NHS Bolton NHS Foundation Trust

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 29 May 2025
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB048/25	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB049/25	**Patient and Staff Story** ***Purpose:*** *To* ***receive*** *the patient and staff story*	*Presentation*		
TB050/25	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB051/25	**Minutes of the previous meeting held on 27 March 2025** ***Purpose:*** *To* ***approve*** *the minutes of the previous meetings*	*Report*	Chair	
TB052/25	**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				
TB053/25	**Chair's Report** ***Purpose:*** *To* ***receive*** *the Chair's Report.*	*Verbal*	*Chair*	**13:20** (10 mins)
TB054/25	**Consent Agenda** ***a. Register of Interests*** ***Purpose:*** *To* ***receive*** *the Register of Interests*	*Report*	*DCG*	**13:30**
TB055/25	**Chief Executive's Report** ***Purpose:*** *To* ***receive*** *the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)

TB056/25	**Annual Governance Declarations** a. Modern Slavery Statement b. Compliance with Fit and Proper Person's Test c. Compliance with NHS Providers Licence Self-Certification d. Code of Governance Compliance ***Purpose:*** *To* ***approve*** *the Annual Governance Declarations.*	*Report*	*DCG*	**13:40** (10 mins)

IMPROVING CARE, TRANSFORMING LIVES

TB057/25	**Integrated Performance Report** ***Purpose:*** *To* ***receive*** *the Integrated Performance Report.*	*Report*	*Exec Directors*	**13:50** (20 mins)
TB058/25	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.*	*Verbal*	*QAC Chair*	**14:10** (05 mins)
TB059/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** ***Purpose:*** *To* ***receive*** *the CNST Maternity Incentive Scheme Report.*	*Report*	*CNO + Director of Midwifery*	**14:15** (05 mins)
TB060/25	**Nursing and Midwifery Staffing Reports** ***Purpose:*** *To* ***approve*** *the Nursing and Midwifery Staffing Reports.*	*Report*	*CNO*	**14:20** (10 mins)
TB061/25	**Learning from Deaths/Mortality Report** ***Purpose:*** *To* ***receive*** *the Learning from Deaths/Mortality Report.*	*Report*	*Medical Director*	**14:30** (10 mins)

A GREAT PLACE TO WORK

TB062/25	**People Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:40** (05 mins)

TB063/25	**Staff Survey Response and Our Voice Programme** ***Purpose:*** *To **receive** the Staff Survey Response and Our Voice Programme Update*	*Report*	*CoP*	**14:45** (10 mins)
TB064/25	**Freedom to Speak Up Annual Report** ***Purpose:*** *To **receive** the Freedom to Speak Up Annual Report.*	*Report*	*CoP*	**14:55** (05 mins)
TB065/25	**Guardian of Safe Working Hours Annual Report** ***Purpose:*** *To **receive** the Guardian of Safe Working Hours Annual Report.*	*Report*	*Medical Director*	**15:00** (05 mins)

COMFORT BREAK (10 mins) — 15:05

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB066/25	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To **receive** assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**15:15** (05 mins)
TB067/25	**Audit and Risk Committee Chair's Report** ***Purpose:*** *To **receive** assurance on work delegated to the committee.*	*Report*	*ARC Chair*	**15:20** (05 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE

TB068/25	**Digital Strategy Update** ***Purpose:*** *To **receive** the Digital Strategy Update.*	*Report*	*CoSP*	**15:25** (10 mins)
TB069/25	**Strategy 2024-29 Update** • Performance against the Annual Plan • Sustainability and Delivery Plan ***Purpose:*** *To **receive** the Strategy 2024-29 Update*	*Report*	*CoSP*	**15:35** (10 mins)

A POSITIVE PARTNER

TB070/25	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:45** (05 mins)

TB071/25	**Feedback from Board Walkabouts** ***Purpose:*** *To* ***receive*** *feedback following walkabouts.*	*Verbal*	*Members*	**15:50** (05 mins)

CONCLUDING BUSINESS

TB072/25	**Messages from the Board** ***Purpose****: To agree messages from the Board to be shared with all staff.*	*Verbal*	*Chair*	**15:55** (02 mins)
TB073/25	**Any Other Business** ***Purpose:*** *To* ***receive*** *any urgent business not included on the agenda*	*Report*	*Chair*	**15:57** (03 mins)

Date and time of next meeting: ***16:00***

- Thursday 31 July 2025 ***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
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
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	
James **Mawrey**	Chief People Officer / Deputy CEO	Nil Declaration	

Name:	Position:	Interest Declared	Type of Interest
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	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
		Lead for GP Strategy and Placements at the University of Bolton	Financial 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 (Leigh)	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of 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**	Chief of Strategy and Partnerships	Trustee George House Trust	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

GUIDANCE NOTES ON DECLARING INTERESTS

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

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

- Any connection with a voluntary or other body contracting for services with NHS services.

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

Types of Interests:

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

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

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

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

Draft Minutes of the Board of Directors Meeting

Held in Boardroom

Thursday 27 March 2025

Subject to the approval of the Board of Directors Meeting on Thursday 29 May 2025

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Andrews	Francis	FA	Medical Director
Crofts	Seth	SC	Non-Executive Director
Ganz	Rebecca	RG	Non-Executive Director
Harriss	Sean	SH	Non-Executive Director
Mawrey	James	JM	Chief of People/Deputy Chief Executive
Noden	Fiona	FN	Chief Executive
North	Martin	MN	Non-Executive Director and Deputy Chair
Roberts	Tyrone	TR	Chief Nursing Officer
Stuttard	Alan	AS	Non-Executive Director
Taylor	Fiona	FLT	Non-Executive Director
Walker	Annette	AW	Chief Finance Officer
Wheatcroft	Rae	RW	Chief Operating Officer
White	Sharon	SW	Chief of Strategy and Partnerships

In Attendance

Bradley	Rebecca	RB	Deputy Chief Nurse (for item 027)
Brockenshaw	Niamh	NB	Associate Divisional Nurse Director, Anaesthetics and Surgical Services Division (for item 027)
Carter	Rachel	RC	Associate Director of Communications and Engagement
Crompton	Victoria	VC	Corporate Governance Manager
Cotton	Janet	JC	Director of Midwifery (for item 35)
Wells	Laura	LW	Associate Divisional Nurse Director, Acute Adult Division ASSD (for item 027)

Apologies

Fairchild	Tosca	TF	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance

There were two observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
TB026/25	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting and apologies for absence were as noted above.	

The Chair informed Board members that Tosca Fairchild had resigned from her role as Non-Executive Director, due to personal reasons. Her term would conclude on 31 March 2025. The Board of Directors expressed their gratitude for her contributions both as a Board member and as Chair of the People Committee.

TB027/25 Patient and Staff Story

The Deputy Chief Nurse shared the experience of Jo, a patient who arrived at the Emergency Department (ED) with abdominal pain. After being assessed by the medical team, Jo was admitted and initially placed on F3 Ward before being transferred to E3 Ward.

During his hospital stay, Jo encountered confusion due to differences in equipment between the ED and the Surgical Assessment Unit. Additionally, there was a lack of clarity regarding his dietary needs, which understandably led to feelings of concern and anxiety during an already difficult time.

Jo's journey underscored the critical importance of clear communication, empathy, and truly listening to patients' experiences and concerns.

Staff Story

In response to the Patient Story, Naimh Brockenshaw advised that the ward team, in collaboration with Matrons and Dietitians, had developed visual aids and patient information leaflets to better communicate dietary options. The initiatives were being overseen by the Trust's Nutritional Steering Committee to ensure consistent implementation.

The Division also prioritised improving communication, encouraging staff to use clear, accessible language. Ward leaders, matrons, and senior nurses engaged directly with patients to better understand their experiences and concerns regarding dietary needs.

Laura Wells reflected on the impact Jo's story had on the team advising that whilst there were positive aspects of Jo's ED journey, key areas for improvement were identified particularly around arrival processes, triage wait times, and the overall patient experience.

ED staff acknowledged that a task-focused approach could sometimes lead to reduced sensitivity to patients' needs in the waiting area. The Reception Manager also recognised that, reception staff were well-trained in the technical aspects of their roles and would benefit from customer care training to help support patients further.

To enhance the waiting room experience, an Electronic Patient Assistance System (ERA) has been implemented, allowing patients to request help with basic needs. Additionally, Health Care Assistants (HCAs) are now assigned to the waiting area to provide support. The ED has also introduced a Senior Nurse Safety Review and Huddle to ensure timely review of patient documentation, risk assessments, and administration of essential medications.

When asked what feedback was most surprising, Laura Wells noted that while the feedback was not unexpected, the emphasis on the need for customer care training for reception staff stood out as a key takeaway.

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

TB028/25 Declaration of Interests Concerning Agenda Items

The Board 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 was 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.

TB029/25 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 30 January 2025, and approved them as a correct and accurate record of proceedings subject to the the amendment on item 010 to show that it was presented by the Chief Operating Officer.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 30 January 2025.

TB030/25 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.

TB031/25 Chair's Update

The Chair commended staff for their efforts, highlighting notable achievements in A&E performance and the successful opening of the Discharge Unit. In terms of finances, the Trust faced a challenging Cost Improvement Programme (CIP), but successfully met its targets without compromising patient care.

The Chair acknowledged the collective efforts of the entire organisation, noting that the Trust performed exceptionally well on several national metrics. While the future presented ongoing challenges, the Trust remained committed to maintaining high-quality care and services for the people of Bolton.

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

TB032/25 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 NHS Staff Survey results for 2024 were published indicating an increase in the response rate to 48%, which meant the results were representative of a broader range of experiences.
- The Trust relaunched the Pennies from Pay scheme that allows colleagues to round up the pennies from their pay and donate to the Charity.
- Our Bolton NHS Charity funded gift packs for patients observing Ramadan with reasonable and flexible adjustments made to help staff.
- As part of National Apprenticeship Week, the Trust highlighted the 150 different apprenticeship courses on offer. During the week the organisation announced it was one of the few NHS trusts in England that would help kick start the careers of the next generation of theatres nurses and practitioners, after launching a brand new theatre support worker apprenticeship.

In response, to a query around the marketing approach to apprenticeships, JM acknowledged that while fully utilising the apprenticeship levy remains a challenge, the organisation has made significant strides in addressing the misconception that apprenticeships are exclusively for individuals aged 16 to 20.

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

TB033/25 Integrated Performance Report

The Chief Operating Officer reported on the Trust's operational performance during February, and highlighted the following key points:

- The waiting list for elective care had reduced to under 40,000 by the end of February, marking the first time this had occurred since May 2023.
- The goal of ensuring no patients waited more than 65 weeks for treatment remained on track, with progress aligned with the set trajectory for March 2025.
- By the end of March, the target was for 77% of cancer patients to be diagnosed within 28 days of referral. The organisation had consistently exceeded this target, ranking as the top performer nationally in December and January.
- Ambulance handover times were within common cause variation. The Integrated Care Board (ICB) had set a target for March, which was achieved.
- The national ambition for overall performance was 78%. Current performance was at 71.6%, representing a 10% improvement from last year. There remained a focus on improvement, with potential additional capital available for those demonstrating significant progress.

The continuous improvement across all areas of operational performance was ongoing, with sincere thanks extended to all staff for their dedication and hard work.

Quality and Safety

The Chief Nurse and Medical Director provided a comprehensive update on quality and safety matters.

The Chief Nurse reported on key areas including pressure ulcers, infection prevention and control, and maternity services. While improvements were noted in some areas, challenges persist in others. Assurance was given that measures were in place to address pressure ulcers and infection control, including the implementation of automated alerts. However, stillbirth rates remain above target, with a disproportionate impact on mothers from deprived and ethnic minority backgrounds.

In response to a recent maternal death, an independent investigation will be conducted by the Maternity and Newborn Safety Investigation Team. An initial internal review has already been completed and shared with the family and key stakeholders.

The Medical Director highlighted strong performance in inpatient clinical correspondence, with Anaesthetics and Surgery achieving over 94%, and Acute Adult over 82%, both indicating special cause variation and positive trends. However, the Family Care Division continued to face challenges in this area, with targeted improvement efforts underway in Gynaecology and Paediatrics.

Financial Performance

The Chief Finance Officer presented the month nine finance update, highlighting the following key points:

- Revenue Forecast – the likely forecast outturn was an adverse variance to plan of £1.6m, which included the impact of 2024/25 pay award pressure. The best-case scenario was currently on plan.
- Cost Improvement Programme – Year-to-date delivery of the Cost Improvement Programme was £23.6m, which was ahead of plan by £3.3m, of which £8.1m had been delivered recurrently.
- Year-to-date Capital spend was £7.9m.

Workforce

The Chief of People presented the workforce update advising that:

- The Trust sickness rate stood at 4.88%.
- For the first time since June 2024, appraisal rates had dipped below the 85% target. Targeted support continues to be directed toward areas with the lowest compliance, and the team is actively promoting the value of meaningful appraisals through the Our Leaders programme.
- Bank usage and associated expenditure remained high, with the year-to-date average monthly spend at £1.8 million. This increase has been influenced by rising demand and a strategic shift away from agency staffing. However, given the current strong vacancy position, spend levels are expected to reduce over time.

JM advised that the recent Integrated Performance Meetings had extremely positive, with senior leaders enthusiastic despite the challenges being faced.

AS queried whether there were any specialities which required additional support with their waiting lists. RW commented that there were some for focus including ENT and Oral Surgery.

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

TB034/25 Quality Assurance Committee Chair's Report

Fiona Taylor presented her Chair's Report from the Quality Assurance Committee meeting held on 26 March 2025; highlighting the following key points:

- Audiology Update – A paper was presented requesting the Audiology department to develop a plan to address existing service gaps and explore innovative approaches to enhance both service delivery and productivity. The Committee agreed on the need for change, and the Chair requested a follow-up paper detailing the quality impacts, particularly those affecting children. The Chief Operating Officer had confirmed that a new service model was currently in development.
- It was noted that Divisions were yet to achieve the 95% target for inpatient and outpatient clinical correspondence. However, inpatient correspondence is showing an upward trend, while outpatient compliance has declined. The Chair requested a further update to be brought forward in May

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

TB035/25 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

The Director of Midwifery reported that the completed CNST Year 6 declaration form was submitted to NHS Resolution on 17 February 2025, and receipt has been formally acknowledged. Monitoring of the associated action plans will continue until the launch of the CNST Year 7 scheme.

Formal notification has been received confirming that the CNST Year 7 scheme documentation and supporting resources will be published on 2 April 2025. NHS Resolution has also advised that Year 6 payments to Trusts are expected to commence from the end of April 2025, following the public release of results.

In response to a query from NR, JC explained that the 10+6 performance metric appears to be influenced by two key factors: the late presentation for booking among some ethnic groups due to cultural beliefs, and operational delays in scheduling initial appointments through the Trust's booking team. The operational process is currently under review. Additionally, the Trust is promoting the "As Soon As You're Pregnant" (ASAP) campaign via social media to raise awareness within local communities.

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

TB036/25 2025/26 Quality Account Improvement Priorities

The Chief Nursing Officer presented the report, informing the Board of Directors of the requirement to select three Quality Account Improvement Priorities for 2025/26. These priorities must clearly align with quality improvement and patient safety objectives. Based on discussions at the Clinical Governance and Quality Committee, the proposed priorities are:

- Recognition and response to the deteriorating patient
- Releasing time to care – Part One: a focus on documentation
- Communication – 'involvement in decision making' as rated by patients and service users

In response to a query from RG regarding whether the communication priority would include family and friends, TR clarified that the initial focus would be on the patient. However, where a patient is unable to communicate, family and friends would be included in the decision making process.

RESOLVED:
The Board of Directors ***received*** the 2025/26 Quality Account Improvement Priorities.

TB037/25 Controlled Drugs Accountable Officers (CDAO) Self-Assessment and Improvement Framework

The Medical Director presented the report, advising NHS England – North West Region requested the completion of the Self-Assessment and Designated Body (DB) Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025. The framework ensured compliance with The Controlled Drugs Regulations 2013 and 2020 and supported Care Quality Commission (CQC) "well-led" and "safe" domains. The self-assessment covered governance, workforce training, reporting, incident investigation, and prescribing oversight.

Key findings indicated that whilst processes were in place for monitoring and reporting controlled drug (CD) concerns, areas for improvement remained, particularly informal information-sharing, prescribing oversight, and board-level reporting. Analysis highlighted three main gaps and made four recommendations:

- Update the CD policy to explicitly include procedures for sharing staff personal information with police, professional regulators, and NHS England CDAOs.
- Invest in CD electronic registers as a way to enhance audit trail relevant when investigating diversion concerns.

- Enhance prescribing oversight, with the development of a BI-generated prescribing report due by the end of Q2 2025/26.
- Strengthen board assurance by implementing an annual CDAO report for Clinical Governance & Quality Assurance Meeting, feeding into Board.

RESOLVED:
The Board of Directors ***received*** the Controlled Drugs Accountable Officers (CDAO) Self-Assessment and Improvement Framework and ***approved*** the recommendations.

TB038/25 People Committee Chair's Report

Alan Stuttard presented his Chair's Report from the People Committee meeting held on 18 March 2025; highlighting the following key points:

- Staffing summary:
  - Total WWTE increased in January 2025 by 87 WWTE.
  - The Trust continued to be under the NHSE agency target of no more than 3.2% of total pay bill (YTD was at 2.1%). Bank spend increased in January when compared to the previous month.
  - Vacancy rates reduced slightly to 5.7% which was still under Trust KPI and would support staffing during winter.
- The Health and Wellbeing update was presented and set the wider context in relation to the intrinsic link to how staff are treated, supported to be their whole self at work and the financial position both locally and more broadly in the NHS.
- IFM Monthly People Update, a Staff Survey was being developed to enable benchmarking with Trust survey results. Temperature checks were being undertaken until the wider survey had been developed.

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

TB039/25 Finance and Investment Committee Chair's Report

Rebecca Ganz presented her Chair's reports from the meetings held on 22 January, and 26 February 2025, and provided a verbal update from the meeting held on 26 March 2025. The following key points were highlighted:

- Operational Plan - initial submission of £13.4m deficit decreased to £6.7m due to additional income and support. Even with a 5.7% CIP target and a headcount reduction of 176, risks remained. Reaching £6.5m impacted waiting lists and weekend work. Analysis had shown that the impact of stopping weekend work would be greater than the impact of Covid with increased waiting lists and worsened 18-week waits.

- GM had requested that the Trust reach a deficit of £6.5m with no compromise on performance.
- The Committee agreed that all three asks were not possible to achieve; control total, performance, assurance statements with the submission plan was to be discussed and agreed at Board of Directors.
- The Trust was on plan with a deficit of £2.7m year to date. The improvement in the position was due to raising a disputed invoice to Bolton Council for the impact of the AFC Pay Award. It was possible the ICB could clawback CDC income of £1.7m which could result in being off plan by £1.6m.
- Pay overspend was driven by a combination of additional expenditure driving the elective income over performance and the variation in type of delivered CIP versus the planned delivery.

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

TB040/25 Audit and Risk Committee Chair's Report

Alan Stuttard presented his Chair' report from the meeting held on 12 February 2025, and the following key points were highlighted:

- Internal Audit Progress Report – the report outlined progress on the remaining 2023/24 audits and the ongoing delivery of the 2024/25 plan. One review was finalised, three were at draft stage, and the rest were in fieldwork or planning. The UEC and Elective Recovery Audit would be deferred to next year, with no impact on the Internal Audit Opinion.
- Escalation of a Deteriorating Patient – a 2023/24 review provided moderate assurance and raised four recommendations. The report was referred to the Quality Assurance Committee to ensure high and medium risk recommendations are addressed and implemented.

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

TB041/25 Charitable Funds Committee Chair's Report

Martin North presented his Chair's Report from the meeting held on 10 March 2025, and the following key points were highlighted:

- Charity Bank Account Transfer – the account had been moved from Royal Bank of Scotland to the Government Banking Service, generating an estimated £28k more in annual interest at a 4.64% rate.
- Highlight report - the Committee received the report for Q3 and Q4, which included activity updates and learning insights across different income streams and wider team functions.
- Finance report – the charity had a net decrease in funds of £123k for the 10 months to 31 January 2025 comprising of income of £165k and expenditure of £288k. The charity's fund balanced total £794k at 31 January 2025.

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

TB042/25 Health and Safety Annual Report 2023/24

The Chief Nursing Officer presented the Health and Safety Annual Report for 2023/24 advising that in 2023/24, the Trust was compliant with all the relevant Health and Safety Legislation. The Trust did not meet the 95% target for Moving and Handling Level 2, and actions were in place to increase divisional compliance. Health Safety and Welfare training compliance had remained consistently above the Trust target.

The total number of incidents reported during the period had increased on the previous year, but the actual harm remained no or low harm in the majority of the incidents with violence and aggression being the top cause. The number of RIDDOR incidents reduced from seven to five in 2023/24.

Two Health and Safety Executives inspections took place in 2023/24 with full satisfaction of the actions taken and processes in place to comply with regulations.

AS commented that he was pleased to see such thoroughness and transparency within the report and queried why clinical negligence clinical negligence were included in non-clinical schemes.

ACTION:
TR to clarify why clinical negligence was included in non-clinical schemes. **TR**

RESOLVED:
The Board of Directors ***received*** the Health and Safety Annual Report 2023/24.

TB043/25 Operational Plan

The Chief of Strategy and Partnerships provided a presentation, advising that in January 2025, the Trust had completed work on a balanced operational plan which

delivered against all headline operational planning targets, delivered a 3% Cost Improvement Plan (CIP), reduced whole time equivalents (WTE) and resulted in a deficit position of £29.7m.

In February, all Greater Manchester (GM) Trusts were issued with a revised control total. Alongside this, the Integrated Care Board (ICB) set a series of conditions which Trusts were required to meet through the planning rounds and which Boards must be assured on. Therefore, the Board of Directors had approved the development of a deficit plan of £13.3m, which would enable delivery of performance standards. Consultation was ongoing with the ICB.

RESOLVED:
The Board of Directors ***received*** the Operational Plan

TB044/25 Questions to the Board

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

TB045/25 Feedback from Board Walkabouts

FLT advised that she had recently visited Cardiology who had just relocated and therefore the patient area was relatively new. There were issues with the disabled doors within the department and the lift which wood frequently break down.

ACTION:
FA would raise the issues with the disabled doors in Cardiology, as feedback received from patients had also highlighted this problem.

SC informed Board members that he had visited G3, where midwifery staffing had been strengthened. Although bed capacity had been reduced due to decanting, staff remained highly proactive. He also visited H1, where space constraints were presenting challenges. Additionally, during his visit to CDS, staff expressed feeling pressured due to the reduction in bed numbers.

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

TB046/25 Messages from the Board

The messages from the Board were agreed:

TB047/25 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 15:30. The next Board of Directors meeting would be held on 29 May 2025 at 1pm in the Boardroom.

Meeting Attendance 2025						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓	✓				
Fiona Noden	✓	✓				
Francis Andrews	✓	✓				
James Mawrey	A	✓				
Tyrone Roberts	✓	✓				
Annette Walker	✓	✓				
Rae Wheatcroft	✓	✓				
Sharon White	✓	✓				
Rebecca Ganz	✓	✓				
Martin North	✓	✓				
Alan Stuttard	✓	✓				
Sean Harriss	✓	✓				
Fiona Taylor	✓	✓				
Seth Crofts	✓	✓				
Tosca Fairchild	✓	A				
Sharon Katema	✓	A				
✓ = In attendance		A = Apologies				

March 2025 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/25/02	27/03/2025	Health and Safety Annual Report	TR to clarify why clinical negligence was included in non-clinical schemes.	TR	May-25	Action complete - TR confirmed that this was an example of learning. Next year will ensure that the claims and learning are related to H&S rather than a selection from all claims.
FT/25/03	27/03/2025	Feedback from walkabouts	FA would raise the issues with the disabled doors in Cardiology, as feedback received from patients had also highlighted this problem.	FA	Jul-25	

Key

complete	agenda item	due	overdue	not due

Report Title:	Register of Interests, Gifts and Hospitality			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	

Purpose of the report	The purpose of the report is to present the Register of Interests, Gifts and Hospitality as assurance of compliance with NHS England updated guidance.

Previously considered by:	Audit and Risk Committee. Reviewed annually as part of assurance processes.

Executive Summary	This report provides an overview of the changes to the NHS Managing Conflicts of Interests Guidance and demonstrates the Trust's compliance with the guidance. Appended to this report are the following registers which evidence compliance and are maintained by the Trust • A register of gifts and hospitality for all staff (Appendix A) • A register of sponsorship for courses/conferences for all staff (Appendix B) • A register of interest for all staff including IFM (Appendix C) • A record of all interests of Board members is included in every Board meeting pack.

Proposed Resolution	The Board of Directors is asked to **receive** the Register of Interests, Gifts and Hospitality as assurance of Trust Compliance with NHS England guidance.

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. In November 2024, NHS England updated the "Managing Conflicts of Interest" guidance initially issued in 2017 to reflect changes introduced by the Health and Care Act 2022. This guidance aims to protect patients, taxpayers, and staff, and covers health services in which there is a direct state interest.

1.2. As a Foundation Trust, the Trust is required to have regard to the FT Code of Governance and the Managing Conflicts of interest guidance through its incorporation into the NHS Standard Contract pursuant to general condition 27. In cases where the wording differs on a particular point, the FT Code of Governance takes precedence.

1.3. The Trust is compliant with this guidance and ensures that there are clear and well communicated processes in place to help staff understand what they need to do.

1.4. The Director of Corporate Governance has responsibility for reviewing:

- current policies and bringing them in line with NHS England guidance
- providing advice, training and support for staff on how interests should be managed
- maintaining register(s) of interests
- auditing policy, process and procedures relating to this guidance at least every 3 years
- Refer potential breaches for investigations by the Local Counter Fraud specialist.

2. Definitions

The Trust has adopted the definitions provided by NHS England as follows:

2.1. **Conflicts of Interests are** defined as
"*a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgment or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold*"

2.2. A conflict of interest may be:

- **Actual –** there is a material conflict between 1 or more interests
- **Potential –** there is the possibility of a material conflict between 1 or more interests in the future

2.3. **Interests** can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. A benefit may arise from the making of a gain or the avoidance of a loss.

2.4. The four types of interest are:

- **Financial interest** – where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

- **Non-financial professional interests** – where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests** – where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests –** These occur when someone closely associated with an individual, such as family, friends, associates, or business partners, has interests that may benefit from the individual's decisions.

3. Summary of Changes

3.1. The changes to the guidance introduced in November 2024 include:

- Ensuring that all staff should declare interests this includes those who are not employees but have a formal role in organisational decision-making, in particular board members.
- As a minimum, organisations should publish the interests of decision-making staff at least annually in a prominent place on their website.
- Clearly articulating where responsibility for managing conflicts of interests rests.
- Identify a team or individual empowered to investigate breaches, involving organisational leads for human resources, fraud, audit as appropriate
- Revising the current definition of Decision Makers from Agenda for Change Band 8c to AFC band 8d.

3.2. The guidance also sets out specific actions for Staff which include the requirement for each member of staff to

- familiarise themselves with the Managing Conflicts of Interest guidance as reflected in the Trust policy,
- using common sense and judgment to consider whether the interests could affect the way taxpayers' money is spent, and
- Regularly considering individual interests and declaring these as they arise.

4. Managing Conflict of Interest Policy

4.1. The Managing Conflict of Interest Policy codifies and introduces consistent principles and rules for managing conflicts of interests at Trust level. The policy was last reviewed in November 2023 to reflect the change to the declaration system.

4.2. *It is proposed that the policy will be amended as follows:*

- *Amending the definition of decision makers as those at Agenda for Change 8C and above to those at Agenda for Change 8D and above. This change reflects the new guidance issued by the Information Commissioner's Office with regard to freedom of information legislation.*
- *Inclusion of Actions for staff and Actions for organisations*

5. Register of Interests

5.1. Collaboration with other organisations in delivering safe, high-quality patient care is a defining characteristic of the work conducted by and with Bolton NHS FT. Such partnerships are beneficial and are aimed at ensuring public funds are utilised efficiently and judiciously. However, the possibility of conflicts of interest emerging is recognised.

5.2. The Trust is aware that failure to manage conflicts of interest (including the perception of such a failure) can lead to **reputational damage** and undermine confidence in the integrity of the decision-making process and give the impression that the organisation or individual has not acted in the public interest. This could also potentially lead to criminal proceedings including for offences such as fraud, bribery and corruption.

5.3. To address this risk, the Managing Conflict of Interest Policy adheres to guidance from NHS England.

5.4. All staff declarations are published on the website as a measure to safeguard against these risks. In exceptional circumstances, an individual's name and/or other information to be redacted from any publically available registers where the public disclosure of information could give risk to a real risk harm or is prohibited by law.

5.5. The Register of interest is available on a public facing web portal that is managed by Civica. This portal also houses the Managing Conflicts of Interest policy as well as some guidance and FAQ to support all staff to make their declarations and enable the public to see what has been declared.

5.6. The Trust Register of interests is published on this link and provides an efficient and easier way to confirm compliance. The register includes the following declarations which are appended to this report:

- A register of interests for all staff, including contractors, agency, volunteers and governors.
- A register of gifts and hospitality for all staff
- A register of sponsorship for courses/conferences for all staff
- A register of any secondary employment for all staff

5.7. A separate but complementary register is held for all Board of Directors and is included in every meeting pack. The Board Register is included in every meeting pack to ensure that all dealings are conducted with the highest standards of integrity.

5.8. Whilst governor's interests are not directly covered by the national policy, a register of Governor's Interests is held in accordance with the Trust's Standing Orders for the Council of Governors.

6. Compliance with Declaration Process

6.1. The Audit and Risk Committee monitors compliance with the Trust's policies on conflicts of interest. This includes ensuring that declarations are made timeously and accurately by all individuals who are required to do so.

6.2. In line with the annual proactive declaration, all decision making staff are required to make a declaration on appointment and as standard practice at the start of each financial year.

6.3. The compliance rate for decision makers for the financial year is 86.7% which is slightly lower than the 2023 rate of 88%. It is worth noting that there has been an increase in number of staff who are classed as decision makers from 352 previously to 414. The Trust has implemented a bi-monthly reminder system for decision makers, with follow-up reminders as necessary.

7. Consequences of not declaring

7.1. Due to change in guidance, there is now a requirement for all staff to make a declaration. The Trust had started to target new employees who are not decision makers to submit their initial declaration. However, there is more work to be done in order to improve our compliance rates in terms of overall staff declaration which is currently 11% as 655 members of staff have made a declaration out of 6,891.

7.2. Plans are in place to ensure that Conflicts of Interests are included as part of the Our Leaders Programme to enable leaders to be able to support their staff with the declaration**.**

8. Conclusion

8.1. The Board of Directors is asked to ***receive*** the Register of Interests', Gifts and Hospitality report, note the progress made and the measures in place to assist with adhering to the regulatory requirements.

Ref	Date Declared	Interest Type	Employee	Date Arose	Year	DM	Role	Display	Interest Description (Abbreviated)	Provider	Approval	Approver
82	22/02/2023	Gifts	Tyrone Roberts	22/02/2023	2022/23	Yes	Chief Nurse	Yes	Free x 10 tickets given to divisions to distribute, to attend an event	Holiday inn Bolton	YES	Fiona Noden
117	02/03/2023	Hospitality	Lianne Robinson	16/11/2022	2022/23	No	Corporate Director of Nursing	Yes	Lunch at NHS providers conference	Newton	YES	Fiona Noden
164	24/04/2023	Gifts	Benjamin Goorney	23/03/2023	2022/23	Yes	Consultant	Yes	Request for life insurance medical update on pt with written consent, payment for admin fee . Forms completed in own time .	Inuvi life Insurance	YES	Emile Morgan
374	20/07/2023	Hospitality	Daniel Hindley	01/04/2023	2023/24	Yes	Consultant Paediatrician	No	Non promotional lecture given on remote platform regarding Angelman Syndrome, a rare genetic condition. This lecture was given on 29/3/22 with payment received shortly afterwards, but this system will not allow me to use that date above.	Proveca Ltd	YES	Gabrielle Lipshen
395	21/08/2023	Gifts	Fiona Noden	18/08/2023	2023/24	Yes	Chief Executive	No	Medical Summer School Gala Dinner, Friday, 18th August x 2 tickets at approximately £50 each.	Albert Halls	YES	Niruban Ratnarajah
463	18/09/2023	Hospitality	Shakti Thakur	16/08/2023	2023/24	Yes	Consultant - Ophthalmology	No	Sponsored attendance at international conference EURETINA, including flights, accommodation, conference fees, some evening meals	Roche	YES	Lisa Sleight
464	18/09/2023	Hospitality	Shakti Thakur	16/08/2023	2023/24	Yes	Consultant - Ophthalmology	No	Dinner for retinal team and opportunity to discuss use of faricimab	Roche	YES	Lisa Sleight
492	09/10/2023	Hospitality	Danielle Posnett	06/10/2023	2023/24	No	Personal Secretary	No	Supplier have donated x5 seats to attend the IHEEM awards with them	Overbury	YES	Fiona McDonnell
497	13/10/2023	Hospitality	Lesley Wallace	10/10/2023	2023/24	Yes	Commercial Director of Finance	Yes	IHEEM Dinner - Overbury had booked a table of 10 to support iFM who were nominated for 2 awards. Invited by Fiona McDonnell to attend the awards on the Overbury table. iFM had also booked a table - approx cost of table £1300	Overbury	YES	Annette Walker
553	04/12/2023	Hospitality	Yasir Abdalla	20/10/2023	2023/24	No	Clinical Specialist GP	Yes	accommodation and registration fees for dermatology educational meeting	almirall	YES	Janet Dutton
584	15/02/2024	Hospitality	Ryan Calderbank	23/10/2023	2023/24	Yes	Divisional Director of Operations	Yes	Invite to the executive summit in Munich with international Siemens customers and other NHS Organisations across the United Kingdom. Inclusive of flights, baggage, hotel transfers, hotel accommodation for two nights, and evening meal.	Siemens Healthineers	YES	Rae Wheatcroft
736	04/04/2024	Hospitality	Benjamin Crooks	21/02/2024	2023/24	Yes	Consultant - Gastroenterology	Yes	Funded place on recent European Crohn's and Colitis Organisation Conference - including flights/hotel/conference fees. This was a conference I was due to attend as part of my annual study leave. Value not known.	Ferring	YES	Lesley Laird
828	30/04/2024	Hospitality	Shakti Thakur	04/04/2024	2024/25	Yes	Consultant - Ophthalmology	Yes	Conference hospitality; travel, accommodation, hotel, evening dinner	Bayer	YES	Lisa Sleight
836	01/05/2024	Gifts	Madeleine Szekely	01/04/2024	2024/25	Yes	Deputy Director of Digital	Yes	Lego Hospital	Imprivata	YES	Brett Walmsley
837	01/05/2024	Hospitality	Madeleine Szekely	01/04/2024	2024/25	Yes	Deputy Director of Digital	Yes	Dinner and Drinks at Rewired conference	Altera Digital Health	YES	Brett Walmsley
2021	01/07/2024	Hospitality	Jacqueline Njoroge	12/06/2024	2024/25	No	Non-Executive Director	No	attended drinks reception at NHSconfed,had orange juice and food	gatenby sanderson	YES	Victoria Crompton
2172	04/10/2024	Hospitality	Sarah Skinner	01/10/2024	2024/25	No	Fundraising Manager	No	Heather Rose from Pink Fizz Social (who I've met through the Ladies Empowerment Circle) has offered a free ticket, understanding the benefit it would offer to the charity's growth and development. Ticket to Social Impact Live including guest speakers (specialising in social media and networking) and refreshments.	Pink Fizz Social	YES	Rachel Noble
2243	05/11/2024	Gifts	Andrew Singleton	18/10/2024	2024/25	No	Assistant Payroll Manager	No	£100 One4all Restaurant gift voucher	A member of staff as a service user	YES	Matthew Greene
2253	13/11/2024	Hospitality	Fiona Noden	09/10/2024	2024/25	Yes	Chief Executive	Yes	Attended dinner hosted by Sir David Dalton at the Racquet Club Hotel & Ziba Restaurant in Liverpool.	Sir David Dalton	YES	Sharon Katema
2254	13/11/2024	Hospitality	Fiona Noden	21/10/2024	2024/25	Yes	Chief Executive	Yes	Attended Siemens Healthineer Executive Summit in Munich Germany on 21st to 23rd October 2024. They paid for flights, travel to and from the airport and accommodation.	Siemens	YES	Sharon Katema
2255	13/11/2024	Hospitality	Fiona Noden	04/11/2024	2024/25	Yes	Chief Executive	Yes	Attended dinner as part of Proud to be Ops Programme at Tattu Manchester, 3 Hardman Square, Gartside St, Manchester M3 3EB, UK	Meet Health Events	YES	Sharon Katema
2256	13/11/2024	Hospitality	Fiona Noden	12/11/2024	2024/25	Yes	Chief Executive	Yes	Attended dinner wit Weightmans at the Bar & Grill, Halifax House, Brunswick St, Liverpool L2 0UU. Invited as part of the NHS Providers Conference	Weightmans	YES	Sharon Katema
2257	14/11/2024	Hospitality	Rae Wheatcroft	04/11/2024	2024/25	Yes	Chief Operating Officer	Yes	Attended a dinner at Tattu in Manchester. I had been invited by the Proud2bOps Network, however, the dinner was sponsored by a private company; Medepher.	Medepher	YES	Fiona Noden
2258	18/11/2024	Hospitality	Fiona Noden	14/11/2024	2024/25	Yes	Chief Executive	Yes	Invited to House of Commons for three course lunch & event. This was funded & organised by 'My Staff App'.	House of Commons	YES	Sharon Katema
2305	20/12/2024	Gifts	Vikki-Lynn Percival	20/12/2024	2024/25	No	Specialist Nurse	No	Patient gave £45 cash to Reception at Churchill Unit stating she had won a raffle & wanted it to go to Dr Song (Clinical Oncologist) team. Nobody got the patient's name	Overwritten for Data Protection	YES	Louise Porritt

Ref	Date Declared	Interest Type	Employee	Date Arose	Year	DM	Role	Display	Interest Description (Abbreviated)	Provider	Approval	Approver
95	22/02/2023	Sponsored Events	Benjamin Goorney	20/04/2022	2022/23	Yes	Consultant	Yes	Registration fee for BHIVA spring conference	GILEAD	YES	Emile Morgan
120	02/03/2023	Sponsored Events	Carolyn Williams	15/12/2022	2022/23	Yes	Consultant Clinical Biochemistry	Yes	Sponsorship for antenatal screening conference hosted and organised by Bolton NHS foundation Trust at Haydock Park racecourse. This is a day event for midwives to attend and national speakers to present at.	Perkinelmer, Randox, GE Healthcare, Illumina, UKNEQAS	YES	Philip Henry
129	07/03/2023	Sponsored Events	Carl Oakden	07/03/2023	2022/23	Yes	Consultant - Anaesthetics	Yes	Teambuilding event in a restaurant. Sponsor providing transport to restaurant. Planned for 23/05/23	Porsche Centre Bolton	YES	Gareth Hughes
138	10/03/2023	Sponsored Events	Benjamin Goorney	11/08/2022	2022/23	Yes	Consultant	Yes	Eve webinar meeting on mental health/sleep disturbance amongst HIV pts-Sheffiield sexual health team	GILEAD	YES	Emile Morgan
139	10/03/2023	Sponsored Events	Benjamin Goorney	07/09/2022	2022/23	Yes	Consultant	Yes	Evening meeting , Presentation to Specialist registrars East Midlands (notts/leicester) on mental heakth sleep dsturbance in HIV pts	GILEAD	YES	Emile Morgan
140	10/03/2023	Sponsored Events	Benjamin Goorney	24/02/2023	2022/23	Yes	Consultant	Yes	North West Sexual Health/HIV trainees meeting,held at Oxford rd campus, MRI hOW TO conduct a study on 4th 90 th including mental health sleep assessment in HIV pts	GILEAD	YES	Emile Morgan
154	21/03/2023	Sponsored Events	Rajesh Kumar Yadavilli	05/09/2022	2022/23	Yes	Consultant - Respiratory	Yes	To attend conference of European Respiratory Congress 2022 virtually.	GlaxoSmithKline(GSK)	YES	Rizwan Ahmed
375	20/07/2023	Sponsored Events	Ambar Basu	20/07/2023	2023/24	Yes	Medical Consultant	No	To attend European Association of Study of Diabetes Annual Conference September 2022 (20-23)	Novo Nordisk	YES	Rebecca Lennon
376	20/07/2023	Sponsored Events	Ambar Basu	20/07/2023	2023/24	Yes	Medical Consultant	No	To deliver educational meeting for GPs in Bolton. Event happened 15/3/2023	Astra Zeneca	YES	Rebecca Lennon
377	20/07/2023	Sponsored Events	Ambar Basu	20/07/2023	2023/24	Yes	Medical Consultant	No	To deliver Educational event for GPs on 14/9/2022	Astra Zeneca	YES	Rebecca Lennon
378	24/07/2023	Sponsored Events	Benjamin Goorney	04/07/2023	2023/24	Yes	Consultant	No	Speaker fee for Virtual eve meeting Blackpool staff Tue 4th July	Gilead	YES	Emile Morgan
379	24/07/2023	Sponsored Events	Katrina Perez	01/04/2023	2023/24	Yes	Consultant	No	registration fee for Virtual Glasgow HIV therapy Conference dates 23-26th October 22 this electronic form would not let me input any date before 1/4/23	ViiV UK	YES	Emile Morgan
380	25/07/2023	Sponsored Events	Benjamin Goorney	25/07/2023	2023/24	Yes	Consultant	No	HIV GLASGOW 2022- REGISTRATION FEE - 24TH -26th OCT 2022	Gilead	YES	Emile Morgan
384	26/07/2023	Sponsored Events	Holly Swinton	26/07/2023	2023/24	No	Clinical Nurse Specialist	No	£75.00 towards the cost of accommodation for the BDNG conference in Harrogate 20-22 September 2022	Dermal Laboratories	YES	Karen Davies-Linihan
385	26/07/2023	Sponsored Events	Holly Swinton	26/07/2023	2023/24	No	Clinical Nurse Specialist	No	Conference fee of 255.00 to attend the BDNG 20-22 Sept 2022	Leo Laboratories	YES	Karen Davies-Linihan
386	26/07/2023	Sponsored Events	Emile Morgan	26/07/2023	2023/24	Yes	Clinical Director HIV Sexual & Repro Health	No	Teaching Session Educating New TS's (Therapeutic Specialists) about HIV disease and its various Treatments.	Gilead	YES	Paul Settle
389	03/08/2023	Sponsored Events	Evangelos Sioras	03/08/2023	2023/24	Yes	Consultant Ophthalmology	No	25-26 November 2022 On behalf of Roche Products Limited, it is our pleasure to welcome you to the first meeting in the 'Oculus in Focus' series. Oculus is an opportunity for members of the Ophthalmology community to attend and participate in plenary presentations, panel discussions, debates and Q&A sessions with the faculty. 2 days retina meeting in London	Roche Products Limited	YES	Jeffrey Kwartz
390	03/08/2023	Sponsored Events	Evangelos Sioras	03/08/2023	2023/24	Yes	Consultant Ophthalmology	No	RETINA MEETING LONDON 26-27 JANUARY 2023	BAYER	YES	Jeffrey Kwartz
391	04/08/2023	Sponsored Events	Krystina Dewhurst	04/08/2023	2023/24	No	Clinical Nursing Lead	No	British Thoracic Society (BTS) winter meeting - 22-25th November 2023. •Registration fees for the BTS 2022 Meeting •Return train travel in economy to London •Return train transfers once in London •Accommodation on a bed and breakfast basis between the 22rd and 25th November	Sanofi Aventis	YES	Dian Huyton
396	23/08/2023	Sponsored Events	Rajesh Kumar Yadavilli	05/04/2023	2023/24	Yes	Consultant Respiratory	No	Asthma educational presentation to Bolton General practitioners sponsored by Cheisi Ltd. Presentation was given on 10/03/2022.	Cheisi Ltd	YES	Rizwan Ahmed
397	29/08/2023	Sponsored Events	Rizwan Ahmed	26/07/2023	2023/24	Yes	Consultant Respiratory	No	Presentation to GPs on COPD management sponsored by AstraZeneca	AstraZeneca	YES	Rauf Munshi
429	05/09/2023	Sponsored Events	Tyrone Roberts	05/09/2023	2023/24	Yes	Chief Nurse	Yes	RCN staff awards - overnight accommodation in liverpool 10.11.23 - system wont allow me to add a future date so adding like this to ensure i dont forget	NHSP	YES	Fiona Noden
434	06/09/2023	Sponsored Events	Kieley Lewthwaite	26/08/2023	2023/24	No	Specialist Nurse	No	Funding for a place at European Society of Cardiology Virtual Conference August 2022. This was to offer an educational opportunity to include updates in heart failure evidence based practice. This was paid directly to the providers of the conference not myself. I was offered a funded place to attend on a Saturday. Please note this was very close to my adoption leave commencing and is the reason this a retrospective declaration.	Astra Zeneca	YES	Karen Keighley
440	11/09/2023	Sponsored Events	Corinna Mendonca	04/07/2023	2023/24	Yes	Consultant Dermatology	No	To attend the British Association of dermatologists annual meeting. This was on 4/7/22.	Dr C Mendonca	YES	Rauf Munshi

504	16/10/2023	Sponsored Research	Dillan Shetty Kadri	06/07/2023	2023/24,202	Yes	Locum Consultant with hours	Yes	To design and develop soft palate retractor for safe deliver to surgery in children undergoing adenoidectomy	Innovation department, AlderHey Childrens hospital Liverpool	YES	Simon Hargreaves
515	19/10/2023	Sponsored Events	Benjamin Goorney	13/07/2023	2023/24	Yes	Consultant	Yes	Chairing and discussion with clinical staff North west london (Virtual eve meeting) "Mental health/sleep disturbance in HIV pts"	Gilead	YES	Emile Morgan
516	19/10/2023	Sponsored Events	Benjamin Goorney	18/10/2023	2023/24	Yes	Consultant	Yes	To chair and lecture to Liverpool drugs/mental health community including sexual health (virtual mtg)	Pharma	YES	Emile Morgan
517	19/10/2023	Sponsored Events	Angela Clough	19/10/2023	2023/24	No	Assistant Divisional Nurse Director	No	The event is for sharing and reviewing best practice related to urinary catheter care to reduce the prevalence of catheter-associated urinary tract infections. This links to the national objective to reduce Gram-negative infections. The sponsorship covers the cost of travel to the US and a return internal flight, accommodation for five nights and meals and sundry expenses	Becton Dickinson	YES	Rebecca Bradley
520	23/10/2023	Sponsored Events	Natasha Denvir	23/10/2023	2023/24	No	Nurse Advanced	No	Epilepsy Nurse Specialist training and workshops. Date attended 4/11/2022 (Would not allow me to enter above as prior to 01.04.23) Please note I did not receive monies for attending. The cost noted was cost of event.	Angellini Pharma	YES	Susan Bannister
523	25/10/2023	Sponsored Events	Nita Patel	01/04/2023	2023/24	No	Qualified Nurse Bank	No	£1720 for sponsored event in 2022.	Novo Nordisk	YES	Sarah Hewinson
529	02/11/2023	Sponsored Events	Ricardo Pardo Garcia	25/09/2023	2023/24	Yes	Consultant - Breast Surgery	Yes	Given a talk at the ORBS, the meeting for Oncoplastic and Reconstructive breast surgeons in Nottingham	Endomag	YES	Claire Loughman
648	02/04/2024	Sponsored Events	Jeremy Jarratt	14/05/2023	2023/24	Yes	Consultant - Orthopaedics	Yes	Knee arthroplasty course	Stryker	YES	Kayleigh Rew
655	02/04/2024	Sponsored Research	Karen Lipscomb	23/10/2023	2023/24	Yes	Consultant - Cardiology	Yes	Observational Study with Cardiac Implanted devices leveraging data to predict unscheduled hospital admission with decompensated heart failure. Data used to contact patients with high alerts to intervene therapeutically Study designed to demonstrate benefit of intervention and determine workforce time involved to plan for future workforce I am the local PI for this GM wide study and the honorarium was payment for an evening PI meeting to plan study, look at data analysis and plan publication	Medtronic	YES	Benjamin Smeeton
735	04/04/2024	Sponsored Events	Benjamin Crooks	29/09/2023	2023/24	Yes	Consultant - Gastroenterology	Yes	Speaker fees for presenting drug data at a meeting for IBD nurses.	Abbvie	YES	Lesley Laird
778	10/04/2024	Sponsored Events	Evangelos Sioras	10/04/2024	2024/25	Yes	Consultant - Ophthalmology	Yes	17-18/11/23 RETINA CONFERENCE LONDON OCULUS IN FOCUS	ROCHE	YES	Jeffrey Kwartz
819	23/04/2024	Sponsored Events	Iain Wallace	19/04/2024	2024/25	No	Senior Capital Project Manager	No	Liverpool Womens Hospital Charity	Steven A Hunt Associates	YES	Wendy Jones
898	09/05/2024	Sponsored Events	Ambar Basu	01/04/2024	2024/25	Yes	Medical Consultant	Yes	For attending international conference	EASD 2023 (2/10/23-6/10/23)	YES	Simmi Krishnan
967	11/06/2024	Sponsored Events	Jade Lau	06/06/2024	2024/25	No	Specialist Rheumatology Pharmacist	No	Travel and accommodation for event 6/6/24 and 7/6/24. The event had speakers on clinical decision making, comorbidities and practical assessments on joints and X-rays.	UCB Pharma Ltd	YES	Susan Cook
2083	23/07/2024	Sponsored Events	Ambar Basu	01/04/2024	2024/25	Yes	Medical Consultant	Yes	GP educational meeting held on 22/1/24	Daiichi Sankyo UK Ltd	YES	Simmi Krishnan
2084	23/07/2024	Sponsored Events	Ambar Basu	13/06/2024	2024/25	Yes	Medical Consultant	Yes	GP educational event	Daiichi Sankyo UK Ltd	YES	Simmi Krishnan
2085	23/07/2024	Sponsored Events	Ambar Basu	04/07/2024	2024/25	Yes	Medical Consultant	Yes	GP educational event	Daiichi Sankyo UK Ltd	YES	Simmi Krishnan
2086	23/07/2024	Sponsored Events	Kamal Ibrahim	01/04/2024	2024/25	Yes	Consultant - Respiratory	Yes	Update on COPD treatments: Date 29/011/2023	GSK	YES	Rizwan Ahmed
2087	23/07/2024	Sponsored Events	Salil Singh	01/04/2024	2024/25	Yes	Consultant - Gastroenterology	Yes	Online access to Union of European Gastroenterology Week which is the main European Gastroenterology annual conference.	Abbvie	YES	Mark Murgatroyd
2091	24/07/2024	Sponsored Events	Janet Roberts	01/04/2024	2024/25	No	Acute Pain Nurse	No	Teaching other Hospital staff about a drug used at Bolton NHS FT carried out Tuesday 24th October, 2024	Flynn Pharma	YES	Julie Pilkington
2092	25/07/2024	Sponsored Events	Benjamin Crooks	28/04/2024	2024/25	Yes	Consultant - Gastroenterology	Yes	This declaration has been added in retrospect and dates back to a conference held on 28-29th April 2023. I was invited, by Janssen, to attend the annual IBD Matters meeting in London. Janssen funded travel and accommodation.	Janssen-Cilag Ltd	YES	Lesley Laird
2095	31/07/2024	Sponsored Events	Juan Manuel Cino Polla	01/04/2024	2024/25	No	Medical LocumMQ00	No	Sponsored educational meeting Event was in October 2022 Payment 19/01/2023 Ref 1900019435	AstraZeneca	YES	Benjamin Smith
2096	01/08/2024	Sponsored Events	Ann Haughton	24/06/2024	2024/25	No	Ophthalmology Clinical Lead for Glaucoma/Retinal	No	education study day study attended 24/06/23 (can not back date)was given study leave. sponsored by Bayer	bayer	YES	Francine Walsh
2142	28/08/2024	Sponsored Events	Ian Webster	06/08/2024	2024/25	Yes	Consultant - Respiratory	Yes	for 2024 financial year to date asked to speak at evening educational events	astrazeneca	YES	Benjamin Smeeton
2145	28/08/2024	Sponsored Events	Ian Webster	29/04/2024	2024/25	Yes	Consultant - Respiratory	Yes	covers the financial year for 2023 paid sponsorship for evening educational meetings with primary care, weekend training and weekend educational events [London COPD update]	astrazeneca	YES	Benjamin Smeeton

2175	11/10/2024	Sponsored Events	Ricardo Pardo Garcia	10/06/2024	2024/25	Yes	Consultant - Breast Surgery	Yes	I did a proctorship at Hinchinbrooke Hospital helping to operate 5 patients teaching the breast surgeons there how to use Magtrace and Magseed as we are the Excellence centre for Endomag. It was done during an annual leave day	Endomag	YES	Bethany Speakman
2236	04/11/2024	Sponsored Events	Akram Girgis	02/10/2024	2024/25	Yes	Locum Consultant	Yes	We had a presentation in the ESSO meeting in Belgium to present our work using Magseeds for Oncoplastic Breast surgery , I had EndoMag company sponsoring the trip .. flights/Train and Hotel but I didn't get any pocket money as a speaker, I am not aware about the full price as it was arranged by the Endomag team and I don't have a receipt for , so that's why i have put an estimate of the cost as I don't have receipts for it	EndoMag	YES	Claire Loughman
2245	06/11/2024	Sponsored Events	Rizwan Ahmed	12/09/2024	2024/25	Yes	Consultant - Respiratory	Yes	I did a talk on COPD management for community clinicals; GP and specialist nurses . The event was sponsored by Astra Zeneca. I had taken annual leave to attend the event.	Astra Zenaca	YES	Arun Kallat
2246	06/11/2024	Sponsored Events	Rizwan Ahmed	24/09/2024	2024/25	Yes	Consultant - Respiratory	Yes	I did a talk on COPD management for community clinicals; GP and specialist nurses . The event was sponsored by Astra Zeneca. I had taken annual leave to attend the event.	Astra Zenaca	YES	Arun Kallat

Ref	Date Declared	Interest Type	Employee	Date Arose	Date Updated	Date Ended	Year	DM	Role	Display	Interest Description (Abbreviated)	Provider	Approval	Approver
9	20/02/2023	Outside Employment	Ravindra Sawant	01/04/2022	02/07/2024		2022/23,2023/24,2024/25	Yes	Consultant Locum with Hours - Histopath	Yes	Ad hoc as a PLAB examiner	GMC	YES	Patrick Waugh
10	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Committee Member - Education & Training Committee	British Thoracic Society	YES	Angela Volleamere
11	20/02/2023	Outside Employment	Ravindra Sawant	01/04/2022	02/07/2024		2022/23,2023/24,2024/25	Yes	Consultant Locum with Hours - Histopath	Yes	AD HOC working as a UKAS assessor	UKAS	YES	Patrick Waugh
12	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Honorary Secretary	Manchester Medical Society	YES	Angela Volleamere
13	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	University of Manchester's Representative Governor and Trustee	The Hulme Hall Trust Foundation (Reg. Charity 526647)	YES	Angela Volleamere
14	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Honorary Treasurer	Hulme Hall Alumni Association	YES	Angela Volleamere
17	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Honorary Clinical Senior Lecturer in School of Clinical and Biomedical Sciences	University of Bolton	YES	Angela Volleamere
18	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Honorary Senior Lecturer in Division of Infection, Immunity & Respiratory Medicine	University of Manchester	YES	Angela Volleamere
20	20/02/2023	Outside Employment	Rebecca Bradley	01/04/2022	02/07/2024		2022/23,2023/24,2024/25	Yes	Deputy Chief Nurse	Yes	Private aesthetics	Cosmetic Aestheitcs	YES	Michaela Toms
24	20/02/2023	Outside Employment	Ravindra Sawant	01/04/2022	02/07/2024		2022/23,2023/24,2024/25	Yes	Consultant Locum with Hours - Histopath	Yes	Postmortem examinations, generally on once a week basis	Bolton Coroners court	YES	Patrick Waugh
25	20/02/2023	Clinical Private Practice	Khwaja Khan	01/04/2022	01/07/2023		2022/23,2023/24	Yes	Consultant Radiology	Yes	Telereporting of radiology scans.	hexarad telereporting	YES	Amanda Law
27	20/02/2023	Clinical Private Practice	Khwaja Khan	01/04/2022	01/07/2023		2022/23,2023/24	Yes	Consultant Radiology	Yes	I provide radiology services to BMI Beaumont Hospital based at Bolton	BMI Beaumont hospital	YES	Amanda Law
29	20/02/2023	Clinical Private Practice	Khwaja Khan	20/10/2022		28/02/2023	2022/23	Yes	Consultant Radiology	Yes	RADIOLOGY REPORTING for cross sectional imaging.	bestway healthcare solutions	YES	Amanda Law
30	20/02/2023	Loyalty Interests	Gareth Hughes	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Co-Opted Governor	Sharples Primary School	YES	Angela Volleamere
38	20/02/2023	Loyalty Interests	Michelle Cox	03/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Divisional Director of Operations	No	I am a Trustee (and Vice Chair) at St Catherine's Hospice. This is not a paid position and the organisation is located outside of GM in Lancashire. I have been doing this position since March 2019	St Catherine's Hospice	YES	Rae Wheatcroft
43	20/02/2023	Loyalty Interests	Shakti Thakur	20/02/2023			2022/23	Yes	Consultant - Ophthalmology	No	Steering Group meeting to decide on implementation of NICE approved drug Vabysmo for diabetic macular oedema . to create recommended pathways for UK	Roche	N/A	
44	20/02/2023	Loyalty Interests	Shakti Thakur	16/11/2022			2022/23	Yes	Consultant - Ophthalmology	No	Attended meeting sponsored by Bayer discussing various retinal treatments for diabetic maculopathy, wet macular degenreration and retinal vein occlusion	Bayer	N/A	
45	20/02/2023	Loyalty Interests	Sharon White	01/04/2022		08/06/2023	2022/23	Yes	Director of Strategic Transformation	Yes	Trustee of the Board - voluntary	Fort Alice - Charity	YES	Fiona Noden
46	20/02/2023	Loyalty Interests	Sharon White	01/04/2022		08/06/2023	2022/23	Yes	Director of Strategic Transformation	Yes	Trustee of the Board	George House Trust - Chairty	YES	Fiona Noden
47	20/02/2023	Loyalty Interests	Sharon White	01/04/2022		08/06/2023	2022/23	Yes	Director of Strategic Transformation	Yes	Governor on the Board - Voluntary	Bolton College of Further Education	YES	Fiona Noden
48	20/02/2023	Outside Employment	Francis Andrews	01/04/2022	03/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - A&E	Yes	I have undertaken appraisals for doctors working for holt doctors Ltd (locum agency). All earnings are declared to HMRC on my tax return I have been doing this since 2016, but ceased this activity in August 2024.	Self employeed	YES	Fiona Noden
49	20/02/2023	Loyalty Interests	Sharon White	01/04/2022		08/06/2023	2022/23	Yes	Director of Strategic Transformation	Yes	Judge She Inspires Awards	She Inspires	YES	Fiona Noden
55	20/02/2023	Clinical Private Practice	Ajmal Eusuf	01/04/2022	05/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthetics	Aj Eusuf	YES	Gareth Hughes
58	21/02/2023	Outside Employment	Rebecca Lennon	01/04/2022	11/06/2024		2022/23,2023/24,2024/25	Yes	Consultant	Yes	New Consultant representative on the Joint Speciality Committee with Palliative Medicine	Royal College of Physicians	YES	Laura Edwards
73	21/02/2023	Clinical Private Practice	Michaela Toms	21/02/2023		04/05/2023	2022/23	Yes	Divisional Nurse Director	Yes	anti wrinkle injections	private aesthetics	YES	Joanne Street
83	22/02/2023	Outside Employment	Chinari Pradeep Kumar Su	05/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant - Microbiology	No	I was contacted and approached by Clinical Director of Orthopaedics at WWL as their exisiting Consultant Microbiologist left the Trust in late 2021 and WWL Trust has been unable to recruit a Consultant Microbiologist with appropriate clinical experience to support the lower limb orthopaedic MDTs. As a Consultant Microbiologist, I support the Lower Limb Orthopaedic MDTs for Wrightington hospital which is held twice a week, on a Tuesday and Friday morning, between 8 and 9 AM. I provide ad hoc Clinical Microbiology advise over the phone and by email to Lower limb Orthopaedic colleagues at Wrightington Hospital outside my contracted hours at Bolton NHS Foundation Trust. I commenced this extra employment from January 2021.	Wrightington, Wigan and Leah NHS Foundatic	YES	Ryan Calderbank
84	22/02/2023	Outside Employment	Carl Oakden	01/04/2022	01/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Employed as a Variable Hours Tutor for University of Bolton; no current ongoing Lecturing roles - 3 days delivered total in past 12 months.	University of Bolton	YES	Gareth Hughes
85	22/02/2023	Shareholdings and other ownershi	Louise Tucker	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant Midwife	Yes	100% of the shares. Company Director	Complementary Birth Limited	YES	Janet Cotton
87	22/02/2023	Clinical Private Practice	Philip Wykes	22/02/2023	08/06/2023		2022/23,2023/24	Yes	Consultant - Orthopaedics	No	provision of upper limb orthopaedic services at the beaumont hospital. this includes medicolegal reports	bolton orthopaedics	YES	Katherine Beh
88	22/02/2023	Clinical Private Practice	Philip Wykes	22/02/2023	08/06/2023		2022/23,2023/24	Yes	Consultant - Orthopaedics	No	partner in a group of Bolton orthopaedic surgeons. we provide waiting list initiative in orthopaedics and other surgical disciplines in bolton	north west surgical services llp	YES	Katherine Beh
89	22/02/2023	Outside Employment	Philip Wykes	22/02/2023	08/06/2023		2022/23,2023/24	Yes	Consultant - Orthopaedics	No	i am the chair of the -BMI- bolton postgraduate education medical charity. it is unpaid.	bolton medical institute- BMI	YES	Katherine Beh
91	22/02/2023	Clinical Private Practice	Vikas Malik	01/04/2022	02/08/2024		2022/23,2023/24,2024/25	Yes	Simulation Lead	Yes	ENT - Routine ENT OPD consultation - Routine ENT surgeries	Beaumont Circlehealthgroup, Bolton	YES	Simon Hargreaves
94	22/02/2023	Clinical Private Practice	Sreekanth Vasireddy	01/04/2022		08/06/2023	2022/23	Yes	Consultant Rheumatologist	Yes	Rheumatology OPD clinic.	OPD CLINIC ROOMS, THE Beaumont Hospital	YES	Rebecca Lennon
97	23/02/2023	Clinical Private Practice	Daniel Nethercott	01/04/2022		08/06/2023	2022/23	Yes	Consultant - Anaesthetics	Yes	Anaesthesia (excluding paediatrics)	Bolton Anaesthetic Group	YES	Gareth Hughes
98	23/02/2023	Outside Employment	Daniel Nethercott	01/04/2022		08/06/2023	2022/23	Yes	Consultant - Anaesthetics	Yes	Certification of fitness to participate in amateur sporting events. On-line process via website owned by a friend. Income managed through ltd company/corporation tax all declared. No possible route it could conflict with NHS clinical or other work.	sportsmedicalcertificates.com	YES	Gareth Hughes
99	23/02/2023	Outside Employment	Daniel Hindley	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant Paediatrician	Yes	Consultancy work regarding epilepsy and neurodisability management of young people at the David Lewis Centre, an independent charity. Currently one session a month.	David Lewis Centre	YES	Gabrielle Lipshen
105	24/02/2023	Outside Employment	Charlotte MacKinnon	01/04/2022	03/07/2023	02/07/2024	2022/23,2023/24	No	Specialist Doctor	No	Named Professional for primary care, safeguarding children	GM ICB (Bolton)	YES	Rosie Connor
107	26/02/2023	Outside Employment	Stephen Hodgson	01/04/2022	20/06/2023		2022/23,2023/24	Yes	Consultant - Orthopaedics	Yes	Professor of Surgical Simulation working 8 hours per week using approved secondment agreement	University of Bolton	YES	Katherine Beh
108	27/02/2023	Loyalty Interests	Sophie Kimber Craig	01/04/2022		12/06/2023	2022/23	Yes	Consultant - Anaesthetics	Yes	Alistair is my husband and he is the current Medical Director of Northern Care Alliance's Diagnostics and Pharmacy Care Organisation. (For completeness, for the period of 15 December 2022 to 18 February 2023, he was the Intermin Chief Medical Officer of Northern Care Alliance.)	Alistair Craig	YES	Francis Andrews
111	28/02/2023	Loyalty Interests	Fiona Noden	01/04/2022	05/07/2023	04/04/2024	2022/23,2023/24	Yes	Chief Executive	No	Trustee of the Board - voluntary	NHS Providers	YES	Niruban Ratnarajah
112	28/02/2023	Loyalty Interests	Fiona Noden	01/04/2022	05/07/2023	04/04/2024	2022/23,2023/24	Yes	Chief Executive	No	Trustee of the Board - voluntary	The Octagon Theatre	YES	Niruban Ratnarajah
113	28/02/2023	Loyalty Interests	Fiona Noden	01/04/2022	05/07/2023	04/04/2024	2022/23,2023/24	Yes	Chief Executive	No	Trustee of the Board - voluntary	Bolton CVS	YES	Niruban Ratnarajah
119	02/03/2023	Outside Employment	Ragadeepika Siddabathur	03/05/2022		31/01/2023	2022/23	Yes	Consultant	No	Consultant Occupational Physician Part time- 2 days per week Finished this employment on 31 January 2023	health management ltd	YES	Lisa Roberts
125	06/03/2023	Loyalty Interests	Patrick Waugh	03/01/2023	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Histopathology	No	Hosted by Trust and employed by Trust but must maintain independence from the Trust	Bolton Medical Examiner	YES	Francis Andrews
126	06/03/2023	Outside Employment	Patrick Waugh	01/04/2022	02/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Histopathology	No	Coronial Autopsy Work for Bolton	HMC Bolton	YES	Chinari Pradeep Kumar Subudhi

127	06/03/2023	Clinical Private Practice	Laura Edwards	01/04/2022	05/07/2023		2022/23,2023/24	Yes	Associate Foundation Programme Direct	Yes	Very occasional review of patients presenting with palliative care needs at the Beardwood Hospital Blackburn	Supportive Care UK	YES	Rebecca Lennon
131	07/03/2023	Loyalty Interests	Emma Wheatley	20/02/2023	01/07/2023	02/04/2024	2022/23,2023/24	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Chair of governors	Crawshawbooth Primary School	YES	Gareth Hughes
132	07/03/2023	Loyalty Interests	Emma Wheatley	20/02/2023	01/07/2023	02/04/2024	2022/23,2023/24	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Peer support doctor	British Medical Association	YES	Gareth Hughes
133	07/03/2023	Loyalty Interests	Emma Wheatley	20/02/2023	01/07/2023	02/04/2024	2022/23,2023/24	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Instructor on HF and QI courses	AQuA	YES	Gareth Hughes
135	09/03/2023	Clinical Private Practice	Jeffrey Kwartz	04/04/2022	08/05/2024		2022/23,2023/24,2024/25	Yes	Clinical Lead Consultant - Ophthalmology	Yes	ophthalmology	Kwartz vision limited	YES	Lisa Sleight
141	10/03/2023	Outside Employment	John-Paul Lomas	01/04/2022	13/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Director of IT company for commercialisation of IT projects I have been involved with in spare time	Lomas Digital Limited	YES	Victoria Davis
142	10/03/2023	Outside Employment	John-Paul Lomas	01/04/2022	13/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Trustee for Charity	SCATA	YES	Victoria Davis
143	10/03/2023	Outside Employment	John-Paul Lomas	01/04/2022	13/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Board member of non-profit organisation supporting software development	Die QRL Stiftung	YES	Victoria Davis
144	15/03/2023	Clinical Private Practice	Rizwan Malik	01/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant Radiology	Yes	Diagnostic Thoracic Radiology reporting - in place since I became consultant at RBH from 2007	BMI hospitals Beaumont	YES	Amanda Law
145	15/03/2023	Clinical Private Practice	Rizwan Malik	01/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant Radiology	Yes	Thoracic CT Reporting	Medica Teleradiology	YES	Amanda Law
146	15/03/2023	Outside Employment	Rizwan Malik	01/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant Radiology	Yes	Healthcare and Health IT consultancy - my company	South Manchester Radiology Ltd	YES	Francis Andrews
147	15/03/2023	Outside Employment	Rizwan Malik	01/04/2022		11/12/2023	2022/23	Yes	Consultant Radiology	No	I am the Clinical Director for InHealth Radiology Reporting Services (its teleradiology reporting services) as a Paid Clinical Advisor for the Reporting Service since April 2020 via my consultancy company	InHealth	NO	Francis Andrews
148	15/03/2023	Outside Employment	Rizwan Malik	01/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant Radiology	Yes	I am NOT directly employed by this company but I do provide Clinical Advisory work for them ad hoc. As they currently operate in Greater Manchester and Bolton I declare them as a specific DOI for ward off any real or perceived conflict. Trust and Greater Manchester aware as its been on these Register of Interests since the outset	Qure.AI	YES	Francis Andrews
149	15/03/2023	Outside Employment	Rizwan Malik	01/04/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant Radiology	Yes	I am NOT directly employed by this company but I do provide Clinical Advisory work for them ad hoc - I am engaged purely as a Subject Matter Expert for their Clnical Advisory Group. As they currently operate in Greater Manchester and Bolton I declare them as a specific DOI for ward off any real or perceived conflict. Trust and Greater Manchester aware as its been on these Register of Interests since the outset and eve during the previous GM PACS procurement. Specific measures were taken to ensure I take no part in any commercial decision making involving this company	Wellbeing Software Solutions	YES	Amanda Law
153	20/03/2023	Clinical Private Practice	Insiya Khambalia	12/04/2022	17/05/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthetics	Circle Health Group	YES	Victoria Davis
157	23/03/2023	Clinical Private Practice	Michael McEvoy	01/01/2023	08/06/2023		2022/23,2023/24	Yes	Consultant - Anaesthetics	Yes	Anaesthesia - general and regional	Beaumont hospital	YES	Victoria Davis
160	29/03/2023	Loyalty Interests	Sharon White	01/04/2022		08/06/2023	2022/23	Yes	Director of Strategic Transformation	Yes	Non Financial Personal Interest - Partner employed by Trust	Bolton NHS FT	YES	Fiona Noden
162	19/04/2023	Outside Employment	Peter Sandbach	01/07/2022	02/05/2024		2022/23,2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Directorship. Occasional consultancy work assisting in the writing of literature reviews and the Clinical Evaluation Report for medical device companies. Work is entirely flexible - outside clinical hours and involves no clinical contact. Work is undertaken on a contract-by-contract basis with no ongoing expectation of commitment. Due to the evidence based nature of the work there is no pecuniary interest which can influence my clinical practice.	Sandbach McCune Limited	YES	Lucy McManamon
165	04/05/2023	Loyalty Interests	Lianne Robinson	02/05/2023	03/04/2024		2023/24,2024/25	No	Chief Nurse	No	Trustee	East Lancashire Hospice	YES	Tyrone Roberts
166	04/05/2023	Loyalty Interests	Lianne Robinson	04/05/2023	03/04/2024		2023/24,2024/25	No	Chief Nurse	No	Judge for Nursing Times Workforce awards, nil payment. Judging capacity only.	Nursing Times	YES	Tyrone Roberts
167	04/05/2023	Clinical Private Practice	Michaela Toms	04/05/2023	04/04/2024		2023/24,2024/25	Yes	Divisional Nurse Director	Yes	anti wrinkle injections	private aesthetics	YES	Joanne Street
169	04/05/2023	Outside Employment	Lisa Roberts	01/04/2022	04/09/2023		2022/23,2023/24	No	Occupational Health Service Manager	No	SEQOHS (Safe Effective Quality Occupational Health Services) Accreditation Scheme. As an assessor for the faculty, I will carry out audits on Occupational Health services (both in private and public sector).	Faculty of Occupational Medicine	YES	Carol Sheard
170	04/05/2023	Clinical Private Practice	Rubeena Razzaq	01/04/2022	08/04/2024		2022/23,2023/24,2024/25	Yes	Consultant - Radiology	Yes	Diagnostic Radiology	Beaumont Hospital	YES	Amanda Law
178	08/06/2023	Clinical Private Practice	Atir Khan	01/04/2022			2022/23	Yes	Consultant Gen Med Diabetes & Endocrir	No	Nil	Beardwood hospital - Circle Health Group	YES	Rebecca Lennon
179	08/06/2023	Outside Employment	Annette Walker	01/04/2022		11/08/2023	2022/23	Yes	Director of Finance & Procurement	No	Public Sector Director of Brahm Lift Company	One Partnership	YES	Fiona Noden
180	08/06/2023	Clinical Private Practice	Atir Khan	02/04/2022			2022/23	Yes	Consultant Gen Med Diabetes & Endocrir	No	Nil	Lancaster Hospital - Circle Health Group	YES	Rebecca Lennon
181	08/06/2023	Clinical Private Practice	Atir Khan	02/04/2022			2022/23	Yes	Consultant Gen Med Diabetes & Endocrir	No	Nil	Sancta Maria Hospital - Swansea	YES	Rebecca Lennon
186	08/06/2023	Outside Employment	Bohdan Smajer	01/04/2023	02/04/2024		2023/24,2024/25	Yes	Consultant - Upper GI Surgery	No	Weekend NHS backlog work, no private patients	Manchester Surgical Services	YES	Claire Loughman
190	08/06/2023	Clinical Private Practice	Sreekanth Vasireddy	08/06/2023	09/04/2024		2023/24,2024/25	Yes	Consultant Rheumatologist	Yes	Rheumatology OPD clinic.	OPD CLINIC ROOMS, THE Beaumont Hospital	YES	Rebecca Lennon
191	08/06/2023	Outside Employment	Amy Nickson	01/04/2023			2023/24	Yes	Consultant - A&E	No	Bank staff - Sexual Offences Examiner	Lancashire Teaching Hospitals NHS Trust	YES	Maria Papaioannou-Moran
192	08/06/2023	Outside Employment	Daniel Nethercott	08/06/2023	01/04/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Certification of fitness to participate in amateur sporting events. On-line process via website owned by a friend. Income managed through ltd company/corporation tax all declared. No possible route it could conflict with NHS clinical or other work.	sportsmedicalcertificates.com	YES	Gareth Hughes
193	08/06/2023	Clinical Private Practice	Daniel Nethercott	08/06/2023	01/04/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthesia (excluding paediatrics)	Bolton Anaesthetic Group	YES	Gareth Hughes
210	08/06/2023	Loyalty Interests	Sharon White	08/06/2023	08/04/2024		2023/24,2024/25	Yes	Director of Strategic Transformation	Yes	Non Financial Personal Interest - Partner employed by Trust	Bolton NHS FT	YES	Fiona Noden
211	08/06/2023	Loyalty Interests	Sharon White	08/06/2023		08/04/2024	2023/24	Yes	Director of Strategic Transformation	Yes	Judge She Inspires Awards	She Inspires	YES	Fiona Noden
212	08/06/2023	Loyalty Interests	Sharon White	08/06/2023	08/04/2024		2023/24,2024/25	Yes	Director of Strategic Transformation	Yes	Governor on the Board - Voluntary	Bolton College of Further Education	YES	Fiona Noden
213	08/06/2023	Loyalty Interests	Sharon White	08/06/2023	08/04/2024		2023/24,2024/25	Yes	Director of Strategic Transformation	Yes	Trustee of the Board	George House Trust - Chairty	YES	Fiona Noden
214	08/06/2023	Loyalty Interests	Sharon White	08/06/2023	08/04/2024		2023/24,2024/25	Yes	Director of Strategic Transformation	Yes	Trustee of the Board - voluntary	Fort Alice - Charity	YES	Fiona Noden
227	08/06/2023	Outside Employment	Dean Eckersley	01/04/2023	03/04/2024		2023/24,2024/25	Yes	Integration and Systems Development M	No	Provide out of hours IT support for 2 small businesses.	Self Employment	YES	Brett Walmsley
231	08/06/2023	Clinical Private Practice	Moulinath Banerjee	01/04/2023			2023/24	Yes	Medical Consultant	No	Diabetes, Endocrinology, Hypertension, Lipid disorders & General Medicine. Been doing this clinic since Feb 2018.	The Beaumont Hospital clinic	YES	Rebecca Lennon
232	08/06/2023	Clinical Private Practice	Moulinath Banerjee	01/04/2023			2023/24	Yes	Medical Consultant	No	Diabetes, Endocrinology, Hypertension, Lipid disorders & General Medicine	The Spire Regency Hospital Clinic	YES	Rebecca Lennon
238	08/06/2023	Clinical Private Practice	David Smith	01/04/2023	03/07/2024		2023/24,2024/25	Yes	Consultant - Colorectal	No	General Surgery Colorectal Surgery Endoscopy	BMI Beaumont	YES	Claire Loughman
246	08/06/2023	Clinical Private Practice	Priya Bhatt	01/04/2023	09/04/2024		2023/24,2024/25	Yes	Consultant - Ophthalmology	No	Oculoplastics: all eyelid surgery	Beaumont Hospital, Face & Eye clinic	YES	Lisa Sleight
256	09/06/2023	Outside Employment	Patrick Waugh	03/04/2023	02/04/2024		2023/24,2024/25	Yes	Consultant - Histopathology	No	Medical Examiner Lead Bolton	NHS England	YES	Charlotte Kelly
259	09/06/2023	Outside Employment	Shaista Meraj	01/04/2023			2023/24	Yes	Consultant Radiology	No	Consultant Associate Started in Oct 2021. This form only allows me to put 1 April 2023	SOUTH MANCHESTER RADIOLOGY LTD	YES	Amanda Law
260	09/06/2023	Clinical Private Practice	Shaista Meraj	09/06/2023			2023/24	Yes	Consultant Radiology	No	teleradiologist	Everlight teleradiology	YES	Amanda Law
273	12/06/2023	Outside Employment	Jennifer Ruddlesdin	01/04/2023	14/05/2024		2023/24,2024/25	Yes	Consultant Orthogeriatrician	No	Question writing group member and editorial board member for SCE Geriatric Medicine - annual meeting at location determined by Royal College of Physicians (usually Warwick University or Royal College of Physicians, London). Expenses paid.	Royal College of Physicians	YES	Katherine Beh

274	12/06/2023	Outside Employment	Jennifer Ruddlesdin	01/04/2023	14/05/2024		2023/24,2024/25	Yes	Consultant Orthogeriatrician	No	External clinical advisor for PHSO - ad hoc consultancy, usually once or twice a year for approximately 5 hours.	Public Health Service Ombudsman	YES	Katherine Beh
284	12/06/2023	Loyalty Interests	Sophie Kimber Craig	12/06/2023	03/04/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Alistair is my husband and he is the Chief Officer of Oldham Hospital and previously was the MD of NCA's Diagnostic and Pharmacy Care Organisation. (For completeness, for the period of 15 December 2022 to 18 February 2023, he was the Intermin Chief Medical Officer of Northern Care Alliance.)	Alistair Craig	YES	Francis Andrews
305	20/06/2023	Outside Employment	Stephen Hodgson	01/04/2023	20/06/2023		2023/24	Yes	Consultant - Orthopaedics	Yes	Professor of Surgical Simulation	University of Bolton	YES	Alun Wall
307	20/06/2023	Outside Employment	Salil Singh	01/04/2023			2023/24	Yes	Consultant - Gastroenterology	No	Private Practice	Beaumont Hospital	YES	Mark Murgatroyd
311	29/06/2023	Outside Employment	Mani Narayanappa Subra	03/04/2023	02/04/2024		2023/24,2024/25	Yes	Speciality Doctor	No	I do average of 8 hours of work a week, at Locala [Wigan and Leigh Sexual health] in my free time and it doesn't clash with my timings at Bolton centre of Sexual and reproductive health [including DCC and SPA] . There is no clash of interest from my job at Bolton with the job I do outside.	Locala Health and Well Being - Wigan and Lei	YES	Emile Morgan
330	03/07/2023	Clinical Private Practice	Sangeeta Das	01/04/2023	03/04/2024		2023/24,2024/25	Yes	Clinical Lead - Obs & Gynae	No	gynaecology. hysteroscopy/ laparoscopy/ hysterectomy	Beaumont Hospital	YES	Nadia Ali-Ross
338	03/07/2023	Outside Employment	Kalyan Guduru	01/04/2023	09/05/2024		2023/24,2024/25	Yes	Associate Specialist - Ophthalmology	No	North Manchester Diabetic Retinopathy screening programme	InHealth Intelligence	YES	Jeffrey Kwartz
342	03/07/2023	Clinical Private Practice	Emile Morgan	10/04/2023	05/06/2024		2023/24,2024/25	Yes	Clinical Director HIV Sexual & Repro Heal	No	G U Medicine (Sexual Health) Consultations	See below but occ. at Beaumont or the Spire	YES	Susan Moss
348	03/07/2023	Outside Employment	Clare Lomax	03/07/2023			2023/24	Yes	Divisional Nurse Director	No	Small family business with husband. Retail of cosmetics	own business	YES	Michelle Cox
352	03/07/2023	Clinical Private Practice	Seelanere Nandini	01/04/2023	05/06/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	No	Anaesthetics	Beaumont hospital and Euxton hospital	YES	Lucy McManamon
355	04/07/2023	Clinical Private Practice	Kanekal Sriramgadarshan	01/04/2023	09/07/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	No	Anaesthetics	Individual	YES	Lucy McManamon
356	04/07/2023	Loyalty Interests	James Mawrey	02/04/2023		01/12/2023	2023/24	Yes	Director of Workforce	No	Trustee of Stamma	Stamma	YES	Fiona Noden
361	05/07/2023	Outside Employment	David Haider	01/04/2023	16/04/2024		2023/24,2024/25	Yes	Consultant - Ophthalmology	No	Although I have been helping the Apperta Foundation for some years (since 2017). I only began to receive remuneration in early 2022. The Apperta Foundation is a clinician-led, not-for-profit company. It protects and assists in the development of the OpenEyes EPR that Bolton use. Apperta wanted more time from me that I was able to provide reasonably within my Bolton work. I therefore provide additional (now paid) work for them, such as OpenEyes product demos outside of my Bolton hours. I also assist in design of the OpenEyes software and contribute to the strategic direction of the software. The title of my role is: - Chair of the OpenEyes Committee of the Apperta Foundation - Chair of the OpenEyes Design Authority	Apperta Foundation	YES	Lisa Sleight
366	11/07/2023	Outside Employment	Maria Papaioannou-Mora	01/04/2023	15/04/2024		2023/24,2024/25	Yes	Consultant - A&E	No	I work night shifts in Salford Royal Emergency Department as the Trauma Team Leader. This is done via the locum agency NHSP.	NHSP	YES	Rauf Munshi
368	12/07/2023	Outside Employment	Neil Harvey	01/04/2023	01/05/2024		2023/24,2024/25	Yes	Consultant Urologist	No	This employment started prior to joining the Trust, on 25th January 2022. This employment includes educational and advisory roles, currently less than 10 hours per year.	Teleflex Incorporated	YES	Kayleigh Rew
369	12/07/2023	Clinical Private Practice	Neil Harvey	01/04/2023	01/05/2024		2023/24,2024/25	Yes	Consultant Urologist	No	Urology - core urological procedures only currently	The Beaumont Hospital (Circle Health Group)	YES	Kayleigh Rew
370	12/07/2023	Shareholdings and other ownershi	Neil Harvey	01/04/2023	01/05/2024		2023/24,2024/25	Yes	Consultant Urologist	No	1 (25%)	Bolton Urology LLP	YES	Kayleigh Rew
371	14/07/2023	Outside Employment	Abdelsattar Farrag	02/05/2023		01/07/2023	2023/24	Yes	Consultant Locum with Hours Ophthalm	No	Honorarium Fees for lectures	Optos Public Ltd (ad division of NIKON Co.Lt	YES	Lisa Sleight
372	14/07/2023	Loyalty Interests	Carol Sheard	14/07/2023	15/04/2024		2023/24,2024/25	Yes	Deputy Director of People	No	Atb (All the B's) Carpet Cleaning is my husband's start up company which may be used by the Trust in relation to private landlord properties that are used by Trust staff/ international recruits. Procurement have been involved and approved.	Atb Carpet Cleaning	YES	James Mawrey
381	25/07/2023	Outside Employment	Nichola Hughes	03/04/2023			2023/24	No	Nurse Advanced Diabetes	No	Pharmaceutical company.	Sanofi	YES	Samantha Kearns
387	28/07/2023	Clinical Private Practice	Hesham Ali	01/04/2023			2023/24	Yes	Consultant Orthodontist	No	Orthodontics	Location can change	YES	Kayleigh Rew
398	29/08/2023	Outside Employment	Richard Hogg	01/08/2023	09/07/2024		2023/24,2024/25	No	Associate Practitioner	No	Graphic design/book publishing.	Self Employed	YES	Karina Hambridge
399	30/08/2023	Outside Employment	Julie Brayshaw	01/04/2023			2023/24	No	Clerical Officer/Receptionist	No	Bank support worker at Next Stage Youth Development. On a zero hours contract and cover the odd shift when free to do so. Commenced role in June 2021.	Next Stage Youth Development	YES	Bethan Mason
402	03/09/2023	Outside Employment	Abdelsattar Farrag	03/09/2023	11/10/2024		2023/24,2024/25	Yes	Consultant Locum with Hours - Ophthalm	No	I work to cover Ad hoc clinics in non working days with locum agency and independent sector outside Bolton area	Ad hoc clinics cover for NHS patients through	YES	Lisa Sleight
419	04/09/2023	Outside Employment	Rachel Noble	04/09/2023	02/04/2024		2023/24,2024/25	Yes	Deputy Director of Strategy	No	Director	The Noble Apothecary Ltd	YES	Sharon White
421	04/09/2023	Outside Employment	Jacqueline Smith	12/07/2023			2023/24	No	Divisional Governance/ Professional Lead	No	Non-Executive Director - to attend 4 meetings per year.	Birthrateplus	YES	Richard Catlin
428	04/09/2023	Clinical Private Practice	Sonia Griffin	01/08/2023			2023/24	No	Assistant Director of Nursing	No	Aesthetics Procedures	SG Medical Aesthetics	YES	Lianne Robinson
432	05/09/2023	Outside Employment	Shankaran Rajmanickam	05/09/2023			2023/24	No	Consultant Physiotherapist	No	Telephone based remote clinics working as an Advanced Practitioner	Connect Health Yorkshire	YES	Susan Greenhalgh
433	05/09/2023	Clinical Private Practice	Andrew Muotune	01/04/2023	04/06/2024		2023/24,2024/25	Yes	Consultant - Obs & Gynae	Yes	Gynaecology Out patient consultations General Gynae Operating	Beaumont Hospital	YES	Nadia Ali-Ross
435	06/09/2023	Clinical Private Practice	Peter Scott	04/04/2023	02/04/2024		2023/24,2024/25	Yes	Clinical Lead Consultant - Cardiology	No	Cardiology Outpatient Clinic	Dr Peter Scott	YES	Benjamin Smeeton
436	06/09/2023	Outside Employment	Lynne Wooff	01/04/2023			2023/24	No	Nurse Advanced Diabetes	No	They asked my to carry out a diabetes presentation to the Heart Failure team at RBH. The actual date of the presentation was in Mar 2022	Astra Zeneca	YES	Helene Strong
438	10/09/2023	Outside Employment	Jeffrey Kwartz	10/09/2023		09/05/2024	2023/24	Yes	Clinical Lead Consultant Ophthalmology	No	attendance / input for key opinion work based on expertise gained in treating dry eye / allergy at Bolton with ciclosporine immune treatment (only one company provides this treatement). Meeting not in NHS time	key opinion leader work- Santen pharmaceuti	YES	Lisa Sleight
439	10/09/2023	Clinical Private Practice	Jeffrey Kwartz	04/04/2023	08/05/2024		2023/24,2024/25	Yes	Clinical Lead Consultant - Ophthalmology	No	ophthalmology - general ophthalmology and cataract surgery within my scope of practice	Personal private practice - nil change over yea	YES	Lisa Sleight
460	18/09/2023	Shareholdings and other ownershi	Wendy Jones	01/04/2023	08/05/2024		2023/24,2024/25	Yes	iFM Director of Operations	No	Approx 100	Assura	YES	Fiona McDonnell
461	18/09/2023	Clinical Private Practice	Richard Harris	01/04/2023	04/07/2024		2023/24,2024/25	Yes	Consultant - General Surgery	Yes	General and minor colorectal surgery	Mr R Paul Harris Ltd	YES	Claire Loughman
476	21/09/2023	Outside Employment	Kelly Harrison	21/09/2023			2023/24	No	Workforce Information Manager	No	Independent travel agent	Inteletravel	YES	Christopher Whittam
495	12/10/2023	Outside Employment	Jennifer Hopwood	04/09/2023			2023/24	No	Specialist Occupational Therapist	No	Independent occupational therapy.	Rehabilitate Therapy Limited	YES	Rachel Barber
496	13/10/2023	Loyalty Interests	Stuart Bates	01/04/2023	08/04/2024		2023/24,2024/25	Yes	Director of Quality Governance	Yes	Varies between 2 - 5 hours per week. Married to existing employee of the trust.	Bolton NHS Foundation Trust	YES	Tyrone Roberts
505	16/10/2023	Outside Employment	Dillan Shetty Kadri	03/04/2023	03/07/2024		2023/24,2024/25	Yes	Locum Consultant with hours	Yes	To work as clinician providing ENT services in the community	Beacon Medical speciality group Manchester	YES	Simon Hargreaves
506	16/10/2023	Outside Employment	Dillan Shetty Kadri	14/08/2023	03/07/2024		2023/24,2024/25	Yes	Locum Consultant with hours	Yes	Bank staff working in theatres for experience in Head and neck, Facial plastics and Rhinology	Lancashire teaching hospitals NHS trust	YES	Simon Hargreaves
508	17/10/2023	Loyalty Interests	Craig Reid	28/08/2023	02/05/2024		2023/24,2024/25	Yes	Associate Director of Estates Services	Yes	My brother in law works for MI CAD	MI CAD	YES	Wendy Jones
512	18/10/2023	Clinical Private Practice	Prabha Kushwaha	01/04/2023		18/10/2023	2023/24	Yes	Consultant - Histopathology	Yes	Histopathology cases reporting under microscope	Backlogs limited	YES	Patrick Waugh
524	30/10/2023	Clinical Private Practice	Anthony Putland	01/04/2023	13/11/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthetics	Beaumont Hospital Bolton	YES	Lucy McManamon
528	02/11/2023	Outside Employment	Sheikh Uzair	02/11/2023	02/04/2024		2023/24,2024/25	Yes	Consultant - General Surgery	Yes	Do endoscopy list on weekends and sometimes on a Wednesday or a Thursday	Endocare	YES	David Smith
533	02/11/2023	Outside Employment	Claire Rehan	03/04/2023	03/04/2024		2023/24,2024/25	Yes	Consultant Clinical Psychologist	Yes	Provide a total of six days teaching per year on the Clinical Health psychology training. This is in my own days off	University of Liverpool	YES	Nicola McAinsh

534	02/11/2023	Clinical Private Practice	Yousaf Akhtar	02/04/2023	29/11/2024		2023/24,2024/25	Yes	Consultant - General Surgery	Yes	General Surgery	Beaumont Hospital. Bolton	YES	Claire Loughman
535	06/11/2023	Clinical Private Practice	James A'Court	06/11/2023	01/05/2024		2023/24,2024/25	Yes	Consultant - Orthopaedics	Yes	Orthopaedics-upper limb	Beaumont hospital	YES	Katherine Beh
539	09/11/2023	Clinical Private Practice	Ian Waite	01/04/2023	08/05/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	anaesthetics	Dr Ian Waite FRCA limited	YES	Lucy McManamon
542	13/11/2023	Clinical Private Practice	William Marley	05/04/2023	21/04/2024		2023/24,2024/25	Yes	Consultant - Orthopaedics	Yes	Trauma and Orthopaedics. Hip and knee replacements	Beaumont Hospital	YES	Katherine Beh
547	18/11/2023	Shareholdings and other ownershi	Zainulabedin Patel	01/04/2023			2023/24	Yes	Consultant - A&E	Yes	Ordinary 22	Astrazenica	YES	Maria Papaioannou-Moran
548	20/11/2023	Outside Employment	Neeraja Singh	04/04/2023	20/05/2024		2023/24,2024/25	Yes	Consultant - Obs & Gynae	No	Shares have been held since 2022 - can't choose ealier date above I am employed as a GMC associate (Examiner) which involves assessing/examining international candidates who appear in PLAB part 2 examination. The doctors need to pass this examination to register with GMC. I have a contract to attend 8 full day examination sessions/year and I use my non clinical/SPA sessions for this. I get paid by GMC for this role.	General Medical Council	YES	Nadia Ali-Ross
550	29/11/2023	Outside Employment	Paula Younger	01/04/2023			2023/24	No	Clinical Librarian	No	Occasional self-employed writing and research support (no NHS clients). UTR available if required; accounts up-to-date and tax returns submitted annually. This self-employment precedes the 1 April 2023 but this is the earliest date I can declare via this method.	Self-employed	YES	Dawn Grundy
551	30/11/2023	Clinical Private Practice	Eifion Price	01/04/2023	02/04/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthesia	Circle Health Beaumont Hospital	YES	Francis Andrews
569	09/01/2024	Clinical Private Practice	Carl Oakden	13/12/2023	01/04/2024		2023/24,2024/25	Yes	Consultant - Anaesthetics	Yes	General Anaesthesia	Beaumont Hospital	YES	Gareth Hughes
570	09/01/2024	Outside Employment	Cara Burns	08/01/2024			2023/24	No	Head of Optometry	No	Locum optometrist	Not an employer as I am self-employed; Andr	YES	Lisa Sleight
572	09/01/2024	Outside Employment	Rachel Brierley	01/04/2023			2023/24	No	Optometrist Specialist	No	Work as Locum Optometrist 6.5 hours a month	Andrew Fletcher Opticians	YES	Lisa Sleight
575	15/01/2024	Outside Employment	Barbara Whetton	01/07/2023	04/04/2024		2023/24,2024/25	No	Podiatrist	No	Advanced Practice Podiatrist (Bank) ad hoc - on Wednesdays Mainly podiatric MSK assessments MDT working Clinic run with support of healthcare assistants and orthoses manufacture specialists	Robert Jones and Agnes Hunt NHS Foundatio	YES	Julia Stell
576	15/01/2024	Outside Employment	Barbara Whetton	01/11/2023	04/04/2024		2023/24,2024/25	No	Podiatrist	No	Self - employed generalist podiatrist. Mainly clinic based On flexible rota.	Self employed	YES	Julia Stell
582	06/02/2024	Outside Employment	Rowena Perry	05/02/2024			2023/24	No	Training and Development Manager	No	Lecturer in Biomedical Science	University of Bolton	YES	Philip Henry
583	08/02/2024	Outside Employment	Amy Oliver	08/02/2024			2023/24	No	Optometrist Specialist	No	I work in other opticians outside of my time at the Royal Bolton Hospital this is both employed and as a locum optometrist up to 4 days a week.	Paul Moore Opticians and Locum Optometrist	YES	Rachel Brierley
607	22/02/2024	Outside Employment	Dalya Fox	19/02/2024			2023/24	No	Optometrist Specialist	No	Locum Optometrist twice weekly	Eye See You ltd	YES	Rachel Brierley
608	22/02/2024	Outside Employment	Sarah Dobinson	06/10/2023			2023/24	No	Optometrist Specialist	No	Locum optometrist days in various Optometry practices on my days off, so far on various Fridays and Saturdays, but may also do Wednesday or Sunday in the future as I am also not working those days. I have worked so far at Morans Optometrists in New Mills, but may work elsewhere in the future.	Various optometry practices	YES	Rachel Brierley
617	07/03/2024	Outside Employment	Olamide Adewole	01/04/2023			2023/24	No	Healthcare Assistant	No	AGENCY SUPPORTED LIVING	PRETTY ARMS CARE	YES	Bryan Mae Degorio
628	15/03/2024	Outside Employment	Sum Ching Ho	15/03/2024			2023/24	No	Physiotherapist	No	Tutoring children.	Reagent Academy	YES	Thomas Allerton
629	18/03/2024	Outside Employment	Munibah Gangat	01/01/2024			2023/24	No	Optometrist Specialist	No	Performing community sight tests at local opticians on my days off when I am not employed by the trust.	Self Employed Locum Optometrist	YES	Cara Burns
630	20/03/2024	Outside Employment	Mahria Akram	11/11/2023			2023/24	No	Optometrist Specialist	No	Self employed - locum optometrist	Self employed - locum optometrist	YES	Cara Burns
631	20/03/2024	Outside Employment	Surabhi Wig	03/01/2024			2023/24	Yes	Consultant Rheumatologist	Yes	Provided weekend rheumatology clinics at university hospital of Derbyshire through a rheumatology insourcing company (Outpatients network).The clinics were on the weekend when I have no commitment with the Bolton NHS Trust. Clinics were provided on 13 and 14 th January , 20 th and 21st Jan and 10th and 11th Feb 2024 . There was one admin day on the 25 th of February 2024.	Outpatient network - rheumatology	YES	Robert Stell
632	26/03/2024	Outside Employment	Conor Magee	26/03/2024			2023/24	No	Optometrist Specialist	No	I intend to perform occasional days of locum work for optometrists in the local area.	Locum employer	YES	Cara Burns
633	26/03/2024	Shareholdings and other ownershi	Sharaz Javeed	02/05/2023			2023/24	No	Pharmacist	No	100% shares I owe the zock LTD company which manufactures and sells metatarsal injury protectors	Zockltd	YES	Suzanne Schneider
647	02/04/2024	Clinical Private Practice	Jeremy Jarratt	01/04/2024			2024/25	Yes	Consultant - Orthopaedics	Yes	Hip and knee surgery as per NHS practice	J W Jarratt Ltd, Bolton Orthopaedics LLP, Nor	YES	Kayleigh Rew
654	02/04/2024	Outside Employment	Tyrone Roberts	01/04/2023	08/05/2024		2023/24,2024/25	Yes	Chief Nurse	Yes	Deliver free on site personal training in small groups. No charge to staff whatsoever. Not affiliated to any company sponsorship.	personal qualification Personal Trainer	YES	Fiona Noden
661	02/04/2024	Outside Employment	Hannah Richards	01/04/2023			2023/24	Yes	Consultant - A&E	Yes	Provide adhoc support to private clients (non Bolton FT staff) for small fee Zero hour contract as Match Day Crowd Doctor and events e.g. concerts	Manchester City Football Club	YES	Hannah Durrant
663	02/04/2024	Loyalty Interests	Emma Wheatley	02/04/2024			2024/25	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Associate member of AQuA Instructor on HF and QI courses	AQuA	YES	Gareth Hughes
664	02/04/2024	Loyalty Interests	Emma Wheatley	02/04/2024			2024/25	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Peer support doctor	British Medical Association	YES	Gareth Hughes
665	02/04/2024	Loyalty Interests	Emma Wheatley	02/04/2024			2024/25	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Chair of governors	Crawshawbooth Primary School	YES	Gareth Hughes
673	02/04/2024	Clinical Private Practice	Kamal Ibrahim	01/04/2023		03/04/2024	2023/24	Yes	Consultant - Respiratory	Yes	Respiratory Clinics	The Beaumont Hospital	YES	Rizwan Ahmed
676	02/04/2024	Outside Employment	James Pollard	01/01/2024	02/05/2024		2023/24,2024/25	Yes	Consultant - Colorectal	Yes	Training programme director, core surgical training, North West	NHS England	YES	David Smith
678	02/04/2024	Outside Employment	Ravindra Sawant	08/03/2024		09/03/2024	2023/24	Yes	Consultant Locum with Hours - Histopath	Yes	Visiting Teaching Fellow: Centre for Contemporary Coronial Law Delivering lectures to aspiring Coroners about pathology. Done outside of core hours, usually 6pm.	Bolton University	YES	Chinari Pradeep Kumar Subudhi
702	02/04/2024	Clinical Private Practice	Alexandra Whalley	01/04/2024	22/05/2024		2024/25	No	Highly Specialist Therapist - Podiatrist	No	Routine assessments and podiatry treatment	Alexandra Whalley Podiatrist	YES	Julia Stell
708	02/04/2024	Outside Employment	Rachel Noble	01/04/2023	02/04/2024		2023/24,2024/25	Yes	Deputy Director of Strategy	Yes	Director	The Noble Apothecary	YES	Sharon White
709	02/04/2024	Clinical Private Practice	Emma Mulgrew	01/04/2023			2023/24	Yes	Consultant - Orthopaedics	Yes	Elective clinic and Shoulder and Elbow surgery	Beaumont Hospital	YES	Katherine Beh
710	02/04/2024	Clinical Private Practice	Jennifer Kelly	01/04/2023			2023/24	No	Highly Specialist Therapist - Podiatrist	No	Mobile Podiatry	Jenny Kelly Mobile Podiatry and Chiropody	YES	Julia Stell
711	02/04/2024	Clinical Private Practice	Eifion Price	01/04/2024	02/04/2024		2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthetics	Ramsay Healthcare	YES	Victoria Davis
716	03/04/2024	Clinical Private Practice	Kamal Ibrahim	03/04/2024			2024/25	Yes	Consultant - Respiratory	Yes	Respiratory Clinics in Glasgow	Ad hoc locum work	YES	Rizwan Ahmed
722	03/04/2024	Clinical Private Practice	Elka Astley	03/04/2024	22/05/2024		2024/25	No	Podiatrist	No	podiatrist	soul to sole	YES	Julia Stell
728	03/04/2024	Clinical Private Practice	Rose Gondwe	01/04/2024			2024/25	No	Podiatrist	No	Podiatry - routine	Total Health Care Farnworth	YES	Alison Spensley
730	03/04/2024	Clinical Private Practice	Khurram Shahzad	23/07/2023	04/07/2024		2023/24,2024/25	Yes	Consultant Radiology	Yes	Radiology, CT and occasional MRI reporting	Medica	YES	Amanda Law
738	04/04/2024	Clinical Private Practice	Aysha Waheed	04/04/2024			2024/25	No	Podiatrist	No	Podiatry	Feet First Podiatry	YES	Alison Spensley
739	04/04/2024	Outside Employment	Jennifer Cromey	01/04/2023			2023/24	No	Specialist Occupational Therapist	No	I am registered as a solo trader for my independent Occupational Therapy practice.	Independent Occupational Therapy Practition	YES	Kimberley Tipping

741	04/04/2024	Outside Employment	Vanessa Moore	03/04/2023			2023/24	No	Physiotherapy Assistant	No	I PA for a young man, who is 17 with SEN needs.	Personal Assistant	YES	Emma Spurling
743	04/04/2024	Loyalty Interests	Fiona Noden	04/04/2024			2024/25	Yes	Chief Executive	No	Trustee of the Board - voluntary	Bolton CVS	YES	Niruban Ratnarajah
744	04/04/2024	Loyalty Interests	Fiona Noden	04/04/2024		31/12/2024	2024/25	Yes	Chief Executive	No	Trustee of the Board - voluntary	The Octagon Theatre	YES	Niruban Ratnarajah
745	04/04/2024	Loyalty Interests	Fiona Noden	04/04/2024		07/07/2024	2024/25	Yes	Chief Executive	No	Trustee of the Board - voluntary	NHS Providers	YES	Niruban Ratnarajah
756	08/04/2024	Clinical Private Practice	Dawn Buck	25/03/2024			2023/24	No	Highly Specialist Therapist - Podiatrist	No	Podiatry treatments	Best Foot Forward	YES	Julia Stell
760	08/04/2024	Clinical Private Practice	James Childs	01/04/2024			2024/25	Yes	Consultant - Orthopaedics	Yes	Orthopaedics: Total Knee Replacement, Uni-compartmental Knee Replacement, Total Hip Replacement, Knee Ligament and Cartilage Surgery	Circle and Spire Health Care	YES	Alun Wall
762	08/04/2024	Outside Employment	Joanne Edge	11/11/2023			2023/24	No	Public Health Nurse - Team Leader	No	Provision of 1:1 therapy sessions.	Self-Employed Transformational Therapy	YES	Patricia Bond
774	10/04/2024	Outside Employment	Philip Wykes	01/04/2024			2024/25	Yes	Consultant - Orthopaedics	Yes	Clinical Chair Circle Beaumont hospital	Circle health	YES	Francis Andrews
775	10/04/2024	Clinical Private Practice	Lisa TRUE	01/04/2024			2024/25	No	Highly Specialist Therapist - Podiatrist	No	Podiatry , Routine footcare	ACE FOOTCARE	YES	Julia Stell
780	10/04/2024	Outside Employment	Joleen Eden	01/04/2024			2024/25	Yes	Consultant Mammographer	Yes	Bank work ad hoc	Tameside and Glossop General Hospital	YES	Elizabeth Read
790	11/04/2024	Outside Employment	Kate Tempest	01/04/2024			2024/25	No	Newborn Hearing Screening Manager	No	On a Friday I work at Salford Audiology and have a clinic day as an assistant audiology practitioner.	Salford Audiology	YES	Martin Anderson
791	11/04/2024	Outside Employment	Angela Frackleton	01/04/2024			2024/25	No	Team Leader	No	Locum once per month as CT Radiographer outside of my contracted hours/days at this trust. Shifts take place at Glan Clywd in Wales.	Radiology Management Solutions	YES	Clare Hall
792	11/04/2024	Outside Employment	Joanne Price	04/04/2024			2024/25	No	Clinical Lead Paediatric Dietitian	No	Locum paediatric dietitian - remote	Guys and St Thomas's NHS Foundation Trust	YES	Louise Calland
793	11/04/2024	Outside Employment	Joanne Price	11/04/2024			2024/25	No	Clinical Lead Paediatric Dietitian	No	Tutor	Manchester Metropolitan University	YES	Louise Calland
795	11/04/2024	Outside Employment	Jessica Man	09/04/2024			2024/25	No	Optometrist Specialist	No	Locum optometrist work	Vision express/Stotts Opticians/Hakim Group	YES	Cara Burns
829	30/04/2024	Clinical Private Practice	Shakti Thakur	13/04/2024			2024/25	Yes	Consultant - Ophthalmology	Yes	Medical Retina and Valeda treatment	EyeMedics	YES	Lisa Sleight
830	30/04/2024	Outside Employment	Shakti Thakur	29/04/2024			2024/25	Yes	Consultant - Ophthalmology	Yes	Real World Data Symposium ; presentation of audit of our outcomes	Roche	YES	Lisa Sleight
832	01/05/2024	Outside Employment	Neil Harvey	01/04/2024	01/05/2024		2024/25	Yes	Consultant Urologist	Yes	Male LUTS pathway education (documents/guides and events); possibly preceptorship/proctorship in future. Currently <10 hours per year.	Olympus Medical	YES	Kayleigh Rew
839	01/05/2024	Loyalty Interests	Madeleine Szekely	01/04/2024			2024/25	Yes	Deputy Director of Digital	Yes	Trust has a partnership agreement in place with the supplier. Contract held by department and reviewed and agreed by procurement and trust secretary	Altera Digital	YES	Brett Walmsley
844	02/05/2024	Clinical Private Practice	Prabha Kushwaha	01/04/2024			2024/25	Yes	Consultant - Histopathology	Yes	Histopathology reporting	Backlogs limited	YES	Patrick Waugh
847	02/05/2024	Outside Employment	Hannah Durrant	01/05/2024			2024/25	Yes	Consultant - A&E	Yes	ad hoc TTL shifts	salford	YES	Scott Gregory
848	02/05/2024	Outside Employment	Hannah Durrant	01/05/2024			2024/25	Yes	Consultant - A&E	Yes	Doctor in the reserves, long standing	Army	YES	Scott Gregory
855	02/05/2024	Outside Employment	Shaista Meraj	01/04/2024			2024/25	Yes	Consultant Radiology	Yes	GMC PLAB 2 Examiner Started in Jan 2022 This system is not letting me backdate it	GMC	YES	James Lay
869	03/05/2024	Clinical Private Practice	Khwaja Khan	01/04/2024			2024/25	Yes	Consultant Radiology	Yes	Telereporting	Axon diagnostics Telereporting	YES	Amanda Law
870	03/05/2024	Shareholdings and other ownershi	Khwaja Khan	01/04/2024			2024/25	Yes	Consultant Radiology	Yes	nominal shares	hexarad	YES	Amanda Law
892	08/05/2024	Clinical Private Practice	Khaled Girgirah	01/04/2024			2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthesia	Different hospitals NHS and Private patients	YES	Victoria Davis
900	09/05/2024	Clinical Private Practice	Sara Pearson	01/04/2024			2024/25	No	Podiatrist	No	Podiatry treatment	Markland Therapy Centre	YES	Alison Spensley
901	09/05/2024	Clinical Private Practice	Michael McEvoy	01/04/2024			2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthesia for orthopaedic, general, ENT, breast and urological procedures	Spire Manchester Hospital	YES	Victoria Davis
902	09/05/2024	Shareholdings and other ownershi	Agapios Gkentzis	09/05/2024			2024/25	Yes	Consultant Urologist	Yes	Director in company. 50%	Gkentzis Urology LTD	YES	Kayleigh Rew
904	10/05/2024	Outside Employment	Jade Lau	21/04/2024			2024/25	No	Integrated Care Pharmacist	No	Locum pharmacist shifts, usually one Sunday 11am - 5pm each month	Tesco	YES	Susan Cook
907	10/05/2024	Outside Employment	Michaela Toms	10/05/2024			2024/25	Yes	Divisional Nurse Director	Yes	Providing expert legal advice related to nursing issues	McCollum Consultancy	YES	Stephanie Clarke
908	10/05/2024	Outside Employment	Dawn Murray	10/05/2024			2024/25	Yes	Divisional Nurse Director	Yes	Negligence Report Writing	McCollum Consultants	YES	Ryan Calderbank
909	13/05/2024	Outside Employment	Clare Lomax	09/05/2024			2024/25	Yes	Divisional Nurse Director	Yes	Legal expert witnesses	Mccollom consultants	YES	Alex Cottrell
914	14/05/2024	Outside Employment	Ruth Eaves	14/05/2024			2024/25	No	Medical Illustration Manager	No	I have produced some medical art work for some books which are to be published. I received no payments for this artwork as the client is my friend. I did not produce the artwork during my Bolton FT contracted hours, and I produced them in my own personal time, at home.	A personal friend	YES	Marc Selby
916	14/05/2024	Outside Employment	Munatsirei Mandangu	01/04/2024			2024/25	No	Highly Specialist Therapist - Podiatrist	No	Associate Podiatrist- attends to do clinics as and when requested on Mondays and Saturdays.	Monton Podiatry	YES	Julia Stell
917	14/05/2024	Clinical Private Practice	Munatsirei Mandangu	20/04/2024			2024/25	No	Highly Specialist Therapist - Podiatrist	No	N/A	Feet First Podiatry Bolton	YES	Julia Stell
932	23/05/2024	Clinical Private Practice	Vikki Garner	01/04/2024			2024/25	No	Podiatrist	No	Routine Podiatry	Markland Therapy Centre Podiatry	YES	Julia Stell
954	03/06/2024	Shareholdings and other ownershi	Zainulabedin Patel	03/06/2024			2024/25	Yes	Consultant - A&E	Yes	increased numbers owned to total 110	GSK	YES	Maria Papaioannou-Moran
956	04/06/2024	Shareholdings and other ownershi	James Young	04/06/2024			2024/25	Yes	Consultant - Ophthalmology	Yes	12 Type A Shares	Manchester West Newmedica Ltd	YES	Lisa Sleight
961	05/06/2024	Clinical Private Practice	George Palmer	25/05/2024			2024/25	No	Physiotherapist	No	Physiotherapist	T4 Physiotherapy Clinic	YES	Richard Bent
963	10/06/2024	Loyalty Interests	Emma Wheatley	10/06/2024			2024/25	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Assessing and treating patients with physiotherapy needs Team member of MRT	Rossendale and Pendle Mountain Rescue Service	YES	Gareth Hughes
964	10/06/2024	Outside Employment	Emma Wheatley	03/06/2024			2024/25	Yes	Clinical Lead Consultant - Anaesthetics	Yes	Appraisals for doctors who do not work within the NHS	MIAD Healthcare	YES	Gareth Hughes
###	21/06/2024	Outside Employment	Jessica Man	11/06/2024			2024/25	No	Optometrist Specialist	No	Optometry work in independent practice	Paul Cheetham Eyecare/ Hakim Group	YES	Rachel Brierley
###	02/07/2024	Outside Employment	Charlotte MacKinnon	02/07/2024			2024/25	No	General Practitioner	No	Named Professional for primary care, safeguarding children	GM ICB (Bolton)	YES	Rosie Connor
###	02/07/2024	Outside Employment	Charlotte MacKinnon	01/04/2024			2024/25	No	General Practitioner	No	Foster Panel Medical Advisor	GM ICB Stockport	YES	Gabrielle Lipshen
###	03/07/2024	Clinical Private Practice	Michelle Sharpe	01/04/2024			2024/25	No	Advanced Practitioner Medical Ultrasoun	No	Perform and report ultrasound scans	ATLAS diagnostics	YES	Christopher Honor
###	03/07/2024	Clinical Private Practice	Zeeshan Malik	29/06/2024	03/07/2024		2024/25	Yes	Consultant - Anaesthetics	Yes	Provision of Anaesthetic Services	ZAN Gasworks	YES	Victoria Davis
###	03/07/2024	Outside Employment	Zeeshan Malik	02/07/2024	03/07/2024		2024/25	Yes	Consultant - Anaesthetics	Yes	Variable Hours Tutor delivering teaching session at Bolton University	Bolton University	YES	Gareth Hughes
###	09/07/2024	Outside Employment	Louise Davies	01/04/2024			2024/25	No	Medical Laboratory Assistant	No	Skin Clinic, Blemish removal and skincare/ skin treatments. On my non hospital days. I have ran the clinic since 2018.	Self	YES	Karina Hambridge
###	09/07/2024	Clinical Private Practice	Kanekal Srirangadarshan	01/04/2024	09/07/2024		2024/25	Yes	Consultant - Anaesthetics	Yes	Anaesthetics	Individual	YES	Lucy McManamon
###	16/07/2024	Outside Employment	Lynn Jackson	16/07/2024			2024/25	No	AD of Nursing Lead for Qual & Patient Sal	No	Consultancy	McCollum Consultants	YES	Dawn Murray
###	16/07/2024	Outside Employment	Ling Keim Lee	01/04/2024			2024/25	Yes	Consultant Urologist	Yes	I have a LLP (LLee Urology Ltd) and I carry out NHS work on the LLP list	Limited Liability Partnership	YES	Kayleigh Rew
###	23/07/2024	Loyalty Interests	Alison Westhead	01/04/2024			2024/25	No	Business Support Administrator	No	My husband, Mr Jonathan Westhead is a Director of Abex Power Components	Abex Power Components	YES	Paul Bridge
###	23/07/2024	Outside Employment	Ambar Basu	23/07/2024			2024/25	Yes	Medical Consultant	Yes	A stepwise approach to lipid management; GP educational meeting; held on 14/9/2023	Daiichi Sankyo UK Ltd	YES	Simmi Krishnan
###	07/08/2024	Outside Employment	Ilze Zommere	01/04/2024			2024/25	Yes	Specialty Doctor - Obs & Gynae	No	Fertility treatment, I have been undertaking a professional development training with this organisation as A Honorary Clinical Fellow	Care Fertility Manchester	Pending	Nadia Ali-Ross
###	08/08/2024	Outside Employment	Kristopher Booth	08/08/2024			2024/25	No	Team Manager (ODP)	No	outsourcing for theatre	LLP	YES	Mark Dixon
###	08/08/2024	Outside Employment	Niamh Brockenshaw	08/08/2024			2024/25	No	Matron-Senior Nurse	No	Theatre outsourcing	LLP	YES	Mark Dixon
###	12/08/2024	Outside Employment	Surabhi Wig	06/07/2024			2024/25	Yes	Consultant Rheumatologist	No	Bank locum rheumatologist for WLI clinics only . Weekend work only and does not impact on my Bolton NHS work at all . So far delivered clinics on 6th and 7 th July and 4th Aug	Mid Cheshire hospital NHS trust	Pending	Robert Stell
###	13/08/2024	Outside Employment	Jodie Ardern	30/07/2024			2024/25	No	Physiotherapist Specialist	No	Pitch side physio for football team	FC Isle of Man	YES	Tejal Patel
###	13/08/2024	Outside Employment	Nicole Chapman	01/04/2024	13/08/2024		2024/25	No	Physiotherapist	No	Casual Sport Rehabilitator/Physiotherapist for Manchester City FC Academy providing trauma pitchside assessment/treatment/pre hospital emergency care, also providing assessment and treatment/rehabilitation programmes for ages 9-16's in regards to MSK injuries. Normally provide cover on weekday evenings for rehab and weekend cover for games.	Manchester City FC	YES	Tejal Patel
###	13/08/2024	Clinical Private Practice	Mick Mitchell	11/05/2024			2024/25	No	Physiotherapist	No	MSK physiotherapy	SP Physiotherapy	YES	Tejal Patel

###	14/08/2024	Outside Employment	Zaheda Gani	14/07/2024	2024/25	No	Specialist Occupational Therapist	No	carer for my family member around work hours	bolton council	YES	Susan Bannister
###	15/08/2024	Outside Employment	Claire Jones	01/04/2024	2024/25	No	Specialist Physiotherapist	No	Personal Training, Sports massage, Physiotherapy	Self employed - Insync Personal Training	YES	Louise Macklin
###	16/08/2024	Outside Employment	Heather Butterworth	03/07/2024	2024/25	No	Physiotherapist Specialist	No	self employment - private physiotherapy at client's own home outside of contracted NHS hours	self employment	YES	Anna Jeary
###	19/08/2024	Outside Employment	Heather Aspbury	01/04/2024	2024/25	No	Physiotherapist Advanced	No	Lecturer	Bolton University	YES	Tejal Patel
###	19/08/2024	Clinical Private Practice	Ashok Bardewa	01/06/2024	2024/25	No	Podiatrist	No	Routine Foot care	Heywood Foot and Leg Clinic	YES	Julia Stell
###	21/08/2024	Clinical Private Practice	Benjamin Odusanya	26/05/2024	2024/25	Yes	Consultant Locum with Hours - Urology	Yes	urology minor procedures only - vasectomy, circumcision	Excellenceaid ltd	YES	Ling Keim Lee
###	28/08/2024	Outside Employment	Hannah Whittaker	01/04/2024	2024/25	No	Clinical Lead Paediatric Dietitian	No	Own business in paediatric dietetics	Bump2baby Nutrition LTD	YES	Louise Calland
###	28/08/2024	Clinical Private Practice	Hannah Whittaker	01/04/2024	2024/25	No	Clinical Lead Paediatric Dietitian	No	Own private practice in paediatric dietetics	Bump2baby Nutrition LTD	YES	Louise Calland
###	28/08/2024	Outside Employment	Hannah Whittaker	01/04/2024	2024/25	No	Clinical Lead Paediatric Dietitian	No	NHS remote working for alternative trust	Merseycare NHS Foundation Trust	YES	Louise Calland
###	28/08/2024	Outside Employment	Paul Brooker	01/08/2024	2024/25	No	Head of Payroll and Pension Services	No	Outside Leisure for Festivals and Parties (bouncy castles)	Self Employed - Financial Interest in a compar	YES	Matthew Greene
###	28/08/2024	Outside Employment	Andrew Kneebone	24/04/2024	2024/25	No	Nurse Consultant	No	30min Presentation on BSM for IBD Nurses (Online/educational meeting)	Takeda	YES	Dawn Murray
###	02/09/2024	Outside Employment	Niruban Ratnarajah	01/09/2024	2024/25	No	Chairman	No	Lead for Strategy and GP Placements	University of Bolton Greater Manchester	YES	Fiona Noden
###	02/09/2024	Outside Employment	Syed Naqvi	01/04/2024	2024/25	Yes	Consultant Locum with Hours - Ophthalm	Yes	I do occasional sessions with eye care providers like SpaMedica or CHEC, NHS cataract surgery providers. I utilise my free session only and i also make it sure it does not interfere with my NHS work.	work through limited company	YES	Lisa Sleight
###	03/09/2024	Outside Employment	Uchenna Ozo	28/08/2024	2024/25	Yes	Consultant - Cardiology	Yes	Covering catheter labs	MFT	YES	Karen Lipscomb
###	09/09/2024	Clinical Private Practice	James Young	29/07/2024	2024/25	Yes	Consultant - Ophthalmology	Yes	I work there as a consultant Ophthalmologis in clinic and theatre.	NewMedica Manchester West	YES	Bethany Speakman
###	13/09/2024	Outside Employment	Mohammed Bhana	22/07/2024	2024/25	No	Reporting Radiographer	No	Bank work.	Ramsay Health	YES	Clare Hall
###	13/09/2024	Outside Employment	Mohammed Bhana	22/08/2024	2024/25	No	Reporting Radiographer	No	Bank work.	Digital Autopsy	YES	Clare Hall
###	23/09/2024	Clinical Private Practice	Graham Hastie	13/08/2024	2024/25	Yes	Consultant - Orthopaedics	Yes	Trauma and orthopaedics, Hip/knee replacement	BMI Beaumont	YES	Katherine Beh
###	23/09/2024	Outside Employment	Moez Zeiton	01/07/2024	2024/25	Yes	Consultant Ortho Surgeon with SI in Low	Yes	Private practice at The Beaumont Hospital (Circle Health Group)	Circle Health Group	YES	Katherine Beh
###	02/10/2024	Clinical Private Practice	Abimbola Williams	01/07/2024	2024/25	Yes	Consultant - Obs & Gynae	No	gynaecology vaginal and abdominal surgery	cheshiregynaecologist	Pending	Nadia Ali-Ross
###	02/10/2024	Outside Employment	Hannah Richards	01/04/2024	2024/25	Yes	Consultant - A&E	Yes	Zero hour contract Match Day Crowd Doctor.	MCFC	YES	Hannah Durrant
###	11/10/2024	Loyalty Interests	Danielle Chivers	27/09/2024	2024/25	No	Clerical Officer	No	I shared that I've started a TikTok account and possibly in the future I may be featured in promotions by brands. The brands could send me products to review. If anyone purchases the product via my video I may receive a small commission. However that being said I haven't had any income from TikTok to date. This isn't an additional income at the moment.	TIKTOK	YES	Lynn McNeill
###	24/10/2024	Outside Employment	Shannon Scaife	24/10/2024	2024/25	No	Student SCPHN Health Visitor Apprentice	No	NHS professionals bank staff with MFT	NHS professionals	YES	Angela Downham
###	30/10/2024	Outside Employment	Katie Ryan	04/10/2024	2024/25	No	Team Leader	No	Ad hoc bank work, MRI scanning	The Christie NHS FT	YES	Clare Hall
###	01/11/2024	Loyalty Interests	Aboobaker Makki	01/04/2024	2024/25	No	Specialist Adolescent H&W Practitioner	No	i am the treasurer of Flowheasion foundation. its is a charity. i have never and will never receive any income or financial gain from Flowheasion. i have no relatives who work for Flowheasion. i have recently block booked a room at flowhesion for a course the team are completing., i did try to book elsewhere but was unable. the room was much cheaper than other places. My conflict of interest is i am booking a room for the NHS for a charity i am the treasurer for. i would not do this if other rooms were avaivable to block book. as well as this the rooms are considerably cheaper than the other rooms i have tried to book.	Flowheasion foundation	YES	Margaret Clugston
###	04/11/2024	Outside Employment	Jack Green	30/09/2024	2024/25	No	Digital Trainer	No	Board game company - I demonstrate board games occasionally on an ad-hoc basis.	Asmodee	YES	Sharon Lythgoe
###	05/11/2024	Outside Employment	Olivia Darby	01/08/2024	2024/25	No	Assistant Practitioner	No	I have been employed by Boots UK on a rolling 2 - 3 month contract to be a User Generated Content creator. I use my knowledge and expertise as a Sports Nutritionist to provide content in video form to inspire the general public to become healthier through exercise and nutrition. I provide on average one video per month to Boots UK where I plan my time accordingly to film and edit during week day evenings, days off from work and on the weekend; so my work for Bolton FT is not effected.	Boots UK	YES	Louise Calland
###	06/11/2024	Outside Employment	Laura O'Neill	06/11/2024	2024/25	No	Workforce Deployment Administrator	No	I make organic, raw and pure natural skincare and beauty products.	Own business; Homemade Happy	YES	Charlotte Coleman
###	06/11/2024	Outside Employment	Deborah Saleh	01/04/2024	2024/25	Yes	Specialty Doctor - Paediatrics	Yes	1. I work as a Consultation Skills Tutor on a sessional basis for the University of Manchester since Sept 23. I do 1-2 sessions per week, only in term times. I have a Casual Appointment contract. It is paid at £60/hr, directly from the university. I provided this information to my department and documented it in my last appraisal. 2. I was appointed 30/10/24 to a new post - Senior Lecturer in Medical Education at the University of Manchester. It is a substantive post, for 12 months in the first instance, 1 session per week, paid through Bolton trust payroll and then reimbursed for the whole year by the university. I do not have a start date yet. I obtained permission from my Divisional MD Dr S Moss before application and have updated her on my appointment.	University of Manchester	YES	Susan Moss
###	07/11/2024	Outside Employment	Claire Bailey	01/04/2024	2024/25	No	Programme Manager	No	I am Governor at Saint Bernard's Primary School Bolton I am lead for health and safety and finance	Governor at Primary School	YES	Shirley Whittaker
###	11/11/2024	Outside Employment	Mark Haworth	11/11/2024	2024/25	No	Community Nurse	No	Support work role with an autism support service.	Time Specialist Support Limited	YES	Gillian Finnigan
###	26/11/2024	Clinical Private Practice	Rebecca Dunn	01/04/2024	2024/25	No	Highly Specialist Occupational Therapist [	No	Associate rehabilitation occupational therapist	Rehabilitate therapy	YES	Susan Bannister
###	29/11/2024	Outside Employment	Jack Waddington	28/11/2024	2024/25	No	Staff Nurse	No	Voluntary role within the gym to facilitate safe gym classes and 1-2-1 use of equipment. Instructing and maintaining safety during classes and 1-2-1 fitness within the gym setting. I have got qualifications for Personal Training but have not utilised these since qualifying and I am only going to be completing a voluntary instructing and safety post.	Big G's Gym	YES	Rachel Taylor
###	03/12/2024	Clinical Private Practice	Richard Simpson	01/09/2024	2024/25	Yes	Consultant Urologist	Yes	Core urology - theatre, clinic, procedure room.	Complete Healthcare Solutions - NHS in sourc	YES	Kayleigh Rew
###	10/12/2024	Outside Employment	Nashir Uddin	10/12/2024	2024/25	No	Senior Therapy Assistant	No	Coffee shop barista	Hot chaii LTD	YES	Thomas Allerton

###	10/12/2024	Outside Employment	Hadeeqa Zafar	10/12/2024	2024/25	No	Enhanced Practice Radiographer	No	Awaiting Contract signage.	Red Rose Healthcare	YES	Clare Hall
									Plain film radiographer			
###	19/12/2024	Outside Employment	Salma Ashrafi	19/12/2024	2024/25	No	Audiologist	No	Complete hearing tests and tympanometry for Rotherham NHS ENT clinic.	HBSUK	YES	Laura Lomas
###	19/12/2024	Outside Employment	Gulafrose Saiyed	19/12/2024	2024/25	No	Audiologist	No	Completing hearing test and tympanometry test for Rotherham NHS ENT clinic	HBSUK	YES	Laura Lomas
###	02/01/2025	Clinical Private Practice	Abhijit Sinha	02/01/2025	2024/25	Yes	Consultant - Anaesthetics	Yes	Orthopaedics,ENT,Gynae	Spire Manchester	YES	Victoria Davis
###	08/01/2025	Clinical Private Practice	Andrew Stewart Mockrid	01/04/2024	2024/25	Yes	Locum Consultant	No	HEMS/Pre-hospital emergency medicine work for an air ambulance charity - done since prior to employment with RBH	The Air Ambulance Service (TAAS) Charity	Pending	Lucy McManamon
###	16/01/2025	Outside Employment	Alicia Stonefield	01/04/2024	2024/25	No	Sexual Health Nurse	No	Aesthetics and beauty treatments	Self employed	YES	Margaret Clugston

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		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

Our Endoscopy service has been recognised for providing high quality consistent care to patients. The Joint Advisory Group (JAG), which carries out an annual assessment of endoscopy services to ensure high quality care is provided, has awarded accreditation until April 2026. JAG accreditation provides independent and impartial recognition that a service demonstrates high levels of quality, meaning patients can feel confident in their endoscopy service and be assured of receiving great care.

Two of our specialist nurses have been highlighted and honoured by a patient for the exceptional quality of care and treatment they delivered. The UK heart failure charity, Pumping Marvellous Foundation, presented the 'You're Simply Marvellous' award to acknowledge the work happening to treat heart failure and improve patient outcomes. The awards are measured by patients' experience, and reflect the direct impact outstanding healthcare professionals have in the local community by producing the highest standard of care.

Two nurses who provided urgent care to a man experiencing a heart attack have received a heartfelt thank you, one year on from their life-saving actions. The patient attended Waters Meeting Health Centre in the hope of finding help after experiencing chest pain while travelling to a family wedding. Two of our nurses provided urgent care in the community ensuring that Michael received the care that he needed in hospital. Our staff were pleased to hear that one year on he is well and has transformed his life with healthier eating and more exercise, with the support of his friends and family.

Our services have been named number one in the country for the accuracy of tests carried out in breast screening in an annual Breast Screening Pathology Audit. These results recognise the importance of ensuring patients receive correct treatment at the earliest opportunity. Good performance in the audit requires excellent working across a number of teams and specialties, from good radiology assessments and biopsies to good pathology interpretation. The full audit is available to read online.

Our Trust is leading national rankings for delivering faster cancer diagnosis and improving patient experience. The latest figures from NHS England's '28-day Faster Diagnosis Standard performance' in December 2024 show that 90.9% of patients received their results within the national timeframe and 86.7% in January 2025.

Performance results also show that we were second in the country for the 62-day referral to treatment standard in December 2024, and have consistently remained in the top ten throughout 2025 so far. In reality for patients this means that there are more people being diagnosed within 28 days and receiving treatment within 62 days compared to the same periods in 2023.

One of the improvements that has contributed towards our cancer diagnosis performance is a new triage process in colorectal, which sees a telephone conversation with a Clinical Nurse Specialist (CNS) to determine the most appropriate pathway and get people the help they need, as quickly as possible.

Ambition 2: A great place to work

Our teams continue to embrace the opportunity to use awareness days to highlight important causes or celebrate their professions.

International Nurses Day gave us an opportunity to celebrate the hard work and dedication of our nurses and shine a spotlight on the incredible difference they make to our Bolton communities. Some of our staff shared what inspired them to become nurses and what they love about providing care to our patients. In return, a dedicated page was set up by Our Bolton NHS Charity for people to leave heartfelt words, with the aim of boosting staff morale and reminding them why their work matters so much.

The celebrations continued when children from Kearsley Academy, High Meadows Nursey and our children's ward also gathered to mark the occasion by planting flower seeds on the grounds at Royal Bolton Hospital. A special service was also held in the hospital's Chapel to celebrate our nurses, featuring prayers and the traditional passing of the lamp between nursing staff.

Administrative Professionals Day highlighted the hard work of our administration and clerical colleagues. How our teams work has changed so much over the years, and will continue to be shaped by developments in technology and the changing landscape of the NHS. Our administration teams are often working behind the scenes to play a vital role in making sure that everything is lined up for our patients to receive the care they need.

International Day of the Midwife provided a great opportunity to celebrate the work of our midwives who provide vital care to babies and families in and around Bolton. Our latest figures show that between March 2024 and March 2025, our midwives helped to deliver 5,047 babies.

We have also celebrated Operating Department Practitioner Day which enabled our teams to reflect on why they are passionate about the jobs they do, and the incredible difference they make to our patients and families.

We have worked through the 2024 NHS Staff Survey results alongside other Trust wide listening mechanisms and used to feedback to shape and refresh phase two of Our Voice Change Programme. The programme is in place to ensure that we address the issues that matter most to our colleagues, fostering a more inclusive and effective working environment.

As well as reflecting the latest key themes from staff, the second phase will seek to ensure that unheard voices are heard, and that staff at all levels feel able to get involved in driving positive change if they wish. Following the feedback from staff, a recommendation has been made to change the areas of focus to living our values, everyday essentials, digital systems and equipment, and our care. Further refinement of the change teams will take place in the coming months and the names of each key theme will be determined by our staff.

Ambition 3:
A high performing, productive organisation

As part of a commitment to providing high-quality services, we have been reminding patients how important having up to date contact details is when it comes to receiving timely updates about appointments, test results, and treatment plans. Making sure we have accurate data in our electronic patient record and maintaining the correct patient details on our systems also supports our healthcare professionals make the best decisions possible for our patients.

As well as their contact details, our patients are encouraged to keep their diversity details, such as disability status, ethnicity, religion, and sexual orientation, up to date too. This helps ensure care is tailored to their individual needs and enables us to better understand and meet the needs of the communities we serve.

Work has continued to respond to the national measures being taken to address the NHS' finances. As a provider organisation we must deliver against national standards and targets and alongside this, we must reduce our costs to deliver better value for money for the tax-payer.

However, financial challenge does not mean that we will compromise the quality and safety of the care we provide. Our financial improvement programme is underpinned by a robust quality and inequality impact assessment framework, with all schemes reviewed by our medical director and chief nursing officer, to reduce the impact on the quality of care we provide.

As part of our plans, we will be pursuing opportunities to transform our clinical services so that they are delivered in the right place and in a way that is better for the people who use them, and more cost effective to deliver.

NHS England has shared the first version of the Model Integrated Care Board Blueprint with ICB leaders. The document is intended to help ICBs produce plans by the end of May to reduce their running costs by 50%. It sets out an initial vision for ICBs as strategic commissioners, and the role they will play in realising the ambitions of the 10 Year Health Plan. NHS England expects to carry out further engagement over the coming weeks, including with providers such as ourselves, to embed local plans.

The blueprint sets out the three shifts in our collective approach to healthcare delivery - from treatment to prevention, from hospital to community and from analogue to digital.

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

The transformation of our Urgent Care Services is underway. In order to keep services running as building work progresses, the pedestrian access for the Emergency Department (ED) has been relocated to a temporary modular building outside of the entrance. Whether arriving by foot, car or taxi, patients are required to use the new reception where they will be assessed by clinicians, before being seen at the appropriate department, if required.

To support with the changes being made, we are also implementing a one-visitor policy, which asks all those attending the ED to only bring a maximum of one person with them. We greatly appreciate the support we have received as we continue to make changes to our department and services as quickly as possible.

Artificial Intelligence (AI) technology is being deployed to speed up the diagnosis of skin cancer and free up capacity within our dermatology service. DERM, by Skin Analytics, assesses and classifies scans of moles or skin lesions that have been taken by a healthcare professional, after patient is referred by a GP for suspected skin cancer. The AI medical device is trained to classify the most common malignant, pre-malignant and benign skin lesions. Benefits of the technology include reduced caseloads for dermatologists by removing patients with benign lesions and fast-tracking patients with suspected malignant or premalignant lesions who require treatment.

The Trust's Artificial Intelligence (AI) policy is in development and will be shared with all staff in due course to ensure our teams and services are making the best possible use of the technology we have available.

We have been awarded some new solar panel funding which allows us to continue to introduce sustainable infrastructure that reduces our carbon footprint and delivers on the plan of action set out in our Green Plan. The Department for Energy Security and Net Zero has announced a package of £100 million from Great British Energy for the NHS to install solar power and battery storage solutions to help drive down energy bills, offering better value for the taxpayer. As part of this groundbreaking new funding we have been allocated more than £300,000 to install 310 solar panels across our Royal Bolton Hospital site.

This month we celebrated the official groundbreaking of the maternity and women's health unit re-development at Royal Bolton Hospital. We joined colleagues from our construction partner and specialist contractor, Robertson, at a ceremonial event to mark the work on site beginning, following a period of enabling works.

The project is being funded by NHS England following the identification of reinforced autoclaved aerated concrete (RAAC) in the existing structure in 2023. The new unit will provide state-of-the-art facilities for women, babies, and families across Bolton and beyond, including a new birthing suite, triage area and gynaecology and early pregnancy unit. Work is expected to be completed in early 2027.

Maternity services remain fully open while the works are ongoing, including all antenatal and postnatal care. Women's health services continue to be run from a separate part of the hospital, and from Lever Chambers Health Centre.

Ambition 5: A positive partner

Our staff have been shortlisted for three awards at the Greater Manchester Health and Care Champion Awards 2025.

The Intravenous (IV) Therapy Team are finalists in the Green Initiative of the Year category for their work to provide care to some patients in their own home environment using elastomeric devices, which

are a greener way forward for administration of antibiotics. The devices allow nurses to only visit patients once a day, instead of three to four times a day.

Since January 2023, the team has used 2,678 less plastic bottles, 4,172 less plastic syringes, 2,678 less plastic giving sets, 4,172 less disposable plastic bags, 4,172 less plastic aprons and 8,344 less gloves. They have saved more than 10,000 miles of travelling, the equivalents of three tonnes of CO2 emissions.

Tyrone Roberts, Chief Nursing Officer, was nominated in the Wellbeing Champion category for launching a free personal training and nutrition programme, which has been delivered to more than 80 colleagues at the Trust. Tyrone has completed qualifications in fitness instruction and personal training with the sole purpose of supporting the health and wellness of his colleagues, tailoring sessions to be inclusive of colleagues working different shift patterns.

Sabana Bhikha, Practice Educator and Neonatal Nurse, was also nominated in the Wellbeing Champion category for her strong passion for wellbeing and ensuring everyone's mental health is prioritised, working tirelessly to boost moral.

Westfield Health has awarded thousands of pounds' worth of grant funding to Our Bolton NHS Charity to fund sleeper chairs for parents and carers who are staying in hospital with a poorly child. The grant from Westfield Health's Giving Back Committee, worth more than £3,000, will allow the charity to purchase three sleeper chairs in the High Dependency Unit (HDU), helping thousands of parents and carers every year to get a better quality sleep and support their physical and emotional resilience. The new chairs can be positioned upright as armchairs during the day and easily converted into beds in the evening.

Our school age immunisation service is now provided by Intrahealth NHS Greater Manchester alongside all other teams in the Greater Manchester locality. The service to children and young people will not alter, and a Bolton team will continue to deliver the full offer of school age vaccinations to Bolton schools.

AO.com have kindly donated a fridge freezer and radio for hard working and dedicated staff working at Royal Bolton Hospital. The donation from the electrical retailer, which is based in Bolton, installed the items in the rest area for staff working on the Acute Medical Unit 1 (AMU1). This unit is the next step following on from the Emergency Department and is extremely busy supporting patients in need of high levels of care.

The donation came after members of the team were looking to purchase new appliances with their own funds and approached AO.com for the best deal. The Smile team at AO.com decided to go one step further and offered to donate the fridge freezer and radio free of charge. The equipment was delivered in time for International Nurses Day on Monday 12 May, to highlight the critical role a healthy workforce plays in improving services and ensuring better outcomes for our communities.

Around the Bank Holiday periods, we have been sharing advice to help people get to know where to go for healthcare. NHS services traditionally see a rise in demand during bank holidays, with an increase in the number of people attending urgent care services. Knowing where to go for medical help can save people time and ensure they get the right care as quickly as possible.

Our Emergency Department is always here to help anyone in a life or limb-threatening condition and we will always prioritise those who are most ill to make sure they get the life-saving care they need. All people who are unsure about their condition are encouraged to contact NHS 111 online or by phone. The service is able to help with non-urgent health conditions and provide advice on where to get help.

Report Title:	Modern Anti-Slavery Statement			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	The Anti-Slavery and Human Trafficking Statement for 2024/25 provides assurance on the Trust's compliance with the Modern Slavery Act 2015.

Previously considered by:	The report was received by the Audit and Risk Committee at the 07 May 2025 meeting.

Executive Summary	The Trust, like all UK businesses with a turnover of £36m or more is required to complete a slavery and trafficking statement for each financial year. The Trust is committed to ensuring that there is no modern slavery or human trafficking in its supply chains or in any part of its business. All internal policies replicate the Trust's commitment to acting ethically and with integrity in all our business relationships. The statement supports the requirements of the Modern Slavery Act 2015 and will be published on the Trust website. Additionally, the statement will be included in our Annual Report for 2024/25.

Proposed Resolution	The Board of Directors are asked to **approve** the Anti-Slavery Statement as assurance of compliance with the Modern Slavery Act 2015.

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**	Financial sanctions including liability for legal costs
Legal/ Regulatory	**No**	Non-compliance with legislation could lead to a High Court Injunction
Health Inequalities	**No**	Could potentially result in a widening of the Health Inequality within community served
Equality, Diversity and Inclusion	**No**	Could potentially leady to unfair and unequal access, experience, and outcomes for all, including those with diverse backgrounds, experiences, and cultures.

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

1. Introduction

1.1. In line with requirements of the Modern Slavery Act 2015, this paper sets out the Bolton NHS FT, including its wholly owned subsidiary Integrated Facilities Management (IFM) Anti-Slavery and Human Trafficking Statement for 2024/25 to the Board for approval.

1.2. The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). It includes a provision for large businesses to publicly state each year the actions they are taking to ensure their supply chains are slavery free.

1.3. The 'slavery and human trafficking statement' must include either an account of the steps being taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any part of its business or its supply chains. Or a statement that the organisation is not taking any such steps (although this is permitted under the Act, it is likely to have public relations repercussions).

1.4. The statement must be formally approved by the organisation, and must be published on its website. Failure to do so may lead to enforcement proceedings being taken by the Secretary of State by way of civil proceedings in the High Court.

2. Modern Slavery and Human Trafficking Act 2015 Annual Statement 2024/25

2.1. All organisations carrying on business in the UK with turnover of £36m or more must from October 2015 complete a slavery and human trafficking statement for each financial year.

2.2. Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

3. Aim of this Statement

3.1. Slavery and human trafficking in global society remains a hidden blight.As an NHS provider, the Trust is committed to upholding the provisions of the Modern Slavery Act 2015 with an expectation that all staff and suppliers comply with the legislation.

3.2. The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking. All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

4. About Us

4.1. Bolton NHS Foundation Trust is a major provider of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital and also providing a wide range of community services from locations across Bolton.

4.2. The Royal Bolton Hospital is a major hub within Greater Manchester for women's and children's services and is the second busiest ambulance- receiving site in Greater Manchester. We employ approximately 6000 staff and in 2024/25 had a turnover of over £400m.

5. Organisational policies in relation to slavery and human trafficking.

5.1. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

5.2. **Recruitment policy:** We operate a robust recruitment policy including conducting eligibility to work in the UK checks for all directly employed staff. External agencies are sourced through the NHS England nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

5.3. **Safeguarding Policies:** All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking. All staff are required to undertake level one adult safeguarding training which includes an awareness of the risks of modern slavery and human trafficking.

5.4. **Raising Concerns (Whistleblowing) Policy:** We operate a whistleblowing policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

5.5. **Equal Opportunities:** We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all statutory and regulatory requirements. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

5.6. These and other internal policies are in place, to protect those that we, and our delivery partners, work with from modern day slavery and human trafficking ensuring that:

- Staff can report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.
- All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices.
- Staff are able to raise concerns through the Freedom to Speak Up Guardian, about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisal.
- Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team.

6. Organisational Structure and Supply Chains

6.1. The Trust policies, procedures, governance, and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our subsidiary organisation iFM Bolton and through any managed service provider contract arrangements.

6.2. The treatment of employees is managed consistently across the Trust by the Human Resources Directorate. The Trust pays above both the national minimum wage and the national living wage thresholds set by the Government.

6.3. To play our part in eradicating modern slavery and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Apply NHS Terms and Conditions for procuring goods and services (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.
- Comply with the Public Contracts Regulations 2015, use reputable frameworks where appropriate and for any procurement processes the Trust uses the mandatory Crown Commercial Services (CCS) Standard Selection Questionnaire. Bidders are always required to confirm their compliance with the Modern Slavery Act.
- Ask our awarded suppliers to, sign up to the NHS Terms and Conditions for procuring goods and services which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains.
- In addition, an increasing number of NHS suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories, as referenced in the Government's Modern Slavery Strategy.

- All new suppliers are now required to declare whether they are classed as a relevant commercial organisation and confirm their organisation's compliance with the annual reporting requirements contained with Section 54 of the Modern Slavery Act 2015.
- All new suppliers are now required to confirm whether they qualify as a relevant commercial organisation and thus state if they comply with the annual reporting obligations under the same Section 54 of the Modern Slavery Act 2015.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2025.

Fiona Noden

Chief Executive

29 May 2025

Report Title:	Compliance with Fit and Proper Person's Test			
Meeting:	Board of Directors' Meeting	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	The FPPT Report provides an overview of the Fit and Proper Persons requirements and confirms full compliance ahead of submission of the annual declaration to the regional team.

Previously considered by:	The report was presented to the Audit and Risk Committee as assurance of the Trust's Compliance with FPPT Framework

Executive Summary	The report sets out the statutory requirements of the Fit and Proper Person Test FPPT and the enhancements introduced by the NHS England FPPT Framework. It confirms the Trust's adherence to the FPPT Framework ensuring that director-level appointees are suitable for their positions according to established regulations. The Trust policy, which is aligned with the FPPT Framework, mandates that directors must have good character, appropriate qualifications, competencies, skills, and experience, and must not have a history of serious misconduct or mismanagement. The report provides assurance that the Trust has systems in place to ensure that only individuals who meet the FPPT standards are hired for director roles and there are processes for ongoing compliance with the FPPT through robust governance and oversight mechanisms. The Chair will consider if all directors meet the 'fit and proper' criteria, and this will be reported in the NHS England Annual Review for 2025/24. Updates following the appraisals will be provided to the Remuneration and Nominations committees of the Board and Council of Governors.

Proposed Resolution	The Board of Directors are asked to **receive** this report as assurance of the Trust's Compliance with FPPT Framework

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**	Completing this annual review provides assurance of the Trust's compliance with the FPPT requirements.
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. Background

1.1. The Fit and Proper Person's Test is set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities). The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Tests' for Directors in November 2014, which became law from 1 April 2015.

1.2. Whilst the legislation remains unchanged, the NHS England Fit and Proper Person Test (FPPT) Framework supports compliance with the legislation and introduces additional checks and balances to ensure directors satisfy regulatory requirements.This approach ensures that providers meet Government regulations about the quality and safety of care, to ensure there's an open, honest and transparent culture within the NHS.

1.3. The FPPT was developed in response to the recommendations made by Tom Kark KC and ensures that providers meet their obligations to only employ individuals who are fit for their role. The Trust adopted the FPPT Framework and can confirm compliance with the FPPT Framework.

1.4. The FPPT framework applies to individuals disqualified from holding office (e.g. under a Director's Disqualification Order). At Bolton NHS Foundation Trust, the FPPT is embedded through a comprehensive policy and governance structure, including:

- A dedicated Fit and Proper Person Policy and FPPT Report Template.
- Annual board-level reviews and reporting to NHS England.
- Integration with recruitment, appraisal, and board assurance processes

2. Fit and Proper Person Test (FPPT) Compliance

2.1. It remains the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

2.2. The Director of Corporate Governance maintains the Trust's register to support compliance with the Fit and Proper Person Test (FPPT)

2.3. **Core Eligibility Criteria for Directors**

Trusts must not appoint a person to an executive or non-executive director role unless they:

- Are of good character
- Have the necessary qualifications, competence, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement when providing a service.

2.4. Additional Requirements introduced by the NHS England FPPT Framework include the following enhancements:

- Web-based register checks on appointment with ongoing annual review
- Use of the Electronic Staff Record (ESR) to retain FPPT compliance data
- A set of standard competencies for all directors through the Board Member Appraisal
- A new way of completing board member references
- Alignment with the Leadership Competency Framework

3. Compliance with FPPT Framework

3.1. The Trust confirms compliance with the new elements of the Fit and Proper Person's Test Framework and has mechanisms in place to ensure the on-going fitness of executive and non-executive directors.

3.2. An annual assessment of compliance with the Fit and Proper Person Test was carried out in May 2025. This involved completion of all annual checks/reviews set out in the Board Fit & Proper Persons Checklist. Appendix A demonstrates full compliance for all Trust board members. A full compliance with FPPT standards summary is also included in Appendix C.

3.3. The Board Fit and Proper Person Checklists will be reviewed by the Chair, alongside each Board member's Fit & Proper Person Self-Attestation. Following this review, full submission template will be signed by the Chair and Senior Independent and submitted to the Regional Director ahead of the deadline of 30 June 2025. The reporting template is attached as Appendix B of this Report.

3.4. Once completed, the reports will be presented to the Remuneration Committee, for all executive directors and Council of Governors for the Chair and NEDs.

4. Compliance at the point of recruitment

4.1. The Trust has in place robust processes with regard to the appointment of directors. Whilst the Trust has not conducted any recruitment during the reporting period, a number of checks are undertaken in addition to normal employment checks for all newly recruited board members as part of the recruitment process and compliance for the Fit and Proper Person Test. These checks are intended to provide assurance on the:

- Identity of the individuals and confirmation of Right to work checks
- Qualifications, competence, skills required, relevant experience and ability
- Consideration to the physical and mental health in line with the role and good occupational health practice
- Disclosure Barring Service (DBS) checks
- Search of insolvency/bankruptcy register
- Search of disqualified directors register
- Search of disqualified trustees with the Charities Commission
- Review of full employment history and explanation of any gaps in employment
- Good character and conduct that the individual has been responsible for, or privy to which may have contributed to or facilitated any serious misconduct or mismanagement.

5. Assessment of continued compliance

5.1. As part of ongoing compliance with FPPT, a bi-annual check is conducted by the DCG to ensure that all directors continue to meet the requirements to hold office of their appointment, where they do not, a recommendation would be made by either the Chief Executive/Chair to the Remuneration committee for Executive Directors and Nomination Committee for non-executive directors

5.2. The Trust is responsible for ensuring the continued compliance of those persons to whom the Regulated Activity Regulations apply. This requirement is fulfilled through a number of processes including:

- The completion of an annual self-declaration upon recruitment and annually
- Annual checks for credit, bankruptcy or insolvency and disqualification
- Formal appraisal processes
- Maintenance of the register of declared interests
- Check any issues relating to FPPT on the person's social media**
- Board member reference**
- Employment Tribunal judgement checks**
- Settlement Agreements**
- Behaviour not in accordance with organisational values and behaviours or related local policies**

****indicates new and strengthened checks***

5.3. Evidence of the above is held securely in individual files by the Director of Corporate Governance

6. Board Member Appraisals

6.1. NHS England published new board member appraisal guidance on 1 April 2025 which applies to chairs, chief executives, non-executive directors (NEDs) and executive directors (EDs). The new format appraisals are designed to set clear expectations and enhance consistency in board member appraisals.

6.2. The guidance is part of a suite of tools to support leadership and management development following the recommendations of the independent review on Leadership for a collaborative and inclusive future undertaken by General Sir Gordon Messenger and Dame Linda Pollard which was published in 2022.

6.3. The Board Member Appraisal supersedes the Framework for conducting annual appraisals of NHS chairs published in February 2024 and incorporates the NHS leadership competency framework (LCF) domains and Fit and proper persons test framework for board members requirements.

6.4. It is intended that the Trust will transition to the new board member appraisal framework. All directors appraisal are due to be undertaken during Q1 2025/26, following which the Board Fit & Proper Person Checklist will be updated.

6.5. The Chair will inform the Remuneration Committee and Council of Governors should any information come to light that changes the outcome of the annual assessment as presented.

7. Recommendation

The Board of Directors are asked to **receive** this report as assurance of the Trust's Compliance with FPPT Framework and note the changes to the Board Member Appraisal Framework.

NHS Bolton NHS Foundation Trust

Board Fit and Proper Persons Register

Name								
	FPPT Checks					Good Practice		
	DBS	**Disqualified directors**	**Bankruptcy and insolvency**	**Removed Charity Trustees**	**Web search of individual**	**Self-Attestation**	**Code of Conduct**	**DOI**
Francis Andrews	Yes	No	No	No	Yes	**	Yes	Yes
Seth Crofts	Yes	No	No	No	Yes	Yes	Yes	Yes
Rebecca Ganz	Yes	No	No	No	Yes	**	Yes	Yes
Sean Harriss	Yes	No	No	No	Yes	Yes	Yes	Yes
Sharon Katema	Yes	No	No	No	Yes	**	Yes	Yes
James Mawrey	Yes	No	No	No	Yes	**	Yes	Yes
Fiona Noden	Yes	No	No	No	Yes	**	Yes	Yes

**To be signed at May 2025 Board of Directors

NHS Bolton NHS Foundation Trust

Board Fit and Proper Persons Register

Name								
	FPPT Checks					Good Practice		
	DBS	Disqualified directors	Bankruptcy and insolvency	Removed Charity Trustees	Web search of individual	Self-Attestation	Code of Conduct	DOI
Martin North	Yes	No	No	No	Yes	**	Yes	Yes
Niruban Ratnarajah	Yes	No	No	No	Yes	**	Yes	Yes
Tyrone Roberts	Yes	No	No	No	Yes	**	Yes	Yes
Alan Stuttard	Yes	No	No	No	Yes	Yes	Yes	Yes
Fiona Taylor	Yes	No	No	No	Yes	Yes	Yes	Yes
Annette Walker	Yes	No	No	No	Yes	**	Yes	Yes
Rae Wheatcroft	Yes	No	No	No	Yes	**	Yes	Yes
Sharon White	Yes	No	No	No	Yes	**	Yes	Yes

*To be signed at May 2025 Board of Directors

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
		Trust		
		Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members						
Executive board members						
Partner members (ICBs)						
Total						

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix C: Compliance with FPPT STandards

No	Standard	Assurance	Update
1.	Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations.	Employment checks are undertaken in accordance with NHS Employers pre-employment check standards, including: • References from previous employer • Qualification and professional registration checks • Right to work checks • Identity checks • Occupational health clearance • DBS checks (where appropriate) • Code of Conduct Declarations • Search of insolvency and bankruptcy register • Search of disqualified directors	**No exceptions to report**
2.	Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	The Chair would take advice from internal and external advisors as appropriate. Any further discussions can be discussed at respective Nomination and Remuneration Committees in future.	**No exceptions to report**
3.	Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	This requirement is included within the job description for relevant posts and is checked as part of the pre-employment checks.	**No exceptions to report**
4.	The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required.	Employment checks include a candidate's qualifications and employment references. The recruitment process also includes and values based questions.	**No exceptions to report**
5.	The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	Any such discussions will be held at Remuneration and Nomination Committee. Actions would be subject to follow-up as part of ongoing review and appraisal.	**No exceptions to report**
6.	When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line	All post-holders are subject to clearance by occupational health as part of the pre-employment process.	**No exceptions to report**

No	Standard	Assurance	Update
	with the requirements of the role, all subject to equalities and employment legislation and to due process		
7.	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	• Trust's Managing Attendance policy. • Occupational Health Assessments • Risk Assessments	**No exceptions to report**
8.	The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	This is incorporated as part of the pre-employment process	**No exceptions to report**
9.	The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	This has been incorporated as a specific declaration as part of the pre-employment process. It is also incorporated into a revised reference request template for all director and director-equivalent posts.	**No exceptions to report**
10.	Only individuals who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS).	DBS checks are undertaken only for those posts which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken.	**No exceptions to report**
11.	As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list.	All appointments are subject to DBS checks.	**No exceptions to report**
12.	The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or	Annual Self-declarations Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process. (*)	**No exceptions to report**

No	Standard	Assurance	Update
	the service users posed by the individual and/or role.		
13.	If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.	The Disciplinary Procedure and Policy provides these arrangements. A provision is included in contracts to allow for termination in the event of non-compliance with regulations and other requirements.	**No exceptions to report**
14.	The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions	This will be undertaken if concerns are identified and revised contracts provide for termination if individuals fail to meet necessary standards.	**No exceptions to report**
15.	Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.	This would be reviewed when concerns are identified.	**No exceptions to report**
16.	The provider informs others as appropriate about concerns /findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries or investigations carried out by others.	This would be completed if any concerns were identified.	**No referrals made**

Report Title:	NHS Provider Licence Compliance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	The purpose of this report is to provide the proposed content of the self-certification against the NHS Provider Licence

Previously considered by:	The NHS Self Certification for the Provider Licence was considered by the Audit and Risk Committee at the meeting held on 7 May 2025.

Executive Summary	The Trust required to carry out self-certification as assurance that it complies with the NHS Provider Licence **Continuity of Services 7 (CoS 7) – Availability of Resources** before 31 May 2025. Where the Trust is not compliant, it is required to explain why and develop an action plan to achieve compliance. This report provides contextual information and sources of assurance with regards to the Annual Trust Self-Certification against the NHS Provider Licence. As part of its annual reporting process, the Board is asked to self-certify its compliance prior to the Self-Certification being published on its website by 30 June 2025.

Proposed Resolution	The Board is asked to **approve** the NHS Self Certification as assurance of compliance with the NHS Provider Licence CoS 7 – Availability of Resources.

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**	Non-compliance penalty can be imposed by NHSE (para 5 Sch 11 2012 Act)
Legal/ Regulatory	**No**	Non-compliance could lead potential revocation of the licence.
Health Inequalities	**No**	Non-compliance could exacerbate existing health inequalities
Equality, Diversity and Inclusion	**No**	Non-compliance could potentially leading to discriminatory practices

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

1. Introduction

1.1. The NHS Provider Licence forms part of the oversight arrangements to regulate providers and ensure the health sector works in the best interest of patients. The licence was modified in 2023 to reflect updated statutoty and policy requirements.

1.2. NHS England has statutory accountability for oversight of all Foundation Trust services under the NHS Act 2006 and the Health and Social Care Act 2012, as amended by the new Health and Care Act 2022 (HCA 2022).

1.3. The NHS Provider Licence was modified in April 2023 and now forms part of the oversight arrangements for NHS foundation trusts. The revisions to the licence included technical amendments in line with the Act 2022, alongside conditions to support effective system working and consideration of the triple aim, health inequalities and climate change.

1.4. The Trust is required to hold a licence and self-certify that it meets the obligations set out in the NHS provider licence and will exercise its functions in accordance with the terms of its provider licence (No. 130014) and all relevant legislation and guidance.

1.5. The Trust required to carry out self-certification as assurance that it complies with the conditions. Where the Trust is not compliant, it is required to explain why and develop an action plan to achieve compliance.

2. The Self-Certification requirements

2.1. The requirement for self-certification, in relation to General Condition 6 and Corporate Governance Statement FT4, was removed within the new licence to reduce duplication with other reporting mechanisms and oversight arrangements incorporated in the NHS Oversight Framework, Annual Report and Annual Governance Statement.

2.2. The self-certification requirement remains in place with regards to ‘Continuity of Services 7 - Availability of Resources’.

2.3. This self-certification requires approval by a resolution of the Board of Directors to be concluded before 31 May 2025.

2.4. Whilst there is no requirement for the Trust to submit the Self-Certification to NHSE, the Trust is required to make the Self-Certification public on its website by 30 June 2025.

3. **Continuity of Services 7 (CoS 7) – Availability of Resources**

3.1. An NHS Foundation Trust is required to always act in a manner calculated to secure that it has, or has access to, the required resources.

3.2. The new licence continues to require Trusts, not later than two months from the end of each Financial Year, to certify as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, including a statement approved by a resolution of the Board of Directors.

3.3. The Board of Directors must select one of the three statements, as detailed below, and provide a statement of the factors taken into account in making the relevant declaration.

3.4. The three statement options are:

a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".

c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

3.5. In considering an appropriate declaration, members should note that 'Required Resources' are defined as follows:

- management resources,
- financial resources and facilities,
- personnel
- physical and other assets

3.6. Factors to consider as part of the declaration include:

- the Trust's financial plan 2025/26 developed in line with national guidance and as part of the Greater Manchester Integrated Care System (ICS)

- the submission for the Trust is a Breakeven plan that includes £6.5m deficit control total funding and a CIP target of £37.1m.
- the Going Concern assessment included in this meeting which will be agreed by the Board on 29 May 2025.
- the implications of any planned or potential services changes in the context of resource availability to accommodate/service such changes,

4. Recommendation

4.1. The Board of Directors is asked to approve the adoption of the following statement and caveats to support the declaration B:

Declation B "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources**".**

The caveats to support the Trust in making Declaration B are listed below.

1. There remain challenges from the labour market in recruiting appropriate staff in various areas, for both clinical and non-clinical areas. Whilst the Trust is able to obtain staff as required to ensure cover for clinical requirements, these are often bank or agency staff who incur premium costs to the Trust and therefore impact the financial position. There may be longer-term impacts for non-clinical posts in respect of the Trust's ability to meet national and Integrated Care Board priorities.
2. The Trust is required to deliver a challenging efficiency programme for the year of £37.1m which is 7% of operational expenditure. Work is underway to fully identify this, given the control total stretch requested by the GM ICB.
3. The Trust has been asked to deliver an reduce its growth in Corporate services by 50% to support front line services which is a £5.5million reduction in costs as part of the changes put in place by NHS England, of which £7.2m is confirmed as deliverable .The Board has not had the opportunity, at the date of this statement, to conclude the planning for delivery of this programme; and therefore does not currently have a view on the potential impacts of the programme on the delivery of services.
4. Internally generated funds to support capital for the year is limited, and the Board has had to prioritise schemes within the available capital funding. Some schemes that the

Board would have wished to pursue have not been able to be taken forward, which may impact on the provision of both clinical services and support services.

Report Title:	Compliance with FT Code of Governance			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	To provide assurance on the Trust's compliance with the Foundation Trust Code of Governance (FT Code) during the 2024/25 financial year

Previously considered by:	This report forms part of the annual reporting cycle

Executive Summary	The FT Code is a vital framework for NHS providers which promotes accountability and transparency. It establishes a unified approach to corporate governance, aligning with developments in UK Corporate Governance and the evolution of integrated care systems. The Code comprises several provisions, some of which operate on a 'comply or explain' basis. Each year, the Board must include a statement in the Annual Report confirming compliance with the Code and explaining any areas of non-compliance. In the latest review of compliance, the Trust meets all mandatory provisions outlined in Appendix C. However, one caveat remains: the requirement for an external review of Board effectiveness. Although originally scheduled for 2024, this review has been deferred to 2025. As a result, this area has been marked as Partially Compliant.

Proposed Resolution	The Board of Directors is asked to **review** Trust Compliance against the FT Code and **approve** the proposed declarations.

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 NHS Foundation Trust Code of Governance (FT Code) originally introduced in 2006, has undergone periodic revisions to reflect statutory developments and updates to the UK Corporate Governance Code. The FT Code aligns with the principles of the UK Corporate Governance Code (2024), which underscores the importance of fostering a corporate culture that aligns with organisational purpose and business strategy, upholds integrity, and embraces diversity. It incorporates best practices from both the NHS and the private sector, offering a robust framework that supports and enhances statutory and regulatory obligations in corporate governance.

1.2. The FT Code establishes a unified framework for the corporate governance of NHS providers, reflecting contemporary developments in UK Corporate Governance. It integrates the best practices of the NHS and private sector and provides a comprehensive corporate governance framework of trusts that enhances the statutory and regulatory obligations.

1.3. The supporting appendices provide assurance that there is good corporate governance, contributing to improved organisational and system performance, ultimately ensuring that providers fulfil their responsibilities in the best interests of patients, staff, and the wider public.

2. Disclosure requirements

2.1. To meet the requirements of “comply or explain” the Trust is required to comply with each of the provisions of the code or, where appropriate, explain in each case provide a clear rationale for any deviations.

2.2. Additionally, the Trust is required to report compliance against the FT Code within its Annual Report as set out in the Foundation Trust Annual Reporting Manual 2024/25.

2.3. The specific set of disclosures that must be submitted as part of the Annual Report are appended to this report as follows:

- Appendix A Supporting explanation required in the Annual Report
- Appendix B Supporting information that is publicly available through the Trust website.
- Appendix C Full review of compliance with the Mandatory Provision of the Code
- Appendix D Full review of compliance with the Comply or Explain Provisions

3. Compliance with the FT Code

3.1. The FT Code provides non-mandatory best practice advice. If the Trust is non-compliant, then this does not constitute a breach of the Provider Licence and, for the majority of provisions, the Trust would be required to explain any deviation from the Code within the

Annual Report. However, there are also several statutory requirements, where compliance is mandatory. These provisions are drawn together in a disclosures section, which must be reported against within the Trust's Annual Report.

3.2. A review of the new Code, a review of compliance with each provision has been undertaken by the Director of Corporate Governance and a summary of the findings is attached in Appendix D.

3.3. A compliance checklist with each of the FT Code provisions has been prepared and confirms that the Trust complies with the Code's provisions with the exception of:

Provision C.4.7 Evaluation of FT boards should be externally facilitated at least every three years.

Bolton NHS FT's Annual Report 2023/24 will confirm compliance with the provisions of the Code and an explanation of the reasons for departure from C.4.7 on the basis that:

The CQC undertook a Well Led Inspection in October 2023. An external review is was scheduled during 2024 but this will now be carried out in 2025.

4. Mandatory Disclosure Requirements

4.1. Accordingly, the FT Code highlights the overlap between good corporate governance and successful delivery against quality standards, for which the Board is ultimately responsible for. The Code aims to provide a framework for robust governance standards and leadership and sets out how the Trust should go about to ensure good governance.

4.2. There are several statutory requirements, where compliance is mandatory. The provisions are drawn together in a disclosures section, which must be reported against in trust's Annual Report. This is reflected in Appendix C.

There are no areas of non-compliance being reported.

5. Recommendations

5.1. The Board of Directors are asked to:

- Note the list of disclosures required in the Annual Report
- Review Trust Compliance against the FT Code and approve the proposed declaration

Appendix A - Supporting explanation required in the Annual Report

Section	Code Provision
B.2.17	A statement to describe how any disagreements between the council of governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.
B.2.13	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.
Appendix B paragraph 2.3. **Retained in FT ARM.**	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
B.2.6	The Board of Directors should identify in the annual report each nonexecutive director it considers to be independent, with reasons where necessary.
C 4.2 and C 2.2.	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.
C 2.5 and C 4.13	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.
C5.15	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
C.4.13	The Board of Directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.
C.4.7	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified and a statement made as to whether they have any other connection with the trust.

Appendix A - Supporting explanation required in the Annual Report

Section	Code Provision
D 2.6 **FT ARM**	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).
D.2.8	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.
D.2.4	A trust should disclose in the annual report: a) if it has an internal audit function, how the function is structured and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.
D.2.4 **D.2.5**	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.
E.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available in the annual report.
FT ARM	***Provision retained in FT ARM only*** The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face to-face contact, surveys of members' opinions and consultations.

Appendix B - Supporting information that is publicly available - this requirement can be met by making information available on request and on the website.

Provision	Requirement	Trust Position
A1.3	The Board of Directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Included in the new 2024-29 Corporate Strategy that will be published on the Trust's website
B.1.4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.	Included in the Annual Report and on the internet
B.2.10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	Published on the internet and within the Annual Report
B.3.2	The terms and conditions of appointment of non-executive directors.	Available on request
C.3.3	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.	Published on the internet, a summary is also published in the Annual Report
D.2.1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the Board of Directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	Available on request and within the Annual Report
E.1.1	The Board of Directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	Included in the Annual Report

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
A.2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The Board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The Trust should describe in its Annual Report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	The Trust is an active partner within both GM Integrated Care Partnership (ICP) and at Bolton Locality level. The Chief Executive is the Place Based Lead for Bolton Locality and represents the trust at Provider Collaborative meetings. This requirement is met and reported through the Performance Overview Report in the Annual Report.	Annual Report	Compliant
A.2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's Vision, Values and Strategy, it should seek assurance that management has taken corrective action. The Annual Report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	This is reported in the Staff Report which includes Disclosures on Staff rewards, wellbeing policies and actions form Staff Surveys.	Annual Report NHS Staff Survey results Board minutes	Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
A.2.8	The Board of Directors should describe in the Annual Report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The Board of Directors should keep engagement mechanisms under review so that they remain effective. The Board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	This is reported in the Performance Overview Report of the Annual Report and also included in the Annual Governance Statement	Annual Report Annual Governance Statement	Compliant
C.2.8	The Annual Report should describe the process followed by the council of governors to appoint the chair and Non-Executive Directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	The annual report will describe the work of the Remuneration and Nominations Committees. Both committees have written terms of reference which are available on the intranet. The Governor Nomination Committee has a Standard Operating Procedure which details the process to appoint Non-Executive Directors.	Published on the Trust website Annual Report	Compliant
C.4.2	The Board of Directors should include in the Annual Report a description of each director's skills, expertise and experience.	Annual report disclosure requirement. Statement about the balance, appropriateness and completeness of the Board on the internet Director biographies on the internet	Annual report Internet	Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
C.4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-Led framework every three to five years, according to their circumstances. The external reviewer should be identified in the Annual Report and a statement made about any connection it has with the Trust or individual directors.	In 2023, the Care Quality Commission (CQC) conducted a formal Well-Led Review, providing external insight into leadership and governance effectiveness. Since then, the Trust has undertaken a series of governance reviews aligned with the NHS Well-Led Framework to support continuous improvement and assurance. This includes a review by the Good Governance Improvement and a peer review of Board and Committee meetings which sought to assess internal governance practices and identify opportunities for enhancement. An external review using the full Well-Led Framework was deferred from 2024 to 2025. This review will provide an independent evaluation of leadership, strategy, culture, and governance processes across the organisation.	Outputs from CQC Well Led Review	Partially Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
C.4.13	The Annual Report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the Board of Directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to Trust Vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the Board reflects the ethnic diversity of the Trust's workforce and communities served • the gender balance of senior management and their direct reports.	The Annual Report will describe the work of both Remuneration and Nominations Committees. Both Remuneration and Nomination Committees have written terms of reference which are available on the intranet. An Equality, Diversity and Inclusion Strategy and Policy and the NHS WRES and WDES metrics are available on the website and included in the Annual Report. The Gender Balance of senior management and their direct report is included in the Annual Report.	Annual Report Nomination and Remuneration Committee terms of reference Trust website	Compliant
C.5.15	Foundation Trust governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	With the launch of the new Strategy, a Governor Focus Group will be established to provide a forum for governors to communicate the opinions of members and stakeholders to the Board of Directors. A statement will be included in the annual report to describe this process.		Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
D.2.4	The Annual Report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS Trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	The required disclosures are included in the Annual Report	Annual Report	Compliant
D.2.6	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	The Annual Report states includes this in the Statement of Accounting Officer's Responsibilities.	Annual Report	Compliant
D.2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the Annual Report.	This is reported in the Performance Overview section of the Annual Report.	Board Assurance Framework Annual Report	Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
D.2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the Annual Report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the Annual Governance Statement in the Annual Report.	The Board of Directors conducts an annual review of effectiveness of its internal control systems, supported by its internal auditors. In addition to this annual review an on-going programme of internal audits reviews controls and assurances	Annual Governance Statement Internal Audit reports	Compliant
D.2.9	In the Annual Accounts, the Board of Directors should state whether it considered it appropriate to adopt the Going Concern basis of accounting when preparing them and identify any material uncertainties regarding Going Concern. Trusts should refer to the DHSC Group Accounting Manual and NHS Foundation Trust Annual Reporting Manual which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over Going Concern are expected to be rare.	This is included in the Performance Overview of the Annual Report.	Annual Report	Compliant
E.2.3	Where a Trust releases an executive director, eg to serve as a Non-Executive Director elsewhere, the Remuneration Disclosures in the Annual Report should include a statement as to whether or not the director will retain such earnings.	This Provision has been noted and has not arisen.	Directors register of interests	Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
	Appendix B, paragraph 2.3 (not in Schedule A) The Annual Report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated lead governor.	The Annual Report identifies governors, their constituency or organisation they represent, whether they were elected or appointed and the duration of their appointment	Annual Report	Compliant
	Appendix B, paragraph 2.14 (not in Schedule A) The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS Foundation Trust's website and in the Annual Report.	The Trust's website provides details of how members can contact their governor this information is also be published in the Annual Report.	Minutes of Council of Governor meetings Annual Report.	Compliant
	Appendix B, paragraph 2.15 (not in Schedule A) The Board of Directors should state in the Annual Report the steps it has taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	The Annual Report will describe how non-executive directors have developed their understanding of the views of governors and members. All Directors attend the Council of Governors meetings including Governor Quality and Strategy Committee.	Minutes of Council of Governor meetings	Compliant

Appendix C - Mandatory disclosure requirements

Section	Code of Governance for NHS providers: Schedule A – disclosure requirements	TRUST POSITION	EVIDENCE	
	Additional requirement of FT ARM If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	The Provision has been noted. The Council of Governors have not exercised their powers under both statutory provisions.		Compliant

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
A. 2.2	The Board of Directors should develop, embody and articulate a clear vision and values for the Trust, with reference to the ICP's integrated care strategy and the Trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	The Trust revised its Strategy for 2024-29 which reflects the Bolton Locality Plan. The Trust publishes an Operational Plan which contains details of its Vision and Strategy. As a system partner within Bolton Locality Board, the CEO is Place Based Lead for Bolton. There is Trust representation at GM Locality and Local Authority partnership meetings. The Trust engages with stakeholders through its governors, members and system partnerships such as Healthwatch and CVS.	• Sustainability Plan • 2024-29 Corporate Strategy • Locality Plan	COMPLIANT
A. 2.4	The Board of Directors should ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five- year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The Board should regularly review the Trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board regularly undertakes a comprehensive review of the systems and processes in place to monitor the Trust's performance. Regular reports on performance are reviewed by the Board and its supporting Committees.	• Integrated performance report • Board minutes • Index of Board papers	COMPLIANT
A. 2.5	The Board of Directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the Board of Directors should commission independent advice, eg from the internal Audit function, to provide an adequate and reliable level of assurance.	The Internal Audit resource is directed towards areas where additional assurance is required; additional independent reviews may be requested if deemed appropriate		COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
A. 2.6	The Board of Directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Trust has a Clinical Governance and Quality Group which is chaired by the Chief Nurse, this Group reports to the Quality Assurance Committee. In attendance at this meeting are Divisional Leadership triumvirate, Governance Leads, Risk Management	• A new Clinical Strategy • Risk Management Plan • Minutes of Clinical Governance and Quality Committee • The Quality Account	COMPLIANT
A. 2.7	The Chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the Trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The Chair should ensure that the Board of Directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS Foundation Trusts must hold a members' meeting at least annually. Provisions regarding the role of the Council of Governors in stakeholder engagement are contained in Appendix B.	The Chair attends GM Provider meetings, regularly meets with staff governors and has a drop in for Council of Governors. The Committee Chairs present their Chair's reports to the Council of Governors meetings which helps directors understand the views of patients, staff and members. The Annual Members Meeting is widely publicised and is held in October.	Chair's update to Board and CoG at each meeting. Council of Governor minutes Annual Report Trust website and Council of Governors' minutes	COMPLIANT
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The Board of Directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has a raising concerns policy The Trust has a Freedom to Speak Up Guardian and a network of Freedom to Speak up Champions who presents a quarterly report to the Board. The Trust has FTSU NED Lead who regularly attends meetings with the FTSU Guardian.	• Raising Concerns Policy • Internal Audit Plan and Committee minutes • People Committee minutes • Board Workplan and minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
A.2.10	The Board of Directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	The Trust has a Managing Conflicts of Interests Policy. Managing Conflicts of Interests reports presented at Audit Committee. The Register of Interests is publically available on a dedicated declarations portal.	• Managing Conflicts of Interests Policy. • Register of Interests, Gifts and Hospitality is published on a website • Audit Committee minutes	COMPLIANT
A.2.11	Where directors have concerns about the operation of the Board or the management of the Trust that cannot be resolved, these should be recorded in the Board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the Chair, for circulation to the Board.	See Section A.4.3		COMPLIANT
B.2.1	The Chair is responsible for leading on setting the agenda for the Board of Directors and, the Council of Governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The Chair of the Trust is also the Chair of the Board of Directors and Council of Governors.	Council of Governors Agenda Board of Directors Agenda	COMPLIANT
B.2.2	The Chair is also responsible for ensuring that directors and, for Foundation Trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A Foundation Trust Chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Board of Directors reviews Trust performance information on a monthly basis both in the formal bi-monthly Board meeting and within the Board Committee meetings. All governors receive appropriate supporting information to enable them to fulfil their role. Training days are also arranged as part of the Development sessions to enable governors to continue to develop their role.	• Board papers and minutes • Council of Governor minutes and papers	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
B.2.3	The Chair should promote a culture of honesty, openness, Trust and debate by facilitating the effective contribution of Non-Executive Directors in particular and ensuring a constructive relationship between executive and Non-Executive Directors.	There is an annual Board Development Workplan that includes development / Group Coaching sessions NEDs meet each month with the Chair without an agenda	Board Development Workplan Board minutes	COMPLIANT
B.2.4	A Foundation Trust Chair is responsible for ensuring that the Board and council work together effectively.	There is an open invite to the Board at COG and a reciprocated invite at Board for governors. All COG meetings have a dedicated networking time for all the governors to meet with Board members before each meeting.	COG Agenda Board minutes	COMPLIANT
B.2.5	The Chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of Chair and Chief Executive must not be exercised by the same individual. A Chief Executive should not become Chair of the same Trust. The Board should identify a Deputy or Vice Chair who could be the senior independent director. The Chair should not sit on the Audit committee. The Chair of the Audit committee, ideally, should not be the Deputy or Vice Chair or senior independent director.	The Chair was classed as independent on appointment and provided a full disclosure of all significant interests held which are included in the Register of Interests. The role of Chief Executive and Chair is held by different individuals. The Vice Chair and SID is split between two individuals. The Chair does not sit on the Audit Committee. The Chair of Audit Committee is neither the SID nor Vice chair.	Board Standing Orders Trust Constitution Council of Governors minutes	COMPLIANT
B.2.7	At least half the Board of Directors, excluding the Chair, should be Non-Executive Directors whom the Board considers to be independent.	The composition of the Board is set out in the constitution. This requires the number of Executive Directors not to outnumber the number of Non-Executive Directors including the Chair with the Chair having a casting vote if appropriate. As at March 2024, the Board comprises of 8 NEDs including the Chair and 7 EDs	Board composition will be reported in the Annual Report and on the Trust website.	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
B.2.8	No individual should hold the positions of director and governor of any NHS Foundation Trust at the same time.	Restriction included in the constitution Annex 3	Constitution Register of interests	COMPLIANT
B.2.9	The value of ensuring that Committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding Chairship and membership of committees. The Council of Governors should take into account the value of appointing a non-executive director with a clinical background to the Board of Directors, as well as the importance of appointing diverse Non-Executive Directors with a range of skill sets, backgrounds and lived experience.	A review of Committee membership was undertaken in 2023. It is planned that a review will be undertaken during 2024. The last recruitment campaign for NED was focused on clinical background and resulted in the appointment of 2 NEDs with a clinical background and 1 NED with lived experience.	Board Composition	COMPLIANT
B.2.10	Only the Committee Chair and members are entitled to be present at Nominations, Audit or Remuneration committee meetings, but others may attend by invitation of the particular Committee.	Membership of the committees is set out in the respective TOR. Officers of the Trust and others attend by invitation.	Audit and Risk ToR Remuneration Committee ToR Governor Nomination Committee ToR	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
B.2.11	In consultation with the Council of Governors, NHS Foundation Trust Boards should appoint one of the independent Non-Executive Directors to be the senior independent director: to provide a sounding Board for the Chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the Foundation Trust Non-Executive Directors should meet without the Chair present at least annually to appraise the Chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.	An Annual appraisal was conducted by the Senior Independent Director using the NHS England Chair Appraisal Framework during 2024. The Trust has adopted the Board Member Appraisal Framework. The SID and has commenced the Chair Appraisal 2025 by meeting with the Governor Nomination Committee.	Governor nomination and Remuneration Committee minutes Council of Governors minutes	COMPLIANT
B.2.12	Non-Executive Directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The Chair should hold meetings with the Non-Executive Directors without the executive directors present.	A meeting of the Remuneration Committee is scheduled every March and September. All NEDs are members of the Remuneration Committee. During 2024/25 the Chair met with all Non-Executives every month without executive directors present..	Remuneration Committee minutes Emails available to evidence meetings	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
B.2.14	When appointing a director, the Board of Directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the Board of Directors, with the reasons for permitting significant appointments explained in the Annual Report. Full-time executive directors should not take on more than one Non-Executive Directorship of another Trust or organisation of comparable size and complexity, and not the Chairship of such an organisation.	The Governors appointed the Chair who started in post on 1 June 2023 for a three year term The Chair provided a full disclosure of all significant interests. No full-time executive director holds such Non-Executive Directorships	Directors register of interests	COMPLIANT
B.2.15	All directors should have access to the advice of the Company Secretary, who is responsible for advising the Board of Directors on all governance matters. Both the appointment and removal of the Company Secretary should be a matter for the whole Board.	The Company Secretary attends meetings of the Exec Directors and also meeting of the Chair with NEDs. The Company Secretary provides support to all members of the Board with advice on governance matters. The Company Secretary is accountable to both the Chair and Chief Executive.	Board minutes Remuneration Committee Minutes	COMPLIANT
B.2.16	The Board of Directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Board has a Quality Assurance Committee chaired by a NED with clinical experience. The Chief Nursing Officer and Medical Director attend the QAC.	Annual Report Quality Assurance Committee minutes	COMPLIANT
B.2.17	All members of the Board of Directors have joint responsibility for every Board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive as the Accounting Officer.	The Board is a unitary Board with members who have different skills and experience.	Board of Director's minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
B.2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, Non-Executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	The Chair encourages input from all directors during Board meetings. This is supported by the AAA Key Issues Report which is presented by the NED Chair of each Committee. The NEDs also review Committee meetings in their session with the Chair that takes place before Board and can highlight any concerns following meeting	Chair's AAA Key Issues Reports Board minutes	COMPLIANT
B.2.17	The Board of Directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The Board meets in public at least six times a year, in addition to this regular Strategy and Development Sessions are held. The Annual Report states how the Board of Directors and Council of Governors operate, including a high-level statement of which types of decisions are taken by each. The Board at its meeting in Nov 2024 approved Standing Orders and Scheme of Delegation.	• Board minutes • Board workplan • Annual Report • Scheme of Delegation • Standing Orders • Trust Constitution	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.2.1	The Remuneration and Nominations Committees of Foundation Trusts, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors. The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the Foundation Trust should engage with NHS England to agree the approach.	The Remuneration Committee received a succession plan for the Executive Directors presented by the Chief Executive. The Governor Nomination Committee regularly review the structure, size and composition of the Board of Directors and give full consideration to succession planning each year..	Remuneration Committee minutes Council of Governors' Minutes	COMPLIANT
C.2.2	There may be one or two Nominations committees. If there are two committees, one will be responsible for considering Nominations for executive directors and the other for Non-Executive Directors (including the Chair). The Nominations committee(s) should regularly review the structure, size and composition of the Board of Directors and recommend changes where appropriate. In particular, the Nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the Board of Directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the Chair.	The Trust has two Remuneration and Nomination Committees – one for Executive which is chaired by the Trust Chair and includes all Non-Executive Directors, and a Governor led Nomination and Remuneration Committee which considers all matters relating to the Non-Executive Directors. In instances where matters concerned relate to the Chair, the SID assumes the Chair of the CoG or Nomination Committee. The requirements are included in the terms of reference for these Committees	Nomination and Remuneration Committee minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.2.3	The Chair or an independent non-executive director should Chair the Nominations committee(s). At the discretion of the Committee, a governor can Chair the Committee in the case of appointments of Non-Executive Directors or the Chair.	Both Nomination and Remuneration Committees are chaired by the Chair. The change to the code with regard to a governor Chair when considering appointments of Non-Executive Directors has been noted	Remuneration Committee minutes Governor nomination and Remuneration Committee minutes	COMPLIANT
C.2.4	The governors should agree with the Nominations Committee a clear process for the nomination of a new Chair and non-Executive Directors. Once suitable candidates have been identified, the Nominations Committee should make recommendations to the Council of Governors.	An agreed process was followed in 2023 for the appointment of four NEDs.	Council of Governor minutes Governor nomination and Remuneration Committee minutes	COMPLIANT
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the Chair and Non-Executive Directors.	This was followed for all appointments since 2022.	Council of Governor minutes Governor nomination and Remuneration Committee minutes	COMPLIANT
C.2.6	Where an NHS Foundation Trust has two Nominations Committees, the Nomination Committee responsible for the appointment of NEDs should have governors and/or independent members in the majority. If only one Nominations Committee exists, when Nominations for non-executives, including the appointment of a Chair or a Deputy Chair, are being discussed, governors and/or independent members should be in the majority on the Committee and also on the interview panel.	Bolton NHSFT has two nomination and remuneration Committees, the Committee responsible for the appointment of Non-Executive Directors consists of a majority of governors.	Council of Governor minutes Governor nomination and Remuneration Committee minutes	COMPLIANT
C.2.7	When considering the appointment of Non-Executive Directors, the Council of Governors should take into account the views of the Board of Directors and the Nominations Committee on the qualifications, skills and experience required for each position.	In making its recommendation/s re the appointment of Non-Executive Directors to the Council of Governors the Remuneration and Nominations Committee take account of the views of the Board of Directors.	Stakeholder Appointment Panel. Council of Governor minutes Governor Nomination Committee minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
	Section C, 3.1 (NHS Trusts only)			
C.4.1	Directors on the Board of Directors and, for Foundation Trusts, governors on the Council of Governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	The Trust fully implements the Fit and Proper Person's Framework. This includes pre-appointment and pre-election checklists. DBS checks are carried out on all new staff Additional checks for Directors are undertaken each year to ensure requirements of Fit and Proper Persons Framework are continuously met. The Trust has adopted and its directors are compliant with the NHS England FPPT Framework On election governors sign a declaration to confirm that they are not exempt by reason of any of the criteria listed	Appointment checklists Governor declaration of eligibility	COMPLIANT
C.4.3	The Chair should not remain in post beyond nine years from the date of their first appointment to the Board of Directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse Board, this period of nine years can be extended for a limited time, particularly where on appointment the Chair was an existing non-executive director. The need for extension should be clearly explained and should be agreed with NHS England.	The Trust complies with this provision.	Board Standing Orders Trust Constitution Annual Report	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.4.4	Elected Foundation Trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re- election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	The Trust complies with this provision.	Council of Governors Standing Orders Trust Constitution Annual Report	COMPLIANT
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the Board of Directors, its Committees, the Chair and individual directors. For NHS Foundation Trusts, the Council of Governors should take the lead on agreeing a process for the evaluation of the Chair and Non-Executive Directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the Chair. NHS England leads the evaluation of the Chair and Non-Executive Directors of NHS Trusts. NHS Foundation Trusts and NHS Trusts should make use of NHS Leadership Competency Framework for Board level leaders.	Individual development plans are agreed at appraisal. A collective Board development programme has also been agreed. The Trust has adopted the new Board Member Appraisal Framework which includes the domains of the NHS Leadership Competency Framework.	Appraisals Board development programme	COMPLIANT
C.4.6	The Chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the Board of Directors. Each director should engage with the process and take appropriate action where development needs are identified.	The Trust has adopted the Leadership Competency Framework which ensures consistency across all 6 NHSE Competency Domains.	Leadership Competency Framework Remuneration Committee minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.4.8	Led by the Chair, the Councils of Governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors • communicating with their member constituencies and the public and transmitting their views to the Board of Directors • contributing to the development of the Foundation Trust's forward plans. The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your Statutory duties: a reference guide for NHS Foundation Trust governors and an Addendum to Your statutory duties...	The Council of Governors has two established Committees with a clearly identified purpose. A Quality Committee and a Strategy Committee	Review of Governor effectiveness Governor work plan Governor sub Committee minutes	COMPLIANT
C.4.11	The Board of Directors should ensure it retains the necessary skills across its directors and works with the Council of Governors to ensure there is appropriate succession planning.	A succession plan report is presented to the Council of Governors for review each year and periodically as and when vacancies arise to ensure the Board retains the necessary skills.	Council of Governors minutes.	COMPLIANT
C.4.12	The Remuneration Committee should not agree to an executive member of the Board leaving the employment of the Trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the Board first completing and approving a full risk assessment.	Requirement noted	Nomination and Remuneration Committee minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.5.1	All directors and, for Foundation Trusts, governors should receive appropriate induction on joining the Board of Directors or the Council of Governors and should regularly update and refresh their skills and knowledge. Both directors and, for Foundation Trusts, governors should make every effort to participate in training that is offered.	An annual Development plan is in place for the Board of Directors and Council of Governors. The governors hold an NHS Providers facilitated session each year as part of the programme.	Board Development Programme COG minutes	COMPLIANT
C.5.2	The Chair should ensure that directors and, for Foundation Trusts, governors continually update their skills, knowledge and familiarity with the Trust and its obligations for them to fulfil their role on the Board, the Council of Governors and Committees. The Trust should provide the necessary resources for its directors and, for Foundation Trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for Foundation Trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	The Trust has adopted the Leadership Competency Framework which is used to complement the FABB Appraisal process.	FABB Appraisal Leadership Competency Framework	COMPLIANT
C.5.3	To function effectively, all directors need appropriate knowledge of the Trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the Trust.	All Directors including NEDs are on the main Trust mailing systems. The Board undertakes 'walkabouts' which enable them to get a better understanding of Trust operations.	Staff Stories at Board NED Walkabout feedback	COMPLIANT
C.5.4	The Chair should ensure that new directors and, for foundation Trusts, governors receive a full and tailored induction on joining the Board or the Council of Governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the Trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	A local induction programme is in place for all governors and NEDs. NEDs attend the NHS Providers NED Induction, Corporate Induction, and meetings with Exec Directors as well all NED networking events supported by NHS North West Leadership Academy.	Governor Induction Programme Governor Handbook Governwell Training NHS Providers NED Induction Programme	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.5.5	The Chair should regularly review and agree with each director their training and development needs as they relate to their role on the Board.	Individual development plans are agreed at appraisal and quarterly 1:1 meetings. A collective Board development programme has also been agreed	Appraisals Board development programme	COMPLIANT
C.5.6	A Foundation Trust Board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	The Council of Governors receives appropriate supporting information to enable it to fulfil its role. Deep dives and more detailed papers are delivered at Committee meetings.	Council of Governor minutes and papers	COMPLIANT
C.5.8	The Chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for Foundation Trusts, governors should seek clarification or detail where necessary.	All meeting papers are circulated in line with ToR normally within 4 days of each meetings. The Council of Governors receive the integrated performance report and have the opportunity to discuss this within Governor meetings and sub group meetings	Council of Governor minutes and papers	COMPLIANT
C.5.9	The Chair's responsibilities include ensuring good information flows across the Board and, for Foundation Trusts, across the Council of Governors and their Committees; between directors and governors; and for all Trusts, between senior management and Non-Executive Directors; as well as facilitating appropriate induction and assisting with professional development as required.	The Council of Governors has issued a standing invitation to all Board members to attend its meetings. The FT Constitution includes a statement relating to the handling of disputes, this was reviewed and updated in 2023.	Minutes of Council of Governor meetings Council of Governors /Board of Director Engagement Policy	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.5.10	The Board of Directors and, for Foundation Trusts, the Council of Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The Board of Directors and, for Foundation Trusts, the Council of Governors should agree their respective information needs with the executive directors through the Chair. The information for Boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The Board of Directors should have complete access to any information about the Trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	The Board of Directors reviews Trust performance information on a monthly basis both in the formal bi-monthly Board meeting and within the Board Committee meetings. The Council of Governors receives appropriate supporting information to enable it to fulfil its role	Board papers and minutes Council of Governor minutes and papers	COMPLIANT
C.5.11	The Board of Directors and in particular Non-Executive Directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the Board of Directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the Trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	A mix of Internal and External assurance has been used to provide analysis of complex and high risk issues.	Internal and External reports providing assurance	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.5.12	The Board should ensure that directors, especially Non-Executive Directors, have access to the independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an External adviser should be the collective decision of the majority of Non-Executive Directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Convention exists that independent advice may be sought by the Board of Directors as appropriate	Board minutes record decisions to appoint External advice External reports	COMPLIANT
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The Board of Directors of Foundation Trusts should also ensure that the Council of Governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Committees are supported by the relevant executive director, senior manager/s and Trust staff The Council of Governors is supported by the Trust Secretary	Council of Governor minutes and papers	COMPLIANT
C.5.14	Non-Executive Directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge Board recommendations, in particular by making full use of their skills and experience gained both as a director of the Trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a Trust as they would in other similar roles.	The NEDs attend the Trust Induction similar to all staff. They are also subject to same Mandatory and Statutory Training and are expected to apply standards of care in their role as NED as they would in other roles.	Trust Induction Trust Statutory and Mandatory Training	COMPLIANT
C.5.16	Where appropriate, the Board of Directors should in a timely manner take account of the views of the Council of Governors on the forward plan, and then inform the Council of Governors which of their views have been incorporated in the NHS Foundation Trust's plans, and explain the reasons for any not being included.	A strategy subgroup has been established to provide a forum for governors to communicate the opinions of members and stakeholders to the Board of Directors. A statement will be included in the Annual Report to describe this process	Strategy subgroup minutes Annual Report	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
C.5.17	The Trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming Foundation Trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the Trust. While there is no legal requirement for Trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the Trust's constitution.	The Trust currently has NHS Resolution cover which covers Directors and Officers liabilities Additional Directors and Officers insurance has been commissioned from a commercial insurance provider. Insurance is not required for the Council of Governors	• NHS Resolution policies • Insurance policy	COMPLIANT
D. 2.1	The Board of Directors should establish an Audit Committee of independent Non-Executive Directors, with a minimum membership of three or two in the case of smaller Trusts. The Chair of the Board of Directors should not be a member and the Vice Chair or senior independent director should not Chair the Audit Committee. The Board of Directors should satisfy itself that at least one member has recent and relevant financial experience. The Committee as a whole should have competence relevant to the sector in which the Trust operates.	The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience	Audit Committee minutes Annual Report of the Audit Committee Audit Committee Terms of reference CV of Audit Committee Chair	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
Section D, 2.2	The main roles and responsibilities of the Audit Committee should include: • monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the Board of Directors) on whether the Annual Report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy • reviewing the Trust's Internal financial controls and Internal control and risk management systems, unless expressly addressed by a separate Board risk Committee composed of independent Non-Executive Directors or by the Board itself • monitoring and reviewing the effectiveness of the Trust's Internal Audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the Board of Directors • reviewing and monitoring the External Auditor's independence and objectivity • reviewing the effectiveness of the External Audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the Board of Directors on how it has discharged its responsibilities.	The Audit and Risk Committee Terms of Reference are based on best practice and revised in accordance with HFMA Audit Committee Handbook. The Committee Workplan and meeting agendas ensures that the Audit Committee fulfils this requirement. The Audit and Risk Committee Annual Report provides assurance to the Board of Directors on how the Committee has discharged its responsibility throughout the year.	• Audit and Risk Committee TOR • Audit and Risk Committee Workplan • Audit and Risk Committee Annual Report to Board • Audit and Risk Committee Minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
D.2.3	A Trust should change its External Audit firm at least every 20 years. Legislation requires an NHS Trust to newly appoint its External Auditor at least every five years. An NHS Foundation Trust should re- tender its External Audit at least every 10 years and in most cases more frequently than this.	Forvis Mazars were appointed as External Auditors in 2024 following a recommendation from the Auditor Panel. The Council of Governors approved the appointment in MONTH 2024.	Papers relating to the appointment of the External Auditor	COMPLIANT
D.2.5	Legislation requires an NHS Trust to have a policy on its purchase of non-Audit services from its External Auditor. An NHS Foundation Trust's Audit Committee should develop and implement a policy on the engagement of the External Auditor to supply non-Audit services.	The Trust complies with this provision.	Reported in the Annual Report	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
E, 2.1	Any performance-related elements of Executive Directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the Remuneration Committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the Trust. Consideration should be given to criteria which reflect the performance of the Trust against some key indicators and relative to a group of comparator Trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The Remuneration Committee should consider the pension consequences and associated costs to the Trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement	The Trust does not currently operate a performance related pay scheme or make provision for annual bonuses.	Nomination and Remuneration Committee terms of reference and minutes	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

	Code of Governance for NHS providers: Schedule A - comply or explain	TRUST POSITION	EVIDENCE	
E.2.2	Levels of remuneration for the Chair and other Non-Executive Directors should reflect the Chair and non-executive director remuneration structure.	The Council of Governors has set the level of remuneration for the Chair and other Non-Executive Directors. Non-Executive remuneration aligned to new NHSE guidance required	Council of governor minutes Governor nomination and Remuneration minutes	COMPLIANT
E.2.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	The Remuneration Committee will be guided by NHS England VSM Framework on such matters.	Remuneration Committee terms of reference	COMPLIANT
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Has not arisen, requirement noted	Remuneration Committee terms of reference	COMPLIANT
E.2.7	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee should also recommend and monitor the level and structure of remuneration for senior management. The Board should define senior management for this purpose and this should normally include the first layer of management below Board level.	The Remuneration Committee has delegated responsibility for setting all executive director remuneration	The Remuneration Committee has delegated responsibility for setting all executive director remuneration	COMPLIANT

Appendix D - Code of Governance for NHS providers: Schedule A - comply or explain

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Deputy Chief Executive		Decision	

Purpose of the report	To present the Month 1 Integrated Performance Report

Previously considered by:	The report was previously discussed at Integrated Performance Meetings (IPMs) and at May Committees.

Executive Summary	The Integrated Performance Report provides an overview of the Trust's performance against the reported metrics during April 2025. The narrative describes issues that are affecting performance and any mitigating actions to improve performance.

Proposed Resolution	The Board of Directors are asked to **receive** the Integrated Perfromance 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:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey, Chief People Officer/Deputy Chief Executive

Bolton NHS Foundation Trust

Integrated Performance Report

April 2025

Guide to Statistical Process Control

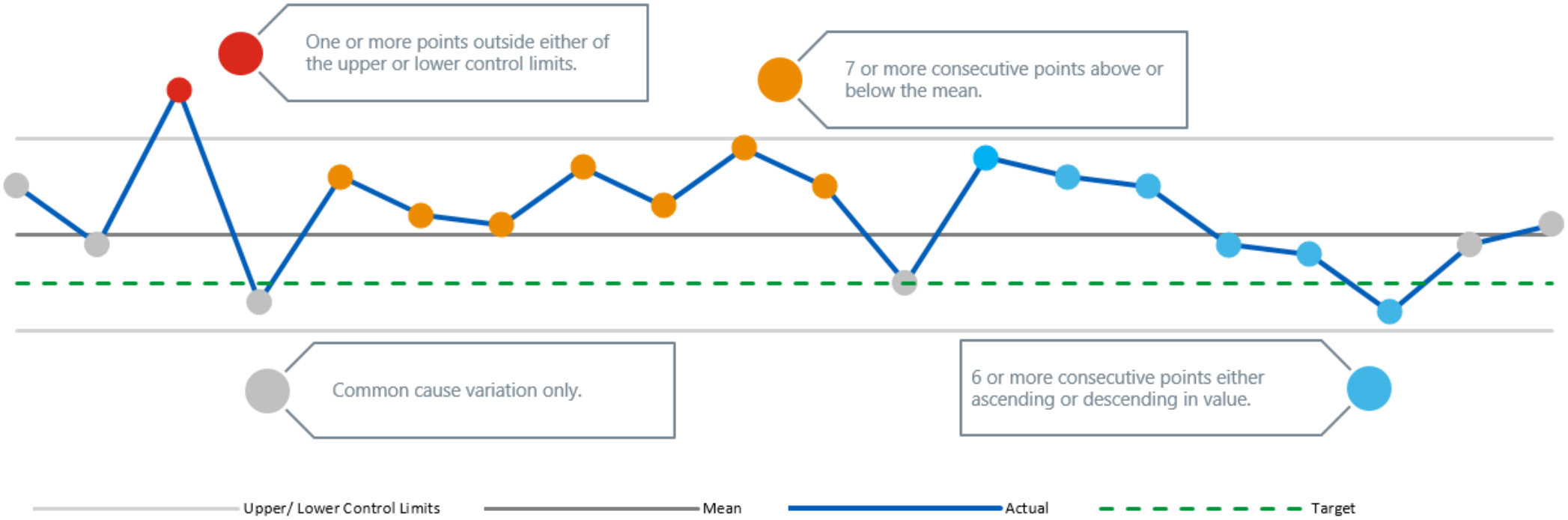
Bolton
NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

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

Variation

Common	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

NHS Bolton NHS Foundation Trust

Pressure Ulcers

This reporting period shows 14 hospital acquired category 2 pressure ulcers (5 in Adult Acute Care, 9 in Anaesthetics and Surgery) and 7 hospital acquired category 3 pressure ulcers (5 in Adult Acute, 2 in Anaesthetics and Surgery), with zero category 4 ulcers. We are in common cause variation for all hospital categories, demonstrating effective interventions.

Our thematic review has identified actions aligning directly with the Pressure Ulcer Change Package: enhanced nurse oversight supports changes 1, 2 and 5 (risk recognition, repositioning, staff education); documentation improvements address changes 2, 3, 4 and 5 (repositioning, equipment, Save our Skin protocol); and improved patient engagement fulfils change 6. The Pressure Ulcer Faculty monitors all initiatives.

In the community settings, 14 category 2 pressure ulcers were recorded (1 within the Paediatric Service), 4 category 3 and 2 category 4 pressure ulcers. Community pressure ulcer categories 2 and 3 show common cause variation, while category 4 shows a deteriorating special cause variation. To address this trend, we've implemented enhanced mitigation strategies including increased tissue viability nurse involvement, earlier escalation protocols, advanced pressure-relieving equipment deployment, and a dedicated rapid response team for high-risk patients. Despite category 4 concerns, evidence shows appropriate risk assessment, care planning and monitoring across community services, maintaining alignment with all six elements of the Change Package.

To note: Pressure Ulcer data remains unvalidated for 60 days from date of reporting whilst patient safety incident response framework review underway

Falls

Four patients experienced falls with harm during this reporting period: 3 in the Adult Acute Care Division and 1 in the Anaesthetics and Surgery Services Division. All falls with harm underwent comprehensive Patient Safety Review assessment which determined that each fall was accidental and unavoidable, involving patients with capacity who were independently mobile.

The Patient Safety Committee actively monitors implementation of improvement measure and seeks assurance that learning from incidents is translated into clinical practice. Action plans with specific interventions have been developed and are being embedded into standard care protocols.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
9 - Never Events	= 0	0	Apr-25		= 0	0	Mar-25	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.57	Apr-25		<= 5.30	4.15	Mar-25	<= 5.30	4.57	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	4	Apr-25		<= 1.6	4	Mar-25	<= 1.6	4	

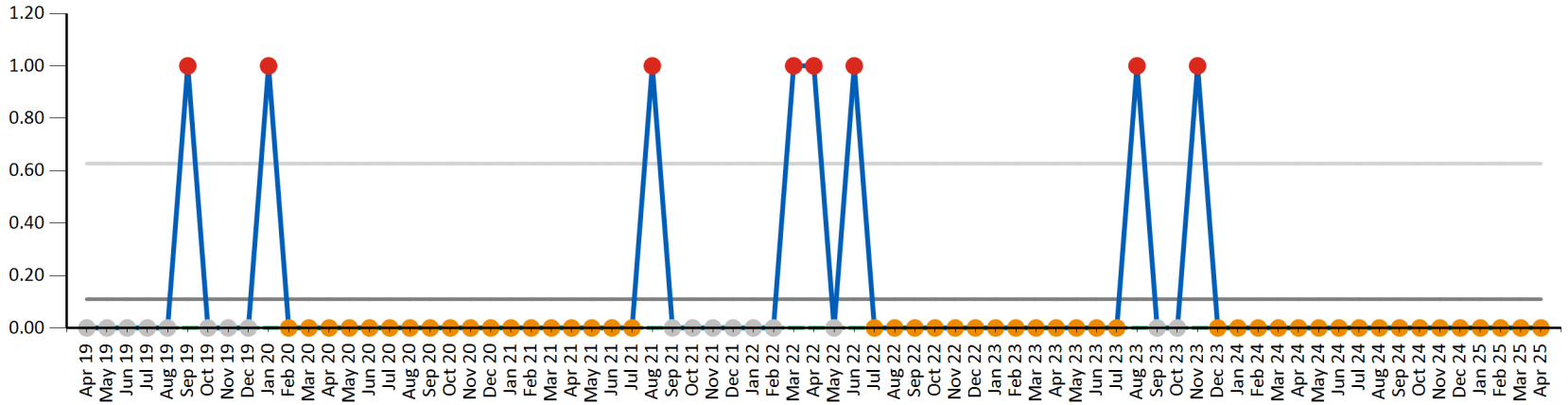
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	15.0	Apr-25		<= 6.0	21.0	Mar-25	<= 6.0	15.0	?
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	7	Apr-25		<= 1	0	Mar-25	<= 1	7	?
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Apr-25	L	= 0.0	0.0	Mar-25	= 0.0	0.0	?
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	13.0	Apr-25		<= 7.0	12.0	Mar-25	<= 7.0	13.0	?
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	4	Apr-25		<= 4	9	Mar-25	<= 4	4	?
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	2.0	Apr-25	H	<= 1.0	0.0	Mar-25	<= 1.0	2.0	?
535 - Community patients acquiring pressure damage - significant learning category 2		0	Apr-25	L		0	Mar-25		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Apr-25			0	Mar-25		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Apr-25			0	Mar-25		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	76.4%	Apr-25	H	>= 95%	81.4%	Mar-25	>= 95%	76.4%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	60.7%	Apr-25	L	>= 95.0%	58.5%	Mar-25	>= 95.0%	60.7%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Apr-25		= 100%	100.0%	Mar-25	= 100%	100.0%	?
88 - Nursing KPI Audits	>= 85%	95.8%	Apr-25	H	>= 85%	96.0%	Mar-25	>= 85%	95.8%	P
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	100.0%	Apr-25		= 100%	100.0%	Mar-25	= 100%		?
8 - Same sex accommodation breaches	= 0	9	Apr-25		= 0	16	Mar-25	= 0	9	F

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	Apr-25

Previous

Plan	Actual	Period
= 0	0	Mar-25

Year to Date

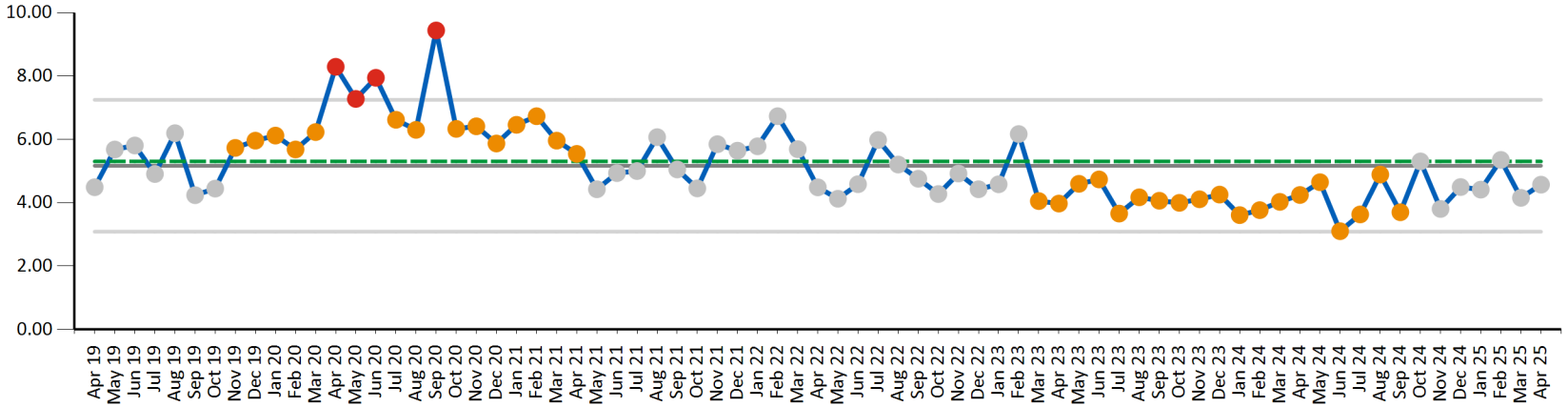
Plan	Actual
= 0	0

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

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 5.30	4.57	Apr-25

Previous

Plan	Actual	Period
<= 5.30	4.15	Mar-25

Year to Date

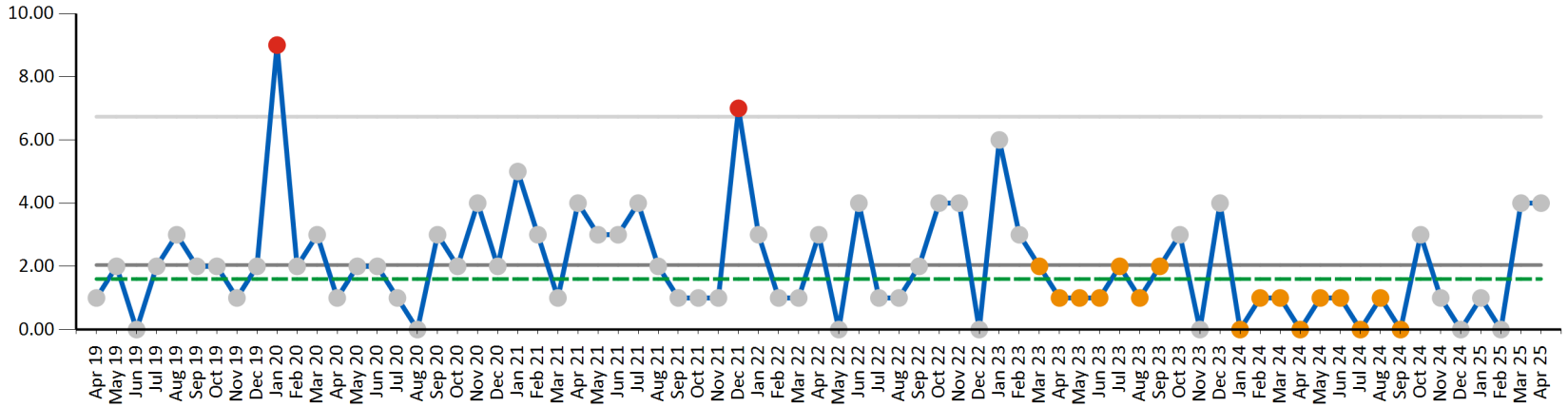
Plan	Actual
<= 5.30	4.57

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 1.6	4	Apr-25

Previous

Plan	Actual	Period
<= 1.6	4	Mar-25

Year to Date

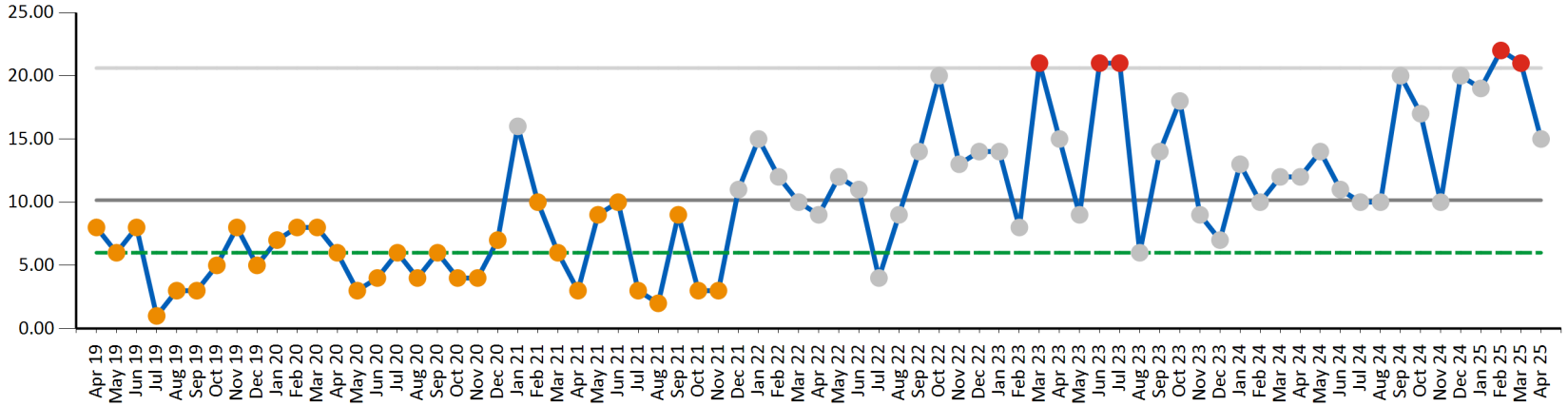
Plan	Actual
<= 1.6	4

15 - Number of Acute Inpatient incidences - pressure damage (category 2)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6.0	15.0	Apr-25

Previous

Plan	Actual	Period
<= 6.0	21.0	Mar-25

Year to Date

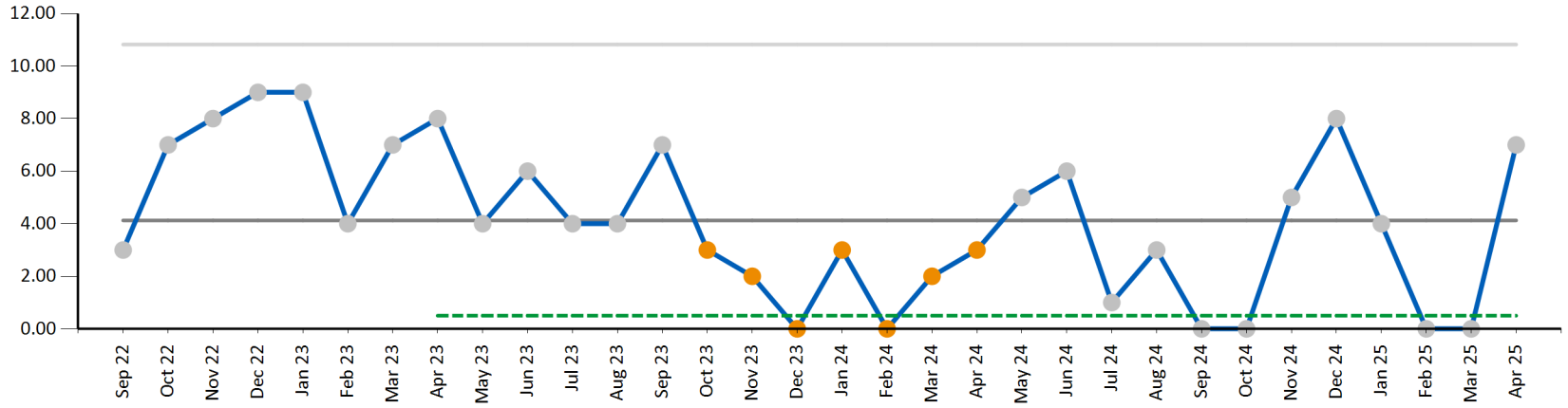
Plan	Actual
<= 6.0	15.0

620 - Number of Acute Inpatient incidences - 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	7	Apr-25

Previous

Plan	Actual	Period
<= 1	0	Mar-25

Year to Date

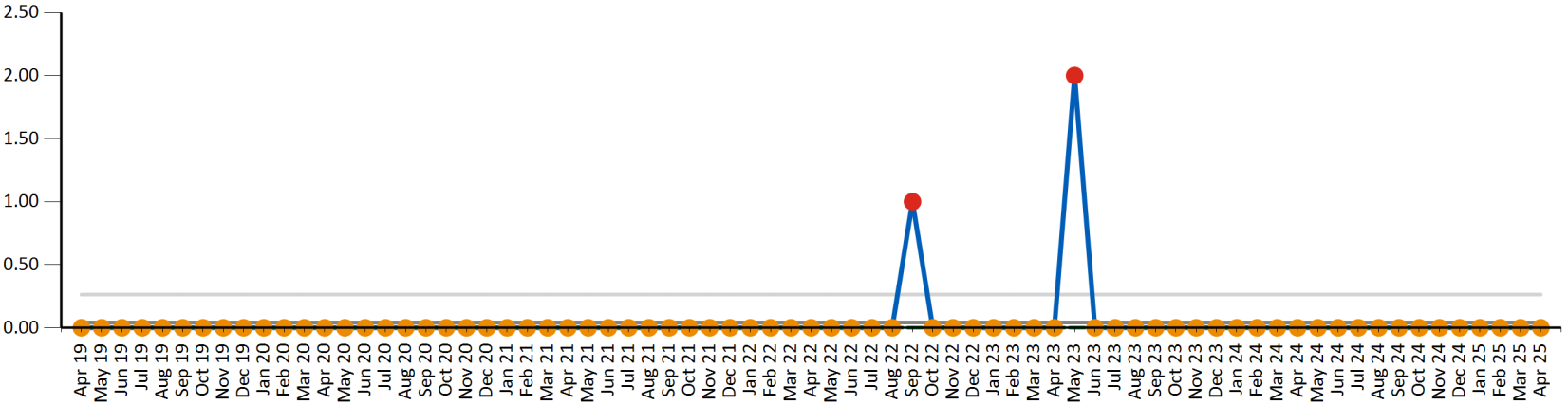
Plan	Actual
<= 1	7

17 - Number of Acute Inpatient incidences - 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	Apr-25

Previous

Plan	Actual	Period
= 0.0	0.0	Mar-25

Year to Date

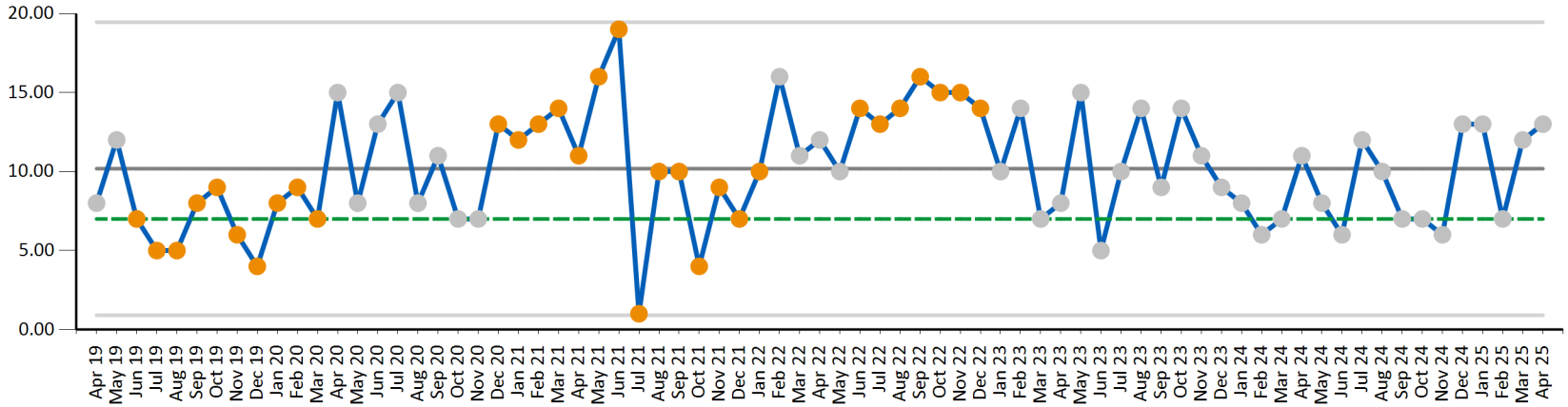
Plan	Actual
= 0.0	0.0

18 - Number of Community incidences - pressure damage (category 2)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 7.0	13.0	Apr-25

Previous

Plan	Actual	Period
<= 7.0	12.0	Mar-25

Year to Date

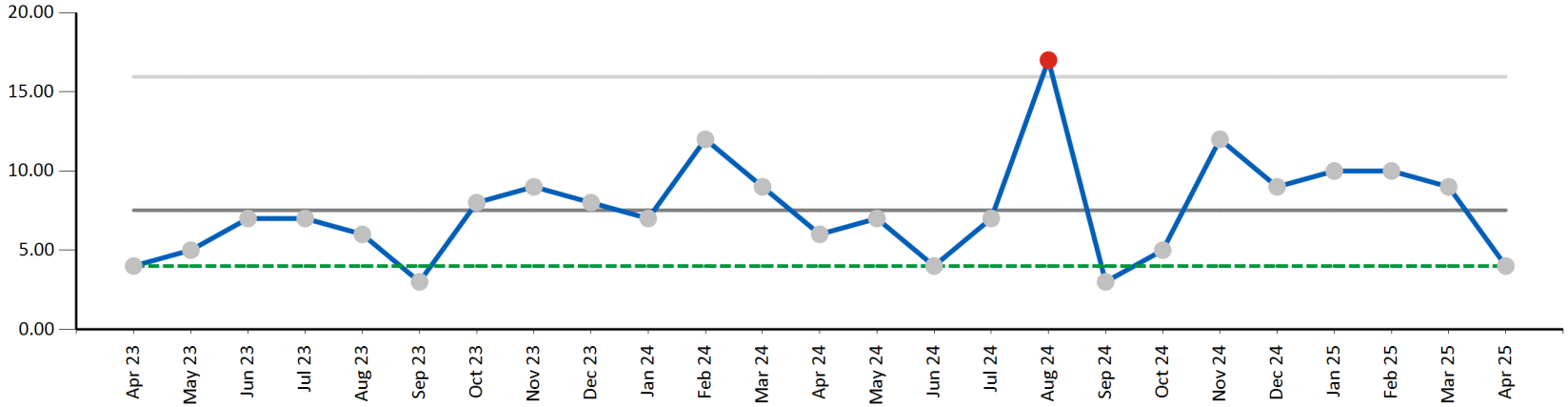
Plan	Actual
<= 7.0	13.0

621 - Number of Community incidences - pressure damage (category 3 plus unstageables)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 4	4	Apr-25

Previous

Plan	Actual	Period
<= 4	9	Mar-25

Year to Date

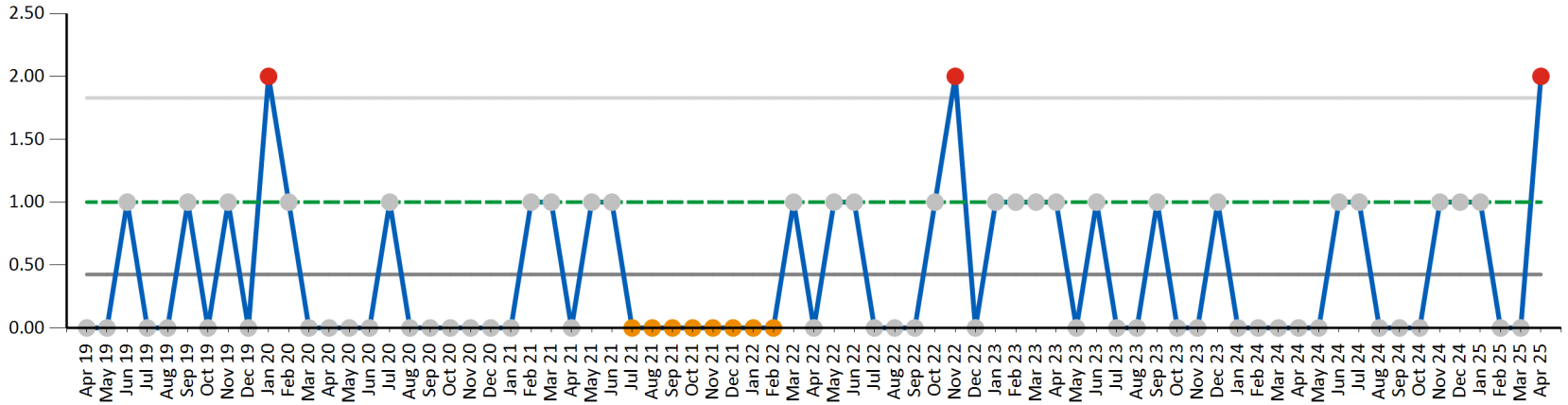
Plan	Actual
<= 4	4

20 - Number of Community incidences - pressure damage (category 4)

Special cause variation with deteriorating performance

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

5/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Apr-25

Previous

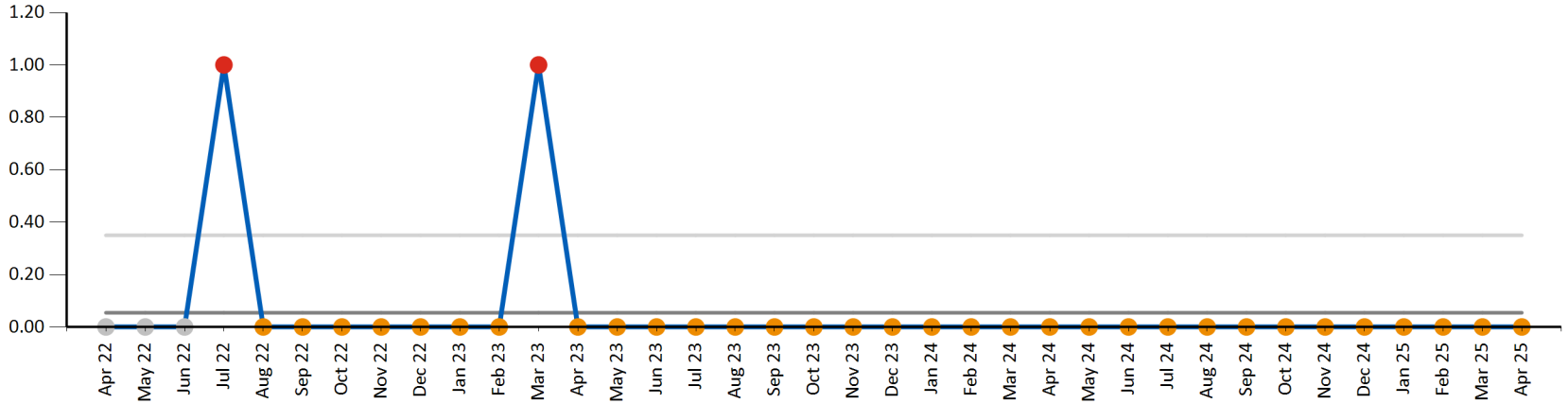
Plan	Actual	Period
<= 1.0	0.0	Mar-25

Year to Date

Plan	Actual
<= 1.0	2.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Apr-25

Previous

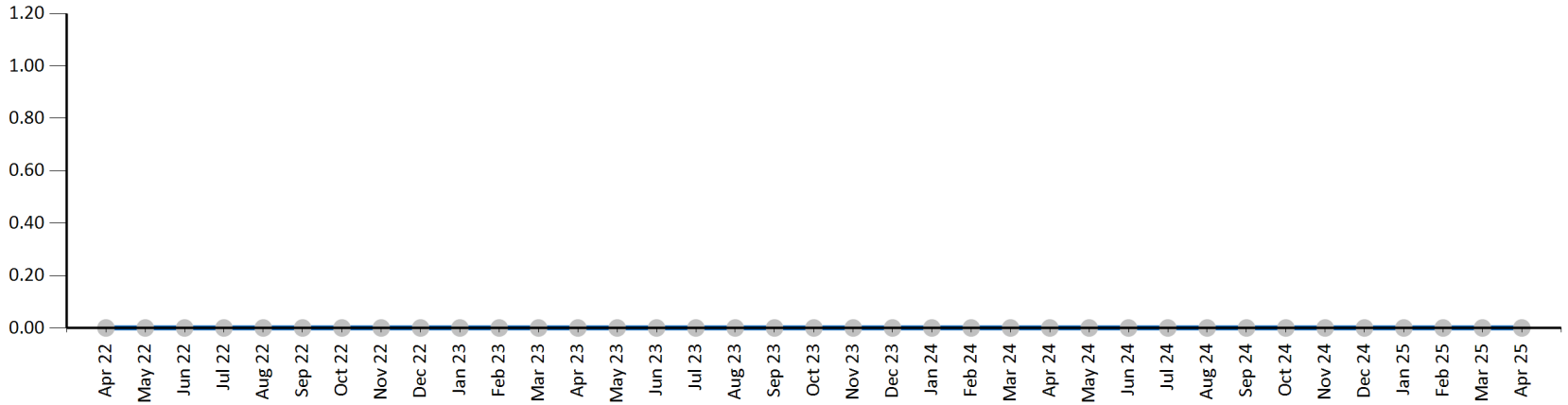
Plan	Actual	Period
	0	Mar-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-25

Previous

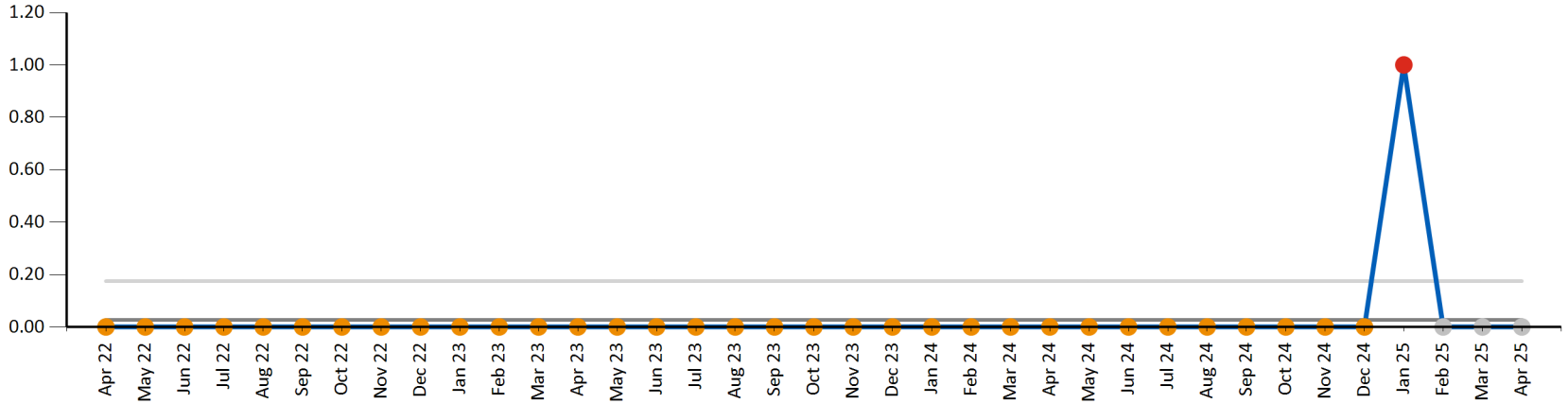
Plan	Actual	Period
	0	Mar-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-25

Previous

Plan	Actual	Period
	0	Mar-25

Year to Date

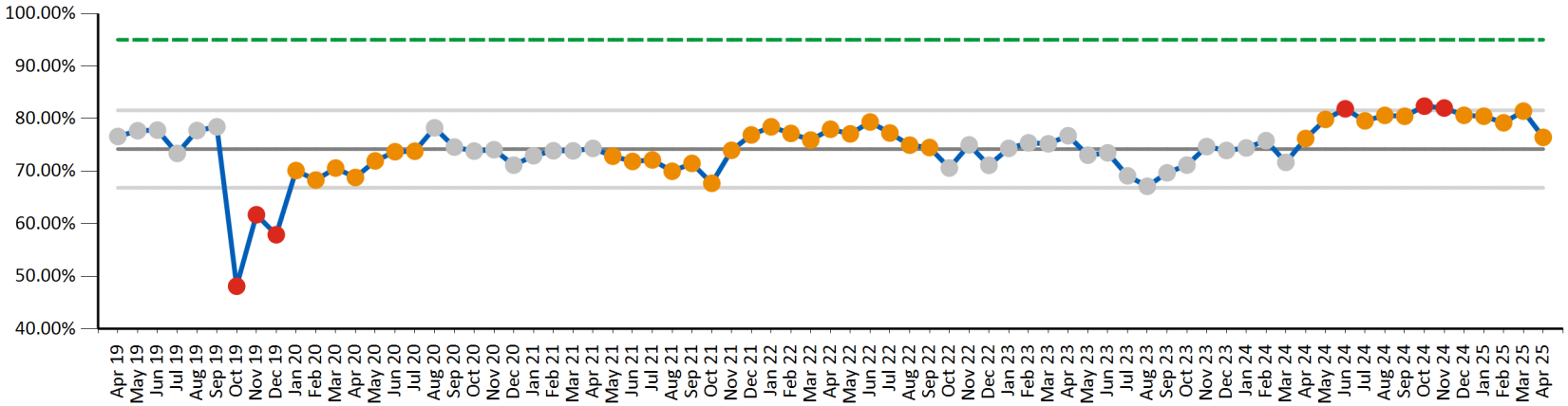
Plan	Actual
	0

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%	76.4%	Apr-25

Previous

Plan	Actual	Period
>= 95%	81.4%	Mar-25

Year to Date

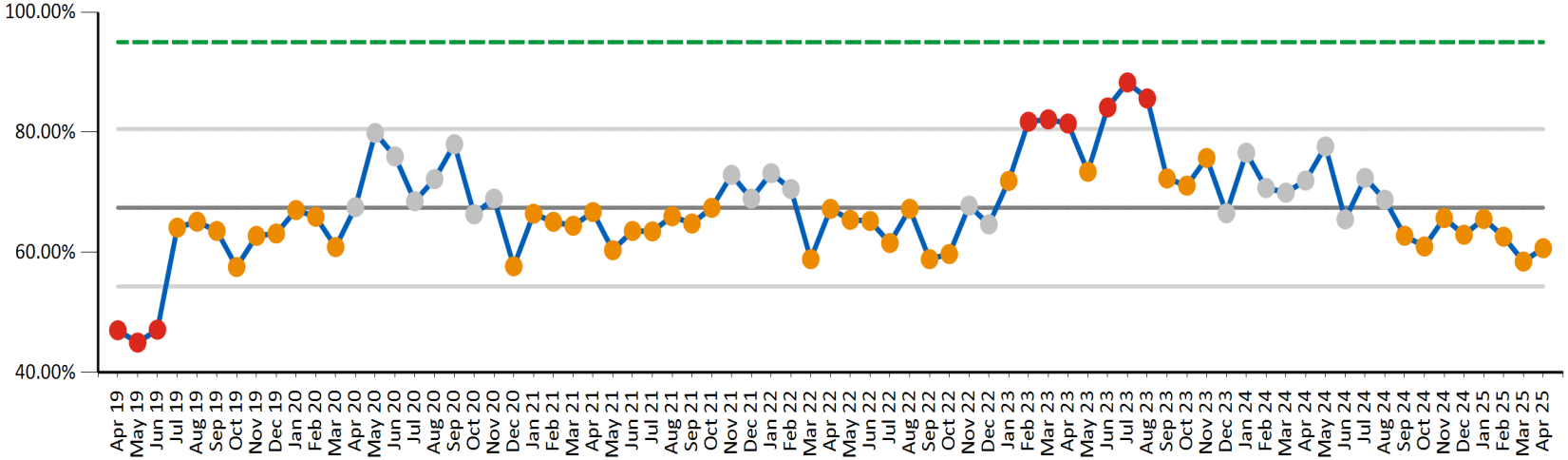
Plan	Actual
>= 95%	76.4%

31 - Clinical Correspondence - Outpatients %<5 working days

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	60.7%	Apr-25

Previous

Plan	Actual	Period
>= 95.0%	58.5%	Mar-25

Year to Date

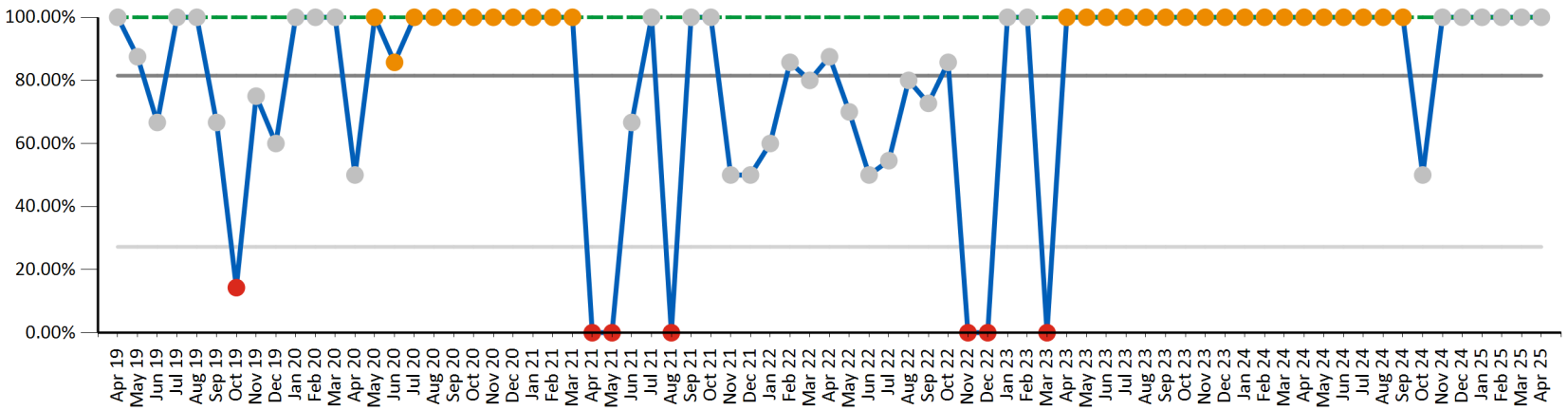
Plan	Actual
>= 95.0%	60.7%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 100%	100.0%	Apr-25

Previous

Plan	Actual	Period
= 100%	100.0%	Mar-25

Year to Date

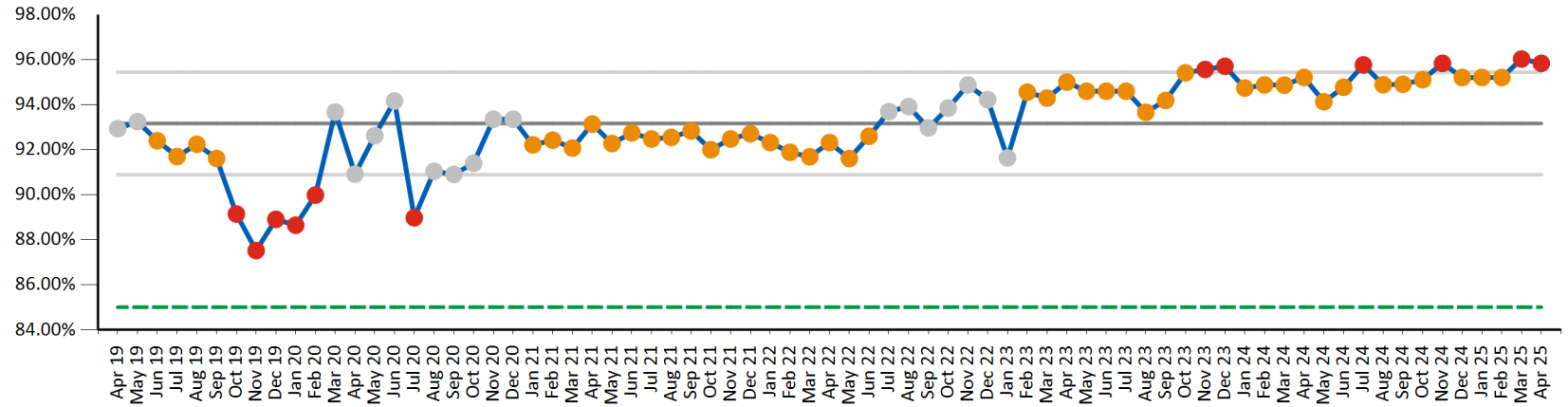
Plan	Actual
= 100%	100.0%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.8%	Apr-25

Previous

Plan	Actual	Period
>= 85%	96.0%	Mar-25

Year to Date

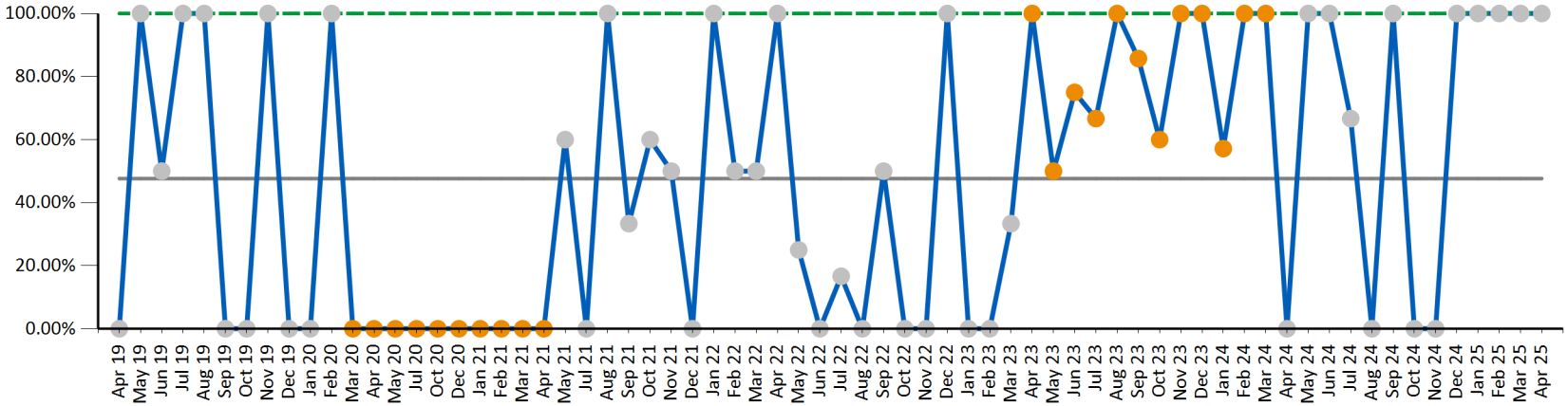
Plan	Actual
>= 85%	95.8%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Apr-25

Previous

Plan	Actual	Period
= 100%	100.0%	Mar-25

Year to Date

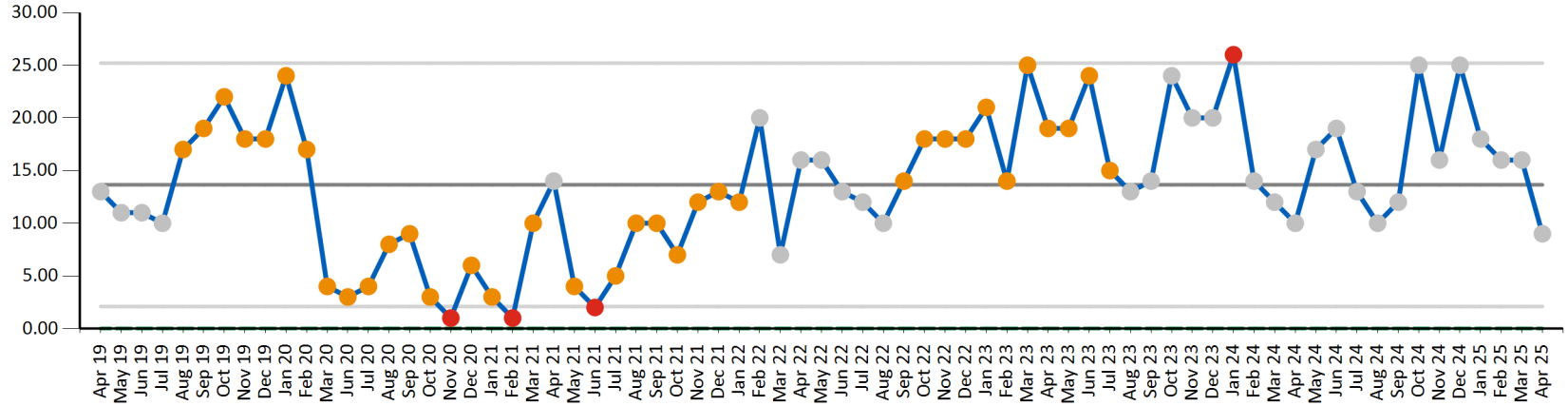
Plan	Actual
= 100%	

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	9	Apr-25

Previous

Plan	Actual	Period
= 0	16	Mar-25

Year to Date

Plan	Actual
= 0	9

Quality and Safety - Infection Prevention and Control

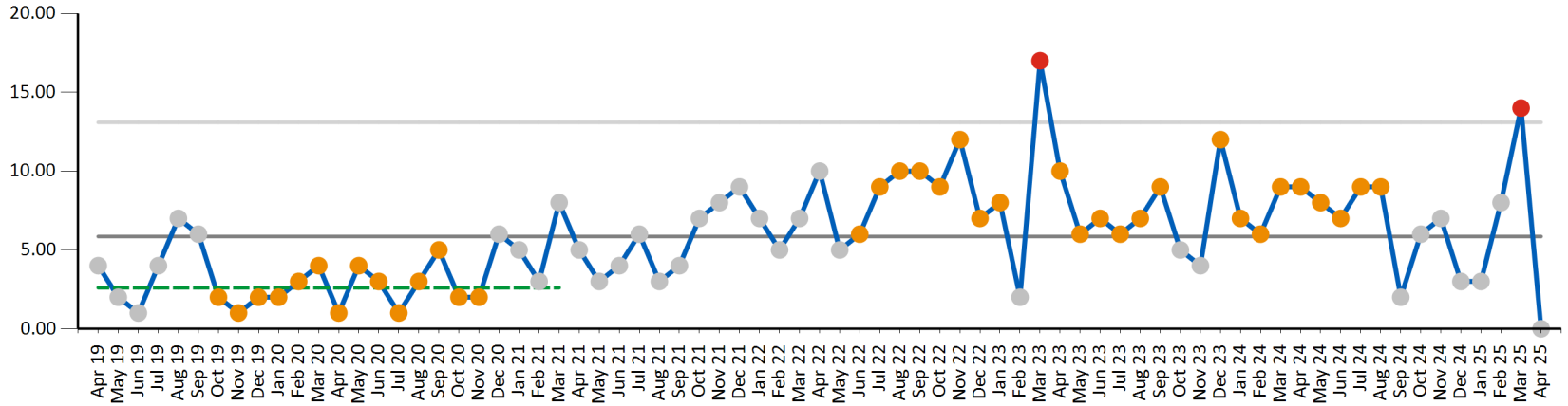
NHS Bolton NHS Foundation Trust

There were no healthcare associated CDT cases in April; there was a 37 period between the last case of 24/25 and the first case in 25/26. There is now a more detailed weekly focus on the factors leading to delays in isolation.
For the remainder of the HCAI measures, Bolton is the best performer in GM with the exception of Pseudomonas aeruginosa BSI for which Bolton ranks fourth.

	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		0	Apr-25			14	Mar-25		0	
346 - Total Community Onset Hospital Associated C.diff infections		0	Apr-25			1	Mar-25		0	
347 - Total C.diff infections contributing to objective	<= 10	0	Apr-25		<= 10	15	Mar-25	<= 10	0	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Apr-25		= 0	0	Mar-25	= 0		
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	3	Apr-25		<= 5	3	Mar-25	<= 5	3	
219 - Blood Culture Contaminants (rate)	<= 3%	2.3%	Apr-25		<= 3%	3.9%	Mar-25	<= 3%		
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Apr-25		<= 1.0	1.0	Mar-25	<= 1.0	1.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	1	Apr-25		<= 1	1	Mar-25	<= 1	1	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Apr-25		= 0	1	Mar-25	= 0		
491 - Nosocomial COVID-19 cases		11	Apr-25			19	Mar-25		11	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-25

Previous

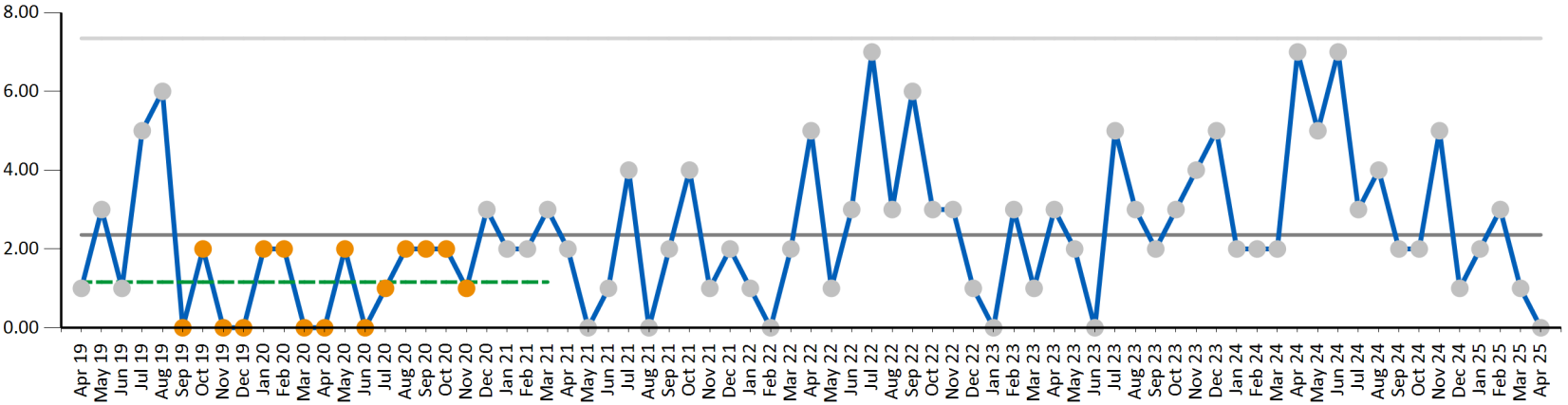
Plan	Actual	Period
	14	Mar-25

Year to Date

Plan	Actual
	0

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-25

Previous

Plan	Actual	Period
	1	Mar-25

Year to Date

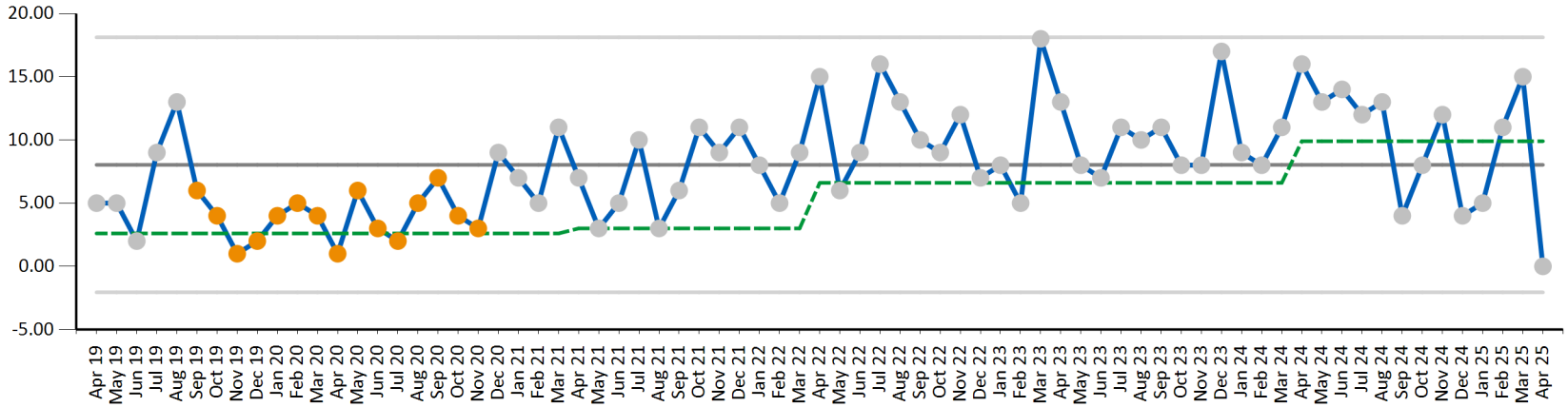
Plan	Actual
	0

347 - Total C.diff infections contributing to objective

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 10	0	Apr-25

Previous

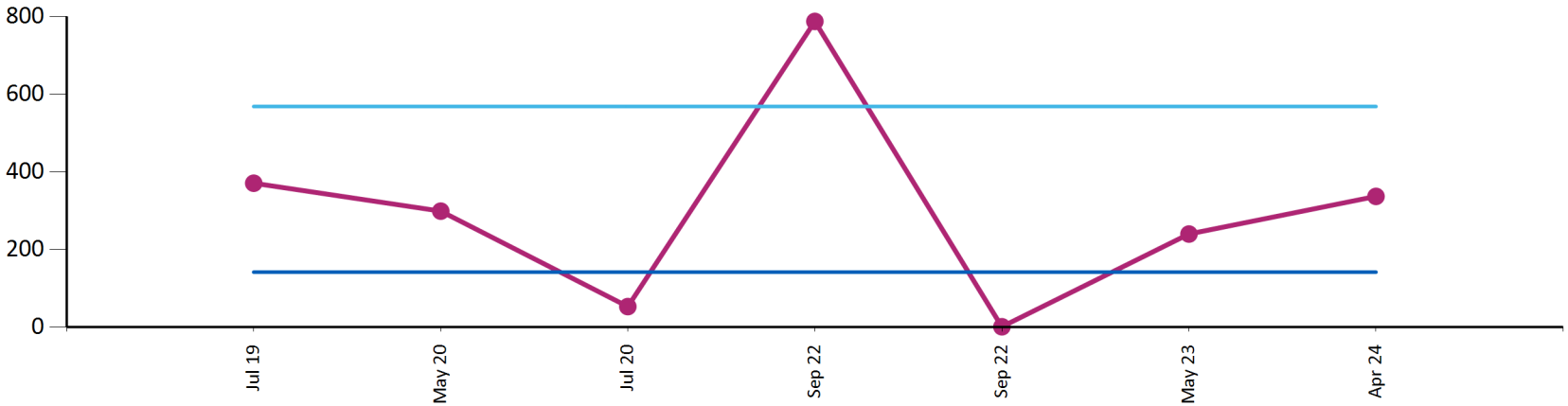
Plan	Actual	Period
<= 10	15	Mar-25

Year to Date

Plan	Actual
<= 10	0

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Apr-25

Previous

Plan	Actual	Period
	0	Mar-25

Year to Date

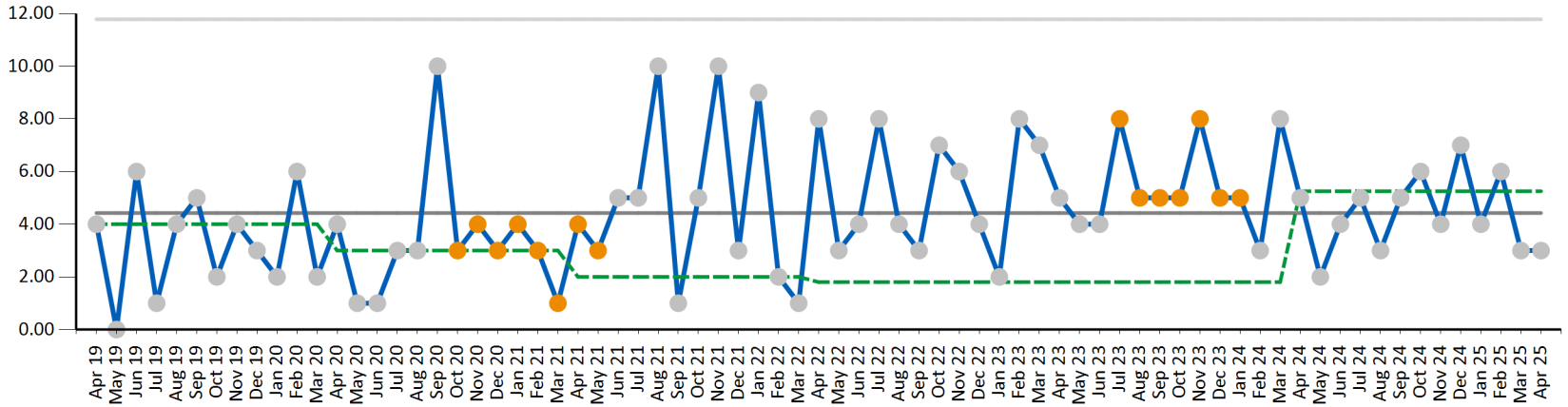
Plan	Actual

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 5	3	Apr-25

Previous

Plan	Actual	Period
<= 5	3	Mar-25

Year to Date

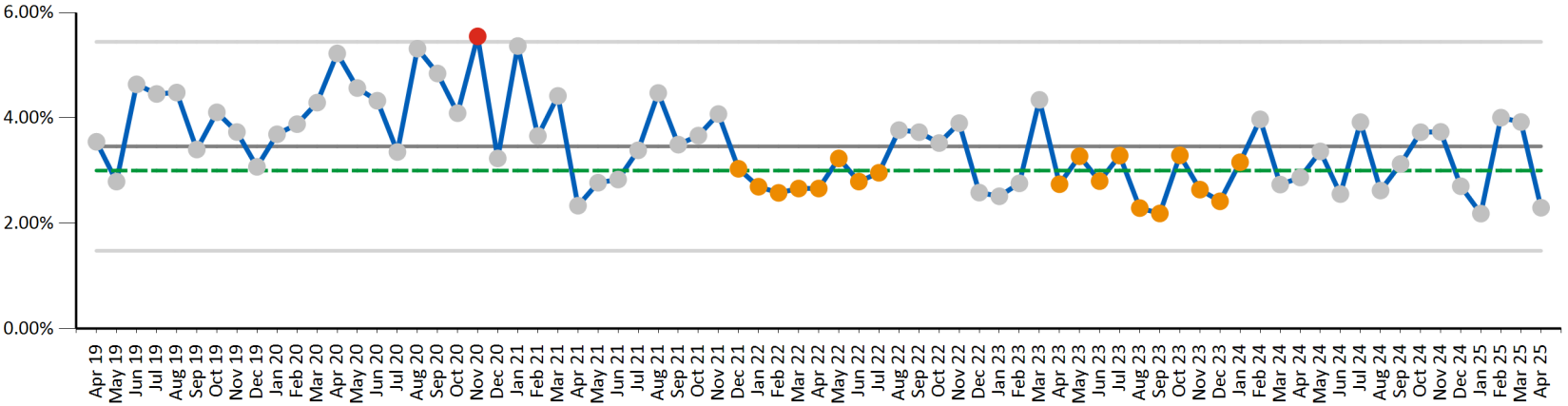
Plan	Actual
<= 5	3

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3%	2.3%	Apr-25

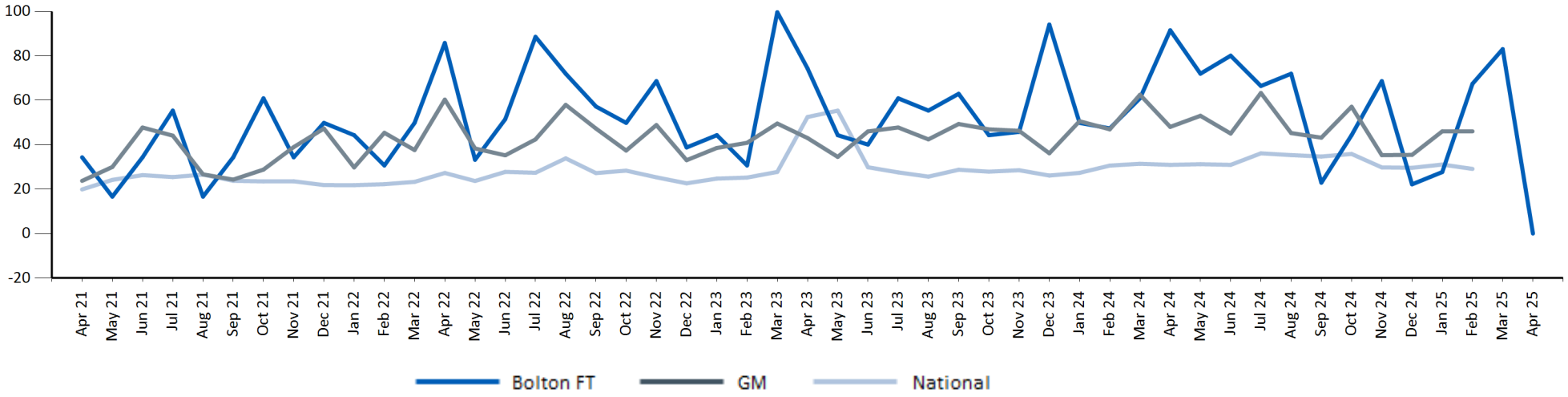
Previous

Plan	Actual	Period
<= 3%	3.9%	Mar-25

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

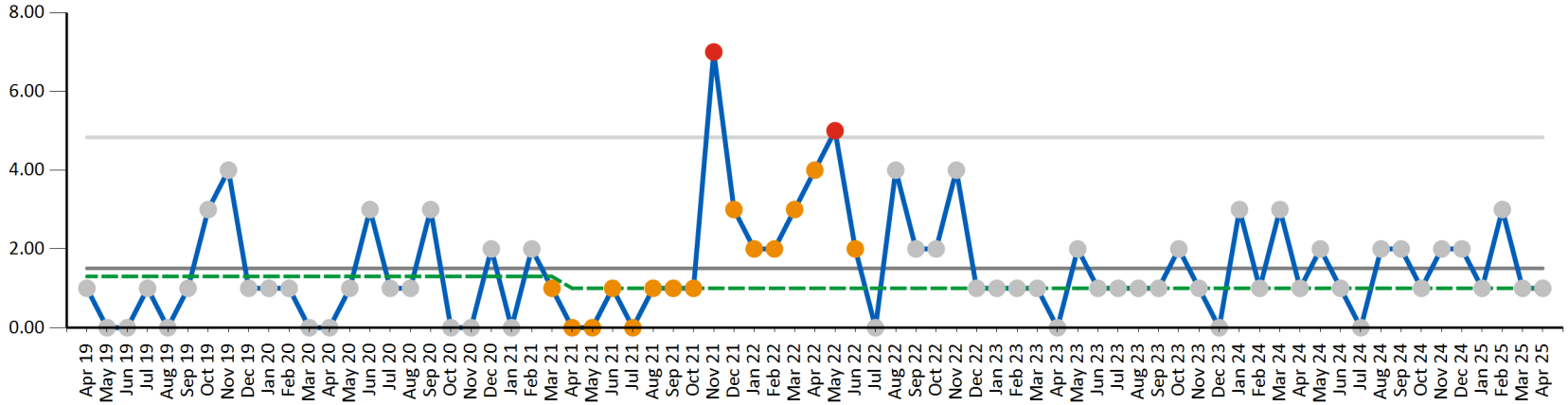


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Apr-25

Previous

Plan	Actual	Period
<= 1.0	1.0	Mar-25

Year to Date

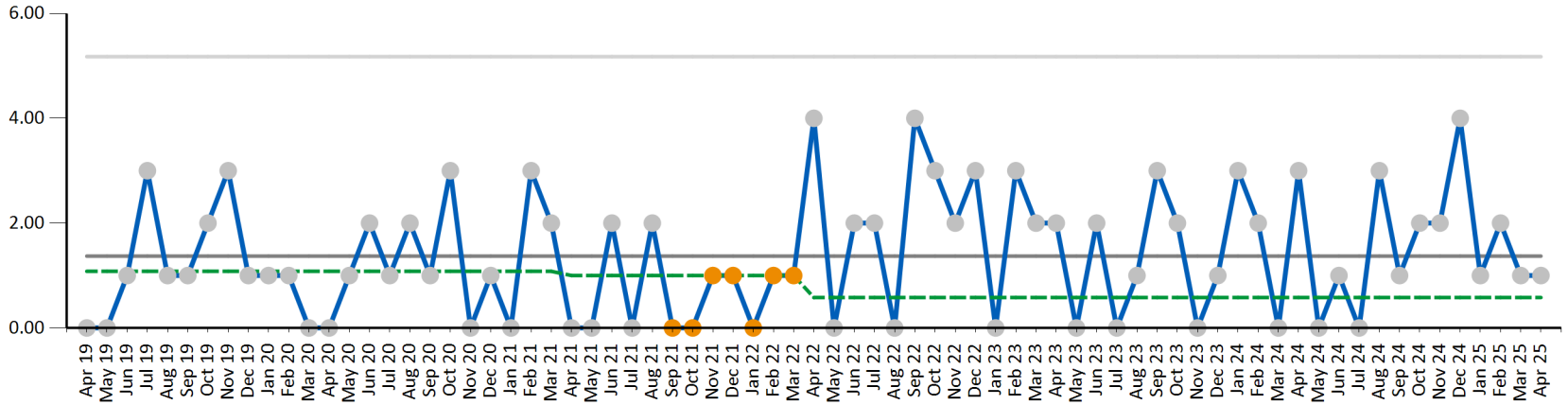
Plan	Actual
<= 1.0	1.0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 1	1	Apr-25

Previous

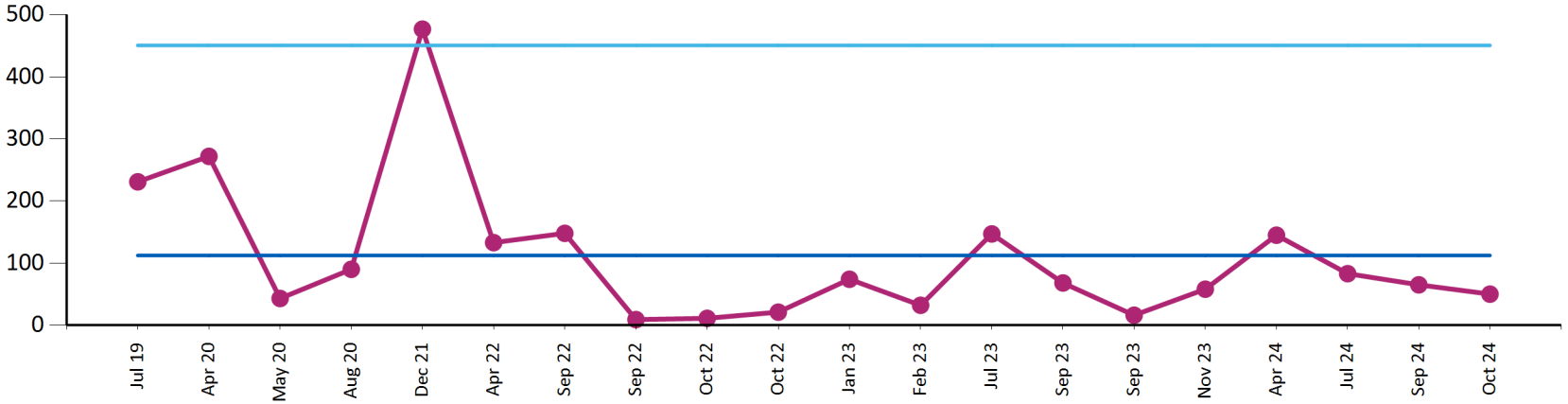
Plan	Actual	Period
<= 1	1	Mar-25

Year to Date

Plan	Actual
<= 1	1

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

0/6



Latest

Plan	Actual	Period
	0	Apr-25

Previous

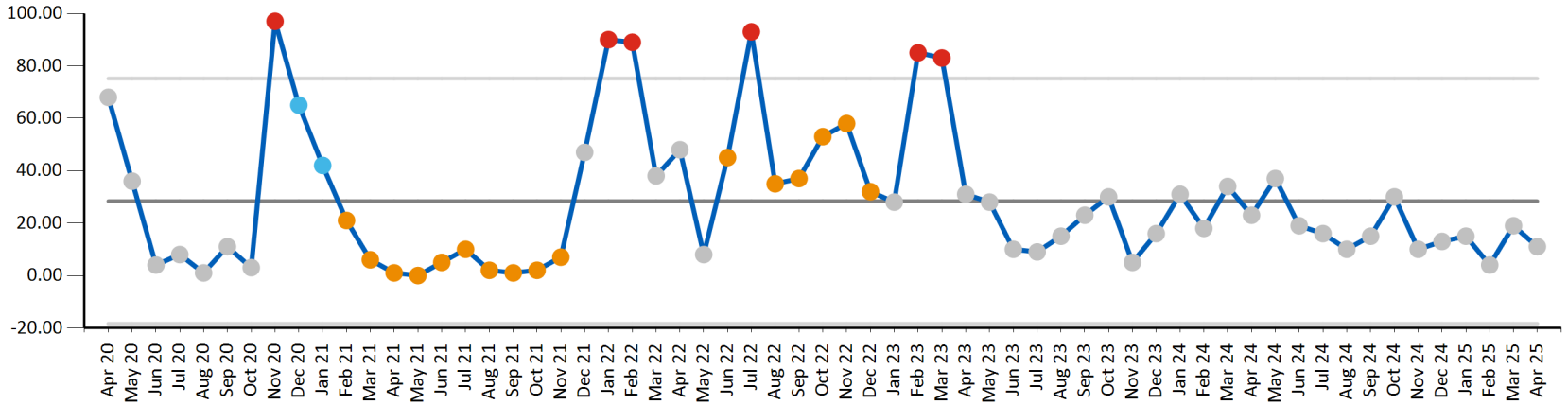
Plan	Actual	Period
	0	Mar-25

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	11	Apr-25

Previous

Plan	Actual	Period
	19	Mar-25

Year to Date

Plan	Actual
	11

Quality and Safety - Mortality

NHS Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing as 15 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is below the average for the period and remains in control. The 12 month rolling average to January 2025 is 113.47 which is a 'Red' alert when compared to other Trusts.

SHMI – In month figure is below the average for the time period and remains in control. The published rolling average for the period January to December 2024 is 117.61 which is 'higher than expected'.

The proportion of Charlson comorbidities is just below 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 above the average for the timeframe.

The early neonatal mortality remains in control and has been for more than 12 months.

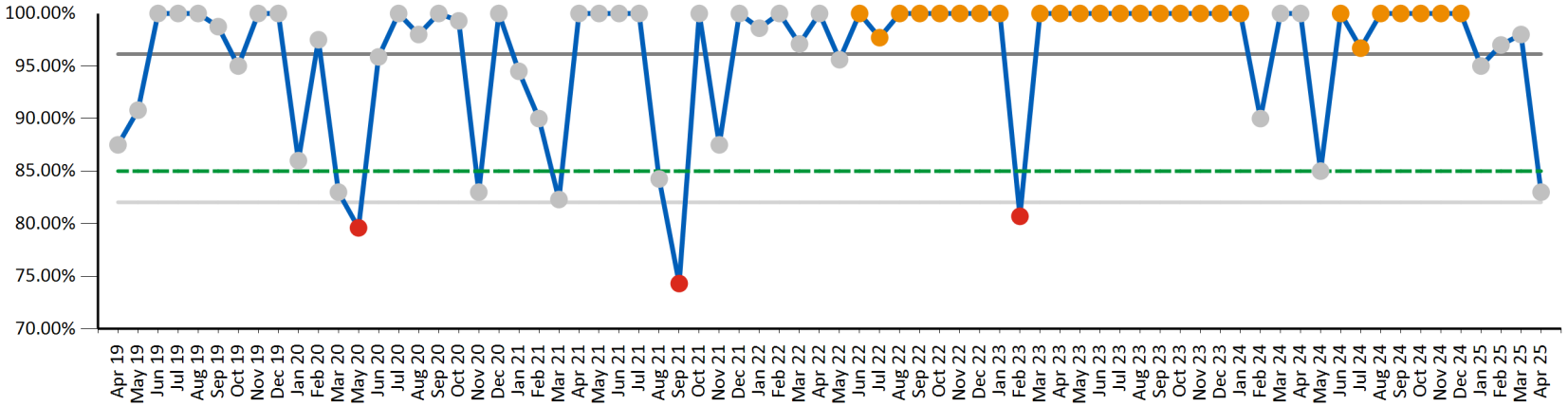
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	83.0%	Apr-25		>= 85%	98.0%	Mar-25	>= 85%	83.0%	
495 - HSMR		103.17	Jan-25			108.47	Dec-24			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	106.20	Nov-24		<= 100.00	110.57	Oct-24	<= 100.00		
12 - Crude Mortality %	<= 2.9%	1.9%	Apr-25	L	<= 2.9%	1.7%	Mar-25	<= 2.9%	1.9%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Jan-25			4	Dec-24			
520 - Depth of recording (First episode of care)		6	Jan-25			6	Dec-24			
521 - Proportion of fully coded records (Inpatients)		97.3%	Jan-25	H		99.6%	Dec-24			
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		2.00	Apr-25			5.00	Mar-25			

3 - National Early Warning Scores to Gold standard

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 85%	83.0%	Apr-25

Previous

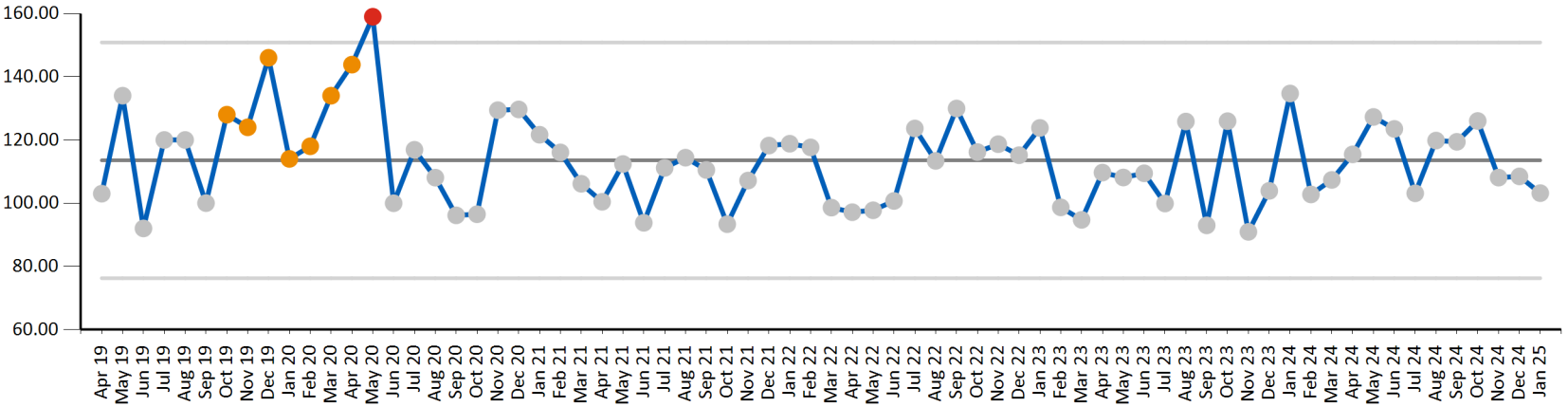
Plan	Actual	Period
>= 85%	98.0%	Mar-25

Year to Date

Plan	Actual
>= 85%	83.0%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	103.17	Jan-25

Previous

Plan	Actual	Period
	108.47	Dec-24

Year to Date

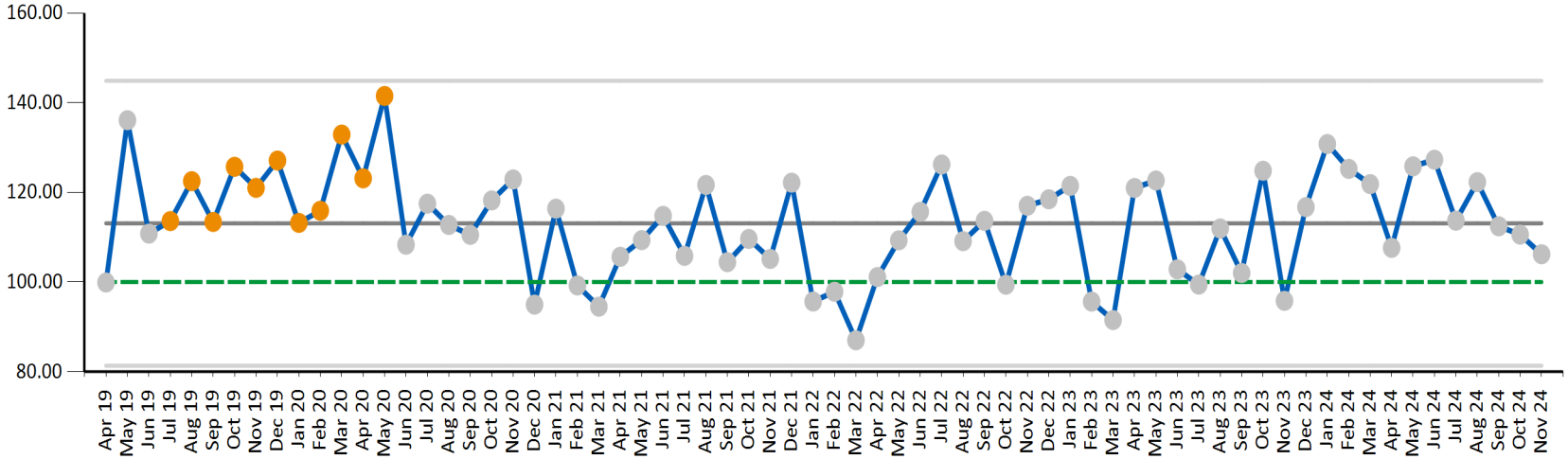
Plan	Actual
	103.17

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	106.20	Nov-24

Previous

Plan	Actual	Period
<= 100.00	110.57	Oct-24

Year to Date

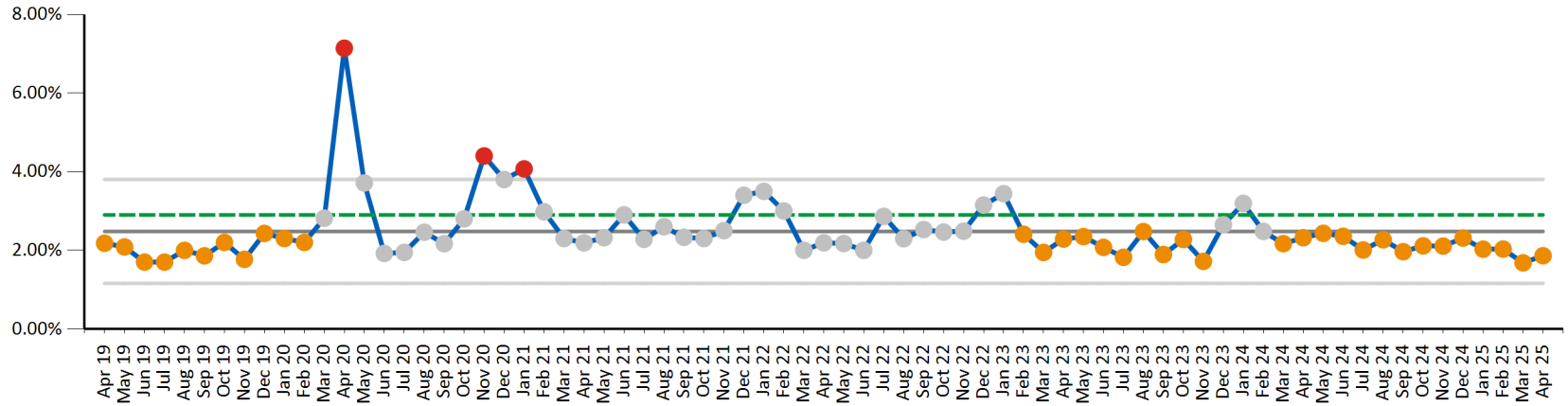
Plan	Actual
<= 100.00	106.20

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%	1.9%	Apr-25

Previous

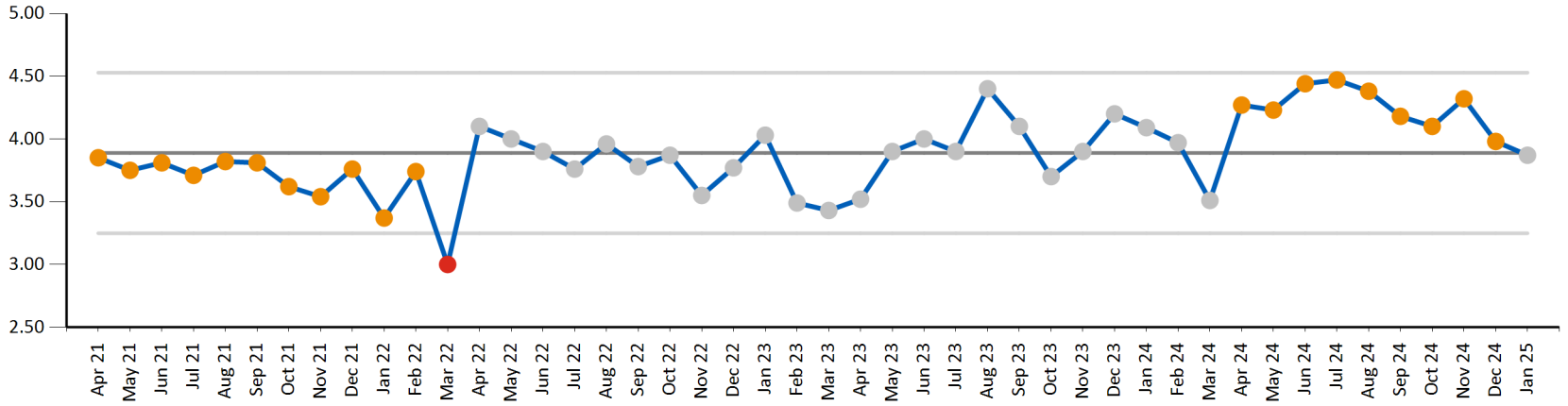
Plan	Actual	Period
<= 2.9%	1.7%	Mar-25

Year to Date

Plan	Actual
<= 2.9%	1.9%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Jan-25

Previous

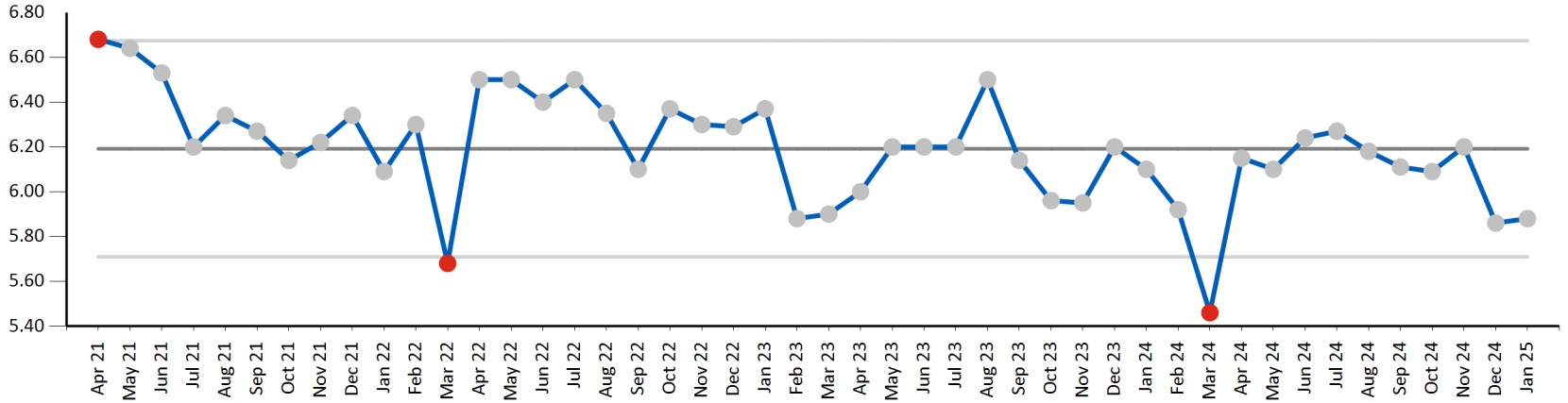
Plan	Actual	Period
	4	Dec-24

Year to Date

Plan	Actual
	42

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	Jan-25

Previous

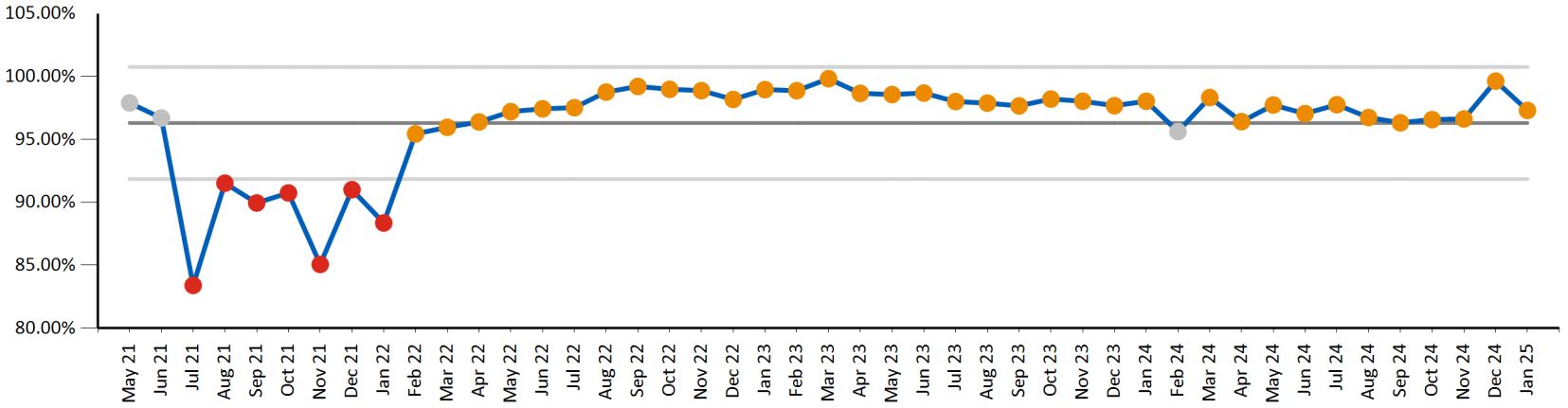
Plan	Actual	Period
	6	Dec-24

Year to Date

Plan	Actual
	61

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	97.3%	Jan-25

Previous

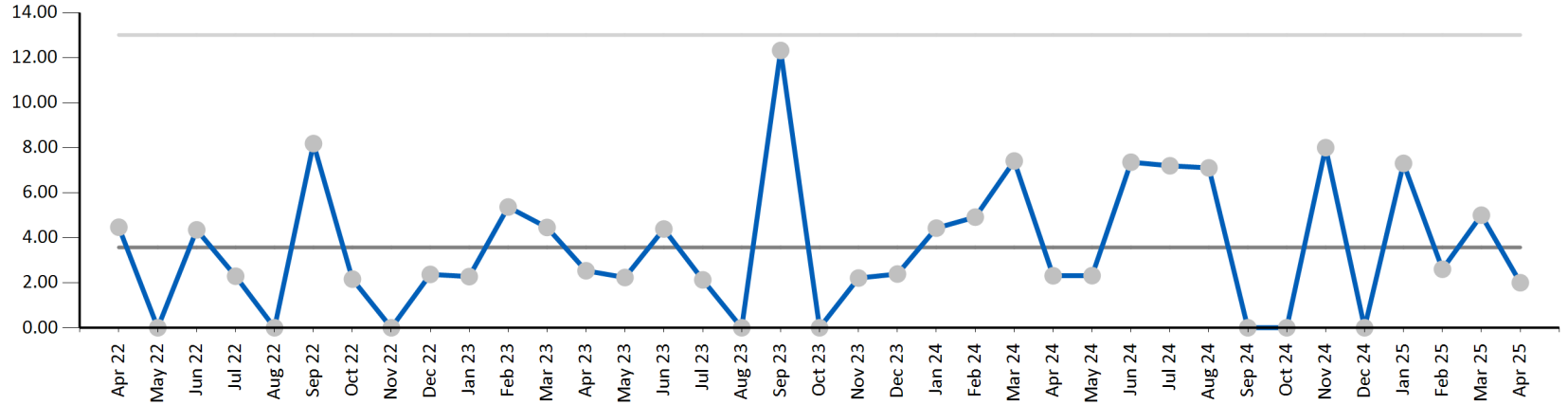
Plan	Actual	Period
	99.6%	Dec-24

Year to Date

Plan	Actual
	97.2%

604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)

Common cause variation.



Latest

Plan	Actual	Period
	2.00	Apr-25

Previous

Plan	Actual	Period
	5.00	Mar-25

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and satisfaction rates

Accident and Emergency response rates remain below the 20% target rate however is within common cause variation. A new process is being trialled which includes the use of QR codes which it is felt will lead to improvement in response rates in paediatric ED. The Department has a patient experience improvement plan in place which addresses the themes that have been highlighted through patient feedback.

Complaint response rates

Complaints responded to within Trust target compliance remain below the target of 95% at 75% however this remains within common cause variation.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.1%	Apr-25	L	>= 20%	14.9%	Mar-25	>= 20%	14.1%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	86.5%	Apr-25		>= 90%	86.7%	Mar-25	>= 90%	86.5%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	26.2%	Apr-25		>= 30%	20.5%	Mar-25	>= 30%	26.2%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.3%	Apr-25		>= 90%	97.4%	Mar-25	>= 90%	96.3%	P
81 - Maternity Friends and Family Response Rate	>= 15%	25.3%	Apr-25		>= 15%	28.8%	Mar-25	>= 15%	25.3%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.0%	Apr-25		>= 90%	93.2%	Mar-25	>= 90%	91.0%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	14.3%	Apr-25		>= 15%	19.7%	Mar-25	>= 15%	14.3%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	96.9%	Apr-25		>= 90%	93.6%	Mar-25	>= 90%	96.9%	?
83 - Birth - Friends and Family Response Rate	>= 15%	39.7%	Apr-25	H	>= 15%	42.5%	Mar-25	>= 15%	39.7%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.0%	Apr-25		>= 90%	94.7%	Mar-25	>= 90%	89.0%	?

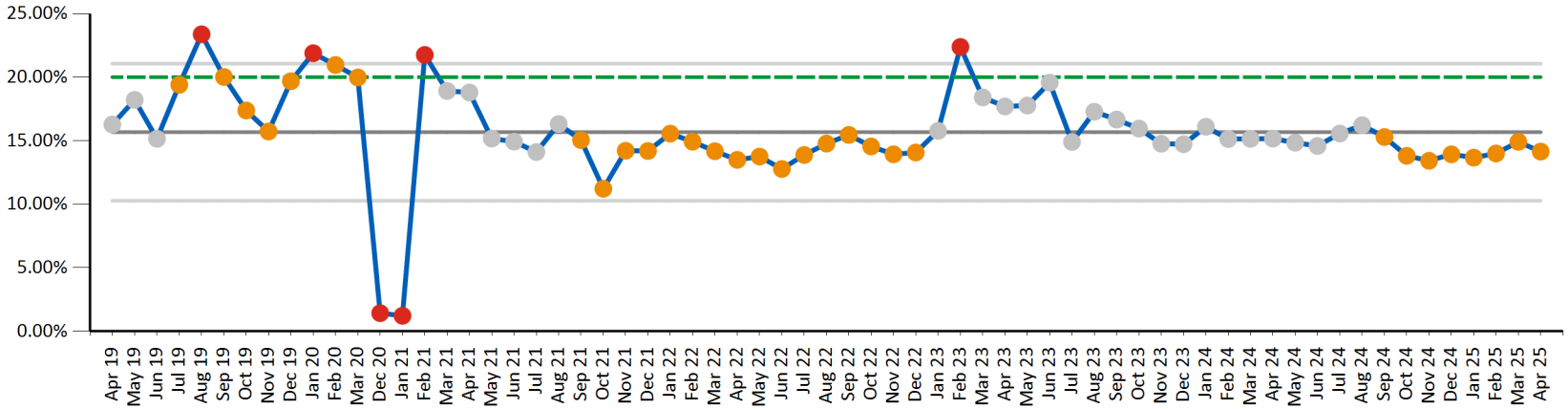
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	18.1%	Apr-25		>= 15%	33.7%	Mar-25	>= 15%	18.1%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	82.4%	Apr-25		>= 90%	92.5%	Mar-25	>= 90%	82.4%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	26.3%	Apr-25		>= 15%	24.3%	Mar-25	>= 15%	26.3%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	94.8%	Apr-25		>= 90%	90.6%	Mar-25	>= 90%	94.8%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Apr-25		= 100%	88.2%	Mar-25	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	75.0%	Apr-25		>= 95%	41.7%	Mar-25	>= 95%	75.0%	

200 - A&E Friends and Family Response Rate

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 20%	14.1%	Apr-25

Previous

Plan	Actual	Period
>= 20%	14.9%	Mar-25

Year to Date

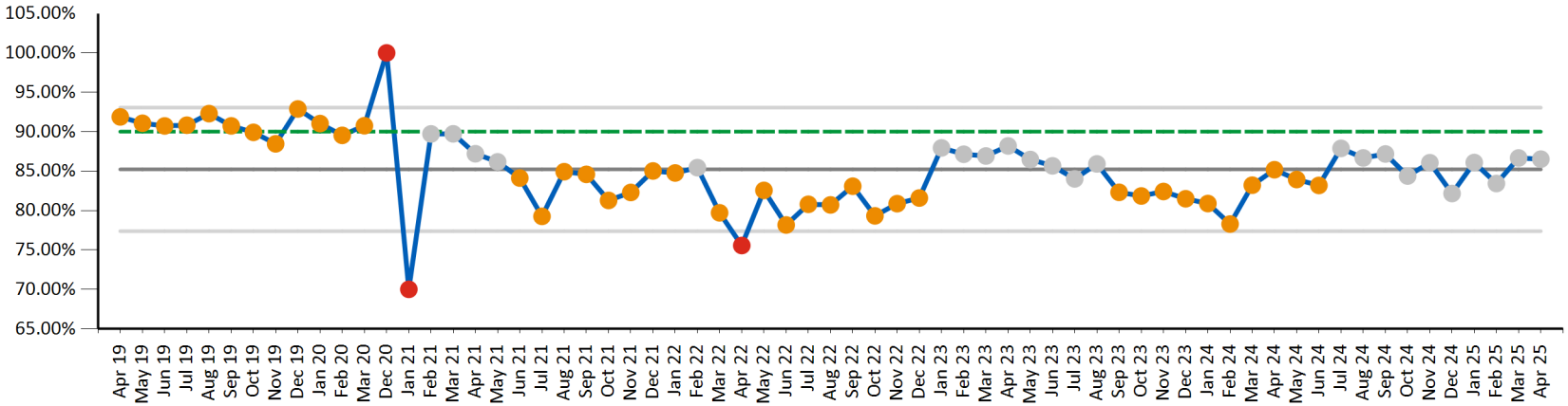
Plan	Actual
>= 20%	14.1%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 90%	86.5%	Apr-25

Previous

Plan	Actual	Period
>= 90%	86.7%	Mar-25

Year to Date

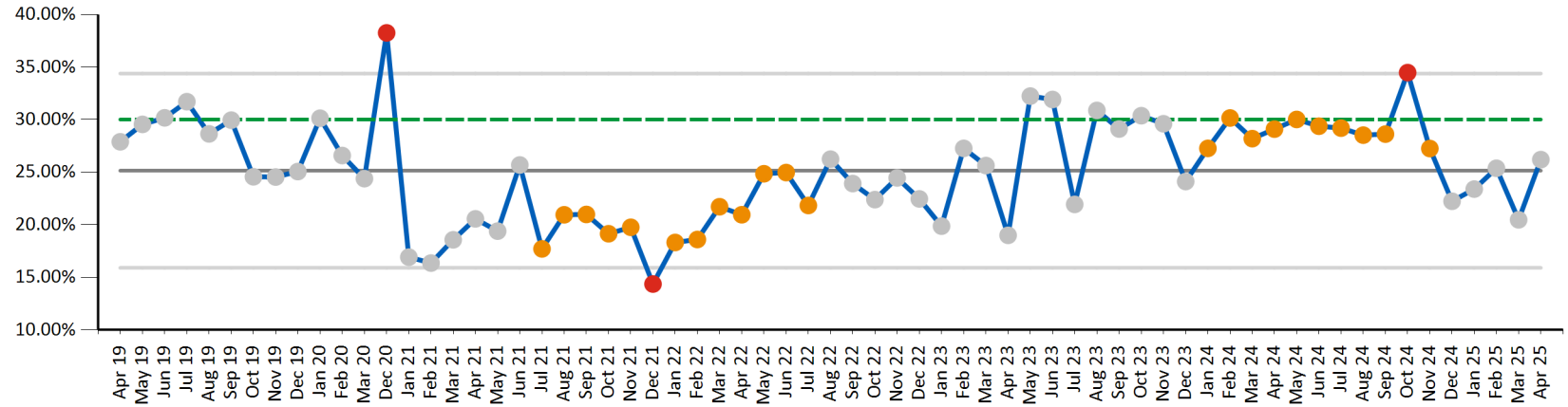
Plan	Actual
>= 90%	86.5%

80 - Inpatient 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
>= 30%	26.2%	Apr-25

Previous

Plan	Actual	Period
>= 30%	20.5%	Mar-25

Year to Date

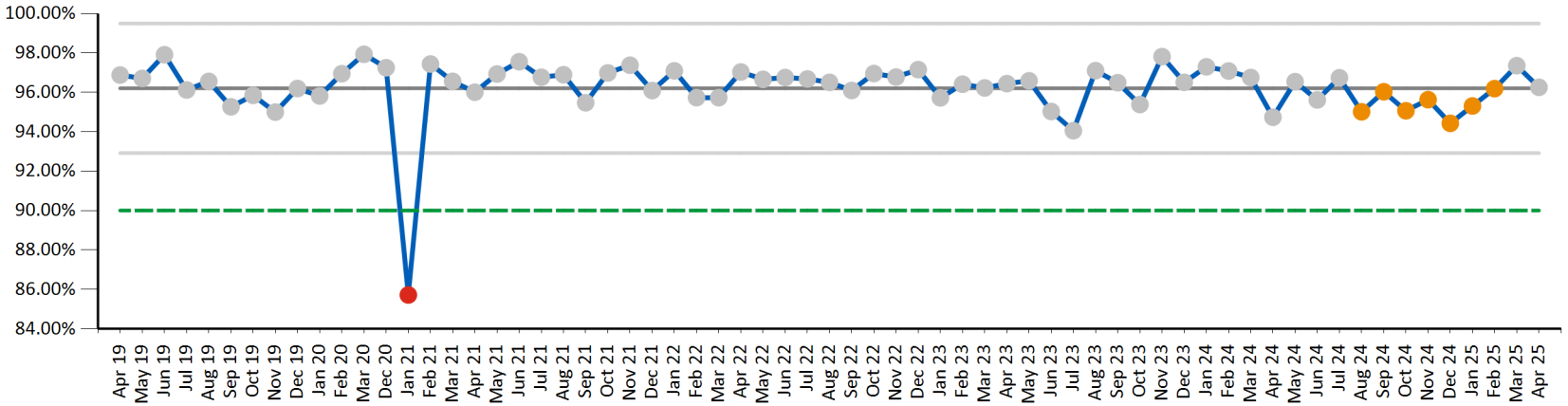
Plan	Actual
>= 30%	26.2%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	96.3%	Apr-25

Previous

Plan	Actual	Period
>= 90%	97.4%	Mar-25

Year to Date

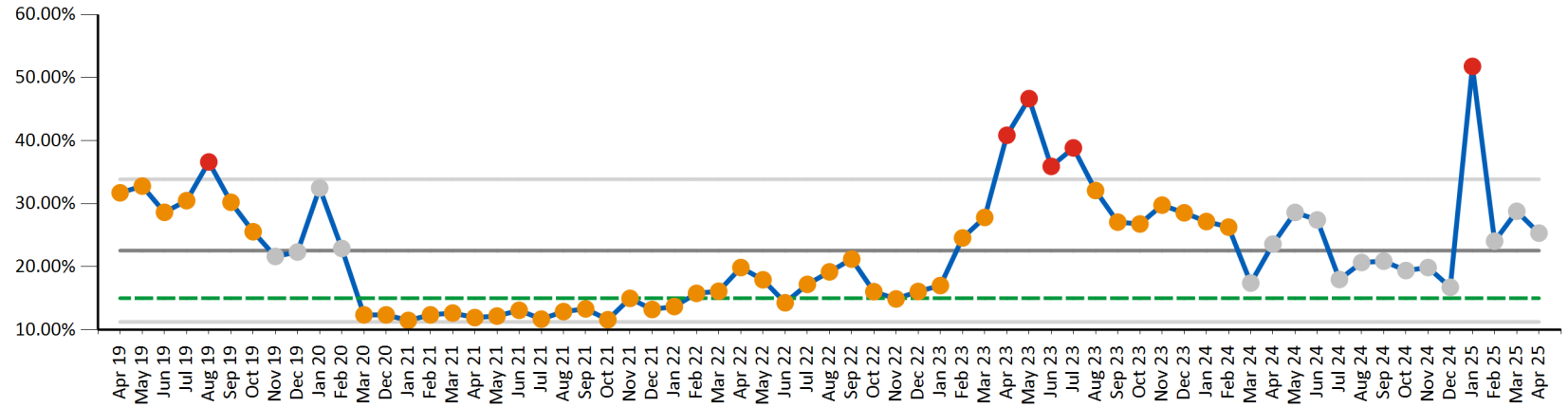
Plan	Actual
>= 90%	96.3%

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%	25.3%	Apr-25

Previous

Plan	Actual	Period
>= 15%	28.8%	Mar-25

Year to Date

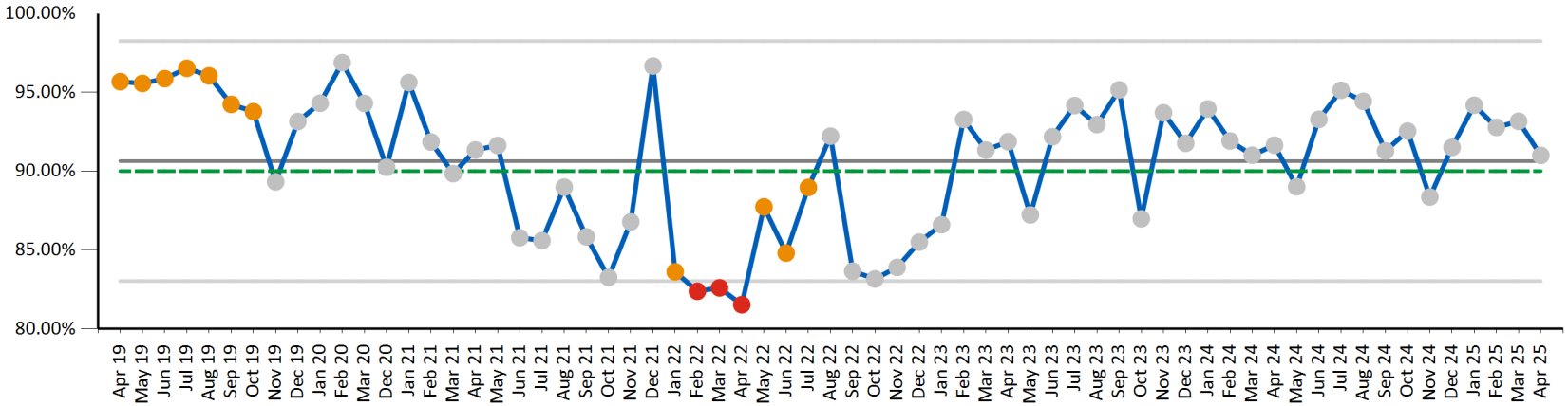
Plan	Actual
>= 15%	25.3%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	91.0%	Apr-25

Previous

Plan	Actual	Period
>= 90%	93.2%	Mar-25

Year to Date

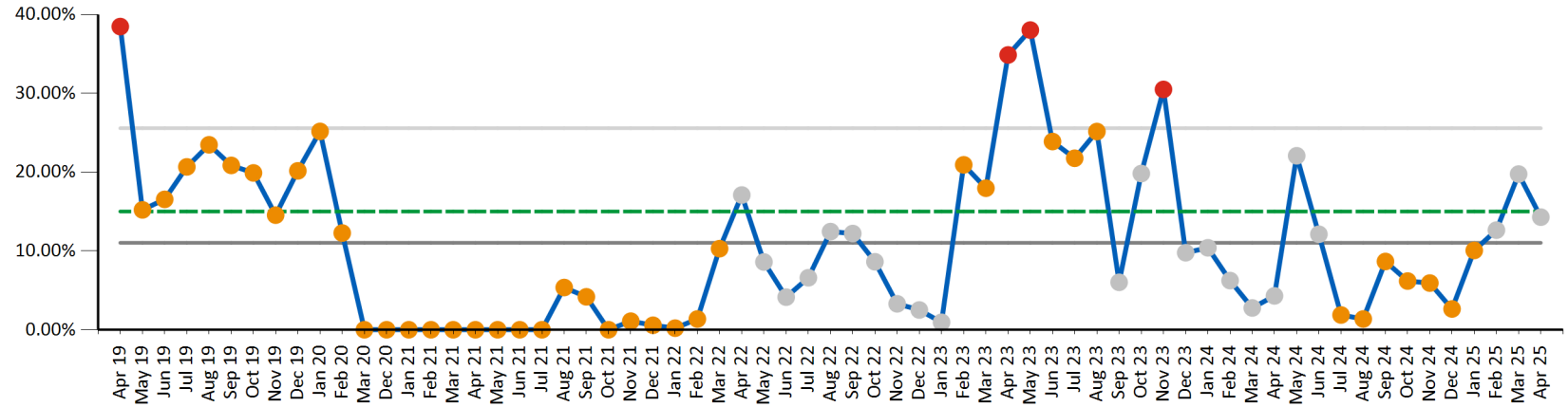
Plan	Actual
>= 90%	91.0%

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%	14.3%	Apr-25

Previous

Plan	Actual	Period
>= 15%	19.7%	Mar-25

Year to Date

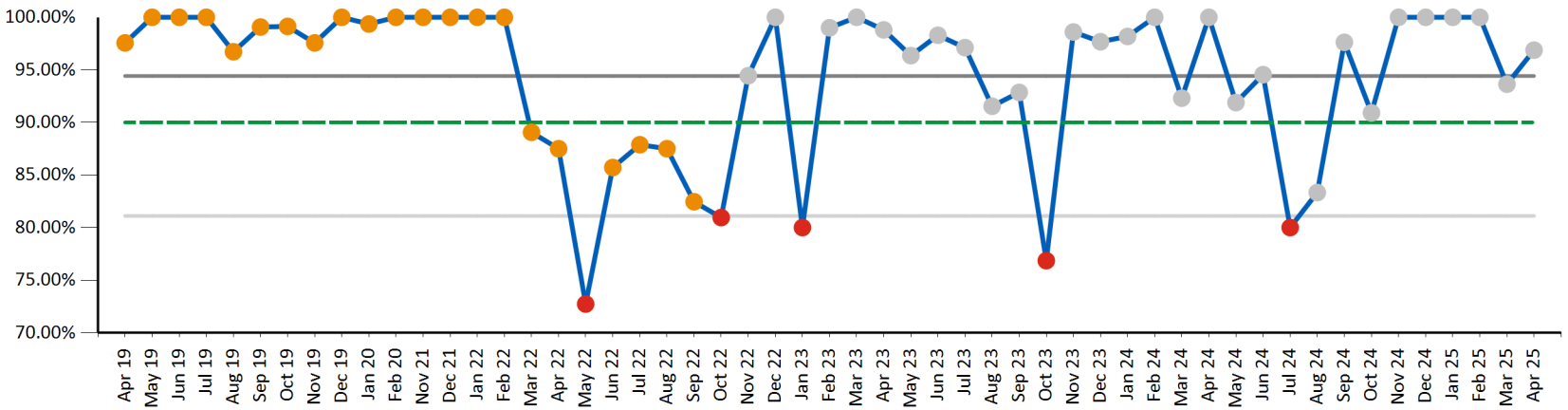
Plan	Actual
>= 15%	14.3%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 90%	96.9%	Apr-25

Previous

Plan	Actual	Period
>= 90%	93.6%	Mar-25

Year to Date

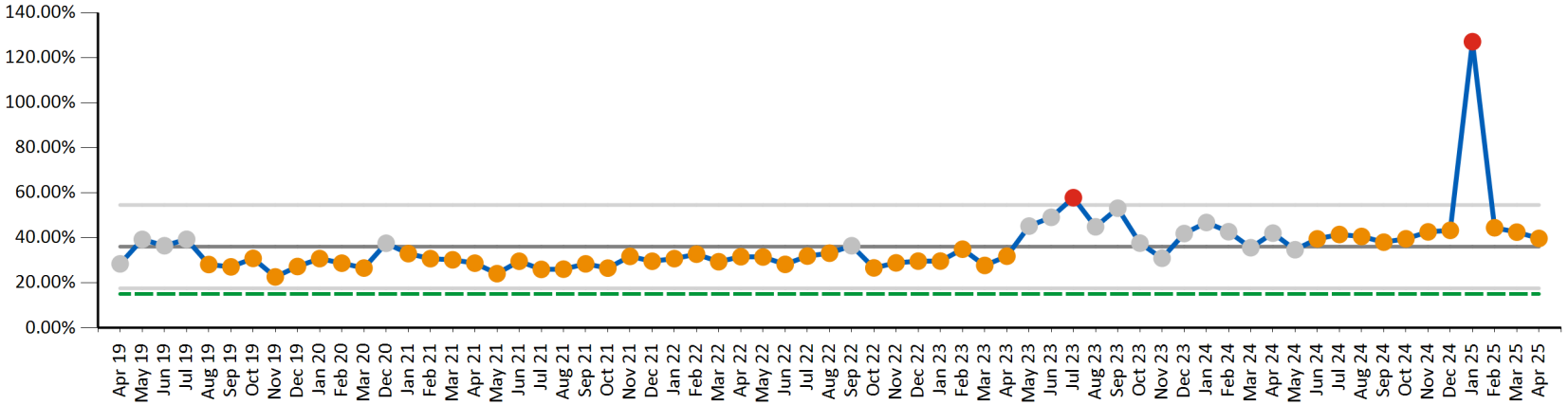
Plan	Actual
>= 90%	96.9%

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%	39.7%	Apr-25

Previous

Plan	Actual	Period
>= 15%	42.5%	Mar-25

Year to Date

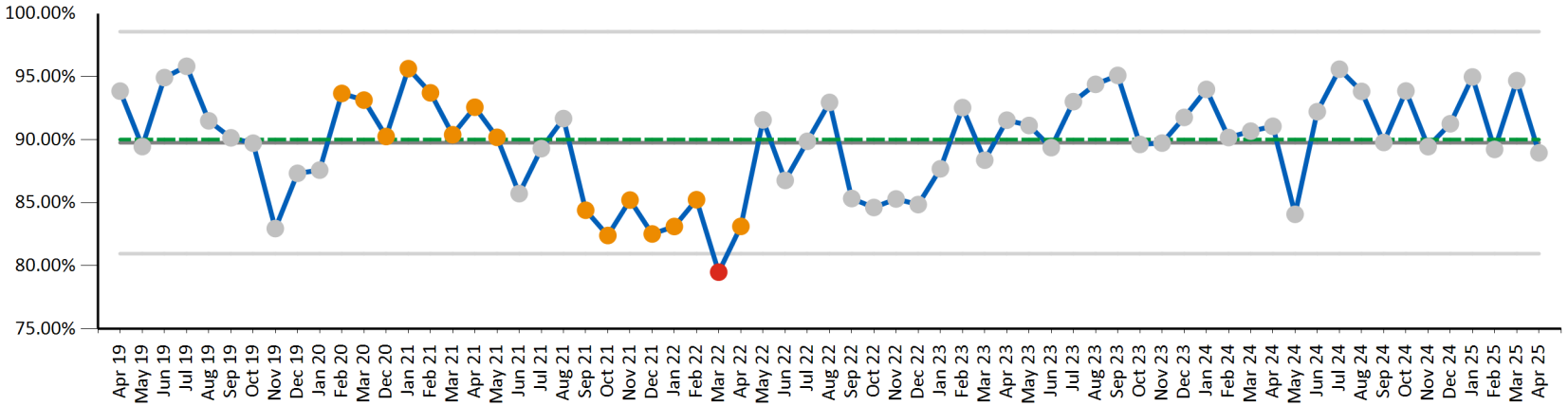
Plan	Actual
>= 15%	39.7%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90%	89.0%	Apr-25

Previous

Plan	Actual	Period
>= 90%	94.7%	Mar-25

Year to Date

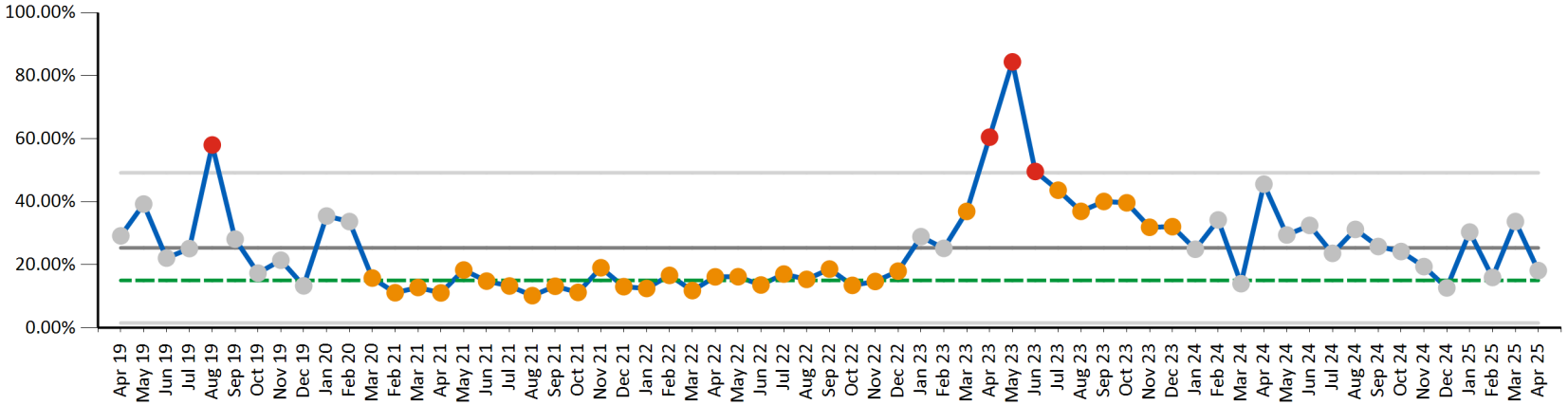
Plan	Actual
>= 90%	89.0%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 15%	18.1%	Apr-25

Previous

Plan	Actual	Period
>= 15%	33.7%	Mar-25

Year to Date

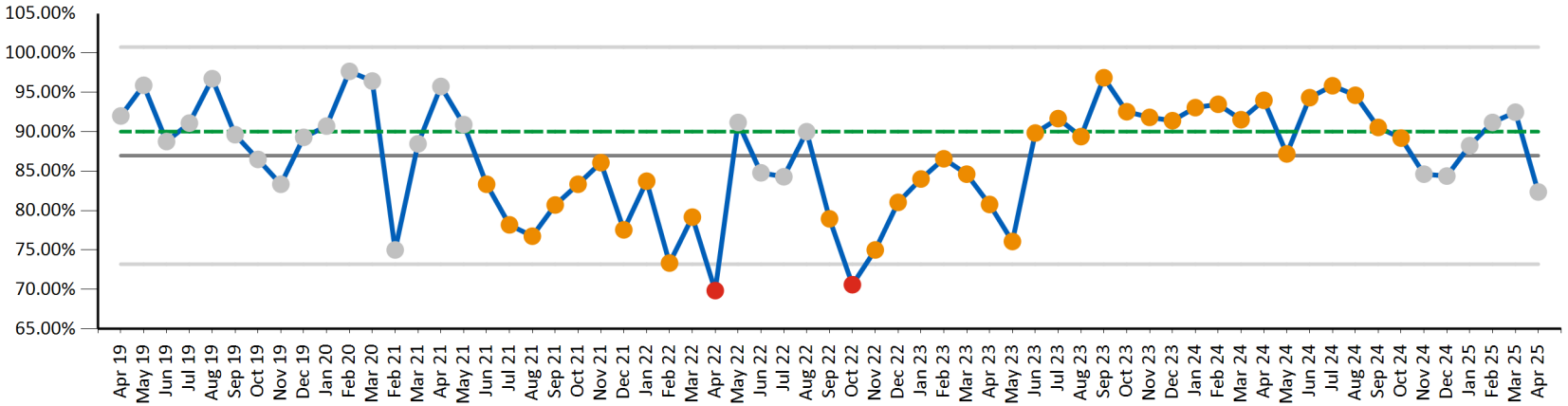
Plan	Actual
>= 15%	18.1%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90%	82.4%	Apr-25

Previous

Plan	Actual	Period
>= 90%	92.5%	Mar-25

Year to Date

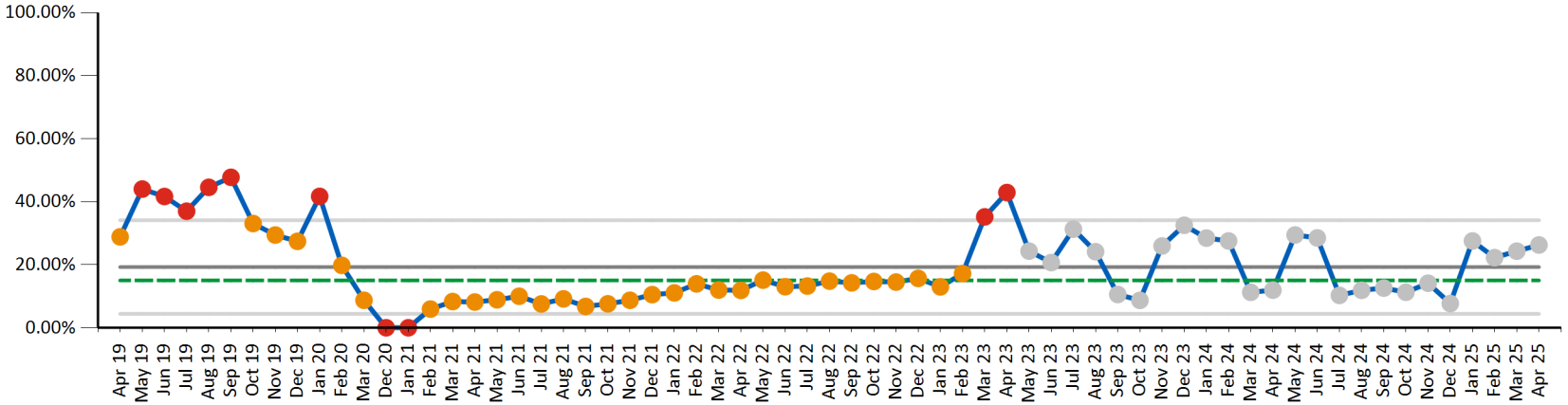
Plan	Actual
>= 90%	82.4%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	26.3%	Apr-25

Previous

Plan	Actual	Period
>= 15%	24.3%	Mar-25

Year to Date

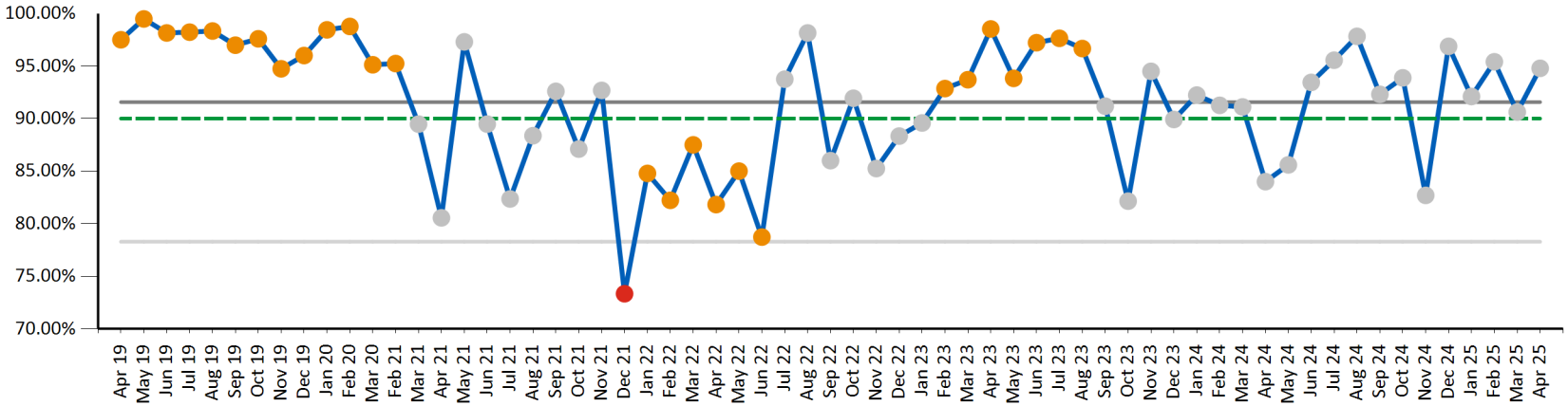
Plan	Actual
>= 15%	26.3%

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%	94.8%	Apr-25

Previous

Plan	Actual	Period
>= 90%	90.6%	Mar-25

Year to Date

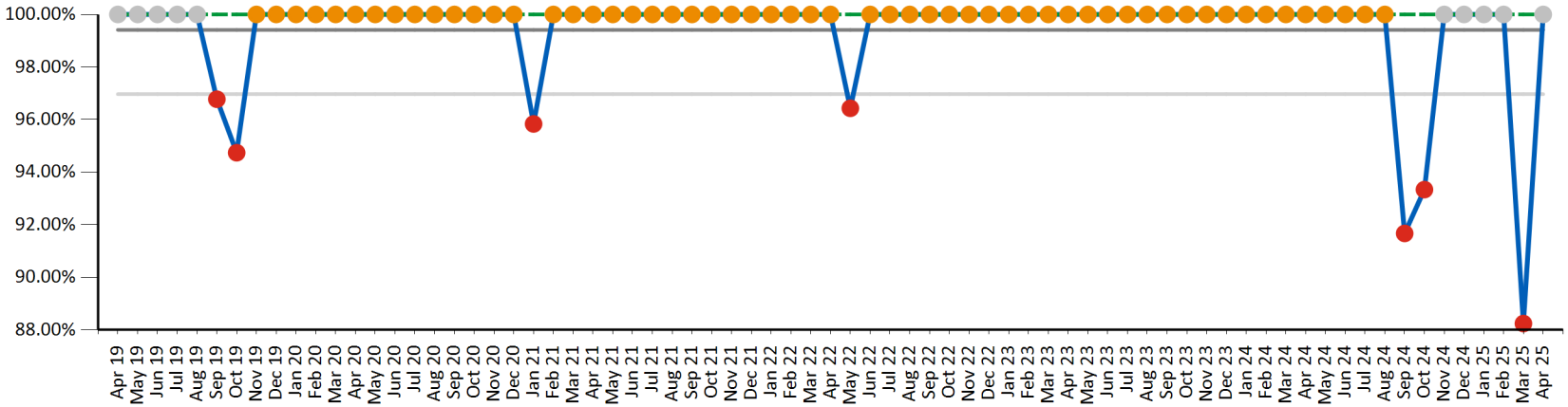
Plan	Actual
>= 90%	94.8%

89 - Formal complaints acknowledged within 3 working days

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Apr-25

Previous

Plan	Actual	Period
= 100%	88.2%	Mar-25

Year to Date

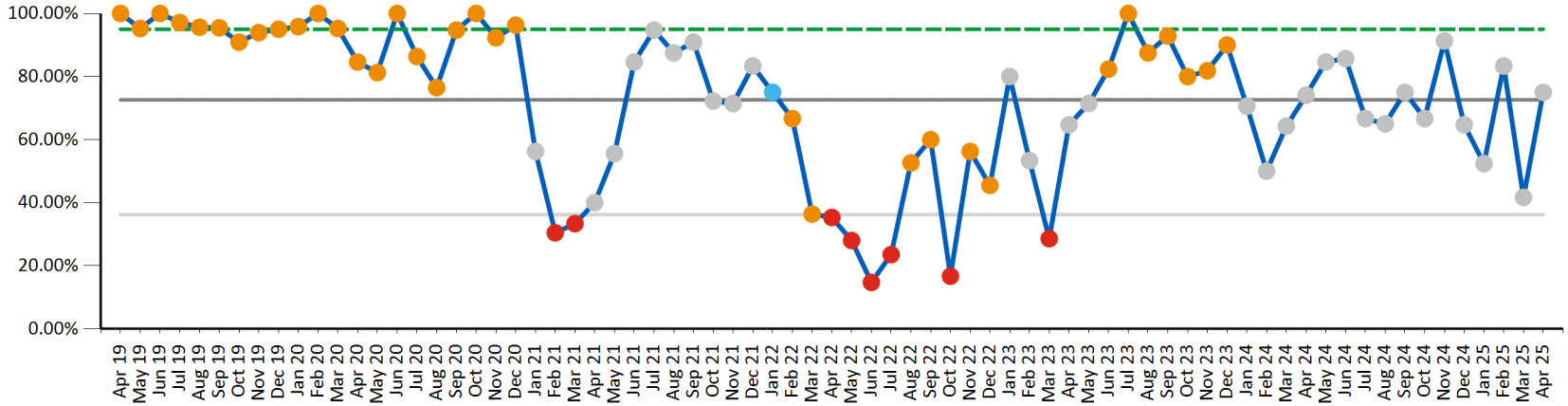
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 95%	75.0%	Apr-25

Previous

Plan	Actual	Period
>= 95%	41.7%	Mar-25

Year to Date

Plan	Actual
>= 95%	75.0%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family Response Rate – Response rate had been sustained at 25.3% in month with common cause variation noted. Overall maternity satisfaction rate in month is 91%%. Sustained improvement noted in antenatal response rate this month at 14.3%

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Incidence 6.52/1000 births in April 2025 (3 cases). 1 case referred to MNSI as suspected intrapartum stillbirth for external investigation. The first REACH circle has been scheduled for June 2025 (involves 8-10 pregnant women who live close together having their antenatal care and education in a community setting together) with a focus on the pregnant cohort between 24-27 weeks gestation. The REACH project pilot will be focussed in an area of deprivation in Bolton and a further update will be presented to Quality Assurance Committee in July 2025.

¾ degree tears – There has been a sustained low rate of 2.1% in month and a decrease in GM average rate over last 12 months at 2.81/1000. Recruitment to the perinatal pelvic health service has now commenced to support the ongoing management and review of the severe tears.

1:1 care in labour – Compliance rate 99.2% in month. Action plan in place as per CNST requirements – staff recruitment continues.

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. Sustained improvement in uptake noted over past two months with 90.2% compliance reported in April 2025 and notable improvement from 84.3% reported in February 2025.

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 steadily improving with 57.9% reported in April 2025.

Inductions of labour delayed by >24 hours – 34.1% of induction of labour cases were delayed by 24 hours in April 2025 – this is noted to be a common cause variation in the statistical process chart evaluation. Work remains ongoing to scope additional bed capacity to relive pressure in the service with a current focus on expansion of the maternity triage capacity.

Breastfeeding initiation – Slight decrease in uptake noted in April 2025 to 67.92% - significant staffing changed to be noted within team. Baby Friendly stage 2 implementation to be delayed until spring 2026 in response.

Preterm birth (less than 37 weeks gestation) – Common cause variation in preterm incidence within month with 8% reported in April 2025. Review of preterm referral pathway to be undertaken in response to recent incident reported.

	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	6.52	Apr-25		<= 3.50	5.01	Mar-25	<= 3.50	6.52	

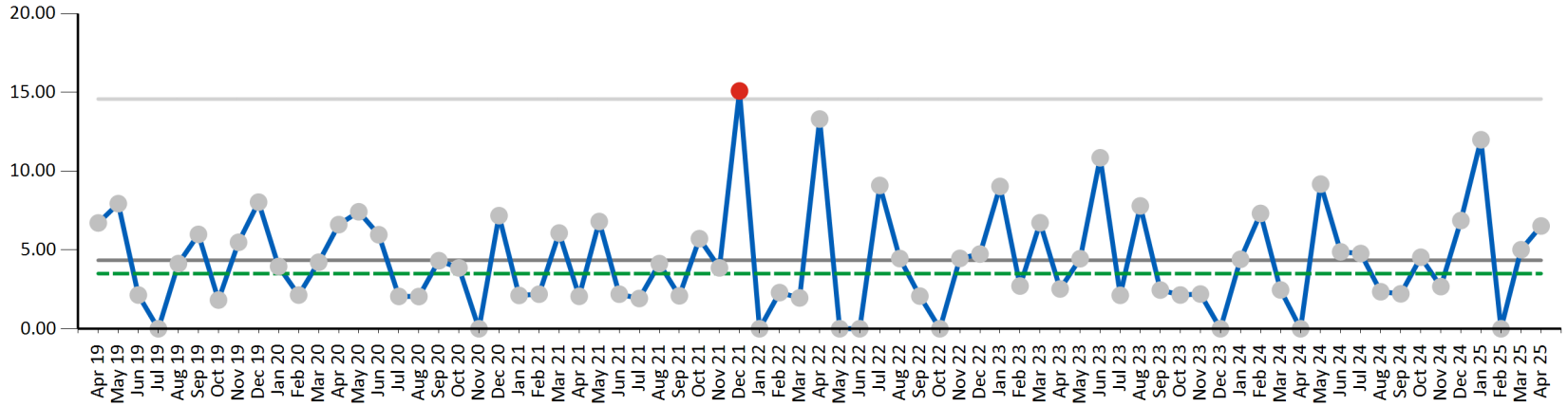
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.1%	Apr-25		<= 3.5%	4.0%	Mar-25	<= 3.5%	2.1%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.2%	Apr-25		>= 95.0%	100.0%	Mar-25	>= 95.0%	99.2%	
203 - Booked 12+6	>= 90.0%	90.2%	Apr-25		>= 90.0%	91.5%	Mar-25	>= 90.0%	90.2%	
586 - Booked 10+0		57.9%	Apr-25			53.6%	Mar-25		57.9%	
204 - Inductions of labour - delayed > 24 hours	<= 40%	34.1%	Apr-25		<= 40%	30.5%	Mar-25	<= 40%	34.1%	
210 - Initiation breast feeding	>= 65%	67.92%	Apr-25		>= 65%	74.42%	Mar-25	>= 65%	67.92%	
213 - Maternity complaints	<= 5	0	Apr-25		<= 5	0	Mar-25	<= 5	0	
319 - Maternal deaths (direct)	= 0	0	Apr-25		= 0	0	Mar-25	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.0%	Apr-25		<= 6%	7.3%	Mar-25	<= 6%	8.0%	

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	6.52	Apr-25

Previous

Plan	Actual	Period
<= 3.50	5.01	Mar-25

Year to Date

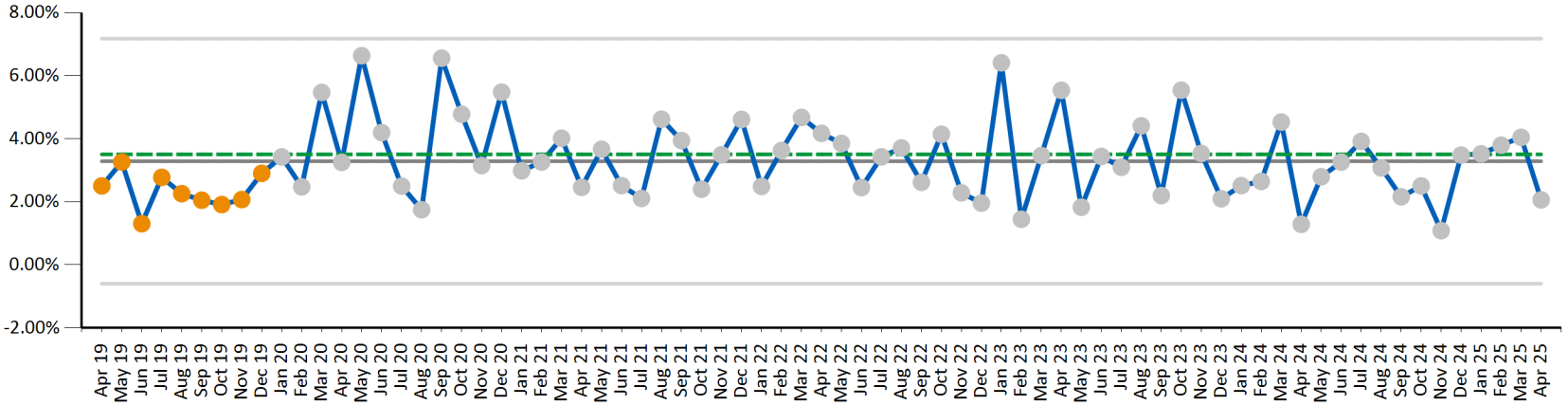
Plan	Actual
<= 3.50	6.52

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3.5%	2.1%	Apr-25

Previous

Plan	Actual	Period
<= 3.5%	4.0%	Mar-25

Year to Date

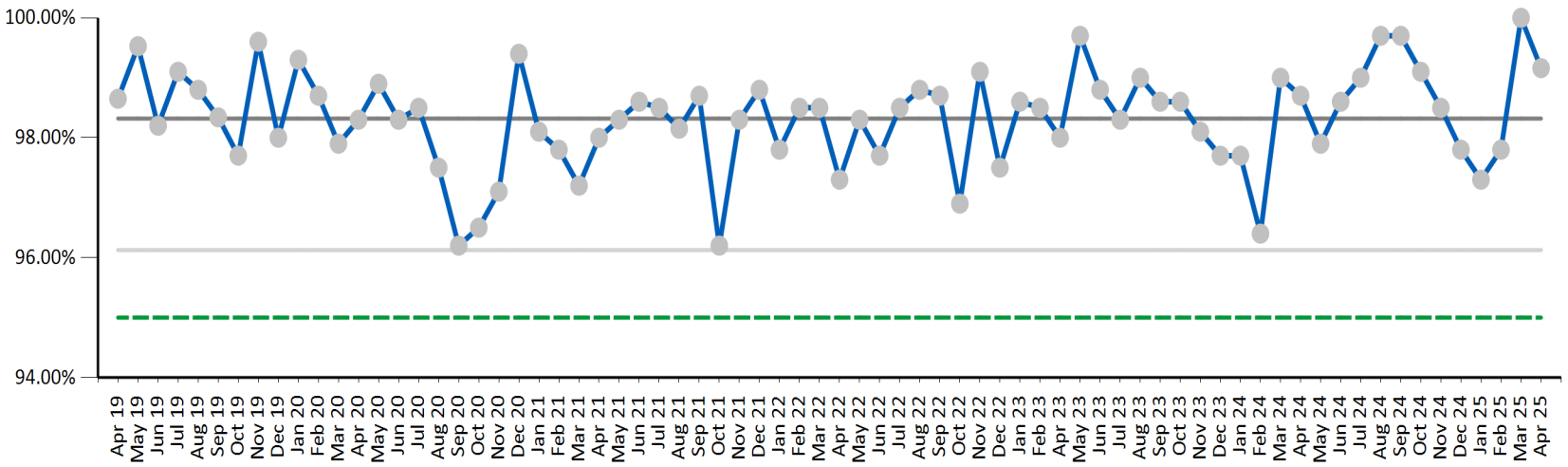
Plan	Actual
<= 3.5%	2.1%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	99.2%	Apr-25

Previous

Plan	Actual	Period
>= 95.0%	100.0%	Mar-25

Year to Date

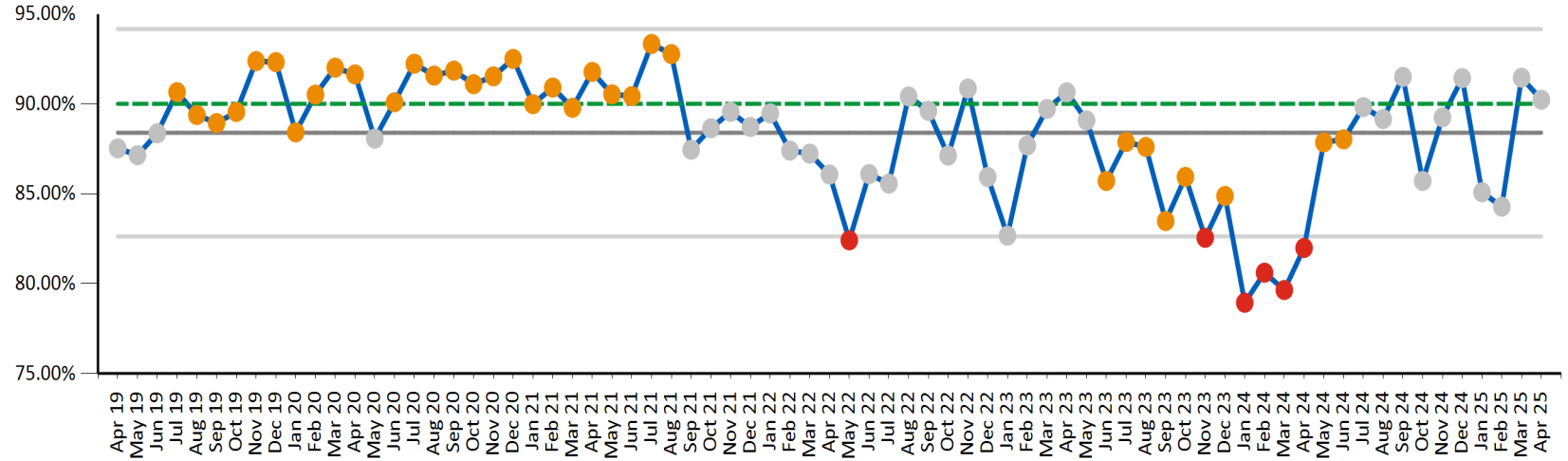
Plan	Actual
>= 95.0%	99.2%

203 - Booked 12+6

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90.0%	90.2%	Apr-25

Previous

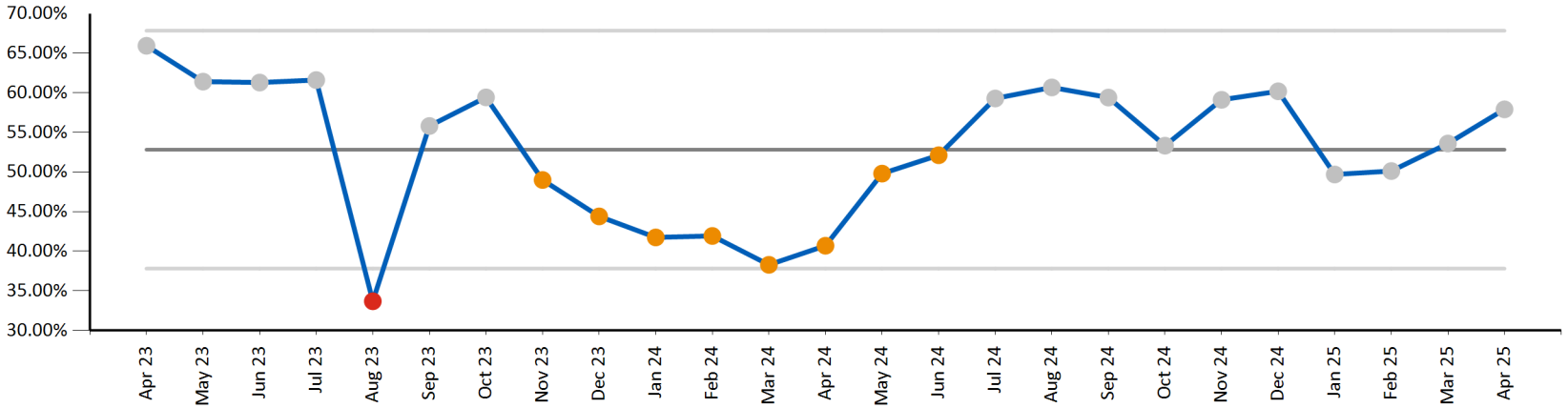
Plan	Actual	Period
>= 90.0%	91.5%	Mar-25

Year to Date

Plan	Actual
>= 90.0%	90.2%

586 - Booked 10+0

Common cause variation.



Latest

Plan	Actual	Period
	57.9%	Apr-25

Previous

Plan	Actual	Period
	53.6%	Mar-25

Year to Date

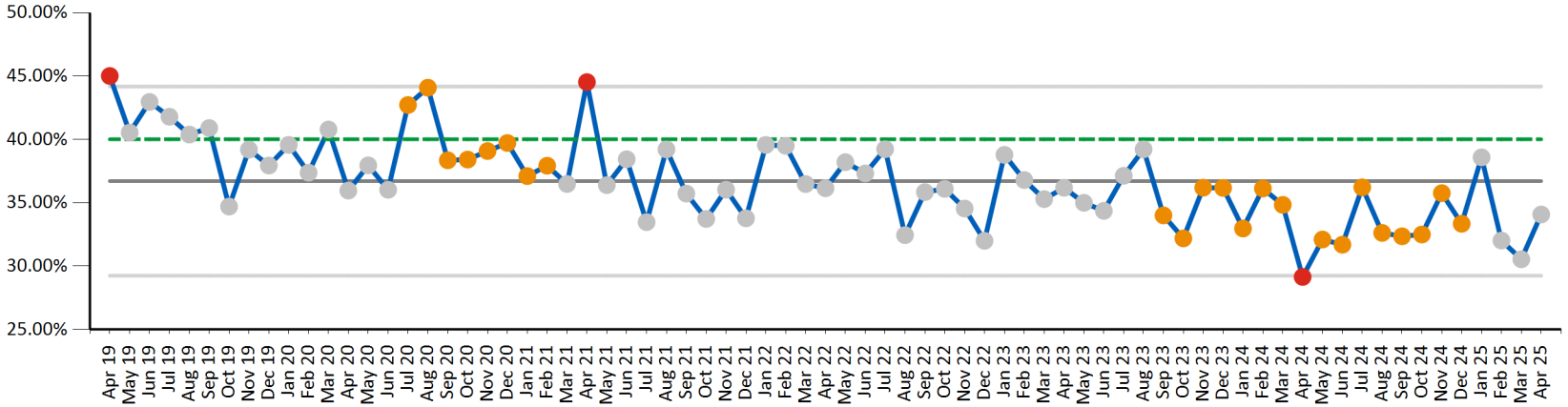
Plan	Actual
	57.9%

204 - Inductions of labour - delayed > 24 hours

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	34.1%	Apr-25

Previous

Plan	Actual	Period
<= 40%	30.5%	Mar-25

Year to Date

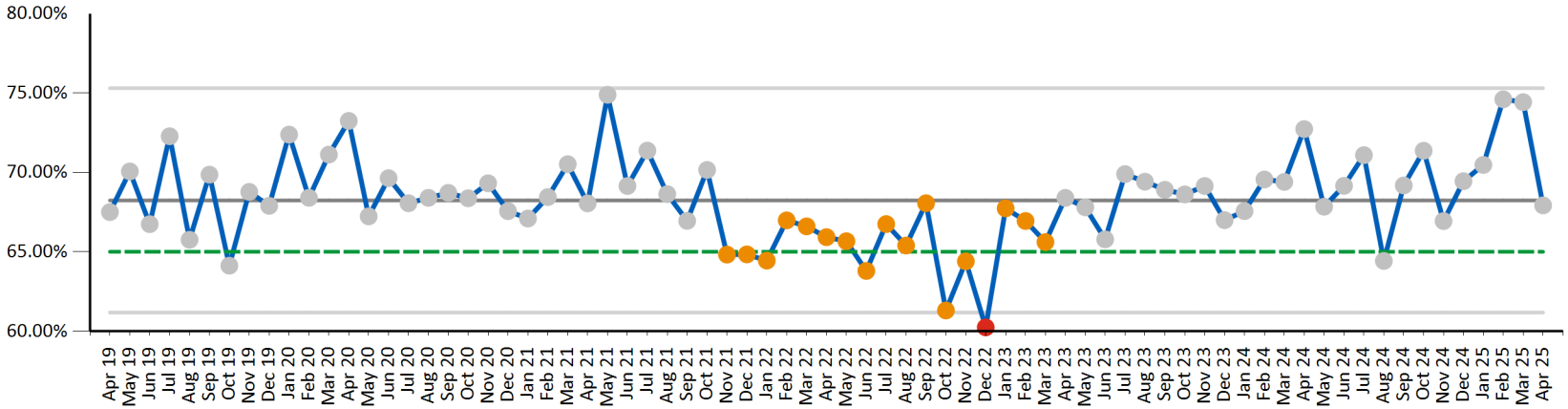
Plan	Actual
<= 40%	34.1%

210 - Initiation breast feeding

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 65%	67.92%	Apr-25

Previous

Plan	Actual	Period
>= 65%	74.42%	Mar-25

Year to Date

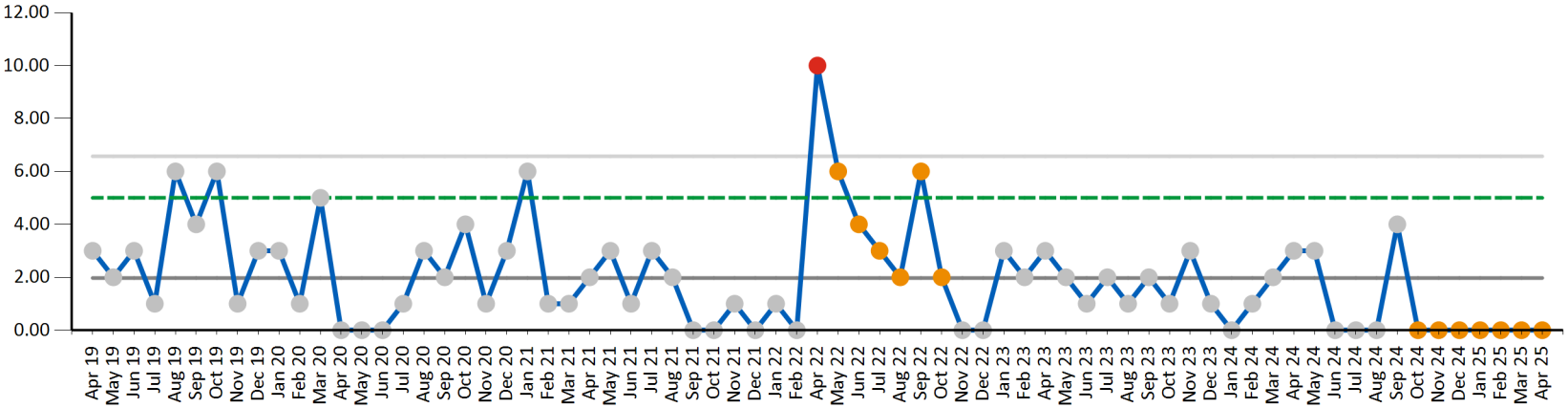
Plan	Actual
>= 65%	67.92%

213 - Maternity complaints

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 5	0	Apr-25

Previous

Plan	Actual	Period
<= 5	0	Mar-25

Year to Date

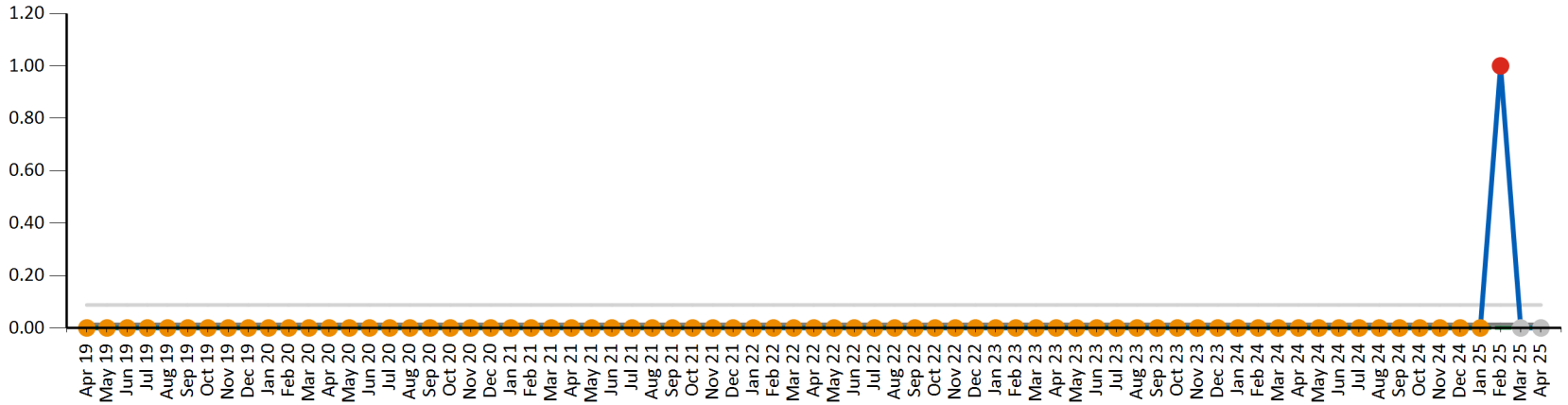
Plan	Actual
<= 5	0

319 - Maternal deaths (direct)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Apr-25

Previous

Plan	Actual	Period
= 0	0	Mar-25

Year to Date

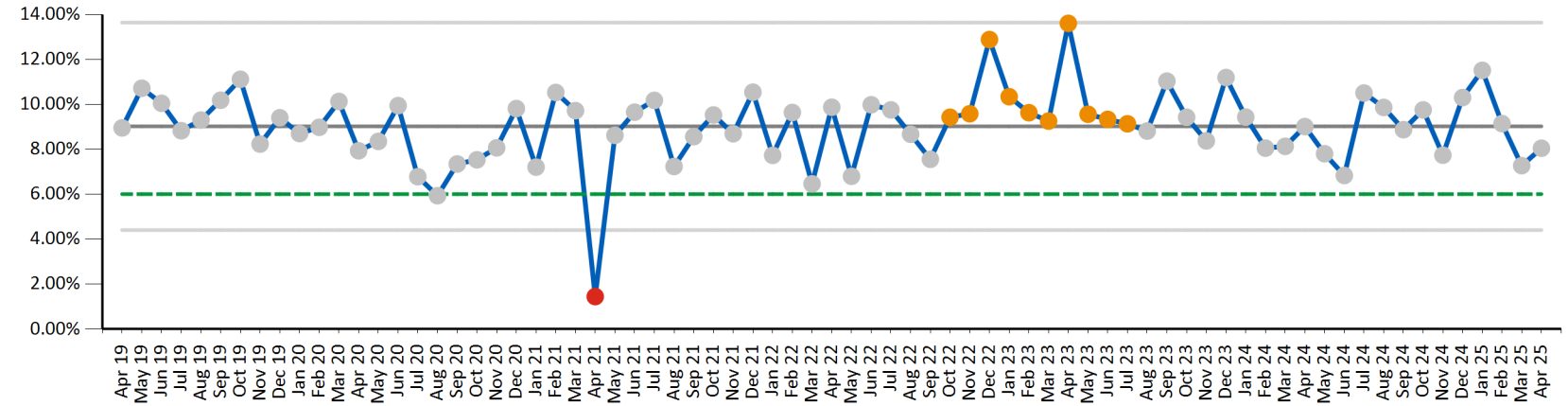
Plan	Actual
= 0	0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6%	8.0%	Apr-25

Previous

Plan	Actual	Period
<= 6%	7.3%	Mar-25

Year to Date

Plan	Actual
<= 6%	8.0%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Urgent Care

In April, performance against the all-types 4-hour standard was 66.3%, which is a decrease of 8.2% from March 2025, noting the March UEC sprint; however, it is an improvement of 6% compared to April 24. A&E attendances for April 2025 were 11,924, which is an increase of 763 attendances from April 2024. Ambulance handovers within 15 minutes decreased to 49.6% from 62.9%, handovers within 30 minutes decreased to 78.6% from 90.6%, and handovers within 60 minutes decreased to 91.37% from 97.66%; all measures are within common cause variation. In April 2025, there was an increase in A&E 12-hour waits by 338 patients when compared to March 2025. Non-elective length of stay has increased by 0.3 days month-on-month and is now at 5.3 days; however, this metric remains in special cause improvement. Re-admissions within 30 days of discharge have decreased by 0.7% to 10.9%, this metric remains in common cause variation.

NOF

For April, our fractured neck of femur performance remained largely static at 20.5%, with 9 of 44 eligible patients getting to theatre within the 36 hour window. Of the 35x patients who breached the target, the vast majority of the patients (26) related to delays due to theatre capacity, with 8x relating to optimisation of patients including anticoagulants, and 1x patient delayed in the Emergency Department prior to listing.

Performance against the 36-hour standard for Bolton is in the lowest quartile against the rest of the country, however mortality is in line with the national average. Additional theatre capacity for trauma patients will be introduced in late-May and an action plan remains in progress in terms of broader service development. Performance for May is currently on track to be improved against April's performance.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 72%	66.3%	Apr-25		>= 78%	71.9%	Mar-25	>= 72%	66.3%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	49.6%	Apr-25		>= 65.0%	62.9%	Mar-25	>= 65.0%	49.6%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	78.6%	Apr-25		>= 95.0%	90.6%	Mar-25	>= 95.0%	78.6%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	91.37%	Apr-25		= 100%	97.66%	Mar-25	= 100%	91.37%	?
539 - A&E 12 hour waits	= 0	969	Apr-25		= 0	631	Mar-25	= 0	969	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	20.5%	Apr-25	L	>= 75%	23.5%	Mar-25	>= 75%	20.5%	?
56 - Stranded patients - over 7 days	<= 200	277	Apr-25	H	<= 200	297	Mar-25	<= 200	277	F

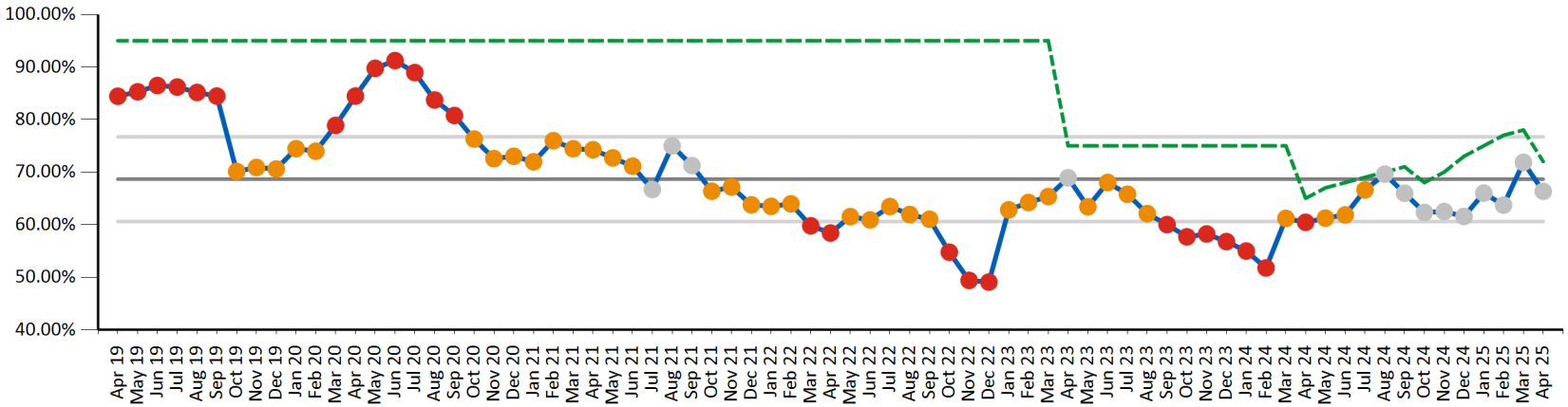
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	106	Apr-25	H	<= 69	119	Mar-25	<= 69	106	?
541 - Adult G&A bed occupancy	<= 92.0%	88.8%	Apr-25	H	<= 92.0%	89.2%	Mar-25	<= 92.0%	88.8%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.30	Apr-25	L	<= 3.70	5.00	Mar-25	<= 3.70	5.30	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.9%	Mar-25		<= 13.5%	11.6%	Feb-25	<= 13.5%		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
>= 72%	66.3%	Apr-25

Previous

Plan	Actual	Period
>= 78%	71.9%	Mar-25

Year to Date

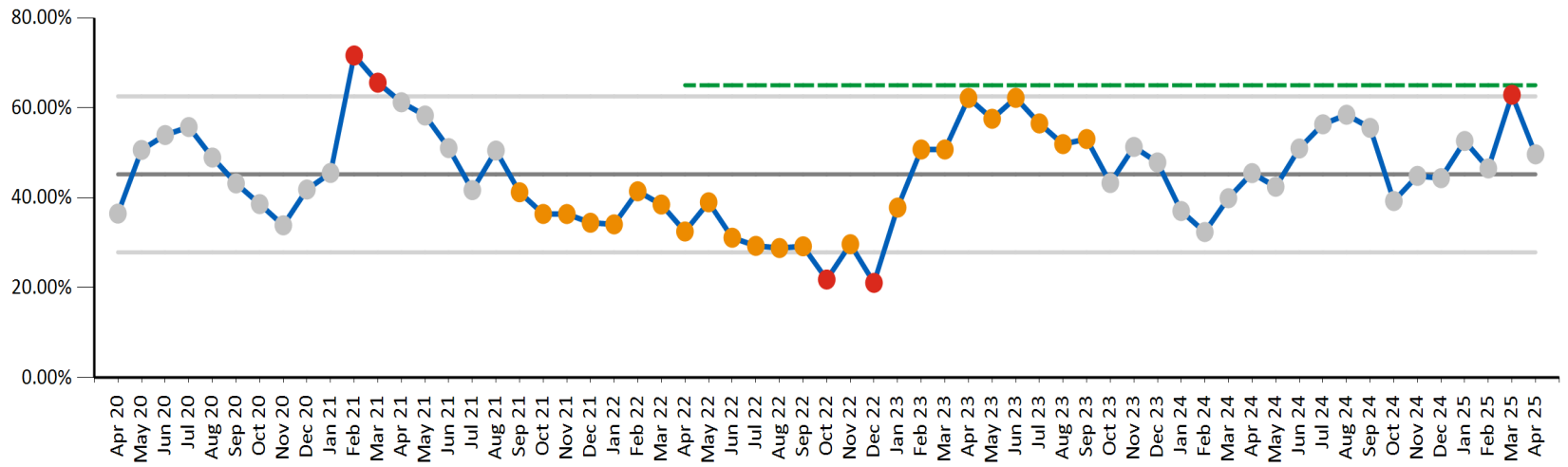
Plan	Actual
>= 72%	66.3%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 65.0%	49.6%	Apr-25

Previous

Plan	Actual	Period
>= 65.0%	62.9%	Mar-25

Year to Date

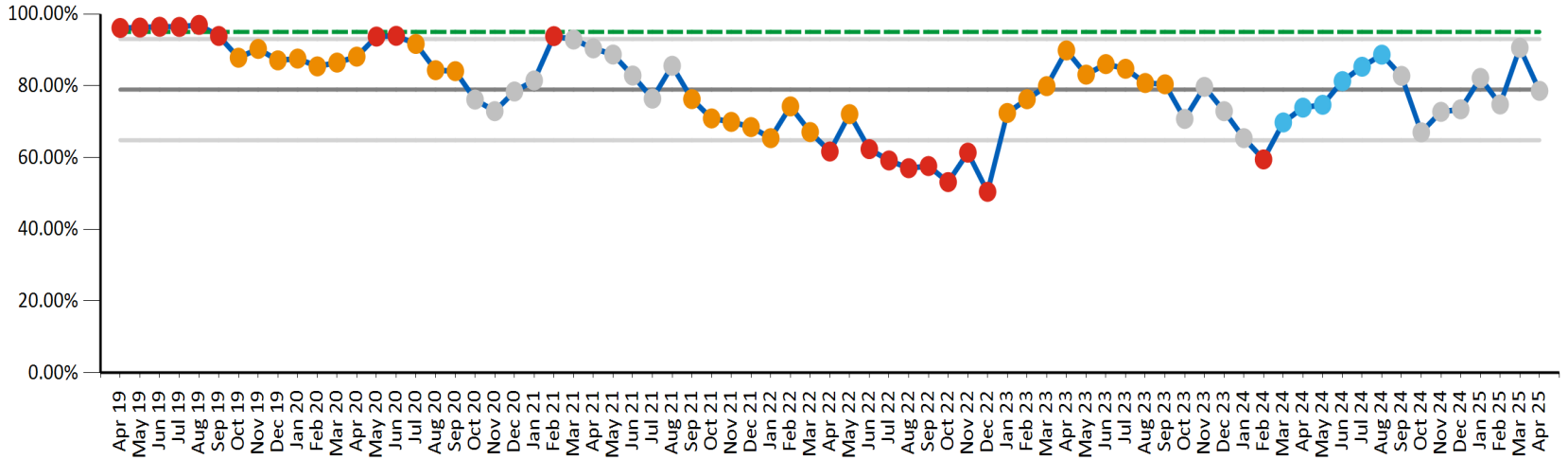
Plan	Actual
>= 65.0%	49.6%

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%	78.6%	Apr-25

Previous

Plan	Actual	Period
>= 95.0%	90.6%	Mar-25

Year to Date

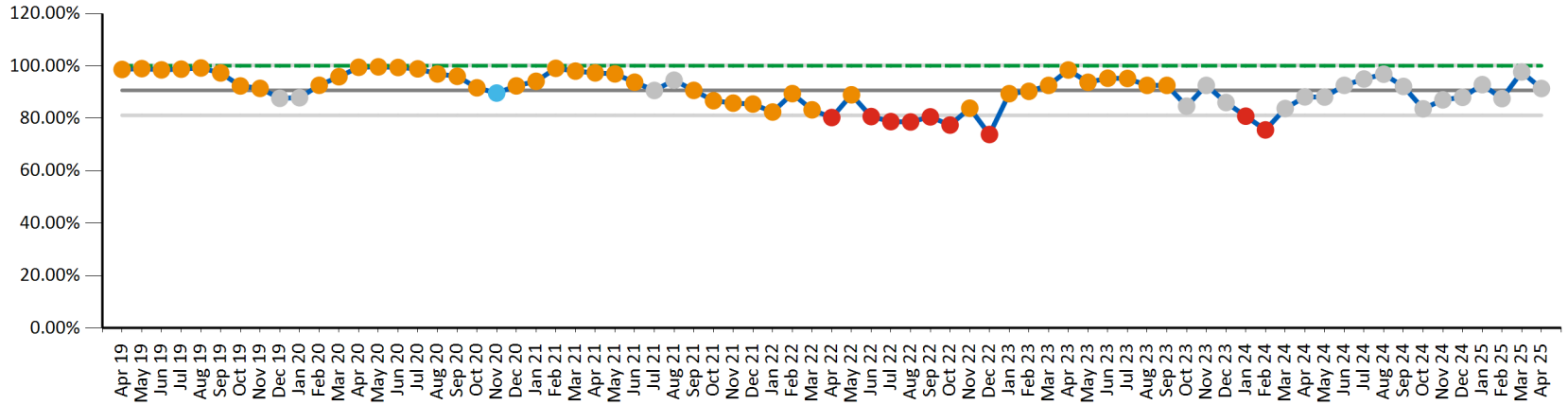
Plan	Actual
>= 95.0%	78.6%

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	91.37%	Apr-25

Previous

Plan	Actual	Period
= 100%	97.66%	Mar-25

Year to Date

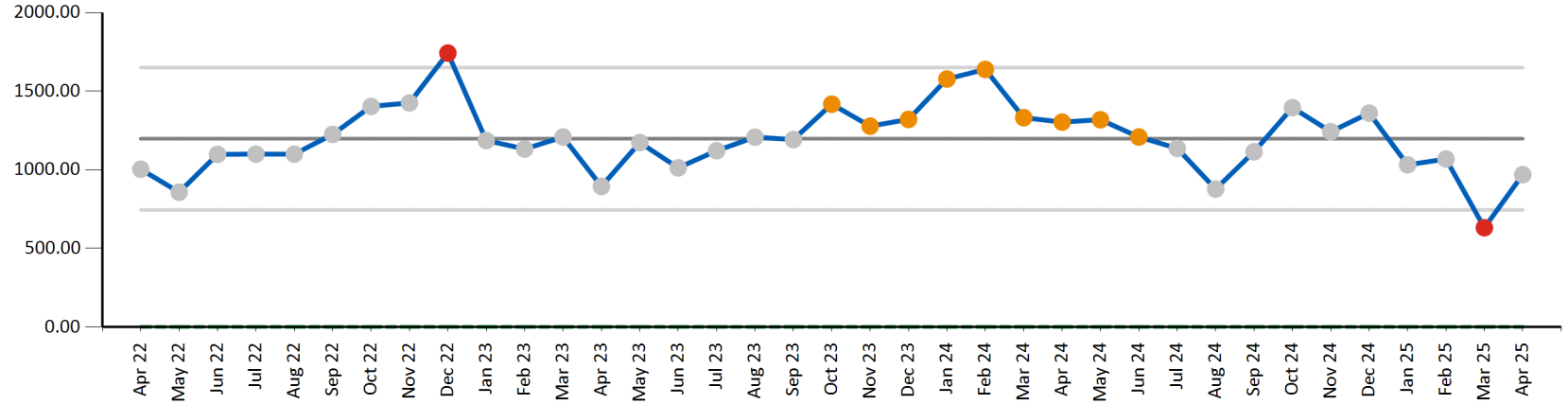
Plan	Actual
= 100%	91.37%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	969	Apr-25

Previous

Plan	Actual	Period
= 0	631	Mar-25

Year to Date

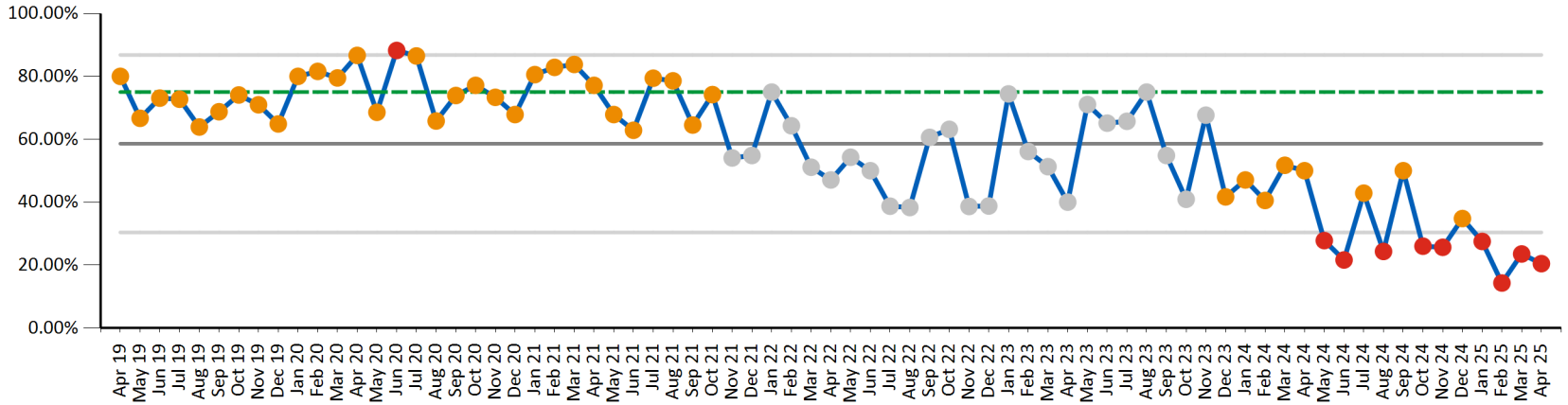
Plan	Actual
= 0	969

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%	20.5%	Apr-25

Previous

Plan	Actual	Period
>= 75%	23.5%	Mar-25

Year to Date

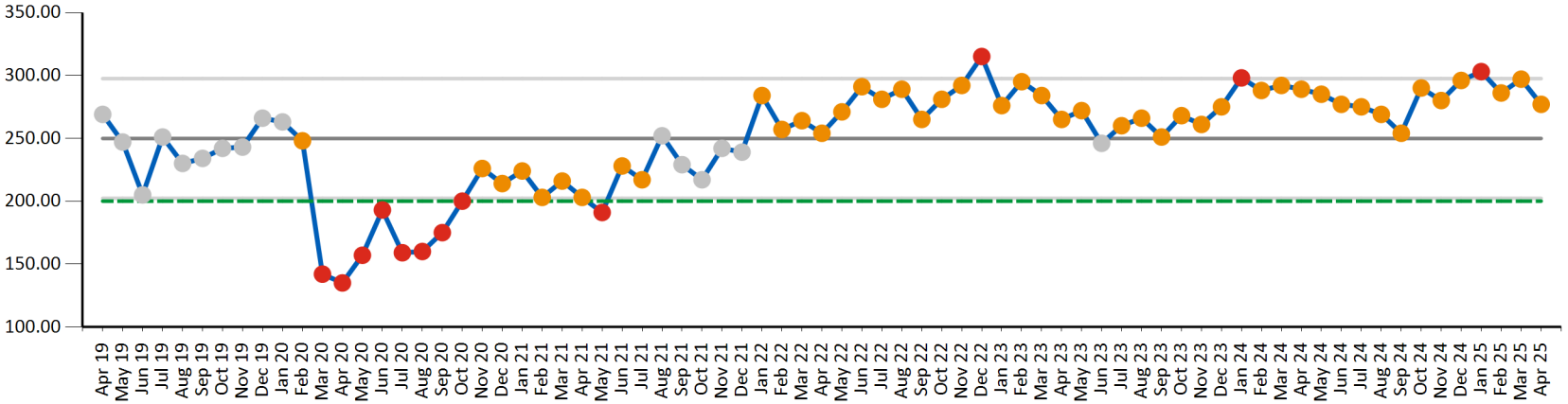
Plan	Actual
>= 75%	20.5%

56 - Stranded patients - over 7 days

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	277	Apr-25

Previous

Plan	Actual	Period
<= 200	297	Mar-25

Year to Date

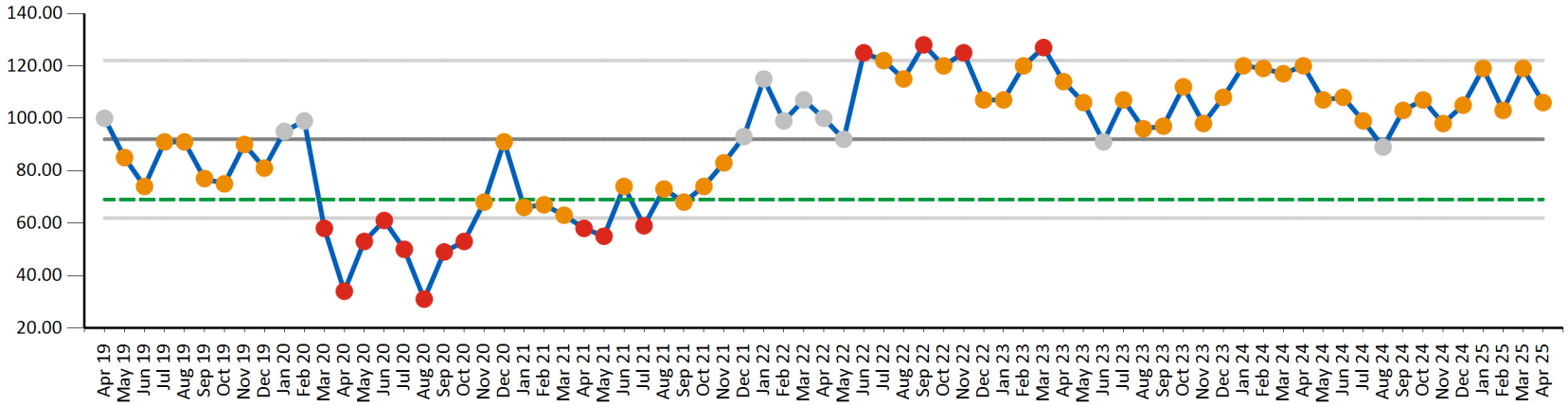
Plan	Actual
<= 200	277

307 - Stranded Patients - LOS 21 days and over

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 69	106	Apr-25

Previous

Plan	Actual	Period
<= 69	119	Mar-25

Year to Date

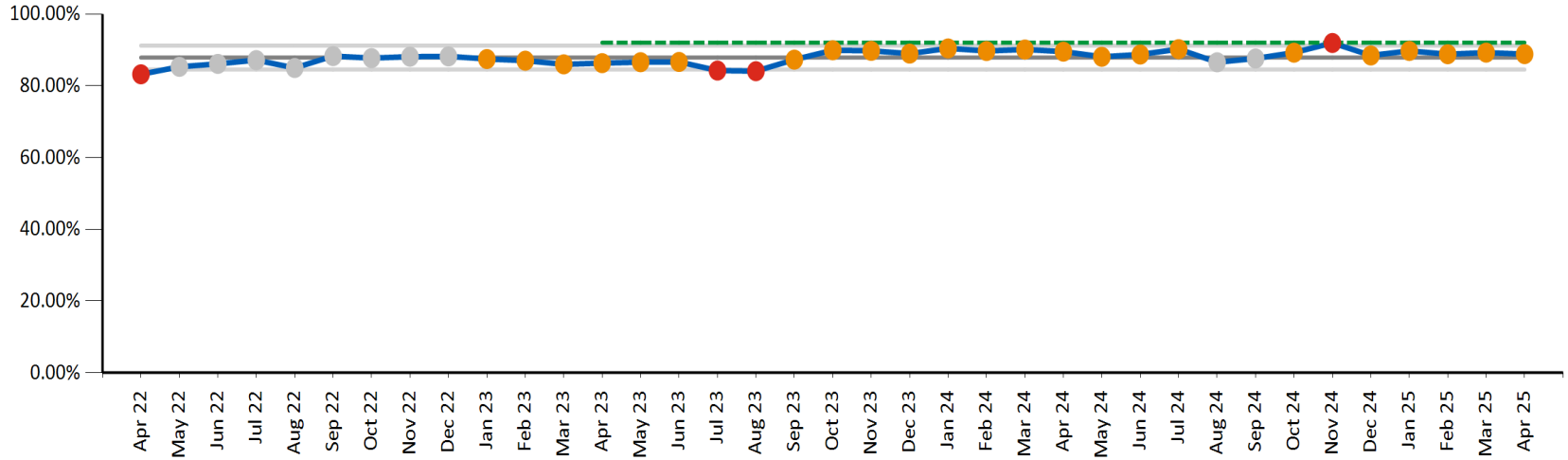
Plan	Actual
<= 69	106

541 - Adult G&A bed occupancy

Special cause variation with deteriorating performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	88.8%	Apr-25

Previous

Plan	Actual	Period
<= 92.0%	89.2%	Mar-25

Year to Date

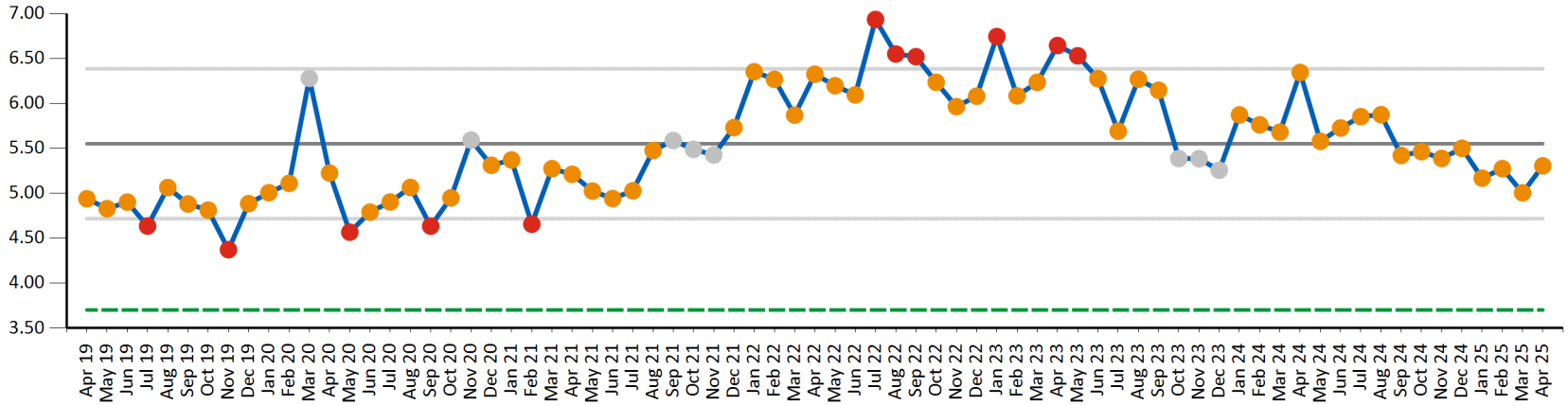
Plan	Actual
<= 92.0%	88.8%

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

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	5.30	Apr-25

Previous

Plan	Actual	Period
<= 3.70	5.00	Mar-25

Year to Date

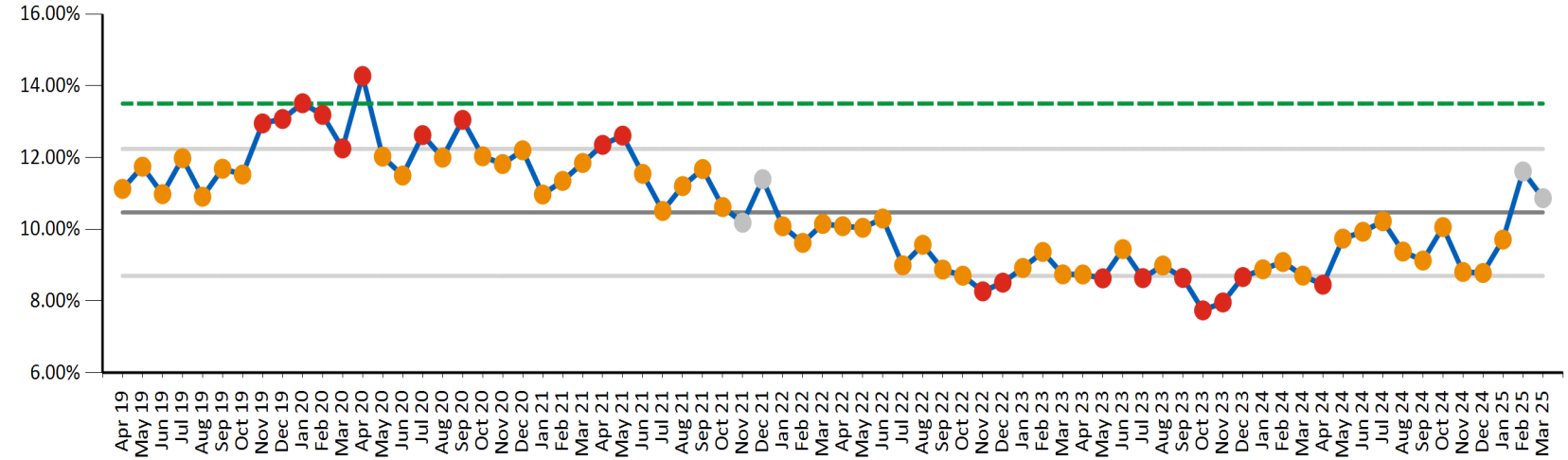
Plan	Actual
<= 3.70	5.30

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	10.9%	Mar-25

Previous

Plan	Actual	Period
<= 13.5%	11.6%	Feb-25

Year to Date

Plan	Actual
<= 13.5%	9.7%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished April with 2x 78-week breaches, both of which were graft patients.

We finished April with 14x 65-week breaches. 9x of these patients were patients awaiting graft material, and 5x patients with complex pathways.

We finished April with 1,254x 52-week breaches. This continues to improve and has decreased by over 1,000 since April 2024. We remain on track for our trajectory for 52-week performance for this financial year.

Our overall waiting list size reduced to 38,173 patients. This is the lowest position since January 2023, and has consistently fallen for 10 months.

DM01

DM01 Month 1 position validated at 10.8% compliance, this is a 5.8% increase in month and above national standard. Cystoscopy, Audiology and Urodynamics have all seen a downturn in performance in their position in month resulting in the overall deterioration in DM01 performance. Barriers to performance, corrective actions and trajectory dates all received, demonstrating grip and control. MRI demonstrated an improvement in month decreasing from 4.0% to 3.6%. Paediatric sedations continue to remain the outliers although specialty are working to address the position.

	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%	54.9%	Apr-25	L	>= 92%	55.4%	Mar-25	>= 92%	54.9%	F
314 - RTT 18 week waiting list	<= 39,439	38,173	Apr-25	H	<= 37,614	39,518	Mar-25	<= 39,439	38,173	P
42 - RTT 52 week waits (incomplete pathways)		1,254	Apr-25	L		1,240	Mar-25		1,254	
540 - RTT 65 week waits (incomplete pathways)	<= 949	14	Apr-25	L	= 0	12	Mar-25	<= 949	14	P
526 - RTT 78 week waits (incomplete pathways)	= 0	2	Apr-25	L	= 0	1	Mar-25	= 0	2	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Apr-25	L	= 0	0	Mar-25	= 0	0	F
72 - Diagnostic Waits >6 weeks %	<= 5%	10.8%	Apr-25	L	<= 5%	5.0%	Mar-25	<= 5%	10.8%	F
489 - Daycase Rates	>= 85%	80.7%	Apr-25	L	>= 85%	79.7%	Mar-25	>= 85%	80.7%	?
582 - Theatre Utilisation - Capped		74.3%	Apr-25			72.9%	Mar-25		74.3%	

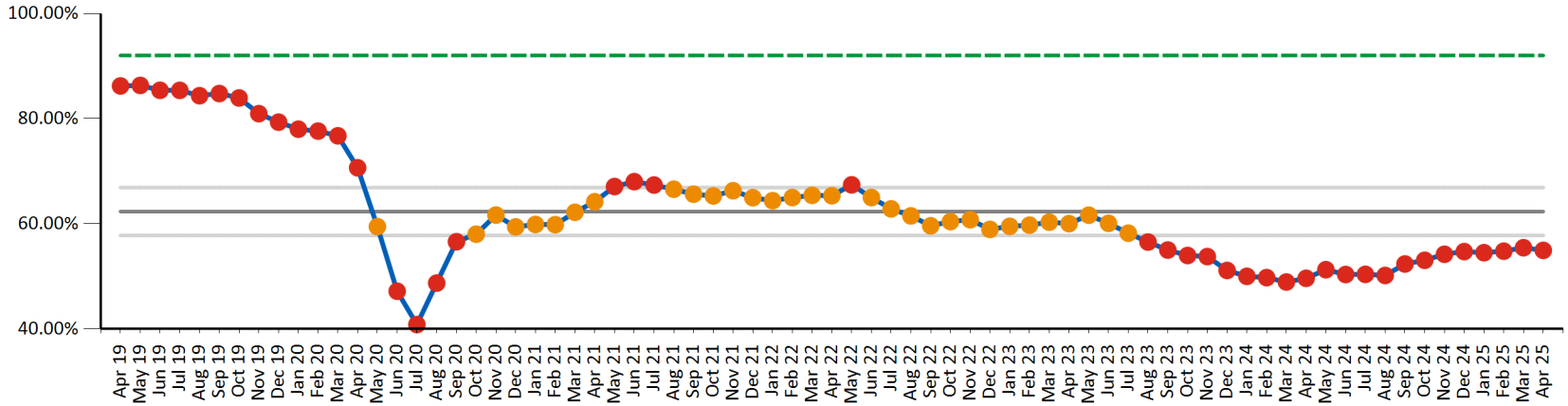
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
583 - Theatre Utilisation - Uncapped		79.1%	Apr-25	L		75.6%	Mar-25		79.1%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.7%	Apr-25	H	<= 1%	1.9%	Mar-25	<= 1%	1.7%	?
62 - Cancelled operations re-booked within 28 days	= 100%	42.3%	Mar-25		= 100%	71.7%	Feb-25	= 100%		?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.83	Apr-25	H	<= 2.00	2.80	Mar-25	<= 2.00	3.83	?
309 - DNA Rate - New	<= 6.3%	9.5%	Apr-25		<= 6.3%	8.7%	Mar-25	<= 6.3%	9.5%	F
310 - DNA Rate - Follow up	<= 5.0%	8.8%	Apr-25	L	<= 5.0%	8.4%	Mar-25	<= 5.0%	8.8%	F

41 - RTT Incomplete pathways within 18 weeks %

L Special cause variation with deteriorating performance

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	54.9%	Apr-25

Previous

Plan	Actual	Period
>= 92%	55.4%	Mar-25

Year to Date

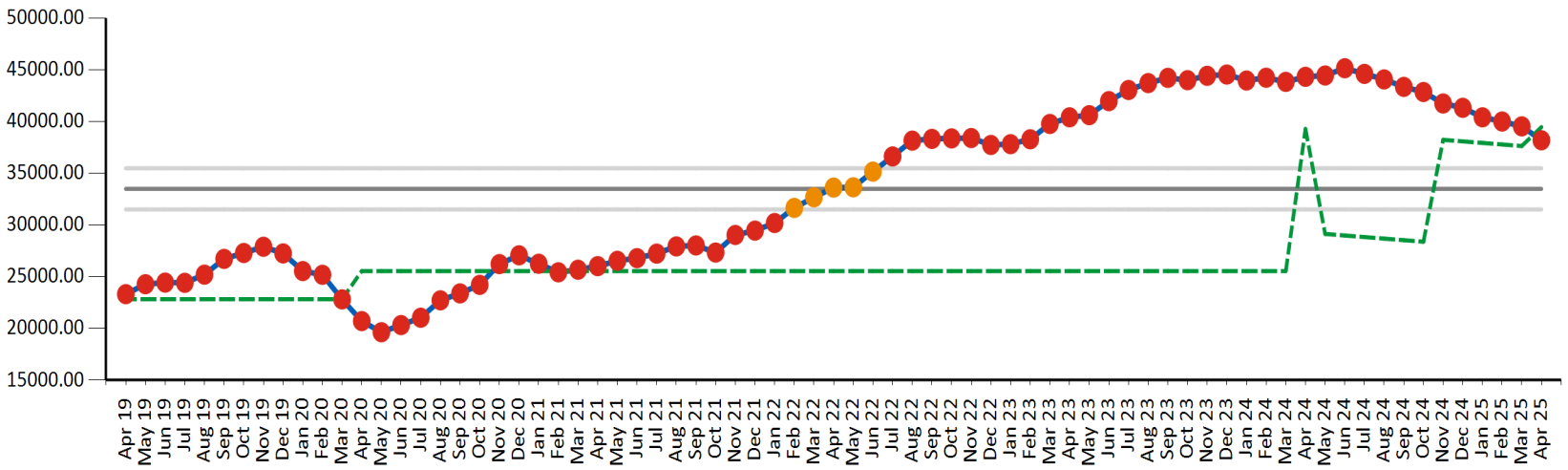
Plan	Actual
>= 92%	54.9%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

1/6



Latest

Plan	Actual	Period
<= 39,439	38,173	Apr-25

Previous

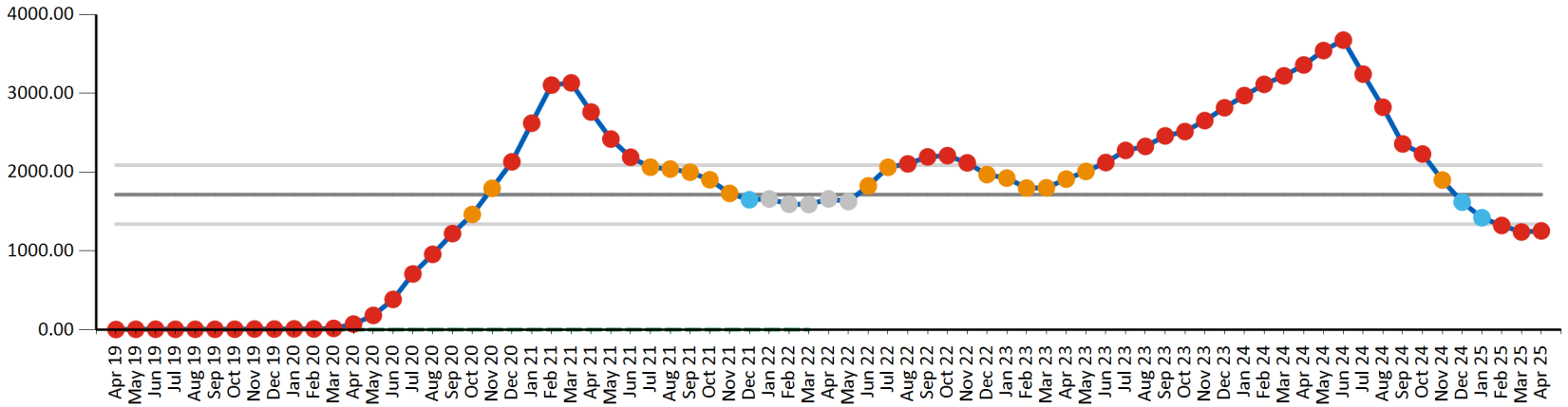
Plan	Actual	Period
<= 37,614	39,518	Mar-25

Year to Date

Plan	Actual
<= 39,439	38,173

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1,254	Apr-25

Previous

Plan	Actual	Period
	1,240	Mar-25

Year to Date

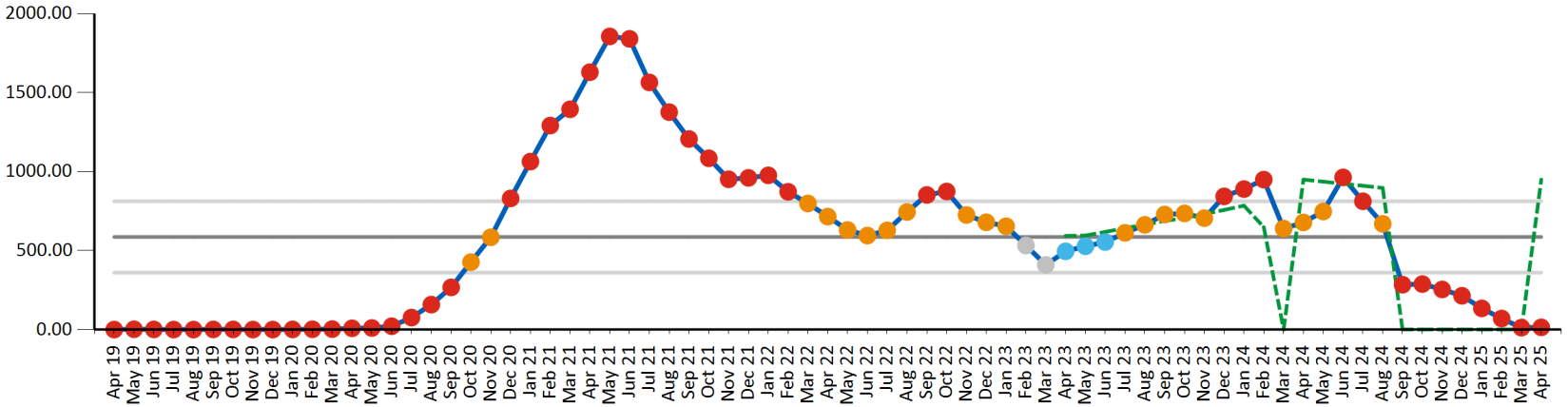
Plan	Actual
	1,254

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

Target will be regularly met.

1/6



Latest

Plan	Actual	Period
<= 949	14	Apr-25

Previous

Plan	Actual	Period
= 0	12	Mar-25

Year to Date

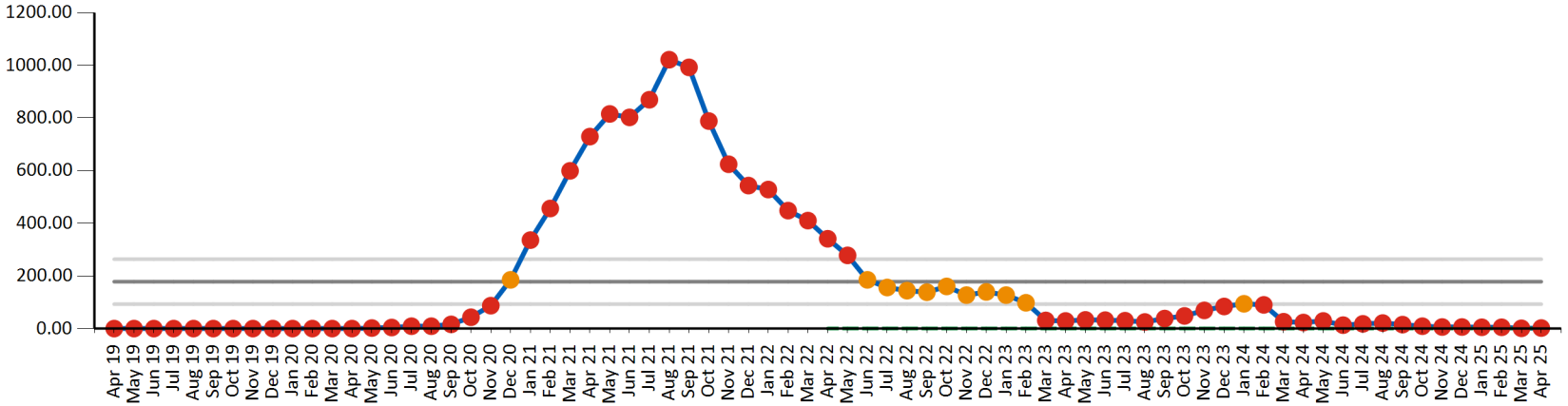
Plan	Actual
<= 949	14

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	2	Apr-25

Previous

Plan	Actual	Period
= 0	1	Mar-25

Year to Date

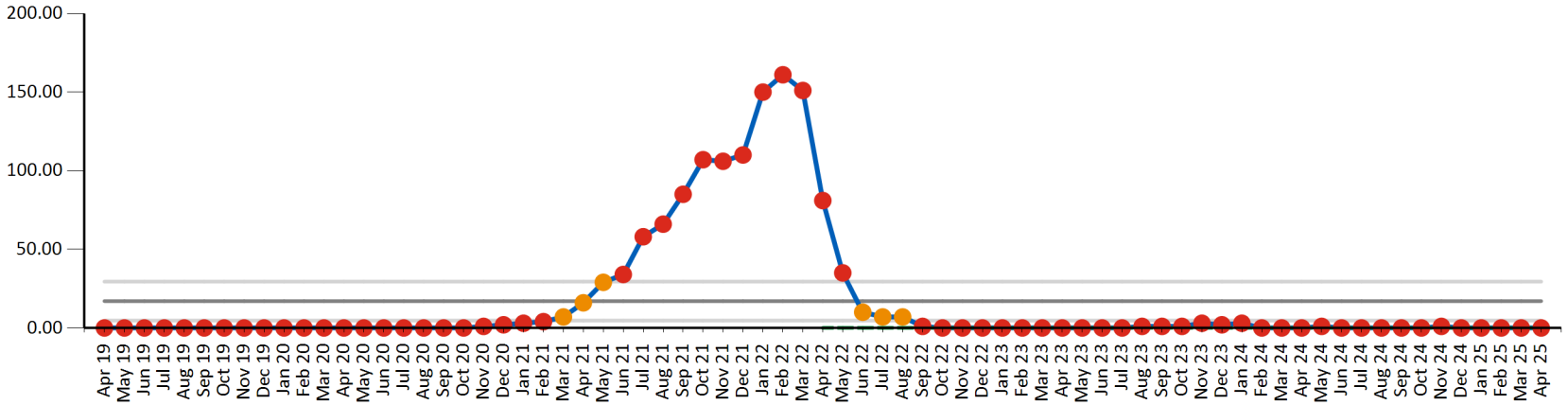
Plan	Actual
= 0	2

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	Apr-25

Previous

Plan	Actual	Period
= 0	0	Mar-25

Year to Date

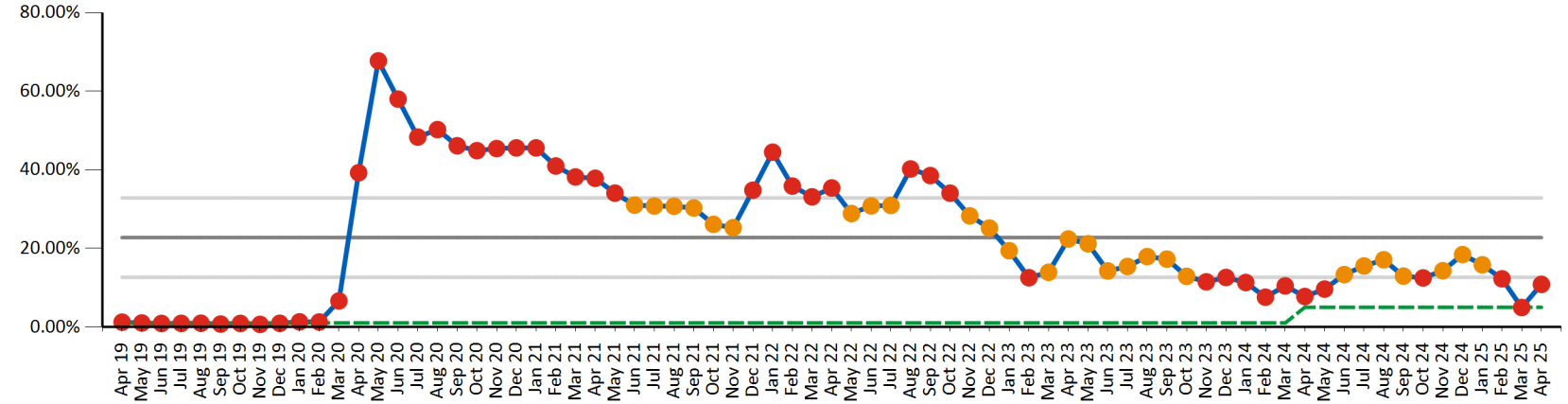
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
<= 5%	10.8%	Apr-25

Previous

Plan	Actual	Period
<= 5%	5.0%	Mar-25

Year to Date

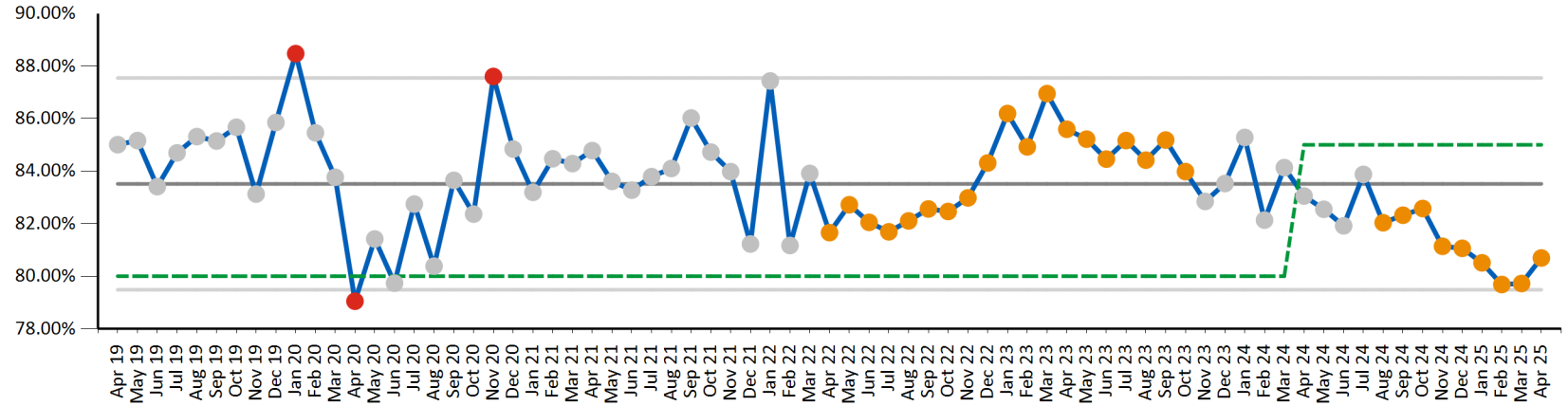
Plan	Actual
<= 5%	10.8%

489 - Daycase Rates

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 85%	80.7%	Apr-25

Previous

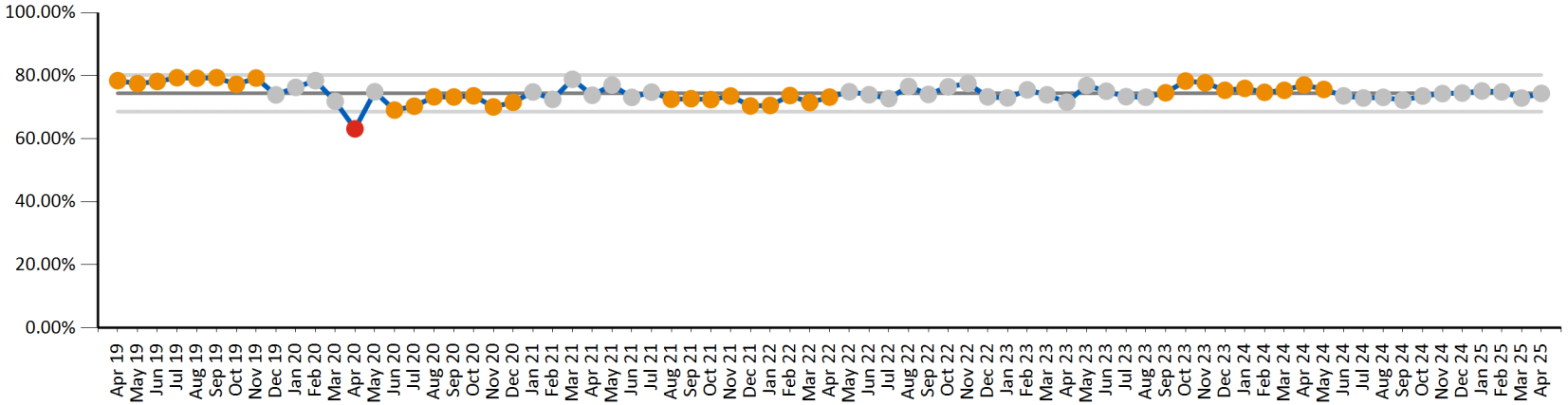
Plan	Actual	Period
>= 85%	79.7%	Mar-25

Year to Date

Plan	Actual
>= 85%	80.7%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	74.3%	Apr-25

Previous

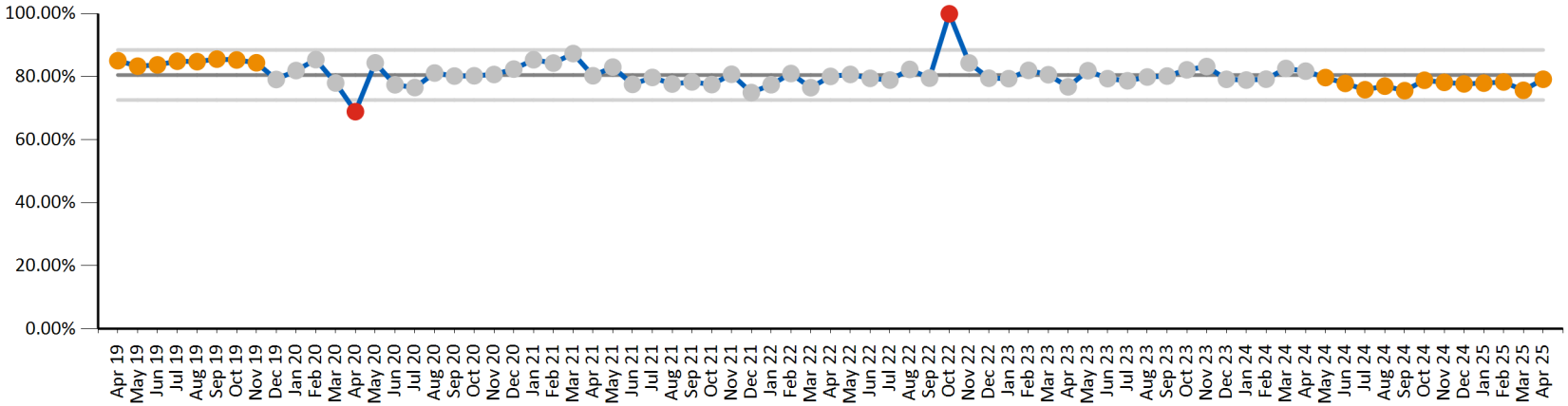
Plan	Actual	Period
	72.9%	Mar-25

Year to Date

Plan	Actual
	74.3%

583 - Theatre Utilisation - Uncapped

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	79.1%	Apr-25

Previous

Plan	Actual	Period
	75.6%	Mar-25

Year to Date

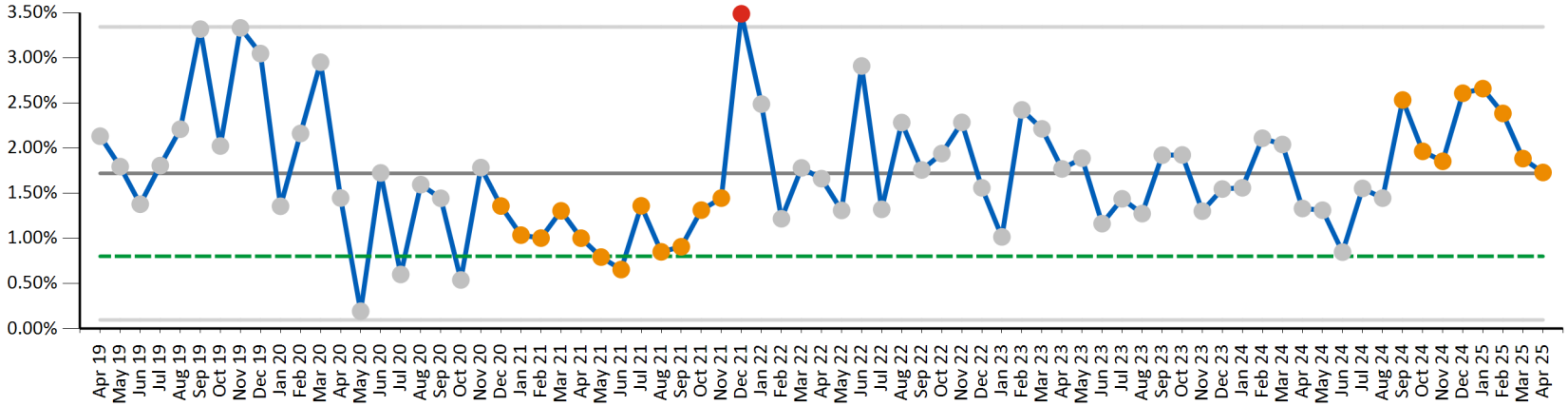
Plan	Actual
	79.1%

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 1%	1.7%	Apr-25

Previous

Plan	Actual	Period
<= 1%	1.9%	Mar-25

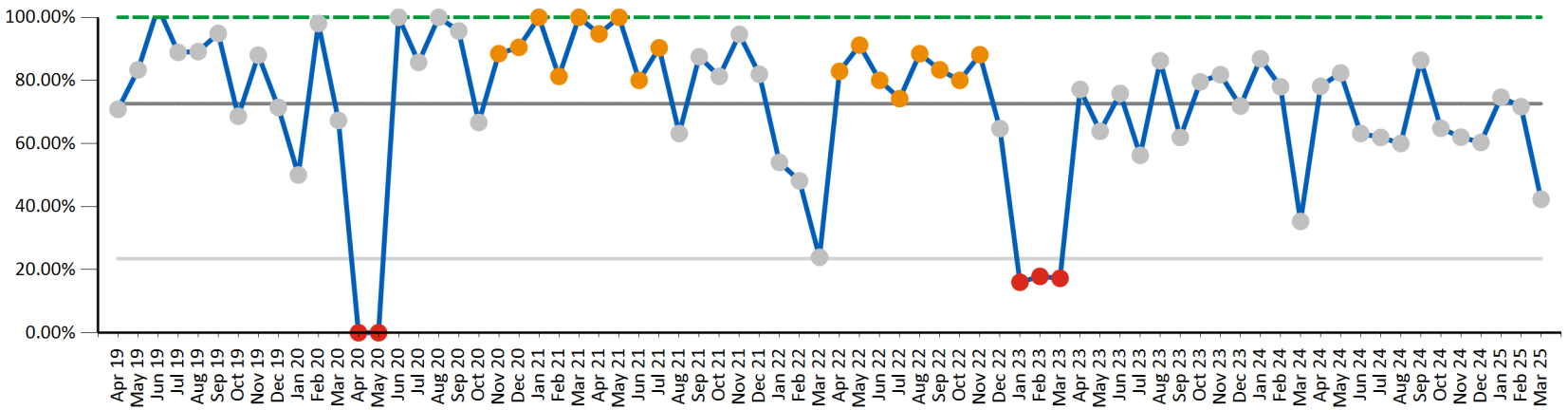
Year to Date

Plan	Actual
<= 1%	1.7%

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%	42.3%	Mar-25

Previous

Plan	Actual	Period
= 100%	71.7%	Feb-25

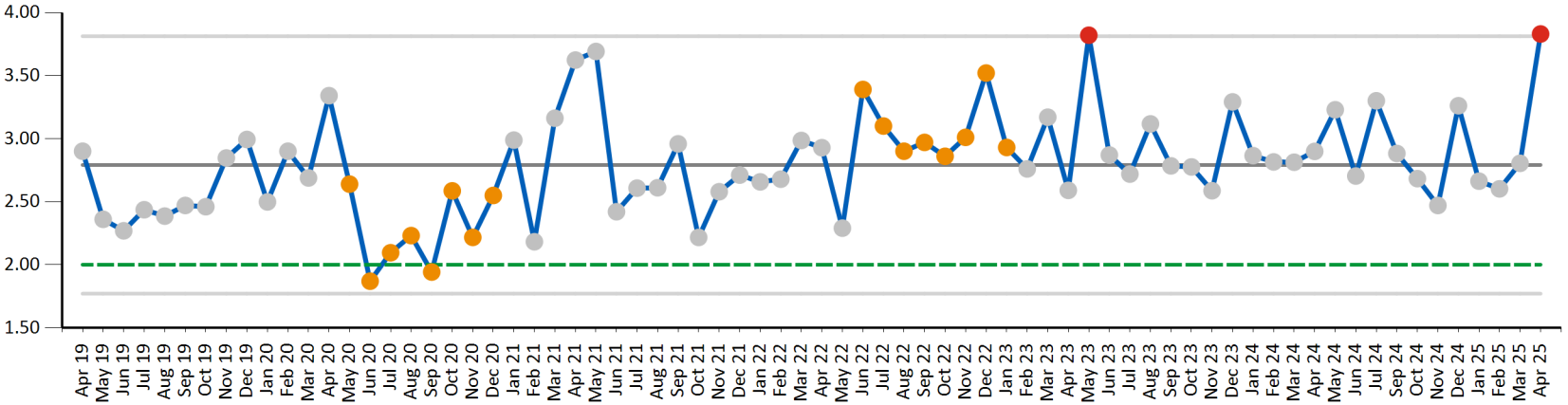
Year to Date

Plan	Actual
= 100%	30.9%

65 - Elective Length of Stay (Discharges in month)

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation. 0/6



Latest

Plan	Actual	Period
<= 2.00	3.83	Apr-25

Previous

Plan	Actual	Period
<= 2.00	2.80	Mar-25

Year to Date

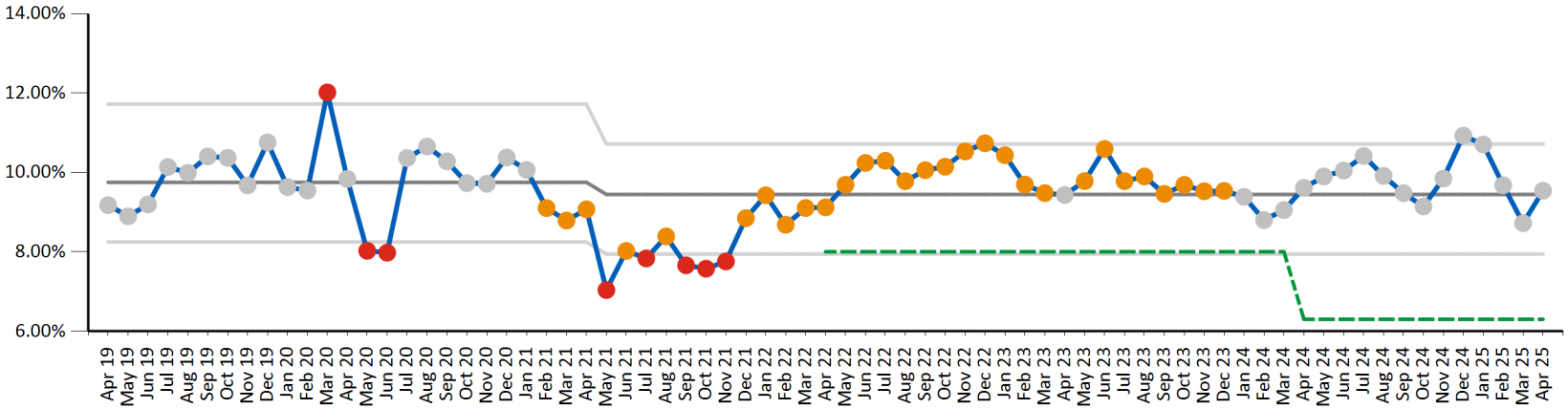
Plan	Actual
<= 2.00	3.83

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.5%	Apr-25

Previous

Plan	Actual	Period
<= 6.3%	8.7%	Mar-25

Year to Date

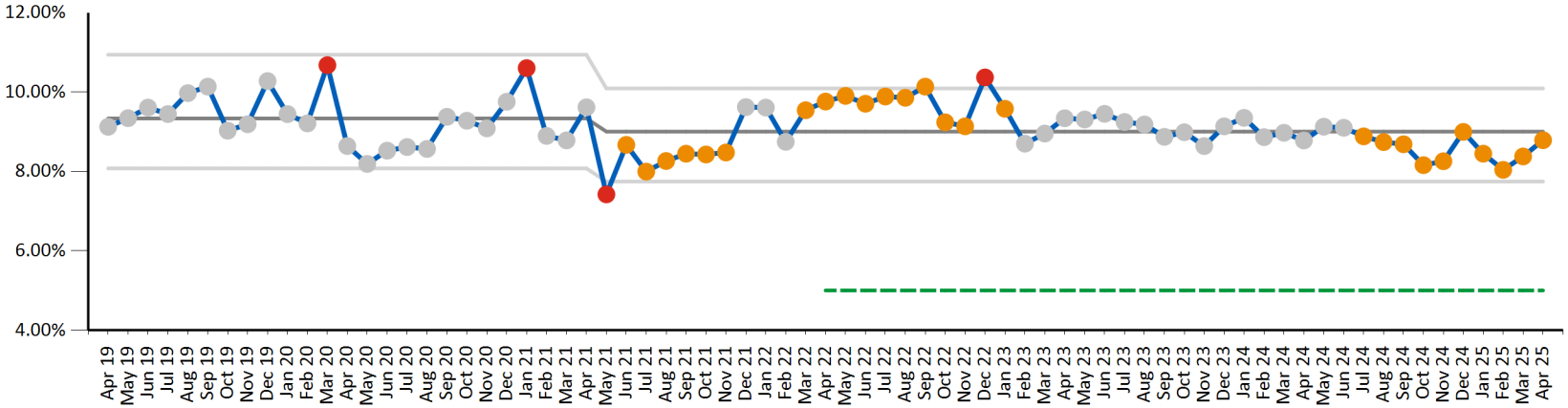
Plan	Actual
<= 6.3%	9.5%

310 - DNA Rate - Follow up

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	8.8%	Apr-25

Previous

Plan	Actual	Period
<= 5.0%	8.4%	Mar-25

Year to Date

Plan	Actual
<= 5.0%	8.8%

Operational Performance - Cancer

Bolton NHS Foundation Trust

For March, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We did not achieve performance the 62-day standard for March. All specialties have recovery actions in place to return to sustained performance; it is expected that we will achieve performance for April.

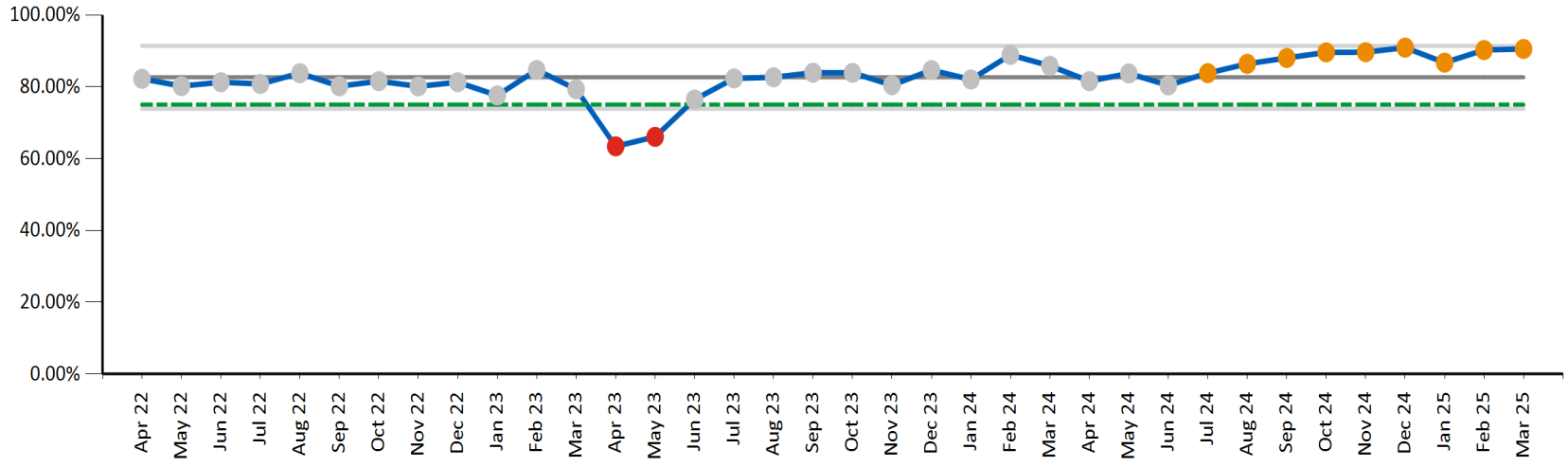
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	90.5%	Mar-25	H	>= 75.0%	90.2%	Feb-25	>= 75.0%		?
584 - 31 Day General Treatment Standard	>= 96%	99.2%	Mar-25		>= 96%	97.7%	Feb-25	>= 96%		
585 - 62 Day General Standard	>= 85%	80.4%	Mar-25		>= 85%	81.5%	Feb-25	>= 85%		

542 - Cancer: 28 day faster diagnosis

H Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	90.5%	Mar-25

Previous

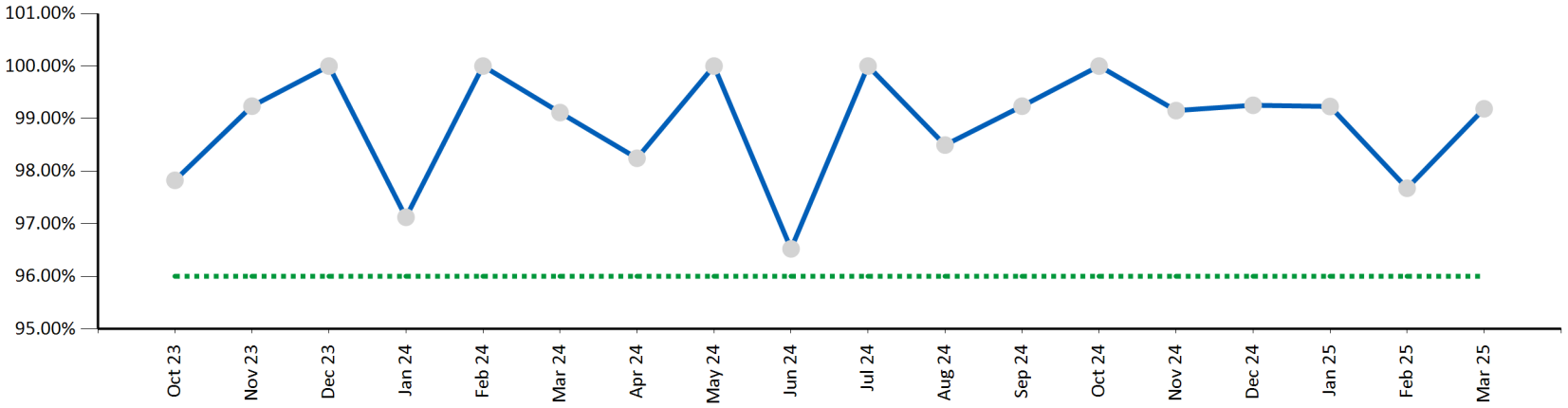
Plan	Actual	Period
>= 75.0%	90.2%	Feb-25

Year to Date

Plan	Actual
>= 75.0%	86.7%

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

6/6



Latest

Plan	Actual	Period
>= 96%	99.2%	Mar-25

Previous

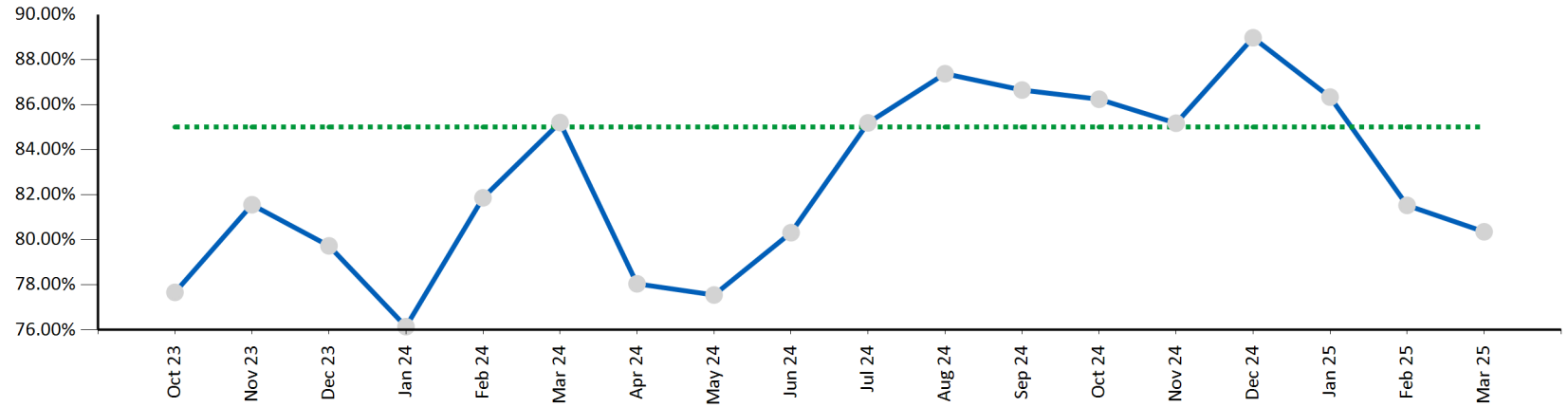
Plan	Actual	Period
>= 96%	97.7%	Feb-25

Year to Date

Plan	Actual
0.96	98.9%

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

4/6



Latest

Plan	Actual	Period
>= 85%	80.4%	Mar-25

Previous

Plan	Actual	Period
>= 85%	81.5%	Feb-25

Year to Date

Plan	Actual
0.85	83.8%

Operational Performance - Community Care

Bolton NHS Foundation Trust

Emergency Department deflections

ED deflections for Month 1 have increased to 582 from 568, 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. Further improvements to ED deflections are expected incrementally over the remainder of the year, based upon the new nationally mandated target of 180 referrals per 100,000 population per month for 2 hr UCR for 2025/2026. The AAT leadership team have in place a robust improvement plan, aligned to the national standard, which includes implementation of new pathways, improved engagement and embedding of call before you convey as business-as-usual practice.

NCTR

In Month 1, the average number of patient with No Criteria to Reside (NCTR) has reduced from 106 to 97 (versus plan of 90), although with a small increase in lost bed days from 655 to 666. The increase in lost bed days relates to a backlog of out of area patients from month 12 and reduced pathway 2 flow related to IPC closures in the IMC bed base. The team have continued to enact OPEL 4 actions, particularly during the easter period, with NCTR bed occupancy reducing from 19.3% to 17.5% month 12 to month 1. Continued individual patient escalations are taking place with Bolton and OOA partners alongside strategic planning with partners to support the UCIG phase 2 NCTR improvement actions.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts has improved although remains off target at 85% in April 2025 (vs 83% in March 2025). This continues the recent trend of improved mandated contact performance. The increase in April was largely due to an 11% improvement in antenatal contacts at 28 weeks or above which represents the best performance since August 2022. Recruitment remains ongoing for health visitors, however, vacancies are still causing pressures and this is recorded on the divisional risk register (R6036). Work is ongoing to build a tableau dashboard that will enable real time monitoring of performance.

EHCP compliance

Compliance has reduced to 91% for April 2025 (97% in March 2025). Reduce performance can be attributed to short notice Consultant sickness. This sickness has now been covered by a fixed term replacement so is expected to improve in May 2025.

Looked after Children

Review Health Assessment performance reduced in April 2025 to 90% (from 95% in March 2025). 2/5 breaches were outside of service control. 3/5 breaches have been reviewed by the service and improvement plans are now in place.

Initial Health Assessment performance was 87.5% in April 2025 (from 93.3% in March 2025). There were just 2 breaches in month – both beyond service control.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	582	Apr-25		>= 400	568	Mar-25	>= 400	582	

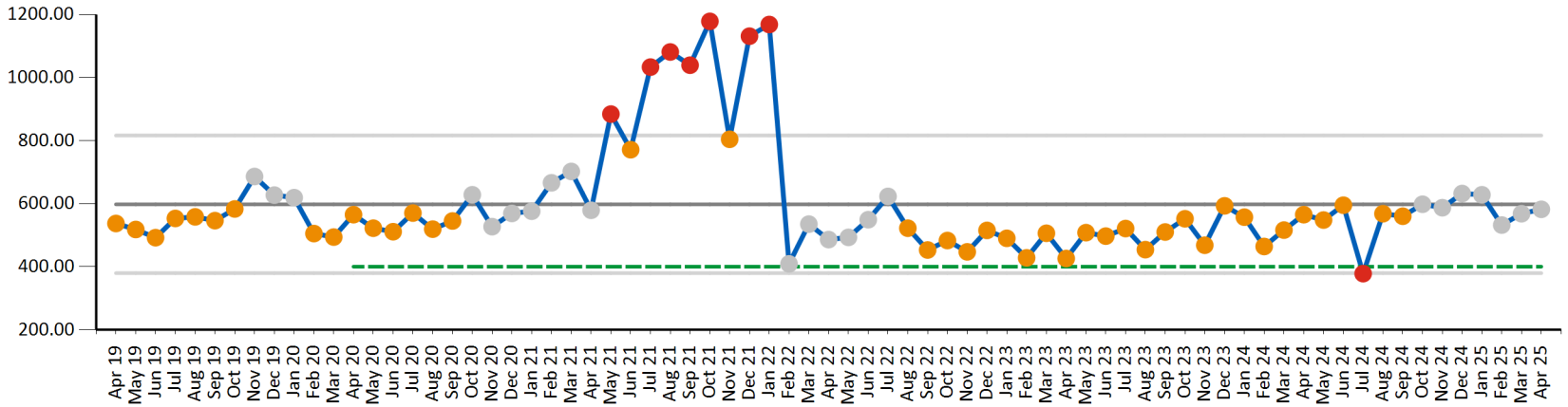
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
493 - Average Number of Patients: with no Criteria to Reside	<= 90	97	Apr-25		<= 90	106	Mar-25	<= 90	97	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	666	Apr-25	L	<= 360	655	Mar-25	<= 360	666	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	85%	Apr-25		>= 95%	83%	Mar-25	>= 95%	85%	F
269 - Education, health and care plan (EHC) compliance	>= 95%	91%	Apr-25		>= 95%	97%	Mar-25	>= 95%	91%	?
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	90.0%	Apr-25	H	>= 90.0%	95.0%	Mar-25	>= 90.0%		?
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	89.0%	Apr-25		>= 90.0%	93.3%	Mar-25	>= 90.0%		?
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Apr-25		>= 90.0%	100.0%	Mar-25	>= 90.0%		?

334 - Total Deflections from ED

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 400	582	Apr-25

Previous

Plan	Actual	Period
>= 400	568	Mar-25

Year to Date

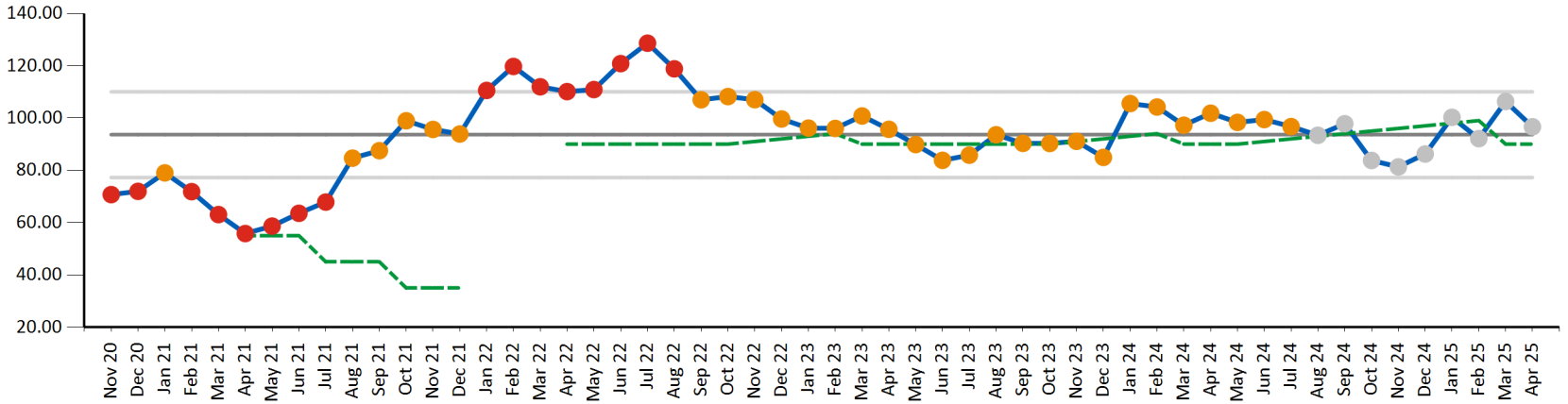
Plan	Actual
>= 400	582

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 90	97	Apr-25

Previous

Plan	Actual	Period
<= 90	106	Mar-25

Year to Date

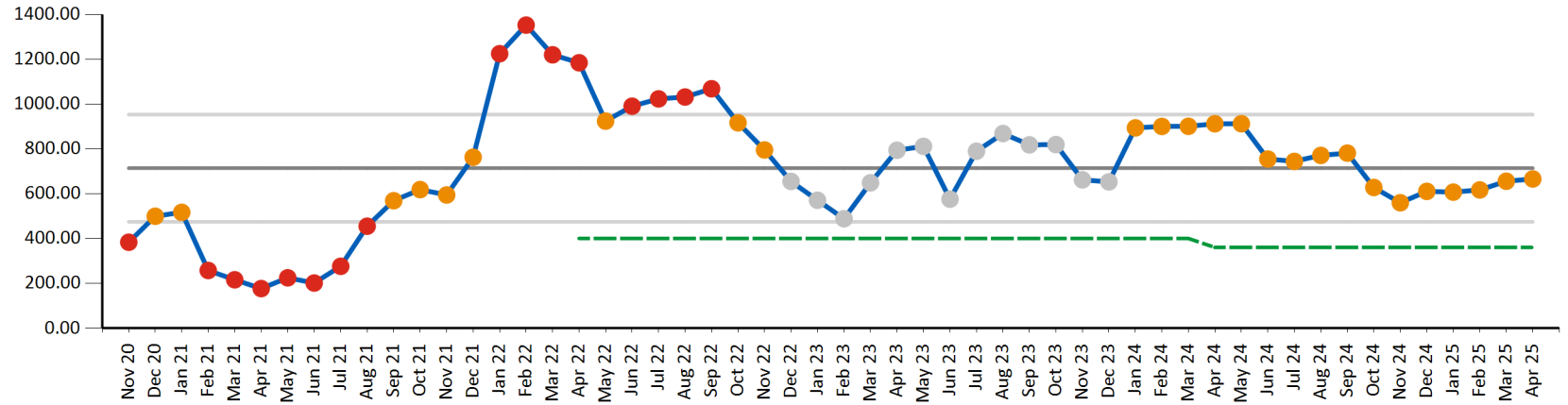
Plan	Actual
<= 90	97

494 - Average Occupied Days - for no Criteria to Reside

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	666	Apr-25

Previous

Plan	Actual	Period
<= 360	655	Mar-25

Year to Date

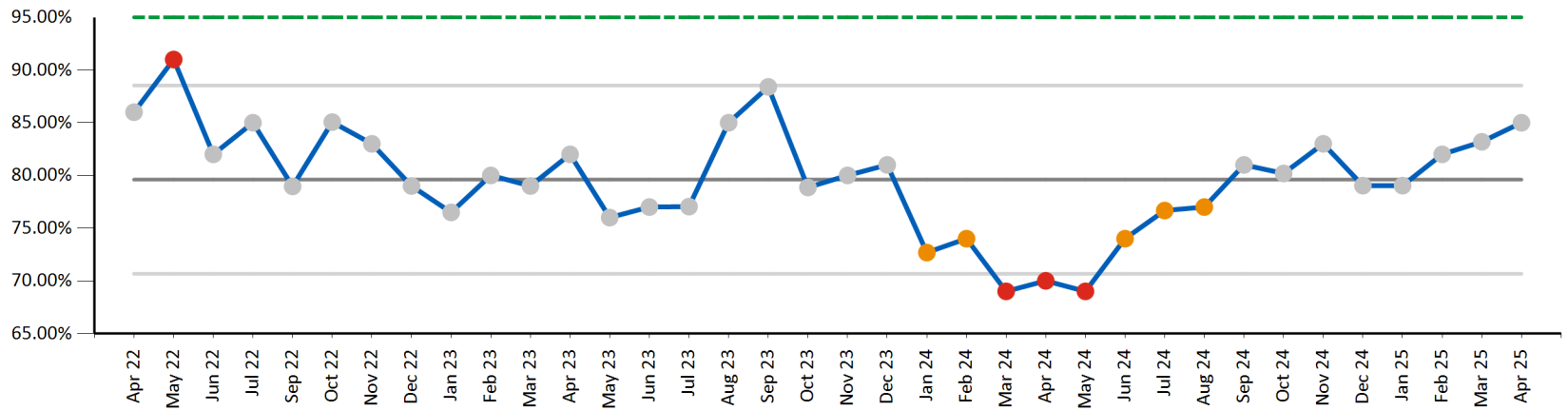
Plan	Actual
<= 360	666

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%	85%	Apr-25

Previous

Plan	Actual	Period
>= 95%	83%	Mar-25

Year to Date

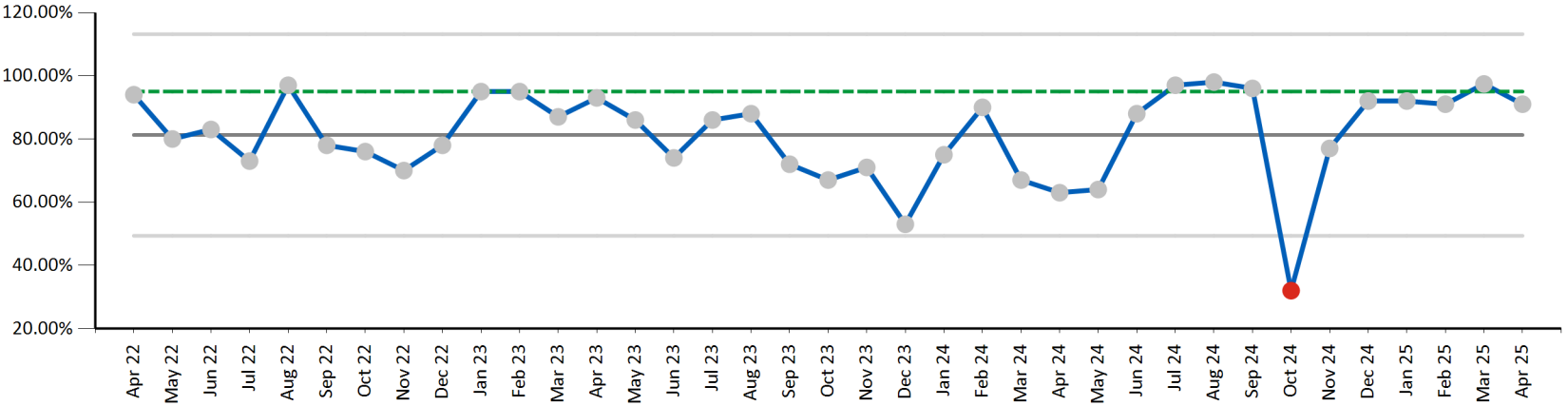
Plan	Actual
>= 95%	85%

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 95%	91%	Apr-25

Previous

Plan	Actual	Period
>= 95%	97%	Mar-25

Year to Date

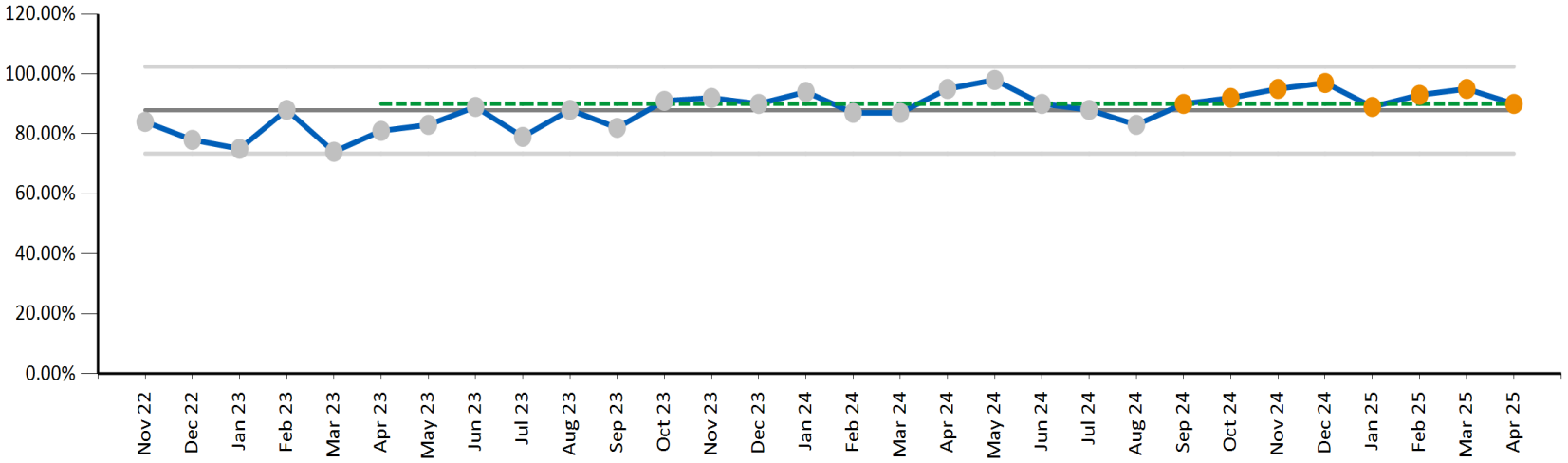
Plan	Actual
>= 95%	91%

550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse

Special cause variation with improving performance

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

5/6



Latest

Plan	Actual	Period
>= 90.0%	90.0%	Apr-25

Previous

Plan	Actual	Period
>= 90.0%	95.0%	Mar-25

Year to Date

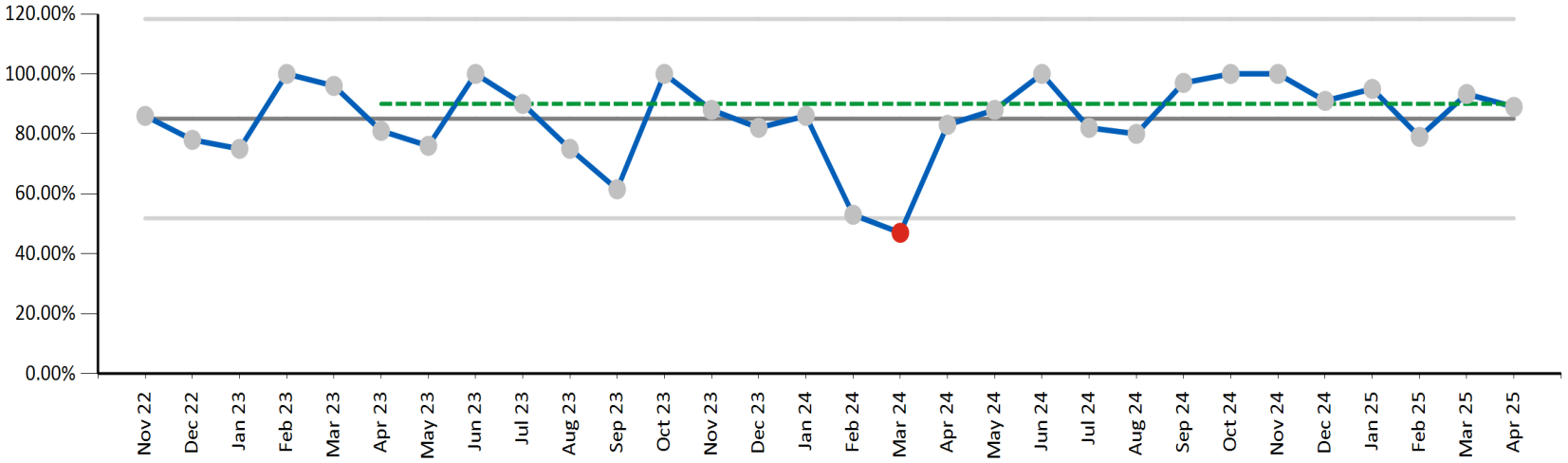
Plan	Actual
>= 90.0%	

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.

4/6



Latest

Plan	Actual	Period
>= 90.0%	89.0%	Apr-25

Previous

Plan	Actual	Period
>= 90.0%	93.3%	Mar-25

Year to Date

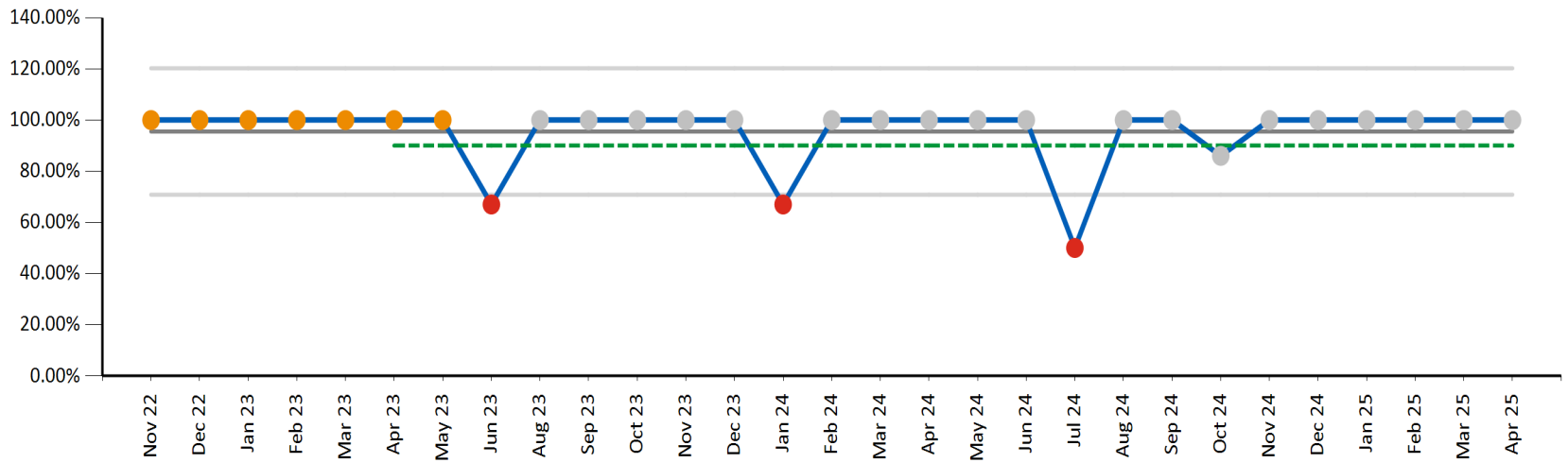
Plan	Actual
>= 90.0%	

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.

6/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Apr-25

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Mar-25

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness has remained fairly static in April 25 at 4.66% compared to 4.84% in March 2025. There has been a decrease in sickness absence in some of the clinical Divisions with the particular reductions in AACD (reduction of 0.72%) and ASSD (reduction of 0.61%) however this has been offset by increases in other clinical divisions and corporate functions. Each Division and corporate function continues to undertake a review of sickness, with an increased focus on providing wellbeing support through Occupational Health and wider wellbeing initiatives. 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.

Vacancy:
Vacancy rates tracked down in 2024/25. Divisional vacancy position is mostly strong, with ASSD and DSSD in a particularly positive position; Family Care expected to improve following positive recruitment activity. Acute Adult have a number of HCA vacancies but a good pipeline of candidates undergoing pre-employment checks and more recruitment underway. From a staff group perspective it is pleasing to note low rates in most registered clinical staff groups.

Turnover:
Turnover was stable in 2024/25 with a slight reducing trend noted in the last quarter of that financial year. We expect to see a similar position for the financial year 2025/26. For April 2025, we started the financial year with a continuation of the reduced trend with turnover at 11.06%. At Divisional & Directorate level the picture is more variable. For staffing groups area of concern should be Additional Clinical Services which are running higher than normal at 15% - coupled with existing vacancies this will need to be carefully monitored.

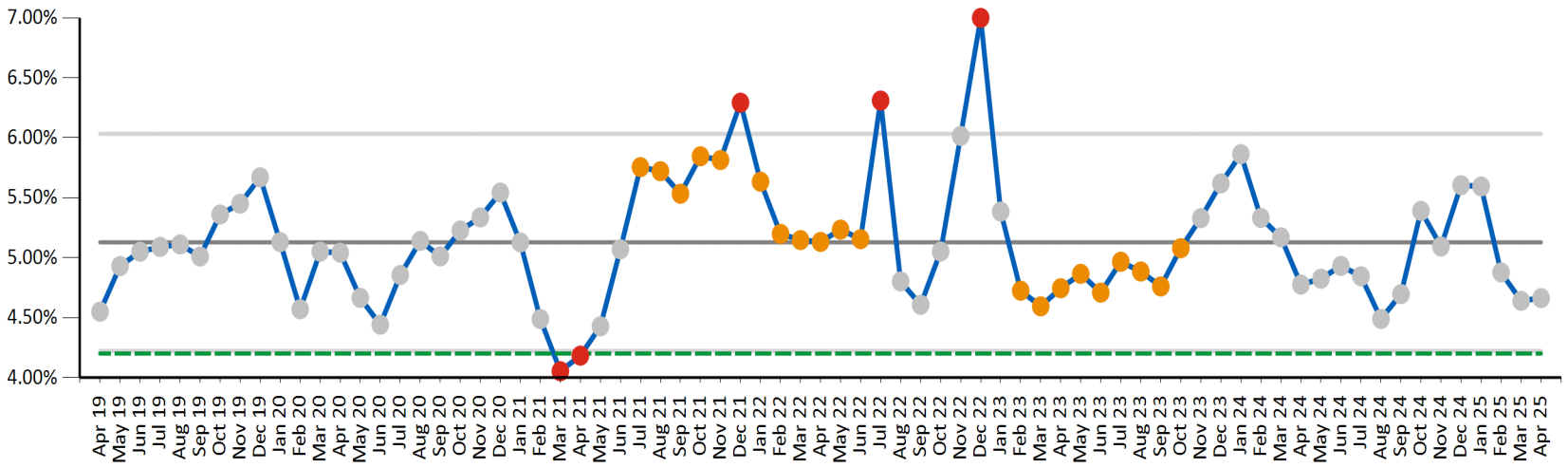
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.66%	Apr-25		<= 4.20%	4.64%	Mar-25	<= 4.20%	4.66%	
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		
121 - Turnover	<= 9.90%	11.06%	Apr-25		<= 9.90%	11.16%	Mar-25	<= 9.90%	11.06%	
366 - Ongoing formal investigation cases over 8 weeks		0	Apr-25			0	Mar-25		0	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	4.66%	Apr-25

Previous

Plan	Actual	Period
<= 4.20%	4.64%	Mar-25

Year to Date

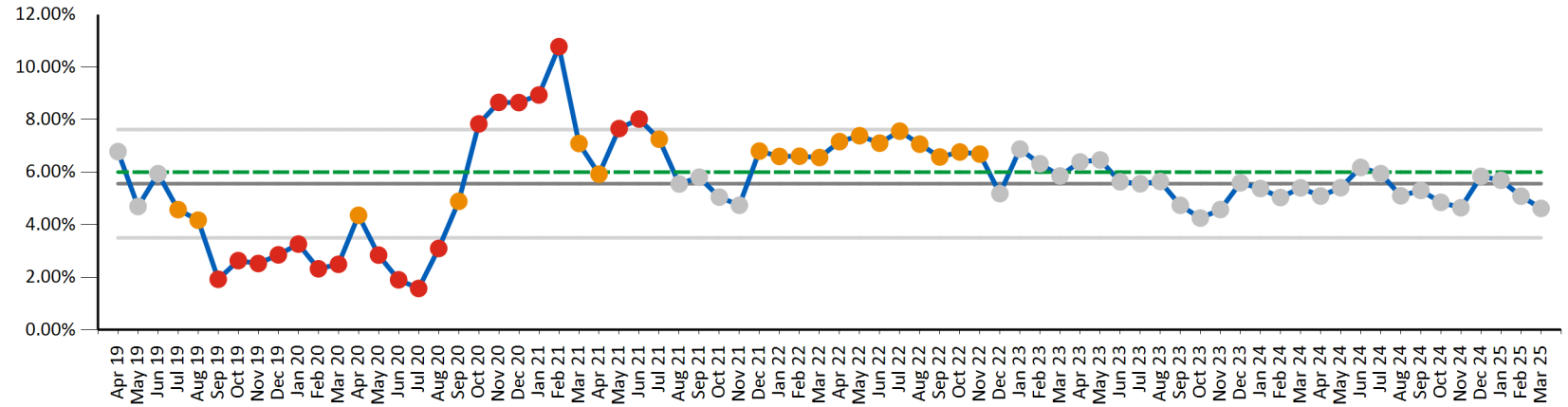
Plan	Actual
<= 4.20%	4.66%

120 - Vacancy level - Trust

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 6%	4.62%	Mar-25

Previous

Plan	Actual	Period
<= 6%	5.08%	Feb-25

Year to Date

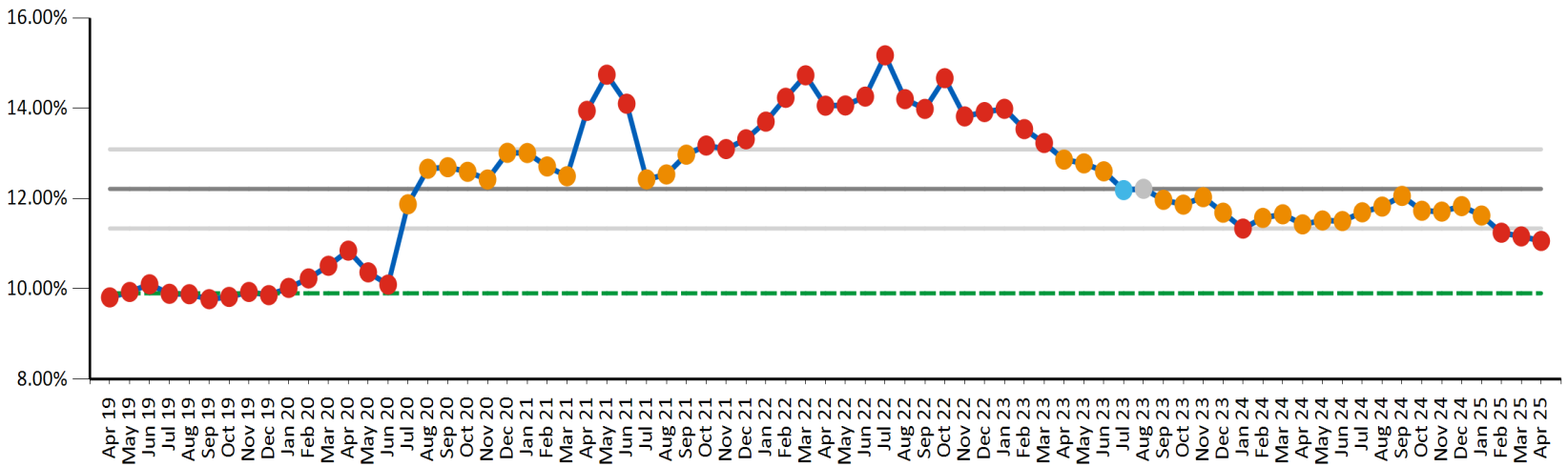
Plan	Actual
<= 6%	5.31%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.06%	Apr-25

Previous

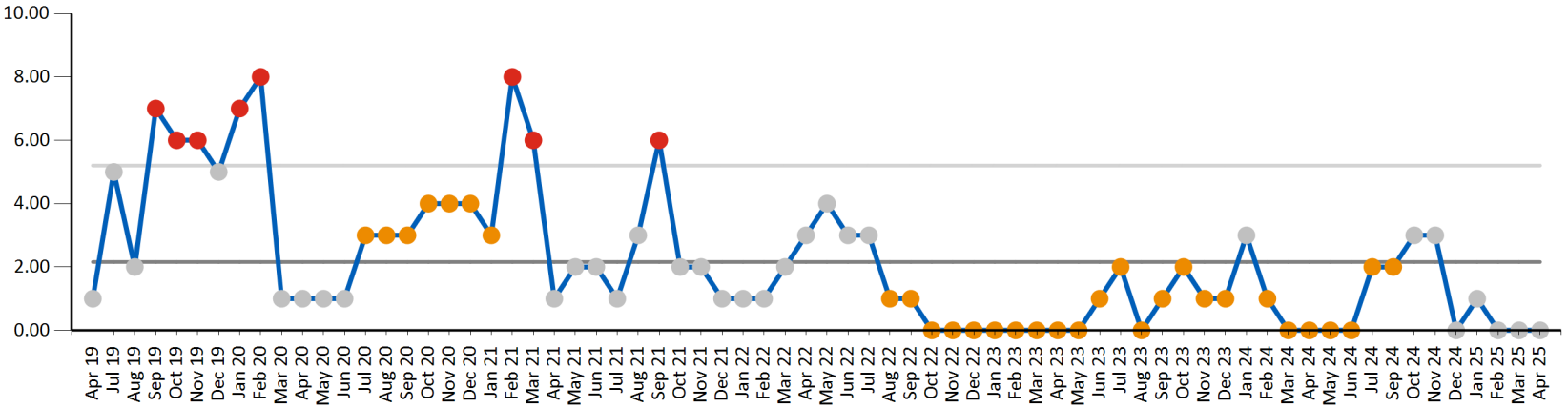
Plan	Actual	Period
<= 9.90%	11.16%	Mar-25

Year to Date

Plan	Actual
<= 9.90%	11.06%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	0	Apr-25

Previous

Plan	Actual	Period
	0	Mar-25

Year to Date

Plan	Actual
	0

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training

The Divisions / Directorates have continued to improve on their monthly overall performance to meet 94.24%. This is an excellent position for Month1 as it is the highest we have ever been for month 1. Moving and Handling has improved slightly to reach 84.3%. New bespoke training for community staff is being tested throughout May and June with the aim to roll out the learning to other bespoke staff groups (Maternity/ Paediatrics) in the next 12 months.

Basic Life Support deteriorated slightly to 88% from 89%. The QI programme project related to DNA's for face to face training commenced in May with the final actions to be agreed with the support of the Divisional leads. It is anticipated this will support an improvement by reducing the number of DNAs.

Trust Mandated Training

Another positive month, with an 0.5% improvement in month. Aseptic non touch technique (84.8%) and blood transfusion (86.1%) are the only subjects out of eight that have not met 90%. The SME for these subjects are working through the challenges as to why staff have not completed the relevant learning in a timely manner to identify support and improvements

Appraisal

There has been a deterioration in position this month by 0.6%. The launch of the new FABB appraisal and regular check-in documents and supporting information, along with access to face to face training (if required) commences 1st June with a transition period until 1st September 2025. This is being signposted from the Our Leaders 2-day event which almost 250 leaders/managers have already completed, with a further 350 booked on.

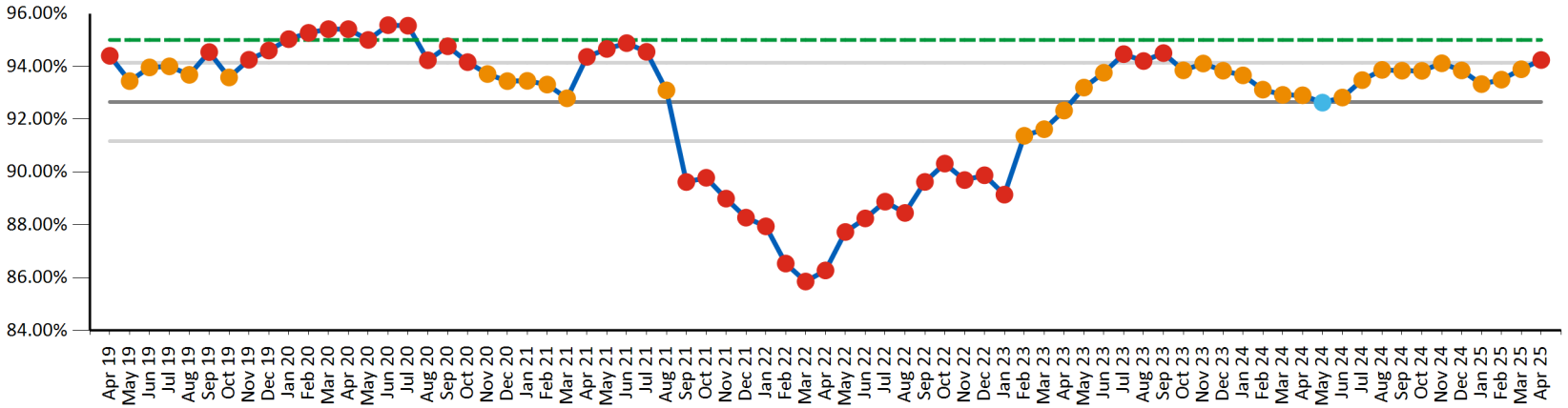
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	94.2%	Apr-25	H	>= 95%	93.9%	Mar-25	>= 95%	94.2%	F
38 - Staff completing Trust Mandated Training	>= 85%	92.0%	Apr-25	H	>= 85%	91.4%	Mar-25	>= 85%	92.0%	P
39 - Staff completing Safeguarding Training	>= 95%	94.33%	Apr-25		>= 95%	93.52%	Mar-25	>= 95%	94.33%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.7%	Apr-25	H	>= 85%	85.3%	Mar-25	>= 85%	84.7%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	51.8%	Q4 2024/25	L	>= 66%	59.6%	Q3 2024/25	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	54.9%	Q4 2024/25	L	>= 80%	59.0%	Q3 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%	94.2%	Apr-25

Previous

Plan	Actual	Period
>= 95%	93.9%	Mar-25

Year to Date

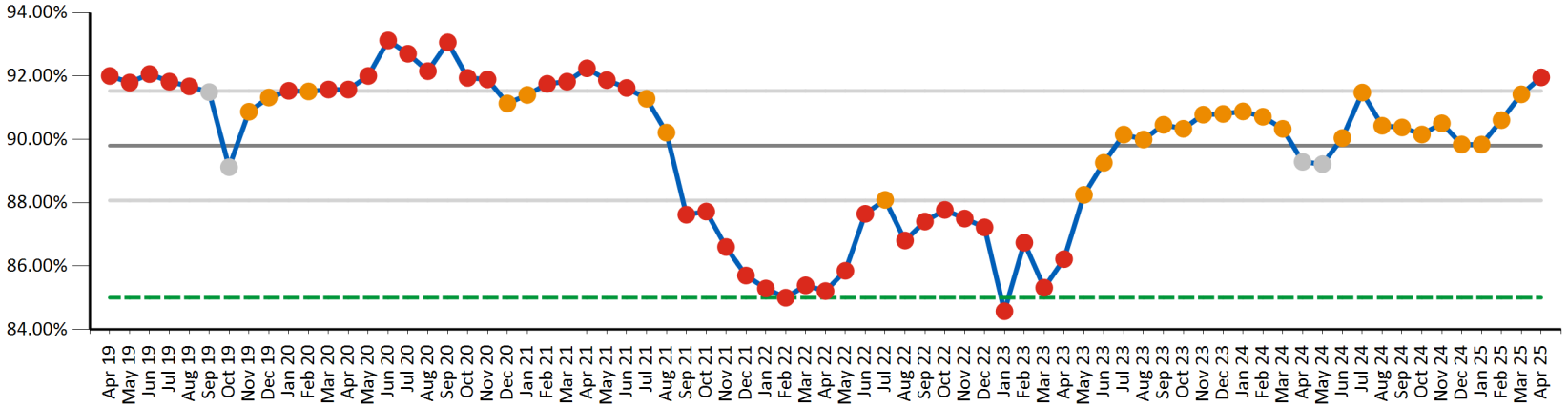
Plan	Actual
>= 95%	94.2%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	92.0%	Apr-25

Previous

Plan	Actual	Period
>= 85%	91.4%	Mar-25

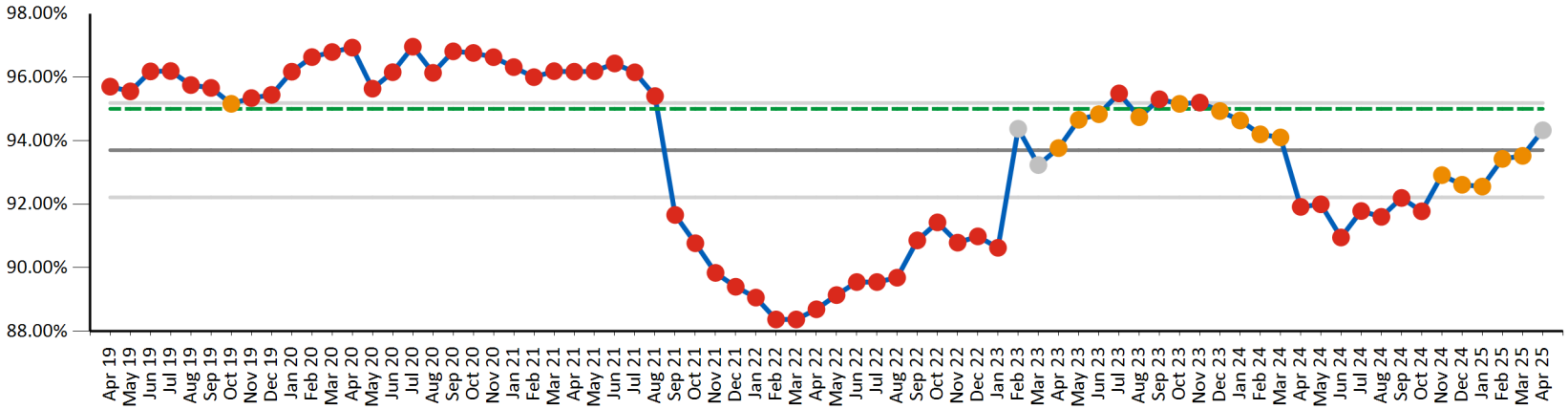
Year to Date

Plan	Actual
>= 85%	92.0%

39 - Staff completing Safeguarding Training

Common cause variation.

We will not regularly meet the target due to normal variation. 0/6



Latest

Plan	Actual	Period
>= 95%	94.33%	Apr-25

Previous

Plan	Actual	Period
>= 95%	93.52%	Mar-25

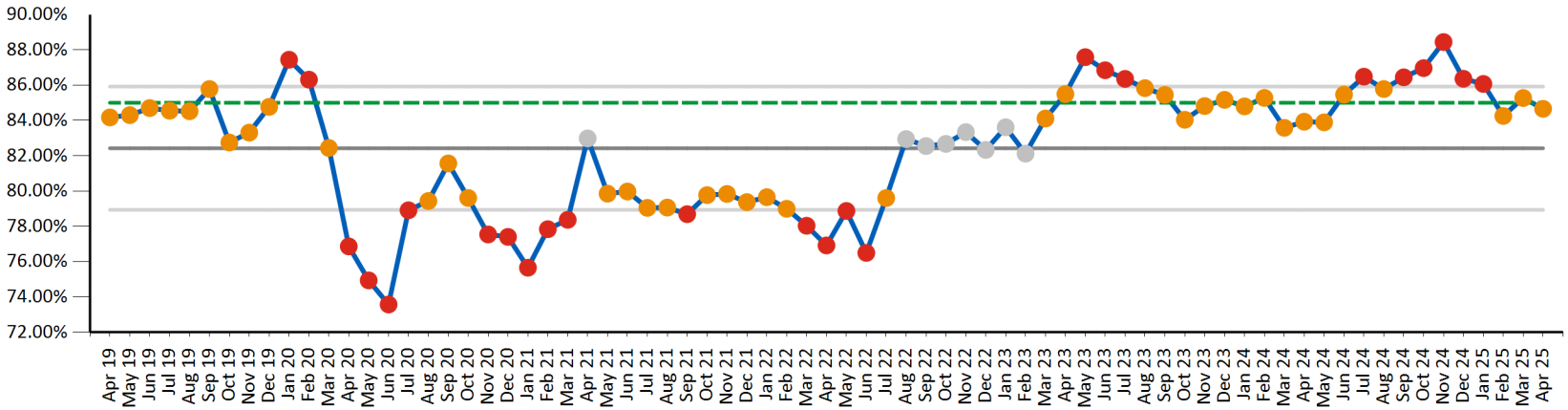
Year to Date

Plan	Actual
>= 95%	94.33%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

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



Latest

Plan	Actual	Period
>= 85%	84.7%	Apr-25

Previous

Plan	Actual	Period
>= 85%	85.3%	Mar-25

Year to Date

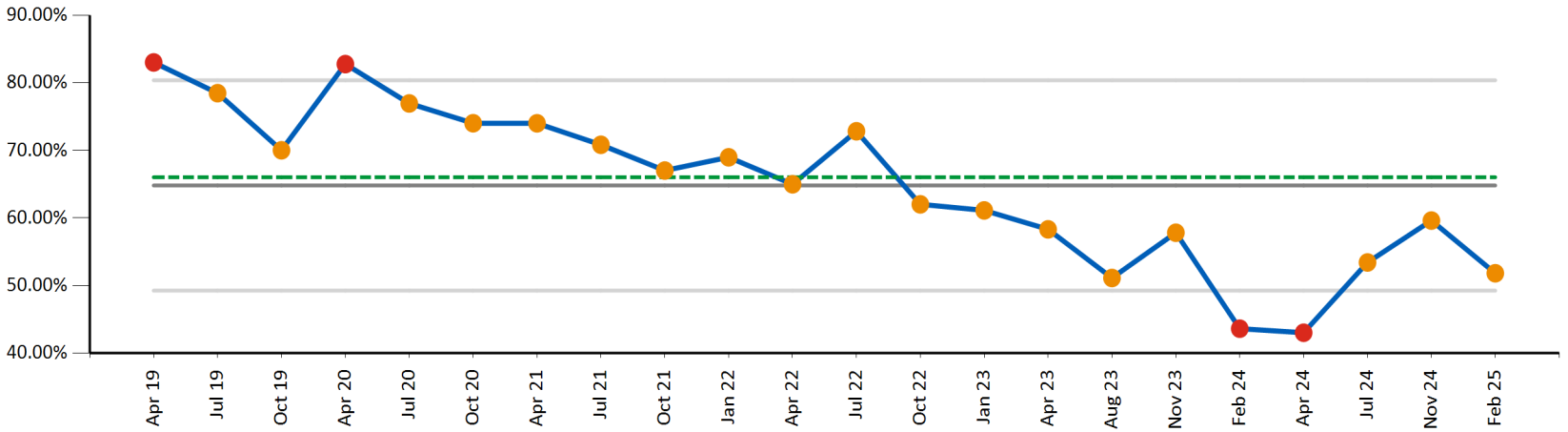
Plan	Actual
>= 85%	84.7%

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 66%	51.8%	Q4 2024/25

Previous

Plan	Actual	Period
>= 66%	59.6%	Q3 2024/25

Year to Date

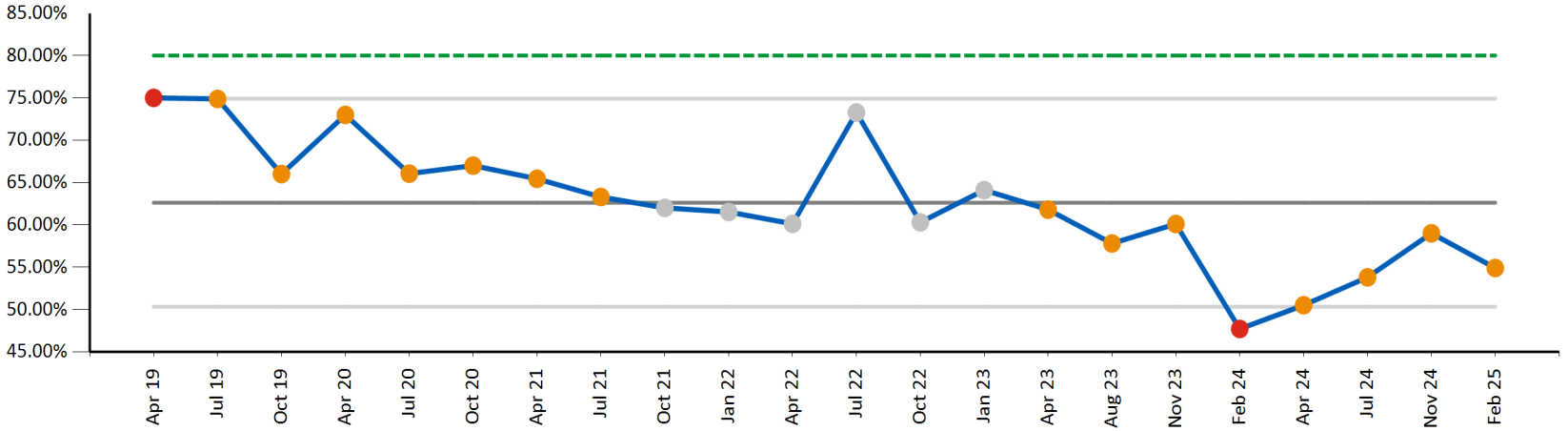
Plan	Actual
>= 66%	

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

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	54.9%	Q4 2024/25

Previous

Plan	Actual	Period
>= 80%	59.0%	Q3 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Agency usage and expenditure reduced significantly in-month when compared to March 2025 (a reduction of 19 WWTE, and £370k reduced spend), thanks to strong controls, substantive recruitment, and a 'switch' of agency workers to cheaper bank working.

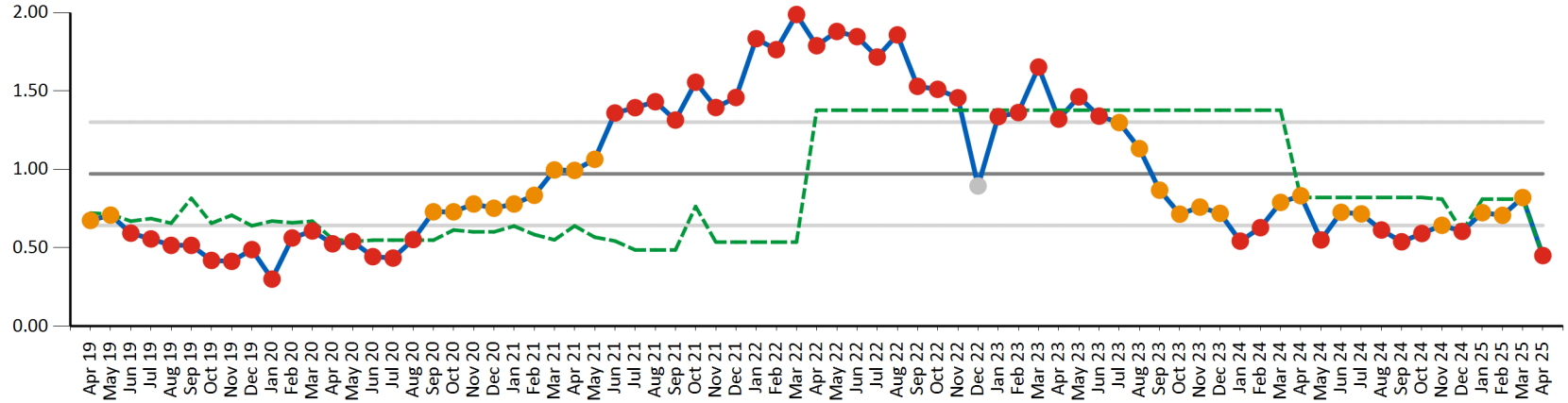
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.45	0.45	Apr-25	L	<= 0.81	0.82	Mar-25	<= 0.45	0.45	F
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.02	0.02	Apr-25	L	<= 0.09	0.09	Mar-25	<= 0.02	0.02	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.51	0.51	Apr-25		<= 0.61	0.60	Mar-25	<= 0.51	0.51	?

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

L Special cause variation with improving performance

F We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 0.45	0.45	Apr-25

Previous

Plan	Actual	Period
<= 0.81	0.82	Mar-25

Year to Date

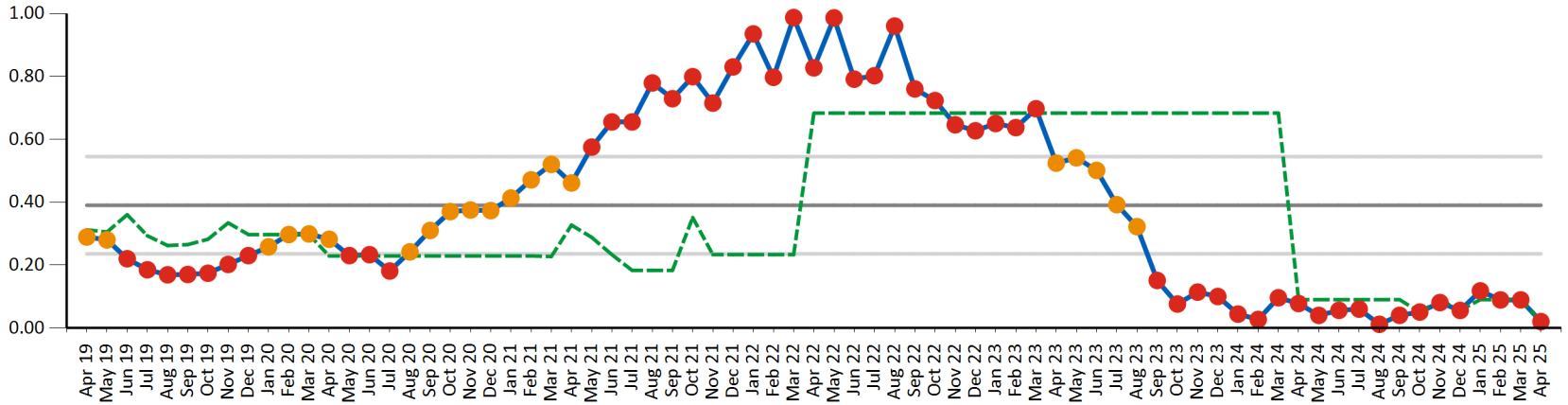
Plan	Actual
<= 0.45	0.45

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

Special cause variation with improving performance

We will regularly fail to meet the target.

4/6



Latest

Plan	Actual	Period
<= 0.02	0.02	Apr-25

Previous

Plan	Actual	Period
<= 0.09	0.09	Mar-25

Year to Date

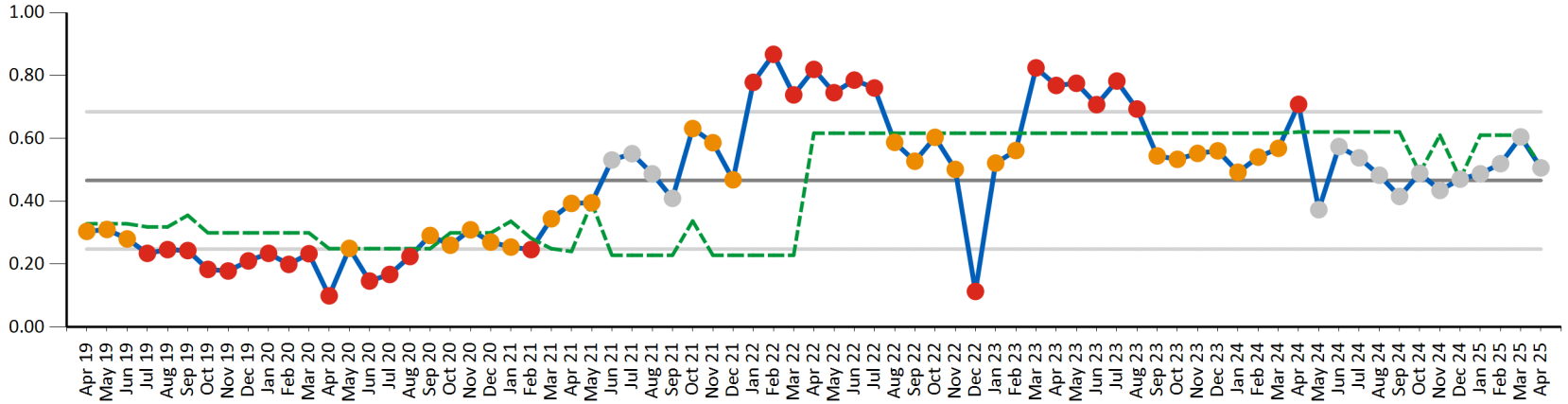
Plan	Actual
<= 0.02	0.02

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
<= 0.51	0.51	Apr-25

Previous

Plan	Actual	Period
<= 0.61	0.60	Mar-25

Year to Date

Plan	Actual
<= 0.51	0.51

Finance - Finance

NHS Bolton NHS Foundation Trust

Surplus / (Deficit)
The Trust is reporting a deficit largely due to CIP under-delivery partially offset by income inflation not yet being spent (incremental drift and non-pay inflation)

Forecast
It is too early to produce a forecast position, no forecast has been reported externally

Income
Commissioner income is based on contractual and budget values

Pay
WTEs and underlying Pay Costs have dropped following a spike at M12, but there is an adverse variance against CIP delivery

Non Pay
Underlying Non Pay Costs have reduced since M12, particularly following spikes on Utilities and Consumables/Appliances, but there is an overall adverse variance, driven largely by under-delivery of CIP

Non Operating
Interest received has been slightly higher than planned.

Cash
The Trust was above plan by £12.6m in Month 1. PDC funding cash has provided a temporary benefit of £7.2m. The underlying cash position is £5m and it is anticipated that cash support will be required during 2025/26, either late in Q1 or early in Q2.

CIP Delivery
Under-delivery in Month 1, there are minimal opportunities for central non-recurrent items to support delivery in 2025/26

Capital
£48.8m of capital budget for the year, the majority is anticipated from Q2 onwards

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -1.5	-2.4	Apr-25		>= 2.0	-6.2	Mar-25	>= -1.5	-2.4	
222 - Capital (£ millions)	>= 0.7	0.5	Apr-25		>= 4.0	2.4	Mar-25	>= 0.7	0.5	

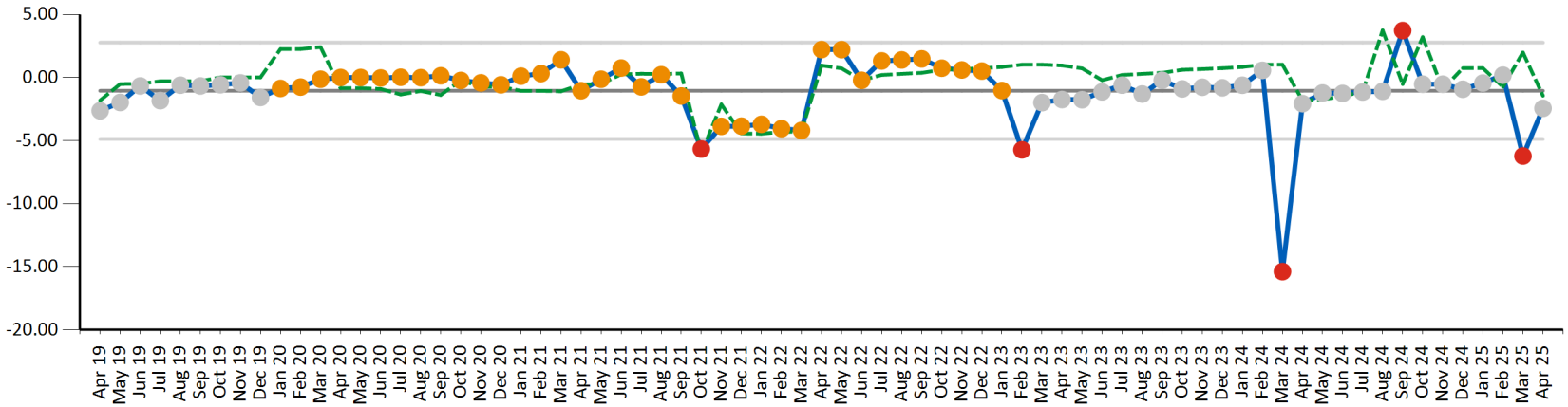
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
223 - Cash (£ millions)	>= 6.9	19.5	Apr-25	L	>= 7.0	7.4	Mar-25	>= 6.9	19.5	P

220 - Control Total (£ millions)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= -1.5	-2.4	Apr-25

Previous

Plan	Actual	Period
>= 2.0	-6.2	Mar-25

Year to Date

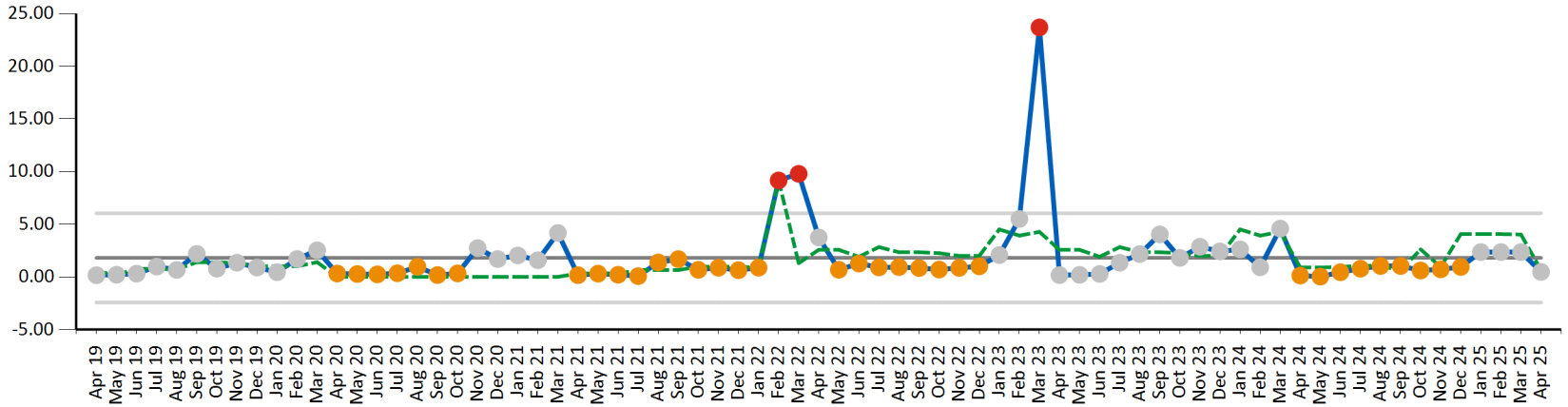
Plan	Actual
>= -1.5	-2.4

222 - Capital (£ millions)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 0.7	0.5	Apr-25

Previous

Plan	Actual	Period
>= 4.0	2.4	Mar-25

Year to Date

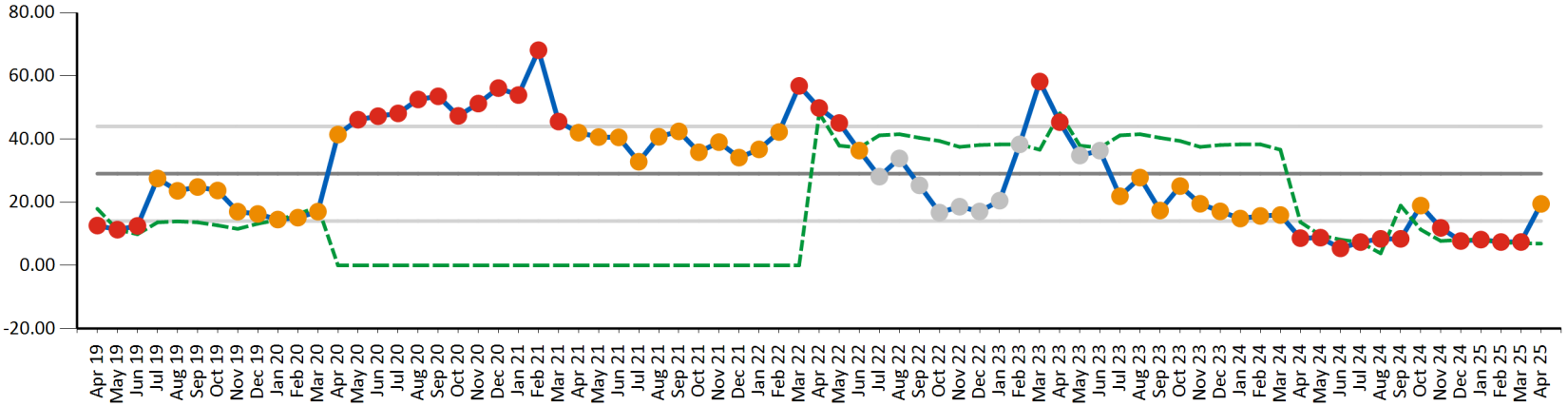
Plan	Actual
>= 0.7	0.5

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

5/6



Latest

Plan	Actual	Period
>= 6.9	19.5	Apr-25

Previous

Plan	Actual	Period
>= 7.0	7.4	Mar-25

Year to Date

Plan	Actual
>= 6.9	19.5

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	
Executive Sponsor	Quality Assurance Committee Chair		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 March 2025.

Executive Summary	The attached report from the Chair of the Quality Assurance Committee provide an overview of matters discussed at the meeing held on 26 March 2025. 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 May 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 are asked to ***receive*** the Quality Assurance Committee Chair's Reports.

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, Quality Assurance Committee Chair	**Presented by:**	Fiona Taylor, Quality Assurance Committee Chair

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	26 March 2025	**Date of next meeting:**	28 May 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Integrated Performance Report
- Board Assurance Framework
- Audiology Update
- Quality Account Improvement Priorities
- Learning from Experience Report
- Maternity Incentive Scheme Year 6 Progress Update (CNST)
- Clinical Correspondence Update
- Controlled Drugs Accountable officer Self-Assessment and Improvement Framework
- Clinical Coding Update
- Health & Safety Annual Report 2023/24
- NHS Resolution Claims Scorecard – Analysis Report
- Clinical Governance & Quality Committee Chair Report
- Performance & Transformation Board Chair Report

ALERT

Agenda items	Action Required
Maternal and foetal death noted and discussed in Board	

ADVISE

Board Assurance Framework (BAF) The Committee reviewed and focused on Ambition 1: Improving Care, Transforming Lives, with emphasis on safety, effectiveness, and experience. The Chair emphasised the need for a Board Development Session to align understanding of risk appetite.

Integrated Performance Report (IPR) – The Chief Nurse, Medical Director and Chief Operating Officer presented the report detailing performance during February.It was noted that:

- Reported on pressure ulcers, infection prevention and control, and maternity concerns.
- Improvements noted, but stillbirths remain above plan, especially among deprived and ethnic minority mothers.
- Automated alerts are now live to support action plans.
- Improvements in clinical correspondence.
- Concerns raised about VTE and mortality rates, partly due to data recording and COVID-19 impact.
- Positive trends in A&E and elective performance.
- Significant progress in cancer diagnosis despite norovirus and flu outbreaks.
- Heatmap report highlighted key performance indicators and improvement outcomes.

Audiology Update – The Chief Operating Officer confirmed that a new model, potentially involving collaboration or private providers, is being developed. Additionally, the Director of Quality Governance mentioned that GM is in the early stages of reviewing Paediatric Audiology Providers across the region. Chair requested a detailed quality impact paper, especially for children.GM is reviewing Paediatric Audiology Providers regionally.

Quality Account Improvement Priorities (2025/26) - The Chief Nurse presented the Quality Account Improvement Priorities paper, highlighting the need for the committee to select three priorities for 2025/26, focusing on quality improvement and patient safety. Proposed priorities:

1. Recognition and response to deteriorating patients
2. Releasing time to care (focus on documentation)
3. Improving communication, especially patient involvement

Learning Experience Report - The Director of Quality Governance presented the report, identifying five key themes: decisions regarding clinical treatment, communication, delay in treatment/escalation, documentation, and review of procedures. The report includes examples of learning and improvements, external investigations from 2024, and a Prevention of Future Deaths report concerning a local care provider. The Committee received assurance that the report is reviewed monthly by the Clinical Governance & Quality Committee.

Clinical Correspondence Update - The Medical Director presented the update, noting that while no divisions have fully achieved the 95% target for inpatient and outpatient correspondence, there is an improving trend in inpatient correspondence, though outpatient compliance has decreased. The Family Care Division's inpatient correspondence shows a 74.2% compliance rate, and outpatient correspondence is at 68.2%, both falling short of the 95% target but within common cause variation

Clinical Coding - The Chief of Strategy and Partnerships reported that a qualified post has been recruited, but first cut (flex) coding completeness has declined, despite maintaining the final cut (freeze) position. Actions underway include using internal and external staff via NHSP and recruiting for two additional vacancies to support backlog recovery. A shift from inpatient spells to A&E Type 5 for SDEC admissions is expected to reduce monthly coding by around 1,000 spells. AI developments may assist with simple coding tasks in the future.

NHS Resolution Claims Scorecard - The Director of Quality Governance presented the report, detailing the Trust's claims over the past decade. From April 2014 to March 2024, the Trust received 565 claims totaling £336,092,406. In 2023/24, there were 63 clinical claims, with obstetrics, emergency medicine, general medicine, cardiology, and general surgery being the top specialties. The number of general and obstetric claims decreased compared to the previous year.

Clinical Governance & Quality Committee - The Chief Nurse presented the Chair's Report. Alerts noted on the Chair Report:

- Translation and Interpreter Services – ongoing concern.

- Blood Product Transfusion Update – wider discussion regarding digital programmes.

Performance & Transformation Board - The Chief Operating Officer presented her Chair's Report from the Performance and Transformation Board. Alerts noted on the Chair Report:

- Community Reactive Care Oversight Group – work underway to address underutilisation of virtual ward.
- Elective Programme Productivity Group – lack of capacity in BI team, may pose risk to effective waiting list analysis.

ASSURE

Maternity Incentive Scheme Years 6 Progress Report - The Director of Midwifery presented the report, confirming the submission of the CNST year 6 declaration form to NHS Resolution and ongoing monitoring of action plans until the CNST year 7 scheme begins. The Trust will receive the CNST year 7 scheme document on April 2, 2025, and year 6 payments are expected by the end of April. The Director also addressed a maternal and foetal death, noting the coroner's ruling of pulmonary embolism as the cause and the implementation of focused actions. Staff affected by this incident have been supported through debriefs and referrals to Occupational Health. Despite digital challenges, such as delays to the Maternity EPR, the Division remains confident in maintaining quality through a single delivery plan and robust medical training.

Controlled Drugs Accountable Officer Self Assessment and Improvement Framework - The Medical Director presented the report, identifying three main gaps: the absence of a policy for sharing personal identifiable information regarding controlled drugs concerns, the need for a robust system to address unusual prescribing patterns, and the lack of structured board-level assurance reporting. Recommendations include updating the controlled drugs policy, investing in electronic registers, and enhancing prescribing oversight with a BI-generated report by Q2 2025/26. Strengthening board assurance involves implementing an annual CDAO report for Clinical Governance & Quality Assurance Meetings.

Health & Safety Annual Report 2023/24 - The Committee noted full compliance with relevant legislation in 2023/24. Despite not meeting the 95% compliance target for Moving and Handling Level 2, actions are in place to improve this, including recruiting a Manual Handling Advisor. Training compliance remained above 85%, and reported incidents increased from 673 to 813, with most causing no or low harm. RIDDOR incidents reduced from 7 to 5, and two Health and Safety Executive inspections were satisfactory. Fire and security risk assessments maintained 95% compliance. The Head of Health and Safety noted an increase in violence and aggression incidents towards staff, with ongoing work to improve standards and training, monitored by the Group Security Committee.

New Risks identified at the meeting: No new risks.

Review of the Risk Register: N/A

Meeting Attendance 2025												
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Fiona Taylor	✓		✓									
Martin North	✓		✓									
Seth Crofts	✓		✓									
Becks Ganz	A		✓									
Francis Andrews	✓		✓									
Tyrone Roberts	✓		✓									
Rae Wheatcroft	✓		✓									
Sharon Katema	✓		A									
✓ = In attendance A = Apologies												

Report Title:	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		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 7 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee and Quality Assurance Committee.

Executive Summary	Key highlights: • Assurance can be provided that confirmation has been received from NHS Resolution that the CNST Year 6 submission has met the requirements of the external verification process. Details of the financial award are anticipated. • The CNST year 7 scheme was published on the 2 April 2025 and the relevant workstreams to deliver the scheme are currently being established. • Ongoing monitoring of defined action plans included in the maternity incentive programme and detailed updates are provided within this report. • This report fulfils the quarterly requirements of the perinatal quality surveillance monitoring and includes the national minimum data set reporting requirements.

Proposed Resolution	The Board of Directors are asked to **receive** the contents of the report and **approve** the action plans detailed within this report. The Board of Directors are also asked to **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
PQSM	Perinatal Quality Surveillance Model
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 year 7 (CNST) Maternity Incentive Scheme (MIS).

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

Assurance can be provided that confirmation was received on the 31 March 2025 from NHS Resolution that the formal Trust CNST Year 6 submission met the requirements of the external verification process. Details of the financial award are now anticipated.

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?

a) **Notify all death:** 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 01 December 2024 onwards.

c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 01 December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. **For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.**

d) **Report to the Trust Executive**: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 01 December 2024.

All cases within the monitoring period have been reviewed to the required standard as detailed in Appendix 1 and this has been cross checked with the national reporting database. The thematic learning and ongoing actions from all cases completed to date is detailed within Appendix 1a.

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

The July 2025 data submission to the maternity services dataset (MSDS) will be used for the assessment in the year 7 scheme and requires data field relating to the birth weight and ethnic category of the mother to be submitted as the assessment criteria. The delay in the implementation of the maternity electronic patient record within the Trust should not impact upon delivery of this standard.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

The service has a detailed action plan in place to progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice (Appendix 2)**.** The action plan will continue to be shared periodically during the year 7 scheme to evidence ongoing progression of the actions as per scheme requirements.

The service can evidence ongoing training of staff in preparation for the delivery of care to neonates from 34 weeks gestation has commenced. Following receipt of the hot cots funded by the hospital charity training has also commenced in their safe use prior to implementation in May 2025.

Modelling of staffing for the future model is currently being scoped and will be included in the upcoming Birth Rate Plus reassessment due in autumn 2025. Full implementation of the revised transitional care service will not be realised until the opening of the first floor renovation with increased cot capacity.

Work remains ongoing on the quality improvement project to reduce term admissions to the neonatal unit and improve thermoregulation of the babies following delivery. Preparations for the implementation of the national Newborn Early Warning Track and Trigger chart (NEWTT2) remain ongoing and the guideline is currently awaiting ratification at Trust level. A further update will be presented to safety champions in May 2025.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a**) Obstetric medical workforce**

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 (table 1). Trusts are required to ensure they are compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations.

The Q3 2024/2025 RCOG attendance audit report has been published and 1 reported breach relating to the birth of a preterm infant out of hours was noted. The breach was appropriate as the consultant was unable to attend immediately as the incident occurred out of hours and needed to travel to the maternity unit. The breach was discussed at the maternity and gynaecology audit meeting held on the 15 January 2025 as per required standard. Compliance in Q3 overall was 96% which met the required standard.

c) Neonatal medical workforce

The reallocation of the PAs following the recent appointment of an additional SAS doctor remains ongoing to release Consultant cover for the Tier 3 rota and the business case is underway in response.

d) Neonatal nursing workforce

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. There are currently 5 staff members in training and a further 4 due to commence training in September 2025.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Assurance can be provided the bi-annual maternity staffing paper that fulfils the requirements of the scheme is due to be presented to the Board of Directors in May 2025.

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 board safety champions and perinatal leadership team last met on the 15 April 2025 and discussed the cultural action plan (Appendix 5). A bespoke survey has recently been completed to seek the wider views of medical staff with regard to improving the culture

and working practices within the maternity service. Feedback sessions have been planned to address improving communication between the wider multidisciplinary team in response to the findings.

As part of the work of the safety champions walkabouts are held bi-monthly. Information gathered continues to be collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 4).

The Board Safety Champion continues to work with the safety champions and utilise safety intelligence to improve safety within the service. The current area of shared focus relates to completion of the maternity early warning score within the maternity triage department in response to the recent maternal death incident. Daily audits of compliance commenced on the 12 March 2025 and were undertaken until 01 April 2025 provided significant assurance of completion of the score charts. The subsequent audit of all 272 cases between the period 01 April 2025 until 13 April 2025 provided further assurance of completion of the charts.

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 (PQSM) 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 1. 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 4.

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. In line with the PQSM, this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback (Appendix 4) and review of the culture survey or equivalent.

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 is identified and escalated. The last bimonthly meeting was held on the 15 April 2025.

A case of maternal death occurred in February 2025 and the cause of death was confirmed as pulmonary embolism and deep vein thrombosis in the third trimester of

pregnancy. The baby was born via peri-mortem caesarean section and care was later withdrawn. The case has been referred to MNSI for an external review and support is being provided to both family and staff members involved. Presentation of the maternal death case by the Director of Midwifery to promote shared system level collaborative learning and oversight is scheduled to take place at the LMNS Safety Assurance panel on the 07 May 2025.

There were five stillbirths in January 2025. Two cases related to an extreme premature twin pregnancy at 24 weeks gestation, one case related to fetal abnormality. The remaining cases are currently subject to review using the perinatal mortality review tool.

Table 1 – 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	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		451	441	374	434	412	383
Maternal deaths direct	0	1	0	0	0	0	0	1
Still Births			1	2	0	3	5	0
Still Birth rate per thousand	3.5	≥4.3	2.2	4.5	0.0	6.9	12.0	0
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	0	0	0	0
HIE (2&3) rate (12 month rolling)	<2	2.5	1.4	1.2	1.2	1.2	1.2	1.2
Early Neonatal Deaths (Bolton Births only)	Information only		0	0	3	0	3	1
END rate in month	Information only		0.0	0	8.0	0	7.3	2.6
Late Neonatal deaths	Information only		0	0	0	1	0	0
PSII Incidents (New only)	0	2	0	0	0	0	0	0
MNSI referrals (Steis reportable)			0	0	0	0	0	1
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	1	0	0	0	1
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	99.7 %	99.1 %	98.5 %	97.8 %	97.3 %	97.8 %
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 indirect (neonatal unit)	>99%	<79%	100. 0%	99.0 0%	100. 0%	95%	95%	90%
Fetal monitoring training compliance (overall)	<90%	>80%	83.6 2%	83.9 0%	94.2 3%	92%	91%	
PROMPT training compliance (overall)	<90%	>80%	85.10 %	82.37 %	99.63 %	99%	96%	

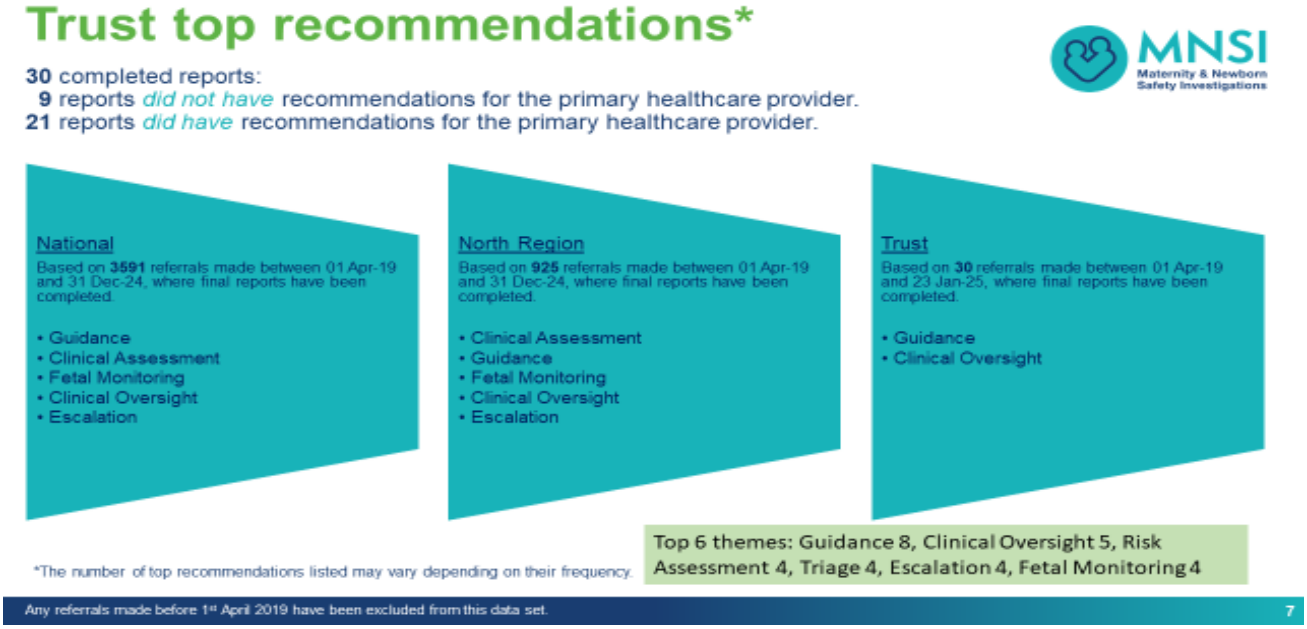
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only	1:22.8	1:21.9	1:21.3	1:21.1	1:21.1	1:20.5
RCOG benchmarking compliance	Information only	100 %	100 %	100 %	82%		
Compensatory rest breaches		0	0	0	0		
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual						
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual						

Thematic Learning

Themes from cases submitted to the Maternity and Newborn Safety Investigation team were considered at the last quarterly meeting held in January 2025 (Table 2). Based on thirty referrals made to MNSI that resulted in a final report between the period from 01 April 2019 and 23 January 2025 clinical oversight and guidance were identified as the main themes to be addressed by the service. The themes identified were reflected in the national and regional perspective.

Interestingly, a theme identified in the recent review of the Q3 Trust scorecard triangulation analysis (Appendix 3) related to clinical assessment. In response the service has been undertaking education sessions on escalation within practice, focussing on improving culture within teams and has implemented the RCOG Advice, Inform and Do (AID) mnemonic in practice to formalise the process of escalation when required.

Table 2 – MNSI quarterly review – January 2025 – Trust recommendations.



5. Summary

This report confirms that confirmation has been received from NHS Resolution that the CNST Year 6 submission has met the requirements of the external verification process. Details of the financial award are anticipated.

This report provides assurance of the ongoing monitoring of the relevant CNST action plans within the year 7 scheme and of defined key performance safety metrics relating to the perinatal quality surveillance model.

6. Recommendations

It is recommended that the Board of Directors:

I. Receive the contents of the report.
II. Approve the action plans detailed within this report.
III. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Perinatal mortality review tool cases as from 1 December 2024

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Notify within 7 working days	Gestation	DOB/ Death	PMRT Started 2 Months Deadline Date	Date parents informed/concerns questions	External Member present at review panel	Report published within 6 months
96354	SB	1	24+4	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96351	NND	1	29+1	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96412	SB	1	33+1	09.12.2024	09.02.2025	10.12.2024		09.06.2025
96482	LFL	3	22-23	13.12.2024	13.02.2025	16.01.2025		13.06.2025
96621	LFL	1	22+3	26.12.2024	26.02.2025	26.12.2024		26.06.2025
96707	SB	1	38+5	31.12.2024	31.02.2025	31.12.2024		31.06.2025
96723	SB	0	24+3	03.01.2025	03.03.2025	03.01.2025		03.07.2025
96783	SB	1	37+1	06.01.2025	06.03.2025	07.01.2025		06.07.2025
96865	SB	0	31+4	11.01.2025	11.03.2025	13.01.2025		11.07.2025
96927	NND	1	27+	15.01.2025 AN care at Preston	15.03.2025	16.01.2025		15.07.2025
97050	SB	0	35+4	24.01.2025	24.05.2025	24.01.2025		24.07.2025
97091	ENND	0	22+6	25.01.2025	25.05.2025	25.01.2025		25.07.2025
97179	ENND	1	22+2	31.01.2025	31.05.2025	31.01.2025		31.07.2025
97164	ENND	0	32+3	02.02.2025	02.06.2025	02.02.2025		02.08.2025
97729	SB	1	24+3	12.03.2025	12.05.2025	13.03.2025		12.09.2025
97757	SB	1	38+5	13.03.2025	13.05.2025	13.03.2025		13.09.2025
97832	NND	1	28	18.03.2025	18.05.2025	19.03.2025		18.09.2025

97882	NND	0	23	23.03.2025	23.05.2025	27.03.2025		23.09.2025
98014	NND	1	23	01.04.2025	01.06.2025	02.04.2025		01.10.2025
98019	NND	0	36+2	02.04.2025	02.06.2025	02.04.2025		02.10.2025
98062	SB	1	40+4	04.04.2025	04.06.2025	04.04.2025		04.10.2025
98164	SB	1	34+0	14.04.2025	15.06.2025	14.4.25		15.10.2025
98259	LFL	1	22+1	18.4.25	18.6.2025			18.10.25

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
17	1	14	2	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
10	0	9	1	0

Appendix 1a – Ongoing themes actions highlighted in completed reviews relevant to the deaths reviewed

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	Antenatal booking appointment to be completed within recommended timeframe	Trudy Delves	01/10/2024	08.10.24 Ongoing Improvement Plan for Maternity Bookings in place. Self-referral booking process progressing with digital support. Monitoring of compliance undertaken monthly via IPM pack of 10+0 and 12+6 pathways.	**3**
2.	Inclusion in the ASAP national programme to promote early booking	Trudy Delves	01/10/2024	17.12.24 Link made with lead from national ASAP programme and initial draft communications shared.	**4**
3.	CO monitoring to be undertaken at each appointment	Trudy Delves	01/10/2024	08.10.24 CO monitors in clinics and all areas. Maternity Tobacco Dependency Midwife allocated training time	**4**

				on new SBLV3 training day agenda. 22.11.24 Ongoing audit of compliance continued in accordance with CNST guidance	
4.	Domestic Abuse question to be asked at booking appointment	Trudy Delves / Jayne Maguire	01/12/2024	08.10.24 Undertake audit of compliance and identify actions to be undertaken in response. 20.02.24 Audit awaited	**2**
5.	Triage BSOT assessment to be undertaken with evidence of audit	Emma Jones	01/10/2024	08.10.24 BSOTS action plan and review of triage in progress. 30.08.24 BSOTs audit ongoing as per clinical audit schedule to monitor delays in assessment and actions as appropriate.	**4**
6.	Sepsis 6 pathway to be followed	Lizzy Dean/Emma Jones	01/3/2025	08.10.24 National MEOWS in process of being implemented as a formal project. 1.11.24 E-learning implementation offered to all staff and added to ESR learning package 20.02.24 National MEWS launch planned for the 28.2.25	**3**
7. 5	Targeted offer for multigravida families in highest risk areas	Trudy Delves	01/03/2025	18.12.24 REACH pregnancy circle training commenced.	**3**

	to be considered using REACH pregnancy circles service.			20.02.24 REACH circles to areas of high deprivation to be piloted. 24.04.25 First circle due to commence in May 2025	
8.	No bereavement care since death of baby			03.01.25 Review of funding for counselling offer for bereaved families completed. Funding secured for an external service to provide this offer.	**4**
9.	Book ANDU appointment at point of discharge			All Ward Clerk staff on CDS advised and trained to offer appts at the point of discharge from Triage rather than advise woman to call to make subsequent apt.	**4**
10.	Glucose Tolerance testing clinic to be delivered in accordance with national standards	Debra Smith	31.05.25	GTT clinic to be reinstated using oral glucose testing as per national standard.	

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

Appendix 2 – Transitional care – 34+4 action plan with updates.

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Transitional Care Lead	1.1 Appoint a Transitional Care Lead	Complex Care Matron	January 2024	**03.10.2023** Transitional care lead appointed – awaiting start date. **29.01.2024** TC lead commenced post.	
2	Workforce Funding	2.1 Seek additional funding for staffing to ensure 24/7 cover, with BAPM guidance of TC staffing ratio being at least 1:4	Director of Midwifery / Operational Business Manager	July 2025	**03.10.2023** Business case to be submitted to seek additional funding to expand the care provision to 24/7 for preterm infants. **21.06.2024** Business case to uplift to BR+ standards awaiting approval for	

					midwifery staffing. **03.10.2024** Birth rate plus staffing model approved for midwifery staffing uplift. **08.10.2024** Meeting arranged with HOM to discuss TC staffing model, staffing model will include x6, Band 6 neonatal nurses/midwives, to cover a 24/7 service in line with BAPM guidance of infant to TC nurse being a ratio of 1:4. The Model of care will provide TC service provision to any infant who meets the criteria for TC within any area of intrapartum care. **04.04.2025** Meeting with ADMD and Matron for complex care to discuss staffing model. Advised to prepare a TC staff job description and person specification. **21.04.2025** TC staff job description and person specification	

					shared with Matron for complex care and NNU ANNP for feedback.	
3	Provision of service	3.1 Confirm location of TC service to be provided	Director of Midwifery / Lead NNU Consultant	March 2025	**06.11.2024** HOM confirmed TC infants will receive service within the new remodel of intrapartum services, with 4 beds being allocated for the most vulnerable of TC infants and all other TC infants will be allocated alternative beds within intrapartum services. NNU Lead consultant discussed with HOM SCBU cots availability, for TC service provisions. **27.01.2025** Divisional Director of Operations shared an update of the redevelopment plans, TC cots allocated within the 1st floor plans and opposite the neonatal resus room.	

		3.2 Audit available equipment for TC service	TC Lead	August 2025	**24.04.2025** TC Lead will audit all equipment when completing the quarterly Aquatherm SOP audit.	
4	Training	4.1 Ensure maternity staff are appropriately trained to provide safe and effective care to neonates from 34-weeks gestation	TC Lead	July 2025	**03.10.2023** Training plan to be developed to include a training passport. **08.10.2024** Confirmed with complex care matron all maternity staff have completed the NHS England ATAIN e-learning module as a one-off training. **03.12.2024** Complex care matron met with NNU ANNP to discuss training package required. **15.01.2025** TC Lead met with NNU ANNP and training package for staff has been started, to share with NNU TC consultant and start training April 2025.	

					24.04.2025 Awaiting confirmation from NNU consultant, that the training materials cover sufficient content. Meeting arranged with NNU ANNP 24.04.2025 to discuss if training can commence.	
		4.2 Design a TC pathway for infants who require naso-gastric feeds and all maternity staff to complete a training package	NNU Consultant, NNU ANNP, TC Lead	July 2025	**10.06.2024** Staff competencies for NG feeding designed. **03.10.2024** Guideline completed, however awaiting plans for model of care to be confirmed prior to dissemination and approval with consultant team. **08.10.2024** Met with NNU Consultant who is supporting TC service development to discuss infant criteria. TC Lead to design a guideline. ANNP supporting TC development to design training	

					package for maternity staff. **03.12.2024** TC Lead completed NGT guideline and to be shared with NNU ANNP and confirmation of which infants will be identified to meet the criteria for TC NGT pathway. **15.01.2025** TC Lead met with NNU ANNP, criteria for guideline agreed, guideline final to be shared with NNU TC consultant. **24.04.2025** Awaiting date to discuss final draft with NNU Consultant, then a robust training plan will be created, to safely train the maternity staff.	
		4.3 Introduce the Aquatherm heated mattresses to be used within intrapartum areas to support thermoregulation	TC Lead	June 2025	**24.10.2024** Delivery to the trust of 8 Aquatherm heated mattresses. **07.11.2024** Aquatherm SOP	

		and all maternity staff to sign an equipment competency after training			sent to NNU Consultant and NNU ANNP for comments. **28.11.2024** Aquatherm SOP sent to Matron for complex care and intrapartum care ward managers for comments. **23.01.2025** TC Lead presented SOP at Maternity PDOC meeting. **10.02.2025** TC Lead sent updated SOP to be added to the Maternity Speciality Governance meeting 26.02.2025 for ratification. **24.04.2025** SOP now added to BOB, staff training to safely use the equipment is ongoing and launch planned for May 2025.	
5	Clinical Governance	5.1 Ensure accessible and evidence-based guidance to underpin clinical practice and a robust audit cycle	TC Lead	Quarterly	**02.05.2024** Q4 2024 TC SOP audit designed and completed. **19.08.2024** Q1 2024 TC SOP sent to HOM, with	

					100% compliance reported. **07.11.2024** Q2 2024 TC SOP sent to HOM, with 100% compliance reported. **10.02.2025** Q3 2024 TC SOP sent to HOM, with 100% compliance reported.	
		5.2 Audit NNU local service activity of 34-weeks gestation infants in Q1 and Q2 2024 admitted to NNU, to benchmark the care requirements for this group of infants.	TC Lead	May 2025	**02.12.2024** Audit data collected with an audit population of babies born between 34+0 weeks and 34+6 weeks that was admitted to NNU and recorded on BadgerNet. **12.12.2024** Audit data analysed and to be formatted into a report to share with HOM, Complex care Matron and NNU consultants. **24.04.2025** TC Lead to meet with NNU ANNP to discuss data, in relation to staff teaching for 34 weeks gestation TC pathway.	

6	Service user experience	6.1 Link with Maternity & Neonatal Voice's Partnership (MNVP) for any service user feedback for 34-weeks gestation experiences, to refine the care model that can be provided within TC	TC Lead	May 2025	**29.11.2024** TC Lead contacted Bolton MNVP to request feedback of families experience with babies born at 34 weeks' gestation. **19.12.2024** Bolton MNVP provided feedback of three families that agreed to be contacted for an informal survey. **01.04.2025** TC Lead reached out to families for feedback and will be presented with audit report for creating the TC pathway.	
		6.2 Review resources available on BAPM, ODN network and design a parental leaflet for TC service	TC Lead, Matron for complex care	August 2025	**10.01.2025** Discussed with matron for complex care, the idea of adding TC service information to PADLET **21.01.2025** Requested sharing of other trust resources used for TC leaflet, at TC LMNS meeting. **24.04.2025** LMNS confirmed there are no generalised	

					TC leaflets being used, TC Lead will gather feedback form service users and design a trust TC leaflet.	

Appendix 3 – Trust scorecard Q3 2024/2025

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q3 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 Stillbirth 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 Resp To Abnrm FHR 5 Inappropriate treatment	Causes 1 Fail To Make Resp To Abnrm FHR 2 Fail To Interpret Uss 3 Fail Antenatal Screening 4 Fail / Delay Treatment 5 Failure/Delay Diagnosis

Themes from complaints Q3

Complaints have been divided into informal and formal complaints and themes have been outlined below.

- Decisions about clinical treatment
- Ineffective communication
- Delays in appointments

Incident themes: Cause Group 1

525 incidents were reported within the maternity speciality throughout Q3 2024,25, and of those, none had a final impact of a category 3, 4 or 5 level harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Incident Cause group 1	Number of Incidents
NNU - Unexpected Admission	111
Clinical Assessment	49
Documentation - Missing/Inadequate/Illegible/found	20
Documentation - Wrong	10
Communication Failure	33

Triangulation of learning Q3

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 3 2024 – 2025.

Delay in clinical assessment.
Recognition of deteriorating patients.

Ref	Key actions	Lead Officer	Deadline	Progress Update	Status
Reduce unexpected admissions to Neonatal Unit for hypothermia and delayed feeding by 20%.	To focus on the term infant transitioning in the "Golden hour" after birth.	Sara Luke	September 2025	04.11.2024 QI project commenced.	
Increase staff ability to recognise deterioration of unwell women	Introduce National MEWS Tool.	Vicky Hamilton	March 2025	18.10.2024 Project commenced. Joint working with ED department to improve care for women attending there. Added to ESR for mandatory training.	

Appendix 4 – 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. Options appraisal submitted for consideration.
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 Staffing consultation process due to commence early in 2025.

November 2024 Trolley needed with rails to support the safe transfer of patients to CDS when required	Trolley provided
January 2025 Antenatal QR code used to collect patient feedback needs updating. Posters to be relocated in cubicle areas with ANDU	Communication team contacted to refresh QR survey offer Posters to be relocated by ward lead.
April 2025 Focus on walk around was on improvements to staff culture	Informal feedback received on day of visit that noted an improvement in culture over past two years Staff survey feedback received in Division and shared in engagement sessions Speciality action plan being developed in response
Changes required to new estates work signage and wayfinding	Changes needed to the physical barriers that had been implemented near the raod crossing at the entrance to the maternity unit as persons were stepping over the barrier – barrier replaced and action resolved Signage posters erected on hoarding to improve wayfinding for persons entering the maternity building.

Appendix 5 - 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 and review skill mix.	• **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 staff commented on the physical estate and the lack of space for rest breaks.	• **Support timely meal breaks in clinical areas.**

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**
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.**
Other	**Change in Neonatal guidelines.** The majority of nurses spoken to were concerned with the change in guidelines and line to increased burnout climate.	

Report Title:	Bi-Annual Nurse Staffing Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	

Purpose of the report	The report provides assurance to the Board of Directors that the current nurse staffing processes and monitoring arrangements are meeting the requirements as set by the NQB and NHSE for safe and sustainable staffing.

Previously considered by:	People Committee

Executive Summary	The 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 acuity audits undertaken in July 2023, February 2024 and September 2024, as prior audits were excluded due to concerns about interrater reliability. The report follows guidance set by the National Quality Board (NQB) to meet the three expectations: right staff, right skills, and right place and time, alongside professional judgement. The report details nationally defined KPIs that determine the presence or absence of safe and effective nurse staffing levels. It shows favourable outcomes in falls prevalence compared to national benchmarks. The National In-patient Survey indicates improved feedback scores, and the Friends and Family Test maintains high recommendation rates. The Trust Heat map has been revised to consolidate the KPIs that partially relate to the presence/absence of safe and effective staffing levels.

Proposed Resolution	The Board of Directors are asked to **approve** the Bi-Annual Nurse Staffing 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**	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 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 Indicator
NHSI	NHS Improvement
NMAHP	Nursing, Midwifery and AHP
NQB	National Quality Board
POST	Patient Observation Scoring Tool
RN	Registered Nurse
SNCT	Safer Nursing Care Tool
SOP	Standard Operating Procedure
WTE	Whole Time Equivalent

Questions raised via Trust People Committee (20.05.2025)

1. **Why is roster compliance so poor?**

Roster indicators have been a development for quite some time and we are focussed on measuring only that which the managers have complete control over such as annual leave, study leave, roster approval time. We also track hours owed to staff, and hours that staff owe us. Chief Nursing Officer (CNO) confirmed he was not fully assured yet that these have been set up correctly as it appears the key performance indicators are taken from one roster period. To explain this, consider a staff member doing a full 6 weeks of nights. This will mean they owe hours as night but these owed hours cannot be given back by staff until the next roster period, hence will always show as 'red'. Deputy Chief Nursing Officer (DCNO) working with workforce colleagues to remedy this.

2. **In view of national efficiency drive, is there any discussions on changes to establishment setting process?**

CNO confirmed that the current safe staffing process in place for nursing and midwifery was commenced following the Mid Staffordshire scandal and subsequent Francis inquiry. The absence of evidenced based staffing levels is well researched as contributing to poor and unsafe care. A recent national call with the CNO for England confirmed there would be no changes to this process, however organisations must assure themselves that data is responded to where there are opportunities for efficiencies to be made, in the same way as reported deficits must also be mitigated with staffing investment.

The report details over establishment of Registered Nurses - does this mean we can reduce by the number stated?

CNO confirmed that the evidenced based outcomes indicate exact staffing levels required based on patient acuity only. Professional judgement and clinical outcomes overlay this assessment as many factors impact as outlined in the staffing report. These include;

- Aged organisational estate which inhibits patient pathways through inadequate number of side rooms requiring staff to regularly undertake patient moves to convert bays from male to female and/or isolate patients out of bays into side room and support bay cleans
- Access to both responsive digital systems and systems which add value in terms of reduced time away from the patients (think the number of clicks it takes to access documents) / accessing multiple competing digital systems
- Skill mix (experience of staff)
- Economies of scale and scope; smaller ward layouts restrict economies of scale as minimum staff levels of 2 registered nurses/midwives sacrosanct
- Organisational systems / pathways / hand-offs - the absence / presence of seamless organisational systems impact on the degree of value-add time for staff at the bedside

Notwithstanding the above, the CNO confirmed that the current 3 census periods for nursing are now being reviewed with a view to amend some establishments. This is being led divisionally with respective ward/department managers owning the review. The CNO confirmed this work will include a wider discussion as any release of establishments must also be accompanied by acceptance that future census periods reporting a deficit in staffing also need to be responded to in the same responsive manner.

Executive Summary

This 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 10 of the 14 NQB (2018) recommendations and partially compliant with the remaining four. An improvement of four from last from the bi-annual report.

Right Staff
Bolton NHS FT continues to increase reliability in ensuring the right staff are in place to meet patient care needs. The Trust utilises the Safer Nursing Care Tool (SNCT) for bi-annual assessments of inpatient acuity and required staffing. The September 2024 census which followed the new national process of auditing over 30 days, showed an aggregate small over-establishment of registered nurses and a reduction in the aggregate under-establishment of healthcare assistants. Enhanced care processes have been improved with the introduction of a live dashboard and the Patient Observation Scoring Tool (POST). The majority of specialist nursing services are compliant with national guidelines where these apply, except in Rheumatology and Diabetes where there are shortfalls against the recommended staffing numbers.

Right Skills
The Trust remains committed to ensuring staff have the right skills through mandatory training, development, and education. Compliance with mandatory training remained above target for most of the reporting period, with a slight dip in December 2024 due to winter pressures. The introduction of Adult Level 3 Safeguarding training for clinical staff has been a significant addition impacting compliance for Compulsory training. A revised training needs analysis for Level 3 Safeguarding has now been implemented.

Right Place and Time
E-rostering and the production of rosters are closely monitored to ensure optimal staffing levels. The revised rostering KPI reports, launched in September 2024, have improved reporting accuracy and oversight of compliance. Daily staffing meetings and the use of SafeCare entries support professional judgment in staff deployment. The Trust has also implemented a new process for validating SNCT census entries, improving the robustness of data collection. The Trust's vacancy forecasting indicates a positive trend, with a projected surplus of registered nurses by the end of the 2025/2026 financial year.

Clinical Quality Outcome Measures
The Trust has revised its monthly heat map to consolidate clinical quality outcome measures and staffing data. Red flag reporting through SafeCare, was introduced in October 2024, and has improved monitoring of nursing-sensitive indicators. The number of falls per 1000 bed days and the incidence of pressure ulcers continue to be closely monitored, with actions taken to address any identified learning. Patient feedback through the Friends and Family Test (FFT) and the National Adult Inpatient Survey have shown positive trends, indicating high levels of patient satisfaction with nursing care.

Summary
The Bi-Annual Nursing Staffing Report for July to December 2024 demonstrates Bolton NHS Foundation Trust's commitment to maintaining safe and effective nurse staffing levels. The Trust has successfully implemented various systems to improve staffing processes, compliance and patient care outcomes.

The data provided and subsequent analysis of nurse-sensitive quality outcomes substantiates the recommendation that Bolton NHS Foundation Trust successfully maintained appropriate safe staffing levels during the period of July to December 2024. By triangulating workforce information with safety, patient experience and clinical effectiveness metrics, the report provides assurance that nurse-staffing establishment are continually reviewed to 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; sign off of the safe staffing policy, complete the roll out of the new enhanced care assessment tool by end of June 2025, and the expansion of SNCT into Gynaecology. These will actively address the current gaps against the NHS Improvement (NHSI) (2018) recommendations, support ongoing improvements and ensure that staffing establishments and nurse skill mix remain fit for the future.

Recommendations:
1. Approve the Bi-Annual Nurse 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 July 2024 - December 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).

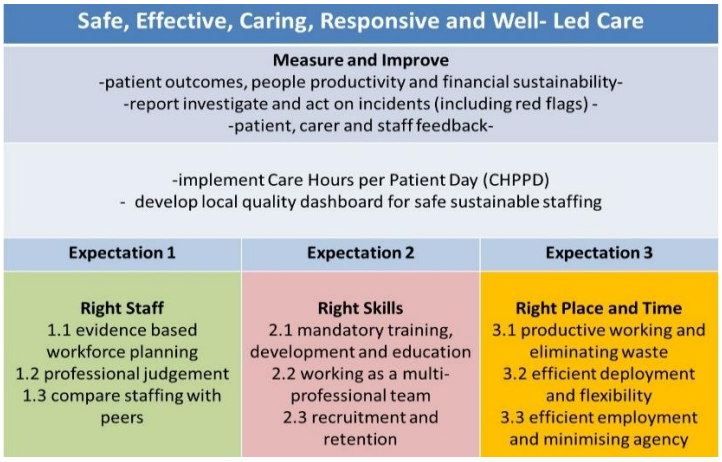
The purpose of this report is to provide assurance to the Board of Directors that current process and monitoring arrangements are successfully fulfilling these requirements.

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]



[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 a consistent process to deploying safe staffing.

The gap analysis against these recommendations was updated in January 2025 using the new NHS England template standards (see appendix 1). The organisation has increased compliance from 6 to 10 of the 14 recommends meeting the target (to increase to 9) set in the last Bi-Annual Staffing report. Actions to meet the remaining 4 standards and to continue to monitor and develop existing processes are monitored through the Chief Nursing Officers' Nursing, Midwifery and Allied Health Professional and Health Care Scientist (NMAHP&HCS) priorities.

3. Updates on the Future Work-Plan from November 2024 Staffing Report

Following the review and relaunch of the Rostering KPI reports in September 2024, the reporting timescales have been aligned to the 4 weekly rostering periods, and a Rostering KPI Assurance meeting has been introduced (see 6.1 for further details).

Trial of a revised enhanced care process including a new risk assessment tool was undertaken in December 2024. The trial also highlighted challenges with enhanced care approaches beyond the assessment tool and a full review of the Trust's enhanced care process is now under way and expected to be fully rolled out by the end of June 2025.

Training for the new Safer Nursing Care Tool (SNCT) to increase the pool of validators was completed ahead of the February 2025 census period. Daily SafeCare entries has been reduced to twice daily, however an error within the system has prevented amendments within SafeCare at present (this has been escalated to optima for resolution). A review of the categories used for daily inputting within SafeCare (used to collect the data for the SNCT census) is underway, and once complete a full roll out of a revised training programme for all staff inputting will be undertaken by September 2025

A safe staffing policy has been drafted and going through the approval process.

This report now includes red flag reporting following roll out of this reporting process through SafeCare in October 2024, see section 4.6.1.

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.

4.1. Evidence Based Workforce Planning

The Trust utilises the evidence based Safer Nursing Care Tool (SNCT) in order to undertake the bi-annual assessment of inpatient acuity and required staffing. Up-to-date licenses are held for the adult inpatient wards and assessment units, paediatric wards, emergency departments (ED), and the Community Nursing Safe Staffing Tool (CNSST). The CNSST was relaunched in February 2025, planning for the roll out of this is currently underway.

The adult inpatient ward and assessment unit SNCT was updated in October 2023 and disseminated to trusts in 2024. The Trust's recent collections in September 2024 and February 2025 have utilised the new tool. Key changes with the tool include the census period now being extended to 30 days including weekends, a updated decision matrix including additional patient categories, 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. The September 2024 SNCT results are included within this report (see section 4.2) and full analysis of the February 2025 census is under way, and will be reported in the next paper. The February 2025 census also included the community bed base for the first time. Scoping is underway plan the implementation of the SNCT within the Gynaecology Assessment Unit and Early Pregnancy Unit.

During the September 2024 census, an amended approach to validating the inpatient areas was adopted. A cohort of senior leaders, who have undertaken the required training with 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 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.

A paediatric inpatient census was also undertaken in September 2024, and although compliance improved it was too low for the results to be deemed valid. A further census was undertaken in February 2025 with increased compliance and the results are now being analysed. The paediatric inpatient teams have significantly improved their compliance with SafeCare submissions and this is now used as part of their daily staffing reviews (see appendix 5). Work is also underway to look at how the full scope of the unit is represented in SafeCare to ensure this accurately reflects their daily staffing requirements.

The first ED census was completed between 1st-12th October 2024 and a second from the 1st-12th February 2025. Analysis of both census results are underway and will be reported in the next bi-annual report. 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 with the overnight collections.

SafeCare continues to be utilised by Divisional Nurse Directors and their leadership teams to review staffing on a daily basis. The previously three times daily SafeCare entry has been stepped down to a twice daily, recognising the need to focus on improving the night entry compliance, as the late overlap s with the early which already has good levels of compliance. 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. The daily staffing meetings were revised and a new process commenced in February 2025. The morning meetings are now Assistant Divisional Nursing Director led and the afternoon meeting is led by the late matron. Actions are recorded and the process supports oversight of shifts being escalated for temporary staffing due to unforeseen staffing shortages. The process also serves as a preliminary assessment to the recently revised Staffing Escalation in Extremis Protocol, which outlines a structured response when clinical safety concerns due to staffing shortages persist, despite mitigations through the daily staffing meeting.

Neonatal activity continues to be reassessed annually using the Activity Capacity and Demand (ACD)

and staffing compliance against British Association of Perinatal Medicine (BAPM) requirements is reported quarterly. The service has achieved an average of 98% compliance with the BAPM requirements during the period of July to December 2024 (an increase from 93% for the previous period), with all 6 months above 95% (see appendix 6).

4.2. SNCT Inpatient Data Summary

Figure 2 summarises the daily averages from the July 2023, February 2024 and September 2024 SNCT census collections for inpatient ward and assessment areas. Patient numbers (Total patient in Figure 2) were lower in September 2024 compared to February 2024 due to September being pre-winter pressures. As anticipated the number of Level 1b patient's increased in September 2025 due to the new tool recording cohorted enhanced care patients under level 1b (rather than recording them as a Level 0 and their enhanced care needs calculate separately).

Figure 2: Summary of the SNCT Daily Averages Comparing the July 2023, February 2024 and September 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	Sep-24
No. Wards	21	22	24
Level 0	316.7	347.87	260.19
Level 1a	19.1	34.63	48.31
Level 1b	130.9	123.37	189.12
Level 2	13.8	16.37	8.36
Level 3	1.5	0.67	0.17
Total Patients	482	522.9	506.15
Patients Per Ward	20.96	20.92	20.24
Enhanced Care L3 Hrs	224.22	215.31	223.07
Enhanced Care L4 Hrs	103.03	107.58	74.58
Enhanced Care L3 Pt No.	N/A	58.57	52.67
Enhanced Care L4 Pt No.	N/A	23.32	14.31

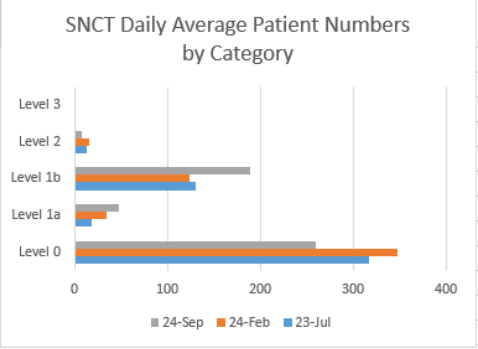


Table 1 summarises the overall Trust data from the July 2023, February 2024 and September 2024 censuses. The WTE output per ward area can be found in appendix 2 for registered nurses and appendix 3 for non-registered nursing workforce.

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))

Total Registered Nursing and Non-Registered Nursing Staff - Comparing Establishments - Funded, SNCT									
Division	Jul-23			Feb-24			Sep-24		
	Est.	Rec (Adj)	+ / -	Est.	Rec (Adj)	+ / -	Est.	Rec (Adj)	+ / -
Registered Nurses	366.06	309.48	56.58	397.29	340.20	57.09	454.65	377.52	77.13
Non- Registered Nursing Staff	366.59	342.49	24.10	400.72	476.88	-76.16	417.52	432.96	-15.44

The SNCT census in September 2024 continued to show an over establishment of registered nurses. The under establishment for health care assistants has reduced in September 2024 due to increased establishment (due to an increased number of wards) and reduced demand correlating to the time of year.

The NQB (2018) advises using at least two, ideally three data sets for establishment reviews to ensure data validity, so a full establishment review process is currently underway due to conclude by September 2025 and the full outcome will be reported in the next staffing paper.
Professional judgement as part of this process will adapt the SNCT results to the specifics of the Trust. The SNCT process also doesn't account for variations such as;

- side rooms numbers/positions
- ward layouts / bed numbers which can reduce economies of scale and therefore limit some opportunities initially reported in the SNCT outcomes
- staff turnover
- non-value-added time due to digital constraints
- skill mix (e.g. difference between the role of a band 2 and band 3 HCA).

4.3. Enhanced Care Summary

Inpatients requiring enhanced care (EC) through direct 1:1 or cohorting/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 average number of EC level 3 patient days between July and December 2024 decreased to 69.0 from 82.2 for the previous reporting period of January to June 2024 and the average number of EC level 4 patient days decreased to 10.6 from 14.3 (see appendix 4). A review of the Avoiding Levels of Harm Assessment (ALOHA) risk assessment tool was undertaken in November 2024, and a pilot of a new tool, the Patient Observation Scoring Tool (POST), commenced in December 2024. Roll out of the POST across the organisation and set up in EPR is under way, with an expected roll out date by end of June 2025.

4.4. Specialist Nursing Services

The Specialist Nursing Services are staffed through historical establishment structures, maintained through skill mix reviews as vacancies occur, and alignment with national guidelines where applicable. However, there is currently no evidence based workforce planning tool that is validated for use in these

areas. Challenges in meeting these establishments include high vacancy rates, difficulty in sourcing skilled bank and agency staff, and the impact of unavailability due to sickness or leave. A full breakdown by division can be found in appendices 8, 9, and 10.

National guidance varies by specialty, with some services having specific recommendations, while others lack formal guidelines (see appendix 8, 9, and 10 for a full breakdown). The Trust is generally compliant with national guidance where applicable, except in Rheumatology and Diabetes where there is a short fall of 1.2 WTE and 1.4 WTE specialist nurses respectively.

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.

5.1. 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 was revised in October 2024 to consolidate these clinical quality outcome measures and staffing data into one dashboard that is narrated by the divisional leadership teams each month, and this has Trust Board oversight. A copy of the revised heat map including the Trust wide summary data for October to December 2024 can be found in Appendix 13.

5.1.1. Red Flag Reporting for Inpatient Areas

In accordance with NICE (2018) guidance for Safe Staffing, clinical establishment reviews should consider the impact of reduced staffing via recording and monitoring of Nursing Sensitive Indicators, known as red flags. Red flag events are classified as:

- An unplanned omission in providing medications
- A delay of more than 30 minutes 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.

Previously red flags were only identifiable where their occurrence had triggered submission of an incident report in the Ulysses Safeguard System, which meant lower level concerns were not formally recorded. From October 2024 Red Flag reporting went live in the SafeCare system for adult inpatient wards and reported monthly via the Trust Heat Map.

Table 2: Trust Summary of Total Number of Red Flags Reported for each Category by month

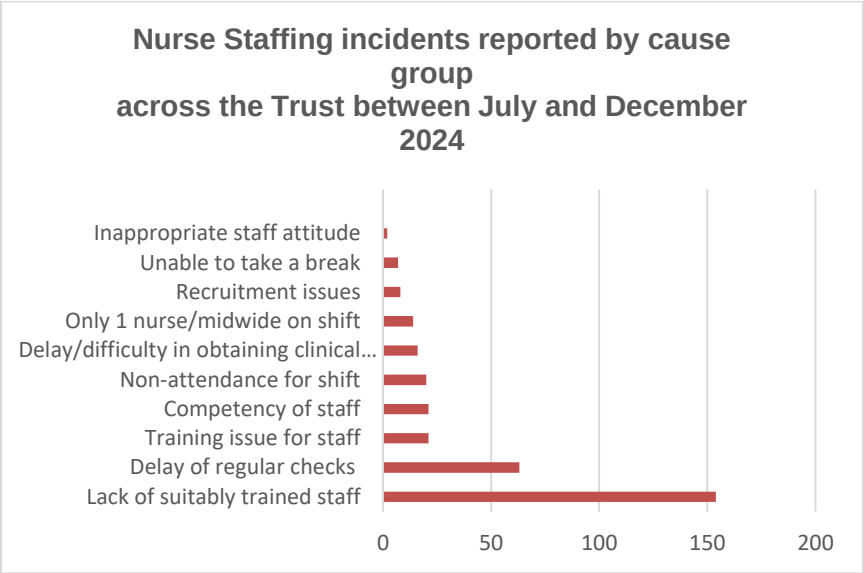
Indicator	Oct-24	Nov-24	Dec-24
Omission in providing medications	0	0	0
Delay in providing medications	1	0	0
Vital signs not assessed/recorded	1	0	0
Missed care provision	13	1	1
Less than 2 RNs on shift	3	4	1
Shortfall in RN time	32	26	9
Delay in discharging	4	1	0
Total Red Flags	58	32	11

Initial challenges following implementation have included misinterpretation of the categories (primarily including HCA time in the shortfall), inclusion of incidents that are directly the result of reduced staffing and difficulties assessing reporting. Further work is planned to continue to support upskilling staff in relation to red flag reporting to improve validity in reporting and to look at how the data can be used to support decision making in the daily staffing meetings.

5.1.2. **Incident Reporting**

In total there were 326 staffing incidents reported related to nursing Trust wide which is an increase compared with the 307 incidents reported between January and June 2024. However the data now includes all nurse staffing incidents where as previously it only contained inpatient nurse staffing incidents. 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 relate to staffing problems/ training issues July and December 2024 for Nursing across the Trust



The actual impact of the incidents reported was 246 no harm and 80 low harm. For all incidents, appropriate escalation and mitigating actions were undertaken including:

- 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.

Fourteen incidents were reported under the cause group of one registered nurse on duty. This is an increase by five in comparison to January to June 2024. Two of the incidents were found to be reported incorrectly, as the narrative indicated there was more than one registered nurse/midwife on duty.

Ten incidents were reported by Ward E5, Paediatric in-patient ward and Ward F5 Paediatric Assessment Unit. The incidents specifically related to Ward F5 Paediatric Assessment Unit, where there is no set ratio for staffing, but is aimed to be staffed by 2 RNs. The ward is directly linked to E5 with an integrated floor plan, so when staffing is reduced the risk is mitigated by flexing staff between E5 and F5. In each of the incidents reported, appropriate escalation to a senior urse is documented. There is currently no national evidence based staffing tool appropriate for F5 that supports nursing ratios based on acuity of care, and the number of children on the unit can fluctuate, so the staffing demand can vary significantly.

Two incidents were reported by the Elective Care Centre, both of which were escalated appropriately and staff were redeployed to support.

Sickness, vacancies and Trust pressures were cited as the cause of the incidents relating to one registered nurse or midwife.

5.1.3. **Falls**

The number of falls per 1000 bed days between July and December 2024 has averaged at 3.75. 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 6 falls with moderate

and above harm, and all were subject to review via the Patient Safety Incident response Framework (PSIRF) with themes and learning shared across the division/organisation. There were no identified themes relating to staffing resource during July to December 2024.

5.1.4. **Pressure Ulcers**

The SPC charts in figures 4, 5 and 6 break down the pressure ulcer numbers by category. They demonstrate special cause variation for both category 2 and 4 pressure ulcers, with no category 4 pressure ulcers, and a common cause variation for category 3 pressure ulcers.

Figure 4: Hospital Acquired Pressure Ulcers Category 2

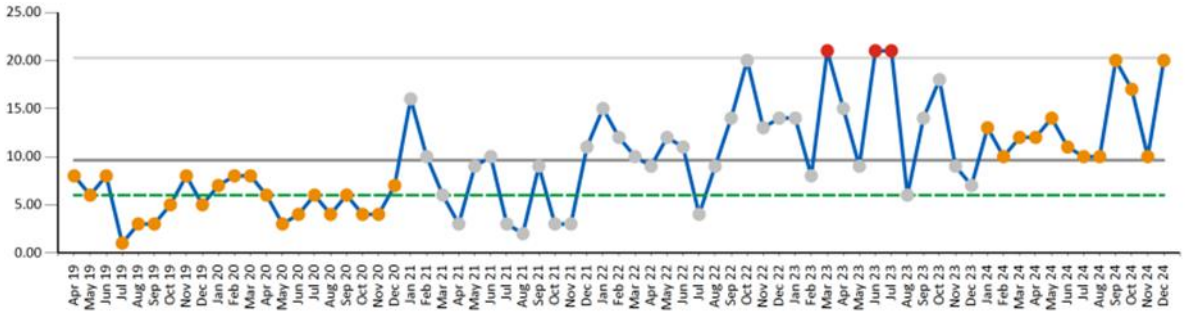


Figure 5: Hospital Acquired Pressure Ulcers Category 3

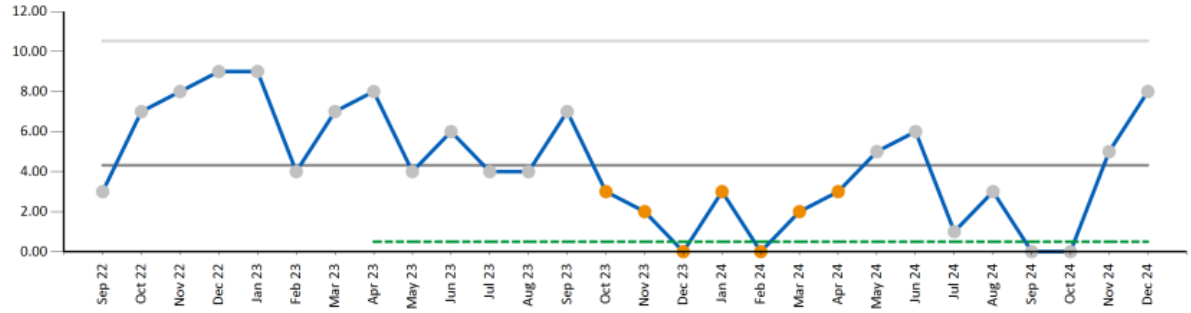
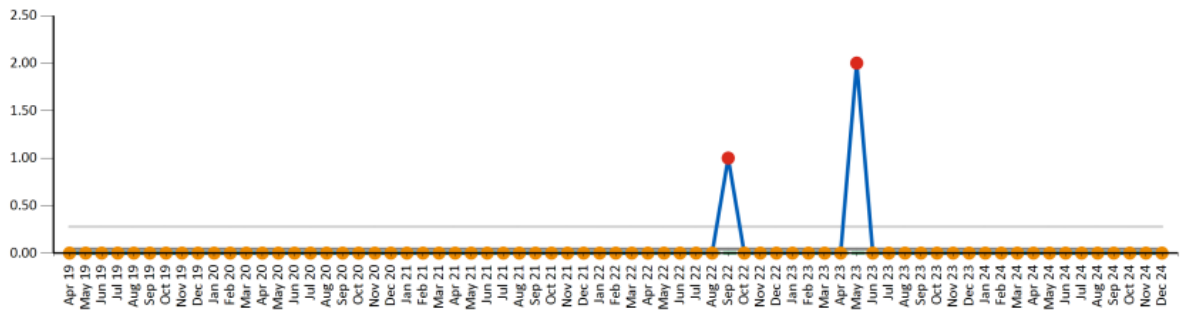


Figure 6: Hospital Acquired Pressure Ulcers Category 4



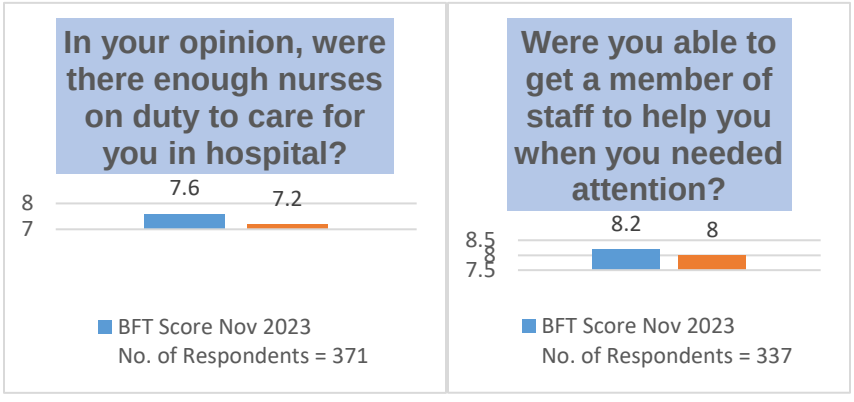
The themes are consistent with the previous reporting period including delays in pressure ulcer risk assessment, long stays in the ED, delays in planned repositioning regimes, and end of life patients receiving care. In addition, learning has been associated with the importance of nutrition, recognising 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 continue to be shared and monitored through the Pressure Ulcer Faculty. The Pressure Ulcer Change Package was launched in September 2024 (following the conclusion of the pressure ulcer collaborative), and work is currently ongoing to ensure all elements of this are embedded in practice.

5.1.5. **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, and 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.

Figure 7 below shows comparative results for Bolton between November 2022 and November 2023, no comparative data to other trusts has been provided for these questions. For both questions, the Trust saw an improvement in the average scores for the 2023 survey.

Figure 7: National Inpatient Survey Question Responses

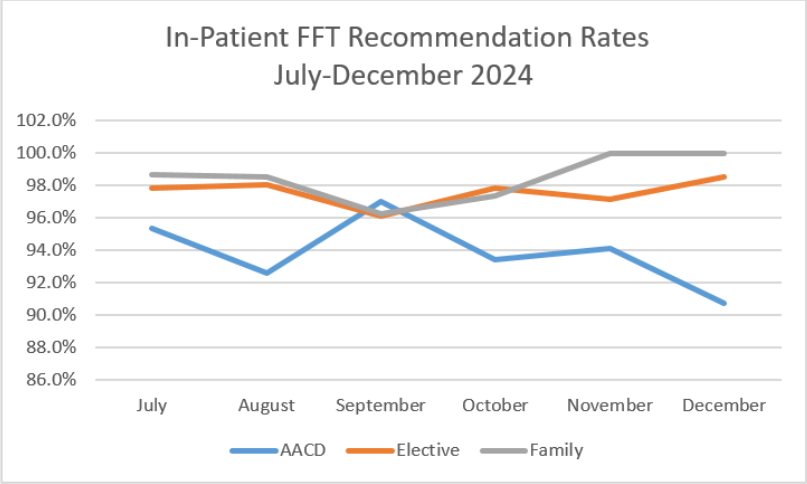


The November 2024 survey results are due to be published in August 2025 and will feature in the next bi-annual report.

5.1.6. **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 8: FFT Inpatient Recommendation Rates and Themes for July to December 2024



Top 5 Positive themes	Top 5 Negative themes
Friendly Staff	Very busy
High standard of care	Short staffed
Listened to needs	Moved wards numerous times
Cleans wards	Waiting too long for pain relief
Professional	Delayed discharge

5.1.7. **Concerns and Complaints**

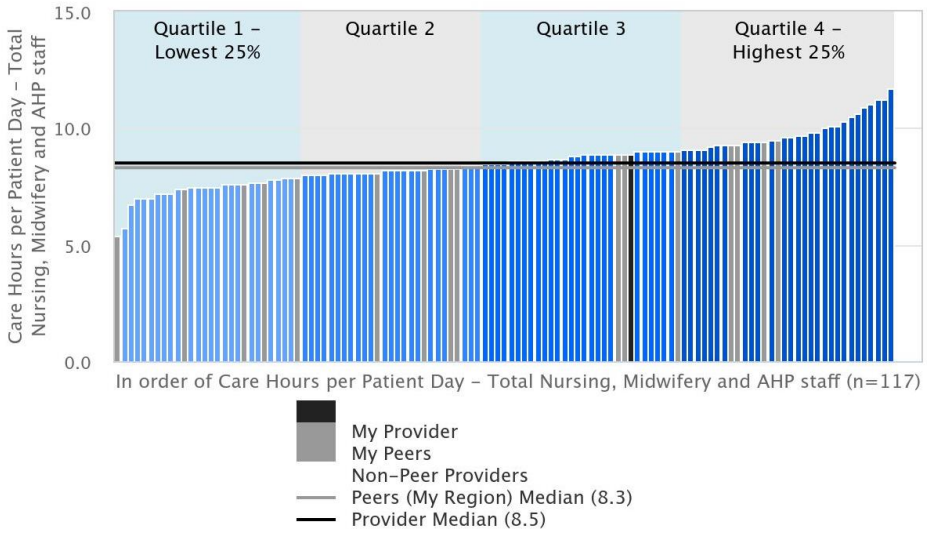
Since the last bi-annual staffing report an in-depth review of previous cases has been completed to ascertain whether there were suggestions from enquirers relating to staffing levels. No specific cases relating to staffing were identified. A specific 'Staffing' category has now been added within the system to reflect this theme and support oversight and understanding of the impact of altered staffing going forward.

For the period of July to December 2024, there were 63 PALS complaints/concerns recorded under the staffing category. However upon review it has been confirmed that all relate to staff behaviour/attitude, none directly related to safe staffing levels and all have been followed up through the Trust's complaints process.

5.2. Care Hours per Patient Day 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 9 below demonstrates Bolton NHS Foundation Trust's current position nationally and in relation to peers. As of December 2024, Bolton averaged 8.9 CHPPD which was above our peer average of 8.3. 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 9: CHPPD – Total Nursing and Midwifery Staff (including Support Staff) National Distribution as of December 2024



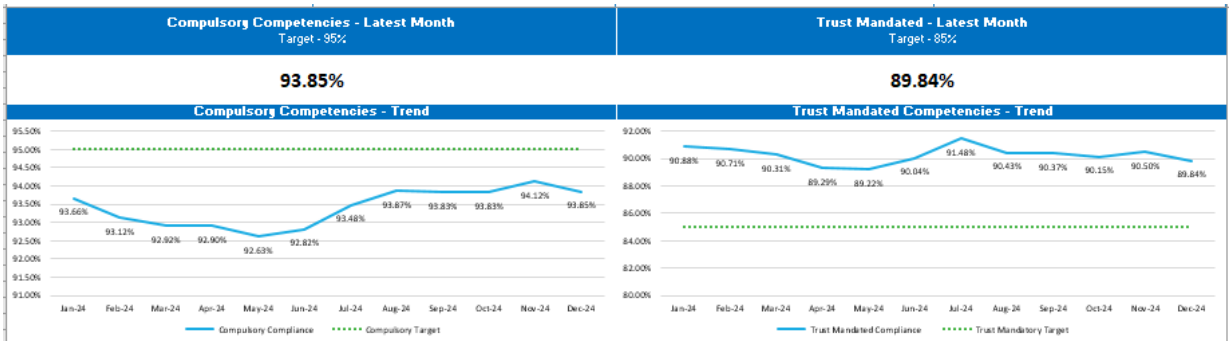
6. Expectation 2: Right Skills

6.1. Mandatory Training, Development and Education

For mandatory training the Trust remained compliant from July to November 2024, but dropped slightly below target in December 2024 to 89.84%. Winter pressures resulted in some instances of staff being delayed in attending training to support patient safety. Remedial actions have been undertaken and compliance has returned to above target from February 2024.

Challenges continue with compliance for compulsory training achieving the Trust wide target of 95%, which at the end of December 2024 was 93.85%. A contributing factor is the addition of Level 3 Safeguarding training requirement for clinical staff (mandated from April 2024), however the training needs analysis and method of delivery has been revised and full amended training roll out is now underway.

Figure 10: Trust Wide Compliance for Compulsory and Mandatory Training



7. Expectation 3: Right Place and Time

7.1. E-Rostering

E-rostering and the production of rosters is closely monitored to ensure all rosters are fully optimised. The rostering KPI reports were revised and launched in September 2024 and are now produced on a 4 weekly timescale in line with the rostering production timescales. Table 3 includes the metrics used to assess compliance within the report and Appendix 11 contains a break down per division of the total compliance for each roster included.

Table 3: Metrics for the revised KPI rostering report launched in September 2024

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.

Total compliance with the rostering KPI's has been consistently low. Work is underway to support divisions in developing their roster management processes to improve the KPI's, and training is planned for Matrons and ward/team managers to help better understand rostering process and how to achieve the KPI's. Monthly assurance meetings with each division have also been introduced from February 2025.

7.2. Staff Measures

HR metrics continue to be reported through divisional Integrated Performance Meetings and at Trust People Committee. Table 4 below shows the HR metrics for each month from July to December 2024.

Table 4: HR metrics from July to December 2024

Measure Type	No.	No.	%	%	£	%	%	%	%	%	%
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
Dec-24	6142	5340.21	5.66%	5.17%	£1,056,378.64	11.85%	86.36%	93.85%	89.84%	93.68%	68.87%
Nov-24	6148	5343.30	5.16%	5.18%	£924,090.33	11.71%	88.07%	94.12%	90.50%	94.13%	68.37%
Oct-24	6104	5300.01	5.51%	5.22%	£1,015,542.95	11.73%	86.96%	93.83%	90.15%	94.43%	68.59%
Sep-24	6098	5302.20	4.81%	5.22%	£836,322.76	12.06%	86.44%	93.83%	90.37%	94.44%	69.82%
Aug-24	6065	5272.27	4.66%	5.26%	£789,544.27	11.82%	85.78%	93.87%	90.43%	94.48%	67.01%
Jul-24	6028	5264.15	5.11%	5.29%	£919,854.89	11.69%	86.48%	93.48%	91.48%	93.24%	69.57%

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%

7.3. Vacancy Forecasting

Nursing vacancy forecasting continues to be mapped through use of a waterfall chart (Figures 11 and 12), which factors in new starters, leavers, vacancies, and students qualifying (both from the degree programme and nurse associates) to provide future projections. The data is used to support student nursing recruitment to ensure we have sufficient pipeline plans for nursing services.

The forecast demonstrates that based on current intake numbers the vacancy position for nursing continues to reduce, with positive projections into 2026 and 2027. The forecast position at the end of the 2025/2026 financial year will be a surplus of 99 WTE registered nurses.

The surplus figure for 2025/2026 is on the assumption that the Trust recruits the full cohort of qualifying nurses (minus attrition numbers) in September 2025 and January 2026. The reality is that once the application and shortlisting processes are complete the number available for recruitment is much smaller than predicted. Subsequent trainee cohort numbers are also reducing (see table 5), so the trend beyond 2027 is anticipated to go into a sharp decline. The waterfall analysis has enable the Trust to successfully and proactively plan recruitment approaches to ensure safe and effective nurse staffing numbers are maintained, and highlights the need for continued work to grow and retain our domestic supply.

Figure 11: Nursing joiners, leavers and vacancy for April 2024- March 2025

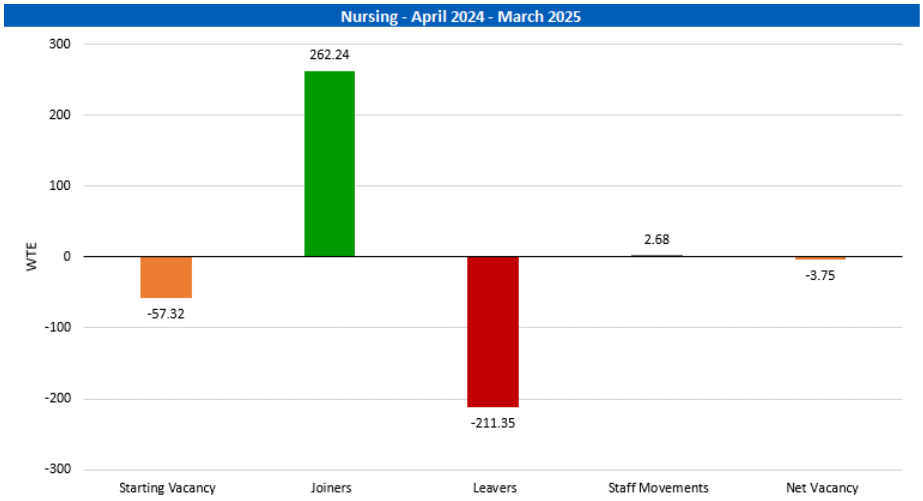


Figure 12: Nursing Vacancy Trend Forecasting

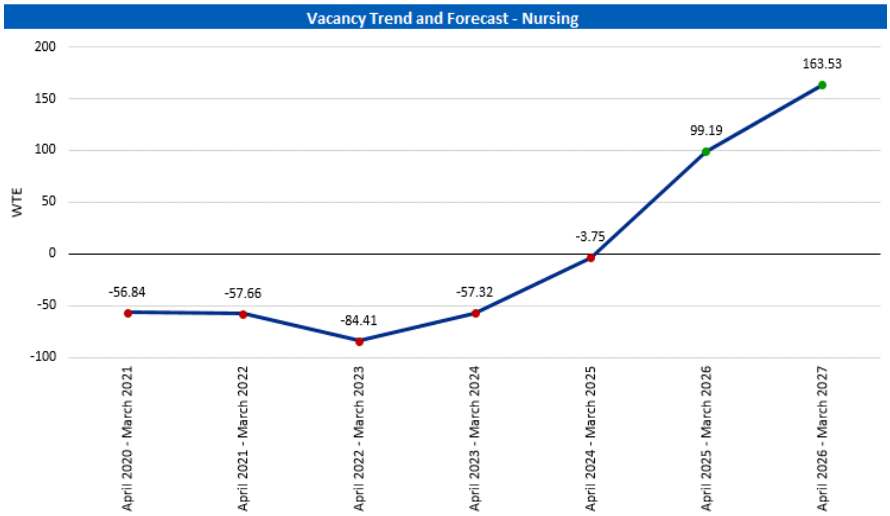


Table 5: Cohort Numbers for the Adult Registered Nursing Courses

Intake Date (Mth/Yr)	Qualifying Date (Mth/Yr)	Number of Students Enrolled
September 2022	September 2025	112
January 2023	January 2026	29
September 2023	September 2026	64
January 2024	January 2027	30
September 2024	September 2027	84
January 2025	January 2028	39

7.4. Temporary Staffing

Where a staffing shortfall is identified, the escalation process found in the rostering policy should be followed. 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.

Figures 13 and 14 below demonstrate the month-by-month breakdown of WTE hours for registered and unregistered bank and agency staff across the Trust from July 2024 to December 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 has increased. Figure13 demonstrates the gradual increase in substantive worked WTE 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 13: Registered bank and agency usage (Worked WTE)

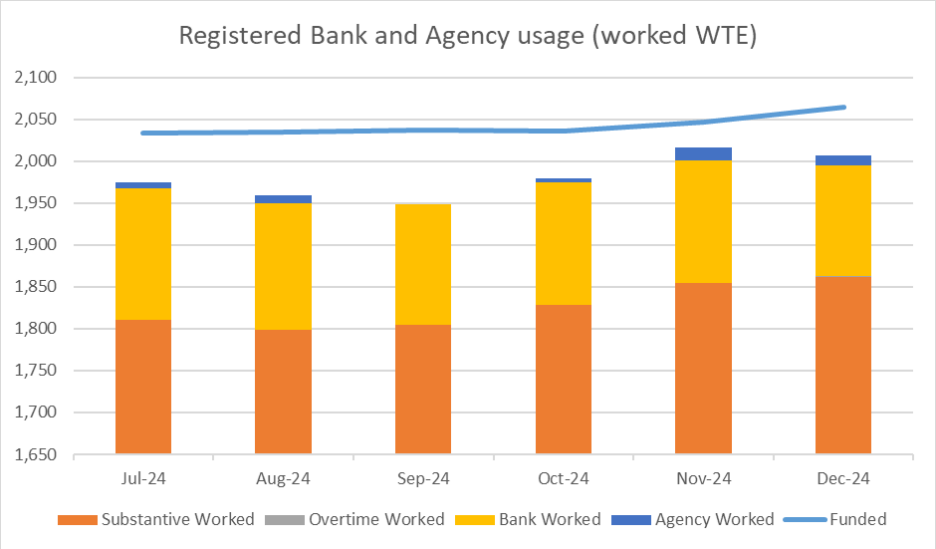
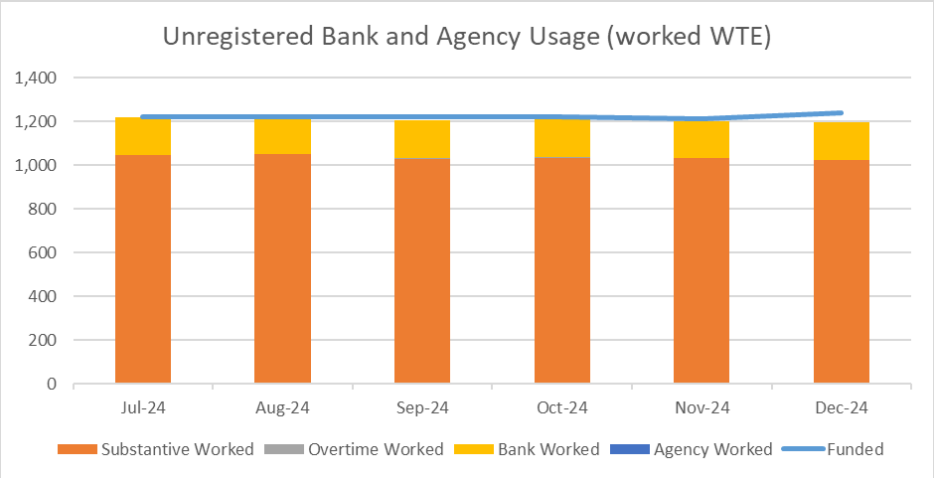


Figure 14: Unregistered bank and agency usage (Worked WTE)



6.4 Staffing Risks

There are currently 18 nurse-staffing risks on the risk register with scores ranging from 6 to 16. All have controls in place and ongoing actions to reduce the score (see Appendix 12 for a summary of the risks). Figures 15 and 16 break the risks down by score and division.

Figure 15: Nurse Staffing Risks by Score

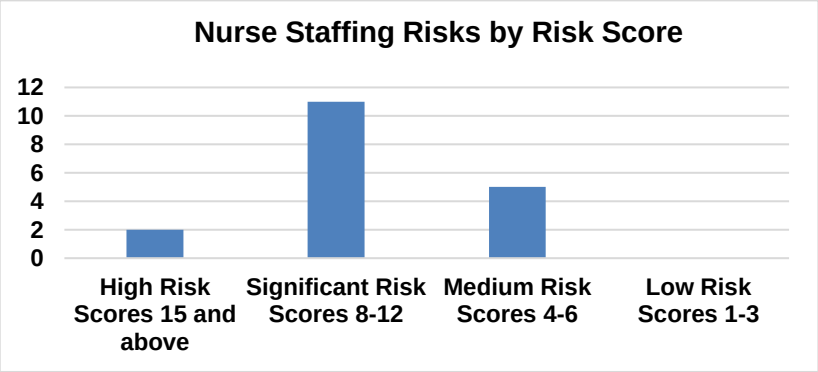
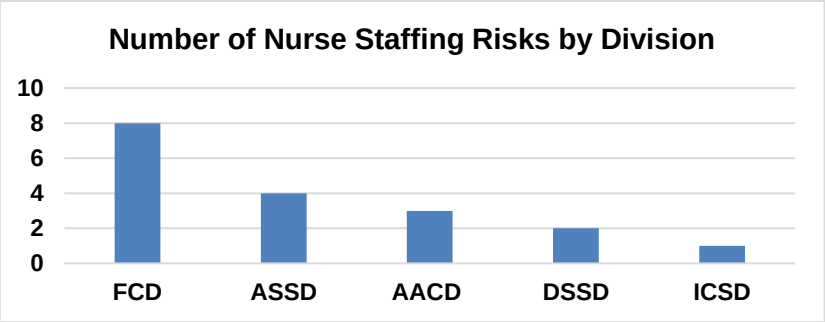


Figure 16: Number of Nurse Staffing Risks by Division



8. 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 1, which are monitored through the NMAHP&HCS priorities and CNO meetings. The key priority areas for the next 12 months are listed below:

- Sign off Safe Staffing Policy at Procedural Document Oversight Committee
- Review of the categories used for daily inputting within SafeCare (used to collect the data for the SNCT census) is underway, and once complete a full roll out of a revised training programme for all staff inputting will be undertaken.
- Complete scoping and roll out of SNCT into Gynaecology
- Roll out of the new Community Nurse Safe Staffing Tool
- Review of Paediatric Unit SafeCare to reflect the full set up of the different components of the unit (e.g. E5, F5, day case and HDU)
- Analysis of the February 2025 census data for all inpatient areas and community bed base
- Analysis of the ED census' from September and February 2025
- Completion of a full establishment review process for inpatient areas.
- Implementation of revised enhanced care assessment process by end of June 2025
- Delivery of training regarding red flags to improve consistency of reporting.

9. Conclusion

Based on the detailed analysis and findings presented in the Bi-Annual Nurse Staffing Report for July to December 2024, it is evident that Bolton NHS Foundation Trust has made significant strides in ensuring safe and effective nurse staffing levels. The Trust has successfully implemented various initiatives including revised e-Rostering KPI reports and assurance processes, revised Heat Map including workforce and quality indicators, red flag reporting, and robust validation methods for SNCT census', which have contributed to improved compliance and increased assurance.

This report identifies further areas for continued improvement to increase compliance against the NQB Workforce Safeguard recommendations. The ongoing transformation initiatives, including the sign off of the safe staffing policy, wider roll out of the enhanced care assessment tool, and the expansion of SNCT into new areas, demonstrate the Trust's commitment to continuous improvement and patient safety.

In conclusion, the organisation continues to enhance nurse staffing processes and monitoring arrangements has achieved positive outcomes, ensuring that patient care remains safe, effective, and sustainable. The recommendations and next steps outlined in this report will ensure the Trust continues on a positive trajectory in achieving its strategic ambitions, maintaining high standards of care and to ensure delivery of the NQB's key principals of having right staff, with the right skills, in the right place at the right time.

10. Recommendations

It is recommended that the Board of Directors Committee:

1. Approve the Bi-Annual Nurse Staffing Report and recommendation
2. Note the next steps and transformation work ongoing to further develop the Nursing workforce and safe staffing.

Appendices

Appendix 1:
Bolton NHS Foundation Trust Gap Analysis against the NHSI Workforce Safeguard Recommendations on the updated NHSE template.

Points of note:
Timescales for the completing the Safe Staffing Policy have had to be extended due to a need to complete the work with the staffing meetings and the Staffing Escalation in Extremis Protocol first.
All other actions have been completed within timescales or are on track to do so.

	Developing workforce	Current Position	Gap Analysis	Actions Required to Meet Compliance	Target Completion Dates
1	**Trust are formally using NQB guidance 2016 in safe staffing governance**	• Trust has a workforce governance structure that sees Divisional People's Groups, feeding into Trust Workforce and Organisational Development Group which then reports into the Executive led Trust's People Committee. • Bi-annual nurse and midwifery staffing reports completed and presented to the Board of Directors (BoD) . Organisation is currently exploring how other staff groups can be represented e.g. AHP • Safe Staffing metrics for inpatient areas now included in monthly Heat Map dashboard, and submitted for BoD. Further work required for community equivalent and clinical teams not currently represented within these. • Process in place for Red Flag data collection within SafeCare . Further work to support embedding process across inpatient and assessment areas, and rolling out to Paediatric ward. Further consideration as to how similar metrics could be collected for wider staff groups is currently being scoped. • Process in place for three times daily SafeCare entries by adult and paediatric wards. Further work required to improve overall compliance. • Twice daily staffing meetings in place, currently under review to improve the effectiveness of the process. • Staffing Escalation SOP in place • Safe Staffing Policy under development. • Trust has undertaken a gap analysis for nursing staff in relation to the workforce safeguards, and are undertaking one for AHP's.	**Partially Compliant**	• Complete Review of Staffing Escalation SOP and Daily Staffing Meetings • Review of terms of reference for workforce meetings to ensure alignment to the requirements of the Developing Workforce Safeguards. • Review of Bi-Annual reporting process to include all clinical staff • Review of the community heat map to align to Developing Workforce Safeguard requirements, and to ensure representation of all clinical groups.	• End of Quarter 4 25/26 - COMPLETE • Future Pipeline for 25/26 • Future Pipeline for 25/26 • Future Pipeline for 25/26
2	**Trust apply the principles of safe staffing - triangulation**	• SNCT (or equivalents) currently used within the Adult and Paediatric wards, Adult Assessment Units and ED. Community tool due to restart in 2025. • Birth Rate Plus embedded in Maternity • Work required to embed SNCT in wider nursing areas such as IMC and Gynaecology • Work underway within AHP staff groups to look at using the Workforce Optimisation Tool to understand service demand and capacity.. • Professional judgement embedded in daily staffing processes in relation to SafeCare entries. • Professional judgement considered at multiple points through the SNCT process e.g. as part nursing establishment reviews. • Outcomes defined locally by services as part of divisional integrated performance management meetings • Monthly Trust Heat Map includes agreed Trust wide metrics for inpatient areas, need to be reviewed for community and extended to clinical services not currently represented.	**Partially Compliant**	• Extend the use of SNCT into IMC and Gynaecology wards • Extend the use of the AHP workforce optimisation tool to wider AHP services. • Mapping of tools in use in other professions	• End of Quarter 1 25/26 Complete for IMC, and scoping underway with Gynaecology but on track • This will be a rolling programme over the next 2-3 years • Future pipeline for 25/26
3	**Monthly safer staffing report - including all staff groups registered and unregistered**	• Currently bi-annual nurse and midwifery staffing reports completed and approved at BoD. • Safe Staffing data for inpatient areas is reviewed monthly through production of Trust Heat Map that is reported at BoD • Work underway to review accuracy of AHP workforce data and improve reporting processes.	**Partially Compliant**	• Complete work on automating AHP workforce data • Mapping of bi-annual staffing report to understand where report can be adjust to represent all staff groups.	• Complex piece of work linking into wider trust departments/systems and Greater Manchester work streams, timeframes to be agreed, further clarity expected during quarter 1 25/26. • Future Pipeline for 25/26
4	**Monthly actual vs planned staffing levels to be displayed on Trust website ensuring easy access**	• CHPPD data published on the Trust website and reported into NHSE monthly as per requirements. • Heat Map with additional data shared with BoD, complete with narrative (Integrated Performance Report)	**Compliant**		
5	**Single Oversight Framework (SOF)submission to include staffing metrics**	• SOF produced annually including workforce metrics.	**Compliant**		
6	**Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board**	• Bi-annual and Annual staff report sign off process is in place via BoD	**Compliant**		

7	**Workforce plan should be in place and agreed / signed off by CEO & executive leaders and discussed at Public Board meeting**	• Workforce plan with establishments produced annually by workforce team and reported through the Trust Workforce and Organisational Development Group (and then Trust Peoples Commitee). • Discussed in a public Trust board.	**Compliant**		
8	**Agreed local quality dashboards on staffing & skill mix that is cross checked with comparative data from Model Hospital each month and reported to the board.**	• Clinical services have locally agreed, service specific report through divisional integrated performance meetings, and divisional governance meetings. • Data is reviewed and collated monthly for a number of workforce metrics, quality indicators and operational measures nursing and midwifery vacancy forecasting, across a number of reports e.g. Roster KPI, Heat Map, PWR report • Trust Heat Map is reported directly to Trust Board as part of the Integrated Performance Report, and others via governance structures and assurance processes • Need to ensure consistency of local metrics across the trust, and ensure in place for all clinical services. • Need to develop process for 'cross-checks' and ensure data is a comparable metric with other organisations in model hospital.	**Compliant**		
9	**Nursing establishments & skill mix of all areas to be reviewed twice a year and reported to the Public Board each time (using NQB guidance & DWS guidance)**	• Bi-annual SNCT census's for Adult Wards and Ax units, Paediatric Ward and ED. • Establishment review process in place and has been re-set following review of Trust SNCT processes in 2022. • Output, recommendations and actions reported to Trust Board via Bi-annual staffing papers • Establishment review process needs to be reviewed to ensure in line with best practice advise from NHSI • Maternity have established establishment review processes in line with Birth Rate Plus requirements. • Work underway to the review processes in place for AHP service which are currently conducted at a divisional level, with plans to work towards an agreed establishment review process for these staff groups inline with Developing Workforce Safeguards requirements	**Compliant**	• Mapping of current process for AHP and agree a process for establishment reviews for AHP services.	• Future pipeline no current date, dependant on complettion of other workforce projects e.g. automating AHP workforce data
10	**Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence based tools**	• SNCT and Birth rate plus used as per license agreement. • Enhanced care requirement continues to be calculated separately (as per the recommendation from NHSI when the old tool was in use), as multipliers in the new tool, attributes to much of the staffing to the nursing, which isn't inline with how Bolton staffs Enhanced Care, and was skewing results.	**Compliant**	None	
11	**Equality Quality Impact Assessment (EQIA) review for service changes including skill mix changes**	• Any skill mixing changes/new roles/design undertaken is subject to QIA, which is considered as part of divisional escalation processes, establishment review processes and vacancy control panels prior to final sign off via the Chief Nursing Officer and Medical Director. • Process will be formalised in Safer Staffing Policy and QIA Standard Operating Procedure	**Compliant**	• Draft and sign off of a Safe Staffing Policy	• End of March 25 - Drafting complete, policy sign off underway will be completed by end of quarter 1 25/26
12	**Equality Quality Impact Assessment (EQIA) review for redesign or introduction of new roles**	• Any skill mixing changes/new roles/design undertaken is subject to QIA, which is considered as part of divisional escalation processes, establishment review processes and vacancy control panels. • Process will be formalised in Safer Staffing Policy	**Compliant**	• Draft and sign off of a Safe Staffing Policy	• End of March 25 - Drafting complete, policy sign off underway will be completed by end of quarter 1 25/26
13	**Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy and staffing escalation matrix/SOP**	• Daily Safer Staffing Meetings in place, the meetings are currently under review to ensure rigorous check & challenge process. • Staffing risk assessments currently managed divisionally, and escalated through trust governance and assurance processes. • Safe Staffing Metrics for inpatient areas now included in Monthly Heat Map Dashboard, narrated monthly by divisions and submitted for Trust Board oversight. Further work required for community equivalent and clinical teams not currently represented within these. • Staffing Escalation SOP currently under review • Need to standardise staffing escalation processes for professions outside of nursing.	**Partially Compliant**	• Completed and signed of updated Staffing Escalation SOP • Complete review of daily staffing meetings • Agree standards and processes for AHP staffing escalations and cross divisional review of AHP risks. • Draft and sign off of a Safe Staffing Policy • QIA Standard Operating Procedure	• End of March 25 - COMPLETE • End of Feb 25 - COMPLETE • Pipeline for 25/26 to understand current position and required processes to then map future actions. • End of March 25 - Drafting complete, policy sign off underway will be completed by end of quarter 1 25/26 • Pipeline for 25/26
14	**Boards to be made aware of continuing or increasing staffing risks**	• Nursing and midwifery staffing risks held on the risk register are included in the bi-annual staffing papers which are reported to BoD. • Staffing risk assessments currently managed divisionally, and escalated through Trust governance and assurance processes. • Divisional People's commitee's have opportunity to escalate to the Trust Workforce and Organisational Development Meeting, and Trust Peoples Committee through Chairs reports, which in turn report into Trust Board • Monthly Heat Map and narrative reporting on safe staffing metrics and reported through Trust Board, supports oversight, assurance and escalation processes.	**Compliant**	None	None

Appendix 2

Registered nursing WTE establishment vs recommended staffing from both the July 2023 and February 2024 census'

Key:

WTE Est.	*Ward Establishment*
Recommended Adj. SNCT WTE	*Adjusted SNCT recommendation to ensure compliance with minimum staffing ratio and whole staff members per shift.*
+/-	*Difference between the establishment and the enhanced care and SNCT WTE combined.*

Registered Nursing - Comparing Establishments - Funded, SNCT Recommended and Adjusted											
Division	Ward/Team	SNCT Tool	Jul-23			Feb-24			Sep-24		
			WTE Est.	Recommended Adj. SNCT WTE	+/-	Est.	Recommended Adj. SNCT WTE	+/-	Est.	Recommended Adj. SNCT WTE	+/-
Total			366.0	309.48	56.58	397.29	340.20	57.09	454.65	377.52	77.13
AACD	CCU (Coronary Care Unit) [0121]	Adult Inpatient Ward	13.57	13.94	-0.37	13.57	13.94	-0.37	14.57	10.56	4.01
AACD	CDU (Clinical Decisions Unit) (0420)	Adult Inpatient Ward	13.55	13.94	-0.39	13.55	13.94	-0.39	14.55	10.56	3.99
AACD	Ward A4 [0214]	Adult Inpatient Ward			0.00			0.00	16.56	13.20	3.36
AACD	Ward B1 [0206]	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	15.84	0.95
AACD	Ward B3 (0408)	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	10.56	6.23
AACD	Ward B4 (0208)	Adult Inpatient Ward	16.53	11.15	5.38	16.53	13.94	2.59	17.54	18.48	-0.94
AACD	Ward C1 [0105]	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	15.84	0.95
AACD	Ward C2 [0109]	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	15.84	0.95
AACD	Ward C3 [0115]	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	13.20	3.59
AACD	Ward C4 (0216)	Adult Inpatient Ward	15.79	13.94	1.85	15.79	13.94	1.85	16.79	23.76	-6.97
AACD	Ward D1 (0409)	Adult Admission and Assessment Unit	28.22	22.31	5.91	28.22	22.31	5.91	29.22	23.76	5.46
AACD	Ward D2 (0411)	Adult Inpatient Ward	25.22	27.89	-2.67	25.22	16.73	8.49	26.22	13.20	13.02
AACD	Ward D3 [0117]	Adult Inpatient Ward	17.60	13.94	3.66	17.60	13.94	3.66	18.60	15.84	2.76
AACD	Ward D4 [0119]	Adult Inpatient Ward	17.60	13.94	3.66	17.60	16.73	0.87	18.60	18.48	0.12
AACD	Ward H3 - Stroke [0204]	Adult Inpatient Ward	16.94	16.73	0.21	16.94	13.94	3.00	17.94	23.76	-5.82
ASSD	Surgery E3 (1513)	Adult Inpatient Ward	18.57	13.94	4.63	18.57	13.94	4.63	19.57	15.84	3.73
ASSD	Surgical Care Unit 2 (SCU2) (1517)	Adult Inpatient Ward	15.93	11.15	4.78	15.93	11.15	4.78	14.69	10.56	4.13
ASSD	Surgical Assessment F3 (1529)	Adult Admission and Assessment Unit	23.51	16.73	6.78	23.51	16.73	6.78	37.79	23.76	14.03
ASSD	ENT F6 (1515)	Adult Inpatient Ward	18.57	13.94	4.63	18.56	11.15	7.41	17.33	10.56	6.77
ASSD	Elective Care Centre - First Floor (0703)	Adult Inpatient Ward	11.53	11.15	0.38	11.53	11.15	0.38	17.98	10.56	7.42
ASSD	Orthopaedic Male E4 (0705)	Adult Inpatient Ward	17.00	11.15	5.85	17.00	13.94	3.06	18.00	15.84	2.16
ASSD	Orthopaedic Female F4 [0707]	Adult Inpatient Ward	16.98	13.94	3.04	16.98	13.94	3.04	18.98	15.84	3.14
FCD	Ward E5 [2309]	Children and Young People				31.24	39.04	-7.80	35.77	21.12	14.65
ASSD	R1 (0309)	Adult Inpatient Ward							0.00	10.56	-10.56

Appendix 3

Non-registered Nursing Workforce WTE Establishment vs Recommended Staffing and Recommended Enhanced Care Staffing from both the July 2023 and February 2024 census'.

Key:

WTE Est.	*Ward Establishment*
Recommended Enhanced Care WTE	*Recommended WTE required for Enhanced Care*
Recommended Adj. SNCT WTE	*Adjusted SNCT recommendation to ensure compliance with minimum staffing ratio and whole staff members per shift.*
+/-	*Difference between the establishment and the enhanced care and SNCT WTE combined.*

Non-Registered Nursing - Comparing Establishments - Funded, SNCT Recommended and Adjusted												
		Jul-23				Feb-24				Sep-24		
Division	Ward/Team	WTE Est.	Recommended Enhanced Care WTE	Recommended Adj. SNCT WTE	+/-	WTE Est.	Recommended Enhanced Care WTE	Recommended Adj. SNCT WTE	+/-	WTE Est.	Recommended Adj. SNCT WTE (including enhanced care)	+/-
Total		366.5	108.29	234.20	24.10	400.72	239.84	237.04	-76.16	417.52	432.96	-15.44
AACD	CCU (Coronary Care Unit) [0121]	4.76	0.00	5.58	-0.82	5.96	0.00	5.58	0.38	6.16	5.28	0.88
AACD	CDU (Clinical Decisions Unit) (0420)	6.16	2.50	5.58	-1.92	5.76	5.58	5.58	-5.40	5.76	5.28	0.48
AACD	Ward A4 (0214)				0.00				0.00	17.39	18.48	-1.09
AACD	Ward B1 [0206]	17.33	11.42	16.73	-10.82	21.24	27.89	11.15	-17.80	21.24	29.04	-7.80
AACD	Ward B3 (0408)	22.14	15.31	16.73	-9.90	22.12	39.04	11.15	-28.07	22.32	23.76	-1.44
AACD	Ward B4 (0208)	25.56	4.93	11.15	9.48	29.55	27.89	16.73	-15.07	29.55	26.40	3.15
AACD	Ward C1 [0105]	14.96	4.26	11.15	-0.45	16.92	11.15	11.15	-5.39	16.92	15.84	1.08
AACD	Ward C2 [0109]	23.02	10.17	22.31	-9.46	24.44	22.31	16.73	-14.60	24.44	26.40	-1.96
AACD	Ward C3 [0115]	23.47	3.92	11.15	8.40	25.90	0.00	11.15	14.75	25.90	18.48	7.42
AACD	Ward C4 (0216)	25.70	8.29	11.15	6.26	20.04	16.73	11.15	-7.84	20.04	18.48	1.56
AACD	Ward D1 (0409)	18.20	10.45	13.94	-6.19	21.60	5.58	13.94	2.08	21.60	26.40	-4.80
AACD	Ward D2 (0411)	13.93	11.42	13.94	-11.43	14.08	22.31	8.37	-16.59	14.08	21.12	-7.04
AACD	Ward D3 [0117]	18.18	3.14	11.15	3.89	21.52	5.58	11.15	4.79	21.52	21.12	0.40
AACD	Ward D4 [0119]	20.06	2.28	11.15	6.63	21.48	16.73	13.94	-9.19	21.48	21.12	0.36
AACD	Ward H3 - Stroke [0204]	16.40	0.90	13.94	1.56	17.61	0.00	16.73	0.88	17.61	21.12	-3.51
ASSD	Surgery E3 (1513)	16.98	4.37	11.15	1.46	18.59	5.58	11.15	1.86	18.59	18.48	0.11
ASSD	Surgical Care Unit 2 (SCU2) (1517)	12.59	0.00	5.58	7.01	13.28	0.00	5.58	7.70	11.04	7.92	3.12
ASSD	Surgical Assessment F3 (1529)	15.93	1.57	8.37	5.99	13.28	0.00	8.37	4.91	13.28	15.84	-2.56
ASSD	ENT F6 (1515)	14.50	2.91	11.15	0.44	15.91	5.58	8.37	1.96	13.67	13.20	0.47
ASSD	Elective Care Centre - First Floor (0703)	6.68	0.00	2.79	3.89	5.45	0.00	2.79	2.66	5.45	5.28	0.17
ASSD	Orthopaedic Male E4 (0705)	25.39	3.17	8.37	13.85	26.50	11.15	11.15	4.19	26.50	23.76	2.74
ASSD	Orthopaedic Female F4 [0707]	24.65	7.28	11.15	6.22	26.51	16.73	11.15	-1.38	25.51	23.76	1.75
FCD	Ward E5 [2309]					12.98	0.00	13.94	-0.96	17.47	21.12	-3.65
ASSD	R1 (0309)				0.00				0.00	0.00	5.28	-5.28

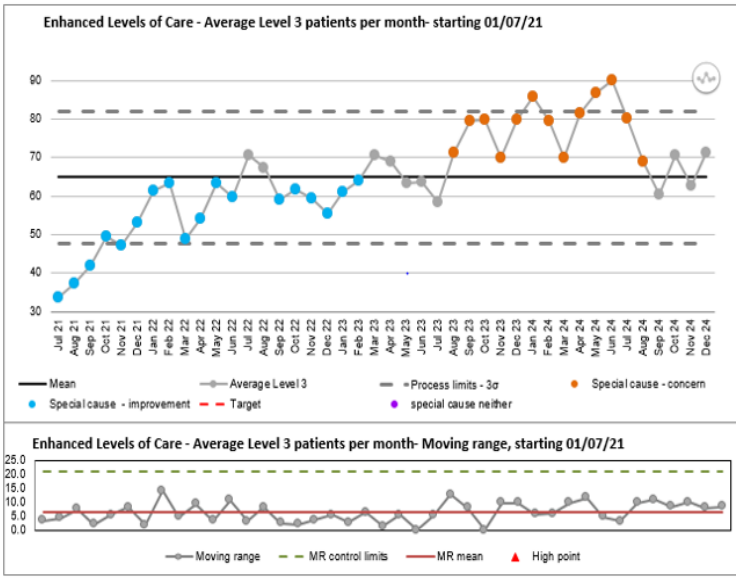
Appendix 4

Enhanced Care Data Breakdown

Level 3 Enhanced Care

1. Average Monthly Number of Enhanced Care Level 3 Patients on selected wards

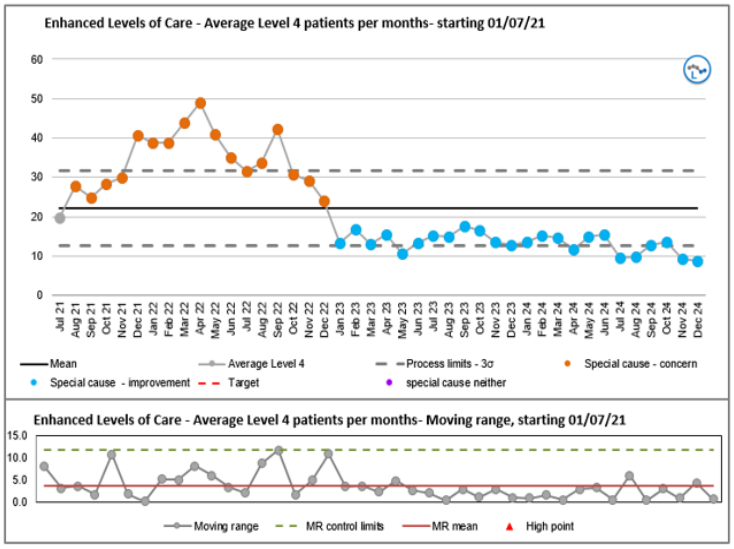
Date	Average Level 3	Date	Average Level 3	Date	Average Level 3	Date	Average Level 3
Jul 21	33.7	Nov 23	69.9				
Aug 21	37.3	Dec 23	79.8				
Sep 21	41.8	Jan 24	85.7				
Oct 21	49.5	Feb 24	79.6				
Nov 21	47.3	Mar 24	69.8				
Dec 21	53.0	Apr 24	81.6				
Jan 22	61.2	May 24	86.6				
Feb 22	63.2	Jun 24	89.9				
Mar 22	48.9	Jul 24	80.1				
Apr 22	54.0	Aug 24	69.0				
May 22	63.4	Sep 24	60.4				
Jun 22	59.8	Oct 24	70.6				
Jul 22	70.6	Nov 24	62.6				
Aug 22	67.3	Dec 24	71.2				
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	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	Aug 24	9.8				
May 22	40.8	Sep 24	12.8				
Jun 22	34.9	Oct 24	13.6				
Jul 22	31.6	Nov 24	9.3				
Aug 22	33.6	Dec 24	8.7				
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 5

Family Care Division Acute Paediatrics Staffing Review: July – December 2024

Bi-Annual Nurse Staffing Update	
Division:	Family Care Division
Teams covered by this report:	Acute Paediatrics
Management of Current Establishment: How do we know our current establishment is correct?	
• **Safer Nursing Care Tool:** The Safer Nursing Care Tool (SNCT) for children and young people, released in 2017, recommends completing the tool for 30 days 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 September 2024, unfortunately the census compliance was not valid and a further census was completed in February 2025 and analysis of the results is now underway. • **Staffing Reviews:** at least annually or more frequently in response to known service pressures, such as increased clinical acuity and seasonal activity. • **Staff Competence:** o Ensure staff have the right knowledge, skills, expertise, and competence to meet the child's needs. o Each shift should have a nurse with Advanced Paediatric Life Support (APLS) qualifications. • **Additional Staff:** o Do not include additional and unregistered staff in the nursing ratio establishment for inpatient areas. o Supervisory ward sister/charge nurse o Supernumerary a shift coordinator covering a 24-hour period, not included in the baseline bedside establishment. • **Play Worker Cover:** 7-day play worker cover.	
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability's • Vacancies	
• Weekly paediatric staffing meeting that reviews the rota for the subsequent 7 days, identifies gaps, scrutinise where roster changes can be made and or ward leadership (co-ordinator, Ward Manager, Governance Lead) can support with patient caseload. In cases where adjustments cannot be accommodated, Bank is approved by the DND. A weekly staffing log is completed. • Paediatric Acute has adopted the new Trust process for Agency approval and send requests to DND 24 hours in advance of the shift and CNO approval sought.	

- During the last 12months the ward has had a high number of staff on Maternity Leave (4.4wte) 9.9% of the workforce. Bank shifts have been utilised to cover the unavailability.
- There are currently no vacancies in nursing staffing in Acute Paediatrics and the unit currently has candidates who were successful at interview on the reserve list/employment pool, for when posts become available.

Current National Staffing Guidance for Specialty and Compliance:

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

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.

Current Staffing Risks and Narrative:

Risk No.	Description	Target Date	Score
5505	If staffing levels are not achieved and maintained for E5, F5, HDU inpatient services, then there is a risk of inadequate monitoring for all patients, delay in treatment and triage which will result in worsened patients outcomes and poor patient experience.	15.01.2026	3(S) x 4(L) = 12

Completed By:	Faye Chadwick	**Date:**	28.04.2025

Appendix 6

Family Care Division- Neonatal Unit Staffing Update July to December 2024

Bi-Annual Nurse Staffing Update	
Division:	Family Care Division
Teams covered by this report:	Neonatal Unit (NNU)
Management of Current Establishment: How do we know our current establishment is correct?	
• Monthly 1:1s with the Financial account to review staffing figures and vacancies. • Quarterly staffing returns to North West Neonatal Operational Delivery Network and NHS England • Annual Activity Capacity and Demand (ACD) reviews staffing figures against activity and British Association of Perinatal Medicine (BAPM) requirements.	
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability's • Vacancies	
• Recent changes to NHSP rates of pay have made rates non-competitive across GM in Neonates, leading staff to banking elsewhere for better pay, which has impacted safe and sustainable staffing. • Use of agency is infrequent in NNU and as a last resort. • Recruitment remains ongoing with currently 2.51WTE (clinical roles) vacancies remaining – a staffing proposal to skill mix the current workforce has been submitted. • Nurse staffing was last calculated using the nursing workforce tool in April 2025 (Appendix 6a). The service is currently compliant with 61.1% compliant with direct cot side BAPM standards and fully compliant with the required standard of 70% when quality roles included. • Non clinical roles have been a challenge to recruit into with Housekeeper posts being held by EPP. Use of relief staff has been utilised but this poses a significant risk to the service, as staff are not equipped or trained to work on NNU so this limits the task they are able to fulfil and hinders IPC compliance. In turn this poses a clinical risk. • The NNU sickness rate remains high at 5.72% although this is improving. The unit is often above Trust target and is an outlier within division. Regular deep dive exercises are undertaken by the Matron and Human Resources to review any common themes. • Stress and anxiety is the most common theme but not workplace-related. The NNU has implemented practices to support staff including; human factors training is	

included in mandatory training and induction, regular Schwartz rounds and weekly confidential wellbeing sessions. The unit has been commended for its culture, offering bystander training, monthly meditation, and team-building away days, all receiving positive feedback.

- Mental health and wellbeing support on the NNU has improved with the recent recruitment of clinical psychology (0.5 WTE offer). This was recommended in the Neonatal Critical Care review to aid both staff and parents. The support has been well received, especially amid national scrutiny and the upcoming Thirwell Inquiry.
- Maternity leave is prevalent at 2.2 WTE, and while not included in staffing uplift (in line with national guidance), the NNU strives to backfill through existing recruitment processes.

Current National Staffing Guidance for Specialty and Compliance:

- The NNU is a level 3 regional unit which consist of 35 cots. (9 Intensive care cots, 7 High dependency and 19 Special care cot). It provides care for extremely premature infants on the cusp of viability to sick term infants requiring Neonatal input. Activity within Neonates is unpredictable – with staffing levels often reflecting the activity and acuity on the NNU and maintaining adequate skill mix to accommodate unexpected admissions, transfers etc.
- To date Bolton NNU has been working at 140% above the HDU cots allocated and recent conversation with commissioners have taken place to discuss an increase in cot base. Activity has been hindered with the unforeseen changes in reducing Maternity capacity. Inability to accept regional requests for IUTs and Postnatal transfers could compromise the NNUs tertiary status.
- Band 7 coordinators review staffing daily and manage in accordance with unit acuity. Where staffing levels are compromised nurses are transferred between NNU and the Children's ward (where appropriate) in line with the standard operating procedure.
- As part of the Neonatal Critical Care Review, the Neonatal unit secured funding for 18 WTE new nurses, this as a reflection of actual direct cot-side care against average activity over a 3-year period. To date recruitment is ongoing to establish the 18WTE; to date the current gap is 2.51 WTE inclusive. All vacancies have been advertised with imminent interview dates. A staffing proposal to skill mix the current workforce to support ongoing work on culture and quality pending the outcome of the National Thirwall inquiry has been submitted.
- BAPM compliance has significantly improved with increased retention rates:

MONTH	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
BAPM COMPLIANCE	98%	96%	100%	99%	100%	96%

Current Staffing Risks and Narrative:

Risk No.	Description	Target Date	Score
5128	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.	30/05/2025	6

Narrative: Current vacancy is 2.51 WTE with all vacancies now shortlisted and imminent interview dates scheduled for 23rd April 25. Candidate quality is high and thus, the NNU are confident recruitment will be successful and then the current risk can be closed.

Completed By:	Catherine Bainbridge	**Date:**	03/04/25

Appendix 6a - Nursing workforce calculation completed in April 2025

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 110.78, of which 77.55 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	105.94	87.86	100.55	5.39	-12.69
Total reg nurses	101.78	83.70	92.89	8.89	-9.19
Total QIS	84.78	51.11	75.01	9.77	-23.90
Total non-QIS	17.00	32.59	17.88	-0.88	14.71
Total non-reg	4.16	4.16	7.66	-3.50	-3.50
Reg nurses as % nursing staff	96.1%	95.3%	92.4%		
QIS as % reg nurses	83.3%	61.1%	80.8%		

Appendix 7

Family Care Division- Gynaecology Assessment Unit and Early Pregnancy Unit Staffing Update July to December 2024

Bi-Annual Nurse Staffing Update	
Division:	Family Care Division
Teams covered by this report:	Gynaecology Assessment Unit and Early Pregnancy Unit
Management of Current Establishment: How do we know our current establishment is correct?	
Gynaecology Assessment Unit and Early Pregnancy Unit currently has 12 beds (6 in a bay and 6 single rooms). The unit manages assessments through a waiting room and has clinic rooms available to assess women. There are two procedure rooms, one for nurse led procedures and one for Doctor led procedures. The unit also runs a triage telephone service which operates 8am – 5pm by a Band 6 nurse (the demand would warrant this service being available to 8pm if the staffing was increased). This service manages women phoning in with early pregnancy issues and manages women who have been discharged and are on a virtual ward pathway. The unit also has an ultrasound service Monday to Friday offering 16 slots per day. The current establishment on H1 is Early – 5 RNs 2 HCAs Late – 4 RNs 2 HCAS Night - 3 RNs 1 HCA At weekends there isn't a ultrasound scan service or procedure clinics and therefore women are sent home where safe to do so, to return during the week, the weekend establishment is therefore Early – 3 RNs 2 HCAs Late – 2 RNs 2 HCAS Night - 3 RNs 1 HCA Due to the complexity off the service provided by the Gynaecology Assessment Unit and Early Pregnancy Unit, and the different operational delivery models of different aspects of the service, assessment of capacity and demand is difficult. There has not been a formal SNCT data collection on the Gynaecology Assessment Unit and Early Pregnancy Unit, however this would support professional judgement on staffing levels. Further work is required to understand capacity and demand, the last 12 months data demonstrates around 950 – 1000 admissions/attendances per month. Recent changes to data collection, through recording contacts in LE 2.2 has supported better understanding of the demand and benefits of the Triage service, in supporting admission avoidance and early discharge.	

Scoping is currently underway to look at implementation of SNCT for the bedded areas of the Gynaecology Assessment Unit and Early Pregnancy Unit. Data collection to support understanding demand and waiting times in the waiting room is also underway.
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability's • Vacancies
The establishment template on Gynaecology Assessment Unit and Early Pregnancy Unit remains incorrect following approval of a business case to increase staffing by 3.27 WTE band 5s and 0.38 WTE Band 6. This was to support the change to a 24 hours service (previously the service was 8am – 8pm). The business case was approved and recruited to however the budget and template was not realigned with the new establishment. Bank is utilised to cover sickness where required and agency is rarely used (in extenuating circumstances only). For long term sickness alternatives such as fixed terms contracts are explored where applicable.
Current National Staffing Guidance for Specialty and Compliance:
NICE clinical guideline 154 recognises the vital importance of improving the diagnosis and management of early pregnancy loss to reduce the incidence of the associated psychological morbidity and avoid the unnecessary deaths of women with ectopic pregnancies. There isn't currently national staffing guidance for EPAU or Gynaecology assessment Units.
Current Staffing Risks and Narrative:
None

Completed By:	Karen Keighley	**Date:**	15/04/2025

Appendix 8

Integrated Community Services Division (ICSD) Annual Specialist Nursing Staffing Update

Annual Specialist Nursing Staffing Update	
Division:	Integrated Community Services Division
Teams covered by this report:	Rheumatology Specialist Nursing Specialist Palliative Care Stroke Nurse Neurological long term conditions Specialist Nurse (Parkinson's Disease and Epilepsy Bladder and Bowel Health Diabetes Specialist Nurse Anticoagulation Specialist Nurses
Management of Current Establishment: How do we know our current establishment is correct?	
The current staff in post are based on historical recruitment/establishments. Skill mix is reviewed on a case by case basis as vacancies occur to ensure it is in alignment with the demands of the service.	
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability • Vacancies	
Unable to backfill with bank due to the specialty in most community nurse specialist (CNS) posts; if extra staff are required due to sickness in the team the staff attempt to do this or the tripartite leadership teams review what is core business and step down activity which is not an urgent priority and is clinically safe to do so for a short period of time. When the specialist services have staffing gaps the impact of this is directly on the patient's waiting lists and time to be seen increases which can have an impact on patient's long term conditions and ability to self-manage conditions. Vacancies across specialist services are difficult to recruit to due to the lack of opportunities to become a specialist nurse. Within ICSD we have offered development posts which is great opportunity for developing staff, however this impacts service capacity due to the time it takes to train a specialist nurse to be competent and practicing at the specialist level required. Specialist Palliative Care has minimal capacity to backfill with bank due to the specialist nature of the service, this leads to increased waiting times for patients at the end of life for nursing and therapy needs**.** This decreases patient satisfaction and lowers staff morale**.**	

Current National Staffing Guidance for Specialty and Compliance:

Rheumatology: British Society for Rheumatology guidance advises 1 (band 7 or above) per consultant per 60,000 patients. Currently the team have 5 WTE Consultants and 3.8 WTE specialist nurse, a shortfall of 1.2 WTE against the recommendations.

Specialist Palliative Care: National guidance for the community is five Specialist Nurses per 250,000 population. Currently the Community Specialist Palliative Care Team staffing is compliant, consisting of 2.46 WTE Band 7, 3 WTE Band 6, 1 WTE Band 4 Nurse Associate.
National guidance for the hospital is one Specialist Nurse per 250 beds. Currently the team consists of 2.2 WTE band 7 and 2 WTE band 6 and is compliant against the national guidance.

Neurological long term conditions: national requirements for epilepsy is 1 CNS per 250 patients and for Parkinson's 1 CNS per 300 patients (Parkinson's UK).

Bladder and Bowel Health: There is no national guidance published on this, as it depends on complexity of patients. On average Bolton has approx. 7000 patients on the caseload yearly. Current staffing 1 FT Band 7 SPN (NMP and Team Lead), 1 FT band 6 SPN, 1 band 6 SPN part time, 1 Band 5 continence nurse part time, 1 Band 4 assistant practitioner part time. Total WTE of the team is 4.4 WTE which equates to a caseload of over 1500 patients per staff member. The bladder and bowel staffing has not increased since the service commenced only bandings reduced, previously the team had 2 band 8a specialist nurses within establishment.

Diabetes Specialist Nurses (DSN): For inpatients Getting it Right First Time (GIRFT) recommendations state 1 Diabetes Specialist Nurse per 250 beds. Last audit states a hospital Bolton's size required 6.7 WTE DSN's to run the inpatient service for 7 days a week. There is no specific national recommendations for community DSN's, however guidance states 4 WTE DSN's per 250,000 population. Bolton as a higher prevalence of diabetes than other GM areas and 2 of our neighbourhood teams have this as their specialist priority for this year. Current staffing in team for both inpatient and community is 9.3 WTE DSN's. The service is 1.4 WTE DSN's below national recommendations.

Stroke: There are no current mandated national recommendations.

Current Staffing Risks and Narrative:

There are 2 staffing risks associated with the departments covered by this report.

Risk No. & Dept.	Description	Target Date	Score
6456 Anti-Coagulation	IF the team have gaps in staffing due to sickness and flexible working THEN there will be a clinical risk due to reduced capacity within clinic and domiciliary visits leading to cancelled clinic slots, longer waiting times and delays in treatment.	26.05.2025	9
6247	IF the vacancy within the Stroke SLT service is not recruited to/filled THEN there will be no dysphagia	30.05.2025	6

Therapy - Stroke	provision within the Stroke SLT service which will then lead to increased patient safety concerns, increased waiting list, reduced / delayed patient recovery, increased carer burden and reduced patient experience			
Completed By:	Michaela Toms	**Date:**	14/4/25	

Appendix 9

Acute Adult Care Division (AACD) Annual Specialist Nursing Staffing Update

Annual Divisional Update for Specialist Nursing Teams	
Division:	Acute Adult Care Division (AACD)
Teams covered by this report:	Fifteen specialist Nursing services with approximately 100 specialist nurses of various grades.
Management of Current Establishment: How do we know our current establishment is correct?	
All specialist nursing services are overseen and managed by either a nurse consultant, matron or ADND.	
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability's • Vacancies	
No agency staff are used to back fill vacancy/sickness or annual leave, but some specialist nurses have been added to the bank to back fill gaps within their own teams.	
Current National Staffing Guidance for Specialty and Compliance:	
There is no known current guidance for the specialist nursing teams within AACD	
Current Staffing Risks and Narrative: No specialist nursing risks	

Risk No.	Description	Target Date	Score
5596	If the Lung Function team continues to operate with the current qualified staffing level of 0.75 WTE, then there is a risk that urgent patients, including patients with lung cancer, will be unable to have 6 minute shuttle walks or pulmonary function tests when the Respiratory Diagnostic Manager is not in work. This will negatively impact the Trust's cancer performance and patient care, and we will not meet British Thoracic Society guidelines which states there should be 0.6 WTE physiology support per consultant post.	31/12/2025	9
6246	If staffing levels within TB team are not increased, the length of time patients waiting to initiate latent TB treatment will increase - this has the potential for them to become actively infectious which may constitute a public health risk	31/08/2025	9

6038	If patients requiring ventilated tracheostomies are admitted with an acute episode to D3/D4, without their specialist support care staff, then staff on D3/D4 may not be trained or competent in the specific pieces of equipment used by the patient increasing the risk of acute distress.		8

Completed By:	Dawn Murray	**Date:**	2/4/25

Appendix 10

Anesthetics and Surgery Service Division (ASSD) Annual Specialist Nursing Staffing Update

Annual Divisional Update for Specialist Nursing Teams			
Division:	Anaesthetics and Surgery Services Division		
Teams covered by this report:	Cancer nursing services Bowel screening team Ophthalmology nurses		
Management of Current Establishment: How do we know our current establishment is correct?			
The Cancer Nurse Specialist (CNS) is an established role, supporting a specific tumour site and roles will usually be band 6 or 7 depending on an individual's experience and competency. The CNS assists the patient with their cancer pathway decision making, providing information and clarity, listening to patient concerns and signposting to other help and services. Many of these roles have been pump-primed by Macmillan Cancer Support with the expectation that the Trust will then take on the role. Depending on the setting the CNS role can work across the cancer pathway, undertakes personalised care, more complex treatments and follow up care as patients are living longer with cancer. The role of CNS at Bolton is currently undergoing a service review of all tumour groups to link with job planning. Bowel specialist nurses work alongside the general surgeons to support patients with newly formed stomas. Urology and ophthalmology deliver clinics under guidance of the consultant teams and some procedure work.			
Challenges Meeting Current Establishments: Please include (but not limited to): • Use and management of bank and agency • Management & impact of unavailability's • Vacancies			
Vacancy and turnover in cancer services is leading to gaps in service. Teams cross cover to support as sourcing appropriately skilled bank and agency staff is challenging.			
Current National Staffing Guidance for Specialty and Compliance:			
Cancer services posts are often back filled and funded by Macmillan. All specialist are in the process of under taking job role review and skill mix.			
Current Staffing Risks and Narrative:			
None			
Completed By:	Claire Williams	**Date:**	11.04.2025

Appendix 11

Divisional e-Rostering KPI Reports total compliance scores and trend for rosters up to and including the Rostering period from the 9th December 2024.

Acute Adult Care Division:

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%	38.24%	44.61%	39.62%	41.82%								
A&E Majors (0419)	10.00%	0.00%	10.00%	10.00%	20.00%								
A&E Minors (0422)	40.00%	30.00%	40.00%	40.00%	50.00%								
A&E Paeds (0423)	50.00%	10.00%	30.00%	20.00%	50.00%								
CCU (Coronary Care Unit) [0121]	40.00%	60.00%	50.00%	50.00%	50.00%								
CDU (Clinical Decisions Unit) (0420)	40.00%	20.00%	40.00%	40.00%	50.00%								
Discharge Unit (0415)	100.00%	70.00%	80.00%	60.00%	40.00%								
SDEC (0404)	60.00%	40.00%	40.00%	70.00%	50.00%								
Ward A4 (0214)	60.00%	60.00%	40.00%	40.00%	50.00%								
Ward B1 [0206]	30.00%	50.00%	60.00%	10.00%	50.00%								
Ward B3 (0408)	60.00%	20.00%	40.00%	40.00%	30.00%								
Ward N3 (0208)	40.00%	50.00%	50.00%	50.00%	30.00%								
Ward C1 [0105]	60.00%	50.00%	50.00%	60.00%	50.00%								
Ward C2 [0109]	30.00%	50.00%	70.00%	60.00%	30.00%								
Ward C3 [0115]	60.00%	40.00%	60.00%	50.00%	30.00%								
Ward C4 (0216)	30.00%	70.00%	40.00%	40.00%	30.00%								
Ward D1 (0409)	50.00%	30.00%	30.00%	40.00%	30.00%								
Ward D2 (0411)	40.00%	40.00%	50.00%	50.00%	40.00%								
Ward D3 [0117]	40.00%	30.00%	40.00%	30.00%	60.00%								
Ward D4 [0119]	70.00%	20.00%	30.00%	10.00%	30.00%								
Ward H3 - Stroke [0204]	50.00%	50.00%	20.00%	30.00%	50.00%								
Escalation Ward R1 (0309)	100.00%	30.00%	70.00%	60.00%	70.00%								
Ward B2 (0207)	30.00%	0.00%	50.0%	20.0%	30.0%								

Anesthetics and Surgery Division:

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	50.85%	42.52%	44.88%	43.31%	46.46%								
Anaesthetics (ODP) (1910)	71.43%	71.43%	57.14%	42.86%	57.14%								
Critical Care Unit (1935)	50.00%	50.00%	50.00%	30.00%	60.00%								
Day Care Surgery DCU (1931)	80.00%	70.00%	70.00%	70.00%	60.00%								
Elective Care Centre - First Floor (0703)	60.00%	30.00%	50.00%	40.00%	60.00%								
ENT F6 (1515)	30.00%	20.00%	50.00%	50.00%	50.00%								
Ophthalmology Department (1003)	70.00%	50.00%	60.00%	40.00%	60.00%								
Orthopaedic Female F4 (0707)	100.00%	40.00%	20.00%	30.00%	30.00%								
Orthopaedic Male E4 (0705)	50.00%	40.00%	30.00%	40.00%	30.00%								
Recovery (1910)	70.00%	40.00%	70.00%	80.00%	50.00%								
Surgery E3 (1513)	30.00%	40.00%	40.00%	70.00%	30.00%								
Surgical Assessment F3 (1529)	30.00%	50.00%	20.00%	20.00%	30.00%								
Surgical Care Unit 2 (SCU2) (1517)	30.00%	20.00%	30.00%	20.00%	60.00%								
Theatres Scrub (1909)	40.00%	40.00%	40.00%	30.00%	30.00%								

Integrated Community Services Division:

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	56.25%	48.75%	46.25%	49.35%	41.25%								
Central North Neighbourhood [3925]	60.00%	40.00%	40.00%	30.00%	40.00%								
Central South Neighbourhood [3924]	60.00%	30.00%	30.00%	40.00%	20.00%								
District Nursing - Evenings & Nights (38	60.00%	80.00%	60.00%	90.00%	70.00%								
East Neighbourhood [3918]	20.00%	20.00%	10.00%	40.00%	10.00%								
Laburnum Lodge (3818)	50.00%	60.00%	50.00%	60.00%	30.00%								
North Neighbourhood [3919]	60.00%	50.00%	70.00%	60.00%	50.00%								
South Neighbourhood [3921]	80.00%	60.00%	50.00%	28.57%	60.00%								
West Neighbourhood [3926]	60.00%	50.00%	60.00%	40.00%	50.00%								

Diagnostic and Support Services Division:

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	61.33%	56.45%	59.68%	53.85%	53.85%								
Infection Control (5103)	57.14%	57.14%	71.43%	57.14%	57.14%								
Infection Control Community (4002)	85.71%	85.71%	71.43%	57.14%	85.71%								
Nurse Led IV Access Service [5102]	70.00%	71.43%	85.71%	60.00%	80.00%								
OPD General Nursing (3205)	70.00%	50.00%	50.00%	60.00%	70.00%								
Pharmacists (6201)	57.14%	42.86%	57.14%	42.86%	14.29%								
Pre Op Assessment Outpatients (3207)	80.00%	50.00%	70.00%	60.00%	50.00%								
Radiography (4303)	28.57%	28.57%	14.29%	14.29%	14.29%								
0	40.00%												
Ultrasound (4309)	57.14%	71.43%	57.14%	71.43%	42.86%								

Family Care Division:

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	41.12%	39.25%	43.93%	42.99%	33.64%								
Antenatal - Ward G3 [3004]	60.00%	60.00%	50.00%	60.00%	40.00%								
Antenatal Clinic - ANDU [3009]	50.00%	40.00%	60.00%	40.00%	30.00%								
Central Delivery Suite (CDS) [3011]	40.00%	40.00%	30.00%	30.00%	30.00%								
Community Midwives (3007)	20.00%	40.00%	40.00%	40.00%	40.00%								
Maternity Triage (3017)	60.00%	50.00%	40.00%	60.00%	50.00%								
Neonatal Unit [3013]	30.00%	30.00%	40.00%	40.00%	30.00%								
Perinatal Mental Health Midwives [301	71.43%	71.43%	71.43%	71.43%	57.14%								
Postnatal G4 [3005]	60.00%	20.00%	40.00%	30.00%	30.00%								
Specialist Midwives [3002]	30.00%	30.00%	40.00%	20.00%	20.00%								
Ward E5 [2309]	20.00%	0.00%	20.00%	30.00%	20.00%								
Ward M1 [3101]	20.00%	60.00%	60.00%	60.00%	30.00%								

Appendix 12

Summary of Current Nurse Staffing Risks

Division	Specialty	Risk No.	Department	Title	Risk Score	Target Date
Acute Adult Care	Emergency Care	6133	A&E - Adult	Mental Health Patent in ED - Observations	16	31/05/2025
Family Care	Gynaecology	6443	M1 And M6 Gynae & Early Pregnancy	Reduced skilled staffing (B7) across Gynae specialty due to retirement and LTS	15	30/04/2025
Family Care	ICPS (Integrated Community Paediatric Service)	5266	ICPS - Paed Special Schools	Paediatric nursing staffing for special school provision	12	01/08/2025
Family Care	Acute Paediatrics	5505	Ward E5 (Children's Unit)	Acute Paediatric Nursing Provision	12	04/04/2025
Anaesthetics & Surgical	Acute Pain Team	3085	Acute Pain Team	Acute Pain Service Delivery currently is a 5-day a week service.	10	30/06/2025
Anaesthetics & Surgical	General Medicine	6425	Ward B4	B4 staffing model	9	23/04/2025
Acute Adult Care	Cardiology	5612	Cardiac Liaison Team	Delays to review and treat heart failure patients	9	31/12/2025
Diagnostic & Support Services	Pre Admission	6241	Pre Assessment (Bolton One)	Meeting pre-op capacity v demand	9	31/03/2025
Diagnostic & Support Services	Radiology	6399	Imaging - Nuclear Medicine	Current Radiology Nurse/Stress Leader set to retire 31st March 2025. Leaving only 1 other qualified stress leader to run the Myocardial Stress Sessions. Unable to run full cardiac service without the correct number of suitably qualified staff, without compromising patient safety.	9	26/05/2025
Family Care	ICPS (Integrated Community Paediatric Service)	6381	ICPS - Reactive Team	ICPS Reactive Inadequate Staffing and Impact on Responsiveness	9	04/07/2025
Integrated Community Services	Community Nursing	6444	IV Therapy Team	IV Team staffing	9	31/07/2025
Family Care	Sexual Health	6057	Sexual Health - BCSH	Staffing concerns within HCA, Band 4 and reception staff groups at Bolton Sexual Health	8	31/03/2025

Family Care	ICPS (Integrated Community Paediatric Service)	5233	ICPS - Proactive Team	ICPS continuing care team reduced staffing levels and workforce stress	8	06/06/2025
Family Care	Paediatric Learning Disability	6346	Paed Learning Disability Service	PLDS reduced staffing	6	13/07/2025
Family Care	Neonatal Services	5128	Neonatal Unit (NICU)	Neonatal Nursing Staffing	6	30/05/2025
Anaesthetics & Surgical	General Medicine	6390	Ward B4	Senior staff allocation to ward B4 (Winter Escalation Ward)	6	23/05/2025
Acute Adult Care	Administration / Clerical	5376	Acute Adult Divisional Office	Nursing and HCA staffing Levels	6	31/12/2025

Appendix 13

Inpatient Heat Map Summary October – December 2024 (please note the new Heat Map launched in October 2024, so only three instead of six months of data is represented in this report).

	Indicator	Target	Oct-24	Nov-24	Dec-24
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	94.5%	94.5%	94.5%
	C - Diff	*Target = 0*	6	7	3
	MSSA BSIs	*Target = 0*	1	2	2
	E.Coli BSIs	*Target = 0*	5	3	4
	MRSA acquisitions	*Target = 0*	5	9	7
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	89	62	78
	Harms related to falls (moderate+)	*Target = 1.6*	3	1	0
	New pressure Ulcers (Category 2)	*Target = 0*	17	9	20
	New pressure Ulcers (Category 3)	*Target = 0*	0	5	9
	New pressure Ulcers (Category 4)	*Target = 0*	0	0	0
Patient Experience	FFT Response Rate	*Target = 30%*	27.2%	32.4%	44.5%
	FFT Recommended Rate	*Target = 97%*	95.1%	92.1%	95.2%
	Number of complaints received	*Target = 0*	0	11	10
Governance	Incidents > 14 days, not yet signed off	*Target = 0*	106	116	157
	Harm related to Incident (Moderate+)	*Target = 0*	0	1	0
	Overdue Duty of Candour	*Target = 0*	0	0	0
Staff Development	Appraisals	*Target = 85%*	91.3%	89.8%	87.9%
	Statutory Training	*Target = 95%*	94.6%	94.7%	93.7%
	Compulsory Training	*Target = 85%*	92.5%	93.5%	90.7%
SafeCare Compliance and Red Flags	SafeCare Compliance	*Target = 95%*	75.6%	68.1%	67.6%
	Omission in providing medications		0	0	0
	Delay in providing medications		1	0	0
	Vital signs not assessed/recorded		1	0	0
	Missed care provision		13	1	1
	Less than 2 RNs on shift		3	4	1
	Shortfall in RN time		32	26	9
	Delay in discharging		4	1	0
	Total Red Flags		58	32	11
Staffing & Workforce	% Qualified Staff (Day)		93.6%	95.7%	95.5%
	% Qualified Staff (Night)		98.1%	101.6%	102.2%
	% un-Qualified Staff (Day)		96.1%	97.8%	99.2%
	% un-Qualified Staff (Night)		116.7%	114.5%	112.9%
	Registered Agency % (Day)		2.0%	2.3%	1.9%
	Registered Agency % (Night)		1.1%	1.1%	2.1%
	Care Hours Per Patient Per Day (CHPPD)			11.75	10.0%
	Sickness (%)	*Target < 4.2%*	7.49%	6.46%	7.22%

Report Title:	Maternity Bi-Annual Staffing Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		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 staffing review for the period July to December 2024.

Previously considered by:	People Committee

Executive Summary	This report details the findings of the Bolton Foundation Trust 2024 bi-annual maternity staffing review. • This report provides assurance that the Birth Rate Plus review of maternity staffing levels was last undertaken in 2022 and is due to be repeated in autumn of 2025. • The funded establishment of 282.95WTE (inclusive of skill mix) is in accordance with the 2023 Birthrate Plus report recommendations of 283WTE and recruitment is underway to appoint to the total establishment during 2025 in line with re-opening of current reduced capacity. • There were no reported breaches of the supernumerary co-ordinator standard during the July – December 2025 period. • One to one care in labour compliance rates remained below the 100% standard throughout July – December 2024, due to the ongoing yet decreasing vacancy position circa 20WTE during this period. An action plan is detailed within this report. • The 2024 maternity survey results highlighted a significant improvement in the experience reported by service users when compared to the 2023 survey findings. In summary, the report highlights the ongoing maternity workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance in order to provide assurance of a safe maternity service. 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.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Maternity Bi-Annual Staffing 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		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

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

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 2024 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 2025) 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.

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 clinical areas is planned for March 2026 and 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 2023 Birth Rate Plus 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.

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 of 282.95WTE (inclusive of skill mix) is in accordance with the 2023 Birthrate Plus report recommendations of 283.07WTE and recruitment is underway to appoint to the total establishment during 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.

Monthly establishment reconciliations continue to be shared with the service that detail the funded and vacant positions within the funded establishment. In October 2024 a reconciliation of the funded establishment was undertaken by the Director of Midwifery and midwifery clinical leaders to align staffing with the agreed funding uplift to meet the Birth Rate Plus 2023 report recommendations as detailed in Appendix 2. The reconciliation confirmed a funded establishment of 282.95WTE with appropriate skill mix applied

Since the last Birth Rate Plus report was published in 2023 the clinical activity has remained static, capacity issues have continued 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 July 2024 – December 2024 continued to be managed on Delivery Suite, significantly impacting upon patient flow within the maternity unit. The lack of flow 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. It is anticipated that bed capacity issues will ease following the opening of the alongside birthing centre and enhanced maternity triage area in 2026 followed by the re-opening of the refurbished first floor of the maternity unit with increased bed capacity in 2027.

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 October 2024 26.19WTE 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 (26.19WTE) is therefore within the recommended

specialist midwifery requirements. The specialist workforce calculation includes a 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

The 2023 report advised the overall ratio that should be applied to the service at Bolton based upon activity and acuity in all inpatient areas is to 1:23. 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. 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 July and December 2024 was higher than the required 2023 Birthrate standard, with bank and agency usage being used to mitigate the ongoing staffing vacancy factor of circa 20WTE during this period.

Table 2: Midwife to birth ratio

Indicator	Goal	Red Flag	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Midwife/ Birth Ratio (rolling) target changed July 21	1.23	1.3	1:22.6	1:22.9	1:22.8	1:21.9	1:21.3	1:21.1
Midwife /birth ratio (rolling) actual worked Inc. bank	information only		1:21.3	1:21.5	1:21.5	1:20.9	1:20.5	1:20

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%.

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 undertaken in October 2024. The review included the Director of Midwifery, Maternity Matrons with finance colleagues and considered:

- Acuity requirement
- Ward/Dept leadership
- Ward/Dept layout and environment
- Additional specific training requirements
- Support of carers/patients

In response to the professional judgement review undertaken all roster templates were aligned to meet the Birth Rate Plus 2023 report recommendations. The rosters were not implemented during the July – December 2024 period.

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 July – December 2024.The dashboard reflects a reduction in maternity diverts with 2 incidents during the period of review.

The maternity dashboard indicators reflect a challenged yet improving service during the period July - December 2024. One to one care in labour compliance rates remained below the 100% standard, due to the ongoing yet decreasing vacancy position circa 20WTE during this period. 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.

Performance with regard to the booking of women prior to 12+6 week gestation fluctuated during the period July - December 2024 within the community setting with improvement in the metric seen in December 2024 attaining 91.4%. Work remains ongoing to introduce a digital self-referral tool in the service to improve the booking process. 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.

Local variation in the incidence of stillbirth was identified on the Trust integrated performance dashboard in July and December 2024 GMEC data highlighted a quarterly improvement in Trust performance in December 2024 when comparing performance from the previous two quarters and highlighted an improvement decreasing from 4.73/1000 to 3.12/1000.

A detailed review of 21 stillbirth cases that occurred in 2023/2024 was completed in response and presented to Quality Assurance Committee on the 22 January 2025 with a detailed action plan of ongoing actions. Key areas of ongoing improvement focus identified within the review

included implementation of all six elements of the saving babies lives care bundle version 3 (evidence based measures to improve perinatal mortality and morbidity outcomes) and implementation of REACH pregnancy circles for women in deprived areas between 24-27 weeks gestation.

The Trust incidence of Obstetric Anal Sphincter Injury (OASI) (3rd and 4th degree) tears was flagged on the Trust dashboard on three occasions during the period July to December 2024 with a sustained improvement noted in September – November 2024. Learning from best practice continues to be shared in the local maternity system and £107k was awarded to the service to establish a GMEC perinatal pelvic health service at Bolton that will serve population of Bolton and receive referrals from other Trusts.

Table 3 - Critical Safety Indicators

Indicator	Goal	Red Flag	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Critical Safety Indicators								
Stillbirths per 1000 births (per month) as of January 24, (including TOP)	3.5	≥4.3	4.8	2.3	2.2	4.5	2.7	9.2
HIE Grades 2&3 (Bolton Babies only)	0	1	1	1	0	0	0	0
% Completed Bookings by 12+6 BI calculation	90%	<90	89.40%	89.40%	91.72%	85.70%	89.30%	91.90%
ICU/ HDU Admissions	Information only		0	0	1	0	0	0
Post-Partum Hysterectomy	0	>1	0	0	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	7	3	9	4	0
1:1 Midwifery Care in Labour	95%	<90%	99.0%	99.7%	99.7%	99.1%	98.5%	97.8%
% Instrumental Vaginal Deliveries (% of Total Deliveries)	<=13%	15%	12.90%	10.79%	9.34%	13.13%	9.41%	10.11%
3rd /4th Degree Tears (rate in month)	3%	>3.1%	3.91%	3.07%	2.16%	2.49%	1.08%	3.48%
3rd / 4th degree tears (12 month rolling)	3%	>3.1%	3.2%	3.1%	3.1%	2.8%	2.7%	2.8%

Breastfeeding Initiated within 48 Hours	65%	<65%	71.2%	64.4%	68.9%	71.4%	66.9%	69.4%
PSII (Inc. MNSI Lead)	Information only		0	0	0	0	0	0
MNSI	Information only		2	1	0	0	0	0
Access Standards								
Unit Closures	0	1	0	0	1	0	1	0

4. Expectation 2 – Right Skills

Mandatory and statutory staff training compliance during the period July - December 2024 remained below the Trust standard due to a Registered Midwife vacancy position of circa 20WTE. In response the service had to prioritise profession specific elements of essential training namely emergency skills training and fetal monitoring training within the service.

The dashboard highlights deficiencies in the professional specific training compliance during the period July – December 2024 that were reflective of the staffing challenges during this period. Assurance can be provided of attainment of the required 90% standard with PROMPT, fetal monitoring and newborn life support training compliance by the 30 November 2024. Table 4 highlights compliance as of 01 December 2024 with additional information detailed in Appendix 4.

Table 4 – Training compliance as of 1 December 2024

Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	100.00%	NA	100.00%	100.00%	100.00%	97.44%	100.00%	NA	NA	NA	100.00%	100.00%
Fetal Monitoring GMEC Comp. Assessment	99.36%	NA	100.00%	100.00%	NA	NA	99.23%	NA	NA	NA	NA	NA
Neonatal Life Support	97.74%	100.00%	NA	NA	NA	NA	96.92%	100.00%	100.00%	99.14%	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.

Assurance can be provided that 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. Table 5 shows gaps in Registered Midwife staffing levels on G3, despite use of bank and agency usage the fill rates on ward G3 during the period July – December 2024. There was a notable overfill of non-registered staff during the day prior to the realignment of the staffing templates undertaken in September / October 2024. This followed the final reconfiguration of the ward areas in March 2024 in response to the finding of reinforced aerated concrete in the service in December 2023. In response the roster template for the clinical areas was reviewed in October 2024.

Table 5: Planned versus actual fill for maternity ward inpatient areas.

Ward/Team	Grade Type Category	Day/Night	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
			Fill %	Fill %	Fill %	Fill %	Fill %	Fill %
Central Delivery Suite (CDS) [3011]	Registered	Day	92.66%	93.46%	93.46%	101.91%	98.90%	97.45%
	Non-Registered	Day	84.07%	83.75%	83.75%	86.28%	79.10%	89.90%
	Registered	Night	87.16%	82.95%	82.95%	79.22%	78.96%	93.48%
	Non-Registered	Night	90.20%	95.55%	95.55%	96.69%	94.85%	92.77%
Antenatal - Ward G3 [3004]	Registered	Day	86.57%	88.95%	88.95%	75.68%	80.51%	73.37%
	Non-Registered	Day	177.78%	183.92%	183.92%	169.47%	183.72%	181.91%
	Registered	Night	71.20%	73.12%	73.12%	77.50%	77.87%	60.08%
	Non-Registered	Night	94.50%	100.00%	100.00%	105.06%	96.65%	103.33%
Postnatal G4 [3005]	Registered	Day	95.22%	72.14%	72.14%	84.69%	88.16%	103.08%
	Non-Registered	Day	66.57%	80.27%	80.27%	78.43%	84.69%	92.22%
	Registered	Night	68.70%	59.98%	59.98%	93.78%	72.50%	88.87%
	Non-Registered	Night	61.24%	92.68%	92.68%	98.19%	98.89%	92.03%

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.

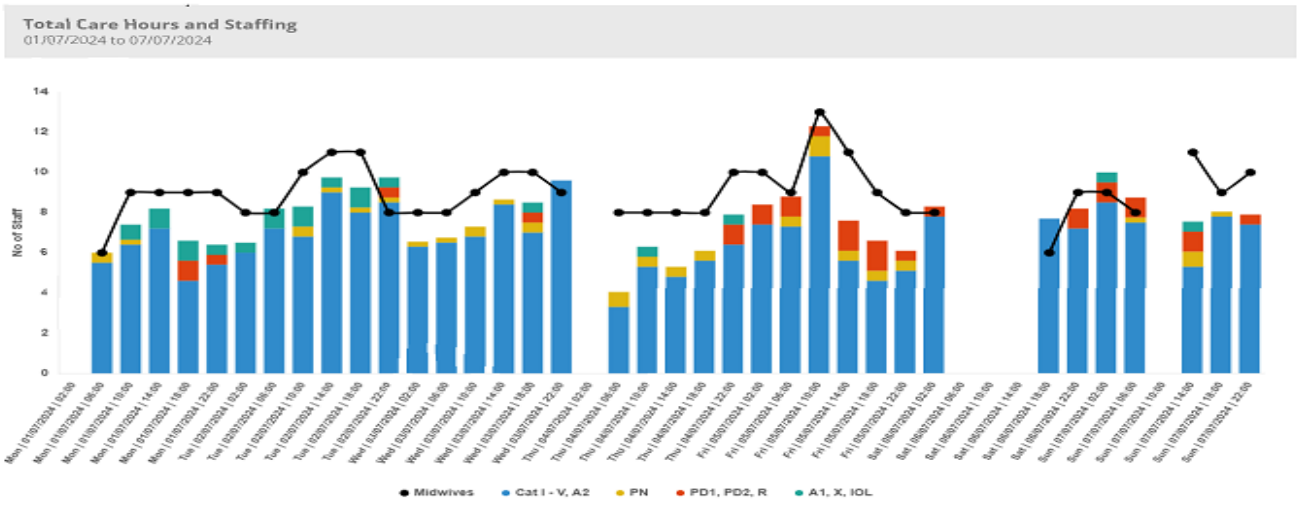
- Incident reporting system is used to report staffing incidents and all red flag incidents are audited on a quarterly basis.
- Regular reviews with ward managers, Matrons, Assistant Divisional Midwifery and Nursing Director and the Director of Midwifery
- Daily operational safety huddle meetings are 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 as an example from July 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 – July 2024



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.

Non-recurrent £37k of funding was awarded by the Local Maternity and Neonatal System via contract variation in December 2024 to fund a support worker within the enhanced midwifery team, who provide care to the most vulnerable women with the highest level of safeguarding which will release midwifery time. The monies have been used to introduce advocacy during intrapartum care. Additional funding was also awarded to support the clinical development of staff working in this team and fund PROMPT community midwifery training and to introduce Pregnancy Circles to the most vulnerable women in our care.

5.4 Workforce Metrics

The sickness absence data for the period July – December 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 2024

Indicator			July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Monthly percentage sickness	4%	>=4.75%	7.14%	6.31%	5.72%	7.19%	5.66%	5.87%

5.5 Red Flags

Nationally reported 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. In total 462 red flag events were reported during the period July – December 2024 with the majority relating to delayed activity caused by the reduction in bed capacity within the service.

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 identified in the clinical audit undertaken using the Birth Rate Plus acuity tool during the period July - December 2024.

Table 8 highlights compliance with the standard throughout the July - December 2024 period. Indicator RF9 extracted from the Birthrate Plus acuity tool confirms no breaches of the required supernumerary standard during the period July - December 2024.

Table 8: Supernumerary status episodes of non-compliance (per shift)

Number of Red Flags recorded
01/07/2024 to 31/12/2024

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	6	1%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay of >30 minutes between presentation in triage and review	1	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	0%
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	Coordinator unable to maintain supernumerary status	0	0%
RF11	11. Delivery suite co-ordinator is not supernumerary and is NOT providing 1:1 care	2	0%
RF12	12. Delay of 24 hrs in accessing CDS for continuation of IOL once identified as ready for transfer	449	97%
TOTAL		462	

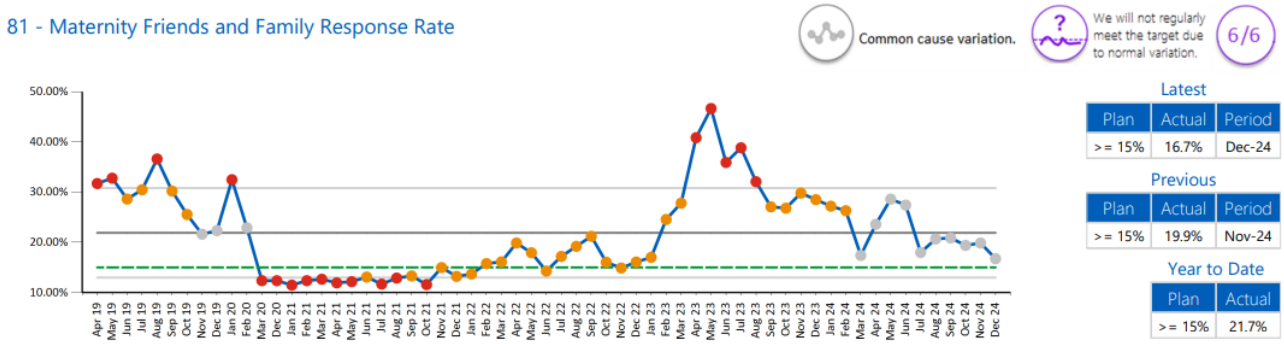
*The % is rounded to nearest whole number

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 deterioration in the response rate was noted during the period July - December 2024. The service commenced transfer to digital collection methods in June 2024 in response to issues relating to delays in the manual data inputting and has since introduced a QR digital code and a collection system at mealtimes to improve the response rate.

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.

Themes from the 2024 CQC Maternity Care Survey

The CQC national Maternity Survey 2024 results were published on 28 November 2024.

Bolton Foundation Trust received a CQC rating of 'about the same' as other providers for all metrics with no positive or negative outliers. The scores for Bolton NHS Foundation Trust were predominantly better than the sector scores.

At question level, when compared to other organisations surveyed by IQVIA, 12 scores were in the top 20% range. 39 scores (60%) were in the intermediate range and 5 were in the bottom range. The 2024 results highlighted a significant improvement in the experience reported by service users when compared to the 2023 survey findings when only 4 of the scores were in the top range and 22 of the results were in the bottom range.

Recommended areas of focus

IQVIA recommended the following areas of focus for the service in response to the findings of the survey. To be noted some of the areas of focus have been addressed by the actions taken prior to publication of the report.

Antenatal Care

- Review why some patients said they did not receive sufficient support for their mental health during their pregnancy. Evaluate the range of support services provided, and how this information is communicated, ensuring it is clear, accessible, and meets a variety of patient needs.

Labour and the birth

- Examine the reasons why some patients felt that they received insufficient support with pain management during labour and birth. Assess the data in more detail to highlight areas where this is of most concern.

- Review the process of dealing with patient concerns, given that some patients did not feel that the concerns they raised during labour and birth were taken seriously. Ensure patients are actively listened to when raising concerns and that the response or outcome is communicated clearly.

- Review the question breakdowns to see which stage of labour women felt they were left alone. To reduce concerns, always explain why staff are leaving and when they will return.

- Prioritise addressing why some patients said they did not receive help from staff during labour and birth when they needed it.

- Examine staffing levels and resourcing to ensure there is support available in order to meet patient needs – work ongoing.

Significant work had already been undertaken within the service to address the issues highlighted in the report prior to publication of the survey findings, this has included funding approval to reinstate the alongside birth centre within the service, the extension of visiting hours for families and funding to uplift the midwifery and infant feeding team establishments. In response to the audit findings a review of the additional survey findings has been undertaken in conjunction with the maternity and neonatal voice partnership.

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 in 2022 and published in 2023.

This report provides assurance that the funded midwifery staffing establishment as of October 2024 aligned with the 2023 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 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 circa 20WTE during this period.

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 be enacted in March 2026 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 October 2024 to align with the Birth Rate Plus 2023 report recommendations

	Birthrate Plus WTE	Revised Proposed Health Roster	Current Est
Band 7	231.61	22.56	22.20
Band 6		187.21	180.06
MSW – Band 3	25.73	22.14	5.20
Band 2 (not included in BirthRate+)			
Of which Clinical Specialist:-			
Band 8a		1.60	1.60
Band 7		4.01	4.00
Band 6		14.58	11.14
Band 4		4.00	4.00
Band 3		2.00	1.00
Total	**257.34**	**258.10**	**229.20**
Non-Specialist & Mgt:-	25.73		
Band 9		1.00	1.00
Band 8c		1.00	1.00
Band 8b		1.00	1.00
Band 8a		5.40	5.40
Band 7		14.45	10.74
Band 6		2.00	1.80
BirthRate+	**283.07**	**282.95**	**250.14**

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**	**July 24**	**Aug 24**	**Sep 24**	**Oct 24**	**Nov 24**	**Dec 24**
Shifts covered by NLS trained staff	Information only		81%	80%	94%	89%	98%	96%
Medical Device Compliance Training Midwifery why so low	95%	80%		55.00%			85.00%	
Safeguarding compliance level 3	95%	80%	60.78%	60.43%	69.85%	74.92%	76.10%	84.19%
Safeguarding supervision outreach only	Information only		94.00%	94.00%	94.00%	94.00%	100.00%	100.00%
PROMPT training (added Oct 21) (CNST requirement)	90%	<90%	86.22%	83.00%	85.10%	89.00%	100.00%	99.00%
Fetal monitoring training compliance (overall) (CNST requirement)	90%	<90%	87.40%	88.00%	83.62%	90.00%	90.00%	92.00%
Return to work interview percentage completed (number due and completed in comments please)	Information only		54.29%	52.50%	55.88%	59.38%	60.78%	73.17%
Exit Interview percentage completed (number due and completed in comments please)	Information only		33%	25%	20%	25%		20%
Monthly percentage sickness	4%	>=4.75%	7.14%	6.31%	5.72%	7.19%	5.66%	5.87%
Compulsory Training	95%	<95%	87.96%	88.16%	88.76%	89.15%	89.88%	89.48%
Mandatory Training	85%	<80%	88.18%	84.02%	84.73%	86.55%	87.51%	87.09%
Completed Staff Appraisals	85%	<=75%	95.00%	94.22%	95.03%	92.98%	93.79%	90.44%

Report Title:	Combined Mortality and Learning from Deaths update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Medical Director		Decision	

Purpose of the report	This report will provide an update on the current risk adjusted mortality and an update on Learning from Deaths.

Previously considered by:	Clinical Governance and Quality Committee and Quality Assurance Committee

Executive Summary	From September 2024, updates on Mortality and Learning from Deaths (LfD) are reported together, with this being the third combined report. **Mortality**: The latest SHMI (November 2023–October 2024) for Bolton is 118.34, placing it in the 'higher than expected' range and showing an increase from 117.65. This rise is primarily due to a national methodology change, which caused a 3.8% shift in SHMI between December 2022 and November 2023. An action plan has been developed to address four key areas: diagnosis accuracy, Charlson comorbidity recording, coding capacity, and quality assurance. **Learning from Deaths**: The LfD Committee, reporting into the Mortality Steering Group, has implemented revised governance from September 2024. Between November 2024 and January 2025, 313 deaths occurred, with 79 selected for primary review and 38 completed. Three secondary reviews were required this quarter; one has been completed with learning focused on advanced care planning. Nine secondary reviews remain outstanding from the previous quarter. Key themes from LfD include: 1. Response to deteriorating patients

	2. DNACPR decisions 3. Communication and documentation 4. Advance care planning 5. End-of-life recognition Action plans for both Mortality and LfD are detailed within the full report.

Proposed Resolution	The Board of Directors is asked to ***receive*** the combined Mortality and Learning from Deaths Update.

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:	Dr Rauf Munshi, Associate Medical Director Nicola Caffrey, Corporate Business Manager for the Medical Director Liza Scanlon, BI Michelle Parry, Clinical Audit and Effectiveness Manager	**Presented by:**	Dr Rauf Munshi, Associate Medical Director

Mortality

This paper will provide an update on the latest mortality data and the actions within the mortality action plan.

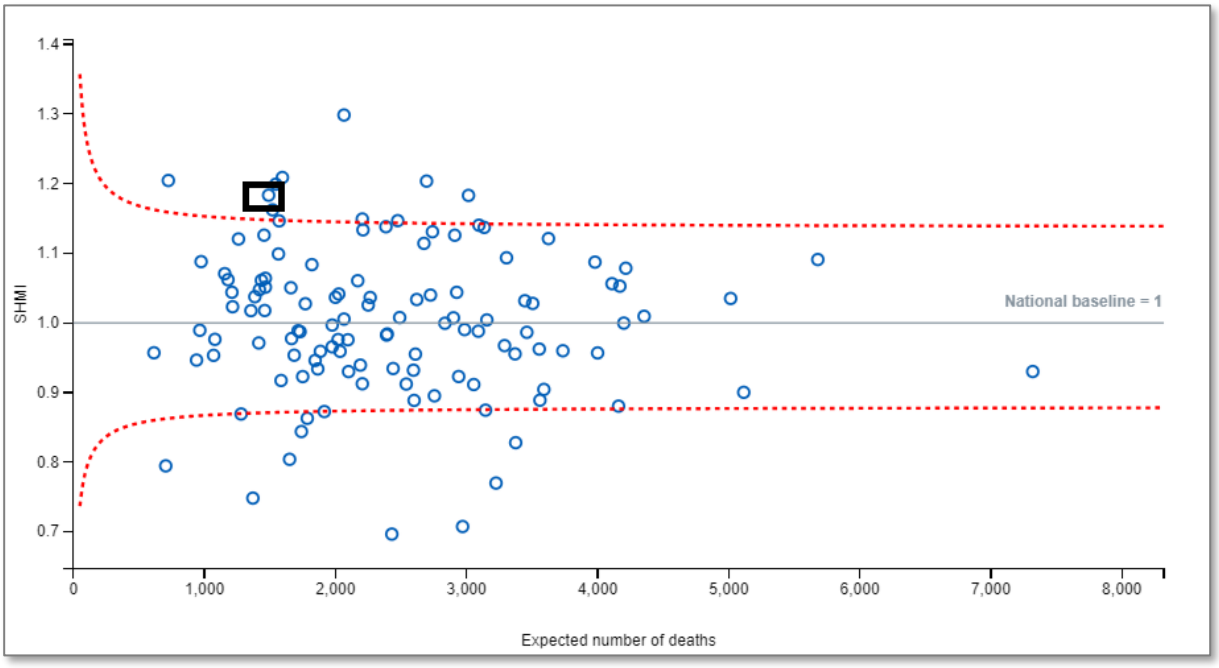
Data update for Quarterly mortality report - April 2025

HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator) are both monitored to provide a comprehensive view of hospital mortality, ensuring Trusts can identify areas for improvement and maintain high standards of care. HSMR focuses on the overall mortality rate compared to the expected rate and helps identify if a trust's mortality rate is better, worse, or as expected compared to the national average, while SHMI provides a more detailed, disease-specific analysis which can help pinpoint specific areas of focus for quality improvement initiatives.

Summary Hospital-level Mortality indicator – SHMI

NHS Digital data for SHMI (November 2023 to October 2024) shows Bolton at **118.34**, which is in the 'higher than expected' range. The SHMI has increased since the last reported figure of 117.65[1] [2].

Chart 1 – Funnel chart indicating SHMI position for Bolton FT compared to other NHS Trusts



[1] Patients with Covid are now included in SHMI if the discharge date is from September 2021. This is following a national change in the methodology from NHS Digital

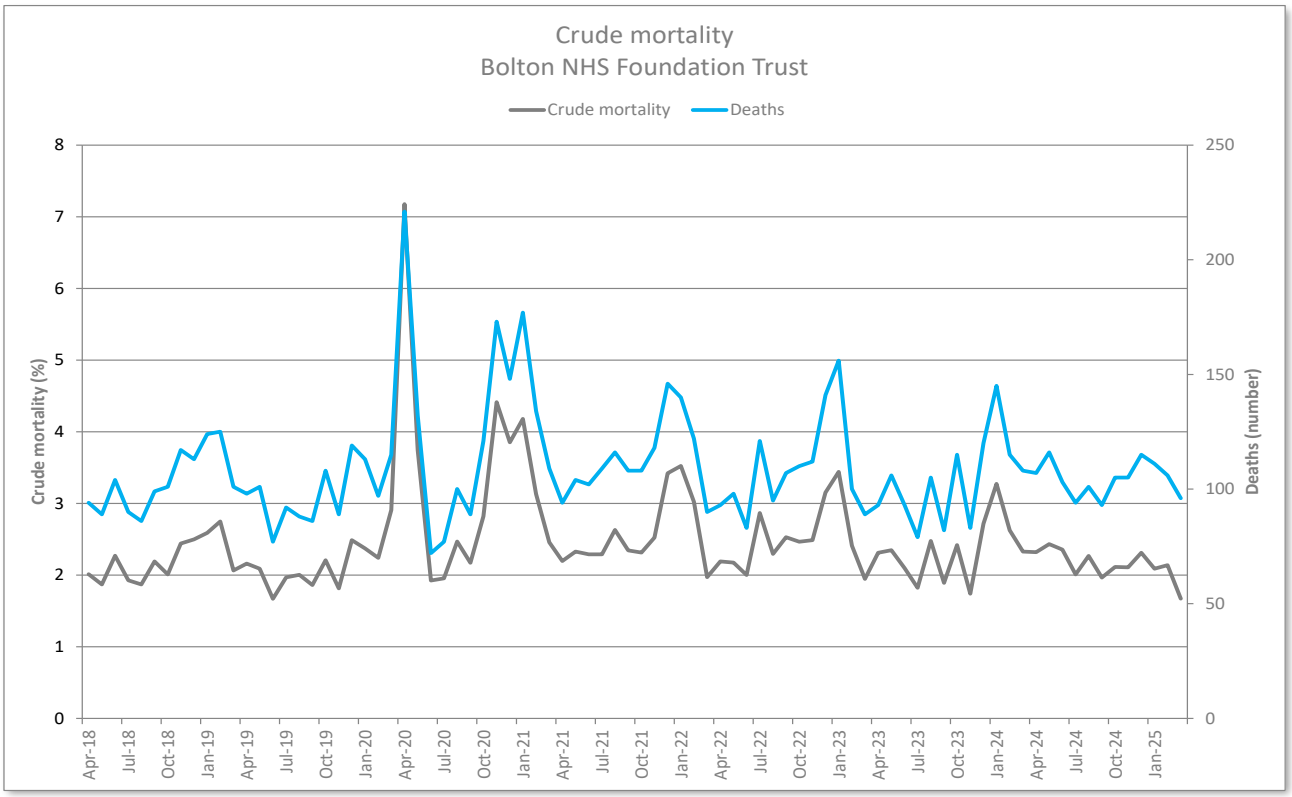
[2] All data in this section is published data from NHS Digital which includes patients who have 'opted out' of their data being shared for research purposes

Crude rate (excluding day cases)

Using the crude number of deaths as a proxy for the SHMI/HSMR positions indicates that there has not been a decrease in the recorded number of deaths at certain points during the year – usually the spring and summer months historically demonstrate where the number drops to less than 100 per month. This has not been the case in 2024 - whilst there has been a drop in deaths following the winter rise from May 2024 it is not to the same extent as in previous years and with the usual rise up towards winter occurring will mean that the numerator in SHMI and HSMR will not fall to give a corresponding fall in the rate.

The Bolton pattern is similar to that of peers, Greater Manchester and nationally where the winter peak of 2023/24 was lower but lasted longer. The winter peak over 2024/25 is substantially lower than the historical patterns of previous years (Covid excluded). There is a potential for this to demonstrate a reduction in the SHMI, over the next six months, although this is dependant on the status of other trusts' SHMI rates as this will impact the denominator.

Chart 2 – Crude Mortality Figure v's Actual Deaths



Outlying groups

The process of clinical and the coding team working together to check accurancy of primary diagnosis and comorbidity recording of alerting groups remains an improvement priority, but is dependant on the capacity of the coding team. This will impact the ability to provide the right and relevant assurance and ensure the learning part is improved with a requirement for dissemination and communication out via Division and clinical leads.

SHMI (January to December 2024)

Using control limits in line with NHS Digital any group alerting 'Red' would be outside of the 95% over dispersed confidence limit; 'Amber' over the 90% confidence limit.

Red Alert - Cancer of bronchus; lung
A clinical review of the records have been sent to the clinical lead for lung cancer

Amber alert - Invalid primary diagnosis
These would be uncoded records at the time of 'freeze' . The majority of the deaths were outside of the hospital within 30 days, deaths occurring in hospital are prioritised by coding team at the Trust. The majority of the uncoded deaths were August – November 2024 when although the deadline was hit there was a slight drop in the proportion of coded episodes due to the coding teams capacity, resulting in no risk adjustment being made.

December 2024 showed no uncoded episodes or deaths.

HSMR (January to December 2024)

Any diagnosis group alerting 'Red' would be outside of the 99.8% confidence limit, 'Amber' would be over 95%.

Amber alerts:

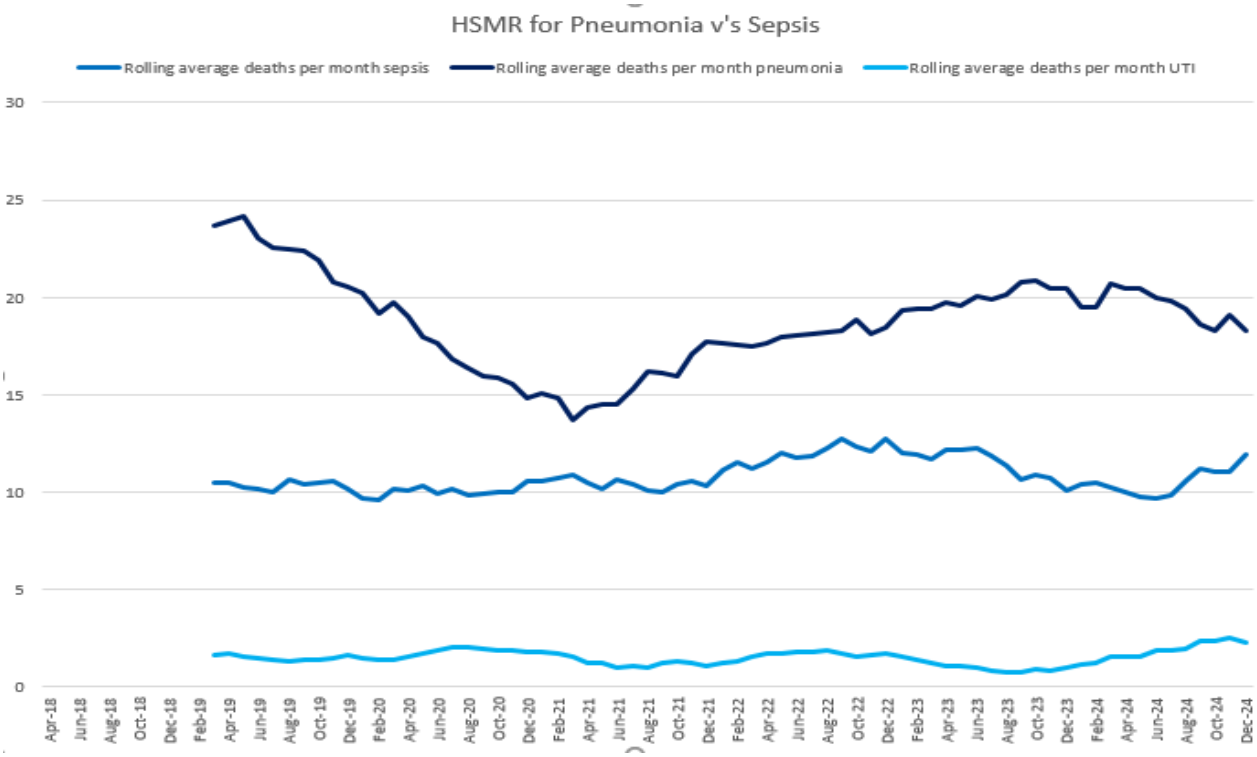
Other perinatal conditions

A deep dive of the records and a full clinical review was undertaken at the request of the Families Medical Director (information provided within Appendix C, which is the divisional report for families). A liaison link between CDS deaths and coding team has been established to improve the data quality and recording.

Urinary Tract Infections
A clinical review of the records will be undertaken by the relevant division with the update to be provided within the next mortality report.

Septicemia (except in labour)
A clinical review of the records will be undertaken by the relevant division with the update to be provided within the next mortality report. The increase is likely due to the under reporting of septicaemia historically and as the clinical teams focus on improving the primary diagnosis, this has resulted in a reduction in the pneumonia mortality but a concurrent increase in the septicaemia mortality.

Chart 3 – HSMR for Pneumonia v's sepsis



Update on pneumonia

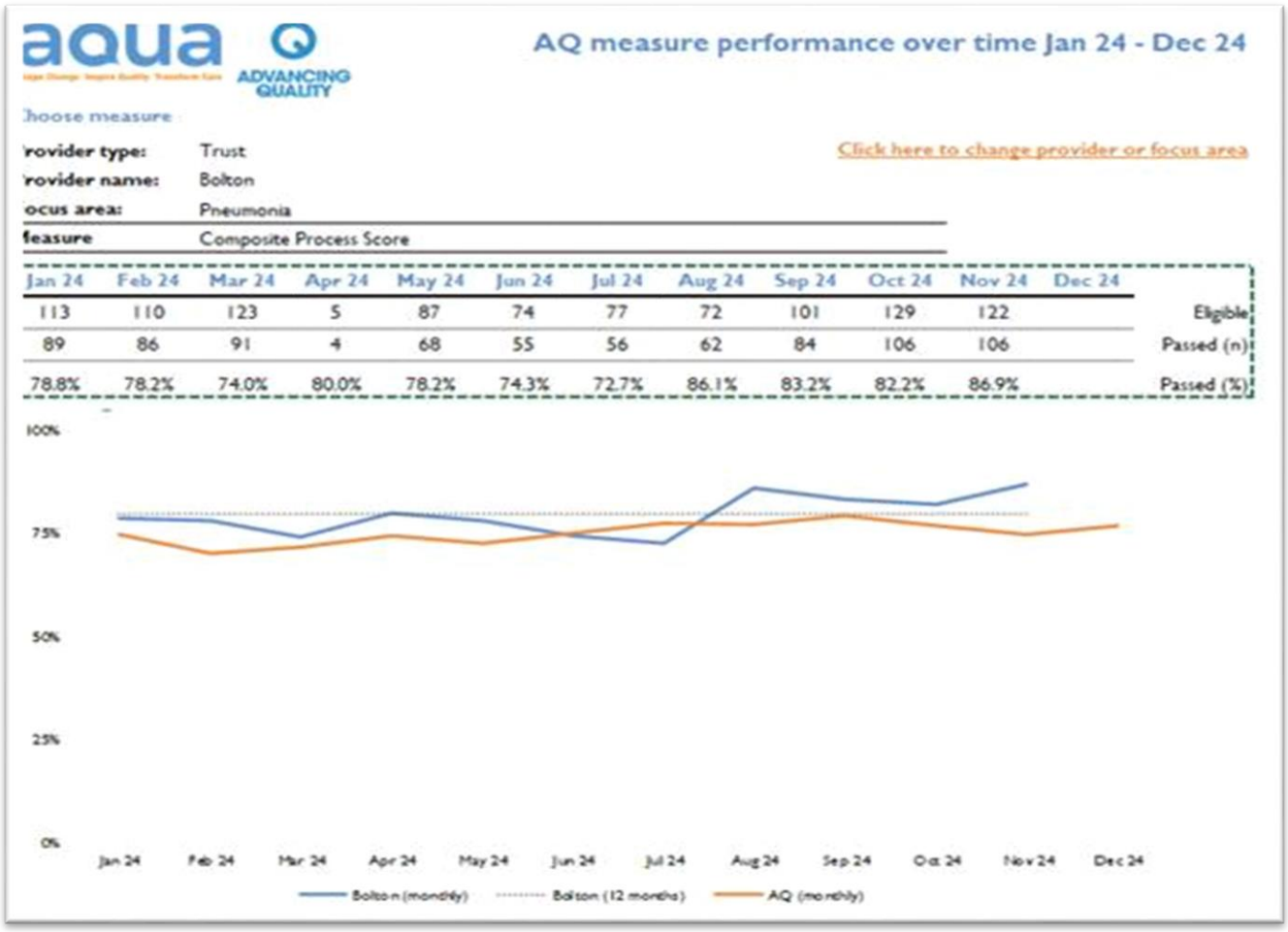
Pneumonia was previously a red alert for SHMI

Bolton NHS Foundation Trust continues to participate in the AQUA pneumonia audit and improvement work which provides assurance on the quality of care against national standards. Current performance is:

Oxygen assessment within four hours of arrival	99.1%
Chest x-ray within four hours of arrival	68.1%
Initial antibiotic received within 4 hours of hospital arrival	51.2%
CURB-65 Recorded	74.4%
Appropriate antibiotic selection	90.7%

The composite process score combines all the AQUA variables which are based on NICE guidance. The current composite score for all of the evidence based standards is 86.9%.

Chart 4 – Composite Process Score for Key Peformance Metrics January 24 – November 2024



The Emergency Department at Bolton FT introduced Rapid Assessment Treatment (RAT) model in April 2024 and subsequently, our performance has improved in comparission to both our previous ED performance and against other trusts in the North West that participate in the AQUA audits.

There are two areas of improvement activity identified within the data – time to chest x-ray and time to antibiotics. There is an expectation from the ED improvement team that this compliance will continue to increase aligned to the the improvements seen with the new initial RAT process and additionally demonstrate where other factors such as radiology delays are contributing to performance issues. The BI team are continuing to work through the data to support the programme team.

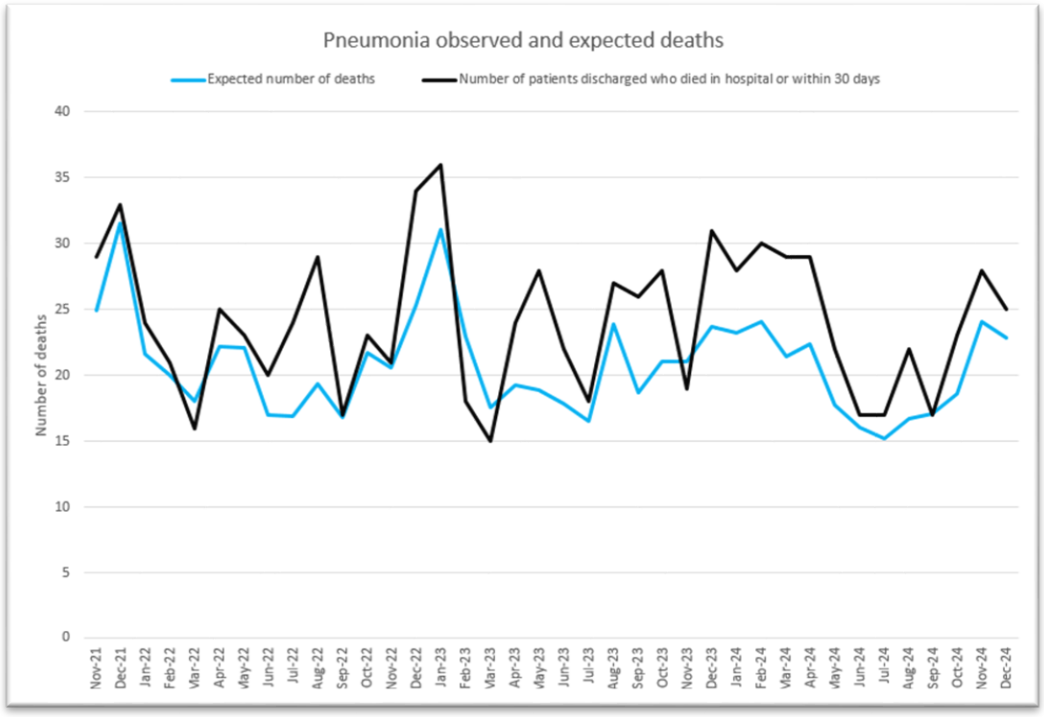
The ED team have recognised that patients with pneumonia go directly to other services, in particular medicine, which has not been included in this audit process. Acute medicine has been asked to provide similar audit data for patients with pneumonia seen directly in the assessment areas.

As part of the audit process, the respiratory consultants reviewed the pneumonia related deaths provided by BI to understand if the primary diagnosis recorded at the first completed episode was correct and concluded that:

- 12 out of 31 patients did not have evidence of consolidation on the chest x ray which would mean that 39% of pneumonia related deaths were incorrectly labelled as pneumonia.
- Cause of death in a significant proportion of cases are due to old age and frailty
- One third of patients had dementia
- Median age is about 86 years
- Significant proportion of patients died from their co-morbidities e.g. Cancer, MND, old age, frailty

This improvement is also indicated within the pneumonia observed and expected deaths improvements within the SHMI data sets.

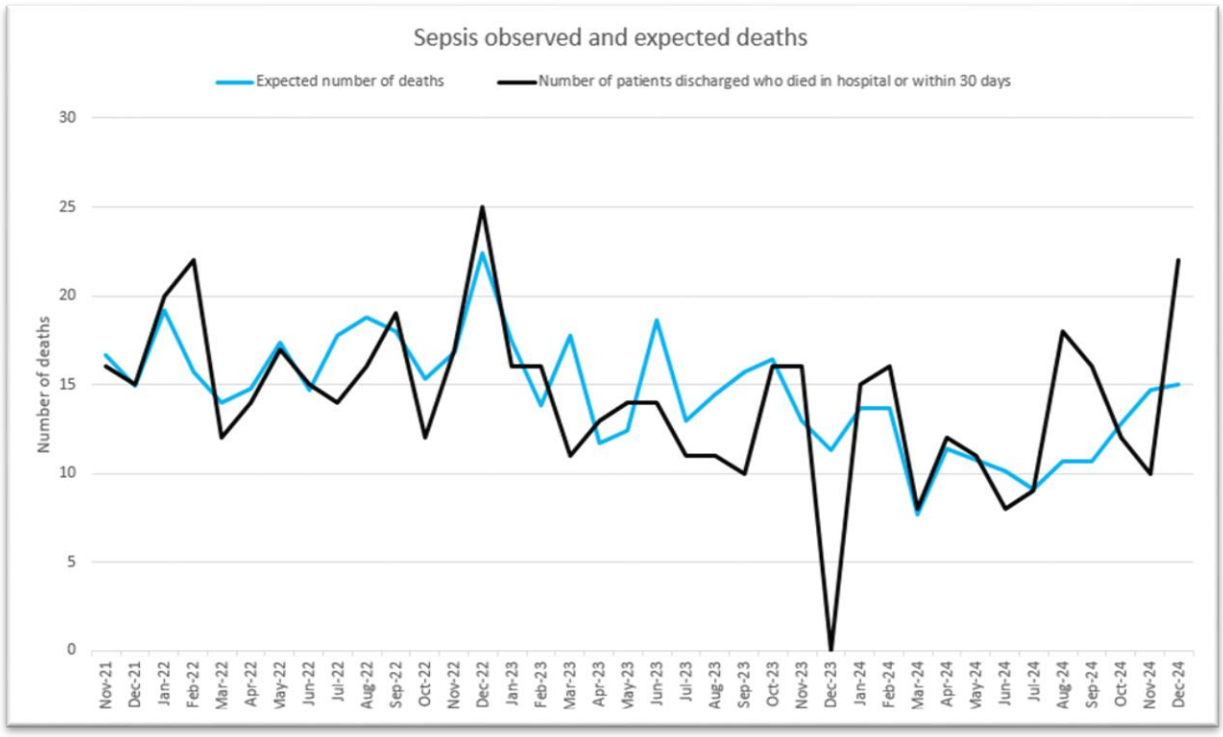
Chart 5 –Pneumonia observed and expected deaths



As the chart demonstrates, the gap between observed and expected deaths for pneumonia is narrowing.

However, as the SHMI for Pneumonia has come down (as demonstrated in the chart above) we have seen a slight increase in the SHMI for sepsis for the first time in several years across the same timeframe.

Chart 6 – Sepsis observed and expected deaths



A deep dive into the sepsis mortality is being commissioned for clarity and will be monitored through the MSG action log and Deteriorating Patient Group.

The acute adult care division will explore how they improve the accuracy of the primary diagnosis to continue to help improve the risk adjusted mortality.

Progress update on mortality action plan

The action plan set out 3 key areas of focus for improving mortality across all divisions with the overaching emphasis on the assurance of care provided

Theme 1 - Accuracy of the primary diagnosis (FCE)
Theme 2 Average co-morbidity recording
Theme 3 Coding to flex date to allow collaboration between clinicians and coders

This following section will provide a detailed narrative update on completed actions from the action plan across the three themes, the divisions and the overarching organisation position relating to quality assurance.

Completed actions update:

Theme 1 - Accuracy of the primary diagnosis - First Consultant Episode

Documentation guide for clinicians

This was designed to provide guidance to clinicians on how to record the primary diagnosis for common conditions accurately so we can maximise the risk adjustment. A list of the common clinical presentations has been submitted from AACD and urology and is currently with the coding team. Information still outstanding from the rest of the acute surgical specialities (open on the action log).

FCE timings

Issue relating to short FCE was identified as this can have an impact on the risk adjustment when there is a short episode without the accuracy relating to primary diagnosis and depth of recording added. Audit to measure the impact patient changing consultants leading to brief FCE was completed. Findings indicated that ward clerks were creating new episodes rather than amending the existing or first episode when patients were being transferred. Episodes identified through the audit were amended appropriately and the SOP created and sent out via ward clerks meeting and monitored through divisions and Clinical Audit which should positively impact the short FCE issue. Consultation with NHS England digital team made to ensure that the Bolton methodology relating to closing of the episodes everytime there was a change in lead consultant due to rotational ward cover was aligned to the approved process and confirmed to be correct.

Data Quality

Review completed of day cases in relation to patients being incorrectly inputted as elective when arriving at SDEC via the bed bureau which was negatively impacting mortality risk adjusments. Training and education completed for ward clerks which should positively impact improvements going forward.

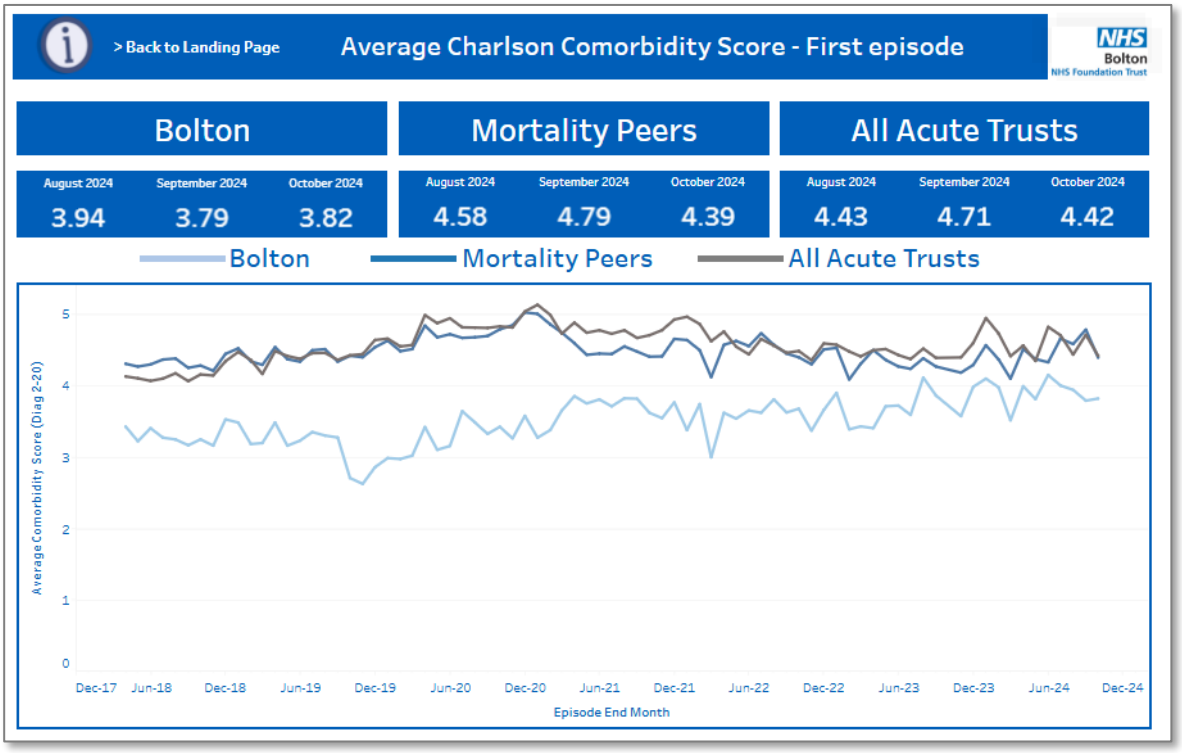
Theme 2 - Average Charlson Comorbidity Recording and SHMI

Charlson comorbidities

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

Despite improvements in the recording there remains a gap to Mortality Peers and All Acute Trusts. The successful inclusion of mandatory comorbidity recording with auto population of the Health Issues section of our EPR should result in an improvement in this metric. The below chart does show the gap between Blton FT and all acute trust narrowing.

Chart 7 – Average Charlson Comorbidity Score for the First Completed Episode (FCE) – Bolton v's both peers and all Acute Trusts



Specialty split of Charlson recording

The Charlson score at first episode is calculated as this is the episode in which the majority of SHMI and HSMR would be based. Whilst the ASSD specialties fair reasonably when compared nationally, they are below the recording of Acute Adult peers. It is still unclear why the overall average for Bolton FT is below the national average for all acute trusts as demonstrated in the above graph when the co-morbidity recording split by speciality is comparable to other acute trusts. This requires additional analysis to clarify this discrepancy.

There will be a new audit undertaken to review all deaths of patients over the age of 65 with zero Charlson co-mobidities recorded to understand where where the lack of comorbidity recording originates from.

Anecdotally, feedback has been received that non elective admissions to SDEC may be under recorded and non daycase elective admissions may be under reported. Clarity on this issue can be expected following the audit of over 65's with no Charlson comorbidities recorded.

Chart 8 – Average Charlson Comorbidity Score for the First Completed Episode (FCE) split by speciality compared to all acute trusts

> Back to Landing Page

Average Comorbidity Charlson Score - First episode

NHS Bolton NHS Foundation Trust

Bolton

August 2024	September 2024	October 2024
3.94	3.79	3.82

All Acute Trusts

August 2024	September 2024	October 2024
4.43	4.71	4.42

Acute Adult

August 2024	September 2024	October 2024
9.56	9.39	9.34

ASSD

August 2024	September 2024	October 2024
4.49	4.38	4.67

Family Care

August 2024	September 2024	October 2024
0.40	0.35	0.31

Bolton - Specialty

	August 2024	September ..	October 20..
100 - General surgery	4.09	4.05	4.01
101 - Urology	6.02	4.87	7.17
103 - Breast surgery	2.15	6.14	5.00
104 - Colorectal surgery	3.00	15.50	7.40
110 - Trauma & orthopaedics	5.18	5.07	5.41
120 - Ear nose and throat	2.35	1.98	2.32
130 - Ophthalmology	4.00	0.00	0.00
180 - Emergency medicine	0.00	13.67	9.00
300 - General internal medicine	7.90	7.63	7.90
301 - Gastroenterology	13.05	7.85	7.68
302 - Endocrinology	21.00	4.00	8.00
303 - Clinical haematology	4.75	1.50	1.00
320 - Cardiology	13.62	9.05	10.25
340 - Respiratory medicine	9.78	10.77	12.66
420 - Paediatrics	0.45	0.32	0.20
422 - Neonatal critical care	0.00	0.00	0.00
424 - Well babies	0.00	0.00	0.01
430 - Elderly medicine	11.85	12.20	12.09
501 - Obstetrics	0.47	0.41	0.39
502 - Gynaecology	0.60	0.63	0.72

All Acute Trusts - Specialty

	August 2024	September ..	October 20..
100 - General surgery	3.41	3.54	3.31
101 - Urology	4.89	4.97	4.94
103 - Breast surgery	6.01	6.70	5.86
104 - Colorectal surgery	3.95	4.10	3.95
110 - Trauma & orthopaedics	4.21	4.53	4.49
120 - Ear nose and throat	2.35	2.37	2.43
130 - Ophthalmology	2.53	2.55	2.82
180 - Emergency medicine	4.37	4.47	4.15
192 - Intensive care medicine	6.51	7.21	6.07
300 - General internal medicine	7.12	7.77	7.07
301 - Gastroenterology	7.07	7.34	6.83
302 - Endocrinology	8.59	9.39	8.37
303 - Clinical haematology	6.08	6.17	5.86
320 - Cardiology	8.14	8.39	7.96
340 - Respiratory medicine	8.37	9.00	8.14
420 - Paediatrics	0.32	0.31	0.29
422 - Neonatal critical care	0.02	0.03	0.02
424 - Well babies	0.00	0.00	0.00
430 - Elderly medicine	12.03	13.38	12.34
501 - Obstetrics	0.39	0.41	0.41
502 - Gynaecology	1.00	0.98	0.98

Audit review methodology

In order to get clarity on the gaps within comorbidity recording, bed holding divisions were tasked with the completion of a case note audit to identify opportunities for when full recording of comorbidities should have been identified. This was completed alongside a review by the coding team of the same 25 patients who focused on the quality of the information recorded for the selected patients. The basis of the audit was to review the information within our EPR and the information available within GMCR to ensure comprehensive recording of all available comorbidities, to identify where missed opportunities for comprehensive comorbidity recording was, whilst also ensuring the recorded information was detailed enough for maximum risk adjustment from a coding perspective.

AACD

A case note audit was carried out by the DMD of the medical division of 25 patients provided by BI of deaths that were recorded during the months of October to December 2024.

Of the 25 notes audited:

- 13 patients were under the care of elderly medicine consultants. The remaining 12 were from other specialities – cardiology, respiratory, gastroenterology and diabetes
- All patients audited had **all** the comorbidities listed except for one patient where the extensive past surgical history was not recorded including right hemicolectomy/ small bowel resection / ileostomy with high output stoma
- Two of the deaths were due to an unexpected cardiac arrest. 23 patients had a DNACPR order in place.
- Nine patients had pneumonia mentioned as a cause of death despite six of those having significant co – morbidities including dementia/ cancer/ decompensated heart failure / alcohol induced decompensated liver disease Six patients likely had bronchopneumonia which is a terminal event for most patients with significant co morbidities.

The completion of this audit by the coding team is currently outstanding.

ASSD

A case note audit was carried out by coding team of 25 patients provided by BI of deaths that were recorded during the months of October to December 2024.

Of the 25 notes audited:

- Five had **no** co-morbidities recorded.
- Four had R code diagnosis (sign and symptoms which carries less risk adjustment)
- Six cases indicated that there were inconsistencies within the documentation or lacked detail to allow accurate recording by the coding team

The completion of this audit by the divisional clinical team is currently outstanding.

Based on the case note audit and an additional review by the Clinical Coding team of five patients who were readmitted, findings have suggested that the Charlson scoring is inconsistent at each admission which could be contributing to the risk adjustment:

- 4 out of 5 patients were recorded and/or coded inconsistently, with 1 out of 5 recorded and coded correctly.
- Across 13 admissions for the 5 patients, total Charlson score was 94, with a probable score of 83 missing (10 missing Charlson co-morbidities across multiple episodes), so total score should have probably been 177. This means there were missed opportunities when patients were admitted due to inconsistent co-morbidity recording.
- Health Issues did contain the Charlson co-morbidity at the time of coding but for 12 out of 26 (46.15%) Charlson co-morbidities were found from other sources.

- GMCR did contain the Charlson co-morbidity at the time of coding for 18 out of 22 (81.82%) Charlson co-morbidities found elsewhere. GMCR was unavailable for 4 Charlsons (2 discharges).
- Where Health Issues does contain a Charlson co-morbidity they were coded 12/12 times (100%).
- 4/14 co-morbidities were coded despite not being on Health Issues and 10/14 were not coded but recorded elsewhere (6 GMCR and 4 from clinic letters / other documentation). 2 out of 4 not coded may have been on GMCR but GMCR information was not available as the patient was now deceased.

The coding team concluded that:

- There is still variability in the recording and / or coding of some activity, and the use of the EPR tick box.
- The main documentation within EPR can be difficult to read and extract information from. It can also be inconsistent between discharges.
- When documented on Health Records, Charlsons were coded.
- When not documented on Health Records, coders are reliant on GMCR, the main documentation or having time to read the wider documentation / query. Issues relating to deadline pressure (time to read), GMCR availability (regularly unavailable) and inconsistency within the current documentation, can then come in to play and this has resulted in 10/14 Charlsons that were not documented on Health Issues, not being coded.
- Where we can identify inconsistencies in Charlson score across multiple discharges, there is an opportunity to review and amend the coding.
- By completing Health Issues in EPR the next admission of the patient will have the comorbidities already entered

Outcomes of the audit are shown in MSG Appendix B

Theme 3 - Coding Capacity

Coding team and clinical team collaboration will lead to improvements due to earlier clarification of diagnosis and recorded co-morbidities before freeze date. It will also allow the opportunity for any amendments between the flex and freeze date, providing clarity and appropriate depth of recording.

The improvement work and changes are summarised below with the actions being held in Digital Transformation Board and relevant updates shared and monitored in MSG:

- We have been effective in utilising our own staff and recruiting externally from other Coding teams for extra NHSP work (equivalent to 1.5 WTE for 9 months in 24/25 so far). This is a more cost-effective way of sourcing extra coding than using agency coders that continue to be much more expensive.
- NHSP staff are currently utilised (in-part) to code SDEC activity (around 1000 discharges per month). There are plans to move most of this activity to type 5 A&E attendances from July 2025, which would also remove the need for them to be coded by the Clinical Coding team. This would have a major impact in terms of helping the department move back towards coding to flex deadlines, as although it is straightforward and

simple coding, it is high volume. The risk here is that the denominator will change and this could increase the SHMI by upto 5%. This will average out if all Trusts change within the same month, however, if not then Bolton FT could outlie further outside the funnel chart. This timing will require some consideration.

- Another potential tool for driving improvement in both the productivity and quality of coding is the use of a piece of software called an encoder. We are the only in trust in Greater Manchester who do not use software of this type, and it would potentially (once fully implemented and embedded), result in coders being able to code more quickly (depending on the method of implementation) and being able to utilise various coding tools that come with the software. Purchasing this software is currently dependent on an interface being created between the software and our PAS system or Data Warehouse. A date for the exploration work is being actively pursued around the other digital projects.
- Coder retention and recruitment is of particular concern, and has been raised with Greater Manchester HR directors. Particularly in relation to the use of the London Higher Cost Allowance payment plus retention and recruitment premium to 100% remote workers by some London Trusts.
- National work continues with an Artificial Intelligence Clinical Coding Task Force, to utilise AI within Clinical Coding. Whilst the ability to apply the complex suite of coding rules to spells in an automated way is not yet available for complex spells, it does exist in limited forms for very simple spells. There may also be further developments in the ability to use generative AI to generate short form summaries of inpatient records, which if tested and proven to be accurate, has the potential to considerably speed up the time it takes to code individual spells.
- Other data quality errors at input have been identified and corrected. These errors have had a significant impact on mortality but also other factors due to inaccuracies in the data have a wide-ranging impact both internally and externally. For example, data input errors at source of patients this has made our elective mortality rate third highest in the country so is under scrutiny at national level. Further to this, coders are required to code all episodes within the spell, however, errors in the way the consultant or specialty of which the patient care is recorded has meant the creation of new episodes rather than the edit of the original input. This means that there are extra episodes to code and documents to be researched and evaluated by the coding team adding to the pressures they are already under. To rectify this an audit has been amended so records are fixed before extract and education for users of Le2 initiated with a SOP created.
- Recording improvement schemes such as Trust wide and Divisional Counting and Recording which has recently restarted, and educational events such as Know Your Patient week (10th – 14th of February) and Data Quality sessions on Junior Doctor inductions, continue. The Data Quality priority plan is held by the Counting and Recording Group with full divisional ownership, and reports into Performance and Transformation Board.

Organisational Update

Assurance on the quality of the care provided through review of red alerting groups reviewed through audit process via the completion of SJR's for 20% of cases within the identified red identifying groups as part of the

LfD groups and process which will continue as part of the Learning from Deaths Structured Judgement Review process.

Additionally, all cases are scrutinised by the medical examiner who are also able to refer into the SJR process for learning from deaths . this process, plus the clinical effectiveness governance structure will provide the assurance that the elevated risk adjusted mortality is not linked to poor quality of care.

Conclusion

As this paper demonstrates, the current SHMI for Bolton is 118.34 shows Bolton at 118.34, which is in the 'higher than expected' range. The SHMI has increased since the last reported figure of 117.65.

We are assured that the crude rate seen is similar to that of peers both in Greater Manchester and nationally, and although the crude mortality remained higher in the spring and summer months where you would normally see a decrease, the overall crude mortality for the year remains comparable to previous.

The board requests for an update on the pneumonia mortality, which has been reviewed and included within the paper, provides assurance that standards of care are in line with national recommendations with an action plan provided by AACD to continue to improve on pneumonia mortality.

Data suggests a small increase in sepsis mortality which correlates with the reduction in pneumonia mortality which may be due to an increase in septicaemia being recorded as a primary diagnosis instead of pneumonia. This is being prioritised as a deep dive review.

The focus within the action plan mainly remains on primary diagnosis on first completed episode, Charlson comorbidity recording and coding capacity which will be monitored through Mortality Steering Group, Clinical Governance and Quality Committee and Quality Assurance Committee.

These actions should provide the required improvement for the organisation relating to risk adjustment.

However, the quality assurance mechanisms held across a number of governance structures including Clinical Effectiveness Group, structured judgement reviews, Learning from Deaths and the Medical Examiner service provides assurance on the quality of care provided and the issue is not relating to a lack in the standards or quality of care.

It is acknowledged that there are still a number of actions required to improve mortality, across data quality, recording of primary diagnosis, Charlson comorbidity recording, but there is much greater visibility of these issues and improvement actions are held in the action plan.

Appendix A – Action Log

Ref No	Theme	Description	Action	Responsible	When	Update/Outstanding actions May 2025	RAG	Status
1	Accuracy of the primary diagnosis - First Consultant Episode		Clinical coding team to develop a guide for clinicans to use to support accurate recording of information. Create a list of around 20 most common reasons for hospital admission for inclusion in local drive info	A Volleamere	Jan-25	Information to be provided by ASSD (not urology) to progress the documentation guide for clinicians		Open
1.1	Accuracy of the primary diagnosis - First Consultant Episode	Documentation guide for clinicians	Clinical coding team to develop a guide for clinicans to use to support accurate recording of information	Clinical coding team	Feb-25	Guide to be provided for those specialities who have provided the information but still outstanding due to capacity issues in the coding team		Open
2	Average Charlson Comorbidity Recording and SHMI	Audit review	25 medical and 25 surgical patients to be reviewed by coding and clinical teams to identify opportunities for when recording of comorbidities should have been identified to inform learning.	PT and sending out to Divisions by RM	Feb-25	ACCD completed audit - awaiting completion of the px quality review by coding ASSD - Coding have completed their aspect of the audit - clinical audit is still outstanding from ASSD		**Open**
2.1	Average Charlson Comorbidity Recording and SHMI	Sepsis SHMI Deep dive	Deep dive audit into the sepsis SHMI to be completed due to the increase from December 2024 onwards	SI	Jun-25			**Open**
2.2	Average Charlson Comorbidity Recording and SHMI	Comorbidity recording for over 65's without any Chalrlson scoring	New audit to be undertaken to review all deaths of patients over the age of 65 with zero Charlson co-mobidities recorded to understand where where the lack of comorbidity recording originates from. Those px admitted under medicine will be reviewed by ACCD and px admitted under surgery will go to ASSD	BI and Divisional Governace Teams	Aug-25			**Open**
3	Coding Capacity		Coding queries process to be publicised	PT	Nov-24	Coding team to create information to share with divisions		**Open**
3.1	Coding Capacity	Publicising the coding queries process	SOP to be created for discussion with clinicians as to how this will work in practice	PT	Nov-24	Coding team to send the SOP for coding queries to be shared with the clinical teams		**Open**
3.3	Coding Capacity	Closer working between coders and clinicians	Regular meetings between coders and clinicians to identify and rectify coding queries relating to the FCE and co morbidities	PT	Jan-25			**Open**
4	Organisation wide - quality assurance	Assurance on the quality of the care provided through review of red alerting groups	Complete SJR for 20% of cases within the identified red alerting groups as part of the LfD groups and process	Clinical Audit/BI	Ongoing	Complete SJR for 20% of cases within the identified red alerting groups as part of the LfD groups and process		Open
4.1	Organisation wide - quality assurance	Outlier groups	Clinical review of the records have been sent to the clinical lead for lung cancer (current red alert)	IW	Aug-25			Open
4.2	Organisation wide - quality assurance	Outlier groups	Urinary Tract Infections - Clinical review of the records will be undertaken by the relevant division (current amber alert)	AACD	Aug-25			Open
4.3	Organisation wide - quality assurance	Outlier groups	Septicemia (except in labour) and sepsis mortality - A clinical review of the records will be undertaken by the relevant clinical leads aligned to the Deteriorating Patient Group activity (current amber alert)	DPG	Aug-25			Open

Appendix B – Case Note Audit Outcome

Patient 1 - RMC****26**:

EC1 (Orthopaedic) 25/06/2024 - **Charlson Score 13**

SDEC 08/10/2024 – **Charlson Score 0 (should probably be 13)**

- **LVF (I50.1) - 13** – coded June 24 but not October 24.
  - **Documentation** - On pre-op documentation (June 2024) – Echo 2022. Not in PMH list for SDEC (LVF or LVSD).
  - **Health Issues** - Not recorded (only LVSD – different code – I51.8). 5 co-morbidities on Health Issues – no Charlson.
  - **GMCR** – Left Ventricular Impairment as per Echo 2022, coder hasn't picked up, but they have coded LVSD as per Health Issues.

Patient 2 - RMC****16:**

F3 (Surgical) 16/08/2024 - **Charlson Score 0 (should probably be 18)**

SDEC 13/09/2024 - **Charlson Score 18**

- **Renal cancer (C64.X) 8** – coded on September discharge but not August discharge (has had for three years and still under surveillance).
  - **Documentation –** Admitted with haematuria and Cancer stated as "had" and "possible recurrence" on August episode - not coded (however no history coded either). Scan in April had shown "probable" recurrence and was being managed as such.
  - **Health Issues -** Added for September 2024 discharge (not on for August). 26 PMH entries (5 new In September).
  - **GMCR** – Can't check as patient has since died.

- **CKD (N18.3) - 10** – coded on September discharge but not August discharge.
  - **Documentation -** No mention of CKD in August documentation.
  - **Health Issues -** Added for September 2024 discharge (not on for August).
  - **GMCR** – Can't check as patient has since died.

Patient 3 - RMC****82:**

EC1 (Orthopaedic) 18/09/2024 - **Charlson Score 4**

SDEC 12/10/2024 - **Charlson Score 0 (should probably be 4)**

- **Asthma (J45.9) - 4** – coded on September admission but not October.
  - **Documentation –** September discharge documents Asthma but October one doesn't mention any co-morbidities, only inhalers.
  - **Health Issues** - Nothing recorded on health issues (blank).
  - **GMCR** - Asthma on GMCR as current / on meds..

- **CKD 3 (N18.3) 10** - Not coded on either admission. Not definite.
  - **Documentation** - Not documented on either admission
  - **Health Issues** - Nothing recorded on health issues (blank).
  - **GMCR** – Recorded as current but last update in 2010.

Patient 4 - RMC****40**:

EU 22/05/2024 - **Charlson Score 7**

SC2 9/10/2024 - **Charlson Score 7**

E3 23/10/2024 - **Charlson Score 13**

- **Asthma (J45.9) - 4** and **Type 2 Diabetes (E11.9) - 3** coded consistently on all three discharges.
  - **Documentation –** Both documented.
  - **Health Issues -** Both on Health Issues (all).
  - **GMCR –** Both on GMCR.

- **Gangrene (R02.X)** - No inconsistency, as patient had gangrene (R02.X – 6) associated with post-op infection on third admission in October. Nothing recorded on Health Issues.

Patient 5 - RMC****62:**

EU 25/04/2024 - **Charlson Score 4 (should probably be 20)**

EU 05/08/2024 - **Charlson Score 4 (should probably be 20)**

E3 09/08/2024 - **Charlson Score 17 (should probably be 20)**

F3 27/08/2024 - **Charlson Score 7 (should probably be 20)**

- **COPD (J44.9) - 4** has been coded across all four admissions.
  - **Documentation –** in all documentation.
  - **Health Issues -** On Health Issues.
  - **GMCR –** On GMCR.

- **Chronic right sided heart failure (I50.0) -13** Heart failure only coded once in four admissions and not on health issues.

- **Documentation** – Both Endoscopy say Heart Disease but not what (no tick sheet?). Final two discharges both state heart failure in places but not consistently.
- **Health Issues** – Not on health issues.
- **GMCR** – Clearly documented as chronic / current for all.

- **Type 2 diabetes (E11.9) 3** - only coded once across four episodes (Aug 24).
  - **Documentation** - 3/4 admissions say Yes for Diabetes, second admission in August (EU) says no diabetes.
  - **Health Issues** – Not on Health Issues.
  - **GMCR** – Not on GMCR.

Appendix C

Divisional Mortality Report
Families Division
April 2025

Current position / performance*

SHMI and HSMR for Families Division are calculated by using the Treatment Specialty on admission. The same treatment specialties in other Trusts have been matched to calculate the Divisional SHMI and HSMR for those areas for comparison. Mortality Indicators are built by Diagnosis group so caution should be used when interpreting in this way as the data will mask problem areas.

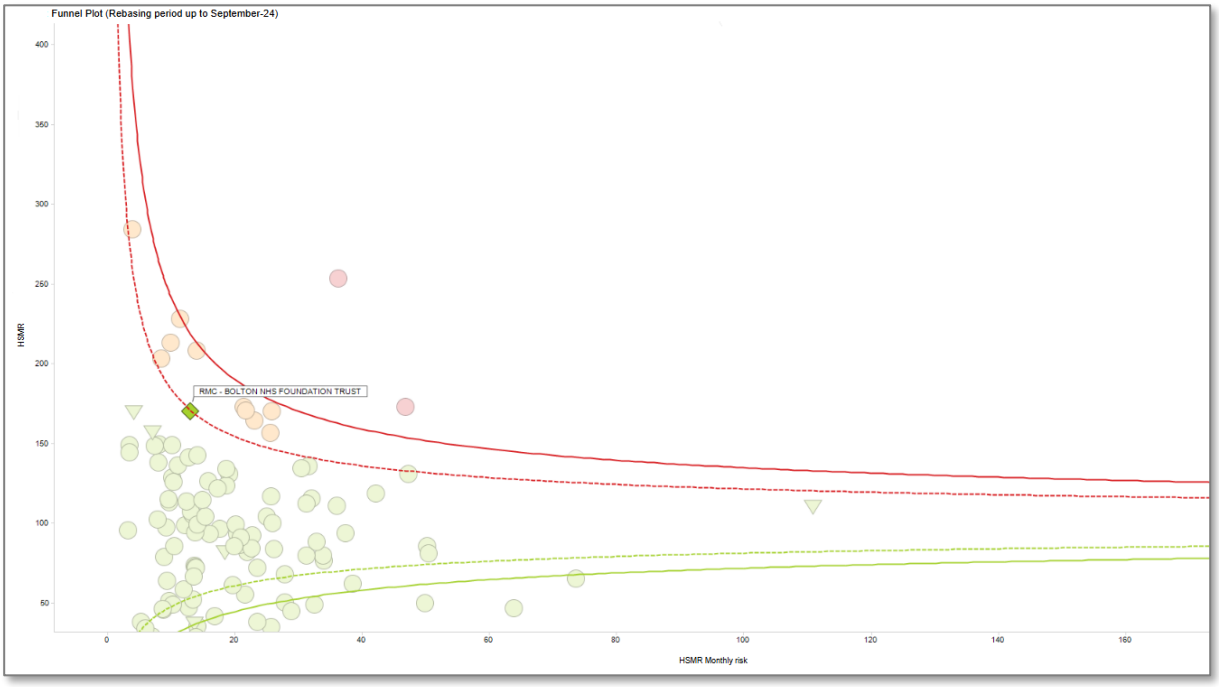
Both SHMI and HSMR are within range when compared to other Trusts for the period December 2023 to November 2024

The recording of Charlson comorbidities and the subsequent risk adjustment from these comorbidities is limited within the Division as a lot of the Charlson comorbidities will not affect children and babies.

HSMR – December 2023 to November 2024

There are fundamental differences in SHMI and HSMR in that certain disease groups are excluded from HSMR, this affects Families Division more than others Divisions as the majority of them are disease groups affecting neonatal admissions e.g., 'Short gestation; low birth weight and fetal growth retardation', 'Intrauterine hypoxia and birth asphyxia', 'Nervous system congenital anomalies'. All of these groups hold higher risk adjustments which would increase the expected score. As these are excluded from HSMR, the deficit to expected rate (denominator) is large (slightly offset by a smaller number of deaths).

Stillbirths are also included in HSMR but excluded from SHMI which gives more observed deaths in the numerator.
HSMR has fallen from alerting Amber back to within range for this reporting period, although the HSMR could be improved further.



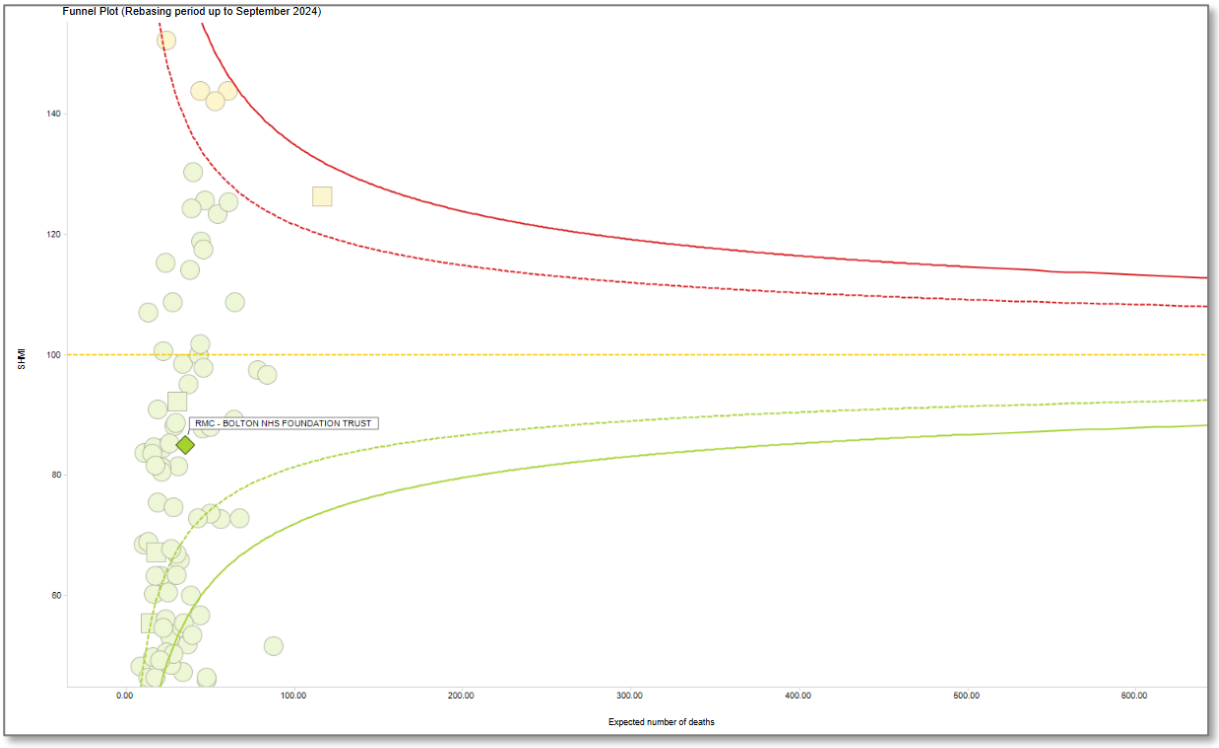
The observed deaths for the period December 2023 to November 2024 included in Families Division were 22, expected 12.92 giving an HSMR of 170.25. The table below shows the observed, expected and number of discharges by CCS diagnosis group of the patients who were deceased. Nine of the deaths within the 'Other perinatal conditions' were stillbirths, two were terminations and this group when compared to other Trusts is alerting 'Amber'.

Note – most obstetrics diagnosis groups are excluded from HSMR

CCS Group (of diagnosis)	HSMR	Number of observed deaths	Expected number of deaths	Number of discharges	Obs.- Exp	Comorbidity score per super-spell
224 - Other perinatal conditions	199.11	19	9.54	692	9.46	0
2 - Septicemia (except in labor)	245.5	1	0.41	61	0.59	1.03
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	206.99	1	0.48	140	0.52	0.63
125 - Acute bronchitis	154.53	1	0.65	1130	0.35	0.23

SHMI – December 2023 to November 2024

Families Division SHMI is well within range, the inclusion of other diagnosis groups that are excluded from HSMR is helping to bring down the rate due to the increased risk adjustments for these diagnosis groups. Stillbirths are excluded from SHMI which means the numerator is lower also bringing down the rate.



All the deaths in Family Division are split by CCS diagnosis group. There are different diagnosis groups included in SHMI which hold a higher risk score and stillbirths are excluded. There is a further risk adjustment in SHMI for the birthweight of babies included in the perinatal diagnosis groups.

CCS Group (of discharge)	SHMI	Number of patients discharged who died in hospital or within 30 days	Expected number of deaths	Number of provider spells	Average comorbidity score per spell	Obs.- Exp.
219 - Short gestation; low birth weight; and fetal growth retardation	100.11	16	15.98	417	0.01	0
224 - Other perinatal conditions	186.52	7	3.75	689	0	3
2 - Septicemia (except in labor)	231.94	1	0.43	62	1.02	1
27 - Cancer of ovary	76.68	1	1.3	8	7	0
58 - Other nutritional; endocrine; and metabolic disorders	515.79	1	0.19	71	0.11	1
97 - Peri-; endo-; and myocarditis; cardiomyopathy (except that caused by tuberculosis or sexually transmitted disease)	428.45	1	0.23	2	6.5	1
125 - Acute bronchitis	109.05	1	0.92	1135	0.23	0
199 - Chronic ulcer of skin	487319.6	1	0	1	0	1
221 - Respiratory distress syndrome	818.77	1	0.12	57	0	1

Data analysis

The HSMR data may be improved by further reviewing what detail is put in the stillbirth around primary diagnosis as well as the neonatal deaths. This may help to further risk adjust our data.

The deaths for Q3 (Oct 24 – Dec 24) are summarised below as reported on LE2. This LE2 data is what feeds our HSMR and SHMI. This report will review the deaths in quarter 3 in more detail and go on to outline the

governance and learning/recommendations around the deaths. The patient detail has been added to the table to provide more information and this will be expanded on later in the report.

You will note in the table below there were 2 terminations of pregnancy which resulted in live births so have been recorded as patient deaths. 1 late termination of pregnancy (TOP) for fetal anomalies is recorded as a stillbirth on LE2.2 due to gestation being over 24 weeks. On E3 this TOP was recorded as a late termination of pregnancy. There will be no PMRT reviews for these 3 deaths.

The admission specialty has recorded some cases as well babies. There is further data quality work to be undertaken here to understand this specialty name and why this is being chosen. We also need to understand why some deaths are under neonatology and others under paediatrics.

LE2 data for Q3

Date of death	Admission ward	Discharge method LE2	Admission Primary diagnosis	Patient detail	Admission Specialty Name
Oct 2024	H1	Discharged	Malignant neoplasm of ovary	81yr old lady discharged to hospice care for palliation and EOLC	Gynaecology
Oct 2024	SCBU	Patient Died	Respiratory distress syndrome of newborn	Extreme prematurity (24 weeks)	Neonatology
Oct 2024	CDS	Stillbirth	Fetal death of unspecified cause	Attended at 28+3 with reduced fetal movements, confirmed fetal death in utero for twin 1.	Well Babies
Oct 2024	CDS	Stillbirth	Fetal death of unspecified cause	26 weeks. Reduced Fetal Movements. Maternal fibroids	Well Babies
Nov 2024	CDS	Patient Died	Termination of pregnancy, affecting fetus and newborn	20^{+6} with congenital abnormalities. Lived 6 hours post delivery	Well Babies
Nov 2024	CDS	Patient Died	Termination of pregnancy, affecting fetus and newborn	18^{+3} weeks TOP. Lived briefly post-delivery.	Neonatology
Nov 2024	SCBU	Patient Died	Other low birth weight	Extreme prematurity (23weeks)	Neonatology

Nov 2024	CDS	Stillbirth*	Down Syndrome, unspecified	TOP at 34+5 for Down syndrome and AVSD.	Paediatrics
Dec 2024	CDS	Stillbirth	Fetal death of unspecified cause	24 weeks. Attended routine appointment and no fetal heartrate identified.	Neonatology
Dec 2024	SCBU	Patient Died	Other low birth weight	Hypoxic Ischaemic Encephalopathy	Neonatology
Dec 2024	CDS	Stillbirth	Fetal death of unspecified cause	31^{+3} week Placental abruption	Paediatrics
Dec 2024	CDS	Stillbirth*	Congenital malformation of heart, unspecified	Late TOP	Well Babies
Dec 2024	CDS	Stillbirth	Fetal death of unspecified cause	38^{+5} weeks Attended routine community antenatal appointment, no fetal heartrate present and fetal death in-utero identified	Well Babies

*were TOPS at gestation over 24 weeks so recorded on LE2 as Stillbirth

It is important to note that SHMI and HSMR data sits behind our data collection and the mortality/morbidity reviews conducted by PMRT/MNSI and CDOP are not produced until 6 months from the time of death.

Gynaecology Deaths:

In Q3 there was one death in gynaecology. This lady was admitted under the general surgeons with a 7 day history of abdominal pain. A CT scan showed a pelvic mass originating in the left adnexa with peritoneal deposits and ascites. Care was transferred to gynaecology where further investigations and MDTs were carried out. A diagnosis of a rapidly advancing metastatic grade 4a ovarian cancer was made. Palliative care team were involved to help manage pain and later end of life care. Patient was discharged to hospice care and died soon after. At present there isn't a process to alter gynaecology of deaths after discharge. This is under review and we are linking with BI to receive this data. There was one area of care that could have been improved following a review of this case around a delayed diagnosis of a pulmonary embolus. This did not impact on the patient outcome and therapeutic treatment was commenced. An incident has been submitted and a review into how this was missed will be undertaken by Gynaecology lead and learning shared through governance structures.

Mortality Risk (SHMI)	Age (single year)	Sex	Admission Method	SHMI Diagnostic Group	Total Charlson score	Diagnosis Grouping - CCS (dominant)	Admission Date	Discharge Date	Death certificate
0.156	81	Female	21 - Emergency: via Emergency Care Department	21 :: Cancer of ovary	0	27 - Cancer of ovary	03/09/2024	04/10/2024	C56 - Malignant neoplasm of ovary

Child Deaths:

During October to December 2024 there were no child deaths.

All children who have an expected death at Bolton have a child death review meeting completed locally with a child death analysis form being sent to Child Deaths Overview Panel (CDOP). CDOP is a multi-agency panel that reviews deaths of children under 18 years old. Those that die elsewhere will be reviewed by the respective team. Children who die unexpectedly are subject to a joint agency response. This is co-ordinated by the Sudden Unexplained Death in Childhood (SUDC) Consultant Paediatrician which is a GM wide service. The process can be lengthy and so information regarding cause of death etc. is limited for these children.

Neonatal deaths:

During Q3 we had a total of 3 neonatal deaths at Bolton. 2 deaths occurred at other organisations. These 2 deaths will appear in our MBRRACE data in 2024 as the antenatal care and births babies' occurred at Bolton. These deaths do not appear in our other mortality metrics but are included here for completeness.

NICU	Oct	Nov	Dec
Died @RBH	1	1	1
Died other unit	1	0	1
Births	440	374	439
Mortality rate/1000 births	4.5	2.6	4.5

The causes of death are detailed below.

Month	Type	Primary Category
Oct	Post neonatal death >28	Extreme prematurity (24 weeks), pulmonary hypoplasia, maternal prolong rupture of membranes
Oct	Post neonatal death >28	Necrotising Enterocolitis (NEC) and extreme prematurity (23weeks)
Nov	ENND <7 days	Extreme prematurity (23weeks), Pulmonary haemorrhage, Grade 4 Intraventricular haemorrhage
Dec	Late NND >7 and <28	Hypoxic Ischaemic Encephalopathy (HIE)
Dec	Post neonatal death >28	HIE

All neonatal deaths on NICU go through a series of reviews, first a rapid review, followed by

a detailed notes review and then using the standardised national perinatal mortality review tool (PMRT). Reviews are planned for 6-8 weeks after the baby has died. Each case is then assigned a grade (A-D, see below) for neonatal care.

	Grading of care of the baby from birth up to the death of the baby (PMRT)
Grade A	No issues with care identified from birth up to the point the baby died
Grade B	Care issues identified which would have no difference to the outcome
Grade C	Care issues identified which may have made a difference to the outcome
Grade D	Care issues identified which were likely to have made a difference to the outcome

All reviews have been undertaken. In 1 case there was a grade A care issue found and in 3 cases a grade B issue identified. Recommendations and actions are tracked by the teams through governance and in the neonatal quarterly neonatal mortality reports. These cases are also discussed regionally.

Stillbirths:

There were 5 stillbirths during Q3. These are detailed below in the table pulled from the PMRT tracker which monitors the cases and ongoing governance for each case.

The PMRT data is different from the data pulled from LE2 where there were 7 stillbirths recorded in the same time period. 2 stillbirths were TOPs at a gestation above 24 weeks and therefore do not appear on the PMRT tracker and will be excluded from the MBRRACE data. They will not be undergoing a PMRT review and there are no care delivery concerns for these cases. As the TOPs were recorded as stillbirths on LE2, they will feature in the HSMR data.

The tracker details the governance around the stillbirths which all occurred antepartum. All cases have had a PMRT review tool completed and submitted, the reports with recommendations from the PRMTs are due back to Bolton this month and through to June 2025. The review team at Bolton have only identified level A and B grade care concerns which would not have had an impact on the outcome. Low levels of deprivation were a theme in this quarter.

PMRT tracker

Type of Death	Gestation	Ethnicity	Deprivation code	Smoking Status	BMI	Narriative
Stillbirth	28	Black African	2	Never Smoked	33.13	Twin pregnancy, SROM at 22+5 with Twin 1, managed appropriately. Attended at 28+3 with reduced fetal movements, confirmed fetal death in utero for twin 1. Twin 2 alive and well. PMRT review complete and graded A and A. No learning identified.
Stillbirth	26	Black African	2	Never Smoked	33.57	Reduced fetal movements. M/H of large fibroids. Care graded B and A. No referral for obstetric review despite large uterine fibroids. PMRT finalised without PM, can reopen if any findings from PM.
Stillbirth	24	White British	2	Gave up before pregnancy	28.13	Attended routine appointment and no fetal heartrate identified. Final PRMT booked 17.04.2025
Stillbirth	33+1	White British	6	Never Smoked	25.24	Placental abruption. For full PMRT review and final 24.04.2025
Late Fetal Loss	22		1	Unbooked	Unbooked	Unbooked pregnancy, unaware of pregnancy. Attended A&E and delivered a 500g baby. No concern or learning. For full PMRT review and final booked for 24.04.2025.
Late Fetal Loss	22+3	White British	2	Smoker	27.22	Attended private scan, no fetal heartrate identified. No concerns or learning. For full PMRT review and final booked for 01.05.2025
Stillbirth	38+5	White British	2	Never Smoked	19.56	Attended routine community antenatal appointment, no fetal heartrate present and fetal death in-utero identified. No initial learning identified. PMRT review completed and graded A and B. The review group identified that an obstetric review was not conducted postnatally although this would not have made a difference to care. COMPLETE

Ongoing challenges / care requirements

There are ongoing DQ issues where stillbirths are incorrectly input across the different systems at the Trust will directly influence the data contained in SHMI and HSMR. An SOP and education of the ward clerk teams is underway to standardise the process.

There is a known DQ issue where a number of stillbirths have been recorded incorrectly as 'Patient died' or not included on LE2 at all which is skewing the numbers of deaths included in SHMI and potentially influencing the high SHMI score for Well Babies. Note, there is no risk adjustment for the specialty a patient is included under but gives assurance across the Division to split the data by specialty.

The process for which the recording of the correct diagnosis in the correct order for neonatal admissions which would move patients into a higher risk scoring group was changed in April 2023. This is improving the risk scores as the expected score for the 12 months to January 2024 is very similar to the observed.

The birthweight of a baby is a risk adjustment in SHMI. The data extract from Le2 is not recognising certain birth episodes so is not extracting the birthweight for these episodes. This is affecting the risk adjustment for SHMI as there is nothing there to calculate an increased score.

Action plan

- Investigations into missing birthweights. Ongoing with BI.
- Continuation of liaison between neonatal and paediatric consultants for all SCBU and child deaths with coding team to ensure accuracy at primary diagnosis. Review if there is more detail that can be added to stillbirths, current coding is limited.
- Ensure that the correct discharge is added onto LE2.2 for stillbirths, some are still being entered as discharged. CDS matron working with ward clerks to improve data inputting.
- SM and LS to review 'well babies' entry.
- Agree process to alter gynaecology of deaths within 30 days for mortality and morbidity reviews.
- Gynaecology to review the near miss around delayed diagnosis of a PE.
- Decision about what quarterly specialty data to bring through this report. Do we align with the financial year or do we align with the SMHI and HSMR. Decision this time was to bring Oct-Dec 2024 for most specialties as there is overlap with HSMR and SHMI to Nov 24. In the next mortality report do we review the deaths for Q4 (24-25) and Q1 (25-26). Seek agreement with RM and steering group.

Learning from Deaths Update

This report is the third iteration following the review of the governance, structure and efficacy of the Learning from Deaths (LfD) Committee which is now one of the groups that report into the Mortality Steering Group via an AAA chairs report. Of note, the reporting lag is 2 months.

The number of deaths in month continues to align year or year with no significant months noted as outliers. Across the past 12 months, the number of deaths in the Trust per month ranges from 89 to 111 in month, following expected seasonal variance.

The amount of alerts for the statutory and other alerting groups remains steady between 20% and 25% of all deaths.

From November 2024 to January 2025, there were 313 deaths.

- 79 were identified for primary review (Alerts).
- 38 have been completed to date.
- There are 3 secondary reviews required from this quarter, of which 1 has been completed. The Learning around this case focused on advanced care planning
- There are currently 9 secondary reviews outstanding in total that have been carried over from last Quarter

The current learning themes include the lack of advance care planning for patients reaching end of life, failure to recognise dying in a timely way and communication.

In September 2024 the alerting groups were modified based on organisational intelligence and priorities to include:

- Deaths by suicide
- Nursing home residents who have died within 30 days of attendance, admission or discharge
- Deaths from or with C difficile.
- Patients who have died within 30 days of joint replacement

Alerts for SJR process

	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
Total deaths in month	105	111	99	90	97	91	101	99	111	103	104	89
Total Alerts	25	27	29	26	22	19	20	26	26	27	21	17
Total Patients in an alerting group	24	25	24	25	20	19	20	23	23	24	21	15
Total Available Reviewers	10	8	39	19	18	36	29	29	34			
Total patients with alerts (from dashboard)												
Total alerts CDiff	2	5	7	3	5	3	2	2	0	2	4	2
Total alerts Joint replacement	0	0	1	4	0	0	1	0	2	2	0	0
Total alerts Learning Disability	1	2	0	0	0	2	1	1	1	0	1	1
Total alerts MH history	5	4	3	0	3	1	1	5	6	5	1	3
Total alerts Nursing home	13	11	15	16	9	10	10	13	13	13	11	9
Total alerts pneumonia (random selection)	4	5	3	3	5	3	5	5	4	5	4	2
Suicide						0	1	1	0			
Medical Examiner	0	0	1	0	0	2	0	0	1			
Requested by cons/matron/Other	0	0	1	0	0	1	0	0	0			

Data is presented as 'Date of Death'. Number of alerts will not calculate as some patients have more than one alert, plus alerts can be sent via palliative care, Medical Examiners and ward staff which are not recorded on the Trust PAS (Le2.2)

Alerting groups changed from September 2024

Approval was received for the business case for secondary reviewers which means that there is dedicated time available for the legislative completion of the required secondary reviews, which will be completed by the trained individuals.

Appendix B

		Completed No Further Action
		Complete/On-going
		In progress not complete
		Overdue

Ref N	Theme	Description	Action	Responsible	When	Comments Feb 25	Comments May 25	RAG	Status
1	Recognition of end of life	Earlier recognition of dying	Participation in the NCEPOD 'Planning for the End' study	MP	Mar-25	Gap analysis to be completed with recommendation to come back through LfD	The gap analysis has been completed, action plan with SMART objectives required for completeness to be held with EOLC steering group		Open
2	Communication and documentation	Trust wide Record Keeping Audit 2024/2025	Annual completion of the Trust wide record keeping audit as part of the GMC MHPS standards	MP	Mar-25	Combined report to be presented at CEG - May 25	Raw data has been produced, the report is being presented at May CEG. Update to be provided at next LfD meeting. Additionally, communication is now confirmed as an organisational quality account priority		Open
3	Response to the deteriorating patient	Response to the deteriorating patient	Participation and divisional leadership within the Trust wide collaborative	Divisions	Mar-26	Ongoing through the Trust wide collaborative	Link to the DPC continuing, update provided for LfD paper		Open
5	DNAR	Inappropriate resuciatation of patients	Further clarity on changes of DNAR governance to be confirmed and brought back to clinical divisions for implementation	MP	Feb-25	MP to provide update following the scheduled meeting in Feb 25	new framework and an audit proforma has been designed and tested. See appendix D		Open

Appendix C

Update for Learning from Deaths for the Deteriorating Patient Collaborative

Introduction

Following final proposal acceptance in November 2024, the Deteriorating Patient QI Collaborative commenced 13th February 2025 with Learning Session 1.

The collaborative is a Quality Account improvement priority for 2024/25 and 2025/26 to focus on testing improvement ideas on a number of innovation wards focusing on the broad remit of recognition and response to the deteriorating patient.

The pathway focused project was accepted at DPG due to being more inclusive for all wards and all patient groups and could potentially have a greater impact as a result of having a broader subject area, different identification pathways and patient demographics. It was also agreed that this structure of project would be more inclusive for all staff to be involved in. To date, medical colleagues have found it difficult to release time to contribute to the collaborative. In order to help with this, the QI Team produced a 12 month schedule of all collaborative meetings and this was widely shared in the run up to launch in February 2025.

Teams were nominated by DNDs and were chosen based on their influence within identification and escalation of deterioration. Participating teams are as follows:

AACD	C3 - Gastro
	D4 - Respiratory
ICSD	Admission Avoidance Team
	Community Learning Disability Team
FCD	Maternity
	Paediatrics
ASSD	F3 – General Surgery
	E4 - Orthopaedics

'Advisory' teams have been selected in a QI collaborative for the first time. Hospital at Night, Critical Care Outreach, Laboratory Medicine and Digital EPR were highlighted as integral to the patient pathway, specifically in identification and management of a deteriorating patient. Their role for the collaborative will be as subject matter experts/advisors/enablers in relation to our nominated collaborative teams listed above.

Co-produced tests of change between main collaborative teams and advisory teams are being encouraged, and should advisory teams want to address a problem in relation to deteriorating patients, the QI Team will offer support.

Collaborative Aim

To reduce the number of cardiac arrests across inpatient and community sites by 20% by 28th February 2026 and by a further 30% by 31st March 2028.

Due to the diverse nature of deterioration amongst our collaborative teams, it was decided through conversation with expert groups that an overarching outcome measure of reducing cardiac arrests across the Trust would be appropriate. This will be stratified as below:

Number of Cardiac Arrests

- *Avoidable*
- *Should have been DNACPR*
- *Non-avoidable*

However, it is understood that each collaborative team will have their own main metric for deterioration. For example, in Maternity the focus may be on preventing Pre-eclampsia while in Paediatrics, the focus may be on Respiratory Arrests.

As a result, there could be more movement within the collaborative Process Measures as below:

Sepsis Standards – Risk Ax, time to treatment	HSMR
AKI Standards – Risk Ax, time to treatment	Crude mortality
NEWS2 / MEWS / PEWS	Incidents – avoidable deaths
2222 calls	Martha's Rule calls
Peri-arrests	Admission rates

Balancing measures of length of stay and critical care referrals are also being monitored.

Team Focus

Teams are at an early stage with scoping and data collection in relation to their respective tests of change. Themes of their work so far are focusing on improving sepsis 6 compliance, accurate and timely fluid balance by involving patients, removing barriers to timely escalation in a community setting, trialling of new tools to highlight respiratory deterioration and adaptation and testing of the wellness trajectory – Worry & Concern.

Next Steps

The Project Group meetings on 23rd April and 20th May provided support to teams from QI Team and other collaborative members in relation to their projects.

The next collaborative Learning Session will be Thursday 5th June, 09.30 – 12.30, Seminar Room 1, Education Centre. At this event, teams will formally present their updates on their tests of change ideas. This will take approximately 90 minutes and the remainder of the event is yet to be finalised.

Psychological Safety was a popular topic cited by the collaborative teams in their feedback for future sessions and may form part of the event.

Appendix D – For Information Only, update to PEOLC Steering Group

Title:	Planning for the End. A review of the quality of care provided to adult patients towards the end of life.

Meeting:		**Purpose**	Assurance	
Date:			Discussion	√
Exec Sponsor			Decision	

Summary:	Planning for the End. A review of the quality of care provided to adult patients towards the end of life. An overview of the outcomes and recommendations from the above review

Previously considered by:	N/A

Proposed Resolution	For information only to update steering group

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓

*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Laura Edwards	**Presented by:**	Laura Edwards

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

EOLC	End of life care
NCEPOD	National Confidential Inquiry into Patient Outcome and Death (2024)
MDT	Multi-disciplinary team
EPaCCS	Electronic palliative care coordination system
PPC	Preferred place of death
ACP	Advance Care Planning
SPC	Specialist Palliative Care
SPCT	Specialist Palliative Care Team
LTC	Long Term Condition

1. Background

As a trust we were asked to participate in this NCEPOD review of the quality of care towards the end of life of patients with a diagnosis of one or more of dementia, heart failure, lung cancer or liver disease. This was by providing an assessment of 6-8 sets of case notes of patients who had died or had their final admission between 1st April 2022 and 30th September 2022. Organisational data was supplied to NCEPOD by NACEL. 350 sets of case notes were reviewed in total nationwide.

The review stated that over 600000 people die in the UK per year and that 70% die from long-term conditions where death could have been anticipated well in advance. With the number of deaths in the UK predicted to rise to 736000 by mid-2035 it must be ensured that care at the end of life meets the needs of the population.

2. Findings

1. Parallel Planning

Not enough patients had access to early palliative care alongside existing treatments to improve symptoms and quality of life. 30.8% had parallel planning. Specialist Palliative Care was involved in 51.6% of patients in their final admission. Where this approach was not taken there was a link to scope for improved care for 41.4% of these patients.

2. Normalise Conversations about Death and Dying

72.5% of patients did not have their preferences for care at the end of life recorded.

3. A named Care Co-ordinator

Where a lead person is documented it is more likely that specific end of life care documentation would be used. 66.7% vs 32.8%. Named care-coordinators are less common in LTC than in cancer.

4. **Access to services**
   Seven day palliative care services are available in 59.5% of hospitals. Parallel planning happened more where there was Specialist Palliative Care involvement. For 17.3% of patients it was concluded that specialist palliative/end of life care input could have been better.
5. **Palliative Care as a Core Competency**
   Training in end of life care was included in induction in 64% hospitals and in mandatory training in 51.4% of hospitals. Training in end of life care for all patient-facing staff is needed to recognise who would benefit from palliative and specialist palliative care.

3. Implications for Bolton

1. **Parallel Planning**

   The most recent NACEL indicates that in Bolton we do not sufficiently discuss the possibility of dying with patients and patients are not involved in their plan of care although most families/significant others are. Advance Care Planning happens late and few patients have PPD documented. We do not discussing dying with patients because we are recognising the fact that the patient may die too late (32% survive longer than 48 hours following recognition of dying. We also have a peak at 4-8 hours 18% vs 7% nationally.

2. **Normalise Conversations about death and dying**

   As above. Interestingly the NACEL Staff Survey revealed that 100% of staff surveyed felt confident in recognising dying. They felt confident in their skills in involving patients and those important to them in decisions about end of life care (96%). However, this likely reflects a low response rate to the NACEL staff survey (24 responses) and a significant proportion of respondents working in Critical Care.

3. **A named care coordinator**

   Named 'Keyworkers' are common in Cancer and Palliative Care. The Hospital SPCT have worked very hard to foster relationships with teams caring for patients with other long-term conditions eg Heart failure and liver MDT. The Palliative Care Therapy Team are excellent advocates for patients with neurological disease. Proactive caseload management should ensure coordination of care eg Frailty Virtual Ward.

4. **Access to services**

   NACEL also recommends that hospitals should have access to Palliative Care Services face to face 9am-5pm 7 days a week and by phone 24/7. In Bolton there is SPCT face to face availability 8 hours a day, 7 days a week. There is 24 hour SPC telephone advice from Bolton Hospice Helpline which is underpinned by Bolton Hospice on call. The expertise available via this system is variable depending on which clinician is on call.

   Our SPC nursing staff WTE per 100 beds was below the national mean in previous NACEL. The team has grown since by 2 WTE but needs to increase further to allow us to meet these recommendations.

5. **Palliative Care as a Core Competency**

   The NACEL Staff Survey revealed that 54% of staff had completed end of life care training in the last three years. 33% had not. We have a dedicated End of Life Educator who provides a comprehensive portfolio of training in Communication skills, ACP and symptom management. End of Life Care Training is not part of mandatory training in Bolton

4. Recommendations

1. Parallel Planning

Ensure that patients with advanced chronic disease have access to palliative care alongside disease modifying treatment

Non-specialist palliative care should be a core competency for all healthcare staff.

Build parallel planning into normal hospital processes. This report suggests 'A box on an admission proforma to help identify patients in need of palliative care support'.

Questions for Bolton

Do we add 'Recognising Dying' to Trust Mandatory Training?

Do we need a prompt on admission documents on EPR?

The 'Early' Project in collaboration with Salford and Wigan will help identify patients likely to have limited prognosis from information on EPR

The SPC ED project with our 2 senior clinicians is helping to identify patients requiring palliative care at the 'Front door' and is having benefits in terms of ACP, reduced LOS, improved symptom control.

Where SPC team was involved there was more parallel planning. One way of improving ACP is to increase manpower in SPCT.

We do not feel that the suggestion of a 'Box on an admission proforma' would be helpful as we know that non-specialist staff are not picking up palliative care needs.

2. Normalise Conversations Around Death and Dying

Consider the surprise question. 'Would you be surprised if this patient died within the next 12 month? Consider recurrent hospital admissions of patients with advanced chronic disease.

Questions for Bolton

Do we need to consider AMBER Care Bundle or similar (this was raised following NACEL). Where this has been successfully implemented it has been labour intensive and difficult to maintain? We believe that the project will pick up patients requiring palliative care review and ACP will follow.

How do we improve liaison between secondary and primary care re GSF?

How do increase the numbers of patients in the last year of their life who have a recorded and updated EPaCCs?

3. A named Coordinator

Ensure all patients with advanced chronic disease are allocated a named care coordinator.

Questions for Bolton

Is this a realistic/appropriate model?

Would an increase in the number of 'Virtual wards' encourage similar outcomes?

4. Access to services

Provide specialist palliative care services in hospitals and in the community to ensure all patients, including those with non-malignant diseases receive the palliative care they need.

Early access to non-specialist and end of life care should be available to all who need it. Specialist palliative care services should be available when a patient's symptoms cannot be adequately controlled.

This report suggests sharing of knowledge and dual training of clinical nurse specialists.

MDTs including SPCT sufficient to provide a seven day service (as per NICE Cancer Standards) could be applied to non-cancer conditions.

Questions for Bolton

Our SPCT will see patients regardless of diagnosis. Enhancing our service with more Senior Clinicians will allow for Specialist Palliative Care Decision-making 7 days a week. A skill-mix team will help to improve identification of patients who would benefit from ACP discussions.

Can we support improved resources for the SPCT in both the Acute Trust and Community?

How do we improve our reach to ensure that all patients have access to palliative and specialist palliative care when they need it? How do we increase our impact with the resources that we have?

5. **Train patient-facing healthcare staff in palliative and end of life care**

Embed palliative care and end of life care training as a core competency. A similar example would be Basic Life Support (BLS) training.

Focused training to a level appropriate to the job role with agreed core competencies.

Questions for Bolton

The Specialist Palliative Care Team work in a 'liaison' capacity sharing knowledge with clinical staff at the bedside. The 8a role in ED is enhancing skills of staff in ED.

Palliative Care and End of Life Care Training is available to all nursing staff. Basic communication skills training is available to all.

We provide teaching on Palliative and End of Life Care to Foundation trainees, CMTs and GPSTs. We offer Difficult Conversation SIM sessions to F1 doctors.

We are developing DNACPR Decision-making training for Senior Clinicians.

None of this is mandatory-how do we improve uptake? We need Palliative and End of Life Care KPIs on Acute wards and in community.

6. **Ensure that existing advance care plans are shared between all providers involved in a patient's care**

Use electronic records or send the document with the patient when they go home

Questions for Bolton

How do we make everyone aware of EPaCCS and increase the number of patients with an ACP documented on an EPaCCs?

7. **Raise Public Awareness to increase the number of people with a registered health and welfare Lasting Power of Attorney (LPA) before it is needed**

Media campaign required

Conclusions

The findings of this National Review are in keeping with our own findings from NACEL.

We need to improve the number of patients with both malignant and non-malignant disease who have a documented Care Plan. We need to improve use and access to EPaCCS.

We need to improve our recognition and acknowledgement of the dying phase. We need to ensure access to education and training for all staff. Some aspects of training in End of Life Care should be mandatory (All of us die).

However, educational will only go so far and with high staff turnover it is important that there is access to Specialist Palliative Care in all care settings. In order to improve and to meet the needs of patients as numbers of deaths increased it is important to support development of the Specialist Palliative Care Team.

Appendix E – For Information Only

Report Title:	DNACPR governance			
Meeting:	Clinical Governance and Quality	**Action Required**	Assurance	
Date:			Discussion	
Executive Sponsor	Chief Nurse and Medical Director		Decision	✓

Purpose of the report	To outline the expectations of divisions regarding DNACPR governance and reporting responsibilities.

Previously considered by:	Resuscitation Committee

Executive Summary	To improve the governance with DNACPR decision making at the Trust and to support a cycle of learning and improvement: For divisional governance teams to audit DNACPR decision making in their clinical areas and present the results, along with an action plan, to the Resusciation Committee quarterly. Divisional governance teams to report on compliants and incidents relating to DNACPR in their quarterly reports. For the Resuscitation Committee to present the divisional quarterly reports, along with cardiac arrest RCAs and FOIs to Mortality Steering Grop for scrutiny, as well as Learning from Deaths for oversight.

Proposed Resolution	The Clinical Governance and Quality Committee is asked to approve the DNACPR governance 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	Improving the Trust's understanding of DNACPR decision-making within divisions and support a cycle of learning and improvement
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Dr Rebecca Lennon	Presented by:	Dr Rauf Munshi

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

DNACPR	Do not attempt cardiopulmonary resuscitation
RCA	Root cause analysis

1. Background

The Specialist Palliative Care team were responsible for version 9 of the DNACPR policy, supported by a DNACPR steering group, which was poorly attended despite efforts to improve engagement.There is not enough clinical expertise and oversight within the Specialist Palliative Care team to understand the issues with DNACR decision making in all patient groups across the Trust, audit and drive appropriate improvement. Responsibility for the DNACPR policy has therefore moved back to the Resuscitation Committee to provide this oversight and improve the governance support for DNACPR decision making. This paper sets out the governance framework for DNACPR decision making that this committee will oversee and what the responsibility of divisions should be.

Auditing the Trust's DNACPR policy used to take place on an annual basis by the Specialist Palliative Care team. The audit would include all ward areas, excluding paediatrics. As such, only recommendations could be made to support improvement. Trust-wide changes were made, but it was challenging to influence any changes that were robustly monitored at divisional or service level. This paper proposes an audit design for divisions to follow, so that audit is completed to the same standard across the divisions.

2. Governance framework

To improve the governance with DNACPR decision making, the Resuscitation Committee has taken back ownership of the DNACPR policy. The committee already has clinical expertise from other divisions, but it will now also have representation from a Palliative Medicine Consultant.

The committee will receive the following information:

<u>Quarterly from divisional representatives</u>

- DNACPR decision making audit results and action plans
- Complaints related to DNACPR decisions
- Incidents relating to DNACPR decisions

<u>From the Resuscitation Officers</u>

- Cardiac arrest RCAs

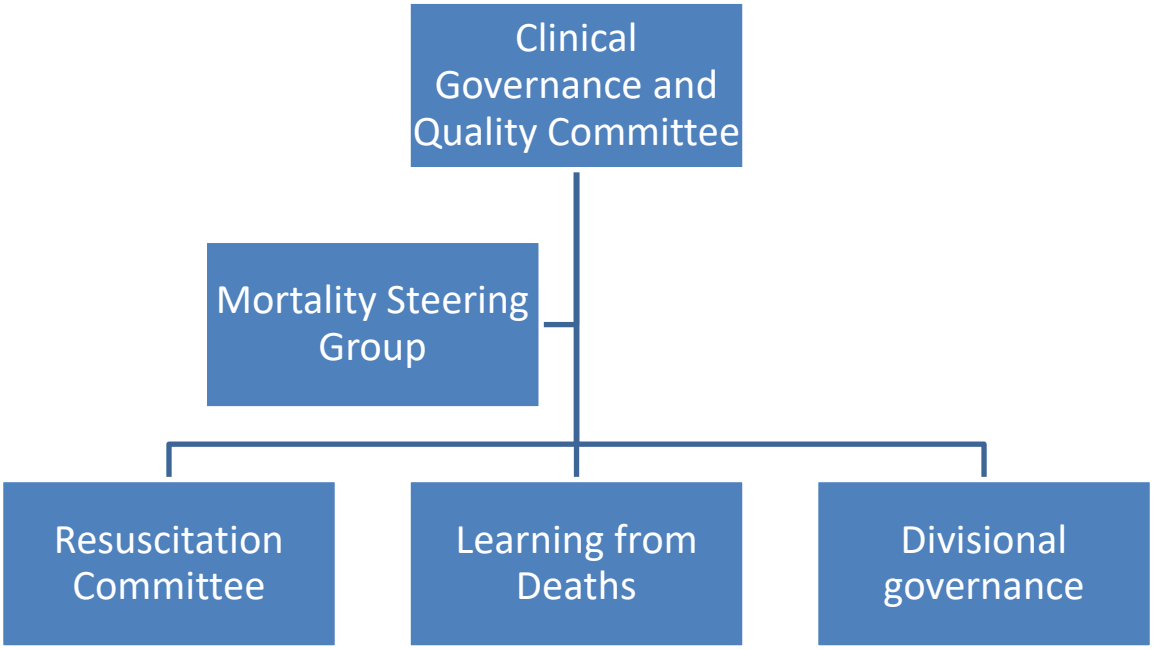
<u>From the Chair of the Resuscitation Committee</u>

- Freedom of information requests

This will allow for a greater oversight of issues relating to DNACPR decision making and ensure there are robust action plans for improvement overseen at divisional level, with Trust-wide action plans supported by the Resuscitation Committee where appropriate.

These reports will be fed into Mortality Steering Group and also to Learning from Deaths committee for oversight.

The Trust DNACPR policy will be reviewed by the Resuscitation Committee members in line with anticipated review time-frames.



3. Divisional Audits

NHS Improvement commended the Trust-wide annual audit, so this proposal includes the elements of this audit, which includes scrutinising both the documentation and decision-making elements of DNACPR decision-making.

The annual audit looked at every DNACPR decision that was present in the Trust on one day. The rates of DNACPR decision-making differs though between divisions, with Acute Adult being the division that makes the most DNACPR decisions. It is therefore more resource intensive for this division to audit DNACPR decision making. Moving to a quarterly audit will lessen the resource needed without affecting the validity of the audit results.

Audit standards

Case note review:

1. A DNACPR decision must be discussed with the patient, unless they do not have capacity or the discussion would cause severe psychological harm (not just distress)

2. If the patient does not have capacity, then a capacity assessment must be documented and decisions taken in the best interests of the patient
3. If the patient does not have capacity, the DNACPR decision must be discussed with their nominated person promptly and there should be reasonable attempts made to contact this person, even if out of hours
4. The DNACPR decision and discussion should be documented in the patient's notes
5. The DNACPR decision should also be documented on the lilac unified DNACPR form
6. The rationale for the DNACPR decision should be justified by documenting the severity of that condition(s)
7. If the DNACPR decision was made by a resident doctor, the decision must be verified by the Consultant in charge of the patient's care at the earliest opportunity (within 24 hours)
8. There should be a resuscitation and escalation plan completed on the EPR
9. An Electronic Palliative Care Coordination System (EPaCCS) should be completed on GMCR if the patient has a life-limiting condition

Ward level assessment:

10. Staff know who has a DNACPR decision on the ward, when asked, through handovers and discussion at safety huddles

BoSCA assessment:

11. Staff know where the DNACPR paper forms are filed/stored
12. Staff know where to find the DNACPR information leaflet
13. Staff know that the unified DNACPR lilac form is given to the patient or their family member on discharge

4. Recommendations

For divisional governance teams to audit DNACPR decision making in their clinical areas and present the results, along with an action plan, to the Resusciation Committee quarterly.

Divisional governance teams to report on compliants and incidents relating to DNACPR in their quarterly reports.

For the Resuscitation Committee to present the divisional quarterly reports, along with cardiac arrest RCAs and FOIs to Mortality Steering Grop for scrutiny, as well as Learning from Deaths for oversight.

Appendix 1 – audit proforma

version 3 DNACPR Audit 2024 - Blank P

Appendix 2 – audit guidance

How divisions decide to audit should be based on the frequency of DNACPR decision making within the division. Most DNACPR decisions are made within 24-48 hours of attendance, so auditing on a ward is not usually reflective of the DNACPR decision making of that clinical team. Auditing a full ward of patients in medicine is more likely to be indicative of the practices across the whole division.

The audit needs to be completed by staff who are familiar with making and documenting DNACPR decisions. Wards should not audit themselves, in case they are auditing their own decision making, but this should be done by a clinician independent to the ward.

<u>When on the ward:</u>

Locate where the patient paper files are kept. Look in each folder for a liliac DNACPR form. Make a list of these patients.

Approach the nurse in charge to inform of the audit and ask which patients on the ward have a DNACPR decision. They are allowed to consult their handover documentation.

Audit all the lilac forms as per the proforma. Make any relevant notes on the proforma or in supporting information.

1 – audit what has been documented on the form and the rationale if not discussed.

2 – audit what has been documented on the form and the rationale if not discussed.

3 – the severity of the medical conditions must be documented, as requested by CQC. For example, frailty must be quantified by a CFS, heart failure or COPD must indicate that it is severe or end-stage. Documenting multi-morbidity is not acceptable, as not every medical condition the patient has will be life-threatening. Only the conditions that make CPR futile need to be documented. Collect data on what clinicians are documenting.

4 – the clinical responsibility for the patient lies with the most senior clinician, therefore all DNACPR decisions should be ratified by a consultant within 24 hours. This is written within the policy.

<u>On EPR:</u>

Check the banner of each patient on the ward and see if they are for CPR or DNACPR. Check that the list of patients with a paper DNACPR decision matches who is DNACPR on EPR. Make a note in supporting information if there are any discrepancies.

Audit all the patients who are DNACPR on EPR as per the proforma. If they do not have a paper DNACPR form, then leave this section black. Make any relevant notes on the proforma or in supporting information.

5 – the easiest way to check this is by pulling the patient banner down as resus status is documented on there. This will only say DNACPR if the resuscitation status and treatment escalation plan has been used. This document should be used, as this pulls through to all templates and subsequent admissions.

6 – there needs to be documented evidence that the DNACPR decision has been discussed with the patient. This is a legal requirement. If they do not have capacity when the decision was made, but have since regained capacity, it must be discussed with them then. If it has not been discussed due to the risk of significant psychological harm, the rationale and justification for this must also be documented. The risk of causing distress is not enough of a reason to not discuss the decision. The discussion documentation will be found within the resuscitation status and treatment escalation plan form or within the notes at the time the DNACPR decision was made. If this was a decison made on on a previous admission, it is good practice to make sure the patient is still happy with the decision, so there should still be a discussion documented, even if this is brief.

7 – an indication of capacity should be documented on the resuscitation status and treatment escalation plan. If the patient does not have capacity, an assessment should be documented on the formal capacity assessment.

8 – there needs to be documented evidence of a DNACPR decision discussion with the relevant other, unless the patient has not consented for information to be shared with them. This is a legal requirement. This will be found within the resuscitation status and treatment escalation plan form or within the notes. If the patient has capacity, this does not need to take place at the same time the DNACPR decision is made.

9 – if the patient does not have capacity, then the relevant other needs to be informed of the decision at the time of the decision is made, even if this is out of hours. If this person is not contactable, then attempts to contact that person should have been documented and repeated attempts evident.

10 – each patients GMCR record should be accessed to check for an EPaCCS. This should be evident on the landing page (figure 1). DNACPR decisions should never be done in isolation. They should be part of a wider discussion about ceilings of care and advance care planning, which should be documented on EPaCCS.

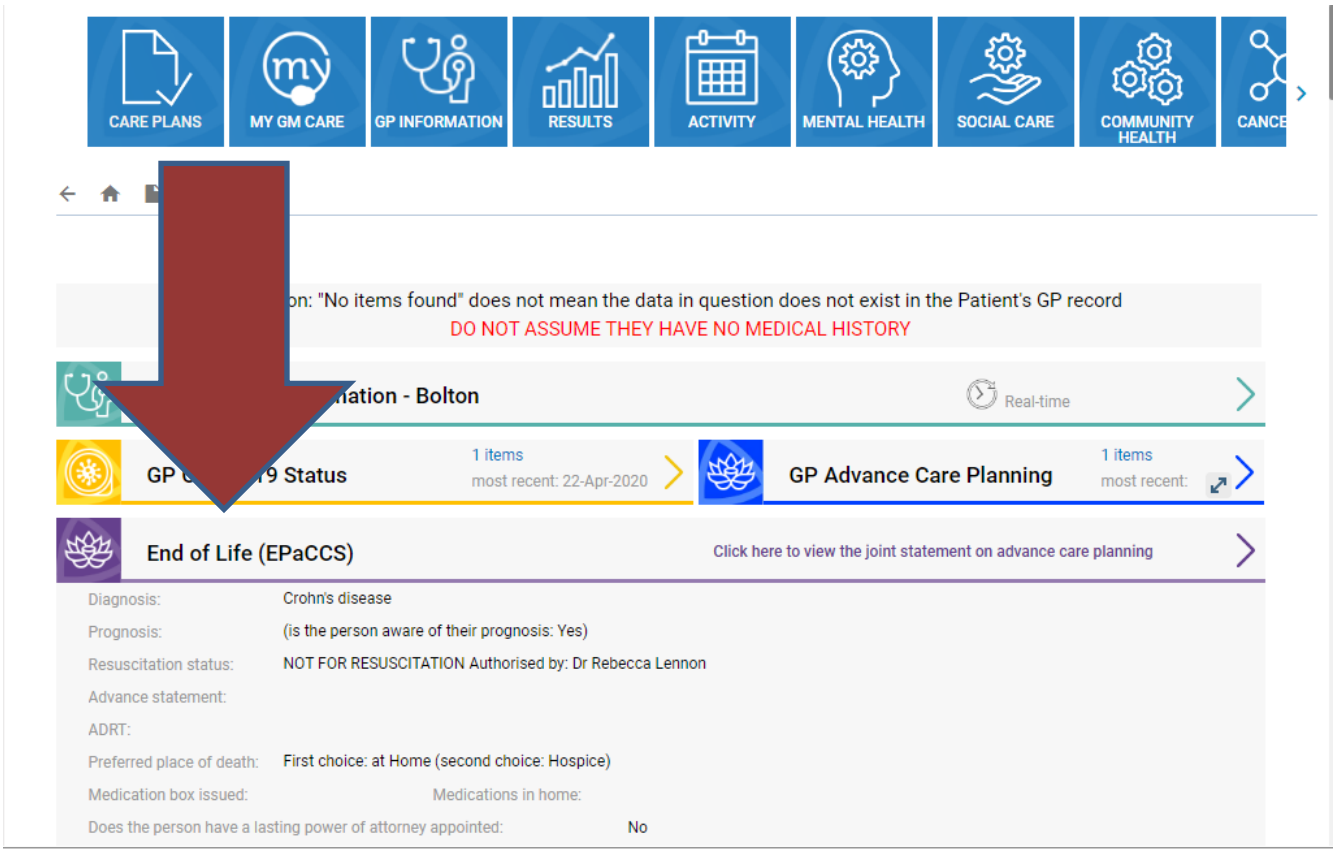

CARE PLANS
MY GM CARE
GP INFORMATION
RESULTS
ACTIVITY
MENTAL HEALTH
SOCIAL CARE
COMMUNITY HEALTH
CANCE
on: "No items found" does not mean the data in question does not exist in the Patient's GP record
DO NOT ASSUME THEY HAVE NO MEDICAL HISTORY
nation - Bolton
Real-time
GP 9 Status
1 items
most recent: 22-Apr-2020
GP Advance Care Planning
1 items
most recent:
End of Life (EPaCCS)
Click here to view the joint statement on advance care planning
Diagnosis: Crohn's disease
Prognosis: (is the person aware of their prognosis: Yes)
Resuscitation status: NOT FOR RESUSCITATION Authorised by: Dr Rebecca Lennon
Advance statement:
ADRT:
Preferred place of death: First choice: at Home (second choice: Hospice)
Medication box issued:
Medications in home:
Does the person have a lasting power of attorney appointed: No

Figure 1.

Report Title:	People Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	
Executive Sponsor	Chief People Officer		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.

Executive Summary	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 20 May 2025. 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, Chief People Officer	Presented by:	Sean Harriss, Non-Executive Director

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

Name of Committee /Group:	People Committee	**Reports to:**	Board of Directors
Date of Meeting:	20 May 2025	**Date of next meeting:**	15 July 2025
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- NHS Staff Survey Results/Our Voice Change Programme
- NHS England Health & Wellbeing Presentation
- Freedom to Speak Up Annual Report
- Guardian of Safe Working Annual Report
- Employee Relations Update
- Resourcing & Retention Update
- Nursing & AHP Staffing Report
- Midwifery Staffing Report
- IFM Monthly People Report
- Culture Dashboard
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

ALERT

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ADVISE

NHS Staff Survey Results/Our Voice Change Programme - This item is on the Board of Directors agenda for discussion. The main areas considered at the People Committee are addressed in the cover paper.

NHS England Health & Wellbeing Presentation - Following an on site visit from NHS England to Bolton FT earlier this year to showcase the Our Voice Programme, we were asked to present at the North Network Event as a good practice example of how cultural improvement ultimately supports approaches to reduce absence and support wellbeing during challenging times. Over 150 delegates from Trusts across the North West and North East attended the session via Teams and we recived positive feedback around Bolton's journey and requests for further information both at the event and afterwards. The Committee welcomed this presentation and noted that Bolton it is important that we celebrate our successes and the culturual journey that has been taking place.

Resourcing & Recruitment Update - The Committee received a presentation that outlined key resourcing metrics, highlighting both strong performance areas and ongoing challenges. It compares Worked Whole Time Equivalent (WWTE) figures against workforce plans submitted to NHSE for 2024/25 and 2025/26. WWTE rose significantly in March 2025 due to increased substantive and bank staffing, although the year has started off with a stronger Month 1 position which shows a reduction of 122 WWTE. The Committee welcomed the detailed paper but noted further work was required to help triangulate the financial and workforce reporting.

Given the importance of controlling our workforce numbers and resultant spend then the Committee heard the following is in place.

- Board level governance. Standing item on both People Committee and Finance Committee. Escalations to BoD via Chair reports. The Quality Assurance Committee will also consider the Quailty Impact Assessments on the proposed plans.
- Executive and Senior team level governance. WTE reduction monitored via Financial Improvement Group; Resourcing Group and improved forecasting at EPP.

- Divisional / Departmental. Enhanced forecasting reporting has been developed to look at substantive staffing using recruitment, turnover, and exit data – drilled down at Divisional level. Detailed reporting being provided on agenda for change temporary staffing via NHSP.

It was confirmed that the Trust has supported 79 Mutually Agreed Resignations (MARS). Those MARS supported were linked to the organisationl change programmes in place within the organization.

IFM Monthly People Report – The Committee received the update report on staffing matters relating to iFM. The report provides oversight of the performance of workforce metrics and key people projects in line with the iFM People Plan. The Committee noted that iFM in conjunction with IQVIA were aiming to run the Annual Staff Survey from September2025. The Committee asked that the workforce plans were fully reflected in the overall Trust's plans with regard to the savings plans for 2024/25.

Employee Relations Update – The Committee received the report covering the period July to December 2024 which detailed set out the employee relations activity covering disciplinary,grievance and tribunal cases for the Trust.

Culture Dashboard – Noted.

ASSURE

Freedom to Speak Up Annual Report - This item is on the Board of Directors agenda for discussion. The main areas considered at the People Committee are addressed in the cover paper.

Guardian of Safe Working (GOSW) Annual Report – This item is on the Board of Directors agenda for discussion.

The number of exception reports submitted has remained consistent, with 194 reports this year compared to 193 in the previous year. The primary reason for exception reporting has been junior doctors working above their contracted hours due to high workload and/or low staffing levels, a pattern that has been consistent over the years. Exception reports from resident doctors highlighting missed educational sessions due to service pressures were escalated to the Director of Medical Education as per protocol. Two exception reports were identified as 'immediate safety concerns' by the doctors. These were reviewed by the relevant educational supervisor and GOSW, and concerns were escalated as appropriate. No work schedule reviews or fines have been levied by the GOSW during the reporting period. Most exception reports submitted by junior doctors who worked extra hours have been actioned for payment. The GOSW will continue to liaise with doctors, particularly those grades and specialties not currently exception reporting, to encourage the use of the system. Discussion took place on previous concerns raised about General Surgery and the Committee were advised that this was being addressed through work being ubdertaken on the rotas.

Nursing & AHP Staffing Report – This item is on the Board of Directors agenda for discussion.

The Bi-Annual Nursing and AHP Staffing Report for July to December 2024 highlights significant progress made by Bolton NHS Foundation Trust in ensuring safe and effective nurse staffing levels. The Trust has implemented various initiatives, including revised e-Rostering KPI reports, assurance processes, a revised Heat Map with workforce and quality indicators, red flag reporting, and robust validation methods for Safer Nursing Care Tool (SNCT) census. These efforts have led to improved compliance and increased assurance.

The report also identifies areas for continued improvement to enhance compliance with the National Quality Board (NQB) Workforce Safeguard recommendations. Ongoing transformation initiatives, such as the sign-off of the safe staffing policy, the wider rollout of the enhanced care assessment tool, and the expansion of SNCT into new areas, demonstrate the Trust's commitment to continuous improvement and patient safety. The organisation's efforts to

enhance nurse staffing processes and monitoring arrangements have yielded positive outcomes, ensuring that patient care remains safe, effective, and sustainable. The recommendations and next steps outlined in the report will help the Trust maintain high standards of care and achieve its strategic ambitions, ensuring the delivery of the NQB's key principles of having the right staff, with the right skills, in the right place at the right time.

Maternity Staffing Report - This item is on the Board of Directors agenda for discussion

The Bi-Annual Maternity Staffing Report for July to December 2024 highlights the ongoing maternity workforce challenges and details the actions taken to mitigate risk to clinical safety and improve training compliance in order to provide assurance of a safe maternity service. 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.

New Risks identified at the meeting: None

Review of the Risk Register: None

Members	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug		
Tosca Fairchild (Chair)	✓		**A**							
Fiona Taylor	✓		✓		✓					
Alan Stuttard	✓		✓ **chair**		✓ **chair**					
James Mawrey	✓		✓		✓					
Fiona Noden	✓		✓		✓					
Tyrone Roberts	**A**		✓		✓					
Sharon White	✓		**A**		✓					
Sharon Katema	✓		**A**		✓					
Annette Walker	✓		✓		✓					
Sean Harriss	✓		✓		✓					
Francis Andrews			**A**		✓					
Seth Crofts	✓		✓		✓					
Rebecca Ganz					✓					

Report Title:	Staff Survey Response, Our Voice Change Programme & People Promise Plan			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Chief People Officer/Deputy Chief Executive		Decision	

Purpose of the report	This report proposes how the organisation intends to respond to the 2024 staff survey – specifically the trust wide cross cutting themes.

Previously considered by:	The report has been discussed at People Committee who requested a series of actions to bring back to the next meeting (detailed within this Board report).

Executive Summary	The report provides the results of the 2024 NHS National Staff Survey. It provides: • A summary and findings of the 2024 National Staff Survey results • A survey data deep dive and free text responses summary • A response and accompanying actions including next steps for the Our Voice Programme • The People Promise Plan

Proposed Resolution	The Board is asked to ***receive*** the details of this report and that the People Committee will oversee all relevant actions on behalf of 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	**Yes**	The findings of the survey will be a key resource to support the acceleration & implementation of our Financial Improvement Plan
Legal/ Regulatory	**Yes**	The survey data and response will support the delivery of statutory objectives such as the Equality Act and Workforce Race Equality Standard (WRES) and Worlforce Disability Equalty Standard (DES) .
Health Inequalities	**Yes**	The survey data and response can help reduce health inequalities by highlighting workforce inequalities, supporting inclusive workforce policies and creating a culture of belonging.
Equality, Diversity and Inclusion	**Yes**	The findings of the survey will be a key resource to support the acceleration & implementation of our EDI Improvement Plan

Prepared by:	Lynne Doherty, Staff Engagement Practitioner Dawn Grundy, People Promise Manager Lisa Rigby, Assistant Director Organisational Development	**Presented by:**	James Mawrey, Deputy Chief Executive and Chief People Officer

1. Introduction

The People Committee received the 2024 NHS Staff Survey response, Our Voice Programme update and updated People Promise Plan. A full and detailed discussion took place around the areas of focus.

Board members will be aware that fostering a culture of listening and acting on feedback, linked to wider culture improvemen remains a critical priority for Bolton Foundation Trust and is a key ingredient of the Trust Strategy, People Plan and NHS People Promise.

2. People Committee discussions and actions

The Committee of the Board expressed their appreciation for the comprehensive report and noted the following points during their discussion:

- The amount of data to respond to in relation to the staff survey is extensive and the People Committee acknowledged the further work taken since the March meeting to dig deeper into the data and provide a summary of areas of focus alongside a thematic analysis of the free text comment themes.
- The Committee welcomed the review of the Our Voice Programme and associated change themes building on the success so far.
- The introduction of a range of other inclusive listening mechanisms at local levels which act on 'live' themes was positively received.
- The People Promise Action Plan proposed was endorsed, with the Committee supporting the importance of linking the survey to wider cultural themes and linking people metrics alongside quality and performance.
- The Trust recently presented at a National forum about the positive cultural actions being taken and the outputs being deomstrated. This was welcome and encouraged.
- The signifanct improvement in response rate was discussed and all agreed that we need to build on this good work and ensure as many colleagues as possible respond to the survey.
- The Committee welcome the news that IFM will be undertaking the same survey in the same timescales. This will help the organisation better understand our group position.

3. Recommendation to the Board of Directors

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.

1. Introduction

The Bolton NHS Foundation Trust Staff Survey 2024 provides invaluable insights into the experiences, perceptions, and opinions of the Trust's workforce. This report aims to provide a high level recap on the key findings of the survey, identify areas of strength and improvement, and proposed trust-wide recommendations to enhance staff satisfaction and organisational performance aligned to our strategic ambition as a great place to work.

2. Staff Survey 2024

The full findings of the NHS Staff Survey have already been published and shared throughout the organisation. A total of 2940 colleagues completed the 2024 survey from a usable headcount of 6107 staff, this is a 6% increase from 2023.For the Trust's comparator group, the response rate median was 49%

The People Promise scores are noted below:

People Promise Element / Theme	2023	Significance	2024	Significance	Sector Av Score
We are compassionate and inclusive	7.37	Not Significant	7.40	Significantly Better	7.21
We are recognised and rewarded	6.06	Not Significant	6.12	Significantly Better	5.93
We each have a voice that counts	6.79	Not Significant	6.80	Significantly Better	6.67
We are safe and healthy	6.05	Significantly Improved	6.16	Significantly Better	6.09
We are always learning	5.66	Not Significant	5.74	Not Significant	5.64
We work flexibly	6.13	Significantly Improved	6.34	Significantly Better	6.24
We are a team	6.93	Not Significant	6.98	Significantly Better	6.74
Theme - staff engagement	6.92	Not Significant	6.91	Not Significant	6.84
Theme – morale	5.91	Significantly Improved	6.03	Significantly Better	5.93

2.1. Key Findings:

- The staff survey finding is an opportunity to celebrate what we have done well but to also ensure that focus is given to those areas requiring improvement.
- IQVIA have communicated that our results are excellent, and give an indication of a well-managed Trust which is continuing to improve the experiences of staff.
- In what remains a challenging time for the NHS, the results show a Trust which is responding well to current challenges, while maintaining a happy and engaged workforce. This will impact positively on patient care
- When comparing our results we are above the national average for all of the People Promise elements and themes which demonstrates an improvement from the 2023 survey. The survey did tell us, however that there are areas showing a decline which require improvement.

2.2. Areas of Strength

- Team work, Line Managers and Culture
- Morale
- Flexible Working & Work Life Balance
- Health & Safety Climate & Negative Experiences

2.3. Areas for Improvement

- Recommended as a Place of Care:
- Discrimination (Religion)
- Unwanted Sexual Behaviour: (patients/public)
- Paid Hours
- Access to equipment, materials & supplies
- Appraisals (objective setting, training & development)

2.4 Deep Dive into survey data

IQVIA (survey providers) recommended we explore the following themes in more detail:

- Recommend as a place to receive treatment (Q25d)
- Access to adequate materials, supplies and equipment (Q3h)
- Have experienced discrimination on the grounds of religion (Q1603)

Appendix 1 details a breakdown of these questions.
For Q25d (recommend as a place to receive treatment) data shows that Patient Safety & Experience, Medical Education & DSSD have the highest negative response to this question.

For Q3h (access to adequate materials, supplies and equipment) Medical Education, Family Care Division & DSSD have the highest level of negative response to this question.

For Q1603, (have experienced discrimination on the grounds of religion) Family Care Division, DSSD & Workforce & OD have the highest negative response to this question.

When looking at professional groups, AHP's, Add Prof Scien Tech and Admin staff are professions which would benefit from further in depth analysis as focus areas.

It is critical that Divisional and Professional Staff Group Leads, supported by Corporate Teams, collectively acknowledge reality whilst also being curious about variation, celebrate successes and good practice, identify priority areas for action and support and empower teams to drive improvements.

2.5 Free Text Comments

The 2024 survey free text survey comments have been thematically analysed both by the Trust and IQVIA. In the 2024 NHS staff survey, 599 colleagues provided a free text comment, seeing an increase from 528 comments in the 2023 survey. For context, the amount of surveys completed by colleagues in 2024 was 2940 (48%) a rise of 6% from the 2023 survey. The areas which received the most amount of comments, are in the left hand column below with observations and recommendations:

Theme	Observations	IQVIA Recommendations
Staffing, Pressures & Resources (negative)	Expressed concerns about the sustainability of current staffing levels and the need for better support and investment in frontline staff.	• Address Understaffing • Improve Resource Allocation • Provide Support
Values & Leadership (negative)	Perception of organisation objectives on targets and financial goals. Some comments around perceived lack of consultation and involvement in decision-making	• Align Goals with Values of patient care and staff well-being • Enhance Communication • Promote a Positive Culture & encourage collaboration • Provide training for managers to enhance their leadership skills and ensure they are approachable and supportive
Positive Comments	Many staff members appreciated the supportive and friendly nature of their teams and felt proud of their work.	• Leverage Positive Feedback • Celebrate Successes
Career Progression, Recognition & Pay	Some comments around banding structures and lack of opportunities for progression and training.	• Invest in Training and Career Progression • Enhance Recognition Programmes

The full set of free text comments have been shared with the Executive,Divisions and key stakeholders alongside the recommendations from IQVIA.

3. Survey Response

3.1 Trust wide actions – response to IQVIA recommendations

The following are the key deliverables identified as part of the 2024 staff survey results. These focus areas were shared via a series of All Staff Briefings in April 2024. Highlighted in bold is how these actions support the two People Promise themes and seven People Promise elements.

Action	Recommendation/Response
Understand and remedy the decline in staff confidence in recommending the Trust as a **place of care** **"We are compassionate and inclusive"** "Compassionate Culture" "**Staff Engagement**- Advocacy"	IQVIA Recommendation: *Work directly with staff groups to understand why some would not recommend the organisation to a friend or relative if they needed treatment. Prioritise action plans that address any factors related to health and safety. Explore staff data/comments to identify whether this view is held across the organisation or limited to a particular area / staff group* Trust Response A paper is due at Executives on 12 May to set out phase 2 of the Our Voice Change Programme, this will recommend Place of Care as a new focus area.
Access to adequate materials, supplies and equipment **"We are safe & healthy"** "Health & Safety Climate" **Morale** "Work Pressure"	IQVIA Recommendation: *Take action to provide staff with the essential equipment necessary to perform their job and ensure that an efficient system for requesting materials is in place. Consider gathering feedback from staff and complete an audit to identify individuals or groups that require additional materials, supplies and equipment. Review provision of IT equipment and systems.* Trust Response We have increased the number of devices out within the organisation for staff in the last 3 years, increase in laptops by 919% between 2022-2025. However alongside deploying equipment we need to improve the service we provide to maintain, fix and update these devices so that we do not have staff with a device that hinders them carrying out their role, i.e its faulty, broken. Actions to improve these: • Internal workshop regarding how we improve our Service Delivery (ticketing) system - Completed (20th March) o Includes divisional oversight to all tickets but visible by priority o Service catalogue - making ordering equipment easier o End user communication more transparent and progress of equipment available • Work with ServiceNow to plan a roadmap of making improvements as collated in the workshop - (9th May) • Produce timeline of development to ServiceNow • Produce KPIs for Digital Service delivery • Present monthly KPI updates to Digital Transformation Board and Clinical Governance and Quality Committee • Our Voice Change Programme – 'take it out and about' to teams. The survey data provides heatmap 'hotspots' to focus on • The EDI Assurance Group will ensure access to equipment identified as reasonable adjustments is improved
Action against discrimination (religion) **"We are compassionate and inclusive"**	IQVIA recommendation *Identify the staff groups experiencing discrimination because of their religion. Ensure there are visual prompts of the zero tolerance policy in every patient-facing area so staff feel empowered to remind patients/ service users and members of the public of the expected standard of behaviour.* Trust Response • Triangulation of evidence from several sources to explore which groups are experiencing discrimination based on their religion, and from whom. This may include further listening events. • Zero-tolerance posters to be displayed in each patient-facing area to reinforce Trust policy on discrimination. • New governance structure via EDI Assurance Group ties together both patient and colleague EDI critical focus areas.

	• Monitor Anti Racism framework priorities through EDI Assurance Group • Launch new EDI Plan focusing on Data, Inclusive Recruitment, Reasonable Adjustments and Good Culture for staff. The plan also outlines an ambition to upskill both HR and OD in emerging inclusion themes. • Continue to roll out the 'We Belong' section of the Our Leaders Programme • Continue to grow our Neurodiversity Peer Support Group • Launch EDI Blended Learning Bundle self-serve training packages • Continued rollout of a strengthened Equality Impact Assessment requirement and governance, alongside supportive materials and drop in sessions.
Additional PAID hours **"We are safe and healthy" Health, Wellbeing and safety at work**	IQVIA have made a recommendation that we further explore the significance between 2023 and 2024, of colleagues working additional PAID hours over and above contracted hours.This score has significantly declined from 2023 to 2024 (29% to 32%), however the organisation is significantly better than the sector average of 37%. Trust Response: • The Trust monitors and reports on additional working (undertaken via Trust banks, overtime, and medical waiting list initiatives) and this includes checks to ensure our staff are not working above maximum weekly hours as outlined in Trust policies. • Increases seen in additional hour working in 2024-25 were mostly in relation to bank work and were influenced by increased demand (operational pressures, elective recovery, opening of additional capacity, enhanced care) • Circa 40% of all bank bookings in March 2025 were in support of increased demand has this has driven the increase in bank usage seen in year. • Vacancy rates below 5%, with clinical staffing groups showing low vacancy numbers. We expect to see a reduction in additional hour working in 2025-26.
Unwanted sexual behaviour from patients/service users, their relatives or other members of the public. **"We are safe and healthy" – Unwanted sexual behaviour**	IQVIA have made a recommendation that we further explore the following: 306 staff responded that they had been a target of unwanted behaviour of a sexual nature in the workplace by patients/service users or the public. This has shown both a significant negative trend in both in our results compared to 2023 when 229 staff reported this, and against the sector average percentage itself. Trust Response • The Trust has signed up to the NHS England sexual safety charter • The Trust has an implementation group developing a dedicated Policy and implementation plan to support staff in the workplace, outlining clear standards and processes and support mechanisms for any staff who experience this behaviour • It is important that staff feel safe at work and any incidents of unwanted behaviour are raised. Staff are able to raise their concerns through their line managers,the HR team, Trade Union representatives and Freedom to Speak Up Guardians and Champions.
Review and development of FABB Appraisals **"We are always learning" Appraisals**	IQVIA recommendations *Revisit resources and standards for appraisers, including systems used to conduct appraisals. Direct appraisers to identify any areas of improvement in conjunction with tangible resources / training for them to improve (e.g. inform staff of opportunities for learning development). Stress the value of mentorships, learning and development resources. Ensure line managers allocate time to listen to staff and receive feedback to inform what resources staff may need to improve their job.* *Evaluate the usefulness of training materials for appraisers as well as the appraisal structure. Ensure appraisers not only clarify staff members' roles, responsibility and goals, but also that staff leave appraisals with clear objectives to work towards. Direct appraisers to share the objectives of the team as well as wider organisation, and to allocate time to discuss and agree upon each staff member's objectives for the following year.* Trust Response:

	• Conclusion & rollout of the refresh of the guidance and documentation of FABB appraisal and check-ins guidance following period of engagement with staff and managers/leaders • A Blended learning bundle on FABB conversations and appraisals is now live, for staff and leaders/managers. These include a range of learning resources, with access to face-to-face 'bite size' sessions • Full scale roll out of Our Leaders Programme to emphasise the importance of quality check-in conversations and appraisals and their responsibilities to carry out meaningful conversations as part of the Our Leaders Framework .

3.2 Trust wide survey improvement actions – People Promise Plan

The OD team have updated the Trust People Promise Plan (Appendix 2) which responds to the IQVIA recommendations, takes into account the deep dive data and free text comments and qualitative data from listening mechanisms since the survey.

3.3 Divisional Actions

The Divisional Teams are in the process of pulling together their actions and these will be monitored at their Divisional People Committees,Staff Experience Steering Group and reported up to the People Committee. A visual representation of survey results has been offered to divisions, so they can easily share headline results, and key focus areas. A staff survey toolkit has also been devised by the People Promise Manager to support colleagues in discussing survey results within teams.

4 Our Voice Programme

4.1 Recap and future focus

In addition to the data discussed in section three of this report, there are changes to the programme underway. As in 2024, the free text survey comments (alongside key focus areas) will form a key part of the next phase of the Our Voice Change Programme to ensure continued organisational focus on the areas which mean the most to colleagues.

A critical element of phase two of the Programme will be exploring how we hear the voices of staff that may be currently unheard and driving local listening activity.

In reviewing the success of the current programme activity, Flexible Working results have significantly improved and the Trust is one of the top regional improvers. Looking at the other programme activity, we had a reduction in comments around working environment and car parking. For Digital and Values & Leadership themes there is still some work to do.

The change programme has been highlighted by NHS England as a good example of staff engagement and the pulse survey showed us that 71% of respondents are aware of the programme.

We are undertaking a refresh of the change team structure alongside other listening and engagement activities (as discussed in section 4.2) to ensure actions are focussed and taken forward at pace.

Colleagues in IFM due to national policy are not eligbible for the NHS Survey, however we are supporting IFM in identifying mechanisms to undertake a survey and benchmark the results with the Trust. We will continue to work alongside IFM on improvements.

4.2 Communications & Engagement

Enhancing our Communications Channels to support Divisions & Directorates to be inclusive of unheard voices at pace is a priority.
Other measures of success to support the actions and responses to the staff survey and the work which will be undertaken as part of the People Promise includes:

- regular updates from the Our Voice Change Programme as part of the monthly All Staff Briefing (and localised versions)
- a weekly piece in the staff update on the change programme and the Quarterly special edition updates
- the rollout of the Great to Work Noticeboards with supporting materials.

- exploring 'hot topics' Trust wide via polls, team conversations and listening activity
- increased local engagement at scale through polls and huddles, randomised invitations to change programme focus groups and events.
- to continue to work closely to explore the issues via focused conversations at Staff Networks, Support Groups, Champions and any other networks.

4. Linking survey results to wider cultural themes

The Workforce & OD Team are developing the following to bring together 'live' themes that help provide a wider and more informed picture of our organisational culture. These include:

- Developing a bi annual 'Cultural Snapshot' of the organisation from a range of sources such as Employee Relations, FTSU Themes, NQPS, NHS Staff Survey. This will run in parallel with the Cultural Dashboard, the snapshot will also tap into and triangulate data from sources such as the Chaplaincy, Health & Wellbeing Champions and Staff Networks. This will help us make more informed, timely and targeted improvements.
- Piloting a Team Cultural Assesment Tool aligned to the Our Way behaviour framework to help teams identify areas of strength and improvement

5. Governance

The OD team will be monitoring delivery of the Bolton NHS FT Staff Survey Response & People Promise Plan. In addition, the team are supporting divisions/directorates to maximise the insights gained from the 2024 NHS national staff survey at a local level. It is intended for the Trust-wide People Promise Plan to set the overall direction of travel with the action plans complementing and picking up the nuances within their Divisions/Directorates for appropriate areas of focus needed for their teams.

The Trust-wide action plan and divisional/directorate action planning will be monitored and reported on through the Staff Experience Steering Group, Divisional People Committees and Workforce & OD Group and People Committee.

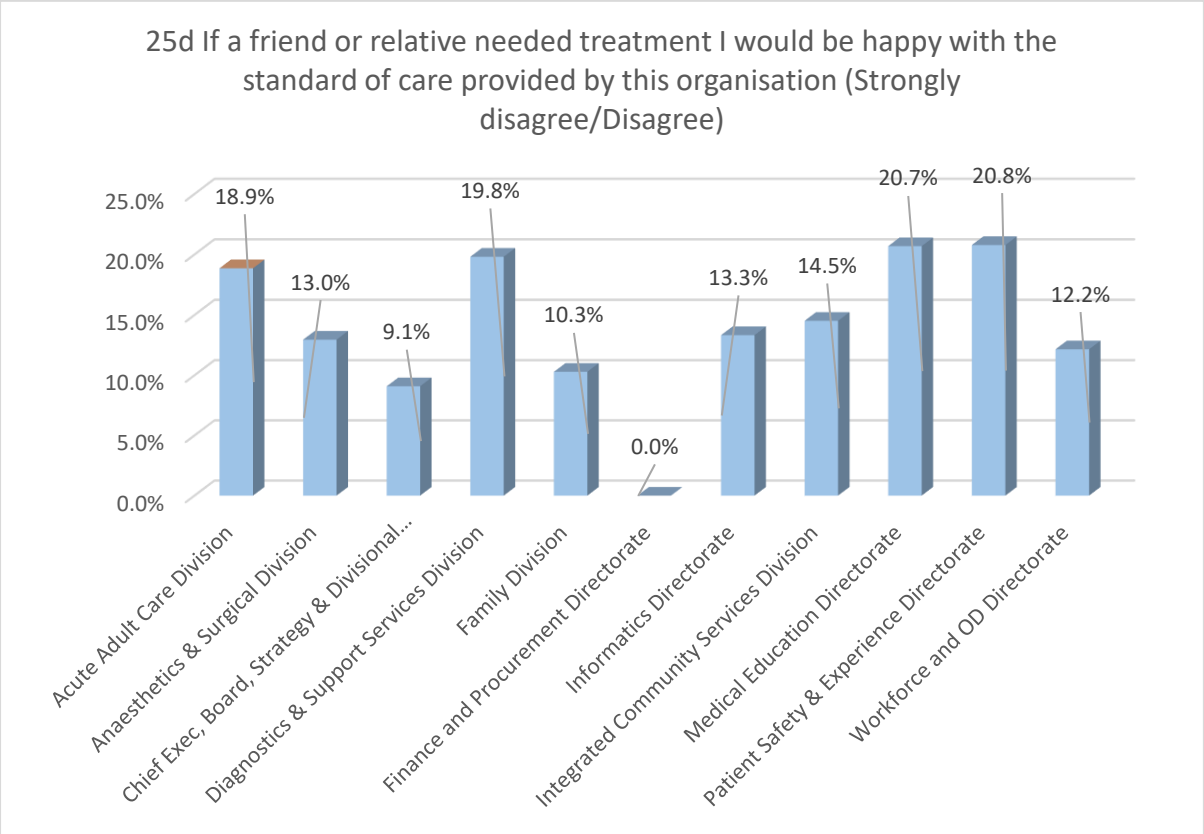
6. Conclusion

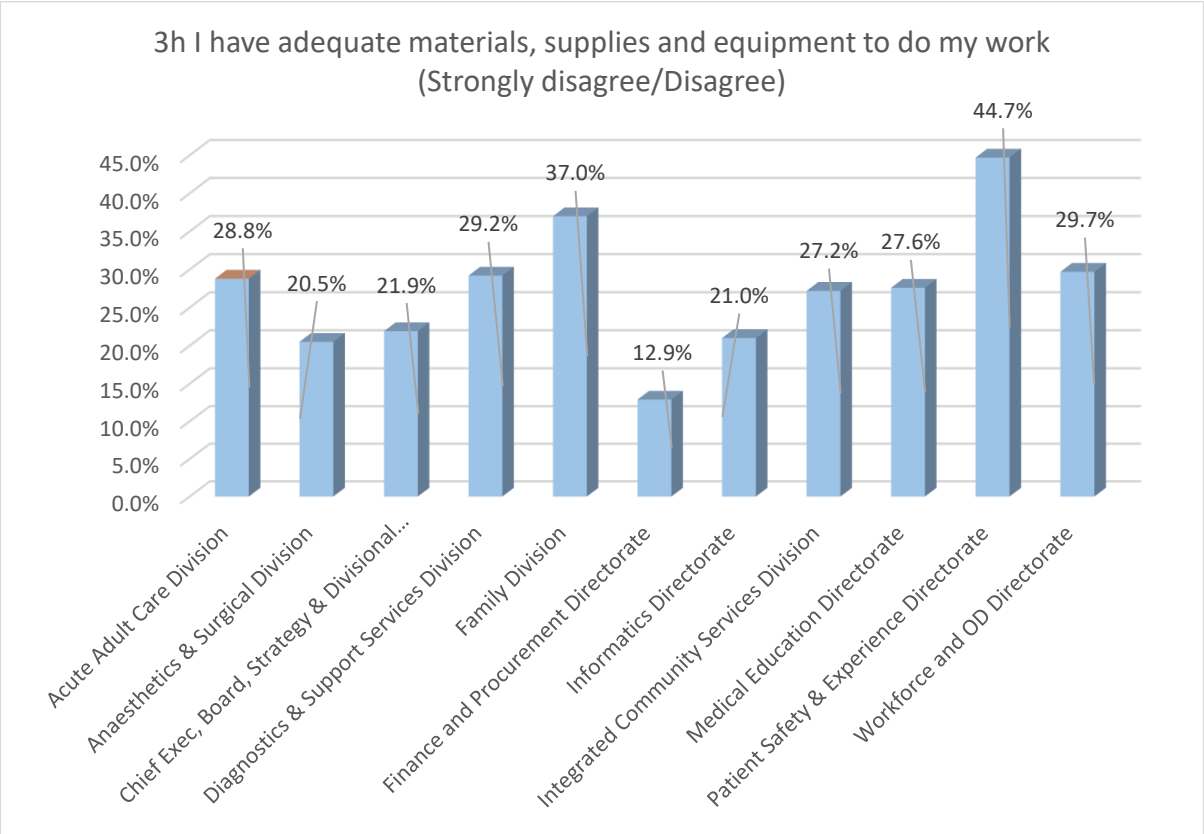
The delivery of the Staff Survey Response & People Promise Plan aligned to the Our Voice Programme is important to ensure that the Trust makes improvements on the priority areas of focus detailed within this paper. This will ensure that the Trust continues to build on its successes, learns where things can be even better and most importantly takes action as a result of colleague feedback to ensure that Bolton NHS Foundation Trust is a great place to work.

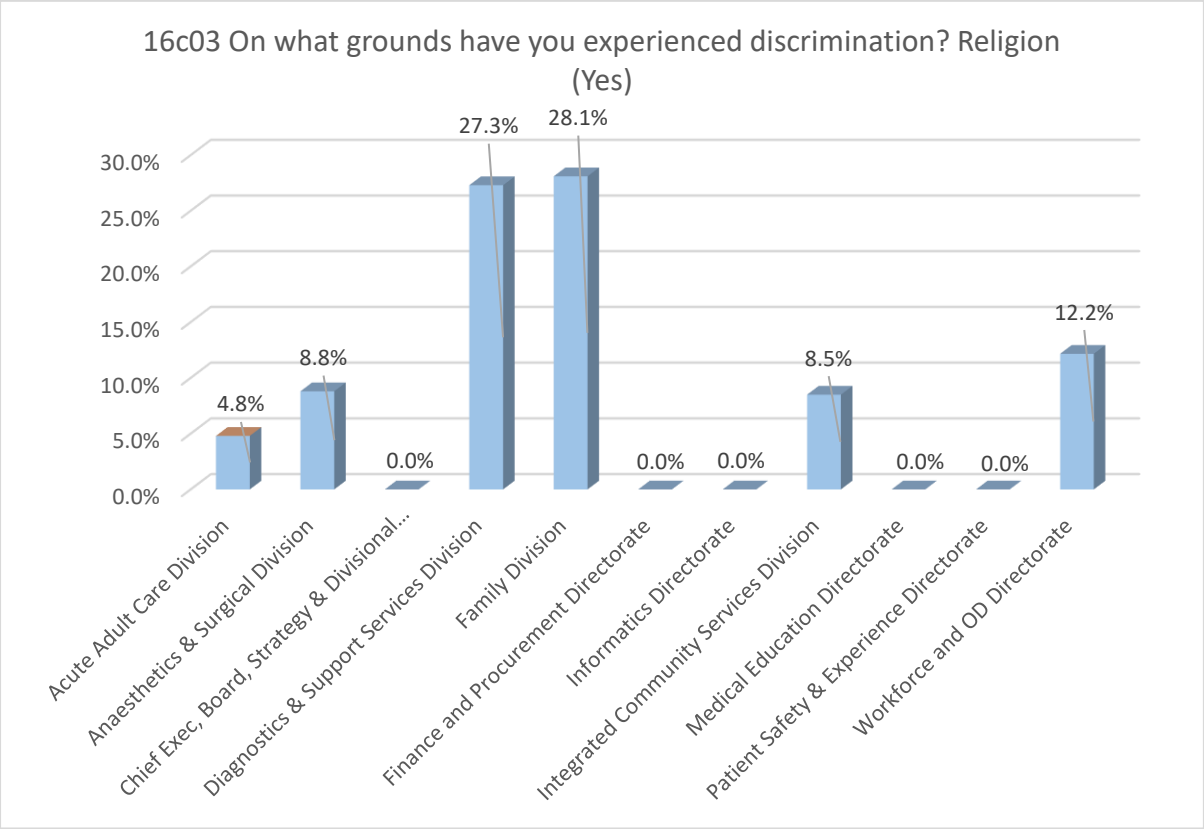
7. Recommendations

It is recommended that the Board of Directors consider the information contained within this report and support the themes noted and recommended actions set out within the paper and in the 2025-2026 People Promise Plan.

Appendix 1 – Focus Area Data Breakdown






16c03 On what grounds have you experienced discrimination? Religion (Yes)
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
4.8%
8.8%
0.0%
27.3%
28.1%
0.0%
0.0%
8.5%
0.0%
0.0%
12.2%
Acute Adult Care Division
Anaesthetics & Surgical Division
Chief Exec, Board, Strategy & Divisional...
Diagnostics & Support Services Division
Family Division
Finance and Procurement Directorate
Informatics Directorate
Integrated Community Services Division
Medical Education Directorate
Patient Safety & Experience Directorate
Workforce and OD Directorate

Appendix 2 - Bolton NHS FT People Promise 2025-2026

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
We are compassionate and inclusive 	Actions against discrimination on the grounds of religion: • We are investigating the data further to better understand the numbers experiencing the discrimination and the sources of the discrimination. • Comparison of our numbers to more comparable Trusts (with comparable diverse populations) to establish further if we are an outlier. • Better triangulation between OD, HR, FTSU. EDI and Chaplaincy on this matter to monitor, including collecting further feedback from staff regarding religious discrimination via anonymous routes to identify causes and solutions. • Releasing the EDI Blended Learning Bundle, which has Religion and Cultural competency as main topics.	EDI Assurance Group Divisions/Directorates	Decline in religious discrimination reports (NSS24- 8.2% to 12%) - significantly worse than sector average ↓ (6.7%)	
We are recognised and rewarded 	Implement more robust recognition programmes to acknowledge and reward staff contributions and achievements: • Develop a comprehensive, clear & accessible package with a mix of financial and non –financial rewards	Staff Experience Steering Group Divisions/Directorates	The extent to which my organisation values my work. (positive response) NSS24 45% ↑ (43%)	

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
	• Sharing colleague stories across the organisation in forums such as Divisional People Committee & Staff Experience Steering Group		Managers value the work of their team members' NSS24 75% ↑ (74%)	
We each have a voice that counts 	Our Voice Change Programme – everyone has a voice that counts –inclusive and 'unheard voices' engagement strategy	Staff Experience Steering Group Divisions/Directorates	The localised NQPS question "Have you heard of the Our Voice Change Programme? 71% positive Q4 ↑ from 64% in Q2.	
	Freedom To Speak Up: • Board Development Event with NGO • Focus on embedding a culture of listening, and action- not just encouraging speaking up but demonstrating that concerns lead to meaningful action. • Work on data triangulation with other speaking up routes.	Chief People Officer FTSU Guardians	If I spoke up about something that concerned me I am confident my organisation would address my concern NSS24 49% positive response ↑ (48%)	
We are safe and healthy 	Unwanted sexual behaviour: • The Trust has signed up to the NHS England sexual safety charter • The Trust has an implementation group developing a dedicated Policy and implementation plan to support staff in the workplace, outlining clear standards and processes and support mechanisms for any staff who experience this behaviour	Deputy Director of People/Head of Resourcing Patient Safety & Experience Divisions/Directorates	Significant decline in unwanted sexual behaviour from patients, service users and members of the public NSS24 (9% to 10%) ↓ and also significantly worse than the sector average (8%)	

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
	Paid Hours: • We will continue to monitor and report on additional working (undertaken via Trust banks, overtime, and medical waiting list initiatives) and this includes checks to ensure our staff are not working above maximum weekly hours as outlined in Trust policies.	Deputy Director of People/Head of Resourcing Divisions/Directorates	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours? This has significantly declined from 2023 to 2024 (29% to 32%) ↓ though it is significantly better than the sector average ↑ (37%)	
We are always learning 	Invest in Training: • Conclusion of the refresh of the guidance and documentation of FABB appraisal and check-ins guidance following period of engagement with staff and managers/leaders • Rollout of the guidance to start from July 2025 as part of wider Our Voice and Our Way comms, with key emphasis on the importance of regular FABB conversations • Blended learning bundles on FABB conversations and appraisals are now live, for staff and leaders/managers. These include a range of learning resources, with access to face-to-face bite size sessions • Full scale roll out of Our Leaders Programme from February 2025 onwards (18 months) to all leaders/managers (estimated 1500) to emphasise the importance of quality check-in conversations and appraisals and their responsibilities to carry out meaningful conversations as part of the Our Leaders Framework	Assistant Director of OD Divisions/Directorates	Appraisals helping to agree clear objectives for my work 33% ↑ (30%) significant improvement but significantly worse than sector average (36%) ↓	

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
	• We will continue to celebrate the success of FABB compliance via the Divisional People Groups, in conjunction with the HR Team.		Appraisal compliance is high 93% ↑ (92%) and significantly above the sector average ↑ (85%)	
We work flexibly 	Regular Reviews & Support: • Policy review to shorten process and provide managers with greater responsibility • Recording of Flexible Working Applications • Animation in production – launching May • Flexible rostering	Deputy Director of People Divisions/Directorates	Can approach immediate manager to talk openly about flexible working 74% ↑(70%) – significant improvement and significantly better than sector average (70%)	
We are a team 	Encourage Collaboration & Align Goals with Trust Values: • Our Leaders Programme and Blended Learning Bundles • Team Effectiveness Toolkit • Our Way Launch	Assistant Director of OD Divisions/Directorates	Staff feel trusted to do their job 93% ↑ (91%) Teams enjoying working with each other 83% ↓ (84%) – however significantly better than sector average (80%)	
Staff Engagement	Understand and remedy the decline in staff confidence in recommending the Trust as a place of care: • Divisional and corporate led workstreams - with data led response reporting • Explore embedding into Our Voice Change Programme	Chief/Deputy Nurse Patient Safety & Experience Divisions/Directorates	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation 59% ↓ (61%) – significantly lower than sector average (62%)	

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
Morale	Ensuring that colleagues have the resources they need to do their jobs: • Internal workshop regarding how we improve our Service Delivery (ticketing) system o Includes divisional oversight to all tickets but visible by priority o Service catalogue - making ordering equipment easier o End user communication more transparent and progress of equipment available • Work with ServiceNow to plan a roadmap of making improvements as collated in the workshop • Produce timeline of development to ServiceNow • Produce KPIs for Digital Service delivery • Present monthly KPI updates to Digital Transformation Board and Clinical Governance and Quality Committee • Our Voice Change Programme – 'take it out and about' to teams. The survey data provides heatmap 'hotspots' to focus on	Director of Digital Divisions/Directorates	Satisfaction with having adequate materials, supplies and equipment to do their work 52% → (52%) significantly worse than sector average (57%)	

Area	What actions are we taking?	Who is responsible?	How will we measure the success?	Progress Status (RAG)
	• The EDI Assurance Group will ensure access to equipment identified as reasonable adjustments is improved • Continuation of the Our Voice Change Programme – Digital Systems and Equipment Change Team Celebrate successes: Regularly celebrate and share success stories to boost morale and foster a positive work environment.	Associate Director of Communications & Engagement Divisions/Directorates	The Trust People Promise Score for Morale has significantly improved (6.03) ↑ (5.90) and is significantly better than sector average (5.93)	

Report Title:	Freedom to Speak Up (FTSU) Annual Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Chief People Officer		Decision	

Purpose of the report	The report outlines the numbers and themes relating to FTSU activity in 2024/25 and how the organisation is promoting a speak up, listen up, follow up culture.

Previously considered by:	People Committee 20 May 2025

Executive Summary	Effective FTSU 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 where speaking up, listening up and following up become business as usual. There were 172 concerns raised by workers via FTSU Route in 2024/25: • Many of the concerns relate to behavior and leadership (or both) • Work has begun on the new Our Leaders programme and relaunching the Trust values and behavior framework

Proposed Resolution	The Board of Directors is asked to ***note*** the FTSU Report and that the People Committee will oversee all relevant actions on behalf of the Trust 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:	Tracey Garde, Freedom to Speak Up Guardian Louise Cartin, Freedom to Speak Up Guardian	**Presented by:**	James Mawrey, Chief People Officer/Deputy Chief Executive

1. Introduction

1.1 The People Committee received the FTSU Annual Report 2024-25 at the meeting on 20 May 2025. A full and detailed discussion took place and the committee requested areas of focus moving forward.

1.2 Board Members will be aware that the provision of an open, transparent speak up, listen up, follow up culture remains a key priority for Bolton NHS FT.

2. High level summary of findings for Board members

2.1 High level summary of FTSU activity is contained within the attachment of the report.

3. People Committee discussions and actions

3.1 The People Committee expressed their appreciation for the report and noted the following points during their discussion:

- Benchmarking data- The Committee asked for assurance that we are in line with our peers with regards case numbers. However, measuring numbers of cases alone can be misleading as what constitutes a good speak up culture- high numbers of concerns or low numbers? High numbers of FTSU concerns in an organisation could suggest a positive speak up culture with high numbers of workers raising concerns via FTSU. It could also indicate a culture where workers were fearful of raising concerns via the usual managerial route. Low numbers could signify a culture where staff are fearful to speak up or it could be an organisation where workers feel confident to speak up to their manager and not require support from elsewhere. Comparing numbers of cases with peers does not therefore tell the whole story. It is more important to understand our own story by effective triangulation of data by all the various speak up routes.

- Monitoring of detriment faced for speaking up. The FTSU Policy is very clear that any staff member who feels they have faced detriment for speaking up will be taken seriously. Levels of detriment in the organisation is low and nationally is seen in 4% of cases. Any cases of detriment is reportable to the National Guardian Office on a quarterly basis along with numbers and themes of cases. The People Committee has requested that numbers of cases of detriment are included in the FTSU reports going forward.

- The People Committee asked for guidance on providing feedback to workers who have spoken up particularly when there has been a formal process. The Guardians have to realistically manage the expectations of the worker at the beginning of the speak up process and explain that due to confidentiality they will not receive full and comprehensive feedback of any sanctions that may arise as a result of any formal

investigations. What they will receive is feedback and assurance that the Guardian is satisfied that actions have been taken in line with the organisations policies and procedures. They are also made aware that they may not always get the outcome that they want but they will be assured that their concerns will be taken seriously and appropriate actions will be taken.

- The Guardians were asked about the FTSU Champion Network and were there any gaps. The FTSU Champion Network has grown considerably over the last few years and is a very diverse network of volunteers who are passionate about supporting workers to feel able to speak up safely. As this is a voluntary role, the Guardians are reliant on workers coming forward wanting to take on further training and the additional responsibility. However the Guardians are proud to see so many workers who want to support improving the speak up culture. The Guardians do regularly try and target specific areas where there are no FTSU Champions during walkabouts and in awareness sessions.

- The People Committee asked what the Executive Team and NEDS can do both as individuals and as a collective to help the speak up culture knowing that things are likely to get tougher over the next year and that nationally there has been a plateau in confidence. One of the biggest barriers to a positive speak up culture is Futility. There has been a lot of work done to encourage speaking up. But if people do not see actions as a result then they will lose confidence and believe there is no point. The Guardians therefore ask that they are supported to ensure appropriate actions take place when workers raise their concerns. Listening, Communication and Feedback are also key to building confidence that speaking up, via whichever route, is worthwhile.

- Concerns were raised about anonymous concerns being raised and how can we ensure that workers receive feedback. Speaking up for some workers is a very difficult thing to do, especially in the current climate. Making it easier to speak up by providing workers the option of speaking up anonymously, if they feel that is the only way they feel confident to do so, is a national recommendation. Whilst the Guardians will always promote speaking up is done openly or confidentially, they are also aware that some workers are reluctant to do this.

4. Recommendation to the Board of Directors

4.1 The Board are asked to note the details of this paper and note that the People Committee will continue to oversee all relevant actions.

FREEDOM TO SPEAK UP ANNUAL REPORT 2024/25

1.0 Introduction

1.1 In healthcare, Freedom to Speak Up (FTSU) is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviors or attitudes at work, or an idea which could improve processes or make things even better. All leaders must make it their mission to instill confidence in their workers to speak up.

Listening to the concerns of our workers helps us to identify areas for improvement and creates a culture of safety and support for both our workers, our patients and the community we serve. However, relying on workers 'being brave' enough to speak up isn't enough. We also need to ensure as an organisation, we are listening and acting on the information we are hearing.

As Sir Robert Francis said, to "feel pride, not fear" when workers want to speak up – whether that is to voice a concern, or an idea for improvement. Confidence to speak up comes from knowing that when you speak up, what you raise will be actioned appropriately. If speaking up feels futile, workers may remain silent, and we have seen too often that silence can be dangerous. Leaders at all levels set the tone when it comes to fostering a healthy organisational culture. A supportive speaking up culture, led from the top, improves both workers and ultimately patient experience, as well as enhancing organisational performance.

Researchers from the University of Cardiff found that curiosity (in the form of reflexive monitoring and a problem-sensing approach to Freedom to Speak Up) could be recognised as a barometer of speaking up culture. Curious leaders of trusts demonstrated a problem-sensing approach to Freedom to Speak Up and the Guardian role. They consistently monitored the contribution of speaking up to the organisation and normalised rigorous analysis of Freedom to Speak Up data, triangulating with other data sources. Researchers found that achieving change beyond the surface level was dependent on leaders being comfortable "with the idea of being challenged, not comfort-seeking all the time".

Demonstrable benefits of curiosity included improving the experiences of minority communities and workers who may otherwise be seldom heard from, alongside learning that fed into service improvements. By contrast, where incuriosity was normalised, Freedom to Speak Up Guardians often worked within restrictive boundaries and practices in which senior leaders were disengaged and limited data was collected and 'reported', rather than analysed, triangulated and integrated, into routine organisational processes of reflection and improvement. We therefore ask you all to remain curious and be receptive to being positively challenged, as this is the way we can all learn and improve.

FTSU Guardians and Champions work to ensure that those who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. They also work proactively to support the organisation to tackle barriers to speaking up.

1.2 This report gives an update from the Trusts FTSU Guardians of the reporting period of 1 April 2024 to 31 March 2025.

1.3 The organisation currently employs 2 part-time FTSU Guardians, each working 22.5 hours per week. The FTSU Guardian role is 50% Proactive and 50% reactive:

- Proactive- Education re: Speaking Up.Removing barriers etc
- Reactive- Responding in a timely way to all contacts made, opening cases and offering appropriate support. Ensuring actions are taken and feedback is provided.

The Guardians Tracey Garde and Louise Cartin are supported by a Network of FTSU Champions who carry this role out on a voluntary basis following interview and training. In 2024/ 25, a further 11 Champions were trained which takes the total to 87 (Appendix one). The Guardians are aiming to develop the diverse FTSU Network even further by having FTSU Champions across all disciplines and in all areas where possible.

The National Guardian's Office (NGO) recommends a clear distinction between the roles of FTSU Champion and FTSU Guardian. Only Freedom to Speak Up Guardians, having received National Guardian's Office training and registered on the NGO's public directory, should handle speaking up cases. This ensures quality and consistency in how workers are supported when speaking up.

Freedom to Speak Up Champions however have a vital role in:

• **Awareness raising** – Ensuring workers understand the importance of speaking up, listening up and following up. Being visible and promoting speaking up and being a positive role model

• **Signposting** – Discussing concerns with workers and providing details of speaking up routes as stated in the organization's FTSU Policy.

• **Promoting a positive speaking up culture**- Supporting the organisation to welcome and celebrate speaking up.

Our FTSU Champion Network is a huge asset in promoting speaking up across all Divisions and across the many diverse roles across the organisation. The Guardians meet with the FTSU Champions quarterly and provide them with the knowledge and skills to promote speaking up across their areas. In October 2024 a sucessful FTSU Champion Development Day was held and this has become an annual event during National Speak up month.

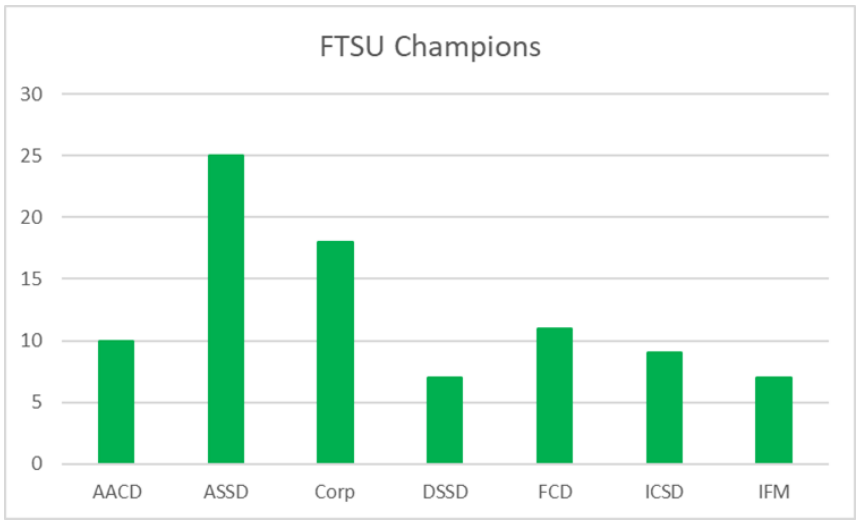


Figure 1: FTSU Champions per Division

1.4 The FTSU Guardians continue to meet with the Chief Executive, the Deputy Chief Executive/ Director of People and Non-Executive Leads for FTSU on a monthly basis. An overview of the cases raised, actions that have been taken and themes identified are shared whilst ensuring that all workers remain completely anonymous. The aim of these meetings is to allow the Chief Executive and Director of People to ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases and ensure that good practice and learning is shared across the organisation. The NEDs provide an avenue of support to the Guardians and also ensure a positive challenge for the executives.

The Guardians also meet monthly with the Head of HR to discuss any themes that arise from the concerns specifically raised relating to HR policies or processes. The Guardians also continue to meet monthly with the leads for each division to discuss cases in more detail and allow them to be followed up locally.

The Guardians are also supporting the establishment of a monthly 'round table' with colleagues from EDI, trade unions, human resources, patient safety, chaplaincy, safeguarding etc. to broadly discuss any themes or trends and triangulate any data. This would also enable quicker identification of issues and aid quicker resolution. The Guardians are aware this process works well in other organisations and prevents silo working.

1.5 The Guardians remain fully engaged with the National Guardian's Office and the Northwest FTSU Guardian's Network to learn and share best practice. The Guardian role also supports new local Guardians and acts as a 'buddy' providing peer support and guidance to new and junior Guardians across the Northwest. One of Bolton's FTSU Guardians, Tracey Garde

continues to work in the role of Joint Chair of the Northwest Regional FTSU Guardian Network. This commitment at a regional level raises the profile of Bolton NHS Foundation Trust further and allows the Guardian to work closely with the NGO and other regional leads. Tracey Garde also co- arranged the annual FTSU Guardian Northwest Conference in November 2024.

2.0 FTSU cases

2.1 From the period of 01 April 2024 to 31 March 2025 a total of 172 cases were reported via the FTSU route. This is an increase of three cases compared to the previous year.

2.2 The graph below shows the number of cases per quarter compared to the number of cases reported since April 2018 (Figure 2).

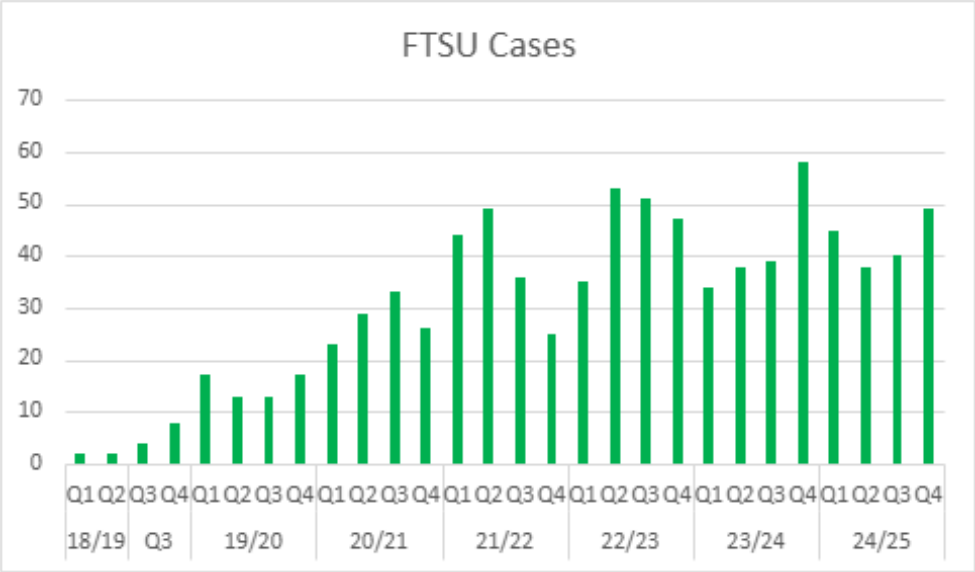


Figure 2: Number of FTSU cases quarterly within Bolton FT

2.3 The Guardians formally report the number of individual cases and themes for each quarterly period to the National Guardian Office.

The Guardians have taken appropriate steps to ensure that workers are being well supported and that they are thanked for raising their concerns and that these concerns are being addressed appropriately and swiftly. The Guardians also ensure that workers receive feedback either directly or indirectly.

2.4 The graph below shows a breakdown of the 172 individual cases raised in 2024/25 by Division (Figure 3) and a breakdown by quarter in each Division (Figure 4)

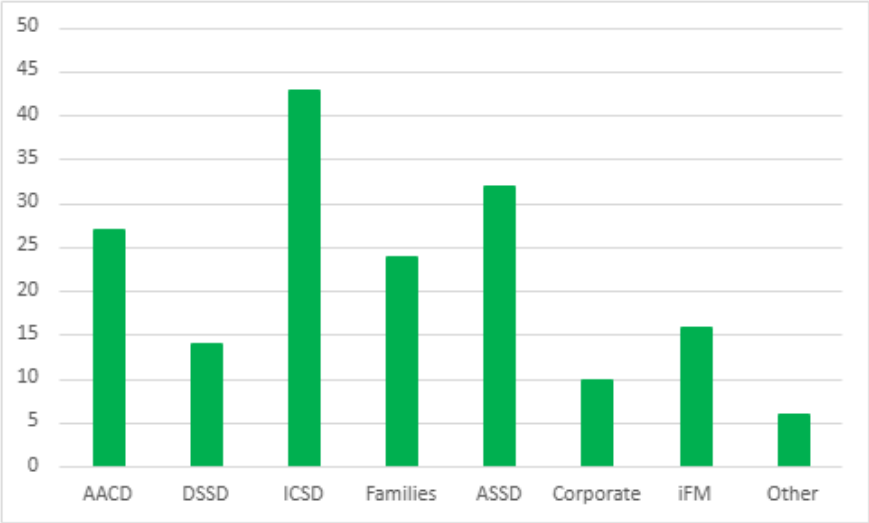


Figure 3: Breakdown by Division in 2024/25

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Annual Total
AACD	4	5	7	11	27
DSSD	4	5	1	4	14
ICSD	19	4	3	17	43
FCD	8	6	5	5	24
ASSD	2	13	11	6	32
CORP	2	1	7	0	10
IFM	5	2	6	3	16
OTHER	1	2	0	3	6
Total	45	38	40	49	172

Figure 4: Breakdown by quarter by Division 2024/25

2.5 For national reporting, everyone that speaks up has to be recorded separately. Therefore, whilst some concerns are collectively conveyed, each worker is captured within the data individually. The highest number of concerns were recorded in ICSD in 2024/25 however 16 of these were from the same team as the Division had specifically requested the Guardians provide some individual 1:1 listening sessions following an anonymous concern raised by a member of a large team.

2.6 All of the FTSU concerns raised have been discussed with the relevant divisional senior leadership teams/managers/HRBM and have been or are being dealt with accordingly. Workers who speak up are not discussed by name with senior management unless the Guardians have the individuals express consent to do so as confidentiality is paramount. However in cases that require a HR process to address the issue then consent is gained to escalate accordingly.

Once the Guardians receive the necessary assurance that the individual case has been dealt with, any lessons that have been learned/actions taken and the individual who has spoken up is satisfied their concern has been listened to and they have received feedback, then the case is then closed in agreement with the individual. Sometimes the outcome may not always be what the worker was hoping for, but as long as they have been listened to and their concerns acted on appropriately, following policy and due process, the Guardians will look to close the case. A confidential feedback survey is then sent to the individual about their speaking up experience within 3 months of their case being closed.

The Guardians also have to record if any detriment has taken place because of speaking up as this is reported nationally to the NGO. Workers who suffer detriment are less likely to speak up in the future, so it is really important to understand about any detriment they believe they have faced and ensure that it is acted on.

The Guardians explain to workers who speak up that the FTSU Guardian is not the fixer of the concern but acts as a conduit for a resolution elsewhere. Realistic options and possible outcomes for those options are discussed with the individual(s). During the meetings where concerns are raised, the welfare of the worker(s) is of paramount importance to the Guardians and the individual will be supported throughout any formal processes. Occupational health support or Vivup support are regularly signposted to, as are on-going follow-up discussions and support should they be required.

2.7 The graphs below provide a breakdown of the concerns raised in 2024/25 by theme across the organisation (Fig 5) and by each Division (Fig 6). In Bolton leadership/support is the top theme reported via the FTSU route in 2024/25 followed by behavior. Inappropriate behaviours and attitudes was the most reported theme nationally in 2023/24 with 38.5% of cases. Nationally 32.3% of cases had an element of worker safety or well being and almost 20% of cases included an element of bullying and harassment. The leadership issue within ICSD was predominantly related to a large number in one specific team where the Guardians were asked

to undertake a series of listening events following an anonymous concern relating to leadership was received.

Some of the learning that has arisen from concerns raised include:

- Cultural awareness and inclusion work following summer riots
- Improved support around access to work for staff with neurodiversity and physical disabilities
- Improving support for SAS Doctors
- Identifying support for rotational AHPs
- Leadership training to promote more compassionate leadership styles
- Fair and equitable recruitment practices
- Fair and equitable rostering practices for additional staffing requirements
- Fair and equitable flexible working agreements

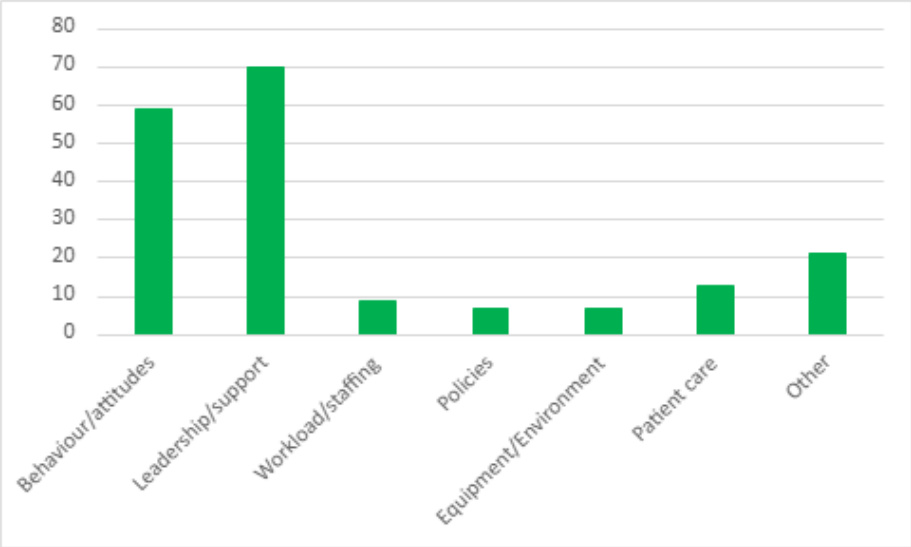


Figure 5-Themes of Concerns across organisation in 2024/25

Theme	Q1	Q2	Q3	Q4	Total
Behaviour/attitudes	13	14	16	16	59
Leadership/support	22	7	20	21	70
Workload/staffing	0	0	0	9	9
Policies	3	3	2	0	7
Equipment/Environment	2	2	3	0	7
Patient care	0	8	1	4	13
Other	5	4	6	6	21

Figure 6: Themes by quarter in 2024/25

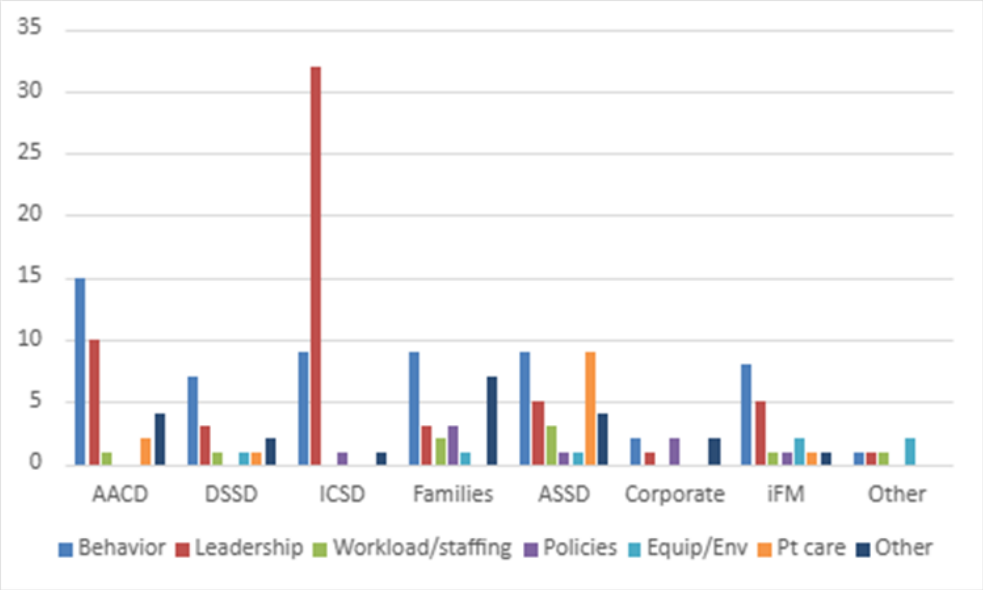


Figure 7-Themes by Division in 2024/25

2.8 The graph below (Figure 8) provides a breakdown of the concerns by staffing group. Registered Nurses/ Midwives was the largest staff group in 2024/25 to speak up using the FTSU route which is not a surprise as they make up the largest staff group in the organisation.

There were 23 cases raised anonymously in 2024/25- many of these were due to the anonymity requested at the listening events carried out in Q4.The Guardians are expecting to see a potential increase in concerns raised anonymously going forward sinceR code is launched. The QR code will enable workers to complete a form about their concern anonymously or complete their details to request a meeting with the Guardian.

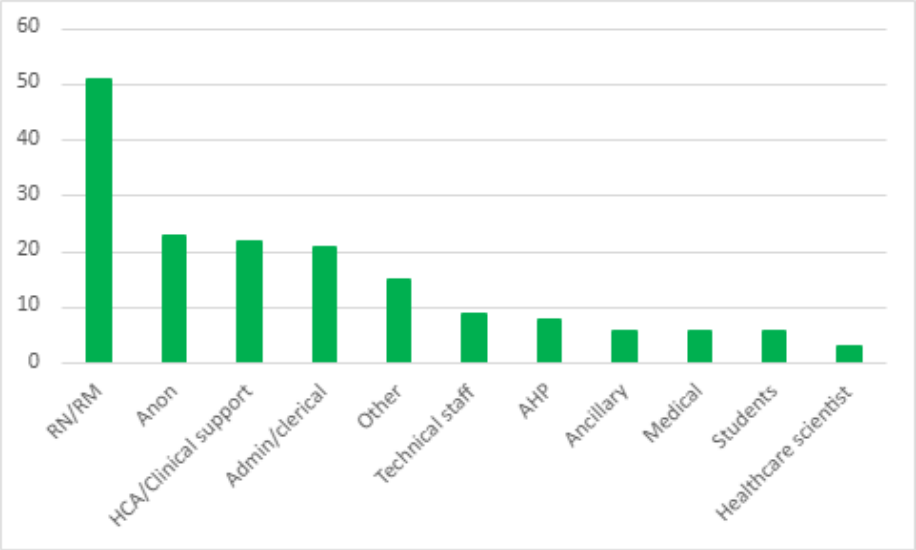


Figure 8- Job roles of workers who have spoken up in 2024/25

2.9 During 2024/25 44 of the 172 concerns were raised by workers from a black, Asian, minority ethnic (BAME) background (Figure 9 below). This equates to 24.4% of the concerns.

The Guardians continue to be allies to our BAME workforce and we have increased the diversity of the Champion Network with 11 BAME FTSU Champions.

The Guardians welcome that inclusivity will be a thread running through the new Our Leaders programme and that the behavioral framework is being relaunched as part of the Our Voice Programme - Living our Values workstream. The Guardians also welcome that the organisation is fully committed to becoming an anti-racist organisation with a zero tolerance to any behavior that is deemed to be racist.

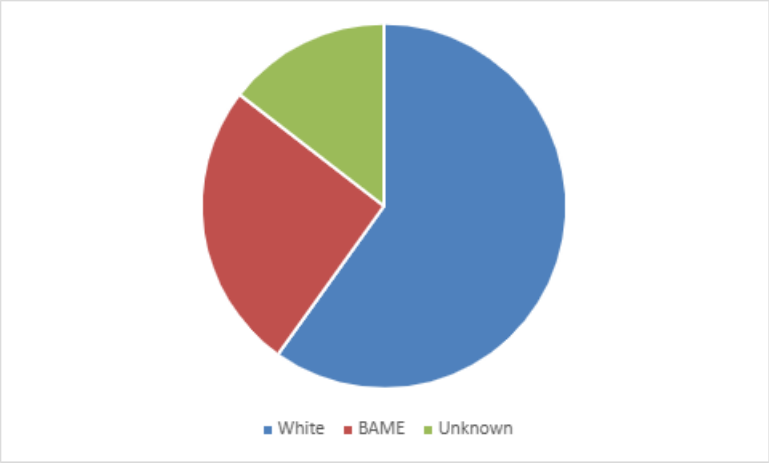


Figure 9: Ethnicity of workers who raised concerns in 2024/25

2.10 Speaking up takes great courage and it is important that the Guardian and Champions respond to individuals in a timely manner. Whilst it is not an NGO metric, the Guardians aim, even outside of normal office hours or days of work, to ensure that all workers receive an initial acknowledgement of their concern within 48 hours. In 2024/25 79.6% of workers received a response/acknowledgement within one hour and 90.11% received an initial response/ acknowledgement within 4 hours (Figure 10).

A small number of concerns can be dealt with quite quickly such as signposting or providing information. However, with most concerns, it is necessary to meet with the worker either face to face or remotely to understand their issue and to ensure they receive the required support. These meetings usually take place within the same week and some take place on the same day if there is a Guardian on site and available.The Guardians receive feedback that workers value this timely response as it clearly demonstrates that their concerns are important to the Guardians and the organisation.

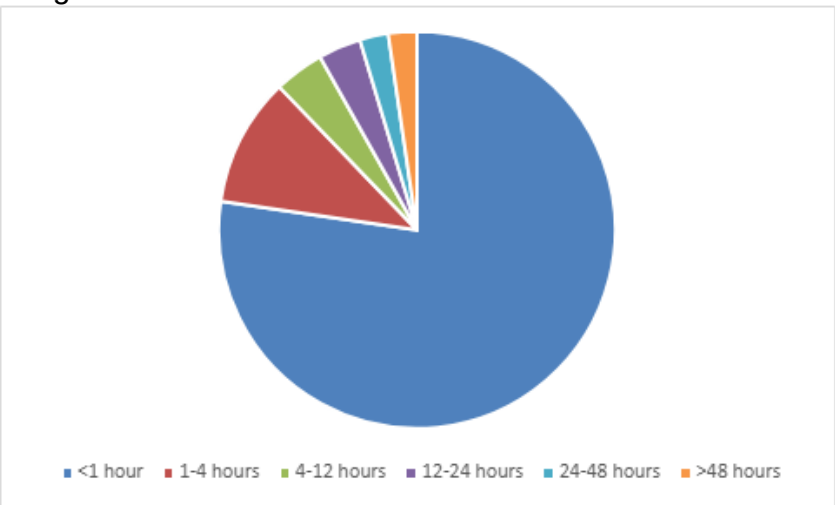


Figure 10: Time to first response in 2024/25

3. Enhancing our approach

3.1 The Guardians are pleased to see the work being carried out within the organisation to respond to the main themes that our workers speak up to FTSU Guardians and Champions about. The two largest themes of concerns relating to leadership and behavior have helped to shape the development of the 'Our Leaders Programme' and the new behavior framework 'Our Way' which has been part of the discussions in the Our Voice Change Programme as part of the Living our Values workstream. The Guardians have been working with the People Promise Manager and colleagues in the OD Team to act as subject matter experts in 2 of the Our Voice Change Programme work streams and are keen to support all the work to improve the overall culture of the organisationgoing forward.

3.2 During the summer months in a reaction to a horrific event in Southport, we all witnessed the worst racial tensions across the country that have been seen for a long time. Bolton is an extremely diverse community and the events that unfolded caused a lot of fear both in the local community and in the workplace.In 2024, the Guardians, accompanied by NED Seth Croft commenced a series of regular walkabouts across the organisation and during this difficult time, they carried out a check in with large numbers of staff across the site. This was welcomed by all the workers that were seen. Following this, the BAME Staff Network was used as an open listening event for any staff who felt affected by the tensions or for their allies to come together and show support. This was really welcomed and valued by those workers who attended as they felt really listened to and supported by the organisation.

3.3 In July, the National Guardian Dr Jayne Chidgey Clarke met virtually with our CEO Fiona Noden and Chair Niruban Ratnarajah accompanied by the FTSU Guardians. This was a positive meeting to explore how, as an organisation we can really embed our speak-up, listen-up, follow-up culture. A follow up face to face session with the National Guardian and our Board is being set up for April 2025. This clearly demonstrates the commitment the organisation has to ensure all our workers feel safe speaking up and that when they do, they will be thanked, listened to and their concerns addressed. We are looking to make sure all board members have completed their Speak-Up Listen-Up Follow-Up E Learning before April 2025.

3.4 In Q2 the NGO presented their new strategy. Dr Jayne Chidgey-Clark, National Guardian for the NHS, said:

"*While progress has been made, there is still a long way to go before we can say that speaking up is business as usual. That is why for our strategic vision we want to move the dial on Freedom to Speak Up. Of course, workers should be safe to speak up – safety is the bare minimum – what we are aiming to achieve over the next few years is confidence. This comes when workers feel not only encouraged to raise matters, but that actions will be taken when they do."*

The National Guardian's Office has set out its six strategic goals to achieve the National Guardian's vision, improving existing services as well as making some step changes to drive further change across the system. These are:

1. Continuing to improve the resources and the offer to Freedom to Speak Up Guardians.
2. Developing additional support and guidance for organisational leaders.
3. Using the National Guardian's independent voice to champion Freedom to Speak Up and challenge the healthcare system by raising awareness of issues which affect workers' confidence to speak up.
4. Using the insight gathered by the National Guardian's Office to drive recommendations to improve speak up measures and culture, for example through Speak Up Reviews, and challenging organisations to do better.
5. Improving partnership working with key organisations to deliver change.
6. Improve the organisational maturity and internal infrastructure of the National Guardian's Office to support these ambitions.

Dr Jayne Chidgey-Clark, said:

"It is of concern to me that this year's NHS Staff Survey results show a lack of improvement nationally in the responses to the questions about speaking up. A lasting cultural shift is needed to realise the ambition of making speaking up business as usual. This strategy will give the National Guardian's Office the framework for us to provide the expert advice, support and challenge to help make that change."

3.5 In July the Guardians supported a Health and Well-being event held on the hospital site and supported a further community event later in the year.This event brought together a wealth of people all with a shared goal of supporting our valuable workers.

3.6 The National Speak Up Month theme for 2024 was 'Listen Up- the power of listening' and the Guardians focused on promoting active and effective listening, and the important part which listening plays in encouraging people to feel confident to speak up.

Confidence to speak up comes from knowing that if you speak up, you will be listened to, and that appropriate action will be taken. We all have a part to play in listening to one another with respect and compassion. Speak Up Month provided an opportunity for leaders at all levels to show they are always available to listen and their commitment to fostering a Speak Up, Listen Up, Follow Up culture in their team.

The Guardians encouraged workers and leaders to complete the Freedom to Speak Up Listen Up and Follow Up Elearning and make a Listen Up Pledge.To show that everyone is 'here to

listen', and visibly supportive of Freedom to Speak Up we also asked workers to take part in "Wear Green Wednesday" on Wednesday16 October.

The Guardians also hosted their second FTSU Champion Awayday on Friday 11 October to further support the development of our FTSU Champions. The day provided an opportunity to promote the work the organisation are doing to enhance the leadership training offer and develop a positive behavioural framework. There was also an inspiring talk about neurodiversity and the challenges some of our workers face.

The Guardians and Champions also held a variety of awareness sessions such as Tea and Gas, Knit and Natter and a corridor stall to promote speaking up and listening as well as promoting the annual national staff survey.

3.7 In January 2025 the Guardians and one of the FTSU Champions in Maternity were invited to speak at the Greater Manchester and East Cheshire Strategic Clinical Network Event. This was to talk about the importance of promoting a speak up culture in maternity services and how culture can impact on the psychological safety of workers. The presentation was well received and highlighted the journey that Maternity services in Bolton have been on over the last few years.

3.8 In February 2025 Tracey Garde was invited by the Associate Dean, Post Graduate Medicine NHSE (NW) to speak at a Peer Ally Network Event about FTSU and the role of the FTSU Guardian in an acute Trust. The Peer Ally Network has been established to support Doctors and Dentists in training across the North West and encourage them to speak up about any concerns they may have and to ensure they receive the necessary support.

3.9 In March 2025 the results of the 2024 National NHS Staff Survey were published. The survey provides crucial insight into workers experiences. Nationally there has been a plateau in confidence around speaking up. Whilst the numbers of staff speaking up has risen many staff feel that speaking up is futile and feel that their concerns will lead to any change. A speaking up culture without action carries the risk of disillusionment, distrust and disengagement. The fear is that if workers see no actions from the concerns raised they may stop speaking up. As an organisation we must move beyond just encouraging workers to speak up and demonstrate that speaking up leads to meaningful change.

The NGO are calling for three key changes to ensure improvements are made:

1. **Embedding a culture of listening and action-** creating more avenues for workers to speak up is essential but insufficient- there needs to be a stronger focus on listening and acting. There needs to be a consistent and structured approach to ensure concerns are taken seriously and lead to action. This includes:

- Clear standardised processes so that leaders at all levels understand and fulfil their responsibility to act.
- Training that goes beyond awareness- equipping leaders with the skills and accountability to respond effectively.

2. **Greater accountability for leaders and organisations**- there must be stronger accountability for both individual leaders and organisations ensuring that concerns are taken seriously and workers are protected from victimisation. This means:

- Leaders must be held responsible for fostering a culture where staff feel safe to speak up and seeing their concerns addressed.
- Organisations must be accountable for how they handle concerns – not just encouraging to speak up but demonstrating that concerns lead to meaningful action.
- System wide oversight must be strengthened, ensuring that when concerns are raised there is clear follow through and consequences for inaction.

3. **Strengthening and standardising the Guardian role**- there must be greater consistency in how the FTSU Guardian role is implemented across organisations. This includes:

- Ensuring Guardians have sufficient time and resources to carry out their duties effectively.
- Safeguarding their impartiality, recognising that whichever model organisations use presents potential challenges in maintaining impartiality and trust.

In Bolton we have seen a slight improvement in workers feeling safe to speak up about any concerns and the confidence that the organisation will respond however there is room to further improve. A Board Development session is planned with the NGO in April 2025 to identify how as an organisation we can continue on the upward trajectory and build on the work done so far.

The Guardians will continue with the walkabouts with the NEDS and with the FTSU Champions and provide some listening events for workers. Videos are being planned to share some positive staff stories whilst maintaining confidentiality and anonymity.

4.0 Recommendations

The Committee is asked to:

- Reflect and comment on the FTSU 2024/25 information
- Continue to support the FTSU approach and enable the Guardians and champions to carry out their important roles.

Appendix One

Current FTSU Champions Network April 2025

Kirsty Buckley	Haematology Specialist Nurse	Adult Acute Division
Dr Natalie Walker	Acute Physician	Adult Acute Division
Shauna Barnes	Practice Development Lead Nurse	Adult Acute Division
Alistair Soutar	Senior Charge Nurse A&E	Adult Acute Division
Angela Hughes	Bed Management	Adult Acute Division
Sonia Edwards	HCA B3 Ward	Adult Acute Division
Jess Shields	Ward Manager C2 Ward	Adult Acute Division
Dr Haider Abbas	Doctor in Training	Adult Acute Division
Emma Lewin	ACP A&E	Adult Acute Division
Kyle Turner	Registered Nurse	Adult Acute Division
Julie Pilkington	Assistant Divisional Nurse Director	Anaesthetics & Surgical Division
Ruth Tyrer	Anaesthetics/Ops Support Manager	Anaesthetics & Surgical Division
Emma Wheatley	Consultant Anaesthetics/Critical Care	Anaesthetics & Surgical Division
Corinne Houghton	Health Care Assistant Recovery	Anaesthetics & Surgical Division
Lisa Haughton	Health Care Assistant Critical Care	Anaesthetics & Surgical Division
Jenny Ruddlesdin	Consultant Orthopaedics/Elderly Med	Anaesthetics & Surgical Division
Vicky Jolley	RN Breast Unit	Anaesthetics & Surgical Division
Janet Roberts	Acute Pain Nurse Specialist	Anaesthetics & Surgical Division
Dr Adam Creissen	Core Surgical Trainee	Anaesthetics & Surgical Division
Georgina Withington	Registered Nurse Ophthalmology	Anaesthetics & Surgical Division
Laly Joseph	RN Critical Care	Anaesthetics & Surgical Division
Declan Haydock	RN Critical Care	Anaesthetics & Surgical Division
Karen Roberts	RN Critical Care	Anaesthetics & Surgical Division
Lauren Mayoh	Sister Critical Care	Anaesthetics & Surgical Division
Cath Smith	Ward Clerk F6	Anaesthetics & Surgical Division
Zoe Geddes	Matron Critical Care	Anaesthetics & Surgical Division
Kay Marshall	Acute Oncology Care Co-ordinator	Anaesthetics & Surgical Division
Helene Jackson	Registered Nurse	Anaesthetics & Surgical Division
Jody Peterson	Practice Educator	Anaesthetics & Surgical Division
Sumera Motala	HCA	Anaesthetics & Surgical Division
Onaga Oluchukwu	Registered Nurse	Anaesthetics & Surgical Division
Zeb Boodhun	Divisional Personal Secretary	Anaesthetics & Surgical Division
Simon Vanderlinden	Senior ODP	Anaesthetics & Surgical Division
Jenny Allen	Registered Nurse Theatres	Anaesthetics & Surgical Division
Dawn Kelly	Opthalmology	Anaesthetics & Surgical Division

Rahila Ahmed	Equality, Diversity & Inclusion Lead	Corporate Services Division
Neville Markham	Chaplain	Corporate Services Division
Sharon Lythgoe	EPR Project Manager	Corporate Services Division
Gina Riley	Associate Director of Governance/ Pt Safety Lead	Corporate Services Division
Nicola Caffrey	Corporate Business Manager for Medical Director	Corporate Services Division
Robin Davis	TNA	Corporate Services Division
Cherechi Ochemba	Digital Facilitator	Corporate Services Division
Nannette Gallagher Ball	Senior Nurse Educator	Corporate Services Division
Dawn Grundy	People Promise Manager	Corporate Services Division
Lynne Doherty	Staff Engagement Practitioner	Corporate Services Division
Toni Anderton	Senior Practitioner ECIST	Corporate Services Division
Sylwia Desantis	Senior Management Accountant	Corporate Services Division
Jonathan Benn	Clinical Information Assurance Lead	Corporate Services Division
Jack Ramsay	Public Governor	Corporate Services Division
Micha Roberts	TNA	Corporate Services Division
Lyndsey Westby	Clinical Educator	Corporate Services Division
Sarah Richards	Head of People Development	Corporate Services Division
Catherine Spruce	People Development Lead	Corporate Services Division
Louise Quigley	Health Records Reception Coordinator	Diagnostic and Support Services
Suzanne Lomax	Clinical Service Lead –Bereavement Services	Diagnostic and Support Services
Dr Katy Edwards	Consultant Microbiologist	Diagnostic and Support Services
Caroline Burke	Senior Clinical Pharmacist,	Diagnostic and Support Services
Jodie Hughes	Administrator/ Personal Assistant Pharmacy	Diagnostic and Support Services
Louise Smith	Admin Lab Services	Diagnostic and Support Services
Katie Ryan	CT Team Leader	Diagnostic and Support Services
Jeanette Fielding	Midwife	Family Care Division
Vicky O'Dowd	Midwife	Family Care Division
Dr Bim Williams	Obstetrics & Gynaecology Consultant	Family Care Division
Maria Lawton	Pelvic Health Physiotherapist	Family Care Division
Karen Keighley	ASST DND	Family Care Division
Firyal Atcha	Paediatric SALT	Family Care Division
Anne-Marie Price	Medical Secretary	Family Care Division
Louise Cartin (Currently Acting FTSU Guardian)	Enhanced Midwife	Family Care Division

Sharon Foster	Neonatal Nurse	Family Care Division
Sam Carney	Divisional Director of Ops	Family Care Division
Kayleigh Mills	Midwife Ultrasound	Family Care Division
Jenni Makin	Specialist Physiotherapist Community Learning Disabilities Team	Integrated Community Services
Joshua Sharpe	MSK Physio	Integrated Community Services
Sarah Moore-Whitfield	Shared Team Lead / Occupational Therapist	Integrated Community Services
Alison Brennan	DNs Evening/Night Service	Integrated Community Services
Eleanor Speak	OT	Integrated Community Services
Gareth Valentine	Registered Nurse	Integrated Community Services
James Foster	Physiotherapist	Integrated Community Services
Rachel Taylor	Matron	Integrated Community Services
Lisa Brownlow	Divisional Governance Support Manager	Integrated Community Services
Rachel Hemingway	Head of Therapies	Integrated Community Services
Keeley Barlow	Switchboard/ Uniforms Department	IFM
Michelle Barber	Personal Secretary	IFM
David Waite	Materials Management Assistant	IFM
Lorraine Makinson	Recruitment/ Training Officer	IFM
Kirstie Barlow Hart	Domestic Supervisor	IFM
Charlotte Green	Catering Assistant	IFM
William Robinson	Porter	IFM

Report Title:	Guardian of Safe Annual Report 2024-2025			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	✓
Executive Sponsor	Francis Andrews		Decision	

Purpose of the report	To provide an update on the exception reporting activity from 01 April 2024 to 31 March 2025.

Previously considered by:	People Committee

Executive Summary	The Exception Reporting process gives resident doctors the opportunity to highlight variations from their contractually agreed service requirements and educational activities. The system has been implemented to allow issues to be addressed in real time. The report contains details of the Exception Reports by department, grade and type with outcomes reached for the year, 01 April 2024 to 31 March 2025, together with activities and issues arising during the reporting period.

Proposed Resolution	The Board of Directors is asked to ***receive*** the GOSW 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**	**Payment for additional hours worked.**
Legal/ Regulatory	**Yes**	**Exception reporting was introduced through the 2016 resident doctor contract and is instrumental to improve morale, quality of medical education and patient safety.**
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Joanne Warburton Ian Webster	**Presented by:**	Dr Francis Andrews Medical Director

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

BMA	**British Medical Association**
COW	**Consultant of the week**
DMD	**Divisional Medical Director**
DRS	**Doctors Rostering System**
ER	**Exception Report**
ES/CS	**Educational Supervisor/Clinical Supervisor**
FY1/2	**Foundation Year 1/2**
GMMH	**Greater Manchester Mental Health**
GOSW	**Guardian of Safe Working**
JLNC	**Joint Local Negotiating Committee**
LED	**Locally Employed Doctor**
MEM	**Medical Education Manager**
NWGOSW	**North West Guardian of safe working**
RDF	**Resident Doctor Forum**
ST	**Specialty Trainee**
WTE	**Whole Time Equivalent**

Guardian of Safe Working Hours (GOSW)
Annual Report: 01 April 2024 – 31 March 2025

1. Introduction

1.1 The Terms and Conditions of Service (TCS), of the junior doctor contract (2016) requires the Guardian of Safe Working (GOSW) to submit quarterly reports as well as an annual report to the Trust Board via the People Committee.

1.2 Quarterly reports have been submitted to the People Committee and this is the annual report to reflect the findings for the period 1st April 2024 to 31st March 2025.

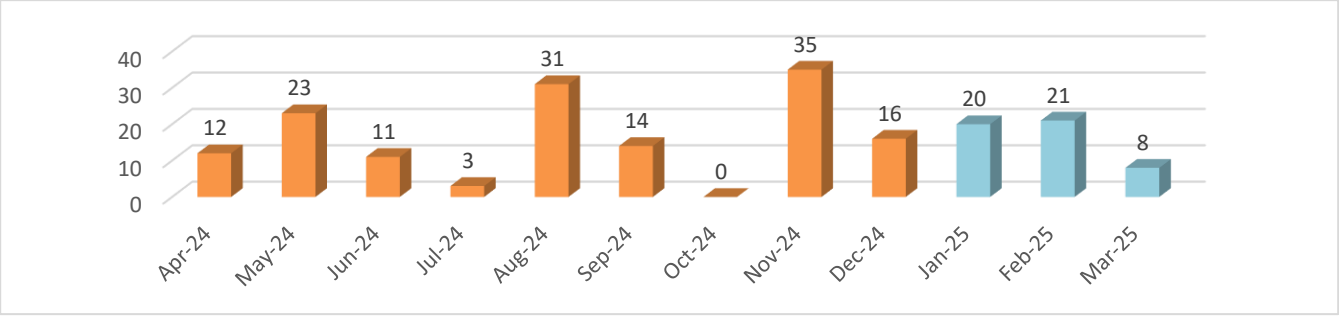
2. High level data

Number of doctors in training	275 WTE
Number of doctors working less than full time	72
Number of locally employed junior doctors (LED)	68
Time available in job plan for GOSW	1 PA/week
Administration support provided to GOSW	7.5 hours/week
Number of recognised Educational/Clinical Supervisors	185 both ES/CS 42 CS only

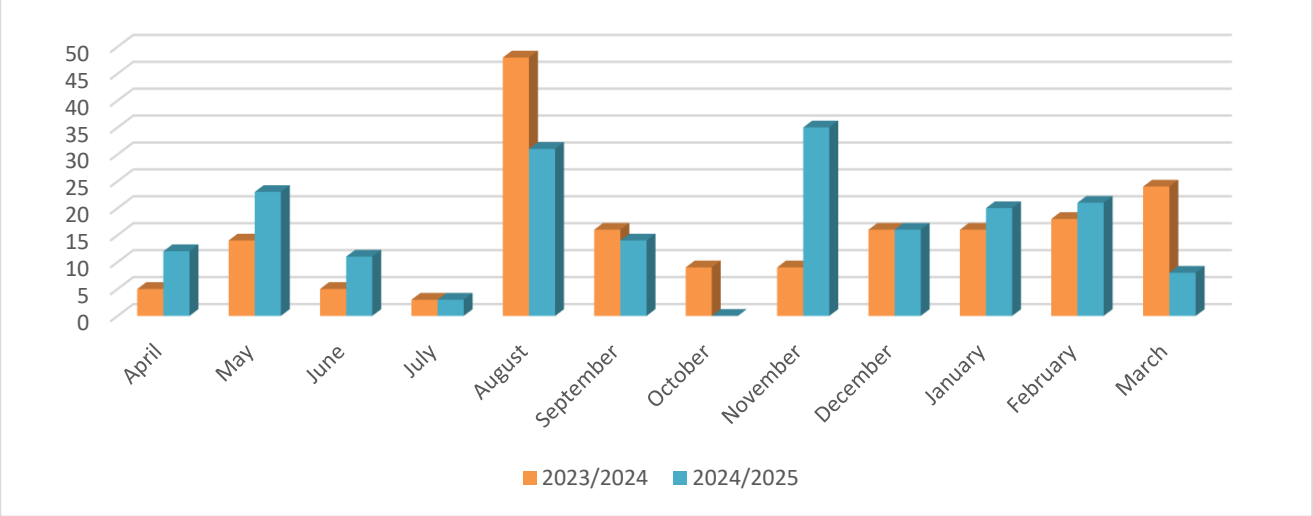
3. Exception Reporting Activity

3.1 Doctors in training are asked to electronically submit exception reports when they work over their contracted hours, when they are unable to achieve breaks/rest periods or for missed educational opportunities. Within the reporting period there were **194** exception reports submitted. This has remained consistant from the previous year when 193 exception reports were submitted.

3.2 Exception reports submitted by month. No exception reports were received in October whilst we moved over to the new RLDatix Allocate system. Doctors were asked to keep a record of all exceptions and report in November.

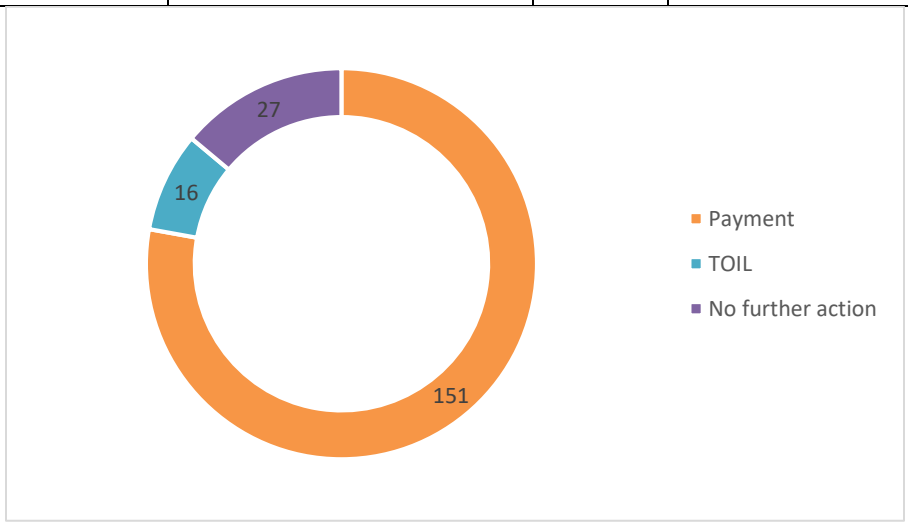


3.3 Exception reports submitted by month compared with the previous year.



3.4 Exception reports submitted by outcome.

Outcome	No of exception reports raised in this period	%	Number of extra hours equates to
Payment for additional hours	151	78%	Day time hours = 138 Night time hours = 13
Time off in lieu	16	8%	29.75
No further action required	27	14%	
Total	**194**	**100%**	



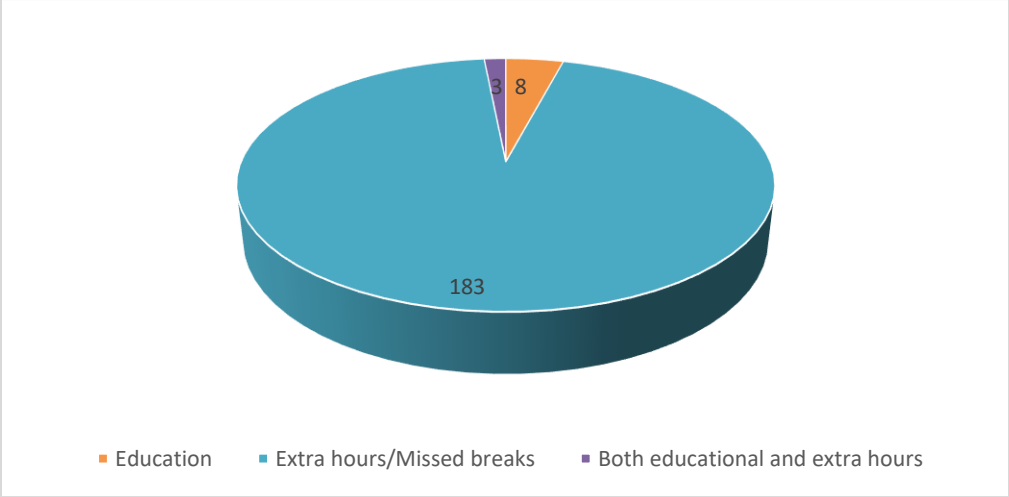
3.5 The costing of exception reports for the year 2024-2025 (**for RBH payroll only**) is shown below:

Quarter	Number of hours claimed	Value
Quarter 1	35.75	700.20
Quarter 2	58.50	1279.80
Quarter 3	38.75	884.95
Quarter 4	31.50	762.18
Total	**164.50 hours**	**£3,627.13**

The remaining hours are for lead employer doctors for whom we don't have payroll costings.

3.6 Exception reports submitted by type.

Type	No of exception reports submitted in this period	%
Education	8	4%
Extra hours/missed breaks	183	94%
Both education and additional hours	3	2%
Total	**194**	**100%**



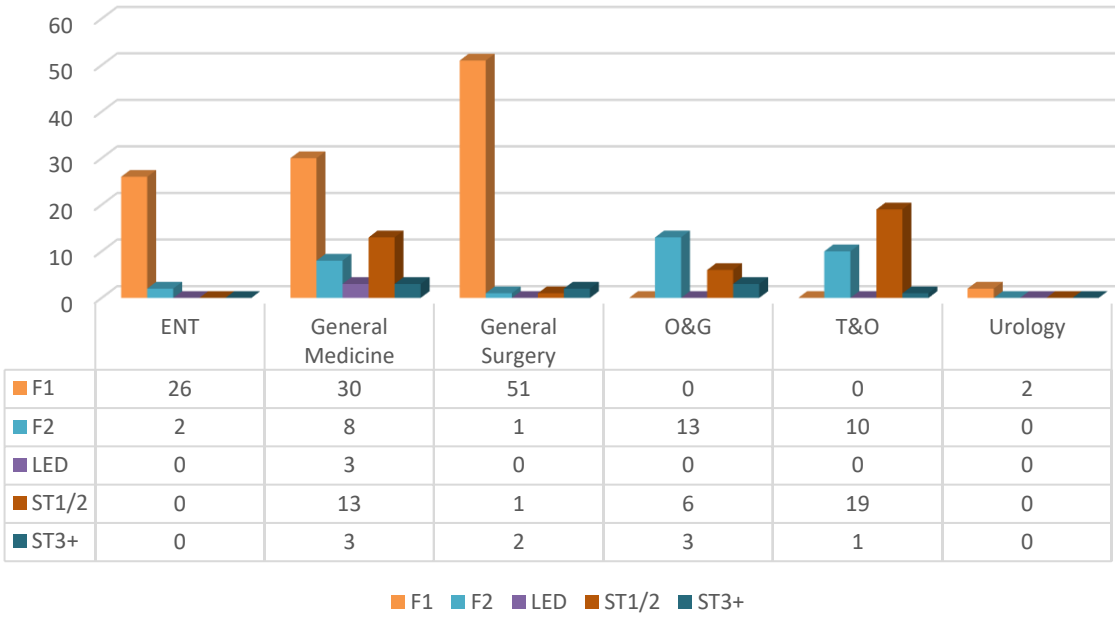
3.7 Number of exception reports submitted by specialty.

Specialty	No or ER submitted
ENT	28
General Medicine	58
General Surgery	55
Obstetrics & Gynaecology	22
Trauma & Orthopaedics	29
Urology	2

3.8 Number of exception reports submitted by grade.

Grade	No of ER submitted
FY1	109
FY2	34
LED	3
ST1/2	39
ST3+	9

3.9 Exception reports submitted by specialty and grade



4. Work Schedule/Rota Reviews

4.1 No work schedule reviews have taken place during the reporting period.

5. Immediate Safety Concerns

5.1 In the last 12 months 2 exception reports were identified by doctors as being an 'immediate safety concern'.

Specialty	Number of safety concerns submitted	Reason
General Medicine	1	Patients waiting over 60 hours for PTWR. No infrastructure to ensure patients in ED under medical team

		are receiving day 2 review. Patients at risk and medical team facing extreme pressure on medical on-call.
General Surgery	1	Locum F1 unable to prescribe or access clinical systems to view patient notes. Unsafe leaving to carry out planned work with acutely unwell patients on ward.

5.2 The safety concerns have been managed and closed.

- General Medicine – consultant supervisors made aware of the situation and the exception report was included in the detailed monthly report to the division. Discussed at Resident Doctor Forum and the Medical Grand Round. Feedback session took place as part of Grand Round meeting.
- General Surgery – consultant supervisor made aware and the exception was included in the detailed monthly report to the division. Resident doctor received payment for extra hours worked covering locum doctor workload.

6. Fines

6.1 To date the GOSW has not levied any fines.

7. Resient Doctor Forum

7.1 As part of the TCS (2016) there is a requirement to hold a regular Resident Doctor Forum (RDF). The main purpose of the forum is to provide doctors in training with the opportunity to feedback about the contract and to agree on how any monies accrued from fines should be spent.

7.2 The RDF meets on a quarterly basis at Bolton NHS FT. Meetings were held in July, September and November 2024. The meeting scheduled for 12th February 2025 was unfortunately cancelled. We have continued to see good attendance over the last year. The regional BMA advisor and rota coordinators also attend the forum.

8. GOSW Activity

The Guardian has continued to meet regularly with the trainees, rota managers and staff from the trainee team in the Resident Doctor Forum.
The Guardian has prepared [and presented where possible] quarterly reports reflecting exception reporting and specific rota issues.

At these meetings, issues from each rota have been discussed as identified by exception reporting and the forum has provided a space for feedback outwith this.

Specific training concerns

In April 2025 GOSW was contacted by GM mental health trainees with a number of concerns regarding working conditions

- Cover at the Rivington Unit. The trainees explained that when on call there would sometimes not be enough medical staff to cover the Unit
- Limited/ no supervision of Mental Health trainees in ED
- No EPR logins make it difficult to access notes
- Withdrawal of cardiac arrest team from the rivington unit
- Allegations of "bullying" in relation to attending Liaison patients in ED

Through the year, Bolton Hospital NHS Foundation Trust trainees have raised issues such as

- Sickness cover and one trainee having to do 2 doctors work [was escalated to agency but not appointed]
- Early start and late finish with clinical pressure negating break
- Overall pressure/ intensity of work
- Unsafe because of constant bleeps for discharge summaries
- Cover of both obs and gynae bleeps

9. Summary

9.1 The number of exception reports submitted has remained consistent with 194 being submitted this year compared to 193 in the previous year.

9.2 Exception reporting moved from DRS4 to the new RLDatix Allocate system in October 2024. Any exception reports for October were submitted in November 2024 when the new system went live.

9.3 The primary reason for exception reporting related to junior doctors working above their contracted hours due to high workload and/or low staffing levels and this pattern has been consistent over the years.

9.4 Exception reports submitted by resident doctors highlighting missed educational sessions as a result of service pressures were escalated to the Director of Medical Education as per protocol.

9.5 Two exception reports were identified by the doctors as being an 'immediate safety concern'. These were reviewed by the relevant educational supervisor and GOSW and concerns escalated as appropriate.

9.6 No work schedule reviews have taken place during the reporting period.

9.7 No fines have been levied by the GOSW during the reporting period.

9.8 The majority of exception reports submitted by junior doctors who have worked extra hours have been actioned for payment. The GOSW will continue to liaise with doctors, particularly those grades and specialties who are not currently exception reporting, to encourage use of the system.

10. Recommendation

10.1 The Board of Directors is asked to note the contents of this report.

Appendix: Bolton NHS FT Medical Director Response to issues identified in the report

A requirement of the Guardian of Safe Working report is that it is independent of the Medical Director, but at the request of the People Committee on 20 May, 2025, a response by the Medical Director Dr Francis Andrews regarding issues identified is provided below, for clarification.

Exception reports

- High levels of reporting are noted in ENT which is a relatively small specialty and reflects the fact that at junior resident level, the out of hours rota is combined between General and ENT surgery, making this a very busy job. This is being addressed by the employment of an additional clinical fellow
- Workload pressures in ENT and general surgery are on the risk register. Proposals are being worked up through business cases to look at options to increase medical staffing in these areas. Every effort is made to cover rota gaps with appropriate bank and agency staff to reduce workload pressures

Immediate safety concerns

- These are completely anonymous so triangulation of these events with other data is not possible
- The general medicine concern is believed to reflect the situation prior to the urgent care redesign when patients were in A&E having been refereed to medicine but not being able to move to inpatient wards due to flow issues. Increased consultant staffing rotas in acute medicine as part of the redesign are designed to offset this risk
- The general surgery issue is addressed in that for locums, access is provided by issuing of locum usernames and passwords for each locum shift rather than smartcards so it is unclear on this occasion why this occurred

Rivington Unit

- This issue relates to foundation year residents who are employed by Bolton NHS FT but who rotate to GMMH as part of their training
- Previous cohorts of residents complained that whilst working for the General Medicine out of hours rota at Bolton NHS FT, that they were having to attend cardiac arrest calls at the Rivington unit and that this was too far from the main acute trust general medicine ward base to cover both areas.
- Discussions were held with GMMH and a model adopted as for other co-located mental health and acute services whereby cardiac arrests are dealt with by trained GMMH staff with appropriate equipment and calling 999. Our resuscitation service supported this change with appropriate liaison and advice prior to handover of the service.
- The residents at GMMH feel that they cannot venture from the Rivington Unit to our A&E to see patients with mental health issues in case a mental health

in patient at the Rivington Unit deteriorates and needs cardiac arrest treatment

- To be clear, none of the bullying allegations are about Bolton NHS staff.
- The Bolton NHS MD is meeting with the GMMH MD on Tuesday 27th May to discuss. The GMMH MD has indicated that the will address the issues
- As the MD at Bolton NHS FT, (and a director of Advanced Life Support Courses for many years), I am satisfied that the model adopted by GMMH is safe and in keeping with usual practice for similar units.

Other issues

- The issue of bleeps interrupting work is difficult to resolve and is related to weekend out of hours work. As part of the urgent care design, board rounds include being proactive around patients being identified and discharge summaries being prepared as much as possible in advance of out of hours discharges.

Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		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 March and April 2025.

Executive Summary	The Chairs' reports attached provide an overview of matters discussed at the meeting held on the 28 March and 23 April 2025. 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 May 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:**	Rebecca Ganz, Finance and Investment Committee Chair

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

Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**26 March 2025**	**Date of next meeting:**	**23 April 2025**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Operational Plan
- Month 11 Finance Report
- Accounts Going Concern Assumptions
- Estates Strategy Planning and Building Closures/Moves Update
- Board Assurance Framework Ambition 3
- Board Assurance Framework Ambition 4 – changes to digital risk
- EPR Update for Maternity, Out-patient and Community EPR Deployment
- Contract Award Recommendation for the Management and Supply of Water Services
- Contract Award Recommendation for the Maintenance and Support Services of Flexible Scopes

ALERT

Agenda Items	Action Required
Operational Plan • Initial submission of £13.4m deficit decreased to £6.7m due to additional income and cash support. • Even with a 5.7% CIP target and a headcount reduction of 176, significant risks remain. • Assurance statements have been provided to the ICB, not all of which can be affirmed currently. Finance are reviewing additional assurance questions. • CIP schemes totalling £24.5m are on the tracker, required to reach £37m next week. • Delivering the required financial targets for 2025/26 may impact waiting lists and weekend working • Analysis has shown that the impact of stopping weekend work would be greater than the impact of Covid with increased waiting lists and worsened 18-week waits. • Providers have been asked to deliver control totals wihout compromising on performance. • The Committee agreed that all three asks are not possible to achieve; control total, performance, positive assurance statements, with the submission plan is to be discussed and agreed at Board tomorrow. • Potential cash shortages by Q2; careful management needed. • High NHS Resolution Premium to be investigated to see if this can be driven down.	

ADVISE

Month 11 Finance Report

- The Trust is on plan with a deficit of £2.7m year to date. It is possible the ICB could clawback CDC income of £1.7m which could result in being off plan by £1.6m at the end of the year. This clawaback was not expected and

was notified late in the financial year.

- Capital spend to month 11 was £9.4m (gross of disposals) with a year end forecast of £17.67m which is expected to be achieved.
- Cash position is on plan.

ASSURE

Accounts Going Concern Assumptions

The Finance & Investment Committee approved the annual accounts being prepared on a going concern basis.

Estates Strategy Planning and Building Closures/Moves Update

The Chief Finance Officer presented the planned building relocations and closures across acute and community sites some of which have been implemented. These plans aim to create a fit-for-purpose estate and drive savings.

Board Assurance Framework Ambition 3 &4

The Board Assurance Framework (BAF) Ambition 3 and 4 were brought to the Committee for review and comment. The Committee agreed there is a need to refresh the BAF in the light of recent developments in the NHS

EPR Update for Maternity, Out-patient and Community EPR Deployment

The Chief of Strategy and Partnerships updated the Committee on the current status of the EPR programme, encompassing Maternity, Outpatients and Community deployments. It was highlighted that there are currently a number of risks due to the very tight deadlines around resources and interfaces. Progress has been made w and further updated wir and further updates will continue to be provided future Finance & Investment Committee meetings.

Contract Award Recommendation for the Management and Supply of Water Services

T The Committee recommended the Contract Award of Water Supply for approval by the Board of Directors.

Contract Award Recommendation for the Maintenance and Support Services of Flexible Scopes

The Committee recommended the Contract Award of the Maintenance and Support Services of flexible scopes, for approval by the Board of Directors.

Any Other Business

The Chief Finance Officer updated that the Finance Department has has been recommended for approval of the Level 3 accreditation.

The new ledger system Centros will be in use from the 05 April 2025.

The Chair advised of planning a visit to the Finance Department with the Chair of the Audit Committee to thank them for all that has been achieved.

New Risks identified at the meeting:

None identified.

Review of the Risk Register: NA

Meeting Attendance 2025										
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Rebecca Ganz	✓	✓	✓							
Annette Walker	✓	✓	✓							
Rae Wheatcroft	✓	✓	✓							
Sharon Katema	✓	**A**	**A**							
James Mawrey	✓	✓	✓							
Sharon White	✓	✓	✓							
Sean Harriss	✓	**A**	✓							
Martin North	✓	✓	✓							
Tosca Fairchild	✓	✓	**A**							
✓ = In attendance A = Apologies										

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

Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**23 April 2025**	**Date of next meeting:**	**28 May 2025**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Confirmation of Finance Plan 2025/26
- CIP Schemes Update 2025/26
- Month 12 Finance Report
- Trust Banking Arrangements
- EPR Update for Maternity, Out-patients and Community EPR Deployment
- RAAC Eradication – Laboratory Medicine

ALERT

Agenda Items	Action Required
Confirmation of the Finance Plan 2025/26 • The finance plan was submitted on 23 April 2025. The final submission is due to be sent to NHSE on the 30 April 2025 aiming for a break-even position with a control total of £6.5m • The plan includes £37m CIP & a £48M capital budget. • Cash flow is high risk potentially requiring support of £9.9m to maintain a minimum £1.6m cash balance through the year. • Concerns were raised about the feasibility of achieving the CIP without significant balance sheet contributions. • Cash flow scenarios were requested to better understand the impact of different capital support levels. **CIP Schemes Update 2025/26** • The current CIP tracker shows £32.5m identified against a target of £37m. • Focus is on delivering schemes in Q1, with a need to aim for £45m plus to account for potential slippage. • £5.9m CIP has been added in the week. • The top scheme is vacancy scrape totally £4.9m. This scheme is to be broken down into 4 schemes to show better visibility. • Discussions highlighted the need for radical changes and strategic planning to achieve the targets.	

ADVISE

Month 12 Finance Report

- At year end the Trust had an accounts deficit of £8.9m which includes £8m of impairments of assets.
- The NHSE adjusted performance is a deficit of £0.6m which is on plan.
- Cash was above plan by £3.6m Month 12 at £10.6m. Within this is £8.6m of PDC cash. Revenue based cash at bank was 31st March 2025 was £2m.
- Capital spend was £16.7m which is slightly under plan.

- CIP was delivered but heavily towards non-recurrent savings.
- The Chair thanked Finance for the huge achievement for the financial year 2024/25 particularly given a new finance system went live as planned on 01 April 2025.

EPR Update for Maternity, Out-patients and Community EPR Deployment

The Director of Digital advised the Committee that although all three EPR projects are on red this does not reflect the progress made and it is most likely these will shortly change to green. The delivery date for Maternity roll out is to be agreed in May. Outpatients and Community continue to be on track for mid June rollout.

ASSURE

Trust Banking Arrangements
Government Banking Services have undergone a recent National tendering exercise for banking services for government departments. The outcome is that the Trust's banking services will remain with NatWest via GBS.

RAAC Eradication – Laboratory Medicine
The Committee recommended option 3 of the business case for RAAC eradication in Laboratory medicine to the Board of Directors for approval.

New Risks identified at the meeting: *None identified.*

Review of the Risk Register: NA

Meeting Attendance 2025										
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Rebecca Ganz	✓	✓	✓	✓						
Annette Walker	✓	✓	✓	**A**						
Rae Wheatcroft	✓	✓	✓	✓						
Sharon Katema	✓	**A**	**A**	✓						
James Mawrey	✓	✓	✓	**A**						
Sharon White	✓	✓	✓	✓						
Sean Harriss	✓	**A**	✓	✓						
Martin North	✓	✓	✓	✓						
Tosca Fairchild	✓	✓	**A**							
✓ = In attendance A = Apologies										

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an update from the Audit and Risk Committee meeting held since the last Board of Directors meeting.

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

Executive Summary	The Chair's Report attached from the Audit and Risk Committee provides an overview of matters discussed at the meeting held on 07 May 2025. 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 Audit and Risk 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		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Alan Stuttard, Non-Executive Director	**Presented by:**	Alan Stuttard, Chair of Audit Committee

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

Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	07 May 2025	**Date of next meeting:**	25 June 2025
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Draft Audit and Risk Committee Annual Report 2024/25
- Going Concern Statement
- Draft Annual Accounts 2024/25
- Draft Annual Governance Statement 2024/25
- Draft Annual Report 2024/25
- Audit Strategy Memorandum 2024/25
- Internal Audit Progress Reports
- Draft Internal Audit Plan 2025/26
- Counter Fraud Work Plan 2025/26
- Counter Fraud Annual Report 2024/25
- Modern Anti-Slavery Statement
- Annual Register on the use of the Trust Seal
- Compliance with Fit and Proper Person's Test
- NHS Provider Licence Compliance Report
- Risk Management Committee Chair's reports

ALERT

Agenda Items	Action Required

ADVISE

Draft Audit and Risk Committee Annual Report 2024/25
The Committee received the draft Audit and Risk Committee Annual Report and noted that the final version will be produced for the next meeting.

Draft Annual Accounts 2024/25
The Committee received the draft Annual Accounts for 2024/25. The Associate Director of finance provided explanations around some of the key issues arising from the accounts. The accounts show that the Trust had a year end deficit of £8,9470k which after adjustments for impairments, capital donations and centrally procured inventories was an operational deficit of £5,900k which represented the operational deficit as reported to the ICB/NHSE. The Trust had a year end cash balance of £10,6460k and capital expenditure of £16,7030k. The External Auditors are currently undertaking the audit of the accounts. The Committee thanked the ADOF and the Finance Team for completing the Accounts in accordance with the deadline.

Draft Annual Governance Statement 2024/25
The Committee received the draft Annual Governance Statement for 2024/25 and noted that the final AGS will be presented at the next meeting.

Draft Annual Report 2024/25
The Committee received the draft Annual Report for 2024/25 and noted that the final Annual Report will be presented at the next meeting.

ASSURE

Going Concern Statement
The Committee confirmed that the 2024/25 accounts are prepared on a Going Concern basis.

External Audit Strategy Memorandum 2024/25
The External Auditors presented the Audit Strategy Memorandum for 2024/25. The Memorandum outlined the key risks and materiality in the audit of the accounts. The External Auditors advised there were regular updates with the finance team and there are no major issues identified at this time.

Internal Audit Progress Reports
The Internal Auditors presented the latest updates on their reports. A number were in the final stages of completion.

The Internal Auditors presented their draft Head of Internal Audit Opinion (HoIAO) and it was noted that this might change depending on the final outcome of the outstanding reports. Currently the HoIAO draft opinion is showing as moderate assurance which was a reduction from the substantial assurance in 2023/24.

Draft Internal Audit Plan 2025/26
The Internal Auditors presented the draft Internal Audit Plan for 2025/26. A discussion took place on the process for determining the plan and the input of the Committee into the plan. Confirmation was provided by the Internal Auditors that the reviews would cover cyber security and uninterrupted power supplies. The Committee approved the plan.

Counter Fraud Work Plan 2025/26
The Local Counter Fraud Specialist presented the Counter Fraud Work Plan for 2025/26. The Committee approved the plan.

Counter Fraud Annual Report 2024/25
The Local Counter Fraud Specialist presented the Counter Fraud Annual Report for 2024/25. It was noted that there was one case currently with the CPS.

Modern Anti-Slavery Statement
The Director of Corporate Governance presented the Modern Anti-Slavery Statement which the Committee received as assurance of compliance.

Annual Register on the use of the Trust Seal
The Director of Corporate Governance presented the Annual Register on the use of the Trust Seal which the Committee received as assurance of compliance.

Compliance with Fit and Proper Person's Test
The Director of Corporate Governance presented the Fit and Proper Person's Test which the Committee received as assurance of compliance.

NHS Provider Licence Compliance Report

The Director of Corporate Governance presented the NHS Provider Licence report which the Committee received as assurance of compliance.

Risk Management Committee Chair's reports

The Chief Finance Officer presented the Risk Management Chair's reports. A discussion took place around the links between the Risk Management reports and the Board Assurance Framework. The Director of Corporate Governance advised that the triangulation between risk management and the BAF will be discussed at the Risk Management Committee in July before it is presented to the Audit Committee.

New Risks identified at the meeting:

None

Review of the Risk Register:

Not required

Members	Feb	May	June	Sept	Dec	Feb	May	June	Sept	Dec
Alan Stuttard	A	✓								
Sean Harris	A	✓								
Tosca Fairchild	✓									
Fiona Taylor	✓	✓								

✓ = In attendance A = Apologies NA = no longer a member

Report Title:	Digital Update May 2024 to May 2025			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 May 2025		Discussion	
Executive Sponsor	Chief of Strategy and Partnerships Senior Information Risk Owner (SIRO)		Decision	

Purpose of the report	To update the board on the progress made with the Digital Strategy between May 2024 and May 2025.

Previously considered by:	N/A

Executive Summary	In November 2022, the Board of Directors approved the Digital three year plan. The following presentation provides the annual update and informs of progress made and planned.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Digital Update.

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:	Brett Walmsley Director of Digital and Data Services	**Presented by:**	Sharon White, Chief of Strategy and Partnerships

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

EPR	**Electronic Patient Record**
LIMS	**Laboratory Information Management System**
ORBIS	**Lone worker App**
MIPA	**Medical Photography App for District Nurses**
Infoflex	**Clinical Care Pathway software**
MIYA	**Observations and Assessment Software (replaced the PatientTrak system)**
CQC	**Care Quality Commission**
NPEWs	**National Paediatric Early Warning System**
MEOWs	**Modified Early Obstetric Warning Score**
ECDS	**Emergency Care Data Set**
EDMS	**Engineering Document Management System**
Somerset	**Cancer Register**
PACS	**Picture Archiving and Communication System**
OPAS G2 OCC Health	**Occupational Health Software System**
E3	**Maternity Software System**
IQEMO	**Chemotherapy prescribing system**
PreventX	**Sexual Health Testing System**

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Our Digital Strategy

2022-2025

MAY 2025 UPDATE

...for a better Bolton

OUR DIGITAL STRATEGY

2022-2025

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MAY 2025 UPDATE

START OF DIGITAL STRATEGY

November 2022 the Trust Board approved a new three-year Digital Strategy

STRATEGY REVIEW

Reviews the implementation of the Bolton NHS Foundation Trust Digital Strategy

NEW DIGITAL FUTURE

Create a new strategy aligned with the new clinical strategy, GM and national objectives

2022 | 2023 | 2024 | 2025 | 2026

Care Quality commission

JUNE CQC FEEDBACK

Review of progress against the strategy, alignment to the wider GM Digital Strategy & opportunities for acceleration

our voice

END OF 2025 STRATERGY

Review the impact and lessons learnt.

NHS Bolton NHS Foundation Trust

2022 – 2025 Update

☑ In progress

Digital Integration

86%

- Virtual Consultations
- Trust Website. Updated but, developing internally ☑

Digital Care

81%

- Voice Recognition ☑
- Maternity EPR, Community EPR and OPD EPR ☑
- LIMS ☑

Digital Workforce

100%

- Agile Working
- IDG & Virtual Smartcards, RPA
- New Bob, Room Booking, Annual Leave Apps

Digital Infrastructure

85%

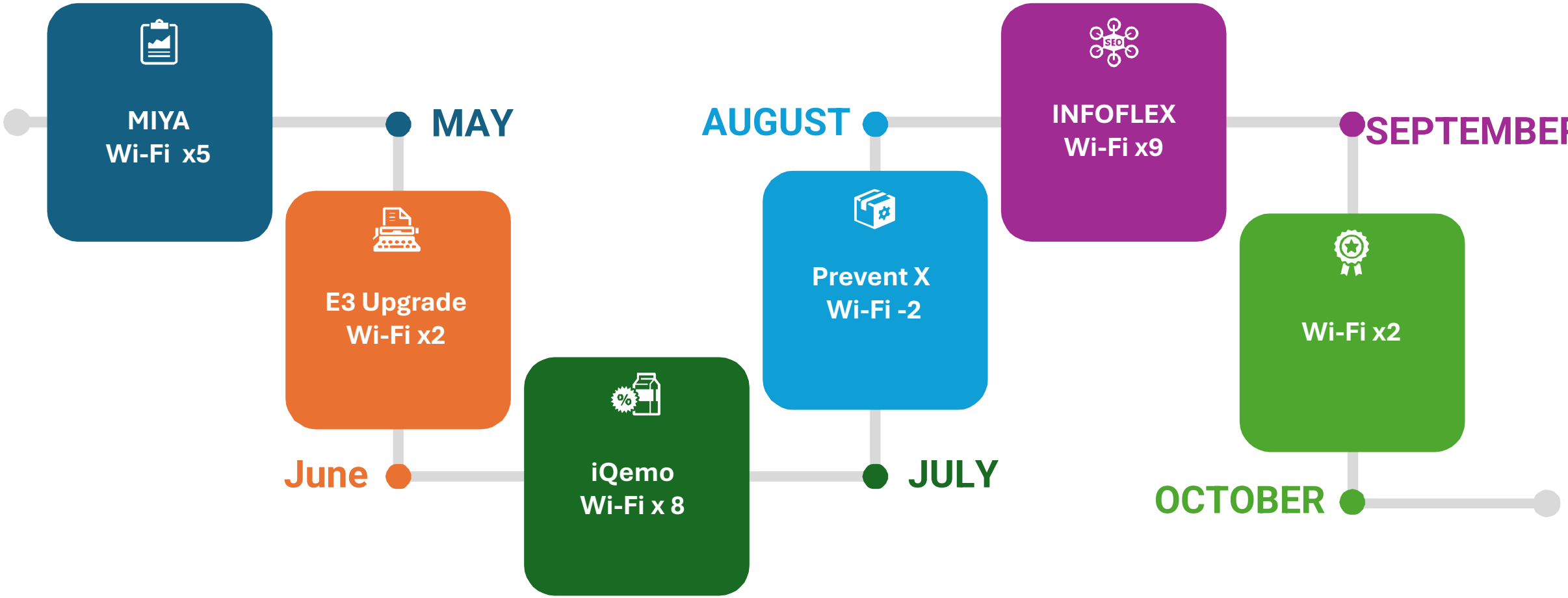
- Network Refresh
- Signal Boosters
- 365 (full migration) ☑

Extra

+

- 55 location moves in 12 months (RAAC | Buildings)
- Da Vinci, InfoFlex, ORBIS Horwich Hub, MIPA
- NHS P Migration, Integrated Community Hubs

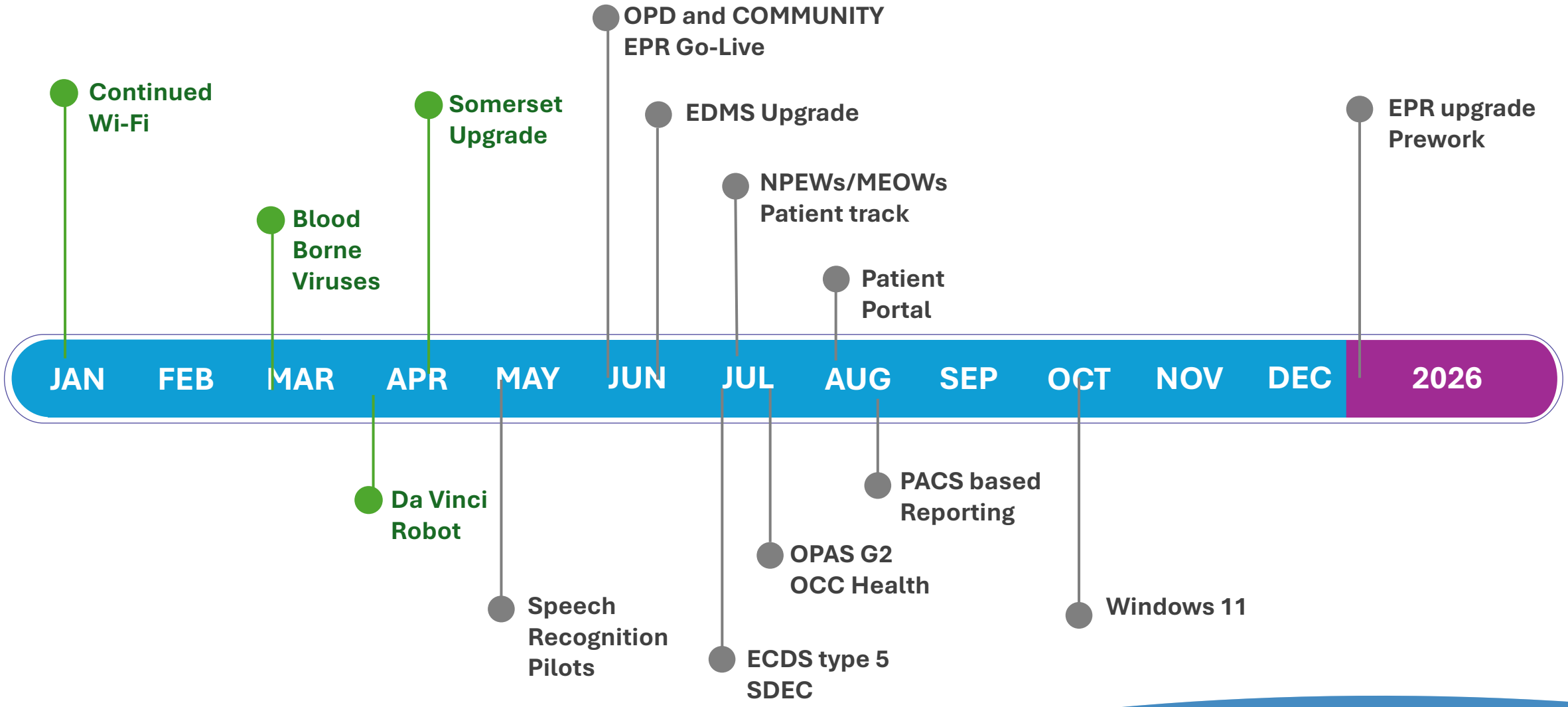
2024 Highlights



OUR DIGITAL STRATEGY UPDATE

Vision | Openness | Integrity | Compassion | Excellence

2024 to 2025



What has changed

CQC and Service Delivery

01

Our Voice

Fully integrated into the 'our voice' programme with digital sessions and feedback

02

Weekly Wards

Clinical and service desk teams visit wards in acute and community to proactively help

03

Community Base

Following successful trial and feedback from May 25 a permanent community base

04

Digital Days

Digital and Accessibility days with digital and external suppliers for feedback and demonstrations

05

Ward Equipment

Significant increase in access to equipment to match staffing ratios

CQC and Service Delivery

06

Staff Induction

Fully integrated into staff induction process

07

Automated Tickets

Automated service desk tickets for system and security alerts

08

Outage Planning

Improved maintenance and outage planning

09

TipTok

Bite size videos and tips and tutorials on BoB

CQC and Service Delivery

NEXT STEPS

Service Desk Development

Capture & report on new metrics e.g. duplicate logs, service catalogue

01

2025

Proactive Clinical Visits & CQC Sessions

Increased proactive clinical area visits and staff face to face feedback sessions

02

2025

Divisional Alignment

IT Service to 4 divisions for continuity, ownership and optimisation.

03

2025

SharePoint Feedback

BoB feedback and forums to help service delivery using 'Our Voice' and various common themes

04

2025

Accessibility SOP

Clear SOP and process for access to work for digital equipment

05

2025

CIP and Risks

Digital Enabler

Admin modernisation

Identified ~800k CIP

Microsoft Licensing

Product Consolidation

Resources Risk

Delivery of BAU,

Projects, digital enablement

Cyber Resilience

Impact on Patient Care

New legislation June 2025

CYBER

Cyber Threat

JANUARY 2025

5 Million Attacks

87000 Known threats

15000 Removed

3.5 Million Emulations downloads

3.4 Million Malicious Emails

4.4 Million received

330000 Grey or spam

7.4 Million Applications

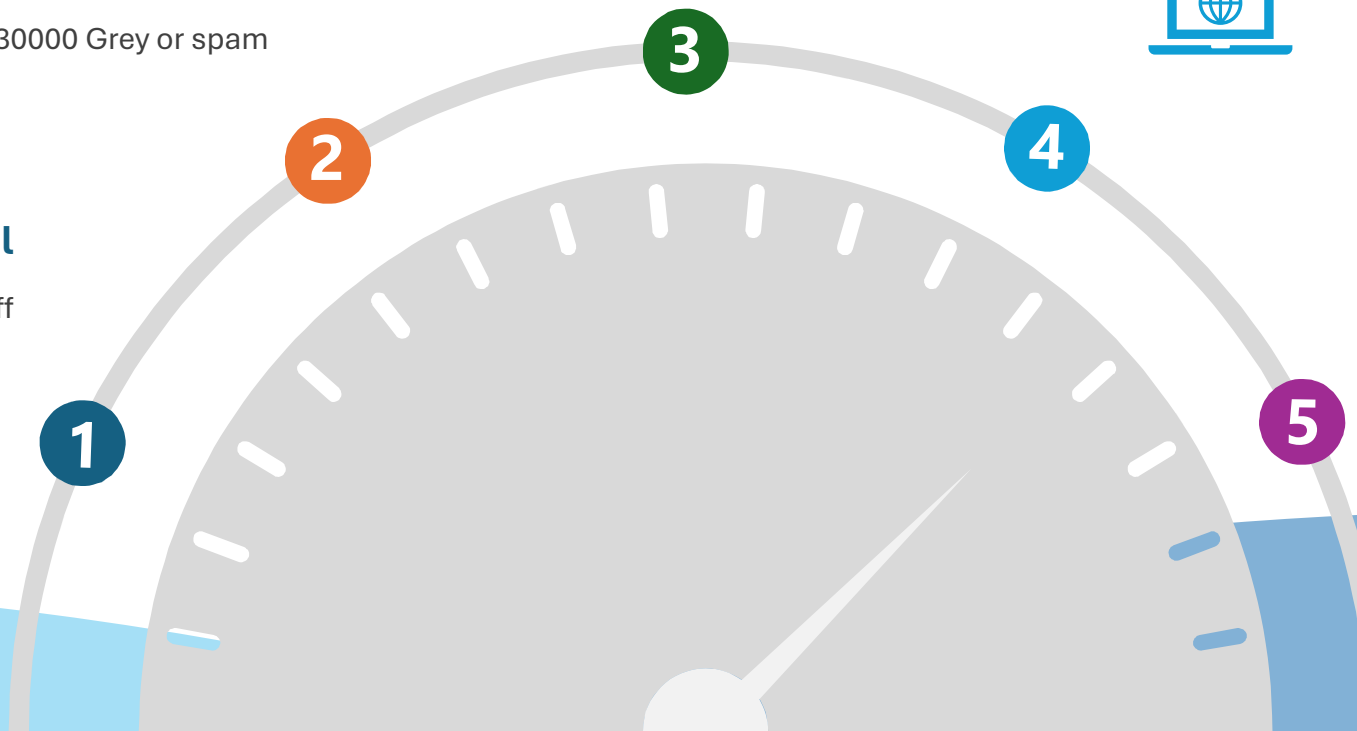
1.6 Million Malicious downloads blocked

230 Sophisticated Email

Targeted against staff

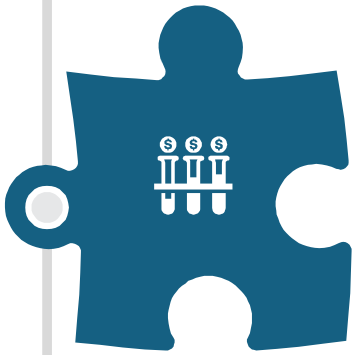
1760 Security Patches

This was only for Microsoft Windows



Digital Next Steps

2025

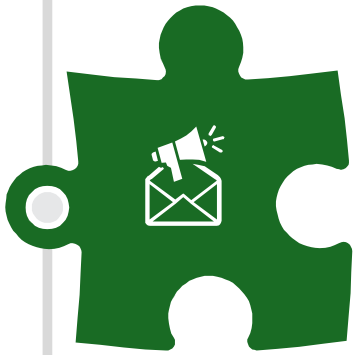


LIMS, OPD & Community EPR go live

2025

Altera Contract

2025



Patient Portal

2025/26

PAS Replacement

2025/26

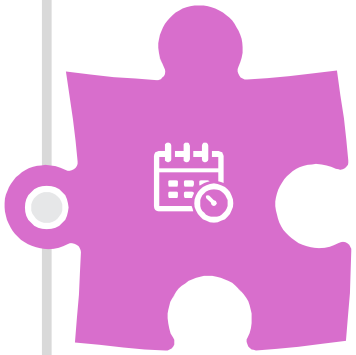
Continued CIP

Digital Next Steps

2026

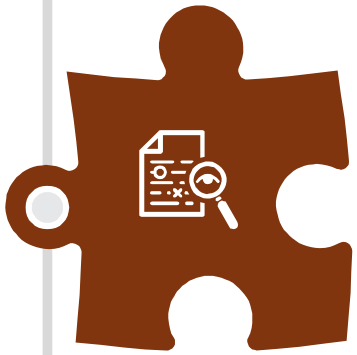
Clinical System Consolidation

2025/26



Maternity EPR Go live

2025/26



GP IT Contract

2025/26

WWL Collaboration

2025/26

Continued RPA and safe AI

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NHS
Bolton
NHS Foundation Trust

Our Digital Strategy

2022-2025

MAY 2025 UPDATE

THANK YOU

...for a better Bolton

Report Title:	Strategy 2024-29: Annual Plan 2024-25 evaluation and Sustainability & Delivery Plan			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	29/05/25		Discussion	✓
Executive Sponsor	Sharon White		Decision	✓

Purpose of the report	To receive the evaluation of the 2024-25 Annual Plan and approve the Sustainability & Delivery Plan priorities.

Previously considered by:	Executive Directors

Executive Summary	As part of the Trust's commitment to tracking strategic progress, an evaluation of 2024-25 Annual Plan priorities (appendix 1) shows that overall good progress has been made on the majority of priorities. The creation of a new Sustainability & Delivery Plan is an action from the operational planning round and a commitment made to the ICB to describe our actions to ensure sustainability. The development of the Sustainability & Delivery Plan (appendix 2) framework has previously been presented to the Executive team, with the key themes, priorities, and outcomes agreed. This document replaces the Trust annual plan. This plan reflects a shift towards longer-term planning, stronger strategic alignment, and a whole-organisation view of transformation and delivery.

Proposed Resolution	The Board is asked to: • Receive the evaluation of performance against 2024/25 priorities and note that the carry-over priorities have been built into BAU and the new plan • Approve the priorities in the Sustainability & Delivery Plan • Note that work is ongoing to refine the plan and effectively deploy it across the organisation

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**
✓	✓	✓	✓	✓

Prepared by:	Francesca Dean, Head of Strategy & Planning, Rachel Noble Deputy Director of Strategy	**Presented by:**	Sharon White, Chief of Strategy and Partnerships

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NHS Bolton NHS Foundation Trust

Strategy 2024-29: Annual plan evaluation & Sustainability and Delivery Plan

Trust Board
29 05 2025

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Exec summary

Annual plan 2024/25

An evaluation of 2024-25 priorities (appendix 1) shows that overall good progress has been made on the majority of priorities, though many remain ongoing priorities for the sustainability and delivery plan and supporting improvement plans.

Sustainability & Delivery Plan

The development of the Sustainability & Delivery Plan (appendix 2) framework has previously been presented to the Executive team, with the key themes, priorities, and outcomes agreed. The creation of the plan is an action from the operational planning round and a commitment made to the ICB to describe our actions to ensure sustainability, and replaces the Trust annual plan.

This plan reflects a shift towards longer-term planning, stronger strategic alignment, and a whole-organisation view of transformation and delivery.

To reiterate, the Sustainability & Delivery Plan is intended to be a *living framework* — one that links high-level strategic priorities and outcomes. It draws direct connections between these core priorities and the supporting initiatives, outcomes, enabling capabilities and measures required for success.

Deployment & Delivery

Work is underway to ensure the effective deployment and delivery of the plan.

There will be a session at Service Review Day that focuses on the deployment of the Sustainability and Delivery Plan.

Recommendations:

- Receive the evaluation of performance against 2024/25 priorities and note that the carry-over priorities have been built into BAU and the new plan
- Approve the priorities in the Sustainability & Delivery Plan
- Note that work is ongoing to refine the plan and effectively deploy it across the organisation

NHS Bolton NHS Foundation Trust

Annual plan 2024/25: evaluation

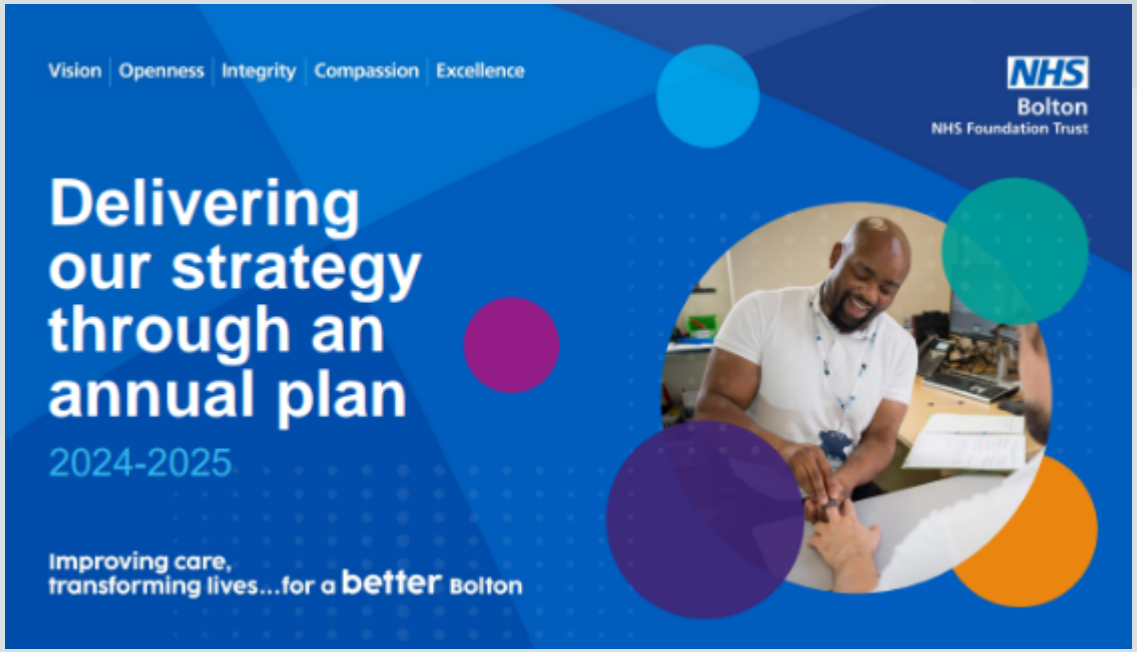
Deputy Directors have led a review and evaluation of the 2024/25 annual plan priorities, which has been received by the Executive.

The complete evaluation is included at Appendix 1.

Overall, good progress has been made on the majority of priorities, though many remain ongoing for the sustainability and delivery plan and supporting improvement plans.

Lessons learned from 2024/25 have been embedded in the development of the new plan and include:

- Improving the visibility of the plan through Trust governance
- Aligning delivery resource to plan
- Ensuring regular reporting through the Board and Executive and tracking through Deputy Directors Forum
- Changing the format of the plan from narrative document to Excel to enable better tracking and reporting



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NHS Bolton NHS Foundation Trust

Sustainability and Delivery Plan
Our priorities

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

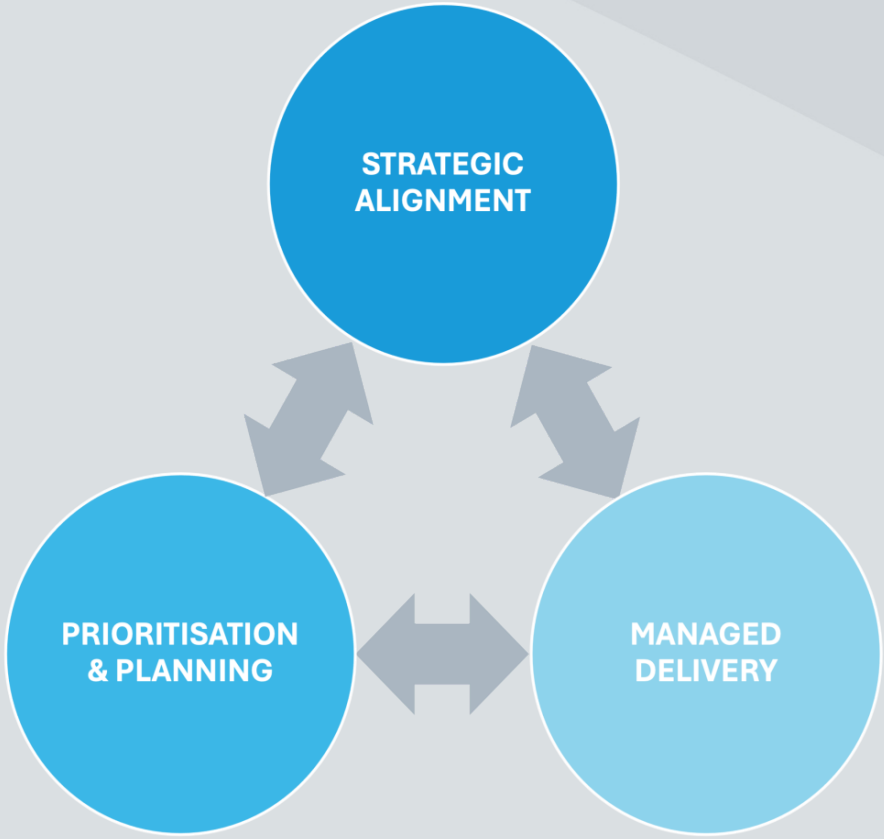
NHS Bolton NHS Foundation Trust

Why we've created this plan

The **Sustainability and Delivery Plan (Appendix 2)** is a clear, practical framework that focuses the Trust's priorities over the next 2–3 years and beyond, ensuring we stay aligned, accountable, and impact-driven. It will help us to deliver further, faster and we have committed to the ICB that we will develop and embed this plan.

This plan enables more effective decision-making, better use of resources, and stronger alignment between our strategic goals and operational delivery. It will:

- 🔄 Help us think and plan longer-term
- 🔗 Strengthen alignment across clinical, financial, and transformation goals
- 🧩 Encourage a whole-organisation view — we all play a part and understand our roles
- 🧭 Supports effective decision-making and resource allocation
- 🎯 Ensures projects are driving the organisation's goals
- 🛑 Stops overload and reallocates resources to what matters
- 📈 Tracks actual impact, not just activity
- 👥 Empowers operational and clinical teams to define *how* delivery happens



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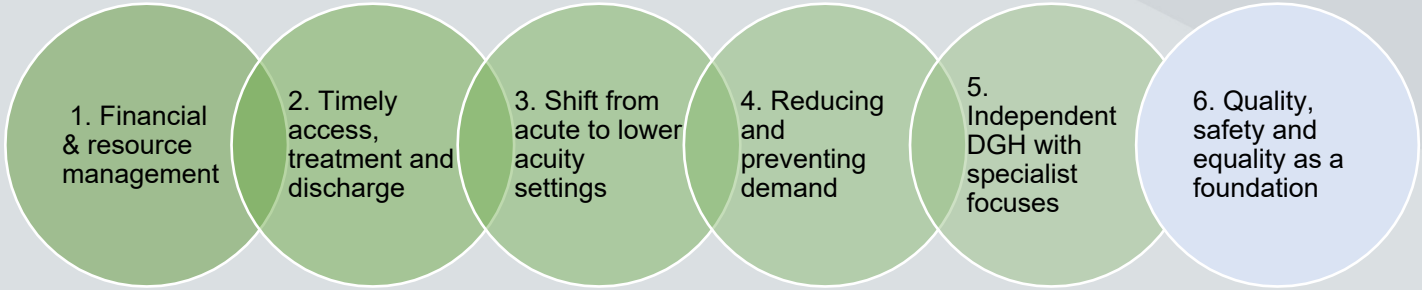
Sustainability & Delivery Plan Priorities

- A key action in developing and aligning the plan to delivery is reaching agreement on the priorities and outcomes. These priorities have been shaped through thorough analysis of multiple plans, goals, learning from 2024/25 and requirements of the organisation; both current and future.
- The first five priorities track our progress from recovery to future sustainability, with quality, safety, and equality forming a foundational core.
- Underpinning the plan are core enablers, and it is important to note that this plan does not replace BAU work but focuses us on strategic change.
- The plan begins to draw connections between risks, dependencies, resources and outcomes and work will continue on this to ensure effective deployment and sustainable delivery.
- Alongside this, work continues to refine the plan and embed regular tracking and reporting.



Core enablers; infrastructure

Business as Usual

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

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Recommendations

The Board is asked to:

- **Receive** the evaluation of performance against 2024/25 priorities and note that the carry-over priorities have been built into BAU and the new plan
- **Approve** the priorities in the Sustainability & Delivery Plan
- **Note** that work is ongoing to refine the plan and effectively deploy it across the organisation

Annual Plan 2024/25 outcome evaluation

Declined / Significant Setbacks (Performance has worsened, or key issues remain unresolved)	**Not Achieved (Progress is limited, and targets have not been met)**	**Progress Made, But Not Fully Achieved** (Good improvements observed, but further work is needed.)	**Achieved** (Targets met, and objectives successfully delivered)

Priority	Outcome	Lead	RAG Status – *As Currently Known*	Expected RAG Status by End of March 2025	Supporting Narrative – Indicate Key Supporting Projects to delivery (Provide final figures, supporting metrics, and evidence where available)	Is this a priority for 2025/26? – Yes / No / Don't Know
SEE	Achievement against the objectives and targets in the Nursing, Midwifery & AHP plan, QI plan and maternity improvement plan	S.Bates/R.Bradley			NMAHPHCS objectives monitored via CNO leadership meetings and drivers agreed via CNO away day. QI plan on track monitored via CG&QC. CNST year 6 achieved.	Yes
SEE	Sustained reduction in C-Diff	R.Bradley			Noted reduction in cases through continued improvment but sustained improvement not yet noted.	Yes
SEE	30% increase in staff trained in the fundamentals of QI* (*baseline 242 in 23/24) and 30% of those trained to start their own improvement project	S.Bates			23/24: 232 staff trainined in QI fundementals. End of January 2025 a further 103 staff have received this training (increase of 44%). Not a requirement to complete a QI project. There is a QI project library available on BOB.	Yes
SEE	Continual improvement in internal quality standards as measured by BOSCA (eliminate white status and 10% improvement in bronze to silver and sliver to gold)	S.Bates/R.Bradley			566% increase in gold awards, a 64% increase in silver and 85% reduction in bronxe awards.	Yes
SEE	Enhanced clinical outcomes and effectiveness through alignment with best practices and continuous learning	R.Bradley/ S.Bates			Improved patient experience in obtaining and evaluating a minimum of 30 responses per ward/patient cohort in relation to the 2 additional FFT questions (involved in care/treated with dignity and respect). Delivered and sustained special cause reduction in falls. Pressure Ulcer collaborative has seen significant and sustained improvement in PU (86% redciton in cat 3s, zero cat 4s in 350 days and zero in community in 2 years).	Yes
SEE	Improved reliability of information reporting to Quality Assurance Committee	R.Bradley/ S.Bates			Quality Governance framework reviewed and new reporting lines introdcued via Patient Safety Group, Patient Experience Group and Clinical Effectiveness Group. GGI Review of divisional governance to ensure standardisation of functions.	No
SEE	Improved service delivery with user-driven changes in at least three new areas	R.Bradley/ R.Munshi			1. Delivered and sustained special cause reduction in falls. 2.Improvement in PU (86% redciton in cat 3s, zero cat 4s in 350 days and zero in community in 2 years)	Yes
SEE	Improvement in patients who reported that they were involved in decision making	S.Bates/R.Bradley			Monitored via QPEF and CG&QC.	Yes
Staff	Increase the percentage of staff who would recommend the Trust as a place to receive care and to work by 5%	L.Rigby			Increased the extent to which national NHS staff survey respondents agree to recommend Bolton as a place to work by 1.4% (58.6% to 60%. Place to care has seen a reduction of 1.4% (60.6% to 59.2%)	Yes
Staff	Increase response rate to NHS Staff Survey & Quarterly Surveys by 3%	L.Rigby			Increased Annual Staff Survey resppnse by 6.6% (41.5% in 2023 to 48.1% in 2024)	Yes
Staff	Completed rollout of the updated Trust values and behaviour framework with clear expectations and alignment across all levels of the Trust	L.Rigby			Draft Our Way framework developed and engagement sessions with staff underway . Final version due at People Commitee May 2025	Yes
Staff	Achieved appraisal rate of 85%, with more people reporting that their appraisals are meaningful	L.Rigby			We are consistently achieving the 85% target, however seasonal pressures affected this slightly. FABB Appraisal documentation paperwork review is underway and more to do in this year to make them meaningful and high quality conversations	Yes
Staff	Achieved compulsory and mandatory training rate of 95%	L.Rigby			We are consistently achieving the 85% target for Mandatory Training, however seasonal pressures affected this slightly. Compliance is currently over 90%. The target for Compulsory Training is 95% and we are currently very close to that figure at 93%.	Yes
Staff	Optimised workforce with reduced sickness (<=4.2%) turnover (8-10%), agency spend (2.2%) and vacancy rates (4%), leading to improved stability and efficiency	C.Sheard			Vacancy rates better than target (6%) for the full year. Turnover within target range and reducing. Absence - KPI of 4.2% not achieved but BFT consistently lower abence rate than Acute Trust GM peers. Agency spend NHSE target not to exceed 3.2% of total pay bill achieved for full year. Bank spend above forecase for 2024/25 and subject to enhanced controls.	Yes
Staff	Established service level agreement with University of Bolton to formalise the partnership for creating a new medical school	R.Noble			Service level agreement is in place and work will continue into 2025-26 to develop the business case and delivery model for the partnership	Yes
Staff	Achievement of Equality, Diversity & Inclusion plan objectives and targets. Specifically ensuring we have a workforce that represents the Bolton population	L.Rigby			EDI Plan and Themes under review alongside a full review of the EDI Governance Structure	Yes
Staff	Broadened application of Quality Improvement (QI) principles, with Board members equipped to lead and support QI initiatives	S.Bates			In plans for 25/26. Initial Board development session held. Further work around leadership and culture being prgressed.	Yes
PC	Reduce diagnostic, cancer and elective care waiting times in line with national standards and targets	M.Cox			Forecasting full deliver of operating plan metrics for 24/25 including 5% for DM01, no patients waiting over 65 weeks and delivery of cancer standards	Yes
PC	Development of a comprehensive plan for community services to reduce long waiting times	M.Chew			Joint plan in place between ICSD and FCD, new dataset in place - being led by ICSD Deputy DDO	Yes
PC	Increase in the proportion of procedures performed as day cases rather than inpatient stays	A.Cottrell			Day case rates have deteriorated over the past year, plan to increase over the course of the next year. Expansion of criteria led discharge model will support improvement of this metric. Embedded in improvement plan for elective.	Yes
PC	Reduction in the average length of stay for elective procedures	A.Cottrell			Position has remained largely static, although improved performance seen in Trauma and Orthopaedics in line with planning guidance from last year. However expansion in day case rates may result in this metric deteriorating	Yes
PC	Number of patients opting for PIFU and virtual appointments and the impact on appointment volumes and patient outcomes	A.Cottrell			PIFU model has expanded and virtual activity has marginally increased, however no concurrent impact on activity levels due to requirement to deliver activity to support 65-weeks.	Yes – PIFU expansion, No - virtual expansion
PC	Improvements in appointment scheduling leading to optimised clinic and theatre capacity	S.Clarke			Full improvement plan in place following GIRFT feedback and all processes being reviewed and improved through the admin improvement programme	Yes
UPC	Increase in the number of people receiving care in the most appropriate setting for their needs	R.Calderbank/ S.Ball			w Acute Medical Model, RAT/streaming, direct to specialty pathways in situ. These are supporting patients to receive care in the most appropriate setting by the most appropriate team. Additional work around call before convey and NWAS direct admissions to support patients to receive care in the community where appropriate. Further optimisation required and planned as part of phase 2 UEC plan.	Yes
UPC	Reduction in hospital admissions for conditions treatable at home or in the community	R.Calderbank/ S.Ball			New pathways in place delivered as part of phase 1 UEC plan	Yes
UPC	Improved emergency department assessment and treatment times, leading to improved experience and outcomes	R.Calderbank/ S.Ball			Delivered as part of phase 1 UEC plan	Yes
UPC	A minimum of 78% performance against the 4hr urgent care standard by March 2025	R.Calderbank/ S.Ball			Progress and improvement has been made but achievement of 78% will be a challenge	Yes
UPC	Reduction in avoidable length of stay	R.Calderbank/ S.Ball			Overall trust LOS remains in common cause variation however, evidence of localised improvement with AACD demonstrating special cause improvement. Further work planned as part of phase 2 UEC plan and supported by ECIST e.g. LLOS review, SAFER boards.	Yes
UPC	Achievement against a NCTR target of 75	M.Chew/ R.Calderbank			Improvement has been made against 23/25 performance but the target of 75 has not been reached	Yes
UPC	Increase in people dying in a preferred or more suitable location, such as home or care home, rather than in a hospital setting	N.Caffrey/ R.Munshi			Completing a broad piece of work around advanced care planning. This is looking at two areas: 1. Increasing the utilisation of advanced care plans in end of life and palliative care. 2. Increasing the visibility and access to advanced care plans across the system. This includes improving the ability to share and access information on e-PACS (palliative care record across GM). A test of change is on-going with Farnworth care home and the respective PCN. We are working with ICB colleagues to support with advance care planning. They have offered to train the staff at Farnworth care home. We will discuss with the care home about where is recorded and utilising admission avoidance whilst we progress conversations about EPACCS. This aligns with the Glenesk feedback on short term care and the proactive care agenda.	Yes
UPC	Reduction in complaints	S.Bates			In 2023/24 the Trust received 188 formal complaints. As of 27.02.2025, the Trust has received 187 formal complaints. Therefore, it is likely for 2024/25 the Trust will see an increase in the number of formal complaints received. Quality Governance role is to ensure there is a complaint function in place to meet the regulatory requirement. Volume of complaints is outside of control.	Yes
UPC	Improved staff experience	R Calderbank			Rolling program of internal staff comms and briefing sessions, particularly in UEC. Improved staff survey response rate. Further work planned following results of staff	Yes
BUR	Achievement of the financial plan and cost improvement plan (CIP)	A.Chilton/ L.Wallace			Decision on final plan deficit and CIP £/% not yet made, so ability to deliver not known	Yes
BUR	Delivery of national elective recovery fund (ERF) target	A.Chilton			Targets not issued to ICB let alone Providers, so unsure if abkle to delive the national requirements within the envelope	Yes
BUR	Enhanced operational efficiency and improved financial management through successful implementation of PLICS (patient level information & costing system)	A.Chilton			Captured in new plan with delivery expected in 2026/27	Yes
BUR	2% increase in commercial income	L.Wallace			Additional income from parking achieved and recurrent. Funding received for stock management system - roll out commences 5th March 25 and will continue in to 25/26	Yes
BUR	Enhanced productivity through targeted measures	L.Wallace			productivity tracker to be developed	Yes
BUR	Implemented digital solutions with well-defined benefits that are being successfully realised	B.Walmsley			Vague priority. Tightened in new plan and forming part of BAU	Yes
BUR	Commenced RAAC (reinforced autoclaved aerated concrete) eradication programme in maternity	F.McDonnell			Work commenced and will be delivered in 2025/26	Yes
BUR	Established a programme board with Wrightington, Wigan & Leigh Foundation Trust to deliver progress against the joint work plan	R.Noble			Collaboration board established and meeting on a bi-monthly basis. 3 tranches of work have been identified and work will progress in 2025/26 with a focus on delivering operational targets and taking cost out	Yes

Strategic Framework: Sustainability & Delivery Plan

Date: 09/05/2025

All contribute to great place to work and improving care TF lives - then all should contribute to access

Strategic Priorities & Outcomes			Year of focus					Status - SECTION TO BE DEVELOPED W/C 12/5/25				Links			Resource					Governance				How summary (see How tabs for detailed breakdown of milestones/dates etc)
1. Financial & Resource Management	THE CHANGE	SMART	**Year 0 (24/25)**	**Year 1 (25/26)**	**Year 2 (26/27)**	**Year 3**	**Year 4**	**Stage**	**Delivery readiness (BRAG)**	**Delivery progress (BRAG)**	**Notes/actions**	**Interdependency**	**Risks**	**Strategic alignment**	**Cost Savings (£)**	**Investment (£)**	**Delivery Areas/partners**	**Core Enablers**	**Transformation (TFI)/ Improvement / QI/ PMO support**	**Exec sponsor**	**Governance (committees/groups)**	**Delivery leads**	**Delivery Governance**	**How**
Impact Area	**Outcomes**	**3-Year Proxy Measures**																						
1a **Financial Balance**	Operating within budget while improving care	Yearly financial result: -£6.5M → Break-even → +1% surplus	✓	✓	✓	✓						Depends on delivery of cost reduction, productivity, and balancing requirements across all programmes	Cost pressures outpace savings; activity growth outstrips funding; underachievement on efficiency and CIP targets; GM priorities	High performing productive	£37m 2025/26 6.5m + 25/26 underdelivered CIP + 26/27 + investment surplus	Ad hoc - linked to wider portfolio	Execs, Deps & DDCs (all involved in delivery)	Finance	Yes (PMO already allocated)	A Walker	F&I	L Wallace/Deps	FIG	The "How" will span multiple strategic priorities and outcome areas, with reference numbering in Column B to ensure consistent alignment across the framework. Key milestones, activities, and projects will be systematically mapped to enable clear tracking of delivery at an organisational level. This structured approach is designed to support effective decision-making and resource allocation. The CEO and Board retain ownership of the strategic priorities and outcomes, while Executive Leads are accountable for the delivery of programmes and projects that contribute to these priorities. Operational and clinical teams will be empowered to define how delivery happens — providing the creativity, flexibility, and permission needed to innovate and tailor implementation at the front line. Routine business-as-usual (BAU) activity will remain outside the Sustainability & Delivery portfolio unless it involves significant transformation or has a material impact on strategic objectives. In such cases, it will be brought under portfolio oversight to ensure alignment and governance.
1b **Reduced Operating Costs**	Lower cost per unit of service	Corporate reduction 50% growth reduction from 18/19 to 2023/24 Cost per patient episode: ↓ 2% → ↓ 3% → ↓ 5%		✓	✓	✓	✓					Linked to workforce optimisation, P&E, digital enablement, and improved care models (e.g. community shift); PLICS utilisation	Unrealised transformation/improvement benefits; inflation; resistance to change in clinical and corporate practice; Data quality and analytics	High performing productive	TBC	TBC	Execs Deps	Finance, BI	Yes	TBC	TBC	TBC	TBC	
1c **Investment in Strategic Enablers**	Targeted capital investment in digital, estates, workforce, and care models	% of budget for transformation: (example 5% → 8% → 10%)	✓	✓	✓	✓	✓					Enables all other transformation domains (e.g. digital. neighbourhood teams. EPR. AI)	Funding constraints; capital delays; lack of visible ROI undermines future investment	Fit for the future	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	
1d **Workforce Optimisation**	Reduced WTE spend	WTE spend reduction (CIP summary for Y1)	✓	✓								Depends on successful digital automation, skill mix changes, recruitment and retention	Workforce gaps; staff burnout; industrial action; inability to upskill or recruit to new roles	High performing productive	£5.7m savings (agency/bank)	Yes	Clinical, ops, corporate	Workforce, finance	Yes (TF role allocated to admin)	J Mawrey	People Committee	P Henshaw R Bradley & M Cox	Resources & Talent Pipeline Group	
1e **Non-Pay Spend**	Optimised procurement and contracts	[Metrics to be defined]	✓	✓	✓							Relies on digital procurement tools and service redesign (e.g. product standardisation, shared contracts)	Poor contract management; fragmented procurement; miss use of resources	High performing productive	£6.6m savings	Yes (centos)	Clinical, ops, corporate	Finance	Yes (PMO role allocated to centos)	A Walker	F&I	L Wallace	FIG	
1f **Service & Organisational Performance**	Best quartile in quality, efficiency, and productivity	% of services in top quartile: 40% → 60% → 80%		✓	✓	✓						Dependent on improvement across clinical pathways, digital maturity, and performance management	Low adoption of improvement tools; workforce disengagement; variation in practice; data quality and analysis	High performing productive	TBC	TBC	Clinical, ops, corporate	Finance, BI, workforce	TBC	R Wheatcroft? F Andrews	QAC?	M Cox S Kimber-Craig	EPPG	
1g **Service Planning**	Forecast demand and align resources	Dynamic modelling (activity, workforce, finance) in place; refreshed annually			✓	✓	✓					Informs all other planning domains (workforce, finance, estates); essential for right-sizing services	Poor modelling assumptions; lack of integration across data sources; misalignment with ICS planning; data quality and analysis	Fit for the future	TBC	TBC	Clinical, ops, corporate	Finance, BI, workforce, strategy	TBC	TBC - need a programme to be developed around this	QAC	Strategy/Medical Directors Office/Ops	PTB	
2. Timely Access, Treatment, and Discharge																								
Impact Area	**Outcomes**	**3-Year Proxy Measures**																						
2a **Elective, Cancer & Diagnostics**	Shorter waits across pathways	Elective 18-week RTT: x% → x% → x% Diagnostics: 95% maintain Cancer -	✓	✓	✓							Relies on timely diagnostics, workforce capacity, Booking and theatre P&E, ERF income	Growing backlogs; staffing shortages; increased referrals; finance constraints	High performing productive Improving care, transforming lives	£3–5m efficiency potential and £5m+ ERF income	Business case approved Yr 0 (£x)	Clinical, ops, IS, primary care	Digital, BI, estates	Yes (Theatre TF, Diagnostics TF & PMO TF roles allocated)	R Wheatcroft	QAC	A Cottrell	PTB	
2b **Acute Patient Flow**	Faster recovery and discharge	A&E 4 hours - Average Length of Stay: ↓ 0.5 days per year Ward closure 2 - 3 - 4	✓	✓								Linked to community care availability, discharge-to-assess models, and integrated neighbourhood teams	Delays in social/community care; discharge bottlenecks; community resource gaps	High performing productive Improving care, transforming lives	£2–3m savings from flow improvements. 77£ efficiency potential	Business case approved Yr 0 (£0)	Clinical, ops, primary care, care homes	Digital, workforce, BI, estates	Yes (PMO TF role allocated)	R Wheatcroft T Roberts	QAC	M Cox	PTB	
3. Shift from Acute to Lower-Acuity Settings																								
Impact Area	**Outcomes**	**3-Year Proxy Measures**																						
3a **Shift to Community**	More acute care managed outside hospitals	Community-based delivery: 50% → 60% → 70%		✓	✓	✓						Dependent on workforce, estates, digital tools, and aligned commissioning/internal funding shifts	Community services underfunded or understaffed; variability in alternative service capacity across locality	Positive partner Improving care, transforming lives	£3–4m saved over 2 years??	Yes (business case being developed)	Clinical, ops, primary care, care homes, social care	Digital, workforce, BI, estates	TBC	R Wheatcroft	QAC	M Chew/R Calderbank	PTB	
3b **Integrated Neighbourhood Teams**	Seamless transitions and joint planning	100% shared care records; ≥3 ICS-wide pathways	✓	✓	✓	✓						Linked to digital maturity, social care integration, and new care models. Realisation of UEC TF	Resistance to change in clinical practice. Unrealised transformation/improvement benefits from UEC programme	Positive partner Improving care, transforming lives	To quantify	TBC	Clinical, ops, IS, primary care, care homes, social care	Digital, workforce, BI	TBC	R Wheatcroft	QAC	M Chew	PTB	
3c **Self-Managed & Tech-Enabled Care**	Empowered, digitally supported patients	Use of portals/remote monitoring: 30% → 50% → 75%		✓	✓	✓	✓					Dependent on digital tools, patient activation, and clinical confidence in virtual monitoring	Digital exclusion; low patient uptake; technology integration issues	Fit for the future Improving care, transforming lives	To quantify	TBC	Clinical, ops, corporate	Digital, Comms, BI	Yes	F Andrews?	QAC	Digital Team	DPTB?	
4. Reducing and Preventing Demand																								
Impact Area	**Outcomes**	**3-Year Proxy Measures**																						
4a **Avoidable Attends and Admissions**	Fewer unnecessary admissions and A&E visits	Non-Elective (NEL) admissions ↓ 3% per year Reduction in emergency admissions by 5%;		✓	✓	✓						Requires effective prevention pathways, virtual wards, primary care resilience, and public health	Insufficient community alternatives; population health challenges; demand management	High performing productive Improving care, transforming lives	To quantify	Linked to patient flow B/C.	Clinical, ops, primary care, care homes, social care	Digital, Comms, workforce	Yes (PMO TF role)	F Andrews R Wheatcroft	QAC	Community/AACD	PTB	
4b **Cancer & LTC Management**	Earlier diagnosis, reduced variation	Stage I/II Cancer: 60% → 70% → 75% (by 2028) LTC risk-based interventions ↑ 10%		✓	✓	✓	✓					Relies on screening programmes, population health tools, and pathway redesign	Screening backlogs; poor uptake in target groups; diagnostic capacity constraints	Improving care, transforming lives	To quantify	TBC	Clinical, ops, primary care, care homes, social care, CVS, public health	Digital, Comms, BI	TBC	F Andrews/R Wheatcroft	QAC	AACD/ASSD/Community	PTB	
4c **CYP Health**	Improved early support, reduced crisis presentations	[Detailed metrics to be defined]				✓	✓					Dependent on schools, local authorities, early years services, and CAMHS involvement/capacity	Fragmented service coordination across education, health, and social care	Positive partner Improving care, transforming lives	To quantify	TBC	Clinical, ops, primary care, GMMH. Social care	TBC	TBC	R Wheatcroft	QAC	Community/AACD	PTB	
5. Independent DGH with Specialist Focuses																								
Focus Area	**Outcomes**	**3-Year Proxy Measures**																						
5a **Women & Children's Centre of Excellence**	Recognised for outstanding outcomes	Designation achieved; Top 10% quality indicators, extended service capacity		✓	✓	✓						Relies on workforce specialisation, estate development, and alignment with GM maternity plans	Recruitment of paediatric/maternity specialists; capacity gaps; dependency on capital & TF funding	A positive partner Improving care, transforming lives	Neutral or reinvestment from efficiencies	TBC	Clinical, ops, ICB	Digital, Comms, estates	TBC (7FC TF role)	R Wheatcroft	QAC	Community/AACD/Women's & Diagnostics	PTB	
5b **Community Health**	High-quality, integrated care	[Detailed metrics to be defined]				✓	✓					Requires aligned pathways with primary/community care, digital support, and risk stratification tools	Fragmented care delivery; insufficient community capacity; poor adoption of personalised care planning	A positive partner Improving care, transforming lives	To be quantified	TBC	Clinical, ops, primary care, care homes, social care, CVS, ICB, public health	TBC	TBC	R Wheatcroft	QAC	Community	PTB	
5c **Partnership with Wigan**	Resilient and efficient service delivery	[Joint delivery metrics to be confirmed]		✓	✓							Linked to shared pathways, joint governance, and information sharing across trusts	Misaligned priorities; lack of shared infrastructure; cross-organisational cultural friction	A positive partner Improving care, transforming lives	To be quantified	TBC	Clinical, corporate, wigan, ICB	BI, finance, workforce, comms, strategy	TBC	S White	BFT/WWL Collaboration Board	Strategy	PTB	
5d **Teaching and research partner**	Supporting high-quality clinical training and applied research	Formal partnership signed; >5-10 joint research projects; 10% increase in clinical placements	✓	✓	✓							HEI partnership alignmnet, Clinical departments readiness, digital infrastructure, reserach partnerships	Lack of capacity for student supervision, Delays in research approvals/governance, Competing clinical pressures limit participation, Insufficient digital maturity to support research	A positive partner Great place to work	To be quantified	Yes (for medical school)	Clinical, university, hospital partners	Finance, strategy	Yes	F Andrews	QAC	Strategy/Medical Education	TBC	
6. Quality, Safety, and Equality as a Foundation																								
Impact Area	**Outcomes**	**3-Year Proxy Measures**																						
6a **Avoidable Harm & Mortality**	Safer care, fewer complications	Priority metrics to be define	✓	✓	✓	✓	✓					Relies on strong governance, staff training, digital surveillance, and pathway redesign	Underreporting; fatigue among staff; data quality; low capacity for QI cycles	Improving care, transforming lives	To be quantified - ie £2–4m through harm reduction, efficiency	Yes - as agreed in year	All	All	QI team	T Roberts/F Andrews	QAC	M Cox/R Bradley/H Bharaj/S Bates	Clinical & Quality Governance Group	
6b **AI & Decision Support**	Faster, more accurate diagnosis	AI deployed in 2 → 5 → 8 key pathways				✓	✓					Depends on digital maturity, clinical engagement, and interoperability of EPR	Resistance to AI; integration delays; data governance/compliance barriers	Fit for the future Improving care, transforming lives	To be quantified	TBC	Clinical, commercial partners,	Digital, BI	TBC	S White	QAC	J Ryan/V Malik	DPTB	
6c **Health Inequalities (CORE20PLUS5)**	Equitable access and outcomes	Health Inequality gap closure: ↓ 2% → ↓ 4%	✓	✓	✓	✓	✓					Requires population health management, community outreach, and aligned commissioning	Inadequate local engagement; poor data on deprivation; lack of targeted investment	Improving care, transforming lives	To be quantified	TBC	Clinical, ops, primary care, care homes, social care, CVS, ICB, public health	BI	TBC	S White	QAC	S Clarke/J Ryan	PTB	
6d **Workforce equality**	A fair, inclusive, and representative workforce at all levels	[Workforce metrics to be defined]		✓	✓							Recruitment & promotion policies, Leadership development programmes, Workforce planning, Staff networks and engagement	of progress eroding trust, Inadequate leadership buy-in, Tokenistic interventions lacking impact	Great place to work	To be quantified	TBC	Clinical, corporate, ops	Workforce	TBC	J Mawrey	People Committee	L Rigby	EDI Group	
Core Enablers: Infrastructure																								
Component	**Outcomes**	**3-Year Proxy Measures**																						
E **Estates**	Safe, sustainable, fit-for-purpose facilities	Backlog maintenance ↓ 30%; Estates efficiency ↑ TF projects complete	⊖	⊖	⊖	⊖	⊖					Supports service redesign, acute and community transformation, and specialist/community hub development	Capital funding constraints; delays in planning approvals; outdated sites	Fit for the future	TBC	TBC				A Walker	F&I	F McDonnell	Strategic Estates Grp	
D **Digital**	Full EPR, remote monitoring, and integrated digital tools for care delivery	Digital maturity: 60% → 70% → 85%	⊖	⊖	⊖	⊖	⊖					Critical to almost every domain (workforce, diagnostics, AI, integration, patient empowerment)	Poor user adoption; cyber risk; cost overruns; interoperability issues; investment constraints in both deployment, implementation and maintenance	Fit for the future High performing productive	TBC	TBC			Digital PMO	S White	F&I	B Walmsley	DPTB	
DI **Data & Intelligence**	Full analytical coverage enabling automation, predictive modelling, planning, and insights	Predictive models implemented in ≥5 pathways; 70% of reports automated; ≥3 planning cycles supported with real-time integrated dashboards	⊖	⊖	⊖	⊖	⊖					EPR and data infrastructure, Clinical and operational teams (to define use cases), Digital maturity, Service planning and workforce strategy alignment	Poor data quality or access. Lack of skilled analysts/data scientists, Low adoption by frontline teams, Fragmented data systems or integration failures	Fit for the future High performing productive	TBC	TBC				S White	F&I	J Ryan	DPTB	
W **Future-Ready Workforce**	Skilled, engaged, and agile teams with capabilities aligned to future models of care	[Workforce metrics to be defined]	⊖	⊖	⊖	⊖	⊖					Foundation for care model changes, digital rollout, and productivity gains	Training gaps; retention challenges; limited pipeline for new roles (e.g. AHPs, data analysts)	Great place to work	TBC	TBC				J Mawrey	People Committee	C Sheard	Resources & Talent Pipeline Group	
SPD **Strategy, Planning and Delivery**	Strategic priorities and resources aligned to enable successful delivery and impact	Progress against delivery milestones: 60% → 70% → 85% on track, % of corporate resources aligned to strategic priorities ↑ annually, % of teams reporting clear line-of-sight to strategic goals ↑	⊖	⊖	⊖	⊖	⊖					Finance (resource allocation), Workforce and OD (capacity and skills), Clinical & operational leads (delivery plans/ownership), BAF and risk management alignment	Siloed or disconnected planning and delivery cycles, Misalignment of resources, Inconsistent ownership and accountability, Poor-quality or delayed decision-making, Limited or delayed	Fit for the future High performing productive	TBC	TBC								
Business-As-Usual (BAU) Priorities																								
Patient Experience	Consistently high-quality, person-centred care experiences	Improve	⊖	⊖	⊖	⊖	⊖													T Roberts	QAC	R Bradley	Clinical & Quality Governance Group	
Staff Experience	Valued, supported, and empowered workforce	Improve	⊖	⊖	⊖	⊖	⊖													J Mawrey	People Committee	C Sheard/L Rigby	Staff Experience Group	
Quality & Safety (Q&S)	Reliable, safe, and continuously improving care	Improve	⊖	⊖	⊖	⊖	⊖													T Roberts/F Andrews	QAC	S Bates	Clinical & Quality Governance Group	
Governance & Risk	Effective oversight, accountability, and proactive risk mitigation	Align	⊖	⊖	⊖	⊖	⊖													T Roberts	QAC	S Bates	Risk Management Committee	
Core Standards Compliance	Consistent delivery of national and local standards, including CQC and NHS Constitution	Meet	⊖	⊖	⊖	⊖	⊖													T Roberts/F Andrews	QAC	R Bradley/S Bates/M Cox/H Bharaj	Clinical & Quality Governance Group	
Finance and resource management	Sustainable use of resources that supports long-term value and transformation	Transform	⊖	⊖	⊖	⊖	⊖													A Walker	F&I	A Chilton/L Wallace	FIG	