Location: Boardroom **Time: 09.30**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.30	1.	Welcome and Introductions	Chairman	verbal	
09.35		Patient Story – Family Care			
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chair	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 28 May 2020	Chair	Minutes	To approve the previous minutes
	5.	Action sheet	Chair	Action log	To note progress on agreed actions
	6.	Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
09.50	7.	Chair's Welcome	Chair	Verbal	To receive a report on current issues
Safety Quality and Effectiveness					
10.00	8.	CEO Report	CEO	Report	To receive
10.10	9.	QA Committee Chair Report	QA Chair	Report	To provide assurance on work delegated to the sub committee
10.20	10.	F & I Committee Chair Report	F&I Chair	Report	To provide assurance on work delegated to the sub committee
10.30	11.	Audit Committee Chair Report	Audit Chair	Report	To provide assurance on work delegated to the sub committee
10.40	12.	Workforce Assurance Committee Chair Report	CEO	Report	To provide assurance on work delegated to the sub committee
10.50	13.	Mortality Update	Medical Report	Report	To receive the mortality update
11.00	14.	IPC Update	Director of Nursing	Report	To note

Coffee break

Strategy					
11.30	15.	Maternity Services Update	Family Care Division	Report/ Presentation	To receive an update on maternity services
Covid-19 Pandemic Response					
12.00	16.	Covid update	Dir Strategic Transform and COO	Presentation	To receive an update on the Covid restart programme
Governance					
12:20	17.	Guardian of Safeworking Quarterly Report	Medical Director	Report	To receive and note
	17.1	Guardian of Safeworking Annual Report	Medical Director	Report	To receive and note
12.30	18.	Freedom to Speak Up	Director of Workforce	Report	To note
12.40	19.	Integrated Performance Report	COO	Report	To receive
	20.	Any other business			
Questions from Members of the Public					
	21.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
13.00	22.	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted			

Break

Meeting	Board of Directors Meeting
Time	9.30am
Date	28th May 2020
Venue	WebEx

Present:-

Mrs D Hall	Chair	DH
Mrs F Noden	Chief Executive	FN
Mr A Thornton	Non-Executive Director	AT
Dr F Andrews	Medical Director	FA
Dr M Brown	Non-Executive Director	MB
Mr A Ennis	Chief Operating Officer	AE
Mrs M Forshaw	Interim Director of Nursing	MF
Ms R Ganz	Non-Executive Director	RG
Mrs S Martin	Director of Strategic Transformation	SM
Mr J Mawrey	Director of Workforce	JM
Mrs J Njoroge	Non-Executive Director	JN
Mr M North	Non-Executive Director	MN
Mr A Stuttard	Non-Executive Director	AS
Mrs B Ismail	Non-Executive Director	BI
Mrs A Walker	Director of Finance	AW

In attendance: -

Mrs E Steel	Director of Corporate Governance	ES
Miss V Lomas	Corporate Governance Manager	VL

Five observers in attendance including members of the Council of Governors and Bolton News

Apologies

Declarations of Interest

Mrs E Steel	Company Secretary iFM Bolton
Ms R Ganz	NED iFM Bolton

Patient Story

Mrs S prepared a video of her experience as an inpatient in Darley Court. Mrs S was an inpatient at the hospital between August and November 2019 with a number of illnesses and explained that she felt the care she received was amazing.

It was agreed that following discharge she would be transferred to Darley Court,

in the first instance, to support her with learning to walk again. Mrs S advised the care at Darley Court was fantastic and the facilities were clean and she was well cared for.

Mrs S was an inpatient in Darley Court over the Christmas period and commented on what a wonderful Christmas she experienced despite being apprehensive about being a patient over the festive period.

Board members queried what support was in place for Mrs S when she returned home and it was confirmed that she received a number of pieces of support equipment and two carers visited in the morning and in an evening for one week.

In response to a query, Mrs S advised that there was nothing more the Trust could have done to improve her experience. The care that she received went over and above her expectations and the nurses and carers provided constant care.

Resolved: the patient story was noted.

4. Minutes of The Board Of Directors Meetings held 26th March 2020

The minutes of the meetings held on 26th March were approved as a true and accurate reflection of the meeting.

5. Action Sheet

The action sheet was updated to reflect progress made to discharge the agreed actions.

6. Matters Arising

There were no matters arising.

7. Chair Welcome

The Chair welcomed attendees to the meeting.

Thanks were given to Executives for their management of the pandemic so far and to the Bolton system as a whole for their continued work.

8. CEO Report

The Chief Executive presented the CEO report providing a summary of reportable incidents, awards, recognition and media interest.

Resolved: the report was noted.

9. Quality Assurance Committee Chair Report

Mr Thornton, the NED Chair of the Quality Assurance Committee presented his report from the meeting held on 20th May 2020.

The QA Committee received divisional updates from each of the five clinical divisions which focussed on the current operational challenges. It was also reassuring to see each division also highlighted some important learning which

will be taken forward as part of the recovery plan.

One SI report was approved at the meeting. A further SI report was to be updated to add further clarity in regard to the incident. It was noted that there were a number of factors in relation to the incident and the staff involved had displayed a great deal of candour.

There were no risks to escalate.

In response to a query it was confirmed there were no significant concerns raised from the Covid Risk Assurance Report despite the obvious challenges the Trust faces.

Resolved: the Chair Report was noted.

10. Finance and Investment Committee Chair Report

Mr Stuttard, the NED Chair of the Finance and Investment Committee presented his report from the meeting held on 26th May 2020.

Key points for the Board to note were:

- The financial position for month 1 shows an overall break-even position. This is in line with the new financial regime that has been introduced to help deal with the Covid-19 position.
- There is a risk associated with the £1.9m NHSI top up request as the Trust has not yet had confirmation this will be funded.
- The cash position is strong and as a consequence the Trust has paid 94.8% of suppliers against a 95% target required by the Better Payment Practice Code. This is the highest position for some years.
- The Capital Programme has been revised for the current financial year. Excluding Covid capital items the programme now amounts to £7.6m.
- The 2019/20 accounts are still subject to final sign off by the Auditors. The accounts will be presented to the Audit Committee on 9th June 2020.

Board members queried as part of the reset and driving efficiencies how divisional cost effectiveness would be maintained. It was confirmed that prior to Covid this was a focus and this will be resumed.

In response to a query it was confirmed that returning to business as usual will be a phased approach. The ICIP programme did not cease completely and a number of ICIPs have continued in the background.

Discussions are recommencing with divisions to ensure there are efficiency metrics that can be driven forwards when the Trust returns to business as usual.

It was queried whether the procurement guidance could be reviewed to ensure that local suppliers are prioritised. It was confirmed that currently trusts are being controlled on procurement arrangements nationally, but arrangements are made with local suppliers where possible. The Director of Finance agreed to check the current Procurement Policy regarding the use of local suppliers.

FT/20/19	AW to check regarding procurement policy in light of Covid-19 impact on local economy	**AW**

Resolved: the Chair Report was noted.

11. Workforce Assurance Committee Chair Report

Board members received the Workforce Assurance Committee Chair Report noting that there were no risks escalated.

Resolved: the Chair Report was noted.

12. ICP Update

The Director of Strategic Transformation and Managing Director, Bolton ICP provided a presentation about the Bolton Integrated Care Partnership.

Board members queried whether the voluntary sector is involved and it was confirmed that Darren Knight the Chief Executive of Bolton CVS is a member of the ICP Board and four representatives from the voluntary sector have been identified to support business planning. It was also noted that Bolton CVS have given agreement for one of their representatives to work in the Trust in order to improve integration with the sector.

It was confirmed that an engagement activity has been completed with residents to ascertain what they feel is important and a public campaign is being developed.

Board members discussed challenges around carers noting that at the start of Covid many patients had family members step in to assist with their needs. Consideration needs to be given as to how this is managed as people return to work. It was confirmed that contact has been maintained with patients throughout the pandemic and there is an awareness of the scale of the challenge.

In response to a query it was advised that Section 75 will provide a framework to ensure the ICP operates safely. It is estimated it will take three months to complete and it will be presented to the Board for final agreement towards the end of summer. It was agreed that the ICP requires freedom to act, but organisations still need assurance and Section 75 should outline how this can be achieved.

Discussion took place regarding the digital challenges for the ICP and it was confirmed the Trust currently supports GPs digitally and the Bolton Care Record is already in place. Practically organisations need to be working towards staff being able to access patient's records from wherever they may be working.

It was noted that prior to Covid the system had agreed to a piece of work on the digital requirements as this is a major challenge.

Concern was raised that staff may not be aware of accountability and structural boundaries due to the rapid implementation because of Covid, it was confirmed that accountability was very streamlined and details will be set out in the Alliance Agreement and Section 75.

Board members were advised that work has been completed in order to understand the different neighbourhoods within the borough and there will be leadership links within each neighbourhood. A plan will be developed for how work will be done in each area.

Board members queried what the Trust can do to support the ICP and it was confirmed digital and IT support is required and the freedom to act and how to

continue to be as nimble as it was during Covid.

Board members agreed it was uplifting and positive to discuss integrated services and the good relations with social care.

Resolved: the presentation was noted.

14. Health and Wellbeing of Staff in Covid

The Director of Workforce and Organisational Development presented the report highlighting his thanks to the OD team. It was stated there are a number of actions from the last 12 weeks, but this is on-going and there is a Wellbeing Steering Group which reports into the Workforce and Assurance Committee.

Executives commented that the Trust has been well supported by the team.

Board members queried the plans for supporting staff with their psychological needs as the Trust returns to business as usual and it was advised that it is recognised that there will be more work to do around this and updates will be provided to Board via the Workforce Assurance Committee Chair Report.

The Director of Nursing indicated she meets with Band 7 staff regularly to ascertain how they are coping and a number of issues have been highlighted which herself and the Director of Workforce have managed to resolve collectively.

Resolved: the report was noted.

13. Covid Update

The Chief Operating Officer and Director of Strategic Transformation provided a presentation on the ongoing impact of Covid and progress with the reset plan.

The number of Covid patients within the Trust was outlined and it was indicated that the R rate in the North of England is currently higher than in the South. This is a significant issue as if there is a second wave organisations in the North will start from a higher level of cases.

Details of the reset plan were outlined noting there are three levels for the Trust, the locality and Greater Manchester.

Concern was raised regarding Covid funding and the possibility that trusts may be adequately funded but social care may not. It was stated that work is being completed with social care and other organisations to consider their risks and how these can be mitigated.

Board members discussed improving the general health of the Bolton population and it was advised that Helen Lowey is leading on public health messages and it is important the Trust works with her and supports these.

Board members discussed elective activity and it was stated that there is a significant risk around waiting lists despite the Trust managing well to date. There is also an issue around the public's willingness to come into hospital. Patients will be required to isolate for two weeks prior to a procedure and for four weeks afterwards which will have significant social and poverty implications for example for self-employed people.

There are two options to assist with waiting lists including working as a system with GM and extending the agreement with the private sector to continue to utilise them beyond June.

It was agreed to circulate the Operating Framework to Board members for information.

FT/20/20	Operating Framework to be sent to board members for information	COO

Resolved: the presentation was noted.

14. Integrated Performance Report

Board members conducted a page turn of the Integrated Performance Report – in response to questions the following points were noted:

- Despite less recorded falls there have been less occupied bed days. When mapped there have been more falls per 1000 bed days, but the SPC chart highlights the figures average out over a period of time.
- Compliance with antibiotic prescribing standards at 71%. It was noted there were five components to the audit and for four of the areas a score of 85% was achieved. The issues were around the prescription of the saline flush part of the audit and actions are being addressed.
- SHMI – there is a risk this will increase due to Covid, but this will be the same for all trusts. The SHMI is still a valid measure and can be broken down into different diagnosis.
- It was confirmed the Trust took the decision to continue to respond to complaints during Covid despite national guidance that this could have been stood down.
- Board members noted that A&E attendances are rapidly increasing and are significantly ahead of the rest of Greater Manchester. Work is being completed to ascertain why this is the case for Bolton. Communications will be completed to reinforce the message to patients to only attend A&E in an emergency and that visitors cannot attend.

  It was confirmed following a query that the Trust has not achieved 100% for the A&E target due to the challenges around the different Covid pathways. It is expected the Trust will achieve 90% this month.

  Concern was raised that patients from certain GP surgeries were more likely to attend A&E, and it was advised that this is generally due to socio economic factors and not the surgeries themselves. Work is being completed with GM to develop new ways of working as there is not necessarily a need for the service to continue in the same way.
- Cancer performance has improved but there has been a reduction in referrals during Covid.
- RTT is severely challenged but work with the private sector has assisted with this.
- Noted that for diagnostics endoscopy is the biggest concern in terms of volume. Future diagnostic pathways is the biggest area of push to restart.
- Medically optimised and delayed transfers of care are very good. The community team along with the Local Authority have completed amazing work.

- Board members queried what percentage of staff who are shielding are actually working from home.

FT/20/21	Provide update to confirm how many of the "shielded" staff are working from home	**JM**

Board members discussed whether Model Hospital data should be included within the performance report as this is not a focus at the moment. It was agreed that the Director of Finance and Director of Strategic Transformation will consider this.

FT/20/22	SM and AW to consider if Model Hospital data should be included within the performance report pack	**AW/SM**

Discussion took place around how the Trust can compare itself with other best performing trusts not just those within Greater Manchester. It was noted that benchmarking is completed against similar organisations and this information is brought through various committees. It was agreed to bring a report back around how the Trust compares nationally.

FT/20/23	Report on national benchmarking comparison	AW

Resolved: the report was noted.

9. **Any other business**

No other business.

10. **Date and Time of Next Meeting**

28th May 2020

Resolved: to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted

May 2020 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/20/20	28/05/2020	Covid-19 update	Operating Framework to be sent to BoD for info	SM	Jun-20	
FT/20/21	28/05/2020	Workforce update	provide update to confirm how many of the "shielded" staff are working from home	JM	Jun-20	
FT/20/24	28/05/2020	staff story	update to Board on future provision/funding of Health Improvement Practitioners	SM	Jun-20	
FT/20/22	28/05/2020	performance report	SM and AW to consider if Model Hospital data should be included within the performance report pack	SM/AW	Jun-20	This will be removed and reinstated if and when appropriate.
FT/20/04	30/01/2020	Ward visits	Discussion with iFM re space utilisation and development of Day Rooms	Execs	Jun-20	action to be closed - ongoing estates work overseen by Strategic estates group and through space utilisation group
FT/20/19	28/05/2020	Finance Committee chair report	AW to check regarding procurement policy in light of Covid-19 impact on local economy	AW	Jun-20	This is to be picked up by the procurement steering group. As we are expected to use national frameworks it is difficult to prioritise local suppliers.
FT/20/16	30/04/2020	performance report	update on spike in 3rd and 4th degree tears to QA committee	MF	Jun-20	division to cover in maternity update
FT/20/08	27/02/2020	Mortality report	DoN and MD to discuss if any action in relation to clinical coding should be taken through the EPR Clinical Design group	MF/FA	Jul-20	mortality update on Board agenda
FT/20/14	27/02/2020	Planned Care transformation	update to be provided	SM	Aug-20	
FT/19/75	28/11/2019	patient story - Admiral Nurse	Follow up report on dementia care and closing the gap to be included within next dementia update to the QA Committee	MF	Aug-20	
FT/20/12	27/02/2020	Operational Plan and contract changes	update for Board on Primary Care Networks	SM	Sep-20	align with themed board meetings to link with next ICP
FT/20/23	28/05/2020	performance report	Report on national benchmarking comparison	AE	Sep-20	
FT/19/78	28/11/2019	F and I Report	update on EPR implementation	AE	Sep-20	
FT/20/09	27/02/2020	Seven Day services	Further discussion on implications of guidance through Execs then WAC and back to Board in three months	FA/JM	Sep-20	
FT/19/84	19/12/2019	patient story	report back on the offer for children with special needs	MF	Oct-20	
FT/20/02	30/01/2020	patient story	AE to follow up with JN potential for student involvement in environmental/sustainability developments	AE	Oct-20	
FT/20/10	27/02/2020	AHP update	update on AHP workforce to be added to Workforce Assurance Committee workplan	JM	Oct-20	
FT/20/17	30/04/2020	performance report	Repeat SPC education session		Oct-20	future Board development item
FT/19/82	28/11/2019	iFM business plan	Carbon Neutral strategy and update on the work of the sustainability group	AE	Sep-21	

Key

complete	agenda item	due	overdue	not due

Agenda Item No:	**8**
Meeting:	Board of Directors
Date:	25 June 2020

NHS Bolton NHS Foundation Trust

Title:	Chief Executive Report
Purpose	To provide the context for the Board meeting and an update on key current issues for the Board of Directors
Executive Summary:	The Chief Executive report: • Provides an overview of the current climate in which we are operating. • Includes a summary of key issues including risks, incidents and achievements. • Includes any key updates from stakeholders and regulatory bodies which the Board of Directors need to be aware.
Previously considered by:	Prepared in consultation with the Executive Team
Recommendation Please state if approval required or if for information	For information

Confidential y/n	n

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

Prepared by:	Fiona Noden Chief Executive Esther Steel Director of Corporate Governance	**Presented by:**	Fiona Noden Chief Executive

All information provided in this written report was correct at the close of play 22/06/20 a verbal update will be provided during the meeting if required

1. Context

In recent weeks, the spotlight has been shone on the need to speak up against racism, discrimination and hatred. It takes courage and strength to speak up, and we need to speak up together. My personal commitment is that in our organisation we are totally dedicated to having an inclusive and compassionate workplace, and as a public body we have a duty to work with our partners to develop fair and cohesive communities. We will provide a focused update on our EDI strategy and agreed actions for inclusivity to our July Board of Director (BoD) meeting.

NHSI have also recognised the need to ensure BAME staff are supported and in addition to the creation of a strategic EDI forum a BAME advisory group will be established to hold the regional NHS to account on all matters of concern to BAME staff. In discussion with our Chair we agreed that we should nominate our Non-Executive Director, Bilkis Ismail, to join this group.

Last week ended with some really positive news: we had no deaths from COVID-19 for a full week; we had no COVID-19 patients in critical care and had waved home a COVID-19 patient who had been in our care for 75 days.

I really hope there are more weeks like this to come but we can't afford to be complacent, particularly because we remain at risk of spreading the virus between ourselves in the hospital and in our clinics. That's why it is really important to keep hand washing and to stay apart through social distancing. The new guidance on the wearing of masks is in place so that all staff are wearing masks except when in areas that are designated as COVID-19 secure – this means that while office based staff might be able to work in their offices without a mask all staff are wearing masks whilst in public areas.

We have also taken the difficult decision to continue with our policy to restrict visiting; it's really important that we take advice from Directors of Infection, Prevention & Control, and as we continue to work with other Trusts in Greater Manchester we have to make sure that the visiting policy is applied consistently. A public summary of our visiting policy is available on our website. Your support to implement this policy reliably and fairly is paramount.

2. This month's Board papers

We have a full agenda for this month's BoD meeting; members of the leadership team from our Family Care Division will be attending to provide a six month update on maternity services. As a centre of excellence for women and children it is really important that our services users and our BoD are assured that we are doing everything we can to continually improve the services we offer to our mums and babies. Our patient story and our staff story have been selected to fit with this theme.

Other reports include updates to provide assurance on a number of key areas including mortality, safeguarding and infection prevention and control. We will also receive reports from our Freedom to Speak up Guardian and our Guardian of Safe Working on the work they are both doing to ensure our staff are supported

3. Awards & Recognition

We took the decision to step down our daily FABB awards at the end of May; these will be replaced with a new system of awards which will continue to be reported within my monthly report. The winners of the last FABB awards were as follows:

26 May 2020	Ward C3	Calmly carrying on and providing a great service to our patients despite having a significant number of Covid patients during the peak of the pandemic
27 May 2020	BART (Bolton Acute Respiratory Team)	For their continued excellent care provided to a very vulnerable patient group
28 May 2020	Community IPC Team	For supporting community services
29 May 2020	The Parallel	For uninterrupted service during pandemic

4.0 Reportable Issues Log

Issues occurring between 21st May and 22nd June 2020.

4.1 Serious Incidents & Never Events

There have been no new serious incidents or never events reported since my last report.

4.2 Red Complaints

No red complaints since the last report.

4.3 Regulation 28 Reports

There have been no coroner letters or regulation 28 reports.

4.4 Health & Safety Executive

There have been four RIDDOR reportable incidents during this period.

Two incidents on B3 ward, both involved nursing staff who were attempting to catch patients to prevent their falls and injured their backs resulting in time off work. The Manual Handling Co-ordinator is working with the Falls Co-ordinator to clarify the policy, (staff should not risk injury to themselves in this way but should try to protect the patient's head) and enhancements will be made to the manual handling level 2 training course.

The third incident was also a manual handling incident caused when a paralysed patient on ICU was being turned. His leg fell during the turn and the nurse who went to catch the leg injured her arm and neck in the process.

The final injury happened when a porter fell on the stairs sustaining an ankle fratcure. The incident has been investigated by iFM who have identified no fault with the stairs or footwear. The porter appears to have just lost their footing.

4.5 Maternity Incidents

There were 535 live births in May 2020.

While there were no maternity reportable incidents there were sadly three stillbirths, three neonatal deaths and one compassionate induction.

4.6 Whistleblowing & Freedom to Speak Up

The Freedom to Speak Up annual report is included within the BoD pack and will be presented by our Freedom to Speak up Guardian.

4.7 Media coverage

Our communications team continue to support both our internal and external communications both in relation to COVID-19, in terms of the immediate incident response, our reset planning and also in relation to our business as usual.

5 Board Assurance Framework

The Board Assurance Framework (BAF) is used to record the risks to the achievement of the our strategic objectives, the controls to reduce or mitigate these risks, any identified gaps in these controls and the assurance that the controls are effective. The full BAF is reviewed in detail within the Audit Committee and the Risk Management Committee with a summary provided to the Board of Directors on a monthly basis through the CEO report.

Clearly COVID-19 will have a significant impact on progress towards our long term objectives.

During the early stage of COVID-19 we temporarily suspended a number of our Assurance Committee, and although these are now back in diaries much of the business is focused on the priority of providing safe and effective care during the current pandemic.

We reviewed the BAF to reflect the impact of COVID-19 on each of our strategic objectives and have, as discussed in our April Board meeting, introduced a framework to provide assurance that the risks in relation to COVID-19 are being managed, we have also in line with NHSI guidance populated an infection control assurance framework which will be shared with BoD members through our Quality Assurance Committee.

While some trusts have taken a decision to effectively put the BAF on hold we have agreed as an executive team that it is still a valuable source of assurance for our BoD. Our internal auditors undertook a review of our BAF and provided assurance that: “the BAF was viewed as a well-designed and a useful assurance mechanism, with risk appetite seen to inform decision making after full consideration of the associated risks.”

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	17th June 2020	Date of next meeting:	15th July 2020
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	A Thornton, A Ennis, F Andrews, M Forshaw, J Njoroge, R Ganz, M Brown, R Sachs. Representation from the five clinical divisions	Quorate (Yes/No):	Yes
		Key Members not present:	D Hall, F Noden, E Steel

Key Agenda Items:	RAG	Key Points	Action/decision
The Quality Assurance Committee met by WebEx on Wednesday 17th June 2020. The meeting was well attended with representation from all clinical divisions and the majority of the Trust Non-Executive Directors in attendance.			
Patient Story		The Committee received an extremely positive story of a gentleman who presented at A&E in April, complaining of shortness of breath. The patient was diagnosed as Covid positive after being transferred to Critical Care and placed on a ventilator. The story outlined the care received and the support the Critical Care Covid Communication Team provided to ensure he continued to have contact with his family as they were unable to visit. The patient spent 50 days in hospital before being discharged.	Committee members suggested the patient story was presented at Board of Directors.
Clinical Governance and Quality Committee Chair Report		Committee members received and noted the Chair Report.	No risks to escalate.
Anaesthetics and Surgical Divisional Quarterly Quality Report		The Committee commended the report which provided a balanced view of challenges and successes.	
Diagnostics and Support Services Divisional Quarterly Quality Report		The Committee commended the report which provided a balanced view of challenges and successes.	
Family Care Divisional Quarterly Quality Report		The Committee commended the report which provided a balanced view of challenges and successes. Concern raised by the committee around issues in CDS and the division confirmed there are some problems which have been acknowledged and an action plan is being developed.	Agreed to bring an update on CDS in three months.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

National Inpatient Survey		**Embargoed**	
Mental Health Support in A&E		Report received outlining the actions taken since the last update. It was noted that as part of Covid a new pathway was introduced. Pressure is now increasing on the service again as attendances rise. It was noted that this report refers to adults only. Concern was raised by committee members around the mental health of young people as they return to school and university. It was confirmed there are also worries around the physical health of children and planning is being completed by paediatric services and school nursing.	
Impact of Delays in Vascular Service		Report received outlining the arrangements agreed with MFT to ensure a robust service is provided going forward and the interim arrangements in place for Covid. It was noted further work is required around the diabetes and vascular provision.	
Radiology Report		Progress against the previous action plan was noted. It was advised that the impact of Covid has been significant and resulted in a reduction of CXR backlog and committee members discussed the sustainability of this. Discussion took place around KPIs which have been in place a number of years and it was agreed that these will be revisited.	It was agreed a quarterly update to be received by QA committee.
Quality Dashboard		Noted.	
Learning From Deaths		Report received which provides a response and supplementary information to accompany the PWC Internal Audit Report.	
SI Report 142902/142849		The committee received the SI report which related to a stillbirth at 27 weeks gestation related to placental abruption, secondary to underlying PET.	SI Report approved.
SI Report 144103		The committee received SI report 144103 which had been amended to provide additional clarity.	SI Report approved.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Patient Experience, Inclusion and Partnership Committee Chair Report		Committee members received and noted the Chair Report including the risk escalated to the Strategic Informatics Group.	No risks to escalate.
Risk Management Committee Chair Report		Committee members received and noted the Chair Report including the escalated risks.	
Strategic Transformation Board Chair Report		Chair report received.	No risks to escalate.
Comments			
Risks Escalated –			

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	23rd June 2020	Date of next meeting:	21st July 2020
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Donna Hall, Bilkis Ismail, Rebecca Ganz, Fiona Noden, Andy Chilton, Lesley Wallace, Andy Ennis, Annette Walker, Martin North, Sharon Martin, Mark Costello	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Costing Update – including 2019/20 Reference Costs Update		Head of Financial Management	The Head of Financial Management (MC) gave an update on the requirements for the Costing return for 2019/20. He explained that a new Costing system was being implemented (Patient Level Information and Costing System – PLICS) which would provide more detailed information on the costs and would meet all the requirements for the submission. In addition it would provide better information internally within the Trust to look at the costs relating to the activity across each of the Divisions. The implementation of PLICS and the Reference Costs submission was being led by a new Head of Costing who took up post on 1st June. The submission date for the return has been pushed back due to Covid-19 and will now be 5th November. Members of the Committee welcomed the improvement in the Costing arrangements and commented that this would make a big improvement to understanding our costs at a patient level. The importance of engagement to the success of the project was expressed and an engagement/roll out plan with comms and training is required.	For noting.

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

<table>
<tr>
<td>Month 2 Finance Report</td>
<td></td>
<td>Deputy Director of Finance</td>
<td>The Deputy Director of Finance (AC) gave an update on the financial position at Month 2.

The financial position for Month 2 shows an overall break-even position. This is in line with the new financial regime that has been introduced to help deal with the Covid-19 situation. The financial position is summarised in the table below:

<table>
<tr><th></th><th>Month 2
£m</th><th>YTD
£m</th></tr>
<tr><td>Base Income</td><td>28.2</td><td>56.7</td></tr>
<tr><td>NHSI automatic top up</td><td>1.3</td><td>2.6</td></tr>
<tr><td>NHSI top up request</td><td>2.1</td><td>4.0</td></tr>
<tr><td>Total</td><td>31.6</td><td>63.2</td></tr>
<tr><td>Expenditure</td><td>31.6</td><td>63.2</td></tr>
<tr><td>Surplus/Deficit</td><td>0.0</td><td>0.0</td></tr>
</table>

AC explained the key elements of expenditure during the month, in particular the pay expenditure in relation to overtime, bank and agency and additional staffing in relation to student doctors and nurses. In total £1.4m of pay costs related to Covid-19. On non-pay there was an additional spend of £1.0m relating to Covid-19 which included the costs of testing kits, equipment, PPE, remote working and consumables.

In total for April and May the amount spent on Covid-19 was £3.8m. AC advised that the additional top up of £1.9m in April had now been fully reimbursed by NHSI. AC indicated that the costs of Covid-19 were subject to detailed review by NHSI and there was a risk that the costs might not be fully reimbursed.

AC reported that in accordance with the national advice the requirement to deliver cost improvements had been paused, but savings would be required to fund internal pressures. The Divisions are still identifying opportunities and work will be recommencing on identifying savings going forward.

With regard to capital expenditure the Trust had spent £591.0k of which £260.0k relates to Covid-19.</td>
<td>For noting.</td>
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Committee/Group Chair's Report

Month 2 Finance Report (continued)			The Trust's cash position is showing a balance of £46.1m at the end of May and this is mainly due to the payments for June being made in advance. In addition AC confirmed that the Trust had received the Provider Sustainability Fund (PSF) monies from Q4 of 2019/20 of £2.1m and also the incentive Financial Recovery Fund (FRF) monies of £6.3m. AC advised that an exercise was being undertaken across Greater Manchester to deal with all the outstanding debtors and creditors across the various health organisations. The Trust's Better Payments Practice Code (BPPC) again performed strongly with 94.5% of invoices being paid promptly. AC reported that the Annual Accounts had been finalised and agreed at the Audit Committee at its meeting on 9th June.	
Annual Report of the Finance & Investment Committee	N/A	Deputy Director of Finance	AC presented the 2019/20 Annual Report on the activities and performance of the Finance & Investment Committee. The report set out the performance against the Committee's objectives for 2019/20 and gave them a RAG rating of red, amber or green. The report set out an explanation of each of the objectives and the action taken. Overall there were 7 greens, 3 ambers and 1 red. The Committee asked for a small number of minor amendments to be made to the wording in the report. Included within the report were the objectives and workplan for 2020/21. The Committee asked for more emphasis to be placed on the strategic objectives in line with the overall discussions that were taking place within the Trust. It was agreed that the report would be updated and brought back to the Committee for approval prior to submission to the Board of Directors.	For review.

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Committee/Group Chair's Report

Annual Terms of Reference Review	N/A	Deputy Director of Finance	AC presented the Terms of Reference for the Finance & Investment Committee as part of the annual review process. A number of comments were made by the Committee again relating to the strategic items and it was agreed that the Terms of Reference would be revised and brought back to the next meeting of the Committee prior to submission to the Board of Directors.	For review.
Month 2 iFM Finance Report		iFM Director of Finance	The iFM Director of Finance (LW) presented the iFM financial position for Month 2 and year to date. The overall position is a post tax profit of £111.0k on turnover of £3.62m. LW advised that iFM were aiming to fully implement their cost improvements over the course of the year and also made reference to the anticipated increase in cost in Quarter 4 related to the pay award increase. LW advised that the External Auditors were nearing completion of the audit work on the iFM Accounts and no major issues had so far been identified.	For noting.
Chair Report from the Capital and Revenue Investment Group	N/A	Director of Finance	The Director of Finance (AW) provided a report on the Capital and Revenue Investment Group. The Group had reviewed a number of submissions relating to revenue, capital and Covid-19 items. It was noted that there were quite a number of these and it was agreed that a table setting out a financial summary would be helpful going forward. Assurance was sought that a number of the items were in line with the Trust's overall strategy. Reference was also made as to whether a couple of the capital items could be considered against Charitable Funds and AW agreed to look into this.	For noting.
Chair Report from the Contract & Performance Review Group	N/A	Director of Strategic Transformation	The Director of Strategic Transformation (SM) gave an update on the work of the Contract & Performance Review Group. Overall it was reported that the cancer performance should be achieved as a result of the recovery plans put in place but there was concern over diagnostic testing and long waiters. SM also provided an update on income reporting and coding.	For noting.

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Committee/Group Chair's Report

Chair Report from Strategic Estates Board	N/A	Chief Executive	The Chief Executive (FN) provided an update on the work of the Strategic Estates Board. The Board reviewed the Covid-19 capital update and an update on the Trust's Capital Programme. FN also made reference to the work to be undertaken on the carbon footprint for the Trust. This was an important strategic consideration in terms of the green agenda.	For noting.
Chair Report from Digital Transformation Board	N/A	Chief Operating Officer	The Chief Operating Officer (AE) provided an update on the work of the Digital Transformation Board. Particular reference was made to the 0-19 service which had gone live successfully with EPR and a number of milestone achievement certificates relating to the EPR project. AE reported that the two major areas for full implementation in 2020/21 were Outpatients and Accident & Emergency, with Community Services following in 2021/22.	For noting.
Our Strategic Agenda	N/A	Committee Chair	The Committee Chair (AS) put forward the proposal to revise the agenda for the Committee going forward to be divided between operational matters, strategic matters and risk/assurance. The aim was to give the appropriate focus on strategic matters in line with the overall direction for the Trust. The Committee agreed to the changes.	For noting.
Risks escalated There are no additional items to escalate to the Board.				

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Committee/Group Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	9th June 2020	Date of next meeting:	29th September 2020
Chair:	Jackie Njoroge, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Jackie Njoroge, Martin North, Malcolm Brown, Becks Ganz, Annette Walker, Catherine Hulme, Esther Steel, Lesley Wallace, Richard Sachs, Collette Ryan, Internal and External Audit	Quorate (Yes/No):	Yes
		Key Members not present:	N/A

Key Agenda Items:	RAG	Key Points	Action/decision
Collection and Depositing Controls from Fundraising (Charitable Funds)		Committee members received the high risk report from Internal Audit. There were two high risk and three medium risk recommendations. Committee members were assured that actions are in place to address the issues identified.	A weekly task and finish group has been established to ensure all of the actions are addressed and considerable work has already been completed.
Board Assurance Framework (BAF)		Committee members received and noted the low risk report from Internal Audit which had one advisory finding. Committee members agreed that the BAF provides a strong source of assurance that the risks to the strategic objectives are managed.	
Cost Improvement Programme		Internal Audit presented the low risk report which included one medium and one low risk finding.	
Progress and Follow Up Report		The follow up report was received noting a number of open actions. It was confirmed that since publication of the report evidence has been received from iFM which will close a number of these actions.	It was agreed that if the annual opinion is changed due to closure of some of the actions this should be circulated to committee members electronically.
Draft Internal Audit Annual Report		Committee members received the report which highlights the work carried out by Internal Audit during the year and the Head of Internal Audit Opinion which is separated between the FT and iFM.	It was agreed to recirculate the final version of the report to committee members.
Internal Audit Charter		The committee received and noted the Internal Audit Charter which sets out the objectives, responsibilities and reporting lines of the Internal Auditors.	

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Committee/Group Chair's Report

Internal Audit Plan		Internal Audit presented the plan for 2020/21 noting that this has been discussed extensively with management and director leads have been identified for each area.	The Internal Audit Plan for 2020/21 was approved.
KPMG Year End Report		External Audit presented their year-end report which includes one recommendation.	
Letter of Representation		Committee members received and noted the Letter of Representation.	
Annual Accounts		The Audit Committee received the draft Annual Accounts.	The accounts were approved and committee members noted the tremendous work done and thanked KPMG for their support.
Annual Report including Annual Governance Statement		Committee members received the draft Annual Report noting that an updated Remuneration Report had been circulated prior to the committee. It was confirmed that the Chair and Chief Executive will be required to provide final sign off on 22nd June before final submission of the report.	The Annual Report was approved and committee members thanked the Director of Corporate Governance for her work on this.
Register of Sealings		No sealings to note during the reporting period.	

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Trust Board
Date of Meeting:	June, 2020	Date of next meeting:	July, 2020
Chair:	A Ennis	Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, M Forshaw, F Andrews, S Martin, C Sheard, L Gammack , and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	F Noden, A Walker, E Steele

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & OD Dashboard		• The refreshed Dashboard was very well received. • The report triangulated key workforce data to support informed discussions. • Members positively noted that the Trust had the lowest level of absence in the North West; Agency spend remained low; Statutory & Mandatory training were positively above target. As anticipated a reduction in Appraisal rates were shown for the Covid period, that said the Committee supported the remedial measures being taken.	**Actions agreed:-** • The improved Dashboard to be replicated for all Divisions. • Deep dive on retention / turnover rates to be undertaken. • Report back in August on the steps being taken to support the Menopause.
Risk Assessment for High Risk Staff		• The report provided an update on COVID 19 Health Risk Assessment process for the following categories of staff:- Extremely Vulnerable/Shielding, High Risk – Health, High Risk – BAME. • At the time of the meeting then 56% of assessments had been completed with a project finish date of end of June. • Members noted that more work was required to support those shielding staff to return to meaningful work (e.g. working from home)	**Actions agreed:-** • Given the report noted some data errors (shielding staff) it was agreed that the report would be recirculated to colleagues within a week. • Report back in the next meeting on progress being made.

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Committee/Group Chair's Report

Recruitment & resourcing Update		• The fast-rack recruitment initiatives during Covid proved very successful; between 1st March and 31st May 2020, a total of 538 new starters • The Trust deployed significantly more students than any other GM Trust during the Covid period. Positive support has been noted by the Universities. • The main priorities for focus moving forward were agreed: Branding (FT and link to Bolton Locality), Inclusion / positive actions and enhanced focus on 'hard to fill' posts.	**Actions agreed:-** • The paper was very positively noted and the Committee fully supported the direction of travel
Voice Behaviour Framework		• The Committee fully endorsed the updated VOICE Behaviours and agreed that it will be presented to the Board of Directors in July.	**Actions agreed:-** • Full paper and presentation to Trust Board in July.
Health & Wellbeing Update		• The Committee received an update on the plethora of actions being taken to support our workforce. BoD will recall the paper that they received in May and further actions have been taken since this report. A detailed discussion on PTSD support took place and it was noted that this will be discussed at the Executive team.	**Actions agreed:-** • The paper was very positively noted and the Committee fully supported the direction of travel
HENW Action plan		• The Committee received an update on the plan and whilst progress had been made on the actions taken it was noted that further work was required on measuring the outputs.	**Actions agreed:-** • Division and Workforce team to review measureable KPI's • Report back to the Committee in August
FTSU report		• The Committee positively received the FTSU Annual report last month and as requested this report provided further details on the recruitment process for the FTSU Champions and the Divisional reporting process.	**Actions agreed:-** • The report was noted. • FTSU Annual report to Board of Directors in June

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Committee/Group Chair's Report

Assurance from reporting Committees • Staff Health & Wellbeing Group • Staff Engagement Group		• All reports were noted and risks being managed. No matters required escalation to Trust Board	
Risks escalated None – matters being managed within Committee **Matters for noting** The Committee fully supported the VOICE behaviours in advance of being presented to BoD.			

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Agenda Item No:	**13**
Meeting:	Board of Directors
Date:	25th June 2020

Title:	Mortality Update
Purpose	This paper describes current mortality metrics for Bolton NHS FT and highlights areas of concern
Executive Summary:	Data is presented to show the crude mortality rate as well as RAMI, HSMR and SHIMI. The main areas of concern have been pneumonia, acute bronchitis, heart failure and respiratory disease, although SHIMI for pneumonia has improved to 'as expected category'.. Extensive work continues on pneumonia mortality and a partnership with AQUA is expected to yield further positive benefits. Initial work is being done around acute bronchitis and other respiratory failure but these are low numbers of deaths. Heart failure is the subject of intense focus and learning from deaths committee have been undertaking SJRs to explore issues in care. A particular issue has been identified around coding which has been magnified following the introduction of EPR and a coding group has been set up to address these issues
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	Board are asked to approve the paper

Confidential y/n	n

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

Prepared by:	Francis Andrews, MD	**Presented by:**	Francis Andrews, MD

1 Introduction

The quarterly mortality report provides an update to the Trust board on the most recent information available to the Trust to support the focus of reducing the Trust's current mortality ratio.

2 Methodology

Information is collated via CHKS (Our healthcare intelligence provider) based on a 12 month period. The data contained in this report is until end of March 2020 all indicators other than SHMI which is up to December 2019. From July 2018 the figures for CRUDE mortality EXCLUDES day cases – this is in line with national guidance and is also consistent with the Board and IPM figures reported within the Trust.

The Medical Director requested that a comparison peer group be selected to identify the most similar (overall) Trusts to Bolton-see

3 Key Points

- Crude mortality – decreased slightly to 2.05% from 2.12% in the previous comparison year (April 2018 – March 2019). These are the actual number of deaths divided by the number of admissions.
- RAMI – index decreased (improved) slightly from the comparison year at 96.23 (April 2019 – March 2020). The index is higher than the selected peer value of 89.66. This measure is the total number of observed in hospital deaths divided by the expected number of deaths.
- SHMI – The index is at 116.5 for the latest published period (January – December 2019); it is still significantly higher than the national average. This measure is the Total number of observed deaths/expected deaths in hospital and within 30 days of discharge from the hospital
- HSMR – ratio decreased (improved) to 108.4 for the latest period (January 2019 – December 2019) from 114.8 in the previous year. This is still higher than expected. HSMR refers to spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell and uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England.

4 Scorecard views

4.1 Mortality Indicators (April 2019 – March 2020)

Description	Local Numerator	Local Denominator	Apr 19 - Mar 20	Apr 18 - Mar 19	Change	Peer Value	Performance	Excess (mean)
CI: Mortality rate excluding day cases	1184	57697	2.05%	2.12%	-3.19%	1.90%		85.07
Rate of Mortality in hospital within 30 days of elective surgery	3	2892	0.10%	0.09%	16.22%	0.12%		-0.60
Rate of Mortality in hospital within 30 days of Non elective surgery	59	7254	0.81%	1.04%	-21.66%	1.36%		-39.97
RAMI (Risk adjusted mortality index) 2018	1184	1230.44	96.23	100.42	-4.17%	89.66		-46.44

4.2 SHMI (January – December 2019)

Description	Local Numerator	Local Denominator	Jan 19 - Dec 19	Jan 18 - Dec 18	Change	Peer Value	Performance	Excess (mean)
SHMI (Summary Hospital-Level Mortality Index)	1724	1480.32	116.46	118.41	-1.64%	99.95		243.68

4.3 Mortality indicator – HSMR (January – December 2019)

Description	Local Numerator	Local Denominator	Jan 19 - Dec 19	Jan 18 - Dec 18	Change	Peer Value	Performance	Excess
HSMR (Hospital Standardised Mortality Ratio)	1062	979.52	108.42	114.85	-5.60%	94.30		82.48

4.4 Mortality Indicators by Division (April 2019 – March 2020)

Description	Local Numerator	Local Denominator	Apr 19 - Mar 20	Apr 18 - Mar 19	Change	Peer Value	Performance	Excess (mean)
Mortality Rate	1184	80784	1.47%	1.51%	-2.94%	1.18%		226.99
Acute Adult Care - Inpatients	1018	24704	4.12%	4.08%	0.99%	2.39%		427.57
Anaesthetic and Surgery Services	141	26942	0.52%	0.58%	-9.14%	0.53%		-2.07
Family Care	25	29136	0.09%	0.09%	-4.49%	0.08%		2.72
CI Mortality rate excluding day cases	1184	57697	2.05%	2.12%	-3.19%	1.90%		85.07
Acute Adult Care - Inpatients	1018	17363	5.86%	5.77%	1.54%	3.71%		373.35
Anaesthetic and Surgery Services	141	11808	1.19%	1.31%	-8.91%	1.18%		1.37
Family Care	25	28524	0.09%	0.09%	-4.79%	0.08%		0.88
RAMI (Risk adjusted mortality index) 2018	1184	1230.44	96.23	100.42	-4.17%	89.66		-46.44
Acute Adult Care - Inpatients	1018	1030.34	98.80	101.12	-2.29%	91.46		-12.34
Anaesthetic and Surgery Services	141	170.76	82.57	95.78	-13.80%	87.05		-29.76
Family Care	25	29.18	85.66	101.61	-15.69%	89.86		-4.18

5 Mortality rates by type

5.1 Crude Mortality Rate – Day cases excluded

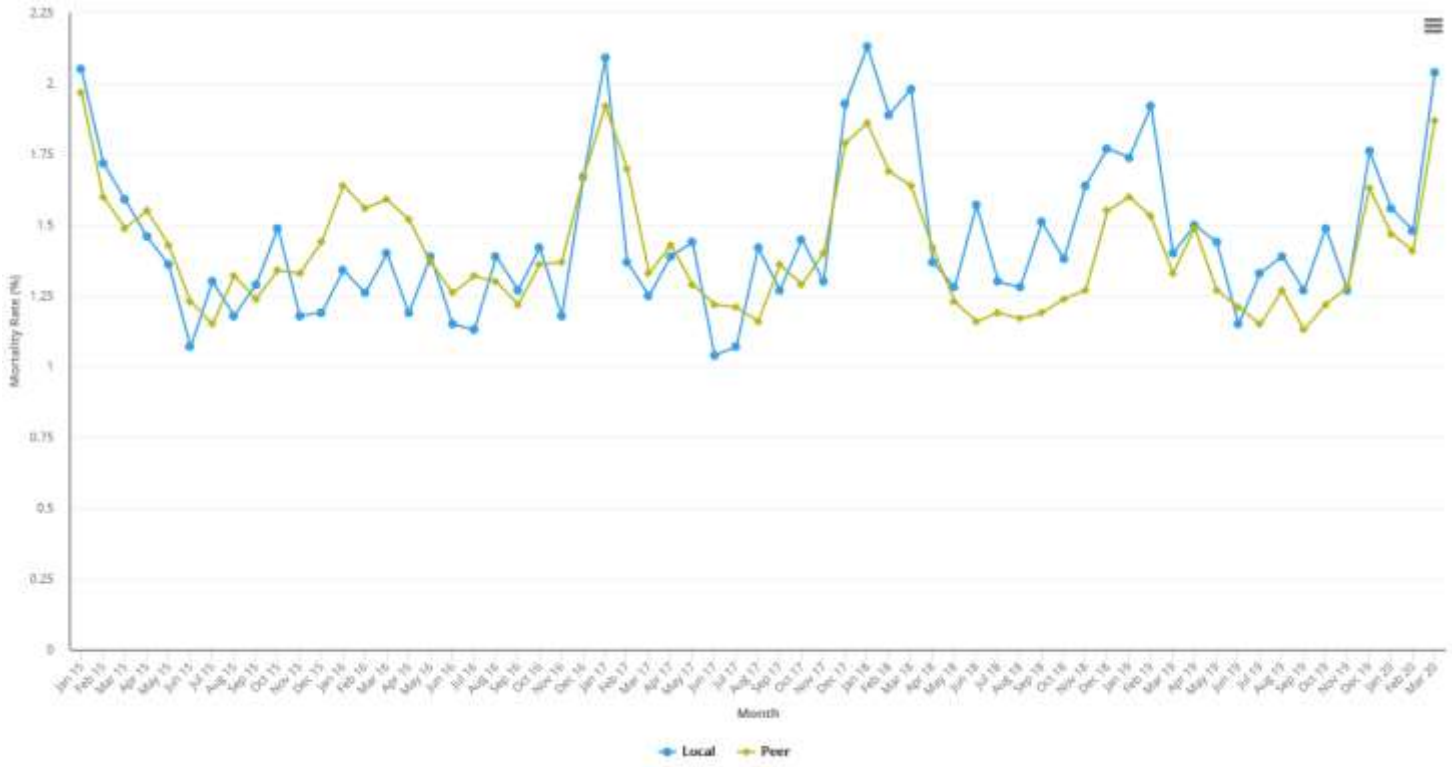
Definition

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in a specific time period and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. It tells you how a Trust's mortality rate changes over time; however it cannot be used to compare or contrast between hospitals.

From July 2018 the crude mortality figures stated in this report EXCLUDE day cases which has caused the rate to rise because of the lower denominator.

Time series by selected hospital peer group (April 2019 – March 2020)

The crude rate shows a cyclical pattern over the time frame with the rate peaking over the winter months. The peer value is shown for information.



Top 10 Primary diagnoses of patients on admission – Crude mortality – based highest number of deaths (April 2019 to March 2020)

The top three numbers of deaths making up the crude rate were for CCS groups 122 (pneumonia), 2 (septicaemia except in labour), 108 (congestive heart failure; non-hypertensive). The peer group value refers to the selected hospital peers.

Description	Local Numerator	Local Denominator	Apr 19 - Mar 20	Apr 18 - Mar 19	Change	Peer Value	Performance	Excess (mean)
Mortality Rate	1184	80784	1.47%	1.51%	-2.84%	1.36%		86.93
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	247	1810	13.65%	17.28%	-21.04%	13.01%		11.47
2 - Septicemia (except in labor)	121	861	14.05%	13.67%	2.80%	15.44%		-11.98
108 - Congestive heart failure; nonhypertensive	59	431	13.69%	14.41%	-5.03%	10.61%		13.28
129 - Aspiration pneumonitis; food/vomitus	46	145	31.72%	30.11%	5.37%	26.73%		7.24
109 - Acute cerebrovascular disease	45	346	13.01%	12.53%	3.80%	13.79%		-2.73
127 - Chronic obstructive pulmonary disease and bronchiectasis	39	1082	3.60%	4.56%	-20.92%	3.74%		-1.42
150 - Liver disease; alcohol-related	34	192	17.71%	10.67%	65.93%	11.32%		12.27
68 - Senility and organic mental disorders	33	397	8.31%	6.35%	30.92%	6.20%		8.38
157 - Acute and unspecified renal failure	32	290	11.03%	13.11%	-15.86%	10.36%		1.96
19 - Cancer of bronchus; lung	25	127	19.69%	16.67%	18.11%	3.91%		20.03

5.2 Risk Adjusted Mortality Index – RAMI

Definition

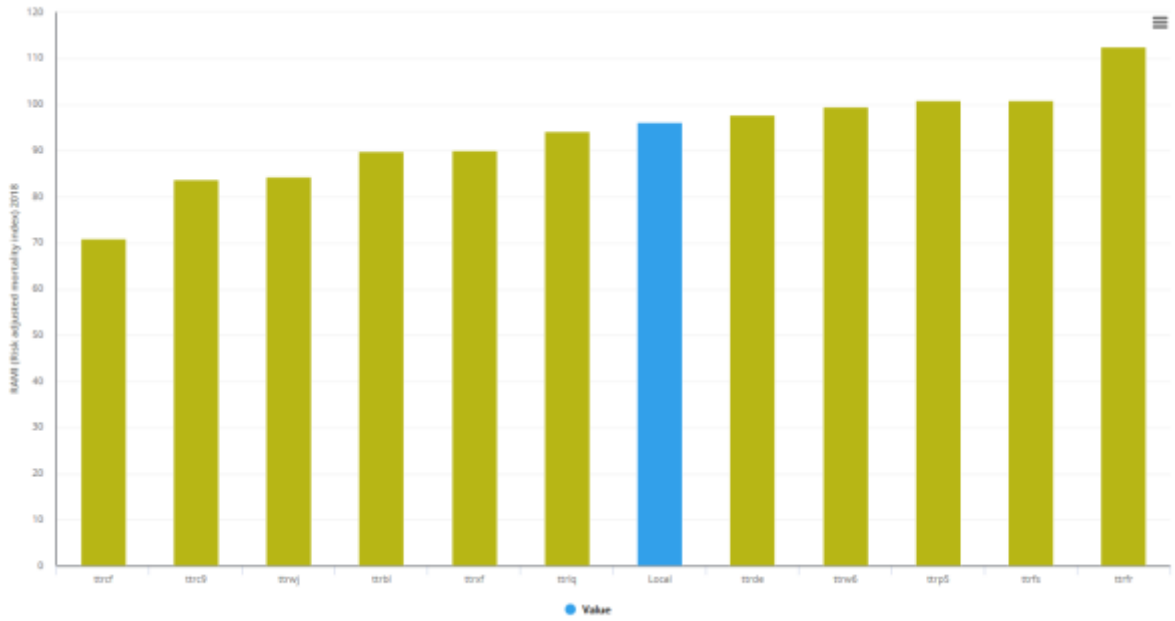
Risk Adjusted Mortality Indicator (RAMI): This is the CHKS risk adjusted standardised mortality ratio (see appendix 2 for details of risk adjustments). Anything lower than 100 is interpreted as fewer deaths than expected. It includes deaths occurring in hospital only.

Time series by selected hospital peer group (April 2019 – March 2020)

The monthly RAMI fluctuates widely but roughly follows the pattern of the selected peer groups. The index has been at a higher level than the peer group in eight out of the final 12 months of the reporting period.

Peer distribution (April 2019 – March 2020) – selected hospitals

Bolton FT is mid table when compared against the selected hospital with a RAMI of 96.23. The range is 70.95 to 112.53.



Top 10 deaths by CCS Groups within RAMI – based on number of deaths (April 2019 –March 2020)

Peer group value is selected hospitals.

Description	Local Numerator	Local Denominator	Apr 19 - Mar 20	Apr 18 - Mar 19	Change	Peer Value	Performance	Excess (mean)
RAMI (Risk adjusted mortality index) 2018	1184	1230.44	96.23	100.42	-4.17%	93.84		-46.44
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	247	267.30	92.40	118.12	-21.77%	94.52		-20.30
2 - Septicemia (except in labor)	121	153.45	78.85	81.38	-3.10%	93.64		-32.45
108 - Congestive heart failure; nonhypertensive	59	61.78	95.50	114.62	-16.68%	102.72		-2.78
129 - Aspiration pneumonitis; food/vomitus	46	31.96	143.95	100.37	43.42%	101.77		14.04
109 - Acute cerebrovascular disease	45	51.13	88.01	70.97	24.02%	92.30		-6.13
127 - Chronic obstructive pulmonary disease and bronchiectasis	39	48.58	80.29	108.32	-25.88%	96.41		-9.58
150 - Liver disease; alcohol-related	34	21.43	158.68	112.37	41.22%	99.08		12.57
68 - Senility and organic mental disorders	33	29.13	113.29	84.39	34.25%	112.77		3.87
157 - Acute and unspecified renal failure	32	37.57	85.18	117.14	-27.28%	107.23		-5.57
19 - Cancer of bronchus; lung	25	28.15	88.81	69.70	27.42%	89.89		-3.15

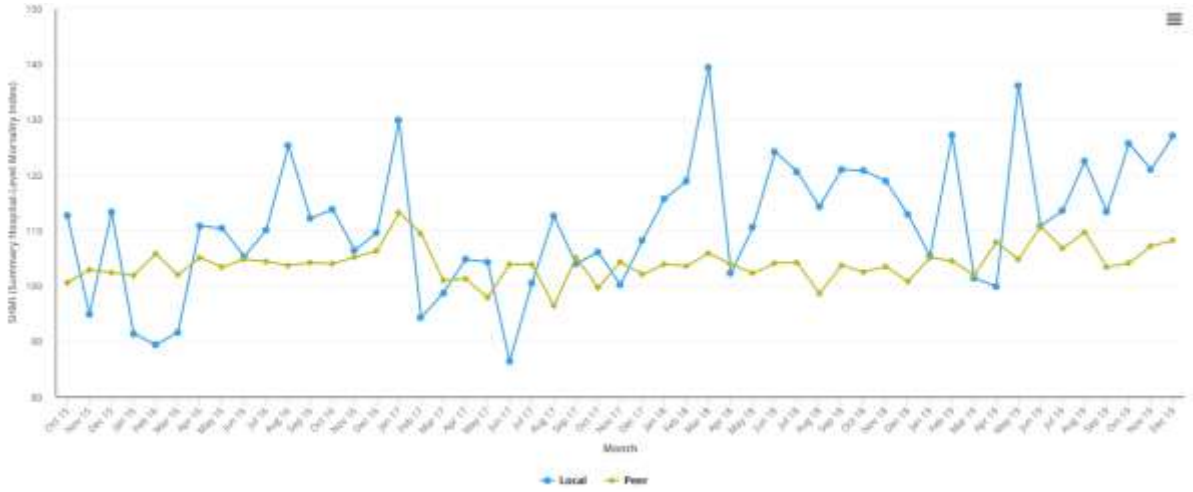
5.4 Summary Hospital-level Mortality indicator – SHMI

Definition

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Different variable factors are taken in to account in calculating the scores - the principle one of these is that SHMI includes deaths following a patient's discharge (within 30 days). As SHMI includes all deaths post discharge it is always at least 6 months behind the current date due to data being include from the Office for National Statistics.

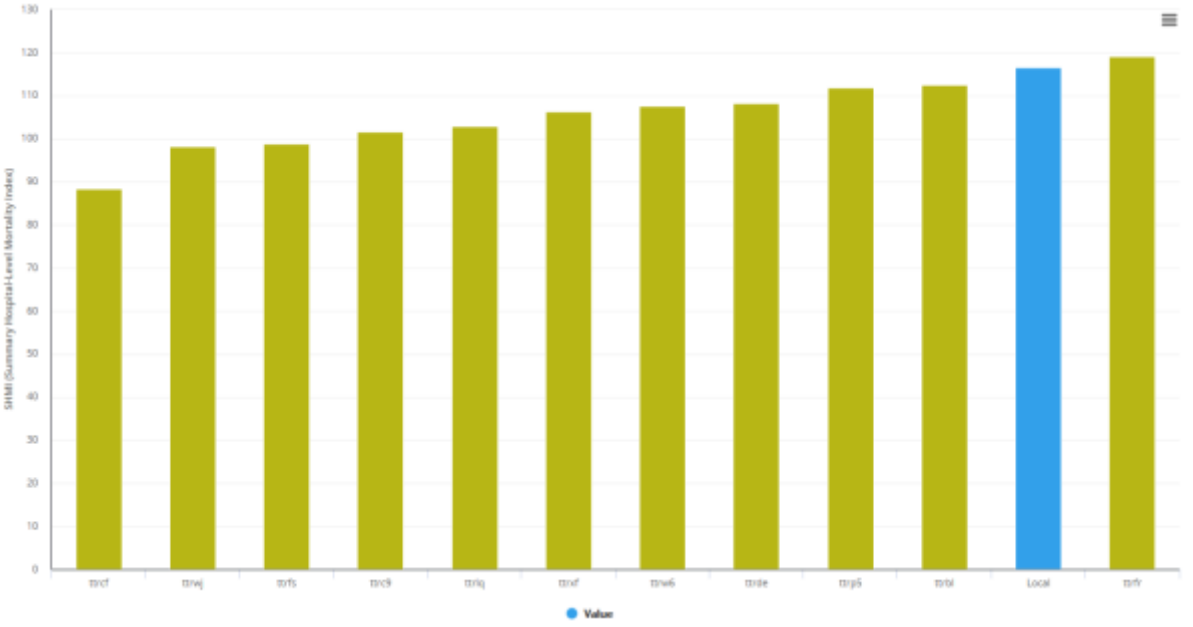
Time series (January – December 2019)

The most recent published SHMI 12 month average for the period January - December 2019 is 116.5. The actual in month values are reported below. Top 10 conditions data not yet available from CHKS.



Peer distribution (January – December 2019)

Bolton FT is second highest amongst the peers at 116.5 in the 12 months to December 2019. The range in values is from 88.42 (Airedale NHS Foundation Trust) to 119.08 (The Rotherham NHS Foundation Trust) being the highest. Unlike most Trusts, we exclude ambulatory care cases and previously we have shown that this moves us out of the 'epected range'.



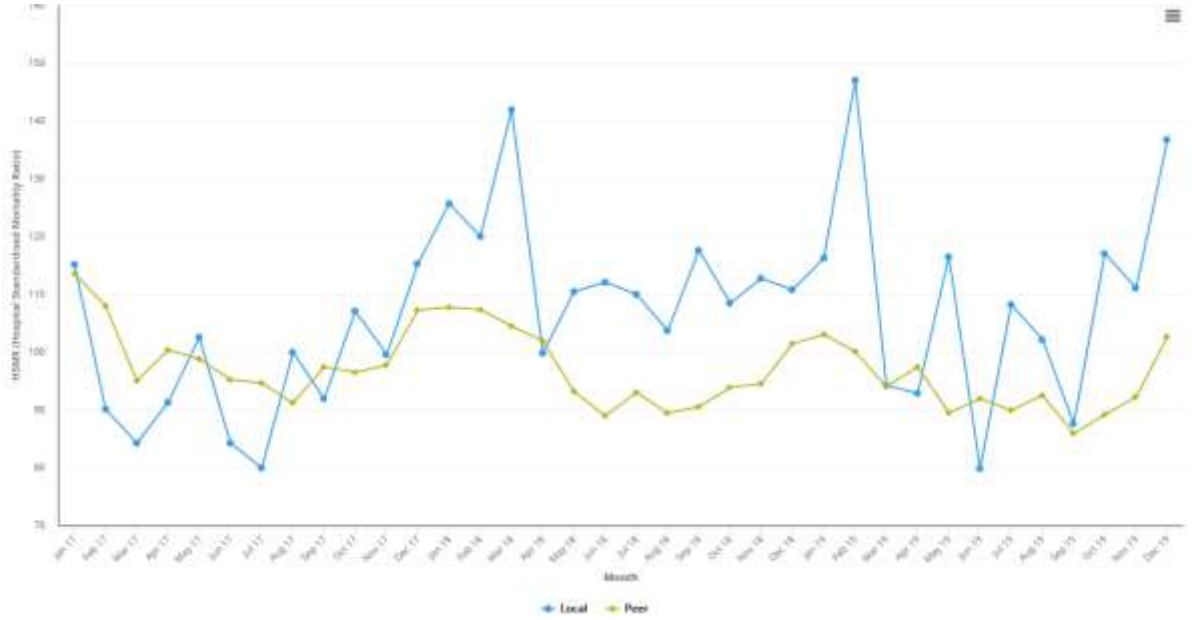
5.5 Hospital Standardised Mortality Ratio (HSMR)

Definition

The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. This indicator will be a month behind the data supplied for RAMI and crude as it is calculated using HES data so the time lag is longer. CHKS can calculate RAMI and crude more timely as this can be calculated based on the data submitted directly to them. The importance of HSWR is that this is used by the CQC to monitor Trusts.

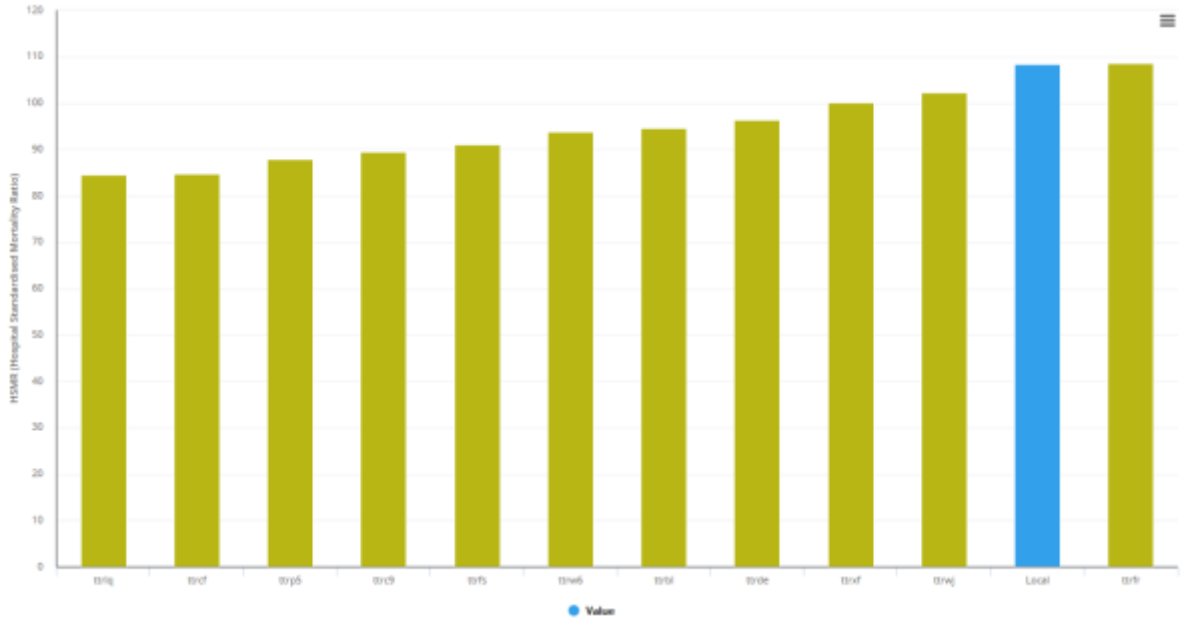
Time series

The monthly HSMR is reported below against the peer group of the most similar Trusts. The HSMR has fallen below that of the peers group in only two out of the twelve previous months. As can be seen, the HSMR is climbing higher than it should be and will require further investigation.



Peer distribution (January – December 2019)

The range in values is between 84.5 and 108.5.



6 HSMR CuSUM deaths above expected

Definition

This is the cumulative variance between the actual numbers of deaths to what is expected. The average of previous 12 months variance to the expected value is studied. Data is available to March 2020. The peer group only includes the selected peers for consistency. Diagnoses that are above expected limits are:

- CC 122 Pneumonia (except that caused by tuberculosis or sexually transmitted disease)
- CC 125 Acute bronchitis
- CC 133 Other lower respiratory disease
- CCS 108 Heart failure

In addition, using the Hospital Standardised Mortality Rate (HSMR), any CCS groups that have been rising but are still within normal mortality limits are monitored through mortality reduction group and breaches of upper limits are noted, and investigated if breaches persist.

7 Outlier CQC alerts

The trust composite is a pilot indicator created from 12 specific indicators within insight. The composite indicator score helps to assess a trusts overall performance but it is neither a rating nor a judgement. The composite should be used alongside other evidence in monitoring Trusts.

Taken from *CQC Insight for Acute NHS Trust, May 2020 release*

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
E2		**Hospital Standardised Mortality Ratio (HSMR)** Dr Foster - Dr Foster - HSMR (08 Apr 2020)	100.0	117.3 Oct 17 - Sep 18	117.9 Oct 18 - Sep 19	→	MW
E2		**Hospital Standardised Mortality Ratio (Weekend)** Dr Foster - Dr Foster - HSMR (08 Apr 2020)	100.0	114.6 Oct 17 - Sep 18	128.1 Oct 18 - Sep 19	↓	MW
E2		**Summary Hospital-level Mortality Indicator (SHMI)** NHS Digital - SHMI (07 Apr 2020)	1.00	1.14 Oct 17 - Sep 18	1.16 Oct 18 - Sep 19	→	MW
E2		**In-hospital mortality: Acute bronchitis** Hospital Episode Statistics - CQC - HES Mortality (27 Apr 2020)	100	133.6 Jan 18 - Dec 18	198.4 Jan 19 - Dec 19	↓	W
E2		**In-hospital mortality: Pneumonia** Hospital Episode Statistics - CQC - HES Mortality (27 Apr 2020)	100	150.5 Jan 18 - Dec 18	127.8 Jan 19 - Dec 19	↑	W
E2		**Mortality outlier alert: Pneumonia** Care Quality Commission - CQC - Outliers (05 May 2020)	-	NA	Action plans being followed up by CQC May 20	NA	W

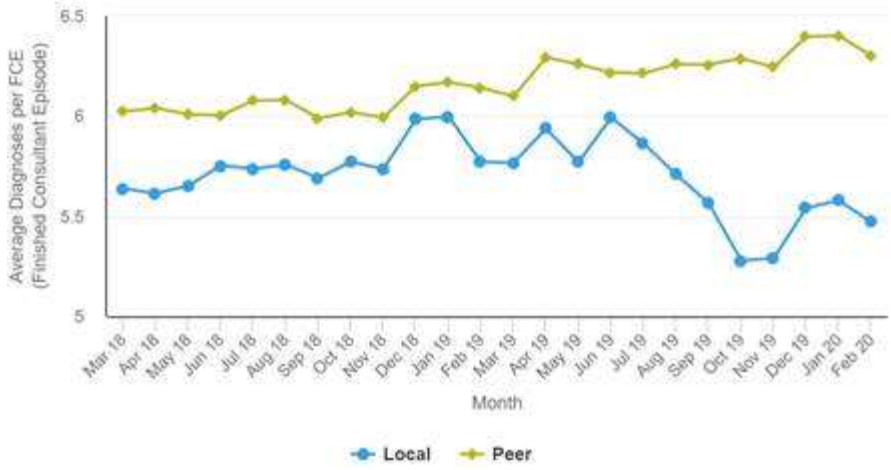
HSMR

For some time, the HSMR for the trust has been high for weekdays and not for weekends. This is reported to us via the CQC insight publication every 2 months. This is the reverse to what would be expected with the more usual problem being that mortality being measured in this way being. The latest CQC insight report has though shown that the HSMR for the trust is higher than expected is higher than expected. Therefore our BI unit are currently producing run charts for the last three years of observed and expected mortality. Examination of this SPC data will hopefully explain whether it is the expected or observed (or less likely both) sets of deaths have changed to that there

can be further interrogation as to where the issue may lie. This initial work is expected to be completed by end of July 2020, and then further analytical work undertaken.

For bronchitis, an initial analysis has been undertaken as follows:

An HSMR observed/expected deaths chart was not available at in time for paper submission but has been requested to look at this issue further. The number of deaths coded as acute bronchitis is very small so the sudden rise in HSMR needs to be interpreted with caution; a factor that may be contributing to this is that there appears to be an issue with the depth of coding as demonstrated. If not all the comorbidites are recorded and then coded, then the expected deaths will fall. The chart below appears to shoe that the introduction of EPR was accompanied by a fall in the number of co-morbidities coded (the effect is only seen for non-elective admissions):



Actions being undertaken

1. Run SPC chart to look at observed and expected deaths for acute bronchitis and acute respiratory disease to determine which component has suddenly changed, followed by examination of other factors

2. Clinical coding education

The medical director has commisoned a clinical coding group comprising the medical director, clinical coding manager, chief clinical information officer (CCIO) and clinical director for acute medicine.

The takss are:

- to develop a medical education package on clinical coding which is due for completion by the end of July 2020
- To optimise the EPR (Electronic Patient Record) for clarity around the phrases that should be used around the primary and secondary diagnoses in the FCE (First Consultant Episode) used for coding and to capture more comorbidities. Timescale for completion-August 2020.

3. Audit of clinical coding process

This has been undertaken in conjunction with PWC but has been stalled due to Covid19 and other factors. Further discussions will take place with PWC around reviewing the forward plan.

Heart failure

This has been audited previously and this showed that the patients dying from this were sicker than those in other trusts, with more advanced disease. These deaths were being monitored through learning from deaths; the programme was suspended due to covid19 but has now restarted and this

will be updated-so far 33 cases have had a completed SJR. A community heart failure clinic started last year to optimise the treatment of these patients, the rise in mortality remains unclear.

Pneumonia

The issue remains to understand why the mortality for pneumonia has remained high. However, the SHIMI for pneumonia for the Trust has returned to 'within expected limits' for the period December 2018-November 2019, measured at 121.2 (this will be the nationally reported way of reported SHIMI). However, it remains to be seen if this will be sustained so further work is on-going as detailed below. It should be noted that trust IPM data is reported as an SPC run chart-the figure for the *month* of November 2019 was 122.

1. Depth of coding audit

For the 19 patients who died of pneumonia at the Trust in November 2019, all the case notes have been audited for recording of past medical history to see if additional information should have been gleaned for the GP Summary Care Record (SCR). Given the historical lack of depth of coding for secondary diagnoses (past medical history) in Bolton compared with peers, recording co-morbidities medical record was examined. This has shown that:

- 4 patients had comorbidities which were not recorded in the case notes but may have counted towards a higher charlson score.
- For 15 patients, either no information was available on the SCR or more information was recorded in the patient case notes on admission under past medical history than was recorded on the SCR.

2. Work with AQUA.

The trust have now partnered with AQUA following the work they have done with the Royal Liverpool University hospital to get their pneumonia mortality down. A pneumonia group has been set up under the acutes division and this will entail a multidisciplinary group (including the head of clinical coding) auditing all pneumonia patients over a 3 month period commencing July 2020 to produce a dataset for AQUA to look at the entire patient journey and conversion to coding. AQUA will then analyse and support quality improvement methodology where required.

Main findings from an AQUA analysis of SUS data is that we have a very low rate of pneumonia (26/1000 admissions versus 35/1000 admissions regionally) yet our length of stay at 5 days is identical to the regional average and our readmission rate is lower at 23.9%, versus 26.4%. Moreover, we have far more patients with a prefix for hospital acquired pneumonia than expected even though some have never been previously admitted-this may be related to our antibiotic policy suggesting treating residential and nursing home residents as hospital acquired rather than community acquired pneumonia for clinical reasons. AQUA believes that based on their work we need to ensure that pneumonia is diagnosed, documented and coded more accurately.

Conclusions

Data is presented to show the crude mortality rate as well as RAMI, HSMR and SHIMI. The main areas of concern have been pneumonia, acute bronchitis, heart failure and respiratory disease. Extensive work continues on pneumonia mortality and a partnership with AQUA is expcted to yield further positive benefits. Initial work is being done around acute bronchitis and other respiratory

failure but these are low numbers of deaths. Heart failure is the subject of further analysis and learning from deaths committee have been undertaking SJRs to assess the quality of care-so far 23 have been completed and but no recurrent themes have been identified so far. A particular issue has been identified around coding which has been magnified following the introduction of EPR and a coding group has been set up to address these issues.

Recommendations

Board are asked to appove the report and support the actions described within this report.

Appendix 1. Comparator trusts identified as most similar using the distribution of activity by HRGs are as below:

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

Appendix 2: Understanding Mortality Rates – CRUDE, HSMR, RAMI and SHMI

	Crude	SHMI	HSMR	RAMI
Numerator	Actual number of deaths	Total number of observed deaths in hospital and within 30 days of discharge from the hospital	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England	Total number of observed in hospital deaths
Denominator	Number of admissions	Expected number of deaths	Expected number of deaths	Expected number of deaths
Adjustments		• Sex • Age group • Admission method • Co-morbidities based on Charlson score • Year index • Diagnosis group No adjustment is made for palliative care. Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summar y-hospital-level-mortality-indictorshmi	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge	• Age - six groups • Admission type - elective or non-elective • Primary clinical classification - all CCS groups • Sex • Length of stay - specific groups only • Most significant secondary diagnosis
Exclusions	Excludes day cases, still births and well born babies.	Excludes specialist, community, mental health and independent sector hospitals; Stillbirths, Day cases, regular day and night attenders. Palliative care patients not excluded.	Excludes day cases and regular attendees. Palliative care patients not excluded	None
Whose data is included		All England non-specialist acute trusts except mental health, community and independent sector hospitals via SUS/HES and linked to ONS data for out of hospital deaths. Deaths that occur within 30 days are allocated to the last hospital the patient was discharged from.	England provider trusts via SUS/HES	Admissions to all trusts/boards in England, Wales and Northern Ireland

Agenda Item No:	**14.**
Meeting:	Board of Directors
Date:	25th June 2020

NHS Bolton NHS Foundation Trust

Title:	IPC Update
Purpose	This paper provides an overview of HCAI performance and an update on IPC
Executive Summary:	There are currently no national objectives set for *Clostridium difficile* cases, nor MSSA, *E. coli* and *Klebsiella spp.* bacteraemia as intended from a briefing paper produced by NHSE/I in 2019. There has been one hospital onset MRSA bacteraemia. There have been five HOHA & COHA *Clostridium difficile* cases. MSSA and *E. coli* bacteraemia cases continue to demonstrate improvements based on the past 18 months. COVID cases have been added to this paper for surveillance purposes.
Previously considered by:	NA
Recommendation Please state if approval required or if for information	Continued surveillance

Confidential y/n	N

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

Prepared by:	R Catlin	**Presented by:**	M Forshaw

Introduction

This paper outlines the Trust HCAI/IPC performance to the end of May 2020.

Summary:

	Hospital Onset MRSA BSI Cases	Hospital Onset MSSA BSI Cases	Hospital Onset *E. coli* BSI Cases	Hospital Onset *Klebsiella spp.* BSI Cases	Hospital Onset *P. aeruginosa* BSI Cases	HOHA & COHA *Clostridium difficile* Cases	*CPE Cases*	*Blood Culture Contaminants*
Apr	0	1	3	0	0	1	0	5.2%
May	1	2	1	1	2	6	0	4.6%
Jun								
Jul								
Aug								
Sep								
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								
Total	1	3	4	1	2	7	0	**4.9%**
Target	0	12	36	NA	0	32	NA	3%

	All COVID-19 Cases	Nosocomial COVID-19 Cases	Nosocomial Proportion
Apr	339	66	19%
May	99	31	31%
Jun			
Jul			
Aug			
Sep			
Oct			
Nov			
Dec			
Jan			
Feb			
Mar			
Total	**438**	**97**	**22%**

1. Methicillin-resistant Staphylococcus aureus (MRSA)

There has been one hospital onset MRSA case in May 2020. This case is currently being investigated but the provisional findings are that the patient had a known history of MRSA and was admitted with an infection. The investigation will be reviewing primarily whether or not there was a missed opportunity to collect a blood culture sample earlier.

There has also been one community onset MRSA case in May 2020. The patient in question is a known MRSA positive patient and is an injecting drug user. The CCG are currently undertaking a review of this case supported by the Trust IPC team.

2. Blood Culture Contaminant Rate

The Trust has an active surveillance programme for the rate of false positive or contaminated blood cultures. Where skin bacteria are identified in blood cultures and no other bacteria that cause infections, these are classed as false positives or contaminants. There is no requirement for these rates to be monitored or reported formally but the IPC Committee does so as a marker of the quality of aseptic procedures. Academic studies suggest that a rate of 3% or lower is best practice.

	All Blood Cultures	Positive Blood Cultures	Blood Culture Contaminants	Contaminant Percentage
Apr	670	71	35	5.2%
May	635	71	29	4.6%
Jun				
Jul				
Aug				
Sept				
Oct				
Nov				
Dec				
Jan				
Feb				
Mar				

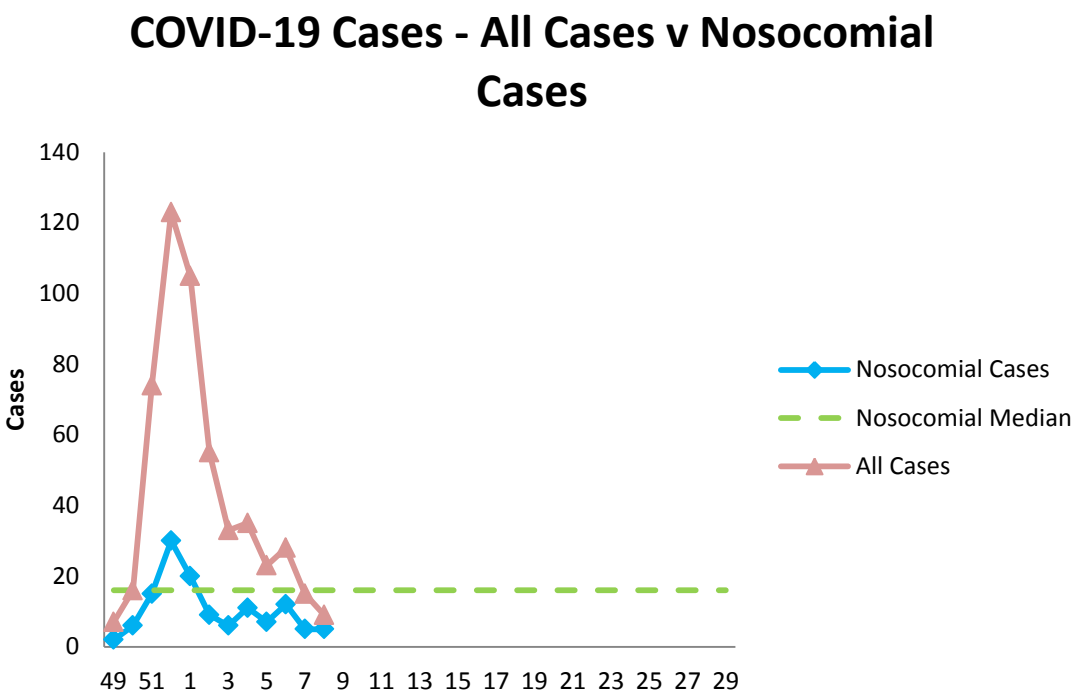
Action has been taken in the departments where the proportion of blood culture contaminants has increased – in particular in ED. It is anticipated the reductions seen between April and May will continue into June and beyond.

3. COVID-19

We are now monitoring all COVID-19 cases and also all nosocomial cases. Nosocomial is a term that means an infection has been acquired after admission to hospital. NHSE/I have created some definitions about which COVID-19 cases are likely to be nosocomial – this is based on the incubation period (the period of time from exposure to the virus and developing signs or symptoms of infection) for COVID-19 infection being up to 14 days.

HCAI Category	Criteria	
Community Onset (CO)	Positive specimen taken date <= 2 days after admission to trust	**Not nosocomial**
Hospital-Onset Indeterminate Healthcare-Associated (HOIHA)	Positive specimen taken date 3-7 days after admission to trust	**Not nosocomial**
Hospital-Onset Probable Healthcare-Associated (HOPHA)	Positive specimen taken date 8-14 days after admission to trust	**Nosocomial**
Hospital-Onset Definite Healthcare-Associated (HODHA)	Positive specimen taken date 15 or more days after admission to trust	**Nosocomial**

This chart shows all COVID-19 cases and all nosocomial COVID-19 cases displayed weekly since 12/03/20 to the end of May.



Universal screening for all admissions has commenced with pre-admission screening used for elective admissions where possible. From mid-May, repeat screening at seven and 14 days has commenced to improve surveillance.

Additional use of personal protective equipment (PPE) – mostly the use of surgical face masks – has been introduced in line with national guidance.

Through the pandemic two issues have been noted that increase the likelihood of nosocomial infection and transmission between staff:

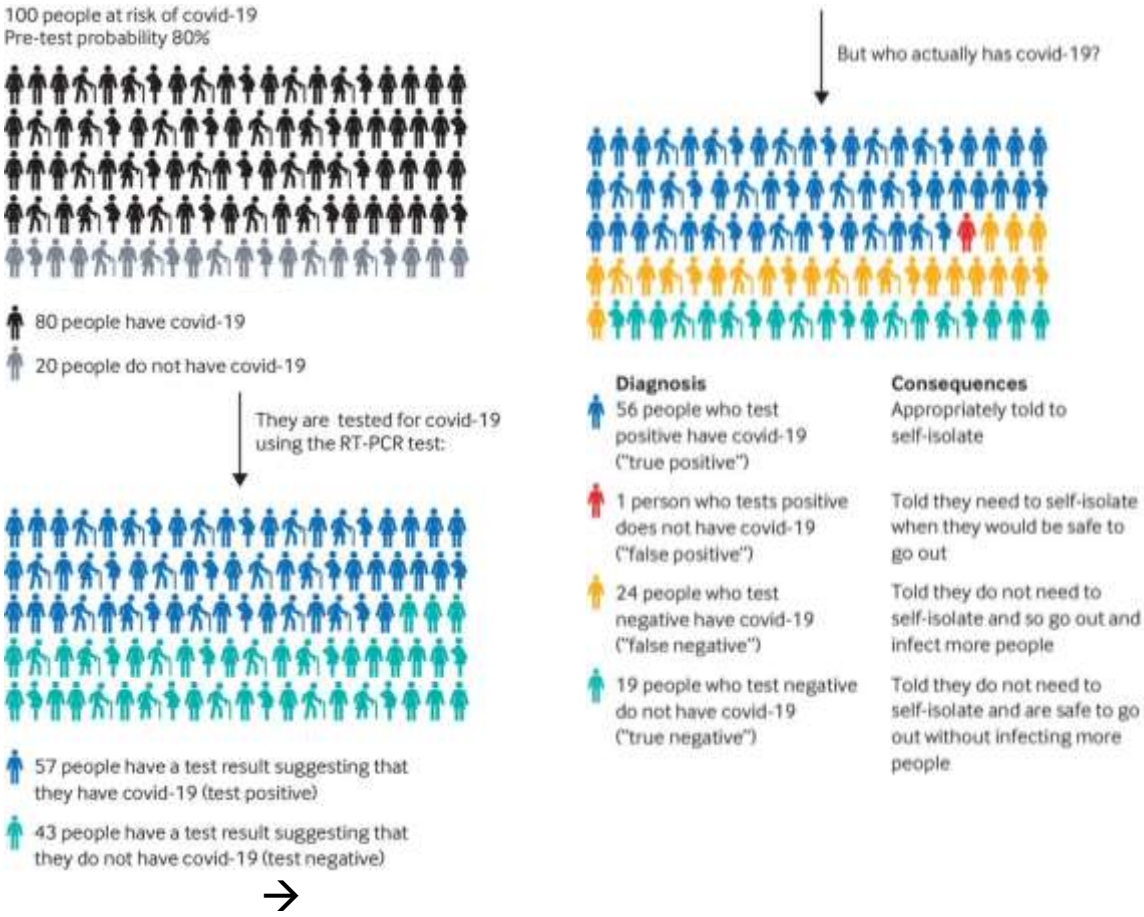
a. Transmission of COVID-19 by individuals without symptoms
b. The number of false negative results from the nose/throat swabs;

Testing

- **Testing for Clinical Infections**

Testing for clinical infections is done using a nose and throat swab. The test looks for genes that are specific for the virus SARS-2-CoV which causes

COVID-19. What has been observed in all testing using this method is a number of false negative result; the individual has COVID-19 but the result is negative. Between 20-25% of these false negatives have been observed. Below is a useful infographic from a British Medical Journal that illustrates what this means:



Patients at Bolton FT are not managed on the basis of a result only. The patient has medical review and confirms whether or not the result is consistent with the patient's clinical condition.

- **Testing for Past Infection**

The Trust has now introduced COVID-19 antibody tests:

- For patients as requested by medical staff
- All Bolton FT and Bolton iFM staff
- Other staff on behalf of GM including but not limited to NWAS, Bolton Primary Care staff

Bolton is one of three sites in GM able to support the antibody tests as the laboratory already had a testing platform that could be used with the antibody test kits that became available. As such we are providing support to the GM system to provide antibody testing across the city.

The test looks for antibodies – chemicals produced by the immune system in order to help fight future infections. These antibodies are specific to particular bacteria – or in this case – virus. The test used at Bolton does not distinguish between a current infection or past infection. At this stage of scientific understanding, it is impossible to say whether the presence of antibodies in an

individual's blood provides future protection from further infections. These large scale tests will be useful in building this knowledge.

Due to the uncertainty about how or if the results of these tests can be used, the current guidance from the medical microbiologists is that patient results should not be used to direct treatment or management. Actions should be directed by signs, symptoms and other diagnostic information.

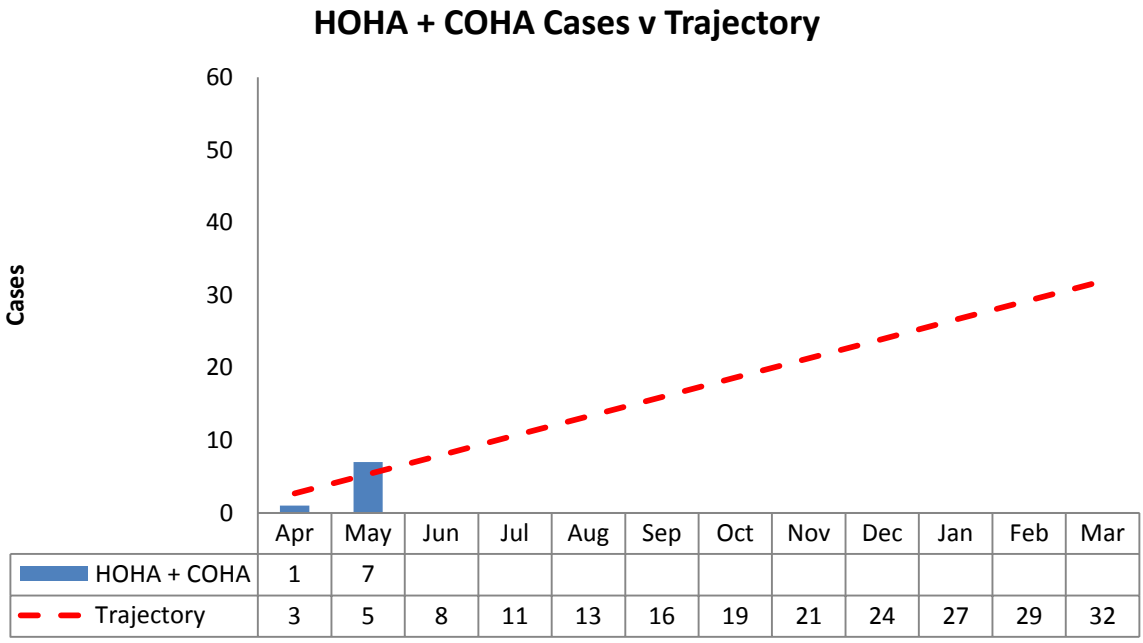
Visiting

The government has advised that the restrictions on patient visitors may be extended where it is safe to do so, but left the decision down to local organisations. This advice has been reviewed locally and citywide and with the current regional variations in the R_0 number (the disease reproduction number) a decision has been made to keep the policy on visitors strict. The Bolton FT Policy makes adjustments for end of life care, a birthing partner, cognitive impairment/learning disability and the parent of a child. Visitors are required to undertake safe measures to protect their families on return to their home such as isolation.

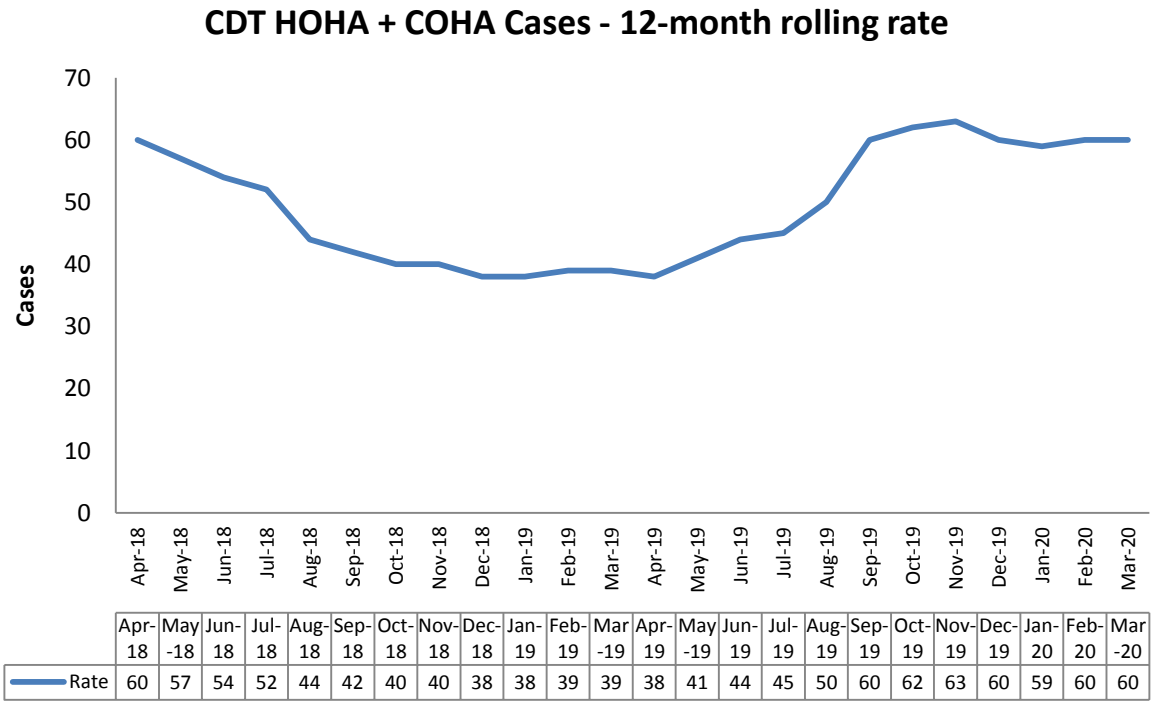
This decision has not been taken lightly but has been taken in line with patient, staff and visitor safety with the current R_0 rate.

4. Clostridium difficile

The objectives for CDT cases has not been published for 2020/21 yet, this assumes that the objectives will remain the same as 2019/20; not to exceed 32 hospital onset hospital associated (HOHA) cases and community onset hospital associated (COHA) cases.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HOHA + COHA	1	7										
Trajectory	3	5	8	11	13	16	19	21	24	27	29	32



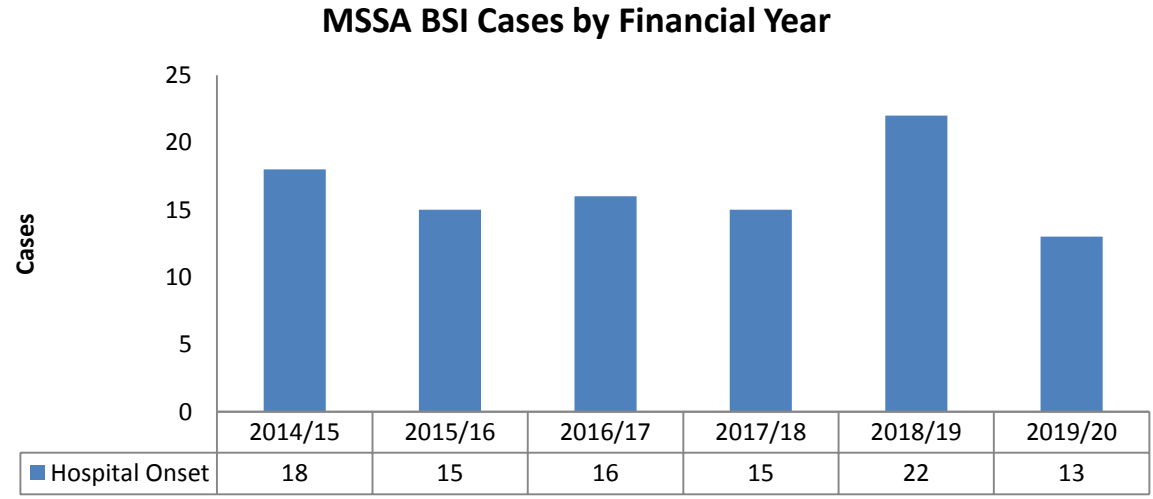
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Rate	60	57	54	52	44	42	40	40	38	38	39	39	38	41	44	45	50	60	62	63	60	59	60	60

This data suggests that the burden of HOHA and COHA cases has plateaued.

The IPC team will be actively reinforcing the principles of *Clostridium difficile* management and the application of SIGHT[1].

5. Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemias

There has been an improvement in MSSA cases from 2019/19-2019/20:



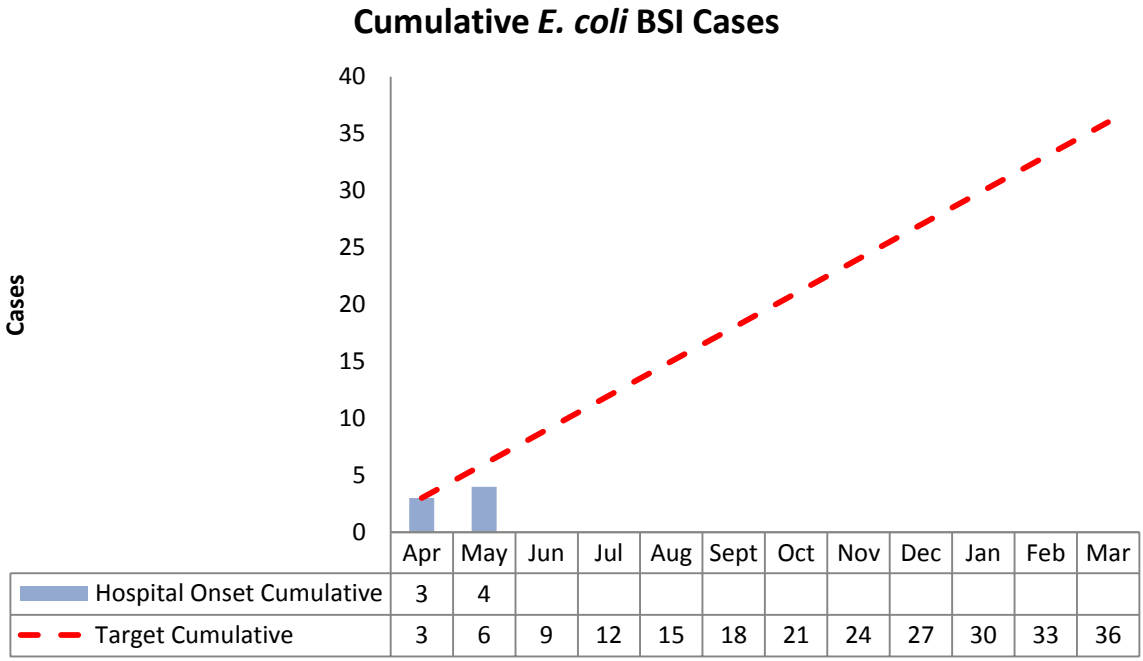
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Hospital Onset	18	15	16	15	22	13

The work will continue to maintain and improve in 2020/21.

[1] **S**uspect **I**solate **G**loves **H**and washing **T**est

6. Escherichia coli (*E. coli)* Bacteraemias

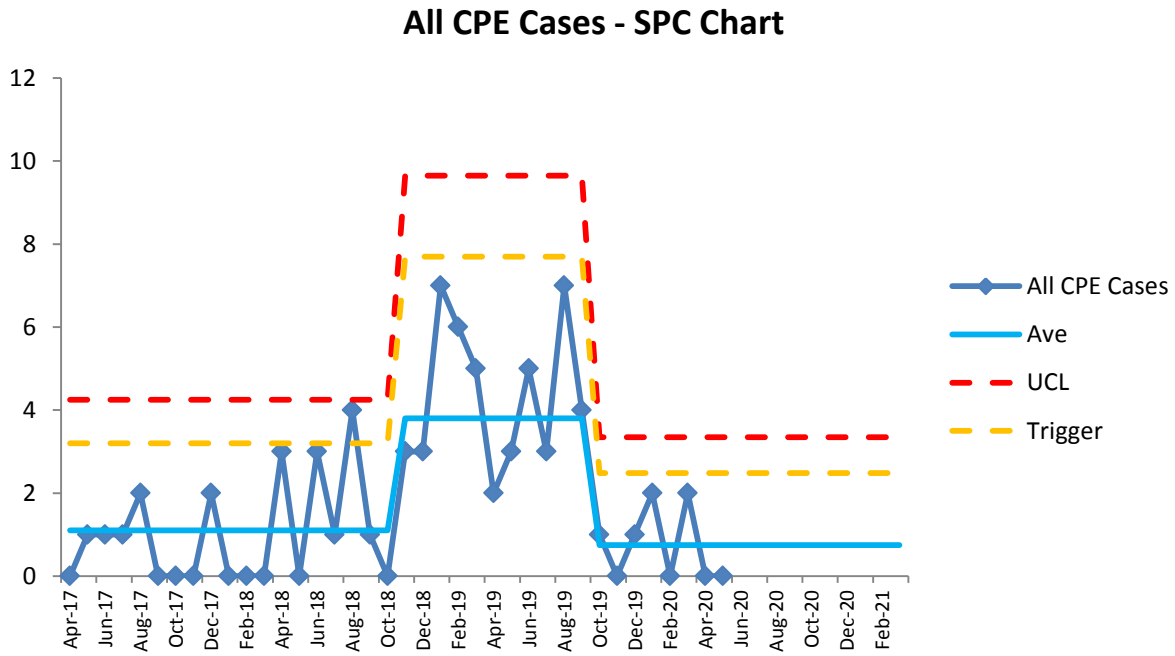
In the absence of central targets regarding reductions in *E. coli* bacteraemias the IPC team has adopted a target of 36; a 10% reduction based on the 41 cases in 19/20.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Hospital Onset Cumulative	3	4										
Target Cumulative	3	6	9	12	15	18	21	24	27	30	33	36

7. Carbapenemase Producing Enterobacteriaceae (CPE)

There has been a significant decrease in the number of CPE cases identified at the Trust and no cases since March 2020.



This chart demonstrates that there has been a statistically relevant reduction in all CPE cases.

8. Recommendations

Board members are asked to note the update on the range of infection prevention and control data.

Agenda Item No:	**15**
Meeting:	Board of Directors
Date:	25th June 2020

Title:	Maternity Update Paper
Purpose	This paper supports the presentation on Maternity Services to the Bolton NHS FT Trust Board and provides additional narrative to underpin the Maternity story.
Executive Summary:	A national 5 year campaign to transform maternity services in England with the publication of 'Better Births - a national maternity services review' (2016) coincided with the announced CQC inspection of maternity services at Bolton NHS FT. This paper describes the journey Bolton maternity services have had since 2016 implementing both the CQC recommendations and simultaneously implementing the key recommendations within 'Better Births'. It is useful to note that when the CQC inspect maternity services now, they are benchmarking against the recommendations of 'Better Births' and that is why there is an emphasis of this in the paper. This paper describes that journey by highlighting what we are doing well in that 4 year period, and also describing the current challenges the Family Care Division face in achieving this ambition of moving from good to outstanding at the next CQC inspection.
Previously considered by:	6 monthly update from the Family Care Division to the Board
Recommendation Please state if approval required or if for information	For information

Confidential y/n	

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

Prepared by:	Jackie Smith, FCD Governance Lead & Val Clare HOM/ DND	**Presented by:**	Marie Forshaw, Director of Nursing, Midwifery and AHPs

Maternity Report – Good to Outstanding

Introduction

Bolton NHS Foundation Trust aspires to be a 'super centre' for maternity, neonatal and children's services providing safe, quality care to women and their families with a birth rate of approximately 6,000 per year. We volunteered and became a national pioneer site for 'Better Births' (2016), whereby we are committed to offering women and their families' personalised care and the choice of where to receive their care throughout the pregnancy continuum. The maternity and neonatal team have a wealth of expert knowledge, specialist skills and experience to support and care for women and their families during pregnancy, birth and in the early weeks following the birth of their baby.

We are committed to providing the highest quality care possible in order to improve outcomes, to reduce inequalities and avoid unwarranted variations in care. The Family Care Division strive to enable our teams to train together to become a high performing team and support them to deliver care that is women centred. All of this is achievable in our organisation which is deemed 'outstanding' for being 'well led' (CQC 2019). We want to maintain a culture which promotes innovation, continuous learning, and break down organisational and professional boundaries.

Context on maternity provision in Bolton NHS FT

We are currently within year 4 or the '5 year forward view of maternity services' (5YFV). In 2016 there was the publication of 'Better Births' that arose following a national review of maternity services. This was instigated after the publication of the Kirkup report into the failings of the maternity services at Morecambe Bay, and has led to the maternity transformation currently being seen.

Better Births gave maternity providers a list of objective which collectively should ensure 'better births'. That is, births that are kinder, safer, and responsive with services wrapped around the needs of women and their families. The 6 key objectives within 'Better Births' are listed below, with Bolton's response to them. It is useful to note that 2016 was the time of the announced inspection at Bolton so the improvements described in this report are in response to both the recommendations from the 2016 inspection and also to the publication of the 5YFV.

The 6 key objectives to emerge from 'Better Births':

At Bolton, we believe that women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in one of our MLUs, or onsite in the obstetric led unit of the Delivery Suite. It is important that women are provided with information and evidence on the safest place for her to birth. On occasion a woman will make a personal decision on an option that may not be in line with the recommendations or evidence. In these circumstances the woman will be supported to have the birth experience she wants, and the team will put plans in place to mitigate any possible risks and have an agreed contingency in place with the woman if required.

We strive to book women by 12+6 weeks gestation; this is a national standard so women can commence antenatal and newborn screening early and be in the optimum health for pregnancy. By booking at this early gestation there can be a discussion on the benefits and

risks associated with each place of birth option. We undertake an initial risk assessment with each woman and begin to plan her personalised care journey. Bolton has been achieving 88%-89% of this target over the last year, and in the last 6 months, Bolton has begun to regularly achieve and exceed the target of 90%. We are the second best performers on this standard in Greater Manchester and Eastern Cheshire after Macclesfield maternity services.

Continuity of Carer (CoC) - The national ambition is for each maternity provider to have achieved 20% CoC by March 2019-20, 30% by 20-21, and most women (>50%) by March 2021 onwards. In May 2020 we had achieved 29% of our women booked onto a CoC pathway. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally. Since the CoC model has been introduced nationally in March 2019, Bolton has adopted a blended approach, trying different models for different staffing groups and different cohorts of women. The NHS Long Term Plan (2019) advises that women from BAME communities have poorer obstetric outcomes and sets a goal that 75% of women from these communities receive CoC by 2024. Bolton is not an outlier for poor outcomes in this cohort of women, but in response to the NHS Long Term Plan, we have recently recruited a Specialist Midwife for Cultural Liaison. Having come into post in April 2020, she has been tasked with scoping out what needs to be improved for the pregnant women of Bolton within these BAME communities and will be supported to implement the necessary changes which will include improving how we maximise the benefits of using interpreting services.

In line with the Better Births recommendations we currently plan that each team of community midwives have an identified obstetrician who can get to know and become part of a named geographical population for Bolton, and can advise on issues as appropriate. This will ensure the whole team from midwife to woman and obstetrician is clear on the plan for that individual woman. This is opposed to the community midwife referring the high risk woman into ANC to the care of another team of clinic midwives. This aspiration is gold standard to improve outcomes and achieve the national safety ambition to reduce maternal deaths, stillbirths, brain injuries and premature births as the evidence informs us that a woman who is known to her care givers will have a better outcome for herself and her baby. Thus, the importance of personalised care and continuity of care.

At Bolton, everything we do is to ensure we provide safe care. We investigate with integrity and honesty when things go wrong. Within the Family Care Division we have excellent systems in place to identify and monitor incidents and near misses. We are open and transparent and strive to ensure the learning is cascaded back to the teams. We work alongside the Health Safety Investigation Branch (H-SIB) who meet with us quarterly and update us on our safety performance from our cases that meet their criteria to investigate. They are assured of our performance to date and have not raised safety concerns that were not already addressed within the Division. Of the 3 cases investigated and finalised by H-SIB

since April 2019, no major safety recommendations have been identified. 2 have returned no safety recommendations, and 1 case identified only minor safety recommendations which had already been addressed through our own internal investigation.

In line with the national safety ambition, to provide unfettered communication 'from floor to board', we have a board level champion for maternity services to ensure a board level focus on improving safety and outcomes as part of improving maternity services; this is the Director of Nursing, Midwifery and AHPs. In accordance with the CNST safety standards, she meets with the Midwifery, Neonatal and Obstetric safety champions bi-monthly and is appraised on the quality and safety within the maternity and neonatal services and any safety improvement initiatives taking place.

At Bolton we achieve 1:1 care in labour over 98% of the time, and our Birthrate plus is at the optimum 1:27 (expected range 1:28-1:31). We report red flags for staffing 3 times a day. All Maternity diverts are reported to the Greater Manchester and Eastern Cheshire Strategic Clinical Network via the Greater Manchester and Eastern Cheshire Maternity Safety Lead, with completed RCA's for learning. Feedback from the Network demonstrates good performance for Bolton with low numbers of Diverts compared to peer.

The 5YFV recommendation for better postnatal and perinatal mental health care has been addressed at Bolton with the appointment in 2018 of a Specialist Midwife for Perinatal Mental Health, along with the recruitment of a small team to support her. The Specialist Midwife works in partnership with the designated perinatal mental health obstetrician to work towards achieving significant positive impact on the life chances and wellbeing of the woman, baby and family. Women at Bolton have access to their midwife and the obstetrician as they require after having had their baby. Those requiring longer care, have a personalised plan in place and the Specialist Midwife ensures there is appropriate provision and follow up in the postnatal period. At Bolton, we ensure a smooth transition between midwife, obstetric and neonatal care, and on-going care in the community from their GP and health visitor. The Health Visiting team also sit under the Family Care Division.

Bolton has well embedded Multi-professional working between the midwives, obstetricians, anaesthetists and other professionals to deliver safe and personalised care for women and their babies. The evidence tells us those who work together should train together and multi-professional learning and multi- professional training is a standard part of continuous professional development, both in routine situations and in emergencies. At Bolton we do this formally through PROMPT (Practical Obstetric Multi-professional Training), a package developed with the aim of reducing preventable harm to mothers and their babies. This is mandatory for all midwives, obstetricians and maternity anaesthetic staff. Compliance is also monitored through the CNST safety standards. Due to Covid this had been suspended nationally, but has restarted again on 8th June. PROMPT is increasingly focussing on Human factors and situational awareness. The multi-disciplinary team benefitted from an external company 'Treema' providing additional training on Human Factors which has been incorporated into our PROMPT training.

Bolton NHS FT is part of the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS). In order for women to have personalised care, safety and choice it is necessary for organisations to stop working in silos, and to work together, and that is what LMSs and the Maternity Transformation Board are assisting us to do. In January 2019, Pennine maternity services birthed their first baby with us at Ingleside, and it is models such as this that we aspire to replicate such as the potential for joint teams providing a home birth service.

Ingleside MLU, established in April 2018 is a community where maternity services, both antenatally and postnatally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies.

GMEC providers and commissioners work together with all providers working to common agreed standards and guidelines. This practice goes towards reducing unwarranted variation and a woman should not have a poorer outcome due to her postcode in GMEC. Since 2016, Bolton has participated as professionals, providers and commissioners coming together on a larger geographical area through Clinical Networks, and a Consultant Obstetrician from Bolton is the chair of the GMEC Strategic Clinical Network. This is coterminous for both maternity and neonatal services where we share information, best practice and learning, provide support and advise about the commissioning of specialist services to support the Local Maternity System (LMS).

The Family Care Division works in partnership with the maternity commissioners, both Bolton and Salford who are involved and proactive in taking clear responsibility for improving outcomes and reducing health inequalities, by commissioning against clear outcome measures. The commissioners empower the Family Care Division to make service improvements and they monitor our progress regularly.

CQC Inspection 2016

In 2016, Bolton NHS Foundation Trust was inspected by the CQC. Maternity services were rated good for all domains.

Maternity and gynaecol	Good	Good	Good	Good	Good	Good

There were no MUST dos' or SHOULD do's for Maternity following the inspection. The only recommendation identified for maternity services was to consider improving the electronic patient management system. This was to be built into the Trust EPR solution. Maternity transformation funding was applied for, to enable systems to share data. Maternity services use K2 electronic systems and E3. These are linked to Badgernet. The maternity electronic patient management system is not currently linked into the Trust EPR solution although prescribing and ordering is in place. Since this time, things have moved forward in that the Greater Manchester and Eastern Cheshire Local Maternity System are exploring having an electronic solution together. This will enable women to have choice and move between maternity providers where they will have the ability to communicate with each other on the same electronic system.

CQC Inspection 2018

In December 2018, Bolton received an un-announced re-inspected by the CQC, with a focus on well-led, urgent and emergency care, medicine and maternity services. All maternity areas were visited, including obstetric theatres. Staff, patients and relatives were spoken with as part of the inspection, and very positive feedback was received. Maternity was again rated good across all domains.

Maternity and gynaecol	Good	Good	Good	Good	Good	Good

The Family Care Division are proud of this achievement but are cognisant that the implementation of Better Births to a very high standard , as well as demonstrating continually learning, compassionate leadership and outstanding patient experience are crucial to achieving the expectation of outstanding in a future inspection. The Family Care Division work closely with Maternity Voices Partnership to continuously improve our services.

Safer Births

The Family Care Division are committed to delivering the maternity national safety ambitions:

- To reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur soon after birth by 20% by 2020, and 50% by 2025.
- Reducing national rate of preterm births from 8% to 6% by 2025.

The Division continues to successfully deliver against all national maternity safety initiatives:

- Saving Babies Lives 2 (SBL 2) care bundle
- Better Births - national maternity services review
- Spotlight on Maternity Services
- Maternity and Neonatal Safety Collaborative
- Each Baby Counts
- Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBBRACE-UK)
- Clinical Negligence Scheme for Trusts (CNST)

Significant progress has been seen with our stillbirth rates since the introduction of the Saving Babies Lives Bundles. However, the 12 month rolling average has seen an increase over recent months. This change has not reached statistical significance (as seen on the run chart below) and the department's performance is still better than at the time of the previous MBRRACE report. We have, however, looked at the SBL work streams to make sure that all the elements are in place and are on track. The Division has found no deviation in practice over the past few months, but will be keeping stillbirth rates under close review.

Smoking cessation results are still good. We also have had good results on the detection of small for gestational age babies over the past few months with our increased scanning.

The Division has seen an improvement in HIE (Hypoxic Ischaemic Encephalopathy; brain injury) rates over the past six months so that we now compare well with peers. The two babies cooled for HIE in the most recent quarter both had normal Magnetic Resonance Imaging (MR) scans. Early neonatal death rates have also improved following a spike in October 19.

NHSR and CNST – NHS Resolution is running its 3rd year of the maternity incentive scheme for Trusts to continue to support safer maternity care. As in year 2, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate that they have achieved ALL of the TEN safety actions will recover the element of their contribution relating to the CNST maternity incentive fund, and will also receive a share of any unallocated funds.

Bolton Maternity Services were successful in meeting all 10 CNST safety standards for a second year. We are actively working towards achieving these safety standards for a third consecutive year.

As a Trust our maternity services have been praised by NHSR (formerly NHS Litigation) and Capsticks for our open and transparent approach to incident investigation and our approach to involving patients at the earliest opportunity to enable early resolution. We have also been recognised by H-SIB as having fewer H-SIB investigations than peer.

How we compare to peer locally and nationally

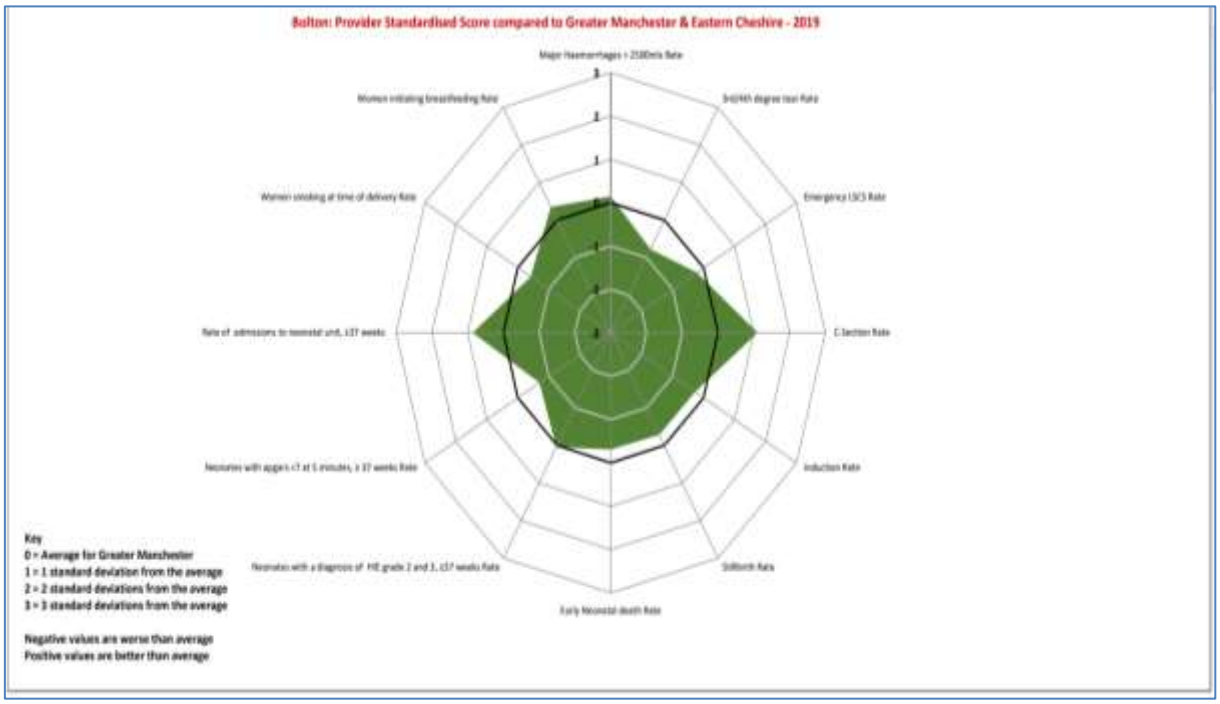
We monitor our performance through our local and regional dashboards, MBRRACE reports, National Maternity Survey, national safety reports, Better Births, Maternity Transformation Plan, patient and staff feedback, and feedback via Maternity Voices Partnership who we work closely alongside for service improvements.

We have a very good reputation within Greater Manchester and with our Commissioners and our Head of Midwifery works closely with the LMS, setting the strategic direction of maternity services locally. She also supports the national maternity leads to give assurance on safe maternity provision at Bolton NHS FT. A Bolton Consultant Obstetrician, is also the GM Maternity Strategic Clinical Network Lead.

Compared to peer locally and nationally Bolton maternity performance is good. Our perinatal mortality rates can be seen below and show that we are lower than North West OD and Greater Manchester for mortality across all gestations.

NWNODN- North West neonatal operational delivery network

MORTALITY Gestation 24-27 WEEKS	NWNODN	23%	24%	14%	16%	4%	33%	12%	19%	5%	23%	25%	13%	18%
	Greater Manchester	20%	9%	10%	11%	0%	20%	7%	7%	0%	27%	11%	0%	11%
	Royal Bolton	0%	0%	25%	0%	0%	0%	0%	0%	0%	29%	0%	-	8%
MORTALITY Gestation 28-31 WEEKS	NWNODN	0%	1%	4%	0%	2%	0%	2%	4%	0%	6%	0%	4%	2%
	Greater Manchester	0%	2%	0%	0%	0%	0%	5%	6%	0%	11%	0%	7%	3%
	Royal Bolton	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
MORTALITY Gestation 24-31 WEEKS	NWNODN	7%	7%	6%	7%	3%	9%	5%	9%	1%	12%	8%	6%	7%
	Greater Manchester	4%	4%	3%	6%	0%	7%	6%	6%	0%	16%	4%	6%	5%
	Royal Bolton	0%	0%	11%	0%	0%	0%	0%	0%	0%	15%	0%	0%	3%



Bolton compares favourably against peer, deviating only for 3rd and 4th degree tears and Apgars less than 7.

Improving 3rd and 4th degree tears

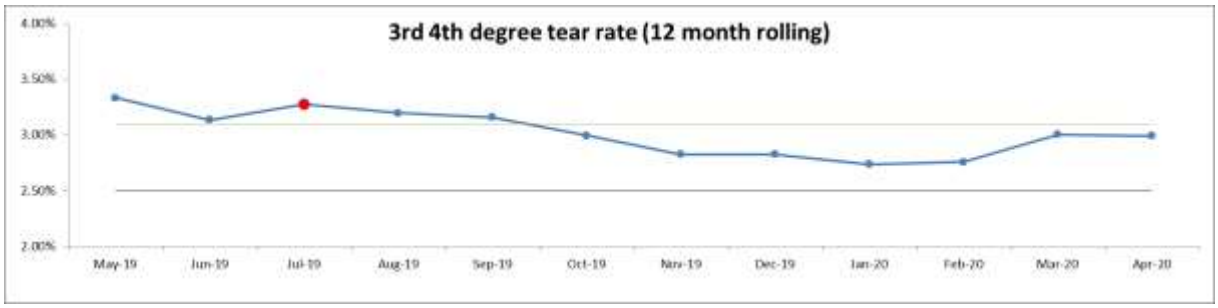
The Trust has signed up to the Obstetric Anal Sphincter Injury (OASI 2) care bundle pilot, in an attempt to reduce our 3rd and 4th degree tears. The OASI (1) bundle was established by the Royal College of Obstetricians and Gynaecologists (RCOG) as there was an increasing incidence in 3rd and 4th degree tears. The OASI 2 care bundle is the next iteration of this, and is an 18 month programme of measured interventions commencing in October 2020. A Consultant Obstetrician who is the author of the RCOG guidance, and an Advanced Midwife Practitioner are leading on this project for Bolton.

In the meantime there are monthly deep dives into the data to explore for possible causes for this performance, and the Head of Midwifery has requested additional training for midwives in intrapartum areas on the performing of episiotomies and perineal suturing.

Improving on performance of Apgar score of <7

The Apgar score is a score given to babies at birth which describes their condition at birth. The optimum score is >7. An Apgar score of <7 usually requires some form of resuscitation at birth. This is linked into a quality improvement, CNST safety standard work stream to avoid unexpected term admissions to neonatal units (ATAIN). We are actively working through and are on track with our ATAIN action plan. Improved monitoring is key to

improving outcomes for babies and we are currently 100% compliant with our CTG training on CDS for midwives and obstetricians who work on Delivery Suite.



Innovation Awards

In addition to our good performance data, Bolton NHS FT Maternity Services have also been recognised locally and nationally for our innovation:

Bolton maternity services have won the Innovation Award at the Northern 2019 Maternity and Midwifery Festival Awards for outstanding achievement and commitment in the maternity services at Ingleside.

The FCD were shortlisted for the Trust Patient Safety Award and were a finalist for the National HSJ Patient Safety Award 2019.

We achieved (TAMBA) now called Twins Trust exemplar status as 1 of only 4 Trusts.

We take an open and transparent approach towards incident reporting, investigating and learning from incidents. Maternity incidents are reviewed at our weekly Maternity Risk Meetings where learning is identified and actions taken to address deficits. The Division is well cited on areas of risk, with all rapid reviews and divisional reviews presented at our weekly Divisional Case Review Meeting chaired by the Divisional Medical Director and attended by the Senior Leadership Team. Areas of learning are discussed and change is implemented as required.

A number of risk areas have been identified which have impacted upon progress and a Business Case was presented to Execs in March 2019. This included an identified deficit in our Consultant numbers against peer and RCOG recommendations. The business case was approved and we are out to recruitment with 14 candidates shortlisted for interviews taking place next month. The benefits of the business case are highlighted below.

Ongoing areas for improvement:

- Inability to open a second maternity theatre when required leading to delay in emergency C-Section patient safety incidents - Revision of business case for fully staffed additional Theatre and Anaesthetic staff based on increase in activity.

- For a maternity unit with over 6,000 births per year (6,300 births in 2019/20) there is an expectation that 2 Theatres are able to run consecutively with the ability to open a second emergency theatre is required - Team mobilised from main theatres if an emergency arises.

- Maternity Estate - An agreement via a business case has been approved to a minor refurbishment and longer term planning for a new build unit. Many areas of the Estate are outdated, including temperature control issues.

- Inconsistent use of translation services for non-English speaking women - The Division have employed a BAME Specialist Midwife who has been carrying out a gap analysis. A memo has gone out to all Midwives regarding their duty to ensure translators are used at all contacts with non-English speaking women.

- The service plans to introduce Non English speaking clinics with face to face translators present; close working with the VSCE for collaborative work in the future; development of educational tools and workshops for staff, and working with Dads Matters and Professor Husain to develop work with BAME fathers.

Recommendations

To note the good progress that has been made within the maternity service at Bolton NHSFT since the last announced inspection of 2016 when we were rated as GOOD across all domains. Since the last inspection we have had a successful journey being a pioneer for the Better Births 5YVF and have seen our maternity outcomes for women and babies improve.

We will continue to achieve the recommendations within Better Births and national safety care bundles, but we will need executive support to assist us in our ambition to be outstanding with investment in the fabric of the maternity building and the addition of another maternity theatre.

Agenda Item No:	**17**
Meeting:	Board of Directors
Date:	25th June 2020

NHS Bolton NHS Foundation Trust

Title:	Guardian of Safe Working (GOSW) Quarterly Report
Purpose	The purpose of the report is to give assurance to the Board of Directors that the doctors in training are safely rostered and their working hours are compliant with the Terms and Conditions of the Junior Doctor Contract 2016.
Executive Summary:	The Exception Reporting process gives trainees the opportunity to highlight variations from their contractually agreed service requirements and educational activities. The system has been implemented to allow issues to be addressed in real time. The GOSW has oversight of all Exception Reports and is responsible for monitoring compliance to the process. Safety issues identified in these reports are escalated to the responsible DMD and Medical Director. An electronic system is in place in the Trust to report instances where hours are worked outside of safe working; limits as determined by the TCS; where breaks are missed; where there are deficiencies in service; and missed educational opportunities. The report contains details of the Exception Reports by department, grade and type with outcomes reached for the quarter, 1st January to 31st March 2020, together with activities and issues arising during the reporting period.
Previously considered by:	Workforce Assurance Committee
Recommendation Please state if approval required or if for information	

Confidential y/n	

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

Prepared by:	Joanne Warburton, MEM Dr Yunus-Usmani, GOSW	**Presented by:**	GOSW

Guardian of Safe Working Hours (GOSW)

Quarter 4 Report: 1st January – 31st March 2020

1. Introduction

1.1 This is the Quarter 4 Report concerning the progress of the Guardian of Safe Working and the Exception Reporting system for January to March 2020. The system is that established by the 2016 Terms and Conditions for Junior Doctors and Dentists.

1.2 The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. The Guardian role was introduced with the responsibility of ensuring doctors are appropriately paid for all their work and to ensure doctors are not working unsafe hours.

1.3 The Exception Reporting process gives trainees the opportunity to highlight variations from their contractually agreed service requirements and educational activities.

1.4 The GOSW has oversight of all Exception Reports and is responsible for monitoring compliance to the process; safety issues identified in these reports are escalated to the responsible Divisional Medical Director and the Medical Director.

1.5 An electronic system is in place in the Trust to report instances where hours are worked outside of safe working limits as determined by the Terms and Conditions; where breaks are missed; where there are deficiencies in service; and missed educational opportunities.

Table 1

Number of doctors in training	214 WTE
Number of doctors working less than full time	52
Time available in job plan for GOSW	1 PA/week
Administration support provided to GOSW	8 hours/week
Number of recognised Educational/Clinical Supervisors	138 both ES/CS 47 CS only

2. Exception Reporting Activity

2.1 Within the reporting period there were **57** exception reports submitted. This is compared to 125 submitted in Quarter 3, 96 submitted in Quarter 2 and 30 exception reports submitted in Quarter 1.

- **49** related to trainees working additional hours and being unable to achieve breaks
- **5** related to missed educational opportunities
- **3** related to both additional hours/missed breaks and missed educational opportunities

2.2 Of the **57** submitted;

- **55** have been actioned by the Educational Supervisor, GOSW or MEM.
- **2** remain open awaiting trending.

The GOSW has cleared all the previous ER some dating as far back from Oct 2019. Monthly reports are sent to the Divisional Medical Directors detailing the exception reports submitted per month and information relating to non-responders

2.3 Outcomes of the **55**:

Table 2

Number	Action agreed	Hours Equated
14	payment for additional hours worked	16.5 hours
29	time off in lieu	34.5 hours
12	no further action required	-

Costing information for the 'additional hours worked' payments from Bolton NHS FT and St. Helens & Knowsley lead employer finance teams, has been requested. Awaiting response.

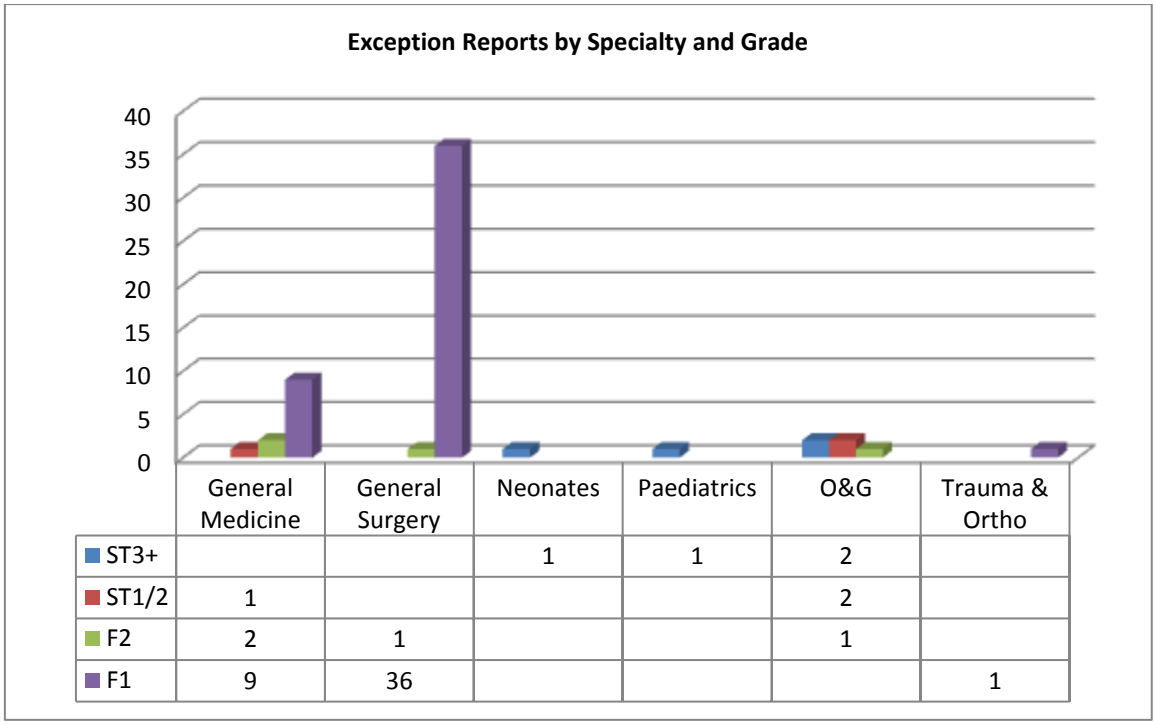
2.4 Exception Report response times:

Time taken to close exception reports continued to improve during January, February and March.

Table 3

Month	**Number of ERs submitted**	**Number closed**	**Number open**	**Number responded to and closed within 7 day timeframe**	**% responded to and closed within 7 day timeframe**
January	30	30	0	14	47%
February	18	16	2	9	56%
March	9	9	0	8	89%

Table 4



3. Themes

Work Schedule/Rota Reviews

3.1 Receiving advanced information regarding a doctor's next training placement is known to improve morale and reduce stress. NHS employers advise that doctors in training should receive their work schedule 8 weeks before commencement. On call rotas should be finalised and available 6 weeks prior to commencement of the new post.

3.2 Although the rota coordinators work hard to meet these targets the feedback from the doctors is that this doesn't always happen. This may be due to late notifications from the lead employer and is being monitored with the next rotations.

3.3 No work schedule reviews have taken place during the reporting period.

3.4 The rota pattern in some specialities has changed to an emergency rota (12 hourly on calls) and junior doctors have been reallocated to meet the needs of the service (either on the choice of the junior doctor or in agreement with the junior doctor) during the COVID19 pandemic. The Working Time Regulations 1998 (WTR) will be the fall back position for the duration of the pandemic with maximum weekly working hours increased to 56 hours.

Immediate Safety Concerns

3.4 Three exception reports were recorded by trainees as being an 'immediate safety concern'. These concerns related to General Medicine and Obs & Gynae. Explanations below as taken from the DRS4 system in the trainees own words:

3.5 *There were some unwell patients on the ward. There were several important family discussions. There was an urgent blood test that came back abnormal and warranted discussion with several specialties. I handed over what was appropriate to the on call; however I finished 2 hours late.*

3.6 *Several unwell/dying patients on the ward that I had to review throughout the day (on C4). A fall to review and several important family discussions prior to this. I handed over to the on call any appropriate jobs. I was unable to find any time to have a break throughout the day and had lunch whilst working.*

3.7 *No On call Gynaecology SHO was scheduled today on the OBGYN rota so I covered the On Call bleep from 8am-5pm. I was due to be covering the ward (M1/M6) and Antenatal clinic in the afternoon. Missed antenatal clinic as a result; and was difficult to fulfill all ward commitments due to On call responsibilities (clerking new patients/additional jobs on other wards). Due to prior commitments (and the fact that I was scheduled to work 8-5pm) I was unable to cover the shift between 5pm-8pm which meant the post was not filled during these hours.*

4. Fines

4.1 To date the GOSW has not levied any fines however trending for breaches of rest hours is in progress which might lead to fines in the future.

5. Staffing levels data

5.1 See **Appendix 1** for data requested by GOSW.

5.2 This area of work needs continued development to ensure the information gathered informs the GOSW to make decisions relating to exception reports. The information relating to locum spend is something that is intended to be included in future reports.

6. GOSW Activities

6.1 Meetings with rota coordinators and the BMA Industrial Relations Officer have taken place to highlight expectations of the GOSW role. Issues regarding access to information from rota coordinators and BMA support and advice to the GOSW were discussed.
6.2 Due to COVID19 the Junior Doctor Forum meeting on 25th March was cancelled, as was the quarterly JLNC meeting on the 22nd April and the Foundation clinical supervisor update on 23rd April.

6.3 The GOSW has proposed quarterly meetings with clinical supervisors in order to understand and address any issues faced with the working hours or exception reporting process. Unfortunately the first meeting scheduled for the 2nd April had to be cancelled due to COVID19.

6.4 The new BMA advice '***Terms and Conditions of Service for NHS Doctors and Dentists in Training (England): 2016 joint statement on the application of contractual protections during the pandemic'*** issued on 30/3/2020 has been escalated to all junior doctors and clinical supervisors.

https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Joint-statement-on-managing-rotas-NHS-Employers-and-BMA.pdf?la=en&hash=A91E5E8C448CEE795862F54877F20B7B2E587B4E

7. Summary

7.1 The GOSW has actively engaged with her new role and has shown her presence at team briefs and on the intranet system. A link is now active on the intranet for the GOSW. Emails and powerpoint presentations have been sent to all junior doctors and senior medical staff explaining the exception reporting system and the requirement of both groups of staff equally.

7.2 With excellent administration support, the GOSW has been able to clear all previous open exception reports. Only 2 remain open which require trending for missed break/rest hours.

7.3 The GOSW will continue to work with both junior doctors and senior colleagues to achieve cultural improvements to reinforce the exception reporting process.

7.4 The Medical Education team support the GOSW with the process of chasing up supervisors, to respond to exception reports in a timely manner, and thus improve response times.

7.5 A survey has been proposed for the first time by the GOSW and has been sent out to the trainees, supervisors and admin support staff recently. It is planned to be posted quarterly to record satisfaction towards the GOSW and role. The results will be analysed and added to future reports.

7.6 Trainee rotas are compliant when set however it remains difficult to confirm continued compliance with the junior doctor contract when accounting for the provision of cover for acute gaps in the rota.

7.7 Information relating to the cost of locum cover and the cost of exception reporting payments has been requested and shall be added as an addendum if received prior to submission of this report to the Trust.

8. Recommendation

8.1 The Board is asked to note the contents of this report.

Appendix 1

Staffing levels

Vacancies by month						
Specialty	**Grade**	**Month 1 January**	**Month 2 February**	**Month 3 March**	**Total gaps (average)**	**Locum Spend**
A&E	FY1-2	0	0	0	0	
	CT1-2	0	0	0	0	
	ST3-8	6	6	6	6	
	NTMG*	3	3	3	3	
Anaesthetics	FY1-2	0	0	0	0	
	CT1-2	0	0	0	0	
	ST3-8	0	0	0	0	
	NTMG*	0	0	0	0	
Medicine (General)	FY1-2	2	2	2	2	
	CT1-2	0	0	0	0	
	ST3-8	1	1	1	1	
	NTMG*	0	0	0	0	
Neonates	FY1-2	0	0	0	0	
	CT1-2	0	0	0	0	
	ST3-8	1	1	1	1	
	NTJG*	0	0	0	0	
	NTMG*	0.2	0.2	0.2	0.2	
Obs & Gynae	FY1-2	0	0	0	0	
	CT1-2	1.5	1.5	1.5	1.5	
	ST3-8	2.5	2.5	2.5	2.5	
	NTMG*	0	0	0	0	
Paediatrics	FY1-2	0	0	0	0	
	CT1-2	1	1	1	1	
	ST3-8	1	1	1	1	
	NTMG*	0	0	0	0	
Surgery ** (General)	FY1-2	0	0	0	0	
	CT1-2	0	2	2	1.33	
	ST3-8	0	0	0	0	
	NTMG*	0	0	0	0	

Trauma & Orthopaedics	FY1-2	0	0	0	0	
	CT1-2	0	0	0	0	
	ST3-8	0	0	0	0	
	NTMG*	0	0	0	0	
	Total	**19.2**	**21.2**	**21.2**	**20.53**	

*NTJG = Non-Training Junior Grade

*NTMG = Non-Training Middle Grade

** General Surgery has 3 full time long-term NTMG

Agenda Item No:	**17.1**
Meeting:	Board of Directors
Date:	25th June 2020

NHS Bolton NHS Foundation Trust

Title:	Guardian of Safe Working (GOSW) Annual Report
Purpose	The purpose of the report is to give assurance to the Board of Directors that the doctors in training are safely rostered and their working hours are compliant with the Terms and Conditions of the Junior Doctor Contract 2016.
Executive Summary:	All doctors in training at Bolton NHS FT are working under the 2016 Terms and Conditions of Service (TCS). The contract requires them to report all exceptional hours worked outside of their contracted hours. The data gathered from exception reports provides useful information about the intensity of the workload on each rota. It is a useful tool to alert the Trust to unsafe working practices that may lead to a reduction in patient safety. The data from this process is presented in this report alongside the report on rota gaps and vacancies over the last 12 months. Conclusions drawn from the data should take into account that non engagement in the process could lead to underestimation of junior doctor safe working. It is recognised nationally that not all junior doctors report the extra hours that they work outside their contracted hours for a variety of reasons. Important: Due to the increasing demand on the workforce during the COVID19 pandemic, doctors TCS may have changed to Working Time Regulations (WTR) 1998 as a fall-back position. Details in the report.
Previously considered by:	Workforce Assurance Committee
Recommendation Please state if approval required or if for information	Confidential y/n:

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

Prepared by:	Joanne Warburton, MEM Dr Yunus-Usmani, GOSW	**Presented by:**	GOSW

Guardian of Safe Working Hours (GOSW)

Annual Report: 1st April 2019 – 31st March 2020

1. Introduction

1.1 The Terms and Conditions of Service, (TCS) of the junior doctor contract (2016) requires the Guardian of Safe Working (GOSW) to submit quarterly reports as well as an annual report to the Trust Board via the Workforce Assurance Committee.

1.2 Quarterly reports have been submitted to the committee and this is the annual report to reflect the findings for the period 1st April 2019 to 31 March 2020.

1.3 As of February 2020 all doctors in training have now transferred onto the 2016 TCS.

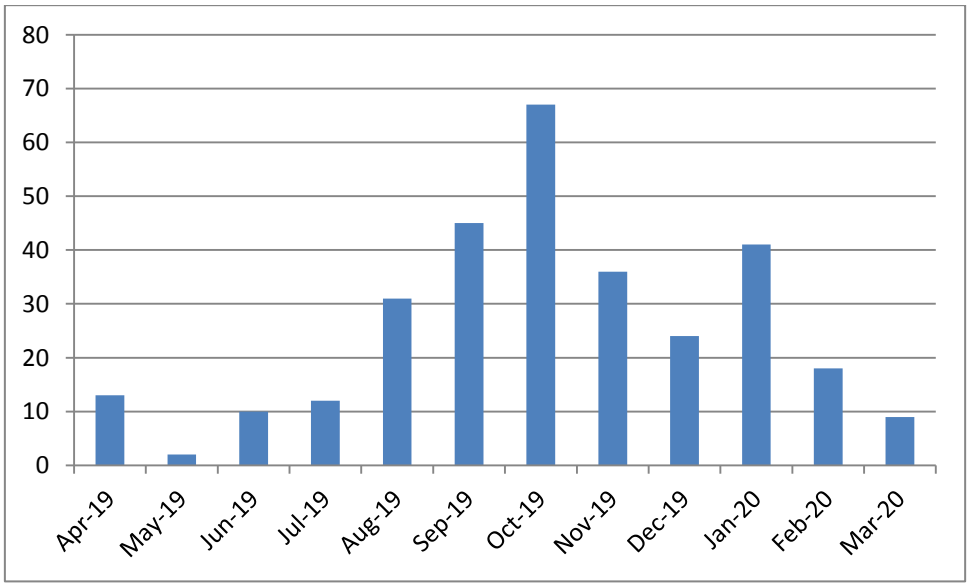
1.4 Due to COVID19, rota patterns may have changed to emergency 12 hour on call in many specialities and hence WTR 1998 would be the fall back position for the duration of the pandemic, as per the new BMA advice issued, and as highlighted in the last quarter report. This may lead to either less or no Exception Reports (ER) being generated from April onward. The GOSW and team will keep this under review and update in the next quarterly report.

Number of doctors in training	214 WTE
Number of doctors working less than full time	52

2. Exception Reporting Activity

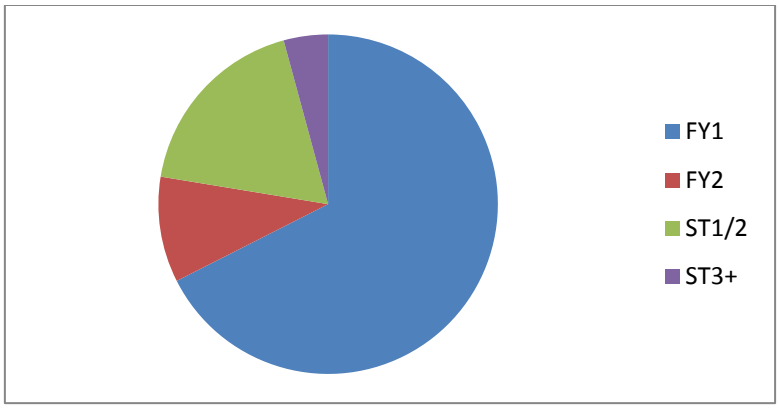
2.1 Doctors in training are asked to electronically submit exception reports when they work over their contracted hours, when they are unable to achieve breaks/rest periods or for missed educational opportunities. Within the reporting period there were **308** exception reports submitted.

2.2 Exception reports received by month



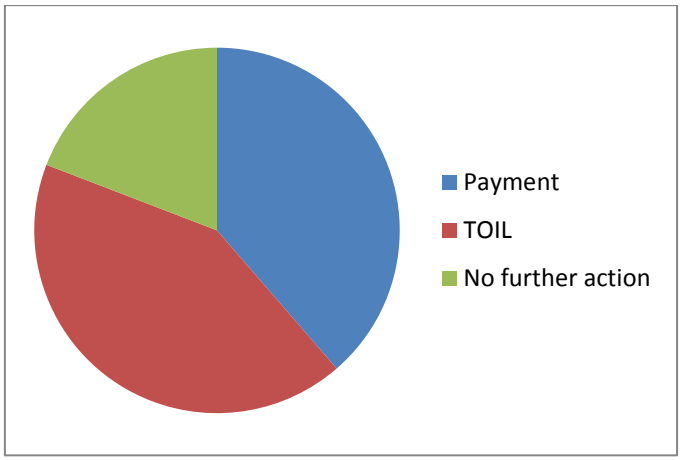
2.3 Exception reports received by grade

Grade	No of exception reports raised in this period	%
FY1	208	68%
FY2	31	10%
ST1/2	56	18%
ST3+	13	4%
Total	**308**	**100%**



2.4 Exception reports received by outcome

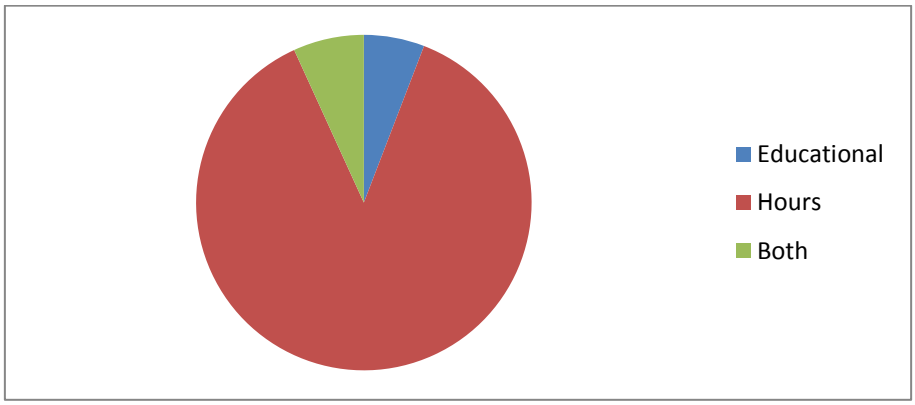
Outcome	No of exception reports raised in this period	%	Number of extra hours equates to
Payment for additional hours	119	39%	156.25
Time off in lieu	130	42%	147.25
No action required	59	19%	
Total	**308**	**100%**	**303.5**



2.5 Costing information for payment of additional hours has been requested and escalated by the GOSW to the Bolton payroll team and forwarded to the finance team for their perusal. Details, if received prior to presentation of this report by the GOSW to the Trust, would be added as an addendum.

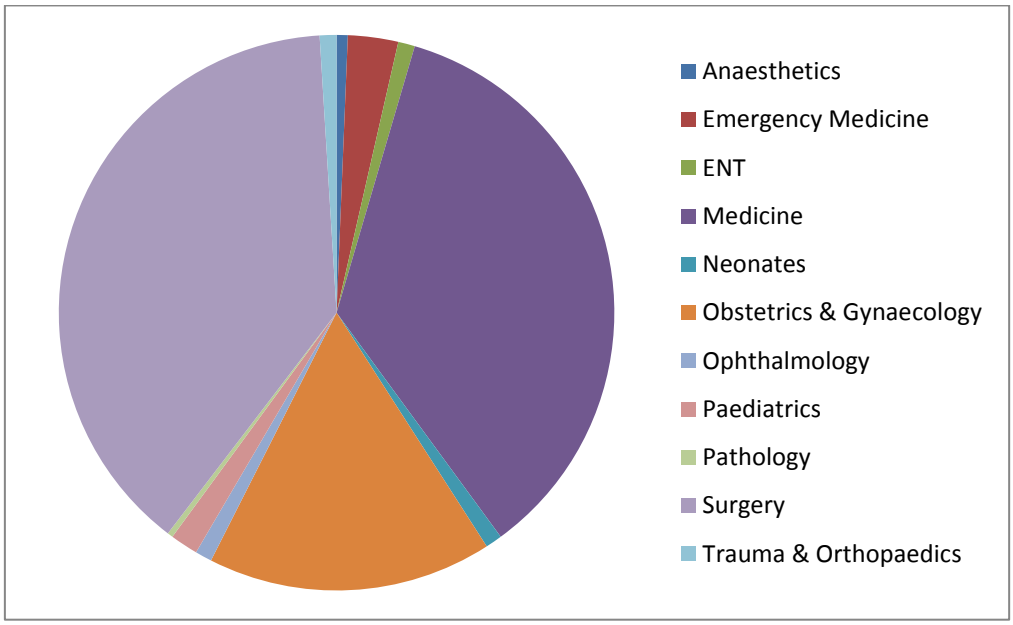
2.6 Exception reports received by type

Type	No of exception reports raised in this period	%
Educational	18	6%
Extra hours/missed breaks	269	87%
Both educational and additional hours	21	7%
Total	**308**	**100%**



2.7 Exception reports received by specialty

Specialty	No of reports
Anaesthetics	2
Emergency Medicine	9
ENT	3
Medicine	109
Neonates	3
Obstetrics & Gynaecology	51
Ophthalmology	3
Paediatrics	5
Pathology	1
Surgery	119
Trauma & Orthopaedics	3
Total	**308**



3. Immediate Safety Concerns

3.1 Twelve of the exception reports were identified by the reporting doctor as an immediate safety concern. Most of these were associated with low staffing levels, working extra hours due to workload and working extra hours due to differences in rota pattern.

4. Work Schedule/Rota Reviews

4.1 Two work schedule reviews have taken place over the reporting period.

4.2 The FY1 Surgical Rota was reviewed, with input from the doctors working on the rota, and changes implemented for the December 2019 rotation.

4.3 The Emergency Medicine junior doctor rota was reviewed, with junior doctor input, and the changes implemented in February 2020. These changes have been required to meet the change in the Junior Doctor Contract from a 1 in 2 weekend frequency to a 1 in 3 weekend frequency.

5. Fines

5.1 To date the GOSW has not levied any fines however trending for breaches of rest hours is in progress which might lead to fines in the future.

6. Junior Doctor Forum

6.1 As part of the TCS (2016) there is a requirement to hold a Junior Doctor Forum (JDF). The main purpose of the forum is to provide trainees with the opportunity to feedback about the contract and also to agree to how any money accrued from fines should be spent.

6.2 The JDF at Bolton meet on a quarterly basis. Due to COVID19, the meeting due to be held on the 25th March was cancelled but generally attendance is good from foundation trainees. More engagement from other grades would be welcomed.

6.3 During the reporting year the Trust was allocated £30k of Fatigue and Facilities funding to improve the facilities for junior doctors throughout the Trust. The use of this funding has been discussed at the JLNC and also at the JDF meetings. Final sign off was due to take place at the JDF meeting scheduled for the 25th March however the meeting was cancelled due to COVID19. This will be discussed and finalised at the next JDF.

7. Staffing levels data

		Q1			Q2			Q3			Q4			MONTHLY	
DEPT.	GRADE	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL	AVERAGE
A&E	FY1-2	2	2	0				0	0	0	0	0	0	4	0.44
	CT1-2	0	0	0				0	0	0	0	0	0	0	0.00
	ST3-8	10	10	0				14	0	0	6	6	6	52	5.78
	NTMG	3	3	0				3	0	0	3	3	3	18	2.00
ANAES	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				0	0	0	0	0	0	0	0.00
	ST3-8	0	0	0				0	0	0	0	0	0	0	0.00
	NTMG	0	0	0				0	0	0	0	0	0	0	0.00
GEN MED	FY1-2	4	4	0				2	2	2	2	2	2	20	2.22
	CT1-2	2.8	2.8	3.8				0	0	0	0	0	0	9.4	1.04
	ST3-8	4	4	3				1	1	1	1	1	1	17	1.89
	NTMG	1	1	0				0	0	0	0	0	0	2	0.22
NEO	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				0	0	0	0	0	0	0	0.00
	ST3-8	0	0	0				1	1	1	1	1	1	6	0.67
	NTJG	1	1	0				1	1	0	0	0	0	4	0.44
	NTMG	0.2	0.2	0				0.2	0.2	0.2	0.2	0.2	0.2	1.6	0.18
PAEDS	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				1	1	1	0	2	2	7	0.78
	ST3-8	2	2	0				1	1	1	0	0	0	7	0.78
	NTMG	0	0	0				0	0	0	0	0	0	0	0.00
OG	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				1.5	1.5	1.5	1.5	1.5	1.5	9	1.00
	ST3-8	0	0	0				2.5	2.5	2.5	2.5	2.5	2.5	15	1.67
	NTMG	0	0	0				0	0	0	0	0	0	0	0.00
GEN SURG	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				0	0	1	0	2	2	5	0.56
	ST3-8	0	0	0				0	0	0	0	0	0	0	0.00
	NTMG	0	0	0				0	0	0	0	0	0	0	0.00
T&O	FY1-2	0	0	0				0	0	0	0	0	0	0	0.00
	CT1-2	0	0	0				0	0	0	0	0	0	0	0.00
	ST3-8	0	0	0				0	0	0	0	0	0	0	0.00
	NTMG	0	0	0				0	0	0	0	0	0	0	0.00
TOTAL		**30**	**30**	**6.8**	**0**	**0**	**0**	**28.2**	**11.2**	**11.2**	**17**	**21.2**	**21.2**	**177**	**19.67**

8. Summary

8.1 The Trust is committed to improve the experience of junior doctors and work continues to be undertaken to support this.

8.2 Work schedule reviews have taken place where issues have been identified and action taken to address.

8.3 In addition to rota gaps, heavy workload and low staffing in some areas has led to late finishes as demonstrated by the large number of exception reports for this area. The GOSW will continue to monitor.

8.4 The majority of exception reports are submitted by FY1 doctors. The GOSW will continue to liaise with junior doctors, particularly with the grades and specialties who are not currently exception reporting to encourage use of the system.

8.5 All doctors in training are now on the new TCS as of February 2020.

8.6 The new GOSW commenced in post in March 2020 and is committed to working with the junior doctors and clinical supervisors to improve the working environment.

8.7 New quarterly meetings with clinical supervisors have been proposed by the GOSW. Unfortunately the first meeting was cancelled due to COVID19 but future dates will be circulated in due course.

8.8 Due to COVID19, all face to face meetings from mid-March onwards had to be cancelled including the JDF meeting, Foundation and Clinical Supervisor meetings. Recent JLNC meeting did occur via Webex on 7th May 2020.

9. Recommendation

9.1 The Board is asked to note the contents of this report.

Agenda Item No:	**18**
Meeting:	Board of Directors
Date:	25th June 2020

NHS Bolton NHS Foundation Trust

Title:	Freedom to Speak Up: 2019/20 Annual Report
Purpose	This report provides an update on Freedom to Speak Up activity within the Trust during 2019/20.
Executive Summary:	Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement. The FTSU approach continues to be embedded to support the organisation to develop an inclusive and transparent culture.
Previously considered by:	Workforce Assurance Committee
Recommendation Please state if approval required or if for information	Board of Directors are asked to: • Note the details of the paper and continue to support the FTSU approach.

Confidential y/n	No

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

Prepared by:	Tracey Garde, FTSU Guardian Lisa Gammack, Associate Director of OD	**Presented by:**	Tracey Garde, FTSU Guardian James Mawrey, Director of Workforce & OD

1. Introduction

1.1 Effective speaking up arrangements help improve patient safety, staff experience and continuous improvement. Every member of staff needs to feel valued, listened to and treated fairly at work. A positive environment with a supportive culture is a key element of the NHS People Plan. This report provides an update from the Freedom to Speak Up (FTSU) Guardian on FTSU activity for 2019/20.

1.2 At the time of writing this report there are 18 FTSU champions across the organisation. They have been trained to support staff to raise concerns and raise the profile of speaking up within their division. The FTSU network is diverse in terms of the champions' gender, ethnic background, job roles and employing department. A full list of champions is attached at appendix one.

1.3 The FTSU approach continues to be promoted via our normal internal communication channels, corporate induction programme, presentations and workplace visits.

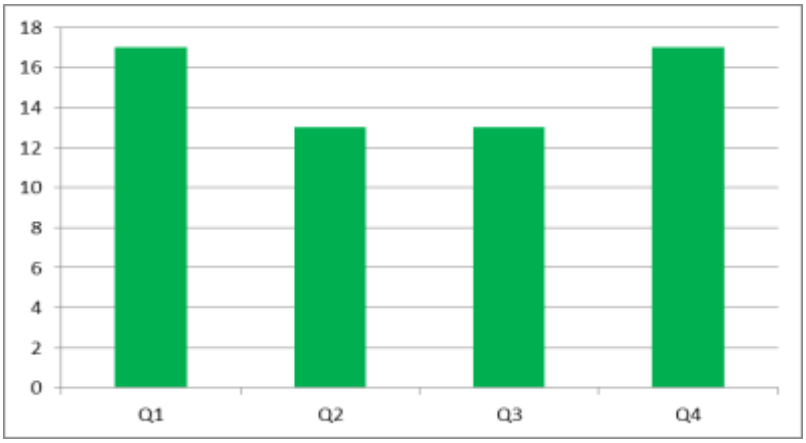
1.4 The FTSU Guardian continues to meet monthly with the Chief Executive and the Executive Director of Workforce and OD. At these meetings the Guardian provides an overview of the cases reported, the themes identified and actions taken. The Chief Executive and Executive Director ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases and ensure that good practice and learning is shared across the organisation.

1.5 The Guardian remains fully engaged with the National Guardian's Office and the North West FTSU Guardians Network to learn and share best practice. The FTSU Guardian has also expressed an interest in becoming the Co-Chair of the NW Network and is awaiting a decision on this.

2. 2019/20 FTSU Analysis

2.1 During the period from 1st April 2019 to 31st March 2020 a total of 60 cases were reported through the FTSU route. This is significantly higher compared to the previous year where a total of 16 cases were reported. This evidences that the refreshed FTSU approach is having a positive effect and more staff are aware of how to raise concerns.

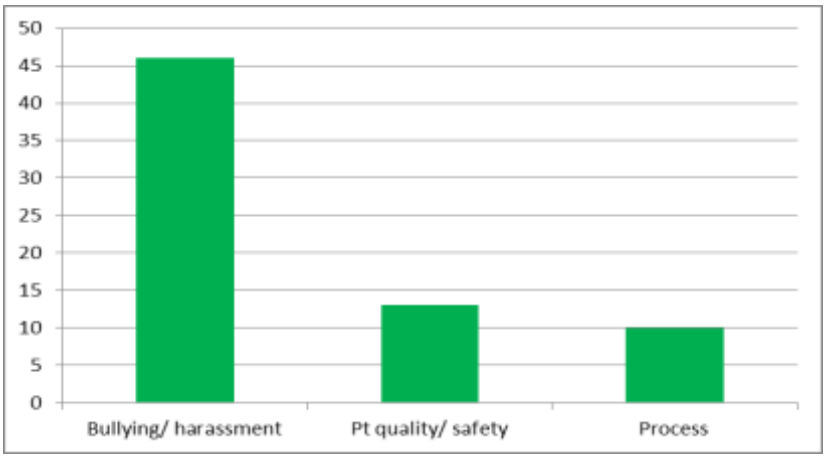
2.2 The graph below shows the number of cases during 2019/20 broken down by each quarter. The Guardian formally reports the number of cases for each quarterly period to the National Guardian Office.



2019/20 breakdown of cases by quarterly reporting periods

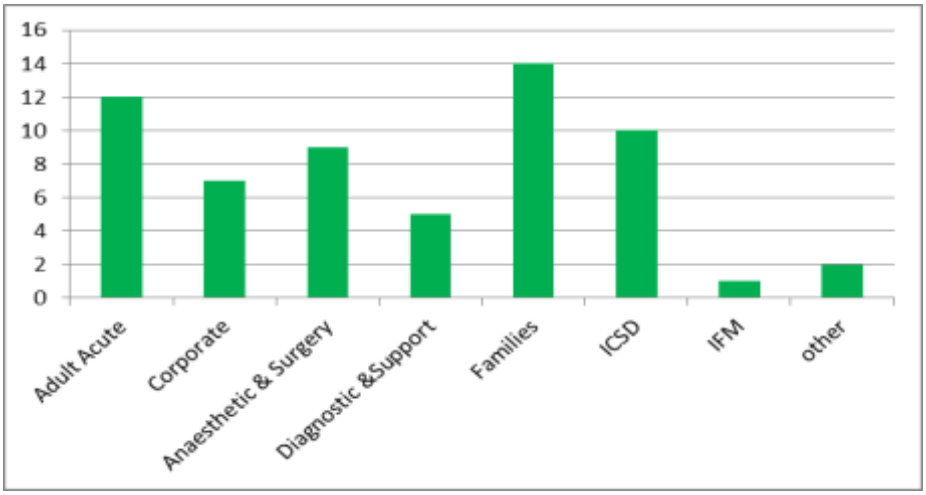
2.3 The cases in Bolton related to allegations of bullying/ harassment, patient safety/ quality issues and process issues are detailed in the graph below. Some staff raised concerns that were both behavioural issues that also impacted on patient quality of care. Having reviewed this matter externally with other NHS organisations it is

'normal' for bullying/harassment to make up the largest proportion of FTSU matters raised.



2019/20 breakdown of types of cases

2.4 The graph below provides a breakdown by division of the number of staff who approached the FTSU Guardian or Champion to speak up. Seven of the concerns raised by staff in the Families Division related to the same clinical area and a robust action plan was put in place to address the concerns raised. The two staff who have been classed as 'other' were employees who had previously worked for us but had since left the organisation. One ex-employee worked in the Anaesthetic and Surgery Division and the other in the Diagnostics and Support Services Division. Former employees can provide the organisation with valuable feedback which can be used to help make the Trust a great place to work.



2019/20 Divisional breakdown of cases

2.5 The table below provides a divisional breakdown of cases by theme. Some staff concerns related to both patient safety/quality and bullying/harassment.

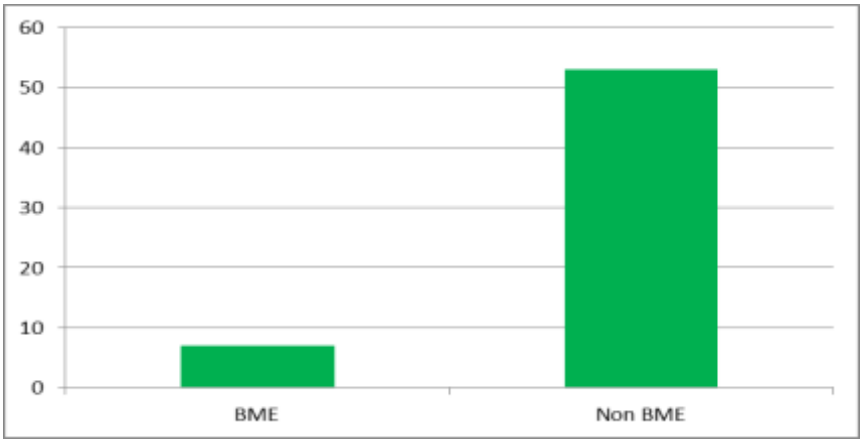
	Number of staff	Patient Safety / Quality	Elements of Bullying / Harassment	Process
Adult Acute	12	2	7	4
Corporate	7	0	6	1
Anaesthetic & Surgery	9	2	7	1
Diagnostic & Support	5	0	4	1
Families	14	9	10	2
ICSD	10	0	9	1

IFM	1	0	1	0
Other	2	0	2	0
Total	**60**	**13**	**46**	**10**

2019/20 Divisional breakdown of cases by theme

2.6 Of the 60 cases raised in 2019/20, actions have been taken or started to resolve every case. The Chief Executive and the Director of Workforce and OD are sighted on the progress being made in these cases through the monthly meetings.

2.7 Approximately 12% of the total number of cases raised during 2019/20 were raised by BME employees and 88% by non-BME employees. The table below shows the breakdown by ethnicity. This is proportional as BME staff make up 12.4% of the our workforce.

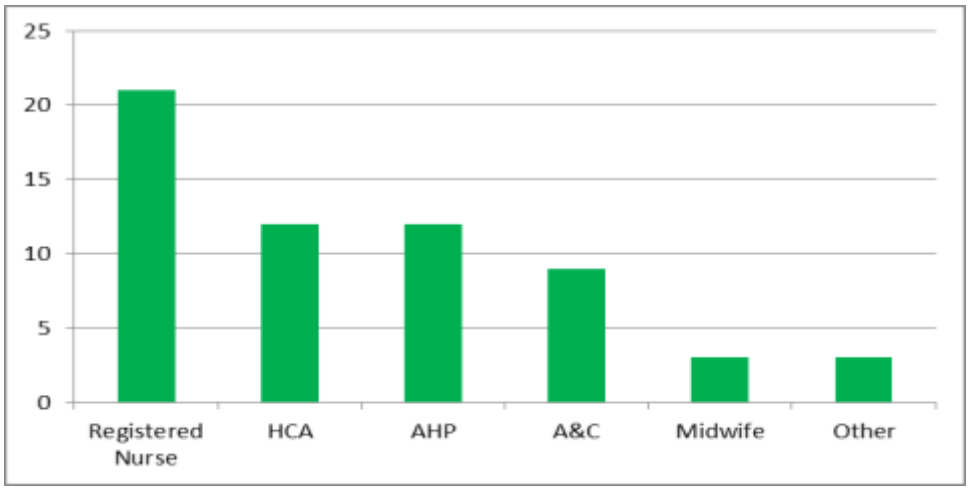


2019/2020 Breakdown by ethnicity

2.8 The FTSU Guardian has attended the Trust's BME Staff Forum to promote the FTSU process and addresses any concerns that forum members have about the FTSU culture. The Guardian regularly attends the BME Staff Forum meetings and time is made available at the end of forum meetings for BME staff to talk privately to the Guardian which has been positively received by the group.

2.9 The Guardian has taken active steps to recruit champions from a BME background to ensure that the network reflects the diversity of our organisation and to encourage staff to speak up about any issues they have.

2.10. Given that Nursing is the highest proportion of our workforce it comes as no surprise that the highest majority of cases during 2019/20 have been raised by nursing staff - either qualified or unqualified. There have been no cases where medical staff have approached the Guardian or champions within this time period.



2019/2020 Breakdown by staff group

3. FTSU Champions

3.1 To help further embed our FTSU approach the Guardian has recruited and trained six additional champions over the last three months. Two medical consultants from AACD and ICSD have recently joined the FTSU champion network, which it is hoped will further raise the profile of speaking up within the medical workforce. In addition, a specialist nurse, band 6, in AACD, a Midwife, a Radiographer and a Clerical Supervisor, band 5, in Health Records have also been selected to join the FTSU champions network. Details of all the champions with contact details are available on the intranet and promoted via our internal communication channels.

4. Improving our Speaking Up Culture

4.1 The Guardian continues to promote the FTSU approach to staff groups across the Trust via walkabouts, attending staff forums, holding awareness sessions.

4.2 The Trust's speaking up culture is measured through the Go Engage quarterly surveys. The table below shows the overall percentage of staff that responded positively to the specific FTSU questions.

- **I am aware of how to raise a concern under the Freedom to Speak Up process.**

	Q1	Q2	Q3	Q4
Trust	63.72%	64.17%	74.93%	72.26%
Adult Acute	69.88%	68.35%	74.58%	74.68%
Elective Care	56.29%	56.03%	67.31%	64.71%
Corporate	78.79%	82.81%	94.23%	81.13%
Family Care	62.77%	63.16%	85.25%	69.80%
ICS	55.56%	60.61%	60%	75.81%

- **I feel safe to raise a concern under the Freedom to Speak Up process.**

	Q1	Q2	Q3	Q4
Trust	58.61%	62.99%	64.01%	66.60%
Adult Acute	61.44%	64.56%	69.49%	72.15%
Elective Care	52.98%	56.74%	58.65%	55.88%
Corporate	69.70%	75%	78.85%	64.15%
Family Care	56.38%	65.79%	59.02%	67.79%
ICS	61.11%	61.61%	58.33%	70.16%

4.4 Our 2019 NHS national staff survey results showed an increase in staff feeling secure in raising concerns about clinical practice from 72.9% to 75.6% plus an increase in confidence that the organisation would address their concerns from 65.9% to 67.8%. These scores are well above the average score for our benchmarking group which further demonstrates an improvement in the culture of speaking up and the confidence that staff have that their concerns will be acted upon.

5. Bullying and Harassment

5.1 The NHS Staff Survey shows that Bullying & Harassment continues to be an issue across the NHS. In Bolton the NHS Staff Survey shows that 13.2% of our staff reported that they had suffered personally from bullying/ harassment from managers. This is an approximate 2% increase compared to the previous year and is above average compared to our benchmark group. In addition, 18.3% of staff reported personal experience of bullying/harassment from colleagues. This is 1% higher than our previous year's results but only 0.3% higher than the average.

5.2 Our FTSU cases during 2019/20 have further highlighted that we need to do more to communicate to staff how we expect them to behave and what constitutes bullying and harassment. The work that is currently being done on developing a set of employee

and manager behaviours will provide us with additional tools to help ensure that we recruit people with the right behaviours, we reward great behaviour and tackle any behaviour that does not reflect the organisation we want to be.

6. Looking Forward

6.1 The Guardian intends to take the following action before the end of June 2020:

- Refresh the FTSU promotional materials e.g. video, posters, pull-up banners, intranet information etc.
- Restart the monthly champions meetings and awareness sessions via Webex and invite the Chief Executive to a future meeting (date to be confirmed).
- Refresh the FTSU content within the Trust's new corporate induction session which recommences in June 2020.
- Amend plans to hold promotional activities and learning sessions in October 2020 as part of FTSU month.

7. Conclusion

7.1 It is evident that the refreshed FTSU approach is having a positive impact across the organisation. Through the concerns raised we are gaining new insights into our culture and how we can improve systems, approaches and our environment to make speaking up business as usual within this Trust.

8. Recommendations

8.1 The Board of Directors are asked to:

- Note the details of the paper and continue to support the FTSU approach.

Appendix 1 – FTSU Champions as at May 2020

Kirsty Buckley **NEW**	Haematology Specialist Nurse	Adult Acute Division
Natalie Walker **NEW**	Acute Physician	Adult Acute Division
Julie Pilkington	Acting DND	Anaesthetics and Surgical Division
Rahila Ahmed	Equality, Diversity & Inclusion Lead	Corporate Services Division
Tony Mackay	Falls Co-ordinator	Corporate Services Division
Neville Markham	Chaplain	Corporate Services Division
Rachel Davidson **NEW**	Senior Radiographer	Diagnostic and Support Services
Rebena Khan	Pharmacist	Diagnostic and Support Services
Louise Quigley **NEW**	Health Records & Receptions Coordinator	Diagnostic and Support Services
Jeanette Fielding **NEW**	Midwife	Families Care Division
Alison Toft	Paediatric Occupational Therapist	Families Care Division
Bim Williams	Obstetrics & Gynaecology Consultant	Families Care Division
Simon Crozier	Principle Service Lead / Advanced Physiotherapist- Stroke	Integrated Community Services
Atir Khan **NEW**	Consultant Physician Diabetes & Endocrinology	Integrated Community Services
Suzanne Lomax	Clinical Service Lead – Palliative & End of Life Care	Integrated Community Services
Gina Riley	Deputy Divisional Nurse Director	Integrated Community Services
Chris Vernon	Integrated Neighbourhood Team Leader	Integrated Community Services
Gareth Valentine	Staff Nurse	Integrated Community Services

Bolton NHS Foundation Trust

Integrated Performance Report

May 2020

Guide to Statistical Process Control

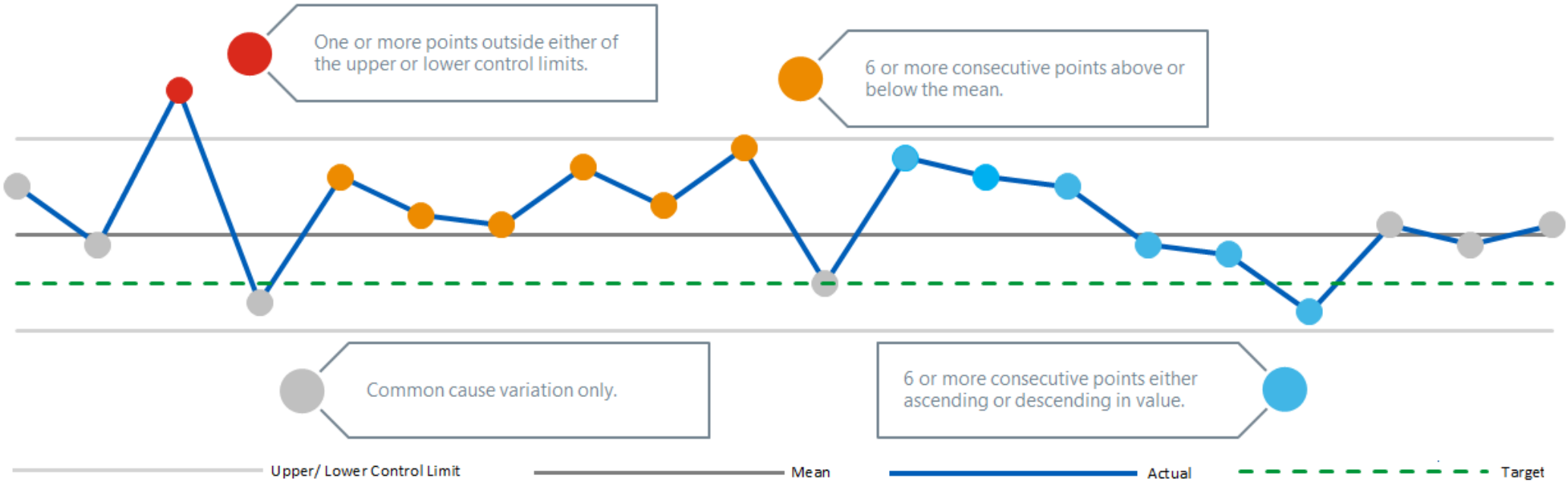
NHS Bolton NHS Foundation Trust

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – 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. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **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.

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.



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	1	0	1	0	1	0	14
Infection Prevention and Control	5	0	2	1	0	0	0	8
Mortality	3	0	0	0	1	0	0	4
Patient Experience	12	1	0	0	3	5	0	11
Maternity	7	0	1	2	0	1	0	9
Operational Performance								
Access	5	0	2	3	1	0	4	7
Productivity	5	0	3	1	2	0	1	10
Cancer	5	1	0	0	1	2	1	4
Community	0	1	3	0	0	0	0	4
Workforce								
Sickness, Vacancy and Turnover	3	0	0	0	0	0	1	2
Organisational Development	2	1	0	0	1	1	0	3
Agency	1	0	2	0	0	0	0	3
Finance								
Finance	2	1	1	0	0	1	1	2
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	Indicates that we are consistently meeting the target for the indicator in question.
F	Indicates that we are consistently falling short of the target for the indicator in question.
?	Indicates that we will not consistently meet the target for this indicator as the target is within the range of common cause variation.

Quality and Safety

Harm Free Care

Pressure Ulcers
In May there was a reduction in category 2 hospital acquired pressure ulcers, however there were 2 hospital acquired category 3 pressure ulcers in May, which is an increase. In the community, there was a reduction in category 2 pressure ulcers, and a small increase, by 1, of category 3 pressure ulcers. There continued to be no category 4 pressure ulcers in May.
There were 5 lapses in care across both hospital and community settings in May, 3 of these in the hospital setting, and 2 in the community.

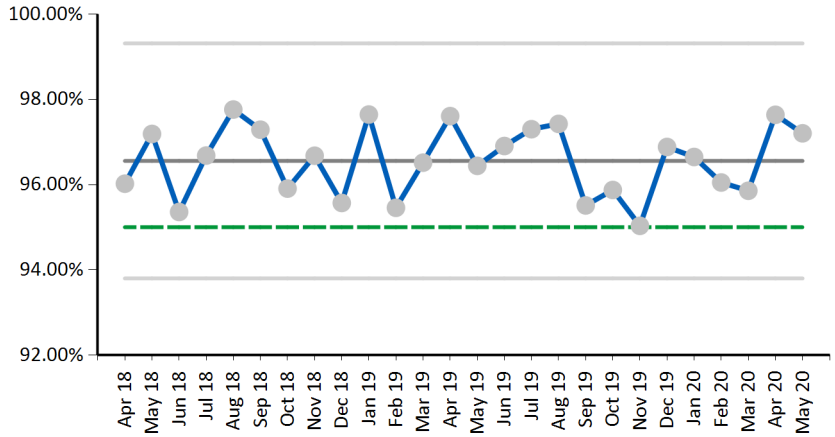
Falls
Falls per 1000 bed days has reduced slightly but actual falls have increased by 2 in month. This is a reflection of the increase in occupied bed days during May and COVID-19 situation whilst reduced significantly is still impacting on falls prevention overall. We are still performing above the national and local benchmarks. Falls with harm has increased to 2 patients with harm in May.

Nursing KPI's - Wards/departments/teams were not obligated to return KPI audit data in May due to the Covid 19 outbreak. There was a planned relaunch in June.

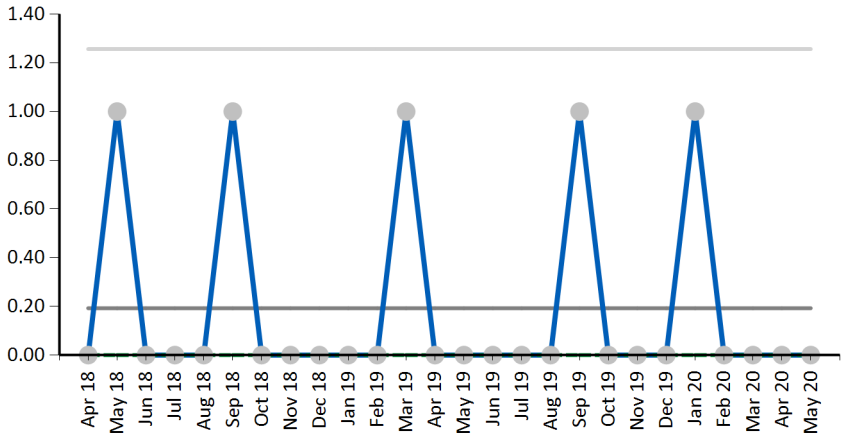
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	97.2%	May-20		>= 95%	97.6%	Apr-20	>= 95%	97.4%	
9 - Never Events	= 0	0	May-20		= 0	0	Apr-20	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	7.27	May-20	H	<= 5.30	8.29	Apr-20	<= 5.30	7.74	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	May-20		<= 1.6	1	Apr-20	<= 3.2	3	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	3.0	May-20		<= 6.0	6.0	Apr-20	<= 12.0	9.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	2.0	May-20		<= 0.5	0.0	Apr-20	<= 1.0	2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	May-20		= 0.0	0.0	Apr-20	= 0.0	0.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	8.0	May-20		<= 7.0	15.0	Apr-20	<= 14.0	23.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	3.0	May-20		<= 4.0	2.0	Apr-20	<= 8.0	5.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	May-20		<= 1.0	0.0	Apr-20	<= 2.0	0.0	
21 - Total Pressure Damage due to lapses in care	<= 6	5	May-20		<= 6	0	Apr-20	<= 11	5	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	92.2%	Q2 2019/20		>= 90%	92.2%	Q2 2019/20	>= 90%		
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	90.0%	Q2 2019/20		>= 90%	90.0%	Q2 2019/20	>= 90%		
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	81.0%	May-20		>= 80%	71.5%	Apr-20	>= 80%	76.7%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	87.8%	May-20		>= 72.5%	76.4%	Apr-20	>= 72.5%	82.5%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	100.0%	May-20		= 100%	50.0%	Apr-20	= 100%	75.0%	
88 - Nursing KPI Audits	>= 85%	92.6%	May-20		>= 85%	90.9%	Apr-20	>= 85%	91.8%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	May-20		= 100%	0.0%	Apr-20	= 100%		

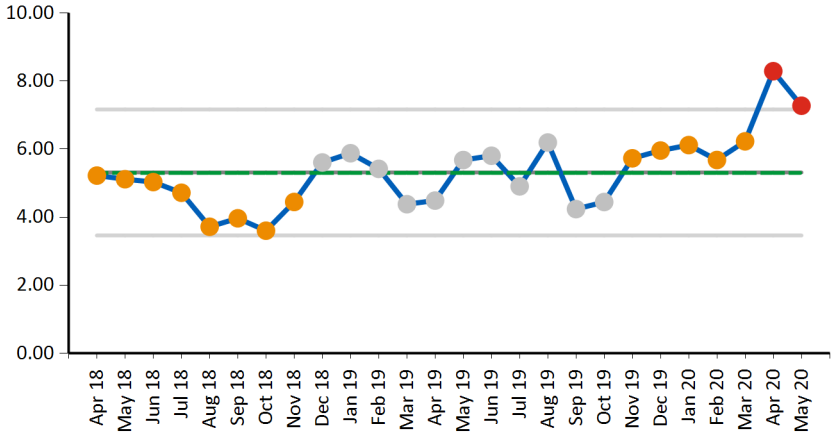
6 - Compliance with preventative measure for VTE



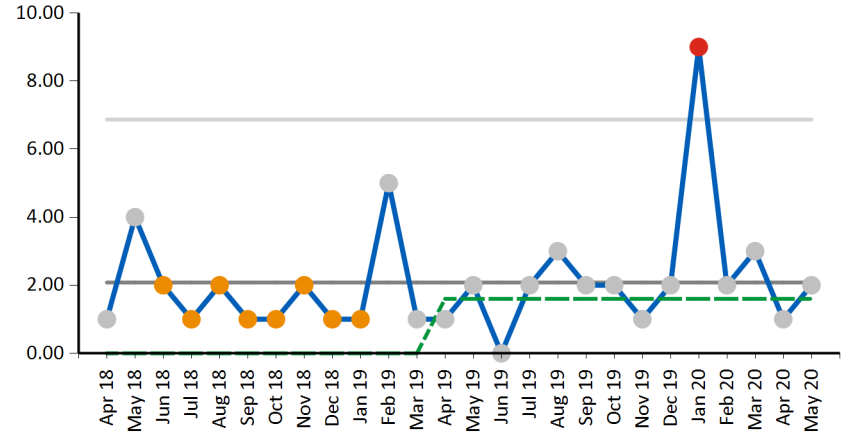
9 - Never Events



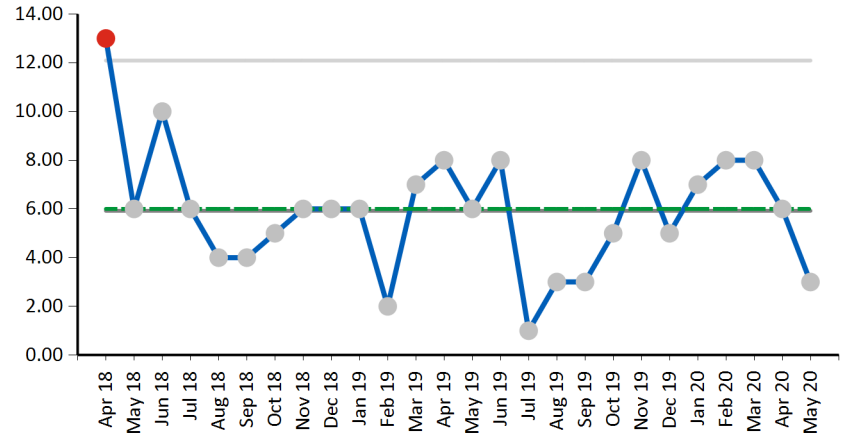
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



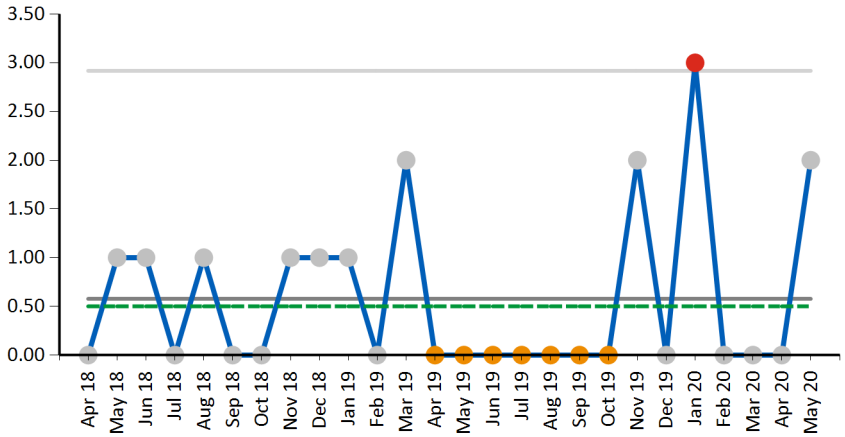
14 - Inpatient falls resulting in Harm (Moderate +)



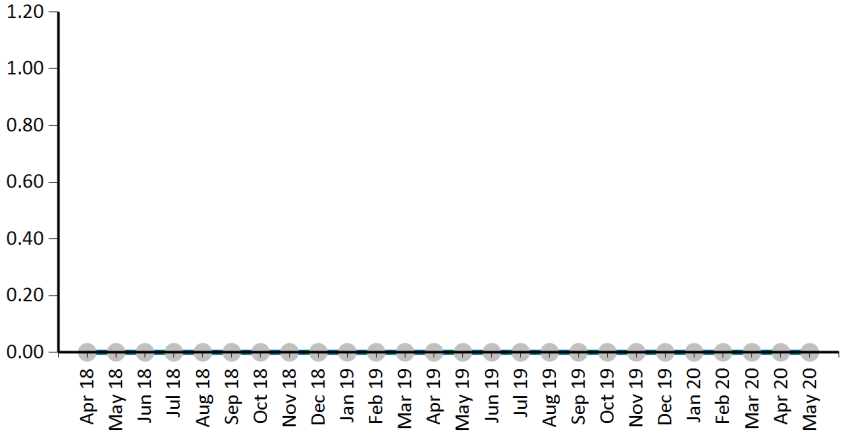
15 - Acute Inpatients acquiring pressure damage (category 2)



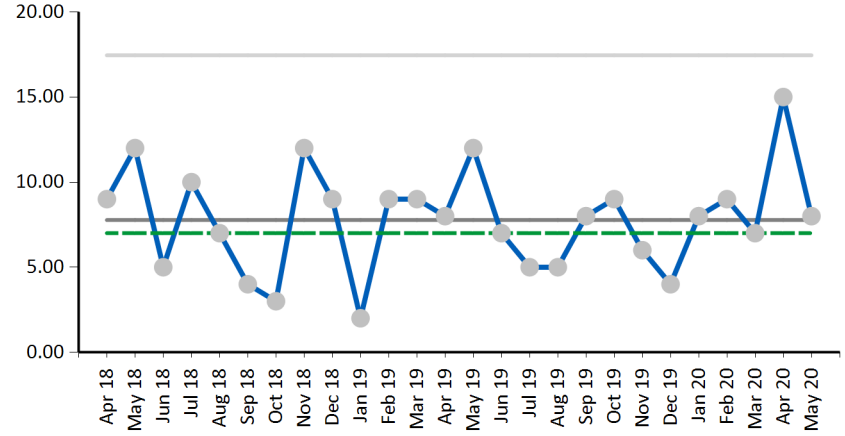
16 - Acute Inpatients acquiring pressure damage (category 3)



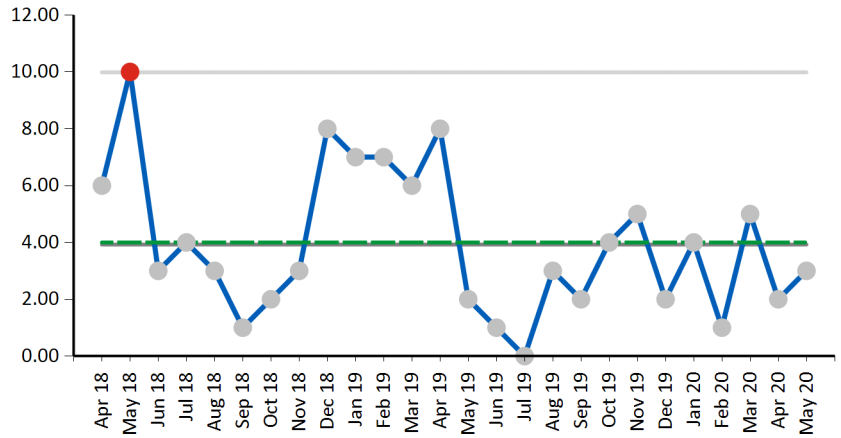
17 - Acute Inpatients acquiring pressure damage (category 4)



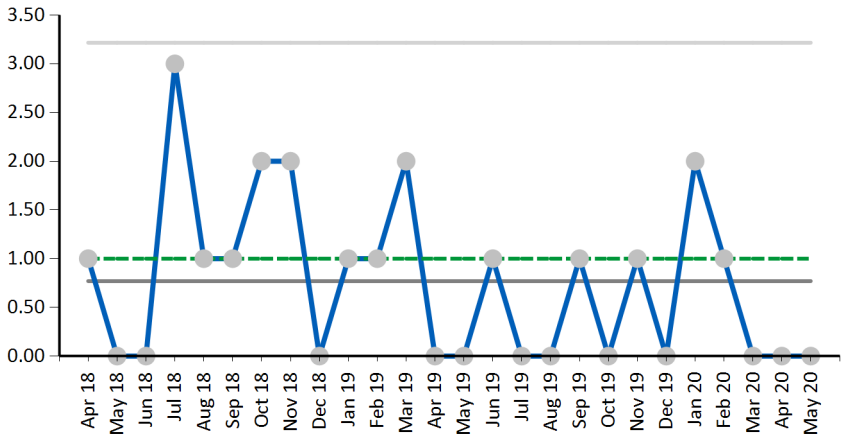
18 - Community patients acquiring pressure damage (category 2)



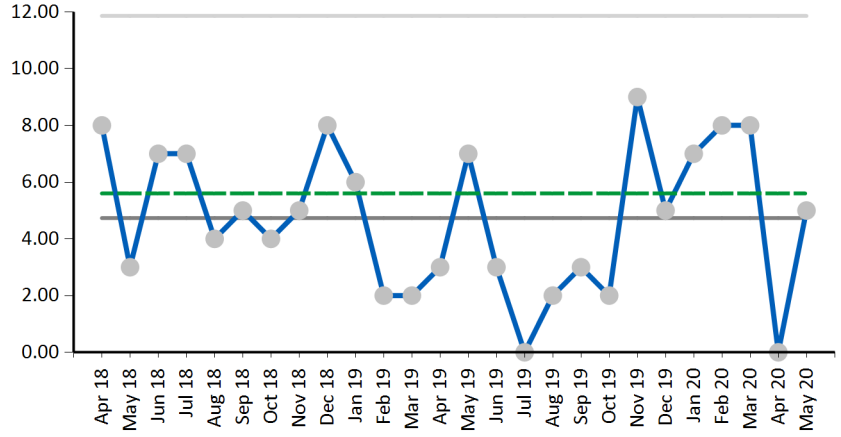
19 - Community patients acquiring pressure damage (category 3)



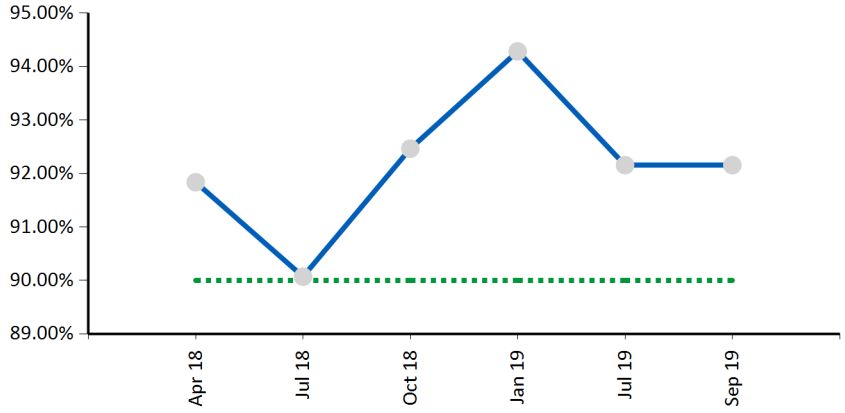
20 - Community patients acquiring pressure damage (category 4)



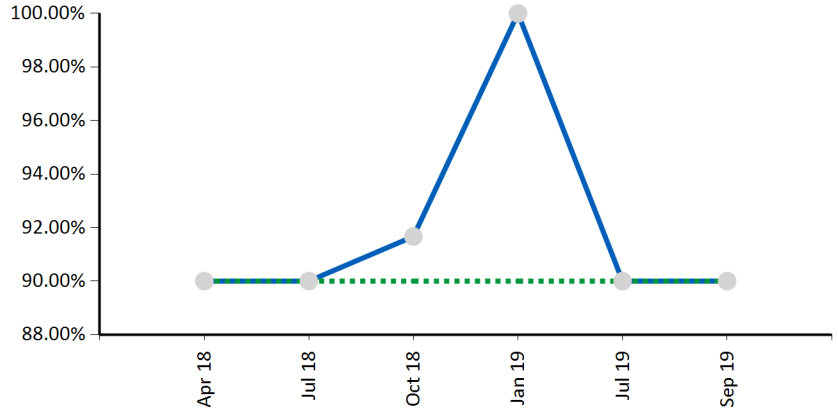
21 - Total Pressure Damage due to lapses in care



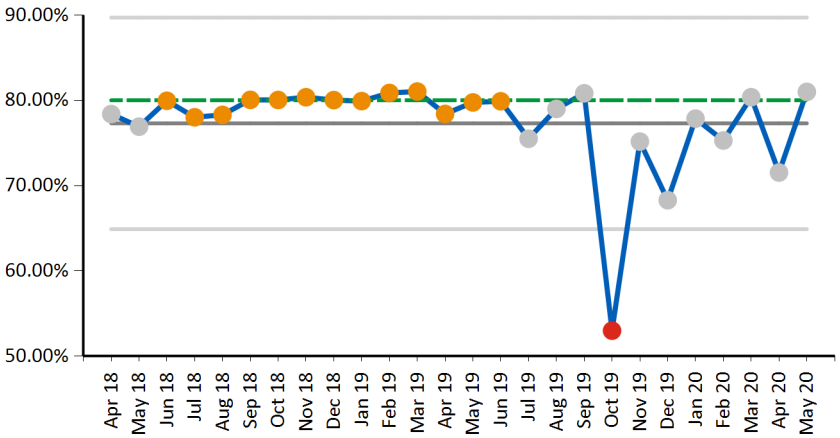
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points



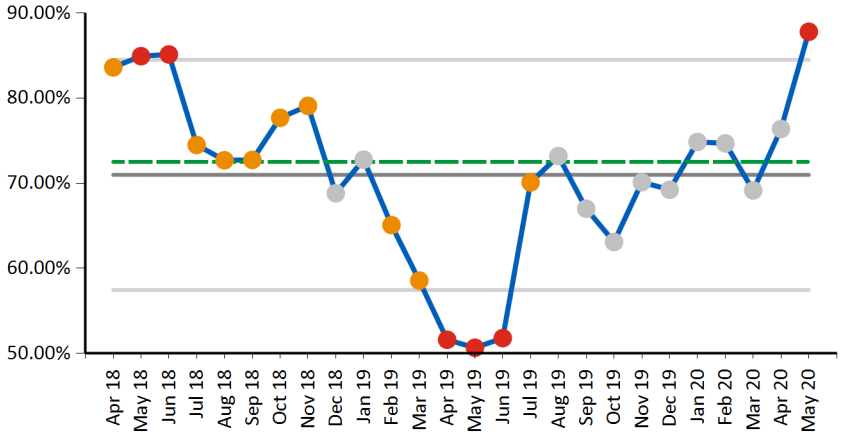
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



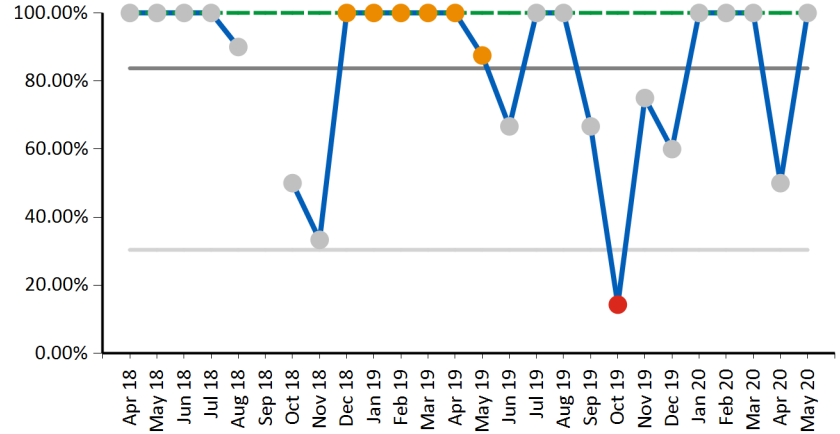
30 - Clinical Correspondence - Inpatients %<1 working day



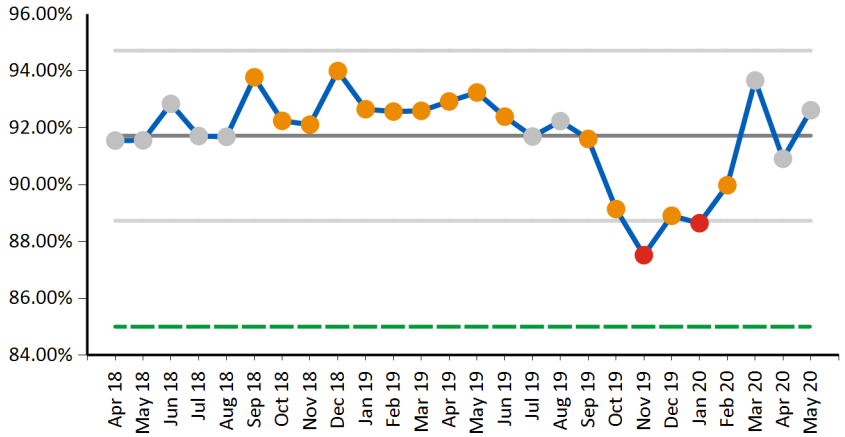
31 - Clinical Correspondence - Outpatients %<5 working days



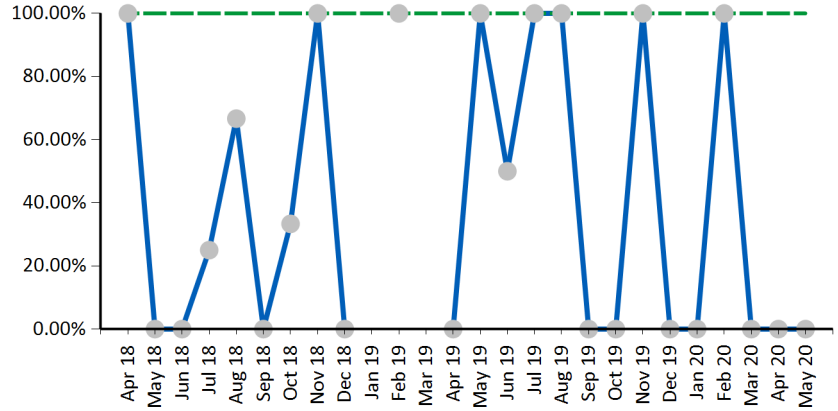
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days

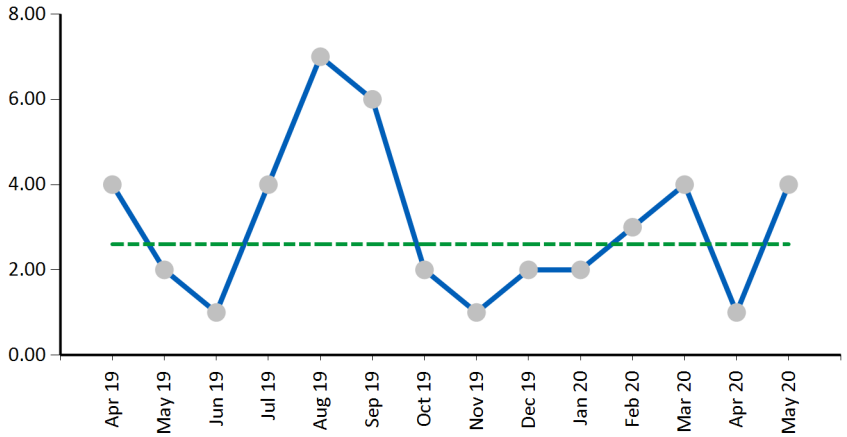


Infection Prevention and Control

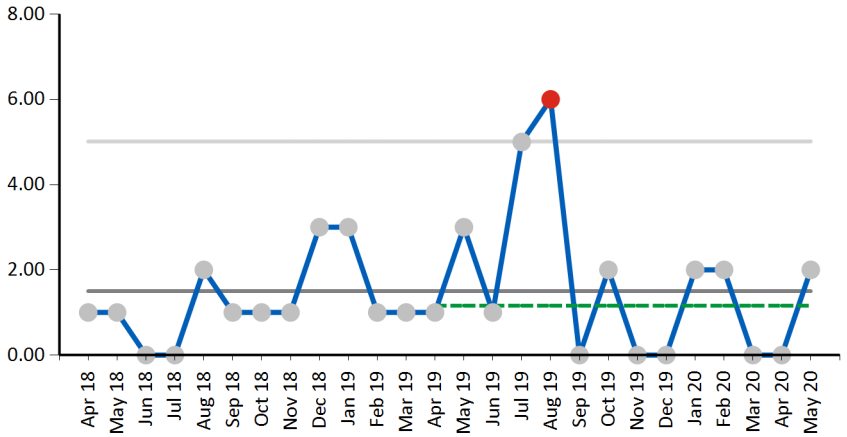
There are currently no national objectives set for Clostridium difficile cases, nor MSSA, E. coli and Klebsiella spp. bacteraemia as intended from a briefing paper produced by NHSE/I in 2019.
There has been one hospital onset MRSA bacteraemia.
There have been five HOHA & COHA Clostridium difficile cases.
MSSA and E. coli bacteraemia cases continue to demonstrate improvements based on the past 18 months.

	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	4	May-20		<= 3	1	Apr-20	<= 5	5	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	2	May-20		<= 1	0	Apr-20	<= 2	2	
347 - Total C.diff infections contributing to objective	<= 3	6	May-20		<= 3	1	Apr-20	<= 5	7	
217 - Total Hospital-Onset MRSA BSIs	= 0	1	May-20		= 0	0	Apr-20	= 0	1	
218 - Total Trust apportioned E. coli BSI	<= 3	1	May-20		<= 3	3	Apr-20	<= 6	4	
219 - Blood Culture Contaminants (rate)	<= 3%	4.6%	May-20		<= 3%	5.2%	Apr-20	<= 3%	4.9%	
199 - Compliance with antibiotic prescribing standards	>= 95%	71.0%	Q3 2019/20		>= 95%	87.0%	Q2 2019/20	>= 95%		
304 - Total Trust apportioned MSSA BSIs	<= 1.3	1.0	May-20	L	<= 1.3	0.0	Apr-20	<= 2.6	1.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 1	1	May-20	L	<= 1	0	Apr-20	<= 2	1	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	2	May-20	H	= 0	0	Apr-20	= 0	2	

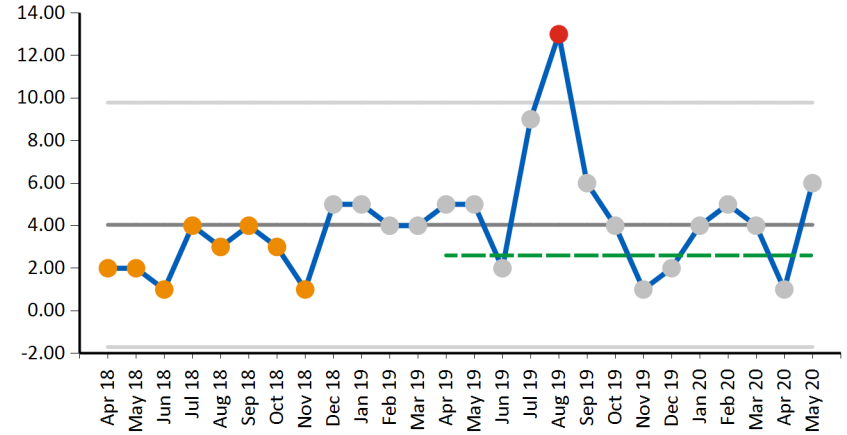
215 - Total Hospital Onset C.diff infections



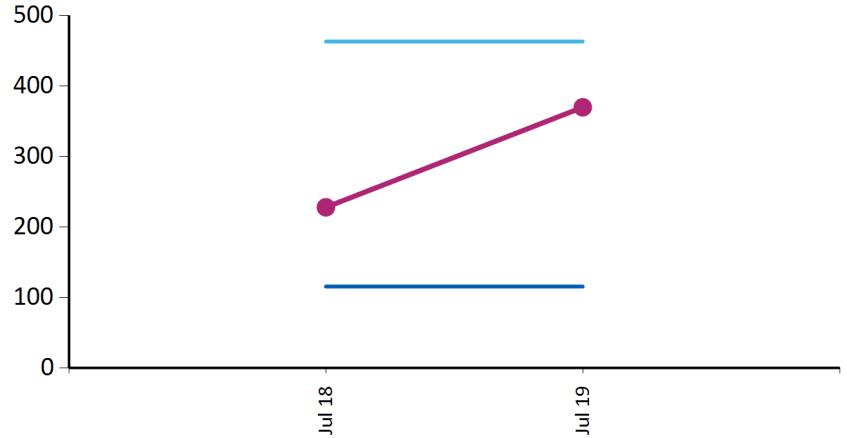
346 - Total Community Onset Hospital Associated C.diff infections



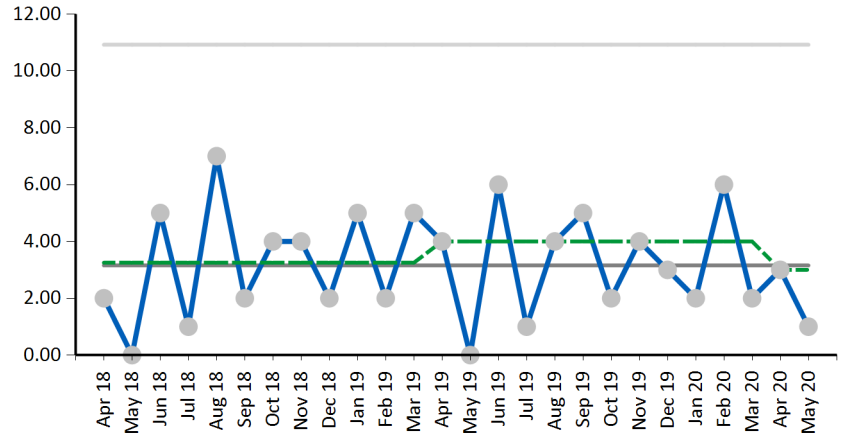
347 - Total C.diff infections contributing to objective



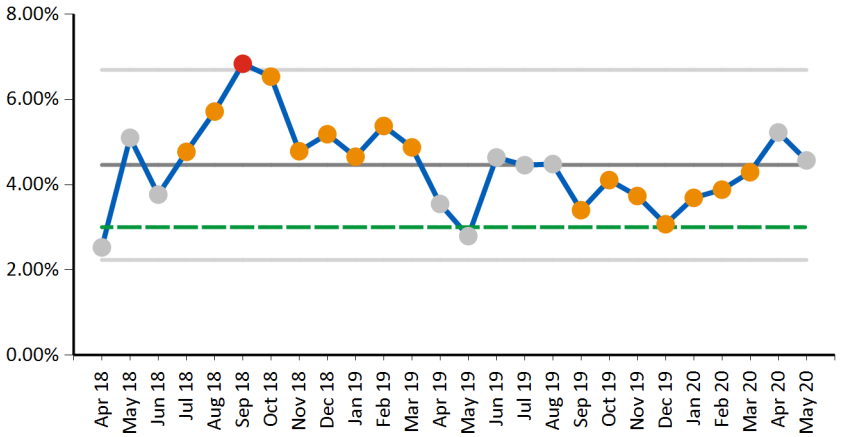
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



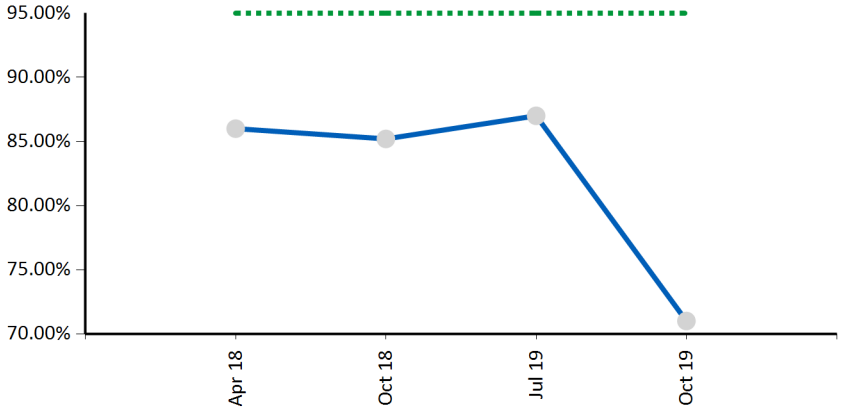
218 - Total Trust apportioned E. coli BSI



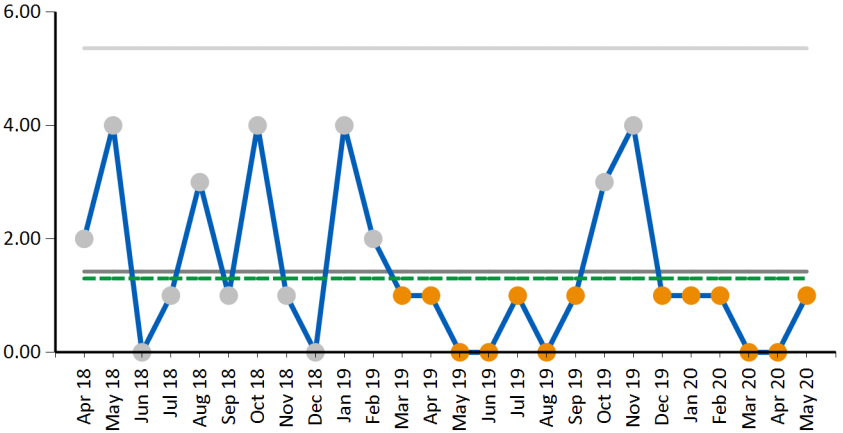
219 - Blood Culture Contaminants (rate)



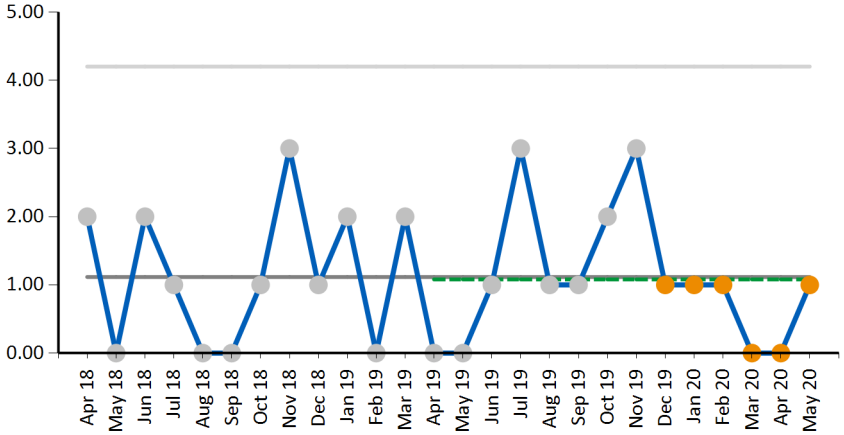
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



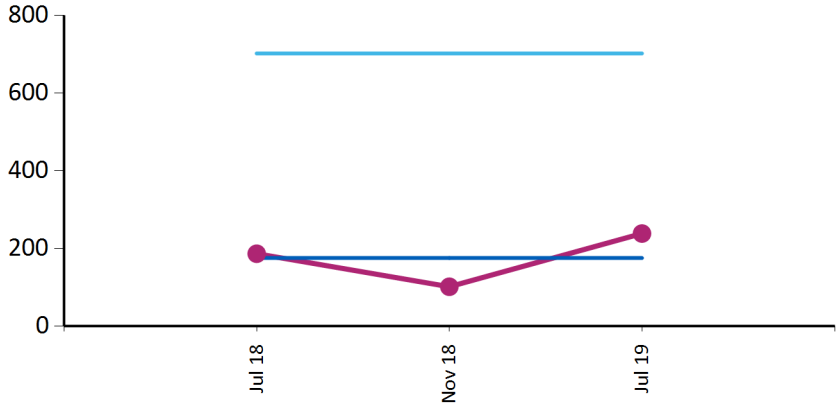
304 - Total Trust apportioned MSSA BSIs



305 - Total Trust apportioned Klebsiella spp. BSIs



306 - Total Trust apportioned Pseudomonas aeruginosa BSIs - G Chart (Days Between Cases)



Mortality

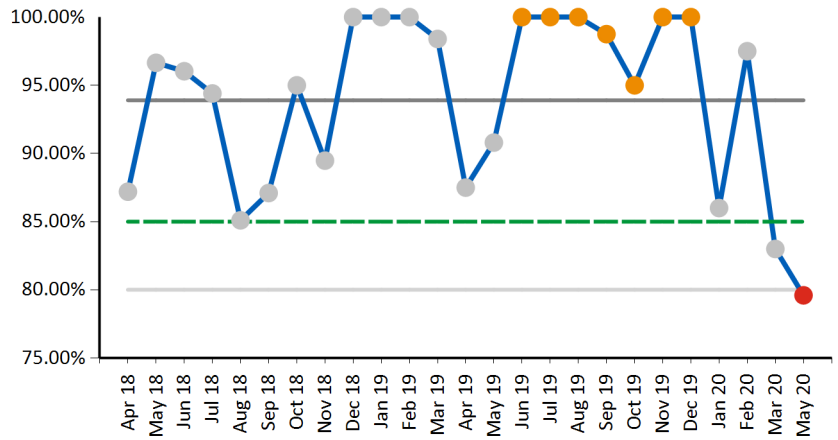
Crude Mortality rate – the deaths in month are again inflated due to Covid-19, at 132 deaths in month which is around 30 deaths higher than average for May over the previous 4 years. There was also an increase in activity compared to April which has increased the denominator and further reduced the rate from the April peak back to within the normal ranges at 3.7%. Although this figure is higher than the average and target set for Trust it is partly explained by the pandemic deaths and reduced activity compared to previous years. This indicator is not adjusted for comorbidities or any other factor.

RAMI – the in-month figure for RAMI remains within the normal controls, however it is expected to rise next month as the reporting period hits the peak for Covid-19 within Bolton. The 12 month rolling average for this indicator is 96.2.

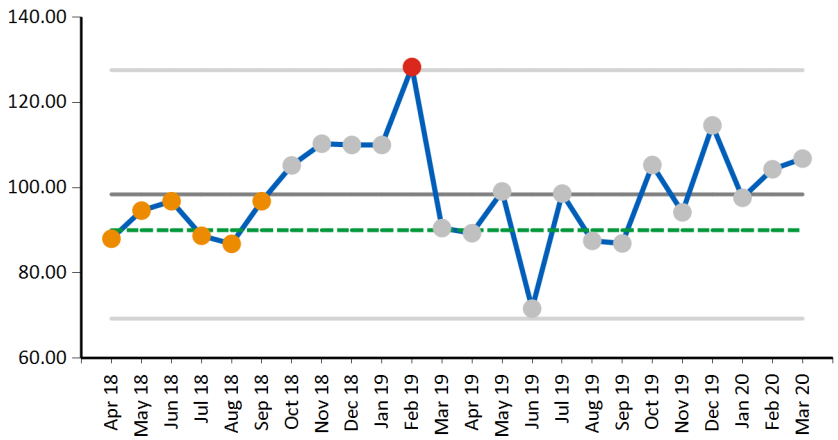
SHMI – SHMI remains significantly higher than peers with a rolling 12 month average of 116.5 for January 2019 to December 2019. The in-month figure (December 2019) has shown a slight rise from the previous month which is as expected for the time of year. The SHMI group for pneumonia is back within 'expected levels' for the reporting period but will continue to be monitored via Learning from Deaths Committee and the Mortality Board on a quarterly basis.
There has been notification that SHMI will be excluding any COVID-19 activity from future publications. Although the current reporting period does not include the Covid-19 deaths work will begin within the Trust to audit patients with a positive result and the ICD10 coding in anticipation of this directive. This should ensure that the reporting of SHMI is as consistent as possible with those from previous reporting periods.

	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%	79.6%	May-20		>= 85%	83.0%	Mar-20	>= 85%	79.6%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	106.8	Mar-20		<= 90	104.3	Feb-20	<= 90		
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	127.10	Dec-19		<= 100.00	121.00	Nov-19	<= 100.00		
12 - Crude Mortality %	<= 2.9%	3.7%	May-20		<= 2.9%	7.1%	Apr-20	<= 2.9%	5.4%	

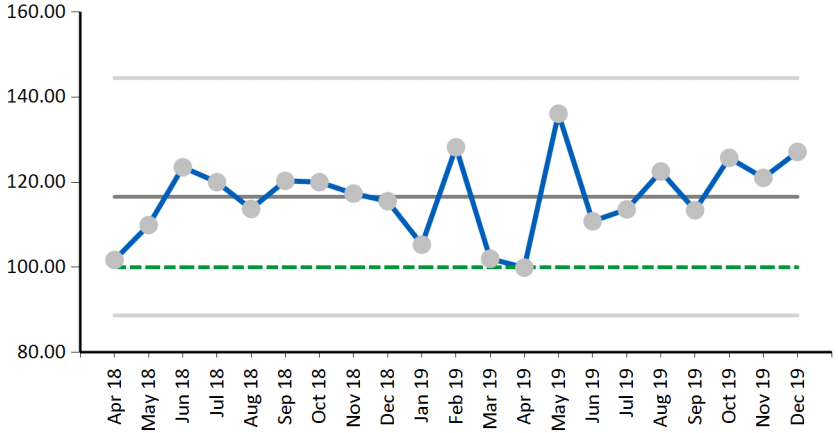
3 - National Early Warning Scores to Gold standard



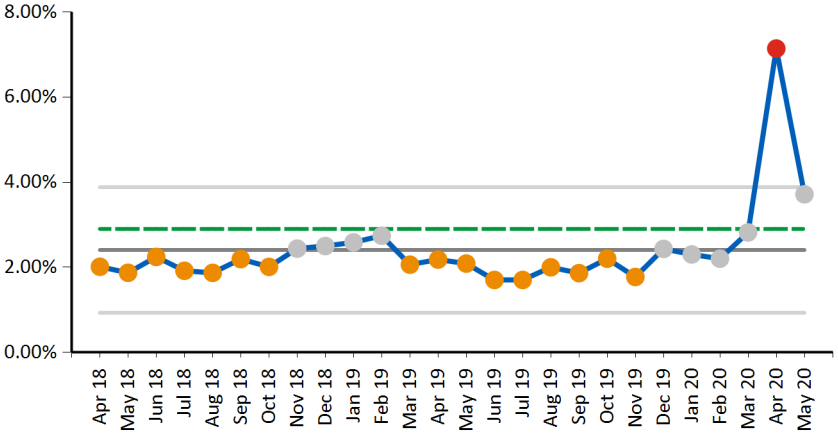
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)



11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)



12 - Crude Mortality %



Patient Experience

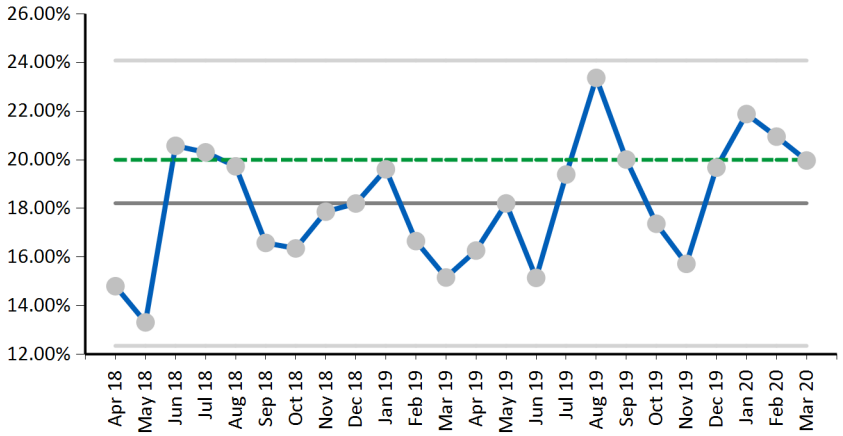
Friends and Family Test
Due to NHSE guidance to suspend the collection of FFT, no data is available for May 2020. The current guidance extends to the end of June 2020 and the position will be reviewed once further guidance is received.

Complaints
Guidance was provided from NHSE to suspend the NHS complaints process during the CODI-19 pandemic. Bolton FT chose to continue to receive and respond to complaints received during the COVID-19 pandemic and 3 complaints breaching the 35 working day target. There were various reasons for this as the team and divisional colleagues adapted to the daily challenges and working practices in response to COVID-19 which caused delays in obtaining vital information to support a quality response. As a result, the Patient Experience Manager has asked for a timeline for each of the breached cases to be shared with the relevant Divisions to show where the learning is and to identify how breaches can be avoided during the pandemic.

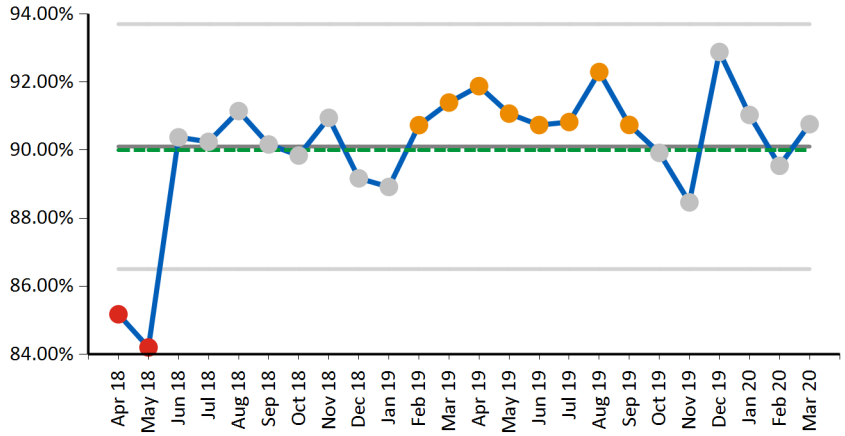
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	20.0%	Mar-20		>= 20%	21.0%	Feb-20	>= 20%		?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	90.8%	Mar-20		>= 90%	89.5%	Feb-20	>= 90%		?
80 - Inpatient Friends and Family Response Rate	>= 30%	24.4%	Mar-20		>= 30%	26.6%	Feb-20	>= 30%		?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.9%	Mar-20		>= 90%	96.9%	Feb-20	>= 90%		P
81 - Maternity Friends and Family Response Rate	>= 15%	12.4%	Mar-20		>= 15%	22.9%	Feb-20	>= 15%		?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	94.3%	Mar-20		>= 90%	96.9%	Feb-20	>= 90%		P
82 - Antenatal - Friends and Family Response Rate	>= 15%	0.0%	Mar-20		>= 15%	12.3%	Feb-20	>= 15%		?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%		Mar-20		>= 90%	100.0%	Feb-20	>= 90%		P
83 - Birth - Friends and Family Response Rate	>= 15%	26.5%	Mar-20	L	>= 15%	28.7%	Feb-20	>= 15%		P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	93.1%	Mar-20		>= 90%	93.7%	Feb-20	>= 90%		?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	15.8%	Mar-20		>= 15%	33.7%	Feb-20	>= 15%		?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.4%	Mar-20		>= 90%	97.7%	Feb-20	>= 90%		?

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	8.7%	Mar-20		>= 15%	19.8%	Feb-20	>= 15%		
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	95.1%	Mar-20		>= 90%	98.8%	Feb-20	>= 90%		
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	May-20		= 100%	100.0%	Apr-20	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	81.3%	May-20		>= 95%	84.6%	Apr-20	>= 95%	83.3%	

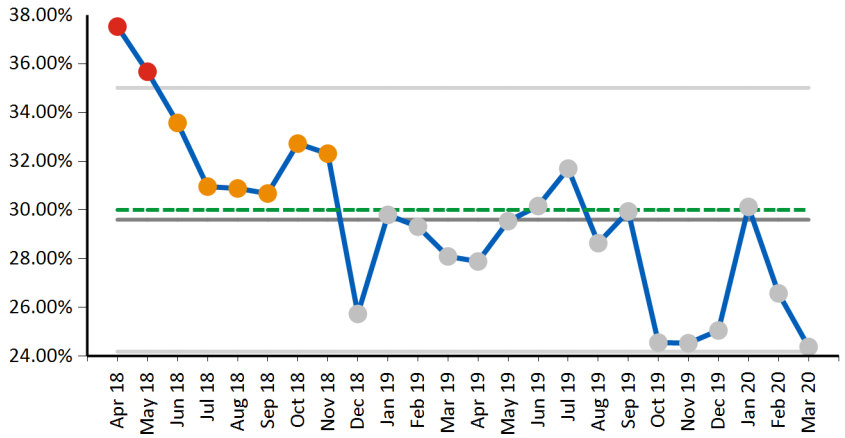
200 - A&E Friends and Family Response Rate



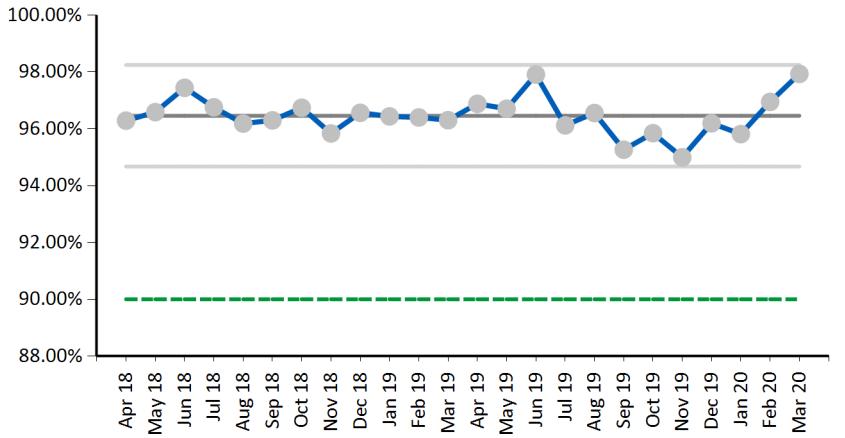
294 - A&E Friends and Family Satisfaction Rates %



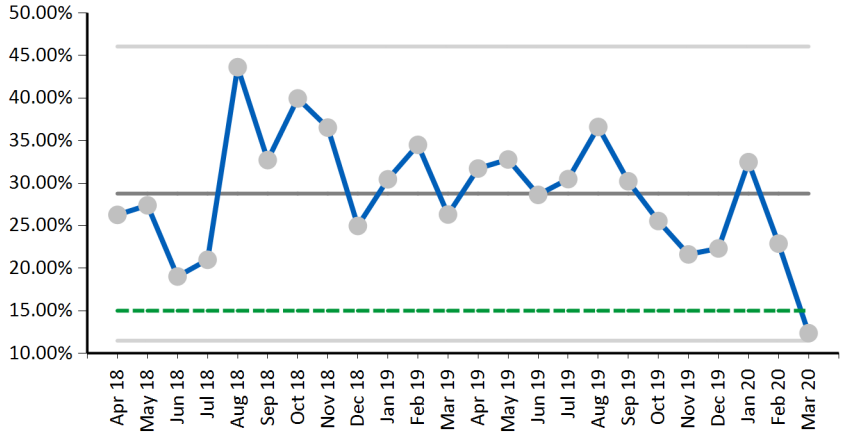
80 - Inpatient Friends and Family Response Rate



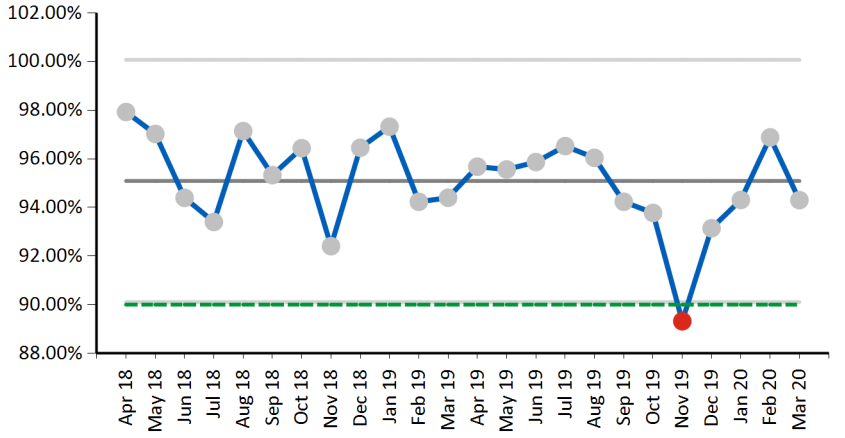
240 - Friends and Family Test (Inpatients) - Satisfaction %



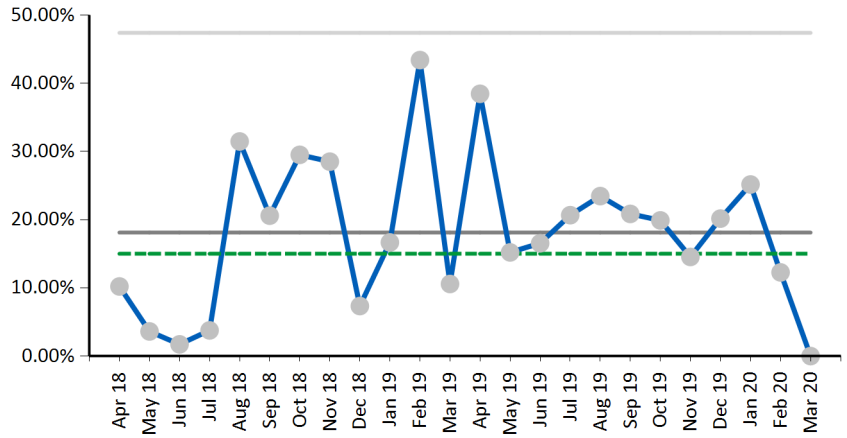
81 - Maternity Friends and Family Response Rate



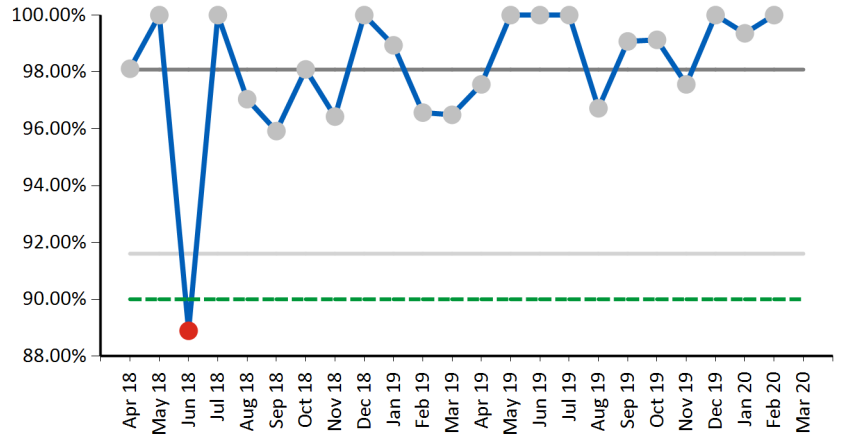
241 - Maternity Friends and Family Test - Satisfaction %



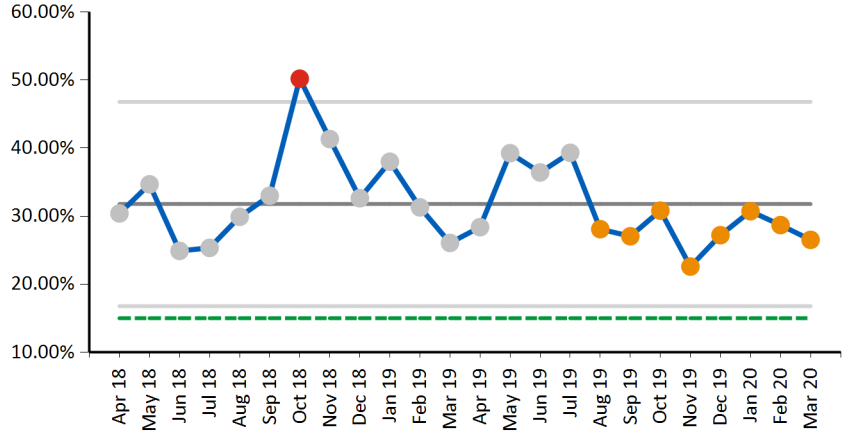
82 - Antenatal - Friends and Family Response Rate



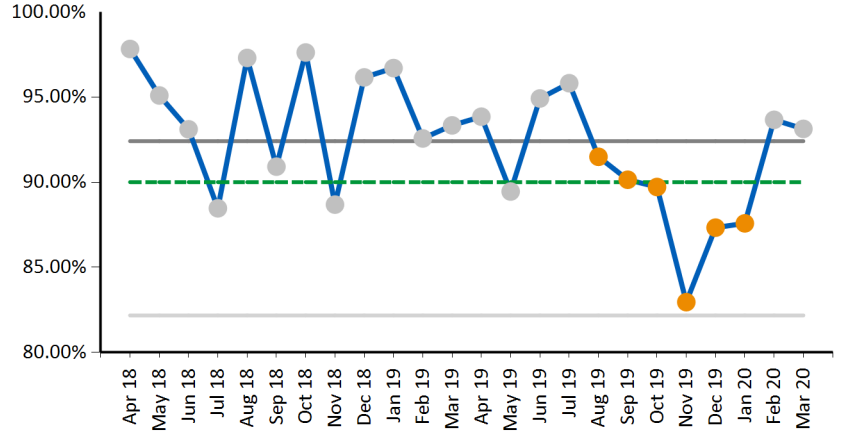
242 - Antenatal Friends and Family Test - Satisfaction %



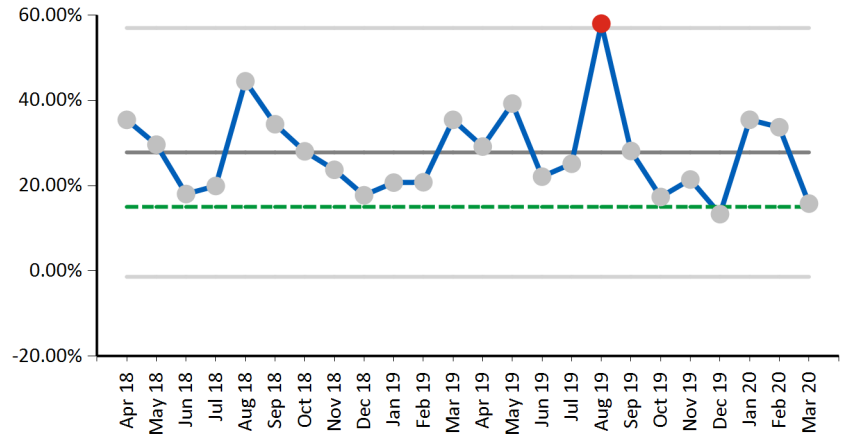
83 - Birth - Friends and Family Response Rate



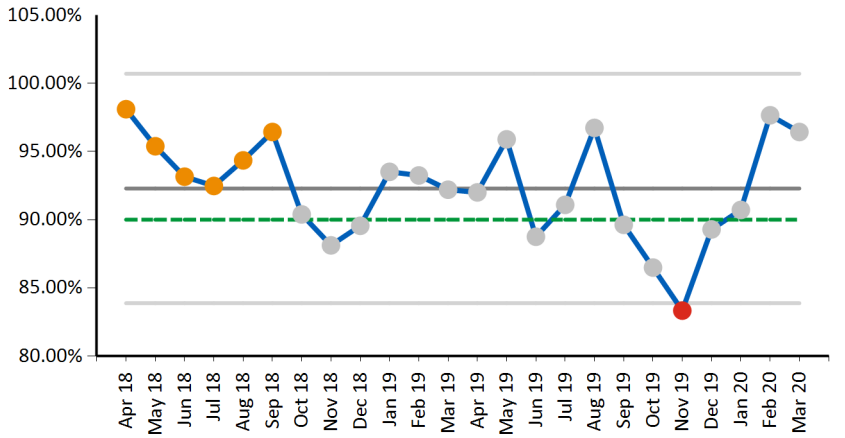
243 - Birth Friends and Family Test - Satisfaction %



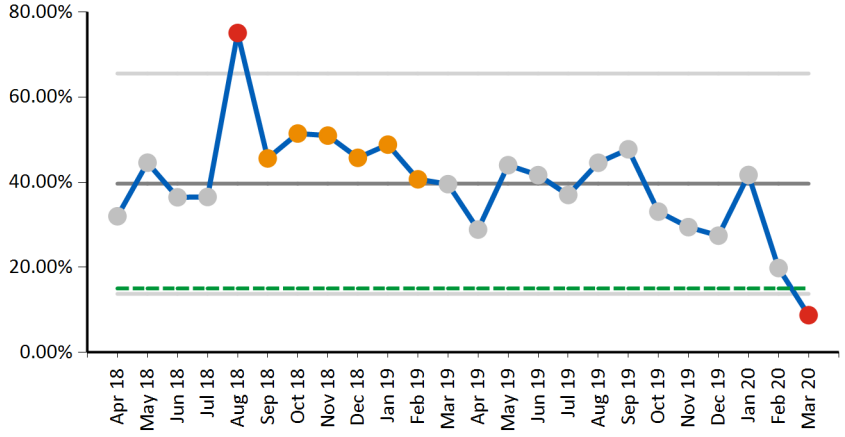
84 - Hospital Postnatal - Friends and Family Response Rate



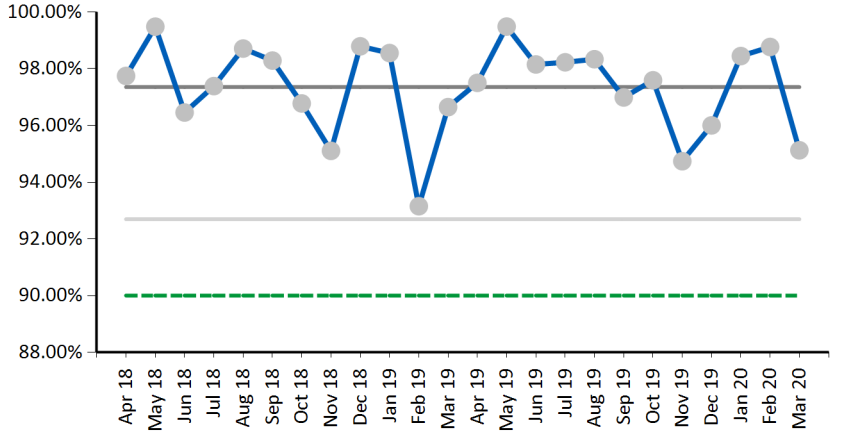
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



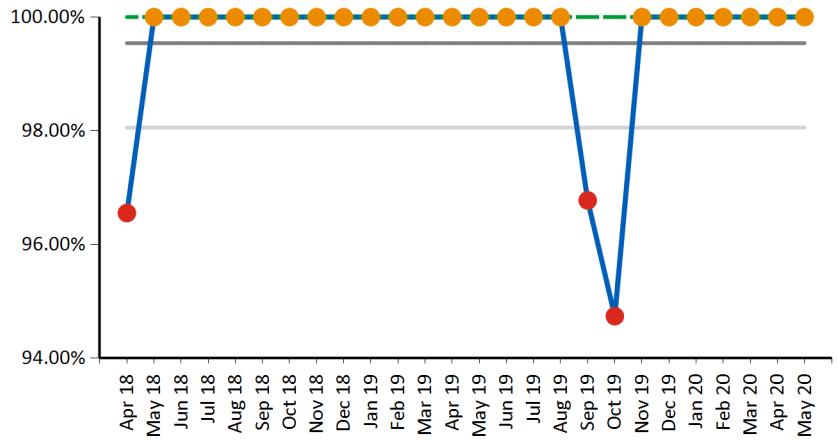
85 - Community Postnatal - Friend and Family Response Rate



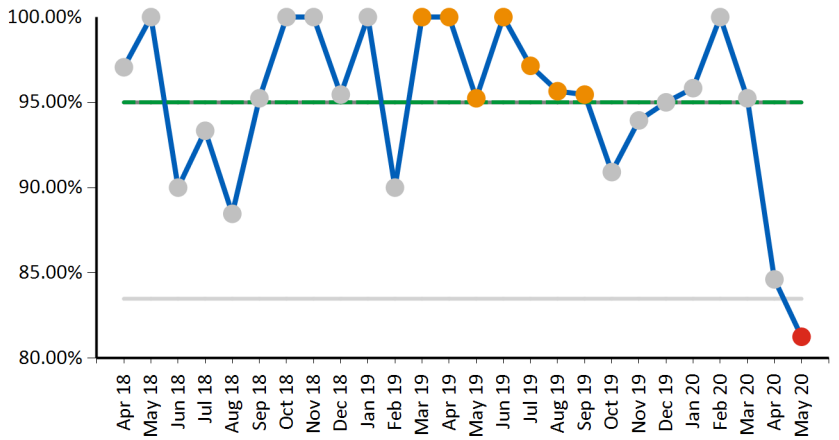
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

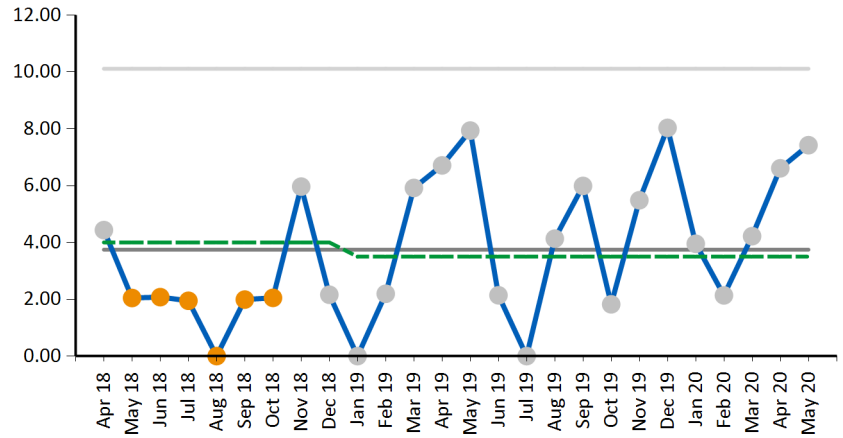
In May 2020 we sadly had 3 still births. Two have progress to Divisional Review, one was expected due to ongoing health issues of feotus.

12+6 unfortunately saw a decline in performance, In June there were over 9% women presenting late for booking, some had DNA'd earlier appointments (may have been due to Covid reasons) . We have had 2x late referrals from Salford Gp 's which Salford GP commissioner is addressing.
Some BL3 women have been late to present for booking and we have tasked Benash and Paula to do some work with this looking at comms in various languages stressing the importance of booking early.

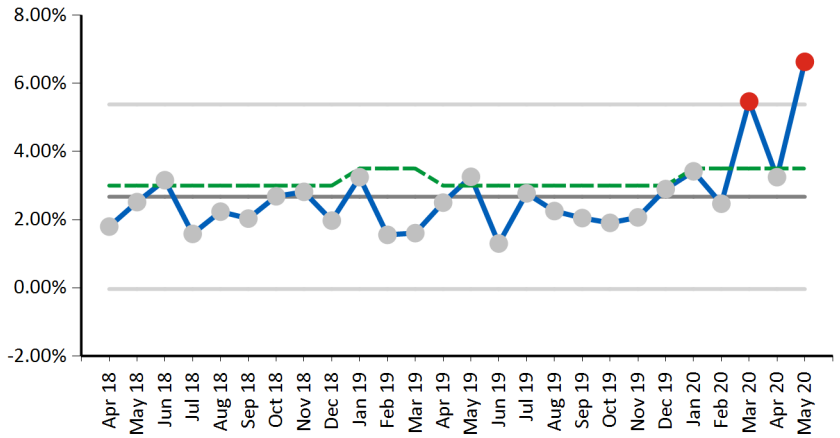
3rd and 4th degree tears again increase in month. This was 17 normal vaginal births, (all different midwives), but no episiotomy performed in any of these cases, 2 forceps and 5 kiwis. Out of the 6 instrumental deliveries 2 doctors were involved in 4 of the cases. This is being escalated to the maternity PEFs to undertake some training with midwives around timeliness of performing an episiotomy. The Clinical Director will be asked to review the technique of the 2 doctors. In addition, we have volunteered to become a pilot site for the OAS2 care bundle, to improve.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	7.42	May-20		<= 3.50	6.61	Apr-20	<= 3.50	7.05	
23 - Maternity -3rd/4th degree tears	<= 3.5%	6.6%	May-20	H	<= 3.5%	3.2%	Apr-20	<= 3.5%	5.1%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.9%	May-20		>= 95.0%	98.3%	Apr-20	>= 95.0%	98.6%	P
203 - Booked 12+6	>= 90.0%	88.1%	May-20		>= 90.0%	91.6%	Apr-20	>= 90.0%	90.1%	
204 - Inductions of labour	<= 40%	37.9%	May-20		<= 40%	36.0%	Apr-20	<= 40%	37.0%	
208 - Total C section	<= 33.0%	32.3%	May-20	H	<= 33.0%	30.8%	Apr-20	<= 33.0%	31.6%	
210 - Initiation breast feeding	>= 65%	67.23%	May-20		>= 65%	73.24%	Apr-20	>= 65%	69.96%	
213 - Maternity complaints	<= 5	1	May-20		<= 5	0	Apr-20	<= 10	1	
319 - Maternal deaths (direct)	= 0	0	May-20	L	= 0	0	Apr-20	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.3%	May-20		<= 6%	7.9%	Apr-20	<= 6%	8.2%	

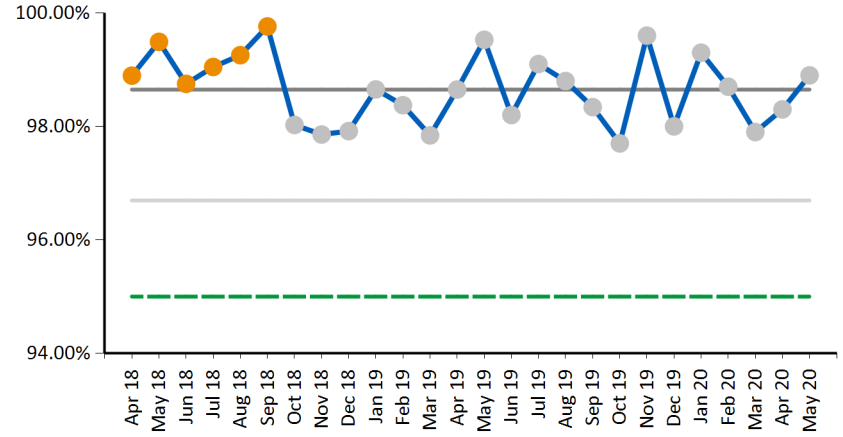
322 - Maternity - Stillbirths per 1000 births



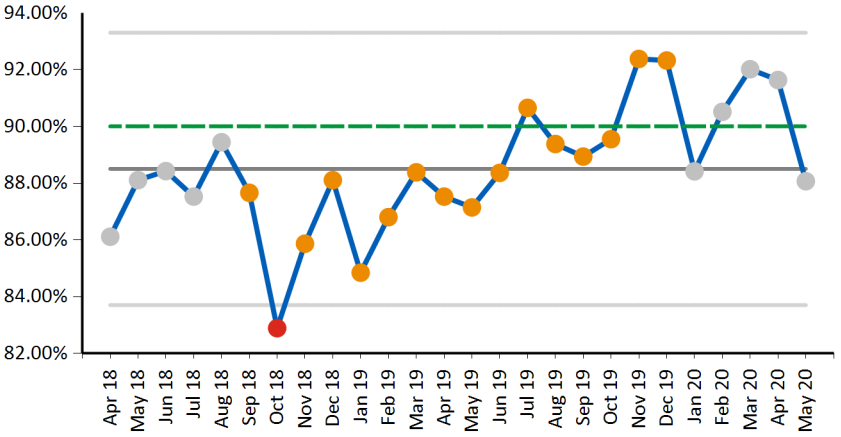
23 - Maternity -3rd/4th degree tears



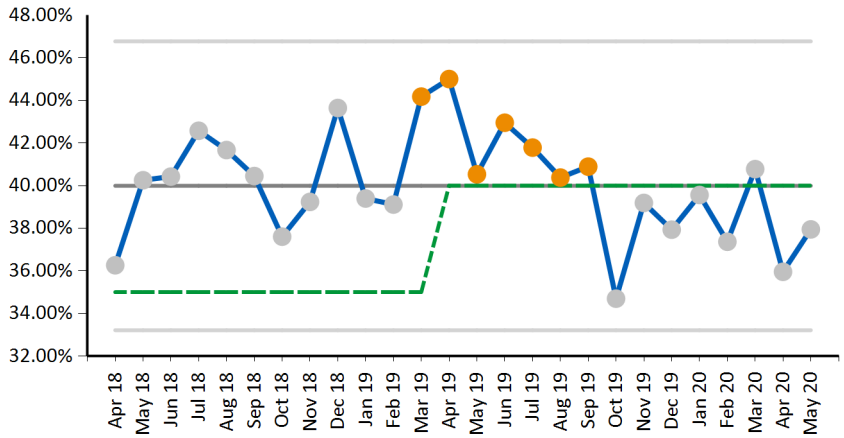
202 - 1:1 Midwifery care in labour



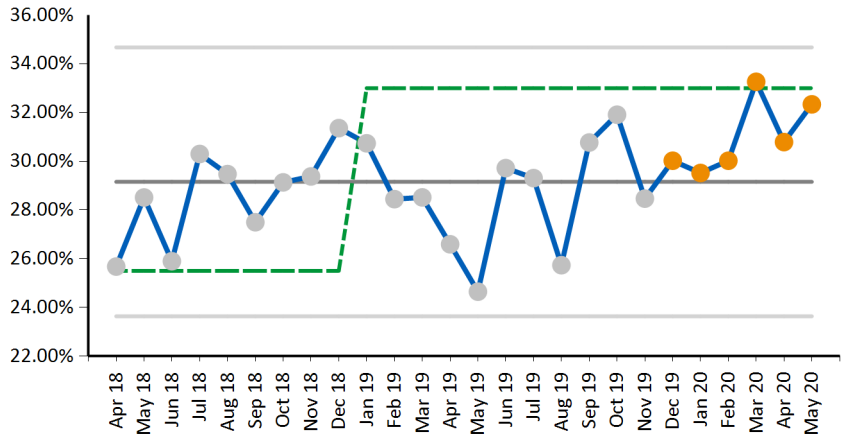
203 - Booked 12+6



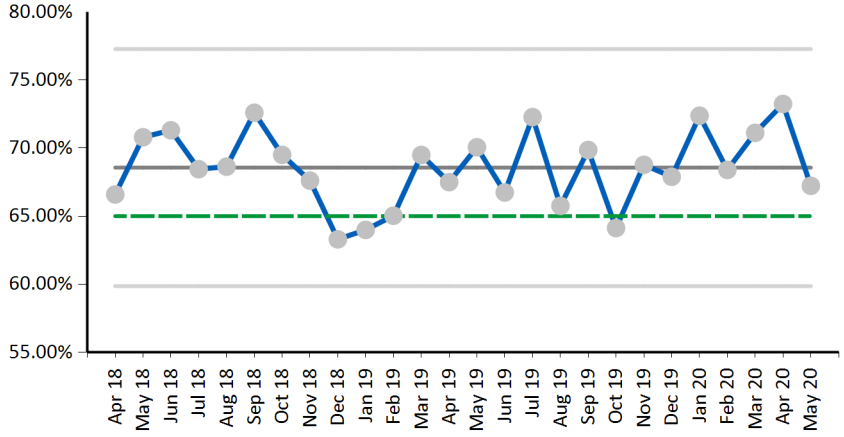
204 - Inductions of labour



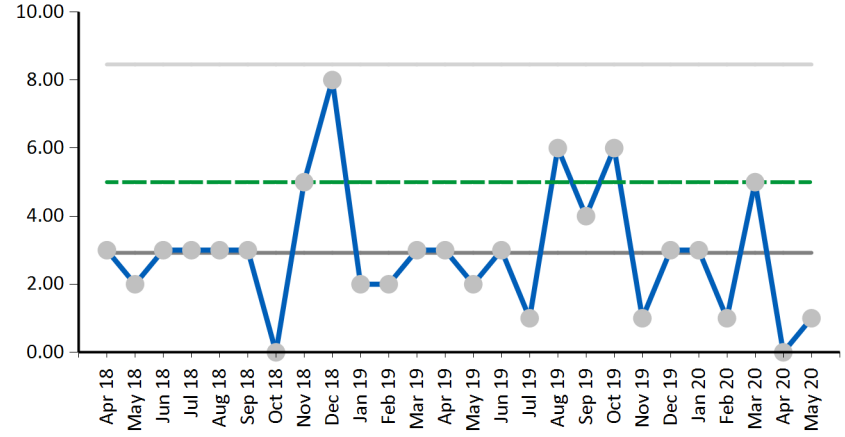
208 - Total C section



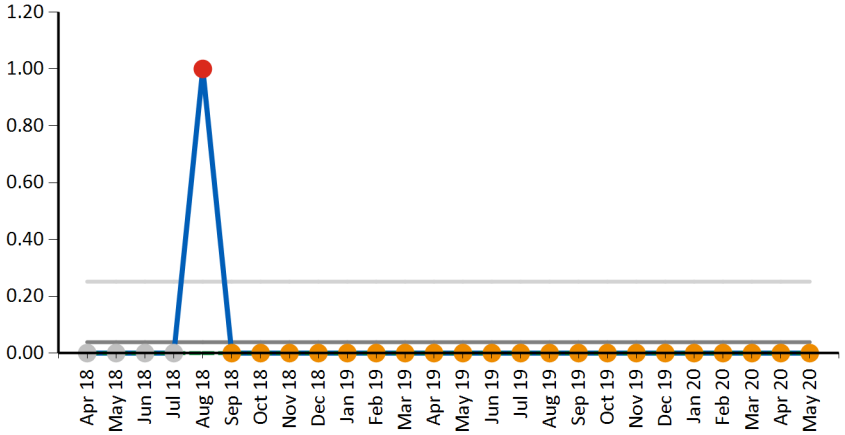
210 - Initiation breast feeding



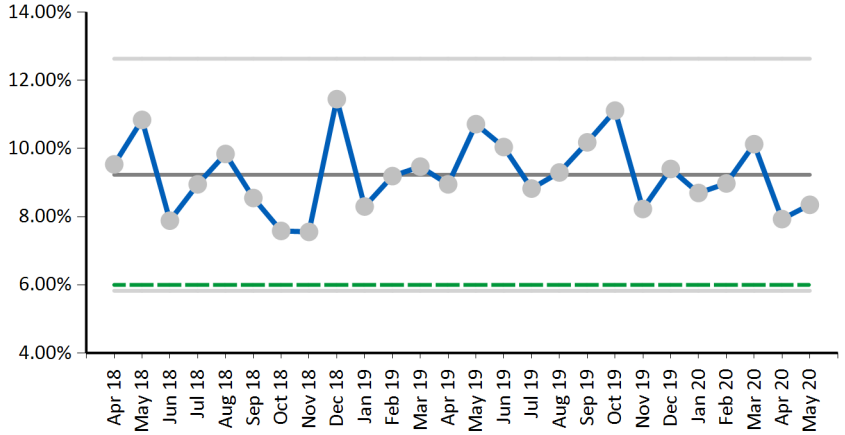
213 - Maternity complaints



319 - Maternal deaths (direct)



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

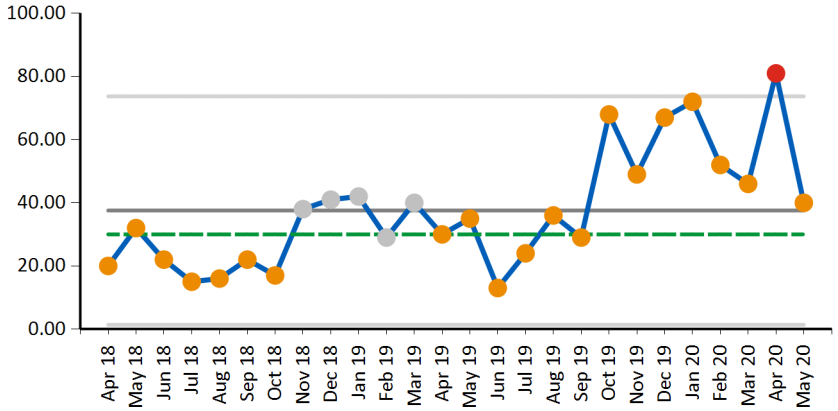


Operational Performance

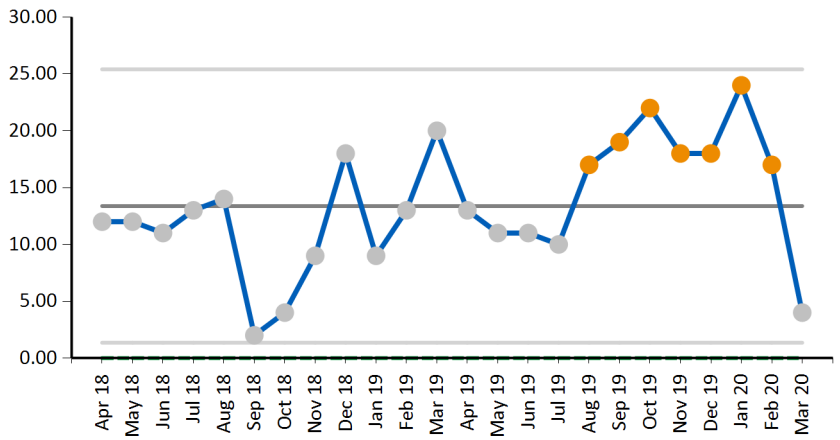
Access

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	40	May-20	H	<= 30	81	Apr-20	<= 60	121	?
8 - Same sex accommodation breaches	= 0	4	Mar-20		= 0	17	Feb-20	= 0		F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	68.6%	May-20		>= 75%	86.7%	Apr-20	>= 75%	76.9%	?
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	59.4%	May-20	L	>= 92%	70.6%	Apr-20	>= 92%	65.2%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	182	May-20	H	= 0	72	Apr-20	= 0	254	?
314 - RTT 18 week waiting list	<= 25,530	19,615	May-20	L	<= 25,530	20,695	Apr-20	<= 25,530	19,615	?
53 - A&E 4 hour target	>= 95%	89.8%	May-20		>= 95%	84.5%	Apr-20	>= 95%	87.5%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	0.7%	May-20	L	= 0.0%	11.4%	Apr-20	= 0.0%	5.4%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	0.00%	May-20		= 0.00%	0.55%	Apr-20	= 0.00%	0.24%	?
72 - Diagnostic Waits >6 weeks %	<= 1%	67.7%	May-20	H	<= 1%	39.2%	Apr-20	<= 1%	54.8%	?
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	90.0%	May-20		= 100%	66.7%	Apr-20	= 100%	78.3%	?

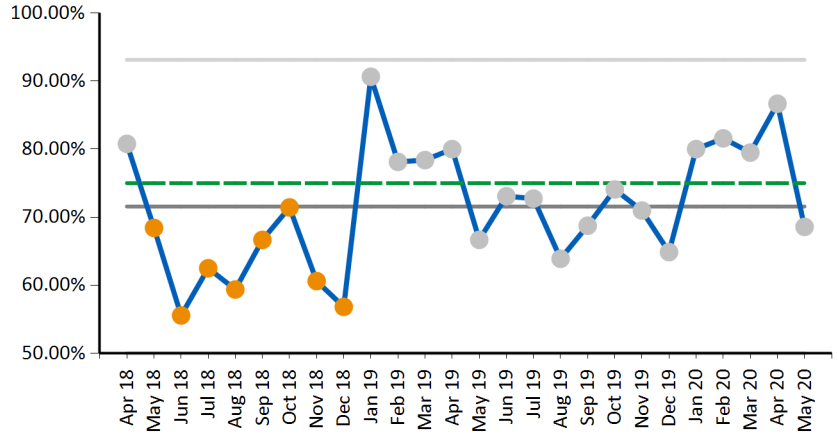
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



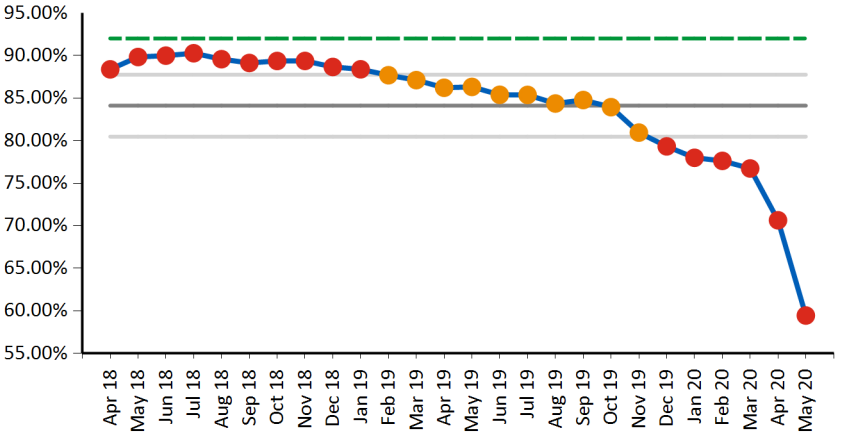
8 - Same sex accommodation breaches



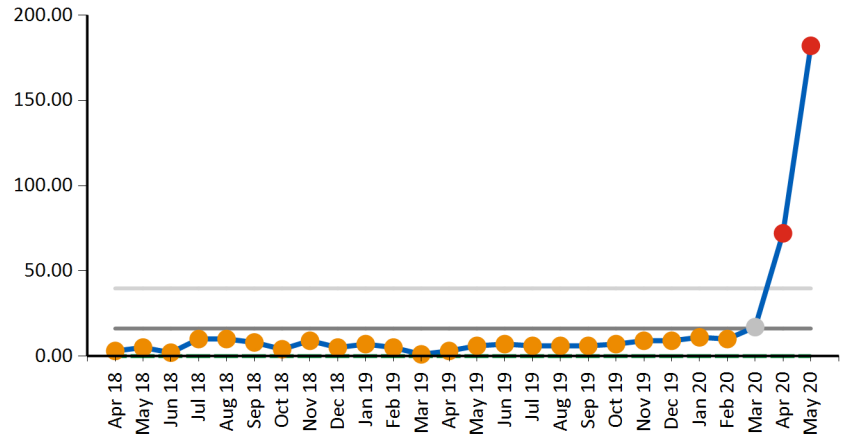
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



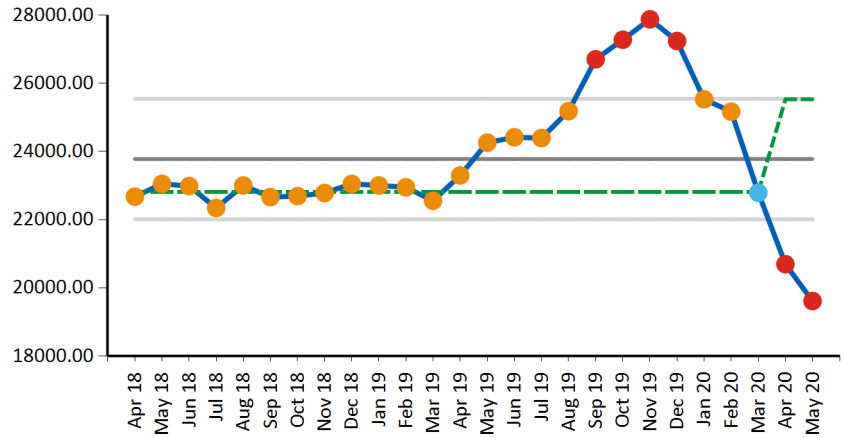
41 - RTT Incomplete pathways within 18 weeks %



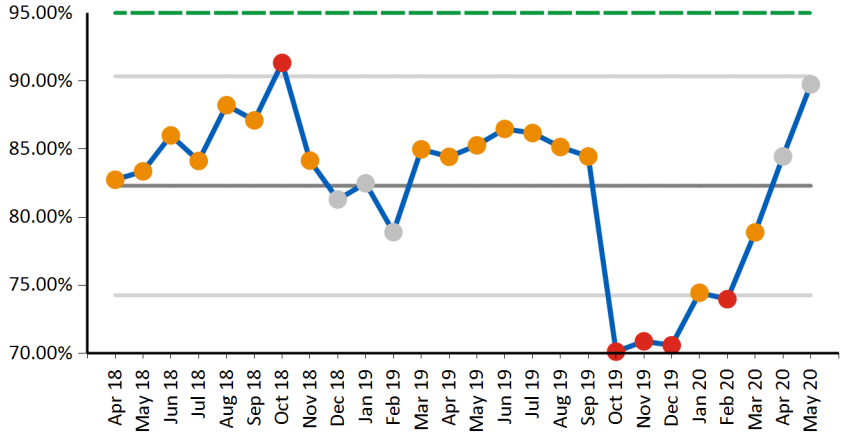
42 - RTT 52 week waits (incomplete pathways)



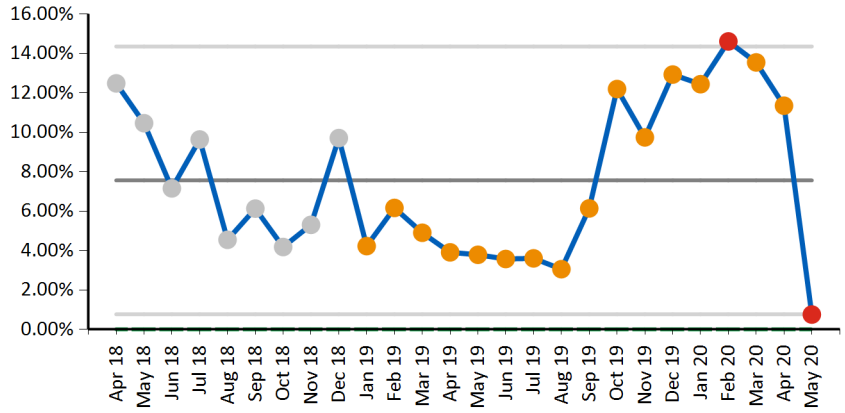
314 - RTT 18 week waiting list



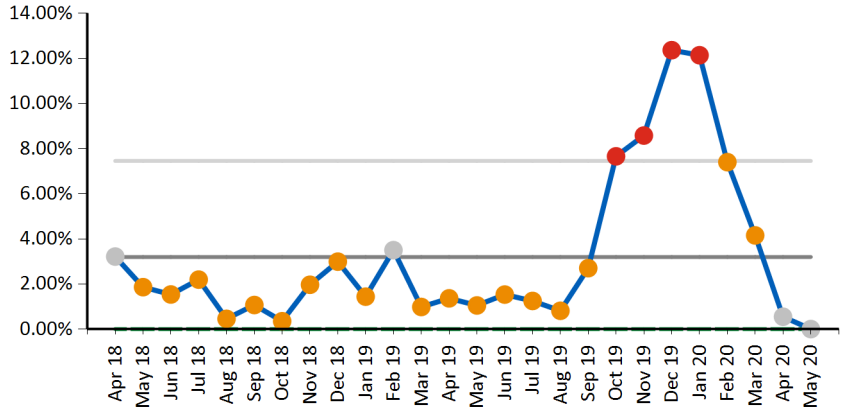
53 - A&E 4 hour target



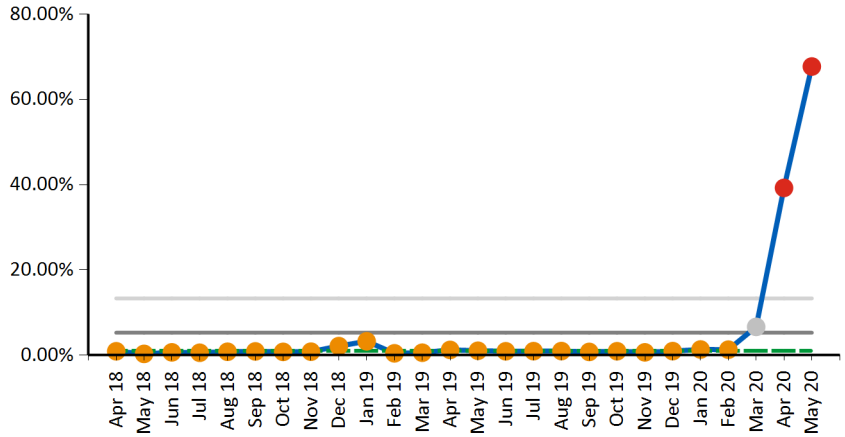
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



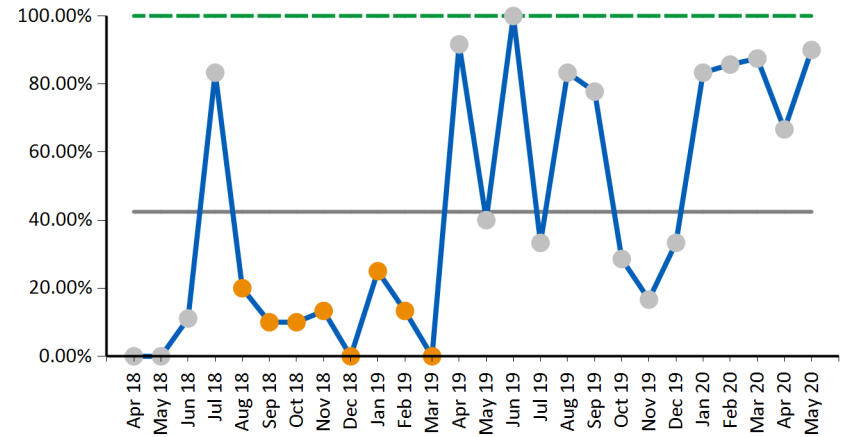
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



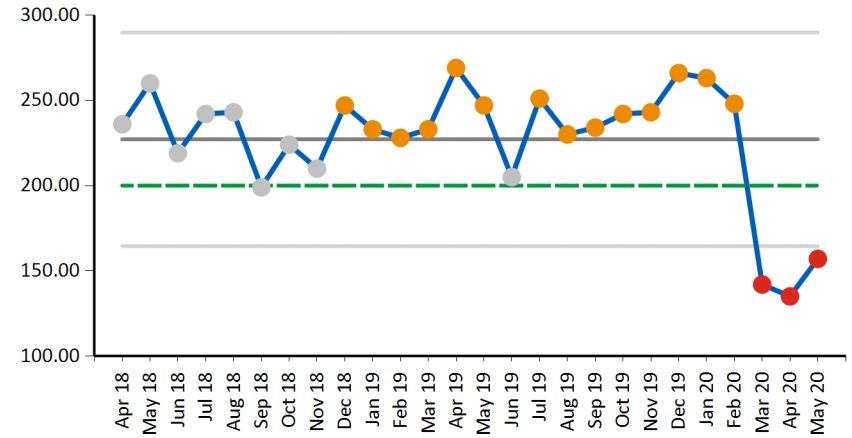
27 - TIA (Transient Ischaemic attack) patients seen <24hrs



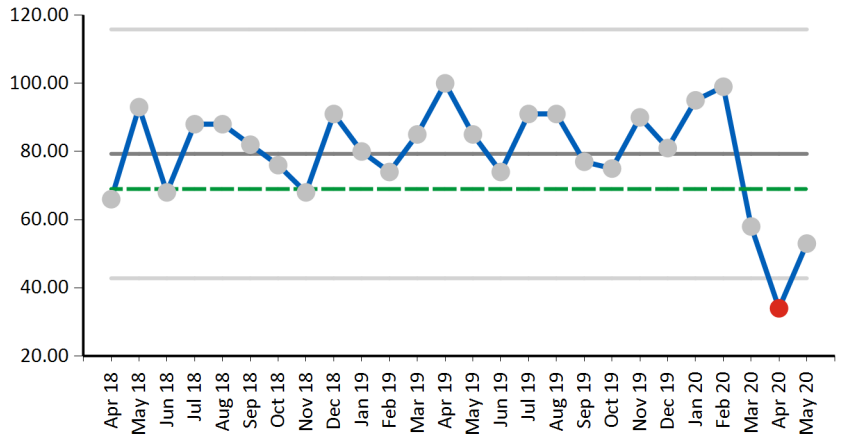
Productivity

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	157	May-20	L	<= 200	135	Apr-20	<= 200	157	?
307 - Stranded Patients - LOS 21 days and over	<= 69	53	May-20		<= 69	34	Apr-20	<= 69	53	?
57 - Discharges by Midday	>= 30%	18.1%	May-20	L	>= 30%	15.3%	Apr-20	>= 30%	16.7%	?
58 - Discharges by 4pm	>= 70%	58.9%	May-20		>= 70%	55.5%	Apr-20	>= 70%	57.3%	?
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	14.3%	Apr-20	H	<= 13.5%	12.3%	Mar-20	<= 13.5%	14.3%	?
489 - Daycase Rates	>= 80%	87.8%	May-20		>= 80%	87.8%	May-20	>= 80%	87.2%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	0.2%	May-20	L	<= 1%	1.4%	Apr-20	<= 1%	0.8%	?
62 - Cancelled operations re-booked within 28 days	= 100%	0.0%	May-20	L	= 100%	0.0%	Apr-20	= 100%	322.2%	?
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	0.9%	May-20	L	<= 3.3%	0.5%	Apr-20	<= 3.3%	0.7%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.64	May-20		<= 2.00	3.34	Apr-20	<= 2.00	2.99	?
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.04	May-20		<= 3.70	6.06	Apr-20	<= 3.70	5.05	F
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	94.1%	Feb-20		>= 80%	82.8%	Jan-20	>= 80%		?

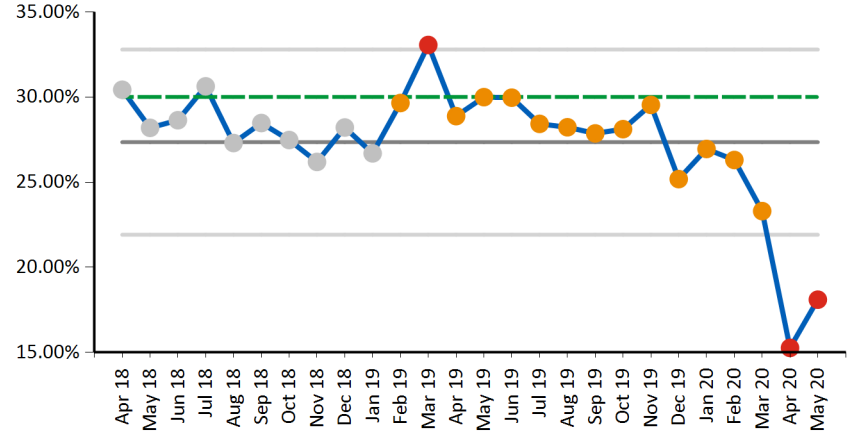
56 - Stranded patients



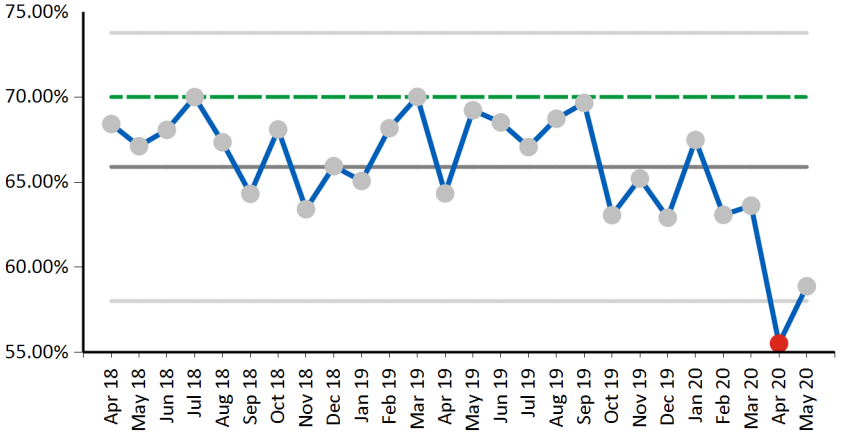
307 - Stranded Patients - LOS 21 days and over



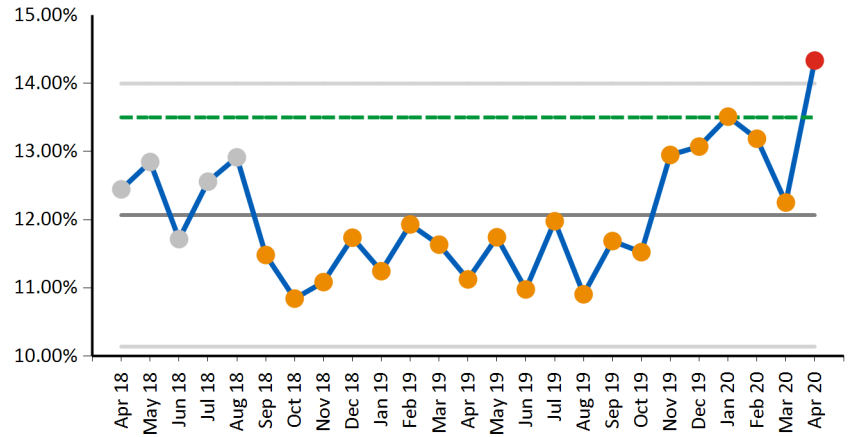
57 - Discharges by Midday



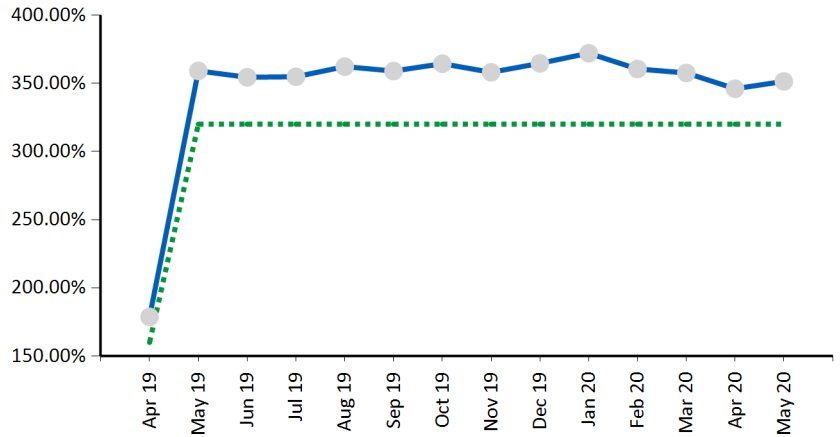
58 - Discharges by 4pm



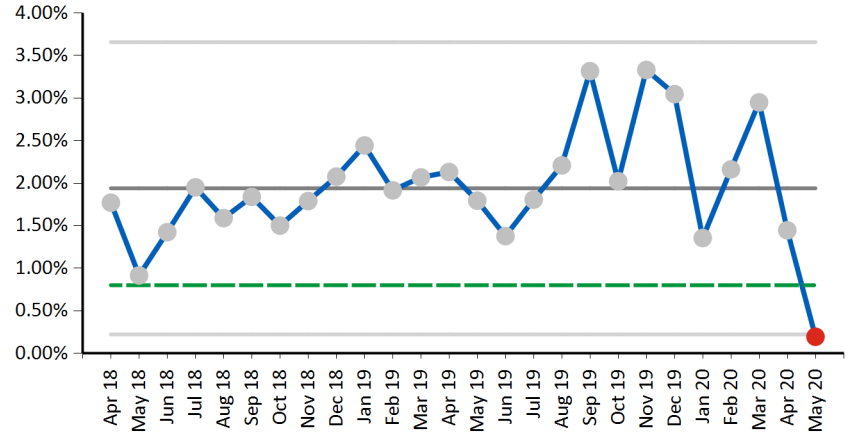
59 - Re-admission within 30 days of discharge (1 mth in arrears)



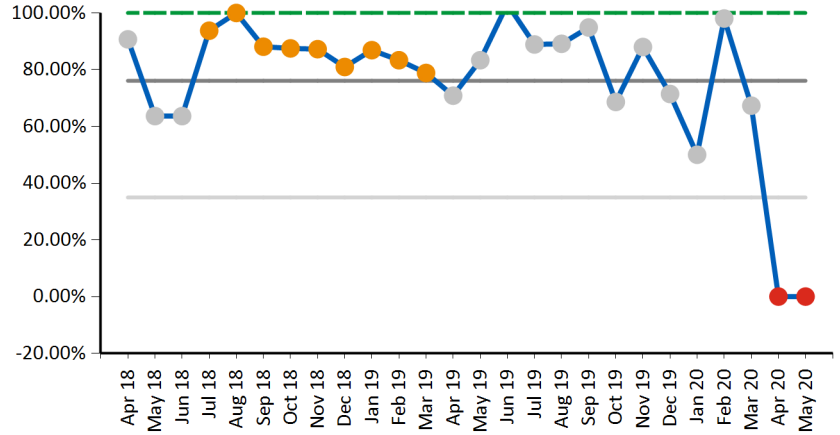
489 - Daycase Rates - SPC data available after 20 data points



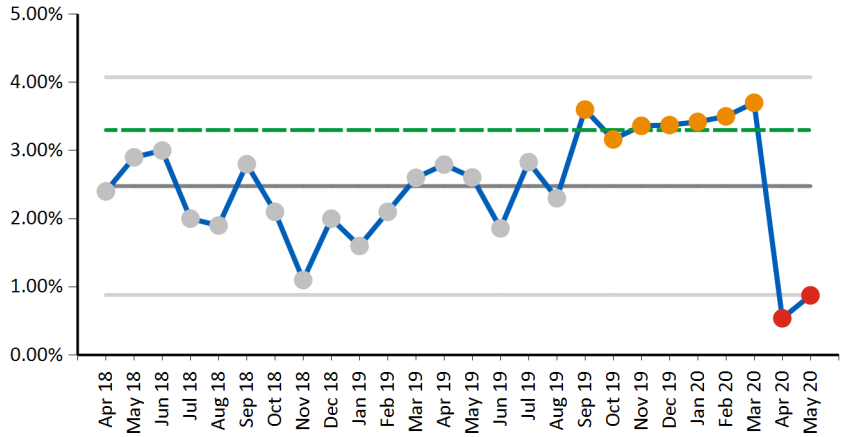
61 - Operations cancelled on the day for non-clinical reasons



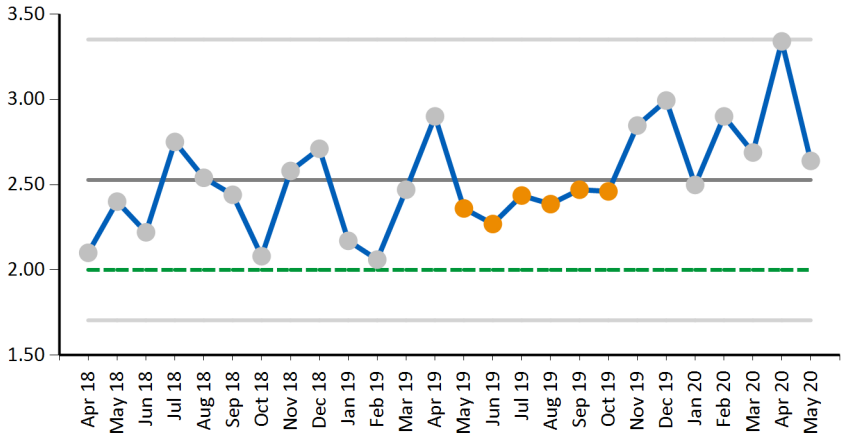
62 - Cancelled operations re-booked within 28 days



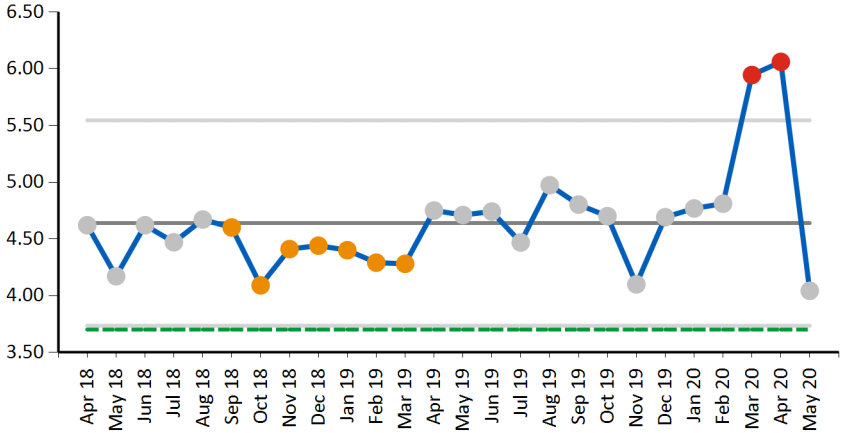
318 - Delayed Transfers Of Care (Trust Total)



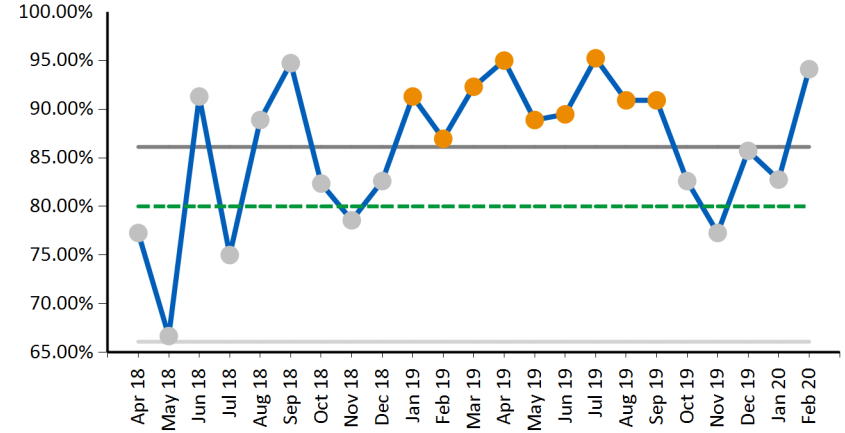
65 - Elective Length of Stay (Discharges in month)



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



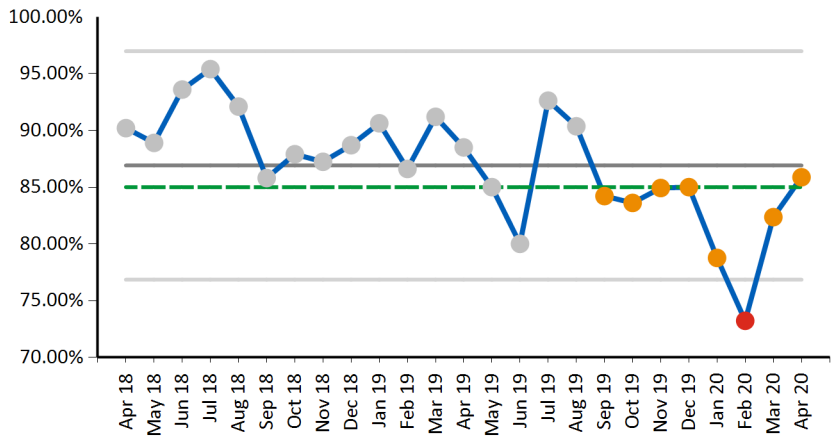
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



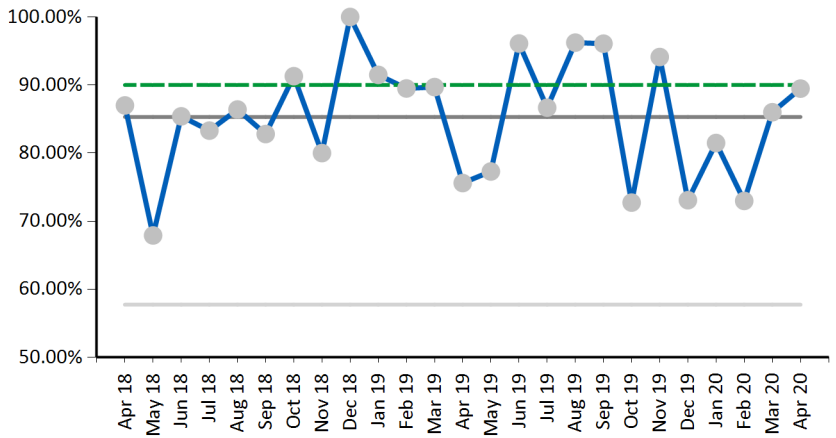
Cancer

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
46 - 62 day standard % (1 mth in arrears)	>= 85%	85.9%	Apr-20	L	>= 85%	82.4%	Mar-20	>= 85%	85.9%	?
47 - 62 day screening % (1 mth in arrears)	>= 90%	89.5%	Apr-20		>= 90%	86.0%	Mar-20	>= 90%	89.5%	?
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Apr-20		>= 96%	100.0%	Mar-20	>= 96%	100.0%	P
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Apr-20		>= 94%	83.3%	Mar-20	>= 94%	100.0%	?
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Apr-20		>= 98%	100.0%	Mar-20	>= 98%	100.0%	P
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	96.2%	Apr-20		>= 93%	98.0%	Mar-20	>= 93%	96.2%	?
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	95.6%	Apr-20	H	>= 93%	89.7%	Mar-20	>= 93%	95.6%	F

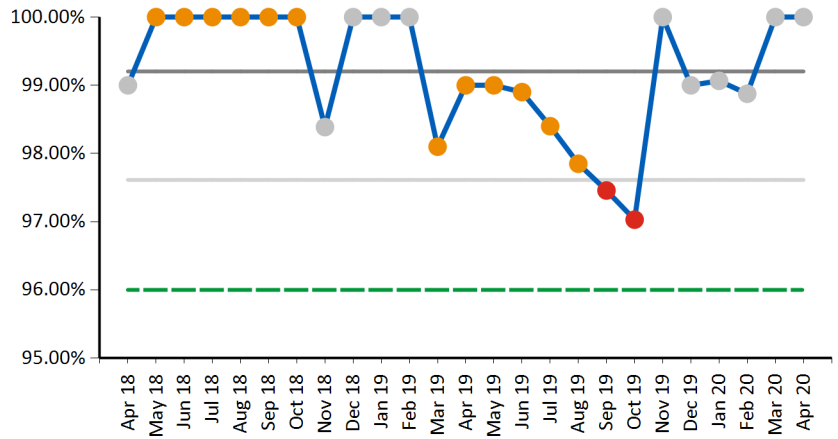
46 - 62 day standard % (1 mth in arrears)



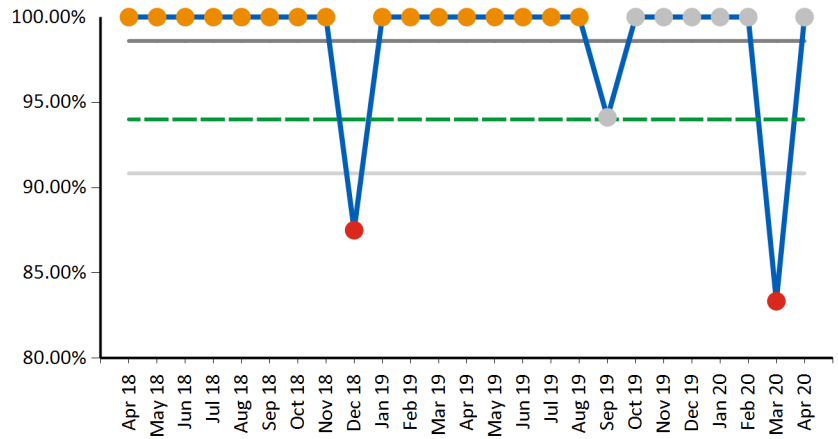
47 - 62 day screening % (1 mth in arrears)



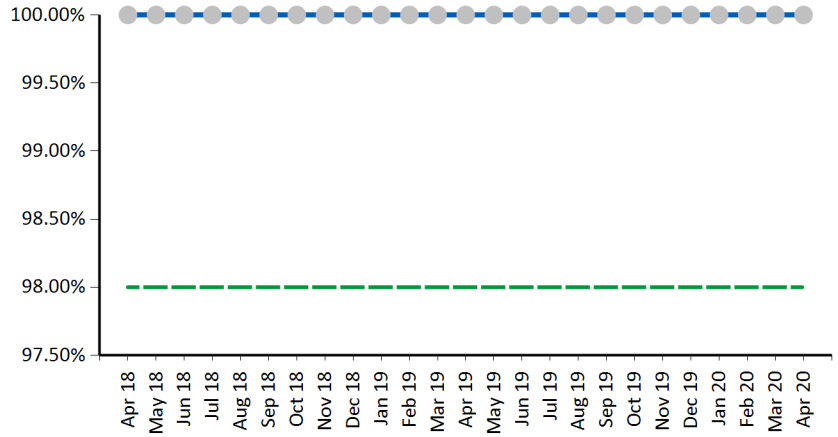
48 - 31 days to first treatment % (1 mth in arrears)



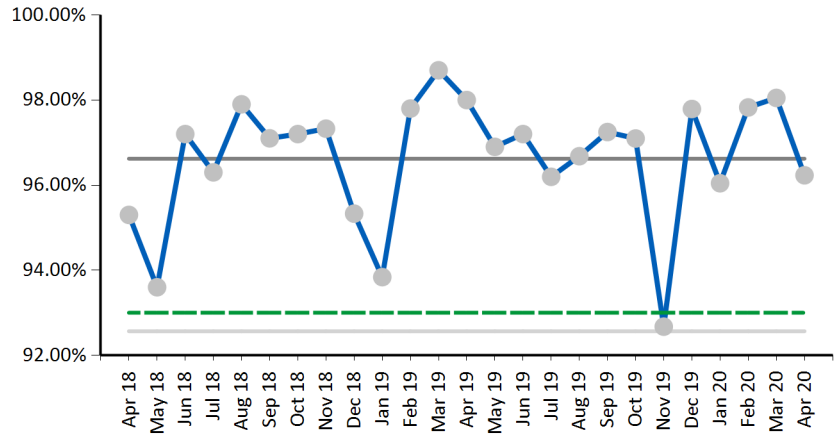
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



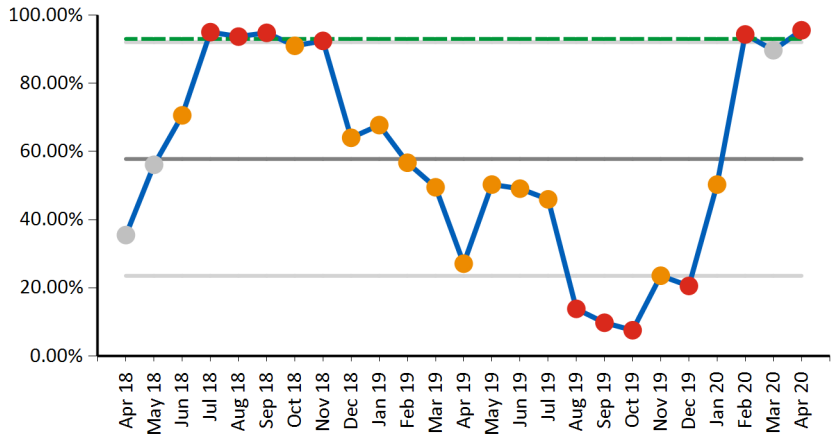
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



51 - Patients 2 week wait (all cancers) % (1 mth in arrears)



52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)

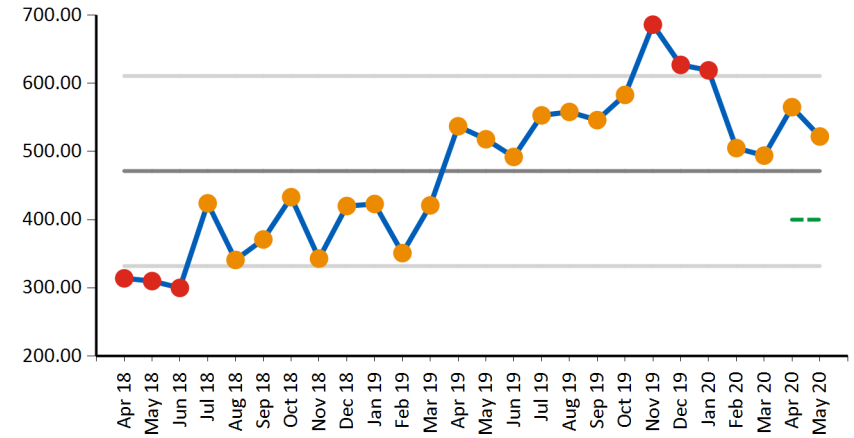


Community

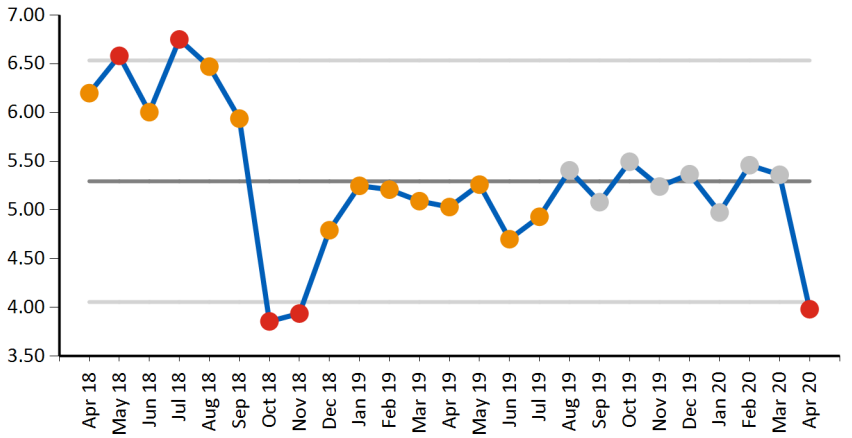
Delayed Transfers of Care/Medically Optimised/ITS Length of Stay
The implementation of the discharge service requirements which were mandated for hospital and community providers in March, continue to have a positive impact by helping people leave hospital in a timely way. Phase 2 planning for the Integrated Community Service Division focuses on how the service standards can be sustained in the long term.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	522	May-20	H	>= 400	565	Apr-20	>= 800	1,087	?
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	3.98	Apr-20	L		5.36	Mar-20	<= 6.00	3.98	?
230 - Medically Optimised Numbers	<= 50	8	May-20	L	<= 50	11	Apr-20	<= 100	19	?
231 - Medically Optimised Days	<= 209	14	May-20	L	<= 209	21	Apr-20	<= 418	35	?

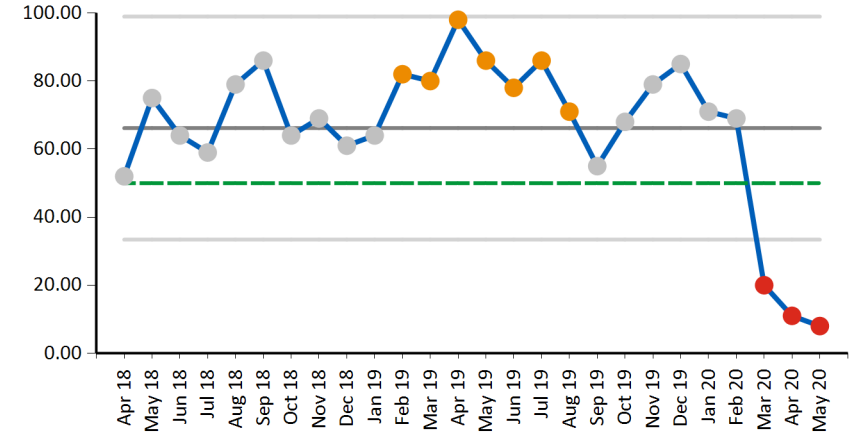
334 - Total Deflections from ED



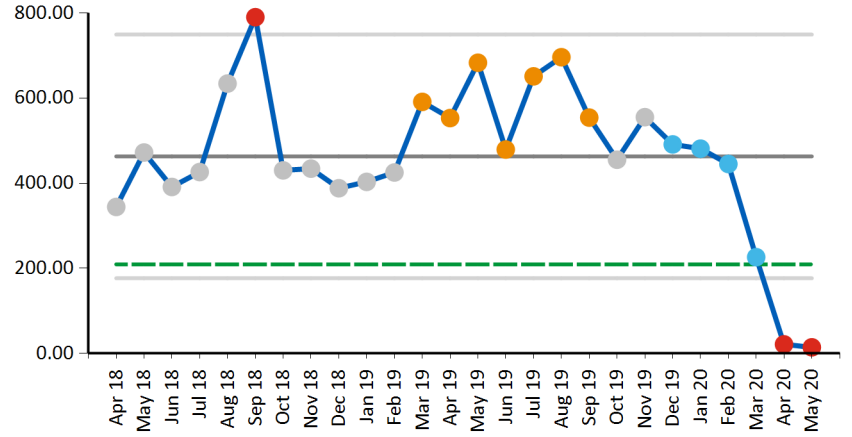
335 - Total Intermediate Tier LOS (weeks)



230 - Medically Optimised Numbers



231 - Medically Optimised Days



Workforce

Sickness, Vacancy and Turnover

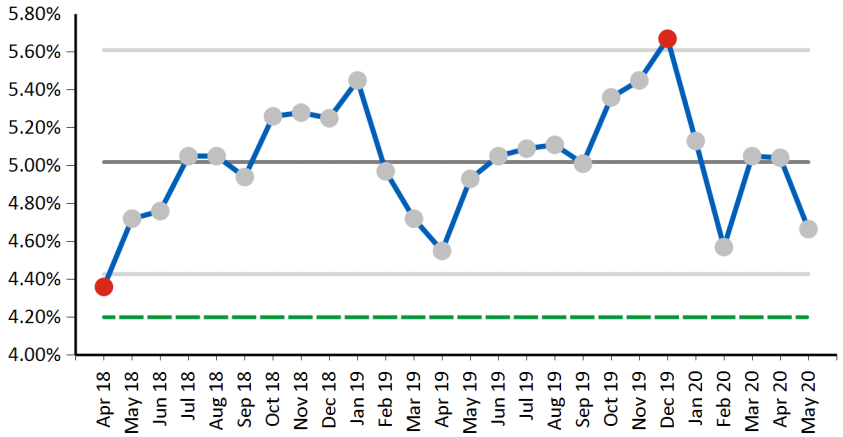
Sickness, turnover, vacancy rate and investigations
Board members will note that the sickness rate has reduced. Of note though the sickness absence figures noted do not include those on sick leave due to Covid (currently 29 staff), furthermore the number does not include those staff that are shielding (189). Daily reports on total unavailability are presented to the Executive team (and wider organisation) on a daily basis.. Noted within the Board papers are the Health & Wellbeing measures that are being taken to support our staff at this difficult time.

Performance on the recruitment & retention metrics remains strong. The Workforce Assurance Committee is sighted on the high level of recruitment activities that have been taking place during the Covid period (along with assurance that Safe Employment measures are being undertaken). Strong partnership working between the Divisional & Workforce Teams is evident which is supporting this positive position.

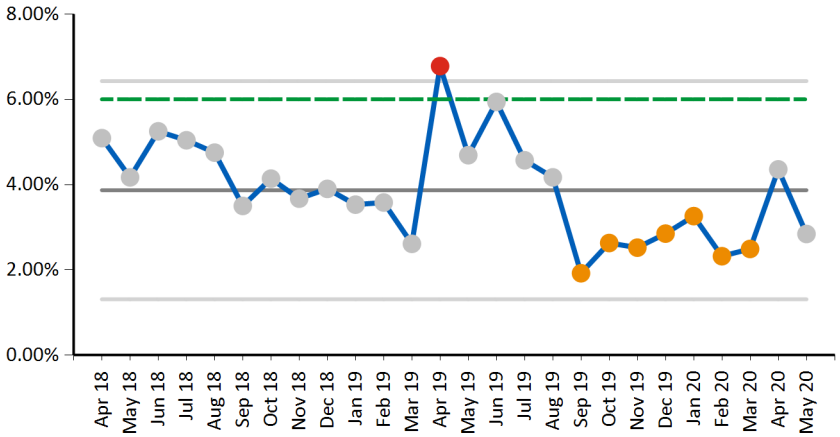
The number of investigations over 8 weeks remains low.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.66%	May-20		<= 4.20%	5.04%	Apr-20	<= 4.20%	4.85%	F
120 - Vacancy level - Trust	<= 6%	2.84%	May-20		<= 6%	4.36%	Apr-20	<= 6%	3.60%	?
121 - Turnover	<= 9.90%	10.36%	May-20		<= 9.90%	10.85%	Apr-20	<= 9.90%	10.60%	?
366 - Ongoing formal investigation cases over 8 weeks		1	May-20			1	Apr-20		2	

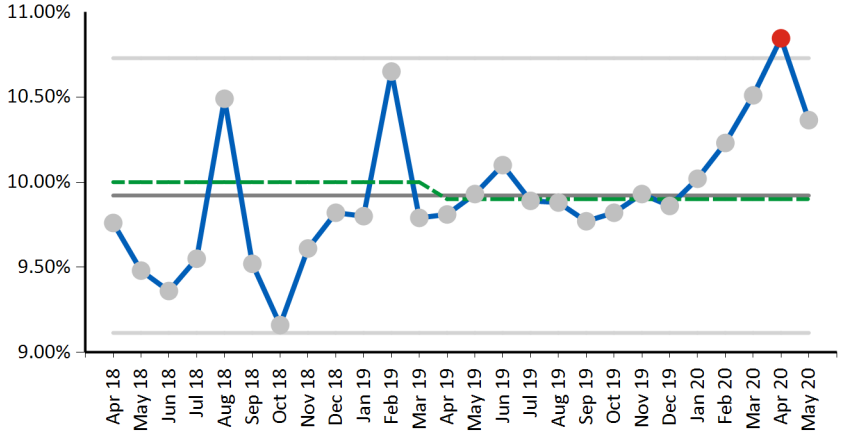
117 - Sickness absence level - Trust



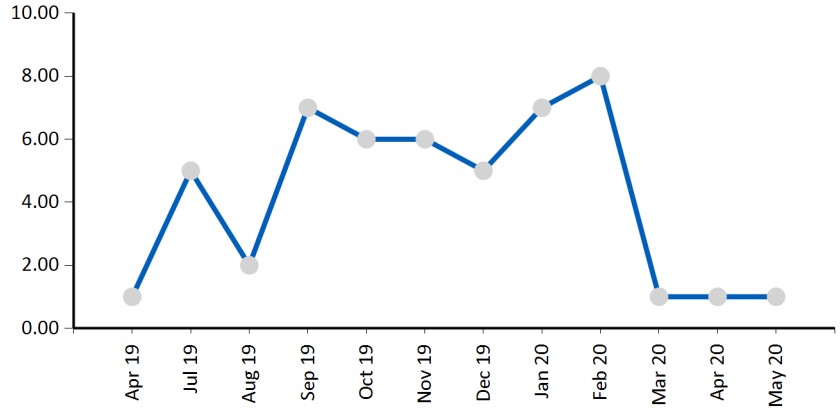
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks - SPC data available after 20 data points



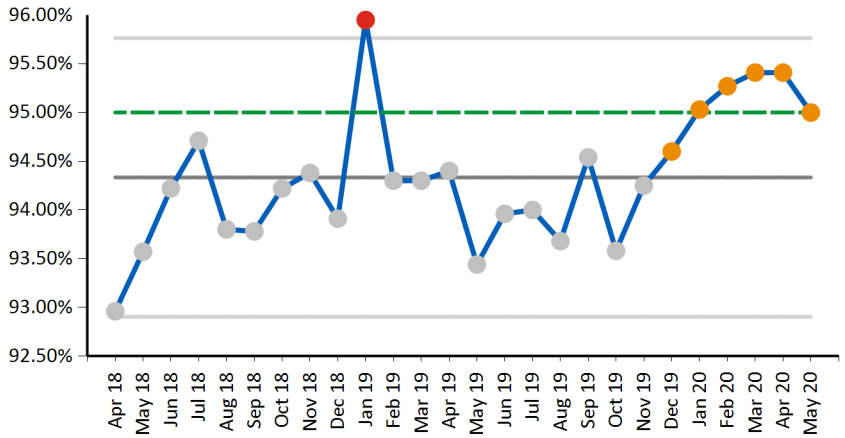
Organisational Development

OD metrics
The OD indicators remain strong, with Mandatory Training, Statutory Training above target. There has been a dip in the number of Appraisal being undertaken which, whilst this is understandable and may continue for the next few months, that said the OD team is working with the Divisions on potential recovery actions that can be taken. As previously noted there have been made as to how we manage key training matters during the Covid period, Board members can be assured that safety remained the key consideration in any changes that have been made..

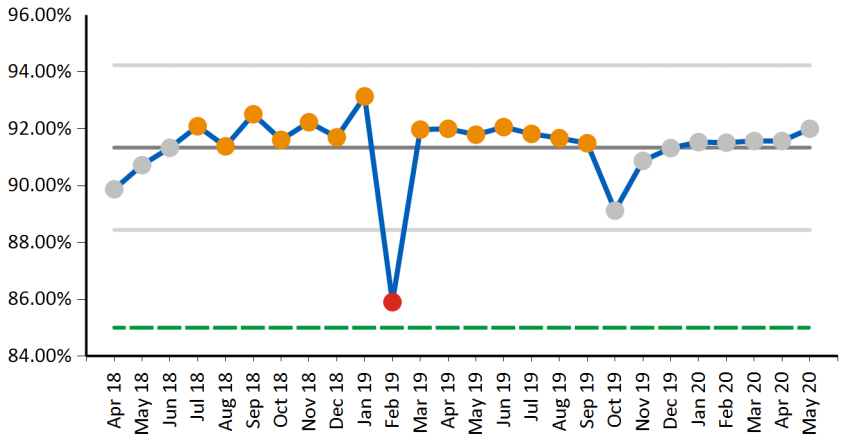
NHS Staff Survey – At the next Board meeting we will be able to report on Q4 data. As noted for the NHS Staff Survey we benchmark very positively in Greater Manchester (joint top for Acute Trusts') and in the top 25% nationally.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	95.0%	May-20		>= 95%	95.4%	Apr-20	>= 95%	95.2%	
38 - Staff completing Mandatory Training	>= 85%	92.0%	May-20		>= 85%	91.6%	Apr-20	>= 85%	91.8%	
39 - Staff completing Safeguarding Training	>= 95%	95.64%	May-20		>= 95%	96.93%	Apr-20	>= 95%	96.28%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	74.9%	May-20		>= 85%	76.9%	Apr-20	>= 85%	75.9%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	70.0%	Q3 2019/20		>= 66%	78.5%	Q2 2019/20	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	66.0%	Q3 2019/20		>= 80%	74.9%	Q2 2019/20	>= 80%		

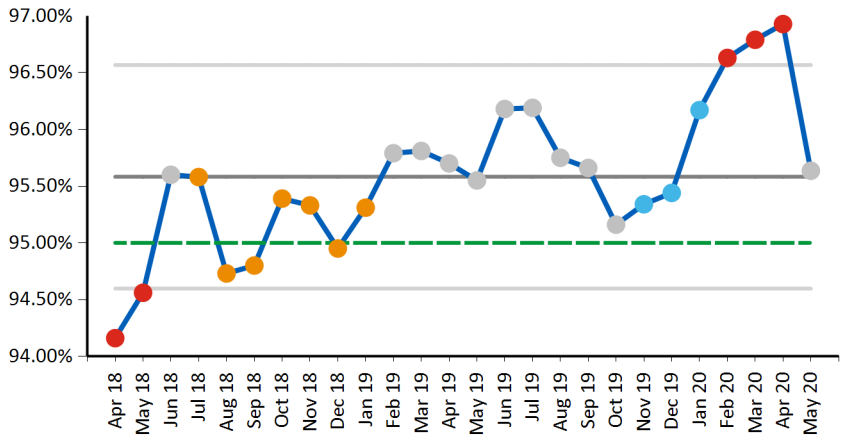
37 - Staff completing Statutory Training



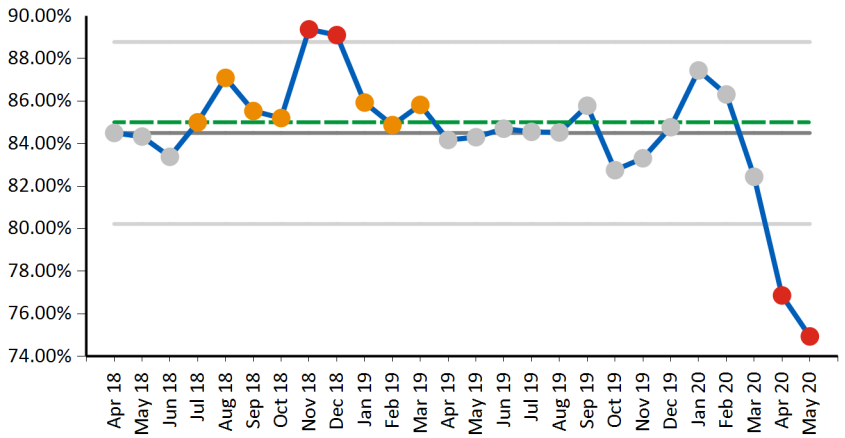
38 - Staff completing Mandatory Training



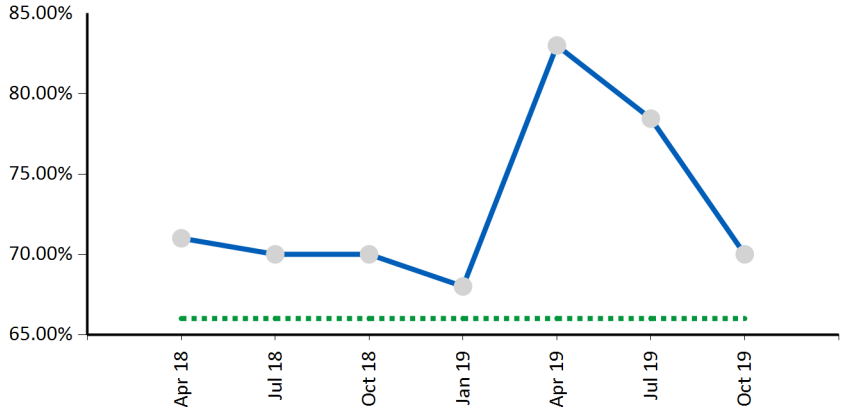
39 - Staff completing Safeguarding Training



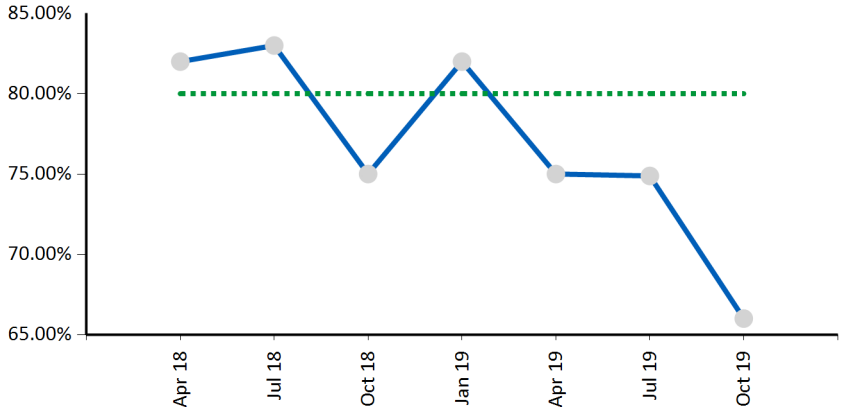
101 - Increased numbers of staff undertaking an appraisal



78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) - SPC data available after 20 data points



79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) - SPC data available after 20 data points

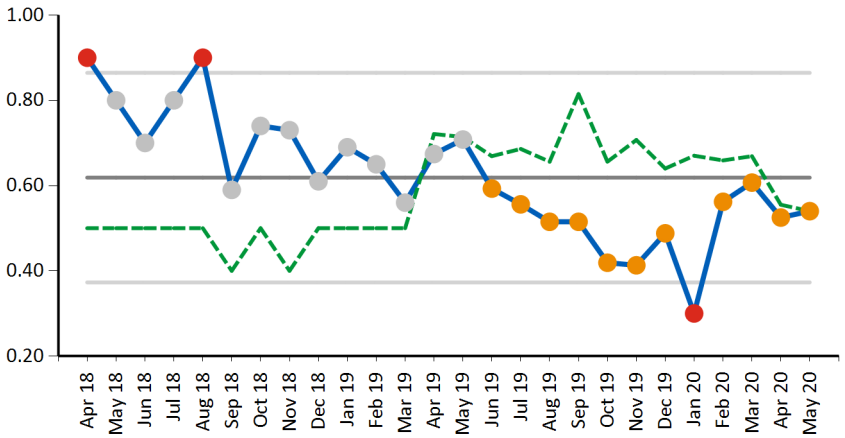


Agency

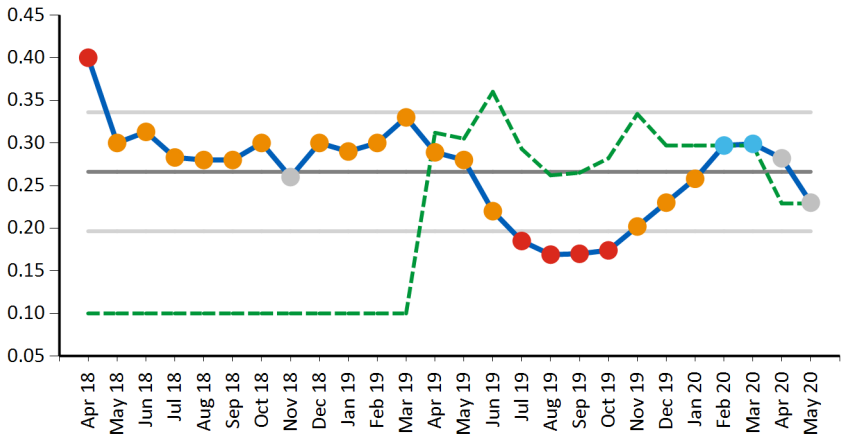
Agency
Colleagues will note the in-month Agency spend remains below the Trust's forecast. As would be expected the two areas of greatest spend being Nursing, Medical.The Trust continues to benchmark very favourable on Agency spend when compared to peer organisations for % Agency spend versus overall pay.

	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)	<= 0.54	0.54	May-20		<= 0.56	0.53	Apr-20	<= 1.10	1.07	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.23	0.23	May-20		<= 0.23	0.28	Apr-20	<= 0.46	0.51	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.25	0.25	May-20		<= 0.25	0.10	Apr-20	<= 0.50	0.35	

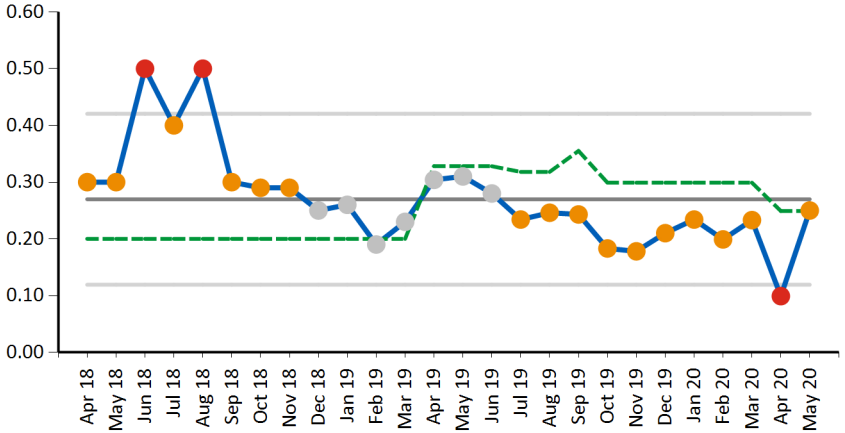
198 - Trust Annual ceiling for agency spend (£m)



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



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



Finance

Finance

Revenue Performance - The position for the month overall was break even after £2.1m of additional top up income was requested to cover the £2.4m spent on Covid and had an income shortfall of £0.8m. This regime will continue to month 4, when new guidance on funding will be given for the remainder of the year. NHSI are putting increased scrutiny on the additional top ups and none have been agreed as yet.

Cost Improvement - Cost improvement requirements are currently suspended. Savings of £5.7m were identified prior to March but risk rated down to £2.2m. The cost improvement target was £9.0m but this will be subject to review once BAU returns.

Variable Pay - We spent £2.3m on variable pay in month 2, marginally less than April. Of this, the premium increased to £0.4m and is Covid related.

Capital Spend - We spent £0.3m during month 2 including Covid items. Our plan for the year was originally set at £8.6m, but this has been revised down to £7.6m following a request from NHSI to scale back non Covid capital spend.

Cash Position - We had cash of £46.1m at the end of the month. This is due to cash payments from CCGs being made in advance and a healthy year-end balance.

Loans and PDC - We have loans of £44.4m outstanding with a further £3.2m expected to be drawn this year. PDC will be drawn down to cover Covid capital costs and the balance of the LED lighting project.

Aged Receivables and Payables - The analysis of receivables and payables shows a reduction on payables, whilst receivables is static. An exercise is on-going across Greater Manchester regarding clearing provider to provider amounts.

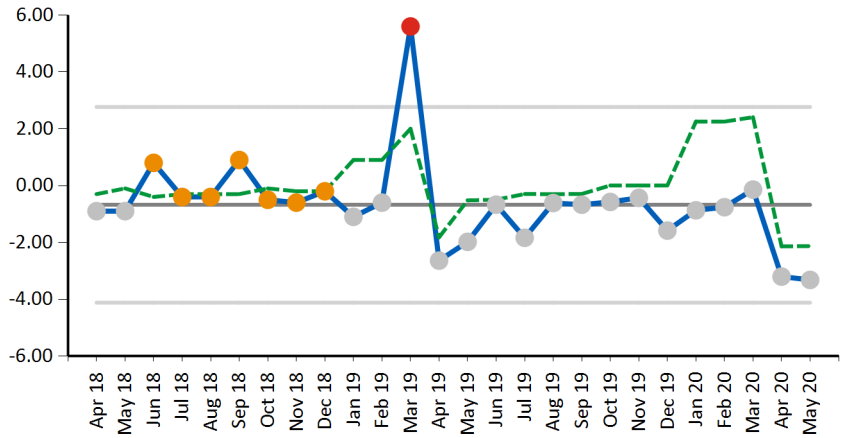
Better Payment Practices Code - We paid 94.5% of our invoices within 30 days. This is the strongest performance in years.

Use of Resources Rating - This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

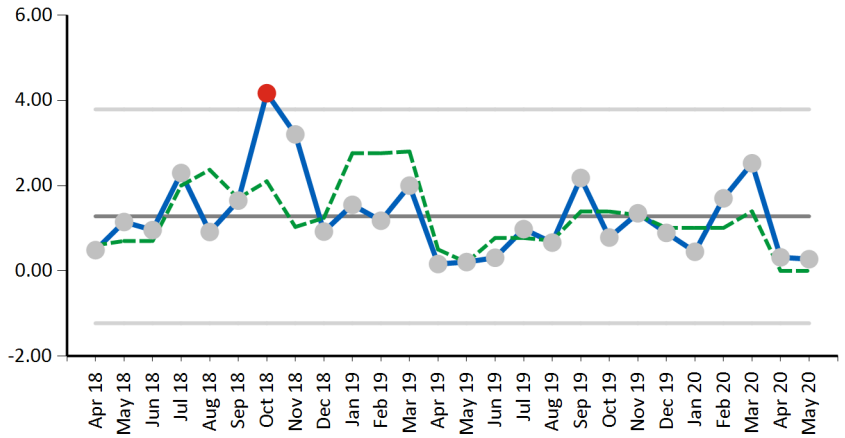
Risks - With the normal regime suspended, the financial risks mainly relate to shortfalls in top up income and PDC to meet Covid costs. There is also a risk that there is a loss of focus on cost improvement due to the change in the financial regime.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= -2.1	-3.3	May-20		>= -2.1	-3.2	Apr-20	>= -4.3	-6.5	
222 - Capital (£ millions)	= 0.0	0.3	May-20		= 0.0	0.3	Apr-20	= 0.0	0.6	
223 - Cash (£ millions)	= 0.0	46.1	May-20	H	= 0.0	41.4	Apr-20	= 0.0	46.1	P
224 - Use of Resources	= 0	0	May-20	L	= 0	0	Apr-20	= 0	0	F

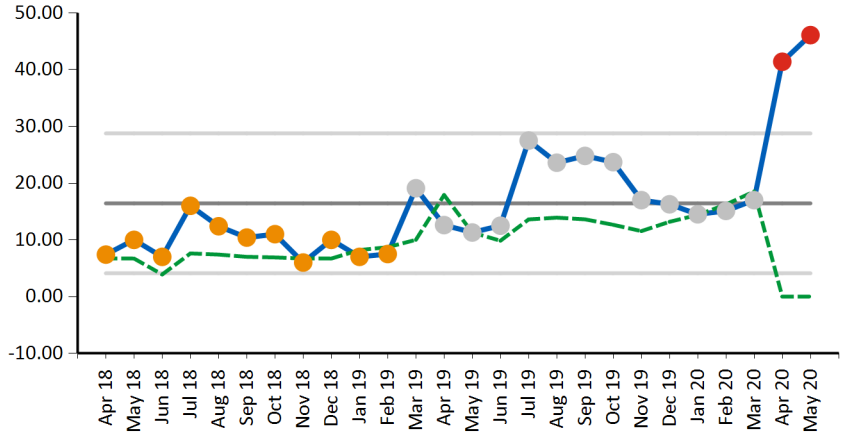
220 - Control Total (£ millions)



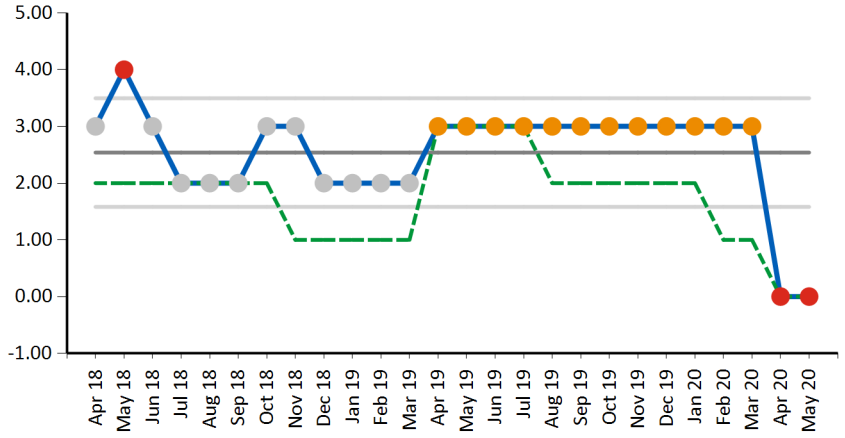
222 - Capital (£ millions)



223 - Cash (£ millions)



224 - Use of Resources



oard Assurance Heat Map - Hospital

	Indicator	Target	ICSD	Acute Division																			Anaesthetics & Surgical Division												Families Division											
			Darley Court	AED-Adults	AED-Paeds	A4	B1 (Frailty Unit)	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	H3 (Stroke Unit)	EU (daycare)	HDU	ICU	E3	E4	F3	F4	G3/TSU	G4/TSU	G5	DCU (daycare)	H2 (daycare)	UU (daycare)	E5 (Paed HDU and Obs)	F5	M1	M1A	EPU	M2	CDS	M3 (Birth Suite)	Ingleside	M4	M5	NICU	Overall
	Total Beds	*N/a*	30	0	0	18	0	0	21	10	25	26	26	27	10	14	26	22	27	27	12	24	9	10	8	25	25	25	24	24	24	16	25	11	4	38	7	15	2	6	26	15	5	4	44	22	38	797
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%	100.0%	90.0%			100.0%	85.0%		95.0%	100.0%	100.0%	95.0%	100.0%	100.0%	85.0%	50.0%	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%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.0%	100.0%	95.0%	98.0%
	IPC Rapid Improvement Tool %	*Target = 95%*	96.0%	77.0%	86.0%			78.0%	74.0%		91.0%	96.0%			96.0%		73.0%	91.0%	100.0%	91.0%		88.0%	100.0%	100.0%	100.0%	96.0%	96.0%	79.0%	92.0%	92.0%	83.0%		100.0%	100.0%						100.0%	96.0%	100.0%			87.0%	100.0%	95.0%	93.0%
	Mattress Audit Compliance %	*Target = 100%*	100.0%					100.0%	100.0%		100.0%	98.7%	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%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%
	C - Diff	*Target = 0*	1	0	0	0	0	0	0	0	0	0	1	2	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	0	0	5
	MSSA BSIs	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	E.Coli BSIs	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	MRSA acquisitions	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Harm Free Care	Safety Thermometer Survey (%)	*Target = 95%*																																													
	All Inpatient Falls (Safeguard)	*Target = 0*	12	2	0	1	0	6	1	0	5	7	7	8	0	1	6	5	3	6	0	3	0	0	0	7	1	2	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	87
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	0	0		0	1	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	0	0	2
	VTE Assessment Compliance	*Target = 95%*						12.5%	100.0%		88.9%	100.0%	94.4%	100.0%	94.6%	99.6%	99.7%	97.6%	100.0%	87.5%		100.0%	99.5%	100.0%	100.0%	100.0%	76.2%	99.1%	97.5%	100.0%	100.0%	100.0%	92.3%	60.0%	100.0%			96.8%	100.0%	84.6%	99.6%	88.1%	85.7%			58.8%	98.1%		97.2%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	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	0	2
	Monthly New pressure Ulcers (Grade 3)	*Target = 0*	0	2	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	2
	Monthly New pressure Ulcers (Grade 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	0	0
	PU due to lapses in care	*Target = 0*	0	2	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	0	0	0	0	0	0	0	0	3
Audit	Monthly KPI Audit %	*Target = 95%*	98.1%															94.7%													77.7%																97.1%	94.8%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*	92.3%	75.3%	75.3%	84.2%	64.2%	58.3%	81.4%		81.6%	75.6%	82.3%	75.8%	84.3%	76.4%	75.1%	83.2%	92.9%	90.2%	71.8%	85.7%	86.3%	92.1%	96.6%	86.8%	81.7%	90.8%	77.7%	90.4%	90.9%	85.3%			88.2%	90.1%	90.1%	81.3%	81.3%	81.3%	91.9%	90.3%	90.4%		71.4%	71.4%	90.3%	83.0%
	BoSCA Rating		platinum	silver	silver	silver	bronze	bronze	silver		silver	silver	silver	silver	silver	silver	silver	silver	platinum	gold	bronze	silver	silver	platinum	platinum	bronze	silver	platinum	silver	platinum	gold	silver			silver	platinum	platinum	silver	silver	silver	platinum	gold	gold		bronze	bronze	gold	Silver
Patient Experienc	FFT Response Rate	*Target = 30%*																																													
	FFT Recommended Rate	*Target = 97%*																																													
	Number of complaints received	*Target = 0*	0	1	0	0	0	0	1		0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	8
Governance	Serious Incidents in Month	*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	0
	Incidents > 20 days, not yet signed off	*Target = 0*	2	22	4	3	0	1	2	1	0	2	0	2	0	1	2	1	2	1	0	0	1	0	0	0	2	3	0	1	1	0	0	0	0	0	0	1	18	1	0	8	0	1	84
	Harm related to Incident (Moderate+)	*Target = 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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Staff Development	Appraisals	*Target = 85%*	87.9%	73.0%		80.0%	84.9%		71.7%		69.7%	69.1%	92.3%	52.6%	85.7%	90.0%	81.6%	75.7%	91.9%	52.6%	100.0%	86.8%	92.3%	70.2%	79.7%	27.8%	78.8%	68.4%	77.4%	83.3%	93.5%	70.0%	81.3%	78.9%	88.2%	79.7%		72.4%			88.9%	74.8%	79.2%	100.0%	79.3%	61.3%	83.3%	74.9%
	Statutory Training	*Target = 95%*																																													
	Mandatory Training	*Target = 85%*																																													
Staffing & Workforce	% Qualified Staff (Day)																																														
	% Qualified Staff (Night)								8.0%																																						
	% un-Qualified Staff (Day)																																														
	% un-Qualified Staff (Night)																																														
	Budgeted Nurse: Bed Ratio (WTE)		4.44	1.90	1.90	7.94	7.27	0.00	4.87	0.00	4.89	0.27	6.20	6.09	4.85	-1.59	3.41	4.48	3.71	2.59	0.00	2.29	12.14	-3.04	-0.45	0.47	5.78	4.96	5.72	4.70	1.99	1.95	2.35	1.75	1.54	2.95	2.95	0.97	-2.87	0.23	-1.29	-6.05	5.44	6.08	-2.72	-0.21	9.14	119.99
	Current Budgeted WTE (Ledger)		45.38	73.28	73.28	39.29	38.03	0.00	43.34		33.71	41.23	42.69	40.70	26.93	19.97	50.82	40.30	40.01	39.97		36.15	60.26	38.58	55.02	35.52	35.60	42.40	34.92	44.50	44.49	19.72	32.75	50.92	16.92	33.83	33.83	25.97	3.00	17.92	22.00	86.31	24.64	66.93	26.34	26.34	105.69	1709.46
	Actual WTE In-Post (Ledger)		40.94	71.38	71.38	31.35	30.76	0.00	38.47		28.82	40.96	36.49	34.61	22.08	21.56	47.41	35.82	36.30	37.38		33.86	48.12	41.62	55.47	35.05	29.82	37.44	29.20	39.80	42.50	17.77	30.40	49.17	15.38	30.88	30.88	25.00	5.87	17.69	23.29	92.36	19.20	60.85	29.06	26.55	96.55	1589.47
	Actual Worked (Ledger)		46.72	78.91	78.91	29.10	28.16	1.79	45.19		33.59	45.47	45.13	42.14	25.42	27.82	58.36	42.72	38.40	45.68		40.00	46.60	45.39	62.66	34.44	33.43	40.08	33.18	44.08	44.72	18.00	30.09	47.94	15.20	29.10	29.10	23.45	8.84	18.20	24.24	89.22	20.57	58.59	30.41	27.82	93.87	1702.73
	Sickness (%)	*Target is < 4.2%*	2.51%	6.99%		19.97%	13.78%		16.84%		2.88%	1.69%	7.81%	6.57%	2.01%	3.61%	4.38%	6.49%	6.00%	10.44%	0.00%	6.28%	7.41%	7.63%	10.22%	6.56%	10.21%	4.53%	10.82%	9.16%	5.52%	7.59%	17.07%	9.46%	5.31%	7.66%		3.77%			1.45%	5.01%	0.00%	0.00%	0.38%	3.67%	1.72%	4.66%
	Current Budgeted Vacancies		-5.78	-7.54	-7.54	2.25	2.60	-1.79	-6.72	0.00	-4.77	-4.51	-8.64	-7.53	-3.34	-6.26	-10.95	-6.90	-2.10	-8.30	0.00	-6.14	1.52	-3.77	-7.19	0.61	-3.61	-2.64	-3.98	-4.28	-2.22	-0.23	0.31	1.23	0.18	1.78	1.78	1.55	-2.97	-0.51	-0.95	3.14	-1.37	2.26	-1.35	-1.27	2.68	119.99
	Pendppointment																																														0.00
	Substantive Staff Turnover	*Target is < 10%*	8.3%	5.6%		13.7%	10.5%		23.5%		17.4%	10.8%		14.46	12.2%	3.4%	4.9%	13.2%	18.9%	12.1%	19.6%	0.0%	9.8%	7.6%	2.1%	10.5%	8.0%	11.3%	9.3%	18.5%	16.2%	11.8%	0.0%	5.3%	16.4%	11.1%	12.7%		14.0%			6.3%	1.6%	0.0%	0.0%	0.0%	0.0%	4.3%	10.36%

Data Legend

No data returned	
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists or Doctors.

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

Board Assurance Heat Map - District Nursing Domiciliary

	Indicator	Target	ICS Division												Overall
			Avondale and Chorley old Road	Breightmet & Little Lever	Crompton with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Treatment Rooms	
Infection Control & Harm Free Care	Safety Thermometer Survey %	*Target = 95%*													
	Hand Washing Compliance %	*Target = 100%*		100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	1	2	0	2	0	0	0	0	1	1	0		7
	Monthly New pressure Ulcers (Grade 3)	*Target = 0*	2	0	1	0	0	0	0	0	0	0	0		3
	Monthly New pressure Ulcers (Grade 4)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0		0
	PU due to lapses in care	*Target = 0*	1	0	0	1	0	0	0	0	0	0	0		2
Audit	Monthly KPI Audit %	*Target = 95%*		98.05%	95.02%	96.88%	95.67%	96.75%		98.30%	98.33%	97.86%			95.61%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*	92.41%	94.93%	91.10%	87.07%	95.95%	91.42%	96.15%	97.55%	91.74%	97.11%	96.93%	87.10%	93%
	BoSCA Rating		platinum	platinum	gold	silver	platinum	platinum	gold	gold	platinum	platinum	gold	silver	gold
Patient Experience	Friends and Family Response Rate %	*Target = 30%*													
	Friends and Family Recommended Rate %	*Target = 97%*													
	Number of Complaints received	*Target = 0*	1	0	0	0	0	0	0	0	0	0	0	0	1
Staffing & Workforce	Current Budgeted WTE														0.00
	Actual WTE In-Post														0.00
	Actual WTE Worked														0.00
	Pending Appointment														0.00
	Current Budgeted Vacancies (WTE)														0.00
Staff Development	Sickness (%)	*Target is < 4.2%*	0.0%	0.0%	2.9%	4.9%	0.6%	0.0%	0.0%		0.8%	7.9%	6.7%	14.6%	2.8%
	Substantive Staff Turnover Headcount	*Target is < 10%*	8.3%	6.1%	5.0%	54.1%	0.0%	20.0%	12.9%		11.4%	18.2%	12.3%	12.7%	11.2%
	12 month Appraisal	*Target = 85%*	40.0%	93.3%	80.0%	80.0%	66.7%	100.0%	100.0%		82.4%	66.7%	75.9%	93.3%	66.67%
	12 month Statutory Training	*Target = 95%*													
	12 month Mandatory Training	*Target = 85%*													

Data Legend

No data returned	
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