BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 12 noon on Thursday 30 January 2024
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB001/25	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB002/25	**Patient and Staff Story** *Purpose: To **receive** the patient and staff story*	*Presentation*		
TB003/25	**Declaration of Interests concerning agenda items** *Purpose: To record any interests relating to agenda items*	*Verbal*	Chair	**12:00** (20 mins)
TB004/25	**Minutes of the previous meeting held on 28 November** *Purpose: To **approve** the minutes of the previous meetings*	*Report*	Chair	
TB005/25	**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				
TB006/25	**Chair's Report** *Purpose: To **receive** the Chair's Report.*	*Verbal*	*Chair*	**12:20** (10 mins)
TB007/25	**Consent Agenda** a. *Care Hours Per Patient Day (CHPPD) Data Report* *Purpose: To **receive** the CHPPD Report*	*Report*	*Chief Nurse*	**12:30**
TB008/25	**Chief Executive's Report** *Purpose: To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**12:30** (10 mins)

TB009/25	**Updated Governance Structure** *Purpose: To **approve** the Updated Governance Structure.*	*Report*	*DCG*	**12:40** (05 mins)
	IMPROVING CARE, TRANSFORMING LIVES			
TB010/25	**Integrated Performance Report** *Purpose: To **receive** the Integrated Performance Report*	*Report*	*Exec Directors*	**12:45** (25 mins)
TB011/25	**Quality Assurance Committee Chair's Report** *Purpose: To **receive** assurance on the work delegated to the Committee.*	*Report*	*QAC Chair*	**13:10** (10 mins)
TB012/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *Purpose: To **receive** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme*	*Report*	*CNO + Director of Midwifery*	**13:20** (10 mins)
TB013/25	**In-patient Survey Report** *Purpose: To **receive** the In-patient Survey Report*	*Report*	*Chief Nurse*	**13:30** (10 mins)
TB014/25	**Learning from Deaths and Mortality Report** *Purpose: To **receive** the Learning from Deaths and Mortality Report*	*Report*	*Medical Director*	**13:40** (10 mins)
	A GREAT PLACE TO WORK			
TB015/25	**People Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*PC Chair*	**13:50** (10 mins)
TB016/25	**Gender Pay Gap Report** *Purpose: To **approve** the Gender Pay Gap Report*	*Report*	*DOP*	**14:00** (10 mins)
	COMFORT BREAK (10 mins)			**14:10**
	A HIGH PERFORMING PRODUCTIVE ORGANISATION			
TB017/25	**Finance and Investment Committee Chair's Report**	*Report*	*F&I Chair*	**14:25** (10 mins)

	*Purpose: To **receive** assurance on work delegated to the committee.*			
TB018/25	**Audit and Risk Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*ARC Chair*	**14:35** (05 mins)
TB019/25	**Our Bolton NHS Charity Annual Report** *Purpose: To **approve** the Our Bolton NHS Charity Annual Report and Accounts.*	*Report*	*CofSP*	**14:40** (10 mins)
	AN ORGANISATION THAT'S FIT FOR THE FUTURE			
TB020/25	**Strategy and Operations Committee Chair's Report** *Purpose: To **receive** assurance on work delegated to the committee.*	*Report*	*SOC Chair*	**14:50** (05 mins)
TB021/25	**iFM Report** *Purpose: To **receive** the iFM Report.*	*Report*	*CFO*	**14:55** (15 mins)
	A POSITIVE PARTNER			
TB022/25	**Questions to the Board** ***Purpose:** To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:10** (05 mins)
TB023/25	**Feedback from Board Walkabouts** ***Purpose:** To **receive** feedback following walkbouts.*	*Verbal*	*Members*	**15:15** (10 mins)
	CONCLUDING BUSINESS			
TB024/25	**Messages from the Board** ***Purpose**: To agree messages from the Board to be shared with all staff.*	*Verbal*	*Chair*	**15:25** (02 mins)
TB025/25	**Any Other Business** ***Purpose:** To **receive** any urgent business not included on the agenda*	*Report*	*Chair*	**15:27** (03 mins)
	Date and time of next meeting: • Thursday 27 March 2025			***15:30*** ***Close***

Chair: Niruban Ratnarajah

Name:	Position:	Interest Declared	Type of Interest
Francis **Andrews**	Medical Director	Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest
Seth **Crofts**	Non-Executive Director	External Academic, Appointed Representative, The Open University, Academic Quality and Governance Committee	Non-Financial Professional interest
Tosca **Fairchild**	Non-Executive Director	Chief of Staff – NHS South East London Integrated Care Board	Financial Interest
		Trustee – South East London ICB Charity	Non-Financial Professional Interest
		Client Executive (Consultancy) – Bale Crocker Associates	Financial Interest
		Partner is Consultant in Emergency Care / Deputy Medical Director – University Hospitals of Derby NHS Foundation Trust	Non-Financial Interest
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest
		Director, Harriss Interim and Advisory	Financial Interest
		Family member works for Astra Zeneca	Non-Financial Personal Interest
		Non-Executive Director Borough Care	Financial Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	

Name:	Position:	Interest Declared	Type of Interest
James **Mawrey**	Chief People Officer / Deputy Chief Exec	Nil Declaration	
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Judge on She Inspires Awards	Non-Financial Professional Interest
		Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
		Egerton Pre School Committee Chair	Non-Financial Personal Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Director: Ratnarajah Medical Services Limited (also T/A Extracellular, Private GP and Lifestyle Medicine)	Financial Interest
		Lead for GP Strategy and Placements at the University of Bolton	Financial Interest
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

Name:	Position:	Interest Declared	Type of Interest
		Trustee Women for Well Women (Leigh)	Non-Financial Personal Interest
Annette **Walker**	Chief Finance Officer	Chief Finance Officer of both Bolton Foundation Trusts and GM ICP Bolton	Non-Financial Professional Interest
Rae **Wheatcroft**	Chief Operating Officer	Nothing to declare	
Sharon **White**	Director of Strategy	Trustee 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 Trust.

Types of Declared 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 28 November 2024

Subject to the approval of the Board of Directors Meeting on Thursday 30 January 2025

Present

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

In Attendance

Carter	Rachel	RC	Associate Director of Communications and Engagement
Chadwick	Faye	FC	Divisional Nurse Director for Children and Sexual Health (item 134)
Crompton	Victoria	VC	Corporate Governance Manager
Cotton	Janet	JC	Director of Midwifery (for item 146 and 147)
Cox	Michelle	MC	Director of Operations
Pennington	Louise	LP	Specialist Adolescent Health Nurse (for item 134)

Apologies

Sean	Harriss	SH	Non-Executive Director
Rae	Wheatcroft	RW	Chief Operating Officer

There were two observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead

TB133/24 **Chair's Welcome and Note of Apologies**

The Chair welcomed everyone to the meeting and apologies for absence were as noted above.

TB134/24 **Patient and Staff Story**

Faye Chadwick, Divisional Nurse Director for Children and Sexual Health presented the patient story regarding an 18 year old female who had contacted her GP with urinary symptoms and was signposted to her local pharmacy where she was offered treatment for cystitis relief.

The patient was still concerned regarding her symptoms and so attended the Parallel Health Centre which provided sexual health services for young people, citing dysuria and abnormal vaginal discharge. During the consultation unprotected sexual intercourse was also disclosed and emergency contraception was issued, along with the commencement of ongoing hormonal contraceptive method. Results of the tests undertaken were received five days later and included Group B streptococcus. The patient was contacted and she attended the drop in clinic for treatment the same day, a follow up call was completed seven days post treatment.

The patient stated that her experience at the Parallel health centre was positive and that she had felt listened to, and her concerns addressed. FC highlighted that this case underscores the importance of cohesive and proactive healthcare communication with GP's and pharmacies to Make Every Contact Count. Whilst the issue had been resolved for this patient, she had made two previous visits with other providers and would have ultimately attended the Emergency Department had she not attended the Parallel.

Staff Story

Louise Pennington, Specialist Adolescent Health Nurse attended to present the Staff Story. She advised that a clinical audit had been undertaken for a small sample of patients who attended The Parallel in a one month period for suspected urinary tract infection (UTI).

The review highlighted all the patients would have been correctly treated as uncomplicated lower UTI as per NICE guidance whether they attended primary care, urgent care or The Parallel. A likely outcome for the patients would have been UTI treatment with signposting to other services such as Sexual Health or Pharmacy for self-treatment. However, the majority of the patient group were unlikely to attend multiple services and/or would not have sufficient funds to purchase over the counter treatment.

It was noted that there was routine screening for differential diagnosis based on history taking. As a result staff identified, diagnosed and treated a range of conditions, in addition to promoting and providing contraceptive advice and treatment. This provided an enhanced service for patients and improved public health outcomes by pro-actively diagnosing and treating STI's which would not have been considered by the patient.

Although staff routinely treated chlamydia they did not offer treatment for gonorrhoea as this required referral to Sexual Health which could be a barrier for some patients. As a result colleagues would prefer to be able to undertake this, and were qualified to do so therefore it had been highlighted to the senior nursing team.

FN highlighted that cohesive team working of all colleagues based at The Parallel was fantastic and FC added it was the team which made the centre so successful.

In response to FLT's query regarding how the service was adapted for young people with learning disabilities, FC advised that the Paediatric Learning Disability Service actively referred to the service and parents were also welcome to attend with the young person. There was also a doctor within the team whom colleagues could refer patients to, if required.

RESOLVED:
The Board of Directors ***received*** the Patient and Staff Story from the Family Care Division.

TB135/24 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.

TB136/24 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 26 September 2024, and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 26 September 2024.

TB137/24 Matters Arising and Action Logs

The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions.

RESOLVED:
The Board of Directors ***approved*** the action log.

TB138/24 Chair's Update

The Chair advised there were two items under the consent agenda the Information Governance Annual Report which was presented at the Strategy and Operations Committee and the Safeguarding Annual Report which was presented at the Quality Assurance Committee.

NR thanked colleagues for their continued hard work and dedication under the pressures being experienced and outlined the fantastic work which was being completed in the neighbourhoods.

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

TB139/24 Information Governance Annual Report

The Board received the report which outlined the key activity, achievements and issues relating to Information Governance (IG) within the Trust for the period 01 July 2023 to 30 June 2024 and stated the objectives for the forthcoming year. The report also provided assurance against the Data Security and Protection Toolkit (DSPT) requirements, which reflected the national standards and legislation for data security and protection in health and social care.

RESOLVED:
The Information Governance Annual Report was noted.

TB139/24 Safeguarding Annual Report

The Board received the report which highlighted the Trust performance against its statutory safeguarding obligations for children, young people and adults at risk throughout 2023-2024. Under the Chief Nurse's leadership, comprehensive systems aligned with key legislation and guidelines. The Trust had approved additional safeguarding resources, creating roles such as MCA/DoLs Lead and Named Nurse for Looked After Children. Contractual standards improved, with red-rated areas eliminated and management plans implemented for amber areas.

RESOLVED:
The Safeguarding Annual Report was noted.

TB140/24 Chief Executive's Report

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

- The Trust had set out a commitment to being an anti-racist organisation. Racial inequalities existed in Bolton and had a profound impact on the experiences and outcomes of staff, patients and the community.
- The Trust's Finance Team was a finalist at the Public Finance Awards 2024 in the Finance Team of the Year – Frontline Services category for their work to deliver high quality services for the NHS in Bolton.
- The Proud2bOps network won two awards at the first ever Proud2bOps Awards. The Trust won the Trust Network of the Year award and the Director of Operations, Michelle Cox, was announced and received the award for Operational Role Model of the Year.

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

TB141/24 Board Assurance Framework

The Director of Corporate Governance presented the Board Assurance Framework (BAF) which had been revised to ensure alignment with the 2024-29 Strategy. The BAF provides a structure and process that enables the Board to review its principal objectives, the extent to which the Trust had appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. The BAF had been presented for review at all committees prior to presentation at Board. It was noted that the BAF now included KPIs which were taken from the Strategy Outcomes Framework and incorporated the three main Corporate Objectives from the Strategy.

RESOLVED:
The Board of Directors ***received*** the Board Assurance Framework.

TB142/24 Committee Effectiveness Reports

The Director of Corporate Governance presented the Committee Effectiveness Report which summarised the key points from the annual reviews and sought to inform planned discussions on committee performance, as well as provide assurance on the efficacy of the committees.

Overall, the responses to the surveys were positive and indicated committees had continued to improve their effectiveness. The high level of engagement allowed the committee chair's to assess if their committees met their objectives and responsibilities as well as identify any gaps in assurance In areas where improvement was identified these issues would be further discussed with resulting actions planned for 2025.

Throughout 2024, member attendance at committees remained high, with quoracy consistently maintained at each meeting, thereby supporting effective decision-making and oversight. The committee chair's had reflected on the results and thanked the Executive PA team for their work in supporting the meetings.

RESOLVED:
The Board of Directors ***received*** the Committee Effectiveness Reports.

TB143/24 Board Workplan

The Director of Corporate Governance presented the Board Workplan which detailed items to be presented throughout the calendar year to ensure the Trust met its regulatory and statutory duties. It was intended the Workplan would be used to inform the work plans of the committees. The Board workplan would also be presented at the December Council of Governors meeting.

In response to a query from TF regarding presentation of the Fit and Proper Person's Report at People Committee, SK confirmed that the Fit and Proper Person Report was presented at the Audit and Risk Committee for an oversight on compliance and individual elements were presented to the Remuneration Committee and Governor Nomination and Remuneration Committee.

RESOLVED:
The Board of Directors ***approved*** the 2025 Board Work plan.

TB144/24 Integrated Performance Report

The Director of Operations reported on the Trust's operational performance during October and drew attention to the following issues:

- There was an overall deterioration in ambulance handover times and performance deteriorated slightly with the 4 hour standard at 62.3%.
- Work was completed to improve patient flow including transforming pathways and the implementation of a Rapid Assessment Treatment (RAT) model.
- A number of initiatives had been put in place to get patients home as quickly as possible, working on the ethos of 'why not home, why not today'.

- There had been a reduction in the number of lost bed days to 628 and a reduction in the number of patients with No Criteria to Reside (NCTR) in October.
- The percentage of patients seen and treated within 18 weeks improved slightly.
- The number of patients waiting over 52 weeks to complete their care pathways also reduced in October to 2229.
- All Cancer targets were achieved in September.

Quality and Safety

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

- Further improvements had been made in maternity booking by 12+6, which was the timeframe for completion of antenatal bookings.
- Maternity and Women's services redevelopment had been approved.
- Clostridium Difficile cohort ward was scheduled to open in November 2024.
- Feedback received from the third cohort of Medical leadership programme was overwhelmingly positive with clear qualitative evidence of the impact of the programme
- Patients with a fractured Neck of Femur were scheduled for theatre within 36hours.

Financial Performance

The Chief Finance Officer advised that the revenue year to date was a deficit of £3.5m which was on plan, the most likely forecast outturn was an adverse variance to plan of £5.8m, which included the impact of the 24/25 pay award pressure.

Workforce

The Director of People provided an update on workforce, advising that the there was a low vacancy rate of under 5% and across the majority of clinical staffing groups, resulting in the Trust being in a strong position going into winter. Sickness had increased and additional support was being provided to managers. Staff were being encouraged to take up the offer of flu vaccinations to support keeping well.

RG queried the capacity of the Emergency Department and whether an extension of the department would be required in future. MC advised the aim was to have a minimal amount of patients coming through the Emergency Department and activity in other areas such as Admission Avoidance was being tracked.

SC enquired when it was anticipated the benefits of the new medical model would be felt in the organisation. FN confirmed that Emergency Care Improvement Support

Team (ECIST) had advised there would be a deterioration in performance initially, before the benefit would be realised. MC added that it was a three stage process, but some improvements were starting to be evident and ECIST were also providing additional support with the elective recovery.

FN queried the DN01 diagnostic standard. MC advised that the Trust was focussing on three areas to ensure the improvement of this standard and was also looking to source mutual aid to support audiology.

NR raised the cohort ward for C Diff and TR indicated R1 had side rooms and smaller bays, a Quality Impact Assessment had also been completed.

In response to a query FA confirmed that a capacity and demand exercise was being undertaken for fractured neck of femur which would assist to support a way forward. Other factors which could also support would also be considered.

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

TB145/24 Quality Assurance Committee Chair's Report

Fiona Taylor presented her Chair report from the meeting held on 25 September and provided a verbal update from the meeting held on 27 November 2024. The following key points were highlighted:

- Integrated Performance Report – An important safety concern around VTE was noted and an update would be brought to the next meeting.
- SHMI methodology had been updated to include COVID deaths. The Trust had previously reviewed the quality of care which had not been found to be substandard. An action plan would be included in next Mortality Report.
- Clinical Correspondence Update on EPR – the report provided an update on work to improve outcomes associated with clinical correspondence. There was an improving picture, but challenges were noted. An update would be brought in three months.
- Maternity Incentive Scheme Year 6 Progress Update (CNST) - an issue was raised around increasing the capacity of the triage department and the importance of aligning pathways, particularly for managing reduced fetal movements. The long-term plan involved moving the triage department to a new location for better emergency transfer routes.

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

TB146/24 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

The Director of Midwifery presented the report advising the service was progressing well with all ten safety actions and had attained 25 of the 94 recommendations to date. Eight of the outstanding actions highlighted as red related to the final submission and verification of the evidence by an approving body.

Work was ongoing to meet the required 90% standard for relevant staff groups with regards to multi-professional training and a focus on medical staffing groups. An action plan for rotational medical staff that commenced in the Trust after July 2024, was included for Board approval to recover the training compliance position to 90% within a maximum 6-month period from their start-date with the Trust if required.

It was noted that Board were advised on the position regarding neonatal medical and neonatal nurse staffing compliance for British Association of Perinatal Medicine (BAPM) staffing levels in September 2024. The subsequent actions plans were included in the report for approval of the Board in response to achieve the required standards.

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

TB147/24 Nursing and Midwifery Staffing Reports

The Director of Midwifery presented the Maternity Staffing Report which highlighted ongoing maternity workforce challenges, detailed actions taken to mitigate risk to clinical safety, and improve training compliance to provide assurance of a safe maternity service. Safe staffing levels were maintained during the period, in part mitigated by the ongoing closure of Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels.

The Chief Nurse presented the bi-annual nurse staffing report which triangulated workforce information with patient safety measures to ensure staffing was balanced in line with patient acuity. It included the outcomes from two acuity audits undertaken in July 2023 and February 2024, as prior audits were excluded due to concerns about interrater reliability. The Trust was almost 100% compliant and for those areas which were not there was an action plan.

The Chief Nurse raised concern regarding lower numbers of nursing students and advised that Executives and the Board of Directors would have to give consideration to workforce planning over the forthcoming months.

RESOLVED:
The Board of Directors ***received*** the Nursing and Midwifery Staffing Reports.

TB148/24 People Committee's Chair's Report

Tosca Fairchild presented her Chair Report from the People Committee meeting held on 19 November 2024; highlighting the following key points:

- Improving Culture Update – an update was received on Our Leaders Programme, as well as the NHS Staff Survey. Committee members were updated on the positive NHS Staff Survey turnout to date, with two weeks remaining for colleagues to submit their responses.
- Freedom to Speak up Q2 Report - This report outlined the numbers and themes relating to FTSU activity in Q2.
- Guardian of Safe Working - the report contained details of Exception Reports for the period 01 July to 30 September 2024. No matters of concern were escalated.

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

TB149/24 EDI Plan and Annual Report

The Director of People presented the report which provided an analysis of the diversity profile of the workforce and patients at Bolton NHS Foundation Trust, during the period 01 April 2023 to 31 March 2024. The report demonstrated the impact of the Equality, Diversity and Inclusion (EDI) policies, procedures and practices.

The priorities were aligned with the new Trust Strategy 2024-29 to ensure the Trust was a great place to work and that it was improving care and transforming lives of patients whilst intentionally including those who experienced health inequalities.

RESOLVED:
The Board of Directors ***received*** the EDI Plan and Annual Report.

TB150/24 Finance and Investment Committee Chair's Report

Rebecca Ganz presented the Chair report from the meeting held on 25 September and 23 October 2024 and provided a verbal update from the meeting held on 27 November 2024. The following key points were highlighted:

- Cost Improvement Programme – the overall and risk rated positions had increased. £26.3m CIP identified in year, £21.8m of which is recurrent. A number of high risk schemes were included in the overall identified value, leaving a risk rated positon of £23.9m in year and £17.2m recurrent.
- IFM Annual Performance Report - The report was brought to the Committee as the shareholder and customer. Quarterly reports were presented to the Trust via the Chief Finance Officer and Chief Operating Officer. The Chair asked for the Committee's thanks to be passed to the IFM team for their achievements.

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

TB151/24 Standing Financial Instructions and Scheme of Delegation

The Chief Finance Officer presented the Standing Financial Instructions which were the financial rules and regulations by which the organisation was governed in order to ensure compliance with the law, probity, transparency and value for money.

The Financial Scheme of Delegation set out the powers and financial levels of authority for the Board, its Committees and the Executive. The SFI and Financial Scheme of Delegation combined to form part of the Standing Orders of the organisation and were reviewed periodically. It should be noted that minor changes may continue to be made following the publication of committee papers.

RESOLVED:
The Board of Directors ***approved*** the Standing Financial Instructions and Scheme of Delegation.

TB152/24 Standing Orders

The Director of Corporate Governance presented the Board Standing Orders which were last reviewed by the Board of Directors in January 2024. Since then, a review had taken place and other than the template being update to reflect the new Trust strategy there were no proposed changes.

The Standing Orders would also be scheduled for discussion at the Audit and Risk Committee meeting in December, any further changes proposed as a result of that debate would be brought back to the Board of Directors for approval.

RESOLVED:
The Board of Directors ***approved*** the Standing Orders.

TB153/24 Strategy and Operations Committee Chair's Report

Sean Harriss presented the Chair's Report from the Strategy and Operations Committee held on 23 September and provided a verbal update from the meeting held on 28 November 2024. The following key points were noted:

- EPR Update - the decision for a single-phased approach was based on the challenges in dividing the project into multiple phases without firm timelines. A contributing factor was the overlap between Community and Outpatient services, which shared certain pathways.

- Neighbourhoods Update – the Committee acknowledged the enormous amount of work and the difference the Neighbourhoods had already made, and the potential for an even greater difference in the future.

FLT queried whether the EPR Report had a completed Quality Impact Assessment and SW confirmed it did not, but this would be taken through the Quality Assurance Committee.

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

TB154/24 EPRR Core Standards Report

The Director of Operations presented the report advising that NHS England required all health organisations participating in the 2024 NHS Core Standards self-assessment process to ensure their Boards or governing bodies were sighted on the level of compliance achieved and the action plan for the forth-coming period.

Following self-assessment the Trust had demonstrated substantial compliance across the necessary standards with an action plan to take forward within the stated time frames.

Board members thanked Jimmy Tunn, EPRR Manager who was retiring from the organsiation after 35 years' service.

RESOLVED:
The Board of Directors ***approved*** the EPRR Core Standards Report.

TB155/24 Questions to the Board

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

TB156/24 Feedback from Board Walkabouts

- MN had visited Business Intelligence (BI) and feedback from the team was that they spent a lot of time data cleansing despite holding drop in sessions for staff and providing outreach services.
- SC visited Pikes Lane Health Centre and sat with the District Nursing Team for their huddle. He commented they were a very cohesive team, but noted there were issues around accessing medication particularly at the weekend as the Pharmacist kept a limited supply. AS advised he had also visited Pikes Lane Health Centre and commented on their cohesive working. He also spent time with

the Wound Care Team, who were aiming to achieve 100% response rate for the Staff Survey, and the Enhanced Care Home Team. Both were fantastic teams.

- FLT had visited Pharmacy and commented both the area and staff were very impressive and the leadership within the department was fantastic. She had also been to the Library and the staff were very friendly and helpful.

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

TB157/24 Messages from the Board

The following messages from the Board were agreed:

- Burnout survey
- New medical model
- Neighbourhood teams
- ED and admission avoidance.
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TB158/24 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 15:45.

The next Board of Directors meeting would be held on 30 January 2025 at 1pm in the Boardroom.

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

Status

Red	Overdue (Significantly delayed)
Amber	Slightly delayed and/or of low risk
Green	Completed
Yellow	Included on Agenda
Blue	Not yet due

Board of Director's Meeting

Matters Arising Action Log

Action Log updated 23 January 2025

Bolton NHS Foundation Trust

ONGOING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
FT/24/04	30.05.24	**Patient flow Presentation**	RW to provide a further update on patient flow in six months	**RW COO**	May-24	Nov-24	**November 24 Update: Item included in presentation. Action Completed**.	**Green**

Report Title:	Care Hours Per Patient Day (CHPDD) Month 9 Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	
Executive Sponsor	Chief Nursing Officer		Decision	

Purpose of the report	The purpose of this report is to provide a comprehensive analysis of nursing and healthcare staff fill rate, demonstrating optimal staffing levels and ensuring patient safety through evidence-based workforce management.

Previously considered by:	N/A

Executive Summary	The CHPPD metric, introduced in 2018 following the Mid-Staffordshire inquiry, is one method for reviewing staff deployment across NHS inpatient wards. It is calculated by the sum of all hours rostered over a 24 hour period, divided by the number of patients at midnight. Additionally, organisations are required to publish their percentage fill rates for registered nurses, midwives and support staff. To ensure Board visibility, these will now be distributed to Board colleagues monthly as well as publication to the turst website. It is noteworthy however that inter-organisational comparisons are limited for percentage fill rates, as they are based on agreed establishments which vary for legitimate reasons across providers. Similarly, CHPPD provides only a crude metric without any reference to skill mix, patient acuity or dependency and so the Chief Nursing Officer's bi-annual staffing paper ,supported by the Safer Care Nursing Tool and Birth Rate Plus methodology, is the optimal reference for evidence based assurance on safe staffing. For this reporting period, safe staffing levels have been maintained.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Care Hours Per Patient Day (CHPDD) 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**	Potential increased costs from bank and agency staffing
Legal/ Regulatory	**Yes**	Demonstrating transparent reporting of CHPPD metrics Meeting statutory requirements for safe staffing levels
Health Inequalities	**Yes**	Targeted support for patients with enhanced care requirements Ensuring consistent care quality across different patient dependency levels
Equality, Diversity and Inclusion	**Yes**	Inclusive staffing model supporting varied clinical skill sets

Prepared by:	Kimberley Oldham, Workforce Information Manager Rebecca Bradley, Deputy Chief Nurse Tyrone Roberts, Chief Nursing Officer	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

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Care Hours Per Patient Day (CHPPD)

Nursing and Midwifery

... for a better Bolton

Dec-24

NHS Bolton NHS Foundation Trust

Ward name	Specialty 1	Day		Night		This months CHPPD	Last Months CHPPD	CHPPD Difference from Last month		Comments
		Registered Nurse/ Midwife	Non-registered Nurses/ Midwives (Care Staff)	Registered Nurse/ Midwife	Non-registered Nurses/ Midwives (Care Staff)					
Total		**93.54%**	**100.61%**	**95.58%**	**111.02%**	**8.93**	**8.83**	**0.10**	↓	
Acute Frailty Unit - B1	300 - GENERAL MEDICINE	96.17%	98.05%	119.92%	115.76%	7.49	9.21	-1.73	↓	
Coronary Care Unit	320 - CARDIOLOGY	94.17%	108.03%	101.61%	141.94%	9.56	10.75	-1.19	↓	
Ward C1	320 - CARDIOLOGY	94.27%	108.24%	102.14%	112.95%	5.82	6.66	-0.84	↓	
Ward C2	300 - GENERAL MEDICINE	90.48%	88.87%	100.00%	114.52%	7.12	8.23	-1.11	↓	
Ward C3	301 - GASTROENTEROLOGY	102.23%	93.60%	99.76%	101.61%	6.80	8.25	-1.45	↓	
Ward C4	300 - GENERAL MEDICINE	94.81%	107.84%	109.84%	128.28%	7.64	9.38	-1.74	↓	
Ward D3	340 - RESPIRATORY MEDICINE	102.66%	93.69%	104.91%	103.23%	6.72	8.00	-1.28	↓	
Ward D4	340 - RESPIRATORY MEDICINE	98.20%	95.32%	102.15%	111.22%	6.19	7.50	-1.31	↓	
Ward H3	328 - STROKE MEDICINE	104.38%	100.35%	104.84%	134.55%	7.01	8.47	-1.46	↓	
Critical Care Unit	192 - CRITICAL CARE MEDICINE	92.18%	105.31%	94.11%	67.74%	23.56	28.12	-4.56	↓	expected fluctuation due to increase in acuity within the unit and across the rest of the trust
Ward E3	100 - GENERAL SURGERY	102.38%	106.55%	100.00%	119.78%	6.88	8.62	-1.74	↓	
Ward E4	110 - TRAUMA & ORTHOPAEDICS	100.63%	120.87%	99.58%	110.38%	8.56	9.65	-1.09	↓	
Ward F4	110 - TRAUMA & ORTHOPAEDICS	98.90%	117.63%	100.00%	115.08%	8.19	9.52	-1.33	↓	
Ward G3	501 - OBSTETRICS	73.37%	181.91%	60.08%	103.33%	4.55	6.68	-2.12	↓	
Ward G4	501 - OBSTETRICS	103.08%	92.22%	88.87%	92.03%	7.83	10.36	-2.53	↓	
Central Delivery Suite	501 - OBSTETRICS	97.45%	89.90%	93.48%	92.77%	29.61	45.07	-15.46	↓	
Neonatal Unit	422 - NEONATOLOGY	80.58%	85.76%	88.48%	77.56%	10.57	13.05	-2.48	↓	
Ward E5	420 - PAEDIATRICS	77.89%	91.31%	84.78%	214.10%	10.23	10.49	-0.25	↓	
Ward H1	502 - GYNAECOLOGY	106.72%	95.30%	98.27%	103.70%	15.21	12.12	3.09	↑	
Ward B3 - Bluebell Unit	300 - GENERAL MEDICINE	115.72%	107.37%	146.77%	107.26%	9.39	10.73	-1.34	↓	
Ward F6	120 - ENT	81.71%	100.62%	79.39%	97.01%	7.77	7.94	-0.17	↓	
Ward B4	300 - GENERAL MEDICINE	94.78%	78.44%	101.61%	106.46%	15.42	8.85	6.56	↑	Unit relocated to a smaller ward bed capacity has fluctuated while ward is established. Now called Ward N3.
Ward A4	302 - ENDOCRINOLOGY	94.12%	92.88%	100.14%	107.57%	7.32	9.76	-2.44	↓	
Ward D2	430 - GERIATRIC MEDICINE	93.45%	113.00%	99.82%	177.42%	8.72	10.17	-1.46	↓	
Elective Care Centre	110 - TRAUMA & ORTHOPAEDICS	97.65%	100.80%	98.36%	96.77%	13.05	18.87	-5.82	↓	increase due to change in priorities in theatre activity
SCU	100 - GENERAL SURGERY	95.77%	83.57%	100.00%	83.02%	9.75	9.03	0.72	↑	

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

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Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 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:	N/A.

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 are asked to receive 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	**No**	

Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

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

Ambition 1: Improving care, transforming lives

A reflective look back on 2024 revealed that despite another busy and challenging year with increasing demand, our service teams have continued to have an incredible impact on our communities.

8.6 million tests have been carried out to help diagnose a wide-range of conditions, more than 5,000 babies were born in Royal Bolton Hospital's maternity department, and approximately 7,000 children have received support from the 0-19's public health team each month this year. The figures also revealed the Trust supported more than 80,000 inpatient and day case attendances and 548,732 outpatient attendances. The full analysis can be found on our website.

Our Neonatal Unit has introduced a new app that will keep parents updated and involved in their baby's care. vCreate NICU Diaries enables the hospital's nursing teams to reassure parents with positive video and photo updates that capture precious milestone moments to keep forever. Parents and families are able to view updates through the vCreate app whenever they are unable to be on the unit, and they can also ask questions and get important updates about their baby's progress. The app provides a multi-language feature and auto-translates messages to and from families to improve communication and improve access to care.

Royal Bolton Hospital has become the first location in Greater Manchester to carry out digital autopsies that reduce the need for invasive post mortems and release bodies to families and loved ones sooner. In partnership with Digital Autopsy UK and Manchester West Coronial Service, the CT scanning suite from Digital Autopsy UK allows organs and tissues to be assessed using radiology, which can highlight causes of death for the deceased without the need for invasive procedures. Using advancements in technology, digital autopsies aim to reduce traditional invasive post mortems, in which a pathologist would use specialist tools to investigate a cause of death, by three quarters (75%).The facility, which will support families living in Bolton, Salford and Wigan, was officially opened on Thursday 9th January by the Mayor of Greater Manchester, Andy Burnham.

We experienced an increase in flu cases and as a result, introduced face masks in our in-patient areas to prevent the spread of viruses and infection. We saw a high number of flu cases in recent weeks, with 42 patients being admitted into the hospital with flu on Thursday 2nd January, up from an average of seven cases in September. To address this, all staff, patients and visitors were asked to wear fluid repellent surgical face masks in inpatient areas from Monday 6th January. Dr Francis Andrews our medical director, and Nicola Kirlew, our D4 respiratory ward manager, were interviewed by ITV Granada Reports to raise awareness of why we were taking these increased steps. Following a reduction in flu cases, this has now been stepped down to discretionary use.

As the world celebrated the start of 2025, our midwives were helping families in Bolton to welcome the first babies of the new year. In 2024, the maternity department at Bolton NHS Foundation Trust delivered more than 5,000 babies.

Our organisation has become the highest recruiting site in the North West for an important study that's looking at how to help babies breathe if they are born a few weeks early. At the start of December, our Neonatal Unit reached a major milestone after recruiting their 50th baby to the SurfON study. SurfON

is aiming to find out how to best treat babies who are born two to six weeks early and admitted to the Neonatal Unit with breathing problems.

The Royal Bolton Hospital site is now completely smokefree, with visitors instead being directed to a designated vape zone away from the main entrance should they wish to use it. As part of the programme, we will be offering additional support to staff and patients who wish to quit or who need nicotine replacement whilst an inpatient, through our occupational health and CURE teams respectively.

Ambition 2: A great place to work

One of our dedicated volunteers who regularly gives her time up to support staff and patients in the Churchill Unit celebrated a milestone birthday, turning 90 years old earlier this month. Before joining Bolton NHS Foundation Trust as a volunteer, Edna was previously a volunteer with the Women's Royal Voluntary Services, supporting the hospital's main reception, on the wards and in the thoracic department.

Three of our community nurses have been recognised by the Queen's Nursing Institute for their commitment to ongoing learning, leadership and excellence in healthcare. Gillian Finnigan, Joanne Simpson and Rachel Taylor have all been awarded the prestigious title of a Queen's Nurse. 587 nurses working in the community, in primary care and social care received the title of Queen's Nurse in 2024. The total number of Queen's Nurses in England, Wales and Northern Ireland is now around 3,000.

Our very own Our Voice Choir has won a special award from Manchester's prestigious orchestra, The Hallé. The choir, made up of NHS staff from across the Trust, won the Hallé Workplace Choir Competition, which invites businesses and organisations from across the North to compete for the chance to perform on stage with the Hallé at The Bridgewater Hall on Friday 13th December.

The Trust is celebrating receiving a gold level award for its commitment to patient safety. The Trust successfully completed a national data quality audit programme, which is monitored by the National Joint Registry (NJR) for the performance of hip, knee, ankle, elbow and shoulder joint replacement procedures to support work to improve the clinical outcomes for the benefit of patients. The programme also provides feedback on surgical performance to orthopaedic clinicians and joint replacement implant manufacturers.The registry collects high quality orthopaedic data in order to support patient safety, standards in quality of care, and overall value in joint replacement surgery.

Our thoughts remain with our fellow NHS colleague in Oldham who was attacked whilst at work this month, and we wish her and her family well as she continues to recover from the experience. We know that this had a personal impact on many of our staff, and we reminded our colleagues of the measures in place across the Trust to protect and support them. We will continue to review our processes to make sure we are doing absolutely everything we can to keep our colleagues as safe as possible at work.

We have received the first draft of the early findings from the NHS Staff Survey 2024, which are currently under embargo until March. Until the official report is published in the coming weeks we will be working to understand what our colleagues have shared about working here in Bolton, and if the actions taken since last year's survey have had a positive impact on their experience of work.

Ambition 3:
A high performing, productive organisation

We have joined a Greater Manchester campaign called 'Your Medicines Matter' to remind patients to bring their medicines with them when they come into hospital for an appointment, are admitted or need to attend the Emergency Department. Greater Manchester's hospitals are making the 'Your Medicines Matter' plea to improve safety and provide a better experience for patients. It is important that patients bring in medicines from home because this will help hospital staff decide on the best and safest treatments, reduce waste and help reduce delays when patients are going home.

We are now using new AI (artificial intelligence) technology that will help doctors to detect diseases, including lung cancer, quicker. It will see an AI-powered chest X-ray decision-support system used to read chest X-rays, with the tool able to detect up to 124 findings on chest radiographs. The new technology is being rolled out at seven NHS Trusts across Greater Manchester as part of a partnership between Greater Manchester Cancer Alliance, Greater Manchester Imaging Network and global health tech firm Annalise.ai.

The work of our urgent care improvement programme continues to have a positive impact on patient flow and experience in our emergency department and across the organisation. The launch of our acute medical model is already having a significant impact on pressures within the department, with 58% of patients being treated and discharged in the same day that could have otherwise been waiting lengthy times in the ED. We have also seen significant improvements in the number of delayed days, that is the amount of days our patients could have been at home with their families instead of in hospital, reducing the figure by around 500 throughout 2024.

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

Our Elective Care Centre celebrated one year since the doors to the state-of-the-art complex first opened to patients. The centre has four theatres which have been used to help with waiting lists and treat thousands of patients each year. All departments have worked together to overcome any early teething problems, in order to make sure that patient safety and care is of the highest standard.

Our Princess Anne Maternity Unit will undergo a major redevelopment to create a new space that is fit for families and the future, removing the (Reinforced Autoclaved Aerated Concrete) RAAC. The multi-million pound transformation project will start shortly, and include refurbished maternity wards for women during and after pregnancy, creating new, modern and spacious environments. The hospital's birthing suite will also be fully refurbished to create four brand new, modern birthing rooms with pools, there will be a new seven-bed triage area alongside the maternity unit, and the ability to adapt the

spaces between antenatal and postnatal ward areas to manage demand. Our women's health services will also have a welcome upgrade, with both the gynaecology and early pregnancy assessment areas being fully refurbished as part of the development.

Teams and individuals presented their improvement projects at the Quality Improvement Project Showcase Event, organised by the Quality Improvement (QI) team, who support health professionals to find ways of improving services that will lead to better patient outcomes, system performance and professional development. One of the projects showcased was work to improve access to care and prevent delays for patients who are suspected to have gynaecological cancers. Until this year, gynaecology patients with a suspected cancer needed to travel to different clinics for blood tests. Clinical Nurse Specialists have now been trained to perform blood tests in outpatient clinics, reducing the need to travel and speeding up access to treatments.

Another QI project has seen a dedicated, nurse-led, telephone service set up to for head and neck patients that have a negative cancer diagnosis so that they are informed about their outcome much sooner.

Key goals for quality improvement at Bolton NHS Foundation Trust between 2024 and 2028 have also been outlined in a dedicated Quality Improvement Plan, putting the provision of safe and high quality care at the heart of the organisation to secure the best outcomes for patients and staff.

Ambition 5: A positive partner

We continue to work with our partners at The University of Greater Manchester, (formerly the University of Bolton) to help develop their training offer, and explore opportunities for our clinical colleagues to expand their portfolio with educator roles at the new Institute of Medical Sciences. We are actively promoting engagement events and encouraging colleagues to take a tour of the site and learn more about what is on offer.

A huge amount of work has happened to fully establish our six neighbourhood teams, and we heard all about this from Jo Dorsman and Martin Ashton at this month's Locality Board. It has taken a while to get where we are today but we are starting to see the results of a cultural shift and the impact we can have on our communities, which was made clear with some of the people stories they shared.

We are extremely grateful to some of our incredible partners who have generously donated to Our Bolton NHS Charity to help spread festive cheer to people who are staying in hospital over Christmas. Hundreds of presents, ranging from children's toys to pamper products for some of the hospital's older patients, have been dropped off at and distributed across our services throughout December.

Local businesses, communities and individuals have supported Santa and his elves by raising money and collecting gifts to lift the spirits of those unable to spend Christmas at home. Go North West donated presents for some of the hospital's adult patients on the Complex Care wards, and also sponsored seven Christmas trees that have been installed across the hospital site.

Players, management and Lofty the Lion from Bolton Wanderers Football Club and Bolton Wanderers in the Community also visited the hospital, dropping off gifts across the wards, including the children's ward, the children's Emergency Department and the neonatal unit. A full list of contibutors including Jaguar Land Rover Bolton, Ladybridge High School and Leverhulme Academy Trust can be found on the Trust's website.

Report Title:	Corporate Governance Framework Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	The purpose of this report is to set out the Trust's corporate governance arrangements for 2025.

Previously considered by:	The report codifies and builds on the previous Board update.

Executive Summary	Corporate Governance Framework is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. The Corporate Governance Framework brings together the governance arrangements and provides a detailed update on the approach to Board and Committee arrangements. A part of this report includes a summary of The Corporate Governance Manual which will provide an overview of all documents that are necessary for the effective running of the organisation and will include the following: • The Trust Constitution • Standing Orders; • Standing Financial Instructions; • Reservation of Powers to the Board and Delegation of Powers • Management of Interests Policy • Governance structure • Committee Terms of reference;

Proposed Resolution	The Board is asked to **approve** the Corporate Governance 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	**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. Bolton NHS Foundation Trust is a public benefit corporation as constituted under the NHS Act 2006. The Trust provides a range of health and wellbeing services to the people of Bolton, delivering care at Royal Bolton Hospital, in a range of community venues and in people's homes.

1.2. The Health and Social Care Act 2022 enhances and amends the Health and Social Care Act 2012 Act, setting out the legal framework within which the Foundation Trust operates.

1.3. Whilst as a Foundation Trust, the Board has financial and strategic decision making autonomy, there is a framework of local accountability to the membership through the Council of Governors elected from that membership, and to NHS England.

2. Corporate Governance

2.1. Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity.

2.2. The FT Code of Governance states that every Trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust and generating value for members, patients, service users and the public. The Trust reviews its compliance with the FT Code of Governance annually at the May Board of Directors' meeting.

2.3. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to support that autonomy and accountability, and to achieve its clinical, quality and financial objectives. Robust corporate and quality governance arrangements are in place at the Trust and these complement and reinforce one another.

2.4. Quality governance is the combination of structures and processes at and below Board level to lead on trust-wide quality performance, including

- ensuring required standards are achieved and
- investigating and acting on sub-standard performance.

2.5. Whilst clinicians are at the frontline of ensuring patients receive quality care, The Board of Directors takes final and definitive responsibility for improvements, successful delivery and, equally, failures in the quality of care.

3. Board of Directors

3.1. Bolton NHS FT is governed by a Board of Directors who in turn are accountable to the Council of Governors.

3.2. The Board of Directors are a unitary board meaning that the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All

directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

3.3. The Board's main role is to promote the long-term sustainability of the Trust as part of the Integrated Care System (ICS) and wider healthcare system in England, generating value for members, patients, service users and the public.

3.4. The Board provides strategic leadership and is responsible for:

- Promoting the long-term success of the Trust for the benefit of its patients, staff and community it serves.
- Demonstrating ethical leadership, high standards of behaviour and overseeing good governance
- Ensuring effective engagement with and encourage participation from shareholders and key stakeholders
- Setting and monitoring the Trust Values, Purpose and Strategy and ensuring that these and its Culture are aligned.
- Setting a framework of prudent and effective controls, which enable risk to be assessed and managed
- Reviewing management performance and the operating and financial performance, ensuring effective financial stewardship through value for money and financial controls.
- Ensuring that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery.
- Ensuring that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically,
  (this list is not exhaustive)

3.5. The Board has a number of key roles and delegates responsibility to its Committees to oversee specific areas. A full Governance Structure is included in Appendix A which sets out the Statutory and Assurance committees.

3.6. The Board is composed in line with the provisions of para 2.6 of the Trust Constitution.

3.7. Further information on the current members of the Board can be found on our website.

4. The Council of Governors

4.1. The Council of Governors (COG) is comprised of 34 seats, 20 of which represent the public, 6 which represent staff, and 8 which are directly appointed by partner organisations.

4.2. The constituencies and Governor election rules are laid out in the Trust's Constitution.

4.3. The Council of Governors has two responsibilities:

- Holding the non-executive directors individually and collectively to account for the performance of the Board of Directors

- Representing the interests of the members and the public as a whole

4.4. The Council of Governors has two committees namely the Governor Strategy and Governor quality Committee both of which are chaired by governors.

4.5. In addition, the COG has a statutory Nominations Committee which is constituted by and reports to the Council of Governors. This Committee oversees the appointment of Non-Executive Directors, and which approves their annual appraisal process/reviews the outcomes of that process. It is comprised of the Governors, and is chaired by the Chair of the Board.

4.6. All business of the Council of Governors shall be conducted in accordance with the Standing Orders for the practice and procedures of the Council of Governors which are detailed in Annex 6 of the Constitution.

4.7. Information on the membership of the Council of Governors can be found on our website:

5. Board Role Profiles

5.1. Chair

The Council of Governors and the Board of Directors are led by the Chair who has responsibility for the overall effectiveness of the Trust.

The responsibilities of the Chair include:

- Creating the conditions for overall Board and individual director effectiveness thus promoting a culture of openness and debate
- Setting a board agenda primarily focused on strategy, performance, culture, stakeholders and accountability
- Ensuring the Board has effective decision-making processes and applies sufficient challenge to major proposals
- Fostering constructive relations between executive and non-executive directors based on trust, mutual respect and open communications
- Developing a productive working relationship with the Chief Executive, providing support and advice, while respecting executive responsibility;
- Leading the annual Board evaluation, with support from the Senior Independent Director as appropriate, and acting on the results;
- Ensuring there is a timely flow of accurate, high-quality and clear information;

(this list is not exhaustive)

5.2. The Chief Executive

The Chief Executive is the Accounting Officer of the Trust who leads the Executive team in the running of the Trust, ultimately ensures that the Trust's Vision and Strategy is achieved and that all risks are effectively managed.

Some of the responsibilities of the Chief Executive include:

- Delivering effective corporate governance that ensures that the Trust meets its statutory requirements and service obligations as set out in the Terms of Authorisation. This includes ensuring appropriate internal controls are in place, and that legal and regulatory obligations (e.g. CQC requirements) are fully understood.
- Developing a productive working relationship with the Chair;
- Ensuring that effective business and financial controls and risk management processes are in place
- Ensuring management provides the Board with accurate, timely and clear information.
- Ultimately be responsible for the Foundation Trust's clinical governance and standards of clinical care and ensure that appropriate assurance and management processes are in place to ensure safe, compassionate and high quality care is delivered.
- Ensure effective mechanisms are in place to implement systems and monitor organisational learning from untoward incidents and good practice arising within the Foundation Trust and wider healthcare system.
- Ensure the effective implementation and governance of Board of Directors decisions.
- Maintain the highest standards of conduct and integrity across the Foundation Trust.
- Ensure continuous reviews of practice are enshrined in how the Foundation Trust works – internally and with partners.
- Create a climate of collaboration and partnership with patients, commissioners and other service providers to ensure the best possible outcomes for patients.
  (this list is not exhaustive)

5.3. Executive Directors

The Executive Directors play a crucial leadership role in the day to day running of the Trust and are responsible for the overall performance and strategic direction of the Trust.

Key aspects of their role include:

- **Strategic Leadership - c**ontribute to setting the Trust's strategic direction and ensure that it aligns with national health priorities and policies.
- **Operational Management** They oversee the day-to-day operations, ensuring that services are delivered efficiently and effectively
- **Financial Oversight –** through managing the Trust's budget, ensuring financial sustainability and accountability
- **Quality and Safety** – ensuring that safe, high standards of care are maintained and that patient safety is a top priority
- **Workforce Management -** They are responsible for the recruitment, development, and retention of staff, fostering a positive and inclusive workplace culture
- **Stakeholder Engagement -** Working with a range of stakeholders, including patients, staff, regulators, and the wider community, to ensure that the Trust meets its goals

5.4. **The Non-executive directors**

Non-executive directors are independent members of the Board, who alongside executive directors are an equal member of the Unitary Board. They jointly share responsibility with the other directors for the decisions made by the Board and for success of the organisation in leading the local improvement of healthcare services for patients.

Non-executives use their skills and personal experience as a member of their community to:

- Formulate plans and strategy
- Bring independent judgement, external perspectives and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the executive board develop proposals on such strategies to enable the organisation to fulfil its leadership responsibilities to patients, for healthcare of the local community.
- Assist fellow directors in setting the trust's values and standards and ensure that its obligations to its stakeholders and the wider community are understood and fairly balanced at all times.
- Contributing external experience and knowledge;
- Providing constructive challenge and strategic guidance to the executive directors;
- Devoting sufficient time to discharge their responsibilities effectively;
- Developing a good understanding of the business and its relationships with significant stakeholders;

5.5. **The Senior Independent Director**

The Senior Independent Director has a key role in supporting the Chair in leading the Board of Directors and acting as a sounding board for the Chair. The role is undertaken by a non-executive director with all general duties of a NED in common with other NEDs.The responsibilities of the SID include:

- Supporting the Chair in the delivery of their objectives,
- Leading the evaluation and carrying out the annual appraisal of the Chair and compiling a report to the Nominations Committee and the Council of Governors on the outcome
- Ensuring an orderly succession planning process for the Chair, working with the Governor Nominations Committee;
- Leading the process for searching and nominating a new Chair
- Assuming the Chair of the Nominations Committee when matters concerning the incumbent Chair of the Trust are being considered.
- Ensuring (where required) that the issues and concerns of members and governors are communicated to the other non-executive directors and, as necessary, the Board as a whole
- Resolving any disagreements that may arise between the Council of Governors and Board of Directors, in accordance with any procedures agreed by the Trust and set out in the Constitution.

5.6. Non-Executive Director Committee Chairs

The responsibilities of the Chairs of the Board Committees include:

- Setting the agenda and running meetings of the Committee in line with Committee Terms of Reference;
- Liaising as appropriate with the Executive Leads on the scope and content of papers for the Committee and ensuring the timely delivery of papers;

- Encouraging engagement and participation in Committee meetings and where a member is unable to attend a meeting, to capture their input beforehand
- Ensuring that Committee members understand the issues and are kept up to date on relevant requirements and best practice
- Reporting Committee activities and recommendations to the Board.

5.7. Non-Executive Director Champion Roles

The Trust has identified five NEDs to fulfil the NED champion roles which are either statutory requirement or there is a requirement for a named individual to discharge . These are

- Maternity board safety champion
- Wellbeing guardian
- Freedom to Speak Up
- Doctors disciplinary
- Security management

Role	NED	Legal Basis	Role Description
Maternity Board safety champion	Fiona Taylor	*Recommended role which applies to all trusts providing maternity services*	The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.
Wellbeing guardian	Tosca Fairchild Becks Ganz (Deputy)	Recommended role to provide assurance to the Board	The role should help embed a more preventative approach, which tackles inequalities.
FTSU NED	Sean Harriss Alan Stuttard (Deputy FTSU)	Recommended role	The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board
Doctors Disciplinary NED	Seth Crofts	Statutory role and can be rotated	NED member is “the designated member” to oversee each case to ensure momentum is maintained.
Security management NED	Alan Stuttard through the Audit and Risk Committee	Statutory role	The promotion of security management (inc in its broadest sense is discharged through the designated NED. The Audit and Risk Committee has a role in overseeing specific functions related to counter fraud and violence/aggression

6. 2025 Board Arrangements

6.1. Board of Director's meetings

Bolton NHS FT aspires to have a leading edge system of governance, learning from best practice elsewhere and enabling it to deliver the highest standards of conduct and accountability. To that end, the Board reinforcing its commitment to openness and transparency in its work, holds meetings in public on the last Thursday of every other month .

The meetings are held in the Boardroom, Trust HQ with all dates, times and meeting papers published on the Trust website and can be accessed on the below QR code.

6.2. Board Development Sessions

In those months where a Board meeting is not scheduled, discrete sessions focussing on Strategy or Board development are usually held. For 2025, these sessions will be held as follows:

- 27 February Board Strategy Session
- 24 April Board Development Session
- 26 June Annual Service Review Day
- 07 August Board Development Session
- 23 October Board Strategy Session
- 18 December Board Strategy Session

The Board believes strongly that fundamental to achieving the highest standards in its systems of governance will be the way it operates, its culture and behaviours. An on-going programme of Board and organisational development has been developed with support from NHS North West Leadership Academy. This reinforces and supports the Board in their commitment to undertaking regular reviews of Board and organisational performance to ensure that its aspirations are met.

6.3. Board Strategy and Annual Service Review Day

Directors have legal duties, as listed in the Companies Act 2006, one of which is to use reasonable care, skill and diligence. Keeping the board informed on matters relating to the Trust Strategy and the organisation's performance against the Annual Corporate Objectives ensure that the Board of Directors are well informed on Strategy enabling them to effectively discharge this duty.

The Annual Service Review Day provides an opportunity to celebrate achievements, plan for the future, and engage in meaningful discussions about the Trust's Strategy and goals. This day also provides the

Board with an opportunity to interact with all Clinical Divisional Leadership teams as well as the Corporate Services Leadership Teams.

7. Board Committee Arrangements

7.1. The Finance and Investment Committee

The Finance and Investment Committee provides the Board with an objective review of, and assurances, in relation to:

- Finance, contracting and commissioning issues; presenting reports and recommendations in relation to ensuring we maintain cash liquidity and are an effective going concern.
- Financial governance processes.
- Business cases referred to it by the Capital & Revenue Investment Group requiring major capital investment.
- Reviewing and challenging budgets.
- Compliance with legislative, mandatory and regulatory requirements in terms of the Committee's scope.
- Receive assurance on the delivery of the Estates Masterplan within the defined parameters of time, cost, quality and specification.
- Through the Executive Team, the Committee oversees the delivery of the Estates Masterplan ensuring that cost implications of the programme are fully set out within robust financial plans and that it remains within the Trust's overall affordability.
- Digital Investment and Performance

Membership of the Finance and Investment Committee will be as follows:

NED Membership		Exec Membership	
Becks Ganz	Chair	Annette Walker	Exec Lead
Tosca Fairchild	Member	Rae Wheatcroft	Member
Sean Harriss	Member	Sharon White	Member
Martin North	Member	James Mawrey	Member

7.2. Quality Assurance Committee

The Quality Assurance Committee provides the Board with an independent and objective review in relation to:

- All aspects of quality, specifically: clinical effectiveness, patient experience and patient safety; monitoring compliance against the essential standards of quality and safety set out in the registration requirements of the Care Quality Commission
- Governance processes for driving and monitoring the delivery of high quality, clinically safe, patient-centred care.
- Performance against internal and external quality and clinical improvement targets,
- and directing management on actions to be taken on sub-standard performance.

- The overarching Quality Strategy.
- Assurance on safeguarding quality and to provide appropriate scrutiny to clinical effectiveness, patient safety and patient experience.
- Assurance (positive and negative) derived from clinical audits is reported through its reporting operational groups/

The QAC has responsibility for reviewing the Integrated Performance Report prior to presentation at Board including Operational Performance matters.

Membership of the Quality Assurance Committee will be as follows:

NED Membership		Exec Membership	
Fiona Taylor	Chair	Francis Andrews	Exec Lead
Becks Ganz	Member	Tyrone Roberts	Member
Martin North	Member	Rae Wheatcroft	Member
Seth Croft	Member	Sharon White	Member

7.3. Audit and Risk Committee

In accordance with its Standing Orders and as required by the Health and Social Care Act 2006 (amended 2012), the Trust has an Audit and Risk Committee. The Audit and Risk Committee is tasked with reviewing the establishment, adequacy, and effective operation of the organisation's overall system of governance and internal control which encompasses risk management (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

The Audit and Risk Committee is a statutory committee of the Board whose memberships consists only of non-executive directors

- Alan Stuttard Chair
- Fiona Taylor Member
- Tosca Fairchild Member
- Sean Harris Member

This Committee operates independently from the Executive to ensure the Board that the Trust's interests are safeguarded in financial reporting and internal control. It reviews the effectiveness of internal controls and ensures legal, regulatory, and best practice compliance. The Committee reports to the Board any matters in respect of which the Committee considers that action or improvement is needed and makes recommendations as to the steps to be taken

7.4. Charitable Funds Committee

The Charitable Funds Committee sits within the wider Corporate Governance structure, as it is responsible for running Our Bolton Charity. The Trust is a trustee of the Charity, and therefore reports from the Charitable Funds Committee are taken regularly to Board, both to keep them updated of the ongoing work and to request approval where required for initiatives and/or strategy. meets quarterly.

Membership of the Charitable Funds Committee will be as follows:

NED Membership		Exec Membership	
Martin North	Chair	Sharon White	Exec Lead
Alan Stuttard	Member	Francis Andrews	Member
Becks Ganz	Member	Tyrone Roberts	Member
Seth Crofts	Chair	James Mawrey	Member

7.5. People Committee

The People Committee provides the Board with line of sight on workforce related issues. Key duties of the Committee include:

- Overall responsibility for the Our People Plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process.
- Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce.
- Monitoring and reviewing workforce key performance indicators to ensure achievement of our strategic aims and escalate any issues to the Board of Directors.
- Oversight of staff engagement levels as evidenced by the results of the national and any other staff surveys.
- Seeking assurance to ensure that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality diversity and inclusion.

Membership of the People Committee will be as follows:

NED Membership		Exec Membership	
Tosca Fairchild	Chair	James Mawrey	Exec Lead
Alan Stuttard	Member	Sharon White	Member
Sean Harriss	Member	Tyrone Roberts	Member
Fiona Taylor	Member	Francis Andrews	Member
Seth Crofts	Member	Annette Walker	Member

8. Corporate Governance Manual

The Corporate Governance Manual is used to describe the key governance documents that are in place within the Trust and in conjunction with the legislation and regulations set out a framework within which the Trust operates.

The Corporate Governance Manual includes the following documents:

- Constitution (including Standing Orders for practice and procedures of the Board of Directors and the Council of Governors);

- The Standing Orders
- Standing Financial Instructions as a framework for financial governance,
- Scheme of Reservation and Delegation which describe the powers reserved to and delegated by the Board
- Registers of Interest

These documents together provide a regulatory framework for the business conduct of the Foundation Trust.

8.1. **The Constitution**

The Trust's Constitution sets out how the Trust is governed and can be be accessed on our website on this link.

8.2. The Standing Orders

The Standing Orders are annexed to the Trust Constitution and are contained within the Trust's legal and regulatory framework. They set out the regulatory processes and proceedings for the Board of Directors and its committees and working groups including the Audit and Risk Committee, whose role is set out below, thus ensuring the efficient use of resources.

The Board of Directors reviewed and approved the changes to the Standing Orders in November 2024.

8.3. The Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's Standing Orders and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

The Board receives the SFIs each year and approved the SFI at the meeting held in November 2024.

8.4. Scheme of Reservation and Delegation

This sets out those matters that are reserved to the Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that

decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision-making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

The Board receives and approved the SoRD at the meeting held in November 2024.

8.5. Counter Fraud

The Bribery Act, which came into force on 1 July 2011, makes it a criminal offence for commercial and public sector organisations who fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Board places reliance on the Audit and Risk Committee to ensure that as far as practicable, appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

8.6. Register of Interests

The Trust has published an up-to-date register of interests, including gifts and hospitality for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

Our policy, Managing Conflict of Interests, has clearly set out these obligations which are monitored by the Audit and Risk Committee on behalf of the Board.

The Register of Interests is publicly available and is published on the dedicated declarations platform. Access to the register can also be obtained on request from the Director of Corporate Governance.

9. The Risk Management Process

Risk management is fundamental to our ability to effectively deliver safe, high quality services, with systems and processes in place throughout the organisation to identify, assess and mitigate risk, as well as provide the necessary training and development opportunities for staff with specific responsibilities for co-ordinating and advising on risk management.

Risk management is integrated into our philosophy, practices and business plans. Risk management is the business of everyone in the organisation. Risk management by the Board is underpinned by three interlocking systems of internal control:

- The Board Assurance Framework
- The Risk Management Process
- Corporate Risk Register

9.1. Board Assurance Framework (BAF)

The Board has established a robust Board Assurance Framework (BAF) which deals with statements of internal control and assurances. A BAF ensures the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

The Executive Team has responsibility for the development and maintenance of the system of internal control. The Board Assurance Framework itself provides further evidence on the effectiveness of controls that manage the risks to the organisation achieving its principal objectives.

The BAF provides a mechanism for the Board to be assured that the systems, policies, and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved. It identifies our principal objectives and their associated principal risks. The control systems, which are used to manage these risks, are identified together with the evidence for assurance that these are effective. Lead Directors are identified to deal with gaps in control and assurance and are responsible for developing action plans to address the gaps.

The BAF includes a description of risk appetite for each risk to the achievement of operational objectives and additional background information including links to associated risks on the risk register and tracking the score of the risk over time.

9.2. Risk Management Process

The risk assessment process clearly states the escalation process for monitoring, management and mitigation of risk according to overall likelihood and consequence. The risk assessment process is applied to all types of risk, clinical, financial, operational, capital, and strategic.

All business cases are supported with a risk assessment. All projects aimed at improving efficiency are accompanied by a quality impact assessment (QIA) which is overseen by the Chief Nurse and the Medical Director, if above a certain score, as a safeguard to ensure that savings are not achieved at the cost of safety or quality.

The Risk Management Policy clearly outlines the leadership, responsibility, and accountability arrangements. The responsibilities are then taken forward through the Board Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation

9.3. The Corporate Risk Register

The Corporate Risk Register includes all risks rated 15 and above or those scoring Catastrophic for Impact.

In addition, the Audit and Risk Committee monitors the risk management systems and processes and receives the Board Assurance Framework on a quarterly basis.

9.4. Risk Appetite Statement

The development of risk appetite in the public sector requires a slightly different approach to that of the private sector in that, this is driven by shorter term funding approaches and measures of successful outcomes are broader and may not be financially focused.

The setting of risk appetite is a key tool in communicating the Board assessment of the nature and extent of the principal risks that the Trust is exposed to and is willing to take in order to achieve its Strategic Ambitions. Risk Appetite provides a framework that enables the Trust to make informed planning and management decisions. In defining Risk Appetite, the Trust is able to clearly identify and set the optimal position in pursuit of its Strategic Ambitions and Vision.

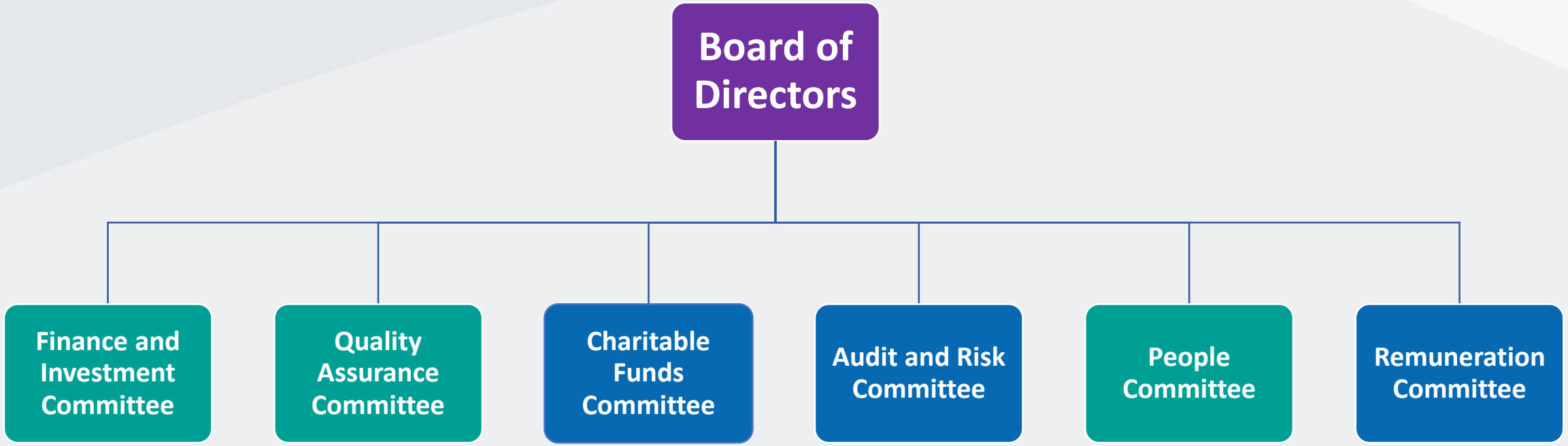
When approving the Board Assurance Framework, the Board agree their Risk Appetite for each of the strategic Ambitions of the organisation. The Risk Appetite is also reviewed at each quarterly iteration of the BAF and discussed at Committees and Board.

10. Conclusion

The Board is asked to approve the Corporate Governance Framework.

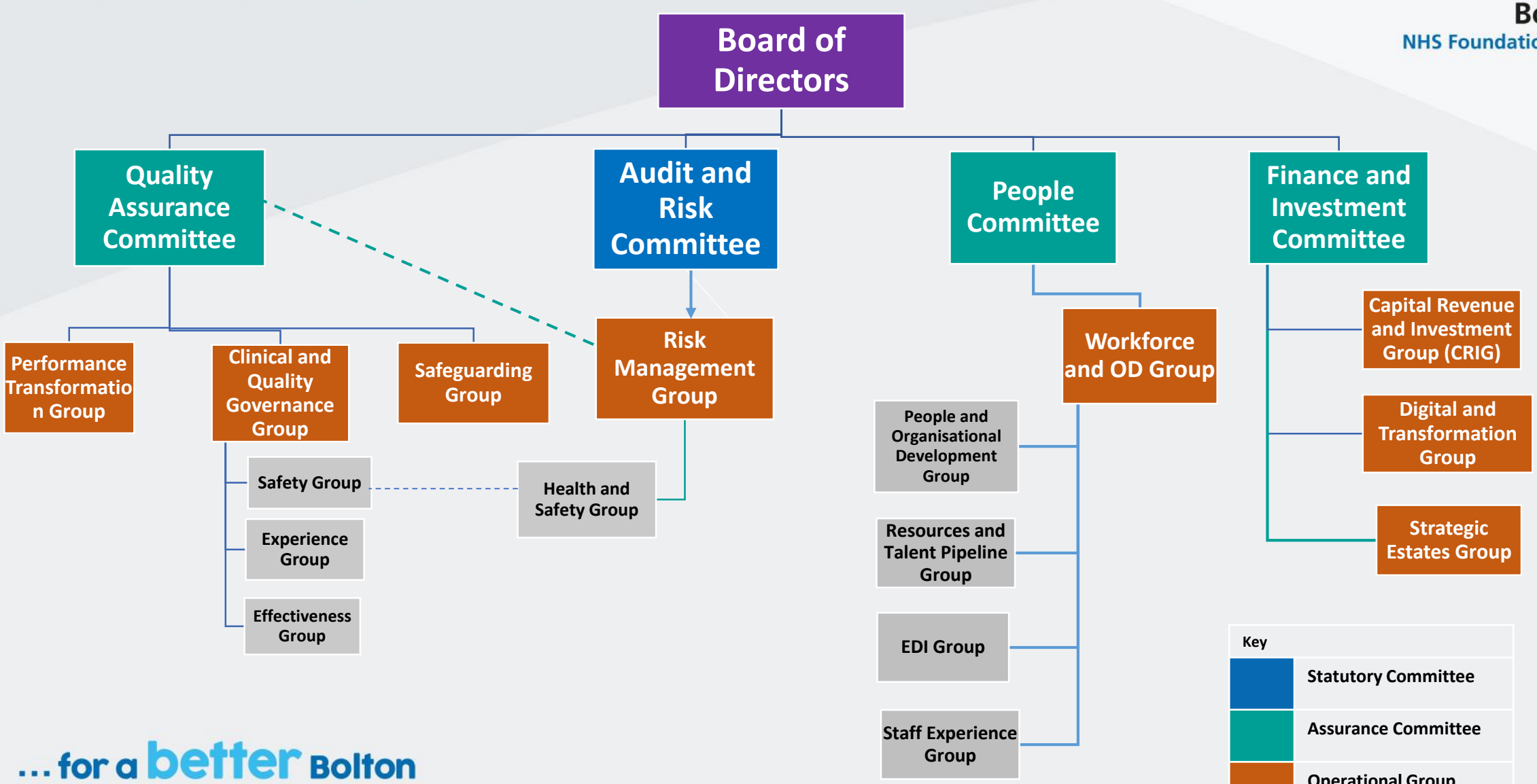
NHS Bolton NHS Foundation Trust

New Governance Structure



Key	
	Statutory Committee
	Assurance Committee
	Board

NHS Bolton NHS Foundation Trust



Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief Operating Officer		Decision	

Purpose of the report	To present the Month 9 Integrated Performance Report

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

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

Proposed Resolution	The Board of Directors is asked to ***receive*** the Integrated Performance Report

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

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	**Trust performance included within report, for any areas of concern narrative is provided.**
Legal/ Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey, Chief People Officer/Deputy Chief Executive

Bolton NHS Foundation Trust

Integrated Performance Report

December 2024

Guide to Statistical Process Control

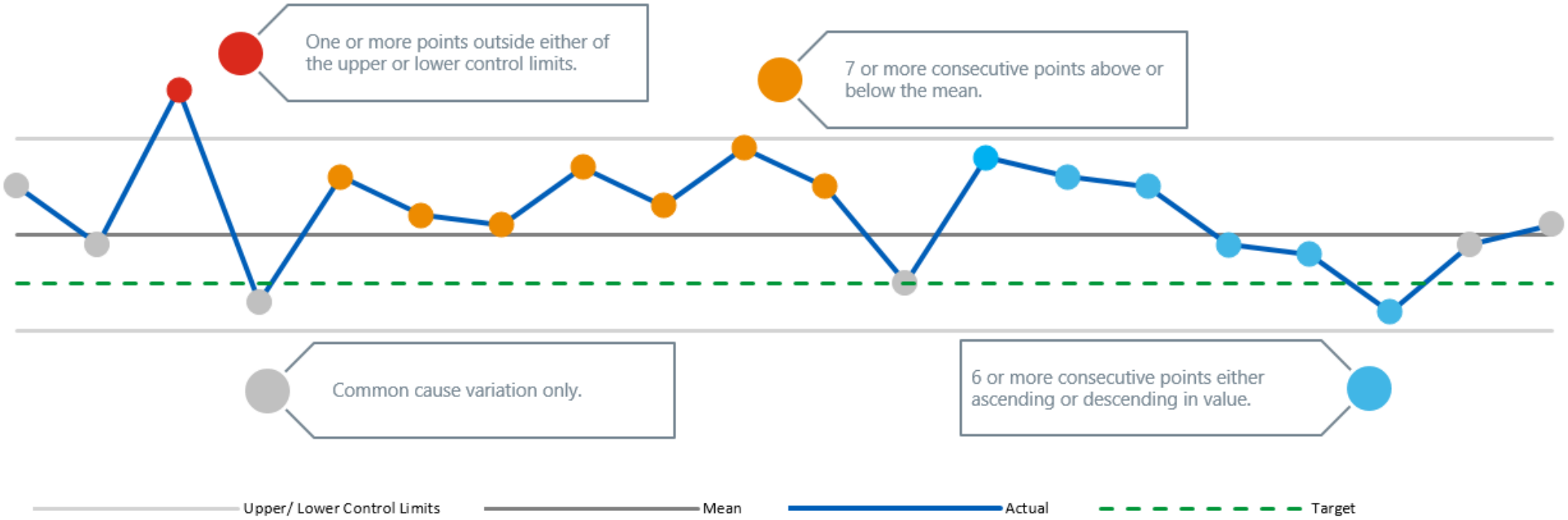
NHS Bolton NHS Foundation Trust

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

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

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

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



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	2	3	1	0	1	3	12
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	4	2	1	0	1	0	0	3
Patient Experience	15	1	0	0	0	2	0	14
Maternity	9	0	1	0	0	1	0	8
Operational Performance								
Urgent Care	8	0	1	1	1	2	5	4
Elective Care	6	0	5	2	2	1	7	4
Cancer	1	0	0	0	0	0	0	1
Community Care	8	0	0	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	1	0	0	0	2	0	0	0
Appendices								
Heat Maps								

Variation

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

Assurance

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

Performance

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

Quality and Safety - Harm Free Care

Bolton NHS Foundation Trust

Pressure Ulcers

In month 9, eight Category 3 pressure ulcers were reported affecting four patients, with three patients developing multiple ulcers. This indicator remains within normal variation. Further analysis has identified primary themes: device-related pressure damage linked to an orthopaedic patient cared for within a medical speciality (overriding presenting condition required medical care) and potential human factors linked to the orthopaedic elements of care, repositioning compliance issues, and delays in medical illustration documentation. There is also emerging a potential issue relating to a sudden change in consistency of some groups of ward staffs. All themes are subject to 60 working day review and will inform any subsequent interventions. The hospital setting continues to see an increase in Category 2 pressure ulcers with themes remaining linked to overcrowded Emergency department restricting timely assistance with patient turns due to space restrictions and also patients who have fallen at home and experienced extended waits for emergency transport to the ED. In December 2024, the process for reviewing all patients with a decision to admit, whom are being cared for in an escalation bed-space has been further strengthened and now includes an additional check, once every 8 hours, from Matron or above. The current improved ED position with reduced over-crowding, if maintained, should lead to a reduction in category two prevalence.

One Category 4 pressure ulcer was reported in the community setting, with investigation finding no care delivery omissions in respect of health care staff, the Chief Nursing Officer is also reviewing this incident.

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

Falls

The organisation has maintained strong performance in falls prevention, recording zero falls with harm during month 9. Overall falls rate stands at 4.47 per 1000 bed days. The corporate team continues to collaborate with Divisions to review falls incidents, identify themes and implement targeted actions for sustained improvement.

Patient Safety Incident Investigation turnaround performance by agreed deadline December 2024

In December 2024, there was one Patient Safety Incident Investigation (PSII) report that was approved after the deadline. The report has now been approved at the Executive Sign off panel.

There are currently no Patient Safety Incident Investigations underway.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	95.7%	Nov-24		>= 95%	95.2%	Oct-24	>= 95%	96.1%	
9 - Never Events	= 0	0	Dec-24		= 0	0	Nov-24	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.47	Dec-24		<= 5.30	3.78	Nov-24	<= 5.30	4.20	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	0	Dec-24		<= 1.6	1	Nov-24	<= 14.4	7	

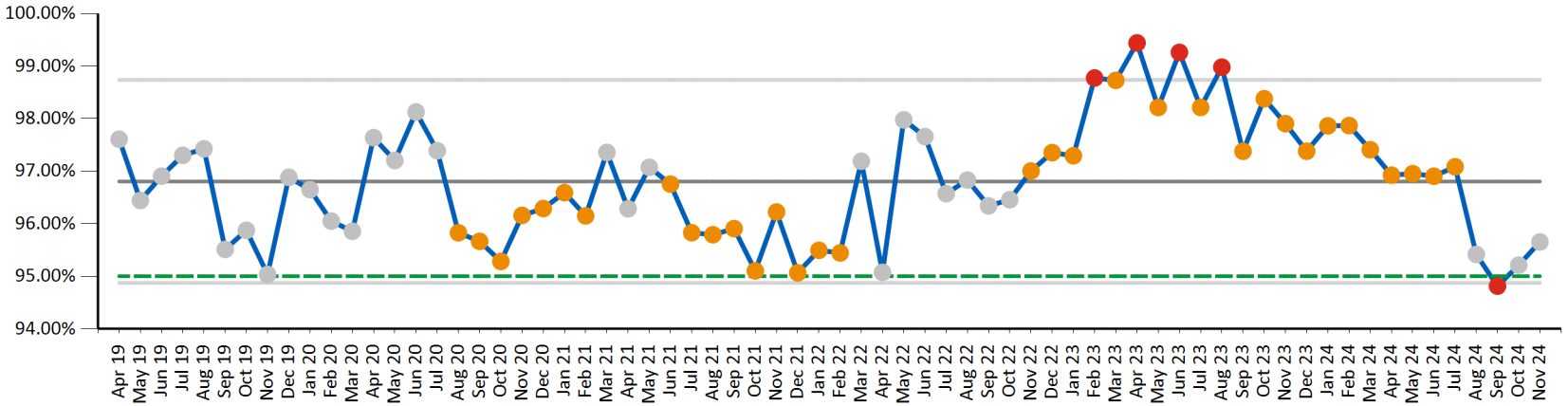
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	20.0	Dec-24		<= 6.0	10.0	Nov-24	<= 54.0	124.0	
620 - Acute Inpatients acquiring pressure damage (category 3 plus unstageables)	<= 1	8	Dec-24		<= 1	5	Nov-24	<= 5	31	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Dec-24		= 0.0	0.0	Nov-24	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	13.0	Dec-24		<= 7.0	6.0	Nov-24	<= 63.0	80.0	
621 - Community patients acquiring pressure damage (category 3 plus unstageables)	<= 4	9	Dec-24		<= 4	12	Nov-24	<= 36	70	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Dec-24		<= 1.0	1.0	Nov-24	<= 9.0	4.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Dec-24			0	Nov-24		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Dec-24			0	Nov-24		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Dec-24			0	Nov-24		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	80.6%	Dec-24		>= 95%	82.0%	Nov-24	>= 95%	80.4%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	62.9%	Dec-24		>= 95.0%	65.7%	Nov-24	>= 95.0%	67.5%	
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Dec-24		= 100%	100.0%	Nov-24	= 100%	94.4%	
88 - Nursing KPI Audits	>= 85%	95.2%	Dec-24		>= 85%	95.8%	Nov-24	>= 85%	95.1%	
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Dec-24		= 100%	0.0%	Nov-24	= 100%	177.8%	
8 - Same sex accommodation breaches	= 0	25	Dec-24		= 0	16	Nov-24	= 0	147	

6 - Compliance with preventative measure for VTE

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 95%	95.7%	Nov-24

Previous

Plan	Actual	Period
>= 95%	95.2%	Oct-24

Year to Date

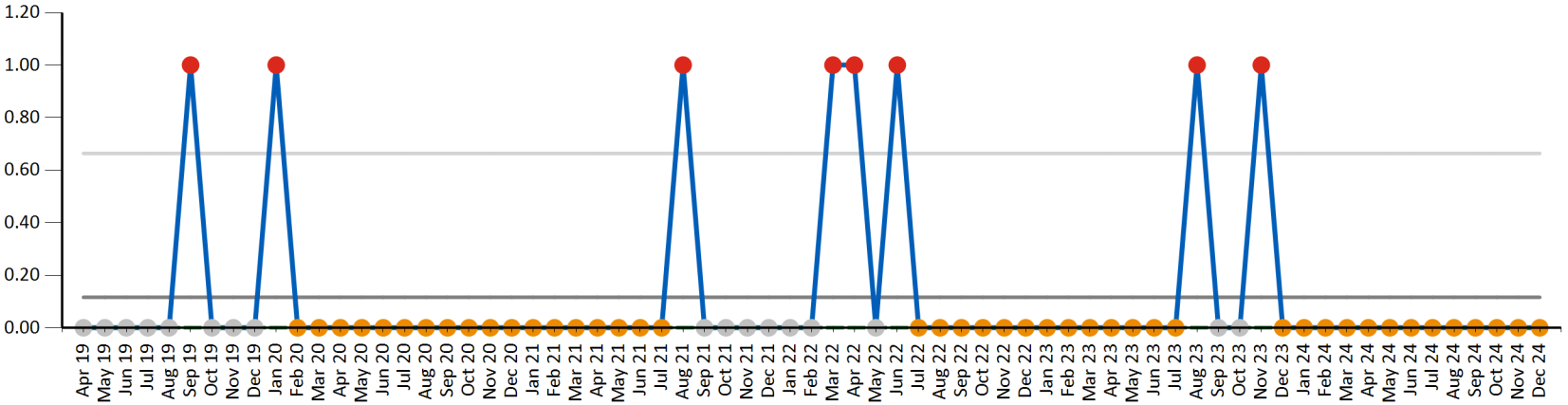
Plan	Actual
>= 95%	96.1%

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	Dec-24

Previous

Plan	Actual	Period
= 0	0	Nov-24

Year to Date

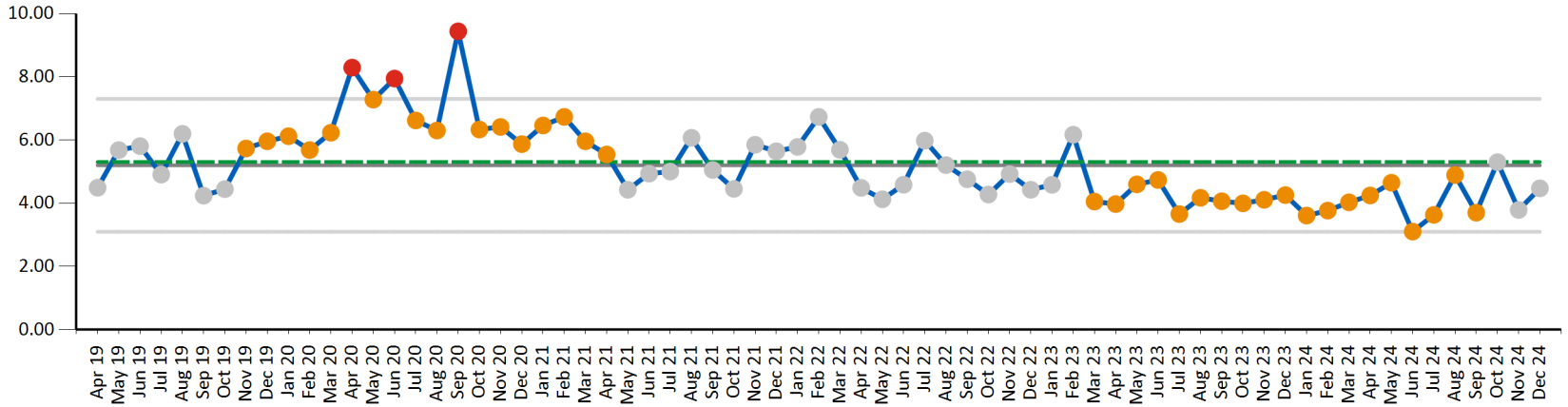
Plan	Actual
= 0	0

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

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5.30	4.47	Dec-24

Previous

Plan	Actual	Period
<= 5.30	3.78	Nov-24

Year to Date

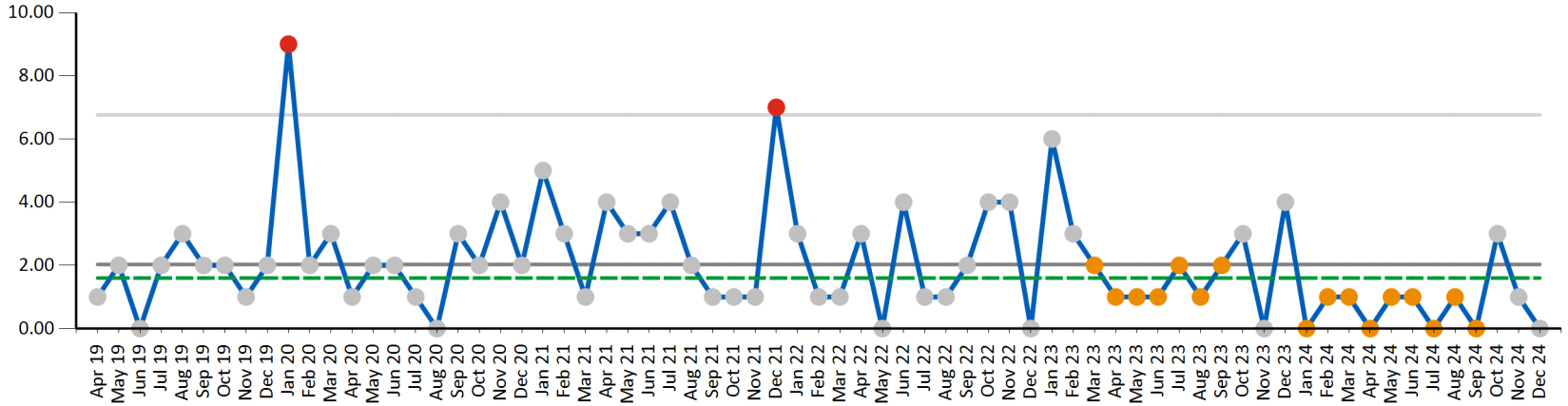
Plan	Actual
<= 5.30	4.20

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 1.6	0	Dec-24

Previous

Plan	Actual	Period
<= 1.6	1	Nov-24

Year to Date

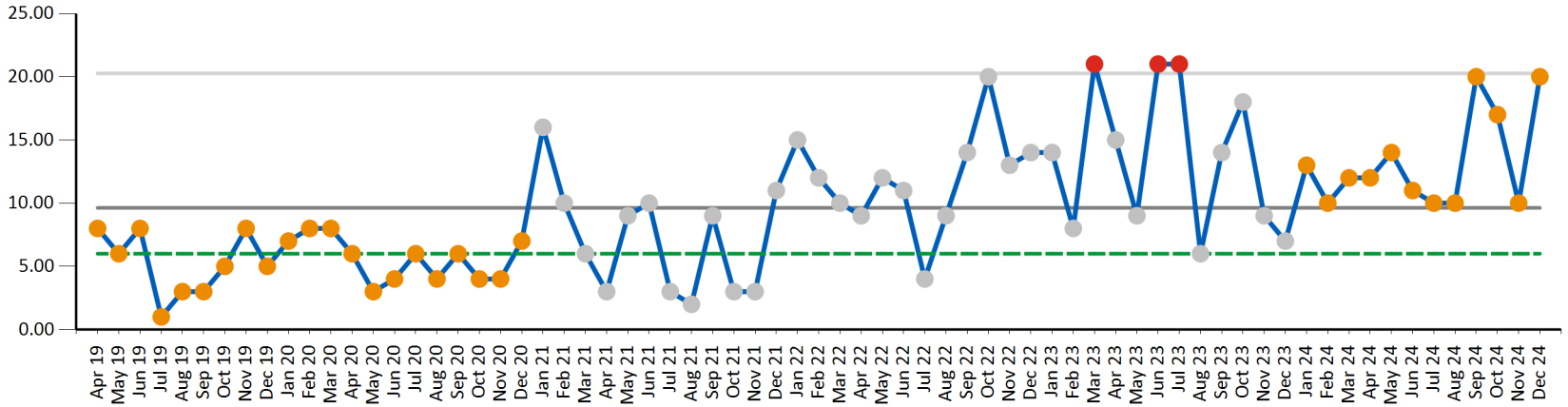
Plan	Actual
<= 14.4	7

15 - Acute Inpatients acquiring pressure damage (category 2)

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 6.0	20.0	Dec-24

Previous

Plan	Actual	Period
<= 6.0	10.0	Nov-24

Year to Date

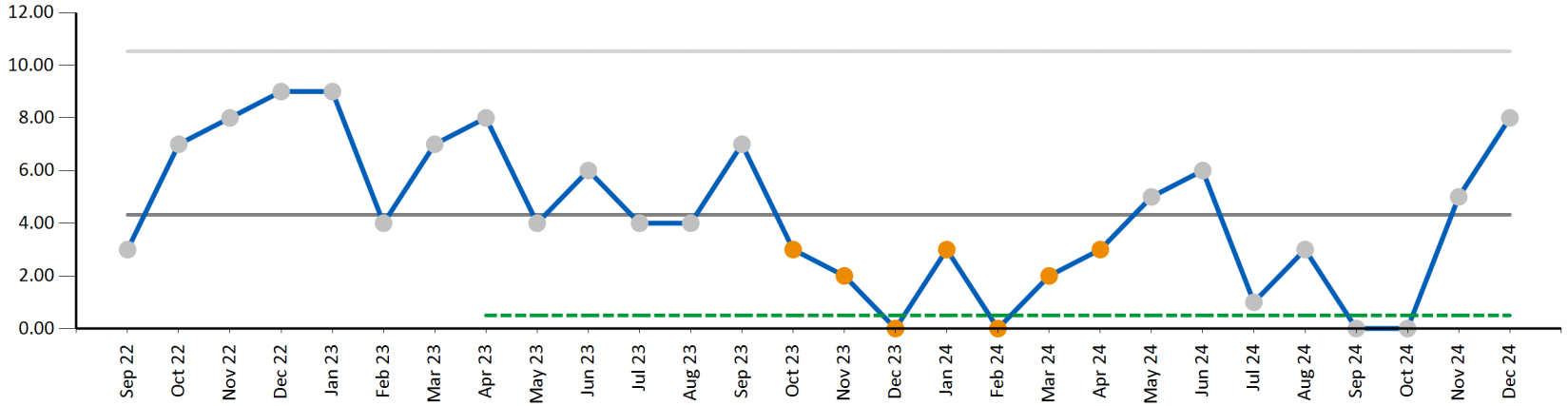
Plan	Actual
<= 54.0	124.0

620 - Acute Inpatients acquiring pressure damage (category 3 plus unstageables)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1	8	Dec-24

Previous

Plan	Actual	Period
<= 1	5	Nov-24

Year to Date

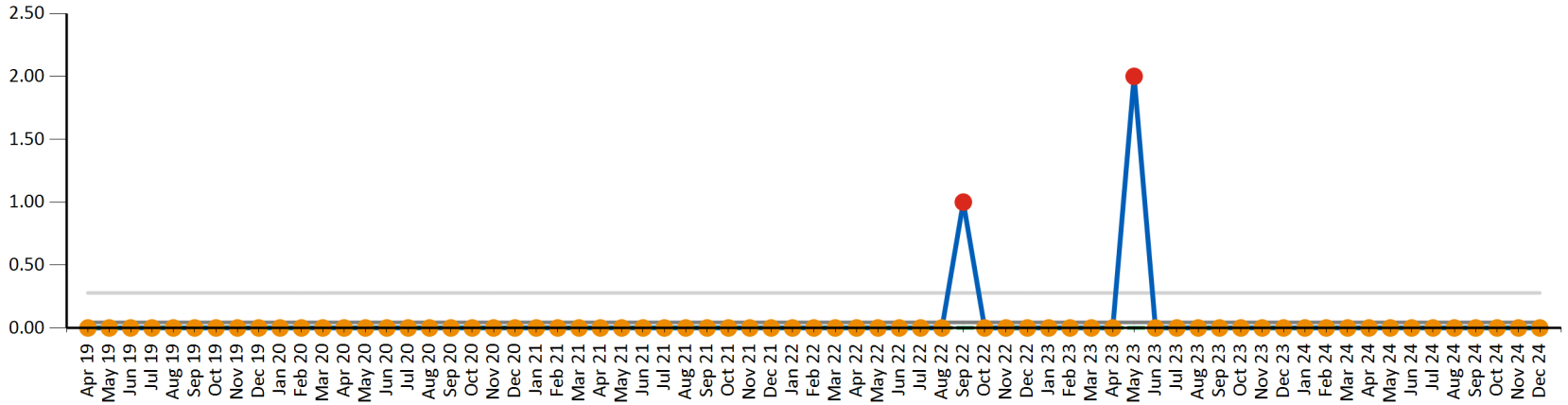
Plan	Actual
<= 5	31

17 - Acute Inpatients acquiring pressure damage (category 4)

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
= 0.0	0.0	Dec-24

Previous

Plan	Actual	Period
= 0.0	0.0	Nov-24

Year to Date

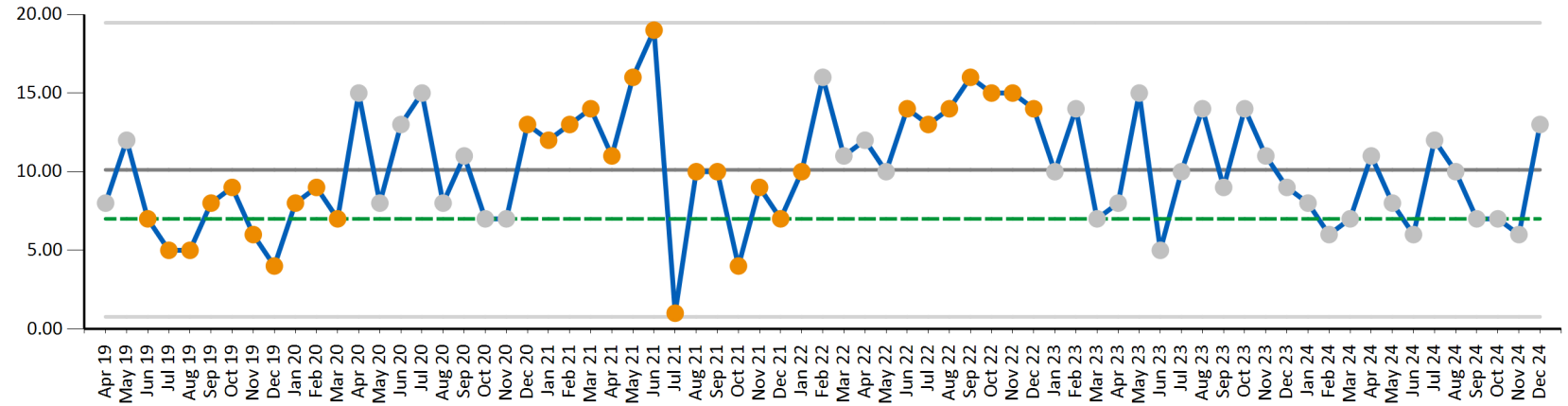
Plan	Actual
= 0.0	0.0

18 - Community patients acquiring pressure damage (category 2)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 7.0	13.0	Dec-24

Previous

Plan	Actual	Period
<= 7.0	6.0	Nov-24

Year to Date

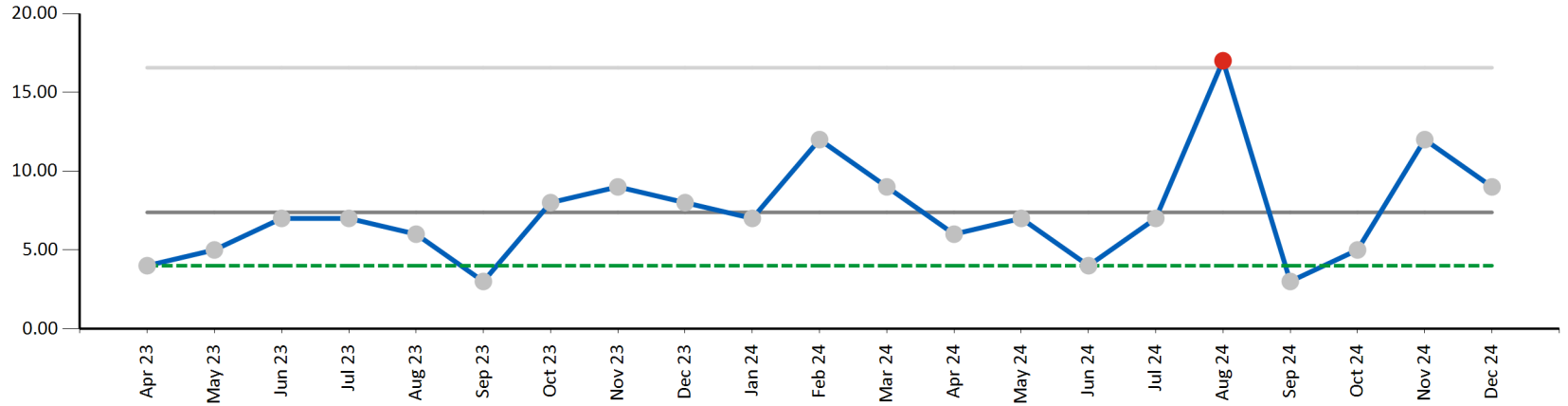
Plan	Actual
<= 63.0	80.0

621 - Community patients acquiring 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	9	Dec-24

Previous

Plan	Actual	Period
<= 4	12	Nov-24

Year to Date

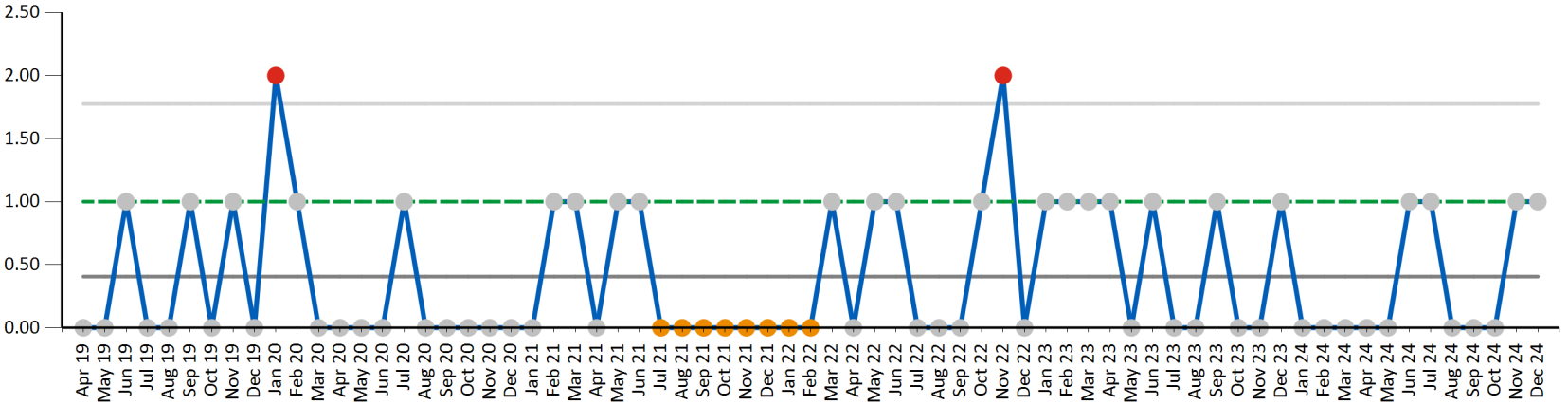
Plan	Actual
<= 36	70

20 - Community patients acquiring pressure damage (category 4)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Dec-24

Previous

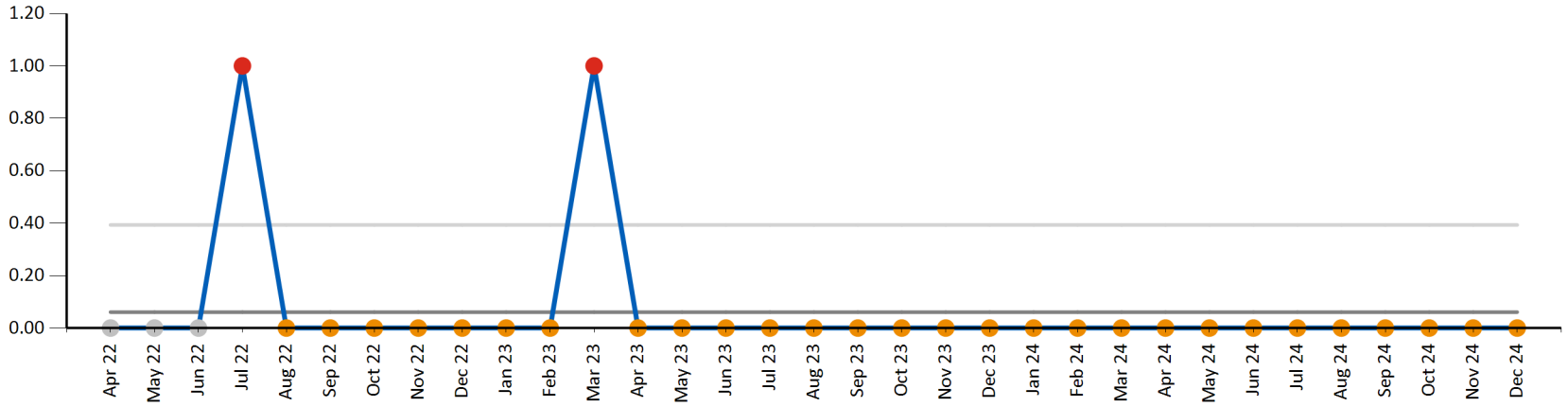
Plan	Actual	Period
<= 1.0	1.0	Nov-24

Year to Date

Plan	Actual
<= 9.0	4.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Dec-24

Previous

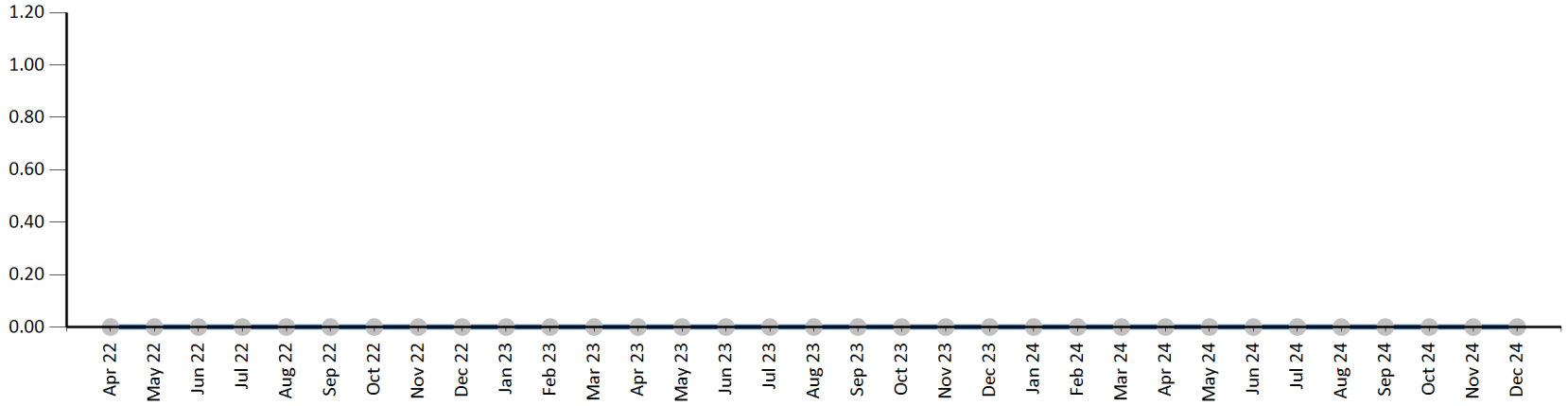
Plan	Actual	Period
	0	Nov-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-24

Previous

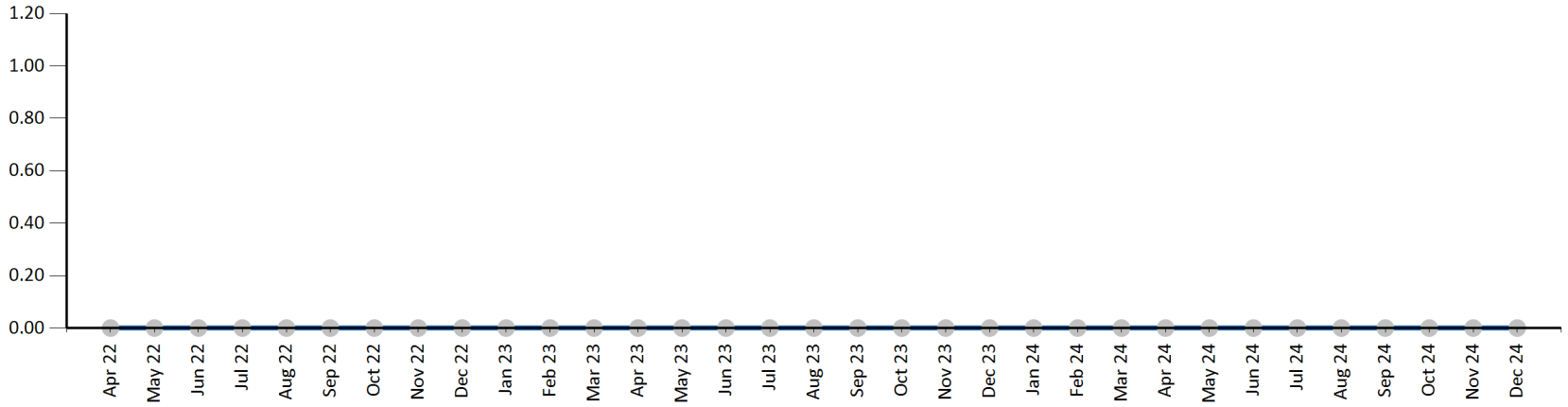
Plan	Actual	Period
	0	Nov-24

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-24

Previous

Plan	Actual	Period
	0	Nov-24

Year to Date

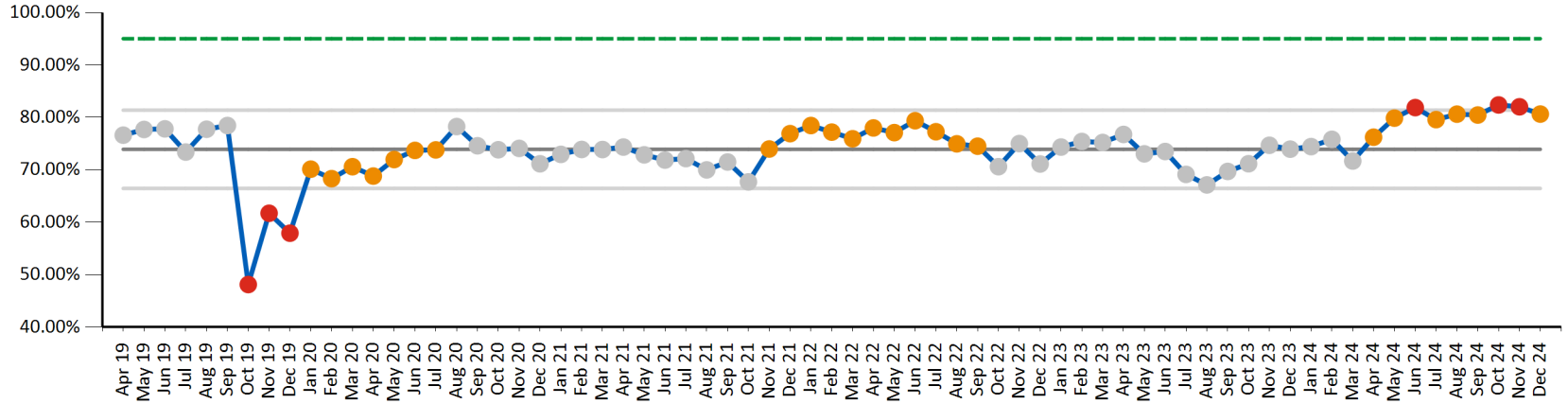
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	80.6%	Dec-24

Previous

Plan	Actual	Period
>= 95%	82.0%	Nov-24

Year to Date

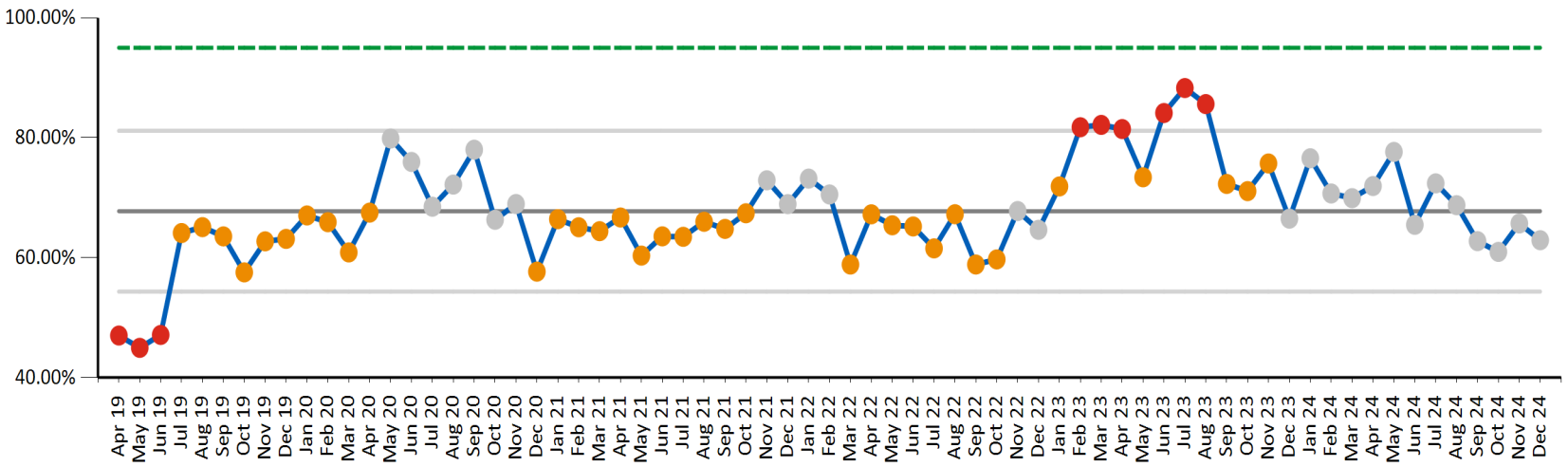
Plan	Actual
>= 95%	80.4%

31 - Clinical Correspondence - Outpatients %<5 working days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	62.9%	Dec-24

Previous

Plan	Actual	Period
>= 95.0%	65.7%	Nov-24

Year to Date

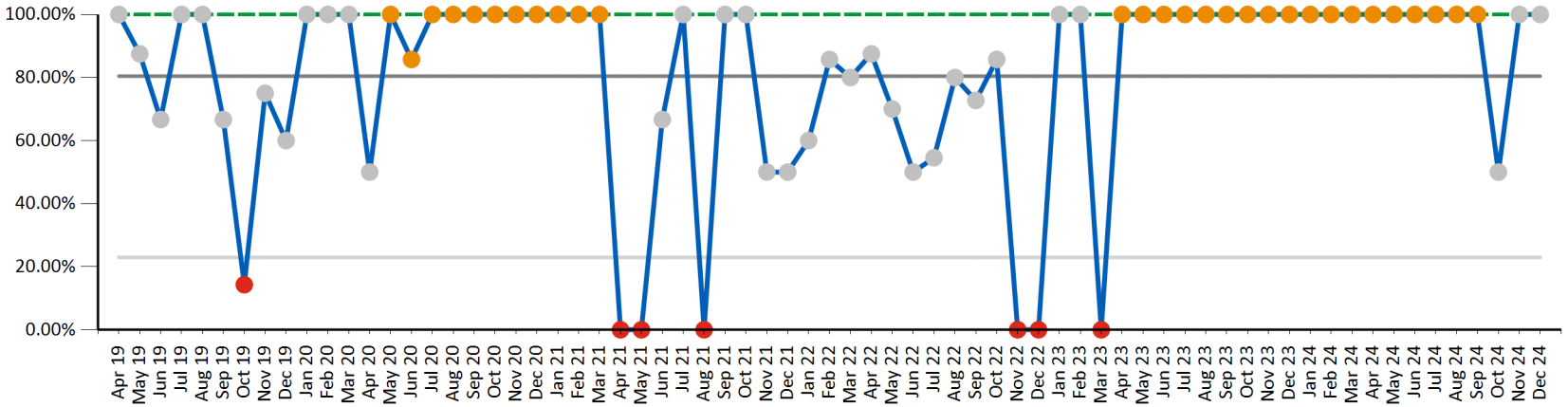
Plan	Actual
>= 95.0%	67.5%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Dec-24

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-24

Year to Date

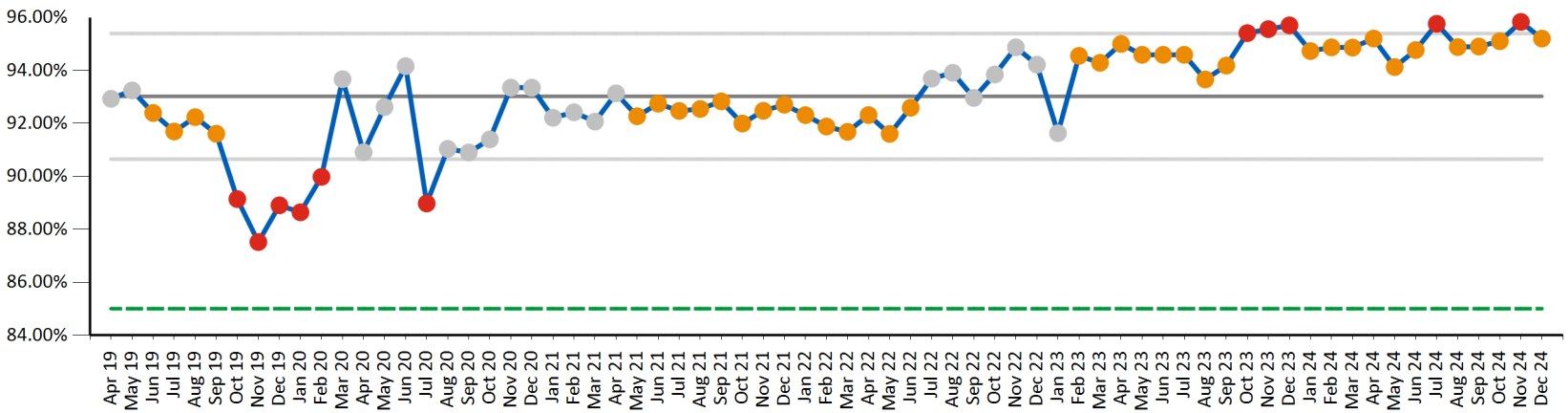
Plan	Actual
= 100%	94.4%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	95.2%	Dec-24

Previous

Plan	Actual	Period
>= 85%	95.8%	Nov-24

Year to Date

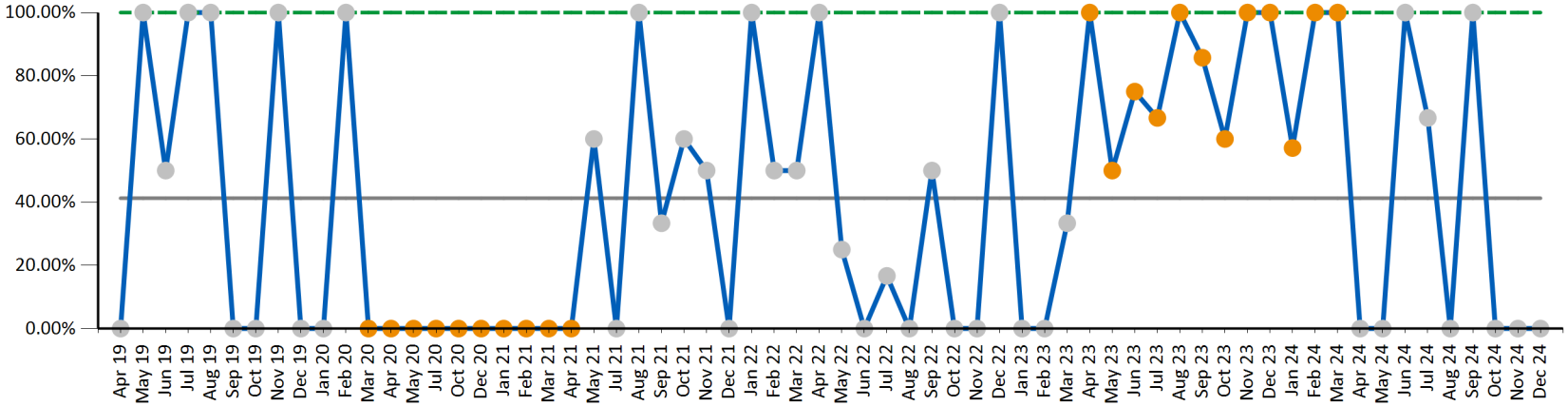
Plan	Actual
>= 85%	95.1%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
= 100%	0.0%	Dec-24

Previous

Plan	Actual	Period
= 100%	0.0%	Nov-24

Year to Date

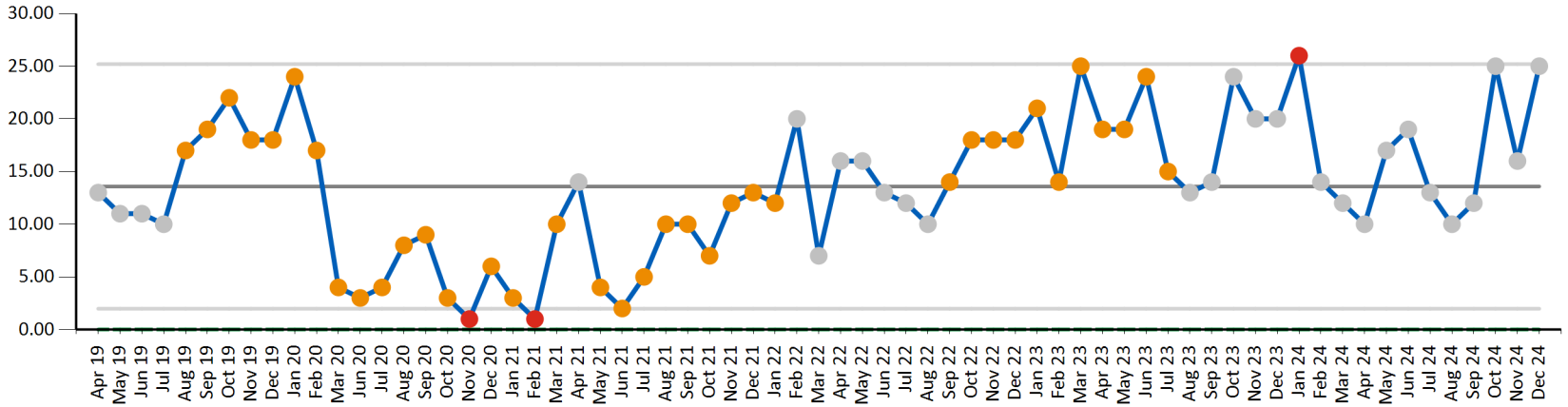
Plan	Actual
= 100%	177.8%

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	25	Dec-24

Previous

Plan	Actual	Period
= 0	16	Nov-24

Year to Date

Plan	Actual
= 0	147

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

There has been a reduction in Clostridium difficile infection cases in December to four healthcare associated cases although this remains within common cause variation. The cohort ward for Clostridium difficile infection patients was opened in December however, with only three positive patients suitable for cohorting and increased demand for acute beds, the decision was made to close this ward. If there are no sustained improvements in key measures such as timely isolation, then the decision to reopen the dedicated ward in February, regardless of bed pressures will be made.

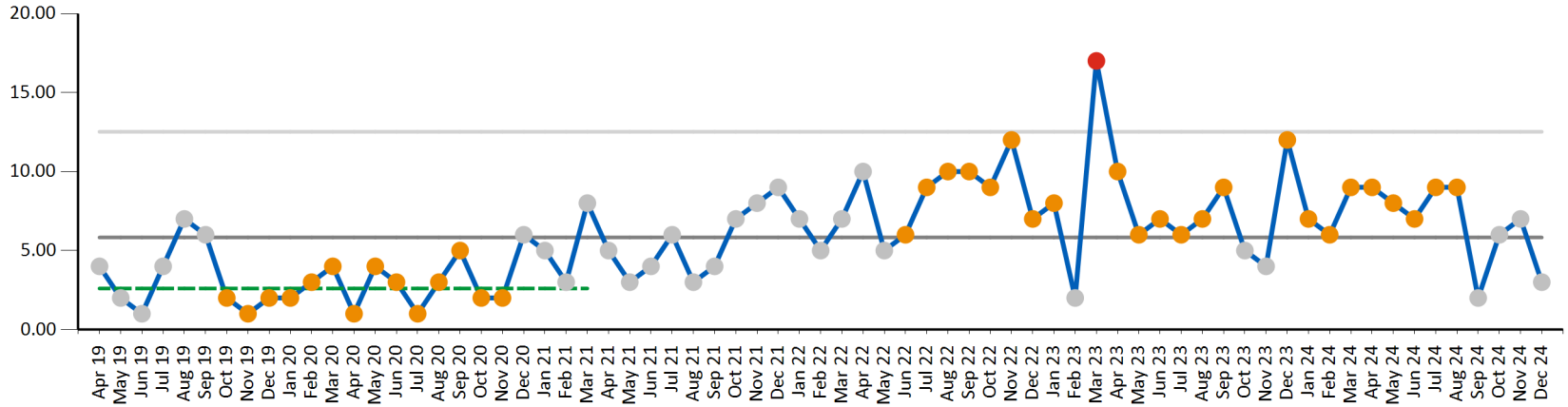
The Infection Prevention and Control Committee remains assured about the delivery of care related to other key healthcare associated infections.

The Trust has experienced the impact of influenza, with many patients presenting to the Emergency Department and requiring admission. For a three-week period, a dedicated ward was opened to create additional capacity for influenza positive patients. As the number of cases has now decreased, this ward has returned to managing general patients.

	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		3	Dec-24			7	Nov-24		60	
346 - Total Community Onset Hospital Associated C.diff infections		1	Dec-24			5	Nov-24		36	
347 - Total C.diff infections contributing to objective	<= 10	4	Dec-24		<= 10	12	Nov-24	<= 89	96	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Dec-24		= 0	0	Nov-24	= 0	1	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	7	Dec-24		<= 5	4	Nov-24	<= 47	41	
219 - Blood Culture Contaminants (rate)	<= 3%	2.7%	Dec-24		<= 3%	3.7%	Nov-24	<= 3%	3.1%	
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Dec-24		<= 1.0	2.0	Nov-24	<= 9.0	13.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	4	Dec-24		<= 1	2	Nov-24	<= 5	16	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Dec-24		= 0	1	Nov-24	= 0	4	
491 - Nosocomial COVID-19 cases		13	Dec-24			10	Nov-24		173	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	3	Dec-24

Previous

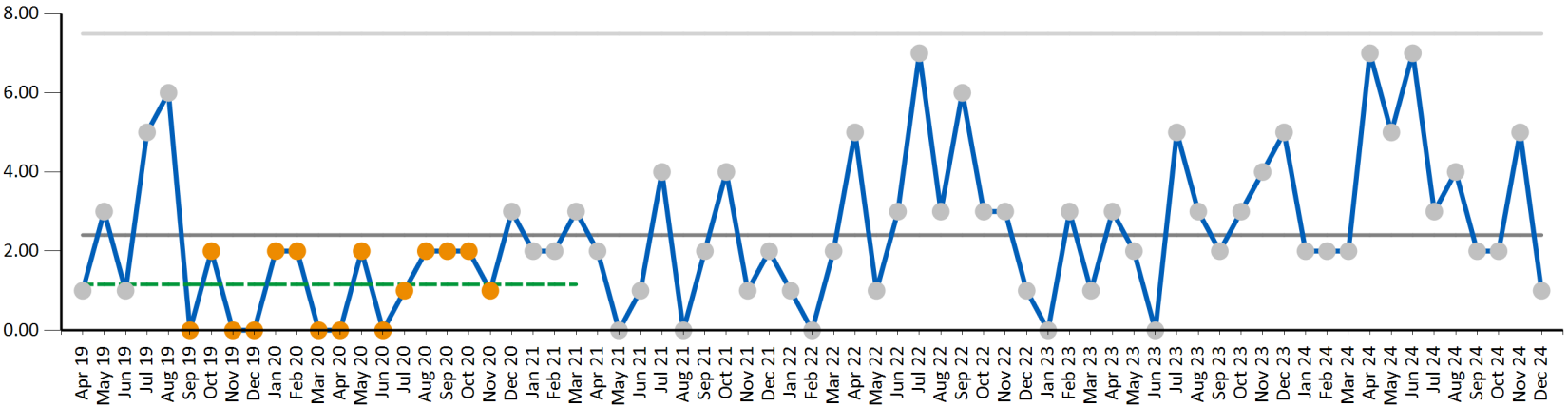
Plan	Actual	Period
	7	Nov-24

Year to Date

Plan	Actual
	60

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	1	Dec-24

Previous

Plan	Actual	Period
	5	Nov-24

Year to Date

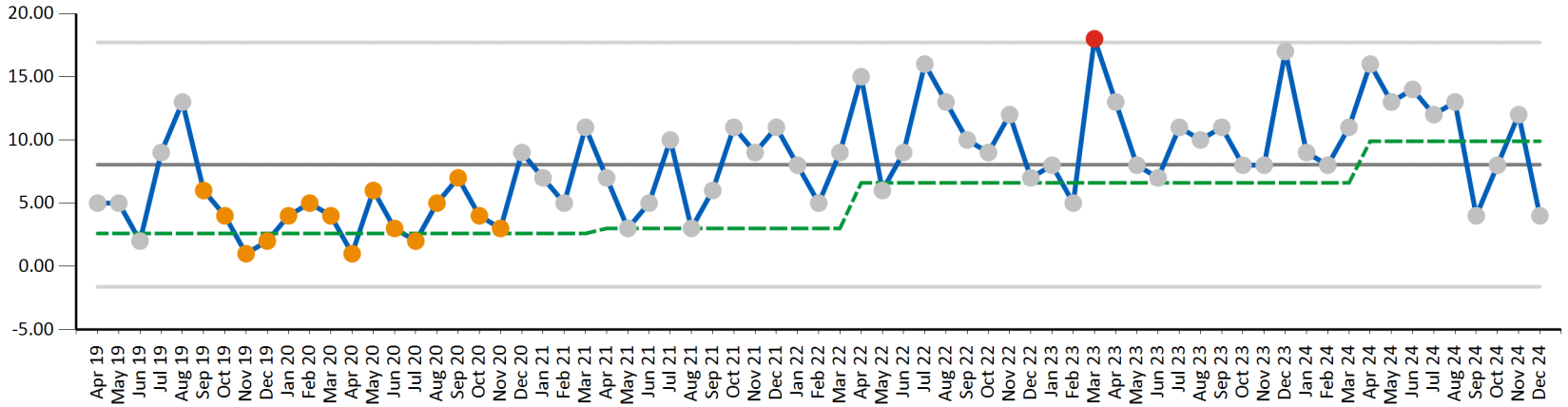
Plan	Actual
	36

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	4	Dec-24

Previous

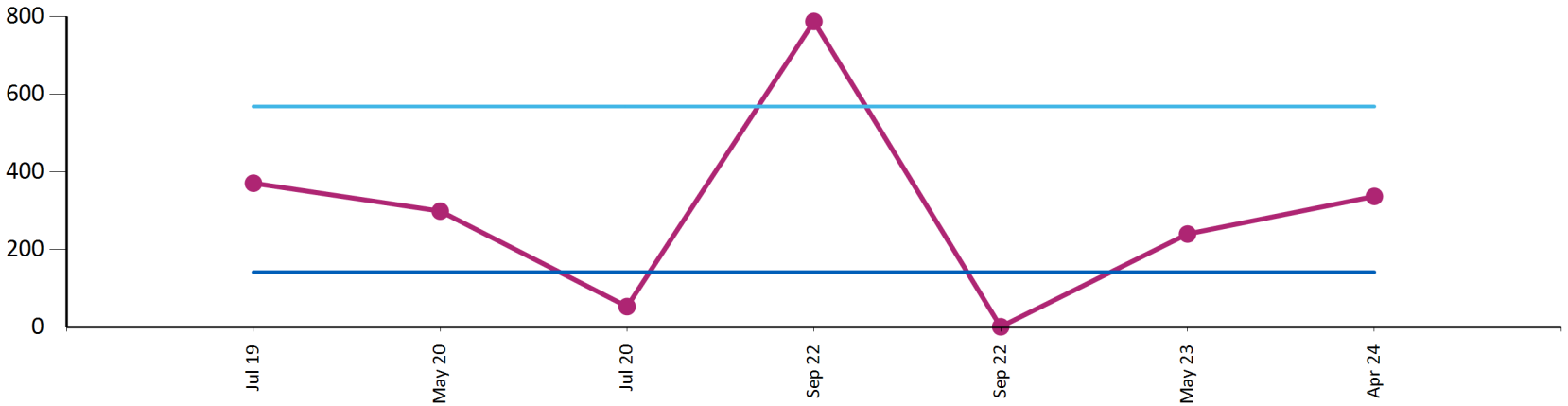
Plan	Actual	Period
<= 10	12	Nov-24

Year to Date

Plan	Actual
<= 89	96

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Dec-24

Previous

Plan	Actual	Period
	0	Nov-24

Year to Date

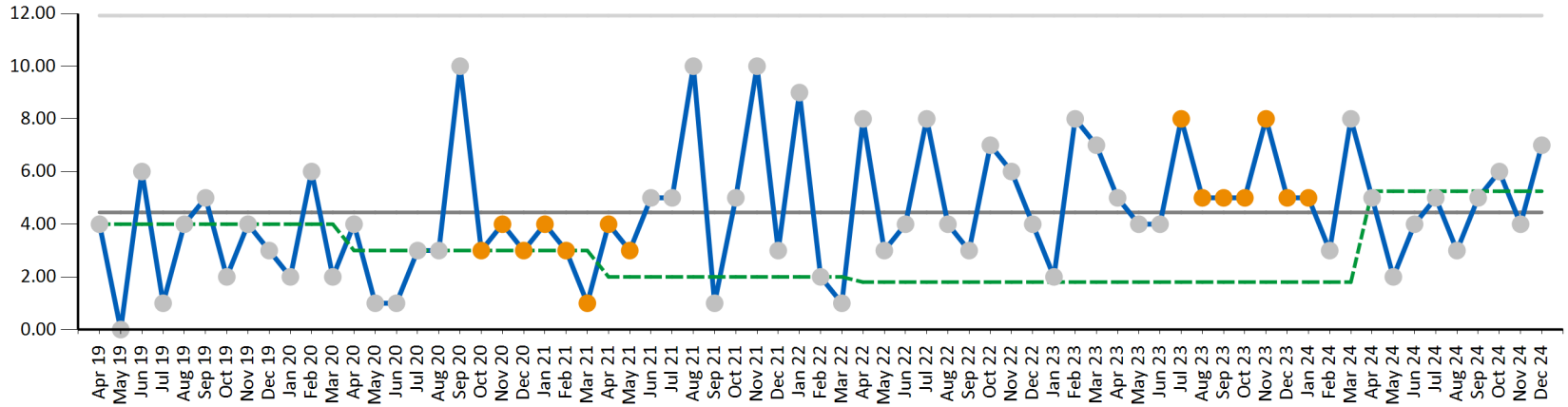
Plan	Actual

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 5	7	Dec-24

Previous

Plan	Actual	Period
<= 5	4	Nov-24

Year to Date

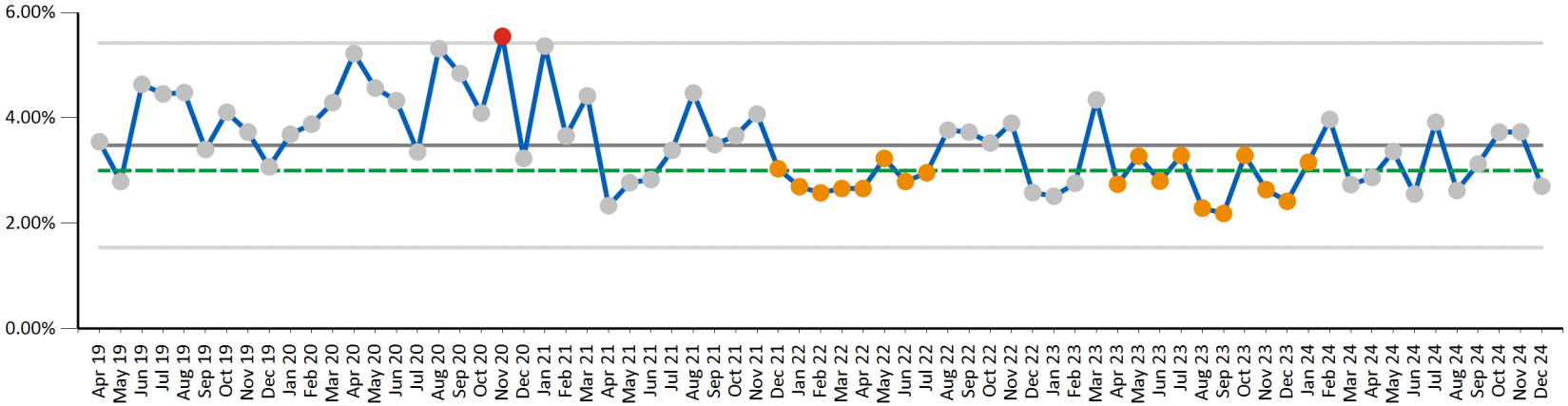
Plan	Actual
<= 47	41

219 - Blood Culture Contaminants (rate)

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 3%	2.7%	Dec-24

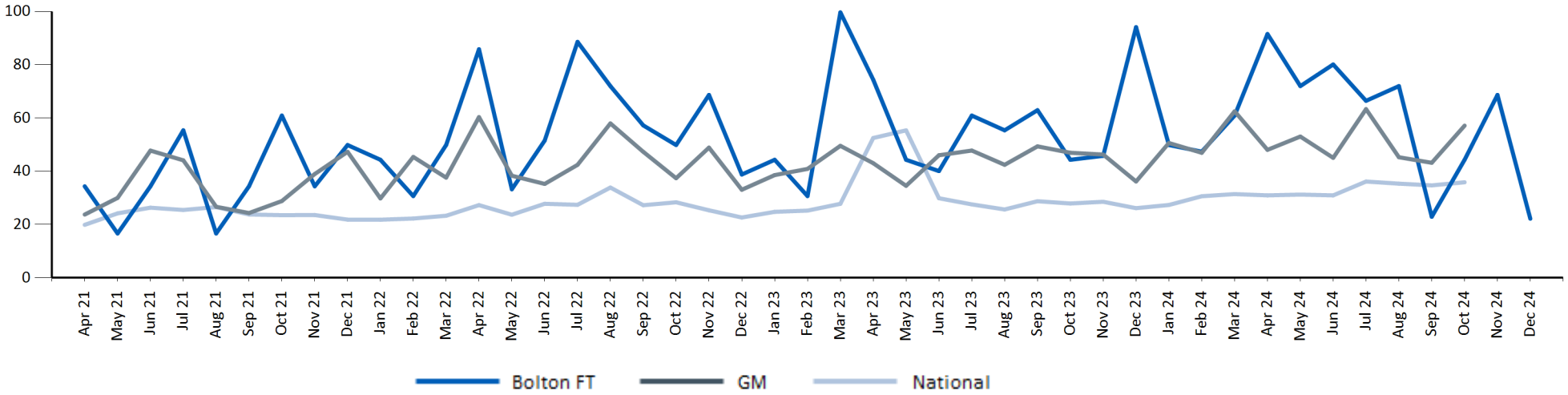
Previous

Plan	Actual	Period
<= 3%	3.7%	Nov-24

Year to Date

Plan	Actual
<= 3%	3.1%

549 - C Diff Rate Comparison

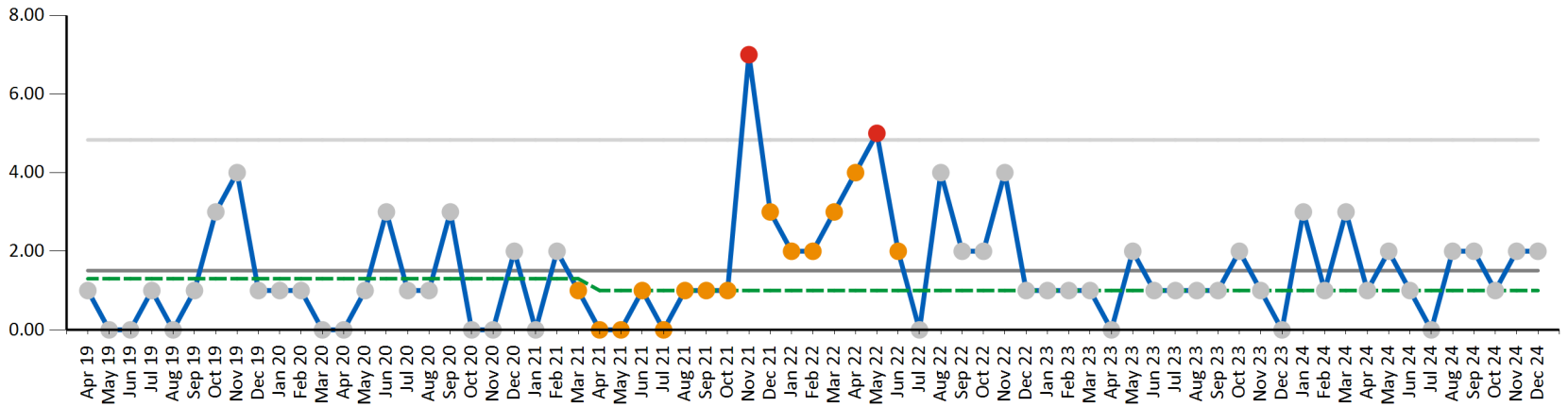


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Dec-24

Previous

Plan	Actual	Period
<= 1.0	2.0	Nov-24

Year to Date

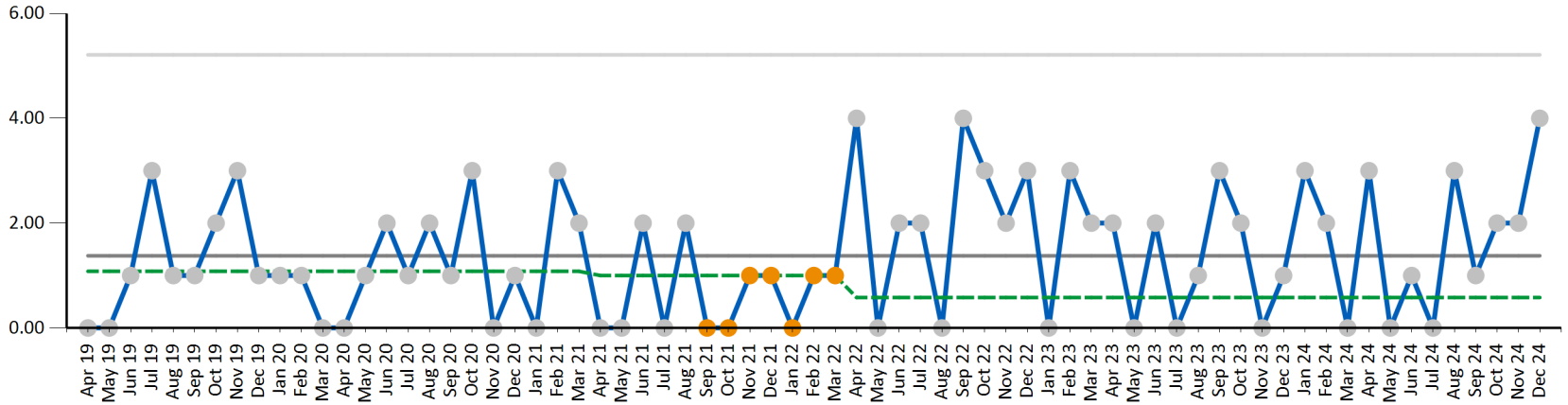
Plan	Actual
<= 9.0	13.0

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

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 1	4	Dec-24

Previous

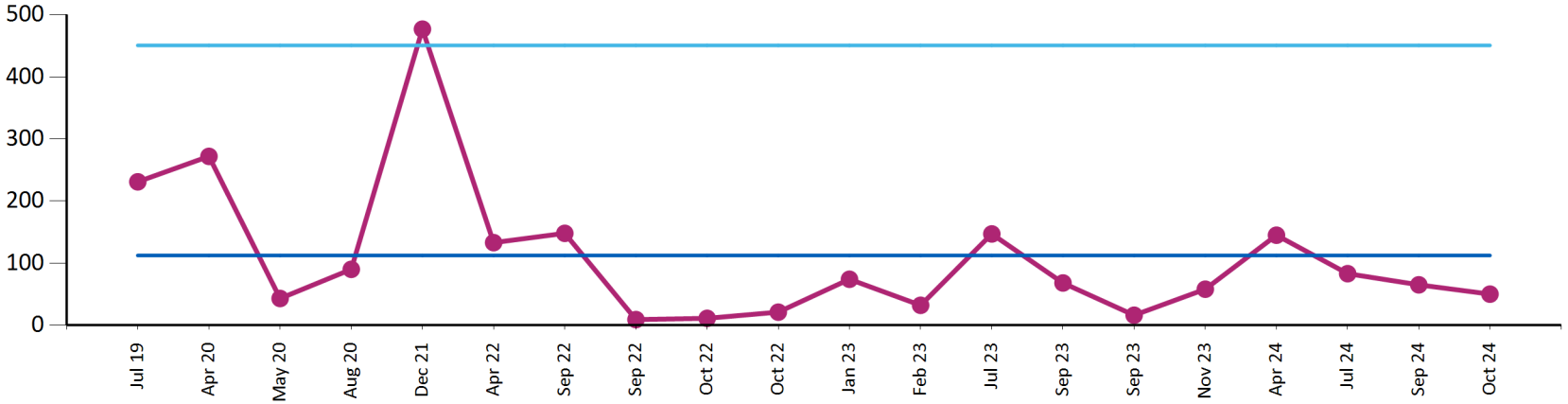
Plan	Actual	Period
<= 1	2	Nov-24

Year to Date

Plan	Actual
<= 5	16

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

0/6



Latest

Plan	Actual	Period
	0	Dec-24

Previous

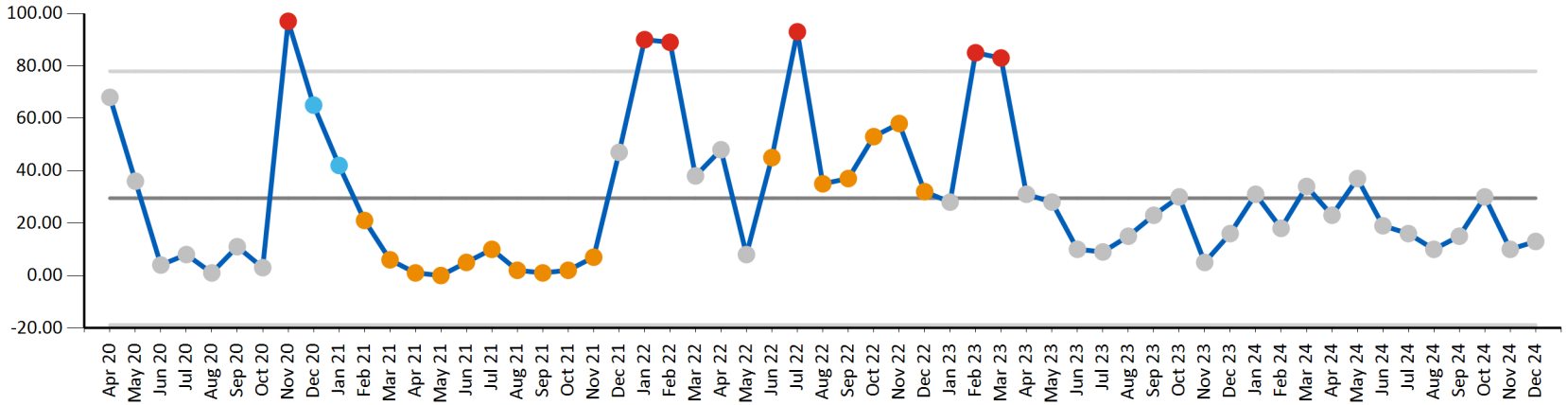
Plan	Actual	Period
	0	Nov-24

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period
	13	Dec-24

Previous

Plan	Actual	Period
	10	Nov-24

Year to Date

Plan	Actual
	173

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 an improvement of 11 months below the average. It has now remained in control for more than 3 years.

HSMR – in month figure is at the average for the period, however remains in control. The 12 month rolling average to September 2024 is 115.9 which is an 'Red' alert when compared to other Trusts.

SHMI – In month figure is at the average for the time period and remains in control. The published rolling average for the period September 2023 to August 2024 is 118.8 which is 'higher than expected'.

The proportion of Charlson comorbidities is at the average for the time frame. The depth of recording remains in control but is lower than average and is in special cause being under the average for 9 months. Both indictors are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot remains within range and above average.

The early neonatal mortality remains in control and has been for the last 12 months.

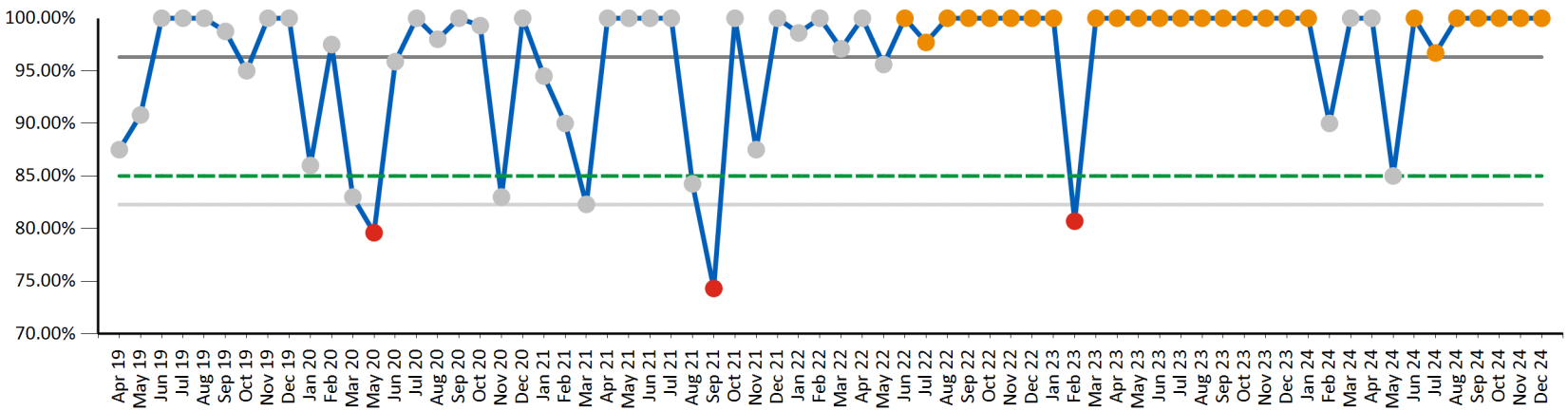
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Dec-24	H	>= 85%	100.0%	Nov-24	>= 85%	98.0%	?
495 - HSMR		124.16	Sep-24			123.67	Aug-24		124.16	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	114.27	Jul-24		<= 100.00	128.35	Jun-24	<= 100.00	114.27	?
12 - Crude Mortality %	<= 2.9%	2.2%	Dec-24	L	<= 2.9%	2.0%	Nov-24	<= 2.9%	2.2%	?
519 - Average Charlson comorbidity Score (First episode of care)		4	Sep-24			4	Aug-24		24	
520 - Depth of recording (First episode of care)		6	Sep-24	L		6	Aug-24		35	
521 - Proportion of fully coded records (Inpatients)		96.6%	Oct-24	H		96.3%	Sep-24		96.9%	
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		0.00	Dec-24			8.00	Nov-24			

3 - National Early Warning Scores to Gold standard

Special cause variation with improving performance

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

6/6



Latest

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

Previous

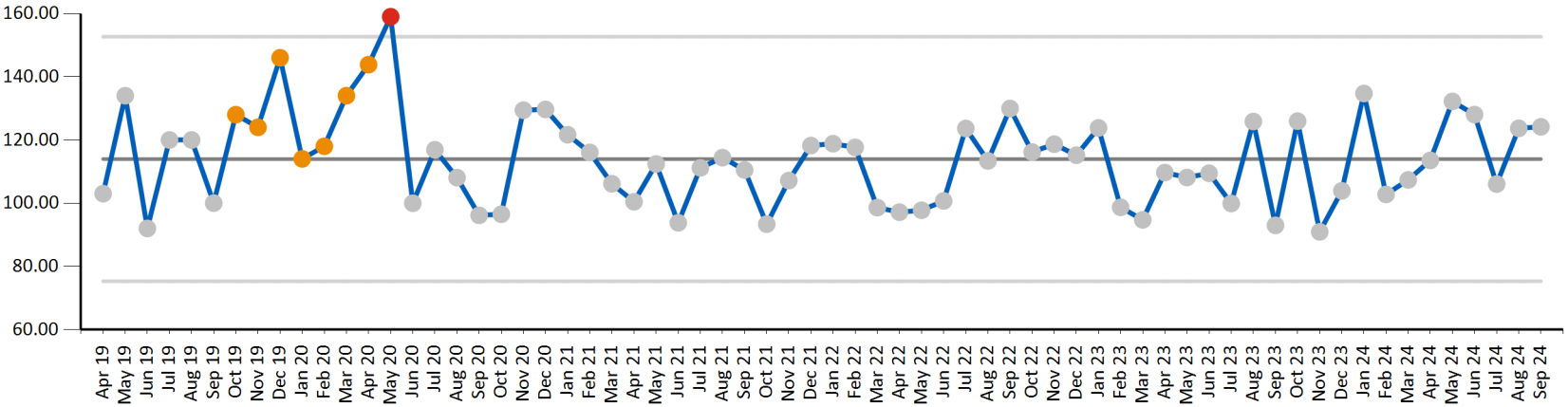
Plan	Actual	Period
>= 85%	100.0%	Nov-24

Year to Date

Plan	Actual
>= 85%	98.0%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	124.16	Sep-24

Previous

Plan	Actual	Period
	123.67	Aug-24

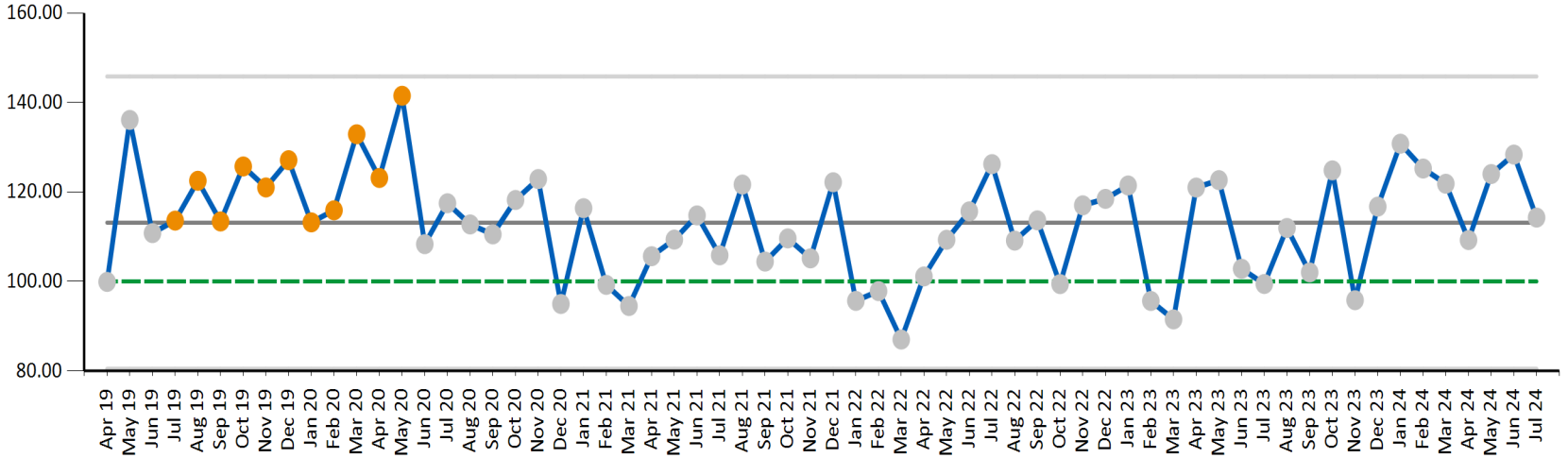
Year to Date

Plan	Actual
	124.16

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	114.27	Jul-24

Previous

Plan	Actual	Period
<= 100.00	128.35	Jun-24

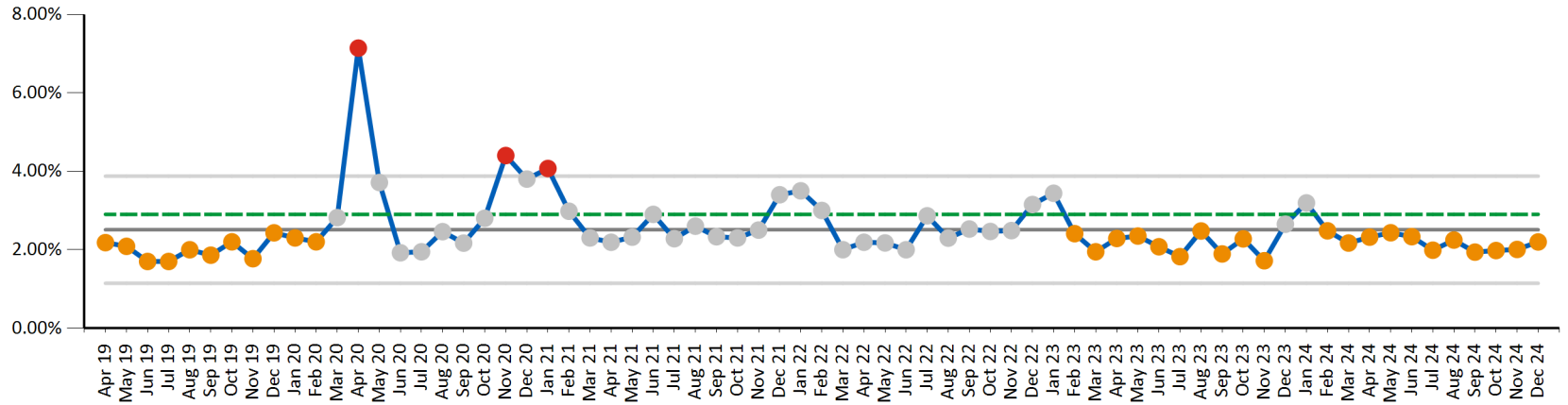
Year to Date

Plan	Actual
<= 100.00	114.27

12 - Crude Mortality %

Special cause variation with improving performance

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



Latest

Plan	Actual	Period
<= 2.9%	2.2%	Dec-24

Previous

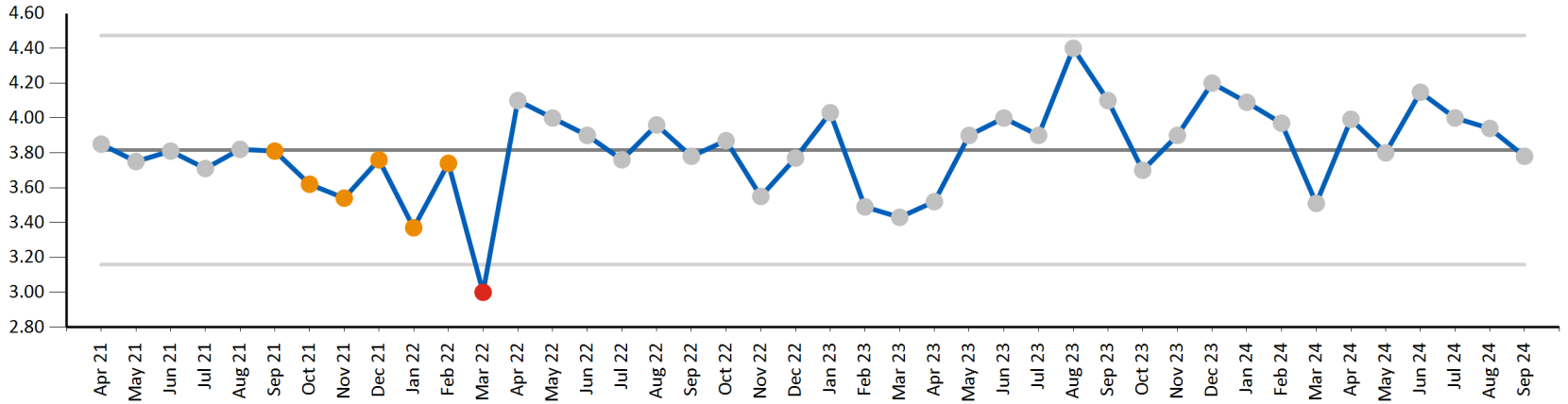
Plan	Actual	Period
<= 2.9%	2.0%	Nov-24

Year to Date

Plan	Actual
<= 2.9%	2.2%

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

Common cause variation.



Latest

Plan	Actual	Period
	4	Sep-24

Previous

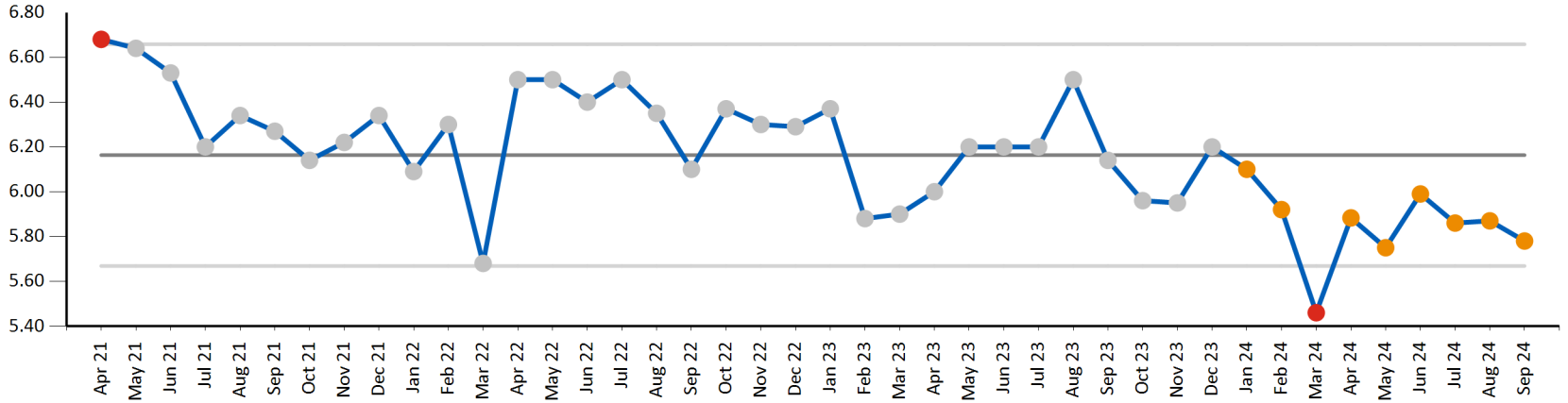
Plan	Actual	Period
	4	Aug-24

Year to Date

Plan	Actual
	24

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Sep-24

Previous

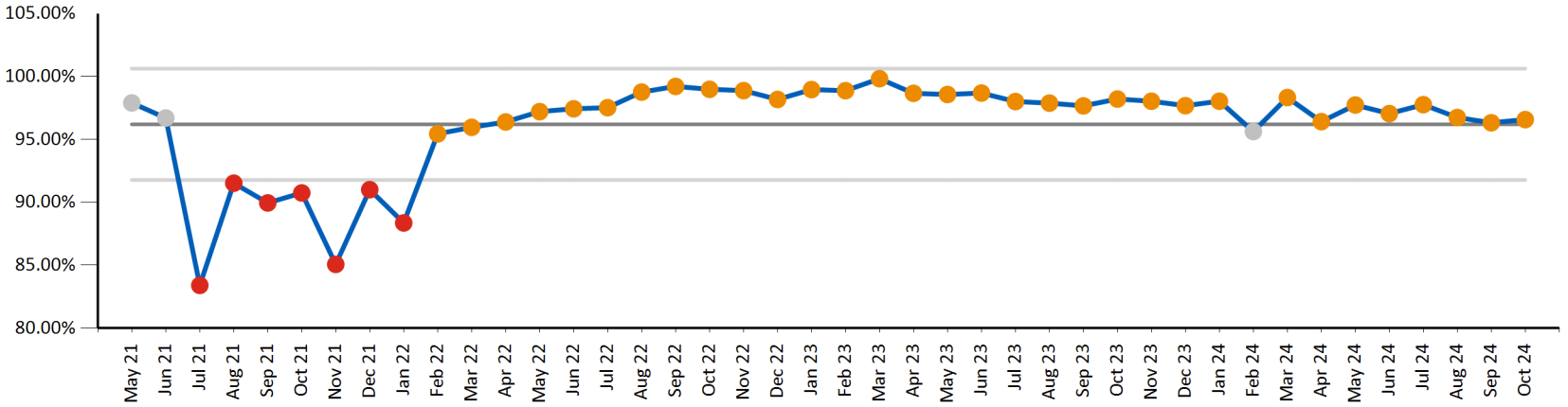
Plan	Actual	Period
	6	Aug-24

Year to Date

Plan	Actual
	35

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	96.6%	Oct-24

Previous

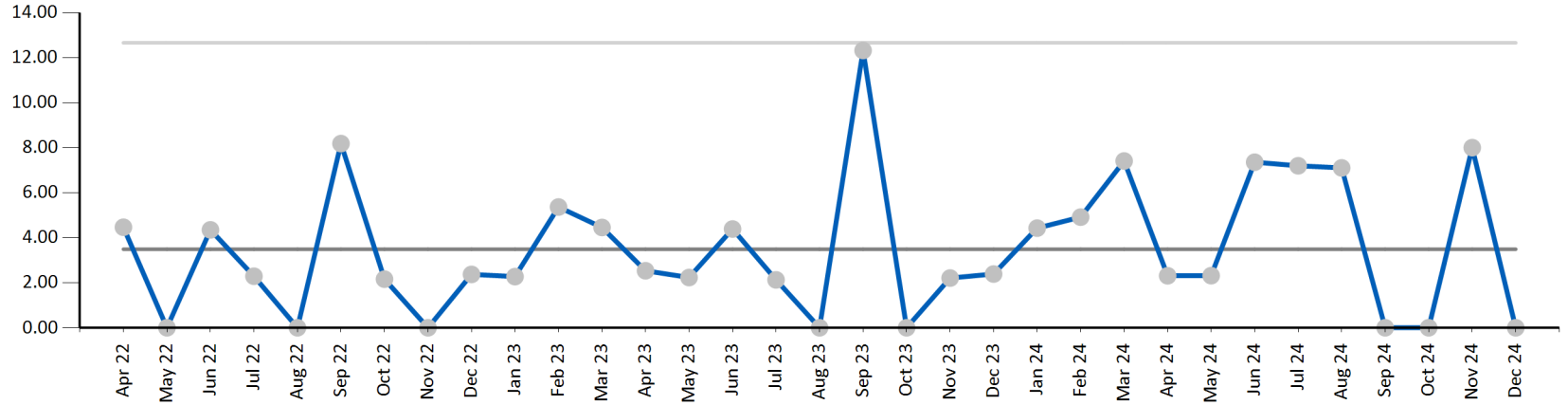
Plan	Actual	Period
	96.3%	Sep-24

Year to Date

Plan	Actual
	96.9%

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

Common cause variation.



Latest

Plan	Actual	Period
	0.00	Dec-24

Previous

Plan	Actual	Period
	8.00	Nov-24

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction Rates December 2024
Inpatient response rates show a slight reduction which remains below target. Accident and Emergency department response and satisfaction rates remain below target however are within common cause variation.
Maternity satisfaction rates continue to improve from the previous months and continue to be above target. Antenatal satisfaction rates are at 100% for the second consecutive month. Community Postnatal satisfaction rates have improved and are above target at 96.9%.

Complaint Response Rates December 2024
Complaints response compliance rates remain below target at 64.7% however this remains within common cause variation.
In December there were 14 complaints received and 17 responses due. Ten responses were provided within timeframe. Five complaint responses were provided after the agreed response date and were therefore overdue. Two complaint responses remain outstanding and outside of the agreed response date and are currently at latter stages of review. These complaints are within ASSD and DSSD.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	13.9%	Dec-24		>= 20%	13.4%	Nov-24	>= 20%	14.7%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	82.2%	Dec-24		>= 90%	86.1%	Nov-24	>= 90%	85.2%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	22.2%	Dec-24		>= 30%	27.2%	Nov-24	>= 30%	28.2%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	94.4%	Dec-24		>= 90%	95.6%	Nov-24	>= 90%	95.6%	P
81 - Maternity Friends and Family Response Rate	>= 15%	16.7%	Dec-24		>= 15%	19.9%	Nov-24	>= 15%	21.7%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	91.5%	Dec-24		>= 90%	88.4%	Nov-24	>= 90%	91.8%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	2.6%	Dec-24		>= 15%	5.9%	Nov-24	>= 15%	7.3%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Dec-24		>= 90%	100.0%	Nov-24	>= 90%	94.0%	?
83 - Birth - Friends and Family Response Rate	>= 15%	43.3%	Dec-24	H	>= 15%	42.6%	Nov-24	>= 15%	40.1%	P

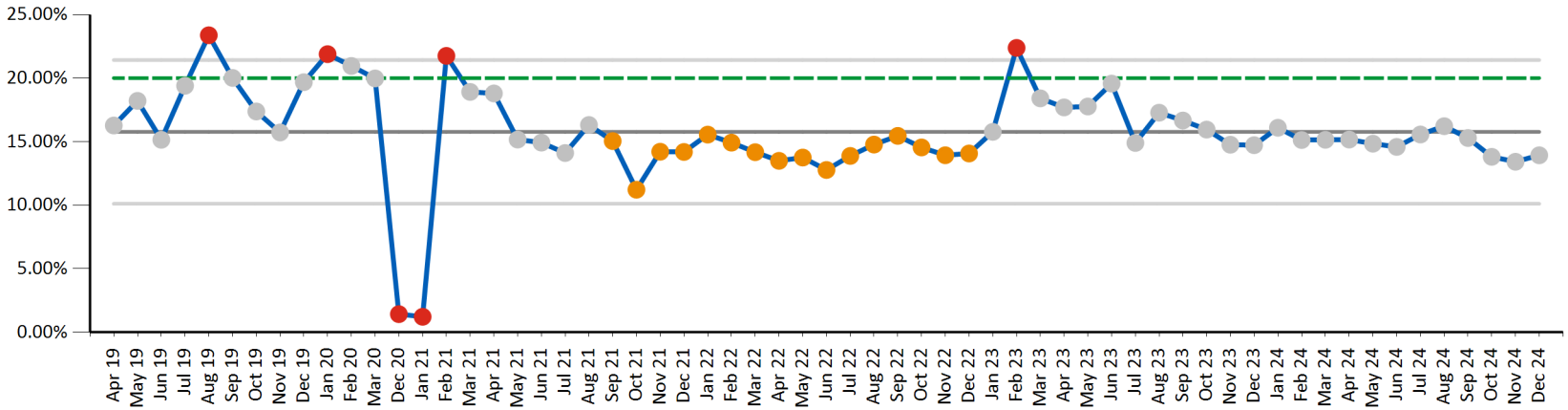
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	91.3%	Dec-24		>= 90%	89.4%	Nov-24	>= 90%	91.3%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	12.6%	Dec-24		>= 15%	19.4%	Nov-24	>= 15%	27.3%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	84.4%	Dec-24		>= 90%	84.6%	Nov-24	>= 90%	91.5%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	7.7%	Dec-24		>= 15%	14.1%	Nov-24	>= 15%	15.3%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.9%	Dec-24		>= 90%	82.7%	Nov-24	>= 90%	90.6%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Dec-24		= 100%	100.0%	Nov-24	= 100%	98.4%	
90 - Complaints responded to within the period	>= 95%	64.7%	Dec-24		>= 95%	91.3%	Nov-24	>= 95%	73.9%	

200 - A&E Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 20%	13.9%	Dec-24

Previous

Plan	Actual	Period
>= 20%	13.4%	Nov-24

Year to Date

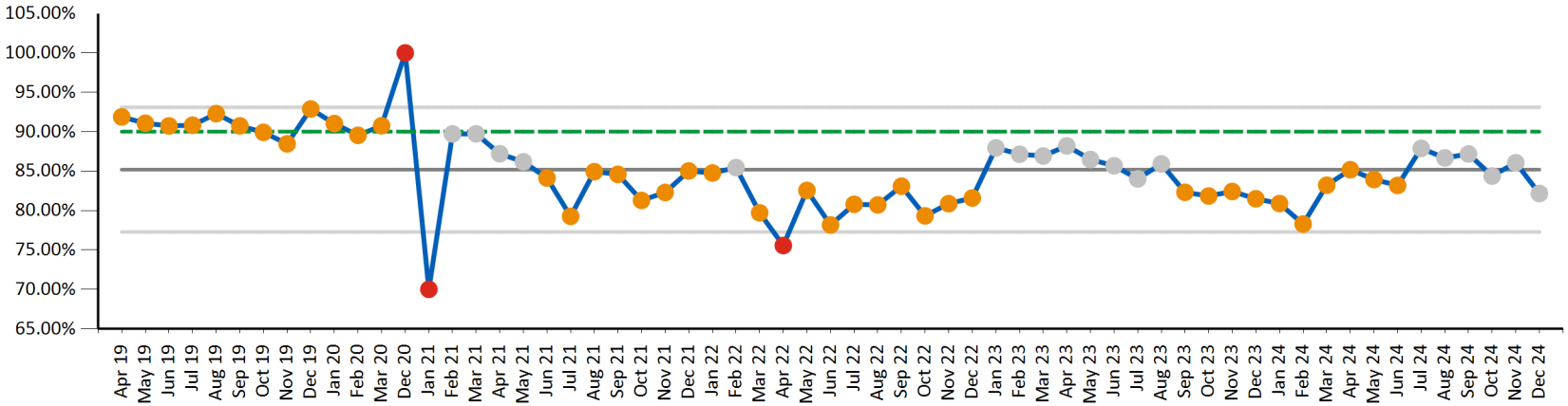
Plan	Actual
>= 20%	14.7%

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%	82.2%	Dec-24

Previous

Plan	Actual	Period
>= 90%	86.1%	Nov-24

Year to Date

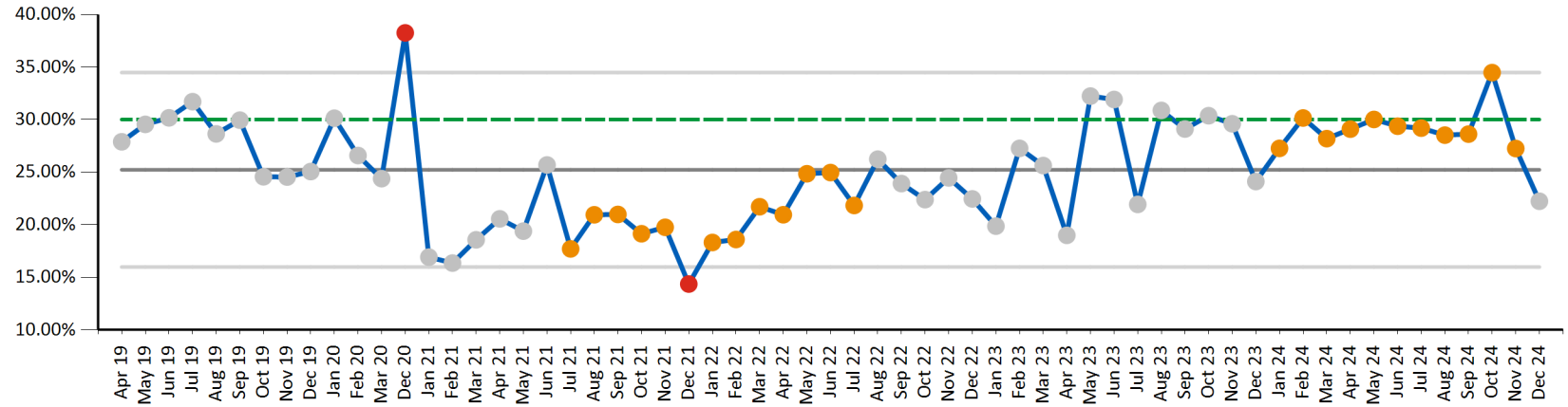
Plan	Actual
>= 90%	85.2%

80 - Inpatient 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
>= 30%	22.2%	Dec-24

Previous

Plan	Actual	Period
>= 30%	27.2%	Nov-24

Year to Date

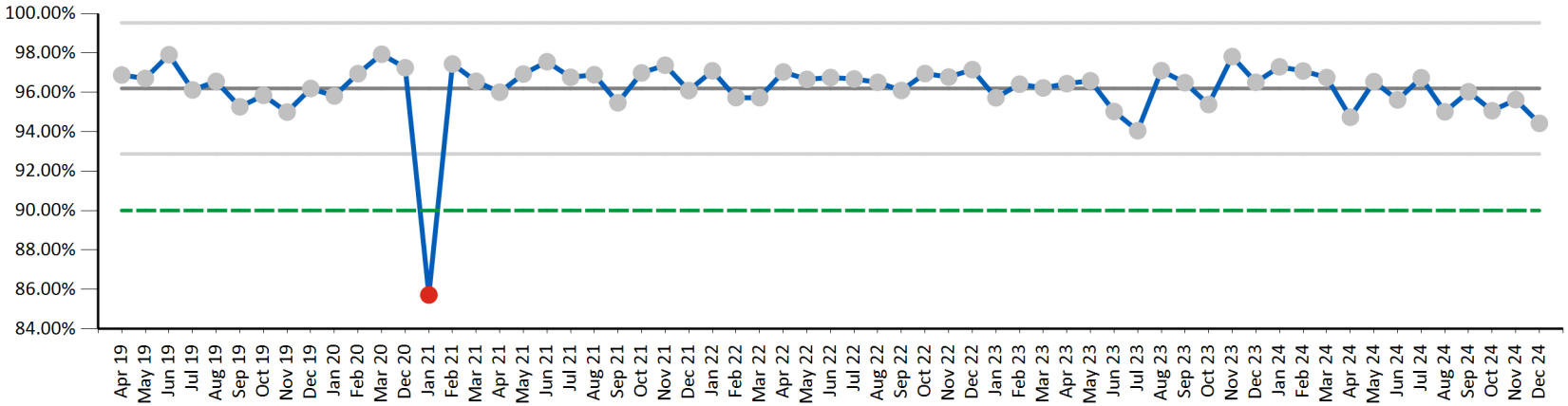
Plan	Actual
>= 30%	28.2%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	94.4%	Dec-24

Previous

Plan	Actual	Period
>= 90%	95.6%	Nov-24

Year to Date

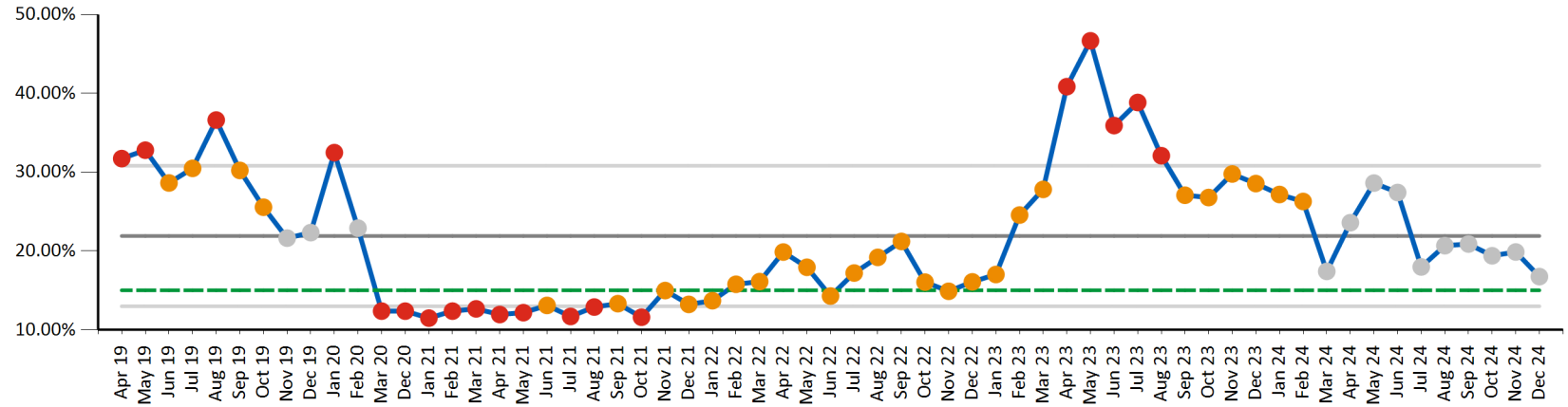
Plan	Actual
>= 90%	95.6%

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%	16.7%	Dec-24

Previous

Plan	Actual	Period
>= 15%	19.9%	Nov-24

Year to Date

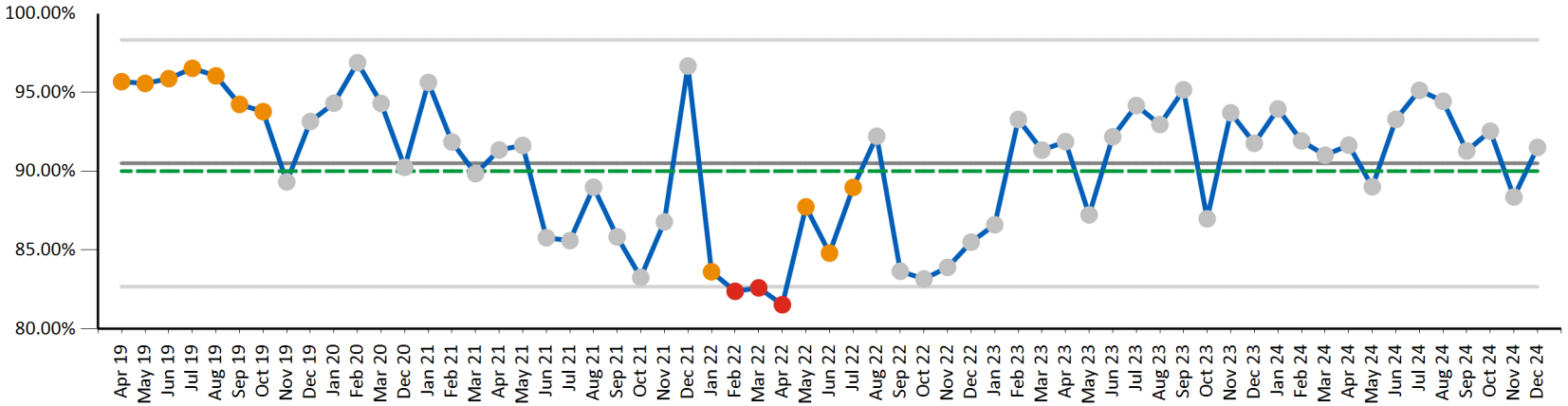
Plan	Actual
>= 15%	21.7%

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%	91.5%	Dec-24

Previous

Plan	Actual	Period
>= 90%	88.4%	Nov-24

Year to Date

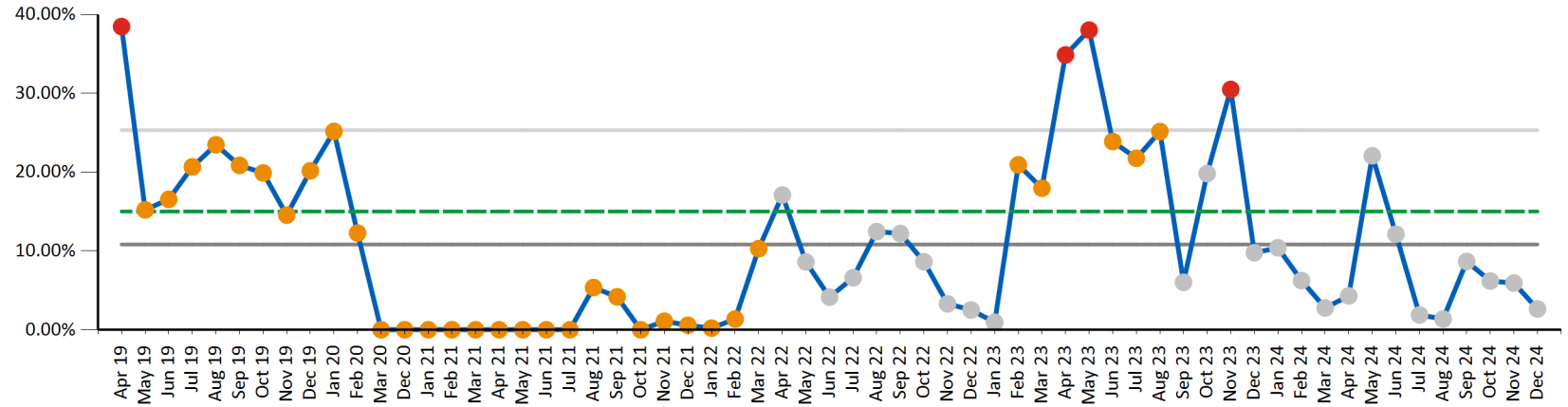
Plan	Actual
>= 90%	91.8%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 15%	2.6%	Dec-24

Previous

Plan	Actual	Period
>= 15%	5.9%	Nov-24

Year to Date

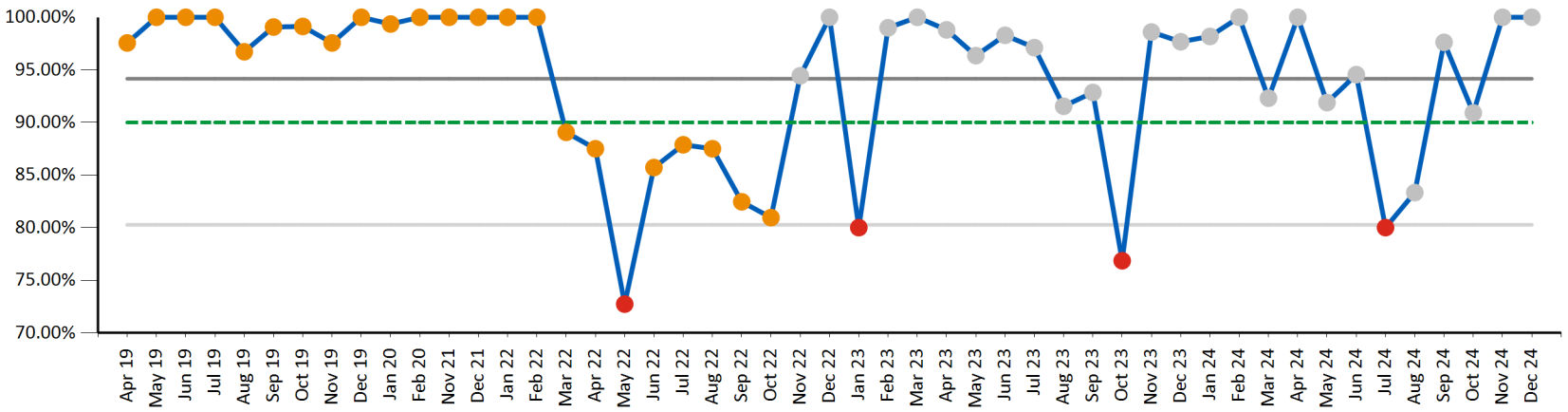
Plan	Actual
>= 15%	7.3%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 90%	100.0%	Dec-24

Previous

Plan	Actual	Period
>= 90%	100.0%	Nov-24

Year to Date

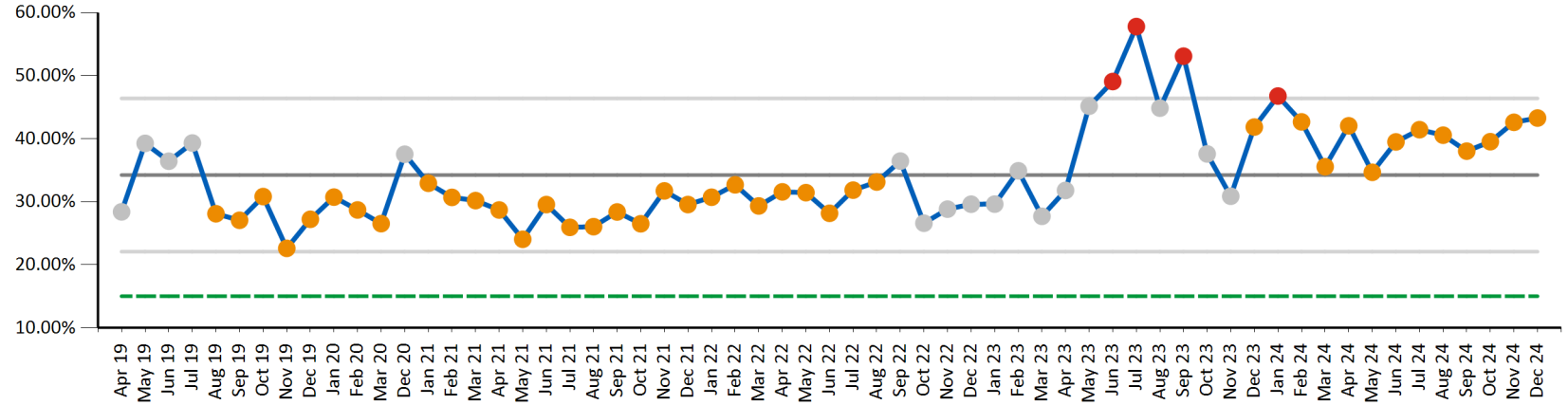
Plan	Actual
>= 90%	94.0%

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%	43.3%	Dec-24

Previous

Plan	Actual	Period
>= 15%	42.6%	Nov-24

Year to Date

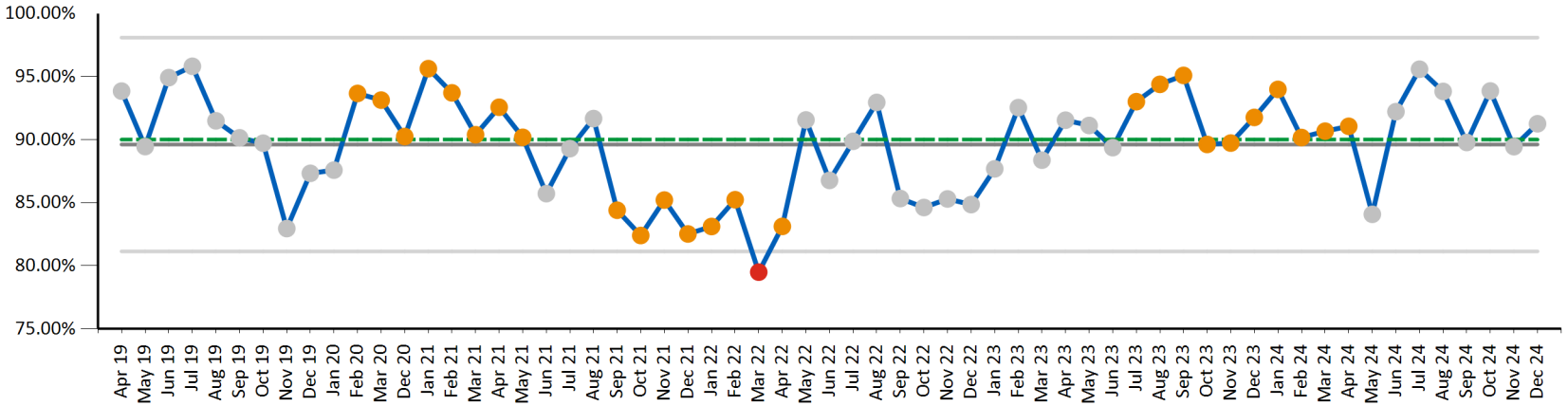
Plan	Actual
>= 15%	40.1%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 90%	91.3%	Dec-24

Previous

Plan	Actual	Period
>= 90%	89.4%	Nov-24

Year to Date

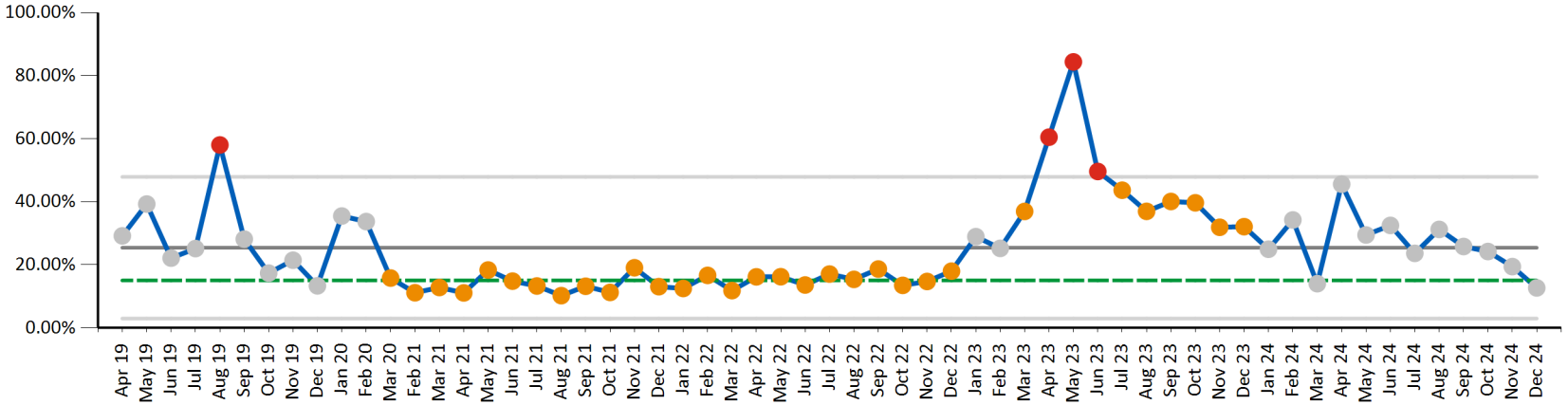
Plan	Actual
>= 90%	91.3%

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%	12.6%	Dec-24

Previous

Plan	Actual	Period
>= 15%	19.4%	Nov-24

Year to Date

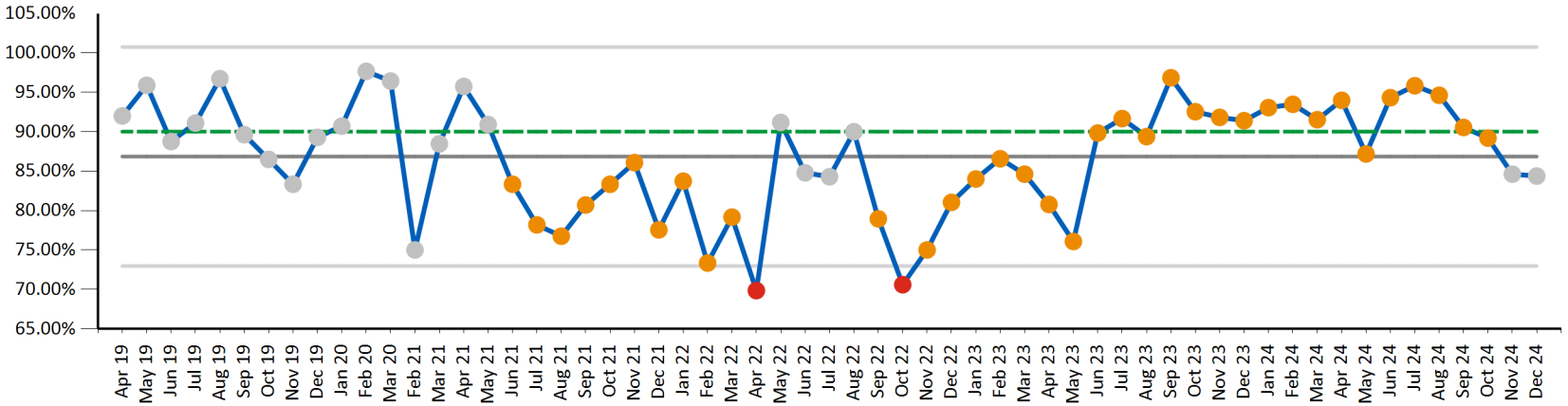
Plan	Actual
>= 15%	27.3%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 90%	84.4%	Dec-24

Previous

Plan	Actual	Period
>= 90%	84.6%	Nov-24

Year to Date

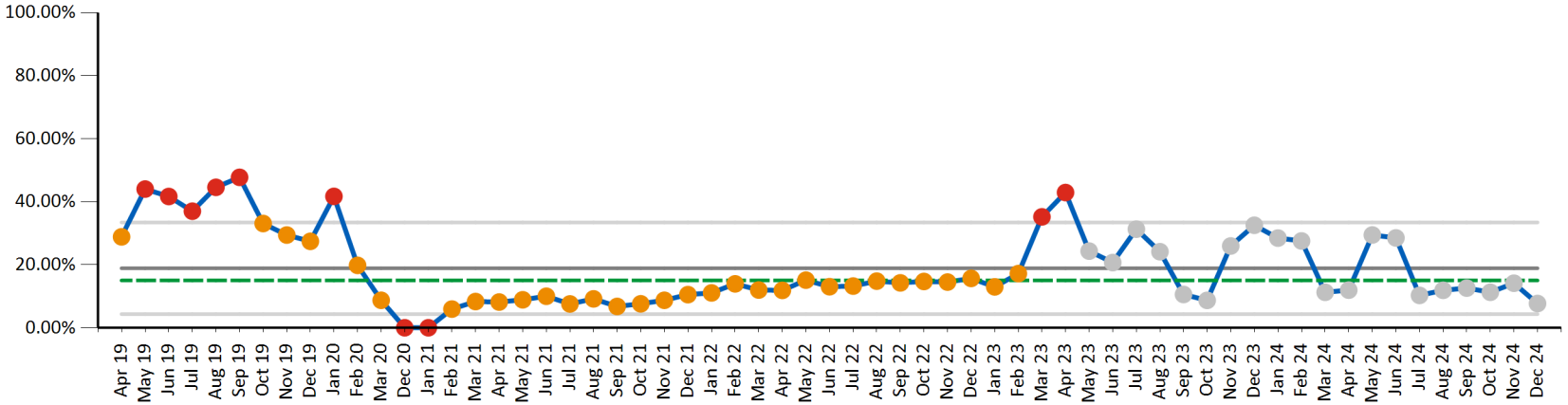
Plan	Actual
>= 90%	91.5%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 15%	7.7%	Dec-24

Previous

Plan	Actual	Period
>= 15%	14.1%	Nov-24

Year to Date

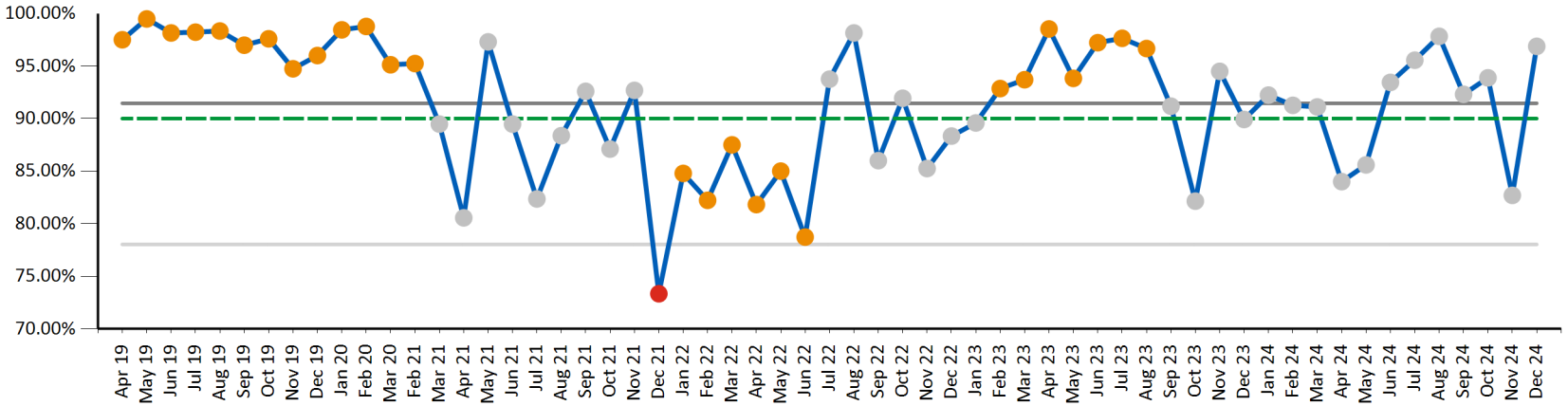
Plan	Actual
>= 15%	15.3%

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%	96.9%	Dec-24

Previous

Plan	Actual	Period
>= 90%	82.7%	Nov-24

Year to Date

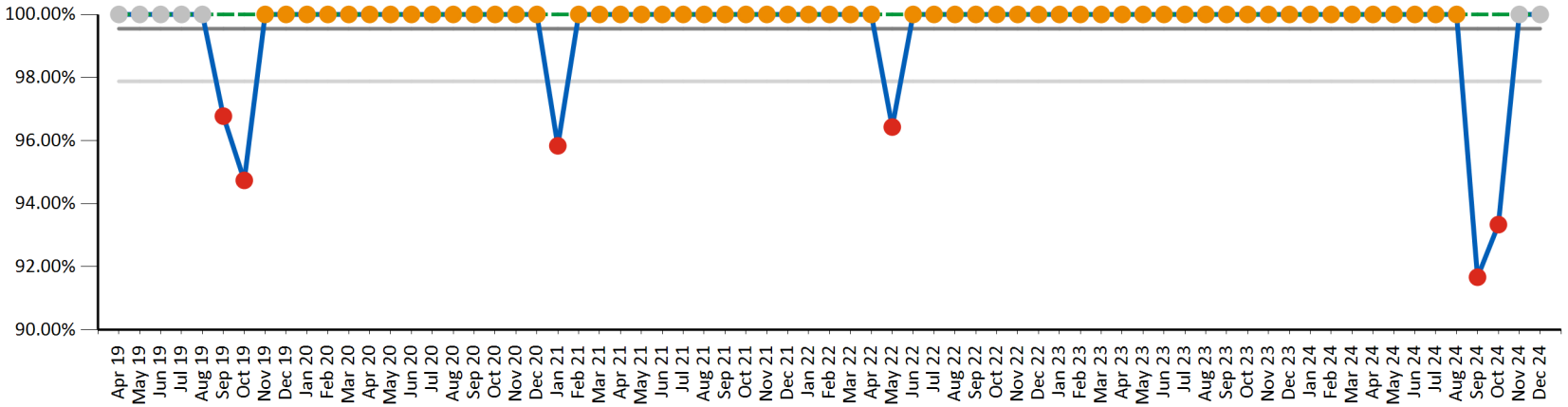
Plan	Actual
>= 90%	90.6%

89 - Formal complaints acknowledged within 3 working days

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	100.0%	Dec-24

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-24

Year to Date

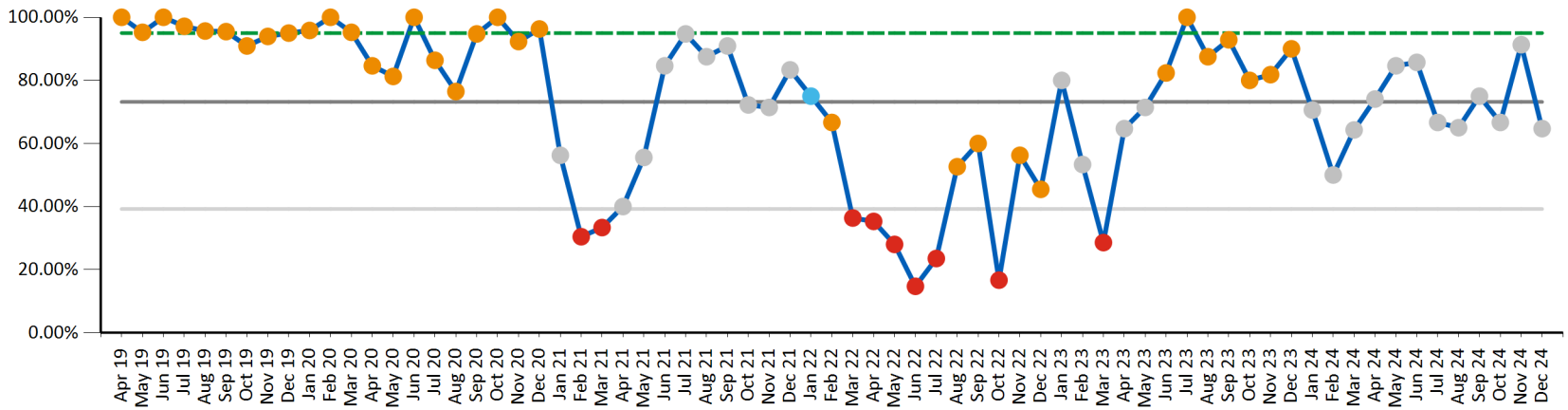
Plan	Actual
= 100%	98.4%

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%	64.7%	Dec-24

Previous

Plan	Actual	Period
>= 95%	91.3%	Nov-24

Year to Date

Plan	Actual
>= 95%	73.9%

Quality and Safety - Maternity

Bolton NHS Foundation Trust

Friends and Family Response Rate – Reported rate 16.7% following introduction of QR code. QR code content amended during month in response to patient feedback – text option now being considered. Overall maternity satisfaction rate in month has improved at 91.5% compared to last month 88.4%

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – Incidence 6.86/1000 births in December 2024 (3 cases and 1 case of compassionate termination). GMEC data highlights quarterly improvement in Trust performance compared to last quarter 3.12/1000 decreasing from 4.73/1000. A detailed review of all stillbirth cases 2023/2024 has been completed and is due to be presented to Quality Assurance Committee on the 22 January 2025 with a detailed action plan of ongoing actions. Current areas of ongoing improvement focus include aligning the Triage pathways with national guidance and implementation of all six elements of the saving babies lives care bundle version 3 (evidence based measures to improve perinatal mortality and morbidity outcomes).

¾ degree tears – £107k awarded for service to establish a GMEC perinatal pelvic health service at Bolton that will serve population of Bolton and receive referrals from other Trusts.

1:1 care in labour – Common cause variation in rate at 97.8% within month. Action plan in place as per CNST requirements.

Booked by 12+6 is a clinical indicator relating to the timing of the initial antenatal booking visit that ensures women access care in a timely way and are still in a position to have a scan and antenatal screening blood tests taken. Sustained improvement in the metric seen during 2024 attaining 91.4% in December 2024. Digital self-referral form progressing

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 60.2% continues to demonstrate sustained improvement in attainment.

Inductions of labour delayed by >24 hours – 33.3% of induction of labour cases by 24 hours were delayed in December 2024. Quality improvement project on G3/G4 in progress with daily oversight and monitoring. Quality improvement project ongoing with a time frame for completion of September 2025.

Breastfeeding initiation – Slight variation in month to 69.44% from 66.94%. Changes in team structure continue. Service has a plan in place to attain Baby Friendly stage 2 status by September 2025. New leader commenced in service.

Preterm birth (less than 37 weeks gestation) – Common cause variation in preterm incidence within month reported to 10.3%. Trust 12 month quarterly rate 9.44% increased from 7.69%. All Trusts notified in 2024 that the fetal fibronectin swab used to detect biomarkers of preterm labour was being discontinued and thus replacement Actim Partus point of care swab implemented as an alternative. Interim supply issues reported with Actim Partum during the transition period.

	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	6.86	Dec-24		<= 3.50	2.67	Nov-24	<= 3.50	4.18	

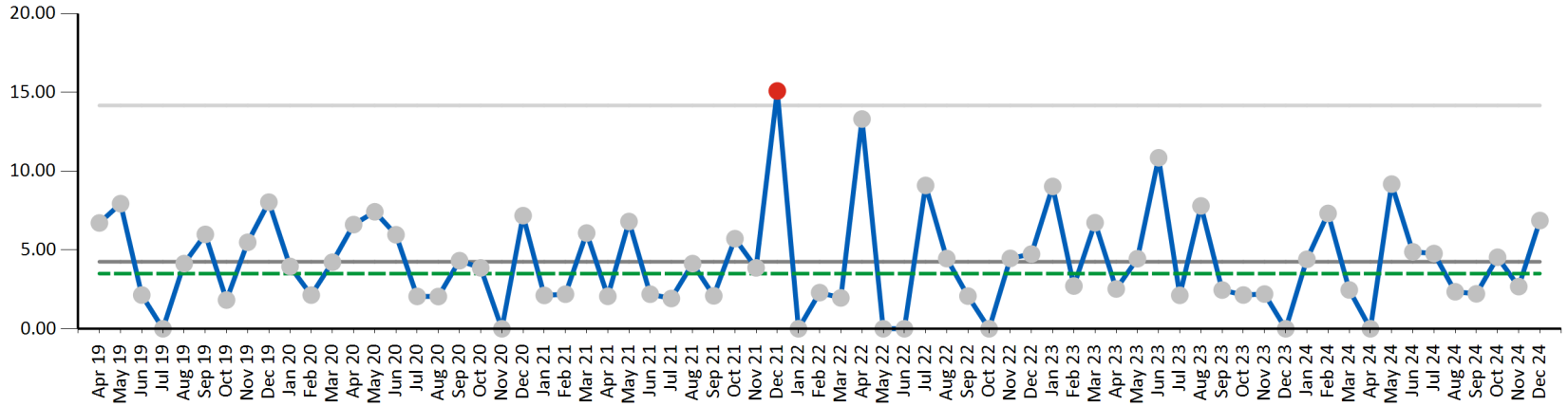
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
23 - Maternity -3rd/4th degree tears	<= 3.5%	3.5%	Dec-24		<= 3.5%	1.1%	Nov-24	<= 3.5%	2.6%	
202 - 1:1 Midwifery care in labour	>= 95.0%	97.8%	Dec-24		>= 95.0%	98.5%	Nov-24	>= 95.0%	98.8%	
203 - Booked 12+6	>= 90.0%	91.4%	Dec-24		>= 90.0%	89.3%	Nov-24	>= 90.0%	88.2%	
586 - Booked 10+0		60.2%	Dec-24			59.1%	Nov-24		54.7%	
204 - Inductions of labour - over 24 hours	<= 40%	33.3%	Dec-24		<= 40%	35.8%	Nov-24	<= 40%	32.8%	
210 - Initiation breast feeding	>= 65%	69.44%	Dec-24		>= 65%	66.94%	Nov-24	>= 65%	69.17%	
213 - Maternity complaints	<= 5	0	Dec-24		<= 5	0	Nov-24	<= 45	10	
319 - Maternal deaths (direct)	= 0	0	Dec-24		= 0	0	Nov-24	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	10.3%	Dec-24		<= 6%	7.7%	Nov-24	<= 6%	9.0%	

322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
<= 3.50	6.86	Dec-24

Previous

Plan	Actual	Period
<= 3.50	2.67	Nov-24

Year to Date

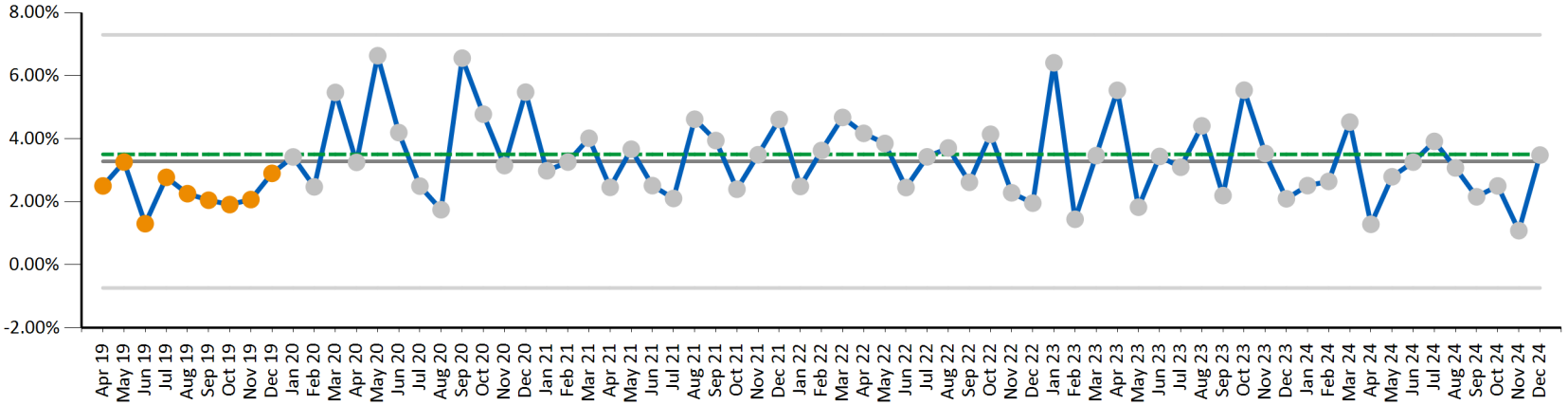
Plan	Actual
<= 3.50	4.18

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
<= 3.5%	3.5%	Dec-24

Previous

Plan	Actual	Period
<= 3.5%	1.1%	Nov-24

Year to Date

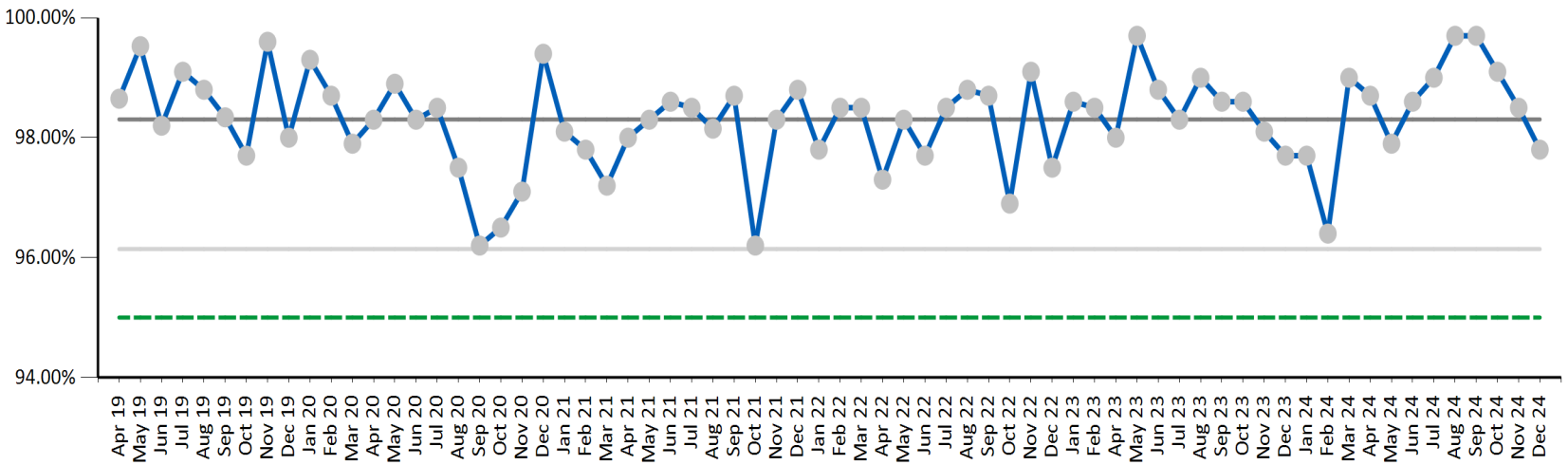
Plan	Actual
<= 3.5%	2.6%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	97.8%	Dec-24

Previous

Plan	Actual	Period
>= 95.0%	98.5%	Nov-24

Year to Date

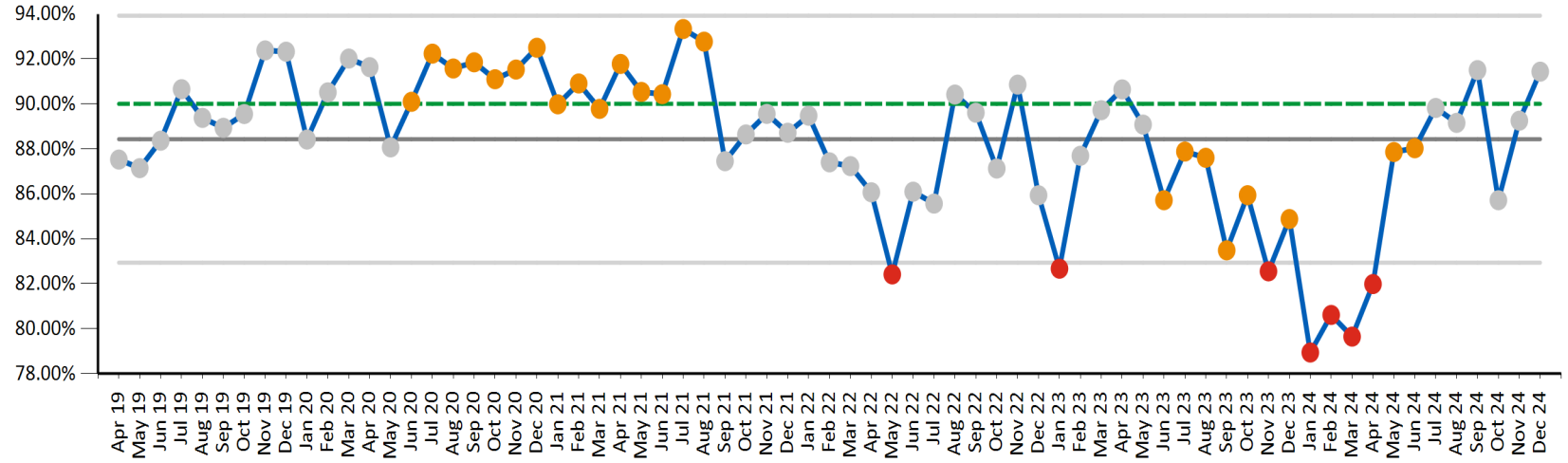
Plan	Actual
>= 95.0%	98.8%

203 - Booked 12+6

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90.0%	91.4%	Dec-24

Previous

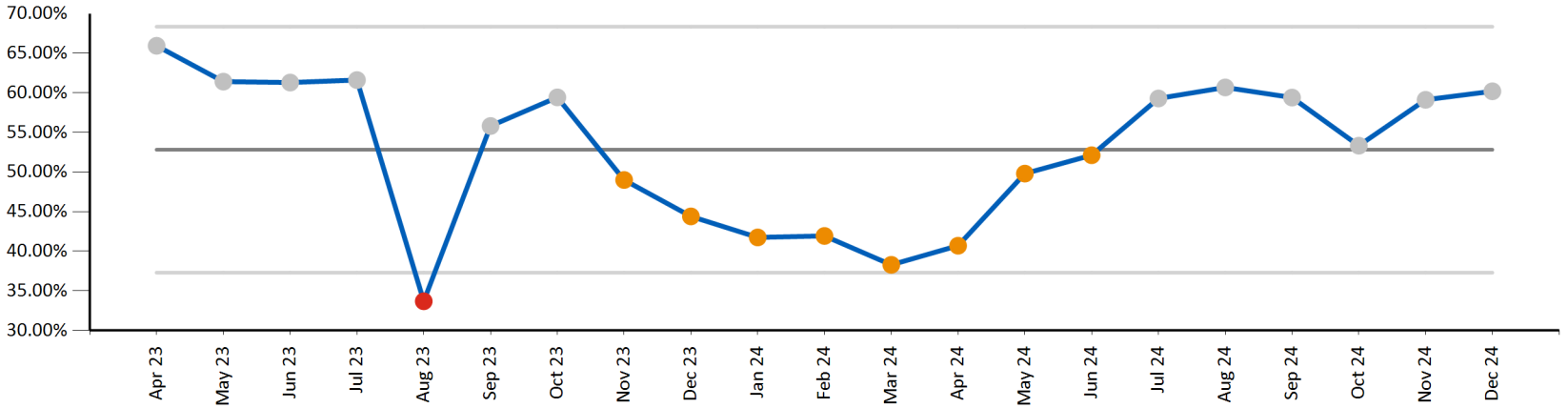
Plan	Actual	Period
>= 90.0%	89.3%	Nov-24

Year to Date

Plan	Actual
>= 90.0%	88.2%

586 - Booked 10+0

Common cause variation.



Latest

Plan	Actual	Period
	60.2%	Dec-24

Previous

Plan	Actual	Period
	59.1%	Nov-24

Year to Date

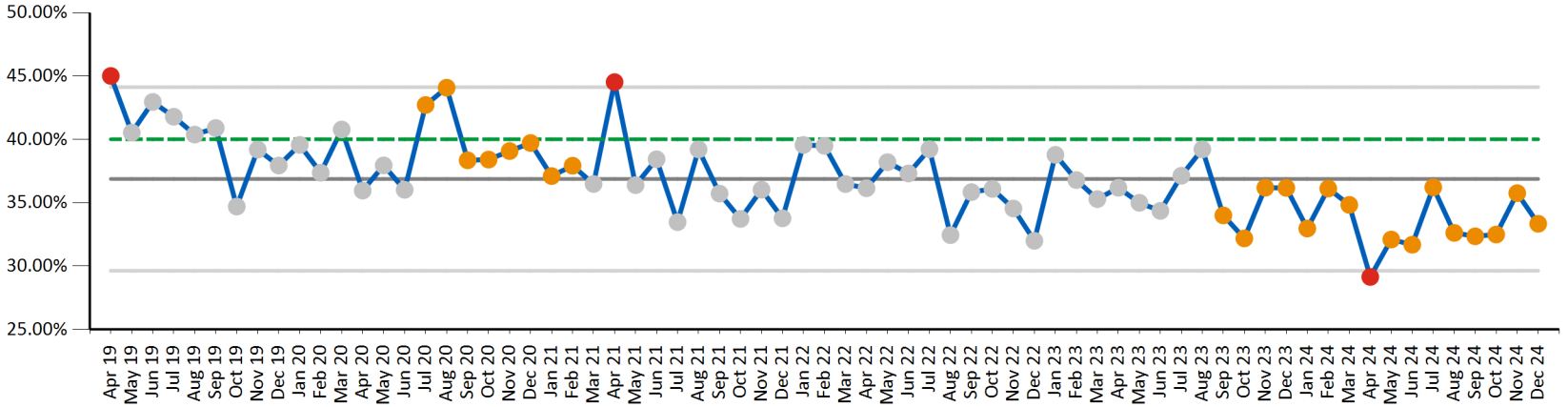
Plan	Actual
	54.7%

204 - Inductions of labour - over 24 hours

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 40%	33.3%	Dec-24

Previous

Plan	Actual	Period
<= 40%	35.8%	Nov-24

Year to Date

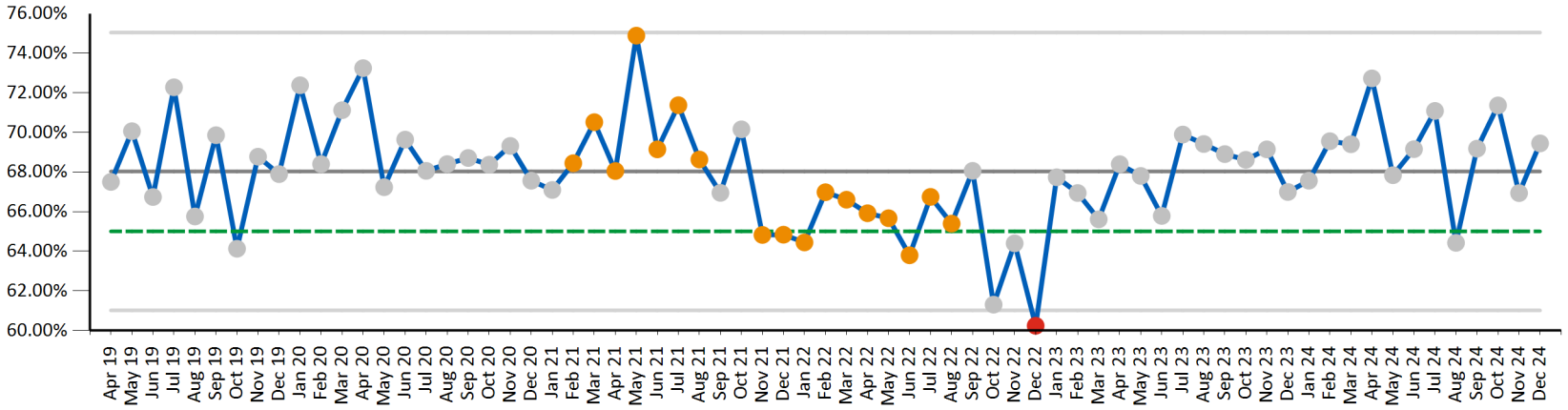
Plan	Actual
<= 40%	32.8%

210 - Initiation breast feeding

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 65%	69.44%	Dec-24

Previous

Plan	Actual	Period
>= 65%	66.94%	Nov-24

Year to Date

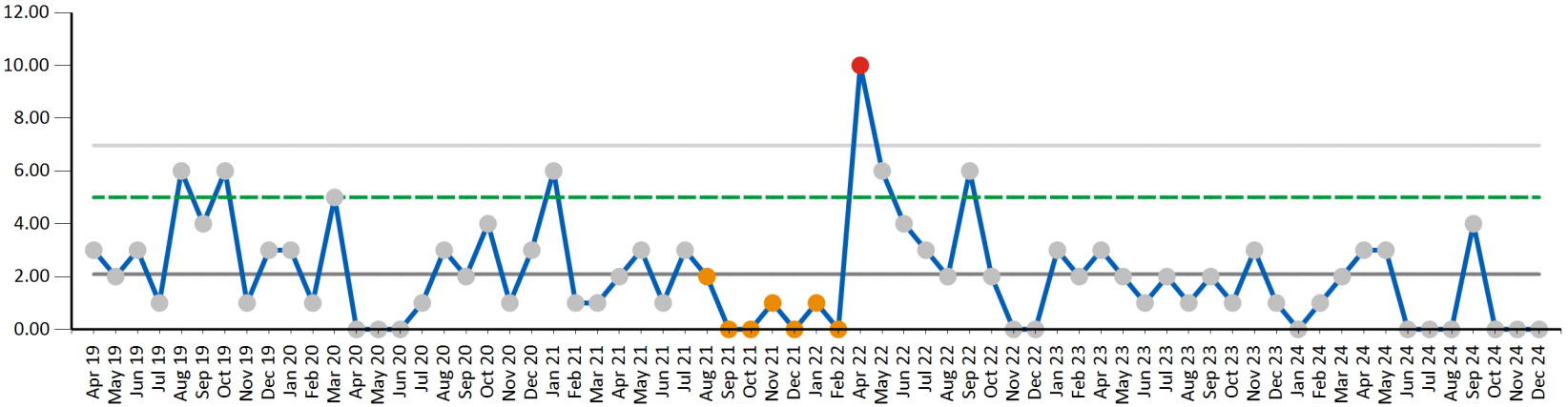
Plan	Actual
>= 65%	69.17%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	0	Dec-24

Previous

Plan	Actual	Period
<= 5	0	Nov-24

Year to Date

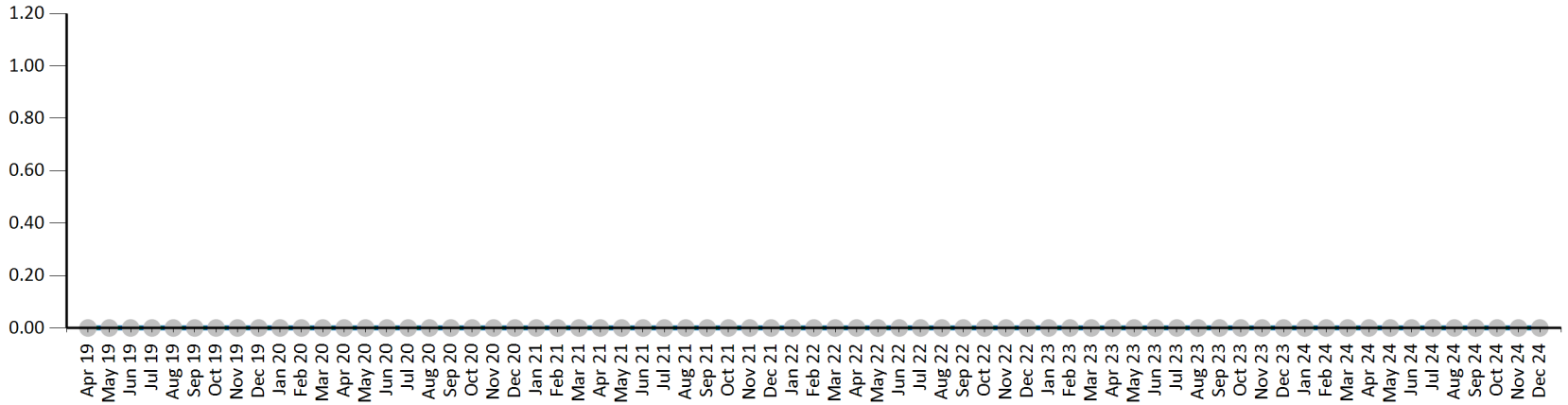
Plan	Actual
<= 45	10

319 - Maternal deaths (direct)

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
= 0	0	Dec-24

Previous

Plan	Actual	Period
= 0	0	Nov-24

Year to Date

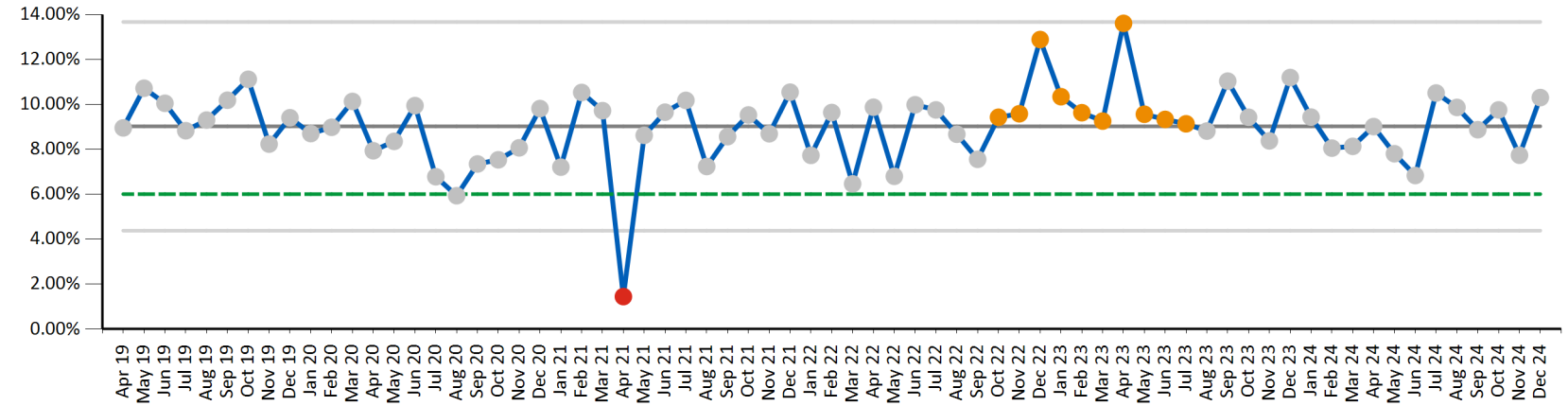
Plan	Actual
= 0	0

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 6%	10.3%	Dec-24

Previous

Plan	Actual	Period
<= 6%	7.7%	Nov-24

Year to Date

Plan	Actual
<= 6%	9.0%

Operational Performance - Urgent Care

NHS Bolton NHS Foundation Trust

Urgent Care

In December, performance against the all-types 4-hour standard was 61.6%, which is a decrease of 0.9% on November 2024. Attendances remained within common cause variation in relation to both walk in and ambulance arrivals. Ambulance handover within 15 minutes remained static at circa 44% whilst handover within 30 minutes improved to 73.4%. G&A occupancy rates decreased with additional seasonal inpatient capacity going live through December. Non-elective length of stay is largely static month-on-month and remains in common cause variation during a period where length of stay typically increases.

NOF

For December, our fractured neck of femur performance improved to 34.8%, with 17 of 46 eligible patients getting to theatre within the 36 hour window. Of the 29x patients who breached the target, the vast majority of the patients (23) related to delays due to theatre capacity, 3x related to optimisation of patients including anticoagulants, and 3x related to delays in the Emergency Department and transfer to a bed.

Performance against the 36-hour standard remains in line with the average across the country and Bolton performs well against GM peers for several key metrics. A paper outlining key required actions for sustained NOF improvement has been submitted to Clinical Governance and Quality Committee, and through to Quality Assurance Committee.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 73%	61.6%	Dec-24		>= 70%	62.5%	Nov-24	>= 73%	63.5%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	44.3%	Dec-24		>= 65.0%	44.8%	Nov-24	>= 65.0%	48.5%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	73.4%	Dec-24		>= 95.0%	72.7%	Nov-24	>= 95.0%	77.6%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	88.00%	Dec-24		= 100%	87.04%	Nov-24	= 100%	90.11%	F
539 - A&E 12 hour waits	= 0	1,360	Dec-24		= 0	1,242	Nov-24	= 0	10,953	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	34.8%	Dec-24	L	>= 75%	25.6%	Nov-24	>= 75%	32.5%	?
56 - Stranded patients - over 7 days	<= 200	296	Dec-24	H	<= 200	280	Nov-24	<= 200	296	?

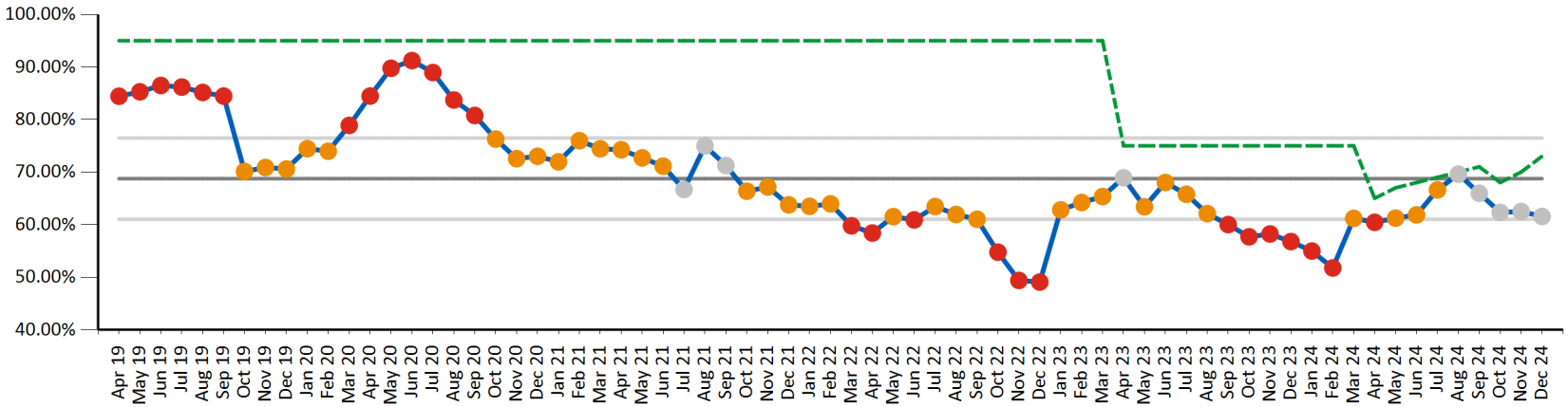
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	105	Dec-24		<= 69	98	Nov-24	<= 69	105	?
541 - Adult G&A bed occupancy	<= 92.0%	88.4%	Dec-24		<= 92.0%	91.9%	Nov-24	<= 92.0%	88.9%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	5.50	Dec-24		<= 3.70	5.39	Nov-24	<= 3.70	5.78	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	8.3%	Nov-24	L	<= 13.5%	10.1%	Oct-24	<= 13.5%	9.4%	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
>= 73%	61.6%	Dec-24

Previous

Plan	Actual	Period
>= 70%	62.5%	Nov-24

Year to Date

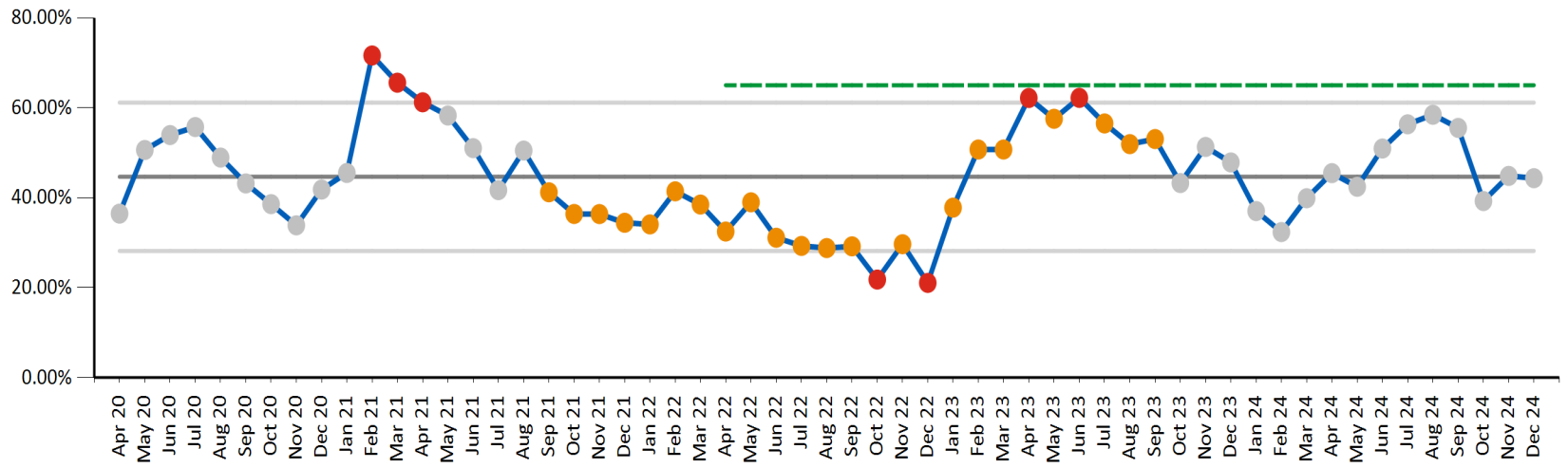
Plan	Actual
>= 73%	63.5%

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%	44.3%	Dec-24

Previous

Plan	Actual	Period
>= 65.0%	44.8%	Nov-24

Year to Date

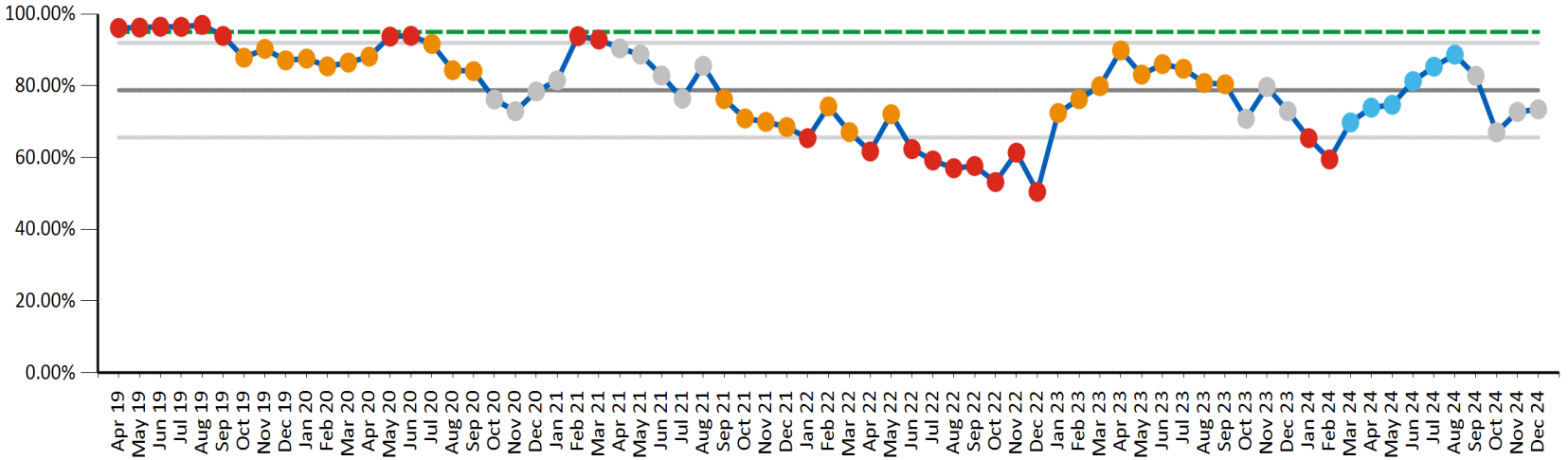
Plan	Actual
>= 65.0%	48.5%

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%	73.4%	Dec-24

Previous

Plan	Actual	Period
>= 95.0%	72.7%	Nov-24

Year to Date

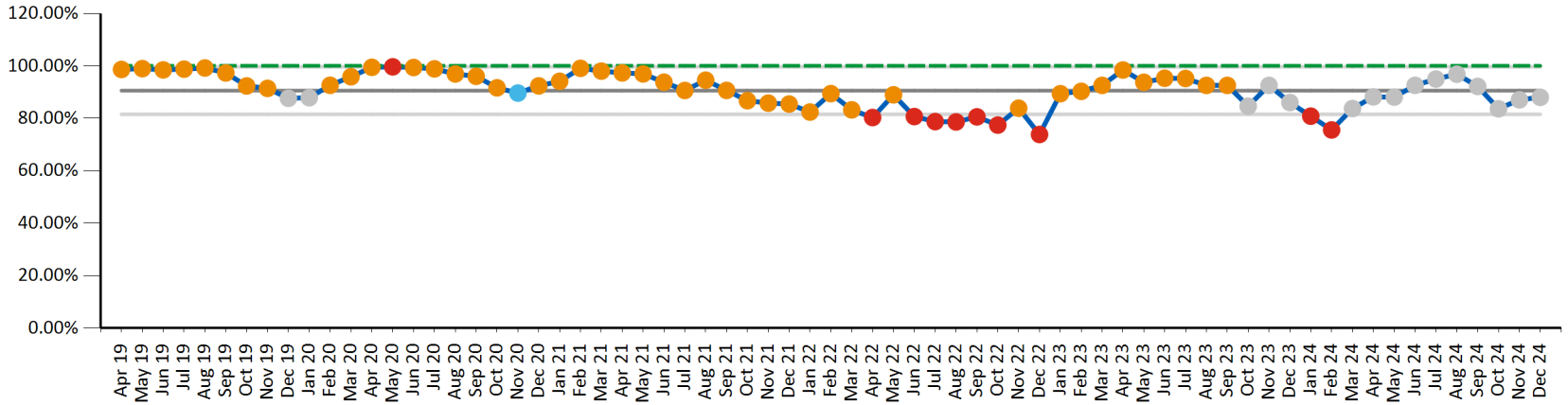
Plan	Actual
>= 95.0%	77.6%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 100%	88.00%	Dec-24

Previous

Plan	Actual	Period
= 100%	87.04%	Nov-24

Year to Date

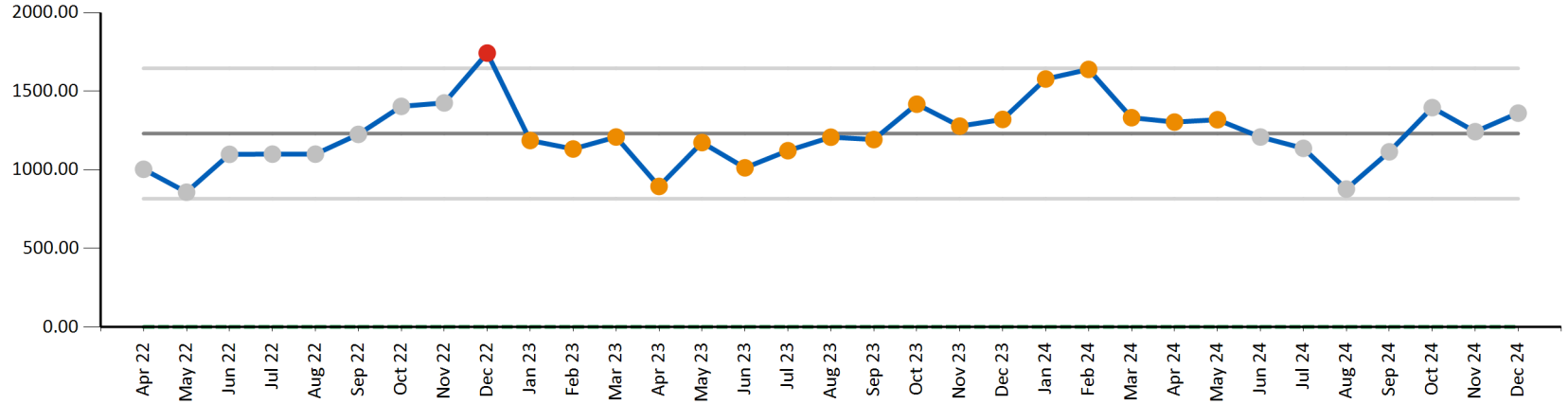
Plan	Actual
= 100%	90.11%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,360	Dec-24

Previous

Plan	Actual	Period
= 0	1,242	Nov-24

Year to Date

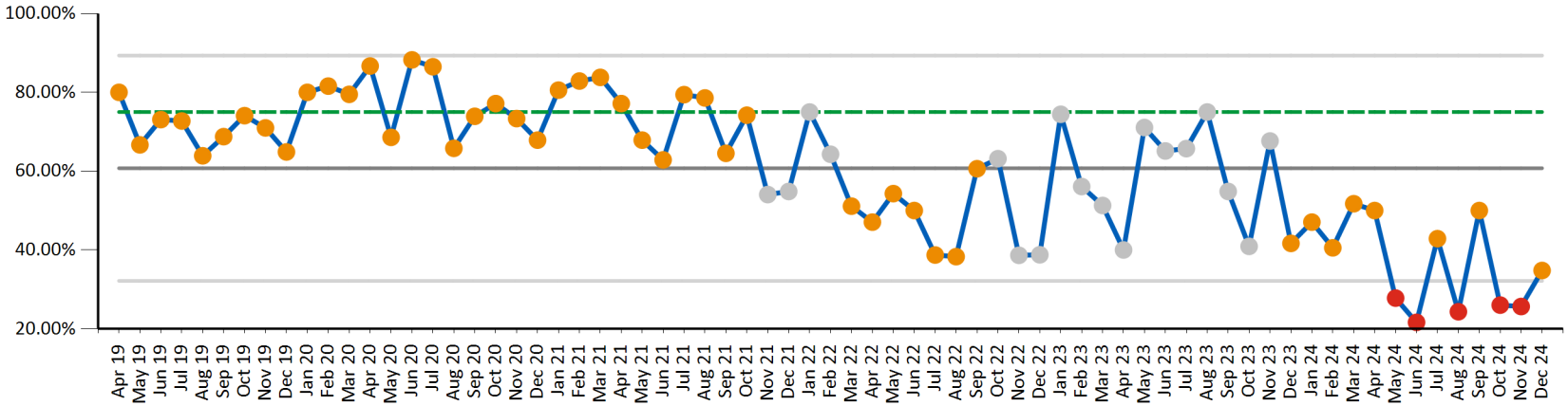
Plan	Actual
= 0	10,953

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%	34.8%	Dec-24

Previous

Plan	Actual	Period
>= 75%	25.6%	Nov-24

Year to Date

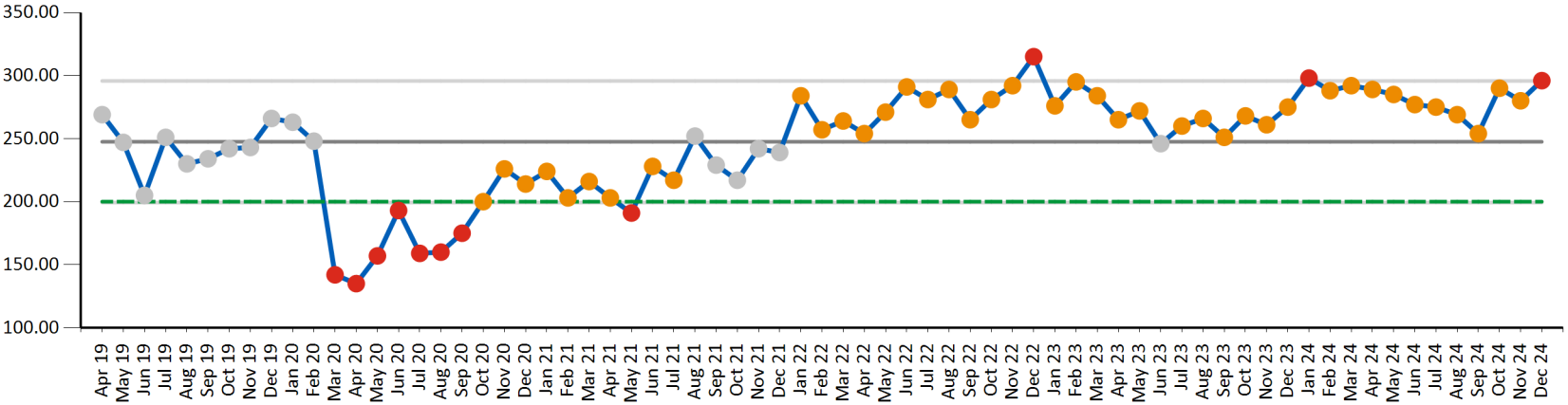
Plan	Actual
>= 75%	32.5%

56 - Stranded patients - over 7 days

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
<= 200	296	Dec-24

Previous

Plan	Actual	Period
<= 200	280	Nov-24

Year to Date

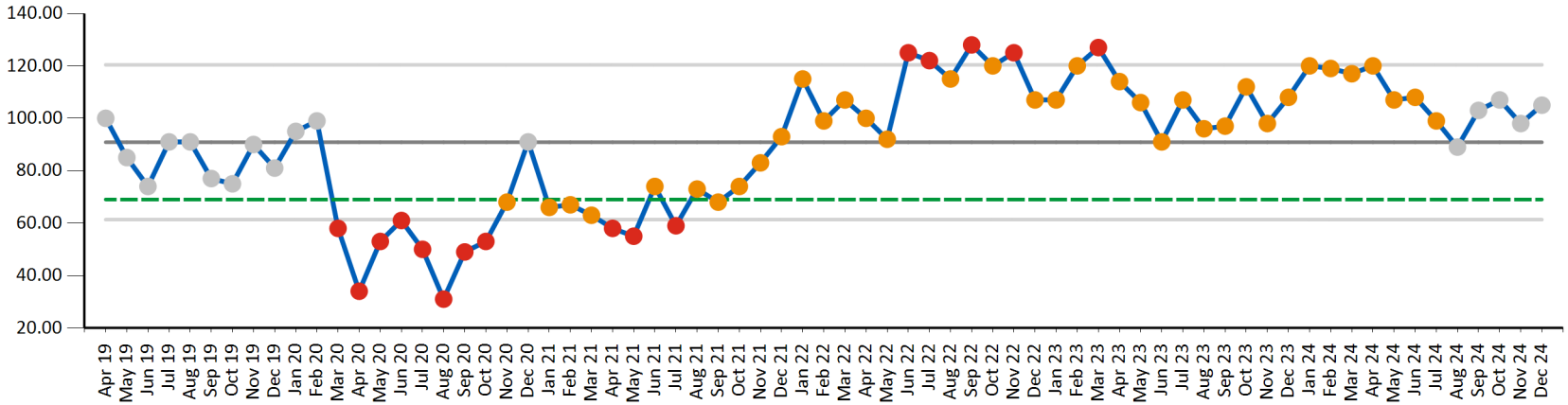
Plan	Actual
<= 200	296

307 - Stranded Patients - LOS 21 days and over

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 69	105	Dec-24

Previous

Plan	Actual	Period
<= 69	98	Nov-24

Year to Date

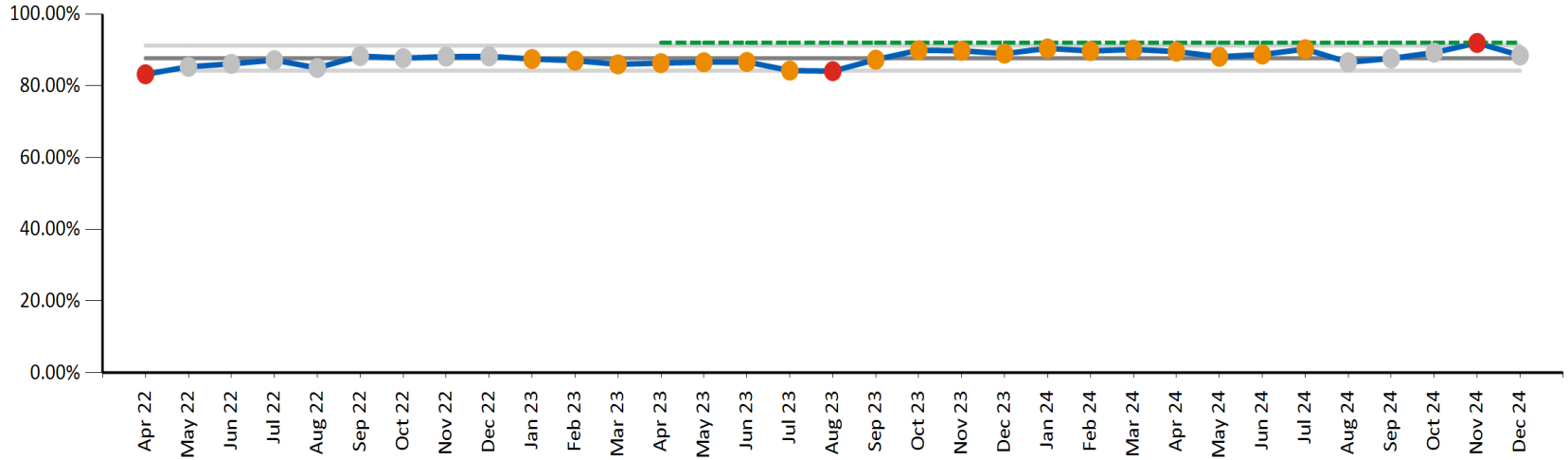
Plan	Actual
<= 69	105

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	88.4%	Dec-24

Previous

Plan	Actual	Period
<= 92.0%	91.9%	Nov-24

Year to Date

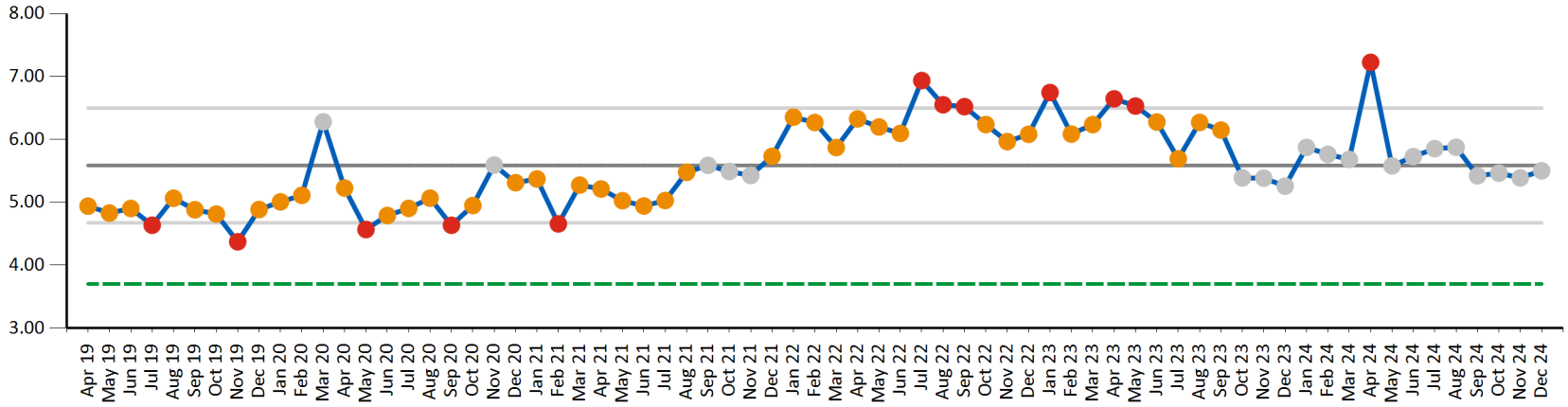
Plan	Actual
<= 92.0%	88.9%

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	5.50	Dec-24

Previous

Plan	Actual	Period
<= 3.70	5.39	Nov-24

Year to Date

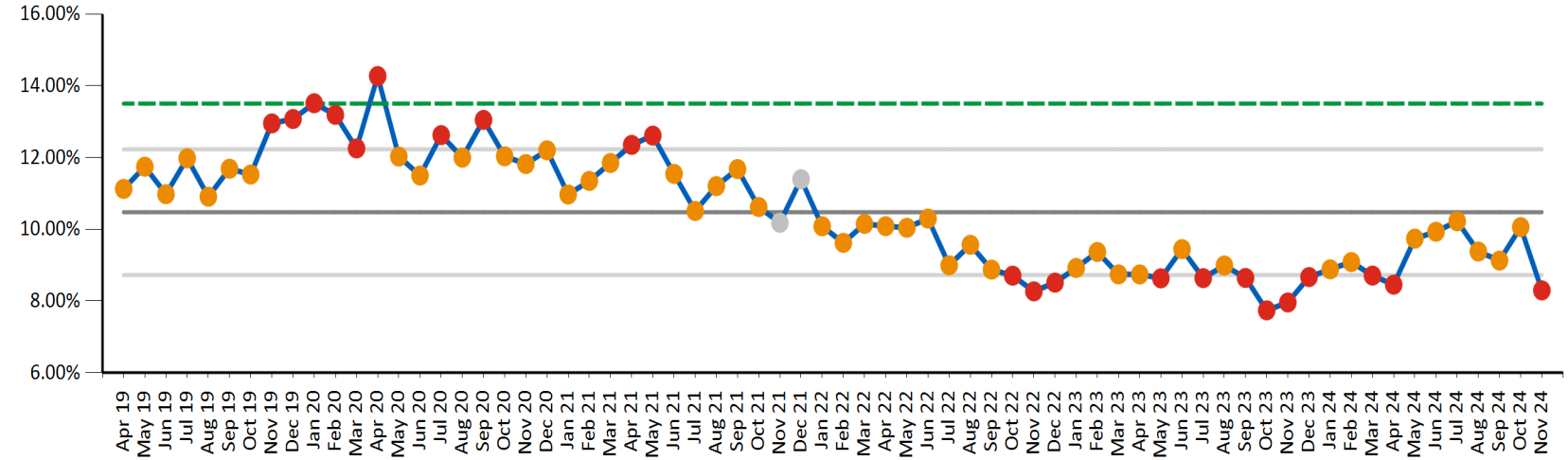
Plan	Actual
<= 3.70	5.78

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

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	8.3%	Nov-24

Previous

Plan	Actual	Period
<= 13.5%	10.1%	Oct-24

Year to Date

Plan	Actual
<= 13.5%	9.4%

Operational Performance - Elective Care

RTT
We finished December with 6x 78-week breaches:
- 6x were patients awaiting corneal graft material.

We had 0 104-week waiters at the end of December.
We finished December with 214x 65-week breaches. While this is not in line with our target of 189x patients waiting longer than 65-weeks, our December position reflects a significant improvement against October and November. Work will continue at pace to ensure that we can eliminate 65-week waiters as soon as possible.
We finished December with 1,619 52-week breaches. Over the course of the last 6 months we have managed to reduce this number by over 50%.

DM01
Performance remains outside of National standard at 18.5% against our recovery trajectory of 6% . However, individual specialities have provided updates and assurance that they are forecasted to attain the national standard of 5% by March 25. December is often a challenging month for capacity due to seasonal illness, staff annual leave and multiple bank holidays and this has had an impact upon capacity, and therefore performance despite plans to mitigate this where possible. In order to achieve our forecasted trajectory, specialities are utilising additional, short term resource in order to bring their performance back in line and continue to work towards the Trust recovery trajectory to meet the national standard of no more than 5% of our patients waiting over 6 weeks for a diagnostic procedure by March 25.

	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%	54.7%	Dec-24	L	>= 92%	54.2%	Nov-24	>= 92%	51.7%	F
314 - RTT 18 week waiting list	<= 38,064	41,310	Dec-24	H	<= 38,214	41,728	Nov-24	<= 38,064	41,310	P
42 - RTT 52 week waits (incomplete pathways)		1,619	Dec-24	L		1,899	Nov-24		24,745	
540 - RTT 65 week waits (incomplete pathways)	= 0	214	Dec-24	L	= 0	254	Nov-24	<= 4,613	4,909	F
526 - RTT 78 week waits (incomplete pathways)	= 0	6	Dec-24	L	= 0	6	Nov-24	= 0	140	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Dec-24	L	= 0	1	Nov-24	= 0	2	F
72 - Diagnostic Waits >6 weeks %	<= 5%	18.4%	Dec-24	L	<= 5%	14.3%	Nov-24	<= 5%	13.4%	F

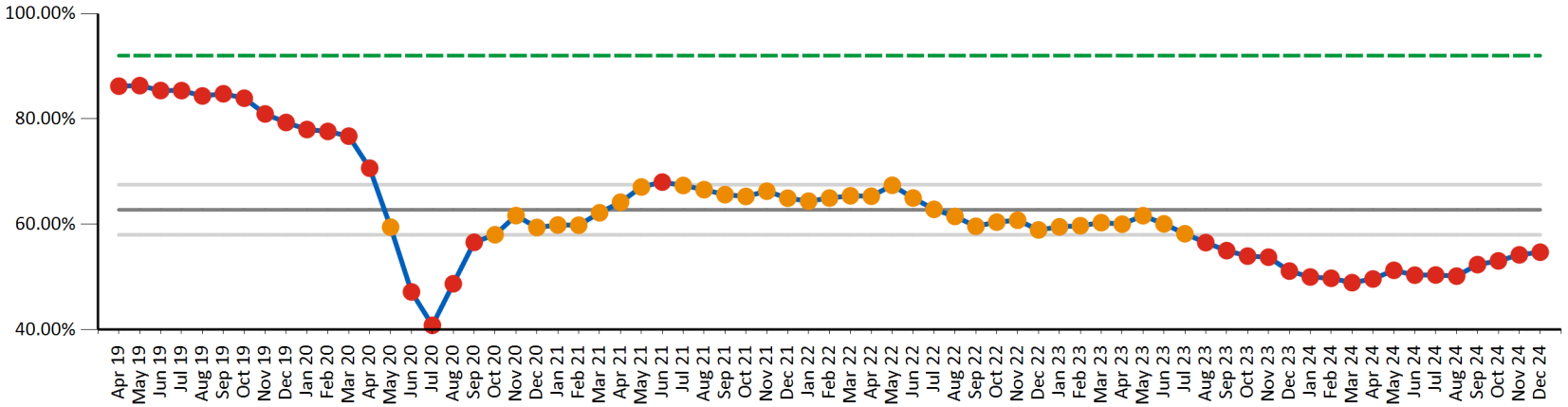
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
489 - Daycase Rates	>= 85%	81.1%	Dec-24		>= 85%	81.1%	Nov-24	>= 85%	82.3%	?
582 - Theatre Utilisation - Capped		74.5%	Dec-24			74.3%	Nov-24		74.1%	
583 - Theatre Utilisation - Uncapped		77.7%	Dec-24	L		78.2%	Nov-24		78.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.0%	Oct-24		<= 1%	2.5%	Sep-24	<= 1%	1.6%	?
62 - Cancelled operations re-booked within 28 days	= 100%	80.3%	Sep-24		= 100%	60.0%	Aug-24	= 100%	27.8%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.26	Dec-24		<= 2.00	2.47	Nov-24	<= 2.00	2.93	?
309 - DNA Rate - New	<= 6.3%	10.9%	Dec-24	H	<= 6.3%	9.8%	Nov-24	<= 6.3%	9.9%	F
310 - DNA Rate - Follow up	<= 5.0%	9.0%	Dec-24		<= 5.0%	8.3%	Nov-24	<= 5.0%	8.7%	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%	54.7%	Dec-24

Previous

Plan	Actual	Period
>= 92%	54.2%	Nov-24

Year to Date

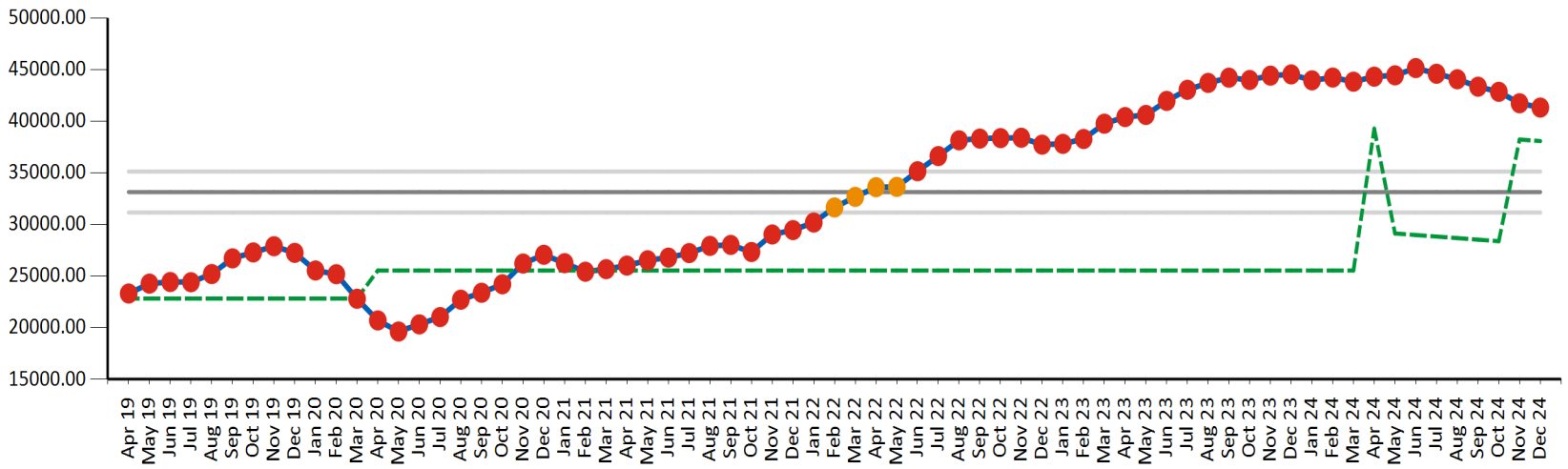
Plan	Actual
>= 92%	51.7%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

0/6



Latest

Plan	Actual	Period
<= 38,064	41,310	Dec-24

Previous

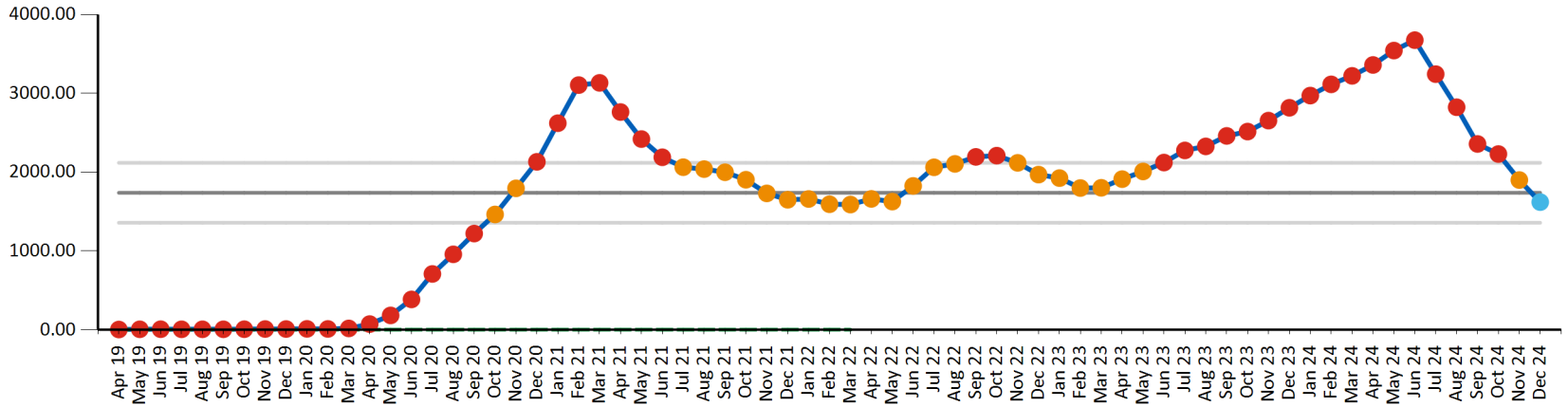
Plan	Actual	Period
<= 38,214	41,728	Nov-24

Year to Date

Plan	Actual
<= 38,064	41,310

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1,619	Dec-24

Previous

Plan	Actual	Period
	1,899	Nov-24

Year to Date

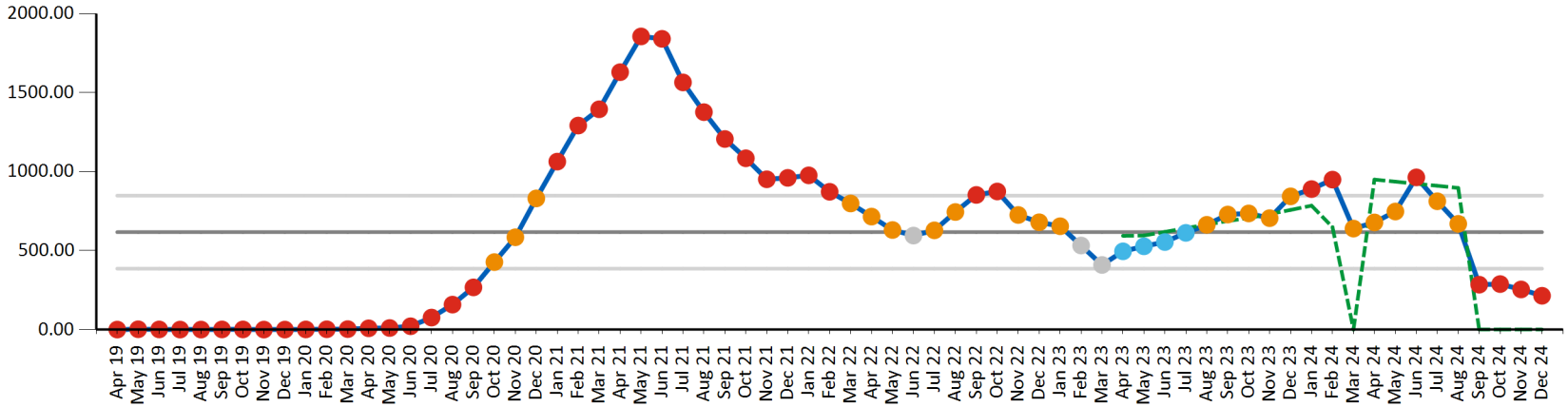
Plan	Actual
	24,745

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6



Latest

Plan	Actual	Period
= 0	214	Dec-24

Previous

Plan	Actual	Period
= 0	254	Nov-24

Year to Date

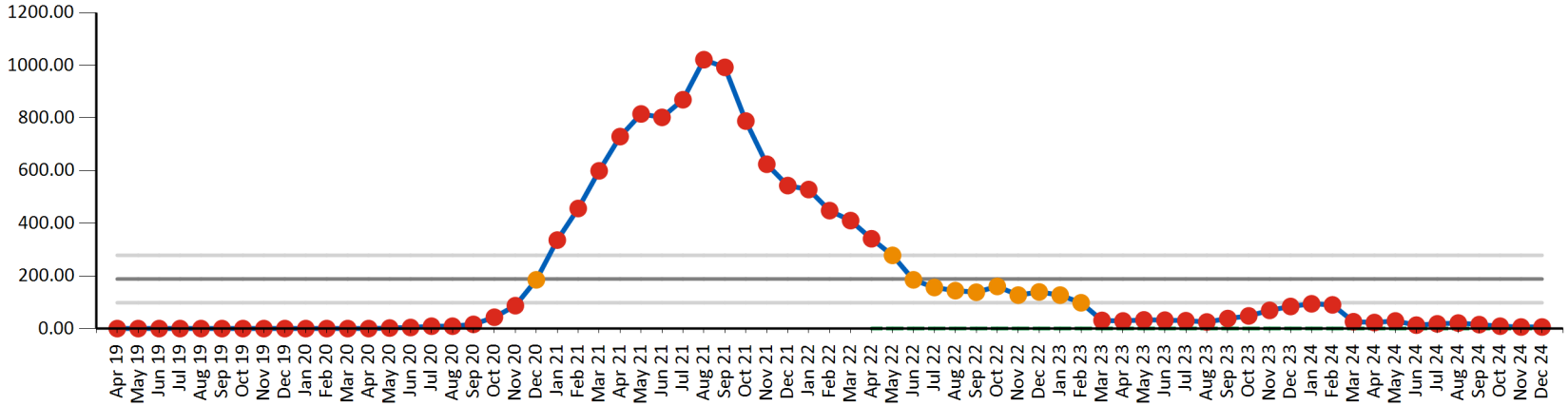
Plan	Actual
<= 4,613	4,909

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	6	Dec-24

Previous

Plan	Actual	Period
= 0	6	Nov-24

Year to Date

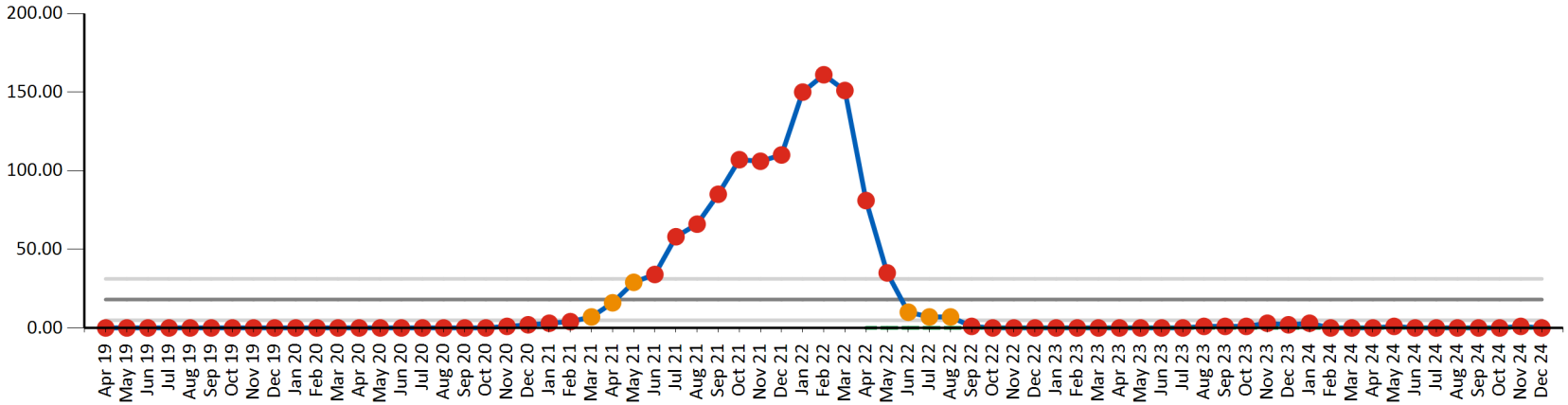
Plan	Actual
= 0	140

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	Dec-24

Previous

Plan	Actual	Period
= 0	1	Nov-24

Year to Date

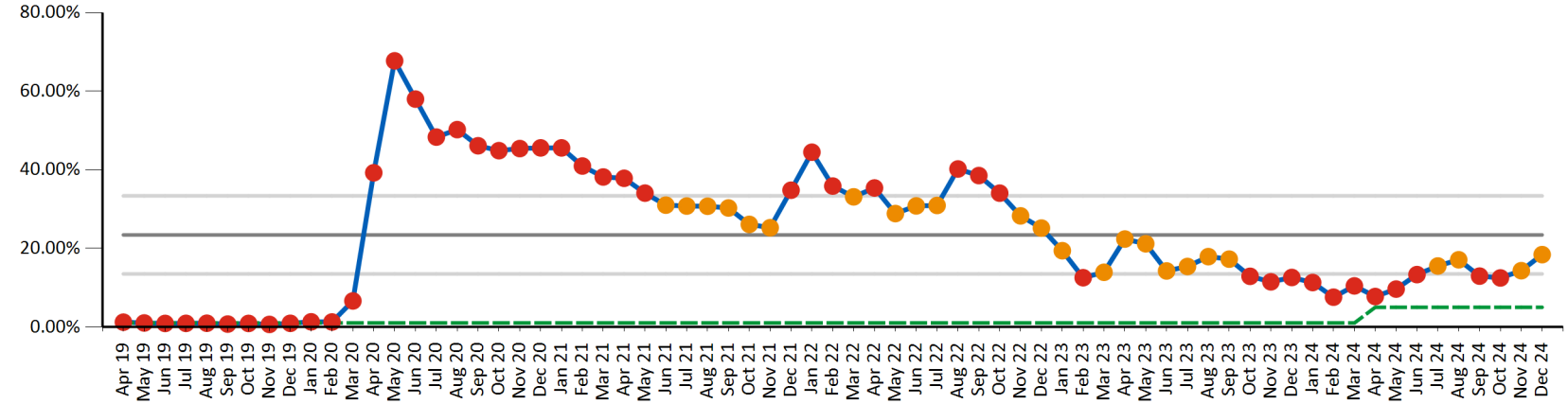
Plan	Actual
= 0	2

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5%	18.4%	Dec-24

Previous

Plan	Actual	Period
<= 5%	14.3%	Nov-24

Year to Date

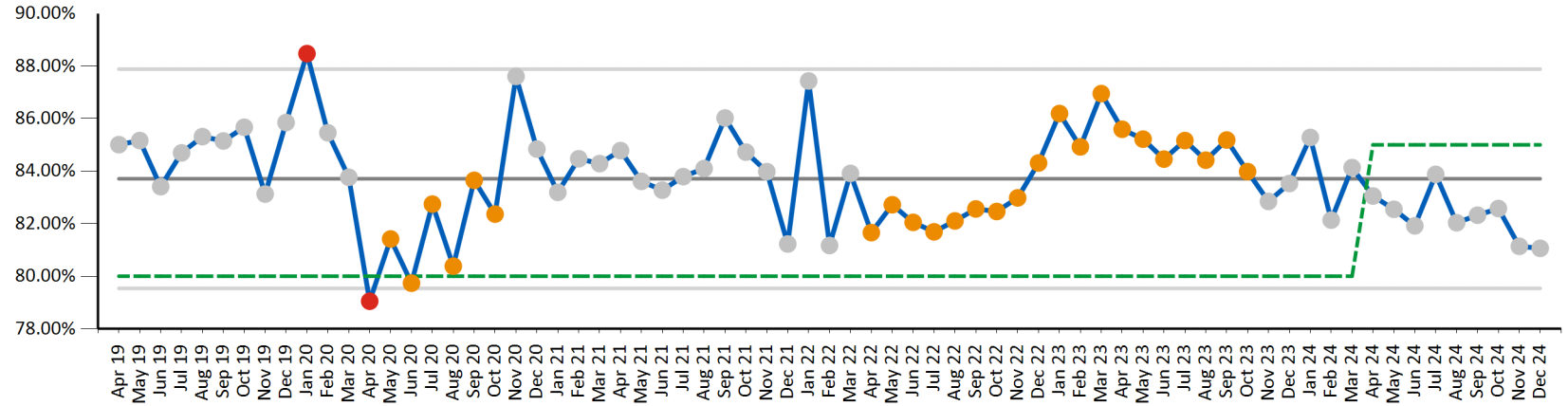
Plan	Actual
<= 5%	13.4%

489 - Daycase Rates

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 85%	81.1%	Dec-24

Previous

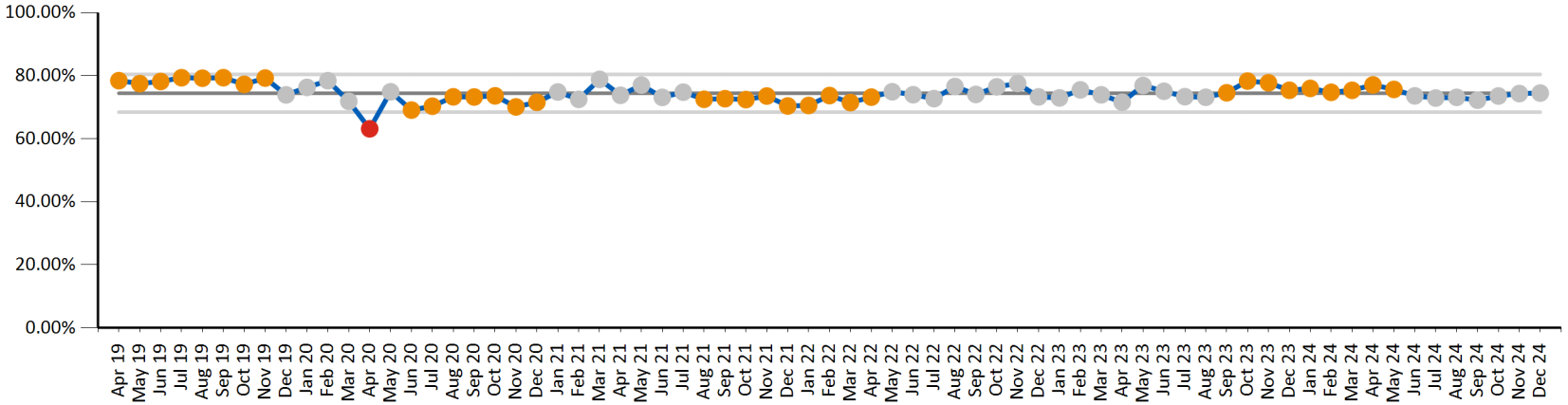
Plan	Actual	Period
>= 85%	81.1%	Nov-24

Year to Date

Plan	Actual
>= 85%	82.3%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	74.5%	Dec-24

Previous

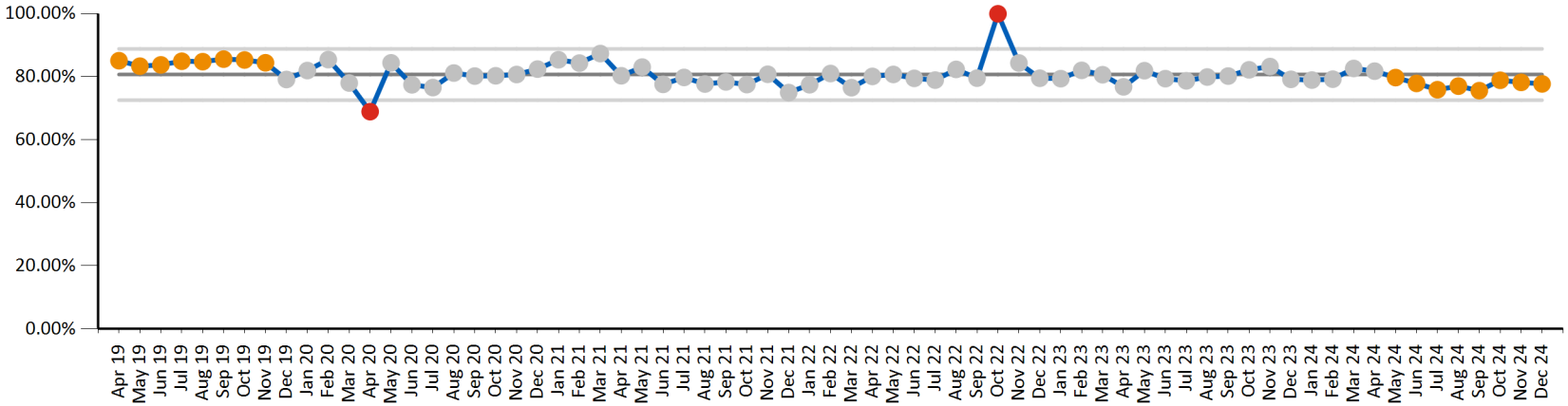
Plan	Actual	Period
	74.3%	Nov-24

Year to Date

Plan	Actual
	74.1%

583 - Theatre Utilisation - Uncapped

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	77.7%	Dec-24

Previous

Plan	Actual	Period
	78.2%	Nov-24

Year to Date

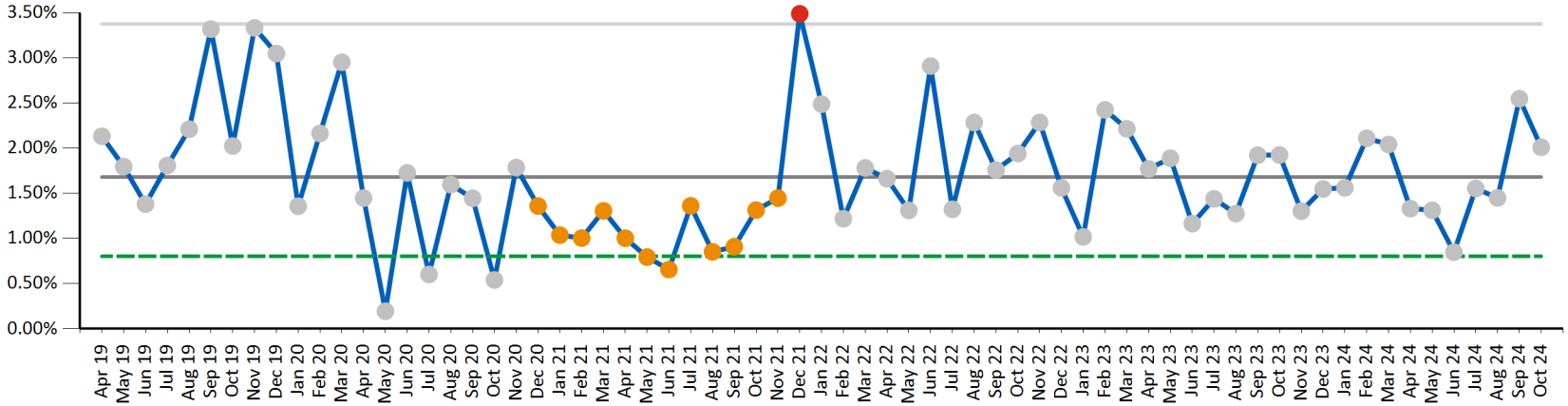
Plan	Actual
	78.0%

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

Common cause variation.

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

0/6



Latest

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

Previous

Plan	Actual	Period
<= 1%	2.5%	Sep-24

Year to Date

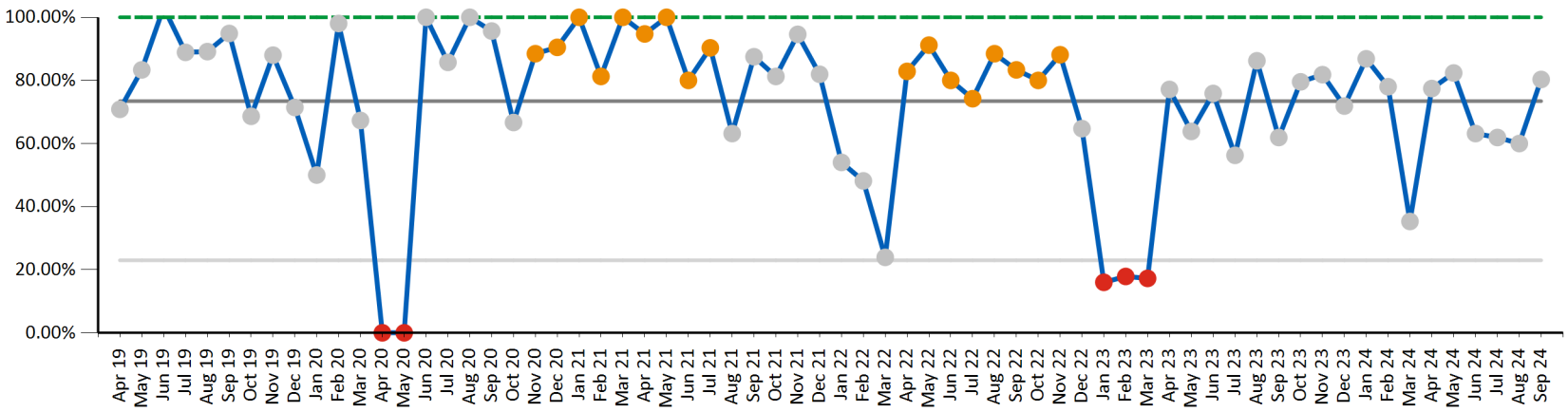
Plan	Actual
<= 1%	1.6%

62 - Cancelled operations re-booked within 28 days

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
= 100%	80.3%	Sep-24

Previous

Plan	Actual	Period
= 100%	60.0%	Aug-24

Year to Date

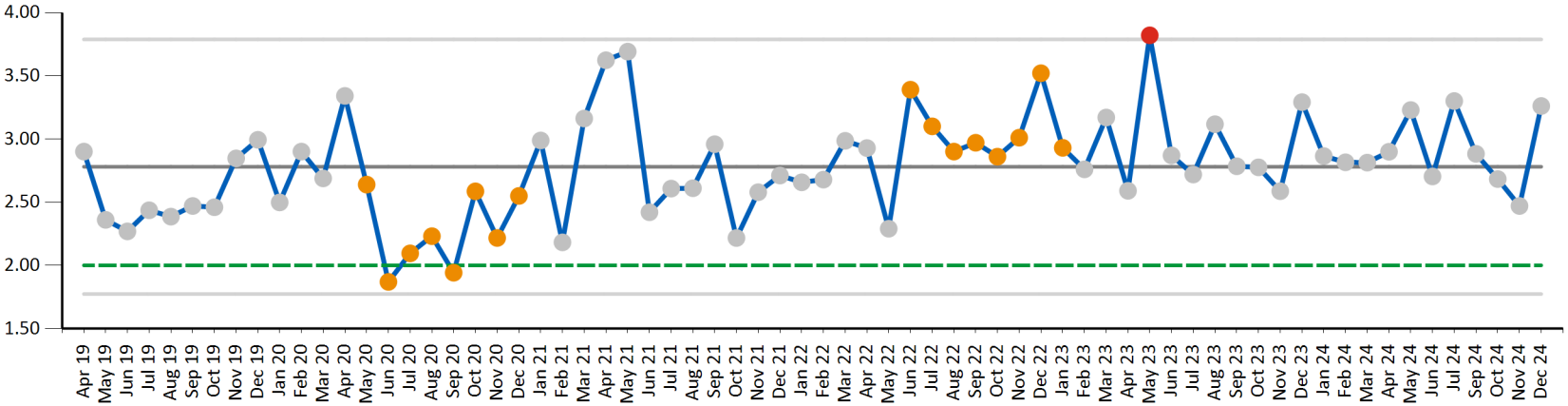
Plan	Actual
= 100%	27.8%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
<= 2.00	3.26	Dec-24

Previous

Plan	Actual	Period
<= 2.00	2.47	Nov-24

Year to Date

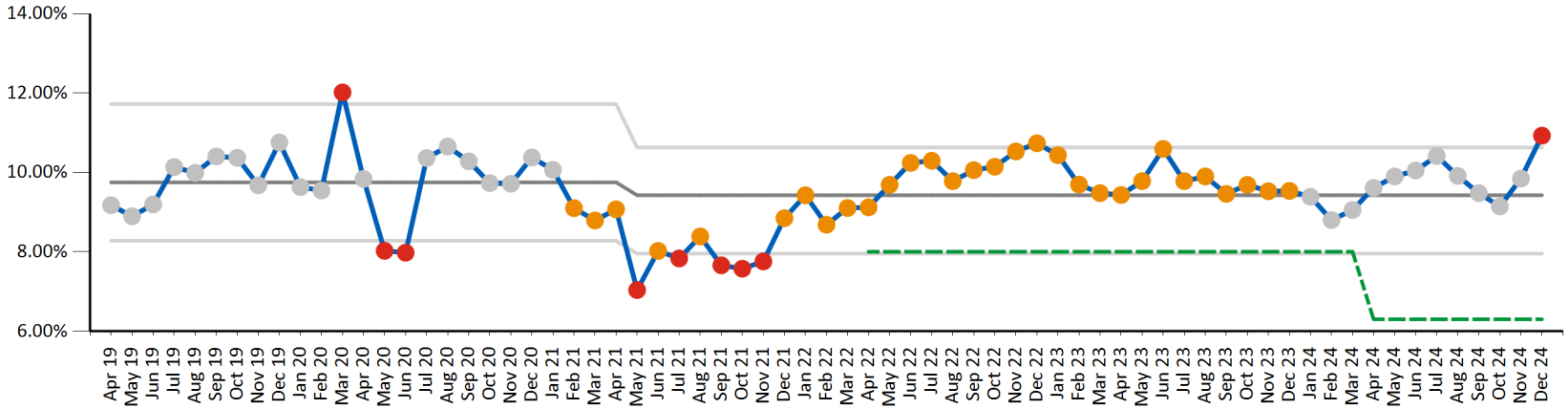
Plan	Actual
<= 2.00	2.93

309 - DNA Rate - New

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	10.9%	Dec-24

Previous

Plan	Actual	Period
<= 6.3%	9.8%	Nov-24

Year to Date

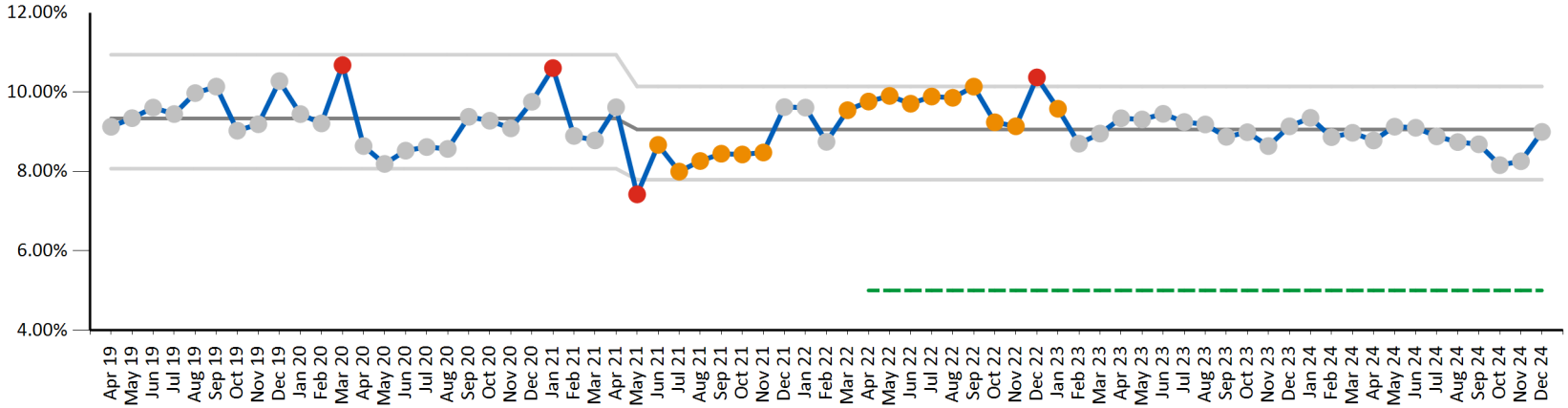
Plan	Actual
<= 6.3%	9.9%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.0%	Dec-24

Previous

Plan	Actual	Period
<= 5.0%	8.3%	Nov-24

Year to Date

Plan	Actual
<= 5.0%	8.7%

Operational Performance - Cancer

Bolton NHS Foundation Trust

For November, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We also achieved performance the 62-day standard for November, and it is expected that we will achieve performance in December. All specialties have recovery actions in place to return to sustained performance. Achievement in December would signify 6 months of achievement of all standards, which has not been achieved since before the pandemic.

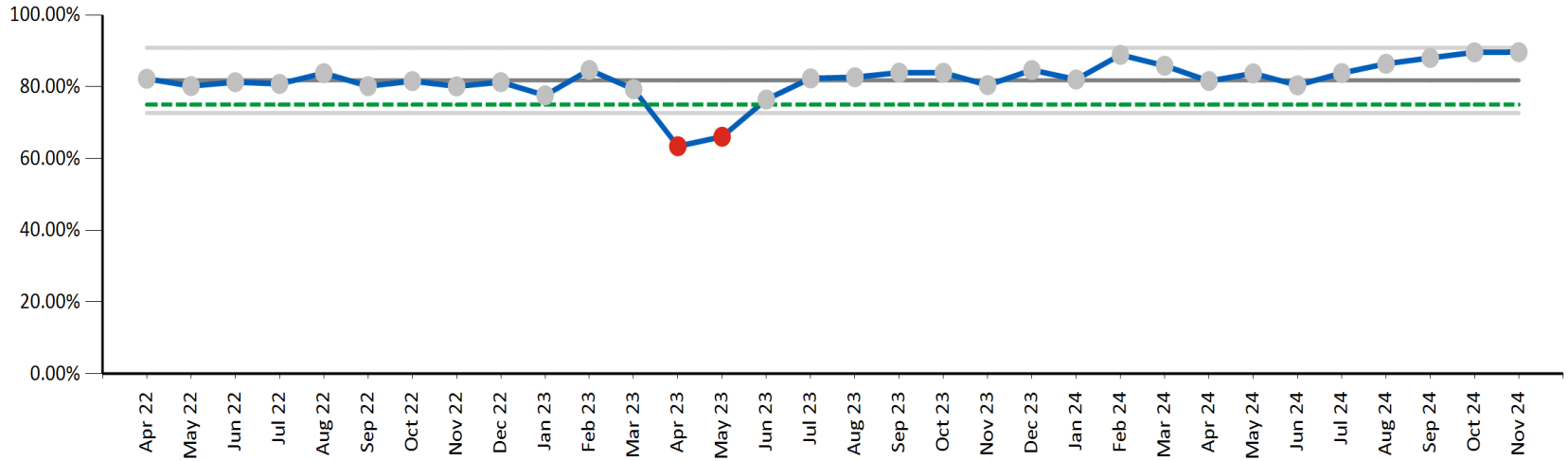
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	89.6%	Nov-24		>= 75.0%	89.6%	Oct-24	>= 75.0%	85.3%	
584 - 31 Day General Treatment Standard	>= 96%	99.2%	Nov-24		>= 96%	100.0%	Oct-24	>= 96%	99.0%	
585 - 62 Day General Standard	>= 85%	85.2%	Nov-24		>= 85%	86.2%	Oct-24	>= 85%	83.5%	

542 - Cancer: 28 day faster diagnosis

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
>= 75.0%	89.6%	Nov-24

Previous

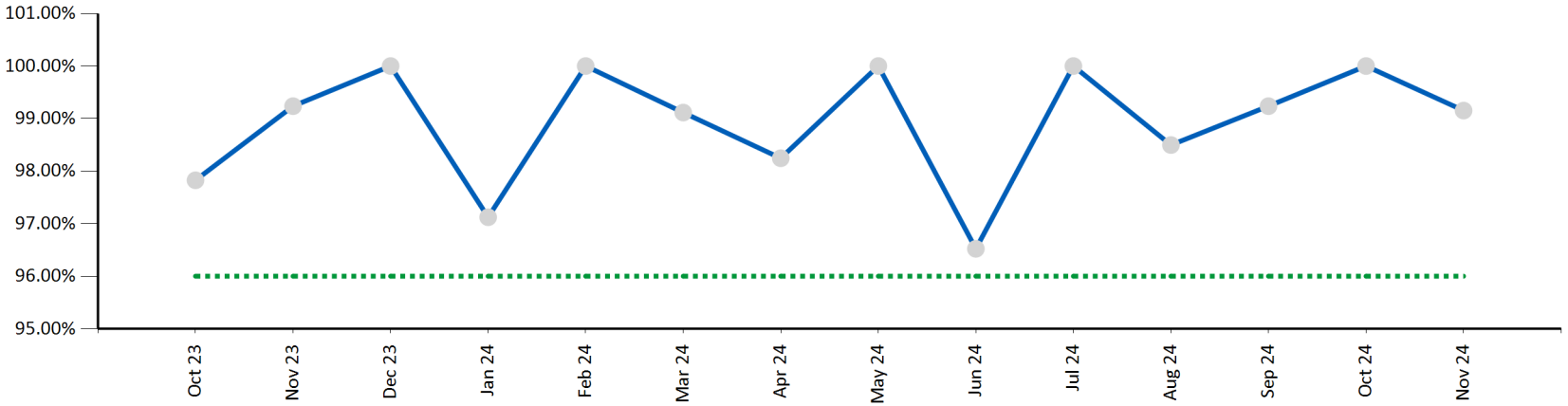
Plan	Actual	Period
>= 75.0%	89.6%	Oct-24

Year to Date

Plan	Actual
>= 75.0%	85.3%

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

6/6



Latest

Plan	Actual	Period
>= 96%	99.2%	Nov-24

Previous

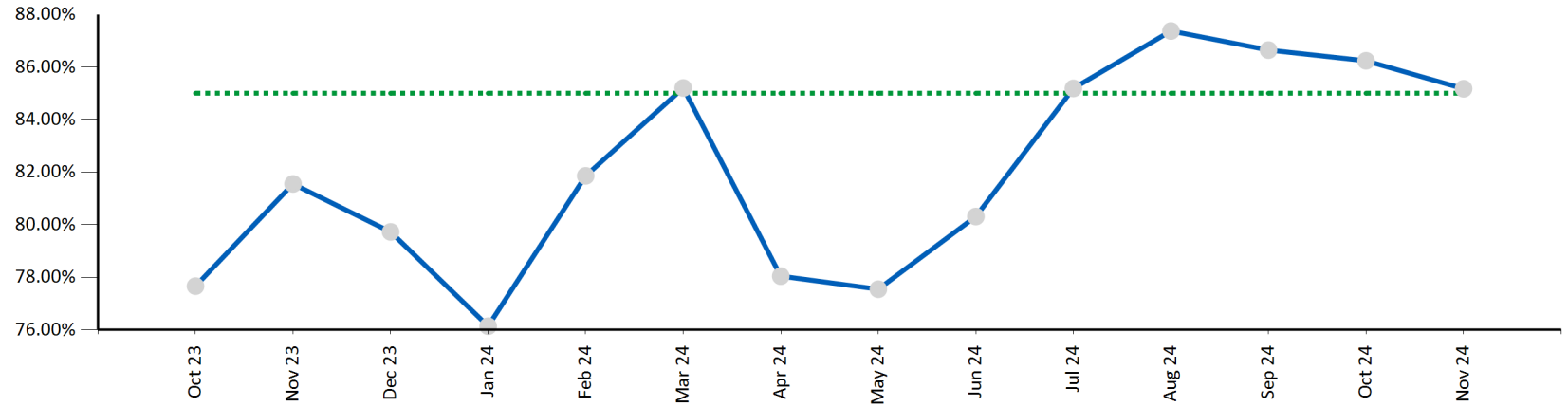
Plan	Actual	Period
>= 96%	100.0%	Oct-24

Year to Date

Plan	Actual
0.96	99.0%

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

5/6



Latest

Plan	Actual	Period
>= 85%	85.2%	Nov-24

Previous

Plan	Actual	Period
>= 85%	86.2%	Oct-24

Year to Date

Plan	Actual
0.85	83.5%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

Emergency Department deflections

ED deflections for Month 9 have increased to 632 from 587, remaining above the plan of 400. The number of deflections has continued to remain above 500 and this demonstrates the impact of the continued work by the Admission Avoidance Team in relation to promotion of 2hr Urgent Care Response and pathways into the service from North West Ambulance Service, Primary Care and Care Homes. Work is ongoing support ED deflections, use of the Admission Avoidance Team 30 day readmission pathway and a wider focus on the top ten care homes with high attendances to ED and NWAS callouts. In December and into January AAT are supporting a call before you convey pilot which supports NWAS to explore alternative opportunities to ED attendances for patients. Further improvements to ED deflections are expected incrementally over the remainder of the year as the team develop an improvement plan based upon nationally mandated criteria of 157 referrals per 100,000 population per month for 2 hr UCR.

NCTR

The monthly average number of patients with No Criteria to Reside has increased by 5, but remains below our operating plan at an average of 86 across the month. Delayed bed days has also increased to 610 from 559 in month 8. For context this remains a reduction on 912 at Month 2 and this has been a result of progress with implementation of the NCTR Urgent Care Improvement Group actions, along with the previously mentioned coding change for patients awaiting mental health liaison interventions.
The NCTR recovery plan and UCIG NCTR actions are ongoing alongside additional improvement schemes identified during September's Greater Manchester super multi agency discharge event. We continue to work with partners across GM localities due to the high numbers of patients residing in the hospital who don't live in Bolton.
Into January we expect to see continued challenges in relation to both NCR numbers and lost bed days, as expected due to seasonal demand pressures across secondary care and into the community bed base. The post bank holiday surge in additions to the NCR list, along with IPC closures across both the Trust and in care homes will be mitigated by the opening of Dove House to 20 patients in partnership with the local authority. Despite the seasonal pressures faced, we expect our position to be improved when compared to January 2024 as a result of the NCTR recovery plan and associated UCIG actions implemented to date.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts has remained relatively stable although remains off target (deterioration in December 2024 from 83% (November 2024) to 74% due to reduced capacity). Underperformance can be attributed to staffing challenges within the 0-19 service, winter pressures and disruption due to transition to the new service model. Recruitment to Health Visiting vacancies has been positive despite the national challenges regarding health visitors, however, vacancies are still causing pressures and this is recorded on the divisional risk register (R6036).

EHCP compliance

Compliance has improved from November (77%) to December 2024 (92%). Performance is expected to continue to improve throughout January 2025.

Looked after Children

Performance continues to be very strong across our Looked After Children (LAC) pathways: initial reviews (IHA 91%), review health assessments (RHA 97%) and special school reviews (LAC 100%) are all above target.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	632	Dec-24		>= 400	587	Nov-24	>= 3,600	5,031	

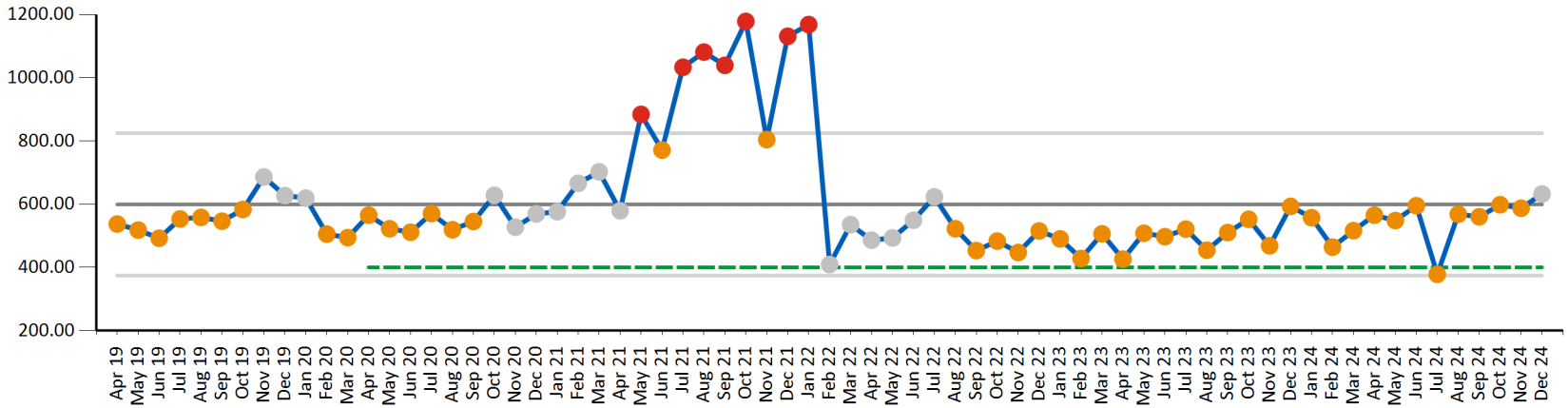
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
493 - Average Number of Patients: with no Criteria to Reside	<= 97	86	Dec-24		<= 96	81	Nov-24	<= 97	86	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	610	Dec-24		<= 360	559	Nov-24	<= 3,240	6,671	
267 - 0-5 Health Visitor mandated contacts	>= 95%	79%	Dec-24		>= 95%	83%	Nov-24	>= 95%	77%	
269 - Education, health and care plan (EHC) compliance	>= 95%	92%	Dec-24		>= 95%	77%	Nov-24	>= 95%	79%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	97.0%	Dec-24		>= 90.0%	95.0%	Nov-24	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	91.0%	Dec-24		>= 90.0%	100.0%	Nov-24	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Dec-24		>= 90.0%	100.0%	Nov-24	>= 90.0%		

334 - Total Deflections from ED

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 400	632	Dec-24

Previous

Plan	Actual	Period
>= 400	587	Nov-24

Year to Date

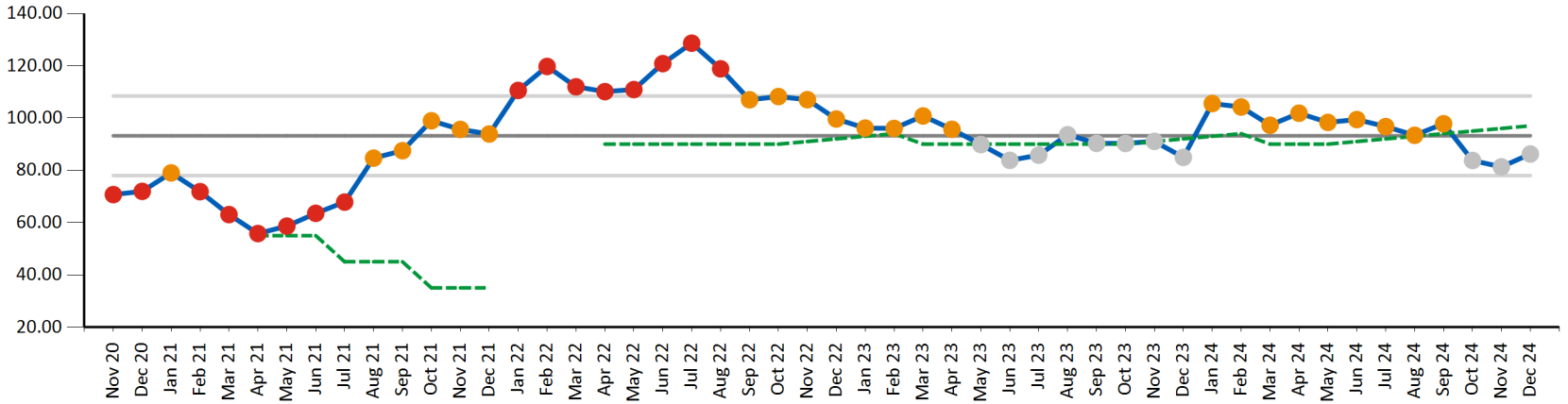
Plan	Actual
>= 3,600	5,031

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
<= 97	86	Dec-24

Previous

Plan	Actual	Period
<= 96	81	Nov-24

Year to Date

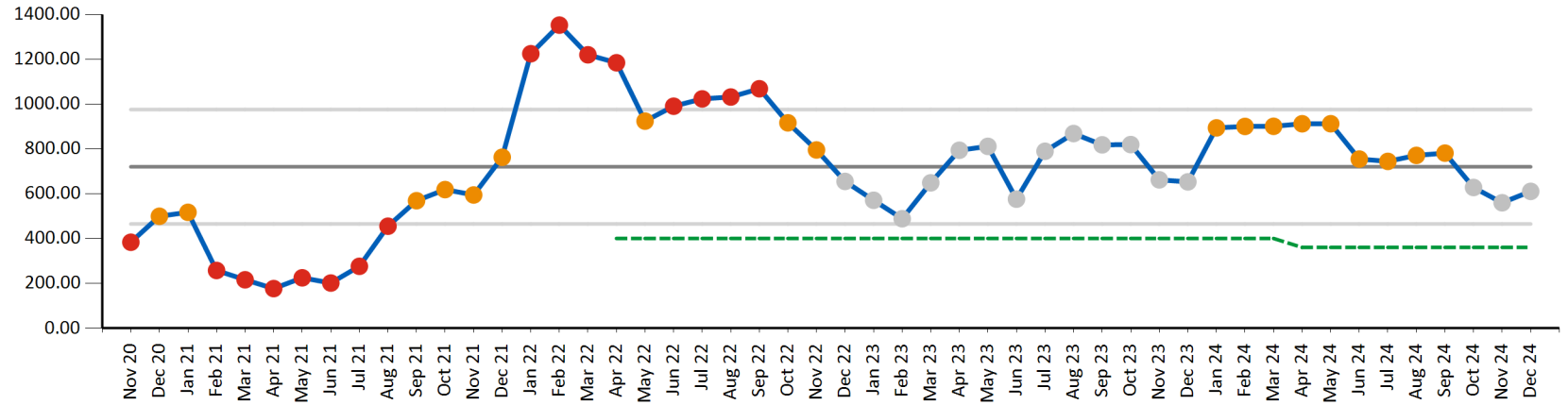
Plan	Actual
<= 97	86

494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	610	Dec-24

Previous

Plan	Actual	Period
<= 360	559	Nov-24

Year to Date

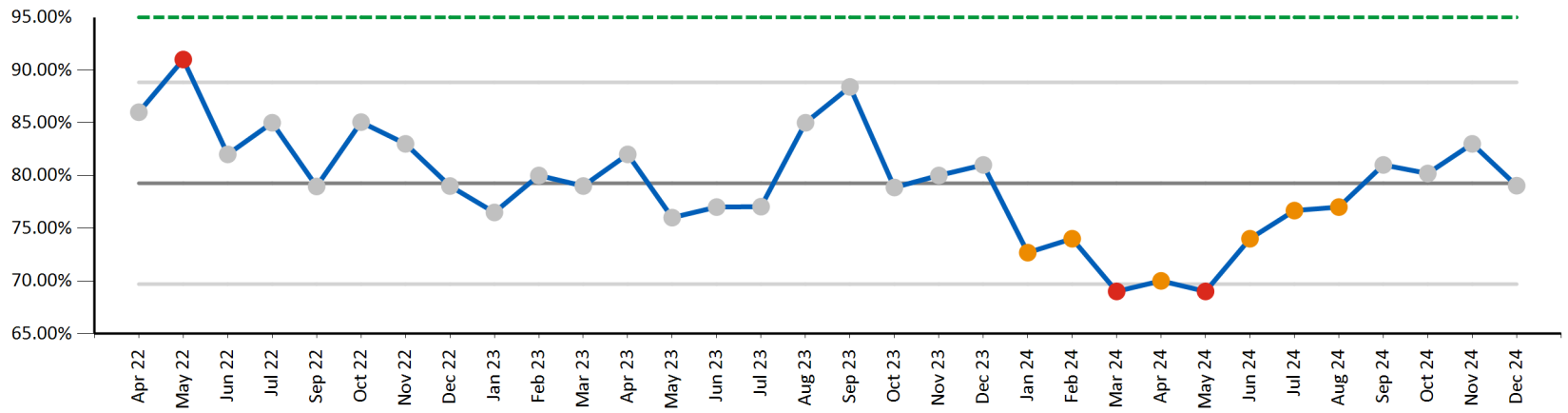
Plan	Actual
<= 3,240	6,671

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%	79%	Dec-24

Previous

Plan	Actual	Period
>= 95%	83%	Nov-24

Year to Date

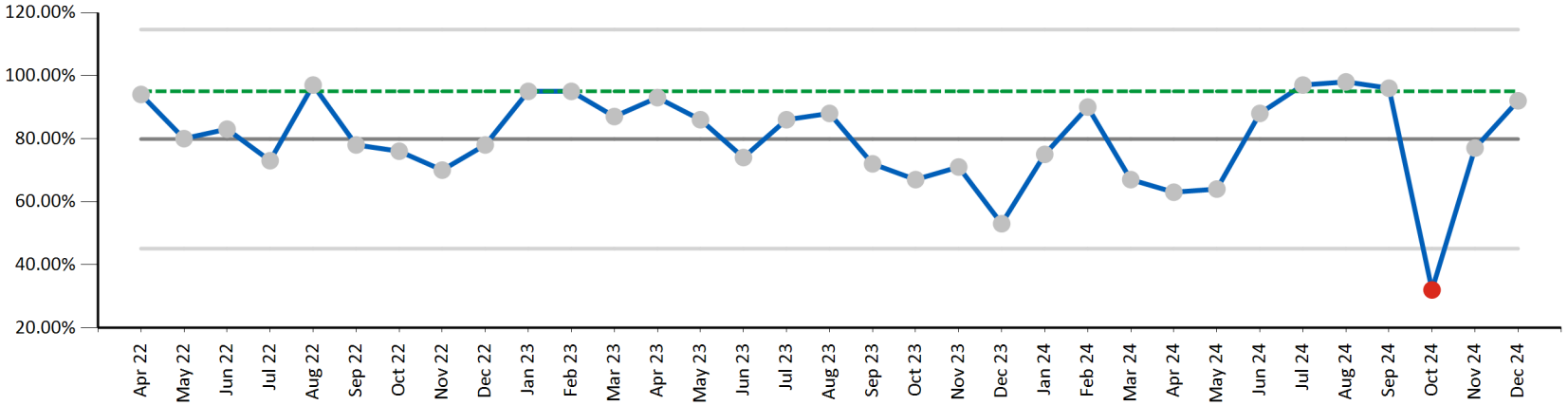
Plan	Actual
>= 95%	77%

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

Common cause variation.

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

3/6



Latest

Plan	Actual	Period
>= 95%	92%	Dec-24

Previous

Plan	Actual	Period
>= 95%	77%	Nov-24

Year to Date

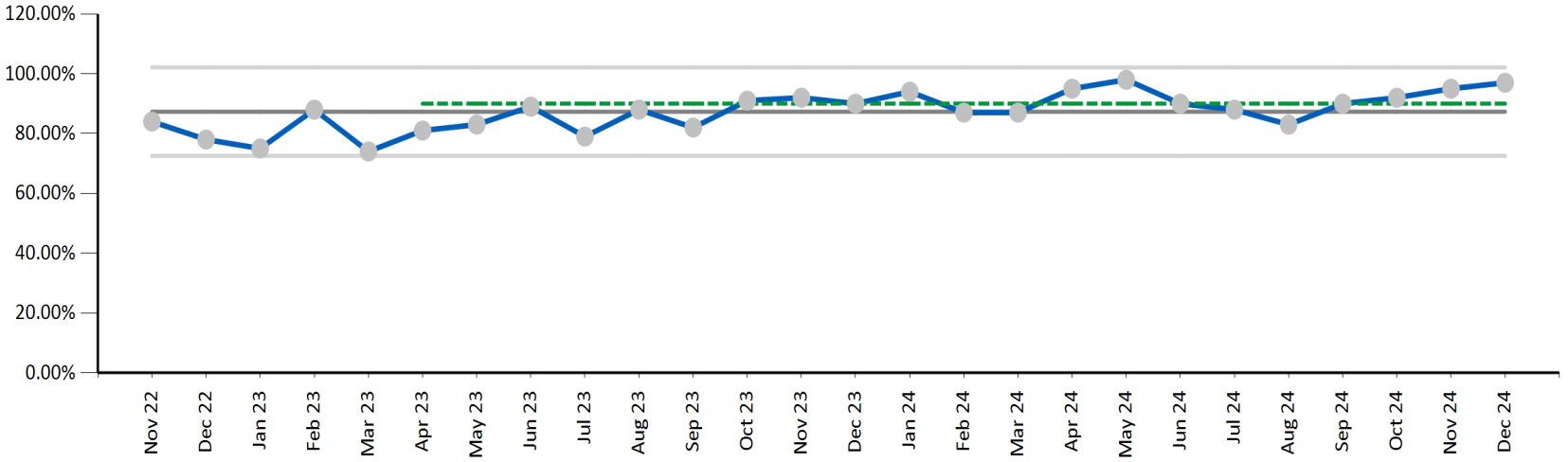
Plan	Actual
>= 95%	79%

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	97.0%	Dec-24

Previous

Plan	Actual	Period
> = 90.0%	95.0%	Nov-24

Year to Date

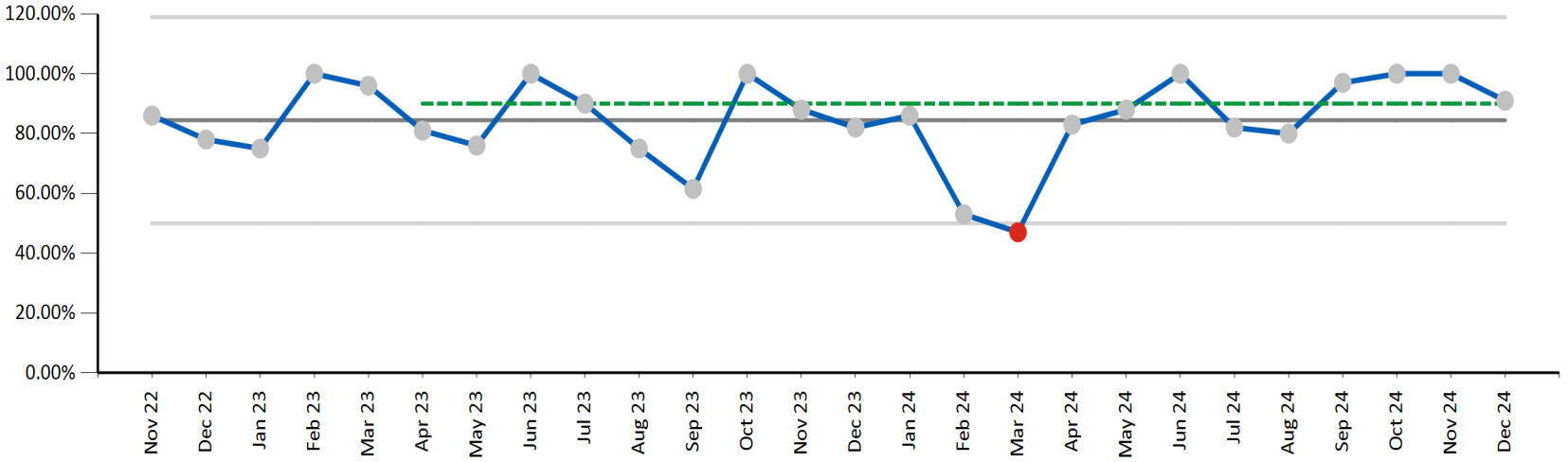
Plan	Actual
> = 90.0%	

551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	91.0%	Dec-24

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Nov-24

Year to Date

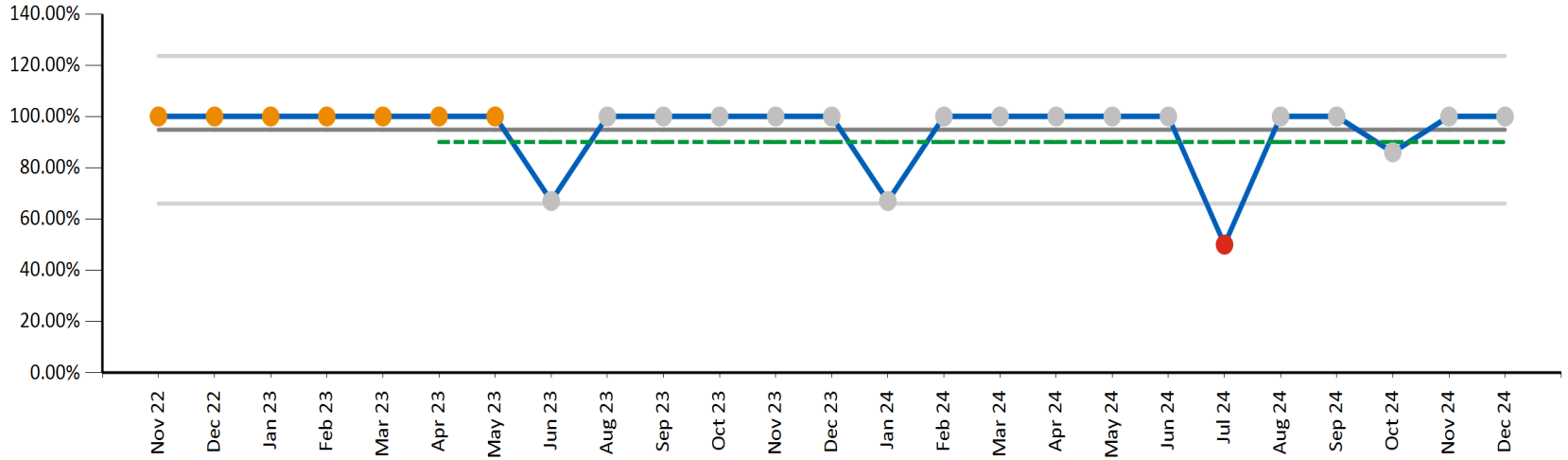
Plan	Actual
> = 90.0%	

552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Dec-24

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Nov-24

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

Bolton NHS Foundation Trust

Sickness:
Sickness increased in month from 5.09% to 5.60% in December 2024. There has been an increase in sickness absence across all the majority of Divisions with the increases predominantly due to seasonal sicknesses (such as Cold/Flu and D&V absences) which have continued to remain high in December 2024. The Integrated Community Case Division has however seen a reduction in their overall rates of sickness reducing further to 4.71%. Each Division continues to undertake a review of sickness, with a renewed focus on ensuring staff are offered and take up both Flu and Covid vaccines. The Divisional and Workforce teams continue to work together to closely monitor sickness, and provide a range of health and well-being support to our staff.

Turnover:
We expected turnover to be stable in 2024/25 (circa 12%). At overall Trust level this is playing out in the YTD; we had seen a slight increasing trend between July and Sept 24 but December 24 data shows a continuation of turnover rates below 12%.

Vacancy:
Vacancy rates tracked down through 2023/24 and have been stable in 2024/25 YTD. December 2024 showed a slight increase to 5.84% (4.64% in November) but December new starter intake is historically lower and there is an expectation that rates will fall back below 5% in January. We continue to be in a strong position with vacancy rates which will support our services as we progress through winter.

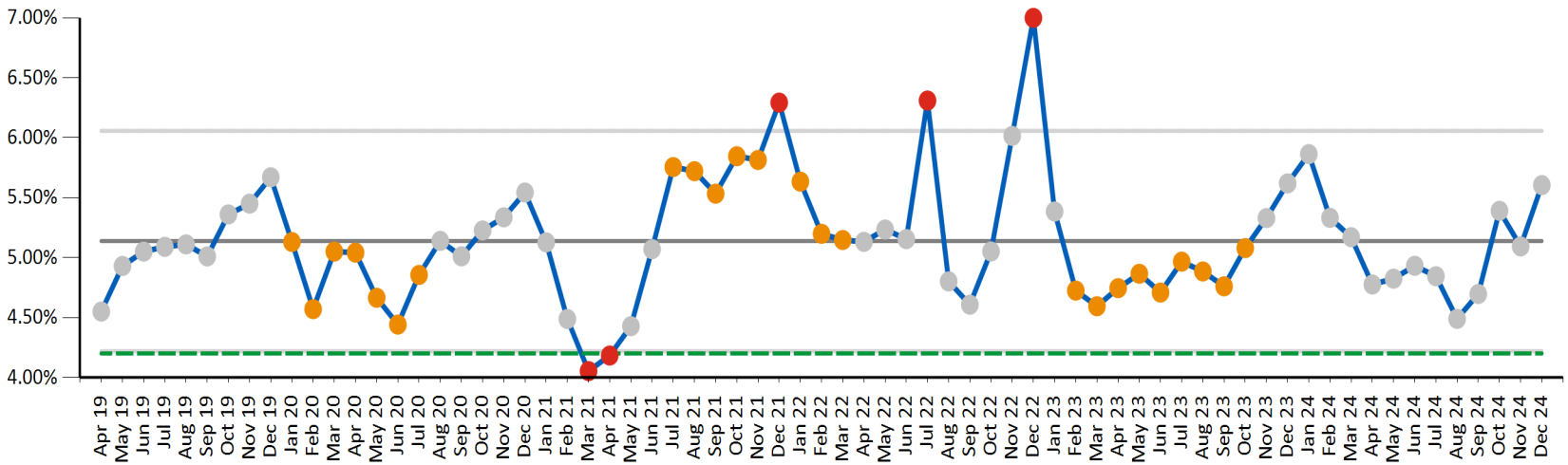
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.60%	Dec-24		<= 4.20%	5.09%	Nov-24	<= 4.20%	4.96%	F
120 - Vacancy level - Trust	<= 6%	5.84%	Dec-24		<= 6%	4.64%	Nov-24	<= 6%	5.37%	?
121 - Turnover	<= 9.90%	11.83%	Dec-24	L	<= 9.90%	11.71%	Nov-24	<= 9.90%	11.70%	F
366 - Ongoing formal investigation cases over 8 weeks		3	Nov-24			3	Oct-24		10	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	5.60%	Dec-24

Previous

Plan	Actual	Period
<= 4.20%	5.09%	Nov-24

Year to Date

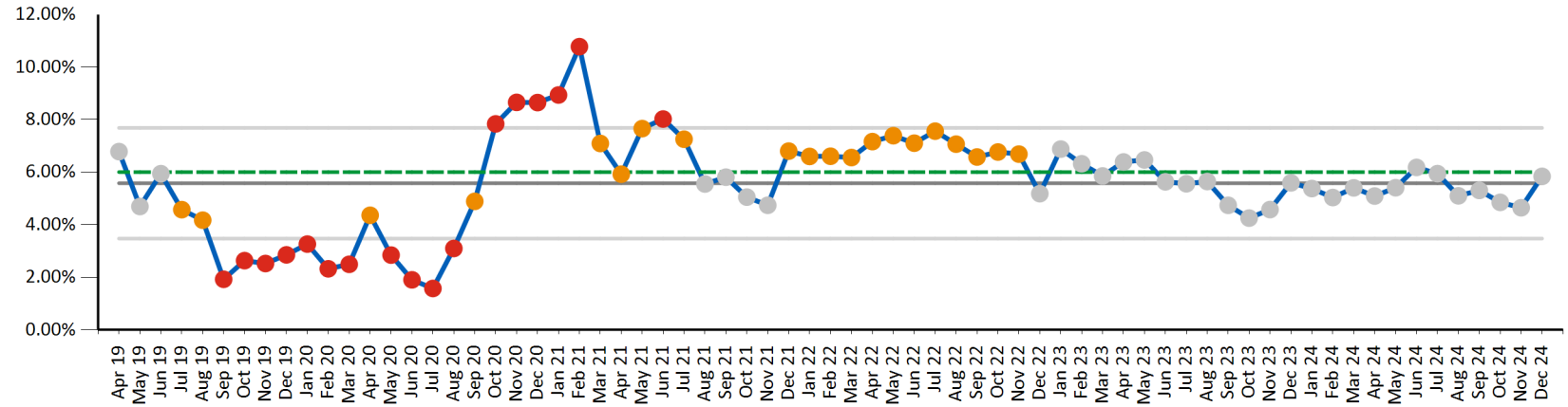
Plan	Actual
<= 4.20%	4.96%

120 - Vacancy level - Trust

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 6%	5.84%	Dec-24

Previous

Plan	Actual	Period
<= 6%	4.64%	Nov-24

Year to Date

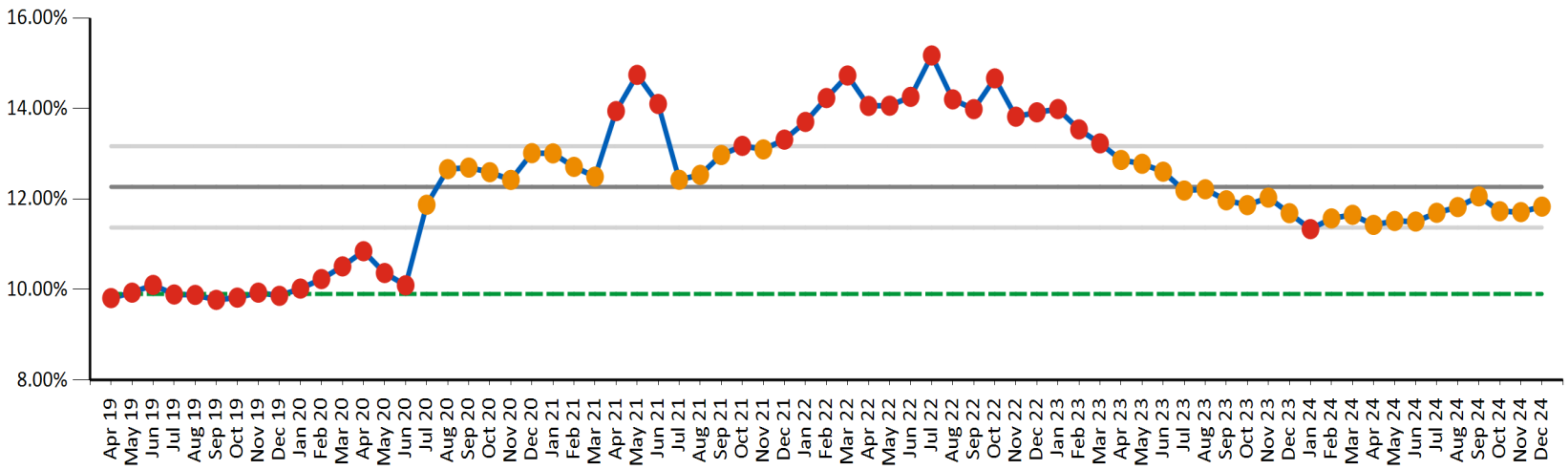
Plan	Actual
<= 6%	5.37%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
< = 9.90%	11.83%	Dec-24

Previous

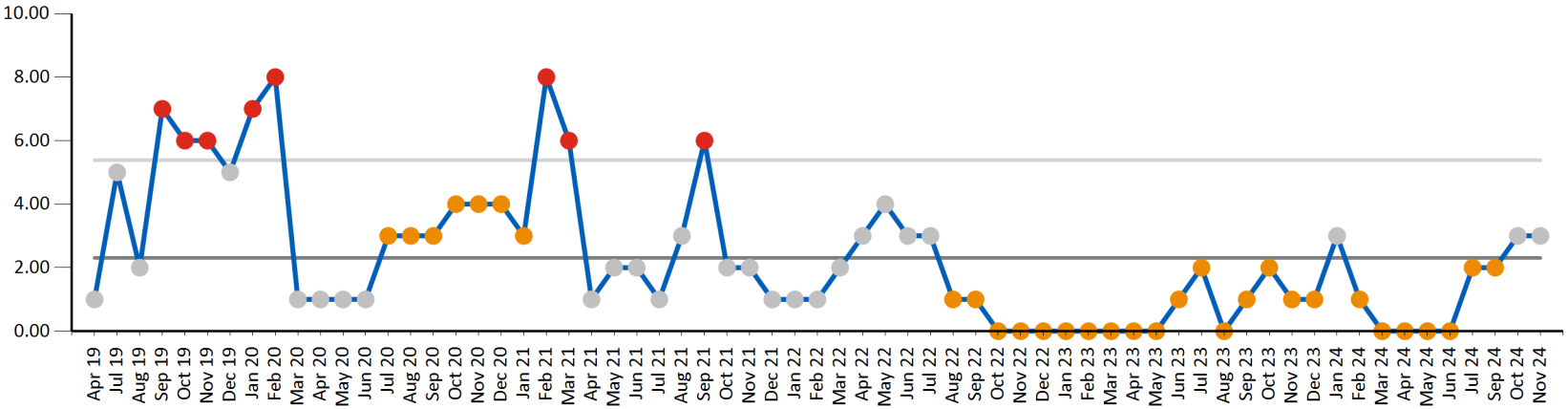
Plan	Actual	Period
< = 9.90%	11.71%	Nov-24

Year to Date

Plan	Actual
< = 9.90%	11.70%

366 - Ongoing formal investigation cases over 8 weeks

Common cause variation.



Latest

Plan	Actual	Period
	3	Nov-24

Previous

Plan	Actual	Period
	3	Oct-24

Year to Date

Plan	Actual
	10

Workforce - Organisational Development

Bolton NHS Foundation Trust

Compulsory Training
A slight drop in compliance from 94.1% to 93.85%. Those subjects that require face to face training - BLS (87%) / M&H (84.5%)/ Safeguarding Adults level 3 (75.4%) remain the most challenged. There is a good uptake for booking this training but the high level of did not attend (DNA) is the main reason for poor compliance.

Trust Mandated
A slight drop in compliance from 90.5% to 89.8%. The focus is to ensure all new medical staff are competent with insertion of Naso-gastric (NG) Tube training and there is a continued focus to support staff to complete Oliver McGowan e-learning

Appraisal
A great effort by all services has led to a 0.52% improvement to record the monthly position as 86.96% against a compliance target of 85%.
Appraisal training - There has been a 2% reduction in compliance to 86.4%. Although this remains above 85% target there needs to be a continued focus by all Divisions / Services to ensure staff appraisal/ FABB conversations are maintained. Appraisal training dates are now on offer, via ESR, to support staff with undertaking a quality appraisal.

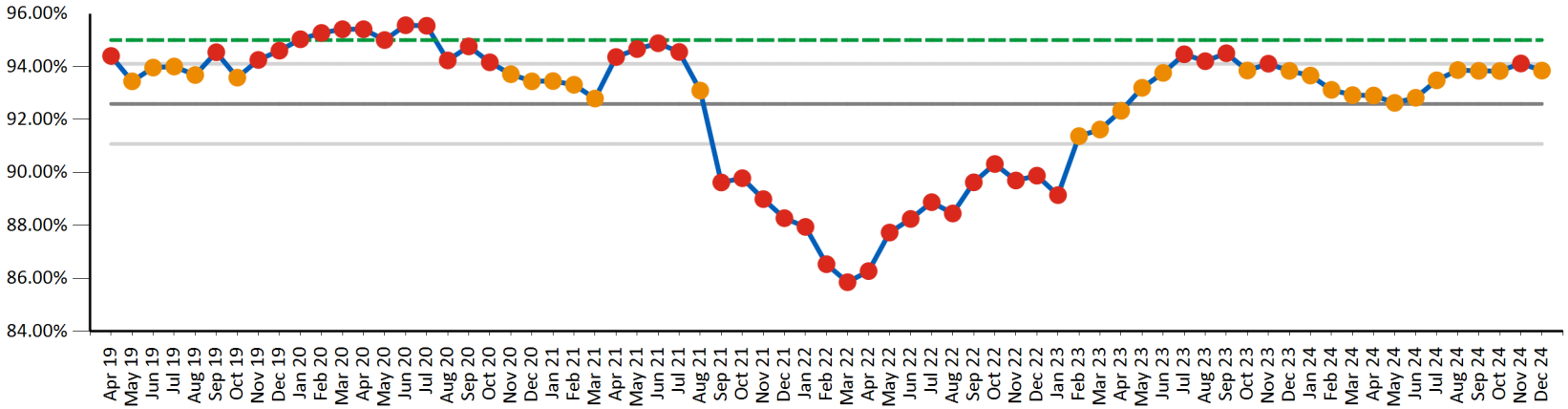
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	93.8%	Dec-24	H	>= 95%	94.1%	Nov-24	>= 95%	93.5%	F
38 - Staff completing Trust Mandated Training	>= 85%	89.8%	Dec-24	H	>= 85%	90.5%	Nov-24	>= 85%	90.1%	P
39 - Staff completing Safeguarding Training	>= 95%	92.61%	Dec-24	L	>= 95%	92.91%	Nov-24	>= 95%	91.97%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	86.4%	Dec-24	H	>= 85%	88.4%	Nov-24	>= 85%	86.0%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	53.4%	Q2 2024/25	L	>= 66%	43.0%	Q1 2024/25	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	53.8%	Q2 2024/25		>= 80%	50.5%	Q1 2024/25	>= 80%		F

37 - Staff completing Compulsory Training

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	93.8%	Dec-24

Previous

Plan	Actual	Period
>= 95%	94.1%	Nov-24

Year to Date

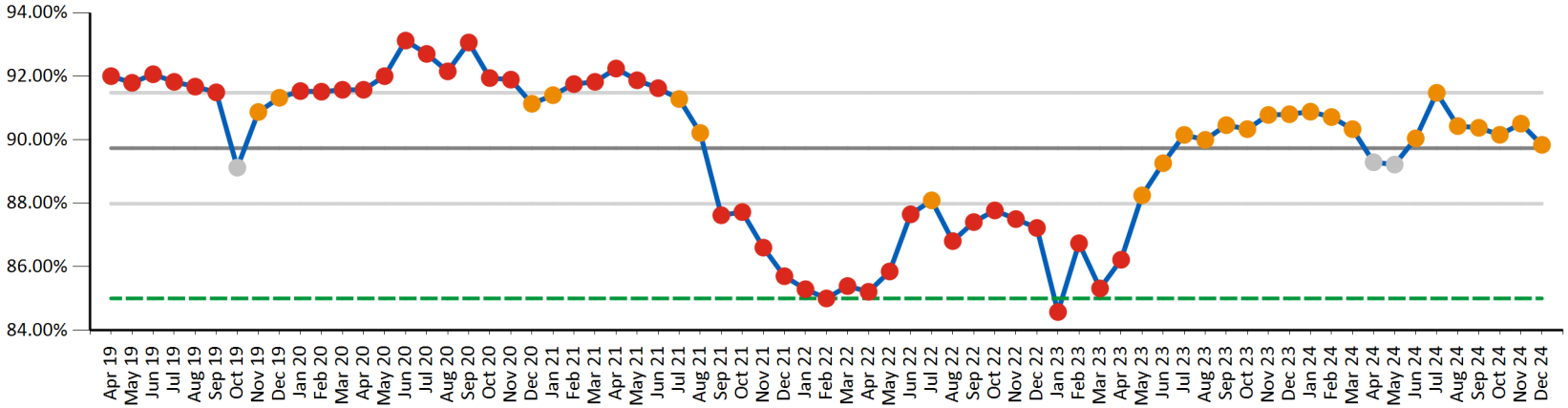
Plan	Actual
>= 95%	93.5%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	89.8%	Dec-24

Previous

Plan	Actual	Period
>= 85%	90.5%	Nov-24

Year to Date

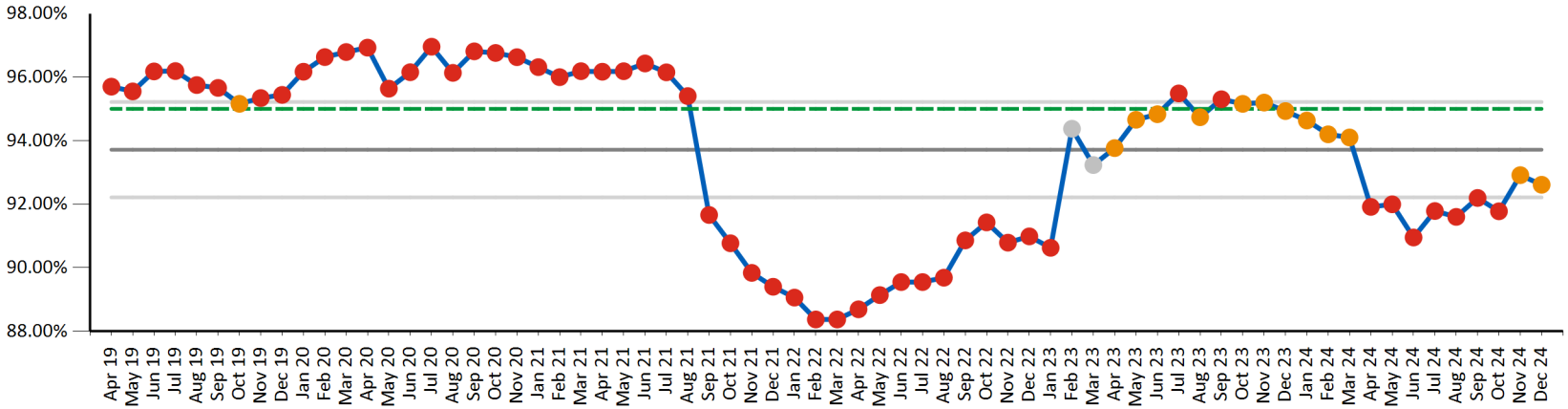
Plan	Actual
>= 85%	90.1%

39 - Staff completing Safeguarding Training

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 95%	92.61%	Dec-24

Previous

Plan	Actual	Period
>= 95%	92.91%	Nov-24

Year to Date

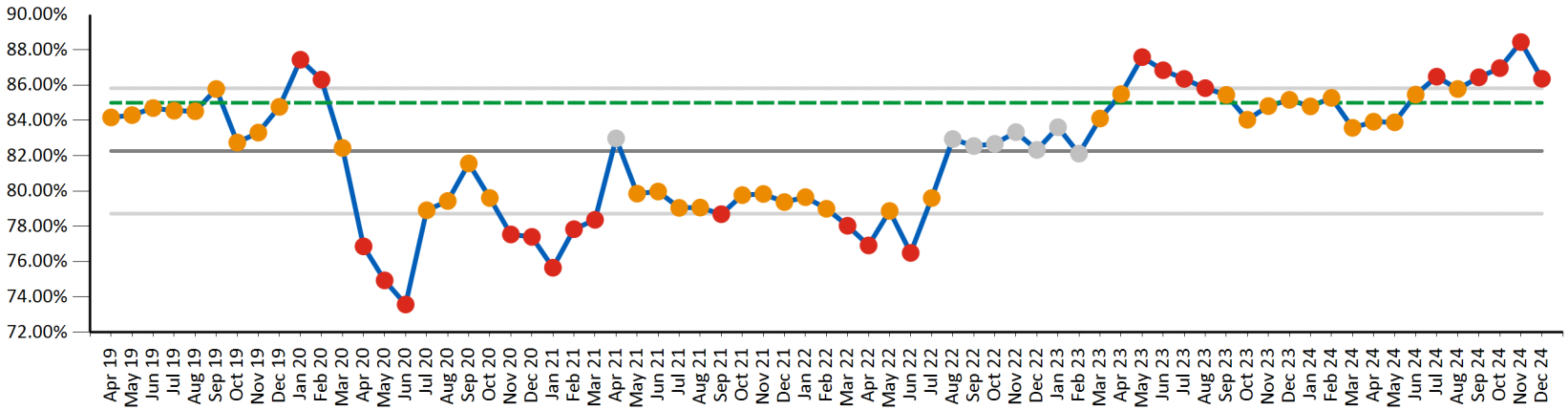
Plan	Actual
>= 95%	91.97%

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.

6/6



Latest

Plan	Actual	Period
>= 85%	86.4%	Dec-24

Previous

Plan	Actual	Period
>= 85%	88.4%	Nov-24

Year to Date

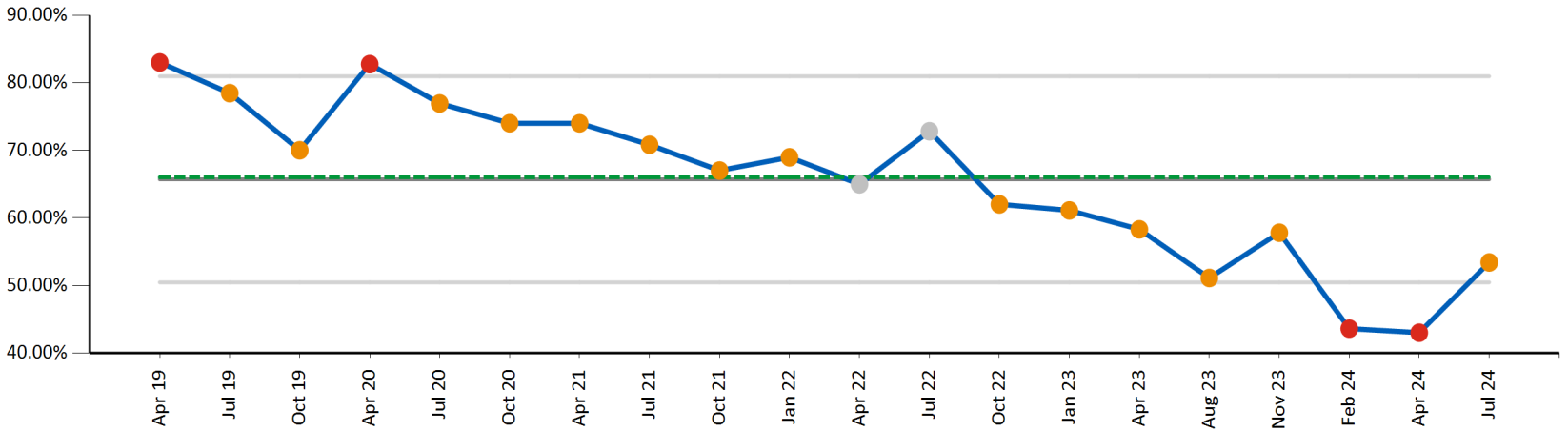
Plan	Actual
>= 85%	86.0%

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

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 66%	53.4%	Q2 2024/25

Previous

Plan	Actual	Period
>= 66%	43.0%	Q1 2024/25

Year to Date

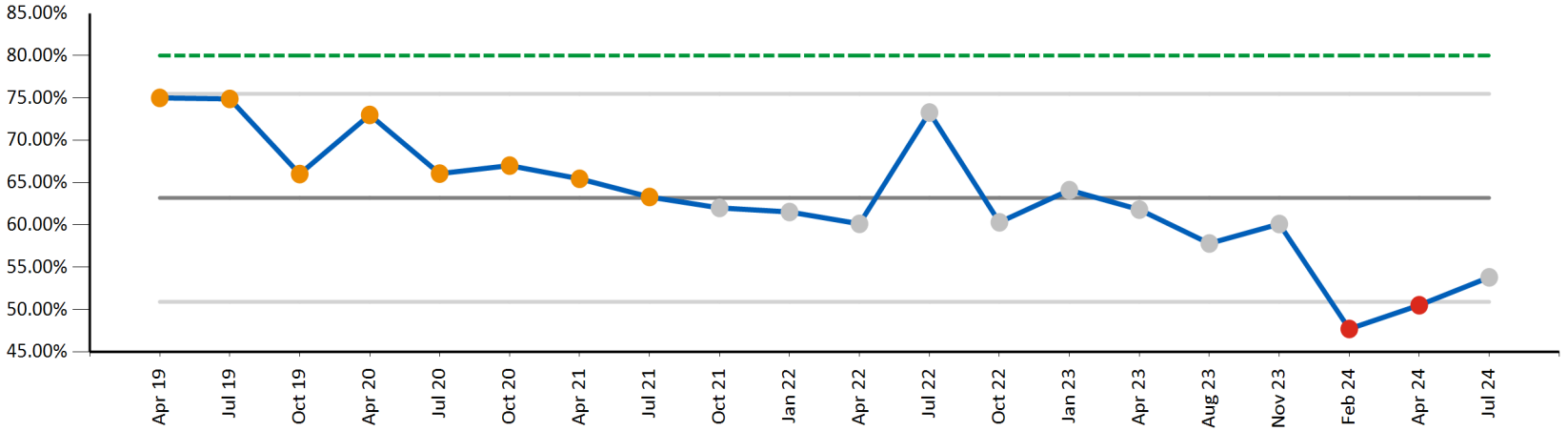
Plan	Actual
>= 66%	

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

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	53.8%	Q2 2024/25

Previous

Plan	Actual	Period
>= 80%	50.5%	Q1 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Agency spend reduced by £39k in M9. Agenda for change staffing groups agency usage remains very low. We are currently under internal agency spend plan by £1.4m and on course to end the year under plan by £2.6m if we maintain current spend trend.

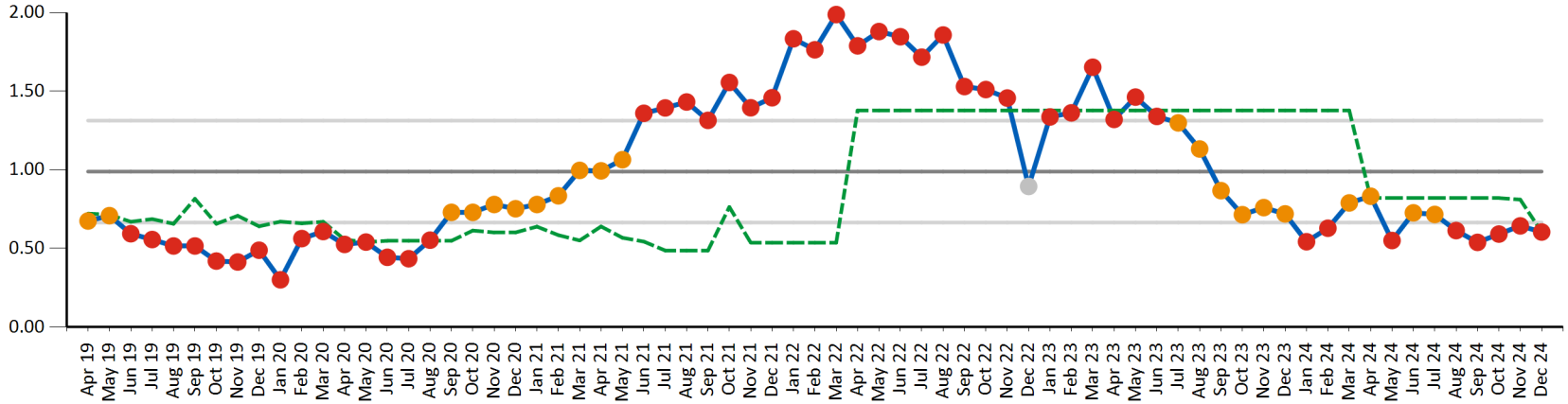
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.60	0.60	Dec-24	L	<= 0.81	0.64	Nov-24	<= 7.15	5.81	F
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.06	0.06	Dec-24	L	<= 0.09	0.08	Nov-24	<= 0.74	0.47	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.47	0.47	Dec-24		<= 0.61	0.43	Nov-24	<= 5.29	4.48	?

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

L Special cause variation with improving performance

F We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
<= 0.60	0.60	Dec-24

Previous

Plan	Actual	Period
<= 0.81	0.64	Nov-24

Year to Date

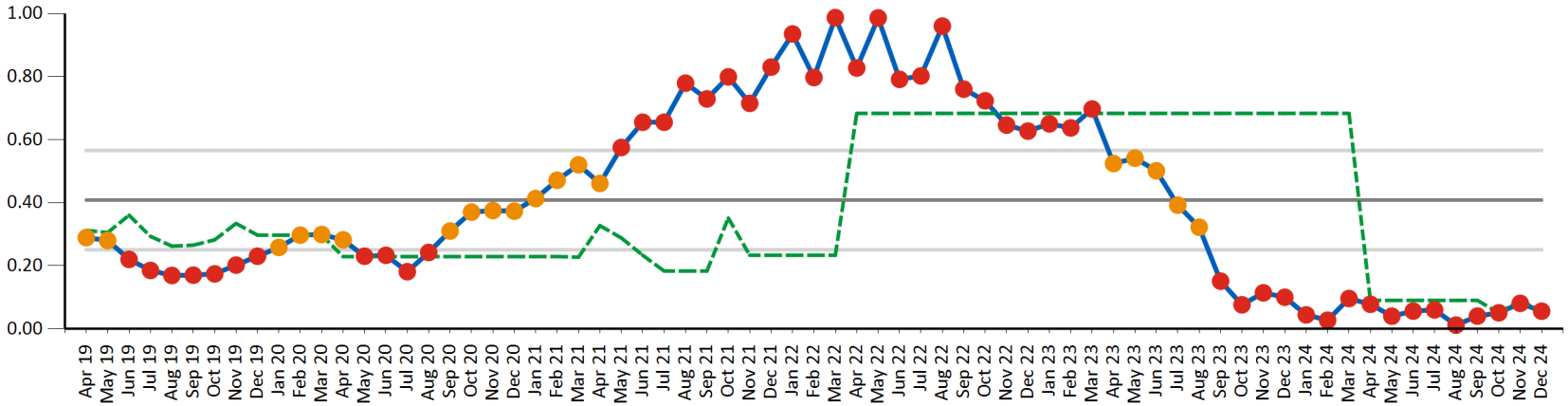
Plan	Actual
<= 7.15	5.81

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

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
<= 0.06	0.06	Dec-24

Previous

Plan	Actual	Period
<= 0.09	0.08	Nov-24

Year to Date

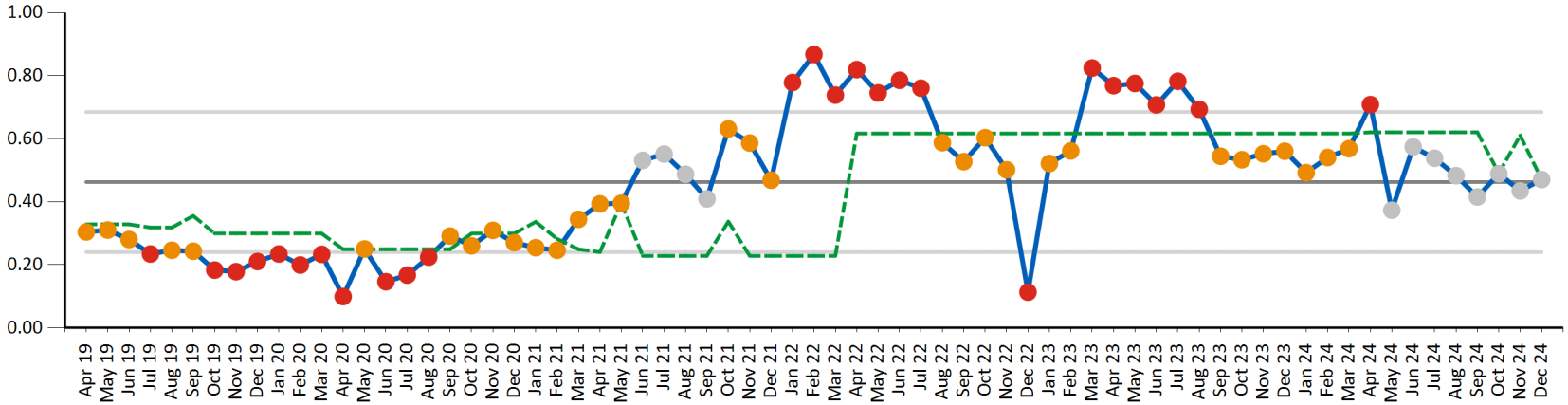
Plan	Actual
<= 0.74	0.47

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
<= 0.47	0.47	Dec-24

Previous

Plan	Actual	Period
<= 0.61	0.43	Nov-24

Year to Date

Plan	Actual
<= 5.29	4.48

Finance - Finance

NHS Bolton NHS Foundation Trust

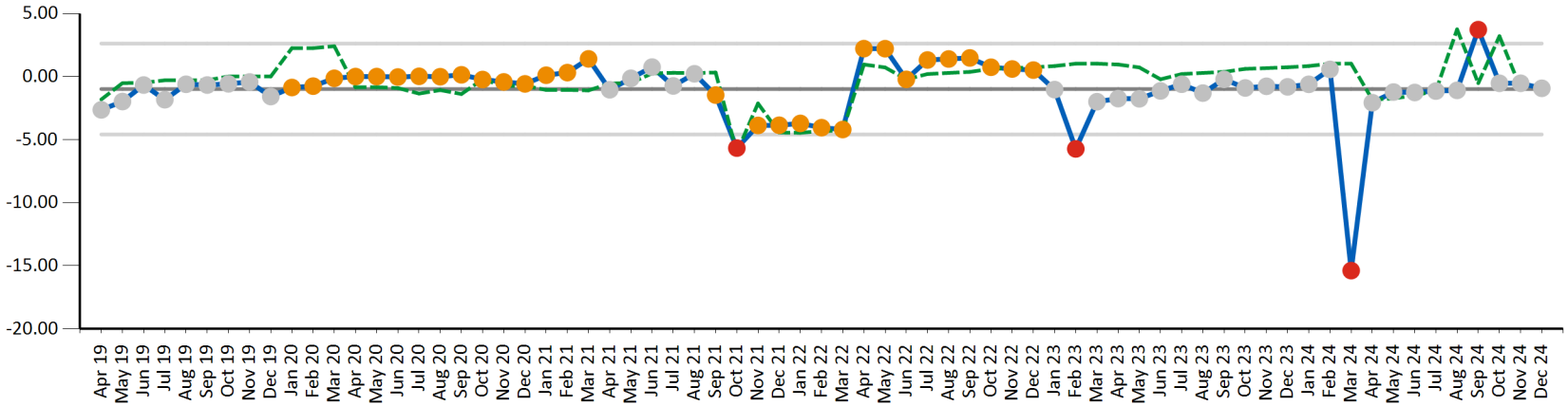
Surplus / (Deficit) - The Trust is behind plan by £1.2m YTD. This is adverse variance is driven by the pay award pressure which is £1.6m in total for 24/25.
Income - ERF over performance of £2.8m has been included YTD at Month 9.
Pay - Overspend is driven by a combination of pay awards, additional expenditure driving the elective income over performance and unidentified CIP. Agency costs are 2.1% of pay YTD against an NHSE target of 3.2%
Non-Pay - The Trust is incurring additional cost with various insourcing / outsourcing providers which has supported additional elective income.
Non-Operating - Interest received has been higher than planned. It is anticipated that interest will reduce throughout the year as cash balances reduce.
Cash - The Trust had £1.7m less cash than planned at Month 9. In the likely case forecast scenario, the Trust will be overdrawn by Month 11 and will finish the year £4.9 overdrawn. However, PDC funding cash that the Trust is due to receive may mean that the Trust does not end up overdrawn in 24/25.
CIP Delivery - The Trust has released significant non recurrent benefit to support in year delivery of plan.
Capital - Plan values now represent the latest capital forecast agreed with the GM ICB. CDEL spend is £1.1m behind the GM forecast YTD and IFRS 16 spend is £0.1m lower than forecast.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)		-0.9	Dec-24		>= -0.9	-0.5	Nov-24	>= -0.7	-5.1	
222 - Capital (£ millions)		0.9	Dec-24	L	>= 0.9	0.7	Nov-24	>= 9.0	5.7	
223 - Cash (£ millions)		7.7	Dec-24	L	>= 7.7	11.9	Nov-24		7.7	

220 - Control Total (£ millions)

Common cause variation.

2/6



Latest

Plan	Actual	Period
	-0.9	Dec-24

Previous

Plan	Actual	Period
>= -0.9	-0.5	Nov-24

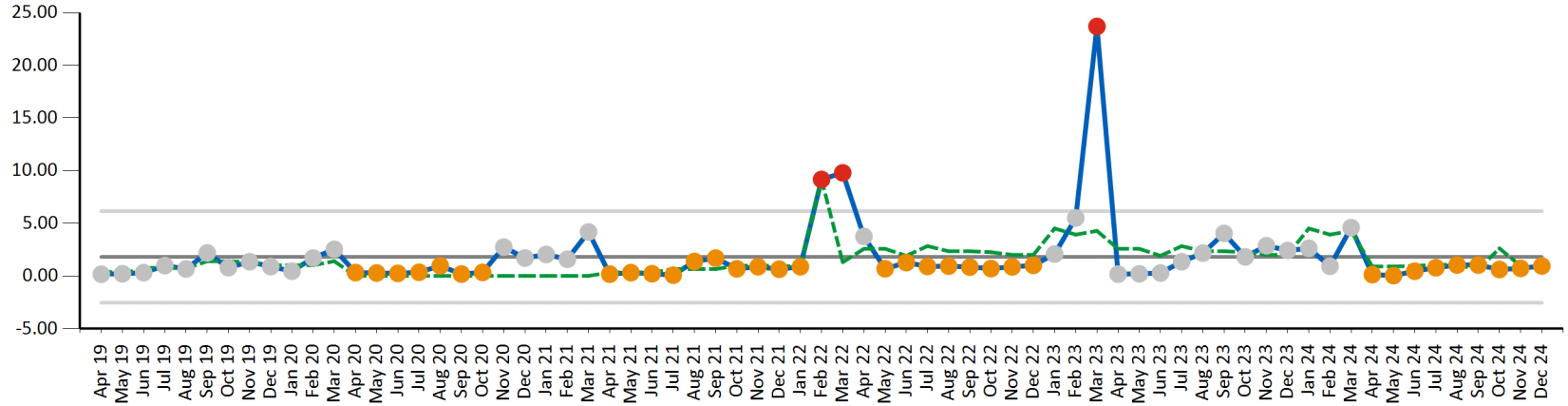
Year to Date

Plan	Actual
>= -0.7	-5.1

222 - Capital (£ millions)

Special cause variation with deteriorating performance

1/6



Latest

Plan	Actual	Period
	0.9	Dec-24

Previous

Plan	Actual	Period
>= 0.9	0.7	Nov-24

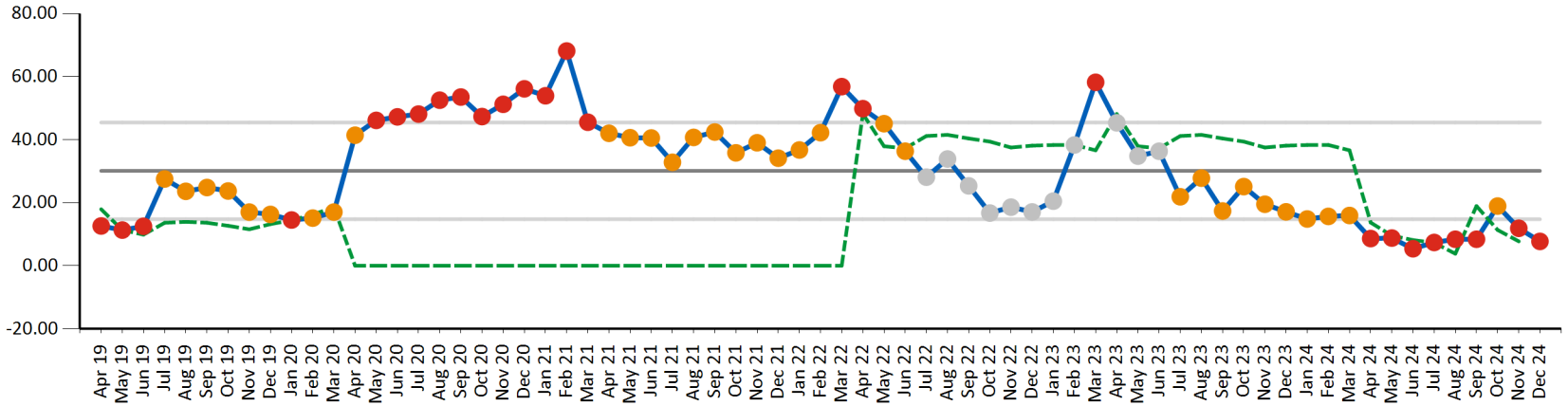
Year to Date

Plan	Actual
>= 9.0	5.7

223 - Cash (£ millions)

Special cause variation with deteriorating performance

4/6



Latest

Plan	Actual	Period
	7.7	Dec-24

Previous

Plan	Actual	Period
>= 7.7	11.9	Nov-24

Year to Date

Plan	Actual
	7.7

Heatmap Narrative – Trust Overview

Infection Prevention and Control

Adult Acute
Two Clostridium Difficile cases identified across wards: Ward D1 completed management plan, patient isolated within 2 hours. Ward B1 closed due to norovirus outbreak, where patient tested positive for Clostridium Difficile with previous Glutamate Dehydrogenase positive status. Clinical Decision Unit recorded hand hygiene compliance at 45%, requiring improvement among medical staff. Matter escalated to Clinical Lead with daily Matron review implemented.

Anaesthetics and Surgery
Ward E3 reported one Clostridium Difficile case inpatient receiving multiple intravenous antibiotics and medications. Patient isolated with care plans implemented. Ward E4 reported one Methicillin-sensitive Staphylococcus Aureus case related to discitis. One Methicillin-resistant Staphylococcus Aureus case attributed to external facility. Hand hygiene compliance issues noted, for review at divisional infection prevention meeting. One Escherichia coli case investigated with no source identified.

Family Care Division
NNU – IPC E.coli – no known source identified. MRSA PII meeting held on 17/01/25 5 cases discussed, one possible transmission awaiting confirmation on DNA PCR. Actions agreed with IPC team and underway.

Harm Free Care

Adult Acute
There were 11 occurrences of category 2 inpatient pressure damage across multiple wards. There were 7 occurrences of category 3 inpatient pressure damage, comprising two occurrences on Ward C4, one occurrence on Ward D3, and four occurrences on Ward B1 (affecting one patient). All divisional actions remain in place, and we will be implementing the full Pressure Ulcer Collaborative change package. An additional Trust-led patient safety review panel will be attended to support learning and improvements..
0 x occurrences of Falls resulting in patient harm in month. 65 falls in AACD in December. Reduction from previous month. Falls continues to be discussed at AACD safety senate as a standard agenda item.

Anaesthetic and Surgery
There has been an increase in category 2 pressure ulcers. Upon review of E4 this represents one patient with four pressure ulcers logged at four points on the spine. The patient is non-concordant with treatment and is on a non-concordant care plan. Critical Care incidents were both device-related. One incident was related to tracheostomy and adhesive dressing causal factor, while another was related to ear probe for oxygen delivery causing pressure ulcer to ear. A full care plan is in position as the patient is combative. No falls with harm in division

Audit, Patient Experience and Governance

Adult Acute
94 outstanding incidents exceed 14 days unsigned, with 63 from Emergency Department. Emergency Nurse Practitioner assigned to clear backlog. Unit manager sickness and matron vacancy slowed closure rates. Inpatient Friends and Family Test: 25% response rate, 91% satisfaction. Emergency Department: 13.92% response rate, 82.16% satisfaction. Emergency Department action plan in progress with daily matron audits of waiting room care.

Anaesthetics and Surgery
Division investigating Friends and Family Test recording discrepancies in envoy and heat map. Working with Business Intelligence as ward data not pulling through correctly. Weekly incident reviews with ward managers and Assistant Divisional Nurse Director .

Family Care
9 overdue incidents on Central Delivery Suite pending reviews. Weekly monitoring by Governance Lead via Divisional heat map. Currently no overdue incidents on Central Delivery Suite.

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Heatmap Narrative – Trust Overview

Staff Development, Staffing and Workforce

Adult Acute
Division's appraisal rate at 83.02%, below trust target. Teams supporting clinical needs while scheduling staff appraisals and updating ESR records. Statutory training decreased to 91.86%, below 95% target. Oversight continues through monthly IPM and ward assurance submissions. Ward C4 reported red flags , increased falls with no harm correlated with higher numbers of wandering, confused patients. Staffing challenges managed through daily meetings.

Anaesthetics and Surgery
Monthly workforce oversight to review all appraisals and metrics. Hot spots have monthly action plans. Ward E3 experienced high acuity in December, additional twilight shifts approved by Divisional Nurse Director. Ward E4 SafeCare compliance under matron review.

Family Care
SafeCare compliance at 49.1%. Band 6 staff received additional Safer Nursing Care Tool training, with daily completion checks by Matron and Assistant Divisional Nurse Director. Sickness deep dive completed with HR. Action plan includes return to work training, flu vaccine promotion, civility training for Healthcare Assistants, and reasonable adjustments where needed. Appraisals at 55.6% with 32 outstanding. Appraisal dates added to rosters with compliance trajectory in place.

	Indicator	Target	Council-EA-MC6E-AECE-AE	Acute Division																			Elective Division														Families Division									
			Lab Lodge	AED Adults	AED Paeds	A4	B1	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1	D2	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	SDEC	Critical Care	Elective care Ground Floor (Daycare)	Elective care First Floor (Inpatients)	E3	F3	F6 (Surgery)	E4 (Male T&O)	F4 (Female T&O)	H2 (Daycare)	R1	SC1 Left side (Day cases)	SC2 Right side (Inpatients)	UU (Daycare)	CDS	E5	F5	Ingleside closed	G3 (Antenatal)	G4 (Postnatal)	M3 (Birthtubs) closed	H1 (Gynae short stay)	NICU	Overall
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*		N/R		100.0%	N/R	80.0%	100.0%	90.0%	N/R	100.0%	100.0%	100.0%	100.0%	45.0%	95.0%	100.0%	90.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%			75.0%	85.0%	100.0%	N/R	85.0%	100.0%	100.0%	80.0%	95.0%	95.0%	100.0%	95.0%	95.0%		100.0%	100.0%		100.0%	95.0%	94.5%
	C - Diff	*Target = 0*		0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	MSSA BSIs	*Target = 0*		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	E.Coli BSIs	*Target = 0*		0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	4
	MRSA acquisitions			0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	7
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	3	4	0	4	4	0	3	1	4	5	9	11	0	2	6	5	0	1	1	5	0	1	0	1	1	1	0	0	2	0	1	0	0	0	0	1	0	0	0	1	1	78
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New pressure Ulcers (Category 2)	*Target = 0*	0	3	0	0	0	2	0	0	0	1	1	1	0	0	0	0	3	0	0	0	0	1	2	0	0	1	0	0	5	1	0	0	0	0	0	0	0	0	0	0	0	0	20
	New pressure Ulcers (Category 3)	*Target = 0*	1	2	0	0	3	0	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
	New pressure Ulcers (Category 4)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience	FFT Response Rate	*Target = 30%*	N/R			73.0%	294%	53.0%	12.0%	N/R	21.0%	20.0%	50.0%	8.0%	34.0%	36.0%	61.0%	64.0%	N/R	40.0%	N/R	N/R	4.0%	N/R	61.0%	31.2%	74.0%	N/R	42.0%	16.0%	18.0%	13.0%	21.7%	N/R	35.9%	28.0%	28.9%	N/R	N/R	0.0%	N/R		N/R	N/R		N/R	62.0%	
	FFT Recommended Rate	*Target = 97%*	N/R			91.0%	79%	88.0%	100.0%	N/R	92.0%	89.0%	97.0%	100.0%	100.0%	97.0%	94.0%	92.0%	N/R	97.0%	N/R	N/R	100.0%	N/R	100.0%	95.2%	100.0%	N/R	99.0%	100.0%	88.0%	88.0%	97.7%	N/R	94.1%	100.0%	92.9%	N/R	100.0%	N/R		N/R	N/R		N/R	100.0%	
	Number of complaints received	*Target = 0*	N/R	3	2	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0		1	0		0	0	10
	Quality Questions																																														
Governance	Incidents > 14 days, not yet signed off	*Target = 0*	1	60	3	2	1	0	5	5	1	6	0	0	0	4	0	0	0	5	0	0	2	0	1	0	5	4	4	0	0	2	1	0	2	4	5	19	7	1		1	0		0	6	157
	Harm related to Incident (Moderate+)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overdue Duty of Candour	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staff Development	Appraisals	*Target = 85%*		79.33%	78.79%	96.8%	92.1%	89.19%	95.1%	95.0%	58.1%	85.0%	95.0%	73.7%	92.3%	78.9%	97.9%	92.3%	100.0%	77.8%	88.9%	85.7%	90.0%	82.1%	90.8%	92.0%	88.9%	97.6%	86.4%	100.0%	87.0%	85.0%	77.8%	78.6%	92.0%	88.9%	100.0%	84.9%	55.6%			93.1%	93.2%		97.0%	89.5%	87.9%
	Statutory Training	*Target = 95%*		92.32%	96.86%	96.78%	93.44%	78.90%	89.45%	87.80%	94.64%	91.27%	95.01%	90.83%	92.04%	91.81%	95.95%	95.84%	97.29%	91.45%	92.66%	94.68%	94.35%	97.36%	95.81%	97.57%	97.79%	93.88%	96.95%	94.13%	88.34%	95.30%	88.11%	88.89%	92.30%	91.67%	96.59%	91.0%	94.2%			94.4%	88.5%		94.3%	95.98%	93.7%
	Compulsory Training	*Target = 85%*		94.37%	97.39%	97.9%	87.8%	92.6%	87.4%	93.3%	91.1%	86.3%	89.1%	86.7%	88.2%	87.9%	90.5%	88.0%	97.4%	91.9%	88.2%	94.4%	77.6%	97.8%	95.6%	92.3%	94.3%	90.4%	90.7%	90.5%	87.0%	91.0%	88.2%	88.5%	97.5%	92.7%	94.3%	93.9%	89.2%			85.0%	86.0%		96.9%	96.7%	90.7%
Safe Care Compliance and Red Flags	SafeCare Compliance	*Target = 95%*	100.0%			92.9%	65.2%	65.2%	85.7%	51.8%	85.7%	66.1%	52.7%	70.5%	86.6%	67.0%	95.5%	79.5%	87.5%	90.2%			54.5%		90.2%		75.0%	74.1%	62.5%	76.8%	39.3%	69.6%				71.4%		0.0%	49.1%			0.0%			60.7%	96.0%	67.6%
	Omission in providing medications					0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			0	0					0	0
	Delay in providing medications					0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			0	0					0	0
	Vital signs not assessed/recorded					0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			0	0					0	0
	Missed care provision					0	0	0	0	0	0	0	0	1	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			0	0					0	1
	Less than 2 RNs on shift					0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			1	0					0	1
	Shortfall in RN time					0	0	0	0	0	0	0	0	1	0	0	0	0	0	0			0		0		0	4	0	1	0	2	0			1			0	0					0	9
	Delay in discharging					0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		0		0	0	0	0	0	0	0			0			0	0					0	0
	Total Red Flags					0	0	0	0	0	0	0	0	2	0	0	0	0	0	0			0		0		0	4	0	1	0	2	0			1			1	0					0	11
Staffing & Workforce	% Qualified Staff (Day)					94.1%	96.2%		115.7%	94.8%	94.3%	90.5%	102.2%	94.8%	94.2%			93.5%	102.7%	98.2%			104.4%		92.2%		97.7%	102.4%		81.7%	100.6%	98.9%				95.8%		97.4%	77.9%			73.4%	103.1%		106.7%	80.6%	95.5%
	% Qualified Staff (Night)					92.9%	98.0%		107.4%	78.4%	108.2%	88.9%	93.6%	107.8%	108.0%			113.0%	93.7%	95.3%			100.3%		105.3%		100.8%	106.5%		100.6%	120.9%	117.6%				83.6%		89.9%	91.3%			181.9%	92.2%		95.3%	85.8%	102.2%
	% un-Qualified Staff (Day)					100.1%	119.5%		146.8%	101.6%	102.1%	100.0%	99.8%	109.8%	101.6%			99.8%	104.9%	102.2%			104.8%		94.1%		98.4%	100.0%		79.4%	99.6%	100.0%				100.0%		93.5%	84.8%			60.1%	88.9%		98.3%	88.5%	99.2%
	% un-Qualified Staff (Night)					107.6%	115.8%		107.3%	106.5%	113.0%	114.5%	101.6%	128.3%	141.9%			177.4%	103.2%	111.2%			134.5%		67.7%		96.8%	119.8%		97.0%	110.4%	115.1%				83.0%		92.8%	214.1%			103.3%	92.0%		103.7%	77.6%	112.9%
	Registered Agency % (Day)					0.0%	1.4%		0.0%	4.0%	3.2%	5.9%	1.2%	2.8%	3.5%			1.4%	2.3%	4.3%			0.0%		0.0%		8.9%	0.7%		5.1%	0.4%	1.9%				1.0%		0.0%	0.6%			0.0%	0.0%		0.0%	0.0%	1.9%
	Registered Agency % (Night)					0.0%	1.9%		2.8%	0.0%	10.3%	10.5%	0.0%	6.2%	0.2%			0.0%	1.8%	1.5%			3.1%		0.0%		2.9%	0.0%		0.0%	0.0%	3.0%				0.0%		0.0%	9.6%			0.0%	0.0%		0.0%	0.0%	2.1%
	Care Hours Per Patient Per Day (CHPPD)					7.32	7.49		9.39	15.42	5.82	7.12	6.80	7.64	9.56			8.72	6.72	6.19			7.01		23.56		13.05	6.88		7.77	8.56	8.19				9.75		29.61	10.23			4.55	7.83		15.21	10.57	
	Sickness (%)	*Target < 4.2%*		10.20%	2.23%	15.36%	7.42%		6.06%		13.56%	6.76%	3.20%	7.72%	9.92%	9.56%	8.05%	7.53%	8.32%	7.71%	0.22%	8.03%	0.98%	16.78%	4.63%	9.83%	4.18%	5.30%	4.99%	8.90%	2.45%	4.23%	0.38%			15.13%	1.83%	6.91%	9.57%			13.06%	2.31%		5.94%	8.61%	7.22%

Data Legend

No data returned	N/R
No Eligible patients	
Colours	Colours represent the differentiation from target (green) on a sliding scale according to frequency of values across the wards. Colours towards amber and red represent worse outcomes for that indicator
WTE	Nursing staff only. The figures do not include data for Doctors, Therapists or Admin

Board Assurance Heat Map - District Nursing Domiciliary & ICS Services

	Indicator	Target	ICS Services															DN Teams							District Therapies						Treatment Rooms			
			Admission Avoidance	Acute Therapies	Anti-coagulant Team	Asylum & Refugee/ Homeless & Vunerable	Bladder & Bowel Service	Community IV Therapy	Diabetes & Endo	Dietetics	District Therapies	Home First	Neurology & LTC	Podiatry	Rheum-atology	SLT	Stroke	North	East	South	West	Central North	Central South	Evening Service	North	East	South	West	Central North	Central South	North	West	South	Overall
Infection Control & Harm Free Care	Monthly New pressure Ulcers (Grade 2)	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	6	2	2	0	0	0	0	0	0	0	0			13
	Monthly New pressure Ulcers (Grade 3)	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	1	1	1	2	0	0	0	0	0	0	0	0			3
	Monthly New pressure Ulcers (Grade 4)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0			1
Patient Experience	Friends and Family Response Rate %	30%	85.0%		95.0%	100.0%	53.0%	100.0%	6.3%	65.0%	16.7%		90.0%		100.0%	45.0%	45.0%	19.2%										5.0%			20.0%			
	Friends and Family Recommended Rate %	97%	94.1%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%										100.0%			100.0%			
	Number of Complaints received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staff Development	Sickness (%)	8.25%	3.7%	6.6%	4.1%	12.03%	14.8%	9.1%	4.9%	3.08%		0.5%	4.6%	1.8%	6.1%	2.3%	3.8%	2.5%	6.1%	4.0%	1.7%	1.7%	8.8%	3.1%							6.7%			5.23%
	Substantive Staff Turnover Headcount (rolling average 12 months)	11.76%	15.5%	14.7%	14.3%	0.0%	20.0%	6.9%	13.3%	27.0%		13.3%	16.9%	13.2%	17.4%	17.1%	12.9%	22.2%	0.0%	15.8%	20.0%	4.8%	4.7%	8.2%							6.6%			12.41%
	Appraisals	85.71%	94.0%	84.8%	100.0%	100.0%	100.0%	78.6%	81.0%	89.5%		100.0%	92.3%	97.1%	88.2%	88.2%	89.3%	81.0%	100.0%	66.7%	92.0%	95.5%	69.2%	89.2%							93.5%			89.88%
	Statutory Training	97%	97.1%	90.1%	95.7%	92.0%	98.0%	100.0%	96.4%	95.2%		97.5%	98.9%	97.0%	97.2%	96.6%	96.5%	95.1%	98.6%	96.7%	91.7%	97.8%	96.2%	95.5%							97.7%			96.36%
	Mandatory Training	97%	93.8%	91.2%	97.1%	97.9%	95.8%	97.8%	93.7%	100.0%		100.0%	100.0%	96.3%	95.1%	100.0%	96.6%	96.2%	97.0%	96.6%	91.5%	97.6%	94.8%	96.3%							92.7%			94.59%

Data Legend

No data returned	N/R
No Eligible patients	

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

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

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	
Executive Sponsor	Medical Director		Decision	

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

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee meetings held in November 2024 and January 2025.

Executive Summary	The attached reports from the Chair of the Quality Assurance Committee provide an overview of matters discussed at the meeings held on 27 November 2024 and 22 January 2025. The reports also set out the assurance 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 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, Non-Executive Director	**Presented by:**	Fiona Taylor, Non-Executive Director

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

Name of Committee /Group:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	27 November 2024	**Date of next meeting:**	22 January 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Committee Effectiveness Review
- Board Assurance Framework
- Integrated Performance Report
- CQC Well Led Recommendations – Medical Director
- Clinical Correspondence on EPR
- Maternity Incentive Scheme Year 6 Progress Update (CNST) Infection Control Annual Report
- Safeguarfing Annual Report
- Patient Safety Incident PSII 251 025
- Patient Safety Incident PSII 244 372
- Clinical Governance & Quality Chair Report

ALERT

Agenda items	Action Required
None.	

ADVISE

- Integrated Performance Report - an important safety concern around VTE was noted. One division had recovered their position, but another had a continuing issue although this was awaiting validation. An update on VTE performance will be brought to the next meeting.
- SHMI methodology had been updated and now included all COVID deaths. The Trust had previously reviewed the quality of care which had not been found to be substandard. An action plan on SHMI will be included in next Mortality Report.
- Clinical Correspondence Update on EPR – the report provided an update on the work to improve outcomes associated with clinical correspondence across the Trust. Despite no divisions fully achieving the target for inpatient and outpatient correspondence, there was a mainly improving picture, but challenges were noted in Paediatrics and Outpatients. It was noted that a digital solution was required to address the delays in Outpatients, but this had been deferred until June 2025. The decision to delay to the Electronic Patient Record (EPR) in Outpatients was made to safeguard the delivery of the Maternity EPR, but the timeframe for roll out of Outpatients EPR had been shortened to offset the delay. An update would be brought back to the meeting in three months and include worst and best-case scenarios.
- Maternity Incentive Scheme Year 6 Progress Update (CNST) - the service was progressing well with all ten safety actions and had attained 25 of the 94 recommendations. Eight of the outstanding actions highlighted as red related to the final submission and verification of the evidence by an approving body. An issue was raised around increasing the capacity of the triage department and the importance of aligning pathways, particularly for managing reduced fetal movements, to ensure consistent care and reduce variations that could impact stillbirth rates was highlighted. Planned improvements included introducing telephone triage, updating assessment cards, and realigning staffing. The long-term plan involved moving the triage department to a new location for better emergency transfer routes.

ASSURE
• Committee Effectiveness Review - Overall, the results from the survey were positive and indicated the Committee had continued to build on its effectiveness since the last report in November 2023. • Board Assurance Framework - following the last presentation of the BAF it had been reviewed and updated to reflect the new Trust Strategy. • CQC Well Led Recommendation – following the CQC Well-Led report which had identified pharmacy as an area for improvement the Pharmacy Department had been tasked with delivering three key actions which had been completed. • Infection Control Annual Report – ther report outlined performance against key metrics including but not limited to healthcare associated infections (HCAI) that are reported externally as part of the mandated UKHSA Data Capture System (DCS). Overall the data provided assurance that the Trust was a provider of clean safe care. • Safeguarding Annual Report - the report advised the Trust had upheld its statutory safeguarding obligations for children, young people and adults at risk throughout 2023-2024. The Trust had approved additional safeguarding resources and contractual standards improved, with red-rated areas eliminated and management plans implemented for amber areas. • Patient Safety Incident Report – PSII 251 025 and PSII 244 372 - the reports provided assurance that the patient safety incidents had undergone a robust investigation process under the NHSE Patient Safety Incident Response Framework (PSIF) and appropriate learning and improvement actions had been identified.
New Risks identified at the meeting: No new risks.
Review of the Risk Register: N/A

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	22 January 2025	**Date of next meeting:**	19 March 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Integrated Performance Report
- Mortality and Learning from Deaths Report
- Fractured Neck of Femur
- Maternity Incentive Scheme Year 6 Progress (CNST)
- Annual Stillbirth Report
- National In-patient Survey Report
- Internal Audit of Divisional Governance Assignment Report 2024/25
- Clinical Governance and Quality Chair Report
- Performance and Transformation Board Chair Report

ALERT

Agenda items	Action Required

ADVISE

- Mortality and Learning from Deaths – the report highlighted that the mortality rate was above expected, this was due to the inclusion of covid-19 cases in the calculations and other changes in the methodology relating to the first consultant episode. It was noted there was a requirement for improved documentation and coding practices to support the accuracy of mortality data. An action plan had been developed to address issues identified in the report.
- Still-birth Review – the review covered the period April 2023 to March 2024 during which 21 stillbirths occurred. A thematic analysis of the data was undertaken using the defined elements of the Saving Babies Lives bundle. The demographic analysis confirmed 60% of the 20 cases reviewed were of Black Asian and Minority Ethnic groups and the local incidence of stillbirth occurred in the highest areas of deprivation in Bolton, which aligned with national findings. The review highlighted areas for service improvement to reduce risk relating to the detection of sepsis, monitoring of foetal growth, care of multigravida women and improving the uptake of an early booking appointment. The report also highlighted the need for targeted interventions in areas of high deprivation. The Director of Midwifery was scoping opportunities to move initial contact points earlier in pregnancy aligned to the still birth review suggestive of finding that higher percentage of stillbirths occurred at 24-27 weeks. Current pathways are in line with national guidance, however to ensure the organisation reduces any avoidable inequalities in care outcomes there is a need to consider re-aligning pathways to maximise impact. An update would be brought to the committee in six-months.

ASSURE

- Integrated Performance Report – the quality elements of the performance report were received and the key points were highlighted. The Chief Operating Officer provided a verbal update on the key operational highlights from December advising:
    - Overall Type 4 hour performance was 61.6% which showed a decline compared to November's performance. However, January to date, performance had improved.
    - There had been a statistical improvement in performance across a wide range of metrics on the Operational Safety Wall.
    - The Trust was slightly over trajectory for 65 week wait patients, however, the number of patients waiting 52 weeks had halved in the last six months. Efforts would continue to reduce this.
    - Diagnostic performance was at 18.5% there was an improvement trajectory project and plans were in place to address this.

  The committee discussed Audiology and agreed a deep dive into the Audiology waiting list would be completed and an update brought to the next meeting.
- Fractured Neck of Femur - performance over recent months against the 36 hour standard for these patients had deteriorated, with a marked deterioration over the course of the last year. This was as a result of increased demand, increased acuity, and changes to the theatre timetable. The Division would continue to work through the action plan outlined to bring about sustained improvement to performance and ultimately an improvement to patient safety and experience. It was expected that an improvement in performance would be seen by Q4 2025. The Medical Director would provide an update to the committee in six months.
- Maternity Incentive Scheme Year 6 Progress (CNST) – the organisation was in a position to be able to declare compliance with the CNST year scheme. However, it was noted that there would continue to be ongoing monitoring and focus on the training and digital requirements.
- National In-Patient Survey Report – the report highlighted that the Trust was in-line with other organisations. Areas for improvement were highlighted which included the length of time for receiving a bed and the quality of food.
- Internal Audit of Divisional Governance Assignment Report 2024/25 – the internal audit report provided substantial assurance on the trust's governance processes. All actions from the audit had been completed.

New Risks identified at the meeting:
No new risks.

Review of the Risk Register:
N/A

Report Title:	Clinical Negligence Scheme for Trusts Year 6 Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to confirm the final compliance position with regard to attainment of the ten safety actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Year 6 Scheme (MIS), prior to formal submission of the declaration to NHS Resolution by the 03 March 2025.

Previously considered by:	This report was discussed at Quality Assurance Committee on 22 January 2025. Comments from the meeting are included on page one of this report.

Executive Summary	Key highlights: • Assurance can be provided that the service successfully met the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint review undertaken on the 09 January 2025. • The declared position assumes that all evidence submitted to the Local Maternity and Neonatal System (LMNS) within the defined timeframes will be presented to the relevant integrated care system quality surveillance committees on behalf of the Trust. • Ongoing monitoring of defined action plans within the programme will continue until commencement of the CNST year 7 scheme and detailed updates are provided within this report. • This report provides assurance that the service has not received any external reports that may contradict the maternity incentive scheme declaration and confirms that the final position has been shared with commissioners prior to submission to the Board of Directors. This report confirms that compliance with all requirements of the CNST year 6 maternity incentive scheme can be evidenced in accordance with the requirements detailed in the declaration form.

Proposed Resolution	The Board of Directors are asked to: i. Receive the contents of the report. ii. Approve the action plans detailed within this report. iii. Authorise the signing of the declaration form by the Chief Executive prior to submission to NHS Resolution by the 3 March 2025. iv. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required

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

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Potential impact upon maternity incentive scheme fund reimbursement.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

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

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

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries
RCOG	Royal College of Obstetricians and Gynaecologists

Summary of additional detail requested by Quality Assurance Committee meeting following presentation of the paper on the 22 January 2025.

1. Request made for statistical process control charts to be added to Table 4 – Safety Champions locally agreed dashboard to evidence changes in data over time for key metrics – addition will be made to future reports.
2. Amendment fetal monitoring training compliance metric to align with table 3 compliance – amendment made.

1. Introduction

The purpose of this report is to confirm the final compliance position with regard to attainment of the ten CNST maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (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

A summary of progress to date with regard to the attainment of all MIS ten safety actions identified within the CNST year 6 scheme is detailed in table 1 as reflected in the Trust declaration document.

Table 1 – CNST year 6 progress update as of 9 January 2025

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes		6	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes		19	0
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?	Yes		9	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes		8	0

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

The maternity service has met all reporting requirements relating to the national perinatal mortality review scheme and the evidence submitted has been verified by the Local Maternity and Neonatal System.

The maternity service was advised formally in June 2024 that that upon conclusion of the year 6 scheme all activities to meet the year 6 SA1 standards should continue, prior to the announcement of the start of year 7.

The maternity service will therefore continue to submit a report each quarter that includes details of all deaths reviewed from the 8 December 2024 and continue to monitor the required indicators in future board reports namely: .

- a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.
- b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
- c) **Review the death and complete the review**: For deaths of babies who were born and died fin your Trust multi-disciplinary reviews using the PMRT should be carried out from 2 April 2024; 95% of reviews should be started within two months of the

death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

All cases that have occurred since 8 December 2023 are detailed with Appendix 1 with progress relating to thematic actions identified from the completed reviews detailed in Appendix 1a.

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

The service presented an action plan to the Board of Directors in September 2024 that detailed progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice. A copy of the updated ongoing action plan is detailed in Appendix 2.

A recent update on the quality improvement project to reduce unexpected admissions to the neonatal unit for term babies with Respiratory Distress Syndrome was presented at the Maternity Safety Champions meeting on the 6 November 2024. An overview of the quality improvement work was also formally presented to LMNS colleagues on the 4 November 2024.

The aim of the quality improvement work is to reduce the number of babies admitted to the Neonatal Unit with respiratory distress syndrome with a particular focus on care and feeding provision in the first hour often referred to as the ‘golden hour’.

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

a**) Obstetric medical workforce**

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 4)

c) Neonatal medical workforce

An assessment of the neonatal medical staffing in accordance with BAPM standards was undertaken during Q1 2024/2025 which highlighted a 2WTE gap in the 24/7 Tier 3 practitioner presence within the service. The action plan to attain full compliance and demonstrate progress since the CNST year 5 scheme was presented to the Board of Directors in September 2024.

Progress since submission of the year 5 action plan can be evidenced as resident cover has now commenced two days per week and successful recruitment has taken place during the interim period. A reallocation of the PAs following the recent appointment of an additional SAS doctor is currently being undertaken to release Consultant cover for the Tier 3 rota prior to collation of a business case for the remaining uplift.

Table 2 - Neonatal medical staffing – overview of compliance with British Association of Perinatal Medicine (BAPM) standards for neonatal medical staffing.

NICUs	Tier 1 separate rota compliance 24/7	Tier 2 separate rota compliance 24/7	Tier 3 separate rota compliance 24/7	Tier 3 presence on the unit
Greater Manchester				
RBH	Compliant	Compliant	Compliant	Non-compliant

d) Neonatal nursing workforce

An assessment of the neonatal nursing workforce summary tool was last formally undertaken by the North West Neonatal Operational Delivery Network (NWODN) as part of an annual review in conjunction with the service in Q1 2024/2025. The action plan to attain full compliance and demonstrate progress since the CNST year 5 scheme was presented to the Board of Directors in September 2024.

The Q2 NWODN return completed in October 2024 confirmed the service had a 20.47WTE Registered Nurse deficit in accordance with the nursing workforce calculator and BAPM standards for direct patient care.

BAPM optimum standards for Neonatal care recommend that 70% of the “Nursing establishment” should be Qualified in Speciality (QIS) trained.

The NNU nursing establishment (inclusive of quality roles) is currently funded for 82% Qualified in Speciality (QIS) trained and is 62% compliant with the QIS standard for direct cot side only.

The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cot side care with ongoing recruitment and progression of staff to undertake further training. The service continues to support and identify staff to undertake the QIS training which occurs twice per year (October and February). The service continues to identify staff to attend the QIS training cohorts and further increase the QIS compliance within the service.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

A quarterly assurance review of the bundle implementation was undertaken on 17 December 2024 attended by the LMNS / ICB (as commissioner) and the Trust. The discussion included a review of progress to date, monitoring of progress against local plans and a review of themes and trends with regard to each of the six elements of the care bundle. Progress with regard to attainment of the six bundle elements is detailed in Appendix 3.

A grading of significant assurance and compliance score of 89% was awarded to the service with regard to full implementation of the care bundle (Appendix 3). The LMNS have also provided written verification that they are assured that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory

A declaration letter has been signed by the Executive Medical Officer to provide assurance that progress towards the full implementation will continue to be monitored by the Trust Board and LMNS in line with the required improvement trajectory. Future assurance progress updates will be provided in subsequent quarterly Board reports.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

The service attained all required training compliance metrics prior to the 30 November 2024 as per table 3.

It is to be noted that the requirement for maternity support workers to attend the newborn life support training update is determined by local policy as per CNST requirements. Currently within the maternity service the support staff do not attend the full newborn life support update as they are trained in their appropriate role response to all emergency situations in the current PROMPT training and this includes role appropriate actions such as calling for support and scribing when appropriate. The LMNS have however highlighted that this practice is not in accordance with other local maternity providers and thus the attendance of support workers at the full newborn life support update session will be reviewed prior to commencement of the year 7 scheme.

Table 3: CNST professional training matrix – updated 29 November 2024

Course	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	NA	100%	100%	100%	97.44%	100%	NA	NA	NA	100.00%	100%
Fetal Monitoring Core Competency Stds.	NA	100%	100%	NA	NA	100%	NA	NA	NA	NA	NA
Fetal Monitoring GMEC Comp. Assessment	NA	100%	100.00%	NA	NA	99.23%	NA	NA	NA	NA	NA
Neonatal Life Support	100.00%	NA	NA	NA	NA	96.92%	100.00%	100.00%	99.14%	NA	NA

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

The recent SCORE cultural survey was published in May 2024 following completion of the perinatal quadrumvirate cultural leadership programme. Formal feedback was provided to the quadrumvirate team on the 29 August 2024 following engagement sessions with staff groups and a cultural improvement plan was developed to align with the Family Care Division Staff Survey Plan (Appendix 4). The action plan includes actions to address the issues identified in the SCORE survey relating to capacity and resource, collaboration within teams, leadership and learning.

The board safety champions and perinatal leadership team last met on the 2 January 2025 and discussed the cultural action plan. Engagement sessions are currently being held with both medical and midwifery staff groups to improve communication and engagement between all parties. A survey is also currently in progress to seek the wider views of medical staff with regard to improving the culture and working practices within the maternity service. Staff walkabout sessions and celebratory events are also scheduled to thank staff for their valued contribution and promote leadership visibility.

As part of the work of the safety champions walkabouts are held bi-monthly. During the visit in January 2025 feedback was sought from service users regarding the friends and family test and the ideal location of the posters for the QR responses – this was enacted immediately during the visit. Information gathered continues to be collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 5).

The Board Safety Champion continues to work with the safety champions to address the reduced bed capacity within the ward G3/G4 environment and review the impact upon safety outcomes using the integrated performance dashboard metrics.

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Assurance audit

An internal audit to ascertain compliance with the reporting of qualifying cases for MNSI*/ NHS Resolutions Early Notification scheme has been undertaken for the outstanding period from the 01 October 20204 until the 30 November 2024.

The audit demonstrated that no cases were reported during this period.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the 'Implementing a revised perinatal quality surveillance model' guidance published in 2020.

In response Board level safety champions have presented a locally agreed dashboard to the Trust Board quarterly since November 2022 as detailed in table 4. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff / service user feedback sessions are displayed in Appendix 7.

The dashboard is used in conjunction with monthly integrated performance management reports to evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. The dashboard will continue to be presented by a member of the perinatal leadership team to provide supporting context.

Ongoing monitoring of the metrics is undertaken at bi-monthly safety champion meetings with the perinatal quadrumvirate leadership team where any additional support required of the Board can be identified an escalated. The last bimonthly meeting was held on the 2 January 2025.

Table 4 – Safety Champions locally agreed dashboard

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

Indicator	Goal	Red Flag	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		410	419	426	451	441	374
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			2	2	1	1	2	0
Still Birth rate per thousand	3.5	≥4.3	4.9	4.8	2.3	2.2	4.5	0.0
HIE Grades 2&3 (Bolton Babies only)	0	1	1	1	1	0	0	0
HIE (2&3) rate (12 month rolling)	<2	2.5	1.9	2.2	1.8	1.4	1.2	1.2
Early Neonatal Deaths (Bolton Births only)	Information only		3	3	3	0	0	3
END rate in month	Information only		7.4	7.2	7.1	0.0	0	3.0
Late Neonatal deaths	Information only		0	0	0	0	0	0
PSII Incidents (New only)	0	2	0	0	0	0	0	0
MNSI referrals (Steis reportable)			2	2	1	0	0	0
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	0	1	0	0	0
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	98.6%	99.0%	99.7%	99.7%	99.1%	98.5%
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%	94.0%	98%	99.0%	100.0%	99.00%	100.0%
Fetal monitoring training compliance (overall)	<90%	>80%	84.33%	87.40%	88.00%	83.62%	83.90%	94.23%
PROMPT training compliance (overall)	<90%	>80%	81.61%	86.22%	83.00%	85.10%	82.37%	99.63%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:22.6	1:22.6	1:22.9	1:22.8	1:21.9	1:21.3
RCOG benchmarking compliance	Information only		85.7%	60%	100%	100%		
Compensatory rest breaches			0	0	1	0	0	0
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual		37.3%					
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual		69.2%					

The service attained the required compliance standards relating to newborn life support, fetal monitoring and emergency skills training at the end of November 2024 following the dedicated efforts of the wider multidisciplinary team and wider Divisional colleagues.

The service reported two intrapartum stillbirths during 2024 to MBRRACE. Both cases have been reviewed using the perinatal mortality tool and both related to preterm infants at 25 weeks gestation with known complications.

5. Summary

This report confirms the final compliance position with regard to attainment of the ten safety actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Year 6 Scheme (MIS), prior to formal submission of the declaration to NHS Resolution. The report provides assurance of ongoing monitoring of the CNST year 6 scheme requirements.

This report provides assurance that all requirements of the CNST year 6 maternity incentive scheme can be evidenced in accordance with the requirements detailed in the declaration form. In response, the Committee are asked to approve the signing of the completed declaration form by the Chief Executive prior to submission to NHS Resolution by the 3 March 2025.

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

Appendix 1 – Perinatal mortality review tool cases as from 08 December 2023

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Gestation	DOB/ Death	Reported within 7 days	PMRT Started 2 Months Deadline Date 100% factual questions	Date parents informed/concerns questions	Report published Deadline Date 6 months
90970	Postnatal NND. 28 days	24	20.12.23	0	20.2.23 done 2.1.24	20.12.2023	20.6.23 **Done 30.5.24**
90993	ENND	22	21.12.23	0	Assigned to MFT 21.02.24	21.12.23	21.6.24
91162	SB	25+2	03.01.2024	0	03.01.2024	03.01.2024	20.6.2024
91589	ENND	35+3	29.01.2024	0	29.01.2024	29.01.2024	**27.06.2024**
91686	ENND	38+0	04.02.2024	0	06.02.2024	04.02.2024 and 06.02.2024	**04.07.2024**
91814	SB	25+3	09.02.2024	0	09.02.2024	10.02.2024	**25.07.2024.**
91853	SB	26+3	11.02.2024	1	11.02.2024	11.02.2024	18.07.2024
91945	Post NND > 29 DAYS OLD	30	18.01.2024 17.02.2024	0	17.04.2024 Assigned to Blackpool	20.02.2024	18.07.2024

91972	SB	40+0	19.02.2024	0	19.02.2024	19.02.2024	19.08.2024
91991	ENND	26+1	18.02.2024 20.02.2024	0	20.04.2024 Assigned to MFT (NMGH)	24.02.2024	20.08.2024
92299	SB T2	27+ DIAG/36+ BIRTH	11.03.2024	0	07.06.2024	10.03.2024	11.09.2024
92395	NND	34	07.02.2024 29.02.2024	15 due to not known- Community /home Death	19.03.2024	05.06.2024	29.08.2024
92646	Late Fetal Loss	22+3	02.04.2024	0	02.04.2024	05.04.2024	02.10.2024
92923	NND	24+	14.04.2024 20.04.2024	0	21.04.2024	22.04.2024	22.10.2024
93126	SB	38+1	01.05.2024	0	03.05.2024	02.05.2024	01.11.2024
93150	SB	29	02.05.2024	0	03.05.2024	20.05.2024	02.11.2024
93167	SB	40	05.05.2024	0	06.05.2024	06.05.2024	05.11.2024
93360	ENND	22+1	16.05.2024	2	18.05.2024	18.05.2024	16.11.2024
93394	SB	25	19.05.2024	1	20.05.2024	21.05.2024	19.11.2024

93618	SB	24+6	03.06.2024	0	04.06.2024	15.06.2024	03.12.2024
93712	SB	39+2	09.06.2024	1	10.06.2024	10.06.2024	07.11.2024
93915	ENND	40	16.06.2024 21.06.2024	0	24.06.2024	21.06.2024	21.12.2024
94081	ENND	23+	28.06.2024 01.07.2024	0	02.07.2024	01.07.2024	01.01.2025
94116	SB	31+4	02.07.2024	0	02.07.2024	03.07.2024	02.01.2025
94292	SB	26+2	13.07.2024	2	13.09.2024	14.07.2024	13.01.2025
94328	ENND	24+3	16.07.2024	1	16.08.2024	16.07.2024	16.01.2025
94798	ENND	22+1	19.08.2024	0	assigned to Wigan 23.08.2024	19.08.2024	19.02.2025
94819	SB	25+5	19.08.2024	1	20.08.2024	20.08.2024	19.02.2025
95000	LATE MISC	23+2	01.09.2024	1	02.09.2024	05.09.2024	01.03.2025
95082	SB	27+1	06.09.2024	3	01.11.2024	11.9.24	06.03.2025
95840	SB	27+2	29.10.24	1	30.11.24	29.10.24	

96169	NND	23+0	21.11.2024 23.11.2024	0	23.01.2025	25.11.2024	23.05.2025
96354	SB	24+4	04.12.2024	1	04.02.2025	04.12.2024	04.06.2025
96351	NND	29+1	04.12.2024		04.02.2025	04.12.2024	04.06.2025
96412	SB	33+1	09.12.2024	1	09.02.2025	10.12.2024	09.06.2025
96482	LFL	22-23	13.12.2024	3	13.02.2025	16.01.2025	13.06.2025
96621	LFL	22+3	26.12.2024	1	26.02.2025	26.12.2024	26.06.2025
96707	SB	38+5	31.12.2024	1	31.02.2025	31.12.2024	31.06.2025

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.	3
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 on new SBLV3 training day agenda.	3

				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 / Fran Ireland	01/12/2024	08.10.24 Undertake audit of compliance and identify actions to be undertaken in response.	**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	**2**
7. 5	Targeted offer for multigravida families in highest risk areas to be considered using REACH pregnancy circles service.	Trudy Delves	01/03/2025	18.12.24 REACH pregnancy circle training commenced.	**2**
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.	
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.	

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 – Safety Action 3 – Action plan to introduce care to preterm infants in transitional care.

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	January 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.	
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	

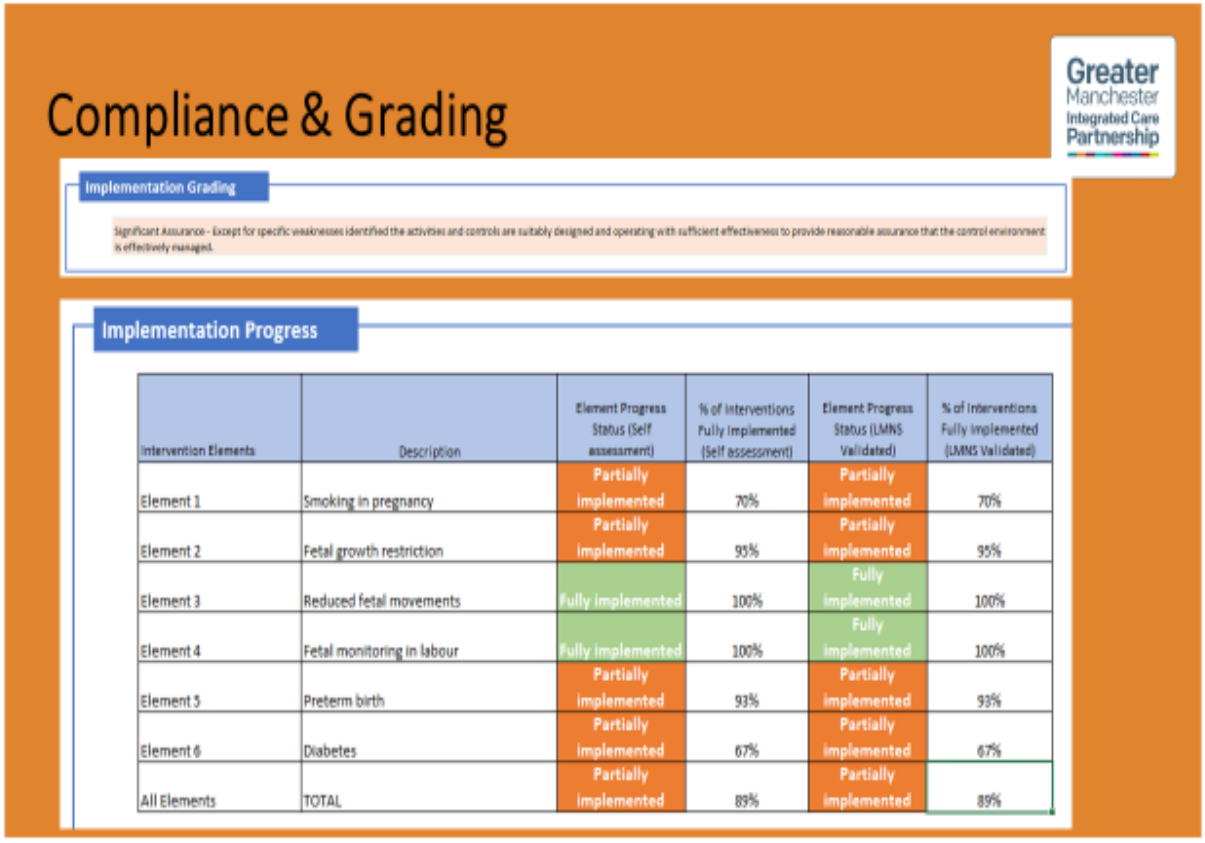
					alternative beds within intrapartum services. NNU Lead consultant discussed with HOM SCBU cots availability, for TC service provisions.	
		3.2 Audit available equipment for TC service	TC Lead	February 2025		
4	Training	4.1 Ensure maternity staff are appropriately trained to provide safe and effective 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 HEE ATAIN e-learning module as a one-off training. **03.12.2024** Complex care matron met with NNU ANNP to discuss training package required.	

		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.	

		4.3 Introduce the Aquatherm heated mattresses to be used within intrapartum areas to support thermoregulation and all maternity staff to sign an equipment competency after training	TC Lead	March 2025	**24.10.2024** Delivery to the trust of 8 Aquatherm heated mattresses**.** **07.11.2024** Aquatherm SOP 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.	
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.	
		5.2 Audit NNU local service activity of 34-weeks gestation infants in Q1 and Q2 2024 admitted to NNU, to benchmark the	TC Lead	January 2025		

		care requirements for this group of infants.				
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	January 2025		
		6.2 Review resources available on BAPM, ODN network and design a parental leaflet for TC service	TC Lead, Matron for complex care	April 2025		

Appendix 3 – LMNS SBLV3 compliance rating as of 17 December 2024



Compliance & Grading

Greater Manchester Integrated Care Partnership

Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	70%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	93%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	89%	Partially implemented	89%

Appendix 4 - 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 themContinue 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.	

Appendix 5 – Staff and patient feedback from the safety walk rounds.

You Said	We did
May 2024 Lack of bed capacity remains an ongoing concern for staff.	Staff briefed on the submission of the RAAC business case to NHS England and the interim actions taken to reduce the ongoing pressure such as the provision of an extra doctor at weekends and a NIPE Midwife to support activity. Options appraisal in progress to consider short to medium term actions to be taken until all works completed.
Battery pack needed in baby resuscitation units to ensure heating can be provided during transfer to other areas.	Giraffe unit being procured
July 2024 Additional ward equipment required	Request made for additional equipment to be provided namely: - CTG machines on G3 - Additional computer G4 - Medicine trolley for G4 - Examination of the newborn equipment.
September 2024 Room for telephone Triage awaited	Estates request approved for sink removal in consultant room Work commenced – October 2024
Staff not aware of progress of RAAC works	Engagement sessions scheduled to promote staff and service user engagement.
Midwifery staffing	Professional judgement review of all clinical areas undertaken and staff will be realigned to the new allocations 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.

Maternity incentive scheme - Year 6 Guidance

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

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

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

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025
Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

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

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	No
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	Yes
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		

9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	No
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
11	Was the above workforce action plan shared with the LMNS?	Yes
12	Was the above workforce action plan shared with the ODN?	Yes
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

Safety action No. 5

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	No
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	Yes

Safety action No. 6

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes

12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 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?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Section A : Maternity safety actions - Bolton NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
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?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

Section B : Action plan details for Bolton NHS Foundation Trust

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

Action plan 1

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

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

Action plan 2

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

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

Action plan 3

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

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

Action plan 4

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

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

Action plan 5

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

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

Action plan 6

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

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

Action plan 7

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

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

Action plan 8

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

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

Action plan 9

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

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

Action plan 10

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

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

NHS Resolution

Maternity Incentive Scheme - Year 6 Board declaration form

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

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

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

Sign-off process confrming that:

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

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

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

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Bolton NHS Foundation Trust
Name:	
Position:	
Date:	

Signatures added in PDF

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Family Care Division

CNST year 6 Update
30 January 2025

Our new Maternity and Women's Health Unit

CNST Year 6 summary

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
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?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

Headlines

- ✓ All 10 safety actions achieved
- ✓ Trust level quality improvement and transformational project support received throughout programme
- ✓ External LMNS checkpoints have supplemented the evidential verification process
- ✓ External Future Collaboration platform used to enhance ICB/LMNS visibility

Highlights

Frequent oversight of evidence for approval of Board or Committee

- Regular Board level and Executive oversight has ensured timely escalation of concerns and provision of support

Training & education

- Dedicated administrative support has improved management and oversight of training database and compliance

LMNS support

- All evidence uploaded to external Future Collaborations channel
- LMNS checkpoints continued and data externally reviewed by dedicated LMNS panel

Next Steps

- Approval of presentation and declaration on 30 January 2025
- Final CEO sign off and submission of declaration form to LMNS after Trust Board
- LMNS will then submit the completed form to the Accountable Officer for the Integrated Care Board and then return to the Trust
- Trust submission of the signed declaration form by the Chief Executive Officer to NHS Resolution by the 3 March 2025

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

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Our new Maternity and Women's Health Unit

Report Title:	2023 National Adult In-Patient Survey Summary Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	To provide the Board with a summary of the findings of the 2023 National Adult in-patient survey.

Previously considered by:	**Quality Patient Experience Forum** (QPEF), to receive and approve actions to be taken in response and oversight of progress of actions. **Clinical Governance and Quality Committee** (04 December 2024). Report reviewed and recommendations accepted. Confirmed iFM as critical partner in relation to patient experience will be invited to QPEF in future to ensure oversight and support in relation to aspects of the report related to cleanliness and food. **Quality Assurance Committee** (22 January 2025)

Executive Summary	The scores for Bolton NHS Foundation Trust (BFT) are mostly in line with the sector scores and are stable year on year. In relation to the survey and benchmarking undertaken by IQVIA, when compared to the other sector organisations, 15 scores are in the top-20% range. There are 33 scores that are in the intermediate-60% and one in the bottom-20%. Based on National benchmarking by the CQC, the Trust was “about the same” when compared to other trusts for 44 questions, “somewhat better than expected” in one question and “better than expected” in four questions. The findings from the IQVIA report have been presented at the QPEF and a number of actions agreed.

Proposed Resolution	The Board of Directors are asked to: • Note the findings and scores from the National Adult Inpatient Survey 2023 • Note the recommendations agreed at the QPEF and approved at CG&QC • Note progress of actions will be reported and overseen at QPEF and reported to CG&QC for assurance.

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:	Tracy Joynson Patient Experience Manager Stuart Bates Director of Quality Governance	**Presented by:**	Tyrone Roberts, Chief Nurse

Background

The CQC oversee the National NHS Patient Survey Programme. Bolton NHS Foundation Trust (BFT) Commissions IQVIA UK&I Healthcare (formerly Quality Health) to undertake the National Adult Inpatient Survey on our behalf.

The IQVIA benchmarking provided is based on those Trusts surveyed by IQVIA. Benchmarking data based on all Trusts by the CQC is published Nationally.

For BFT, 384 surveys were completed and returned from the 1215 sample, which provided an overall response rate of 32% compared with 33% in 2022.

IQVIA – Initial benchmarking

The scores for BFT are mostly in line with the sector scores and stable year on year.

In relation to the survey and benchmarking undertaken by IQVIA, when compared to the other sector organisations, 15 scores are in the top-20% range. There are 33 scores that are in the intermediate-60% and one in the bottom-20%.

Compared to the 2022 National Adult Inpatient survey, seven scores were in the top-20% of scores and three scores were in the bottom-20% of scores.

From the 2023 survey, the score in the bottom-20% range was*: How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?* This was also in the bottom-20% of scores in 2022. Although this does feature in the bottom-20% of scores in 2023, it does appear on review of the benchmarking report that there has been some improvement in this score. However, IQVIA have changed the way results are displayed and recorded in 2023 and therefore it is not possible to state with certainty the actual change. The below table summarises the scores based on average scores in a section.

Section	Bolton Hospital NHS Foundation Trust	All Trusts surveyed by IQVIA
Admission to hospital	6.72	6.96
The hospital and ward	7.65	7.52
Doctors	8.84	8.70
Nurses	8.47	8.32
Your care and treatment	8.22	8.09
Leaving hospital	7.24	6.86
Overall	7.50	7.37

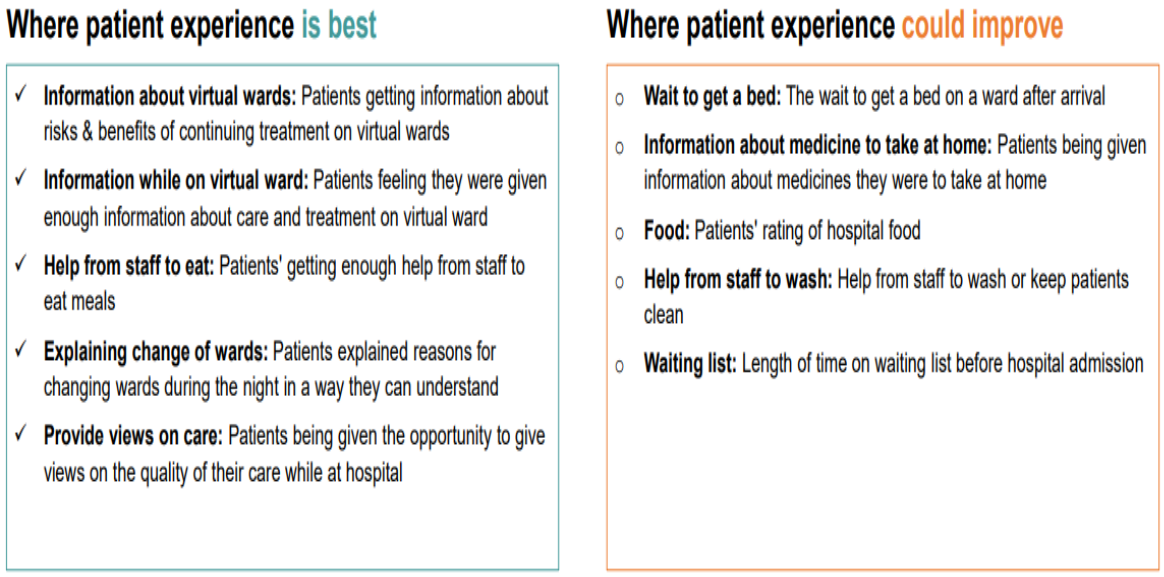
The table below indicates BFT highest and lowest scoring results for 2023 across the entire survey.

Top 5 questions	Score
Q28 Were you given enough privacy when being examined or treated?	9.70
Q16 During your time in hospital, did you get enough to drink?	9.46
Q6f Were you every prevented from sleeping at night by any of the following@ Room temperature	9.20
Q40 To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	9.17
Q48 Overall, did you feel you were treated with respect and dignity while you were in hospital?	9.12
Bottom 5 questions	**Score**
Q6h Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping.	3.60
Q50 During your hospital stay, were you given the opportunity to give your views on the quality of your care?	3.91
Q41 Thinking about any medicine you were to take at home, were you give any information?	3.97
Q36 To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.64
Q5 How long do you feel you had to wait to get a bed on a ward after you arrived at hospital?	5.73

CQC National benchmarking

Based on National benchmarking by the CQC, the Trust was “about the same” when compared to other trusts for 44 questions, “somewhat better than expected” in one question and “better than expected” in four questions.

Overall, areas where patient experience was best and where this could improve have been identifed.



The Trust was not a negative outlier for any questions when benchmarked nationally. However, one question was considered to be "significantly worse" when compared to the 2022 Adult Inpatient Survey results. This appear to relate to: *How clean was the hospital room or ward that you were in?*

The Trust compared "better than expected" in relation the below questions:

- Did you get enough help from staff to eat your meals?
- Were you given enough privacy when being examined or treated?
- Were you given enough information about the care and treatment you would receive while on a virtual ward?
- Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

The Trust compared "somewhat better than expected" in relation to the below question:

- To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

Quality Patient Experience Forum

The findings from the IQVIA report have been presented at the QPEF and a number of actions agreed.

- **Recommendation 1** (related to long stays) is being focused on by a separate Urgent Care workstream therefore QPEF does not recommend that there be a separate workstream related to this. The group will receive quarterly summaries of developments.
- **Recommendation 2** (related to cleanliness), this is being monitored at the IPC Committee and as part of the Clostridium Difficile Quality Improvement Collaborative. As above, QPEF will receive an update and quarterly summaries of developments.
- **Recommendation 5** (related to food). this standard is measured as part of the PLACE (Patient-Led Assessments of the Care Environment) inspection. This took place 6 November 2024 and as such QPEF recommends that iFM produce a formal report from the 2024 PLACE inspection with a special focus on the quality and quantity of food and agree what the expectations are for the forum to oversee improvements.
- There are two remaining recommendations that will be reviewed by Divisional representatives to understand and explore how they plan to make improvements in medication discharge information and the provision of personal hygiene for patients. Once proposed and agreed, QPEF will require updates no less than quarterly on any initiatives commenced.

As the National benchmarking position has now been completed by CQC, this will be reported to QPEF and any additional actions will be identified and monitored via this forum.

Recommendations

The Board of Directors are asked to:

- Note the findings and scores from the National Adult Inpatient Survey 2023
- Note the recommendations agreed at the QPEF and approced by CG&QC
- Note progress of actions will be reported and overseen at QPEF and reported to CG&QC for assurance.
- Note the report has been presented to QAC on 22 January 2025.

Report Title:	Combined Mortality and Learning from Death Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Medical Director		Decision	

Purpose of the report	The Mortality and Learning Deaths Update provides an update on the current risk adjusted mortality and an update on Learning from Deaths

Previously considered by:	Quality Assurance Committee

Executive Summary	**Mortality** NHS Digital data for SHMI between August 2023 and July 2024 shows Bolton at 117.65, which is in the 'higher than expected' range. The SHMI has increased since the last reported figure of 114.97. This is largely driven by the change in methodology which led to a 3.8% change in the SHMI between December 2022 and November 2023. The key areas of focus that have been identified to impact and improve the SHMI are: 1. Review of clinical care 2. Improving primary diagnosis 3. Increase Charlson co-morbidity recording 4. Aim to code by 'flex' date **Learning from deaths** This report is the second iteration following the review of the governance, structure and efficacy of the Learning from Deaths (LfD) Committee which now reports into the Mortality Steering Group. Following the clinical review of the mandatory definition of national mandated alerting groups and the identification of organisational priorities for LfD reviews came into effect from September 2024. For the months of September and October, there were 195 deaths. 57 were identified for primary review. 17 have been completed to date. There are 0 secondary reviews, but the number will

	increase as the primary reviews are completed due to the reporting lag of two months. There are currently 18 secondary reviews outstanding that have been carried over from Q2. The themes identified from Learning from Deaths are: 1. Response to deteriorating patients 2. DNACPR 3. Communication and documentation 4. Advance care planning 5. Recognition of end of life Action plans related to both work streams (Mortality and Learning from Deaths) are included in the body of the paper.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Mortality and Learning from Death 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:	Dr Rauf Munshi, Interim Associate Medical Director, Nicola Caffrey, Corporate Business Manager for the Medical Director, Liza Scanlon, BI and Michelle Parry, Clinical Audit and Effectiveness Manager	**Presented by:**	Dr Rauf Munshi, Interim Associate Medical Director

Mortality Update

National reporting process for calculating risk adjusted mortality and the key influencing factors

National guidance sets out how risk adjusted mortality should be calculated and is a standardised process. SHMI (Summary Hospital-level Mortality Indicator) measures mortality outcomes at a hospital level, comparing the actual number of deaths to the expected number of deaths for a standard population. It is adjusted by comorbidities, patient demographics and other contributing factors such as clinical characteristics.

The risk adjusted mortality is calculated based on the primary diagnosis at the first consultant episode, the recorded Charlson co-morbidities and the number of completed coded episodes. The First Consultant Episode (FCE) refers to the first time a patient sees a consultant following admission for a specific health issue. The ED assessment is not part of the mortality calculation process. The FCE is critical to coding accuracy as it influences how coders assign diagnostic codes for the initial encounter which impacts the ongoing care episode. The issue of recording within the FCE is also related to the rules of coding recording which does not always align to the way clinician's document information within patient records which can lead to misunderstanding between clinicians and coders and inaccuracies when submitting coding data.

During the FCE, any existing health issues (i.e. comorbidities) need to be properly recorded to ensure the patient's outcome is accurately reflected based on their current health and the likelihood of survival. Poor or under recorded co-morbidities will lead to a disparity between expected death and observed death, resulting in the risk adjusted mortality falling out of the control range.

The ward based administrative team, mainly the ward clerks have an important role to play here as well. When a patient is admitted to the hospital, how the information is recorded in LE2.2 will have an influence on the risk adjusted mortality. The longer the FCE is open, the better the chance of capturing the most detail and information. The FCE closes as soon as patient care is changed from one consultant to another. This can have numerous times within the first 24 hours as patients change from the on call consultant to the ward consultant their care is transferred under. This can lead to the FCE completing before all the information is gathered. On some wards, a new episode is created every time consultants rotate which could be every week or fortnightly even if the patient does not change ward or specialties. This can potentially impact mortality recording.

The coding team work to 2 different deadlines; 'flex' date and 'freeze' date with a 6 week gap between these two dates. The coding rules allow this time for further clarification and

amendments between flex and freeze date, therefore by coding the majority of the episodes for the month before the flex date should allow time between flex and freeze date for the clinicians and coding team to work together to further clarify the primary diagnosis and the co-morbidities recorded.

The four main improvement themes that have been identified in relation to mortality are held within the mortality action plan (Appendix A).

Impact for Bolton on national methodology changes

NHS Digital introduced changes to the methodology that creates SHMI from the May 2024 publication (for the period February 2023 to January 2024 and onwards).

The changes and impact were:

1. Inclusion of COVID-19 diagnosis and the creation of its own diagnosis group.

Previously any patient stay with a diagnosis of COVID-19 was excluded in its entirety even if the diagnosis was a secondary condition and diagnosed later on in the patient stay. All COVID-19 activity is now included in the SHMI if the discharge date is on or after 1 September 2021, this means it is included in the underlying 3 year model that is used to calculate the risk adjustments. The inclusion was made because the death rate for COVID-19 stabilised from mid-2021 compared to the initial stages of the pandemic and so it is now feasible to include this activity in the SHMI.

Impact for Bolton NHS Foundation Trust of the inclusion of COVID

Proportionately, Bolton has seen 6th biggest shift across the country in the SHMI with an extra 260 deaths and 1,421 spells included across all diagnosis groups with the new methodology. This includes 60 deaths and 377 spells forming the new diagnosis group for COVID-19 leaving 200 deaths and 1,044 spells split across the other diagnosis groups. 152 spells have an invalid diagnosis.

SHMI based on old methodology v new – December 2022 to November 2023

	Old methodology	New methodology	Percentage change
SHMI	107.64	111.76	3.8%
Observed deaths	1427	1687	18.2%
Expected deaths	1325.66	1509.43	13.9%
Discharges	55384	56805	2.6%

The increase in the number of observed deaths included is proportionately the 4th highest in the country. This means that the number of patients who were once excluded in the old methodology who went on to die (not necessarily from COVID-19) is proportionately a lot higher than other Trusts - this directly corresponds with the high level of COVID-19 in Bolton reported throughout the pandemic.

The risk adjustments applied to all discharges have not shown such a proportionate increase. The expected number of deaths have remained low due to not recording the correct number of co-morbidities which has led to a bigger disparity between the expected and observed deaths. This means that the levels of Charlson co-morbidities applied to the patient stay were not high enough which a known historical issue is. This is now an issue across all diagnosis groups not just the COVID-19 diagnosis group as there are deaths and discharges now included where COVID-19 would have been a secondary diagnosis and therefore once excluded. In the last 12 months there has been a focus on improving co-morbidity recording which included the introduction of Charlson co-morbidity recording section within the clerking document on EPR.

2. **Change in dominant episode.**

If the diagnosis was unclear and the consultant wrote a sign or symptoms diagnosis, this was termed an 'R' code as part of the coding guidance. 'R' codes lead to a low risk adjustment score. In this situation, the second consultant episode would therefore be used to determine the primary diagnosis being treated. If this was still recorded as a sign and symptom, then this would be taken as the main diagnosis being treated. Now the primary diagnosis will be taken from the first episode where an R code is not in primary position (this could be 3rd episode or further into the spell).

Impact for Bolton NHS Foundation Trust relating to the change in dominant episode

The dominant episode used to determine the diagnosis grouping is now at the first episode in the spell where the diagnosis is not an 'R' code - this could be late on in the patient stay. Previously this would be the second episode if the first was an 'R' code. This will be beneficial for Trusts where the diagnosis is not fully determined until much later in a patient journey.

The diagnosis is generally determined at first or second episode in Bolton and has been the case historically. Using the same timeframe (December 2022 to November 2023) the proportion of provider spells with a primary diagnosis which is a symptom or sign is 18th lowest when compared to all acute trusts. This means that the diagnosis has been determined by the second episode in the majority of cases. Therefore, there will not be much of a change in the diagnosis grouping and risk adjustments associated with the primary diagnosis in Bolton.

However, it will positively impact other Trusts where the proportion of spells was a symptom or sign was higher as the diagnosis was determined later on in the spell. This is because the risk adjustment for a 'sign and symptom' code is low, therefore any Trust where this is no longer the primary diagnosis for SHMI calculations will have an increase in the expected deaths, in turn reducing their SHMI. As a result of this their SHMI will likely improve which could worsen the relative position of Bolton when compared against all trusts.

3. **Inclusion of blank records (invalid) as their own diagnosis group.**

Previously these were combined with another diagnosis group. Blank records skew the data as there are not any risk adjustments applied in terms of the primary diagnosis or any Charlson comorbidities entered.

Impact for Bolton NHS Foundation Trust on the inclusion of blank records as separate diagnosis group

There have been capacity issues in coding in recent times resulting in more records being uncoded at deadline. This will be closely monitored to evaluate the impact.

All these factors have resulted in the shift in the calculation of SHMI to a level that is almost 4% higher than the previous methodology, shifting the position of the Trust over the 90% upper confidence[1] limit (red dotted line) at 111.76. Previously the Trust was below the 90% upper confidence limit line at 107.46.

NHS Digital classes a Trust as 'as expected' until it is above the upper 95% confidence limit indicated by the solid red line in the charts below. Bolton is still classed 'as expected' despite worsening and falling above the 90% upper limit. The split to an Amber alert (over the 90% upper limit but below the 95% upper limit) is shown for reference only and to easily show the worsened position due to the change in methodology.

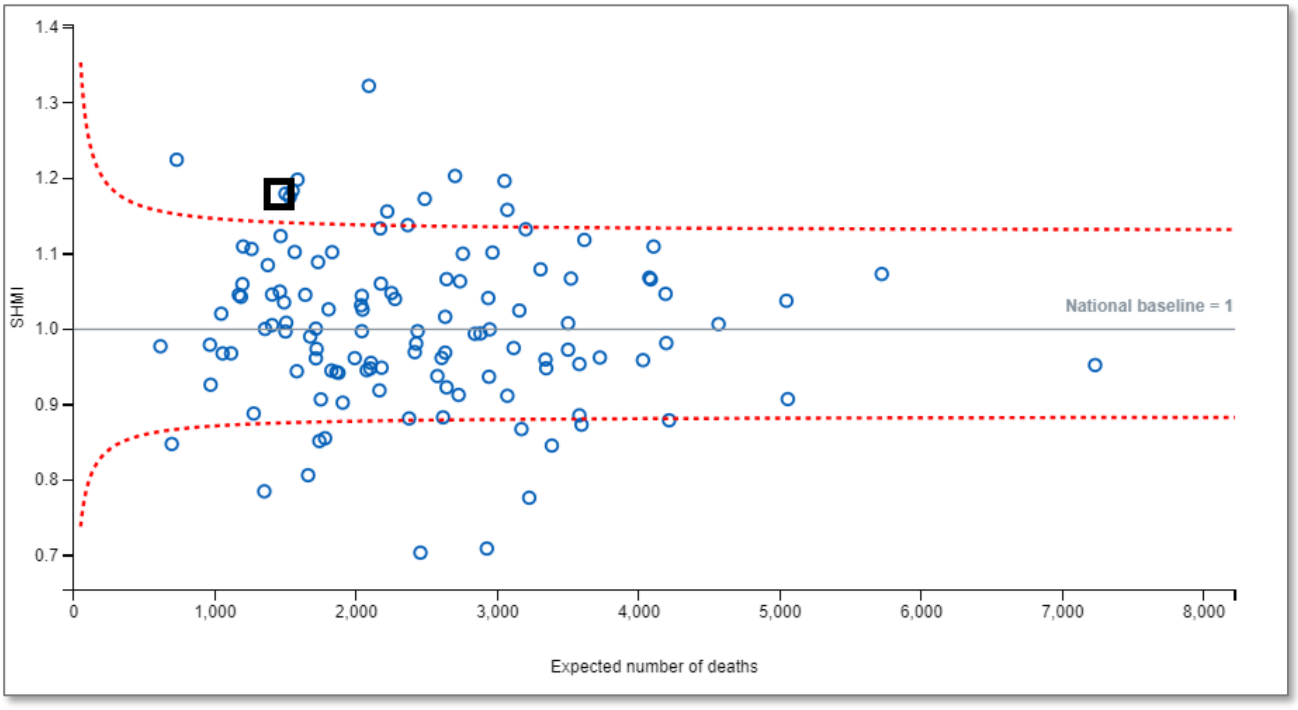
Current risk adjusted data

1.1 Summary Hospital-level Mortality indicator – SHMI

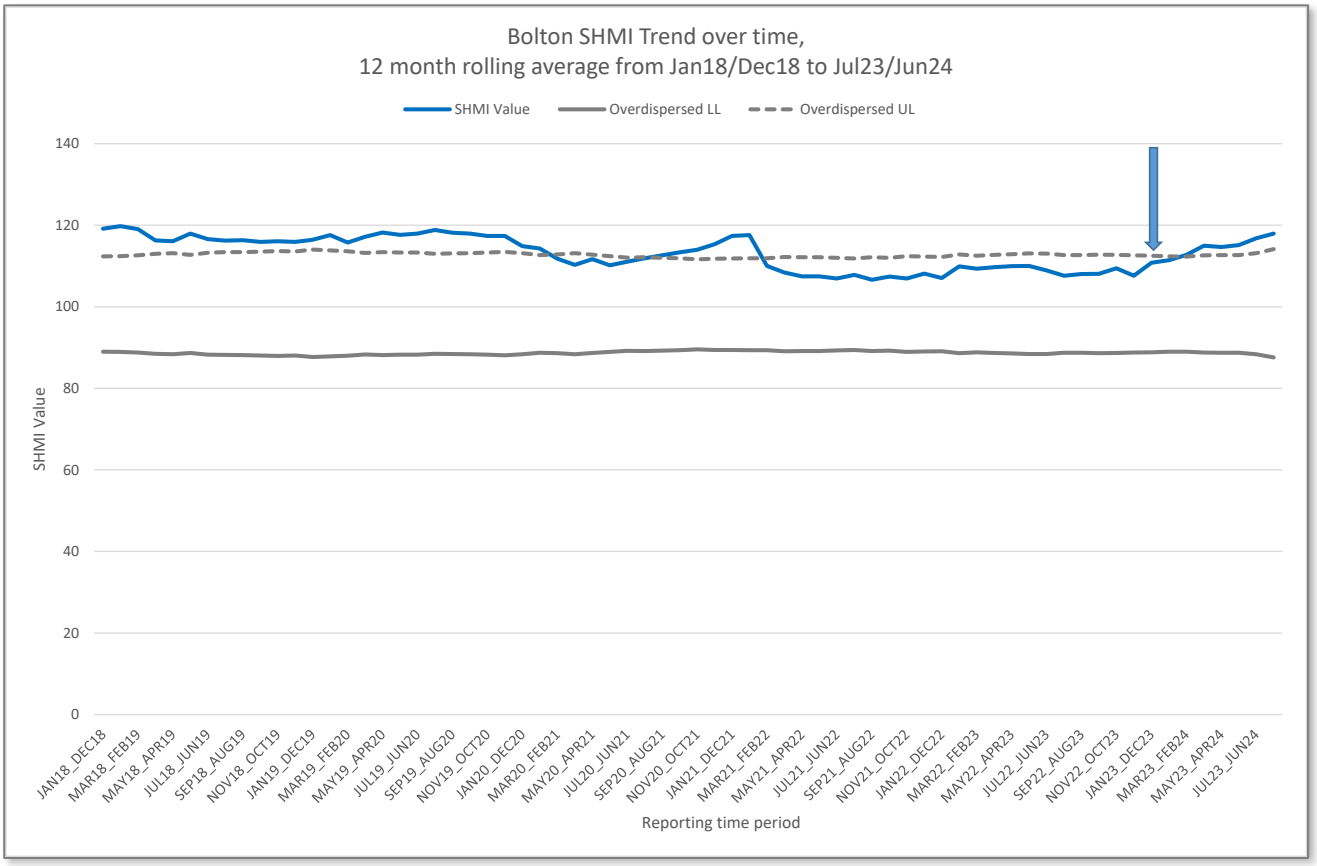
NHS Digital data for SHMI (August 2023 to July 2024) shows Bolton at **117.65**, which is in the 'higher than expected' range. The SHMI has increased since the last reported figure of 114.97[2] [3].

[2] 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

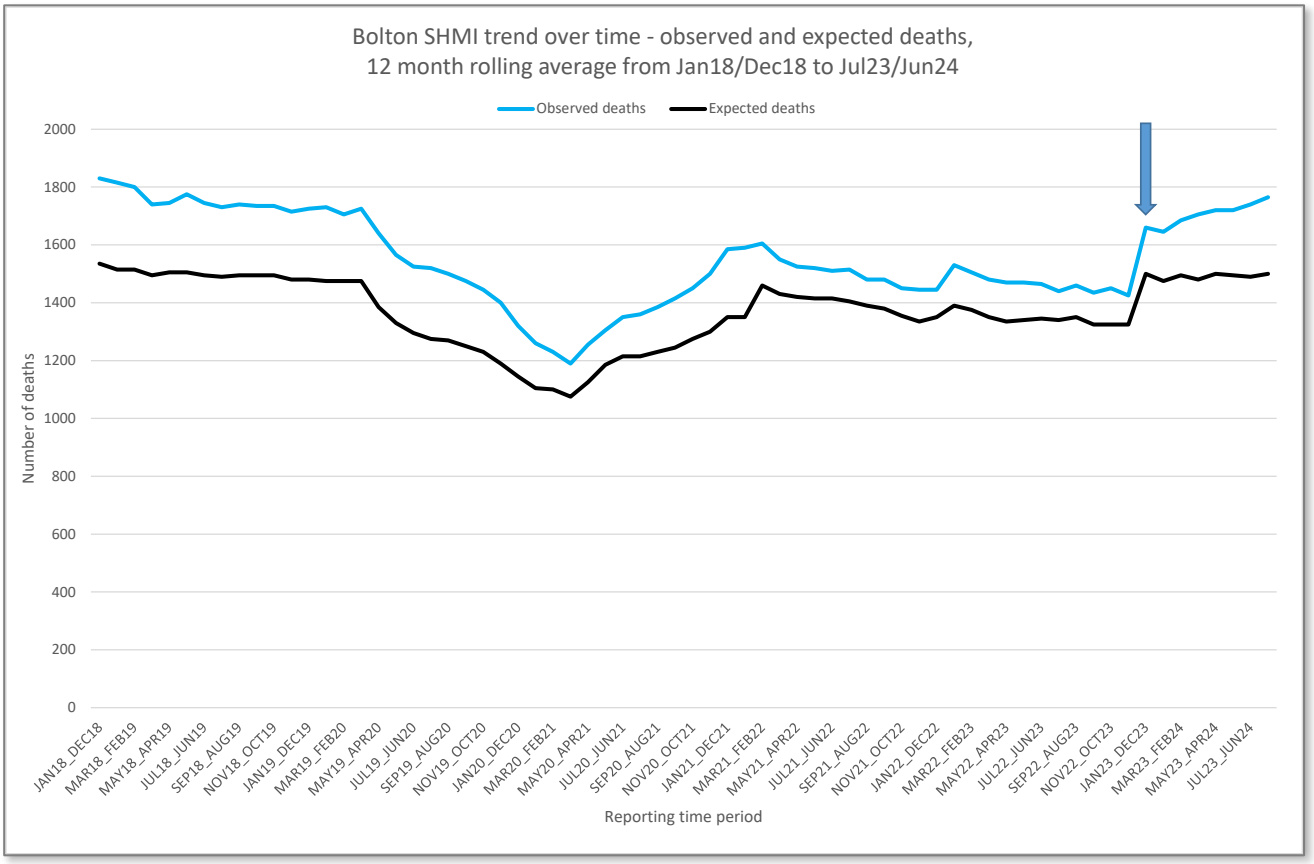
[3] All data in this section is published data from NHS Digital which includes patients who have 'opted out' of their data being shared for research purposes



The rolling average for Bolton tipped into the 'higher than expected range' from March 2023 to February 2024, this is slightly after the methodology change. The gap between the observed and expected deaths at this point increased causing a shift that has not been recovered from and is further highlighted in the observed and expected deaths chart.

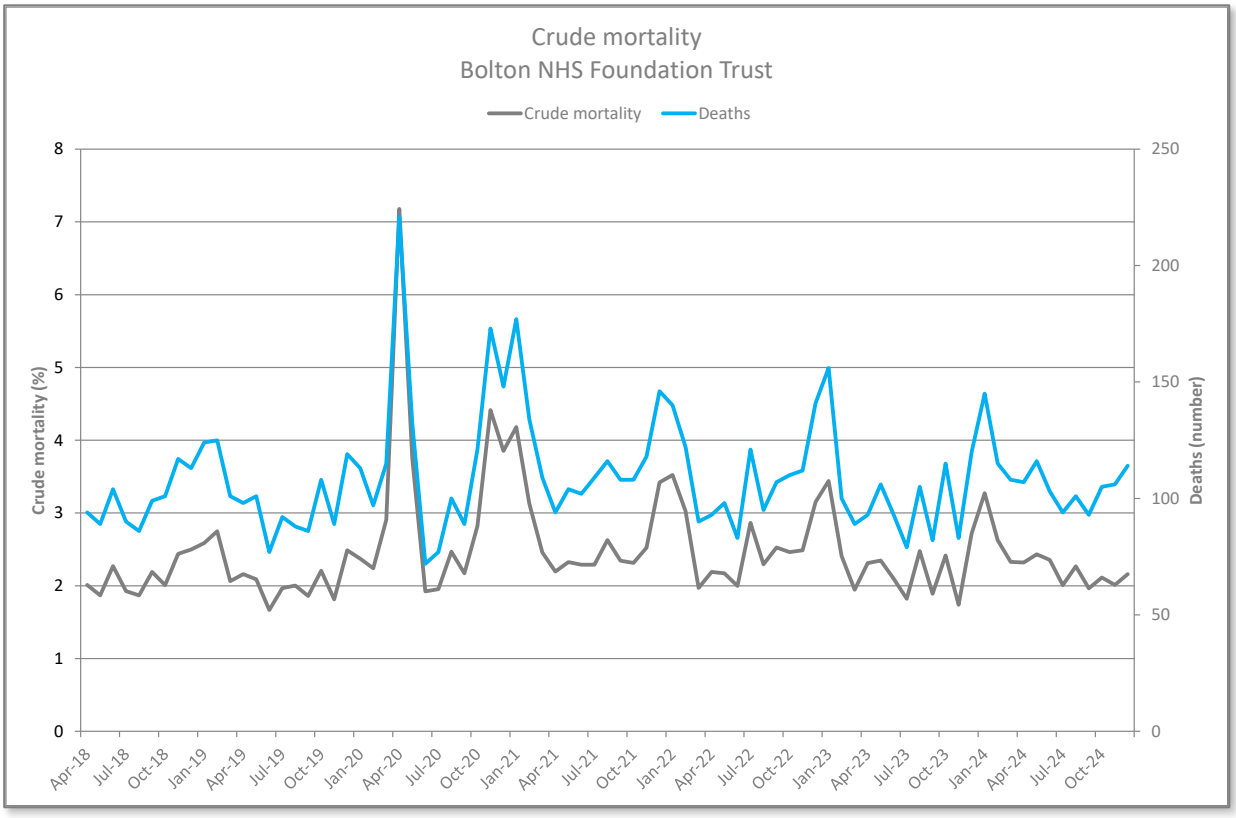


The gap between observed and expected deaths shows a distinct increase from the change in methodology. The number of observed cases continues to rise to pre pandemic levels but the expected has plateaued and not increased in line with the increase in observed deaths.



Crude mortality (excluding day case patients)

Using the crude number of deaths as a proxy for the SHMI/HSMR positions shows that there has not been any drop in the recorded numbers 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. Feedback from clinicians suggest that this may be in line with the urgent care pressures and the high acuity observed throughout the last 12 months but will be monitored through the mortality governance processes.



Mortality improvement themes and action plan

Theme 1 – Assurance on the quality of the care provided

The first priority has been to confirm that the change in risk adjusted mortality was not due to poor care.

Using control limits in line with NHS Digital, any group alerting 'Red' would be outside of the 95% over dispersed confidence limit.

Through reviewing the SHMI red alerts by diagnosis group (12 months to August 2024) the alerting diagnosis outlier groups for Bolton within this time period and when compared with other Trusts are Pneumonia, Influenza, skin disorders (including Other inflammatory condition of skin, Chronic ulcer of skin, Other skin disorders) senility, peripheral and visceral atherosclerosis.

Continuing clinical audits through the Learning from Deaths SJR process reviewed the quality of care for a randomised selection of the outlier group and no care issues were identified that triggered a secondary review.

Theme 2 – First Consultant Episode

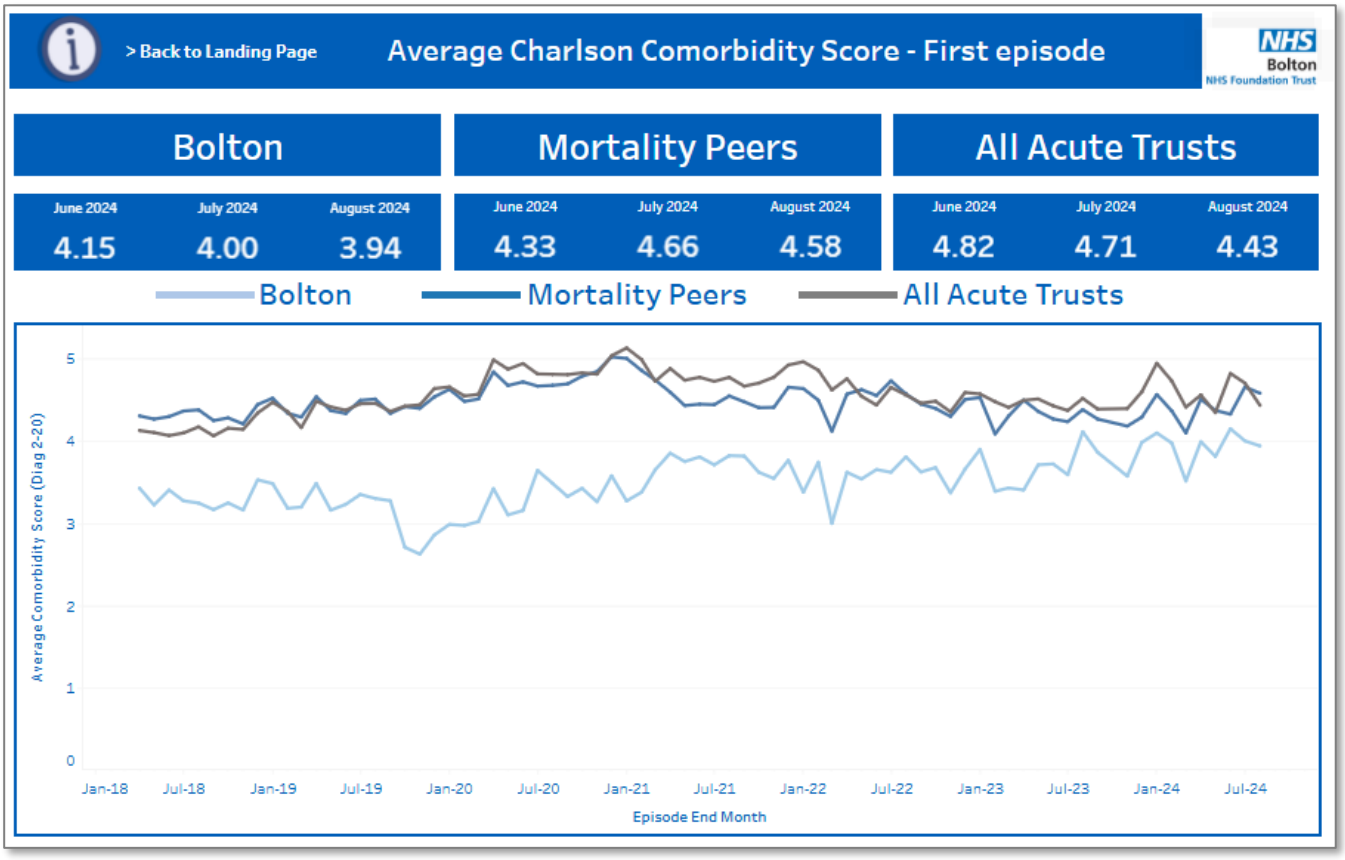
To influence a positive impact on risk adjusted mortality, we need to improve the accuracy of the primary diagnosis. For example, a diagnosis of UTI carries a low risk of death but a diagnosis of septicaemia is significantly higher and therefore the likelihood of death is greater, reducing the expected against the observed deaths.

By improving the data quality relating to the FCE and the way that the information in inputted into LE2.2, a positive impact on the risk adjusted mortality. In addition, by keeping the FCE open as long as possible will allow for more accuracy in documentation and recording depth.

Theme 3 - Average Charlson Comorbidity Recording and SHMI

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

Despite improvements in the recording there remains a gap to Mortality Peers and All Acute Trusts. The successful inclusion of mandatory comorbidity recording with auto population of the Health Issues section of our EPR should result in an improvement in this metric in the coming months.



The difference in Charlson score per spell for those who have died and those discharged is understandably higher as a higher Charlson score would indicate the patient is sicker, however, Bolton patients show a lower average score when compared against peers. The table below[4] [5] shows the average Charlson score for all discharges in Bolton being lower than Wigan and Stockport which is our neighbouring Trust and one of our Mortality peers respectively, both are located within Greater Manchester. Charlson score is one of the main drivers for the risk adjustments within HSMR and SHMI after the diagnosis at primary level in the First episode of care.

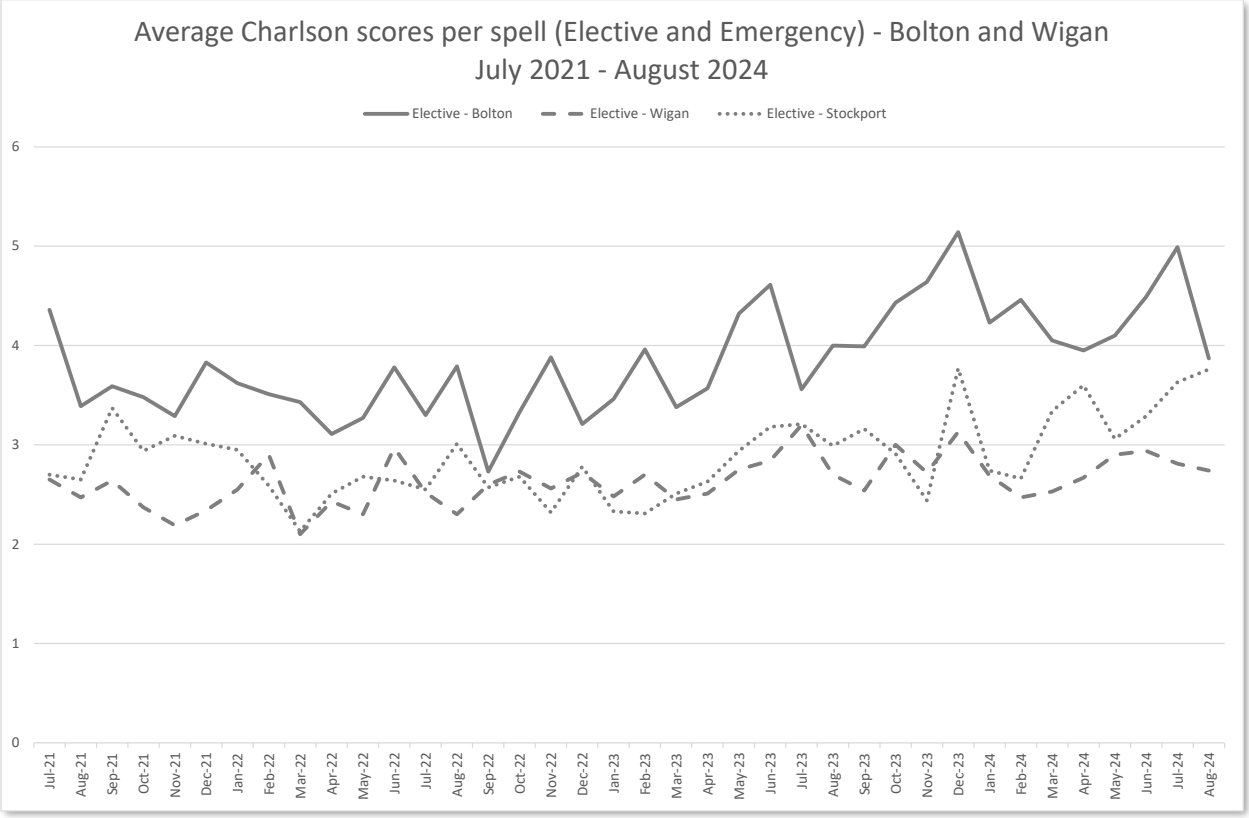
[4] Data is shown for July 2024 only

[5] The data is different in this section. The first table is at first consultant episode, all other data, charts and tables show the average score for the spell

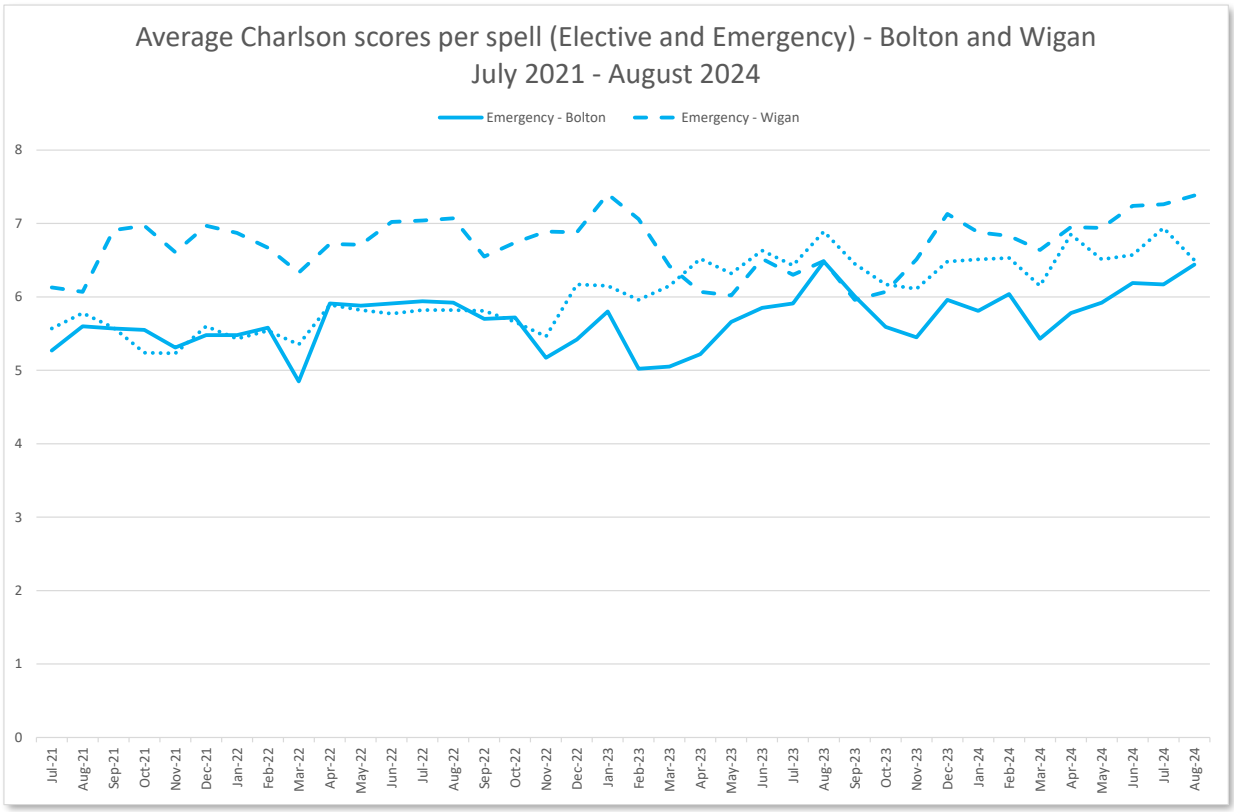
Organisation (provider)	Discharge Method	Number of provider spells	Average comorbidity score per spell
RMC - BOLTON NHS FOUNDATION TRUST	1 - Discharged on clinical advice	4583	3.86
	4 - Died	107	17.87
	9 - Not known	10	7.6
RRF - WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1 - Discharged on clinical advice	3750	5.65
	4 - Died	80	19.08
	8 - Not applicable		34
RWJ - STOCKPORT NHS FOUNDATION TRUST	1 - Discharged on clinical advice	4202	5.06
	4 - Died	94	19.54

The average Charlson scores per spell are split by elective and non-elective and our position is again compared against Wigan and Stockport.

Whilst our elective position scores highly in comparison the position is well below that of emergency average Charlson score per spell.



The Bolton position for emergency admissions is lower than the comparators despite an overall improvement over the timeframe.



Theme 4 - Coding Capacity

There are local and national challenges in the availability and affordability of clinical coders. This has been recently made worse for Bolton due to one clinical coder leaving in January 25 and another handing their notice in. Therefore, this drastically reduces coding team capacity with the risk of not being able to fully code all episodes by freeze date. This means that these patients will all be recorded blank and therefore will have no risk adjustment.

The ambition of having enough capacity within the coding team to be able to full code episodes by flex date will offer the best opportunity to identify and improve accuracy and depth of recording of primary diagnosis and co-morbidities. Currently, regular meetings between coding and clinical leads wherever possible, but the meetings for reviews between flex and freeze are not happening due to no capacity within the coding team.

Appendix A

Action Log

Mortality and Learning from Deaths Overarching Action Log

	Completed No Further Action
	Complete/On-going
	In progress not complete
	Overdue

Ref No	Theme	Description	Action	Responsible	When	Comments	RAG
	Assurance on the quality of the care provided	Review of red alerting groups	Complete SJR for 50% of cases within the identified red alerting groups as part of the LfD groups and process	Clinical Audit/BI	Ongoing	LS and MP managing future iteration of automation of the process	
	First Consultant Episode	Documentation guide for clinicians	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	R Munshi/A Kallat/A Volleamere	Jan-25	Information submitted from AACD	
			Clinical coding team to develop a guide for clinicans to use to support accurate recording of information	Clinical coding team	Feb-25	Coders action dependant on provision of information from AACD and ASSD	
		FCE timings	Audit to measure the impact patient changing consultants leading to brief FCE	LS/GP/PT	Oct-24	Ongoing due to coding capacity	
			SOP created for amending the episode rather than creating a new one for clinician and specialty changes. Discuss with relevant ward clerks	DQ Business Intelligence	Dec-24	This will remove incorrect very short stay episodes	
			Data input by ward clerks to be owned and audited for compliance by Divisions	All Divisions	Mar-25	To commence once SOP ratified	
			Discussion at Tactical Information Group (TIG) the creation of a new episode at rota change of clinicians and possible change to this to stay as one episode if the patient does not change specialties	LS	Dec-24	NHS England contacted for advice, change in consultant at rota change to continue as per definition.	
		Data quality review - day cases	Day cases are excluded from HSMR and SHMI but if entered as 'elective – planned' they will flow through.	BI/DQ	Dec-24		
		'Elective – planned' admissions onto H3	Patients who transfer from Salford back to Bolton had incorrect admission method of 'elective – planned' (should be 'transfer')	BI/DQ	Oct-24	All patients fixed. Ongoing audit to prevent re-occurrence	
	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	November discharges to be audited	
	Coding Capacity	Publicising the coding queries process	Coding queries process to be publicised	PT	Nov-24		
			SOP to be created for discussion with clinicians as to how this will work in practice	PT	Nov-24		
		Coding to flex date	Escalate to board and corporate leads relating to the loss and lack of coding capacity for action and inclusion on the risk register	RM	Jan-25		
		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		

Learning from Deaths Update

This report is the second 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.

Quarter 2 learning from deaths update

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

In order to facilitate this change and ensure a smooth changeover, all historic outstanding alerts from 2023 were analysed and prioritised.

At that time the outstanding reviews totalled:

- 2022/2023 - 105
- 2023/2024 - 101
- 2024/2025 – 17

185 of above reviews were related to MH Diagnosis. Upon clinical review and oversight from specialist colleagues, the definition of severe mental illness (SMI) was reviewed and overlaid to the outstanding reviews to ensure alignment with the national definition, (for example depressive episode, Anxiety, Mild cognitive disorder were removed)

There were 185 cases that were therefore not deemed to meet the threshold for SMI based on the revised methodology from the national definitions and were removed from the outstanding reviews. The remaining 38 were added to the quarter 2 data with 3 reviews currently outstanding. The outstanding reviews are not exclusive to patients who died within that period, however is related to the period when the review was identified.

For Quarter 2 with the inclusion of the backlog, there are 18 secondary reviews that require completing

Quarter 3 Learning from Deaths Update

The methodology for Learning from Deaths changed in September 2024 meaning that there was one month of Q2 impacted by the change in methodology. Any standard or mandated reviews from September (i.e. last month of Q2) has been reviewed under the new methodology and included in the cases for Q3.

Therefore, for September and October 2024, 57 cases were identified which required a primary review. Currently 19% have been completed which have so far identified 0 secondary reviews. However, there are still 18 secondary reviews carried over from the Q2 which will be completed in Q3. Due to the 2 month reporting lag, the data for November and December is not yet available to complete Q3's data set.

	Sep	Oct
Number of In-patient Deaths	93	102
Number Cases identifed *not exclusive by month of death, some may be from previosu months*	**36**	**21**
COMPLETED	13	4
RETURN RATE %	**36**	**19**
Number of Reviews		
First review completed - close review	11	4
First review completed - secondary review required	**2**	0
Secondary completed	0	**0**
Action required from Secondary Review	**0**	**0**
Source	*New Alerts	
Mandated Death (Alert Diagnosis)	-	-
LD Death (LeDeR)	4	1
C Diff	3	2
Deaths within 30 days from a care home	11	11
Joint replacement infection	2	3
Severe Mental Health	1	1
Suicide	0	0
Mental Health Death / In-Patient MH	-	-
Sample	12	3
Requested by cons/matron/Other	1	0
Diabetes Death	0	0
NELA Death	0	0
Medical Examiner	2	0
30 Days PEG Mortality	0	0
BAME + COVID Death	0	0
	36	**21**
Overall Score		
1 (Very Poor)	0	0
2 (Poor)	2	0
3 (Adequate)	4	3
4 (Good)	4	0
5 Excellent	3	1
	13	4

Secondary reviews have historically been completed by the consultant body on a good will basis with no funding. However, there have been a number of changes within this consultant body including retirement of a number of doctors or changes to roles, including supporting WLI's to help with elective recovery and urgent care pressures. In other organisations across GM, there is dedicated job planned time to support the mortality governance processes. This activity does not fall within core SPA but would be within the remit of additional SPA. There is a business case going through CRIG to fund consultant job planned time to support the learning from deaths committee which will include secondary reviews.

Learning from Deaths improvement themes and action plan

Since April 2023, the top themes that have been identified through the Learning from Deaths: Thematic Analysis for first and secondary reviews completed by Clinical Audit and Effectiveness and Quality Improvement team includes:

Theme 1 – Recognition of End of Life

The trust is currently participating in the NCEPOD 'Planning for the End' study. This will be discussed at next LfD Committee and the recommendations will be reviewed via gap analysis with a deadline date of March 2025.

https://www.ncepod.org.uk/2024eolc/Summary%20report_end%20of%20life%20care.pdf

Theme 2 – Communication and Documentation

Trust wide Record Keeping Audit 2024/2025. Annual completion of a Trust wide documentation audit is required to provide assurance to the CQC. Auditing documentation is also part of the GMC MHPS and been the subject of a previous Coroner's action. A selection of proformas have been developed to support the auditing of Medical, Nursing and AHP Documentation.

A target date of completion has been set for March 2025, with a combined report to be presented at CEG 13th May 2025.

Theme 3 – Response to the deteriorating patient

Trust wide collaborative taking place from February 2025 and is also part of the organisational Deteriorating Patient Group.

Theme 4 – Advanced Care Planning

This is part of the virtual frailty ward and admission avoidance team work stream with a focus on care homes to avoid unnecessary admissions. There is a role within the FT for the clinical teams to increase advance care planning prior to discharge of patients back into the community. This is being led by the geriatricians with an update to come back to Clinical Governance by March 2025

Theme 5 – DNACPR

There is a Trust wide DNACPR Audit. A pilot of the compliance of DNACPR Governance Framework was undertaken in November 2024 and presented at the final AQuIL Committee.

The pilot looked at key 8 standards however further clarity is required regarding the wider changes around DNACPR Governance and how this may impact the audit. A meeting is scheduled for February 2025

Appendix B

Action Log

Mortality and Learning from Deaths Overarching Action Log

	Completed No Further Action
	Complete/On-going
	In progress not complete
	Overdue

Ref No	Theme	Description	Action	Responsible	When	Comments	RAG
	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	
	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	
	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	
	Advanced Care Planning	System wide approach to improvements for EOLC planning	Divisions to demonstrate trust and community improvemements to the completion and availabilty of ACP focusing on frailty	AK	Mar-25	AACD to provide first update	
	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	
	Secondary Reviews	Lack of availability for secondary reviewers	Business case has been completed and is being taken to Investment Assurance Group and Financial Investment Group	RM	Feb-25		

Report Title:	People Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 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 21st January 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:	Tosca Fairchild, 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:	21 January 2025	**Date of next meeting:**	18 March 2025
Chair	Tosca Fairchild	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- NHSP Update
- Resourcing & Retention/Volunteer Update
- Organisational Development & EDI Update
  - Our Way Update
  - EDS2022
  - Gender Pay Gap Report
- Freedom to Speak Up Q3 Update
- Guardian of Safe Working Q3 Update
- IFM Monthly People Report
- MIAA Bank & Agency Staff Controls Review
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

ALERT

Agenda items	Action Required

ADVISE

Gender Pay Gap/EDS2022 – The Committee commended the report to the Board of Directors for approval. The discussions that took place on this item are considered in the Board papers.

EDS2022 2024. This is an annual report and the committee were advised of the progress made in the last 12 months and highlights the need for increased focus on patient equity and health inequalities to improve each domain score next year. As a reminder the Trust has recently introduced an enhanced EDI assurance Group to ensure continued momentum in this key area.

Freedom to Speak Up Q3 Update - The report highlighted that 39 Concerns raised in Q3 via FTSU Route; Good response to Octobers National Speak Up Month; Common themes in Q3 are Leadership/ Management and behaviour. It was noted that the Our Leaders Programme and Our Way behaviour framework (mentioned above) are intented to support changes required. The Committee thanked the FTSU Guardians for this independent report and for all their work. It was requested that it would be heplfulf for the Employee Relations report to come at the same time as this report to ease with triangulation for Committee members. All members committeed to completing their FTSU training (Level 2 or 3 dependent on role) withing this calender year.

Guardian of Safe Working Q3 Update - Within the reporting period there were 51 exception reports submitted. This is compared to 34 exception reports submitted during the same period in 2023. 46 related to doctor hours of working; 2 related to the pattern of work; 3 related to the service support available to the doctor. Of these two related to patient safety issues it was agreed that these matters should be reported to the Quality & Safty Committee. No levy was issued by THE GOSW in this quarter. The Medical Director confirmed that he is working with the Surgery Division regarding issues being raised in this area and will report back to the Committee.

Volunteer Services - The report also provided the Committee members with an annual report on the usage of

volunteers across the Trust. Colleagues noted the positive numbers of active volunteers, and the breadth of volunteer roles being used.It was highlighted that we recently celebrated the 90th brirthday of one of our volunteers.

Improving Culture – The Committee welcomed the update on all the cultural work that is taking place across the organisation and particulary how this is horizontally and verticaily aligned. The Our Way and the Our Leaders update both received detailed discussion. It was noted that 1500 leaders to attend a programme is a considerable ask but all commented on the importance of this to ensure 'buy in' across the organisation, It was considered that a Team Cultural Assessment tool is in development that will be used by teams to support them with their cultural journey.

NHSP Update – The People Committee received an update on the financial impact on moving to NHSP. This paper focused on the workforce, operational and quality implications. As a reminder NHS Professionals (NHSP) were engaged by the Trust to provide temporary staffing services (bank and agency) for all agenda for change staffing groups. The contract with NHSP commenced in September 2023 and our contract with them is currently on a rolling basis (with a notice period of 90 days). The majority of GM providers use NHSP so this decision also brought the Trust in line with others and gave us access to rate/trend information from across GM as part of a data-sharing agreement.

Committee members noted a relatively strong overall fill rate for temporary staffing requests (comparable to Trust internal services used prior to NHSP engagement) with a continued shift from agency usage to internal banks (albeit that some of that shift was as a result of historic and new Trust instructions as well as NHSP regional insight and action). Availability of management performance information provided by NHSP has been impressive, but some focussed work has been needed between Trust and NHSP teams to ensure that external reporting on performance has been accurate. Further work is underway to ensure we are utilising this information to continue to improve our management of temporary staffing.

It was discussed at the Committee that we do have a shortage of bank staff for AHP, HCS, and Clerical roles and the actions being taken were discussed.

The Commiteee noted that NHSP delivery will remain under review by the CPO and CFO and updates will be provided to the respective Committees.

Resourcing & Retention Update – This is a standing agenda item for the People Committee. The presentation focusses on key resourcing indicators, areas of good performance, and areas of concern. The Committee heard of the positive performance on variable pay spend with agency running at 2% of paybill against an NHSE target of 3.2%. Bank spend remains under review as operational pressures are having an impact on spend. It was also noted that recruitment performance remains strong. The Committee were advised that whilst performance in recruitment has been positive this has not been supporting the overall financial impact.

ASSURE

MIAA Bank and Agency Staff Controls Review - This report received subsutatial assurance from our auditors. The Committee thanked Paul, his team and the wider organisation for all their hard work in this area .

BAF – There have been no changes since the last meeting. However, a full review of the BAF is planned ahead of the presentation of the next iteration and will reflect the updates following the Risk Appetite Development Session and the feedback from the recent discussions at the Board of Directors and Audit Committee.

New Risks identified at the meeting: None

Review of the Risk Register: None

Report Title:	Gender Pay Gap Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief People Officer		Decision	✓

Purpose of the report	The purpose of this paper is to present the 2024 Gender Pay Gap report.

Previously considered by:	The paper has been discussed at the People Committee whose requested actions are detailed within the Board report.

Executive Summary	This report provides an analysis of the Gender Pay Gap across Bolton NHS Foundation Trust workforce for 2024. The report provides: • An update of our 2024 Gender Pay Gap data position • A summary of work undertaken in the last 12 months to support the reduction of the Gender Pay Gap • Specific action we propose to take to continue to address the Gender Pay Gap in the next 12 months, led by the revised EDI Governance Structure with measurable outcomes.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Gender Pay Gap Report and support the external publication during February 2025. .

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		**Some of the actions required on the action plan require funding.**
Legal/ Regulatory		**This report, in part, allows the Trust to comply with our Public Sector Equality Duty.**
Health Inequalities		**This report summarises health inequality work that is ongoing and planned.**
Equality, Diversity and Inclusion		**This report is the Equality Diversity and Inclusion annual report and plan.**

Prepared by:	Rahila Ahmed, EDI Lead/ Toria King, Head of EDI	**Presented by:**	Lisa Rigby, Assistant Director Organisational Development

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

BAME	Black, Asian and Minority Ethnic
WRES	Workforce Race Equality Standard

WDES	Workforce Disability Equality Standard
MWRES	Medical Workforce Race Equality Standard
CPD	Continued Professional Development

1. Introduction

1.1. The People Committee received the 2024 Gender Pay Gap report at the last meeting on 21st January 2025. A full and detailed discussion took place and this Committee of the Board requested areas of focus moving forward.

1.2. Board members will be aware that reducing the Gender Pay Gap and fostering a culture of inclusion remains a critical priority for Bolton Foundation Trust and is a key element of the Trust Strategy and People Plan.

2. High level summary of findings for Board members

2.1 Board members can see the full findings of the Gender Pay Gap report contained within the attachment to this report.

3. People Committee discussions and actions

3.1 The Committee of the Board expressed their appreciation for the comprehensive report and noted the following points during their discussion:

- Reducing the gender pay gap is a long-term process, particularly in an organisation of our size and complexity. It was noted that this is replicated on a local, regional, national level. Despite these challenges, we are committed to address the gender pay gap.
- The Committee discussed the data set out in the report in detail, including medical staff groups, award payments, career progression and a range of other areas identified in the report as areas of focus.
- Work is underway to develop an "EDI plan on a page" to bring out key EDI actions together and facilitate engagement and communication with wider audiences.

4. Recommendation to the Board of Directors

4.1 The Trust Board are asked to note the details of this paper and note that the People Committee will continue to oversee all relevant actions.

Gender Pay Gap Report 2024

Executive Summary

This report examines the gender pay gaps across Bolton NHS Foundation Trust.

These findings are contextualised within broader national patterns (of which we are not an outlier) and compliance with the Equality Act 2010.

- The **mean** gender pay gap stands at **26.2%** while the **median** gender pay gap is **13.0%.**
- Women are well-represented in middle and lower pay bands
- **Divisions** with the largest gender pay gaps are Acute Adult Care, Anaesthetics & Surgical, and Family Care. A sharp deterioration in the **Corporate Division's** gender pay gap (from 2.8% to 19.8%) indicates a potential emerging issue.
- **Part-time** female staff experience a **mean** pay gap of **32.36%** and a **median** gap of **14.93%,** highlighting a pay disparity for part-time roles.
- **Excluding medical staff** reduces the **mean** hourly pay gap to **4.6%** and the **median** to **2.6%.**

Addressing these gaps is critical to meeting the NHS People Promise and fostering an inclusive culture aligned with our EDI objectives.

We will introduce targeted actions, including revising recruitment practices, enhancing flexible working policies for senior roles, and working on improving talent management practices in all professions, but especially focussed on medical roles.

Accountability mechanisms will be strengthened through the newly launched EDI governance structure, ensuring measurable progress on these initiatives.

1. Background

1.1 In 2017 the Government introduced legislation that made it statutory for organisations with 250 employees or more to report annually on their Gender Pay Gap (GPG). The GPG reporting requirements are detailed within The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

1.2 The gender pay gap shows the difference in the average pay between all men and women in a workforce. Pay gaps often indicate that female workers are missing out on opportunities that could lead to higher pay, such as opportunities to progress in their careers, or to work full time hours through flexible working patterns.

1.3 The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally based on their gender.

1.4 Understanding the difference is important because the solutions to the gender pay gap are different to those required to ensure equal pay. It may be surprising, but it is possible to have genuine pay equality and still have a significant gender pay gap. For example if a company employs 11 people, i.e.; 10 engineers and one managing director, the 10 engineers (nine women and one man) all earn exactly £50,000 per year so they are all on equal pay. The managing director, who happens to be a man, is on £100,000 per year. The average salary for women in the organisation is £50,000 per annum while the average pay for men in the organisation is £75,000 per annum (£50,000 + £100,000 ÷ 2), a gender pay gap of £25,000 or 50%. Although the reporting requirements apply to organisations larger than this the example illustrates the point.

1.5 All NHS organisations manage equal pay through robust job evaluation systems, these systems ensure that pay for work of equal value is recognised; for example, a male nurse and female nurse entering nursing with some qualifications and experience are paid the same pay scale; however, the best job evaluation system will not address the gender pay gap if an organisation has a majority of men in higher-paid roles.

1.6 Our workforce is predominantly female. A significant portion of female staff work part-time or in flexible roles, impacting overall pay equity. These factors contribute to a complex pay landscape requiring tailored analysis and intervention.

1.7 The Gender Pay Gap is calculated and reported as six measures based on the hourly rates of pay and the bonuses of all eligible employees on a snapshot date, which for Public Sector organisations is 31st March 2024:

i. percentage of men and women in each hourly pay quarter

ii. mean (average) gender pay gap using hourly pay

iii. median gender pay gap using hourly pay

iv. percentage of men and women using bonus pay

v. mean average gender pay gap using bonus pay

vi. median gender pay gap using bonus pay

1.8 Gender pay gap reporting is a crucial step to better understanding our own position and the broader factors which contribute to pay disparity.

1.9 The cause of the gender pay gap is complex, and as the report will show there are certain issues peculiar to specific staffing bands / levels. Understanding these peculiarities is important as this will help to address the gender pay gap disparity in the years to come via robust actions.

2. What do the calculations mean?

2.1 The information in this report demonstrates the gender pay gap taking into account all Trust employees (excluding iFM).

2.2 Definitions of the terminology used in this report are included in appendix 1. When reporting the gender pay gap, both mean and median averages are used.

2.3 The median is often used as a headline measure because it's less swayed by extreme values, particularly the small number of people on high salaries.

2.4 The mean is useful because it does capture the effect of a small number of high earners. This is something we're interested in, given that women's responsibilities beyond work have traditionally limited their access to higher-level, higher-paid jobs.

2.5 The difference between an organisation's mean and median pay gap can provide valuable insight. The presence of very low earners can make the mean smaller than the median. A group of very high earners can make the mean larger than the median.Please note that the medical staff receive Clinical Excellence Awards and based on national Gender Pay Gap guidance this is termed a bonus. This paper therefore reports based on this national guidance. The bonus pay gap is intended to reflect the distribution of bonus payments made to male and female employees in the 12 months to 31st March 2024. As noted as an NHS organisation the only pay elements that fall under the bonus pay criteria are within the medical workforce, i.e. National clinical impact awards/distinction awards.

3. Key Findings

The **mean** gender pay gap stands at **26.2%** while the **median** gender pay gap is **13.0%**	**Excluding medical staff** reduces the **mean** hourly pay gap to **4.6%** and the **median** to **2.6%**	Women are well-represented in middle and lower pay bands, but poorly represented in senior medical roles.	**Part-time** female staff experience a **mean** pay gap of **32.36%** and a **median** gap of **14.93%,** highlighting a pay disparity for part-time roles.

Divisions with the largest gender pay gaps are Acute Adult Care, Anaesthetics & Surgical, and Family Care.	A sharp deterioration in the **Corporate Division's** gender pay gap (from 2.8% to 19.8%) indicates a potential emerging issue.	The **mean bonus** gap is **25.52%** and the **median bonus** gap is **0%** with men more likely to receive bonuses.	Although women make up a high proportion of employees in all **pay quartiles**, the top pay quartile has a higher proportion of men (and shows a 2.2% increase over last year).

4. Findings

4.1 Our Workforce

We collected our gender pay gap data on the snapshot date of 31st March 2024. At this time there were 6195 staff employed in the Trust. Of those 5256 (85%) were female and 939 (15%) were male.

4.2 Hourly Pay Gap

Over the last 12 months the Trust's gender pay gap has marginally increased in both the mean measures and also increased in the median. The Table 1 and Table 2 show the mean and median hourly rates by gender and the overall percentage pay gap as at March 2023 and March 2024.

The data indicates that:

- Overall on a mean average men earn more than women by 26.2% meaning the gender pay gap has increased by 0.3%.
- Overall on a median indicator men earn more than women by 13.0% which is an overall increase in the median gender pay gap of 3.17%.

As set out in section 2 the median is often used as a headline measure because it's less swayed by extreme values, particularly a small number of people on high salaries. The mean is useful because it does capture the effect of a small number of high earners. This is something we're interested in, given that women's responsibilities beyond work have traditionally limited their access to higher-level, higher-paid jobs.

The Trust's mean is significantly larger than the median, indicating that it is likely that a number of high earning male staff are impacting on the average figures.

Table 1: 2023 Mean and median hourly pay gap

2023

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£ 24.5	£ 18.6
Female	£ 18.1	£ 16.7
Difference	£ 6.3	£ 1.8
Pay Gap %	25.9%	9.83%

Table 2: 2024 Mean and median hourly pay gap

2024

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£ 25.9	£ 20.2
Female	£ 19.1	£ 17.6
Difference	£ 6.8	£ 2.6
Pay Gap %	26.2%	13.0%

4.3 Pay Gap by Band

Mean

Figure 1 aims to illustrate a number of trends in the mean hourly pay gaps across different bands in the Trust and the variance since 2023.

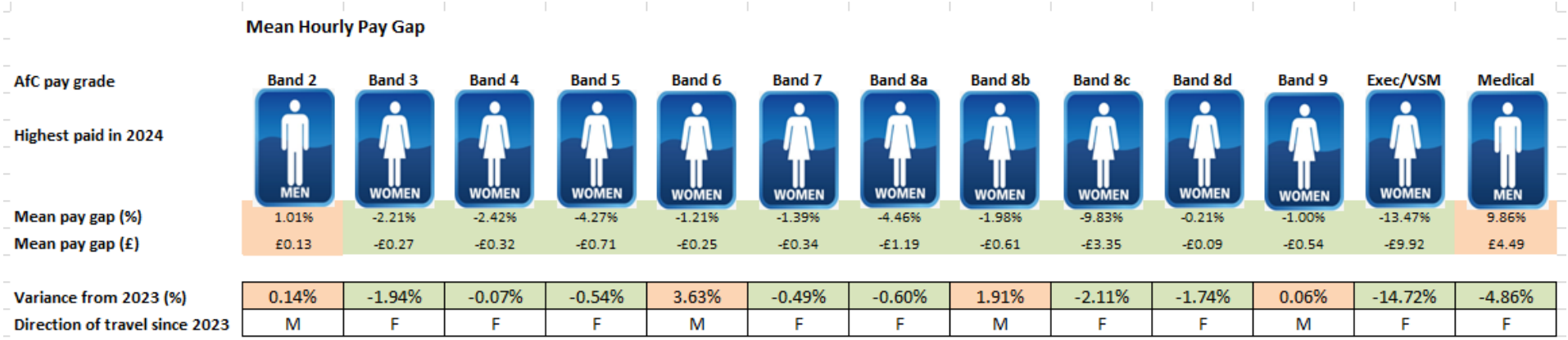


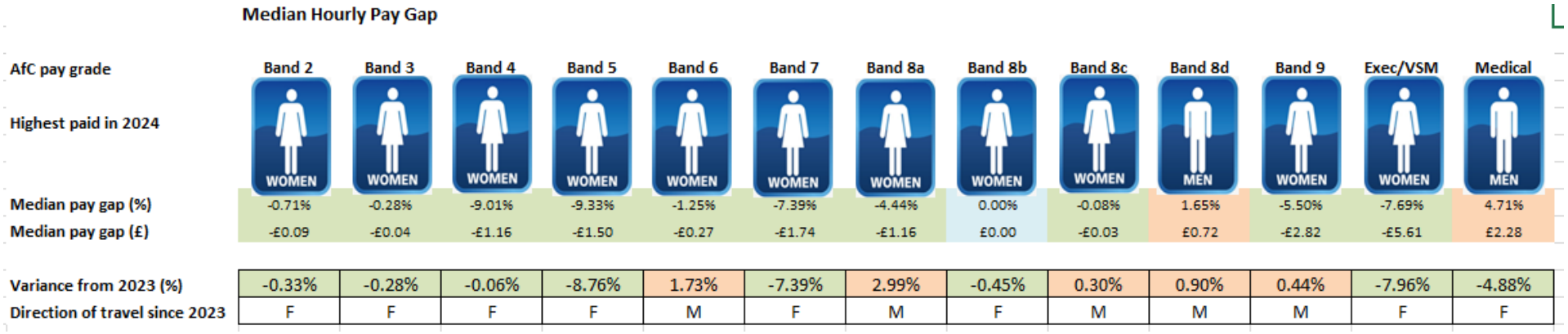
Fig 1: Mean hourly gender pay gap 2024 split by pay band

On the mean indicator, **women earn more** than men in in every job band except Band 2 and in medical/dental grades, where men earn more than women.

If medical staff are removed from the calculations, our mean Gender Pay Gap reduces to 4.6%. This highlights that the disparity in our gender pay gap is significantly influenced by the medical workforce, a group historically dominated by men, particularly in senior and higher-paid roles.

Median

Figure 2 aims to illustrate a number of trends in the median hourly pay gaps across different bands in the Trust and the variance since 2023.



AfC pay grade	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Exec/VSM	Medical
Highest paid in 2024	WOMEN	WOMEN	WOMEN	WOMEN	WOMEN	WOMEN	WOMEN	WOMEN	WOMEN	MEN	WOMEN	WOMEN	MEN
Median pay gap (%)	-0.71%	-0.28%	-9.01%	-9.33%	-1.25%	-7.39%	-4.44%	0.00%	-0.08%	1.65%	-5.50%	-7.69%	4.71%
Median pay gap (£)	-£0.09	-£0.04	-£1.16	-£1.50	-£0.27	-£1.74	-£1.16	£0.00	-£0.03	£0.72	-£2.82	-£5.61	£2.28
Variance from 2023 (%)	-0.33%	-0.28%	-0.06%	-8.76%	1.73%	-7.39%	2.99%	-0.45%	0.30%	0.90%	0.44%	-7.96%	-4.88%
Direction of travel since 2023	F	F	F	F	M	F	M	F	M	M	M	F	F

Fig 2: Median hourly gender pay gap 2024 split by pay band

On a median measure, **women earn more** than men in bands 2,3,4,5,6,8a,8c, 9 and VSM.
On a median measure, women and men earn the same in band 8b.
On a median meaure, **men earn more** than women in bands 8d and Medical/dental grades

If medical staff were removed from the calculations **our median Gender Pay Gap reduces to 2.58%**,

4.4 Full/ Part time Gender pay gap

Tables 3 and 4 compare the gender pay gaps for full and part time staff.

Table 3: mean gender pay gaps by working pattern

Mean	Full Time	Part Time
Men	£25.60	£27.38
Women	£19.66	£18.52
Difference	£5.94	£8.86
Gender Pay Gap%	23.20%	32.36%

Table 4: media gender pay gaps by working pattern

Median	Full Time	Part Time
Men	£20.19	£20.68
Women	£17.59	£17.59
Difference	£2.60	£3.09
Gender Pay Gap%	12.86%	14.93%

There is a slightly higher pay gap for full time staff than for part time staff, although the pay gap for part time staff is still signifcant at 23.26% (mean) and 2.95% (median).

4.5 Analysis by staff group

In order to provide further understanding of the gender pay gap a breakdown of mean gender pay gap by staff group is depicted in Figure 3.

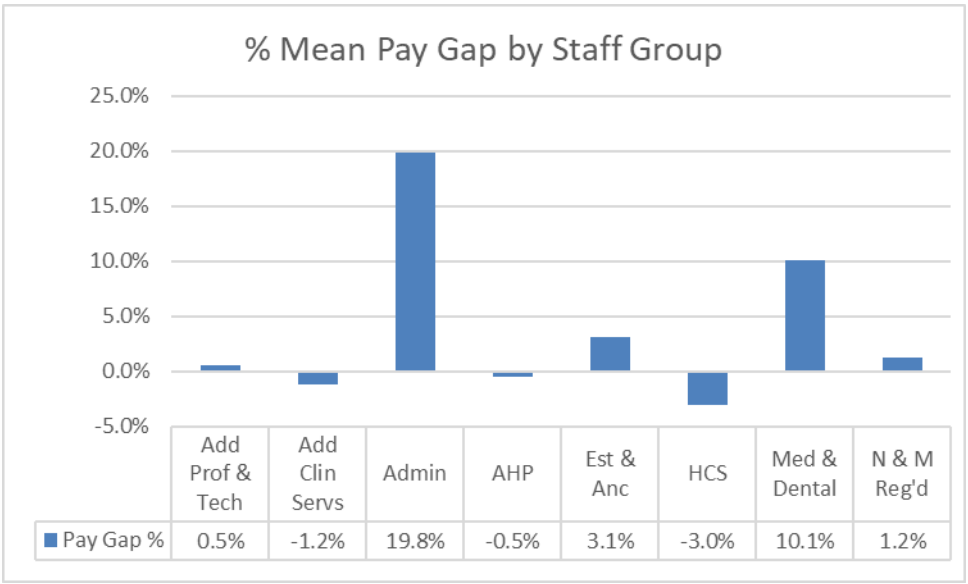


Fig. 3: Mean Pay Gap by Staff Group

The staff group with the largest mean pay gap is Administrative and Clerical, where the mean hourly pay rate is 19.8% higher for men than for women. This group includes corporate and senior management posts, as well as administrative and clerical staff.

This is followed by the medical and dental staff group, where the mean hourly pay rate is 10.1% higher.

Staff groups where women receive a marginally higher mean hourly rate than men are Additional Clinical Services (1.2% higher) AHPs (0.5% higher) and Healthcare Scientists (3.0% higher).

4.6 Analysis by Division

The mean gender pay gap by Division is depicted in Figure 4.

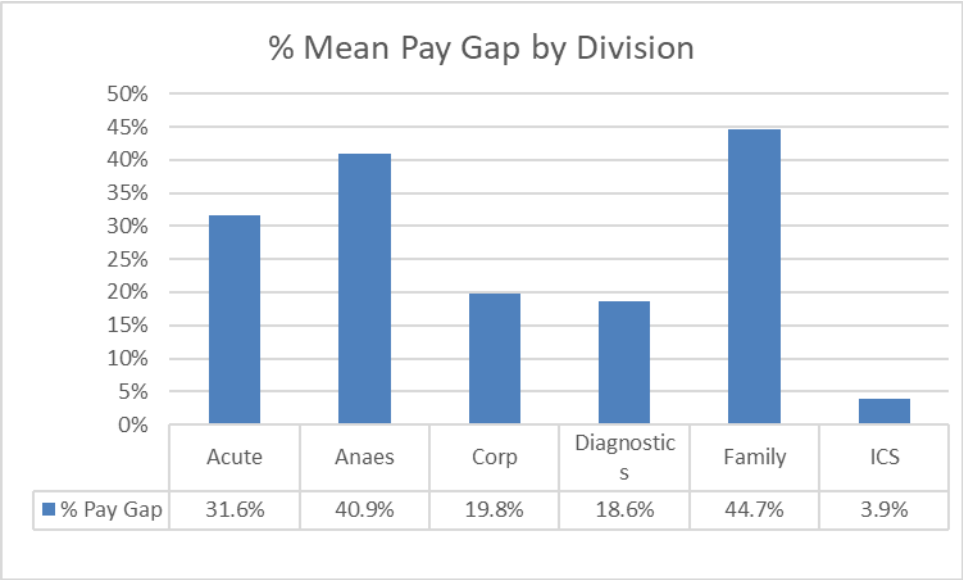


Fig.4: Divisional Gender Pay Gaps

The three divisions with the largest pay gap are Acute Adult Care, Anaesthetics & Surgical and Family Care. It should be noted that these are also the three divisions with the largest medical workforces. However, there has been a deterioratoin in the gender pay gap in Corporate division where the gender pay gap last year was 2.8% and is now at 19.8%.

4.7 Proportion of males and females in each pay quartile

Figure 5 demonstrates that the number of females within each pay quartile is reasonably consistent, although there is a significant increase in the proportion of males in the top pay quarter and this has increased since the last reporting year by 2.2%. This correlates with the analysis by pay band, showing that the largest pay gaps exist within the 8d and medical pay grades.

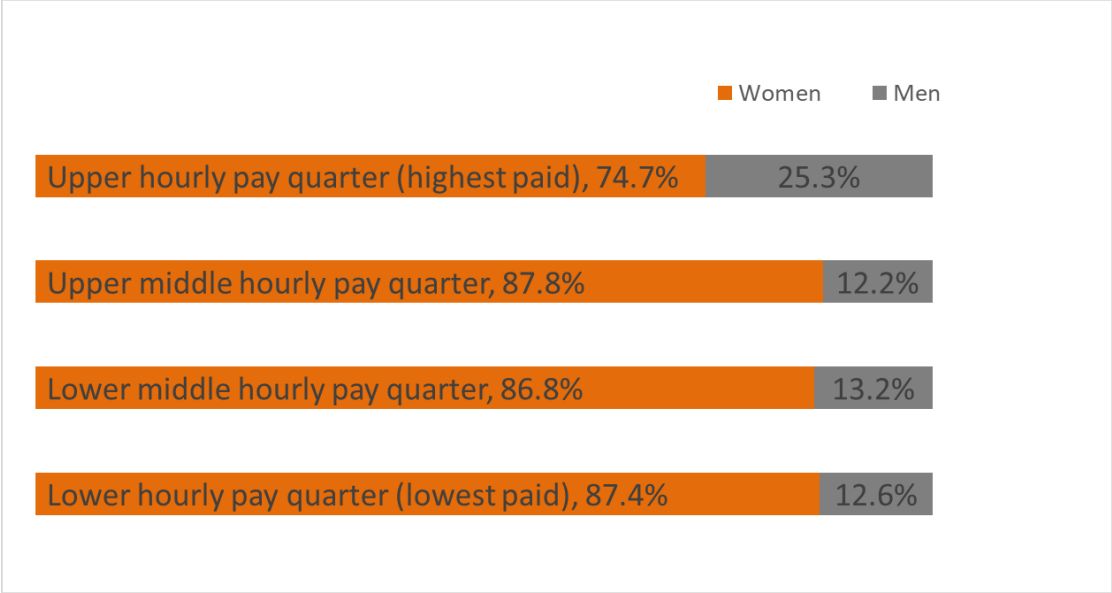


Fig.5: Analysis of proportion of females and males in each pay quartile

4.8 Awards / Merits Pay Gap

We are required to report on the gender pay gap for bonus / merits awards. Agenda for Change (AFC) staff are not eligible for bonus awards. This metric is therefore focused on payment of the consultant National Clinical Impact Awards and Distinction Awards.

Bonus pay gap is set out in Tables 5-8

Table 5

The mean and median gender bonus gap at Bolton NHS Foundation Trust

2023 (Bonus)

Gender	Mean Pay	Median Pay
Male	£12,722.7	£ 9,048.0
Female	£10,028.4	£ 9,048.0
Difference	£ 2,694.2	£ -
Pay Gap %	21.2%	0.0%

Table 6

2024 (Bonus)

Gender	Mean Pay	Median Pay
Male	£ 8,519.1	£ 3,983.9
Female	£ 6,346.7	£ 3,983.9
Difference	£ 2,172.4	£ -
Pay Gap %	25.5%	0.0%

Table 7

2023

Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	49	954	5.14%
Female	30	5516	0.54%

Table 8

2024

Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	115	1155	9.96%
Female	99	5386	1.84%

Points of note are:

- 1.84% of females in the Trust received an award (bonus) compared to 9.96% of males. However, this is distorted by the fact that only medical staff (where the gender split is more equal than the Trust's profile) receive a bonus.
- When looking at this in the context of the medical workforce 13% of female medics and 19% of male medics received bonus pay.
- In relation to the value of the award women earn £1 for every £1 that men earn when comparing median bonus pay, meaning that on a median calculation there is no bonus pay gap.
- However average (mean) bonus pay is 25.52% lower for women than for men. This has increased from the 2023 mean bonus pay gap of 21.2%.
- Since 2018 the local Clinical Excellence Award monies have been shared equally amongst all eligible consultants.
- Those that were given awards before 2018 under the previous scheme arrangements have maintained those awards, which will contribute to the mean bonus pay gap. There has been no opportunity to redress any bonus pay gap during that period under the local scheme.
- National Clinical Impact Awards will also contribute to the bonus pay gap.
- As the consultant pay award offer was accepted effective April 2024 the contractual entitlement to access an awards round ceased and the allowance is incorporated into basic pay. Therefore going forward, the historical pre 2018 awards and the national clinical impact awards will be the only factors influencing the bonus pay gap.

5. Current position

We know that we must be restless in tackling the gender pay gap, despite acknowledging that it cannot be 'fixed' quickly and longer terms solutions are required in order for it to reduce. We know from the latest data that we are not an outlier across Greater Manchester Trusts in our hourly mean, median or bonus gender pay gaps (see Table 9 in Appendix 2)

5.1 What have we done so far?

Closing the gender pay gap is about more than just the numbers, it's about increasing support for female staff. There is significant good work already going on in relation to this within the Trust:

5.1.1. Recruitment / Promotion

All Trust adverts and advertising materials (e.g. Job Descriptions, and Person Specifications etc.) are reviewed and approved by our HR team before being advertised to ensure they do not contain any discriminatory statements. Good practice is already in place around shortlisting processes, to ensure fairness and equality of the process at this stage. The Trust TRAC e-recruitment system ensures that applications to Trust employment are shortlisted on the basis of skills,

experience, education and knowledge only (no personal details such as name / gender etc. are provided to shortlisting panels). This eliminates, as much as possible, any potential for discrimination at application stage.

Interview panels comprise at least two people, to increase objectivity of decision making, and other assessments are encouraged to further increase objectivity- e.g. work related testing; criteria based interviewing against defined criteria. . Guidance is provided to every interview panel stating that interview questions should be based on role requirements only.

This year, we have agreed that inclusive recruitment initiatives should be prioritised and the inclusive recruitment and career progression working group has been set up. This group will be trialling a number of initiatives to increase diversity of our workforce through recruitment and promotion opportunities. The initiatives that have been agreed by People Committee include inclusive recruitment training, having an independent panel member on recruitment panels, providing interview questions in advance, using Equality Advocates that can challenge if they feel a biased decision has been made, widening recruitment routes into the Trust, using work based assessments more in recruitment and interview and application workshops.

5.1.2. Flexible Working

To become a truly modern organisation and support staff in balancing their home and work lives, the Flexible Working Change Team has been driving efforts to ensure flexible working is accessible to all. The team's main achievements and ongoing priorities include:

Training and Development

The Change Team has collaborated with Organisational Development (OD) to design a flexible working ‘masterclass.’ This training includes:

- Real-life examples and scenarios to improve understanding and application of policies.
- Common-sense guidance for staff and managers** to promote flexible working effectively.
- Insights from staff networks and forums, enhanced by case studies, to foster deeper understanding.

Developing a Myth-Busting Guide

The team has addressed misconceptions and unwritten “rules” that create barriers to flexible working. A Myth-Busting Guide has been developed to debunk outdated or incorrect beliefs and promote clarity and consistency.

Policy Review

The Flexible Working policy has been reviewed, and work has progressed on:

- Updating the Agile Working Policy to align with flexible working principles.
- Evaluating the Reasonable Adjustments Passport to ensure compatibility with flexible working.
- An Agile Working Group—comprising colleagues from operations, estates, HR, BI, and facilities management—has been established to define objectives and draft a comprehensive Agile Working Policy.

Additional Focus Areas

- Stay Interviews: Processes have been developed to gather data and feedback on how flexible working influences retention.
- Manager Awareness: Myth-busting communications have been introduced to ensure managers understand what is and isn't possible under flexible working policies.

Sexual Safety Charter

The Trust's adoption of the sexual safety charter demonstrates that we are committed to ensuring sexual safety in the workplace for all our staff. The Trust has an action plan to ensure that it is meeting the 10 pledges outlined in the charter. A Policy for sexual misconduct is in initial draft stage and incorporates the NHSE guidance and template policy which was released in November 2024. The Trust has strengthened the links to other existing policies (Disciplinary, FTSU) with this new policy. The Trust is also reviewing the ongoing training requirement associated with the Policy and Charter.

Table 9: Key matters to note, potential underlying causes and suggested actions

Key Matters	Potential underlying causes	Actions
Overall Gender Pay Gap Trends: The Trust's mean hourly pay gap is 26.2%, and the median hourly pay gap is 13.0%, both of which have increased compared to the previous year. The widening of the median gap suggests a structural issue affecting a broader range of pay levels. The disparity in the mean pay gap highlights the influence of high-earning male staff on the overall figures.	A higher concentration of men in senior, high-paying roles, particularly in the medical workforce, is driving the gap. Historical barriers, such as limited access to leadership development and full-time working opportunities for women, persist. Social and cultural factors, including women's disproportionate caregiving responsibilities, restrict their access to higher-paid, senior-level roles.	Inclusive recruitment actions such as: • Representative panels • Interview questions provided in advance • Equality Advocates • Inclusive recruitment training for hiring managers • Widening recruitment routes into the Trust, • Using work based assessments in selection processes • Application and interview skills workshops
Analysis by Pay Band: On the mean measure, men earn more in Band 2 and medical/dental grades, but women earn more in all other bands. On the median measure, women earn more in most bands, but men earn more in Band 8d and medical/dental grades.	Women are well-represented in middle and lower pay bands, which correlates with flexible working patterns. Men's dominance in higher pay bands, such as 8d and medical grades, is a key contributor to the overall pay gap.	• **Medical Talent:** Identify and nurture high-potential female medics • **Leadership training:** Track data to assure that a high proportion of leaders on the Our Leaders programme are female.

Pay quartiles Although women make up a high proportion of employees in all pay quartiles, the **top pay quartile has a higher proportion of men (2.2% increase over last year)**.	An increase in high-earning male staff, combined with limited progression opportunities for women into the top quartile, has contributed to the pay gap.	• **Talent conversations and succession planning:** As a Trust, we are strengthening our development conversations and are introducing transparency and quality into our talent conversations and process for succession planning.
Part-Time Work Impact Part-time female staff experience a **mean pay gap of 32.36%** and a **median gap of 14.93%**, highlighting a pay disparity for part-time roles.	Part-time roles are more common among women and are often concentrated in lower-paid positions. Men in part-time roles are more likely to occupy higher-paying positions, skewing the mean and median figures	• Explore pathways for part-time employees to access progression opportunities, addressing the significant gap for part-time women • Improve flexible working culture 'norm' of working part time. • Improve the organisation's use of job sharing, especially for senior roles.
Divisional Variances Divisions with the largest gender pay gaps (e.g., Acute Adult Care, Anaesthetics & Surgical, and Family) also have the largest medical workforces. A sharp deterioration in the **Corporate Division's** gender pay gap (from 2.8% to 19.8%) indicates a potential emerging issue.	Divisional gaps reflect the distribution of male-dominated senior roles within those areas. The significant increase in the gender pay gap in the Corporate division, from 2.8% to 19.8%, could be due to factors such as shifts in the gender composition of the workforce, with women potentially moving into lower-paid roles or fewer women being promoted to senior positions. Changes in bonus structures, temporary staffing, or organisational restructuring might also disproportionately affect	• Collaborate with divisions such as Acute Adult Care and Corporate and analyse data to identify specific barriers contributing to their higher pay gaps and develop tailored interventions. • Use surveys or focus groups to identify perceived barriers and priorities for female employees.

	women's pay. Additionally, data reporting issues or changes in role classifications could contribute to this discrepancy.	
Medical Workforce Impact Excluding medical staff significantly reduces the gender pay gap, bringing the mean gap down to 4.6% and the median gap to 2.58%. Men dominate senior medical and dental roles, which are among the Trust's highest-paid positions.	The gender imbalance in medical specialties and senior consultant roles reflects wider societal trends in healthcare. The bonus pay gap, while equal at the median, has widened at the mean level due to legacy payments under pre-2018 Clinical Excellence Award schemes, which disproportionately benefited men.	• Encourage and support more women into senior medical roles through leadership development through mentorship, and career coaching. • Implement the Mending the Gap actions.
Awards / Bonus Pay Gap **Mean bonus pay** is **25.52% lower** for women, an increase from the previous year's 21.2%. Only **1.84% of women** received bonuses compared to **9.96% of men**, though the **median bonus gap remains 0%**.	Historical legacy bonus schemes (pre-2018) continue to disproportionately benefit male consultants. Current bonus eligibility, limited to the medical workforce, is gender-equal but fails to redress historical imbalances. Who applies for (and are granted) National Clinical Impact Awards will impact future bonus gender pay gaps.	• Current national impact award holders to mentor female colleagues who are eligible to encourage and coach them through the application process.

Appendix 1: Glossary of Acronyms and Specialist words/phrases

- **Agile Working Policy:** A policy enabling staff to work flexibly across different locations and settings, aligned with organisational needs.
- **AHPs (Allied Health Professionals):** Healthcare professionals such as physiotherapists, radiographers, and occupational therapists.
- **Bonus payment percentages:** These are intended to reflect the distribution of bonus payments made to men and women employees, who were paid bonus pay in the 12 months up to the 31st March 2024. As an NHS organisation the only pay elements that fall under the bonus pay criteria are within the medical workforce.
- **Distinction Awards:** Bonus payments made to medical consultants for outstanding contributions, under older NHS schemes.
- **Equality Act 2010:** UK legislation that protects against discrimination based on protected characteristics e.g. gender, race, and disability.
- **Equality Advocates:** Individuals who ensure fairness and challenge biases in recruitment processes.
- **Flexible Working Policy:** Guidelines allowing staff to modify their working arrangements to balance personal and professional needs.
- **Mean hourly rate**: The difference between the mean (average) hourly pay of men, and the mean (average) hourly pay of women. It is calculated by adding up all the hourly rates of men or women and then dividing by the number of men or women.

- **Median hourly rate:** The difference between the median hourly pay for a man and the median hourly pay for a woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.
- **Mean and median pay and bonus gaps**: These are expressed as a percentage. So if our mean gender pay gap, for example is 15% this means that women in the workforce are paid 15% less than the men in the workforce or 85p for every £1 paid to men. If the gap is a negative percentage this means that men are paid on average less than female employees.
- **National Clinical Impact Awards:** A National bonus payment scheme recognising the exceptional contributions of NHS consultants.
- **OD (Organisational Development):** The department focused on improving organisational performance and staff experience.
- **Pay Quartile:** A division of the workforce into four equal groups based on pay, used to analyse pay distribution. This is designed to show the spread of employees across salary ranges. The assumption is that for most organisations women will be concentrated in the lower quartiles but men will be concentrated in the upper quartiles.
- **Stay Interviews:** Conversations with employees to understand their needs and motivations for staying with the organisation.

Appendix 2

Table 9: Benchmarking of gender pay gap across Greater Manchester NHS Trusts – sorted by Median hourly pay gap.

Employer	% Difference in hourly rate (Mean)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Greater Manchester Mental Health NHS Foundation Trust	7.50	-2.30	75.60	72.70	79.80	70.80	1.00	4.70	6.30	0.00
Lancashire & South Cumbria NHS Foundation Trust	12.20	1.10	82.60	76.40	80.70	74.70	0.50	3.00	17.10	0.00
Pennine Care NHS Foundation Trust	11.20	2.00	81.70	76.10	77.60	73.70	0.30	2.00	-2.80	50.00
Lancashire Teaching Hospitals Nhs Foundation Trust	21.00	3.20	77.00	77.00	82.00	69.00	1.20	7.60	45.90	0.00
The Christie Nhs Foundation Trust	19.00	5.50	72.70	78.70	76.10	62.50	2.40	9.40	36.00	0.00
Northern Care Alliance NHS Foundation Trust	23.50	8.80	80.00	81.00	83.30	67.60	1.90	13.00	21.40	0.00
Bolton N H S Foundation Trust	25.90	9.80	88.10	88.40	87.60	77.10	0.50	5.10	21.20	0.00
East Cheshire Nhs Trust	30.90	11.50	85.40	84.70	83.60	71.80	0.90	8.10	46.80	0.00
Mid Cheshire Hospitals Nhs Foundation Trust	21.30	11.60	86.80	82.90	84.60	75.90	0.20	2.60	10.10	0.00
Tameside and Glossop Integrated Care NHS Foundation Trust	27.50	12.50	85.70	79.70	84.70	68.60	0.30	3.00	22.70	34.80
Wrightington, Wigan And Leigh Nhs Foundation Trust.	27.60	12.70	84.30	82.10	84.90	69.70	0.80	10.60	63.50	0.00

Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 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 November.

Executive Summary	The Chairs' reports attached provide an overview of matters discussed at the meeting held on the 27 November 2024. The reports also set out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. Due to the timing of the January 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:	Sean Harriss, Finance and Investment Committee Chair	**Presented by:**	Annette Walker, Chief Finance Officer

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**27 November 2024**	**Date of next meeting:**	**22 January 2024**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- **Cost Improvement Programme**
- **Month 7 Finance Update**
- **GM/National System Update**
- **NHSP Update**
- **IFM Annual Performance Report**
- **Board Assurance Framework**
- **Finance & Investment Committee Effectiveness Survey**
- **Standing Financial Intructions and Scheme of Delegation**

ALERT

- At Month 7 the Trust had a deficit of £3.5m which was in line with the plan.
- Cash is likely to be required for Quarter 1 of 2025/26.
- NHS Professionals has not delivered as expected and a further review is being undertaken to evaluate the financial and non financial benefits and relevant next steps.

ADVISE

Cost Improvement Programme

The overall and risk rated positions have increased since the last Finance & Investment Committee meeting. £26.3m CIP identified in year, £21.8m of which is recurrent. A number of high risk schemes are included in the overall identified value, leaving a risk rated positon of £23.9m in year and £17.2m recurrent. The Chief Executive referenced the Provider Oversight Meeting which took place yesterday where it was acknowledged there is more to do but the Trust were congratulated on the positive financial impact from the schemes implemented.

Month 7 Finance Update

- The Trust has a revised deficit plan for the year of £0.6m.
- The most likely forecast outturn is currently an adverse variance to plan of £5.8m including the impact of the pay award pressure which is likely to be £1.6m.
- CIP of £14.9m has been delivered compared to a plan of £11m.
- Capital spend for month 7 year to date is £3.0m owned, £0.7m leased.
- The Trust had a closing cash position of £18.9m which is an increase of £15.7m from month 6 against a plan of £2.5m. This is due to profiling of cash and the Local Authority have paid for all contracts. Cash received for UEC and RAAC will mean cash support is not required this financial year.
- The Finance Team have been awarded the 'Finance Team of the Year – Frontline Services' in the Public Finance Awards.

GM/National System Update

Year to date GM have a deficit after cash support of £151m and whole time equivalents are still rising. Early indicators suggest there will be a £0.5 billion deficit after CIP included. The Chief Executive advised

realistic targets be set for next year with a CIP of 3% to be discussed further at the Board of Directors meeting being held on the 28 November 2024.

NHS Professionals Update

Since working with NHSP, the Trusts AFC agency expenditure has reduced by £9.3m (82%). In the same period, bank costs have increased by £7.6m. This shows an overall reduction in variable pay expenditure since moving to NHSP, and the switch from agency to bank should provide quality, safety and patient experience improvements. While it is difficult to directly attribute these savings and switch to NHSP, it has undoubtedly been a contributory factor to these successes. Some of the anticipated financial benefits of moving to NHSP have not been fully recognised. The Trust will share its findings with NHSP and agree an action plan to increase the financial benefits recognised by the Trust. A further update will be provided to the committee in 6 months.

ASSURE

IFM Annual Performance Report

This report was brought to the Committee as both shareholder and customer. Quarterly reports are presented to the Trust via the Chief Finance Officer and Chief Operating Officer. The Chair asked for the Committee's thanks to be passed on to the IFM team for their achievements.

Board Assurance Framework

The Director of Corporate Governance presented the latest iteration of the BAF which had been reviewed by the Director of People and updated to reflect the new Trust Strategy. There are 3 corporate objectives with an Executive Lead for each. It is still in the process of being worked through and it is to be presented to the Board of Directors for further discussion on the 28th of November 2024. Questionnaires around risk appetite will be sent out afterwards.

Finance & Investment Committee Effectiveness Survey

The Committee Effectiveness Survey was circulated in November 2024 to all Finance and Investment Committee members. Overall, the results from this survey were generally positive and indicate that the Committee has continued to build on its effectiveness since the last report in November 2023.

Standing Financial Instructions and Scheme of Delegation

The changes which have been made to the Standing Financial Instructions and Scheme of Delegation were presented to the Committee and recommended for approval at the Board of Directors meeting on the 28 November 2024.

New Risks identified at the meeting:

None identified.

Review of the Risk Register: NA

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 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 reports were discussed and agreed at the Audit and Risk Committee held in December 2024.

Executive Summary	The Chair's Report attached from the Audit and Risk Committee provides provides an overview of matters discussed at the meeting held on 04 December 2024. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.

Proposed Resolution	The Board of Directors are asked to ***receive*** the 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:	**Annette Walker** **Chief Finance Officer**	**Presented by:**	**Annete Walker** **Chief Finance Officer**

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

Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	04 December 2024	**Date of next meeting:**	12 February 2025
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Audit Committee Effectiveness
- Review of Audit Committee Terms of Reference and Annual Work Plan
- Internal Audit Reports
- External Audit Progress Report
- Local Counter Fraud Specialist Progress Report
- Updated Standing Financial Instructions and Scheme of Delegation
- IFM Bolton Statutory Accounts Year ended 31 March 2024
- Standing Orders and Matters referred to the Board
- Board Assurance Framework
- Corporate Risk Register
- Fraud Corruption Bribery Policy and Response Plan
- Risk Management Chair's Report

ALERT

N/A

ADVISE

Audit Committee Effectiveness

The Audit and Risk Committee considered the Annual Effectiveness Report and noted that the results were generally positive and indicated that the Committee has continued to build on its effectiveness since the last report in November 2023. The Committee discussed two areas where there were slightly different approaches to those recommended from the HFMA handbook but the Committee agreed with the approach that Bolton had adopted.

Review of Terms of Reference and Work plan

The Audit and Risk Committee reviewed the Terms of Reference and noted they have been updated to include the new areas of Risk and Information Governance. A few minor changes were also made to the Terms of Reference. The Terms of Reference were recommended for approval to the Board of Directors. The Committee also approved the Annual Work plan.

ASSURE

Internal Audit Reports

The Internal Auditors, Mersey Internal Audit Agency (MIAA) presented their progress report. They advised that the final outstanding report from 2023/24 had now been completed and would be presented to the next Audit and Risk Committee. There were 2 final reports form the 2024/25 plan; Divisional Quality Governance (substantial assurance) and Bank and Agency Staff Controls (substantial assurance). The Committee discussed the two reports and recommended that these be referred back to the respective Committees from the point of view of the positive nature of these reports and to thank the staff involved in these areas of work. The Committee also considered the follow up report on recommendations from previous reports. The follow up was extremely positive with 4 recommendations completed and 16 not yet due which was recognised as very good practice.

External Audit Progress Report

The External Auditors, Forvis Mazars presented their progress report. In respect of the 2024/25 financial statements and the 2024/25 value for money arrangements these were in the planning phase. It was confirmed that Forvis Mazars had been engaged as the Auditors for IFM Bolton for 2024/25 onwards. It was also confirmed that Forvis Mazars had been engaged to carry out the independent examination of Our Bolton NHS Charity for 2023/24 and

onwards.

Local Counter Fraud Specialist Progress Report
The Local Counter Fraud Specialist presented the progress report for the period September to November 2024. It was pleasing to note the positive reporting by staff of concerns. It was noted that for one particular case involving the Crown Prosecution Service a decision on the outcome was expected shortly.

IFM Bolton Statutory Accounts Year ended 31 March 2024
The Associate Director of Finance presented the IFM Bolton Statutory Accounts for year ended 31st March 2024. The accounts showed a small loss of £43k but with a strong cash balance of £4m. The aim was to submit the accounts before the end of the calendar year. The Committee thanked the Associate Director of Finance and the team for their work in completing the accounts in a timely manner. It was noted that this would be the final set of accounts undertaken by KPMG, the previous External Auditors.

Updated Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)
The Committee received the updated SFIs and SoD. These had previously been approved by the Board and the Audit and Risk Committee confirmed their agreement to the updates

Standing Orders and Matters Referred to the Board
The Committee received the Standing Orders and Matters Referred to the Board which had previously been approved by Board of Directors. The Audit and Risk Committee confirmed their agreement of the reports as assurance of compliance.

Board Assurance Framework
The Director of Corporate Governance presented the Board Assurance Framework setting out the assurance on the five Strategic ambitions for the Trust. The BAF provides assurance that the principle risks to achieving the Trust's ambitions are identified, regularly reviewed and systematically managed. The Committee commended the comprehensive work which had been undertaken in constructing the BAF. The Committee noted that the BAF had also been presented to the Board of Directors.

Corporate Risk Register
The Chief Finance Officer presented the Corporate Risk Register. It was noted that there were 32 risks which scored at 15 and above. The Committee made 2 recommendations to strengthen the link between the Corporate Risk Register and the Board Assurance Framework. These related to identifying which of the five ambitions each risk referred to and identifying the Committee responsible for overseeing each of the risks. The intention being to create a golden thread from the original identification of risk at the Divisions/Corporate Services through to the Board Assurance Framework for the Board of Directors.

Fraud Corruption Bribery Policy and Response Plan
The Local Counter Fraud Specialist presented the updated Fraud Corruption Bribery Policy and Response Plan which was approved by the Audit and Risk Committee.

Risk Management Chairs' Reports
The Chief Finance Officer presented the Risk Management Chairs' reports for September, October and November. It was noted that this was the first time the Committee had received the BAF, Corporate Risk Register and Risk Management Chairs' Reports together which provided a high level of assurance. It was also noted that Audit and Risk Committee Chair had observed a recent Risk Management Committee meeting and was pleased to see the high level of discussion and debate.

New Risks identified at the meeting:
N/A

Review of the Risk Register:
N/A

Meeting Attendance 2024/25												
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Alan Stuttard		✓			✓	✓			✓			✓
Martin North		✓			✓	✓			✓			**A**
Tosca Fairchild		✓			**A**	✓			A			**A**
Fiona Taylor		A			✓	✓			✓			✓
In Attendance	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Annette Walker		✓			✓	✓			✓			✓
Sharon Katema		✓			✓	✓			✓			✓
✓ = In attendance A = Apologies												

Report Title:	Our Bolton NHS Charity's annual report and accounts for year ending 31 March 2024			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief of Strategy and Partnerships		Decision	

Purpose of the report	To provide the Board of Directors with a copy of Our Bolton NHS Charity's annual report and accounts, which have been independently examined by and the signed letter of representation.

Previously considered by:	Charitable Funds Committee

Executive Summary	The annual report and financial statements describe the structure, governance and management of the Charity; provide a breakdown of income and expenditure; outline some of our key priorities for 2024/25 and set out the financial position for the year ending 31 March 2024. The annual report and accounts will be submitted to the Charity Commission by the deadline of 31 January 2025.

Proposed Resolution	The Board of Directors is asked to ***approve*** Our Bolton NHS Charity's annual report and accounts for year ending 31 March 2024

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 report sets out the financial statements up to 31st March 2024
Legal/ Regulatory	Yes	The annual report and accounts are a key part of charity governance
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Sarah Skinner, Charity Manager and Karen Sharples, Finance Manager	**Presented by:**	Sharon White, Chief of Strategy and Partnerships Annette Walker, Chief Finance Officer

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

BMCC	Bolton Masjids Chanda Committee
ECG	Electrocardiogram
FABB	For A Better Bolton
FICare	Family Integrated Care
FRS	Financial Reporting Standard
ISA	International Standard on Auditing
NICU	Neonatal Intensive Care Unit
RBH	Royal Bolton Hospital
RBS	Royal Bank of Scotland
SIBA	Specialist Interest Bearing Account
SORP	Statement of Recommended Practice
UK GAAP	UK Generally Accepted Accounting Practice
VAT	Value-Added Tax
VCSE	Voluntary, Community and Social Enterprise

Registered as a charity number: 1050488

Annual Report, Unaudited Financial Statements and Independent Examiner's Report

Year ending 31st March 2024

Contents

Chair's statement

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

It is my pleasure to present the annual report and audited financial statements for Our Bolton NHS Charity for the year ending 31st March 2024

Throughout 2023/24, we continued to receive valued support from the local community, including the Mayor of Bolton. At his inauguration on Wednesday 17 May 2023, Councillor Mohammed Ayub announced Our Bolton NHS Charity as his one of his three chosen charities/good causes. In August 2023, we were delighted to welcome the Mayor of Bolton to Royal Bolton Hospital and give him a tour of charity-funded schemes and projects, including the new faith facilities and those captured in the expenditure highlights on page 14 of this report.

We also received £114,000 in voluntary donations, £81,000 in legacies and £25,000 as gifts in kind, and we continue to be humbled by the reasons our supporters donate and fundraise in aid of Our Bolton NHS Charity.

Acting on behalf of the Corporate Trustee, we have a legal duty to ensure that money received is used appropriately and responsibly. In 2023/24, we invested £510,000 in a range of schemes designed to improve staff wellbeing and the patient experience at Bolton NHS Foundation Trust. A full breakdown of direct charitable expenditure can be found on page 13 but a particular highlight is the production of the charity's first official video, which was funded through the NHS Charities Together development grant. Please scan the QR code to watch the video and learn what the support of our donors and fundraisers means to us and those we care for.

In terms of impact, it has been absolutely wonderful to see the new faith facilities in full use (and growing in popularity) during 2023/24, and to hear how staff, patients and communities are continuing to benefit from the Mosque, Temple and Community Hub.

"The original prayer rooms were no longer adequately serving the needs of hospital staff and patients, so the new facilities have been transformational. Everyone is just so pleased to have the space they always wanted. Colleagues consistently tell us the quality of the faith facilities conveys a powerful message about how the Trust values and cares for them, and that positivity ripples back into the care and services they provide to patients, families and communities."

Reverend Neville Markham, Head Chaplain, Bolton NHS Foundation Trust

On behalf of the Charitable Funds Committee, I would like to take this opportunity to thank our incredible supporters, without whom, none of the above would have been possible. We have exciting and ambitious plans for 2024/25, but we cannot deliver them on our own so please get involved and help us make a lasting and meaningful difference to the people of Bolton, and beyond.

Martin North
Chair of the Charitable Funds Committee

Reference and administrative details

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

The Charity's annual accounts for the year ended 31st March 2024 have been prepared by the Corporate Trustee in accordance with the Charities Act 2011 and Statement of Recommended Practice (SORP): Accounting and Reporting by Charities. The Charity's accounts include all the separately established funds for which the Bolton NHS Foundation Trust is the sole beneficiary.

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

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

The principal office for the Charity is:

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

Principal staff (employed by Bolton NHS Foundation Trust):

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

The following services were retained by the Charity during 2023/24:

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

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

Independent examiner
David Hoose, FCA
Forvis Mazars LLP,
30 Old Bailey,
London,
EC4M 7AU

Structure, governance and management

Structure of funds

The Charity currently has three special purpose trusts/funds.

As at March 2024, the Trust had 61 individual funds relating to individual wards and departments. Ward Managers and Heads of Department manage funds at a local level and all expenditure is authorised in accordance with the Trust's standing financial instructions, standing orders and charitable fund procedures.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds the Corporate Trustee respects the wishes of the donors.

Charitable Funds Committee

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

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

Risk management

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

Investment policy

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

Reserves policy

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

Our objectives and activities

Objective

We work in strategic partnership with Bolton NHS Foundation Trust, using charitable funding to enhance NHS provision, but not substitute it. The objective of the charity is 'for any charitable purpose or purposes relating to the National Health Service'.

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

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

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

Mission statement

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

Activities

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

Where our funds came from

In 2023/24, the Charity received £114,000 from donations, £81,000 from legacies, £30,000 from grants and £25,000 from gifts in kind.

The year in review

The period of stability we were hoping to see post-Covid sadly didn't materialise and instead the NHS charity sector has faced a number of challenges:

- Rising costs/inflation meaning charitable funds don't stretch as far as they used to
- A cost of living crisis resulting in a reduction in people's financial capacity to donate to charity
- Heavily oversubscribed grant programmes, including a move to competitive grants rounds for NHS Charities Together

Despite a challenging landscape and a decline in voluntary donations, 2023/24 has been a positive year in terms of foundational work, building relationships through networking with the local business community, and raising the profile of Our Bolton NHS Charity both on a local and national platform.

NHS Charities Together development grant

The NHS Charities Together development grant programme was designed to empower the NHS charity sector to be high performing, effective and impactful, and we were delighted to receive a one-off grant of £30,000 in June 2023. Use of the grant has been prioritised around three core themes (fundraising, influencing and operations) and has supported our efforts to grow and raise the profile of the charity within the local community and the wider NHS charity sector. To date, the development grant has supported investment in leadership coaching and professional training with the Chartered Institute of Fundraising, and the production of Our Bolton NHS Charity's promotional video.

The power of networking

The Ladies Empowerment Circle™ is a 'dynamic networking and support group designed exclusively for women across the North West of England'. Since April 2023, Our Bolton NHS Charity has been one of the Ladies Empowerment Circle's chosen charities and has benefitted from a number of fundraising events, including the Christmas lunch and shopping event in November 2023 and the International Women's Day event in March 2024. Based on these events, and subsequent events organised by members of the Ladies Empowerment Circle, Our Bolton NHS Charity has received over £4,000, and there are exciting fundraising plans for 2024/25, including a Spring charity lunch and sky dive.

Our Contribution to NHS Charities Together

Our Bolton NHS Charity continues to be an active and valued member of NHS Charities Together. Over the past 12 months, the team has offered support and insight in order to influence policy and strategy, shape future grant funding opportunities and advocate for smaller NHS charities at a national level:

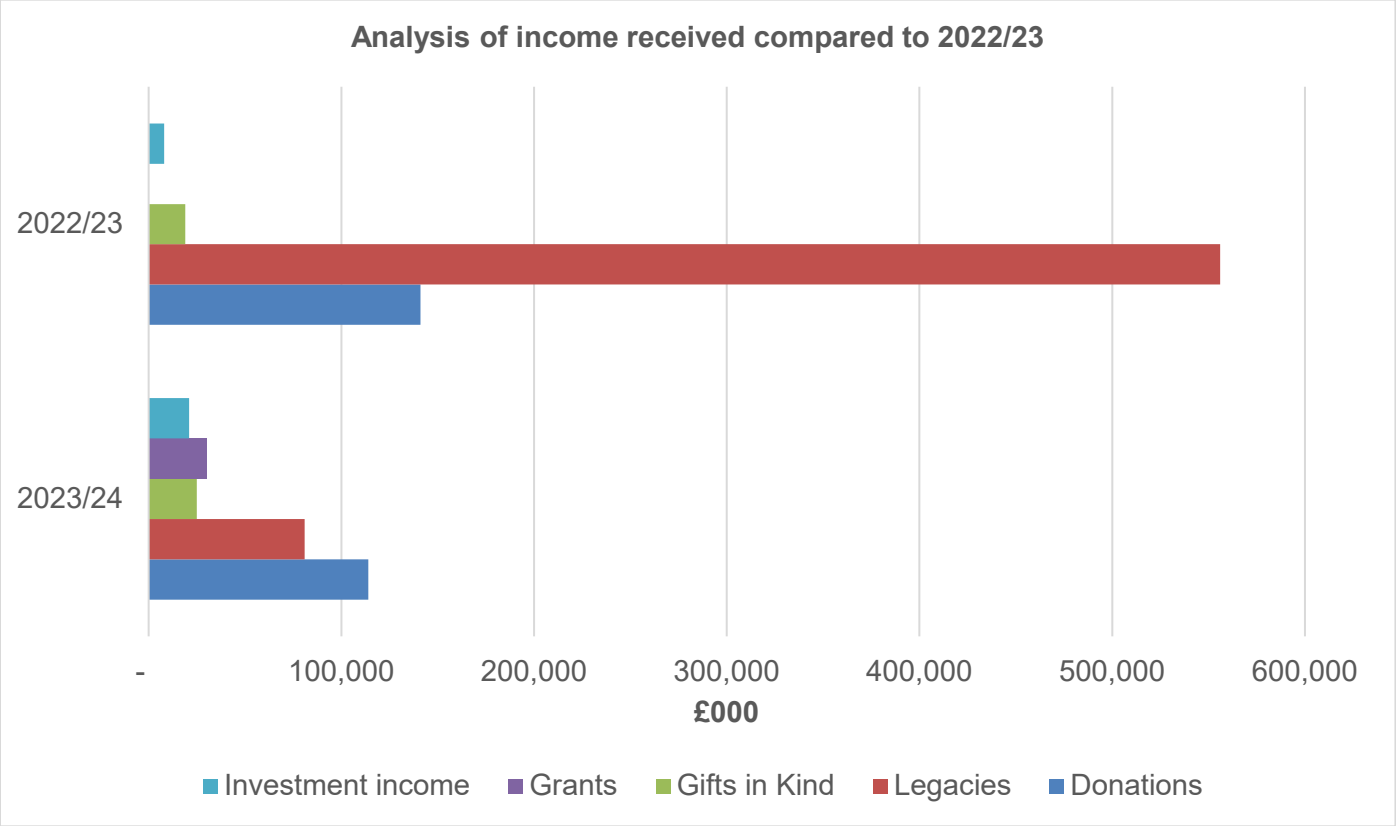
- Members of the Senior Leadership Team were involved in a strategy engagement session with the Director of Strategy & Impact at NHS Charities Together
- The Charity Manager attended a breakfast meeting with the Chief Executive of NHS Charities Together and the Chief Strategy Officer for NHS England to promote the new faith facilities at Royal Bolton Hospital and highlight the role of faith and spiritual wellbeing in enhancing the experience of patients, communities and the NHS workforce
- Members of the Senior Leadership Team presented at the Charity Leaders Engagement Event about the power of Trust and Health Boards working strategically with their respective NHS charities
- The Charity Manager continues to co-chair the Sole Fundraisers Special Interest Group

Bolton NHS Foundation Trust 'For a Better Bolton' Awards

The charity-funded faith facilities at the Royal Bolton Hospital have had a profound impact on staff, patients and visitors. The facilities demonstrate the role of spirituality in improving health outcomes for patients; supporting staff health and wellbeing, and providing bereavement support for grieving families. In recognition of their collective efforts, the Faith Facilities Project Team (comprising of Charity, Chaplaincy and Estates teams) was nominated and won the 'collaboration' award at the Bolton NHS Foundation Trust FABB Awards in November 2023.

Income analysis

The total income for 2023/24 was £250,000 compared with £716,000 in 2022/23. The majority of income came from donations (including funds raised through 'in aid of' events) and legacies; however there was a respective decrease of 19.1% and 85.4% when compared with 2022/23.

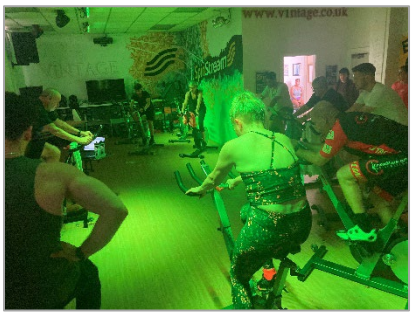


Fundraising highlights

From ultra-marathons to music composition, from Lands' End to John O'Groats, we've been humbled by the determination, creativity and energy of our supporters, and the distances they will travel to raise funds for Our Bolton NHS Charity in 2023/24.

Whatever the method or motivation, our supporters help us to invest in advanced medical equipment, comfortable and modern patient/staff facilities, and the small things that have a big impact. Quite simply, our supporters allow us to make a lasting and meaningful difference to the people of Bolton and beyond.

Fundraising by Bolton NHS Foundation Trust employees and the Integrated Care System



On 9 September 2023, five teams from Bolton NHS Foundation Trust and the wider Integrated Care System, took part in a six-hour spinathon. The event was organised and hosted by Gareth Price, owner of Bolton Spin Studio and long-standing supporter of Our Bolton NHS Charity. Despite temperatures nearing 30 degrees, our teams kept the wheels turning and their energy levels up for the full six hours and raised more than £3,600 for Our Bolton NHS Charity. Funds raised were allocated to the general purposes fund, which gives us maximum flexibilty to direct funds where they are needed most.

Fundraising by former patients and their families

The Real family organised their fourth charity ball in honour of World Prematurity Day and raised £22,000, which was split equally between Our Bolton NHS Charity (specifically the Paediatric and Neonatal specialty fund), Ronald McDonald House Charity and SANDS Charity. Our Bolton NHS Charity was awarded a share of the funds in recognition of the care the family's three-year-old twins received from when they were born prematurely at the Royal Bolton Hospital in 2019. The family has already registered their fifth charity ball and hope to raise a further £25,000.

Fundraising by the local faith communities

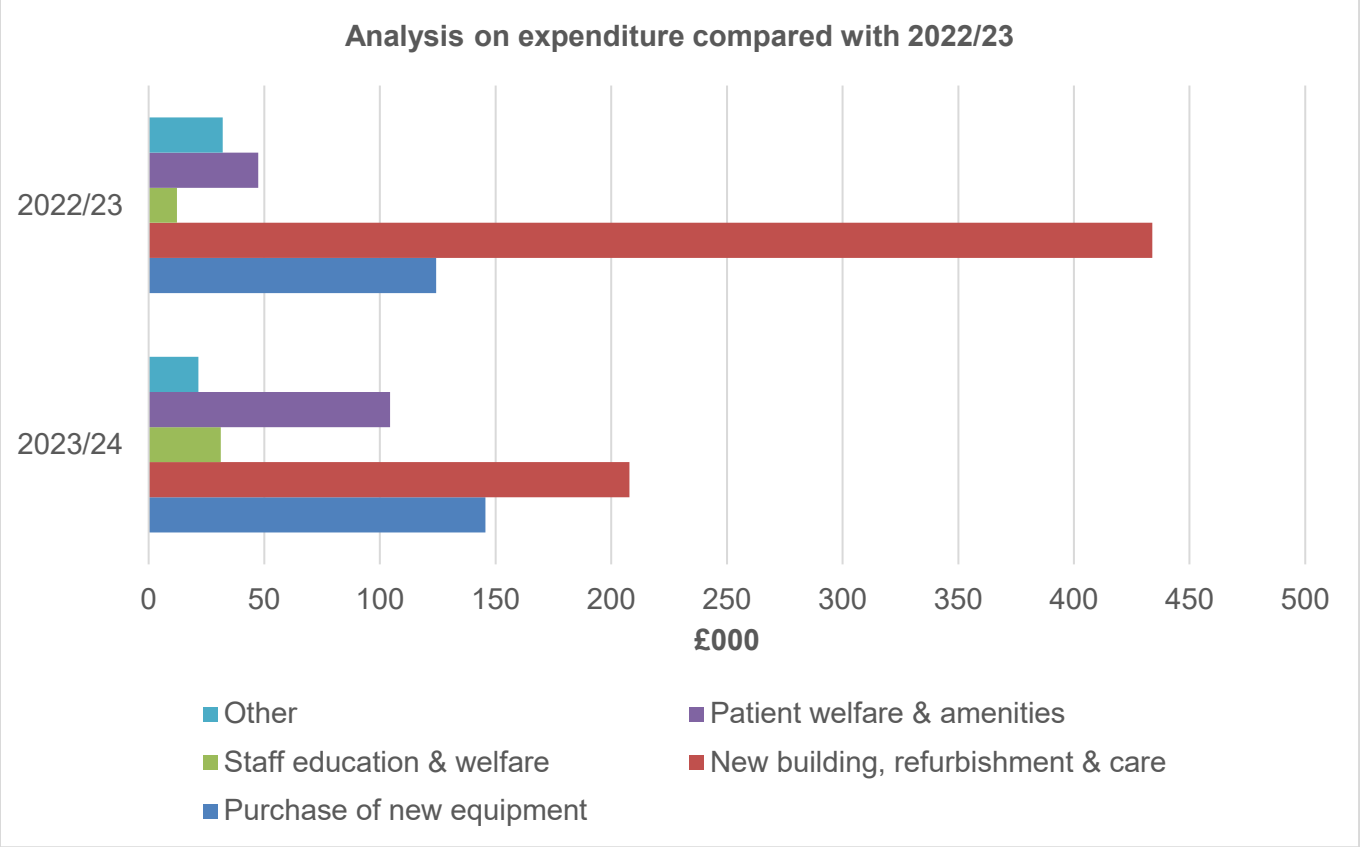
The Bolton Masjid Chanda Committee – which represents 11 mosques in Bolton – invited donations from its worshippers during Ramadan, which ran from 22 March to 20 April 2023. Representatives from the 11 mosques were invited to a charity presentation and tour of the new faith facilities in August 2023 where Chair of Bolton Masjid Chanda Committee presented Our Bolton NHS Charity with a cheque for £18,000. This donation was allocated to the 'general purposes fund', which gives the charity the flexibility to direct funds where they are needed most and will have the greatest impact.

Fundraising through the arts

Healing Tales is a collaborative music piece – composed by Professor Alan Williams – which tells the stories of eight Bolton NHS Foundation Trust employees, and their experience of working through the Covid-19 pandemic. The composition took five months to develop and involved a series of individual interviews and group workshops to plan the story and shape the score. Healing Tales was performed at the New Adelphi Theatre on 20 July 2023 by the Latitude Ensemble, along with live drawing and dance, and raised £621 through ticket sales for Our Bolton NHS Charity.

Expenditure analysis

Of the £595,000 total expenditure (£753,000 in 2022/23), £510,000 (£650,000 in 2022/23) was on direct charitable activities across a range of programmes, for the benefit of patients, service-users and the local health community. The remaining £85,000 is attributed to gifts in kind (£25,000) for the benefit of patients, and governance costs (£60,000), which relate to independent examination (2024), statutory external audit (2023) and staffing costs.



Charity-funded schemes and expenditure highlights

Supporting the development of the charity through the NHS Charities Together development grant

Charity video

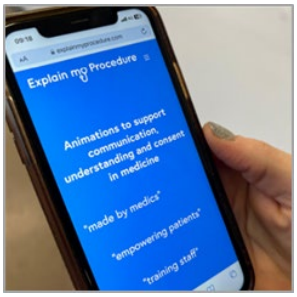
Thanks to the NHS Charities Together development grant, we funded our first official charity video. The video harnesses the power of story-telling to demonstrate how we use funds to make a difference to patients and their families, when it matters most. The premiere of the video took place at the annual staff awards evening, in front of 300 Bolton NHS Foundation Trust employees, and now features in the fortnightly corporate induction for all new Trust employees. In addition, the video is playing on digital screens across the Trust footprint and on digital screens in Bolton Town Centre and in GP surgeries across Bolton.

Improvements to facilities and services for patients and their families

Furniture for the parents' sitting area on the Neonatal Unit

We have funded furniture for the parents' sitting area thanks to historical donations to the Special Care for Special Babies appeal. The furniture has helped to create a welcoming space where parents can take time out away from the cot-side. Recent charitable expenditure, which includes reclining chairs and a twin cot, has supported the Neonatal Unit in achieving full FiCare accreditation. FiCare is a model, which empowers parents to become confident, knowledgeable and independent primary caregivers, and is shown to improve neonatal outcomes.

Patient information videos for breast cancer patients and their families



Our Bolton NHS Charity has funded a 12-month pilot with Explain my Procedure, which specialises in patient information videos about common procedures, including (but not limited to) undergoing a general anaesthetic, mastectomy with axillary node clearance, and wide local incision with sentinel node biopsy. The videos – supported by animations – help to explain procedures in a simple and accessible way, which improves patient (and relative) understanding and shared decision-making. Use of these videos in other trusts has resulted in a significant reduction in complaints and serious incidents due to failure to inform.

Purchasing new equipment to improve health outcomes and improve the NHS experience

20 Portable ECG machines for the Cardiology department

Thanks to a legacy left to the Cardiology speciality fund, Our Bolton NHS Charity has funded 20 portable ECG machines for the Cardiology department. The additional devices will provide a minimum of 20 additional appointments per week, resulting in shorter wait times and earlier diagnosis and treatments for patients.

Royal Bolton Hospital's first medical gaming cart

Thanks to the phenomenal fundraising efforts of local secondary school children, Our Bolton NHS Charity was able to fund Royal Bolton Hospital's first medical gaming cart for the children's ward. The gaming cart includes an Xbox Series S gaming console and is pre-loaded with the latest age-appropriate games, including (but not limited to) FIFA 22, Paw Patrol, Minecraft and Lego Star Wars. The medical gaming cart helps to reduce anxiety in children and young people and – on average – will benefit more than 2,000 young patients each year.

Supporting staff wellbeing, training and development

We're proud to invest in projects that support staff wellbeing, and subsequently have an indirect, yet tangible benefit to patients.

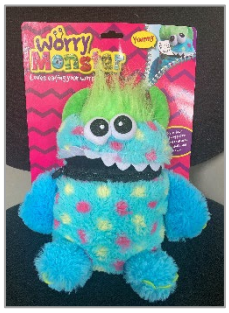
Reclining chairs as part of the 'All Heroes Need Sleep'

Studies show there is positive correlation between night-shift working and reduced accuracy and confidence in clinical decision-making, which can lead to poorer health outcomes for patients. The 'All Heroes Need Sleep' campaign was designed to raise awareness of the impact of fatigue and change the culture around rest/sleep during shifts. To support this work, Our Bolton NHS Charity funded 21 reclining chairs, which are located at various sites around the hospital. Staff are encouraged to use the reclining chairs during a night-shift and/or before travelling home. This work has been shortlisted in the HSJ Patient Safety awards.

The small things that make a big difference

Worry monsters for children who are bereaved

Losing a loved one can be a confusing and scary time for a child, and can often lead to an increase in stress and anxiety. Thanks to donations from supporters, Our Bolton NHS Charity has funded a supply of worry monsters to support children affected by bereavement.



- The worry monster will be sent home with a child whose relative has died at the Royal Bolton Hospital
- The child can write or draw a picture of anything that worries them and place it in the worry monster's mouth
- The parent/guardian can remove the worry whilst the child is sleeping
- The child will wake to discover the worry monster has eaten the worry
- The parent/guardian can discuss the worry with the child in a sensitive and appropriate way

The worry monsters are the latest addition to charity-funded bereavement support and compliment the memory boxes, fingerprint keyrings and information booklets, already funded by Our Bolton NHS Charity.

Free extended TV access for patients to watch the coronation

Our Bolton NHS Charity partnered with WiFi SPARK and switched all 588 Hospedia bedside units at Royal Bolton Hospital to 'free-to-use' from Friday 5 to Monday 8 May so patients had the opportunity to watch the coronation of their Majesties King Charles III and Queen Camilla at Westminster Abbey and many other programmes/events including the Coronation Concert, live from Windsor Castle.

Looking ahead to 2024/25

Use of the development grant to invest in digital technology and increased visibility

Thanks to the NHS Charities Together development grant, we plan to invest in and install three contactless donation terminals at locations across the Royal Bolton Hospital site. In addition, we will purchase contactless card-readers that can be used to accept donations by card and mobile at engagement and fundraising events, including (but not limited to) the annual FABB awards, the Wave of Light event and Festive Friday.

At present, the charity has very little visibility across the Trust footprint so we plan to utilise the development grant to design and print a series of 'Our Bolton' stories. These assets will harness high-impact imagery and the power of story-telling to inform staff, patients, service-users and visitors how supporting Our Bolton NHS Charity makes a difference. We have a range of spaces to explore, including (but not limited to) lift doors, digital screens, doors and external signage.

NHS Charities Together

We will continue our paid membership with NHS Charities Together, in recognition of the benefits to Our Bolton NHS Charity, including (but not limited to) access to training and development, peer support and exclusive grant-funding opportunities.

Working in collaboration with other charities and grant-making organisations

We've seen from NHS Charities Together grant-intentions for 2024 that there is greater emphasis on partnership working with VCSE sector organisations and we know our reach and impact are greater when we collaborate with organisations with similar aims and objectives. With the cost of living crisis set to get worse before it gets better and fierce competition for resources, we will continue to build relationships with other charities and grant-making organisations and explore working in partnership to make a lasting and meaningful difference, together.

Statement of the Corporate Trustee's responsibilities

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

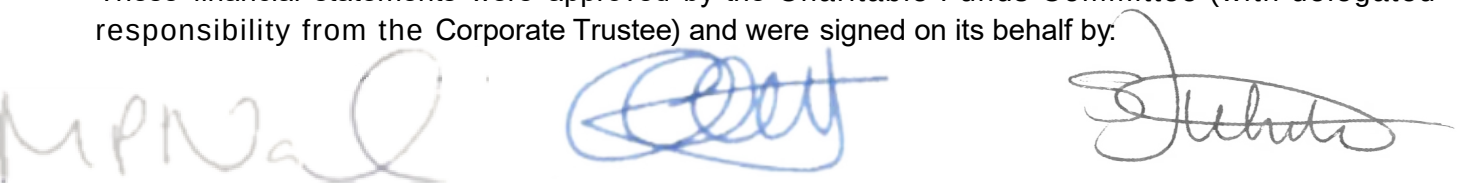
The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees:

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

The Corporate Trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. It is responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the Corporate Trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision.

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



Martin North
Chair of the Charitable Funds Committee

Annette Walker
Director of Finance

Sharon White
Chief of Strategy and Partnerships

Statement of financial activities for the year ended 31st March 2024

	Note	Restricted Funds £000	Un-Restricted Funds £000	Endowment Funds £000	Total Funds 2024 £000	Total Funds 2023 £000
Incoming Resources:						
Incoming resources from generated funds:						
Voluntary income:	3					
Donations		28	86	0	114	141
Legacies		0	81	0	81	556
Gift In Kind		0	25	0	25	19
Grants		30	0	0	30	0
Sub total voluntary income		**58**	**192**	**0**	**250**	**716**
Activities for generating funds:						
Investment income	4	1	20	0	21	8
Total incoming resources		**59**	**212**	**0**	**271**	**724**
Resources Expended						
Costs of generating funds:						
Charitable activities:	5					
Purchase of new equipment		32	114	0	145	124
New building, refurbishment & care		117	92	0	209	434
Staff education & welfare		4	27	0	31	12
Patient welfare & amenities		7	97	0	104	47
Other		17	3	0	20	32
Sub total direct charitable expenditure		**177**	**333**	**0**	**510**	**650**
Other resources expended						
Gift In Kind	5	0	25	0	25	19
Governance Costs	6	4	56	0	60	84
Total resources expended		**181**	**414**	**0**	**595**	**753**
Net incoming/(outgoing) resources before transfers		(121)	(203)	0	(324)	(29)
Net incoming/(outgoing) resources before other recognised gains and losses		**(121)**	**(203)**	**0**	**(324)**	**(29)**
Net movement in funds		**(121)**	**(203)**	**0**	**(324)**	**(29)**
Reconciliation of Funds						
Total Funds brought forward		454	912	42	1,408	1,437
Total Funds carried forward		**332**	**710**	**42**	**1,084**	**1,408**

Balance sheet for the year ended 31st March 2024

	Note	Restricted Funds £000	Un-Restricted Funds	Endowment Funds £000	Total Funds 2024 £000	Total Funds 2023 £000
Current assets:	10					
Debtors		0	0	0	0	6
Cash and Cash Equivalents		336	732	42	1,110	1,452
Total current assets		**336**	**732**	**42**	**1,110**	**1,458**
Liabilities	11					
Creditors falling due within one year		(4)	(22)	0	(26)	(50)
Net current assets or liabilities		**332**	**710**	**42**	**1,084**	**1,408**
Total assets less current liabilities		332	710	42	1,084	1,408
Net assets or liabilities		**332**	**710**	**42**	**1,084**	**1,437**
The funds of the charity:						
Endowment funds		0	0	42	42	42
Restricted Income Funds		332	0	0	332	455
Un-Restricted income funds		0	710	0	710	911
Total charity funds		**332**	**710**	**42**	**1,084**	**1,408**

The notes at pages 21 to 29 form part of these accounts.

Signed: 

Name: Annette Walker

Date: 23rd January 2025

Statement of cash flow for the year ended 31st March 2024

	2024 £000	2023 £000
Net movement in funds for the reporting period (as per the statement of financial activities)	**(324)**	**(29)**
Adjustments for:		
(Increase)/decrease in debtors	6	2
Increase/(decrease) in creditors	(24)	15
Net Cash provided by (used in) operating activities	**(342)**	**(12)**
Cash Flows from investing activities:		
Dividends, interest and rents from investments	0	0
Net cash provided by (used in) investing activities	**0**	**0**
Change in Cash and cash equivalents in the reporting period	**(342)**	**(12)**
Cash and cash equivalents at the beginning of the reporting period	**1,452**	**1,464**
Cash and cash equivalents at the end of the reporting period	**1,110**	**1,452**

Notes on the accounts

1. Accounting Policies

(a) Basis of preparation

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

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

Going Concern

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

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

(b) Income and Endowments

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

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

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

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

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

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the charity; this is normally upon notification of the interest paid or payable by the bank.

Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

(c) Expenditure Recognition

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

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

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

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

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

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

(d) Allocation of overhead, support and governance costs

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

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

(e) Expenditure on raising funds

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

(f) Expenditure on Charitable Activities

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

(g) Irrecoverable VAT

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

(h) Funds structure

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

(i) Realised gains and losses

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

(j) Going Concern

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

(k) Transfer of Funds from NHS Bodies

There have been no transfers in 23/24 from NHS bodies.

2. Related party transactions

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

- Fiona Noden, Chief Executive
- Annette Walker, Chief Finance Officer
- Rae Wheatcroft, Chief Operating Officer
- Francis Andrews, Medical Director
- Sharon White, Chief of Strategy and Partnerships
- James Mawrey, Chief People Officer/Deputy CEO
- Niruban Ratnarajah, Chair of Bolton NHS Foundation Trust
- Tyrone Roberts, Chief Nursing Officer
- Seth Crofts, Associate Non-Executive Director
- Tosca Fairchild, Non-Executive Director
- Jackie Njoroge, Non-Executive Director
- Martin North, Non-Executive Director
- Alan Stuttard, Non-Executive Director
- Sean Harris, Non-Executive Director
- Rebecca Ganz, Non-Executive Director
- Fiona Taylor, Non-Executive Director
- Sharon Katema, Director of Corporate Governance/Trust Secretary

None of the above have received honoraria, emoluments or expenses from the Charity for the year ended 31st March 2024.

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

3. Analysis of voluntary income

	Restricted Funds £000	Un-Restricted Funds £000	Total Funds 2024 £000	Total Funds 2023 £000
Donations				
Breast Fund	0	8	8	18
Neonatal & Paediatric Services Fund	10	21	31	28
General Purposes Fund	0	43	43	66
Cancer Services	0	3	3	3
Critical Care Fund	0	4	4	4
Special Care for Special Babies	0	0	0	1
Other Funds (55)	18	7	25	21
Sub total	**28**	**86**	**114**	**141**
Gift In Kind				
General Purpose Fund	0	25	25	19
Sub total	**0**	**25**	**25**	**19**
Legacies				
General Purpose Fund	0	68	68	258
Cardiology	0	11	11	283
Ophthalmology	0	1	1	14
Neonatal & Paediatric Services Fund	0	1	1	1
Sub total	**0**	**81**	**81**	**556**
Grants				
General Purpose Fund	30	0	30	0
	30	**0**	**30**	0
Total	**58**	**192**	**250**	**716**

4. Analysis of investment income

Gross income earned from:	Restricted Funds £000	Un-Restricted Funds £000	2024 Held in UK £000	2023 Held in UK £000
Interest from Bank Account	1	20	21	8
Total	**1**	**20**	**21**	**8**

5. Analysis of charitable expenditure

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

	Activities undertaken directly £'000	Grant Funded activity £'000	Gift In Kind £'000	Support Costs £'000	2024 Total £'000	2023 Total £'000
Purchase of new equipment	146	0	0	16	162	140
New building, refurbishment & care	11	197	0	24	232	488
Staff education & welfare	31	0	0	4	35	13
Patient welfare & amenities	104	0	25	15	144	75
Other	21	0	0	1	22	36
Total	**313**	**197**	**25**	**60**	**595**	**753**

6. Allocation of support costs and overheads

Allocation and apportionment to Governance Costs	Allocated to Governance £'000	Residual for Apportionment £'000	2024 Total £'000	2023 Total	Basis of Apportionment
Salaries & related costs	58	136	194	183	Fixed and transactional
Independent Examination (inc VAT)	2	0	2	0	Governance
Statutory External Audit (inc VAT)	0	0	0	7	Governance
Total	**60**	**136**	**196**	**190**	

7. Analysis of grants

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

8. Transfers between funds

There have been no transfer between funds during the year.

9. Analysis of fundraising events

There have been no fundraising events during the year.

10. Analysis of current assets

Debtors under 1 year	Restricted Funds £000	Un-Restricted Funds £000	2024 Total £000	2023 Total £000
Accrued Income and Aged Debt	0	0	0	6
Total	**0**	**0**	**0**	**6**

Analysis of cash and deposits	Restricted Funds £000	Un-Restricted Funds £000	Endowment Funds £000	2024 Total £000	2023 Total £000
R.B.S. Special Interest Bearing Account	336	722	42	1,100	1,442
R.B.S. Current Account	0	10	0	10	10
Total	**336**	**732**	**42**	**1,110**	**1,452**
Total Current Assets	**336**	**732**	**42**	**1,110**	**1,458**

11. Analysis of current liabilities and long term creditors

Creditors under 1 year	Restricted Funds £000	Un-Restricted Funds £000	2024 Total £000	2023 Total £000
Other creditors	3	13	16	19
Accruals	1	9	10	31
Total	**4**	**22**	**26**	**50**

12. Contingencies

The Charity has no contingent liabilities or assets.

13. Commitments

The Corporate Trustee acknowledges that it has commitments for goods or services that have yet to be received for £72,041.76.

14. Analysis of charitable funds

Material Funds	Balance b/fwd £000	Income £000	Resources Expended £000	Gains & Losses £000	Fund c/fwd £000
RBH General Purposes	484	174	(325)	0	333
Cancer Services	76	4	(46)	0	34
Cardiology	309	17	(85)	0	241
Elderly Medicine	11	1	(2)	0	10
Special Care for Special Babies	44	0	(27)	0	17
Community Funds	86	11	(13)	0	84
Breast Unit	64	9	(17)	0	56
Eye Unit	39	2	(6)	0	35
Other Funds	253	53	(74)	0	232
Total	**1,366**	**271**	**(595)**	**0**	**1,042**

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

During the year the General Purposes Fund has received donations in the form of a legacies and general donations. The General purpose fund has funded a Garden of Reflection for the benefit of both staff and patients and chairs for patients.

The Cancer Services Department receives many donations from grateful patients, funds are mainly used to purchase equipment for the department and to enhance patient areas. During the year the department funded the refurbishment of the main entrance

The Cardiology Department receives many donations from grateful patients and also from legacies, funds are mainly used to purchase equipment for the department. This year the department has purchased 20 ECG event recorders.

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

The Special Care for Special Babies campaign was launched in 2017 and the funds are being used to create a spacious and calm environment for families to be with their babies. This year the department has purchased furniture for the neonatal unit to ensure patients can visit and care for their baby in optimum comfort.

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

The Breast Unit receives many donations from grateful patients and also from legacies, funds are mainly used to purchase equipment for the department. Funds are used mainly used to purchase medical equipment and post op kits. This year the department has purchased LED headlight system and invested in animations to explain various breast procedures.

The Eye Unit receives many donations from grateful patients and also from legacies, funds are mainly used to purchase medical equipment for the unit.

15. Post balance sheet events

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

Independent Examiner's Report to the Trustees of Our Bolton NHS Charity

I report on the financial statements of Our Bolton NHS Charity for the year ended 31 March 2024, which are set out on pages 18 to 29.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the financial statements. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustees as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

Since the charity's gross income exceeded £250,000, your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination by being a qualified member of the Institute of Chartered Accountants in England and Wales which is one of the listed bodies.

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of Our Bolton NHS Charity in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or
- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

David Hoose FCA,
Forvis Mazars LLP,
30 Old Bailey,
London,
EC4M 7AU

Date:

Our Bolton NHS Charity,
Dowling House,
Royal Bolton Hospital,
Minerva Road,
Farnworth,
BL4 0JR

23 January 2025

Forvis Mazars LLP,
Two Chamberlain Square,
Birmingham,
B3 3AX

Dear Sirs/Madams,

Our Bolton NHS Charity – independent examination of the financial statements for the year ended 31st March 2024.

This representation letter is provided in connection with your Independent Examination of the financial statements of the Charity for the year ended 31st March 2024.

We confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

Our responsibility for the financial statements and accounting information

We believe that we have fulfilled our responsibilities for the true and fair presentation and preparation of the financial statements in accordance with applicable law and the applicable Financial Reporting Framework.

Our responsibility to provide and disclose relevant information

We have provided you with:

- Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- Additional information that you have requested from us for the purpose of the Independent Examination; and

- Unrestricted access to individuals within the charity you determined it was necessary to contact in order to obtain Independent Examination evidence.

We confirm as trustees that we have taken all the necessary steps to make us aware, as trustees, of any relevant Independent Examination information and to establish that you, as examiners, are aware of this information.

As far as we are aware there is no relevant information of which you, as examiners, are unaware.

Accounting records

We confirm that all transactions undertaken by the charity have been properly recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all management and trustee meetings, have been made available to you.

Accounting policies

We confirm that we have reviewed the accounting policies applied during the year in accordance with the requirements of applicable law and applicable Financial Report Framework and consider them appropriate for the year.

Accounting estimates, including those measured at fair value

We confirm that any significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- Information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- The amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the charity have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with applicable law and applicable Financial Reporting Framework.

Laws and regulations

We confirm that we have disclosed to you all those events of which we are aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

We acknowledge our responsibility as trustees of the charity, for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

We have disclosed to you:

- All the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- All knowledge of fraud or suspected fraud affecting the entity involving:
- Management and those charged with governance;
- Employees who have significant roles in internal control; and
- Others where fraud could have a material effect on the financial statements.

We have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

We confirm that all related party relationships, transactions and balances, (including sales, purchases, loans, transfers, leasing arrangements and guarantees) have been appropriately accounted for and disclosed in accordance with the requirements of applicable law and the applicable Financial Reporting Framework.

We have disclosed to you the identity of the charity’s related parties and all related party relationships and transactions of which we are aware.

Impairment review

To the best of our knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the fixed assets below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Charges on assets

All the charity's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

We have no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

We confirm all events subsequent to the date of the financial statements and for which the applicable law and applicable Financial Reporting Framework require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, we will advise you accordingly.

Audit requirement

We confirm that there are no specific requirements for an audit to be carried out in the governing document of the charity, in any special trusts associated with the charity or as a condition of any grants made to the charity.

Restricted funds

We confirm that we have provided all information to enable the appropriate disclosure of funds in the relevant and previous financial years.

Yours faithfully,

Martin North,
Chair of the Charitable Funds Committee, on behalf of the Corporate Trustee

Report Title:	Strategy and Operations Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	
Executive Sponsor	Chief Operating Officer and Chief of Strategy and Partnerships		Decision	

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

Previously considered by:	The matters included in the Chairs Report were discussed and agreed at the Strategy and Operations Committee meeting held on 25 November 2024.

Executive Summary	The attached report from the Chair of the Strategy and Operations Committee provides an overview of matters discussed at the meeting held on 25 November 2024. The report also sets out the assurances received by the Committee and may identify specific concerns that require the attention of the Board of Directors. Due to the timing of the November meeting of the Strategy and Operations Committee, a verbal update was provided to the Board of Directors in November 2024, and the written report is now provided for the January meeting.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Strategy and Operations Committee Chairs Report.

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

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

Prepared by:	Sean Harriss, Non-Executive Director/Chair of Strategy and Operations Committee	**Presented by:**	Sean Harriss, Non-Executive Director/Chair of Strategy and Operations Committee

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee /Group:	Strategy and Operations Committee	**Reports to:**	Board of Directors
Date of Meeting:	25 November 2024	**Date of next meeting:**	
Chair	Sean Harriss, Non-Executive Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Committee Effectiveness Review
- Spotlight: NCTR and Neighbourhoods Update
- Operational IPM
- EPR Update
- EPRR Core Standards Report
- Op Plan – GM Submission
- EPR and Maternity EPR Update
- Data Strategy
- Performance and Transformation Board Chairs Report
- Digital Performance and Transformation Board Chairs Report
- Bolton Strategy, Planning and Delivery Committee Minutes

ALERT

N/A

- **Urgent Care** – Performance for the 4-hour standard was 62.3% for October, which is a decrease of 3.7% from September 2024. The Committee did not receive assurance that the 78% UC performance target can be achieved by March 2025 in light of the dip in performance in October due to the implementation of the 'medical model' and this being one of the biggest challenges faced by the Trust. Current performance was challenging the expected increased performance outcomes of the 'waterfall diagram' but the Committee noted that the implementation of the 'medical model' in October was an ECIST recommendation to drive improvements
- **Outpatients and Community EPR** -

ADVISE

- **Elective Care –** the Trust is confident of achieving zero 65 ww by March 2025
- **EPRR Core Standards Report –** To ensure that the Trust is properly assessing the change that AI will have brought to the way in which we deal with EPRR compliance, the Cybersecurity section of the AI Policy will be updated to reflect the EPRR element
- **GM Op Plan submission –** although at an early stage to forecast performance against the assumed targets, the Trust is proposing to meet the majority of the headline targets with the exception of RTT and Virtual Wards.
- **Data Strategy -** Currently working on testing out some of the assumptions and building them out as a broad map of what needs to be delivered using the RAISE (Readiness, Assurance, Intelligence,

Sharing, Education) Framework ahead of the draft launch in January 2025. The Strategy will be driven from an end user and outcomes perspective to achieve a data enabled organisation that is able to utilise high quality data to make high quality decisions
ASSURE
• **EPR Update** - the decision by Executive Directors for a single-phased approach was based on the challenges in dividing the project into multiple phases without firm timelines. One contributing factor was the overlap between Community and Outpatient services, which share certain pathways. This has made it difficult to determine the best placement of these services within each phase of deployment and this introduced confusion, as ensuring both patient safety and ease of use for staff requires precise alignment across phases. The changes allow for comprehensive planning, including adjustments to clinical capacity to ensure a more manageable transition for clinicians, reduces fatigue and allows adequate time for training, reduces resource strain on the Maternity roll-out and allows necessary governance improvements. • **Neighbourhoods Update -** The Committee acknowledged the enormous amount of work to date and the difference that the Neighbourhoods has made already and the potential for an even greater difference in the future. The maturity matrix will be revisited with system partners in the New Year. • **Community Care –** overperformance for ED Deflections, reduction in No Criteria to Reside (NCTR) and Long Length of Stay (LLoS) acknowledged and attributed to improved working partnerships with colleagues across the whole system • **Committee Effectiveness Review** - Overall, the results from the survey were generally positive and indicated that the Committee has continued to build on its effectiveness since the last report in November 2023.
New Risks identified at the meeting: None identified
Review of the Risk Register: None identified

Report Title:	iFM Annual Performance Report – April 2023 to March 2024			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	30 January 2025		Discussion	✓
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an overarching review of the Annual Performance of iFM for FY 23/24

Previously considered by:	iFM Bolton Board, Trust Executives and Finance and Investment Committee

Executive Summary	The purpose of the iFM Annual Performance Report is to provide an overarching review of the performance of iFM, including the key achievements and challenges for the period April 2023 to March 2024. The Key areas / updates included in this report are:- • Executive overview • Health Safety & Sustainability • Overview of FM Estates and Facilities challenges • RAAC update • Operations & Special services update • Strategy and Transformation update • Procurement update • People report The report also includes the iFM Outlook Prioirities for 2024/25 and closing thoughts on the financial year 2023/24.

Proposed Resolution	The Board of Directors is asked to ***receive*** the iFM Annual Performance Report April 2023 to March 2024.

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:	Fiona McDonnell, MD iFM	**Presented by:**	Annette Walker, Chief Finance Officer

iFM Bolton
Clean, Safe and Sustainable
A wholly owned subsidiary of Bolton NHS Foundation Trust NHS

Annual Operating Summary Report

April 2023 to March 2024

Contents

Section One

Executive Overview

April 2023 to March 2024

Executive Overview

FY23/24 Full Year Report -

Welcome to the Annual Operating Report for Bolton, for the financial year 2023/24.

Through this report our aim is to present all of the achievements, challenges and risks that have been part of day-to-day life for IFM in 2023/24.

Delivering Estates & Facilities activities on behalf of Bolton Foundation Trust is an absolute privilege, and the duty we have to the people of Bolton to ensure their experience of Bolton FT is a positive one, remains the overarching priority for IFM. We practically achieve this by linking our strategic plans and operational activities to the 5 Trust ambitions, and we have ensured that all of the achievements within this report are linked to those ambitions.

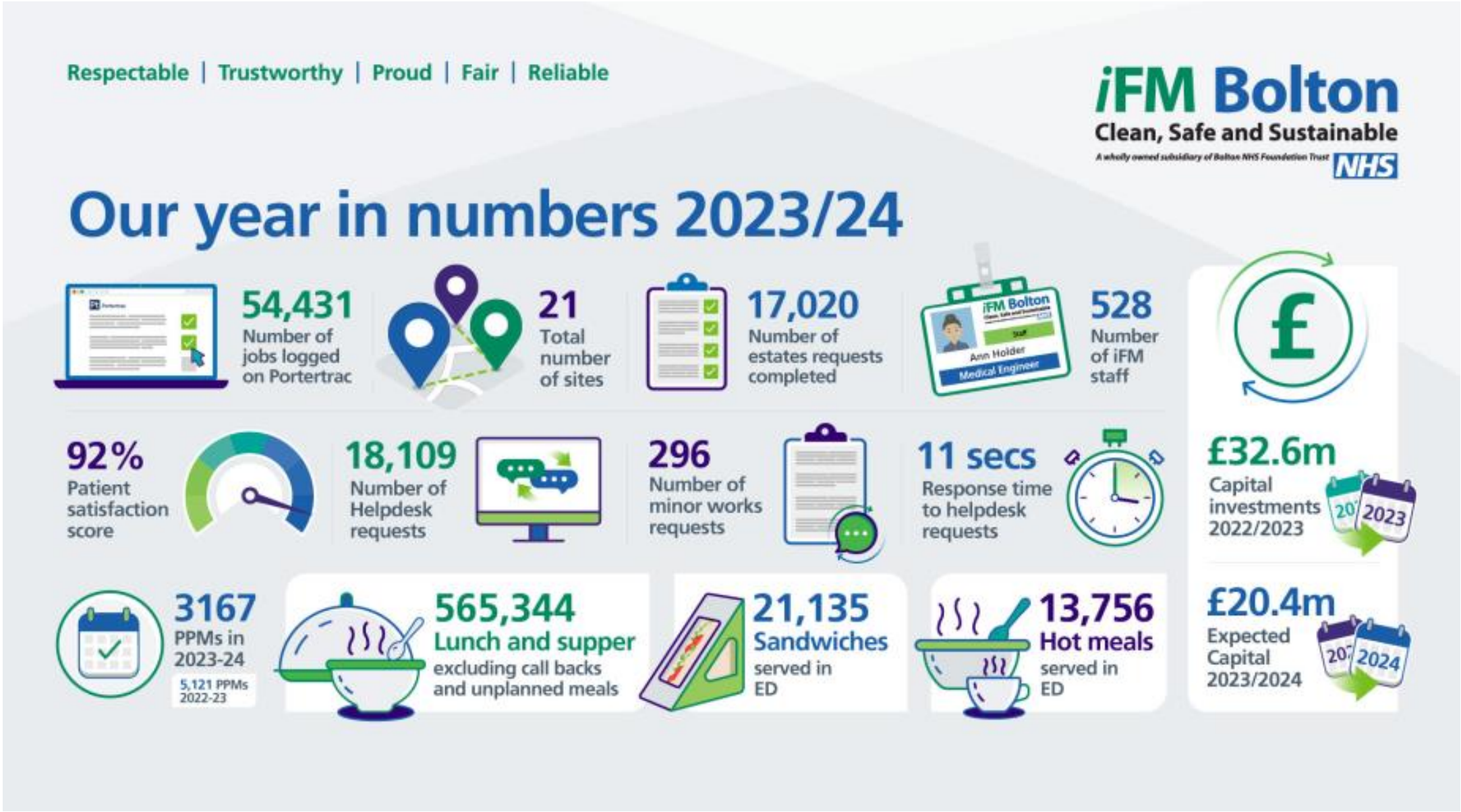
We also understand that to remain effective in the delivery of our services in a challenging health environment, we need to remain agile whilst ensuring governance is both established and adhered to. Within our Half Year Report we spoke of the Governance Model we have developed, and that model continues to underpin the safe delivery of services, along with ensuring effective collaborative effort with the Trust in relation to health, safety and compliance.

There have been countless key achievements delivered in 2023/24, some of our proudest include;

- Our **response to the identification of RAAC** at Royal Bolton Hospital, which culminated in the successful allocation of £975k initial funding from the National RAAC Programme to support surveys and RAAC mitigation works
- On time and within budget delivery of key Capital schemes, including the **Modular Theatres** and **Community Diagnostic Centre**
- Procurement support which **delivered savings valued at £7.03m FYE**, £1.24m over the recorded savings for 2022/23
- Delivered efficiencies as part of the wider Trust CIP, that totalled **£419k of recurrent savings**
- Leading and delivering key Trust strategic programmes such as the '**Estates Utilisation & Building Closures**' programme, including a full review of the Trusts bookable space system.
- Supporting the delivery of objectives contained within the Trusts '**Green Plan**'
- Continued focus of our Estates & Facilities teams, who provide a safe delivery model and enhance the Patient Experience in challenging circumstances
- Developing our leadership & transforming our workforce

We are incredibly proud of our team and their achievements in 2023/24, and we hope you enjoy the content of this report.

Fast Facts – 23/24



Positive Recognition

IHEEM Award Nominations

During Q3, our team attended the prestigious IHEEM Gala Awards following the shortlisting of within two categories:

- **Estates & Facilities Team of the Year**
- **Diversity & Inclusion Award – Multi-faith Centre**

The IHEEM judges shared that the standard of entries was a record high, with fierce competition in each of the 12 categories. Although we were unsuccessful on the night, it was a fantastic achievement for all who played a part.

Members of the team at the IHEEM award ceremony

Memorial Garden Improvements

Keely Barlow, our Customer Services Lead, helped drive improvements to the baby memorial garden in 23/24.

Gaining £27k in material donations from local suppliers, and pulling together Estates resources and volunteers in delivering the improvements, IFM were instrumental in this important initiative.

Keely Barlow, pictured far left, with Trust colleagues at the opening of the much improved Baby Memorial Garden

EMBE – FABB Award Winner

Led by Karen Stanton, our EBME team, attended the annual FABB Awards Ceremony and won 'Divisional Diamonds of the Year' Award.
This was for our support to the Bolton Wheelchair Service.

Karen Stanton, pictured 3rd from left, with members of the award winning EBME team

Continuous Improvement

Our Voice Change Programme

IFM are a key and active participant in the Our Voice Change Programme sessions that have occurred in 2024.

Providing input to the 'Your Working Environment' and 'Car Parking' working groups, alongside the Trust we have listened to the concerns of colleagues, and taken subsequent steps to support the Trust with resolutions on some of the issues.

Your Working Environment

Key discussion points include;

Smoking
- We have supported the group by installing tannoys which give a 'no smoking message' in problem areas at the hospital
- We have helped to erect new smoking signage
- We have enhanced the external cleaning activities to remove unsightly smoking debris

Catering/Break Facilities & Spaces
- We are considering new hot vending machines
- We have procured additional catering options
- We will lead with creating new spaces for breaks

Toilet Facilities
- Restroom facility audit undertaken, with action plan being created to resolve any defects and problems within them

Car Parking

Key discussion points include;

- We are supporting with ensuring some patient disabled bays are left free for patients
- We are reviewing the staff v patient car park allocation
- We are exploring access improvements to J Block from the nearby car park
- We have provided key car parking data from ParkingEye, which informs the group on who is using patient car parks
- We are exploring and provided quotes for new car park lighting
- We have received and passed on proposals for the creation of a one-way system around the site
- We have secured proposals and costs for a multi-storey car park, along with proposals and costs to increase car parking capacity through other solutions
- We have provided additional car park paying machines

Section Two

Quality, Safety, Health & Environment (QSHE)

April 2023 to
March 2024

Quality, Safety, Health & Environment (QSHE)

Key Achievements for FY23/24

Safety is a core value at IFM, and our key achievements in 23/24 demonstrate the progress we have made to manage risks and strengthen governance.

Strengthened Governance Routes & Structure - Working collaboratively with the Trust to achieve our key ambitions through the continued development of working groups and committees. This ensures we are providing assurance through collective responsibility for delivery of services. In summary we have strengthened our working relations to ensure decisions are agreed and actioned.

Premises Assurance Model (PAM) - In summary, the key change when comparing year on year (YOY) for the domains within PAM is the increase overall of 'Good' responses. 2021 – 2023 summary for the consolidated responses demonstrate progression of 108 responses, which highlights improvement and increased compliance for key safety areas of our estate.

RIDDOR Reportable incidents – A 75% reduction in injuries, ill-health and dangerous occurrences. Having 1 RIDDOR is too many, but observing a reduced number is a positive trend.

Fire Compartmentation – 100% completion of fire compartmentation surveys and remedial works identified. 10% of the identified remedial works have been completed, with the remaining 90% tracked through Clinical Operation & Estates Liaison Meeting (COEL). A plan to complete the remaining remedial actions will be devised through that Group.

Risk Management – Continually manage risks associated with the estates and facilities at Royal Bolton Hospital. We continue to promote a clear governance structure to ensure we manage, mitigate and reduce risk to a tolerable level. We have observed an increase in the number of risks, however that is largely due to a lack of funding to permanently mitigate the risk.

Safety Audits – 27 audits completed have identified best practice and areas for improvement. The purpose of safety audits is to ultimately prevent accidents, prevent injuries, improve employee morale and reduce costs. This is reflective in our safety statistics which details a reduction in slips, trips and falls, claims and RIDDOR reportable incidents in comparison to the previous year.

Monitor and Reduce Personal Injury Claims – 46% of claims have resulted in successful outcomes for IFM. Long term this should help to reduce insurance premiums. We continue to work with our insurance brokers to reduce claims.

Fire Risk Assessment (FRA) Compliance – There has been a 19% increase in FRA compliance from FY 22/23. There has largely been a continual monthly improvement for clinical, non-clinical and community premises presented to the Fire Safety Committee. There have been 58 FRA's undertaken in this reporting period.

Fast Facts

Working Groups/ Committees

18

FRA compliance increase

>19%

Slips, Trips & Falls reduction

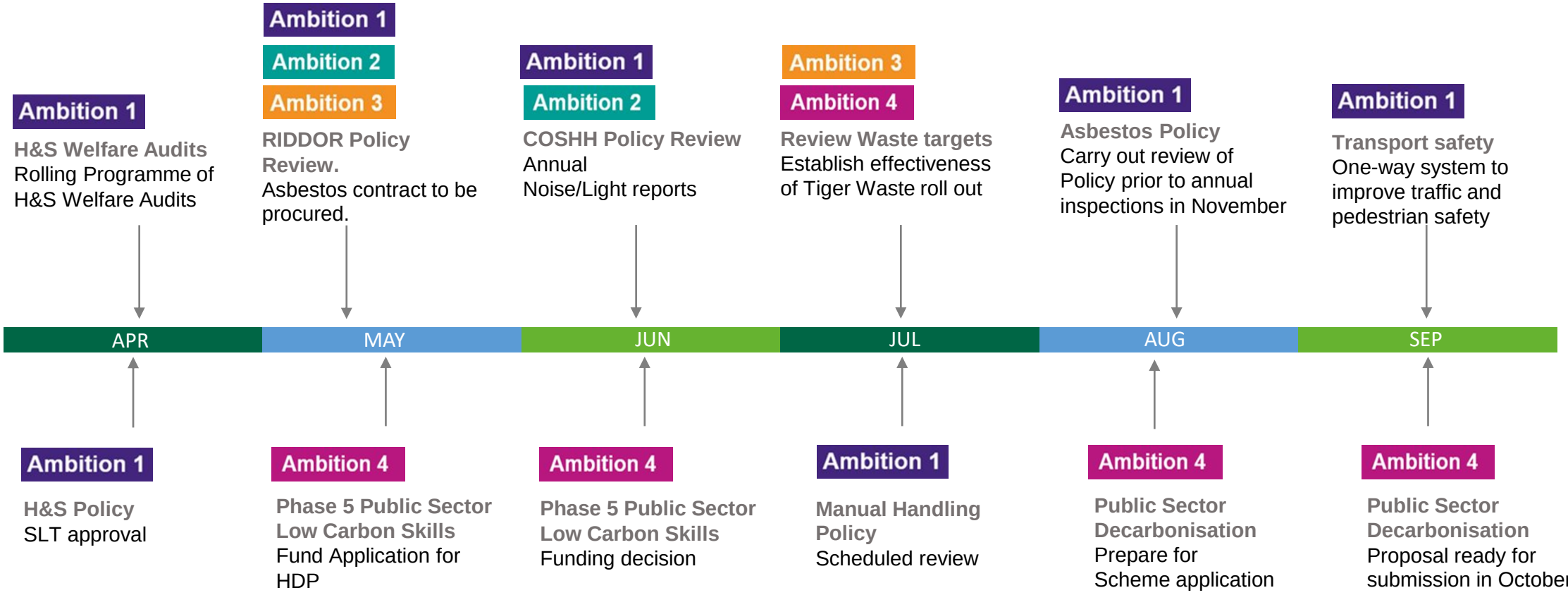
<24%

Fire Compartmentation Surveys Completed

100%

Quality, Safety, Health & Environment (QSHE)

24/25 Outlook for Half 1



Quality, Safety, Health & Environment (QSHE)

Green Plan Overview

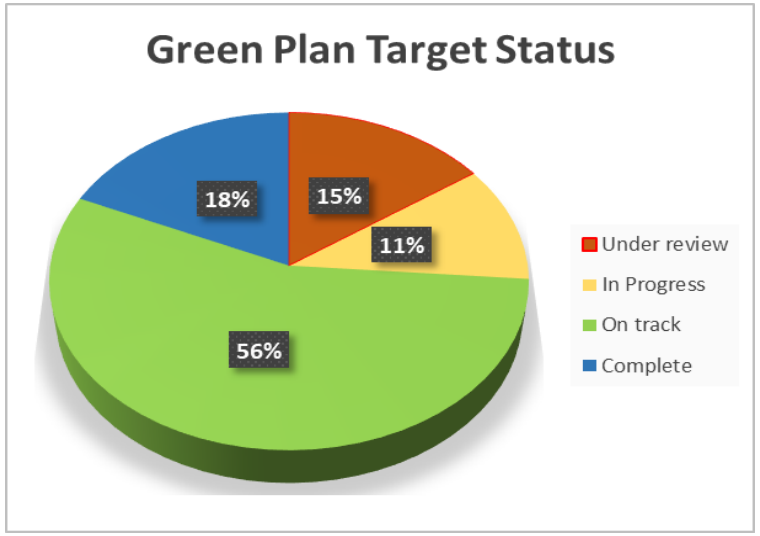
IFM oversee and support The Green Plan which aims to address greener NHS aspirations for a sustainable healthcare system. The Green Plan has 12 categories with 71 actions, and the plan is published and available to the public on the Bolton NHS website. The breakdown of targets by category are shown in Fig.1 below.

In terms of progress of targets, 52 of the 71 are either complete or on track for completion, with only 8 (11%) currently in progress pending review by the RBH Green Group.

'The Trust strives to deliver brilliant care outcomes through brilliant people and be a leading partner within an integrated system of health and social care, providing a patient experience without boundaries'.

Fig 1

Categories	Total No. Targets	No. Targets In Progress	No. Targets On Track	No. Targets Complete
Corporate	8	1	5	1
Estates & Facilities	10	4	1	0
Travel & Transport	5	0	2	1
Supply Chain & Procurement	6	1	1	4
Food & Nutrition	5	0	3	2
Medicines	4	0	3	1
Sustainable Models of Care	6	0	6	0
Digital Transformation	4	0	3	1
Workforce & Leadership	6	0	5	1
Greenspace & Biodiversity	6	0	4	1
Use of Natural Resource	6	0	4	1
Climate Adaption	5	2	1	1
TOTALS	71	8	38	14



Ambition 4
Our estate will be sustainable and developed in a way that supports staff and community health and wellbeing

Quality, Safety, Health & Environment (QSHE)

Green Plan Key Milestones

To support the Green Plan, a full Heat Decarbonisation Plan (HDP) has been drafted and we have engaged with multiple specialists to identify and map the current infrastructure, with an objective of identifying the technical data relating to the carbon impact of our heating and cooling systems. The benefits of the HDP are:

- A roadmap to a carbon net-zero heating/cooling system for the Estate
- A major component of the Estates strategy, as the initiatives will include reduction measures on energy demand (double glazing, insulation etc), energy production (renewable energy assets) and electrification of the heating systems (fossil fuel to electric).
- Removing our gas usage will reduce our carbon emissions by upwards of 80% and remove our UK ETS requirements (£0-5k in management fees and £150k+ in certain civil penalties annually)

Corporate - Established Green Champions network - introduction of 19 Green Group Champions and monthly working group.

- A means of promoting sustainability (efficiencies and cost savings) throughout the Trust
- Improved networking through the Trust e.g. the Sustainability Manager is closely working with the clinical leads and the Green Champions network, promoting working between the medical gases lead and community nursing

Corporate - Support the Bolton £ to ensure locality spend and investment within small business

- Free access (ICS funded) to an external verifier for our Travel Plan, leading to a focused Travel Plan that has been externally verified (Modeshift STARS)
- Currently running a pilot scheme with funding from Transport for Greater Manchester (TfGM) to provide selected car park permit holders from Bolton Hospital NHS Foundation Trust with a free monthly bus pass
- Our longer term aim is to reduce the demand on the car park, reduce congestion on the local roads, reduce our carbon emissions and promote staff to use public transport as their main means of commuting

Workforce & Leadership - Develop and implement a sustainability communications strategy

- COP – 28 Week, promotion of waste management, including general waste streams and water usage with a linked media article
- Sustainability awareness communication – Electrical usage, waste streams and water usage campaigns
- Tree planting – 250 trees received to plant on our estate(Provided by NHS Forest)

Ambition 4

Our estate will be sustainable and developed in a way that supports staff and community health and wellbeing

Section Three

Operations

Incl Estates, Facilities, Capital & Specialist Services

April 2023 to
March 2024

Estates

Key Achievements for FY23/24

We have an incredibly passionate and dedicated Estates Team, with a vision that is closely aligned to our Ambitions. We collectively operate on the guiding principle that without a safe building we have no Hospital. Striving to deliver a safe building and enhancing the patient experience has been at the centre of everything our Estates Team have delivered so far.

Management of Risk – Greater focus on risk management and several key risks entered with business cases written to mitigate

Water Safety – Increased governance and assurance presented to the Water Safety Group regarding regulatory compliance

Contractor Management – New contractor management dashboard with KPIs, contractor management policy and RESET assurance Portal

Authorised Engineer (AE) Appointments - Ensured key posts and disciplines were fulfilled with suitably qualified personnel

Ventilation Safety – Improved assurance presented to the Ventilation Safety Group regarding HTM adherence

Estates Team Leadership & Restructure – New leadership with Chartered Engineer expertise along with redefined roles in the team

Low Voltage (LV) Program – Development and delivery for LV infrastructure across the site

Improved KPI Tracker Implemented – Enhanced visibility of performance to ensure service delivery improves

3-year Capital Backlog Plan Developed – Outlines the investment required to safely maintain/replace Trust assets

Capital funding – Capital funding for lift upgrades, Chamber 2 and 3 redesign and Sub-station 4 and 6

Fast Facts

Planned Preventative Maintenance (PPM)
Our PPM routines have now been migrated to a new CAFM planning system. This will greatly improve our compliance assurance, create task allocation efficiencies and removed large amounts of paper from the system.

Reactive Works Monitoring
Our team have the ability to monitor our response to reactive Tasks in real-time, ensuring resources are deployed to the most urgent and appropriate task via Helpdesk. This provides the team with real time data to update customers and manage the team affectively

Reactive Works Volume
Our team responded to a total of 16,871 tasks in 2023/24 which is an increase from 2022/23 of 3,786.
This increase can be attributed to an aging estate and the migration over the new helpdesk in early 2023.

Reactive Works Performance

We were able to respond to 89% of all reactive tasks raised in the allocated SLA time.

Estates

Backlog Maintenance Overview

Position Summary

In 2022, a six-facet survey was conducted across Royal Bolton Hospital which highlighted a number of high and significant risks in relation to old, non-compliant and/or obsolete equipment.

The present aim is to gain support to secure vital funds to upgrade the estates infrastructure, ensuring that clinical services can operate within normal parameters and without significant disruption. Without investment to rectify the infrastructure of the hospital in the next 10 years, the current estimate of £150.3m (as shown in Fig.1) which is an increase of £71m. The increase is due to RAAC remedial costs in Maternity and Pathology plus 10% for inflation. This cost does not include any hospital/clinical downtime that could result through unplanned and forced outages due to defective infrastructure.

Fig.1 - Estates Backlog Breakdown by Risk

Risk Rating	Investment required (£M)
High risk Backlog	10,171
Significant Backlog	13,341
Moderate Backlog	91,542
Low backlog	32,278
Total	**150,333**

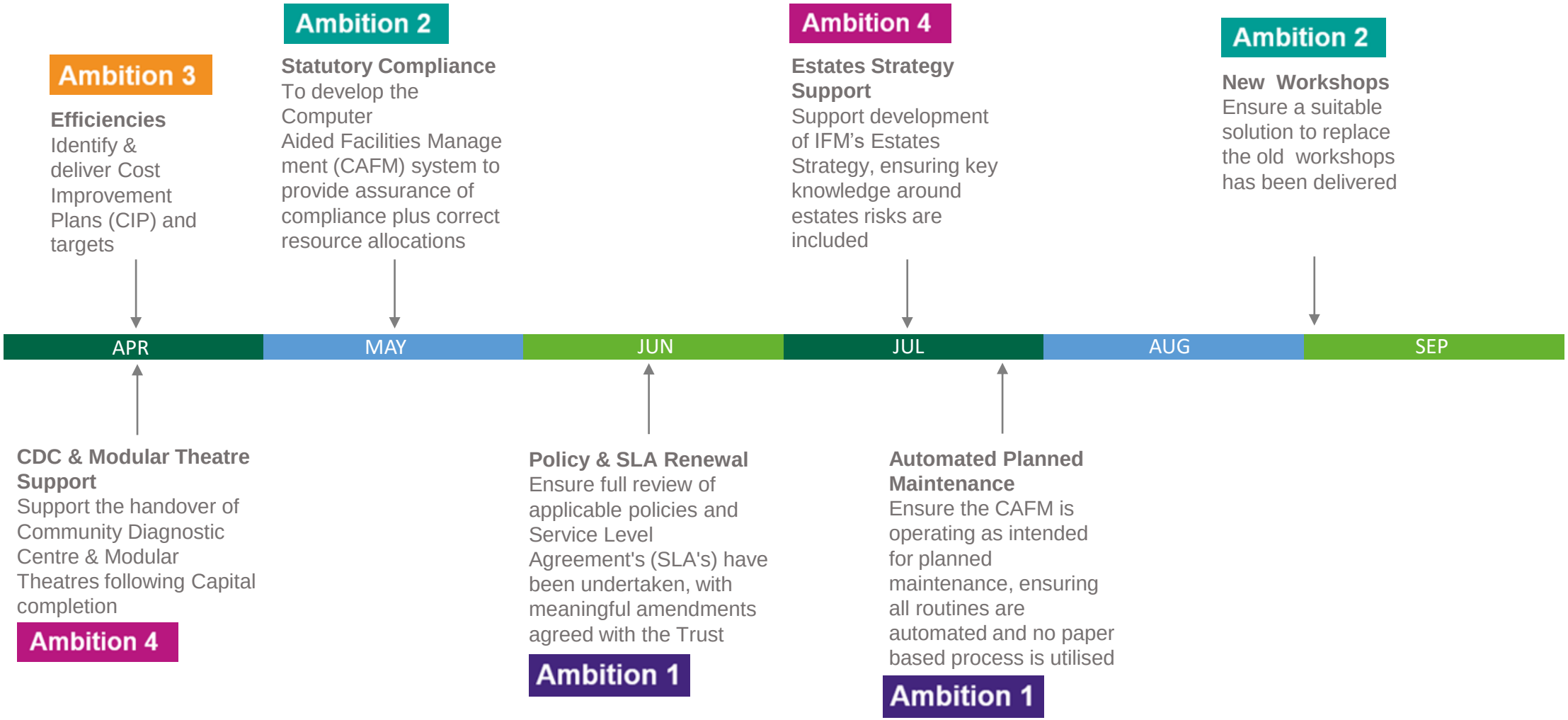
Mitigation

In the absence of the full funding required to address the whole Estates Backlog, controls have been put in place to mitigate the overarching risk, as far as reasonably practicable.

- Trained and competent estates staff, including Authorised Person and Authorised Engineers
- Specialist contracts in place and managed
- Regular Trust committee meetings for specialist services
- Business continuity plans are in place for critical services
- Development of a Capital Estates Backlog Program

Estates

24/25 Outlook for Half 1



Facilities

Key Achievements for FY23/24

Our Facilities Team is made up of over 450 dedicated individuals. Working across the Trust Estate 24hrs a day, 365 days a year, they are the life-blood of our organisation. Often interacting with patients on a daily basis, they are the proud face of IFM Bolton. This last year has seen our fantastic Catering Team win a North West Hospital Caterers Association (HCA) award. This industry recognition demonstrates the high level of service they offer, built on the foundations of a 5-star Hygiene Rating awarded earlier in 2023.

Cost Saving Initiatives – we have been working with Procurement to ensure all contracts are awarded through NHS Frameworks, giving us the most competitive prices and a quality service throughout. We have also removed various agency contracts and lack of value for money contracts

Catering Innovations – A huge amount of work has been undertaken in progressing some key Catering innovations, which would deliver improvements to the patient experience, whilst reducing food waste through, such as MenuMate and Steamplicity, which remain on our outlook for 2024/25.

Additional Portering and Domestics Support – Additional Porters have been deployed to support the Flow Office with extra moves across the hospital, and we've supplied new staff to both our recently opened CDC and Elective Care Unit to keep the flow of patients moving. The Domestics team have also played a key part by providing extra deep cleans and heavy duty cleans. With Catering supporting A&E during the strikes, serving food to patients in A&E

Additional Pop-up Catering Options – Carrs Pasties & Joe's Coffee introduced to site which enhances lunchtime options for patients and staff and generates revenue for the Trust to re-invest. This has now been extended to weekend trading and with a plan to introduce a third food van on site near to the new CDC

Ward Deep Clean Programme – Leading the program plan for the teams to coordinate estates/fire compartmentation and cleaning. This has had a huge impact and allowed us to work closely with our Trust colleagues to make areas brighter, cleaner and safer

Fast Facts

Average Food waste generated each month

7.88%

Total number of Security patrols over the last 12 months

7,385

Total No. of Deep Cleans undertaken in the last 12 months

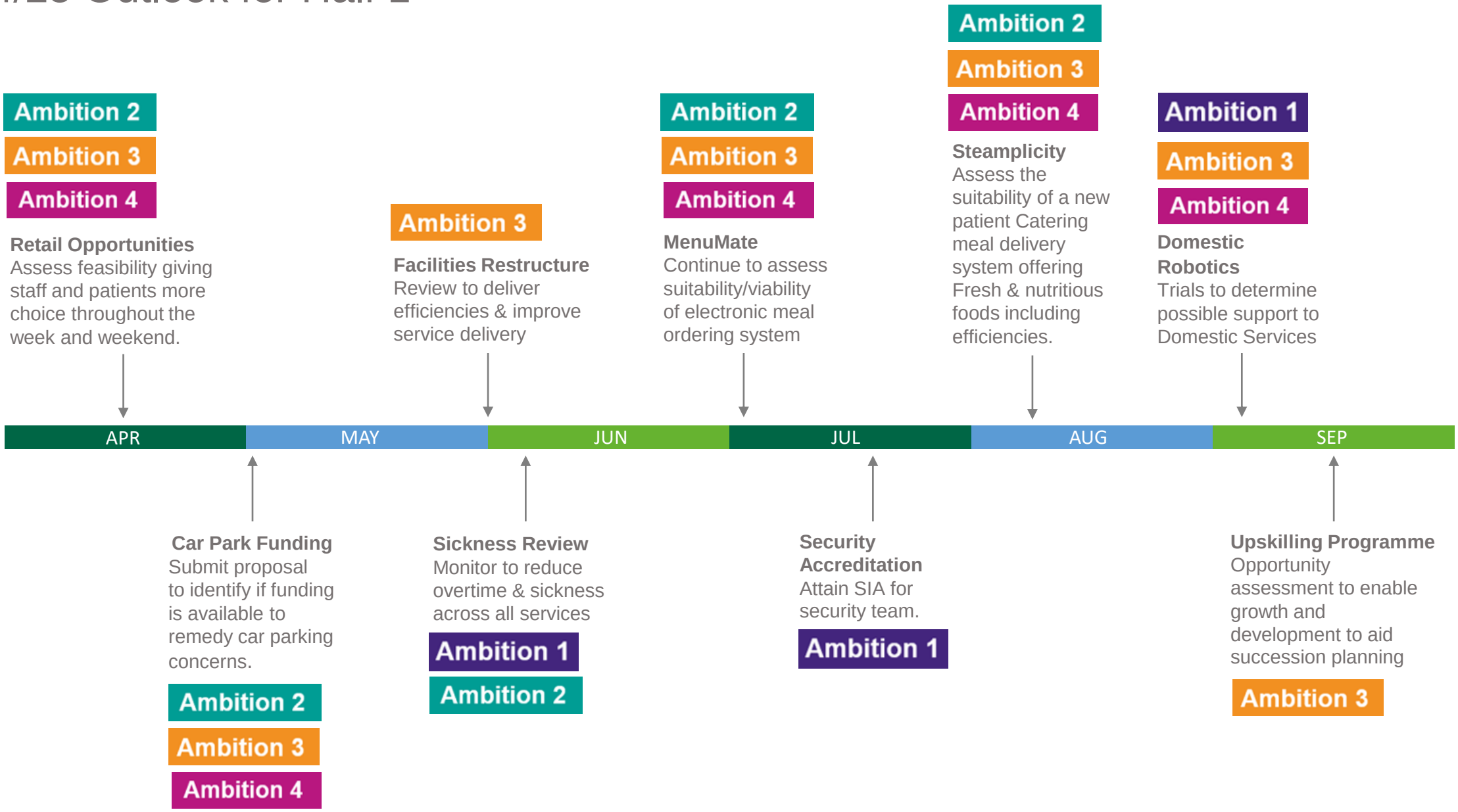
7,995

Total Portering Calls taken in last 12 Months

76,128

Facilities

24/25 Outlook for Half 1



Capital

Key Scheme Delivered - New Modular Theatres

Start Date: March 2022
Completion Date: 12/12/2023
Value: £19 Million (Budget Achieved)

Scheme Overview
Two-storey modular theatre complex comprising of 4 new state of the art operating theatres, a 16 bedded Day Care on the ground floor and 16 bedded elective Orthopaedic ward on the first floor.

Completion Photos

Capital

Key Scheme Delivered - Community Diagnostic Centre (**CDC**)

Start Date: June 2023
Completion Date: 14/03/2024
Value: £11.3 Million (Budget Achieved)

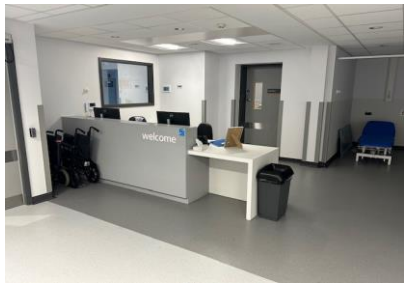
Scheme Overview
A ground, first and second floor extensive refurbishment which will act as new Diagnostic Centre for clinical care, a newly refurbished Out-Patients Department and a generic clinical space on the second floor.

The multi million pound centre is fitted out with the latest technology in MRI, CT, X-ray and ultrasound to provide accurate and potentially life-saving diagnostic tests and scans for people across Greater Manchester.

Trust & Leadership at the opening of the CDC

Project team accepting delivery of a new MRI scanner

Completion Photos



Capital - 24/25 Outlook for Half 1

iFM Bolton
Clean, Safe and Sustainable
A wholly owned subsidiary of Bolton NHS Foundation Trust

Ambition 1
Ambition 2
Ambition 3

Processes & Projects

To encompass all Trust schemes (of any value) relating to updating/changing & creating a new estate.
Ongoing through Q1 and Q2

Ambition 3

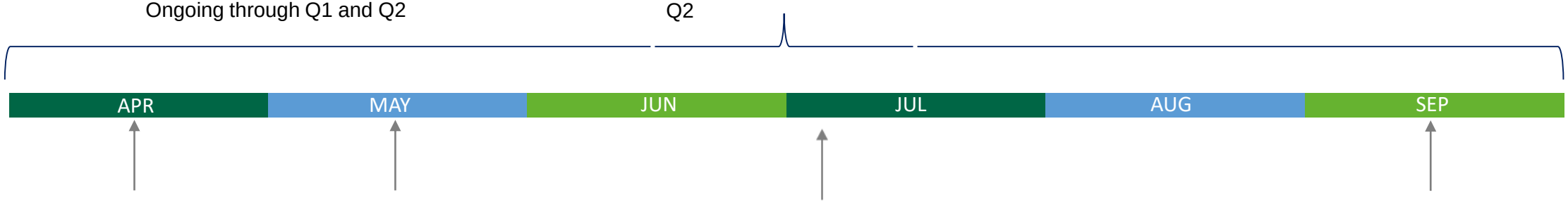
Regular Capital position updates via Sharepoint

To ensure share point is representative of the capital position along with current / future plans
Ongoing through Q1 and Q2

Ambition 4

Partnership working with estates teams

To continue to develop & deliver critical capital plans with colleagues.
Ongoing through Q1 and Q2



Review Capital Team Structure

To secure a workforce that is sustainable and provides a multitude of skill sets in support of the Capital and Estates strategy.

Ambition 2

Review contractors and frameworks with procurement

To ensure compliance and value for money, protecting the Bolton pound and spending wisely.

Ambition 3

Review of RAAC process

Business Case submitted to RAAC national team
Submission of monthly updates to RAAC national team
On boarding of John Murphy – Project Manager
Set up RAAC ToR and Governance

Establish plans for continuation of Pediatric Hub

To continue with Bolton's Pediatric Hub, supporting children in the locality and across Greater Manchester.

Ambition 1
Ambition 3
Ambition 4

Specialist Services – EBME / HSDU / Telecomms

Key Achievements for FY23/24

EBME

Capital Projects - Facilitated the ordering, delivery and commissioning of all the medical devices for the New Modular Theatre and Community Diagnostic Centre ensuring a smooth transfer of all devices into clinical service

Efficiencies - We transferred our remaining services onto the CAFM database, including our Loan Stores, which means all requests are logged centrally and we can now track all 500+ monthly device loans.

Fast Facts

Total No. of Assets Managed

15,838

HSDU

New Key Equipment Installation - The installation and commissioning of the 4 new RapidAER endoscope washer disinfectors and the Reverse Osmosis Treatment Plant. Replacement of 3 obsolete ISIS endoscope washer disinfectors which is now fully operational.

New Modular Theatre Support - The volume of instrument trays and equipment being requested for new theatres, main theatre and DCU is at an all time high and demand continues to increase.

Fast Facts

Total No. Of Trays Processed

89,436

Total No. Of Endoscopes Processed

12,765

Telecomms

Switchboard Team – Calls responded to within 40 seconds are exceeding the 75% KPI significantly, and were between 87% & 91% FY 23/24

Response Time to Emergency 2222 Calls – Switchboard have continued to meet the demand of emergency 2222 calls maintaining an average of 4 seconds.

Fast Facts

Total Switchboard Calls

555,611

Total 2222 Emergency Calls

4,931

Section Four

Strategy & Transformation

April 2023 to
March 2024

Strategy & Transformation

Key Achievements for FY23/24

There have been various changes to the Strategy & Transformation function in the 2nd half of 2023/24, including personnel changes and arising priorities which have resulted in some key projects not having progressed as much as originally anticipated.
The identification of RAAC in November 2023, and the immediate response to that up until March 2024, was a heavy focus for the Strategy & Transformation function. Our focus in 2024/25, is to push ahead with our other key strategic projects, and ensure meaningful progress is made.

New Bolton Operational Estates Group - The re-establishment of a Bolton FT specific estates forum following a lengthy absence happened in the 2nd half of 2023/24. This offered a cross-functional team to come together to discuss key and strategic estates related issues.

RAAC Support – The function led the immediate response to the discovery of RAAC at Royal Bolton Hospital and were instrumental in securing funding for 23/24 RAAC works, and set the governance up for ongoing management of the situation by others.

Service Strategy Away Day – Our SLT were joined by Service Leads to discuss various aspects of current service delivery. Service Strategy Action Plans were subsequently developed which are reviewed on a routine basis by the Service Lead and SLT driving efficiencies in process and cost

Community Building Closures & Improved Space Utilisation – A large amount of input was offered to a project to close community buildings and reorganise the manner in which various services/departments utilise space at Royal Bolton Hospital. Work continues and is expected to be closed out in half 2 of 24/25

New Performance Reporting Framework – A new performance reporting framework was created and introduced within IFM, to ensure all service leads are measuring and presenting back to senior leadership, and specific key performance data developed in relation to their respective services.

Strategy & Transformation

24/25 Outlook for Half 1

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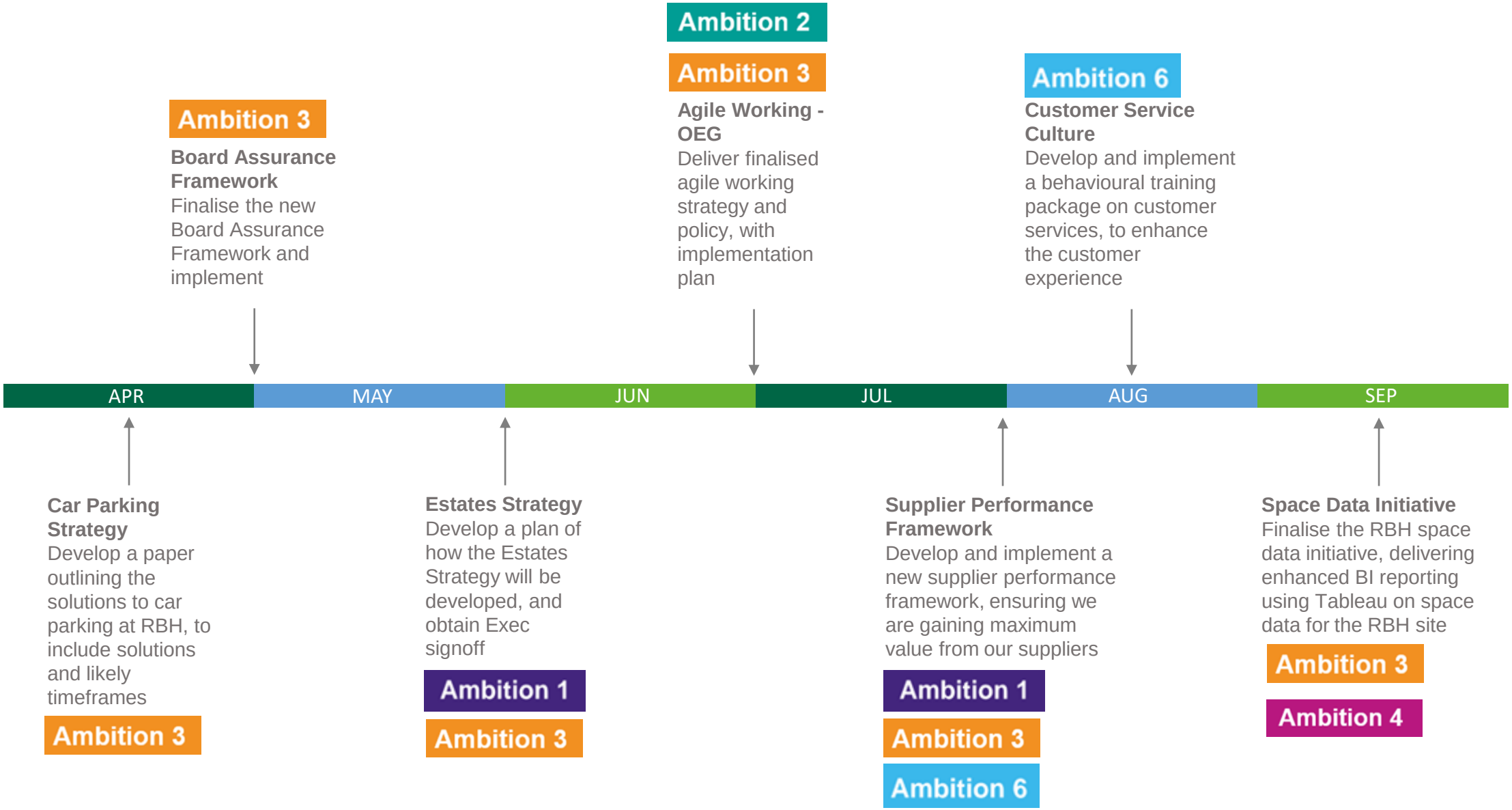


Section Five

Procurement

April 2023 to
March 2024

Procurement

Key Achievements for FY23/24

Procurement are **committed to the pursuit of value for money, robust contracting and compliance with Group Standing Financial Instructions**. The Procurement team is made up of 14 members of staff looking after strategic tendering and contracting, transactional processing of purchase orders as well as Inventory management. Engagement with stakeholders is critical to ensure fit for purpose goods and services are procured with Divisional Procurement Partners facilitating this. Savings figures for 23/24 demonstrate the department continues to achieve and positively contribute to the Group position.

Savings - £7.03m FYE Ratified Savings recorded

GM ICS Collaboration - Bolton recorded the largest savings figure across the ICS due to high levels of participation in collaborative projects.

Divisional Engagement - The introduction of divisional procurement partners is actively increasing engagement, enhancing relationships and improving procurement compliance within divisions.
Contract compliance – 93% of PO value and 72% of PO lines processed

Procurement System – Implementation of Atamis the end-to-end Procurement Portal and the further development work using the data to plan projects, report spend, calculate savings as well as record contract management activity and IG compliance.

Inventory Management – Procurement are championing the benefits of efficient and electronic stock management with further expansion into clinical areas supported by the transformation team along with business case development for a new/more advanced system aligned with GM Trusts.

Fast Facts

Direct - Purchase Order Lines Processed

67,620

Direct - Total Value of Purchase Orders

£152.4m

No. NHS Supply Chain Order lines Processed

188,642

Value of NHS Supply Chain Order lines Processed

£13.4m

Ratified Savings

£7.03M

Procurement

24/25 Outlook for Half 1

Ambition 3

Inventory Management
Business case for investment in new IM system and IM team to manage all clinical consumables across the Trust

Ambition 3

Contract Compliance - PO spend
Contract compliance increased to 95% of PO value and 80% of order line volume

Ambition 3

Contract Registration Capture
Registration of 100% of contracts within the Atamis portal.

Ambition 3

Efficiencies
Integrated working with performance team to drive procurement opportunities for savings delivery

Frameworks
Embed new framework process as mandated by NHS England whilst supporting divisions with compliance

Ambition 3

E-Procurement - (Catalogue Management)
Catalogue coverage increased to 82% of order lines

Ambition 3

Information Governance
Attend IG board and improve IG/Supplier data capture and compliance

Ambition 3

Procurement Accreditation
Prepare for and complete peer review accreditation process for commercial standards

Ambition 3

Section Six

People

April 2023 to
March 2024

People

Key Achievements for FY23/24

Our IFM People Plan has been aligned to the Trust People Plan, ensuring consistency in language used. Our Key People Ambitions are therefore:

- **Attracting** - The best people will want to join the IFM Bolton team, because they know working here is more than just a job
- **Developing & Leading** - Our people will be encouraged to grow and feel inspired to be the best they can be
- **Sustaining & Retaining** - People will have long and happy careers at IFM Bolton and will not want to work anywhere else
- **Including** - Making IFM Bolton a place where we all feel we belong

Attracting

- A redesign of our recruitment processes has reduced the time taken to recruit by 25%
- Implementation of a new Recruitment system, to enable processes to be automated
- Standardisation of our advertisements, job descriptions and recruitment communication to ensure a professional and engaging message to applicants
- Successful implementation of the Government KickStart program supporting the vision of Bolton Jobs for Bolton People
- Working with local partners such as Team Bolton and Bolton Council to promote Bolton as an employer

Developing & leading

- Developed and implemented a Leadership Development Programme for our 10 Service Managers
- Implementation of HR Business Manager Model, where HRBMs are aligned to our SLT structure, providing dedicated support
- Absence Management Audits undertaken, to understand compliance with the Attendance Management policy
- Redesign of our Appraisal System, linked to our newly implemented Organisational Objectives. Apprais al completion rates increased by 30%.
- Offering Technical & Management Apprenticeship / Pre-Apprenticeship programmes

Sustaining & retaining

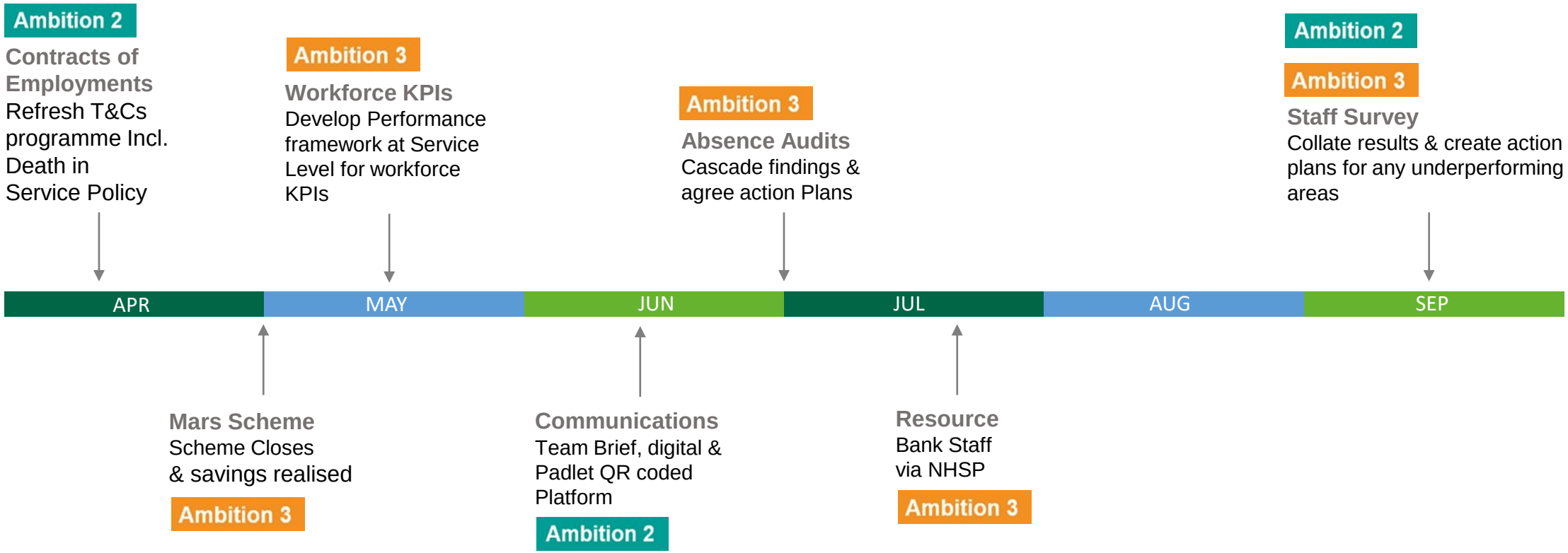
- Looking after the health and wellbeing of our workforce by embracing flexible working, continuing to really listen to feedback about the things that mean the most to our people, and encouraging people to speak up when something isn't quite right
- Delivery of a fit for purpose Corporate Induction
- Updated contracts of employment have been provided to staff who have been assimilated to NHS Pay scales
- Promotion of colleague recognition, from peers and service users, through mechanisms such as World FM Day, FABB Awards & Long Service Awards

Including

- New cascade Team Brief process launched January, with process developed to collate metrics on staff who have received face to face Team Brief
- Mental Health Awareness communication and training: dedicated communications for Stress Awareness Month in April 2024 and Mental Health Awareness week commencing 13 May 2024
- Review of digital communications plan and how this can be progressed with system to be launched in 24/25

People

24/25 Outlook for Half 1



Section Seven

Closing Thoughts

Closing Thoughts

Summary

As we close out 2023/24, we celebrate the achievements that our team have delivered. Without the commitment, dedication and hard work of our people, we clearly would not have achieved all that we have. Our people are our most important asset, and we will continue to invest in the development and training of our people to both benefit the individual, and benefit the people of Bolton through the services our people deliver.

Whilst we celebrate success, our continuous improvement culture also ensures that we identify areas for improvement and act upon them. This includes receiving and acting upon customer feedback, along with the management of risk process, which predominantly links to risks presented by the Trust Estate. It's clear that whilst some fantastic Capital schemes have been delivered which ultimately improve the quality of the Estate and consequently improve the quality of services being delivered to the people of Bolton, the wider Estate is in need of significant investment. A continued lack of funding to remedy these wider Estates issues could result in the risks we manage in relation to the Estate growing in volume in 2024/25. We will continue to manage risk in collaboration with the Trust, and utilise the business case process to support funding requirements.

The discovery and subsequent management of RAAC from Nov 2023 is testament to the agile way in which IFM can operate, and the future strategy development we are currently working through in collaboration with the Trust will be an absolute priority for 2024/25. We anticipate this to be a challenge that extends beyond 2024/25, and we are wholeheartedly committed to deliver solutions to this problem with guidance and input from the Trust.

We must acknowledge our financial result for 2023/24. We must also acknowledge however, that the detailed OHF review very much highlights that IFM is a financially sustainable business, and we feel confident that once the contract variations are addressed 2024/25 will offer a very different financial result. This will be underpinned by robust financial reviews with each service, each month, along with greater focus and delivery of efficiencies.

We are proud of our team and we are proud of their achievements, We strive to deliver excellence and embrace change when things don't go quite right. We are a committed Estates & Facilities team that put the people of Bolton and colleagues at Bolton FT first. We pledge that unwavering support to Bolton FT in 2024/25, and we are confident that we will close out next year with an even more positive result than 2023/24.

Section Seven

24/25 Outlook
Our priorities

Outlook

Our Priorities for 2024/25

Priority 1
Business Critical & Urgent

- Deliver the Estates Strategy including a resolution for RAAC at Royal Bolton Hospital
- Fulfil Green Plan actions and apply for funding for our Heat Decarbonisation Plan
- Delivery of iFM Efficiency Programme
- Meet Estates Statutory & Legislative requirements & NHS / IPC Cleaning Standards
- Deliver Zero Harm to people and the environment

Priority 2
Business Critical & Non-urgent

- Deliver the Facilities Restructure
- Enhance the patient and staff experience for car parking
- Inventory Management optimisation through best in class Procurement service
- Finalise the MAR Scheme and release any related savings
- Ensure smooth, safe and on-budget delivery of Capital schemes

Priority 3
Important & Non-urgent

- Progress Agile Working agenda and develop a strategy
- Deliver the Staff Survey and create actions to make iFM a great place to be
- Progress and deliver approved Catering improvements around Menumate & Steamplicity
- Undertake a full business wide Policy Review
- Supply Chain review to ensure best-value and innovation