assurance Committee, any feedback follwing review will be provided verbally.

Date	Comments
25/02/20	Full page risk description added
15/05/20	Narrative updated
16/11/20	Update – risk score increased
06/01/2021	Review to focus on strategic risks/issues
30/06/22	Risk reviewed - no changes proposed
March 23	No change in risk score
July 23	No changes proposed to the Risk Score remains at 12.
Nov 23	Risk reviewed in light of new risk relating to Estates that currently has a risk score of 25. It is proposed that Committee approve the increase in risk score to 20.
Mar 24	Risk reviewed - no change in risk score.

Ambition 5
To integrate care

LEAD DIRECTOR	**Director of Strategy, Digital and Transformation**
LEAD COMMITTEE	**Strategy and Operations Committee** SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

RISK ASSESSMENT

Linked Risks *(Scoring 16+ or Catastrophic for impact / 5 Severity on Risk Register)*

There are no risks scoring 16+ to be included.

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
March 2024	4	4	**16**	4	3	**12**	4	2	**8**

Principal Risk: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

Overall Assurance Level: Amber

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

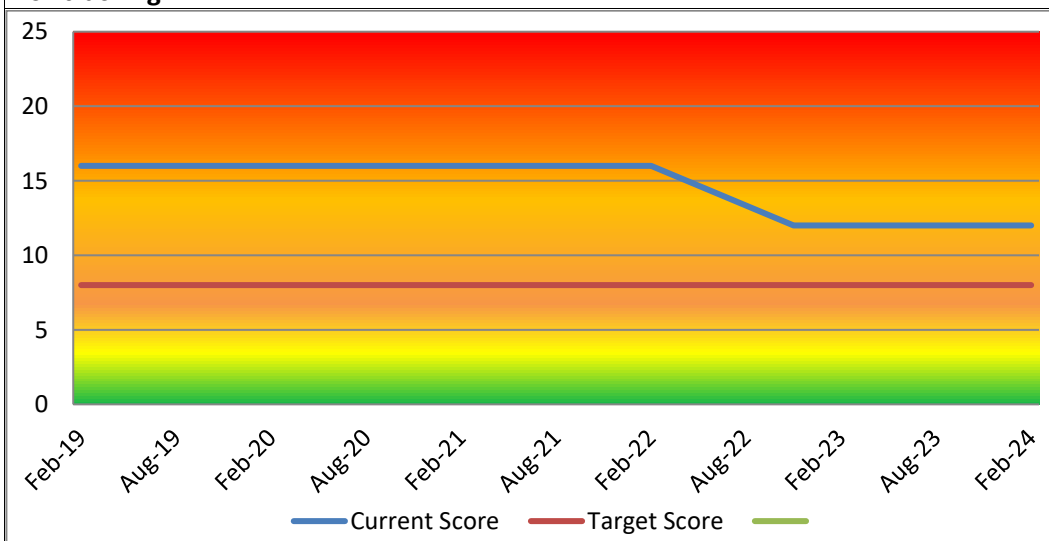
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls /assurance
If the organisation does not cooperate with its partners to understand, respond to and seek to improve population health, then the people of Bolton will not experience improved health outcomes, and demand for acute and community services will remain high in future **Causes** • Not understanding the impact of changes to the Health and Care Act 2022 • Impact of organisations financial Cost Improvement Programmes on the development of the ICP • If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development • Lack of collaboration with system partners to understand and respond to the wider determinants of health **Consequences** • Changes in the wider health economy may destabilise our organisation • the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future • potential fragment integration and slow development	• Community engagement plan developed for Bolton Locality • *Accountability for delivery of through the Place Based Lead* • Bolton Alliance Agreement to support the governance of the partnership • Representation at Locality Board and System Finance Board on use of the of the Bolton £ . • ICB Locality Delegation agreement with GM in place with *Governance model for delivery in place.*	• Refreshed Locality Plan, outcomes framework ~~Strategy~~ and ~~delivery plans in development~~ expected to be published in Spring 2024 • System transformation plan to transform services and drive integration being developed • System finance plan in development	***1st Line of Defence (Operational Management)*** Monthly report to Performance and Transformation Board on Community Transformation Report to Bolton Strategy Planning and Delivery Committee from 7 Transformation workstreams delivering against key priorities **2nd Line of Defence (Reports to board and Committees)** • Reports to the Strategy and Operations Committee including oversight of indicators through IPR • Spotlight on service transformation of the Neighbourhoods to SOC • Oversight of system finance and any impact to the FT through F&I and the Financial Controls Committee. • Oversight of Workforce Transformation through People Committee 3rd Line of Defence (independent and semi-independent assurance) Reports to Bolton Locality Meetings Reports to Bolton Health Overview and Scrutiny Committee Reports to GM scrutiny and oversight •Reports to Locality Board with engagement from key partners Reports to Locality Board and System Finance Board on use of the of the Bolton £ .	• New/immature structures – ongoing development including collaborative workshops across the system • Lack of agreed locality strategy, plans and approach to delivery (though these are in development and will be available in Q4 2023/24) • Fully functioning neighbourhood Teams in place **Q4 2023** • System transformation plans to transform services and drive integration are being developed and agreed • Locality workforce strategy being developed	• Revision and refresh of the Trust Strategy. **Q4 2023/4** • Locality strategy development by **Q4 2023/24** • ~~Development of a System Financial recovery Plan~~. Now superseded and enhanced by PWC Financial Recovery and Performance Committee. **Ongoing** • Development of System transformation plan to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the system to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.**Q.1 2024** • Refresh and embed the Locality ~~Strategy~~ Plan and ensure delivery **Ongoing**

5 **Ambition - To join up services to improve the health of the people of Bolton**

Risk tracking



Background

The Strategy and Operations Committee chaired by a non-executive director has oversight of the challenges and risks to achieve our ambition join up services to improve the health of the people of Bolton.

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update

Date	Comments
10/5/20	Inherent risk score 16 as of Feb19. Risk Narrative Reviewed
16/11/20	Risk Narrative Reviewed
16/11/21	Reviewed
17 May 22	Risk reviewed and updated following changes to national and local policies
16 Nov 22	No change to risk score as Risk remains Significant
March 23	Risk Reviewed, no change to risk score
July 23	Risk reviewed No Change to score Risk Appetite reduced to Seek from Mature. Approved at Strategy &Ops Committee 26.06.23
Nov 23	Risk reviewed No Change to score
March 24	Risk reviewed. No change to score

Ambition 6
To develop partnerships

Lead Director	**Director of Digital, Strategy and Transformation**
Lead Committee	**Strategy and Operations Committee** *SOC can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge*

6

Risk Assessment

Linked Risks *(Scoring 16+ or Catastrophic for impact / 5 Severity on Risk Register)*

	Inherent Risk Rating			Current risk rating			Target Risk Rating		
Date of last review	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
March 2024	4	4	16	4	3	**12**	4	**2**	**8**

Principal Risk: If the Trust fails to develop partnerships that support the achievement of our strategic ambitions, then this could result in a negative impact to the services we provide, our infrastructure and our financial position.

Overall Assurance Level

RISK APPETITE

1. **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
2. **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
3. **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
4. **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).
5. **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

RISK MANAGEMENT - Control of the Risk

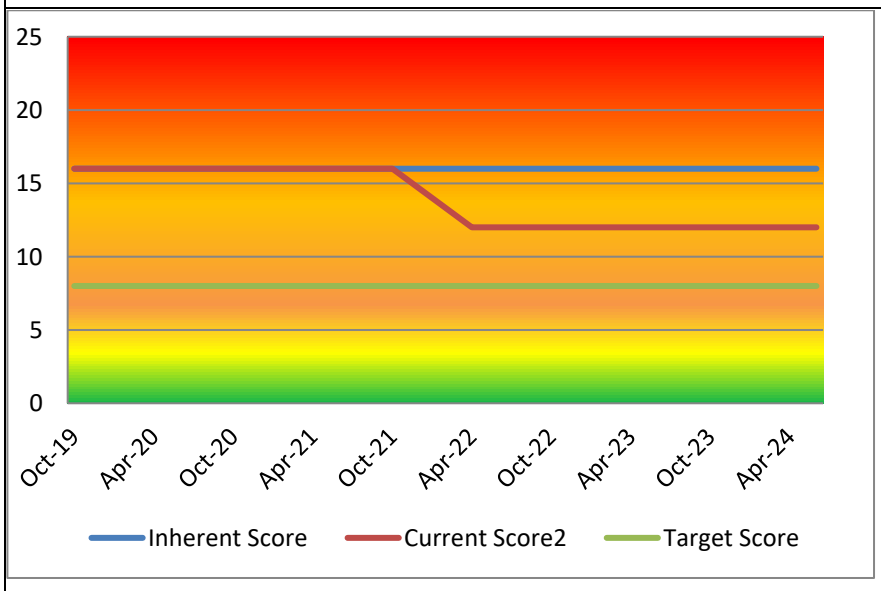
Having reviewed this Strategic Risk and considered the level of risk, the way in which it impacts the Trust and how it aligns with the risk appetite. It is proposed that the appropriate way to control the risk would be to:

Treat. *The purpose of taking action to reduce the chance of the risk occurring. Not necessarily to remove the risk, but to contain it to an acceptable level*

Issues impacting achievement of the objective	Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
Demand on services across Greater Manchester and workforce shortages are resulting in resilience issues in some services and requires different partnership approached to mitigate risk and could change the services we provide **Causes** • Resilience of GM clinical services • Increasing demand for services • Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services • Develop Provider Collaborative across GM • Sustainable Workforce Pipeline • Lack of relationships with neighbouring landowners and developers. • Missed opportunity for strategic partnerships **Consequences** • Inadequate workforce to deliver safe, effective care. • strategic partnership opportunities will be missed • adjacent land may be developed in a way that negatively impacts the Trust estate, meaning that our ambitions to improve our estate may be limited • Impact to access, experience and outcomes for the people of Bolton	• Strong Educational partnership through Bolton Health and Academic Partnership Board to support workforce development • Strong Private sector partnerships through Health Innovation Bolton Partnership • Attendance at Greater Manchester (GM) Trust Provider Collaborative (TPC)and its work streams • Participation in the GM Sustainable Services programme • Engagement through GM Exec Director Forums/ TPC • Reporting structure for Bolton Academic Partnership and Programme Management/Support • GM Joint Forward Plan • Regular meetings between Directors of Strategy for BFT and WWL • Increased productivity and partnerships through Clinical Diagnostics Centre	Substantive membership and participation in service transformation programmes within GM. Development of Local pathology, radiology and pharmacy clinical service strategies	***1st Line of Defence (Operational Management)*** Engagement with senior leaders on Strategy at Trust Provider Collaborative meetings (TPC) Health economics to understand future changes in demand which will influence our clinical Strategy Reports to Place Based Leadership Team ***2nd Line of Defence (Reports at Board and Committee Level)*** • Reports into People Committee • Reports into Strategy &~~ic~~ Operations Committee • Reports to Board and discussion at informal board meeting. • Board Development Day sessions ***3rd Line of Defence (Independent or Semi-independent assurance)*** Membership and attendance at GM Provider Collaborative Board and other Joint Leadership Group • Attendance at GM Director Forums • Membership of Health Innovation Bolton group • Report to the Bolton Health and Academic Partnership • Reports to the Bolton Health Innovation Partnership	• GM Sustainable Services work programme at an early stage though conversations ongoing through Directors of Strategy and Executive Medical Directors • Finalisation of GM network agreements • ~~Finalisation of GM Forward Plan~~	• Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **expected to be ongoing throughout 2024/25** • Continued participation in GM working group to shape and influence the developing programme - **expected to be ongoing throughout 2024/25** • Implementation of GM PACs and LIMS procurements **- Ongoing** • Finalisation of GM network agreements ~~July 2023~~ **Ongoing** • Development of Local pathology, radiology and pharmacy clinical service strategies **expected to be ongoing throughout 2024/25** • ~~Phase 2 of the CDC programme – Building Commenced~~ Completed • Completion Financial Plan and Digital Plan **- Ongoing** • Working group to move towards medical school - **expected to be ongoing throughout 2024/25** • Expansion of clinical courses and programmes mapped to workforce demand ~~**November 2023**~~ **Revised target completion date - expected to be ongoing throughout 2024/25** • Development of new programmes to fulfil recruitment issues e.g. health informatics ~~**November 2023**~~ **Revised target date - expected to be ongoing throughout 2024/25** • Production of a shared vision for the site and neighbouring land – **expected to be ongoing throughout 2024/25**

6 **To develop partnerships across GM to improve services**

Risk Tracking



Background

As a partner in the Greater Manchester Health and Social Care Partnership and the Bolton Locality we have prioritised the key actions we must take to achieve a sustainable Health and Social Care System.
We recognise there are services where the best solution to the challenge of limited resource is to work in partnership with other organisations.
As a foundation trust we have a duty to the public of Bolton to ensure their access to essential services is not compromised

Committee Feedback

Due to timing of the meeting, the feedback from the Strategy and Operations Committee will be included in the verbal update

Date	Comments
21/10/19	c/f and aligned to new strategy
05/11/20	Risk reviewed
08/01/21	Risk reviewed
16/11/21	Risk Reviewed
17/05/22	Risk Reviewed and Likelihood reduced to 3
16/11/22	Risk reviewed no change to risk score
March 23	Risk reviewed no change to risk score
July 23	Risk reviewed no change to risk score
Nov 23	Risk reviewed and no proposed change to risk score.
Mar 24	Risk review and no proposed change to risk score

Report Title:	Compliance with Fit and Proper Person's Test

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	Director of Corporate Governance		Decision	✓

Purpose	The purpose of this report is to provide assurance on the Trust's compliance with the Fit and Proper Person's Test FPPT Framework by March 31, 2024.

Summary:	The report confirms the Trust's adherence to the Fit and Proper Person Test (FPPT) Framework set by NHS England, ensuring that director-level appointees are suitable for their positions according to established regulations. The Trust has updated its policy to align with the FPPT Framework, which mandates that directors must have good character, appropriate qualifications, competencies, skills, and experience, and must not have a history of serious misconduct or mismanagement. The Trust has systems in place to ensure that only individuals who meet the FPPT standards are hired for director roles and to monitor ongoing compliance. Additionally, the Trust will integrate the Leadership Competency Framework (LCF) into annual director appraisals in the first quarter of the fiscal year 2024/25. The Chair will consider if all directors meet the 'fit and proper' criteria, and this will be reported in the NHS England Annual Review for 2023/24. Updates following the appraisals will be provided to the Remuneration and Nominations committees of the Board and Council of Governors.

Previously considered by:
N/A

Proposed Resolution	The Board is asked to receive this report as assurance of the Trust's Compliance with FPPT Framework and approve the Fit and Proper Person's Policy.

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

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

CQC	Care Quality Commission
FPPR	Fit and Proper Persons Regulations
FPPT	Fit and Proper Persons Test
NEDs	Non-Executive Directors
NHSE	NHS England

1. Introduction

1.1. The Fit and Proper Person's Test is set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities).

1.2. The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Tests' for Directors in November 2014, which became law from 1 April 2015.

1.3. In August 2023, NHS England issued a Fit and Proper Person Test (FPPT) Framework, to support compliance with the regulatory requirements, introducing new checks and balances. This approach ensures that providers meet Government regulations about the quality and safety of care, to ensure there's an open, honest and transparent culture within the NHS.

1.4. NHS England have requested organisations adopt the FPPT Framework by 31 March 2024.

1.5. The Director of Corporate Governance maintains the Trust's register to support compliance of the 'Fit and Proper Person Test'.

2. Background

2.1. The FPPT Framework is a regulation to ensure that providers meet their obligations to only employ individuals who are fit for their role. The regulations also extend to individuals who are prevented from holding the office (for example, under a Director's disqualification order)

2.2. In summary, Trusts must not appoint a person to an executive or non-executive director level post unless they meet the following criteria:

- Are of good character
- Have the necessary qualifications, competence, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement when providing a service.

2.3. In addition, Trusts must have processes in place to ensure the on-going fitness of executive and non-executive directors.

2.4. In August 2023, NHS England issued a Fit & Proper Person Test (FPPT) Framework, developed in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. Legislation has not changed; the new framework supports compliance and includes additions to the checks and balances to ensure directors satisfy regulatory requirements.

2.5. The Trust can confirm compliance with the NHS England requirements by 31st March 2024.

3. New Requirements

3.1. New requirements introduced via the FPPT Framework are summarised as:

- Additional checks of web-based registers to be completed on appointment for directors, with on-going annual review;
- A means of retaining information relating to testing the requirements of the FPPT using relevant fields added to the Electronic Staff Record (ESR);
- A set of standard competencies for all directors through a new appraisal proforma;
- A new way of completing board member references.

3.2. It remains the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

3.3. A Fit & Proper Persons Test Privacy Notice' will be issued to all directors, including details of information to be collected and processed in relation to the FPPT Framework.

4. Fit and Proper Person Policy

4.1. Included as part of this report is the Fit and Proper Person Policy that has been updated to reflect the requirements of the new NHS England FPPT Framework. The Policy details the processes in place to ensure compliance with both the Regulations and the FPPT Framework, and a process to deal with any concerns in this regard.

4.2. The Board of Directors is asked to review and approve the Policy, noting that the annual assessment for 2023/24 had been undertaken in line with the draft Policy.

5. Recruitment

5.1. As part of the recruitment process and compliance for the Fit and Proper Person Test, a number of checks are undertaken in addition to normal employment checks for all newly recruited board members. These checks are intended to provide assurance on the:

- Identity of the individuals
- Qualifications, competence, skills required, relevant experience and ability
- Consideration to the physical and mental health in line with the role and good occupational health practice
- Good character and conduct that the individual has been responsible for, or privy to which may have contributed to or facilitated any serious misconduct or mismanagement.

5.2. As part of ongoing compliance with FPPT, a bi-annual check is conducted by the DCG to ensure that all directors continue to meet the requirements to hold office of their appointment, where they do not, a recommendation would be made by either the Chief Executive/Chair to the Remuneration committee for Executive Directors and Nomination Committee for non-executive directors.

6. Annual Fit & Proper Person Assessment

6.1. An annual assessment of compliance with the Fit and Proper Person Test will be carried will be completed in May 2024. This will involve completion of all annual checks/reviews set out in the Board Fit & Proper Persons Checklist (Appendix 3 in the Policy).

6.2. Evidence of the above is held securely in individual files by the Director of Corporate Governance.

6.3. The Board Fit and Proper Person Checklists and Letters of Confirmation will be reviewed by the Chair, alongside each Board member's Fit & Proper Person Self-Attestation. If on completion of the review, the Chair concludes all directors continue to be 'fit and proper persons' this will be confirmed in the NHS England Annual Review 2023/24 (Appendix 6) submission.

7. Leadership Competency Framework

7.1. On 28 February 2024, NHS England published a new Leadership Competency Framework (LCF) which reflects seven principles of public life (Nolan principles), NHS values and aligns with NHS England Leadership Way and People Promise publications. It is a requirement under the FPPT Framework for organisations to incorporate the Leadership Competency Framework (LCF) into annual appraisals of all directors.

7.2. The LCF applies to all board members and is intended to complement and support the recommendations from the Kark 2019 review of Fit and Proper Tests. The recommendations included the "*design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed."*

7.3. The framework has been built around six competency domains which inform a series of competencies. The six domains are:

- Driving high quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Creating a compassionate, just and positive culture
- Building a trusted relationship with partners and community.

7.4. Appraisals for directors will be undertaken during Q1 2024/25, following which the Board Fit & Proper Person Checklist will be updated. The Chair will inform the Board of Directors should any information come to light that changes the outcome of the annual assessment as presented.

7.5. It is worth highlighting that the Trust will be adopting the revised Chair Appraisal Framework and will transition to the new board member appraisal framework once it has been published this autumn.

8. Next Steps

8.1. The LCF has been developed with a view to

- Support the appointment of diverse, skilled and proficient leaders
- Support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- Help organisations to develop and appraise all board members
- Support individual board members to self-assess against the six competency domains and identify development needs.

8.2. The competency domains will be incorporated into all new board member job descriptions and recruitment processes **by 1 April 2024**. They can be used to help evaluate applications and design assessment processes

8.3. The board member appraisals will be aligned to the competency domains to support the development of individuals and the whole board.

8.4. Whilst a new Board member appraisal framework to support the LCF will be published in autumn 2024, all board members will be asked and supported to self-assess using the scoring guide against the six competency domains as preparation for annual appraisal, incorporating development activity, for review with line managers.

Fit and Proper Person Policy

Document type:	Policy
Version:	Three
Author (name and designation):	Sharon Katema Director of Corporate Governance
Validated by	Procedural Document Oversight Committee
Date validated	
Ratified by:	
Date ratified:	
Name of responsible committee/individual:	Board of Directors
Name of Executive Lead (for policies only)	Director of Corporate Governance
Master Document Controller:	Trust Secretariat
Date uploaded to intranet:	
Key words	Recruitment, fit and proper
Review date:	21 March 2024

Version control

Version	Type of Change	Date	Revisions from previous issues
2	Review	13 August 20	Minor revision for job titles
3	Review	31 August 23	Full revision to reflect the changes and recommendations from Kark Review

Equality Impact

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHS FT aims to ensure that, none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).

Contents	

1. Introduction

1.1. Regulatory standards for the Fit and Proper Persons requirements for directors came into force for all NHS provider organisations from 27 November 2014. This was a direct response to the Francis report.

1.2. A Fit and Proper persons test is a statutory requirement outlined under Regulation 5 of the *Health & Social Care Act 2008 (Regulated Activities) Regulation 2014* (referred to as the 2014 Regulations)

1.3. It is the ultimate responsibility of the Chair to discharge the requirements placed on the Trust to ensure that all directors and 'equivalents' meet the fitness test and do not meet any of the unfit criteria.

2. Scope

2.1. This policy applies to all Directors and people performing "the functions of, or functions equivalent or similar to functions" of a Director. This includes rights.

- Executive Directors
- Non-Executive Directors
- Any other position designated by the Chair or Chief Executive as being a role that performs a function of, or functions equivalent or similar to those of a Director. For the avoidance of doubt, this would include Associate Non-Executive Director appointments, interim appointments, permanent, interim and associate positions, irrespective of their voting
- This includes those directors who were already in post when the 2014 Regulations came into force.

2.2. An individual falls under the requirement of the Regulated Activity Regulations regardless of whether they undertake the role on a permanent of interim basis.

3. Roles and Responsibilities

3.1. The Role of the Chair of the Trust

3.1.1 It will be the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria. This includes systems to ensure only those fit for the role of Director are appointed; regularly reviewing the fitness of Directors and having arrangements in place to respond to concerns about a person's fitness arising after appointment.

3.1.2 The Chair has overall accountability for arrangement in their organisation to ensure that:

- assessments are carried out for Board members on appointment and annually, and at any time that something new comes to light
- the Board Member Reference is completed for any Board member who leaves the Board for whatever reason, whether or not a reference has been requested
- assessments for the whole Board are concluded (executive and non-executive, permanent or temporary, voting or non-voting) and update Electronic Staff Record

- the annual summary is submitted to relevant regional director.

3.2. The Role of the Director of Corporate Governance

3.2.1 To inform the Chair of any concerns on the Fit and Proper Person Declaration or on checks of insolvency and bankruptcy registers and register of disqualified directors.

3.2.2 To work with the Senior Independent Director and carry out the Fit and Proper Person Test Assessment for the Chair.

3.2.3 To support the Chair in establishing arrangements for the Fit and Proper Person Test and for:

- testing elements of Fit and Proper Person test assessment and recording outcome and evidence for chair to review and conclude
- completing the annual submission form to NHS England

3.3. The role of the Director of People

To work with the Director of Corporate Governance and support the Chair in establishing arrangements for the Fit and Proper Person Test and specifically for accessing and entering information onto Electronic Staff Record

3.4. Role of the Senior Independent Director

With support from the Director of Corporate Governance

- carry out the Fit and Proper Person Test Assessment for the Chair:
- undertaking investigations into any concerns raised about the Chair

3.5. The Role of all Directors

To make self-declarations in a form prescribed by the Chair and provide any additional information required to demonstrate compliance with Regulation 5. Additionally all directors are asked to:

- Give their consent, on request, to the pre-employment checks described in Appendix 3;
- Provide evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position;
- Confirm that they are a fit and proper person on appointment (by signing the declaration provided in Appendix 4 for new directors) and thereafter on an annual basis;
- Identify any issues which may affect their ability to meet the statutory requirements on appointment and bringing any issues on an on-going basis to the Chair

3.6. The role of the Council of Governors

As a minimum the Governor Nomination and Remuneration Committee, and through them the Council of Governors, will need to satisfy themselves that the relevant checks as set out in this policy have been carried out and they will want to satisfy themselves that the Board has adequate assurances on the robustness of procedures.

3.7. The Role of the CQC

The CQC will examine how the Trust has discharged its responsibility under Regulation 5. It will test that the Trust understands the requirements of the Regulation and whether the Trust has put in place adequate and appropriate measures to ensure that they are met. It will confirm that the Trust has undertaken appropriate checks and is satisfied that all directors are of good character and not unfit on appointment and subsequently. This may involve checking personnel files.

3.8. The Role of NHS England

3.9. Standard condition G4 of the provider license requires that a Foundation Trust must not appoint or allow an unfit person to remain in post without Monitor's permission. At present Monitor's definition is the narrower definition set out in the Schedule 7 of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

4. Standards and Practice

4.1. Fit and Proper Person Definition

This is defined in Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 sets out the criteria that a director must meet on appointment, and on an ongoing basis. This mandates that a Trust must not appoint a person to a Director level post unless:

- they are of good character
- they have the necessary qualifications, competence, skills and experience for the relevant office or position or the work for which they are employed
- they are able by reason of their health, after reasonable adjustments are made, properly to perform tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
- they have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement in the course of carrying on a regulated activity
- not to be 'unfit' by any reason of matters in the paragraph below; and
- none of the grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations apply to them

4.2. The 'Unfit Person test' and considerations relating to 'Good Character'

Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (see Appendix 4) describes the unfit person test (part 1) and matters to be considered relating to 'good character' (part 2). Its purpose is to ensure that the Trust is not managed or controlled by individuals who present an unacceptable risk to the organisation or to patients.

Under Schedule 4, Part 1, a director is deemed unfit if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period applies under a debt relief order, which applies under prat VIIA (debt relief orders) of the Insolvency Act 1986(1);

- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.3. In determining whether an individual is of good character, consideration must be given to Schedule 4, Part 2:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

4.4. The document Regulation 5: Fit and proper persons: directors released by the Care Quality Commission in 2018 provides additional guidance to help providers interpret and implement the regulation. This guidance will be taken into account by the Trust in reviewing an individual's compliance with the Fit and Proper Person Test. The document outlines:

- Definitions of misconduct and mismanagement and when proven misconduct or mismanagement should be assessed as 'serious'
- Factors to consider around concerns regarding serious misconduct or mismanagement
- Features that would normally be associated with 'good character' and factors to consider when assessing 'good character'

5. Codes of Conduct

5.1. The Codes of Conduct for NHS Boards and NHS Managers set out the key public service values. They state that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:

- **Accountability:** Everything done by those who work in the authority must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity:** Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.
- **Openness:** The health body's activities should be sufficiently public and transparent to promote confidence between the authority and its staff and the public.

5.2. Directors must act in accordance with the *Standards of Business Conduct policy* with regard to any potential conflict of interest, including but not limited to offers of gifts, benefits, hospitality or sponsorship.

6. New Director Appointment

6.1. All appointments will be subject to the individual satisfactorily meeting the Fit and Proper Person Test prior to confirmation of offer of employment/office. An agreed sign-off process with all relevant

checks (Appendix 3) will be carried out prior to final checking by the Trust Chair or nominated deputy and conditional offer. This will include completion, by the individual, of a self-attestation (Appendix 3). All offers must be conditional on meeting the statutory requirements.

6.2. Where a senior level post or interim is sourced by an agency or executive search company, the agency will be made aware of the Trust's Fit and Proper Person Test process and must confirm that they have undertaken the necessary checks; compliance will be confirmed by the Trust.

6.3. Disclosure & Barring Service checks - Where the position and role of the director meets the eligibility criteria, a Disclosure & Barring Service check will be undertaken in accordance with the Trust's Recruitment Selection Policy.

6.4. Disqualification - A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.

6.5. Ineligibility of candidates - If the candidate fails to show that they meet the Fit and Proper Person Test as outlined in 4.1 above, the Trust will withdraw the provisional offer of employment.

7. Existing Directors:

7.1. Annual Review and Self-Attestation Process

7.1.1 The Trust is responsible for ensuring that relevant individuals continue to meet the Fit and Proper Person Test. This shall be done through an annual review which will be aligned with appraisal dates to ensure that outcomes are available for reference at individual appraisals. Documentation will include:

- Completion of the self-attestation form (Appendix 3) by the individual
- Annual checks against the disqualified directors register, the bankruptcy and insolvency register, the removed charity trustees register and relevant professional registers

7.1.2 The Chair will review and sign to confirm that the annual checks have been completed and that the person continues to meet the Fit and Proper Person Test. Confirmation of compliance will be declared in the Trust's Annual Report

7.2 Responsive Review Process

7.2.1 Circumstances may arise where concerns are raised about the Fit and Proper Person status of an individual, either by self-notification, or as a result of concerns raised by a third party.

7.2.2 Should this occur then a review should take place outside of the normal testing schedule

7.3 Action required via Annual / Responsive Review process

7.3.1 If an individual is deemed competent but does not hold relevant qualifications, there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director.

7.3.2 If an individual is deemed unfit (they failed the Fit and Proper Person Test) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member. In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England

regional director for review, either as part of the annual Fit and Proper Person Test submission for the NHS organisation, or on an ad hoc basis as a case arises.

7.3.3 If an individual is deemed to no longer meet the Fit and Proper Persons Test (either through the annual review process, or via a responsive review), the Chair will be notified and is responsible for making an informed decision regarding the course of action to be followed.

8. Dispute Resolution

8.1. Outcome of Fit and Proper Person Test assessment

Where a board member disagrees with the outcome of the Fit and Proper Person Test assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
    - Where this results in a board member being terminated from their appointed role, a Board Member Reference must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
    - NHS organisations may wish to take their own legal advice or seek advice from NHS England.
- At any point, employees have the right to take the matter to an Employment Tribunal.

8.2. Data and information

8.2.1. Where a board member identifies an issue with data held about them in relation to the Fit and Proper Person Test, they should request a review which should be conducted in accordance with local policies in the first instance.

8.2.2. Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and Non-Executive Directors and Integrated Care Board Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the Senior Independent Director or deputy chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
    - referring the matter to the Information Commissioner's Office
    - taking the matter to an employment tribunal (for executive director roles only)
    - instigating civil proceedings.

8.3. Personal data

8.3.1. Personal data of board members relating to the Fit and Proper Person Test assessment will be retained in local record systems and on the NHS Electronic Staff Record.

8.3.2. Fit and Proper Person Test outcomes must be entered onto Electronic Staff Record so that an Electronic Staff Record Fit and Proper Person Test Dashboard can reviewed by the Chair. Once satisfied, the Chair must update and sign off each Board member on Electronic Staff Record.

8.3.3. An annual submission form (Appendix 6) will be generated for Chair sign off and submitted to the NHS England Regional Director, where the NHS England Fit and Proper Person test central team will collate records from NHSE regions

8.4. Board Member Reference Request

8.4.1. NHS organisations will need to request board member references (Appendix 7), and store information relating to these references so that it is available for future checks; and use it to support the full Fit and Proper Person test assessment on initial appointment.

8.4.2. NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally on Electronic Staff Record.

8.4.3. Board member references will apply as part of the Fit and Proper Person test assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

- New appointments that have been promoted within an NHS organisation.
- Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
- Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.
- Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

9. Monitoring Compliance

Area to be monitored	Methodology	Who	Reported to	Frequency
Self-Declaration Forms for new appointments retained on personal file.	Audit	Trust Secretary/Director of Corporate Governance	Chairman	Annual
Self-Declaration Form for those in post completed annually	Audit	Trust Secretary/Director of Corporate Governance	Chairman	Annual

Appendix One

Core public information sources that CQC believe are relevant for Trusts to use as part of their FPPR due diligence (this list is not exhaustive):

- Any provider whose registration had been suspended or cancelled due to failings in care in the last five years or longer if the information is available because of previous registration with CQC predecessor bodies.
- Public inquiry reports about the provider.
- Information where we the CQC notified about any relevant individuals who have been disqualified from a professional regulatory body. This information would be shared with the individual and the provider in accordance with the Data Protection Act.
- Serious case reviews relevant to the provider.
- Homicide investigations for mental health trusts.
- Criminal prosecutions against providers.
- Ombudsmen reports relating to providers.

Appendix 2 - Fit and Proper Person Test Declaration

Bolton NHS Foundation Trust Annual / new starter self-attestation	
Declaration	**Confirmed Yes/No**
I am of good character by virtue of the following:	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years	
• I am not an undischarged bankrupt	
• I am not the subject of a bankruptcy order or an interim bankruptcy order	
• I do not have an undischarged arrangement with creditors	
• I am not included on any barring list preventing them from working with children or vulnerable adults	
I Have the qualifications, skills and experience necessary for the position I hold on the Board	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider	
I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.	
Signed	
Name	
Position	
Date	
For chair to complete	
Signature of chair to confirm receipt:	•
Date of signature of chair:	•

Appendix Three

Bolton NHS Foundation Trust Fit and Proper Persons File Check List	
Name	
Position	
Date commenced in post	
Recruitment Source	

	Criteria for checking	Outcome
Pre-employment checks	Photo ID	
	Satisfactory References	
	Employment History (application form or CV)	
	Occupational Health Clearance	
	Relevant qualifications	
Fit and Proper Persons Checks	Fit and Proper Person self-declaration	
	Disqualification of Directors check	
	Bankruptcy check	
	Disclosure and Barring Service (DBS)	
	Date of last appraisal	
Good Practice	Board code of conduct completed and signed	
	Declaration of interests completed	
	Checklist completed by	
	Name	
	Position	
	Date	

Appendix 4

Regulation 5 – Schedule 3: Information required in respect of persons employed or appointed for the purposes of a regulated activity

1. Proof of identity including a recent photograph.

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(**1**), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(**2**).

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—

(a) health or social care, or

(b) children or vulnerable adults.

5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.

6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

9. For the purposes of this Schedule—

(a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;

(b) "satisfactory" means satisfactory in the opinion of the Commission;

(c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Appendix 5 - Annual NHS Fit and Proper Person Test submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: Fit and Proper Person Test outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: Fit and Proper Person Test reviews / inspections

Use this section to record any reviews or inspections of the Fit and Proper Person Test process, including Care Quality Commission, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Care Quality Commission				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [NAME OF TRUST] [YEAR]				
For the Senior Independent Director/Deputy Chair to complete:				
Fit and Proper Person Test for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the Fit and Proper Person Test being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the Fit and Proper Person Test submission is complete, and the conclusion drawn is based on testing as detailed in the Fit and Proper Person Test framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 6 - Board Member Reference

Bolton NHS Foundation Trust – Board Member Reference

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Bolton NHS Foundation Trust – Board Member Reference Request for NHS Applicants

Board Member Reference request for NHS Applicants:
To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in Electronic Staff Record under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS)

(This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)

Date Disclosure and Barring Service check was last completed.	Date
Please indicate the level of Disclosure and Barring Service check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □

10. Did the check return any information that required further investigation?	Yes □	No □

If yes, please provide a summary of any follow up actions that need to/are still being actioned:

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**	Yes □	No □

• **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the Care Quality Commission definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	no	
	• Ethnic origins (including gypsies and travellers)	no	
	• Nationality	no	
	• Gender (including gender reassignment)	no	
	• Culture	no	
	• Religion or belief	no	
	• Sexual orientation	no	
	• Age	no	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	no	
2.	**Is there any evidence that some groups are affected differently?**	no	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	no	
4.	**Is the impact of the document/guidance likely to be negative?**	no	
5.	**If so, can the impact be avoided?**	no	
6.	**What alternative is there to achieving the document/guidance without the impact?**	no	
7.	**Can we reduce the impact by taking different action?**	no	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Co-ordinator together with any suggestions as to the action required to avoid/reduce this impact.

Document Development Checklist

Type of document	Fit and Proper Person Policy
Lead author:	Sharon Katema, Director of Corporate Governance
Is this new or does it replace an existing document?	Replaces fit and Proper Person Policy version one
What is the rationale/ Primary purpose for the document	To outline the Trust process for ensuring directors of the Trust meet the "Fit and Proper Person" requirements
What evidence/standard is the document based on?	Statutory requirement outlined under Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 (referred to as the 2014 Regulations)
Is this document being used anywhere else, locally or nationally?	Statutory requirement
Who will use the document?	Trust staff
Is a pilot run of the document required? (optional)	No
Has an evaluation taken place? What are the results? (optional)	No – review of existing policy with minimal changes
What is the implementation and dissemination plan? (How will this be shared?)	Review of existing policy.
How will the document be reviewed? (When, how and who will be responsible?)	The regulations will be reviewed regularly with the policy updated as required.
Are there any service implications? (How will any change to services be met? Resource implications?)	No
Keywords (Include keywords for the document controller to include to assist searching for the policy on the Intranet)	Fit and Proper Person, director recruitment
Staff/stakeholders consulted	No material change
If the document refers to a medicine, has the reference been reviewed by the senior divisional pharmacist.	N/A
EIA	Completed by Sharon Katema Director of Corporate Governance
Signed and dated By validating officer	.....
Signed and dated By ratifying officer	....

Report Title:	Modern Anti-Slavery Statement

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	28 March 2024		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Purpose	The Anti-Slavery and Human Trafficking Statement for 2023/24 seeks to provide assurance on the Trust's compliance with the Modern Slavery Act 2015.

Summary:	From October 2015, there has been a requirement for all UK businesses with a turnover of £36m or more to complete a slavery and trafficking statement for each financial year. The Trust is committed to ensuring that there is no modern slavery or human trafficking in its supply chains or in any part of its business. All internal policies replicate the Trust's commitment to acting ethically and with integrity in all our business relationships. The Board of Directors are asked to confirm that every member has considered and approves this statement and will continue to support the requirements of the legislation. The attached statement will be included in our Annual Report for 2023/24 and will also be published on our website.

Previously considered by:
Is presented annually in line with the Board Workplan.

Proposed Resolution	The Board is asked to **approve** the Anti-Slavery Statement

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

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

1. Introduction

1.1. In line with requirements of the Modern Slavery Act 2015, this paper sets out the Bolton NHS FT, including its wholly owned subsidiary Integrated Facilities Management (IFM) Anti-Slavery and Human Trafficking Statement for 2023/24 to the Board for approval.

1.2. The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). It includes a provision for large businesses to publicly state each year the actions they are taking to ensure their supply chains are slavery free.

1.3. The 'slavery and human trafficking statement' must include either an account of the steps being taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any part of its business or its supply chains. Or a statement that the organisation is not taking any such steps (although this is permitted under the Act, it is likely to have public relations repercussions).

1.4. The statement must be formally approved by the organisation, and must be published on its website. Failure to do so may lead to enforcement proceedings being taken by the Secretary of State by way of civil proceedings in the High Court.

2. Modern Slavery and Human Trafficking Act 2015 Annual Statement 2023/24

2.1. All organisations carrying on business in the UK with turnover of £36m or more must from October 2015 complete a slavery and human trafficking statement for each financial year.

2.2. Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

3. Aim of this Statement

3.1. The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking. All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

4. About Us

4.1. Bolton NHS Foundation Trust is a major provider of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital and also providing a wide range of community services from locations across Bolton.

4.2. The Royal Bolton Hospital is a major hub within Greater Manchester for women's and children's services and is the second busiest ambulance- receiving site in Greater Manchester. We employ approximately 6000 staff and in 2023/24 had a turnover of over £400m.

5. Organisational policies in relation to slavery and human trafficking.

5.1. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

5.2. **Recruitment policy:** We operate a robust recruitment policy including conducting eligibility to work in the UK checks for all directly employed staff. External agencies are sourced through the NHS England nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

5.3. **Safeguarding Policies:** All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking. All staff are required to undertake level one adult safeguarding training which includes an awareness of the risks of modern slavery and human trafficking.

5.4. **Raising Concerns (Whistleblowing) Policy:** We operate a whistleblowing policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

5.5. **Equal Opportunities:** We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all statutory and regulatory requirements. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

5.6. These and other internal policies are in place, to protect those that we, and our delivery partners, work with from modern day slavery and human trafficking ensuring that:

- Staff can report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.
- All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices.
- Staff are able to raise concerns through the Freedom to Speak Up Guardian, about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisal.

- Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team.

6. Organisational Structure and Supply Chains

6.1. The Trust policies, procedures, governance, and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our subsidiary organisation iFM Bolton and through any managed service provider contract arrangements.

6.2. The treatment of employees is managed consistently across the Trust by the Human Resources Directorate. The Trust pays above both the national minimum wage and the national living wage thresholds set by the Government.

6.3. To play our part in eradicating modern slavery and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Apply NHS Terms and Conditions for procuring goods and services (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.
- Comply with the Public Contracts Regulations 2015, use reputable frameworks where appropriate and for any procurement processes the Trust uses the mandatory Crown Commercial Services (CCS) Standard Selection Questionnaire. Bidders are always required to confirm their compliance with the Modern Slavery Act.
- Ask our awarded suppliers to, sign up to the NHS Terms and Conditions for procuring goods and services which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains.
- In addition, an increasing number of NHS suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories, as referenced in the Government's Modern Slavery Strategy.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2024

Signed

28 March 2024

Report Title:	Gender Pay Gap Report March 2023 Reporting Period

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	28 March 2024		Discussion	
Exec Sponsor	James Mawrey		Decision	✓

Purpose	The purpose of this report is to present the Gender Pay Report following review at People Committee.

Summary:	The People Committee received the Gender Pay Gap report in February, 2024. The following key matters were noted:- • Over the last 12 months the Trust's gender pay gap has reduced in both the median and mean measures. Overall on a median indicator men earn more than women by 9.83% which is an overall decrease in the median gender pay gap of 4.65%. Overall on a mean average men earn more than women by 25.9% meaning the gender pay gap has reduced by 2.4%. • If medical staff are removed from the calculations our mean Gender Pay Gap reduces to 4.2%. If medical staff were removed from the calculations our median Gender Pay Gap reduces to 1.43%. Therefore the disparity between our gender pay is tilted by our medical workforce which historically was a male dominated profession. • The People Committee were also advised about the Gender Pay Gap disparities by Band; by Full time / Part time colleagues and by Bonus Payments (Clinical Excellence Awards are regarded as bonus payments under the guidance). • Whilst the Committee heard of the underlying drivers to the Gender Pay Gap it was accepted that further progress is of course required. With this in mind the Committee supported the actions that are being taken on this matter (outlined in the appendices) and noted that they will receive an annual update on the progress being made. They also asked that the next paper consider setting internal trajectories so we can better understand the incremental improvements that need to be made year by year.

Previously considered by: NA

Proposed Resolution	The Board of Directors are asked to **receive** the Gender Pay Gap Report and **approve** its publication on the Trust website.

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

Prepared by:	Deborah Lowe	**Presented by:**	James Mawrey, Deputy CEO & Director of People

Executive Summary for Board

The People Committee received the Gender Pay Gap report in February 2024.

In summary the People Committed noted:-

- Over the last 12 months the Trust's gender pay gap has reduced in both the median and mean measures. Overall on a median indicator men earn more than women by 9.83% which is an overall decrease in the median gender pay gap of 4.65%. Overall on a mean average men earn more than women by 25.9% meaning the gender pay gap has reduced by 2.4%.

- If medical staff are removed from the calculations our mean Gender Pay Gap reduces to 4.2%. If medical staff were removed from the calculations our median Gender Pay Gap reduces to 1.43%. Therefore the disparity between our gender pay is tilted by our medical workforce which historically was a male dominated profession.

- The People Committee were also advised about the Gender Pay Gap disparities by Band; by Full time / Part time colleagues and by Bonus Payments (Clinical Excellence Awards are regarded as bonus payments under the guidance).

- Whilst the Committee heard of the underlying drivers to the Gender Pay Gap it was accepted that further progress is of course required. With this in mind the Committee supported the actions that are being taken on this matter (outlined in the appendices) and noted that they will receive an annual update on the progress being made. They also asked that the next paper consider setting internal trajectories so we can better understand the incremental improvements that need to be made year by year.

- The Trust Board is asked to note the details contained within this report and agree that the People Committee oversee the resulting actions.

Gender Pay Gap Report presented to the

People Committee in February, 2024

1. Background

1.1 In 2017 the Government introduced legislation that made it statutory for organisations with 250 employees or more to report annually on their Gender Pay Gap (GPG). The GPG reporting requirements are detailed within The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

1.2 The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally based on their gender. Understanding the difference is important because the solutions to the gender pay gap are different to those required to ensure equal pay. It may be surprising, but it is possible to have genuine pay equality and still have a significant gender pay gap. For example if a company employs 11 people, ie; 10 engineers and one managing director, the 10 engineers (nine women and one man) all earn exactly £50,000 per year so they are all on equal pay. The managing director, who happens to be a man, is on £100,000 per year. The average salary for women in the organisation is £50,000 per annum while the average pay for men in the organisation is £75,000 per annum (£50,000 + £100,000 ÷ 2), a gender pay gap of £25,000 or 50%. All NHS organisations manage equal pay through robust job evaluation systems, these systems ensure that pay for work of equal value is recognised; for example, a male nurse and female nurse entering nursing with some qualifications and experience are paid the same pay scale; however, the best job evaluation system will not address the gender pay gap if an organisation has a majority of men in higher-paid roles.

1.3 The Gender Pay Gap is calculated and reported as six measures based on the hourly rates of pay and the bonuses of all eligible employees on a snapshot date, which for Public Sector organisations is 31st March 2023:

i. percentage of men and women in each hourly pay quarter

ii. mean (average) gender pay gap using hourly pay

iii. median gender pay gap using hourly pay

iv. percentage of men and women using bonus pay

v. mean average gender pay gap using bonus pay

vi. median gender pay gap using bonus pay

1.4 The cause of the gender pay gap is complex, and as the report will show there are certain issues peculiar to specific staffing bands / levels. Understanding these peculiarities is important as this will help to address the gender pay gap disparity in the years to come via robust actions.

2. What do the calculations mean?

2.1 The information in this report demonstrates the gender pay gap taking into account all Trust employees (excluding iFM).

2.2 Definitions of the terminology used in this report are included in appendix 1 of this report. When reporting the gender pay gap, both mean and median averages are used.

2.3 The median is often used as a headline measure because it's less swayed by extreme values, particularly the small number of people on high salaries.

2.4 The mean is useful because it does capture the effect of a small number of high earners. This is something we're interested in, given that women's responsibilities beyond work have traditionally limited their access to higher-level, higher-paid jobs.

2.5 The difference between an organisation's mean and median pay gap can provide valuable insight. The presence of very low earners can make the mean smaller than the median. A group of very high earners can make the mean larger than the median.

2.6 The bonus pay gap is intended to reflect the distribution of bonus payments made to male and female employees in the 12 months to 31st March 2023. As an NHS organisation the only pay elements that fall under the bonus pay criteria are within the medical workforce, i.e. distinction awards and clinical excellence awards.

3. Key Findings

3.1 Our Workforce

We collected our gender pay gap data on the snapshot date of 31st March 2023. At this time there were 6311 staff employed in the Trust. Of those 5382 (85%) were female and 929 (15%) male.

3.2 Hourly Pay Gap

Over the last 12 months the Trust's gender pay gap has reduced in both the median and mean measures. The tables below show the mean and median hourly rates by gender and the overall percentage pay gap as at March 2022 and March 2023.

The data indicates that:

- Overall on a median indicator men earn more than women by 9.83% which is an overall decrease in the median gender pay gap of 4.65%.
- Overall on a mean average men earn more than women by 25.9% meaning the gender pay gap has reduced by 2.4%.

2022

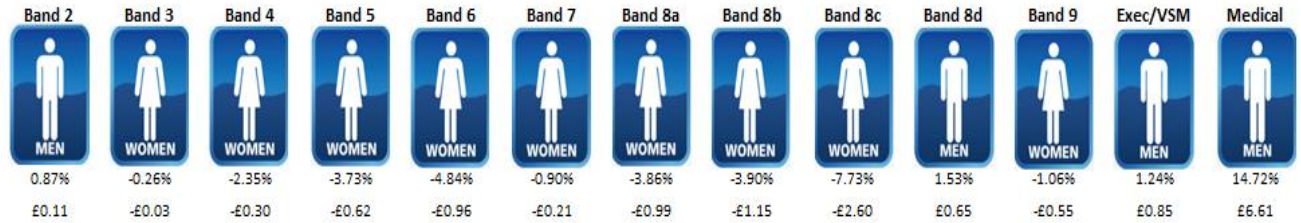
Gender	Mean Hourly Rate	Median Hourly Rate
Male	£ 24.3	£ 18.9
Female	£ 17.4	£ 16.1
Difference	£ 6.9	£ 2.7
Pay Gap %	28.3%	14.48%

2023

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£ 24.5	£ 18.6
Female	£ 18.1	£ 16.7
Difference	£ 6.3	£ 1.8
Pay Gap %	25.9%	9.83%

3.3 Pay Gap by Band

3.3.1 Mean



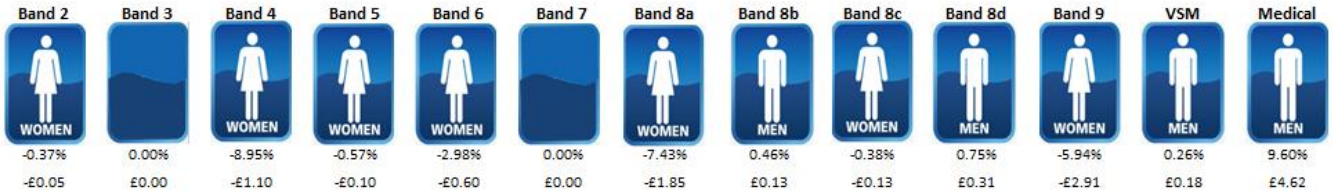
Variation from 2022

-5.49%	-0.66%	-2.37%	-0.17%	-0.23%	-0.88%	-1.44%	-1.91%	-2.22%	-10.27%	-3.27%	2.14%	4.38%
F	F	F	F	F	F	F	F	F	F	F	M	M

- On the mean indicator, **women earn more** than men in bands 3-8c, and 9.
- On the mean indicator, **men earn more** than women in bands 2, 8d, VSM and medical grades

If medical staff are removed from the calculations **our** mean **Gender Pay Gap reduces to 4.2%**. Therefore the disparity between our gender pay is tilted by our medical workforce which historically was a male dominated profession.

3.3.2 Median



Variation from 2022

-0.54%	-0.97%	-8.95%	-19.76%	-17.84%	-6.92%	-0.14%	2.50%	1.04%	-13.03%	-6.51%	-2.13%	4.76%
F	F	F	F	F	F	F	M	M	F	F	F	M

- On a median measure, **women earn more** than men in bands 2,4,5,6,8a,8c, and 9.
- On a median meaure, **men earn more** than women in bands 8b, 8d, VSM and Medical grades

If medical staff were removed from the calculations **our median Gender Pay Gap reduces to 1.43%**.

3.4 Full/ Part time Gender pay gap

The table below shows the mean and median pay gaps for full and part time staff.

Mean	Full Time	Part Time
Men	£24.85	£23.00
Women	£18.65	£17.65
Difference	£6.20	£5.35
Gender Pay Gap%	24.95%	23.26%

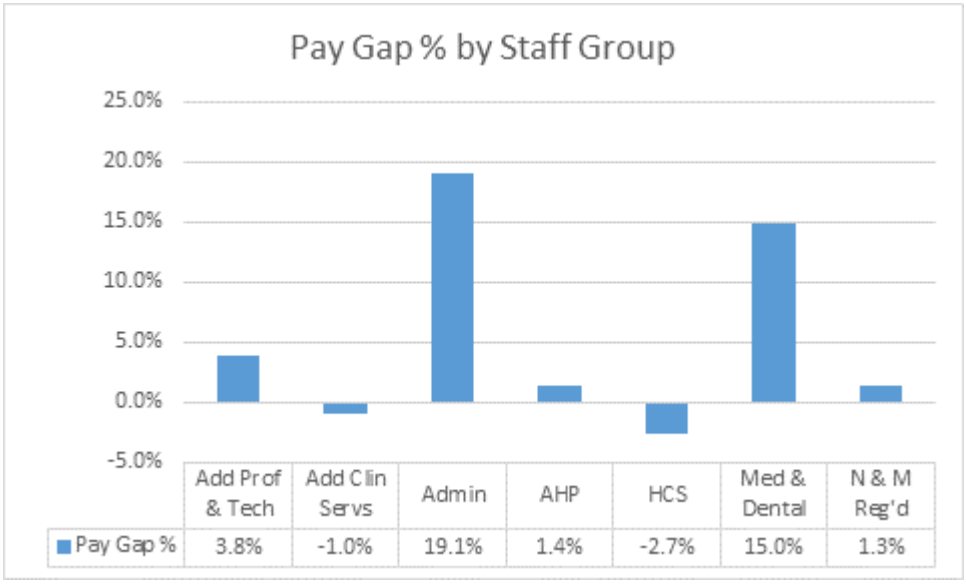
Median	Full Time	Part Time
Men	£18.10	£17.26
Women	£16.75	£16.75
Difference	£1.35	£0.51
Gender Pay Gap%	7.46%	2.95%

There is a slightly higher pay gap for full time staff than for part time staff, although the pay gap for part time staff is still signifcant at 23.26% (mean) and 2.95% (median).

3.5 **Analysis by staff group**

3.5.1 In order to provide further understanding of the gender pay gap a breakdown of mean gender pay gap by staff group is below:

Mean Pay Gap by Staff Group



3.5.2 The staff group with the largest mean pay gap is Administrative and Clerical, where the mean hourly pay rate is 19.1% higher for men than for women. This group includes corporate and senior management posts, as well as administrative and clerical staff. There are 1263 staff in this group, of which 200 are men (16%). The median pay gap for this staff group is 17.4%. As mentioned earlier, where the mean is higher than the median this can indicate that a group of high earners are impacting the average.

This is followed by the medical and dental staff group, where the mean hourly pay rate is 15% higher, and the median 9.6% higher. Of the 429 staff in this group, 221 are men (52%).

Staff groups where women receive a marginally higher mean hourly rate than men are Additional Clinical Services (1% higher) and Healthcare Scientists (2.7% higher).

The 'Estates and Ancillary' staff group has been excluded from this chart, as at the time of reporting there were only 2 employees in this staff group, both of whom were male.

3.6 Bonus Pay Gap

We are required to report on the gender pay gap for bonus awards. Agenda for Change (AFC) staff are not eligible for bonus awards. This metric is therefore focused on payment of the consultant Clinical Excellence Awards (CEA) and Distinction Awards (Staff Grade).

Bonus pay gap is set out in the charts below:

2022 (Bonus)

Gender	Mean Pay	Median Pay
Male	£ 11,299.4	£ 9,048.0
Female	£ 10,569.5	£ 9,048.0
Difference	£ 729.9	£ -
Pay Gap %	6.5%	0.0%

2023 (Bonus)

Gender	Mean Pay	Median Pay
Male	£ 12,722.7	£ 9,048.0
Female	£ 10,028.4	£ 9,048.0
Difference	£ 2,694.2	£ -
Pay Gap %	21.2%	0.0%

2022

Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	59	834	7.07%
Female	32	5156	0.62%

2023

Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	49	954	5.14%
Female	30	5516	0.54%

Points of note are:

- Since 2018 the local Clinical Excellence Award monies have been shared equally amongst all eligible consultants. Those that were given awards in 2018 under the previous scheme arrangements have maintained those awards, therefore there has been no opportunity to redress any bonus pay gap during that period under the local scheme.

3.7 Next Steps

3.7.1 It is important to note that gender pay gap cannot be 'fixed' quickly and longer terms solutions are required in order for it to reduce. The complexities of this agenda means it may take many decades for this to happen.

3.7.2 Staff Networks - The Trusts' Gender Staff Network has recently been established and has held a number of listening events. As a new network there is significant opportunity for the group to review the findings of this report, consider opportunities to improve opportunities for female staff and work to reduce the Gender Pay Gap.

3.7.3 Recruitment / Promotion - All Trust adverts and advertising materials (e.g. Job Descriptions, and Person Specifications etc.) are reviewed and approved by our HR team before being advertised to ensure they do not contain any discriminatory statements. Good practice is already in place around shortlisting processes, to ensure fairness and equality of the process at this stage. The Trust TRAC e-recruitment system ensures that applications to Trust employment are shortlisted on the basis of skills, experience, education and knowledge only (no personal details such as name / gender etc. are provided to shortlisting panels). This eliminates, as much as possible,

any potential for discrimination at application stage. Interview panels comprise at least two people, to increase objectivity of decision making, and other assessments are encouraged to further increase objectivity- e.g work related testing; criteria based interviewing against defined criteria. . Guidance is provided to every interview panel stating that interview questions should be based on role requirements only.

3.7.4 Flexible working - The Trust has recently introduced a new Flexible Working Policy, which ensures no flexible working request is declined by an immediate line manager without it being escalated for wider consideration. This facilitates managers looking more creatively to support requests wherever possible. In addition, new retirement options introduced, including the ability to draw down pension whilst remaining in your current role gives staff the opportunity to increase their work life balance. This is likely to be beneficial for staff with caring responsibilities, more likely to be female. There have been flexible working sessions held as part of the Our Voice programme, looking at understanding staff's lived experience and ensure that feedback informs reality and the gap between espoused policy and real life and real changes and improvements can then be made.

3.7.5 Celebrating - Friday, 8th March is International Women's Day. We will promote this within the Trust, and also to use this as an opportunity to promote the Staff Gender Network, to encourage staff to work with us on closing our gender pay gap. The Health and Care Women's Leaders Network is holding a webinar to highlight and celebrate work underway to progress gender equality and enhance inclusivity for women working in healthcare. This will be promoted via Trust communications and awareness raised of the Health and Care Women Leaders network, a free network for all women working across health and social care.

4 Recommendations

The People Committee are asked to:

- Note the details of the gender pay report and the requirements for the details to be published by the end of March 2024.
- Note the actions that have been taken in regard to this agenda, along with the actions that will be taken moving forward. All actions will be overseen by the EDI Steering Group

Appendix 1

Definitions / Explanations

The percentage of men and women in each hourly pay quarter

This is designed to show the spread of employees across salary ranges. The assumption is that for most organisations women will be concentrated in the lower quartiles but men will be concentrated in the upper quartiles.

The mean hourly rate

The difference between the mean (average) hourly pay of men, and the mean (average) hourly pay of women. It is calculated by adding up all the hourly rates of men or women and then dividing by the number of men or women.

The median hourly rate

The difference between the median hourly pay for a man and the median hourly pay for a woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

The bonus payment percentages

These are intended to reflect the distribution of bonus payments made to men and women employees, who were paid bonus pay in the 12 months up to the 31st March 2023. As an NHS organisation the only pay elements that fall under the bonus pay criteria are within the medical workforce - distinction award (Staff grade and associate specialist) and clinical excellence awards (consultants).

The mean bonus

The difference between the mean (average) bonus pay paid to men, and bonus pay paid to women.

The median bonus

The difference between the median bonus pay paid to men and the median bonus pay paid to women

The mean and median pay and bonus gaps

These are expressed as a percentage. So if our mean gender pay gap, for example is 15% this means that women in the workforce are paid 15% less than the men in the workforce or 85p for every £1 paid to men. If the gap is a negative percentage this means that men are paid on average less than female employees.

Appendix 2 – Gender breakdown by band

Band	Female	Male	Grand Total	% Males
Apprentice	4		4	0
Band 2	1196	138	1334	10
Band 3	620	88	708	12
Band 4	444	53	497	11
Band 5	1142	139	1281	11
Band 6	969	133	1102	12
Band 7	514	65	579	11
Band 8A	189	48	237	20
Band 8B	53	21	74	28
Band 8C	16	7	23	30
Band 8D	6	5	11	45
Band 9	12	5	17	29
Exec/VSM	9	5	14	36
M&D	208	222	430	52
Grand Total	**5382**	**929**	**6311**	**15**