Location: Boardroom **Time: 0900**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story	DoN		For the Board to hear a recent patient story to bring the patient into the room (Press and public to be excluded to preserve confidentiality)
09.30	1.	Welcome and Introductions	Chairman	verbal	
	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 30 January 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
	7.	Chair's Welcome	Chair	Verbal	To receive a report on current issues
	8.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09.45	9.	Quality Assurance Committee Chair Report 19 February 2020	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	10.	Finance and Investment Committee – Chair Report - 25 February 2020	FC – Chair	verbal	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	11.	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
	12.	Urgent Care Delivery Board Chair Report –	CEO	Report	To receive a report on the Urgent Care Delivery Board
	13	Audit Committee Chair Report	Audit Chair	Report	AC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10.30	14	Mortality Report	Medical Director	Report	For assurance
10.45	15	Seven Day Services	Medical Director	Report	To receive for information

COFFEE

11.10	16	AHP Focus	Associate Director AHP	Presentation	To receive for information
11.30	17	Integrated Performance Report	Exec team	Report	To receive for information
Governance					
12.00	18	Integrated Community Partnership Business Plan	CEO	Report	
Strategy					
12.10	19	Research and Development - briefing	Dir Qual Gov	Report	To receive for information
12.30	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					
	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				

Lunch

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	30 January 2020
Venue	Boardroom RBH

Present:-

Mrs D Hall	Chair	DW
Dr J Bene	Chief Executive	JB
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
Ms B Ismail	Non-Executive Director	BI
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 A Walker	Director of Finance	AW

In attendance: -

Mrs E Steel	Trust Secretary	ES

Apologies Mr A Thornton – Non Executive Director

Declarations of Interest

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

Patient Story

J attended to share her experiences as a patient with a long standing respiratory condition resulting in over 70 admissions for inpatient care primarily in D4 but also including time in A&E, assessment areas and high dependency areas. J's story highlighted the importance of communication with patients to ensure that patients have a good understanding of their condition and are a partner in their treatment.

J had lots of praise for nursing staff and advised that although staff were caring and compassionate there were times when staffing levels felt stretched, the ward

environment could at times compromise a patient's privacy and dignity and on D4 the lack of a day room meant there was nowhere to go to get away from the bed space. Board members discussed the plans to develop communal spaces and the potential for development of outside areas overseen by the environmental group.

Resolved: Board members thanked J for sharing her experiences and agreed to address the points raised feeding back through the PEIP and QA Committees.

FT/20/01	FA/MF to follow up on issues raised by the patient including privacy and dignity	FA/MF
FT/20/02	AE to follow up with JN potential for student involvement in environmental/sustainability developments	AE

4. Minutes of The Board Of Directors Meetings held 19 December 2019

The minutes of the meetings held on 19 December 2019 were approved as a true and accurate reflection of the meeting subject to a correction to item 10 which now reads "*targeting and now achieving 600 deflections per month"*.

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's Report

The Chair welcomed Board members and observers to the first meeting of 2020.

8. Chief Executive report

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

Flu Vaccination

The Trust's response to the NHSE checklist for staff flu vaccination had been submitted confirming that the Trust were fully compliant with all aspects of the checklist. 98% or all medical staff and 76.6% of all frontline staff had received flu vaccination and the programme was still running.

Wuhan Corona Virus

Further guidance is anticipated on actions to take in readiness for any cases of the Wuhan Corona virus – the Trust previously put plans in place to respond to Pandemic flu and SARS – the infection control and emergency planning leads

are prepared and confident that any cases will be managed appropriately.

Board Assurance Framework

Board members noted the summary BAF – it was agreed that the newly formed commercial development group would be an additional mitigation for the financial risk.

Resolved: the board noted the CEO update.

9. Quality Assurance Committee Chair Report

In the absence of Mr Thornton, the NED Chair of the Quality Assurance Committee The Interim Director of Nursing presented the report from the meeting held on 15 January 2020.

Key points for escalation noted from the meeting were as follows:

- The Clinical Governance Committee escalated that alerts for IV training and NG tube insertion remained outstanding – actions had been identified to address this
- The committee received an update on the Quality Account priority for diabetes and expressed some concern about the progress made – discussions focused on the actions needed to ensure the Trust continues to do the right thing for patients with diabetes.
- A verbal update was provided on the care of patients with mental health issues in A&E, additional capacity in mental health has reduced long waits and further development to develop a team approach is required.
- The Mortality Committee escalated that SHMI remains high, they had also been advised that some issues with Wi-Fi and EPR have impacted on the functionality of e-obs and data collection.

Referring back to the patient story and other feedback from patients, the QA Committee were asked if consideration needed to be given to staff listening and ensuring patient understanding particularly when patients have a hearing or other sensory loss. The Interim Director of Nursing agreed to discuss potential actions including the roll out of the all about me booklet through the PEIP Committee

Resolved: The Board noted the report from the Chair of the Quality Assurance Committee

FT/20/03	PEIP to follow up on action to develop "All about me" for patients with sensory impairments	MF

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 21 January 2020.

At the end of month 9, the deficit excluding PSF was £11.0m against a planned deficit of £3.7m. The main reasons continue to be income shortfall, overspend and ICIP performance. The Trust is still forecasting that it will achieve the financial recovery plan of a £13.1m deficit (pre PSF)

The Committee received an update on ICIP progress, the main shortfall being in relation to system savings. Work has commenced on identifying plans for 20/21 with recognition that this gets harder each year and will only be achieved through realising benefits of transformation.

The Committee received a detailed report on staffing levels, overall in 2019/20, headcount has increased, an element of this is due to the TUPE of staff on the 0 – 19 contract, some through recruitment to reduce agency expenditure including the conversion of overtime and bank staff work to substantive employment and some has been investment to ensure the safety or our staff and patients. A robust approval process is in place for all vacancies to ensure this is not "creep" The Finance Committee agreed that the report provide useful data for triangulation and requested it as a standing item on a quarterly basis.

Resolved: The Board noted the report from the Finance and Investment Committee.

11 Workforce Assurance Committee Chair Report

The Chief Executive presented her report from the meeting of the Workforce Assurance Committee held on December 20 2019.

Key discussion points from the meeting were as follows:

- Sickness absence remains the main issue of the workforce metrics monitored on the workforce dashboard
- The results from the staff survey including benchmarking will be reported to the Board in March 2020 – the response rate was slightly lower than average – it was agreed that in future the GoEngage survey would not be issued in the same quarter as the national staff survey.
- The Committee noted measure put in place to address sickness absence within the HCA workforce – a further follow up paper was requested.
- The Committee received the gender pay gap report and supported the publishing of this in line with national requirements.
- A new Guardian of Safe Working has been appointed

12 Six Monthly Nurse Staffing Report

The Interim Director of Nursing presented the six monthly safe staffing report to provide the Board with a comprehensive update on inpatient and midwifery staffing levels.

The report provided board members with detailed information on staffing levels, turnover, recruitment and retention included a summary of actions and initiatives being undertaken within each clinical division to address specific challenges and ensure the provision of safe staffing levels across the Trust.

The Interim DoN confirmed that all clinical areas should be aiming for 100% fill rates, NHSE/I have recognised the work the Trust has done to develop a positive culture with strong leadership and good staff retention.

A new process for exit interviews was introduced in April 2019, the outcomes from this will be reviewed within the Workforce Assurance Committee – exit interviews are undertaken by an employee's line manager but there is an option for this to be done by HR if requested.

In response to a question requesting a comparison with previous years, the Interim DoN confirmed that staffing levels have improved, staffing for contingency beds is always a challenge but this has been achieved.

Resolved: The Boar noted the report and thanked the Interim Director of Nursing and her team for their work to provide a comprehensive and coherent review.

13 Learning from Deaths Quarterly Report

The Medical Director presented the quarterly learning from deaths report, in line with guidance this report sets out the total number of inpatient and Emergency Department deaths and detail of the deaths subjected to case record review. Of the deaths reviewed in Q3, 1 case was scoped as an SI as it was felt the death was likely to be due to problems with care.

The Learning from Deaths Committee provides an oversight of the process and receives the detailed outcomes from case reviews; in Q3 in addition to the 1 case scoped as an SI 7 other cases were rated as poor. All cases judged to be poor or very poor are subject to a secondary review, learning slides generated from this process are distributed to clinical teams across the Trust. Often when a case is rated as poor it is in relation to end of life care rather than clinical treatment where it is felt that more could have been done to meet a patient's holistic needs.

Board members discussed the provision of end of life care, the importance of providing dignity and of meeting a patients needs with regard to their preferred place of death.

Resolved: The Board received the Learning from deaths quarterly report.

(an update on end of life care has been added to the Board workplan for April 2020)

14 Introduction of new performance report

The Chief Operating Officer introduced Julie Ryan, Head of Business Intelligence in attendance to provide Board members with an introduction to the new performance report.

Following the presentation from NHSI at the November Board, the BI team had worked on developing a new report as recommended by NHSI using SPC charts the new format of charts will enable identification of metrics where changes are a significant trend rather than common cause variation – narrative can then focus on understanding decreased or increased performance and the impact of actions taken to improve should be noticeable if the actions have the desired effect.

Resolved: board members thanked the BI team for their input to transform the dashboard.

15. Integrated Performance Report

Board members reviewed the metrics presented in the new format report with the Executive team highlighting areas for focus and action.

16. **Scheme of Delegation**

The Director of Finance asked Board members to consider and approve changes to the Scheme of Delegation as outlined in the paper.

Resolved:

The Board approved a change to the Scheme of Delegation to create an additional level of approval for matrons to approve expenditure up to £2.5k.

The Board approved a proposal for future changes to levels below £50k to be approved by the Director of Finance

The Scheme to be updated to reflect the Governor role in the appointment of the External Auditor.

Any other business

Board members received copies of the Bolton Family pledge card and endorsed the organisation's commitment to the pledges.

14. **Questions from members of the public**

No questions from the public

Date and Time of Next Meeting

27 February 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.

January 2020 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/83	19/12/2019	patient story	video to share learning opportunity from family experience	MF	Feb-20	complete - unable to progress request
FT/19/68	03/10/2019	Workforce strategy update	WAC to undertake a focus on retention and report back thru Chair report	JM	Jan-20	agenda item
FT/19/38	27/06/2019	Seven Day services	Verbal update on benchmarking, written update in six	FA	Feb-20	agenda item
FT/19/64	03/10/2019	performance report	Mortality update	FA	Feb-20	agenda item
FT/19/65	03/10/2019	performance report	update on outpatient improvement plan including action to	SM	Feb-20	agenda item
FT/19/77	28/11/2019	CEO report	Review of risk appetite	ES	Feb-20	agenda item
FT/19/89	19/12/2019	future strategy	update on research opportunities	MF	Feb-20	agenda item
FT/20/05	30/01/2020	Ward visits	Follow up regarding use of hand held devices on C1	AE	Feb-20	verbal update
FT/20/06	30/01/2020	Ward visits	Follow up on availability of same sex staffing	MF	Feb-20	verbal update
FT/19/62	03/10/2019	Shadow Board	Report through Workforce Assurance Committee on the Shadow Board programme	JM	Mar-20	
FT/19/73	31/10/2019	performance report	update to QA committee on Breast waiting times	AE	Mar-20	
FT/19/84	19/12/2019	patient story	report back on the offer for children with special needs	MF	Mar-20	
FT/19/85	19/12/2019	Urgent Care Board	update on the people plan to Board	JM	Mar-20	
FT/19/87	19/12/2019	complaints process	update on complaints and concerns process to QA Committee	MF	Mar-20	
FT/19/88	19/12/2019	future strategy	review potential to be designated as a teaching hospital	SM/JM	Mar-20	
FT/20/01	30/01/2020	patient story	FA/MF to follow up on issues raised by the patient including privacy and dignity	MF/FA	Mar-20	report back through QA Committee
FT/20/02	30/01/2020	patient story	AE to follow up with JN potential for student involvement in environmental/sustainability developments	AE	Mar-20	
FT/20/03	30/01/2020	QA chair report	PEIP to follow up on action to develop "All about me" for patients with sensory impairments	MF	Mar-20	
FT/20/04	30/01/2020	Ward visits	Discussion with iFM re space utilisation and development of Day Rooms	Execs	Mar-20	
FT/20/07	30/01/2020	Ward visits	Consideration of incentives for attendance to reduce sickness absence	JM	Mar-20	report through WAC Chair report
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	Apr-20	
FT/19/78	28/11/2019	F and I Report	update on EPR implementation	AE	Apr-20	
FT/19/51	25/07/2019	sustainability	update on work of the sustainability group	AE	May-20	
FT/19/82	28/11/2019	iFM business plan	Carbon Neutral strategy	AE	Jun-20	

Key

complete	agenda item	due	overdue	not due

Agenda Item No:	
Meeting:	Board of Directors
Date:	27 February 2020

NHS Bolton NHS Foundation Trust

Title:	Chief Executive Report

Purpose	The Chief Executive update includes a summary of key issues since the previous Board meeting, including but not limited to:
	• NHS Improvement update
	• Stakeholder update
	• Reportable issues log
	  ○ Coroner communications
	  ○ Never events
	  ○ SIs
	  ○ Red complaints

Executive Summary:	
Previously considered by:	
Recommendation Please state if approval required or if for information	Provided for information 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*	✓
Negative Impact		**Neutral Impact**	**Positive Impact**

Prepared by:	Esther Steel Trust Secretary	**Presented by:**	Dr J Bene Chief Executive

1. Awards and recognition

Employee of the Month

Dillon Robertson, Booking Clerk, Access, Booking & Choice, Diagnostic & Support Services Division. Dillon went above and beyond by not just booking to rule, but by striving to do better for the specialty and the patients, by dedicating himself to being as responsive as possible when booking in patients to maximise the slot utilisation. One of the clinical specialists took the time to say how fantastic Dillon had been by being helpful, proactive and responsive in his work at ensuring all slots are utilised - he was making a real difference to the running of the clinics for the specialty and improving throughput as well as quality and timeliness for patients

Team of the Month

As Board members are aware, the BI team have worked extremely hard to deliver a significant change in terms of how data is presented to the Trust Board and through the Integrated Performance reports.

This significant change will be instrumental in supporting the organisation demonstrate the oversight of patient safety and experience, performance and financial management. This will strongly link to the Trusts roll out of the QI plan and enhance the understanding of how to measure and understand the SPA methodology. Business Intelligence, Informatics Directorate

2. News and Developments

2.1 NHSI/E

Board members were previously advised that the Trust costing submission for National Cost Collection 2019 (FY 2018/19) was incomplete and a decision has now been taken by NHSI/E and the relevant Arms Lengths Bodies to exclude our data from 2018-19 national costs publication.

Failing to submit data as required by the regulator is a breach of Provider Licence clause P2 paragraph 37. To address this, NHSI/E require the following:

- A summary of the issues which lead to the trust being unable to submit accurately costed the mandated costing data
- An action plan which provides details of how and when these issues will be addressed
- The plan for the 2020 costing submission.

The Costing team, along with NHS England & NHS Improvement's Regional Team, will implement on-going review of the action plan and will arrange to visit the trust in quarter 1 of 2020 to assess the arrangements in place to address the issues and ensure the 2020 submission is accurate.

Depending on progress and review and consideration of the 2020 submission, the Trust may also be visited as part of the Costing Assurance Programme in 2020-21. Subject to the outcome of this review and other relevant information, NHS England & NHS Improvement may consider further investigation and whether mandated support is necessary in accordance with the Single Oversight Framework (SOF).

The Trust will be independently audited on the costing process within the trust, designed to identify in more detail the issues with the trust's costing systems and processes, and to assist us in making improvements.

Subject to the outcome of the audit and other relevant information, NHS Improvement may consider further investigation and mandated support in accordance with the SOF.

2.2 Coronavirus update

The Trust Coronavirus Priority Assessment Pod utilising the re-purposed E.D. decontamination room is now operational and in line with NHSE requirements

2.3 NHS operational planning and contracting guidance 2020/21

NHS England and NHS Improvement (NHSE/I) published the operational planning and contracting guidance for 2020/21 on 30 January. This overarching document sets the delivery task for both NHS providers and commissioners for the coming financial year, covering system planning, finances, operational performance, and workforce.

The guidance says:

- Systems are required to improve urgent and emergency care performance next year, cutting acute bed occupancy by expanding bed capacity and providing more community care.
- Elective care waiting lists should be reduced, while 52 week waits for planned care should be eliminated. Performance against cancer standards should also improve. At least 70% of people should receive a cancer diagnosis within 28 days, under a new standard being introduced in 2020/21.
- Half of all financial recovery fund payments will depend on system-wide financial performance.
- A "system by default" model is being introduced to strengthen system working, in preparation for all areas to become integrated care systems by April 2021.
- An additional £1.44bn is to be invested in primary medical and community services, while 100% of the population should have access to online GP consultations.
- NHSX and NHSE/I, will explore a "minimum and optimal" indicative benchmark for revenue spend on digital technology.

2.4 Freedom to speak up guardians annual survey report

The National Guardian Office has published a new report which sets out findings from its annual survey of Freedom to Speak Up Guardians about how speaking up is being implemented in their organisations. More people have reported that they think their work is making a difference, and that awareness of the guardian role is improving.

However, the survey shows an increase from the previous year in the proportion of guardians indicating they have no ring-fenced time to carry out their role. In response to the findings, CQC has said it will be looking more closely at how hospital trusts are ensuring guardians are given protected time in future inspections.

The report also highlights that BAME workers are under-represented in the guardian network. The National Guardian Office has asked the NHSE/I workforce race equality standard (WRES) team to help it understand this and whether this aspect of guardian demographics does, in practice, impact on speaking up.

2.3 Recognition

The Trust received a note of thanks from Graham Urwin Regional Director of Performance & Improvement NHSE/I to acknowledge the mutual aid that was in place following the EPR outage at WWL.

The note acknowledged the consequence this would have had at Bolton, and acknowledged the effectiveness of the two organisations working together

3.0 <u>Reportable Issues Log</u>

Issues occurring between 30/01/20 and 18/02/20

3.1 Serious Incidents and Never events

We have reported three serious incidents, one of which was a never event although it did not lead to any permanent harm

Incident 149979: delayed C-Difficile diagnosis (StEIS reported 22/01/2020)

Incident 151137: Never Event - Wrong finger block (StEIS reported 23/01/2020)

Incident 151478: Maternity Incident/Baby transferred to NNU (StEIS reported 05/02/2020)

3.2 Red Complaints –

No red complaints

3.3 Regulation 28 Reports

No regulation 28 reports

3.4 Maternity incidents

With effect from next month's report a new section will be added to this report to include maternity and neonatal incidents defined as reportable in the revised CNST guidance. Board members may recall that we have previously submitted an annual declaration – this increased level of reporting is to increase assurance with regard to the safety of care within our maternity and neonatal services.

3.5 Whistleblowing

Nothing reports to escalate

3.6 Media Coverage – significant media coverage since the last Board meeting including:

- Good uptake of flu jab by medical staff
- Breast services – new role for breast screening; random acts of crochet kindness – items found by Breast Unit staff; M & S donation of softee bra inserts; new breast screening equipment
- Parents of premature twins help organise ball
- Hindu group donate toys to help children overcome anxiety about hospital stays
- Pod in place at hospital re coronavirus
- Hospital's ANPR to be provided by Parking Eye
- Longer ambulance waiting times
- Staff sickness absence rises
- Never event (NHSI figures for April – December 2019)
- MP talks about mother's death from sepsis at RBH
- Longer ambulance waits
- Staff ukulele band

4 Board Assurance Framework

The full Board Assurance Framework (BAF) is used to record and report the risks to the achievement of the Trust's 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 BAF has been reviewed to align with the new five year strategy; comments are welcome on how the risks to our new ambitions are reflected within the BAF

The full BAF is included within the papers for part two when the Board will discuss risk appetite for each area of the BAF.

Ambition	Lead	I	L	Feb	Jan	Dec	Key Risks/issues	Key actions	Oversight
To give every person the best treatment every time – reducing deaths in hospital	FA	4	4	16	16	16	Prompt identification and escalation of ill patients Increase in HSMR/RAMI	Ensure learning points are captured by Learning from deaths committee and that assurance fed back Ensure KPIS for E-obs/NEWS are agreed and monitored for improvement Ensure learning from deaths committee looks at diagnostic groups with greater than expected deaths using SJRs End of life strategy role out including education on identifying patients who are nearing end of life 17/-2/20 - Development of a robust Quality Improvement approach using Apprentice Levy funding with approved 3rd party provider with internal QA to ensure approach resonates with Trust and staff Make the best use of internal and external mortality intelligence Commission PwC to review Learning from Deaths processes, and share best practice observed in other clients – ongoing as at 17/02/20 Finalise Learning from Deaths Policy 02/01/2020 – instigated procurement/tendering process for peer benchmarked mortality intelligence (current contract ends September 2020) – Director of Quality Governance co-ordinating obo MD 27/12/2019 – literature search commissioned for peer reviewed articles focused on addressing raised mortality – shared with key staff for information 17/02/20 - Ensure complaints intelligence (where a death has occurred) is reviewed and reported to the LfD Committee – completed	QA committee Mortality Reduction Group Learning from Deaths
To give every person the best treatment every time – Delivery of Operational Performance	AE	4	5	20	20	20	Urgent Care pressure and increased demand on Diagnostic and Elective work **All** • Staffing in key departments • Changes in pension rules • Urgent care pressures **Urgent Care** – • Bed capacity in hospital and community • Ensuring best practice followed **RTT** • Capacity – physical and staffing • Increase in Cancer referrals **Cancer** • Increase in demand • Multi centre pathways and capacity in diagnostics • Sharp increase in demand	Urgent Care programme plan to ensure best practice, e.g. SAFER Enhanced pathways as part of the new streaming model Cancer and RTT Patient treatment list management Review of OPD and Theatre capacity and transformation Detailed capacity and demand management Joint working with GM on cancer pathways Validation of waiting lists	Urgent care prog board System Sustainability Board Contract and Performance GM Cancer Board

To be a great place to work	JM	4	4	16	16	16	Recruitment, limited pool of staff Pensions / Tax implications Sickness rates Reliance on Non-Core Staff – Premium spend (Agency)	Recruitment workplan in place Reviewing options to mitigate pension/tax implications Targeted actions to reduce sickness absence Tight focus on controls of Agency staff Regular "focus on" at Workforce Assurance Committee Staff Engagement and wellbeing programme	IPM Workforce committee
To use our spend our money wisely Financial sustainability	AW	4	4	16	16	16	Delivery of cost improvement is becoming more difficult every year Transformation may not result in cash releasing savings Achievement of system wide savings and transformation Lack of central support re Financial Recovery Funds In year cost pressures as a result of pressures in services and increased standards expected Agency cost pressures due to work force shortages Income/contracting risk Commissioning decisions leading to destabilisation of services Financial challenges in CCGs leading to shortfalls in income to cover service costs Transformation funding ending leading to redundancies and cost pressures Operational planning and Long Term Plan increases the requirements on providers without the associated funding Cash flow shortfalls Loss of PSF	**Controls** Weekly PMO and ICIP escalation meetings Monthly IPM meetings with divisions Integrated Care partnership development Monthly contract and performance group meetings Weekly Financial Recovery Oversight Group meetings with CCG Monthly System Savings Board Transformation board Routine review of benchmarking including Model Hospital **Actions** Improve links with specialist commissioners April 20 Review of costs and income (patient level costing) August 20 Develop system wide financial strategy April 20 Agree financial recovery trajectory with GM and NHSI Develop Strategic Workforce Modelling April 20	F&I committee Board IPM Transformation Board System Savings Board Workforce Assurance Committee
To make our hospital and our buildings fit for the future	AW	4	3	12	12	12	Availability of capital funding Changes to capital regime Technical accounting rules (IFRS 16) consequences Lack of revenue to support capital Planning considerations – traffic and car parking constraints Clarity of Improving Specialist Care/Healthier Together Backlog maintenance	Development of detailed Business Cases Detailed Estates Strategy Working with LA and other partners Capital process to ensure correct prioritisation	Strategic Estates Board Strategic Estates Group Finance Committee
To join up services to improve the health of the people of Bolton	SM	4	3	12	12	12	Failure to Deliver Integrated Care Partnership	Locality Business Plan developed and engagement on the final draft of the Business Plan prior to board consideration. This includes:- • Core elements of delivery model • Translation of the core elements to activity • Identify and model the workforce requirements • Model the financial requirement Sprints underway in January with PCNs to Identify target population Robust Communication and Engagement Plan across all providers in place	Strategy / Transformation Board QA Board

								Development of an OD Framework to support cultural change Development of a system approach to community engagement.	
To develop partnerships across Greater Manchester to improve services	JB/SM	4	4	16	16	16	Delivery of Healthier together/Improving Specialist Care	Executive Provider Oversight Group overseeing implementation of Healthier Together NW Sector Partnership Board in place to oversee the delivery of the outputs of the Improving Specialist Care programme. Robust Programme Plan in place across GM for the delivery of the Improving Specialist Care Programme. Executive Level involvement in the Improving Specialist Care Programme.	Strategy / Transformation Board QA F and I Board

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	19th February 2020	Date of next meeting:	18th March 2020
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	D Hall, J Bene, M Brown, J Njoroge, A Ennis, M Forshaw, E Steel, R Sachs. Representation from the five clinical divisions D Sankey	Quorate (Yes/No):	Yes
		Key Members not present:	F Andrews

Key Agenda Items:	RAG	Key Points	Action/decision
Patient story		The Integrated Care Division shared a story of a patient who had been sleeping rough on moorland for the last 15 years. The patient was referred to the Homeless and Vulnerable Adults Team via Chorley Police and Urban Outreach. The patient has now been diagnosed with COPD and although he remains anxious about reintroduction into society he is willing to work with the nursing team and GP practice to improve his health outcomes.	Committee members noted the challenges relating to the treatment of the most vulnerable members of society and the importance of partnership working
Clinical Governance and Quality Committee chair report		Key topics discussed at the February Clinical Governance Committee were the Safer Surgery Policy – approved, Quality Accounts priorities and process and the CQC insight report and action plan.	Although the Chair report from Clinical Governance Committee included a number of areas assessed as amber QA Committee members were content that there were no issues to escalate to the Board.
Falls Quarterly Report		The committee received the Q3 falls update noting that although there had been a slight increase in the falls for the quarter this remained below the national threshold and annual performance for the Trust was below the agreed stretch target. Some areas have seen improvements particularly in Darley Court. In discussing the report, the QA Committee reflected on the risk of falls in patients who are medically	Agreed to move towards SPC charts in future reports.

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

		optimised and the benefits of enhanced care in reducing the number of falls.	
Pressure Ulcers Q3 Update		Committee members received the Q3 pressure ulcer report which demonstrates a reduction in the number of patients developing pressure ulcers under the care of the Trust.	Report noted
IV Medication		Work is being completed with the Education Department to develop a training package for staff which should be out for consultation at the end of March.	A written report will be submitted to the Clinical Governance and Quality Committee.
Learning Disability Benchmarking		It was confirmed that data has been submitted and a report will be received back later in the year.	
SI Report – 145851		The SI report was discussed and actions noted. Discussion focused on medicine reconciliation and the management of Addison's disease	SI Report approved.
SI Report - 144857		The SI report was discussed and actions noted. Concerns raised regarding resources available for mental health patients – recognised that this is a system wide issue.	Agreed CCG to take action to consider system issue and feedback into the report being prepared for May Quality Assurance Committee around care of mental health patients in A&E. SI Report approved
SI Report – 137433		Committee members received the SI report into a neonatal incident noting that a HSIB had provided an external of this case	
Quality Account Priorities		The committee agreed to five Quality Account Priorities for 2020/21. Confirmed that Governors have chosen Diabetes as there chosen metric for External Audit.	

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Committee/Group Chair's Report

Risk Management Committee			
Safeguarding Committee			
Comments			
Risks Escalated –			

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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:	25th February 2020	Date of next meeting:	23rd March 2020
Chair:	Martin North	Parent Committee:	Board of Directors
Members Present:	Bilkis Ismail, Andy Chilton, Lesley Wallace, Andy Ennis, Annette Walker, Mark Costello	Quorate (Yes/No):	Yes
		Key Members not present:	Alan Stuttard, Jackie Bene, Sharon Martin, Catherine Hulme

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Month 10 Finance Report		Deputy Director of Finance	The financial position to the end of January 2020 (Month 10), excluding PSF, is a deficit of £11.9m, against a deficit plan of £3.7m. Taking PSF/MRET into account the deficit is £6.3m which is £9.8m off plan. The main reasons for the shortfall are: • Income shortfall of £3.1m • Pay overspend year to date of £6.4m • ICIP off track by £3.9m In month there was an overall deficit of £0.1m on last month, an improvement of £0.9m on last month. Probable outturn excluding PSF is £13.4m deficit, an improvement of £0.1m from last month. Mitigations are identified to bring it back in line with the forecasted deficit of £13.1m. Long term debt continues to reduce and the cash position at the end of January was a balance of £14.5m. The Committee also discussed the individual Divisions and their forecasted outturn and work will be undertaken during the Summer to understand the financial construction of Anaesthetics & Surgical Services given the size of their deficit.	For noting.

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Committee/Group Chair's Report

ICIP Progress Update – Month 10	**Internal** **System**	Director of Finance	The Committee received an update on the ICIP progress. The Divisions continue broadly on track and we have confidence in £9.2m worth of savings with continued work to try and achieve the internal target of £9.5m. Conversations with system partners continue to try and mobilise the system savings.	For noting.
NHS Operational Planning & Contracting Guidance 2020/21		Director of Finance	The Committee received a report on the NHS Operational Planning and Contracting Guidance which seeks to guide Providers and Commissioners on the broad outline of targets for next year. The general view of the Committee was that the targets and objectives as currently listed in the document are not affordable and further discussions will be needed as to how these targets can be realised.	For noting.
Tariff Impact Assessment 2020/21		Head of Financial Management	The Committee received a report on the impact of the Tariff Assessment. The main change is to do with the introduction of blended payments which we are largely protected from due to our AIC arrangement with Bolton CCG. Overall impact is a shortfall of £800k based on initial assessment and discussions will be underway to work out how we can mitigate this shortfall.	For noting.
2020/21 Contract with Bolton CCG		Director of Finance	The Committee were given an update as to progress with contract discussions with the CCG. The overall position is that the contract discussions are positive and that the contract is looking to be constructed in a more balanced and transparent way than it has been previously. There is still work to be done but the Committee are assured that discussions are continuing in a positive way for both the Trust and the CCG.	For noting.

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Committee/Group Chair's Report

Reference Cost Collection 2018/19		Director of Finance	The Committee was previously informed that the deadline was not met for our Reference Cost submission. We have received and replied to formal letters about the position. We have submitted a full plan of recovery which includes the procurement of a new system so that we do not get into this position again. The Committee were concerned that the timeline still looked very tight and that further assurances would be needed in the coming months to assure the delivery of a plan. We may be subject to further scrutiny within the next few months as to our competency on returning Reference Costs.	For noting.
NHS Efficiency Map (December 2019)		Director of Finance	The Committee received further assurances around our application of the NHS Efficiency Map calculator and were assured that most of the recommendations were already underway.	For noting.
Month 10 iFM Finance Report		Director of Finance, iFM Bolton	The Committee received an update on the iFM financial position at Month 10. iFM are reporting a profit year to date of £412.0k which is adverse to budget of £43.0k. iFM are forecasting outturn of £576.0k against a plan of £545.0k. The iFM Director of Finance updated the Committee on the tax position for iFM for the coming year which may have a positive net benefit. Discussions with PwC are ongoing and the iFM Director of Finance will report back next month on its viability.	For noting.
Appointment of an MTC Contractor by iFM		Director of Finance, iFM Bolton	The Director of Finance for iFM updated the Committee on the appointment of a new Measured Term Contractor. The Committee were assured that the processes are in place to ensure that the contract is not abused and is used in the spirit that it is intended to be used.	For noting.
Committee Chair Reports			The Committee received Chair reports from: • Capital and Revenue Investment Group • Digital Transformation Board • Bolton System Finance & Savings Board The Digital Transformation Board raised a particular risk in relation to the 0-19 Service with Bridgewater which is beginning to carry significant risk.	For noting.

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Committee/Group Chair's Report

Risks escalated

There are no new risks to be escalated to the Board.

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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:	February 2020	Date of next meeting:	March, 2020
Chair:	J Bene	Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, A Ennis , L Gammack , L Denman, E Steele, and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	F Andrews, M Forshaw

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & OD Dashboard		• The report triangulated key workforce data to support informed discussions. • Members positively noted the in-month Agency spend along with other key Workforce & OD metrics. The exception being sickness management (albeit in-month improvement and an improved benchmark position). Detailed discussion took place on all the pro-active and reactive actions being taken. • Dashboard included a deep dive on retention / turnover rates which highlighted no cause for concern.	**Actions agreed:-** • To streamline the Dashboard for April Committee.
Head Count Analysis Paper		• The Committee received the paper that had previously been considered at the Finance Committee and then reported to the Trust Board. As such no further detail is provided within this Chair report.	**Actions agreed:-** • Report continues to be provided on quarterly basis.
Workforce Digital Paper		• The Committee received an update on the objectives and strategic actions needed to realise the benefits of Workforce systems, in order to maximise the capacity and capability of the Trust's people. • The paper detailed the current position, proposed developments and opportunities through which digital transformation can be sustained	**Actions agreed:-** • HR Digital Workforce group to provide monthly Chair report to both WAC and Digital Transformation Board. • Update to be provided in the next meeting on the introduction of E Payslips

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Committee/Group Chair's Report

NHS Staff Survey		• The Committee were pleased to receive the findings of the NHS Staff Survey. It was noted that we remain the highest performing Acute Trust in GM and in the top 20% for all NHS Organisations for our levels of Staff Engagement. • It was noted that a full paper will be coming to the Trust Board in March. This paper will consider the findings in full, along with the enabling actions that will now be taken at a Trust and Divisional level to ensure further improvement.	**Actions agreed:-** • Full paper to Trust Board in March.
HCA Engagement		• In December 2019 the Committee received an update on the health and wellbeing of the Trust's health care support workforce. The Committee then requested a further report outlining the details of the proposed HCSW forum and annual HCSW event. • The Committee approved the need for HCSW Forums to be implemented at both Trust and Divisional level – 'hub and spoke'	**Actions agreed:-** • A follow up paper in six months on the actions that have been taken and benefits realised.
Apprentice Programme Strategy		• The Committee received an update on the Trust's apprenticeship programme and progress made against the public sector apprenticeship target (Trust is forecasted to achieve 113, levy target 131). • The Committee supported proposals to improve our ability to maximise our levy spend and increase the number of apprenticeships across the Trust (Quality Improvement being notable change) .	**Actions agreed:-** • Report back in 6 months' time on progress being made • Request that the DDoF update Finance Committee on Levy position
Library Strategy		• Committee received this Strategy for the first time. • The Committee commended the strategic direction for Library and Knowledge Services (LKS) over the next five years.	**Actions agreed:-** • Annual Update to be provided on delivery against the Strategy

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Committee/Group Chair's Report

Guardian Of Safeworking report		• The Committee were pleased to receive a much improved report (noting previous reports had been Red rated). The report noted that a new GOSW had been appointed and that the Divisions had a stronger grip on the exception reporting and subsequent actions required. • No matters of concern were escalated within the presentation / report.	**Actions agreed:-** • Quarterly update to continue
Foundation Doctors Annual Report to HEE		• The Committee received the annual report which provides a review of the last academic year and in particular describes the notable practice: Support for trainers, Curriculum Committee involvement in the teaching programme, Work of the Clinical Fellow in Education, Peer mentoring, Handbook created by foundation doctors for foundation doctors, Awards	**Actions agreed:-** • The Committee noted the report
Freedom to Speak Up Quarter 3 report		• The Committee were pleased to note that FTSU concerns continued to be raised via this approach. Further FTSU Champions had been recruited to ensure even spread across the organisation and staffing groups. • No matters of concern were escalated via the FTSU Guardian.	**Actions agreed:-** • The Committee noted the report
Assurance from reporting Committees • Equality, Diversity & Inclusion Group • Staff Health & Wellbeing Group • Education Governance Group		• All reports were noted and risks being managed. No matters required escalation to Trust Board	
Risks escalated None – matters being managed within Committee			

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	13 Feb 2020	Date of next meeting:	28 April 2020
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	J Njoroge, B Ismail M Brown, M North, A Walker, L Wallace, E Steel, Internal Audit, External Audit, C Ryan	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Terms of Reference		Revisions approved – appended for Board approval	Approved subject to revision
Internal Audit Progress Report/follow up report		Follow up report presented including overdue actions – further discussion required with auditors to agree scope of Assurance Framework Review	noted
iFM Payroll controls review		Medium risk report – the iFM team have been proactive in work to introduce E-Roster supported by biometric clocking in system.	Actions needed with regard to the development of consistent policies and ensuring timely communication in relation to staffing changes
Final Capital Assets Report		Low risk report noted	
Accounting Policies and plan for Annual Report and Quality Report		Update on accounting requirements and timescale for the preparation of the accounts and annual report noted.	
Compliance with FT code of Governance		The Committee noted the evidence supporting a declaration of full compliance with the FT Code of Governance	Agreed that under the "comply or explain" requirement of the FT Code of Governance the Trust declare compliant
Local Counter Fraud Specialist Report		The Committee continue to be assured that robust processes are in place to reduce the risk of fraud	Report noted
Board Assurance Framework		The Committee noted the summary BAF and approved the proposed schedule of deep dive reviews	Full BAF to be discussed at Board with a focus on risk appetite followed by a development session to consider further actions once risk appetite determined

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Agenda Item No:	
Meeting:	Trust Board
Date:	27th February 2020

NHS Bolton NHS Foundation Trust

Title:	Mortality report
Purpose	To report the current mortality figures for Bolton NHS Foundation Trust and to offer analysis for outlying figures
Executive Summary:	The SHIMI for Bolton NHS FT continues to be higher than expected with the major contributor being pneumonia. AQUA have analysed our data further and are partnering the Trust to provide detailed analysis of clinical recording and coding. The Trust HSMR has risen and this needs to be analysed-the methodology has been identified and further work will now be undertaken to support this.
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	Boar are ased to approve this 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*	
Negative Impact	**Neutral Impact**	**Positive Impact**	

Prepared by:	Dr Francis Andrews	**Presented by:**	Dr Francis Andrews

Introduction

Patent mortality figures are monitored by the Medical Director and business intelligence team in partnership with CHKS who provide further data analysis, reports are received at Mortality Reduction Group. The main indicator to understand is SHIMI (Summary Hospital Level Mortality Indicator) as this is a standardised way of comparing mortality between hospitals. Other indicators include HSMR-Hospital Standardised Mortality Ratio (used by Dr Foster) and RAMI (Risk Adjusted Mortality Indicator (specific to CHKS). RAMI is not further considered here as it is not nationally reported.

Current position

1. SHIMI

SHIMI for period October 2018 to September 2019 is 116 which is higher than expected the (95% upper confidence interval is 114). The SHIMI for pneumonia is currently 129 which is higher than expected and is the main contributor to the apparent higher than expected SHIMI.

2. HSMR

Dr Foster HSMR (06 Jan 2020) Hospital Standardised Mortality Ratio has deteriorated to 118.7 (July 2018 to June 2019), the weekday figure has deteriorated to 115 and the weekend figure, which has previously been within normal limits, has deteriorated markedly to 125.8- from 108 for the previous year. The national average for these metrics is 100. The only clinical condition which is an outlier for HSMR is pneumonia.

HSMR

This data has not been analysed yet but the plan is to analyse based on a method articulated by Mohammad and Stevens[i]. This will entail working out via run charts whether the changes are due to observed or expected deaths, followed by examination of patient risk profiles and depth of coding. This will need to be done with the assistance of Business Intelligence and CHKS-HSMR data and run charts are not currently provided as part of our data set from CHKS. Given the fact that only pneumonia id flagging as an individual HSMR outlier, it is likely from analysis of other providers that the number of expected deaths will have fallen due to data issues resulting in coding fewer expected deaths.

Pneumonia

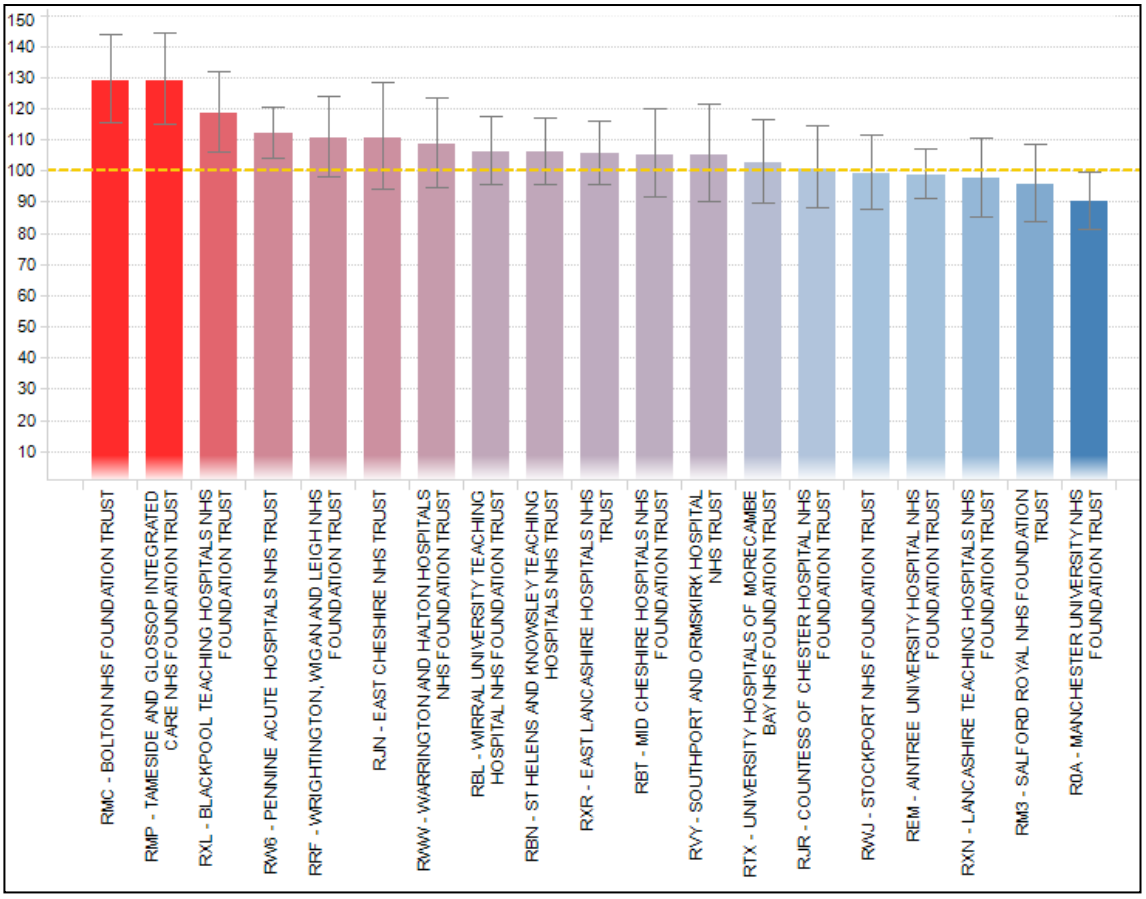
As before, it is pneumonia which continues to be a mortality outlier, despite previous audits suggesting that generally the quality of care was good. The introduction of EPR has been welcome but unfortunately the introduction of a pneumonia care bundle on paper has meant that compliance with it after initial success dropped once EPR was introduced. A project is underway to programme the bundle into EPR but the date for the introduction for this is not yet finalised. The care bundle is an aide memoir to ensure that patients have a timey chest X-ray which is commented on by the clinician, early antibiotics and severity assessment as well as the right diagnostic tests.

We had planned to analyse recording and coding of pneumonia cases internally but given the complexity and time required, attempts so far to do this have struggled. Therefore AQUA (Advancing Quality Alliance) have been engaged to help with his work. They have done an analysis of current data which has revealed the following:

A total 1547 patients had a primary diagnosis of pneumonia between September 2018 and August 2019 (taken from NHS digital SUS-Secondary Uses Survey data) with 296 deaths giving an overall crude mortality of 19.1% compared with the Northwest average of 14.9%. To give a better comparison, SHIMI is used which a standardised mortality statistic is taking into account co-morbidities, age, gender, why patient hospitalised and method of admission to hospital

The data for the Northwest is shown in table 1.

Table 1: Pneumonia SHIMI for Northwest England



Despite the apparent high SHIMI for pneumonia, according to SUS, Bolton has a low rate of CAP (Community Acquired pneumonia) – 26 of every 1,000 admissions compared to 35 in every 1,000 for the north-west as a whole; Bolton is second lowest in the northwest.

Despite being an outlier for mortality, length of stay at Bolton is 5 days-the same as the regional average and the 30 day readmission rate is lower at 23.9% compared with 26.4% for the northwest. However, if pneumonia is being under-recorded, this may not be accurate.

Therefore, the business analyst at AQUA has questioned whether what is being coded is an accurate reflection of what is actually happening at Bolton and whether all cases of pneumonia are actually being coded. Previous work by Emma Donaldson, acute medicine consultant has suggested that some of these are being coded with sepsis as the primary diagnosis instead. It may be that are not always make it easy for coders to identify that there was a pneumonia diagnosis and co-morbidities may not be fully captured.

More detailed analysis by AQUA has revealed that 1,547 patients at Bolton discharged between September 2018 and August 2019 had a primary diagnosis of pneumonia, which should mean they acquired pneumonia in the community. However, 146 (nearly 1:10) has the nosocomial code Y95X straight after the primary diagnosis code-this code means the pneumonia was acquired in hospital

Not all of these patients has a previous, recent hospital stay in SUS (so the pneumonia cannot be regarded as hospital acquired) and AQUA believe that these patients actually have hospital acquired pneumonia (HAP), and most importantly this is not the primary (SHIMI) diagnosis with which they were admitted. HAP has a higher mortality rate.

Therefore AQUA plan to use the following method. Eligible patients (those coded as CAP) are identified. They will then load all of these patients or a statistically significant random sample

(using the same method as for a clinical trial) into PIQS, their data collection and reporting system. Data coordinators at Bolton will then check these cases in detail to ensure they actually had pneumonia. Previous work done by AQUA in this way has found that around 1 in 3 patients coded as pneumonia turn out not to have it as their final diagnosis. AQUA plan to randomly sample 22 cases a month in this way and to create a pneumonia-specific, validated dataset to form the basis for more in-depth analysis. This programme starts in March 2020 and is expected to continue for the rest of the year.

Conclusion

This paper outlines current mortality statistics for Bolton. Given the rises in HSMR, the methodology to deal with this is now understood and will require further data analysis from our internal and external data partners. A timed plan is being developed to support this and to identify resources. Regarding pneumonia, AQAU have now performed a preliminary analysis and a detailed plan is again being devised to analyse these cases.

Reference:

[i] Mohammed MA, Stevens AJ (2013) A Simple Insightful Approach to Investigating a Hospital Standardised Mortality Ratio: An Illustrative Case-Study. PLoS ONE 8(3): e57845. https://doi.org/10.1371/journal.pone.0057845

Agenda Item No:	
Meeting:	Trust Board
Date:	27th February 2020

NHS Bolton NHS Foundation Trust

Title:	7 Day Services update
Purpose	This paper describes the revised 7 day services Board Assurance framework and measures our performance against the 10 required standards as well as updating progress on relevant actions still required. A copy of the required completed 2019/2020 Autumn/Winter return for NHS Improvement is given as an appendix.
Executive Summary:	The results of the 7 day services autumn 2019/2020 audit are included as an appendix. Standards 5 and 6 have been met for the Autumn/Winter audit of 7 day services but standard 2 has not been met and appears to have deteriorated particularly with respect to acute medicine. Standard 8 was met except for once daily reviews at weekends. Progress has been slow on actions due to workload pressures and therefore PMO assistance will be sought to help manage this project. A return has been completed in the format required by NHS Improvement.
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	Board are asked to approve the report

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*	
Negative Impact	**Neutral Impact**	**Positive Impact**	

Prepared by:	Dr Francis Andrews	**Presented by:**	Dr Francis Andrews

Introduction

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services ('providers') to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and on-going review (Clinical Standard 8) every day of the week. To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

Providers have measured their delivery of 7DS using a survey tool since 2016. But unfortunately, the significant changes and considerable improvements have not always been reflected in the survey results due to the quality of source data and validation issues. The survey also places a significant administrative burden on providers as it involves reviewing many patient case notes.

To resolve these issues and enable provider boards to directly oversee reporting on this work, the survey tool has been replaced with a board assurance framework for measuring 7DS delivery.

This report describes the standards along with the evidence required for the standards, and also describes the current position for Bolton FT as well as actions required for improvement. It should be noted that the return for NHS improvement only requires the template to be submitted. The colour coding as to whether standard met on this return is determined by the case note audit results-see appendix.

Results (see Appendix 1)

For the Autumn/Winter audit, Bolton, standards 5 and 6 have been met but standard 2 has not been met and standard 8 narrowly not been met. Nationally, the results for standard 2 being met are 32% and 46% for standard 8. Only Wigan has met standard 2 in Greater Manchester whereas Wigan, Stockport, Manchester University Hospitals and Stockport have met standard 8

The four priority standards

Clinical Standard 2: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on three sources of evidence that in combination give a complete view of delivery of Clinical Standard 2. These are as follows:

Evidence source 1 – consultant job plans

To deliver this standard, a provider should confirm that consultant job plans in all specialties that receive emergency admissions provide sufficient daily consultant presence to support the delivery of 7DS Clinical Standard 2 within the organisation.

Evidence source 2 – local clinical audit

If a provider believes it has sufficient consultant presence to deliver the standard in theory, this should be evidenced by data from audits of delivery taken from patient case notes or data taken from electronic patient records if these are able to provide this information.

An option is to conduct an audit that is representative of the provider's normal emergency admission patient profile. If a provider does this, once again an example of the minimum statistically significant sample size would be 70 case notes out of 500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery.

Evidence source 3 – wider performance and experience measures

Alongside an assessment of job plans and supporting clinical audit evidence of delivery, wider sources of information with potential links to delivering this standard could indicate whether it is being achieved

Current evidence for Bolton FT for standard 2:

Evidence	RAG	lead	Key points	Action
Consultant job plans		DMDs	Apart from critical care and obstetrics/gynaecology, Consultant job plans do not yet contain sufficient daily presence to support this standard in electives. Previous modelling for a compliant 7DS has shown significant cost pressure. The current consultant job planning exercise is being concluded and in the future policy, compliance with 7DS standards will be an aspiration within this	Review of previous modelling for each division has been received from paediatrics, some information from acute medicine and non from surgery **Action: DMDs to be asked to ensure CDs and OBMs compare Wigan job plans with Bolton to understand why Wigan has achieved this standard.**
Local audit (70 patients)		Clinical effectiveness	Audit completed	Need to understand why such a

				drop in performance for review by 14 hours. **Action- concentrate on paediatrics and acute medicine and ask CDs for comment**
Wider performance		Francis Andrews	-GMC survey 2019: Handover and supportive environment within range for all specialities except GP O&G -Weekend HSMR 'as expected' at time of audit	Explore other metrics such as RCP guidance on safer staffing Complete by September 2019 **Update-still to be actioned re RCP guidance**

Clinical Standard 5: the availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.

Self-assessment of delivery of this standard should be based on a response to the following question for each of the diagnostic tests:

Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?

- *Computerised tomography (CT)*
- *Ultrasound (USS)*
- *Echocardiography*
- *Upper GI endoscopy*
- *Magnetic resonance imaging (MRI)*
- *Microbiology*

Evidence	RAG	lead	Key points	Action
From relevant clinical leads		N/A	All compliant	None required

Clinical Standard 6: 24-hour access seven days a week to nine consultant-directed interventions.

Self-assessment of delivery of this standard should be based on a response to the

Following question for each of the interventions:

Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?

- *Critical care*
- *Interventional radiology*
- *Interventional endoscopy*
- *Emergency surgery*
- *Emergency renal replacement therapy*
- *Urgent radiotherapy*
- *Stroke thrombolysis*
- *Percutaneous coronary intervention*
- *Cardiac pacing*

Evidence	RAG	lead	Key points	Action
From relevant clinical leads		N/A	All compliant except non vascular interventional radiology: weekend on call is by ad-hoc arrangement as only small number of radiologists locally can provide this	Requires a NW sector solution via GM

Clinical Standard 8: Clinical Standard 8 relates to the on-going consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment.

The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition.

In practice this means that patients with high dependency needs, usually but not always sited in AMU, SAU and ITU should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on four sources of evidence that in combination give a complete view of delivery of Clinical Standard 8.

Evidence source 1 – consultant job plans

To deliver this standard, a provider must confirm that consultant job plans in all specialties that cover emergency admissions provide sufficient daily consultant presence to support the delivery of twice-daily ward rounds for high dependency patients and once-daily ward rounds for all other patients.

Evidence source 2 – systems to support on-going review

In addition to the requisite level of consultant presence to deliver the standard, providers should have systems to support seamless and appropriate on-going review, specifically:

1. A board round system that enables the responsible consultant to delegate reviews appropriately based on clinical need and the presence of agreed written protocols

2. A system of escalation for deteriorating patients based on agreed protocols, ideally built around monitoring each patient's National Early Warning Score (NEWS)

3. A clear process to decide which patients do not need a daily consultant review and the proportion of admitted patients in this category.

Evidence source 3 – local clinical audit

If a provider believes it has sufficient consultant presence to deliver Clinical Standard 8 in theory, this should be evidenced by data from clinical audits of patient case notes

An option is to conduct an audit that is representative of the provider's normal emergency admission patient profile. If a provider does this, once again an example of the minimum statistically significant sample size would be 70 case notes out o500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery.

Evidence source 4 – wider performance and experience measures

Alongside an assessment of job plans and supporting clinical audit evidence of delivery, wider sources of information with potential links to delivering this standard could indicate whether it is being achieved

Evidence	RAG	lead	Key points	Action
Consultant job plans		DMDs	Critical care compliant and general paediatrics; acute medicine partially compliant, but no other speciality is	Need to look at medical and general surgical job plans as per standard 2 but also examine in these areas whether delegation is working in practice **Update: outstanding**
Systems to support		DMDS	-NEWS scoring fully implemented -Board round system in place in acute medicine and paediatrics -no formal process to decide on whether to review except paediatrics	Implementation of board round review and process on who to review by October 2019 for each directorate **Update: outstanding**

Local audit		CE	Audit completed	
Wider performance		Francis Andrews	-GMC survey 2019: Handover and supportive environment within range for all specialities except GP O&G -Weekend HSMR 'as expected'	Explore other metrics such as RCP guidance on safer staffing Complete by September 2019 **Update: outstanding**

Comment

Unfortunately progress has been poor on these actions due to competing workloads; help will be sought from the PMO to try and work through these actions effectively, and also for the following standards for continuous improvement.

Standards for continuous improvement

The standard and the relevant evidence required are detailed below

1 – Patient experience
Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. Feedback from wider sources of patient experience, such as levels of complaints and local Healthwatch feedback directly related to quality of care on weekdays and at weekends
3 – Multidisciplinary team review
Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for on-going/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours
4 – Shift handovers
Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multi-professional participation from the relevant incoming and outgoing shifts. Assurance that these handover processes, including communication and documentation, are reflected in hospital policy and standardised across seven days of the week.
7 – Mental health
Assurance that liaison mental health services are available to respond to referrals and provide urgent and emergency mental healthcare in acute hospitals with 24/7 emergency departments 24 hours a day, seven days a week.
9- Transfer to community, primary and social care
Assurance that the hospital services to enable the next steps in the patient's care pathway, as Determined by the daily consultant-led review, are available every day of the week. These services should include: • discharge co-ordinators. • pharmacy services to facilitate discharge (e.g. provision of TTAs within same timescales on weekdays and at weekends) • physiotherapy and other therapies • access to social and community care providers to start packages of care • Access to transport services.
10-Quality improvement
Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.

Assessment of compliance for continuous improvement

Standard	RAG	Lead	Key points	Action
1. Patient experience		Tracy Joynson	FFT: very little information on doctors, and mainly positive. No issue from Healthwatch and national in patient survey doesn't cover this.	To capture weekday/weekend category for PALS & complaints database **Not yet actioned**
3. MDT review		Marie Forshaw Steve Simpson	-Adult discharge and transfer of care policy -Medicines policy covering medicines reconciliation	
4. Handover		DMDs	Fully compliant and audited for Obstetrics and gynaecology, critical care and acute medicine; SOP for general surgery, orthopaedics, general paediatrics,	Need to ensure handover regularly audited in all divisions and reported to MRG by September 2019. Medical Director to provide handover policy by October 2019. **Update: outstanding**
7. Mental Health		RAID team	Fully compliant as confirmed with RAID team	None
9. Transfer to community, primary and social care		Rae Wheatcroft	Fully compliant as confirmed with operational services and pharmacy	None
10. Quality improvement		Francis Andrews	QI strategy which is monitored at Mortality reduction group; Learning from deaths looks at day of admission, monitoring of HSMR weekend and weekday mortality, readmissions monitored, length of stay monitored at IPM, Guardian of safe working report	Some metrics such as readmissions and length of stay and GOSW report need further analysis by weekend/weekday. September 2019 **Update: outstanding**

Conclusion

Standards 5 and 6 have been met for the Autumn/Winter audit of 7 day services but standard 2 has not been met and appears to have deteriorated particularly with respect to acute medicine. Standard 8 was met except for once daily reviews at weekends. Comparison of national figures has shown that Wigan is compliant with standards 2 and 8 and therefore a comparison needs to be made with them as to how they are achieving these standards. Progress has been too slow on actions due to workload pressures and therefore PMO assistance will be sought to help manage this project. A return has been completed in the format required by NHS Improvement; however not all the information detailed in this paper is required for this return

Report ends

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	93 randomised patient episodes where reviewed over the 7 day period of 14/10/2019-20/10/2019, patients cases were reviewed utilsing EPR. . The Trusts percentages for patients seen by a consultant within 14 hours were 47% during the weekdays and 48% at weekends. The admitting specialities captured in the randomised patient review were as follows; Acute Medicine, Emergency Medicine, General Surgery, Geriatric Medicine, Paediatric Medicine, Palliative Care, Trauma and Orthopaedics and Other (ENT & General Medicine). The overall (weekday + weekend) percentage, for patients seen within 14 hours - 47% Weekday percentages of patients seen by a consultant within 14 hours, broken down by specialty; Acute Medicine 25%, Emergency Medicine 100%, General Surgery 36%, Geriatric Medicine 100%, Paediatric Medicine 40%, Palliative Care 0%, Trauma and Orthopaedics 55%, Other (ENT & General Medicine) 37%. . Weekend percentages of patients seen by a consultant within 14 hours, broken down by specialty; Acute Medicine 25%, Emergency Medicine n/a, General Surgery 75%, Geriatric Medicine 67%, Paediatric Medicine 40%, Palliative Care n/a, Trauma and Orthopaedics 60%, Other (ENT & General Medicine) 20%.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Magnetic resonance imaging (MRI) - Yes, available on site but limited to 2 slots per weekend day (difficult to determine whether 2 slots is sufficient for urgent activity, as is variable).	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	No the intervention is only available on or off site via informal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Interventional Radiology: Vascular Interventional Radiology: Yes, available off site via formal arrangement (MFT). Non-Vascular Interventional Radiology: Partial available onsite 9am-5pm and on site via informal arrangement outside of these hours. Emergency Surgery: Colorectal/upper GI surgery: Yes, available on site. Orthopaedics: Yes, available on site. Urology: Yes, mix of on-site and off-site by formal arrangement. Cardiac Pacing - temporary pacing wire would be fitted on CCU by the cardiologist on call at the weekend.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients requiring once daily review: There were 198 weekday once daily reviews required in the audit, 185 of these once daily reviews were completed (93%) meeting the standard of 90%. There were 78 weekend once daily reviews required in the audit, 51 of these once daily reviews were completed (65%) falling short of the standard requirement of 90%. Patients requiring twice daily review: There were 6 weekday twice daily reviews required in the audit, 6 of these twice daily reviews were completed (100%) meeting the standard of 90%. There was 1 weekend twice daily review required in the audit, which was completed (100%).	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 - Patient Experience: no evidence of issues from healthwatch. Pal to record weekday/weekend for PALS and complaints Standard 3 - Multidisciplinary review: Evidence for Medicines reconciliation in Medicines policy, Patient discharge and transfer policy Standard 4 - Shift Handovers: These are occurring in all specialities but further assurance will be undertaken re audit and evidence of SOPs. Standard 7 - Mental Health: Mnental health liaison team are here on site 24/7 to respond to our urgent and emergency referrals. Standard 9 - Transfer to community, primary and social care: We are fully compliant with this standard. All services listed (discharge co-ordinators, pharmacy services to facilitate discharge, physiotherapy and other therapies, access to social and community care providers, access to transport services) within the standard are provided every day of the week. Standard 10 - Quality Improvement: The trust has a quality improvement strategy and the executive lead for quality improvement is the medical director. Intelligence around patient outcomes and experience is used at both divisional and trust level to inform areas of quality improvement for example weekday and weekend mortality, length of stay, readmissions rates and any areas of potential harm such as pressure ulcers, falls etc. The Trust has appointed a Guardian of Safeworking. The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The GOSW identifies and either resolves or escalates problems, and act as a champion of safe working hours for junior doctors. The guardian provides assurance to the Workforce Assurance Committee (quarterly) and to the Trust Board (annually) that issues of compliance with safe working hours are addressed, as they arise. The guardian reports to the Executive Medical Director and is accountable to the Trust Board.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Not applicable

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Bolton NHS Foundation Trust

Integrated Performance Report

January 2020

Guide to Statistical Process Control

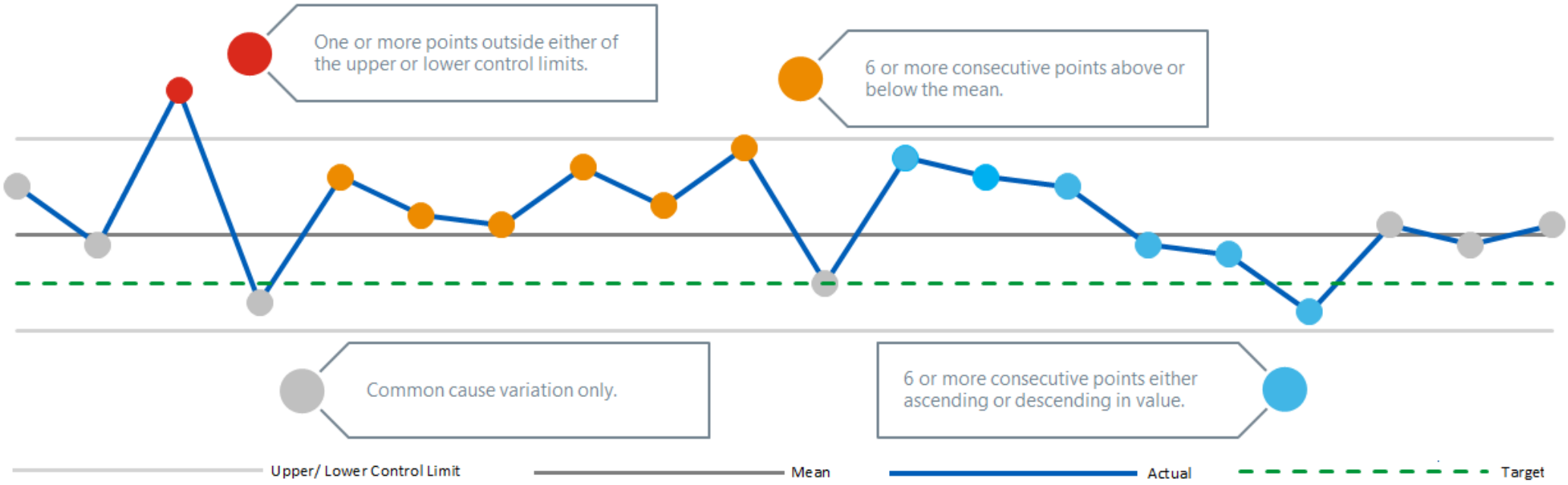
NHS Bolton NHS Foundation Trust

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	11	0	0	2	2	1	0	14
Infection Prevention and Control	5	0	3	0	0	0	0	6
Mortality	2	0	0	1	0	0	0	3
Patient Experience	12	1	0	0	3	4	0	12
Maternity	8	1	1	0	0	1	0	9
Operational Performance								
Access	5	0	0	5	1	0	4	7
Productivity	9	1	0	1	1	1	1	10
Cancer	6	0	0	0	1	3	0	4
Community	3	1	0	0	0	0	1	3
Workforce								
Sickness, Vacancy and Turnover	1	0	1	1	0	1	1	1
Organisational Development	3	1	0	0	0	1	0	3
Agency	0	0	3	0	0	0	0	3
Finance								
Finance	1	1	0	1	2	0	1	4
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
There has been an increase in pressure ulcer development in January. Inital themes relate to documentation and the Tissue Viability Service are working with ED to improve the care and interventions that are put into place as soon as a patient arrives.

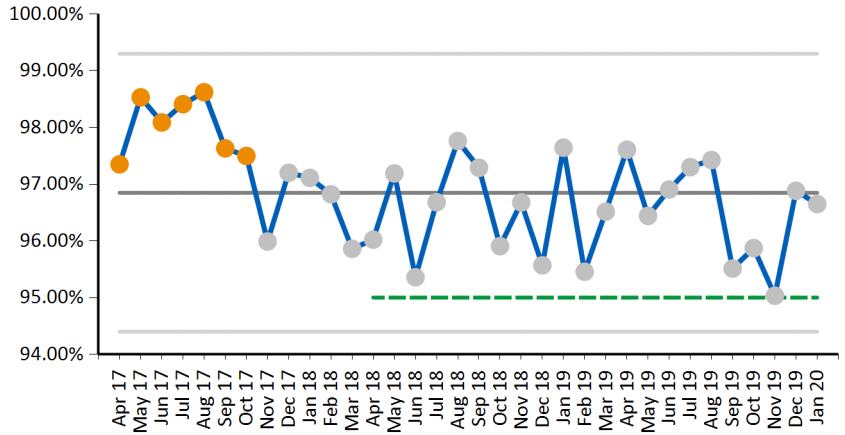
Falls
We have seen a rise in inpatient falls in January with a significant rise in falls with harm, predominantly in Acute Adult Division. The falls steering group is actively engaged with the divisions to analyse the underlying themes to reduce the incidence of falls moving forward. Through the Harm Free Care Panel it is noted that whilst this is an increase, panel outcomes have demonstrated that six were unpreventable, one was preventable and two are awaiting outcome.

The never event is currently under investigation regarding wrong site nerve block (hand). It will (as per policy) be subject to a final panel meeting chaired by a Non-Executive.

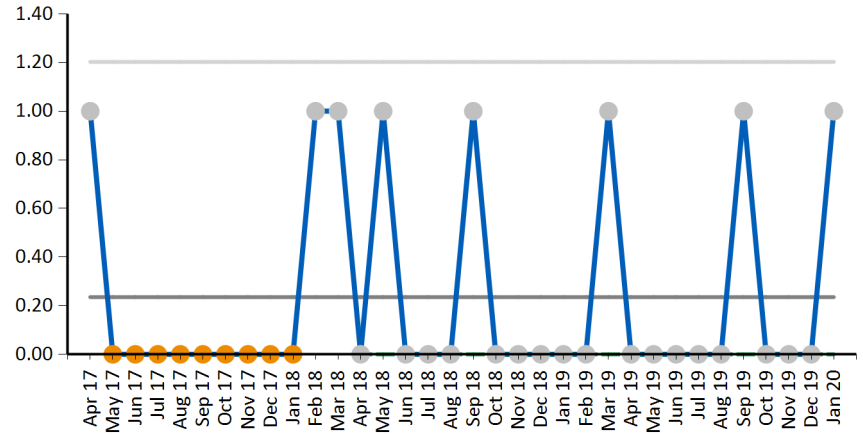
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.6%	Jan-20		>= 95%	96.9%	Dec-19	>= 95%	96.6%	
9 - Never Events	= 0	1	Jan-20		= 0	0	Dec-19	= 0	2	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	6.12	Jan-20		<= 5.30	5.96	Dec-19	<= 5.30	5.37	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	9	Jan-20	H	<= 1.6	2	Dec-19	<= 16.0	24	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	7.0	Jan-20		<= 6.0	5.0	Dec-19	<= 60.0	54.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	3.0	Jan-20	H	<= 0.5	0.0	Dec-19	<= 5.0	5.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Jan-20		= 0.0	0.0	Dec-19	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	8.0	Jan-20		<= 7.0	4.0	Dec-19	<= 70.0	72.0	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	4.0	Jan-20		<= 4.0	2.0	Dec-19	<= 40.0	31.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	2.0	Jan-20		<= 1.0	0.0	Dec-19	<= 10.0	5.0	
21 - Total Pressure Damage due to lapses in care	<= 6	7	Jan-20		<= 6	5	Dec-19	<= 56	41	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	94.3%	Q4 2018/19		>= 90%	92.5%	Q3 2018/19	>= 90%		
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2018/19		>= 90%	91.7%	Q3 2018/19	>= 90%		
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	69.7%	Jan-20		>= 80%	58.0%	Dec-19	>= 80%	71.2%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	70.8%	Jan-20		>= 72.5%	67.6%	Dec-19	>= 72.5%	64.1%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	100.0%	Jan-20		= 100%	60.0%	Dec-19	= 100%	77.0%	
88 - Nursing KPI Audits	>= 85%	88.6%	Jan-20		>= 85%	88.9%	Dec-19	>= 85%	90.8%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	Jan-20		= 100%	0.0%	Dec-19	= 100%	222.2%	

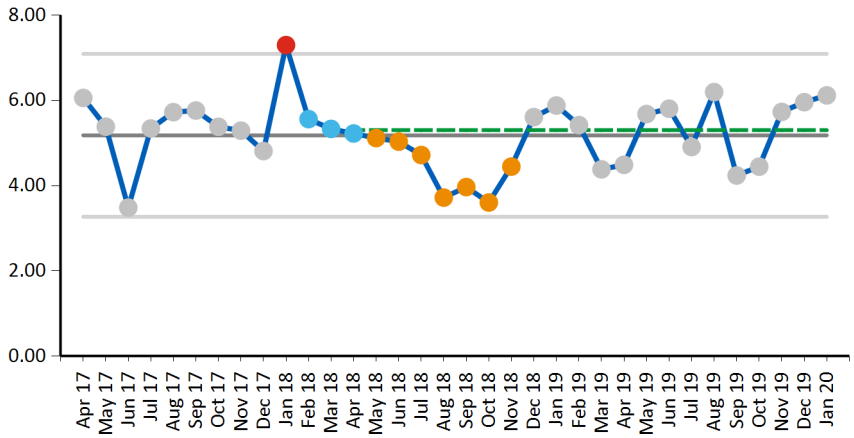
6 - Compliance with preventative measure for VTE



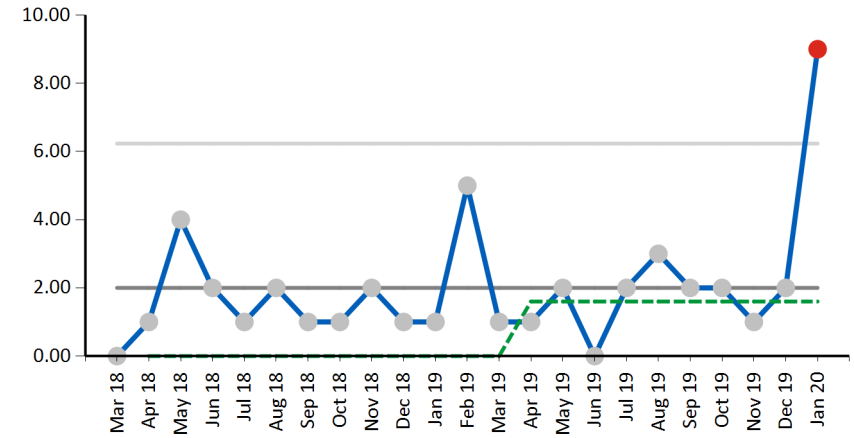
9 - Never Events



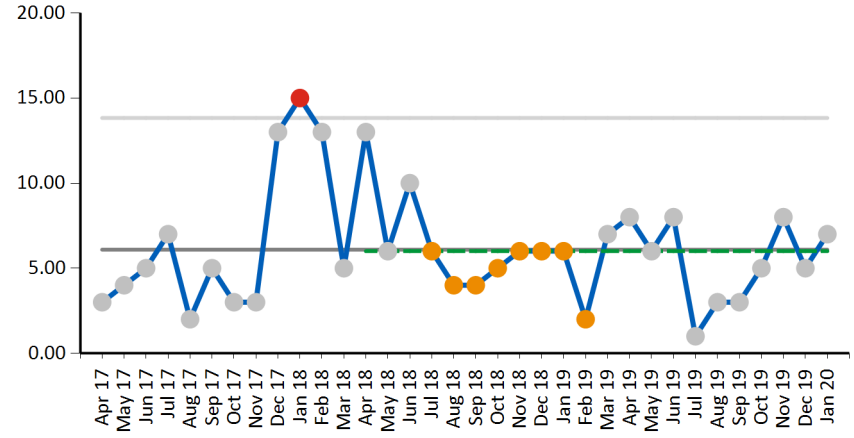
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



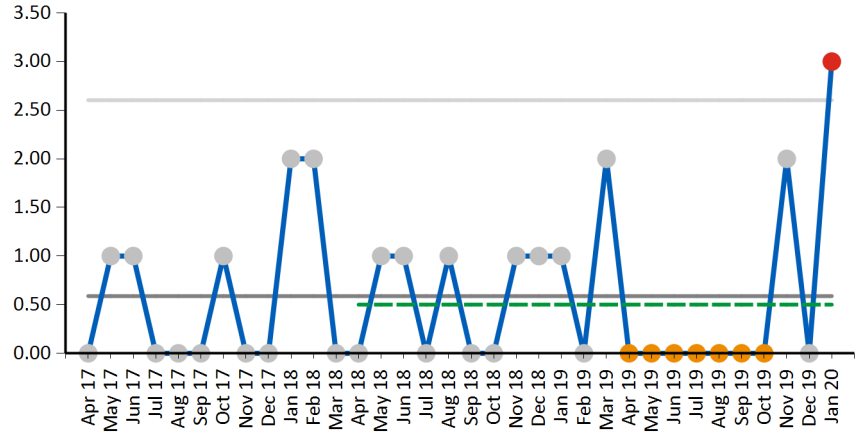
14 - Inpatient falls resulting in Harm (Moderate +)



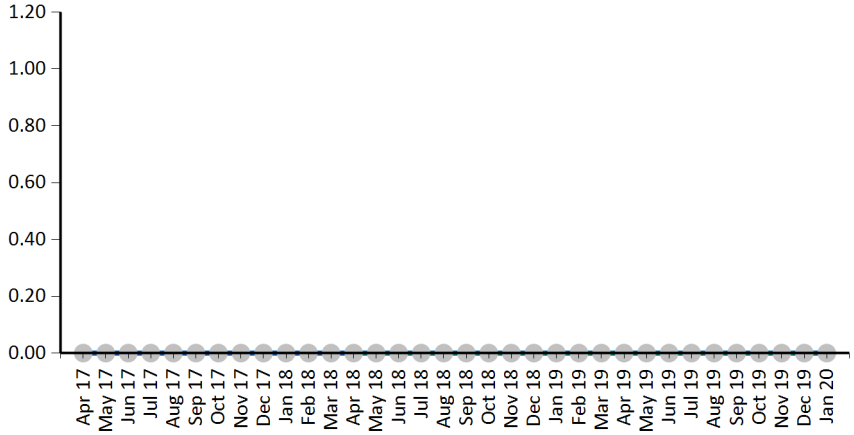
15 - Acute Inpatients acquiring pressure damage (category 2)



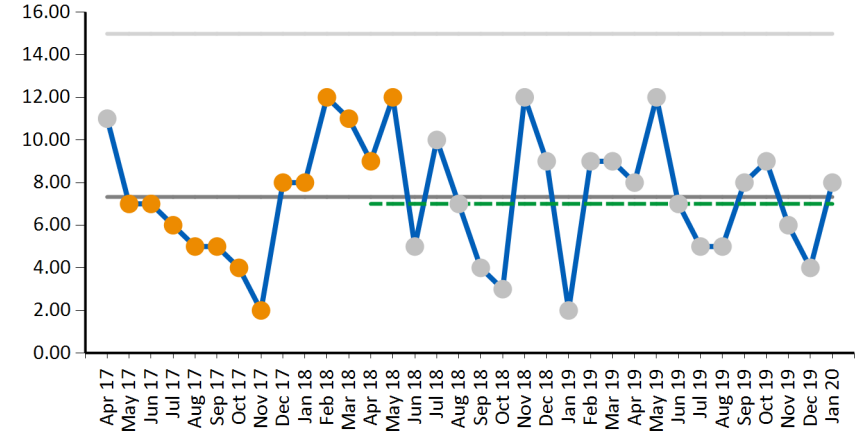
16 - Acute Inpatients acquiring pressure damage (category 3)



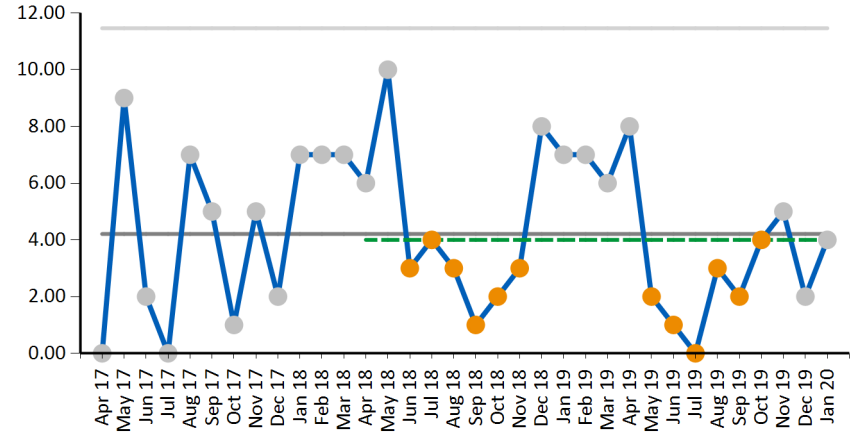
17 - Acute Inpatients acquiring pressure damage (category 4)



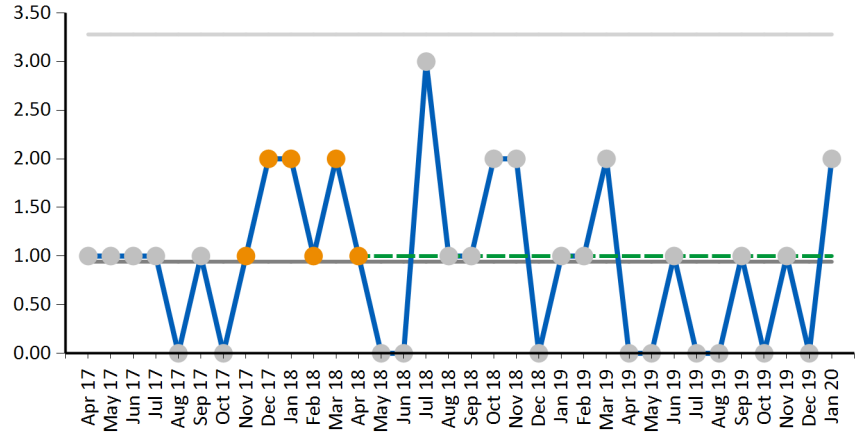
18 - Community patients acquiring pressure damage (category 2)



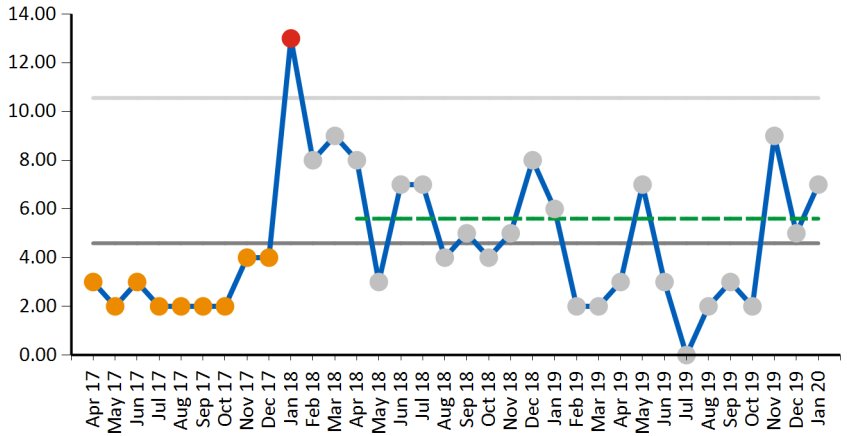
19 - Community patients acquiring pressure damage (category 3)



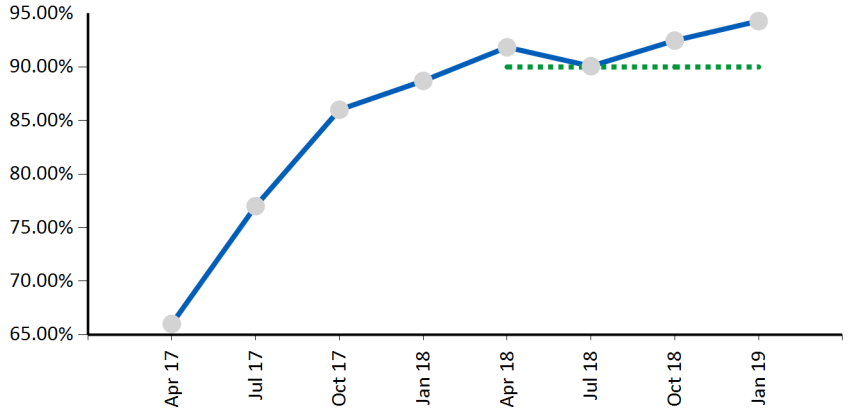
20 - Community patients acquiring pressure damage (category 4)



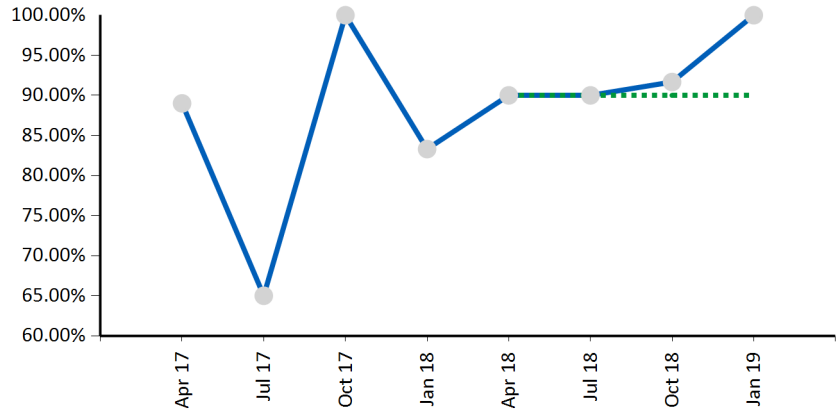
21 - Total Pressure Damage due to lapses in care



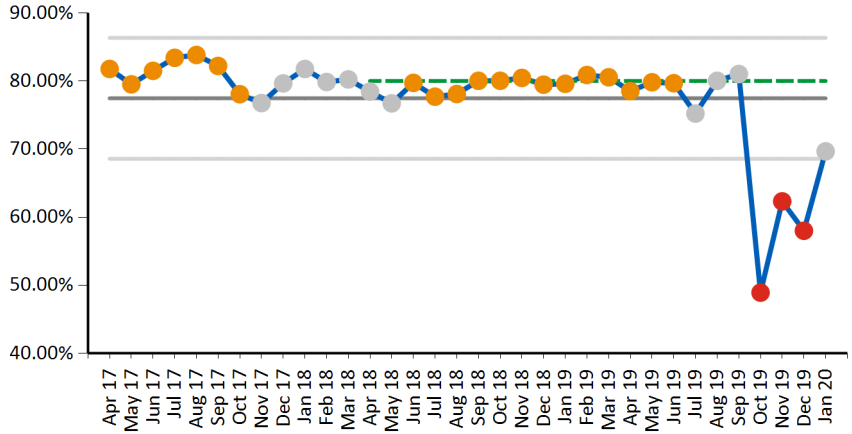
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points



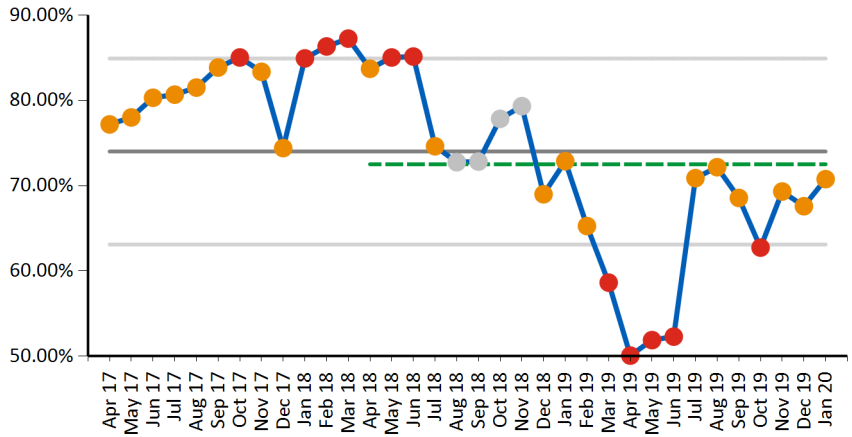
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



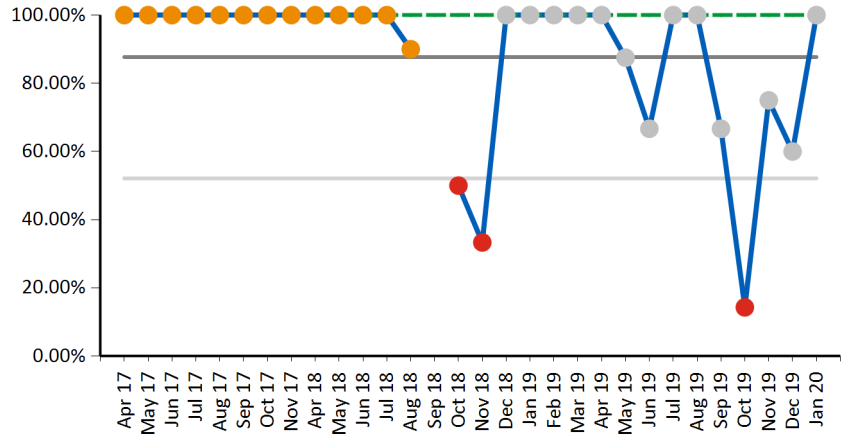
30 - Clinical Correspondence - Inpatients %<1 working day



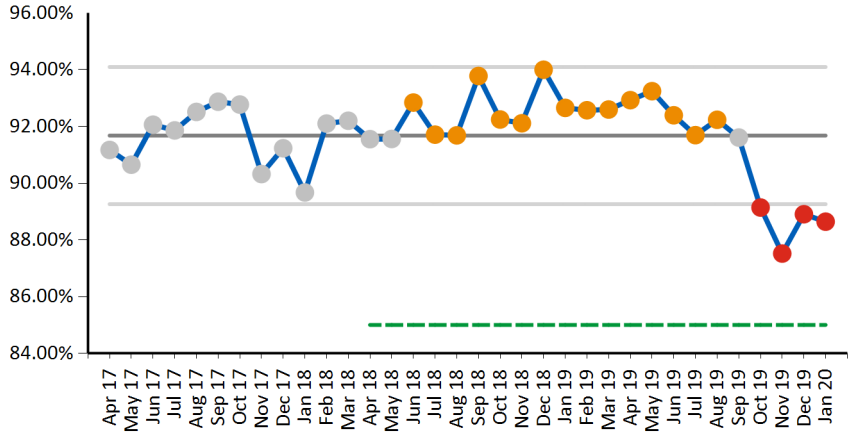
31 - Clinical Correspondence - Outpatients %<5 working days



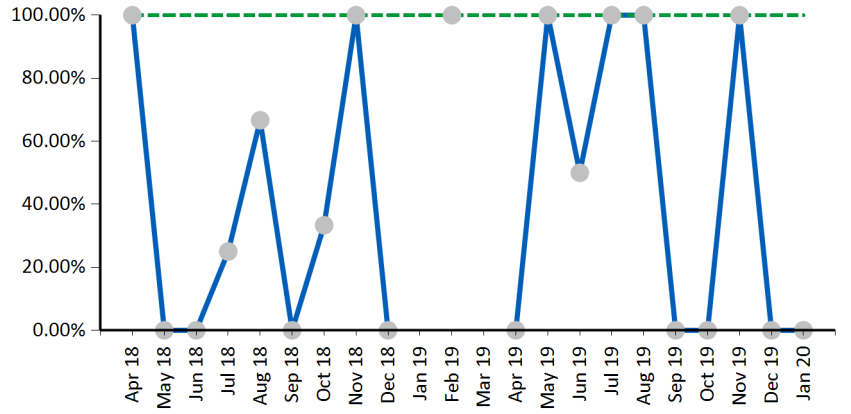
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



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

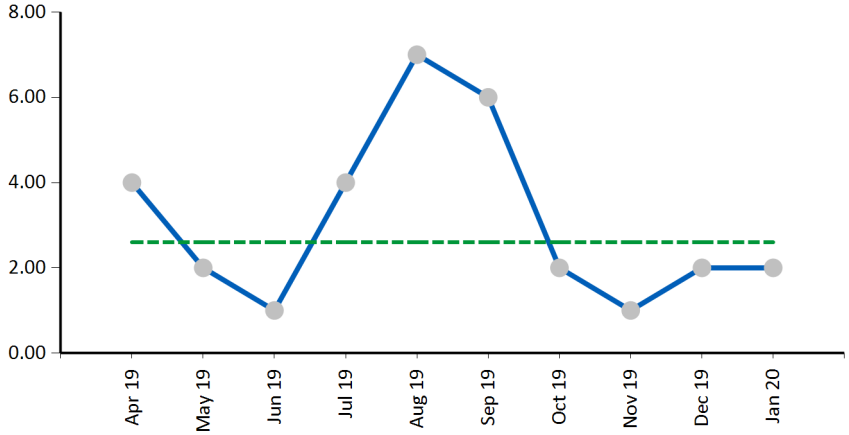


Infection Prevention and Control

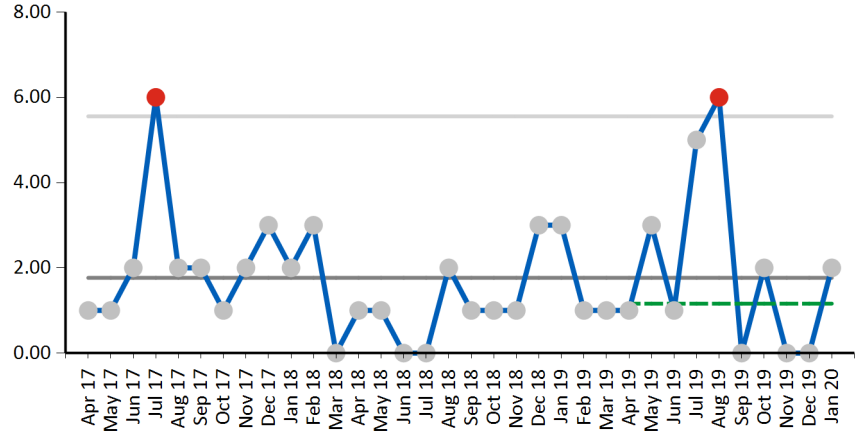
CDT cases continue to be lower than mid-year but have now settled above the baseline in late 2019/20 of 3 cases/month. Blood culture contaminants remain above the target 3% but are reduced and this reduction has been sustained.

	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	2	Jan-20		<= 3	2	Dec-19	<= 26	31	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	2	Jan-20		<= 1	0	Dec-19	<= 12	20	
347 - Total C.diff infections contributing to objective	<= 3	4	Jan-20		<= 3	2	Dec-19	<= 26	51	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Jan-20		= 0	0	Dec-19	= 0	1	
218 - Total Trust apportioned E. coli BSI	<= 4	2	Jan-20		<= 4	3	Dec-19	<= 40	31	
219 - Blood Culture Contaminants (rate)	<= 3%	3.7%	Jan-20		<= 3%	3.1%	Dec-19	<= 3%	3.8%	
199 - Compliance with antibiotic prescribing standards	>= 95%	87.0%	Q2 2019/20		>= 95%	85.2%	Q3 2018/19	>= 95%	87.0%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	1.0	Jan-20		<= 1.3	1.0	Dec-19	<= 13.0	12.0	
305 - Total Trust apportioned Klebsiella spp. BSIs		1	Jan-20			1	Dec-19		13	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs		0	Jan-20			0	Dec-19		1	

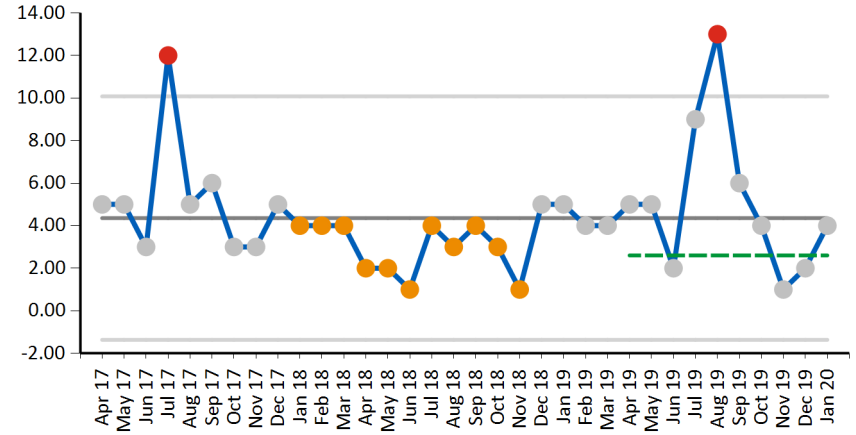
215 - Total Hospital Onset C.diff infections



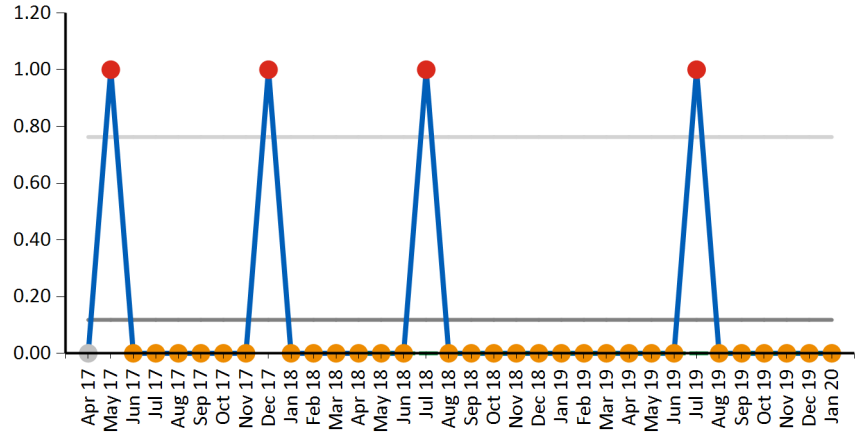
346 - Total Community Onset Hospital Associated C.diff infections



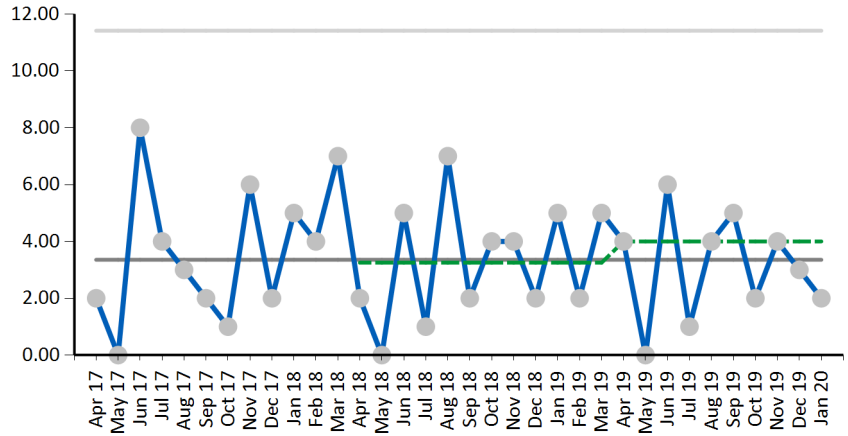
347 - Total C.diff infections contributing to objective



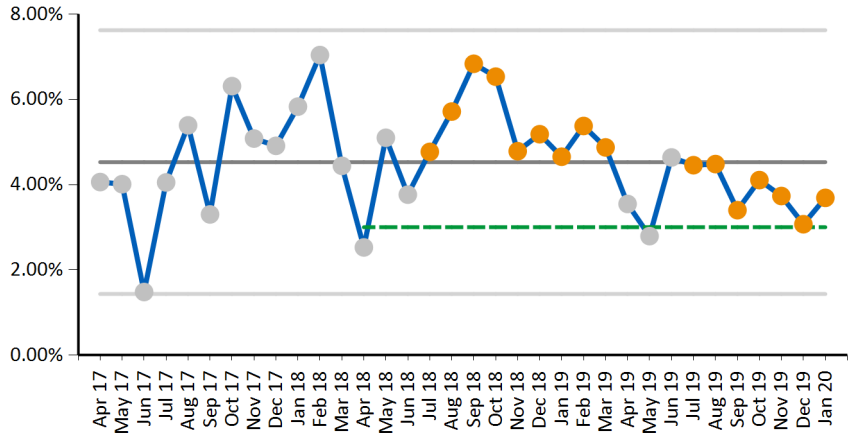
217 - Total Hospital-Onset MRSA BSIs



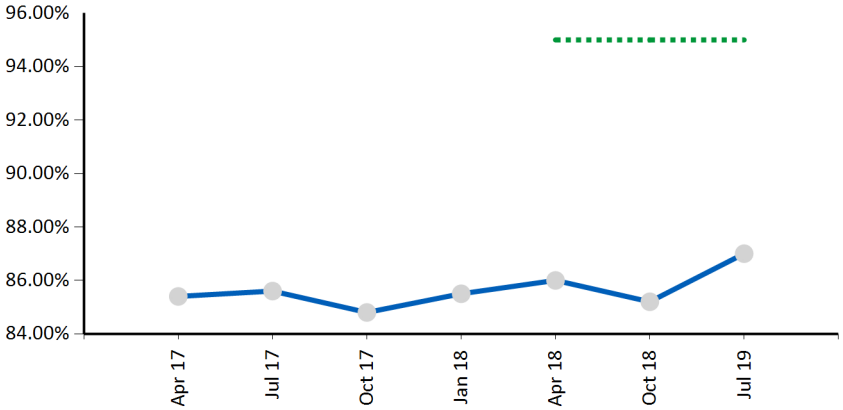
218 - Total Trust apportioned E. coli BSI



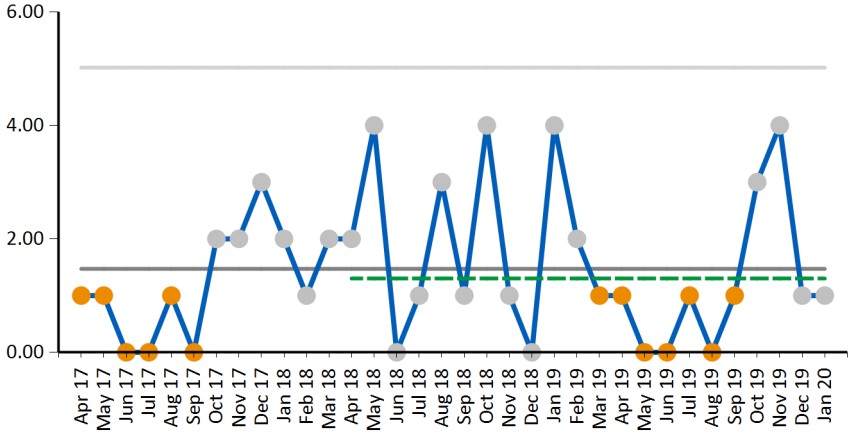
219 - Blood Culture Contaminants (rate)



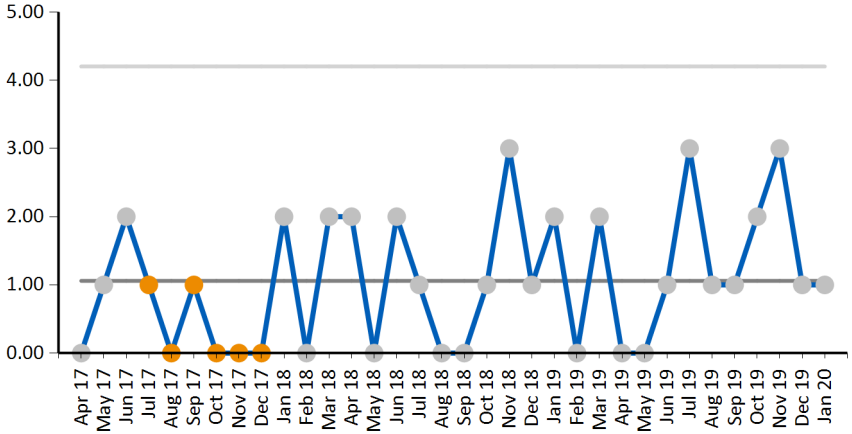
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



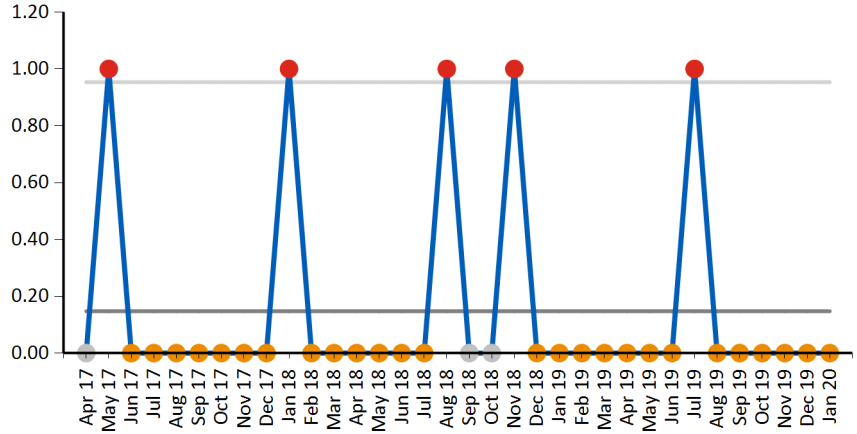
304 - Total Trust apportioned MSSA BSIs



305 - Total Trust apportioned Klebsiella spp. BSIs



306 - Total Trust apportioned Pseudomonas aeruginosa BSIs



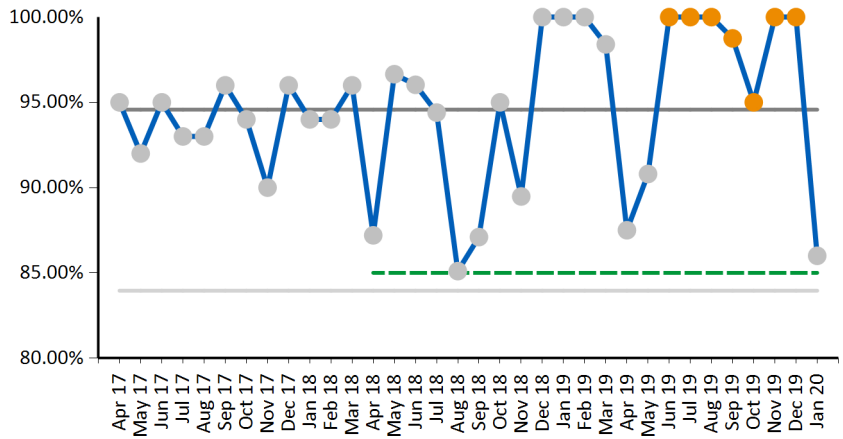
Mortality

Crude mortality remains below target and within control.

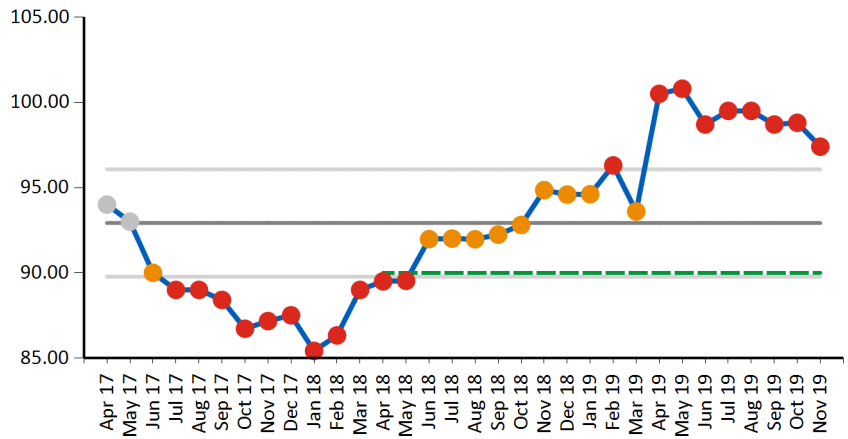
RAMI continues to remain outside the upper confidence limit. As mentioned previously the model used to formulate RAMI is rebased each year and this isn't taken into account in this SPC.

	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%	86.0%	Jan-20		>= 85%	100.0%	Dec-19	>= 85%	95.8%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	97.4	Nov-19		<= 90	98.8	Oct-19	<= 90	97.4	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	116.30	Aug-19		<= 100.00	115.80	Jul-19	<= 100.00	116.30	
12 - Crude Mortality %	<= 2.9%	2.3%	Jan-20		<= 2.9%	2.4%	Dec-19	<= 2.9%	2.0%	

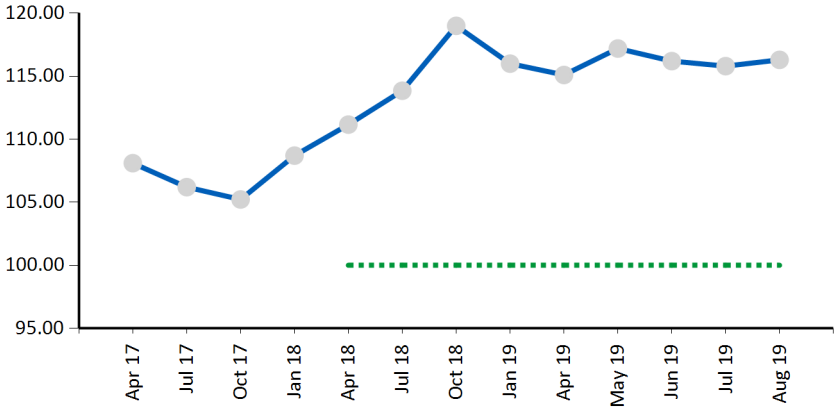
3 - National Early Warning Scores to Gold standard



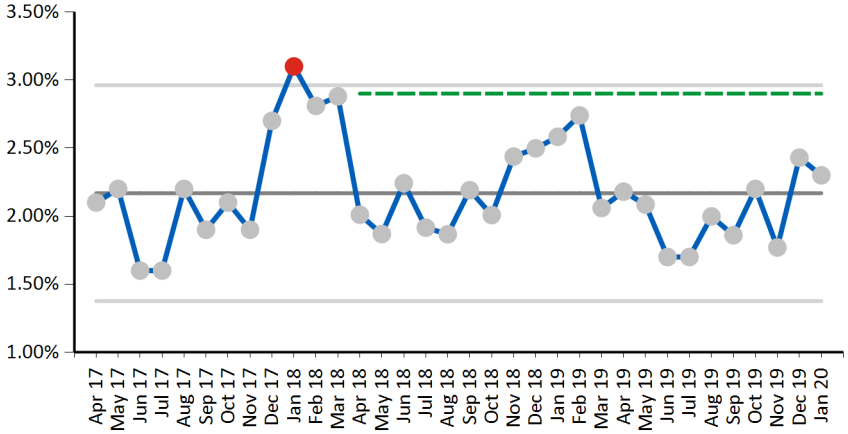
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)



11 - Standardised Hospital Mortality (ratio) (quarterly in arrears) - SPC data available after 20 data points



12 - Crude Mortality %



Patient Experience

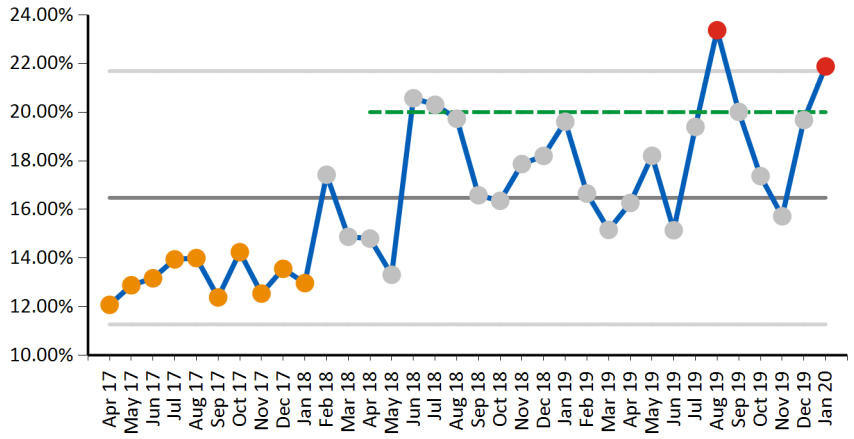
FFT
The new national guidance continues to be worked on ahead of implementation from the 1st April.

Complaints acknowledgement and response rates
The KPIs for acknowledgement and response rates of complaints achieved their respective targets in January.

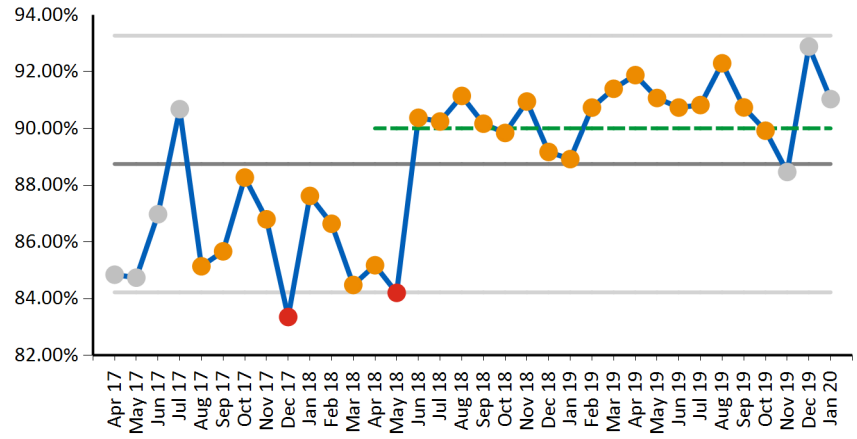
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	21.9%	Jan-20	H	>= 20%	19.7%	Dec-19	>= 20%	18.7%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	91.0%	Jan-20		>= 90%	92.9%	Dec-19	>= 90%	91.0%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	30.1%	Jan-20	L	>= 30%	25.1%	Dec-19	>= 30%	28.2%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.8%	Jan-20		>= 90%	96.2%	Dec-19	>= 90%	96.2%	P
81 - Maternity Friends and Family Response Rate	>= 15%	32.5%	Jan-20		>= 15%	22.3%	Dec-19	>= 15%	29.1%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	94.3%	Jan-20		>= 90%	93.1%	Dec-19	>= 90%	94.6%	P
82 - Antenatal - Friends and Family Response Rate	>= 15%	25.2%	Jan-20		>= 15%	20.2%	Dec-19	>= 15%	21.4%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	99.4%	Jan-20		>= 90%	100.0%	Dec-19	>= 90%	98.8%	P
83 - Birth - Friends and Family Response Rate	>= 15%	30.7%	Jan-20		>= 15%	27.2%	Dec-19	>= 15%	30.9%	?
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	87.6%	Jan-20	L	>= 90%	87.3%	Dec-19	>= 90%	90.6%	?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	35.4%	Jan-20		>= 15%	13.3%	Dec-19	>= 15%	28.4%	?
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	90.7%	Jan-20		>= 90%	89.3%	Dec-19	>= 90%	91.5%	?
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	41.7%	Jan-20		>= 15%	27.4%	Dec-19	>= 15%	37.3%	?
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.4%	Jan-20		>= 90%	96.0%	Dec-19	>= 90%	97.7%	P

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Jan-20		= 100%	100.0%	Dec-19	= 100%	98.9%	
90 - Complaints responded to within the period	>= 95%	95.8%	Jan-20		>= 95%	95.0%	Dec-19	>= 95%	95.6%	

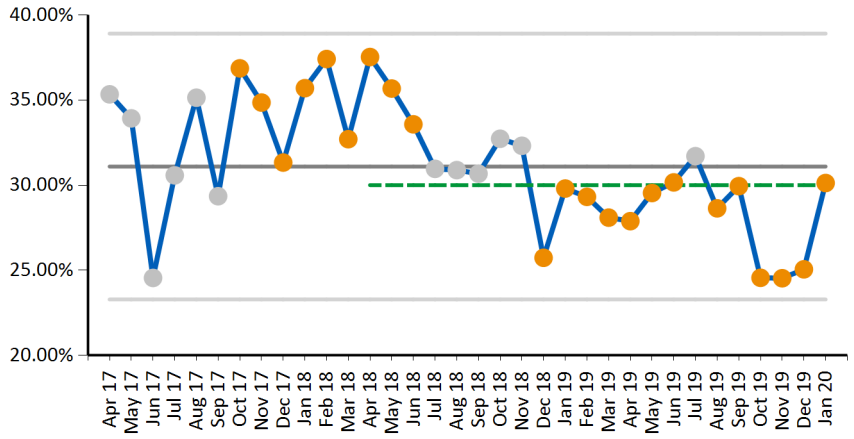
200 - A&E Friends and Family Response Rate



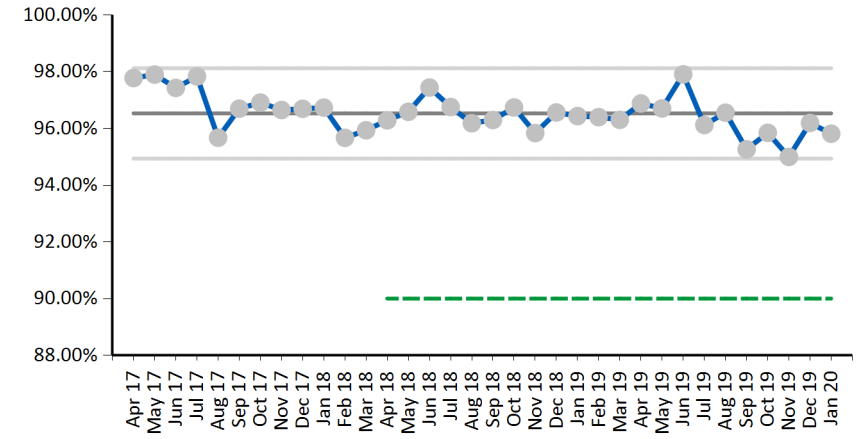
294 - A&E Friends and Family Satisfaction Rates %



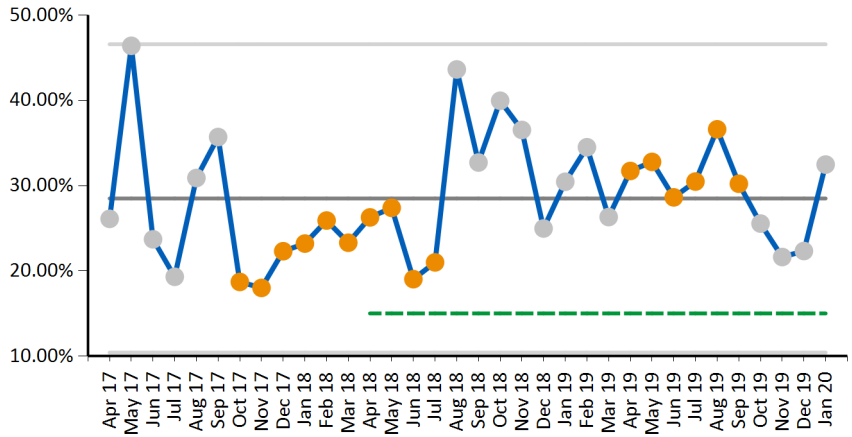
80 - Inpatient Friends and Family Response Rate



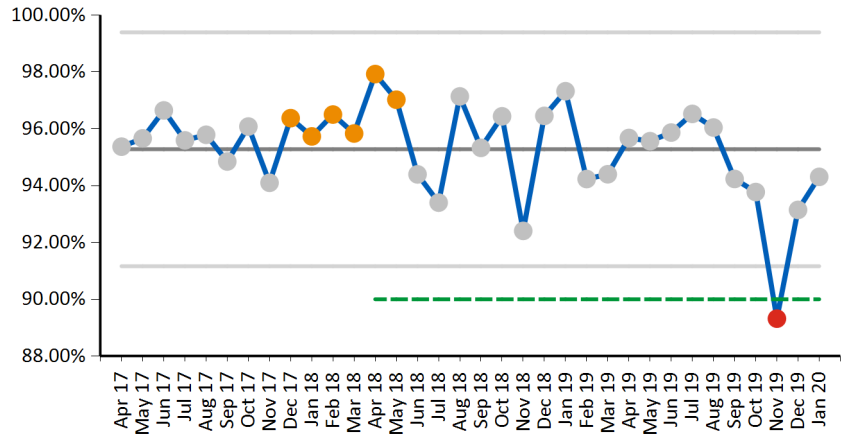
240 - Friends and Family Test (Inpatients) - Satisfaction %



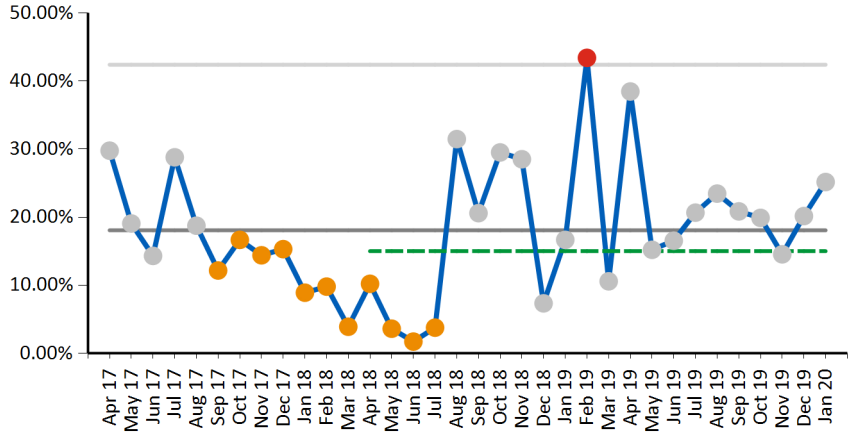
81 - Maternity Friends and Family Response Rate



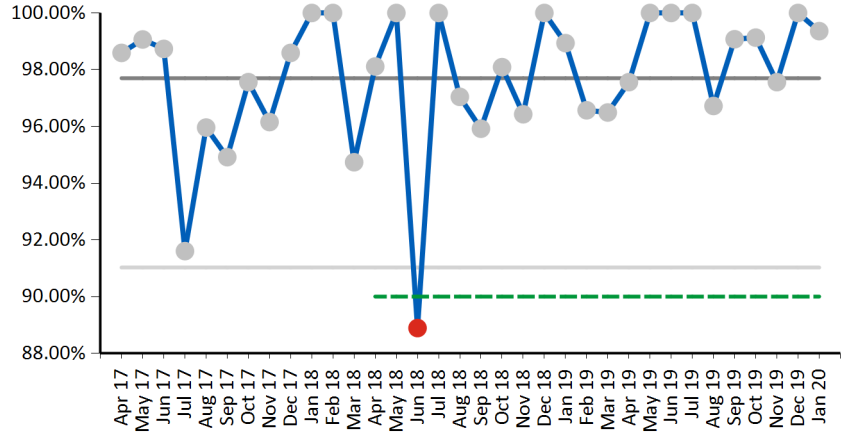
241 - Maternity Friends and Family Test - Satisfaction %



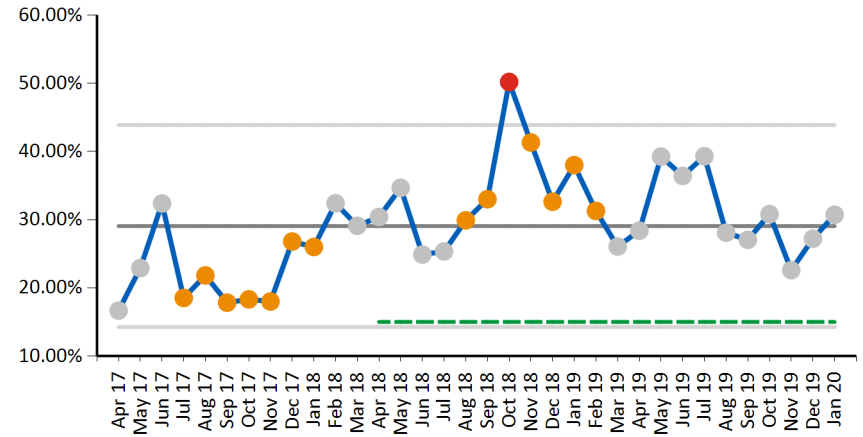
82 - Antenatal - Friends and Family Response Rate



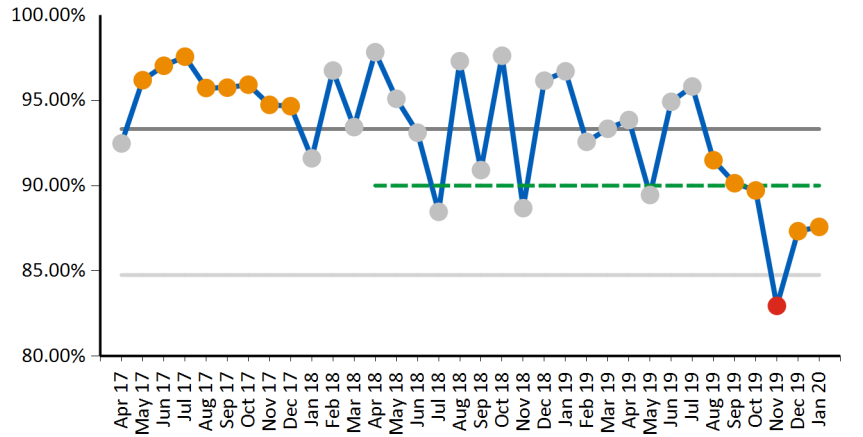
242 - Antenatal Friends and Family Test - Satisfaction %



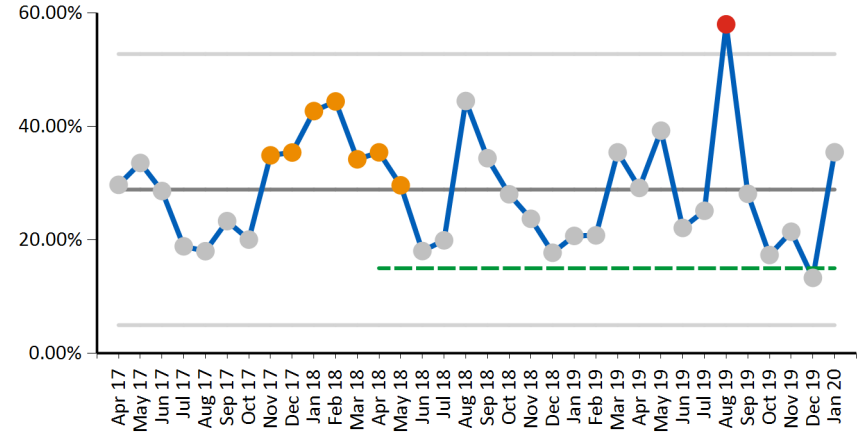
83 - Birth - Friends and Family Response Rate



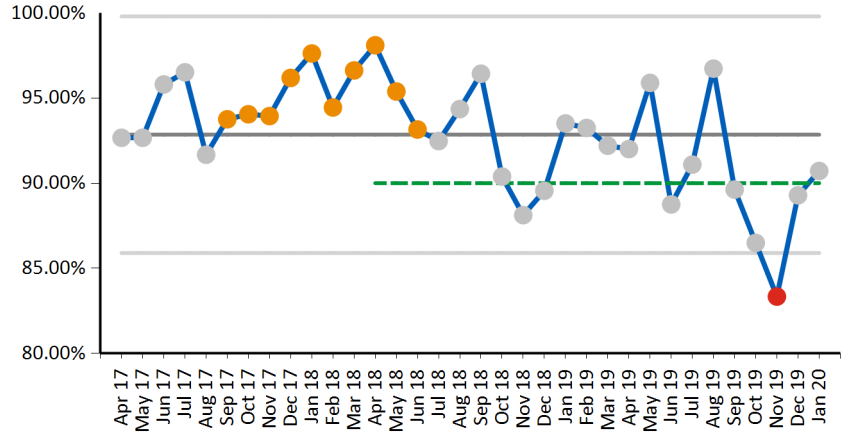
243 - Birth Friends and Family Test - Satisfaction %



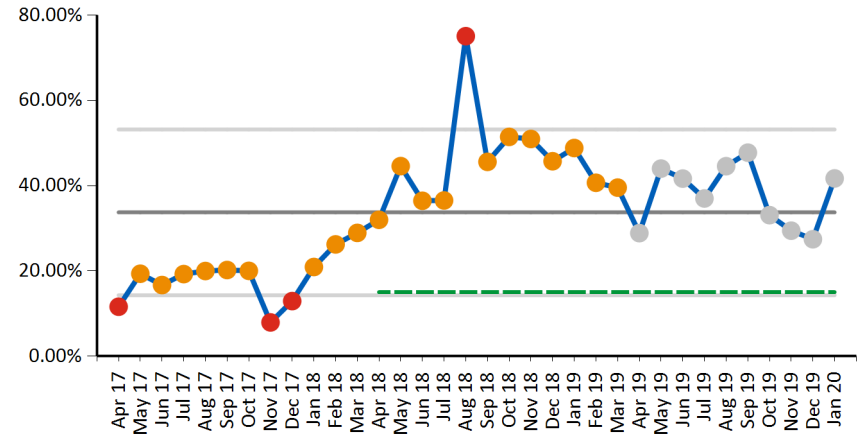
84 - Hospital Postnatal - Friends and Family Response Rate



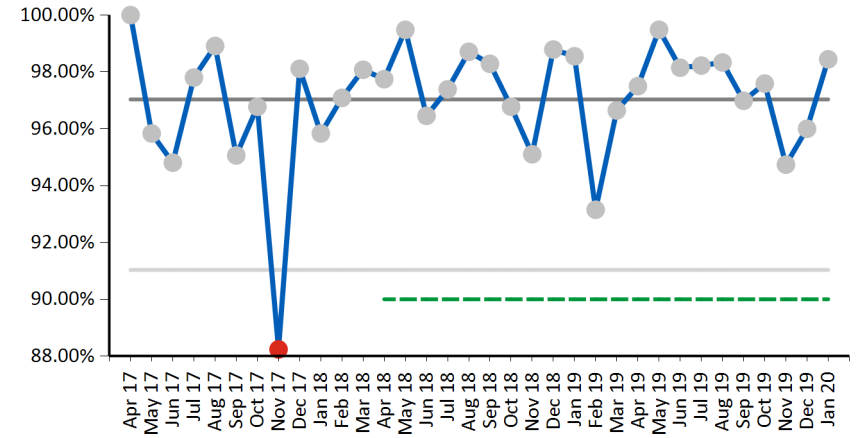
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



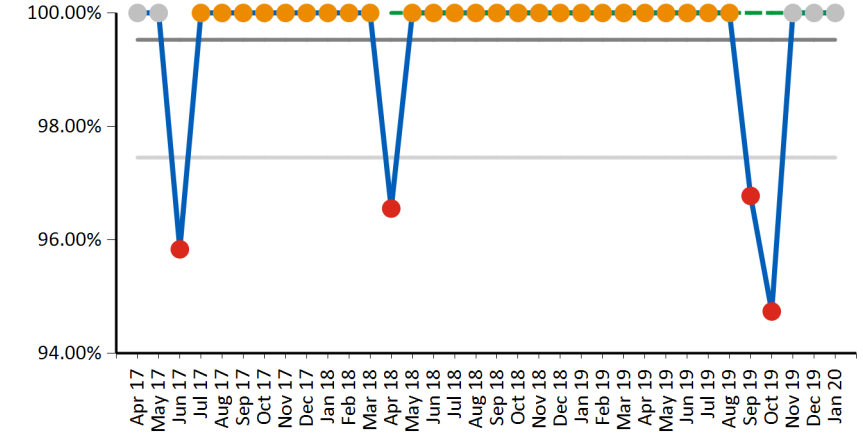
85 - Community Postnatal - Friend and Family Response Rate



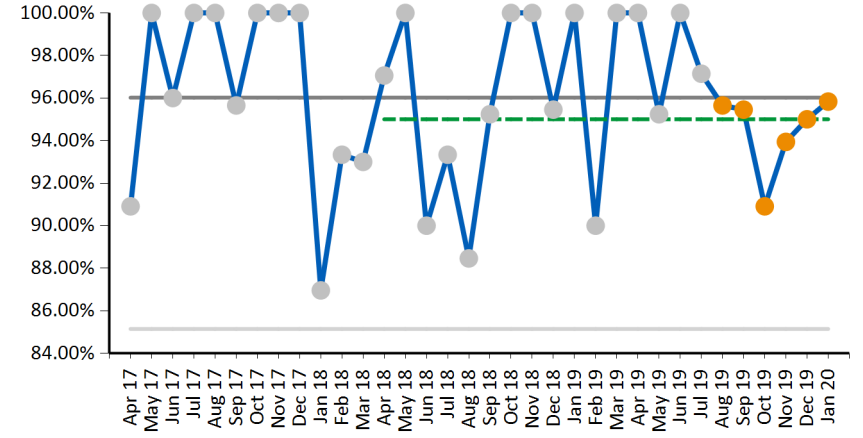
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

12+6 - Performance has deteriorated in January, progress was impacted by the festive period.

Stillbirths - there were 2 in January, both of which are in the process of being reviewed.

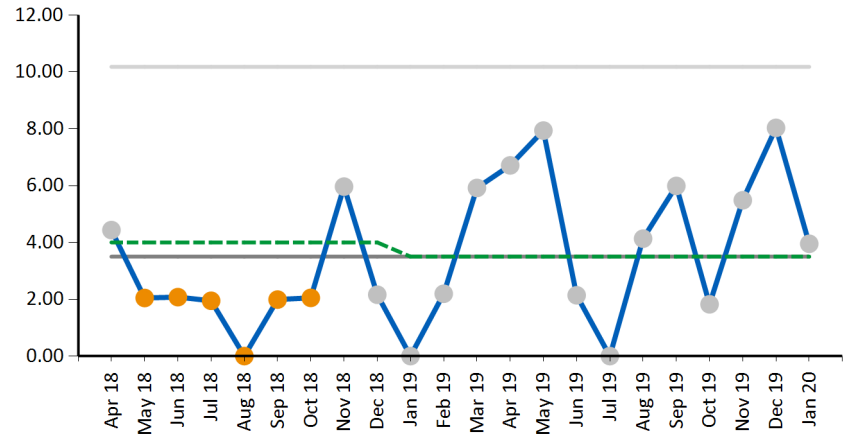
We are please to report that breastfeeding initiation rates were 72.% in January (target 65%).

January has seen bookings increase to 591 (average in 524) September will be a busy month for births again.

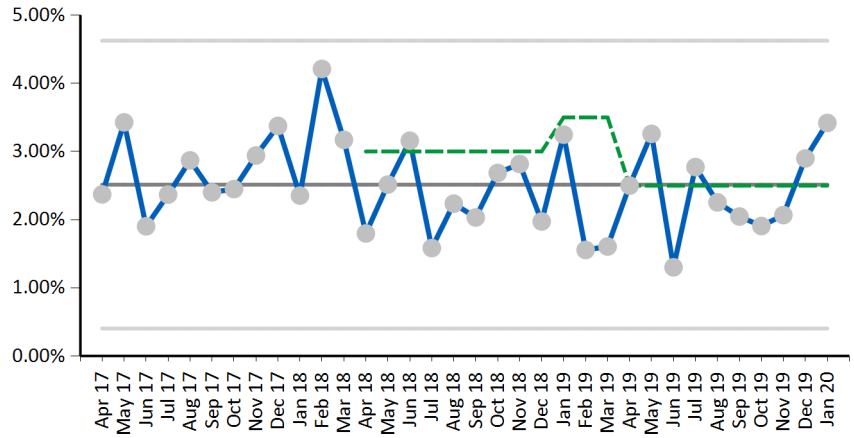
We note that there has been an increase in the number of 3rd and 4th degree tears, 3.4% in January, we are exploring participation in a national pilot that helps to facilitate sustained improvement.

	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	3.95	Jan-20		<= 3.50	8.03	Dec-19	<= 3.50	4.59	
23 - Maternity -3rd/4th degree tears	<= 2.5%	3.4%	Jan-20		<= 2.5%	2.9%	Dec-19	<= 2.5%	2.4%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.3%	Jan-20		>= 95.0%	98.0%	Dec-19	>= 95.0%	98.7%	
203 - Booked 12+6	>= 90.0%	88.4%	Jan-20		>= 90.0%	92.3%	Dec-19	>= 90.0%	89.4%	
204 - Inductions of labour	<= 35%	39.6%	Jan-20		<= 35%	37.9%	Dec-19	<= 35%	40.2%	
208 - Total C section	<= 29.0%	29.5%	Jan-20		<= 29.0%	30.0%	Dec-19	<= 29.0%	28.7%	
210 - Initiation breast feeding	>= 65%	72.38%	Jan-20		>= 65%	67.89%	Dec-19	>= 65%	68.54%	
213 - Maternity complaints	<= 5	3	Jan-20		<= 5	3	Dec-19	<= 50	32	
319 - Maternal deaths (direct)	= 0	0	Jan-20		= 0	0	Dec-19	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.7%	Jan-20		<= 6%	9.4%	Dec-19	<= 6%	9.5%	

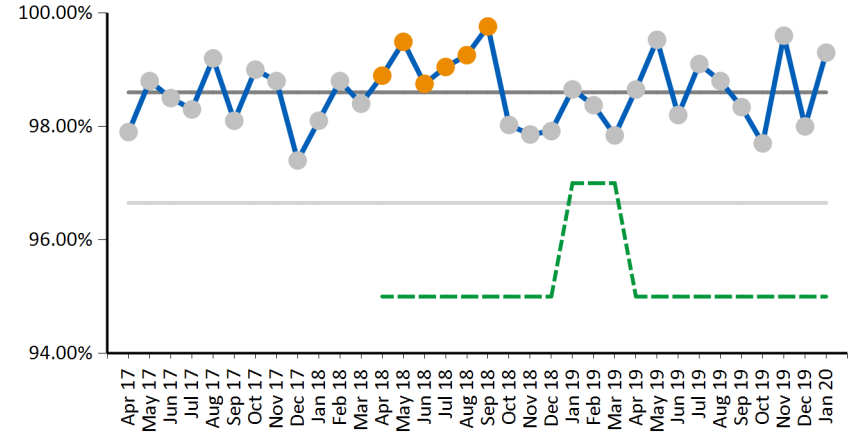
322 - Maternity - Stillbirths per 1000 births



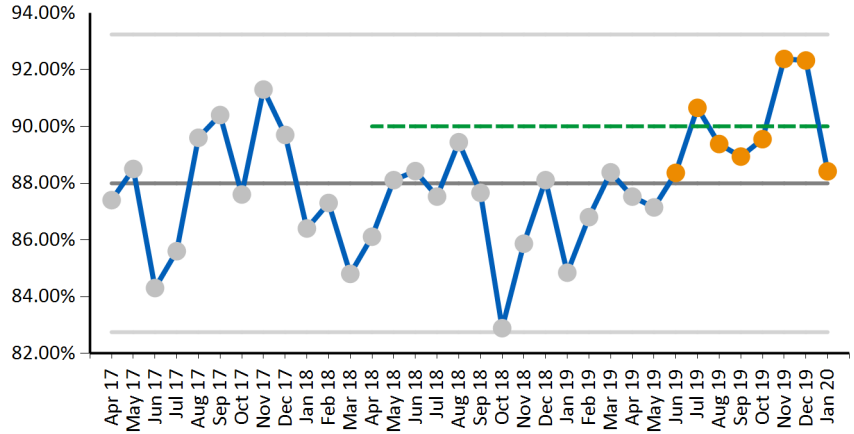
23 - Maternity -3rd/4th degree tears



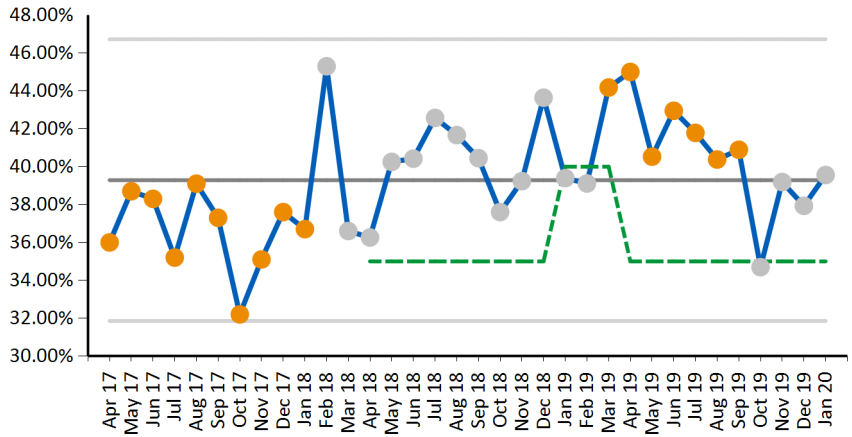
202 - 1:1 Midwifery care in labour



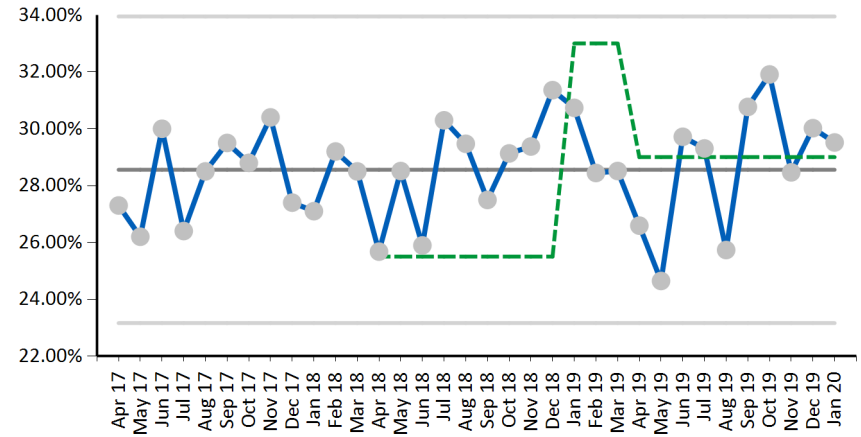
203 - Booked 12+6



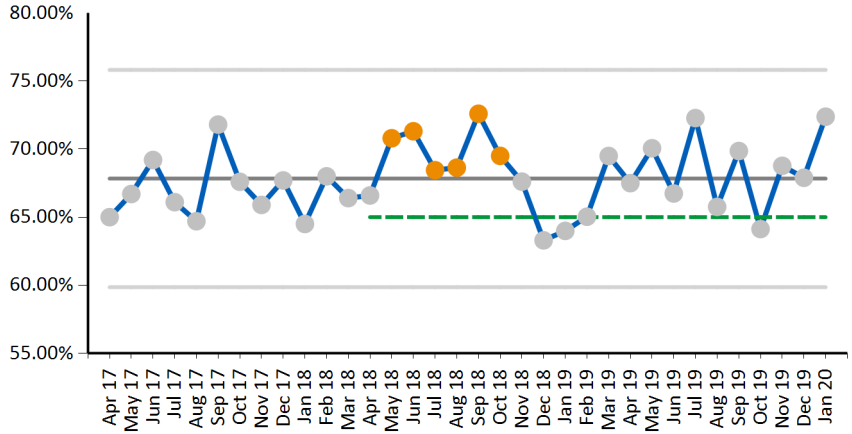
204 - Inductions of labour



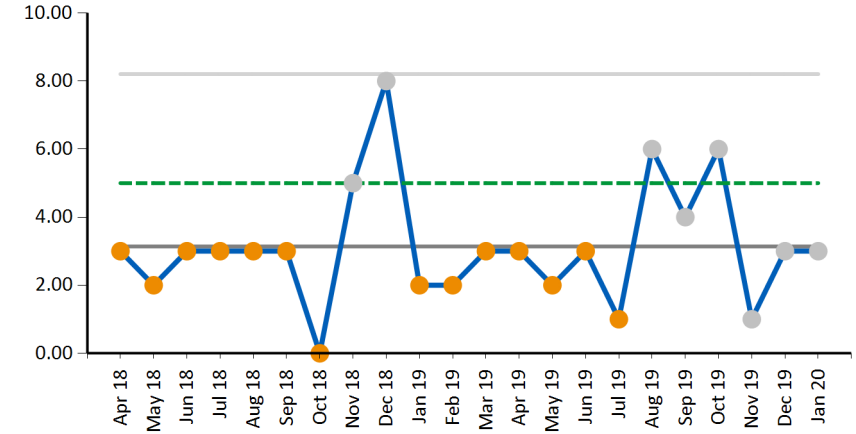
208 - Total C section



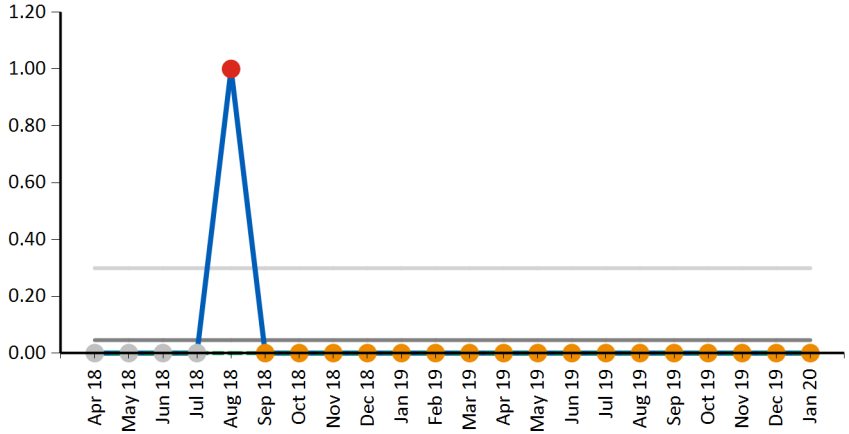
210 - Initiation breast feeding



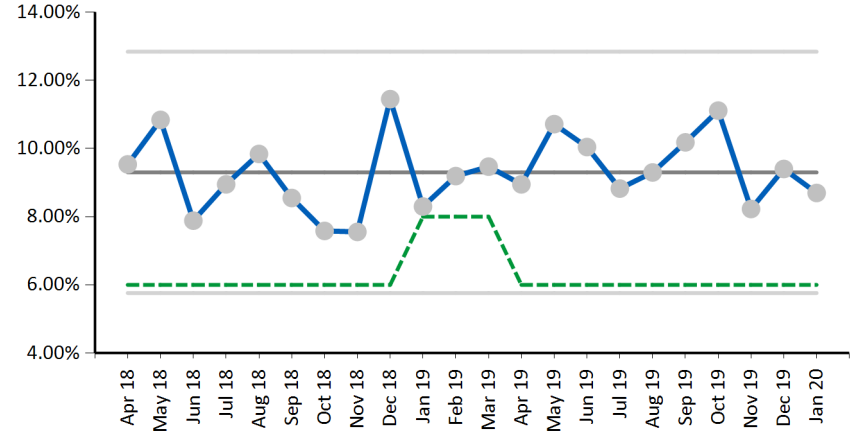
213 - Maternity complaints



319 - Maternal deaths (direct)



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



Operational Performance

Access

Transfers between 11-6
In common with a number of metrics connected to Urgent Care performance, we have seen a sharp decline in performance against the standard in the last quarter. Some of the performance is recording error which is being addressed, but the key action is to get beds earlier in the day. The Trust has asked ECIST to review our practice and identify where there is deterioration in practice, this visit is now planned from April.

RTT
It is pleasing to note the waiting list is coming down due to the actions taken by the Trust and is expected to achieve the revised target of less than 25000, by the end of March. The number of patients waiting more than 52 weeks remains significant, however 78% reported this month are related corneal graft availability. A national shortage of donors is causing specific challenges, NHSE are reviewing the issue on a regional basis. The Trust is carrying out an internal review as part of the new year contract setting, given the continued month on month decline as to what capacity would be need to improve performance against the standard.

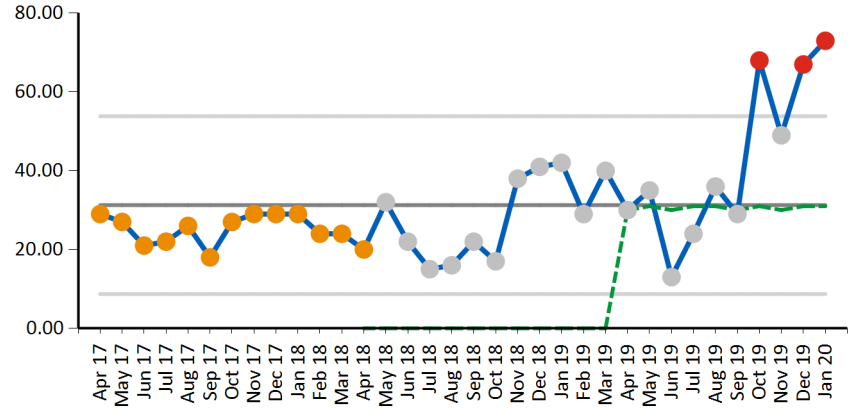
Urgent Care
As already noted, Since October, in common nationally but particularly in Greater Manchester, urgent care performance has been particularly challenging, there is some improvement in January and this continues in February, but it is slow, work continues and with the support of ECIST we expect to identify opportunities to accelerate improvements. Ambulance handovers have been particularly hard hit, but these are improving, in part due to actions taken by the clinical teams.

TIA
Performance is variable against the standard, numbers are small but the CCG have written to the Trust formally to introduce in contract, a new pathways which it is expected would remove the variation.

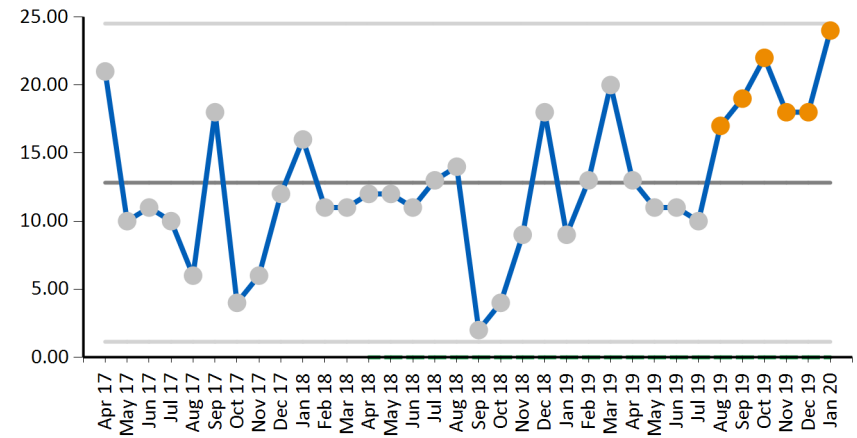
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 31	73	Jan-20	H	<= 31	67	Dec-19	<= 306	424	?
8 - Same sex accommodation breaches	= 0	24	Jan-20	H	= 0	18	Dec-19	= 0	163	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	80.0%	Jan-20		>= 75%	64.9%	Dec-19	>= 75%	71.5%	?
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	78.0%	Jan-20	L	>= 92%	79.3%	Dec-19	>= 92%	83.4%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	11	Jan-20	H	= 0	9	Dec-19	= 0	70	?
314 - RTT 18 week waiting list	<= 22,812	25,530	Jan-20	H	<= 22,812	27,240	Dec-19	<= 22,812	25,530	?
53 - A&E 4 hour target	>= 95%	74.4%	Jan-20		>= 95%	70.6%	Dec-19	>= 95%	79.8%	F

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	12.4%	Jan-20		= 0.0%	12.9%	Dec-19	= 0.0%	7.2%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	12.15%	Jan-20	H	= 0.00%	12.37%	Dec-19	= 0.00%	5.04%	?
72 - Diagnostic Waits >6 weeks %	<= 1%	1.3%	Jan-20		<= 1%	0.9%	Dec-19	<= 1%	1.0%	?
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	83.3%	Jan-20		= 100%	33.3%	Dec-19	= 100%	58.8%	?

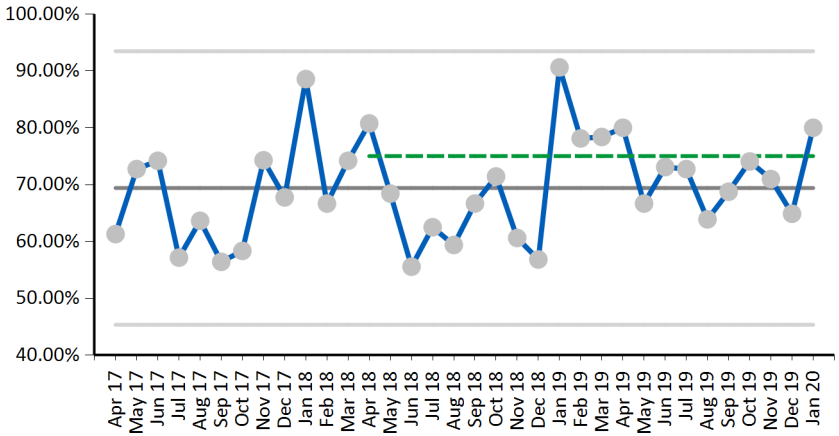
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



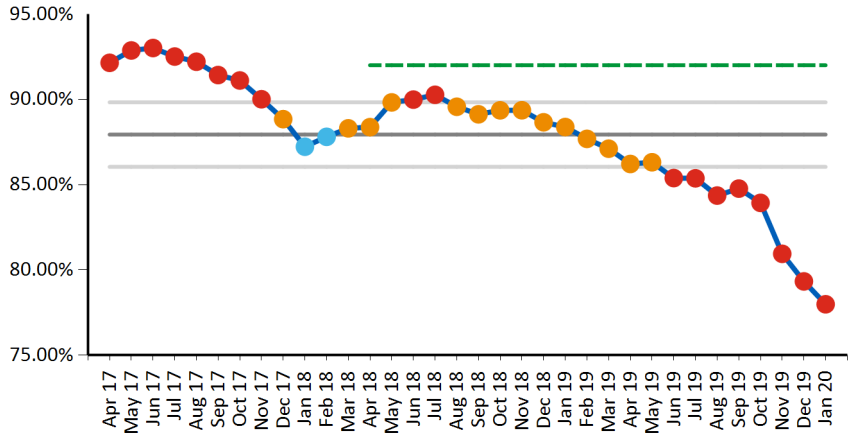
8 - Same sex accommodation breaches



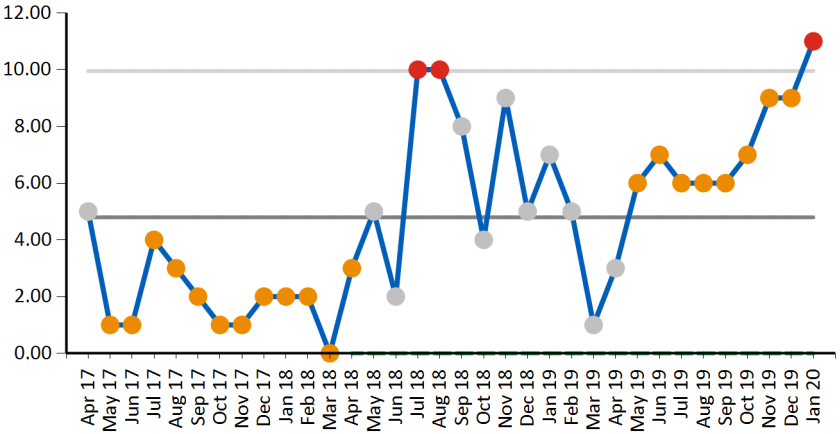
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



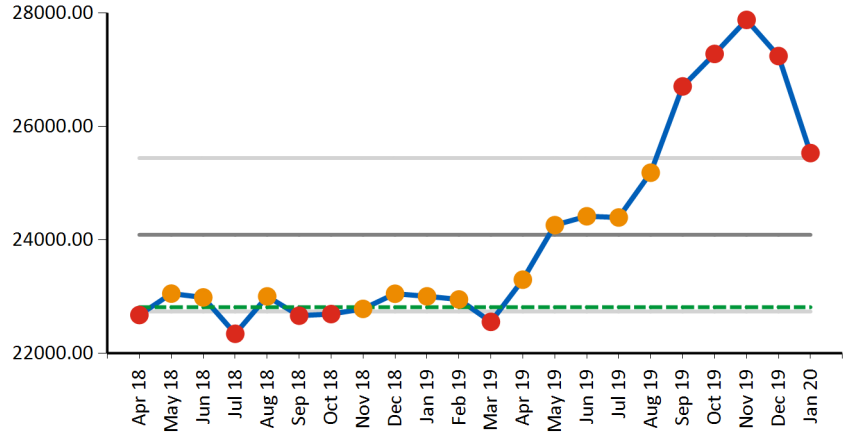
41 - RTT Incomplete pathways within 18 weeks %



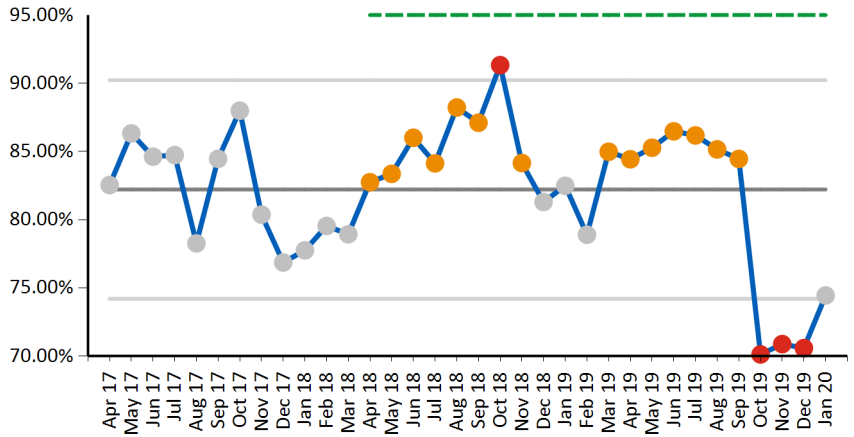
42 - RTT 52 week waits (incomplete pathways)



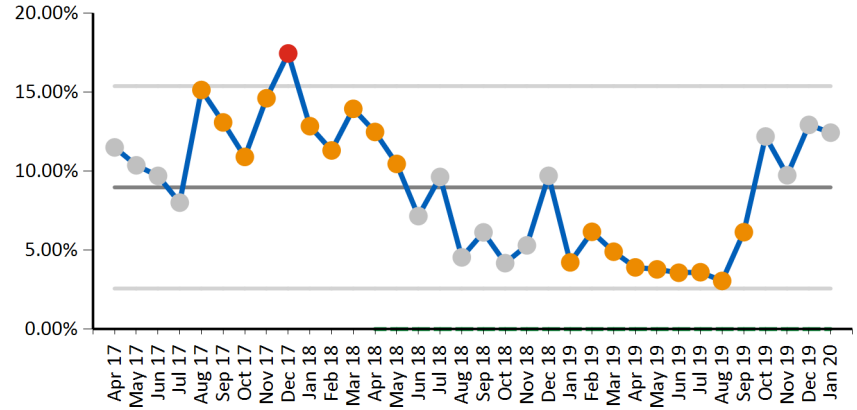
314 - RTT 18 week waiting list



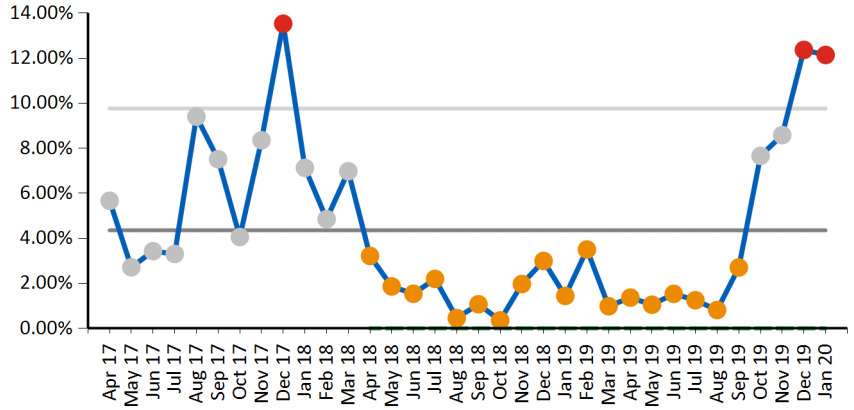
53 - A&E 4 hour target



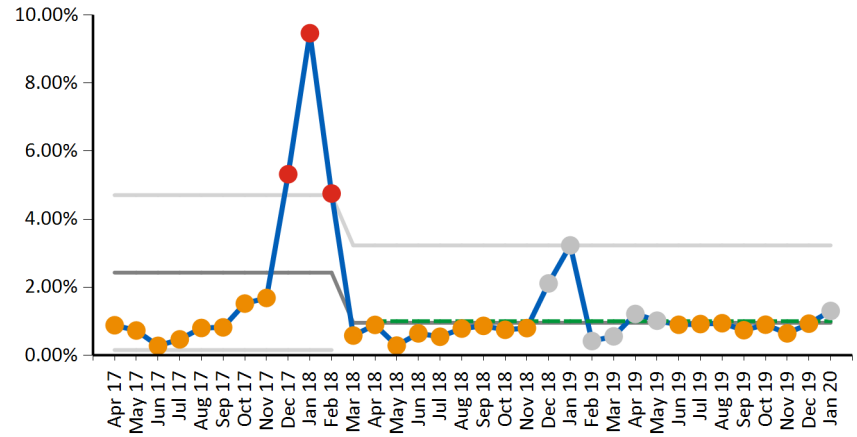
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



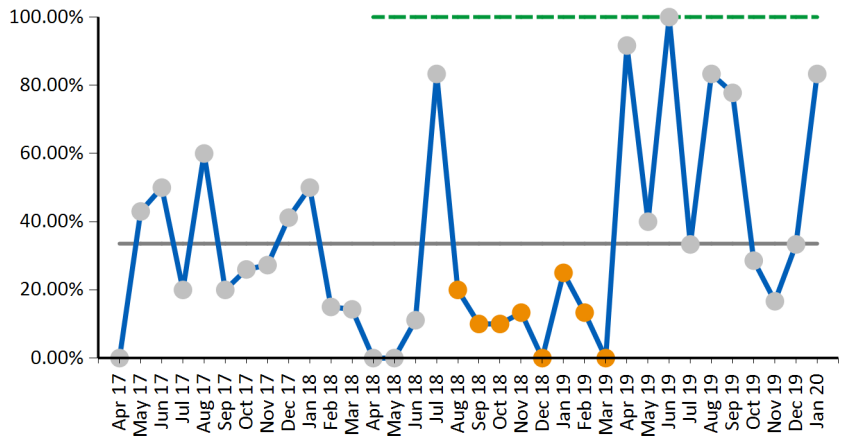
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



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



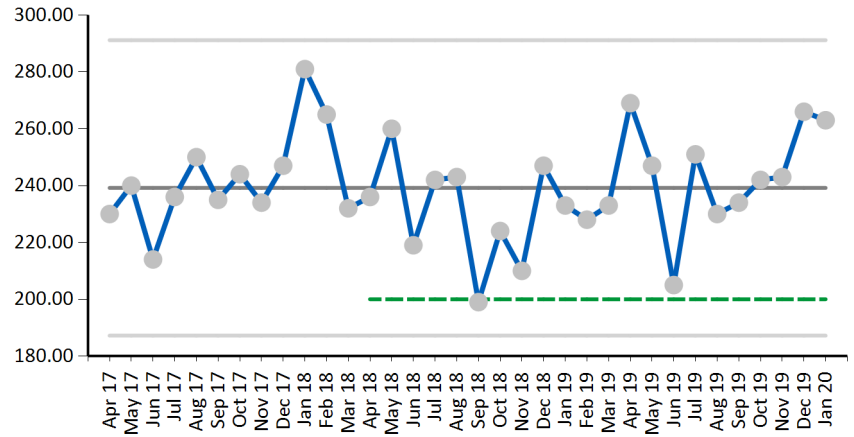
Productivity

Stranded Patients/ DTOC
The urgent care pressures have been exacerbated by the rise in stranded patients (7, 14 and 21 day LOS are rising) which does reflect a rise in acuity as to be expected at this time of year. But delayed transfers of care are also up, denoting a system pressure. We have introduced a system led review of delays and LOS which has supported some recent improvement in LOS reduction. More beds have also been opened to support flow.

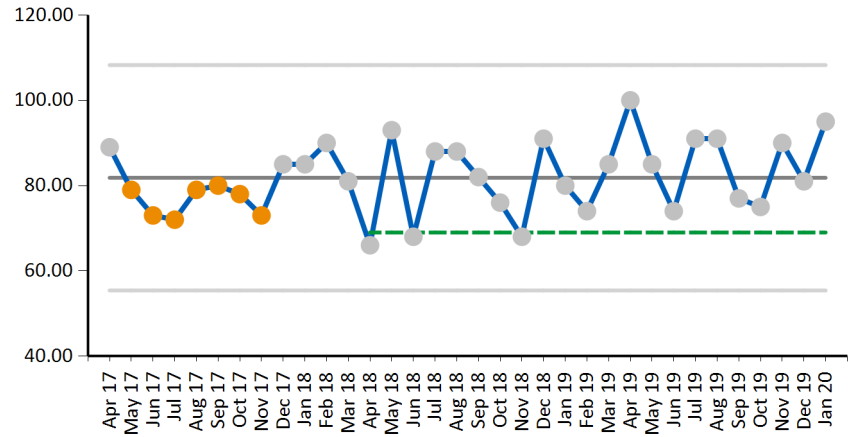
Readmissions
A review is being carried to why the sharp rise in month for readmissions.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	263	Jan-20		<= 200	266	Dec-19	<= 200	263	
307 - Stranded Patients - LOS 21 days and over	<= 69	95	Jan-20		<= 69	81	Dec-19	<= 69	95	
57 - Discharges by Midday	>= 30%	26.9%	Jan-20		>= 30%	25.2%	Dec-19	>= 30%	28.3%	
58 - Discharges by 4pm	>= 70%	67.5%	Jan-20		>= 70%	62.9%	Dec-19	>= 70%	66.6%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	15.6%	Dec-19	H	<= 13.5%	12.9%	Nov-19	<= 13.5%	12.0%	
60 - Daycase Rates	>= 80%	93.0%	Jan-20	H	>= 80%	91.2%	Dec-19	>= 80%	90.2%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Jan-20		<= 1%	3.0%	Dec-19	<= 1%	2.2%	
62 - Cancelled operations re-booked within 28 days	= 100%	50.0%	Jan-20	L	= 100%	71.4%	Dec-19	= 100%	81.7%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	3.4%	Jan-20		<= 3.3%	3.4%	Dec-19	<= 3.3%	2.9%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.50	Jan-20		<= 2.00	2.99	Dec-19	<= 2.00	2.56	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.77	Jan-20		<= 3.70	4.69	Dec-19	<= 3.70	4.67	F
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	85.7%	Dec-19		>= 80%	77.3%	Nov-19	>= 80%	88.4%	

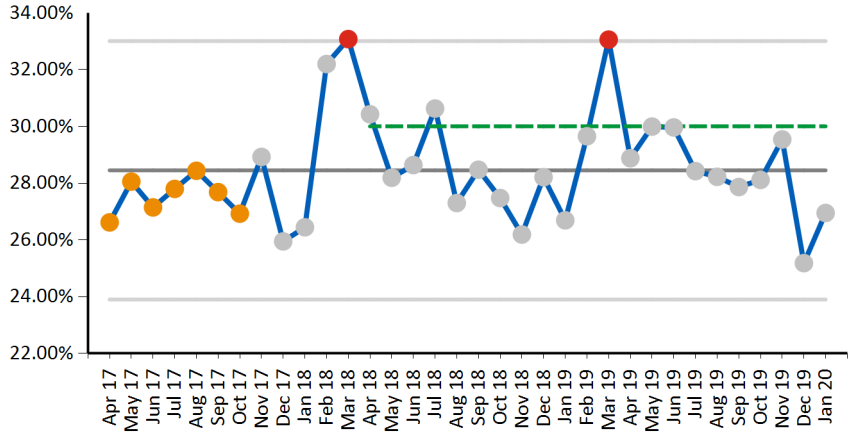
56 - Stranded patients



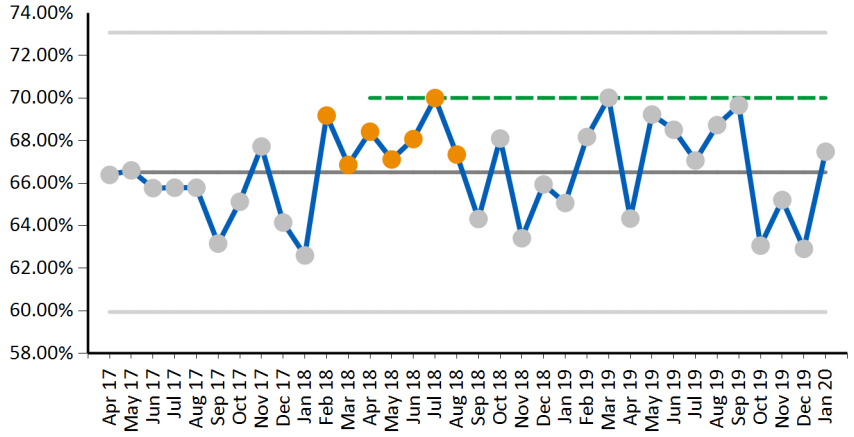
307 - Stranded Patients - LOS 21 days and over



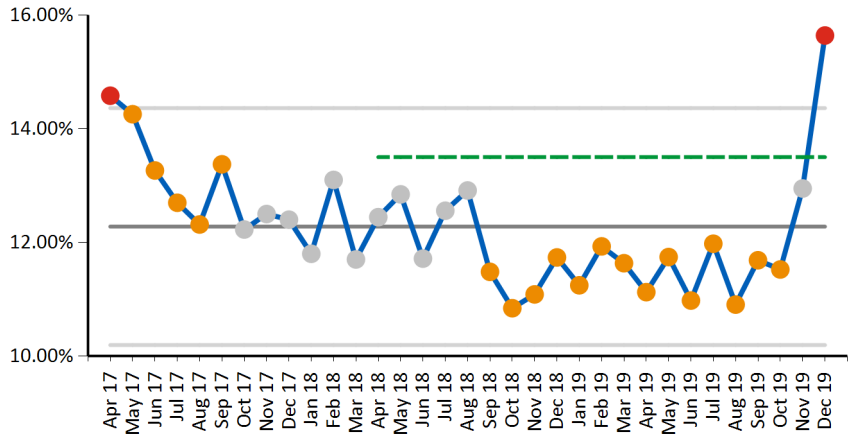
57 - Discharges by Midday



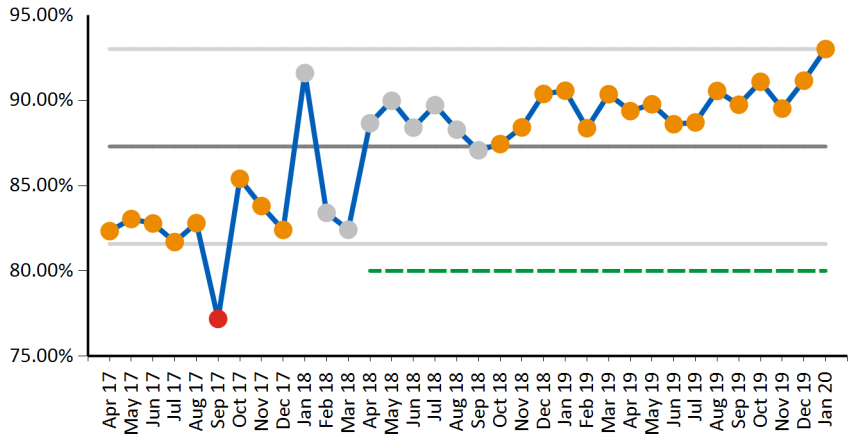
58 - Discharges by 4pm



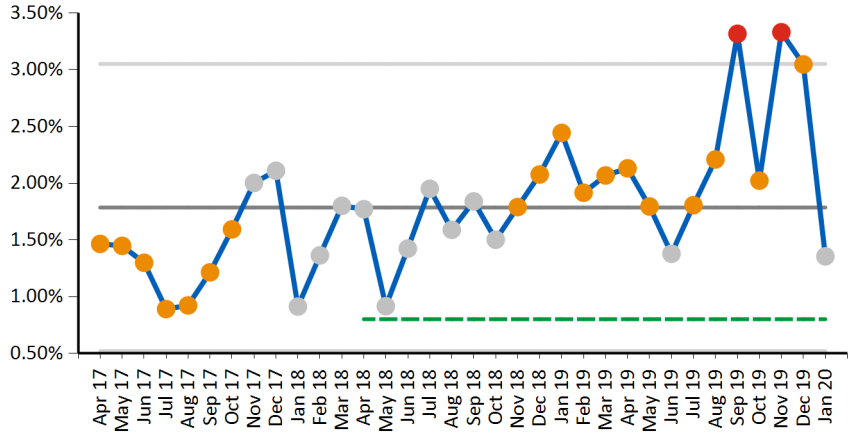
59 - Re-admission within 30 days of discharge (1 mth in arrears)



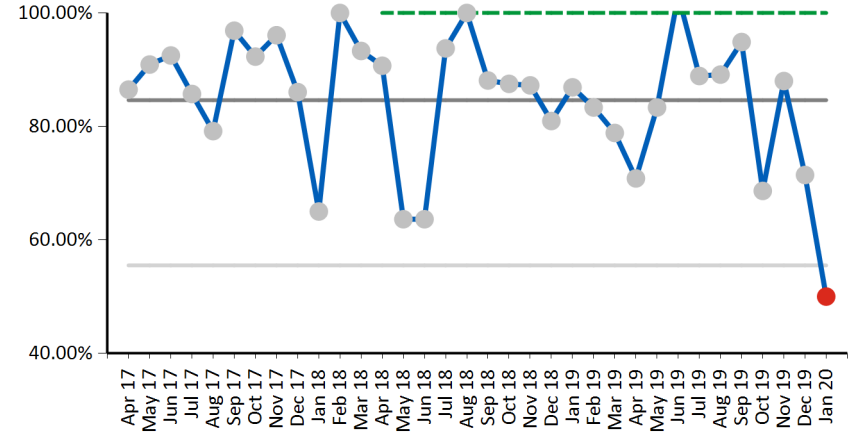
60 - Daycase Rates



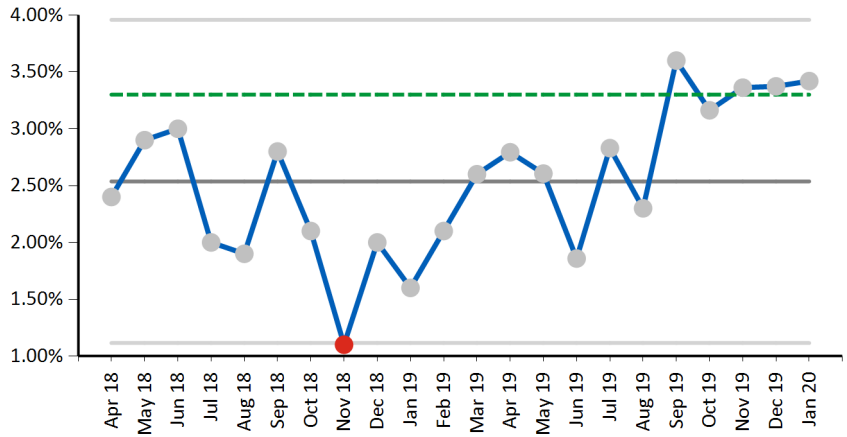
61 - Operations cancelled on the day for non-clinical reasons



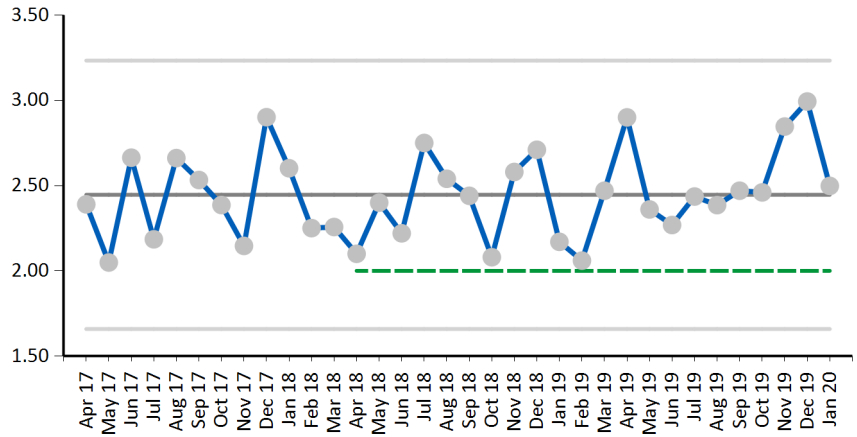
62 - Cancelled operations re-booked within 28 days



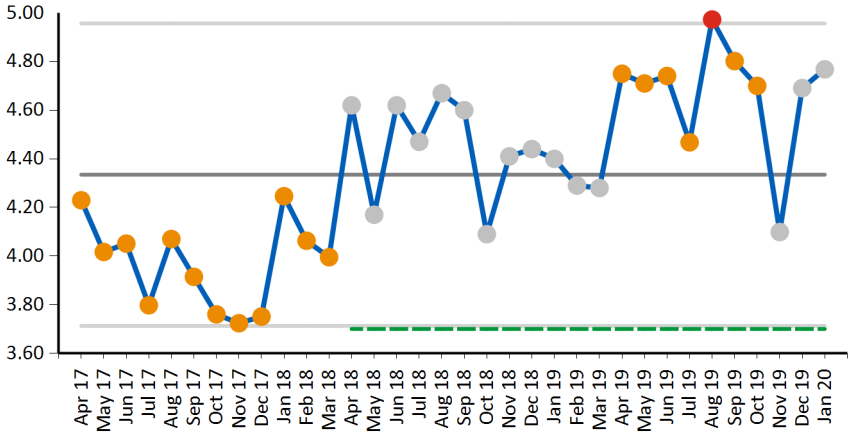
318 - Delayed Transfers Of Care (Trust Total)



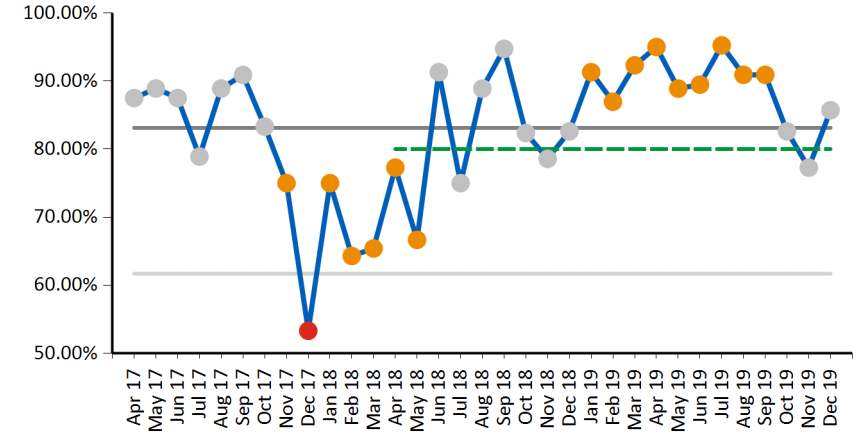
65 - Elective Length of Stay (Discharges in month)



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)



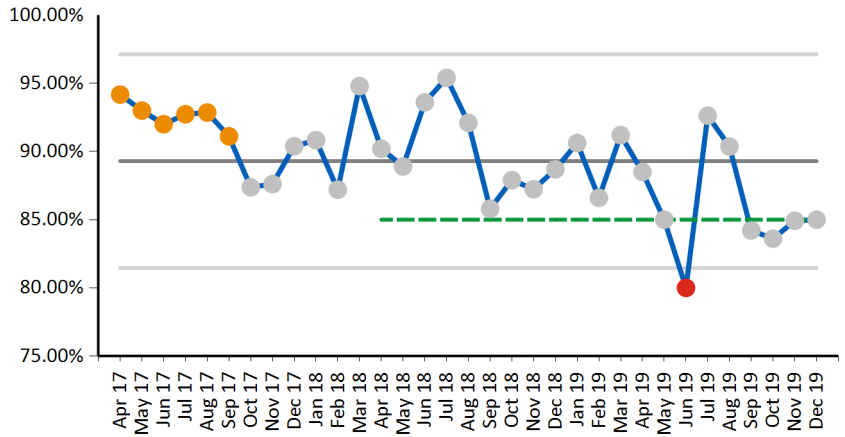
Cancer

62 day standard
The Trust has passed December, but this is not enough for the quarter which under achieved by 0.6%. The pressure remains for quarter 4, but we expect to achieve for the quarter.

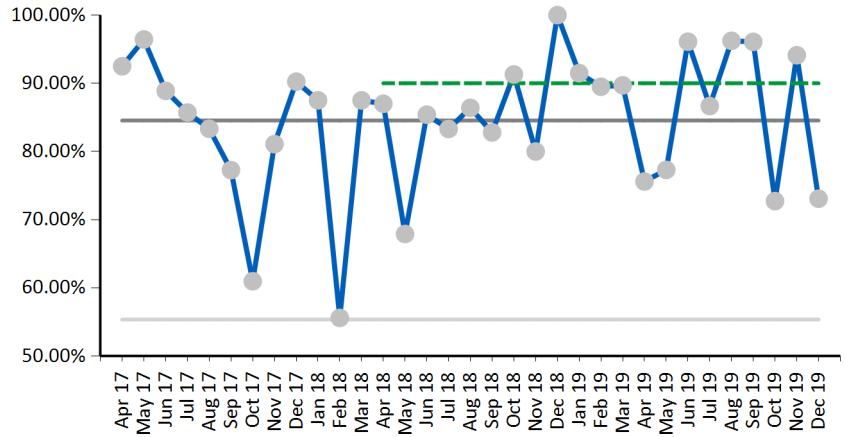
2 week Breast symptomatic
The Trust set a recovery trajectory for March against the standard, it is expected the recovery plan will be achieved.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	85.0%	Dec-19		>= 85%	84.9%	Nov-19	>= 85%	86.1%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	73.1%	Dec-19		>= 90%	94.1%	Nov-19	>= 90%	85.3%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.0%	Dec-19		>= 96%	100.0%	Nov-19	>= 96%	98.5%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Dec-19		>= 94%	100.0%	Nov-19	>= 94%	99.3%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Dec-19		>= 98%	100.0%	Nov-19	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	97.8%	Dec-19		>= 93%	92.7%	Nov-19	>= 93%	96.6%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	20.6%	Dec-19		>= 93%	23.6%	Nov-19	>= 93%	28.5%	

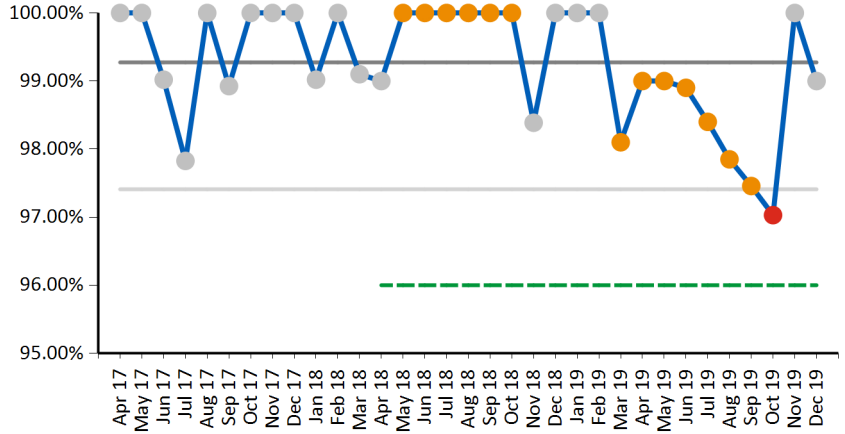
46 - 62 day standard % (1 mth in arrears)



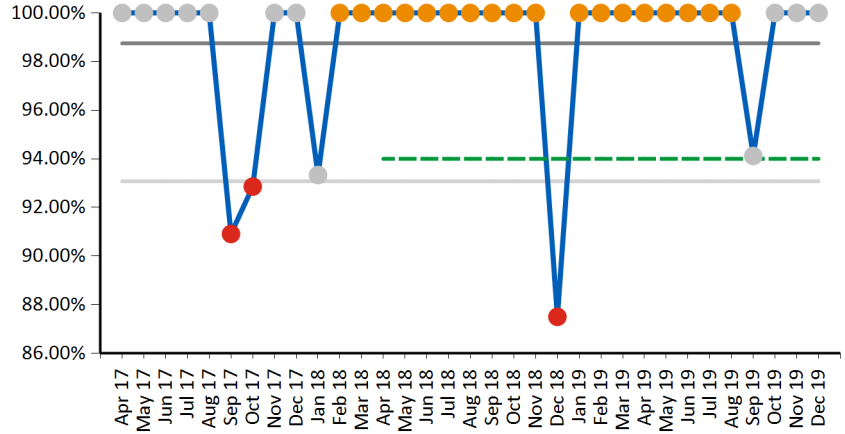
47 - 62 day screening % (1 mth in arrears)



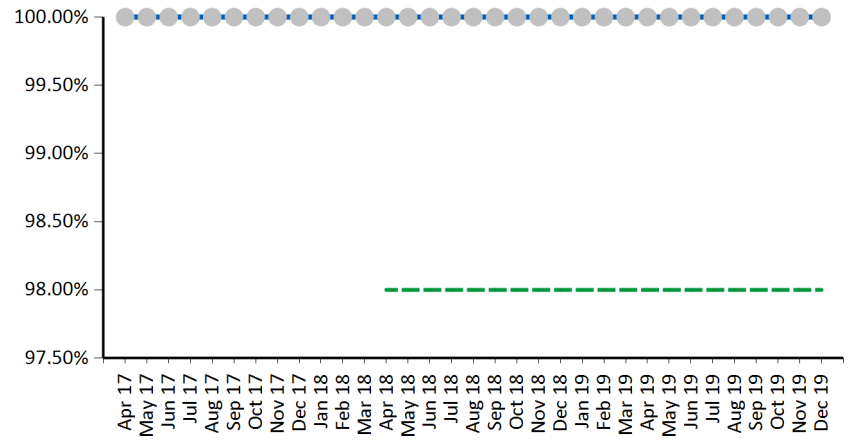
48 - 31 days to first treatment % (1 mth in arrears)



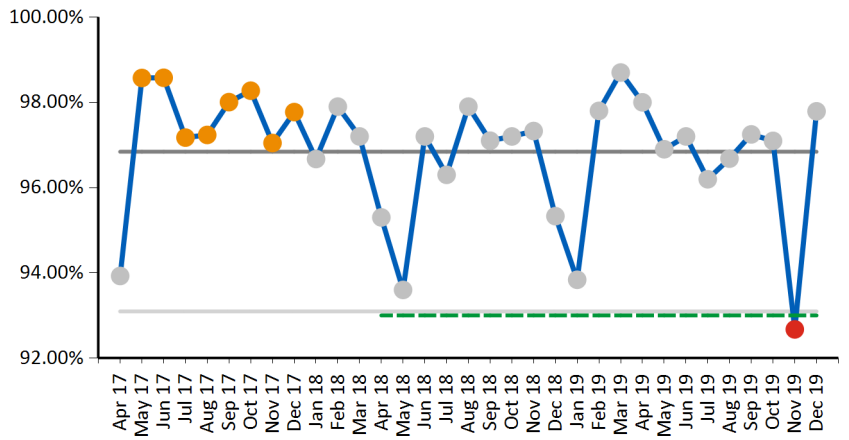
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



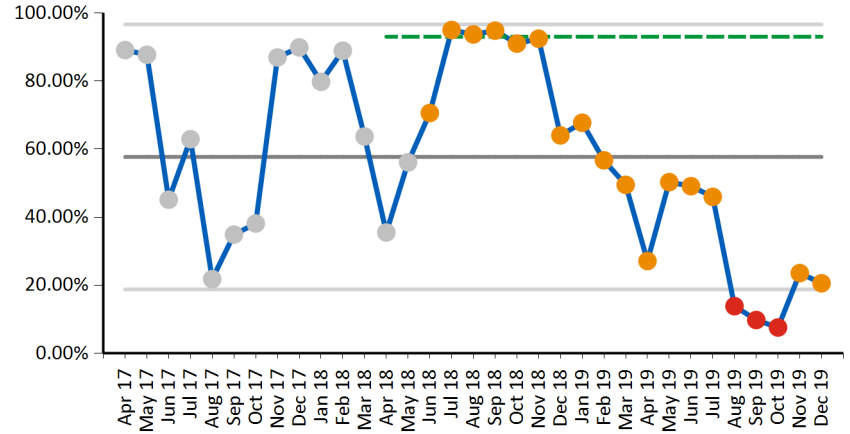
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



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



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



Community

DToC
Current performance for Delayed Transfers of Care remain just above the target. Within January a system escalation process was implemented which includes thresholds for triggering a formal escalation meeting with system partners. This process continues to be refined and examples of good practise have been reviewed from other systems in GM. The top 3 reasons for being delayed in January were 1. Awaiting completion of assessments; this is usually MDT assessments required for a safe discharge but taking place after medical optimisation and ongoing past the agreed discharge date 2. Awaiting further non-acute NHS care; this is usually intermediate care and is congruent with problems with flow into and out of Bolton Intermediate care in January 3. Awaiting care package in own home; this could be Reablement packages or permanent packages, the majority of delays experienced in January have been Reablement delays. All 3 top delay themes have got associated improvement work underway.

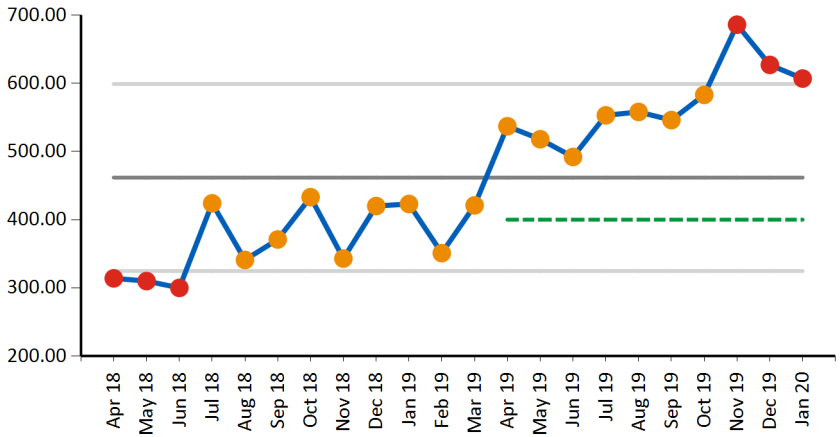
Total Deflections from Urgent Care
The total number of people deflected from urgent care by our Home First Team and Admission Avoidance Team remains consistently above the target and has now been above the stretch target of 600 for 3 months.

Total Length of Stay in Intermediate Tier
The length of stay in intermediate tier remains under the target of 6 weeks but has seen variability around the mean over the last 6 months. There is considerable variability within the bed based part of the pathway with some people staying significantly longer than the target 28 days; work is underway to reduce long stays in this part of the tier.

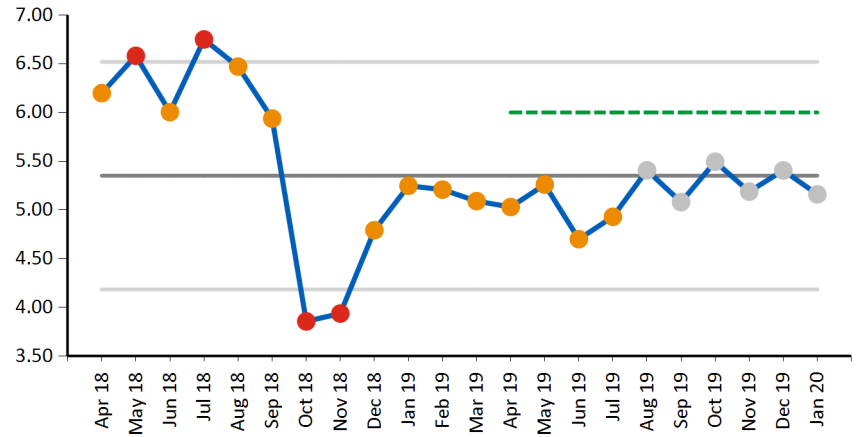
Medically Optimised
Both the numbers of people in hospital who are medically optimised and the number of days occupied by people once medically optimised remain above the target and show high degrees of variability. Work to reduce towards the target is closely aligned to improvement priorities associated with DToC.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	607	Jan-20		>= 400	627	Dec-19	>= 4,000	5,707	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.16	Jan-20		<= 6.00	5.41	Dec-19	<= 6.00	5.16	
230 - Medically Optimised Numbers	<= 50	71	Jan-20		<= 50	85	Dec-19	<= 500	777	
231 - Medically Optimised Days	<= 209	481	Jan-20		<= 209	491	Dec-19	<= 2,090	5,598	

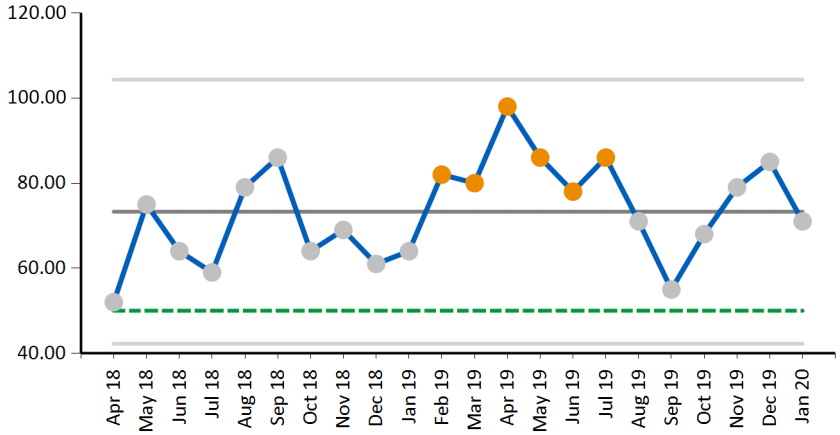
334 - Total Deflections from ED



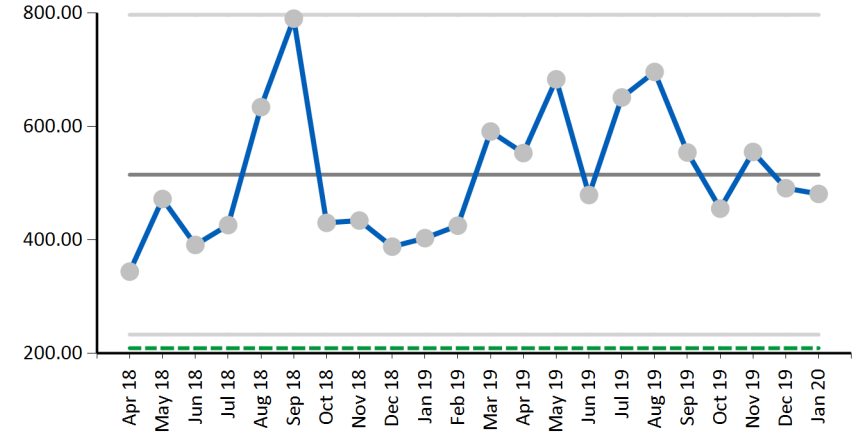
335 - Total Intermediate Tier LOS (weeks)



230 - Medically Optimised Numbers



231 - Medically Optimised Days



Workforce

Sickness, Vacancy and Turnover

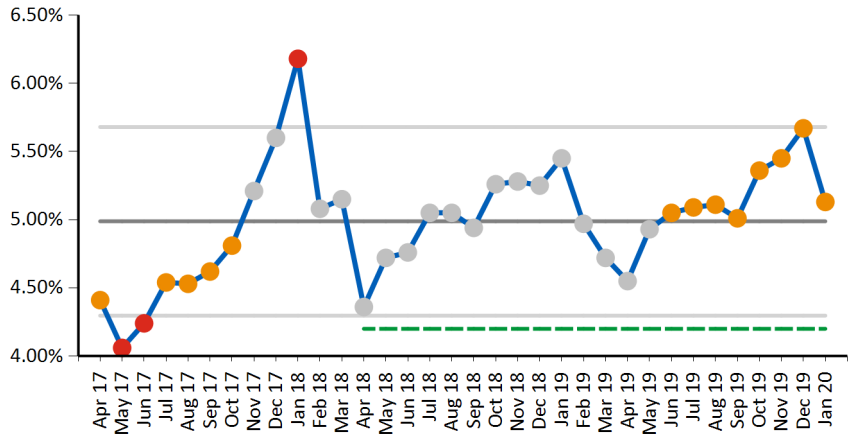
Sickness, turnover, vacancy rate and investigations
Sickness absence rates have decreased since last month (5.13%), and lower than the same time last year (5.45%). Whilst sickness absence rates remain high the local benchmarking undertaken shows an improving position (5.08-6.49%). The Workforce Assurance Committee (WAC) noted that the Staff HWB strategy action plan has been refreshed and a range of actions continue to be taken. WAC was also briefed as to the proposed changes to the absence policy (including potentially introducing incentives), improved Mental health support offering, Menopause Friendly organisation and the introduction of the Shiny Mind App (Wellbeing App accessible to all staff). The organisation continues to work with colleagues within the locality on the findings previously discussed between higher sickness absence rates and Bolton population demographics.

Performance on the recruitment & retention metrics remains strong (albeit slight increase in turnover rate). Via the Workforce Dashboard the Workforce Assurance Committee are sighted on the areas within the organisation that remain 'hard to fill', along with the clear set of actions that are in place. Strong partnership working between the Divisional & Workforce Teams is evident which is supporting this positive position.

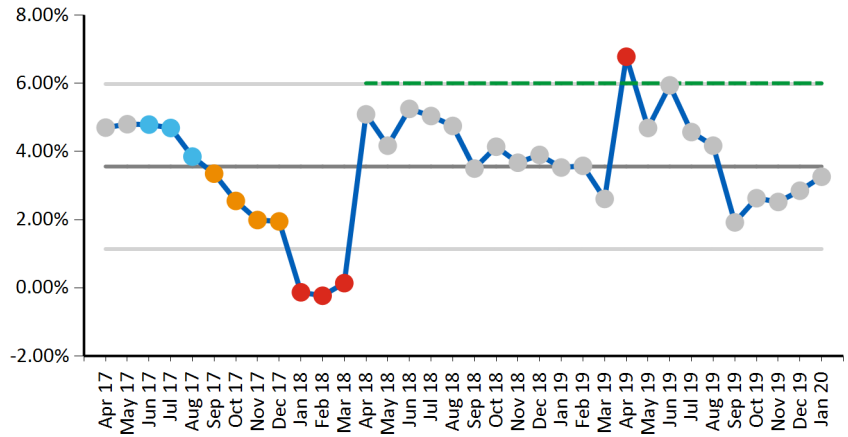
As noted in the previous Board Dashboard colleagues will see that the Dashboard includes the number of investigations over 8 weeks. A KPI will be set in Quarter 2, 2020-2021 to allow time to bed in and review.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.13%	Jan-20		<= 4.20%	5.67%	Dec-19	<= 4.20%	5.14%	
120 - Vacancy level - Trust	<= 6%	3.26%	Jan-20		<= 6%	2.85%	Dec-19	<= 6%	3.93%	
121 - Turnover	<= 9.90%	10.02%	Jan-20		<= 9.90%	9.86%	Dec-19	<= 9.90%	9.90%	
366 - Ongoing formal investigation cases over 8 weeks		7	Jan-20			5	Dec-19		38	

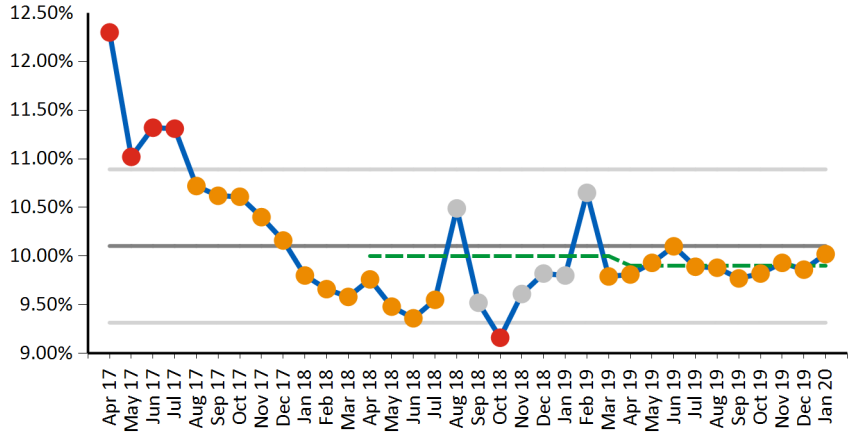
117 - Sickness absence level - Trust



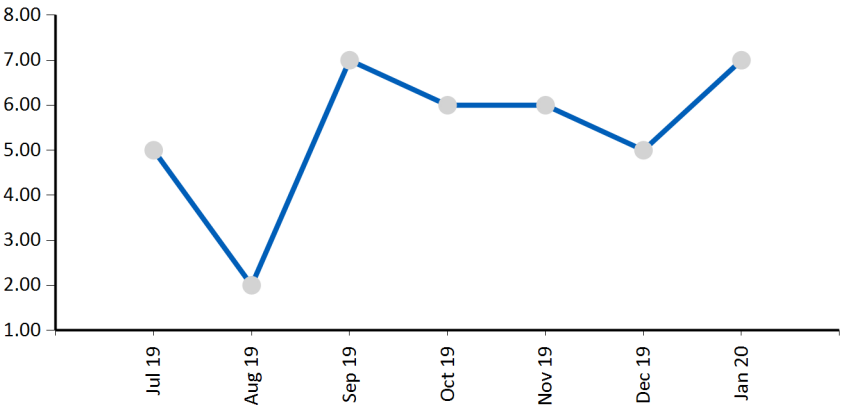
120 - Vacancy level - Trust



121 - Turnover



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



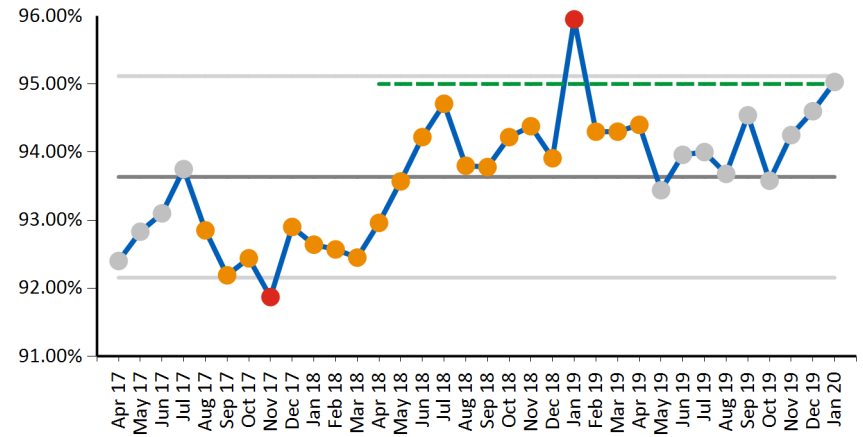
Organisational Development

The OD indicators remain strong, with Mandatory Training, Statutory Training and Appraisal all above target.

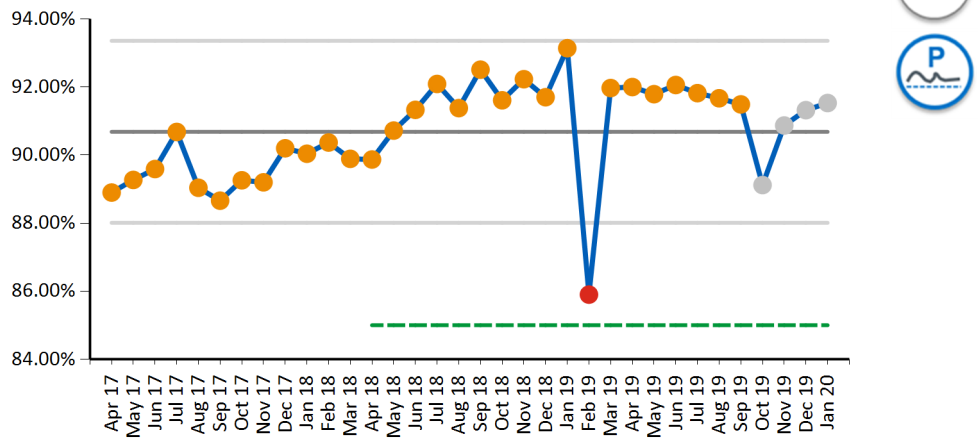
NHS Staff Survey – The NHS Staff Survey was published on 18th February. At a very high level Bolton has maintained our overall staff engagement score of 7.30. Given that we are already one of the highest performing Trusts in this area then it is positive that we have maintained the same staff engagement level as last year. Whilst we are of course looking to further improve our staff engagement position, colleagues will recall that in the period when the Staff Survey was open (October-December) there were a number of local matters being managed. Whilst there remain many positives there are clearly areas for focus moving forward. These will be considered in full at the Staff Engagement Steering Group and Workforce Assurance Committee. A full paper will of course be coming to the Trust Board in March.

	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%	Jan-20		>= 95%	94.6%	Dec-19	>= 95%	94.1%	
38 - Staff completing Mandatory Training	>= 85%	91.5%	Jan-20		>= 85%	91.3%	Dec-19	>= 85%	91.4%	
39 - Staff completing Safeguarding Training	>= 95%	96.17%	Jan-20		>= 95%	95.44%	Dec-19	>= 95%	95.71%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	87.4%	Jan-20		>= 85%	84.8%	Dec-19	>= 85%	84.6%	
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%		

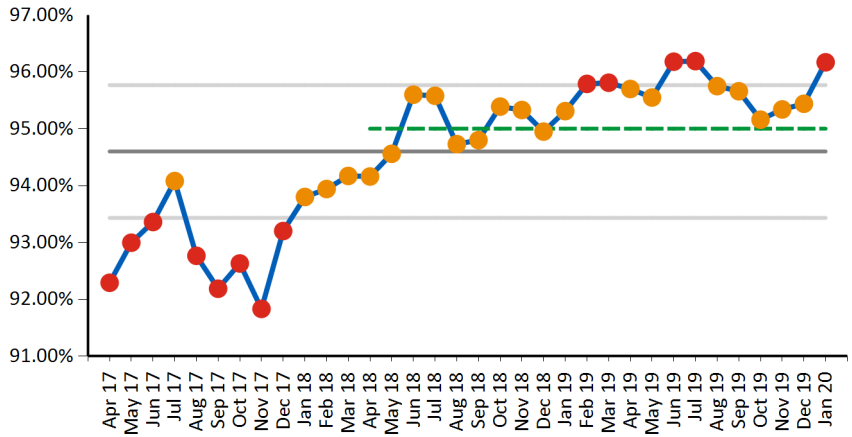
37 - Staff completing Statutory Training



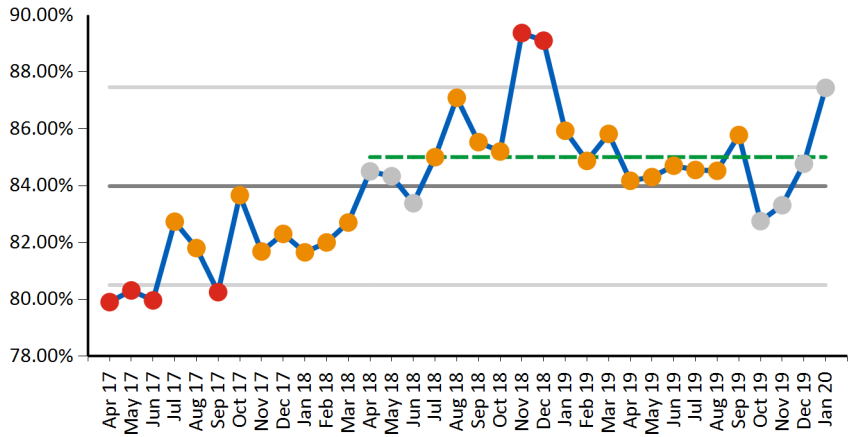
38 - Staff completing Mandatory Training



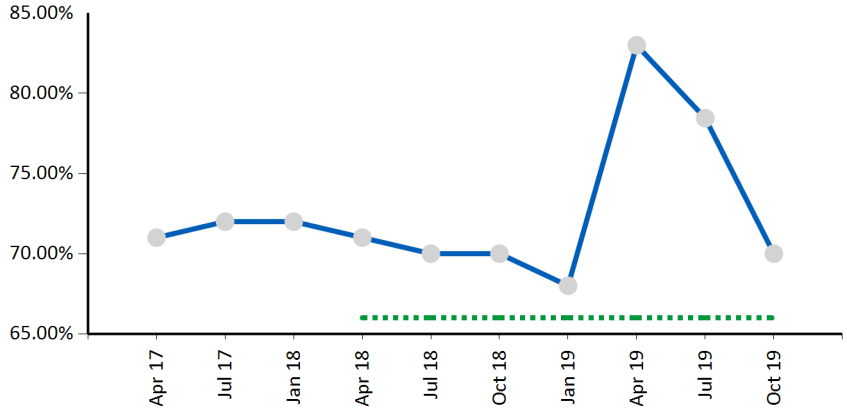
39 - Staff completing Safeguarding Training



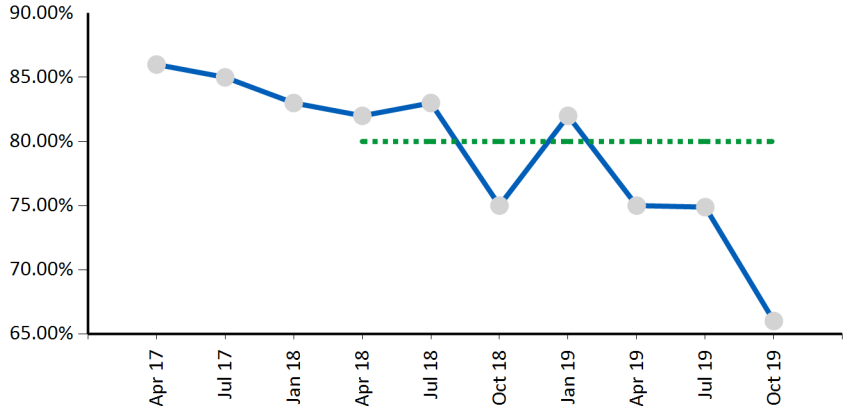
101 - Increased numbers of staff undertaking an appraisal



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

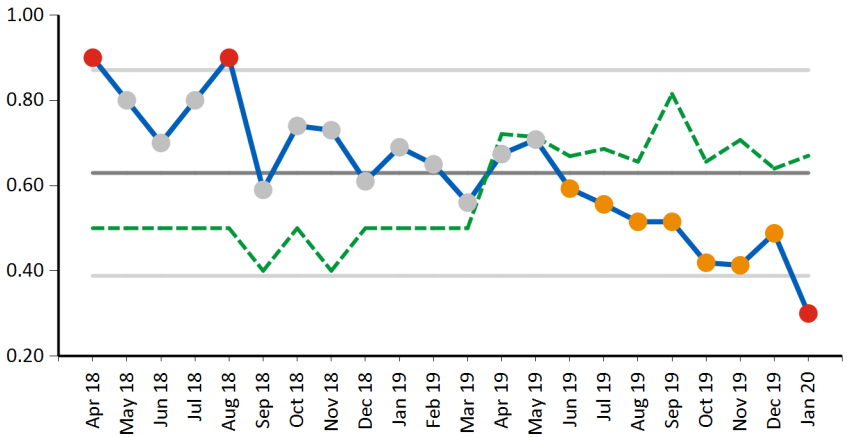


Agency

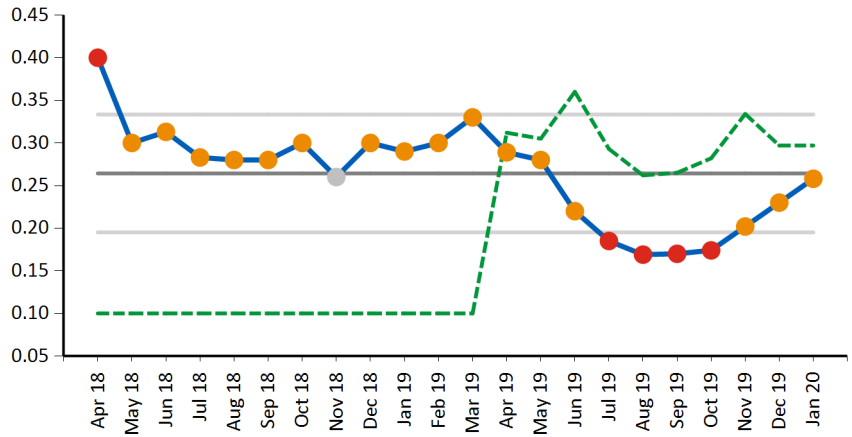
Agency
Colleagues will note the in-month Agency spend remains below the Trust's forecast and the NHSI forecast. As would be expected the two areas of greatest spend being Nursing and Medical. As would be anticipated there has been slight increases in these areas due to Winter pressures. The Trust continues to benchmark very favourable on Agency spend when compared to peer organisations for % Agency spend versus overall pay, that said the Workforce Assurance Committee remains sighted on the multiple actions that are being taken to drive down agency spend to the lowest possible level.

	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)	<= 0.67	0.30	Jan-20		<= 0.64	0.49	Dec-19	<= 6.93	5.18	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.30	0.26	Jan-20		<= 0.30	0.23	Dec-19	<= 3.01	2.18	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.30	0.23	Jan-20		<= 0.30	0.21	Dec-19	<= 3.17	2.42	

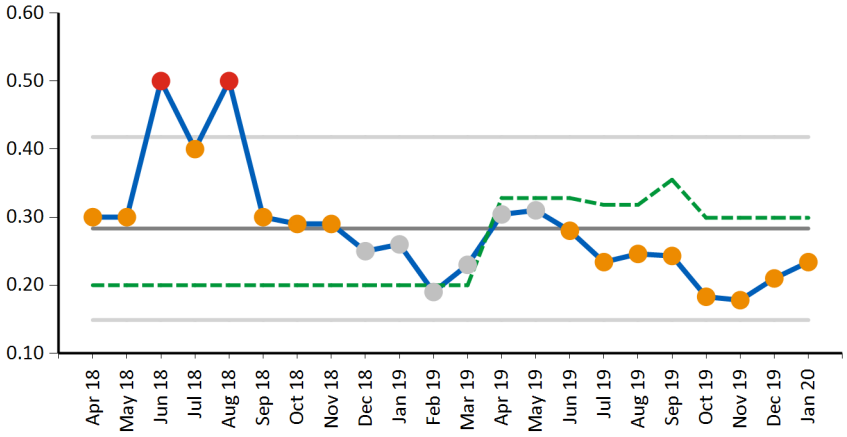
198 - Trust Annual ceiling for agency spend (£m)



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



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



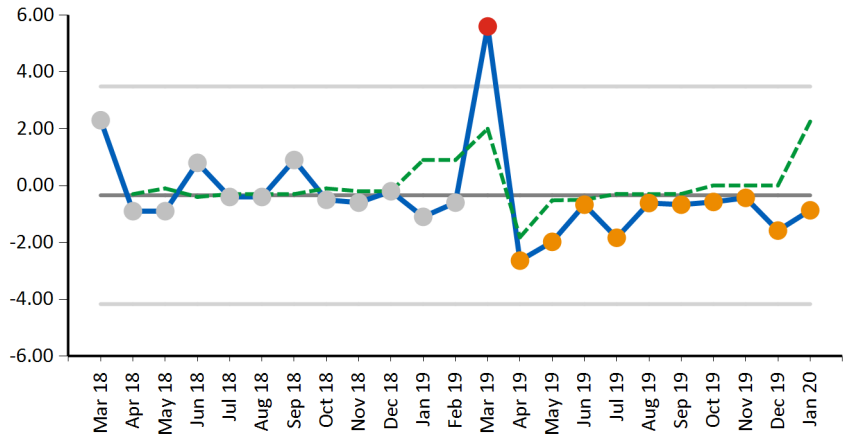
Finance

Finance

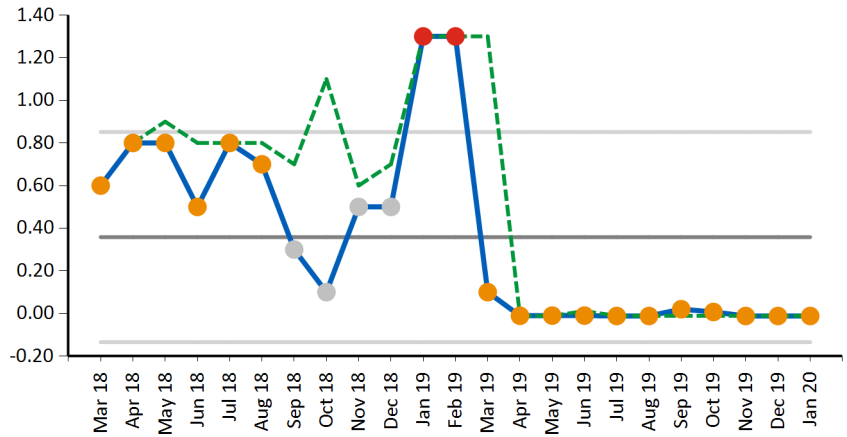
• Year to date deficit at the end of month 10 of £11.9m before receipt of PSF – £10.4m worse than plan.
• Year to date deficit of £6.3m after taking account of PSF income of £5.6m - £9.8m worse than the year to date plan.
• In month the there was a deficit of £0.1m, an improvement of £0.9m on last month.
• ICIP delivered year to date is £7.0m, which is off track by £3.9m.
• PSF of £5.6m has been earned year to date compared to a plan of £5.1m. The £0.5m over performance relates to an additional allocation relating to 2018/19.
• Probable forecast out-turn (excluding PSF/MRET) is £13.4m, an improvement of £0.1m from last month's forecast position. Mitigations are being identified to ensure this is brought back in line with the mid case forecast deficit of £13.1m submitted to NHSI.
• Capital expenditure year to date is £8.0m, which is £0.7m under plan mainly due to phasing.
• Cash balance is £14.5m, which is £0.1m above plan.
• Trust overall risk rating for use of Resources was a 3 in January compared to a plan of 2.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 2.3	-0.9	Jan-20		>= 0.0	-1.6	Dec-19	>= -1.5	-11.9	
221 - Provider Sustainability Fund (£ millions)	>= -0.01	-0.01	Jan-20		>= -0.01	-0.01	Dec-19	>= -0.09	-0.06	
222 - Capital (£ millions)	>= 1.0	0.4	Jan-20		>= 1.0	0.9	Dec-19	>= 9.1	8.0	
223 - Cash (£ millions)	>= 14.4	14.5	Jan-20		>= 13.2	16.3	Dec-19	>= 14.4	14.5	
224 - Use of Resources	<= 2	3	Jan-20		<= 2	3	Dec-19	<= 2	3	

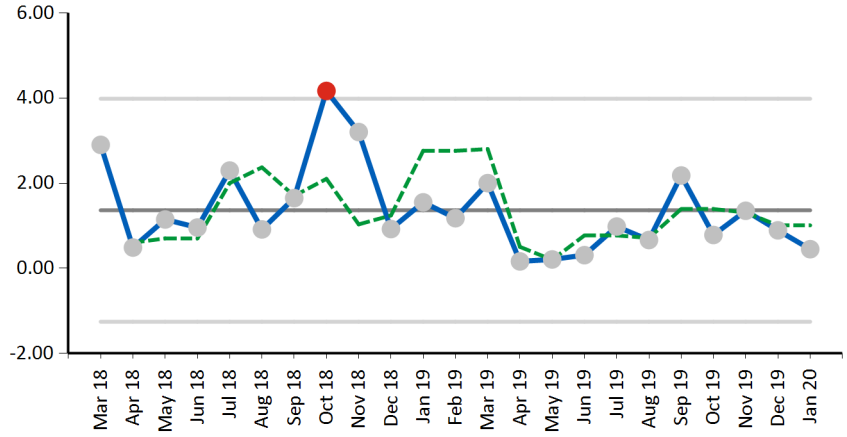
220 - Control Total (£ millions)



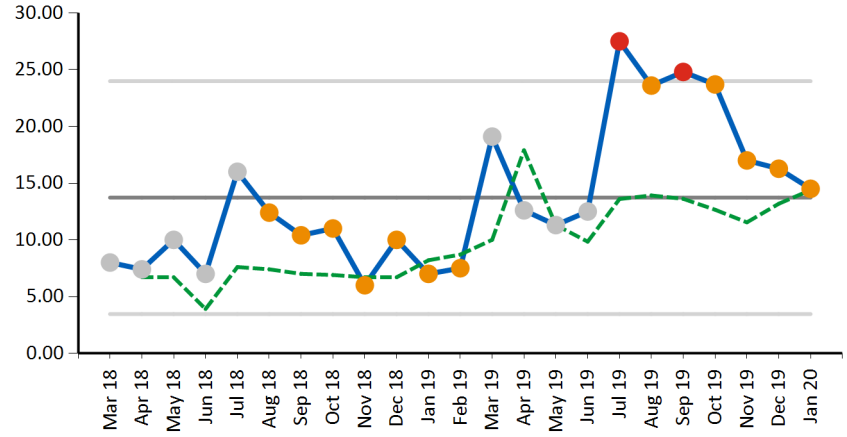
221 - Provider Sustainability Fund (£ millions)



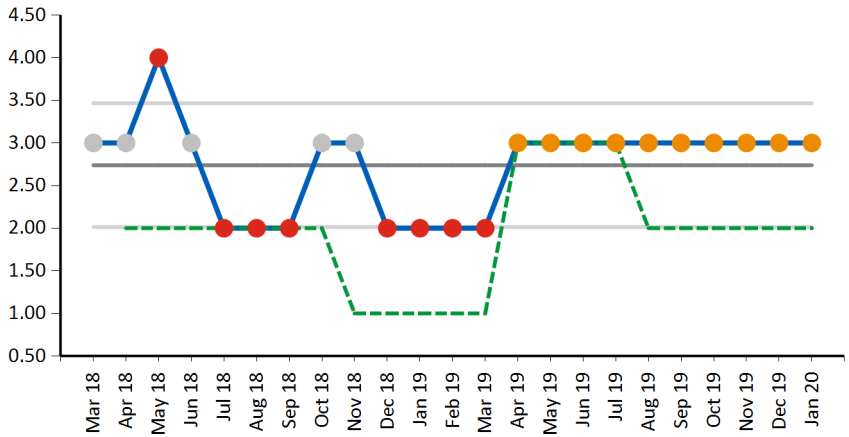
222 - Capital (£ millions)



223 - Cash (£ millions)



224 - Use of Resources



Board Assurance Heat Map - Hospital

	INDICATOR	Target	ICS				Acute Division																	Elective Division												Families Division										
			Darley Court	A4	AED-Adults	AED-Paeds	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)	UU (daycare)	H2 (daycare)	E5 (Paed HDU and Obs)	F5	M1 and M1A	EPU (M6)	M2	CDS	M3 (Birth Suite)	Ingleside	M4/M5	NICU	Total
Beds	Total Beds		30	22	0	0	23	26	21	6	25	26	26	27	10	14	26	22	27	27	12	24	9	10	8	25	25	25	24	24	24	16	25	4	11	38	7	17	6	26	15	5	4	44	38	824
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R = <80%	100.0%	100.0%	90.0%	80.0%			100.0%		100.0%			100.0%	90.0%	100.0%	75.0%	90.0%	90.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	95.0%	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	90.0%	90.0%	100.0%	75.0%	100.0%		100.0%	100.0%	95.2%
	IPC Rapid Improvement Tool %	<80%=R, >80% <94.9%=A,>95%=G	87.0%	100.0%	77.0%	70.0%	92.0%	71.0%	79.0%		86.0%	100.0%	83.0%	79.0%	96.0%	96.0%	71.0%	78.0%	100.0%	88.0%	96.0%	88.0%	91.0%	100.0%	100.0%	91.0%	88.0%	92.0%	96.0%	96.0%	75.0%	91.0%	100.0%	78.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		91.0%	100.0%	91.4%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%	100.0%			100%	100%	84%		100%		100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	99.5%
	C - Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	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	2
	MSSA BSIs	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	1	1
	E.Coli BSIs	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
	MRSA acquisitions	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
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	91.4%	100.0%			90.0%	100.0%	100.0%		100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	92.6%	96.3%		87.0%		90.0%	100.0%	95.7%	95.7%	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%	97.6%
	All Inpatient Falls (Safeguard)	0	7	8	2	0	8	7	12	0	5	6	12	3	2	4	2	4	4	2	0	5	0	0	0	2	3	6	1	0	3	4	0	0	0	1	0	0	0	0	0	0	0	1	0	114
	Harms related to falls (moderate and above)	1.6	1	0	1	0	0	1	0	0	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	9
	VTE Assessment Compliance	95%		50.0%			25.0%	25.0%		66.7%	100.0%	75.0%	96.6%	57.1%	96.3%	99.3%	98.7%	97.7%	100.0%	90.0%		66.7%	99.5%	93.8%	100.0%	95.5%	100.0%	99.3%	84.8%	87.4%	98.4%	93.1%	98.1%	63.3%	97.9%	0.0%		92.6%	98.9%	99.6%	98.1%	80.0%	77.5%	100.0%		96.7%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
	Monthly New pressure Ulcers (Grade 3)	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	Monthly New pressure Ulcers (Grade 4)	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	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	95.8%	85.1%	91.2%	94.9%	78.6%	67.0%	79.6%		79.3%	57.8%	90.9%	86.8%	99.0%	71.9%	89.9%	94.9%	70.9%	73.6%		91.1%	100.0%	100.0%	99.4%	83.8%	88.5%	95.8%	89.4%	87.1%	90.0%	97.6%	100.0%	100.0%	90.4%	98.0%	98.0%	96.1%		99.4%	98.7%	99.5%	96.8%	93.4%	95.0%		
	BoSCA Overall Score %	w=<55%,B>55%<74.9%,S=>75%<89.9%,G>90%	92.3%	84.2%	75.3%	75.3%	59.5%	58.3%	81.4%		82.1%	80.1%	82.3%	75.8%	84.3%	91.3%	75.1%	83.2%	92.9%	90.2%		85.7%	86.3%	90.7%	93.9%	72.4%	81.7%	90.8%	81.6%	90.4%	90.9%	85.3%		88.2%		90.1%	90.1%	75.5%		91.9%	90.3%	90.4%		71.4%	90.3%	85.1%
	BoSCA Rating	white, bronze, silver, gold, platinum	platinum	silver	silver	silver	bronze	bronze	silver		silver	silver	silver	silver	silver	gold	silver	silver	platinum	gold		silver	silver	platinum	platinum	bronze	silver	platinum	silver	platinum	gold	silver		silver		platinum	platinum	silver		platinum	gold	gold		bronze	gold	Silver
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	78.8%	17.7%	32.7%	32.1%	14.4%	82.6%	0.0%	50.7%	30.8%	39.0%	66.7%	51.1%	26.4%	25.8%	37.0%	26.0%	50.0%		26.7%	28.8%	70.0%	100.0%	44.5%	28.6%	32.1%	43.4%	34.6%	42.9%	27.6%	31.1%	35.0%	30.3%	45.2%	0.0%	17.9%	100.0%	25.2%	20.1%	22.8%		35.4%	78.9%	30.1%
	Friends and Family Recommended Rate	**97%**	90.5%	90.2%	88.3%	95.6%	100.0%	95.7%	100.0%	N/A	97.1%	100.0%	96.7%	88.5%	95.8%	96.6%	85.3%	86.5%	100.0%	94.7%		100.0%	93.9%	100.0%	100.0%	91.8%	96.9%	98.5%	100.0%	96.3%	100.0%	87.5%	92.7%	100.0%	91.8%	100.0%	N/A	100.0%	100.0%	99.4%	90.0%	100.0%		90.7%	100.0%	95.8%
	Number of complaints received	**0**	0	0	3	1	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0	3	0	13
Governance	SIs in Month	**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	1	0	0	0	0	0	0	0	0	0	3	0	0	0	0	5
	Incidents over 20 days, not yet signed off (excl. incidents reported externally by the Trust)	**0**	3	0	156	2	11	19	1	9	10	10	8	10	0	0	7	3	3	1	2	1	11	0	0	4	1	1	1	1	3	2	0	0	0	4	2	46	27	1	22	16	31	38	1	468
	Harms related to Incidents (Moderate and above)	**0**	1	0	2	0	0	1	0	0	3	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1	0	1	13
Staff Development	Appraisals	85%	96.6%	97.3%	87.0%		96.8%		93.5%		93.9%	97.6%	92.1%	64.9%	91.7%	85.0%	97.6%	76.3%	100.0%	80.6%	100.0%	83.8%	91.6%	81.4%	95.2%	74.3%	66.7%	55.3%	60.0%	93.3%	90.9%	77.8%	82.4%	100.0%	70.6%	85.9%		92.3%	90.0%						93.3%	87.4%
	Statutory Training	95%	98.86%	95.08%	95.87%		91.12%		92.47%		92.07%	96.04%	94.79%	95.37%	98.15%	94.17%	88.67%	95.33%	89.92%	89.62%	98.21%	90.08%	91.56%	95.10%	98.85%	95.83%	90.87%	95.07%	84.55%	90.06%	96.52%	97.58%	94.19%	100.00%	92.31%	96.6%		94.67%	92.1%						97.56%	95.0%
	Mandatory Training	85%	99.0%	85.4%	86.39%		81.2%		82.2%		88.1%	92.4%	85.1%	85.2%	79.8%	89.5%	77.1%	91.0%	86.9%	81.3%	97.0%	77.7%	89.9%	85.3%	88.5%	87.8%	83.9%	87.0%	82.0%	81.7%	92.8%	90.1%	83.9%	100.0%	84.6%	93.4%		79.4%	77.9%						95.3%	91.5%
Staffing & Workforce	% Qualified Staff (Day)			100.2%			91.1%		84.9%		85.7%	68.3%	88.5%	90.3%	101.2%				93.3%	97.6%		90.9%		86.0%	90.5%	90.4%	95.0%		96.4%	83.1%	80.5%	88.8%				68.3%		90.1%		91.9%	82.2%	69.6%		67.6%	99.8%	85.9%
	% Qualified Staff (Night)			100.3%			99.3%		100.0%		98.7%	97.9%	94.8%	98.6%	100.0%				98.5%	100.0%		99.9%		92.8%	87.2%	98.9%	99.3%		135.1%	99.1%	99.5%	100.6%				78.7%		99.3%		93.6%	78.5%	48.1%		64.9%	98.2%	90.1%
	% un-Qualified Staff (Day)			108.2%			86.6%		93.4%		84.5%	102.8%	84.7%	74.4%	104.4%				81.1%	103.4%		98.0%			166.8%	83.7%	92.0%		105.8%	95.3%	112.2%	117.6%				126.1%		105.6%		87.8%	85.2%	95.0%		84.8%		93.6%
	% un-Qualified Staff (Night)			112.8%			107.5%		108.1%		99.6%	107.7%	88.3%	79.9%	106.7%				79.8%	113.9%		99.6%				83.9%	93.9%		130.4%	82.7%	100.4%	116.8%				0.5%		103.2%		96.6%	87.5%	90.5%		104.7%		95.8%
	Budgeted Nurse: Bed Ratio (WTE)		2.44	1.97	-3.68	1.32	3.91	-6.00	1.23	-1.00	2.58	0.66	5.51	-0.95	1.34	-1.59	-2.67	1.52	-2.04	3.77	0.00	2.00	10.01	-1.20	-0.50	2.34	-2.15	-4.65	-5.87	4.90	-1.08	0.30	-1.51	0.76	-2.25	-0.38	0.63	2.66	-4.56	0.44	0.44	0.44	0.44	0.44	6.80	16.75
	Current Budgeted WTE (From Ledger)		43.18	32.83	73.28	73.28	38.03	0.00	43.34	0.00	33.71	41.23	42.69	40.69	26.93	19.97	50.82	40.30	40.01	39.97	0.00	36.15	60.39	38.58	55.02	35.52	30.21	37.79	30.21	44.49	44.49	18.07	29.25	15.88	50.91	33.83	33.83	25.72	44.55	44.55	44.55	44.55	44.55	44.55	105.69	1673.55
	Actual WTE In-Post (From Ledger)		40.74	30.86	71.96	71.96	33.48	0.00	39.11	0.00	31.13	38.96	37.18	39.64	23.59	21.56	46.88	36.86	37.05	36.20	0.00	34.15	50.38	39.78	53.92	33.18	32.36	39.44	33.16	39.59	43.57	15.85	29.76	15.12	51.16	33.20	33.20	23.06	44.11	44.11	44.11	44.11	44.11	44.11	98.89	1601.58
	Actual Worked (From Ledger)		45.63	35.58	75.56	75.56	39.83	0.00	46.84	0.00	35.37	41.44	42.24	44.39	22.26	20.30	51.41	41.40	42.17	43.50	0.00	37.33	51.43	37.26	53.87	32.22	35.79	41.00	40.33	44.27	47.87	20.96	30.86	15.55	49.37	32.72	32.72	25.36	43.15	43.15	43.15	43.15	43.15	43.15	94.43	1685.71
	Sickness (%) (January)	R = >4.75. A = 4.2 - 4.75. G = <4.2	6.78%	1.27%	4.63%		9.37%		6.90%		6.36%	6.18%	5.91%	7.33%	6.71%	4.28%	10.51%	4.84%	9.35%	9.11%	0.00%	11.05%	10.52%	0.98%	2.19%	3.34%	11.98%	5.39%	19.76%	7.65%	10.89%	6.82%	6.85%	11.40%	9.25%	6.61%		0.86%	5.34%						6.74%	5.13%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		2.44	1.97	-3.68	1.32	3.91	-6.00	1.23	-1.00	2.58	0.66	5.51	-0.95	1.34	-1.59	-2.67	1.52	-2.04	3.77	0.00	2.00	10.01	-1.20	-0.50	2.34	-2.15	-4.65	-5.87	4.90	-1.08	0.30	-1.51	0.76	-2.25	-0.38	0.63	2.66	-4.56	0.44	0.44	0.44	0.44	0.44	6.80	18.41
	Pending Appointment				5		1	6	3	1		1.61		2	2		6.61	1.92	5						1.6			3	2.92		2	1.92	1		2	1			5							53.56
	Substantive Staff Turnover Headcount (rolling average 12 months)	10%	11.7%	13.0%	3.9%		15.8%		21.8%		19.7%	11.2%	19.5%	12.5%	3.3%	0.0%	15.5%	13.2%	16.9%	14.0%	0.0%	2.5%	6.7%	2.1%	9.0%	8.6%	15.6%	4.8%	5.9%	13.5%	6.4%	0.0%	5.3%	5.9%	7.1%	12.6%		17.2%	8.8%						10.0%	

Board Assurance Heat Map - District Nursing Domiciliary

	INDICATORS	Avondale and Chorley old Road	Breightmet & Little Lever	Crompton merged 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	Total
Harm Free Care	Total Monthly New pressure Ulcers (Grade 2)(Lapse in Care + No Lapse in Care)	3	0	0	2	1	0	0	0	1	1			8
	Total Monthly New pressure Ulcers (Grade 3)(Lapse in Care + No Lapse in Care)	0	0	1	1	0	0	0	1	1	0			4
	Total Monthly New pressure Ulcers (Grade 4)(Lapse in Care + No Lapse in Care)	0	0	0	0	0	0	0	0	2	0			2
	Total Monthly New Pressure Ulcers - due to lapses in care	2	0	0	0	0	0	0	0	0	1			3
Audit	Monthly KPI Audit % (Revised Buddy Assessed Audit)	93.3%	97.2%	91.5%	96.4%	90.5%	91.8%	NA	98.7%	99.2%	94.6%	94.8%		
	BoSCA Overall Score %	92.4%	94.9%	91.1%	87.1%	96.0%	91.4%	NA	94.7%	91.7%	93.4%	96.9%		
	BoSCA Rating	platinum	platinum	gold	silver	platinum	platinum		gold	platinum	gold	gold		
Patient Experience	Friends and Family Response Rate %	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		60.00%	
	Friends and Family Recommended Rate %	97.80%	97.80%	97.80%	97.80%	97.80%	97.80%	97.80%	97.80%	97.80%	97.80%		100.00%	
	Number of Complaints received	0	0	0	0	0	0	0	0	1	0	0	0	1
Staffing and Workforce	Current Budgeted WTE	11.64	13.72	24.11	18.24	7.11	13.15	NA	17.13	9.13	11.09	19.84	25.39	170.55
	Actual WTE In-Post	11.04	15.00	14.90	15.40	10.44	11.70	NA	12.00	10.01	9.80	16.80	23.13	150.23
	Actual WTE Worked	11.04	15.05	14.99	13.56	11.32	12.51	NA	12.81	10.92	10.50	17.09	23.78	153.57
	Pending Appointment	0.8		0.8	3.6			0.5	0.5		1.8		0.8	8.80
	Current Budgeted Vacancies (WTE)	1.00		1.80	2.00	1.00	2.90	1.00	1.00	1.80	2.00	4.47	1.8	20.77
Staff Development	Sickness (%) (December)	0.00%	0.51%	0.27%	9.92%	19.58%	0.55%	1.01%		9.76%	3.75%	5.45%	10.79%	3.57%
	Substantive Staff Turnover Headcount	6.67%	0.00%	17.14%	43.75%	0.00%	13.33%	11.76%		20.00%	21.43%	13.11%	9.68%	16.95%
	12 month Appraisal	93.3%	100.0%	93.8%	90.9%	60.0%	100.0%	100.0%		78.6%	86.7%	82.76%	96.30%	88.7%
	12 month Statutory Training	98.9%	99.1%	95.8%	97.0%	93.6%	96.4%	93.3%		92.3%	95.8%	97.02%	98.15%	95.9%
	12 month Mandatory Training	96.61%	98.68%	92.06%	93.18%	95.00%	91.07%	87.93%		90.38%	93.75%	93.75%	95.10%	92.61%

Agenda Item No:	17
Meeting:	Foundation Trust Board
Date:	27 February 2020

NHS Bolton NHS Foundation Trust

Title:	Bolton Health and Care Integration Update - Integrated Care Partnership Developments
Purpose	To describe the progress being made by the Bolton Health and Care Partnership to develop a Strategic Commissioning Function and an Integrated Care Partnership and to seek approval to progress to the next phase of development and leadership for a provider Alliance agreement.
Executive Summary:	In July 2018, recognising the significant health challenges Bolton faces and the increased demands on our services, Bolton Foundation Trust, Bolton Clinical Commissioning Group and Bolton Council agreed to come together as a strategic multi-agency group the Bolton Partnership Board. This Partnership is set up to oversee and inform the developments of a Strategic Commissioning Function (SCF); bringing CCG and Council commissioning and budgets more closely together and developing an Integrated Care Partnership (ICP) to join-up health and care provision based on a neighbourhood model. This over-arching paper provides background information on the Partnership aims and summarises progress to date. It signposts to three further separate documents which contain specific details for consideration. **Part A** – provides details of the **Strategic Commissioning Function's** progress towards a single commissioning structure and the establishment of a Director of Strategic Commissioning underpinned by a Section 75 Agreement. This paper is for information and to note. **Part B** - sets out proposals for **Bolton's Integrated Care Partnership and associated Business Plan**. It seeks approval to progress developments for a provider Alliance Agreement as the vehicle for delivery which includes: • proposals for an integrated leadership structure to support the delivery of the Alliance Partnership; • recruitment of an Independent Chair and Operational Managing Director; • development of a Section 75 agreement to enable employees to operate within the ICP. **Part C** – provides an **equality impact assessment** which demonstrates how the Health and Care Partnership has given due consideration to how the proposals contained within these reports affect equality. This paper is for information and to note.

Previously considered by:	Bolton NHS Foundation Trust Board 30th January 2020

Next steps/future actions (please ✓):	The Board of Bolton NHS Foundation Trust, as the core statutory partners of the Integrated Care Partnership, is requested to: • Note the progress made and support the case for progressing to an Alliance delivery vehicle. • Authorise the Director of Strategic Transformation to work with the Council's Borough Solicitor and Deputy Director of People (DASS) to progress the development of the Section 75 Agreement and Alliance Agreement including the integrated leadership structure for the Alliance; bringing all draft agreements to the Foundation Trust Board for approval.			
	Discuss	✓	Receive	
	Approve (Part B)	✓	Note (Part A, C)	✓
	For Information (Part A, C)	✓	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*	
Negative Impact	**Neutral Impact**	**Positive Impact**	

Prepared by:	Sharon Martin, Director of Strategic Transformation	**Presented by:**	Sharon Martin, Director of Strategic Transformation

1. Introduction

In July 2018, recognising the significant health challenges Bolton faces and the increased demands on our services, Bolton Foundation Trust, Bolton Clinical Commissioning Group and Bolton Council agreed to come together as a strategic multi-agency group the Bolton Partnership Board. This Partnership is set up to oversee and inform the developments of a Strategic Commissioning Function (SCF); bringing CCG and Council commissioning and budgets more closely together and developing an Integrated Care Partnership (ICP) to join-up health and care provision based on a neighbourhood model.

The purpose of this paper is to describe the progress being made by the Bolton Health and Care Partnership to develop a Strategic Commissioning Function and an Integrated Care Partnership and to seek approval to progress to the next phase of development and leadership for a provider Alliance agreement.

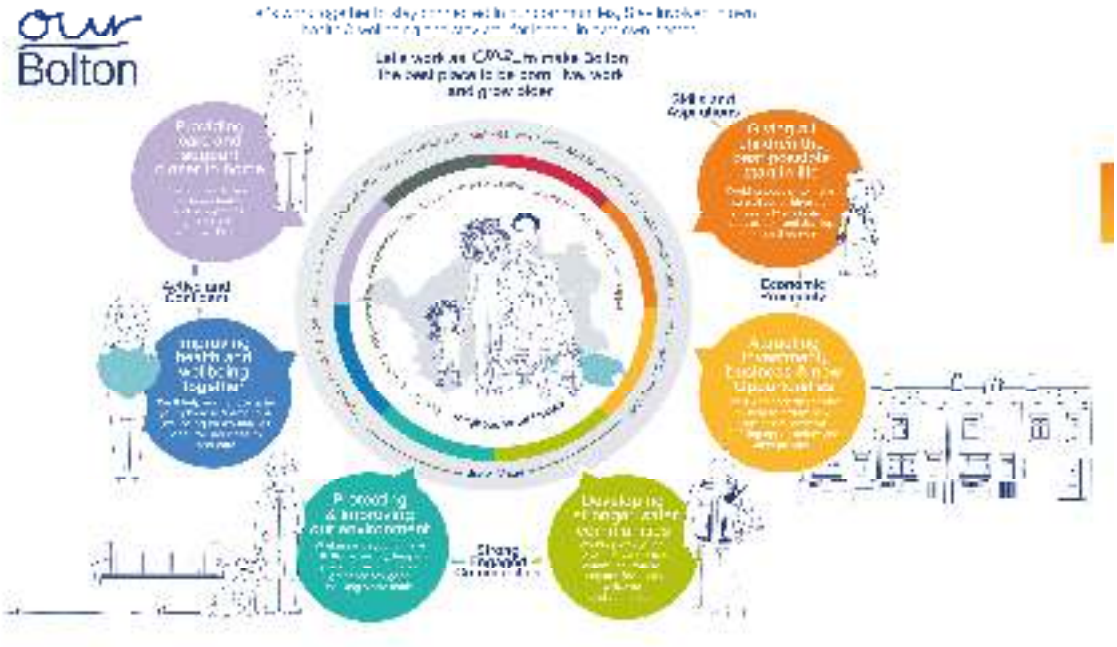
2. Background: Bolton's approach to health and care

2.1 Bolton's health inequalities and financial pressures make a compelling case for the need to work differently together. Quality of life in some areas is good, but there are enduring poor levels of health and wellbeing and multiple health conditions in many of our communities.

There are significant differences between the health of people depending on where they live. Alongside this demographic challenge, like all health and social care economies, Bolton faces significant financial challenges despite each organisation delivering sizeable cost improvement and efficiency programmes over recent years.

2.2 Meeting the twin challenges of our health inequalities and reducing resources requires a new way of working including:

- A place based approach to health and care: If we are to improve health outcomes we cannot achieve this by joining up health and care services alone. A person's home and community all have an impact on their wellbeing and life chances. Therefore working closely with the voluntary and community sector, housing and the police is a key priority for all health partners in Bolton.
- Working differently with our communities: This is about recognising the aspirations, resources and capabilities which can be mobilised to improve the wellbeing of Bolton people. Health and Care partners are committed to identifying and working with personal and community strengths rather than focusing on needs and deficits.
- Establishing a new Model of Care: Our model of care, summarised in the diagram below, will be critical to delivering a new way of working - rooted in communities, people will be at the heart of everything we do. Services and organisations will align to one service delivery footprint of 9 neighbourhoods and 1 locality to ensure all services from health and social care to housing and criminal justice integrate and direct resources to this framework. This will enable residents and services to easily access the right support they need in their community only needing to 'tell their story once'



2.3 This approach is set out in Bolton's refreshed Locality Plan and is aligned to the principles of the Vision 2030. Our approach and impact will be measured by a Single Outcomes Framework for Bolton ensuring that health and care providers and wider organisations are working to shared outcomes to improve the wellbeing of Bolton people, these outcomes are:

- Our children get the best start in life, so that they have every chance to succeed and be happy.
- The health and wellbeing of our residents is improved, so that they can live healthy, fulfilling lives for longer
- People in Bolton stay healthier for longer, and feel more connected with their communities
- Businesses and investment are attracted to the Borough, matching our workforce's skills with modern opportunities and employment
- Our environment is protected and improved, so that more people enjoy it, care for it and are active in it
- Stronger, cohesive, more confident communities in which people feel safe, welcome and connected

3. The next phase of integrated health and care in Bolton

3.1 Over the last 18 months, the Strategic Commissioning Function and Integrated Care Partnership have already been working more closely together, joining up the planning and delivery of services and making best use of the Bolton £. It is now necessary to move to the next phase of development which will offer the leadership capacity and skills required to further progress integration including joining up services, creating the conditions for our workforce to work differently and innovatively and make best use of limited resources.

3.2 Proposals have been made to the Bolton Council Cabinet and NHS Bolton Clinical Commissioning Group Board to formally agree to the formation of a Strategic Commissioning Function led by a Director of Commissioning.

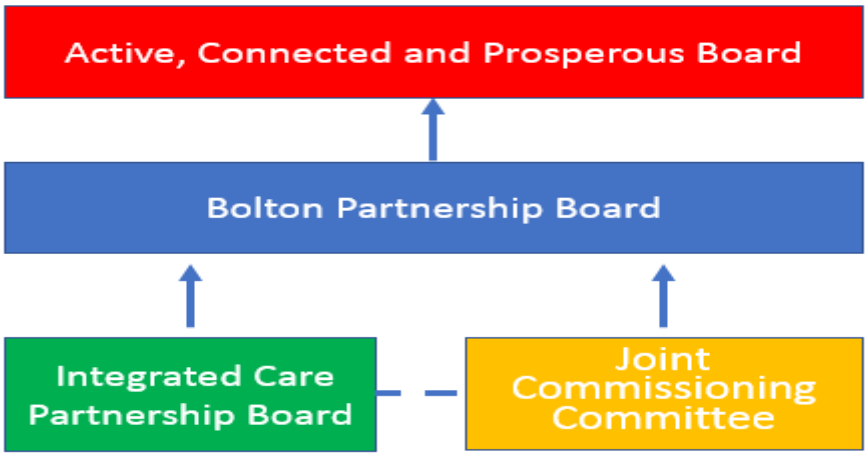
3.3 **Paper A**, which is attached to this overview, provides details of the **Strategic Commissioning Function's** progress towards a single commissioning structure and the establishment of a Director of Strategic Commissioning underpinned by a Section 75 Agreement. This paper is for information.

3.4 Paper B, which is attached to this overview sets out proposals for **Bolton's Integrated Care Partnership and associated Business Plan**. It seeks approval to progress developments for a provider Alliance Agreement as the vehicle for delivery which includes:

- proposals for an integrated leadership structure to support the delivery of the Alliance Partnership;
- recruitment of an Independent Chair and Operational Managing Director;
- development of a Section 75 agreement to enable employees to operate within the ICP.

3.5 Overseeing the development of the next phase will be the system governance that is already largely in place. The Bolton Partnership Board consisting of Councillors, Council Officers, CCG Board Members, GPs, Foundation Trust Board Members, Greater Manchester Mental Health Trust, Greater Manchester Police and Bolton CVS will continue to oversee the strategic design and delivery of health and social care integration including the development of the ICP and SCF.

The Joint Commissioning Committee and the Integrated Care Partnership Board will report through to this Board. The Partnership Board is accountable to the Active, Connected and Prosperous (ACP) Board (repurposed Bolton Health and Wellbeing Board). The newly formed ACP Board will provide system leadership for health and wellbeing holding all organisations to account and will make intelligence-led decisions informed by the emerging Joint Strategic Needs Assessment and our Pharmaceutical Needs Assessment.



Lines of accountability will remain back to individual organisations and clinical and democratic leadership remains as part of this governance model.

4. Equality Impact Assessment

4.1 Under the Equality Act 2010, the Foundation Trust must have due regard to:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;
- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Fostering good relations between people who share a protected characteristic and people who do not share it.

4.2 It is therefore important to consider how the proposals contained within this report may positively or negatively affect this work.

4.3 **Paper C**, which is attached to this over view, contains the Equality Impact Assessment (EIA) screening form for The Integrated Care Partnership and Strategic Commissioning Function proposals.

4.4 The EIA looks at the anticipated (positive and/or negative) impacts of the proposal on people from Bolton's diverse communities, and whether any group (or groups) is likely to be directly or indirectly differentially affected.

4.5 At this stage it is not anticipated that the Integrated Care Partnership or Strategic Commissioning Function proposals will have a disproportionate impact on any of Bolton's diversity groups.

5. Recommendations:

5.1 The Bolton NHS Foundation Trust Board, as the core statutory partners, are requested to:

- Note the progress made toward a Strategic Commissioning Function.
- Note the progress made and support the case for progressing to an Alliance delivery vehicle
- Authorise the Director of Strategy to work with the Council's Borough Solicitor and Deputy Director of People (DASS) to progress the development of the Section 75 Agreement and Alliance Agreement including the integrated leadership structure for the Alliance; bringing all draft agreements to the Foundation Trust Board for approval.

PART A – Strategic Commissioning Function

This document is a standard paper that is also being considered by the Bolton Council Cabinet and NHS Bolton Clinical Commissioning Group.

1. Purpose

1.1 This report sets out proposals for the next phase of Bolton's Strategic Commissioning Function (SCF) which is intended to make best use of the skills and capacity within Bolton in the context of reducing resources. This report sets out in more detail the benefits of an integrated commissioning function between the Council and CCG and the proposal that this is led by a Director of Commissioning on behalf of both organisations to progress this.

2. Background

2.1 In July 2018 the Council's Cabinet and NHS Bolton Clinical Commissioning Group (CCG) Board and formally agreed to the formation of a Strategic Commissioning Function (SCF) with the aim of:

- Making decisions on the best use of Bolton resources together
- Bringing professionals, politicians and clinicians together
- Influencing the wider determinants of health

The SCF supports Bolton's agreed vision for integration of commissioning to:

- Support and enable integrated neighbourhood delivery
- Base decisions on the needs and assets of local populations
- Deliver improved outcomes for local people
- Make the best use of scarce resources
- Improve quality, safety and efficiency
- Innovate and test new ways of working, informed by evidence and data
- Build collaboration, co-design and co-production
- Bring together the complementary skills within the Council and CCG

2.2 Over the last 18 months significant work has taken place by the CCG and Council to develop the strategic intent, structures and processes required to move to a strategic commissioning system. This progress has been in accordance with the agreement between the Council and CCG and is aligned to the clear national (NHS Long Term Plan) and Greater Manchester (Greater Manchester Unified Model of Public Services and Greater Manchester Health and Social Care Partnership's Prospectus) expectation that organisations in localities will come together to take collective responsibility for managing resources, delivering NHS standards and improving population health.

2.3 In Bolton, this builds on the strong history of partnership working between the Local Authority and the NHS by bringing two leadership teams together using their skills with matrix style working as part of a wider place based system.

The following key milestones have been achieved:

- Single Accountable Officer for Health and Care in Bolton was agreed in December 2018. This role is accountable for the pooled commissioning programmes; provides leadership for the SCF and is accountable to the GM Partnership for the coordination of overall transformation and delivery outlined in the Locality Plan.
- Co-location of CCG and Council teams began in February 2019 as part of a phased move. The CCG's commissioning team moved into the Town Hall and were co-located alongside the Council's commissioning teams and wider services.
- £160 million (first phase) pooled budget for adults agreed with joint risk share and an 'open book' approach to all commissioning budgets/expenditure. This is underpinned by a Section 75 Agreement, a formal partnership agreed by both parties.
- Greater collaborative decision making between the Council and CCG through the Joint Commissioning Committee which oversees the pooled budget bringing together democratic and clinical leadership

2.4 The integration of health and care in Bolton is a priority for Bolton Council, Bolton CCG and key partners to deliver the improvements in health and wellbeing outcomes we have all agreed are our priority. While good progress has been made on joining up commissioning between both organisations the partnership is now mature enough to move to the next phase of development. In the context of contracting resources and the need to enable teams to work closer together, we need to bring teams together under single operating principles with single leadership.

2.5 Many people in Bolton need support from both NHS and social care services and the way we commission, deliver services and strategies and policies currently can lead to gaps, duplication and confusion for the local population. Bolton partners have also recognised the critical importance of moving to a person and community centred approach of health and social care integration which focuses on prevention and early intervention and offering the right level of care in the right place at the right time. This means making services and interventions more joined up, supporting all staff to work in new ways, and enabling people, and their families, to become more independent by taking control of their own health and wellbeing.

3. The benefits of an Integrated Commissioning Structure

3.1 The intention of this proposal is to bring the skills, experience and capacity of Bolton Council and Bolton CCG commissioning teams together to form an integrated commissioning approach which supports the system to make decisions on the best use of resources which target improvements in health and wellbeing and takes into consideration the wider determinants of health. This population health approach will prioritise prevention and early intervention in order to support local people to live healthier lives and to rely less on statutory services and complex care. By bringing together expertise from the system, including public health, this will enable the whole commissioning cycle to be appropriately implemented, with the right services at the right level being commissioned to meet the needs of the local population and also decommissioning/recommissioning decisions where services are not delivering the required outcomes.

3.2 This proposal will enable the move to the next phase of integrated commissioning by:

- Creating one team operating as the engine room for strategic commissioning, working to a single vision and strategic commissioning plan.
- Integrating leadership and operations enabling better information sharing, the creation of a whole system view and greater ability to influence and improve efficiency and the quality of services.
- A greater focus on prevention and early intervention within a Place Based system. This will see positive changes in the way commissioning teams operate, working more closely together and with public health teams to change mindsets and identify opportunities to invest in prevention.
- Supporting the business of the Joint Commissioning Committee and system leaders by ensuring an integrated business process from beginning to end.
- Giving the integrated capacity required to support pooled budget expansion
- Supports recommendations in the Council's Peer Review regarding integration and is aligned to national, Greater Manchester and local ambitions set out in Bolton's Locality Plan and Vision 2030
- Complements and supports the development of the Integrated Care Partnership

3.3 The integrated commissioning structure would also enable the delivery of the full commissioning cycle from needs assessment through to ongoing evaluation and innovation.

4. Proposed SCF integrated structure arrangements

4.1 It is proposed that this move to greater joint working is enabled by the establishment of a joint post between the CCG and the Council to provide the single integrated leadership arrangements required. This is a common feature of integrated systems across Greater Manchester and is a well tested approach to ensuring joined up commissioning. The Director of Strategic Commissioning will:

- Be responsible (working to the Accountable Officer and in partnership with Statutory Directors) for the development and delivery of Bolton's Strategic Commissioning Plan (SCP) which will set out Bolton's long term plan for health and care commissioning in Bolton
- Manage and develop a commissioning team to build the capacity and skills to deliver strategic commissioning across health and care. This team will be responsible for supporting the development of the full SCP. While line management will change under these proposals, staff will remain employed by their existing organisations.
- Develop and deliver a full OD programme for the new integrated commissioning team (incorporating wider teams involved in the commissioning cycle as appropriate)

4.2 The Director of Strategic Commissioning post will be a Council and CCG partnership post hosted by the CCG. The accountability of the post back to the organisations will be underpinned by a Section 75 Agreement between both parties.

5. Finances

5.1 The leadership structure will be funded through the reprofiling of an existing post within the commissioning partnership.

6. Accountability and legal arrangements

6.1 The Director of Strategic Commissioning will be hosted by the CCG on behalf of the Strategic Commissioning Function and will lead the commissioning of 'all age' services across the Council and CCG. The Assistant Director for Health and Social Care Commissioning, and areas of responsibility will report to the Director of Strategic Commissioning, they will be professionally supported by the existing statutory roles within the Council, in particular, the Director of Adult Social Care.

6.2 The Director of Strategic Commissioning will be responsible and accountable for directly commissioning all adult, children & family services within the People Department of the Council in partnership with statutory directors as well as commissioned services in the CCG. While the scope includes Public Health Commissioning there will be no reporting changes to Public Health Directorate staff.

6.3 Underpinning these arrangements will be a Section 75 Agreement which will clearly set out how the arrangements between both organisations will work including:

- Detail how statutory duties will be discharged by the Director of Strategic Commissioning on behalf of the Directors of Adult Social Care; Children's Services and Public Health.
- Detail the accountability process and any Schemes of Delegation to be put in place.
- Arrangement for management of staff; resources & engagement with Trade Unions

It is proposed that this Section 75 Agreement is developed by the Council's Borough Solicitor and Deputy Director of People (DASS) with the Accountable Officer and Director of Strategic Commissioning. While this will mean a change to working arrangements, it will not alter the discharge of statutory functions and democratic and clinical oversight of these services will not be diluted. It is anticipated the proposal will enhance the planning and buying of services across the NHS and Local Authority for the good of Bolton people.

7. Human Resources

7.1 Staff affected by these proposals will remain employed by their current organisation. The proposals set out a single leadership arrangement that will be underpinned by a Section 75 legal agreement building on existing integrated arrangements.

7.2 The Director of Strategic Commissioning post will be a Council and CCG partnership post hosted by the CCG and reporting to the Accountable Officer. Recruitment for the Director will be through a redesign of an existing post ensuring there is local knowledge and expertise to lead the SCF.

8. Recommendations

9.1 Bolton NHS Foundation Trust, as a core statutory partner, is requested to note the proposal.

Part B: proposals for Bolton's Integrated Care Partnership and Associated Business Plan

1. Introduction

1.1 This report sets out proposals for Bolton's Integrated Care Partnership (otherwise known as Local Care Organisations (LCOs) in Greater Manchester) and associated Business Plan (Appendix 1) and seeks approval to progress developments for a provider Alliance Agreement as the vehicle for delivery.

1.2 The Business Plan sets out the approach to Bolton's Health and Care providers embarking on a new way of working to deliver Integrated Care aimed at improving the health and wellbeing of Bolton People. It is a strategic Business Plan for Bolton's Integrated Care Partnership and links to our local Partnership plans: Vision 2030 and the Bolton Locality Plan.

1.3 The plan outlines the move to an Alliance of providers, which will help us to deliver this new model of care, setting out a high-level assessment which includes the rationale, vision, proposed leadership and governance required and work programme.

1.4 The Integrated Care Partnership (ICP) will bring together primary care, community health, mental health services and adult social care with strong links to the voluntary and community sector, housing and Police. It will focus on delivering excellent care, close to home and that responds to what matters to the person.

1.5 This report also proposes an integrated leadership structure to support the delivery of the Alliance Partnership, it will be resourced from within the partnership and be cost neutral over time.

2. Background

2.1 In July 2018 the Council's Cabinet and the respective Boards of the NHS Bolton Clinical Commissioning Group (CCG) and Bolton NHS Foundation Trust formally agreed to the formation of an Integrated Care Partnership (loose federation via a Memorandum of Understanding) with the aim of delivering integrated health and care services for Bolton residents.

2.2 The ICP commenced in shadow form in July 2018. Since that time the following progress has been made: -

- Establishment of an Integrated Care Partnership with an SRO and a formal Board made up of Bolton providers.
- Developed the vision and operating characteristics for the partnership and the neighbourhood model of care
- Embarked on designing the neighbourhood model of care for adults with care and support needs in collaboration with staff and people with lived experience.
- The model of care is already being tested in neighbourhoods with neighbourhood team meetings in place and sustained engagement with key partners in neighbourhoods including primary care, housing and police teams
- Development of key enablers to support and further integration including further joint working between teams on finance, IT, estates and communications and engagement.

The proposals set out in the report state how moving to the next phase of their development, will help us to further progress the pace and scale of integration and therefore ensure improvements for local people.

3. Proposal for the ICP delivery vehicle

3.1 Bolton's integrated system and the ICP share the ambition of the Greater Manchester Health and Social Care Partnership that ICPs (or Local Care Organisations as they are sometimes known) are the principal means by which health and social care services within a locality are integrated and delivered in a financially and clinically (professionally) sustainable manner. This means that Bolton ICP's long term aim, in terms of its form as a delivery vehicle, is to ensure the inclusion of the large majority of services currently commissioned and provided to Bolton people as health and care services 'in scope' of the ICP.

3.2 The ICP partnership is currently constituted by a Partnership Agreement which has enabled us to develop relationships, begin coalescing delivery around our model of care and organise ourselves around a single vision and plan. However, to enable us to deliver our model of care and realise our ambitions of improving Bolton people's experience of services as well as their health and wellbeing, the ICP Board considers that an Alliance is the best fit for Bolton because it enables:

- **Working as one team in a place**: An Alliance enables us to bring together multiple providers to deliver one model of integrated health and care in neighbourhoods and in Bolton with single line management and way of working. An Alliance model with a single leadership structure will give integrated leadership, direction and support to those neighbourhood leaders and to some services working to a footprint that spans the borough. It will also give valuable leadership capacity to the ICP ensuring a safe transition to the new way of working and giving assurance to the wider system.

- **Strong framework:** An Alliance and Alliance Agreement gives us a binding agreement which sets out accountabilities and responsibilities and the governance structure we will work to and does not replace existing organisational accountabilities, offering some protection to parent organisations to deliver their statutory or contractual obligations.

- **Autonomy and innovation**: Gives us the autonomy to act as one provider and begin to make tangible changes to planning and delivering care. An Alliance gives the ICP both the flexibility to work collaboratively on contracts and also adopt a lead provider model (the lead could potentially be any of the providers within the Alliance) where needed.

3.3 The ICP is proposing to adopt a staged approach to transforming health and care, including our neighbourhood model of care to ensure we are able to deliver a viable and sustainable model. However, a whole population and whole system approach will still be part of the emerging approach from the outset. (Further details are contained in the Business Plan).

4. Options considered

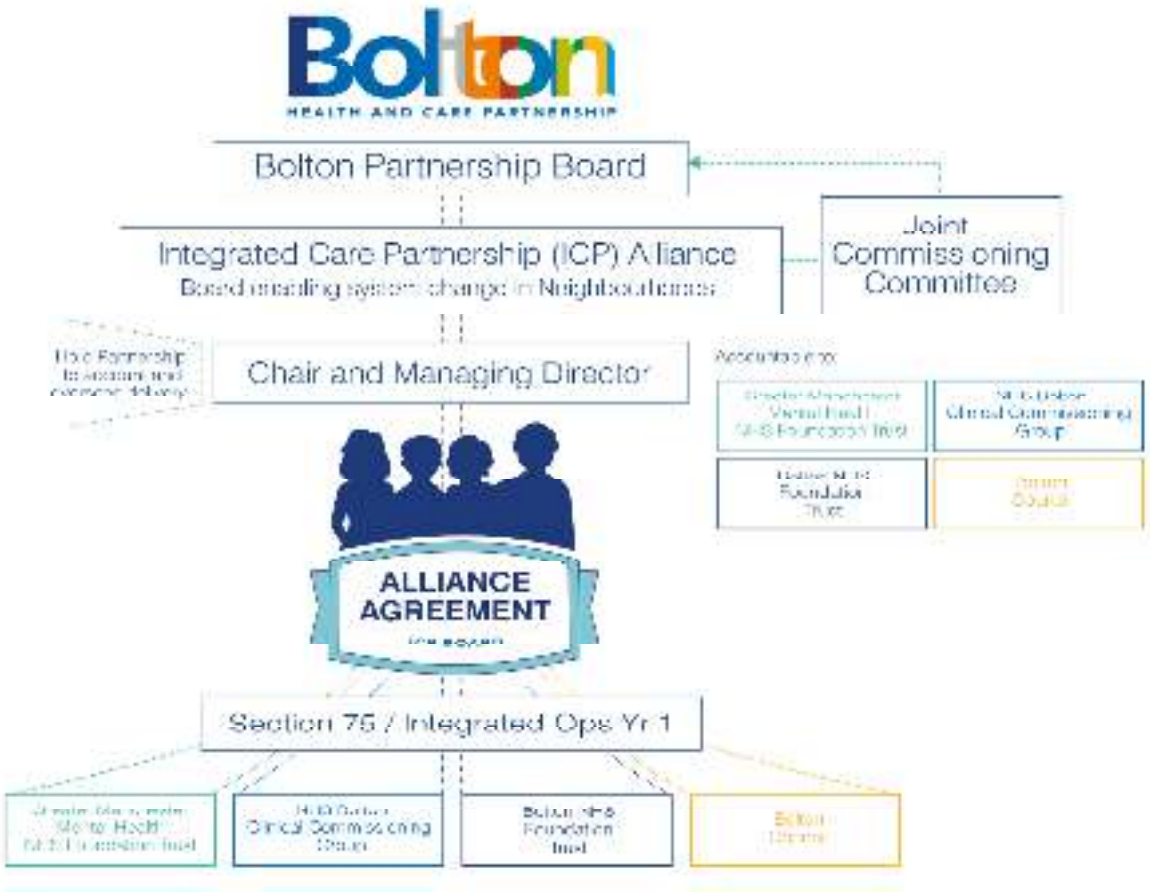
4.1 Consideration was given to the different delivery vehicles available to support integrated health and care systems, and the ambition for Bolton to grow in a way that enables new models of care to be the focus for improved experiences of Bolton people. The vehicle model proposed enables integration to progress at a pace which is right for Bolton.

The other models considered and discounted are summarised in the table below;

5. Impact and implications

5.1 Governance

The Business Plan (Appendix 1), sets out a proposal to operate the ICP as an Alliance of Providers. A Board of Directors will be made up of key officers from the Alliance, reporting to the Health and Care Partnership and Joint Commissioning Committee, as detailed in diagram below:



As part of the Board's development, it will further develop robust governance arrangements including corporate, clinical and professional governance. This will include developing a management and leadership structure at nine neighbourhoods which we anticipate will broadly reflect the structure and principles of triumvirate leadership.

It is proposed that an Independent Chair will be appointed to the ICP who will facilitate the development of relationships within the ICP, across the broader Bolton system partnership and into Greater Manchester. The Chair will co-ordinate inspirational leadership and drive innovation. They will be accountable to the Bolton Partnership Board.

A Managing Director position will be created from within the system to ensure the safe day to day running and oversight of operations including operationalization of service models, performance and finance. Both the Managing Director and Independent Chair, supported by Clinical Leads, will be responsible for overseeing the Alliance Agreement and its implementation. All ICP Board members will be accountable to the Independent Chair for their performance within the Partnership.

5.2 Financial

The resources required to establish the leadership structure will be funded from within the integrated structure.

5.3 Legal

Approval of the ICP Business Plan will enable the partnership to develop a mutually binding Alliance Legal Agreement, and the development of a Section 75 Agreement between the organisations deploying staff into the integrated operational directorate.

The proposed Alliance Agreement will include both the overarching governance and managements arrangements for the services included and the clinical/professional governance arrangements in place to ensure delivery of safe services. The proposed ICP Alliance and specifically the ICP Board with the Independent Chair and Managing Director will have oversight of the agreement.

The organisations who deploy their staff into the ICP will also sign up to a Section 75 Agreement that will ensure integration of the Adult Social Care operations, Community Health services, some Mental Health services and Primary Care support development from the CCG. It will set out the governance and accountabilities back to the parent organisations.

5.4 Human Resources

Staff affected by these proposals will remain employed by their current organisation, there will be no implications for staff terms and conditions. The proposals set out integrated leadership and management arrangements that will be supported by a S75 legal agreement, and replicate existing integrated arrangements in operational services (Intermediate Tier, Community Learning Disability Services, Community Mental Health Services) but propose these at scale within the Alliance arrangements.

The proposed leadership structure for the ICP; Independent Chair and Managing Director contracts will be hosted by the Foundation Trust on behalf of the ICP as the infrastructure organisation for the ICP.

Recruitment for the Managing Director will be an internal process from within the Alliance partner organisations to ensure there is local expertise to continue to lead operational services and the development of the Alliance.

The Business Plan sets out in Section 5 the services that will deployed into the ICP under the integrated leadership and management arrangements.

6. EIA

6.1 Under the Equality Act 2010 Bolton NHS Foundation Trust, must have due regard to:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;
- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Fostering good relations between people who share a protected characteristic and people who do not share it.

6.2 It is therefore important to consider how the proposals contained within this report may positively or negatively affect this work. To support this analysis, an Equality Impact Assessment (EIA) screening form has been completed for the proposals outlined in this report, and is attached (Part C) of this report

6.3 The EIA looks at the anticipated (positive and/or negative) impacts of the proposal on people from Bolton's diverse communities, and whether any group (or groups) is likely to be directly or indirectly differentially affected.

6.4 At this stage it is not anticipated that the proposals will have a disproportionate impact on any of Bolton's diversity groups.

7. Recommendations

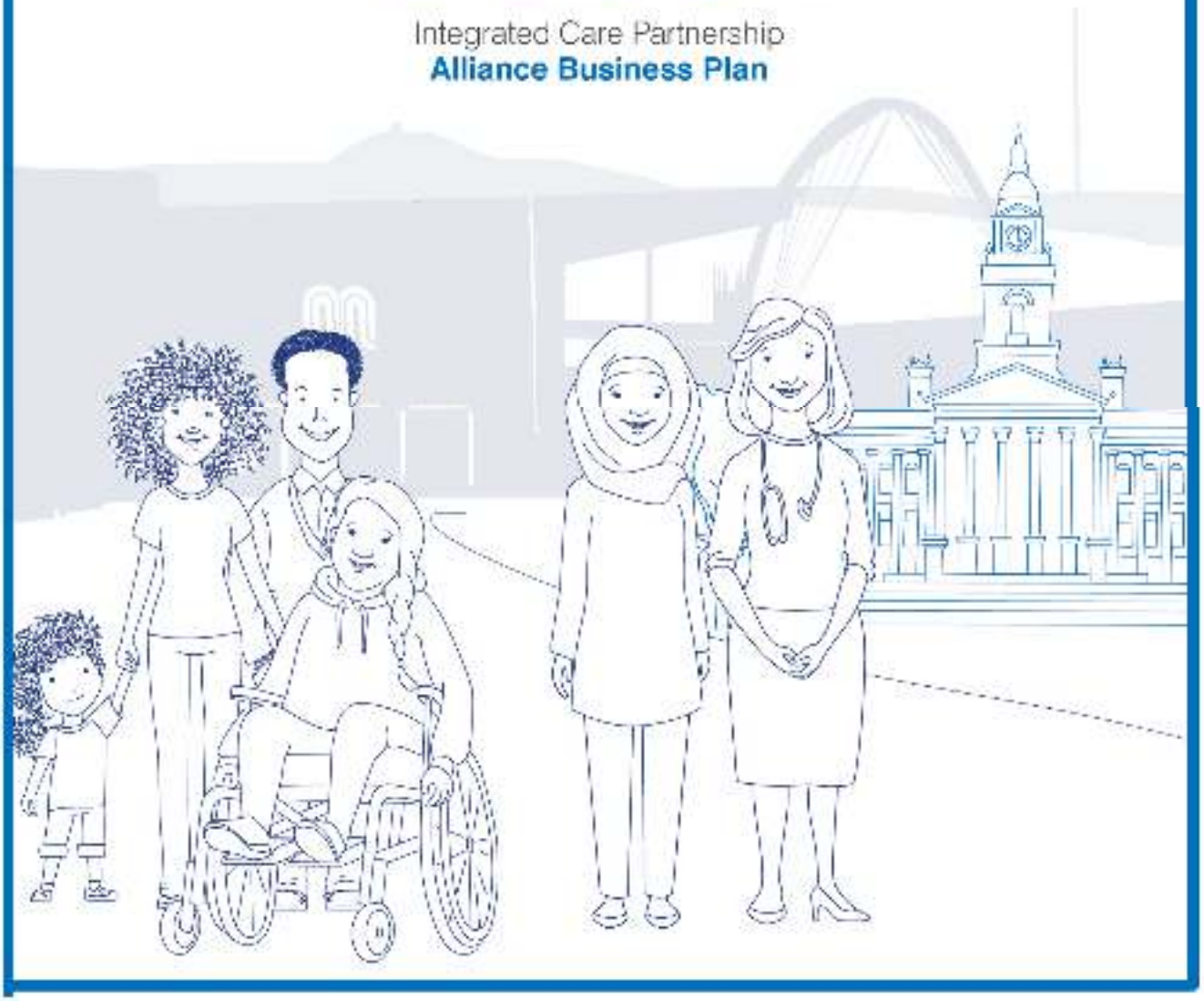
7.1 The Council's Cabinet; NHS Bolton Clinical Commissioning Board and the Board of Bolton NHS Foundation Trust, as the core statutory partners, are requested to:

- **Note the progress made and support the case for progressing to an Alliance delivery vehicle**
- **Authorise the Director of Strategy to work with the Council's Borough Solicitor and Deputy Director of People (DASS) to progress the development of the Section 75 Agreement and Alliance Agreement including the integrated leadership structure for the Alliance; bringing all draft agreements to the Foundation Trust Board for approval.**

Bolton
HEALTH AND CARE PARTNERSHIP

Working together for... our Bolton

Integrated Care Partnership
Alliance Business Plan



Bolton Integrated Care Partnership Plan for Integrated Care

1. Purpose
2. Executive summary
3. Case for Change
4. Our journey so far
5. The Alliance in 2020/21
6. Integrated Care Partnership Structure
7. Service Integration Programme
8. Outcomes Framework
9. Workforce and OD Transformation
10. Project Plan

1. Purpose of this Document

This Business Plan sets out the approach to Bolton Health and Care providers embarking on a new way of working to deliver Integrated Care supporting local people to improve their health. It is a strategic business plan for Bolton Integrated Care Partnership and links to our local partnership plans: Vision 2030 and the Bolton Locality Plan.

Our Integrated Care Partnership is a group of providers collaborating to meet the needs of the Bolton population responsible for:

- Focusing on prevention and proactive, joined up care to improve the health and life chances of Bolton people and, in turn, reduce unwarranted escalation and use of bed-based care
- Actively managing health and wellbeing, improving key risk factors and delivering person centred care
- Operating within current contracts and specifications, budgets to be allocated by Commissioners (whether at a local, GM or national basis) to deliver services
- Achieving the triple aim of improved health and wellbeing, better quality and sustainable finances

This Business Plan outlines the move to an Alliance, which will help us to deliver this new model of care, setting out a high-level assessment which includes the rationale, vision, proposed leadership and governance required and work programme.

2. Bolton ICP Plan for Integrated Care: Executive Summary

Our Business plan sets out an exciting vision for a new way of providing health and care services in Bolton and, specifically, shares how we deliver this through a new Alliance of health providers. Our Integrated Care Partnership (ICP) will bring together primary care, community, mental health services and adult social care. It will focus on delivering excellent care, close to home and that responds to what matters to the person.

Bolton is a place with a strong sense of community. We are proud of our town, our services and staff who provide good quality care and support. We have a vibrant and diverse voluntary sector and Bolton people, many of whom support their families and their communities on a daily basis.

Quality of life in some areas is good, but unacceptable levels of deprivation and poor levels of health and wellbeing, and multiple health conditions continue to affect too many of our residents. There are significant differences between the health of people depending on where they live. People in wealthier areas are living longer in better health than people in poorer parts of Bolton. Our commitment is to help all Bolton people find and keep good health for longer and achieve a better overall quality of life.

Often people needing care and support can experience a lot of processes and assessments which can be difficult to understand and navigate. Too often, what matters to the person and their family and carers is not prioritised and their voice isn't heard. People have told us that the current system is fragmented and lacks co-ordination of care across organisational boundaries. This in turn can be challenging for our staff that come to work to do the best they can for local people.

To improve this, Bolton's health and social care providers agree that we need to move to deliver services in a more integrated way that puts people and families at the heart of everything thing we do, listening to them and understanding what they need to be happy, healthy and live as independently as possible.

To deliver this change we are creating the Integrated Care Partnership. Our proposal is to deliver as an Alliance of health and social care providers working closely with VCSE, housing, police and other partners to deliver integrated health and care services.

Our Partnership will incorporate the VCSE recognising their key role in delivery reaching, connecting and developing trust within our communities. Our model of care is focussed on not only integrating our health and care services but working more closely with the voluntary sector, police and housing services recognising the impact our homes, work and communities have on our wellbeing.

The ICP will enable people to take care of themselves and others making sure we provide early intervention when people need it. This will be a new way of working for our frontline staff, our leaders, organisations and communities in which the emphasis will be on seeing people's strengths rather than their deficits or needs alone. This approach aligns to Bolton's Health and Care Locality Plan and our commitment to work differently with our communities.

This Business Plan outlines the proposal to develop an Alliance which will enable us to deliver the transformational changes required to improve people's experiences of health and care services improving their health and wellbeing. Given the scale of the change required, the ICP will take a stepped approach to developing both the ICP Alliance and delivering the programme of transformation of services.

In its first year, the ICP Alliance will focus on working with all adults in Bolton with a priority focus on those with complex needs, whilst also testing how we can prevent instances of ill health and intervening earlier when people start to become unwell. This will be a place based approach, working with, the VCSE, housing, police and other key partners. Our form as an Alliance reflects this focus. Our ambition to realise an all age model of care in 2022 and beyond will mean that we will continue to work closely with all services which affect the lives of children and families working collaboratively on key projects in the interim.
This is a single partnership document that has been developed by the Integrated Care Partnership Board and further shaped by commissioners and feedback from wider stakeholders and partners for consideration.

3. Case for Change

Improving health outcomes

Bolton has a burning platform to improve Bolton's population health and wellbeing and reduce inequality. It makes a compelling case for change and ultimately supporting closer integration of services through an Alliance model.

- Bolton has a growing and changing resident population, which will reach 300,000 over the next decade, with increasing numbers of both older people and those living with complex long-term conditions. It is recognised that the GP registered list of patients is already exceeding this figure.

- People in Bolton have poorer health and outcomes and use more acute hospital services than the national average.

- When people are living longer, they are not necessarily doing so in good health- in Bolton the number of years a person is expected to live not in good health is 15 years for men and 22 years for women. This means demand for services is predicted to increase e.g. the number of people aged 65+ with dementia is expected to grow by 35.9% to 4,203 in 2025.

- There is substantial inequality within Bolton, such as life expectancy between the most and least healthy wards. For example, a baby boy born to parents living in Bromley Cross, is likely to live 10 years longer than a boy born to parents living in Halliwell.

- Bolton sees higher than average levels of alcohol related harm, smoking related deaths, and hip fractures in older people, more deaths from drug misuse and more hospitalisation for self-harm.

- Bolton adults are less likely to be physically active than people elsewhere in England and 1 in 5 children who start primary school are overweight or obese.

- Bolton has more mothers who smoke at time of delivery and fewer women who breastfeed.

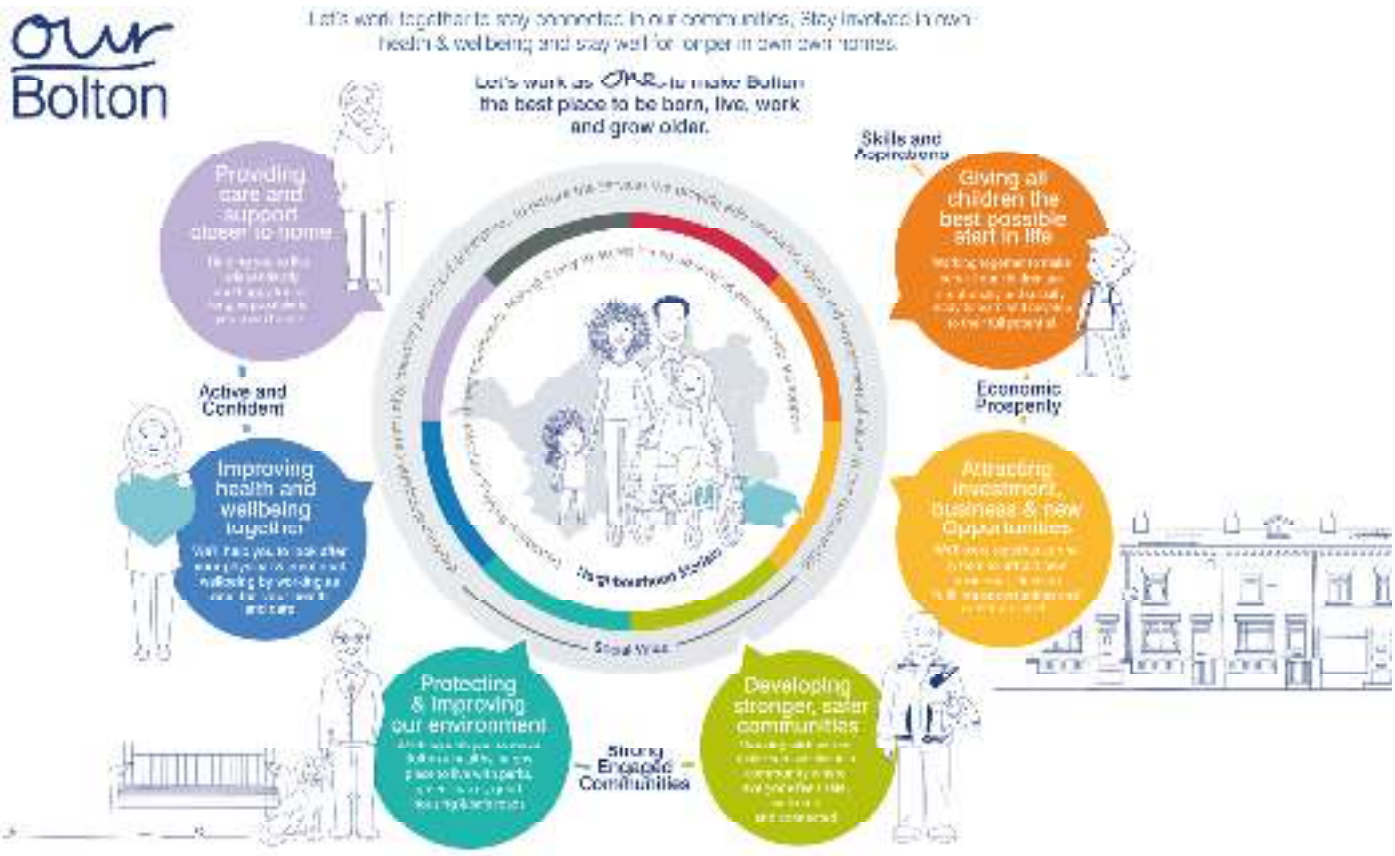
- Bolton has higher than average rates of adult admission into long term care than comparator areas with significant numbers of adults receiving care at home

Alongside this demographic challenge, like all health and social care economies, Bolton faces significant financial challenges despite each organisation delivering sizeable cost improvement and efficiency programmes over recent years.

3.1. Alignment with National, Greater Manchester and Local Policy

Our challenges regarding the health and wellbeing of our residents is one faced by neighbouring areas and across the UK. In response to these challenges, nationally there is a clear move to drive the integration of services at a local and neighbourhood level as set out in the government's NHS Long Term Plan and Forward View and enshrined within the recent Greater Manchester Unified Model of Public Services and the Greater Manchester Health and Social Care Prospectus.

In Bolton, we have committed to a place based approach to health and care, integrating services at a neighbourhood level which span beyond health and care to include services such as housing. This approach recognises that improving the health of Bolton people cannot be achieved by joining up health and care services alone and we therefore need to work more closely with the voluntary sector, housing, police and education. This is set out in Bolton's 2030 Vision and in Our Bolton: Health and Care Locality Plan. The below diagram visualises our approach showing how the health and care system will work closely with a wider range of services to improve health and wellbeing aligned to the GM Model of Care:



This plan sets out our approach to a new way of delivering health and care aligned to these principles.

3.2. Financial Case

Bolton like many other health and care economies, faces an extremely challenging trajectory of growing demand and constrained resources. Services are already facing unprecedented financial pressure, with each organisation implementing planned cost improvement programmes. These pressures are projected to increase in future years. Despite health and care partners working together for some time delivering sizeable cost improvement and efficiency programmes, it is clear that the scale of financial challenges cannot be addressed by the current way of working.

Review of evidence and best practice relating to the organisation, opportunities and benefits of Integrated Care approaches including integrated delivery vehicles show there is compelling evidence that joined up care in which professionals are enabled to work closely together improves responsiveness of care, people's experience and therefore reduced demand for hospital and other acute care and support. There are also compelling links to reducing utilisation of secondary care; social care; admission lengths of stay and emergency readmission.

This has clear cost saving implications for the Bolton £ however it is anticipated that the totality of these savings and reduced pressures will not be realised in the short to medium term.

A closer partnership of providers as an Alliance will provide the platform and framework to transform services and drive integration and efficiencies to contribute to bridging the financial gap over time. It will allow the ICP to take a collective view on financial risks to the services and agree actions to address these for the benefit of front-line services, Bolton people and the Bolton £.

3.3 Feedback on our services

We know that local people want to better understand what services are available and where to go to if they need support. When they do need care, they expect this to be co-ordinated, listening to what they and their family need to help them to live and enjoy life to the best of their ability. While there are undoubtedly pockets of good practice across Bolton, like many areas we know that care can be fragmented and that people have to 'tell their story' multiple times and that we miss opportunities to enable people to manage their own health avoiding instances of preventable illness.

The pressing challenge of improving health outcomes, demographic pressures, changes to national and local policy and financial constraints mean we cannot leave the system as it is. Bolton's Integrated Care System (ICS), as commissioners (SCF) and providers (ICP), have a shared view that significant change delivered through more integrated care is required. We have reviewed national and international evidence on integration of health and social care and listened to what local people, our communities, our staff and our partners tell us about the need for change. Research tells us there is potential for integration to help deliver these improvements.

4. Our Journey So Far

All partners in Bolton's integrated health and care system are passionate about improving both the services people experience, and the outcomes for Bolton's ever-changing population. We have a shared Bolton Vision for a healthier place and people as set out in our Vision, 2030

"Bolton will be a vibrant place built on strong cohesive communities, successful businesses and healthy, engaged residents. It will be a welcoming place where people choose to study, work, invest and put down roots. We want our people and our place to prosper and we will make this happen by driving inclusive growth and reforming our services, in partnership, to promote wellbeing for all"

Our shared vision is to work together to design and deliver a very different approach to health and care to deliver tangible improvements for all local people.

In July 2018 the Council's Cabinet and the respective Boards of the NHS Bolton Clinical Commissioning Group (CCG) and Bolton NHS Foundation Trust formally agreed to the formation of an Integrated Care Partnership with the aim of delivering integrated health and care services for Bolton residents. The ICP commenced in shadow form in July 2018. Since that time the following progress has been made: -

4.1 Developing relationships and the purpose of the ICP

At its inception, the Integrated Care Partnership developed a Steering Group led by the ICP Senior Responsible Officer with the immediate purpose of developing relationships across providers to support a robust cross sector partnership. This was constituted by a Partnership Agreement, which all providers signed up to in January 2019 and was endorsed by Bolton Partnership Board.

From October 2019, the ICP Steering Group developed and was supported by a six-month AQuA development programme. The development programme focussed on:

- Working with senior leaders on leadership and governance to build relationships and the spirit of collaboration and a plan for the ICP's development
- Understanding activity in Bolton's neighbourhoods across health and social care and wider services to create a cross organisational team to drive integrated place based delivery.
- Frontline engagement to design the model building on existing good practice

This work enabled development of the ICP Vision, operational characteristics (see sections 4.1.1 and 4.1.3) and a Partnership Agreement which set out the ICP's purpose, roles and responsibilities, expectations and obligations of members and the relationship between the ICP and the wider system (section 4.1.2). It also set out the high-level deliverables for the ICP in its early stages.

4.1.1 ICP Vision

The ICP' Vision is to deliver an integrated health and care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home. More than that, we will seek to transform local services to deliver proactive care and support, focused on promoting health and wellness, rather than care and support that is solely reactive to ill health.
Core to the model of care is the philosophy of health, care and wider public services working together to promote and support independence, utilising statutory, voluntary and community assets, and where appropriate, independent sector services to deliver the right care, in the right place at the right time.
Our vision is for whole family and system redesign at an organisational level, seeking to work in collaboration across the health and care landscape to build and implement an innovative workforce redesign model. This will enable the local economy to develop and deploy a workforce fit for the future of integrated health and care delivery across current professional boundaries.

4.1.2 Partnership Agreement

A partnership agreement was developed at the end of 2018 which set out the ICP's purpose, roles and responsibilities, expectations and obligations of provider members and the relationship between the ICP and the wider system.
In consultation with Integrated Care System partners and wider partners including the Partnership Board, it was agreed that the development of the model of care would take precedence in 2019. This enabled the development of a high-level model and its core functions to shape the future form of the Integrated Care Partnership.

4.1.3 Operational characteristics

The following operational characteristics were agreed in 2018. These guide everything the ICP does and is our commitment to our residents and our staff:

- Co-ordinate care around the person and not organisations
- Designed and delivered through a place based approach based on the registered list and geographical best fit
- People will be supported in their home and community for as long as it is appropriate and possible. The right care, at the right time by the right person.
- People will only have to 'tell their story once'
- Optimal use of the Bolton £ ensuring we maximise social value.
- Work together and with wider partners, to tackle health inequalities and inequality between neighbourhoods including the wider determinants of health
- Focus on increasing prevention and early intervention
- We will have a conversation with Bolton people and partners about how we spend our funding
- Support solutions in communities by communities of identity and place.
- A partnership that people aspire to work for and be part of.
- Single leadership structure with managerial support and clear lines of accountability
- One workforce empowered to make the right decisions sharing collective resources, skills and knowledge, at the right spatial level.
- Enable the workforce to have conversations that focus on personal strengths and which connects people to their community assets.
- Workforce has a single set of values and behaviours to work to. A climate is created where different professionals work together in a positive, open and trusting culture of continuous improvement
- Maximising technology to enable self care and independence
- Care models will be based on evidence and learning from best practice that focusses on quality and outcomes
- Enable integration wherever possible and appropriate, reducing duplication and use of resources more efficiently
- Integrated care records
- One visible and transparent performance and outcomes framework
- Create the conditions for providers to work together to meet the needs of the whole person avoiding risk shift from organisations
- Governance recognises contractual relationships, and accountability to regulatory organisations.

These operational characteristics directly informed the design and implementation of the neighbourhood model and inform the proposal to move to the first phase of an Alliance

4.2 Neighbourhood Model

In January 2019 a Senior Change Team (SCT), a cross organizational task and finish group, began developing a headline neighbourhood model. This involved translating the agreed ICP vision and operational characteristics into tangible deliverables.

The Senior Change Team undertook the following process:

The core components of the model are co-located neighbourhood teams with a single vision, one team and line management and single holistic assessment in place. The following milestones have been delivered to achieve this:

- Team meetings in all nine neighbourhoods testing the approach. While this is predominantly health and care at this stage, the ICP is working with housing and police to consider their interface into this area.
- Readiness for integration is critical to the success of the model of care ensuring that services are already functioning productively before we bring them into an integrated offer. Work to understand, and where necessary, enhance the current state of services is underway. In particular, work with Therapy teams has been undertaken to understand and implement changes to reduce wait times for patients. This is supporting a smoother transition for this service as the model mobilizes.
- Action plan in place for the first phase of co-location of neighbourhood teams including key enablers such as estates and IT.
- Mapping registered populations of primary care networks against geographical neighbourhoods to ensure 'best fit' service delivery footprints of registered and resident population.
- 4 voluntary sector representatives appointed to provide leadership capacity to support VCSE contribution across all Integrated Care Partnership development.
- GMP have aligned their delivery to the nine neighbourhoods footprint and housing providers, through the Bolton Community Homes Partnership, are working to align resource to the neighbourhoods.
- Ongoing development on the detailed design and planning work needed to mobilise neighbourhood teams is underway by cross agency teams using a 'Sprint methodology' e.g. developing workstreams; metrics; holistic assessments etc.
- Communication and engagement events with 300+ staff and initial engagement with local people with more engagement planned for 2020.

4.3 Strategic Delivery Footprint

Aligned to the work across Greater Manchester, the Integrated Care Partnership has been working to a Strategic Delivery Footprint (SDF) of 9 neighbourhoods and 1 borough. These neighbourhoods are focused on improving the health and well-being of populations of approximately 30-50,000.

The rationale of the SDF is to have a common currency by which all health and care and wider services can resource delivery. This neighbourhood approach recognises that people's health, wellbeing and ability to live independently starts with living well day to day, supported by their families and wider community. A range of services including the VCSE will support this approach developing a new way of working with Bolton people. Primary care are ideally placed to help develop a wider community-based approach with Primary Care Networks affording the opportunity to strengthen the foundations of joint working with pharmacies and other services within SDFs to improve the health of their populations. Primary Care Networks therefore are at the heart of our approach.

The ICP is integrating services and provision based on the neighbourhood model and is working to coordinate services and staff who will be working in the nine neighbourhoods. This enables us to take a whole population health view ensuring that all Bolton people are able to benefit from integrated health and care and working with wider partners on prevention and the wider determinants of health. A single footprint also enables us to understand need at different spatial levels in Bolton coming to a collective view across partners as to current and emerging needs in communities. This, in turn, enables us to inform the planning and deployment of services. Finally, the ICP recognises that there are pockets of need and deprivation that span Bolton and its neighbourhoods. These are communities who cross over or are within a neighbourhood which have complex health and social issues and where a different more targeted approach is required. Our delivery footprint enables us to work together with communities to address these inequalities. As the ICP moves forward this targeted approach will be tested and implemented.

4.4 Moving to the next phase: Developing our identity and form

Our partnership is currently constituted by a Partnership Agreement which has enabled us to develop relationships, begin coalescing delivery around our model of care and organise ourselves around a single vision and plan. However, to enable us to deliver our model of care and realise our ambitions the ICP Board considers that an Alliance is the best fit for Bolton because:

- **Working as one team in a place**: An Alliance enables us to bring together multiple providers to deliver one model of integrated health and care in neighbourhoods and in Bolton with single line management and one way of working. An Alliance model with a single leadership structure will give integrated leadership, direction and support to those neighbourhood leaders and to some services working to a footprint that spans the borough. It will also give valuable leadership capacity to the ICP ensuring a safe transition to the new way of working and giving assurance to the wider system.

- **Strong framework:** An Alliance and Alliance Agreement gives us a binding agreement which sets out accountabilities and responsibilities and the governance structure we will work to.

- **Autonomy and innovation**: An Alliance gives us the autonomy to act as one provider and begin to make tangible changes to planning and delivering care. An Alliance gives the ICP both the flexibility to work collaboratively on contracts and also adopt a lead provider model (the lead could potentially be any of the providers within the Alliance) where needed.

The remainder of this documents shares the plan for moving to the first phase of an Alliance and what we wish to achieve particularly in 2020/21.

5. Services in the Alliance in 2020/21

Bolton's ICS and ICP share the ambition of the Greater Manchester Health and Social Care Partnership that ICPs (or Local Care Organisations as they are sometimes known) are the principal means by which health and social care services within a locality are integrated and delivered in a financially and clinically (professionally) sustainable manner. This means that Bolton ICP's long term aim, in terms of its form as a delivery vehicle, is to ensure the inclusion of the large majority of services currently commissioned and provided to Bolton people as health and care services 'in scope' of the ICP.

The ICP is proposing to adopt a staged approach to transforming health and care including our neighbourhood model of care to ensure we can deliver a viable and sustainable model. However, a whole population and whole system approach will still be part of the emerging approach from the outset. Indicative phasing is summarised as follows:

- 2020/21: In our first year of delivering integrated services as a proposed ICP Alliance, we will be prioritising people with (or at risk of) complex needs. This will include vulnerable adults. This will be a place based approach, working with the VCSE, housing and the police and developing the neighbourhood model of working through the ICP. A significant part of developing the ICP in its first year as an Alliance, will be developing a new way of working at a leadership and operational level which focuses on putting what matters to people at the heart of our planning and delivery and ensures seamless delivery. This behaviour change piece is significant and will need to be a major focus of the ICP Alliance in its early stages. The form of the ICP will reflect this focus but, given the inherent flexibility of the proposed Alliance model, will still enable us to work collaboratively where required with wider providers, organisations, and services including children and families.

- 2021/22: We will build on the already close working with services and organisations supporting children and families to develop the first phase of an all age model of care. This will have a particular focus on integrating the 0-19 Healthy Child Service and Early Help approach working with Schools, Police and housing as part of the models of care through the ICP. We will review the membership and scope of the Alliance in 2021/22 to take account of this expanded scope.

- 2022/23: Further development of the model to ensure that we are moving to a more preventative model of care, stepping up closer working in planning and delivery with partners such as education, housing, criminal justice and welfare partners. We will review the membership and scope of the Alliance in 2022/23.

In order to enable delivery of the neighbourhood model of care in 2020/21 the ICP Board proposes that the following services are part of the integrated operations:

Integrated Operations Managing Director Section 75	Alliance Services in view

Council	Foundation Trust	GMMH	CCG	Other
• District Social Work & front door • Integrated Neighbourhood social care workforce • Independent Living services and equipment stores • Community Learning Disability Services • Safeguarding and DoLs • Social Care Provider services; Intermediate Care & Reablement • Mental Health Social Work • Brokerage and placement finding	• District Nursing • Integrated Neighbourhood community health workforce • Integrated Discharge Team • Intermediate Tier • IV therapy • Rehabilitation services • Specialist community services • Falls and community therapy • Treatment room services • Heath improvement services • Asylum and Vulnerable adults service	• Integrated Neighbourhood Mental health workforce • Community Mental Health Adult's and Older People Services • IAPT • AMHP Hub • Best & Active choices *GMMH led integrated partnership with Social Care statutory functions (Section 75 Agreement)	• Primary care development support	GMMH – community services e.g. RAID Single Point of Contact Achieve VCSE – (Social prescribing / community assets) GP federation – enhanced primary care workforce

Accountability and governance to parent organisations

Organisations and services which are part of integrated operations in in the first year of the Alliance will be led and managed by an integrated leadership structure. The ICP Board and management team will be responsible for decision making and monitoring of services. Statutory responsibilities and regulatory accountability will remain with the organisation which employs the staff. Staff will therefore remain employed by their existing organisation.

Subject to the approval to develop an Alliance, a Section 75 Agreement will be developed to ensure agreed operating arrangements between these parties. There may be specific instances in the future where further services are invited to join the integrated operations however this will be subject to the relevant parent organisations' agreement.

There will be services which will be strategically planned and coordinated by the ICP governance arrangements, with staff, managers and professional leaders being members of the ICP management team. Operational models developed by the ICP will often include these services. However, these services will not form part of the Section 75 Agreement arrangement and will be managed through existing arrangements.

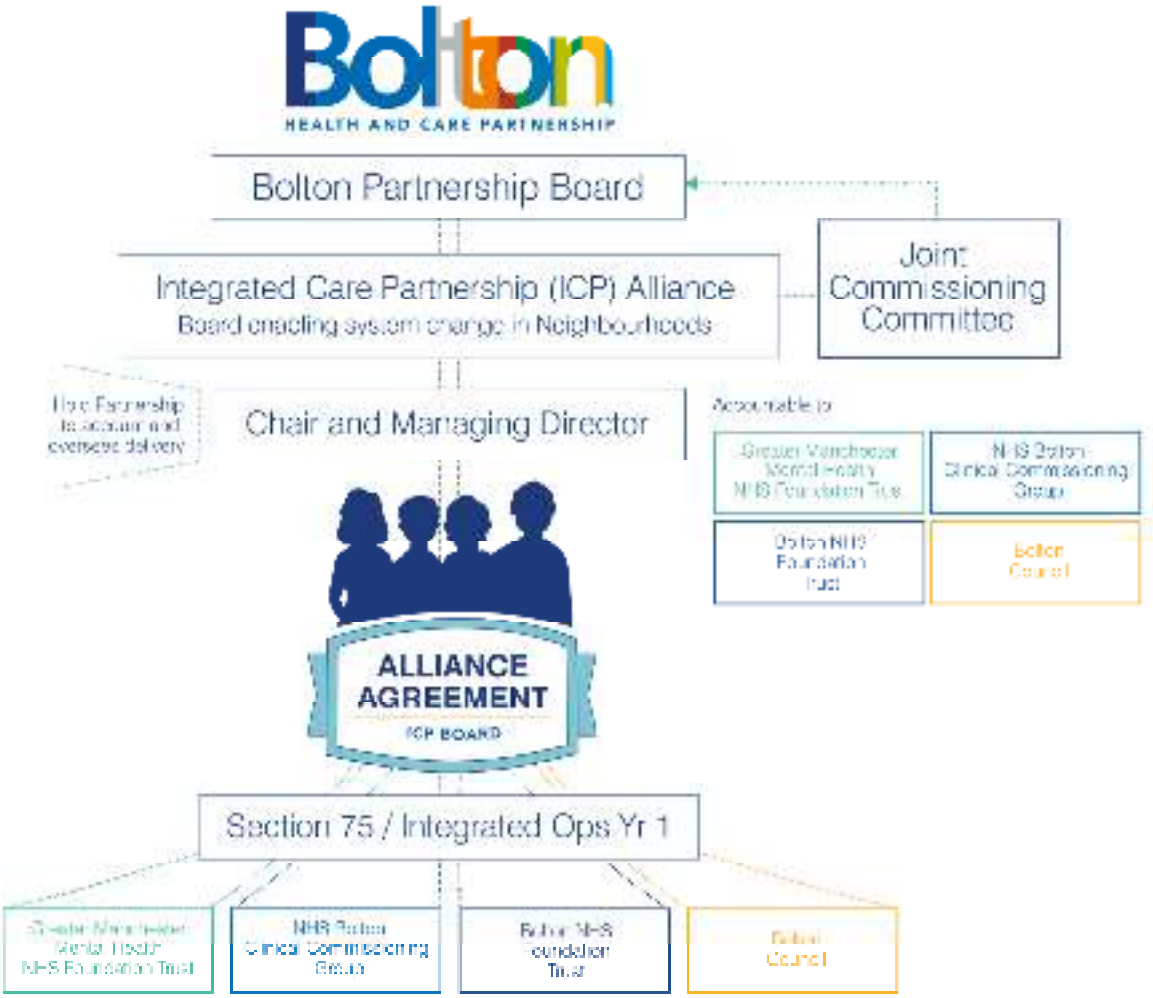
Critical to becoming a mature partnership, will be the sharing of skills and knowledge amongst Board members to deliver the best health and care for Bolton people. It will be essential to bring expertise in areas where the ICP's knowledge may need to be improved such as finance, governance and commercial insights. They will augment the knowledge of the Board enabling Board Directors to keep pace with the ICP's needs as it evolves, and new challenges arise.

There may be specific instances where services or organisations may be invited to join the ICP for key meetings or topics.

6. ICP Structure

Our structure starts with the 280,000 people we serve across Bolton and ensuring our form is fit for purpose and can, therefore, enable delivery of a sustainable model of care for Bolton people. Wherever possible we will deliver at nine neighbourhoods with populations of around 30-50,000 linked to Primary Care Networks.

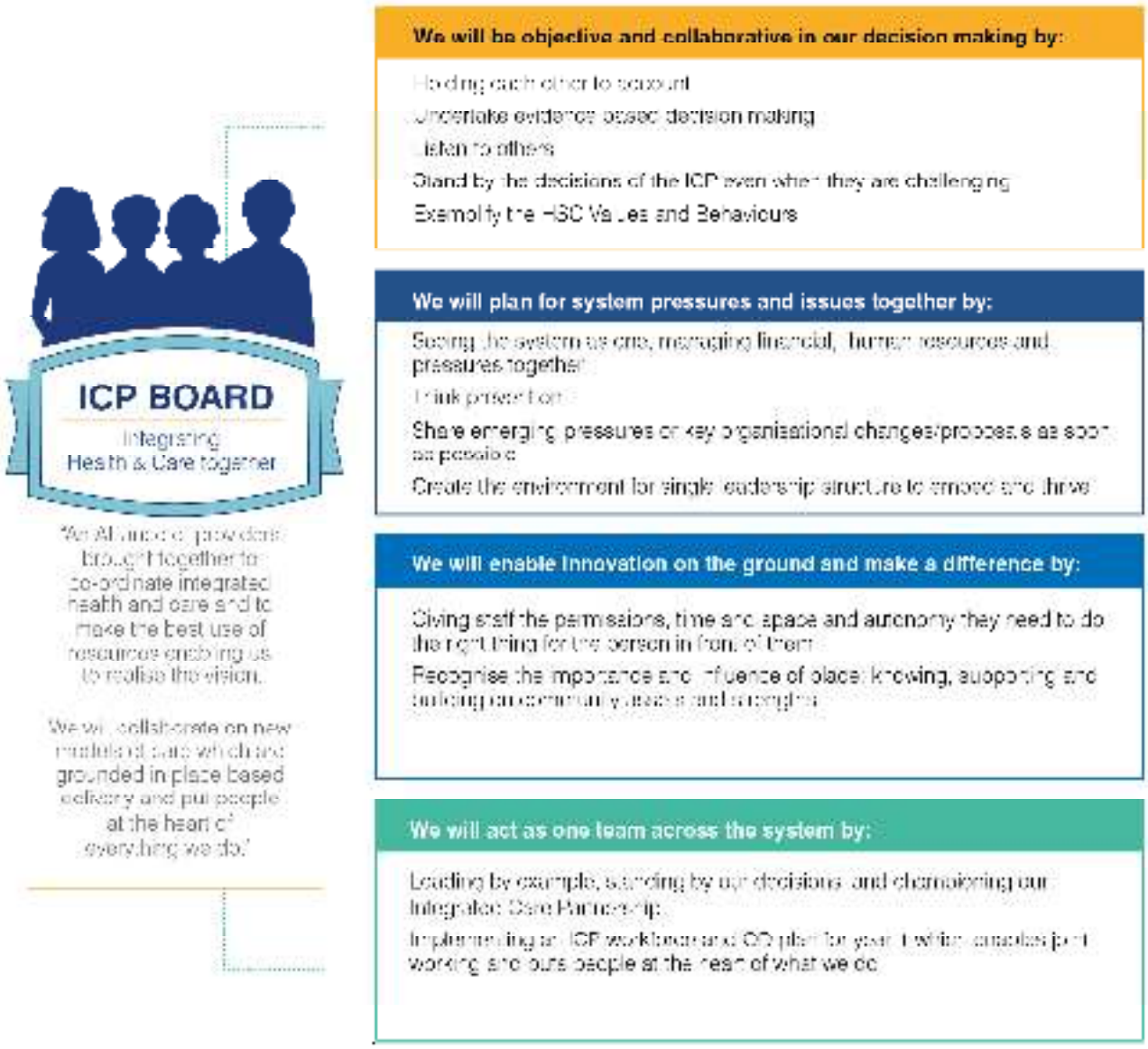
The governance for the Integrated Care Partnership is outlined below:



6.1 Governance

The ICP Board of Directors will drive integrated health and care services at a neighbourhood and Bolton level. It will ensure delivery of the outcomes set by commissioners via the Joint Commissioning Committee and national specifications. The Board will be focussed on enabling seamless delivery focussed on what matters to people, prevention and reduction of inequalities. It sets the conditions for integration to occur including fixing the barriers to collaboration and integration at a neighbourhood and management level. It will also have oversight of strategy, reviewing performance (including financial) and ensuring risks are identified and mitigated.

The principles we are working to are set out below:



All Board members will be equal and will contribute to ICP development and decision making. The ICP Board will operate and take decisions on a consensus basis.

This approach will support us to deliver our 2020/21 programme detailed at section 7 and will be further enabled by our integrated structure.

As detailed in Section 5 (Services in the Alliance in 2020/21), the ICP Board will include those services which will be led and managed by the integrated leadership structure and those which which will be strategically planned and co-ordinated by the ICP governance arrangements. It will also include advice and guidance on areas such as strategy and governance which will provide support to the ICP's development and good governance principles.

As part of the Board's development, we will further develop robust governance arrangements including corporate, clinical and professional governance in the first year. This will include developing a management and leadership structure at nine neighbourhoods which we anticipate will broadly reflect the structure outlined above (at a 'one level'). Supporting the ICP Board and its business will be a clinical and professional advisory group and Lived Experience Panel to ensure robust development and decision making.

It is proposed that an Independent Chair will be appointed who will facilitate the development of relationships within the ICP and across the broader Bolton partnership and into Greater Manchester. They will co-ordinate inspirational leadership and drive innovation. They will be accountable to the Bolton Partnership Board. A Managing Director will ensure the safe day to day running and oversight of operations including operationalization of service models, performance and finance. Both the Managing Director and Independent Chair, supported by Clinical Leads, will be responsible for overseeing the Alliance Agreement and its implementation. All ICP Board members will be accountable to the Independent Chair for their performance within the Partnership.

6.2 Legal Framework

This Business Plan outlines a new form, proposed as an Alliance, which will help us to deliver a new model of care. If approved, the ICP will develop a legal framework to support the integrated governance and management arrangements for services with clear accountabilities back to the employing organisations.

Approval of this plan will enable us to move to develop a mutually binding Alliance Agreement with Board Directors and the development of a Section 75 Agreement with GMMH, the Council, CCG and Foundation Trust. The proposed Alliance Agreement will include both the overarching governance and managements arrangements for the services included and the clinical/professional governance arrangements in place to ensure delivery of safe services. The proposed ICP Alliance and specifically the ICP Board with the Independent Chair and Managing Director will have oversight of the agreement.

The four organisations will deploy their staff into the ICP. The Section 75 will ensure integration of the Adult Social Care operations with Community and Mental Health services. This will allow better experience and improved outcomes for service users whilst also increasing efficiency across the system and ensuring effective population management.

7. Service Integration Programme

Bolton ICP has established a Service Integration Programme to run alongside the services which will be delivered by the ICP. This will enable us to transform our services to deliver in a new way which is rooted in communities and where people will be at the heart of everything we do, delivering against the Single Outcomes Framework.

The Service Integration Programme has 5 mobilising work streams and 6 enabling work streams which underpin key areas of work and activities to achieve the Bolton ICP vision. In our first year of delivering integrated services as a proposed ICP Alliance, we will be prioritising people with (or at risk of) complex needs. This will include vulnerable adults recognising their often complex social and health needs which need a whole system joined up approach at a neighbourhood level. These Programmes have been co-created with partners from across the system and are outlined in the table below: -

Our Transformation Programme - will set-out our priority activities for transformation	Our Enabling Programmes - will provide the appropriate support and infrastructure for the programme delivery:
• **Community Empowerment / Self-Care, Prevention and Early Intervention (proactive care)** we will support people to enjoy Healthy Lives in their communities. We will work with our partners to implement a social prescribing model • **Neighbourhood Model Development**: we will develop 9 neighbourhoods across Bolton (linked to PCNs) to deliver our Model of Care. • **Specialist Roles:** we will review specialist roles and develop capability of community services to create Enhanced Community based Services which support neighbourhood care • **Bolton Access to Care**; This will be an approach to a single point of access for people into Health and Care for enquiries, developing a culture across services of no wrong door. • **Intermediate Care** support people closer to home or in their community.	• **Finance:** we will work to integrate budgets where possible and move to integrated financial governance. • **Digital:** we will utilise the most appropriate digital technology to support the delivery of our vision. • **Workforce and Organisational Development:** we will work with colleagues and communities to ensure Bolton ICP has the people capability (capacity, competence and confidence) required to meet local population needs delivered through person-centred care • **Communication and Engagement:** we will work together to raise awareness of the work of the Bolton promote healthy lifestyles and involve residents in shaping local service provision by listening to, learning from and responding to their experiences. • **Performance and Intelligence:** we will enable the Bolton ICP to make full use of all information (Financial and Pathway) to achieve its overarching outcomes and goals. • **Estates:** develop an Estates Strategy for Bolton ICP • **Governance**: ensure that Bolton ICP is developed with a foundation of good governance.

These individual workstreams each have their own programme plans which are available on request.

8. Our Outcomes Framework

The ICP has been working as part of the Integrated Care System and Vision partners to develop a Single Outcomes Framework for Bolton recognising there is a need for one approach to transforming health and social outcomes for Bolton people. They set out the outcomes we want to achieve over the next decade. The outcomes framework will inform commissioning priorities and the performance management of the health and care system. However, it will also be used by wider partners such as the voluntary sector, housing, and police to measure their impact. These outcomes will be supported by a range of metrics and indicators and will be at the core of all aspects of the new health and care system. The Single Commissioning Function (SCF) will commission and hold to account the Integrated Care Partnership through this Framework. This work is currently in development.

The ICP is committed to measuring success based on the experiences of local people. We will therefore use the below 'I statements' to inform our approach and assess our impact.

Bolton people will start to say:

- Me and my family are listened to. I only have to tell my story once
- I am supported to understand my choices and achieve goals
- I feel more in control of my health and wellbeing
- I live the life I want to live to the best of my ability
- I'm more connected to what is happening in my community
- I know who is coordinating my care
- My carer/family have their needs recognised and are given support

Our workforce will say:

- We are beginning to operate as one team
- I understand what other staff and services do
- I understand what's happening in my neighbourhood
- We can make decisions at a local level and move resources around
- I can access my IT recording system remotely. There is a plan in place to share information across the system
- I promote the values and behaviours of the ICS and ICP

9. Workforce and OD Transformation

Promoting a new way of working, though service integration and greater coordination, requires a broad and deep process of organisational and people development. The Integrated Care Partnership is one team working for Bolton people. A particular focus of the proposed Alliance in its first year is developing multi-agency teams working in neighbourhoods to a single vision and operating principles that focuses on meeting the needs of people rather than organisational drivers. The emphasis in the planning and delivery of services will be working with and coproducing solutions with communities, enabling people to take care of themselves and identifying personal strengths rather than focusing on needs and deficits. This spans our frontline staff to our leaders. These will be embedded in the ICP recruitment and workforce development processes and are summarised in
our values and behaviours:

In our first year, we will develop an ICP Workforce and OD Plan, linked to the wider ICS approach which will support our ambition. To deliver a changed relationship between our citizens and staff we need to change the way we work. Our staff will be empowered to have a different conversation with local people. One that sees the whole person and puts them at the heart of everything we do. To do this, we are committed to creating the conditions including reviewing policy, practices, assessments and organisational form to allow staff to work in this new way. We will enable them to focus on prevention and early intervention supporting people to connect to their community. We will work
with Trade Unions, membership and professional bodies as we develop our approach.

10. Project Plan

Q4

- Single Outcomes Framework agreed
- Agreed process and job description for the Managing Director and Independent Chair
- Appointment of the Managing Director

Q1

- Phase 1 of neighbourhood teams in place
- Staff engagement events
- Appointment of Independent Chair
- Section 75 Agreement in Place
- Alliance Agreement in place
- ICP Communications and Engagement plan in place
- ICP OD plan linked to system OD plan in place
- Alignment of budgets to neighbourhoods
- Research and evaluation process agreed
- System Savings plan developed

Q2

- Workforce Development Plan agreed
- Next iteration of Neighbourhood teams
- Phase 2 of the Alliance planning process

Part C – Equality Impact Assessment for the Integrated Care Partnership developments

Equality Impact Assessment

Title of report or proposal:
Bolton Health and Care Integration - Integrated Care Partnership Developments

Directorate:	Health and Care Partnership: Report and EIA written by Council (People Dept) and Foundation Trust on behalf of the Integrated Care Partnership
Section:	
Date:	07/02/2020

Public sector bodies need to be able to evidence that they have given due regard to the impact and potential impact on all people with 'protected characteristics' in shaping policy, in delivering services, and in relation to their own employees.

Under the Equality Act 2010, the council has a general duty to have **due regard** to the need to:

1. **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
2. **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
3. **foster good relations** between people who share a protected characteristic and people who do not share it.

By completing the following questions the three parts of the equality duty will be consciously considered as part of the decision-making process.

Details of the outcome of the Equality Impact Assessment must also be included in the main body of the report.

1. **Describe in summary the aims, objectives and purpose of the proposal, including desired outcomes.**

This proposal set out in the report and Business Plan updates on the progress of Bolton's Integrated Care Partnership (ICP) and requests to progress developments for a provider Alliance Agreement as the vehicle for delivery of integrated care. The ICP will bring together primary care, community health, mental health services and adult social care with strong links to the voluntary and community sector, housing and Police. It will focus on delivering excellent joined up care, close to home and that responds to what matters to the person. Also proposed is an integrated leadership structure to support the delivery of the Alliance Partnership. This will be resourced from within the partnership and will be cost neutral over time.

2. **Is this a new policy / function / service or review of existing one?**

This proposal sets out the next phase of the existing Integrated Care Partnership between key health and care providers in Bolton. The Alliance and integrated leadership and operations are new proposals intended to support the Partnership to improve the joining up and quality of services for local people.

3. **Who are the main stakeholders in relation to the proposal?**

- Staff: in particular those staff who will be part of the integrated operations overseen by an integrated leadership structure as detailed in the ICP report and Business Plan (Council Adult Social Care, Foundation Trust Community Services, some GMMH services and CCG Primary Care Development)
- Trade Unions
- Bolton People – in particular those in receipt of health and care services
- Elected Members
- Providers and Commissioners of health and care services
- Wider partners including housing and police

4. **In summary, what are the anticipated (positive or negative) impacts of the proposal?**

- The move to an Alliance as the entity which delivers a new, joined up model of health care in Bolton, will enable people to get the right care at the right time for them and/or their family. Multiple health and care providers working to one single vision, in particular through the ICP's integrated operations and leadership described in the report, will reduce disjointed, fragmented delivery of health and care and instead will enable seamless delivery which focuses on what matter to the person.

- Staff who are working together will have clearer leadership arrangements as part of the proposed integrated operations and leadership structure. This will enable them to work more easily across organisational boundaries to support Bolton people with their needs.

- Recognising the importance that homes, families, communities and environment have on people's health, the Alliance will enable health and care providers to work closely with services such as housing and police to work together in the planning and delivery of services for the good of local people.

- The proposals enable joined up services and delivery in a time of constrained resources across providers of health and care making best use of limited resources and leading to more efficient delivery over time.

- While staff delivering health and care may experience changes to their working arrangements through closer joint working between disciplines and organisations, staff will remain employed by their current organisation.

5. What, if any, cumulative impact could the proposal have?

This is an impact that appears when you consider services or activities together. A change or activity in one area may create an impact somewhere else.

A key element of the Alliance will be providers working together to improve the quality of care and tackle demand and pressures on their services together. This, in turn, will help reduce the risk of this or future proposals having a negative or unintended impact on a particular organisation or service.

6. With regard to the stakeholders identified above and the diversity groups set out below:

Consider:

- How to avoid, reduce or minimise negative impact (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- How to **advance equality of opportunity.** This means considering the need to:
  - Remove or minimise disadvantages suffered by people with protected characteristics due to having that characteristic.
  - Take steps to meet the needs of people with protected characteristics that are different from people who do not have that characteristic
  - Encourage protected groups to participate in public life and in any other activity where participation is disproportionately low
- How to **foster good relations.** This means considering the need to:
  - Tackle prejudice; and
  - promote understanding between people who share a protected characteristic and others.

	If you are completing this form prior to consultation: Is there any potential for (positive or negative) differential impact? Could this lead to adverse impact and if so what? If you are completing this form following consultation: List any adverse impacts identified from data or engagement (Delete as appropriate)	**Can this adverse impact be justified on the grounds of promoting equality of opportunity for one group, or for any other reason? Please state why**	**Please detail what actions you will take to remedy any identified adverse impact i.e. actions to eliminate discrimination, advance equality of opportunity and foster good relations**
Race (this includes ethnic or national origins, colour or nationality, and caste, and includes refugees and migrants; and gypsies and travellers	No differential impacts are anticipated. The proposal is intended to benefit the whole population by making best use of limited resources and ensuring the ICP can effectively join up and improve health	N/a- no adverse impact anticipated.	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire to improve health and care delivery for

	and care services which are closer to people's home. The ICP and the move to an Alliance is focussed on improving the health and wellbeing of Bolton people responding to what matters to them. Staff who are part of the integrated operations, as set out in the Business Plan and report (some GMMH services, Council Adult Social Care Services, Foundation Trust Community Services and CCG Primary Care Development services), will experience changes to their working arrangements due to closer joint working but will remain employed by their existing organisation.		Bolton people including those with a protected characteristic. Staff will be updated on these proposals and will be involved in developing the ICP. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.
Religion or belief (this includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief)	See above points. No differential impacts are anticipated on any stakeholder including the public or staff	N/a- no adverse impact anticipated.	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire to improve health and care delivery for Bolton people including those with a protected characteristic. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.

Disability (a person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities)	No differential impacts are anticipated. The ICP as an Alliance will be working in partnership to deliver joined up health and care services. Many people in receipt of these services will have a disability. The proposal is designed to ensure that providers work closely together to improve the experience of people receiving support ensuring joined up services which respond to the needs of the person and what matters to them.	N/a- no adverse impact anticipated.	We anticipate benefits for Bolton people and in particular people in receipt of health and/or care services (who may have a disability) because the proposal is focussed on a single approach to delivery of health and care services focussed on driving better and more person centred care for Bolton people. Staff will be updated on these proposals and will be involved in developing the ICP. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.
Sex / Gender	No differential impacts are anticipated.	N/a- no adverse impact anticipated.	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire to improve health and care delivery for Bolton people including those with a protected characteristic. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.

Gender reassignment / Gender identity (a person who's deeply felt and individual experience of gender may not correspond to the sex assigned to them at birth, they may or may not propose to, start or complete a process to change their gender. A person does not need to be under medical supervision to be protected)	No differential impacts are anticipated.	N/a- no adverse impact anticipated	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire to improve health and care delivery for Bolton people including those with a protected characteristic. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.
Age (people of all ages)	No differential impacts are anticipated. The intention is for the ICP Alliance to deliver joined up care for all Bolton people. In its first year the Alliance will prioritise working more closely together to support people with (or at risk of) complex needs. This will include vulnerable adults whilst also making close links to children and family services. By the second year the Alliance will move to an all age model of care	N/a- no adverse impact anticipated	We anticipate benefits for Bolton people and in particular people in receipt of health and/or care services of any age due the focus on joining up the delivery of health care focussed on what matters to the person. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.

Sexual orientation - people who are lesbian, gay and bisexual.	No differential impacts are anticipated.	N/a- no adverse impact anticipated	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire, and informed by best practice, to improve the experience of people receiving health and care services in Bolton - ultimately improving their wellbeing. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.
Marriage and civil partnership (Only in relation to due regard to the need to eliminate discrimination)	No differential impacts are anticipated.	N/a- no adverse impact anticipated	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. These proposals are driven by the desire, and informed by best practice, to improve the experience of people receiving health and care services in Bolton - ultimately improving their wellbeing. While staff may see some changes to the way in which they work through closer joint working, in particular those who are part of the ICP integrated operations and leadership structure, staff will remain employed by their current organisation.

Caring status (including pregnancy & maternity)	No differential impacts are anticipated. People in receipt of or caring for someone in receipt of services should benefit from these proposals. It is anticipated that by providers working more closely together through an Alliance and an integrated leadership and operations structure, this will reduce the potential for fragmented delivery of services for individuals and their families and/or carers.	N/a- no adverse impact anticipated	We anticipate benefits for Bolton people and in particular people in receipt of health and/or care services who may be a carer or be supported by a carer because the proposal is focussed on a single approach to delivery of health and care services driving better and more person centred care for Bolton people.
Socio-economic	No differential impacts are anticipated. on stakeholders including the public or staff	N/a- no adverse impact anticipated	There are no negative effects anticipated by these proposals for Bolton people including those with protected characteristics. See above sections.
Other comments or issues.	Approval of the ICP report and Business Plan will enable the partnership to develop a mutually binding Alliance Legal Agreement, and the development of a Section 75 Agreement between the organisations deploying staff into the integrated operational directorate. The proposed Alliance Agreement will include both the overarching governance and managements arrangements for the services included and the clinical/professional governance arrangements in place to ensure delivery of safe services. The proposed ICP Alliance and specifically the ICP Board with the Independent Chair and Managing Director will have oversight of the agreement. The organisations who deploy their staff into the ICP will also sign up to a Section 75 Agreement that will ensure integration of the Adult Social Care operations, Community Health services, some Mental Health services and Primary Care support development from the CCG. It will set out the governance and accountabilities back to the parent organisations. Staff affected by these proposals will remain employed by their parent organisation, there will be no implications for staff terms and conditions. The proposals set out integrated leadership and management arrangements that will be supported by a S75 legal agreement, and replicate existing integrated arrangements in operational services		

Please provide a list of the evidence used to inform this EIA, such as the results of consultation or other engagement, service take-up, service monitoring, surveys, stakeholder comments and complaints where appropriate.	• Best practice regarding the leadership and delivery of integrated health and care including examples from across Greater Manchester localities. • Existing evidence showing what matters to Bolton people when receiving health and care services. • Ongoing feedback and engagement from health and care staff including ICP staff events.

This EIA form and report has been checked and countersigned by the Directorate Equalities Officer before proceeding to Executive Cabinet Member(s)

Please confirm the outcome of this EIA:

No major impact identified, therefore no major changes required – proceed	x
Adjustments to remove barriers / promote equality (mitigate impact) have been identified – proceed	
Positive impact for one or more groups justified on the grounds of promoting equality - proceed	
Continue despite having identified potential for adverse impact/missed opportunities for promoting equality – this requires a strong justification	
The EIA identifies actual or potential unlawful discrimination - stop and rethink	

Report Officer

Name:	Kate Smith, Health and Care Transformation Programme Manager
Date:	07/02/20

Directorate Equalities Lead Officer

Name:	Donna Cooper
Date:	10/02/20

Agenda Item No:	
Meeting:	Board of Directors
Date:	27th February 2020

NHS Bolton NHS Foundation Trust

Title:	Research & Development Position Statement
Purpose	Further to a Exec/Non-Exec walk around in December 2019, to outline the R&D position to the Board of Directors ahead of receiving a full R&D annual report 2019/20 in July 2020
Executive Summary:	• R&D at Bolton NHS Foundation Trust is a cost neutral, reputation enhancing activity • R&D at Bolton NHS Foundation Trust needs to be viewed in the wider context of R&D in GM and beyond in order to create an ambitious and realistic strategic vision for R&D
Previously considered by:	In principle at the R&D Committee
Recommendation Please state if approval required or if for information	• The Board of Directors will receive an annual R&D report for the period 2019/20 later in the year (July 2020), there should at this time be an opportunity for the Board to consider the long term direction of travel for R&D in the organisation • The Board of Directors to consider commissioning PwC to undertake a review of the R&D function with focus on exploring effectiveness and efficiency of the existing model and the feasibility of cost neutral (or costs consumed within growth) expansion as an addition to the 2020/21 PwC Audit Plan – allowing for an impartial assessment of the current R&D function and future opportunities given the national direction of travel with a focus on in-patient facilities in University Teaching Hospitals. This report can then inform the Board of Directors discussion in July 2020

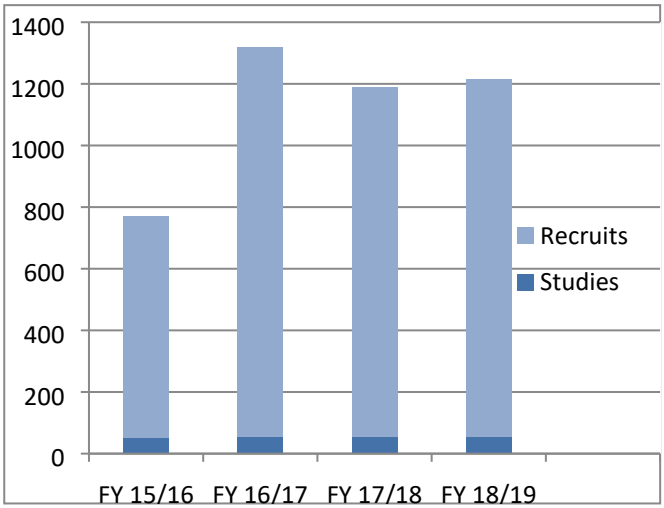
Confidential y/n	n

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*	✓
Negative Impact	**Neutral Impact**	**Positive Impact**	

Prepared by:	Alison Loftus, R&D Manager Richard Sachs, Director of QG Francis Andrews, Medical Director	**Presented by:**	Francis Andrews, Medical Director

Research and Development

Research activity across the Trust has remained consistent over the past 4 years, with NIHR Targets for recruitment to portfolio studies met year on year. Our research portfolio balances a good mix of interventional and observational studies across key research active areas.



	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Studies	52	56	57	55
Recruits	718	1264	1133	1159

Background

The primary function of the Research Department is to support the delivery of high quality research studies on the NIHR Portfolio, to improve patient health and NHS services. The department works in partnership with NIHR Clinical Research Network (CRN) GM, who provides funding, training and practical support for the delivery of research across Greater Manchester.

Department Structure

The Research Department is a centralised clinical research support team combined with an R&D function which manages the feasibility, set-up, safety and effectiveness of all research activity undertaken. Divisional Research leads (clinical) provide a link between the Research Department and the Trust Divisions, supporting research activity across their clinical areas.

Research is supported at by the Deputy Medical Director who acts as chair to the Research Committee and the Medical Director represents the Trust at NIHR CRNGM Partnership board.

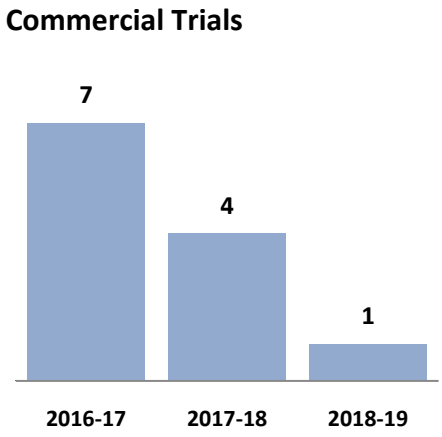
Core Staffing Establishment / Funding

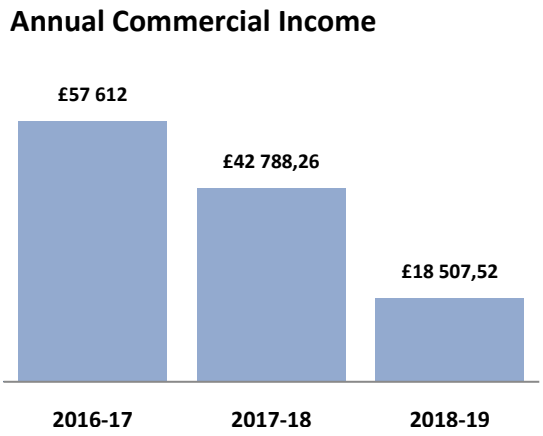
The Research Department is cost neutral to the Trust at present with all staff and resources funded from external sources. Bolton NHS Foundation Trust is allocated an annual budget to support clinical research staff and support services though NIHR CRN GM. It also receives a block allocation of funding to enable the provision of research activity over and above standard care by our support departments. The NIHR CRN fund clinical/patient facing staff and support functions, however do not allocate any funding for the R&D Function.

Commercial Research / Income

Commercial research is increasingly becoming more complex with industry looking for sites able to deliver more complex, lower phase trials. As a Trust it is increasingly difficult to attract new commercial research due to lack of required facilities and research support including: 24 hour consultant care, a dedicated research facility, a staff model and equipment to deliver this type of research activity.

The Trust has seen a decrease in research income over the past 3 years due to an inability to explore commercial opportunities, impacting on our available resources to support further activity. The department is currently reliant on income from commercial research to fund the Trust R&D Function and to fund additional research support staff where costs are not met by the CRN Funding allocation.





Research activity at Bolton NHS FT

Research activity has remained stable over the past 4 years, with NIHR targets for recruitment at the Trust met consistently. Through increased visibility and engagement across the Divisions we have seen an increase in the number of specialty areas involved in delivering research.
In 2018/19 the Trust recruited 1116 Patients into 54 Portfolio Studies across 16 specialties.

Research Ambition

It is the Trust ambition, to maintain an active R&D profile, to continuously improve the quality and quantity of clinical research over the next five years, and embed a culture of research excellence as an essential and valued part of what we do.

Benefits to Organisation

- Improved quality and safety of healthcare
- Improved patient outcomes and experience
- Improved career development opportunities for staff
- Increased clinical knowledge and insight into new healthcare discoveries
- Patient access to new treatments and care pathways
- More cost effective treatments / Economic benefits
- Reduce treatment times / costs
- Income generation from commercial research

Current Challenges

- Research team working to full capacity. Increasingly finding it difficult to support additional research activity and enable growth of our portfolio. Currently taking on research projects on a one out, one in basis
- Our clinical teams are lacking the capacity to support the required trial activity
- Difficulty identifying PI/Clinical leads for new research – no time in consultant job plans
- Difficulty engaging specialties in research activity due to lack of research culture
- Difficulty engaging staff to complete required research training
- Lack of resource/time within support departments to facilitate research support activity e.g additional scans / blood tests
- Lack of dedicated finance support for research.

What we want to do

- Enable access to Research for ALL patients
- Embed a culture of research excellence throughout the Trust
- Increase research visibility across all areas.
- Empowering staff to promote and participate in research delivery.
- Provide our clinical teams with access to the latest research opportunities
- Support the development of staff to ensure the skills and capacity to lead
- Promote the Trust as a research active organisation.

R&D future options

Do nothing – Aim to maintain current levels of research activity within key areas:

- Without further resource to attract industry trials the Trust would see a decrease in commercial income, leading to loss of funding for the R&D department and the additional research staff required to maintain current levels of activity
- A reduction to our research team establishment would mean increased difficulty in committing to new research opportunities due to the lack of resource
- As trials become more complex and require more dedicated clinical support and advanced tests, the Trust face falling behind, due a lack of dedicated research resource across the clinical teams and support departments.

Explore new collaborations - Seek out opportunities to collaborate with other research active organisations:

- Increased engagement with our local community, partner organisations, academia and industry could provide opportunities for funding and expertise to support and grow our research capability
- Aligning with the development of the new educational campus on site, the Trust could build opportunity for joint projects / research fellowship posts / shared knowledge and expertise

- Collaborative working could enable access to the resource needed to develop home grown research and put Bolton NHS FT Trust on the map as a centre of research excellence.

Invest/Increase Capacity - Increase capacity within clinical areas to build research into everyday practice within the context of the national direction of travel with R&D in the NHS:

- Increasing funding and resource for Research would enable the Trust to expand its research activity, ensure safe and effective management of trials and enable the Trust to tap into new markets, developing new commercial opportunities.
- Investment into additional resources and time dedicated to research would provide increased support for a change in culture – where Research is seen as part and parcel of what we do, not an add on. This would include:
    - Research time included in Consultant job plans.
    - Research time built into Medical / Surgical trainee posts.
    - Expansion of research posts across the Nursing and AHP workforce with the introduction of research link roles.
    - Trust funded R&D Department ensuring all our research activity is feasible, safe, ethical and effective.
    - Dedicated Finance support for research.
    - GCP Training accessible / mandatory for all key clinical staff / trainees to ensure research readiness across the Divisions.
    - A dedicated research facility for staff and patients, which is fit for purpose and provides a suitable work / clinical environment.

Recommendations

- The Board of Directors will receive an annual R&D report for the period 2019/20 later in the year (July), there should at this time be an opportunity for the Board to consider the long term direction of travel for R&D in the organisation
- The Board of Directors to consider commissioning PwC to undertake a review of the R&D function with focus on exploring effectiveness and efficiency of the existing model and the feasibility of cost neutral (or costs consumed within growth) expansion as an addition to the 2020/21 PwC Audit Plan – allowing for an impartial assessment of the current R&D function and future opportunities given the national direction of travel with a focus on in-patient facilities in University Teaching Hospitals. This report can then inform the Board of Directors discussion in July 2020.