Location: Boardroom   **Time: 0900**

Time		Topic	Lead	Process	Expected Outcome
09.00		Patient Story (acute adult division)	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 19 December 2019	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 Report	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 15 January 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 - 21 January 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 escalate any items of concern to the Board
10.15	12.	Six monthly nurse staffing report	DoN	Report	To receive for assurance
10:30	13.	Learning From Deaths Quarterly Report	Medical Director	Report	To receive and note
10:50 Coffee					

Time		Topic	Lead	Process	Expected Outcome
11:10	14.	Introduction of new performance report	Julie Ryan	Presentation	To note
11:25	15.	Integrated Performance Report	Exec team	Report	To receive for information
Governance					
11.55	16.	Scheme of Delegation	Director of Finance	Report	To approve
	17.	Any other business			
Questions from Members of the Public					
	18.	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					
12:00	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	19 December 2019	
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
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
Mr A Thornton	Non-Executive Director	AT
Mrs A Walker	Director of Finance	AW

In attendance: -

Mrs E Steel	Trust Secretary	ES

Apologies

Declarations of Interest

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

Patient Story

G attended to provide the story of her daughter's involvement with the services from the age of three when challenges including difficulties with learning were identified. G told of challenges navigating a complex system including multiple appointments and the need for a clear joined up approach ideally with an identified lead to support the family with a holistic approach.

Board members thanked G for her clearly articulated story and agreed the importance of a strong advocate for children and families to help support and understand the journey and develop a clear personal plan.

FT/19/83	video to share learning opportunity from family experience
FT/19/84	report back on the offer for children with special needs

4.   Minutes of The Board Of Directors Meetings held 28 November 2019

The minutes of the meetings held on 28 November 2019 were approved as a true and accurate reflection of the meeting.

5.   Action Sheet

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

6.   Matters Arising

There were no matters arising.

7.   Chair's Report

The Chair welcomed Board members and attendees with a special mention for Mrs Forshaw in attendance as Interim Director of Nursing following the move of the previous Director of Nursing to take up a Chief Executive post.

Following two days of interviews and assessment centre exercises the Remuneration Committee would be convening after the Board meeting to discuss the appointment of a new Chief Executive to take over from Dr Bene at the end of March 2020.

8.   Chief Executive report

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

Board Assurance Framework

Board members discussed the financial risk and while it was agreed that the current position presents a significant challenge the risk of achieving the longer term financial plan was potentially less challenging – agreed to discuss further within Finance and Investment Committee to agree risk score

Resolved: the board noted the CEO update.

9.   Urgent Care Delivery Board – Chair report and seasonal plan update

The Chief Operating Officer presented the Chair report from the Urgent Care Delivery Board and an update on the recent business continuity incident and recovery.

The Urgent Care delivery Board had discussed the recent incident in detail and agreed actions to review streaming options and to look at options to increase community capacity. In the run up to the business continuity incident on Monday 16th December performance had been in line with recent weeks however following a weekend with increased attendances and admissions the week started with a full ED department and similar pressures across GM. The level of pressure in the system triggered a business continuity incident with actions taken including the cancellation of elective work, expedited discharge and consultants working at the front door of ED for early review and identification of alternative treatment where appropriate.

There was a good system response to the incident with GPs providing support in ED and community and social care services providing support for early discharges. Although the pressure in the system remains a challenge there has been a good recovery and the Trust remains mid table for performance. The incident, response and recovery were discussed in detail in the QA Committee meeting on 18 December; the QA Committee have requested an update to provide assurance on the on-going effectiveness of system actions.

Non-Executive Directors recognised the work to respond to the challenge and achieve recovery in a short period of time and asked if on reflection there were any actions taken that could be implemented as a new normal. The COO advised that although there were always lessons to learn the activity undertaken as part of the continuity incident could not be sustained.

Board members discussed indications of potential additional funding and how this could be used in both the short and medium term to facilitate transformation and achieve the headroom to move forwards. The Director of Finance reminded Board members that with the Trust currently forecasting a deficit additional funding would cover the coasts of activity already being undertaken potentially making day to day operations less challenging.

Board members discussed the need to think differently across the system and address changing demand using digital services where possible to build a connected system to manage and support service users.

Resolved: the board asked for a formal note of thanks to all staff.

10   Admissions Avoidance

Jo Street Divisional Director of Operations for Intermediate Care Services and Jenifer Sharples Operational Manager Intermediate Tier Services attended to deliver a presentation on admissions avoidance and home first – a collection of deflection schemes run in partnership with other agencies within Bolton to deliver an integrated crisis response pathway targeting 600 and now achieving deflections per month.

Board members discussed the impact of the initiatives with reduced ambulance attendances, reduced admissions for over 65s and reduced admissions from care homes achieved through a proactive approach which results in better patient experience.

Resolved – Board members thanked the team for their presentation and their continued work to provide care for the Bolton population.

11   Quality Assurance Committee Chair Report

Mr Thornton, the NED Chair of the Quality Assurance Committee presented a verbal report from the meeting held on 18 December 2019.

As previously referred to the Committee had spent time discussing the impact of the Business Continuity Incident and would be receiving an update in February to provide assurance that appropriate actions had been taken.

The Committee received the quarterly divisional reports from the Elective Care and Family Care divisions – while these continued to provide assurance both of the quality of care and the open culture within the Trust attendees noted a potential theme of incidents/complaints linked to attitude which would be discussed further within the PEIP committee.

The Committee approved the final SI reports from three recent incidents, extensive action plans had been agreed for each incident and the committee were assured that appropriate action was being taken to prevent future incidents.

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

12   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 17 December 2019. Although the meeting had not been quorate, there was good quality discussion on the current financial performance and future financial challenges.

Board members discussed the report included within the Board pack and the financial position to the end of month 8 excluding PSF which is a deficit of £9.4m against a deficit plan of £3.7m. The main reasons for the shortfall continue to be income shortfall, overspend on pay and underachievement of ICIP.

Board members asked for further information on pay pressures and specifically if this was a trust wide challenge or if some areas were under more pressure than others. The Director of Finance advised that the Family Care Division have the largest overspend on rotas although agency expenditure is now under control; the Director of Workforce advised that he would be attending the next meeting to support triangulation of the head count, agency and playbill expenditure and ICIP plans.

Board members discussed the importance of balancing planned and actual activity, the impact of the aligned incentive contract and the importance of depth of coding to ensure accurate contracting in future years.

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

13   Any other business

No other business

14.   <u>**Questions from members of the public**</u>

<u>**Date and Time of Next Meeting**</u>

19 December 2019

December 28 2019 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/81	28/11/2019	EDI report	Comms to work with EDI to develop summary report of key messages for communication	KS	Jan-20	verbal update -
FT/19/86	19/12/2019	Urgent Care Board	update on approach to population flu immunisation	MF	Jan-20	verbal update
FT/19/63	03/10/2019	Urgent Care Board	update on system working	JB	Jan-20	agenda item
FT/19/67	03/10/2019	Workforce strategy update	JM to share staff pledges with Board members	JM	Jan-20	verbal update - work on-going, for Board when complete
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	included in chair report
FT/19/70	31/10/2019	Workforce Assurance Committee	GoEngage results to be presented to Board	JM	Jan-20	through WAC chair report - full report on NHS Staff survey March 2020 - complete
FT/19/71	31/10/2019	Urgent and Emergency Care Board	PEIP Committee to consider process for patient engagement and feedback in neighbourhood services	MF/SM	Jan-20	complete - Jo Dorsman and Lynne to go to Patient Participation Group to talk about engagement in neighbourhoods
FT/19/80	28/11/2019	Workforce Assurance Committee	update on plan for Workforce of the future including triangulation of agency, pay and recruitment metrics	JM	Jan-20	F and I chair report - action complete
FT/19/65	03/10/2019	performance report	update on outpatient improvement plan including action to reduce DNA	SM	Feb-20	
FT/19/38	27/06/2019	Seven Day services	Verbal update on benchmarking, written update in six months	FA	Feb-20	
FT/19/64	03/10/2019	performance report	Mortality update	FA	Feb-20	
FT/19/36	27/06/2019	Urgent Care Board	System wide discussion/report on mental health including proactive approach	AE	Apr-20	verbal update on approach to mental health patients to January QA committee written report for April
FT/19/51	25/07/2019	sustainability	update on work of the sustainability group	AE	Feb-20	
FT/19/62	03/10/2019	Shadow Board	Report through Workforce Assurance Committee on the Shadow Board programme	JM	Feb-20	
FT/19/73	31/10/2019	performance report	update to QA committee on Breast waiting times	AE	Feb-20	
FT/19/77	28/11/2019	CEO report	Review of risk appetite	ES	Feb-20	
FT/19/84	19/12/2019	patient story	report back on the offer for children with special needs	MF	Feb-20	
FT/19/83	19/12/2019	patient story	video to share learning opportunity from family experience	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/19/89	19/12/2019	future strategy	update on research opportunities	MF	Mar-20	
FT/19/75	28/11/2019	patient story - Admiral Nurse	Follow up report on dementia care and closing the gap to be included within next dementia update to the QA Committee	MF	Apr-20	
FT/19/78	28/11/2019	F and I Report	update on EPR implementation	AE	Apr-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:	30 January 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
	
	    o Coroner communications
	
	    o Never events
	
	    o SIs
	
	    o 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**

Internal

Employee of the Month – Rebecca Philpot - Becky goes beyond her job requirements by offering support to other members of the team when specialist advice and skills are required to support complex discharges which involve moving and handling equipment.

Team of the Month – Surgery and Critical Care Therapy team – For their person centred post-operative approach to a seriously ill vulnerable person.

2.   **News and Developments**

2.1   **EU Exit**

Following the general election and subsequent acceptance of the EU Exit bill, the NHS has stood down all formal E.U. exit no deal planning

It has been formally recognised and praised by the present govt. that the NHS was one of the most prepared organisations for a potential no deal scenario, against an additional background of severe operational pressures.

From the 31 Jan 2020 the UK will start an implementation process to finalise arrangements in time for the formal / actual exit to be completed on 31 Dec 2020.

The govt. is confident that within this period arrangements will be completed and agreed by the E.U. and as a result has stood down the "Yellow Hammer" No deal contingency Plan.

- Any NHS staff seconded into a role dealing exclusively with EU exit matters should be released to their usual roles
- No further EU Exit related spending should be undertaken. (any costs to date should be archived)
- NHS Provider and commissioner organisations should return to "business as usual" but retain their "Organisational memory" of personnel and arrangements to date.
- A single point of contact mechanism will be maintained for each organisation. (Probably via a monthly generic e-mail response)

We were informed that a full briefing will be circulated in due course by NHSE/I

2.2   **NHSI/E Visit**

On January 22nd the Trust hosted a visit from Prerana Issar the NHSIE Chief People Officer and Hugh McCaughey the NHSIE National Director of Improvement. Prerana and Hugh met with a number of teams in acute and community settings. We showcased the work we have been doing on our EDI agenda and discussed integration and system leadership.

2.4   **Partnership working**

An update will be provided in our Part Two Board meeting covering GM and Bolton partnership working

2.5   **Handover to new CEO**

Fiona Noden currently the COO and Deputy CEO at The Christie has been appointed to succeed me when I leave the Trust at the end of March. Fiona and I will be meeting on a regular basis to ensure a smooth transition.

Appointment of a new Director of Nursing

We have started the process to appoint a new Director of Nursing, the interviews for this important post will be held on March 24th and 25th 2020.

3.0   **Reportable Issues Log**

Issues occurring between 20/11/19 and 12/12/19

3.1   **Serious Incidents and Never events**

We have reported six serious incidents since our last Board meeting, three relate to maternity and neonatal incidents, two to corporate incidents and one an infection control case. These incidents will be investigated in line with our policy and reported in full to the QA Committee on the completion of the investigation.

3.2   **Red Complaints** –

There have been no red complaints reported since our last Board meeting

3.3   **Regulation 28 Reports –** no new concerns from coroner reports

3.4   **Whistleblowing**

3.5   **Media Coverage**

- Appointment of new Chief Executive – local media and HSJ (also reach of 37,811 via twitter)
- OBE for Consultant Physiotherapist Dr Sue Greenhalgh – local media and specialist press
- Coverage of EPR implementation in numerous specialist media outlets
- Operation Save Christmas – maternity staff arranged for family of pregnant woman to join her in hospital at Christmas
- Christmas and New Year babies and Christmas meals for inpatients
- Visits by Father Christmas and Bolton Wanderers
- Music group for people with dementia and their carers
- Prestigious Nightingale scholarship for matron Antony Makepeace
- Planning application to extend pathology department
- Hospital to have ANPR
- Winter pressures
- Missed waiting time target in breast
- Criticism of care of woman whose baby was stillborn
- Phone problems.

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 was reviewed in detail within the November Audit Committee; changes since the December Board are shown in red.

5   **Management of Clinical waste Across the Healthcare Sector**

In response to an enquiry regarding the management of Clinical waste from NHS estates, the Trust can confirm:

The management of clinical waste for the Trust is compliant and managed through SRCL, IFM are continually taking further steps to improve better practice to along with environmental standards by implementing coloured bags to segregate waste in site which will be rolled out this financial year in preparation for a site inspection in the next year.

Ambition	Lead	I	L	Jan	Dec	Nov	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 Development of a robust Quality Improvement approach 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 Finalise Learning from Deaths Policy 02/01/2020 – instigated procurement/tendering process for peer benchmarked mortality intelligence (current contract ends September 2020) 27/12/2019 – literature search commissioned for peer reviewed articles focused on addressing raised mortality – due 31/01/2020	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	IPM Workforce committee

						Risk	Controls	Assurance
To use our spend our money wisely Financial sustainability	AW		4	4	16 16 16	Delivery of ICIPs In year cost pressures Agency cost pressures Income/contracting risk Commissioning decisions Transformation funding Cash flow iFM performance System wide savings Loss of PSF	PMO and ICIP escalation meetings IPM meetings Integrated Care partnership development Actions to address agency pressures PBR/income review Develop links with specialist commissioners Development of joint budgets within local system Review of costs and income (patient level costing) iFM development including strategy and business plan System wide savings governance	F&I committee Board IPM Transformation Board ICIP escalation
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 Development of an OD Framework to support cultural change Development of a system approach to community engagement.	Strategy / Transformation Board QA Board
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

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	15 January 2020	Date of next meeting:	19 February 2020
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	D Hall, J Bene, M Brown, A Ennis, F Andrews, M Forshaw, E Steel, R Sachs. Representation from the five clinical divisions D Sankey	Quorate (Yes/No):	Yes
		Key Members not present:	J Njoroge

Key Agenda Items:	RAG	Key Points	Action/decision
Patient story	🟩	The Acute Adult Division shared a story of a patient who although currently an inpatient under the care of haematology had experienced recent care in A&E and on the orthopaedic wards. The patient who initially attended with what was thought to be an acute spine injury was subsequently diagnosed with Myeloma and has since had further treatment including surgery. In telling her story to the Deputy DND the patient stressed the importance of staff listening and the impact it could have when staff really took the time to listen. Staff realised how much the lady was missing her dog and made arrangements for her pet to visit her on the ward.	Story noted, although the lady painted a mixed picture of care actions had been identified and addressed
Clinical Governance and Quality Committee chair report	🟧	Chair report from Clinical Governance Committee included a number of areas assessed as red or amber in terms of assurance. The Committee received and update of the Never Event Assurance Framework and noted that alerts for IV therapy training and NG tube insertion remained outstanding The Trust remains an outlier in mortality Diabetes steering group report noted – this will become a monthly report to ensure oversight of actions.	Actions identified to address outstanding alerts Further work required to understand position and address.

🟥	No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key
🟧	Moderate assurance – potential moderate impact on quality, operational or financial performance	to identify the level of assurance/risk to the Trust
🟩	Assured – no or minor impact on quality, operational or financial performance	

Committee/Group Chair's Report

Acute Adult Care divisional quality report	■	The comprehensive quarterly report included the achievements and challenges for the division in Q 2. QA Committee members commended the openness within the report and noted that it was good to see a reduction in contaminants – previously flagged through this report	Report noted
Integrated Care Divisional quality report	■	Quarterly report presented to provide a picture of successes and challenges within the division. QA Committee members welcomed the report and noted the significant improvements made over the previous two years. Discussions focused on actions in relation to diabetes care and in particular care of the diabetic foot with recognition that discussion was needed with commissioners to provision of a service to meet patients' needs	Report noted – no actions required
Quality Account - Diabetes	■	Update provided on progress against the Quality Account priority for diabetes – some concern expressed about progress made with discussion focusing on the actions needed to ensure the Trust continues to do the right thing for patients with diabetes.	Report noted – update requested in March 2020
Care of patients with mental health issues in A&E	■	Verbal update provided – additional capacity in mental health services has reduced long waits for ED patients attending with acute mental health episodes. Some work still required to develop team approach	Update to be provided in four months
Bowel cancer	■	Update provided on performance against the metrics to monitor bowel cancer screening including uptake, results and waiting times. Although the service has retained its JAG accreditation limited capacity has had an impact on the 14 day target – it is hoped that recent improvement to clinical	Report to remain quarterly until assured that capacity issues addressed

■ No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
■ Moderate assurance – potential moderate impact on quality, operational or financial performance	
■ Assured – no or minor impact on quality, operational or financial performance	

	🟧	capacity will reduce waiting times. Committee members also discussed uptake of screening after positive test.	
Quality Account 19/20 governance arrangements and selection of 20/21 priorities		Committee members reviewed the proposed priorities but agreed that the focus should continue to be on priorities agreed for 19/20	Final approval of priorities in February, timescale noted for publication of report within annual report at the end of May
Mortality Committee	🟥	SHMI remains high, some issues with Wi-Fi and EPR impacting on functionality of e-obs and data collection Work is on-going with the clinical coding team to pneumonia cases	Report noted, including escalation of EPR associated issues which will be discussed further with IT
Comments			
Risks Escalated –			

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

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

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee		Report to:	Trust Board
Date of Meeting:	December, 2019		Date of next meeting:	February, 2020 (January cancelled - in line with Winter pressures / planning)
Chair:	J Bene		Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, F Andrews, A Ennis , M Foreshaw, C Sheard, L Gammack , A Chilton and all the clinical divisions present		Quorate (Yes/No):	Yes
			Key Members not present:	E Steele

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce & OD Dashboard	🟩	• The Committee received the Integrated Workforce Performance Report. The report triangulated key workforce data to support informed discussions. • Members positively noted that the in-month Agency spend continues to be below the Trust's forecast and the NHSI forecast. • Workforce & OD metrics positive with the exception of sickness management (albeit in-month improvement). Detailed discussion took place on all the pro-active and reactive actions being taken. • Dashboard included updates on turnover rates which remain positive and better than national average.	**Actions agreed:-** • Noted that update on the Health & Wellbeing Strategy to be provided to the January (now February) Committee.
HCA Health & Wellbeing Update	🟧	• The Committee noted the range of measures that have been put in place since the HCA event in the summer. Such as:- Caring for Yourself Programme, Review of the Sickness Management Policy, Special leave provisions, Menopause friendly Trust, Staff resilience and wellbeing App, Improving rest facilities for staff, Review of the Trust's recognition approach. That said concern remains that this is the staffing group with significantly the highest level of sickness absence.	**Actions agreed:-** • Given concerns raised within the paper there is a need for a follow up paper in three months on the enabling actions being taken.

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

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

Committee/Group Chair's Report

NHS Staff Survey and Go Engage		• The Committee were informed that the NHS Staff Survey has closed; disappointingly the response rate is slightly below average. It was noted that at the time of the Survey there were a number of unique operational and media matters that may impact the findings. Specifically EPR, Divisional Management Reshaping and announcements' regarding the CEO and Deputy CEO leaving. • The Committee received an update on the Quarter 3 Go Engage findings. It was noted that whilst there had been some deteriorations the Trust continued to benchmark positively.	**Actions agreed:-** • NHS Staff Survey Findings Report to Trust Board in March.
Staff Deal		• The Committee noted that the work is on-going on the plans to introduce a staff pledge and refreshed behavioural framework, aligned to a refocused staff recognition approach. A subgroup meeting has been arranged for 8th January, 2020.	**Actions agreed:-** • It was agreed that this would remain a standing item until which time the Committee would be able to make final recommendations to the Trust Board.
Gender Pay Gap report		• Members noted that some improvements have been made since last year on the Gender Pay Gap, albeit there is more work that is required. • Committee noted that the disparity between Gender Pay within the trust is skewed by the medical workforce which historically was a male dominated profession. On a median, women earn more than men in bands 2-8b, 8d, 9 and VSM. On a median, men earn more than women in bands 8c and medical grades. • Actions being taken include: Focus on Talent Pipeline, Flexible Working, Levelling of Clinical Excellence Awards, Women in Leadership programme.	**Actions agreed:-** • The Committee supported the publishing of the report, which all organisations are required to undertake and publish by the 30 March 2020.

No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
Moderate assurance – potential moderate impact on quality, operational or financial performance	
Assured – no or minor impact on quality, operational or financial performance	

Committee/Group Chair's Report

Inclusion Quarterly report	■	• The paper provided a very helpful update on the Committee on the strategic plan to accelerate improvement within workforce equality, diversity and inclusion workstream. • The following key matters were considered at length:-Strategic Leadership, Training and Career Development, Recruitment and Retention, Workplace experience, Governance. • The performance metrics showed that improvements were being made in many of the key Workforce Inclusion metrics.	**Actions agreed:-** • The Committee supported that this should be a quarterly report
Shadow Board Video		• Launch of the Shadow Board video • Noted that a paper would be coming in February confirming next steps for the programme.	**Actions agreed:-** • The Committee agreed that it would be helpful for the video to be shown at the next Trust Board
Workforce Cost Improvement Programme		• The Committee received an update on the Workforce Cost Improvement Programme. It was noted that this remains a regular item on the Financial Recovery Group which reports to the Finance Committee.	**Actions agreed:-** • Report noted
Assurance from reporting Committees • Equality, Diversity and inclusion Group • Staff Health & Wellbeing Group • Education Governance Group • Medical Education Group • Staff Engagement Group		• All reports were noted and risks being managed. No matters required escalation to Trust Board	
Risks escalated None – matters being managed within Committee			

■ No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
■ Moderate assurance – potential moderate impact on quality, operational or financial performance	
■ Assured – no or minor impact on quality, operational or financial performance	

Agenda Item No:	12
Meeting:	Board of Directors
Date:	30th January 2020

Title:	Staffing Paper – Comprehensive Overview
Purpose	This report provides the Board with a comprehensive update on inpatient nurse and midwifery staffing.
Executive Summary:	This report focuses the bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.
Previously considered by:	Board of Directors
Recommendation Please state if approval required or if for information	To note the report
	Confidential y/n	

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

Negative Impact	Neutral Impact	Positive Impact

Prepared by:	Linda Denman, Interim Deputy Director of Nursing, DNDs and Workforce	**Presented by:**	Marie Forshaw, Interim Director of Nursing

Contents Page

Board of Directors – 30th January 2020

Comprehensive Staffing Paper Update

1. **Purpose**

This report provides the Board with a comprehensive update on nurse and midwifery staffing, focusing within the inpatient bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

2. **Background**

NHS Trusts have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. Significant investment has been approved and made into a variety of nursing establishments. The majority of investment has been made within our inpatient areas and has been based on NICE guidance (Inpatient staffing 2014 and Maternity services 2015), professional judgment, the enhanced care project and consideration of quality indicators.

Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and NICE guidelines (2014). The National Quality Board (2016) guidance includes expectations for nursing and midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

The intense focus on staffing levels, nurse recruitment and retention has demonstrated an improved position, but continues to be managed as a significant organisational priority.

3. **Current Position**

Table 1 provides a breakdown of our UNIFY fill rate data (July to December 2019 inclusive) that is collected and submitted externally on a monthly basis for our inpatient areas. It shows a percentage of the planned versus actual staffing levels for the Day and Night shifts split by registered and unregistered staff.

The guidance stipulates only inpatient areas should be included. As a result, D1, D2 & CDU are not included.

Table 1

Percentage fill rate – Unify Submission

Month	Registered Day %	Unregistered Day %	Registered Night %	Unregistered Night %
Jul-19	89.90%	94.10%	95.60%	95.70%
Aug-19	85.00%	96.00%	92.00%	94.00%
Sep-19	84.00%	95.00%	93.00%	93.00%
Oct-19	87.00%	98.00%	94.00%	95.00%
Nov-19	88.00%	99.00%	96.00%	96.00%
Dec-19	87.00%	94.00%	94.00%	95.00%
Average	86.82%	96.02%	94.10%	94.78%

A 100% fill rate would indicate that staffing is aligned to the established requirement. It is important to note that there are occasions where this has been below the desired fill rate. For these occasions the patient and safety issues are managed by the measures outlined later in the report.

4. Staff in Post

The FTE of Trust inpatient staff in post is consistent throughout the last 12 months. The period commencing July 2019 shows 1,1151.09 FTE in post (of which 677.20 Band 5 and above, 473.89 Band 4 and below, 1.00 Other Band or Grade) and the period ends with 1,1154.22 FTE in post (of which 691.33 Band 5 and above, 462.89 Band 4 and below, 1.00 Other Band or Grade). This net increase of 2.4 FTE slightly masks that at Bands 5 and above there has been a net increase of 14.13 whereas there was a reduction of 11.73 at Band 4 and below. The biggest step changes in these figures occurred in September (Band 5 and above) which saw a month-on-month increase of 19.38 FTE and December (Band 4 and below) which saw a reduction of 13.74 FTE.

5. Trust Turnover

Table 2

Inpatient Units												
	2019 / 01	2019 / 02	2019 / 03	2019 / 04	2019 / 05	2019 / 06	2019 / 07	2019 / 08	2019 / 09	2019 / 10	2019 / 11	2019 / 12
Headcount	1,305	1,296	1,314	1,321	1,327	1,348	1,346	1,353	1,377	1,375	1,372	1,350
FTE	1,117.09	1,109.60	1,124.79	1,134.60	1,138.36	1,158.05	1,152.09	1,157.54	1,177.67	1,174.87	1,172.18	1,152.69
Leavers Headcount	14	7	15	15	11	9	8	7	16	12	12	16
Leavers FTE	11.28	5.58	12.08	12.87	9.20	7.09	6.87	4.36	13.32	10.07	10.40	12.46
Starters Headcount	29	9	20	22	18	12	6	13	23	12	13	8
Starters FTE	23.35	7.36	17.75	20.41	16.25	10.87	5.75	10.17	21.15	9.52	12.16	7.35
Maternity	39	38	39	40	44	43	44	46	46	43	42	41
Turnover Rate (Headcount)	1.06%	0.53%	1.14%	1.14%	0.83%	0.68%	0.61%	0.53%	1.21%	0.91%	0.91%	1.21%
Turnover Rate (FTE)	1.00%	0.50%	1.07%	1.14%	0.82%	0.63%	0.61%	0.39%	1.18%	0.89%	0.92%	1.11%
Leavers (12m)	133	132	139	144	146	148	142	139	139	133	135	142
Turnover Rate (12m)	10.22%	10.14%	10.67%	11.05%	11.19%	11.31%	10.82%	10.55%	10.50%	10.00%	10.11%	10.59%
Leavers FTE (12m)	104.40	103.54	108.37	113.27	114.83	115.86	112.05	107.23	108.32	106.00	109.40	115.58
Turnover Rate FTE (12m)	9.37%	9.30%	9.72%	10.15%	10.28%	10.34%	9.97%	9.50%	9.55%	9.30%	9.56%	10.07%

6. Recruitment and Retention

There is a planned approach to nursing and HCA recruitment with events scheduled for January, March and September 2020.

There are a number of on-going initiatives at Corporate and Divisional level to support the trust with recruitment and retention. These include:

- Weekly meetings held between Divisional Nursing recruitment leads and Employee Service Manager to discuss adverts and progress with all nursing vacancies at offer stage.
- Bespoke adverts created for wards and departments and these are used alongside rolling recruitment campaigns.
- Focused work with the Ward Managers and Matrons on hard to recruit areas with regard to development opportunities available.
- Working with Communications and Human Resources to promote the Trust as a great place to work through best use of social media.

- The Trust continues to have a very strong focus on ensuring we appoint newly qualified nurses and this includes, thanks to the creation of a non-commissioned nurse training programme in partnership working with Bolton University, four separate intakes of newly qualified nurses into the Trust each year.
- A significant increase in student nursing training places.
- Band 7 and Band 6 study days focusing on leadership and development.
- Continuation of listening events for international recruits, HCA and new nursing staff in preceptorship at 3 monthly intervals
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level.
- Commencement of talent management and succession planning considerations for grades 7 and 8a.
- Cohorts of newly Qualified/International Nurses.
- Operating Department Practitioners into Preceptorship programme.
- Proactive focus to retain experienced staff who are due to retire.

7. Temporary Staffing

When staffing numbers are predicted to fall below agreed staffing levels there are systems and processes in place that allows Managers to fill gaps with temporary staffing. The Trust's Temporary Staffing is managed in house within the Human Resource Department.

Total shift fill rate has consistently remained within a 4% variance of 88-92%. Registered Nursing fill rate is lower than for Care Staff/Healthcare Assistants (87.30 vs. 94.19% respectively).

Control measures are in place aligned to the Carter Efficiency Checklist when shifts are required to be released to agency.

Table 3

Year / Month	Reg. Fill %	Non Reg. Fill %	Grand Total Fill %
2019/07	90.17%	95.16%	92.24%
2019/08	84.82%	93.83%	88.55%
2019/09	84.39%	92.18%	87.61%
2019/10	87.75%	95.65%	90.94%
2019/11	88.99%	95.76%	91.76%
2019/12	87.72%	92.53%	89.69%

8. Acuity and Dependency

The Trust uses a variety of tools and methods to match staffing to acuity. It is important that not one tool is considered in isolation but triangulated through a variety of methods. It is important to note that any tool used to assess is always used in tandem with professional judgement.

Care hours per patient day (CHPPD)

CHPPD was developed, tested and adopted to NHS Improvement to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff on inpatient wards. It

produces a single comparable figure that represents both staffing levels and patient requirements, unlike actual hours or patient requirements alone this allowing comparisons. As CHPPD is calculated after dividing by the number of patients, the value does not increase due to the size of the ward, enabling comparisons between wards of different sizes.

It also offers the ability to differentiate registered nurses and midwives from healthcare support workers for reporting purposes, ensuring skill-mix is well-described and the nurse-to-patient ratio is taken into account in staff deployment, along with an aggregated overall score.

In accordance with the fill rate, Care Hours per Patient Day (CHPPD) has also remained fairly consistent, seeing a minimum of 7.90 and maximum of 8.49: a variance of only 35 minutes per patient per day. Non-registered CHPPD was particularly consistent with a minimum of 3.46 and maximum of 3.62: a difference of 9 minutes per patient per day. There does not appear to be any correlation between Nursing and Care Staff CHPPD, i.e. where Nursing levels of care are lower, HCAs are not increased to plug the shortfall. This is good practice.

9. SafeCare

Safecare matches staffing levels to patient acuity, providing control and assurance from bedside to board. Staff numbers and skill mix can be compared alongside actual patient demand in real time, allowing you to make informed decisions and create acuity driven staffing.

As the Workforce team have enhanced their E Roster expertise and a new work stream is proposed for 2020 to re-establish the utilisation of safe care to maximise the intelligence it can provide.

10. Processes of Governance and Escalation for Safe Staffing

Nurse staffing remains a significant challenge within our wards, departments and community settings. To manage patient safety and quality effectively, the Trust has assurance processes in place to enable appropriate daily oversight to take place to be able to take appropriate action.

Through the utilisation of E Roster the Matron of the Day visits all ward areas to discuss patient acuity and dependency, and to review the level of care that patients who need additional supervision require, so that decisions about staff movement between areas is informed by this.

Staffing gaps are highlighted at Corporate Bed Meetings, and support from other Divisions is requested and provided as able.

Staffing incidents are reviewed as part of the Divisional Governance process and senior staff have oversight through the daily Early Bird incident report. Incident reporting is also monitored via the Bolton System of Care Accreditation (BoSCA).

11. Staffing & Skill Mix Reviews Update by Division

11.1   Acute Adult Division Staffing Establishment Review

11.1.1 Summary of actions taken July – December 2019

- Lead Matron for recruitment and retention identified with clear objectives related to reducing turnover and vacancy levels.
- Nurse Associate recruitment to assessment areas with further use of the role to support the Ambulatory Care Expansion.
- Profile requirements for Trainee Nurse Associates 2020-2022 underway.

- Review of staffing model for enhanced respiratory care bay to include the recruitment of two Nursing Associates in April when they qualify after a successful pilot with TNAs within enhanced respiratory care bay.
- B1 deep dive review of flexible working and reasonable adjustment requests affecting roster compliance across all bands of staff.
- Introduction of streaming shift 12-12 to cover busy periods in ED department and support effective streaming of patients.
- Successful seasonal planning to enable a winter ward to be opened to support additional bed based capacity.

11.1.2 Staffing Reviews Undertaken

- All ward based areas.
- Enhanced care and housekeeper requirements across all bed base.
- Review of Deep Vein Thrombosis (DVT) service to include succession planning in short and medium term to ensure right level of knowledge and skills are available.
- Review of Gastroenterology specialist nurses commenced to include succession planning for potential retirement of Nurse Consultant and replace role with ANP.
- Respiratory specialist nurses review to include succession planning for retirement of Respiratory Specialist Nurse/Lead for Quality and Development in April 2020 with appointment of an ANP.
- Review of the Endoscopy unit (recently transferred to AACD).

As part of wider service re-design staffing re-modelling commenced for:

- Acute Care Unit as part of streaming work with recruitment of Band 6 posts.
- Appointment of a Practice Development Nurse who will support training and competencies within the assessment area.
- Frailty ANP and comprehensive Frailty in-reach into the Emergency Department 5 days a week. Recruiting to expand to cover a 7 day service in line with GM frailty standard and adopting a collaborative approach with Home First.
- Frailty Steering Group established to oversee progress.
- Cardiology to develop further the idea of rotation of staff between CCU and Pacing lab to support development and opportunities.
- Gastroenterology to develop further the idea of developing staff to support career progression within wider specialities of IBD nurse, alcohol nurse as well as management route.

11.1.3 Ward/Department Based Areas

All ward based areas have had nurse staffing reviews undertaken. Review of the clinical ward manager role which includes planned clinical shifts per week, late shift support to enable ward managers to work closely with their junior staff, meet with night staff at evening handover and focus on improving patient and carer experience.

Discussions held to ascertain the possibility of altered and different shift patterns of registered nurses and rotation of health care assistants and a review to standardise ward start and finish times.

Winter Contingency Beds

There was a planned requirement for 16.94 wte registered nurses and 23.84 wte HCA to support extra bed bases as part of winter contingency planning. Additional 16 beds were planned to open on

December 23rd. A further increase to 26 beds was planned for December 30th. Due to unexpected seasonal pressures 26 beds were opened on Ward B2 on 25th November.

Staffing for the Winter Contingency Beds was provided by a combination of the winter contingency permanent establishment returning from Discharge Lounge, further internal recruitment and secondment from supporting wards and Elective and ICSD.

The Winter Contingency Ward has retained the short stay admission model that was introduced last year. This model has provided the Trust with a ward that regularly provides early and high numbers of discharges. This is reliant on the admission only of patients who meet strict clinical criteria.

11.1.4 Additional Roles, Initiatives and Innovation

Ward C3 – successful appointment of Registered Mental Health Nurse as a test of change. A review of the specialist nurses across the division has commenced.

11.1.5 Division Specific Info

Services transferred into and out of the division

Over the past six months the division transferred Ward A4 and Therapy Services into Integrated Community Services Division. The Endoscopy Unit and Bowel Screening transferred in to AACD in November 2019.

11.2 Elective Care Division Staffing Establishment Review

11.2.1 Staffing reviews undertaken January- June 2019

A staffing review has commenced. All wards within Elective Care have had individual meetings with the DND, Matron, OBM and the ward manager to ensure that each individual ward needs have been taken into consideration.

The Division are assessing the impact of the new ways of working with urology.

The role of the Nurse Associate and joint cross working with ENT department is being modelled.

A review is underway on F3 and G5 to determine the appropriate grade, skill mix and shift patterns.

11.2.2 Additional Roles, Initiatives & Innovation

Surgical Ambulatory Care Unit (SACU)

As a result of GM reconfiguration of surgical services and Healthier Together, early indication shows that the standard staffing model, environmental requirements and predicted service delivery requires further transformation at Bolton. At present the current configuration is not in line with the predicted standards therefore a proposed relocation and refurbishment of facilities is being worked through. The current SACU team will join the F3/ Surgical Assessment Unit team in 2020 and a further staffing review will be completed in line with the reconfiguration timescales.

A complete staffing review has also taken place in non-bed based areas:

- Theatres
- Ophthalmology

Nursing Associates and Trainee Nursing Associates

The first qualified Nursing Associate is now in post in the Out Patient Department.

Contingency Area requirements

G5 is currently enacting its winter plans where the ward has opened for two weeks pre Christmas to take trauma patients with clean elective activity stood down. Additional staff plan in place to manage additional acuity during this time period.

11.3   Family Care Division Staffing Establishment Review

11.3.1 Summary of actions taken July – Dec 19

Nursing Staffing review paper has demonstrated a requirement to increase the establishment of the Gynaecology nursing and support workforce as a priority to ensure it is safe and fit for the future. The Gynaecology Matron oversees the deployment of trained staff across the gynaecology service.

The budgeted nursing and support staffing includes an uplift of 1.0 wte over the winter months Dec 19 – Feb 20, as part of the 'Winter Planning' to support safe care during periods of high acuity and dependency.

11.3.2 Staffing Reviews Undertaken

This review has taken into consideration NICE recommendations such as NICE recommended Birthrate Plus (BR+) tool for midwifery staffing, and professional judgment.

Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. This means that taken overall to provide safe high quality maternity services, the NHS in England needs 1 clinical midwife for every 28 births.

Graph 1
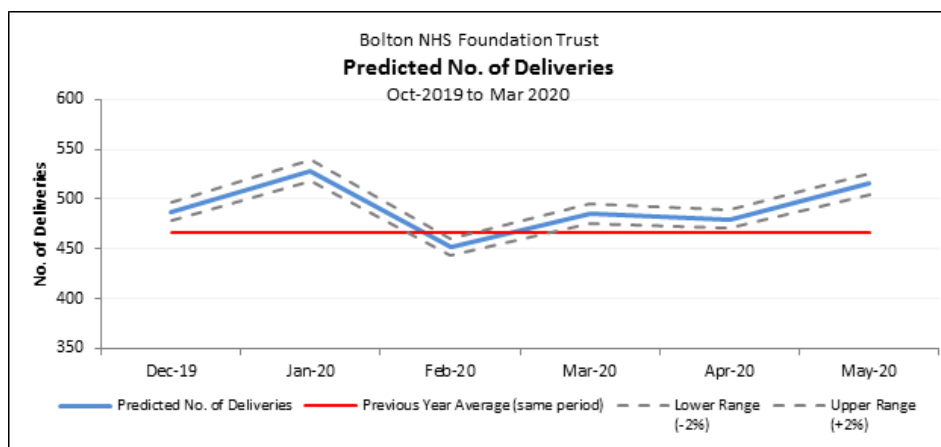
Bolton Maternity Birthrate Plus® establishment is currently set at 1:27. This was captured as 1:29.7 in November due to the particularly high number of births in month. There were 547 births against Bolton average of 466 per month.

The introduction of the Birthrate Plus Acuity Tool on Central Delivery Suite assists the coordinator in assessing 'real time" workload arising from the numbers of women needing care and their condition on admission and during the processes of labour and birth.

Analysis of the Delivery Suite Acuity Tool September 2019

The delivery suite acuity tool advises where the midwives need to be and the Helicopter bleep holder ensures the staffing follows the women to the areas where demand is required at that point in time.

A maternity red flag report which captures maternity staffing particularly achieving the supernumerary status of the Delivery Suite Coordinator is monitored 3 times a day.

Nurse Associates and Trainee Nurse Associates

As part of future proofing this service, the introduction of Trainee Nurse associate (TNA) cohorts commencing April 20 and Sept 20 will hopefully see placements within Gynaecology.

Advanced Practitioners

The recruitment of an Advanced Nurse Practitioner in Gynaecology is a proposed new way of working within the Gynaecology Nursing and Support Workforce Review Paper. Considered job planning is necessary for both medical and nursing profession, taking into account the interdependencies with obstetrics and emergency care.

11.3.3 Division Specific Info

Highlights July-December 2019

Twenty-one newly qualified midwives appointed in September and October 2019. Flexible employment options are available in accordance with the RCM 'Caring for you Campaign'. Efficient deployment of trained staff is maximized on a shift by shift basis overseen by the Helicopter bleep holder, with clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.

An additional 2.2 WTE band 7 Delivery Suite coordinators appointed to carry the Helicopter Bleep at night. This supernumerary cover will now be provided 24/7, and will have an overview of the safety of the maternity unit.

The Division consistently achieve around 99% 1:1 midwifery care in labour which is a strong indicator that there is sufficient midwifery resource in the workforce

Contingency Area Requirements

The Gynecology ward is frequently used as a contingency area to transfer outliers from other Divisions, in particular orthopedic patients. The Trust has approved the increase in staffing levels to support an additional HCA role over the winter to support the continuation of care.

11.4   Children's Services

Bolton NHS FT provides acute and community services for children aged 0-19 years under the Family Care Division. This includes acute children's medicine and high dependency, planned surgery, universal healthcare and health promotion within the 0-19 service, and acute and complex community children's nursing provided by the Integrated Community Paediatric Nursing team and the Paediatric Learning Disability Nursing team.

Paediatric Wards

The standards for general inpatient children's wards should reflect the age of the child as well as acuity. The changing health environment increasingly indicates that the bedside care of children has little difference between day and night and this should be acknowledged in staffing models. The RCN standards provide an indicative baseline ratio of registered nurses to children and young people, taking into account the distinct care requirements linked to age and development.

Guidance also states that the ward should also have a supervisory ward sister/charge nurse and a shift coordinator covering a 24 hour period who is not included in the baseline bedside establishment.

High Dependency

The Paediatric Intensive Care Society (PICS) Standards for the Care of Critically ill Children are widely used during workforce planning in critical care, and give useful guidance on nursing workforce planning. In Bolton, High Dependency care is provided on the children's ward with 3 dedicated High Dependency beds, staffed as per national guidance with high dependency trained nursing staff dedicated to this area of work.

Bolton FT Acute Paediatric service provides nursing care to children and young people from Bolton and surrounding areas such as Salford, Wigan and Bury in the following inpatient settings:

Staffing

There are yearly staffing reviews, and the unit is successful at filling vacancies and has a low turnover of staff demonstrating that Bolton Paediatric Unit is a sought after place to work.

The agreed Bolton staffing ratios are one registered nurse (RN child) to five patients (1:5) regardless of age, and this is based on professional judgement, local demand and acuity. The agreed Bolton Children's Nursing ratio of 1:5 takes into account that the children's nurses on the ward are supported by a robust infrastructure of Paediatricians of all grades, Advanced Paediatric Nurse Practitioners (APNP), Health Care Assistants (HCA), Assistant Practitioners (AP), Nurse Associates (NA), Play Specialists, Ward Clerks and House Keepers. These staff work together to ensure the care of children is prioritised.

The paediatric department also meets the required standards for a Paediatric Critical Care Unit (PCCU) of 1:2 along with other standards set by the Critical Care Network. This is monitored 4 times a day in order to maintain and sustain an effective service.

Table 4 below outlines the staff ratios for Q2 and October and November in Q3 (December figures were not available) for E5 Children's unit, and outlines comparisons with 2018 figures for the same quartiles.

Table 4 - Nurse to child ratio & Supernumerary shift co-ordinator

Month	July	August	September	October	November
2018 **Nurse to Child Ratio – IP wards – RCN Standards**	1:2.5	1:2.8	1:3.2	1:3.2	1:4.4
2019 **Nurse to Child Ratio – IP wards – RCN Standards**	1:3.1	1:2.2	1:3.3	1:3.3	1:4.5
2018 **Supernumerary shift coordinator**	100%	97%	97%	100%	86%
2019 **Supernumerary shift coordinator**	90%	100%	90%	96%	80%

Neonatal services

Staffing levels on the Neonatal Unit are monitored in accordance with national standards agreed by the British Association of Perinatal Medicine 2011 (BAPM). These standards provide staff to patient ratios based on acuity which are 1:1 for intensive care, 1:2 for high dependency care and 1:4 for special care, as well as a supernumerary shift coordinator (band 7) in charge.

Winter Planning

Bolton has winter and summer models of staffing which are monitored and reviewed on a rolling basis. This planned model has facilitated a more robust winter plan which has reduced the risk of limited staff availability on the ward, Paediatric Assessment Unit and High Dependency during high acuity winter months.

11.5   Integrated Community Services Division

11.5.1 Summary of actions taken – July to December 2019

- Staff have commenced the Specialist Practitioner Course in September 2019. 8 students for District nursing and 1 student for Learning Disabilities. The course completes in June 2020.
- Trainee Nurse Associates - There are currently 6 TNA's from the division, 2 commenced in April 2019 and 1 commenced in Sept 19. 2 TNAs will complete the course in April 2020, 1 will complete in Sept 2020.
- Recruitment to the Bladder and Bowel team and Epilepsy Team has been completed.
- The bed based services within the ICS Division now includes Ward A4 and Darley Court. From an intermediate care perspective the team is fully established with staff
- The intermediate care bed based units have also welcomed a number of new local authority

staff from reablement services following on from a number of staffing consultations affecting working hours.

11.5.2 Additional Roles, Initiatives & Innovation

- Diabetes Nurse Specialist review: The GIRFT review has highlighted the need to identify dedicated nursing time for inpatient and Type 1 Diabetes care. Matron has been allocated to lead the Diabetes service for 6 months and a new Team Leader has been appointed
- Introduction of a Clinical Educator role
- Frailty Lead: Advance Clinical Practice

Trainee Nurse Associates and Advanced Clinical Practice

The Division has 3 trainee nursing associates on the apprenticeship program 2018 - 2020.
There are two Advanced Clinical Practitioners on the Masters program 2018- 2020 sponsored by Health Education England.

Advanced Practitioners

The Division currently has advanced clinical practitioners working within the Admission Avoidance Team and the homeless and vulnerable adult's team. Additionally, there are also 2 trainees due to qualify in September 2020 1 is a RN working within AAT and the other an OT currently based in the Home First team.

12. Future supply: Student Nurses

The trust presently supports the practice placements for adult student nurses from the University of Bolton and the University of Salford. Graph 2 illustrates the numbers of Adult Nursing students, the trusts future workforce supply, accommodated for their practice placements between January 2020 – September 2022 (NB. This is an indicative number as students step on and off the programme over the 3 years). Graph 3 has broken the numbers down into numbers due to qualify per year.

Graph 2
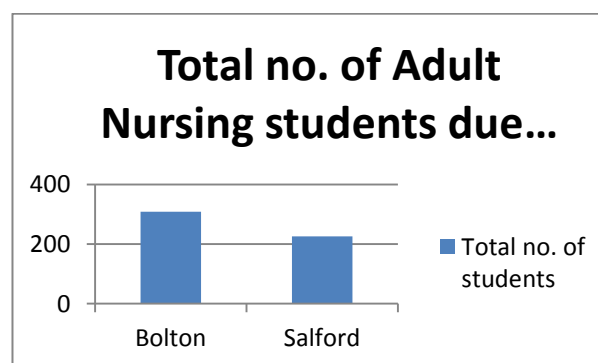
Graph 3
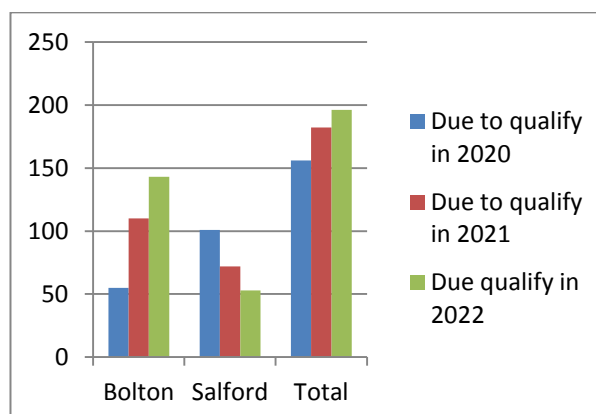
13. Conclusion

Safe staffing levels impact on the ability of nursing and midwifery staff to provide high quality care. As with previous reports, the Trust continues to carry a number of nursing vacancies. This is reflected in the Trust Board Assurance Framework (BAF) and the Division's Risk Registers.

Reviews of staffing numbers and skill mix will continue to be ongoing and any changes will be based on triangulation of acuity, current quality indicators and outcomes and professional judgment, whilst taking into account any available national guidance.

14. Recommendation

The Board is asked to note the report. Support the direction of travel currently being taken particularly in relation to recruitment and on-going establishment reviews.

Finally, the Board is also asked to recognise and commend the work and efforts of the entire nursing and midwifery workforce who are committed to, and continue to deliver safe and effective care whilst working in a challenging environment.

Agenda Item No:	**13**	
Meeting:	Board of Directors	
Date:	30th January 2020	

Title:	Learning From Deaths Quarter 2 Report for 2019-2020

Purpose	Trusts are required to collect and publish on quarterly basis specified information on deaths via board. This data includes the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care, and be accompanied by relevant qualitative information and interpretation. This paper describes the Q1-3 summary from the learning from deaths programme at Bolton NHS FT.

Executive Summary:	Overall, across the three quarters, 76% of SJRs are being completed but there is difficulty in getting them completed in the suggested 4 week timeframe. For the last quarter, 1 case reviewed was send for scoping to an SI panel as it was felt that the death was more than likely due to problems in care. The estimate for the number of deaths which were more than likely due to problems in care is 2.5% for Q3. Resultant learning slides are attached. Finally, in keeping with good practice, data now includes all maternal, stillbirth, neonatal and childhood deaths.

Previously considered by:	N/A

Recommendation Please state if approval required or if for information	The board are asked to approve the paper		
		Confidential y/n	n

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

Negative Impact	Neutral Impact	Positive Impact

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

Introduction

The learning from deaths committee became fully operational in April 2019 and currently has 37 trained reviewers. Trusts are required to collect and publish on quarterly basis specified information on deaths. This is through a paper and an agenda item to a public Board meeting in each quarter publication of the data and learning points. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care, and be accompanied by relevant qualitative information and interpretation. This report only covers in patient deaths in patients age 18 and over (excluding maternal deaths). Maternal, neonatal and paediatric deaths are subject to different nationally directed processes but are now also reported here to give a comprehensive picture for information.

New developments

From November 2019, a new Trust based system for Subjective Judgement Reviews has been introduced to replace the external system (Datix) which was previously provided via the Royal College of Physicians, London. This new platform has been led by Debbie Redfern (quality improvement programme manager), working in conjunction with informatics. It is accessed as an app on BOB and offers several new advantages:

- Security - only people who have been granted access will be able to input or view completed reviews – so is totally secure
- Patient identifiable information – As the app is secure and reviews will only be accessible to those who are granted permissions, patient identifiable information can be included, which means we can avoid duplication in generated reference numbers and easily identify patients and link information from SJR to other forms of investigation e.g. complaints/incidents/reviews
- Permissions are linked to the Trust standard computer log-in, so there is no need to input a separate username and password to access the system and passwords for this system will not expire
- The platform is linked to LE2.2, so on entering the Patient's RMC number some information will be pre-populated
- The system is fully
- An enhanced reporting function is being built – to allow for further data and trend analysis
- Sustainable and configurable – the platform is hosted by the Trust. An example of this is that the first reviewer can offer a judgement as to whether the death was more than likely due to problems in care (not available on the Datix system)

Moreover, the successful deployment of EPR means that as soon as the monthly list of required reviews is published, all patient notes including the scanned A&E notes are available electronically without having to wait for paper notes to arrive.

Methodology

Overall total inpatient deaths are described (including A&E) followed by the numbers of cases scheduled for an SJR (structured judgement review) and the actual numbers of SJRs completed. These are known as primary reviews and are conducted by one of trained multidisciplinary reviewers and are randomly allocated. Individual components of care are scored on a 5 point scale and an overall score is also determined by the reviewer. For any patient who is scored as 1 or 2 (very poor or poor) overall then then the learning from deaths committee members collectively undertake a secondary review to determine whether the reviewer scores, especially the overall score are justified. Each case is also reviewed to determine whether on balance the death was more likely than not to have resulted from problems in care. If after the secondary review the overall score is 1 or 2 then the case is scoped to determine whether a divisional review or serious incident report needs to occur.

Results

These are shown in table 1 and 2 below. Data from quarter one and two is also included for comparison. Approximately three quarters of cases are being reviewed each month, which is a marked improvement on the previous trust mortality review system but the data is currently being audited to understand cumulatively how many cases are outstanding since April 2019-this will be described

Table 1: numbers of adult in-patient deaths including A&E deaths per month for Q3

Total number of adult inpatient deaths (including A&E)	October	November	December	Total for quarter
number	99	122	129	

Table 2. Details of cases by source and score for Q1-3

	Pilot	Quarter 1			Quarter 2			Quarter 3		
	March	April	May	June	July	Aug	Sept	Oct.	Nov	Dec
Number Cases (Sample)	23	29	35	32	26	27	24	22	24	17
COMPLETED	22	26	31	28	19	19	18	18	17	4
Outstanding Cases	1	3	4	4	7	8	6	4	7	13
Not Yet Received - Within Deadline	0	0	0	0	0	0	0	0	0	13
Outstanding -Surpassed Deadline	1	2	2	4	5	8	6	4	7	0
Missing notes unable to find	0	1	2	0	2	0	0	0	0	0
%	**95.7**	**89.7**	**88.6**	**87.5**	**73.1**	**70.4**	**75.0**	**81.8**	**70.8**	**23.5**
Source										
Mandated Death (Alert Diagnosis)	22	18	25	21	4	2	7	11	6	0
Unexpected Death	0	1	7	2	6	6	9	/	/	/
LD Death	0	0	0	1	0	0	0	1	1	/
Mental Health Death	1	6	1	4	7	9	1	1	10	4
Case Sample	0	4	2	4	9	9	7	8	4	11
Requested by Division	0	0	0	0	0	1	0	/	3	2
Diabetes Death	/	/	/	/	/	/	/	/	/	/
NELA Death	/	/	/	/	/	/	/	1	/	/
	23	29	35	32	26	27	24	22	24	17
Overall Score										
1 (Very Poor)	0	0	0	0	0	0	0	0	0	1
2 (Poor)	3	4	3	2	3	1	6	3	4	0
3 (Adequate)	5	9	8	3	9	6	3	5	3	0
4 (Good)	13	11	15	19	6	8	6	9	6	3
5 Excellent	1	2	4	4	1	4	3	1	4	0
TOTAL	22	26*	30*	28	19	19*	18	18	17	4

*Mandated diagnoses were pneumonia to June 2019, then congestive cardiac failure from July 2019.

Details of maternal deaths, still births, neonatal deaths and childhood deaths are given in table 3 so that an overall position of trust mortality is available to board but it should be noted that these are subject to a separate process of investigation and reporting

Table 3: Deaths for Q1-3: Maternal, stillbirths, neonatal and childhood deaths

	Q1 April-June 19	Q2 July-Sept 19	Q3 Oct – Dec 19	Investigated Q3
Maternal Deaths	0	0	0	0
Still births	7	5	8	1 case in October had a rapid review completed. This was escalated to a Divisional Safeguarding Review and completed. 3 cases in November all had rapid reviews completed. 4 cases in December have all had rapid reviews completed. 1 of those cases has been taken forward as a Trust SI.
Neonatal deaths	7	1	7 6 in October and 1 in November.	Of the 6 cases in October: 2 cases of congenital abnormalities - T18 and non-immune hydrops respectively, rapid reviews by NNU team. 1 rapid review completed in maternity and escalated to a Divisional review. 3 late miscarriages which do not currently receive a review. Rapid review was completed for the one case in November.
Child deaths (excluding stillbirth and neonatal death)	No data supplied	No data supplied	1	Child drowning brought into A&E in cardiac arrest, resuscitation unsuccessful

Total number of adult cases where death was more than likely to have occurred due to problems with care

Of the 39 cases that so far for quarter three, 7 have been rated as poor and 1 as very poor. Of these deaths classed as poor/very poor care, 1 was classed as a death more than likely due to problems in care and was referred for a Serious Incident investigation. Estimate therefore 2.5% all deaths more than likely due to problems with care.

Learning

At each learning from deaths committee, for each case where the care was judged to be poor or very poor, a secondary review is completed by the committee and learning points are collated in and disseminated via a learning slide from clinical governance to clinical governance and quality assurance committee and the divisions for circulation. The learning slides are distributed each month via the Better care together group email for cascade and distribution at ward level. Copies of the learning slides are then made available to everyone via the Governance page on BOB. This process commenced in August. As can be seen, some cases at learning from deaths committee are highlighted for excellent care and this learning is also fed back. The learning slides for the last three quarters are given in appendix 1.

Further issues

Consideration is being given to raising the number of cases randomly selected to 10% of reviews. We have attempted to do this but we are still only reaching 5% due to problems with reviewer capacity so plans are being made for further reviewers to be trained this year. General surgery have also agreed to undertake SJRs on post laparotomy deaths as per requirements under the Healthier together North West Sector programme, but because the focus of these being on surgical decision making, these will be reviewed by surgeons, anaesthetists and intensivists, but will still be reported in performance tables.

A comprehensive action log and case tracker is now established but given the amount of detail it is not replicated here. As this report was being prepared, a meeting was being held to determine the best way to add this to the report.

Conclusion

The learning from deaths programme continues to evolve with continuing evidence of evidence of lessons learned now being circulated. All cases are now being tracked for learning feedback but this needs further work to distil into a reporting format and will be included with the next quarterly report.

Appendix 1: Learning from deaths governance slides

Governance Learning Slides 2019-2020
Oct 2019 – Quality Improvement

NHS
Bolton
NHS Foundation Trust

Learning from deaths:

- 150 deaths reviewed to date 21/10/19 – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive learning

Cases 1 – 3 rated as poor/very poor, cases 4 & 5 rated as excellent

1. Escalation policy not followed, no documented evidence of discussion re prognosis and pt's preferences, lack of holistic approach to end of life care
2. Missed opportunities to advance care plan - focus on active management of physical condition, without considering holistic condition, comments re patients poor mood and the impact on care is documented, but lack of action or exploration of preferences or wishes with patient/relative . Patient died alone.
3. Good admission/initial assessment. Lack of medical input on weekend. Failure to recognize severity of illness (AKI) and escalate. Medication not withheld when appropriate to do so.
4. Early identification of patient prognosis and therefore excellent advanced care planning. Appropriate escalation to deterioration, prompt review by medical staff. Clear documentation of communication and involvement with family and End of life care booklet used. Family present at time of death and supported by staff, privacy and dignity maintained .
5. Out of hospital cardiac arrest - managed appropriately in ED with discussion with UHSM for ECMO. Transferred to ICU for ongoing care. Evidence of discussion with family and appropriate information gathering. Patient and family received excellent care

Action/Learning Points:
Case 1 & 3
- Refer for Divisional Review
All applicable learning:
- Reference to pathway in notes – inappropriate us e of language
- Good care should be holistic – medical and psychological,
- Importance of advanced care planning - Continue to promote good quality conversations with patients re prognosis and wishes
  Case 4, - Clear evidence of good palliative care provided by the team. Family members were well informed throughout the duration of short admission, and involved in decision making. - – R Sachs to feedback positive findings to CDU clinical lead to share with staff involved in care and discuss at dept. governance, Overall
- Case 5 - value in the SJR as an independent review and feedback to staff involved and recognition of excellent practice, especially in difficult and sensitive circumstances of patient's death
- Promote the different mechanisms to support staff following challenging circumstances

Governance Learning Slides 2019-2020
Nov 2019 – Quality Improvement

NHS
Bolton

Learning from deaths:

- 165 deaths reviewed to date 22/11/19 – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive learning

Secondary reviews:
Case 1:
complex health needs i.e. dialysis, it was felt the patient did not die directly as a result of problems in treatment - however, issues highlighted resulted in was poor care/experience for both patient and relative.
Negatives: (admission and initial treatment phase, e.g.
  - delay to abx, delay to surgical review,
  - lack of working diagnosis/treatment plan and acknowledgement of dialysis and how to manage
  - lack of consideration for Sepsis
Positives:
- Documentation/active treatment and communication with family improved once on ICU
- There was recognition patient was going to die, but the active treatment and treatment to palliate was entirely appropriate in this case.
- Good documentation of post-death care by nursing team

Case 2:
Very complex patient with known mental health history. On reflection the clinical outcome would not have been affected, but patient experience was poor.
Negatives:
- Complex holistic needs of the patient which compounded compliance issues, however failure to review holistic needs.
- poor support from a mental health perspective
- Wrong drug administration - no harm, incident form submitted.
- Reason for inpatient fall not documented.
Positives:
- Medical review was adequate
- liaison with family e.g. feed at risk decision
- Good palliative care involvement.

Action/Learning Points:
Case 1
- Action: refer to SI Scoping
- Learning points: Dialysis patients - need to ensure clinical teams are aware of the patient's dialysis requirements to enable consideration when building treatment plan from the start

Case 2
- Drug error - check incident form has been submitted Fall - check incident form submitted for patient fall Share review with GMMH for learning

- **All applicable learning:**
- Internal mortality review platform has now gone live
- Access granted to trained reviewers and read only access to clinical leads for discussion of cases at departmental governance

Governance Learning Slides 2019-2020
Dec 2019 – Quality Improvement

Learning from deaths:

- >180 deaths reviewed to date 09/12/19 – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive

Secondary reviews:

Patient 1

Positives:
- Good care e.g. thorough clerking, review and investigation.
- Very clear working diagnosis,
- pressure areas review and frailty notes.
- excellent care in terms of home first review and falls assessment
- CPR incident - Event documented and incident reported by Med SpR

Negatives:
- Attempted resuscitation with DNACPR in place, poor death for patient and experience for relatives.
- context – patient died day 2 of EPR go live. Recognition DNACPR in place at home, updated on EPR but no paper record updated - visual tracker boards not operational so no visual way to id DNACPR
- Patient's blood results in terms of potassium was not actionned – users of EPR comment there is an overload of information that makes it difficult to quickly view important aspects e.g. potassium levels – this issue has been raised with EPR design group

The committee concluded that it was not likely that the death was due to problems in care, however rated the overall as Very Poor due to the CPR on a patient with a DNAR form in place.

Patient 2: Cause of death: Intracerebral haemorrhage

Key areas of discussion:

Positives:
- In reach by geriatrician-good care
- Committee disagreed with original review of poor care and felt neurosurgical discussion rather than acute stroke unit was the appropriate referral and given patient's frailty
- Appropriate end of life care given

Negatives:
- Quality of documentation – documentation does not reflect care provided e.g. potassium not documented, but reference in notes results seen and noted

The committee concluded that it was not likely that the death was due to problems in care. The committee rated the overall care as ADEQUATE

Action/Learning Points:

Case 1
- problems identifying blood results e.g. low potassium quickly on EPR - check this has been referred to EPR team to address –
- SBAR re paper copy DNACPR as well as epr update has already been circulated (see next slide)
- Check if SBAR on EPR was fully completed
- Case will be referred to further review at Cardiac arrest RCA clinic
- Ensure apology to family has been issued
- Circulate completed SJR to clinical lead for review

Case 2
- Learning points - some issues re documentation i.e. not documenting test, but reference made in the notes that this has been done - however, will be fixed with EPR implementation
- (case prior to EPR go live and issues will be mitigated by EPR). EPR documents a clinical frailty score so that may help someone who has not seen the patient make a judgement on recovery potential

All applicable learning:
- Internal mortality review platform has now gone live
- From Nov reviewing deaths where care record available on EPR – assisting with the reviews

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Governance SBAR
Subject: DNACPR
Date: 2nd December 2019
Expiry: Before 28th February 2020

URGENT - FOR ACTION:
ALL CLINICAL STAFF

Small print: Governance SBARs will be issued at a frequency rate of $\leq$1 per month, please action accordingly. Questions and queries about the Governance SBARS can be directed to emily.harrison@boltonft.nhs.uk

Situation: Inconsistent recording of DNACPR status on paper forms and EPR.

Background: Incidents have been found where a patient has had a paper form indicating that they were **NOT for** CPR but **WERE for** CPR on EPR (and visa-versa). Paper DNACPR forms were not always located in the correct files – these are needed as a legal record which are used across all organisations involved in the patient's care.

Assessment: The CPR status in the clerking document within the EPR looks the same as the paper form so staff may think that they are completing a DNACPR form. Staff may not be aware they also need to complete CPR status on EPR if the patient brings in a paper DNACPR form. As patient files are used rarely, incorrect placement of notes is not being highlighted in a timely way.

Recommendations/Actions:
A paper DNACPR form must be completed for all patients who are not for CPR. The CPR status should also be changed to DNACPR on EPR. The two records MUST read the same. The paper form must be moved with a patient within their paper records.

VISION   OPENNESS   INTEGRITY   **COMPASSION**   EXCELLENCE

Version: 3.0 July 2019
Review: April 2020

Governance Learning Slides 2019-2020
Dec 2019 – Quality Improvement

Learning from deaths:

- >180 deaths reviewed to date 09/12/19 – deaths with overall rating of poor, very poor are subject to MDT secondary review at Learning from Deaths Committee where actions and learning points recorded, plus reviews rated as excellent reviewed for positive

Excellent reviews:

Patient 3:

Context – patient with mental health history , Cause of death – CAP, COPD

Summary:

- Seen by consultant (acute med) in ED. Clear plan made and documented. Clear documentation and NEWS appropriate obs. Referral to respiratory ward. Good communication with family.
- Not showing improvement. Escalation status and DNACPR discussed with family. Appropriate decisions made. Patient too unwell and semi conscious to discuss on-going care. Results discussed with microbiology and full medical care continued. NEWS appropriate When no further improvement discussion with family by consultant and further treatment with-held. Anticipatory drugs prescribed
- Patient identified at end of life and appropriate not to escalate care
- No aggressive overtreatment as recognition patient was dying
- Care was excellent throughout and case is a good example of positive impact on quality of death

Patient 5:

Context – patient with mental health history , Cause of death – Suicide by hanging

Summary:

- Timely and appropriate care from senior A&E and ITU staff, rapid CT scanning performed. Medical care clearly documented at all stages Ancillary documentation and nursing records clear and legible
- Multiple, detailed discussions with the family regarding medical condition and poor prognosis documented from admission.
- No specialist palliative care input due to rapid death.
- Active treatment withdrawn due to futility; discussed with family. Clear documentation of clear efforts by A&E and ITU nursing and medical staff to keep the family informed and comfort them.
- Condition and prognosis documented, explanations of what to expect given. Written and verbal advice provided following death.

Action/Learning Points:
Patient 3 and Patient 5

- Medical Director to feedback outcome of reviews to the team/s involved, highlighting good practice and thanking them for provision of excellent care

- The acknowledgement of examples of excellence and good care by an independent reviewer is greatly valued by teams involved in that patient's care and will now become standard practice

Report ends

Bolton NHS Foundation Trust

Integrated Performance Report

January 2020

Guide to Statistical Process Control

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.

One or more points outside either of the upper or lower control limits.

6 or more consecutive points above or below the mean.

Common cause variation only.

6 or more consecutive points either ascending or descending in value.

Upper/ Lower Control Limit	Mean	Actual	Target

Executive Summary

Trust Objective	Variation					Assurance		
	(common)	H/L	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	0	0	0	2	1	0	14
Infection Prevention and Control	6	0	1	0	0	0	0	5
Mortality	1	1	0	1	0	1	0	2
Patient Experience	16	0	0	0	0	4	0	12
Maternity	8	1	1	0	0	1	0	9
Operational Performance								
Access	5	0	0	4	2	0	5	6
Productivity	10	1	0	1	0	1	0	11
Cancer	5	0	0	0	2	3	0	4
Community	3	1	0	0	0	0	1	3
Workforce								
Sickness, Vacancy and Turnover	1	0	1	1	0	0	1	2
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	0	5
Appendices								
Heat Maps								

Variation

- **Common cause variation.**
- **H (orange):** Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
- **L (orange):** Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
- **H (blue):** Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
- **L (blue):** 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

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.9%	Dec-19		>= 95%	95.0%	Nov-19	>= 95%	96.5%	
9 - Never Events	= 0	0	Dec-19		= 0	0	Nov-19	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.96	Dec-19		<= 5.30	5.73	Nov-19	<= 5.30	5.28	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	Dec-19		<= 1.6	1	Nov-19	<= 14.4	15	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	5.0	Dec-19		<= 6.0	8.0	Nov-19	<= 54.0	47.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Dec-19		<= 0.5	2.0	Nov-19	<= 4.5	2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Dec-19		= 0.0	0.0	Nov-19	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	4.0	Dec-19		<= 7.0	6.0	Nov-19	<= 63.0	64.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	2.0	Dec-19		<= 4.0	5.0	Nov-19	<= 36.0	27.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Dec-19		<= 1.0	1.0	Nov-19	<= 9.0	3.0	
21 - Total Pressure Damage due to lapses in care	<= 6	5	Dec-19		<= 6	9	Nov-19	<= 50	34	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	94.3%	Q4 2018/19		>= 90%	92.5%	Q3 2018/19	>= 90%		

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
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%	81.0%	Sep-19		>= 80%	80.0%	Aug-19	>= 80%	79.0%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	67.6%	Dec-19		>= 72.5%	69.3%	Nov-19	>= 72.5%	63.2%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	60.0%	Dec-19		= 100%	75.0%	Nov-19	= 100%	74.5%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	88.9%	Dec-19		>= 85%	87.5%	Nov-19	>= 85%	91.1%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	Dec-19		= 100%	100.0%	Nov-19	= 100%	177.8%	

6 - Compliance with preventative measure for VTE
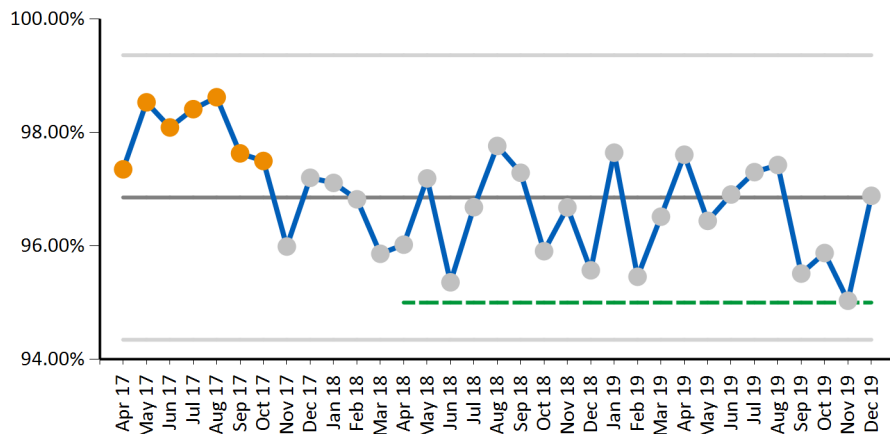
9 - Never Events
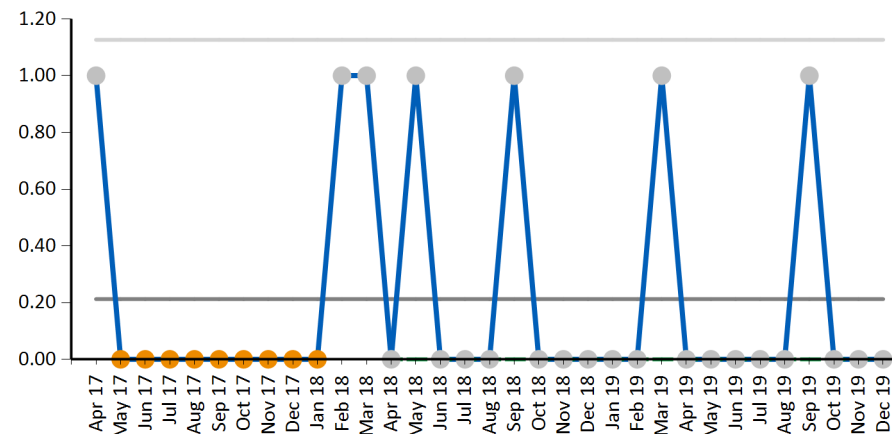
13 - All Inpatient Falls (Safeguard Per 1000 bed days)
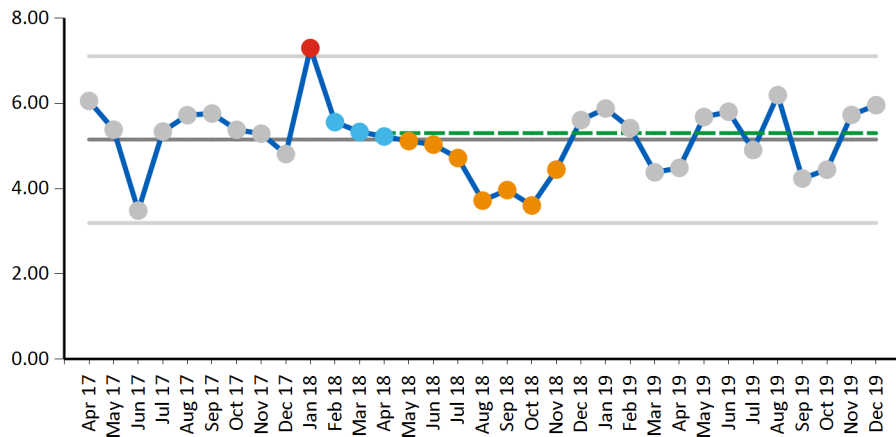
14 - Inpatient falls resulting in Harm (Moderate +)
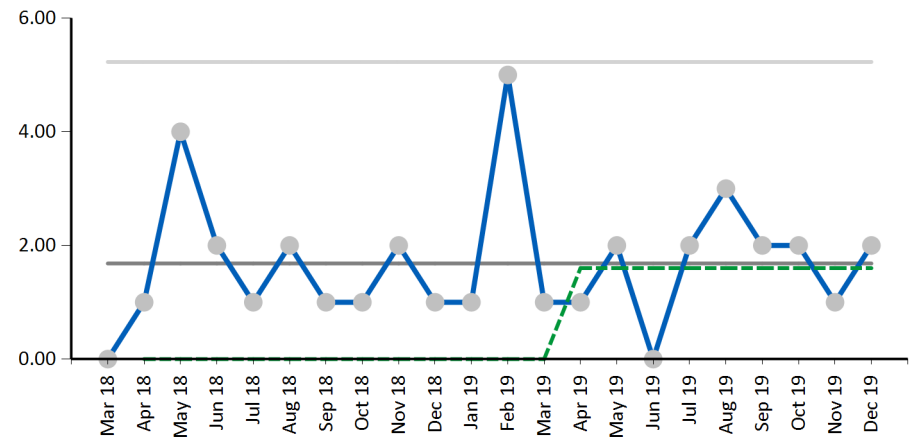
15 - Acute Inpatients acquiring pressure damage (category 2)
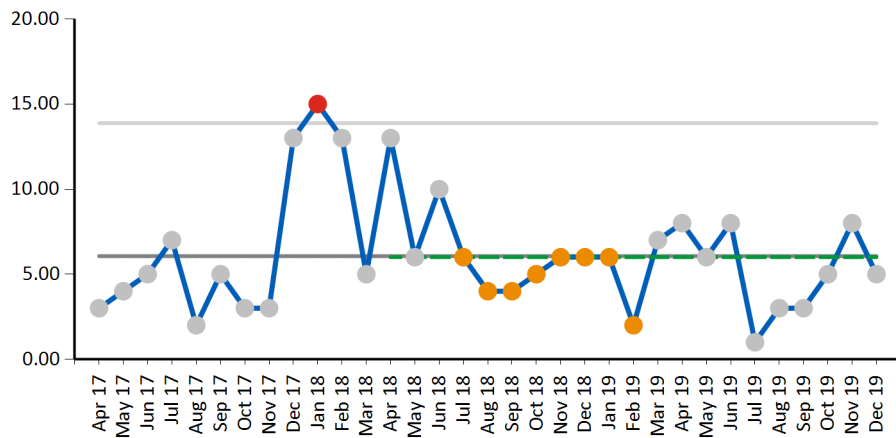
16 - Acute Inpatients acquiring pressure damage (category 3)
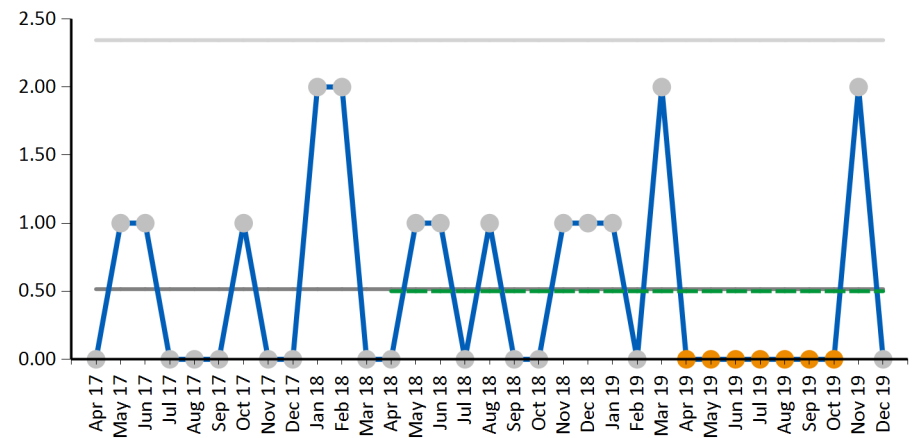
17 - Acute Inpatients acquiring pressure damage (category 4)
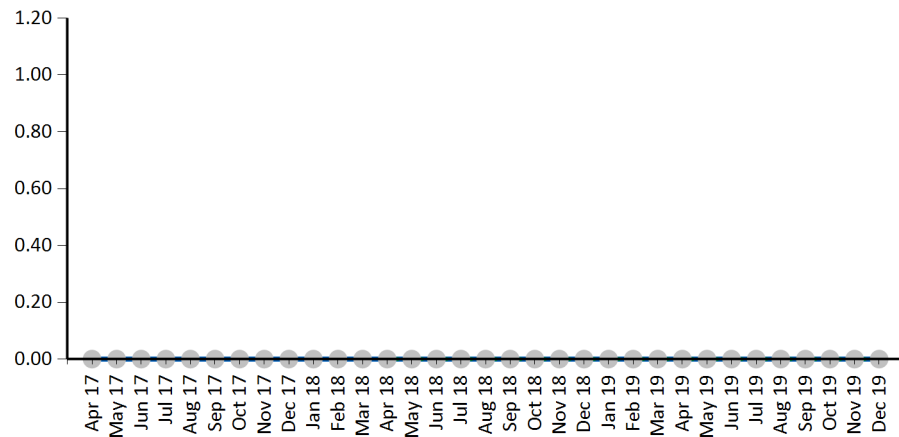
18 - Community patients acquiring pressure damage (category 2)
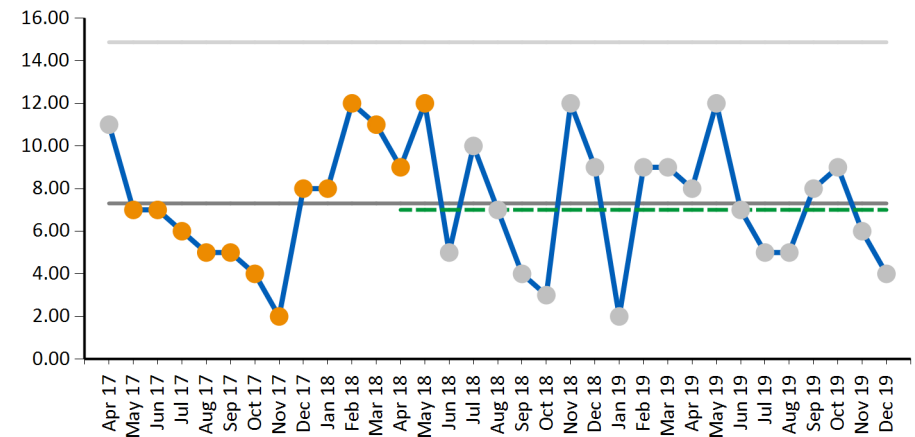
19 - Community patients acquiring pressure damage (category 3)
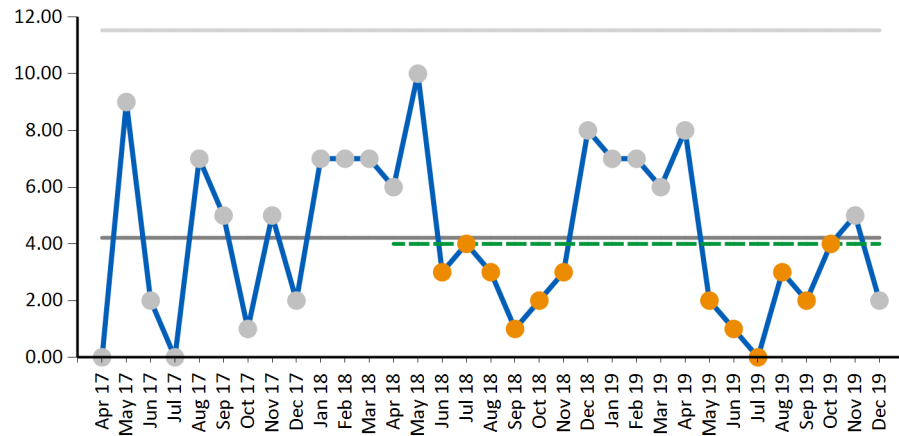
20 - Community patients acquiring pressure damage (category 4)
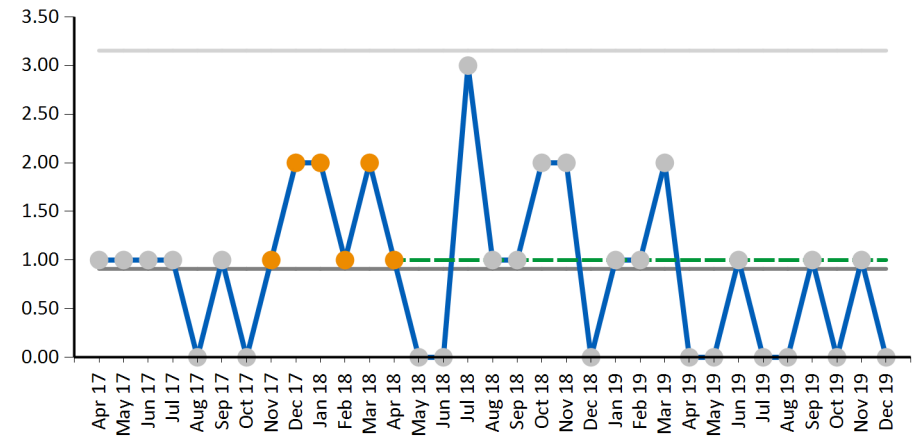
21 - Total Pressure Damage due to lapses in care
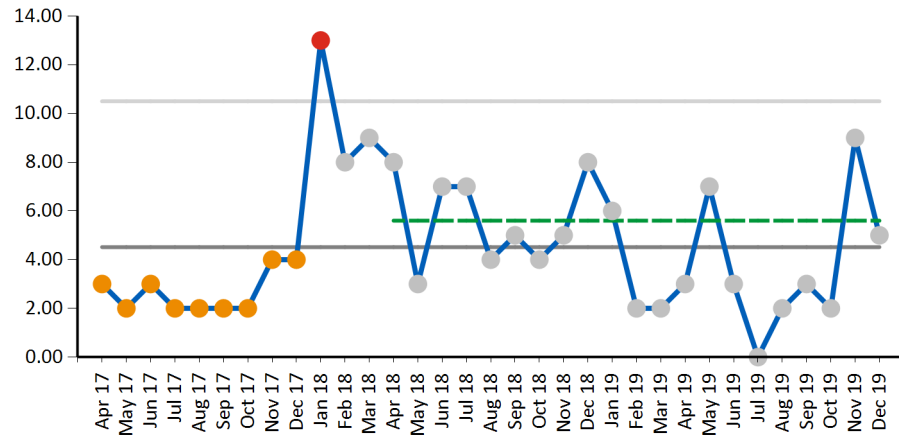
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points
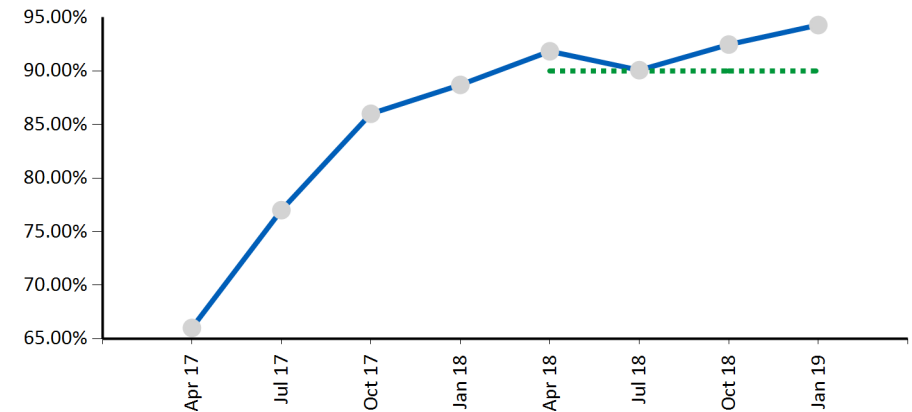
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points
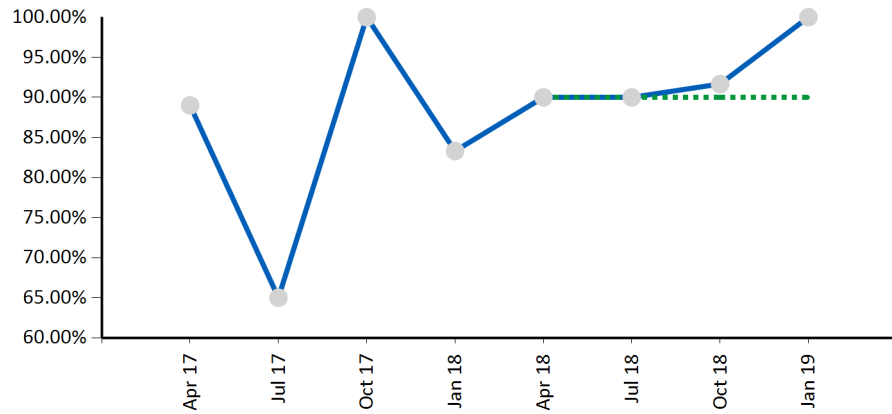
30 - Clinical Correspondence - Inpatients %<1 working day
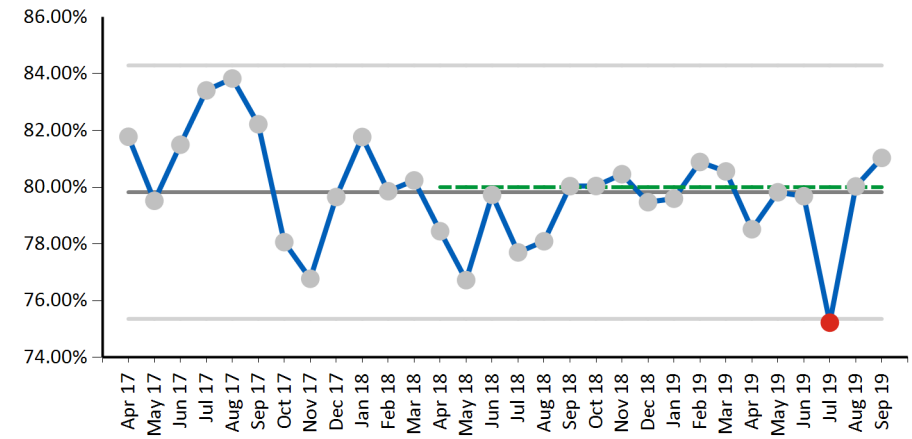
31 - Clinical Correspondence - Outpatients %<5 working days
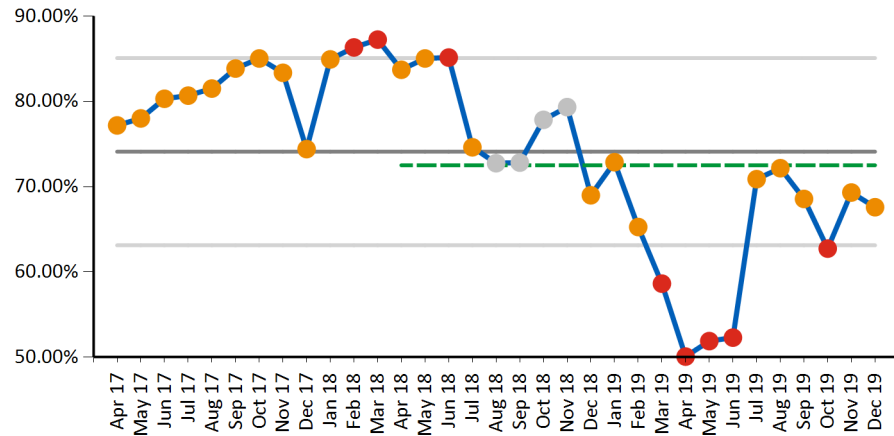
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance
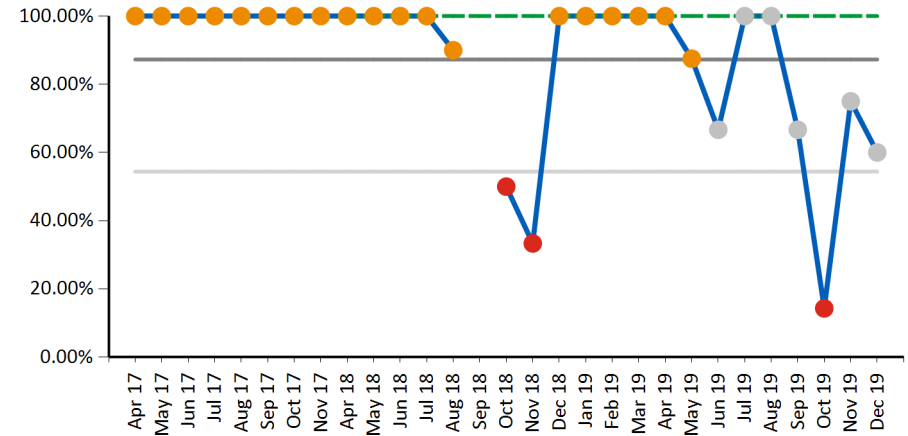
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)
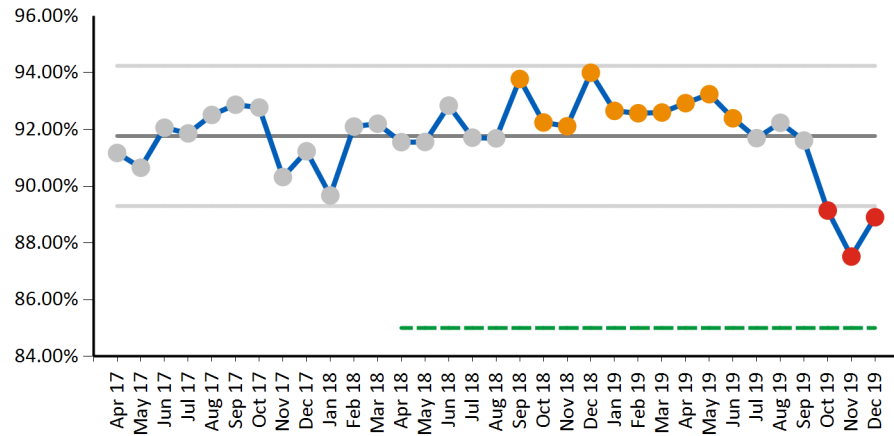
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days
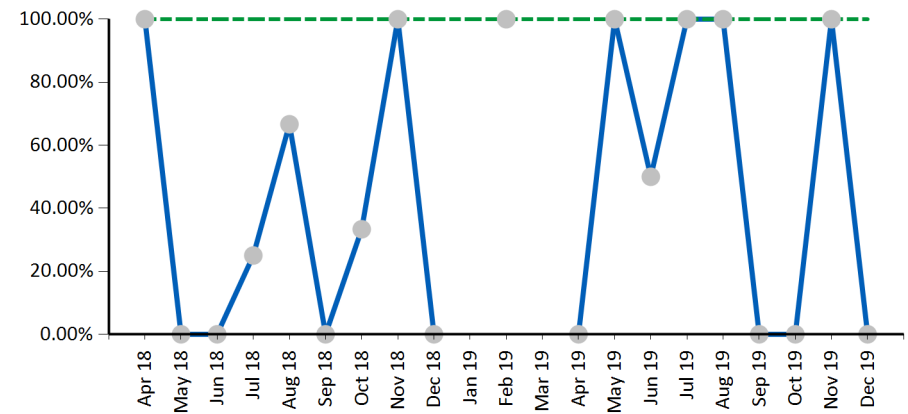
Infection Prevention and Control

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
215 - Total Hospital Onset C.diff infections	<= 3	2	Dec-19	●	<= 3	1	Nov-19	<= 23	28	?
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	0	Dec-19		<= 1	0	Nov-19	<= 10	21	
347 - Total C.diff infections contributing to objective	<= 3	2	Dec-19		<= 3	1	Nov-19	<= 23	44	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Dec-19	●	= 0	0	Nov-19	= 0	1	?
218 - Total Trust apportioned E. coli BSI	<= 4	3	Dec-19	●	<= 4	4	Nov-19	<= 36	29	?
219 - Blood Culture Contaminants (rate)	<= 3%	3.1%	Dec-19	(L)	<= 3%	3.7%	Nov-19	<= 3%	3.8%	?
199 - Compliance with antibiotic prescribing standards	>= 95%	85.2%	Q3 2018/19		>= 95%	86.0%	Q1 2018/19	>= 95%		
304 - Total Trust apportioned MSSA BSIs	<= 1.3	1.0	Dec-19	●	<= 1.3	4.0	Nov-19	<= 11.7	11.0	?
305 - Total Trust apportioned Klebsiella spp. BSIs		1	Dec-19	●		3	Nov-19		12	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs		0	Dec-19	●		0	Nov-19		1	

215 - Total Hospital Onset C.diff infections
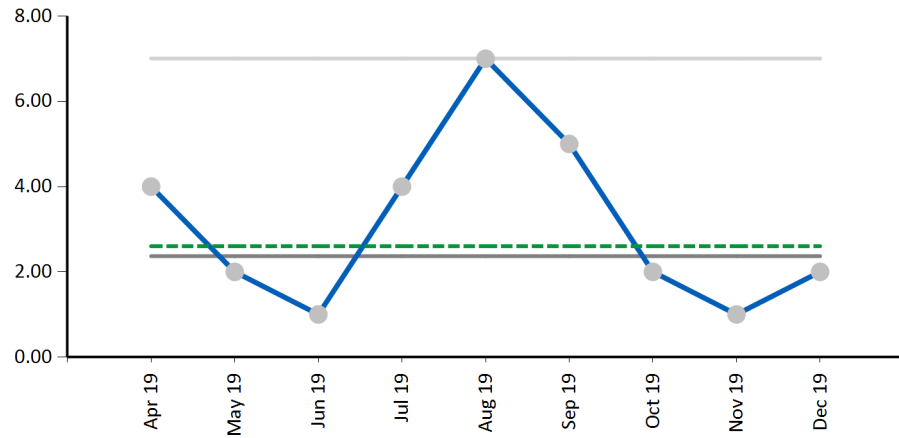
346 - Total Community Onset Hospital Associated C.diff infections - SPC data available after 20 data points
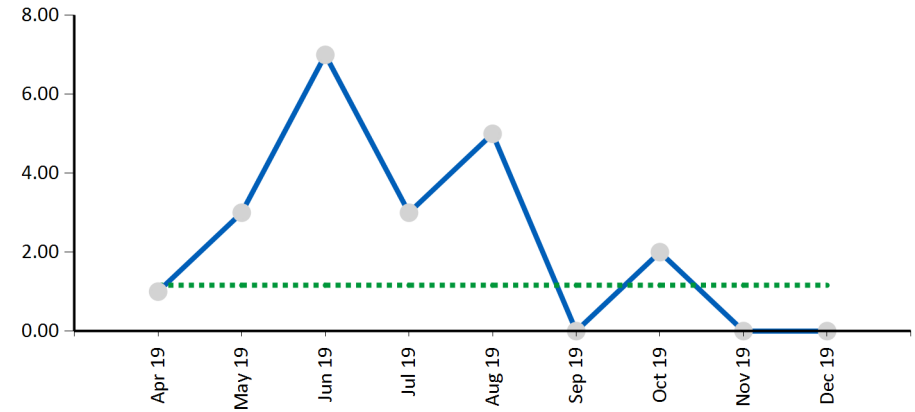
347 - Total C.diff infections contributing to objective - SPC data available after 20 data points
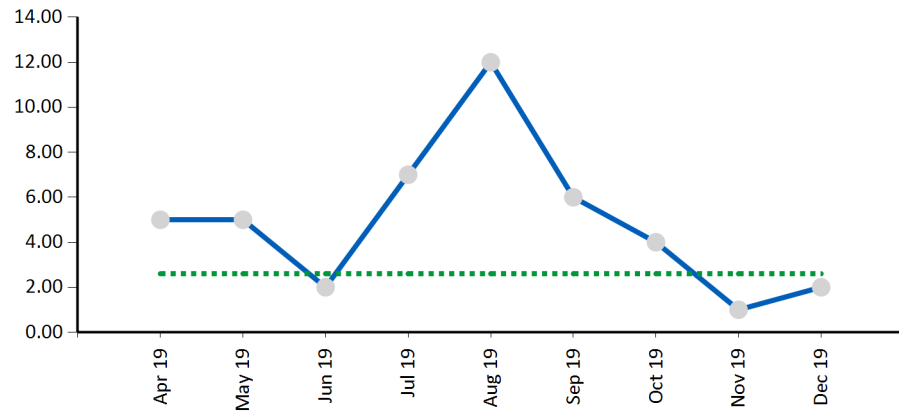
217 - Total Hospital-Onset MRSA BSIs
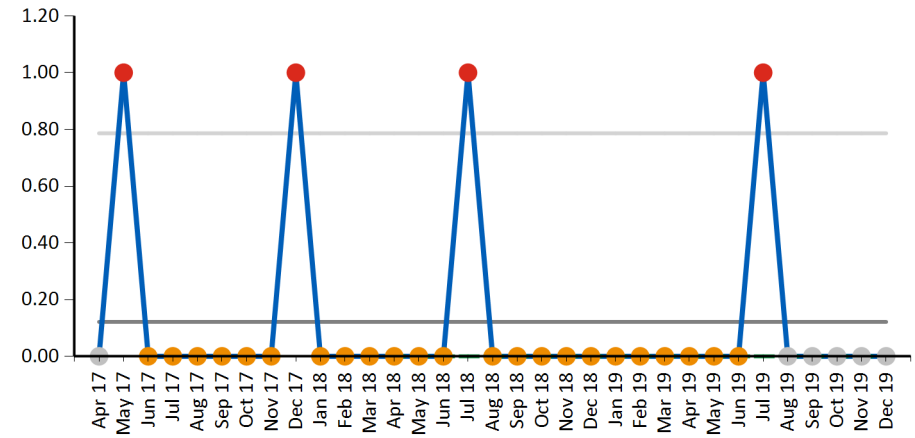
218 - Total Trust apportioned E. coli BSI
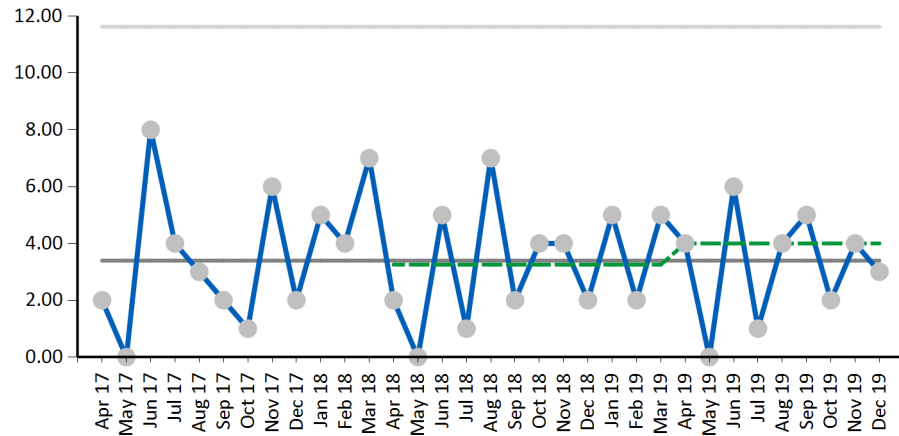
219 - Blood Culture Contaminants (rate)
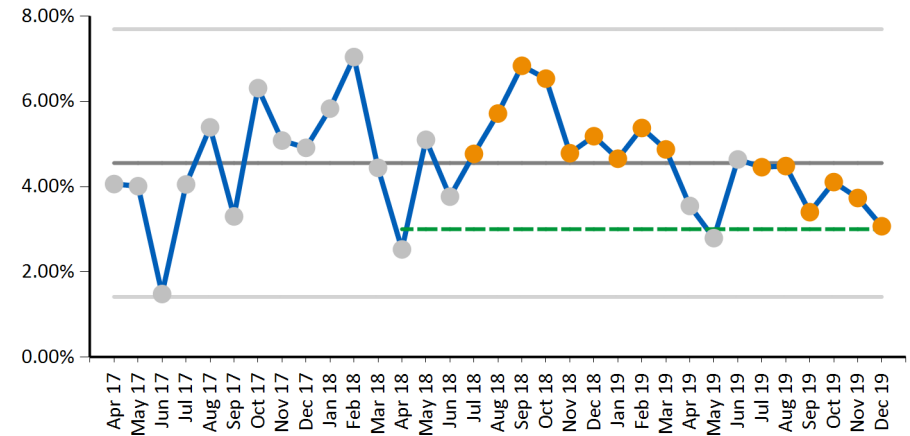
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points
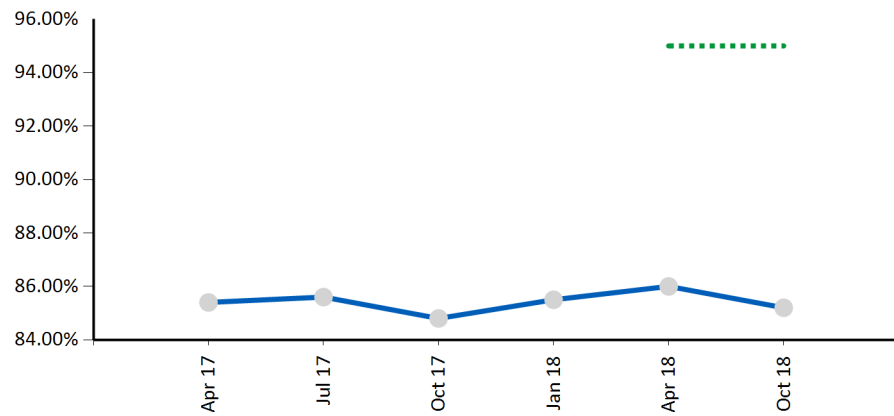
304 - Total Trust apportioned MSSA BSIs
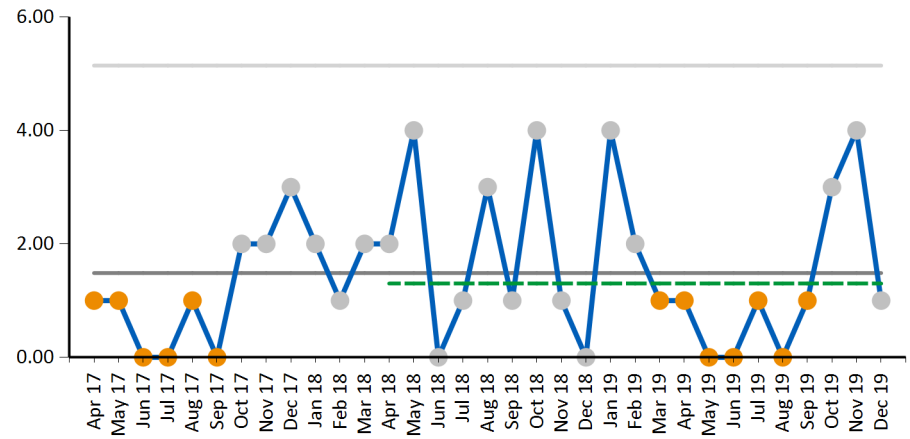
305 - Total Trust apportioned Klebsiella spp. BSIs
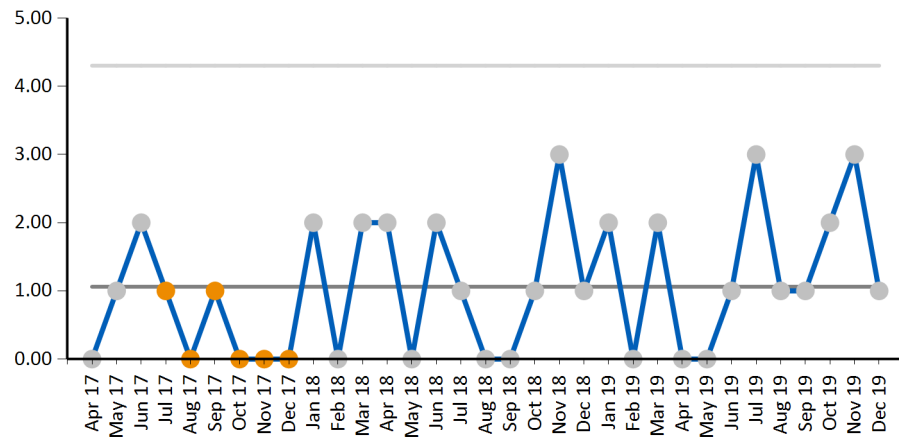
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs
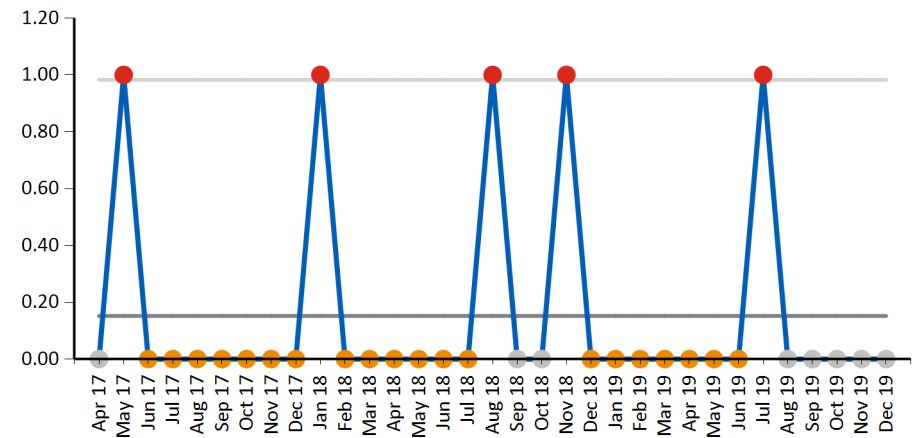
Mortality

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Dec-19	H	>= 85%	100.0%	Nov-19	>= 85%	96.9%	P
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	98.8	Oct-19	H	<= 90	98.7	Sep-19	<= 90	98.8	?
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	116.30	Jul-19		<= 100.00	116.60	Jun-19	<= 100.00	116.30	
12 - Crude Mortality %	<= 2.9%	2.4%	Dec-19		<= 2.9%	1.8%	Nov-19	<= 2.9%	2.0%	?

3 - National Early Warning Scores to Gold standard
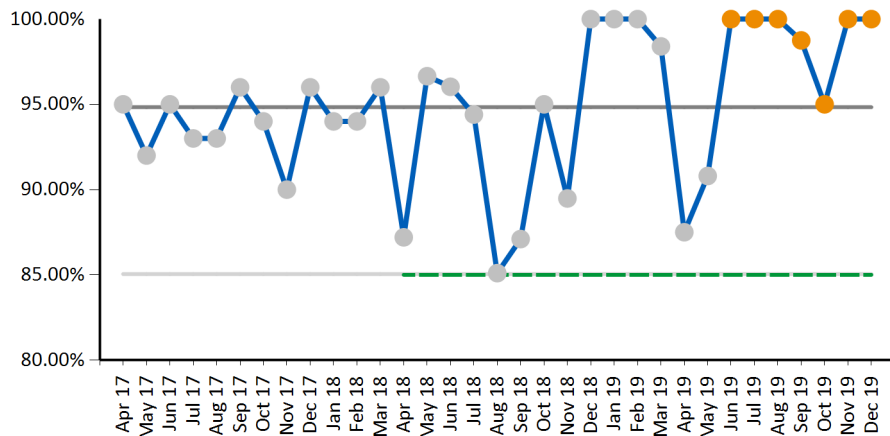
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)
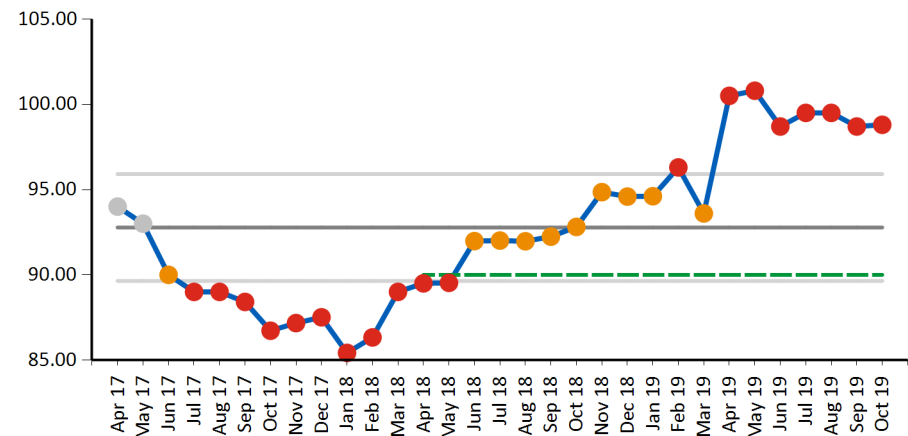
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears) - SPC data available after 20 data points
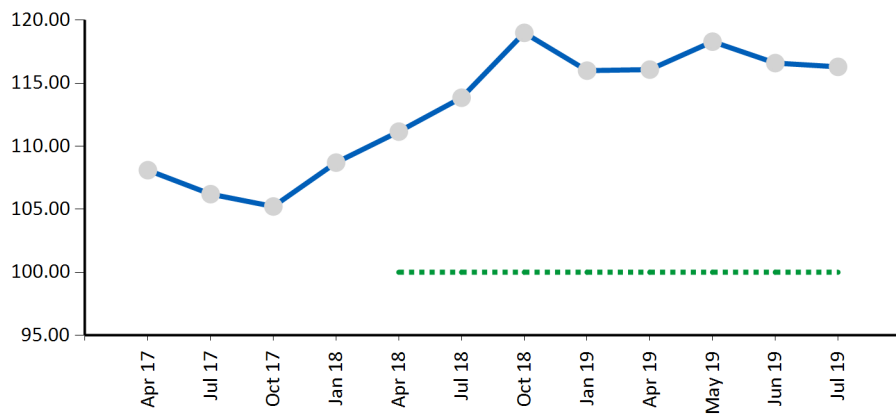
12 - Crude Mortality %
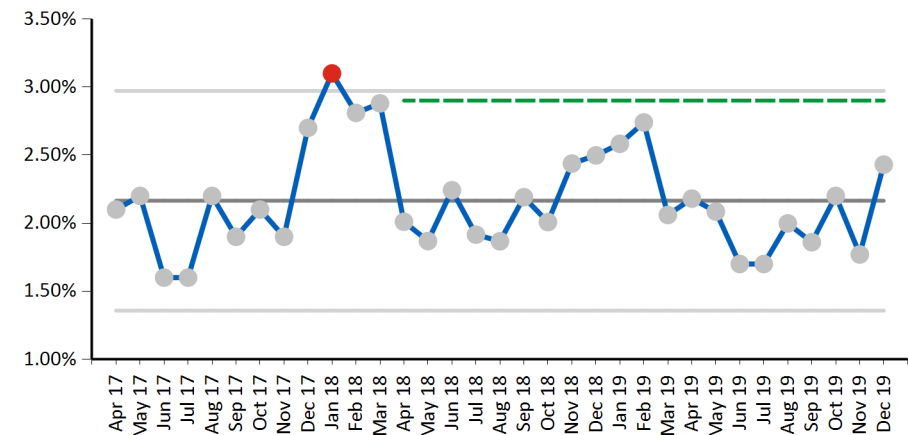
Patient Experience

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	19.7%	Dec-19		>= 20%	15.7%	Nov-19	>= 20%	18.3%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	92.9%	Dec-19		>= 90%	88.5%	Nov-19	>= 90%	91.0%	
80 - Inpatient Friends and Family Response Rate	>= 30%	25.1%	Dec-19		>= 30%	24.5%	Nov-19	>= 30%	27.9%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.2%	Dec-19		>= 90%	95.0%	Nov-19	>= 90%	96.3%	
81 - Maternity Friends and Family Response Rate	>= 15%	22.3%	Dec-19		>= 15%	21.6%	Nov-19	>= 15%	28.7%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	93.1%	Dec-19		>= 90%	89.3%	Nov-19	>= 90%	94.7%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	20.2%	Dec-19		>= 15%	14.5%	Nov-19	>= 15%	20.9%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Dec-19		>= 90%	97.6%	Nov-19	>= 90%	98.7%	
83 - Birth - Friends and Family Response Rate	>= 15%	27.2%	Dec-19		>= 15%	22.6%	Nov-19	>= 15%	30.9%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	87.3%	Dec-19		>= 90%	82.9%	Nov-19	>= 90%	91.0%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	13.3%	Dec-19		>= 15%	21.4%	Nov-19	>= 15%	27.6%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.3%	Dec-19		>= 90%	83.3%	Nov-19	>= 90%	91.6%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	27.4%	Dec-19		>= 15%	29.4%	Nov-19	>= 15%	36.8%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.0%	Dec-19		>= 90%	94.7%	Nov-19	>= 90%	97.6%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Dec-19		= 100%	100.0%	Nov-19	= 100%	98.8%	
90 - Complaints responded to within the period	>= 95%	95.0%	Dec-19		>= 95%	93.9%	Nov-19	>= 95%	95.6%	

200 - A&E Friends and Family Response Rate
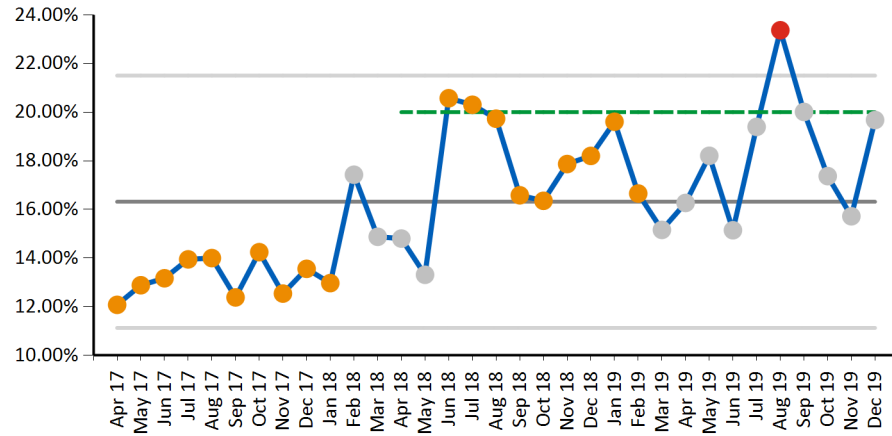
294 - A&E Friends and Family Satisfaction Rates %
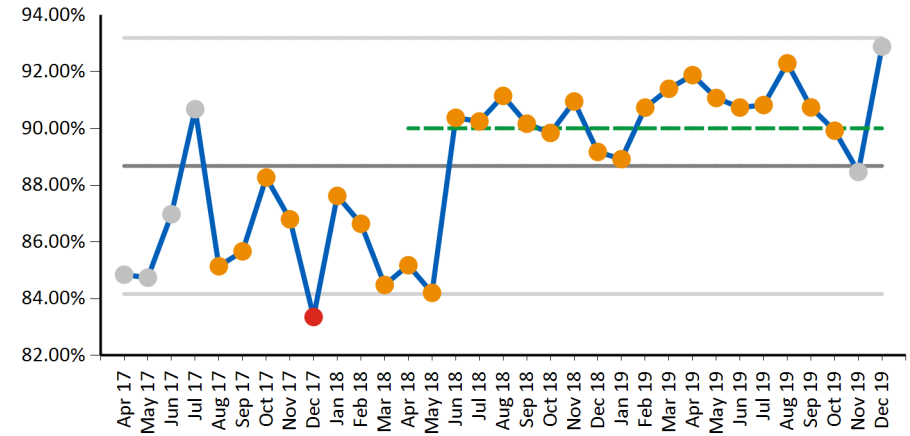
80 - Inpatient Friends and Family Response Rate
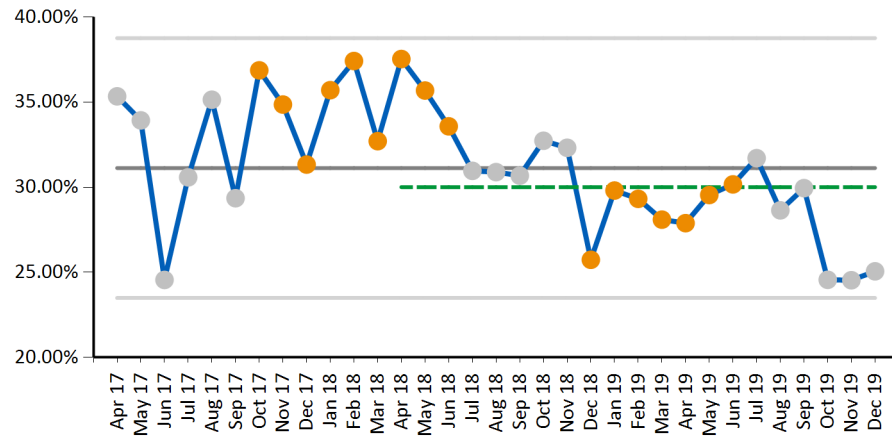
240 - Friends and Family Test (Inpatients) - Satisfaction %
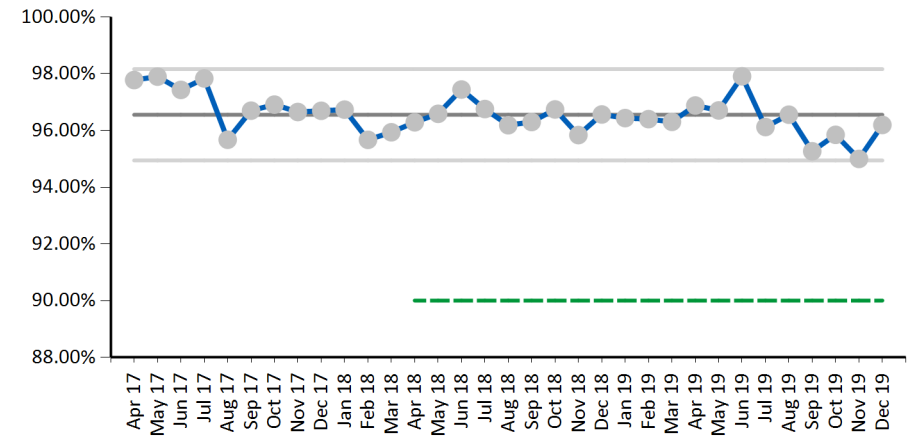
81 - Maternity Friends and Family Response Rate
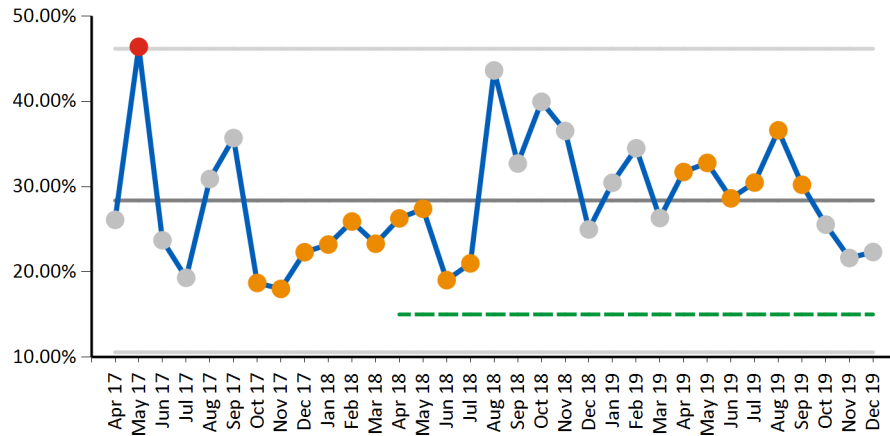
241 - Maternity Friends and Family Test - Satisfaction %
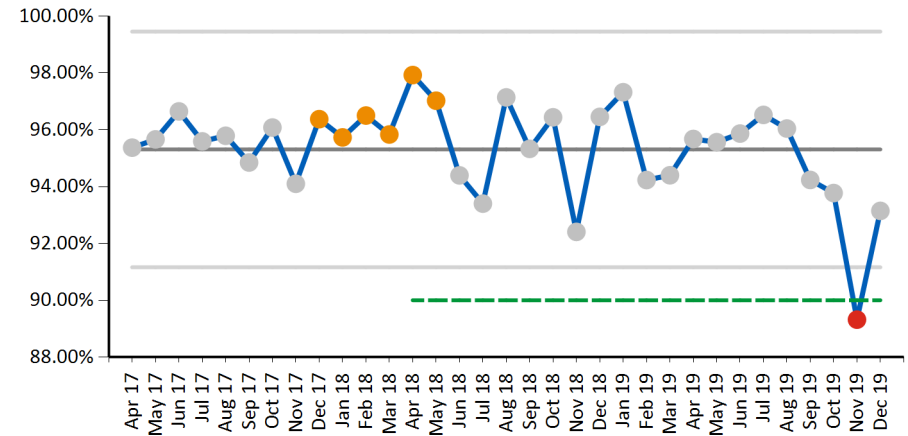
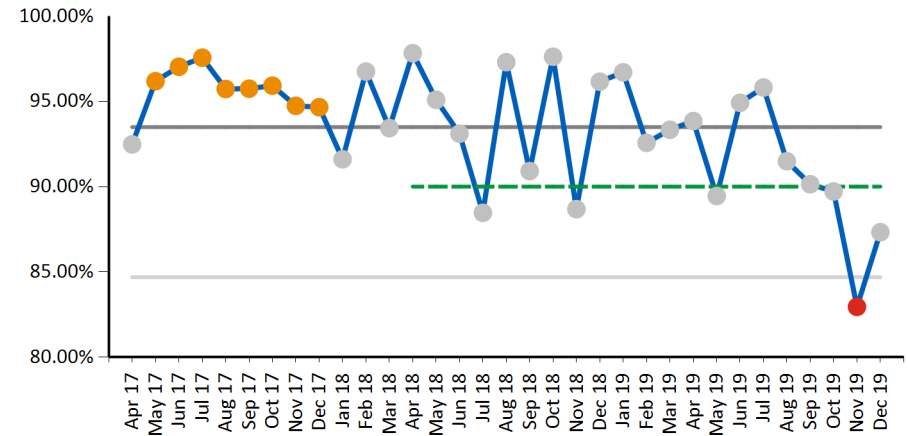**82 - Antenatal - Friends and Family Response Rate**
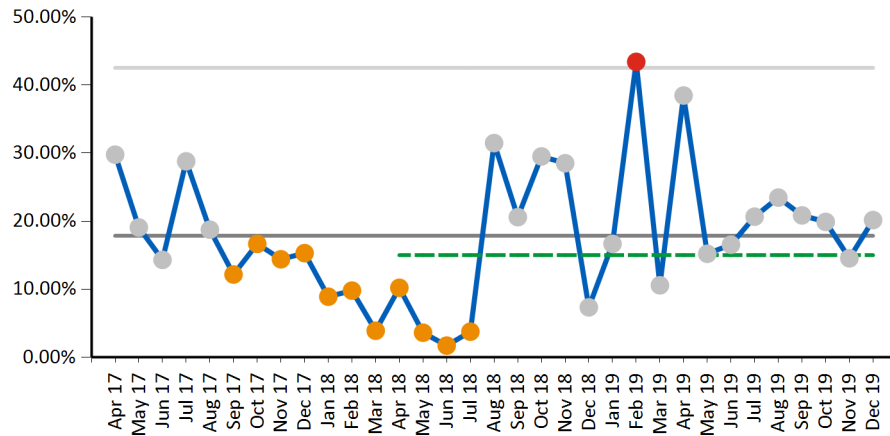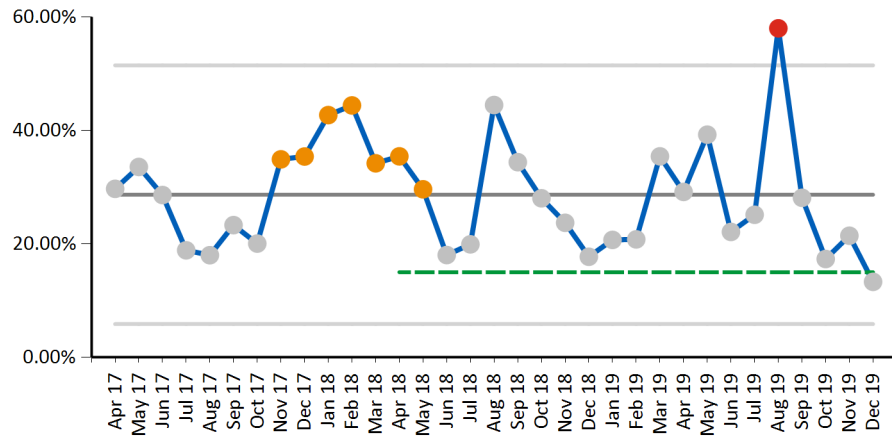

242 - Antenatal Friends and Family Test - Satisfaction %
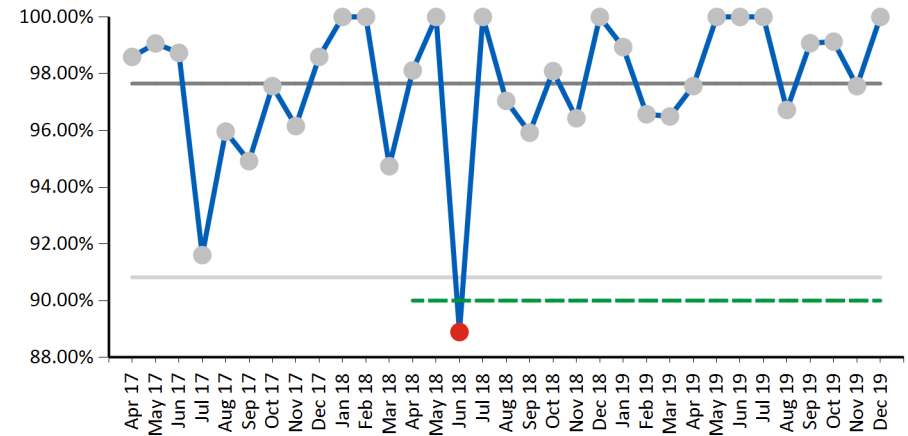
83 - Birth - Friends and Family Response Rate
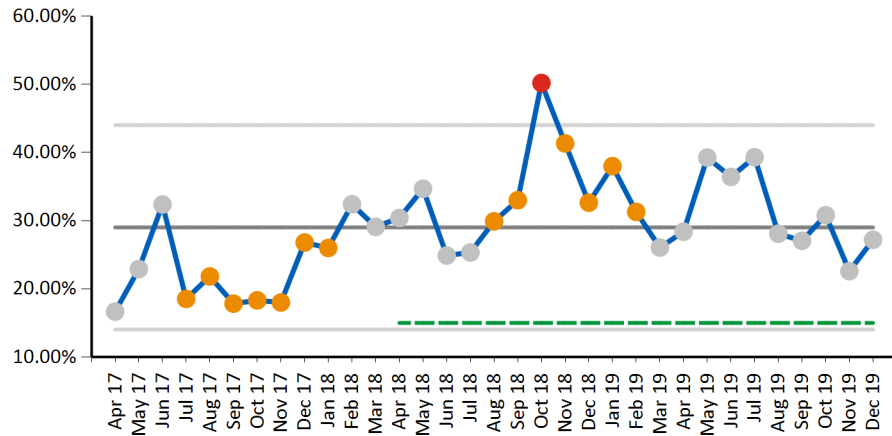
243 - Birth Friends and Family Test - Satisfaction %

84 - Hospital Postnatal - Friends and Family Response Rate

244 - Hospital Postnatal Friends and Family Test - Satisfaction %
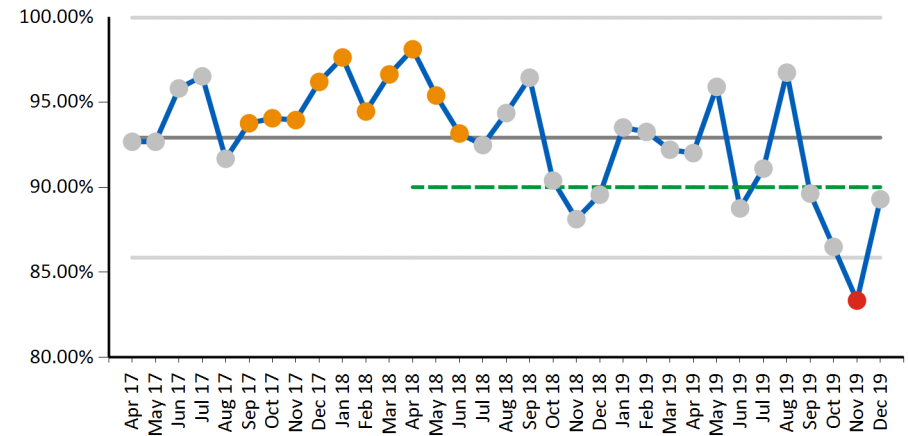
85 - Community Postnatal - Friend and Family Response Rate
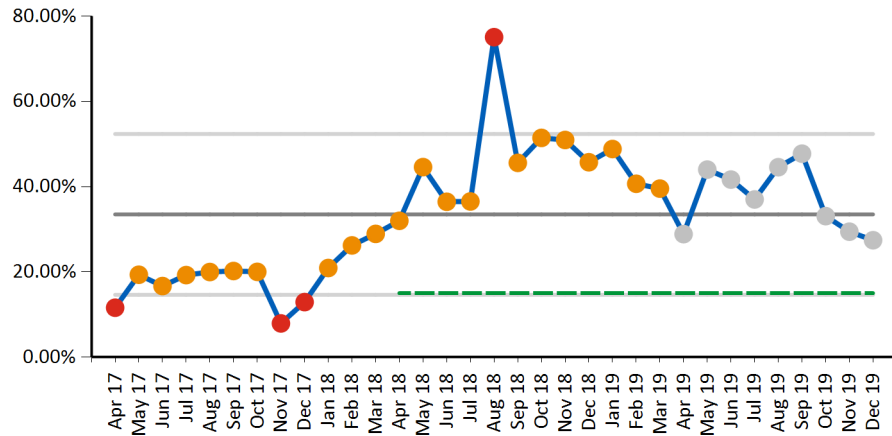
245 - Community Postnatal Friends and Family Test - Satisfaction %
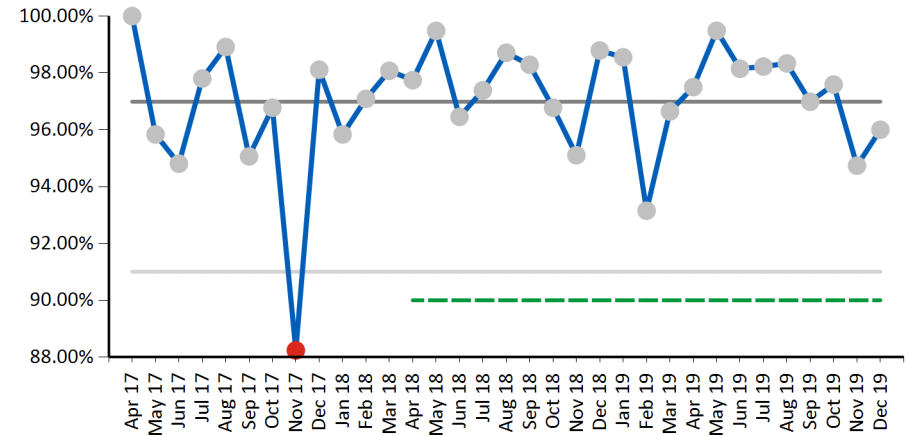
89 - Formal complaints acknowledged within 3 working days
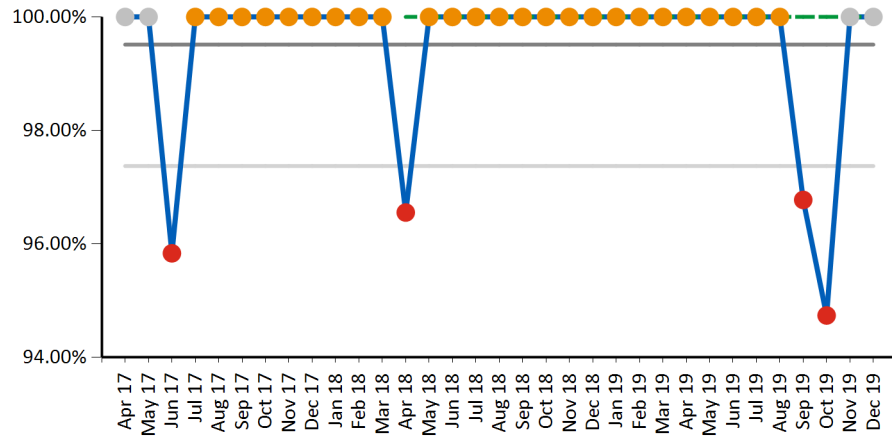
90 - Complaints responded to within the period
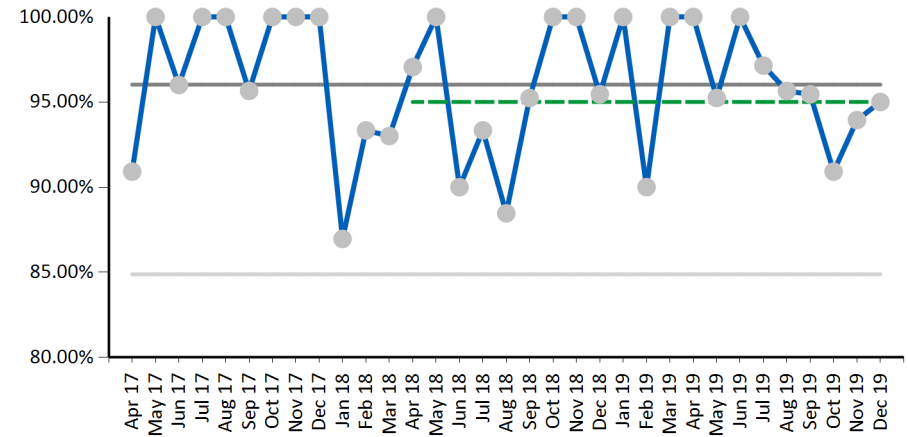
Maternity

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	8.03	Dec-19		<= 3.50	5.48	Nov-19	<= 3.50	4.66	
23 - Maternity -3rd/4th degree tears	<= 2.5%	2.9%	Dec-19		<= 2.5%	2.1%	Nov-19	<= 2.5%	2.4%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.0%	Dec-19		>= 95.0%	99.6%	Nov-19	>= 95.0%	98.7%	
203 - Booked 12+6	>= 90.0%	92.3%	Dec-19		>= 90.0%	92.4%	Nov-19	>= 90.0%	89.6%	
204 - Inductions of labour	<= 35%	37.9%	Dec-19		<= 35%	39.2%	Nov-19	<= 35%	40.2%	
208 - Total C section	<= 29.0%	30.0%	Dec-19		<= 29.0%	28.5%	Nov-19	<= 29.0%	28.6%	
210 - Initiation breast feeding	>= 65%	67.89%	Dec-19		>= 65%	68.77%	Nov-19	>= 65%	68.11%	
213 - Maternity complaints	<= 5	3	Dec-19		<= 5	1	Nov-19	<= 45	29	
319 - Maternal deaths (direct)	= 0	0	Dec-19		= 0	0	Nov-19	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.2%	Dec-19		<= 6%	8.2%	Nov-19	<= 6%	9.6%	

322 - Maternity - Stillbirths per 1000 births
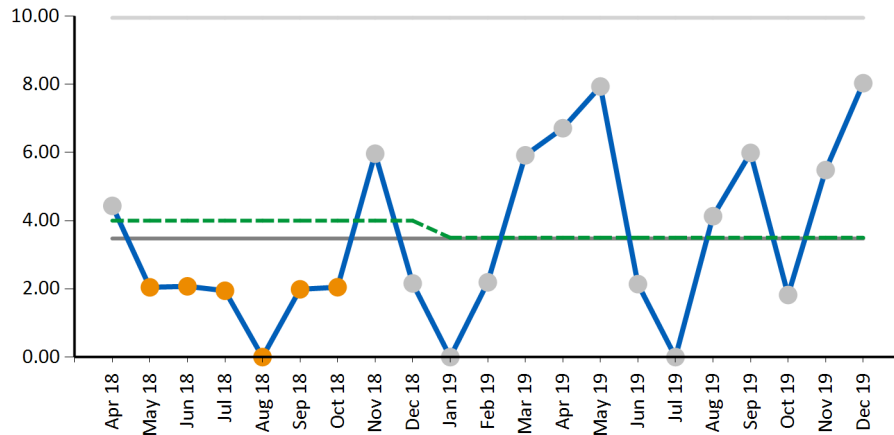
23 - Maternity -3rd/4th degree tears
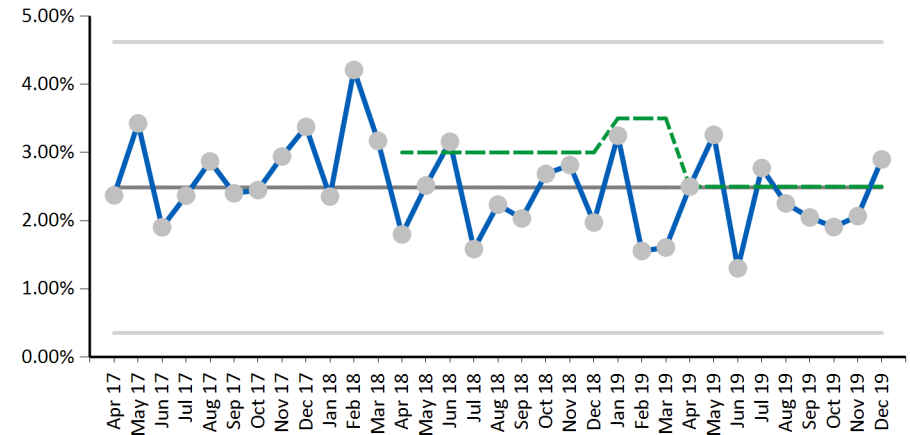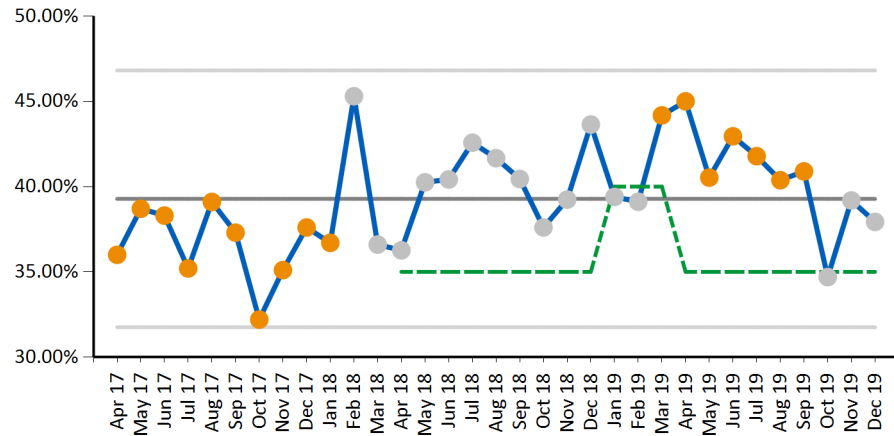

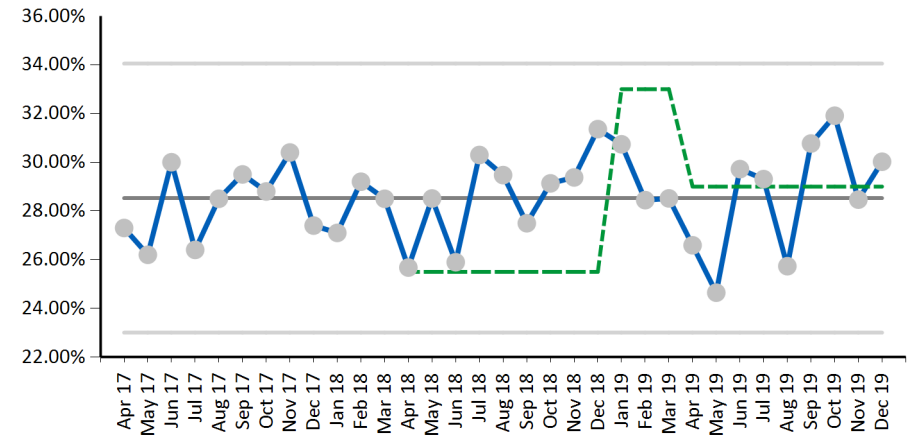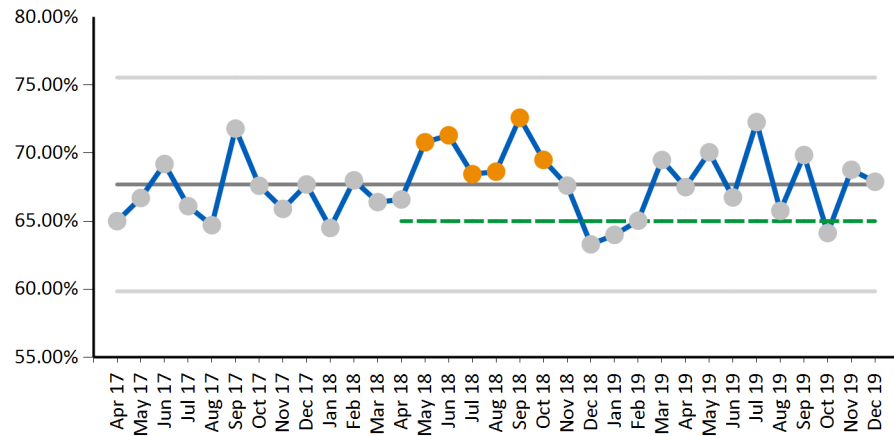## 202 - 1:1 Midwifery care in labour
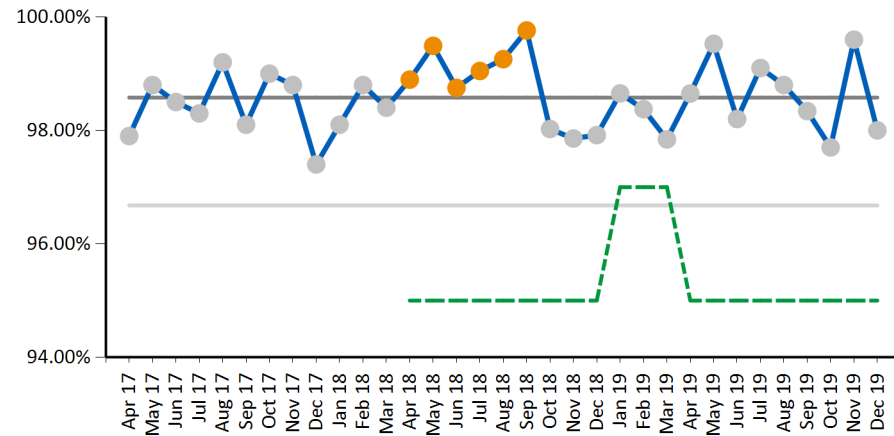
203 - Booked 12+6
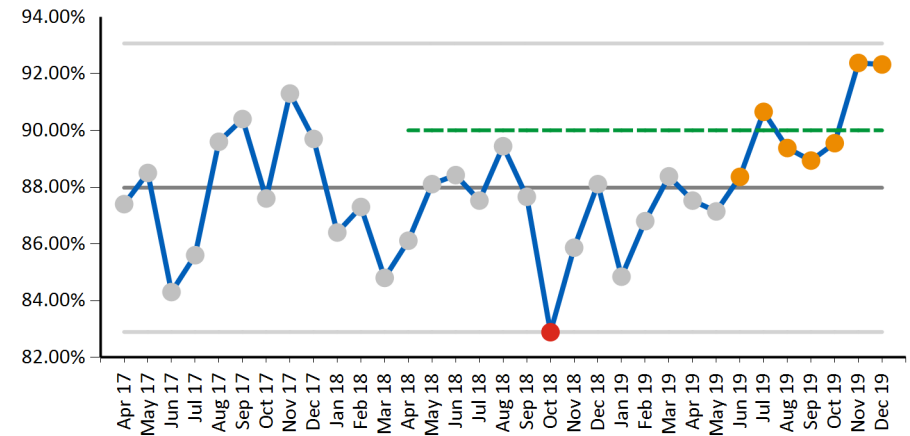
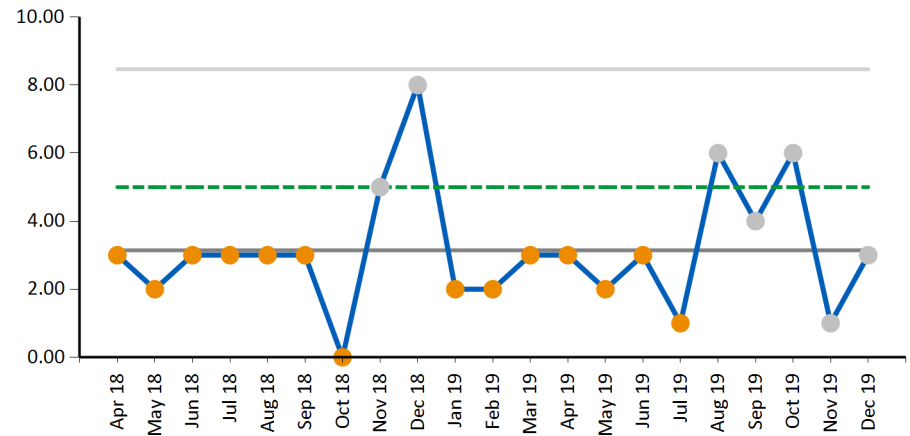## 204 - Inductions of labour

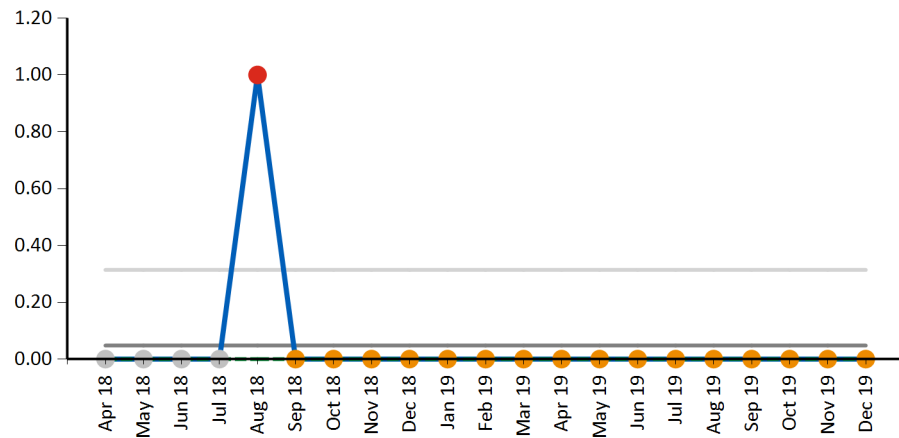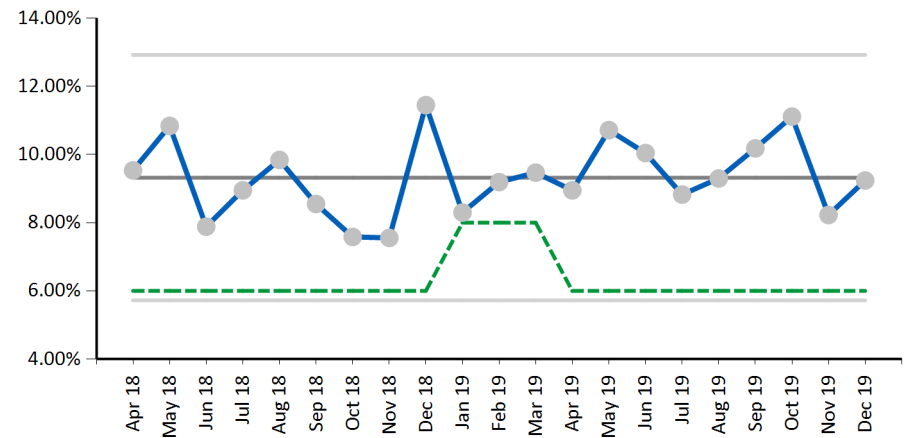## 208 - Total C section

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

| Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 31	67	Dec-19	H	<= 30	49	Nov-19	<= 275	351	?
8 - Same sex accommodation breaches	= 0	18	Dec-19		= 0	18	Nov-19	= 0	139	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	64.9%	Dec-19		>= 75%	71.0%	Nov-19	>= 75%	70.2%	?
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	78.4%	Dec-19	L	>= 92%	80.9%	Nov-19	>= 92%	83.8%	F
42 - RTT 52 week waits (incomplete pathways)	= 0	9	Dec-19	H	= 0	9	Nov-19	= 0	59	?
314 - RTT 18 week waiting list	<= 22,812	27,562	Dec-19	H	<= 22,812	27,878	Nov-19	<= 22,812	27,562	F
53 - A&E 4 hour target	>= 95%	70.6%	Dec-19	L	>= 95%	70.9%	Nov-19	>= 95%	80.4%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	12.9%	Dec-19		= 0.0%	9.7%	Nov-19	= 0.0%	6.6%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	12.37%	Dec-19	H	= 0.00%	8.58%	Nov-19	= 0.00%	4.19%	?
72 - Diagnostic Waits >6 weeks %	<= 1%	0.9%	Dec-19		<= 1%	0.6%	Nov-19	<= 1%	0.9%	?
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	33.3%	Dec-19		= 100%	16.7%	Nov-19	= 100%	56.1%	?

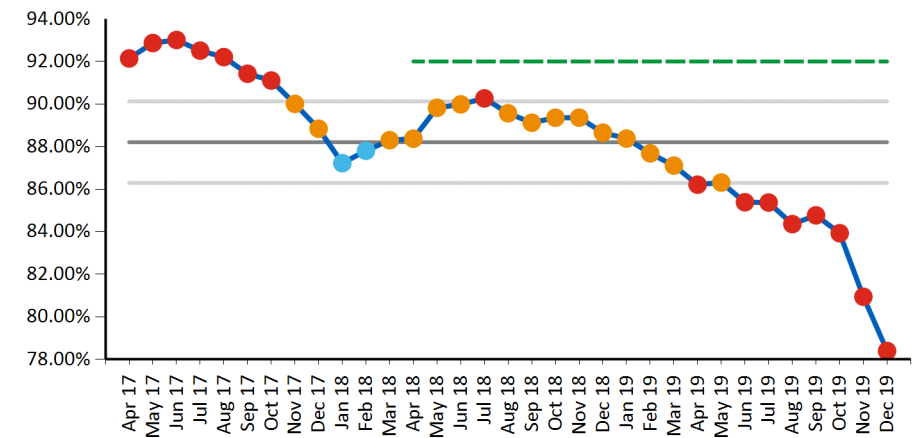**7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)**
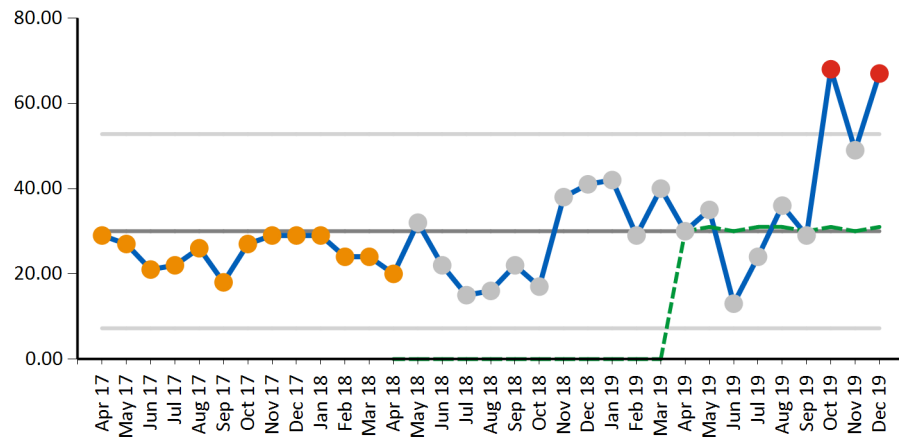
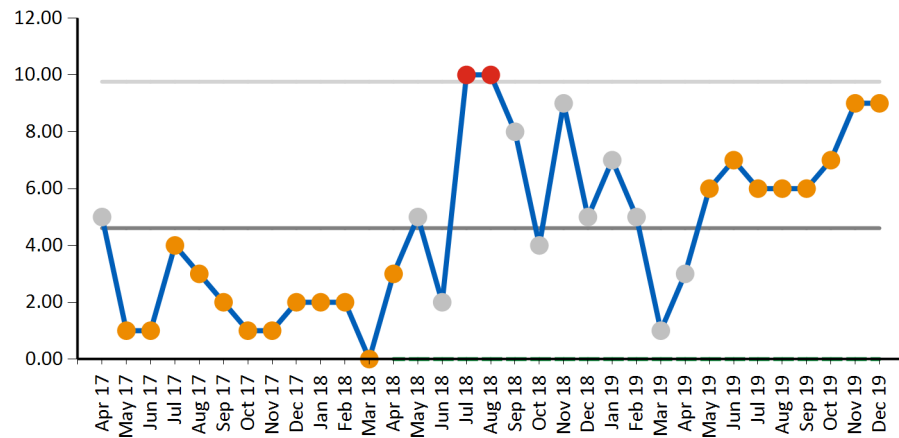**8 - Same sex accommodation breaches**
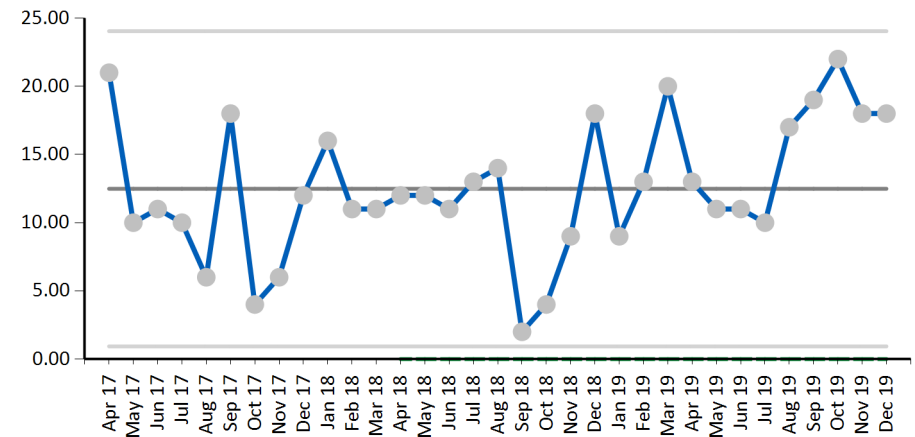
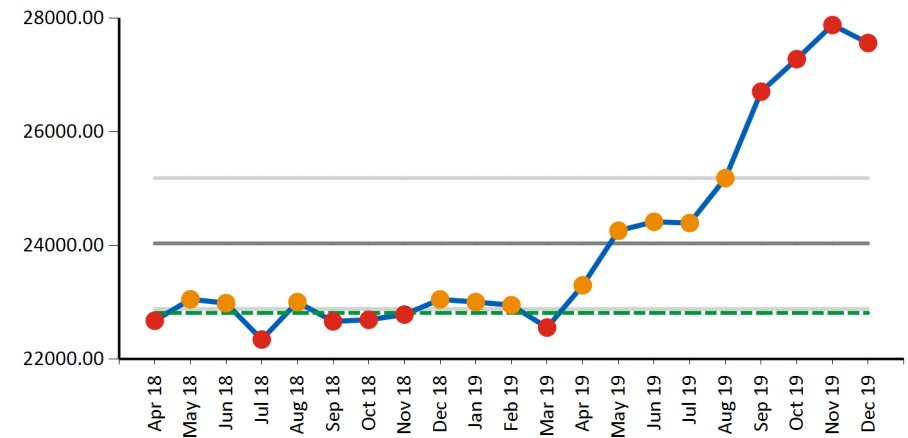**26 - Patients going to theatre within 36 hours of a fractured Neck of Femur**
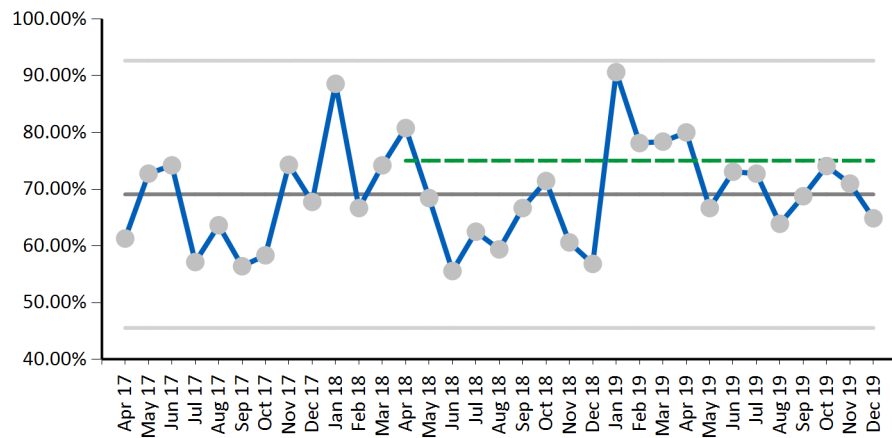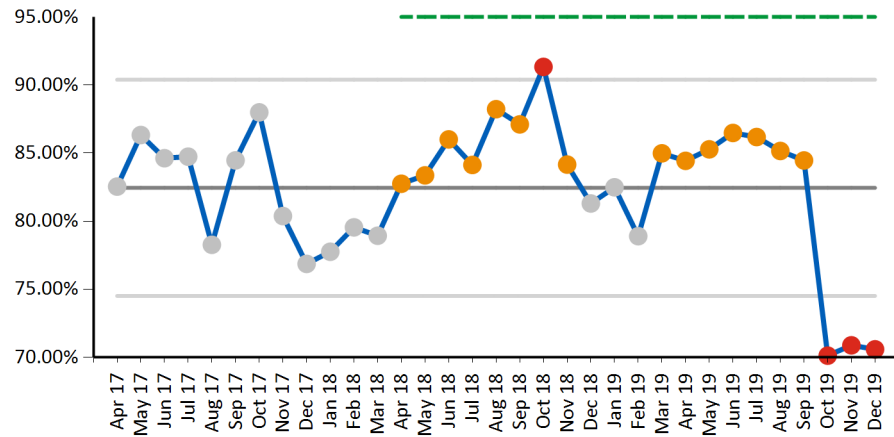

41 - RTT Incomplete pathways within 18 weeks %
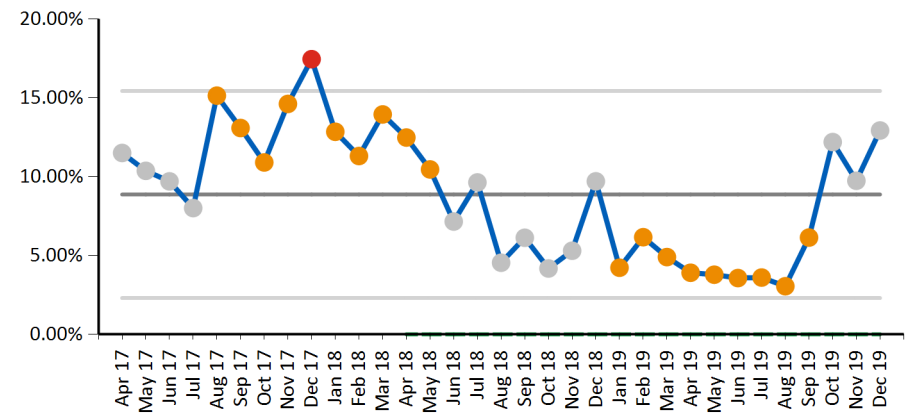
42 - RTT 52 week waits (incomplete pathways)

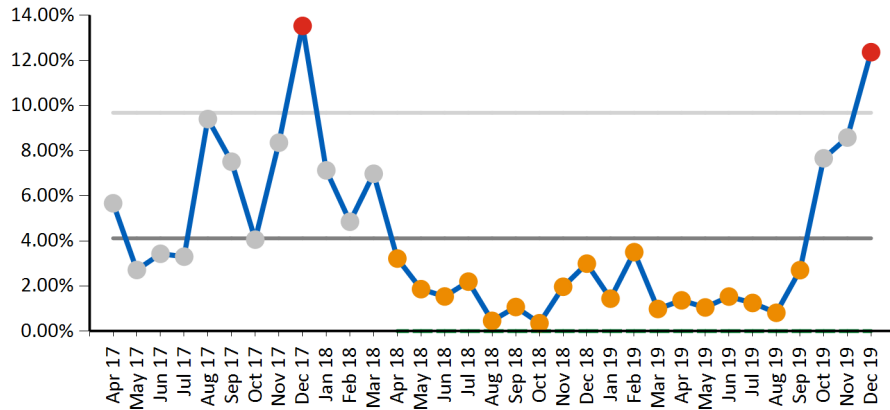**314 - RTT 18 week waiting list**

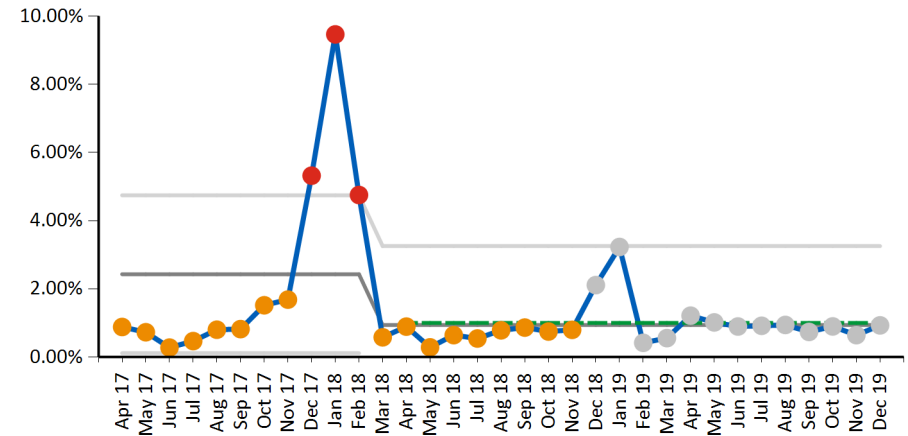**53 - A&E 4 hour target**

70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)
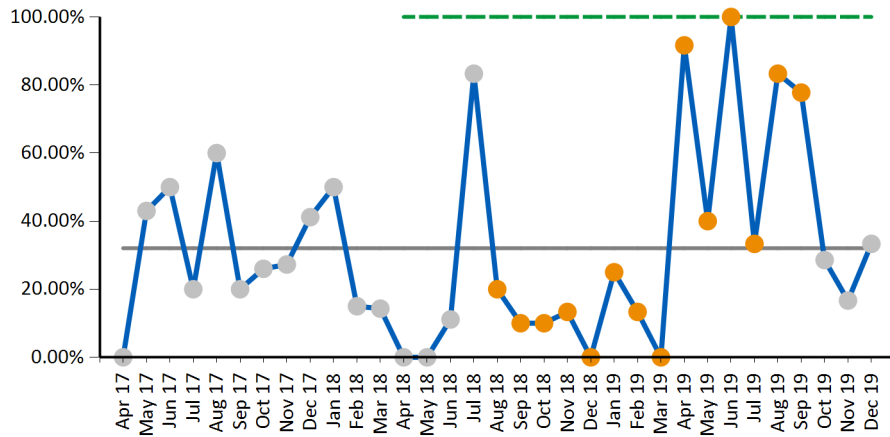
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)


72 - Diagnostic Waits >6 weeks %


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

Productivity

| Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	266	Dec-19		<= 200	243	Nov-19	<= 200	266	
307 - Stranded Patients - LOS 21 days and over	<= 69	81	Dec-19		<= 69	90	Nov-19	<= 69	81	
57 - Discharges by Midday	>= 30%	25.2%	Dec-19		>= 30%	29.5%	Nov-19	>= 30%	28.5%	
58 - Discharges by 4pm	>= 70%	62.9%	Dec-19		>= 70%	65.2%	Nov-19	>= 70%	66.5%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	13.7%	Nov-19		<= 13.5%	11.4%	Oct-19	<= 13.5%	11.7%	
60 - Daycase Rates	>= 80%	91.7%	Dec-19		>= 80%	89.8%	Nov-19	>= 80%	89.9%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	3.0%	Dec-19		<= 1%	3.3%	Nov-19	<= 1%	2.3%	
62 - Cancelled operations re-booked within 28 days	= 100%	71.4%	Dec-19		= 100%	88.0%	Nov-19	= 100%	84.0%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	3.4%	Dec-19		<= 3.3%	3.4%	Nov-19	<= 3.3%	2.9%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.99	Dec-19		<= 2.00	2.85	Nov-19	<= 2.00	2.57	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.69	Dec-19		<= 3.70	4.10	Nov-19	<= 3.70	4.66	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	77.3%	Nov-19		>= 80%	82.6%	Oct-19	>= 80%	88.6%	

56 - Stranded patients
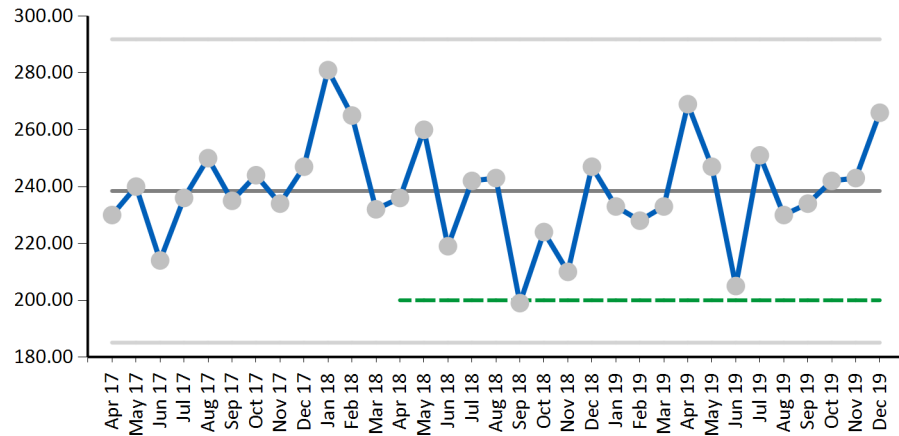
307 - Stranded Patients - LOS 21 days and over
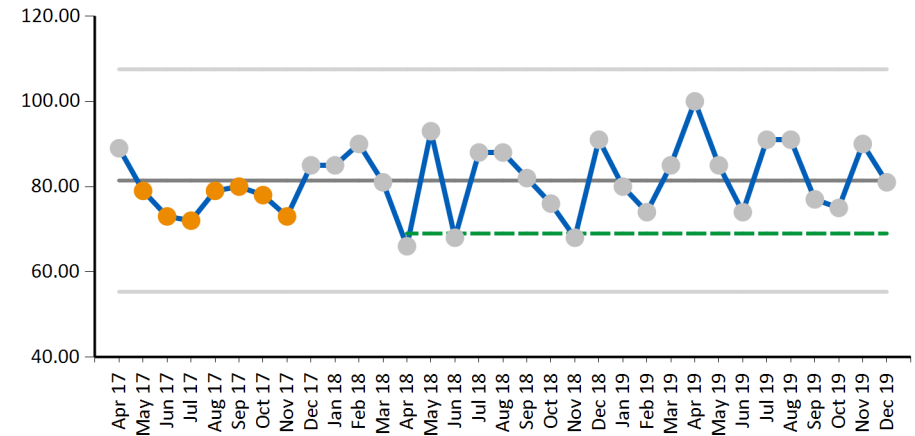
57 - Discharges by Midday
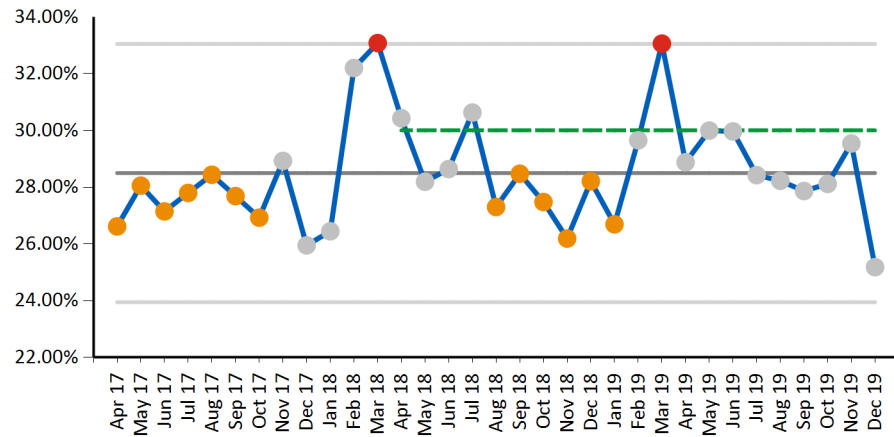
58 - Discharges by 4pm
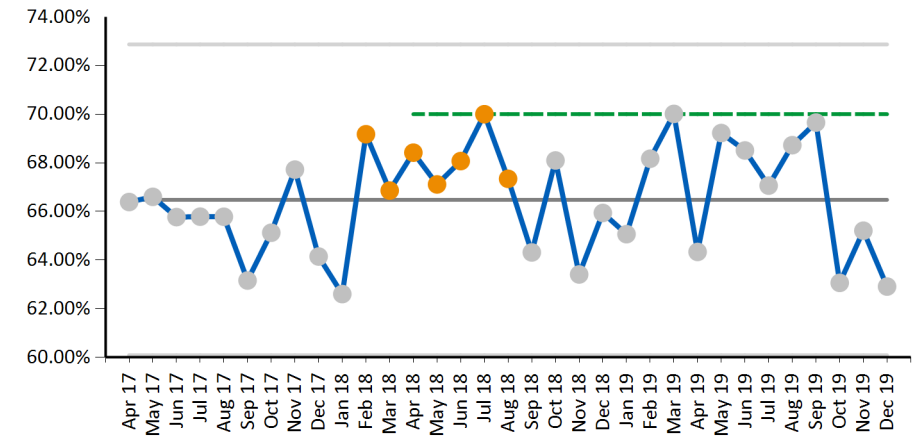
59 - Re-admission within 30 days of discharge (1 mth in arrears)
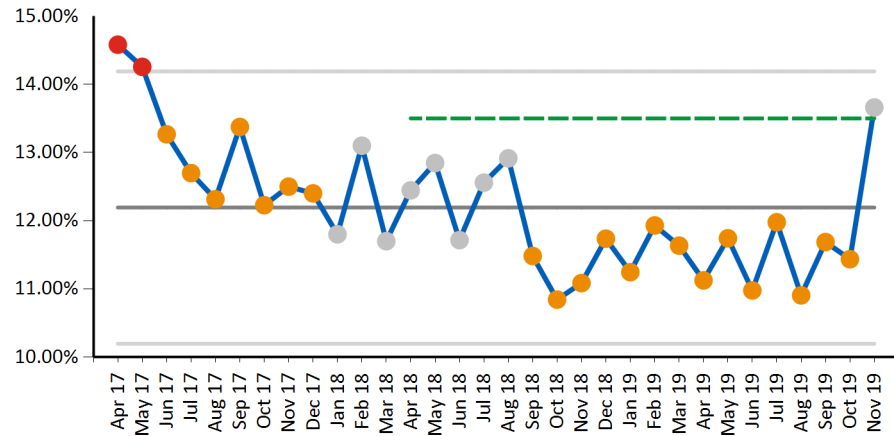
60 - Daycase Rates
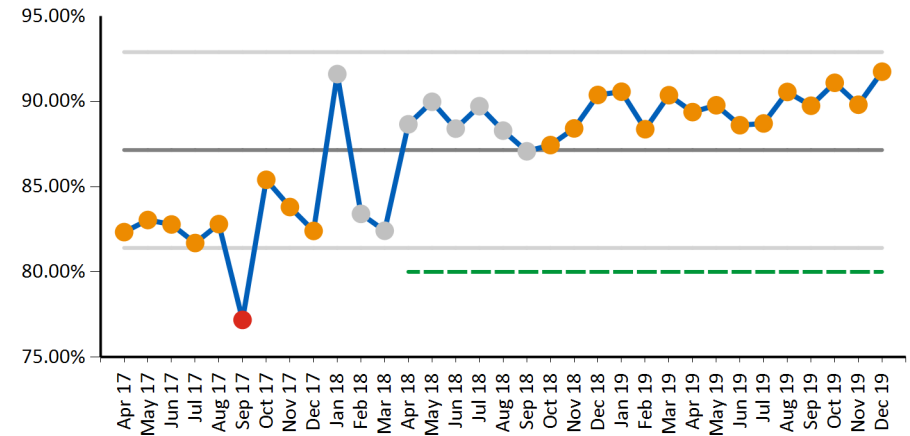
61 - Operations cancelled on the day for non-clinical reasons
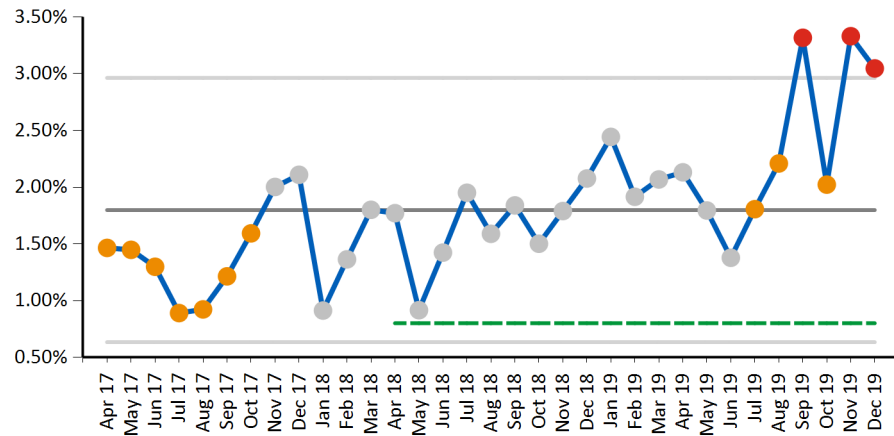
62 - Cancelled operations re-booked within 28 days

318 - Delayed Transfers Of Care (Trust Total)

65 - Elective Length of Stay (Discharges in month)

66 - Non Elective Length of Stay (Discharges in month)
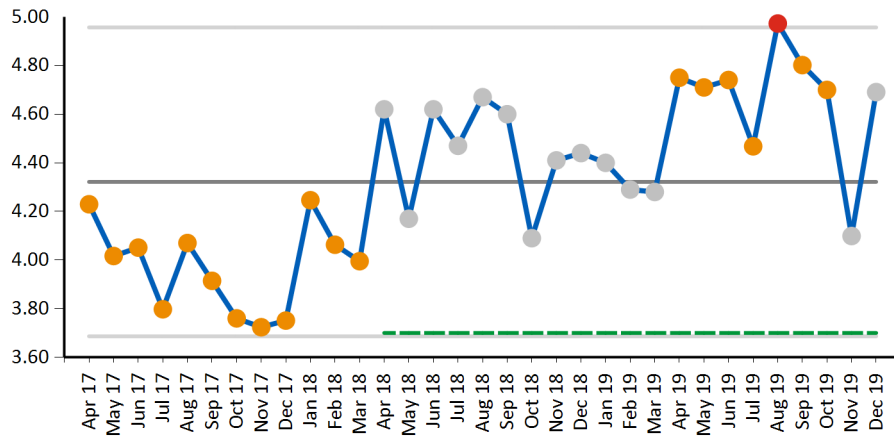
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)
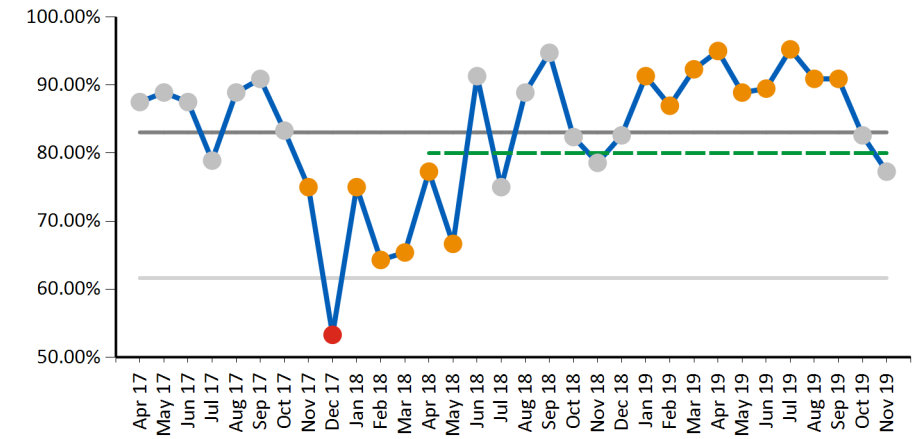
Cancer

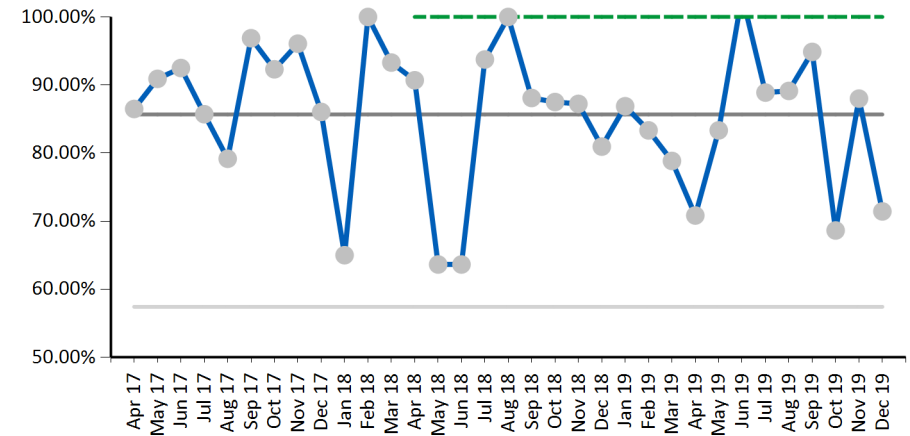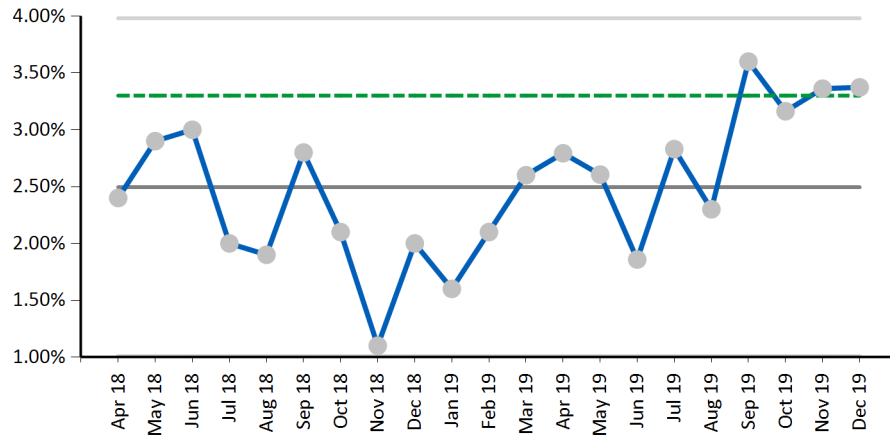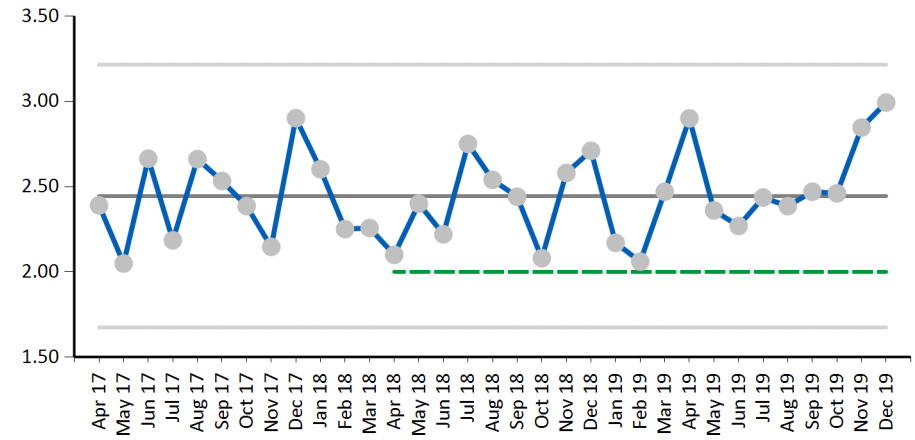| Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	84.9%	Nov-19		>= 85%	83.6%	Oct-19	>= 85%	86.2%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	94.1%	Nov-19		>= 90%	72.7%	Oct-19	>= 90%	86.9%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Nov-19		>= 96%	97.0%	Oct-19	>= 96%	98.4%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Nov-19		>= 94%	100.0%	Oct-19	>= 94%	99.2%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Nov-19		>= 98%	100.0%	Oct-19	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	92.7%	Nov-19		>= 93%	97.1%	Oct-19	>= 93%	96.5%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	23.6%	Nov-19		>= 93%	7.6%	Oct-19	>= 93%	29.7%	

46 - 62 day standard % (1 mth in arrears)
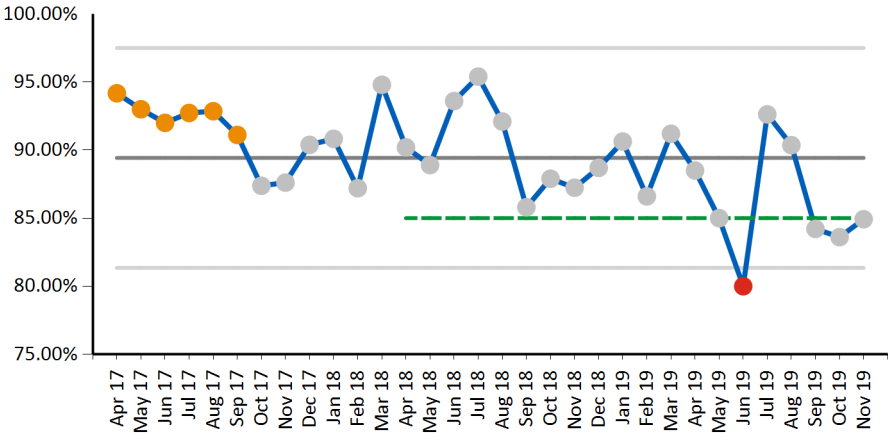
47 - 62 day screening % (1 mth in arrears)
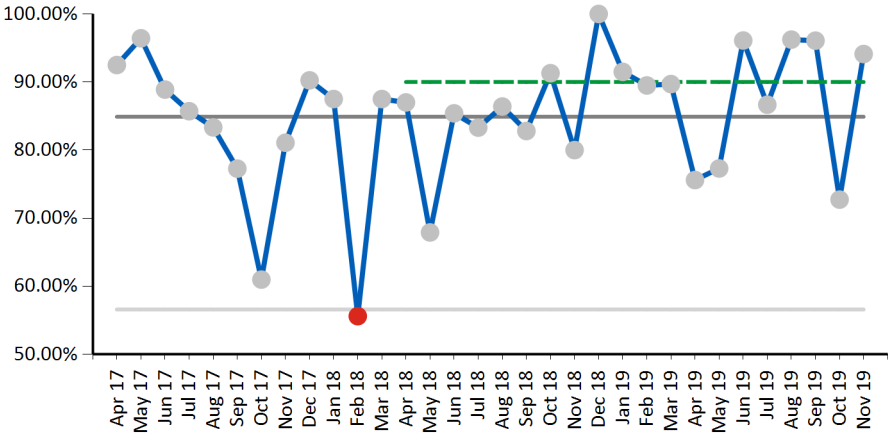
48 - 31 days to first treatment % (1 mth in arrears)
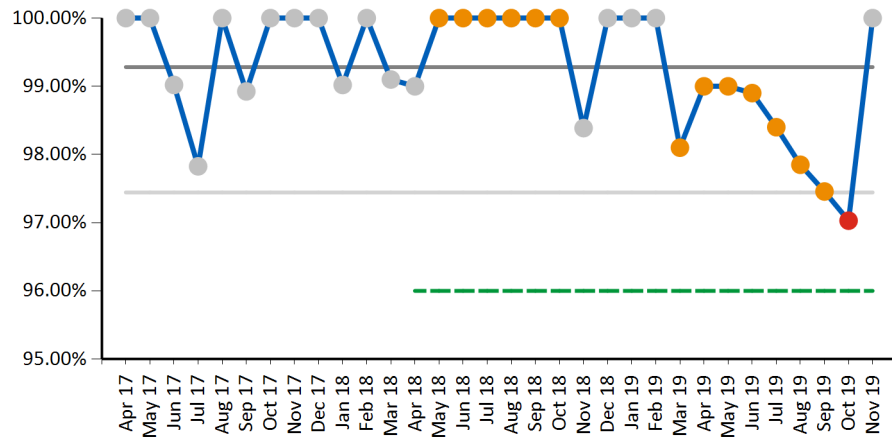
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)
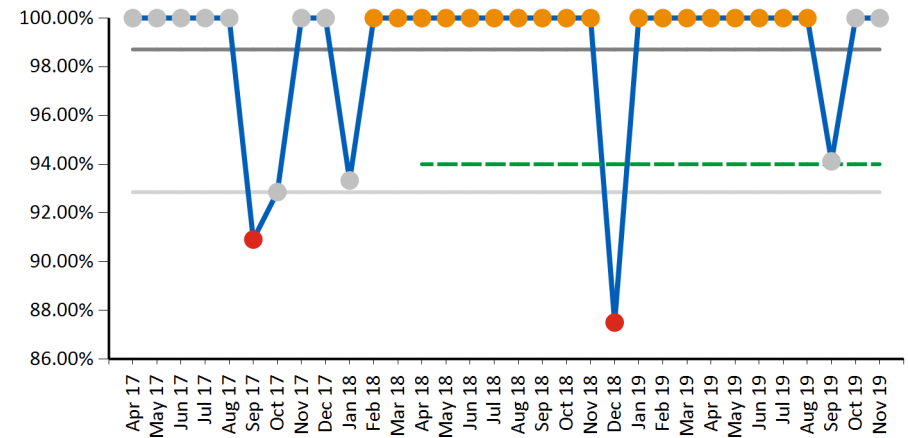
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)
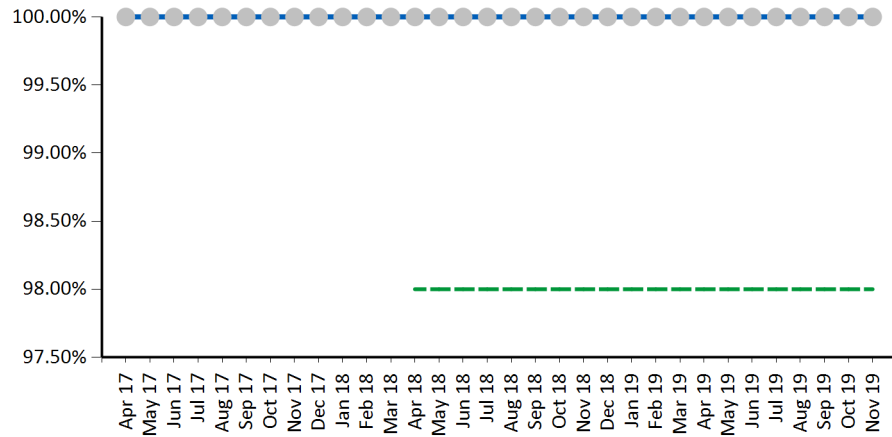
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)

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

Community

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	627	Dec-19		>= 400	686	Nov-19	>= 3,600	5,100	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.48	Dec-19		<= 6.00	5.18	Nov-19	<= 6.00	5.48	
230 - Medically Optimised Numbers	<= 50	85	Dec-19		<= 50	79	Nov-19	<= 450	706	
231 - Medically Optimised Days	<= 209	491	Dec-19		<= 209	555	Nov-19	<= 1,881	5,117	

334 - Total Deflections from ED
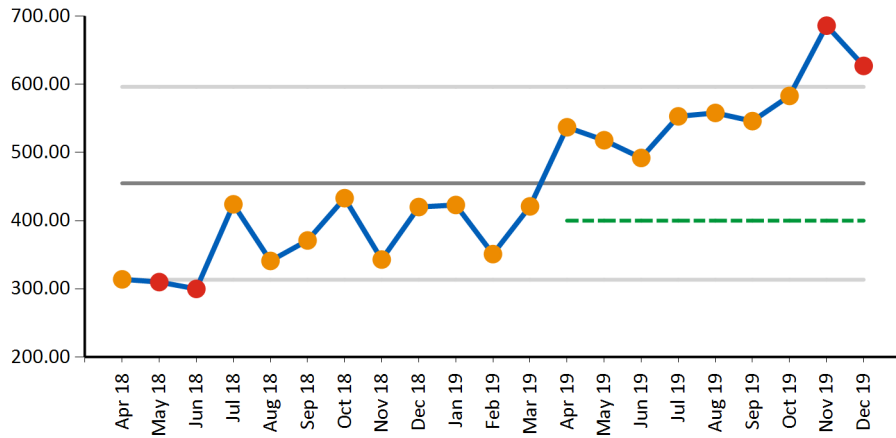
335 - Total Intermediate Tier LOS (weeks)
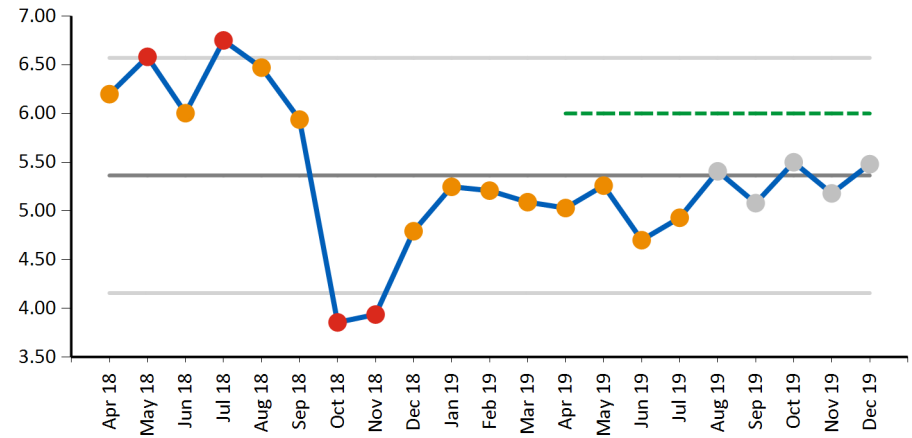
230 - Medically Optimised Numbers

231 - Medically Optimised Days

Workforce
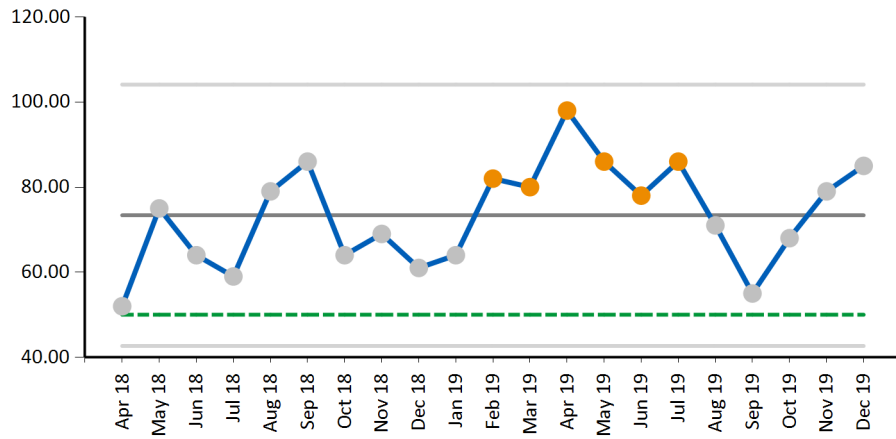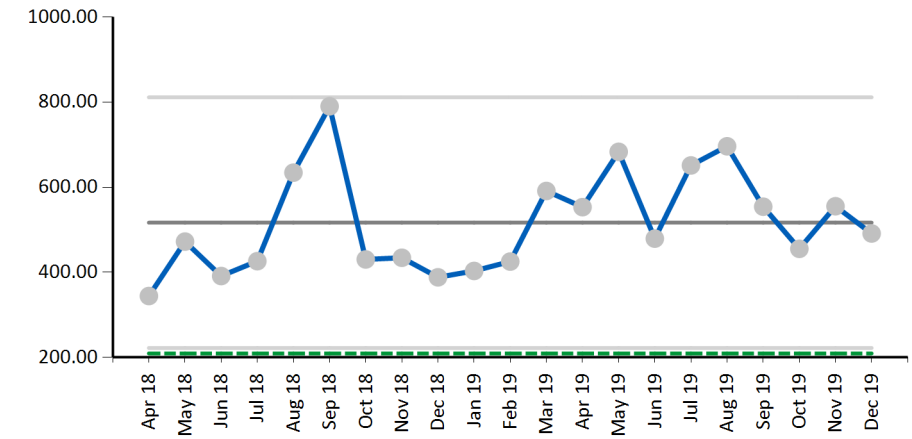
Sickness, Vacancy and Turnover

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
117 - Sickness absence level - Trust	<= 4.20%	5.67%	Dec-19	(H)	<= 4.20%	5.45%	Nov-19	<= 4.20%	5.14%	(F)
120 - Vacancy level - Trust	<= 6%	2.85%	Dec-19		<= 6%	2.52%	Nov-19	<= 6%	4.01%	(?)
121 - Turnover	<= 9.90%	9.86%	Dec-19	(L)	<= 9.90%	9.93%	Nov-19	<= 9.90%	9.89%	(?)
366 - Ongoing formal investigation cases over 8 weeks		5	Dec-19			6	Nov-19		31	

117 - Sickness absence level - Trust
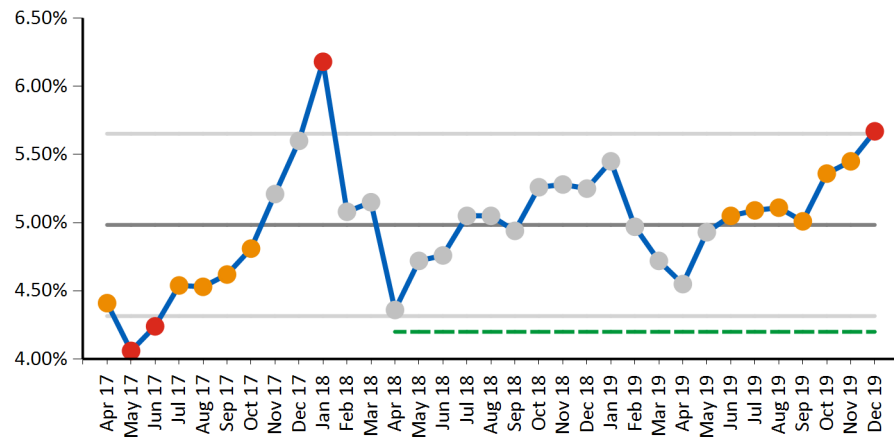
120 - Vacancy level - Trust
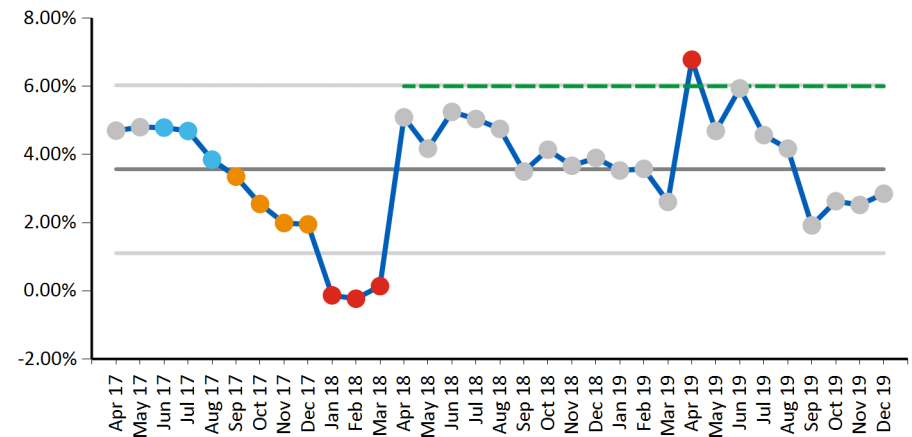
121 - Turnover
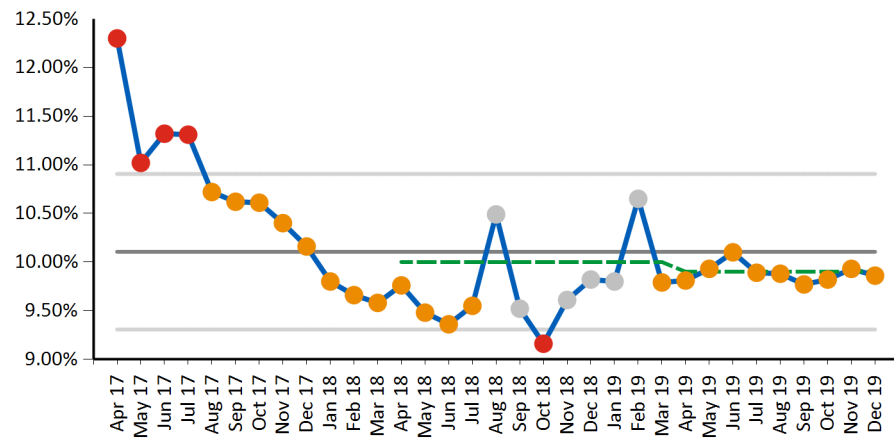
366 - Ongoing formal investigation cases over 8 weeks - SPC data available after 20 data points
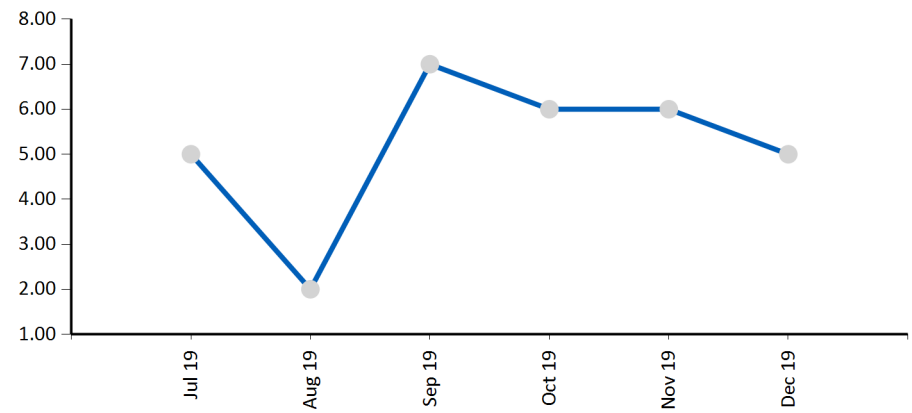
Organisational Development

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	94.6%	Dec-19		>= 95%	94.3%	Nov-19	>= 95%	94.1%	
38 - Staff completing Mandatory Training	>= 85%	91.3%	Dec-19		>= 85%	90.9%	Nov-19	>= 85%	91.3%	
39 - Staff completing Safeguarding Training	>= 95%	95.44%	Dec-19	H	>= 95%	95.34%	Nov-19	>= 95%	95.66%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.8%	Dec-19		>= 85%	83.3%	Nov-19	>= 85%	84.3%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	83.0%	Q1 2019/20		>= 66%	68.0%	Q4 2018/19	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	75.0%	Q1 2019/20		>= 80%	82.0%	Q4 2018/19	>= 80%		

37 - Staff completing Statutory Training
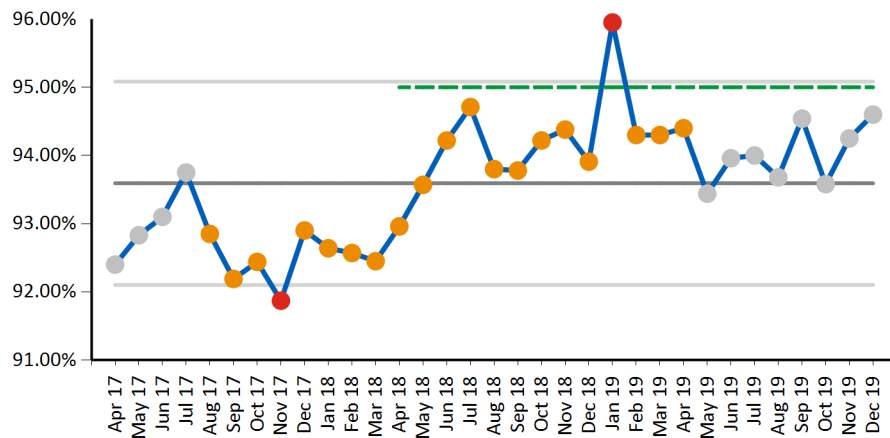
38 - Staff completing Mandatory Training
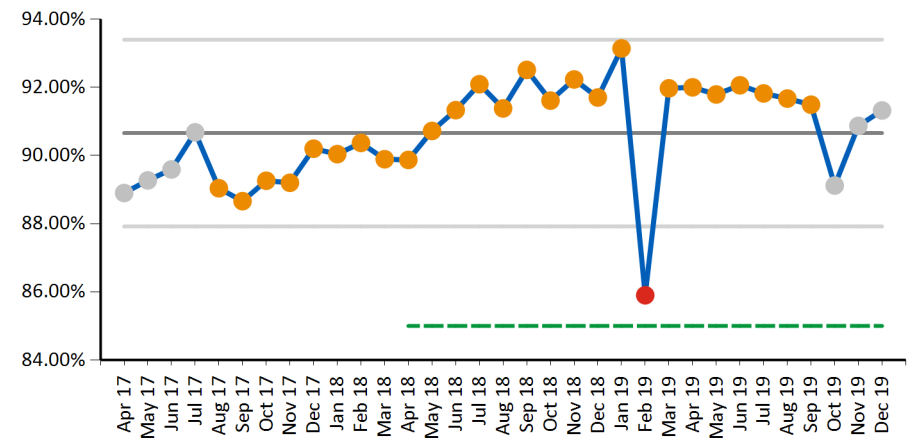
39 - Staff completing Safeguarding Training
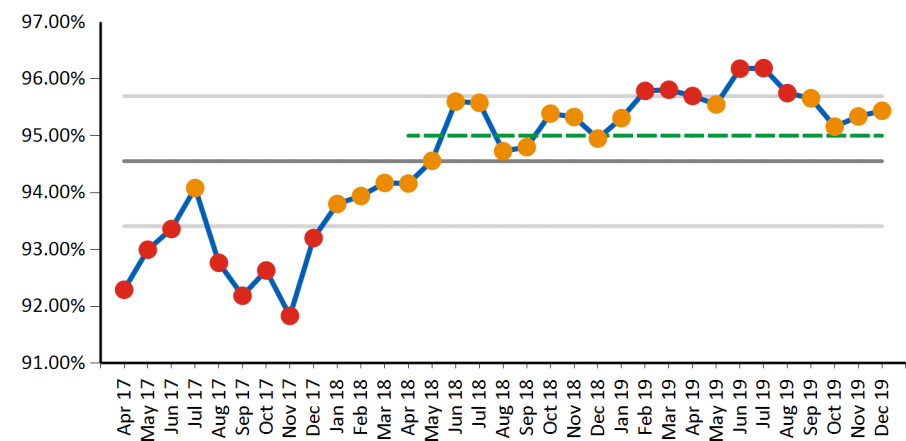
101 - Increased numbers of staff undertaking an appraisal
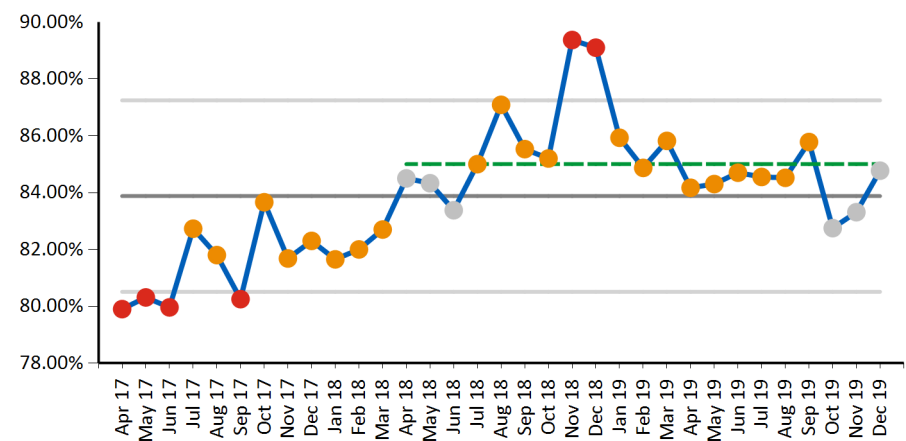
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) - SPC data available after 20 data points
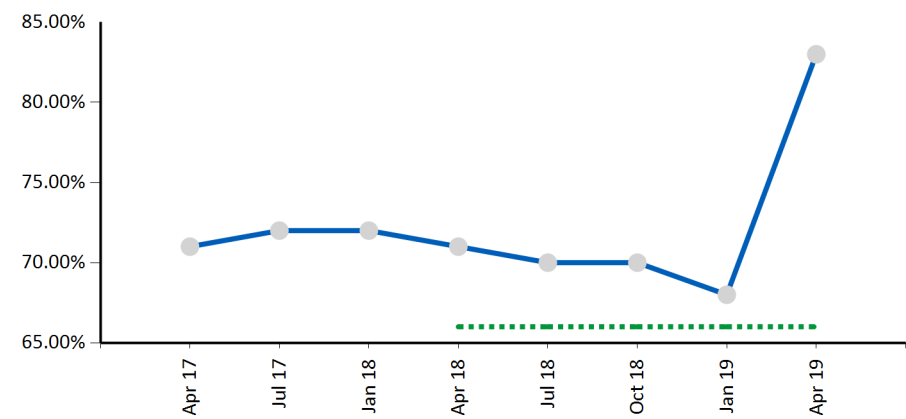
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) - SPC data available after 20 data points

Agency

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.71	0.41	Nov-19		<= 0.66	0.42	Oct-19	<= 5.62	4.39	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.30	0.23	Dec-19		<= 0.33	0.20	Nov-19	<= 2.71	1.92	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.30	0.21	Dec-19		<= 0.30	0.18	Nov-19	<= 2.87	2.19	

198 - Trust Annual ceiling for agency spend (£m)
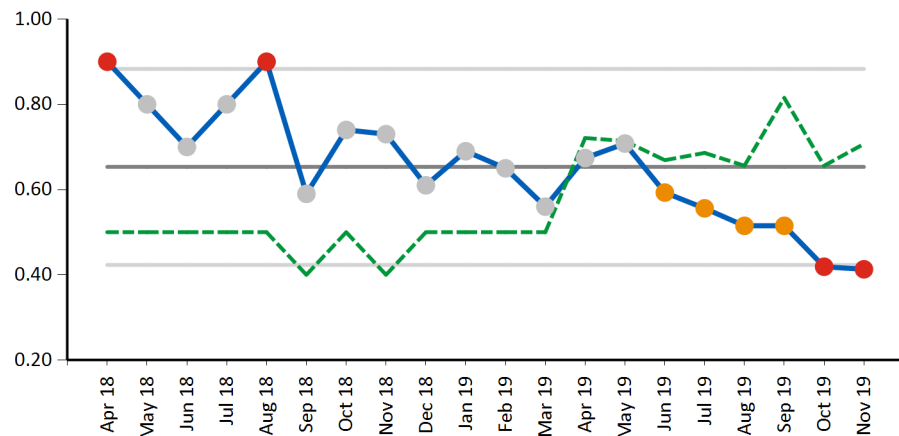
111 - Annual ceiling for Nursing Staff agency spend (£m)
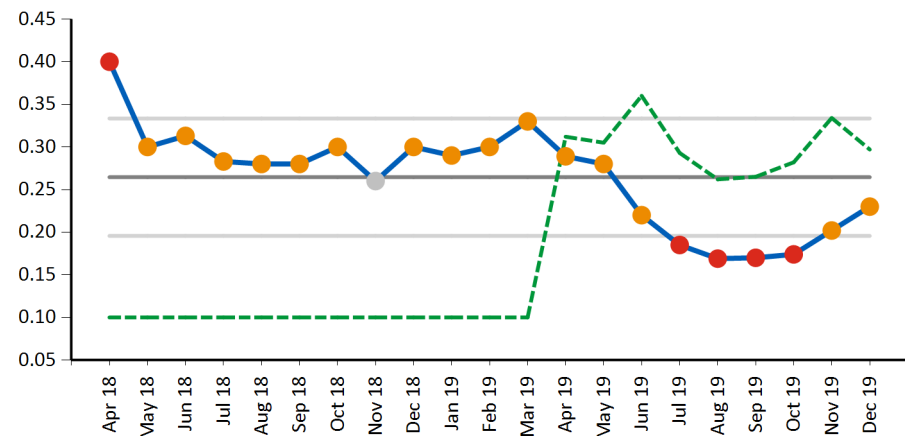
112 - Annual ceiling for Medical Staff agency spend (£m)
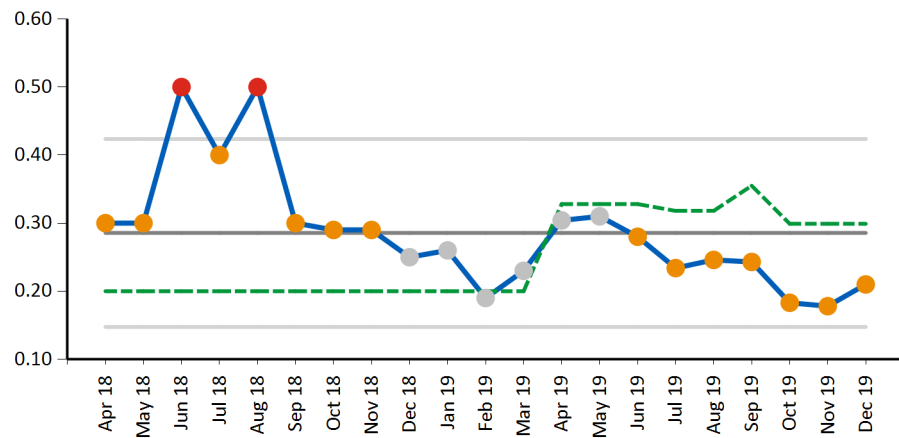
Finance

Finance

Outcome Measure	Latest				Previous			Year to Date		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 0.0	-1.6	Dec-19	L	>= 0.0	-0.4	Nov-19	>= -3.7	-11.0	?
221 - Provider Sustainability Fund (£ millions)	>= -0.01	-0.01	Dec-19	L	>= -0.01	-0.01	Nov-19	>= -0.08	-0.05	?
222 - Capital (£ millions)	>= 1.0	0.9	Dec-19		>= 1.3	1.4	Nov-19	>= 8.0	7.5	?
223 - Cash (£ millions)	>= 13.2	16.3	Dec-19	H	>= 11.5	17.0	Nov-19	>= 13.2	16.3	?
224 - Use of Resources	<= 2	3	Dec-19	H	<= 2	3	Nov-19	<= 2	3	?

220 - Control Total (£ millions)
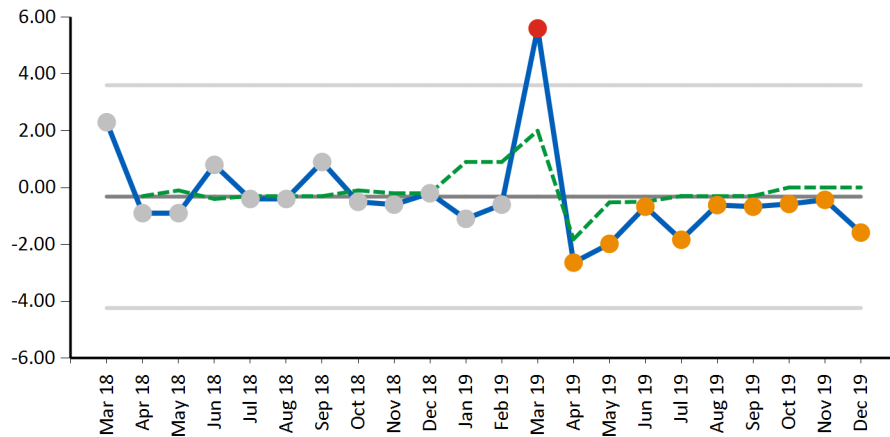
221 - Provider Sustainability Fund (£ millions)
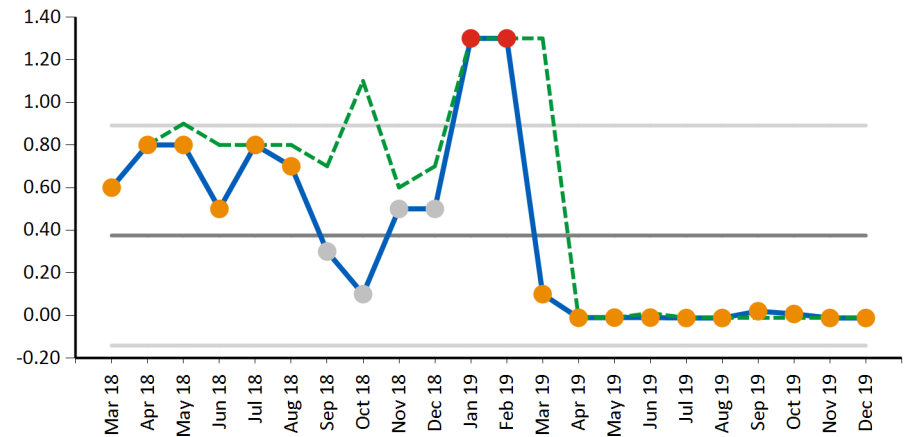
222 - Capital (£ millions)

223 - Cash (£ millions)

224 - Use of Resources
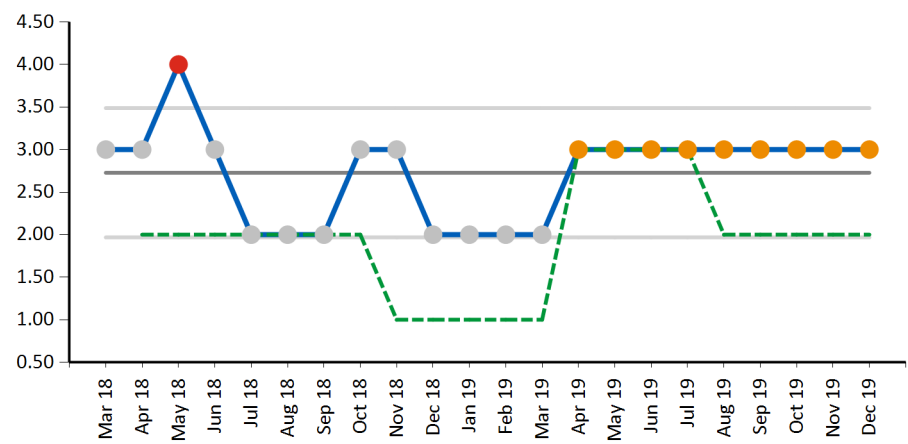
Board Assurance Heat Map - Hospital

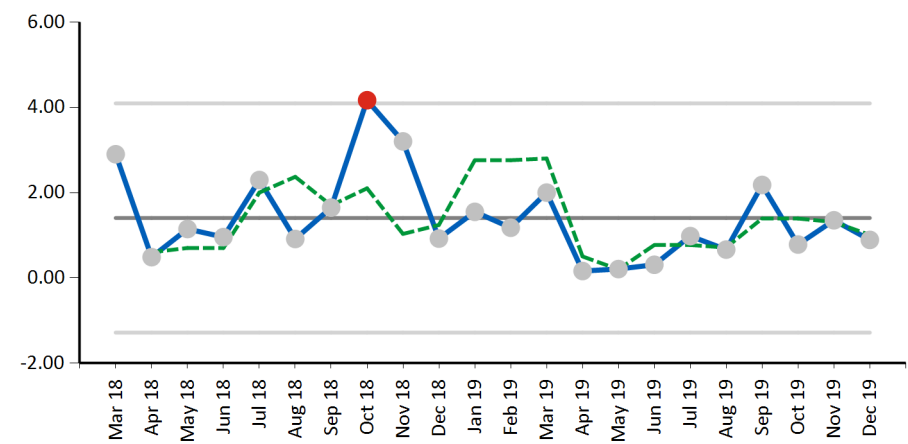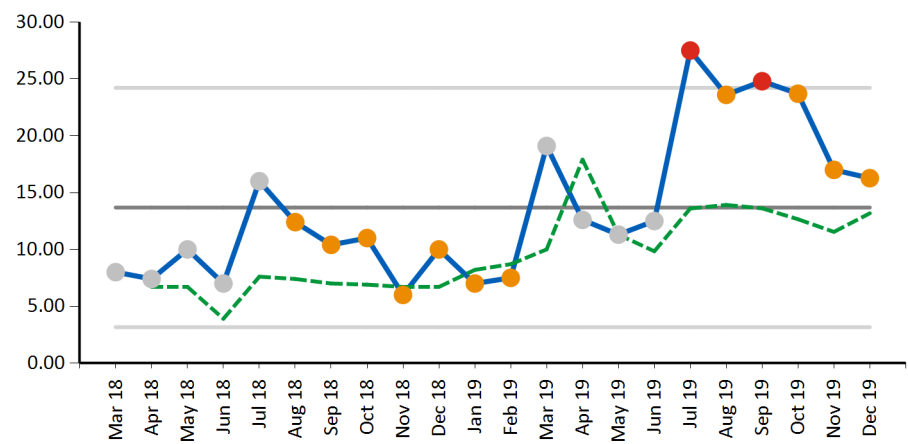| INDICATOR	Target	Darley Court	A4	AED-Adults	AED-Paeds	B1 (Frailty Unit)	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	H3 (Stroke Unit)	HDU	ICU	E3	E4	F3	F4	G3/TSU	G4/TSU	G5	DCU (daycare)	EU (daycare)	H2 (daycare)	UU (daycare)	E5 (Paed HDU and Obs)	F5	M1 and M1A	EPU	M2	CDS	M3 (Birth Suite)	Ingleside	M4/M5	NICU	Total
Beds		ICS				Acute Division																Elective Division													Families Division										
Total Beds		30	22	0	0	22	26	21		25	26	26	27	10	14	26	22	27	26	12	24	10	8	25	25	25	24	24	24	16	25	9	11	4	38	7	17	6	26	15	5	4	44	38	816
Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R = <80%	100.0%	100.0%	95.0%	90.0%		90.0%	100.0%		90.0%	100.0%	90.0%	100.0%	100.0%		85.0%	100.0%	95.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	70.0%	100.0%	95.0%	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	95.0%	100.0%	100.0%	100.0%		100.0%	90.0%	97.5%
IPC Rapid Improvement Tool %	<80%=R, >80% <94.9%=A, >95%=G	100.0%	91.0%	77.0%	91.0%	93.0%	61.0%	92.0%		91.0%	100.0%	88.0%	83.0%	100.0%	100.0%	83.0%	87.0%	92.0%		96.0%	79.0%	100.0%	100.0%	92.0%	100.0%	96.0%	100.0%	88.0%	96.0%	96.0%	100.0%	96.0%	96.0%	96.0%	100.0%	100.0%	96.0%	96.0%	100.0%	92.0%	<100.0%		87.0%	95.0%	93.8%
Mattress Audit Compliance %	Yes=G, No Return=White	100.0%	100.0%				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%	100.0%			100%	100%	100.0%
C - Diff	0	0	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	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	0	0
E.Coli BSIs	0	0	0	0	0	0	0	0		0	1	0	0	0	0	0	0	0	0		0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
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
Safety Express Programme Harm Free Care (%)	95%	96.4%	100.0%			91.3%	100.0%	100.0%		96.0%	95.7%	96.2%	100.0%	100.0%	92.9%	95.8%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	97.6%
All Inpatient Falls (Safeguard)	0	4	7	3	0	5	3	13		1	8	5	2	2	6	4	4	10	4	0	6	1	0	3	6	1	1	2	3	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	106
Harms related to falls (moderate and above)	1.6	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
VTE Assessment Compliance	95%		50.0%			33.3%	100.0%	100.0%		100.0%	100.0%	97.0%	50.0%	100.0%	99.6%	96.7%	97.8%	100.0%	91.3%		84.0%	100.0%	100.0%	90.5%	90.5%	96.9%	87.1%	98.5%	98.8%	99.0%	98.8%	99.5%	99.6%	57.7%			84.8%	97.2%	98.8%	99.0%	94.6%	83.3%	100.0%		96.9%
Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	1	0	0		0	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	98.6%	95.7%	95.6%	98.8%	85.6%	85.6%	84.9%		78.3%	68.5%	89.1%	75.8%	85.6%	61.3%	79.7%	89.5%	79.4%	67.8%		86.7%	100.0%	93.2%	92.2%	90.3%	91.7%	79.7%	93.2%	84.0%	94.8%	89.0%	100.0%	95.4%	100.0%	94.3%	94.3%	98.5%		96.3%	99.5%	100.0%	97.1%	100.0%	93.7%	
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%	90.7%	93.9%	72.4%	81.7%	90.8%	81.6%	90.4%	90.9%	85.3%		81.4%			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	platinum	platinum	bronze	silver	platinum	silver	platinum	gold	silver		silver			platinum	platinum	silver		platinum	gold	gold		bronze	gold	Silver
Friends and Family Response Rate	30%	100.0%	79.5%	17.7%	22.9%	44.2%	19.9%	90.0%		45.3%	34.1%	35.9%	7.7%	61.4%	33.9%	24.3%	36.0%	21.9%	39.7%		29.3%	27.3%	18.2%	33.6%	39.3%	31.2%	13.0%	39.7%	19.2%	45.9%	25.0%	24.8%	30.6%	33.3%	18.8%	0.0%	18.9%	17.6%	100.0%	13.3%	32.1%		13.3%	60.0%	25.1%
Friends and Family Recommended Rate	97%	84.2%	96.6%	90.8%	96.8%	100.0%	96.6%	88.9%		100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	85.2%	93.8%	100.0%	96.6%		91.7%	100.0%	100.0%	97.5%	94.3%	98.3%	100.0%	96.6%	100.0%	89.7%	94.4%	94.7%	92.6%	100.0%	96.6%	N/A	97.7%	100.0%	100.0%	88.1%	100.0%		91.1%	100.0%	96.2%
Number of complaints received	0	0	1	2	0	1	0	0		0	0	1	1	0	0	1	2	1	0	0	0	0	0	0	1	0	0	0	2	1	0	0	0	2	1	1	1	1	1	1	0	0	1	0	23
SIs in Month	0	0	0	0	0	0	0	0		0	0	0	0	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	1
Incidents over 20 days, not yet signed off	0	2	0	109	1	13	9	1		3	4	6	15	0	1	8	2	3	13	0	5	0	0	5	1	0	3	2	0	2	2	12	3	0	22	13	38	25	5	27	14	22	43	5	439
Harms related to Incidents (Moderate and above)	0	0	0	0	0	0	0	0		1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	7
Appraisals	85%	100.0%	84.6%	90.6%	90.6%	77.1%		89.8%		87.9%	95.4%	95.0%	65.9%	87.5%	76.2%	77.3%	81.1%	82.5%	58.5%	100.0%	87.2%	87.0%	84.9%	75.8%	68.6%	68.3%	58.1%	82.6%	91.5%	81.0%	86.1%	90.4%	74.1%	100.0%	84.0%	84.0%	96.4%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	85.2%	84.8%
Statutory Training	95%	98.60%	95.45%	95.67%	95.67%	87.98%		92.12%		91.63%	95.89%	93.80%	88.64%	97.71%	97.62%	88.79%	92.42%	96.12%	93.07%	98.21%	91.94%	96.10%	98.15%	95.13%	90.63%	98.20%	89.14%	91.37%	93.99%	94.74%	95.16%	92.58%	93.10%	100.00%	95.5%	95.5%	94.54%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	96.23%	94.6%
Mandatory Training	85%	98.5%	77.7%	80.42%	80.4%	69.8%		79.9%		78.6%	83.9%	82.1%	79.1%	75.0%	82.4%	71.7%	77.0%	86.7%	79.1%	90.9%	77.9%	80.5%	81.2%	82.1%	75.4%	90.8%	76.0%	80.7%	79.4%	82.8%	81.5%	90.8%	78.5%	98.4%	92.1%	92.1%	74.1%	71.3%	71.3%	71.3%	71.3%	71.3%	71.3%	94.1%	91.3%
% Qualified Staff (Day)			100.2%			89.4%		88.8%		89.5%	86.6%	95.3%	96.0%	100.0%	0.0%	0.0%	0.0%	96.6%	103.3%		97.4%	83.4%	85.0%	98.0%	99.9%	83.4%	101.0%	92.5%	79.8%	88.8%					0.0%			93.3%	79.1%	71.9%	#N/A	87.6%	97.2%	
% Qualified Staff (Night)			98.2%			101.7%		102.1%		100.1%	100.3%	87.4%	102.4%	100.4%	0.0%	0.0%	0.0%	95.6%	100.4%		101.7%	90.1%	84.5%	100.4%	100.0%	98.6%	143.8%	100.0%	100.0%	103.5%					0.0%			92.3%	69.5%	54.3%	#N/A	81.9%	97.7%	
% un-Qualified Staff (Day)			100.0%			81.3%		100.2%		84.5%	105.0%	80.2%	76.4%	111.8%	0.0%	0.0%	0.0%	77.4%	107.1%		104.2%	92.5%	69.1%	86.7%	88.9%	71.6%	114.1%	102.2%	111.2%	102.7%					0.0%			90.6%	83.7%	95.0%	#N/A	99.1%	0.0%	
% un-Qualified Staff (Night)			99.7%			100.8%		104.2%		101.4%	112.9%	92.4%	84.6%	96.7%	0.0%	0.0%	0.0%	79.4%	113.1%		115.5%	40.0%	2.7%	94.0%	93.0%	55.6%	135.4%	93.4%	96.9%	113.9%					0.0%			84.0%	81.2%	90.0%	#N/A	98.7%	0.0%	
Budgeted Nurse: Bed Ratio (WTE)		2.94	2.89	-4.79	2.13	2.69	-3.92	3.92		0.97	-0.73	5.29	1.25	3.40	-1.67	1.33	-0.48	3.96	0.77	0.00	2.21	-1.12	-0.90	1.65	-3.07	-2.65	-5.56	1.40	-0.08	3.03	-2.51	11.77	-2.36	1.19	0.29	0.29	1.09	-6.16	0.14	0.14	0.14	0.14	5.72	5.72	30.46
Current Budgeted WTE (From Ledger)		43.18	32.83	73.27	73.27	38.03	0.00	43.34		33.71	41.23	42.69	40.69	26.93	19.97	50.82	40.30	40.01	39.97	0.00	36.15	38.58	55.02	35.52	30.21	37.79	30.21	44.49	44.49	18.07	29.25	60.39	50.91	15.88	33.83	33.83	25.72	53.46	53.46	53.46	53.46	53.46	105.69	105.69	1779.23
Actual WTE In-Post (From Ledger)		40.24	29.94	71.14	71.14	32.70	0.00	39.42		32.74	38.96	37.40	39.44	22.73	21.64	47.49	37.86	35.05	38.20	0.00	33.94	38.78	54.92	30.87	31.36	37.44	32.77	40.87	43.57	14.04	29.76	47.62	51.27	14.69	33.54	33.54	23.63	53.32	53.32	53.32	53.32	53.32	99.97	99.97	1695.21
Actual Worked (From Ledger)		44.11	34.58	75.18	75.18	40.20	0.00	43.13		34.51	42.56	41.10	45.31	23.33	21.55	50.88	41.79	41.20	42.60	0.00	38.51	37.08	54.94	32.90	37.38	40.93	40.71	46.05	46.39	19.17	30.49	50.02	48.81	16.35	37.14	37.14	25.53	53.79	53.79	53.79	53.79	53.79	96.36	96.36	1798.38
Sickness (%) (December)	R = >4.75. A = 4.2 - 4.75. G = <4.2	5.97%	4.25%	5.58%		14.37%		5.47%		7.30%	9.44%	6.01%	7.28%	3.39%	9.36%	19.65%	5.44%	10.67%	6.96%	7.33%	10.33%	2.89%	3.53%	0.86%	11.55%	4.13%	21.12%	8.70%	10.33%	5.74%	7.65%	10.90%	4.07%	10.98%	9.83%		6.20%	5.76%					8.43%		5.67%
Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		2.94	2.89	-4.79	2.13	2.69	-3.92	3.92	0.00	0.97	-0.73	5.29	1.25	3.40	-1.67	1.33	-0.48	3.96	0.77	0.00	2.21	-1.12	-0.90	1.65	-3.07	-2.65	-5.56	1.40	-0.08	3.03	-2.51	11.77	-2.36	1.19	0.29	0.29	1.09	-6.16	0.14	0.14	0.14	0.14	5.72	5.72	30.46
Pending Appointment				6.92		3	3.92				3			0.8		2	2.92	1	1			0.9	1.0	3	1.92	3	3	2.22	1	1	2	1	2							1	6.3				53.56
Substantive Staff Turnover Headcount (rolling average 12 months)	10%	15.0%	13.2%	3.2%		15.1%		23.1%		21.5%	8.7%	16.3%	17.3%	3.3%	0.0%	11.1%	12.2%	19.8%	8.8%	0.0%	2.4%	0.0%	6.9%	8.7%	18.5%	7.1%	6.0%	11.8%	6.0%	0.0%	8.1%	6.4%	7.2%	5.6%	10.0%		17.8%	8.2%					7.7%		9.9%

	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
Board Assurance Heat Map - District Nursing Domiciliary														
Harm Free Care	Total Monthly New pressure Ulcers (Grade 2)(Lapse in Care + No Lapse in Care)	0	0	1	0	0	1	0	0	0	0			2
	Total Monthly New pressure Ulcers (Grade 3)(Lapse in Care + No Lapse in Care)	0	0	2	0	0	0	0	0	0	0			2
	Total Monthly New pressure Ulcers (Grade 4)(Lapse in Care + No Lapse in Care)	0	0	0	0	0	0	0	0	0	0			0
	Total Monthly New Pressure Ulcers - due to lapses in care	0	0	0	0	0	0	0	0	0	0			0
Audit	Monthly KPI Audit % (Revised Buddy Assessed Audit)	97.1%	97.2%	97.7%	97.7%	95.2%	97.7%		100.0%	97.4%	98.2%	98.2%		
	BoSCA Overall Score %	95.7%	94.9%	91.1%	87.1%	96.0%	91.4%	NA	94.7%	91.7%	93.4%	95.6%		
	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%		92.50%	
	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	1	0	0	0	0	0	0	0	0	0	1
Staffing and Workforce	Current Budgeted WTE	11.64	13.72	16.00	8.11	19.96	18.24	7.11	13.15	17.13	25.39	9.13	25.39	184.97
	Actual WTE In-Post	11.04	15.00	14.90		16.59	12.80	10.44	11.70	12.00	22.13	10.01	22.13	158.75
	Actual WTE Worked	11.09	15.12	14.77		17.45	14.34	10.72	12.23	12.93	23.35	10.62	22.37	164.98
	Pending Appointment				3.6				2	2.4	3.8	3.8		15.60
	Current Budgeted Vacancies (WTE)	1.00		1.80	2.00	1.00	2.90		1.00	1.00	2.00	1.38	2.4	16.48
Staff Development	Sickness (%) (November)	3.46%	0.60%	1.91%	5.01%	16.93%	0.00%	0.42%		3.81%	4.42%	4.46%	5.64%	3.67%
	Substantive Staff Turnover Headcount (rolling average 12 months)	0.00%	0.00%	16.67%	33.96%	0.00%	12.57%	11.37%		19.25%	28.13%	19.46%	9.68%	16.75%
	12 month Appraisal	87.5%	100.0%	87.5%	91.7%	80.0%	92.9%	93.3%		92.3%	66.7%	86.21%	93.10%	86.7%
	12 month Statutory Training	97.9%	99.1%	90.6%	93.6%	93.6%	97.6%	92.2%		98.7%	94.1%	97.02%	94.25%	95.3%
	12 month Mandatory Training	98.41%	98.68%	88.89%	90.38%	95.00%	89.29%	91.38%		96.15%	92.86%	92.86%	91.82%	92.67%

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NHS

Model Hospital

Bolton NHS Foundation Trust

Finance & Use of Resources

Summary of data on effective use of resources including expenditure, cost improvement programmes and SOF finance scores. Supports Use of Resources assessments.

Report Date: 23 January 2020
Generated by: Emma Cunliffe
The Model Hospital website: https://model.nhs.uk

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Single Oversight Framework

Understand performance on Single Oversight Framework monthly finance scores, based on monthly returns from providers.

Data period: latest available at the time of generating this report

Peer group: 'My Region'

The Finance Score	Data period	Trust value	Performance band description
Single Oversight Framework segment	Dec 2019	Targeted support offer	(amber / green)
The finance score	Oct 2019	3	

Financial Sustainability	Data period	Trust value	Performance band description
Capital service capacity - value	Oct 2019	-0.06	In quartile 1 - Lowest 25% (blue)
• Capital service capacity - SOF Score	Oct 2019	4	
Liquidity (days) - value	Oct 2019	10.16	In quartile 4 - Highest 25% (blue)
• Liquidity (days) - SOF Score	Oct 2019	1	

Financial Efficiency	Data period	Trust value	Performance band description
Income and expenditure (I&E) margin - value	Oct 2019	-2.96%	In quartile 2 - Mid-Low 25% (blue)
• Income and expenditure (I&E) margin - SOF score	Oct 2019	4	

Financial Controls	Data period	Trust value		Performance band description
Distance from financial plan - value	Oct 2019	■	-2.62%	In quartile 1 - Lowest 25% (blue)
• Distance from financial plan - SOF score	Oct 2019	■	4	
Distance from agency spend cap - value	Oct 2019	■	23.00%	In quartile 3 - Mid-High 25% (blue)
• Distance from agency spend cap - score	Oct 2019	■	2	

Use of Resources Framework

Compare performance on core metrics used in Use of Resources assessments, a framework developed by the Care Quality Commission and NHS Improvement.

Data period: latest available at the time of generating this report

Peer group: 'My Region'

Clinical Services	Data period	Trust value	Performance band description	Peer median	National median
Pre-procedure elective bed days	Q2 2019/20	0.13	In quartile 3 - Mid-High 25% (amber / red)	0.17	0.12
Pre-procedure non-elective bed days	Q2 2019/20	1.22	In quartile 4 - Highest 25% (red)	0.74	0.65
Did not attend (DNA) rate	Q2 2019/20	9.54%	In quartile 4 - Highest 25% (red)	7.72%	7.13%
Emergency Readmission 30 days	Q2 2019/20	7.83%	In quartile 2 - Mid-Low 25% (amber / green)	7.81%	7.85%

Clinical Support Services	Data period	Trust value	Performance band description	Peer median	Benchmark value
Top 10 Medicines - % Delivery of Savings Target Achieved to Current Month	To Nov 2017	73%	Below the benchmark (red)	N/A	100%
Overall cost per test	2018/19	£1.80	In quartile 2 - Mid-Low 25% (amber / green)	£1.69	£1.94

People	Data period	Trust value	Performance band description	Peer median	National median
Staff retention rate	Dec 2018	86.9%	In quartile 3 - Mid-High 25% (amber / green)	86.8%	85.6%
Sickness absence rate	Oct 2019	5.73%	In quartile 4 - Highest 25% (red)	5.09%	4.42%
Total pay cost per WAU	2017/18	£2,434	In quartile 4 - Highest 25% (red)	£2,351	£2,180
Substantive Medical staff cost per WAU	2017/18	£412	In quartile 1 - Lowest 25% (green)	£459	£533
Substantive Nursing staff cost per WAU	2017/18	£967	In quartile 4 - Highest 25% (red)	£826	£710
Substantive AHP staff cost per WAU	2017/18	£184	In quartile 4 - Highest 25% (red)	£148	£130

Corporate services, procurement, and estates and facilities	Data period	Trust value	Performance band description	Peer median	National median
Total non-pay cost per WAU	2017/18	🟩 £1,058	In quartile 1 - Lowest 25% (green)	£1,222	£1,307
Finance function cost per £100m turnover (comparison within sector)	2018/19	🟩 £643.56k	In quartile 2 - Mid-Low 25% (amber / green)	£641.75k	£653.29k
HR function cost per £100m turnover (comparison within sector)	2018/19	🟩 £870.62k	In quartile 2 - Mid-Low 25% (amber / green)	£952.29k	£910.73k

Corporate services, procurement, and estates and facilities	Data period	Trust value	Performance band description	Peer median	National median
Estates & Facilities Cost (£ per m2)	2018/19	🟩 £288	In quartile 1 - Lowest 25% (green)	£316	£377
Procurement League Table: Process Efficiency and Price Performance Score (scaled 0 to 100)	Q4 2018/19	🟥 62	In quartile 2 - Mid-Low 25% (amber / red)	75	69

Finance	Data period	Trust value	Performance band description
Capital service capacity - value	Oct 2019	⬛ -0.06	In quartile 1 - Lowest 25% (blue)
Liquidity (days) - value	Oct 2019	⬛ 10.16	In quartile 4 - Highest 25% (blue)
Distance from agency spend cap - value	Oct 2019	⬛ 23.00%	In quartile 3 - Mid-High 25% (blue)
Income and expenditure (I&E) margin - value	Oct 2019	⬛ -2.96%	In quartile 2 - Mid-Low 25% (blue)
Distance from financial plan - value	Oct 2019	⬛ -2.62%	In quartile 1 - Lowest 25% (blue)

About the peer group referenced in this report

Peer group

Your trust is benchmarked against the peer group My Region

Trusts in your NHS England and NHS Improvement region

Peer group members

University Hospitals of Morecambe Bay NHS Foundation Trust	Warrington and Halton Hospitals NHS Foundation Trust
Manchester University NHS Foundation Trust	Lancashire Teaching Hospitals NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust	Aintree University Hospital NHS Foundation Trust
East Lancashire Hospitals NHS Trust	East Cheshire NHS Trust
Cheshire and Wirral Partnership NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust	Christie NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust	North West Ambulance Service NHS Trust
Lancashire Care NHS Foundation Trust	Tameside and Glossop Integrated Care NHS Foundation Trust
Salford Royal NHS Foundation Trust	Bolton NHS Foundation Trust
Clatterbridge Cancer Centre NHS Foundation Trust	Walton Centre NHS Foundation Trust
North West Boroughs Healthcare NHS Foundation Trust	Wirral Community NHS Foundation Trust
Pennine Acute Hospitals NHS Trust	Liverpool Womens NHS Foundation Trust
Pennine Care NHS Foundation Trust	Alder Hey Childrens NHS Foundation Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust	St Helens and Knowsley Hospital Services NHS Trust
University Hospital of South Manchester NHS Foundation Trust	Royal Liverpool and Broadgreen University Hospitals NHS Trust
Stockport NHS Foundation Trust	Bridgewater Community Healthcare NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust	Southport and Ormskirk Hospital NHS Trust
Liverpool Community Health NHS Trust	Mersey Care NHS Foundation Trust

Colour meanings

The Model Hospital uses colour to indicate a trust's performance relative to a national median or other benchmark. Different colours represent quartiles of the national data set or your trust's position on a red-amber-green scale.
For some metrics a relatively low value, putting the trust into Quartile 1, would indicate a weak performance, but for other metrics a low value can indicate a strong performance. The colour coding helps you understand whether low values should be interpreted as weak or strong.

	Green	Either • Lowest quartile, where low represents best productivity • Highest quartile, where high represents best productivity • Performance better than benchmark, in a chart using a red-amber-green scale
	Amber/green	Either • Mid-low quartile, where low represents best productivity • Mid-high quartile, where high represents best productivity
	Amber/red	Either • Mid-high quartile, where low represents best productivity • Mid-low quartile, where high represents best productivity
	Amber	Performance approaching benchmark, in a chart using a red-amber-green scale
	Red	Either • Highest quartile, where low represents best productivity • Lowest quartile, where high represents best productivity • Performance below benchmark, in a chart using a red-amber-green scale
	Blue	We have not judged whether a high or low quartile is more desirable.

Agenda Item No:	16
Meeting:	Board of Directors
Date:	30th January 2020

NHS Bolton NHS Foundation Trust

Title:	Review of the Trust's Scheme of Delegation

Purpose	To review and approve the Trust's Scheme of Delegation.

Executive Summary:	The paper summarises the Scheme of Delegation and proposes two amendments:- 1) An additional level of authorisation at £2.5k for Matrons is proposed. 2) Future amendments to the Scheme of Delegation for Divisional Director of Operations (DDO's) and below is authorised by the Director of Finance.

Previously considered by:	The additional level of authorisation for matrons has been discussed with the DDO's.

Recommendation Please state if approval required or if for information	The Board is asked to approve the two amendments to the Scheme of Delegation.
	Confidential y/n	

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

Prepared by:	Catherine Hulme Head of Financial Services	Presented by:	Annette Walker Director of Finance

Review of Scheme of Delegation

Introduction

The Trust's Scheme of Delegation was approved by the Board of Directors in September 2017.

Scheme of Delegation – Revenue Expenditure

The current Scheme of Delegation has 7 levels of approval for expenditure, details are shown below:

1	Board	Expenditure over £1m
2	Chief Executive or Director of Finance	Expenditure up to £1m
3	Executive Directors	Expenditure up to £250k
4	Deputy Directors of Operations / Divisional Directors of Finance (DDO's)	Expenditure up to £50k
5	Deputy Directors/General Managers/Professional Leads	Expenditure up to £10k
6	Departmental Managers	Expenditure up to £5k
7	Ward Managers	Expenditure up to £1k

It is proposed that an additional expenditure category "Matrons expenditure up to £2.5k" be added. The proposed 8 levels of approval for expenditure are shown below:

1	Board	Expenditure over £1m relating to the Trust* Expenditure over £1m relating to IFM
2	Chief Executive or Director of Finance	Expenditure up to £1m Expenditure over £250k and up to £1m relating to IFM
3	Executive Directors	Expenditure up to £250k
4	Deputy Director of Operations, Divisional Director of Operations (DDO's), Deputy Director of Finance and direct reports to Board.	Expenditure up to £50k
5	Deputy Directors/General Managers/Professional Leads	Expenditure up to £10k
6	Departmental Managers	Expenditure up to £5k
7	Matrons	Expenditure up to £2.5k
8	Ward Managers	Expenditure up to £1k

* The Deputy Director of Finance transacts in the system expenditure over £1m as approved by the Board.

There are a couple of exemptions to the above table and these are listed below

- Chief Pharmacist - drugs expenditure up to £50k
- Head of Payroll - processing expenditure for 24/7 doctors up to £50k

It is proposed that any amendments to the Scheme of Delegation for levels 4 to 8 (including adding and removing levels) are approved by the Director of Finance going forward.

Scheme of Delegation - Capital

The current levels of authority for capital are as follows:

Approval By	Proposed Level of Authority £
CRIG	£0 - £1,000k
F&I	£1,001 - £2,000k
Board	>£2,000k

No changes to the levels of authority for capital expenditure are proposed.

A copy of the proposed Scheme of Delegation is provided in Appendix 1.

Recommendation

The Board is asked to approve

1) The Scheme of Delegation
2) The Director of Finance to approve any changes to the Scheme of Delegation to levels 4 to 8 (including adding and removing levels).

SCHEDULE OF DECISIONS/POWERS RESERVED TO THE BOARD/ COMMITTEES AND SCHEME OF DELEGATION TO DIRECTORS AND MANAGERS

RESERVATION OF POWERS

Trust Board The Board reserves to itself approval of the following:	Committees Approval of the items below is reserved to specific Committees	Director Specific Approval of the items below is reserved to specific Directors
Vision and Overall Strategic Direction Approval of Business Cases or major service changes e.g. Introduction of new Services or Discontinuation/ Transfer of Services involving income or expenditure > £1m Revenue or Capital and any associated loans ➢£2m capital expenditure and associated loans Board level (Risk) Assurance Framework Annual Revenue (I&E) Budget Capital Programme and Annual Capital Budget Sale and/or acquisition of Land Demolition of buildings Waiver of competition requirements/acceptance of other than lowest price for goods/services/works over £1m Standing Orders Treasury Management Policy This schedule of decisions/powers reserved to the Board/ Committees and Scheme of Delegation to Directors and Managers Corporate Strategies e.g. Workforce Strategy IT Strategy	Audit Committee Appointment of Internal Audit Internal & External Audit Plans Annual Accounts Standing Financial Instructions Approval of the Annual Governance Statement having overseen risk management and assurances process during the year Waiver of competition requirements/acceptance of other than lowest price for goods/services/works over £250k up to £1m Remuneration Committee Approval of Executive Directors' Pay Awards and any other variations to Executive Director terms and conditions of employment Severance settlements for senior managers and any settlements outside of normal rules Approval of Pay and Terms and Conditions of senior managers on local pay arrangements Executive Board Approval of Trust-wide Clinical and Non-Clinical Policies and Procedures Approval of Business Cases or significant service changes whether investment or disinvestment/discontinuation of services up to £1m revenue or capital. Finance Committee Approval of Business Cases for Capital Schemes up to £2m. Approval of budget increases/virements over £50k. Approval of the use of Measured Term Contracts for capital schemes over £50k. Approval to progress to tender for schemes costing over £1 million. Approval of the Treasury Management Policy and Banking arrangements. Approval of arrangements for loans approved by the Board. Approval of any special payments/ex gratia payments over £50k (excluding those delegated to the Remuneration Committee above).	Director of Human Resources Salary banding of new posts and changed posts Variations to Terms & Conditions Issue of Contracts of Employment Director of Finance Opening Bank Accounts Income generation contracts over £250k Pricing strategies, fees and charges in relation to income Prepayments and/or contracts which commit the Trust to pay in advance of services received Long term financial commitments including leases Financial systems and controls Disposal or sale of capital equipment Chairman Approval of Chief Executive travel/ other expenses / study leave Chief Executive/Deputy Chief Executive Introduction of new services, or discontinuation/transfer of services up to £1m pa. Delegation of budgets to Directorates/Divisions Travel expenses/study leave of Directors Chief Executive or Director of Finance Requisitions/contracts (revenue or capital) over £250k up to £1m Changes to budgeted establishment financed from income or virement from non-pay budgets Approval of Capital Scheme budget increases up to £50k Authorisation of sponsorship (e.g. of new posts) by external bodies (Drug companies, suppliers, Macmillan etc.) including bids to secure sponsorship Ex gratia payments over £5k up to £50k. Waiver of competition requirements and/or acceptance of other than lowest tender for goods/services/works over £10k up to £250k (retrospectively reported to Audit Committee for scrutiny).

Estates Strategy	CRIG (Capital Revenue and Investment Group)	Authorisation of disposal of all items on the capital asset register up to £1m.
Deputy Director of Finance Transacts in the system expenditure over £1m as approved by the Board	Approval of Business Cases for Capital Schemes up to £1m. Approval of business cases for revenue (expenditure or income) up to £1m per annum.	

SCHEME OF DELEGATION

| Executive Directors

Approval of Expenditure within Directorate/ Divisional Expenditure Budget including: | Deputy Directors of Operations, Divisional Director of Operations(DDOs), Deputy Director of Finance and direct reports to Board

Approval of Expenditure within Directorate/ Divisional Expenditure Budget including: | Deputy Directors/General Managers/ Professional Leads

Approval of Expenditure within Departmental Budget including authorisation of: | Departmental Managers

Approval of Expenditure within Ward/Department/Unit Budget including authorisation of: | Matrons

Approval of Expenditure within Ward/Department/Unit Budget including authorisation of: | "Ward / Unit Managers" or equivalent

Approval of Expenditure within Ward/Departmental /Unit Budget including authorisation of: | Managers within Ward / Unit

Authorisation within Ward/Department/Unit Budget of: |
|---|---|---|---|---|---|---|
| Non-stock revenue requisitions up to £250k

Delegation of budgets within the Directorate/ Division including authorisation of signatories

Travel expenses/study leave of DDOs | Non-stock revenue requisitions up to £50k

Changes to budgeted establishment within pay budget

Virement within non-pay budget

Delegation of budgets within the Directorate/ Division including authorisation of signatories

Travel expenses/study leave of Heads of Division/General Managers/Professional Leads

Waiver of competition requirements and/or acceptance of other than lowest price for goods/services/works up to £10k (retrospectively reported to Audit Committee for scrutiny)

Ex-gratia payments over £1k to £5k (reported to the Audit Committee) | Agency temps/locums

Revenue or capital requisitions up to a limit which will be agreed by DDOs but not exceeding £10k

Advertisement of vacant posts (within budgeted establishment)

Travel expenses/study leave of Departmental Managers

Disposal of obsolete furniture and equipment but excluding capital items

Ex-gratia payments to patients or staff for loss of personal effects up to £1k (request for payment to be clearly identified as "ex gratia" and reported to the Audit Committee).

<u>Chief Pharmacist</u>
Drugs expenditure up to £50k

<u>Head of Payroll</u>
Processing expenditure for 24/7 doctors | Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £5k

Travel expenses/study leave of Ward Managers/equivalent | Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £2.5k

Travel expenses/study leave of Ward Managers/equivalent

Timesheets including overtime and internal bank hours and scheduling of annual leave | Timesheets including overtime and internal bank hours and scheduling of annual leave

Special Duty Claims

Travel Expenses of Managers

Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £1k. | Timesheets including overtime and internal bank hours and scheduling of annual leave

Special Duty Claims

Travel Expenses of staff at bands of the same or below their own band. |
| One per cost centre | One per cost centre | One per cost centre | One per cost centre | | One per cost centre | Multiple per cost centre |