BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 13:00 on Thursday 28 November 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB133/24	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB134/24	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*		
TB135/24	**Declaration of Interests concerning agenda items** *Purpose: To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB136/24	**Minutes of the previous meeting** a) Meeting held on 26 September *Purpose: To **approve** the minutes of the previous meetings*	*Report*	Chair	
TB137/24	**Matters Arising and Action Logs** *Purpose: To consider matters arising not included anywhere on agenda, review outstanding and approve completed actions.*	*Report*	Chair	
WELL LED FRAMEWORK				
TB138/24	**Chair's Report** *Purpose: To **receive** the Chair's Report.*	*Verbal*	*Chair*	**13:20** (10 mins)
TB139/24	**Consent Agenda** **a. Information Governance Annual Report** **b. Safeguarding Annual Report** *Purpose: To **receive** items on the Consent Agenda*	*Verbal*	*Chair*	**13:30**

TB140/24	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)
TB141/24	**Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework.*	*Report*	*DCG*	**13:40** (10 mins)
TB142/24	**Committee Effectiveness Reports** *Purpose: To **receive** the Committee Effectiveness Reports.*	*Report*	*DCG*	**13:50** (10 mins)
TB143/24	**Board Workplan** *Purpose: To **approve** the Board Workplan.*	*Report*	*DCG*	**14:00** (10 mins)
	IMPROVING CARE, TRANSFORMING LIVES			
TB144/24	**Integrated Performance Report** *Purpose: To **receive** the Integrated Performance Report*	*Report*	*Exec Directors*	**14:10** (10 mins)
TB145/24	**Quality Assurance Committee Chair's Report** *Purpose: To **receive** assurance on the work delegated to the Committee.*	*Report*	*QAC Chair*	**14:20** (05 mins)
TB146/24	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme*	*Report*	*CNO*	**14:25** (10 mins)
TB147/24	**Nursing and Midwifery Staffing Reports** *Purpose: To **receive** the Nursing and Midwifery Staffing Reports*	*Report*	*Chief Nurse*	**14:35** (10 mins)
	A GREAT PLACE TO WORK			
TB148/24	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:45** (05 mins)

TB149/24	**EDI Plan and Annual Report** *Purpose: To **receive** the EDI Plan and Annual Report*	*Report*	*DOP*	**14:50** (10 mins)

COMFORT BREAK (10 mins)

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB150/24	**Finance and Investment Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**15:10** (05 mins)
TB151/24	**Standing Financial Instructions and Scheme of Delegation** *Purpose: To **approve** the Standing Financial Instructions and Scheme of Delegation.*	*Report*	*CFO*	**15:15** (10 mins)
TB152/24	**Standing Orders** *Purpose: To **approve** the Standing Orders.*	*Report*	*DCG*	**15:25** (10 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE

TB153/24	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*SOC Chair*	**15:35** (05 mins)
TB154/24	**EPRR Core Standards Report** *Purpose: To **receive** the EPRR Core Standards Report.*	*Report*	*COO*	**15:40** (10 mins)

A POSITIVE PARTNER

TB155/24	**Questions to the Board** ***Purpose:** To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:50** (05 mins)
TB156/24	**Feedback from Board Walkabouts** ***Purpose:** To **receive** feedback following walkbouts.*	*Verbal*	*Members*	**15:55** (05 mins)

CONCLUDING BUSINESS

TB157/24	**Messages from the Board** ***Purpose**: To agree messages from the Board to be shared with all staff.*	*Verbal*	*Chair*	**16:00** (02 mins)
TB158/24	**Any Other Business** ***Purpose:** To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**16:02** (03 mins)
	Date and time of next meeting: • Thursday 30 January 2025			***16:05*** ***close***

Chair: Niruban Ratnarajah

Name:	Position:	Interest Declared	Type of Interest
Francis **Andrews**	Medical Director	Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest
Seth **Crofts**	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
		Non-Executive Director Borough Care	Financial 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
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Trustee Bolton Octagon	Non-Financial Personal Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
		Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).	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
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
		Lead for GP Strategy and Placements at the University of Bolton	Financial Interest

Name:	Position:	Interest Declared	Type of Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Nothing to declare	
Fiona **Taylor**	Non-Executive Director	Chair of Governors St Georges CE Primary & Nursery School	Non-Financial Personal Interest
		Trustee St Ann's Hospice	Non-Financial Personal Interest
		Trustee Women for Well Women	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 Minutes of the Board of Directors Meeting

Held in Boardroom

Thursday 26 September 2024

Subject to the approval of the Board of Directors Meeting on Thursday 28 November 2024

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Andrews	Francis	FA	Medical Director
Crofts	Seth	SC	Associate Non-Executive Director
Fairchild	Tosca	TF	Non-Executive Director
Ganz	Rebecca	RG	Non-Executive Director
Harriss	Sean	SH	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance
Noden	Fiona	FN	Chief Executive
North	Martin	MN	Non-Executive Director and Deputy Chair
Stuttart	Alan	AS	Non-Executive Director
Taylor	Fiona	FLT	Non-Executive Director
Mawrey	James	JM	Director of People and Deputy CEO
Wheatcroft	Rae	RW	Chief Operating Officer
Roberts	Tyrone	TR	Chief Nursing Officer
Walker	Annette	AW	Chief Finance Officer
White	Sharon	SW	Director of Strategy, Digital and Transformation

In Attendance

Carter	Rachel	RC	Associate Director of Communications and Engagement
Crompton	Victoria	VC	Corporate Governance Manager
Williams	Clare	CW	Divisional Nurse Director, Anaesthetics and Surgical Services Division (for item 108)

Apologies

None

There were two observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB107/24	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting and noted there were no apologies for absence.	

TB108/24 Patient Story

Clare Williams, Divisional Nurse Director, Anaesthetics and Surgical Services Division presented the story of a 57 year old gentleman who had collapsed and was diagnosed with Rhabdomyolysis and renal failure. He also underwent an emergency fasciotomy due to having compartment syndrome.

The patient was extremely complimentary about their experience on Critical Care, but felt the standards of cleanliness on R1 were below standard, and provided feedback to the Divisional Nurse Director during a routine cleaning inspection. Concerns were also raised by the patient in regards to staff turnover and his pain control, although he commented there had been a new Ward Manager which had resulted in staff turnover stabilising and overall the ward had improved.

CW outlined the actions taken following this feedback which included improving the staffing model and working alongside iFM to improve cleaning compliance.

The Board thanked CW for the patient story and commented on the importance of continually using patient feedback to make improvements.

RESOLVED:
The Board of Directors ***received*** the Patient Story.

TB109/24 Declaration of Interests Concerning Agenda Items

NR advised he had been appointed as Lead for GP Strategy and Placements at the University of Bolton, the Declarations of Interests Register had been updated.

The Board also noted FN's ongoing declaration as Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity and Neonatal System (LMNS) with regards to the CNST paper. The declaration is noted on the register.

There were no other declarations of interest relating to agenda items.

RESOLVED:
The Board of Directors ***received*** the Declarations of Interest.

TB110/24 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 25 July 2024, and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 25 July 2024.

TB111/24 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 of Directors ***approved*** the action log.

TB112/24 Chair's Update

The Chair advised there were two items under the consent agenda the Complaints Annual Report which was presented at the Quality Assurance Committee and the Staff Health and Wellbeing Report which had been presented at People Committee.

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

TB113/24 Complaints Annual Report

The Chief Nursing Officer presented the Annual Concerns and Complaints Report for 2023-24 which detailed the Trust's complaint management performance and highlighted improvements in handling patients concerns and feedback.

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

TB113/24 Staff Health and Wellbeing Report

The Director of People presented the Staff Health and Wellbeing Report which outlined the Trust's enhanced staff health and wellbeing offer and associated actions to support colleagues.

RESOLVED:
The Board of Directors ***received*** the Staff Health and Wellbeing Report.

TB114/24 Chief Executive's Report

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

- The Trusts new strategy for 2024-29 had been published.
- Enhanced support was provided and put in place for staff who were affected by the unrest in Bolton and beyond, which included alternative transport to work and network support sessions.
- The report following an inspection of services for children with special educational needs and disabilities (SEND) has been published. Inspectors highlighted several areas where the SEND partnership in Bolton was performing well and some areas were identified for improvement.

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

TB115/24 Integrated Performance Report

The Chief Operating Officer reported on the Trust's operational performance during August and drew attention to the following issues:

- Performance for the four hour standard in August was the best performance since September 2021, achieving 69.6% against the plan of 70%.
- Improvement work in the Emergency Department resulted in non-admitted breaches being at the lowest level so far year to date. The next part of the improvement plan was to extend the hours the Rapid Assessment and Treatment model was delivered by senior clinical staff.
- There was a huge focus on delivering the elective recovery milestones, but despite this the overall waiting list size had remained fairly consistent at 44,000 patients waiting for treatment. The Trust continued to have a small number of patients who have waited over 78 weeks.
- Unfortunately, the organisation would also have around 300 patients who would have waited more than 65 weeks for treatment at the end of September.
- The Trust achieved the 28 day faster diagnosis standard for Cancer and, the 31 day treatment standard. Though there is still work to do to consistently achieve the 62 day performance standard.

Quality and Safety

The Chief Nurse and Medical Director provided an update on Quality and Safety advising that:

- The Clostridium Difficile improvement work had delivered reliability across process measures such as hand hygiene and early anti-microbial stewardship audits were reassuring.

- A new statutory medical examiner system across primary and secondary care had been successfully implemented.
- The Annual Organ Donation Report demonstrated continuing increase in donor referrals.
- Summary Hospital level Mortality Indicator (SHMI) was now above expected. This was due to changes in national calculation methodology. Work continued to improve comorbidity coding and proportion of fully coded records.

TF queried whether improvements seen in the Emergency Department were due to the recommendations from the Emergency Care Improvement Support Team (ECIST) or natural improvements due to summer. RW advised that pressures over winter were always greater, but this reinforced the need to continue to address the actions to ensure there was greater improvements in preparation for the winter pressures. NR added the improvement trajectory was higher than being seen elsewhere which would suggest that the work completed with ECIST were having an impact.

In response to a query from TF with regard to learning from Serious Incidents, TR confirmed the organisation aims to embed as much process led actions as possible.

Financial Performance

The Chief Finance Officer advised the likely forecast outturn was to achieve plan, assuming that £4.9m of mitigations were fully delivered. However, the worst-case scenario suggested an adverse variance to plan of £11.9m.

AW advised the recent Price Waterhouse Cooper (PWC) Report would be presented at the Finance and Investment Committee in October. The report was positive in respect of Bolton and the Cost Improvement Programme (CIP) within the organisation.

Workforce

The Director of Workforce provided an update on workforce, advising that:

- Agency spend was tracking down and had reduced by £103K in August.
- Low vacancy rate of 5.10% at Trust level, and this was mirrored in most clinical staffing groups due to strong recruitment activity and effective retention.
- There were some pockets of hard-to-recruit roles and work was underway to fill these.

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

TB116/24 Quality Assurance Committee Chair's Report

Fiona Taylor presented her Chair report from the meeting held on 24 July 2024, which provided an overview of matters discussed. A verbal update was provided from the meeting held on 25 September 2024, and the following key points were highlighted:

- VTE performance had dropped slightly but remained above the dashline.
- Clinical correspondence performance was improving achieving over 80%.
- Fracture neck of femur was showing a downward trend for the 36 hour standard, however it was noted mortality had not significantly increased due to this.

RG raised concern around the Paediatric Audiology re-accreditation and it was confirmed this was discussed during the committee and the Medical Director was not assured on the timelines. An update would be presented to the Quality Assurance Committee to ensure outstanding actions were completed.

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

TB117/24 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

The Director of Midwifery presented the report which provided 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 CNST year 6 scheme guidance was launched in April and the service was progressing well with all ten safety actions and had attained 13 of the 92 recommendations to date.

The evidence collated had been uploaded to the Futures Collaboration platform and would be subject to external oversight by LMNS prior to submission. Ongoing work continued to meet the required 90% standard for relevant staff groups with regard to multi-professional training with a particular focus on medical staffing groups. Training relating to maternity emergencies, foetal monitoring and newborn life support was being prioritised and trajectories of compliance had been compiled to track progress.

In response to FLT'sconcern around the training for medical staff, JC confirmed there were nine weeks until submission and the Trust was performing well. Attainment of the 90% standard was based on all staff and if there were issues going forward this would be reported at the November Board along with an action plan. FA advised that the training requirements for medics had increased which had caused some difficulties, but going forward the timing of training would change which would alleviate pressure.

RESOLVED:
The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

TB118/24 Organ Donation and Transplantation Annual Report 2023/24

The Medical Director presented the Organ Donation and Transplantation Report for 2023/24, which provided assurance around the annual data regarding organ and tissue donation across the Trust and the future plans to improve organ and tissue donation and to move forward in line with national guidance.

RESOLVED:
The Board of Directors ***received*** the Organ Donation and Transplantation Report.

TB119/24 NHS England Self-Assessment for Placement Providers 2024

The Medical Director presented the NHS England Self-Assessment for Placement Providers 2024 which required the Trust to confirm whether standards were being met across all professions/learner groups, and it was noted the vast majority were being met despite some challenges. Areas of good practice were highlighted including

RePAIR workshops in Nursing, International Medical Graduate support and Clinical Psychology teaching initiatives. Educational leads from across professions had contributed to the report and once approved the report would be submitted to NHS England.

RESOLVED:
The Board of Directors ***approved*** the NHS England Self-Assessment for Placement Providers 2024.

TB120/24 People Committee's Chair's Report

Alan Stuttard presented the Chair Report from the People Committee meeting held on 17 September 2024, the following key points were highlighted:

- The Workforce Equality Standard (WRES) and Workforce Disability Standard (WDES) reports were received noting the Trust had achieved an improved position since 2023 for a number of indicators. However, for several indicators the organisation had scored worse than the national average.
- The Trust's NHS Staff Survey dates were agreed as 01 October to 29 November 2024. The report set out the communications and engagement activity which to update the workforce and key stakeholders and provide the staff with the knowledge to promote and engage with the survey.
- Agency spend reduced in July 2024. A static spend trend was noted in most staff groups and pleasingly nursing and midwifery spend remained at relatively low levels.

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

TB121/24 Workforce Race Equality Standard and Workforce Disability Equality Standard Reports

The Director of People presented the Workforce Race Equality Standard and Workforce Disability Equality Standard Reports highlighting that the Trust had achieved an improved position since 2023 for a number of indicators. There were however several indicators where the Trust scored worse than the national average and the respective action plans would be monitored by the People Committee.

TF commented that in order to address discrimination throughout the organisation it would be important to educate and communicate with those in middle management positions. TR advised that good progress had been made and senior staff were undertaking mentorship to raise awareness.

NR advised it was important to ensure that the workforce represented the local community.

RESOLVED:
The Board of Directors ***received*** the Workforce Race Equality Standard and Workforce Disability Equality Standard Reports.

TB122/24 Anti-Racist Framework: Statement of Intent

The Director of People advised the North West BAME Assembly Antiracism Framework was a strategic initiative designed to eradicate systemic racism within public services across the North West of England, by embedding antiracism principles into organisational policies, practices, and cultures.

The Trust has committed to apply for Bronze in April 2025. One of the first steps to Bronze is for the Board to write and publish a statement of intent on antiracism. The statement aimed to align to the Trust VOICE values and with the new Trust Strategy and had been inspired by statements from other Trusts within the locality.

RESOLVED:
The Board of Directors ***approved*** the Anti-Racist Framework: Statement of Intent.

TB123/24 Appraisal and Revalidation Report

The Medical Director presented the report to assure the Board of Directors that governance systems for appraisal and revalidation and professional standards for non-training grade medical staff were in place and fit for purpose.

RESOLVED:
The Board of Directors ***approved*** the Appraisal and Revalidation Report.

TB124/24 Finance and Investment Committee Chair's Report

Rebecca Ganz presented the Chair report from the meeting held on 24 July 2024, and provided a verbal update from the meeting held on 25 September 2024. The following key points were noted:

- £23.8 million Cost Improvement Programmes (CIP) identified in year, an increase of 2.2m. £25.8 million recurrent identified, an increase of 0.9 million.
- The Month 3 Position highlighted the Trust had a deficit of £4.5m compared with a plan of £5m with the most likely forecast outturn being £4.9m worse than plan.

RESOLVED:

The Board of Directors ***received*** the Finance and Investment Committee Chair's Report.

TB125/24 Audit and Risk Committee Chair's Report

Alan Stuttard presented his Chair's report from the Audit and Risk Committee held on 18 September 2024, the following key points were highlighted:

- MIAA presented their Internal Audit Progress Report against audits from the 2023/24 Internal Audit Plan and progress made in delivery of the 2024/25 Internal Audit Plan.
- The Committee received and accepted the Information Governance Annual Report. The report provided assurance on information governance and security activity for the period 01 July 2023 to 30 June 2024.
- The Committee also received the Register of Waivers and Losses and Special Payments Reports.

NR queried whether the Internal Auditors completed any benchmarking and AS confirmed that MIAA provided Internal Audit services for a number of Trusts so benchmarking could be undertaken and an Audit Committee Chair's meeting which takes place had been beneficial with regards to networking.

RESOLVED:
The Board of Directors ***received*** the Audit and Risk Committee Chair's Report.

TB126/24 Charitable Funds Committee Chair's Report

Martin North presented the Chair's Reports from the Charitable Funds Committee meetings held on 03 June and 09 September 2024 advising that the charities fund balance totaled £1,078k on 01 April 2024. For the five months to the 31 August there had been a net decrease in funds of £25k and the Charity had a call on funds (commitments) of £254k leaving an available balance of £799k.

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

TB127/24 Strategy and Operations Committee Chair's Report

Sean Harriss presented the Chair Report from the Strategy and Operations Committee held on 22 July 2024, and provided a verbal update from the meeting held on 23 September 2024, the following key points were highlighted:

- The Winter Plan was presented and approved.
- The Committee acknowledged the significant undertaking that the three EPR projects for Outpatients, Community and Maternity EPR had presented in terms of organisational risk and capacity to deliver.

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

TB128/24 Winter Plan

The Chief Operating Officer presented the Winter Plan which outlined the strategy to manage winter demand whilst maintaining patient experience and meeting clinical quality indicators. The plan focused on ensuring the best possible care, safety, and experience for patients, managing flu and COVID-19, and delivering the Clinical Strategy for Urgent Care.

The plan was designed to complement the Urgent Care Improvement Plan and overall it aimed to support patients and staff, ensuring a high standard of care throughout the winter season.

Board members discussed the importance of vaccinations for staff and FA advised that Occupational Health had been proactive planning for the roll out of vaccinations.

RESOLVED:
The Board of Directors ***approved*** the Winter Plan.

TB129/24 Questions to the Board

There were no questions received from members of the public to the Board of Directors.

TB130/24 Feedback from Board Walkabouts

RG advised she had visited the Medical Discharge Unit and Discharge Lounge. The areas were calm and well organised and had strong grip and control of agency usage.

MN had visited Laburnum Lodge and although the environment was very nice patients were keen to return to their own homes. Staff required improved rest facilities and it was suggested they contact the Trust Charity for this.

SC advised he had visited M4 and M5 wards commenting that the units were very fast paced with staff working very hard.

TF had visited E4 and the feedback received from staff would be that it would be nice to open the ward out so that patients could sit outside.

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

TB131/24 Messages from the Board

The following messages from the Board were agreed:

- Workforce Race Equality Standard and Workforce Disability Equality Standard Reports.
- Anti-Racist Framework: Statement of Intent.
- Winter Plan.

TB132/24 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 16:00.

The next Board of Directors meeting would be held on 28 November 2024 at 1pm in the Boardroom.

Meeting Attendance 2024						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓	✓	A	✓	✓	
Fiona Noden	✓	✓	✓	✓	✓	
Francis Andrews	✓	✓	✓	✓	✓	
James Mawrey	✓	✓	✓	✓	✓	
Tyrone Roberts	✓	✓	✓	✓	✓	
Annette Walker	✓	✓	✓	✓	✓	
Rae Wheatcroft	✓	✓	✓	✓	✓	
Sharon White	✓	✓	✓	✓	✓	

Rebecca Ganz	✓	✓	✓	A	✓	
Jackie Njoroge	✓	✓	✓	✓		
Martin North	✓	✓	A	✓	✓	
Alan Stuttard	✓	✓	A	✓	✓	
Sean Harriss	✓	✓	✓	✓	✓	
Fiona Taylor	A	✓	✓	✓	✓	
Seth Crofts	✓	✓	✓	✓	✓	
Tosca Fairchild	✓	✓	A	✓	✓	
Sharon Katema	✓	✓	✓	✓	✓	
✓ = In attendance A = Apologies						

September 2024 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/24/04	30.05.24	Patient Flow Presentation	RW to provide an further update on patient flow in six months	RW	Nov-24	On agenda

Key

complete	agenda item	due	overdue	not due

Report Title:	Information Governance (IG) Annual Report 2023-24			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Chief of Strategy and Partnerships		Decision	

Purpose of the report	The Information Governance (IG) Annual Report is provided to the Board of Directors for information and assurance.

Previously considered by:	IG Committee and Strategy and Operations Committee

Executive Summary	The report outlines the key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 01 July 2023 to 30 June 2024 and state objectives for the forthcoming year. The report also provides assurance against the Data Security and Protection Toolkit (DSPT) requirements, which reflect the national standards and legislation for data security and protection in health and social care. • **Cyber Risk Management**: the report assures the Board of effective oversight and management of cyber crisis, including independent scrutiny and assurance measures. • **Cyber Security & IG Policies**: The document lists several department policies in place to meet our legal obligations under UK GDPR/NIS Directive and our obligation as a NHS organisation. • **Data Quality Policies**: Only one policy within the Data Quality Team, the Information Quality Assurance Policy, has not been updated since 2019. • **FOI Request Statistics**: The Trust received 937 FOI requests in 2023/24, with a compliance rate of 57%, down from 76% the previous year, due to staffing limitations. • **Complaints to ICO**: Two FOI requests were raised with the ICO as complaints with one upheld and the other not upheld • **Subject Access Requests (SARs):** The Trust handled 2525 SARs with a 100% compliance rate in the Medical Legal Department, but the Litigation Department had only a 42% compliance rate due to staff losses.

	• **Information Governance Training**: IG training compliance dropped to 89% due to technical issues, although the Trust achieved a 95% target mandated by NHS England. • **Data Protection Incidents**: There were 186 Information Governance incidents reported, with six reported to the ICO. The most common incidents involved breaches of patient confidentiality. • **Internal Audit Findings**: MIAA reviewed the DSPT process and found substantial assurance against self-assessment veracity and moderate assurance against the 10 National Data Guardian standards. • **Accreditations and Certifications**: The Trust maintains ISO 27001 and ISO 9001 certifications, demonstrating its commitment to data security and quality management. • **Recommendations for 2024-25**: Recommendations include prioritizing Information Assets and Data Flow Mapping Registers, maintaining an up-to-date contracts register, and conducting annual Business Continuity Planning exercises.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Information Governance Annual Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Sharon White, Chief of Strategy and Partnerships	**Presented by:**	Sharon White, Chief of Strategy and Partnerships

Vision | Openness | Integrity | Compassion | Excellence

NHS
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NHS Foundation Trust

Information Governance Annual Report

2023-24

... for a better Bolton

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Information Governance Annual Report 2023-24

Improving care,
transforming lives...for a better Bolton

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

DSP	Data Security and Protection
DSPT	Data Security and Protection Toolkit
DPIA	Data Privacy Impact Assessment
ESR	Electronic Staff Record
FOI	Freedom of Information Act
ICO	Information Commissioner's Office
IG	Information Governance
ISMS	Information Security Management System
KLOEs	Key Lines of Enquiry
NDG	National Data Guardian
NHS	National Health Service
NIS	Network and Information Systems Regulation
QMS	Quality Management System
SAR	Subject Access Request
SIRO	Senior Information Risk Officer
UK GDPR	United Kingdom General Data Protection Regulation
DPA 2018	Data Protection Act 2018
DPO	Data Protection Officer
ISO	International Organisation for Standardization. It is an independent, non-governmental international organisation that develops and publishes standards to ensure the quality, safety, and efficiency of products, services, and systems.
ISO 27001	Is an internationally recognised standard that sets forth the requirements for establishing, implementing, maintaining, and continually improving an Information Security Management System (ISMS).
ISO 9001	Is the international standard that defines the requirements for a Quality Management System (QMS).

Contents

Executive Summary

This Report outlines key activity, achievements and issues relating to Information Governance (IG) within the Trust for the reporting period 1st July 2023 to 30 June 2024 and state objectives for the forthcoming year.

Recommendation to the Committee

The Strategy & Operations Committee is requested to:

- **RECEIVE** and **ACCEPT** this annual report which provides assurance on the Information Governance and Security activity for the period 1st July 2023 to 30th June 2024.

Information Governance Annual Report
1st July 2023 to June 2024

1. Introduction

The purpose of this report is to outline key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 1st July 2023 to 30 June 2024 and state objectives for the forthcoming year.

Improving Information Governance is a key NHS priority. This is reflected in national standards set out in the Data Security and Protection Toolkit (DSPT), which the Trust is required to complete and submit every year, specifically at the end of June 2024 for this reporting period.

Completion of DSPT demonstrates that the organisation is compliant with the following legislation and guidance framework:

- UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA 2018).
- Network and Information Systems Regulation (NIS Directive), as an Operator of Essential Services.
- Compliance with the expected data security standards for health and social care for holding, processing or sharing personal data.
- Readiness to access secure health and care digital methods of information sharing, such as NHS mail and Summary Care Records, Greater Manchester Care Record (GMCR).
- Good data security to the CQC as part of the Key lines of Enquiry (KLOEs).
- Freedom of Information Act 2000.
- Access to Health Records Act 1990.
- Computer Misuse Act 1990.
- Common Law Duty of Confidentiality.
- Privacy and Electronic Communications

The Trust Information Governance Department has undertaken a programme of work covering a number of activities in order to provide assurance against the Data Security and Protection Toolkit requirements. This report summarises the outcomes of the key work programme over the period.

2. Key Trust Roles & Reporting Structure over the Period

2.1 Senior Information Risk Officer (SIRO), Director of Strategic Transformation, Strategy & Planning

The SIRO is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level. She must provide the Chief Executive with assurance that information risk is being managed appropriately and effectively across the organisation and for any services contracted for by the organisation.

2.2 Caldicott Guardian

The Caldicott Guardian is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Caldicott Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

2.3 Data Protection Officer/Head of Information Governance

The Data Protection Officer is the Head of Information Governance and the role involves:

- Informing and advising the Trust about complying with UK General Data Protection Regulation (UK GDPR) and other data protection legislations.
- Supporting and monitoring compliance with internal audits.
- Advising on and monitoring Data Protection Impact Assessments, advising on whether a DPIA is necessary, how to conduct one and expected outcomes.
- Cooperating with the ICO.
- Submission of the Data Security and Protection Toolkit (DSPT).
- Data protection incidents investigations.

2.4 Reporting Structure for Information Governance

The Information Governance Committee has oversight of the work of the Information Governance team and progress towards the Trust's Information Governance strategic objectives.

Updates and relevant reporting documentation including relevant policy approvals go to the Risk and Audit Committee. In terms of governance:

- To provide assurance to the Board on the effective and adequacy of oversight in the management of cyber risk including appropriate levels of independent scrutiny and assurance.
- Receive the results of the Annual DSP toolkit audit and receive assurance over the Trust's plans to address any areas of improvement identified.
- Receive an Information Governance Annual Report focussed on compliance with data protection and Freedom of Information (FOI) rules number/type of breaches; and plans to develop and improve compliance.
- Receive assurance on the quality of data relied on for decision-making, plans on maintaining proper controls over data quality, including regular independent audits.

Please see appendix A the Governance Structure in terms of the reporting structure.

3. Data Security and Protection Toolkit (DSPT): 01st July 2023 – 30th June 2024

The Data Security and Protection Toolkit is an online self-assessment tool produced by NHS England that allows organisations to measure their performance against the National Data Guardian (NDG) "10 Data Security Standards".

The completion of the DSPT is a contractual requirement specified in the NHS England Standards Conditions contract and remains a policy of the Department of Health and Social Care that all organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The toolkit is split into 10 different sets of data security standards. Under each standard there are a number of assertions/requirements which we need to complete.

Standard 1 - Personal Confidential Data	**Standard 6** - Responding to Incidents
Standard 2 - Staff responsibilities	**Standard 7** - Continuity Planning
Standard 3 - Training	**Standard 8** - Unsupported software
Standard 4 - Managing Data Access	**Standard 9** - IT Protection
Standard 5 - Process Reviews	**Standard 10** - Accountable suppliers

For the 2023-24 period, the toolkit is formed by **128 requirements**, divided into **108 mandatory requirements** and 20 non-mandatory requirements.

The Trust has achieved significant advancements in adhering to the 10 standards outlined, ensuring compliance with the toolkit requirements for the 2023-24 period. This accomplishment reflects the Trust's dedication to continuous improvement and adherence to established guidelines.

In addition, the Trust has not only focussed on the mandatory requirements but significant work has been undertaken to ensure that the non-mandatory requirements are also met.

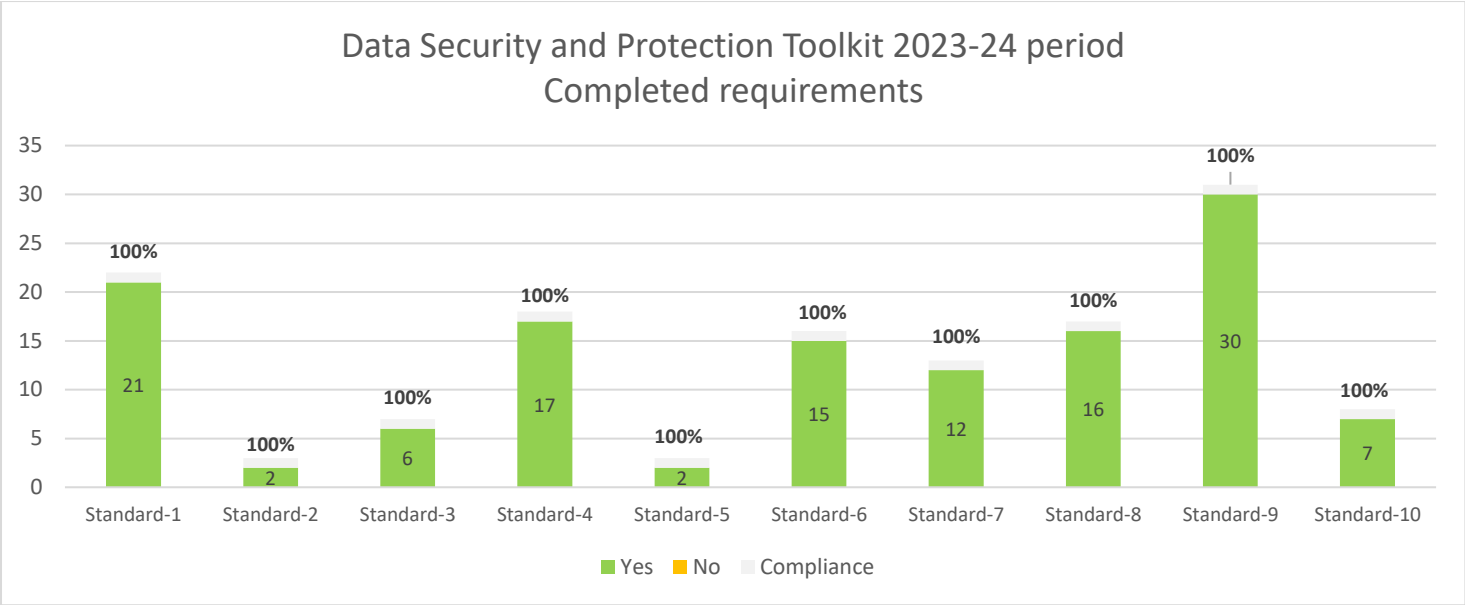
The Trust were able to submit:

	Number of evidence	Compliance
Mandatory requirements:	108/108	**100%**
Non-mandatory requirements:	20/20	**100%**
Overall evidence provided:	**128/128**	**100%**

Bolton NHS Foundation Trust submitted at the end of June and meet NHS England Standards.

Status	Date Published
2023-24 (version 6) Standards Met	25/06/2024
2023-24 (version 6) Baseline	27/02/2024
2022-23 (version 5) Standards Met	23/06/2023
2022-23 (version 5) Baseline	24/02/2023

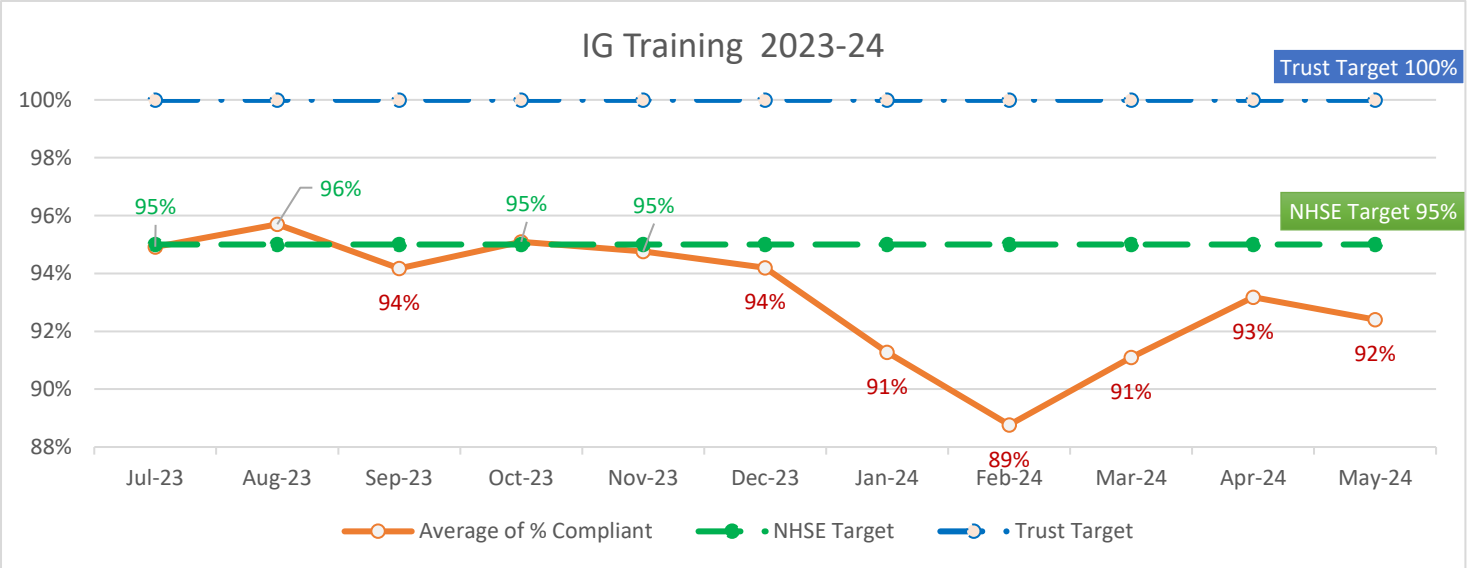
Please see appendix B for DSPT certification.



4. Information Governance training

The organisation struggled with Information Governance training for the 2023-24 period due to technical problems within ESR, our average monthly compliance of 93 to 96% dropped due to these problems to 89%.

The Trust has successfully met the 95% target set by NHS England in four instances within the last year, with our highest achievement being 96%. As a Trust, we are dedicated to consistently reaching our monthly targets, reflecting our commitment to excellence and patient care.



5. Information Governance/Security Related Policies – Keeping Up to Date

Keeping Trust documentation up to date and relevant in terms of the Information Governance/Information Security is critical for ensuring and maintaining an appropriate level of Information Governance.

During 2023-24 the following policies have been reviewed and approved:

Information Governance Policies

No	Department	Policy Name	Type	Version	Expire date
1	IG	Closed Circuit Television (CCTV) Policy	**Policy**	1.1	Aug-25
2	IG	Data Protection Policy	**Policy**	8.3	May-27
3	IG	Freedom of Information (FOI) Policy	**Policy**	6.3	Aug-25
4	IG	Health Records Keeping Policy	**Policy**	5.4	Apr-26
5	IG	Information Risk Management Policy	**Policy**	4.2	Feb-26
6	IG	Information Sharing Policy	**Policy**	1.2	Jan-25
7	IG	Personal Data Breach Procedure	SOP	1.1	May-25
8	IG	Registration Authority Procedure	SOP	3.2	Jan-25
9	IG	Records Management Policy	**Policy**	6.2	Jan-25

Cyber Security Policies

As part of the Informatics certification process under ISO 27001 the following policies are in the process to be approved, to meet national standards from the National Cyber Security Centre.

No	Department	Policy Name	Type	Version	Expire date
1	IT	Email and Internet Usage Policy	**Policy**	4.4	Jan-25
2	IT	Information Security Policy	**Policy**	6	Mar-26
3	IT	Mobile Device Management	**Policy**	1	Feb-27
4	IT	Password and Multi Factor Authentication Policy	**Policy**	1	May-27
5	IT	Patching and CareCert Alerts Policy	**Policy**	1	May-27
6	IT	Network and Security Policy	**Policy**	1	Feb-27
7	IT	Backup Policy	**Policy**	Draft	
8	IT	Clear Screen and Desk Policy	**Policy**	Draft	
9	IT	Information Classification Policy	**Policy**	Draft	
10	IT	Third party access	**Policy**	Draft	
11	IT	Remote working	**Policy**	Draft	
12	IT	M365 Overall Policy BFT	**Policy**	Draft	
13	IT	MS Teams BFT	**Policy**	Draft	
14	IT	Encryption Policy V2	**Policy**	Draft	
15	IT	Information Asset and Risk Management Procedure	**SOP**	Draft	
16	IT	Secure Transfer of Data DRAFT	**Policy**	Draft	

Data Quality Policies

Within the Data Quality Team there is only one policy that has not been updated since 2019.

No	Department	Policy Name	Type	Version	Expire date
1	DQ	Information Quality Assurance Policy	**Policy**	1	Mar-19

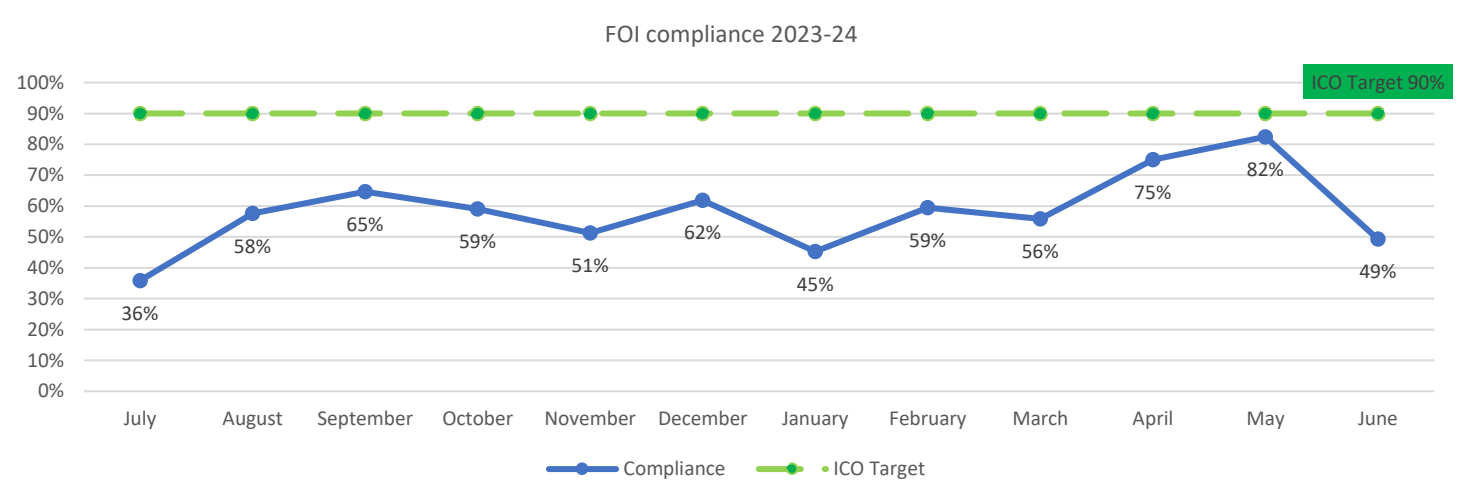
6. Freedom of Information (FOI) Request

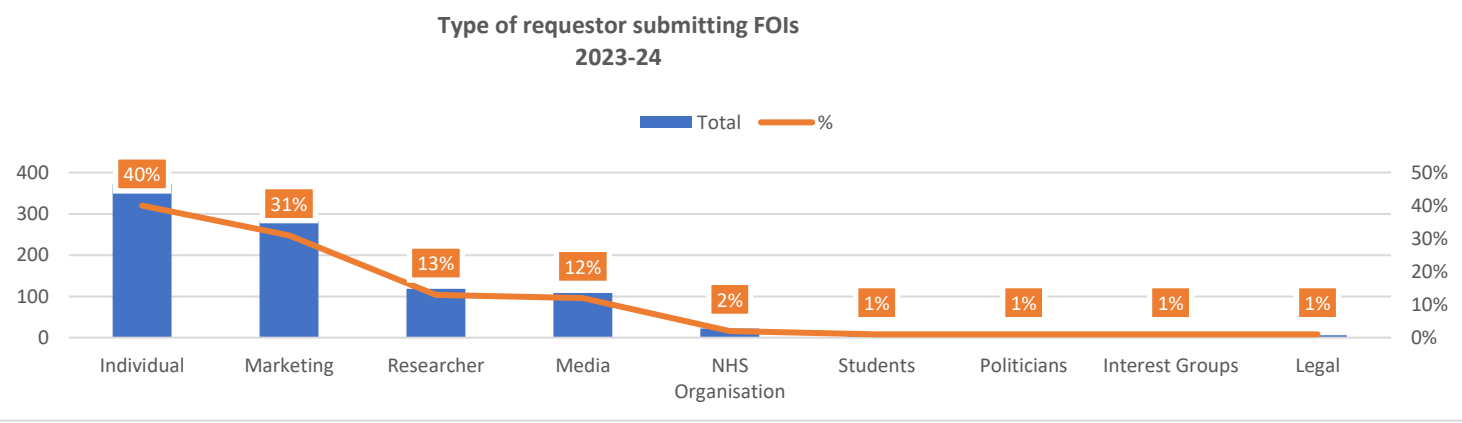
The Freedom of Information Act 2000 provides a general right of access to recorded information held by any public authority. Anyone can make a request for information – there are no restrictions on the requesters' nationality or where they live.

Under the Freedom of Information Act 2000, the Trust must respond to all written requests for information within 20 working days. Failure to comply with this deadline could lead to a complaint by the specific requestor to the Information Commissioners Office (ICO). The ICO has the power to serve a Decision Notice on the public authority for failing to comply with the 20-working day deadline.

	2022/23	2023/24
Total number of request	851	937
# of request completed within 20 days	649	536
Compliance	**76%**	**57%**

Due to staffing limitations in the Information Governance Department over the past 14 months, meeting the ICO's desired targets has been challenging. Operating at 50% staff capacity and handling complex subject access requests took precedence over Freedom of Information matters.





6.1 Complaints raised to the ICO

2 of 937 request were raised to the ICO as a complaint.

Index	Description	Reason of complaint	Outcome
2023-688	Request sent to IFM asking for the body worm cameras model	Information not provided by department	**Complaint upheld** - The ICO issues a decision notice after we provided the information to the requestor.
2024-736	Governance report	Information was refused under section 40 under the FOI	**Complaint not upheld** - the Commissioner's decision is that the Trust is entitled to rely on section 40(5B)(a)(i) of FOIA to refuse to confirm or deny whether it holds the information requested. The Commissioner does not require any steps to be taken as a result of this decision.

6.2 Section 50 Decision Notices

Under section 50 of the Freedom of Information Act 2000, the ICO has the power to issue section 50 Decision Notices on a public authority after a requestor has made a complaint to the ICO about the manner in which a public authority has handled its FOI request.

There was one decision notice served to the Trust during 2023/24 period, this is related to 2023-688, the requestor asked for the model of the body worm cameras.

7. Subject Access Requests

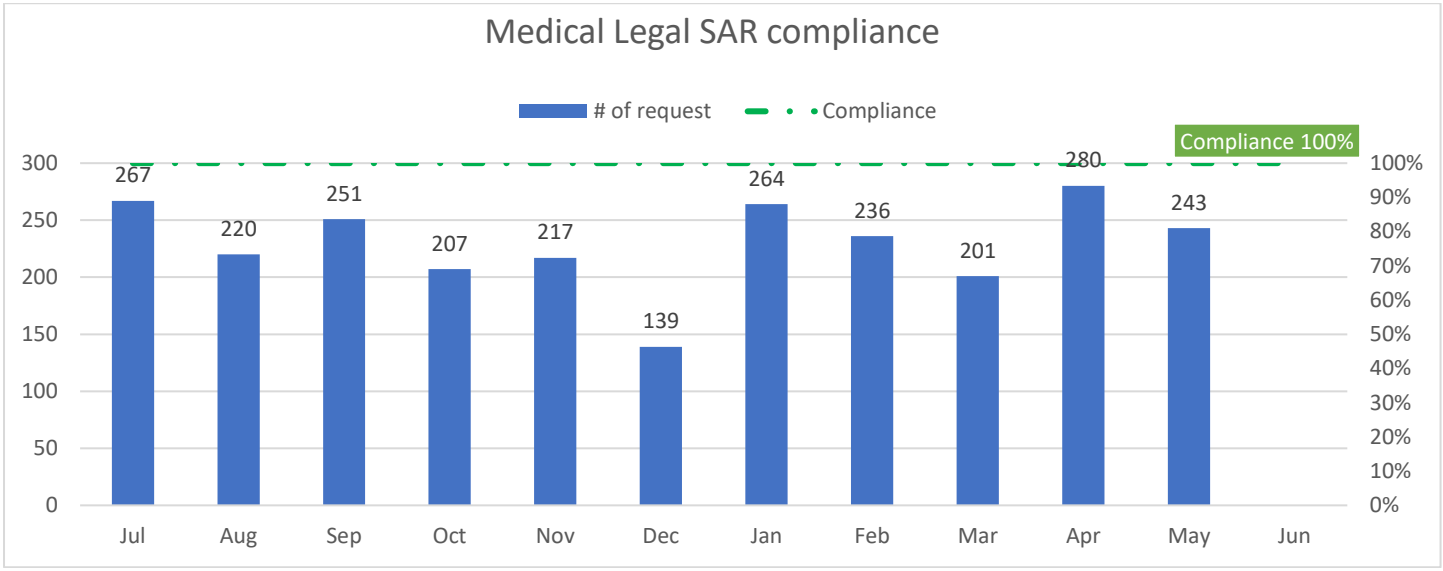
The main legislative measures that give rights to individuals to receive a copy of their data and other supplementary information:

- The UK GDPR and Data Protection Act 2018 - rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf (for example, a solicitor).
- The Access to Health Records Act 1990 - rights of access to deceased patient health records by specified persons.
- The Medical Reports Act 1988 - right for individuals to have access to reports, relating to themselves, provided by medical practitioners for employment or insurance purposes.

Under the Data Protection Act 2018 and Access to Health Records Act 1990 the Trust must give individuals the right of access to their personal information. An individual can send a subject access request requiring the personal information about them held by the Trust, and to provide them with a copy of that information. The Trust has a calendar month to respond to a valid request as part of the UK General Data Protection Regulation (UK GDPR).

7.1 Subject Access Requests from patients – Medical Legal Department

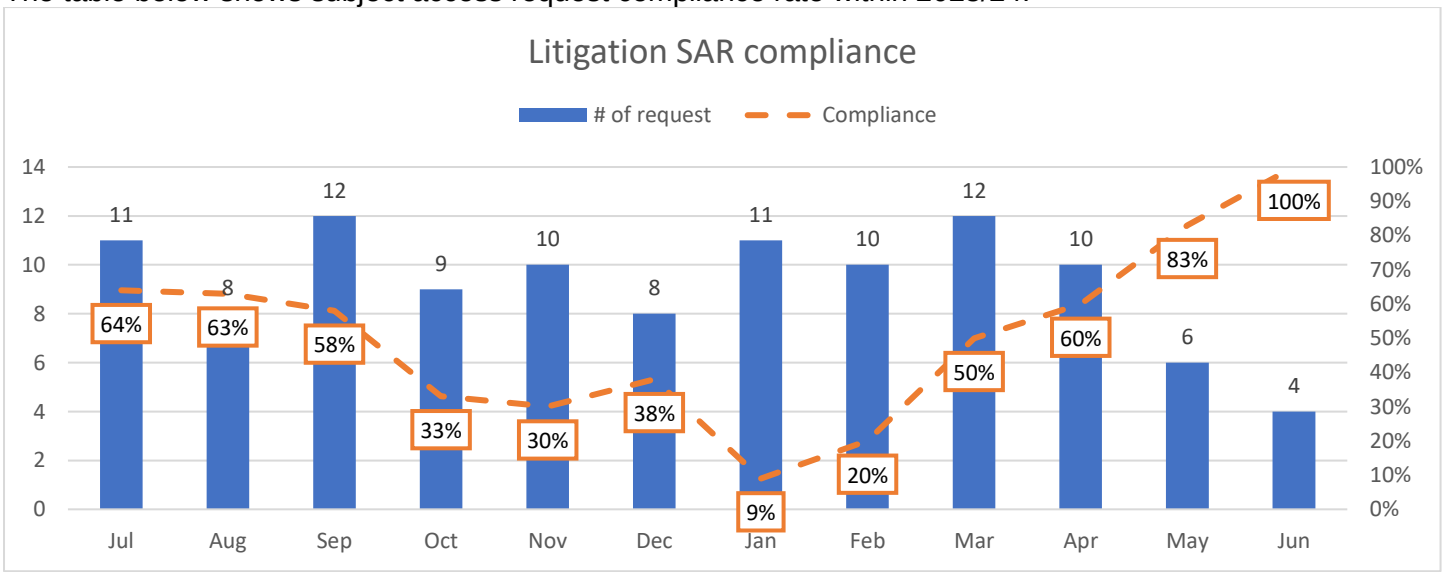
The table below shows subject access request compliance rate within 2023/24:



There were 2525 subject access requests in total during this period made to the Medical Legal Department, with an average compliance of 100%.

7.2 Subject Access Requests from patients – Litigation Department

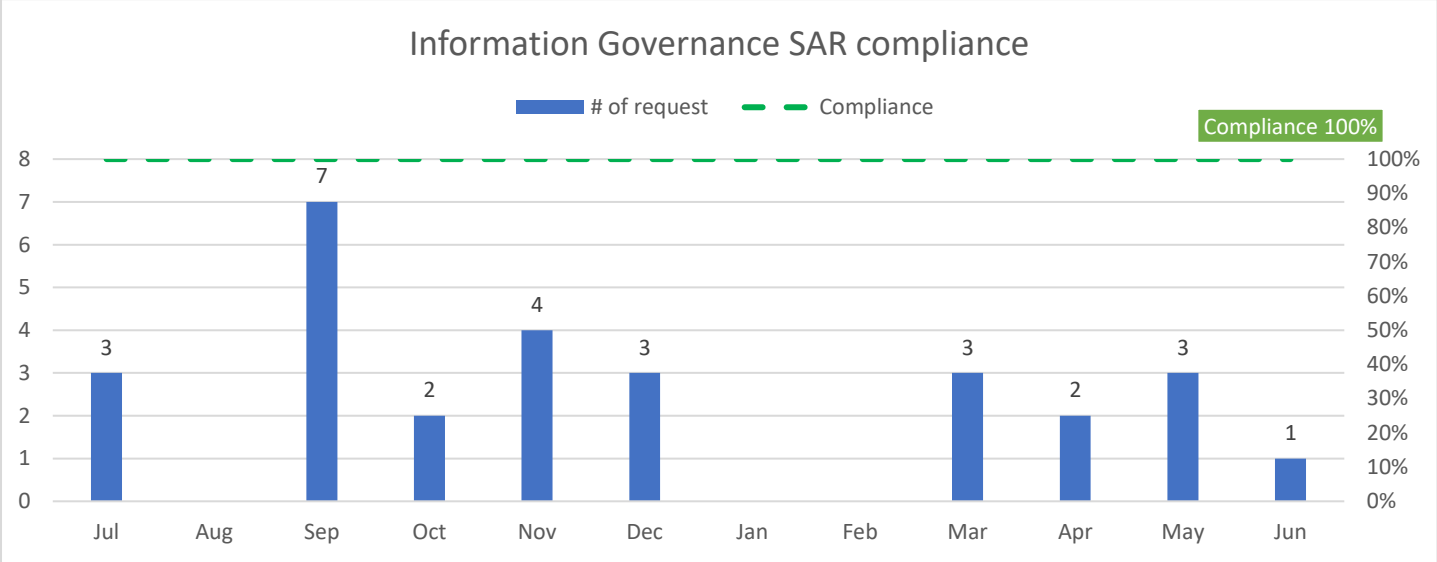
The table below shows subject access request compliance rate within 2023/24:



There were 107 subject access requests in total during this period made to the Litigation Department, with an average compliance rate of 51%. Compliance within the Litigation Department has been impacted due to the lost of staff.

7.3 Subject Access Requests from patients/staff – Information Governance Department

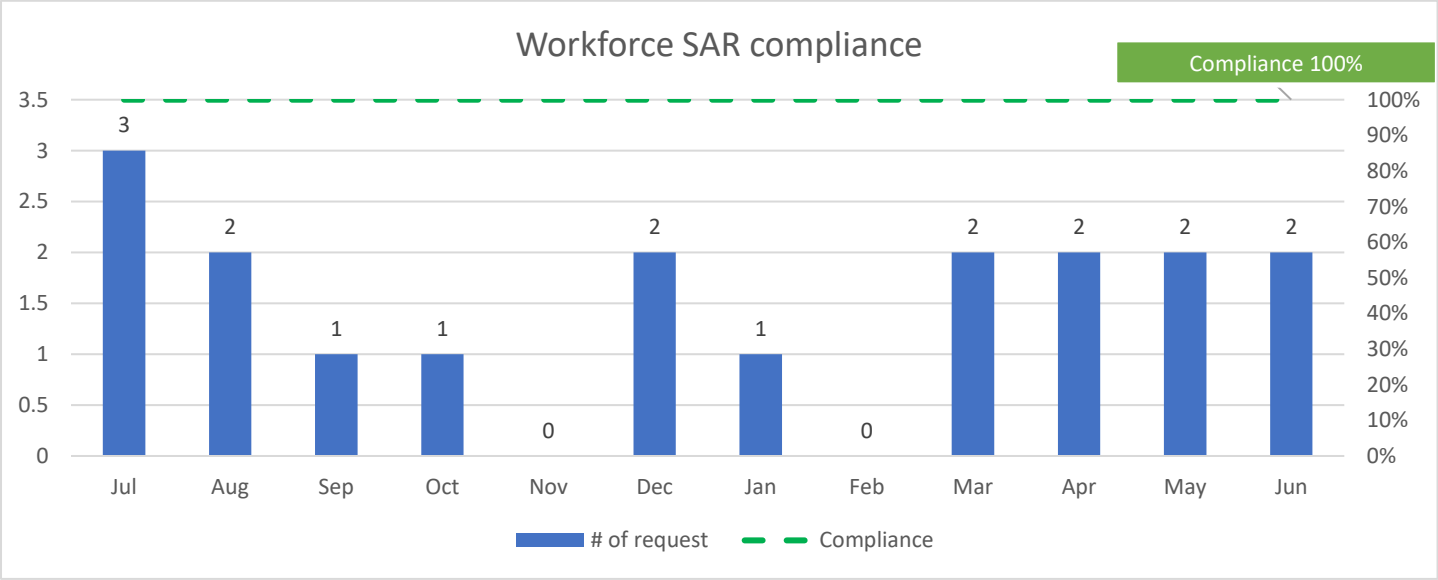
The table below shows subject access request compliance rate within 2023/24:



There were 28 subject access requests in total during this period made to Information Governance, with an average compliance rate of 100%.

7.4 Subject Access Requests from staff – Workforce

The table below shows subject access request compliance rate within 2023/24:



There were 18 subject access requests in total during this period made to Workforce, with an average compliance rate of 100%.

8. Data Protection Incidents

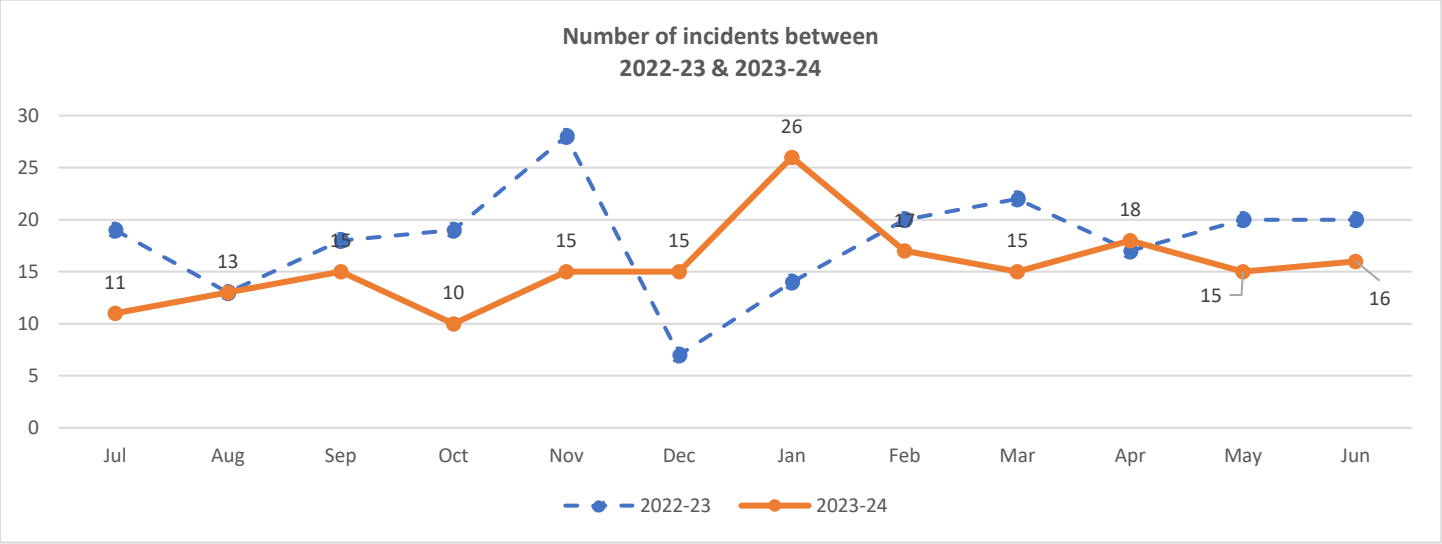
Patient confidentiality and security of information about service users is very important to the Trust. Confidential information is held largely in electronic and paper form, when is electronic information this is within different systems, for example EPR, PAS, ESR, E-rostering.

All incidents that involve the loss or unauthorised disclosure of personal information are reported centrally and are closely monitored on the Trust's Safeguard system. In addition to local clinical and corporate incident management and reporting tools, the personal data breaches incidents that reach the threshold to be reported via the Data Security Protection Toolkit, which reflects the reporting requirements of the UK GDPR, and the Networks and Information System (NIS Directive) Regulations and ICO.

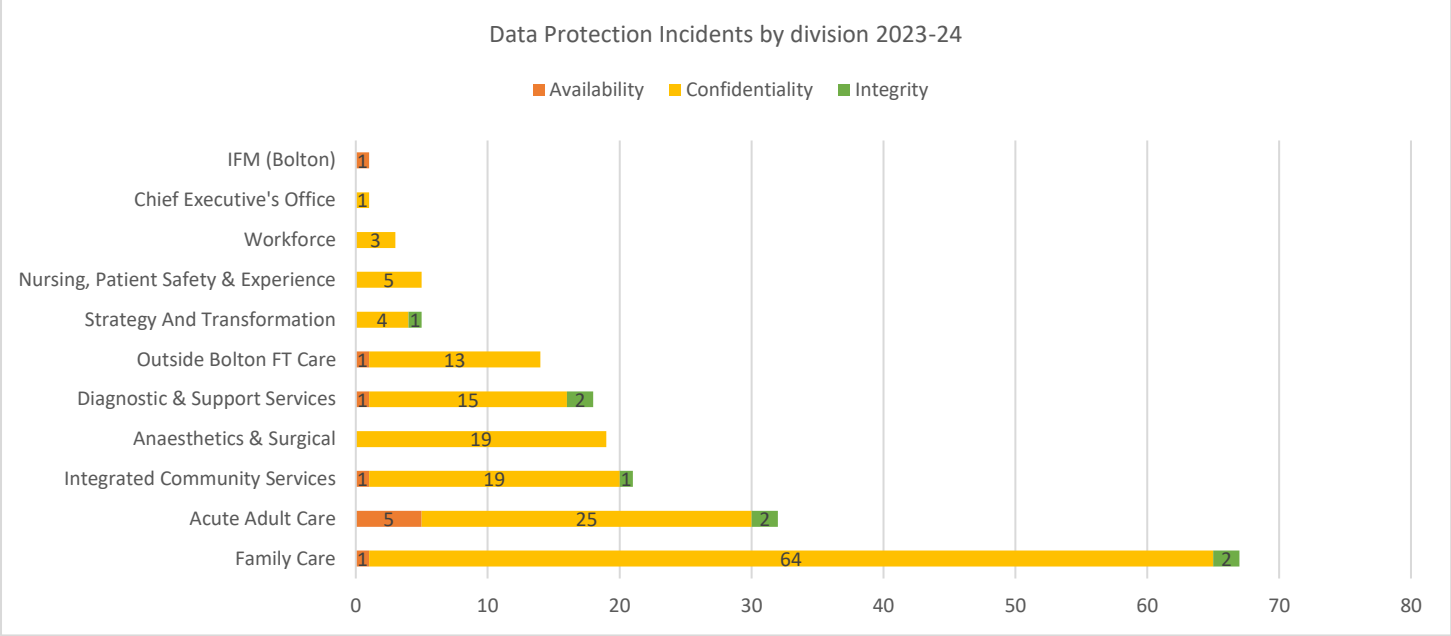
The Trust has a duty to report a notifiable breach to the Information Commissioner's Office without undue delay, and within 72 hours after we became aware of the incident. Once submitted, the notification will be sent to NHS Digital, the Information Commissioners Office (ICO) and other regulators and sometimes the Department of Health, depending in the score of the incident.

The below table shows the number of reported Information Governance incidences for this reporting timeframe within Safeguard.

During 2023/24 there were **186** Information Governance incidents reported via Safeguard.



- **From the 186 incidents there were six incidents reported externally (Information Commissioners Office (ICO) via the Data Security and Protection Toolkit.**
- **During the specified period, there were 7 claims made under UK GDPR. Of these, one case has been resolved, while the remaining 6 are still ongoing.**



8.1 Incidents reported externally.

No.	Reference	Reported	What happened	Reported to
1	37764	28/06/2024 14:52	New complaint via email was emailed and shared with divisional investigation team and accidently the email contained the email address of a current complainant with same first name as a senior manager as intended recipient.	ICO
2	37757	28/06/2024 13:36	A patients post operative clinic letter was attached to another patient's letter and subsequently sent to the wrong patient. The letter contains sensitive information regarding the patients cancer treatment and future hysterectomy details.	ICO
3	37131	17/05/2024 14:34	Delay to send out patient letters from January to April 2024, resulted in an out of date patient list being used to update a number of patients. Potential that patients who have since been passed away have been written to.	ICO
4	36231	14/03/2024 13:29	Staff member accessing patient records without a legitimate reason	ICO
5	35839	15/02/2024 12:31	The patient has recently received a discharge letter. Unfortunately, the letter belonged to another child. She is assuming the other family have received her child's discharge letter as they have probably been put into the wrong (hand written) envelopes....	ICO
6	34088	26/09/2023 14:33	Parked in car park near town centre, laptop bag was in the boot of the car and was taken away between 08:00 - 16.00 hours on 22/09/2023. Bag contained laptop, laptop charger, USB headphones, IPad charger, phone charger. Meeting minutes, Within this...	ICO

	Qtr3			Qtr4			Qtr1			Qtr2			Grand Total
Cause	Jun-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	
Breach Of Patient Confidentiality	9	12	11	10	15	15	26	17	11	18	15	15	174
Breach Of Staff Confidentiality	2	1	2						2				7
Theft/Loss Of Docs Containing Patient Info			1						2				3
Theft/Loss Of IT Containing Patient Info			1									1	2
Grand Total	**11**	**13**	**15**	**10**	**15**	**15**	**26**	**17**	**15**	**18**	**15**	**16**	**186**

Among these, the highest number of incidents are related to breach of patient confidentiality. This includes appointment letters were sent to patient's old address, emails sent to wrong recipients, patient letters sent to wrong patients.

To address the concerns regarding the high number of incidents within the Family Division, the committee has requested a report from the Governance Lead in Family Division. In response to the increase in incidents, an action plan has been implemented to learn from these incidents and prevent their recurrence. This plan includes specific measures and strategies aimed at improving processes and protocols to ensure the safety and well-being of all involved. It is a proactive step towards mitigating risks and enhancing the division's ability to manage and respond to such situations effectively.

Every incident is individually assessed by the Head of IG/ IG Department and advice given to prevent the reoccurrence of this happening for example further training, raising team awareness, poster/checklist/ advice and developing letter templates for patients affected. The Information Governance team continues to issue guidance and provide training to prevent reoccurrences in order to improve information governance and information security compliance.

9. Internal Audit Findings

MIAA reviewed the process for compiling the Data Security and Protection (DSPT) Toolkit and the evidence available for a sample of 54 requirements, were 45 were mandatory to meet the standards. Following the DSPT Independent Assessment Framework and Guidance published by NHS Digital.

The Trust has achieved a substantial assurance against the veracity of the self-assessment and moderate assurance against the 10 national data guardian standards. As per the published guidance, a Moderate rating is given when there are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited', however, not all standards are rated as 'Substantial'. The rating is based on a mean risk rating score at the National Data Guardian (NDG) standard level.

9.1 Assessment of self-assessment

In our view, the organisation's self-assessment against the Toolkit deviates only minimally from the Independent Assessment and, as such, the assurance level in respect of the veracity of the self-assessment:

Substantial Assurance

9.2 Assessment against National Data Guardian Standards

The rating is based on a mean risk rating score at the National Data Guardian (NDG) standard level. Scores have been calculated using the guidance from the independent assessment Guidance document.

As a result of the above, our overall assurance level across all 10 NDG Standards is rated as:

Moderate assurance

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level	Overall risk assessment across all 10 NDG Standards
1. Personal Confidential Data	**Moderate**	**Moderate**
2. Staff Responsibilities	**Substantial**	
3. Training	**Substantial**	
4 .Managing Data Access	**Substantial**	
5. Process Reviews	**Substantial**	
6. Responding to Incidents	**Substantial**	
7. Continuity Planning	**Substantial**	
8. Unsupported Systems	**Substantial**	
9 .IT Protection	**Substantial**	
10. Accountable Suppliers	**Moderate**	

Determination of Overall Risk Rating

Unsatisfactory	Limited	Moderate	Substantial
1 or more Standards is rated as 'Unsatisfactory'	No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'	There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'.	All of the standards are rated as 'Substantial'

9.3 Areas of good practice

There is a well-designed process for the compilation and review of the evidence required to support the Trust's annual Toolkit submission. An action plan is maintained by the Data Protection Officer, which assigns responsibility for the preparation of supporting evidence to responsible officers. Some of the good practice are as follows:

During the review the auditors noted the following areas of good practice:

- The Trust demonstrated a clear framework in relation to data security and protection with clear commitment and support by senior management.

- The Trust's registration with the Information Commissioner's Office was up to date and privacy notices were published and accessible via the website (1.1.1, 1.1.3).
- Key roles and responsibilities were assigned, including the role of Senior Information Risk Owner (SIRO), Caldicott Guardian (CG), Information Governance Manager and Data Protection Officer (DPO) (1.1.5).
- The Trust demonstrated cyber security and information governance matters received attention by the Board and senior management (3.1.1, 3.2.1).
- Logging and monitoring policies and procedures were in place with retention periods sufficient to enable investigation of incidents (4.4.1).
- Controls were in place to manage privileged users and permissions for high-risk functions (4.4.2).
- Data security and protection incidents were being reported and root cause analysis and lessons learned (5.1.1).
- Technical controls were in place for the management of antivirus solutions deployed, including updates and scanning of files downloaded or opened, however it was noted that the Trust was in the process of migrating to a new solution (6.2.1, 6.2.3, 6.2.4).
- Technical controls were demonstrated as in place to prevent connections to malicious websites (6.2.5) and email controls were accredited to DCB 1596 secure email standard (6.2.5, 6.2.8, 6.2.9);
- The Trust demonstrated its business continuity arrangements and had plans in place for a sample selected for testing, with further work to be undertaken (7.1.1, 7.1.2).
- Standard operating procedures were in place for the management of security patches and threat and vulnerability management. The Trust employed a range of threat intelligence sources and vulnerability scanning was evidenced. (8.4.1, 8.4.2, 8.4.3).
- Annual penetration testing had been scoped and completed (9.2.1, 9.2.3).
- The Trust evidenced secure configuration and change management for its infrastructure and systems, including restrictions relating to installation of software and autorun, device encryption and centrally deployed and managed standard builds. A sample of approved change requests were reviewed and confirmed. (9.5.1, 9.5.2, 9.5.3, 9.5.5, 9.5.6, 9.5.7, 9.6.4).
- Remote access solutions were in place and evidenced, Multifactor authentication was being matured and embedded and technical controls employed (9.5.8, 9.5.9).
- Technical controls were demonstrated as in place for a sample of accounts. (9.6.2).
- Boundary and local firewalls were in place and configured to block all unauthenticated inbound traffic by default. Reviews of the rules were evidenced with further reviews planned (9.6.1, 9.6.3, 9.6.5, 9.6.6).

9.4 MIAA findings and recommendations

Finding 1:	Information Assets Register and Data Flow Mapping	Rating:	MEDIUM
Related assertions:	**1.1.2 -** The Trust should demonstrate an up to date and comprehensive record of processing activities and confirm how the organisation gains assurance that it contains all the organisations processing activities that involve personal data. They should progress the project to remediate anomalies identified, and evidence a policy / process detailing how the record of processing activities will be maintained (1.1.2).		
Potential implications:	Failure to document the organisation's processing activities is in breach of legislation (e.g. Article 30 of the UK GDPR) and may result in unlawful and insecure data flows and processing. This may lead to reputational damage and monetary penalties.		
Recommendation /management action:	• The Trust should evidence data flows for key systems such as - finance, pharmacy, radiology, incident management and EPR prior to submission. • The Trust should evidence a policy / process detailing how the record of processing activities is updated and / or reviewed when there is a new or changed processing activity involving personal data. • The Trust should ensure that they have demonstrated that they have a comprehensive IAR / ROPA, documenting what personal data is held across the estate and evidencing it is reviewed regularly. • Mature and embed the planned improvement programme / assurance and continue to conduct a gap analysis to identify and remediate any anomalies. • The Trust should confirm how the organisation will gain assurance and report that the record of processing activities contains all of the organisation's processing activities that involve personal data. • Any residual risk should be considered and, if appropriate be acknowledged, recorded and accepted.		

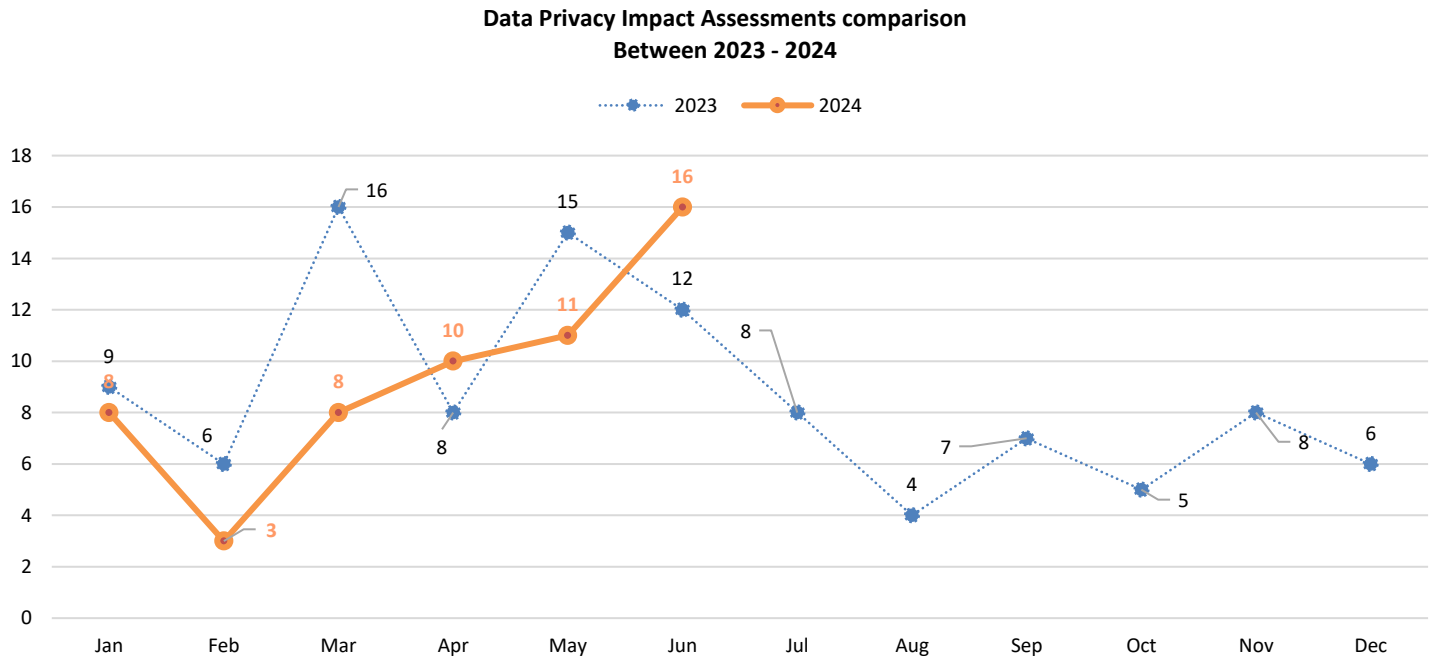
Finding 2:	Robust contract register	Rating:	MEDIUM
Related assertions:	**10.2.1 &10.2.4 -** The Trust should demonstrate an up to date and comprehensive contracts register, tracking appropriate accreditation and contracts that process personal data, and evidencing it is reviewed regularly. They should formalise an assurance strategy for the lifetime of the contract, ensuring contracts detail the roles and responsibilities for both parties (Trust / supplier), conduct a gap analysis and seek further assurance for any anomalies identified (10.2.1 & 10.2.4).		
Potential implications:	**10.2.1 -** The Trust as the accountable organisation would be responsible for any issues experienced by processes undertaken by suppliers on their behalf and as such it is essential that appropriate checks are in place and repeated periodically. **10.2.4 -** Data protection and security responsibilities may not be understood and adhered to if contracts do not specify the roles and responsibilities for all parties.		
Recommendation /management action:	**10.2.1** • The Trust should also ensure that they have demonstrated that they have a comprehensive register, tracking appropriate certification and contracts that process personal data, across the estate, and evidencing it is reviewed regularly. • The Trust should mature and embed ongoing certification and contract assurance to ensure due diligence pre procurement and ongoing throughout the duration of the contract is evidenced.		

	• The Trust should continue to mature and embed processes for key stakeholders such has procurement, IG, cyber, Information Asset Owners, and conduct a gap analysis to identify and remediate any certification or contractual anomalies. • Any residual risk should be considered and, if appropriate be acknowledged, recorded and accepted **10.2.4** • The Trust should evidence tracking due diligence checking of roles and responsibilities for both parties. • As planned, confirm procurement have undertaken the cyber training. • The Trust should review all critical service contracts to ensure that roles and responsibilities for both parties are clear. • Any residual risk should be considered and, if appropriate be acknowledged, recorded and accepted

10. Data Privacy Impact Assessments

Under UK GDPR, Data Privacy Impact Assessments became mandatory for high risk processing. This is part of the Privacy by Design ethos. The Trust had previously been using DPIAs where new technologies were introduced and they are becoming common place for the Trust as we mostly deal with health information which is a special category of information (similar to DPA 1998 sensitive data) under UK GDPR. We currently use a tool derived from the Information Commissioner's guidance.

In 2023-24 we finished 152 DPIAs, but some of the DPIAs are not approved yet because they need more information or they are complicated projects that require a staged approach to assess the risks.



Some of the challenges we face as a department to meet the Trust responsibilities are as follow:

- Divisions and service managers need to take responsibilities and ownership of the completion of DPIAs, as department managers they need to know why they want to bring a new system or process into the Trusts, know the risk associated with the specific project, etc. **as a department we are here to help and support through the whole process but departments need to complete the DPIA.**
- Poor information within the DPIA making difficult for us to assess the risk associated with the project and delaying the approval.
- One of the main problems we are currently facing is that projects are being authorised without an approved DPIA, this then requires a retrospective DPIA which is in itself challenging, even moreso if we cannot approve a DPIA due to it posing a large risk to the Trust.
- Departments need to plan ahead their projects and to consider privacy by design at an early stage of the project, DPIAs needs to be completed in a timely manner and submitted to the IG Department for approval.

11. Accreditations & Certifications

As a NHS Trust we have accreditations and certifications to reassure partners, customers, suppliers and other stakeholders that Trust operational procedures and processes comply with best practice standards.

11.1 Ensuring Data Security: Our ISO 27001 accreditation

We are proud to have been accredited for the past six years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

ISO 27001 is an internationally recognised standard that sets forth the requirements for establishing, implementing, maintaining, and continually improving an Information Security Management System (ISMS).

Attaining ISO 27001 certification involves a comprehensive audit process conducted by independent assessors to ensure that an organisation’s information security measures are robust and effective.

Why ISO 27001 Matters in Healthcare:

In the healthcare sector, where the protection of sensitive patient information is paramount, ISO 27001 accreditation serves as a critical benchmark. The NHS, being a data-intensive environment, demands stringent measures to safeguard patient records, medical histories, and other confidential information. Our ISO 27001 certification underscores our commitment to upholding the highest standards of information security, providing peace of mind to our clients in the healthcare industry.

Achieving ISO 27001 accreditation is a significant milestone for S&SHIS as it reinforces our commitment to excellence in information security, particularly within the NHS. Our clients can be confident that their sensitive data is in safe hands, backed by internationally recognised best practices. As we continue to evolve in an ever-changing digital landscape, our ISO 27001 certification positions us as a reliable partner dedicated to ensuring the highest standards of data security in healthcare.

11.2 Ensuring Data Security: Our ISO 9001 accreditation

We are proud to have been accredited for the past six years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

ISO 9001 is the international standard that defines the requirements for a Quality Management System (QMS). A Quality Management System enables organisations to manage their processes and systems in order that customer and other stakeholder requirements can be achieved. At its core is the principle of continuous improvement.

Attaining ISO 9001 certification involves a comprehensive audit process conducted by independent assessors to ensure that an organisation's information security measures are robust and effective.

Why ISO 9001 Matters in Healthcare:

ISO 9001 ensure our quality of service is clear, repeatable and defines our commitment to creating products and services that consistently meet both customer and regulatory requirements.

11.3 Ensuring Data Security: Secure Email Standards (DCB1596)

We are proud to have been accredited for the past six years. It is testament to our unwavering commitment to data security and confidentiality. This accreditation is particularly significant as it solidifies our position as a trusted partner within the NHS.

All emails that include health and care information sent to and from health and social care organisations are required to meet the secure email standard (DCB1596), if the organisation does not use NHSmail. The information standard is published under section 250 of the Health and Social Care Act 2012.

The secure email standard sets out the minimum requirements for a secure email service. Meeting the secure email standard means that an organisation's email system is secure enough to keep sensitive information safe. This covers the storage and transmission of email, including where email is used for the sharing of patient identifiable data. The standard includes:

- The information security of the email service
- Transfer of sensitive information over insecure email
- Access from the internet or mobile devices
- Exchange of information outside the boundaries of the secure standard

Why DCB1596 Matters in Healthcare:

Confidential data is a key focus for cyber-attackers, with health and social care organisations a popular target.

To help secure sensitive data, emails that include health and care information sent to and from health and social care organisations are required to meet the Secure Email Standard (DCB1596).

12. Recommendation and priorities for 2024-25 period

- **IG/Divisions:**
  - The Information Governance Department must prioritise the Information Assets and Data Flow Mapping Registers.
  - Support from the divisions is essential for this work, as they are the only ones who can identify the type of asset they hold and how information is shared within their departments.

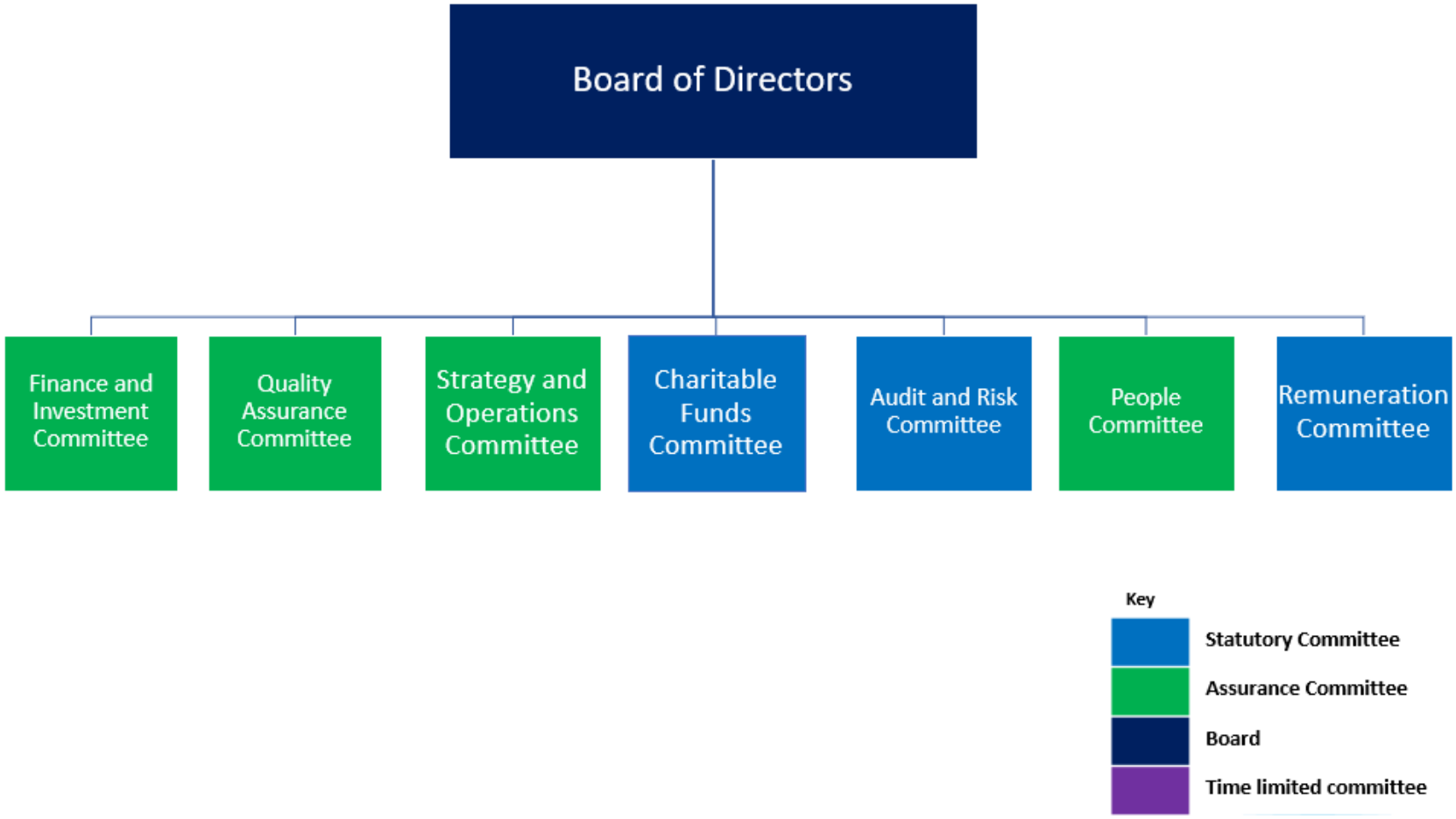
- **Procurement:**
  - The Trust should maintain an up-to-date and comprehensive contracts register.
  - Contracts processing personal data should be tracked, accredited, and regularly reviewed.
  - An assurance strategy for the contract's lifetime should be formalised, specifying roles and responsibilities for both parties (Trust and supplier).
  - Conduct a gap analysis and seek further assurance for any anomalies identified.

- **IT Services:**
  - Prioritise penetration test recommendations to mitigate cybersecurity risks.
  - Report any recommendations that cannot be fixed promptly or will take longer than expected via the Risk Register.

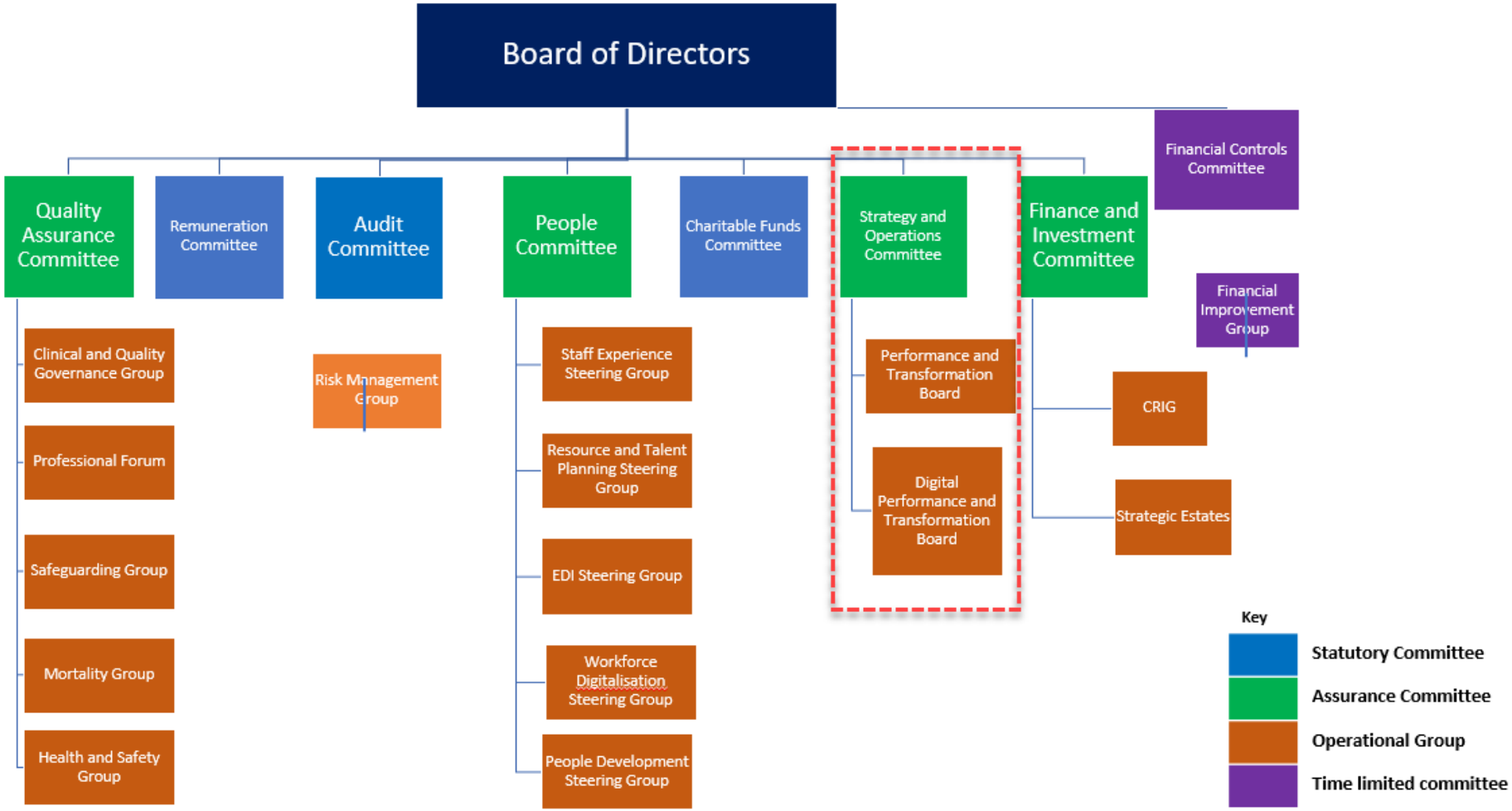
- **Emergency Planning:**
  - Conduct an annual tabletop exercise for Business Continuity Planning (BCP) within the divisions.
  - Understand functions and dependencies of services (internal or external).
  - Completion of the exercise will produce a functional BCP, while for others, it may highlight necessary improvements.

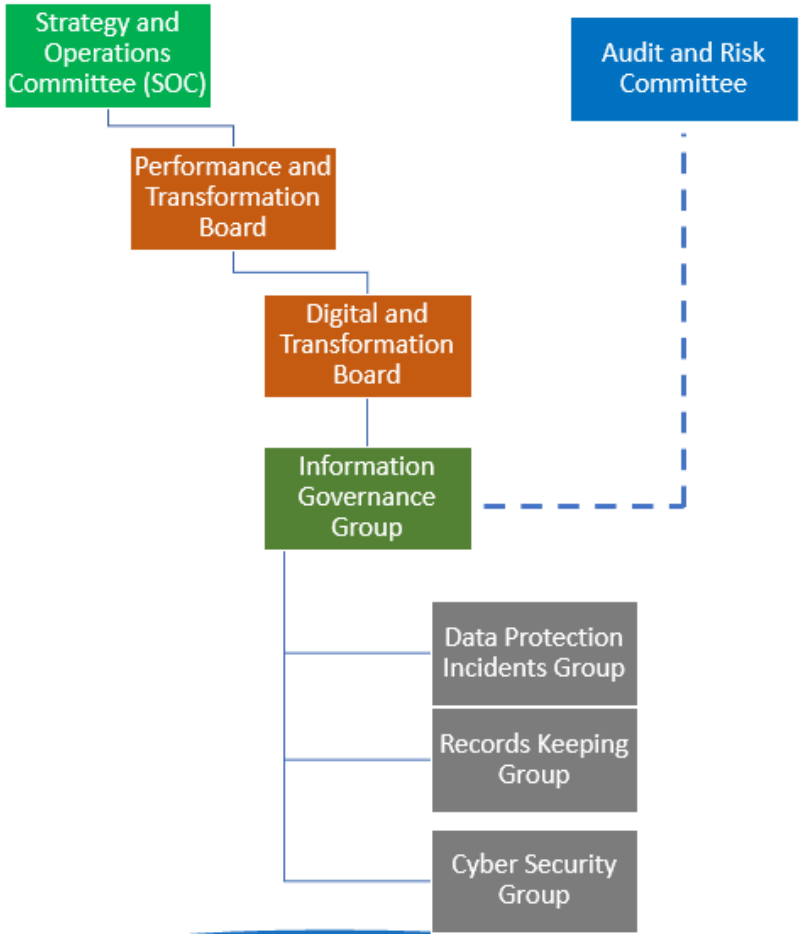
Deiler Carrillo
Data Protection Officer
01st July 2024

Appendix A – Governance Structure



NHS Bolton NHS Foundation Trust





TORs to be revised to the below…

- To provide assurance to the Board on the effective and adequacy of oversight in the management of cyber risk including appropriate levels of independent scrutiny and assurance.
- Receive the results of the Annual DSP toolkit audit and receive assurance over the Trust's plans to address any areas of improvement identified.
- Receive an Information Governance Annual Report focussed on compliance with data protection and Freedom of Information (FOI) rules number/type of breaches; and plans to develop and improve compliance.
- Receive assurance on the quality of data relied on for decision-making, plans on maintaining proper controls over data quality, including regular independent audits.

Appendix B – Data Security and Protection Toolkit Certification

Data Security and Protection Toolkit

NHS Digital

2023-24 (version 6)

BOLTON NHS FOUNDATION TRUST

The Royal Bolton Hospital, Minerva Road, Bolton, England, BL4 0JR

Standards met

Date of publication: **25 June 2024 (valid to: 30 June 2025)**

This organisation has completed a Data Security and Protection Toolkit self-assessment to demonstrate it is practising good data security and that personal information is handled correctly.

www.dsptoolkit.nhs.uk

Report Title:	Annual Safeguarding Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Chief Nursing Officer		Decision	

Purpose of the report	This report evidences safeguarding performance, identifies areas for improvement and ensures compliance with statutory obligations for vulnerable individuals.

Previously considered by:	Trust Safeguarding Committee Quality Assurance Committee

Executive Summary	Bolton NHS Foundation Trust has upheld its statutory safeguarding obligations for children, young people and adults at risk throughout 2023-2024. Under the Chief Nurse's leadership, comprehensive systems align with key legislation and guidelines. The Trust approved additional safeguarding resources, creating roles such as MCA/DoLs Lead and Named Nurse for Looked After Children. Contractual standards improved, with red-rated areas eliminated and management plans implemented for amber areas. The high volume of safeguarding referrals emphasises the importance of robust processes. Outdated policies pose risks of inconsistent practices and protection gaps. However, new safeguarding roles demonstrate commitment to addressing resource needs. While contractual standards have improved, amber-rated areas require ongoing attention. Recent legislative updates necessitate a review of current practices. Going forward, the Trust will implement a comprehensive policy review process and fill new safeguarding roles. Participation in the Bolton Safeguarding Children Partnership will address gaps in updated legislation. Development of Adult Safeguarding referrals dashboards will enhance data analysis. The Trust will monitor care and support statutory guidance reviews, adjusting practices to maintain compliance. Embedding the 'Making Safeguarding Personal' approach remains a priority, ensuring person-centred safeguarding. These actions reinforce the Trust's commitment to protecting vulnerable individuals and maintaining effective safeguarding measures.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Safeguarding Annual Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	Additional safeguarding resources approved, including new roles Potential financial implications for ongoing training and system improvements
Legal/ Regulatory	**Yes**	Statutory safeguarding obligations upheld for 2023-2024 Alignment with key legislation and guidelines Need for policy review due to outdated policies and recent legislative updates Improved contractual standards, but ongoing attention required for amber-rated areas
Health Inequalities	**Yes**	High volume of safeguarding referrals indicates potential health inequalities Creation of Named Nurse for Looked After Children role addresses vulnerable population
Equality, Diversity and Inclusion	**Yes**	Implementation of 'Making Safeguarding Personal' approach promotes person-centred care Development of Adult Safeguarding Referrals dashboards may help identify and address disparities

Prepared by:	Corporate Safeguarding Team Kelly Crumlin Safeguarding Project Manager Angela Clough Associate Director of Nursing: Patient Safety and Quality Rebecca Bradley Deputy Chief Nurse	Presented by:	Tyrone Roberts Chief Nursing Officer

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

SAAF	Safeguarding and Accountability and Assurance Framework
BoSCA	Bolton System of Care and Accreditation
BSAB	Bolton Safeguarding Adult Board
BSCP	Bolton Safeguarding Children Partnership
CDOPs	Child Death Overview Panel
CEAM	Child Exploitation and Missing
CP-IS	Child Protection Information Sharing CP-IS
CPP	Child Protection Plan
CSE	Child Sexual Exploitation
DHR	Domestic Homicide Reviews
DoLS	Deprivation of Libertys
DVA	Domestic Violence & Abuse
EHC Plan	Education and Health Care Plan
EHCP	Education Health & Care Plan
EPR	Electronic Patient Records
FGM	Female Genital Mutilation
GM	Greater Manchester
ICB	Integrated Care Board
IFD	Integrated Front Door
IHA	Initial Health Assessments
LAC	Looked After Children
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Assessment
MS	Modern Slavery
MSP	Making Safeguarding Personal
NRM	National Referral Mechanism
RHA	Review Health Assessments
RIS	Risk Indicator System
SAR	Safeguarding Adults Review
SEND	Special Educational Needs and Disability,
UASC	Unaccompanied Asylum Seekers and Children

Safeguarding Adults, Children and Looked After Children Annual Report 2023/24

Authors:

Fiona Farnworth, Named Nurse, Safeguarding & Looked After Children Nurse

Sheila Mooney, Lead Nurse, Adult Safeguarding

Jayne Maguire, Named Midwife

Kelly Crumlin, Safeguarding Project Lead

Contents

Executive Summary

Bolton NHS Foundation Trust has consistently fulfilled its statutory safeguarding obligations throughout the 2023-24 period, encompassing the protection of children, young people, and adults at risk.

The Chief Nursing Officer for Bolton NHS Foundation Trust has the statutory responsibility for safeguarding, with support from the Deputy Chief Nurse. The trust benefits from the expertise of a Named Nurse for Safeguarding Children, Young People and Looked After Children, as well as a Lead Nurse for Safeguarding Adults. Bolton NHS Foundation Trust has demonstrably implemented systems and processes to support the discharge of its statutory safeguarding duties. These procedures adhere to key legislation and guidelines, including:

- Care Act 2014
- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2023
- The NHSE Safeguarding and Accountability and Assurance Framework (SAAF 2022) contractual requirements

1. Introduction

1.1 Forward

The strategic values of Bolton NHS Foundation Trust are fundamental to the care delivery and operations of the safeguarding team. The Trust's safeguarding arrangements are designed to protect individuals from harm or abuse, irrespective of their circumstances.

During the reporting year, the Statutory Guidance for Safeguarding Children Working Together was updated in December. Safeguarding and promoting the welfare of children is defined as:

- providing help and support to meet the needs of children as soon as problems emerge.
- protecting children from maltreatment, whether that is within or outside the home, including online.
- preventing impairment of children's mental and physical health or development.
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

Child protection is part of safeguarding and promoting the welfare of children it is defined as activity that is undertaken to protect specific children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home, including online.

Effective safeguarding means practitioners should understand and be sensitive to factors, including economic and social circumstances and ethnicity, which can impact children and families' lives.

The safeguarding team ensures that the trusts values are at the heart of everything that they do and can be seen within the table below.

Table 1 - Safeguarding Teams Trust Values

	Trust Values	Safeguarding aligned to Trust Values
Vision	We have a plan that will deliver excellent health and care for future generations, working with partners to ensure our services are sustainable. We make decisions that are best for long term health and social care outcomes for our communities	We ensure that we learn from past practice to improve future provision to keep adults at risk and children safe. We make decisions with our partners to ensure the best outcomes for our patients.
Openness	We communicate clearly to our patients, families and our staff with transparency and honesty We encourage feedback from everyone to help drive innovation and Improvements	We ensure the voice of the child and adult at risk is heard in all decisions regarding care and protection. We are open and honest with parents and carers regarding child protection procedures.
Integrity	We demonstrate fairness, respect, and empathy in our interactions with people We take responsibility for our actions, speaking out and learning from our mistakes	We respectfully and professionally challenge where concerns arise in our patient's best interest. We learn from local and national incidents and investigations and share learning across services.
Compassion	We take a person-centred approach in all our interactions with patients, families, and our staff We provide compassionate care and demonstrate understanding to everyone	We place the needs of the adult and child at risk central in all we do while recognising the importance of a partnership approach with parents and carers
Excellence	We put quality and safety at the heart of all our services and processes We continuously improve our standards of healthcare with the patient in mind	We ensure our service provides quality advice and support to all staff to ensure safeguarding standards are maintained and everyone is aware of their role in keeping children safe.

Bolton NHS Foundation Trust supports a population within Bolton approaching 300,000 people recorded in 2024 and is predicted to rise by 4.3% per year. The trust employs 6,000 dedicated staff to meet the needs of our

population and accepts patients from across the whole of Greater Manchester and further afield. It is a major hub in Greater Manchester for Women's and Children's services and is the second busiest ambulance receiving site in Greater Manchester.

Bolton has a diverse population, with 28% of Bolton's population are from communities that face racial inequality, and it is estimated that 56% of our population live in areas that are amongst the most deprived in the country, meaning that they live longer in poorer health. Children and young people aged 0-19 years make up 26% of the population of Bolton and all those up to the age of 18 years and 19 years if they have a disability should be protected from significant harm, under child statutory safeguarding procedures.

Trust services in the community and on the hospital site work with children and families across all thresholds from universal provision to children who are subject to a Child Protection Plan or children who are looked after. This includes contact with the child or family in the home, clinic, or alternative setting, carrying out assessments and interventions, making referrals to other services and agencies, attending meetings, and writing records and reports.

Within the Safeguarding Adult Team, we have seen a dramatic increase in the number of referrals from all sources and areas within Bolton. The data within the annual report identifies the areas where we as a trust can work together with our partners to developing a strategic preventative work stream, table 2 shows an example of the referrals received and location over the past 3 years.

Table 2 Adult safeguarding referrals

	2021/22	**2022/23**	**2023/24**
Safeguarding referrals from Adults ED	925	2085	814
All other Safeguarding referrals for adults	834	1017	2183

1.2 Background

1.2.1 The safeguarding annual report provides an opportunity to reflect on the achievements of 2023/24 and focus on priorities for 2024/25. The annual report will provide an update to the Trust Board on compliance against statutory safeguarding requirements and will focus on key work streams and achievements of adults, children and looked after children during 2023/24. The report will also highlight some themes from the Bolton Safeguarding Children Partnership (BSCP) and the Bolton Safeguarding Adult Board (BSAB).

1.2.2 In 2023/24, there has been a change to the guidance document Working Together to Safeguard Children 2023. The BSCP are reviewing this during 2024/25 with a dedicated task and finish group working across the

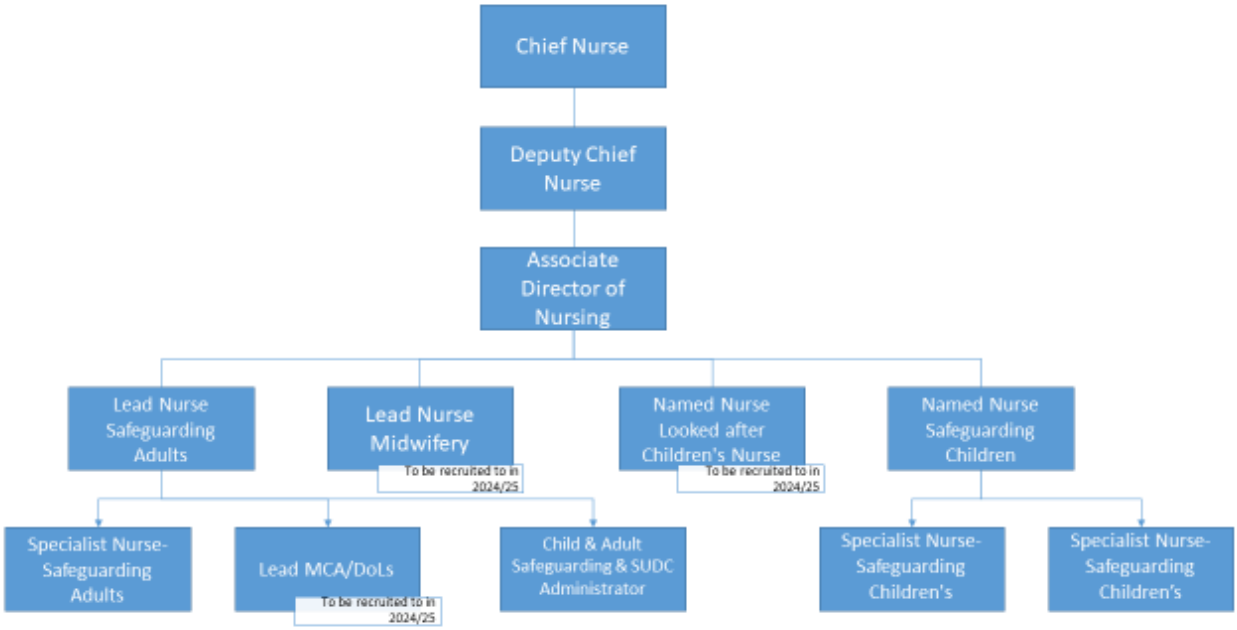
locality. The care and support statutory guidance which adult safeguarding forms a part of is currently under review.

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

1.3 Safeguarding Team

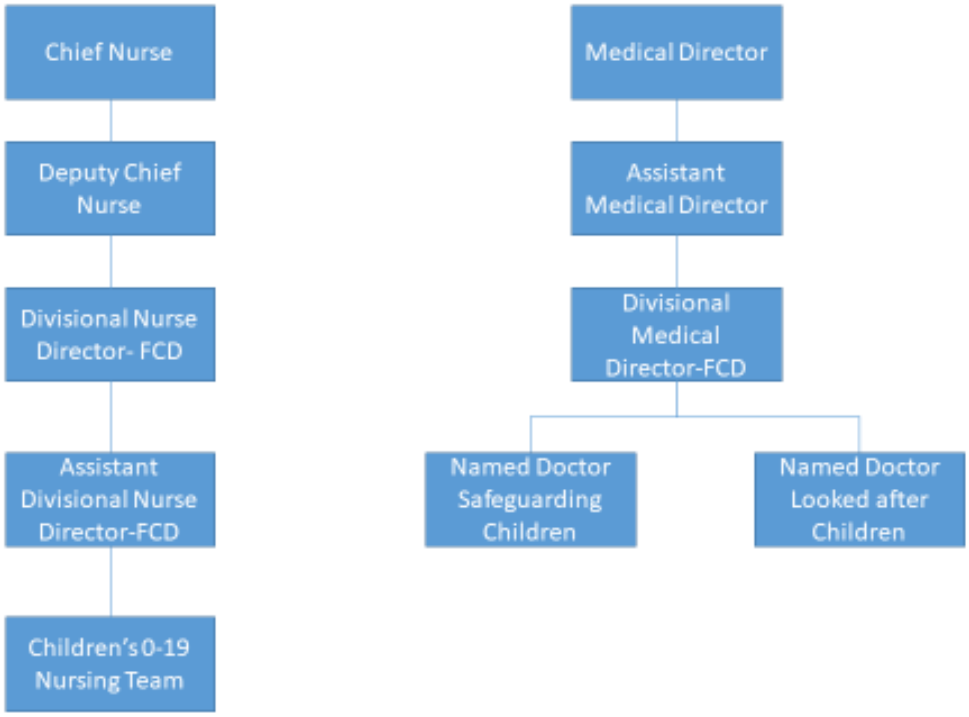
1.3.1 The Safeguarding Team (diagram 1) sits within the organisations corporate structure, providing specialist support across the acute trust and our community services.

Diagram 1- corporate safeguarding nursing reporting structure



1.3.2 Complementing the corporate structure, our named medical posts for safeguarding children and looked after children sit within the Family Care division. These specialist doctor posts (diagram 2) are support with assessments by our nurses within our 0-19 services.

Diagram 2 Named Doctors and specialist nursing support structure



1.3.3 The above diagram highlights how the trust evidences its professional leadership and escalation routes for nursing and medical staff with our Family Care Division to Trust Executives, this supports the SAAF 2022 guidelines.

1.3.4 During 2023/24 the organisation has engaged with all colleagues and our patients to gain views to help to develop the strategic priorities for the next 5 years. The safeguarding team is a key partner in delivering the vision for improving safety, effectiveness, and experience.

1.4 Board Oversight

1.4.1 The Trust Board Executive Lead for safeguarding children, looked after children and adults at risk is the Chief Nursing Officer, who represents the Trust at the Bolton Safeguarding Children Partnership. The Deputy Chief Nurse represents the Trust at the Bolton Safeguarding Adult Board and is responsible for the management of the Safeguarding Team and chairs the Safeguarding Committee.

1.4.2 The Executive Board assures themselves of an organisational culture where all staff are aware of their personal responsibilities for safeguarding children and adults at risk. There is a learning culture to ensure continuous improvement.

1.4.3 The Board provides oversight of the activities of the Safeguarding Team with a 6 monthly update presented to the Quality Assurance Committee which is chaired by a Non-Executive Director.

1.4.4 The Clinical Governance and Quality Committee seeks oversight of the annual report and assurance that the Safeguarding Committee is executing its duties effectively.

2. Achievements

In the 2023/2024 period, the Trust has made significant strides in enhancing its safeguarding capabilities:

- Completion of a comprehensive service review and self-assessment against the NHSE assurance framework.
- Successful submission and approval of a business case for additional funding and capacity to meet statutory responsibilities.

The Trust board has approved the establishment of key designated posts:

- MCA/DoLs Lead
- Named Nurse for Looked after Children
- Named Midwife

These positions are scheduled to be filled during the 2024/25 period.

Additional achievements include:

- Improvements in contractual standards:
  - Elimination of all red-rated areas
  - Implementation of management plans for amber-rated areas, with clear strategies for achievement in 2024/25
- Enhancements in collaboration:
  - Development of Business Intelligence capabilities to gather comprehensive information on vulnerable adult support
  - Active participation as key partners in both Bolton Adult Safeguarding Board and Children's Partnership Board
- Advancements in training:
  - Completion of an organisation-wide training needs analysis
  - Implementation of support programs for the new workforce
- Stakeholder engagement:
  - Successful execution of the Voice of the Child Forum in February 2024, with additional sessions planned for 2024/25

All posts will be appointed to during 2024/25

- Improvements in the contractual standards:

  - No red areas
  - Any ambers are being managed and rolled forward into 2024/25 with clear plans to achieve
- Improvements and collaboration
  - Business Intelligence to gather rich information around supporting our vulnerable adults
  - Active collaboration and key partners of both Bolton Adult Safeguarding Board and Children's Partnership Board
- Success review of training
  - Completion of organisation wide training needs analysis
  - Supporting our new workforce
- Voice of the Child Forum held in February 2024, with more planned during 2024/25

3. Governance Arrangements

3.1 Governance structure

The Chief Nursing Officer maintains board-level oversight for safeguarding within the Trust, with a particular focus on child safeguarding. The Deputy Chief Nurse provides support in ensuring the effective discharge of the Trust's safeguarding duties, as evidenced through the Safeguarding Committee.

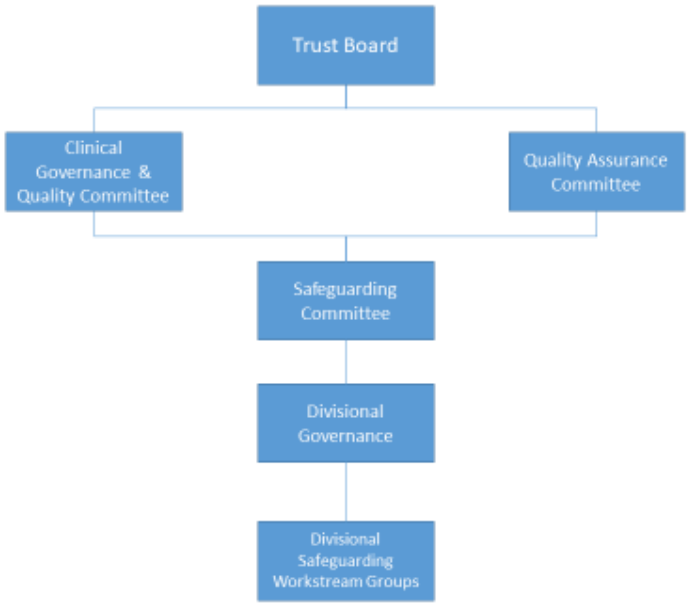
The Safeguarding Committee, a joint Adults and Children's meeting, convenes quarterly to provide comprehensive oversight of the Trust's safeguarding activities and contractual requirements. The committee's objectives include:

- Ensuring the implementation of systems to safeguard service users from harm caused by abuse or neglect.
- Maintaining safeguarding as a high priority within Bolton FT.
- Ensuring compliance with legislative, mandatory, and regulatory requirements pertaining to the entire safeguarding agenda.
- Facilitating the review, monitoring, and development of safeguarding practices across the organisation.
- Providing assurance on the management of adult, children, and young person's safeguarding.
- Overseeing the implementation and monitoring of appropriate systems and processes for mental capacity assessment and deprivation of liberties across the organisation.
- Promoting and developing community engagement strategies that enhance the safeguarding of vulnerable adults, utilising community/users' views, and feedback to ensure their voices drive service provision.
- Ensuring Divisional representatives disseminate information from the Safeguarding Committee to their respective Divisional Boards.

All named professionals within the Trust participate in this committee, providing quarterly update reports that include any escalations or support requirements. Each division within the trust conducts self-assessments and provides assurance on their safeguarding work, including the escalation of any issues or support needs.

The Safeguarding Committee extends invitations to designated named professionals from the ICB (Integrated Care Board) and the independent chair for the adult safeguarding board and partnership groups within Bolton. The committee reports quarterly to the Clinical Governance and Quality Committee and bi-annually to the Quality Assurance Committee (diagram 3). The quarterly Chair's report from the Safeguarding Committee includes updates on the board's statutory responsibilities, structured as alerts, advisories, and assurances.

Diagram 3 Safeguarding reporting structure



3.2 Audit and monitoring

3.2.1 The Safeguarding Team participates in the trust annual audit programme of work and these specific audits are aimed at providing assurance around our systems and processes. Further details of the audits can be found in the relevant sections below.

3.2.2 Adults safeguarding audits that have been undertaken during this reporting period are highlighted in table 3.

Table 3 Adults safeguarding audits

Practice area	Person responsible	Outcome
MCA/DoLS audit	Lead Nurse Adult Safeguarding	The results of this audit display that there are some gaps in knowledge and the perceptions around DoLS and MHA methods/practices.

3.2.3 Children's safeguarding audits within the timescales of this report are highlighted in table 4.

Table 4 Children's safeguarding audits

Practice area	Person responsible	Outcome	Learning	Actions
Health Referrals to IFD (Integrated Front Door)	Safeguarding Nurse IFD	Quality assurance of health referrals working with social care and police colleagues Feedback with examples of good practice and where further information and analysis is required	Generally, number of referrals made to IFD is small. Trust Safeguarding Children team make some referrals Out of Hours contact is made with the Duty SW including for children who live out of area.	IFD Nurse to report findings through FCD Safeguarding Committee and Trust Safeguarding Committee
Child Exploitation Peer Review	Named Nurse and Safeguarding Nurse	GM audit – attended out of area to peer review cases identified and to support the team coming into area to review cases Positive feedback shared through Trust Safeguarding Committee	Formal feedback provided by the GM Health Exploitation Lead and shared with Service Leads and through Trust Safeguarding Committee	Key messages about use of language and terminology included in the Voice of the Child Forum held in February 2024.
MARAC and Daily Risk	Safeguarding Nurse	Dip sample – particularly in repeat cases to	Requirement to track actions are	Domestic abuse pathway in 0-19 service to be

Meeting health actions	MARAC and IFD	ensure health actions have been completed. Escalation to the practitioner and Team Leader if required.	completed in a timely way	strengthened to improve response and consistency.
LAC Health Assessments	Named Nurse and LAC Nurse	Following the agreed GM Quality Assurance Pathway. Feedback in individual cases and to Trust Safeguarding Committee.	Sample identified examples of excellent and good practice.	LAC training updated in light of findings. Update provided to 0-19 Team Leader meetings
Sleep Safe Audit	0-19 Practice Educator	Evidence of embedding new Sleep Safe assessment developed following several child deaths where unsafe sleep was identified.	Effective implementation of new Safe Sleep Assessment on EPR	Task and finish group actions completed. Ongoing training to be provided in 0-19 service, Acute Paeds and Maternity.

3.3 Safeguarding Statutory Requirements

3.3.1 In December 2023, the government issued an update to 'Working together to safeguard Children' legislation. Bolton Safeguarding Children Partnership are reviewing the documentation, and it is anticipated a task and finish group will commence to confirm the current state and develop necessary actions to support gaps during 2024/25. With the safeguarding team being key partners in this workstream.

3.3.2 As of March 2024, the care and support statutory guidance is under review, this is being monitored closely by the adult safeguarding team to ensure we continue to meet our statutory duty.

3.4 Policies and guidance

3.4.1 The Trust implements comprehensive safeguarding policies and procedures to protect vulnerable individuals from harm, abuse, and neglect. These measures ensure staff are adequately trained to recognise signs of abuse, understand their responsibilities, and are knowledgeable about reporting concerns. Our policies promote a culture of vigilance, accountability, and inter-agency collaboration. As of the end of Q4, six policies were identified as requiring updates (refer to Table 1).

3.4.2 A key priority identified for 2024/25 is the development of a comprehensive process to ensure all safeguarding policies undergo regular review and remain current. This will involve implementing a systematic approach to tracking policy status, scheduling reviews, and facilitating timely updates. This new process (table 6) will provide assurance that the trust's safeguarding policies consistently reflect the latest standards and regulatory requirements, thereby supporting best practice in safeguarding across the organisation.

Table 6 Policy Review

Document Title	Date Due	Q4 Update	Plan for Q1/2 24/25
Safeguarding Children Supervision Policy	01/12/2018	Update in progress	Updated document to be in place
Managing Allegations against Bolton FT staff final	01/04/2019	Meeting with HR lead as joint policy	Updated document to be in place
Domestic Violence and Abuse Policy.	01/02/2020	Approved at April Safeguarding Committee	Updated document to be in place
Management of Patients Detained Under the Mental Health Act 1983.	01/11/2021	Update in progress	Updated document to be in place
Managing Missed Appointments for Children, Young People, and their Carers.	01/12/2021	Update in progress	Updated document to be in place
PREVENT Policy	01/11/2023	Awaiting national recommendations by Home Office	Updated document to be in place

3.5 Bolton System of Care and Accreditation (BoSCA)

3.5.1 The trust's accreditation process (BoSCA) is instrumental in our collective efforts to elevate and maintain standards across all services. The BoSCA standards have been meticulously reviewed and aligned with the CQC domains (safe, effective, caring, responsive, well-led) to support consistent, compassionate care delivery to our patients and their families. Safeguarding is a critical component of this accreditation process. The Safeguarding Team's play an active role in monitoring and supporting teams' compliance with this standard.

4. Safeguarding Adults

4.1 Making Safeguarding Personal

4.1.1 'Making Safeguarding Personal' (MSP) is an approach that ensures the individual at risk and/or their advocate are fully engaged and consulted throughout the safeguarding enquiry. This approach places their wishes and views at the centre of the process, informing the final outcomes to the greatest extent possible.

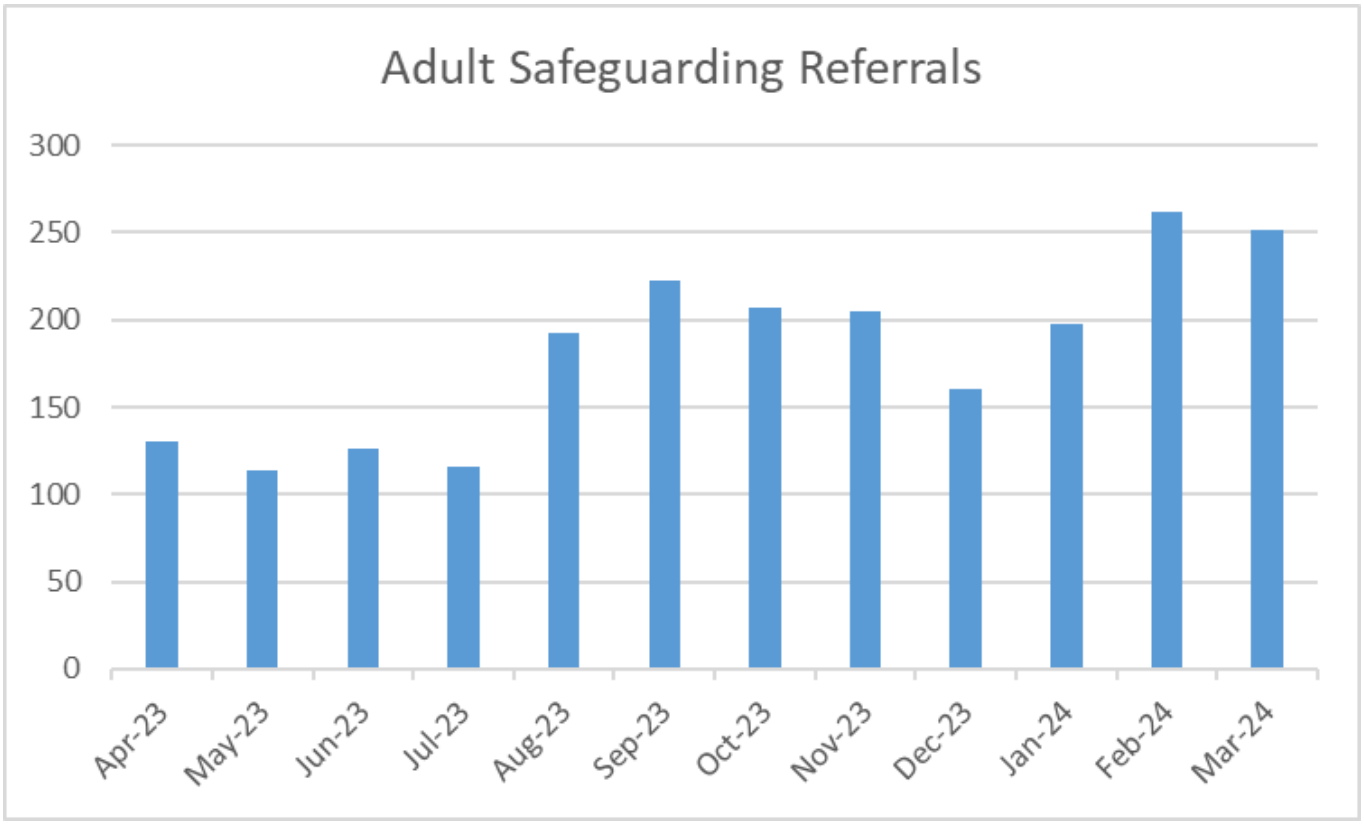
There are 6 principles with the care act that help to describe adult safeguarding these are:

- Empowerment.
- Prevention.
- Proportionality.
- Protection
- Partnership.
- Accountability.

4.1.2 The Adult Safeguarding Team are available to provide advice and support to our teams. As our systems develop, improvements to the data capture of referrals will improve and provide the team with information around the types of concerns being raised.

4.1.3 Development of dashboards commenced for Adult Safeguarding referrals during 2023/24 with further work planned for 2024/25. During 2023/24 there were 2,183 referrals (graph 1) to the adult safeguarding team.

Graph 1: Adult safeguarding team referrals 2023/24



4.3 PREVENT

4.3.1 The trust has representation within the Greater Manchester PREVENT collaborative. The trust provides research for both and children and adults where there are concerns of radicalisation, the Adult's Safeguarding Team attend Chanel Panel when requested, we also attend the GM PREVENT Practitioner's Group, the Local Steering Group, and the Delivery Board.

4.3.2 The trust has only referred 1 adult within 2023/24, there has however been 2 other cases where we have escalated to the PREVENT team and GMP. These cases were brought to the Adult Safeguarding Teams' attention by frontline line staff who had recently completed their PREVENT training. The trusts PREVENT training data for Preventing Radicalisation Basic Awareness and Awareness is uploaded quarterly to NHS Digital. Prevent sits alongside safeguarding duties of professionals to protect people from a range of harm such as substance abuse, involvement in gang activity and physical and sexual exploitation.

4.3.3 Prevent is one part of the government's overall counter-terrorism strategy, CONTEST, based around four work streams, the aim is to reduce the risk to the United Kingdom:

PURSUE: Stop terrorist attacks happening in the U.K and overseas

PREVENT: To safeguard people from becoming terrorists or supporting terrorism.

PROTECT: To strengthen our protection against a terrorist attack in the UK and overseas.

PREPARE: To mitigate the impact of a terrorist incident if it occurs

4.3.4 A representative from the Safeguarding Children Team attends Channel Panel monthly. There have been not direct Prevent referrals made for children in the period of the annual report however children and young people are known to case holders in 0-19 service or may have attended for Urgent Care.

4.3.5 There is updated Channel Duty Guidance from HM Government replacing guidance from 2020.This provides clear guidance about the Channel process, the role of the Chair and the responsibilities of panel members. There has been a change in the language used in terms of radicalisation, it is now described as susceptibility rather than vulnerability in recognition of the fact that a substantial number of adults and children are vulnerable, but this may not relate directly to the process of radicalisation. There is a new requirement for Channel Panels to consider the context of radicalisation locally including taking note and intervening in permissive environments.

4.3.6 Information on training compliance for Prevent can be found in section 11.

4.4 Mental Capacity Act

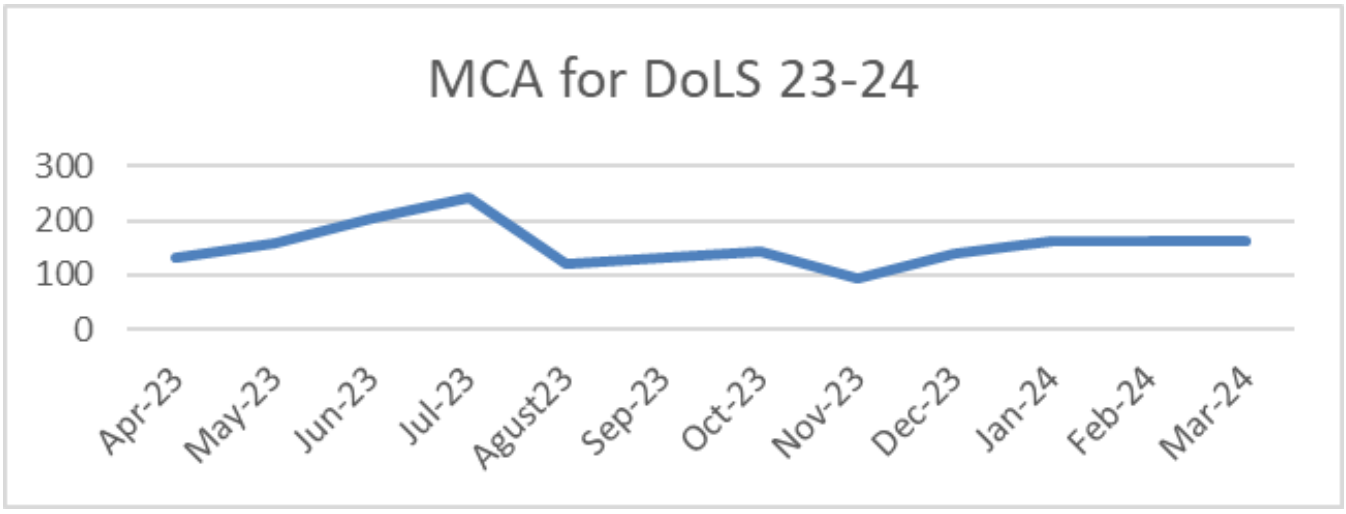
4.4.1 The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

4.4.2 It has been recognised that the trust did not have a statutory position in place and a business case was subsequently approved for an MCA/DoLS lead. This will be a key focus in 2024/25 on delivering further training and ensuring our systems and processes support our patients and workforce.

4.4.3 Mental Capacity Act and Deprivation of Liberty Safeguards training is not mandatory it is included within the L3 adult training, the trust also deliver standalone training which will now be facilitated by the MCA/DoLS lead Practitioner once in post.

4.4.4 Our Electronic Patient Record (EPR) team have also been incredibly supportive developing a full package of MCA/BI/DoLs documentation. The DoLS documentation has been instrumental in increasing the number of Mental Capacity Assessments for a DoLS application. To support this further, there is a quality assurance process undertaken by the Adult Safeguarding team prior to forwarding the application (graph 2) to the appropriate local authority.

Graph 2 MCA/DoLs applications sent to the local authority



4.5 Deprivation of Liberty Safeguards (DoLS)

4.5.1 In certain cases, the restrictions placed upon a person who lacks capacity may amount to "deprivation of liberty". This must be judged on a case-by-case basis. Where a deprivation of liberty might happen, the trust must apply to the local authority where the patient normally resides.

4.5.2 If the patient has a diagnosis of a cognitive impairment or there are concerns their cognition is impaired there must be consideration that a Mental Capacity Assessment may need to be completed. If it is deemed that the patient does not have capacity to make the decision at a specific time to remain in hospital for care and treatment and the Acid Test is applied (patient is under 24 hour supervision and is unable to leave, irrelevant if they are physically able to or not) it is in the person's best interests that a DoLs application is completed. During 2023/24, the trust submitted 560 applications. Once there is an application for a Standard, Urgent and an Extension sent to the appropriate local authority it is then for the local authority to follow the Deprivation of Liberty Code of Practice.

4.5.3 During 2023/24 work has been developed to highlight the process for applying for a DoLS across the trust, with the post of MCA/DoLS post business case being approved ready for recruitment in 2024/25. This post will support our work with local authority colleagues and help us to improve our internal processes on granting DoLS.

4.6 Modern Slavery

4.6.1 Although Modern Slavery (MS) is not defined in law, it is used as an umbrella term that focuses attention on commonalities across these legal concepts. Modern Slavery covers a set of specific concepts including forced labour, debt bondage, forced marriage, slavery and slavery like practices and human trafficking. It is estimated

that across the UK, 122,000 people are victims of modern slavery, thousands of whom are children. These men, women and children are being forced into a life they did not ask for.

4.6.2 Modern slavery is explored within both children's and adult safeguarding training we also discuss case studies and challenge staff to describe areas in Bolton where this may be happening.

4.6.3 Making Safeguarding Personnel is key to a good outcome for the patient if they want referring to the local authority, they will then refer to the National Referral Mechanism (NRM). The NRM is the system used in the UK to identify people who have experienced modern slavery and human trafficking, ensure they receive appropriate support and protection again this is where also comes in to play as the referral can only happen if the person wants to follow this process. We have over the last year been made aware of 2 adult cases, which have been referred to the local authority and to the NRM.

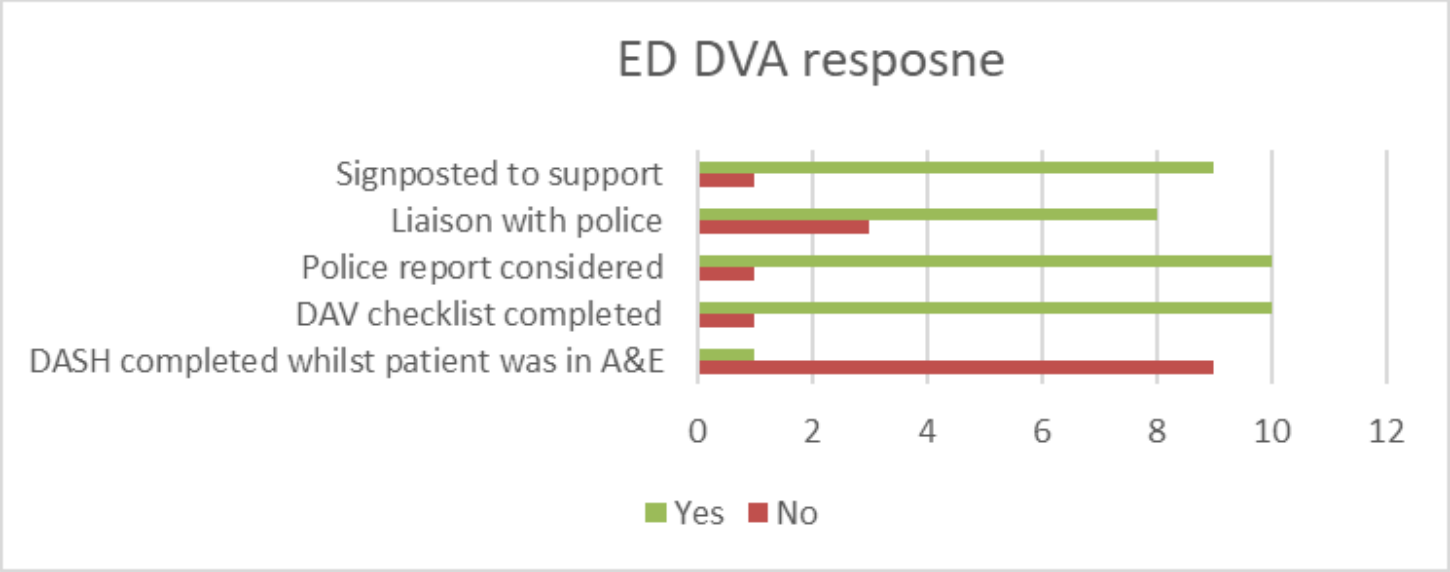
4.7 Domestic Violence and Abuse

4.7.1 We define domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in most cases by a partner or ex-partner, but also by a family member or carer this is quite common.

4.7.2 Domestic abuse is a complex issue that is known to impact on the health and wellbeing of the victim and wider family and individuals. Domestic abuse takes place across all socioeconomic, cultural and gender groups. Irrespective of age, ethnicity, marital status, disability, sexuality, or lifestyle. Both men and women may perpetrate or experience domestic abuse.

4.7.3 The negative impact of domestic abuse can be huge for health and wellbeing; therefore, it is important to have the right guidance in place for staff to feel safe and supported at work to identify domestic abuse and escalate as appropriate. The outcomes of patients being referred (graph 3) for domestic violence and abuse (DVA) by our Emergency Department team.

Graph 3: Domestic Violence and Abuse 2023/24



4.7.4 There has been support from our partners to deliver DVA training to staff across the trust. We have been linking in with Fort Alice, establishing currently knowledge and providing expert training in face-to-face training.

4.7.5 2023-24 is the first year where adults only research is being completed to be represented at MARAC. There has been a significant increase over the year of adults only this means adult with no care responsibilities for children, the adult team only action referrals regarding adults with no childcare responsibilities.

4.8 Bolton Safeguarding Adults Board Priorities

Throughout 2023-24 the Bolton Safeguarding Adults Board (BSAB) has continued to work on the priorities below:

- People in Bolton have a voice
- Reduce the prevalence and impact of hoarding and self-neglect
- Domestic Abuse
- Workforce development with effective practice

The Deputy Chief Nurse and Adults Safeguarding Lead have been active members of the Bolton Safeguarding Adults Board throughout the year, contributing to the ongoing work on these priorities as well as engaging in the work to develop the priorities for 2024 and beyond.

5. Safeguarding Children

5.1 Safeguarding Children Overview

5.1.1 Safeguarding remains a complex and changing area of practice. The remit of the Safeguarding Children Team extends beyond children under the age of 18. It includes unborn, focussed interventions for 16 and 17

year olds who access adult services, children up to the age of 18 who are at every level of locally agreed thresholds (Bolton Framework for Action), where there are concerns about siblings and family members or where there are concerns about parents or carers or adults in a position of trust.

5.1.2 Abuse and harm to children and young people can happen in a variety of contexts and can take many forms, some of which are not obvious or easily identified. The safeguarding children team continue support the trust by evaluating the effectiveness of services taking action to safeguard and promote the welfare of children, to identify steps to improve outcomes for children and families, and to ensure that there is development in safeguarding practice across the Trust.

5.2 Safeguarding children's data

5.2.1 Key Information from the Children's Services Analysis Tool for the end of March 2024 shows:

- Total of children in Bolton identified to be Child in Need in the 6 months prior was 2475.
- There were 1637 referrals to Children's Social Care via the Integrated Front Door in the previous 6 months. The highest number of referrals are consistently from the Police and Education. 8% of referrals are from health which is slightly below the national average.
- There were 566 Looked after Children who were the responsibility of the Local Authority including children resident in Bolton and 349 children placed out of area. There were 349 children placed in Bolton who were the responsibility of other Local Authorities. Children placed in area access local health services.
- The number of Care Leavers reaching the threshold for Leaving Care Services was 541.

5.2.2 The Trust Safeguarding Children's Team continue to work with four main priority areas. These include domestic abuse, child exploitation, children who are victims or perpetrators of violent crime and children presenting in crisis due to mental health/social/behavioural issues or trauma.

5.2.3 Internal referrals from Trust services to the Safeguarding Children Team (table 5) are made via EPR and telephone contact. The team accept and review referrals for children, adults who have caring responsibilities and information is shared from the Mental Health Liaison Team about children and adults with caring responsibilities who are seen for a mental health assessment.

Table 5: Children's teams safeguarding referrals

Month	Children	Adults who have caring responsibilities	Mental Health presentations children and adults with caring responsibilities	Total
Q1 total	810	244	298	1352
Q2 total	651	219	241	1113
Q3 total	745	199	231	1175
Q4 total	794	215	221	1230

5.2.4 The numbers of referrals are variable, however, year on year there has been an increase in number indicating staff are able to recognise safeguarding concerns and take appropriate action. Presenting safeguarding concerns have been identified in the following areas:

- Children presenting with poorly managed health conditions and history of non-attendance for appointments /children who have not attended the GP prior to deterioration and attending A&E.
- Dog bites (adults and children in the family) that require medical/surgical intervention. Noted some known to the child in the family home, some dogs not known prior to the bite.
- Children who are resident out of area where their history is not known, for example, a 16-year-old staying with her sister in Bolton but usually resides in Kent
- Ingestion of household items or adult medication where safety and supervision require further intervention, for example, batteries, vapes, cleaning products, adult family members medication
- Children presenting with low mood and anxiety,
- Children presenting with burns and scalds of all ages
- Complex y/p who are in Care Placements who are struggling to manage behaviour and mental health concerns
- Children and young people who have been the victim of violent crime – assault by peers

5.3 Safeguarding Children Partnership Board

5.3.1 The Trust works closely and is a key partner of Bolton safeguarding children partnership board (BSCP). The Chief Nurse represents the trust at the BSCP.

5.3.2 Through its safeguarding arrangements the BSCP aims to support and enable local organisations and agencies to work together in a safeguarding system where:

- Children are safeguarded, and their welfare promoted.
- Partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies challenge appropriately and hold one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate more accurate and timely decision making for children and families.
- Tackling disadvantage and promoting equality for all children.

5.4 Voice of the Child

5.4.1 The Safeguarding Children Team hosted the first VOTC forum in February with staff attending from across Trust services. This session was supported by partner agencies attending to support group discussions in the following areas of practice:

- Substance use
- Domestic Abuse
- Victims of violent crime and bullying
- Language and record keeping when working with exploitation.

This well received session will be repeated in 2024/25.

5.5 Child Protection Plans

5.5.1 A child protection plan says what decisions were made in the child protection conference to keep your child safe. Case Holders are part of the Core Group for all children subject to a Child Protection Plan. This involves providing health assessments and interventions to the child and family, attending Core Groups and Case Conferences, and drafting reports. The impact of health interventions and analysis of risk and protective factors for the child is reviewed within each review period through our management supervision arrangements.

5.5.2 As of March 2024, 334 children were subject to a Child Protection Plan with 633 children being subject to a Child Protection Plan in the previous 6 months. The highest number of children subject to a Child Protection Plan are where the category of concern is neglect which is the same as the national picture. The second highest category is emotional abuse which reflects the significant number of children living in households where domestic abuse and a risk to the victim and children is present.

5.6 Child Protection Information Sharing (CP-IS)

5.6.1 CP-IS is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings and mandated for schedule care by end of March 2024. CP-IS will share information for those children who are subject to a Child Protection Plan (CCP), Looked after Children (LAC) and any pregnant woman whose unborn child has a pre-birth protection plan.

6. Looked After Children

6.1 Overview

6.1.1 Many children and young people who become looked after in Bolton are victims of abuse or neglect. There are also a number of children who are relinquished by parents or enter care following the death of a parent. Nationally, there has also been an increase in the number of unaccompanied asylum seekers and children, (UASC), who have been trafficked and/or exploited entering the care system.

6.1.2 Looked after children have many of the same health risks and problems as their peers but the extent of those issues is often exacerbated by their experiences of poverty, abuse, and neglect. For example, the

prevalence of emotional and mental health problems is estimated to be between 45 and 72% compared to 10% in their non-looked after peers.

6.1.3 Two thirds of looked after children have been found to have developmental and physical health issues such as speech and language problems, continence issues, coordination difficulties and sight problems. 11% have been found to be on the autism spectrum. Furthermore, the health and wellbeing of young people leaving care has consistently been found to be poorer than that of young people who have never been in care, with higher incidence of teenage pregnancy, drug, and alcohol abuse. Care experienced children and young people are also significantly overrepresented in the criminal justice system.

6.1.4 Children and young people with Special Educational Needs and Disability, (SEND), are overrepresented in the care system. As a group, looked after children are nine times more likely to have an Education and Health Care Plan, (EHC plan) than the general pupil population.

6.1.5 The health of looked after children is an important aspect of their care. It is hoped that the attention we give to the health and well-being of children in care makes an important impact on the community both now and in the future in relation to their health and wellbeing

6.1.6 Named professionals and those in a specialist role contribute to multi-agency working as medical advisors to the adoption and fostering panels and are linked to the Corporate Parenting Board and Permanency Panel and health economy wide meetings and forums.

6.1.7 Monthly data is gathered in relation to the compliance with timescales for statutory health assessments for children in care and it is reviewed within the Trust and submitted to the ICB.

6.1.8 As the majority of Looked after Children in Bolton enter care due to abuse and neglect the timeliness and quality of statutory health assessments is an area of practice that requires scrutiny and prompt action if concerns arise. The compliance data provides evidence of the effectiveness of agreed LAC pathways.

6.1.9 On a monthly basis actions are taken where barriers are identified. Most children who are looked after in Bolton previously resided locally, however, there are children who enter placements in Bolton from other areas and responsibility for the provision of health assessments is with the trust. The numbers of children who require statutory health assessments varies widely every month depending on the circumstances of children identified to be suffering significant harm. The continued fluidity of the LAC population is challenging in practice due to fluctuating numbers of health assessments that are required every month as well as children with complex health needs or high risks.

6.2 Initial Health Assessments (IHA)

6.2.1 These are carried out by community-based paediatricians working in a specialist LAC role and the requirement is that they are completed within 20 days of a child becoming looked after. From April 2023 to March 2024 a total number of 165 IHA were due all of which were appointed on time. 128 were completed on time with

a further 21 completed within the month but outside timescales. This represents 77% completed on time and 90% overall within month.

6.2.2 The reasons for late health assessments are monitored monthly and in over half of cases this was due to services outside the Trust (delay in providing the Trust LAC team with paperwork) or that children were not brought to the appointment. As a flexible and timely response to support completion of IHA the number of children seen out of timescales but within month by offering additional appointments, this demonstrates a continued priority for administrative and medical staff of the importance of assessment of health needs of children entering care.

6.3 Review Health Assessments (RHA)

6.3.1 RHA are completed by community-based nurses (Health Visitors, School Nurses Special School Nurses, and Specialist Nurse LAC) either every 6 months for children under the age of 5 or annually for children over the age of 5. There is a continued oversight by the Named Nurse for LAC of the compliance with statutory timescales for health assessments completed including those completed within month.

6.3.2 The number of RHA required from April 2023 to March 2024 is 601 of which 473 were completed within timescales and a total of 500 completed in month. This represents 78% completed within timescales and 83% completed within month.

6.3.3 The reasons for not completing health assessments within timescales include staffing and capacity issues, children not brought to the appointment and small numbers where it has not been possible to engage with the child to enable the RHA to be completed. Half of the RHA not completed in timescales were due to late actions from other agencies, for example paperwork or consent not provided in a timely way. There is a focus on removing barriers to completing RHA on time with monthly scrutiny of the specific issues identified.

6.4 LAC Quality Assurance process and audit

6.4.1 Audit arrangements are in place to monitor the quality of health assessments to Looked after Children following the Greater Manchester Quality Assurance pathway. This includes quality assurance of 10 assessments completed by all new staff, reviews through annual management reviews and through dip samples carried out twice within each year. The aim of all audit activity is to show continuous learning and improvement rather than being purely a focus on compliance with timescales.

6.4.2 The results of the audit showed that the quality of health assessments for Looked after Children was good with some excellent examples.

6.4.3 Good practice was evident including the use of appropriate language in completing the health assessments, enquiring about, and recording significant relationships including an identified trusted adult and contact with family members and siblings and evidence of excellent communication with a young person who was reluctant to engage but did complete the health assessment.

6.5 Health profile of Looked after Children

6.5.1 There is a requirement to collect data on the health needs of Looked after Children as part of annual Safeguarding and LAC standards. Building a health profile supports better understanding of the needs of LAC to provide responsive services, identify themes and trends, provide data to evidence complexity and to support the tracking of children considered to be high risk. A health profile tool has been devised and tested over 2 years with findings shared across trust services. This will be added to EPR with additional reporting arrangements in place.

6.5.2 The Named Nurse and Specialist Nurse attend the Corporate Parenting Board.

6.6 LAC Assessment Action plans

6.6.1 There have been a number of additional considerations in working with Looked after Children and Care Leavers within the period of the report. These include:

- Capacity in Specialist and Named LAC roles
- New and additional reporting requirements to the ICB and GM
- Awareness of planning applications locally for Care Placements that are unlikely to be used for children who are currently resident in Bolton
- Increasing numbers of complex children from Bolton who are placed out of area where there are barriers and difficulties in them accessing health services and interventions
- Requirement to agree an Escalation Process to the Designated Nurse in the Integrated Care Bolton, for children in and out of area
- Work to progress integration to EPR of LAC Health assessment paperwork and the Health Profile
- Requests for health training for Social Care staff and foster carers
- Review of Care Leavers Passport pathway and compliance

6.7 Child Exploitation

6.7.1 Across Greater Manchester Complex Safeguarding is a term used to describe criminal activity or behaviour associated with criminality that involves children and young people where there is exploitation and a clear safeguarding concern. A contextual approach focuses on the external risks that children face within their community, school, public spaces, and transport, peer group and on-line.

6.7.2 The arrangements for Child Exploitation fall under a number of services and across both Corporate and Family Care Division. Working with Child Exploitation is a priority area of work for staff in a specialist and named safeguarding children role with contribution to multi-agency procedures and processes. This includes responding to daily police updates about children who cause concern, attending monthly CEAM meetings (Child Exploitation and Missing) and the Safeguarding Partnership Exploitation Steering Group. Child exploitation includes both sexual and criminal activity.

6.7.3 The peer review of Bolton Complex Safeguarding Team was conducted by the GM Complex Safeguarding Hub Review Team alongside a team of multi-agency peer-reviewers from Bury Complex Safeguarding Team, in May to July 2023.

6.7.4 Four cases were selected for review; age range 12 - 16 years old, two male and two female, two cases where the primary concern was relating to child sexual exploitation (CSE), and two cases where the concern related to child criminal exploitation (CCE). The ethnicity of the children considered during the review is recorded as White British x 2, Black / Black British-Caribbean x 1, and Romanian / Roma / Gypsy x 1. One of the children whom we reviewed is looked-after / Child-in-Care. One of the children was being considered for an Education Health & Care Plan (EHCP) at the time of our review.

6.7.5 The review methodology centred on a review of the case notes following structured audit tool, discussions with the Safeguarding Specialist Nurse regarding each case, and a multi-agency peer review discussion for all professionals working with each young person. Two cases were reviewed by the Hub team, and two by the Peer team.

6.7.6 Bolton is without a complex Safeguarding Specialist Nurse post, and responsibilities of this role are covered by a Safeguarding Specialist Nurse who sits within the Bolton NHS Foundation Trust Safeguarding Team. This is supported by health colleagues within universal services (school nursing), the Looked After Children's Team (where appropriate), and colleagues within the Parallel Service (which offers an adolescent health service for young people living in Bolton up to the age of 19). The Safeguarding Specialist Nurse is an experienced nurse; and it was evident throughout the review that her knowledge, expertise, and accessibility is valued both by health and multi-agency colleagues alike.

6.7.7 Areas of Strength:

6.7.7.1 Evidence of creative and dynamic health assessments, and robust communication with health colleagues across the borough re onward health needs and actions. Parallel noted as being a positive, accessible, and engaging health resource for the young people we reviewed.

6.7.7.2 Evidence of positive use of opportunistic health interventions, for example discussing dentist care, and addressing outstanding immunisations.

6.7.7.3 Creative use of teen-accessible and relatable resources and interventions by 360 substance misuse workers noted.

6.7.7.4 Evidence of sound information governance around the electronic case notes, this ensures that the Safeguarding Specialist Nurse can gather proportionate clinical information about the child and their health needs in a timely manner to help inform onward joint-working. 'Significant Events' section of case notes provides a useful overview chronology of events.

6.7.7.5 Evidence of positive multi-agency working noted in case notes; e.g. CEAM panel, Strategy meetings, police cause-for-concerns forms etc. Tenacity of Safeguarding Specialist Nurse following a road traffic accident (RTA).

6.7.7.6 Positive Speech and Language Therapy (S&LT) assessment, and findings shared with multi-agency colleagues to promote best communication and understanding with the young person.

6.7.7.7 Clear evidence of trauma-informed work, and good understanding of familial concerns as well as extra-familial risks in all cases reviewed:

- Child's voice / lived experience is clear in majority of case notes reviewed: own views and words are recorded.
- Cultural considerations and use of interpreter (as appropriate) noted.
- Safeguarding supervision offer appears well-embedded for 0-19 workforce across the borough.
- Covid-19 has not impacted the health-offer to young people supported by Bolton Complex Safeguarding Team.

6.7.8 Areas for Reflection:

6.7.8.1 Consideration around which service is best placed to support victim of sexual exploitation, ST Marys SARC or local sexual health service. Concern that significance of exploitation element may be missed if generic services accessed.

6.7.8.2 Consideration of 'flagging' on All Script (trusts electronic patient record); not all the cases we reviewed had flag in place.

6.7.8.3 Consideration around how best to support wider 0-19 workforce in relation to use of language within documentation, one health assessment had a couple of points in it which could be perceived as victim-blaming.

6.7.8.4 Bolton Children's Safeguarding Team does not currently have a dedicated commissioned Complex Safeguarding Specialist Nurse, although it was noted during the review that a Safeguarding Specialist Nurse from the Trust, alongside Named Nurse, has been pivotal in ensuring that health assessments are completed, enabling positive communication between multi-agency colleagues, and onward health needs actioned.

7. Safeguarding in Maternity Services

7.1 Maternity Safeguarding Overview

7.1.1 Historically the Trust has used the expertise within the Enhanced Midwifery team to support safeguarding within maternity. To meet the contractual standards, the trust recognised that a standalone post was required, this was included and approved with the business case.

7.1.2 The Enhanced Midwifery team are a team of 6.56 WTE Midwives, including a Team Lead, who hold a case load specialising in providing personalised care for birthing people & families with complex safeguarding concerns antenatally & postnatally. The team oversee all the out of area safeguarding cases of people booked to delivery at The Princess Anne Maternity Unit but live out of the Enhanced Midwifery Team's catchment area, linking in with 5 Local Authorities, Bolton, Bury, Salford, Wigan & Manchester and equivalent EMT teams

7 1.3 The team have seen a slight decrease in the number of referrals into the Enhanced Midwifery Team from the previous year: 550 in comparison to 578 in the previous year, of which 40 were for people booking for maternity care from out of area.

7 1.4 The number of babies made subject to Interim Care orders and separated from parents during this period April 23 to March 24 was 49. The EMT have been supporting Bolton Safeguarding Partnership in their pre-birth assessment process to implement changes to manage this

7.1.5 Safeguarding Supervision is conducted on a monthly basis, face to face on a 1:1 with the EMT. Ad hoc and peer supervision is offered on an ad hoc basis to the EMT and the wider Maternity Team.

7.2 Female Genital Mutilation (FGM)

7.2.1 Female Genital Mutilation (FGM) is illegal in the UK as is taking a child abroad to undergo FGM. It is also recognised as a form of child abuse (Female Genital Mutilation Act 2003). FGM is medically unnecessary and has serious health consequences both at the time when it is carried out and in later life.

7.2.2 The trust recognises that healthcare workers are in a unique position to identify those who have undergone FGM and those that are at risk of FGM. To support this unique access the trust has in place guidance for all clinicians and services where safeguarding children procedures are indicated.

7.2.3 All staff have a statutory duty to protect girls and women at risk of FGM. One specific consideration is that the potential risk to a girl may be identified at birth, however, as FGM can be carried out at any time throughout childhood, safeguarding measures may need to be in place until adulthood. This is recognised to be significantly different in consideration of timescales compared to other types of harm.

7.2.4 Healthcare professionals should take opportunities to discuss FGM and assess risk within their contacts with families. Interpreters must be used where there are difficulties in communication, family members or influential community representatives should not be used.

7.2.5 There are three nationally developed arrangements in place in relation to sharing information about FGM. This includes:

7.2.5.1 FGM mandatory reporting duty

Section 5B of the FGM Act 2003 includes a mandatory reporting duty for regulated professionals to report "known" cases in under '18s from October 2015.This requirement is a personal duty to report and refer – responsibility for this cannot be transferred. Failure to make appropriate safeguarding referrals could result in fitness to practice proceedings. Known cases are those where either a girl discloses that she has had FGM (however this is described or whatever language is used) or where a person observes physical signs that indicate that a form of FGM has been carried out.

7.2.5.2 FGM Risk Indicator System (RIS)

This system displays an indicator on a child's summary care record application (SCR a) following a risk assessment by a healthcare professional.

7.2.5.3 Scc12026: FGM Enhanced dataset

Known cases of FGM are collated and information submitted to the Health and Social Care Information Centre every month.

The FGM Enhanced Dataset requires organisations to record and collect information about the prevalence of FGM within the female population that has contact with health services. This includes if a woman or child is receiving treatment for any condition; it is not limited to reporting those receiving treatment for FGM-related conditions. In some departments or services, it will be routine to enquire whether a woman has had FGM.

7.2.6 A total of 225 cases of FGM were identified in the Trust within the period of the annual report and data submitted to the Department of Health. All cases were identified in Maternity Services and there is evidence that an FGM Risk Assessment was completed in all cases. This is used to consider any risks to female children in the family including if the new infant is a female. All those identified to have had FGM had it carried out in country of origin and highest number of cases were for women born in Somalia, Ethiopia, and Sudan. No referrals were made under the mandatory reporting requirements.

7.2.7 FGM is included within the quarterly update report to safeguarding committee for appropriate scrutiny and challenge.

8. Multi-agency Reviews

8.1 Safeguarding Children Reviews

8.1.1 A rapid review is undertaken following a serious child safeguarding incident by multi agency partners to identify and act upon any immediate learning. There were 4 rapid reviews in 2023/24 and two thematic reviews – one in relation to child neglect and one in relation to child exploitation.

8.1.2 Recommendations and actions from rapid reviews shared through the Trust Safeguarding Committee and to individuals involved, Team Leaders and Service Managers in 2023/24 include:

- Requirement to review the Trust Managing Missed Appointments Policy.
- Specific review of asthma clinical care pathway.
- Audit of uptake of Asthma Training offer to schools from 0-19 service.
- Disguised compliance and over optimism about parent's capacity to change to be challenged in Management Supervision.
- Correct thresholds where there are extremely poor home conditions.
- Working with families where there is Domestic Abuse.
- Engaging with young people who are thought to be sexually or criminally exploited.

8.2 Safeguarding Adult Reviews (SAR)

8.2.1 A safeguarding Adult Review (SAR) is a multi-agency review which seeks to determine what relevant agencies and individuals involved could have worked differently, that could have prevented abuse or neglect or a death from taking place. During 2023/24 the trust supported 7 reviews

8.3 Domestic Homicide Reviews (DHR)

8.3.1 A Domestic Homicide Review (DHR) must be conducted when a death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. This is a multi-agency review, and any lessons are disseminated across organisations. During 2023/24 the trust supported 0 reviews.

8.4 Section 42 Enquiries

8.4.1 A formal adult safeguarding enquiry from the care act section 42, is the range of actions undertaken or instigated by the Local Authority. This is in response to abuse or neglect concern in relation to an adult with care and support needs who is unable to protect themselves from abuse or neglect or the risk of it. The adult safeguarding team support this process and were part of approximately 36 reviews during 2023/24. During, 2024/25 there is a plan to streamline the process. There are constant themes with the concerns raised documentation, mental capacity and communication between NHS professionals and partner agencies.

8.5 Multi Agency Risk Assessment Conference (MARAC)

8.5.1 This is a locality meeting led by the Police where statutory and voluntary agency representatives share information about people at high risk of domestic abuse. Any agency can refer an adult or child they believe to be a high risk of harm. These meetings are held weekly within the locality and are attended by both adults and children's safeguarding teams. The number of cases discussed every week varies from 25-35.

8.5.2 2023-24 is the first year where adults only research is being completed and presented at MARAC. There has been a significant increase over the year of adults only, this means an adult with no care responsibilities for children. The adult team only action referrals regarding adults with no childcare responsibilities

8.5.3 The aim of these meetings is to share information to increase the safety, health and well-being of victims, survivors, and their children, to jointly construct and implement a risk management plan.

8.5.4 The themes and trends noted during the period of the annual report include increased numbers of risks from extended family, rather than intimate partners and the positive interventions provided to older victims through local specialist domestic abuse services.

9. Learning

9.1 Learning from Deaths

In line with the National guidance, a Learning from Death policy help us to identify, report, investigate and learn from deaths, specifying how to respond to the deaths of patients who die under our care. The policy aims to highlight how we:

- determine which patients are considered to be under our care and included for case record review if they die
- report the death within the trust, and to other organisations who may have an interest (including the deceased person's GP)
- respond to the death of an individual with a learning disability or mental health needs, an infant or child death, and a stillbirth or maternal death
- review the care provided to patients whose death may have been expected, for example those receiving end of life care
- record the outcome of your decision whether or not to review or investigate the death, informed by the views of bereaved families and carers
- engage meaningfully and compassionately with bereaved families and carers

The Learning from Deaths report feeds up through Clinical Governance and Quality Committee to ensure that learning is shared across the organisation.

9.2 Child Death Overview Panel

9.2.1 In accordance with 'Working Together to Safeguard Children' it is a statutory responsibility for Safeguarding Children Partnerships to review all child deaths.

The Greater Manchester region is divided into four CDOPs:

1. Bolton, Salford, and Wigan CDOP

2. Bury, Rochdale and Oldham CDOP
3. Manchester CDOP
4. Tameside, Trafford, and Stockport CDOP

9.2.2 The Child Death Overview Panels (CDOPs) within Greater Manchester collect information and review the deaths of all children aged up to one day under 18 years (excluding stillbirths and planned terminations of pregnancy carried out within the law), who normally reside within the geographical boundaries of that CDOP.

9.2.3 Each CDOP produces an annual report which summarises the data collected that year, reviews any variations or emerging trends, and makes recommendations for future interventions and data collection. Whilst these highlight patterns and trends within each CDOP area, detailed analysis and conclusions are often limited by small numbers, with around 50 to 80 deaths per CDOP per year.

9.2.4 The Trust have a Notification and Review of Child Deaths Policy in place that supports immediate decision making, joint area response and notifications to CDOP. There is a Paediatric Mortality meeting held in the trust chaired by the Named Doctor for Safeguarding and the Designated Doctor for Child Deaths.

9.2.5 The latest published Child Death annual from 2021/22 report has been shared at the trust Safeguarding Committee. The report highlights the requirement to continue to note modifiable factors in child deaths and raise awareness with staff and families. This review period included 45 child deaths that were reviewed and closed by the panel.

9.2.6 National guidance defines potentially preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

9.2.7 The CDOP case review identifies potentially modifiable factors that may have contributed to a child's death and is key to informing future prevention programmes of work. For the reporting year 2020/21, modifiable factors were identified in 22 (48%) of the 45 closed cases reviewed. For Greater Manchester modifiable factors were identified in 57 (43%) of the 132 closed cases reviewed, meaning the BSW CDOP is above average for the GM city region. Closed cases where modifiable factors were identified were in the 'Perinatal/neonatal event' category (n=13), followed by Sudden, unexpected, and unexplained deaths (n=5) and Chromosomal, genetic, and congenital anomalies (n=4).

9.2.8 For child deaths classified as a perinatal/neonatal event, smoking was identified as a modifiable risk factor in 7 of the 13 closed cases; 4 of the 13 closed cases also featured parental substance/alcohol use and 3 of the 13 closed cases featured BMI/maternal obesity. Service delivery was identified in 2 of the 13 cases.

9.2.9 There were 4 closed cases categorised as chromosomal, genetic, and congenital anomalies with modifiable factors identified. Consanguinity was identified in 3 of the 4 closed cases. There were 5 closed cases categorised as sudden unexpected, unexplained death with modifiable factors identified. Safe sleeping was

identified in 4 of the 5 closed cases. Smoking and/or substance misuse were identified in 4 of the 5 cases. Although the case numbers are statistically small; smoking, substance misuse and safer sleeping practices are preventable and contributing factors to local child deaths. Smoking was identified in 12 of 22 cases with modifiable factors, substance abuse in 8 of 22 of cases and safe sleeping practices in 4 of the 5 cases.

9.2.10 By their very nature Sudden Unexplained Deaths in Infants have no identifiable cause but some cases do highlight common features. Whilst the number of cases where co-sleeping is reported does vary it still features year on year despite the advice to parents now being embedded in professionals' training.

10. Partnerships and External Meetings

The Chief Nursing Officer, Deputy Chief Nurse, Associate Director for Nursing (Quality), Named Nurse for Children's and Lead Nurse for Adults attend and support meetings (table7) external to the organisation.

Table 7 Meetings

Name	Team	Frequency	Trust/MA
DAV Partnership Board	Adults & Children	Quarterly	Community Safety
MARAC Steering Group	Adults & Children	Bi-monthly	Community Safety
MARAC	Adults & Children	Weekly	Community Safety
ICB Health Collaborative	Adults & Children	Quarterly	ICB
FCD Safeguarding Committee	Adults & Children	Bimonthly	Trust
AACD Safeguarding Committee	Adults & Children	Monthly	Trust
Vulnerable Service User Group	Adults & Children		Trust
Policy and Practice Group	Adults & Children	Bi-Monthly	Trust
Missing Patient	Adults & Children	Bi-Monthly	Trust
Prevent Steering Group	Adults	Quarterly	Community Safety
Prevent Delivery Group	Adults		Community Safety
Workforce and Development	Adults		BSAB

Communication and Engagement	Adults		BSAB
Safeguarding Adult Risk Management	Adults		BSAB
Quality Assurance and Effectiveness	Adults		BSAB
PSIRF	Adults		Trust
Frequent attenders	Adults		Trust
Challenging Behaviour meeting	Adults		Trust
Safeguarding Intelligence Forum	Adults		LA
Channel Panel	Children's	Monthly	Community Safety Partnership
Paed Mortality Meeting	Children's	Quarterly	Trust
Daily Risk meeting IFD	Children's	Daily	LA
Named and Designated Profs	Children's	Quarterly	ICB
BSCP SEG	Children's	Bimonthly	BSCP
Child Exploitation Steering group	Children's	Monthly	BSCP
Placement/Permanency Panel	Children's	Every 2 weeks	LA
A&E Safeguarding Meeting	Children's	Bimonthly	Trust
Corporate Parenting Board	Children's	Bimonthly	LA
Peer Review	Children's	Bimonthly	Trust
GM LAC Nurses Forum	Children's	Bimonthly	GM
Child Safeguarding Practice Review Group	Children's	Quarterly	BSCB
LAC Team Supervision meeting	Children's	6 weeklies	Trust
Working Together Implementation Group	Children's	monthly	BSCB

CYP Emotional health and wellbeing Transformation Group	Children's	Bimonthly	ICB
GMMH/RBH meeting	Children's	Bimonthly	Multi-agency
CAMHS Interface meeting	Children's	Bimonthly	Multi-agency
Exploitation Assurance Group	Children's	Bimonthly	BSCB
CYP Transformation Programme	Children's	Monthly	Trust
LAC and Care Experienced Children Group	Children's	Bimonthly	ICB
CEAM	Children's	Monthly	BSCB
Safeguarding Supervision	Children's	6 weekly	ICB

11. Training & Supervision

11.1 Training Overview

Training of all staff, regardless of their role, is an integral part of the Trust's safeguarding priorities. This ensures that our employees are provided the necessary knowledge and expertise to make effective safeguarding decisions. During 2023/24, the Trust has been reviewing the training needs of all staff, particularly in relation to Level 3 safeguarding training, to support them in gaining deeper knowledge and applying it to their practice.

The current compliance levels at the end of Quarter 4 are as follows:

Table 8: Trust Safeguarding Level 1,2,3 compliance

Training Level	%Trust Compliance Q4 23/24
Safeguarding Adults Level 1	94.26%
Safeguarding Adults Level 2	95.85%
Safeguarding Adults Level 3	66.74%
Safeguarding Children Level 1	96.15%
Safeguarding Children Level 2	96.17%

Safeguarding Children Level 3	77.22%

11.2 Adult Safeguarding Training

The Trust recognised a significant decline in compliance with Safeguarding Adults Level 3 training by the end of the year. In response, the Trust has undertaken a comprehensive review of the current training program, implementing a targeted approach to address non-compliance.

11.3 Children's Safeguarding Training

The Children's Safeguarding team conducted a thorough training needs analysis for all staff at Levels 1, 2, and 3. This assessment identified the specific training requirements, whether face-to-face or e-learning, for Level 3 safeguarding. The Trust anticipates a significant improvement in compliance once this tailored training is made **available, and with the addition of supplementary sessions planned for the coming year.**

11.4 Children's safeguarding supervision

11.4.1. It is a mandatory requirement that staff have access to specialist advice, guidance, and support commensurate with their role in working with children and families. Effective safeguarding children supervision plays a critical role in ensuring a clear focus on the welfare of the child. This can be linked to improved outcomes by reducing risk and providing appropriate support

11.4.2 Arrangements for supervision are included in the Trust Safeguarding Children Supervision Framework reflecting that supervision is provided in several ways (table 9).

Table 9: Safeguarding Children Supervision Framework

Management Supervision	**Specialist Supervision**	**Mentor, Peer Preceptor**	**Reactive Advice and guidance Consultation**	**Group**
Line Managers/Team Leaders/Nominated Supervisor/Specialist Role	Safeguarding Team/Specialist role	Supervisors in specific staff groups who have undertaken appropriate training	Any Professional/Specialist safeguarding role	Group Supervision Facilitator
Requirements All children made subject to a Child Protection Plan & Looked After Children placed with Biological Parents or with	Requirements Where staff have concerns about a child or in a complex/ exceptional case e.g. Fabricated	Requirements New staff Children causing concern at any level in Framework for Help and Support	Requirements Children at any level on the Framework for Help and Support causing concern.	Requirements Children at all levels on the Framework for Help and Support who are causing the practitioner concern. Medical Peer Review

complex unmet health needs Unborn infants where there are safeguarding concerns	Induced Illness, Complex health needs with escalating risk, Children at high risk of Exploitation		May require a prompt response/single issue or concern	Multi-service or multi-agency
Frequency Following ICPC Minimum 3 Monthly	Frequency As required	Frequency Initial review and then as required	Frequency As required	Frequency Minimum 3 monthly As per agreement

11.4.3 Safeguarding Children Supervision

Specialist, reactive, and group supervision is provided to staff by the Safeguarding Children team. Supervision for children subject to a Child Protection Plan is reported through Divisional IPM (Integrated Performance Management) meetings.

11.5 Adult Safeguarding Supervision

Adult safeguarding supervision is not a mandatory requirement, and this is an area identified for further development and investment. To provide psychological safety, there is an increasing need for the Safeguarding Team and frontline staff to receive restorative safeguarding supervision. To mitigate this gap, the trust provides support to staff through difficult and traumatic safeguarding cases, as well as debriefs, whether on an individual or group basis.

11.6 Maternity Safeguarding Supervision

11.6.1 Working Together to Safeguard Children 2023 provides statutory guidance on how organisations and individuals should work together, recognising that safeguarding children practice involves complex professional judgments. Effective supervision can help promote good standards of practice while offering support and opportunities for development. All staff groups should have access to advice and support from peers, managers, and specialists in safeguarding roles.

11.6.2 Safeguarding supervision supports professionals to reflect critically on the impact of their decisions on the child and their family. It is an accountable, formal process that enhances the knowledge, skills, and values of individuals, groups, or teams, with the purpose of improving the quality of their work to achieve agreed outcomes.

11.6.3 The safeguarding children supervision process is in place for all staff, irrespective of their role, to ensure child-centred practice. It promotes research and evidence-based practice, critical thinking, and analysis, as well as supporting identification of SMART actions and interventions. It clarifies worker roles and responsibilities within interagency working, provides regular feedback, and supports professional development.

11.6.4 The purpose is to embed supervision as part of the intervention process, identify and challenge unsafe, unprofessional, or unethical practice, and ensure a proactive and persistent approach, including escalating concerns within the trust and following the Bolton Safeguarding Children Partnership's Challenge and Escalation Process.

11.6.5 Maternity safeguarding supervision follows the Trust's Safeguarding and Looked After Children Supervision Policy. As case holders, the Enhanced Midwifery Team accesses monthly direct safeguarding supervision with the Team Leader, and all maternity staff receive ad hoc safeguarding supervision and guidance.

11.7 Prevent Training

11.7.1 Prevent training is a key part of the Trust's NHS safeguarding statutory duties and NHS England's safeguarding arrangements. Prevent awareness and other relevant training is delivered to all professionals who provide services to NHS patients.

11.7.2 The Trust mandates Prevent training as part of its safeguarding strategy, which is offered at two distinct levels, determined by individual roles and responsibilities.

11.7.3 As of the end of Quarter 4, Prevent training compliance exceeds the local target of 95%, as shown in Table 10

Table 10 Prevent training

Training Level	%Trust Compliance Q4 23/24
Basic Prevent Awareness	96.25%
Prevent	97.14%

12. Risks and Issues

Safeguarding risks across the organisation are monitored at corporate level. The Safeguarding team maintains a comprehensive risk register, which is reviewed quarterly through safeguarding committee. High-risk areas are escalated to the Trust Risk Management Committee. Each identified risk has an associated action plan, which is regularly updated and evaluated for effectiveness. This ensures timely mitigation and continuous improvement in our safeguarding practices.

13. Priorities

13.1 Priorities Review -2023/24

The trusts safeguarding team are small, with responding to statutory duties and stretched to cover the gaps with the statutory roles, the team were unable to complete some of the additional priorities assigned to them. A review

of last year's priorities and the expansion of the named roles falling into 2024/25 contractual year (table 11), some of the priorities will be rolled over.

Table 11 2023/24 Safeguarding Teams Priorities

Priority	RAG	Update
Further develop the governance framework for Safeguarding including committee reporting structures.	Amber	Multiple critical work streams have been carried forward into 2024/25
Develop a quarterly safeguarding assurance report	Amber	First draft completed in Q1 2024/25
Undertake a full-service review in line with NHSE Safeguarding Assurance Framework	Green	
Develop a safeguarding audit schedule.	Red	Insufficient operational capacity to meet current demands- to be carried forward into 24/25
Identify a trajectory for Level 3 Children safeguarding training for achievement by the end of 2023/2024.	Amber	Comprehensive training needs analysis in progress Developing targeted compliance trajectory
Commence monitoring and reporting of safeguarding adults' level 3 training as per training needs analysis.	Amber	Proactive monitoring and reporting mechanisms established Developing comprehensive implementation strategy
Further develop the DoLs process in partnership with Local Authority.	Red	Mental Capacity Act leadership initiated in Q2 2024/25

13.2 Priorities for 2024/25

- Safeguarding Newsletters, updates in communication teams staff bulletin and Chief Executive Friday takeovers to highlight the work the Safeguarding Team are undertaking
- Monitoring of risk and emerging issues through monthly risk clinics for both adults and safeguarding children
- Capturing the voice of the child, vulnerable adults, and their carers
- Review of Governance arrangements to include:
    - Framework (2023/24 priority)
    - Assurance report (2023/24 priority)
    - Safeguarding audit schedule (2023/24 priority)
    - Learning improvement cycle- embed the learning process
    - Development of internal KPIs to support quality outcomes
    - Comprehensive policy review, in date and meeting current legislation
- Service Review Day
- Monthly internal performance meetings within safeguarding adults and children to show case achievements, evidence good practice and oversight of external data

- Training and Development
  - Trajectory and improvement for safeguarding children training
  - Trajectory and improvement for safeguarding adults training
  - Trajectory and improvement for MCA and DoLS training
  - Development programme for Named professionals

14. Conclusion

Safeguarding activity and protecting our vulnerable patients and service users remains a key focus for the trust in 2024/2025. In line with the priorities from Bolton Safeguarding Children's Partnership (BSCP) and Bolton Safeguarding Adults Board (BSAB). The annual report describes and explains the complex workstreams undertaken by the safeguarding team.

The trust will continue to develop systems and processes to support our staff in delivering their statutory safeguarding duties. A focus on learning will support the safeguarding committee in discharging its responsibilities.

The safeguarding team will continue with effective working relationships and collaboration with our multiagency partners. The new roles within the team will help to develop our organisational knowledge, skills, and expertise to support our staff will ensure that safeguarding is everyone's responsibility and embed a culture of safe practice within the Trust.

By building on the strengths identified in this report and proactively addressing areas for improvement, Bolton NHS Foundation Trust can continue to enhance its safeguarding services, ensuring the safety and wellbeing of all patients under its care

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Chief Executive		Decision	

Purpose of the report	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.

Previously considered by:	Not Applicable.

Executive 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.

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

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

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

Ambition 1: Improving care, transforming lives

Pregnant women in Bolton are being invited to be vaccinated against Respiratory Syncytial Virus (RSV) for the first time in NHS history. RSV is a common cause of coughs and colds but can lead to severe lung infections like pneumonia and infant bronchiolitis, which are highly dangerous to older people and young children.

Our maternity teams have been offering drop-in clinics at Crompton Health Centre and Royal Bolton Hospital for women who are over 28 weeks pregnant and have not yet been vaccinated. A recent study showed that the new vaccine programme could prevent 5,000 hospitalisations and 15,000 A&E attendances for infants – a critical, life-saving step forward to help front line staff prepare for increased winter pressures.

A new scan room has opened in our maternity unit and has been named after one of our retired Obstetric Consultants, Doctor John Tomlinson. The Tomlinson Suite recognises John's many years of commitment to the Ultrasound Department and the specialist foetal ultrasound service. Throughout his career as a consultant, John was dedicated to providing high quality care to mums and babies in some of the most challenging situations.

Our annual Wave of Light ceremony took place in our Baby Memorial Garden at Royal Bolton Hospital for people to come together and remember the lives of babies who sadly died too soon. The candlelit event provided space to reflect in memory of all the babies who lit up lives for such a short time and marked the end of Baby Loss Awareness Week. A special dedication page has been created for families in Bolton to leave photos and special messages to remember their baby.

The Trust has taken part in a major trial that uses artificial intelligence to help detect cancerous tumors during a colonoscopy. The COLO-DETECT trial, led by South Tyneside and Sunderland NHS Foundation Trust and Newcastle University, used the GI Genius AI (artificial intelligence) device, a computer module powered by AI, which is added to the existing technology used during a colonoscopy.

The findings showed greater effectiveness in detecting tumors that could potentially become cancerous. The study has resulted in the continued use of AI equipment in our Endoscopy Department to detect cancers that otherwise may be missed.

We have joined the Smokefree Bolton movement by relaunching our smokefree sites campaign which has included increasing the visual reminders around the site, but most importantly, has put in place the right support for smokers on site. Our patients will be directed to our CURE service who can provide nicotine replacement therapy and support during their stay in hospital.

We will eventually have a vape friendly zone on site, where people who wish to vape can do so freely, away from the main entrance and the areas of heavy footfall.

Ambition 2: A great place to work

As a Board of Directors, we have set out a commitment to being an anti-racist organisation. We know that racial inequalities exist in Bolton and have a profound impact on the experiences and outcomes of our staff, patients and the communities we serve.

Not being racist is simply not enough and our commitment is more than just words. We are an actively anti-racist organisation which means we do not tolerate any form of racism, and actively root out and address racial unfairness of any form. For our words to become a reality for everyone, we have defined the action we will take together.

During October, we held a special edition Our Voice Change Programme all staff briefing to discuss progress that has been made against the change themes; digital systems and equipment, car parking, living our values, flexible working and working environments.

Staff were given the opportunity to share any ideas they have to make Bolton a better place to work and the importance of completing the NHS Staff Survey was highlighted, as key themes will inform the next iteration of our change teams based on the things that matter most to our workforce.

We have continued to use national awareness days and events to raise the profile of our teams and services, and celebrate their achievements.

The vital work of our pathology staff and scientists to diagnose diseases and improve health outcomes for communities was recognised during National Pathology Week. More than eight million tests have been carried out in the past twelve months by the pathology teams at Royal Bolton Hospital, from antenatal screening samples to point of care testing.

Technology is also being used to launch a major new system in our laboratories to make it easier for clinicians to process the millions of patient tests results each year. The new LIMS (laboratory information management system) is integrating a number of systems to create a central service that will ensure a more efficient and productive process now and for years to come. The project is reaching its final stages with the go-live due to take place in early 2025.

As part of Breast Cancer Awareness Month, giant ribbons painted and lit up pink have been installed outside the Sunflower Suite at Royal Bolton Hospital to remind people to check themselves for cancer.

Our Breast Imaging Team hosted an open day for colleagues to shine a spotlight on their work and foster a greater understanding across the hospital's services. Staff from Radiology, including radiographers, radiologists, and imaging leads, as well as administrative and clerical teams, had the chance to see firsthand the work that takes place in clinical rooms.

Throughout the day, people had the opportunity to practice clinical breast examination using a mannequin to find the signs and symptoms of breast cancer, scan a breast phantom with ultrasound to find abnormalities and find out more about the different roles in Breast Imaging.

To mark Allied Health Professions (AHP) Day, the Breast Imaging Team were awarded the AHP Workforce Transformation Award for their work in recruiting the first Consultant Radiographer and the first two Advanced Clinical Practitioners in Radiography at Bolton, marking a significant step in developing a sustainable workforce for the future of Bolton Breast Imaging.

The Trust's Finance Team is a finalist at the Public Finance Awards 2024 in the Finance Team of the Year – Frontline Services category for their work to deliver high quality services for the NHS in Bolton. Over the past twelve months, the team has achieved a number of successes, including launching an ambitious project to create a shared ledger system for NHS providers in Greater Manchester, achieving the highest level of accreditation for NHS finance teams and achieving a spot in the top 15 national NHS Staff Survey scores for NHS finance departments across the country, for the second consecutive year.

Our teams won a Royal College of Nursing (RCN) award to mark their outstanding contribution to the equality, diversity and inclusion agenda at the College's annual regional Black History Month conference. The awards form part of the RCN North West's annual event to recognise and celebrate the outstanding contribution of nursing staff either from or in service of those from the Global Majority who work in health and social care across the region.

The International Recruitment Team were recognised for their exemplary approach to welcoming and settling internationally educated nurses (IEN). From first contact whilst still at home in their native country, to sourcing comfortable accommodation, familiarisation trips and help with everyday activities such as banking and continuing education, the four-person team ensures a warm and familiar welcome to all new recruits.

We held a Remembrance Service on Monday 11 November outside the Main Entrance at Royal Bolton Hospital. The local community, staff, patients and visitors were invited to join the service at 10.50am followed by the raising of the Union Flag, a two-minute silence and the Last Post.

As a Veteran Aware organisation, the Armed Forces Team were on hand offering information and the opportunity for visitors and staff to ask questions about the support available.

Ambition 3:
A high performing, productive organisation

We continue to make progress on reducing long waiting times for patients however, there remains a number of patients nationally still waiting too long for their care. A key pillar of the national oversight and support infrastructure is the tiering programme, which is continuing through 2024/25 for elective recovery, cancer and diagnostics.

Following a review of elective and cancer performance, and in agreement with the regional team, we will remain in Tier 2 for Elective Care. Performance progress for trusts in Tier 1 and Tier 2 is reviewed

regularly between relevant National and Regional NHS England teams, including a formal review on a quarterly basis, the outcome of which is formally ratified at NHSE's sub-board Quality and Performance Committee. We are deeply committed to continuing our efforts in delivering the national ambitions for elective, cancer, and diagnostics to benefit our patients and communities.

We have started our work to prepare for the 2025-26 operational planning guidance being released towards the end of the year. Part of this process involves submitting our plans to Greater Manchester Integrated Care to provide assurance that we are working within their assumptions for the coming year.

Our Proud2bOps network won two awards at the first ever Proud2bOps Awards. Hosted at the annual Proud2bOps Congress on Tuesday 5 November, our Trust won the Trust Network of the Year award for raising the profile of operational management in their organisation and sustaining a network for the future development of professionals. Our Director of Operations, Michelle Cox, was anounced and received the award for Operational Role Model of the Year.

The Trust was the first in the UK to launch our very own Proud2bOps@ network in 2023, bringing staff together to make sure operational voices are heard and that our profile is raised for the benefit of our local communities.

Ambition 4:
An organisation that's fit for the future

Our Annual Members Meeting took place on Monday 14 October at Lever Chambers Centre for Health in Bolton town centre. In 2023-2024, a number of major constructions reached completion at Royal Bolton Hospital to improve access to healthcare and expand facilities for staff and future generations to learn and develop. Those who attended were given the opportunity to discuss the future direction of health and care services in Bolton, following the release of the Trust's new five-year strategy in July.

Our local communities have been invited to share feedback about how they access health services when they need them, to help make improvements for the future. Healthwatch Bolton and Bolton Community and Voluntary Services (CVS) are undertaking a series of engagement sessions to understand the experiences of our local communities, when accessing all types of healthcare.

People are being asked how they use their GP service, phamacist, Emergency Department and out of hours care when either they or a loved one are unwell. The survey and engagement findings will support us to adapt the services on offer outside of hospital, for those who have an urgent need.

The Department of Health and Social Care also launched Change NHS, the biggest ever public conversation about the NHS and what needs to change. We have continued to encourage our staff and patients to partake by sharing their experiences, and will be submitting an organisational response that will be co-produced with our workforce.

We have been accepted onto the Greater Manchester Health Inequalities Development Programme for NHS Provider Trusts. This is a really good opportunity for us and other provider trusts to

understand more about health inequalities, and how we can better support our populations so that we are doing all we can to reduce them.

The programme will allow us to hear from experts and learn from national best practice. Sharon White, Director of Strategy and Partnerships is the Executive lead for the programme and Tosca Fairchild is our Non-Executive Director lead.

Ambition 5: A positive partner

Two members of Walkden Medical Centre recently took part in a sponsored head shave to raise funds for Our Bolton NHS Charity and the Churchill Unit at Royal Bolton Hospital. Colleagues Kate Bowden and Tracey Veitch took the brave decision to remove their hair and managed to raise a total of £2,616 for the unit. This was also in support of their friend and colleague Lisa Olive, who was diagnosed with breast cancer in 2018, and has been undergoing chemotherapy treatment at the unit.

Chief Midwifery Officer for England, Kate Brintworth, has commended Greater Manchester's pioneering 'Smokefree Pregnancy Programme' during a high-profile visit to the region. Delivered between NHS Greater Manchester, local authorities, NHS foundation trusts and technology partner, Accenture – Greater Manchester's Smokefree Pregnancy Programme has successfully reduced smoking at time of delivery by more than 40% and led to more than 6,000 additional babies being born smokefree, since launching in 2018.

The programme offers all pregnant women and birthing people, and their partners, free and personalised stop-smoking support through a specialist maternity stop-smoking service.

Local businesses have been invited to join our first winter market on Monday 2 December, raising money for Our Bolton NHS Charity. The winter market will take place two days after the annual Small Business Saturday UK-wide initiative on Saturday 30 November, which highlights small business success and encourages consumers to 'shop local' and support small businesses in their communities.

People who are living with cancer were invited to attend an event to find out what support, information, advice, and facilities are available, to help them adjust to life with and beyond cancer. Our services joined forces with Bolton Macmillan Cancer Information and Support Service to host another dedicated event. The event provided people who have undergone, or are completing, a course of treatment for cancer, with the opportunity to find out what support, information, advice, and facilities are available, to help them adjust to life with and beyond cancer.

Report Title:	Board Assurance Framework (BAF)			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

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

Previously considered by:	The BAF was presented to the Executive Directors and People Committee ahead of discussion at Board. Due to timing, it will also be presented to all committees ahead of discussion and approval at Board.

Executive 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. The BAF has been reviewed to ensure it is aligned with the new Ambitions from the 2024-29 Strategy. A 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.

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

Strategic Ambition(s) this report relates to				

Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

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 reflects the new Trust Strategy and ambitions.

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. CONCLUSION.

The Board is asked to ***receive*** and **approve** 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 2024-29 Strategy
- 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

- In line with the Trust Risk Management Policy, the full BAF is reviewed at least once a year at Board and twice a year at the Audit and Risk Committee
- The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF;

Improving care, transforming lives...for a better Bolton

OUR AMBITION: IMPROVING CARE, TRANSFORMING LIVES THROUGH FOCUSING ON SAFETY, EFFECTIVENESS AND EXPERIENCE
PRINCIPAL RISK: IF the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities, and unsustainable services
Lead Committee: Quality Assurance Committee
Executive Lead: Medical Director, Chief Nurse, Chief Operating Officer

Corporate Objectives	Enabling Plans
CO.1- Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care.	• Bolton Carers' Strategy • Bolton Locality Plan • Clinical Strategy • Quality Improvement Plan 2024-29 • Research Strategy (in development) • Nursing, Midwifery & Allied Health Professionals and Health-Care Scientist Priorities • Patient safety priorities
CO.2 - Create a culture where staff can innovate and collaborate to improve care.	
CO.3 - Play our part in improving health and preventing illness, so that people live healthier lives	

ANNUAL PRIORITIES / PLAN FOR 2024-25
Reducing the avoidable harms across all of our services by making our environment and processes safer, focusing on prevention, and learning from harm so that everyone is safe in our care

CO1: Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care

Risk Statement: If the trust does not deliver high quality, safe and effective care to patients then everyone will not have a positive experience of our care resulting in an inability to learn from experience, poor clinical outcomes and unsustainable services.

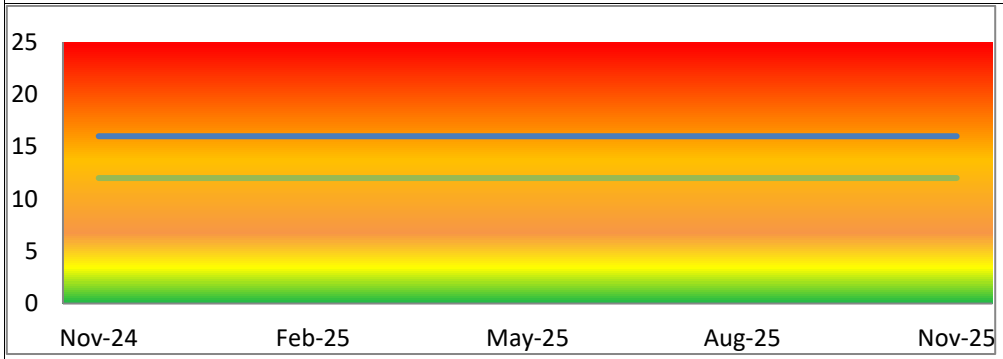
Executive Lead: CHIEF NURSING OFFICER

Risk Assessment	Initial	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Severity	4	4	4	SEEK	5599 – No Criteria to Reside 6164 – ED Capacity (16) 6133 – Mental Health Patients in ED – Observations (16) 6193 - Reduced bed capacity within the maternity service caused by RAAC panel within Princess Anne Maternity Unit (16) 1595 – Critical care delayed discharges & mixed sex accommodation breaches (15) 5332 - Urology Department admin and clerical workforce (15) 5396 – Paediatric Audiology waiting list delays (15) 5850 - Birth Rate Plus Midwifery funded staffing establishment levels - Jan23 (15) 6145 – Maternity Theatres ventilation failures (15) 6159 – Elective gynaecology appointment waiting times (15) 6317 – No capacity for nurse led IV access service to place PICC or midlines due to vacancies (15)
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our objective	KPIs or measures
• Future reductions in supply workforce as predicted based on reduced learner intake which may impact 27/28 • Demand for services exceeding capacity • Insufficient collaboration with adult social care • Regulatory breaches • *Unreliable application of quality improvement science methodology* • Leadership inconsistency with application of required standards • Financial health fragility impacting on service provision • Lack of access to experience and outcome data from all patients / service users • Missed opportunities for Improvement or implementation of evidence based interventions	• Year-on-year improvement in patients who report that they were treated with dignity and respect • Year-on-year reduction in avoidable harm and mortality • Compliant and achieving top quartile against National and local quality recommendations such as GIRFT • Year-on-year improvement in the % of staff reporting they would recommend BFT as a place to receive care • Year-on-year improvement/increase in the number of patients responding to national survey • A minimum of 60% of our wards and departments score a silver or higher by 2029 as measured through our BOSCA accreditation programme • Year-on-year improvement in patients who reported that they were involved in decision making

Controls	Gaps in Controls	Assurances	Gaps in Assurance	Actions
• Quality Account Priorities • Quality Improvement Plan • Patient Safety Incident Response Framework / Plan • Open visiting • Being Open Policy (includes duty of candour) • Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS), • Enhanced accreditation (BoSCA) escalation framework • Safeguarding Assurance Framework • 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 • NHSE workforce safeguards	• Development of a Risk management framework/strategy • Fundamentals of care internal development programme for non-registered clinical staff. • Lack of robust non-medical research plan • Lack of an ACP strategy • Lack of consistency with training needs analysis	**1st line of Defence (Operational Management)** • Risk registers reviewed at Risk Management Group • Real-time patient experience with addition of key questions for all in-patients and community long term caseloads – data reports from 10.23 **Reports to Clinical Governance & Quality Governance Group** • Patient Safety Group • Clinical Effectiveness Group • Patient Experience Group • Infection prevention and control committee • Safeguarding Committee • Mortality Oversight Group • Medicines Safety group • Monthly workforce fill rates • Monthly safe staffing reports produced in line with CHPPD • Midwifery safety dashboard in alignment with national requirements • Bi-annual learning report • Quarterly and annual Safeguarding reports • NMAHP priorities bi-annual report • Annual Claims Scorecard Report • NHS IMPACT self-assessment **2nd Line of Defence (Board and Committee Level)** **Reports to Quality Assurance Committee and Board, namely:** • Integrated Performance Report with monthly heatmap • Safe staffing report to board in line with NQB recommendations within heatmap • Quality Account priorities	• 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 • NHSE workforce safeguards for Nursing partial compliance • Nurse & Midwife sensitive clinical outcomes dashboard requires additional kpis • Lack of robust, co-ordinated & consistent intelligence on patient experience / service user feedback from those without / with limited, mental capacity and / or those for whom English is not first language • Lack of robust process for inclusion of NMAHP&HCS outcome data stratified according to ethnicity and deprivation	• Scoping procurement of a digital solution to support with provision of aggregated data / thematic analysis**. Expected (business case) presentation March 2025)** • Launching a Fundamentals of care internal development programme for non-registered clinical staff. **Commencing Q4** • Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.25 (***currently on pause due to NHSE national pause***)** • Development of Risk management framework with stakeholder engagement **Target Completion Date ~~30.12.2023~~. Revised to April 2025.** • Submit and publication of the monthly Nursing and Midwifery safe staffing report to Board of Directors**. Target due date Dec.2024** • Improvement plan to attain full compliance with NHSE workforce safeguards; 31.3.2026

Controls	Gaps in Controls	Assurances	Gaps in Assurance	Actions
• Reliable deployment of statistical process control charts to monitor agreed indicators • Scheduled programme of patient feedback (positive and opportunities for learning) • Deployment of a blend of QI Methodology (eg Lean and breakthrough series) Two QI collaborative to support embedding of QI methodology around priority areas • QI training offer • Annual leadership conference • Talent management programmes in place for all NMAHP & HCS • Three year Clinical Audit Plan • Participation in National patient surveys		• Mandatory training compliance • Bi-annual Nurse & Midwifery establishment reviews • CNST & other Maternity related specific reports • Quality and Clinical Governance Chair's report • Safeguarding annual report • Complaints Annual report • CQC Improvement Plan reporting/oversight to QAC. Well led recommendations reported through to appropriate committees of the board • Risk Management Group chairs report to Audit and Risk Committee **3rd Line of Defence (Independent or Semi-independent assurance)** • Internal audit reviews • CQC inspection reports, visits, Insight reports, and engagement meetings • Peer reviews and accreditation. • Quality governance review via Good Governance institute 2023 • National patient surveys	• Real-time access to Quality KPIs and access to automated triangulation	• Nurse/midwife sensitive clinical outcome dashboard draft amends piloted from 11.24 • Completion of National research and development gap analysis tool (SORT); 31.3.26 • Provision of inclusive patient experience / service user feedback that represents all users; 31.3.26 • Agreement of initial NMAHP clinical outcomes for stratification by ethnicity and deprivation; 31.3.26 • Launch of our leaders programme **Target Date Q4 24/25** • Introduction of shared decision making councils. **Target date Q4 24/25.** • Development of Quality Governance KPI dashboard. **Target Date Q4 24/25.**

CO1: Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care		
Risk tracking	**Committee Feedback**	**Date**
		*Nov 24*

CO.2 - Create a culture where staff can innovate and collaborate to improve care

Risk Statement: If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff .

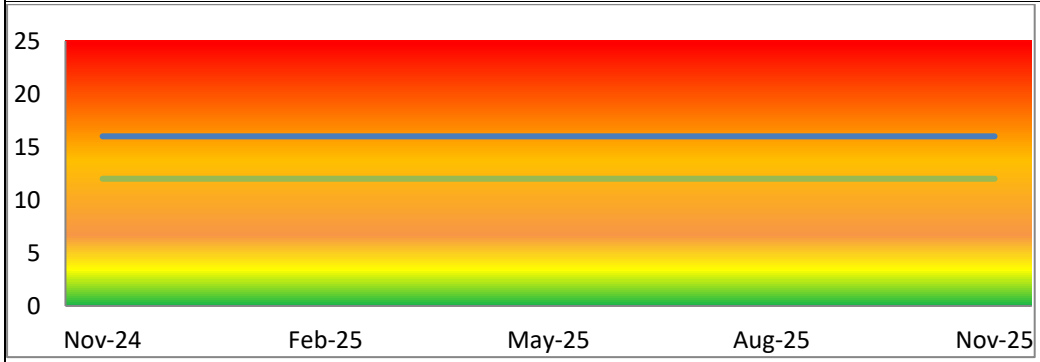
Executive Lead: Medical Director

Risk Assessment	Initial	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	OPEN	6192 – Lack of Medical Director in ISCD (15)
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our objective	KPI /Measures
• Lack of understanding of the mortality and morbidity profiles of different patient groups in Bolton. • No digital solution for Coding Team to identify missing codes from previous admissions • Training compliance not at 100% for nursing and medical staff • Missed Opportunities for Improvement or implementation of evidence-based interventions	• Through developing our approach to quality improvement, embedding QI methodologies and nurturing a culture of improvement and innovation and will ensure that a minimum of 75% percentage of our staff have the skills and knowledge to do this • Annual increase in changes and innovations that are developed and implemented aligned to the priorities in our annual plan • Enhanced corporate and clinical decision-making accuracy and efficiency through the effective utilisation of technologies such as AI, predictive analytics and decision-support • Expanded research collaboration and provision, providing service users with increased access to clinical trials and supporting our workforce to take part in research • Improvement in NHS IMPACT self-assessment Maturity Matrix level

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Quality Improvement collaboratives for deteriorating patients incorporating Martha's Rule (NHSE pilot) • NHSE Improving Patient Care Together (IMPACT) self-assessment Maturity Matrix level • Attendance and membership of the Bolton University Joint Delivery Board. • Systemwide programme for Advanced Care Planning (ACP) to support Admission Avoidance	• Approval of automated solution to comorbidity recording in EPR • Rolling out of Quality Improvement training to all staff. • Development of a Research Plan • Capacity in consultant job planning to support delivery of Ambition.	1st Line of Defence (Operational Management) • Monthly monitoring of HED SHMI & HSMR, mean Charlson comorbidity score & depth of coding plus at Mortality Steering Group • Learning from Deaths Committee reports to MSG: • 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	• Implementing artificial intelligence (AI) and robotic process automation to enhance efficiency and aid in decision-making. **Ongoing throughout 2025** • Expanding research trial access to benefit more people with innovative therapies. **Ongoing throughout 2025**

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• ACP monitoring at Mortality Steering Group (MSG) • AIMS training • MSG monitoring and maintaining the achievement of >98% Coding completeness with accuracy confirmed annually through external assessor. • Medical Leadership Programme	• Resident Doctor listening events • Lack of consistent EPR solution • Refresh and realignment of Medical Leadership Programme to Our Leaders Programme	***2nd Line of Defence (Reports at Board and Committee Level)*** • IPR to QAC and Board • Reports on IPC, transfusion, Medicines Safety, Safeguarding • Quarterly Mortality Steering Group 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 • AQuA audits of care • GIRFT reviews into care provision • External assessments and accreditation • Report to Bolton University Joint Delivery Board		• Implementing continuous improvement techniques and methodologies so we keep improving the things we do. **Ongoing throughout 2025** • Amend EPR to facilitate improved comorbidity recording and depth and consistency of coding ~~(30 June 2023~~ Revised completion -Mar 25 • Development of a Research Plan. **Completion date: Mar 2025** • In partnership with Medical Director, scope resident doctor focus group viability **– Target Completion Date April 25**

CO.2 - Create a culture where staff can innovate and collaborate to improve care		
Risk tracking	**Committee feedback**	**Date**
		

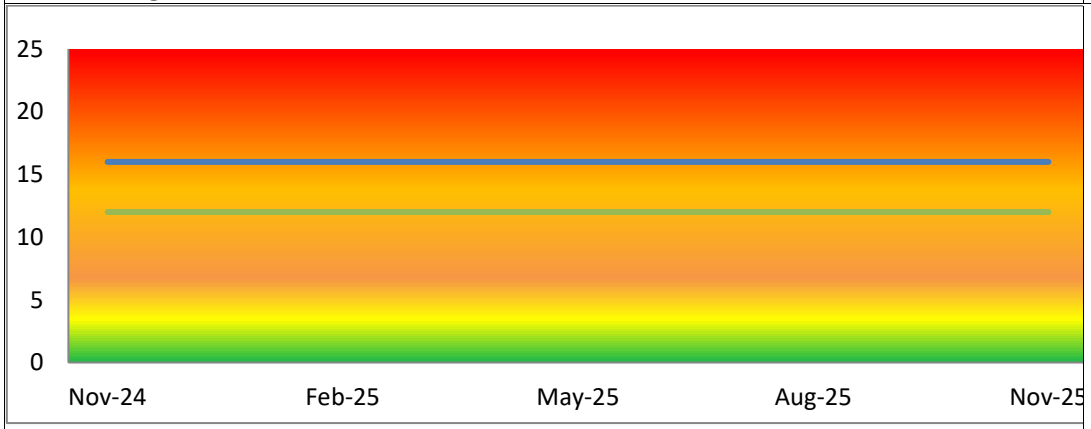
CO.3 - Play our part in improving health and preventing illness, so that people live healthier lives					
Risk Statement: If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequalities, unsustainable services and poor clinical outcomes.					
Executive Lead: Chief Operating Officer					
Risk Assessment	**Inherent**	**Current**	**Target**	**Risk Appetite**	Link to Risks on Corporate Risk Register
Consequence	4	4	4	OPEN	
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our objective	KPIs / Measures
• Widening health inequalities if health disparities are not equitably implemented • Reduced Life expectancy • Increased chronic health diseases leading to long-term health implications and quality of life • Higher healthcare costs resulting in diverting resources from other clinical areas	• Contribute to Smoke Free targets for Bolton locality to support delivery of a reduction in the % of people who smoke • Contribute to reduction in obesity targets for Bolton locality to support delivery of a reduction in the % of people who are overweight or obese through implementation of Making Every Contact Count • Continued optimisation of health outcomes for cancer and chronic conditions through earlier diagnosis and specific interventions; including playing our part in diagnosing 75% of cancers at Stage I/II by 2028 • Working towards decreased acute demand, as a result of proactive and preventive approaches i.e. reduced avoidable admissions, re-admissions and extended hospital stays

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Bolton Locality Plan • NHS Greater Manchester Sustainability Plan • Clinical Strategy • Bolton Public Health Annual Report 2023 • Bolton Joint Strategic Needs Assessment (JSNA) • Benchmarking through Model Hospital • Bolton Carers' Strategy • Health Inequalities Group	Establishing new models of care in the community and through neighbourhoods Using technology to support people with long-term conditions to live well at home.	**1st line of Defence (Operational Management)** Reports from Neighbourhood teams and weekly programme of community visits		• Enhancing links between primary, community, secondary, and social care to ensure people get the services and advice they need promptly. **Ongoing throughout 2025** • Increasing focus on prevention and equitable access, experience and outcomes through community

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Quality Improvement Plan • Educational programme to improve communication with patients, families and carers • Making Every Contact Count Health Programme • Bolton Locality Board		***2nd Line of Defence (Reports at Board and Committee Level)*** •		engagement and neighbourhood groups. **Ongoing throughout 2025** • Identifying and involving carers in care planning, decision making and discharge so that we improve experience. **Ongoing throughout 2025** • Ensuring continuity of care in our Maternity Services for those at most risk and from most deprived areas. **Ongoing throughout 2025**
		3rd Line of Defence (Independent or Semi-independent assurance) Model Hospital metrics National reporting and benchmarking Reports to Bolton Locality Board GM Provider Collaboratives		

CO.3 - Play our part in improving health and preventing illness, so that people live healthier lives

Risk tracking	Committee feedback	Date
		

OUR AMBITION: A GREAT PLACE TO WORK

Principal Risk: If the Trust does not invest in its staff or support them to develop their skills, then it will be unable to recruit, retain and support staff to maximise their potential

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

Lead Directors: Chief People Officer

Our Objectives	Our Enabling Plans
CO.4- Improve the experience of our staff and make our organisation a great place to work	• Equality, Diversity and Inclusion Plan 2022-26 • Medical Workforce Plan • Our People Plan
CO.5 – Help all staff to unlock their potential	
CO.6 – Ensure that our workforce reflects the population we serve	

Executive Lead: Chief People Officer

Annual Plan Priority:	Annual Commitment
Improve the experience of our staff and make our organisation a great place to work.	Ensure no unplanned growth in headcount Reduce agency spend to <3.2% Deliver sickness absence rates of <4.8% Reduce overall vacancy rate lower than 4% by 2025

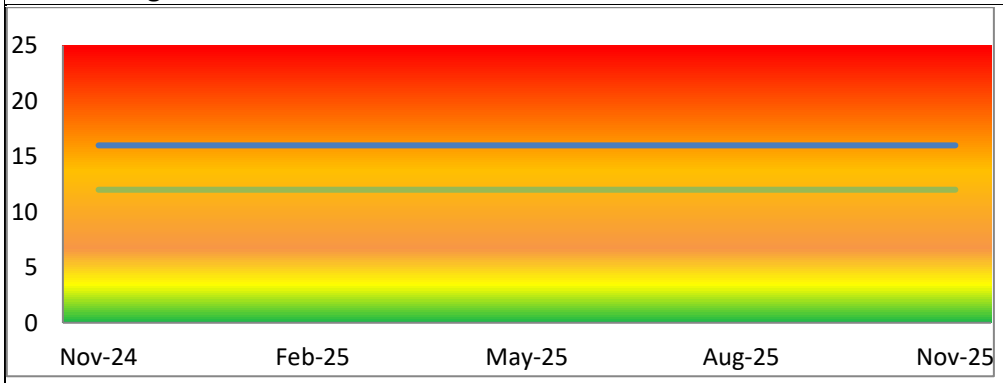
Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Severity	4	4	4	SEEK	*There are no risks rated 15 and above or scoring Catastrophic for Likelihood/Impact to include*
Likelihood	5	4	3		
Risk Score	**20**	**16**	**12**		

Issues impacting achievements of our objective	KPIs / Measures
• Poor provision of health and wellbeing support to staff, leading to an increase in sickness absence rates. • Low staff engagement and satisfaction levels, resulting in low recruitment and retention of staff with the right skills and values. • Failure to reduce reliance on agency staff • Failure to have an inclusive and diverse workforce representative of the population. • Impact on improvement initiatives and attendance, and lost opportunities for increased efficiency and effectiveness • Widening health inequalities impacting care provision, reputation, recruitment and retention	• Year-on-year improvement in % staff reporting that they would recommend BFT as a place to work • To remain in the top 20% of NHS organisations for staff engagement scores • An achieved sickness rate of 4.8% or lower • An achieved turnover rate of 10-12% in line with GM targets • Continue to achieve and sustain an appraisal rate of 85% and deliver a year-on-year improvement in the % reporting that their appraisal helps them to perform their role • Overall Trust vacancy rate lower than 4% by 2025 • To achieve compulsory training rates of 95% or greater • To have a workforce that represents the population we serve as measured by the WRES/ WDES

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions To Address Gaps in Controls and Assurance
• Staff Health and Wellbeing Plan • Occupational Health Provision • Staff Health and Wellbeing programme • Great Place to Work Plan • Weekly / Monthly Safe Staffing meeting • Consultants Job planning • Staff Network groups • Revalidation and annual 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 Panel • NHSE EDI Improvement Plan • Equality Diversity and Inclusion Strategy • Equality Impact Assessments / Equality analysis • Health Inequalities Enabling group • Our VOICE Change Programme	•	1st Line of Defence (Operational Management) • Attendance KPI • Friends and Family Tests • 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 • Report and monitoring of EDS standards at Equality Diversity and Inclusion Steering Group • Reports to Staff Experience Inclusion Steering Group • Reports to Workforce and OD Group 2nd Line of Assurance (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	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** Regular meeting and expansion of Community voices group. **Ongoing** EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date March 2025**

		• 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		

Corporate Objectives 4, 5 and 6

Risk tracking	Committee Feedback	Date
	The Committee received the BAF at its meeting held on 19 November and discussed the Risk Score in detail. It was agreed that further discussions will be held at Board.	19 November 2024

OUR AMBITION: A HIGH PERFORMING, PRODUCTIVE ORGANISATION

Principal Risk: If the Trust does not optimise processes or adhere to standards then this may harm service productivity and efficiency, leading to regulatory action and financial instability.

Lead Committee: Finance and Investment Committee

Lead Directors: Chief Finance Officer and Chief Operating Officer

Our Objectives	Our Enabling Plans
Corporate Objective - Improving access to our services	• Clinical Strategy • Financial Outlook • Green Plan • Test •
Corporate Objective – Being efficient and productive	
Corporate Objective - Delivering financial sustainability	

OUR IN-YEAR PRIORITIES FOR 2024-25

- Reducing the time people spend waiting for urgent and elective care
- Making the best use of our capacity to improve flow, reduce waiting times and improve utilisation of our services
- Delivering recurrent cost improvement efficiencies and processes to make best use of public money.

CO7: Improving access to our services

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

Executive Lead: CHIEF OPERATING OFFICER

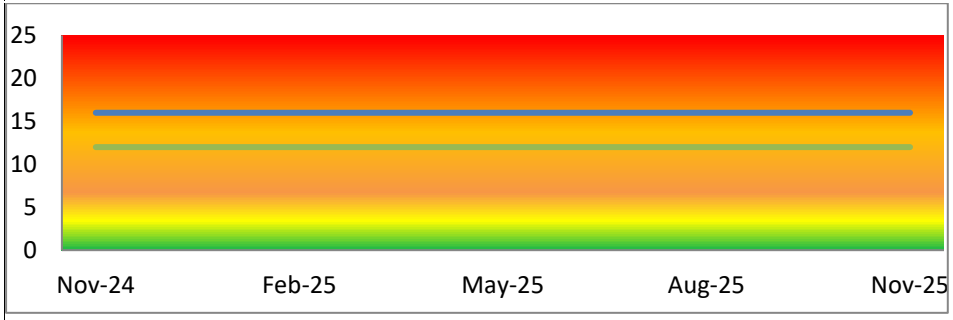
Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Severity	4	4	4	OPEN	**5630 - scored 16**
Likelihood	5	5	3		**5599 – (16)** *Escalation spaces in ED Majors*
Risk Score	**20**	**20**	12		**6072 – (16)** *ED Cohorting in non-clinical areas* **5588 – (15)** *ED Waiting Room*

Issues impacting achievements of our objective	KPIs / Measures
• Increased waiting list size and cancer backlog size since 19/20 baseline • 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 • Failure to deliver against nationally mandated performance targets	• Annual improvement in timeliness of care – including: ○ reduced wait times for appointments and treatment ○ response to requests ○ and length of stay • Deliver annual operating plan targets

Controls	Gaps in Controls	Assurances	Gaps in Assurance	Actions
• 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 to ensure equality of access across GM • Regular validation of waiting lists • Escalation Policy, Access Policy and Discharge Policy now refreshed and implemented • Urgent care assurance meeting with GM • Tier 2 meetings with the regional team about elective care delivery. • Support from the Elective Care Improvement Team (ECIST)	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)** • Monthly Integrated Performance Management (IPM) meetings to review performance data • Divisional Risk Registers at RMC • Review of assurance programmes at Performance & Transformation Board • Weekly Operational Update at Execs with regular Urgent Care Performance reviews **2nd Line of Defence (Reports at Board and Committee Level)** • Spotlight service reviews at SOC • Bi-monthly presentation of the refreshed IPR to QAC and Board • Operational Update at Board • Monitoring of performance at GM meetings **3rd Line of Defence (Independent or Semi-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, ECIST visits & peer reviews • Internal Audit reviews	• Development and review at SOC of the implementation of Emergency Care Intensive Support Team (ECIST of action log. • GM ICS Performance meetings	• Refreshed Capacity & Demand cycle **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)** • Emergency Care Intensive Support Team (ECIST) review and implementation of action log. (Ongoing and subject to periodic review) •

CO.7- Improving access to our services

Risk tracking



Committee Feedback

Date
Nov 24

CO.8 – Being efficient and productive

Risk Statement: If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services

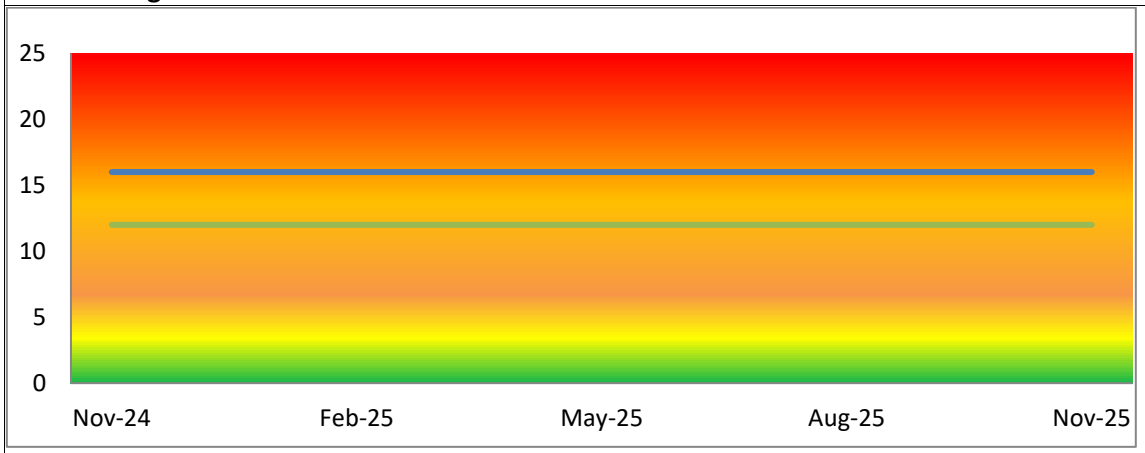
Executive Lead: Chief Finance Officer and Chief Operations Officer

Risk Assessment	Initial	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	5773 (15) Capital Funding 23/24 5770 (15) Revenue Deficit 23/24
Likelihood	5	4	3		
Risk Score	**20**	**16**	12		

Issues impacting achievements of our objective	KPIs / Measures
• Improve performance in urgent & emergency care productivity due to the need to meet targets like reducing the number of patients waiting over 65 weeks. • Financial challenges associated with meeting productivity targets. The need to reduce waiting times often leads to increased costs, impacting the overall budget. • Time constraints make it difficult to implement long-term solutions, leading to short-term fixes that may not be sustainable. • Waiting list initiatives to reduce the number of patients waiting which may not always be the most efficient way to achieve the desired outcomes.	• Deliver year on year improvements in productivity and efficiency as per the op plan • Achieve at least 75% of our annual plan targets • Processes, workflows and pathways are streamlined resulting in minimised waste and optimised recourse allocation and reduced duplication • Improved service performance to the highest benchmarking quartiles in Model Hospital and GIRFT, enhancing overall quality of care and productivity

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Increased productivity and partnerships through Clinical Diagnostics Centre • Increased productivity and partnerships through Clinical Diagnostics Centre • Monthly cash flow forecast • Finance Improvement Group (FIG) • Urgent Care Improvement Group	• Re-establishment of a Finance Intelligence Group • F&I to assume responsibility of tracking productivity to ensure better control and oversight .	1st Line of Defence (Operational Management) Monthly cash flow forecast Chair's Report from Finance Improvement Group (FIG) and Urgent Care Improvement Group to Executive Directors Group	Model Hospital benchmarking reporting to F&I Committee	

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
		2nd Line of Defence (Reports at Board and Committee Level) • Integrated Performance Reports to F&I and Board • Operational Update to Board		
		3rd Line of Defence (Independent or Semi-independent assurance) • GM Provider Oversight Meetings • Model Hospital benchmarking reporting to F&I Committee • Membership and attendance at Trusts Provider Collaborative (TPC) • PLICs reporting • PWC 'Turnaround' Teams Review		

CO.8 – Being efficient and productive		
Risk tracking	**Committee Feedback**	**Date**
		

CO.9 – DELIVERING FINANCIAL SUSTAINABILITY

Risk Statement: If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability.

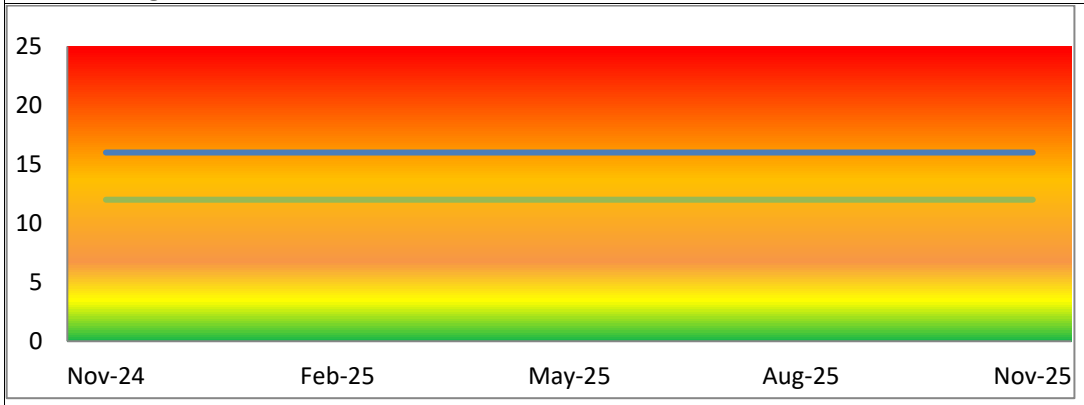
Executive Lead: Chief Finance Officer

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	• 5773 (15) Capital Funding 23/24 • 5770 (15) Revenue Deficit 23/24
Likelihood	4	4	2		
Risk Score	16	16	12		

Issues impacting achievements of our objective	KPIs / Measures
• Bridging the financial gap, noting the scale of the challenge • Delivering a sustainable, recurrent cost improvement to achieve a good financial position. • New Compliance Costs requirements adding to the financial burden. • Staffing Ratios and digital advancements also contribute to increasing costs, making it challenging to provide modern healthcare services within budget • 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).	• Deliver financial break-even • Achieve financial sustainability • A measurable increase in income/revenue growth (measured through recording gains, contract review, commercial opportunities) • Annual achievement of our Cost Improvement Programme • Annual agency spend of 3.8% or lower • Ensuring return on investment through regular review and evaluation of business cases and investments as agreed through Investment Assurance Group

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Executive / CRIG approval of business cases • PMO 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 to DOF • Standing Financial Instructions • Scheme of Delegation	• Revision of the three-year Financial Outlook (previously Strategy) in response to changing financial • 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	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 Q.4 2024 Closer / joint local working in Bolton System. Ongoing and progressing into 2024 Clarity on GM Financial Strategy which would inform local Strategic Planning. ~~December 23~~ **Target Completion May 25**

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• 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		***2nd Line of Defence (Reports at Board and Committee Level)*** 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		Ongoing revision of the three-year Financial Outlook. **Target Completion Mar 25**
		3rd Line of Defence (Independent or 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 • Oversight from GM Performance Oversight Meetings (POM) Action Log, Variable Pay Panel • Meetings with GM ICB Turnaround Director		

CO.9 – Delivering financial sustainability		
Risk tracking	**Committee feedback**	**Date**
		

OUR AMBITION: AN ORGANISATION THAT IS FIT FOR THE FUTURE

PRINCIPAL RISK: If the Trust does not proactively plan for the future, then it will face significant challenges with its estate and digital infrastructure. This could lead to barriers to services, missed opportunities, and potential legal and regulatory breaches.

Lead Committee: Finance and Investment Committee

Lead Directors: Chief Finance Officer and Chief of Strategy and Partnerships

Our Objectives	Our Enabling Plans
Corporate Objective 10 - Being digitally enabled and inclusive	• Digital Strategy • Clinical Strategy • Financial Plan • Green Plan
Corporate Objective 11 – Improving our estate	
Corporate Objective 12 - Delivering financial sustainability	

OUR PLAN FOR 2024-25

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

CO10: Being digitally enabled and inclusive

Risk Statement: If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities.

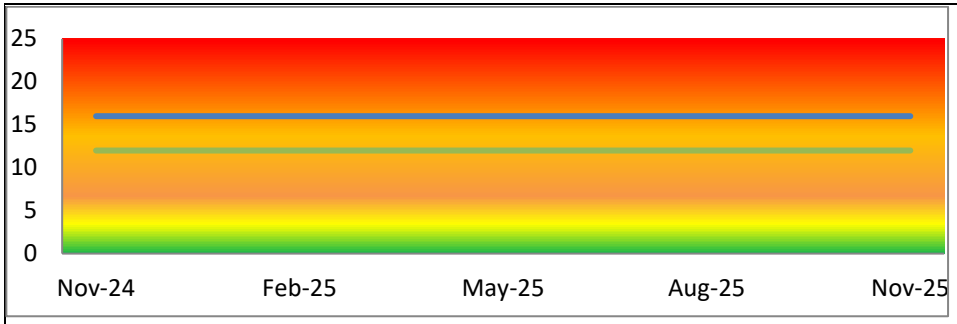
Executive Lead: Chief of Strategy and Partnerships

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Severity	4	4	4	SEEK	There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)
Likelihood	4	4	3		
Risk Score	16	16	12		

Issues impacting achievements of our objective	KPIs /Measures
• Availability of investment for Digital programmes against need and expectations • Digital exclusion within Bolton which can lead to health inequalities • Availability of digital staff to support growing demand • Increased number of Cyber-attacks whilst needed to secure patient and staff data • Increased demand for data and information • Increased digital use results in more Information Governance Risks	• Year on Year improvement in the Digital maturity matrix level • Regular updated capacity and demand data • Full EPR rollout 2026 • Increasing the number of specialties in which Patients will have digital access to Self Help Information & Information about procedures • Sub-KPI: Publication of a clear plan for agile working by 2025

Controls	Gaps in Controls	Assurances	Gaps in Assurance	Actions
• Board approved Digital Plan • Lead Bolton Borough wider Partnership • Digital Performance and Transformation Board • Digital Maturity Matix • Data Protection Toolkit Annual assessment • External and Internal Audit reports • ISO assessments • Regular penetration testing and cyber security testing arranged with external expertise. • All High severity Cyber alerts are acknowledged within 48 hours to NHS Digital (NHSD) and actions and mitigations submitted. • Digital Teams manage delivery of programme based on good practice project methodology • Divisions included in the Digital Performance and Transformation Board to ensure they have oversight of the Digital program	• Require system to understand and respond to staff feedback on Digital support • Digital strategy to be refreshed 2026	**1st line of Defence (Operational Management)** • 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 • All IT projects requiring resourcing go through Capital Resurce Investment Group • Significant IM&T Risks monitored by Risk management Committee • Information Governance Committee meets bi monthly and feeds into Digital Performance Committee. **2nd Line of Defence (Reports at Board and Committee Level)** • Monthly review of Integrated performance report at F&I and Board • Annual Digital Report at Board • IA reports at Audit Committee **3rd Line of Defence (Independent or Semi-independent assurance)** • NHS Digital Toolkit • Internal Audit Reviews • Use of resources benchmarking • Cyber Security national assessments	• Requirement for key Digital roles and increase in substantive capacity in the digital programme - still working with agencies and Procurement for the remainder of the programmes to fill posts. • Capacity within wider trust teams for digital system implementations. • NHS Benchmarking for digital workforce is difficult to compare for Digital Teams so a different system of assurance is required	• Refresh Digital Strategy - **March 2026** • Workforce plan digital team – **March 2025** • System for staff feedback – **March 2025** • Ongoing training program linked to EPR and IG / Cyber – **ongoing into 2025** • Digital and Data capacity and demand assessment by internal audit - **2025/6** • Maternity EPR Rollout – **March 2025** • Community and OPD Rollout – **July 2025**

CO.10 Being digitally inclusive		
Risk tracking	**Committee Feedback**	**Date**



Nov 24

CO.8 – Improving our estate

Risk Statement: If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.

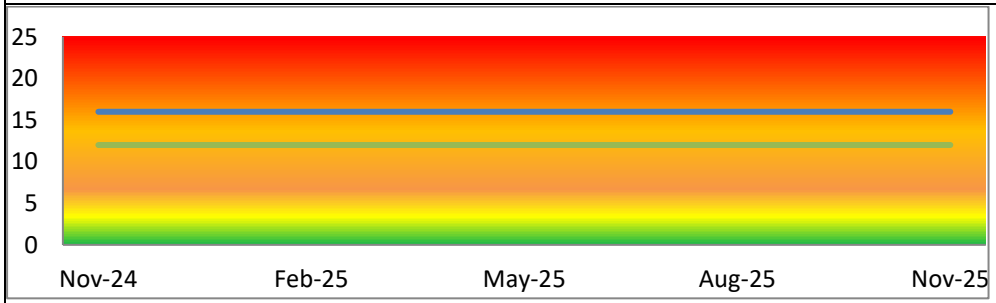
Executive Lead: Chief Finance Officer

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	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)
Likelihood	5	5	2		
Risk Score	20	20	8		

Issues impacting achievements of our objective	KPI or measures
• 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 • PDC bids/funding not linked to Strategy	• Achievement of our Green Plan targets with a focus on annual improvement towards net zero, • Year on Year improvement in estates utilisation • Publication of an estates strategy by 2026 • Improved safety and compliance through a year-on-year reduction in backlog maintenance

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Green Plan	• Achievement of our Green Plan targets	1st Line of Defence (Operational Management)	• Revision of Strategic Estates Group and reporting lines to F&I	

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Estates Strategy and supporting Business Cases to make the case for external capital to CRIG, F&I, Board • Established links to GM and NHSE • Capital processes to ensure correct prioritisation • Links with local partners including LA, University • Membership of Bolton Strategic Estates Group • 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	with a focus on annual improvement towards net zero • Estates Strategy • PDC bids / funding not linked to Strategy • Re-establishment of Space Utilisation Group	• 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 ***2nd Line of Defence (Reports at Board and Committee Level)*** • Integrated Performance Reports to F&I and Board • Annual Estates Report at Board • Green Plan Report to F&I and Board ***3rd Line of Defence (Independent or Semi-independent assurance)*** • ERIC reports, Premises Assurance Model • Model Hospital estates and facilities metrics • Use of resources benchmarking • Locality Board oversight • Management Framework		• Publication of an Estates Strategy. **Target delivery date: by 2026** • Production of a shared vision for the site and neighbouring land – **expected to be ongoing throughout 2024/25** • Introduce quarterly reporting from Bolton Strategy Estates Groups to F&I **Revised target completion date to Dec 24** • Re-establishment of Space Utilisation group. **Ongoing and continuing into Jan 2025** • Manage the estates backlog capital program April 2024 **Ongoing and continuing into 2025** • Monitor and manage the aging estate and escalate urgent issues with the estates. **Ongoing and continuing into 2025**

CO.11 – Improving our estate		
Risk tracking	**Background**	**Date**
		

CO.12 – PROACTIVELY PLANNING FOR THE FUTURE

Risk Statement: If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy.

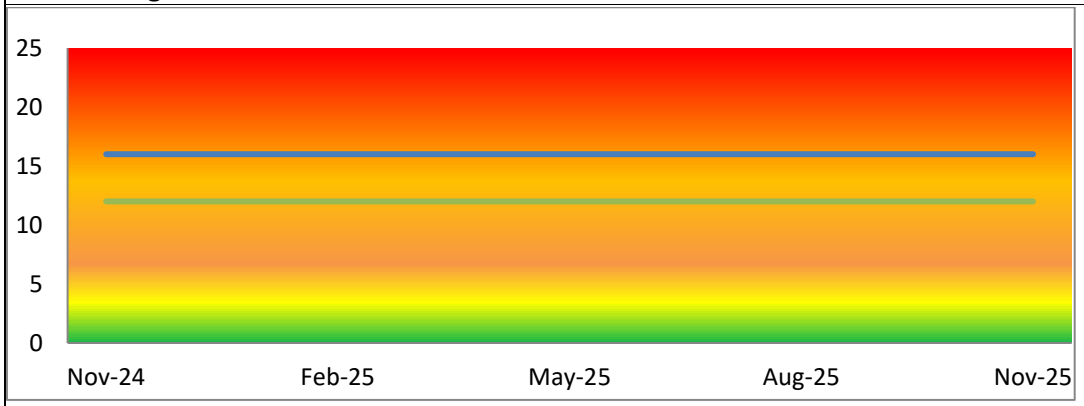
Executive Lead: Chief Finance Officer

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	• 5773 (15) Capital Funding 23/24 • 5770 (15) Revenue Deficit 23/24
Likelihood	4	4	3		
Risk Score	16	16	12		

Issues impacting achievements of our objective	KPIs /Measures
• The Greater Manchester (GM) financial position is a significant factor • Shortage of revenue and capital funding. • Meeting NHS England Productivity requirements. • Working within GM ICB (jointly responsible and reliant on others results)	• Improved accuracy and timeliness in forecasting service demand, leading to optimised resource allocation, strategic planning and enhanced decision making • Comprehensive understanding of long term healthcare trends, their impact on our services and plans in place to address • Estates and capital planning based on data and intelligence on demographic and demand changes • % of clinical services that have access to demographic data and disease prevalence and use this to inform planning • Sub-KPI: Approach to workforce planning and service design informed by population health changes • Sub-KPI: Succession planning effectiveness measured by the percentage of key positions with identified successors

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• PMO coordination of CIP • Annual budget setting and planning processes • Finance department annual business planning process • Finance and Intelligence Group reviews of productivity and actions to improve		**1st line of Defence (Operational Management)** • Annual Planning Process • Reports to Finance and Intelligence Group (FIG) • Review of Cost Improvement Programme at Finance Improvement Group ***2nd Line of Defence (Reports at Board and Committee Level)*** Reports to F&I and Board	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 Q.4 2024 Closer / joint local working in Bolton System. Ongoing and progressing into 2024 Clarity on GM Financial Strategy which would inform local Strategic Planning. **Target Completion May 25**

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
		3rd Line of Defence (Independent or Semi-independent assurance) • Internal and External audit reports • System Reports to Greater • NHSE Operating Plan and Guidance • GM Operating Plan • Model Hospital benchmarking		Ongoing revision of the three-year Financial Outlook. **Target Completion Mar 25**

CO.12 – Proactively planning for the future		
Risk tracking	**Committee feedback**	**Date**
		

AMBITION 5 : A POSITIVE PARTNER

PRINCIPAL RISK: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

Lead Committee: Executive Committee through Trust Management Committee

Lead Directors: Chief of Strategy and Partnerships

Our Objectives	Our Enabling Plans
Corporate Objective 13- Developing our neighbourhoods	• Clinical Strategy • Bolton Locality Plan • Financial Plan • Green Plan
Corporate Objective 14 – Working as one team	
Corporate Objective 12 - Delivering financial sustainability	

CO.13- Developing our neighbourhoods

Risk Statement: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

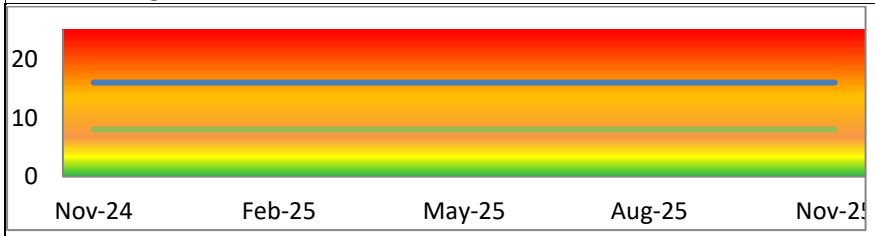
Executive Lead: Chief of Strategy and Partnerships

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Severity	4	4	4	SEEK	There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our Ambition	Key Performance Indicators (KPIs) /Measures toward achieving Ambition.
• If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development • If there is lack of collaboration with system partners to understand and respond to the wider determinants of health • 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	• 6 Neighbourhoods in place with clear development plans and robust relationships to Primary Care Networks • Staff report that neighbourhood working is improving the care, experience and outcomes of the people we serve • Patient, service user and carer feedback demonstrates that neighbourhood working has improved their care, experience and outcomes • Increase in the number of services that are provided in the neighbourhood footprint • Neighbourhood leaders report that they are able to use data and intelligence to inform the health and care priorities for their neighbourhood • Percentage reduction in preventable hospital admissions as our neighbourhoods mature

Controls	Gaps in Controls	Assurances	Gaps in Assurance	Actions
• Locality plan developed for Bolton Locality • Bolton Locality Outcomes Framework in place and progress monitored • Accountability for delivery of through the Place Based Lead and agreed governance framework. • Bolton Delivery Plan to map delivery of the Locality Plan. • 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. • GM Sustainability Plan	• Locality Assurance Framework • Bolton Locality sustainability plan in development	**1st line of Defence (Operational Management)** • Monthly report to Performance and Transformation Board on Locality / Community Transformation • Report to Bolton Strategy Planning and Delivery Committee from 7 Transformation workstreams delivering against key priorities and delivery plan • Report to Strategy Planning and Delivery Board on delivery of the Bolton Outcomes Framework **2nd Line of Defence (Reports at Board and Committee Level)** • Oversight of Workforce Transformation Plan through People Committee • Oversight of system finance and impact through F&I Committee • Spotlight on service transformation of neighbourhoods **3rd Line of Defence (Independent or Semi-independent assurance)** • Reports to Bolton Health Overview and Scrutiny Committee • Reports to GM scrutiny and oversight • Reports to Locality Board with engagement from key partners	• Bolton Cultural Framework • Bolton Digital Strategy • One Plan for Bolton Locality Estate	• Develop Locality Assurance Framework **March 2025** • Evolve Locality Board into formal and informal sessions **Jan 2025** • Locality Cultural Programme to be developed **March 2025** • Plan for Neighbourhood development to be refreshed **March 2025**

CO.13- Developing our neighbourhoods

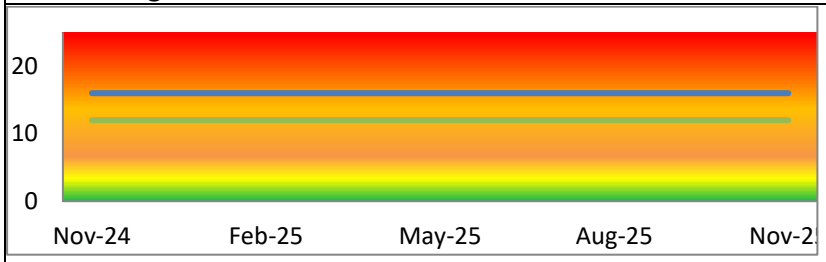
Risk tracking	Committee Feedback	Date
		November 2024

CO.14 – Working as one team					
Risk Statement: If the Trust does not promote a collaborative environment, it could result in fragmented efforts, misaligned objectives, and inefficiencies.					
Executive Lead: Chief of Strategy and Partnerships					
Risk Assessment	**Inherent**	**Current**	**Target**	**Risk Appetite**	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our objective	**KPI or measures**
• Inadequate workforce to deliver safe, effective care. • Strategic partnership opportunities will be missed • Impact to access, experience and outcomes for the people of Bolton	• Year on year increase in the number of services colocated with other oublic bodies • Working with partner organisations to agree integration priorities (i.e. shared systems) and delivering on these priorities • Percentage increase in shared electronic health records linked to partner organisations and Greater Manchester Shared Care Record • Improvement in patient and service user satisfaction and feedback/decreased complaints • Sub-KPI: Staff report an improvement in their ability to work across teams and with partner organisations to achieve organisational priorities

Controls	**Gaps in Control**	**Assurance**	**Gaps in Assurance**	**Actions required to improve controls/assurance**
• Bolton Joint Strategic Needs Assessment (JSNA) • Membership of Bolton Strategic Development and Partnership Meetings • Bolton Locality Governance Structure • Bolton Partner Communication Update	• Locality Assurance Framework • Bolton Locality sustainability plan in development •	1st Line of Defence (Operational Management) Deputy Place Based Lead attendance monthly at Executive Directors	• Bolton Cultural Framework • Bolton Digital Strategy • One Plan for Bolton Locality Estate	• Develop Locality Assurance Framework which demonstrates impact on inequalities **March 2025** • Evolve Locality Board into formal and informal sessions **Jan 2025**

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• Community engagement plan and meetings with partners at Locality • Bolton Alliance Agreement to support the governance of the partnership • Governors Monthly Update • Membership Newsletter • Quarterly update to Locality following BFT Board meetings • Active Connected and Prosperous (ACP)		***2nd Line of Defence (Reports at Board and Committee Level)*** • Locality Updates in Chief Executive's Report to the Board • Bi-monthly presentation of IPR at Committees and Board • Oversight of system finance and impact through F&I Committee • ***3rd Line of Defence (Independent or Semi-independent assurance)*** • Reports to Bolton Strategic Development and Partnership Meetings • GM Local Assurance Meeting (LAM) • Reports to Locality Board and System Finance Board on use of the of the Bolton £ .		• Locality Cultural Programme to be developed **March 2025** • Plan for Neighbourhood development to be refreshed to include appropriate integrated services **March 2025**

CO. 14 – Working as one team		
Risk tracking	**Committee Feedback**	**Date**
		

CO.15 – Partnering for local benefit

Risk Statement: If the Trust does not establish partnerships that align with its Ambitions, then this could negatively affect the services on offer, infrastructure, and financial stability.

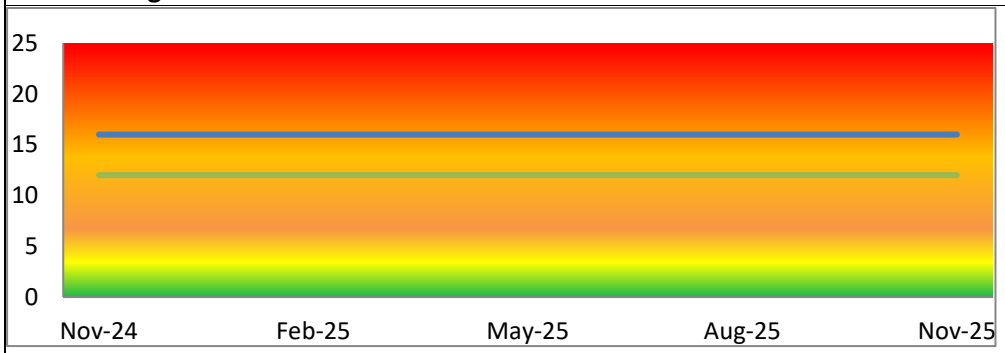
Executive Lead: Chief of Strategy and Partnerships

Risk Assessment	Inherent	Current	Target	Risk Appetite	Link to Risks on Corporate Risk Register
Consequence	4	4	4	SEEK	There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)
Likelihood	4	3	2		
Risk Score	16	12	8		

Issues impacting achievements of our objective	KPIs /Measures
• Resilience of GM clinical services • Increasing demand for services • The developing Provider Collaborative and ICB landscape across GM • Sustainable Workforce Pipeline • Opportunity for strategic partnerships	• Readiness to be lead partner for Bolton Medical School in 2024/25 • 100% of training places filled by local academic partners • 100% tenders published by BFT include a social value section • % of total spend on goods and services from local suppliers

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
• 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 • Increased productivity and partnerships through Clinical Diagnostics Centre • Engagement through GM Exec Director Forums/ TPC to contribute to the GM Joint Forward Plan and GM Sustainability Plan • Regular meetings between Directors of Strategy for BFT and WWL • Involvement in the GM Health and Care Programme	• GM Clinical Strategy • Bolton Locality Sustainability Plan	**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 Bolton Locality Board through Place Based Leadership Team ***2nd Line of Defence (Reports at Board and Committee Level)*** • Reports into People Committee • Reports to Board and discussion at informal board meeting. • Board Development Day sessions	• GM Health and Care Transformation Program work programme at an early stage though conversations ongoing through Directors of Strategy and Executive Medical Directors • Bolton and Wigan Collaborative Program plan being developed • Health Innovation Bolton program plan being developed	• Development of a stronger partnerships with local academic providers to develop a workforce pipeline – **expected to be ongoing into 2025** • Continued participation in GM working group to shape and influence the developing programme - **expected to be ongoing into 2025** • Implementation of GM PACs (complete) and LIMS procurements - **Ongoing** • Expansion of clinical courses and programmes mapped to workforce demand—**expected to be ongoing into 2025** • Development of new programmes to fulfil recruitment issues e.g. health informatics - **expected to be ongoing into 2025**

Controls	Gaps in Control	Assurance	Gaps in Assurance	Actions required to improve controls/assurance
		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 • Report to the Bolton Health and Academic Partnership • Reports to the Bolton Health Innovation Partnership		• Production of a shared vision for the site and neighbouring land – **expected to be ongoing into 2025** • Participation in the GM Anchors network program – **expected to be ongoing into 2025**

CO.15 – Partnering for local benefit			
Risk tracking	**Committee feedback**	**Date**	**Comments**
			

Report Title:	Committee Effectiveness Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	

Purpose of the report	The report seeks to provide assurance on the efficacy of the Committees and demonstrates alignment with best practice and Trust Ambitions.

Previously considered by:	The Committee Effectiveness Reports were subject to discussion at respective committees during the November meeting cycle.

Executive Summary	Efficient Board and committee meetings are essential components of a robust governance framework. Consequently, it is crucial to ensure that the Trust's organisational governance aligns with best practice, statutory requirements, and regulatory guidance. An annual effectiveness review of committees was conducted in accordance with good governance and a cycle of continuous improvement. This report summarises the key points from those reviews and aims to inform planned discussions on committee performance, as well as provide assurance on the efficacy of the committees. • Overall, the responses to the Annual Effectiveness surveys were positive, indicating that the committees have continued to improve in their effectiveness. • The high level of engagement allowed Chairs of the committees to assess if their committees met their objectives and responsibilities without any assurance gaps. • In areas where improvement was identified, particularly through qualitative feedback (comments received), these issues will be further discussed within the committees, with resulting actions planned for 2025. • Throughout 2024, member attendance at committees has remained high, with quoracy consistently maintained at each meeting, thereby supporting effective decision-making and oversight.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Committee Effectiveness Report

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓		

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Victoria Crompton, Corporate Governance Manager	Presented by:	Sharon Katema, Director of Corporate Governance

1. Introduction

1.1. Bolton NHSFT established a number of committees to support the Board and the Executive in fulfilling their responsibilities. The Committee roles include reviewing the comprehensiveness, reliability and integrity of assurances, each within a remit outlined through an approved Terms of Reference (ToR).

1.2. As part of the Board of Directors' corporate governance and performance management arrangements, all committees undertook an annual review of their performance and Terms of Reference.

1.3. The Review was led by the Corporate Governance Team in collaboration with the Chair and Executive Lead of each Committee.

1.4. This paper reflects the key points arising from the committee annual reviews undertaken in November 2024, to inform planned discussion by the Board of Directors of its performance and that of the Committees that it has established.

2. Committee Effectiveness Reports

2.1. Committee Effectiveness reviews are an exercise of self-assessment with the aim of reflecting on areas requiring specific focus and development. The annual performance and effectiveness reviews were conducted in November 2024, using the same questionnaires as last year to enable a comparison of results.

2.2. An internal review of the effectiveness of the committees is carried out annually. This is in line with good governance practice and a cycle of continuous improvement.

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

2.4. The Director of Corporate Governance coordinated and presented the findings from the surveys at each Committee. A summary of the responses is included in *Appendix 1.*

2.5. The reviews focussed on

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

2.6. Participation in all of the surveys was good and the results were generally positive. This positive trend was underscored by low number of "Strongly Disagree" and “Disagree” responses to the questions posed.

2.7. Each Committee had several questions which demonstrated an improved result compared to last year's performance.

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

3. Board Committees

3.1. In line with The Trust’s Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, the Board of Directors has formally established the following Committees and delegated authority to these through agreed Terms of Reference:

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

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

3.3. The Audit and Risk Committee review was undertaken in November 2024 and will be presented to the Audit and Risk Committee at the next meeting in December 2024. This review was based on the recommended checklist from the HFMA Audit Committee handbook (2014).

3.4. The Audit and Risk Committee Effectiveness report will be used to inform the Audit and Risk Committee Annual Report to the Board of Directors.

4. Changes to the Governance Structure and membership of Committees

4.1. There were some changes to the composition of committees and the structure of their meetings during 2024. These changes did not adversely impact delivery of work programmes or the ability to meet quorum requirements, which remained good throughout the period.

5. Conclusion

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

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

Key and Scoring

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

Quality Assurance Committee Effectiveness Review November 2024

Number of respondents: 5

Number of statements: 9

Table 1

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
Quality Assurance Committee Effectiveness Review November 2024	0 [0%]	0 [0%]	0 [0%]	1 [2.2%]	41 [91.1%]	3 [6.7%]	209/210	100%

Breakdown of report by individual statement

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

The Role and Scope of the Committee

Question 1: The Quality Assurance Committee understands the Trust's operating environment and the associated risks

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	5	0	25/24	100%
Nov 2023 responses	0	0	0	2	2	0	18/20	90%
March 2023 responses	0	0	0	2	1	0	13/15	87%

There was an improvement on this question.

Comments

- Strongly focussed on trust strategic plan and clinical strategy

Question 2: The Quality Assurance Committee critically challenges and reviews both the quality and operational issues with an appropriate balance between the two

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	5	0	25/255	100%
Nov 2023 responses	0	0	0	3	1	0	17/20	85%
March 2023 responses	0	0	0	2	1	0	13/15	87%

There has been an improvement on this question as all respondents strongly agreed.

Comments

- Excellent balance and a strong steer away from anecdote.
- Work needs to continue to refine this balance.
- Yes, the committee is always seeking to take a strategic approach.
- QAC creates an environment for challenge and support.

Question 3: At meetings there is a good balance between, quality, operational challenges, governance and risk management

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	1	4	0	24/25	96%
Nov 2023 responses	0	0	0	2	2	0	18/20	90%
March 2023 responses	0	0	1	1	1	0	12/15	80%
								

There has been an improvement in this question

Comments

- This is developing and continually reviewed with committee members to understand if content and structure works.
- Yes, always.
- With the revised format (inclusion of operation IPM and escalation) there will be a better balance between these areas.

Question 4: The Chair ensures that all committee members have the opportunity to participate in the debate

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	5	0	25/25	100%

Nov 2023 responses	0	0	0	2	2	0	18/20	90%
March 2023 responses	0	0	0	1	2	0	14/15	93%
				↑	↑			

There has been a notable improvement in responses to this question

Comments

- Time left for debate and questions to broaden out challenge and to engage a wide variety of views.
- The chair is very inclusive.

Question 5: The secretariat circulates meeting documents in good time before each meeting

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
2024 responses	0	0	0	0	5	0	25/25	100%
Nov 2023 responses	0	0	0	2	2	0	18/20	90%
March 2023 responses	0	1	0	0	2	0	12/15	80%
				↑	↑			

There has been a notable improvement in this question from previous years.

Comments

- Great PA to quality committee, very diligent and excellent minute taking.
- Well administered in all ways.

Question 6: Overall, Quality Assurance Committee is a useful forum for Trust Leaders - please provide your reflections on Quality Assurance Committee

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
2024 responses	0	0	0	0	5	0	25/25	100%

Nov 2023 responses	0	0	0	1	3	0	19/20	95%
March 2023 responses	0	0	0	1	2	0	14/15	93%
				⬆	⬆			

There has been continuous improvement on this question as all responses were strongly agreed.

Comments

- QAC now makes excellent use of our precious commodity - time. it is psychologically safe whilst ensuring challenge is present
- Great arena to showcase great quality improvement and provide 'drill down' on behalf of Board into areas of concern requiring detailed scrutiny.
- Yes, this committee provides an excellent forum for looking at clinical outcomes and strategically improving care outcomes.
- The new format of the committee has created a greater amount of appropriate challenge and support amongst committee members.

Question 7: Overall I think the Quality Assurance Committee works well

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	5	0	25/25	100%
Nov 2023 responses	0	0	0	2	2	0	18/20	90%
March 2023 responses	0	0	0	1	2	0	14/15	93%
				⬆	⬆			

There has been an improvement in this question

Comments

- Provides the Board with assurance on the quality matters and risks within the Trust, within the Trust governance structure.
- Yes, I am very impressed, with the way QAC functions.
- Good level of debate.
- QAC is a high functioning committee.

Question 8: Please use the comments box to suggest what could be better about Quality Assurance Committee

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	3	2	15/15	100%
Nov 2023 responses	0	0	0	1	3	0	5/5	100%
March 2023 responses	0	0	1	0	1	1	8/10	80%
			⟷	↑	↑	↑		

This question has seen an improvement

Comments

- No improvements needed.
- To build further on the feedback that we get from service users.
- None.
- Continued work to refine and hone the content of the papers. Further preparation and development of papers and staff presenting them. More work to consider with front sheets, all moving though in a really positive direction.
- QAC could be even better if there was more focus on experience and effectiveness.

Question 9: I would like Quality Assurance Committee to continue – please use the comments box to explain what you would like QAC to be in the future.

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	1	1	20/20	100%
Nov 2023 responses	0	0	0	0	2	2	10/10	100%
March 2023 responses	0	0	0	0	3	0	15/15	100%
					↓	↑		

This question has stayed the same

Comments

- Vital forum for Board and consideration being given to include performance into the committee. Excellent clinical leadership from Medical Director and Chief Nurse with Director of Midwifery, and including COO.
- This is essential for the successful operation of the trust.
- With the addition of Operational performance, we need to make sure neither ops or quality are squeezed to accommodate the other.

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

Key and Scoring

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

People Committee Committee Effectiveness Review November 2024

Number of respondents: 7

Number of statements: 12

Table 1

							Score	%age
People Committee Committee Effectiveness Review November 2024	1 [1.2%]	1 [1.2%]	3 [3.6%]	21 [25%]	49 [58.3%]	9 [10.7%]	341/375	91%

Breakdown of report by individual statement

Effectiveness Review Nov 2024		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
The Role and Scope of the Committee									
Question 1 The People Committee understands the Trust's operating environment and the associated risks									
1	*2024 responses*	**0**	**0**	**0**	**0**	**7**	**0**	**35/35**	**100%**
	2023 responses	**0**	**0**	**0**	**2**	**4**	**0**	**28/30**	**93%**
					↓	↑			

There was an improvement on this first question from previous years with all respondents selecting Strongly Agree.

Comments

The People Committee understands the Trust's operating environment and the associated risks

- N/A
- Good appreciation from all committee members.
- agree

Effectiveness Review Nov 2024		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
Question 2. The People Committee critically challenges and reviews both the strategic and operational issues with an appropriate balance between the two									
2	*2024 responses*	**0**	**0**	**0**	**3**	**4**	**0**	**32/35**	**91%**
	2023 responses	**0**	**1**	**0**	**3**	**2**	**0**	**24/30**	**80%**
			↑		↔	↑			

There was a slight improvement on this question from the previous year

Comments

The People Committee critically challenges and reviews both the strategic and operational issues with an appropriate balance between the two

- at times, goes too much into the detail and becomes far too operational
- Sometimes a little operational
- Given the challenges facing the Trust, inevitably a lot of focus tends to be on the operational issues of finance (agency costs, vacancy levels etc), recruitment and day to day issues. The Committee has been through a period of change with an interim chair and in the last 12 months a new chair. The meetings have also changed from monthly to every 2 months. Now that the Trust has agreed a 5 year Strategy and the People Committee has signed off the People Plan there is now the opportunity to increase the focus on the strategic issues.
- N/A
- yes
- Good balance and managers able to articulate their areas well.
- agree

Question 3. At meetings there is a good balance between, HR matters, operational challenges, finance, governance and risk management

	Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
3	*2024 responses*	**0**	**0**	**0**	**4**	**3**	**0**	**31/35**	**89%**
	2023 responses	**0**	**0**	**0**	**4**	**2**	**0**	**26/30**	**87%**
					⇔	⇧			

There was a slight improvement on this question from the previous year.

Comments

At meetings there is a good balance between, HR matters, operational challenges, finance, governance and risk management

- unsure

- Feel this is an area needing more work as we continue our journey.
- Can be slightly operational
- Looking at the Agenda over the course of the year there is a good mix of items covering the areas listed. It would be good to look to have more focus on the HR matters (WRES,WDES, partnership links , staff development, talent management, Our Voice)
- N/A
- yes
- good balance

Questions 4. The Chair ensures that all committee members have the opportunity to participate in the debate

	Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
4	*2024 responses*	0	0	0	1	6	0	34/35	97%
	2023 responses	**0**	**0**	**0**	**1**	**4**	**1**	**24/25**	**96%**
					⇔	⇑	⇑		

There was an improvement on this question from the previous year.

Comments

The Chair ensures that all committee members have the opportunity to participate in the debate

- N/A
- Chair opens meeting up for questioning
- good level of debate

Question 5. The secretariat circulates meeting documents in good time before each meeting

	Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
5	*2024 responses*	**0**	**0**	**0**	**1**	**6**	**0**	**34/35**	**97%**

	2023 responses	**0**	**0**	**0**	**2**	**4**	**0**	**28/30**	**93%**
					↑	↑			

There was an improvement on this question from previous years

Comments

The secretariat circulates meeting documents in good time before each meeting

- Sometimes due to time pressures and work pressures for the executive and the HR team , papers do come out late. The pressures are recognised and do not detract from the discussions. In some cases they are supported by presentations.
- N/A
- Good, timely papers.
- works well

Question 5. Overall, People Committee is a useful forum for Trust Leaders - please provide your reflections on People Committee

	Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
6	*2024 responses*	**0**	**0**	**0**	**2**	**5**	**0**	**33/35**	**94%**
	2023 responses	**0**	**0**	**0**	**4**	**2**	**0**	**26/30**	**87%**
					↑	↑			

There was an improvement on this first question from the previous year.

Comments

Overall, People Committee is a useful forum for Trust Leaders - please provide your reflections on People Committee

- People committee has had lots of chairs and so await current chair 'settling in'
- Very good meeting- sometimes too many items
- N/A
- yes

- Helpful to understand the large agenda re workforce in the Trust. Great to see the leadership and cultural development.
- definitely
- The bulk of the papers are written and presented by members of the HR and supporting teams. I strongly support this as it helps the Team Leaders in their development but also gives them and the Committee a much better feel and understanding of the issues rather than being sanitised

Question 7. Overall I think the People Committee works well

Effectiveness Review Nov 2024		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
7	*2024 responses*	**0**	**0**	**0**	**3**	**4**	**0**	**32/35**	**91%**
	2023 responses	**0**	**1**	**0**	**3**	**2**	**0**	**24/30**	**80%**
			⇧		⇔	⇧			

There was an improvement on this first question from previous years

7. **Comments**

Overall I think the People Committee works well

- as above
- Very good - could be slightly more strategic
- Given the amount of change that has taken place and as new arrangements bed in I have scored this as ‘agree’ . Over the next 12 months I expect this to move to Strongly Agree .
- N/A
- yes
- Happy with the committee, content, structure all work well.
- it does

Question 8. Please use the comments box to suggest would could be better about People Committee

Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age

8	*2024 responses*	0	0	0	2	2	3	18/20	90%
	2023 responses	**0**	**0**	**0**	**1**	**1**	**4**	**9/10**	**90%**
					↑	↑	↓		

There was a slight deterioration on the Strongly Agree on this first question from the previous year.

Comments

Please use the comments box to suggest would could be better about People Committee

- more focussed effort on not allowing presenters to read through the report - reports should be read in advance...and presenters provide couple key points only....to then allow debate
- Fewer items
- yes
- keep as is
- N/A
- More work on refining content of papers and assimilation to corporate objectives
- As we have moved to meeting every 2 months I think the length of the meetings needs to increase to give the level of focus to what is a huge agenda in terms of HR/People. I also think all the meetings should be in person as it enhances the debate and discussion. As indicated earlier Now that we have the two key strategies in place more focus on the strategic issue would be helpful.

Question 9. I would like People Committee to continue - please use the comments box to explain what you would like People Committee to be in the future

Effectiveness Review Nov 2024		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
9	*2024 responses*	**0**	**0**	**0**	**0**	**6**	**1**	**30/30**	**100%**
	2023 responses	**0**	**0**	**0**	**1**	**4**	**1**	**24/25**	**96%**
					↓	↑	⟷		

There was an improvement on this first question from previous years

Comments

I would like People Committee to continue - please use the comments box to explain what you would like People Committee to be in the future

- N/A
- it is essential
- yes
- Build on last 12 months developments and continue to refine.
- Strategic overview and join up
- agree
- More strategic focus.

Question 10. The correct level of detail is provided in relation to the information presented at the People Committee

Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
10 *2024 responses*	**0**	**0**	**1**	**2**	**4**	**0**	**31/35**	**89%**
2023 responses	0	1	0	2	3	0	25/30	83%
		↑	↓	↔	↑			

The responses to this question will need to be addressed during the meeting

Comments

The correct level of detail is provided in relation to the information presented at the People Committee

- sometimes, too much operational detail delved into and reports 'read to' too much
- About right, more prep work with managers to not repeat all the content of papers, though this is getting better.
- Too many reports sometimes
- N/A
- yes
- it is

Some of the detail, for example in the Resource papers , has been trimmed back as the Committee has developed its understanding of all the metrics. We do tend to gloss over the Divisional People Committee Reports due to time pressures.

Question 11. Are there any gaps in the information being provided at People Committee

Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
11 *2024 responses*	**1**	**1**	**1**	**2**	**1**	**1**	**19/30**	**63%**
2023 responses	**0**	**0**	**1**	**2**	**2**	**1**	**21/25**	**84%**
								

There is a need for the Committee to discuss the responses to this question further noting a comment regarding increasing more focus on EDI matters.

Comments

Are there any gaps in the information being provided at People Committee

As the governance processes in the Trust are being reviewed and refined the quality of papers are providing the committee with the required detail.

no gaps

seems about right

no

Given recent discussions, probably more focus on the Equality, Diversity and Inclusion matters is required.

No

N/A

Question 12. Are there any other comments you wish to add regarding the People Committee

Effectiveness Review Nov 2024	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
12 *2024 responses*	**0**	**0**	**1**	**1**	**1**	**4**	**12/15**	**80%**

2023 responses	**0**	**0**	**0**	**0**	**2**	**4**	**10/10**	**100%**

The responses to this question will need to be addressed during the meeting.

Comments

Are there any other comments you wish to add regarding the People Committee

- I do feel that given the changes that have affected the Trust and the People Committee did have an impact but the resilience of all those that attend the Committee is to be commended and I would like to thank the HR team and others for the quality of papers and their contributions to the discussions. I have seen those individuals grow in confidence over the last 12/18 months.
- no
- Very good overall - reflect on many a few less update papers
- N/A
- no
- Nothing further to add.
- none

Breakdown of report by category

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

Table 2 2024

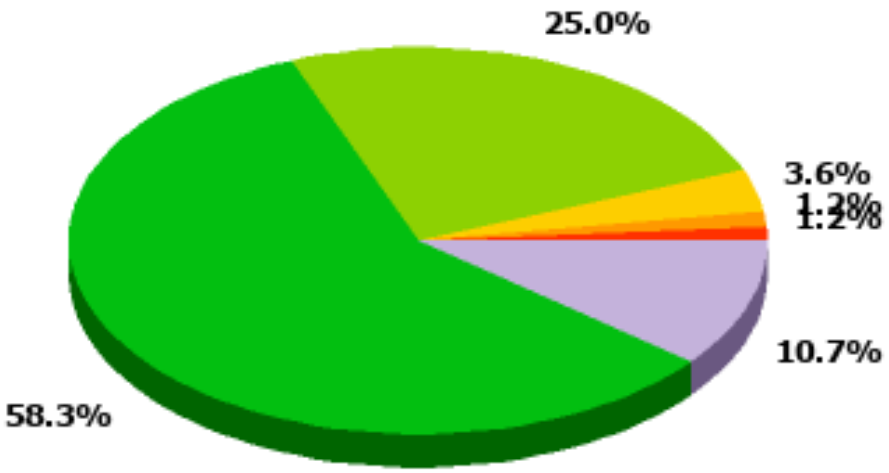
People Committee Committee Effectiveness Review November 2024							**Score**	**%age**
The Role and Scope of the Committee	0	0	0	7	14	0	98/105	93%
Comments	1	1	3	14	35	9	243/270	90%

Table 2 2023

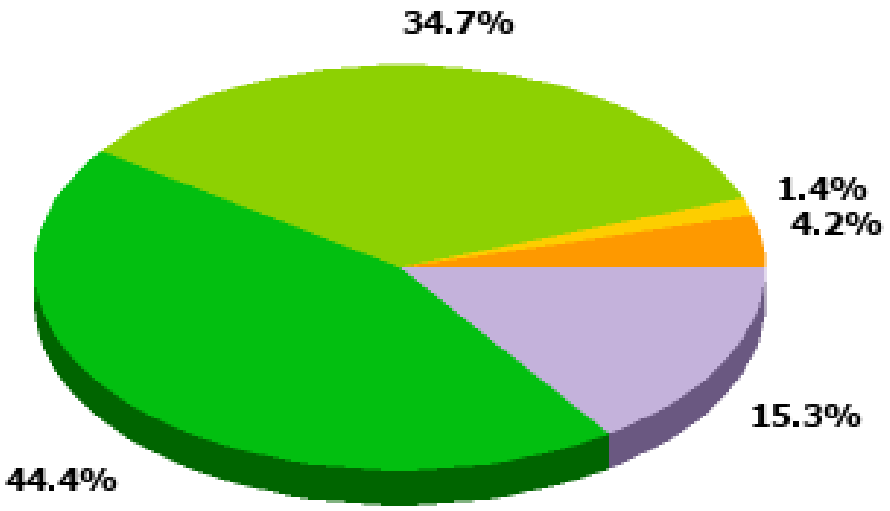
People Committee Committee Effectiveness Review October 2023							Score	%age
The Role and Scope of the Committee	0	1	0	9	8	0	78/90	87%
Comments	0	2	1	16	24	11	191/215	89%

Display 1

People Committee Committee Effectiveness Review November 2024

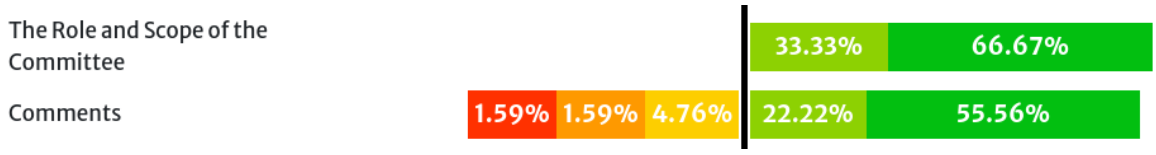


People Committee Committee Effectiveness Review October 2023

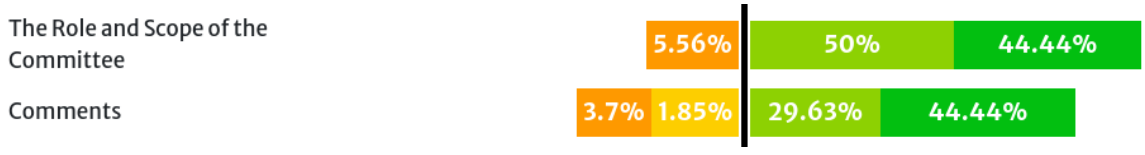


Display 2

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



Responses from 2023 survey below



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

Key and Scoring

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

Finance and Investment Committee Effectiveness Review November 2024

Number of respondents: 6

Number of statements: 15

Table 1

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
Finance and Investment Committee Effectiveness Review November 2024	1 [1.1%]	0 [0%]	1 [1.1%]	15 [16.7%]	65 [72.2%]	8 [8.9%]	389/410	95%

							Score	%age
Finance and Investment Committee Effectiveness Review October 2023	0 [0%]	0 [0%]	4 [6.7%]	14 [23.3%]	39 [65%]	3 [5%]	263/285	92%

Breakdown of report by individual statement

The Role and Scope of the Committee

Question 1: The Finance and Investment Committee understands the Trust's operating environment and the associated risks

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	0	6	0	30/30	100%	None
Nov 2023 responses	0	0	0	1	3	0	19/20	95%	

There was an overall improvement on this question.

Question 2: The Finance and Investment Committee meets its purpose as set out in its Terms of Reference:

- Provides assurance to the Board
- Approves and made any decisions as set out in the Financial Scheme of Delegation,
- Reviews and monitors financial plans and performance of the Trust and iFM as a subsidiary of the Trust,
- Reviews and approves the financial strategy
- Reviews and monitors the role of system working and partnerships on financial governance and performance.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	0	6	0	30/30	100%	None
2023 responses	0	0	0	1	3	0	19/20	95%	

There has been an improvement on this question

Question 3: There is effective triangulation at the committee with operational performance and quality.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	3	3	0	27/30	90%	*See below*
2023 responses	0	0	1	1	2	0	17/20	85%	

There has been an improvement in this question

Comments

- Decisions are taken and conclusions drawn looking at the whole situation, finance is not dealt with in isolation.
- I think more active triangulation with ops and quality would be beneficial including activity levels. Quality is always flagged as a key factor when evaluation finance and investment matters.
- There is effective triangulation, however, quality could feature more in the discussions at times. As expected, the discussion is heavily centred around finance and operational performance.

Question 4: At meetings there is a good balance between, quality, operational challenge, finance, governance and risk management.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	4	2	0	26/30	87%
Nov 2023 responses	0	0	0	2	2	0	18/20	90%
				⇧	⇔			

There has been a slight increase in responses to this question.

Comments

- Yes, there is good balance.
- Being the finance committee, main focus is financial – correctly.
- Strong triangulation that continues to evolve and improve.
- There could be greater discussion about quality.

Question 5: The Finance and Investment Committee has sufficient membership, authority and resources to perform its role effectively and independently.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	1	5	0	29/30	97%	None
Nov 2023 responses	0	0	1	2	1	0	16/20	80%	
				⇧	⇧				

There has been an improvement in this question.

Question 6: The Chair ensures that all committee members have the opportunity to participate in the debate.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	1	5	0	29/30	97%	Recent change of chair, but so far this is ok.
Nov 2023 responses	0	0	0	1	3	0	19/20	95%	

There has been an improvement in this question

Question 7: The secretariat circulates meeting documents in good time before each meeting.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	1	5	0	29/30	97%	None
Nov 2023 responses	0	0	0	0	4	0	20/20	100%	

There has been a slight deterioration overall on % score due to the increase in number of respondents

Question 8: The Finance and Investment Committee meets sufficiently frequently to deal with planned matters and enough time is allowed for questions and discussions.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	0	1	5	0	29/30	97%	None
Nov 2023 responses	0	0	0	0	4	0	20/20	100%	

There has been a slight deterioration overall on % score due to the increase in number of respondents

Question 9: The Finance and Investment Committee considers how it integrates with other committees and with wider performance management.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age	Comments
2024 responses	0	0	1	1	4	0	27/30	90%	None

Nov 2023 responses	0	0	0	1	3	0	19/20	95%	
			↑	↔	↑				

There has been a slight deterioration overall on % score due to the increase in number of respondents

Question 10: Overall, the Finance and Investment Committee is a useful forum for Trust leaders – please provide your reflections on Finance and Investment Committee.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
2024 responses	0	0	0	0	6	0	30/30	100%
2023 responses	0	0	0	0	4	0	20/20	100%
					↑			

This question has stayed the same.

Comments

- Very effective meeting.
- The committee has a lot of business going through it - e.g. capital business cases. Good forum for discussion and ensuring the detail is done outside board.
- There is a continuous drive for improved triangulation and transparency which is proving very beneficial e.g. workforce and CIPs reporting and discussion. The Committee culture fosters discussion and diversity of opinion.
- There is an opportunity for challenge and support through the committee.

Question 11: Overall, I think the Finance and Investment Committee works well.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	**Score**	**%age**
2024 responses	0	0	0	0	6	0	30/30	100%
2023 responses	0	0	0	0	4	0	20/20	100%
					↑			

This question has stayed the same

Comments

- Very effective.
- The Committee culture fosters discussion and diversity of opinion.
- The committee has a good blend of membership and has lots of relevant and appropriate discussion.

Question 12: Please use the comments box to suggest what could be better about the F&I Committee.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	2	4	10/10	100%
Nov 2023 responses	0	0	1	1	1	1	12/15	80%

There has been a slight improvement on this question overall although the committee may wish to discuss the comments in detail.

Comments

- Perhaps occasionally fewer papers.
- Keep the focus on strategic matters and assurance and not diving into too much detail.
- We don't spend enough time on major investments and tracking benefits and productivity.
- I'm not aware of anything to improve the committee.

Question 13: I would like the Finance and Investment Committee to continue – please use the comments box to explain what you would like Finance and Investment Committee to be in the future.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	1	5	0	29/30	97%
Nov 2023 responses	0	0	0	0	4	0	20/20	100%

There has been a slight improvement on this question.

Comments

- With the change of remit there will need to be a relevant amount of time allocated to discuss digital issues.
- Ok as it is now, wouldn't want to dilute with other agendas/portfolios - this would make it unmanageable.
- I'd like more emphasis to include major investments and evaluation benefits and productivity.

Question 14: The right level of detail is provided in relation to the information provided at the Finance and Investment Committee.

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	2	4	0	28/30	93%
2023 responses	0	0	0	3	1	0	17/20	85%

There is a continued improvement on this question overall as evidenced by improvement on the Strongly Agree.

Comments

- In the main this is ok, though some members like more detail than others.
- There is good information provided.
- Good reporting with strong summarising skills including presentations to foster more time for discussion which works well.

Question 15: Are there any gaps in the information being provided to the Finance and Investment Committee.

	Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
	2024 responses	0	0	0	1	5	0	29/30	97%
	Nov 2023 responses	0	0	0	0	4	0	20/20	100%
					⇧	⇧			

There has been a slight improvement on this question.

Comments

- With the change of remit there will need to be a relevant amount of time allocated to discuss digital issues.
- Ok as it is now, wouldn't want to dilute with other agendas/portfolios - this would make it unmanageable.
- I'd like more emphasis to include major investments and evaluation benefits and productivity.

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

Key and Scoring

Strategy and Operations Committee Effectiveness Review November 2024

Number of respondents: 7

Number of statements: 8

Table 1

							Score	%age
Strategy and Operations Committee Effectiveness Review November 2024	0 [0%]	0 [0%]	5 [8.9%]	15 [26.8%]	34 [60.7%]	2 [3.6%]	245/270	91%

Breakdown of report by individual statement

The Role and Scope of the Committee

Question 1: The Committee understands the Trust's operating environment and the associated risks

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	1	6	0	34/35	97%
Nov 2023 responses	0	0	0	1	4	0	24/25	96%
March 2023 responses	0	0	1	0	5	0	28/30	93%
				⟷	⇧			

There was a slight improvement on this question.

Comments

- Yes - There is much discussion on emerging strategy. Risk is considered

Question 2: The Committee critically challenges and reviews both the strategy and operational issues with an appropriate balance between the two

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	1	2	4	0	31/35	89%
Nov 2023 responses	0	0	0	3	2	0	22/25	88%
March 2023 responses	0	0	1	1	4	0	27/30	90%
			⇩	⇩	⇧			

There was a very slight deterioration on this question from Mar 23 responses

Comments

- This is a conundrum that impacts the agenda. To some degree the agenda came about by looking at what areas where not covered in other Committees and came up with Strategy, Operational Performance and Digital. The focus can vary and probably there is a lot of focus of Performance which can get repeated at the Board.
- It is better now more focus on performance and digital
- Yes, but I think the strategy and operations aspects, can compete for time on the agenda. Operational issues have been quite prominent during the last year.
- I feel there is a good balance of support and challenge in the meeting.
- Robust and diverse yet supportive challenge across both strategy and operations in the context of aligning to the new 5 year strategy.

Question 3: At meetings there is a good balance between, strategy, operational challenges, governance, and risk management

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	1	4	2	0	29/35	83%
Nov 2023 responses	0	0	0	3	2	0	22/25	88%
March 2023 responses	0	0	1	4	1	0	24/30	80%
			↓	↑	↔			

There has been a slight decline in overall percentage for this question

Comments

- I think with the development of the Trust 5-year Strategy that this has enabled the Committee to spend more time on Strategic matters. However, the operational matters inevitably take over but there are the signs that this is changing. We do need to ensure that appropriate focus is given the Digital agenda.
- I feel that committee members are well sighted on the risks and issues as well as successes of both digital and operational performance.
- Better now more focussed
- Think we could spend more time on risk appetite and what opportunities there are for transformation and our risk appetite to pursue them.

Question 4: The Chair ensures that all committee members have the opportunity to participate in the debate

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	0	7	0	35/35	100%
Nov 2023 responses	0	0	0	1	4	0	24/25	96%
March 2023 responses	0	0	1	1	4	0	27/30	90%
								

There has been an overall improvement in responses received for this question

Comments

- Always well chaired.

Question 5: The secretariat circulates meeting documents in good time before each meeting

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	2	5	0	33/35	94%
Nov 2023 responses	0	0	1	3	1	0	20/25	80%
March 2023 responses	0	1	1	2	2	0	23/20	77%
								

There has been continuous improvement in this question

Comments

- As with a number of the committees some papers do come out late but the pressures on time and staff are understood and this does not detract from the discussions. The discussions are supported by presentations.
- Always well managed.

Question 6: Overall, Strategy and Operations Committee is a useful forum for Trust Leaders - please provide your reflections on Strategy and Operations Committee

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	1	3	3	0	30/35	86%
Nov 2023 responses	0	0	1	2	2	0	21/25	84%
March 2023 responses	0	0	1	0	5	0	28/30	93%
			⟷	↑	↑			

Although the score is much improved from Nov 23 responses, there has been a deterioration from the March 23 responses to this question

Comments

- Not sure if the strategy and operational balance is right. Much focus currently on real challenges with operational targets.
- I think this has been a successful committee, however, fully appreciate we are stepping the committee down.
- Much better now a clearer focus on performance and digital
- It works well in what it does. The issue is sorting out what it does. The commitment of the individuals who attend is excellent.
- The Committee has a broad remit which it balances well.

Question 7: Overall, I think the Strategy and Operations Committee works well

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	0	2	5	0	33/35	94%
Nov 2023 responses	0	0	0	3	2	0	22/25	88%
March 2023 responses	0	0	1	1	4	0	27/30	90%
				↑	↑			

There has been a slight improvement in this question

Comments

- Good papers
- I agree in terms of what it does.
- I believe there has been some good debate at the committee, however, at times it may have received too much operational detail.
- Yes, papers are well developed and discussions are conducted well.
- Too much-needs to be more succinct.
- Very much support detailed papers being presented in summary to foster greater discussion/challenge. This works very well with strong engagement from all parties.

Question 8: Please use the comments box to suggest how the Strategy and Operations Committee could improve

Committee Effectiveness Review	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)	Score	%age
2024 responses	0	0	2	1	2	2	20/25	80%
Nov 2023 responses	0	0	2	0	1	2	11/15	73%
March 2023 responses	0	0	1	1	0	4	7/10	70%
			⟷	⇧	⇧	⟷		

This question has continued to improve overall

Comments

- This is challenging as SOC is being disbanded.
- I am concerned that finding home for digital and operations that provides the same kind of supportive challenge isn't yet finalised as this committee has proved a valuable forum for its remit.
- Rethinking the balance between strategic and operational issues. To look at how this committee fits into the wider committee structure.
- Good as now.
- The clear issue is to determine exactly what its remit is and whether that remit needs a separate committee or whether it can be done by the other committees taking a share.

Report Title:	2025 Board Arrangements and Workplan			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	28 November 2024		Discussion	
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	This report seeks to set out the arrangements for Board of Directors meetings during 2025 and present the Board Workplan for approval.

Previously considered by:	Reviewed annually as part of Board of Directors cycle of business.

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

Proposed Resolution	The Board of Directors are asked to ***approve*** the 2025 Board Arrangements and Workplan

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

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

1. Introduction

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

1.2. The Board of Director's Meetings are held on the last Thursday of each alternate month. It is proposed that this this schedule of bi-monthly meeting will continue during 2025/26.

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

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

1.5. In those months where a Board meeting is not scheduled, discrete sessions focussing on Strategy or Board development are usually held. For 2025, it is proposed that these sessions will be held as follows:

- 27 February Board Strategy Session
- 24 April Board Development Session
- 26 June Annual Service Review Day
- 07 August Board Development Session
- 23 October Board Strategy Session
- 18 December Board Strategy Session

2. Annual Workplan

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

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

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

- Declarations of Interest
- Patient Story and or a staff story
- Minutes of the previous meeting

- Actions and matters arising
- Integrated Performance Report
- Chair reports from the Board Committees

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

3. Board Development Programme and Strategy Sessions for 2025/26

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

4. Board Effectiveness

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

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

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

4.4. To support good governance across the Trust, a suite of templates necessary for the effective management of meetings, was updated in 2024 to reflect the new Trust Strategy and is now widely used across the organisation. This has ensured that there is standardisation of templates and consistency on how meetings are managed.

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

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

5. Conclusion

The Board is asked to **approve** the Board Arrangements for 2025 and approve the Annual Workplan.

Board of Director's Annual Workplan 2025

	Agenda Item/Report	Purpose		Mar	May	July	Sep	Nov	Jan
STANDING AGENDA ITEMS									
Chief Nurse	Patient Story	To Receive							
Director of People	Staff Story	To Receive							
All	Board Visits / Walkabouts	To Receive							
Chair	Chair's Report / Update	To Note							
CEO	Chief Executive's Report	To Note							
All Executives	Integrated Performance Report	To Receive	All Committees						
Committee Chairs	Committee Chairs' Reports	To Receive	All Committees						
PERFORMANCE, QUALITY AND SAFETY		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Chief Nurse	Quality Account Objectives	To Receive	QAC						
	Nursing and Midwifery Staffing Reports	To Approve	People Cttee						
	Health and Safety Annual Report	To Receive	QAC						
	2024/25 Quality Account	To Approve	QAC						
	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme	To Receive	QAC						
	In Patient Survey	To Receive	QAC						
	Complaints Annual Report	To Receive	QAC						
	Infection Prevention and Control Annual Report	To Receive	QAC						
	Safeguarding Annual Report	To Receive	QAC						
Medical Director	Quality Account Objectives	To Receive	QAC						
	Guardian of Safe Working Hours Annual Report	To Receive	People Committee						
	Learning from Deaths / Mortality Report	To Receive	QAC						
	Revalidation Report	To Approve	People Committee						
Chief Operating Officer	Operational Plan	To Receive	Strategy & Ops						
	Winter Plan	To Receive	Strategy & Ops			Draft			
	EPRR Core Standards Report	To Receive	Strategy & Ops						
DIGITAL		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Director of Strategy Digital and Transformation	Operational Plan	To Receive	Strategy & Ops						
	SIRO / IG Report	To Receive	Strategy & Ops						
	Strategy Review and Update	To Receive	Strategy & Ops						
	Digital Strategy	To Receive	Strategy & Ops						
	Charity Annual Report	To Receive	Strategy & Ops						
FINANCE		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Chief Finance Officer	Financial Plan	To Receive	F&I Committee						
	Annual Accounts	To Receive	F&I Committee						
	Review of Financial Position	To Receive	F&I Committee						
	Green Plan	To Receive	F&I Committee						
	Approval of High Value Contracts	To Receive	F&I Committee						
	Estates Plan	To Receive	F&I Committee						
	SFIs and SOD	To Approve	F&I Committee						
	iFM Report	To Receive	F&I Committee						
WORKFORCE		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Director of People	Staff Survey Report 22/23 Results	To Receive	People Committee						
	Staff engagement – Our Voice Change Programme	To Receive	People Committee						
	Freedom to Speak Up Annual Report	To Receive	People Committee						
	Staff health and wellbeing	To Receive	People Committee						
	Gender pay gap report	To Receive	People Committee						
	Workforce Race Equality Standard and Workforce Disability Equality Standard Reports	To Approve	People Committee						
	EDI Plan and Annual Report	To Receive	People Committee						
	Leadership Development Programme	To receive	People Committee						
GOVERNANCE AND RISK		**Purpose**	**Committee**	**Mar**	**May**	**July**	**Sep**	**Nov**	**Jan**
Director of Corporate Governance	Register of Interests	To Receive	Audit Committee						
	Fit and Proper person declarations	To Approve	Audit Committee						
	Board Assurance Framework	To Approve	**All Committees**						
	Annual Report	To Approve	Audit Committee						
	Annual Governance declarations	To Approve	Audit Committee						
	Board evaluation/Well Led review	To Receive	Audit Committee						
	Standing Orders	To Approve	Audit Committee						
	Modern Slavery statement	To Approve	Audit Committee						
	Board workplan	To Approve	Audit Committee						

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	

Purpose of the report	To present the Month 7 Integrated Peformance Report

Previously considered by:	The report was previously discussed at Integrated Performance Meetings (IPMs) and at November Committees.

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

Proposed Resolution	The Board is asked to **receive** the Integrated Performance Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	**Trust performance included within report, for any areas of concern narrative is provided.**
Legal/Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

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

Bolton NHS Foundation Trust

Integrated Performance Report

October 2024

Guide to Statistical Process Control

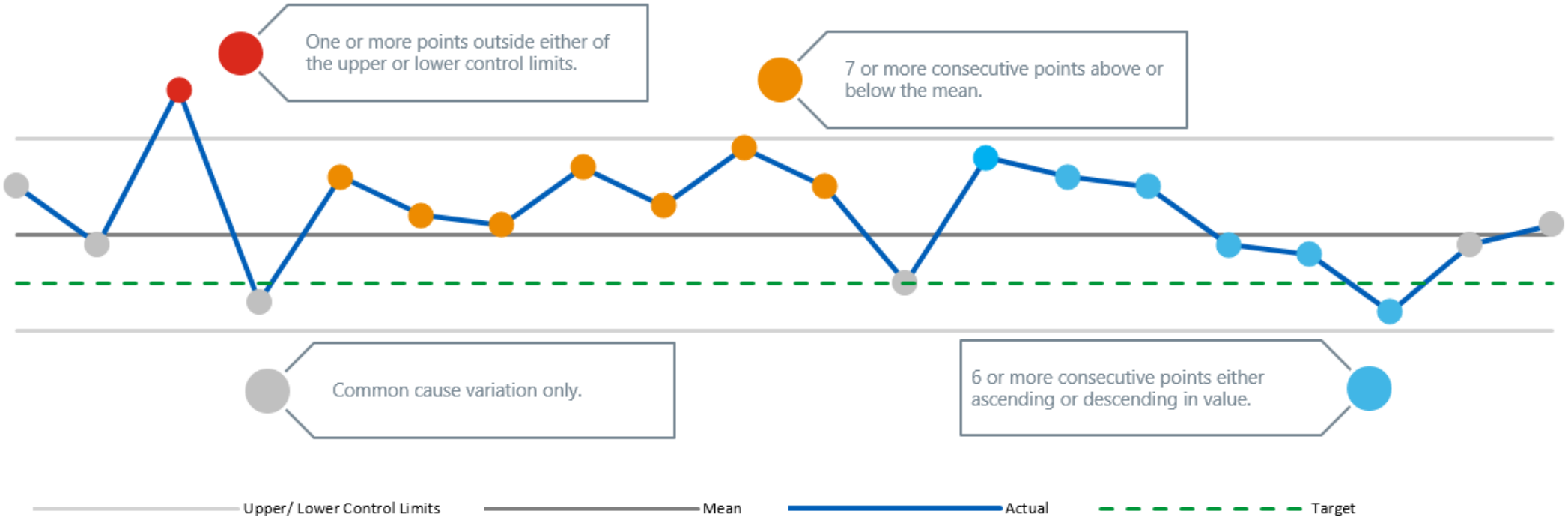
NHS Bolton NHS Foundation Trust

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

Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	10	2	4	2	0	1	3	11
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	6	0	1	0	1	0	0	3
Patient Experience	12	3	0	0	1	2	0	14
Maternity	8	0	1	0	0	1	0	8
Operational Performance								
Urgent Care	9	0	0	1	1	2	5	4
Elective Care	6	2	4	2	1	0	8	4
Cancer	1	0	0	0	0	0	0	1
Community Care	6	0	0	0	2	0	2	6
Workforce								
Sickness, Vacancy and Turnover	3	0	1	0	0	0	2	1
Organisational Development	2	2	0	0	2	1	2	3
Agency	1	0	2	0	0	0	1	2
Finance								
Finance	1	0	0	0	2	0	0	0
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

The Trust has demonstrated sustained improvement with only one hospital-acquired Category 3 pressure ulcer reported in the past 20 months (since December 2022), representing an 88% reduction. Community-acquired cases have decreased by 84%, and the organisation has maintained zero Category 4 pressure ulcers in hospital settings since May 2023.Current reporting shows five Category 3 cases in community services, all thoroughly reviewed with no concerns identified. The successful changes developed through the organisation's innovation work, particularly six key process improvements, provide a strong foundation for further Trust-wide reductions in pressure ulcers when adopted across all areas.
A total of 17 category 2 hospital-acquired pressure ulcers were reported. Through comprehensive investigations of each incident, some key themes and learning were evidenced, including the need for wider deployment of photography at the point of assessment, to ensure reliable categorisation of pressure ulcers, specifically moisture lesions.
The organisation's falls prevention performance shows strong results, with rates at their lowest since April 2019 and remaining below target for 18months. October recorded three falls with moderate harm, all reviewed through Trust processes.
To note: Pressure Ulcer data remains unvalidated for 60 days from date of reporting whilst patient safety incident response framework review underway

Patient Safety Alerts
The Trust position for Patient Safety Alerts at M7 is 50%. There were two alerts with deadlines in October, one was closed as compliant. One of the alerts has not met this deadline as it is not fully compliant.
The alert that the Trust is not fully compliant with is the Reducing risks for Transfusion associated circulatory overload (TACO) NATPSA/2024/004/MHRA.
An internal assessment and audit of the Trust blood transfusion policies and practices has been undertaken to provide a gap analysis to understand what actions are required to be fully compliant with this alert.
A report detailing the findings of the gap analysis has been tabled at the Hospital Transfusion Committee with an action plan in October followed by presentation of the report at Clinical Governance and Quality Committee for oversight and monitoring.
The divisions are responsible for completing the actions which will have ongoing oversight at the Hospital Transfusion Committee. Divisions are to provide updates on the AAA reports presented at Clinical Governance and Quality Committee.

	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%	95.2%	Oct-24		>= 95%	94.8%	Sep-24	>= 95%	96.2%	
9 - Never Events	= 0	0	Oct-24		= 0	0	Sep-24	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.05	Oct-24		<= 5.30	3.45	Sep-24	<= 5.30	3.94	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	3	Oct-24		<= 1.6	0	Sep-24	<= 11.2	6	

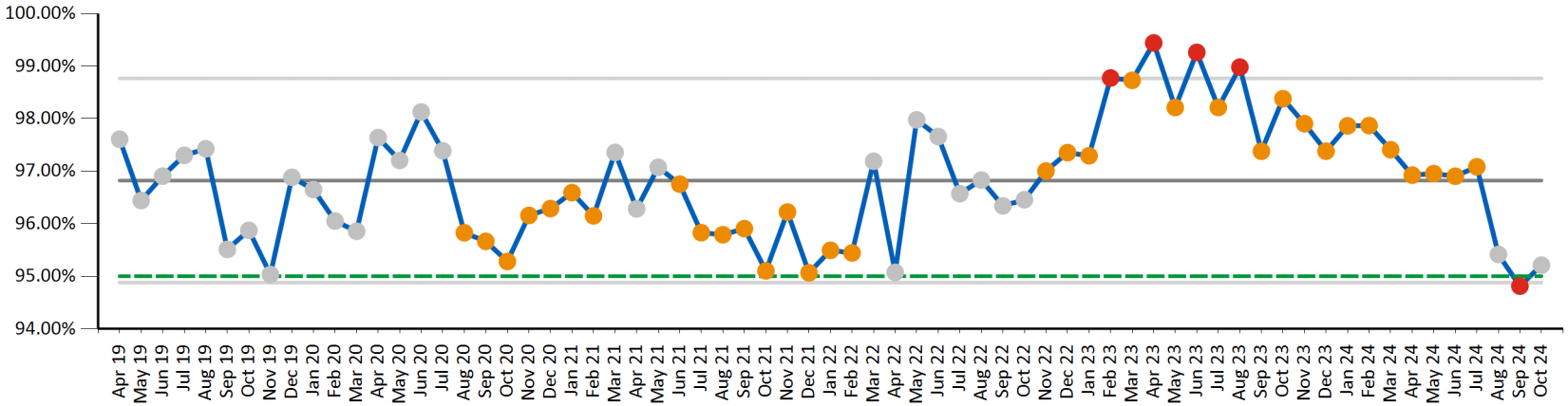
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	17.0	Oct-24		<= 6.0	20.0	Sep-24	<= 42.0	94.0	
620 - Acute Inpatients acquiring pressure damage (category 3 plus unstageables)	<= 1	0	Oct-24		<= 1	0	Sep-24	<= 4	18	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Oct-24		= 0.0	0.0	Sep-24	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	7.0	Oct-24		<= 7.0	7.0	Sep-24	<= 49.0	61.0	
621 - Community patients acquiring pressure damage (category 3 plus unstageables)	<= 4	5	Oct-24		<= 4	3	Sep-24	<= 28	49	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Oct-24		<= 1.0	0.0	Sep-24	<= 7.0	2.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Oct-24			0	Sep-24		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Oct-24			0	Sep-24		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Oct-24			0	Sep-24		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	82.4%	Oct-24		>= 95%	80.4%	Sep-24	>= 95%	80.1%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	61.0%	Oct-24		>= 95.0%	62.8%	Sep-24	>= 95.0%	68.3%	
86 - Patient Safety Alerts - Trust position	= 100%	50.0%	Oct-24		= 100%	100.0%	Sep-24	= 100%	92.9%	
88 - Nursing KPI Audits	>= 85%	95.1%	Oct-24		>= 85%	94.9%	Sep-24	>= 85%	95.0%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Oct-24		= 100%	100.0%	Sep-24	= 100%	44.4%	
8 - Same sex accommodation breaches	= 0	25	Oct-24		= 0	12	Sep-24	= 0	106	

6 - Compliance with preventative measure for VTE

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 95%	95.2%	Oct-24

Previous

Plan	Actual	Period
>= 95%	94.8%	Sep-24

Year to Date

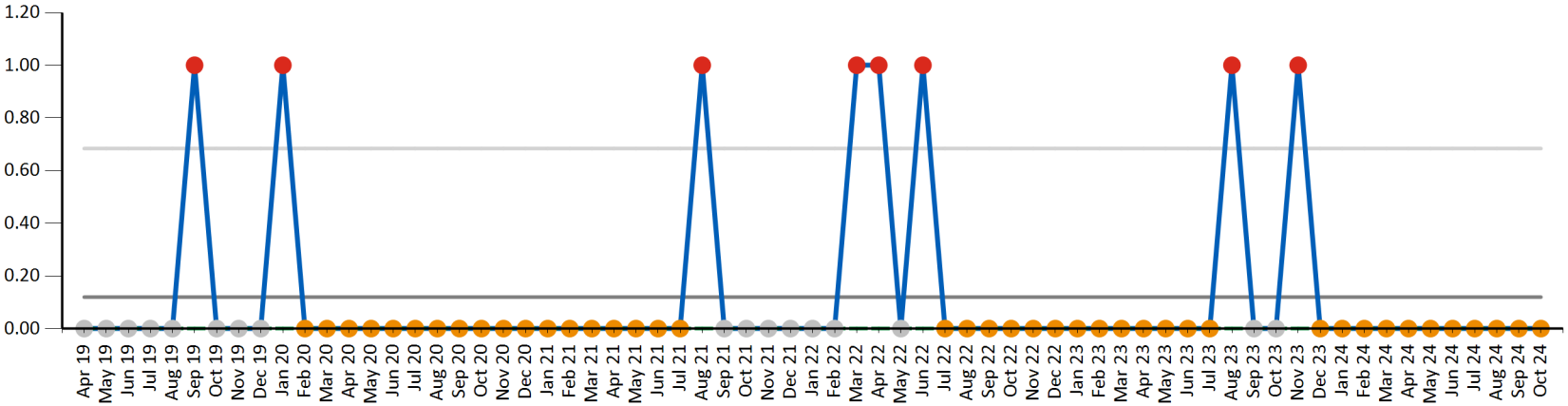
Plan	Actual
>= 95%	96.2%

9 - Never Events

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	Oct-24

Previous

Plan	Actual	Period
= 0	0	Sep-24

Year to Date

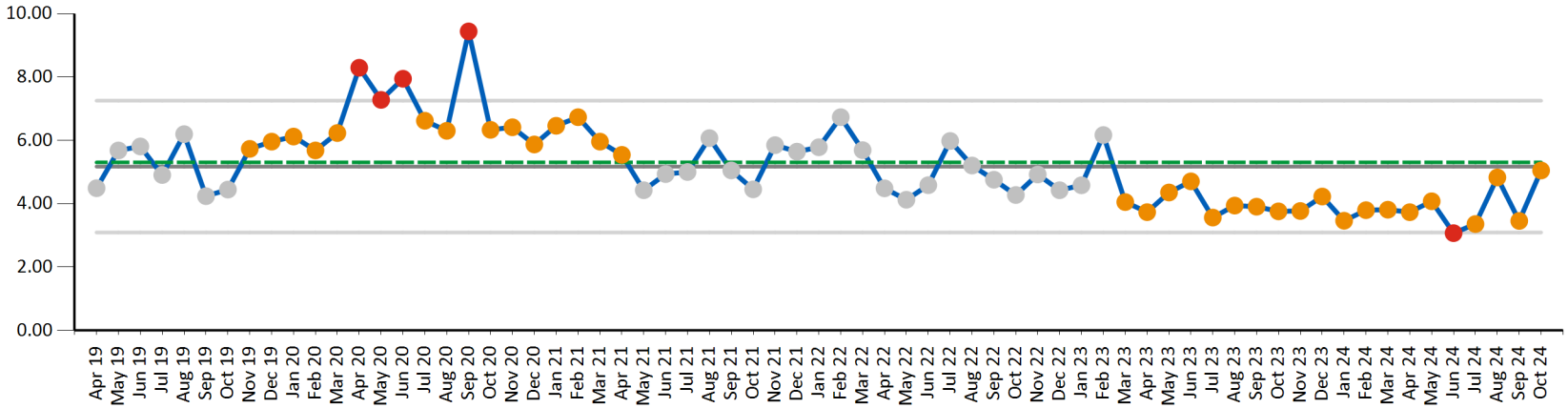
Plan	Actual
= 0	0

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	5.05	Oct-24

Previous

Plan	Actual	Period
<= 5.30	3.45	Sep-24

Year to Date

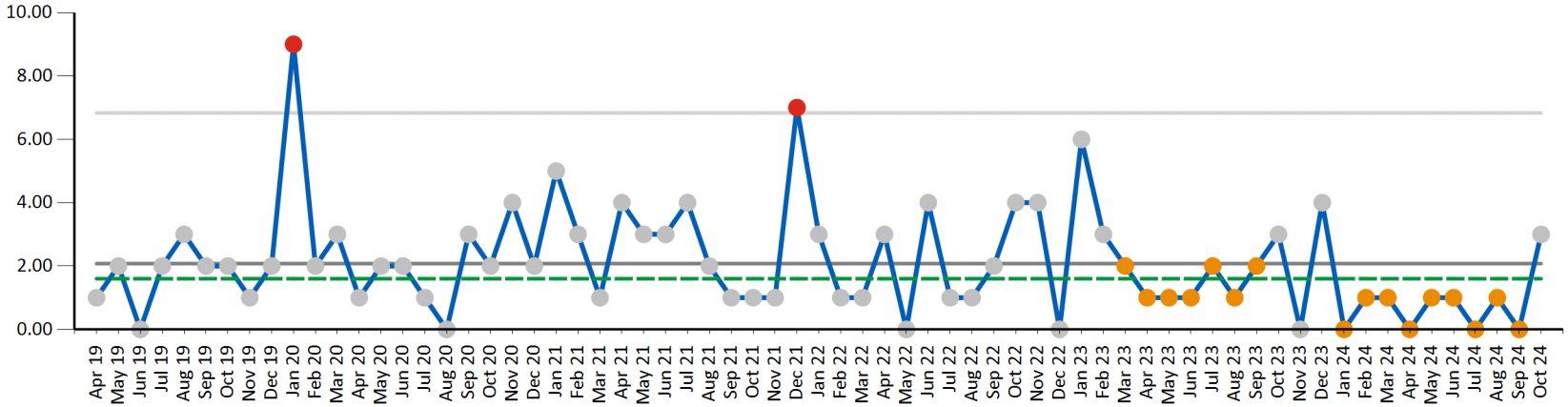
Plan	Actual
<= 5.30	3.94

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 1.6	3	Oct-24

Previous

Plan	Actual	Period
<= 1.6	0	Sep-24

Year to Date

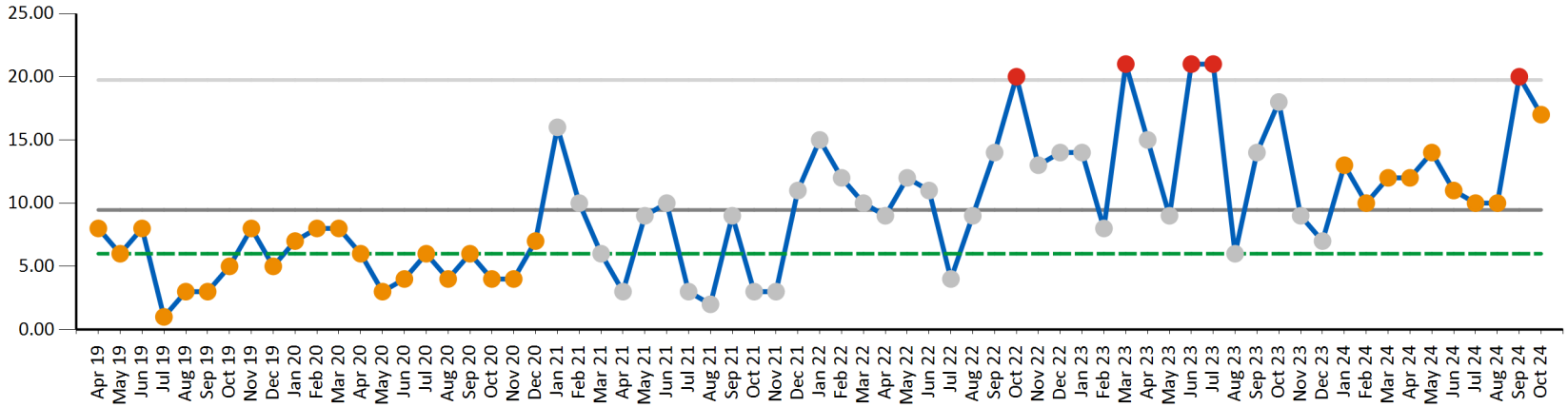
Plan	Actual
<= 11.2	6

15 - Acute Inpatients acquiring pressure damage (category 2)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 6.0	17.0	Oct-24

Previous

Plan	Actual	Period
<= 6.0	20.0	Sep-24

Year to Date

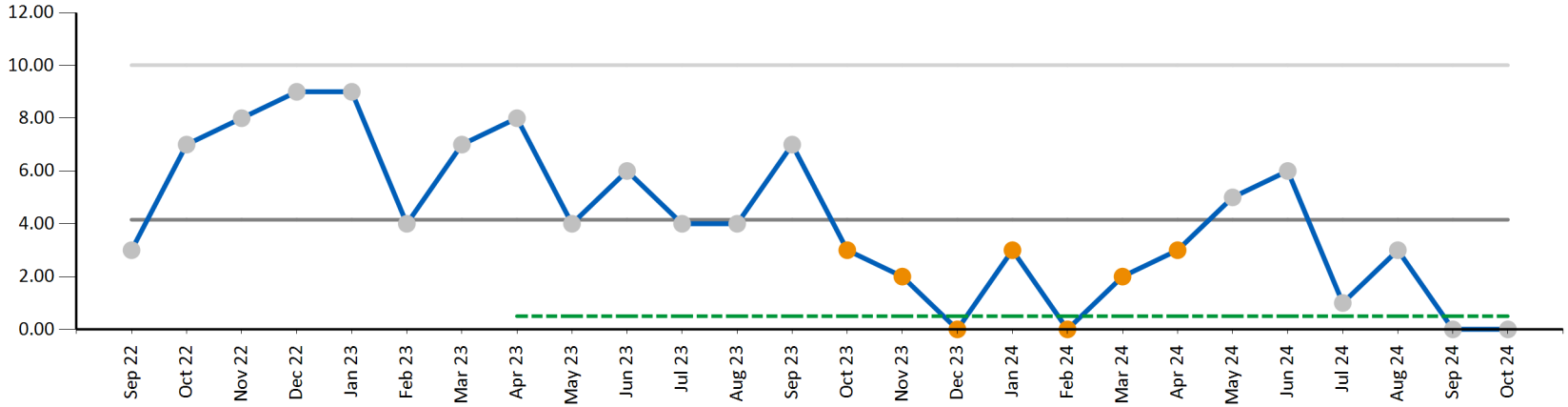
Plan	Actual
<= 42.0	94.0

620 - Acute Inpatients acquiring pressure damage (category 3 plus unstageables)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	0	Oct-24

Previous

Plan	Actual	Period
<= 1	0	Sep-24

Year to Date

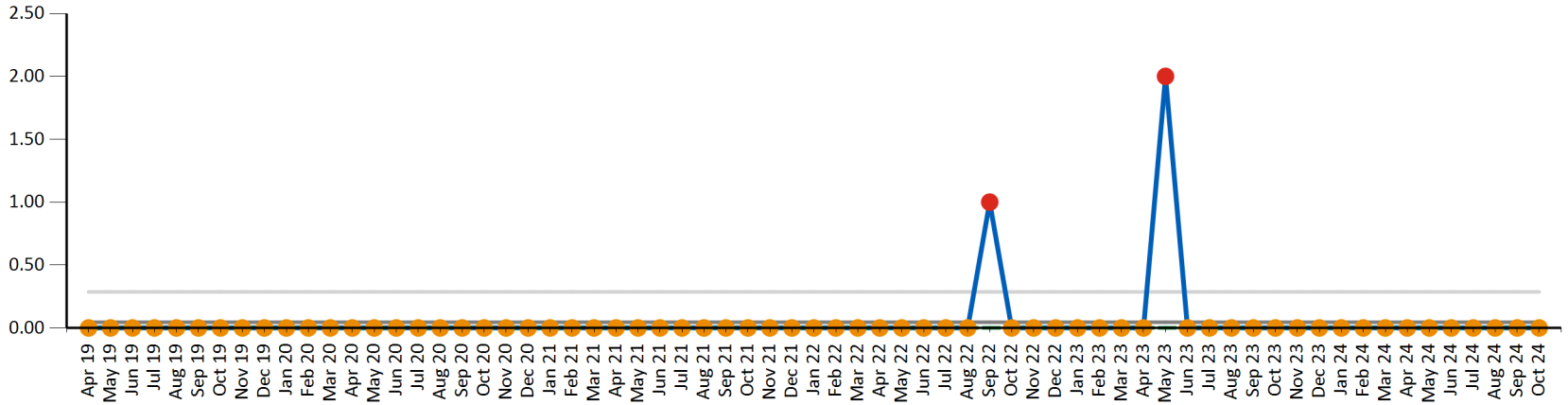
Plan	Actual
<= 4	18

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	Oct-24

Previous

Plan	Actual	Period
= 0.0	0.0	Sep-24

Year to Date

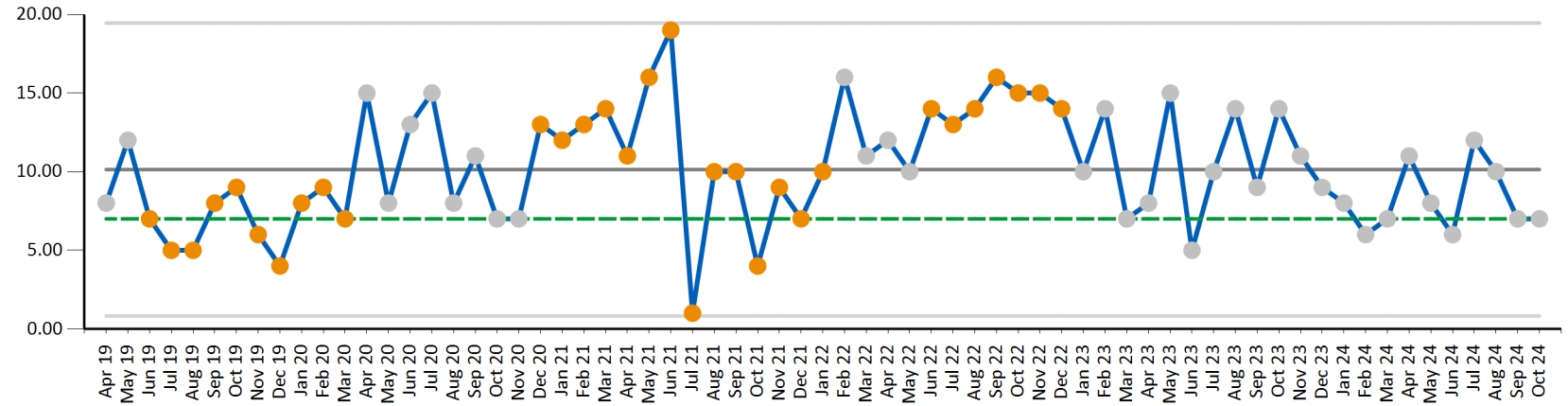
Plan	Actual
= 0.0	0.0

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 7.0	7.0	Oct-24

Previous

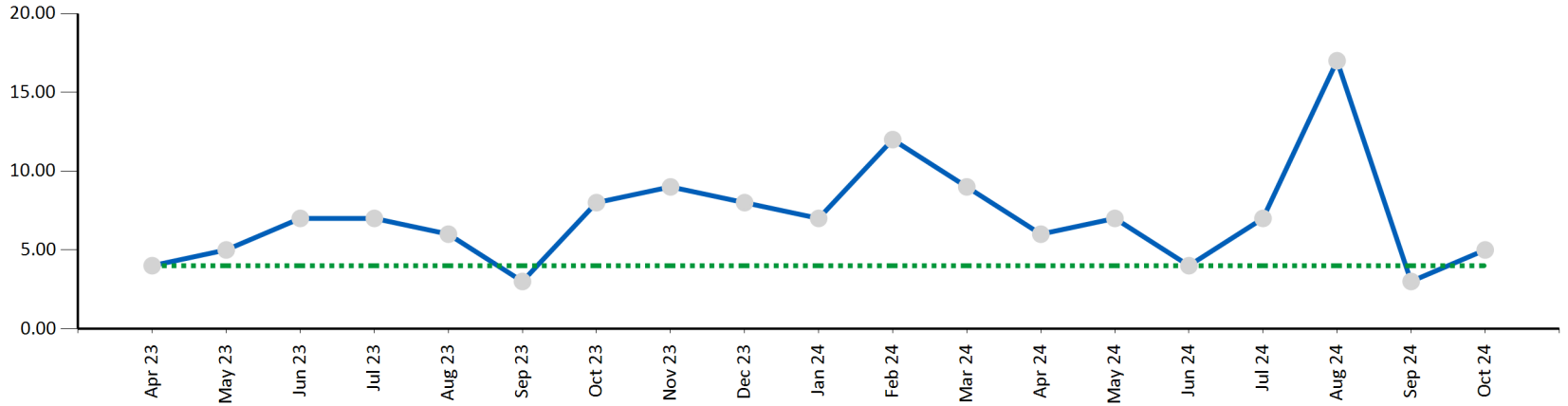
Plan	Actual	Period
<= 7.0	7.0	Sep-24

Year to Date

Plan	Actual
<= 49.0	61.0

621 - Community patients acquiring pressure damage (category 3 plus unstageables) - SPC data available after 20 data points

2/6



Latest

Plan	Actual	Period
<= 4	5	Oct-24

Previous

Plan	Actual	Period
<= 4	3	Sep-24

Year to Date

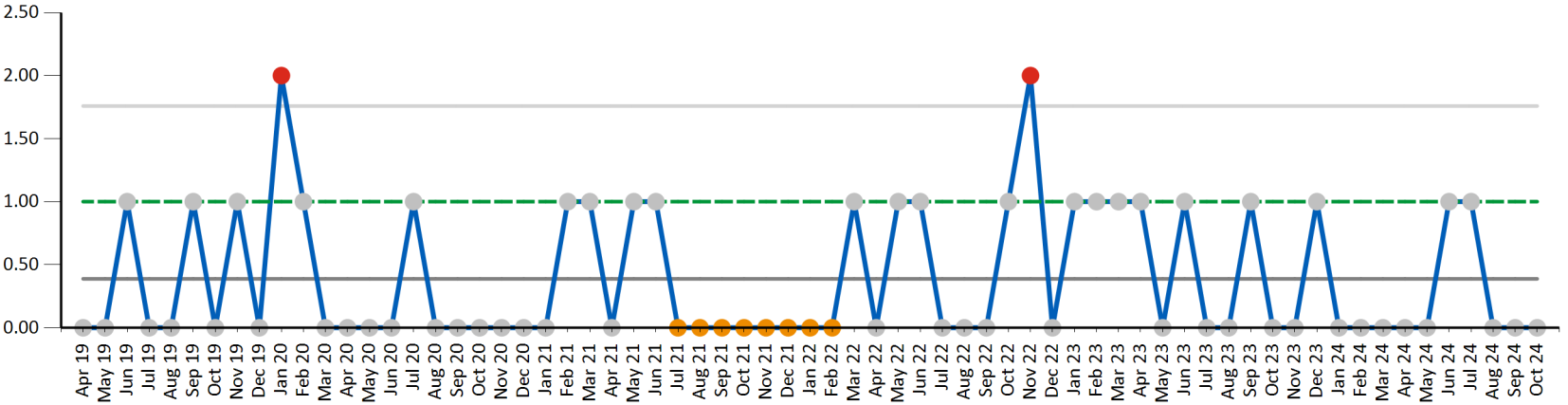
Plan	Actual
28	49

20 - Community patients acquiring pressure damage (category 4)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 1.0	0.0	Oct-24

Previous

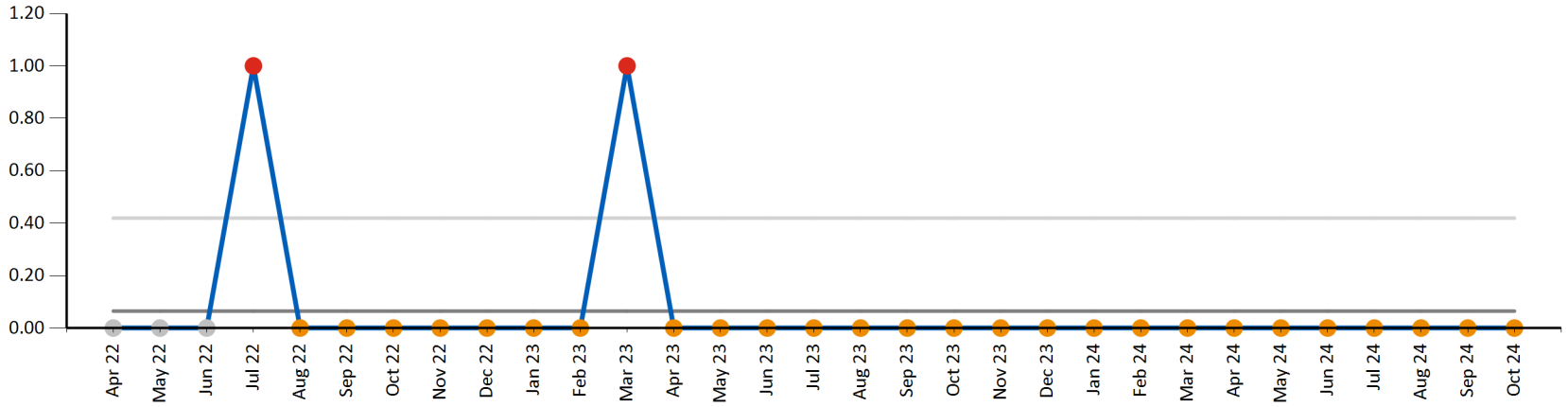
Plan	Actual	Period
<= 1.0	0.0	Sep-24

Year to Date

Plan	Actual
<= 7.0	2.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Oct-24

Previous

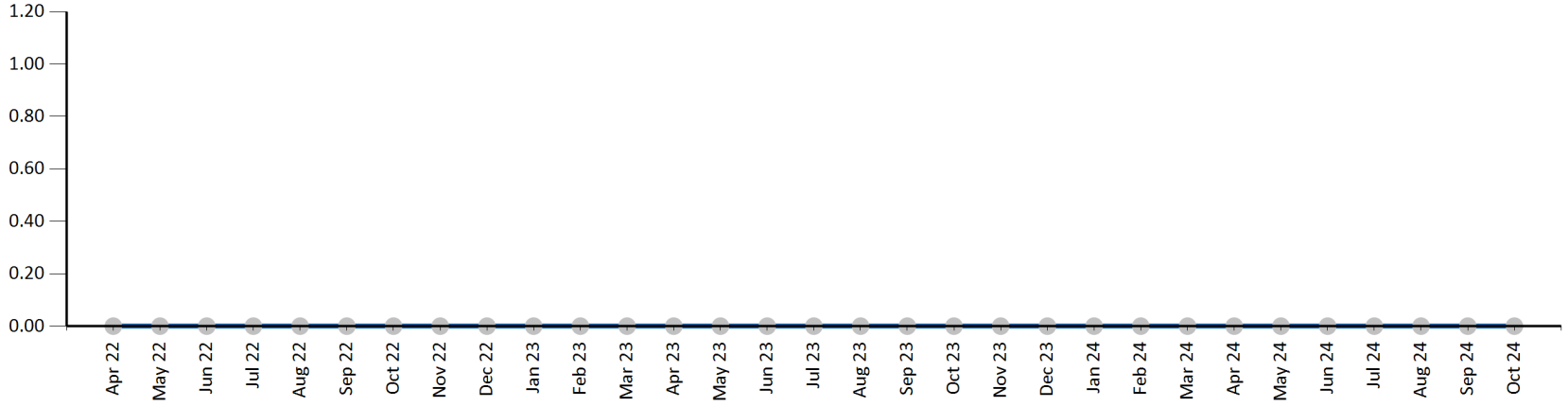
Plan	Actual	Period
	0	Sep-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Oct-24

Previous

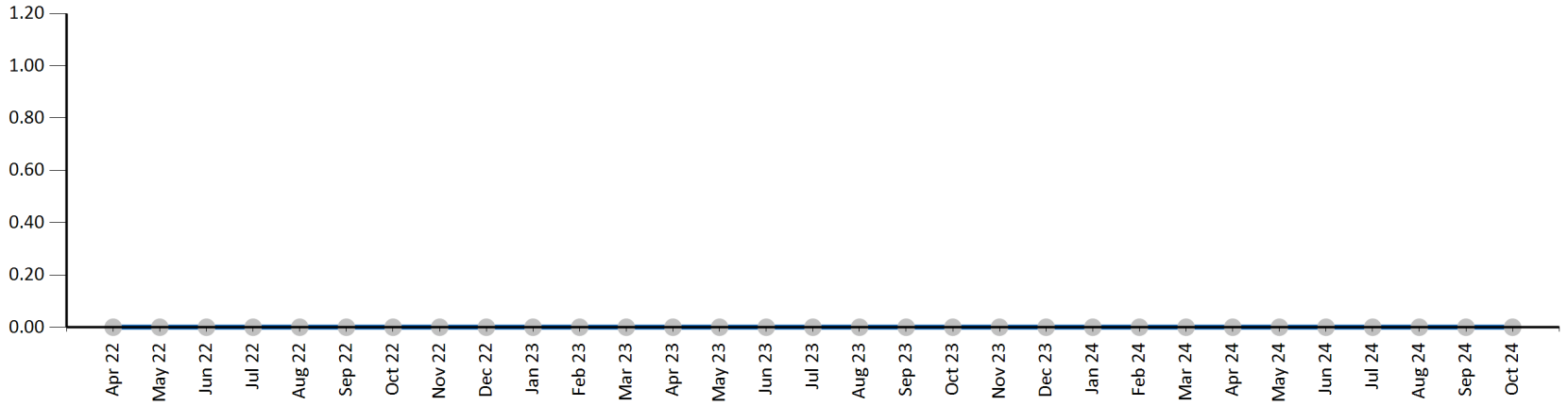
Plan	Actual	Period
	0	Sep-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Oct-24

Previous

Plan	Actual	Period
	0	Sep-24

Year to Date

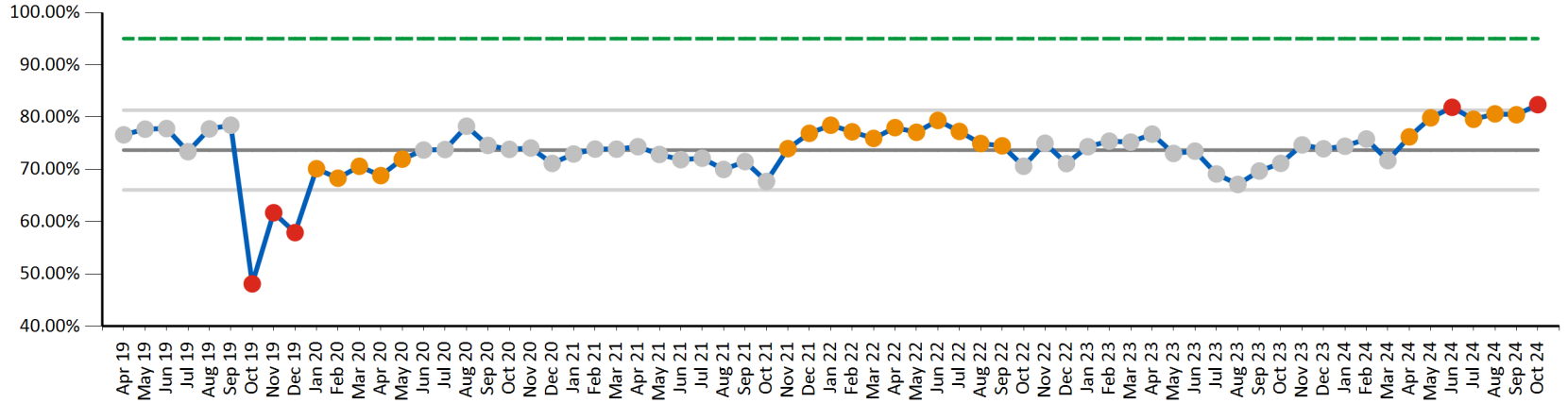
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	82.4%	Oct-24

Previous

Plan	Actual	Period
>= 95%	80.4%	Sep-24

Year to Date

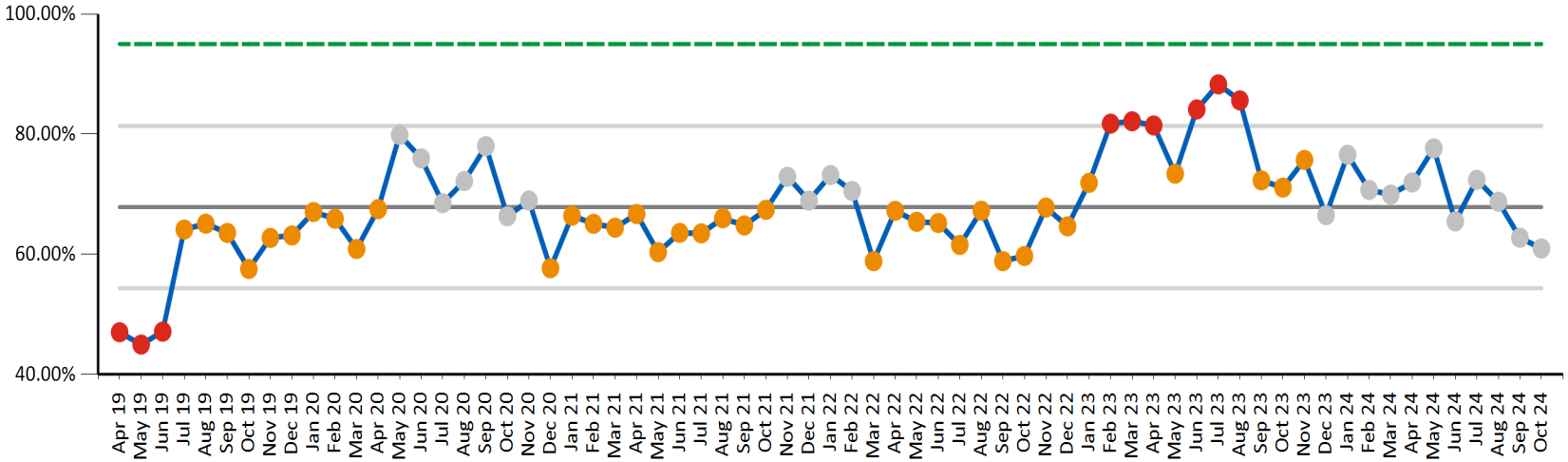
Plan	Actual
>= 95%	80.1%

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%	61.0%	Oct-24

Previous

Plan	Actual	Period
>= 95.0%	62.8%	Sep-24

Year to Date

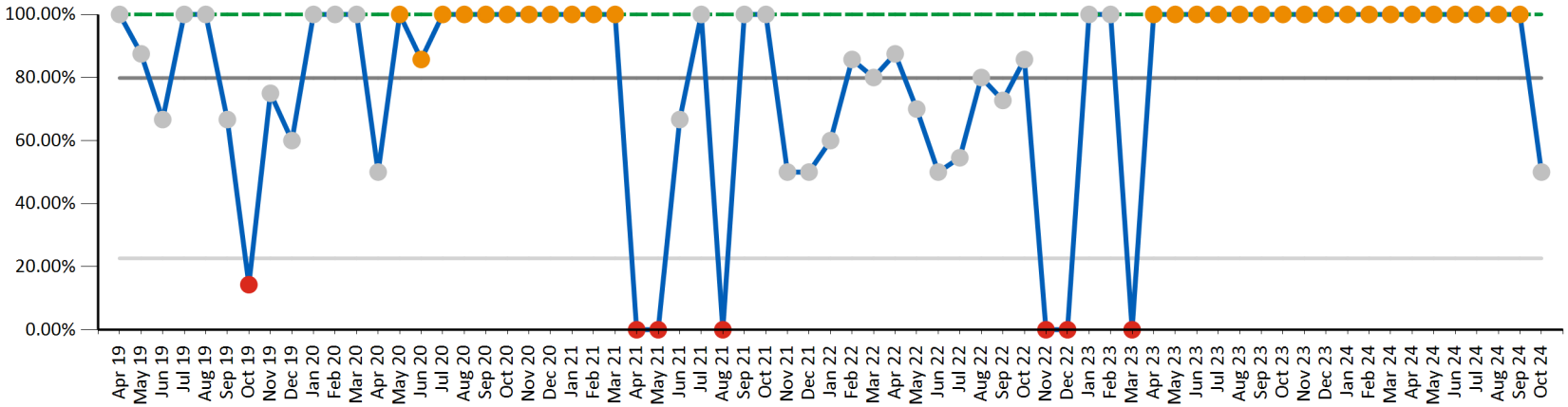
Plan	Actual
>= 95.0%	68.3%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	50.0%	Oct-24

Previous

Plan	Actual	Period
= 100%	100.0%	Sep-24

Year to Date

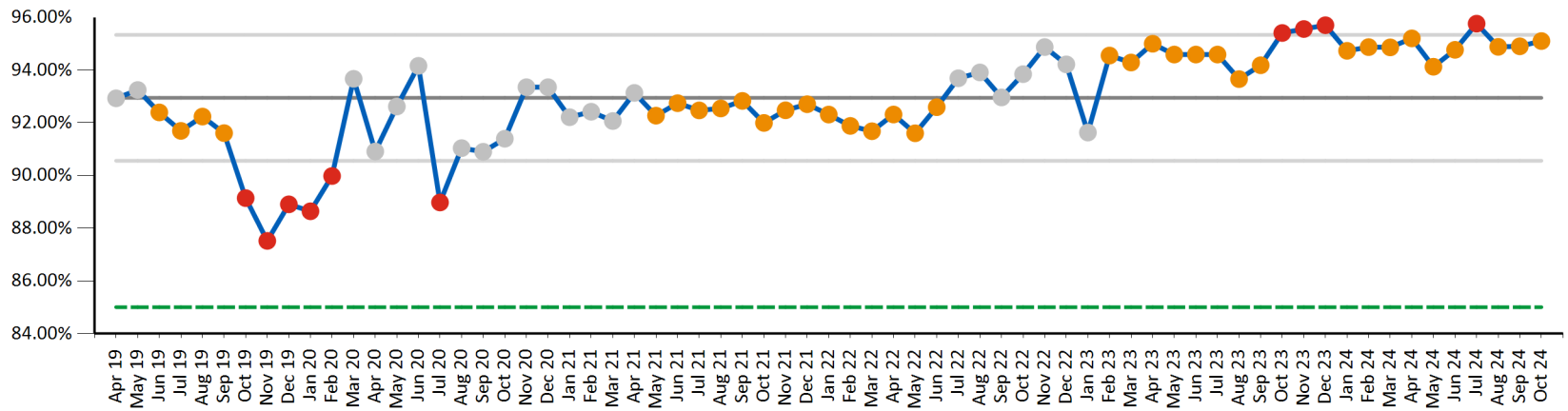
Plan	Actual
= 100%	92.9%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.1%	Oct-24

Previous

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

Year to Date

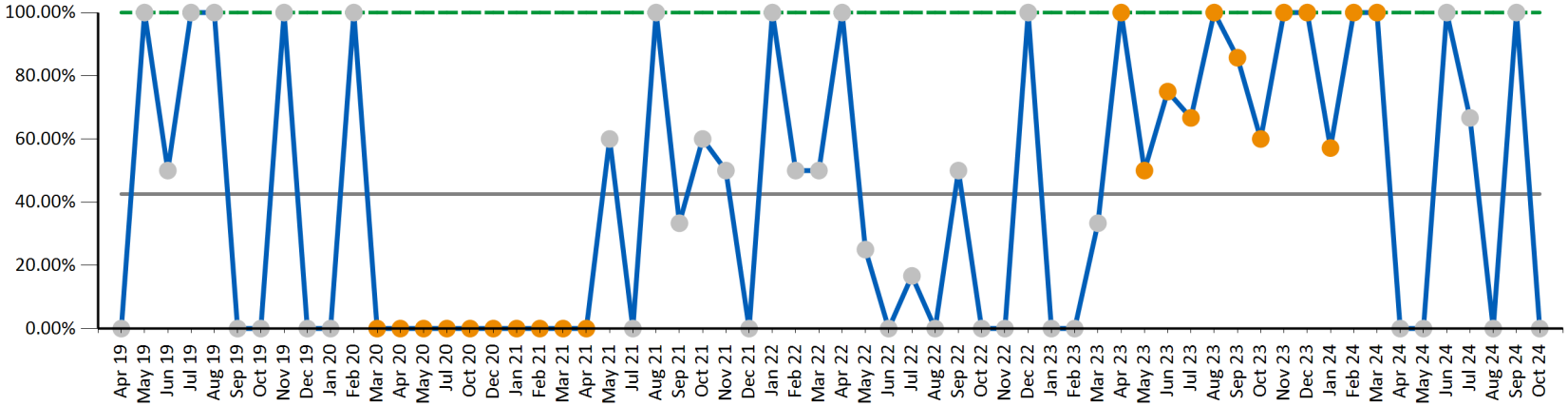
Plan	Actual
>= 85%	95.0%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
= 100%	0.0%	Oct-24

Previous

Plan	Actual	Period
= 100%	100.0%	Sep-24

Year to Date

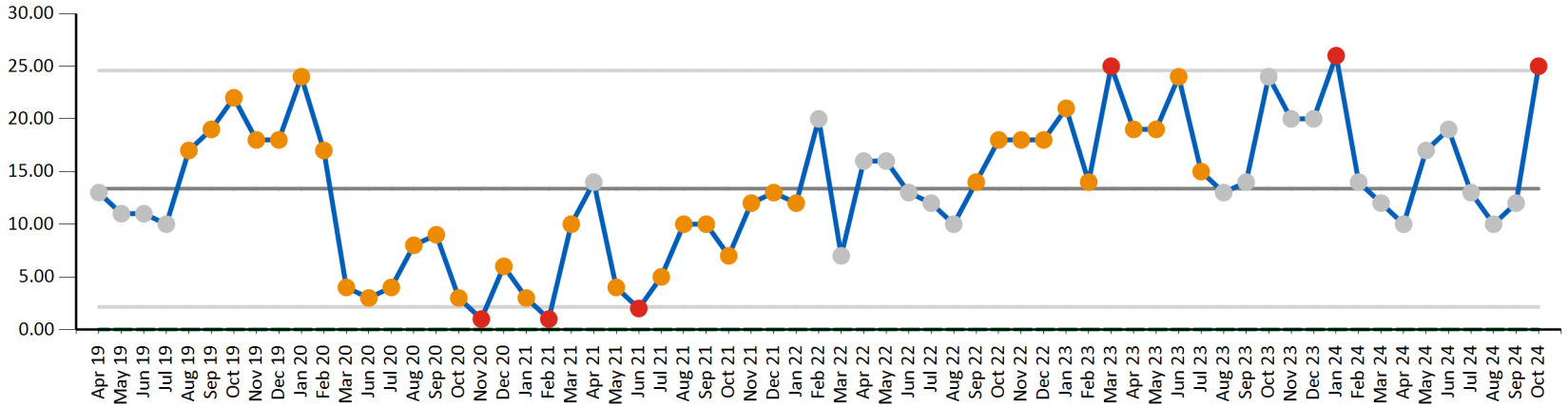
Plan	Actual
= 100%	44.4%

8 - Same sex accommodation breaches

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	25	Oct-24

Previous

Plan	Actual	Period
= 0	12	Sep-24

Year to Date

Plan	Actual
= 0	106

Quality and Safety - Infection Prevention and Control

Bolton NHS Foundation Trust

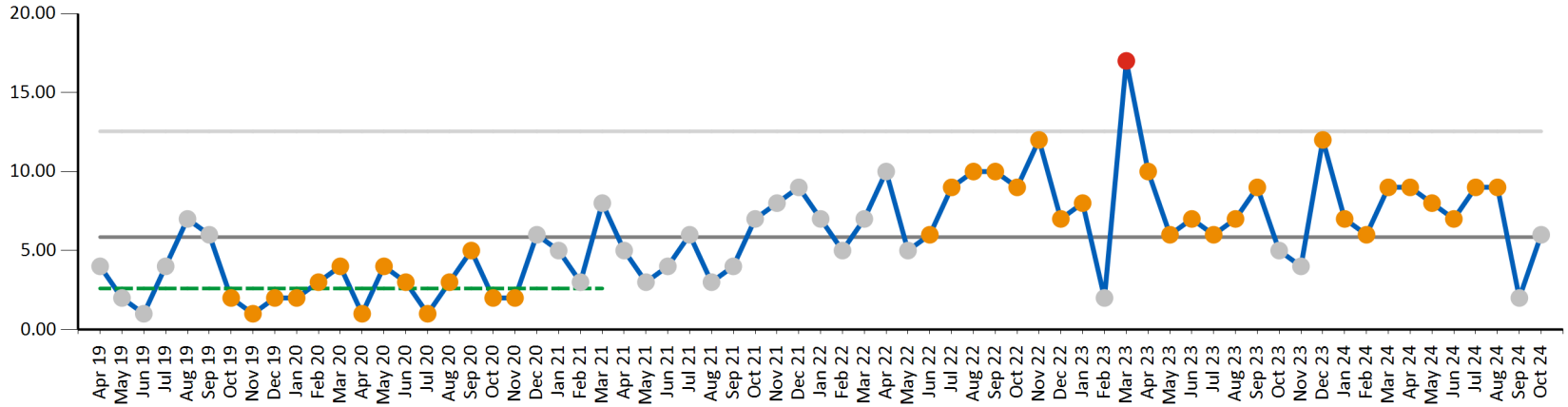
Clostridium difficile (C. diff) infections continue to pose a significant infection prevention and control (IPC) challenge for Bolton, with year-to-date performance exceeding anticipated trajectories. However, a notable improvement emerged in October, with Bolton achieving the lowest infection rate among six Greater Manchester (GM) healthcare trusts for the second consecutive month. Looking forward, the Trust is preparing a dedicated C. diff cohort ward, with preparations underway and a targeted opening date of 25 November 2024. This specialised facility represents a strategic approach to managing and containing potential infections, reinforcing the Trust's commitment to patient safety and infection control

Demonstrating consistent performance across healthcare-associated infections (HCAIs), Bolton has maintained a strong position. The Trust ranks first in Methicillin-Sensitive Staphylococcus Aureus (MSSA) and second in multiple bacteraemia categories, including MRSA, E. coli, Klebsiella species, and Pseudomonas aeruginosa.

	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	Oct-24			2	Sep-24		50	
346 - Total Community Onset Hospital Associated C.diff infections		6	Oct-24			2	Sep-24		34	
347 - Total C.diff infections contributing to objective	<= 10	8	Oct-24		<= 10	4	Sep-24	<= 69	80	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Oct-24		= 0	0	Sep-24	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	6	Oct-24		<= 5	5	Sep-24	<= 37	30	
219 - Blood Culture Contaminants (rate)	<= 3%	3.7%	Oct-24		<= 3%	3.1%	Sep-24	<= 3%	3.2%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Oct-24		<= 1.0	2.0	Sep-24	<= 7.0	9.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Oct-24		<= 1	1	Sep-24	<= 4	10	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Oct-24		= 0	1	Sep-24	= 0	4	
491 - Nosocomial COVID-19 cases		30	Oct-24			15	Sep-24		150	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	6	Oct-24

Previous

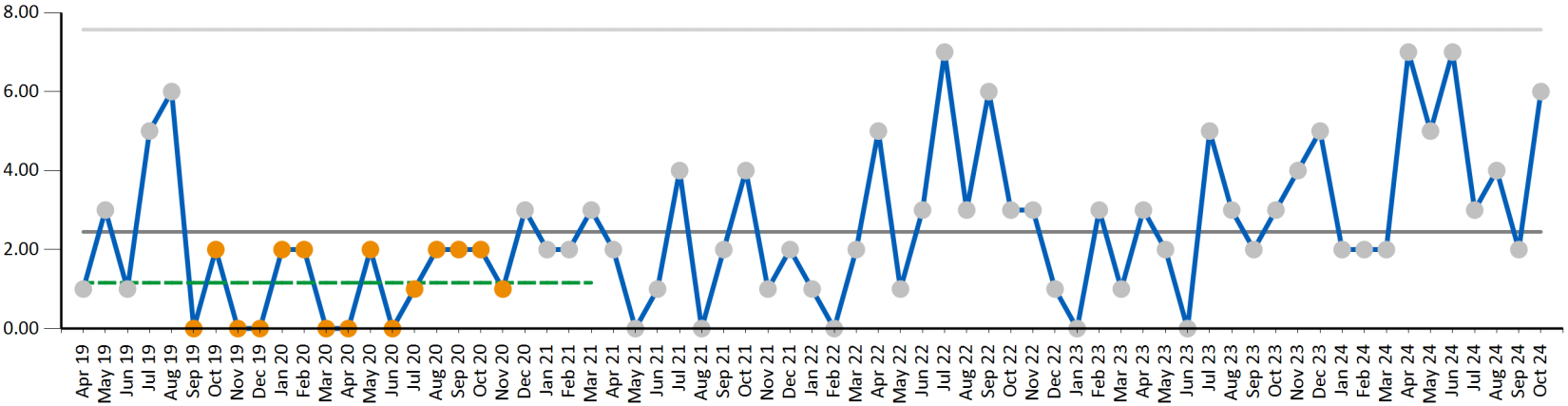
Plan	Actual	Period
	2	Sep-24

Year to Date

Plan	Actual
	50

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	6	Oct-24

Previous

Plan	Actual	Period
	2	Sep-24

Year to Date

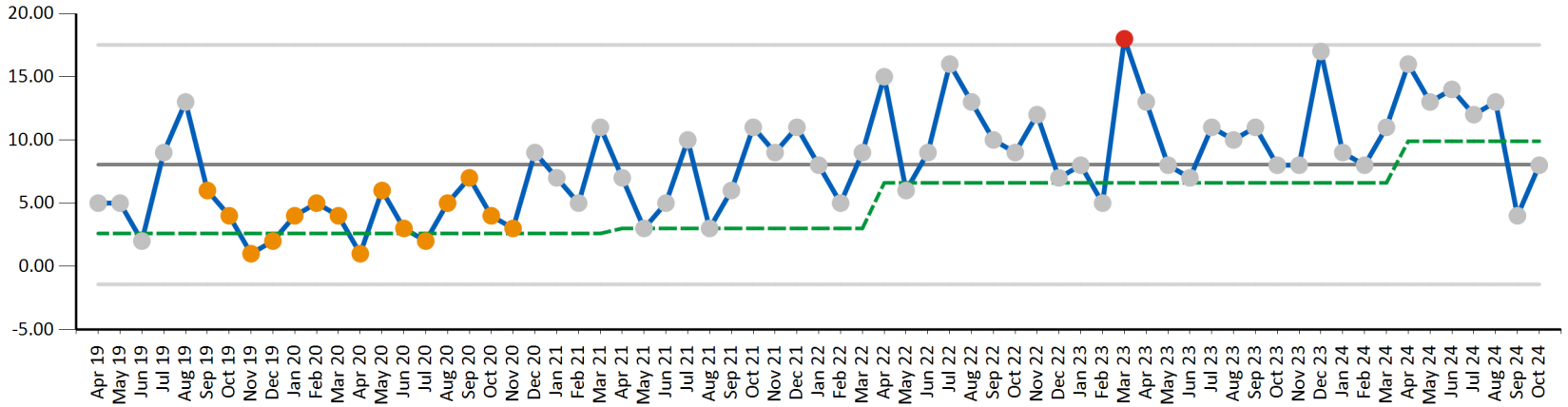
Plan	Actual
	34

347 - Total C.diff infections contributing to objective

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 10	8	Oct-24

Previous

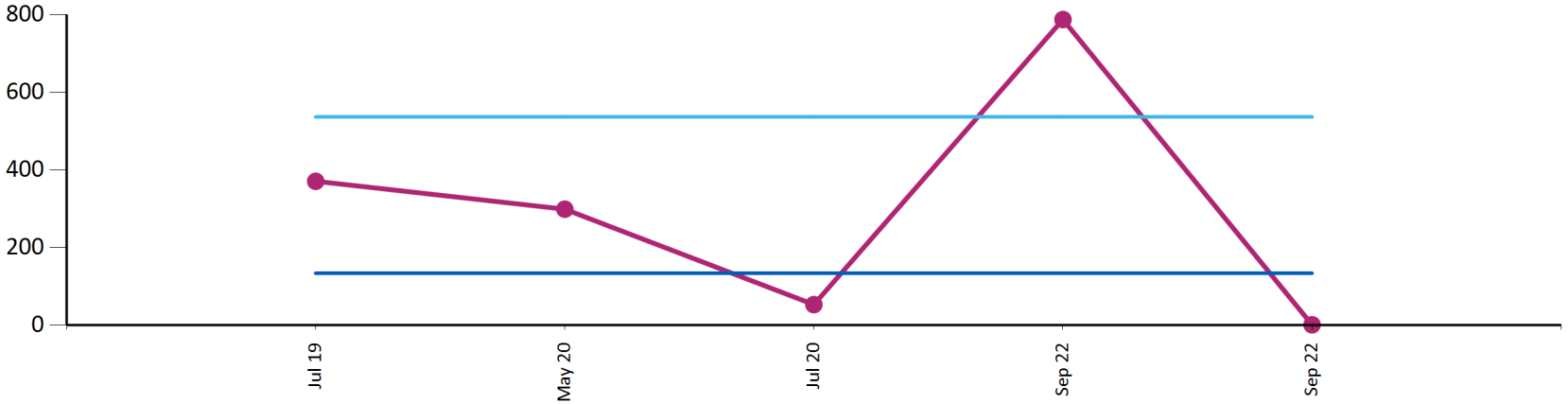
Plan	Actual	Period
<= 10	4	Sep-24

Year to Date

Plan	Actual
<= 69	80

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Oct-24

Previous

Plan	Actual	Period
	0	Sep-24

Year to Date

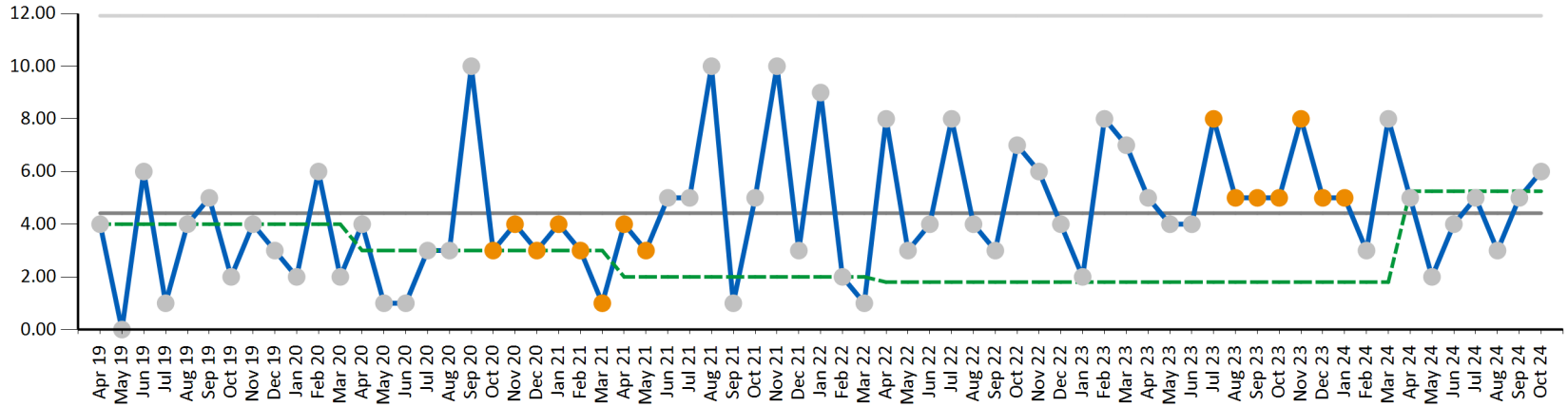
Plan	Actual

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

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 5	6	Oct-24

Previous

Plan	Actual	Period
<= 5	5	Sep-24

Year to Date

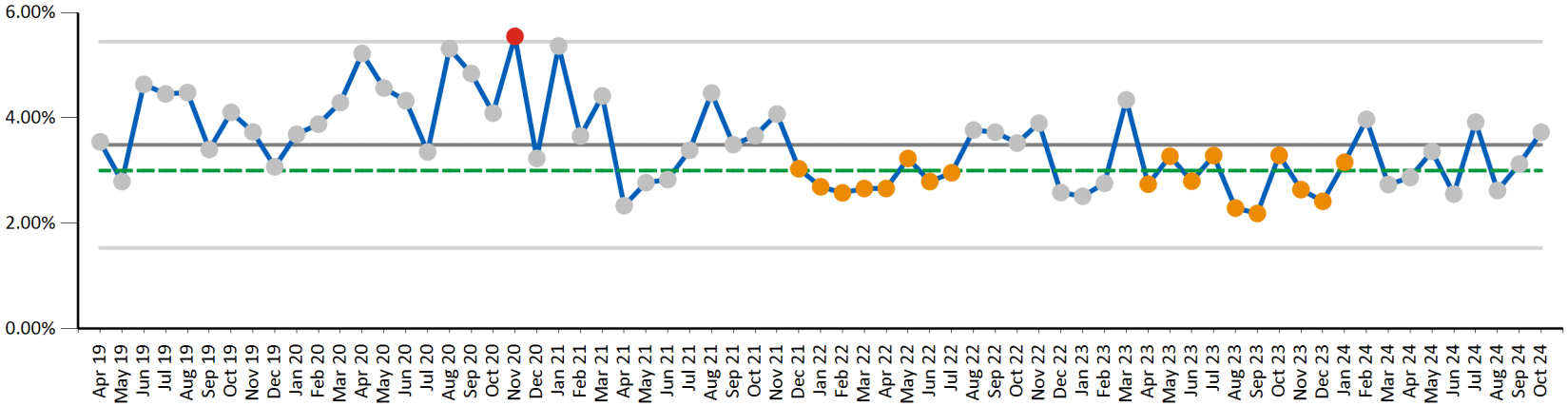
Plan	Actual
<= 37	30

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 3%	3.7%	Oct-24

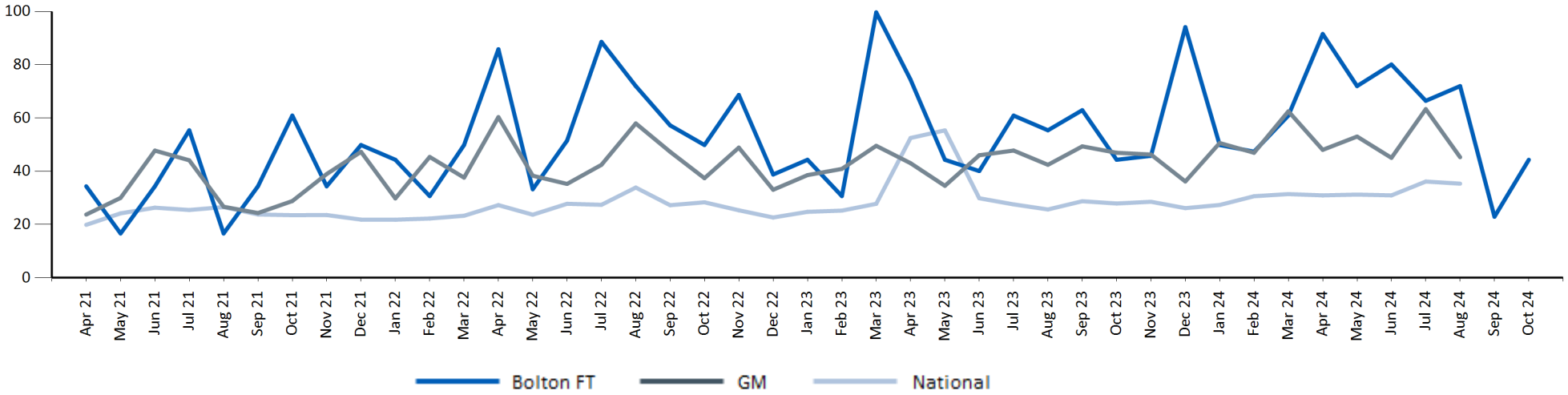
Previous

Plan	Actual	Period
<= 3%	3.1%	Sep-24

Year to Date

Plan	Actual
<= 3%	3.2%

549 - C Diff Rate Comparison

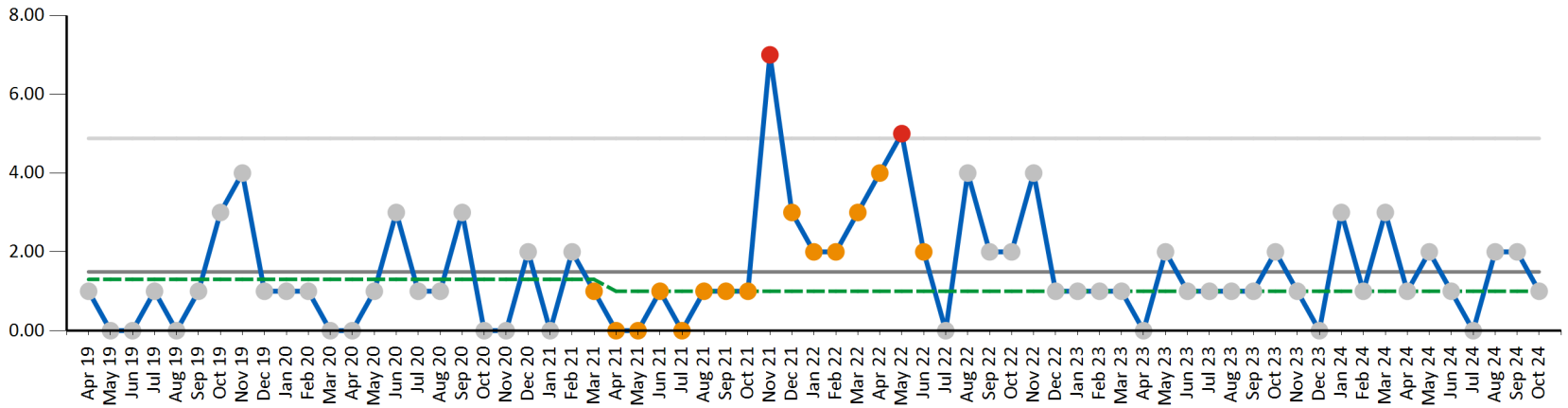


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Oct-24

Previous

Plan	Actual	Period
<= 1.0	2.0	Sep-24

Year to Date

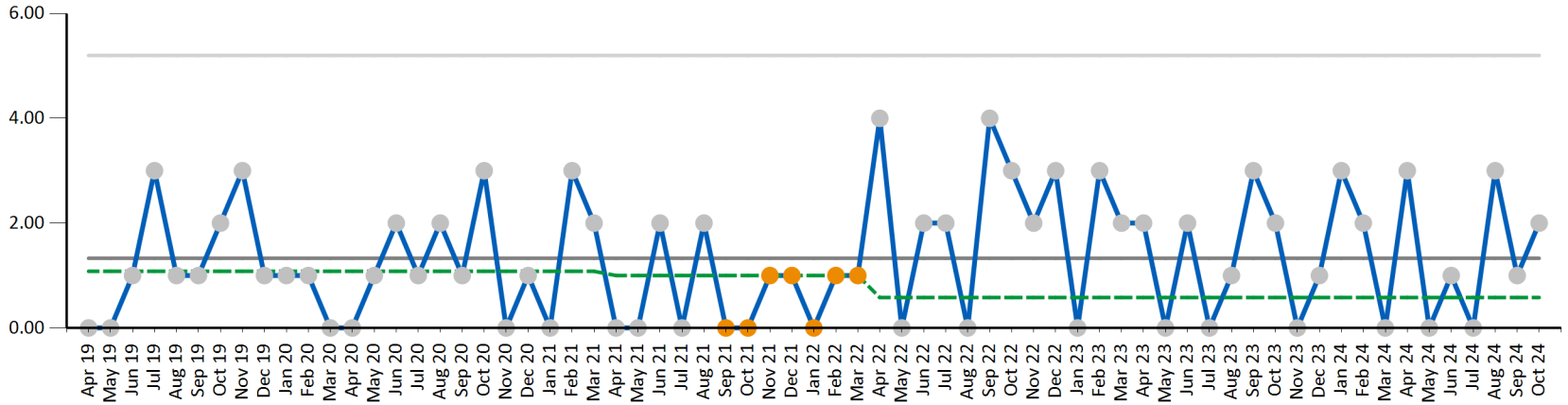
Plan	Actual
<= 7.0	9.0

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	2	Oct-24

Previous

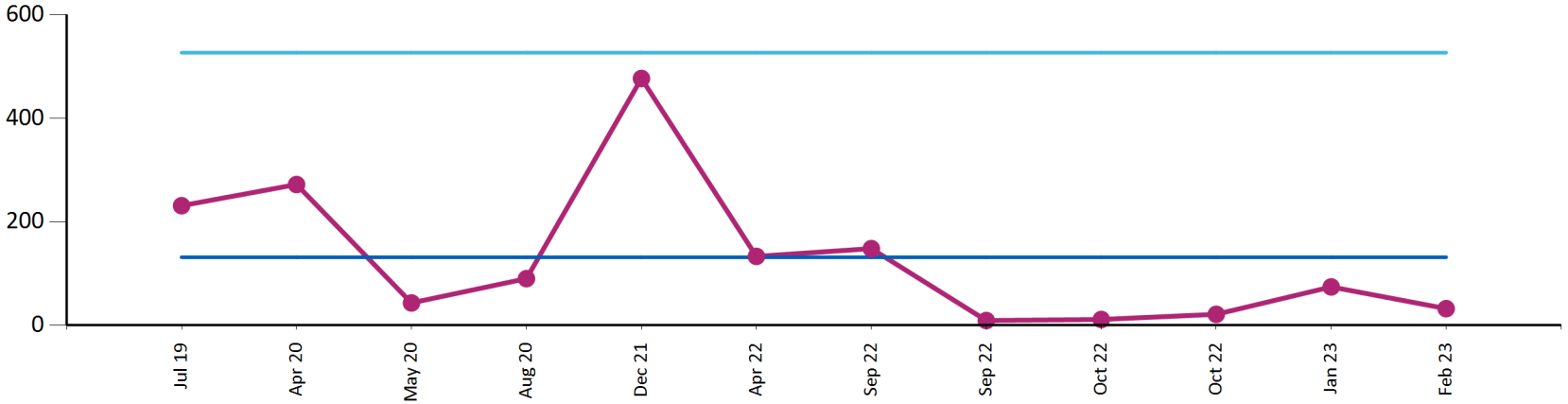
Plan	Actual	Period
<= 1	1	Sep-24

Year to Date

Plan	Actual
<= 4	10

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

0/6



Latest

Plan	Actual	Period
	0	Oct-24

Previous

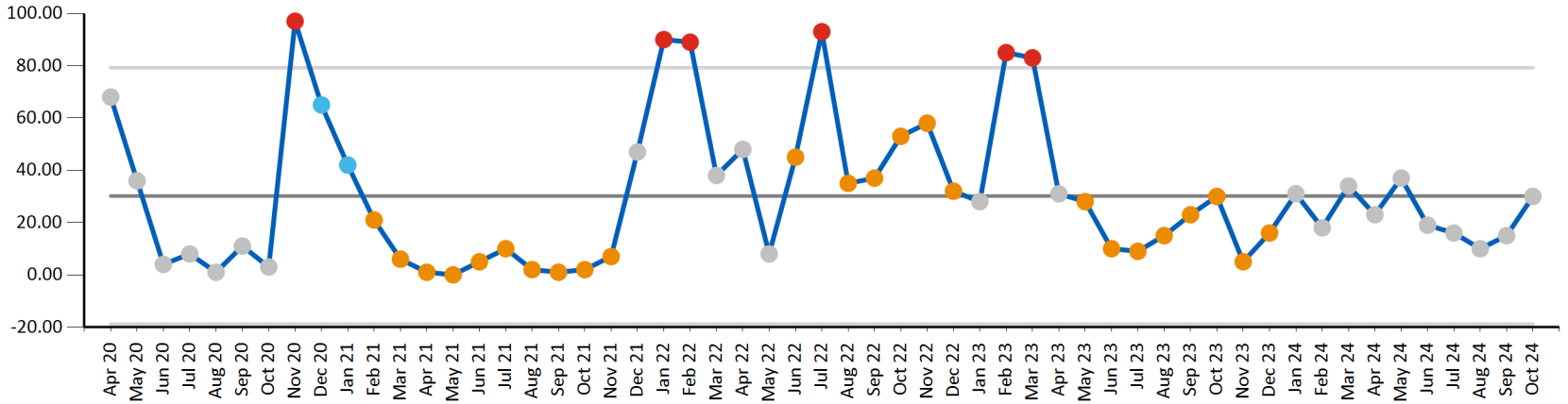
Plan	Actual	Period
	0	Sep-24

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	30	Oct-24

Previous

Plan	Actual	Period
	15	Sep-24

Year to Date

Plan	Actual
	150

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing an improvement of nine months below the average. It has now remained in control for more than 3 years.

HSMR – in month figure is below average for the period, however remains in control. The 12 month rolling average to June 2024 is 113.38 which is an 'Red' alert when compared to other Trusts.

SHMI – In month figure is above average for the time period and remains in control. The published rolling average for the period July 2023 to June 2024 is 116.81 which is 'higher than expected'.

The proportion of Charlson comorbidities is above the average for the time frame. The depth of recording remains in control but is lower than average. Both indictors are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot remains within range and above average.

The early neonatal mortality remains in control and has been for the last 12 months.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Oct-24		>= 85%	100.0%	Sep-24	>= 85%	97.4%	
495 - HSMR		103.60	Jul-24			125.80	Jun-24		103.60	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	124.10	May-24		<= 100.00	108.54	Apr-24	<= 100.00	124.10	
12 - Crude Mortality %	<= 2.9%	2.0%	Oct-24		<= 2.9%	1.9%	Sep-24	<= 2.9%	2.2%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Jul-24			4	Jun-24		16	
520 - Depth of recording (First episode of care)		6	Jul-24			6	Jun-24		23	
521 - Proportion of fully coded records (Inpatients)		96.7%	Aug-24			97.8%	Jul-24		97.1%	

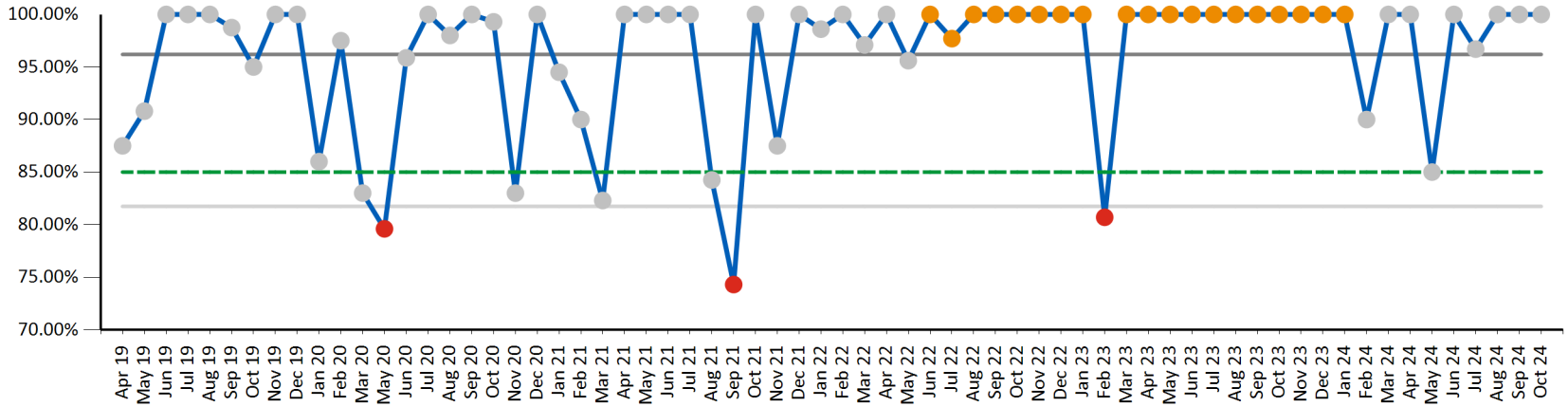
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		0.00	Oct-24			0.00	Sep-24			

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%	100.0%	Oct-24

Previous

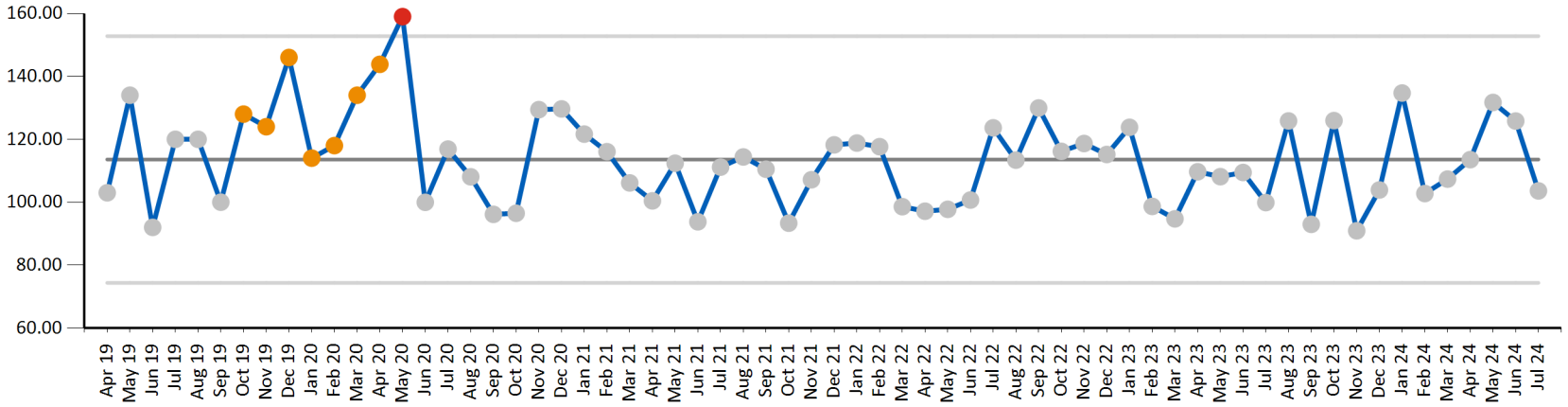
Plan	Actual	Period
>= 85%	100.0%	Sep-24

Year to Date

Plan	Actual
>= 85%	97.4%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	103.60	Jul-24

Previous

Plan	Actual	Period
	125.80	Jun-24

Year to Date

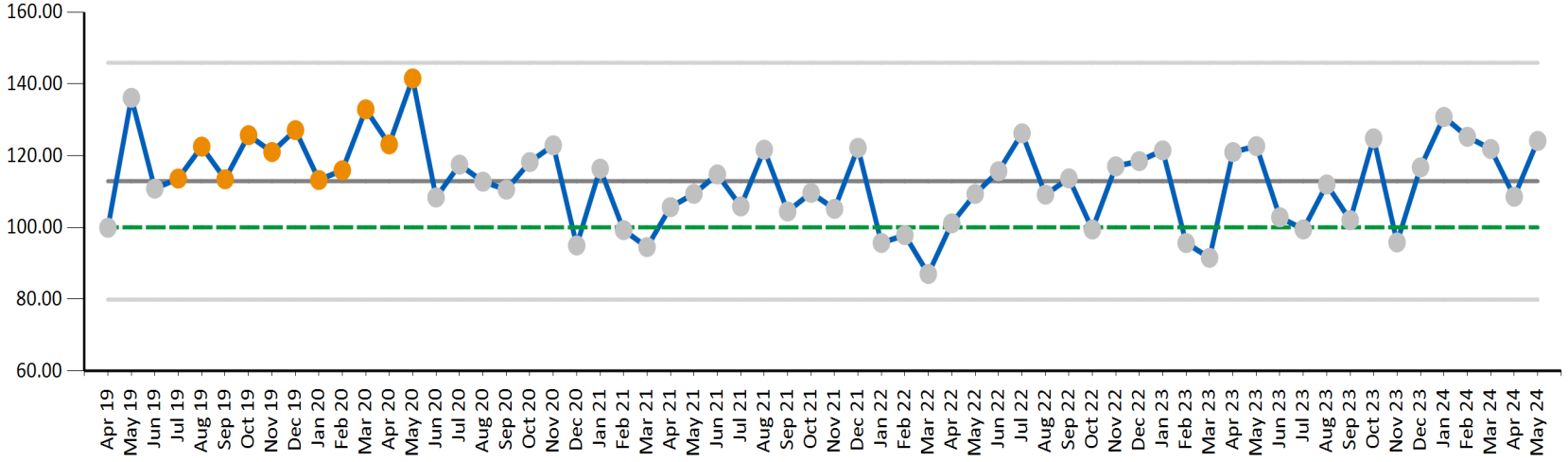
Plan	Actual
	103.60

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 100.00	124.10	May-24

Previous

Plan	Actual	Period
<= 100.00	108.54	Apr-24

Year to Date

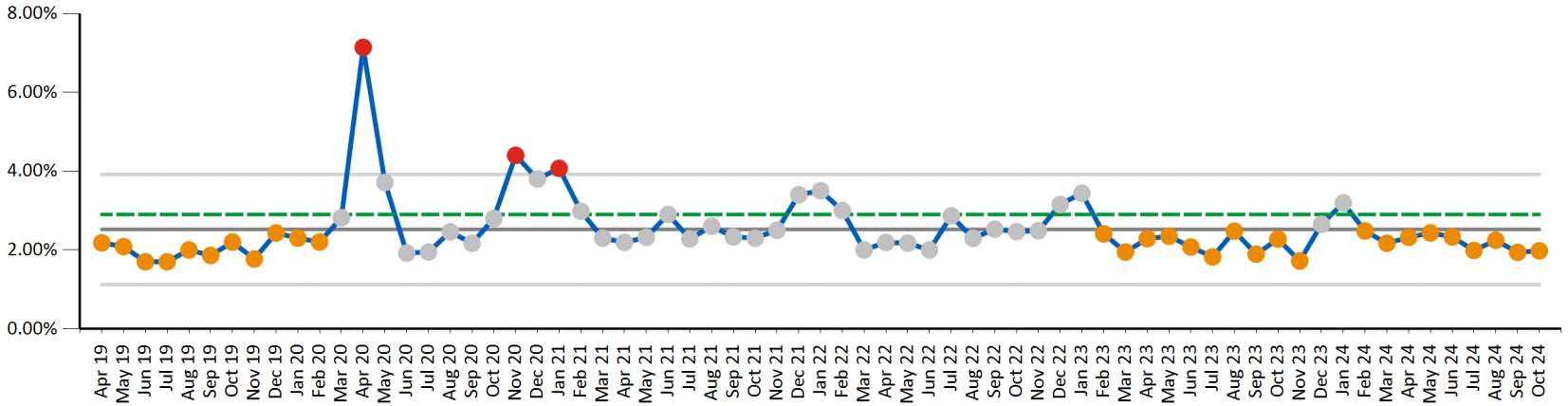
Plan	Actual
<= 100.00	124.10

12 - Crude Mortality %

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 2.9%	2.0%	Oct-24

Previous

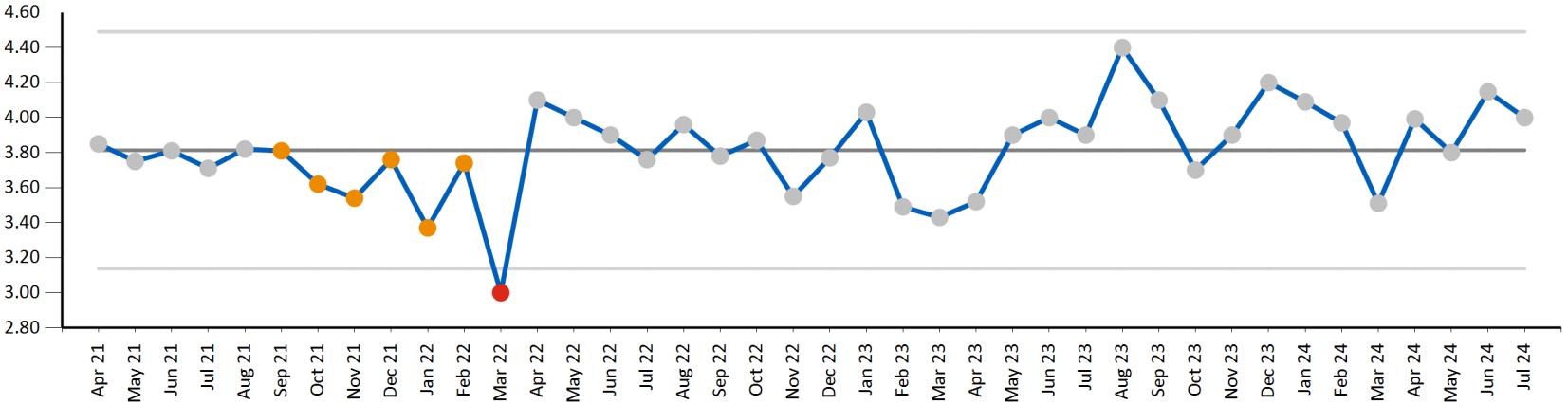
Plan	Actual	Period
<= 2.9%	1.9%	Sep-24

Year to Date

Plan	Actual
<= 2.9%	2.2%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Jul-24

Previous

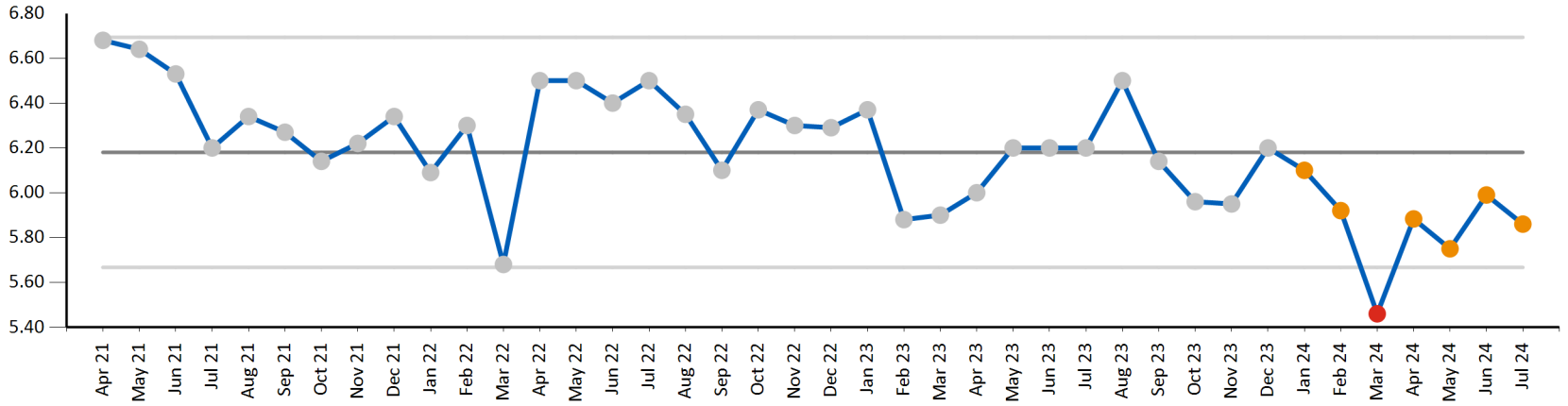
Plan	Actual	Period
	4	Jun-24

Year to Date

Plan	Actual
	16

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Jul-24

Previous

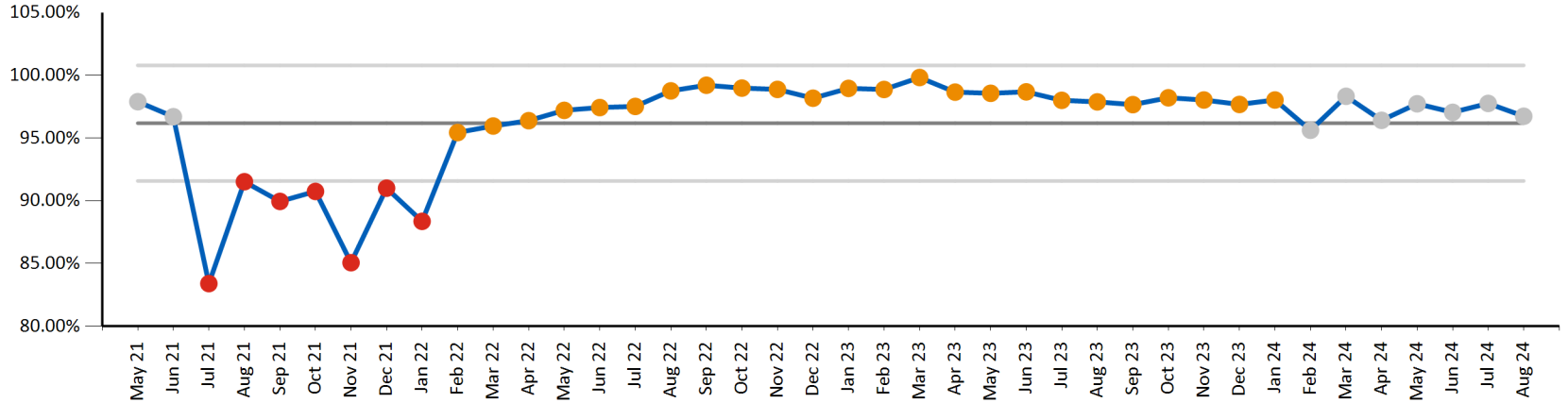
Plan	Actual	Period
	6	Jun-24

Year to Date

Plan	Actual
	23

521 - Proportion of fully coded records (Inpatients)

Common cause variation.



Latest

Plan	Actual	Period
	96.7%	Aug-24

Previous

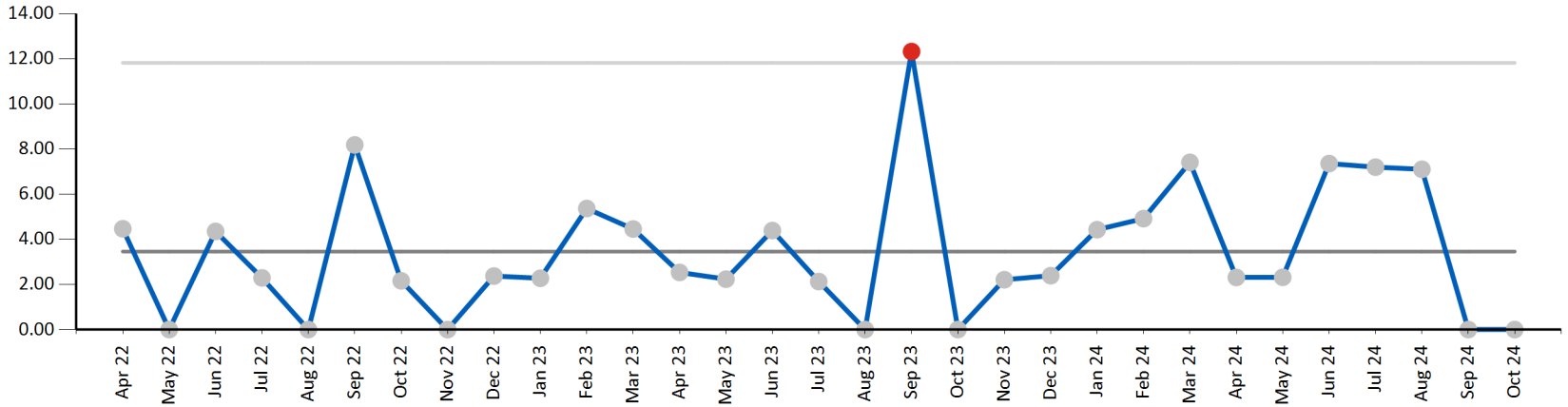
Plan	Actual	Period
	97.8%	Jul-24

Year to Date

Plan	Actual
	97.1%

604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)

Common cause variation.



Latest

Plan	Actual	Period
	0.00	Oct-24

Previous

Plan	Actual	Period
	0.00	Sep-24

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

Bolton NHS Foundation Trust

FFT Response and Satisfaction Rates October 2024
Inpatient response rates show a continued improvement, Accident and Emergency Department response and satisfaction rates remain below target however are within common cause variation. Maternity satisfaction rates have improved on last reporting month and continue to be above planned target.

Complaint Response Rates October 2024
Acknowledgement rate dropped to 93% with one case not meeting the target. This was due to the late identification of the complaint.
Complaints response compliance rates remain below target however are within common cause variation.
In October there were 15 complaints received and 21 responses due. Nine responses were approved and provided to complainants within timeframe. Seven complaint responses have subsequently been provided but were overdue. Five open complaints remain outside of the initially agreed response date and are currently at latter stages of executive review.

	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%	13.8%	Oct-24		>= 20%	15.3%	Sep-24	>= 20%	15.0%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	84.4%	Oct-24		>= 90%	87.2%	Sep-24	>= 90%	85.5%	
80 - Inpatient Friends and Family Response Rate	>= 30%	34.5%	Oct-24		>= 30%	28.6%	Sep-24	>= 30%	29.4%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.1%	Oct-24		>= 90%	96.0%	Sep-24	>= 90%	95.7%	
81 - Maternity Friends and Family Response Rate	>= 15%	19.4%	Oct-24		>= 15%	20.9%	Sep-24	>= 15%	22.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	92.5%	Oct-24		>= 90%	91.3%	Sep-24	>= 90%	92.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	6.2%	Oct-24		>= 15%	8.7%	Sep-24	>= 15%	8.1%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	90.9%	Oct-24		>= 90%	97.6%	Sep-24	>= 90%	93.2%	
83 - Birth - Friends and Family Response Rate	>= 15%	39.5%	Oct-24		>= 15%	38.0%	Sep-24	>= 15%	39.4%	

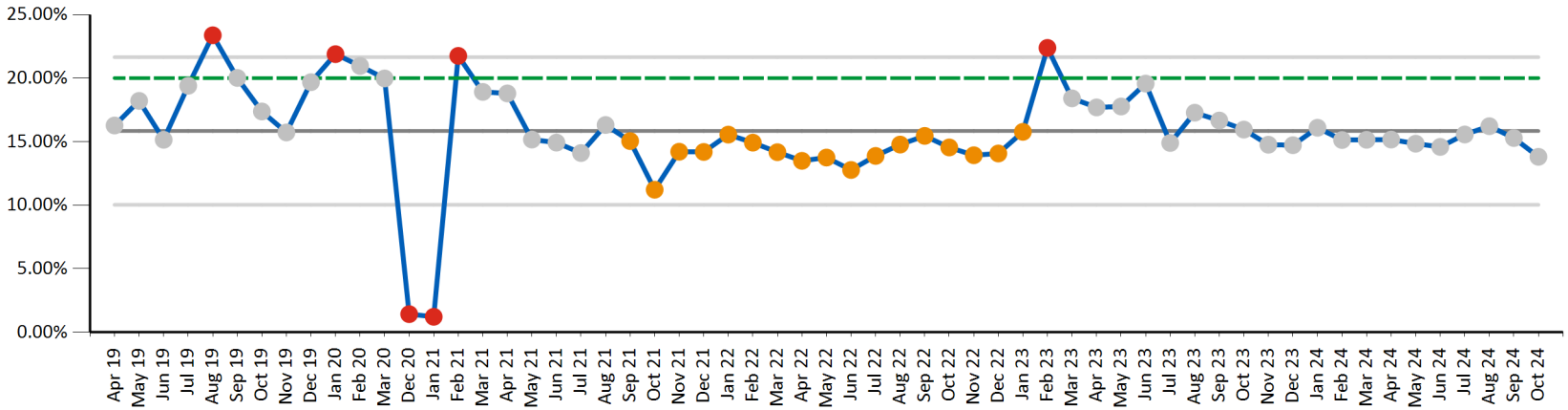
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	93.9%	Oct-24		>= 90%	89.8%	Sep-24	>= 90%	91.6%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	24.2%	Oct-24		>= 15%	25.8%	Sep-24	>= 15%	30.2%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.2%	Oct-24	H	>= 90%	90.5%	Sep-24	>= 90%	92.5%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	11.3%	Oct-24		>= 15%	12.6%	Sep-24	>= 15%	16.5%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	93.9%	Oct-24		>= 90%	92.3%	Sep-24	>= 90%	91.1%	
89 - Formal complaints acknowledged within 3 working days	= 100%	93.3%	Oct-24	L	= 100%	91.7%	Sep-24	= 100%	97.9%	
90 - Complaints responded to within the period	>= 95%	66.7%	Oct-24		>= 95%	75.0%	Sep-24	>= 95%	73.2%	

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%	13.8%	Oct-24

Previous

Plan	Actual	Period
>= 20%	15.3%	Sep-24

Year to Date

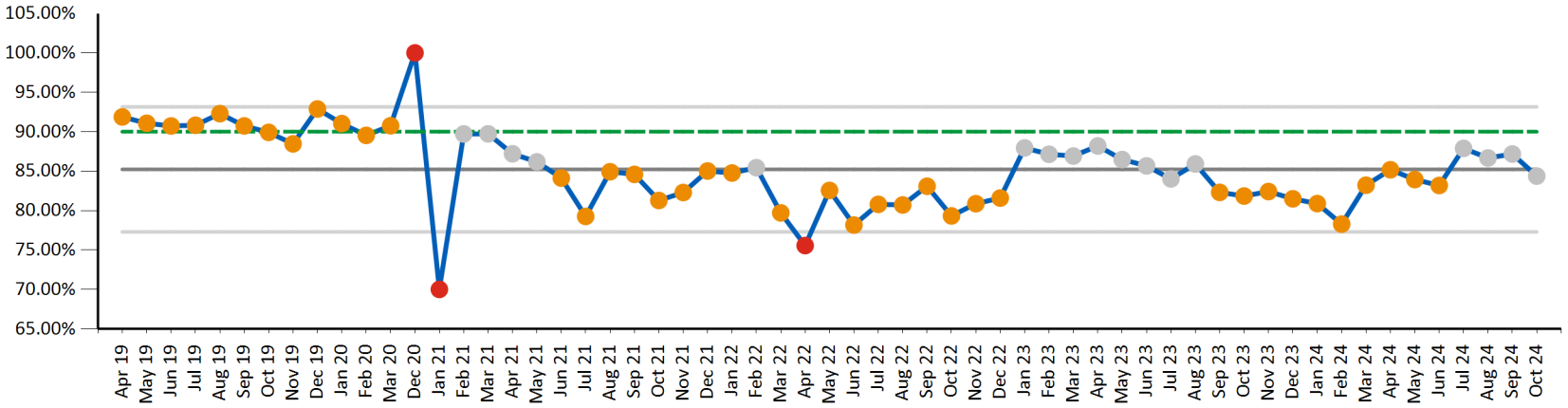
Plan	Actual
>= 20%	15.0%

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%	84.4%	Oct-24

Previous

Plan	Actual	Period
>= 90%	87.2%	Sep-24

Year to Date

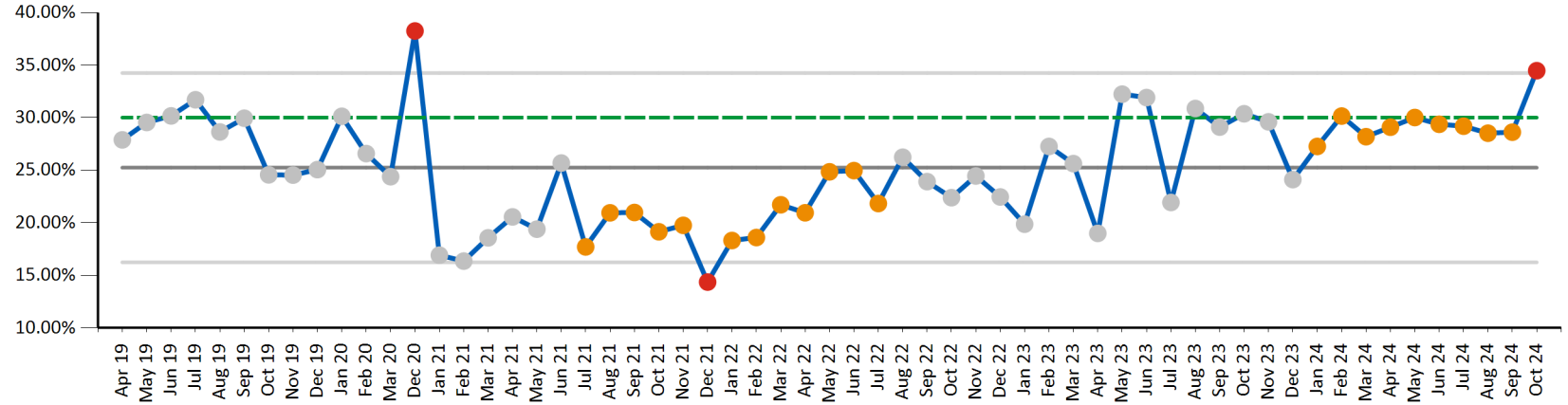
Plan	Actual
>= 90%	85.5%

80 - Inpatient Friends and Family Response Rate

Special cause variation with improving performance

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

2/6



Latest

Plan	Actual	Period
>= 30%	34.5%	Oct-24

Previous

Plan	Actual	Period
>= 30%	28.6%	Sep-24

Year to Date

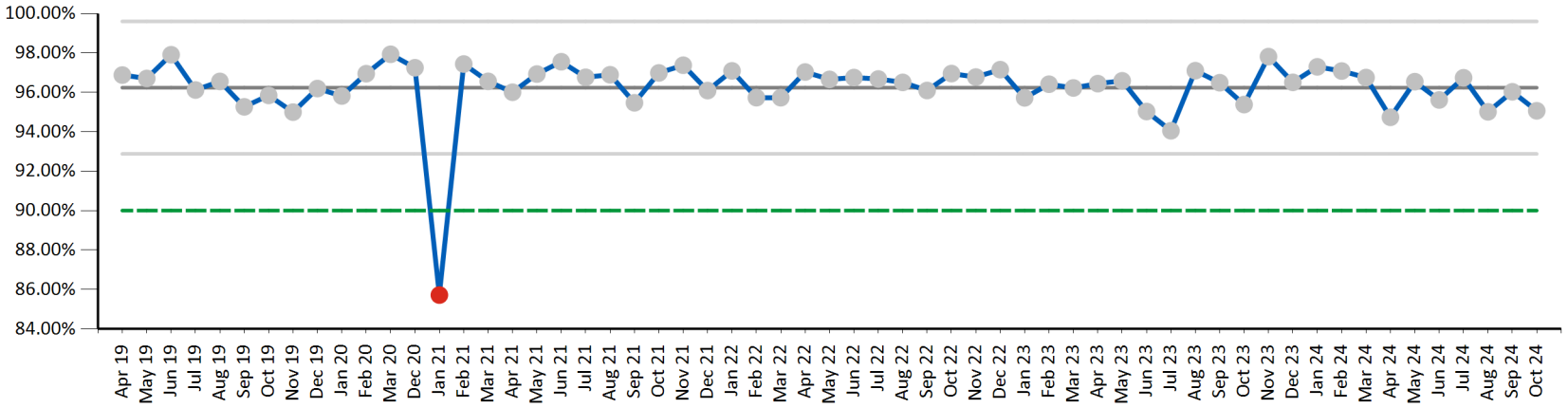
Plan	Actual
>= 30%	29.4%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	95.1%	Oct-24

Previous

Plan	Actual	Period
>= 90%	96.0%	Sep-24

Year to Date

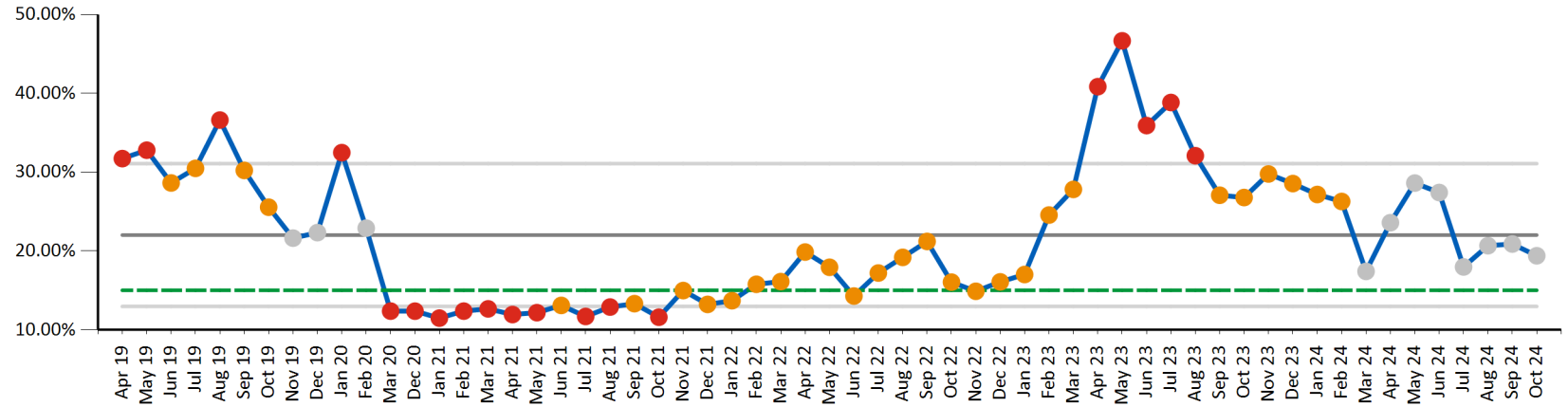
Plan	Actual
>= 90%	95.7%

81 - Maternity 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%	19.4%	Oct-24

Previous

Plan	Actual	Period
>= 15%	20.9%	Sep-24

Year to Date

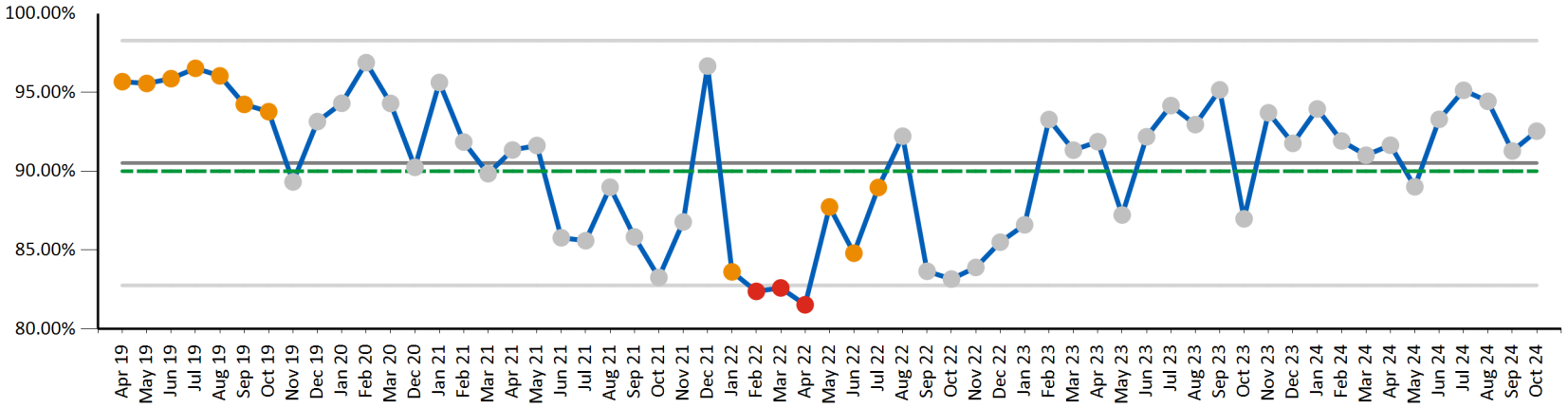
Plan	Actual
>= 15%	22.6%

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%	92.5%	Oct-24

Previous

Plan	Actual	Period
>= 90%	91.3%	Sep-24

Year to Date

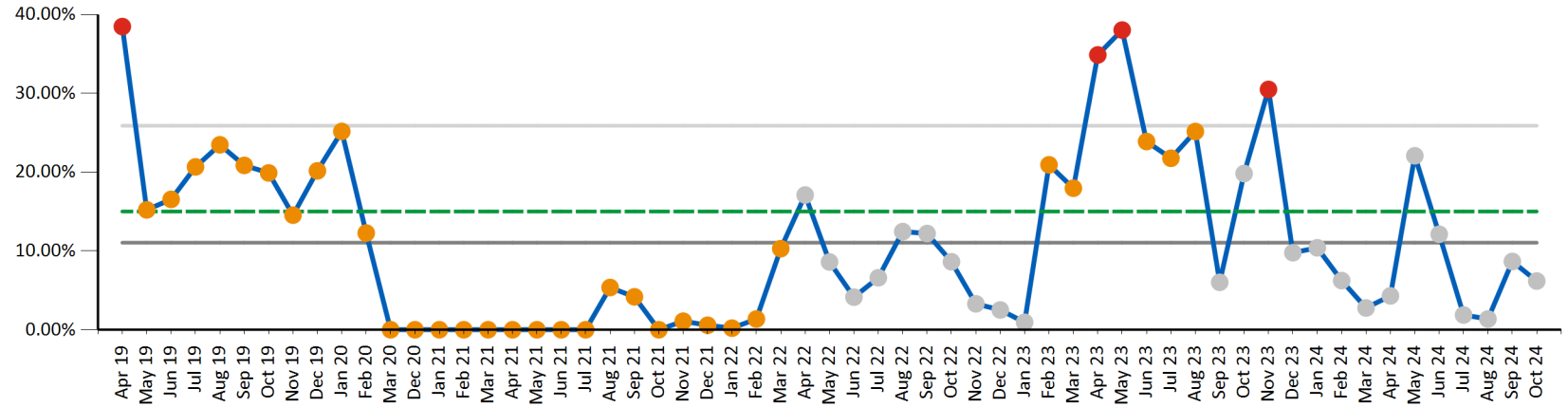
Plan	Actual
>= 90%	92.3%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 15%	6.2%	Oct-24

Previous

Plan	Actual	Period
>= 15%	8.7%	Sep-24

Year to Date

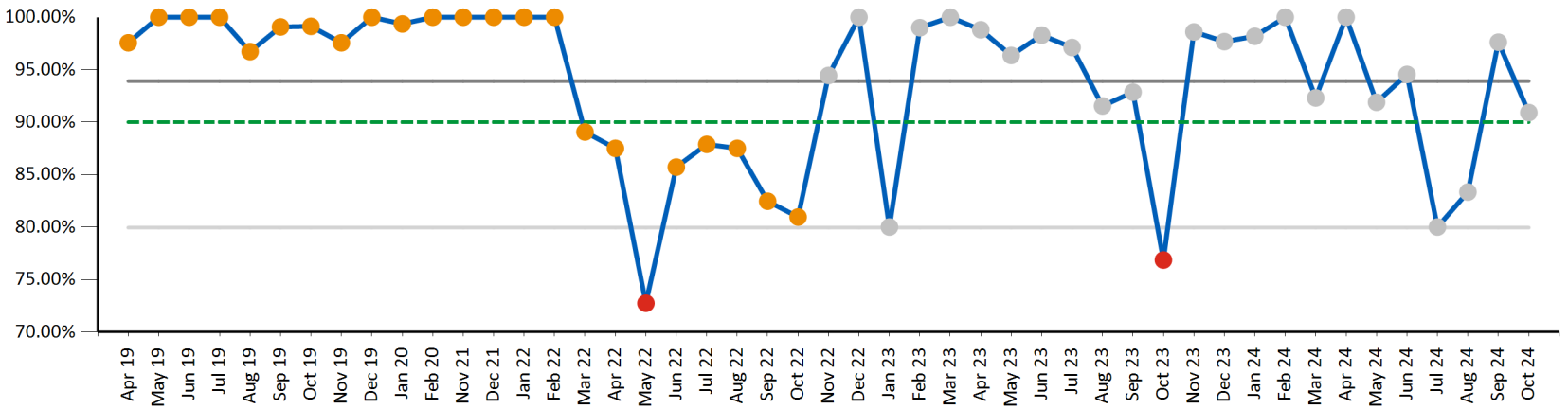
Plan	Actual
>= 15%	8.1%

242 - Antenatal 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%	90.9%	Oct-24

Previous

Plan	Actual	Period
>= 90%	97.6%	Sep-24

Year to Date

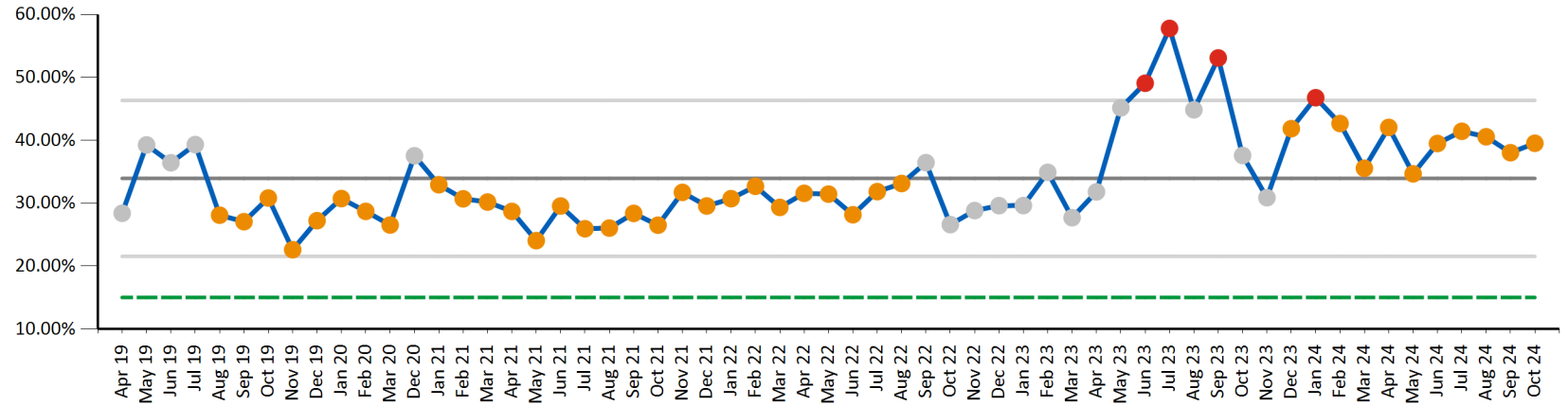
Plan	Actual
>= 90%	93.2%

83 - Birth - Friends and Family Response Rate

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	39.5%	Oct-24

Previous

Plan	Actual	Period
>= 15%	38.0%	Sep-24

Year to Date

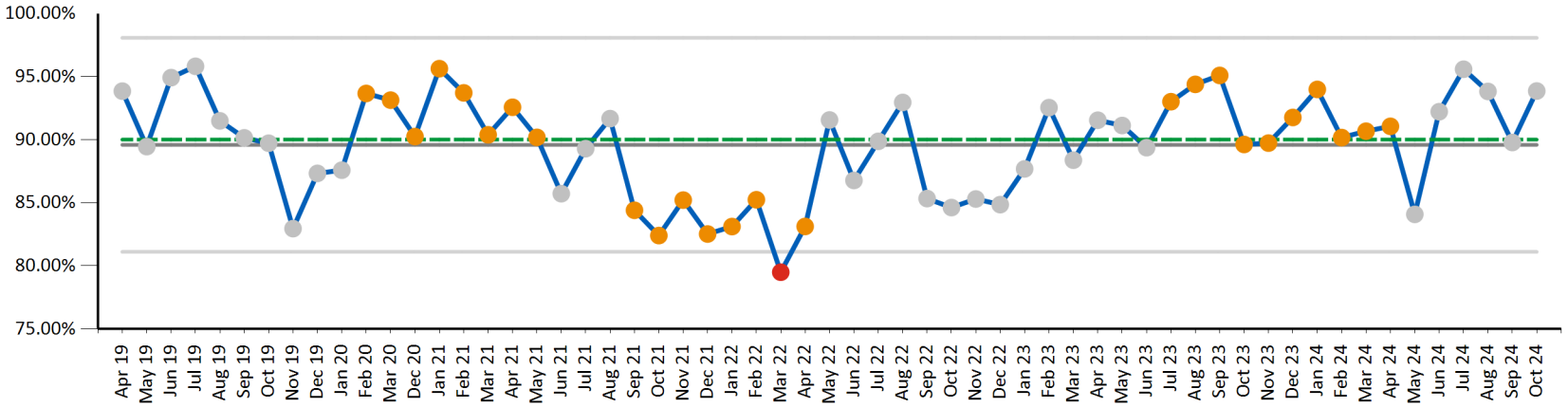
Plan	Actual
>= 15%	39.4%

243 - Birth 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%	93.9%	Oct-24

Previous

Plan	Actual	Period
>= 90%	89.8%	Sep-24

Year to Date

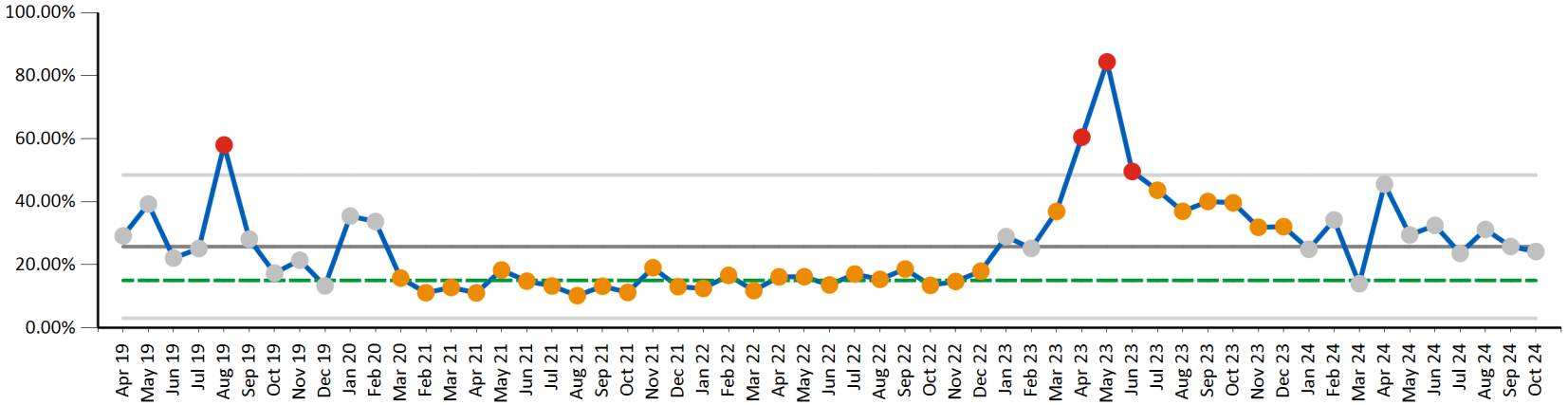
Plan	Actual
>= 90%	91.6%

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%	24.2%	Oct-24

Previous

Plan	Actual	Period
>= 15%	25.8%	Sep-24

Year to Date

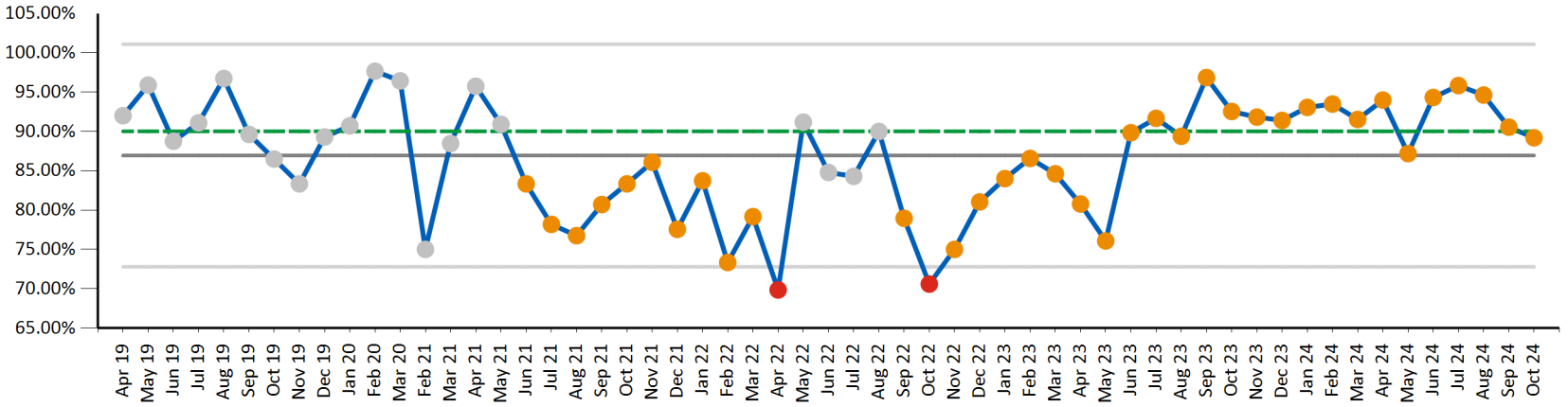
Plan	Actual
>= 15%	30.2%

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.

4/6



Latest

Plan	Actual	Period
>= 90%	89.2%	Oct-24

Previous

Plan	Actual	Period
>= 90%	90.5%	Sep-24

Year to Date

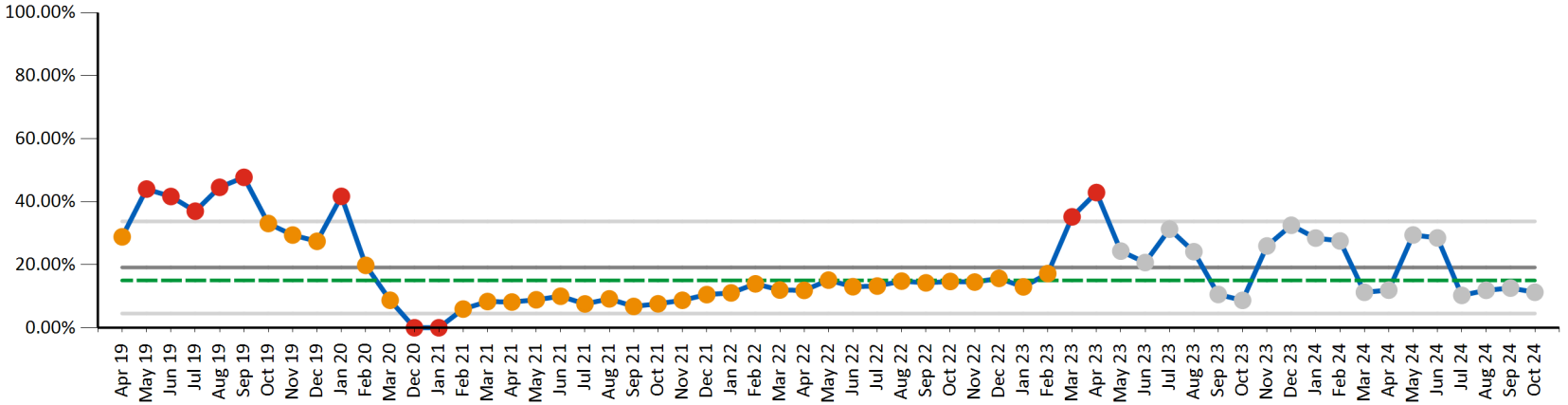
Plan	Actual
>= 90%	92.5%

85 - Community Postnatal - Friend 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%	11.3%	Oct-24

Previous

Plan	Actual	Period
>= 15%	12.6%	Sep-24

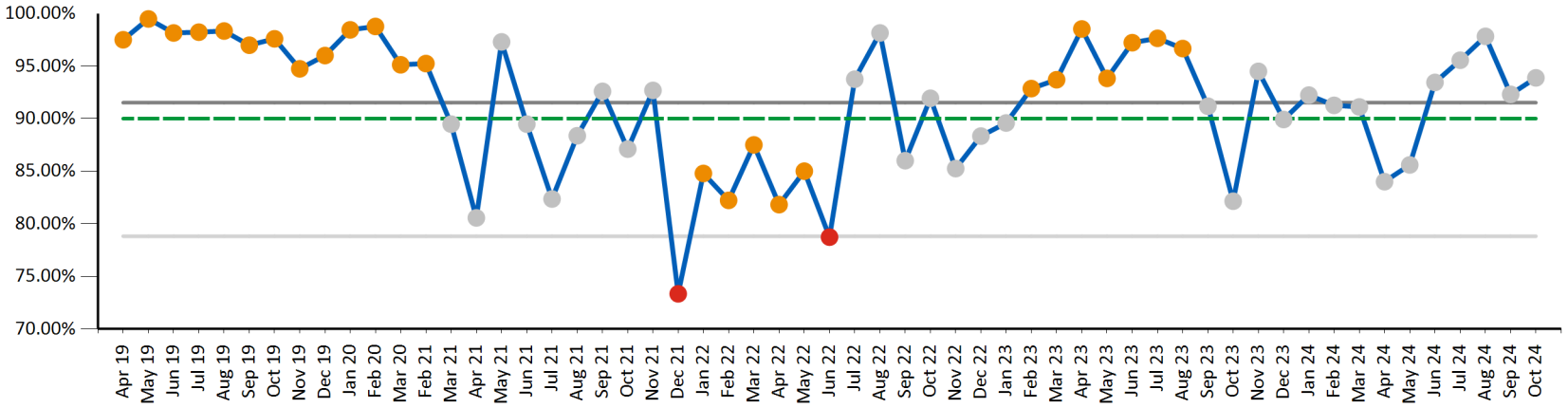
Year to Date

Plan	Actual
>= 15%	16.5%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

We will not regularly meet the target due to normal variation. 5/6



Latest

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

Previous

Plan	Actual	Period
>= 90%	92.3%	Sep-24

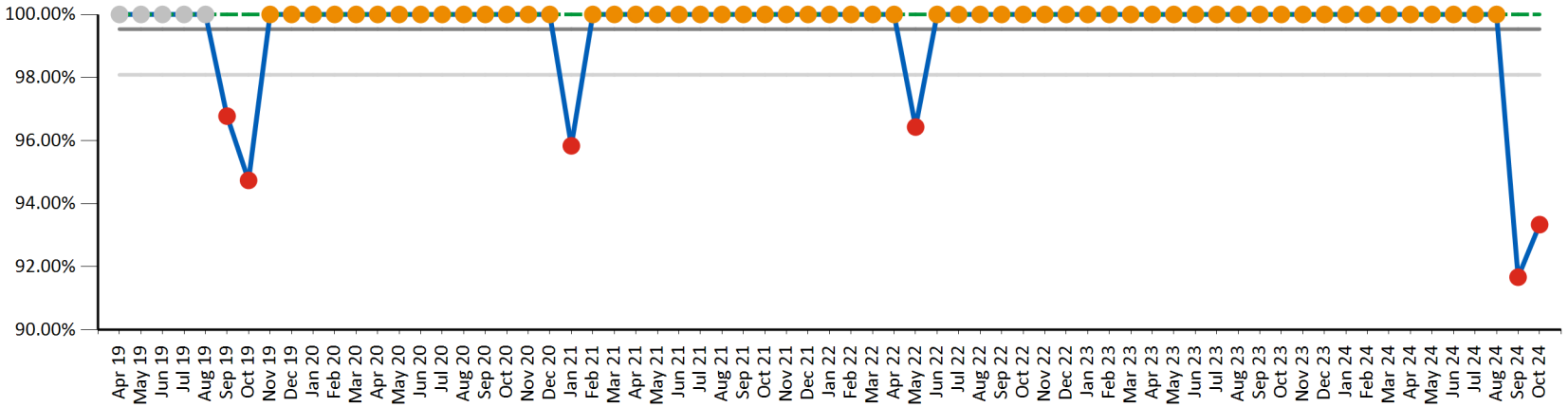
Year to Date

Plan	Actual
>= 90%	91.1%

89 - Formal complaints acknowledged within 3 working days

Special cause variation with deteriorating performance

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



Latest

Plan	Actual	Period
= 100%	93.3%	Oct-24

Previous

Plan	Actual	Period
= 100%	91.7%	Sep-24

Year to Date

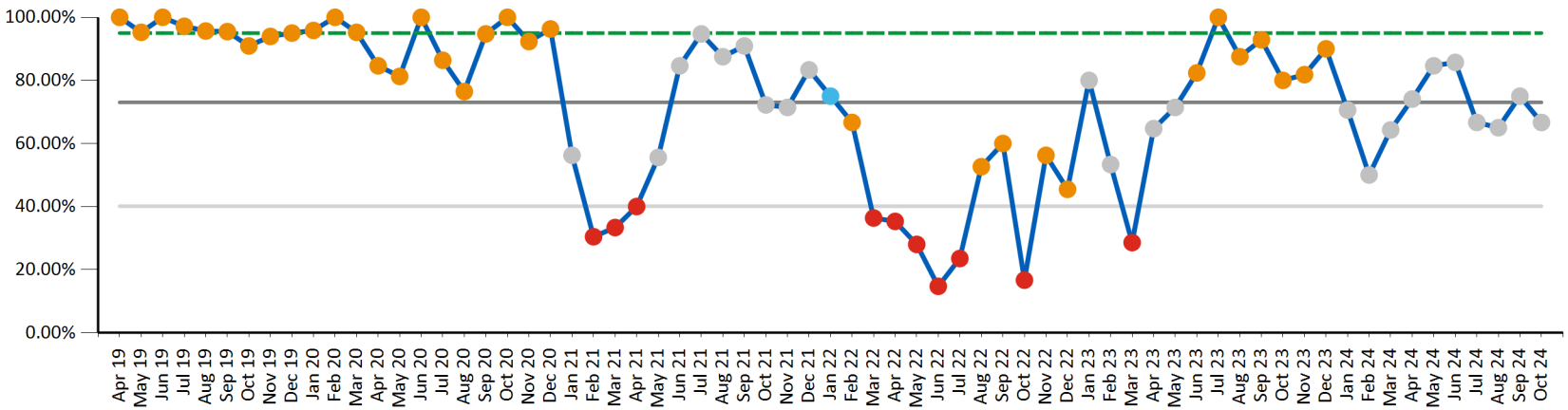
Plan	Actual
= 100%	97.9%

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%	66.7%	Oct-24

Previous

Plan	Actual	Period
>= 95%	75.0%	Sep-24

Year to Date

Plan	Actual
>= 95%	73.2%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family Response Rate – Sustained response rate in month at 19.4% following introduction of QR code. Plan to continue to monitor response rates over next couple of months and review method of collection if required. Overall maternity satisfaction rate in month has been sustained at 92.5% compared to last month at 91.3%.

¾ degree tears – There has been a sustained decrease in month at 2.5%. Trust presented at LMNS in shared learning event and further improvement suggestions identified for action ie: Implementation of the RCOG operative birth simulation training for medical staff (ROBuST) and support for newly qualified staff to undertake episiotomies to be introduced.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Incidence 4.54/1000 births in October 2024 (2 cases) . Trust 12 month average rate 4.29/1000 slightly higher than peer comparator Oldham 3.47/1000. The service continues to focus on improvement in the Triage department and realignment of defined pathways that have been flagged in recent case reviews.

1:1 care in labour – Sustained improvement in incidence in Trust rate sustained (99.1%) within month. Action plan in place as per CNST requirements.

Booked by 12+6 is a clinical indicator relating to the timing of the initial antenatal booking visit that ensures women access care in a timely way and are still in a position to have a scan and antenatal screening blood tests taken. Slight deterioration in performance in month to 85.7%. Digital self-referral form progressing. 8 of the late bookings were avoidable and 15 of the ladies were unaware pregnant. Highest proportion of late bookings were BL3 and BL1 areas where the cultural preference is to book in pregnancy later. Communication support to be requested with messaging and support from cultural midwife to be sought to address.

Booked by 10 weeks (target reflects bookings by 10+0 gestation as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact). Operational focus ongoing to address the issues identified with booking of the initial appointment. Trust performance 53.3% showing sustained improvement in attainment.

Inductions of labour delayed by >24 hours – 32.5% of induction of labour cases by 24 hours were delayed in October 2024 (33 cases). Quality improvement project on G3/G4 now commenced. Introduction of Trist discharge lounge being considered.

Breastfeeding initiation – Slight variation in month to 71.36% from 69.18%. Changes in team structure ongoing. Service has a plan in place to attain Baby Friendly stage 2 status by September 2025. New leader commencing in the team in January 2025.

Preterm birth (less than 37 weeks gestation) – Slight variation in preterm incidence within month reported to 9.8%. Trust 12 month rate 8.63% less than GMEC comparator 10.64%.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	4.54	Oct-24		<= 3.50	2.22	Sep-24	<= 3.50	3.98	

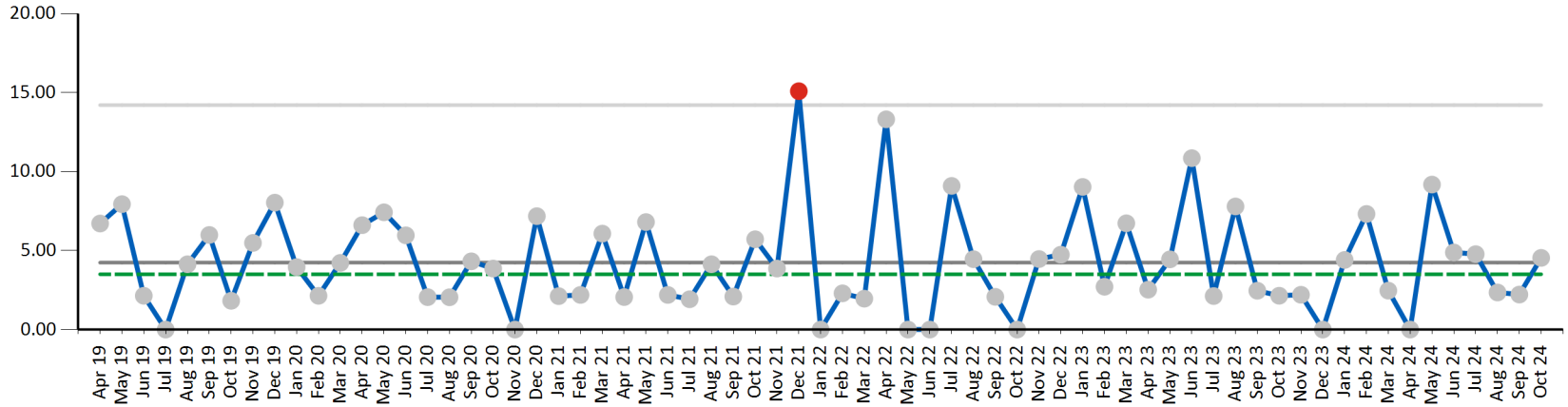
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.5%	Oct-24		<= 3.5%	2.2%	Sep-24	<= 3.5%	2.7%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.1%	Oct-24		>= 95.0%	99.7%	Sep-24	>= 95.0%	99.0%	
203 - Booked 12+6	>= 90.0%	85.7%	Oct-24		>= 90.0%	91.5%	Sep-24	>= 90.0%	87.6%	
586 - Booked 10+0		53.3%	Oct-24			59.4%	Sep-24		53.4%	
204 - Inductions of labour - over 24 hours	<= 40%	32.5%	Oct-24		<= 40%	32.3%	Sep-24	<= 40%	32.4%	
210 - Initiation breast feeding	>= 65%	71.36%	Oct-24		>= 65%	69.18%	Sep-24	>= 65%	69.42%	
213 - Maternity complaints	<= 5	0	Oct-24		<= 5	4	Sep-24	<= 35	10	
319 - Maternal deaths (direct)	= 0	0	Oct-24		= 0	0	Sep-24	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.8%	Oct-24		<= 6%	8.9%	Sep-24	<= 6%	9.0%	

322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 3.50	4.54	Oct-24

Previous

Plan	Actual	Period
<= 3.50	2.22	Sep-24

Year to Date

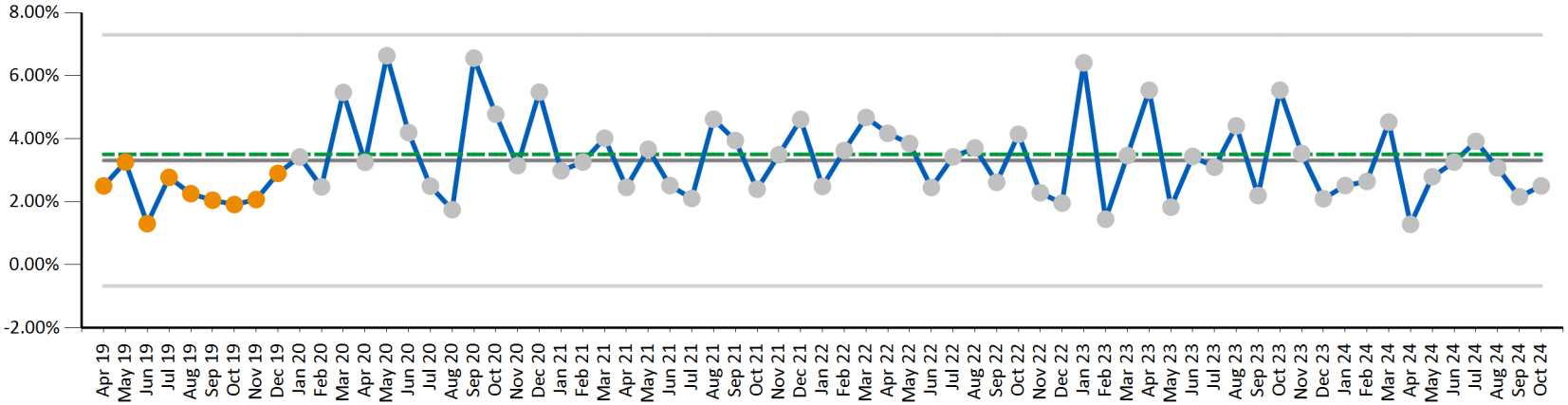
Plan	Actual
<= 3.50	3.98

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

5/6



Latest

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

Previous

Plan	Actual	Period
<= 3.5%	2.2%	Sep-24

Year to Date

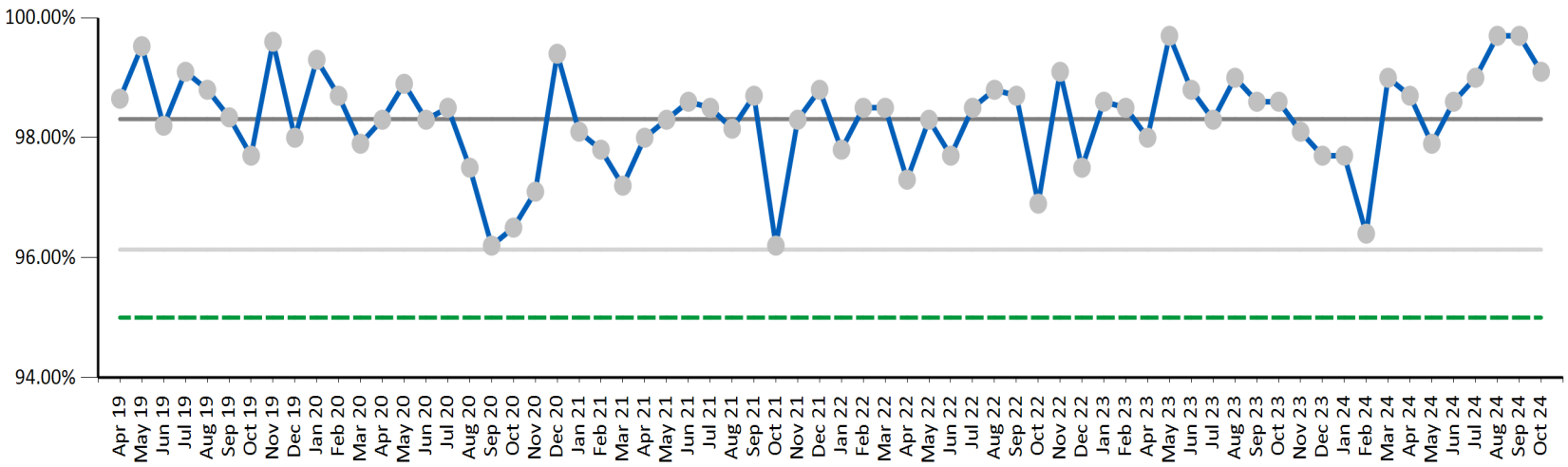
Plan	Actual
<= 3.5%	2.7%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	99.1%	Oct-24

Previous

Plan	Actual	Period
>= 95.0%	99.7%	Sep-24

Year to Date

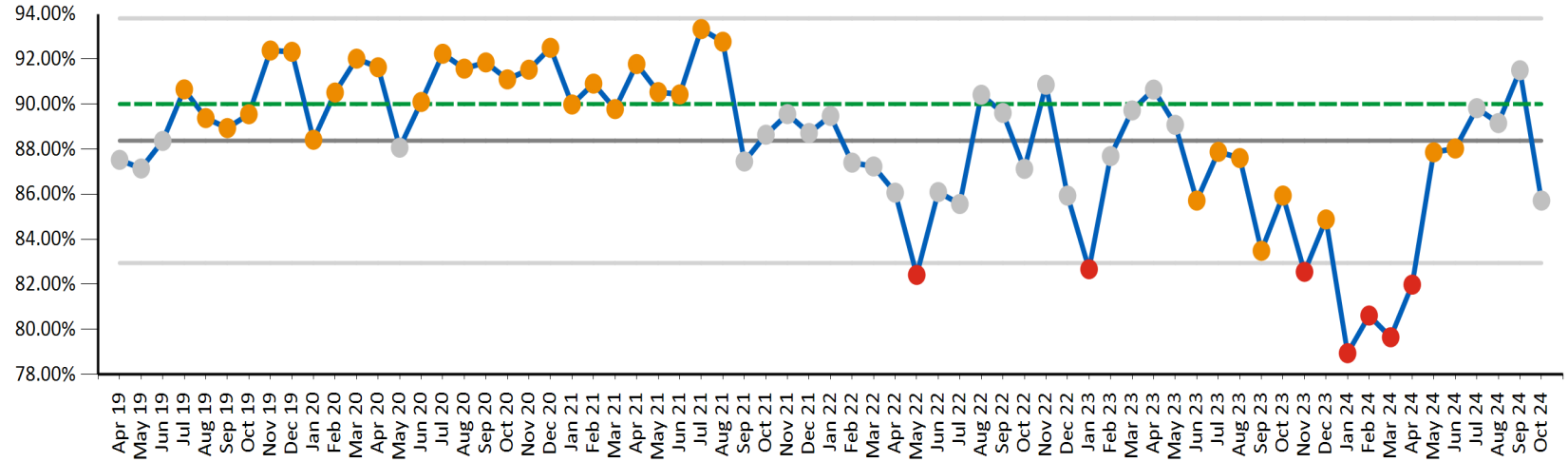
Plan	Actual
>= 95.0%	99.0%

203 - Booked 12+6

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 90.0%	85.7%	Oct-24

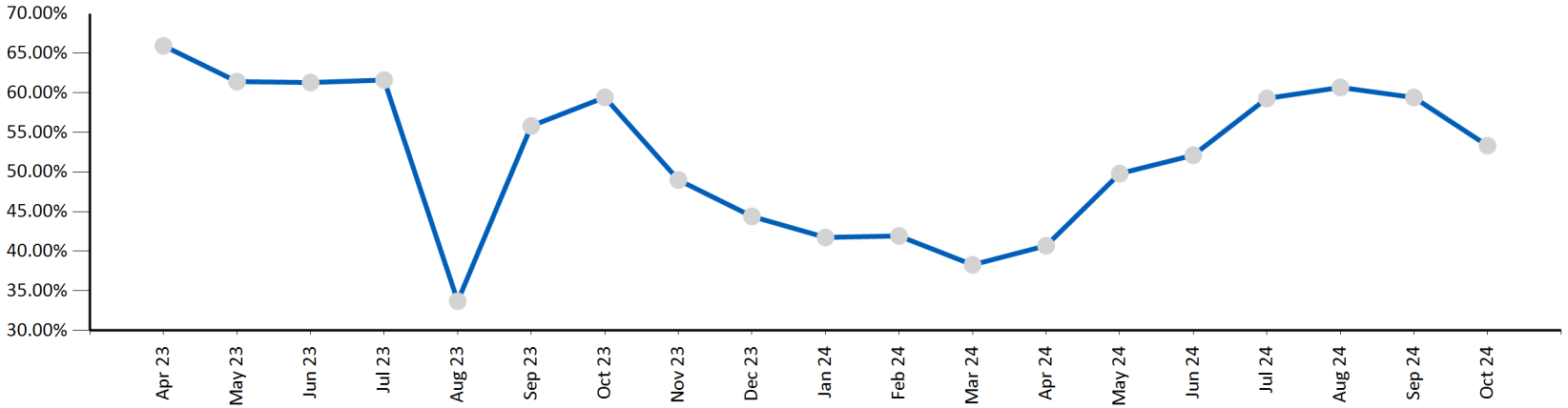
Previous

Plan	Actual	Period
>= 90.0%	91.5%	Sep-24

Year to Date

Plan	Actual
>= 90.0%	87.6%

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



Latest

Plan	Actual	Period
	53.3%	Oct-24

Previous

Plan	Actual	Period
	59.4%	Sep-24

Year to Date

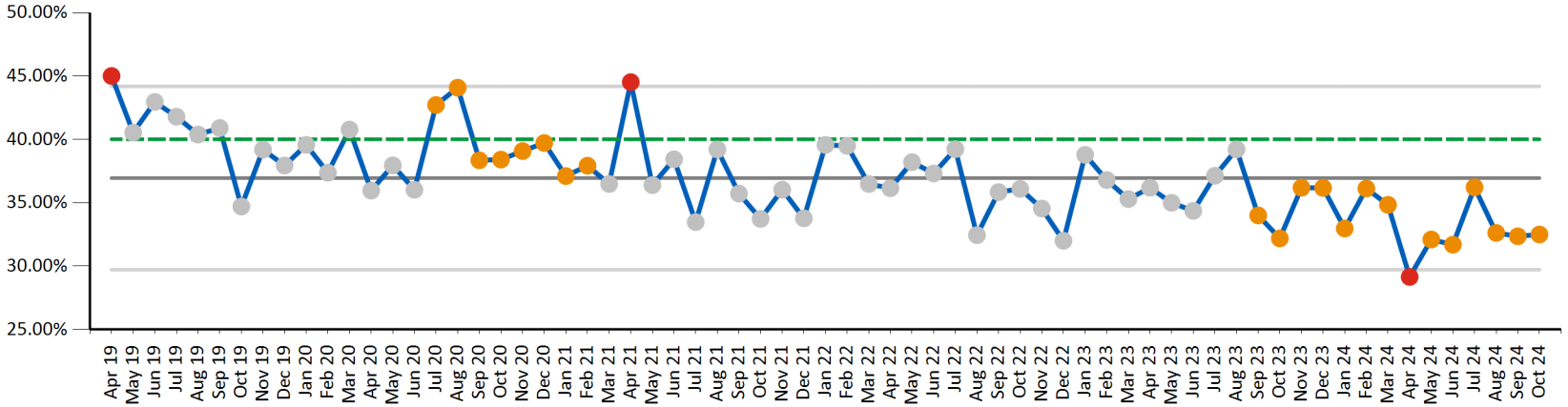
Plan	Actual
	53.4%

204 - Inductions of labour - over 24 hours

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 40%	32.5%	Oct-24

Previous

Plan	Actual	Period
<= 40%	32.3%	Sep-24

Year to Date

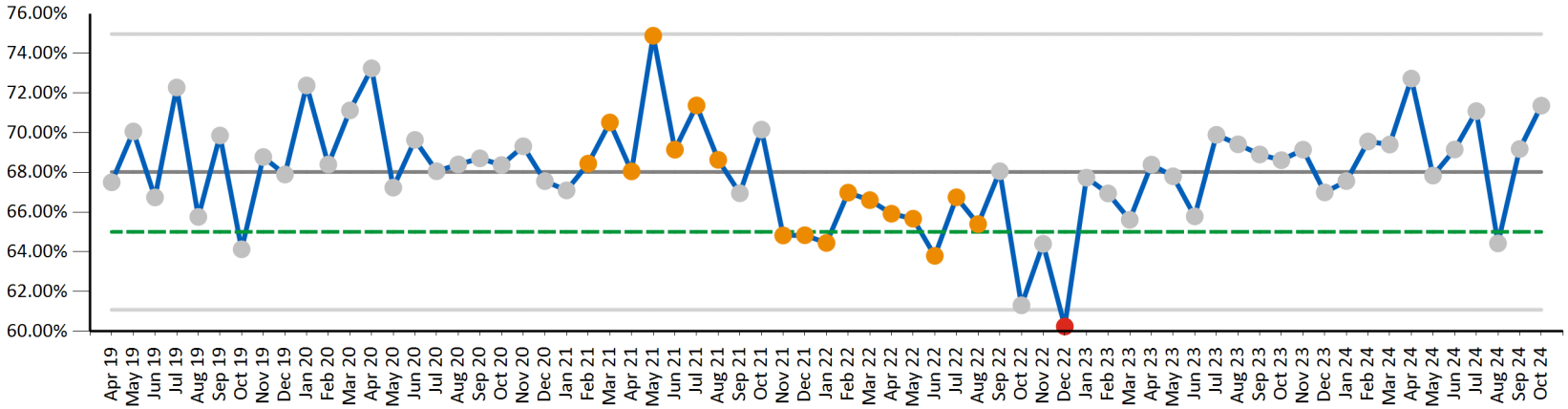
Plan	Actual
<= 40%	32.4%

210 - Initiation breast feeding

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 65%	71.36%	Oct-24

Previous

Plan	Actual	Period
>= 65%	69.18%	Sep-24

Year to Date

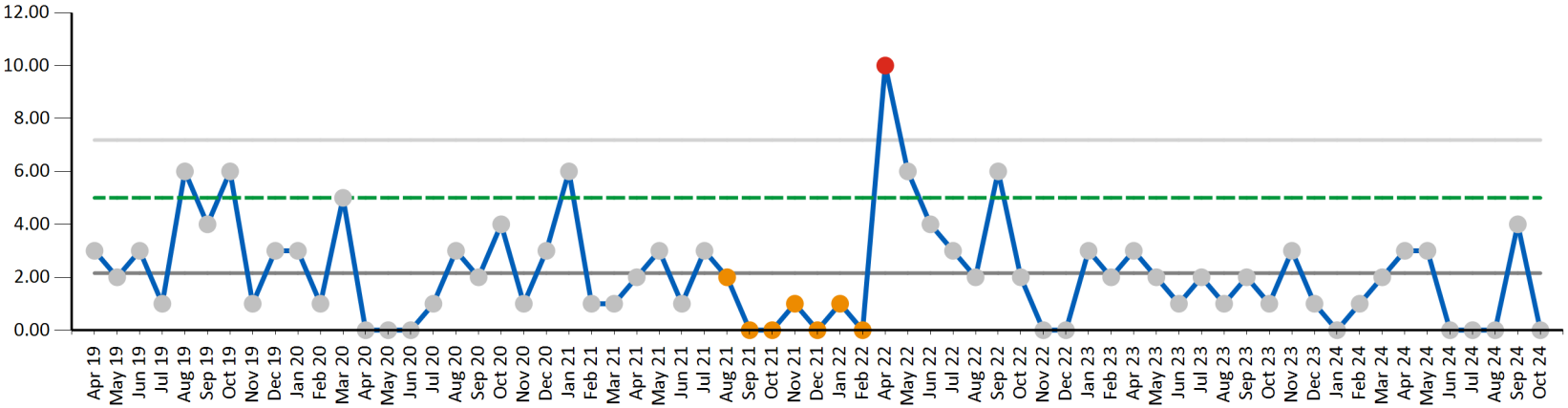
Plan	Actual
>= 65%	69.42%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	0	Oct-24

Previous

Plan	Actual	Period
<= 5	4	Sep-24

Year to Date

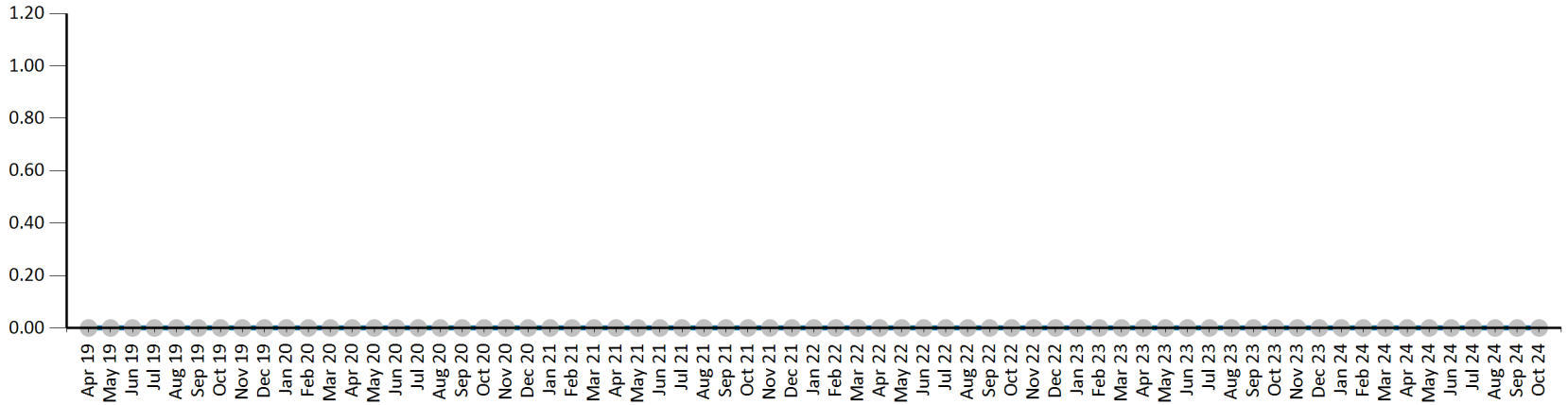
Plan	Actual
<= 35	10

319 - Maternal deaths (direct)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 0	0	Oct-24

Previous

Plan	Actual	Period
= 0	0	Sep-24

Year to Date

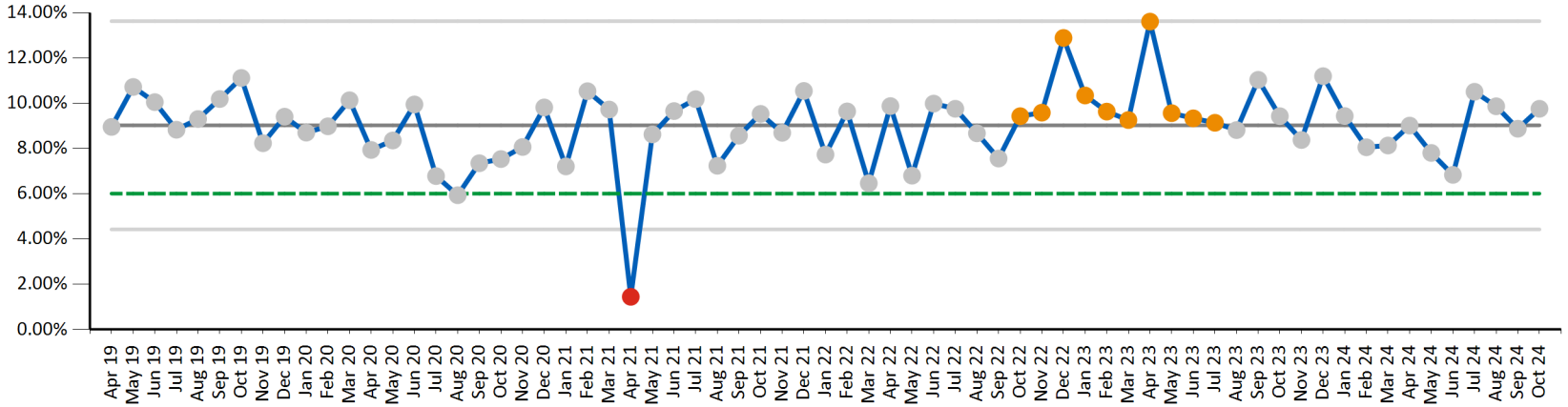
Plan	Actual
= 0	0

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%	9.8%	Oct-24

Previous

Plan	Actual	Period
<= 6%	8.9%	Sep-24

Year to Date

Plan	Actual
<= 6%	9.0%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Urgent Care

A&E performance against the 4-hour standard was 62.3% for October, this is a decrease of 3.7% from September 2024. Attendances were above normal parameters with 12,221 arrivals in October, this represents a 6.2% year-on-year increase. Ambulance handover performance within 15, 30 and 60 minutes has deteriorated in October due to significantly increased ambulance attendances with subsequent impacts upon ED capacity to off-load. Non-elective length of stay has remained static month-on-month, this represents an improvement year-on-year with length of stay generally increasing through winter due to seasonal variation in demand and acuity. Re-admission within 30 days of discharge continues to demonstrate improvement at 10.6% for the period of September.

NOF

For September, our fractured neck of femur performance was 26%, with 13 of 50 eligible patients getting to theatre within the 36 hour window.
50 patients is a significant increase on previous months' demand, which over the last 3 months has averaged closer to 35.
The vast majority of breaches continue to relate to challenges with theatre capacity, however in October 6 patients were delayed due to anti-coagulants, and a further 5 were delayed due to needing additional imaging and optimisation.
Additional assistant practitioners to extend the trauma coordinator team are being recruited, and the Division is preparing a business case to review capacity for ortho-geriatrician support and theatre capacity; demand and capacity analysis is being worked through.
Performance against the 36-hour standard remains in line with the average across the country and Bolton performs well against GM peers for several key quality metrics.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 68%	62.3%	Oct-24		>= 71%	66.0%	Sep-24	>= 68%	64.0%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	39.3%	Oct-24		>= 65.0%	55.5%	Sep-24	>= 65.0%	49.7%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	67.0%	Oct-24		>= 95.0%	82.7%	Sep-24	>= 95.0%	79.0%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	83.62%	Oct-24		= 100%	92.15%	Sep-24	= 100%	90.85%	F
539 - A&E 12 hour waits	= 0	1,395	Oct-24		= 0	1,114	Sep-24	= 0	8,351	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	26.0%	Oct-24	L	>= 75%	50.0%	Sep-24	>= 75%	33.2%	?
56 - Stranded patients - over 7 days	<= 200	290	Oct-24	H	<= 200	254	Sep-24	<= 200	290	?

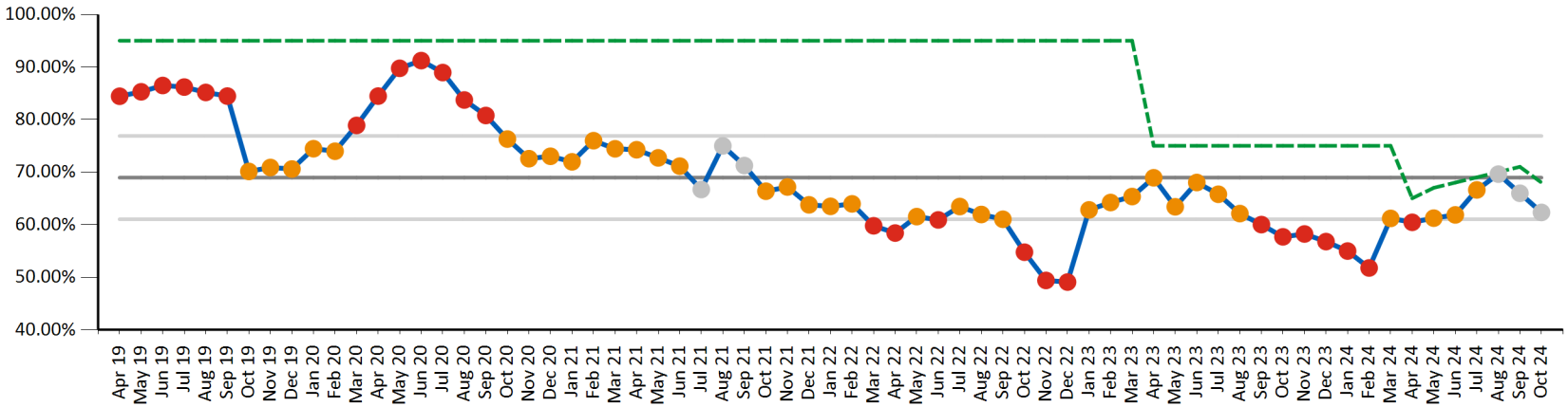
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	107	Oct-24		<= 69	103	Sep-24	<= 69	107	?
541 - Adult G&A bed occupancy	<= 92.0%	89.2%	Oct-24		<= 92.0%	87.6%	Sep-24	<= 92.0%	88.5%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.46	Oct-24		<= 3.70	5.42	Sep-24	<= 3.70	5.88	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.6%	Sep-24		<= 13.5%	11.0%	Aug-24	<= 13.5%	10.0%	P

53 - A&E 4 hour target

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 68%	62.3%	Oct-24

Previous

Plan	Actual	Period
>= 71%	66.0%	Sep-24

Year to Date

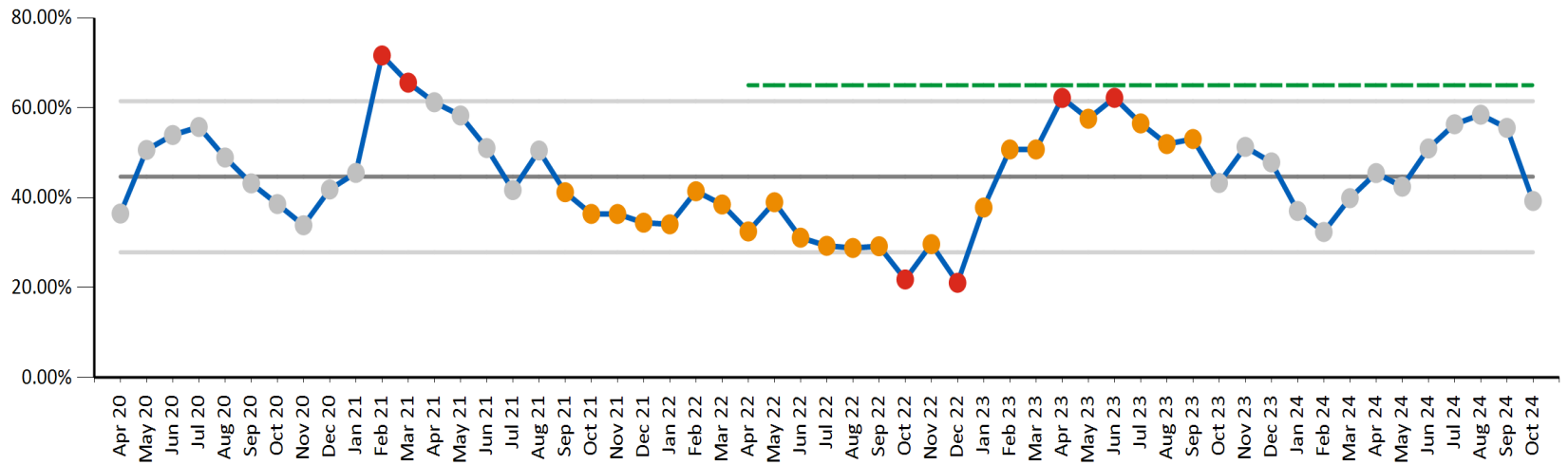
Plan	Actual
>= 68%	64.0%

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%	39.3%	Oct-24

Previous

Plan	Actual	Period
>= 65.0%	55.5%	Sep-24

Year to Date

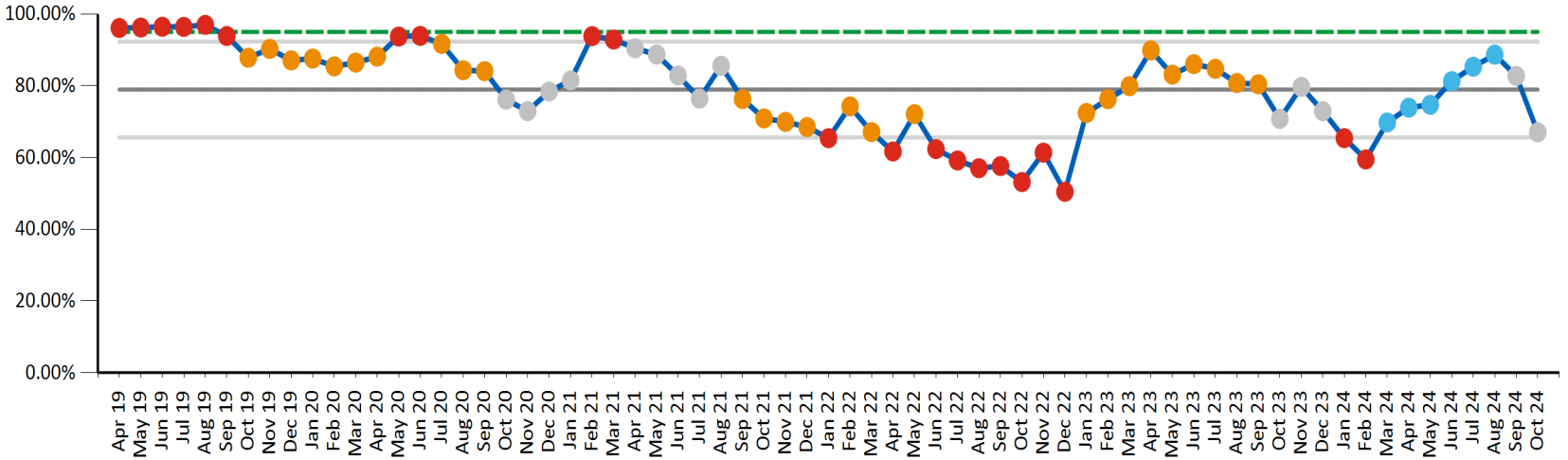
Plan	Actual
>= 65.0%	49.7%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	67.0%	Oct-24

Previous

Plan	Actual	Period
>= 95.0%	82.7%	Sep-24

Year to Date

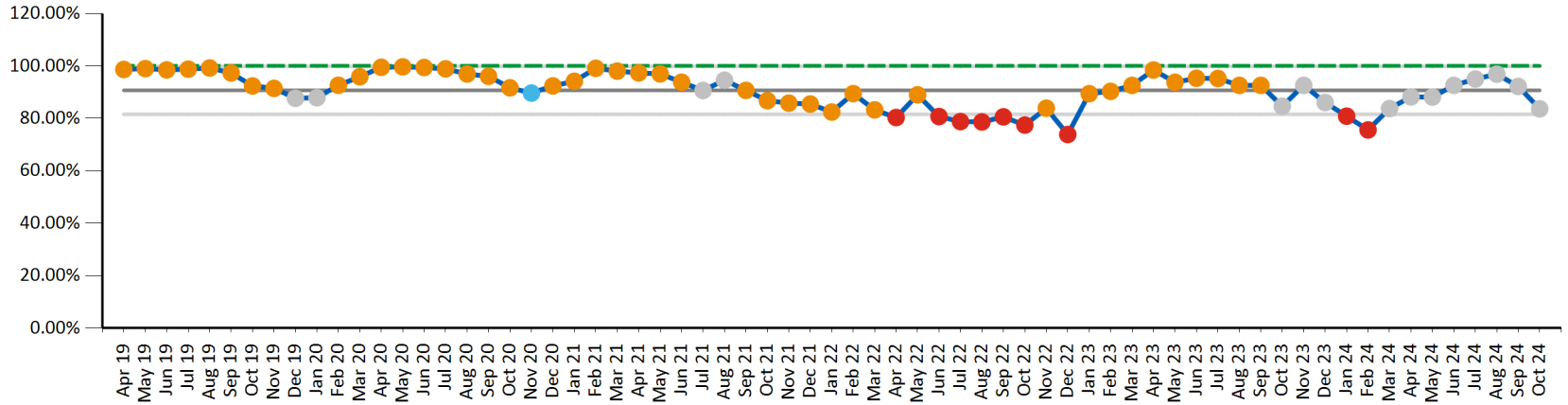
Plan	Actual
>= 95.0%	79.0%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	83.62%	Oct-24

Previous

Plan	Actual	Period
= 100%	92.15%	Sep-24

Year to Date

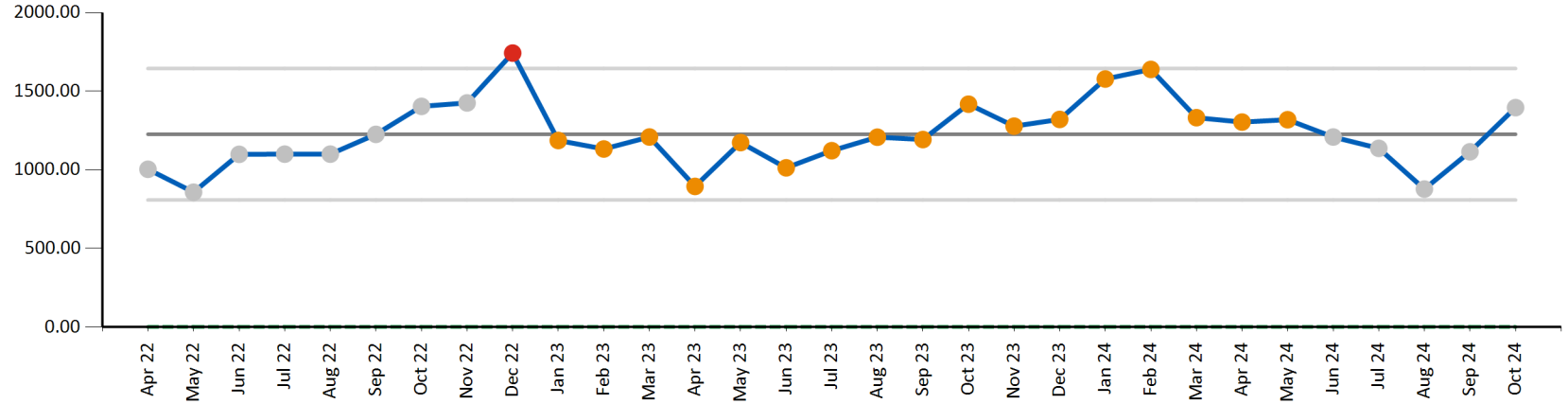
Plan	Actual
= 100%	90.85%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,395	Oct-24

Previous

Plan	Actual	Period
= 0	1,114	Sep-24

Year to Date

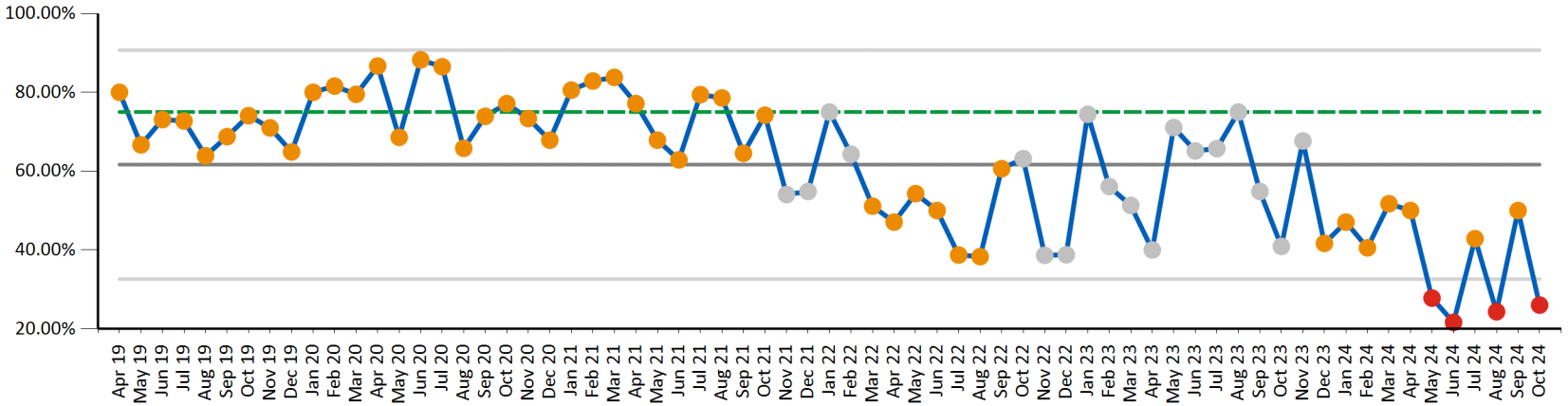
Plan	Actual
= 0	8,351

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 75%	26.0%	Oct-24

Previous

Plan	Actual	Period
>= 75%	50.0%	Sep-24

Year to Date

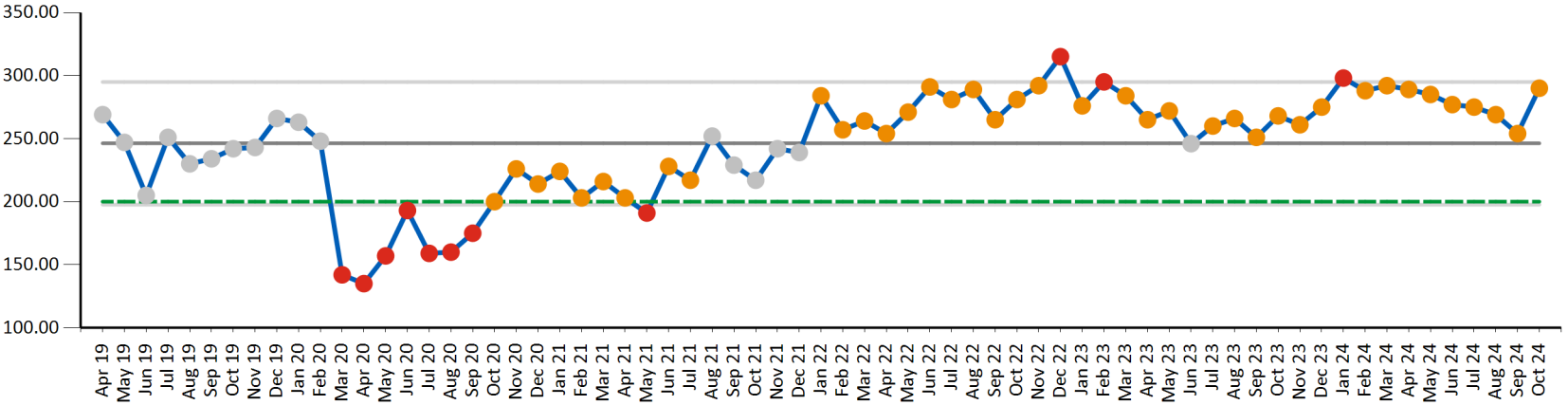
Plan	Actual
>= 75%	33.2%

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	290	Oct-24

Previous

Plan	Actual	Period
<= 200	254	Sep-24

Year to Date

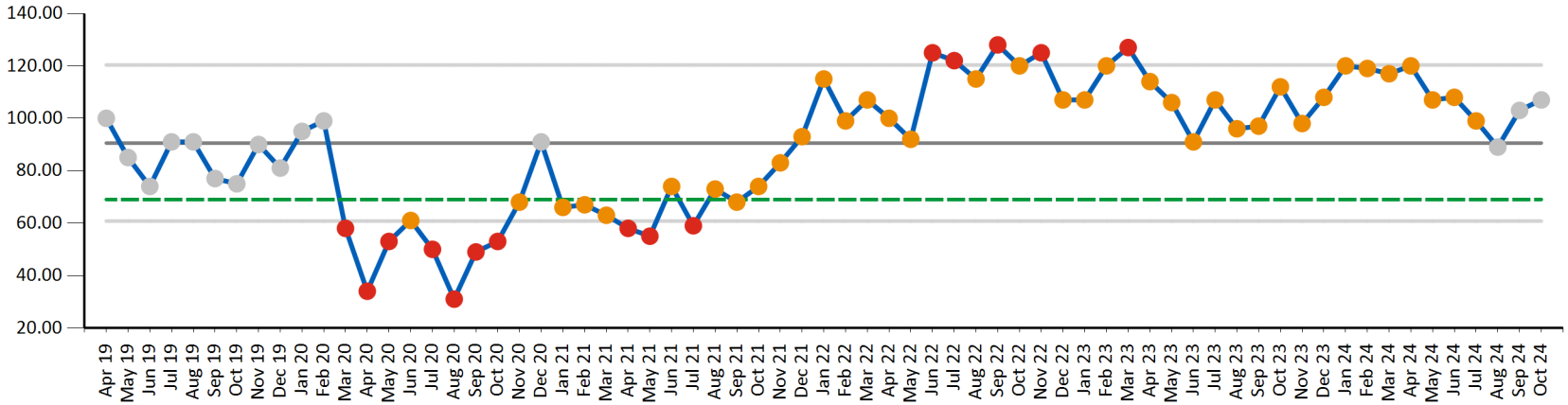
Plan	Actual
<= 200	290

307 - Stranded Patients - LOS 21 days and over

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 69	107	Oct-24

Previous

Plan	Actual	Period
<= 69	103	Sep-24

Year to Date

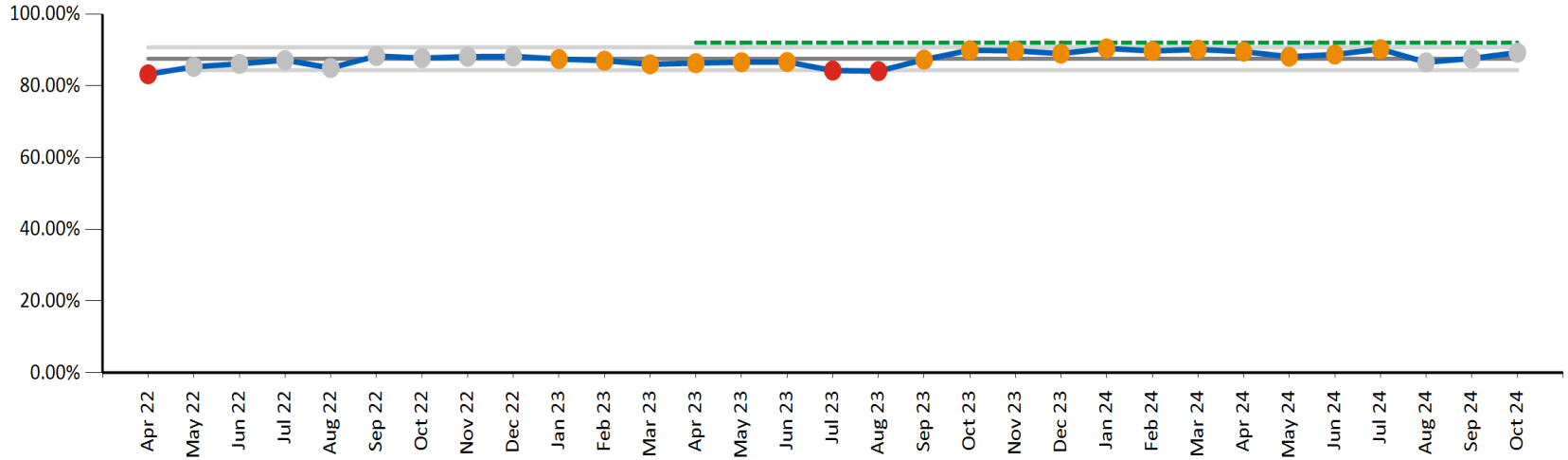
Plan	Actual
<= 69	107

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	89.2%	Oct-24

Previous

Plan	Actual	Period
<= 92.0%	87.6%	Sep-24

Year to Date

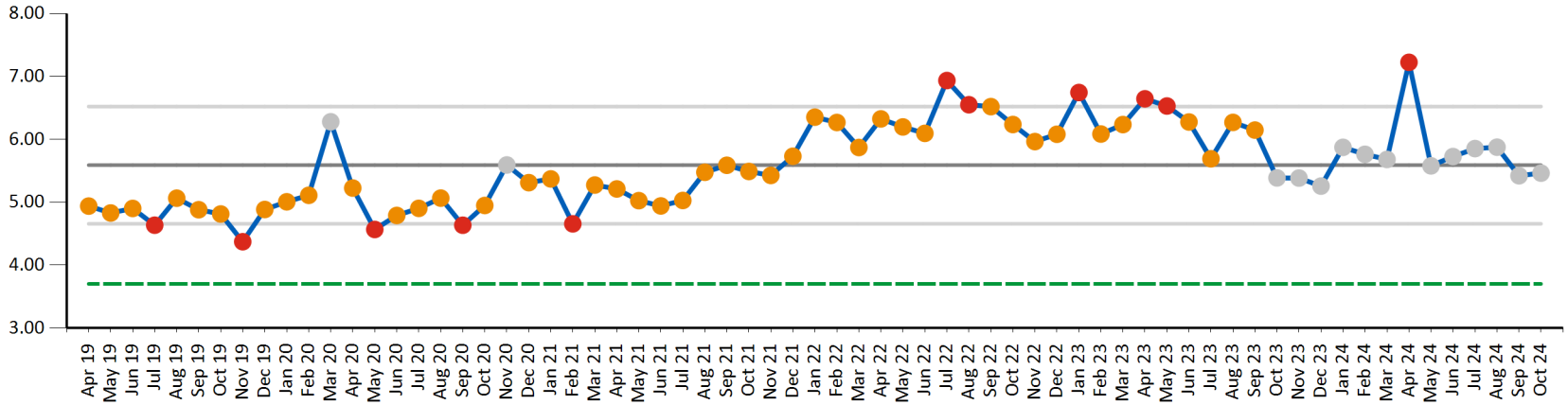
Plan	Actual
<= 92.0%	88.5%

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

Common cause variation.

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	5.46	Oct-24

Previous

Plan	Actual	Period
<= 3.70	5.42	Sep-24

Year to Date

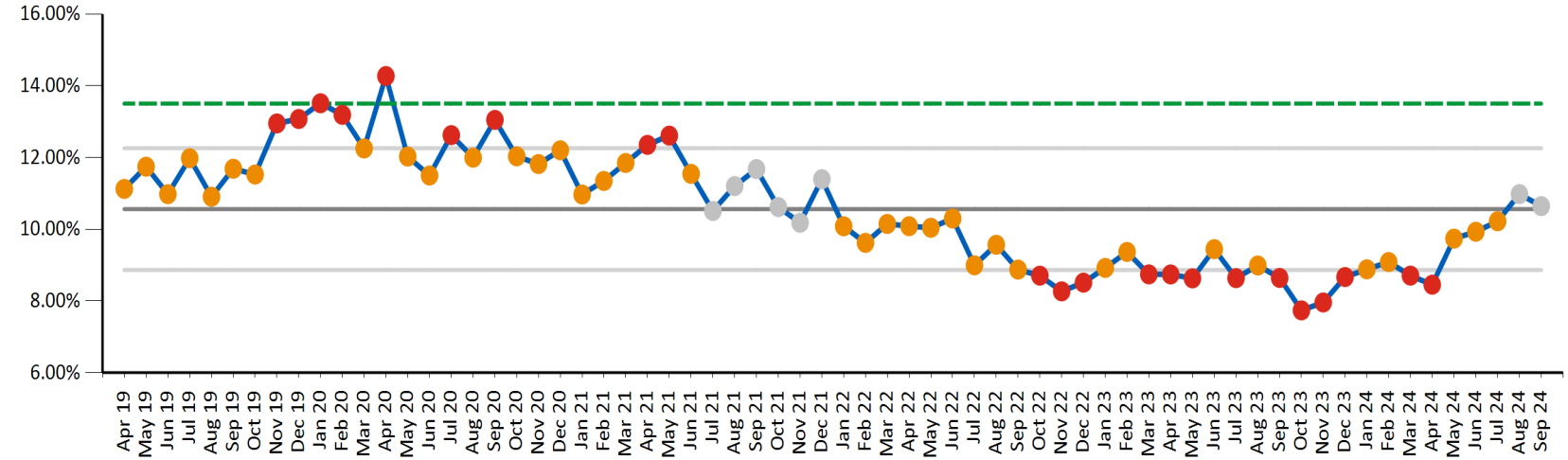
Plan	Actual
<= 3.70	5.88

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

Common cause variation.

P Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	10.6%	Sep-24

Previous

Plan	Actual	Period
<= 13.5%	11.0%	Aug-24

Year to Date

Plan	Actual
<= 13.5%	10.0%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT
We finished October with 9x 78-week breaches:
- 1 was due to patient complexity,
- 8 were patients awaiting corneal graft material.
We had 0 104-week waiters at the end of October.
We continue to work towards eliminating 78-week breaches (excluding graft patients, due to a national graft shortage) as soon as possible and maintaining that position.

We finished October with 288x 65-week breaches. While this is not in line with the target of 0 patients waiting longer than 65-weeks, our October position is in line with our position in September, and reflects our recovery trajectory. Work continues at pacepace to ensure that we can eliminate 65-week waiters as soon as possible, through mutual aid collaboration with WWL and the Beaumont, and through targeted additional activity.

DM01
The Trust position relating to the DM01 standard has improved in month by 0.5% at 12.4%. This is slightly behind our projected trajectory for recovery of 11.5% in month. There has also been a decrease in the number of patients waiting over 6 weeks for their diagnostic test by 56 patients with a reduction in the volume of patients waiting by 323. All areas except for Audiology have made positive improvements towards their recovery targets, and with a built in tolerance we still remain on track to recover prior to the national target in March 25. Our best case recovery will be January 25, likely recovery will be February 25. Audiology are finalising additional capacity arrangement to realign with the original recovery plan.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	53.0%	Oct-24	L	>= 92%	52.3%	Sep-24	>= 92%	51.0%	F
314 - RTT 18 week waiting list	<= 28,364	42,838	Oct-24	H	<= 28,514	43,332	Sep-24	<= 28,364	42,838	F
42 - RTT 52 week waits (incomplete pathways)		2,229	Oct-24	H		2,357	Sep-24		21,227	
540 - RTT 65 week waits (incomplete pathways)	= 0	288	Oct-24	L	= 0	284	Sep-24	<= 4,613	4,441	F
526 - RTT 78 week waits (incomplete pathways)	= 0	9	Oct-24	L	= 0	15	Sep-24	= 0	128	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Oct-24	L	= 0	0	Sep-24	= 0	1	F
72 - Diagnostic Waits >6 weeks %	<= 5%	12.5%	Oct-24	L	<= 5%	12.9%	Sep-24	<= 5%	12.7%	F

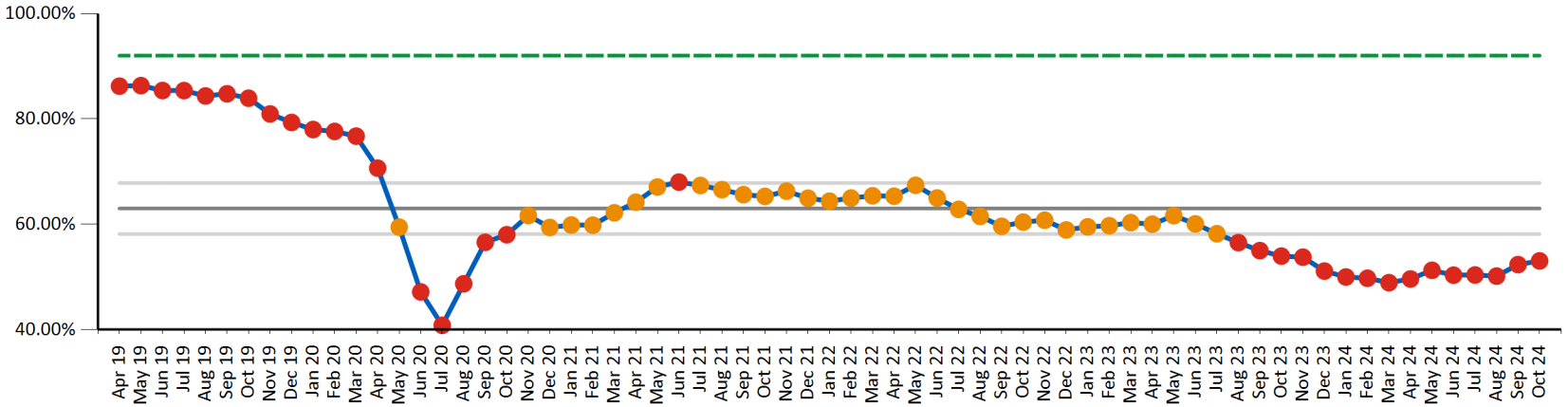
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
489 - Daycase Rates	>= 85%	82.6%	Oct-24		>= 85%	82.3%	Sep-24	>= 85%	82.6%	
582 - Theatre Utilisation - Capped		91.6%	Oct-24			72.2%	Sep-24		76.9%	
583 - Theatre Utilisation - Uncapped		96.9%	Oct-24			75.5%	Sep-24		81.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.0%	Oct-24		<= 1%	2.5%	Sep-24	<= 1%	1.6%	
62 - Cancelled operations re-booked within 28 days	= 100%	80.3%	Sep-24		= 100%	60.0%	Aug-24	= 100%	27.8%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.30	Jul-24		<= 2.00	2.70	Jun-24	<= 2.00	3.03	
309 - DNA Rate - New	<= 6.3%	9.1%	Oct-24		<= 6.3%	9.5%	Sep-24	<= 6.3%	9.8%	
310 - DNA Rate - Follow up	<= 5.0%	8.2%	Oct-24		<= 5.0%	8.7%	Sep-24	<= 5.0%	8.8%	

41 - RTT Incomplete pathways within 18 weeks %

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	53.0%	Oct-24

Previous

Plan	Actual	Period
>= 92%	52.3%	Sep-24

Year to Date

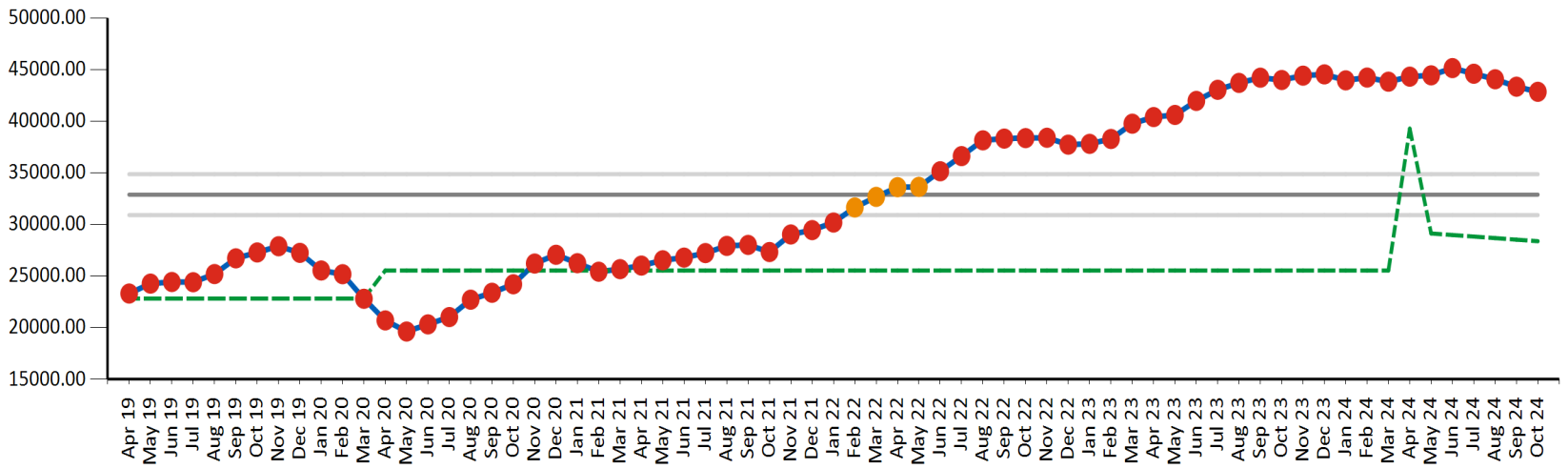
Plan	Actual
>= 92%	51.0%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 28,364	42,838	Oct-24

Previous

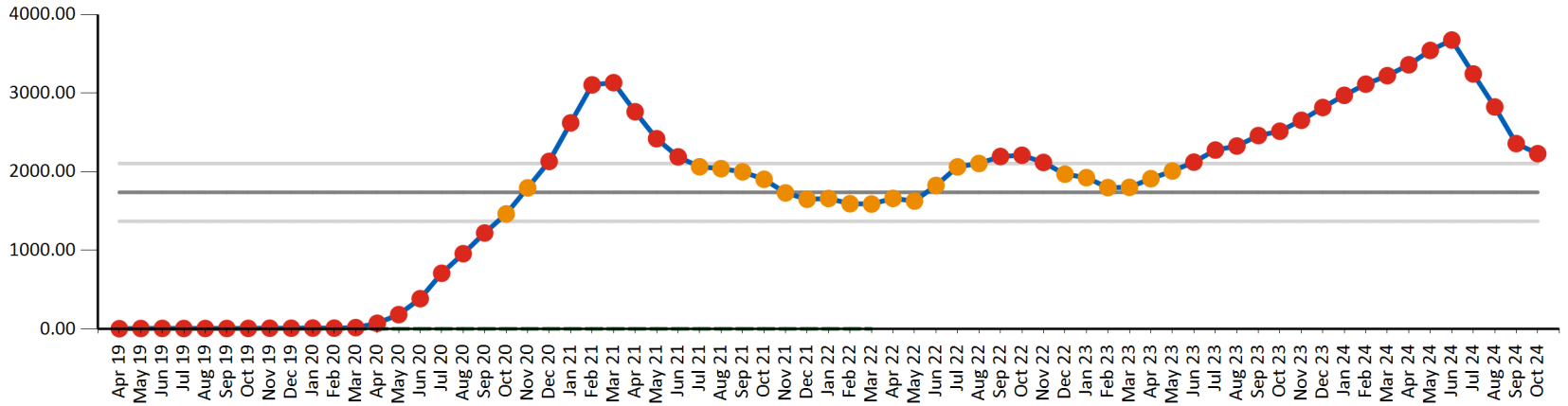
Plan	Actual	Period
<= 28,514	43,332	Sep-24

Year to Date

Plan	Actual
<= 28,364	42,838

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	2,229	Oct-24

Previous

Plan	Actual	Period
	2,357	Sep-24

Year to Date

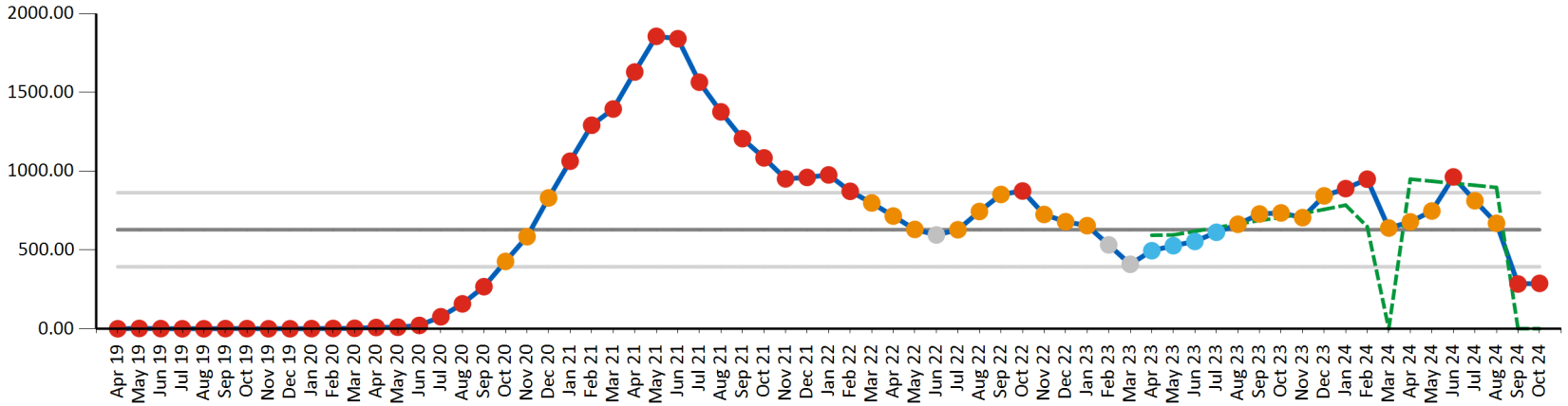
Plan	Actual
	21,227

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

3/6



Latest

Plan	Actual	Period
= 0	288	Oct-24

Previous

Plan	Actual	Period
= 0	284	Sep-24

Year to Date

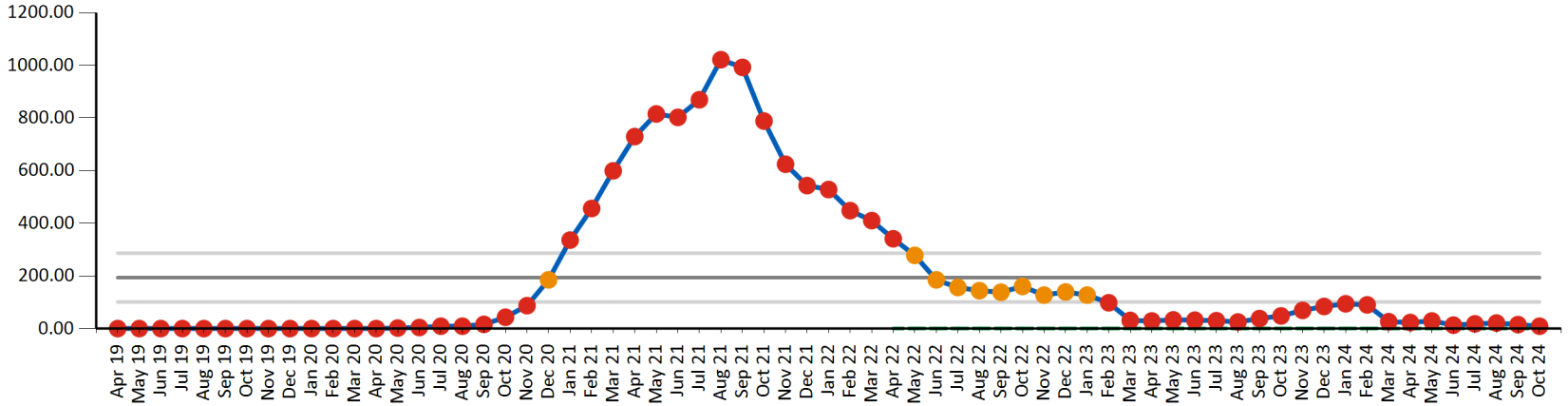
Plan	Actual
< = 4,613	4,441

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	9	Oct-24

Previous

Plan	Actual	Period
= 0	15	Sep-24

Year to Date

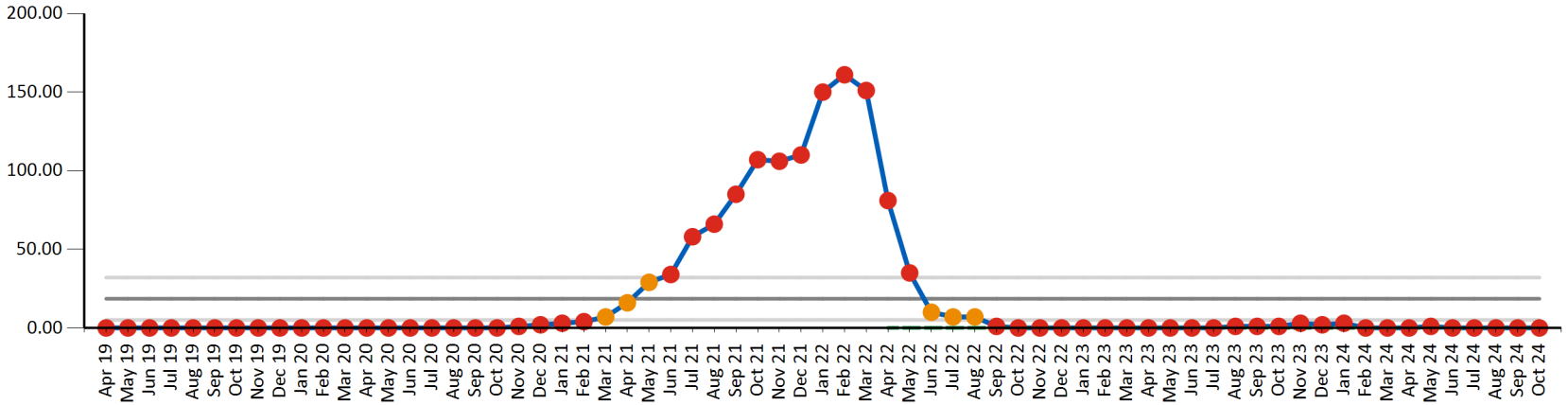
Plan	Actual
= 0	128

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
= 0	0	Oct-24

Previous

Plan	Actual	Period
= 0	0	Sep-24

Year to Date

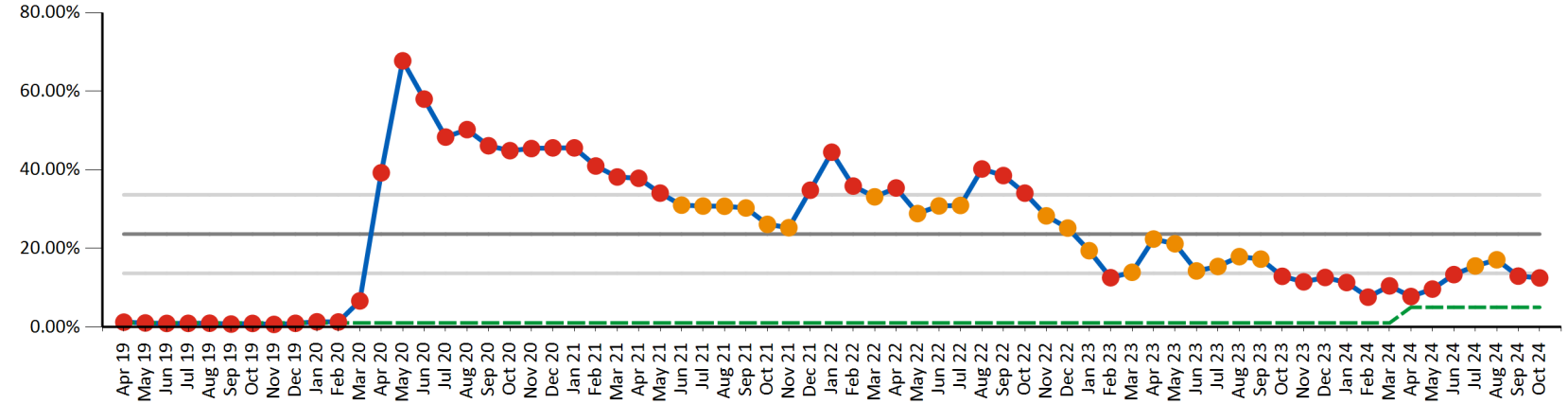
Plan	Actual
= 0	1

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5%	12.5%	Oct-24

Previous

Plan	Actual	Period
<= 5%	12.9%	Sep-24

Year to Date

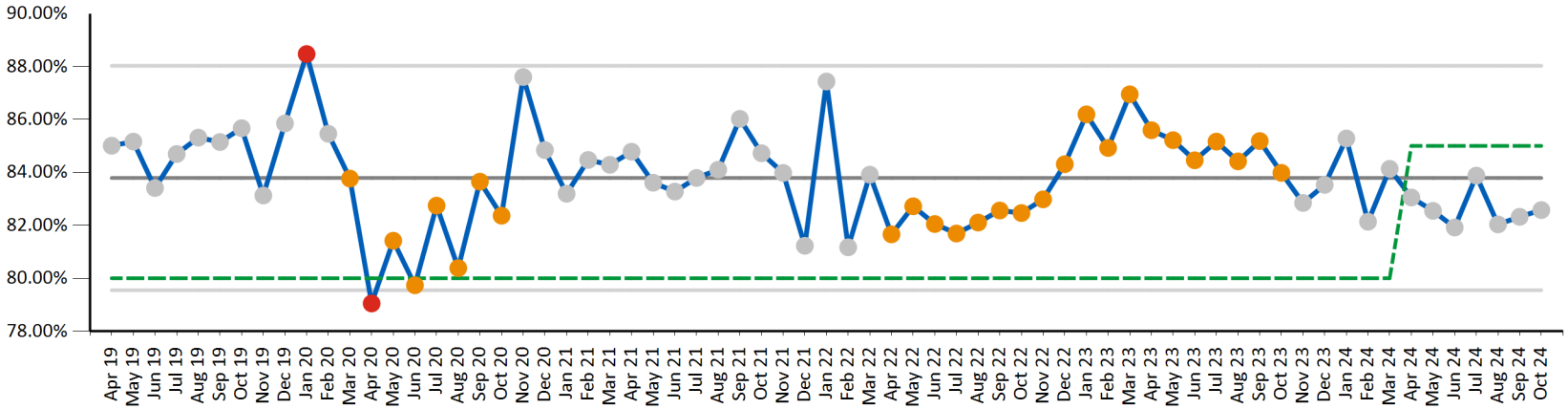
Plan	Actual
<= 5%	12.7%

489 - Daycase Rates

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 85%	82.6%	Oct-24

Previous

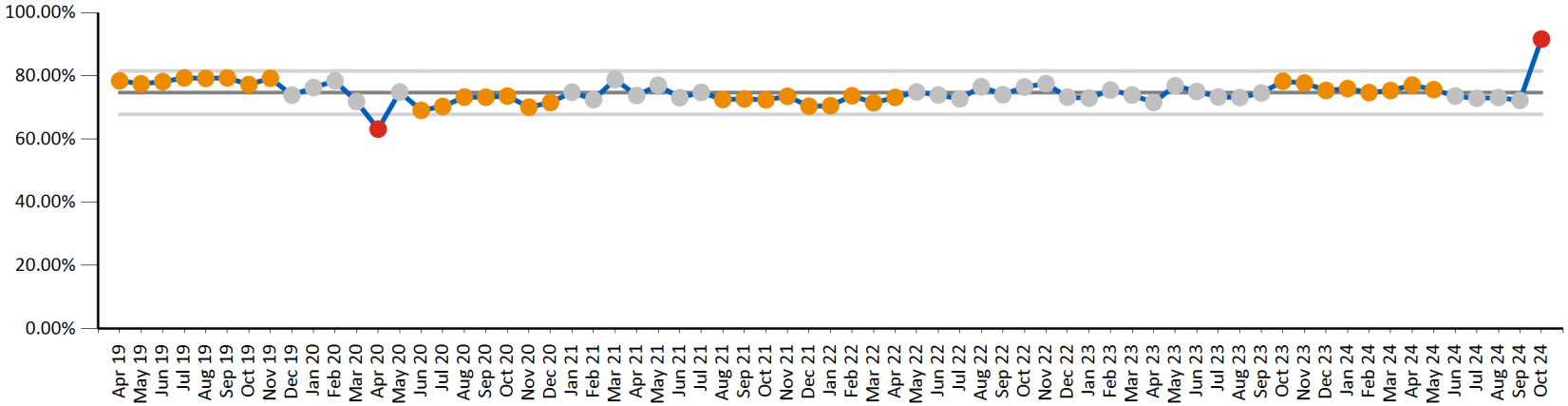
Plan	Actual	Period
>= 85%	82.3%	Sep-24

Year to Date

Plan	Actual
>= 85%	82.6%

582 - Theatre Utilisation - Capped

Special cause variation with improving performance



Latest

Plan	Actual	Period
	91.6%	Oct-24

Previous

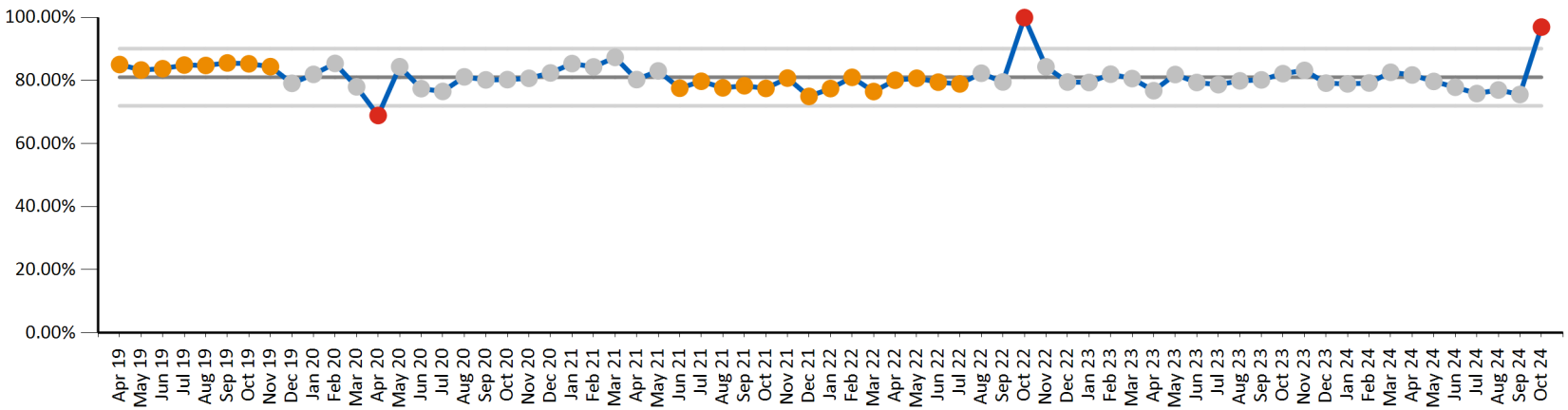
Plan	Actual	Period
	72.2%	Sep-24

Year to Date

Plan	Actual
	76.9%

583 - Theatre Utilisation - Uncapped

Special cause variation with improving performance



Latest

Plan	Actual	Period
	96.9%	Oct-24

Previous

Plan	Actual	Period
	75.5%	Sep-24

Year to Date

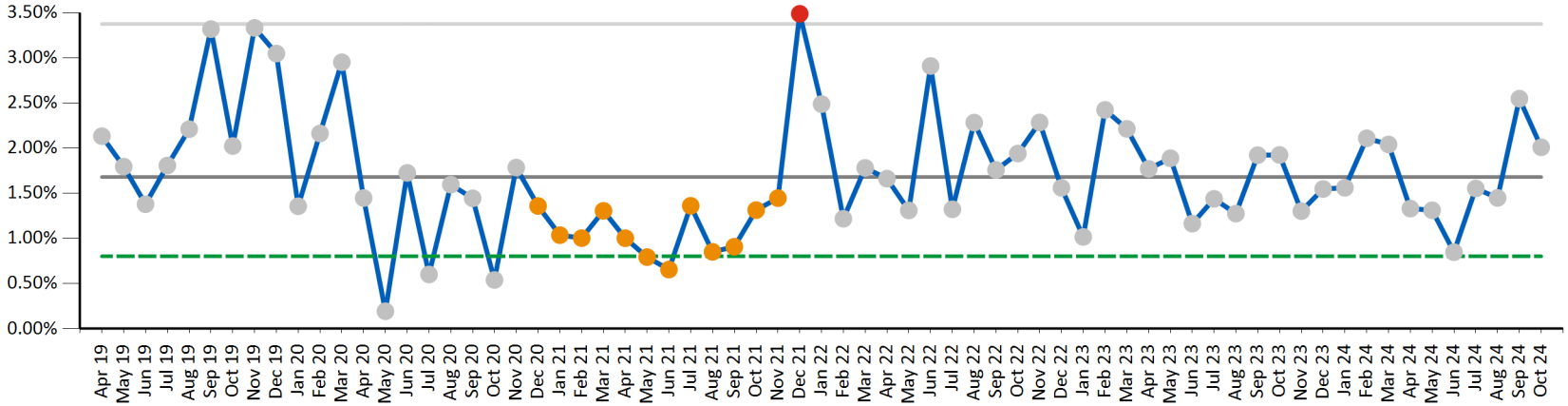
Plan	Actual
	81.0%

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%	Oct-24

Previous

Plan	Actual	Period
<= 1%	2.5%	Sep-24

Year to Date

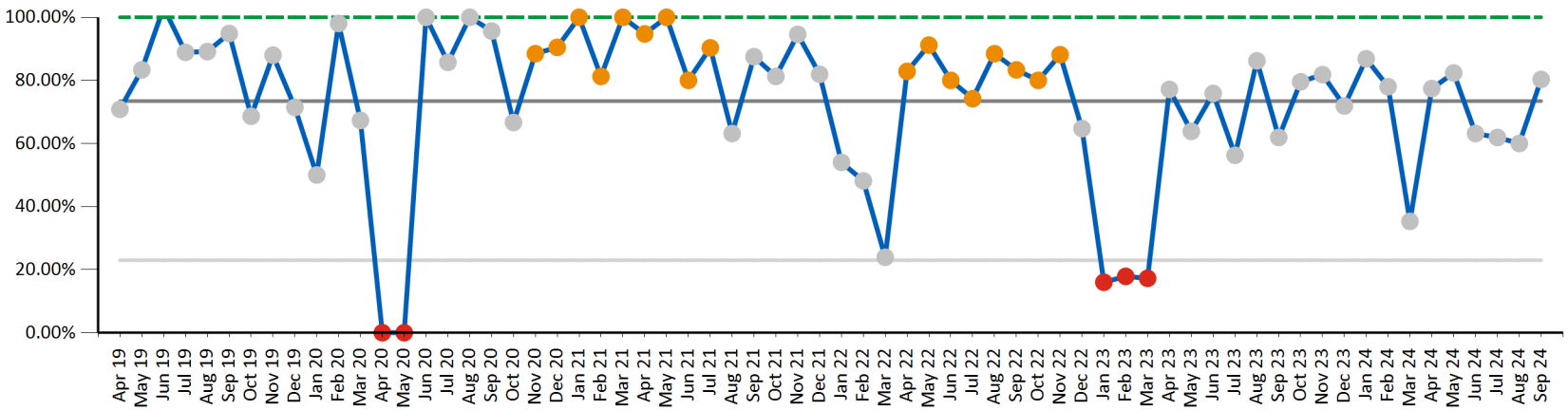
Plan	Actual
<= 1%	1.6%

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%	80.3%	Sep-24

Previous

Plan	Actual	Period
= 100%	60.0%	Aug-24

Year to Date

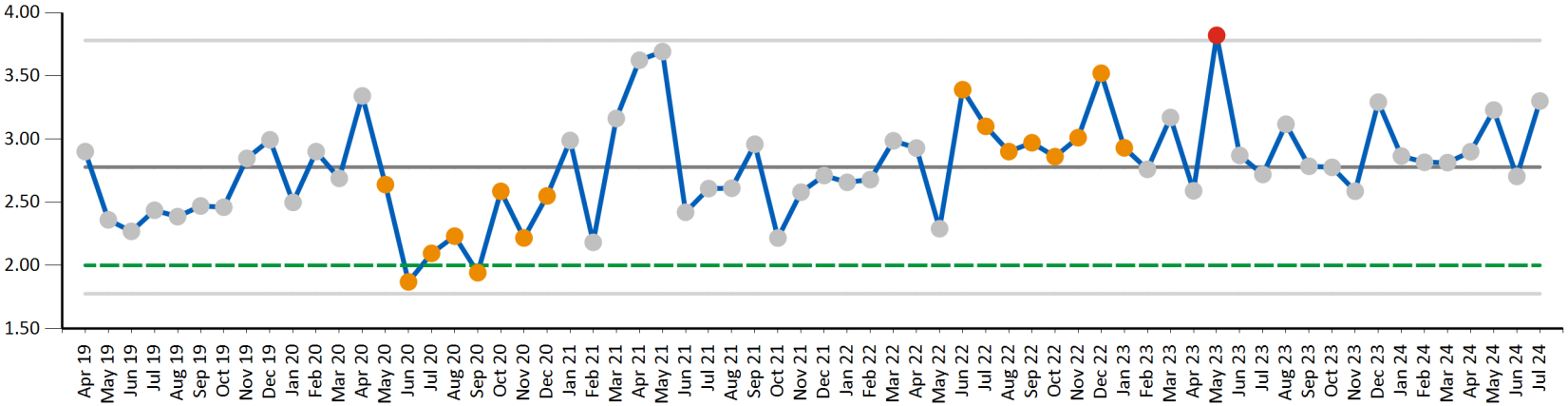
Plan	Actual
= 100%	27.8%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	3.30	Jul-24

Previous

Plan	Actual	Period
<= 2.00	2.70	Jun-24

Year to Date

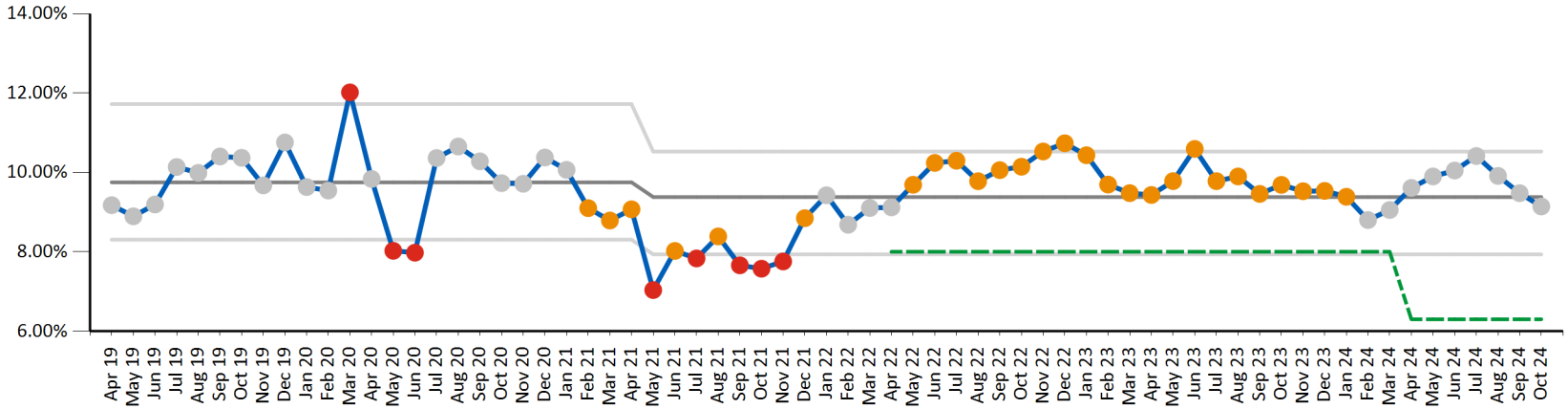
Plan	Actual
<= 2.00	3.03

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.1%	Oct-24

Previous

Plan	Actual	Period
<= 6.3%	9.5%	Sep-24

Year to Date

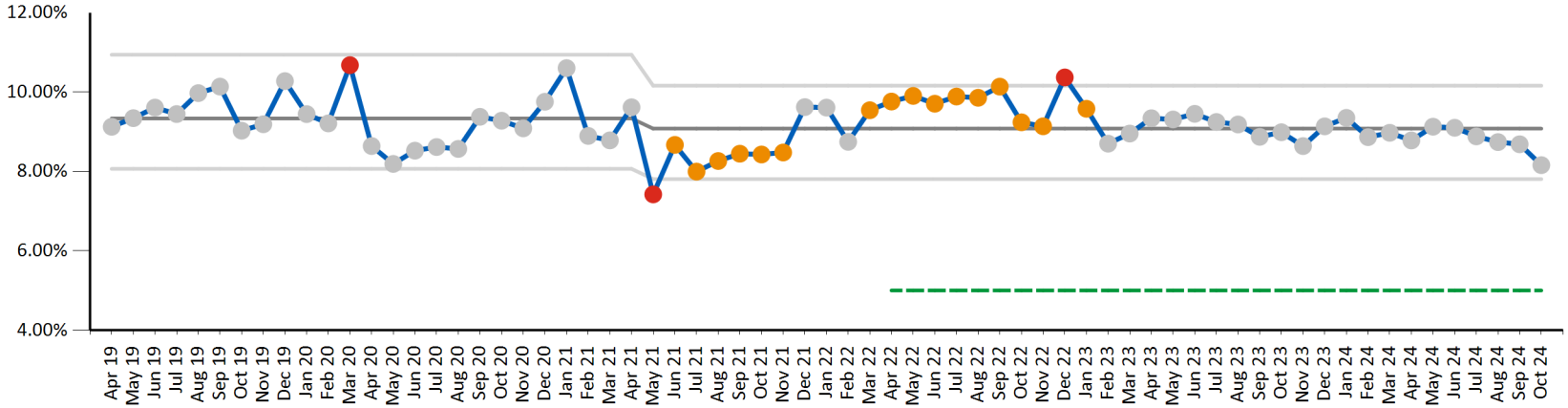
Plan	Actual
<= 6.3%	9.8%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.2%	Oct-24

Previous

Plan	Actual	Period
<= 5.0%	8.7%	Sep-24

Year to Date

Plan	Actual
<= 5.0%	8.8%

Operational Performance - Cancer

Bolton NHS Foundation Trust

For September, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We also achieved performance the 62-day standard, and it is expected that we will achieve performance in October.

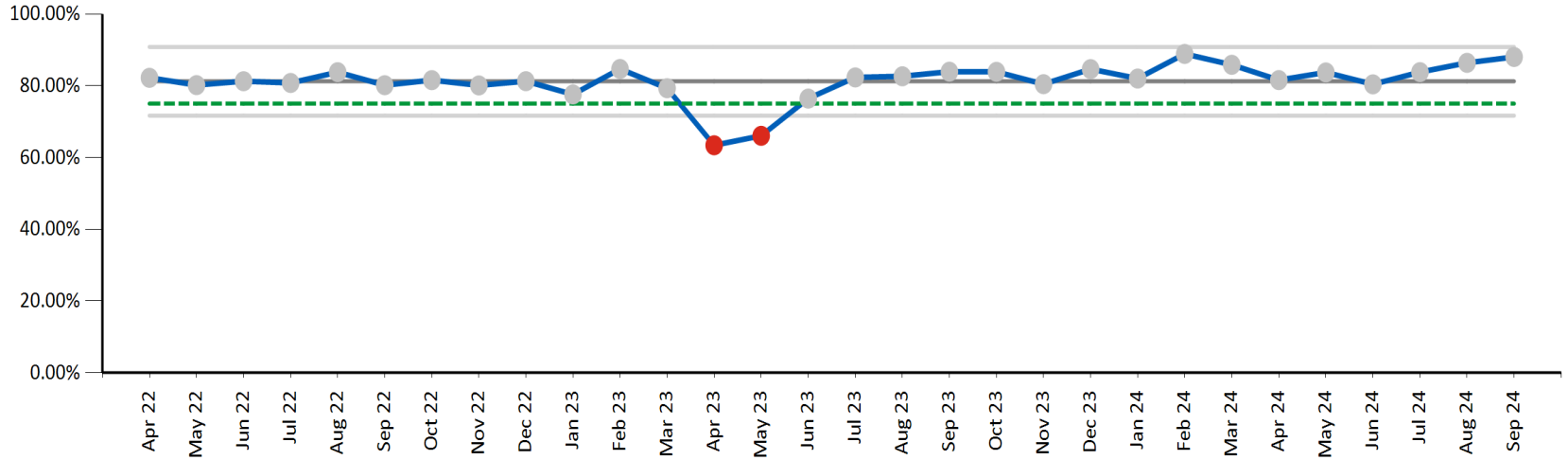
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	88.0%	Sep-24		>= 75.0%	86.4%	Aug-24	>= 75.0%	83.9%	
584 - 31 Day General Treatment Standard	>= 96%	99.2%	Sep-24		>= 96%	98.5%	Aug-24	>= 96%	98.8%	
585 - 62 Day General Standard	>= 85%	86.6%	Sep-24		>= 85%	87.4%	Aug-24	>= 85%	82.8%	

542 - Cancer: 28 day faster diagnosis

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	88.0%	Sep-24

Previous

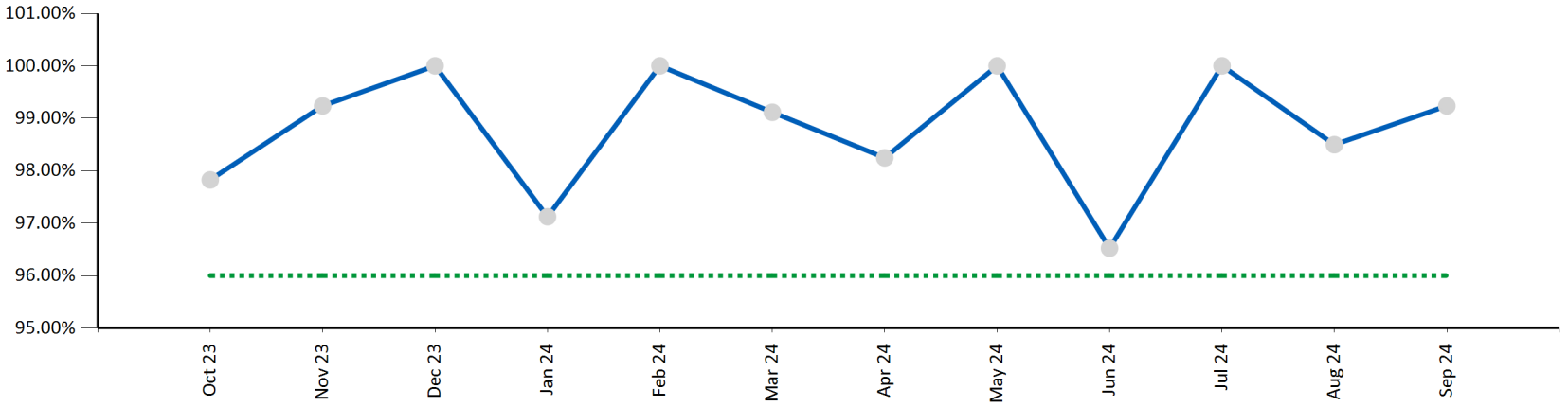
Plan	Actual	Period
>= 75.0%	86.4%	Aug-24

Year to Date

Plan	Actual
>= 75.0%	83.9%

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

6/6



Latest

Plan	Actual	Period
>= 96%	99.2%	Sep-24

Previous

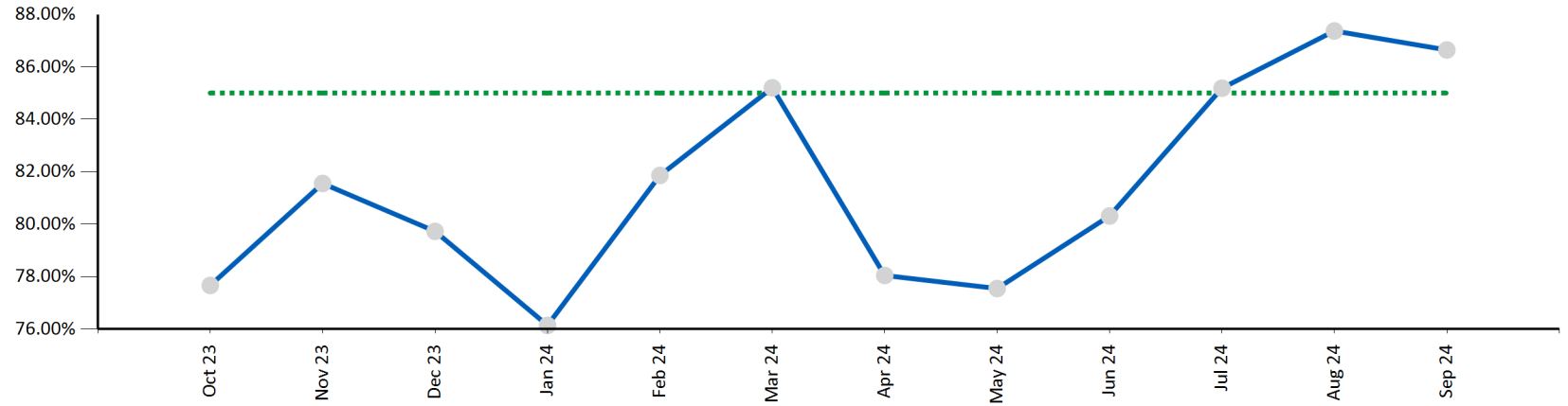
Plan	Actual	Period
>= 96%	98.5%	Aug-24

Year to Date

Plan	Actual
0.96	98.8%

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

3/6



Latest

Plan	Actual	Period
>= 85%	86.6%	Sep-24

Previous

Plan	Actual	Period
>= 85%	87.4%	Aug-24

Year to Date

Plan	Actual
0.85	82.8%

Operational Performance - Community Care

Bolton NHS Foundation Trust

Emergency Department deflections

As forecasted, ED deflections for Month 7 have increased to 598, remaining above the plan of 400. The number of deflections has continued to remain above 500 and this demonstrates the impact of the continued work by the Admission Avoidance Team in relation to promotion of 2hr Urgent Care Response and pathways into the service from North West Ambulance Service, Primary Care and Care Homes. Work is ongoing support ED deflections, use of the Admission Avoidance Team 30 day readmission pathway and a wider focus on the top ten care homes with high attendances to ED and NWAS callouts. Further improvements to ED deflections are expected incrementally over the remainder of the year as the team develop an improvement plan based upon nationally mandated criteria of 157 referrals per 100,000 population per month for 2 hr UCR.

NCTR

The monthly average number of patients with No Criteria to Reside has reduced by 14, below our operating plan at an average of 84 across the month. Delayed bed days has also reduced to 628 in month 7. For context this remains a reduction on 912 at Month 2 and this has been a result of progress with implementation of the NCTR Urgent Care Improvement Group actions, along with the previously mentioned coding change for patients awaiting mental health liaison interventions.

The NCTR recovery plan and UCIG NCTR actions are ongoing alongside additional improvement schemes identified during September's Greater Manchester super multi agency discharge event. We continue to work with partners across GM localities due to the high numbers of patients residing in the hospital who don't live in Bolton.

Into November we expect to maintain below our operating target, however two spikes in additions to the NCTR will result in a levelling off of improvement over previous months. For context, from mid-October to mid-November, Bolton is the only locality in GM to remain below locality NCTR target. Ahead into December we are pleased to be working in partnership with the local authority to open Millview care home. This will provide an overall capacity of 20 beds outside of hospital, as well as co-locating many patients from multiple purchased spot beds across the borough.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts in Month 7 was 81% compared to 77% in Month 6 (4% increase). Mandated contacts continue to recover slowly. Underperformance remains due to staffing challenges within the 0-19 service, in particular due to a shortage of Health Visitors (nationally). Health visitor vacancies are still causing pressures and this has been recorded on the divisional risk register (risk 6036).

EHCP compliance

EHCP compliance in Month 7 fell to 32% compared to 96% in Month 6. There has been significant sickness and turnover within the team in Month 7 alongside annual leave resulting in backlog of referrals and temporary staffing is being used to backfill. This temporary staffing will be increased throughout November and recruitment has been completed with an EHCP co-ordinator starting in December.

Looked after Children

Performance continues to be strong across our Looked After Children (LAC) pathways and there has been further improvement in October.

- Performance for review health assessments was 92% in Month 7 compared to 90% in Month 5 (2% increase), 63 due 58 completed in timescale (larger volume from last month). The 5 breaches have been reviewed and were outside of service control.
- Initial Assessments in Month 7 were 100%, up from 97% in Month 6 (3% increase).
- Special school reviews have dropped to 86% in Month 7, down from 100% in Month 6 (14% decrease). Analysis of the 3 breaches shows all 3 were due to delays in receiving paperwork that were outside of service control.

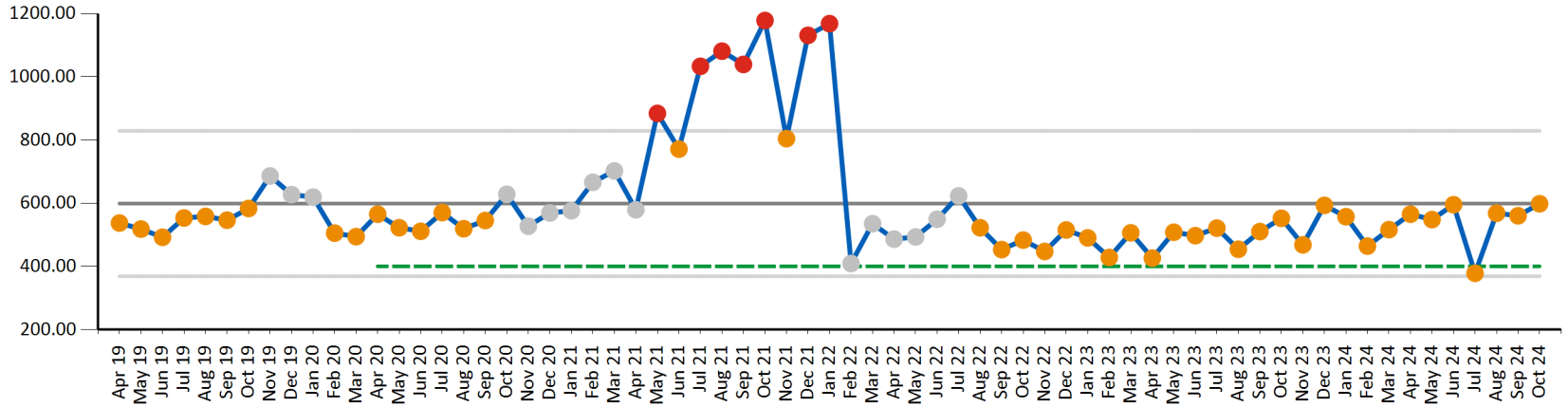
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
334 - Total Deflections from ED	>= 400	598	Oct-24	L	>= 400	560	Sep-24	>= 2,800	3,812	?
493 - Average Number of Patients: with no Criteria to Reside	<= 95	84	Oct-24		<= 94	98	Sep-24	<= 95	84	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	628	Oct-24		<= 360	781	Sep-24	<= 2,520	5,502	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	80%	Oct-24		>= 95%	81%	Sep-24	>= 95%	75%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	32%	Oct-24	L	>= 95%	96%	Sep-24	>= 95%	77%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	92.0%	Oct-24		>= 90.0%	90.0%	Sep-24	>= 90.0%		?
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	100.0%	Oct-24		>= 90.0%	97.0%	Sep-24	>= 90.0%		?
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	86.0%	Oct-24		>= 90.0%	100.0%	Sep-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.

5/6



Latest

Plan	Actual	Period
>= 400	598	Oct-24

Previous

Plan	Actual	Period
>= 400	560	Sep-24

Year to Date

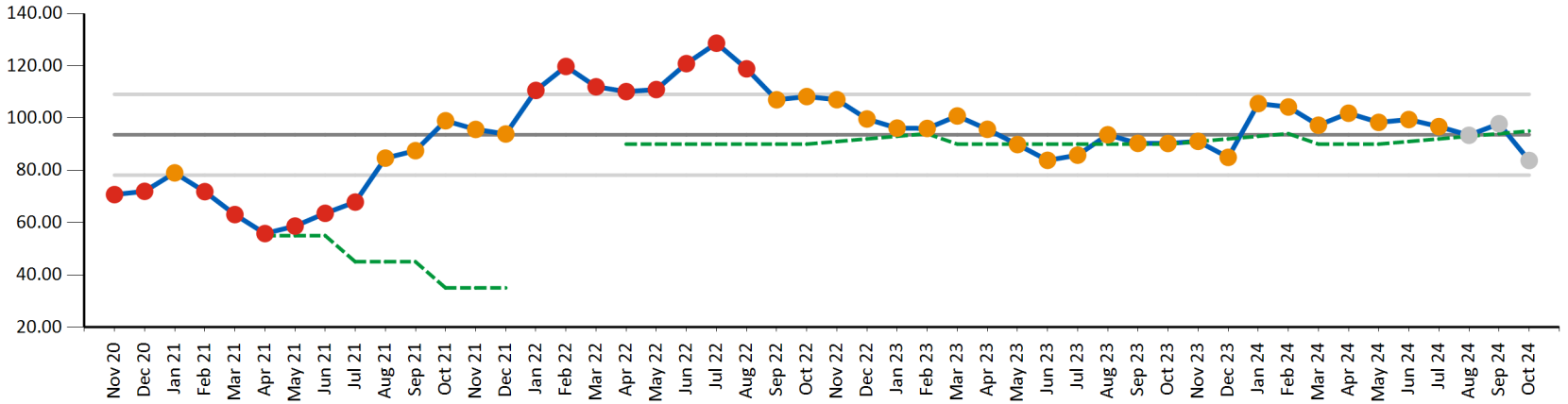
Plan	Actual
>= 2,800	3,812

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 95	84	Oct-24

Previous

Plan	Actual	Period
<= 94	98	Sep-24

Year to Date

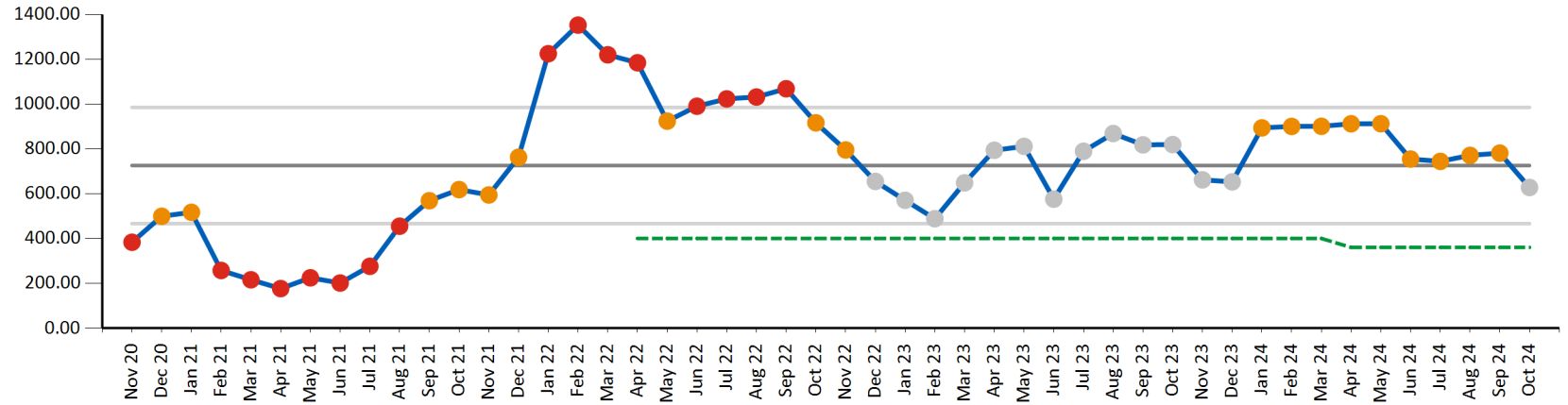
Plan	Actual
<= 95	84

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	628	Oct-24

Previous

Plan	Actual	Period
<= 360	781	Sep-24

Year to Date

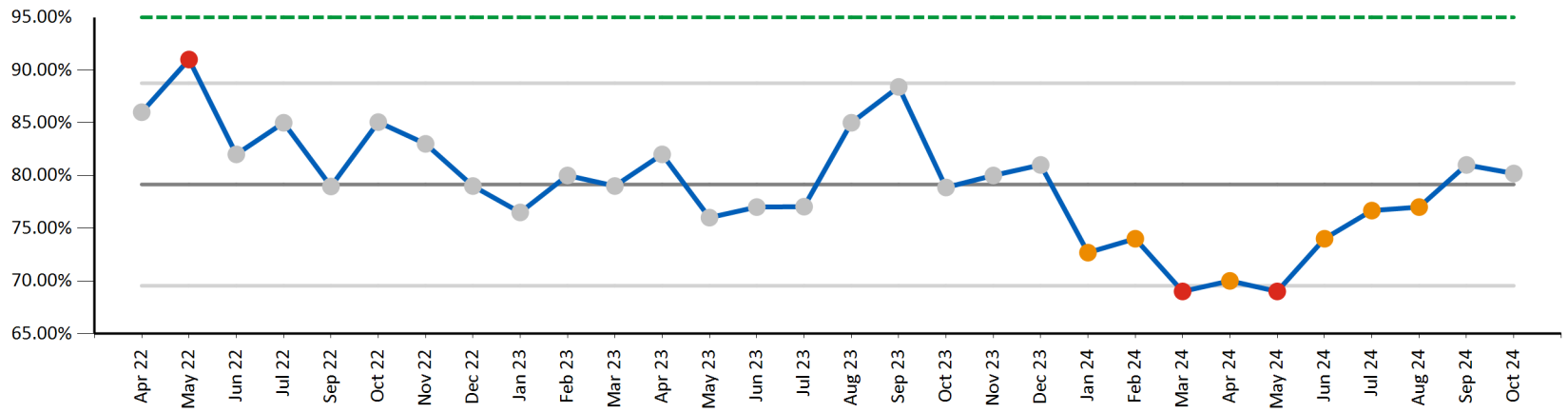
Plan	Actual
<= 2,520	5,502

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%	80%	Oct-24

Previous

Plan	Actual	Period
>= 95%	81%	Sep-24

Year to Date

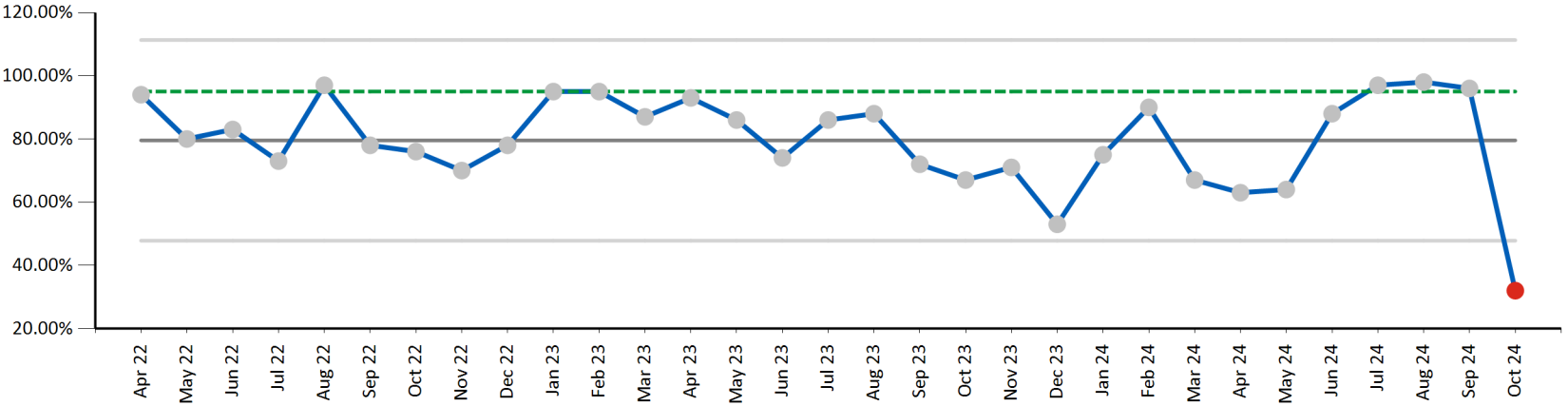
Plan	Actual
>= 95%	75%

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

Special cause variation with deteriorating performance

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

3/6



Latest

Plan	Actual	Period
>= 95%	32%	Oct-24

Previous

Plan	Actual	Period
>= 95%	96%	Sep-24

Year to Date

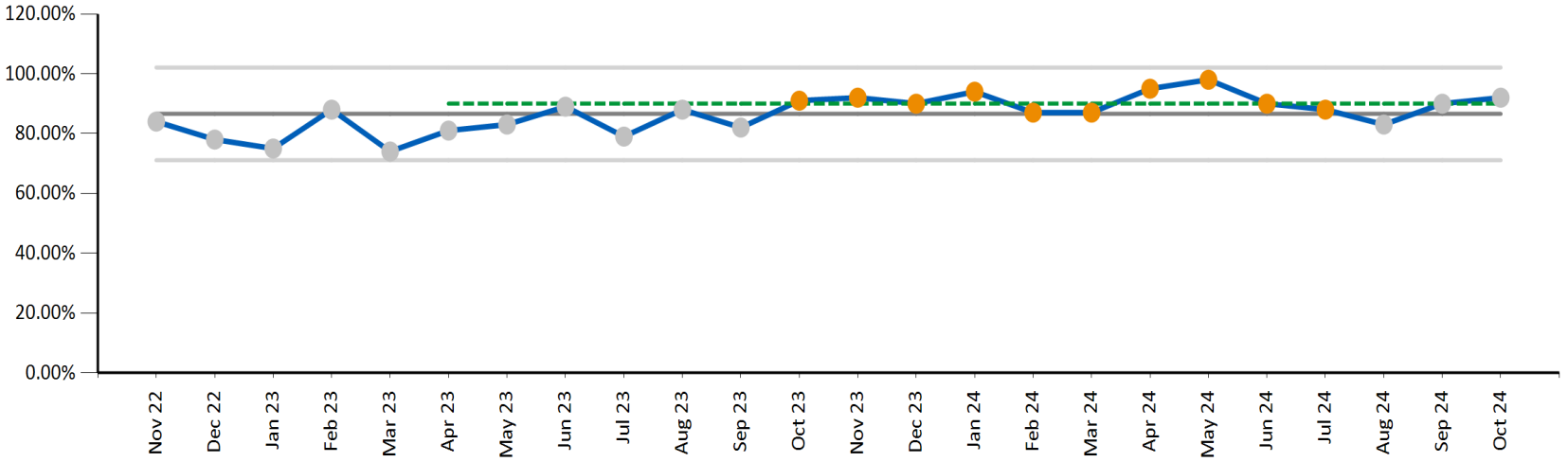
Plan	Actual
>= 95%	77%

550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	92.0%	Oct-24

Previous

Plan	Actual	Period
> = 90.0%	90.0%	Sep-24

Year to Date

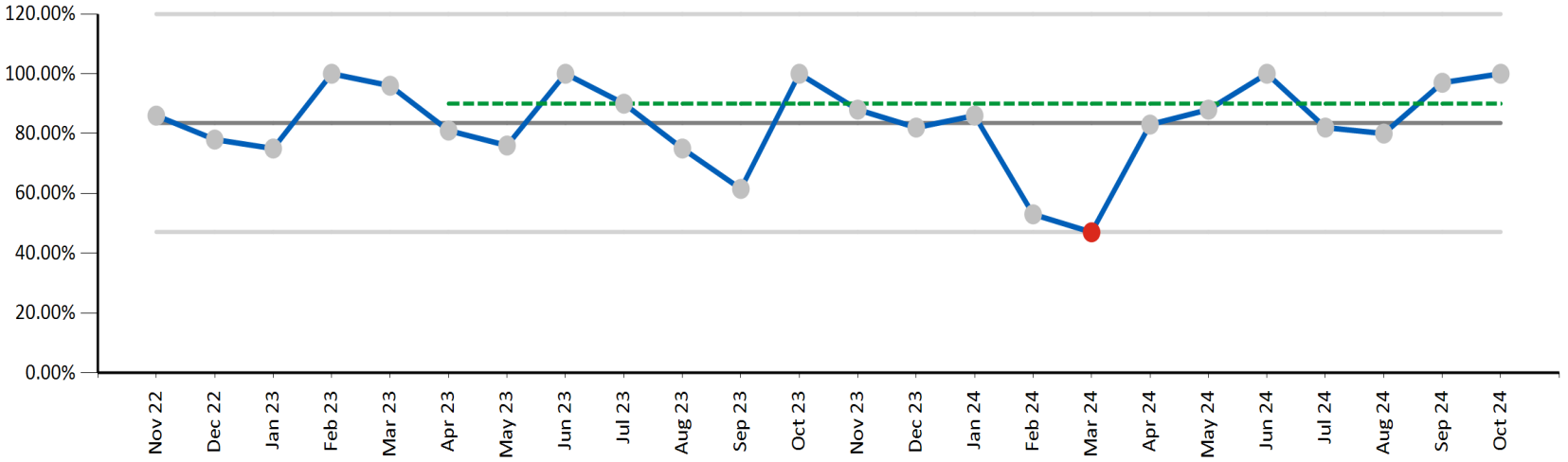
Plan	Actual
> = 90.0%	

551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Oct-24

Previous

Plan	Actual	Period
> = 90.0%	97.0%	Sep-24

Year to Date

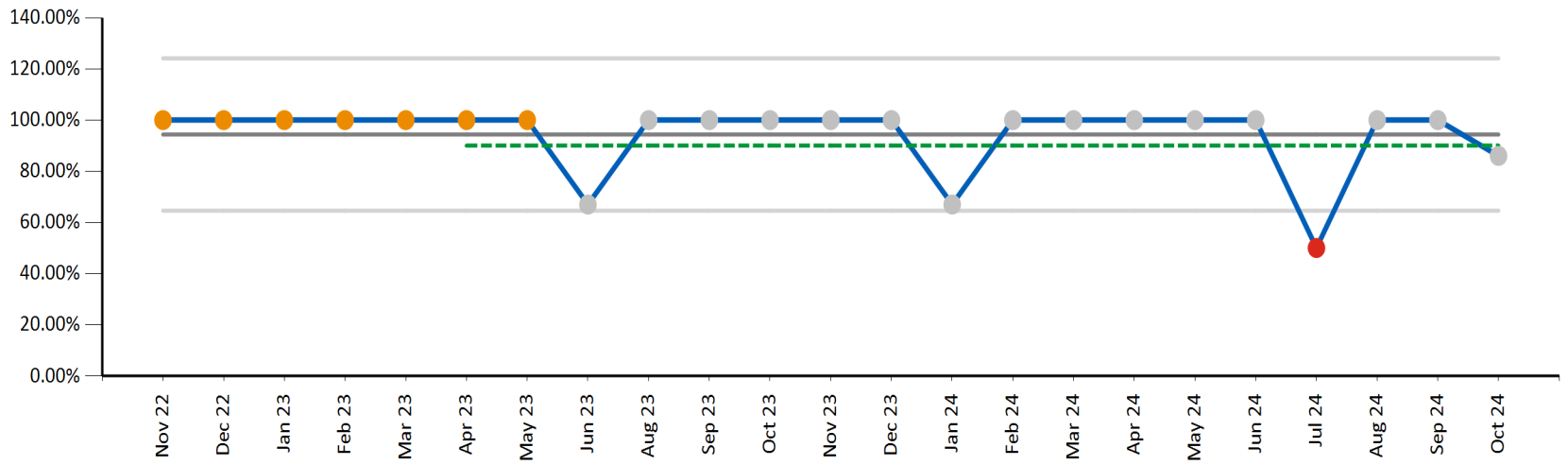
Plan	Actual
> = 90.0%	

552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools

Common cause variation.

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

4/6



Latest

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

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Sep-24

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness increased significantly in month from 4.70% to 5.39% in October 2024. There has been a increase in sickness absence across all Divisions with the increases predominantly due to seasonal sicknesses (such as Cold/Flu and D&V absences) which have occurred earlier this year compared to previous years. Each Division is currently undertaking a further review of these sickness, with a focus on update of vaccine protection. The Divisional and Workforce teams continue to work together to closely monitor sickness, and provide a range of health and well-being support to our staff.

Turnover:
October 2024 performance was at 11.73% at overall Trust level, which is a reduction from the previous month. Performance in the year 2024/25 to date has mirrored our forecasting which suggested that we would see a fairly static trend following a two year period of peaks and troughs.

Vacancy:
Vacancy rates in October 24 and the YTD 24/25 remain under the Trust target (6%) at 4.85% in-month, and 5.41% YTD. This is a very strong position to be in approaching winter pressures.

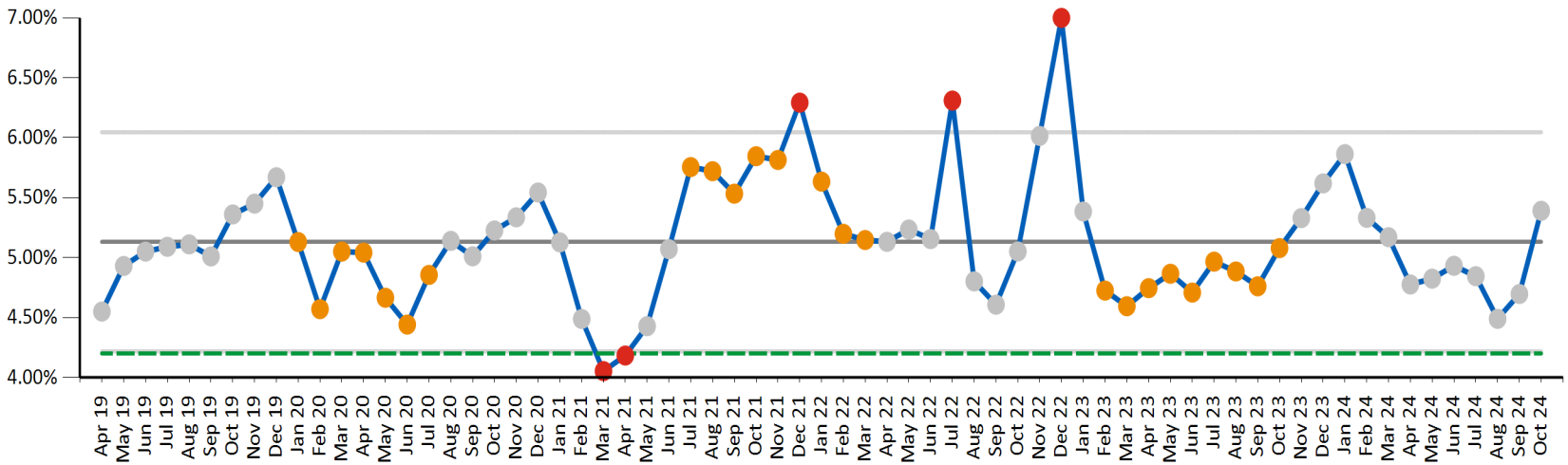
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.39%	Oct-24		<= 4.20%	4.70%	Sep-24	<= 4.20%	4.85%	F
120 - Vacancy level - Trust	<= 6%	4.85%	Oct-24		<= 6%	5.30%	Sep-24	<= 6%	5.41%	?
121 - Turnover	<= 9.90%	11.73%	Oct-24	L	<= 9.90%	12.06%	Sep-24	<= 9.90%	11.68%	F
366 - Ongoing formal investigation cases over 8 weeks		3	Oct-24			2	Sep-24		7	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.39%	Oct-24

Previous

Plan	Actual	Period
<= 4.20%	4.70%	Sep-24

Year to Date

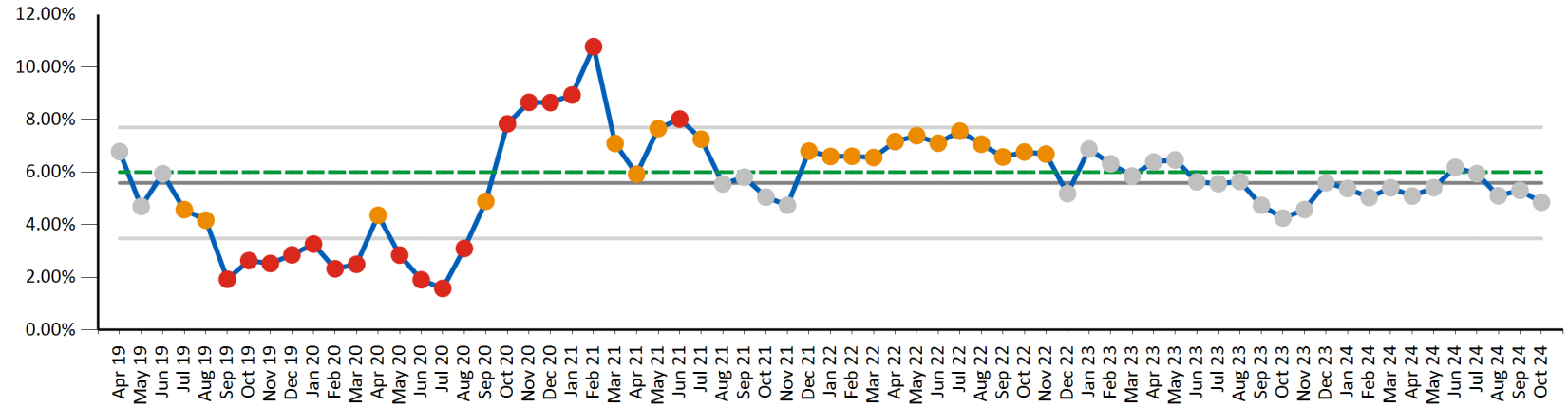
Plan	Actual
<= 4.20%	4.85%

120 - Vacancy level - Trust

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 6%	4.85%	Oct-24

Previous

Plan	Actual	Period
<= 6%	5.30%	Sep-24

Year to Date

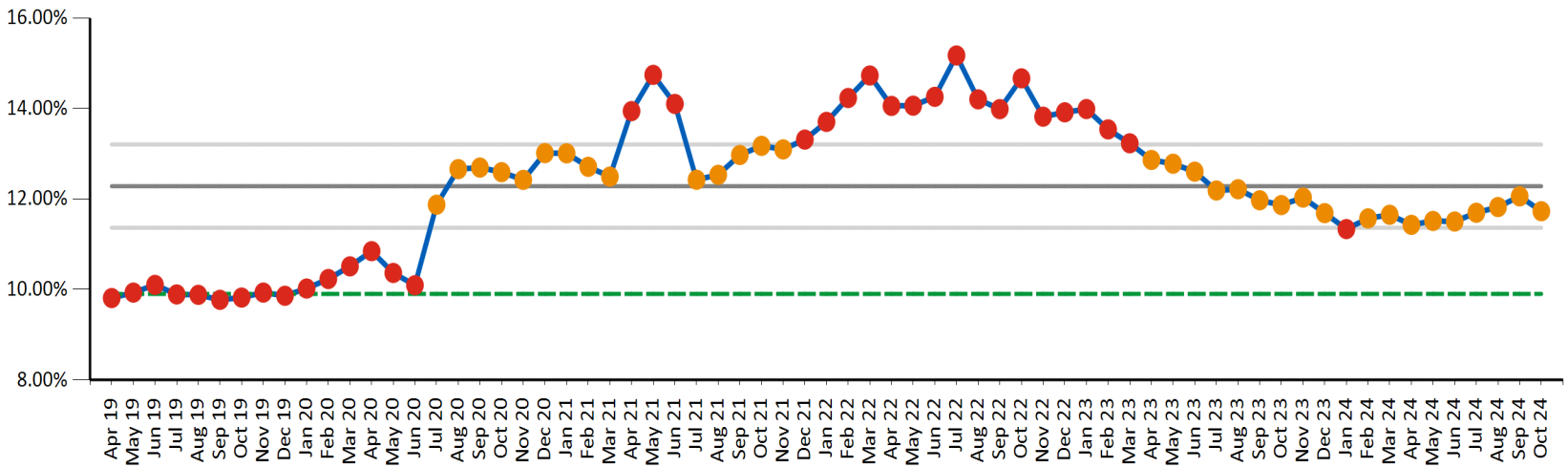
Plan	Actual
<= 6%	5.41%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.73%	Oct-24

Previous

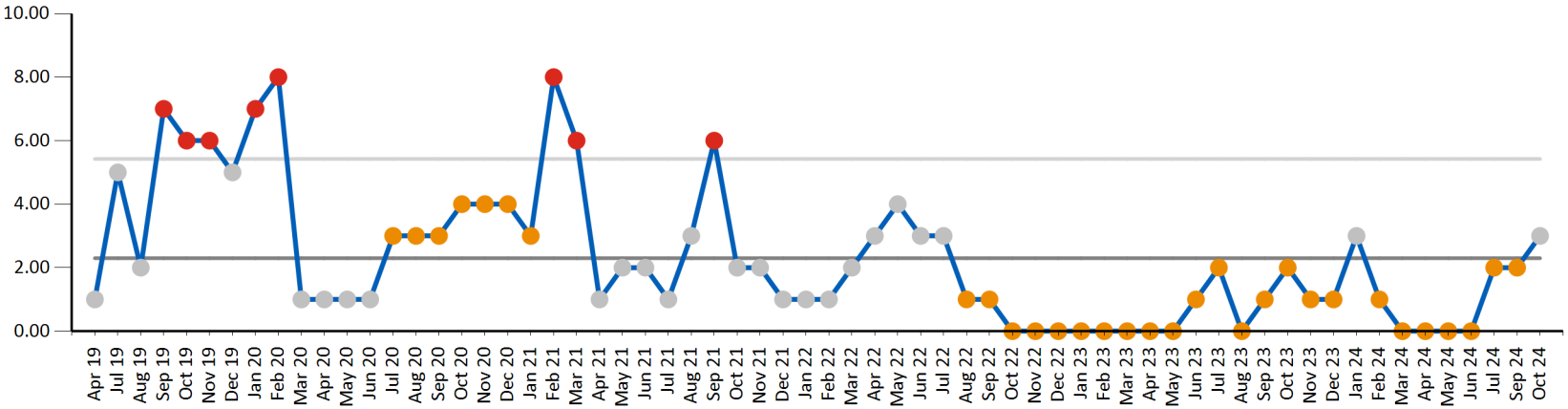
Plan	Actual	Period
<= 9.90%	12.06%	Sep-24

Year to Date

Plan	Actual
<= 9.90%	11.68%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	3	Oct-24

Previous

Plan	Actual	Period
	2	Sep-24

Year to Date

Plan	Actual
	7

Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory Training
Compliance is static this month at 93.83%. A real focus is now needed to achieve over 94% compliance before end of December 2024

Trust Mandated
A very slight dip this month to achieve 90.15% against a present target of 85%

Appraisal
A great effort by all services has led to a 0.52% improvement to record the monthly position as 86.96% against a compliance target of 85%

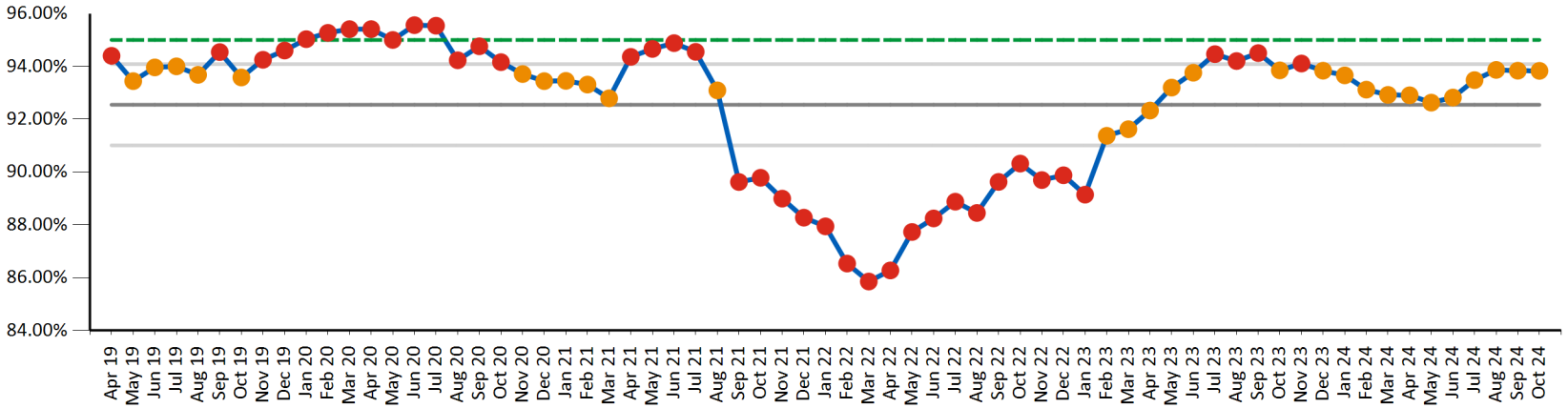
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.8%	Oct-24	H	>= 95%	93.8%	Sep-24	>= 95%	93.3%	F
38 - Staff completing Trust Mandated Training	>= 85%	90.2%	Oct-24		>= 85%	90.4%	Sep-24	>= 85%	90.1%	P
39 - Staff completing Safeguarding Training	>= 95%	91.78%	Oct-24	L	>= 95%	92.20%	Sep-24	>= 95%	91.74%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	87.0%	Oct-24	H	>= 85%	86.4%	Sep-24	>= 85%	85.6%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	53.4%	Q2 2024/25	L	>= 66%	43.0%	Q1 2024/25	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	53.8%	Q2 2024/25		>= 80%	50.5%	Q1 2024/25	>= 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%	93.8%	Oct-24

Previous

Plan	Actual	Period
>= 95%	93.8%	Sep-24

Year to Date

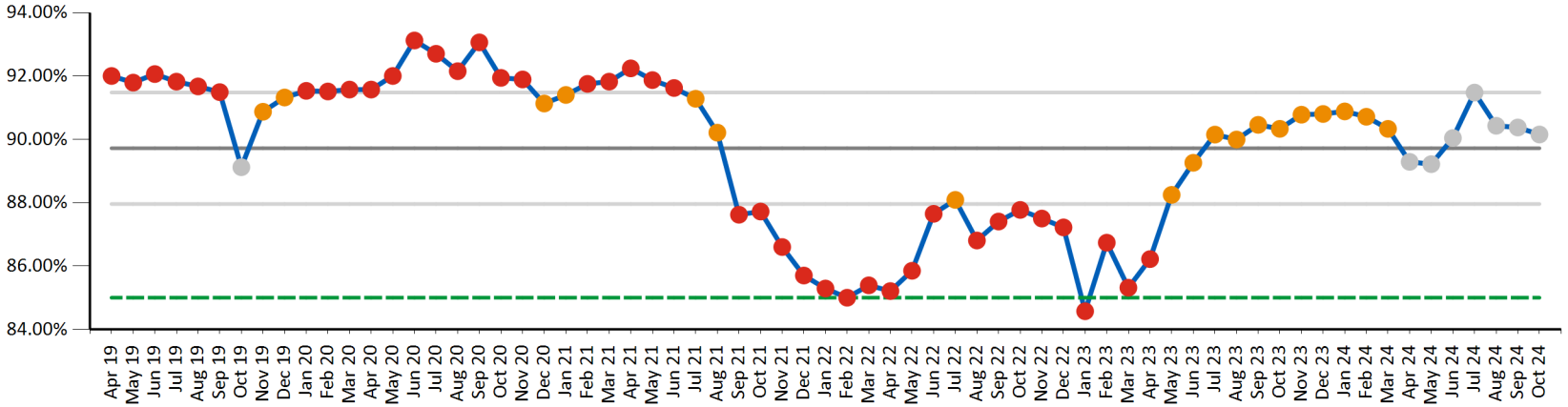
Plan	Actual
>= 95%	93.3%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.2%	Oct-24

Previous

Plan	Actual	Period
>= 85%	90.4%	Sep-24

Year to Date

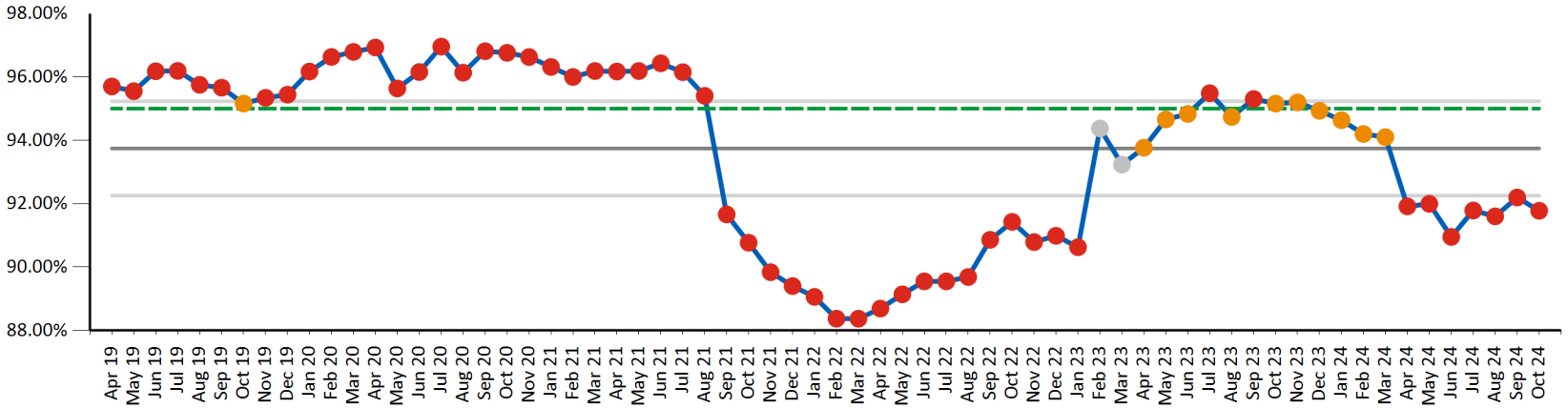
Plan	Actual
>= 85%	90.1%

39 - Staff completing Safeguarding Training

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 95%	91.78%	Oct-24

Previous

Plan	Actual	Period
>= 95%	92.20%	Sep-24

Year to Date

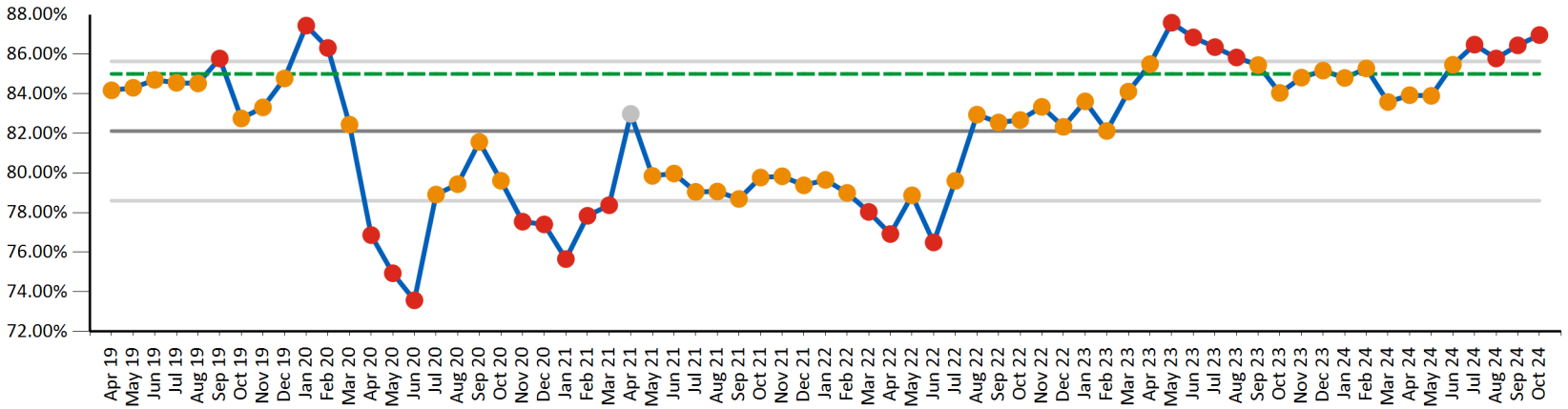
Plan	Actual
>= 95%	91.74%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
>= 85%	87.0%	Oct-24

Previous

Plan	Actual	Period
>= 85%	86.4%	Sep-24

Year to Date

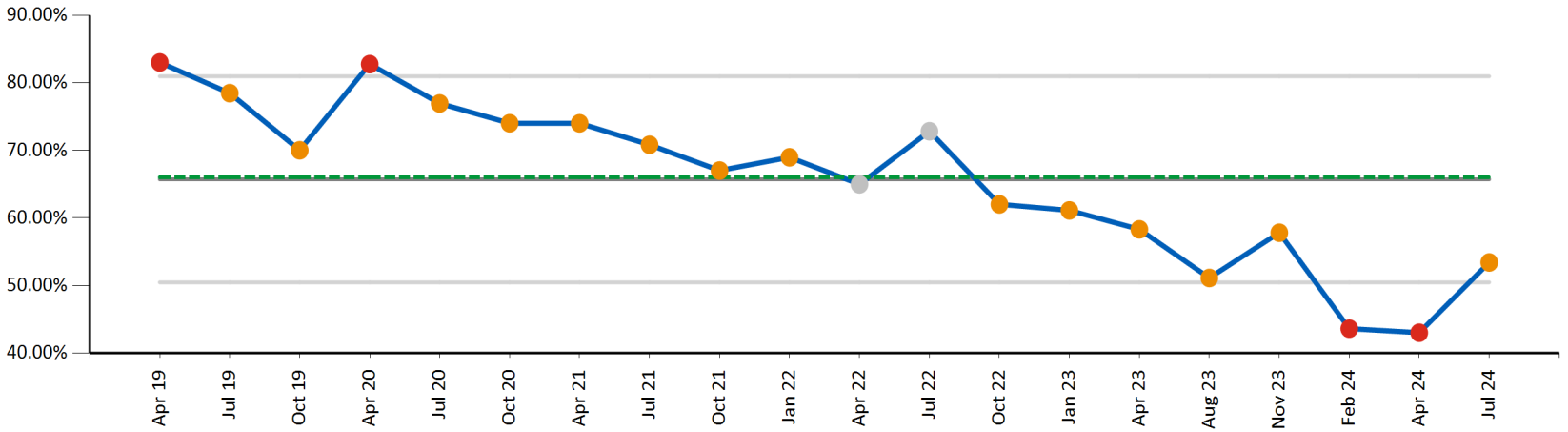
Plan	Actual
>= 85%	85.6%

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.

0/6



Latest

Plan	Actual	Period
>= 66%	53.4%	Q2 2024/25

Previous

Plan	Actual	Period
>= 66%	43.0%	Q1 2024/25

Year to Date

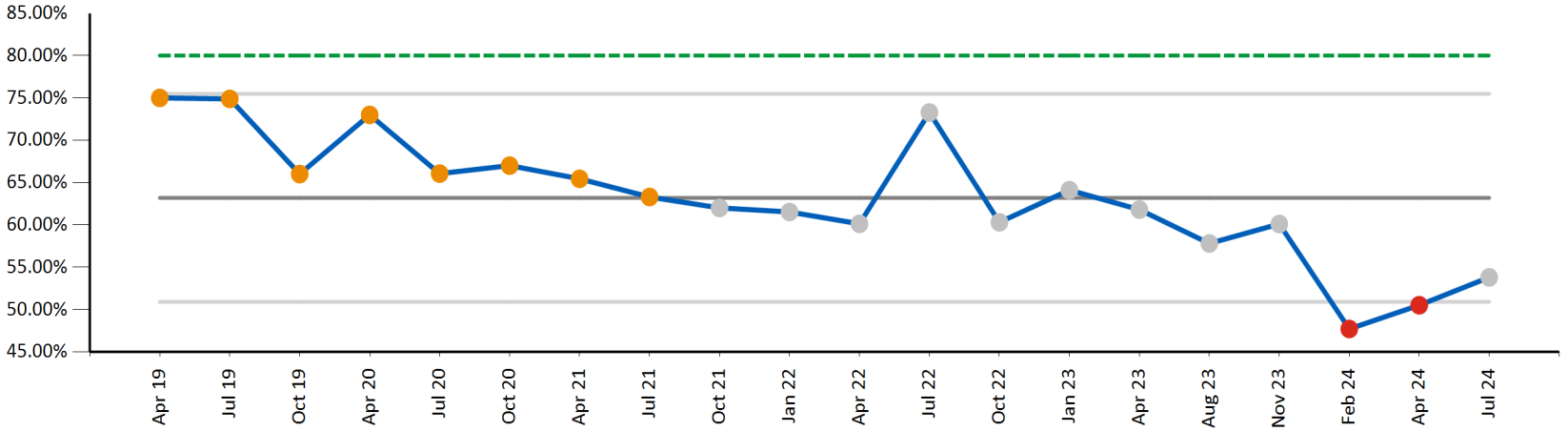
Plan	Actual
>= 66%	

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%	53.8%	Q2 2024/25

Previous

Plan	Actual	Period
>= 80%	50.5%	Q1 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Agency spend increased in-month in October 24 by £53k – mostly in relation to medical staffing. The Trust continues to be under the NHSE target of agency being no more than 3.2% of total pay bill (October 2024 performance was at 1.5%, and YTD is running at 2.1%).

We are currently under our internal agency spend plan (at the end of M7 24/25) by £1.1m (total actual spend of £4.6m against a planned spend of £5.7m).

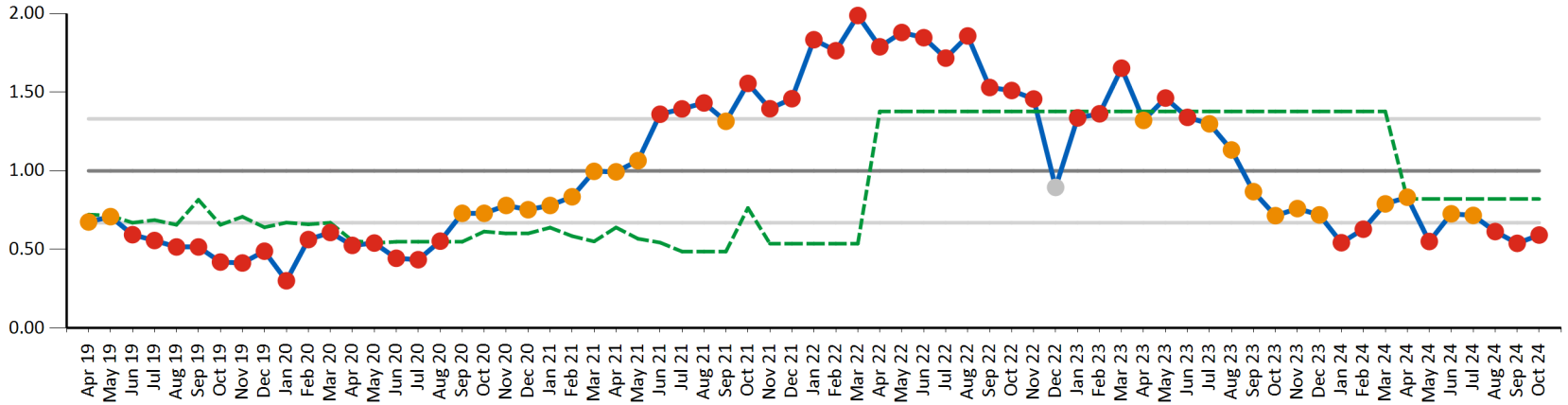
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.82	0.59	Oct-24	L	<= 0.82	0.54	Sep-24	<= 5.74	4.56	?
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.05	0.05	Oct-24	L	<= 0.09	0.04	Sep-24	<= 0.59	0.34	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.49	0.49	Oct-24		<= 0.62	0.41	Sep-24	<= 4.21	3.58	?

198 - Trust Annual ceiling for 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
<= 0.82	0.59	Oct-24

Previous

Plan	Actual	Period
<= 0.82	0.54	Sep-24

Year to Date

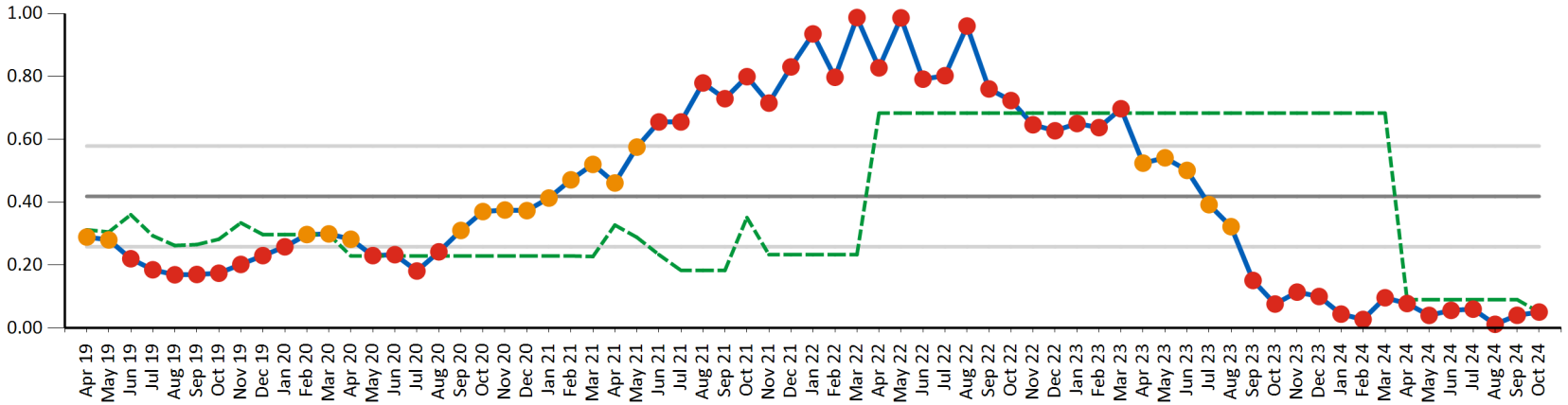
Plan	Actual
<= 5.74	4.56

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

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
<= 0.05	0.05	Oct-24

Previous

Plan	Actual	Period
<= 0.09	0.04	Sep-24

Year to Date

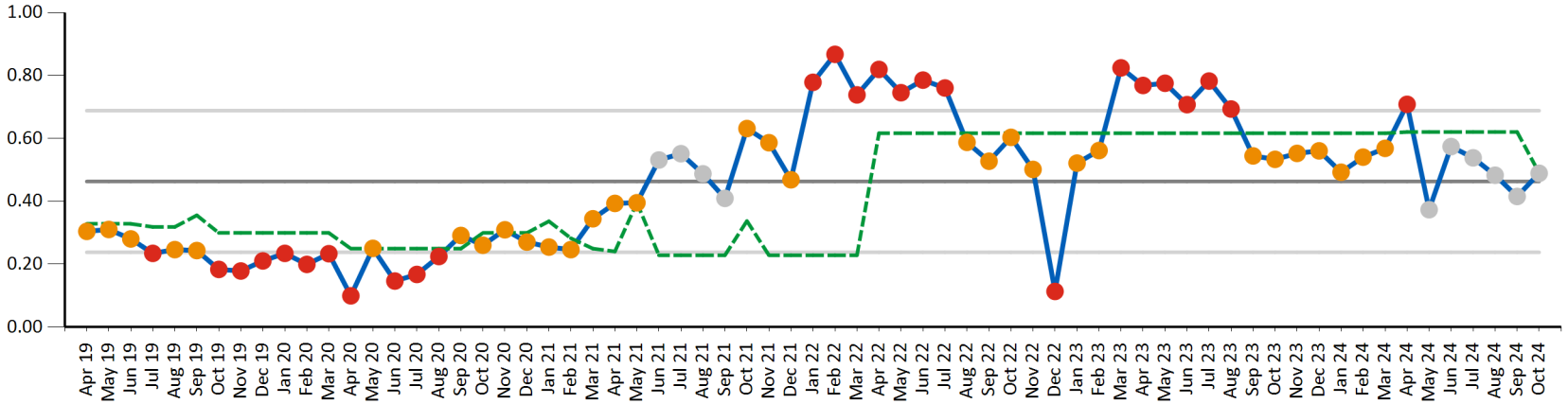
Plan	Actual
<= 0.59	0.34

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 0.49	0.49	Oct-24

Previous

Plan	Actual	Period
<= 0.62	0.41	Sep-24

Year to Date

Plan	Actual
<= 4.21	3.58

Finance - Finance

Bolton NHS Foundation Trust

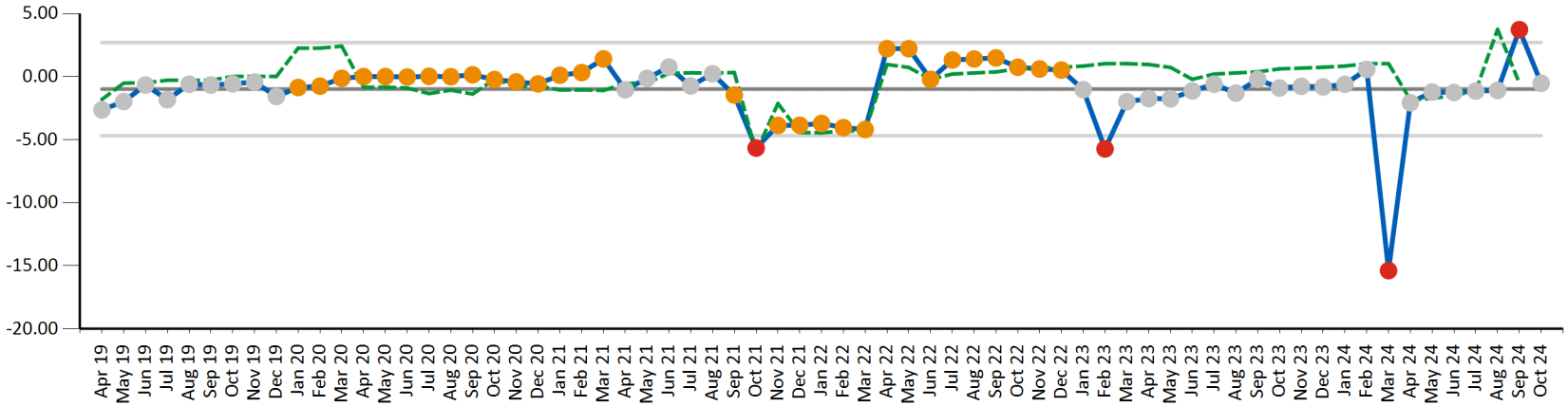
Revenue YTD - Deficit of £3.5mm which is on plan.
Revenue forecast - Most likely forecast outturn is currently an adverse variance to plan of £5.8m, including the impact of 24/25 pay award pressure
Cost improvement - Year to date delivery £3.9m ahead of plan. However, only £5m has been delivered recurrently out of a total £14.9m delivered.
Variable pay - Agency spending is 2.2% of pay costs compared to NHSE target of 3.2% and a plan of 2.2%.
Capital - Continued pressure on forecast allocation.
Balance Sheet - Decrease on total assets employed due to deficit.
Cash Position - Current cash of £18.9m vs plan of £2.5m. Forecast £5.3m overdrawn (before support and excluding PDC cash), based on likely case.
BPPC - 96.8% YTD v target of 95% (by volume).

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)		-0.5	Oct-24		>= -0.5	3.7	Sep-24	>= -3.0	-3.6	
222 - Capital (£ millions)		0.6	Oct-24		>= 0.6	1.0	Sep-24	>= 5.4	4.0	
223 - Cash (£ millions)		18.9	Oct-24		>= 18.9	8.4	Sep-24		18.9	

220 - Control Total (£ millions)

Common cause variation.

3/6



Latest

Plan	Actual	Period
	-0.5	Oct-24

Previous

Plan	Actual	Period
>= -0.5	3.7	Sep-24

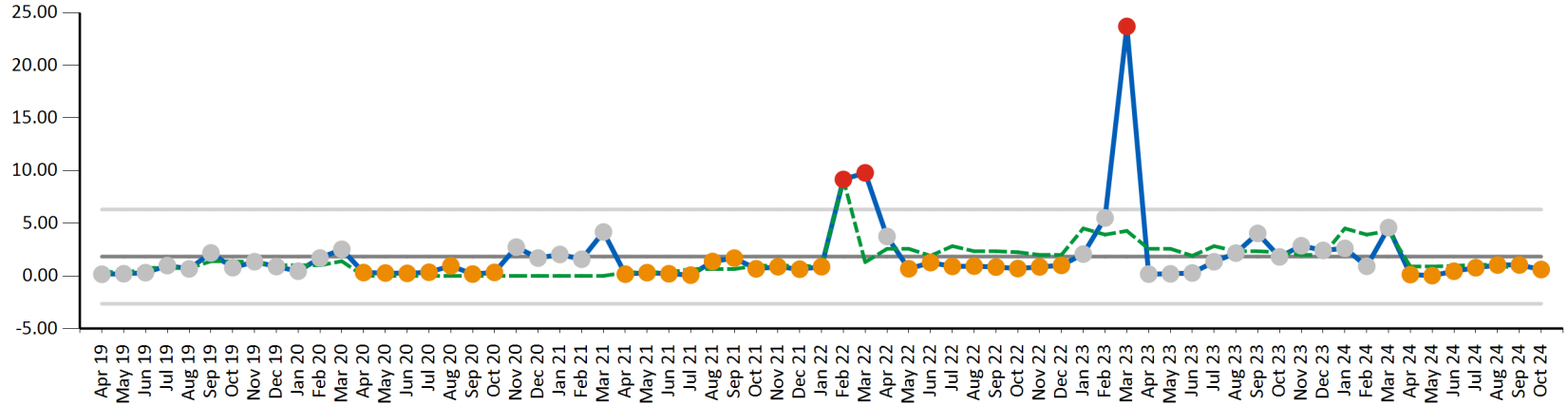
Year to Date

Plan	Actual
>= -3.0	-3.6

222 - Capital (£ millions)

Special cause variation with deteriorating performance

1/6



Latest

Plan	Actual	Period
	0.6	Oct-24

Previous

Plan	Actual	Period
>= 0.6	1.0	Sep-24

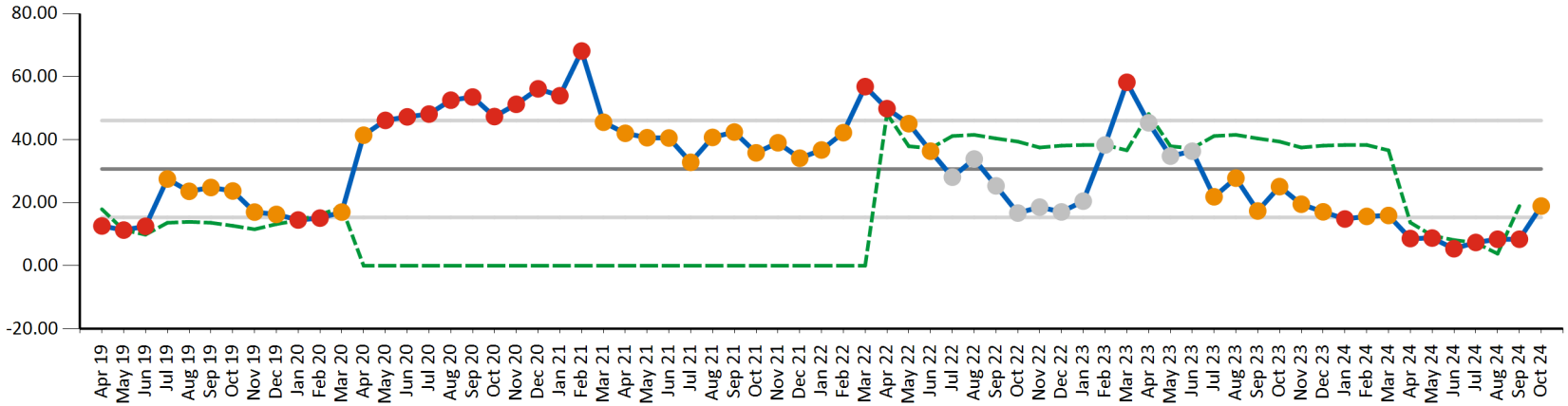
Year to Date

Plan	Actual
>= 5.4	4.0

223 - Cash (£ millions)

Special cause variation with deteriorating performance

2/6



Latest

Plan	Actual	Period
	18.9	Oct-24

Previous

Plan	Actual	Period
>= 18.9	8.4	Sep-24

Year to Date

Plan	Actual
	18.9

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Medical Director		Decision	

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

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee meeting held in September 2024.

Executive Summary	The attached report from the Chair of the Quality Assurance Committee provide an overview of matters discussed at the meeing held on 25 September 2024. The report also sets out the assurance received by the Committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the November meeting of the Quality Assurance Committee, a verbal update will be provided to the Board of Directors with a written report presented to the subsequent Board meeting.

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

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of Key Elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Fiona Taylor, Non-Executive Director	**Presented by:**	Fiona Taylor, Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	25 September 2024	**Date of next meeting:**	27 November 2024
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Patient Story
- MIAA Insight – Quality Assurance Committee
- Integrated Performance Report
- Mortality Assurance Report
- Clinical Correspondence Update
- Clostridium Difficile Update Report
- Organ Donation Annual Report
- Maternity Incentive Scheme Year 6 Progress Update
- CQC Well Led Recommendation
- Patient Safety Incident Report

ALERT

Agenda items	Action Required
• Clostridium Difficile Update Report - there has been an intractable prevalence of C-difficile infections at the Trust since 2019. Whilst part of the increase was linked to covid-19, similar for all organisations, our prevalence nonetheless remains an outlier and elevated disproportionally . A number of improvement methods have been undertaken including but not limited to; a Quality Improvement (QI) collaborative, a C-diff improvement plan aligned to best practice standards and more recently an improvement 'sprint' event in June. It was confirmed that in the last week there were only three confirmed cases, which was an improvement however this needs to be sustained for overall rates to improve. There is also a piece of work ongoing at the moment which is working together with night staff to address out-of-hours isolation concerns. • Future plan includes creation of a cohort ward to optimise timely isolation and also a review of our improvement actions by locality and GM ICB colleagues	The Chair asked for future iterations of the report to include brief narrative on the areas which were not achieving the 100% compliance.

ADVISE

- Integrated Performance Report – the committee were provided with an update and noted the key points. The Medical Director advised the 36-hour standard for fracture neck of femur performance was showing a downward trend. However, it was noted mortality had not significantly increased due to this. The issues were multifactorial as some patients present with more comorbidities and needing to wait longer for the most appropriate surgeon. The committee also requested a report to be presented to provide a clear understanding of capacity issues, patient safety implications and quality of care.
- Clostridium Difficile Update Report - there has been an intractable prevalence of C-difficile infections at the Trust since 2019. A number of improvement methods have been undertaken including but not limited to; a Quality Improvement (QI) collaborative, IPC-led improvement plans and more recently an

improvement 'sprint' event in June. It was confirmed that in the last week there were only three confirmed cases, which was an improvement however this needs to be sustained for overall rates to improve. There is also a piece of work ongoing at the moment which is working together with night staff to address out-of-hours isolation concerns. The Chair asked for future iterations of the update report to include brief narrative on the areas which are not achieving the 100% compliance and that action that needs to be taken for assurance.

- Maternity Incentive Scheme Year 6 Progress Update (CNST) – the committee received and noted the progress update and asked that future reports include clarity on which safety actions were rated as "Red". The Director of Midwifery provided detailed interventions to support compliance attainment regarding training. The main areas of challenge relate to medical colleagues who joined in August 2024, and hence only provide a small window to complete prior to the deadline of end of November 2024.
- CQC Well Led Recommendations – the committee noted the update on the current position of the recommendations and the further work planned in order to provide assurance on reliability of systems and processes.
- Patient Safety Incident Response Report – the committee received the report and agreed with the recommendations identified following the investigation.

- ASSURE

- 2024/25 MIAA Insight – The MIAA Insight Report was shared for information. The Committee already conducts an internal review of effectiveness and will incorporate this feedback into the next review.
- Mortality Assurance Report – new processes were noted around Medical Examiners and it was confirmed that the inclusion of stillbirths in the mortality report would be seen in future iterations.
- Clinical correspondence Update – the Medical Director provided a detailed update to the Committee as part of the Integrated Performance Report.
- Organ Donation Annual Report – the committee noted the positive increase in referrals.

New Risks identified at the meeting:

No new risks identified.

Review of the Risk Register:

N/A

Report Title:	Clinical Negligence Scheme for Trusts Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	✓

Purpose of the report	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 year 6 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee – 06 November 2024 Quality Assurance Committee – 27 November 2024

Executive Summary	Key highlights: • The CNST year 6 scheme guidance was launched on the 02 April 2024 with an associated benchmarking tool. • The service is progressing well with all ten safety actions and has attained 25 of the 94 recommendations to date. Eight of the outstanding actions highlighted as red relate to the final submission and verification of the evidence by an approving body. • All criteria for safety action two that relate to the July 2024 maternity services data services data set submission have been attained. • The CNST evidence collated to date has been uploaded to the Futures Collaboration platform and will be subject to external oversight by the LMNS prior to submission. • Ongoing work continues to meet the required 90% standard for relevant staff groups with regard to multi-professional training and a focus on medical staffing groups. An action plan for rotational medical staff that commenced in Trust after July 2024 is included in Appendix 4 for Board approval to recover the training compliance position to 90% within a maximum 6-month period from their start-date with the Trust if required. In summary, this report provides assurance of ongoing monitoring of the CNST year 6 scheme requirements.

Proposed Resolution	The Board of Directors is asked to: i. Receive the contents of the report. ii. Approve the action plans within this report. iii. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓		✓		

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Potential impact upon maternity incentive scheme fund reimbursement.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

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

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

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries
RCOG	Royal College of Obstetricians and Gynaecologists

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 6 Maternity Incentive Scheme (MIS) launched on the 02 April 2024.

The incentive scheme continues to support safer maternity and perinatal care by driving compliance with ten safety actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

2. CNST year 6 update

Oversight of the year scheme compliance continues to be monitored using the NHS Resolution benchmarking table that is updated following population of the NHS Resolution tool.

All evidence collated to date has been uploaded to the Futures Collaboration platform and will be subject to external oversight by the LMNS prior to submission.

Table 1 – CNST year 6 progress update as of 07 November 2024

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	0	3	0	3
3	0	2	3	0	5
4	4	7	9	0	20
5	0	5	2	0	7
6	2	4	1	0	7
7	0	6	2	0	8
8	2	16	0	0	18
9	0	5	5	0	10
10	0	9	0	0	9
Total	8	61	25	0	94

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

The service is progressing well with all ten safety actions and has attained and can evidence 25 of the 94 recommendations to date.

All criteria for Safety action 2 that relate to the July 2024 maternity services data services data set submission have been attained.

Eight of the outstanding actions highlighted as red relate to the final submission and verification of the evidence by an approving body.

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

The Trust Board is required to receive a report each quarter that includes details of all deaths reviewed from the 8 December 2024.

All cases that have occurred during the period up to the 7 November 2024 are detailed with Appendix 1 and confirm the required standards have been met for all cases namely:

a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.
b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 08 December 2023 onwards.
c) **Review the death and complete the review**: For deaths of babies who were born and died fin your Trust multi-disciplinary reviews using the PMRT should be carried out from 02 April 2024; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

Actions identified in the reviews completed from the 08 December 2023 are detailed in Appendix 1a.

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

Publication of The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series in November 2024 confirmed that the Trust met all data quality metrics for the data submissions relating to activity in July 2024 (Appendix 2) as per required standard.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

The service presented an action plan to the Board of Directors in September 2024 that detailed progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice.

A recent update on the quality improvement project to reduce unexpected admissions to the neonatal unit for term babies with Respiratory Distress Syndrome was presented at the Maternity Safety Champions meeting on the 06 November 2024. An overview of the quality improvement work was also formally presented to LMNS colleagues on the 04 November 2024.

The aim of the quality improvement work is to reduce the number of babies admitted to the Neonatal Unit with respiratory distress syndrome with a particular focus on care and feeding provision in the first hour often referred to as the 'golden hour'.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a**) Obstetric medical workforce**

An audit to assess compliance with the standard operating procedure for the employment of locum doctors in obstetrics and gynaecology was undertaken in September 2024. The audit provided significant assurance of compliance with the RCOG guidance.

The service continues to monitor breaches in compliance with the RCOG compensatory rest guidance and the RCOG workforce document relating to consultant attendance in person for defined clinical situations. Compliance for both metrics is recorded on the maternity safety champion's dashboard (Table 4). One breach of standard was reported in August 2024 that related to an on call shift where the 11 hour rest period was not attained. This incident was escalated to the Clinical Director for review.

The service continues to monitor compliance of consultant attendance for the clinical situations listed in the RCOG workforce document and this is detailed in the safety champion's dashboard.

The Q2 audit report highlighted that 92% compliance was report during quarter 2 with two breaches highlighted that related to lack of attendance during post partum haemorrhage,

a time critical event. All breaches are discussed at the maternity and gynaecology audit meeting held monthly.

b) **Anaesthetic medical workforce**

The anaesthetic service provided a copy of the August 2024 roster and the current operating policy to evidence that a duty anaesthetist is immediately available for the obstetric unit and has clear lines of accountability to the anaesthetic consultant at all times, in accordance with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. Assurance has been provided that an external (ACSA) re-accreditation of the anaesthetic service was undertaken in March 2022.

c) Neonatal medical workforce

An assessment of the neonatal medical staffing in accordance with BAPM standards was undertaken during Q1 2024/2025 which highlighted a 2WTE gap in the 24/7 Tier 3 practitioner presence within the service.

Table 2 - Neonatal medical staffing – overview of compliance with British Association of Perinatal Medicine (BAPM) standards for neonatal medical staffing

NICUs	Tier 1 separate rota compliance 24/7	Tier 2 separate rota compliance 24/7	Tier 3 separate rota compliance 24/7	Tier 3 presence on the unit
Greater Manchester				
RBH	Compliant	Compliant	Compliant	Non-compliant

The action plan to attain full compliance and demonstrate progress since the CNST year 5 scheme was presented to the Board of Directors in September 2024.

d) Neonatal nursing workforce

An assessment of the neonatal nursing workforce summary tool was last formally undertaken by the North West Neonatal Operational Delivery Network (NWODN) as part of an annual review in conjunction with the service in Q1 2024/2025.

The Q1 NWODN return completed in July 24 confirmed the service identified a 22.07 WTE Registered Nurse deficit.

BAPM optimum standards for Neonatal care recommend that 70% of the “Nursing establishment” should be Qualified in Speciality (QIS) trained. All NHSE returns require direct cot side only to be reported.

The NNU nursing establishment (inclusive of quality roles) is currently 71% Qualified in Speciality (QIS) trained and 62.14% compliant with the QIS standard for direct cot side only. The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cot side care with ongoing recruitment and progression of staff to undertake further training.

The service continues to support and identify staff to undertake the QIS training which occurs twice per year (October and February). The service has 4 staff identified to attend the QIS in October 24 which will further increase the QIS compliance within the service.

The action plan to attain full compliance and demonstrate progress since the CNST year 5 scheme was presented to the Board of Directors in September 2024.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The next bi-annual maternity staffing report is due to the Board of Directors in November 2024.

In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birthrate+ or equivalent calculations. Assurance can be provided that the business case seeking uplift to meet the 2023 Birth Rate Plus recommendations was approved at the Trust capital and revenue investment group (CRIG) on the 07 May 2024 and Trust finance and investment committee on the 26 June 2024.

Monitoring of the supernumerary status of the Delivery Suite Co-ordinator continues to be undertaken in Table 4 with 100% compliance reported to date. An internal quarterly assurance audit of the acuity tool is undertaken for assurance and any reported breaches are reviewed in detail by the intrapartum Matron.

The Q2 2024/2025 quarterly audit report highlighted no breaches in the supernumerary allocation of co-ordinator at the start of the shift. One breach of deviation during the shift from the 100% supernumerary standard was reported via Safeguard and when reviewed the coordinator was supernumerary at the start of the shift as per expected standard.

However, a woman arrived in advanced labour, delivered quickly and the patient was handed to a midwife, which was the appropriate action. Assurance has been provided an Advanced Midwifery Practitioner was also present as a supernumerary senior team member / who could also coordinate if required to support the activity.

The revised CNST year 6 guidance v1.2 stipulates that all co-ordinators must commence the shift in a supernumerary capacity, this standard was maintained on all occasions.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

A quarterly assurance review of the bundle implementation was held on 2 September 2024 attended by the LMNS / ICB (as commissioner) and the Trust. The discussion included a review of progress to date, monitoring of progress against local plans and reviewing of themes and trends with regard to each of the six elements of the care bundle. The service reported 83% compliance with all elements at the meeting. Progress with regard to attainment of the six bundle elements is detailed in Appendix 3.

The service is currently on track for full implementation of all elements of the care bundle and the next formal quarterly assurance review with the LMNS is scheduled for 17 December 2024. A validation assessment score will be provided following this meeting.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

The Trust has been formally notified of the re-appointment of the Maternity and Neonatal Voice Partnership (MNVP) Chair Amy Rothwell to support the service.

The MNVP has co-produced an action plan in response to the findings of the 2023 maternity survey and continues to engage with the service at governance forum and also hold engagement sessions to seek feedback from service users.

The action plan is monitored at the maternity and neonatal safety champions meetings held bi-monthly. The plan will be updated in January 2025 in response to publication of the 2024 CQC maternity survey findings.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Further work is required to meet the required 90% standard for all relevant staff groups with regard to multi-professional training and in particular medical staff groups (Table 3). In response the service has scheduled additional training sessions to accommodate the

upcoming demand and leads are utilising trajectories of performance to forecast the improvement. Weekly oversight monitoring of compliance remains in progress.

The service remains committed to attaining the required standard by the 30 November 2024.

The current CNST guidance v1.2 confirms that for rotational medical and anaesthetic staff that commenced work on or after 01 July 2024 a lower compliance will be accepted.

Compliance for anaesthetic doctors on rotation is currently 69.70% for PROMPT training and thus an action plan to recover this position to 90% within a maximum 6-month period from their start-date with the Trust has been collated for approval of the Board (Appendix 4).

All staff that still require their training have been booked to attend a session prior to the 30 November 2024.

Table 3: CNST professional training matrix – updated 07 November 2024

Course	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	NA	94.12%	93.18 %	100. 00%	89. 19%	95.69 %	NA	NA	NA	100.00 %	69.70%
Fetal Monitoring Core Competency Stds.	NA	94.12%	97.14 %	NA	NA	90.98 %	NA	NA	NA	NA	NA
Fetal Monitoring GMEC Comp. Assessment	NA	94.12%	100.0 0%	NA	NA	91.37 %	NA	NA	NA	NA	NA
Neonatal Life Support	100.00 %	NA	NA	NA	NA	93.36 %	100.00 %	100.0 0%	93.04 %	NA	NA

On the 24 June 2024 the Trust was notified by NHS Resolution that a minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024).

Trusts that cannot demonstrate this for MIS year 6 were asked to develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised by year 7 of MIS and ongoing.

In response a detailed review of the current position has been undertaken. Assurance can be provided that all Consultants have undertaken the Generic Instructor Course (GIC) previously within the last four years and all medical rotation staff have undertaken a local newborn life support course in accordance with the BAPM basic capability guidance in September 2024. See Appendix 5 for the action plan.

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

The recent SCORE cultural survey was published in May 2024 following completion of the perinatal quadrumvirate cultural leadership programme. Formal feedback was provided to the quadrumvirate team on the 29 August 2024 following engagement sessions with staff groups and a cultural improvement plan has been developed to align with the Family Care Division Staff Survey Plan (Appendix 6). The action plan identifies actions to address the issues identified in the SCORE survey relating to capacity and resource, collaboration within teams, leadership and learning. The actions have been informed by the themes extracted from the engagement sessions by the external facilitator and the cultural report findings.

The board safety champions and perinatal leadership team continue to meet bi-monthly and have continued the ongoing engagement sessions with staff as per year 5 of the scheme and are next due to meet on 2 January 2025. Information gathered continues to be collated and shared in a ‘You Said – We did’ simple format and displayed in clinical areas (Appendix 7).

The Board Safety Champion continues to work with the safety champions to address the reduced bed capacity within the ward G3/G4 environment and review the impact upon safety outcomes using the integrated performance dashboard metrics.

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Triangulation of learning Q2

The Q2 triangulation review of the Trust scorecard, incident and complaints review is detailed in Appendix 8.

The following themes were identified following triangulation of the maternity incidents and complaints:

- Improve communication in service with regard to telephone access to booking and telephone triage services.
- Post-partum hemorrhage
- Delays in care relating to lack of bed capacity

Ongoing quality improvement projects are currently in progress to address the bed capacity issue, improve the current access to triage and also to improve the post-partum haemorrhage pathway.

Assurance audit

An internal audit to ascertain compliance with the reporting of qualifying cases for MNSI*/ NHS Resolutions Early Notification scheme has been undertaken for the period from 1st July 2024 to the 30th September 2024.

The audit demonstrated that 100% of criteria was met relating to the reporting of the cases, administration of duty of candour and provision of information to the families.

As Trust Board sight of evidence of compliance with the statutory duty of candour.is required NHS Resolution have confirmed anonymised copies of the duty of candour letter are to be included in Board reports. Excerpts from the letters are included in Appendix 9.

An internal audit to ascertain compliance with the reporting of qualifying cases for MNSI*/ NHS Resolutions Early Notification scheme up to 30 November is scheduled and will be reported in the January 2025 Board paper.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the ‘Implementing a revised perinatal quality surveillance model’ guidance published in 2020.

In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022 as detailed in table 4. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff/service user feedback sessions are displayed in Appendix 7.

The dashboard is used in conjunction with monthly integrated performance management reports to evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. The dashboard will continue to be presented by a member of the perinatal leadership team to provide supporting context.

Ongoing monitoring of the metrics is undertaken at bi-monthly safety champion meetings with the perinatal quadrumvirate leadership team where any additional support required of the Board can be identified an escalated. The last bimonthly meeting was held on the 6 November 2024.

The RCOG benchmarking audit report for Q2 highlighted a deterioration in compliance to 60% in July as two postpartum haemorrhages occurred which is a time critical incident where the consultant was not present. In line with recommendations, episodes where attendance has not been possible; the cases will be reviewed at the next maternity audit meeting to determine whether the attendance was possible.

In August 2024 there were 3 cases of early neonatal death reported, two of the cases followed a compassionate termination of pregnancy and one case an extremely preterm infant at 22+1 weeks gestation transferred into the service due for level three neonatal tertiary care.

The service remains focussed on improving the profession specific training required by the CNST maternity scheme to attain the 90% compliance standard. Local reporting continues for all elements and trajectories of improvement monitored for the four key elements of training. Weekly oversight by the senior leads and bi-monthly oversight at Board level continues.

Table 4 – Safety Champions locally agreed dashboard

CQC rating			Overall		Safe		Effective	Caring	Well -Led	Responsive
Regional Support Programme			Requires Improvement		Requires Improvement		Good	Good	Requires Improvement	Good
Indicator	**Goal**	**Red Flag**	**Apr 24**	**May 24**	**June 24**	**July 24**	**Aug 24**	**Sept 24**		
CNST attainment	Information only									
Critical Safety Indicators										
Births	Information only		433	436	410	419	426	451		
Maternal deaths direct	0	1	0	0	0	0	0	0		
Still Births			0	4	2	2	1	1		
Still Birth rate per thousand	3.5	≥4.3	0.0	9.2	4.9	4.8	2.3	2.2		
HIE Grades 2&3 (Bolton Babies only)	0	1	1	1	1	1	1	0		
HIE (2&3) rate (12 month rolling)	<2	2.5	1.7	1.7	1.9	2.2	1.8	1.4		
Early Neonatal Deaths (Bolton Births only)	Information only		1	1	3	3	3	0		
END rate in month	Information only		2.3	2.3	7.4	7.2	7.1	0.0		
Late Neonatal deaths	Information only		0	0	0	0	0	0		
PSII Incidents (New only)	0	2	0	0	0	0	0	0		

MNSI referrals (Steis reportable)			0	2	2	2	1	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	1	0	0	1	0
1:1 Midwifery Care in Labour (Euroking data)	95 %	< 90 %	98.7%	97.9%	98.6%	99.0%	99.7%	99.7%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0
BAPM compliance ratio/nurses acuity (neonatal unit)	>99 %	< 79 %	87.0%	92.0%	94.0%	98%	99.0%	108.0%
Fetal monitoring training compliance (overall)	<90 %	> 80 %	91.00 %	88.00 %	84.33 %	87.40 %	88.00 %	83.62%
PROMPT training compliance (overall)	<90 %	> 80 %	84.00%	81.00%	81.61%	86.22%	83.00%	85.10%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:22.6	1:22.6	1:22.6	1:22.6	1:22.9	1:22.8
RCOG benchmarking compliance	Information only		100%	100%	85.7%	60%	100%	100%
Compensatory rest breaches			0	0	0	0	1	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

5. 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 CNST Maternity Incentive Scheme (MIS). The report provides assurance of ongoing monitoring of the CNST year 6 scheme requirements.

6. Recommendations

It is recommended that the Board of Directors:

i. Receive the contents of the report.

ii. Approve the action plans within this report.

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

Appendix 1 – Perinatal mortality review tool cases as from 3 December 2023

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/concerns questions	Report published Deadline Date 6 months
90970	Postnatal NND . 28 days	24	20.12.23	0	20.2.23 done 2.1.24	20.12.2023	20.6.23 **Done 30.5.24**
90993	ENND	22	21.12.23	0	Assigned to MFT 21.02.24	21.12.23	21.6.24
91162	SB	25+2	03.01.2024	0	03.01.2024	03.01.2024	20.6.2024
91589	ENND	35+3	29.01.2024	0	29.01.2024	29.01.2024	**27.06.2024**
91686	ENND	38+0	04.02.2024	0	06.02.2024	04.02.2024 and 06.02.2024	**04.07.2024**
91814	SB	25+3	09.02.2024	0	09.02.2024	10.02.2024	**25.07.2024**.
91853	SB	26+3	11.02.2024	1	11.02.2024	11.02.2024	18.07.2024
91945	Post NND > 29 DAYS OLD	30	18.01.2024 17.02.2024	0	17.04.2024 Assigned to Blackpool	20.02.2024	18.07.2024

91972	SB	40+0	19.02.2024	0	19.02.2024	19.02.2024	19.08.2024
91991	ENND	26+1	18.02.2024 20.02.2024	0	20.04.2024 Assigned to MFT (NMGH)	24.02.2024	20.08.2024
92299	SB T2	27+ DIAG/36+ BIRTH	11.03.2024	0	07.06.2024	10.03.2024	11.09.2024
92395	NND	34	07.02.2024 29.02.2024	15 due to not known- Community /home Death	19.03.2024	05.06.2024	29.08.2024
92646	Late Fetal Loss	22+3	02.04.2024	0	02.04.2024	05.04.2024	02.10.2024
92923	NND	24+	14.04.2024 20.04.2024	0	21.04.2024	22.04.2024	22.10.2024
93126	SB	38+1	01.05.2024	0	03.05.2024	02.05.2024	01.11.2024
93150	SB	29	02.05.2024	0	03.05.2024	20.05.2024	02.11.2024
93167	SB	40	05.05.2024	0	06.05.2024	06.05.2024	05.11.2024
93360	ENND	22+1	16.05.2024	2	18.05.2024	18.05.2024	16.11.2024
93394	SB	25	19.05.2024	1	20.05.2024	21.05.2024	19.11.2024

93618	SB	24+6	03.06.2024	0	04.06.2024	15.06.2024	03.12.2024
93712	SB	39+2	09.06.2024	1	10.06.2024	10.06.2024	09.12.2024
93915	ENND	40	16.06.2024 21.06.2024	0	24.06.2024	21.06.2024	21.12.2024
94081	ENND	23+	28.06.2024 01.07.2024	0	02.07.2024	01.07.2024	01.01.2025
94116	SB	31+4	02.07.2024	0	02.07.2024	03.07.2024	02.01.2025
94292	SB	26+2	13.07.2024	2	13.09.2024	14.07.2024	13.01.2025
94328	ENND	24+3	16.07.2024	1	16.08.2024	16.07.2024	16.01.2025
94798	ENND	22+1	19.08.2024	0	assigned to Wigan 23.08.2024	19.08.2024	19.02.2025
94819	SB	25+5	19.08.2024	1	20.08.2024	20.08.2024	19.02.2025
95000	LATE MISC	23+2	01.09.2024	1	02.09.2024	05.09.2024	01.03.2025
95082	SB	27+1	06.09.2024	3	01.11.2024	11.9.24	06.03.2025
95840	SB	27+2	29.10.24	1	30.11.24	29.10.24	

Appendix 1a – Ongoing actions highlighted in completed reviews

Perinatal Case ID	Issue comment	Action plan text	Implementation update	Person responsible	Target completion date
90970/1	There is no evidence in the notes that this mother was asked about domestic abuse at booking	CM Matron review booking process/documentation	Review of booking process in progress to support documentation	Trudy Delves	30/12 2024
90970/1	Family were not able to be cared for in a designated room/suite where someone (e.g. her partner) was able to stay overnight with her because the necessary facilities are not available	Review NNU Facilities	Parent accommodation available off NICU for any family member if needed	Catherine Bainbridge	29/08/2024
90970/1	No bereavement care since death of baby	Bereavement process for neonatal deaths > 28 days requires clarification.	Review of funding for counselling offer for bereaved	Maternity Governance Matron	30/11/2024

			families underway.		

Appendix 2 – Safety Action 2 – Clinical Negligence Scheme for Trusts: Scorecard.

Appendix 3 – Safety Action 6 – SBLV3 compliance – September 2024.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	**Partially implemented**	50%		0%
Element 2	Fetal growth restriction	**Partially implemented**	90%		0%
Element 3	Reduced fetal movements	**Fully implemented**	100%		0%
Element 4	Fetal monitoring in labour	**Partially implemented**	60%		0%
Element 5	Preterm birth	**Partially implemented**	93%		0%
Element 6	Diabetes	**Partially implemented**	83%		0%
All Elements	TOTAL	**Partially implemented**	83%		0%

Appendix 4 – Plan for the attainment of CNST training requirements for rotational doctors within six months of commencement in post this includes anaesthetic and medical staff.

Surname	PROMPT Date Booked	PROMPT Completed	FM Booked	FM Completed
Hamad	06/11/24		Not Applicable to Role	Not Applicable to Role
Yan	06/11/24		Not Applicable to Role	Not Applicable to Role
Ahmed	13/11/24		Not Applicable to Role	Not Applicable to Role
Sajjad	19/11/24			13/09/24

Anaesthetist Doctors started on 7th August 2024

	PROMPT Date Booked	PROMPT Completed
Sparke	13/11/24	
Lewis	13/11/24	
Brown	19/11/24	
Prior	27/11/24	
Stewart	27/11/24	

Appendix 5 – NLS plan

CNST	NLS	Actions Required	Rating
8.18	Is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid resuscitation council NLS certification or local assessment in line with BAPM basic capability guidance by year 7 of MIS and ongoing.	All Medics to complete a LOCAL NLS teaching session in line with BAPM basic capability guidance on Doctors induction which occurs every 6 months when the doctors rotate	
		Confirmation from the deanery of which doctors will be attending NLS for a rotation place at Bolton NICU is received approximately 4 weeks before rotation. Doctors will be contacted by Medical Teaching Lead for confirmation of when they completed the 4 yearly NLS course and if anyone is overdue/due we aim to accommodate them on the next course we have candidate availability	
		All permanent medical staff who are not GIC instructors receive annual NLS teaching session in line with BAPM basic capability guidance	
		All permanent medical staff who are GIC instructors but have not taught on a course in 12 months will receive an annual NLS teaching session in line with BAPM basic capability guidance	

Medical Rotation –September 2024

September Rotation Name:	Date Local NLS In line with BAPM basic capability guidance completed:	Date 4 yearly NLS completed:
N	6/3/24	
C	6/3/24	
B	6/3/24	
B	4/9/24	
B	4/9/24	
H	4/9/24	
M	4/9/24	
T	4/9/24	GIC Instructor
C	4/9/24	GIC instructor
C	4/9/24	
Y	4/9/24	
L	4/9/24	
L	4/9/24	Required – Booked on 4/10/24 NLS

Consultants

Surname	Date Local NLS in line with BAPM basic capability guidance completed:	Date 4 yearly NLS Completed
M	N/A	GIC Instructor – last taught on S/D 19/4/24
S	08/08/2024	6/10/24
A	N/A	GIC Instructor – last taught on S/D 19/4/24
S	09/02/2024	GIC Instructor – not taught on course in since 6/10/23
S	01/08/2024	8/10/21
S	N/A	GIC Instructor – last taught on S/D 19/4/24
M	08/08/2024	23/5/23
S	01/08/2024	9/10/20

K	N/A	GIC instructor – last taught on S/D 9/2/24
SJ	N/A	GIC Instructor – last taught on S/D 19/4/24
P	01/08/2024	25/5/23

Appendix 6 - Cultural improvement plan developed to align with the Family Care Division Staff Survey Plan

Theme	Observation	Actions
Capacity and resource	**Burnout is seen as high post Covid.** Majority of staff resonate with high burnout climate, some saw it an issues for senior staff	•**Actively promote resources such as Vivup, Occupational Health, GM Resilience Hub.** •**Take time to check in with colleagues and focus on wellbeing and health** •**Ensure timely referrals and sign posting to support wellbeing** •**Encourage breaks and hydration** •**Encourage self-care and boundaries between work and personal time** •**Encourage staff to engage in activities that recharge them** •**Continue to roll out team engagement days and activities to encourage positivity and teambuilding in the workplace**

	Lack of resources, staffing and duplication in process impacting on burnout. Most staff felt that there were insufficient resources and staffing with appropriate systems and process that required duplication of effort	•**Full staffing review of the service, now recruited to staffing deficit.** •**Further funds to be sought to actively recruit into maternity leave.** •**Staffing updates to be feedback to the team so they are aware of staffing plans and feel included.** •**To continue with ongoing recruitment to support turnover and improve skill mix. Staff to be encouraged to support the recruitment process to allow them exposure and involvement in making improvements and strengthening the team.** •**Management team to remain visible.** •**Ensure staff are utilising annual leave appropriately to support rest and recuperation.** •**Encourage staff to access unit psychology support (once in post)**
	Work life balance and burn out. Some staff feel this was compounded by issues outside work, e.g. cost of living	•**Ongoing reviews of processes to avoid duplication of workload** •**Timely occupational health referral's and reasonable adjustments put in place if necessary.** •**Ensure staff are utilising annual leave appropriately to support rest and recuperation.** •**Encourage staff to access unit psychology support (once in post)** •**Continue to ensure team members access FABB conversations and have an open-door policy.**
	Support to staffing in training / preceptorship. The was a view from some staff that the skill mix of experienced staff to newly qualified needed reviewing and resetting.	•**Training gaps to be identified- to support staff** •**To continue to provide educational support and training to support staff to time manage and review resources which may avoid duplication, and labour intensive measures**
	Perception of a lack of space for rest breaks. A number of	•**Support timely meal breaks in clinical areas.**

	staff commented on the physical estate and the lack of space for rest breaks.	

Theme	Observation	Actions
Collaboration within teams	**Positive team working in community.** Some staff commented positively on elements of team working in community.	•**Daily huddle format updated to incorporate staff daily health and wellbeing concerns.**
	Communication breakdown are often drive by trust system and process. Some staff report that breakdown in communication were exhibited by sub-optimal systems and process	•**Encourage staff to speak out and vocalise the need for support if they feel pressure which may compromise the care they provide and / or their wellbeing.** •**review workloads and allocation on a shift by shift basis**
Theme	**Observation**	
Leadership & learning	**Visibility of the leadership team**. Some staff would welcome the opportunity for more visibility	•**Encourage staff to engage in Family care connect sessions to share any issues or any concerns.** •**Management team to remain visible and accessible to all.** •**Fortnightly walk rounds**
	Positive local line management. Staff felt the community line manager was positive and supportive	•**Continue to ensure team members access FABB conversations and have an open-door policy.** •**Daily check in with staff at safety huddles.** •**To continue to share FCD good news with all staff** •**To improve feedback mechanisms and encourage current measures** •**To encourage staff to attend IPM, CLIP and specialist locality meetings where possible and be involved.** •**Encourage open and honest feedback** •**Invest in development – sharing information about upcoming courses, study days etc.**

		•**Take the time to say Thank You**
	Opportunity for learning and feedback. Some staff felt this needed to be prioritised, as t had fallen off during the pandemic.	•**Continue to champion FTSU guardians as a point of contact for raising concerns.**
Theme	**Observation**	
Other	**Change in Neonatal guidelines.** The majority of nurses spoken to were concerned with the change in guidelines and line to increased burnout climate.	

Appendix 7 – Staff and patient feedback from the safety walk rounds.

You Said	We did
May 2024 Lack of bed capacity remains an ongoing concern for staff.	Staff briefed on the submission of the RAAC business case to NHS England and the interim actions taken to reduce the ongoing pressure such as the provision of an extra doctor at weekends and a NIPE Midwife to support activity. Options appraisal in progress to consider short to medium term actions to be taken until all works completed.
Battery pack needed in baby resuscitation units to ensure heating can be provided during transfer to other areas.	Giraffe unit being procured
July 2024 Additional ward equipment required	Request made for additional equipment to be provided namely: - CTG machines on G3 - Additional computer G4 - Medicine trolley for G4 - Examination of the newborn equipment.
September 2024 Room for telephone Triage awaited	- Estates request approved for sink removal in consultant room - Work commenced – October 2024
Staff not aware of progress of RAAC works	- Engagement sessions scheduled to promote staff and service user engagement.

Midwifery staffing	- Professional judgement review of all clinical areas undertaken and staff will be realigned to the new allocations

Appendix 8 - Q2 triangulation review of the Trust scorecard, incident and complaints

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q2 2024-2025

Claims Scorecard April 2013 – March 2023

Top 5 injuries by volume for Obstetrics	Top 5 injuries by value for Obstetrics
Injury 1 Unnecessary Pain 2 Stillborn 3 Fatality 4 Admit/unnecessary operation(s) 5 Cerebral Palsy	Injury 1 Cerebral Palsy 2 Brain Damage 3 Hypoxia 4 Wrongful Birth 5 Deafness
Top 5 causes by volume for Obstetrics	Top 5 causes by value for Obstetrics
Causes 1 Failure/Delay Diagnosis 2 Fail To Recog. Complication Of 3 Fail / Delay Treatment 4 Fail To Make Recp To Abnrm Pnfl 5 Inappropriate Treatment	Causes 1 Fail To Make Recp To Abnrm Pnfl 2 Fail To Interpret Ubs 3 Fail Antenatal Screening 4 Fail / Delay Treatment 5 Failure/Delay Diagnosis

Themes from complaints Q2

Complaints have been divided into informal and formal complaints and themes have been outlined below.

- Attitude of Midwife - 2
- Complications of surgery – 3
- Ineffective communication – 3
- Clinical treatment decisions - 4

Incident themes: Cause

670 incidents were reported within the maternity specialty throughout Q2 2024.25, and of those, one had a final impact of a category 3 level harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Incident Cause	Number of Incidents
NNU - Unexpected Admission	76
Communication Failure	30
Undiagonosed intrauterine growth	31
Delayed activity	26
Post Partum Haemorrhage	33

Triangulation of learning Q2

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 2 2024 – 2025. An external maternity Healthwatch reported was used to inform the triangulation of themes this quarter.

- Improve communication in service with regard to telephone access to booking and telephone triage services.
- Post partum hemorrhage
- Delays in care relating to lack of bed capacity

Ref	Key actions	Lead Officer	Deadline	Progress Update	Status
Improve telephone communication	Review and update telephone triage access and booking access	Intrapartum and community matron	Oct-24	31.07.24 Room identified for dedicated telephone triage - estates work ongoing	
Delays in care relating to lack of capacity on G2/G4	QI improvement work on G2/G4	Maternity matrons	Dec-24	31.07.24 QI project commenced	

Appendix 9 – Duty of candour letter excerpts reference case 249491 relating to Early Notification Scheme

Thank you for speaking with me on 26 June 2024. On behalf of Bolton NHS Foundation Trust may I once again offer my sincere apologies for the incident, which occurred on 25 June 2024 when your son X was admitted to the Neonatal Unit.

I appreciate that this is a very emotional and distressing time for you. You will have been in contact with many different professionals, and will have been provided with a great deal of information, which can be overwhelming, but we need to let you know that as part of our governance processes we review all cases where there is an unexpected outcome. As a result, there will be an investigation into the circumstances of your labour and birth. To do this, as discussed, we will be working with the Maternity and Newborn Safety Investigation Programme (MNSI) who undertake maternity investigations, which meet certain criteria, and investigate on our behalf with your consent.

The review will also identify any actions that can be taken to improve the care that we provide to our patients in the future and to prevent such an incident happening again.

The cooling treatment that X received on the Neonatal Unit meets the criteria for referral to the Maternity and Newborn Safety Investigation Programme (MNSI) and as such with your consent MNSI will undertake the investigation on our behalf. I hope that the written information I gave to you about MNSI is useful. MNSI will contact you directly, to discuss the process.

Appendix 9a – Case 252699

Thank you for speaking with me on the phone on the 02.09.2024. On behalf of Bolton NHS Foundation Trust, may I once again offer my sincere apologies for the incident, which occurred on the 11.08.2024 when your son X was born.

As discussed, we will be submitting a referral to the Maternity and Safety Newborn Investigations (MNSI) because X was born at full term and experienced seizures. I explained to you that at this time MNSI are not sure if it meets their criteria for review. Once they have received our referral and summary of care they will make a decision and let us know. However, as discussed with you on the telephone MNSI will only investigate if you provide your consent. If MNSI do not investigate, we will undertake a local review of the care and treatment you received to determine if there was an opportunity to have done things differently. The investigation will also identify any actions that can be taken to improve the care that we provide to our patients in the future and to prevent such an incident happening again.

I also discussed with you the Early Notification Scheme, which is a branch of the Department of Health and Social Care. Their purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care. I have sent you a link to their webpage via your email address in addition to the MNSI leaflets.

Appendix 9b – Case 251165

Thank you for speaking with me on 19 July 2024. On behalf of Bolton NHS Foundation Trust, may I once again offer my sincere apologies for the incident, which occurred on 19 July 2024 when your son X was admitted to the Neonatal Unit following his birth.

We will be undertaking an internal review into the care and treatment that you received whilst in the care of our organisation. The review will help us to establish the circumstances surrounding your son's admission to Neonatal Unit and identify if there were any opportunities for us to have done things differently. The review will also identify any actions that can be taken to improve the care that we provide to our patients in the future and to prevent such an incident happening again.

The cooling treatment that X received on the Neonatal Unit meets the criteria for referral to the Maternity and Newborn Safety Investigation Programme (MNSI) as discussed when we met. You will find further information about this in the information that was provided to you. MNSI will contact you directly regarding your decision for consent for them to undertake an investigation.

Report Title:	Bi-Annual Nurse Staffing Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	

Purpose of the report	The report provides assurance that the current nurse staffing processes and monitoring arrangements effectively meet the requirements as set by the National Quality Board (NQB) and NHSE for safe and sustainable staffing.

Previously considered by:	The report was discussed at People Committee on 19 November 2024. Comments from the meeting are included on page 3 of this report with the full summary on **Appendix 11**

Executive Summary	The bi-annual nurse staffing report provides an overview of available data to assure the Board of safe nurse staffing levels. The report triangulates workforce information with patient safety measures to ensure that staffing is balanced in line with patient acuity. It includes the outcomes from two acuity audits undertaken in July 2023 and February 2024, as prior audits were excluded due to concerns about interrater reliability. The report follows the guidance as set by the NQB to meet the three expectations: right staff, right skills, and right place and time, alongside professional judgement. • **Right Staff** - The report provides assurance that the Trust uses recommended national tools to review acuity, has agreed headroom uplift and utilises professional judgement in order to maintain staffing. • **Right Skills** - The report provides evidence that staff are undertaking relevant mandatory training and have been supported to undertake leadership programmes. • **Right Place and Time** - The report provides evidence and assurance that ongoing assessment is place for monitoring E-rostering KPIs and that staff are utilising temporary staffing solutions in order to maintain safety as and when required. The report details nationally set KPIs as partially reflective of the presence or absence of safe and effective nurse staffing levels. It shows favourable outcomes in falls figures compared to national benchmarks, including maintained special cause improvement in 'all falls' and special cause improvement in falls of moderate harm and above for the first time in over 5 years. The National In-patient surveys indicate improved feedback scores, and the Friends and Family Test maintains high recommendation rates. No staffing-related complaints were recorded during the period. From September 2024, the Trust Heat map has been revised to consolidate the KPIs that partially relate to the presence/absence of safe and effective staffing levels. The Board is asked to note the next steps and

	transformation work that is underway to further develop and enhance Registered Nurse staffing.

Proposed Resolution	The Board is asked to ***approve*** the Bi-Annual Nurse Staffing Report and its recommendations, and **note** the People Committee's discussion summary, planned next steps and ongoing transformation initiatives to develop the nursing workforce and maintain safe staffing levels.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	The newly implemented multipliers within the SNCT may lead to recommendations for increased staffing requirements, which could have financial implications for the Trust.
Legal/ Regulatory	**Yes**	The report highlights that the Trust is following the guidance set by the National Quality Board (NQB) to meet the three expectations of right staff, right skills, and right place and time.
Health Inequalities	**Yes**	Inadequate nurse staffing levels can influence patient outcomes and access to care, which may have implications for health inequalities. The report's findings should be analysed through an equity lens to ensure any potential disparities are identified and addressed.
Equality, Diversity and Inclusion	**No**	

Prepared by:	Lisa Hutton - Associate Director of Patient Safety and Quality David Mulligan - Head of Workforce Systems Rebecca Bradley - Deputy Chief Nurse Tyrone Roberts - Chief Nursing Officer	**Presented by:**	Tyrone Roberts Chief Nursing Officer

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

AACD	Acute Adult Care Division
ALOHA	Avoiding Levels of Harm Assessment
ASSD	Anaesthetics and Surgical Services Division
BAPM	British Association of Perinatal Medicine
CHPPD	Care Hours Per Patient Day
CNO	Chief Nursing Officer
CQC	Care Quality Commission
DSSD	Diagnostics and Support Services Division
ED	Emergency Department
ESR	Electronic Staff Record
FCD	Family Care Division
HCA	Health Care Assistant
KPI	Key Performance Indicators
NHSI	NHS Improvement
NMAHP	Nursing, Midwifery and AHP
NQB	National Quality Board
RN	Registered Nurse
SNCT	Safer Nursing Care Tool
SOP	Standard Operating Procedure
WTE	Whole Time Equivalent

Feedback from People Committee

The People Committee reviewed the report on 19 November 2024 with discussion focused around following items:

- Despite the pause of the community nursing acuity tool, electronic monitoring of nursing workloads continues.
- Changes to the Safer Nursing Care Tool (SCNT) may result in increased WTE, with three more census periods planned over 18 months.
- No changes have been made to paediatric staffing; daily safe staffing assessments are ongoing.
- Colleagues will be supported to attend the Trust leadership program, and significant progress has been made in skill mix improvements, particularly through international hires.
- There is partial compliance with NHSE workforce safeguards, with the Associate Director of Patient Quality & Safety leading the remaining deliverables.
- No additional work is needed to standardize the risk approach regarding staffing shortages and the Intravenous nurse service, as local assessments are deemed appropriate.
- Future planning includes incorporating Allied Health Professional (AHP) levels once the national framework is developed by the Director of AHPs.

Executive Summary

The bi-annual nurse staffing report provides a comprehensive overview of available data to assure the board that safe staffing levels are being maintained across the Trust. The report triangulates workforce metrics with key patient safety measures, ensuring staffing is continuously balanced and aligned with patient acuity needs in accordance with the National Quality Board (2018) Developing Workforce Safeguard requirements

The Trust is fully compliant with six of the 14 NQB (2018) recommendations and partially compliant with the remaining eight. This is an improvement from 2022 when only 3/14 were compliant/partially compliant. The previously shared improvement plan continues to progress with agreed timeframes met and no areas off-track.

In October 2024, the organisation was also subject to an external (NHSE) review of compliance with statutory safe staffing regulations. The review was overwhelmingly positive with GM ICB colleagues present recommending that any further requirements for assurance on Bolton FT compliance with safe staffing regulations be referred to the minutes and data pack of the assurance review meeting.

Right Staff

- The Trust utilises the Safer Nursing Care Tool (SNCT) to conduct bi-annual assessments of patient acuity and required staffing. Up-to-date licenses are held for adult inpatient wards, paediatric wards, and emergency departments.

- The latest census collection in September 2024 was the first to use the updated tool and adopted a cohort of senior leaders validating the census entries.
- Following the July 2023 and February 2024 census, establishment review processes were completed. Key outcomes include piloting alternative shift patterns for HCAs involved in enhanced care, redistributing establishments across ASSD impacted by RAAC, and reviewing the supervisory status of ward managers in smaller ASSD inpatient areas.
- A review of the three times daily SafeCare entry is underway to potentially change to a twice-daily SafeCare entry process to improve compliance.
- The Trust has remained compliant with all inpatient nurse-to-patient ratios across both adults and paediatrics. Neonatal unit maintained an average compliance of 93% with British Association of Perinatal Medicine (BAPM) requirements.
- The outputs of the SNCT demonstrate significant challenges with the provision of enhanced care. Enhanced care is where patients are risk assessed as requiring either 'within eyesight' observation or 'within arms reach' observation. The current process for this is under review with an amended pilot due to complete by early December 2024. Current processes for risk assessing enhanced care is not consistently reliable.
- The raw outputs of the SNCT are included in appendix 4 and 5. Overall, the combined two census periods support that our overall establishments in aggregate are appropriate, whilst also providing areas for review with regard to potential registered nurse and un-registered nurse (HCA) skill mix reviews. The process for this includes a multitude of factors, not least; professional judgement overseen by the CNO, and undertaken with ward managers and wider divisional teams, ward layout, number of side-rooms, case mix, skill mix of staff (noting recent recruitment of circa 185 internationally educated staff nurses), non-value-added time restraints due to digital sub-optimality and stability/competence of leadership.

In summary, the outputs from the SNCT have provided assurance that the overall net establishments for the registered nursing and non-registered nursing workforce are appropriate.

Right Skills

- Mandatory training compliance is above target, with ongoing efforts to achieve 95% compliance for compulsory training (average compliance for January to June 2024 was 93.01%).
- The Trust's in-house leadership training programme has been remodeled and the new 'Our Leaders development programme' is set to roll out over the next 18 months.
- National Adult Inpatient Survey: The Trust saw improvements in patient feedback scores for staffing-related questions in the November 2023 survey compared to November 2022.

In summary, our staff remain compliant with statutory, mandatory and professional specific education and patient perception of staffing levels has improved.

Right Place and Time

- E-Rostering and its production are closely monitored to ensure all rosters are fully optimised. Refreshed key performance indicator (KPI) reports launched in September 2024 and will be included in the next bi-annual staffing paper (see appendix 11).
- Where staffing shortfalls are identified, the escalation process outlined in the rostering policy is followed and all potential options explored before making a request for bank and agency. The data shows a gradual increase in substantive worked hours, resulting in a reduction in bank and agency usage.

- There are currently seven nurse-staffing risks on the Risk Register covering inpatient nursing staffing across Acute Adult Care Division (AACD), Anesthetics and Surgical Services Division (ASSD) and Family Care Division (FCD), with scores ranging from 3 to 12. All have controls in place and ongoing actions to reduce the scores.

In summary, the organisation is assured that systems and processes are in place to both ensure effective planned deployment of staff and reliable responses to unforeseen changes in demand or capacity

Clinical Quality Outcome Measures

- From September 2024, the monthly Trust heat map (appendix 11) has been revised to consolidate clinical quality measures and safe staffing data into one dashboard narrated monthly by Divisional Leadership Teams and overseen by the Trust Board.
- The report details incident and red flag reporting, noting an increase in staffing incidents from the previous period but a decrease from the same period in 2023. The most frequent cause being lack of suitably trained staff (due to sickness and vacancy).
- The average number of falls per 1000 bed days was 3.66, below the national benchmark of 6.63 and the Trust's benchmark of 5.3 and the average number of pressure ulcers per month has decreased to 15.2.
- In-patient national survey demonstrate improved feedback scores, and the Friends and Family Test maintains high recommendation rates. No staffing-related complaints were recorded during the period.

In summary, the organisational performance in relation to these clinical outcomes, which are evidenced to be closely aligned with effective nurse staffing levels, provide assurance that staffing levels are both safe and effective.

Summary

The data provided and subsequent analysis of nurse-sensitive quality outcomes substantiates the recommendation that Bolton FT successfully maintained appropriate safe staffing levels during the period of January to June 2024. By triangulating workforce information with safety, patient experience and clinical effectiveness metrics, the report provides assurance that nurse-staffing establishments align with patient acuity and dependency requirements.

The current work-plan at Bolton NHS Foundation Trust focuses on several key priorities to further enhance staffing processes to ensure safe and effective care. These include; changes made to current process for enhanced care risk assessments, developing a Safer Staffing Standard Operating Procedure (SOP), and the roll out of a comprehensive training program for the SNCT with compliance tracking through Health Roster and the NHS Electronic Staff Record (ESR). These will address current gaps against the NQB (2018) recommendations, support ongoing improvements and ensure that staffing establishments and nurse skill mix remain fit for the future.

Finally, to note that the revised multipliers within the SNCT are likely to lead to an increase in output recommendations for the September 2024 audit results and census periods thereafter. These will be considered once three census periods have been completed and reviewed against other factors.

Recommendations:

1. Approve the Bi-Annual Staffing Report and its recommendations.
2. Note the ongoing work to further enhance compliance against workforce safeguards
3. Support the submission of the report to the Board of Directors.

1. Introduction

This report details the findings of the Bolton NHS Foundation Trust's 6-monthly nurse staffing review for January 2024 - June 2024 in line with the requirements of the NHSI Developing Workforce Safeguards (2018)[1] and the National Quality Board (NQB) guidance (2016)[2].

The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators to ensure Bolton NHS Foundation Trust meets the NQB's requirements of deploying sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively. This also correlates to the Care Quality Commission (CQC) Regulation 18 (1).

The purpose of this report is to provide assurance to the Board of Directors that current process and monitoring arrangements are successfully fulfilling these requirements.

2. Background

In 2018, the National Quality Board (NQB) [2] released updated guidance, building on their previous 2016 publication[3] in respect of nursing and midwifery staffing for inpatient wards and assessment units to help NHS provider boards make local decisions to achieve safe and sustainable staffing that will deliver high quality care and improve health outcomes.

The guidance triangulates three key principles; right staff, right skills and right place and time, alongside measured indicators to achieve safe and effective staffing (see figure 1).

Figure 1; NQB's expectations for safe, sustainable and productive staffing[2]

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

[1] NHSI (2018) Developing Workforce Safeguards. https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf

[2] NQB (2018) Safe Sustainable and productive staffing – An improvement resource for adult inpatient wards. https://www.england.nhs.uk/wp-content/uploads/2021/05/safe-staffing-adult-in-patient.pdf

[3] NQB (2016) Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

To underpin this, in 2018 the NHSI publication Developing Workforce Safeguards, provided a comprehensive set of guidelines on workforce planning, reporting and governance approaches to support consistent process to deploying safe staffing. A gap analysis against the recommendations was completed in July 2024 (See Appendix 1) and subsequent action plan devised (see appendix 2). Bolton NHS Foundation Trust scored as fully compliant against six of the 14 recommendations and partially compliant for the other eight. The action plan is monitored through the Chief Nursing Officers NMAHP priorities and projection for the next bi-annual report is for compliance to have increased to nine.

3. Updates on Key Priorities from May 2024 Staffing Report

The review into HCA retention rates and factors influencing turnover has support the development of initiatives such as 'Stay' interviews, which have been well received by the staff group, and implementation of values based recruitment. This has supported a reduction in our average WTE for HCA vacancies; in the last 6 months of 2023/2024, this was 83.08 WTE reducing to 49.7 WTE in the first 6 months of 2024/25.

In recognition of the pivotal role HCA's play in delivering safe and effective care, a Fundamentals of Care package has been devised in line with the Health Education England Learning and Development Roadmap[4] and incorporates the Care Certificate. The programme is currently going through the Trust governance processes for approval

NHSE requires organisations to report red flags, which are national performance indicators directly linked to the provision (or absence) of safe staffing. This reporting has been enhanced by integrating it into SafeCare, a daily staffing management system that provides visibility of staffing levels across wards and departments, ensuring safe staffing principles based on patient numbers, acuity, and dependency. This change was rolled out to inpatient wards in October 2024. Additionally, red flag reporting has been updated within our incident reporting system, Ulysses Safeguard, to better analyse specific patient safety incidents related to reduced staffing. A pilot of 'standby shifts' is also underway in October 2024 to support simplifying the process of redeploying staff on a day to day basis in line with patient acuity, with wider roll out planned for quarter 4 pending the outcome of the pilot.

The Community Safer Nursing Care Tool (SNCT) is currently on hold pending an NHSE validation review; confirmation of a re-release date is awaited.

4. Expectation 1: Right Staff

The NQB recommends that there is an annual strategic safe staffing review, aligned to the organisational annual business planning cycle, with evidence that is developed using a triangulated approach of accredited tools, professional judgement and comparison with peers.

[4] Health Education England. Support Worker Learning and Development Roadmap. https://www.hee.nhs.uk/our-work/talent-care-widening-participation/support-worker-help-resources/support-worker-learning-development-roadmap

4.1. Evidence Based Workforce Planning

The Trust utilises the evidence based Safer Nursing Care Tool (SNCT) in order to undertake the bi-annual assessment of patient acuity and required staffing. Up-to-date licenses are held for the adult inpatient wards and assessment units, paediatric wards and emergency departments (ED). The license for the community tool is on hold, until a relaunch date is confirmed. All current licenses are now tracked to ensure a robust governance process.

The adult inpatient ward and assessment unit SNCT was updated in October 2023 and disseminated to trusts in 2024. The Trust's latest census collection in September 2024 has utilised the new tool. Key changes with the tool include the census period now being extended to 30 days including weekends, a new decision matrix including additional patient categories (see appendix 3) and changes to the multipliers in the workforce calculations. Additional clarification from NHSE has assisted with accurately interpreting the Trust's approach to cohorting Level 3 Enhanced Care patients into the new matrix. A second paediatric inpatient census was also undertaken in September 2024 and the first ED census between 1st-12th October 2024.

During the September 2024 census, an amended approach to validating the in the inpatient areas was adopted. A cohort of senior leaders, who have undertaken the required training based the new tool, validated the census entries provided at ward level. This cohort approach has provided a more robust validation process to support the requirement of the extended census period. This census collection is the third in the series for the adult inpatient wards and assessment units since the a full review of the Trust's SNCT processes was undertaken in 2022 with all previous outputs rejected by the Chief Nursing Officer due to concerns regarding validity and reliability.

The ED census requires a twice-daily collection and validation, which has proved challenging to achieve as it is not compatible with shift patterns of senior leaders. Therefore, a new process has been undertaken, with validation supported by the Clinical Site Managers to improve compliance (particularly with the overnight collections). Currently approaches are being explored to support twice-daily SafeCare submissions and future ED SNCT census collections.

The NQB recommends establishment reviews are undertaken after a minimum of two, ideally three census collections have taken place. Following the February 2024 census, initial establishment review processes have been completed. See section 4.2 for further details and outcomes.

SafeCare continues to be utilised by Divisional Nurse Directors and their leadership teams to review staffing on a daily basis. SafeCare is completed three times a day (Early/Late/Night) by ward teams. The information is reviewed in the twice-daily staffing meetings to support professional judgement and determine the impact of patient acuity so staff are redeployed effectively to mitigate any risks to patient and staff safety. Challenges continue with compliance for the late and night SafeCare entries; therefore, a review of the current process is underway.

The neonatal nursing workforce calculator continues to be used annually to assess neonatal staffing compliance. It was last completed in July 2024 and highlighted a deficit in neonatal

nurses qualified in specialty standard (QIS) and an excess of new starters who are yet to complete the QIS (see appendix 6 for data breakdown). An action plan to address this was presented to the Board in September 2024 and is ongoing.

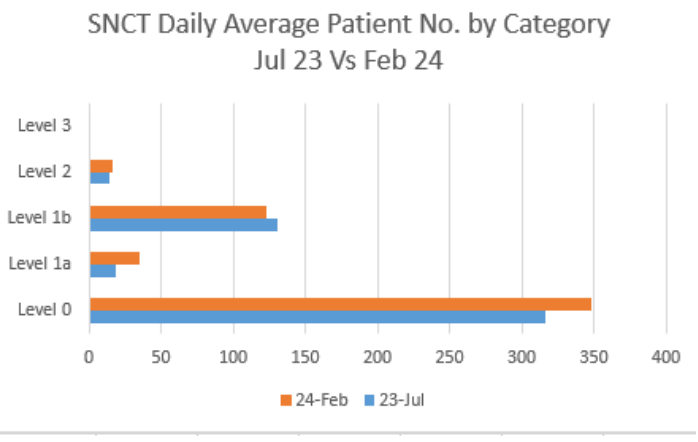
4.2. SNCT Inpatient Data Summary

Figure 2 summarises the daily averages from the July 2023 and February 2024 SNCT census collections for inpatient ward and assessment areas. Patient numbers were higher in February 2024, likely due to winter pressures and also leading to more level 1a patients and fewer level 0 patients. Enhanced Care patient data was collected for the first time in February 2024.

Figure 2: Summary of the SNCT Daily Averages Comparing the July 2023 and February 2024 Census Collections

Summary of SNCT Patient Levels of Care and Descriptor	
Level 0	Patient requires hospitalisation. Needs met by provision of normal ward cares
Level 1a	Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate.
Level 1b	Patients who are stable but are dependant on nursing care to meet most or all of the activities of daily living
Level 2	Maybe managed within clearly identified, designated beds, resources with the required expertise and staffing level, or may require transfer to a dedicated Level 2 facility/unit.
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.
Bolton NHS Foundation Trust Descripotrs for Enhanced Care	
Enhanced Care L3	Patients requiring within eyesight obeservation at all times
Enhanced Care L4	Patients requiring within arms length obeservation (1:1) at all times

SNCT Patient Level Trends (average per day)	Jul-23	Feb-24
No. Wards	23	25
Level 0	316.7	347.87
Level 1a	19.1	34.63
Level 1b	130.9	123.37
Level 2	13.8	16.37
Level 3	1.5	0.67
Total Patients	482	522.9
Patients Per Ward	20.96	20.92
Enhanced Care L3 Hrs	224.22	215.31
Enhanced Care L4 Hrs	103.03	107.58
Enhanced Care L3 Pt No.	N/A	58.57
Enhanced Care L4 No.	N/A	23.32



The SNCT census in February 2024 confirmed that overall the WTE establishment was correct, although opportunities were identified for redistribution of staff between the registered and non-registered workforce.

Registered nurses (RN) were over established by 56.58 WTE in July 2023 and 64.89 WTE in February 2024, whilst non-registered nursing staff were over established by 24.1 WTE in July 2023 and under established by 75.19 WTE in February 2024. No changes to the establishment

is currently recommended due to several factors. The NQB (2018) advises using at least two, ideally three data sets for establishment reviews to ensure data validity. The SNCT process doesn't account for variations like side rooms numbers/positions, ward layouts, staff turnover, non-value-added time due to digital constraints, and skill mix (e.g. difference between the role of a band 2 and band 3 HCA). Professional judgement will adapt the SNCT results to the specifics of the Trust. Additionally, registered nursing numbers include those in their preceptorship period and the recent internationally recruited nurses needing an enhanced induction.

Table 1 summarises the overall Trust data from the July 2023 and February 2024 census. The WTE output per ward area can be found in appendix 4 for registered nurses and appendix 5 for non-registered nursing workforce.

Table 1: Total Registered and Non-Registered Nursing staff – Comparison of establishments (funded, SNCT recommended and adjusted (SNCT results amended to provide whole staff numbers per shift and meet minimal staffing ratios)) between July 2023 and February 2024 censuses

Division	Jul-23					Feb-24				
	Est.	Rec.	+/-	Adj.	+/-	Est.	Rec.	+/-	Adj.	+/-
Registered Nurses	366.06	289.59	76.47	309.48	56.58	366.05	312.64	94.84	301.16	64.89
Non- Registered Nursing Staff	366.59	286.68	108.29	79.91	24.10	387.74	280.44	239.84	223.10	-75.19

In anticipation of achieving three data sets for adult inpatient wards and assessment areas, Bolton has undertaken initial establishment review process to identify objectives, to gather evidence to support future establishment reviews and amendments. Outcomes from the establishment reviews include:

- Pilot of alternative shift patterns for HCA's providing Enhanced Care provision to match patient demand with Ward B1
- Review of the ward manager supervisory status for smaller inpatient areas within ASSD
- Re-distribution and review of establishments impacted by RAAC across ASSD, where the majority of the variation between registered and non-registered nursing staff occurred. However, opportunities have been lost due to the move to smaller areas in response to RAAC, reducing the economies of scale.

The next three census periods between September 2024 and September 2025 will include the new tool and it is expected that some differences will be seen in the data. The increase in multipliers within the tool will deliver higher WTEs of staffing. The number of level 1b patients are expected to rise, due to Enhanced Care level 3 patients receiving care through co-horting being recorded as a level 1b (previously these patients were recorded at a level 0 for nursing need and the additional staffing for the enhanced care provision added separately to the HCA line). The new tool has specific categories 1:1 (or above) Enhanced Care patients, level 1c and level 1d (see appendix 6); analysis is currently being undertaken to explore how we apply the correct ratios of RN to HCA to ensure the staffing output reflects the Enhanced Care model

here in Bolton.

4.3. Enhanced Care Summary

Inpatients requiring enhanced care (EC) through direct 1:1 or co-horting/bay tagging are managed at ward level on a daily basis. This requires redeployment of existing staffing resource and sourcing of additional staffing outside of current ward establishments. Oversight of enhanced care patients within the organisation is now supported by a live dashboard managed by the Enhanced Care team.

The organisation is reviewing its enhanced care patient assessment and management process. While appendix 6 shows an increase in enhanced care level 3 patients, there has been improvement in the enhanced care level 4 cases following the Avoiding Levels of Harm Assessment (ALOHA) implementation in December 2022. A pilot programme across the AACD and ASSD will launch in quarter three focusing on how enhanced care patients are identified and supported by both registered and non-registered clinicians. The change aims to reduce un-necessary EC level 3 patient numbers while ensuring all clinical needs are met appropriately.

4.4. Nurse to Patient Staffing Ratios

A review of nurse to patient ratios has been undertaken between January and June 2024. Ratios remain an aspect of safe staffing through reference to the previously undertaken research by NICE, subsequently adopted by NHSE. The Trust remains in line with the recommended evidence base for registered nurse to patient ratios as detailed in Table 2.

Table 2: Compliance against key recommendations all wards during the months of January – June 2024

Area	Recommended RN to Pt Ratio	Guidance Document	Assessment
Adult Wards	Minimum of 1:8 on day shifts. No recommended ratio for night shifts	NICE (2014) Safe Staffing for Nursing in Adult Inpatient Wards and Acute Hospitals	An in depth review has been undertaken across all adult wards and the average ratio each month has not exceeded the 1:8 for day shifts which is in line with NICE recommendations
Paediatric Unit	Minimum Ratio of 1:5, with the following deviations dependent on age and acuity Level 3 Critical Care = 1:1 Level 2 Critical Care HDU = 1:2 Level 1 Critical Care = 1:3 Ward Care Over 2 years = 1:4 Ward Care Under 2 years = 1:3 Plus supernumerary B6 Shift Coordinator	Greater Manchester Paediatric Network Agreement and NQB (2018) Safe Sustainable and Productive Staffing – An improvement resource for children and young people's inpatient wards in acute hospitals	The paediatric unit achieved an average ratio of 1:3.5 between January – June 2024 across E5 ward, High Dependency Unit, Day Case Surgical patients and F5 Assessment Unit (see appendix 7). The average compliance with a supernumerary shift coordinator for the 6 months period was 93%, with compliance being reduced in January 2024 due to increased acuity of patients requiring the coordinator to work within the numbers to maintain safety.
Neonatal Unit	Staffing levels determined in relation to patient acuity: 1:1 for Intensive Care, 1:2 for High Dependency Care 1:4 for special care Plus a supervisory shift coordinator (band 7)	British Association of Perinatal Medicine (BAPM 2021, DOH 2019 and NICE 2018)	The service has achieved an average of 93% compliance during the period of January to June 2024, with 4 out of 6 months being above the 90% target (see appendix 8).

4.5. Headroom

Headroom relates to the percentage of non-patient facing working days that are included in each establishment (e.g. training, annual leave, sickness absence) and is required to ensure staffing establishment sufficient. Currently headroom is calculated at 23% consisting of 15.7% annual leave, 5% sickness and 2.32% study leave.

4.6. Clinical Quality Outcome Measures

The NQB (2016) recommends that quality measures are utilised to measure the impact of staffing on patient safety, clinical effectiveness and patient experience. This includes patient and carer feedback, staff feedback, access to care, completion of key clinical processes and occurrence of harm.

The monthly trust heat map has been revised from September 2024 to consolidate these clinical quality outcome measures and staffing data into one dashboard that in narrated by the Divisional Leadership teams each month and this has Trust Board oversight. Further work is also being undertaken to transfer the heat map into a data specific visualisation tool (rather than excel). A copy of the revised heat map alongside the previous metrics can be found in Appendix 11.

4.6.1. **Incident and Red Flag Reporting**

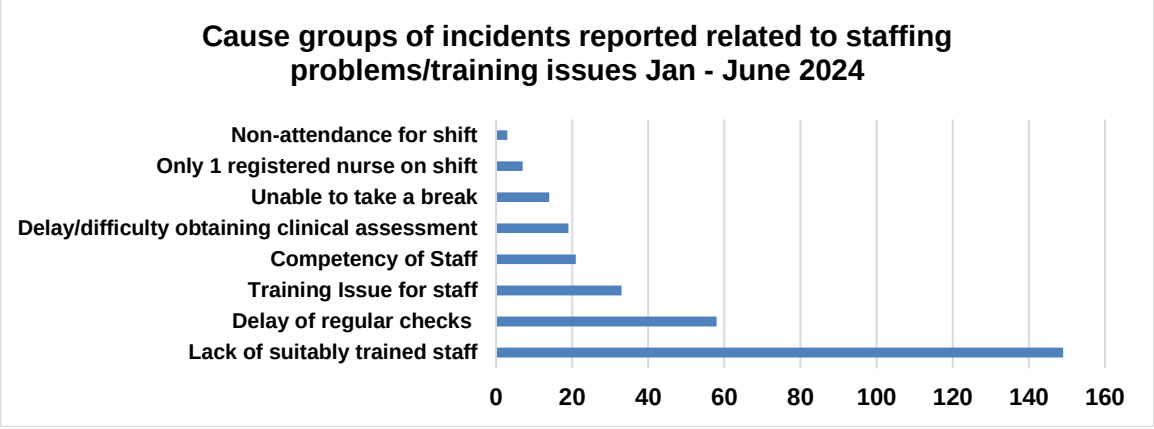
In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments reviews should consider the impact of reduced staffing via recording and monitoring of Nursing and Midwifery red flags. Red flag events are classified as:

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

Currently red flags for inpatient services are reported by clinical staff via Ulysses Safeguard system. From October 2024, red flags will be reported within the SafeCare system and this data will be represented in subsequent reports.

In total there were 307 staffing incidents reported for inpatient areas which is an increase compared with 252 incidents reported between July and December 2023, but a slight decrease on the 312 incidents reported in the same timeframe of January to June in 2023. The most common cause group (Figure 3) was lack of suitably trained staff, which is most frequently due to sickness and vacancy. Daily analysis of red flags occurs as part of the daily staffing meetings and staffing adjustments made accordingly.

Figure 3: Incidents reported (red flags) related to staffing problems/ training issues Jan-Jun 2024 for inpatient areas



The actual impact of the incidents reported was 238 no harm, 67 low harm and 2 incidents have yet to be given a final actual impact, with the initial impacts being reported as low harm. Appropriate escalation was undertaken for all of the incidents reported and mitigating actions included:

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

Seven incidents were reported under the cause group of one registered nurse/midwife on duty. This is an increase by two in comparison to July to December 2023 where 5 were reported. Four of the incidents were found to be reported incorrectly, as the narrative indicated there was more than one register nurse/midwife on duty.

Three incidents were reported correctly, all were within Family Care division and appropriate escalation to senior staff took place with professional judgement used to determine actions and mitigations. Two of the incidents were reported as no harm and one as low harm, although the narrative did not detail any adverse outcomes and should therefore have been downgraded. Sickness vacancies and Trust pressures were cited as the cause of the incidents relating to one registered nurse or midwife.

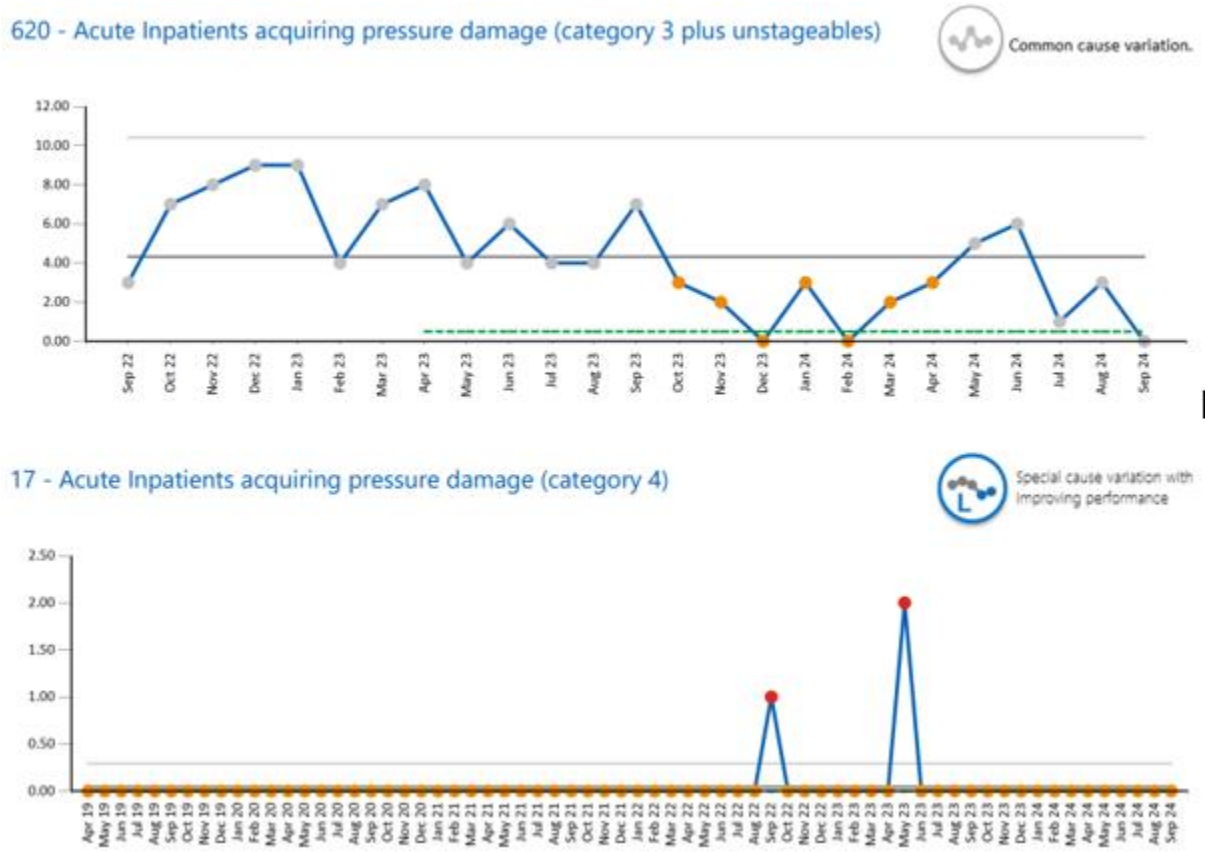
4.6.2. **Falls**

The number of falls per 1000 bed days between January 2024 and June 2024 has averaged at 3.66. This remains favourably below the national benchmark of 6.63 falls per 1000 bed days and below the Trust stretch benchmark of 5.3 falls per 1000 bed days. In this period there has been 4 falls with moderate and above harm, and all were subject review via the Patient Safety Incident response Framework (PSIRF) with themes and learning shared across the division/organisation. There has been no identified themes relateing to staffing resource during January to June 2024.

4.6.3. **Pressure Ulcers**

Pressure ulcers have averaged 15.2 per month from January to June 2024 which is a decrease from 15.83 in the previous reporting period. Unstageable pressure ulcers stopped being reported in April 2024 in line with National wound care strategy guidance, and these have subsequently been reported as Category 3 pressure ulcers, which correlates to the small increase in category 3 pressure ulcers reported from April 2024 onwards. There have been zero reported in-patient category 3 (excluding former unstageables) or category 4 pressure ulcers during this time.

Figure 4: Hospital Acquired Pressure Ulcers Category 3 and 4



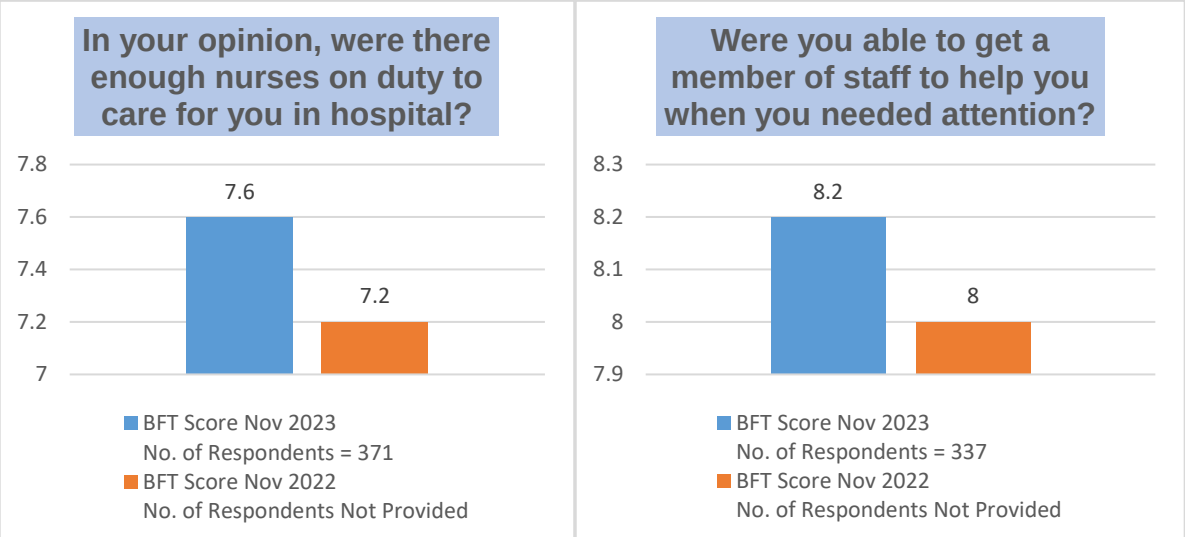
The themes are consistent with previous reporting period; delays in pressure ulcer risk assessment, long stays in the ED, delays in planned repositioning regimes, and end of life patients receiving care. In addition, learning has been associated with the importance of nutrition, recognising the importance of using the wound assessment tool for monitoring, and the importance of requesting photographs for all wounds. The actions associated with this learning is being taken forward, and monitored through the Pressure Ulcer Faculty, which is the driver alongside the Pressure Ulcer Collaborative, which commenced in October 2022 and is due to conclude in September 2024.

4.6.4. **National Adult Inpatient Survey November 2022 vs November 2023**

The National Adult In-Patient Survey includes two questions about staffing for patients who were in our beds during the collection period, which was last conducted in November 2023. Responses to these questions are scored on a scale from 0 to 10, with 10 representing the most positive response and 0 the least positive.

The Figure 5 below shows comparative results for Bolton between November 2022 and November 2023, no comparative data to other Trusts has been provided for these questions. In both questions, the Trust has seen an improvement in the average scores for the 2023 survey.

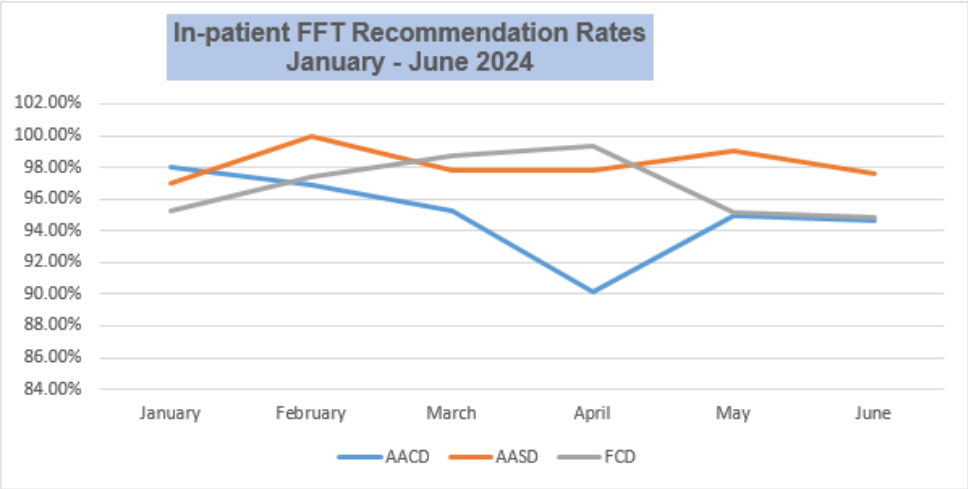
Figure 5: National Inpatient Survey Question Responses



4.6.5. **Friends and Family Test**

Recommendation rates via the Friends and Family Test (FFT) has consistently been maintained above 90% for inpatient areas across all divisions.

Figure 6: FFT Inpatient Recommendation Rates and themes for January to June 2024



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

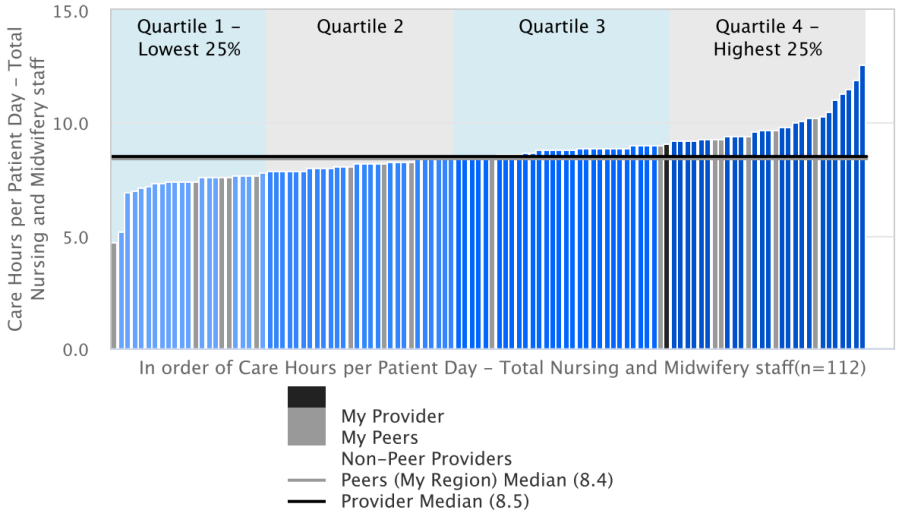
4.6.6. **Concerns and Complaints**

There were no PALS concerns or complaints relating to staffing recorded for January to June 2024. A review of categories is under way to review capturing this in more detail.

4.7. Comparison with Peers

Care Hours per patient day (CHPPD) calculates the total number of staff on duty at midnight on in-patient areas, divided by the number of patients on that ward at midnight. Figure 7 below demonstrates Bolton NHS Foundation Trust's current position nationally and in relation to peers. As of June 2024, Bolton averaged 9.1 CHPPD and sat above both our peer averages of 8.5 and 8.4. This is likely driven through enhanced care, although it could also be impacted by discharges late in the day resulting in temporary empty beds at the midnight census.

Figure 7: CHPPD – Total Nursing and Midwifery Staff (including Support Staff) National Distribution as of July 2024

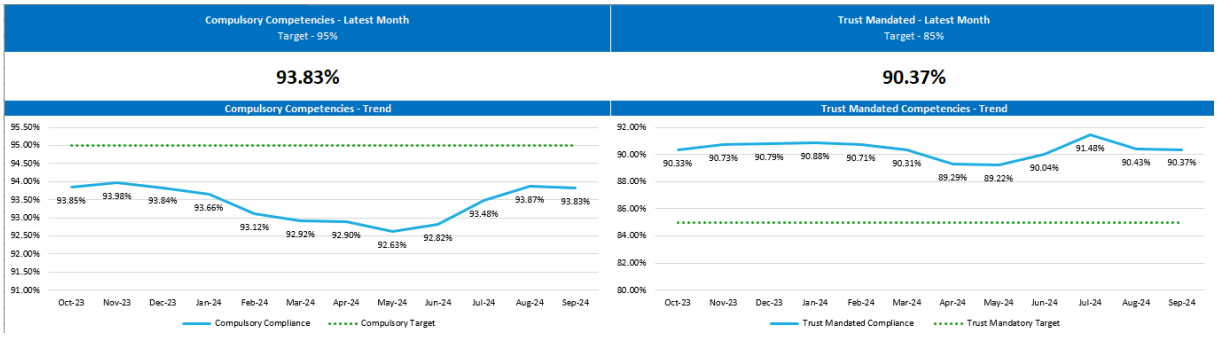


5. Expectation 2: Right Skills

5.1. Mandatory Training, Development and Education

The Trust remains above target for mandatory training compliance. Challenge continues with compliance for compulsory training Trust wide target of the 95%, which for January to June 2024 averaged 93.01%. A contributing factor is the addition of a Level 3 Safeguarding training requirement for clinical staff. A review of the training needs analysis, roll out of this training and compliance trajectory is currently underway.

Figure 8: Trust Wide Compliance for Compulsory and Mandatory Training



The Trust in-house leadership training programme has been remodeled and after a successful pilot stage involving over 80 leaders and managers, work is now underway to roll out the Our Leaders development programme over the next 18 months. The expectation will be for those who have leadership and/or management responsibilities to participate in the 2-day 'Launch Event' alongside others from across the organisation, followed by optional 'blended learning bundles' based on each individual's development plan. A full schedule of dates from February 2025 onwards is due to be released to divisions.

To have established and effective safe staffing processes, there is need to develop the ethos that safe staffing is everyone's business. In recognition of this, future transformation work is planned to support upskilling students and newly qualified staff on the principals of safe staffing through joint work with the local universities and reviews of the Trust preceptorship and induction programmes.

6. Expectation 3: Right Place and Time

6.1. E-Rostering

E-Rostering and the production of rostering is closely monitored to ensure all rosters are fully optimised.

The rostering KPI reports have been on hold for the latter part of the January to June 2024 reporting period whilst a review of the reports have been undertaken. The new look reports launched in September 2024 and will be included in the next bi-annual staffing paper. The KPI reporting periods have been aligned to the four weekly rostering production timetable and monthly assurance meetings are being planned with divisions. An example of the new Rostering KPI report can be found in Appendix 9.

6.2. Staff Measures

HR metrics continue to be reported through divisional Integrated Performance Meetings and at Trust Peoples committee. Table 3 below shows the HR metrics for each month from January to June 2024.

Table 3: HR metrics from January to June 2024

Measure Type	No.	No.	%	%	£	%	%	%	%	**NEW**	%
Period to Measure	Monthly	Monthly	Monthly	12 months	Monthly	12 months	12 months	12 months	12 months	Monthly	Jun-24
Data Month	HC (Active)	WTE	Sickness Absence (includes Covid sickness)	Sickness Absence Rolling	Est. Sickness £ (in-month)	Labour Turnover %	Appraisal (excluding medical staff)	Statutory Training	Mandatory Training	IG	RTW
Jun-24	6028	5264.15	5.11%	5.29%	£919,854.89	11.69%	86.48%	93.48%	91.48%	93.24%	69.57%
May-24	6062	5271.33	5.03%	5.29%	£872,469.48	11.50%	85.46%	92.82%	90.04%	91.34%	69.57%
Apr-24	6095	5300.47	4.97%	5.25%	£895,928.91	11.51%	83.89%	92.63%	89.22%	-	66.91%
Mar-24	6089	5297.87	4.88%	5.25%	£851,914.04	11.43%	83.93%	92.91%	89.29%	-	69.28%
Feb-24	6065	5275.94	5.25%	5.29%	£941,813.27	11.65%	83.58%	92.92%	90.33%	-	65.50%
Jan-24	6067	5278.47	5.45%	5.27%	£893,709.91	11.57%	85.28%	93.12%	90.71%	-	62.79%

RAG KPI's	RED	AMBER	GREEN
Sickness	>=4.75%	20% & <4.74	<=4.20%
Turnover	>=10%	-	<=10%
Appraisal	<=74.99%	5% & <84.9	>=85%
Stat Trainin	<=94.99%	-	>=95%
Mand Train	<=79.99%	0% & <84.9	>=85%
IG	<=94.99%	-	>=95%
RTW	<100%	-	100%

6.3. Nursing vacancy forecasting continues to be mapped through use of a waterfall chart (Figures 9 and 10), which factors in new starters, leavers, vacancies, students qualifying (both from the degree programme and nurse associates) to provide future projections.

The forecast demonstrates that based on current intake numbers the vacancy position for nursing continues to reduce, with positive projections into 2025. The forecast position at the end of the current financial year will be a reduction in vacancies from 57.32 WTE in April 2024 to 3.75 WTE in March 2025. Extrapolating further to the end of the next financial year, the forecast suggests there will be no vacancies and, in fact, there will be 99.19 WTE more nurses and nurse associates in post than available posts. This is based upon a large cohort of student nurses who will qualify and be available to join the organisation during this period. These figures do not dictate that all applications will be successful, however, the organization intends to maximize recruitment during 25/26 as workforce predictions for 26/27 present a significant decline in qualifying numbers based on reductions in entry numbers 3 years prior to 26/27. Assessment will be made on mean numbers of maternity leave, expected retirements and analysis on replacing any remaining agency reliance with substantive staff. This will be underpinned by robust rostering monitoring to ensure reliability with staff deployment.

Figure 9: Nursing joiners, leavers and vacancy for April 2024- March 2025

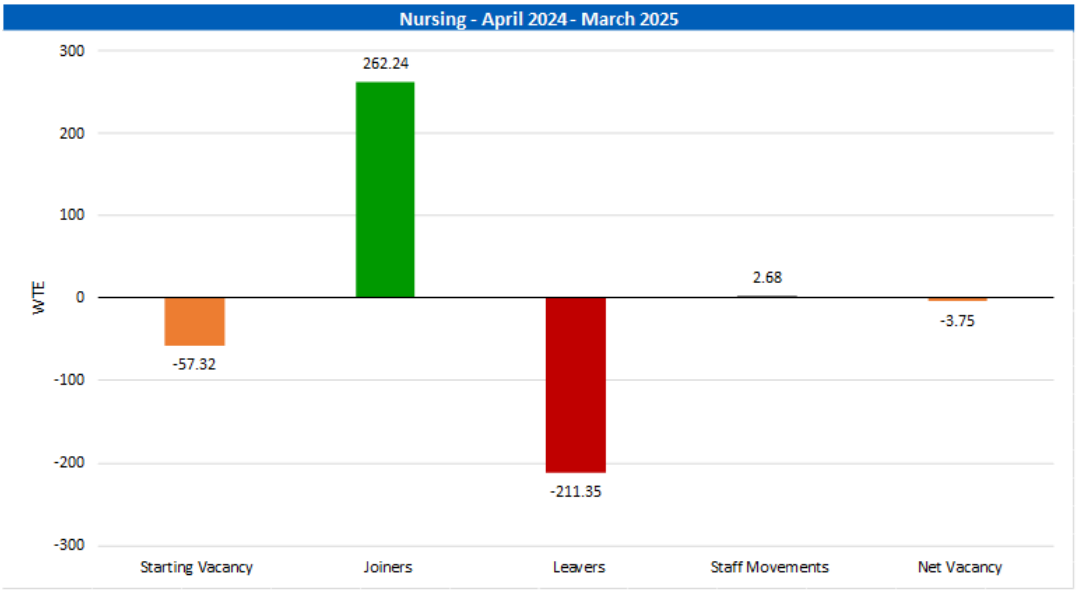
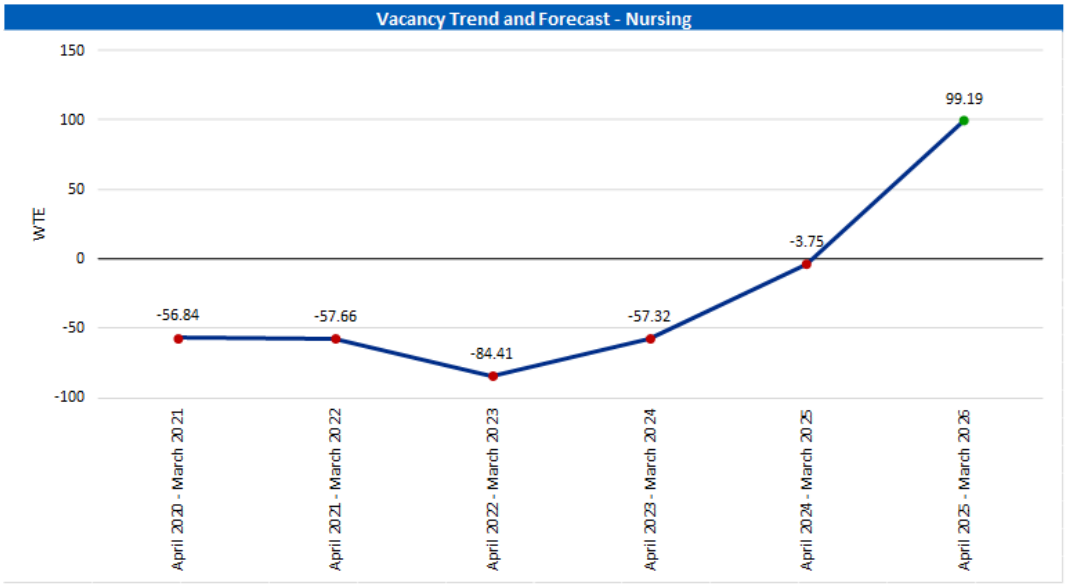


Figure 10: Nursing Vacancy Trend Forecasting



6.4. Temporary Staffing

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

The figures 12 and 13 below demonstrate the month-by-month breakdown of WTE hours for Registered and Unregistered Bank and Agency staff across the trust from January 2024 to June 2024. This is the culmination of all registered staff employed by the respective divisions including outpatient departments and specialist nursing services.

The clinical divisions have been making significant reductions in the use of bank and agency as the number of substantive registered staff increase. Figure13 demonstrates the gradual increase in substantive worked and this is resulting in the reduction of bank and agency usage.

When reviewing the data, it is important to understand that staffing levels above the 'funded' line indicate overstaffing compared to the agreed establishment. However, this overstaffing is due to factors such as sickness and absence (which are mostly covered by the agreed uplift), maternity leave, increased patient acuity, the need for enhanced care, and additional escalation areas that are open. It does not reflect a lack of control over staffing usage.

Figure 12: Registered bank and agency usage (Worked WTE)

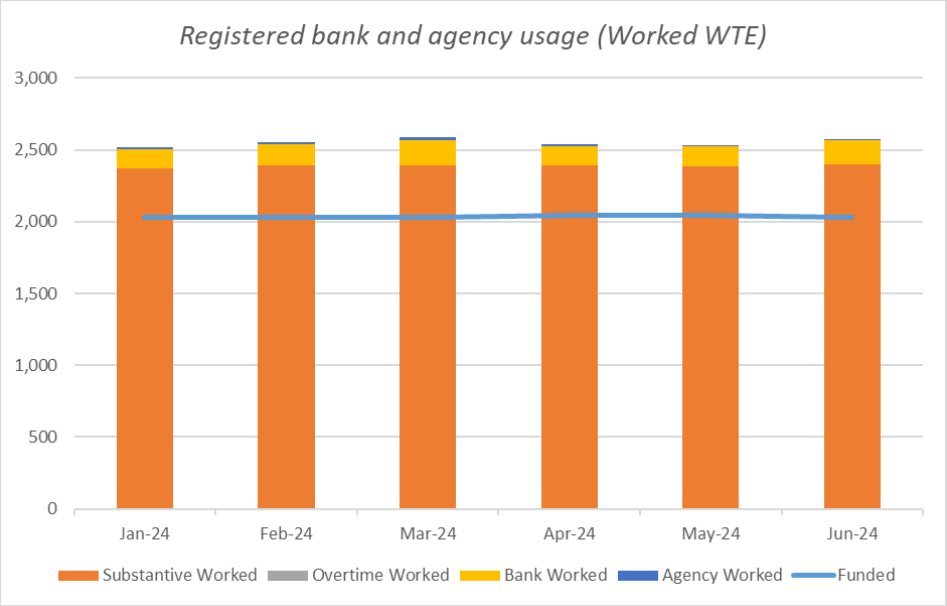
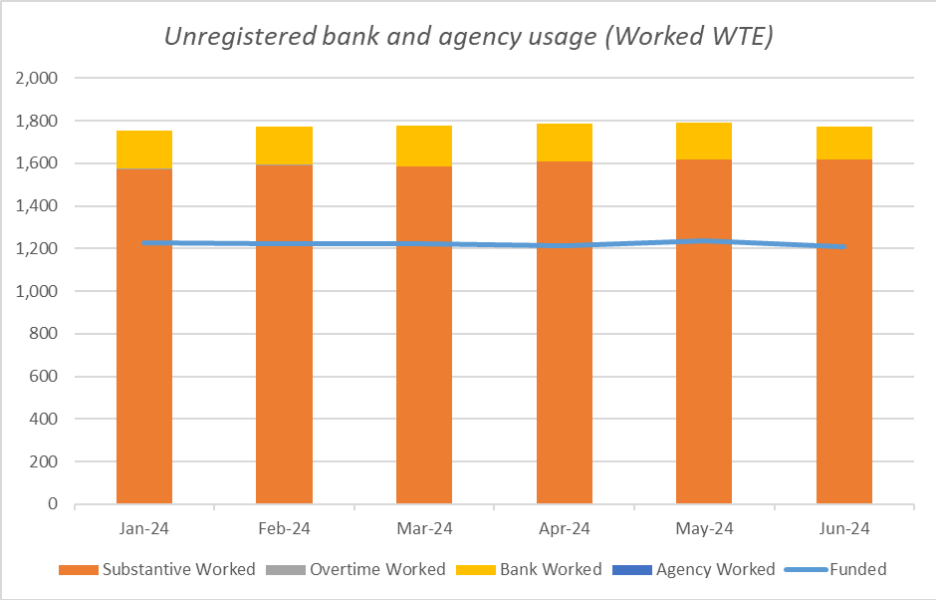


Figure 13: Unregistered bank and agency usage (Worked WTE)



6.4 Staffing Risks

There are currently 7 nurse-staffing risks on the Risk register with scores ranging from 3 to 12. All have controls in place and ongoing actions to reduce the score (see Appendix 10 for a summary of the risks).

7. Future Work-Plan

A number of next steps and priorities for the next 12 months have been referenced throughout this report and are detailed alongside specific actions in Appendix 2, which is monitored through the NMAHP priorities and CNO meetings. The key priority areas are listed below:

- Transfer of roster KPI reports to the data warehouse, alignment of reporting to rostering periods and development of Rostering KPI Assurance Meetings.
- Implementation of revised enhanced care assessment process by December 2024
- Development of rolling training programme for SNCT and compliance tracking through Health Roster and ESR
- Production of a Bolton Safer Staffing SOP to detail Bolton's approach to Safer Staffing.
- Review of SafeCare daily recording process and trial of twice daily recording to support improving compliance.
- Development of training for students, newly qualified staff and new employees of Safe Staffing
- Review of this report to ensure it is effective and to include new metrics such as Red Flag reporting and the scope to include wider staffing groups in the future.

8. Conclusion

This Bi-Annual Staffing report for January to June 2024 provides a comprehensive review of the staffing framework at Bolton NHS Foundation Trust. The report highlights the Trust's commitment to ensuring safe and effective staffing levels through rigorous processes and continuous improvement initiatives.

Key achievements include significant improvements in Health Care Assistant retention rates, the successful implementation of the updated Safer Nursing Care Tool (SNCT), and the introduction of innovative recruitment and retention strategies. The Trust has also maintained compliance with key staffing ratios and safety indicators.

This report identifies areas for continued improvement, particularly in achieving full compliance with all NQB Workforce Safeguard recommendations. The ongoing transformation work, including the development of a Safer Staffing SOP and robust training programs, is expected to address these gaps and further strengthen the Trust's staffing process.

The provision of enhanced care remains challenging, with ongoing efforts to improve the reliability of risk assessments and the management of patients requiring close observation. Additionally, the impact of RAAC on ward layouts has led to reduced economies of scale, necessitating a redistribution of staff and resources to smaller, more fragmented areas. This has further complicated staffing logistics and increased operational costs. Moreover, the introduction of the updated Safer Nursing Care Tool (SNCT) presents a potential risk, as the revised multipliers are likely to result in higher staffing requirements. This necessitates careful consideration and planning to ensure that staffing levels remain both safe and sustainable. Addressing these challenges will be crucial in ensuring that the Trust can continue to provide high-quality care while adapting to evolving demands and constraints.

Overall, this report demonstrates a continued improvement in compliance with workforce safeguards and provides assurance that the triangulated approach undertaken by Bolton NHS Foundation Trust continues on a positive trajectory towards achieving the NQB's three key principals; right staff, right skills and right time and place. The next steps outlined in the report will be crucial in sustaining and building on these achievements, ensuring that the workforce remains fit for the future in maintaining safety and delivery quality care.

9. Recommendations

It is recommended that the People Committee:
1. Approve the Bi-Annual Staffing Report and recommendations
2. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.
3. Support submission of the report to the board of directors.

Appendices

Appendix 1:
Bolton NHS Foundation Trust Gap Analysis against the NHSI Workforce Safeguard Recommendations

Ref No	Recommendation	Date: 07.07.2024 *Completed by: Lisa Hutton (Associate Director of Patient Safety and Quality)*	
		Compliance	Rational
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Partially Compliant	• SNCT process embedded within the Adult and Paeds wards and Community • Birth Rate Plus embedded in Maternity • Work required to embed SNCT in wider areas such ED, neonates, IMC and Gynaecology • Daily Safer Care data collection needs embedding and implementation across all nursing areas. • Full safer staffing implementation SOP required.
2	Trust must ensure the three components are used in their safe staffing process.	Partially Compliant	• SNCT and Birth Rate Plus in use for nursing and maternity • Need to increase compliance across all nursing areas with the SNCT • Need consider approach for other professional groups.
3	Staffing and Governance processes in place - monthly review of all workforce groups ward to board	Partially Compliant	• Currently bi-annual staffing reports completed and discussed at Trust Board. • Need to ensure monthly data review (through production of a Safer Staffing Heat Map) that will provide monthly oversight and assurance • Plans to develop a bi-monthly staffing paper for board
4	Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.	Compliant	• Annual governance statement completed
5	As part of the yearly assessment, assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	Compliant	• Data is reviewed and collated monthly for a number of workforce metrics, quality indicators and operational measures • Whilst compliant we seeking to improve our reporting through the production of a Safer Staffing Heat Map and monthly reporting structure whish will include a wider range of metrics including red flags.
6	As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.	Compliant	• Biannual and Annual staff report sign off process is in place
7	Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	Partially Compliant	• Monthly Rostering KPI reports and Biannual Vacancy Reports in place • Need to confirm process for discussion at board
8	They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	Partially Compliant	• Data is reviewed and collated monthly for a number of workforce metrics, quality indicators and operational measures N&M vacancy forecasting, across of number of reports e.g. Roster KPI, Heat Map • We are seeking to improve our reporting through the production of a Safer Staffing Heat Map and monthly reporting structure whish will include a wider range of metrics including red flags. • Need to develop process for 'cross-checks' and ensure data is a comparable metric with other organisations in model hospital.
9	An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Partially Compliant	• Biannual and Annual staff report sign off processes in place • Establishment review process in place - needs to be reviewed to ensure in line with best practice advise from NHSI
10	There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Compliant	• SNCT and Birth rate plus used as per license agreement. • Data produced on the old tool, enhanced care was calculated separately (as per recommendation from NHSI), shouldn't be required once new tool in use.
11	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	Compliant	• Any skill mixing changes/new roles/design undertaken is subject to QIA • Process will be formalised in Safer Staffing Policy when developed to provide further assurance
12	Any introduction of new roles would be considered a service change and in line with Recommendation 11 must have a full QIA	Compliant	• Any skill mixing changes/new roles/design undertaken is subject to QIA • Process will be formalised in Safer Staffing Policy when developed to provide further assurance
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Partially Compliant	• Daily Safer Staffing Meetings in place, the meetings need developing to ensure rigorous check & challenge process. • Staffing risk assessments currently managed divisionally, and escalated through trust governance and assurance processes. • Development of monthly Heat Map reporting on safer staffing will support oversight and assurance processes.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	Partially Compliant	• Daily Safer Staffing Meetings in place as apoint of escalation, the meetings need developing to ensure rigorous check & challenge process. • Staffing risk assessments currently managed divisionally, and escalated through trust governance and assurance processes. • Development of monthly Heat Map reporting on safer staffing will support oversight, assurance and escalation processes.

Appendix 2:

Action Plan Relating to Workforce Safeguard Recommendations as of 15.10.2024.

Primary Driver	Work streams	Outcome (Grey) /Actions	Action Status	Target date
Evidence Based Staffing	Safer Staffing Processes	Defined Safer Staffing processes for Bolton NHS FT in line with the Workforce Safeguard Recommendations, outlined within an approved Safer Staffing SOP/Policy	G	End of Q4
		Testing of new validation process in Sept/Oct 2024 census periods	B	12.10.2024
		Draft of SOP/Policy	G	30.11.2024
		Draft Circulated for comments	P	31.12.2024
		Progression through governance processes for sign off through Q4	P	31.03.2025
	Training, Reliability and Validation	Established SNCT training approach with compliance monitoring processes	G	Nov-24
		Undertake a Training needs analysis	B	12.07.2024
		Completion of NHSE Training for relevant staff	A	Sep-24
		Defined & agreed approach to in house validation training	G	End Sept 24
		Reporting process for training compliance	G	16.08.2024
Developing Our Quality Governance	Governance and Accountability	Review of Report Format in Relation to Monthly & Bi-Annual Safe Staffing Reports	G	Oct-24
		Establish format and process for bi-month report to board	B	31.08.2024
		Review report format to ensure compliant with requirements, accessible, and to map contributors and production timescales.	P	End of Jan 25
		Development of a Safer Staffing Section of Heat Map and Monthly reporting process	A	Sep-24
		Define Red Flags and reporting process	B	19.07.2024
		Trial of Red Flags Reporting for August 2024	B	29.08.2024
		Full role out of Red Flag Reporting from September 2024	B	01.09.2024
		Meeting with BI to review dashboard and design new aspects	B	15.07.2024
		Role of out new look Dashboard	B	Aug-24
		Feedback from DND's on new heatmap	P	Nov-24
		Further extension fo dashboard to include trust wide summary tab	P	
		Current Licesnses electronic stored alongside documents and guidelines in relation to SNCT	G	19.07.2024
		Set up safer staffing teams channel and add relevant documents	B	19.07.2024
		Set up of tracker for Licenses and renewal dates, store in teams channel with copies of licesnses	B	31.08.2024
		Confirm with Shelford Group if ED and Paeds licenses are current and obtain copies	B	31.08.2024
		Renew Paeds License	B	01.09.2024
		Renew ED License	B	01.09.2024
Professional Development	Education & Future Workforce	Introduction to Safer Staffing and Corporate Team at Trust Induction/Preceptorship/Student Induction	P	End of Q4
		Liaise with ODT to understand current content	P	
		Update content to include intro to corporate team and Bolton specific safer staffing intro	P	
		Pipeline Tracker for Student Projects for Nursing/AHP Leadership students	P	By Q3 Student Intake
		Liaise with the PEF team as to how best to move this forward	P	
		Explore supporting incorporating Safer Staffing into the curriculum at Bolton and Salford University's for Nursing Students	P	TBC
		Meet with SO to understand the impact of the issue further and developments supported by NHSE	P	
		Liaise with Universities to scope out current curriculum around Safer Staffing	P	
Transforming Our Workforce	Rostering	Expanding use of Allocate Rostering Systems	P	TBC
		Understanding the Learning and Implications from the Theatre Roster System and potential application to other areas	P	
		Options appraisal for alternative routes to managing Enhanced Care Staff Rostering	P	

Appendix 3

Updated SNCT Decision Matrix Descriptors (Shelford Group (2023). Safer Nursing Care Tool: Adult Inpatient Wards and Acute Assessment Units Implementation Resource Pack)

Levels of Care	Descriptor – care requirements may include the following:
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.

Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: - Greater than 50% oxygen continuously - Requiring close observation due to acute deterioration and needing advanced organ support - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium - CNS depression of airway and protective reflexes - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/ haemorrhage/sepsis or neuro protection.

Appendix 4

Registered Nursing WTE Establishment vs Recommended Staffing from both the July 2023 and February 2024 census'

Key:
Est. *Establishment*
Rec. *Recommended,*
+/- *Difference*
Adj. *Adjusted SNCT recommendation to ensure compliance with minimum staffing ratio and whole staff members per shift.*

Division	Ward/Team	Jul-23					Feb-24					Notes
		Est.	Rec.	+/-	Adj.	+/-	Est.	Rec.	+/-	Adj.	+/-	
Total		366.0	289.5	76.4	309.4	56.5	366.0	312.0	94.8	301.1	64.8	
AACD	CCU (Coronary Care Unit) [0121]	13.57	10.69	2.88	13.94	-0.37	13.57	10.65	2.92	13.94	-0.37	Establishment includes 'Pacing Lab' to which SNCT is not applicable, manually deducted 3.98 WTE
AACD	CDU (Clinical Decisions Unit) (0420)	13.55	10.61	2.94	13.94	-0.39	13.55	11.27	2.28	13.94	-0.39	
AACD	Ward B1 [0206]	15.79	12.19	3.60	13.94	1.85	15.79	11.47	4.32	13.94	1.85	
AACD	Ward B3 (0408)	15.79	11.48	4.31	13.94	1.85	15.79	11.11	4.68	13.94	1.85	
AACD	Ward B4 (0208)	16.53	9.20	7.33	11.15	5.38	16.53	12.35	4.18	13.94	2.59	
AACD	Ward C1 [0105]	15.79	14.83	0.96	13.94	1.85	15.79	14.32	1.47	13.94	1.85	
AACD	Ward C2 [0109]	15.79	14.49	1.30	13.94	1.85	15.79	12.52	3.27	13.94	1.85	
AACD	Ward C3 [0115]	15.79	11.62	4.17	13.94	1.85	15.79	11.66	4.13	13.94	1.85	
AACD	Ward C4 (0216)	15.79	12.10	3.69	13.94	1.85	15.79	11.67	4.12	13.94	1.85	
AACD	Ward D1 (0409)	28.22	23.71	4.51	22.31	5.91	28.22	22.00	6.22	22.31	5.91	Reduced assessment unit turnover due to lack of egress out of the ward
AACD	Ward D2 (0411)	25.22	29.59	-4.37	27.89	-2.67	25.22	18.15	7.07	16.73	8.49	Historically was an assessment ward and analysed as such, however now changed to frailty ward and so analysed as an inpatient ward
AACD	Ward D3 [0117]	17.60	15.96	1.64	13.94	3.66	17.60	16.05	1.55	13.94	3.66	Sporadic nature of NIV on D3 & D4 will be better captured as we move to new SNCT tool with 30 day capture period from Sept 2024
AACD	Ward D4 [0119]	17.60	14.57	3.03	13.94	3.66	17.60	16.46	1.14	16.73	0.87	
AACD	Ward H3 - Stroke [0204]	16.94	16.23	0.71	16.73	0.21	16.94	16.57	0.37	13.94	3.00	
ASSD	Surgery E3 (1513)	18.57	13.93	4.64	13.94	4.63	18.57	13.33	5.24	13.94	4.63	
ASSD	Surgical Care Unit 2 (SCU2) (1517)	15.93	8.58	7.35	11.15	4.78	15.93	6.10	9.83	11.15	4.78	Surgical areas have been affected by the econmomies of scale due to the changes around RAAC. Changes have been made to offset this.
ASSD	Surgical Assessment F3 (1529)	23.51	16.82	6.69	16.73	6.78	23.51	18.09	5.42	16.73	6.78	
ASSD	ENT F6 (1515)	18.57	14.06	4.51	13.94	4.63	18.56	9.54	9.02	11.15	7.41	
ASSD	Elective Care Centre - First Floor (0703)	11.53	5.70	5.83	11.15	0.38	11.53	4.12	7.41	11.15	0.38	
ASSD	Orthopaedic Male E4 (0705)	17.00	10.64	6.36	11.15	5.85	17.00	11.83	5.17	13.94	3.06	
ASSD	Orthopaedic Female F4 [0707]	16.98	12.61	4.37	13.94	3.04	16.98	11.95	5.03	13.94	3.04	
FCD	Ward E5 [2309]						31.24	41.43	-10.19	39.04	-7.80	Establishment required for F5 (11.15) & Day Case Unit (3.12) deducted from establishment

Appendix 5

Non-Registered Nursing Workforce WTE Establishment vs Recommended Staffing and Recommended Enhanced Care Staffing from both the July 2023 and February 2024 census'.

Key:
Est. *Establishment*
Rec. *Recommended,*
+/- *Difference*
Adj. *Adjusted SNCT recommendation to ensure compliance with minimum staffing ratio and whole staff members per shift.*

Division	Ward/Team	SNCT Tool	Jul-23						Feb-24					
			Est.	Rec. SNCT	Rec. EC	+/-	Adj. SNCT	+/-	Est.	Rec. SNCT	Rec. EC	+/-	Adj. SNCT	+/-
Total			366.5	286.6	108.2	79.91	234.2	24.10	387.7	280.4	239.8	107.3	223.1	-75.15
AACD	CCU (Coronary Care Unit) [0121]	Adult Inpatient Ward	4.76	4.58	0.00	0.18	5.58	-0.82	5.96	4.56	0.00	1.40	5.58	0.38
AACD	CDU (Clinical Decisions Unit) (0420)	Adult Inpatient Ward	6.16	4.24	2.50	1.92	5.58	-1.92	5.76	4.51	5.58	1.25	5.58	-5.40
AACD	Ward B1 [0206]	Adult Inpatient Ward	17.33	18.29	11.42	-0.96	16.73	-10.82	21.24	17.20	27.89	4.04	11.15	-17.80
AACD	Ward B2 (0207)	Adult Inpatient Ward												
AACD	Ward B3 (0408)	Adult Inpatient Ward	22.14	19.14	15.31	3.00	16.73	-9.90	22.12	18.52	39.04	3.60	11.15	-28.07
AACD	Ward B4 (0208)	Adult Inpatient Ward	25.56	15.33	4.93	10.23	11.15	9.48	29.55	20.58	27.89	8.97	16.73	-15.07
AACD	Ward C1 [0105]	Adult Inpatient Ward	14.96	14.83	4.26	0.13	11.15	-0.45	16.92	14.32	11.15	2.60	11.15	-5.39
AACD	Ward C2 [0109]	Adult Inpatient Ward	23.02	21.73	10.17	1.29	22.31	-9.46	24.44	18.79	22.31	5.65	16.73	-14.60
AACD	Ward C3 [0115]	Adult Inpatient Ward	23.47	17.42	3.92	6.05	11.15	8.40	25.90	17.49	0.00	8.41	11.15	14.75
AACD	Ward C4 (0216)	Adult Inpatient Ward	25.70	18.14	8.29	7.56	11.15	6.26	20.04	17.50	16.73	2.54	11.15	-7.84
AACD	Ward D1 (0409)	Adult Admission and Assessment Unit	18.20	13.17	10.45	5.03	13.94	-6.19	21.60	14.00	5.58	7.60	13.94	2.08
AACD	Ward D2 (0411)	Adult Inpatient Ward	13.93	12.68	11.42	1.25	13.94	-11.43	14.08	10.09	22.31	3.99	8.37	-16.59
AACD	Ward D3 [0117]	Adult Inpatient Ward	18.18	13.68	3.14	4.50	11.15	3.89	21.52	13.76	5.58	7.76	11.15	4.79
AACD	Ward D4 [0119]	Adult Inpatient Ward	20.06	14.57	2.28	5.49	11.15	6.63	21.48	16.46	16.73	5.02	13.94	-9.19
AACD	Ward H3 - Stroke [0204]	Adult Inpatient Ward	16.40	18.94	0.90	-2.54	13.94	1.56	17.61	19.33	0.00	-1.72	16.73	0.88
ASSD	Surgery E3 (1513)	Adult Inpatient Ward	16.98	13.93	4.37	3.05	11.15	1.46	18.59	13.33	5.58	5.26	11.15	1.86
ASSD	Surgical Care Unit 2 (SCU2) (1517)	Adult Inpatient Ward	12.59	8.58	0.00	4.01	5.58	7.01	13.28	6.10	0.00	7.18	5.58	7.70
ASSD	Surgical Assessment F3 (1529)	Adult Admission and Assessment Unit	15.93	11.21	1.57	4.72	8.37	5.99	13.28	12.06	0.00	1.22	8.37	4.91
ASSD	ENT F6 (1515)	Adult Inpatient Ward	14.50	12.05	2.91	2.45	11.15	0.44	15.91	8.18	5.58	7.73	8.37	1.96
ASSD	Elective Care Centre - First Floor (0703)	Adult Inpatient Ward	6.68	4.27	0.00	2.41	2.79	3.89	5.45	3.09	0.00	2.36	2.79	2.66
ASSD	Orthopaedic Male E4 (0705)	Adult Inpatient Ward	25.39	13.68	3.17	11.71	8.37	13.85	26.50	15.21	11.15	11.29	11.15	4.19
ASSD	Orthopaedic Female F4 [0707]	Adult Inpatient Ward	24.65	16.21	7.28	8.44	11.15	6.22	26.51	15.37	16.73	11.14	11.15	-1.38
FCD	Ward E5 [2309]	Children and Young People							12.98	13.81	0.00	-0.83	13.94	-0.96

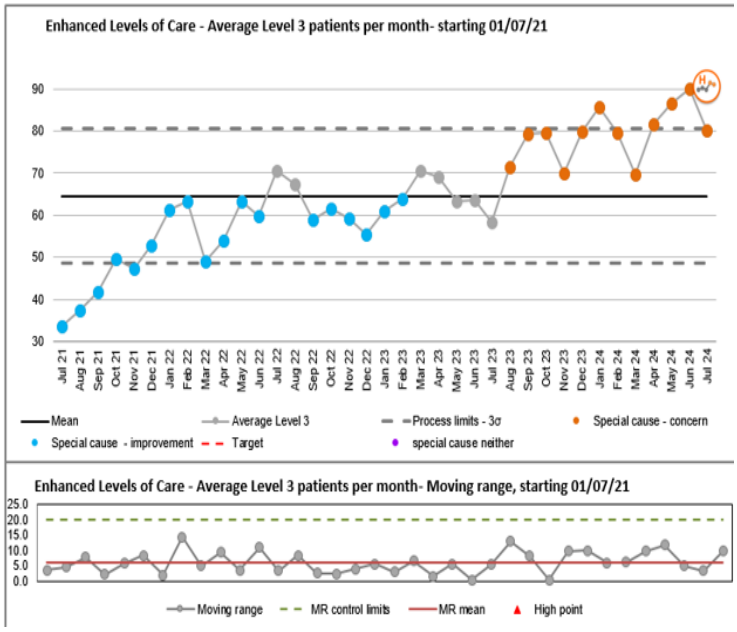
Appendix 6

Enhanced Care Data Breakdown

Level 3 Enhanced Care

1. Average Monthly Number of Enhanced Care Level 3 Patients on selected wards

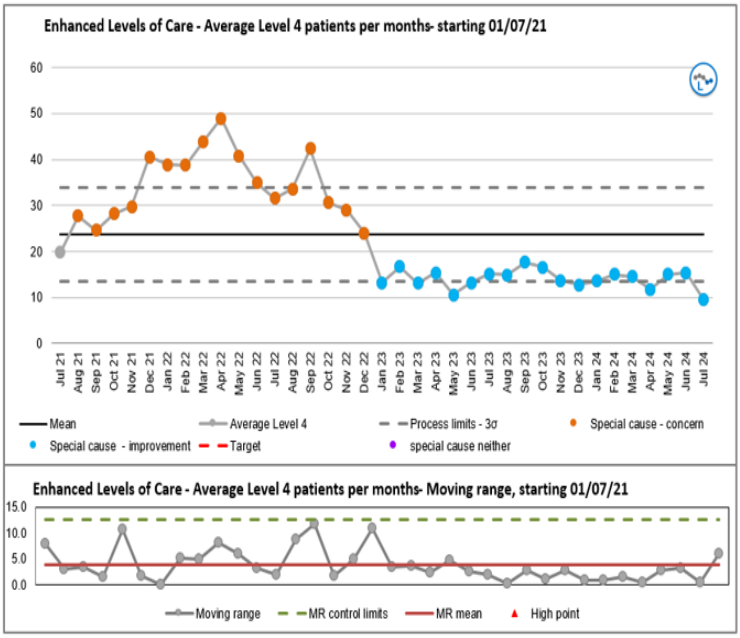
Date	Average Level 3	Date	Average Level 3
Jul 21	33.7	Nov 23	69.9
Aug 21	37.3	Dec 23	79.8
Sep 21	41.8	Jan 24	85.7
Oct 21	49.5	Feb 24	79.6
Nov 21	47.3	Mar 24	69.8
Dec 21	53.0	Apr 24	81.6
Jan 22	61.2	May 24	86.6
Feb 22	63.2	Jun 24	89.9
Mar 22	48.9	Jul 24	80.1
Apr 22	54.0		
May 22	63.4		
Jun 22	59.8		
Jul 22	70.6		
Aug 22	67.3		
Sep 22	58.9		
Oct 22	61.5		
Nov 22	59.3		
Dec 22	55.4		
Jan 23	61.0		
Feb 23	64.0		
Mar 23	70.5		
Apr 23	69.0		
May 23	63.4		
Jun 23	63.7		
Jul 23	58.4		
Aug 23	71.3		
Sep 23	79.4		
Oct 23	79.7		



Level 4 Enhanced Care

2. Average Monthly Number of Enhanced Care Level 4 Patients on selected wards

Date	Average Level 4	Date	Average Level 4
Jul 21	19.8	Nov 23	13.7
Aug 21	27.7	Dec 23	12.8
Sep 21	24.7	Jan 24	13.6
Oct 21	28.2	Feb 24	15.1
Nov 21	29.8	Mar 24	14.6
Dec 21	40.6	Apr 24	11.8
Jan 22	38.9	May 24	15.0
Feb 22	38.8	Jun 24	15.4
Mar 22	43.9	Jul 24	9.5
Apr 22	48.9		
May 22	40.8		
Jun 22	34.9		
Jul 22	31.6		
Aug 22	33.6		
Sep 22	42.4		
Oct 22	30.7		
Nov 22	29.0		
Dec 22	24.1		
Jan 23	13.2		
Feb 23	16.7		
Mar 23	13.1		
Apr 23	15.4		
May 23	10.6		
Jun 23	13.2		
Jul 23	15.2		
Aug 23	14.9		
Sep 23	17.7		
Oct 23	16.6		



Appendix 7

Family Care Division Acute Paediatrics Staffing Review: January – June 2024

Current speciality and National guidance

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

- 28-bed Medical Unit
- 7-bed Surgical Day Case Unit
- 3-bed Level 2 Critical Care Unit
- 9-bed Paediatric Assessment Unit (F5)

At the start of 2024, we clinical areas cared for the highest acuity of patients since before the pandemic. Many children admitted were very unwell, requiring higher-level care, primarily for respiratory illnesses. GM data indicated that Bolton's children's ward had the highest acuity in GM, with the highest prevalence of RSV among children.

Managing staff sickness levels has been challenging, especially with a high proportion of newly qualified staff who had not completed all their clinical practice competencies before the winter pressure period. To address this recurring issue, the Division has invested in a second practice educator role on the ward for preparedness of winter 2024.

The volume of children referred by primary care, Community Children's Nursing Team and Paediatric Emergency Department to the F5 assessment unit has increased, often doubling the unit's capacity of 9. Open access to F5 for blood tests and other procedures has also contributed to higher acuity. The Division has prioritised care pathways that support the Children's Community Nursing Team to reduce pressure on F5, such as the Jaundice Pathway.

The number of young people with complex long-term health care needs and mental health issues continues to grow, affecting ward staffing and causing distress and challenges. Increased parental leave (mainly maternity leave) between January and June has also impacted staffing numbers. This has been addressed by recruiting to fixed-term posts to backfill maternity leave for 12 months.

National Guidance

The Safer Nursing Care Tool (SNCT) for children and young people, released in 2017, recommends completing the tool for one month at least twice a year. It should be used in combination with recommendations from the RCN (2013) and professional judgment, considering contextual factors, subjective and objective judgments, and multi-professional peer reviews.

Ward E5 (excluding F5 and Day Case) completed the SNCT census in February 2024. The actual establishment was 31.24 WTE, with a recommended establishment of 41.43 WTE. After professional adjustment, the final recommendation was 39.04 WTE. A further census has taken place in September 2024 which is under review by the CNO working with the division.

The 2018 guidance "Safe, Sustainable and Productive Staffing - An Improvement Resource for Children and Young People's Inpatient Wards in Acute Hospitals" continues to be followed, with

staffing ratios and standards reflecting the age and acuity of the child, and ensuring staff have the right knowledge, skills, and competence. Key standards identified for paediatric inpatient wards include:

- **Staffing Ratios:** (reflecting the age and acuity of child and that bedside care is similar day and night)
  - Level 3 critical care: 1:1
  - Level 2 critical care HDU: 1:2 (1:1 if the child is in a cubicle/isolation)
  - Level 1 critical care: 1:3
  - Ward care: 1:4 for children over 2 years old, 1:3 for children under 2 years old
- **Staffing Reviews:** at least annually or more frequently in response to known service pressures, such as increased clinical acuity and seasonal activity.
- **Staff Competence:**
  - Ensure staff have the right knowledge, skills, expertise, and competence to meet the child's needs.
  - Each shift should have a nurse with Advanced Paediatric Life Support (APLS) qualifications.
- **Additional Staff:**
  - Do not include additional and unregistered staff in the nursing ratio establishment for inpatient areas.
  - Supervisory ward sister/charge nurse
  - Supernumerary a shift coordinator covering a 24-hour period, not included in the baseline bedside establishment.
- **Play Worker Cover:** 7-day play worker cover.

Local /GM Guidance

Due to the unpredictability of the age groups/acuity of paediatric admissions, the Greater Manchester Network have agreed a nurse / patient ratio of 1:5 24 hours a day for all age groups.

Paediatric Assessment Unit (F5) Ratios:

Short Stay Paediatric Assessment Unit children's nurse staffing should comply with Royal College of Nursing guidelines (a minimum of two children's nurses for every six to eight beds) https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

Compliance with Guidance against Guidance

Staffing is reviewed daily via the Trust Flow Reporting tool and Trust Bed meetings. The Paediatric Senior Leadership team meets weekly to review staffing and highlight shifts of concern.

Registered Nurse to Child Ratio:

The ratios have remained compliant with standards and guidance, achieving a monthly average of 1:3.5 for the reporting period. The ratios below relate to staffing cover for E5 ward, High Dependency Unit, Day Case Surgical patients, F5 Assessment Unit, and ward attenders.

Table 1 – Registered nurse to child ratio

January –June 2024 Compliance	24 hour average
January 2024	**1:4**
February 2024	**1:4**
March 2024	**1:4**
April 2024	**1:3**
May 2024	**1:3**
June 2024	**1:3**

Compliance Staffing KPI:
The inability to maintain a 100% supernumerary shift coordinator has been impacted by increased acuity and staff sickness, particularly from January to March. The ward manager and matron have occasionally undertaken the coordinator role to maintain safety.

The number of APLS band 6/7 nurses reduced in this reporting period due to being unable to training capacity in the band 6 line. Positively, a number of senior band 5 nurses have completed APLS training therefore when counting band 5s we have been able to maintain APLS trained staff on every shift.

Table 2 – Compliance with KPIs and National Standards

July – December 2023 Compliance	Supernumerary shift coordinator	APLS trained Band 6/7	7 day play team cover
January 2024	**88%**	**93%**	**100%**
February 2024	**91%**	**93%**	**100%**
March 2024	**93%**	**93%**	**100%**
April 2024	**95%**	**93%**	**100%**
May 2024	**95%**	**93%**	**100%**
June 2024	**97%**	**93%**	**100%**

Establishment and Vacancy Rates:
There are very few vacancies and staff retention is good. Recruitment is oversubscribed and the unit attracts qualified staff from other units across GM and beyond as well as student nurses.

Table 3 – Establishment and vacancies for Band 5 Staff Nurses and Non-registered staff

Registered Band 5	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Funded WTE	**31.92**	**31.92**	**31.92**	**31.92**	**31.92**	**31.92**
Current WTE	**32.77**	**31.85**	**30.32**	**30.32**	**30.24**	**30.85**
Vacancy	**+1.57**	**-0.07**	**-1.6**	**-1.6**	**-1.68**	**-1.07**
Non Registered HCA	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Funded WTE	**13.52**	**13.52**	**13.52**	**13.52**	**13.52**	**13.52**
Current WTE	**13.42**	13.42	13.42	13.28	13.28	13.19
Vacancy	**-0.42**	**-0.42**	**-0.42**	**-0.24**	**-0.24**	**-0.33**
Band 4 AP and NA	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Funded WTE	**3.78**	**3.78**	**3.78**	**3.78**	**3.78**	**3.78**
Current WTE	**3.06**	3.06	2.14	2.14	2.14	1.52
Vacancy	**-0.72**	**-0.72**	**-1.64**	**-1.64**	**-1.64**	**-2.26**

Compliance with Guidance against Fill Rate

For Registered staff in the months where the fill rates do not meet standards and are lower than expected, this is attributed to higher percentages of sickness, parenting and study leave (See Table 5). For unregistered staff on the Night Shift fill rates have consistently gone over required standard. A deep dive is underway into the rationale for this and work with finance colleagues to understand changes to establishments.

Table 4 - E5 Staffing Fill rates

Registered	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Day	76.08%	81.10%	79.28%	81.41%	77.68%	80.86%
Night	96.76%	91.96%	89.73%	93.13%	89.92%	91.31%
Non Registered	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Day	88.38%	77.43%	70.09%	78.54%	82.18%	76.25
Night	211.94%	198.38%	219.57%	196.52%	200.28%	198.04%

Table 5 - Registered Sickness and unavailability Monthly

Month	Annual leave	Sickness	Parenting	Working Day	Study Leave	Other leave	Total
Jan 24	11.6%	11.1%	3.8%	6.63%	1.1%	1.5%	35.4%
Feb 24	16.8%	4.4%	3.2%	6.4%	1.6%	1.1%	33.6%
Mar 24	22.8%	5.1%	2.2%	4.8%	2.6%	1.1%	34.8%
Apr 24	15.3%	3.5%	2.6%	4.6%	2.3%	1.1%	35.3%
May 24	13.3%	7.2%	5.2%	2.7%	4.0%	2.8%	35.3%
Jun 24	13.1%	3.8%	6.2%	2.7%	4.4%	2.1%	34.9%

Advanced Practitioners

The unit currently has 5 Advanced Paediatric Nurse Practitioners who predominantly work in F5 assessment unit. Work is ongoing to develop the role and ensure that processes are in place to support their APNP development.

Student Nurses/ TNAs/ NAs

The unit currently hosts two Student Nurse Associates (SNA) who are undergoing their training while also supporting children's nursing students from both Salford and Bolton Universities. Additionally, there are two Practice Educators who collaborate closely with students, PEFs, universities, and ensure that the placement is consistently well evaluated. Moreover, student paramedics are seconded to the unit, and we offer work experience opportunities for high school pupils in year 10 who express an interest in Children's Nursing.

Appendix 8

Family Care Division- Neonatal Unit Staffing Update Jan-Jun 2024

Current specialty and National guidance

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

Average levels from January – June 24 of staffing as per BAPM incorporating all patient: staff ratios.

MONTH	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Key:
BAPM COMPLIANCE	97%	97%	87.5%	87%	92%	94%	*95% Green* *90-95% Amber* *< 90% Red*

The neonatal nursing workforce calculator is used to assess compliance annually and was last completed in July 2024. The last review highlighted a staffing deficit in the neonatal nurse qualified in specialty standard (QIS) and an over capacity in staff recruited who have not yet undertaken the qualified in specialty training. An action plan to address the staffing deficit was presented to the Board of Directors in September 2024 and remains ongoing.

BAPM Neonatal Nursing Workforce Assessment July 2024

DIRECT PATIENT CARE - *DO NOT INCLUDE ANY NON-DIRECT PATIENT CARE WTE*				
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**
Sister / Charge Nurse	7	7.44	7.09	9
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	38.34	34.46	41
Staff Nurse QIS	5 QIS	39	12.25	18
Subtotal QIS		**84.78**	**52.69**	**68**
Staff Nurse NON QIS	5 NON QIS	17.15	31.2	35
Subtotal Non QIS		**17.15**	**31.2**	**35**
Nursing Associate	4	0	0	0
Nursery Nurse	4	4.16	4.16	4.16
Healthcare Support Worker	3	0	0	0
Subtotal Non-Reg		**4.16**	**4.16**	**4.16**
TOTAL DIRECT PATIENT CARE		**106.09**	**88.05**	**107.16**

BAPM standards

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

Compliance to the standards are summarised below:

Standard	Compliance	Comments
Supernumerary Band 7 shift coordinator on each shift within tertiary units	Complaint	Neonatal Unit at Royal Bolton is currently fully established and compliant with a supernumerary shift coordinator on every shift.
70% of nurses should be QIS (qualified in specialty trained)	Achieving 49% as of June 2024	The unit has a training trajectory to support increasing compliance. The course runs twice yearly, with a further 3 staff attending in Oct 2024 and 5 in Feb 2025. It is an intensive course and attendees benefit from previous Neonatal experience, so new staff are supported to enrol once appropriate for them to do so. This is represented on the divisional risk register and, due to the national shortage of Neonatal Nurses, has been escalated at NWNODN level, who are undertaking a training needs assessment to support network wide enhanced consolidation.
A ratio of 70:30 for registered nurse to non-registered staff for special care	Compliant	Neonatal Unit at Royal Bolton is currently fully compliant

Whilst undertaking recruitment, with a high number of new starters and turnover, the Neonatal Unit has implemented a Buddy system to support the retention of new and existing staff. The unit has been commended for this initiative

BAPM standards are based on unit activity and acuity, which can vary due to unpredictable admissions. The unit is staffed according to BAPM/ODN guidance at 80% capacity and average activity from NNAP. While staffing to BAPM is recommended, it isn't always necessary, cost-effective, or suitable for all situations (e.g., infants needing 2:1 care). Staffing figures and BAPM compliance are reviewed locally and regionally three times daily, ensuring oversight each shift. Compliance often fluctuates with activity, and escalation measures are taken when safety or staffing is compromised, with closures reported monthly. These fluctuations have sometimes altered staff perception of the unit's BAPM compliance.

The Neonatal Unit

The NNU is a level 3 regional unit, consisting of 35 cots (9 Intensive care cots, 7 High dependency, and 19 Special care cots). The unit provides care for extremely premature infants to sick term infants requiring neonatal input. Activity within neonates is unpredictable, with staffing levels often reflecting the activity on the NNU and the acuity of infants on the unit, to maintain an adequate skill mix to accommodate any unexpected admissions, transfers, etc. Activity has been hindered by unforeseen changes in Maternity involving a lack of capacity. Inability to accept regional requests for IUTs and postnatal transfers could compromise the NNU's tertiary status. Bolton NNU has been operating at 140% above HDU cot allocation, supported by NCCR funding to increase staffing and offset by reduced IC days due to lower acuity from the impact of RAAC. Conversations are underway with commissioners to explore an increase in cot base.

Daily Staffing Management

Band 7 coordinators review staffing daily and manage it in accordance with unit acuity. Where staffing levels are compromised, nurses are transferred between NNU and the Children's ward (where appropriate and not routinely) to alleviate staffing pressures and sustain a safe staff-patient ratio. An SOP supports appropriate guidance around the latter.

Sickness and Wellbeing Initiatives

The Neonatal unit is currently experiencing a high level of sickness at 5.99%, often above the Trust average of 4.2%, and is an outlier within the division. Regular deep dive exercises are undertaken by the Matron and Human Resources to review any common themes. While sickness levels are high with stress and anxiety being common themes, reassuringly this is not workplace-related. The NNU has implemented practices and resources on the unit to support stress and anxiety within the workforce. Human factors training sessions are delivered to all staff as part of mandatory training and induction. The latter endeavors to support wellbeing but also supports governance processes around incident management, allowing for a positive learning environment. The unit holds regular Schwartz rounds inclusive of all staff, and weekly wellbeing sessions are offered as a drop-in service for staff wishing to seek support confidentially.

Support around mental health and wellbeing has been enhanced by the recent recruitment of a clinical psychologist on the NNU. Psychology support was recognised as a recommendation as part of the Neonatal Critical Care Review to support both staff and parents. The support has been well received by both parents and staff alike, particularly due to recent national scrutiny after events in the media and the upcoming Thirwell Inquiry.

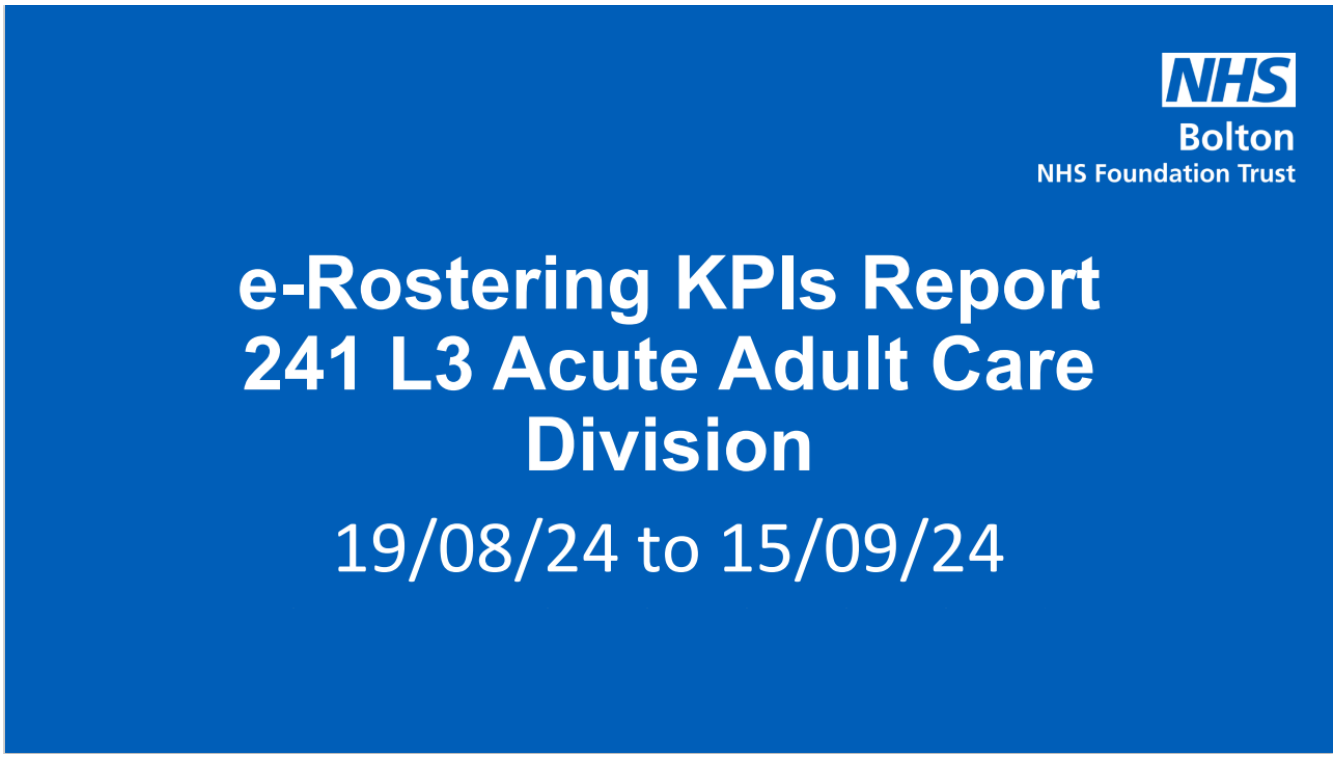
High levels of maternity leave are a common prevalence, currently at 1.24 WTE with a further 1.53 WTE to commence maternity leave in the coming months. Maternity leave, as per national guidance, is not included in staffing uplift; however, the NNU endeavors to backfill during recruitment processes.

Temporary staffing via NHSP and agency is used to support where possible. Following a universal Trust changeover to NHSP, it has been noted that rates of pay are not competitive across GM and thus this may hinder fill rates. NHSP offers a rate of pay for areas deemed critical care, inclusive of neonates. To date, Bolton NNU is an outlier in the GM network, and this has been escalated to SLT for consideration. At this time, the rates of pay remain non-competitive, with staff choosing to bank elsewhere for more recognized pay. The latter has been detrimental to the maintenance of safe and sustainable staffing.

Recruitment and Funding

As part of the Neonatal Critical Care Review, the Neonatal unit recently secured funding for 18 WTE new nurses, reflecting actual direct cot-side care against average activity over a 3-year period. Recruitment is ongoing to establish the 18 WTE; to date, the current gap is 14.06 WTE inclusive. All vacancies have been advertised with imminent interview dates.

Appendix 9: Example of the New Rostering KPI Report Launched September 2024



e-Rostering KPIs Report

Metrics

Metric		Target	Counts Towards Total	Description
Total Compliance		>=90%	*N/A*	Each applicable metric which is compliant and 'counts towards the total' is awarded a score of '1' and non-compliant '0'. Total compliance is therefore the sum of applicable, compliant metrics divided by the total of applicable metrics.
Roster Approval (in Advance)		>=42 Days	Y	Rosters should be 'fully approved' (second-level approved) by the applicable level (dependent on the service) following robust 'check and challenge' that the roster is of sufficient quality. This should be done 6 weeks (42 days) in advance of the roster start date
Additional Duties		0%	Y	Additional duties are duties over/above those contained on the roster template, i.e. in addition to the establishment model. The target is therefore zero.
Time Owing (In-Roster Period)	% Staff Owe >11.5 Hours	0%	Y	Within the month, the percentage of staff who owe more than 11.5 hours (i.e. they have worked less than the number of hours for which they have been paid). Contracted hours should be fully utilised before requesting any bank or agency.
Time Owing (In Roster Period)	% Staff Owed <-11.5 Hours	0%	Y	Within the month, the percentage of staff who are owed more than 11.5 hours (i.e. they have worked more than the number of hours for which they have been paid). Contracted hours should be fully utilised before requesting any bank or agency.
Unavailability (Reg./Non-Reg.)	Annual Leave	12% to 16%	Y	Per grade type category (registered or non-registered), the percentage of contracted hours taken as annual leave from employees' entitlements. Includes Bank Holiday and Bought Annual Leave.
Unavailability (Reg./Non-Reg.)	Other Leave	0%	Y	Per grade type category (registered or non-registered), the percentage of contracted hours of other leave assigned. Commonly used other leave reasons include bereavement, emergency/carers, career break or unauthorised leave.
Unavailability (Reg./Non-Reg.)	Study Leave	<=3%	Y	Per grade type category (registered or non-registered), the percentage of contracted hours assigned to any/all study leave, including stat/mand, CPD, role or post-specific training and apprenticeship outside study.

e-Rostering KPIs Report

Roster Management

Source Data: HealthRoster

Ward/Team	Roster Approval (In Advance) >=42 Days	Additional Duties % 0%	Time Owing: Owe Hours % Staff >11.5 0%	Time Owing: Owed Hours % Staff <-11.5 0%	Unavailability - Registered: Annual Leave 12% to 16%	Unavailability - Registered: Other Leave 0%	Unavailability - Registered: Study Leave <=3%	Unavailability - Non-Registered: Annual Leave 12% to 16%	Unavailability - Non-Registered: Other Leave 0%	Unavailability - Non-Registered: Study Leave <=3%
Total	41.14									
A&E Majors (0419)	40.13	4.84%	8.78%	0.04%	13.80%	0.80%	4.30%	17.70%	1.40%	6.70%
A&E Minors (0422)	42.62	0.64%	11.11%	0.02%	19.40%	0.60%	2.30%	17.40%	0.00%	0.00%
A&E Paeds (0423)	27.59	0.00%	7.14%	0.06%	13.40%	0.00%	7.80%	34.90%	0.00%	0.00%
CCU (Coronary Care Unit) [0121]	33.39	0.00%	6.67%	0.03%	12.90%	0.50%	1.60%	17.10%	9.40%	0.00%
CDU (Clinical Decisions Unit) (0420)	46.58	22.92%	5.26%	0.04%	18.20%	0.00%	2.30%	22.10%	0.00%	9.80%
Discharge Unit (0415)	46.59	0.00%								
SDEC (0404)	46.59	0.93%	9.09%	0.00%	14.00%	2.50%	0.90%	11.80%	0.00%	0.70%
Ward A4 (0214)	37.52	0.73%	0.00%	0.00%	13.00%	0.20%	0.40%	14.70%	3.00%	0.60%
Ward B1 [0206]	22.61	28.47%	2.38%	0.07%	16.20%	0.00%	1.60%	13.10%	0.20%	3.30%
Ward B3 (0408)	46.58	5.89%	2.08%	0.06%	13.40%	0.00%	1.40%	13.10%	0.10%	0.70%
Ward B4 (0208)	46.58	7.60%	10.87%	0.08%	15.10%	0.10%	1.40%	11.50%	0.50%	2.00%
Ward C1 [0105]	37.52	2.66%	0.00%	0.00%	13.50%	6.40%	0.80%	13.10%	0.20%	0.80%
Ward C2 [0109]	46.58	5.18%	4.26%	0.02%	16.60%	0.50%	2.70%	16.50%	0.70%	1.40%
Ward C3 [0115]	46.56	0.69%	2.38%	0.03%	14.10%	0.90%	0.40%	15.00%	0.00%	0.10%
Ward C4 (0216)	46.56	17.81%	8.89%	0.02%	16.20%	5.20%	0.80%	11.40%	1.60%	0.40%
Ward D1 (0409)	46.59	4.97%	5.88%	0.03%	15.80%	0.10%	1.10%	15.10%	4.10%	2.00%
Ward D2 (0411)	46.60	19.89%	2.56%	0.04%	12.70%	4.40%	0.40%	20.00%	0.70%	1.50%
Ward D3 [0117]	46.38	1.67%	4.76%	0.02%	13.80%	0.00%	3.20%	17.50%	0.70%	1.00%
Ward D4 [0119]	46.37	4.67%	4.76%	0.00%	12.90%	0.10%	2.00%	15.00%	0.00%	0.90%
Ward H3 - Stroke [0204]	17.56	9.22%	7.32%	0.11%	14.30%	1.30%	1.10%	15.30%	0.00%	0.50%
Ward R1 (0309)	N/A	0.00%								
Winter Ward (location Ward B2) [0207]	46.37	9.92%	13.64%	0.02%	10.70%	7.00%	0.50%	10.00%	0.60%	0.20%

e-Rostering KPIs Report

Total Compliance Trend

Ward/Team	Roster Compliance: 19-Aug	16-Sep	14-Oct	11-Nov	09-Dec	06-Jan	03-Feb	03-Mar	31-Mar	28-Apr	26-May	23-Jun	Trendline
Total	45.32%												
A&E Majors (0419)	10.00%												
A&E Minors (0422)	40.00%												
A&E Paeds (0423)	50.00%												
CCU (Coronary Care Unit) [0121]	40.00%												
CDU (Clinical Decisions Unit) (0420)	40.00%												
Discharge Unit (0415)	100.00%												
SDEC (0404)	60.00%												
Ward A4 (0214)	60.00%												
Ward B1 [0206]	30.00%												
Ward B3 (0408)	60.00%												
Ward B4 (0208)	40.00%												
Ward C1 [0105]	60.00%												
Ward C2 [0109]	30.00%												
Ward C3 [0115]	60.00%												
Ward C4 (0216)	30.00%												
Ward D1 (0409)	50.00%												
Ward D2 (0411)	40.00%												
Ward D3 [0117]	40.00%												
Ward D4 [0119]	70.00%												
Ward H3 - Stroke [0204]	50.00%												
Ward R1 (0309)	100.00%												
Winter Ward (location Ward B2) [0207]	30.00%												

Appendix 10

Summary of current Nurse Staffing Risks

Risk No.	Title	Descriptor	Current Score	Controls
5128	Neonatal Nurse Staffing	If Neonates do not increase nursing staffing numbers (by reducing vacancy rates) then there is an increased risk of unit closures, incidents, poor patient/parent experience and poor staff experience.	9	Ongoin Recruitment
5505	Acute Paediatric Nurse Staffing	If current staffing establishments remain then there is a risk of inadequate monitoring for all patients, delay in treatment and triage in F5 and a poor patient experience as a result of suboptimal staffing numbers covering inpatients, daycase, HDU and the F5 assessment unit (where only one qualified registered paediatric nurse is rostered to deliver all care required per shift).	12	Cross Cover between E5 & F5 Supernumerary Shift lead who can support F5 Emergency Buzzers in every bed space Winter staffing modelling Skill mixing Use of SNCT to review acuit vs establishment
5376	AACD Nursing and HCA Staffing Levels	IF staffing levels for nursing and HCA's are not achieved across clinical areas THEN there is a risk to the level of clinical care provided to patients	6	Daily Staffing meetings Rolling recrutiment SafCare tool to assess acuity Divisional Recruitment plan Ward manager assurance document Divisional oversight and scrutiny through finance meeting
2151	Staff being redeployed	If F3 ward staff continue to be redeployed due to staff shortage across the trust then there is a risk to patient safety.	6	Daily assessment of staffing Ward manager assessment of impact of redeployed staff Regular incident reporting
5305	Opthalmology Paediatric Nurse Cover - H2 ward	If there is not adequate paediatrically trained nurses within the departmental nursing establishment across the ward and theatre then paediatric patient procedure capacity may be affected at times of annual leave or sickness.	3	Use of bank to cover anticipated staffing gaps
5656	Registered Practitioner staffing - Ophthalmology Theatres	If there is inadequate skill mix in ophthalmology theatres then there is a risk to patient safety. High sickness levels 27.88% March 23 Vacancies- RN 2% , Support Staff 15.9%	9	Support package for new staff Ongoing recruitment Daily review of skill mix Staff enpowerment to escalate concerns Staff training on dual roles
6230	Cancer Services MDT Co-ordinator Workforce	If we do not have sufficient resource in the MDT co-ordinator team, then there is a risk that the workload will not be managed efficiently leading to; delays in patient cancer pathways, incomplete and inaccurate COSD Data, deterioration in cancer performance.	12	Use of bank Weekly oversight of workloads

Appendix 11

Original Heat Map Metrics (pre-Sept 2024) vs Revised Heat Map Metrics Launched in September 2024.

Heat Map Metrics Pre-Septmeber 2024

	Indicator	Target
	Average Beds Available per day	*N/a*
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*
	C - Diff	*Target = 0*
	MSSA BSIs	*Target = 0*
	E.Coli BSIs	*Target = 0*
	MRSA acquisitions	*Target = 0*
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*
	Harms related to falls (moderate+)	*Target = 1.6*
	VTE Assessment Compliance	*Target = 95%*
	New pressure Ulcers (Grade 2)	*Target = 0*
	New pressure Ulcers (Grade 3)	*Target = 0*
	New pressure Ulcers (Grade 4)	*Target = 0*
	New pressure Ulcers (unstageable)	*Target = 0*
Audit	Monthly KPI Audit %	*Target = 95%*
	BoSCA Overall Score %	*w=<55,b>55,*
	BoSCA Rating	*s>75,g>90*
Patient Experience	FFT Response Rate	*Target = 30%*
	FFT Recommended Rate	*Target = 97%*
	Number of complaints received	*Target = 0*
Gover-nance	Serious Incidents in Month	*Target = 0*
	Incidents > 14 days, not yet signed off	*Target = 0*
	Harm related to Incident (Moderate+)	*Target = 0*
Staff Dev - elopment	Appraisals	*Target = 85%*
	Statutory Training	*Target = 95%*
	Mandatory Training	*Target = 85%*
Staffing & Workforce	% Qualified Staff (Day)	
	% Qualified Staff (Night)	
	% un-Qualified Staff (Day)	
	% un-Qualified Staff (Night)	
	Registered Agency % (Day)	
	Registered Agency % (Night)	
	Sickness (%)	*Target < 4.2%*

Heat Map Metrics From Septemeber 2024

	Indicator	Target
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*
	C - Diff	*Target = 0*
	MSSA BSIs	*Target = 0*
	E.Coli BSIs	*Target = 0*
	MRSA acquisitions	*Target = 0*
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*
	Harms related to falls (moderate+)	*Target = 1.6*
	New pressure Ulcers (Category 2)	*Target = 0*
	New pressure Ulcers (Category 3)	*Target = 0*
	New pressure Ulcers (Category 4)	*Target = 0*
Patient Experienc e	FFT Response Rate	*Target = 30%*
	FFT Recommended Rate	*Target = 97%*
	Number of complaints received	*Target = 0*
	Quality Questions	
Gover nance	Incidents > 14 days, not yet signed off	*Target = 0*
	Harm related to Incident (Moderate+)	*Target = 0*
	Overdue Duty of Candour	*Target = 0*
Staff Dev - elopme nt	Appraisals	*Target = 85%*
	Statutory Training	*Target = 95%*
	Compulsory Training	*Target = 85%*
SafeCare Compliance and Red Flags	SafeCare Compliance	*Target = 95%*
	Omission in providing medications	
	Delay in providing medications	
	Vital signs not assessed/recorded	
	Missed care provision	
	Less than 2 RNs on shift	
	Shortfall in RN time	
	Delay in discharging	
	Total Red Flags	
Staffing & Workforce	% Qualified Staff (Day)	
	% Qualified Staff (Night)	
	% un-Qualified Staff (Day)	
	% un-Qualified Staff (Night)	
	Registered Agency % (Day)	
	Registered Agency % (Night)	
	Sickness (%)	*Target < 4.2%*

Appendix 11 – responses from People Committee

Patient safety and service delivery
Q: Are we concerned in relation to the pause of community nursing acuity tool?
A: No concerns - workload monitoring continues through electronic system, visit numbers and skill mix assessment.
Q: Are we concerned in relation to the changes to the Safer Nursing Care Tool (SCNT)?
A: Not concerned, though outcomes may indicate increased WTE. Three further census periods are planned over 18 months, with the reviews incorporating professional judgment and other factors.
Q: Has there been any changes to paediatric staffing based on previous concerns in relation to acuity?
A: Not yet. Daily safe staffing assessments continue while reviewing SNCT outputs and configuration of paediatric inpatient, assessment and high dependency areas.

Workforce Development
Q: Will colleagues be supported to attend the Trust leadership programme?
A: Yes.
Q: Is the Chief Nursing Officer professionally assured in relation to skill mix?
A: Yes. Significant progress has been made over past two years, enhanced by international colleagues' experiences. Areas with diluted ratios due to recruitment receive local support and skill mix adjustments.

Compliance & Risk Management
Q: Compliance with NHSE workforce safeguards - assured in relation to partial compliance?
A: Yes, progress from nil compliance two years ago has been made (due to SNCT reliability issues), the Associate Director of Patient Quality & Safety is leading on the remaining deliverables, and is on track for completion.
Q: Is work needed to standardise the risk approach regarding staffing shortages and the Intravenous nurse service?
A: No. Risks demonstrate appropriate local assessment. The paper covers inpatient areas, community and A&E (excluding specialist services such as IV nursing). Staffing risks rare reviewed by score (12+ at Risk Management, <12 locally). Overall nurse staffing levels are assessed as safe.

Future Planning
Q: Will Allied Health Professional (AHP) levels be included at some point?
A: Yes, pending the national framework development by the Director of AHPs.

Report Title:	Maternity Bi-Annual Staffing Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to outline the findings of the maternity bi-annual review for the period January to June 2024.

Previously considered by:	This report was presented at People Committee on 19 November. Key points raised included: • clarification on the variance between Category 4 and 5 classifications from the 2019 to 2023 census. The changes have been difficult to understand due to shifts in key stakeholders since 2019. The Birth Rate Plus process includes daily census entries by midwives, verified with case note reviews to capture patient medical history thoroughly. • There was a notable increase in high-risk pregnancies (Category V) from 29.3% in 2019 to 51.4% in 2023, significantly affecting staffing needs. This rise is attributed to more obstetric, fetal, medical issues during pregnancy, and higher induction rates. • Promoting Bolton as a preferred birthplace, the focus will be on offering choices between two midwifery-led units, despite current RAAC constraints limiting full options. Ongoing communications will highlight upcoming redevelopments and investments in maternity services, aiming to boost future bookings.

Executive Summary	The maternity staffing report provides an overview of available data to provide assurance to the board of safe staffing levels. The report triangulates workforce information with patient safety measures to ensure that staffing is balanced in line with patient acuity. The report follows the guidance as set out by the National Quality Board to meet the three expectations, right staff, right skills, right place and time. In summary, the report highlights ongoing maternity workforce challenges and details actions taken to mitigate risk to clinical safety and improve training compliance to provide assurance of a safe maternity service. Safe staffing levels were maintained during this period, in part mitigated by the ongoing closure of Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels.

Proposed Resolution	The Board is asked to ***approve*** the Maternity Staffing Report and its ecommendations, and note the People Committee's discussion summary: I. Approve the report and recommendations.

	II. Approve sharing the report within local maternity andneonatal system and at regional level quality surveillance meeting, with submissions to committees as required. III. Approve presentation of report to Trust Board to fulfil CNST scheme requirements.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓			

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	
Legal/ Regulatory	Yes	
Health Inequalities	Yes	
Equality, Diversity and Inclusion	Yes	

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

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

BR+	Birthrate Plus (Staffing Review)
CNST	Clinical Negligence Scheme for Trusts
NICE	National Institute for Clinical Excellence
NQB	National Quality Board
RCOG	Royal College of Obstetricians and Gynaecologists
OASI	Obstetric Anal Sphincter Injury

1. Executive Summary

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

The review incorporates national guidance relating to the provision of safe staffing levels within maternity services and findings of the formal Birthrate Plus (BR+) assessment of the midwifery establishment staffing levels published in 2023.

The report fulfils the requirements outlined in the National Quality Board (NQB 2018) and the Clinical Negligence Scheme Trusts guidance (CNST 2024) that recommended maternity services should undertake a safe staffing review on an annual basis and at a mid-point review every 6 months.

The report follows the guidance as set out by the National Quality Board to meet the three expectations, right staff, right skills, right place and time.

Right Staff

- The current funded Registered Midwife establishment of 242.58WTE is compliant with the 2019 Birthrate Plus report recommendations.
- The non-clinical specialist midwifery establishment is 10% of the overall establishment and within expected parameters
- The last Birthrate Plus review was undertaken in 2022 and published in January 2023. The next review is due in 2025.
- The business case to seek an uplift to the funded establishment to meet the recent Birthrate Plus 2023 report recommendations was approved at Capital Revenue and Investment Group (CRIG) in May 2024.
- The BR+ business case recommended an uplift to the establishment as indicated, which will be phased over 2025 in line with re-opening of current reduced capacity. Recruitment is ongoing.
- The service maintained the supernumerary status of the 2nd Delivery Suite Co-ordinator throughout the January – June 2024 period.
- One to one care in labour compliance rates remained below the 100% standard, with a variation from 97.7% to 98.6% during the period. An action plan to recover performance is detailed within this report.

Right Skills

- Mandatory and statutory staff training compliance during the period January – June 2024 remained below the Trust standard due to ongoing staffing pressures
- The dashboard highlights deficiencies in the professional specific training compliance during the period January – June 2024 were reflective of the staffing challenges during this period. Assurance can be provided attainment of the required 90% standard with PROMPT, fetal monitoring and newborn life support training compliance was attained in February 2024.

Right Place and Time

- In March 2024 the postnatal and antenatal capacity was relocated to alternative area on G3 and G4 resulting in the bed capacity loss of 34 beds. All staff were relocated to the new ward areas during the ward moves.

Clinical outcomes

- Improving performance with regard to the booking of women prior to 12+6 week gestation continued during January – June 2024 within the community setting. The improvement correlated with improvements in the provision of laptops to all community midwifery staff during this period.
- Local variation in the incidence of stillbirth was identified on the Trust integrated performance dashboard in June 2024 with an overall incidence of 4.94/1000 births. The Trust 2024 rolling GMEC average rate in June 2024 was 4.16 /per1000 slightly lower than GMEC rolling 12 months rate 4.370 range of gestation. In response, a new oversight table was developed to enable a detailed review of the data and an additional data verification check to be undertaken each month.
- CQC 2023 maternity survey 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 findings reflected the overall service challenges in early 2023, the decrease in place of birth choice at Bolton since 2022.
- Deterioration and recovery of the overall friends and family response rate noted during the period of review due to delays in the inputting of a paper based forms. Work ongoing to transition to digital inputting via QR codes at the point of survey to negate this delay.

In summary, the report demonstrates the ongoing workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance.
Safe staffing levels were maintained during this period, in part mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICB colleagues.

2. Background

In January 2018, the National Quality Board (NQB) released updated guidance in respect of nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Table 1: NQB expectations for safe, sustainable and productive staffing

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

3. Expectation 1 - Right staff

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

3.1 Birthrate Plus - Evidence based workforce planning

Birthrate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The Birthrate Plus assessment was last published in January 2023 and included case mix data from June to August 2022.

The report acknowledged that the Beehive alongside birthing centre and the Ingleside freestanding birthing centre were closed to birthing activity at the time of the assessment. Both clinical areas remain closed and the re-opening of additional will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

The report confirmed that there had been a noticeable change in the number of women in category V (highest acuity) category of case mix in the 2023 with the % increasing from 29.3% in 2019 to 51.4% in 2023. This increase in acuity had a significant impact upon the required staffing ratio.

Within Greater Manchester and Eastern Cheshire, Bolton has the highest number of women in the highest acuity with 72% in the Cat IV and V classification. This has increased from 63% in 2019. To be noted a rise in acuity has been noted in most maternity services over the last 3-4 years. This increase has been discussed with regional colleagues and a request made by GM ICB Chief Nurse for LMNS Birthrate+ lead to attend a Chief Nurse discussion to discuss the findings, specifically to explain how one locality report can highlight such a significant increase in acuity.

The majority of maternity services have seen an increase in the % of women with significant safeguarding needs which adds to the clinical workload and additional staffing is included in the community staffing for 600 women with significant safeguarding needs in the 2023 report in response to the assessment undertaken.

Findings of the Birthrate Plus 2023 review confirmed that a total clinical staffing establishment of 283.07 Whole Time Equivalent (WTE) was required to deliver a safe midwifery service. The breakdown as to how the staffing establishment was calculated by Birthrate Plus is detailed in Appendix 1.

The funded establishment is not yet compliant with the 2023 Birthrate Plus report recommendations as the Trust has not yet appointed to the approved funded uplift. The BR+ business case recommended an uplift to the establishment which could be phased over 2025 in line with re-opening of current reduced capacity.

A revision of the skill mix is ongoing to ensure a 90:10 mix is deployed in postnatal clinical areas has been undertaken in accordance with professional judgement. Deployment of the reconfigured establishment will be undertaken via consultation in accordance with workforce policy. This will involve an uplift of the maternity support worker roles by 6.6WTE and a reduction in band 2 roles by 10.34WTE.

Monthly establishment reconciliations continue to be shared with the service that detail the funded and vacant positions within the funded establishment. The monthly reconciliation as of

June 2024 is detailed in Appendix 2. The reconciliation undertaken in June 2024 was based upon the total funded clinical WTE establishment defined in the 2019 Birthrate Plus report of 242.58WTE as alignment to the 2023 Birth report recommendations had not been fully approved.

Since the last Birth Rate Plus report was published in 2023 the activity has remained static, yet capacity pressures have exacerbated due to closure of maternity areas following the finding of reinforced autoclaved aerated concrete within the maternity building and subsequent relocation of ward areas resulting in a loss of 34 beds. As a result low risk and high risk birth activity during the period January – June 2024 continued to be managed on Delivery Suite, significantly impacting upon patient flow within the maternity unit. It is the lack of this overflow that continued to impact upon flow within the unit despite the relocation of intrapartum activity to CDS and the implementation of a discharge lounge (4 spaces) on G4. This lack of overall bed capacity on CDS continues to impact upon the timely transfer of cases of induction of labour which has safety implications for both mother and baby.

The Birth Rate Plus review is due to be repeated in autumn of 2025 and should acuity in next BR+ be increased as per national predictions' then a further increase in midwifery establishment can be anticipated.

3.2 Specialist Midwifery Roles

Specialist midwives support the delivery of the maternity service providing expert guidance and specialist support to the midwifery team. In June 2024 26.23WTE specialist midwives were employed in a non-clinical specialist capacity within the maternity service undertaking a range of roles including infant feeding specialist, digital midwife and pastoral support.

Birthrate Plus advises that the additional workforce should equate to no more than 8-10% of the funded clinical midwifery establishment to provide specialist support for the delivery of a safe service. The specialist establishment (26.23) is therefore within the recommended specialist midwifery requirements.

The specialist workforce calculation reflects the non-clinical element of the specialist and management roles. The additional clinical element of the role is included in the overall clinical establishment.

3.3 Registered Midwife to birth ratio

An overall recommended ratio of 1.23 births to 1WTE was highlighted in the 2023 Birthrate Plus report. This ratio was calculated using the case mix and acuity data. Differing ratios are applicable to hospital and community areas as the acuity of the patients differs i.e. community midwifery ratio 1:92.4.

The 2023 report advised the overall ratio that should be applied to the service at Bolton based upon activity and acuity in all areas is to 1:23. This ratio differs from that recommended in the 2019 report namely 1:27 and reflects the increase in acuity reflected in the recent review.

On a monthly basis the Birthrate plus midwife to birth ratio is calculated to provide assurance that staffing levels (including bank and agency usage broadly align with the recommended standard). Fluctuation in the ratio is notable at times of low shift fill. Table 2 highlights that the mean staffing ratio (calculated to include all worked hours) between January and June 2024 met the required 2023 Birthrate standard when bank and agency usage is taken into account.

Table 2: Midwife to birth ratio (in accordance with 2019 recommendation)

Indicator	Goal	Red Flag	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Midwife/ Birth Ratio (rolling) target changed July 21	1.27	1.3	1:23.2	1:22.9	1:22.8	1:22.6	1:22.6	1:22.6
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		1:21.6	1:21.7	1:21.5	1:21.4	1:21.1	1:20.8

3.4 Headroom / Uplift

Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc.). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered. Current headroom/uplift provided within the Trust is 23% with national ranges varying between 19% and 25%.

3.5 Professional judgement

The judgement of senior experienced midwives remains a critical factor in determining staffing levels, as there remains no single factor that can determine staffing levels other than in areas where staffing has mandated levels (e.g. critical care). The last professional judgement annual review was repeated in August 2024.The review included the Director of Midwifery, Maternity Matrons, workforce, and finance colleagues and considered:

- Acuity requirement
- Ward/dept leadership
- Ward/dept layout and environment
- Additional specific training requirements
- Support of carers/patients

3.6 Safety outcome indicators

Maternity sensitive staffing metrics are displayed on the integrated performance maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and thus need investigation and prompt action. The dashboard reflected in Table 3 highlights the staffing related key performance metrics for the period January – June 2024.The dashboard reflects ten maternity diverts during the period of review due to the reduced bed capacity following the ward reconfigurations.

The maternity dashboard indicators reflect a challenged yet improving service during the period January – June 2024. One to one care in labour compliance rates remained below the 100% standard, due to the ongoing yet decreasing vacancy position that ranged from 21.16wte in December 2023 to 12.83WTE in June 2024

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with the 1:1 care in labour standard and an action plan if the standard cannot be demonstrated. The action plan to recover performance is detailed in appendix 3.

Improving performance with regard to the booking of women prior to 12+6 week gestation continued during the period January – June 2024 within the community setting. The improvement correlated with the provision of digital access and laptops to all community midwifery staff during this period. Community midwifery staffing remained a challenge during this time and this deficit impacted upon the team's ability to flex availability and offer weekend/evening clinics for booking to positively influence the 12+6 compliance. To note the Trust mean or median (as GMEC states median) for 12+6 booking compliance aligned with the Greater Manchester and Eastern Cheshire (GMEC) median of 84.88% during this period.

Local variation in the incidence of stillbirth was identified on the Trust integrated performance dashboard. Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Incidence 4.94/1000 births. A new oversight table was developed to aid the review of data and an additional data verification check to be undertaken each month. Trust 2024 rolling GMEC average rate 4.16 /per1000 slightly lower than GMEC rolling 12 months rate 4.370 range of gestation.

The Trust incidence of Obstetric Anal Sphincter Injury (OASI) (3rd and 4th degree) tears was flagged on the Trust dashboard on two occasions during the period January to June 2024. Year to date incidence 3.38% slightly higher than rolling 12 month Greater Manchester and Eastern Cheshire (GMEC) comparator average of 2.69%. The Trust presented at LMNS shared learning event and further improvement suggestions identified ie: Implementation of the RCOG operative birth simulation training for medical staff (ROBuST) and support for newly qualified staff to undertake episiotomies to be introduced.

Table 3 - Critical Safety Indicators

Indicator	Goal	Red Flag	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Critical Safety Indicators								
Stillbirths per 1000 births (per month) as of January 24, (including TOP)	3.5	≥4.3	8.9	7.3	2.5	0.0	9.2	4.9
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	1	1	1	1
% Completed Bookings by 12+6 BI calculation	90%	<90	78.90%	80.80%	79.80%	81.78%	86.63%	88.03%
ICU/ HDU Admissions	Information only		2	1	2	1	0	0
Post-Partum Hysterectomy	0	0	0	1	0	0	0	0
2nd Maternity theatre requested to be opened but delay or unable to open changed to rag rate Aug 21	0	>=1	0	0	0	0	0	0
Admissions to Maternity CCU level 2 care	Information only		4	4	1	4	0	0
1:1 Midwifery Care in Labour	95%	<90%	97.7%	96.4%	99.0%	98.7%	97.9%	98.6%
% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	15.81%	9.58%	11.14%	9.53%	10.00%	8.64%
3rd /4th Degree Tears (rate in month)	3%	>3.1%	2.51%	2.64%	4.48%	1.28%	2.79%	3.24%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.3%	3.4%	3.4%	3.1%	3.2%	3.2%
Breastfeeding Initiated within 48 Hours	65%	<65%	67.3%	69.6%	69.1%	72.8%	67.8%	69.5%
PSII (Inc. MNSI Lead)	Information only		1	0	0	0	0	0
MNSI	Information only			0	0	0	2	2
Access Standards								
Unit Closures	0	1	1	2	3	1	3	0

4. Expectation 2 – Right Skills

Mandatory and statutory staff training compliance during the period January – June 2024 remained below the Trust standard due to a Registered Midwife vacancy position that ranged from 21.16WTE in December 2023 to 12.83WTE in June 2024. In response the service had to prioritise profession specific elements of essential training namely emergency skills training and fetal monitoring training within the service.

Following the launch of the CNST year 5 maternity incentive scheme in May 2023 the professional specific training requirements were revised to align with the national core competency framework version 2 and the GMEC standards. Compliance is now monitored on a profession specific training database.

The dashboard highlights deficiencies in the professional specific training compliance during the period July – December 2023 that were reflective of the staffing challenges during this period. Assurance can be provided attainment of the required 90% standard with PROMPT, fetal monitoring and newborn life support training compliance was attained in February 2024. Table 4 highlights compliance as of June 2024 with additional information detailed in Appendix 4.

Table 4 – Training compliance as of June 2024

Course	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW/HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	NA	94.12%	80.65%	79.41%	88.62%	NA	NA	0.00%	89.47%	86.96%
Fetal Monitoring Core Competency Stds.	NA	88.24%	80.65%	0.00%	88.21%	NA	NA	0.00%	NA	NA
Neonatal Life Support	83.33%	NA	0.00%	0.00%	82.11%	33.33%	50.00%	79.59%	NA	NA

5. Expectation 3 – Right place, right time

5.1 Planned versus actual midwifery staffing levels

The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels. The planned staffing levels outlined in Table 5 highlight the fill rates achieved for registered and unregistered staff incorporating staff in post and additional temporary staff. Table 5 highlights a significant gap in the planned and worked hours for both registered and non-registered staff groups on G4 ward inpatient wards.

Assurance can be provided agency and bank shifts were and continue to be offered to mitigate staffing gaps and pressures when indicated. Safety risks were mitigated within the service by redeploying staff within the service and clinical areas on a daily basis.

In March 2024 the postnatal and antenatal capacity was relocated to wards G3 and G4 resulting in the bed capacity loss of 34 beds. The fill rates on ward G3 highlight the overfill of shifts prior to the realignment of the staffing templates undertaken in September 2024. Staff were redeployed between clinical areas to offset any clinical risk during this period.

Table 5: Planned versus actual fill for maternity ward inpatient areas.

Ward/Team	Grade Type Category	Day/Night	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
			Fill %	Fill %	Fill %	Fill %	Fill %	Fill %
Central Delivery Suite (CDS) [3011]	Registered	Day	62.31%	59.59%	75.03%	91.77%	96.94%	90.41%
	Non-Registered	Day	83.03%	87.35%	81.48%	84.98%	85.50%	66.82%
	Registered	Night	83.14%	83.18%	67.82%	85.14%	87.99%	88.93%
	Non-Registered	Night	96.91%	94.97%	92.17%	94.98%	93.63%	93.31%
Antenatal - Ward G3 [3004]	Registered	Day	102.19%	103.63%	85.66%	98.10%	90.52%	80.15%
	Non-Registered	Day	197.27%	181.06%	192.01%	191.01%	190.41%	189.97%
	Registered	Night	91.94%	98.46%	53.85%	93.18%	72.45%	62.98%
	Non-Registered	Night	105.75%	93.30%	96.76%	99.28%	101.66%	97.37%
Postnatal G4 [3005]	Registered	Day	77.51%	64.53%	53.55%	110.81%	104.52%	89.17%
	Non-Registered	Day	81.88%	91.21%	62.04%	92.91%	71.82%	61.35%
	Registered	Night	64.55%	52.23%	33.56%	78.17%	63.86%	55.35%
	Non-Registered	Night	64.18%	71.11%	59.22%	94.31%	71.49%	49.88%

5.2 Mitigating actions

The maternity service strives to ensure safe staffing levels at all times and to correlate the quality and safety indicators with the safe staffing levels.

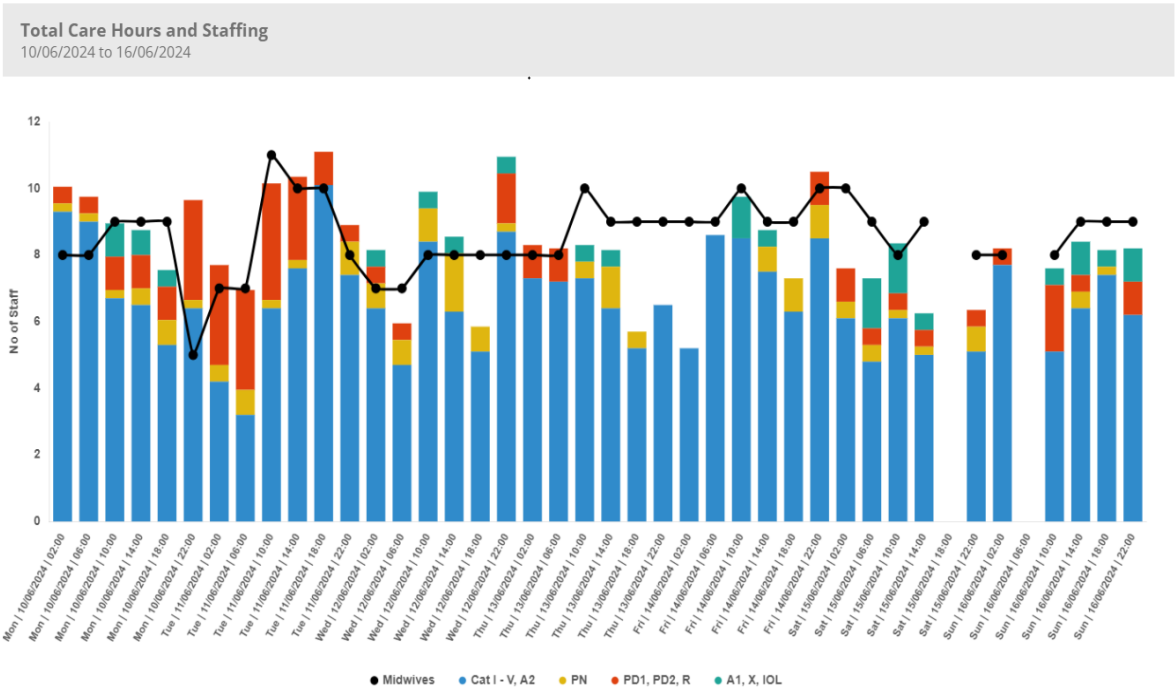
- Incident reporting system is used to report staffing incidents and all red flag incidents are audited on a quarterly basis.
- Regular reviews with ward managers, Matrons, Assistant Divisional Midwifery and Nursing Director and the Director of Midwifery
- Daily operational safety huddle meetings are held by matrons to assess and respond to changes in pressure and demand.
- Midwives move flexibly between delivery suite, maternity wards, birth centres and community to ensure women's needs are met.
- Ward managers work clinically as part of the clinical establishment with matrons, if required, to support patient care.
- Safety huddles occur in maternity twice daily to assess the activity and acuity

- Escalation guidelines are in place and used to respond to elevated demand, to preserve patient safety.
- The publication of rosters in a timely manner so staffing deficits can be safely managed.
- Approval of agency and bank usage to mitigate shortfalls in staffing levels

For additional oversight and scrutiny on a daily basis staffing figures and the acuity levels within the maternity intrapartum areas are input into an additional electronic Birthrate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours.

Table 6 details the acuity recorded on the intrapartum acuity tool in June 2024, highlighting the 4hrly review of staffing levels undertaken by the Delivery Suite Co-ordinator and the periods of increased staffing pressure.

Table 6: Birthrate Plus intrapartum acuity/staffing modelling tool example – June 2024 exemplar



5.3 Midwifery Continuity of Carer

The maternity service received formal notification on 21 September 2022 thereafter from NHS England that there was no longer a national target for Midwifery Continuity of Carer (MCoC). Local midwifery and obstetric leaders were advised to focus on retention and growth of the workforce, and develop plans that would work locally taking account of local populations and current staffing to support the maternity team to work to their strengths.

A recent review of the staffing positon has been undertaken and the Trust is still unable to proceed with MCoC as the default model of maternity care due to the ongoing midwifery staffing deficit and the need to reinstate the alongside midwifery led services within the service in the first instance.

5.4 Workforce Metrics

The sickness absence data for the period January – June 2024 demonstrated an increasing trend in sickness absence reported within the maternity service**.** The main cause of absence related to stress and anxiety. Matrons continue to be supported by workforce partners to monitor absence and support staff members during their absence to return to work.

Table 7: Sickness absence per WTE July – December 2023

Indicator			Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Monthly percentage sickness	4%	>=4.75%	5.35%	4.95%	4.30%	4.76%	7.38%	8.52%

5.5 Red Flags

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Within the maternity service midwifery red flag events are monitored currently using the Birthrate Plus acuity tool as detailed in Table 8. Re-alignment of the red flags with the nationally defined flags as per current NICE guidance was undertaken in January 2024.

5.6 Supernumerary Status

The Delivery Suite Coordinator is a supernumerary member of the team (defined as having no caseload of their own during their shift).This indicator is a red flag safety proxy indicator identified within the clinical negligence scheme for trusts guidance to ensure there is oversight of all birth activity within the service at all times. Currently All co-ordinators are allocated at the start of the shift and thus non-compliance is recorded on the Birthrate Plus acuity tool when the Co-ordinator is the named person providing 1:1 care and is thus unable to retain the status of supernumerary co-ordinator.

CNST requires evidence from an acuity tool, local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status at the start of every shift.

Since April 2023 quarterly red flag reports have been collated to provide assurance that the Delivery Suite Co-ordinator was not allocated as the named midwife for a woman requiring 1:1 care. All cases of non-compliance are reviewed by the Intrapartum Matron on a monthly basis and collated in a red flag report on a quarterly basis. There were no breaches of the standard reported on the Birth Rate Plus acuity tool during the period January – June 2024.

Table 8 highlights compliance with the standard throughout the January – June 2024 period. Indicator RF6 extracted from the Birthrate Plus acuity tool confirms no breaches of the required supernumerary standard during the period January to June 2024.

Table 8: Supernumerary status episodes of non-compliance (per shift)

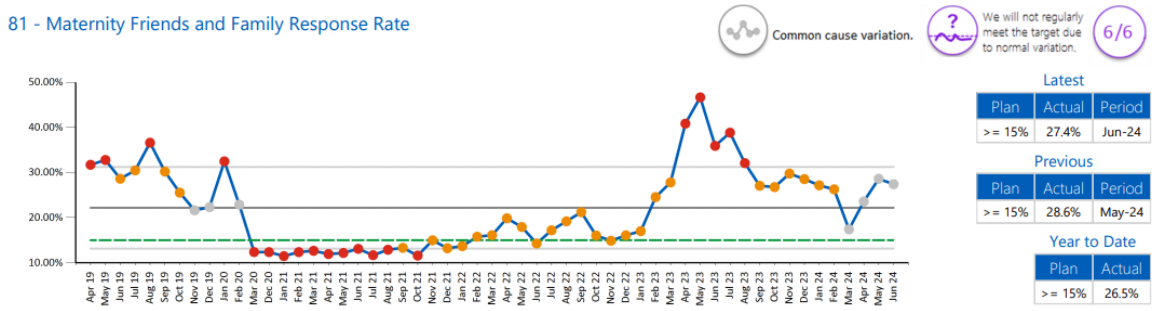
Number of Red Flags recorded
01/01/2024 to 30/06/2024

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	1%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	1%
RF6	The coordinator is the named midwife for a woman requiring 1:1 care	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	1	1%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delay of 24 hrs in accessing CDS for continuation of IOL once identified as ready for transfer	103	97%
TOTAL		106	

6. Patient Experience

Over the last 12 months, the maternity service has actively sought feedback from service users. The friends and family test feedback can be evidenced in the maternity survey, feedback sought from the maternity voices partnership and the friends and family response rates illustrated below. A stabilisation in the response rate was noted during the period January – June 2024 following a peak in the response rate in May 2023. The service commenced transfer to digital collection methods in June 2024 in response to issues relating to delays in the manual data inputting.

Table 9: Friends and Family Response Rates



6.1 Maternity Survey

On 9th February 2024, the CQC published their annual maternity 2023 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.

6.2 Themes from the CQC Maternity Care Survey

The 2023 CQC maternity survey highlighted:

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 two questions.

The report findings reflected 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 53WTE Registered Midwives) that impacted upon the quality of the care provided to families.

6.3 Complaints

Thematic analysis of all complaints is undertaken within the service to identify trends and actions to be undertaken on a monthly basis and a quarterly triangulation review is undertaken to review themes from claims, incidents and complaints data.

The Q4 2023/2024 Triangulation of learning scorecard highlighted there were no explicitly shared themes shared across the claims scorecard, incident and complaints data presented. However the overarching themes relate to the need for:

• Provision of guidance

• Telephone Triage pathway

• Assessment of risk

7. Conclusion

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

This report provides assurance that a systematic evidence based process to calculate the staffing establishment using the Birth Rate Plus tool was undertaken and published in 2023.The report provides assurance that the funded midwifery staffing establishment as of June 2024 met the 2019 Birthrate Plus report recommendations. This report confirms that the specialist midwifery establishment is within recommended Birthrate Plus expected parameters.

A business case to seek an uplift to the funded establishment to meet the Birthrate Plus 2023 report recommendations was approved at CRIG in May 2024 and finally approved at the finance and investment group in July 2024. The business case confirmed the additional establishment, could be phased over 2025 in line with re-opening of current reduced capacity. Recruitment is ongoing to additional posts. The mitigations to address shortfalls in establishment are detailed within this report.

The maternity dashboard indicators reflect a challenged service. Attainment of 100% compliance with one to one care in labour rates remains below the required standard and an area of ongoing focus. Training metrics also highlight sub-optimal compliance with the Trust standard and reflect the Registered Midwife vacancy position that ranged from 21.16wte in December 2023 to 12.83WTE in June 2024 within the maternity service.

The report details the actions required to mitigate the risk within the service and to ensure professional training metrics and key staffing related metrics are detailed on the integrated performance dashboard for ongoing Board oversight and scrutiny. Safe staffing levels were maintained during this period, in part mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels. This report acknowledges that the re-opening of additional clinical areas will only be enacted when safe staffing levels permit and in alignment with BR+ establishment reviews, in partnership with midwifery regional colleagues and GM ICS colleagues.

8. Recommendations

It is recommended that the Board of Directors:

I. Approve the report and recommendations.

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

III. Approve the presentation of this report to the Trust Board in order to fulfil the CNST scheme requirements.

Appendix 1 – Birthrate Plus summary of establishment – January 2023.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Princess Anne Maternity Unit Bolton NHSFT

Final version 23/01/2023

Annual period 2021/22

Combined births — Total births in service: 5922

June to Aug 2022	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	0.2	2.1	25.7	20.6	51.4
Generic %Casemix	1.7	5.1	24.5	19.7	49.0

	Annual Nos.	Required WTE	
Delivery Suite			
Births	5842	77.83	**77.83**
Other DS Activity			
Antenatal Cases	920	4.83	**6.00**
PN Readmissions	36	0.13	
Escorted Transfers OUT	23	0.12	
Non-viables	47	0.56	
Inductions (10%)	196	0.36	
Triage	8455	11.02	**11.02**
Beehive Birth Suite			
Service not fully operating so not assessed and activity within hospital total wte.			
M2 Ward			
Antenatal admissions	1680	16.53	**16.53**
Inductions (90%)	1768		
M4 and 5 Wards			
Postnatal women	5842	58.51	**64.21**
Postnatal Ward Attenders	0	0.00	
Postnatal Re-admissions	235	1.25	
NIPE Clinics		2.88	
Extra Care Babies	177	1.18	
Frenulotomies	775	0.39	
OUTPATIENT SERVICES			
Antenatal Clinics			
Midwife Booking & Follow up clinics		5.27	**11.03**
Specialist Midwife clinics		1.59	
Obstetric clinics		1.46	
Specialist Obstetric clinics		0.65	
Pre-assessment		0.33	
Midwife sonographer		1.24	
Hypnobirthing		0.50	
Day Unit	11640	6.35	**6.35**
COMMUNITY SERVICES			
Home Births	80	2.36	**64.38**
Community Cases	5732	58.83	
Attrition cases	670	0.89	
Additional safeguarding		2.30	
INGLESIDE BIRTH & COMMUNITY CENTRE		257.34	
Service closed so not assessed and activity within community total.			
CLINICAL MIDWIFERY WTE REQUIRED			**257.34**
Additional Specialist and Management wte		25.73	
TOTAL WTE REQUIRED		283.08	

Appendix 2 – Birthrate Plus establishment reconciliation as of June 2024

Midwives		Excluded							
Grade	Sum of Clinical WTE	Sum of Management WTE (Excl)	Sum of Specialist WTE	Sum of WTE not included in BR+	**Funded Ledger WTE**	**WTEC Included M3**	**WTEW Included M3**	WTEW Bank M3	WTEW Agency M3
Antenatal Clinic - ANDU	11.07			0.00	11.21	**11.07**	**11.07**	2.38	
Bolton Birth Suite	0.92			0.00	16.44	**0.92**	**0.92**		
Central Delivery Suite	58.11			0.00	56.36	**58.11**	**54.45**	11.65	
Maternity Triage	12.16				15.84	**12.16**	**11.10**		
Community Midwives	55.33			0.00	54.13	**55.33**	**49.80**	3.21	
Divisional Management Family Care		1.00			2.00	**0.00**			
Ingleside Birth Centre				0.00	2.00	**0.00**			
Maternity Smoking Cessation Team	1.00			0.00	1.00	**1.00**	**1.00**		
Midwifery Management		5.00			5.00	**0.00**			
Perinatal Mental Health Team	3.80		0.60	0.00	4.45	**4.40**	**4.40**	0.13	
Specialist Midwives	15.47	2.00	13.93	0.81	26.23	**29.40**	**29.40**	0.88	
Ward M4 - Post Natal Ward	22.92			0.00	16.00	**22.92**	**22.79**		
Ward M2 - Antenatal Ward	18.60			0.00	15.92	**18.60**	**18.50**	1.37	

Ward M5 - Post Natal Ward	2.53			0.00	16.00	**2.53**	**1.70**	1.70	
	201.91	**8.00**	**14.53**	**0.81**	**242.58**	**216.44**	**205.13**	**21.32**	**0.00**

Appendix 3 – Action plan to improve 1:1 care in labour compliance.

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref		Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1		**Ensure service is recruited to funded establishment**	Continue regular recruitment events to recruit to full establishment	Recruitment and Retention Lead	October 2024	15.03.24 Recruitment ongoing deficit 16WTE. Recruitment event planned for 18 May 2024. Automatic offer of posts to student midwives continues. 18.06.24 Ongoing recruitment successful. Recruited over establishment to address maternity leave backfill.	
			Increase post registration student places within service	Director of Midwifery	March 2024	18.06.24 Post reg student numbers confirmed with University.	

Appendix 4 – Midwifery profession specific training matrix

Workforce								
Indicator	**Goal**	**Red Flag**	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
Shifts covered by NLS trained staff	Information only		92%	92%	90%	75%	73%	73%
Medical Device Compliance Training Midwifery why so low	95%	80%	64.79%	68.00%			55.15%	
Safeguarding compliance level 3	95%	80%	85.65%	76.05%	71.43%	66.51%	52.69%	52.69%
Safeguarding supervision outreach only	Information only		94.00%	94.00%	94.00%	100.00%	94.00%	94.00%
PROMPT training (added Oct 21) (CNST requirement)	90%	<90%	95.76%	94.00%	93.00%	84.00%	81.00%	81.61%
Fetal monitoring training compliance (overall) (CNST requirement)	90%	<90%	91.95%	93.33%	90.00%	91.00%	88.00%	84.33%
Return to work interview percentage completed (number due and completed in comments please)	Information only		64.52%	48.00%	80.50%	74.40%	46.43%	75.00%
Exit Interview percentage completed (number due and completed in comments please)	Information only		0%	33%	0%	50%	0%	0%
Monthly percentage sickness	4%	>=4.75%	5.35%	4.95%	4.30%	4.76%	7.38%	8.52%
Compulsory Training	95%	<95%	85.81%	85.43%	84.64%	83.80%	81.80%	84.44%
Mandatory Training	85%	<80%	81.82%	82.71%	81.26%	80.86%	79.67%	84.79%
Completed Staff Appraisals	85%	<=75%	86.03%	89.04%	87.96%	83.48%	85.59%	91.80%

Report Title:	People Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Director of People		Decision	

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

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the People Committee held on 19 November 2024.

Executive Summary	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 19 November 2024. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

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

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	An optimal workforce is key to the delivery of our financial plan.
Legal/ Regulatory	Yes	Adherence to employment legislation is a key responsibility for our organisation.
Health Inequalities	Yes	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to equal patient care.
Equality, Diversity and Inclusion	Yes	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	James Mawrey, Director of People	Presented by:	Tosca Fairchild, Non-Executive Director

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

Name of Committee:	People Committee	**Reports to:**	Board of Directors
Date of Meeting:	19 November 2024	**Date of next meeting:**	21 January 2025
Chair	Tosca Fairchild	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Terms of Reference
- Nursing, Midwifery & AHP Staffing Report
- EDI Annual Report
- Improving Culture Update
- Freedom to Speak Up Q2 Report
- Guardian of Safe Working Q2 Report
- Employee Relations Update
- University of Bolton Update
- Medical Leadership Evaluation 2023/24
- GM Trainer/Trainee Survey
- Resourcing & Retention Update
- Cultural Dashboard
- Board Assurance Framework
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

ALERT

Agenda items	Action Required
There are no matters to bring to the Board's attention.	

ADVISE

Nursing & AHP Staffing Report – The Committee endorsed the bi-Annual nurse staffing report. The report provides an overview of available data to assure People Committee and Board of Directors of safe nurse staffing levels. The report triangulates workforce information with patient safety measures to ensure staffing is balanced in line with patient acuity. It includes the outcomes from two acuity audits undertaken in July 2023 and February 2024, as prior audits were excluded due to concerns about interrater reliability.

Maternity Staffing Report - The Committee endorsed the bi-annual maternity staffing report provides an overview of available data to provide assurance to the Board of safe staffing levels. The report triangulates workforce information with patient safety measures to ensure staffing is balanced in line with patient acuity. The report follows the guidance set out by the National Quality Board to meet the three expectations, right staff, right skills, right place and time. Colleagues will note the details of the paper within the Board papers.

EDI Annual Report – The Committee endorsed this report, which provides an analysis of the diversity profile of our workforce and patients at Bolton NHS Foundation Trust, during the period 1 April 2023 to 31 March 2024. Colleagues will note the details of the paper and areas discussed within the Board papers.

Improving Culture Update – The Committee received an update on Our Leaders Programme, as well as the NHS Staff Survey. Committee members noted their strong support for the programme and thanked the OD team for the scale of discussion that had taken place. The prospect of over 1500 leaders undertaking this programme is welcomed and pivotal to support our cultural journey. The Committee welcomed the news that 44% of our workforce had completed the NHS Staff Survey and there remained two weeks before the survey closes. Response information was provided at both Trust Level and Divisional Level.

Freedom to Speak Up Q2 Report - This report outlines the numbers and themes relating to FTSU activity in Quarter 2 and how the organisation is promoting a speak up, listen up, follow up culture. Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement. The Trust's FTSU approach continues to be embedded to support the organisation to develop an inclusive and transparent culture.

- 38 concerns raised by workers via FTSU Route in Q2
- Many of the concerns relate to behavior and leadership (or both)
- Work begun on the new Our Leadership programme and relaunching the Trust values and behavior framework
- Any themes and service areas were discussed at the meeting

Guardian of Safe Working - The Exception Reporting process gives resident doctors the opportunity to highlight variations from their contractually agreed service requirements and educational activities. The system was implemented to allow issues to be addressed in real time. The report contains details of Exception Reports by department, grade and type with outcomes reached for the quarter, 01 July to 30 September 2024, together with activities and issues arising during the reporting period. No matters of concern were escalated, although it was noted General Surgery continues to be a negative outlier and a series of actions were requested.

Employee Relations - This report provides an update of employee relations activity that has taken place between April and June 2024, including disciplinary, grievance and tribunal cases. No matters of concern were excalated, although it was noted that one Division appeared to have a higher number of cases and further work was requested to understand the reasons. The committee noted that the Employee Relations climate with our staffside partners continued to be positive.

University of Bolton Medical School – The Committee welcomed the update on the work associated with Bolton Medical School and made reference to the Board's recent visit. The paper discussed included reference to the SLA that the Trust had recently agreed. This SLA notes the agreement for the Trust to confirms its intention to provide clinical placements for UoB students from 2025.

Medical Leadership Evaluation – The Committee received the evaluation following the third cohort of the Medical Leadership Programme which was delivered in 2023/2024. The feedback was overwhelmingly positive with clear qualitative evidence of the impact of the programme. As a reminder the candidates were nominated from divisions based on identification of a diverse group of potential and existing clinical leaders (clinical director level). The 11 candidates found this programme immensely beneficial. Particular highlights of learning were self-reflection around self-awareness, difficult conversations and use of leadership styles.

GM Trainer/Trainee Survey - The survey gathers views of trainees around the quality of their training and the environments they work in. It asks trainers about their experience as a clinical or educational supervisor. National areas of concern were around:Staff wellbing and burnout risk; Rota Design; Time to deliver training and Opportunities for leadership development Reflecting on the national picture for trainers it is note worthy that concerns with time to deliver training and rota issues were not a theme locally. If anything as an organisation we had a number of specialties performing highly against these domains. Amongst trainees it was only within acute and general medicine where clinical supervision was flagged as an outlier against

national performance. Trainees within our organisation score higher for risk of burnout compared with the average of peers nationally. By comparison trainers on average have lower scores for risk of burn out compared to the average of peers nationally however there is variation with Emergency Medicine as an outlier at higher burnout risk.

Resourcing & Retention Update - The presentation focusses on key resourcing indicators, areas of good performance, and areas of concern.

Agency summary: A reduced spend trend seen since Month 4 (July 24) continued into September 2024 where spending reduced by £75k in-month. This was driven by reductions in medical, admin, and AHP staff groups but overall reductions were mitigated by an increase in nursing and midwifery agency. Agency spend increased in October 24 by £53k – mostly in relation to medical staffing. The Trust continues to be under the NHSE target of agency being no more than 3.2% of total pay bill (October 2024 performance was at 1.5%, and YTD is running at 2.1%). We are currently under our internal agency spend plan (at the end of M7 24/25) by £1.1m (total actual spend of £4.56m against a planned spend of £5.69m).

Bank summary: Bank spend increased by £302k in-month, contributory factors are half-term periods in October, some impact of increased sickness absence, and NQ staff on supernumerary working. The report noted that we expect to see this spend trend reducing over coming months in line with improved clinical substantive staffing.

Vacancy Rate 2024/25**:** Vacancy rates in October 24 and the YTD 24/25 remain under Trust target (6%) at 4.85% in-month, and 5.41% YTD. This is a very strong position to be in approaching winter pressures.

Turnover 2024/25: September 2024 performance was at 11.73% at overall Trust level, which is a reduction from the previous month. Performance in the year 2024/25 to date has mirrored our forecasting which suggested that we would see a fairly static trend following a two year period of peaks and troughs.

Cultural Dashboard - The dashboard report provided Q2 quantitative and qualitative data on the key cultural indicators at Trust and Divisional level supporting the Trust People Plan, to make Bolton the best place to work. No matters for escalation to Trust Board

The Board Assurance Framework (BAF). Following the last presentation of the BAF it was been reviewed by the Director of People and updated to reflect the new Trust Strategy. A number of amends were requested and the Committee supported the approach taken, although did highlight a discussion would be helpful at Trust Board on risk scoring.

ASSURE

Terms of Reference – Approved.

New Risks identified at the meeting: None

Review of the Risk Register: None

Report Title:	EDI Annual Report 2023-2024			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	James Mawrey, Chief People Officer		Decision	

Purpose of the report	The purpose of this paper is to share the 2023-2024 Equality, Diversity and Inclusion Annual Information Monitoring report.

Previously considered by:	The paper has been discussed in detail at the People Committee and the Committee of the Board requested a series of actions (detailed within this Board report).

Executive Summary	This report provides an analysis of the diversity profile of our workforce and patients at Bolton NHS Foundation Trust, during the period 1 April 2023 to 31 March 2024. The report demonstrates the impact of our equality, diversity and inclusion (EDI) policies, procedures and practices as follows: • Celebrating our achievements in advancing EDI 2023-24. • Monitoring usage of services and employment practices to measure whether access reflects the local population demographics 2023-24. • Setting EDI priorities and measuring progress against KPIs for 2024-2025. These priorities are aligned with the new Trust Strategy 2024-29 in ensuring that Bolton FT is a great place to work and that it is improving care and transforming lives of our patients whilst intentionally including those who experience health inequalities. As noted the respective action plans will be monitored via the People Committee.

Proposed Resolution	The Trust Board is asked to note the details of this report and that the People Committee will oversee all relevant actions on behalf of the Board of Directors.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Y	Some of the actions required on the action plan require funding.
Legal/ Regulatory	Y	This report, in part, allows the Trust to comply with our Public Sector Equality Duty.
Health Inequalities	Y	This report summarises health inequality work that is ongoing and planned.
Equality, Diversity and Inclusion	Y	This report is the Equality Diversity and Inclusion annual report and plan.

Prepared by:	Rahila Ahmed, EDI Lead/ Toria King, Head of EDI	**Presented by:**	James Mawrey, Chief People Officer/Deputy CEO

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

BAME	Black, Asian and Minority Ethnic
WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard
MWRES	Medical Workforce Race Equality Standard
CPD	Continued Professional Development

1. Introduction

1.1. The People Committee received the Equality, Diversity and Inclusion Annual Information Monitoring Report 2023-2024 at their last meeting. A full and detailed discussion took place and this Committee of the Board requested areas of focus moving forward.

1.2. Board members will be aware that fostering a culture of inclusion remains a critical priority for Bolton Foundation Trust and is a key ingredient of the Trust Strategy and People plan.

2. High level summary of findings for Board members

2.1 Board members can see the full findings of the EDI Annual Report contained within the attachment to this report.

3. People Committee discussions and actions

3.1 The Committee of the Board expressed their appreciation for the comprehensive report and noted the following points during their discussion:

- The scope of Equality, Diversity, and Inclusion (EDI) is extensive, encompassing multiple statutory frameworks and national-level reporting mechanisms. While these frameworks are beneficial, the Committee acknowledged that the current approach can appear fragmented and would benefit from a consolidated, high-level overview to enhance clarity for future discussions.
- The Committee expressed interest in the development of an "EDI plan on a page" to facilitate engagement and communication with wider audiences.
- The proposed governance structure was endorsed, with the Committee highlighting the importance of ensuring building in links with local partners to ensure alignment with local contexts and priorities wherever appropriate.

4. Recommendation to the Board of Directors

4.1 The Trust Board are asked to note the details of this paper and note that the People Committee will continue to oversee all relevant actions.

Annual Equality Information Monitoring Report 2023/24

Consciously Inclusive

Equality, Diversity and Inclusion at Bolton NHS Foundation Trust

Contents

1. Introduction

Bolton NHS Foundation Trust is dedicated to eliminating discrimination, promoting equal opportunities, fostering good relations, reducing health inequalities, and creating an inclusive environment for patients, carers, visitors, and staff. Our goal is to ensure that staff members actively practice inclusivity in their daily interactions with our diverse patients and colleagues, addressing their individual needs.

This report analyses the diversity profile of the workforce and service users at Bolton NHS Foundation Trust for the period from April 1, 2023, to March 31, 2024. It fulfils our obligation to publish annual equality information under the Equality Act 2010 (Public Sector Specific Duties Regulations) and to set equality objectives.

In this report, we will highlight the impact of our equality, diversity, and inclusion (EDI) policies, procedures, and practices, particularly by:

- Celebrating our achievements in advancing Equality, Diversity and inclusion (EDI) in 2023-24.
- Monitoring service usage and employment practices to ensure access reflects local population demographics in 2023-24.
- Establishing EDI priorities for 2024-25 and tracking progress.

These priorities are aligned with the new Trust Strategy 2024-29 in ensuring that Bolton FT is a great place to work and that it is improving care and transforming lives of our patients whilst intentionally including those who experience health inequalities.

The report utilises various data sources, including the latest Census 2021 data, to illustrate our progress. Patient data reflects the number of unique visits or admissions rather than the total number of times patients have used our services.

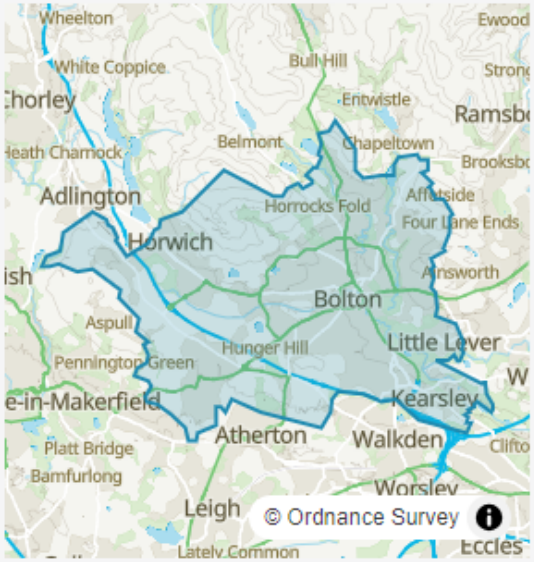
2. Who We Are

2.1. Context

Bolton NHS Foundation Trust is a provider of hospital and community health services in the North West sector of Greater Manchester. The local population demographics are shown below, taken from the latest Census 2021 data.

Bolton

Area map



Population

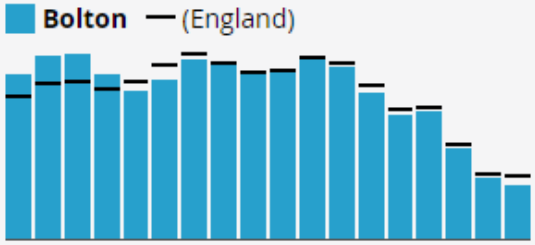
296,000

people

56,490,000 people in England

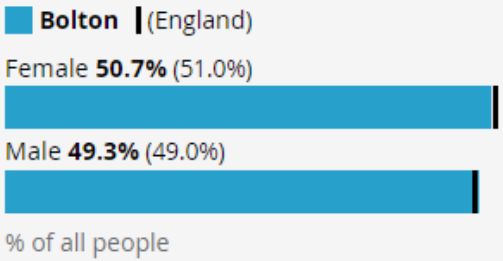
Rounded to the nearest 100 people

Age profile

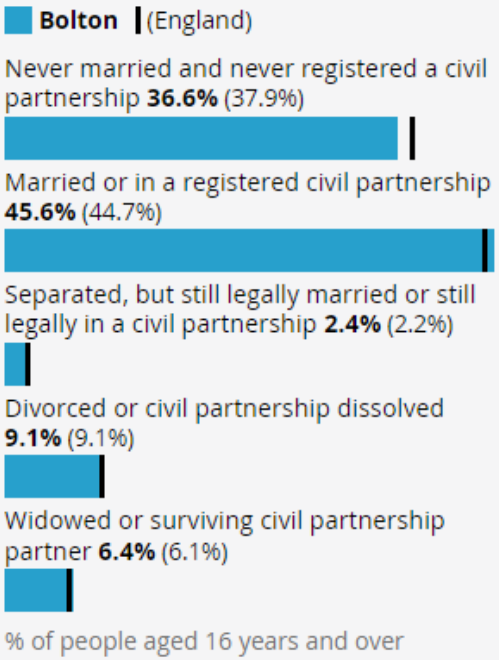


% of all people, 5 year age bands

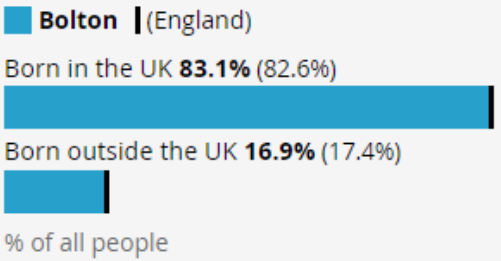
Sex



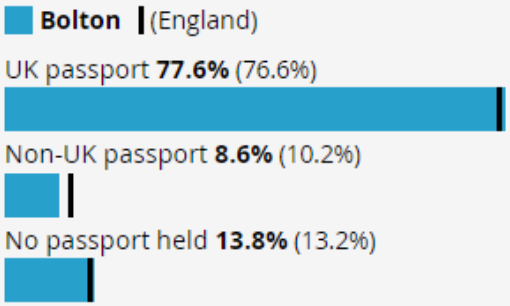
Legal partnership status



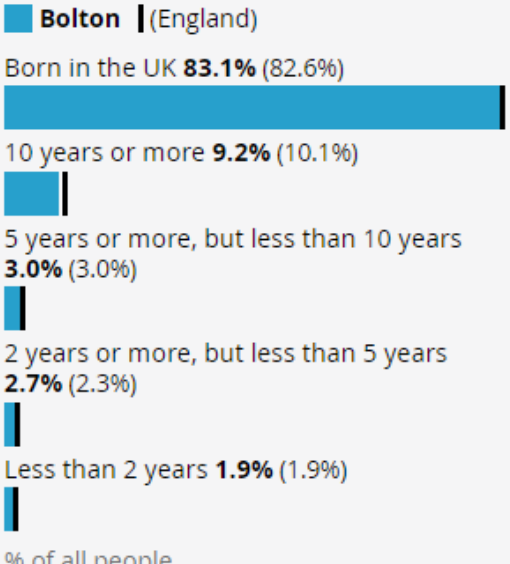
Country of birth



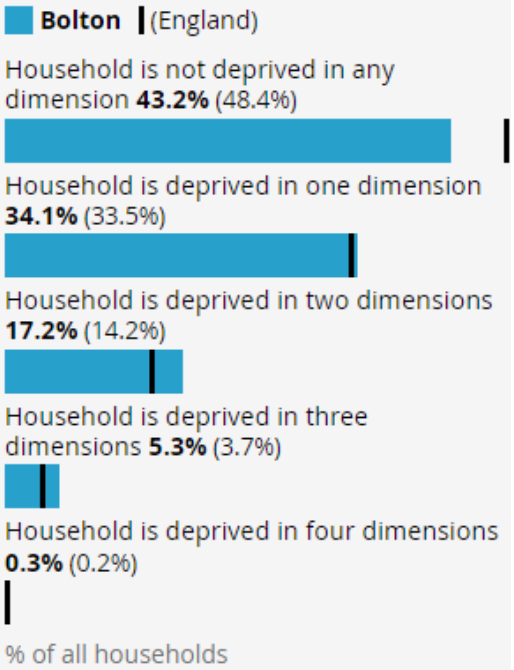
Passports held



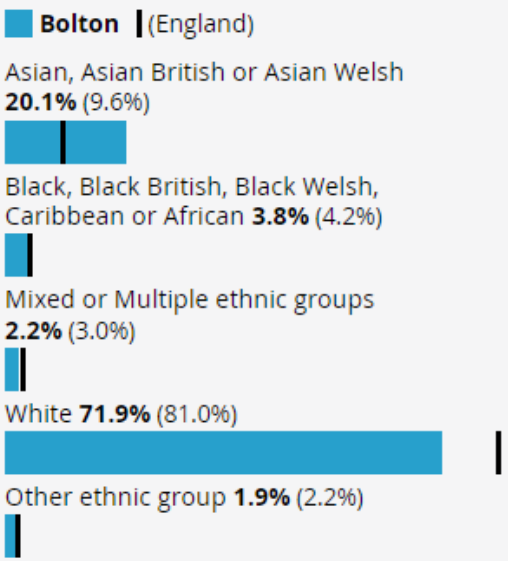
Length of residence in the UK



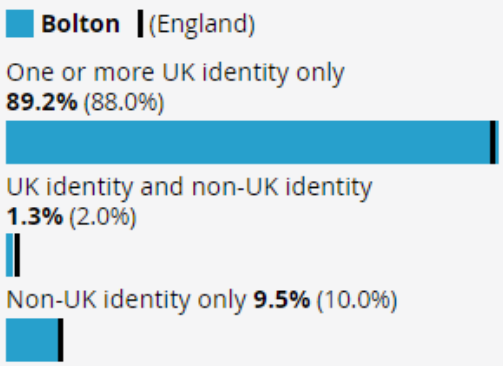
Household deprivation



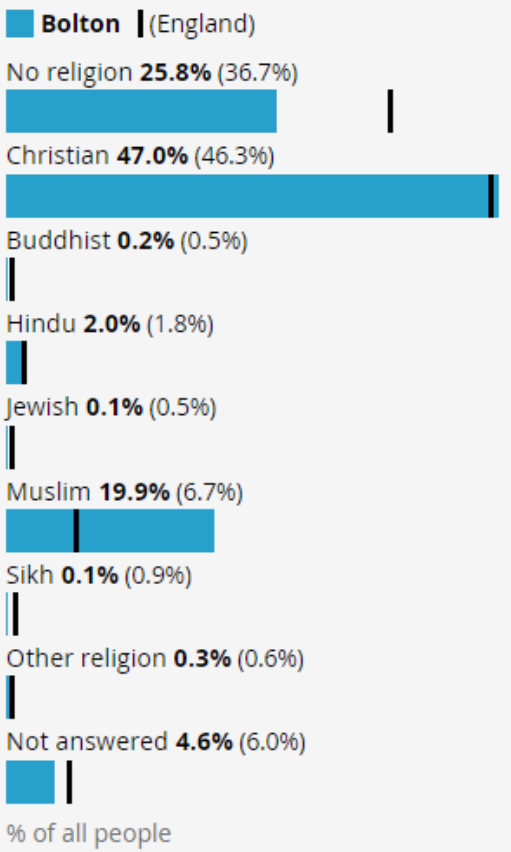
Ethnic group



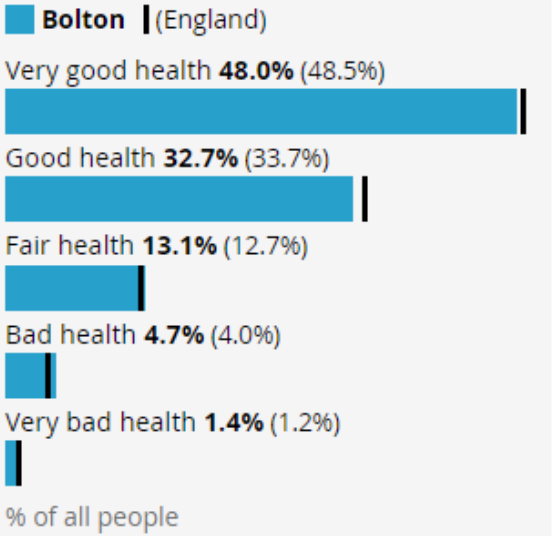
National identity



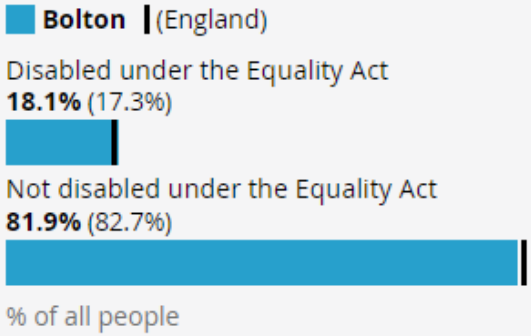
Religion



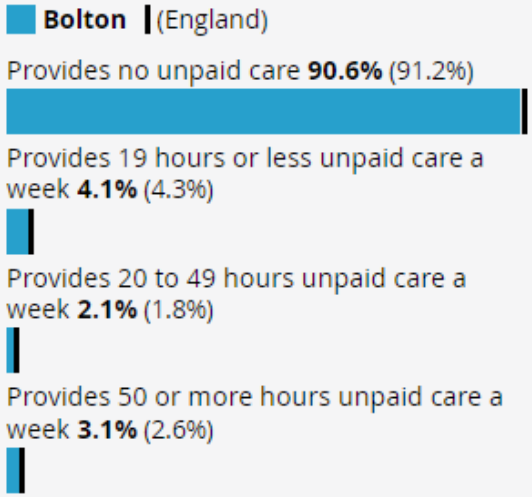
General health



Disability



Provision of unpaid care



Deprivation & Disease Prevalence

The Director of Public Health produces an annual report as set out under in the National Health Service Act (2006) (Part 3, S73B). It reports on the health of the people in the local authority area.

It is aimed at people who live, work, or have another connection to Bolton. It covers data on health inequalities, life expectancy and disease prevalence. It also highlights the main changes in Bolton's population: issues affecting our health, people's experiences and what is important to them. For further information on the latest report, which is used to prepare this document, please see Bolton 2023 Public Health Annual Report.

2.2 Equality Objectives

The Trust has launched its new Equality, Diversity and Inclusion (EDI) Plan 2022 to 2026 with a refreshed set of equality objectives. It sets out the Trust's vision for EDI and its approach to creating an inclusive culture over the next four years in line with the Equality Act 2010. Our vision is 'to inspire and innovate, to attract and embrace difference'. An associated EDI work plan is produced annually. It details high-level actions relating to achieving our ambitions and legal, contractual and regulatory responsibilities.

Ambition 1	Understand the needs of our community and provide services, which meet those needs.
Ambition 2	Create a working environment in which all staff can reach their full potential.
Ambition 3	Recruit and cultivate a workforce that represents Bolton's diversity
Ambition 4	Act on patient, staff and community feedback on how we can improve our approach to EDI.

For further information, please see our approach to equality, diversity and inclusion - Bolton NHS FT (boltonft.nhs.uk)

We have used the 'NHS Equality Delivery System' to develop our equalities work. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three Domains, which are:

1) Commissioned or provided services

2) Workforce health and well-being

3) Inclusive leadership.

For further information on EDS please see: NHS England » Equality Delivery System 2022 – Guidance and resources

2.3 Governance

The EDI Steering Group leads on EDI work at the Trust. It is made up of inclusion practitioners, senior leaders and representatives from the directorates, staff-side colleagues, staff equality networks and allies. The group ensures compliance with our legal duties and the various regulatory obligations. There is a clear focus on continually improving organisational culture, employment experiences of staff and the quality of care to our patients. The EDI Steering Group reports into the People Committee and is accountable to the Trust Board. The governance of EDI is to be updated in 2024-25 and this is summarised in section 5. 'Recommendations.'

3. Our Achievements

Progress on Creating an Inclusive Culture and Service Provision

Over the past year, the Trust has made significant advancements in fostering an inclusive culture and improving service provision for both our employees and patients. Various initiatives have been implemented to enhance access, experiences, and outcomes for individuals with protected characteristics. Below is a comprehensive overview of key activities and achievements:

Workforce

- **Diversity Networks Established:** We continued to support our Black, Asian Minority Ethnic (BAME), Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) and Disability and Health Conditions Staff Networks. These networks play a crucial role in co-designing policies and practices that foster a more inclusive workplace and enhance the care environment for patients and to create a platform for employees from various backgrounds to engage and collaborate.
- **Neurodiversity Support Group:** Launched in November 2023, this group aims to provide peer support and share lived experiences among neurodivergent colleagues. A Neurodiversity toolkit was also introduced to aid workplace integration.
- **Reasonable Adjustments Passport:** Launched in November 2023, this tool provides a live record of agreed reasonable adjustments between employees and their managers, supporting staff with disabilities and health conditions.
- **Increasing Disability Declaration Rates:** The Reasonable Adjustments Task & Finish Group is working to enhance disability declaration rates, with ongoing reviews noted in the Workforce Disability Equality Standard (WDES) report.

- **Increase in Freedom to Speak Up (FTSU) Champions:** The Trust has expanded its pool of diverse FTSU Champions, reflecting our commitment to fostering an open culture. This initiative has empowered staff from various backgrounds to confidently raise concerns about workplace issues, including bullying and harassment, thereby contributing to a safer and supportive environment.
- **Mental Health and Wellbeing Initiatives:** We continue to promote mental health support services, including counselling, wellness programs, and menopause support, ensuring a holistic approach to employee well-being.
- **Pronoun Badges and Rainbow Badges Assessment:** The introduction of pronoun badges helped to foster an inclusive environment for all gender identities, while the Rainbow Badges Assessment of our policies and services have provided a platform from which the Trust can improve from to ensure that LGBTQ+ needs are met.

Learning and Development

- **Mandatory EDI Training:** All staff are required to complete online Equality, Diversity, and Inclusion (EDI) training regularly. This includes specialised training for junior medical doctors and inclusive leadership training, ensuring that all employees are equipped to promote inclusivity.
- **BAME Leadership Development Programme:** Twelve aspiring BAME colleagues participated in this program, designed to equip them with the skills and knowledge necessary for leadership roles within the Trust. This initiative aimed to nurture future leaders and promote diversity at all levels of the organisation.
- **Reciprocal Mentoring Initiatives:** We have continued to establish reciprocal mentoring partnerships, matching junior staff with senior leaders. This initiative provides valuable guidance, support, and career development opportunities, helping to cultivate a more inclusive leadership pipeline.
- **Active Bystander Training:** Our commitment to creating a respectful work environment is reflected in the multiple Active Bystander training sessions delivered across the Trust. These sessions empower staff to challenge poor behaviours and promote a culture of accountability and respect among colleagues.
- **Inclusive Leadership Training:** This content has been embedded within leadership programmes, including the Bridging the Gap Clinical Leadership Programme
- **Unconscious Bias training for hiring managers**: This new training aims to raise awareness among hiring managers about the implicit biases that can influence decision-making during the recruitment process. By recognising and addressing these biases, staff can ensure fairer hiring practices and create a more equitable environment for all candidates.

- **Celebrating Diversity:** A series of events, such as National Staff Networks Day and Deaf Awareness Week, have provided platforms for learning and engagement with diverse communities.

Policies and Procedures

- **Revamped Equality Impact Assessment (EIA) Process:** We have significantly updated our EIA process to incorporate considerations for broader health inequality groups, aligning with NHS England's new Health Equity Assessment Template (HEAT). This overhaul ensures that all policies and projects actively consider and address health disparities.
- **Launch of Reasonable Adjustments Passport:** Introduced during Disability History Month 2023, this innovative tool provides a live record of agreed adjustments between employees and their managers. It supports staff with disabilities and health conditions, ensuring their needs are recognised and accommodated within the workplace.

Awareness, Communications and Celebration

- **2024 Equality and Wellbeing Events Calendar:** We produced an accessible online calendar highlighting key religious and equality events. This resource promotes awareness and encourages staff to celebrate the diversity of our workforce and patient community, fostering a sense of belonging.
- **Successful Cultural Celebrations:** The Trust has hosted a series of events, including Disability History Month, Bolton Pride celebrations and Black History Month. These celebrations featured guest speakers, workshops, and educational sessions that deepened staff understanding of diverse cultures and experiences, enhancing inclusivity within the organisation.

Governance and Reporting

- **Strengthened Governance Framework:** Our governance framework has been enhanced to prioritise data collection, analysis, and a strengthened EDI focus.
- **Legal and contractual duties:** We successfully met our duties to publish our gender pay gap report, Workforce Race Equality Standard, Workforce Disability Equality Standard and EDS2022 report. These reports underscore our dedication to fostering an equitable workplace for all staff.

Patient Experience

- **Improved Interpretation and Translation Services:** The Trust has made substantial improvements to its interpretation and translation services, ensuring effective communication for all patients. This includes the rollout of a new interpretation and translation contract, which enhances access to language support for diverse patient groups, thereby improving their overall experience.

Community & Partnerships

- **Engagement with External Stakeholders:** Practitioners focused on patient experience collaborate with service users and communities to improve health outcomes for individual to ensure their voices are heard and needs met. This ongoing partnership highlights our dedication to community engagement and the importance of feedback in shaping our services.

4. Our Patients and Employees

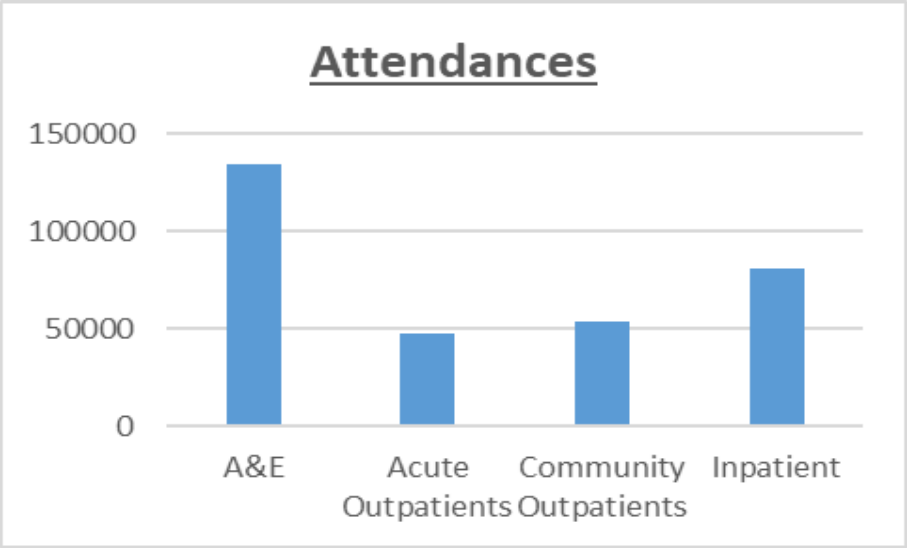
Below is an analysis of the Trust's patient profile, compared to the local Bolton resident population where applicable. This analysis uses data from the 2021 Census, which is the most recent and reliable source of official demographic information.

We are dedicated to ensuring fairness and equity in all aspects of our service delivery and employment practices. To uphold this commitment, it is crucial for us to understand the diverse needs of our patients and employees, enabling us to respond effectively and appropriately.

Through equality monitoring, the Trust assesses its inclusivity, examining whether we provide equal opportunities, access, and outcomes in our services and employment practices. Any identified areas for improvement will be incorporated into the Trust's annual Equality, Diversity, and Inclusion (EDI) action plan.

4.1. Our Patients

Census 2021 data shows Bolton has a resident population of 295,963. Bolton ranked 46th for total population out of 309 local authority areas in England. Over the past decade, the population has increased by 19,163 persons. [1]



[1] Bolton population change, Census 2021 – ONS

- 315,797 individual patients accessed Trust services between 1 April 2023 and 31 March 2024, of which many would have attended on more than one occasion.

- Accident and Emergency services has the highest attendance (42%, 134,073 attendances). This indicates a significant reliance on emergency services and suggests it is a critical component of healthcare service utilisation.

- Inpatient services account for over a quarter of the total attendance, indicating a significant need for hospital admissions. This is followed by Community outpatient service attendance (17%) which is beneficial for ongoing care and chronic disease management. Acute Outpatients account for a smaller portion of total attendance (14%).

- Missed appointments amounted to 28, 377 showing an almost equal split percentage split of acute outpatients and community outpatients.

4.1.1. Patients - Key findings

1. **Service Utilisation**:
   - 315,797 patients accessed Trust services, primarily through Accident and Emergency (42% of attendances).
   - DNA were noted, particularly among younger adults and certain ethnic groups.
2. **Age Profile**:
   - The highest service utilisation is among patients aged 70-79, while the lowest is in the 10-19 age group.
   - Significant healthcare needs are evident in the elderly population (80+).
3. **Sex Profile**:
   - Female patients (54.1%) utilise services more than males (45.8%), though male representation in the resident population is slightly higher.
4. **Ethnicity**:
   - Bolton's population is diverse, with 28.1% identifying as Black, Asian, and Minority Ethnic (BAME), higher than regional and national averages 15% of patients who accessed services in 2023 to 2024 were of BAME origin. Patients from Asian backgrounds represent 10% of the patient population, but this is lower than their 20% representation in the resident population.
   - A substantial portion of patients (24%) did not state their ethnicity, complicating the understanding of service access.
5. **Religion and Belief**:
   - Christian patients (42%) and Muslim patients (7%) represent significant portions, but 38.9% of patients reported unknown religious affiliation, indicating gaps in data collection.

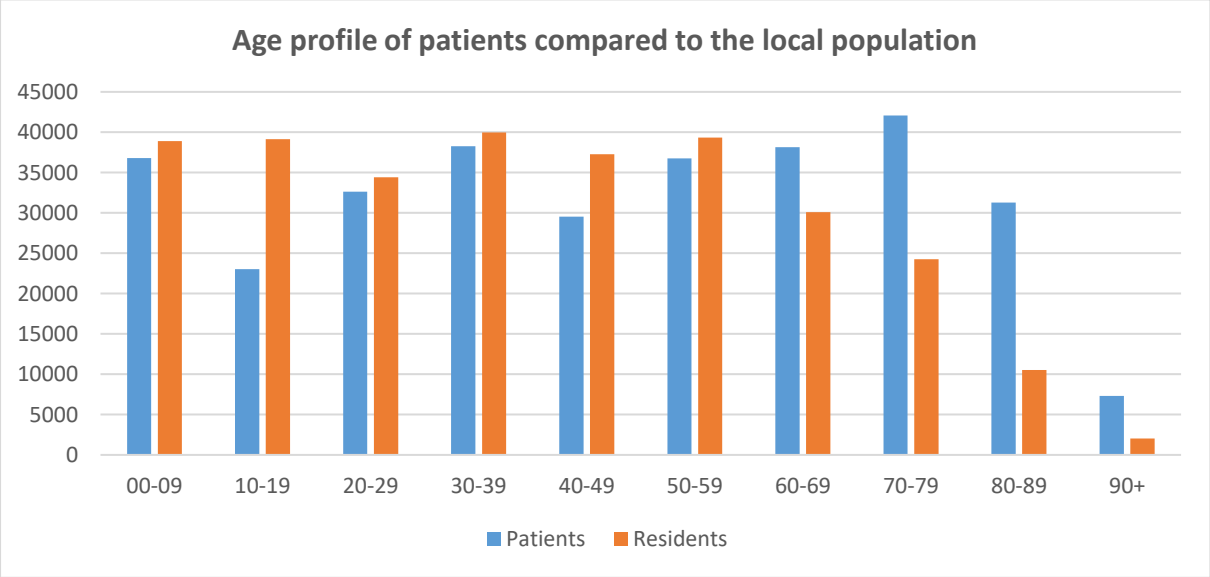
6. **Disability**:
    - The Trust lacks comprehensive data on patients with disabilities, although a significant portion of the Bolton population has long-term health conditions.
7. **Language Services**:
    - Access to interpretation services is established, with Urdu being the most requested language. However, a decrease in face-to-face interpretation requests was noted.

4.1.2. Age Profile [2]

Bolton Age Population Profile

- Just over 1 in 5 of the population in Bolton is a dependent child (21.5% or 63,674), aged 15 and under.
- Approximately, 1 in 6 is of pensionable age (aged 65+ 17 % or 50,721). By 2031, the proportion of those aged over 65 is expected to grow by almost 8,000. [3]
- The average (median) age remained 38 years in Bolton between the last two censuses. This is the person in the middle of the group, meaning that one-half of the group is younger than that person and the other half is older. [4]

Patient Age Profile



- People of all ages are using Trust services.

[2] Census 2021 Bulk - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)
[3] How life has changed in Bolton: Census 2021 (ons.gov.uk)
[4] Population – Bolton JSNA

- The highest usage of Trust services is found for patients aged 70-79 (13%)
- In comparison, patients aged over 90 years (2.32%) and those aged between 10 to 19 years have the lowest usage of services. Health tends to deteriorate with age thus these figures are expected. 19% of patients are under the age of nineteen years.
- Despite the reduced number of residents, patient numbers for those aged 80+ remain high (12%) , highlighting significant healthcare needs among the elderly population
- The highest Acute DNA Rates are within ages 20-29 (17.10%) and 30-39 (17.00%). Meanwhile, the highest Community DNA Rates are within ages 50-59 (16.70%) and 30-39 (14.62%).
- The lowest DNAs for both acute and community show the lowest percentages in the 90+ age group.

4.1.3. Sex Profile

The UK government defines sex as 'referring to the biological sex of an individual as determined by their anatomy; it is something that is assigned at birth and generally male, female or non-binary.

Bolton Sex Population Profile

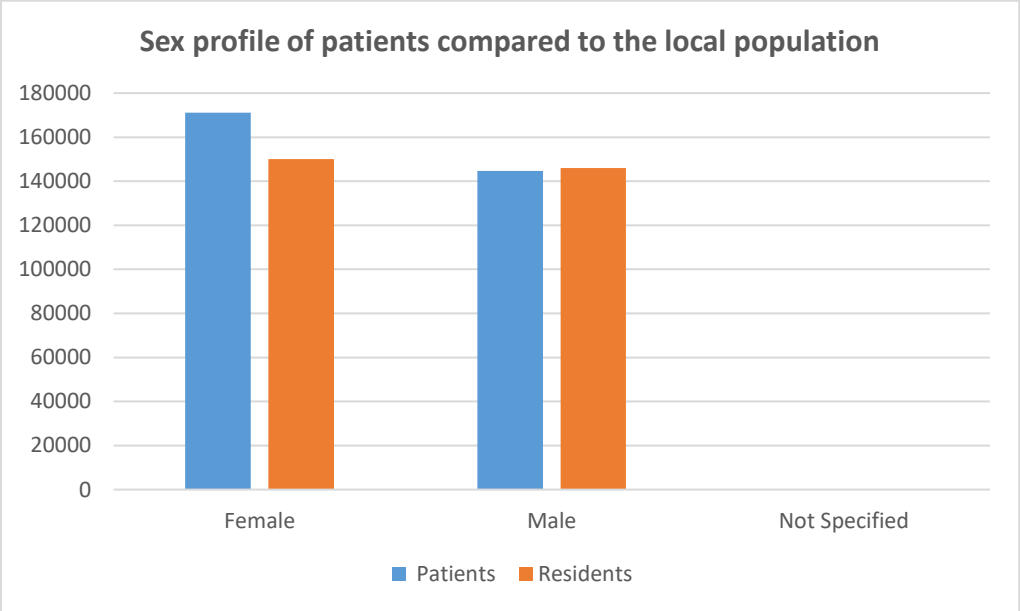
- In 2021, the gender profile of Bolton shows an almost equal split at 49% male (145,907) and 51% female (150,056)

Sex	Bolton	North West	England
Male Life Expectancy	78.0 years	78.3 years	79.6 years.
Female Life Expectancy	81.5 years	81.9 years	83.2 years[5]

- Male life expectancy from birth in Bolton is 1.6 years lower than the national average. Meanwhile, for women the gap is slightly larger at 1.7 years below the national average.

[5] Inequalities Data Report (boltonjsna.org.uk)

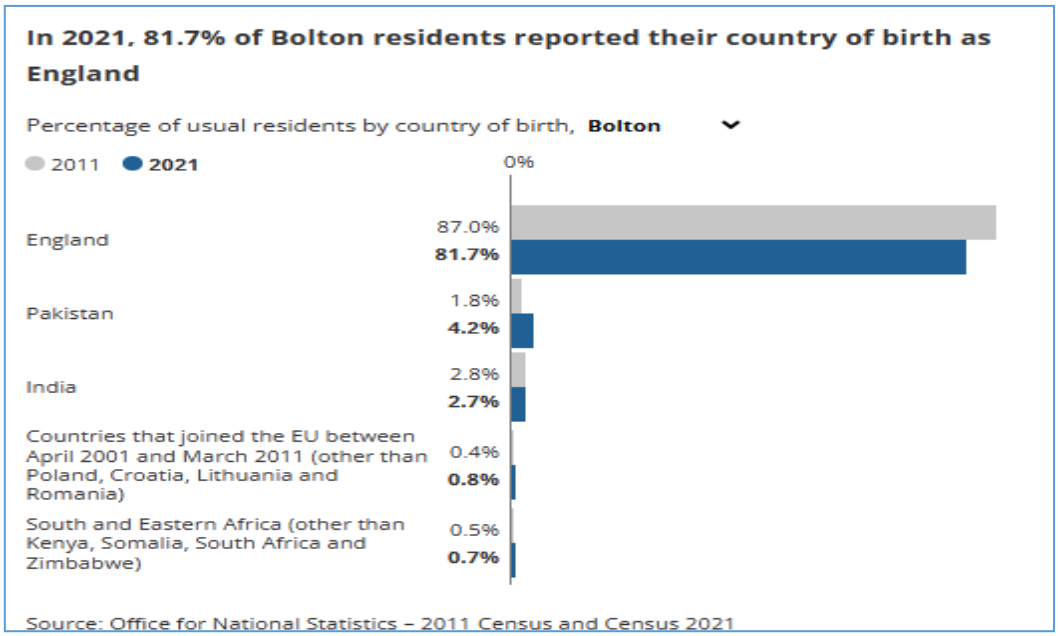
Patient Sex Profile



- The data shows that females utilise healthcare services more than males (54.1%) and is higher than the resident population. This pattern has remained consistent and may reflect some of the services we offer in the Trust such as maternity and gynaecology.
- Males have a slightly higher number of residents but represent a lower percentage of total patients at 45.8%.
- A small number of patients (25) do not have their sex recorded. Limitations with the national data collection system do not allow other groups to be recognised.
- Males show a slightly higher rate of DNAs in acute outpatient settings (51.62%), while females show higher rates in community outpatient services (51.50%). This indicates differing patterns of healthcare engagement.
- Initiatives such as reminder systems, outreach programs, and education about the importance of attending appointments could help reduce DNAs for both genders.

4.1.4. Ethnicity Profile

Bolton Ethnicity Population Profile

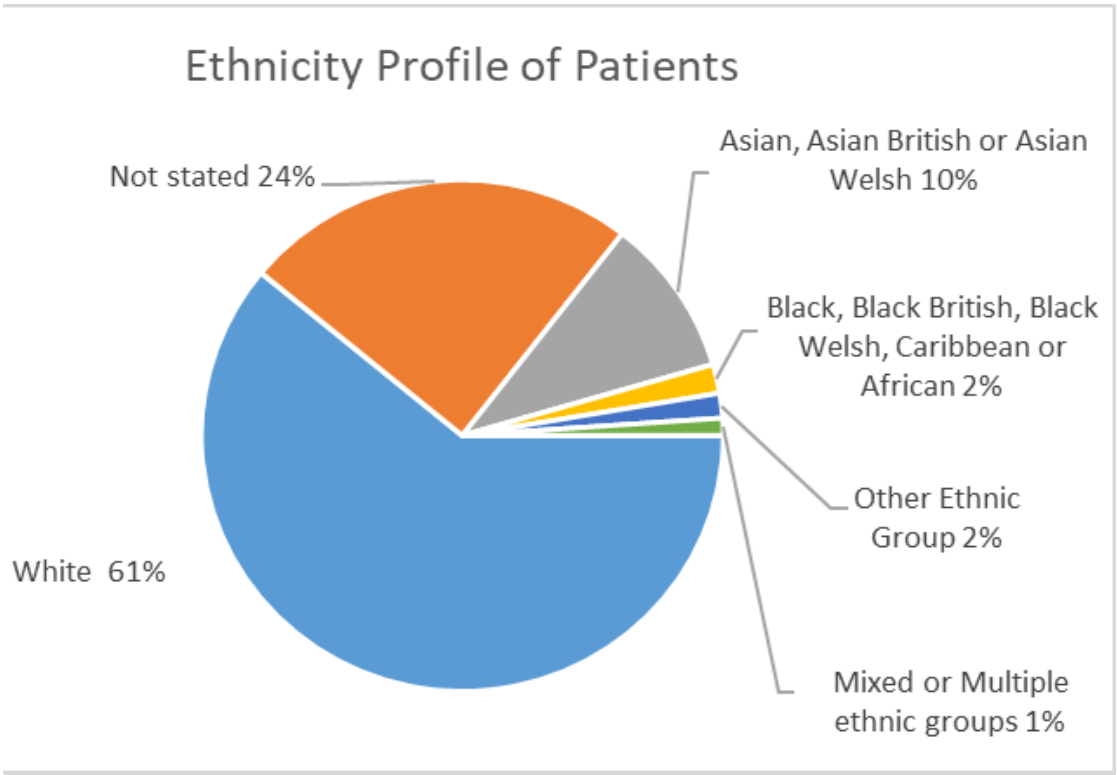


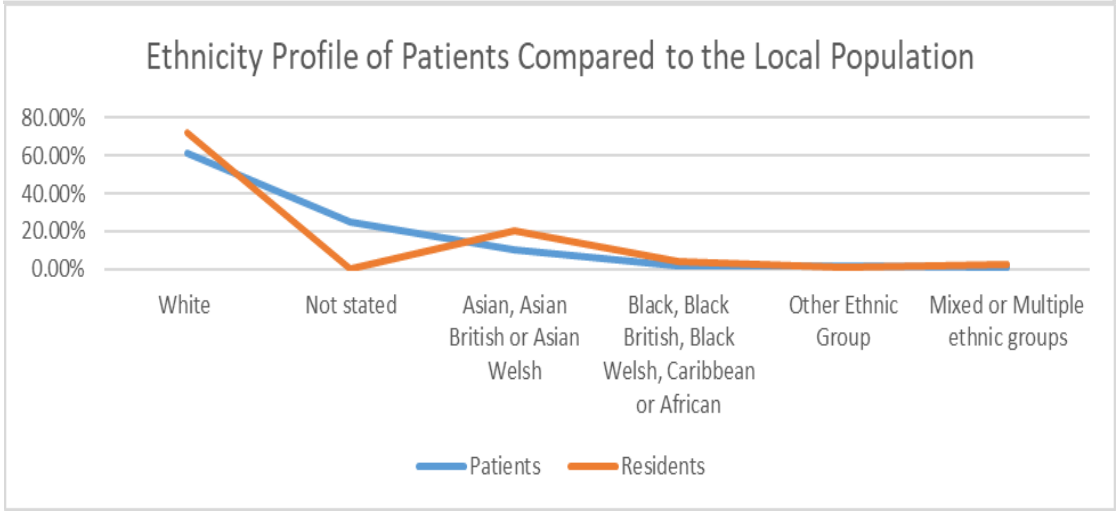
- In 2021, 71.9% of people in Bolton identified their ethnic group within the 'White' category (compared with 81.9% in 2011).
- 28.1% of Bolton residents identify as Black, Asian and/or Minority Ethnic (BAME), which is an increase of 10% from the previous decade. This is higher than the North West regional average at 8.4% and England average at 9.6%.
- The largest BAME group is "Asian, Asian British or Asian Welsh" category, at 21%. The 6.1 % change was the largest increase among high-level ethnic groups in this area since 2011. There was also a 2.1% increase of people identifying with their ethnic group within the "Black, Black British, Black Welsh, Caribbean or African" category (now at 3.8%).[6]
- In Bolton, the percentage of people who did not identify with at least one UK national identity increased from 5.4% in 2011 to 9.5% in 2021.
- 81.7% of the local population (241,800 Bolton residents) said they were born in England. There has been 5.3% reduction since 2011, which at the time represented 87.0% (240,900) of Bolton's population.
- Pakistan was the next most represented, with just under 12,600 Bolton residents reporting this country of birth (4.2%). This figure was up from around 4,900 in 2011, which at the time represented 1.8% of the population of Bolton.

[6] How life has changed in Bolton: Census 2021 (ons.gov.uk)

- The number of Bolton residents born in India rose from just under 7,800 in 2011 (2.8% of the local population) to around 7,900 in 2021 (2.7%).

Patient Ethnicity Profile





- People from all ethnic groups are accessing Trust services.
- A significant majority of both patients (61%) and residents (72%) identify as White. 15% of patients identify as BAME.

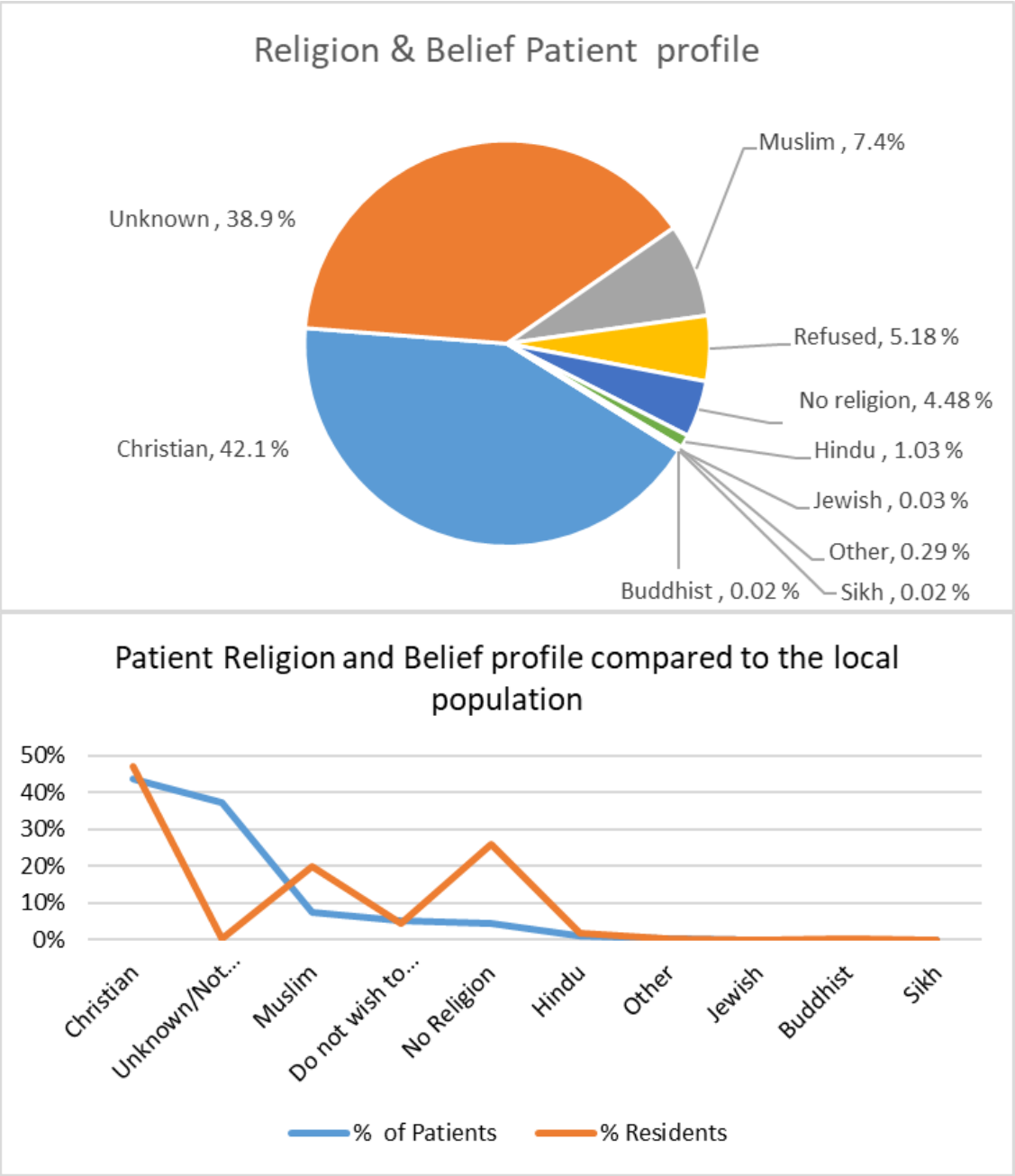
- The percentage of Asian residents (20%) is significantly higher, double, than that of patients (10%). This is most likely due to a younger age demographic.
- A notable portion (24%) of patients have not stated their ethnicity (noted as a count of 77,408), which could hinder understanding of the demographic landscape of healthcare utilization.
- The representation of other ethnic groups is relatively consistent between patients and residents, but still low overall.
- Highest DNA Rates are found for the White British community have the highest DNA rates, amounting to 50% of acute outpatient DNAs and 59% of community outpatient appointments , This is followed by patients categorized as 'not known' (19%) or 'not stated' (12%)
- DNA rates are also high for Pakistani (5% acute outpatient DNA and 6% community DNAs) and Indian patients (4% of acute outpatients and 5% of community DNAs).

4.1.5. Religion and Belief Profile

Bolton Population Religion and Belief Profile

- The most commonly reported religion in Bolton is Christian (47.0%), followed by no religion (25.8%), Muslim (19.9%), and Hindu (2.0%). This question was optional, and 4.6% chose not to answer.
- Christianity remains the majority religion in 2021 at 47%, although this has reduced by 15% since 2011 (62.7%)
- The second largest religious groups was Islam with 19.9% describing themselves as Muslim (up from 11.7% the decade before).
- 25.8% of Bolton residents reported having "No religion", seeing a rise of 8.6% since 2011. This compares to 32.6% across the Northwest and 36.7% across England. The rise of 8.6 percentage points was the largest increase of all broad religious groups in Bolton.
- There are many factors that can cause changes to the religious profile of an area, such as a changing age structure or residents relocating for work or education. Changes may also be caused by differences in the way individuals chose to self-identify between censuses.

Patient Religion and Belief Profile



- People of all religious denominations are accessing Trust services, and is line with the demographics of the local population.
- Christians constitute a significant portion of both patients (42%) and residents (47%). Forty-Five Christian denominations were recorded in the patient administration system.
- Muslim patients had the second highest representation (7% compared to 20% residents).

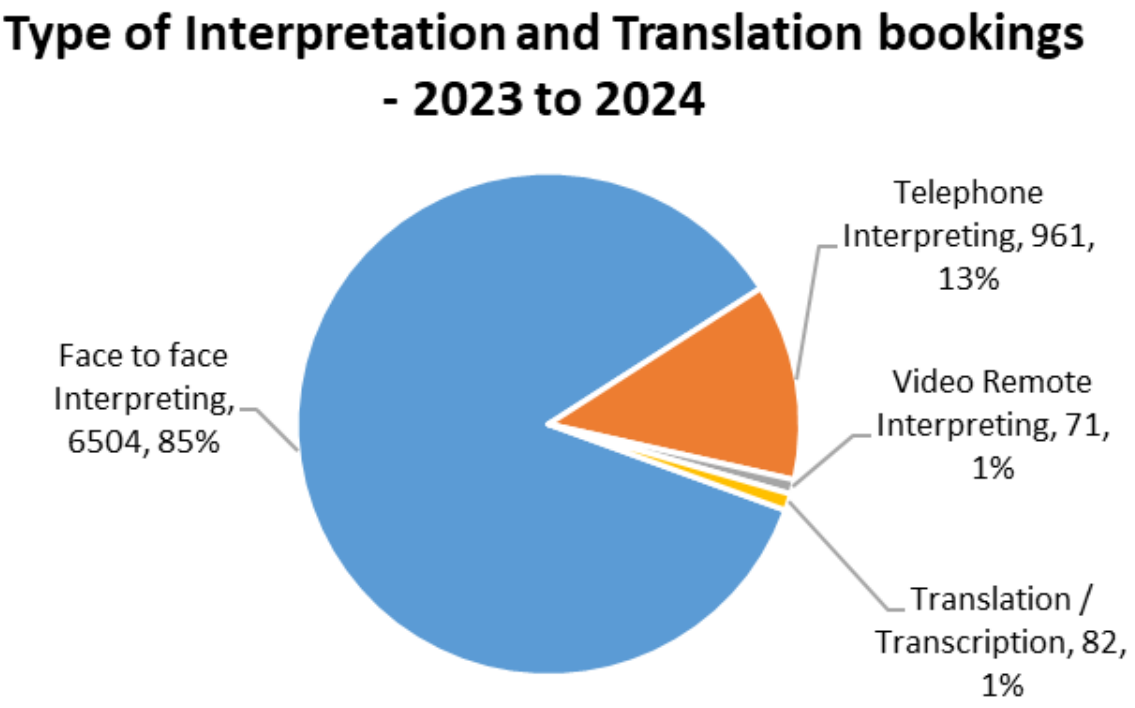
- The high percentage of patients with unknown religious affiliation (38.9%) raises concerns about data completeness. In contrast, a much smaller percentage of residents fall into this category, indicating better data collection or reporting among residents.
- In addition, 5.18% refused to disclose their religious belief.
- The Trust saw a higher representation of patients from the Jewish faith (0.03% versus patients 0.1% residents) and Sikh faith (0.02% vs 0.1% residents) although both groups represent a very small portion.

4.1.6. Interpretation and Translation

All services have access to interpreting and translation services. Patient information is readily available in different languages and formats upon request. Formal contracts are in place with various service providers who can cater for over 200 languages and British Sign Language (BSL). Access to other forms of Communication professionals is also available. Information in a variety of formats is also available upon request. Data from our main provider has been analysed below.

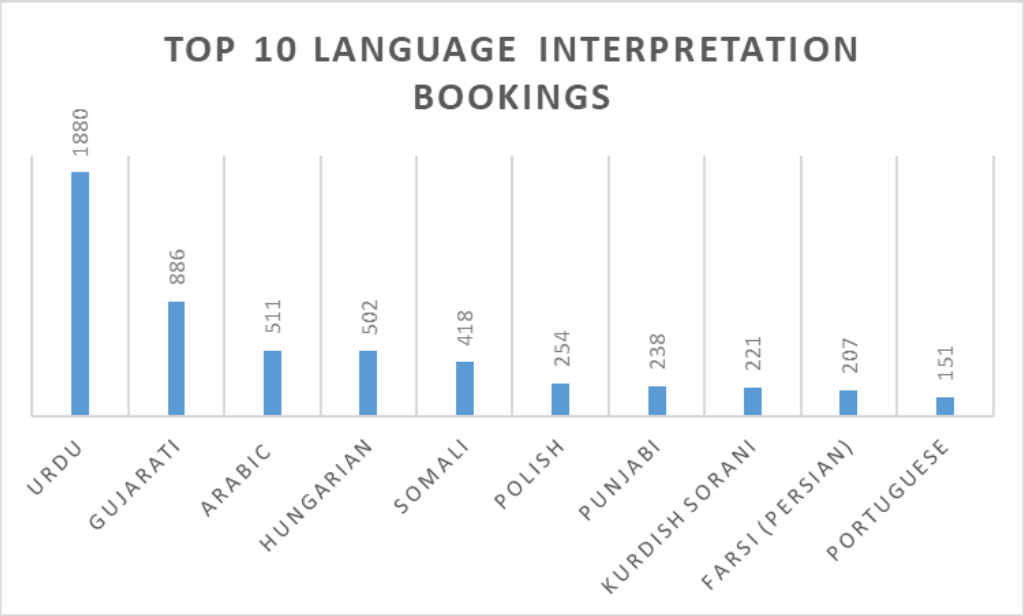
The Trust also employs a Link worker who in the main provides language interpretation in Urdu and Punjabi. The Trust's patient recording system captures details of patients' interpretation and translation needs.

The service is reviewed on a regular basis through the EDI Steering Group to ensure it continues to meet the needs of patients and staff.



- 7618 interpretation and translation bookings were made to our external interpretation providers during 2023 to 2024.

- The vast majority (85%), of interpretation requests continue to be fulfilled face to face.
- 75 foreign languages and dialects were catered for.



Urdu continues to have the highest demand, (1,880 bookings) followed by Gujarati (886 bookings) and Arabic (511 bookings)

- Urdu remains the most requested language, spoken primarily by people of Pakistani origin. It makes up 28% of all interpretation requests. The Trust also employs an Urdu speaking hospital link worker, working on a 0.8FT equivalent contract. Demand for Gujarati also remains high at 13% and Arabic at 7% of all bookings.
- A higher 82 requests were made for translation provision into other languages, when compared to the previous year.

A full list of languages and the total number of face to face and telephone interpretation appointments provided by our external provider are available in Appendix 3.

British Sign Language (BSL) Interpreting & communication Support

In 2023-2024, 275 bookings for BSL were fulfilled by our external providers and six bookings for communication support. This figures does not include support offered by specialised teams at the Trust

4.1.7. Disability profile

Data collection systems are consistently being updated to allow equality monitoring fields to be completed and needs identified. However, the Trust is currently unable at present to provide a full profile of our patients with a disability or health condition. Population profiles are provided below.

A point to note is that the Census 2021 was undertaken during the coronavirus (COVID-19) pandemic. This may have influenced how people perceived their health status and activity limitations, and therefore may have affected how people chose to respond. In addition, the ONS has warned that the wording of the question was different in each census, with 2021 being the first to use the 2010 Equality Act definition of disability, and to explicitly mention mental impairments.

- In the 2021 census, The percentage of people who identified as being disabled and limited a little in Bolton decreased by a marginal 0.5 from the previous decade. 19.3% of adults declared a long term illness, health problem or disability which is higher than the national average at 17.3%
- 8.6% of the Bolton population have a long term health condition or disability which limits their day to day activities a lot
- 9.3% provide unpaid care
- 25,980, (9.3%) of residents stated they provided unpaid care.

Hearing loss [7]

- One in five adults in the UK are deaf, have hearing loss or tinnitus.
- It is estimated that 22% of Bolton residents have hearing loss, which is on par with the regional and national average. [8]
- 2 million adults in the UK are deaf, have hearing loss or tinnitus. That is roughly 10.1 million people in England, 1 million people in Scotland, 610000 people in Wales and 320000 people in Northern Ireland.
- In the UK, more than 40% of over 50s have hearing loss, rising to 70% of over 70s.
- By 2035, we estimate there will be around 14.2 million adults with hearing loss greater than 25 dB HL across the UK.
- An estimated 1.2 million adults in the UK have hearing loss severe enough that they would not be able to hear most conversational speech.

[7] Prevalence of deafness and hearing loss - RNID

[8] NHS England » Hearing Loss Data Tool

Sight impairments [9]

- There are over 2 million people in the UK living with sight loss, which is expected to rise by 2.9 million by 2030[10].
- 340,000 people are registered blind or partially sighted in the UK. There are fifty-seven new registrations each day.[11] These people meet the international definition of vision impairment and include everyone whose vision is worse than 6/12 Snellen – that is halfway down the optician's letter chart. This is also the amount of vision loss that requires people to surrender their driving license in the UK.
- Nearly 80% are 65 or older, and around 60% are 75+.
- Around 60% of people living with sight loss are women. Women have a higher life expectancy and have a higher age-specific prevalence of some of the leading causes of sight loss in older age.
- People from certain ethnic minority groups are at greater risk of some of the leading causes of sight loss: Black African and Caribbean people are four to eight times more at risk of developing certain forms of glaucoma; the risk of diabetic eye disease is around three times greater in South Asian people.

Other disabilities

- There are an estimated 3,125 people over the age of 65 living with dementia in Bolton. This is expected to rise to 4,786 people 2030[12]. Dementia is a progressive neurological condition. It occurs when the brain is damaged by diseases (such as Alzheimer's disease) or by a series of strokes. The symptoms of dementia can include memory loss and difficulties with thinking, problem solving, language and physical function.
- In Bolton an estimated 42,000 (around 15%) of residents aged 16 and over have a common mental health disorder.[13] Studies have shown the coronavirus pandemic has had a negative impact on people's mental health and wellbeing, which has resulted in an increased demand for mental health support.
- There are approximately 2.6% (5,586) adults with learning disabilities in Bolton. As at 31st March 2016, there were 626 adults with a learning disability accessing a long-term service. Of these 17% are from an ethnic minority background with 8% Indian and 4% Pakistani.

[9] Learn more about sight loss statistics across the UK | RNIB
[10] Visual Impairment Awareness Training | Bolton CVS
[11] Registered Blind and Partially Sighted People, England 2019-20 - NHS Digital
[12] bolton-dementia-profile-alzheimer-s-society (boltonjsna.org.uk)
[13] Bolton Council says It's time to talk about mental health! – Bolton Council

4.1.8. Sexual Orientation & Gender Reassignment

- The Census 2021 for the first time provides reliable data on this population profile.
- 5,695 people from Bolton identified as part of the Lesbian, Gay, Bisexual + community. From 2021 census data, 90.7% of people aged 16+ living in Bolton were heterosexual or straight. This question was optional, and 7% chose not to answer. The full breakdown is available in the table below.

Sexual Orientation	Number of residents	% of residents
All usual residents aged 16 and over	232,291	100.0
Straight or Heterosexual	210,665	90.7
Gay or Lesbian	2,807	1.2
Bisexual	2,317	1.0
Pansexual	408	0.2
Asexual	89	0.0
Queer	23	0.0
All other sexual orientations	51	0.0
Not answered	15,931	6.9

- However, the Trust does not record sexual orientation data in its entirety to allow a meaningful comparison to take place.
- Gender Identity: 0.6% of people aged 16+ living in Bolton had a gender identity different from their sex registered at birth (1,469 residents). 'No specific identity given' was the most frequent response at 0.3% of the 16+ population. This question was optional, and 6% chose not to answer. The full breakdown is available in the following table.

Gender Identity	Number of residents	% of residents
All usual residents aged 16 and over	232,289	100.0
Gender identity the same as sex registered at birth	217,137	93.5
Gender identity different from sex registered at birth but no specific identity given	724	0.3
Trans woman	296	0.1
Trans man	314	0.1
Non-binary	85	0.0
All other gender identities	50	0.0
Not answered	13,683	5.9

These findings underscore the importance of tailored strategies to improve health outcomes and ensure equitable access to services for all patient groups.

By implementing these recommendations, Bolton NHS Foundation Trust can foster a more equitable, inclusive, and responsive healthcare environment that meets the diverse needs of its patient population.

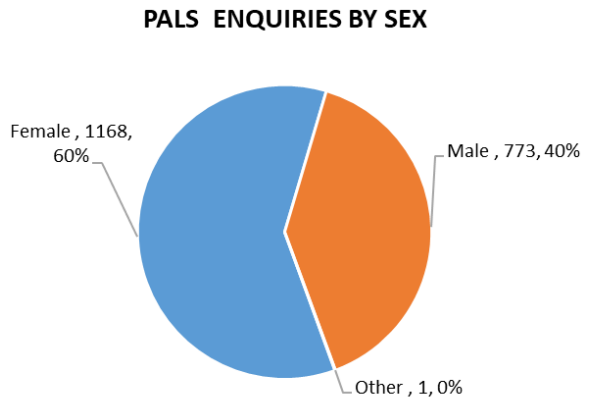
4.2. Equality in Complaints and Concerns

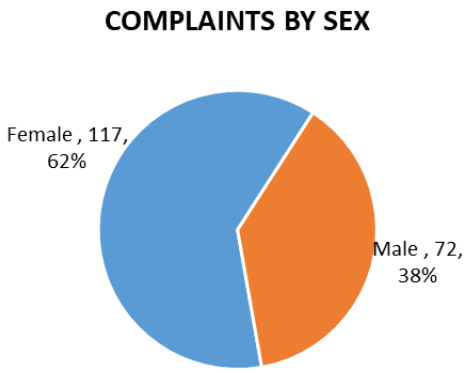
The Patient Advice & Liaison Service (PALS) offers help, support and advice to patients, relatives or carers, if they wish to make enquires, compliments or raise concerns in relation to the hospital. The Complaints department deal with official complaints raised by patients and carers if they are not satisfied with the Trust's attempts to resolve the concern in the first instance.

The PALS and complaints department routinely collect diversity monitoring data on age, gender and ethnicity. Patient information is available in different formats and opportunities are utilised to promote the service at community events. Patients and carers with language or communication barriers are supported to raise concerns with the use of interpreting services and other accessible methods.

In 2023 to 2024, PALS supported 1942 individuals to resolve their concerns and dealt with 189 complaints. The Trust takes seriously that all members of the public should feel comfortable in accessing the PALS and complaints service and as such captures information on the patient's age, gender and ethnicity to support this. A summary of this data is provided which has been measured against patient profile activity.

Sex Breakdown





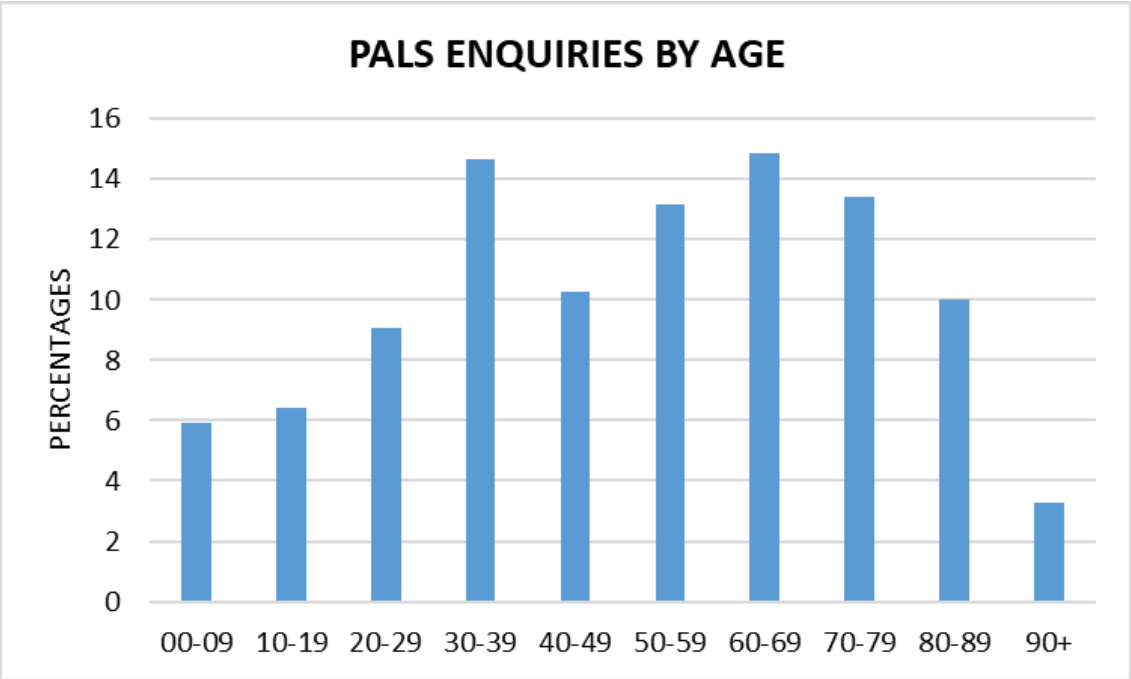
PALS

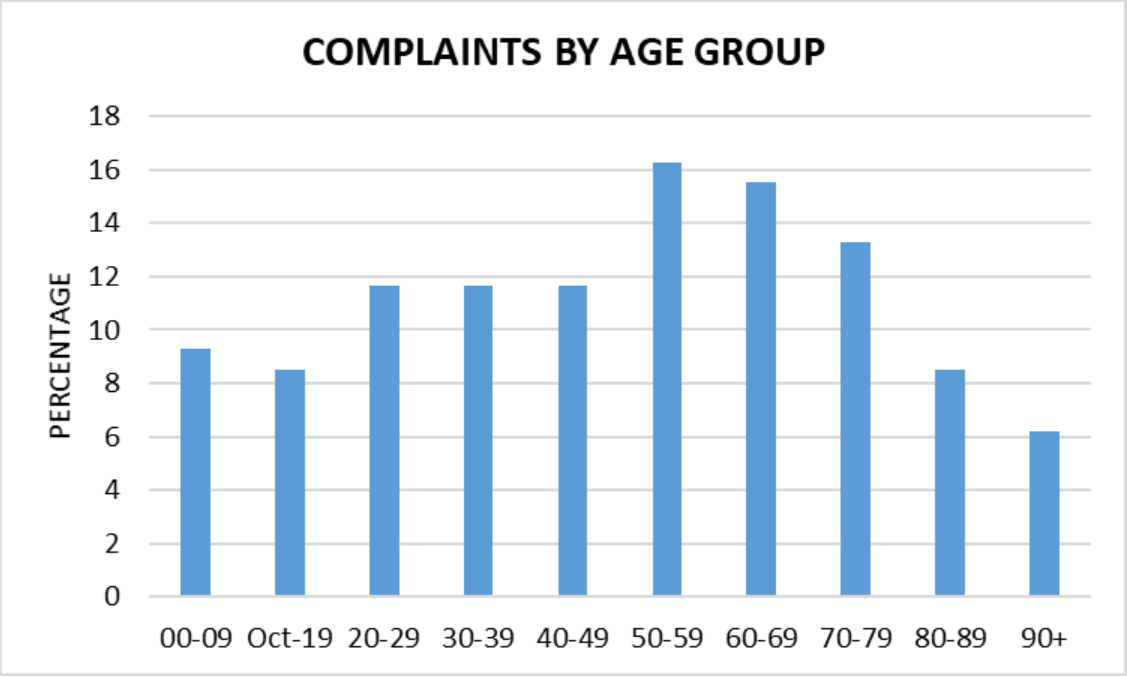
- A significant majority of PALS users are female, with 1,168 users (60%). In comparison Male users account for 773 individuals (40%).

COMPLAINT:

- The data indicates a higher representation of female users in the complaints dataset, accounting for approximately 62% of the total. Male users make up 38% of the complaints.

Age breakdown





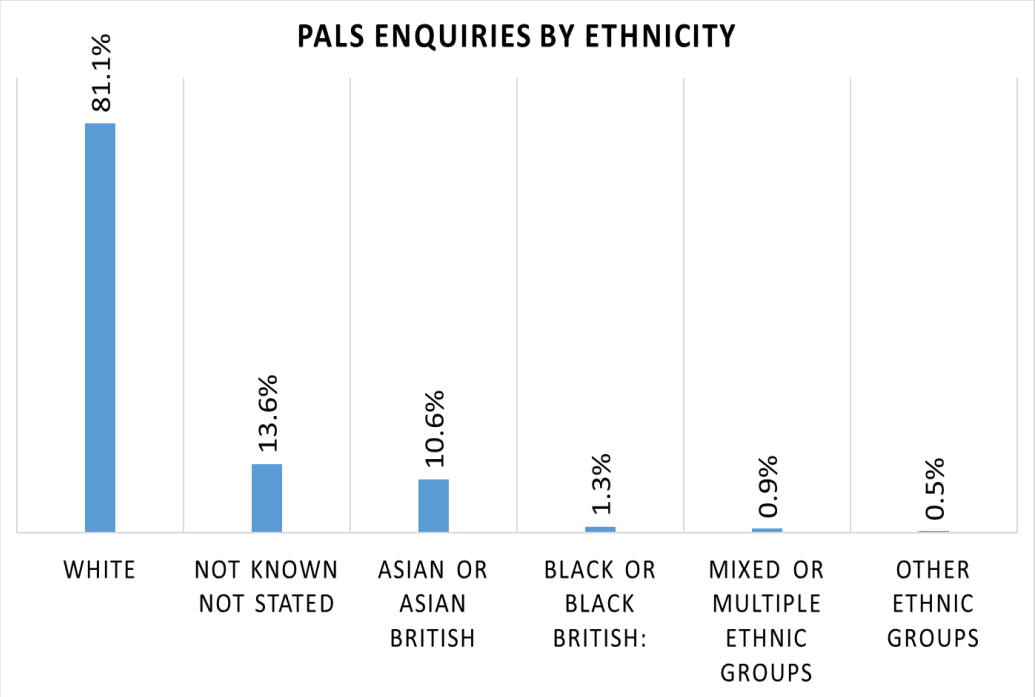
PALS:

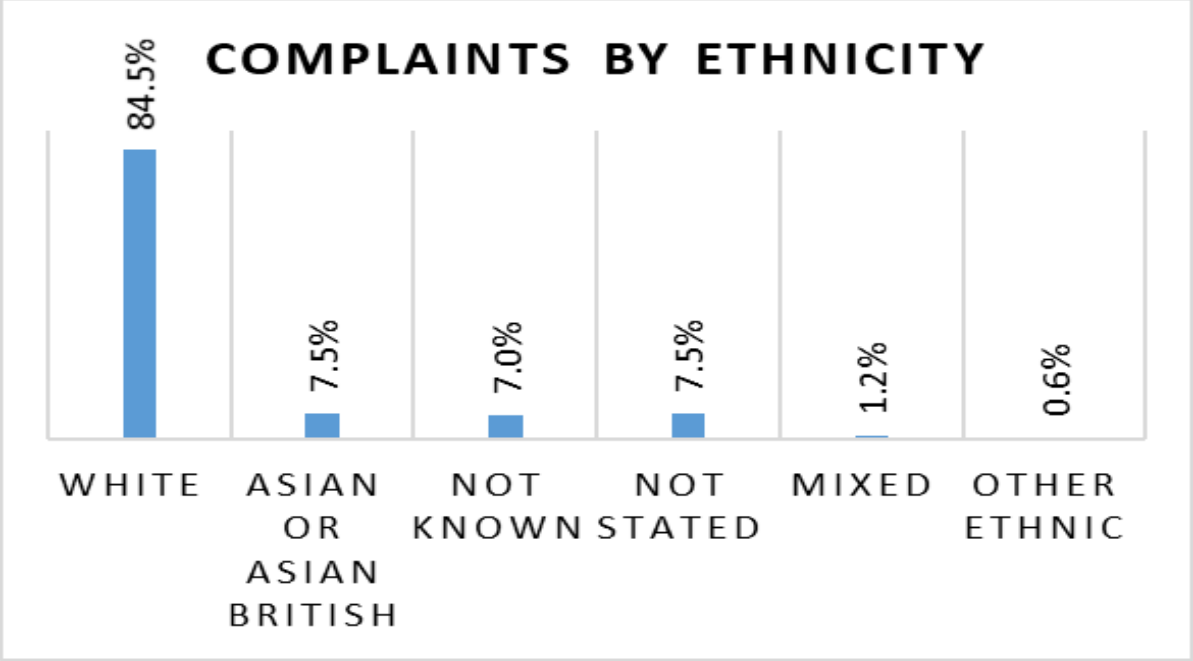
- The majority of NHS PALS users are from the age groups 30-39 (14.6%) and 60-69 (14.9%).
- Individuals aged 40-59 make up a substantial 23.4% of PALS users (10.3% + 13.1%), indicating that middle-aged individuals have notable interactions with PALS for support.
- The youngest group (0-9) has the lowest percentage of PALS users (5.9%), while the oldest group (90+) also shows a low engagement level (3.3%).
- There is a marked decrease in PALS users aged 70 and above, suggesting potential barriers that may prevent this demographic from utilising these services.

Complaints

- The data shows that NHS complainants are most prevalent in the 50-59 age group (16.28%), followed closely by the 60-69 group (15.5%).
- The youngest group (0-9) accounts for 9.3% of complainants, while the 90+ group has the lowest representation at 6.2%.
- The percentage of complainants decreases in older age groups after 70, particularly for those aged 80-89 (8.53%) and 90+ (6.2%), which may suggest barriers to engagement or differing levels of advocacy in these demographics.

Ethnicity breakdown





PALS:

- A significant majority of PALS users (approximately 81.05**%**) identify as White
- The combined percentage of Asian, Black, Mixed, and Other ethnic groups accounts for only about 12.29% of users. Specifically, Asian or Asian British users constitute 10.55%, while Black or Black British users represent just 1.32%.

- The substantial number of users classified as Not Known, Not Specified, or Not Stated (around 13.63%) suggests potential gaps in data collection or reporting.

Complaints

- The White category accounts for a substantial 83.23% of the complaints data.
- The Asian or Asian British category represents only 7.51% of the total complaints. Within this, there is a diverse representation, but still a relatively low proportion compared to the White population.

4.3. Our Workforce

In 2023/24, the Trust employed 6194 staff from diverse backgrounds, 105 more than the previous year. The profile of staff has been broken down below by protected characteristics, highlighting representation by profession, staff group, pay bands and turnover, where applicable. Any notable differences and comparisons to the previous year are reported within.

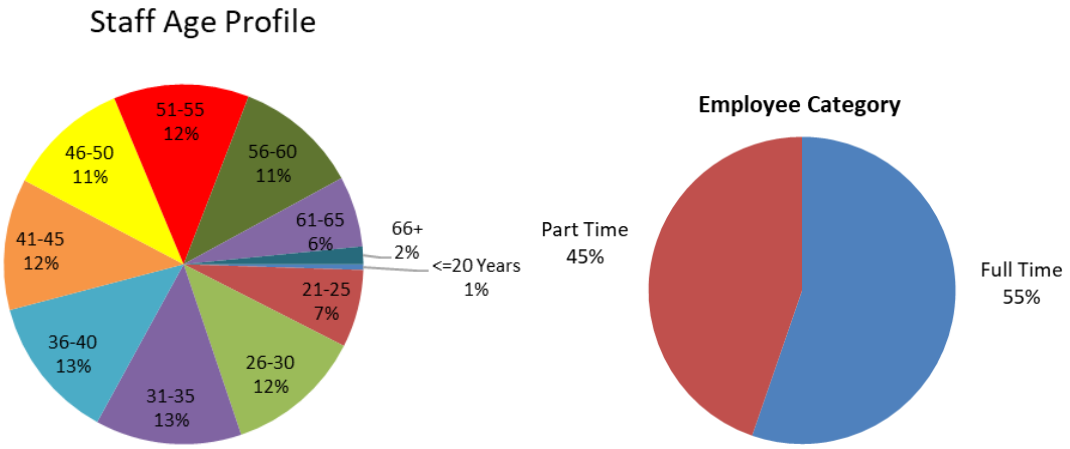
4.3.1. Workforce - Key findings

1. **Workforce Growth**: The Trust employs 6,194 staff, an increase of 105 from the previous year, reflecting ongoing recruitment efforts.
2. **Age Profile**:
    - Largest age group: 31-35 years (13.2%).
    - 54% of staff are over 40, indicating an ageing workforce.
    - 45% of the workforce works part-time, showing active use of flexible working arrangements.
    - Slight increase in staff under 25, attributed to apprenticeship schemes.
    -
3. **Sex Profile**:
    - Predominantly female workforce (85%), exceeding the national average (77%).
    - Higher male representation in Medical and Dentistry roles (52%).
    - Male turnover rate (16.2%) is higher than female (13%).
4. **Disability Profile**:
    - 76% report no disability; 5% identify as having a disability, which is lower than the local population.
    - Disability disclosure has improved slightly, but non-disclosure remains high (over 20%).
    - Higher turnover for disabled staff (15.3%) compared to non-disabled staff.
5. **Ethnicity Profile**:
    - 75% of staff are White, compared to 71.9% in the local population.
    - 21% identify as BAME, a 3% increase from the previous year but still lower than the local demographic (28%).
    - Underrepresentation of BAME individuals in higher pay bands and senior roles.
6. **Gender Reassignment**: Data on gender identity is not recorded, but support is provided for transitioning employees.
7. **Maternity and Leave**: There is usage of maternity, paternity, and adoption leave among staff.
8. **Religion and Belief**:
    - Majority identify as Christian (50%), with 22% not declaring their religion.

- Higher turnover among staff from other religious backgrounds (15.89%).

9. **Sexual Orientation**:
   - Majority identify as heterosexual/straight (77%).
   - Low declaration rates for LGB staff (2%) compared to regional estimates (5-7%).

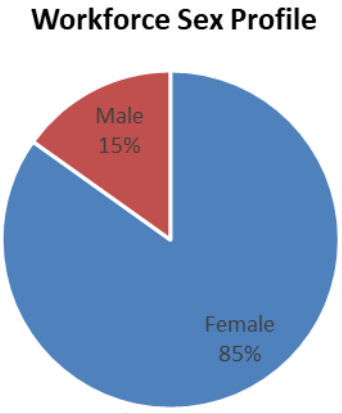
4.3.2. Age Profile



- Employees aged 31- 35 old have the largest representation (13%) of the total workforce followed by employees aged 36-40 (13).
- The smallest representation is from staff under the age of 20 years of age, which is expected. This is probably explained by the time it takes to gain a clinical qualification, which means that they are usually in their mid-twenties when they take up post.
- The Trust has an ageing workforce with 54% of its staff aged over the age of 40 years. An older workforce requires the continuing development of health and wellbeing initiatives and a consideration of flexible working to support caring responsibilities.
- 45% of the workforce work part time demonstrating flexible working opportunities are actively being utilised.
- The number of young people aged under 25 have marginally increased in headcount by 1 employee when compared to the previous year. There have however, been a number of changes in the way younger people in particular are entering into NHS professions, leading to a visible difference in workforce diversity in terms of age. The Trust's apprenticeship schemes are offering alternative routes to completing higher education degree level qualifications.
- There is good representation of people of all ages in all pay bands and occupations with the exception of:

- Staff aged under 20 who are mostly only to be found in administration and additional clinical services and professional scientific and technical roles.
- Staff aged below 41 years of age and above 60 years of age are not found in VSM positions. However, considering experience and skills required to fulfil the requirements of more senior posts increases with age whilst older workers being more likely to reduce hours and levels of responsibility during later years, this is not surprising.

4.3.3. Sex Profile



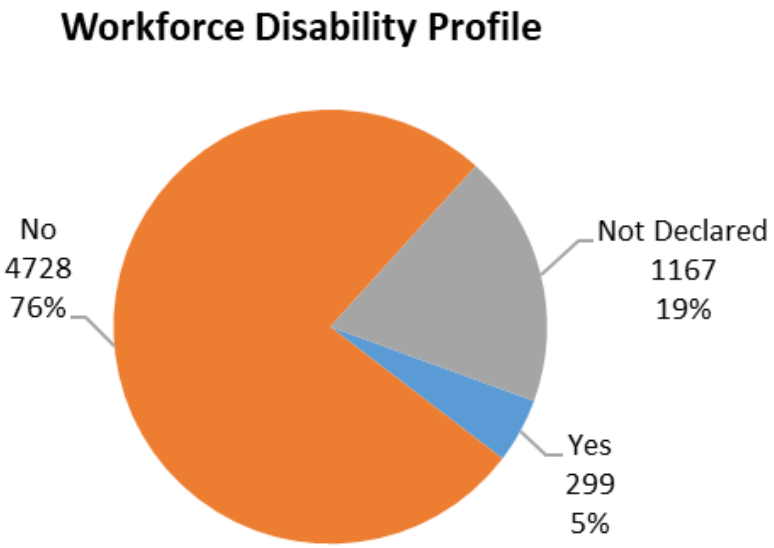
Professional Group	Female (%)	Male (%)
Add Prof, Sci & Tech	79.62%	20.98%
Add Clin Services	88.64%	11.36%
Admin	83.43%	16.57%
AHP	79.02%	20.98%
Estates	82.22%	17.78%
HCS	73.76%	26.34%
Med & Den	47.33%	52.67%
Reg Nur & Mid	93.10%	6.69%
Students	100.00%	0.00%

- The sex profile of the workforce continues to remain as predominantly female (85%) which is higher than the national average at 77% of the NHS workforce. [14]. Data reporting system does not allow for a more inclusive selection including non-binary etc.

[14] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

- The highest representation of females are in Registered Nursing and Midwifery (93%), whilst males are mostly represented in Medical and Dentistry (52%). Males also have good representation in allied Health professional and Additional Professional, Scientific and Technical professionals (21%)
- Males have a higher leaver turnover rate at 16.2% compared to 13% of females.
- It is noted that all eight students recruited by the Trust are females.

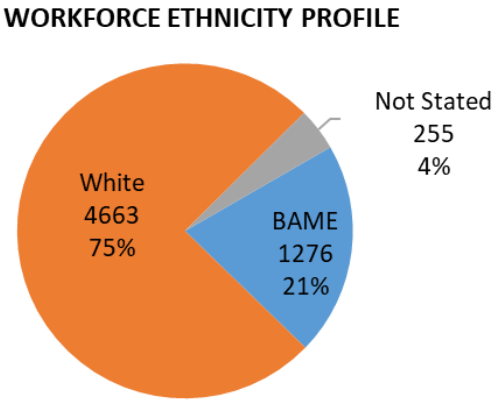
4.3.4. Disability Profile



- 76% of employees report not having a disability.
- 5% of employees identify as having a disability or long-term health condition, showing a 1% increase from the previous year or 52 individuals. This is line with the national average. This could be due to increased confidence or Covid impacts as more people have experienced ill health. However, this figure is lower when compared to the local population (19.3%) and when compared to the most recent staff survey results (24.1%).
- There has also been a 3% decrease in non-disclosure. However almost a fifth of staff chose not to declare (18.6%). This is 2% higher than the national average, which is at 19.1%.

- This gap in data impacts on the analysis of experiences of staff with a disability or health condition. However a 7.9% reduction in the 'Unknown' category over the past five years has been noted,
- Staff with a disability have a higher turnover rate 15% (299 individuals), compared to staff without (13%). However, 15% of leavers have chosen not to declare their disability status.
- The Workforce Disability Equality Standard (WDES) report provides further insight into the experiences of staff. Please see: [Our approach to equality, diversity and inclusion - Bolton NHS FT (boltonft.nhs.uk)]

4.3.5. Ethnicity Profile



Professional Group	BME Count	Grand Total	Percentage of BME
Add Prof, Sci & Tech	52	157	33.12%
Add Clin Services	216	1357	15.93%
Admin	141	1220	11.55%
AHP	118	559	21.10%
Estates	2	45	4.44%
HCS	49	129	38.76%
Med & Den	226	450	50.44%
Reg Nur & Mid	472	2269	20.78%
Students	0	8	0.00%

- The majority of staff are White, (75%) which is higher than the most recent Census 2021 figure at 71.9% local population profile.

- 21% of staff identify as Black, Asian, Minority Ethnic (BAME), This 3% increase (165 individuals) reflects an ongoing efforts to promote diversity. The Trust figure remains 7% lower than the local BAME population demographic now at 28% and lower than the national comparison figure at 24%.
- The local demographic has a large variation in BAME representation but a further breakdown of main ethnic groups is not available to identify any under representation within groups but should be considered in future reports.
- There has been a 1% decrease in non-disclosure rates although 4% of the workforce continue not to disclose their ethnicity.
- BAME colleagues are represented in all staff groups expect in the student group where there is an underrepresentation of BAME students as all eight are White.
- Medical and Dental (50%, 226 individuals have the largest number of BAME representation), followed by Health Care Scientists (38% 49 individuals) and Additional Professional, Scientific and Technical 33% (52 individuals)
- 20% of Nursing and Midwifery staff are from BAME backgrounds (472 individuals).
- The majority of BAME staff are employed at Band 5 (37%).
- In terms of seniority, 2.2% (29 individuals) of the overall BAME staff are recruited at Band 8a and above posts although there are no BAME staff at Very Senior Manager Level.
- BAME staff have the lowest leaver rate at 13.6% compared to 14% of White staff.

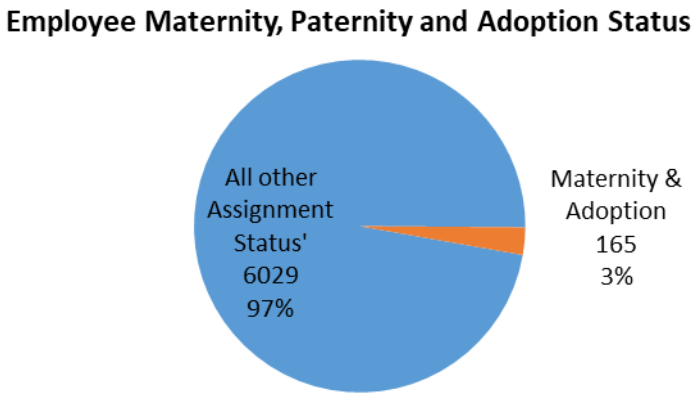
The Workforce Race Equality Standard (WRES) report provides further insight into the experiences of staff from a Black, Asian and Minority Ethnic background at the Trust. Please see: https://www.boltonft.nhs.uk/about-us/trust-publications-and-declarations/equality-and-diversity/

4.3.6. Gender Reassignment Profile

The Trust does not record the number of staff who identify as Trans.

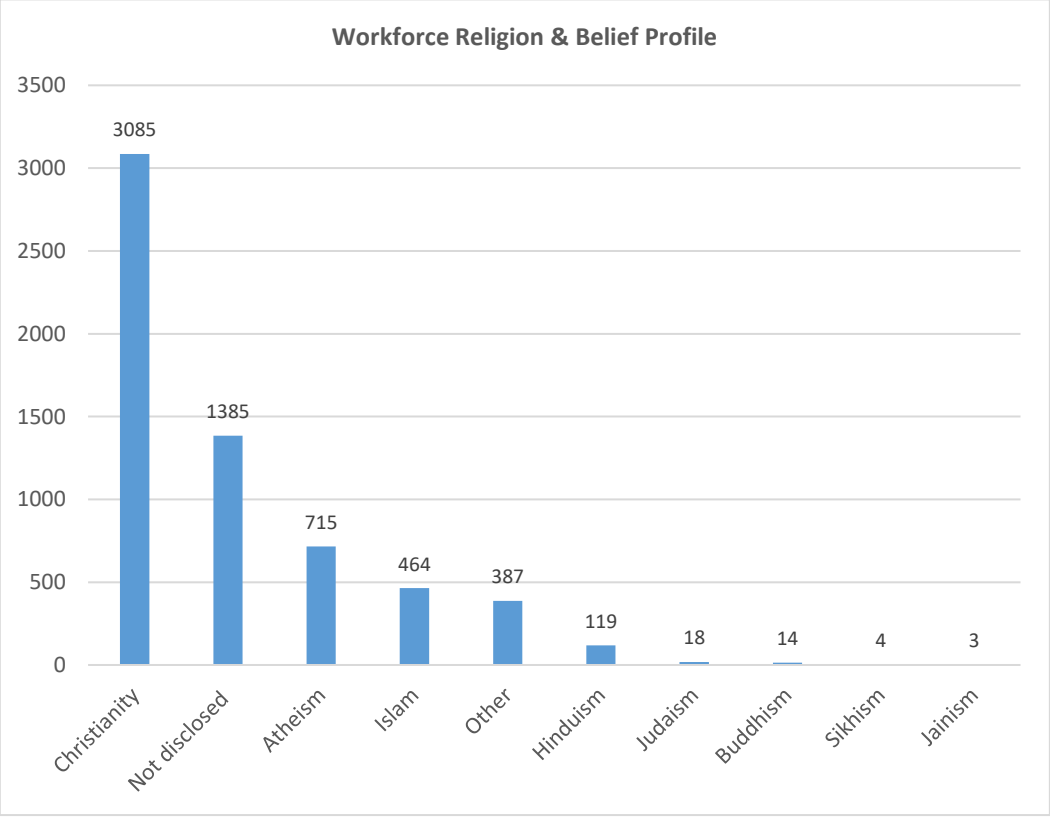
However, the Trust has supported a number of employees through transition and continues to engage with staff via the LGBTQ+ staff network.

4.3.7. Maternity, Adoption and Other Leave Profile



- The above chart demonstrates the staff are taking up maternity, paternity, carers and adoption leave.

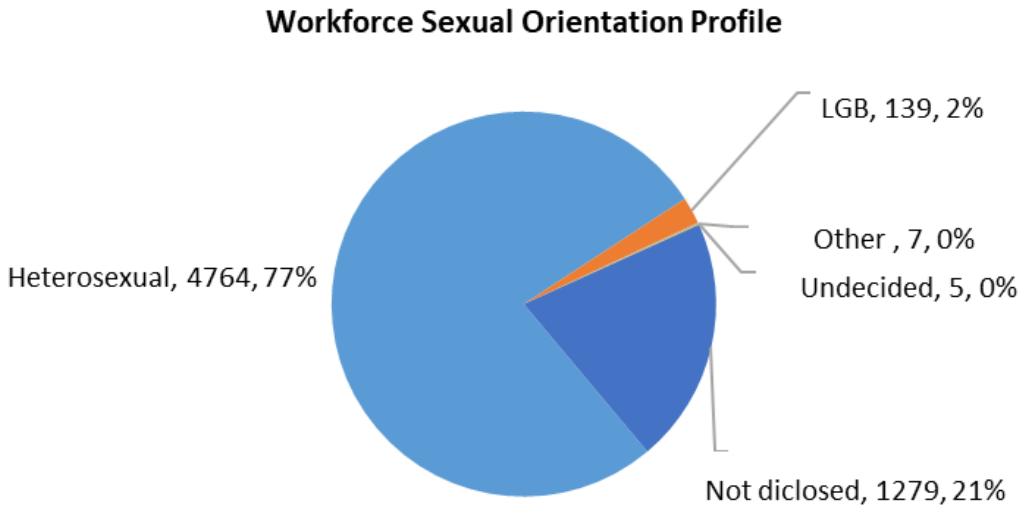
4.3.8. Religion and Belief Profile



Professional Group	Christianity	All Other Religions	IDNWTD
Add Prof, Sci & Tech	36.92%	43.31%	19.74%
Add Clin Services	49.14%	27.64%	23.22%
Admin	49.02%	27.55%	23.44%
AHP	46.70%	34.17%	19.13%
Estates	46.67%	8.89%	44.44%
HCS	34.11%	33.33%	32.56%
Med & Den	22.89%	49.78%	27.33%
Reg Nur & Mid	58.66%	21.13%	20.31%
Students	50.00%	50.00%	0.00%

- The majority of our workforce identify as Christian (50%) followed by Atheist (12%) and Muslim staff (8%).
- 22% of staff have not declared which is an improvement of 1% compared to the previous year.
- The highest representation of other religions is within Students (50%), followed by Medical and Dentistry (50%).
- Employees from other religions have a higher leaver rate at 15.89% compared to 13% Christian colleagues.

4.3.9. Sexual Orientation Profile



- The data shows heterosexual/straight makes up the majority of the workforce (77%).
- 2% of staff continue to identify as Lesbian, Gay or Bisexual (LGB). This is lower than the regional estimate between 5% to 7%. Low declaration rates make analysis difficult to draw any conclusions from.
- 22% of sexual orientation data has not been declared, although this is a 1% improvement from the previous year.

5. Recommendations and Action Plan

On a four yearly basis, the Trust is required to refresh its equality objectives making use of the key equality data highlighted in the annual compliance report.

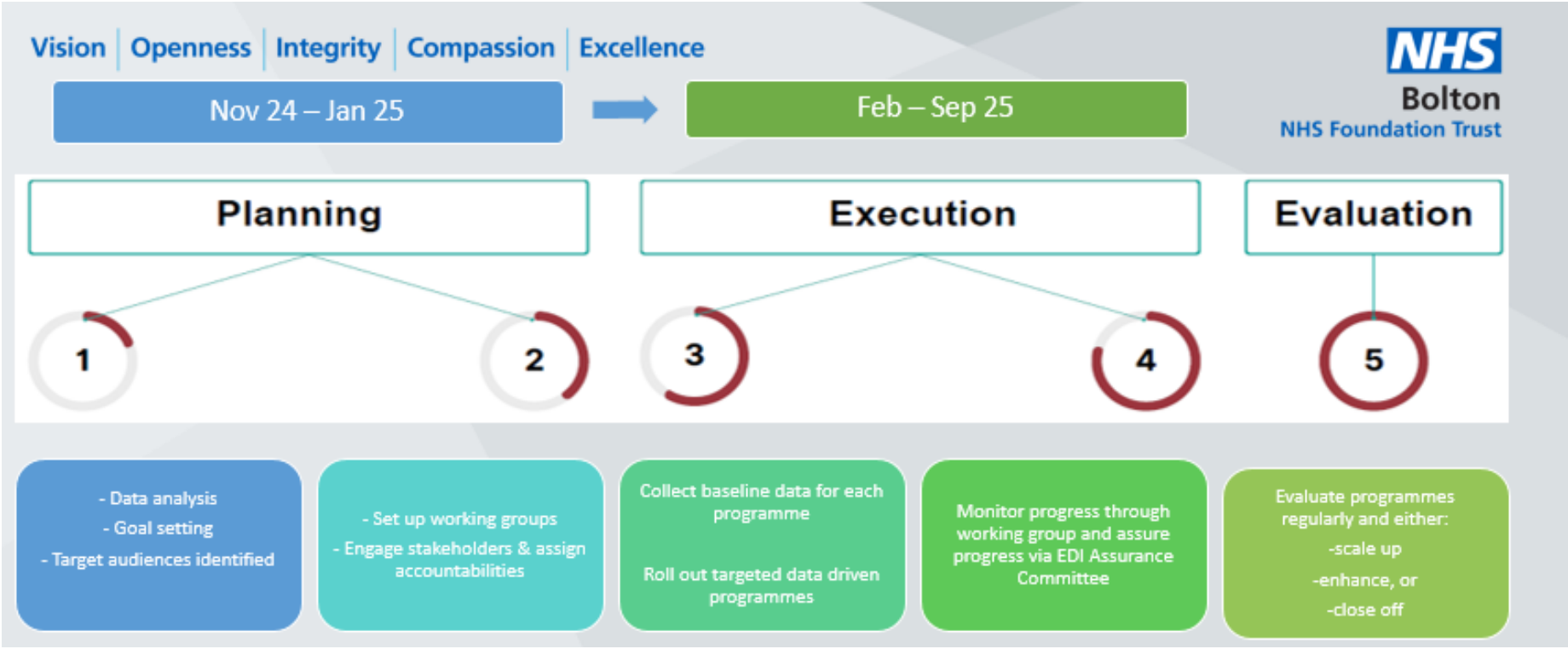
The following key recommendations to improve patient and workforce experience, and outcomes are based on the data analysis within the report and are aligned to these ambitions.

Ambition 1	Understand the needs of our community and provide services, which meet those needs.
Ambition 2	Create a working environment in which all staff can reach their full potential.
Ambition 3	Recruit and cultivate a workforce that represents Bolton's diversity

Ambition 4	Act on patient, staff and community feedback on how we can improve our approach to EDI.

The governance structure to support EDI activity has been refreshed and strengthened and is summarised in Appendix 4.

The following recommended actions for the next year will be treated according to the timeline below and will be worked through in dedicated working groups that report to their respective People or Patient EDI Steering Group (refer to Appendix 4 for more information):



Recommendations:

1. Improving data:
    a. Increase staff equality monitoring declaration rates in ESR
    b. Implement systematic procedures to improve the collection of demographic data during patient registration.
    c. Implement the Accessible Information Standard to identify record, flag, share and meet the information and communication support needs of patients, service users, carers and parents with a disability impairment or sensory loss.
2. Improving experience at work:
    a. Improve recruitment and career progression of BAME & disabled staff.
    b. Streamline our reasonable adjustments processes.
    c. Reduce instances of bullying, harassment and discrimination.
    d. Reduce the gender pay gap.
    e. Implement the updated equality Delivery System (EDS2022).
    f. Strengthen the staff diversity networks to leverage change.
3. Improving patient access and experience:
    a. Actively engage with diverse communities, particularly those underrepresented in service utilisation, to identify barriers to access and specific healthcare needs. Tailor health services and outreach efforts accordingly.
    b. Provide training for staff on cultural competence and sensitivity to better understand and respond to the diverse backgrounds of patients.

All of these actions will be underpinned by a culture of anti-racist principles, with all leaders 8a+ having an anti-racist objective.

The following table outlines a high level action plan that shows the themes tackled and what working groups and steering groups will take ownership of the actions.

Theme	Actions	Working Group > Steering Group	KPIs	Baseline & Targets
Improving Data	Increase staff equality monitoring declaration rates in ESR	Knowing Our Staff > Our People	% declared as disabled on ESR	**Baseline**: 4.9% **Target**: 7% by Sep 25
	Implement systematic procedures to improve the collection of demographic data during patient registration.	AIS > Our Patients	TBC	TBC
	Implement the Accessible Information Standard	AIS > Our Patients	TBC	TBC
Improving experience at work				
Recruitment and career progression	Mandated 'equality advocate' role on interview panels vacancies. Hiring managers asked to justify why BAME / disabled candidate was not appointed specifically if not successful Interview questions to be provided in advance. Prompting recruiting managers to avoid main religious observance days for interviews, and to avoid Friday prayer time or Shabbat. Structured follow up process inc career coaching made available for BAME and disabled staff who have not been successful for promotion. Application/interview skills workshops, supplemented with peer networking events for ongoing support.	Inclusive Recruitment and Career Development > Our People	**BME** AfC: % BME representation at B6+ Medical and Dental % BME representation at consultant level **Disability:** % disabled representation across all AfC, medical and dental and IFM	**BME:** All AfC roles: **Baseline** of BME staff in AfC 6+ = 13.8% as of Sep 24. **Target**: increase to 15% by Sep 25. This represents an extra 26 BME staff at B6+ Medical and Dental: **Baseline** of BME consultants 49.8% as of Sep 24. **Target**: to increase to above 50% by Sep 25 **Disabled** **Baseline**: 4.9% **Target**: 7% by Sep 25.

Theme	Actions	Working Group > Steering Group	KPIs	Baseline & Targets
	Scope possibility to widen recruitment routes into the Trust for certain roles	Inclusive Recruitment and Career Development > Our People	% overall BME representation	**Baseline**: **BME** staff in all AfC roles 19.7% as of Sep 24 **Target**: increase overall **BME** representation by minimum of 1% per year **Disabled** **Baseline**: 4.9% **Target**: 7% by Sep 25.
	Inclusive recruitment training for hiring managers to be compulsory for certain roles	Inclusive Recruitment and Career Development > Our People	% of people trained	Awaiting baseline (survey recruiting managers) **Target**: 50% recruiting managers trained by Sep 25
	Targeted offer of the new Our Leaders programme to marginalised groups and to leaders of diverse teams. Potential Positive Action Programme targeted at BAME staff at Band 5 for certain roles as part of the Embed/Blended Learning Bundles of Our Leaders.	Inclusive Recruitment and Career Development > Our People	% of enrolled candidates who are BME on Our Leaders	**Baseline**: N/A new programme. **Target**: **BAME:** >13.8% of enrolled candidates for Our Leaders are BME (greater representation than current B6+ BME population) **Disabled:** >2.9% of enrolled candidates are disabled (greater than representation of B6+ Disabled staff population)
Reasonable Adjustments	Streamline our reasonable adjustments processes	Reasonable Adjustments Working Group > Our People	% of staff feeling like they have the adjustments they need to do their job	**Baseline**: 72.9% **Target**: 82.9% by next WDES
Bullying Harassment and Discrimination	Reduce instances of bullying harassment and discrimination: specific actions and KPIs TBC by the working group	Good Culture > Our People	TBC	TBC

Theme	Actions	Working Group > Steering Group	KPIs	Baseline & Targets
	Strengthen the staff diversity networks	Good Culture > Our People	Staff membership as a % of all eligible staff	**Baseline**: 13% of all **BME** staff are members. 20% of all **disabled** staff are members. **Target**: 30% of all **BME** staff are members. 30% of all **disabled** staff are members.
	Roll out the Our Leaders programme, which aims to help leaders to become more actively inclusive and tackles race-related barriers.	Good Culture > Our People	Number of staff going through the 2 day programme	**Baseline**: N/A new programme. **Target**: 1500 leaders by July 2026
	Antiracist objectives to be mandated for all VSM and deputies.	Good Culture > Our People	% of VSM and deputies with an anti racist objective	**Baseline**: 0% **Target**: 80% by Sep 2025
Improving patient access and experience	Actively engage with diverse communities, particularly those underrepresented in service utilisation, to identify barriers to access and specific healthcare needs. Tailor health services and outreach efforts accordingly.	HIEG and I&T and AIS groups > Our Patients	TBC	TBC
	Provide training for staff on cultural competence and sensitivity to better understand and respond to the diverse backgrounds of patients.	HIEG > Our Patients	TBC	TBC

More detail including Key Performance Indicators for many of these actions can be found by referring to the latest WRES and WDES action plans that can be found at [Our approach to equality, diversity and inclusion - Bolton NHS FT (boltonft.nhs.uk)]

Appendix 1: Patient Profile Data Tables

The following data will be for First Attendance Only
Disabilities data only includes patients who have 'Learning Disabilities' recorded.
Note - A&E data will have no data for follow up attendances.

Attendances

Attendance	Total	Percentage of Total
A&E	134073	42.46%
Acute Outpatients	47086	14.91%
Community Outpatients	53385	16.90%
Inpatient	81253	25.73%
Grand Total	**315797**	100.00%

Attendances by Age Group

10 Year Age Bands	Total	Percentage of Total
00-09	36776	11.65%
10-19	23029	7.29%
20-29	32648	10.34%
30-39	38260	12.12%
40-49	29537	9.35%
50-59	36740	11.63%
60-69	38135	12.08%
70-79	42077	13.32%
80-89	31268	9.90%
90+	7327	2.32%

Attendances by Gender

Gender	Total	Percentage of Total
Female	171143	54.19%
Male	144629	45.80%
Not Known	7	0.00%
Not Specified	18	0.01%

Attendances by Religion

Religion	Total	Percentage of Total
Not Specified	122943	38.93%
Church of England	86502	27.39%
Roman Catholic	29042	9.20%
Muslim	22888	7.25%
Religion not given - PATIENT refused	16350	5.18%
Christian	10465	3.31%
Not Religious	10093	3.20%
Methodist	4200	1.33%
Atheist	3636	1.15%
Hindu	3237	1.03%
Patient Religion Unknown	1463	0.46%
Anglican	1149	0.36%
Jehovah's Witness	568	0.18%
Ismaili Muslim	477	0.15%
Agnostic	417	0.13%
Catholic: Not Roman Catholic	267	0.08%
Church of Scotland	255	0.08%
Baptist	188	0.06%
Pentecostalist	170	0.05%
Mormon	140	0.04%
Unitarian-Universalist	137	0.04%
Spiritualist	136	0.04%

Pagan	124	0.04%
Jewish	76	0.02%
Protestant	72	0.02%
Sikh	61	0.02%
Reformed Presbyterian	59	0.02%
Orthodox Christian	49	0.02%
Religion (Other Not Listed)	44	0.01%
Buddhist	41	0.01%
Confucianist	40	0.01%
Greek Orthodox	40	0.01%
Divination	34	0.01%
Quaker	33	0.01%
Native American Religion	28	0.01%
Animist	21	0.01%
Seventh Day Adventist	20	0.01%
Zen Buddhist	20	0.01%
Radha Soami	19	0.01%
Russian Orthodox	17	0.01%
Church of Ireland	16	0.01%
Congregationalist	15	0.00%
Old Catholic	14	0.00%
Christadelphian	12	0.00%
Unitarian	12	0.00%
Christian Existentialist	11	0.00%
Church of God of Prophecy	11	0.00%

Lutheran	11	0.00%
Evangelical Christian	10	0.00%
Jain	10	0.00%
Reformed Christian	10	0.00%
Reformed Protestant	10	0.00%
Humanist	9	0.00%
Church in Wales	8	0.00%
Independent Methodist	8	0.00%
Presbyterian	8	0.00%
Salvation Army Member	8	0.00%
Sunni Muslim	8	0.00%
United Reform	8	0.00%
Romanian Orthodox	7	0.00%
Plymouth Brethren	6	0.00%
Advaitin Hindu	5	0.00%
Occultist	5	0.00%
Christian Spiritualist	4	0.00%
Matraism	4	0.00%
Pantheist	4	0.00%
Rastafari	4	0.00%
Theravada Buddhist	4	0.00%
Cyber Culture Religions	3	0.00%
Hasidic Jew	3	0.00%
Ukrainian Catholic	3	0.00%
Universal Life Church	3	0.00%

Attendances by Ethnicity

Ethnicity	Total	Percentage of Total
African	4592	1.45%
Any other Asian background	3604	1.14%
Any other Black background	697	0.22%
Any other ethnic group	4935	1.56%
Any other mixed background	1277	0.40%
Any other White background	5129	1.62%
Bangladeshi	481	0.15%
British	186274	58.99%
Caribbean	507	0.16%
Chinese	435	0.14%
Indian	12236	3.87%
Irish	1208	0.38%
Not stated	77408	24.51%
Pakistani	14839	4.70%
White and Asian	840	0.27%
White and Black African	619	0.20%
White and Black Caribbean	716	0.23%

DID NOT ATTEND :

Bolton NHS Foundation Trust
2024-41851 - Patient Equality Monitoring Data 2023/24
Period: 01/04/2023 - 31/03/2024

Acute/Community Outpatients DNA's

The following data has been derived from appointments that fall under the Adult Acute Care Division and Integrated Community Services Division within Outpatients
Please note: Disabilities data only includes patients who have 'Learning Disabilities' recorded.

DNA's

Service	Total	Percentage of Total
Acute Outpatients DNA	13955	49.18%
Community Outpatients DNA	14422	50.82%
Total	28377	

Attendances by Religion

Religion	Acute Outpatients DNA's	Acute %	Community Outpatients DNA's	Community %
Not Specified	5355	38.37%	3948	27.37%
Church of England	3599	25.79%	4174	28.94%
Roman Catholic	1345	9.64%	1515	10.50%
Muslim	1302	9.33%	1856	12.87%
Religion not given - PATIENT ref	778	5.58%	929	6.44%
Not Religious	424	3.04%	559	3.88%
Christian	418	3.00%	524	3.63%
Atheist	160	1.15%	198	1.37%
Hindu	152	1.09%	185	1.28%
Methodist	124	0.89%	150	1.04%
Patient Religion Unknown	106	0.76%	75	0.52%
Anglican	53	0.38%	65	0.45%
Jehovah's Witness	22	0.16%	29	0.20%
Agnostic	17	0.12%	29	0.20%
Ismaili Muslim	14	0.10%	53	0.37%
Church of Scotland	8	0.06%	10	0.07%
Pagan	8	0.06%	9	0.06%
Sikh	8	0.06%	7	0.05%
Spiritualist	8	0.06%	4	0.03%
Catholic: Not Roman Catholic	5	0.04%	16	0.11%
Reformed Presbyterian	5	0.04%	3	0.02%
Seventh Day Adventist	5	0.04%	2	0.01%
Baptist	4	0.03%	3	0.02%
Mormon	4	0.03%	13	0.09%
Orthodox Christian	4	0.03%		0.00%
Unitarian-Universalist	4	0.03%	5	0.03%
Christian Existentialist	3	0.02%	3	0.02%
Church of Ireland	3	0.02%	1	0.01%
Radha Soami	3	0.02%		0.00%
Divination	2	0.01%	4	0.03%
Pentecostalist	2	0.01%	5	0.03%
Christadelphian	1	0.01%	2	0.01%
Christian Spiritualist	1	0.01%	1	0.01%
Cyber Culture Religions	1	0.01%		0.00%
Humanist	1	0.01%		0.00%
Independent Methodist	1	0.01%		0.00%
Jewish	1	0.01%	3	0.02%
Lutheran	1	0.01%		0.00%
Plymouth Brethren	1	0.01%	1	0.01%
Reformed Protestant	1	0.01%		0.00%
Theravada Buddhist	1	0.01%		0.00%
Buddhist		0.00%	2	0.01%
Celtic Christian		0.00%	1	0.01%
Confucianist		0.00%	1	0.01%
Evangelical Christian		0.00%	1	0.01%
Greek Orthodox		0.00%	2	0.01%
Haredi Jew		0.00%	3	0.02%
Hasidic Jew		0.00%	1	0.01%
Mahayana Buddhist		0.00%	1	0.01%
Native American Religion		0.00%	2	0.01%
Protestant		0.00%	3	0.02%
Quaker		0.00%	3	0.02%
Rastafari		0.00%	1	0.01%
Religion (Other Not Listed)		0.00%	12	0.08%
Romanian Orthodox		0.00%	5	0.03%
Salvation Army Member		0.00%	1	0.01%
Wiccan		0.00%	1	0.01%
Zen Buddhist		0.00%	1	0.01%

Attendances by Age Group

10 Year Age Bands	Acute Outpatients DNA's	Acute %	Community Outpatients DNA's	Community %
00-09	210	1.50%	810	5.62%
10-19	600	4.30%	1147	7.95%
20-29	2386	17.10%	1637	11.35%
30-39	2372	17.00%	2108	14.62%
40-49	1458	10.45%	2079	14.42%
50-59	1974	14.15%	2408	16.70%
60-69	1958	14.03%	1754	12.16%
70-79	1671	11.97%	1338	9.28%
80-89	1096	7.85%	942	6.53%
90+	230	1.65%	199	1.38%

Attendances by Gender

Gender	Acute Outpatients DNA's	Acute %	Community Outpatients DNA's	Community %
Female	6751	48.38%	7427	51.50%
Male	7204	51.62%	6992	48.48%
Not Known		0.00%	3	0.02%
Not Specified		0.00%		0.00%

Attendances by Ethnicity

Ethnicity	Acute Outpatients DNA's	Acute %	Community Outpatients DNA's	Community %
African	275	1.97%	266	1.84%
Any other Asian background	145	1.04%	272	1.89%
Any other Black background	38	0.27%	42	0.29%
Any other ethnic group	229	1.64%	234	1.62%
Any other mixed background	35	0.25%	50	0.35%
Any other White background	136	0.97%	217	1.50%
Bangladeshi	31	0.22%	23	0.16%
British	7027	50.35%	8526	59.12%
Caribbean	24	0.17%	38	0.26%
Chinese	16	0.11%	11	0.08%
Indian	622	4.46%	793	5.50%
Irish	66	0.47%	50	0.35%
Not stated	4498	32.23%	2828	19.61%
Pakistani	731	5.24%	941	6.52%
White and Asian	39	0.28%	48	0.33%
White and Black African	20	0.14%	35	0.24%
White and Black Caribbean	23	0.16%	48	0.33%

DNA's with Learning Diability

Alert	Acute Outpatients DNA's	Acute %	Community Outpatients DNA's	Community %
Learning Disabilities	27	**17.09%**	131	**82.91%**

Appendix 2: Workforce Profile Data Tables

Overall Profile

Age Band	Total	%
<=20 Years	31	0.5%
21-25	433	7.0%
26-30	763	12.3%
31-35	816	13.2%
36-40	800	12.9%
41-45	732	11.8%
46-50	680	11.0%
51-55	755	12.2%
56-60	692	11.2%
61-65	394	6.4%
66+	98	1.6%
Grand Total	6194	100.0%

Religious Belief	Total	%
Atheism	715	11.5%
Buddhism	14	0.2%
Christianity	3085	49.8%
Hinduism	119	1.9%
Islam	464	7.5%
Jainism	3	0.0%
Judaism	18	0.3%
Other	387	6.2%
Sikhism	4	0.1%
IDNWTD	1385	22.4%
Grand Total	6194	100.0%

Band	Total	%
< Band 1	2	0.0%
Band 1	0	0.0%
Band 2	1003	16.2%
Band 3	708	11.4%
Band 4	494	8.0%
Band 5	1416	22.9%
Band 6	1125	18.2%
Band 7	612	9.9%
Band 8a	239	3.9%
Band 8b	80	1.3%
Band 8c	22	0.4%
Band 8d	11	0.2%
Band 9	17	0.3%
Medical	450	7.3%
YSM	6	0.1%
Other	9	0.1%
Grand Total	6194	100.0%

BME	Total	%
BAME	1276	20.6%
White	4663	75.3%
Not Stated	255	4.1%
Grand Total	6194	100.0%

Maternity	Total	%
All other Assignme	6029	97.3%
Maternity & Adopti	165	2.7%

	Total	%
<=20 Years	30	0.5%
21-25	435	7.0%
26-30	759	12.3%
31-35	772	12.5%
36-40	788	12.7%
41-45	688	11.1%
46-50	714	11.5%
51-55	768	12.4%
56-60	670	10.8%
61-65	378	6.1%
66+	87	1.4%
Grand Total	6089	98.3%

Assignment Categor	Total	%
Fixed Term Temp	272	4%
Permanent	5922	96%
Grand Total	6194	100%

Religious Belief	Total	%
All Other Religions	1724	27.8%
IDNWTD	1385	22.4%
Christianity	3085	49.8%
Grand Total	6194	100.0%

Gender	Total	%
Female	5256	84.9%
Male	938	15.1%

SO	Total	%
Heterosexual	4764	76.9%
LGB	139	2.2%
Other	7	0.1%
Undecided	5	0.1%
Not diclosed	1279	20.6%
Grand Total	6194	100%

Disability	Total	%
Yes	299	4.8%
No	4728	76.3%
Not Declared	1167	18.8%
Grand Total	6194	100.0%

TUNROVER AND LEAVERS

Sexual Orientation	Leavers Headcount	Headcount	LTR Headcount %
LGB	21	139	15.11%
IDNWTD	149	1,279	11.65%
Heterosexual or Straight	689	4,764	14.46%
Other SO not listed	1	7	14.29%
Undecided	1	5	20.00%

Disabled	Leavers Headcount	Headcount	LTR Headcount %
No	638	4,728	13.49%
Not Declared	177	1,167	15.17%
Yes	46	299	15.38%

Religious Belief	Leavers Headcount	Headcount	LTR Headcount %
All Other Religions	274	1,724	15.89%
Christianity	402	3,085	13.03%
IDNWTD	185	1,385	13.36%

Ethnic Origin	Leavers Headcount	Headcount	LTR Headcount %
BME	174	1,276	13.64%
Not Stated	33	255	12.94%
White	654	4,663	14.03%

Gender	Leavers Headcount	Headcount	LTR Headcount %
Female	709	5,256	13.49%
Male	152	938	16.20%

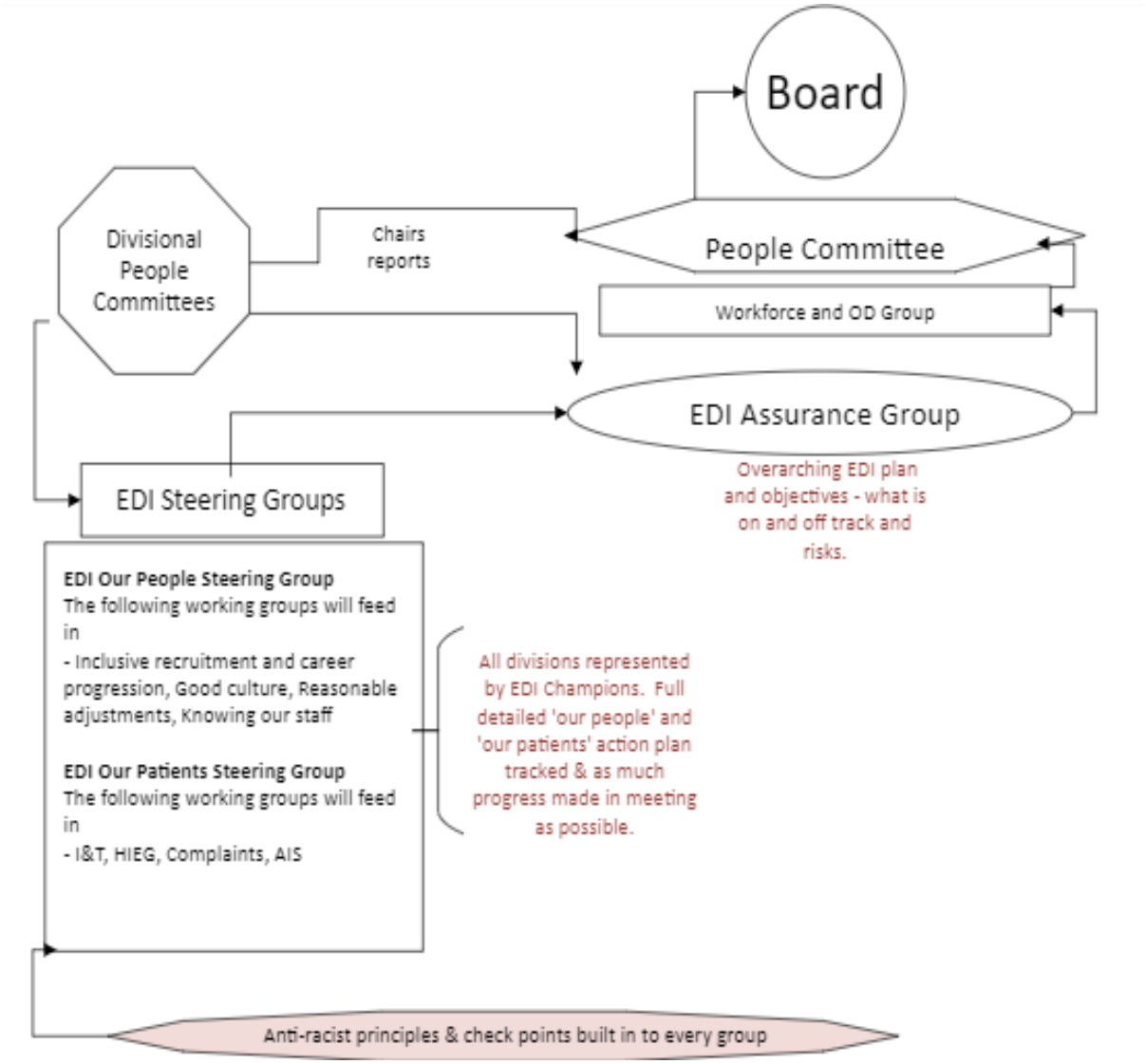
Appendix 3: Interpretation & Translation Data

A full list of languages and the total number of face to face and telephone interpretation appointments provided by our external provider are listed in the table below. 7,618 requests were fulfilled.

Albanian	29
Amharic	22
Arabic	511
Arabic (Kue)	15
Arabic (Moroccan/Tunisian/Algerian/Libyan)	7
Bengali	46
Bosnian	5
Braille	2
BSL (British Sign Language)	275
Bulgarian	13
Burmese	17
Cantonese	142
Croatian	
Czech	119
Dari	21
Dinka	1
Dzongkha	1
Dutch	0
Farsi (Persian)	207
Flemish	1
French	53
Fula (Fulani, Pulaar, Peulh, Fulfulde)	1
German	
Greek	6
Guarani	4
Gujarati	886
Hindi	20
Hungarian	502
Italian	23
Kurdish / Kurdish Sorani	221
Kurdish Badini	12
Kurdish Gorani	3
Kurdish Kurmanji	0
Latvian (Lettish)	3
Lingala	3
Lipspeaker	2
Lithuanian	30

Malayalam	
Mandarin	85
Mandinka (Mande)	1
Mirpuri (Pahari, Potwari)	3
Mongolian	3
Nauru	1
Nepali	4
Nuer	3
Oromo (Afan)	76
Pahari	
Pashtu	118
Polish	254
Portuguese	151
Portuguese (Angolan)	4
Punjabi	238
Romanian	88
Romanian (Moldova)	9
Russian	48
Sign Support English	6
Sinhalese	6
Slovak	139
Slovak-Roma	3
Slovenian	1
Somali	418
Spanish	67
Sudanese Arabic	1
Swahili	75
Sylheti	6
Tamil	9
Thai	2
Tigrinya	38
Turkish	39
Twi	
Ukrainian	30
Urdu	1880
Various	585
Vietnamese	11
Yoruba	10
Zulu	1
Toishanese	4

Appendix 4: Revised EDI Governance Structure from 2024



Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

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

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Finance and Investment Committee held in September and October.

Executive Summary	The Chairs' reports attached provide an overview of matters discussed at the meetings held on the 25 September and 23 October 2024. The reports also set 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 November meeting, a verbal update will be provided to the Board with a written report presented to the subsequent Board meeting.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Finance and Investment Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Rebecca Ganz, Finance and Investment Committee Chair	**Presented by:**	Annette Walker, Chief Finance Officer

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

Name of Committee /Group:	Finance and Investment Committee	**Reports to:**	Board of Directors
Date of Meeting:	25 September 2024	**Date of next meeting:**	23 October 2024
Chair	Rebecca Ganz	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Contract Award
- Da Vinci Robot Business Case
- RAAC Business Case
- UEC Business Case
- Trust Revenue Support Application for Q3
- Cost Improvement Programme 2024/25
- GM/National System Update
- Month 5 Finance Report
- NCC Submission Final Report
- Integra Centros Project Update

ALERT

Agenda items	Action Required
Trust Revenue Support Application for Quarter 3 The Committee received an update on the current cash position and the possibility of needing to apply for cash support. The Committee recommended that the Board be prepared to make a submission for revenue support if required in Q3 with a more likely expectation of a submission in Q4. The Committee recommended that the Board further consider the wider question of how to bring the core business of BFT into financial balance in the context of the Revenue Support.	

ADVISE

The Committee received four papers/business cases as follows:

Contract Award - it was noted that a full business case will be brought through the Committee in 2025 setting out the full range of options to ensure the Board is fully sighted on the proposed changes.

Da Vinci Robot Business Case - the Committee agreed that there is a compelling clinical case for this but expressed concern as to how this would be funded sustainably and noted that it would drive an additional CIP need of circa £800k p.a. The Committee also suggested the paper included the short, medium and long term impact of not purchasing the robot, which are not currently highlighted in the business case. The Committee recommended this business case to Board for approval which is then subject to ICB approval.

RAAC Business Case - the Committee recommended this business case to Board for approval, which has received support from the ICB.

UEC Business Case - the Committee approved this business case of this PDC funded investment in improving the 4-hour performance.

Cost Improvement Programme 2024/25

As of 12 September, £24.3m of CIP has been identified in year which is on target (£20.2m of this has been risk rated). £26.5m of recurrent CIP has been identified which is slightly above target.

The Committee received an update on the WTE triangulation. Currently 40 posts have been removed of 87 in the plan and we are £1.1m behind plan on the pay CIP. A total of 238 posts have been identified as potential CIP (risk rated 126 posts). The Committee discussed that this would generate CIP of £13.2m in year (risk rated £10.5m) if all of these posts were removed and that work is being done to harmonise pay rates as another approach to address the CIP gap.

GM/National System Update

- There is significant focus on delivering the required £175m deficit.
- Concern about the cash position as a number of measures being taken in GM are non-recurrent.
- There is an expectation that in 2025/26 GM will have a deficit of no more than half of this year's position with a break even position required in 2026/2027.
- Capital remains an issue.

Month 5 Finance Report

- At month 5, the Trust has a deficit of £6.7m compared with a plan deficit of £7.3m.
- The most likely forecast outturn is currently to achieve plan, assuming £4.9m of mitigations are fully delivered.
- CIP of £9m has been delivered compared to a plan of £7.2m.
- Capital spend for month 5 year to date is £1.7m owned, £0.7m leased. The agreed Capital allocation for 2024/25 is £7.2m, however could be subject to change at any point during the year. IFRS 16 plan for 2024/25 is £6.7m.
- Closing cash position of £8.3m, which is an increase of £1.0m from Month 4 with a plan of £6.4m.
- The Trust cash position will become challenging in late Q3 of 2024/25. This has been flagged as a key concern during planning discussions with the ICB.
- BPPC is 97.9% in month.

ASSURE

NCC Submission Final Report - the submission was completed on time.

Integra Centros Project Update - the project is ramping up significantly with a go live date of 01 April 2025 agreed for Bolton.

New Risks identified at the meeting:

No new risks identified.

Review of the Risk Register:

There were no risks reviewed.

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**23rd of October 2024**	**Date of next meeting:**	**27th November 2024**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Annual Report for the Finance & Investment Committee
- Cost Improvement Programme Update
- Month 6 Finance Report
- GM/National System Update
- PWC report
- Procurement Update

ALERT

The Trust cash position is expected to become challenging in late Q4 of 2024/25. This has been flagged as a key concern during planning discussions with the ICB.

ADVISE

Cost Improvement Programme Update

- Total CIP identified in year is £24.7m.
- Total recurrent identified in year is £21.6m which is a reduction by £4.8m.
- A risk rated position is calculated to reflect this which equates to £21m in year and £15.5m recurrent, a reduction of £1.6m
- The reductions are identified in the report and are due to several large schemes being removed or transferred to non-recurrent though since the figures were reported the figures have since improved.
- Notwithstanding the change in the recurrent position, there was an increase in CIP in Month 6 of 870K versus month 5.

Month 6 Finance Report

- The Trust has a revised deficit plan for the year of £0.6m. This includes confirmed receipt of £9.7m of deficit support funding to support the GM system to break even in 24/25.
- At month 6, the Trust has a deficit of £3m compared with a plan deficit of £3.5m.
- Most likely forecast outturn is currently an adverse variance to plan of £3.7m, before the impact of unfunded in year pay awards, which could worsen the position by up to £3.7m.
- CIP of £11.2m has been delivered compared to a plan of £9m.
- Capital spend for month 6 year to date is £2.4m owned, £0.7m leased.
- We had a closing cash position of £3.2m, which is a decrease of £5.2m from Month 5; against a plan of £3.8m.
- The intention is to deliver the plan but not to mitigate the variance of the pay award which could be an additional pressure ranging from £1.11m to £3.7m.

GM/National System Update

- The National deficit is currently £2.39b and GM's element of that is £132.5m, 25.2m worse than plan.
- NHSE are concerned about the delivery of plan.
- It is a possibility NHSE are holding back Capital monies which does pose a risk to the Trust as we await large MOUs for RAAC and UEC.
- NHSE have advised not to plan for extra winter funds.
- All providers are facing pay award pressures.

ASSURE

Annual Report for the Finance & Investment Committee

The Committee received and approved the Annual Report for the Finance & Investment Committee and Workplan. It was agreed some adjustments need to be made to the membership for clarity.

Price Waterhouse Cooper (PWC) Report

PWC conducted a rapid review in August 2024 of the 10 Greater Manchester Integrated Care Systems (GM ICS). The review focused on 5 targeted areas and was deemed less intensive than the previous review. The Committee noted the level of progress made since the report was issued and the consequent assurance received and congratulated the team on their efforts.

Procurement Update

The Procurement Department have achieved ratified procurement savings of £3.6m against a forecast of £4m year to date achieved through collaborative working with the Divisions, NHSESC and GM Procurement. Funding for the transformation of Inventory management and roll out of scan4safety has been secured from NHSE/NHS Supply Chain. The new Procurement act will launch in February 2025 transforming procurement processes with fundamental change to current methods of supplier engagement, tendering and transparency including greater flexibility for SMEs to supply the NHS including local companies to further support the Bolton £.

New Risks identified at the meeting:

None identified.

Review of the Risk Register: NA

Report Title:	Standing Financial Instructions and Scheme of Delegation			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Annette Walker		Decision	✓

Purpose of the report	The purpose of this report is to present the Standing Financial Instructions and Scheme of Delegation for approval following review by the F&I Committee.

Previously considered by:	To be discussed at Finance and Investment Committee.

Executive Summary	The Standing Financial Instructions are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. The Financial Scheme of Delegation sets out the powers and financial levels of authority or the Board, its Committees and the Executive. The SFI and Financial Scheme of Delegation combine to form part of the Standing Orders of the organisation and are reviewed periodically. It should be noted that minor changes may continue to be made following the publication of committee papers.

Proposed Resolution	The Board of Directors are asked to **approve** the Standing Financial Instructions and Scheme of Delegation noting the recommendation from F&I Committee.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Catherine Hulme ADOF-Financial Services	**Presented by:**	Annette Walker Chief Finance Officer

Review of Standing Financial Instructions and Scheme of Delegation

The Standing Financial Instructions (SFI's) and Financial Scheme of Delegation form part of the Standing Orders of the Trust and are reviewed periodically. The last review was November 2022.

The Charity is covered by the Trust Standing Financial Instructions but has a separate Financial Scheme of Delegation approved by the Charity Committee.

Summary of Changes from the Previous Version

Financial Scheme of Delegation
• Change of job title of the Director of Finance to Chief Finance Officer • Formal power and approvals for the Commercial Director of Finance to be in line with the Operational Director of Finance • Change of name of Audit Committee to Audit and Risk Committee. • Change of name of Finance Committee to Finance and Investment Committee. • Clarification for Board approval for Measured Term Contractors above £2m. • Other minor wording changes.
Standing Financial Instructions
• Change of job title of the Director of Finance to Chief Finance Officer. • Change of name of Audit Committee to Audit and risk Committee. • Updated the narrative in paragraph 2.1.1 to include Code of Governance for NHS Provider Trusts. • Updated the narrative in paragraph 2.1.3 to include HFMA. • Updated the narrative in paragraph 2.4.6 to remove NHS Protect and include NHS Counter Fraud Authority. • Deletion of narrative in paragraph 2.4.11 - "In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS Security Management." In paragraph 2.4.11, • Inclusion of narrative in paragraph 2.4.12 - "Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management." • Deletion of narrative in paragraph 2.4.12 – "The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Executive Director with lead responsibility for Security Management and a Local Security Management Specialist (LSMS)."

- Deletion of narrative in paragraph 2.4.13 – "The LSMS shall regularly report progress to each meeting of the Health and Safety Committee and upwards to the Trust Executive Committee at least quarterly."
- Replaced "CCG's" with "ICB's" in paragraph 6.1.1.
- Inclusion of narrative in paragraph 7.4.1 – "All invitations to tender will be compliant with the Procurement Law and Regulations as well as following the Trust procurement policies and procedures which ensure a full audit trail is maintained.
- Amendment of paragraph 7.4.3 – "Contracts should be awarded on the "Most Advantageous Tender" basis incorporating qualitative, social value and cost aspects.
- Amendment of paragraph 7.4.5 – "All tenders should be treated as confidential and managed via the tendering portal to ensure auditable records and retention for inspection."
- Inclusion of narrative in paragraph 17.3.3 – "The Register of interest is available on a dedicated Trust Declarations website and will be available to the public on request.
- Other minor wording changes.

Above is a summary of the changes to the SFI's at the time of writing the paper. Changes to Procurement are still to be fed into the paper and delegated authority to be requested for the Chief Finance Officer to make changes as required.

Standing Financial Instructions are for reference purposes. It is not expected or reasonable for every member of staff to know the details intricately. A list of Key SFIs has been drawn up with a corresponding description in simple language. It is reasonable that all staff should know these.

Key SFIs

SFI	Description
1.2.4	If you become aware of a breach of SFIs, then seek advice from the Chief Finance Officer.
3.2.4	Do not use one off money to fund ongoing expenditure.
5.1.2	Do not open a bank account in the name of Trust, only the Chief Finance Officer can open bank accounts in the name of the Trust.
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts.
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed.
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Chief Finance Officer.
6.5.1	You must seek permission from the Chief Finance Officer to set up charitable giving platforms in the name of the Trust.
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables.
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.

9.6.1	Use official orders for non pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Chief Finance Officer has given approval.
9.7.5	Do not split order values to circumvent financial thresholds.
11.1.8	Do not incur capital expenditure without the necessary approval.
11.3.5	Any theft must be reported to the Chief Finance Officer.
13.2.1	Suspected fraud, bribery or corruption must be reported to line management, Local Counter Fraud lead or the Chief Finance Officer.
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct.
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.4	Do not accept personal gifts of cash or vouchers.

Enhanced Controls

In addition to the SFI's and the Scheme of Delegation enhanced controls may be in place. Below are the enhanced controls currently in place:

- All non pay expenditure above £10k requires authorising by and executive director.
- All recruitment is required to be approved by the pay panel.
- All room hire and catering expenditure requires approval by either the Chief Finance Officer or the Chief People Officer.

Recommendation

The Committee is asked to:

- approve the Chief Finance Officer to amend for changes to be made for procurement.
- review the revised Standing Financial Instructions and the Scheme of Delegation and recommend approval to the Board.

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

CFA	Counter Fraud authority
HFMA	Healthcare Financial Management Association
ICB	Integrated Care Board
SFI	Standing Financial Instructions

Bolton
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

November 202~~2~~4

CONTENTS

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1.1 Use and Application

1.1.2 These Standing Financial Instructions are issued by the Board of Bolton NHS Foundation Trust (the Trust). They will have effect as if incorporated in the Standing Orders.

1.1.3 These Standing Financial Instructions detail the financial regulations adopted by the Trust. They are designed to ensure that financial matters are carried out in accordance with the law and relevant Government policy in order to achieve probity, accuracy, and value for money. The Standing Financial Instructions should be used in conjunction with the Financial Scheme of Delegation which sets out powers and financial limits of the Board, its Committees and the Executive.

1.1.4 These Standing Financial Instructions apply to all employees, agency, locum or temporary staff working for the Trust. They also apply to wholly owned subsidiaries, hosted functions and organisations and the Trust Charity unless separate arrangements have been agreed by the Board. Standing Financial Instructions do not provide detailed advice or policies and should therefore be used in conjunction with financial procedure notes.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the ~~Director of Finance~~Chief Finance Officer must be sought.

1.1.6 Wherever the title Chief Executive or ~~Director of Finance~~Chief Finance Officer is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them.

1.2 Failure to Comply

1.2.1 Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter.

1.2.2 Deliberate failure to comply with Standing Financial Instructions could constitute fraud or theft and result in criminal action being taken.

1.2.3 If for any reason these Standing Financial Instructions are not complied with, full details should be reported to the ~~Director of Finance~~Chief Finance Officer who will advise on the appropriate course of action. This will include deciding whether to report to the Audit and Risk Committee and/or the Board if the breach is significant.

1.2.4 All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the ~~Director of Finance~~Chief Finance Officer as soon as possible.

1.3 The Role of the Board

1.3.1 The Board exercises financial supervision and control by:-

(a) approving the financial strategy;

(b) approving of budgets within overall income;

(c) approving important financial policies and systems;

(d) approving the Financial Scheme of Delegation; and

(e) receiving regular assurance on financial strategy and performance.

1.4 The Role of the Chief Executive

1.4.1 The Chief Executive may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.4.2 By law, the Chief Executive of an NHS Foundation Trust is the Accounting Officer. The responsibilities of the Accounting Officer are contained in guidance issued by the Regulator and include the requirement to ensure that:-

(a) there is a high standard of financial management in the NHS Foundation Trust as a whole;

(b) there is efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation; and

(c) financial considerations are fully taken into account in decisions by the NHS Foundation Trust.

1.4.3 It is a duty of the Chief Executive to ensure that the Board and all employees understand their responsibilities within these Standing Financial Instructions.

1.5 The Role of the ~~Director of Finance~~Chief Finance Officer

1.5.1 The ~~Director of Finance~~Chief Finance Officer will carry out duties and responsibilities where delegated by the Chief Executive under these Standing Financial Instructions.

1.5.2 The ~~Director of Finance~~Chief Finance Officer may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.5.3 The ~~Director of Finance~~Chief Finance Officer is accountable for:-

(a) design and implementation of financial policies;

(b) maintaining an effective system of internal financial control;

(c) ensuring that sufficient financial records are maintained;

(d) the provision of strategic financial advice to the Board and employees; and

(f) the preparation and maintenance of accounts, certificates, estimates, records and reports as required.

1.6 The Role of the Board and Employees

1.6.1 The Board and employees must act in the interests of the Trust by:-

(a) avoiding loss of property and valuables;

(b) exercising economy and efficiency in the use of resources; and

(c) conforming with the requirements of these Standing Financial Instructions and the Financial Scheme of Delegation.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with the Code of Governance for NHS Provider Trusts ~~NHS Foundation Trust Code of Governance~~, the Board will formally establish an Audit and Risk Committee of non-executive directors.

2.1.2 The Board will satisfy itself that at least one member of the Audit and Risk Committee has recent and relevant financial experience.

2.1.3 The Audit and Risk Committee will have clearly defined terms of reference and follow guidance from the HFMA NHS Audit Committee Handbook.

2.1.4 The Audit and Risk Committee will meet a minimum of four times a year.

2.2 Internal Audit

2.2.1 The Audit and Risk Committee will ensure that there is an effective internal audit function established by management that meets mandatory audit standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board.

2.2.2 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(a) an independent and objective opinion to the Accountable Officer, the Board and the Audit and Risk Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives; and

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.2.3 The Head of Internal Audit will provide to the Audit and Risk Committee:-

(a) a risk-based plan of internal audit work, agreed with management and approved by the Audit and Risk Committee;

(b) regular updates on the progress against plan;

(c) reports of management's progress on the implementation of actions agreed as a result of internal audit findings;

(d) an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This opinion is used by the Board to inform the Annual Governance Statement; and

(e) additional reports as requested by the Audit and Risk Committee.

2.2.4 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.2.5 The Head of Internal Audit will be accountable to the ~~Director of Finance~~Chief Finance Officer.

2.2.6 The ~~Director of Finance~~Chief Finance Officer is responsible for ensuring that:-

(a) there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit and Risk Committee and the accountable officer;

(c) an annual Internal Audit report is prepared for the consideration of the Audit and Risk Committee;

(d) an annual Internal Audit Plan is produced for consideration by the Audit and Risk Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year; and

(e) ensuring that a medium-term Internal Audit Plan (usually three years) is prepared for the consideration of the Audit and Risk Committee and the Board.

2.3 External Audit

2.3.1 The Audit and Risk Committee will review the findings of the external auditor and consider the implications and management responses.

2.3.2 In accordance with the relevant legal requirements the governors of the Trust appoint the External Auditor. The Council of Governors should take the lead in agreeing with the Audit and Risk Committee the criteria for appointing, re-appointing and removing external auditors. The Council of Governors will need to ensure they have the skills and knowledge to choose the right External Auditor and monitor their performance. However, they should be supported in this task by the Audit and Risk Committee, which provides information to the governors on the External Auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

2.3.3 The Audit and Risk Committee should make recommendations to the council of Governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

2.3.4 The Trust and the Council of Governors must ensure compliance with requirements of the relevant Acts as to who may be an auditor for an NHS Foundation Trust.

2.3.5 While the Council of Governors may be supported by the Audit and Risk Committee in running the process to appoint the external auditor, the Council of Governors must have ultimate oversight of the appointment process.

2.3.6 In appointing and monitoring the External Auditor, the Council of Governors should ensure that the audit firm and audit engagement leader have an established and demonstrable standing within the healthcare sector and are able to show a high level of experience and expertise.

2.3.7 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practice.

2.4 Counter Fraud, Corruption and Bribery ~~and Security Management~~

2.4.1 The Audit and Risk Committee will satisfy itself that the organisation has adequate arrangements in place for countering fraud. NHS organisations must have appropriate counter fraud arrangements.

2.4.2 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

2.4.3 The ~~Director of Finance~~Chief Finance Officer will monitor and ensure compliance with the conditions of the NHS Contract Fraud Standards.

2.4.4 The ~~Director of Finance~~Chief Finance Officer is responsible for deciding at what stage to involve the police in cases of theft, fraud, misappropriation and any other irregularities.

2.4.5 The ~~Director of Finance~~Chief Finance Officer will appoint a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud, Corruption and Bribery Manual and guidance.

2.4.6 The Local Counter Fraud Specialist will report to the ~~Director of Finance~~Chief Finance Officer and will work with staff in ~~NHS Protect~~NHS Counter Fraud Authority (NHS CFA) in accordance with the NHS Fraud, Corruption and Bribery Manual.

2.4.7 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit and Risk Committee. A Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.4.8 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

2.4.9 The Act:-

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

2.4.10 The Trust will produce an annual statement to satisfy the compliance requirements of the Bribery Act.

Security management

2.4.11 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management.

2.4.12 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

~~2.4.11 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS Security Management.~~

~~2.4.12 The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Executive Director with lead responsibility for Security Management and a Local Security Management Specialist (LSMS).~~

~~2.4.13 The LSMS shall regularly report progress to each meeting of the Health and Safety Committee and upwards to the Trust Executive Committee at least quarterly.~~

2.5 Financial Reporting

2.5.1 The Audit and Risk Committee will assure the integrity of the annual financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.6 Scrutiny of Waivers and Registers

2.6.1 The Audit and Risk Committee will be responsible for:-

(a) scrutinising waivers approved by chief Executive and/or ~~Director of Finance~~Chief Finance Officer and approving waivers above £1m;

(b) scrutinising regular reports on losses and compensations; and

(c) scrutinising the registers of interests.

2.7 Raising Concerns

2.7.1 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, non-compliance with Standing Financial Instructions, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Risk Committee should raise the matter at a full meeting of the Board.

2.7.2 The Audit and Risk Committee should review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit and Risk Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action.

2.8 Access to Records and Information

2.8.1 The ~~Director of Finance~~Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:-

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust; and

(d) explanations concerning any matter under investigation.

3. FINANCIAL PLANNING AND MANAGEMENT

3.1 Annual Financial Plans

3.1.1 Prior to the start of the financial year the ~~Director of Finance~~Chief Finance Officer will prepare and submit an annual financial plan for approval by the Board. The financial plan will:-

(a) reflect the Trust's annual plan in terms of developments, workforce, performance etc.;

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the context of available income;

(d) identify potential financial risks;

(e) include a cash flow forecast;

(f) identify an opening capital plan; and

(g) include details of the required level of cost improvement.

3.1.2 The financial plan will be submitted to the Regulator in the required format.

3.1.3 The ~~Director of Finance~~Chief Finance Officer will monitor financial performance against the plan and report to the Finance Committee and/or Board and the Regulator.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The ~~Director of Finance~~Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Delegation to Budget Holders

3.2.1 Budgets will be delegated in accordance with the Financial Scheme of Delegation.

3.2.2 Budget holders must ensure that plans are in place to prevent expenditure budgets from being exceeded.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the control of the ~~Director of Finance~~Chief Finance Officer unless virement is agreed.

3.2.4 Non-recurrent budgets should not be used to finance recurrent expenditure without the authority in writing of the ~~Director of Finance~~Chief Finance Officer.

3.3 Budgetary Control and Reporting

3.3.1 The ~~Director of Finance~~Chief Finance Officer will devise and maintain systems of budgetary control.
These will include:-

(a) monthly financial reports to the Board and/or Finance Committee;

(b) timely and accurate financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from the budget or plan;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers;

(f) determination of budget control totals prior to the start of the financial year; and

(g) a requirement for a monthly report from Divisional Directors to provide an account of their financial performance and forecast outturn.

3.3.2 Budget Holders are responsible for ensuring that:-

(a) any overspending or reduction of income which cannot be met by an approved virement is not incurred;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised;

(c) no permanent employees are appointed without the approval of the ~~Director of Finance~~Chief Finance Officer other than those provided for within the available resources and manpower establishment as approved by the Board; and

(d) they take responsibility for the delivery of savings targets in accordance with the requirements of the annual plan.

3.4 Capital Planning

3.4.1 The Board will approve the capital plan as part of the overall financial plan prior to the start of the financial year.

3.4.2 The Board may delegate decision making to the Finance Committee and the Capital Revenue & Investment Group (CRIG) in line with the Financial Scheme of Delegation.

3.4.3 The ~~Director of Finance~~Chief Finance Officer will provide monthly reports to the Finance Committee monitoring progress against the capital plan.

4. ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Trust must prepare annual accounts in accordance with the requirements of the Regulator. The ~~Director of Finance~~Chief Finance Officer will make arrangements to:-

(a) prepare and submit annual accounts in accordance with the Regulator's requirements, accounting policies and generally accepted accounting practice;

(b) prepare and submit annual accounts to the Board and an audited summary to an annual members meeting convened by the Council of Governors; and

(c) lay a copy of the annual accounts before Parliament.

4.1.2 The annual report should include an Annual Governance Statement in accordance with the relevant requirements.

4.1.3 The annual accounts must be audited by the external auditor and be presented at the annual members' meeting.

4.1.4 The Trust will prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's requirements.

5. BANK AND GBS ACCOUNTS

5.1 Operation of Accounts

5.1.1 The ~~Director of Finance~~Chief Finance Officer is responsible for:-

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) ensuring separate bank accounts for charitable funds;

(c) ensuring accounts are not overdrawn except where arrangements have been made; and

(d) making arrangements for overdrafts if required.

5.1.2 All accounts will be held in the name of the Trust. No officer other than the ~~Director of Finance~~Chief Finance Officer will open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.2 Banking Procedures

5.2.1 Monies belonging to the Trust or its Charity must only be deposited in bank accounts authorised by the ~~Director of Finance~~Chief Finance Officer. All bank accounts must be in the name of the Trust or its Charity.

5.2.2 The ~~Director of Finance~~Chief Finance Officer will ensure that detailed procedures are in place for the operation of bank and GBS accounts.

5.2.3 The ~~Director of Finance~~Chief Finance Officer will advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3 Tendering and Review

5.3.1 The ~~Director of Finance~~Chief Finance Officer will ensure that banking arrangements are reviewed at regular intervals to ensure they reflect best practice and represent best value for money. This will be through local or national competitive tendering exercises.

6. CONTRACTING AND INCOME

6.1 Contracting for Income

6.1.1 The ~~Director of Finance~~Chief Finance Officer is responsible for negotiating, approving and signing contracts with ~~CCGs~~ ICB's and other NHS bodies.

6.1.2 The Trust will contract its services in line with either national tariff arrangements or local price agreements.

6.1.3 The ~~Director of Finance~~Chief Finance Officer will ensure that the appropriate contractual arrangements and documentation are in place for all services provided.

6.1.4 The ~~Director of Finance~~Chief Finance Officer will ensure that reports are produced detailing contract performance and income levels.

6.1.5 The ~~Director of Finance~~Chief Finance Officer will ensure the production of reports to show the profitability of services compared to income generated.

6.2 Income

6.2.1 The ~~Director of Finance~~Chief Finance Officer is responsible for designing and maintaining systems for recording, invoicing, collection and coding of income due.

6.2.2 Private patient and overseas visitors paying for their treatment, are required as far as possible, to make a pre-payment equal to the estimated cost of treatment prior to admission.

6.3 Fees and Charges

6.3.1 The ~~Director of Finance~~Chief Finance Officer is responsible for approving and regularly reviewing the level of fees and charges.

6.3.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is received, the Trust's policy on Standards of Business Conduct and Conflict of Interest must be followed.

6.3.3 All employees must inform the ~~Director of Finance~~Chief Finance Officer promptly of money due from agreements, including provision of services, leases, private patient undertakings and other transactions.

6.4 Debt Recovery

6.4.1 The ~~Director of Finance~~Chief Finance Officer is responsible for ensuring arrangements are in place to recover outstanding debt.

6.4.2 Where income is written off, this should be dealt with in accordance with losses procedures and reported to the Audit and Risk Committee.

6.4.3 All overpayments (including salary) should be recovered wherever possible.

6.5 Security of Cash, Cheques, Payable Orders

6.5.1 The ~~Director of Finance~~Chief Finance Officer is responsible for:-

(a) approving all means of officially acknowledging or recording cash, cheques and payable orders received;

(b) controlling stationery used for receipting funds;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash;

(d) authorisation and provision of safes or lockable cash boxes;

(e) ensuring that policies are in place for the operation of safes including key holding;

(f) systems and procedures for handling cash, postal orders and cheques; and

(g) authorising the use of charitable giving platforms such as Just Giving, Amazon Wish Lists etc and ensuring that there is appropriate oversight and monitoring.

6.5.2 Trust cash will not be used to cash private cheques or "I Owe You's" (IOUs).

6.5.3 All cheques, postal orders, cash etc., will be banked promptly and intact. This means that disbursements (payments) will not be made from cash received prior to banking.

6.5.4 The holders of safe keys will not accept unofficial funds or items for depositing in their safes.

6.5.5 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy & Response Plan& Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures. will comply with the requirements of the law and relevant national guidance and European law as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7. TENDERING PROCEDURES

7.1 Compliance

7.1.1 Trust will comply with the requirements of the law and relevant national guidance and contract regulations as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7.2 Formal Tendering

7.2.1 The Trust will ensure that a minimum of three competitive tenders are invited for:-

(a) the supply of goods, materials and manufactured articles;

(b) the receipt of services;

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) health care services supplied by non NHS providers.

7.3 Exceptions Where Formal Tendering Need Not Be Applied

7.3.1 Formal tendering procedures need not be applied:-

(a) where total estimated annual expenditure with a supplier is expected to be below £15k, at least one written quote is needed;

(b) where total estimated annual expenditure with a supplier is not expected to exceed £50k but is above £15k, a minimum of three written or electronic quotations must be obtained; or

(c) where a competitive process or direct award (where permissible) has been undertaken through a public sector framework agreement co-ordinated by the procurement team.

7.3.2 Formal tendering procedures **may be waived** in the following circumstances:-

(a) in very exceptional circumstances formal tendering procedures would not be practical;

(b) where the timescale genuinely precludes a competitive process; or

(c) where specialist goods/services are required and available from only one source.

7.3.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

7.3.4 All waivers with supporting reasons should be fully documented and approved by the ~~Director of Finance~~Chief Finance Officer or the Chief Executive and reviewed by the Audit and Risk Committee at each meeting.

7.3.5 Where contract expenditure subsequently breaches a tender threshold, advice from the procurement team will need to be sought and the matter reported to the Audit and Risk Committee.

7.4 Tendering Procedures

7.4.1 All invitations to tender will be compliant with the Procurement Law and Regulations as well as following the Trust procurement policies and procedures which ensure a full audit trail is maintained.

7.4.2 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Clarifications may be made regarding qualitative aspects of the tender prior to the award of a contract providing there is a full audit trail of communications and information relevant to all bidders and shared.

7.4.3 Contracts should be awarded ~~based~~ on the "Most Advantageous Tender" basis incorporating qualitative, social value and cost aspects ~~achieving the best value for money, from both quality and cost perspectives~~.

7.4.4 Contracts should not be awarded if they exceed the budget allocated.

7.4.5 All tenders should be treated as confidential and ~~should be retained for inspection~~ managed via the tendering portal to ensure auditable records and retention for inspection.

7.4.6 The ~~Director of Finance~~Chief Finance Officer will ensure that a register of tenders is maintained.

7.5 Financial Standing and Technical Competence

7.5.1 The ~~Director of Finance~~Chief Finance Officer will ensure that procurement processes include the necessary checks on the financial standing, technical competence, legal and regulatory compliance and suitability of contractors/suppliers.

8. PAY EXPENDITURE

8.1 Remuneration and Nomination Committee

8.1.1 The Board will establish a Remuneration and Nomination Committee, with clearly defined terms of reference, specifying which posts and issues fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will report in writing to the Board the basis for its recommendations. The Board will use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

8.1.3 The Trust will remunerate the Chair and non-executive directors of the Board in accordance with resolutions of the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 Remuneration in terms and conditions of other employees will follow nationally negotiated settlements unless otherwise agreed by the Remuneration Committee.

8.2.3 The funded establishment of any department may not be varied except in accordance with the Financial Scheme of Delegation.

8.3 Staff Appointments

8.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration beyond the limit of their approved budget and funded establishment.

8.4 Payroll

8.4.1 The ~~Director of Finance~~Chief Finance Officer will arrange the provision of a payroll service and will be responsible for:-

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment;

(e) ensuring internal controls and audit review; and

(f) ensuring separation of duties.

8.4.2 Managers have responsibility for:-

(a) completing and submitting time records, termination forms and other notifications in accordance with agreed timetables; and

(b) notifying payroll if an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.

8.5 Contracts of Employment

8.5.1 The Director of People will have responsibility for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) making arrangements to deal with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis as part of the annual financial plan.

9.1.2 Authority to incur spend and enter into expenditure contracts will be set in accordance with the Financial Scheme of Delegation.

9.2 Requisitioning of Goods and Services

9.2.1 The requisitioner should use electronic catalogues for the procurement of goods or services. Where this is not possible the procurement team should be consulted to advise on the appropriate route to market.

9.3 Payment of Invoices

9.3.1 The ~~Director of Finance~~Chief Finance Officer will ensure arrangements are in place for prompt payment of invoices and claims. Payment of invoices will be in accordance with contract terms.

9.4 Expenditure contracts

9.4.1 Advice should be sought from the procurement team before signing expenditure contracts of any value. The 'value' of the contract is over its duration rather than per annum. Authority to sign contracts is set out in the Financial Scheme of Delegation.

9.5 Prepayments

9.5.1 Prepayments will only be permitted where this is normal commercial practice or provides a financial advantage to the Trust and the financial standing of the company has been assessed along with the associated financial risk.

9.5.2 In all cases the budget holder is responsible for ensuring that goods and services due under a prepayment contract are received.

9.6 Official Orders

9.6.1 Official orders must be used for all non pay expenditure and contracts unless there is an agreed exception approved by the procurement team. The Trust operates a no purchase order no pay policy. This means that there is no obligation to pay for supplies delivered or work carried out without a purchase order.

9.7 Budget Holders

9.7.1 Budget holders must adhere to the delegated limits specified in the Financial Scheme of Delegation.

9.7.2 Orders should not be issued to any supplier that has made an offer of gifts, reward or benefit to directors or employees, or has in any other way breached the Bribery Act (2010).

9.7.3 Requisitions/orders must not be placed where there is no budget or insufficient budget, unless authorised by the ~~Director of Finance~~Chief Finance Officer or the Chief Executive.

9.7.4 Verbal orders must only be issued very exceptionally and an official order must be obtained as soon as practically possible.

9.7.5 Orders must not be split to circumvent financial thresholds.

9.7.6 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

9.7.7 Changes to the list of employees and officers authorised to certify invoices will be notified to the ~~Director of Finance~~Chief Finance Officer.

9.7.8 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by ~~Director of Finance~~Chief Finance Officer.

9.7.9 Petty cash records will be maintained in a form as determined by the ~~Director of Finance~~Chief Finance Officer.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1 Borrowing and Public Dividend Capital

10.1.1 All loans and overdrafts must be approved by the Board. Any draw-down against working capital facilities must be authorised by the ~~Director of Finance~~Chief Finance Officer and reported to the Board.

10.1.2 Draw down of Public Dividend Capital should be authorised in accordance with the Financial Scheme of Delegation.

10.1.3 The Trust will pay a dividend on its Public Dividend Capital at a rate determined by the Secretary of State.

10.1.4 The ~~Director of Finance~~Chief Finance Officer will report on loans, overdrafts and Public Dividend Capital to the Finance Committee.

10.1.5 The ~~Director of Finance~~Chief Finance Officer will prepare applications for loans and overdrafts for approval by the Finance Committee in accordance with the Regulator's requirements.

10.2 Investments

10.2.1 The ~~Director of Finance~~Chief Finance Officer will prepare a Treasury Management Policy which sets out the Trust's approach to cash management including investments for approval by the Board.

10.2.2 The Treasury Management Policy will seek to obtain competitive rates of interest with minimal exposure to risk.

10.2.3 Cash balances and investments must only be held by banking institutions approved by the Board as part of the Treasury Management Policy.

10.2.4 The ~~Director of Finance~~Chief Finance Officer is responsible for advising and reporting to the Finance Committee on any Treasury Management activities.

10.2.5 The ~~Director of Finance~~Chief Finance Officer will prepare detailed procedural instructions on the operation of Treasury Management activities.

11. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The ~~Director of Finance~~Chief Finance Officer:-

(a) will ensure that there is an adequate process in place for determining capital expenditure priorities;

(b) is responsible for ensuring that monitoring arrangements are in place for capital schemes and that budgets are adhered to;

(c) will put arrangements in place to manage the capital programme within the overall budget available; and

(d) will ensure that the capital investment is not undertaken without the necessary capital financing and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For all capital expenditure the ~~Director of Finance~~Chief Finance Officer will ensure that that a business case has been produced and approved in accordance with the Financial Scheme of Delegation.

11.1.3 The ~~Director of Finance~~Chief Finance Officer will assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.4 The approval of a capital plan will not constitute approval for expenditure on any scheme unless:

(a) the funding has been confirmed in the annual capital budget for the year;

(b) the cost of the scheme remains within the sum allocated whilst still delivering the benefits identified in the business case; and

(c) the supporting Business Case has been approved.

11.1.5 Where the forecast of costs of any scheme rises above the sum allocated in the capital budget, the ~~Director of Finance~~Chief Finance Officer must immediately be notified and an updated business case prepared for the Capital, Revenue and Investment Group approval.

11.1.6 Contractual commitments should not be entered into unless the scheme is approved.

11.1.7 Business cases requiring Board approval under the Financial Scheme of Delegation will be considered and scrutinised by the Finance Committee.

11.1.8 All business cases will be considered by the Capital, Revenue and Investment Group irrespective of the value and either approved or recommended for approval by the Finance Committee or Board according to the Financial Scheme of Delegation.

11.1.9 The ~~Director of Finance~~Chief Finance Officer will approve procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Capital Asset Registers

11.2.1 The Chief Executive is responsible for the maintenance of registers of capital assets, taking account of the advice of the ~~Director of Finance~~Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Chief Executive is also responsible for the maintenance of a register identifying land and/or buildings owned or leased by the Trust.

11.2.3 Capital assets must not be sold, scrapped, or otherwise disposed of without prior approval of the ~~Director of Finance~~Chief Finance Officer. Their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The ~~Director of Finance~~Chief Finance Officer will approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.5 Capital assets will be valued and depreciated in accordance with current accounting and reporting standards.

11.3 Security of Capital Assets

11.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.3.2 Capital asset control procedures must be approved by the ~~Director of Finance~~Chief Finance Officer.
This procedure will make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical location of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded; and

(f) identification and reporting of all costs associated with the retention of an asset.

11.3.3 All discrepancies revealed by verification of physical assets to fixed asset register will be notified to the ~~Director of Finance~~Chief Finance Officer.

11.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and employees in all disciplines to apply appropriate routine security practices in relation to NHS property. Any breach of security practices must be reported in accordance with agreed procedures.

11.3.5 Any theft, loss or damage to premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the ~~Director of Finance~~Chief Finance Officer.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Assets must not be used for private purposes unless agreed in advance by the ~~Director of Finance~~Chief Finance Officer.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores should be:

(a) kept to a minimum;

(b) subjected to annual stock take or a program of rolling stock takes and

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 The day-to-day responsibility for stock control is delegated to departmental employees and stores managers/keepers. The control of Pharmaceutical stocks is the responsibility of the Chief Pharmacist.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations will be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The ~~Director of Finance~~ Chief Finance Officer will ensure systems are in place to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 The ~~Director of Finance~~Chief Finance Officer will ensure there are adequate checks on items in stores at least once a year.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 The ~~Director of Finance~~Chief Finance Officer will identify those authorised to requisition and accept goods from the store. The authorised person will check receipt against the delivery note and notify any discrepancies to Procurement who will pursue correction of delivery or a credit note.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 Land and buildings may not be sold or otherwise disposed of without the approval of the Board.

13.1.2 The ~~Director of Finance~~Chief Finance Officer must ensure procedures are in place for the disposal of assets.

13.1.3 When it is proposed to dispose of a Trust asset, the Head of Department or Divisional Director of Operations will liaise with Procurement and advise the ~~Director of Finance~~ Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 The method of all asset disposals will be recorded and confirmed by a countersignature authorised by the ~~Director of Finance~~Chief Finance Officer.

13.2 Losses and Special Payments

13.2.1 Any employee discovering a suspected fraud should report the matter to their line manager, Local NHS Counter Fraud Specialist or ~~Director of Finance~~Chief Finance Officer in accordance with the Fraud, Corruption and Bribery Policy.

13.2.2 Any employee discovering or suspecting any other loss or theft must immediately inform their head of department, security team and the ~~Director of Finance~~Chief Finance Officer.

13.2.3 Special payments e.g. payments not under legal obligation (or ex gratia) may only be made in line with the Financial Scheme of Delegation.

13.2.4 The ~~Director of Finance~~Chief Finance Officer will be authorised to take any necessary steps to safeguard against the impact of bankruptcies and company liquidations.

13.2.5 For any loss, the ~~Director of Finance~~Chief Finance Officer should consider whether any insurance claim can be made.

13.2.6 The ~~Director of Finance~~Chief Finance Officer will maintain a Losses and Special Payments
Register.

13.2.7 All losses and special payments must be reported to the Audit and Risk Committee on a regular basis.

14. INFORMATION TECHNOLOGY

14.1.1 The Trust must comply with relevant legal and regulatory requirements in relation to IT and information.

14.1.2 The Trust will nominate one of the Executive Directors to act as the Senior Information Risk Officer (SIRO) to ensure controls over data entry, processing, storage, transmission and output to achieve security, privacy, accuracy, completeness, and timeliness.

14.1.3 The Senior Information Risk Officer (SIRO) will ensure that risks arising from the use of IT are identified and mitigated. This will include the preparation and testing of disaster recovery plans.

14.1.4 The ~~Director of Finance~~Chief Finance Officer will ensure that financial systems are implemented, developed and maintained to achieve accuracy and timeliness of data.

14.1.5 The Trust will publish and maintain a Freedom of Information (FOI) Publication Scheme.

14.1.6 The Trust IT strategy will be approved by the Board.

15. PATIENTS' PROPERTY

15.1.1 The Trust has a duty to provide safe keeping of money and other personal property belonging to patients.

15.1.2 The Trust will not accept responsibility or liability for patients' property unless it is handed in for safe keeping and a copy of an official patients' property record is obtained as a receipt.

15.1.3 The ~~Director of Finance~~Chief Finance Officer will ensure that procedures are in operation for the collection, recording, safekeeping and disposal of patients' property.

15.1.4 Where property of a deceased patient exceeds £5,000, the production of Probate or Letters of Administration will be required before release. Where the total value of the property is less than £5,000, this will be released to the next of kin provided forms of indemnity are obtained.

16. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

16.1 Corporate Trustee Arrangements

16.1.1 The Board is the Corporate Trustee of the Trust Charity which is responsible for the management of funds held on trust.

16.1.2 The Board's discharge of Corporate Trustee responsibilities is distinct from its responsibilities for exchequer funds. There must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

16.1.3 The Corporate Trustee may delegate functions as it determines to a Charitable Funds Committee subject to approved written terms of reference. The Board must receive and adopt the annual accounts of the Charity.

16.1.4 The Corporate Trustee will authorise the Chief Executive to make arrangements for the executive leadership and day to day running of the Charity.

16.1.5 The ~~Director of Finance~~Chief Finance Officer will approve the financial governance arrangements of the Charity.

16.2 Administration of Charitable Funds

16.2.1 The ~~Director of Finance~~Chief Finance Officer will oversee the preparation of the annual accounts and the annual audit.

16.3 Accountability to Charity Commission

16.3.1 The Corporate Trustee responsibilities must be discharged separately from the Board and full recognition given accountability to the Charity Commission for charitable funds.

16.4 Applicability of Standing Financial Instructions to Funds Held on Trust

16.4.1 The Charity will apply these Standing Financial Instructions where relevant. Any breaches will be notified to the ~~Director of Finance~~Chief Finance Officer and reported to the Charity Committee.

17. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT

17.1 Policy

17.1.1 The ~~Director of Finance~~Chief Finance Officer will ensure that all staff are made aware of the Trust policy on Managing Conflicts of Interest Standards of Business Conduct which includes guidance on a range of issues including gifts, outside employment and managing conflicts of interest. This policy will incorporate best practice guidance issued by the Regulator and will take effect as if incorporated into these Standing Financial Instructions.

17.2 Declaration of Interests

17.2.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes. Staff members will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

17.2.2 If a staff member comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any interest, direct or indirect, they must make a declaration.

17.2.3 If a staff member has any doubt about the relevance of an interest, this should be discussed with their line manager or the Director of Corporate Governance.

17.2.4 Staff should be asked to declare interests at the start of meetings and recorded in the minutes.

17.2.5 During the course of a meeting, if a conflict of interest arises, the staff member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

17.3 Register of Interests

17.3.1 The Director of Corporate Governance will ensure that all staff and governors are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

17.3.2 The Director of Corporate Governance will ensure that a Register of Interests is maintained to record formal declarations of interests of staff in accordance with the Trust policy.

17.3.3 The Register of interest is available on a dedicated Trust Declarations website and will be available to the public on request.

17.3.4 The Trust operates a zero tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Local Counter Fraud Specialist and/or the ~~Director of Finance~~Chief Finance Officer.

17.3.5 Gifts of cash and vouchers to staff should always be declined.

18. RETENTION OF RECORDS

18.1.1 The Chief Executive will be responsible for maintaining archives for all paper and digital records required to be retained in accordance with guidelines and the Trust's Record Management Policy.

19. RISK MANAGEMENT AND INSURANCE

19.1 Risk Management

19.1.1 The Chief Executive will ensure that risk management arrangements are in place in accordance with relevant requirements, which must be approved and monitored by the Board.

19.1.2 Risk management arrangements will be reported in the Annual Governance Statement within the Annual Report and Accounts.

19.2 Insurance

19.2.1 The Chief Executive will be responsible for ensuring adequate insurance cover is in place in accordance with risk management policy approved by the Board.

19.2.2 The ~~Director of Finance~~Chief Finance Officer should be notified of any changes to risks or property which require insurance.

19.2.3 The ~~Director of Finance~~Chief Finance Officer will ensure that insurance arrangements are regularly reviewed and provide the necessary assurances to the Finance Committee and / or Board.

19.2.4 The ~~Director of Finance~~Chief Finance Officer will authorise claims to be made and these will be reported to the Finance Committee and / or Board.

19.2.5 The Trust will insure for clinical negligence, employers' and public liability claims through the risk pooling schemes administered by the NHS Resolution.

FINANCIAL SCHEME OF DELEGATION

1. Financial Scheme of Delegation – Reservation of Financial Powers and Limits to Board, Committees and Directors

includes non-recoverable VAT

Trust Board The Board reserves to itself the following powers:-	**Committees** Powers reserved to specific Committees unless delegated:-	**Directors** Powers reserved to specific Directors:-
All financial powers emanate from the Board and are delegated according to this Scheme which is incorporated as part of the Trust's Standing Financial Instructions. This scheme can be amended by the Board as required. Powers Approval of the Standing Financial Instructions and Financial Scheme of Delegation Approval of business cases for capital schemes above **£2m** Approval of business cases for revenue expenditure and income impact above **£2m** per annum Approval of invoices and contract values (total life over the contract) above **£2m** Approval of Measured Term Contractor above £2m Approval of working capital facilities and loans Approval of Annual Financial Plan Approval of Capital Programme and Annual Capital Budget Approval of sale or acquisition of land or buildings Approval of sale or disposal of items on the capital asset register above **£1m** Approval of demolition of buildings Approval of waiver of competition requirements over **£1m** Approval of ex gratia payments above **£100k** Approval of Annual Accounts / Annual Report The Board will authorise the appropriate Executive Director as signatories to execute its decisions e.g. contracts, invoices, requisitions. The Operational Director of Finance transacts items on behalf of the Board in the ledger system.	Audit and Risk Committee Approval of the appointment of Internal Auditor Approval of Internal & External Audit Plans Recommending the External Auditor appointment to the governors Scrutiny of the Annual Accounts / Annual Report Review of waivers of competition Review and scrutiny of losses and ex gratia payment registers Review of SFI breaches Finance and Investment Committee Approval of business cases for capital schemes up to **£2m** Approval of business cases for revenue expenditure or income impact up to **£2m** ~~per annum~~ Approval of invoices and contract values (total life over the contract) up to **£2m** Approval of the appointment of Measured Term Contractors up to £2m Approval of the Treasury Management Policy Approval of ex gratia payments up to **£100k** Approval of waivers of competition requirements above **£250k and up to £1m** The Finance Committee will authorise the ~~Director of Finance~~Chief Finance Officer or other relevant officer as signatory to execute its decisions as appropriate Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** ~~per annum~~ Approval of sale or disposal of equipment on the capital asset register up to **£1m** Approval of requisitions, invoices and contract values (total life over the contract) up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events e.g. alcohol Remuneration Committee Approval of Executive Directors' Pay Awards and other variations to their terms and conditions of employment Approval non-contractual severance payments Approval of Pay and Terms and Conditions of senior managers on local pay arrangements Approval of significant variations to national Terms & Conditions	Chair Approval of Chief Executive travel expenses and study leave Chief Executive/Deputy Chief Executive Approval of travel expenses and study leave of Directors Chief Executive or ~~Director of Finance~~Chief Finance Officer Approval of capital or non-recurrent revenue spend up to **£100k** Approval of requisitions, invoices and contract values (total life over the contract) within approved budget up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events ~~Director of Finance~~Chief Finance Officer Final interpretation of Standing Financial Instructions Authorising the opening/closing of bank accounts Approval of financial procedures and financial signatories Authorisation of the use of charitable giving platforms, wish lists etc. Authorisation of the use of safes Approval of pricing strategies, fees and charges in relation to income Deciding when to involve the police in matters of fraud or theft Approval of financial systems and controls including cash handling Approval of sale or disposal of equipment on the capital asset register up to **£100k of the NBV** Approval of financial governance arrangements of charitable funds Approval of changes to the Financial Scheme of Delegation below **£50k** Approval of PDC draw down signatories Approval of insurance claims Access to records to progress financial investigations Deputy Chief Executive Assumes powers and limits in the absence of the Chief Executive Operational Director of Finance Assumes powers and limits in the absence of the ~~Director of Finance~~Chief Finance Officer Capital Revenue & Investment Group - sub group of Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** ~~per annum~~ Review of all capital business cases and capital expenditure

2. Financial Scheme of Delegation – Authorised Powers and Limits to the Executive including non-recoverable VAT

Executive Directors Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Deputy Director of Operations** **Divisional Directors of Operations** **Operational or Commercial Director of Finance** **Deputy Director of Finance** Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Other Deputy Directors** **General Managers** **Professional Leads** Powers and Approval Limits within Departmental Approved Budget:	**Departmental Managers** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**Matrons** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**"Ward / Unit Managers" or equivalent** Powers and Approval Limits within Ward/Departmental/Unit Approved Budget:	**Non Budget Holding Manager** Powers and Approval Limits within Ward/Department/Unit Approved Budget:
Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets (not including overtime or internal bank hours) and scheduling of annual leave
Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£250k**	Revenue or capital requisitions, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£50k** (Operational and Commercial Directors of Finance **£150k**)	Revenue or capital requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£10k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£2.5k**	Revenue requisitions or invoices up to a limit which will be agreed by DDOs but not exceeding **£1k.**	
Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	Travel Expenses for staff of a lower band.	
Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	
Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	Virement within existing non-pay budget	
Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories		
Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget	Virement within existing pay budget			
Recruitment to posts within pay budget	Recruitment to posts within pay budget	Recruitment to posts within pay budget				
Ex gratia payments up to **£5k**	Ex gratia payments up to **£5k**	Ex-gratia payments up to **£1k**				
Approval of changes to Directorate/Divisional	Approval of changes to Directorate/Divisional Control Total	Chief Pharmacist Drugs expenditure up to **£50k**				

Control Total							

3. Financial Scheme of Delegation – Financial Limits by Type of Approval (£) including non recoverable VAT

Type of Approval	Board	Finance Comm	Execs	CRIG	CEO	~~DoF~~CFO	ED	DDOs	Other Deputy Directors	Dep't managers	Matrons	Ward managers
Approval of business cases for capital schemes	>2m	<2m	<1m	<1m	<100k	<100k						
Approval of business cases for revenue expenditure and income impact per annum	>2m	<2m	<1m	<1m	<100k Non rec	<100k Non rec						
Approval of invoices and contract values (total life over the contract) within approved budget	>2m	<2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of requisitions or orders within approved budget	>2m	>2m	<1m		<1m	<1m	<250k	<50k	<10k	<5k	<2.5k	<1k
Approval of sale or disposal of items on the capital asset register	>1m		<1m			<100k						
Approval of ex gratia payments	>100k	<100k	<50k		<50k	<50k	<50k	<5k	<1k			
Approval of waiver of competition requirements	>1m	<1m	<250k		<250k	<250k						
Changes to Financial Scheme of Delegation	>50k					<50K						

Key SFIs – breaches are reported to the Audit Committee

1.2.4	If you become aware of a breach of SFIs, then seek advice from the ~~Director of Finance~~Chief Finance Officer
3.2.4	Do not use one off monies to fund ongoing expenditure
5.1.2	Do not open a bank account in the name of Trust, only the ~~Director of Finance~~Chief Finance Officer can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the ~~Director of Finance~~Chief Finance Officer
6.5.1	You must seek permission from the ~~Director of Finance~~Chief Finance Officer to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the ~~Director of Finance~~Chief Finance Officer has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the ~~Director of Finance~~Chief Finance Officer
13.2.1	Suspected fraud, bribery or corruption must be reported to line management, Local Counter Fraud lead or the ~~Director of Finance~~Chief Finance Officer
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.4	Do not accept personal gifts of cash or vouchers

Report Title:	Board Standing Orders and Matters Reserved for the Board			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	These documents, together with the Trust's Constitution; the Standing Financial Instructions and the Scheme of Delegation provide a regulatory framework for the business conduct of the Trust.

Previously considered by:	N/A

Executive Summary	The Board Standing Orders are a set of rules and procedures that govern the operations of the Board, including the conduct of Board meetings, decision making processes, and the roles and responsibilities of Board members and committees. The Standing Orders fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. The Standing Orders were last reviewed by the Board of Directors in January 2024. Since then, a review has taken place and any changes to exisiting documents are reflected on the tracked changes. and other than the template being update to reflect the new Trust strategy there are no proposed changes. The Standing Orders will also be scheduled for discussion at the Audit and Risk Committee meeting on 04 December 2024. Any further changes proposed as a result of Audit and Risk Committee debate will be brought back to the Board of Directors for approval.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Board Standing Orders and Matters Reserved for the Board.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
		✓		

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

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

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Bolton NHS Foundation Trust

Board of Directors Standing Orders Nov 2024

... for a better Bolton

STANDING ORDERS

November 2024

FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt a "Schedule of matters reserved" and a "Scheme of Delegation". Which, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

It is acknowledged within these Standing Orders and the Standing Financial Instructions of the Trust that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the Trust Board meets its obligation to perform its functions within the financial resources available.

P*rovisions within the Standing Orders which are not subject to suspension under SO 3.32 are indicated in italics.*

CONTENTS

INTRODUCTION

Statutory Framework

Bolton NHS Foundation Trust (the Trust) is a Public Benefit Corporation which was established which came into existence on 1 October 2008 as Royal Bolton Hospital NHS Foundation Trust pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003. The name of the Trust was changed to Bolton NHS Foundation Trust in 2011.

The principal place of business of the Trust is:

Royal Bolton Hospital, Minerva Road, Bolton, BL4 0JR

The functions of the Trust are conferred by 2006 Act and the Trust will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The constitution requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. This document, together with Standing Financial Instructions (SFIs) and Scheme of Delegation set out the responsibilities of individuals.

Delegation of Powers

All business shall be conducted in the name of the Trust. The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any contrary provisions of the 2006 Act given effect by the Constitution.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Scheme of Reservation and Delegation of Powers'. Those powers which it has delegated to Directors are also contained in the Scheme of Reservation and Delegation of Powers.

1. INTERPRETATION

1.1. Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders

1.2. Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made thereunder or in paragraph 42 of the constitution shall have the same meaning in these Standing Orders and in addition:

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"COMMITTEE" shall mean a committee appointed by the Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

“CONSTITUTION” shall be the Constitution of Bolton NHS Foundation Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution.

Directors for the purpose of SO/SFI and Scheme of Delegation are those board members reporting directly to the Chief Executive.

"DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

The expression “the Chair of the Trust” shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

2. THE BOARD OF DIRECTORS

2.1. All business shall be conducted in the name of the Trust.

2.2. All funds received in Trust shall be in the name of the Trust as corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3. The Trust has the functions conferred on it by the 2006 Act and its terms of authorisation.

2.4. Directors acting on behalf of the Trust as a corporate Trustee are acting as quasi-Trustees. Accountability for charitable funds held on Trust is to the Charity Commission. Accountability for non-charitable funds held on Trust is only to NHS England.

2.5. The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6. **Composition of the Board of Directors -** In accordance with the 2006 Act and the constitution, composition of the Board of Directors of the Trust shall be:

The Chair of the Trust

At least 5 non-executive directors

At least 5 executive directors including:

- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

The number of Executive Directors must not be greater than the number of Non-Executive Directors

2.7. **Appointment of the Chair and Directors** – *The Chair and non-executive directors are appointed in accordance with paragraph 21 of the constitution*

The Chair and Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years and may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

2.8. **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair and directors will be in accordance the constitution.

The Chair and Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to rigorous review and NHS England approval. Such appointments beyond six years shall be subject to annual re-appointment and external competition if recommended by the Board and approved by the Council of Governors.

Any re-appointment after the second term of office (irrespective of tenure duration), for the Chair and Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence.

2.9. **Appointment of Deputy Chair**

Subject to paragraph 22 of the constitution, the Council of Governors, on recommendation of the Trust Chair, may appoint a non-executive director to be Deputy Chair for such a period, not exceeding the remainder of his/her term as non-executive director of the Trust, as they may specify on appointing him/her.

Any non-executive director so appointed may at any time resign from the office of Deputy-Chair by giving notice in writing to the Chair and the Council of Governors may thereupon appoint another Non-Executive Director as Deputy-Chair in accordance with this Standing Order.

2.10. **Appointment of Senior Independent Director**

2.11. The Board of Directors shall, following consultation with the Council of Governors, appoint one of the non-executive directors to be the senior independent director and one of the non-executive directors to be the deputy senior independent director.

In accordance with a process to be agreed between the Chair and Council of Governors, the senior independent director will lead in the process for evaluating the performance of the Chair.

The senior independent director shall lead a meeting of the Non-Executive Directors at least annually without the Chair to evaluate the Chair's performance, as part of the process agreed with the Council of Governors for appraising the Chair.

The expression "senior independent director" shall be deemed to include the deputy senior independent director of the Trust if the senior independent director is absent from the meeting or is otherwise unavailable.

2.12. **Powers of Deputy Chair** - *Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair*

owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

2.13. **Joint Directors**

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly and shall count for the purpose of Standing Order 2.6 as one person.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1. **Admission of the Public and Press** – The public shall be admitted to all formal meetings of the Board, but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

3.2. The Board may treat the need to receive or consider recommendations or advice from sources other than Directors, Committees or Sub-Committees of the Board as a special reason why publicity would be prejudicial to the public interest.

3.3. Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner.

3.4. **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5. *The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented, or if, the Chair does not call a meeting within seven days after such requisition has been presented,* at the Trust's Headquarters*, one third or more directors may forthwith call a meeting.*

3.6. **Notice of Meetings** - *Before each meeting of the Board of Directors, a notice of the meeting, shall be delivered to every director, at least three clear days before the meeting.*

3.7. *In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.*

3.8. Public notice of the time and place of any meeting of the Board (open to the public) will be posted on the Trust's web site at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. Such notice, together with a copy of the agenda, will be supplied, on request to the press.

3.9. **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.10. A director desiring a matter to be included on an agenda should make this request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.11. **Chair of Meeting** - *At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they are present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.*

3.12. If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.13. **Annual Public Meeting** - The Trust will publicise and hold an annual public meeting in accordance with the constitution and the Act.

3.14. **Notices of Motion** - A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.8.

3.15. **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.16. **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director

who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months. However, the Chair may do so if considered appropriate.

3.17. **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.18. When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.19. **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final.

3.20. **Voting** - *Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.*

3.21. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.22. If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.23. If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.24. In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.25. An officer who has been appointed formally by the Board of Directors to act up for an executive director will have the voting rights of that executive director. An officer attending the Board of Directors to represent an executive director

without formal acting up status may not exercise the voting rights of the executive director.

3.26. **Non – Voting Directors**

Non-Voting Directors are ones who Board members have determined should attend the Board in order to provide it with particular expertise on a continuing basis. They may be expected to attend some or all Board meeting whether held in public or private.

They will receive all board papers for agenda items against which their contributions are required. They will have the opportunity to participate in all board discussions but may not take part in any voting and may be excluded from any part of a Board meeting at the request of the Chair.

All matters discussed or witnessed by attendees shall be regarded as confidential to the board save for those where actions are agreed otherwise.

In order that they do not become liable for decisions made, the Chair will make clear that they are being invited to comment upon items for debate but not take part in any vote should one occur

3.27. **Minutes**

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.28. **Joint Directors** - *Where a post of executive director is shared by more than one person:*

a) both persons shall be entitled to attend meetings of the Trust:

b) either of those persons shall be eligible to vote in the case of agreement between them:

c) in the case of disagreement between them no vote should be cast;

d) the presence of either or both of those persons shall count as one person for the purposes of SO 3.36 (Quorum).

3.29. **Suspension of Standing Orders** - Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any

meeting, provided that at least half (normally six) of the Board of Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.30. A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.31. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

3.32. No formal business may be transacted while SOs are suspended.

3.33. The Audit and Risk Committee shall review every decision to suspend SOs

3.34. **Variation and Amendment of Standing Orders** –

These Standing Orders shall not be revoked, varied or amended except upon:

a) A report to the Board by the Chief Executive or the Director of Corporate Governance acting on their behalf.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the Chair) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.35. **Record of Attendance** - *The names of the directors present at the meeting shall be recorded* in the minutes.

3.36. **Quorum** - *No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.*

3.37. An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.38. If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1. The Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by an executive director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2. **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3. **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors

4.4. **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or subcommittee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions to perform personally and shall nominate officers to undertake the remaining functions for which the CEO will still retain an accountability to the Board of Directors.

4.5. The Chief Executive shall prepare a Scheme of Delegation, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance and Commissioning or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

5. COMMITTEES

5.1. **Appointment of Committees** - *The Board of Directors may appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust.*

5.2. *A committee appointed under SO 5.1 may, subject to such directions as may be given by the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee.*

5.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

5.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5. Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

5.6. The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. .

5.7. Not used

5.8. The committees formally established by the Board of Directors are:

- Audit and Risk Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People Committee
- Remuneration and Nomination Committee
- ~~Strategy and Operations Committee~~
- Charitable Funds Committee

5.9. **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10. A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. DECLARATIONS ~~OF INTERESTS~~ AND REGISTER OF INTERESTS

Pursuant to paragraph 28 of the constitution, a register of Director's and Governor's interests must be kept by the Trust

6.1. **Declaration of Interests** - The constitution requires Board Directors (including for the purposes of this document Non-executive Directors) and Governors to declare interests, which are relevant and material. All existing board directors should declare relevant and material interests. Any board directors or governors appointed subsequently should do so on appointment or election.

6.2. All employees of the Trust who have a direct financial interest in a private company of any description which may be engaged in the provision of goods or services to the NHS, must declare that interest in in accordance with the "Managing Conflicts of Interest Policy ~~*Standards of Business Conduct Policy*~~" at the time of appointment or commencement of any such interest**.**

6.3. Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should include in the register are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of authority in a charity or voluntary organisation in the field of health and social care.
e) Any connection with a voluntary or other organisation contracting for NHS services.
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks

6.4. If board directors or governors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Governance.

6.5. Any changes in interests should be declared at the next Board of Directors' meeting following the change. It is the obligation of the director or governor to inform the Director of Corporate Governance in writing within seven days of becoming aware of the existence of a relevant or material interest.

6.6. The names of directors holding directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.7. During the course of a Board of Directors meeting or a governor meeting, if a conflict of interest is established, the director or governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

6.8. **Register of Interests** - The details of directors' and governors' interests recorded in the Register of Interests, that is publically available on the Trust website and will be reviewed on a bi-annually for compliance, by the Audit and Risk Committee.

6.9. In accordance with paragraph 30 of the constitution, the Register will be available for inspection. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1. *Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they will at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

7.2. *Not used*

7.3. *The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration*

7.4. *Any remuneration, compensation or allowances payable to a director by virtue of their position as a director of the Trust shall not be treated as a pecuniary interest for the purpose of this Standing Order.*

7.5. *For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if*

- *a) they or a close associate* of theirs, is a director of a company or other body, not being public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or*
- *b) they or a close associate* of theirs is a business partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;.*

7.6. *A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:*

- *a) of membership of a company or other body, with no beneficial interest in any securities of that company or other body;*
- *b) of an interest in any company, body or person as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.*

7.7. *Where a director:*

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
c) if the share capital is of more than one class and the total nominal value of shares of any one class does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to the duty to disclose an interest.

7.8. *Standing Order 7 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee as it applies to a director of the Trust.*

7.9. *For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:*

- *Married persons and those in Civil partnerships or cohabiting. In which case, the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

8. STANDARDS OF BUSINESS CONDUCT

8.1. **Policy** – The Trust has adopted a Standards of Business Policy and staff must comply with this guidance and guidance in the Bribery Act 2010. The following provisions should be read in conjunction with these documents

8.2. **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner

8.3. An officer must also declare any other employment or business or other relationship of theirs or a close associate as previously defined, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff

8.4. **Canvassing of and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such

appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates

8.5. A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7. **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.8. The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9. Prior to acceptance of an appointment directors should disclose to the Trust whether they are related to any other director or holder of any office within the Trus

8.10. Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply

8.11. Any Board member or member of staff who receives or is offered hospitality in excess of £50.00 must decline that hospitality and is required to enter the details of the hospitality in the Trust's Hospitality Register

8.12. The Board recognise the offences set out in the Bribery Act:

- to give, promise or offer a bribe,
- to request, agree to receive or accept a bribe either in the UK or overseas
- A corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENT

9.1. **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place in accordance with arrangements approved by the Board.

9.2. **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board of Directors, a Board Committee or where the Board of Directors has delegated its power

9.3. On approval by the Board, or by the Chair or the Chief Executive under delegated powers, to a transaction in pursuance of which the Common Seal of the Board is required to be affixed to appropriate documents, shall be deemed also to convey authority for the use of the Common Seal

9.4. Where approval to the sealing of a document has been given specifically in pursuance of a resolution of the Board or in accordance with Standing Order No.9.3 above, the Seal shall be affixed in the presence of the Chair, or other Officer duly authorised and an Executive Director of the Trust, and shall be attested by them

9.5. **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit and Risk Committee at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing)

10. SIGNATURE AND INSPECTION OF DOCUMENT

10.1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2. The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority

10.3. A Director of the Board may for purposes of their duty as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, provided that the Director shall not knowingly inspect ore request a document relating to a matter in which they are professionally interested or in which they have directly or indirectly any pecuniary interest.

10.4. This Standing Order shall not preclude the Chief Executive from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

10.5. Nothing in the above paragraphs of this Standing Order 10 shall be interpreted as giving the right to Directors to have access to confidential patient records

11. MISCELLANEOUS

11.1. **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within the Standing Orders and SFIs.

11.2. **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Report Title:	Strategy and Operations Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	
Executive Sponsor	Chief Operating Officer and Chief of Strategy and Partnerships		Decision	

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

Previously considered by:	The matters included in the Chairs Report were discussed and agreed at the Strategy and Operations Committee meeting held in September.

Executive Summary	The attached report from the Chair of the Strategy and Operations Committee provides an overview of matters discussed at the meeting held on 23 September 2024. The report also sets out the assurances received by the Committee and may identify specific concerns that require the attention of the Board of Directors. Due to the timing of the September meeting of the Strategy and Operations Committee, a verbal update was provided to the Board of Directors and the written report is now provided for the November meeting.

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

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Sean Harriss, Non-Executive Director, Chair of Strategy and Operations Committee	**Presented by:**	Sean Harriss, Non-Executive Director, Chair of Strategy and Operations Committee

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	Strategy and Operations Committee	**Reports to:**	Board of Directors
Date of Meeting:	23 September 2024	**Date of next meeting:**	28 November 2024
Chair	Sean Harriss, Non-Exective Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Winter Plan
- Spotlight: Elective Care: Cancer
- Month 5 Operational IPM
- EPR Update
- Maternity EPR Update
- IG Annual Report
- Performance and Transformation Board Chairs Report
- Digital Performance and Transformation Board Chairs Report
- Bolton Strategy, Planning and Delivery Committee Minutes

ALERT

Agenda items

- **Elective Care** – Progress continues to be made towards achieving zero 65-week waiters by the end of September and to sustain that position. GM have been informed that there we are forecasting there to be 200-300 patients still waiting by the end of September and every single patient is being micro-managed on a daily basis to ensure that their treatment goes ahead. The amount of work carried out over the last six months was acknowledged in light of the challenges faced.
- **Outpatients and Community EPR** - The Chair stated that the Committee had not received assurance at this point due to the difficult decision points outstanding on the timeline. An update on the integration issues with Malinko will be provided to the next meeting.
- **Maternity EPR -** The Committee acknowledged the significant undertaking that the three EPR projects presented in terms of organisational risk and capacity to deliver. The Committee has sought as much assurance as it reasonably can, but fundamentally there are some issues and risks that the Committee cannot be assured of.

ADVISE

- **Bolton Strategy, Planning and Delivery Committee Minutes –** The Committee has the potential to drive forward transformational change within the health and social care system the level of primary care engagement at locality level but SOC noted that it is not currently where it needs to be due to current scrutiny on finances and delivery of performance.

ASSURE

- **Cancer Performance –** Positive improvements to performance noted. Recovery of Cancer 62-day performance forecasted for September 2024. Continuously over-performed against predicted performance since May, and are predicting to do so for August. Good assurance received regarding

achievement of the 62 day target in September. • **Urgent Care Performance –** The Committee acknowledged the improved performance to date in relation to the ECIST support • **Winter Plan -** The Committee recommended the Winter Plan through to the Board of Directors meeting on 26th September for approval. Dedicated discharge lounge opened in August 2024, N3 will become the Winter Ward, pilot for a weekend roaming discharge team commenced. Likely scenario we will need 29 beds, worst scenario 57 beds. • **IG Annual Report** – overseen by the audit and Risk Committee. The Committee acknowledged the comprehensive assurance provided by the IG report, and the external accreditation and the work done by the technical team to ensure data protection and cyber security compliance for the period July 2023 to June 2024
New Risks identified at the meeting: None identified
Review of the Risk Register: None identified

Report Title:	2024 NHS England Core Standards Assurance Staement of Compliance			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 November 2024		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	

Purpose of the report	To ensure the Board of Directors or governing bodies are sighted on the level of compliance against the 2024 NHS England Core Standards.

Previously considered by:	This report has being considered by the EPRR team and signed off by the Chief Operating Officer / Acountable Emergency Officer for EPRR.

Executive Summary	NHS England require all health organisations participating in the 2024 NHS Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period. Following self assessment the trust has demonstrated substantial compliance across the necessary standards with an action plan to take forward within the stated time frames.

Proposed Resolution	The Board of Directors are asked to ***receive*** the 2024 NHS England Core Standards Assurance Staement of Compliance as a matter of public record

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓		✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	Yes	The EPRR Core Standards are an annual compliance requirement of NHS England.
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Jimmy Tunn EPRR Manager	**Presented by:**	Rae Wheatcroft, Chief Operating Officer

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

EPRR	**Emergency Preparedness Resilience and Response**
CBRN	**Chemical Biological Radiological Nuclear**
AEO	**Accountable Emergency Officer (Trust Executive rep for EPRR)**
B.C.	**Business Continuity / management and plans**

Introduction:

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance
2024-2025

STATEMENT OF COMPLIANCE

Bolton NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action Bolton NHS FT will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed

25/11/2024	28/11/2024	_____2025_____
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisation's Annual Report

1. Compliance Dashboard:

Please select type of organisation: Acute Providers

Click button to format the workbook Format Workbook

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	55	7	0

Overall assessment:	Substantially compliant

2. Trust Action Plan:

Core Standard:	Compliance:	Action Required:	Lead:	Timeframe:
Adverse Weather	Partial	Integrated adverse weather plan to be developed and put through trust document control process	EPRR	July 2025
Infectious Diseases	Partial	Hospital Outbreak plan to be further developed.	IPC	July 2025
Countermeasures	Partial	Pharmacy to produce Countermeasures action card in event of instruction to commence countermeasures procedure.	Chief Pharmacist	July 2025
Media Strategy	Partial	Trust communications team to develop / source and deliver a Media training package for senior staff	Communications Team	July 2025
Business Impact Analysis/Assessment (BIA)	Partial	DDOs to complete BIAs for each division	DDOs	July 2025
Business Continuity Plans (BCP)	Partial	To ensure BC plans for each division are up to date and in place	Divisional BC Leads	July 2025
BC Audit	Partial	Need for B.C. plans to be completed and audited.	DDOs	July 2025