Bolton NHS Foundation Trust – Board Meeting 22 February 2018

Location: Boardroom **Time: 0930**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story (Integrated Care 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	Chairman	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 25 January 2018	Chairman	Minutes	To approve the previous minutes
	5.	Action sheet	Chairman	Action log	To note progress on agreed actions
	6.	Matters arising	Chairman	Verbal	To address any matters arising not covered on the agenda
	7.	Chairman's Report	Chairman	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	QA Chair	Verbal	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	FC – Chair	verbal	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	11.	Workforce Assurance Committee Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
	12.	Urgent Care Delivery Board Chair Report	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.15	13.	RTT update	COO	Report	To receive an update on RTT performance

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10.30	14.	Sickness absence update	Director of Workforce	Report	To receive the sickness absence update

Coffee

11.00	15.	Mortality – six month update	Medical Director	Report	To receive the mortality update
11.15	16.	Performance summary – key metrics	All	Report	To receive and note
	16.1	Sepsis	Medical Director	Report	To receive and note
	16.2	Finance update	Director of Finance	Presentation	To receive and note
	16.3	DMO1 Performance and Recovery Report	COO	Report	To receive and note
Strategy					
11.45	17.	Planning guidelines and implications for the Trust	Director of Finance	Report	To note
Governance					
12.15	18.	Charitable Funds – Chair Report	CF Chair	Chair report	CF Chair to provide a summary of assurance from the Charitable Funds Committee and escalate any items of concern to the Board
Reports from Sub-Committees (for information)					
	19.	Any other business			
Questions from Members of the Public					
	20.	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					
12.30	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				

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	25th January 2018
Venue	Boardroom Royal Bolton Hospital

Present:-

Mr D Wakefield	Chairman	DW
Dr J Bene	Chief Executive	JB
Mrs T Armstrong-Child	Director of Nursing/Deputy CEO	TAC
Mr Allan Duckworth	Non-Executive Director	AD
Mr A Ennis	Chief Operating Officer	AE
Ms A Gavin Daley	Non-Executive Director	AGD
Dr M Harrison	Vice Chair	MH
Ms B Ismail	Non-Executive Director	BI
Mrs J Njoroge	Non-Executive Director	JN
Mrs A Walker	Director of Finance	AW

In attendance:-

Mrs K Bancroft	Deputy Medical Director (for S Hodgson)	KB
Mrs H Brearley	Interim HR Director	HB
Mr R Mundon	Director of Strategy WWL	RM
Mrs E Steel	Trust Secretary	ES
Ms G Murphy	Insight programme for aspirant NEDs	

Observers

Mrs M Forshaw	Miss A Blackburn
Mr T Pharoe	

Apologies

Apologies were received from Steve Hodgson, Medical Director and Andrew Thornton, Non-Executive Director

Welcome and Introductions

The Chairman welcomed all Board members and observers to the meeting.

1. Patient Story

Mrs M attended accompanied by her Speech and Language Therapist to share her experience of treatment received for aphasia following a stroke in 2016. Mrs M received inpatient care at both Salford NHS FT and Bolton NHS FT following a stroke. She described frustration and anger at the lack of understanding and lack of communication aids provided and had a number of suggestions to improve communication for individuals with aphasia.

Despite initial difficulties and thanks to Mrs M's own determination and support from the charity "Speak Easy" she is now doing very well and is able to communicate clearly.

The Chairman commended Mrs M for her courage in sharing her story and apologised on behalf of the Trust for the difficulties she had experienced.

Board members thanked Mrs M for her time in sharing her experience.

Mrs M and her therapist left the meeting.

The Director of Nursing advised that improvements had been made since Mrs M's stay in hospital; communication sheets have been implemented, areas have speciality specific training and speakeasy literature is available for patients. The concerns raised by Mrs M will continue to be picked up through the Stroke group.

Resolved: The Board noted the impact of Mrs M's experience and requested an update to be provided on actions taken to address the issues raised.

FT/18/01	report back to Board on actions raised in patient story

2. Welcome and Introductions

The Chairman welcomed all attendees and observers to the meeting and explained that Geraldine Murphy a participant in the NHSI/Gatenby Sanderson Insight programme for aspirant NEDs would be attending Board meetings as an observer.

3. Declarations of Interest

No new declarations in addition to those recorded on the Trust Register of Interests.

4. Minutes of The Board Of Directors Meetings Held 21st December 2017

The minutes of the meetings held on 21st December 2017 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. Chairman's Report

A&E performance against the four hour target remains a challenge, the continued efforts of staff are recognised and actions to address the challenge would be discussed later in the meeting.

Step into Health The Chairman advised that along with two members of staff from the Trust he had attended a reception hosted by Prince William to recognise the programme of work to find NHS careers for those leaving the armed forces.

Mark Harrison has confirmed that he will be standing down from the Board at the end of March having completed six years' service. Steve Hodgson the Medical Director has also advised that he will be retiring as Medical Director in August 2018. He will continue to work for the Trust as an Orthopaedic Consultant.

The Board joined the Chairman in congratulating Dr Bene on her recent recognition in the New Year's Honours.

8. CEO report

The CEO highlighted the following items from the written report provided within the Board pack:

Employee of the month – Michelle Bentham – housekeeper in Theatres

Team of the month – the Gastro and Bowel Cancer Screening Team

The Quarterly review meeting with NHSI is scheduled for Monday 29th January, NHSI have been provided with the January Board pack and have set an agenda to cover standard operational, quality and financial metrics.

Two serious incidents have been reported since the last Board meeting, these will be investigated in accordance with the policy.

Board Assurance Framework – Board members discussed the lack of change to the risk scores and while it was accepted that changes to the risk scores for the key strategic risks take time there should be changes to the actions and controls. The Audit Committee will be undertaking a deep dive review of the Nursing and Operational risks on the BAF in February 2018. Risk 2.1 (A&E performance) would be updated to reflect GP streaming and front door working as new controls.

Resolved: The Board noted the CEO report.

FT/18/02	reflect enhanced streaming within the actions on the BAF

9. Quality Assurance Committee Chair Report

In the absence of the QA Committee Chair, the Chairman presented the Chair's report from the meeting held on 17th January 2018. Overall the meeting was very positive providing assurance on a number of significant areas.

- The quarterly report on pressure ulcers and falls showed encouraging signs of improvement, and although one of the two serious incidents reported this month is in relation to a pressure ulcer this was as a result of non-concordance with a care plan.
- The new OBM for Ophthalmology presented a new action plan pulling together the recommendations from all previous reviews into a single comprehensive plan with clear oversight and accountability for achievement.
- The Director of Quality Governance presented the plan for the development of the Quality Account; the Committee approved the longlist of priorities from which the three key priorities would be selected by a vote on Survey Monkey.
- The report from the Mortality Committee provided assurance of a continued reduction in both RAMI and SHMI.

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

10. Finance and Investment Committee Chair Report

The Chair of the Finance and Investment Committee presented his report from the meeting held on 23rd January 2018.

- The risks to delivery of the full year control totals remain significant.
- The underlying cash position also continues to be a cause for concern, this is being closely monitored.
- NHSI have been fully briefed on the Trust's financial performance and key risks; the Trust has been advised to maintain the current forecast.
- There has been further slippage on the capital programme; the Committee were assured that this would not have an adverse impact on future performance.
- The Committee received an update on the development of the 2018/19 ICIP plan including an assessment against opportunities recommended by NHSI. Full ICIP proposals will be debated at the February 2018 meeting.

The Chair of the Audit Committee commented on the significant slippage to the capital programme and asked if there was learning from the slippage to support the management of future capital programmes.

The Director of Finance advised that the three main elements of the slippage were EPR, unified comms and maternity. The new Strategic Estates Board will use robust methodology for capital investment and will provide additional assurance on capital expenditure. The Finance team have also been asked to undertake analysis of balance sheet movements for the February Finance and Investment Committee meeting.

Board members agreed that the newly formed Strategic Estates Board should be asked to reflect on any learning from the capital plan slippage

Resolved: the Board noted the report from the Chair of the Finance and Investment Committee and approved the recommendation to maintain the current forecast.

FT/18/03	Strategic Estates Board to reflect on learning from capital programme

11. Workforce Assurance Committee Chair Report

The Chief Executive presented her report from the meetings held on 22nd December 2017 and 18th January 2018.

The December meeting continued the ground work to develop the committee and establish appropriate reporting lines.

In January 2018 the Committee received a detailed update from the Organisational Development team; this included positive assurance about the benefits of the new Synergy model for student nurse training.

The departure of the Staff Engagement lead in October has resulted in a reduction in staff engagement activities; this will be an area of focus for the new HR director when he starts in post in February 2018.

The Committee received the embargoed staff survey results, this shows a mixed picture with some improvements but also some areas where performance has slipped. The workforce team will work with divisions to develop an action plan to address performance where needed.

The Medical Director presented an update on job planning, the Committee agreed that further work is still required and requested a trajectory to achieve completion of all job plans. The Deputy Medical Director advised that it can be difficult to get clinicians to engage with the process, it is difficult to demonstrate benefits but progress is being made.

The Committee received a report from the Freedom to Speak up Guardian, there has been minimal use of the service prompting a debate as to the whether the current approach is the most appropriate for all staff. In response to a question as to how the Trust compares with others, the CEO advised that data is now being collated and when available this would be used to identify any potential improvements.

The Vice Chair and lead for whistleblowing confirmed that during his time as the named NED for whistleblowing he had not received a single referral.

The Chairman advised that Bilkis Ismail would be replacing Mark Harrison as the Trust's named NED for whistleblowing

Resolved: the Board noted the report from the Chair of the Workforce Committee.

FT/18/04	report back on whistleblowing and Freedom to speak up

12. Urgent Care Delivery Board Chair Report

The Chief Executive presented her report from the meeting of the Urgent Care Delivery Board held on 9th January 2018.

The NW utilisation team audit of ED attendances for the over 65s showed that only half of patients in this age group who arrived at A&E by ambulance required admission. This supports the need for alternative pathways for NWAS, GPs and community services. Board members discussed the implications of this audit, the role of NWAS in handling calls and the need for appropriate alternative pathways to be in place.

The Urgent Care Delivery Board received exception reports from the four programmes that are falling behind plan and not delivering to timelines. It was agreed to separate out the need for an intermediary trusted assessor to facilitate discharge to social care. The ED Home First initiative provided positive assurance and evidence of admission avoidance.

NHSI continue to support the Trust through ECIP

In December there had been concern with regard to access to admissions avoidance, this has now been addressed.

A question was raised to request assurance that if in light of the information presented there was assurance that the focus was on the right actions and metrics. The Chief Executive agreed that this had also been asked within the Urgent Care Board and time had then been spent reviewing the actions and metrics to assess the efficacy of each workstream. As a result of this review five workstreams had been dropped to enable focus on those that would have the most impact. At the weekly review the focus is now on outcomes including overall performance, ED performance measured by decision to admit and minors breaches, flow and bed occupancy.

Resolved: The Board noted the update on the work of the Urgent Care Board.

13. Six Monthly Nurse Staffing Report

The Director of Nursing presented the six monthly staffing report, the following key points were noted:

- The six monthly unify fill rates show a slight reduction in registered fill rates, the main reason for this dip is the stretching of the staffing resource to cover escalation areas.
- The overview of vacancies by area shows a slight decrease in the overall number of vacancies but there is still a significant gap between vacancies and new starters.
- Actions are being taken to tackle HCA vacancies and to support recruitment and retention; this includes the appointment of a Professional Lead for nursing workforce to lead on some of the actions.
- A further ten international nurses have now joined the trust with another 13 in the process of meeting the required standards.
- 45 newly qualified nurses recently commenced in post and a further 30 are due to start in March 2018. 42 of the 45 are from the Salford University cohort and have been recruited as a result of the Professional Lead's efforts.
- Other recruitment initiatives include bespoke recruitment events, increased use of social media, a strong preceptorship programme and

support for students to prepare them for life as a qualified nurse.

- The Acute Adult Division has the biggest challenge, the division are focusing on retention and skill mix with proactive work to look at roles including Nurse consultants and ENP roles in A and E and Nurse Associate roles within ward areas.
- The Elective Care Division have had significant turnover of staff within critical care because of a perceived lack of career progression.
- The Family Care Division have demonstrated some good proactive management of staffing issues and are working to address some of the gaps in the provision of specialist midwives to provide support for ladies with diabetes or with mental health issues.
- The integrated Care Division have successfully recruited to a number of vacancies with only 7 vacancies within district nursing.
- Initiatives to support staffing numbers include the trainee nurse associate programme with a plan to recruit a second cohort of 20 – 25 trainees in April 2018.
- The number of available student placements has been quadrupled

The Director of Nursing advised Board members that staffing remained her main concern however although staffing levels are not ideal and not where they need to be, the discretionary efforts of staff ensured patient safety. This would continue to be a priority but would take a further two years to realise the desired outcome of the actions being taken.

The Chairman and Board members thanked the Director of Nursing for her clear and comprehensive report and commended the proactive approach being taken to increase staffing levels.

In response to a question about the overall market for nurses in Greater Manchester, the Director of Nursing advised that there was good collaboration with colleagues from other Trusts to deliver a collective approach to recruitment and the development of initiatives such as the new Nurse Associate role.

Following up the point on the contribution of discretionary effort, the Director of Nursing advised that the daily input and clinical judgement of the senior nursing team was crucial in monitoring tensions and advising with regard to the availability of staff for escalation areas.

Resolved: The Board noted the nurse staffing report.

FT/18/05	next report to include further information on retention/attrition

14. **RTT Update**

The Chief Operating Officer presented an update on the impact of deferring inpatient elective activity during January 2018. In the run up to winter 2018, the Trust had planned to not schedule in patient elective activity between 26th December and 14th January. This period was extended in accordance with NHSI instructions to extend the elective activity deferral to the end of January. During this period day case activity and surgery for cancer continued

Plans are now underway to restart activity and work is underway with the CCG to

establish plans to reduce the backlog and look for long term solutions to address capacity and demand particularly in trauma and orthopaedics. The cost of recovery is estimated to be between £300k and £1m.

Board members expressed concern with regard to the deterioration in performance against the RTT target and asked for a further report explaining the proposed actions to address capacity and meet the RTT target.

Resolved: The Board noted the RTT update.

FT/18/06	report back to identify actions to address performance

15. **Integrated Performance Report**

The Chief Executive introduced the Integrated Performance Report

Board members were invited to question and comment on the data provided. The following points were made in response to discussion and questions from members of the Board

Quality

A report on sepsis screening was presented to the January 2018 meeting of the Quality Assurance Committee; this will be followed up with a Board paper to the February meeting.

In response to a question about the increase in 3rd and 4th degree tears, the Deputy Medical Director advised that this rate does fluctuate but it is something that can be influenced, an action plan is in place and progress has been made to reduce the rate of tears.

The target for time to theatre following a fractured neck of femur is a particular challenge at weekends relating to the availability of specialist surgeons to undertake the procedure.

The Director of Nursing advised that in the monthly IPM meeting, divisions are challenged to explain how they will bring about improvement to relevant metrics; actions to improve performance for fractured neck of femur will be discussed with the Elective Care Division.

Operational

In response to a question about breast cancer screening performance, the Chief Operating Officer advised that a risk assessed approach had been taken to manage capacity whilst ensuring that the highest risk patients were seen quickly – this had been discussed with NHSI and CCG.

Board members spent some time discussing the changes planned for the dashboard and presentation of metrics including the RAG rating of the objectives

Finance

The Trust has a year to date surplus of£1.0m including STF, this is behind plan. The Trust is expected to achieve breakeven or a small surplus by year end.

Resolved: The Board noted the performance report.

FT/18/07	Board briefing on sepsis screening

16. **North West Sector Business Case**

Mr Mundon presented the North West Sector Business Case and advised that the same report would be presented to the three provider boards to provide and account of the plans developed as a sector. Approval of the case will be through the commissioners.

Board members were critical of the quality of the paper presented, after some discussion the Board expressed the following concerns:

- Noted that the business case demonstrates how the new model of care will be implemented and does not cover any expected output measures. There is also a lack of any measures or targets.
- Noted the absence of any option analysis in this business case.
- Noted that commissioners have considered the case for change, anticipated benefits, value for money and affordability and that these issues are not addressed or evidenced in this business case.
- Noted that due diligence has been undertaken by the commissioners and that trusts have not been asked to agree the final case.
- Noted that the financial case is referenced against costs avoided and that this is a cost plus investment.
- Noted that, within this business case, the analysis of the number of spells and beds expected post implementation shows no reduction or efficiency improvement.
- Noted that, at the time of reading, NWAS have yet to address the issue of how to identify patients with a general surgical emergency from their presenting discriminating factors.
- Noted the reference to the financial arrangements, the provider risk share agreement and the agreement of CCGs to fund additional costs for a time limited period.
- Noted the points raised recently to the Chief Operating Officer of GM in respect of the risk share and financial arrangements.

Resolved:

- The Board received the North West Sector Business Case.
- Having previously written to the Chief Operating Officer of GM to outline concerns in respect of the risk share and financial agreement, the Board delegated authority to the Director of Finance to sign the risk share agreement on behalf of the Trust.

17. **Any other business**

No other business.

18. **Questions From Members of the Public**

No questions raised

Date And Time of Next Meeting

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

January 2018 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/18/02	25/01/2018	Board Assurance Framework	reflect enhanced streaming within the actions on the BAF	AE	Feb-18	complete - BAF update
FT/18/09	25/01/2018	Maternity report	DW to visit maternity	DW	Feb-18	verbal update
FT/18/06	25/01/2018	RTT	report to identify actions to address performance	AE	Feb-18	agend item
FT/18/07	25/01/2018	Performance report	Board briefing on sepsis screening	SH	Feb-18	agenda item
FT/17/100	30/11/2017	Performance report	Report back to provide further understanding and assurance that staff are getting the training they need	JM	Mar-18	
FT/17/99	30/11/2017	Performance report	Report through Workforce Assurance Committee on quality of appraisals	JM	Mar-18	
FT/17/92	26/10/2017	Board Assurance Framework	Audit Committee to discuss potential to revise report to include a projected score if actions have desired effect	ES	Mar-18	
FT/17/110	21/12/2017	Infection control review	full report to QA Committee	TAC	Mar-18	
FT/17/111	21/12/2017	Discharge medication	report back in March 2018 to update on changes and progress	SH	Mar-18	
FT/18/01	25/01/2018	patient story	report back to Board on actions raised in patient story	TAC	Mar-18	
FT/18/08	25/01/2018	Maternity report	consideration of maternity metrics and red flags for Board performance report	TAC	Mar-18	
FT/18/03	25/01/2018	Capital programme	Strategic Estates Board to reflect on learning from capital programme	JB	Apr-18	
FT/18/04	25/01/2018	Workforce Assurance Committee	report back on whistleblowing and Freedom to speak up	TAC	Apr-18	
FT/17/117	21/12/2017	Equality and Diversity	update on E,D&I	TAC	Jun-18	
FT/17/96	30/11/2017	Performance report	TAC to provide update on trajectory to achieve recommended fill rate	TAC	Jul-18	
FT/18/05	25/01/2018	Nurse staffing report	next report to include further information on retention/attrition	TAC	Jul-18	

Key

complete	agenda item	due	overdue	not due

NHS
Bolton
NHS Foundation Trust

Agenda Item No: 8

Meeting	Board of Directors

Date	22 February 2018

Title	Chief Executive Update

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

Previously considered by	

Next steps/future actions	To note			
	Discuss		Receive	
	Approve		Note	✓
	For Information	✓	Confidential y/n	n

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work	✓	To be fit for the future	✓

Prepared by	Esther Steel Trust Secretary	Presented by	Jackie Bene Chief Executive

All information provided in this written report was correct at the close of play 18/01/2018 a verbal update will be provided during the meeting if required

1. Awards and recognition

At the time of reporting the team and employee of the month awards have not been announced.

2. Stakeholders

2.1 NHSI/NHSE

Annual planning guidance has been published – the implications for the Trust are included as an agenda item within the February Board meeting.

At the NHSI Board meeting, the chair summarised developments in the closer alignment of the work of NHS England (NHSE) and NHS Improvement (NHSI), including one initiative to have cross representation on each other's boards.

The NHSI board has appointed David Roberts (deputy chairman, NHSE) as a non-voting associate NED on a two year term from February. Richard Douglas (NED, NHSI) will join the NHSE board in a similar capacity.

Richard and David will co-chair the NHSE/NHSI Joint Finance Committee to ensure that both organisations have a common understanding of the financial targets and performance of the health system as a whole.

NHSI and NHSE intend to have two joint board meetings in 2018, which are planned for May and September.

NHSI is informing DHSC that there is insufficient funding for the Paperless 2020 programme. This situation has been exacerbated by the requirement to fund cybersecurity investment from the programme's budget. Negotiations are ongoing between DHSC and HM Treasury on funding for cybersecurity spending. Implementing the first recommendation of NHS England's WannaCry review would cost £1bn; It was suggested that funding allocated to the Paperless 2020 programme should be used for this purpose.

2.2 CQC

The CQC are continuing their latest round of inspections under the new framework, six North West Trusts have been inspected under this new regime with two inspections ongoing. Although the inspections will be unannounced the Trust will receive a Provider Information Request (PIR) 9 weeks before the inspection window. There will then be a 12 week inspection window during which there will be unannounced inspections of a number of core services (no more than four) and an announced well led review.

2.3 North West Sector

A further Executive to Executive meeting was held with WWL NHS FT to further discussions on potential areas of collaboration.

3. Reportable Issues Log

Issues occurring between 16/01/2018 and 15/02/18

3.1 Serious Incidents and Never events

There have been four serious incidents one of which being a wrong site surgery is also a never event. The other reported incidents relate to a delay in follow up, an unexpected death in CDU and a foetal loss above 24 weeks.

All four will be investigated in accordance with the policy, final reports will be shared with the Board in future part two meetings.

3.2 Red Complaints

One red rated complaint has been received during the reporting period, this relates to a delay in a patient being taken to theatre

3.3 Whistleblowing

Nothing to report

3.4 Media issues

No significant issues, social media coverage of the ongoing development of Ingleside has been very positive.

4 Board Assurance Framework

The Board Assurance Framework has been developed to provide the Board with assurance with regard to the actions in place to ensure achievement of the objectives in the 2017/19 Operational Plan.

The risk score – the product of the likelihood of failing to achieve and the impact of a failure to achieve each objective is reviewed monthly in alignment with the production of the performance report.

For objectives given a score of 16 and higher, the full Board Assurance Framework sets out the risks to achieving the objective, the controls and assurance in place to mitigate the risks and the actions required where there are gaps in controls or assurance. A summary of this is provided on the following page.

The BAF is reviewed in the Risk Management Committee and at the Audit Committee.

In February 2018 the risks within the COO portfolio will be reviewed by the Audit Committee.

	Trust Wide Objective	Lead	I	L		Feb	Jan	Dec	Nov	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	16	Sub-optimal of robust clinical engagement with Antimicrobial Stewardship	External review to be completed in March 2018 Development of Business Case for Antimicrobial Stewardship Pharmacist – March 2018	IPC committee
1.2.1a	For our patients to receive safe and effective care (pressure ulcers)	DON	5	2	-	10	15	15	15	No identified risks, sharing, learning arrangements robust.	Maintain current governance arrangements and enhance ward based training (calibrated to releasing staff safely)	QAC and Harm Free Care
1.2.1b	For our patients to receive safe and effective care (falls)	DON	5	3	-	15	15	15	15	Sub-optimal adoption of all preventative falls measures consistently	Implemented updated Falls Action Plan (in line with National Falls Audit results 2017)	QAC and Harm Free Care
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	3	-	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Roll out mortality review process Drive further improvement in ward observation KPI's Ensure Patient Track Oversight Group delivers on action plan	Mortality reduction
1.4	Staff and staff levels are supported	DON	4	5	-	20	20	20	20	Recruitment, limited pool of staff Staffing for escalation areas Aligning the organisation to all new and emerging national staffing solutions (e.g. trainee nursing associates)	Recruitment workplan New Workforce Assurance Committee	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	20	Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Urgent Care pressure and increased demand on Diagnostic and Elective work	Urgent Care programme plan SAFER ECIP support Capacity and Demand Planning WLI to bring waiting times for diagnostics down	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	20	Healthier Together Access to Transformation Fund Delivery of cost improvement plans Lack of workforce leading to agency cost pressures	Estates Master Planning Capital process – RIBA implementation Strategic approach to cost improvement Locality plan delivery Joint system savings approach LCO Development Strategic financial planning	IPM F&I comm
4.4	Compliance with NHS improvement agency rules	HRD	4	4	-	16	16	16	16	Sickness absence Gaps in rotas	Additional admin support for wards. Ongoing recruitment National recruitment plan	IPM Workforce comm
5.4	Achieving sustainable services through collaboration within the NW sector	CEO	5	4	-	20	20	20	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing engagement with partners Agreement on scope of single service Exec to Exec and Board to Board with WWL Q2	Board F&I
5.5	Supporting the urgent care system	COO	5	4	-	20	20	20	20	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Urgent Care action plan ECIP support	Urgent care prog board

All information provided in this written report was correct at the close of play 15/02/18 a verbal update will be provided during the meeting if required

All information provided in this written report was correct at the close of play 15/02/18 a verbal update will be provided during the meeting if required

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	21 Feb 2018	Date of next meeting:	21 March 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Apologies:	TAC, AW	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story		Great example of end of life care for an elderly couple where the Acute Adult and Integrated Care team worked together to provide care and support	Story noted and to be shared within divisions
Clinical Governance and Quality Committee		Escalated risks relating to Ramblegard fall mats, statutory and mandatory training and AKI (agenda paper also received on AKI	Report noted
Division quarterly report – Acute Adult Division		Strong report illustrating good governance although still some operational challenges with regard to flow. Improved complaints response and incident reporting and good uptake of flu vaccine	Action to Clinical Governance Committee regarding delayed transfer to mortuary
Division quarterly report – Integrated Care Division		Strong report with good acknowledgement of challenges – the committee recognised the improvements made in the report and the work of the DND who retires at the end of February	Report noted
Darley Court		Update on the environmental improvements, a number of issues have now been addressed and work is ongoing with Bolton Council to address outstanding estates issues. Good progress in BOSCA, now a strong silver	Further debate at Strategic Estates Board
DNACPR – Quality Account priority update		Improvement in overall performance	Report noted
Patient stories update of themes and actions		Assurance that actions identified in patient stories received within the Board meeting are addressed	Ongoing work to ensure actions are embedded

	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

Medicines Management		Chief Pharmacist attended to provide an update on progress made against Medicines Optimisation guidance	
Radiology – response to national request for radiology reporting information		Following an incident at Portsmouth Hospitals where a large number of Chest X-Rays were unreported CQC requested data from all trusts. Although the Committee were assured that there is no hidden backlog there is a potential risk from delays to reporting where further assurance was requested	Further assurance to understand risks and mitigation
Safer Maternity Care		Update provided on the Safer Maternity Care action plan – majority of actions green, no reds	
AKI action plan update		Update received on AKI, AKI steering group in place and reporting to Mortality Reduction Group	Recommendation that AKI is one of the three indicators in the Quality Account
Bowel screening action plan update		Update on the action plan noted – rated amber because of capacity issues	
GIRFT litigation in surgical specialties		Data provided which will be a useful resource for the governance team	
Review of regulation 28 actions		Update on actions agreed in response to Reg 28 letters from coroners – provided assurance that actions are addressed	Future reports to be through Clinical Governance Committee for operational review of detail with exceptions escalated to QA committee
GDPR implications for patient data		Paper summarising the impact of new GDPR regulations, impact also considered within Audit Committee – some increased risk in terms of increased fines and access to information	Update noted
Patient Experience, Inclusion and Partnership Committee		Chair report received for information	

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Committee/Group Chair's Report

Risk Management Committee		The Committee received a report on issues with the uninterruptible power supply which resulted in three separate power outages	Third party review requested for assurance
Safeguarding Committee		Chair report for information no risks escalated tow amber items where further updates have been requested	Report noted
IT and Informatics Committee		Chair report identified lack of assurance/significant risk with regard to implementation of Ascribe and approval of the E obs business case	Risks noted
Comments			
Risks Escalated			

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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	20th February 2018	Date of next meeting:	20th March 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Apologies:	M Harrison, B Ismail	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 10)		Director of Finance	Key points noted from the Finance & Activity Report: • the Trust has a year to date surplus of £1.7m including STF, which is £2.6m worse than plan at the end of Month 10; • the NHSI plan is a surplus plan of £10.1m by the end of the year; • the Trust has a year to date deficit of £2.8m when STF is excluded from the position; • balance sheet adjustments of £0.8m were released into the position; • agency costs are at £8.5m against a year to date plan of £5.2m which now exceeds the full year plan of £6.2m; • ICIPs at £12.8m are £0.7m worse than the year to date plan (note the full year target of £20.8m); • the month end cash balance is £4.1m which is worse than plan by £2.9m this month; • year to date capital spend is £14.3m which is £12m below the capital plan; and, • the Trust's Use of Resource Rating is 3 at the end of Month 10 which is below plan.	Risk to delivery of full year control total remains significant. The underlying cash position continues to give cause for concern and requires close monitoring. Risk to be formally escalated to Board. The Committee has requested the development of contingency plans in the event that the cash situation becomes more serious. Further improvement in performance is required to drive forward the revised tactical plan and existing ICIP schemes together with the identification and delivery of additional performance improvement opportunities. Delivery of Control Totals is required to maximise STF income.

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

Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
			Disappointing that M9 performance improvements to pay and agency costs were not sustained through M10. Q4 remains very challenging. Successful delivery of full year plan will require significant improvement in performance as per the tactical plan as well as some additional opportunities. Discussions with NHSI remain ongoing.	Reasonable assurance was provided regarding delivery of the revised tactical plan and additional opportunities, but likely to be contingent upon further contractual discussions (albeit with potential consequences for 2018/19). NHSI continues to be fully briefed and understands the significant risks to delivery. Bolton CCG/Bolton Council continue to work with Bolton NHS FT to identify and deliver additional opportunities required to meet control total targets. On the basis of the above the Committee will continue to recommend that the Board maintains the control total target as its forecast subject to the ongoing assurances of understanding and support.
Capital Programme Update (Month 10)		Director of Finance	The Committee received a paper which reported that expected slippage continues to be £10.2m, mainly due to slippage in EPR, maternity and unified communications. Further discussions are ongoing with the relevant leads and it is likely that there will be further slippage in the forecast spend.	Assurance was requested and received that red rated items will still be delivered in line with reported timescales. Report noted.
Minutes from the Capital, Revenue and Investment Group		Director of Finance	The Committee received the minutes from the meeting held on 9th January.	Report noted.

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

Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Reference Costs		Director of Finance	The Committee received an update on the final reference costs results for 2016/17.	It was noted that this report represents a high level indicator only. Report noted.
2018/19 Planning Guidance		Director of Finance	The Committee received a full suite of documents relating to the 2018/19 Planning Guidance and revised financial control totals. Financial plans are being developed in line with planning guidance.	Revised control total targets for 2018/19 were noted along with the fact that achievement of control totals for 2017/18 will result in a further reduction in the 2018/19 control totals.
2018/19 Revised High Level Financial Plan (update to November 2017 paper)		Director of Finance	The Committee received an updated high level financial plan further to the information presented to the Committee in November and the NHS planning guidance issued recently. It was noted that NHSI will require acceptance of 2018/19 control total targets by 8th March.	The Committee recognised the significant challenge to deliver the 18/19 Control Total target, albeit a reduced level if the 17/18 forecast is achieved. The required level of ICIP is of particular concern. There is however reasonable expectation that ICIP targets will be identified and/or possibly reduced pending the outcome of contract discussions (see next item). Notwithstanding the level of challenge, the potential for receiving significant additional rewards based on full or even partial delivery, together with the possibility that required ICIP levels may yet reduce, leads the Committee to conclude that it would be in the best overall interest of the Trust to accept the Control Total targets, preferably with an appropriate supporting narrative.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
				It was noted that 18/19 Capital Expenditure Plans will be subject to a cap and, in any case, will require careful review and prioritisation for affordability and ability to deliver.
Progress Report: Income and Cost Improvement Programme 2018/19		Director of Finance	The Committee received an update on progress made towards the development of the ICIP for 2018/19.	The level of ICIPs indicated in the current high level draft plan for 2018/19 remains extremely challenging. Extensive discussion, however, led the Committee to conclude that there is a reasonable expectation that the full ICIP will be identified and /or the target reduced pending the outcome of contract discussions. Report noted.
Procurement KPI Report		Director of Finance	The Committee received this regular report which sets out current achievement against the agreed KPIs in the Trust's procurement strategy. The report also provided a brief update on the purchase price index and benchmarking (PPIB) tool and the status in regard to the financial grip and control checklist.	Some concerns were expressed regarding the efficiency and effectiveness of the Trust procurement processes. In response to these concerns the Committee Chairman requested that the Finance Director should instigate an independent review of the effectiveness of Procurement activities and services. Report noted.
Devolution Manchester		Director of Finance	The Director of Finance gave a verbal update in relation to recent progress.	Update noted.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Tender Update		Director of Finance	The Committee received an update in relation to competitive tender exercises that Bolton NHS FT is currently engaged with.	Update noted.

Comments

Risks escalated

2017/18

- Divisional performance/delivery of ICIPs – key material risk for the year. Urgent action required to achieve forecast.
- General risk regarding workforce, both shortages and the cost pressure that this creates, especially variable pay.
- Some contractual risks remain
- Sustainability & Transformation Fund risks
- Under the worst case scenario distress funding will be required
- The Business Case for the transfer of Outpatient Pharmacy: further urgent negotiations to achieve Business Case objectives still not complete
- iFM Bolton delivery of plan
- The underlying cash position is now giving increased cause for concern and requires close monitoring; contingency plans have been requested in the event that the cash situation becomes more serious.

From 2016/17

- Contingent liability on the ill health retirement case still an outstanding issue but mitigation in place

Other Matters Escalated

- Governance Issues relating to iFM Bolton

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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Board of Directors
Date of Meeting:	15 Feb 2018	Date of next meeting:	12 March 2018
Chair:	Jackie Bene	Parent Committee:	Board of Directors
Apologies:		Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Sickness absence update		Remains an area of concern – action plan reviewed	Actions to be refreshed Paper on Board agenda
Recruitment and Retention update		Update provided on the actions planned including the establishment of a Retention sub group to develop a time limited action plan	Report noted – the committee will continue to receive assurance reports with operational aspects overseen through the Workforce Operational Committee
Divisional workforce planning		Reports from the four clinical divisions received – some variation on content and detail but committee later assured that all divisions are working to the same template	Discussed the division plans and how future plans will develop to reflect the Trust's strategy.
Health and Wellbeing update		Overview of the Trust's Health and Wellbeing offer provided	Health and Wellbeing Strategy to be reviewed/refreshed. Strategic decision required with regard to the future of the Sports and Social Club
Staff Awards		Briefing received on the plans for the 2018 staff awards	Board members are asked to note the date of the 2018 awards – October 26 2018
Gender pay gap report		Preliminary report received in advance of report being prepared for March Trust Board and publication in line with reporting requirements	Further work required on the data.
Workforce Operational committee		Escalated risks of increased sickness absence, agency spend levels and staff survey results.	Noted the need to develop a comprehensive Workforce and OD Strategy

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

Committee/Group Chair's Report

Locality Workforce Group		Urgent progress required to develop a cross locality workforce engagement plan	Further work required on workforce redesign and integrating services across the locality
Medical Workforce Improvement Group		Continued issues with job planning in Elective and Acute Adult	
Comments			
Risks Escalated Gender pay gap reporting			

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

Committee/Group Chair's Report

Bolton NHS
NHS Foundation Trust

Name of Committee/Group:	Bolton Urgent Care Delivery Board	Report to:	Bolton FT Trust Board
Date of Meeting:	13th February 2018	Date of next meeting:	13th March 2018
Chair:	Su Long	Parent Committee:	Bolton System Resilience Board
Apologies:		Quorate (Yes/No):	Y

Key Agenda Items:	Assurance Yes/No	Lead	Key Points	Action/decision
Letters from GM Strategic Partnership	Yes	CCG & BFT	Key action points reminder	Confirmed all in place
Exception reports : • Frailty Update • Immedicare work in NH's • Implementation of SAFER	 Yes No Yes	 CCG CCG BFT	 Links to care planning explained Actions against provider discussed Improving performance discussed	 Measures agreed Await outcome Continue progress
Primary Care Streaming Trajectory	Yes	CCG & BFT	Trajectory and timeline shared	Proceed to planning agreed
Performance Dashboard	Partial	BFT	Main issue of concern was the access to admissions avoidance and LOS on their caseload – relates to resources /sickness	.Further assurances sought regards capacity

Agenda Item No : 13

Meeting	Board of Directors

Date	22nd February 2018

Title	18 Week RTT Update

Executive Summary	This paper sets out the RTT Incomplete position at Bolton NHS Foundation Trust, some of the current challenges and options for consideration in relation to treating the backlog of patients with the aim of returning to achieve the 92% incomplete standard.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	

Next steps/future actions				
	Discuss	X	Receive	X
	Approve		Note	
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	x	To be well governed	x
Valued Provider	x	To be financially viable and sustainable	x
Great place to work		To be fit for the future	x

Prepared by	Rayaz Chel, Divisional Director of Operations Elective Care	Presented by	Andy Ennis, Chief Operating Officer

NHS
Bolton
NHS Foundation Trust

18 Week Referral to Treatment

1. Purpose of paper

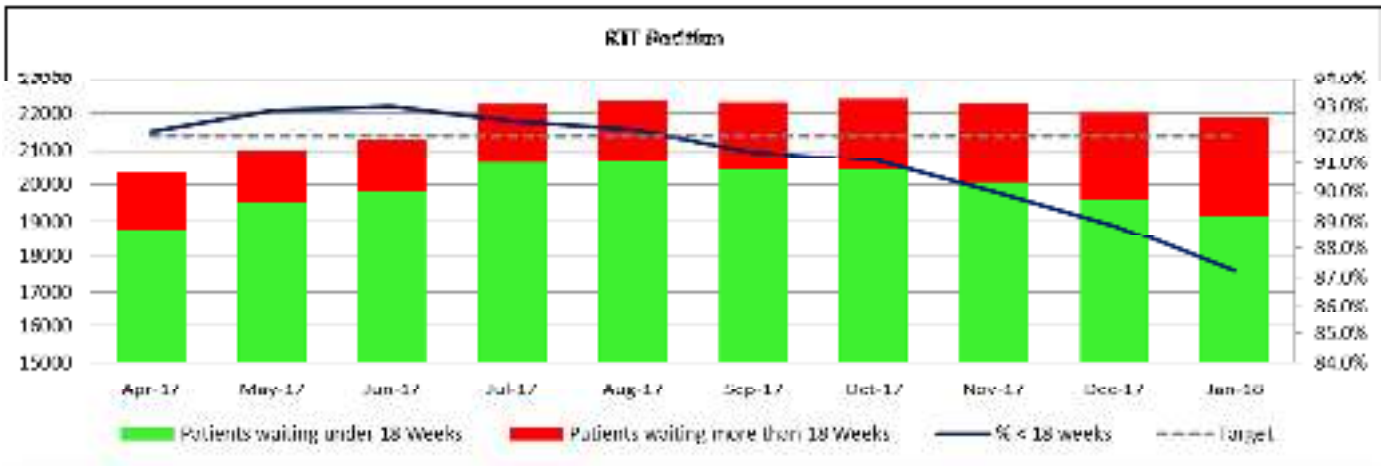
- To highlight current performance against the RTT standard
- To provide a high level estimate of the likely non-recurrent cost to clear the existing backlog
- To advise of ongoing work to secure a sustainable elective position, which consists of three elements:
    - Backlog clearance
    - Demand reduction (review of EUR and clinical thresholds, development of community services, pre-optimisation and shared decision making)
    - Capacity planning (to include the development of services to meet the requirements of the health economy, including collaborative work with other providers, workforce development and alignment of capacity to demand)

2. Summary

- Nationally, meeting demand for elective services is becoming increasingly challenging, in a context of finite resource (in terms of both finance and workforce), and the need to manage non-elective demand.
- Increase in demand at specialty level combined with key capacity constraints has resulted in deterioration of the elective position, with the 92% incomplete standard (which requires 92% of patients awaiting treatment to have been waiting less than 18 weeks) having been failed from September 2017.
- Winter pressures and ongoing cancellations as a result of national emergency planning guidance have contributed to the further deterioration of performance. This has resulted in significant growth in the backlog of patients waiting over 18 weeks.
- In addition, the cancellation of this level of elective activity will have an onward impact in terms of capacity available to treat those patients currently under 18 weeks, as those patients who were cancelled will now need to be treated in upcoming lists.
- There is a need to invest non-recurrent monies to clear this backlog, and to reduce the rate to which the backlog is currently being added to, in order to treat patients within 18 weeks and deliver the 92% incomplete standard. Additionally this will reduce the number of patients with excessively long waiting times (and any associated clinical risk or patient experience concerns).
- In addition, the capacity and demand analysis for 16-17 and 17-18 has highlighted capacity shortages to meet current demand in a number of specialties. This includes specialties with the highest backlog numbers such as T&O, General Surgery and Ophthalmology. Work is underway to identify areas where demand can be reduced but additional capacity will need to be delivered to secure a sustainable elective position.

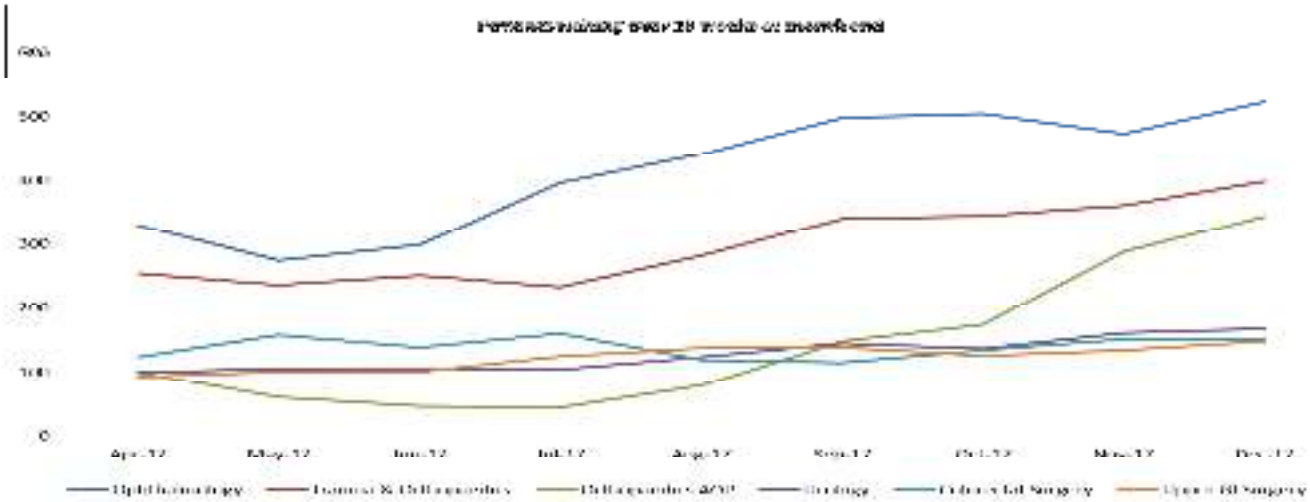
3. Performance

The following chart demonstrates the current backlog as a proportion of the total waiting list, and performance against the 92% incomplete standard.



Month on month the RTT positon has deteriorated, whilst at the same time the backlog continues to grow. Key challenges are within General Surgery (Colorectal and Upper GI), Ophthalmology, Trauma & Orthopaedics, which between them account for 67% of all patients waiting over 18 weeks.

There is no way of determining which patients will move over in to the backlog each month as each pathway is unique. (The patient may not need treatment, may be treated as an outpatient or move on to an admitted pathway). However, the following information gives an indication of the themes over the last 5 months and the likely numbers for key specialties. In summary the backlog continues to grow. (Further growth is expected in January data).



4. Specialty specific challenges include:

Trauma & Orthopaedics

- Very limited additional capacity can be delivered under variable pay due to existing arrangements under North West Surgical Services. This leaves difficulty in the specialty when there are sub specialty challenges within the overall capacity
- Lack of trauma capacity has impacted on the delivery of elective activity, with high volumes of cancellations, the impact on cancellations is significant given the non-admitted pathway challenges OPA / diagnostics and the lack of ability to re-date within breach and remove from the over 18 waits
- Significant sickness in the AOP team has increased the length of wait for first OPA significantly. Approx. 600 slots were loss from March - July 17. 100 extra slots were added through additional sessions, but there was no ability to deliver more. 135 referrals for Upper Limb were re-directed to the surgeons. This showed in specialty pass for RTT in July, when patients were awaiting first OPA but resulted in a significant increase in backlog being created from August.

Actions taken:

- AOP sickness issues are now resolved, but there is a need to clear the current backlog of patients awaiting first appointment. The proposals to do this are detailed in the options appraisal section of this document.
- Review of OIS and Spinal capacity is underway to ensure appropriate resourcing of both services.
- Divisional discussion taken place with CCG to progress the establishment of the Community MSK Service, Operational plan being progressed during Q4 2017/18.

General Surgery

- Shortfall in capacity as per capacity and demand analysis
- 17% more patients seen as 2ww 17/18 compared to 16/17 same period, with some increase in activity
- Some activity cancelled as a result of bed pressures and some due to theatre staffing challenges
- Pressure on endoscopy capacity impacting pathways

Actions taken:

- Collaborative working with community endoscopy provider to source additional capacity for growing demand
- Implementation of straight to test pathways as part of the locally funded Cancer Vanguard project

Ophthalmology

- Significant backlog growth in past 3 months. Significant issues have included the departure of a long standing consultant, and as a result the time to first OPA has risen significantly with patients been seen for first OPA after 18 weeks.
- In addition, hospital eye services are under increasing pressure due to changes in treatment and follow-up pathways, as a result of new treatments being available.
- Capacity and demand analysis indicates a significant shortfall in capacity.

Actions taken:

- Establishment of community Ophthalmology service as part of a joint service redesign with the CCG, providing approximately 2500 appointments in the community in 2017/18, and the potential to deliver up to 8000 appointments in 2018/19. This service commenced in late November 2017.

5. Backlog clearance cost

The table below provides a very high level summary of the costing approaches which could be taken to backlog clearance:

Option Summary	Advantages	Disadvantages	Cost
Option 1: Total clearance of all admitted and non-admitted backlog	Removes whole backlog	Highest cost	£4,152,868
Option 2: Deliver 93% achievement against the incomplete standard, with a focus on clearing admitted pathways (90% admitted)	Treats the majority of longest waiters, who tend to be in admitted pathways (and manages any associated risk) Focuses on pathways which result in definitive clock stops	Is the high cost Requires capacity to be sourced, in a context of ongoing cancellation of elective activity, limited workforce, physical space constraints and urgent care pressures (including trauma)	£2,398,177
Option 3: Deliver 93% achievement against the incomplete standard, with a focus on clearing non-admitted pathways (50% admitted)	Allows for both admitted and non-admitted pathways to be equally targeted Would be a less expensive way of delivering the incomplete standard	Does not treat the longest waiting patients and any associated risks Delivery of non-admitted activity does not guarantee clock stops as pathways are unique and will lead to further admitted numbers	£2,217,140
With all options: Non-recurrent investment should be considered to bring the milestone waits down in key specialties to immediately reduce the number of patients being added to the backlog. Detailed analysis of milestone waits and associated costs can be developed for all specialties.	Prevents further backlog growth Improves the RTT position	Additional non-recurrent cost	Gen Surgery and T&O only £355,000

*costs are based on current backlog. Further growth will be an additional cost. See finance models for full details

Option 1 plus management of milestone waits in key specialties would deliver the greatest impact overall, and presents the best opportunity for creating a more sustainable model. It allows for almost full clearance of the current backlog (accepting that the backlog will continue to grow short term and that some patients will wait more than 18 weeks due to choice and complexity). It also targets the longest waiting patients, and will have a more reliable impact on RTT performance.

If funding was made available for the backlog clearance (and potentially the management of milestone waits), the highest impact actions would be made initially in T&O, Ophthalmology, and General Surgery:

- Delivery of additional outpatient clinics in Ophthalmology
- Delivery of additional outpatient clinics in the OIS
- Delivery of additional T&O elective lists

- Delivery of additional General Surgery elective lists

Options for delivery would need to include the potential use of NWSS theatre lists, pay variations, collaborative work with alternative providers with consideration to the constraints of space and workforce.

Other specialties would then be phased in to the backlog clearance as more detailed costings and trajectories were developed.

The above would need to be supported by additional diagnostic capacity, particularly CT, MRI and endoscopy, as well as support services such as laboratory medicine, pharmacy, administrative and clerical duties, pre-operative assessments and all the constraints in place within these services. If the plan moves at pace there may also be a requirement to use agency to support this.

Within the last week Greater Manchester Health and Social Care have asked Bolton Health Economy through Bolton CCG for a trajectory to recover performance for 18 weeks. This is against a backdrop of national DH / NHSI guidance which does not request organisations to put forward such plans. There are further discussions scheduled between Bolton CCG and Bolton FT to understand the rationale for this requirement as there would be a considerable cost to the health economy to deliver in the timescales being suggested by our commissioners.

6. Delivering a sustainable elective position

Under the aligned incentives contract between Bolton NHS FT and NHS Bolton CCG, a fixed sum has been agreed for the delivery of hospital activity in Bolton. This means that we need to think differently about how we approach capacity issues in the system – as "more of the same" will require proportional investment (or work to be undertaken at a premium rate, via locum or WLI), which we no longer have access to. This work has been commenced at specialty level as part of a joint project between BFT and the CCG. An initial report of opportunities identified through these visits is currently in draft, and will be considered by the Planned Care Planning and Strategy Group initially.

Areas of opportunity may however be summarised at a high level as follows:

- **Review of surgical pathways and clinical thresholds** – including pre-operative optimisation on primary care, shared decision making, thresholds for surgery (including EUR) and enhanced recovery. This is being led by Dr Tarek Bakht and Dr Jeremy Wood, with a proposed approach to pre-operative optimisation and shared decision-making having already been developed for consideration by both the CCG and FT Leadership Teams. EUR procedures have reduced by 235 this year vs last year. However, there is likely to be additional scope to look at surgical thresholds, and as such it is being included in the above programme of work.

- **Working differently -** Both the Trust and the CCG are committed to the principles of efficiency and productivity gained though new ways of working. Two such initiatives are the potential reduction of follow ups through delivery of virtual clinics, and the review of patients discharged at first appointment without treatment, diagnostic or follow up.

- **Community and primary care model development –** identifying opportunities for activity to be delivered on a neighbourhood level in primary care or via community services, to release secondary care capacity, for e.g. development of Ophthalmology community monitoring service.

- **Workforce development initiatives –** using non-medical advanced practice roles to deliver a sustainable workforce, as presented at Strategic Workforce Board in February (2 year lead in)

- **Operational productivity and efficiency improvements -** using tools such as GIRFT to promote efficiency, reviewing clinic and theatre utilisation, standardisation of templates, etc

Such initiatives will contribute to delivering a sustainable elective service; however they will not negate the need to clear the existing and growing backlog, and the gaps between capacity and demand.

7. Risks

Risk	Mitigation
Funding stream for non-recurrent backlog clearance not yet identified	Full high level backlog costing completed, for Board review and system discussion of funding
Lead in time to recommence elective programme due to ongoing cancellation of activity	Identification of quickest high impact actions, including sourcing of outpatient capacity, to start reducing backlog Need for development of detailed plan following discussion of high level cost
Lack of staffing, bed and theatre capacity to deliver additional elective throughput	Identification of quickest high impact actions, including sourcing of outpatient capacity, to start reducing backlog Potential to work with other providers to provide additional capacity
Need for management / project focus to oversee and deliver whole programme, including PTL validation, sourcing additional capacity, agreements with other providers	Need for development of detailed plan with clear ownership at specialty and divisional level
Underlying capacity shortfall leading to backlog increase following initial clearance	Ongoing capacity and demand work to identify actions and timescales and specialty level – these are likely to be longer term so there is also a need to account for bridging arrangements before the benefits of these can be realised
Patients waiting significantly long periods for out-patients appointments and procedures	Risks are being reviewed by specialties and action is being taken to prioritise clinically urgent patients, examples of this include urology and ENT specialties prioritising follow up patients. Ophthalmology identifying the high risk retinal and Wet AMD patients and putting steps in place to manage this cohort of patients. Where patients have been waiting a significant period of time for follow up appointments, clinical notes review have been carried out to assess patients and this has led to a proportion of long wait patients being discharged with no further intervention required within secondary care. With the volume of patients waiting, and waiting times increasing, all risk cannot be mitigated but steps are being taken to mitigate the highest risk.

8. Summary

In summary, the above provides a range of options to bring the Trust back in to line with RTT Incomplete delivery.

The underlying capacity and demand requirements need to be addressed separately, but are a requirement to delivering sustainable performance.

A full action plan and operational delivery model will be created dependent on the model to be undertaken. This will be produced in collaboration with the CCG and may involve third party organisations.

Agenda Item No: 14

Meeting	Board of Directors

Date	Thursday 21 February 2018

Title	Sickness Absence Update Report - 01 Jan 2017 to 31 Dec 2017				
Executive Summary	1. The purpose of this sickness absence report is to update the Trust Board on the current sickness absence rate, together with the actions that will be taken throughout the Trust to reduce sickness absence rates to an acceptable tolerance level. 2. The Trust has not met its sickness absence target (In Month 5.64%, Rolling 4.71%). Colleagues will note the adverse trend line indicating a worsening position. 3. Reducing sickness absence is essential to maintaining safe staffing and reducing the associated cost of staff absence which will help the Trust achieve financial stability.				
Previously considered by	Not Applicable				
Next steps/future actions	Discuss	✓	Receive		
	Approve		Note	✓	
	For Information		Confidential y/n		

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work	✓	To be fit for the future	✓

Prepared by:	Jane Seddon James Mawrey	Presented by:	James Mawrey

Introduction

1. The purpose of this sickness absence report is to update the Trust Board on the current sickness absence rate, together with the actions that are being taken throughout the Trust to reduce sickness absence to an acceptable tolerance level.

2. The management of sickness absence should be part of an all-round healthy working relationship between managers and employees. If employee sickness is supported and managed appropriately sickness absence should be minimised, agency spend reduced and retention and general performance of the department improved.

Performance and Underlying Causes

1. Appendix 1 shows that the Trust has not met its sickness absence target (In Month 5.64%, Rolling 4.71%). Colleagues will note in Appendix 1 the adverse trend line indicating a worsening position.

2. The North West average sickness rates for Provider organisations (data from Jan to Nov 17) is 4.7%. A review of Greater Manchester sickness absence data has been undertaken and the findings are as follows:-

Greater Manchester	Average Absence Rate:
The Christie NHS Foundation Trust	3.3%
Stockport NHS Foundation Trust	3.8%
Wrightington, Wigan and Leigh NHS Foundation Trust	4.2%
Pennine Acute Hospitals NHS Trust	4.2%
Salford Royal NHS Foundation Trust	4.3%
Bolton NHS Foundation Trust	4.7%
Tameside Hospital NHS Foundation Trust	4.9%
Manchester University NHS Foundation Trust	5.0%
Pennine Care NHS Foundation Trust	5.0%
Greater Manchester West Mental Health NHS Foundation Trust	5.6%

3. The sickness absence rate per Division is detailed in Appendix 1. It is perhaps not surprising that the Divisions with a high sickness absence are those which experience the greatest impact of urgent care pressures. The matter is compounded by absence levels being higher amongst some staff groups, namely nursing & midwifery, additional clinical services; and administration & clerical. Given the direct patient facing roles some of these staff groups operational and financial pressures is significant. Of note the section titled ‘Productivity loss’ relates to lost salary, it does not relate to any backfilling associated costs.

4. The Workforce & Organisational Development team have undertaken an analysis as to the reasons for staff taking time off sick in order to identify where to focus their interventions (Appendix 1). Colleagues will note the high levels of stress & anxiety reported as a contributing factor towards Long term absence in particular. Long Term

sickness absence (three weeks plus) accounts for nearly two thirds of sickness absence within the Trust (further details relating to the actions that will be taken in this area are discussed later in the paper).

Actions being taken / to be taken.

The Director of Workforce will work with the Operational teams, Staff-side Partners and his department to ensure a sharpened focus on the management of sickness. Actions to be taken will include (non exhaustive):-

1. Divisional trajectories will be set following an examination of seasonal variations and final targets adjusted to reflect the fluctuations. This will involve the HR Managers working with their Divisional Director and management teams to review what will be achievable by the end of Quarter 1 – 2018/2019. The revised trajectories will be based on a critical assessment of current sickness caseload, planned actions for resolution, local plans in operation to tackle sickness hotspots and in particular reduce long term sickness

2. Linked Issues: There are a number of issues which are impacting on the levels of sickness absence and these linkages will need to be reviewed. Addressing these may have an impact on sickness absence levels across the trust.

    a. Inconsistency of application of the attendance management policy across the trust
    b. Deployment protocols & e-rostering.
    c. Employee special leave / flexible working policies and their inconsistent application.
    d. Improved usage of the Exit Interview process to support in a triangulation of key workforce data.
    e. Management ownership of absence reduction targets

3. Training for Managers: To support better implementation of the attendance management policy then additional training will be provided. Take up of training will be monitored to ensure it correlates with those areas where sickness levels are high. To ease the access to this training then service areas will be able to agree whether a more local condensed approach is the preferred approach (2 hours) or attendance at the normal full day training programme. Fifty seven training programmes will be provided by the Human Resources team in a three month period.

4. Deep Dives on Long Term absences: The Director of Workforce, Human Resources Senior team and HR Managers & HR Advisors to review all long term sickness cases where the absence has been ongoing for longer than 3 months. An update on the findings of this deep dive will be provided to the Workforce Operational Group.

5. Quarterly Deep Dive on Top Sickness Areas: The two highest sickness absence areas within each clinical area have been identified and a deep dive report has been developed. A performance improvement plan has been compiled by the HR

Manager and the operational leads to target improvement and support within these areas.

6. Rehabilitation & redeployment: There are cases where staff with specific issues for example musculoskeletal conditions are remaining absent for lengthy periods of time. Whilst they may be unable to fulfil a full clinical role they are able to undertake alternative work hence an increased focus will be placed on seeking alternative duties / redeployment opportunities for staff to facilitate earlier return to normal duties.

7. Occupational Health Service: The current Occupational Health service (provided in a Joint Venture Partnership with WWL and LTH) provision will be reviewed against local requirements with actions taken to address any gaps identified to ensure the service is 'fit for purpose' going forward. Specifically a review of the counselling service will be required as currently there is only 6 hours of dedicated time for our Trust staff. In addition to a need for more dedicated direct counselling the Trust will review a pro-active offering e.g. mindfulness sessions to help staff manage their own stress. The Trust will also review the potential benefits / return on investment of introducing an Employee Assistance programme. Colleagues may be aware that Employee Assistance programmes offer confidential advice and support for personal problems that might adversely impact work performance, health and well-being. EAP generally include assessment, short-term counselling and referral services for employees and can be offered via phone, electronic communication and face to face. Key performance metrics for the Occupational Health Service will be reported to the Workforce Operational Committee.

8. Pro-active Health & Wellbeing support: It is apparent that the good work which is currently being undertaken on this critical agenda item (e.g. alcohol reduction, obesity awareness, social clubs, exercise programmes and more) is not fully communicated to employees in a consistent and effective way, with many employees being unaware of the range of options available to them. Further work is required on the agenda item to ensure that the work currently being undertaken is aligned to Trust priorities, such as reducing sickness absence.

9. Best Practice: Visits will be made to trusts where sickness absence rates are lower to learn from their experience and best practice.

10. Refreshed Workforce & Organisational Development Strategy: Sickness absence rates should not considered in isolation. There is a clear need to review all the Workforce & Organisational Development activities into a coherent Strategy which sets out a clear vision for our Trust. It is apparent that the People Strategy requires a fundamental review and a fresh Workforce & Organisational Development Strategy produced with clear actions, monitoring & governance arrangements in place. This will support this critical agenda and help the Trust in ensuring that we have an effective, sustainable and affordable workforce which puts patients at the heart of everything we do. The Director of Workforce will engage the Trust over the coming months on this Strategy with a view to seeking the Trust Board sign off in Quarter 2 – 2018-2019.

Recommendations

1. The Trust Board is asked to:
    a. Note the details of the Sickness Absence Exception Report.
    b. Note the actions that will be taken to support a reduction in sickness absence levels. The Trust Board will be updated on the progress being made via the Integrated Performance Dashboard and the Workforce Assurance Committee Chair's report.
    c. Highlight any specific additional assurance / workforce information required.

Appendix 1 - Sickness Absence Exception Report - 01 Jan 2017 to 31 Dec 2017

Divisional (12 month)

	Headcount as at Dec 17	Month only %	Cumulative %	Cumulative Trend Line	Lost Productivity	Short Term %	Short Term Trend line	Long Term %	Long term Trend line
Trust	5329	5.64%	4.71%		£6,492,190	1.39%		3.32%	
Acute	1222	6.96%	5.67%		£1,564,075	1.80%		3.87%	
Elective	1907	5.27%	4.44%		£2,174,921	1.32%		3.12%	
Family	1214	5.27%	4.68%		£1,567,598	1.25%		3.43%	
ICS	593	6.68%	5.31%		£820,831	1.31%		4.00%	
Corporate	393	2.94%	2.62%		£364,765	0.97%		1.65%	

Staff Group (12 Month)

	Headcount as at Dec 17	Month only %	Cumulative %	Cumulative Trend line	Lost Productivity	Short Term %	Short Term Trend line	Long Term %	Long term Trend line
Add Prof Scientific and Technic	169	2.64%	3.63%		£171,101	1.35%		2.28%	
Additional Clinical Services	1226	8.20%	6.76%		£1,360,460	1.99%		4.77%	
Administrative and Clerical	991	6.38%	4.68%		£976,210	1.26%		3.42%	
Allied Health Professionals	454	2.78%	2.94%		£457,897	1.22%		1.72%	
Estates and Ancillary	10	17.36%	4.48%		£55,256	1.38%		3.10%	
Healthcare Scientists	116	2.31%	1.83%		£73,241	1.04%		0.79%	
Medical and Dental	358	1.04%	1.28%		£303,686	0.40%		0.88%	
Nursing and Midwifery Registered	1995	5.70%	4.90%		£3,086,657	1.38%		3.52%	
Students	10	0.00%	2.21%		£7,681	0.00%		2.21%	

Top 5 Absence Reasons (12 Month)

Absence Reason	Total No of episodes	Absence Reason	Short Term Episodes	Absence Reason	Long Term Episodes
Gastrointestinal problems	1,992	Gastrointestinal problems	1,883	Anxiety/stress/depression	402
Cold, Cough, Flu - Influenza	1,347	Cold, Cough, Flu - Influenza	1,298	Other musculoskeletal problems	161
Anxiety/stress/depression	738	Chest & respiratory problems	394	Gastrointestinal problems	109
Chest & respiratory problems	452	Headache / migraine	392	Injury, fracture	82
Other musculoskeletal problems	427	Anxiety/stress/depression	336	Back Problems	76

Agenda Item No: 15

Meeting	Board of Directors

Date	22nd February 2018

Title	Mortality Update

Executive Summary	This paper summarises current performance including benchmarking with other local organisations. There is a description of the ongoing improvement work including the mortality review process.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	

Next steps/future actions				
	Discuss		Receive	✓
	Approve		Note	✓
	For Information	✓	Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	
Valued Provider		To be financially viable and sustainable	
Great place to work		To be fit for the future	✓

Prepared by	Steve Hodgson, Medical Director	Presented by	Steve Hodgson, Medical Director

Board of Directors Meeting – 22nd February 2018

Mortality Update

1. Introduction

Reducing mortality is one of the four domains in our Quality Improvement Strategy with the subject covering all three domains of the definition of quality namely safety, effectiveness and patient experience. Mortality rates were once a high profile way comparing individual Trusts. Since the Keogh review in 2013 where the 12 Trusts with the highest mortality rates were analysed and actions recommended we have learnt as a system that they should be used as a relative indicator of the quality of care. The main cause of difficulty in comparing Trust performance is that research has shown that only approximately 5% of hospital deaths are avoidable/ preventable leaving 95% of hospital deaths regarded as unavoidable. This means that hospital mortality rates are more dependent upon the health of the population served, case mix (tertiary and specialist hospitals tend to have lower mortality rates than acute hospitals), access to primary and hospice care and nursing home provision.

This paper summarises current performance including benchmarking with other local organisations. There is a description of the ongoing improvement work including the mortality review process.

2. Current Performance

Our crude mortality rate for 2017/18 (April – November) was 2.0% compared with 2.1% for 2016/17. Crude mortality continues to demonstrate a positive trend in comparison with national and regional rates (Table 2) and compares favorably with other NW trusts (Table 3).

The 736 deaths for the first 8 months of 2017/18 compares with 771 deaths for the same period in 2016/17. Unvalidated data demonstrates 14 less deaths for December 2017 and January 2018 than for the corresponding months in 2016/17. This suggests that the total number of deaths in 2017/18 will be closer to the 2015/16 figure of 1168 than the 2016/17 figure of 1249 (Table 3).

Table 1 – Trust crude in-hospital mortality rate time-series, AQuA Mortality Report January 2018

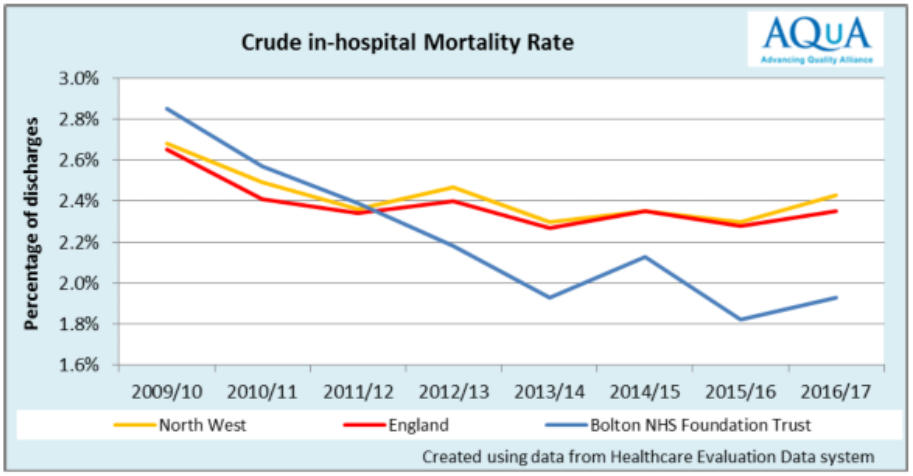


Table 2 – Crude in-hospital mortality rate, AQuA Mortality Report January 2018

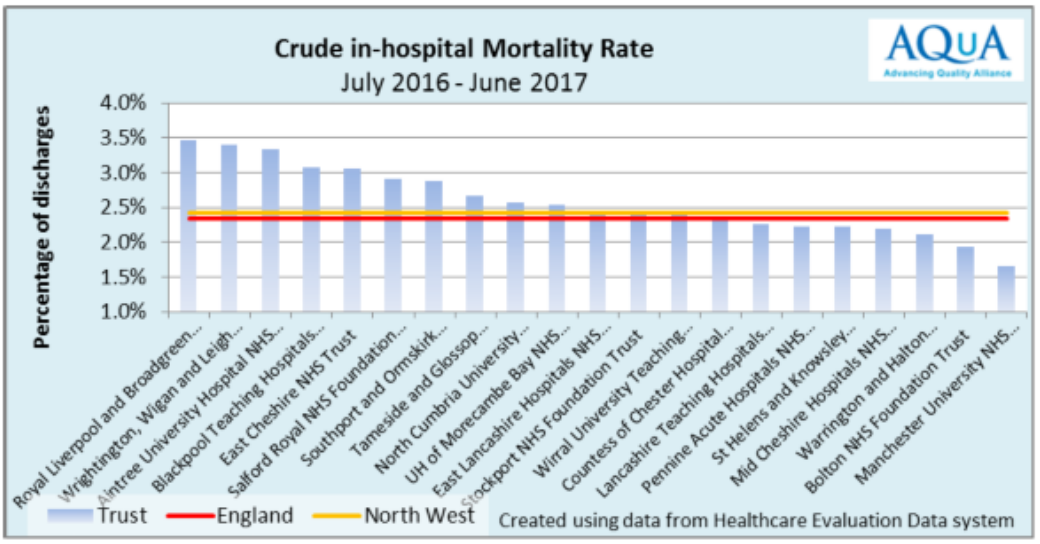
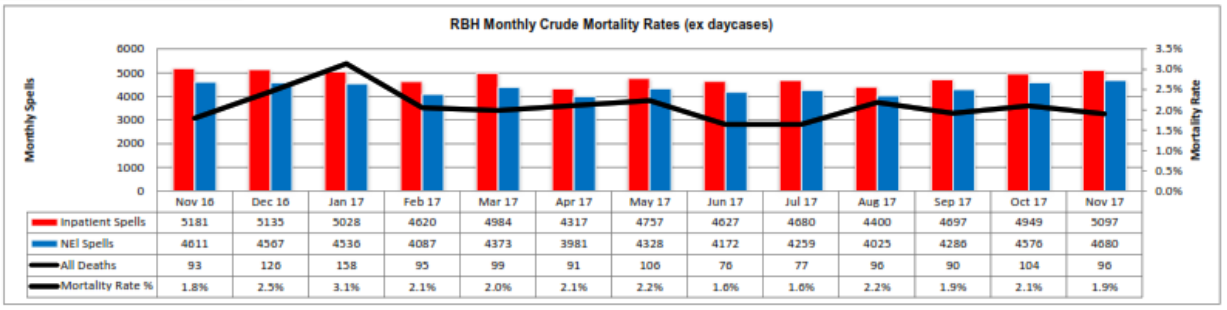


Table 3 – Trust Mortality Rates, Mortality Reduction Group Board Report

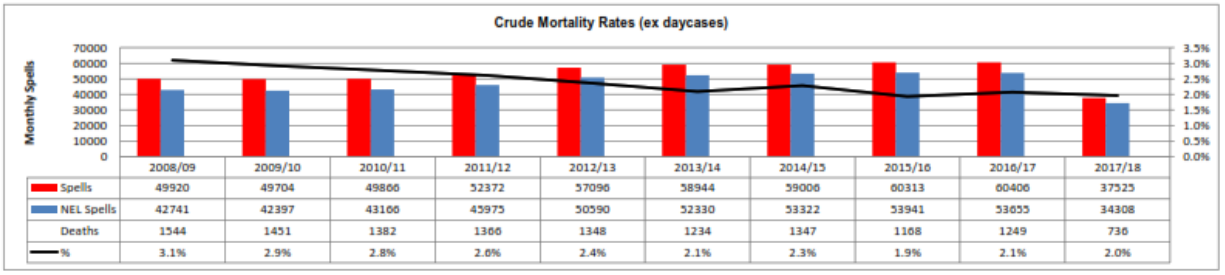
Trust Mortality Rates by Month
November 2016 - October 2017



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Inpatient Spells	5181	5135	5028	4620	4984	4317	4757	4627	4680	4400	4697	4949	5097
NEI Spells	4611	4567	4536	4087	4373	3981	4328	4172	4259	4025	4286	4576	4680
All Deaths	93	126	158	95	99	91	106	76	77	96	90	104	96
Mortality Rate %	1.8%	2.5%	3.1%	2.1%	2.0%	2.1%	2.2%	1.6%	1.6%	2.2%	1.9%	2.1%	1.9%

NB: There may be fluctuations in the numbers of spells & deaths due to when the report is produced. These are refreshed monthly.

Trust Crude Mortality Rates by Financial Year



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Spells	49920	49704	49866	52372	57096	58944	59006	60313	60406	37525
NEL Spells	42741	42397	43166	45975	50590	52330	53322	53941	53655	34308
Deaths	1544	1451	1382	1366	1348	1234	1347	1168	1249	736
%	3.1%	2.9%	2.8%	2.6%	2.4%	2.1%	2.3%	1.9%	2.1%	2.0%

3. Standardised Mortality

SHMI remains our chosen standardised mortality indicator being recognised as a reliable way to monitor an individual organisation's performance. The Dr Foster Hospital Standardised Mortality Ratio is no longer monitored by AQuA, the NW provider of quarterly mortality reports.

Table 4 – Latest SHMI by trust, AQuA Mortality Report January 2018

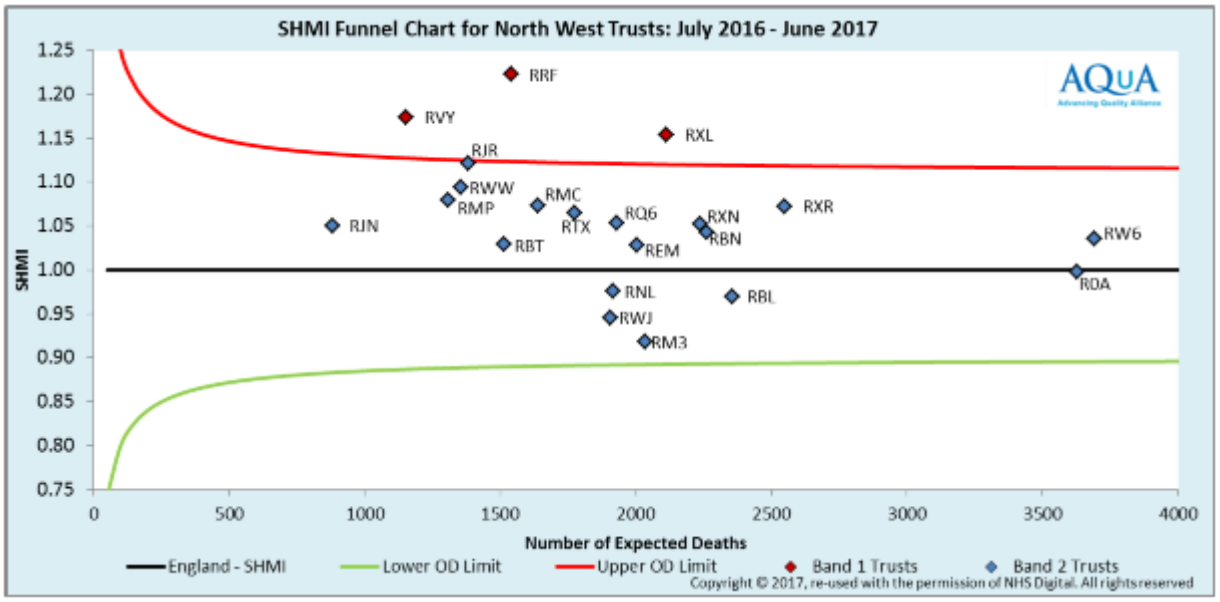
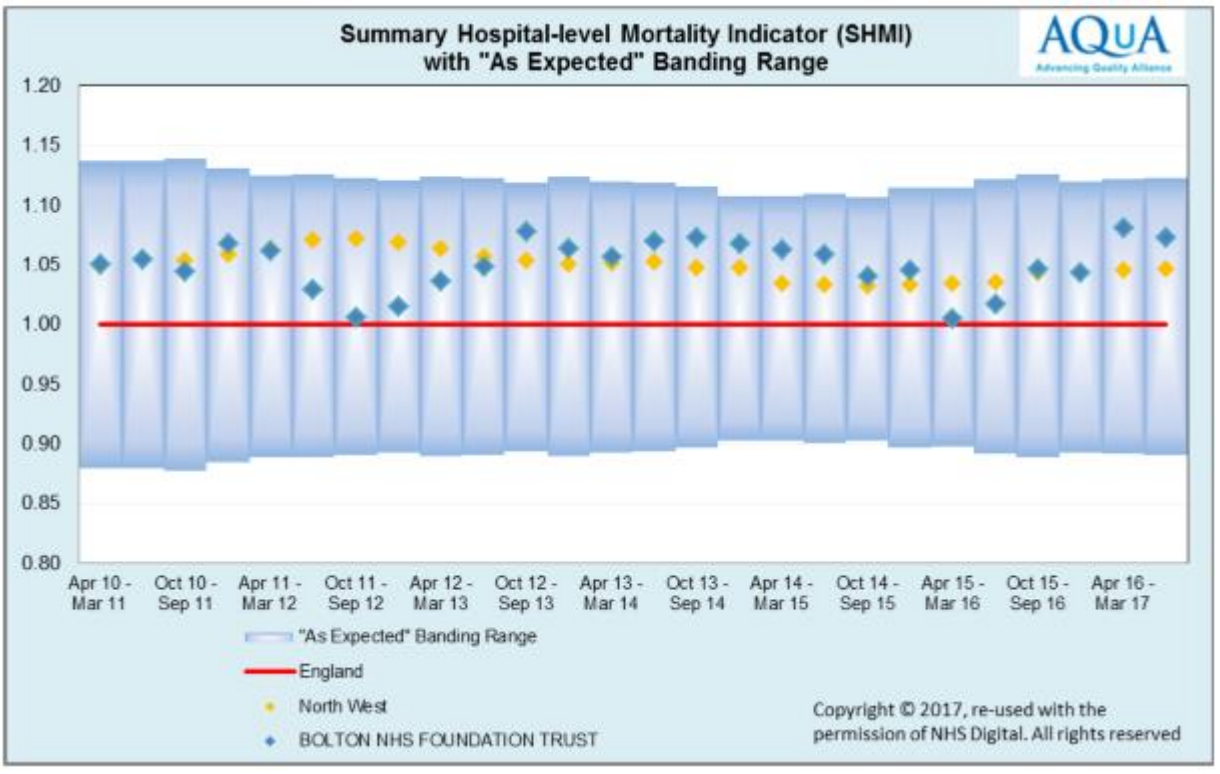


Table 5 - Trust SHMI time-series, AQuA Mortality Report January 2018



The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a Trust. The observed number of deaths is the total number of provider spells for the Trust which resulted in a death either in hospital or within 30 days (inclusive) of discharge from the Trust. The expected number of deaths is calculated from a model that adjusts for the mix of patients in terms of case-mix, age, gender, admission method, Charlson comorbidity index and diagnosis grouping.

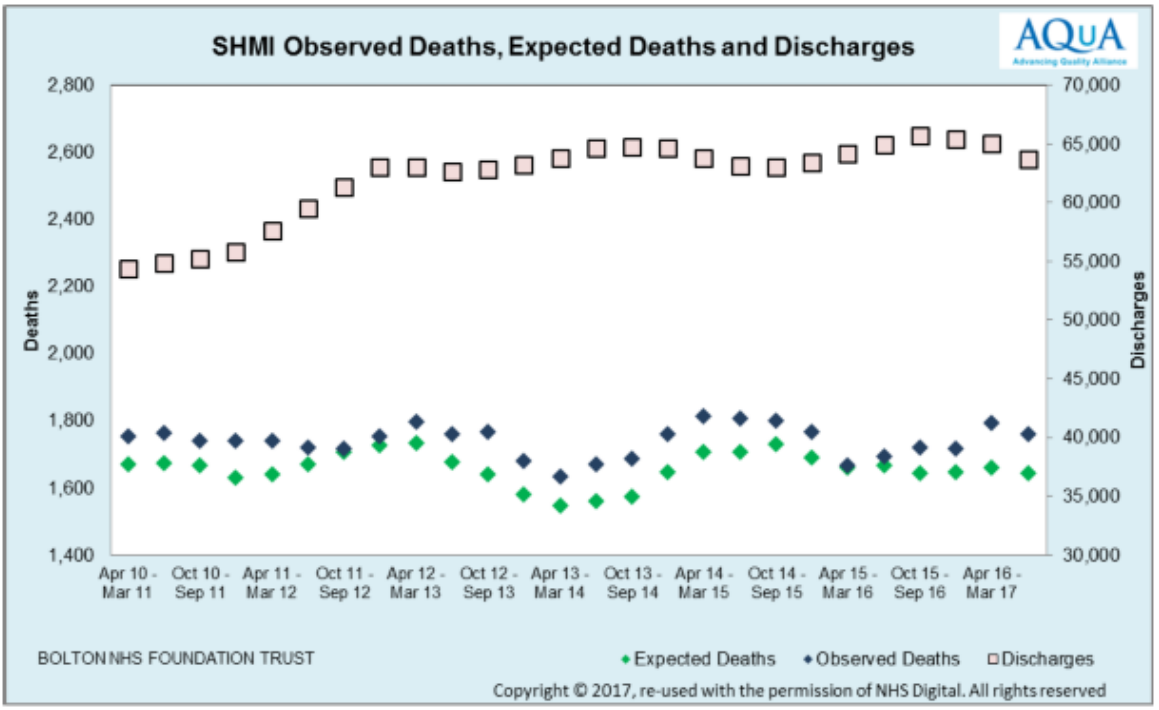
Our latest SHMI is 107.1 (July 2016 – June 2017) down from the previous release of 108 (April 2016 – March 2017). The latest release includes the first quarter with ambulatory care patients excluded from our denominator. Our current SHMI remains in the as expected range (upper limit = 112). Table 4 compares our performance with the other NW trusts.

Our SHMI has fluctuated over the years with a recent increase from 101 to 108 (Table 5). Whilst 100 represents mid-point performance for Trusts in England, the mid-point for Trusts in the North West has been around 104 (Table 5).

Table 5 demonstrates that our SHMI has fluctuated between 100 and 108 over the last 8 years. This degree of relative consistency is seen in many organisations being related to their case mix, recording and coding practices and out of hospital services. In the absence of radical and probably unwarranted changes in any of these factors we will not achieve the Quality Improvement Strategy target of 90 by 2020.

The reduction in discharges seen in Table 6 is likely to be due to the removal of ambulatory care attendances from our admissions denominator. The first quarter of this change has not adversely impacted on our SHMI due to a corresponding reduction in our observed deaths. The full year effect of this change will not be seen until release of our April 2017 – March 2018 SHMI in December 2018.

Table 6 – Observed Deaths, Expected Deaths and Discharges, AQuA Mortality Report January 2018



4. Quality Improvement Activity

Our Quality Improvement Strategy 2017-20 has Reducing Mortality as one of the four domains. The key ambitions for improvement were by 2020 to:

- Reduce our Standardised Mortality Index (SHMI) to less than 90
- Continue year on year reduction in crude mortality
- Reduce avoidable cardiac arrests that result in death by 50%.

As discussed in the previous section our target for SHMI is unlikely to be achieved. Reducing crude mortality remains achievable though may need to factor in the removal of ambulatory care attendances from our denominator. Reducing avoidable cardiac arrests is one of the three focus areas of our 2017/18 Quality Account and at the end of Q3 was on track for achievement.

Quality improvement is at the heart of our Reducing Mortality workstream. Areas of focus and achievement in 2017/18 have included:

- Mortality Review process roll out
- Strengthening of Cardiac Arrest Root Cause Analysis
- Updated Trust KPI observation standards
- Consistent, sustained improvement in observation KPI performance
- Establishment of Patient Track Oversight and Improvement groups including audit of performance
- Revised sepsis tools, pathways and training materials
- Acute Illness management training delivered on a monthly basis
- Establishment of a Deteriorating patient operational working group
- DNACPR status added to ward round checklists
- Improved performance in annual DNACPR audit.

5. Mortality Review Process Update

Context/Evidence

In spring 2016, Jeremy Hunt announced that all trusts would be expected to produce figures of the percentage of patient deaths they would deem to be avoidable. This ambition was then supported by NHS Improvement though with little initial guidance. Bolton NHS FT's initial mortality review process was suspended in 2012 during the investigation into our sepsis diagnosis recording and had not subsequently re-started.

Our new process was designed and developed through our Mortality Reduction Group. The aims were reviewing deaths to identify and share learning, improve the accuracy of primary diagnosis and co-morbidity recording/coding and to determine our percentage of avoidable deaths. The process was approved in August 2016 and pilots commenced in General Surgery and Acute Medicine in September 2016. The process also incorporated learning from deaths in patients with learning disabilities or mental health problems.

In February 2017, NHS Improvement provided further, more detailed guidance giving us the opportunity to benchmark our process and plans against that guidance. There remains debate regarding what percentage of hospital deaths should be regarded as avoidable. Initial research suggested that 10-15% of hospital deaths could be potentially avoidable. More recent research, including the most authoritative paper (Preventable Deaths Due to Problems in Care in English Acute Hospitals): a retrospective case record review study (Black et al, BMJ February 2013) suggests that 5.2% (confidence intervals 3.8-6.6%) of hospital deaths should be regarded as preventable. The definition of preventable is that a problem in care (omission or commission) was identified and it was felt by an assessor that the probability of the deaths being preventable was greater than 50%. Most frequent causes of preventable deaths were problems with clinical monitoring (reviewing investigation results, monitoring patients or responding to deterioration) or with drugs or fluid management. To put the 5.2% figure into context, given our approximately 1200 deaths per year we would expect to see approximately 60 avoidable deaths per year.

Standard Process for Reviewing Deaths

The process starts when a patient death occurs. On the next working day after death a junior doctor involved in the care of the patient attends Patient Services, reviews the case notes and completes an R265 form. Three copies of this form are generated; one is sent to the General Practitioner, one retained in the case notes and one sent to Clinical Effectiveness Department to be entered on our mortality review process register of deaths. The case notes are collected by the Clinical Coding Department. Provisional coding is completed within two working days. The case notes are then sent to the responsible clinician with the provisional coding sheet and blank mortality review forms attached. Within the specialty, a primary mortality review is performed which then goes to a specialty governance meeting for validation. Copies of the mortality review forms are sent to Clinical Effectiveness for collation and to enable the Clinical Effectiveness Department to keep a record of the number of mortality review forms completed against the number of deaths.

The Mortality Reduction Group Sub Committee meets monthly and has supported implementation of effective review processes tailored to individual department's existing meeting structures, whilst providing oversight of these processes collating lessons learnt and validating the reviews.

Progress So Far

Positives:

1. Identified Mortality Leads in Acute Medicine, General Surgery, Trauma & Orthopaedics, Respiratory, Urology, Gastroenterology, Cardiology, Endocrinology. With plans to roll-out to remaining specialties by the end of Q4 2017/18.
2. A mortality review process has been successfully rolled out in the above areas using a standard process.
3. Corporate Mortality Review Policy has been developed and ratified and is available on the intranet and internet, see link below: (http://intranet.boltonft.nhs.uk/Interact/Pages/Content/Document.aspx?id=9775)

4. The cardiac root cause analysis has been modified to incorporate the mortality review process to avoid duplication of reviews, with a standard operating procedure and escalation process established.
5. Scoping meetings chaired by Medical Director where a potentially avoidable cardiac arrest has been identified.
6. The process has facilitated improved engagement and mutual understanding between clinicians and coders to help improve future practice.
7. A gradually increasing completion rate is occurring (see Data section).
8. Joint mortality review where cross departmental learning can be applied
9. The process has enabled some specialties to focus more time in department mortality meeting on deaths with areas for learning.
10. Lessons learnt are being collated and shared via Mortality Review Process Newsletter. Reviews have highlighted themes for improvement with actions in departments to address, including:
    - Importance of patients with abdominal pain being seen in a timely fashion by our general surgeons with a process agreed between Acute Medicine and General Surgery to ensure that this happens
    - The importance of DNACPR decision making
    - Recognition of end of life has been reinforced
11. Review of the 'When someone dies' booklet provided to bereaved relatives to inform them of our process and invite them to register any concerns they would like to be investigated.
12. First Trust Mortality Review newsletter distributed October 2017 (Appendix 1).
13. Our mortality review process deemed 3 (1.2%) out of 274 reviewed deaths as avoidable for the period April to November 2017. In a further 10 deaths (3.6%) learning opportunities were identified. During this period we had a total of 729 hospital deaths.

Areas for improvement and next steps:

Continued focus to increase compliance rates, ensuring that our process is robust and lessons learnt are embedded. Actions being taken to increase compliance rates are:

- Ensuring the efficient flow of case notes of deceased patients to the relevant departments with process agreed for deaths subject to inquest.
- Ensuring our process is robust and met by internal validation at the Mortality Reduction Group Sub-Committee.
- Mortality Champions to have case review training by the end of Q4 2017/18.
- An agreement with Lancashire Teaching Hospital Trust to peer review each other's processes and samples of reviews.
- Ensuring that the Mortality Review Process is part of departmental governance meetings and using the outputs of the reviews to drive corporate quality and improvement projects and ensuring this becomes a regular newsletter.

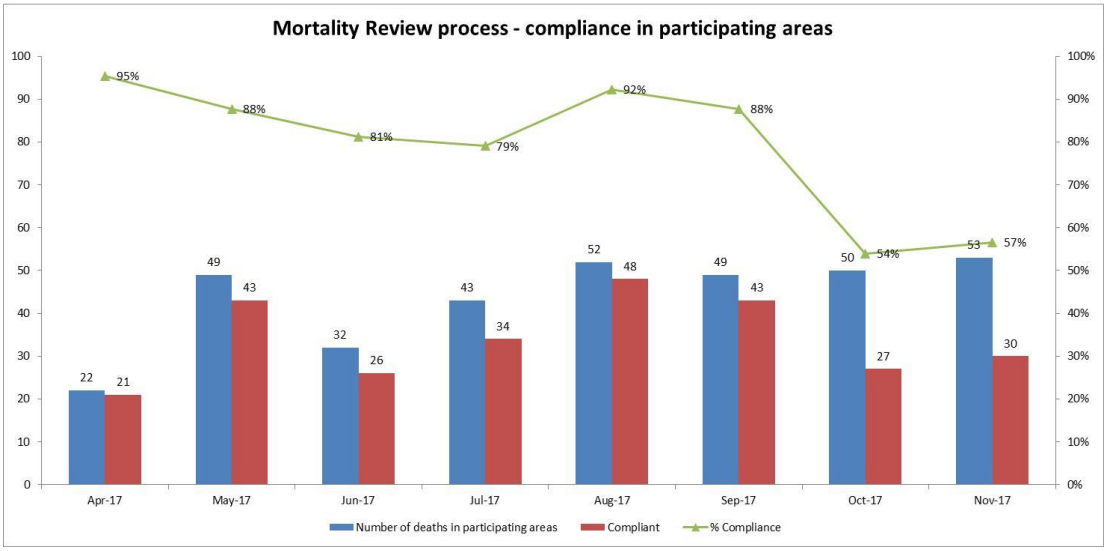
Data

The following chart provides a summary of mortality review process compliance from April to 30 November 2017 (status as at 03/01/2017) – i.e. number of deaths per month in participating specialties from Business Intelligence compared to the number of mortality reviews completed and received by Clinical Effectiveness. It is important to note that due to the time taken to perform the reviews and in some cases the availability of case notes, there is a time-lag between the month of patient's death, review taking place and,

proformas received by Clinical Effectiveness. Therefore compliance figures for October and November will increase.

Participating specialties:

- Acute Medicine (D1/D2)
- General Surgery
- Trauma and Orthopaedics
- Respiratory
- Urology
- Gastroenterology
- Endocrinology (from November)
- Cardiology (start February 2018)



Conclusions

Implementation of our Mortality Review Process with the ambitious target of covering all inpatient deaths is progressing steadily. Our process and policy will comply with national standards, identify learning and enable measurement of avoidable deaths. Regular assurance will be provided in quarterly Mortality Review Process reports to Quality Assurance Committee.

6. Conclusion

This mortality update outlines current performance and describes several components of the work designed to improve patient care, reduce mortality rates and to continue to foster a culture of continuous learning. Current performance compares reasonably favourably with our own historical performance and that of our local peers.

Performance over the last few years suggests that significant changes on our mortality indicators are unlikely. Performance will continue to be closely monitored at Mortality Reduction Group. Our duty remains to prevent all avoidable deaths which means we need to continue our quality improvement work on sepsis, recognising and responding to the deteriorating patient, end of life care, learning from deaths and increasing access to 7 day services.

APPENDIX 1

Mortality Review Process Newsletter – Edition One – October 2017

Why Review Deaths?

There is good evidence that critical review of the case notes of patients who have died identifies learning that can be shared across the organisation. It will also enable us to meet a national requirement to publish our number of potentially avoidable deaths. The most authoritative paper on this subject (Preventable deaths due to problems in care in English Acute hospitals Black et al BMJ 2013) suggests that 5.2% (confidence intervals 3.8% – 6.6%) of hospital deaths could be regarded as preventable. The definition of preventable is that two criteria have to be met; firstly a lapse in care is identified and secondly it is felt by an independent reviewer that that lapse in care probably contributed to the patient's death. We have been keen to re-introduce a Mortality Review Process and have designed our process to comply with standards set out by NHS Improvement.

Our Process

Our process was developed by the Trust Mortality Reduction Group and piloted in Acute Medicine and General Surgery. Case notes of deceased patients are passed from Patient Services via Coding to the individual specialities where initial screening takes place. A more detailed structured review of the case is carried out where the initial review suggests potential learning or fulfils criteria set out by the individual departments. Reviews are collated by our Clinical Effectiveness department who provide a monthly update on performance. Performance is driven at a Mortality Reduction Group Sub-committee set up to drive the process.

Progress

Our process has been rolled out beyond the initial pilot specialities of Acute Medicine and General Surgery and now covers Trauma & Orthopaedics, Urology, Gastroenterology and Respiratory Medicine. It is due to commence in Cardiology and Diabetes/Endocrinology this month with rollout into Complex Care scheduled before the end of 2017. Neonatal and Maternity deaths are already reviewed as part of established departmental processes. We are using and have strengthened our established Cardiac Arrest Root Cause Analysis in the Mortality Review Process in order to avoid duplication.

The Mortality Review policy has been developed and ratified and is available on the intranet and internet. (http://intranet.boltonft.nhs.uk/Interact/Pages/Content/Document.aspx?id=9775)

I would like to thank the departmental Mortality Leads who have helped to drive the process.

- Acute Medicine – Malcolm Dow & Emma Donaldson
- General Surgery – James Pollard
- Urology – Ling Lee
- Trauma and Orthopaedics – Jennifer Ruddlesdin
- Respiratory Medicine – Kamal Ibrahim
- Cardiology – Karen Lipscomb
- Diabetes/ Endocrinology – Moulinath Banerjee
- Cardiac Arrest – Sarah Thornton
- Gastroenterology – George Lipscomb

Compliance Rates continue to improve reaching 69% for the in-scope specialities for August deaths. Lessons learnt include;

- Importance of patients with abdominal pain being seen in a timely fashion by our general surgeons with a process agreed between Acute Medicine and General Surgery to ensure that this happens
- The importance of DNACPR decision making
- Recognition of end of life has been reinforced

Early indications suggest that the annual DNACPR survey shows definite improvements. We are redesigning the 'When someone dies' booklet provided to bereaved relatives to inform them of our process and invite them to register any concerns they would like to be investigated.

Challenges/ Future Plans

These include continuing to increase compliance rates, ensure that our process is robust and most importantly embed lessons learnt. Actions being taken to increase compliance rates are;

- Ensuring the efficient flow of case notes of deceased patients to the relevant departments
- Ensuring our process is robust and will be met by internal validation at the Mortality Reduction Group Sub-committee, ensuring our Mortality Champions have case review training and an agreement with Lancashire Teaching Hospital Trust to peer review each other's processes and samples of reviews
- Ensuring that lessons learnt is being facilitated by ensuring that the Mortality Review Processes are part of departmental governance meetings and using the outputs of the reviews to drive corporate quality and improvement projects and ensuring this becomes a regular newsletter.

Agenda Item No	
Meeting	Board of Directors
Date	
Title	Summary Performance Report – January 2018
Executive Summary	The purpose of this report is to summarise performance for the year against the Trust's business plan. Whilst areas of good performance are noted in the report the main emphasis is highlighting for the Board those material issues where improvement is required.
Previously considered by	It is recommended that the Board note the report

Next steps/future actions	Discuss		Receive	✓
	Approve		Note	
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work	✓	To be fit for the future	✓

Prepared by	Business Intelligence	Presented by	Jackie Bene, Chief Executive

Contents

Performance Summary Exceptions

Areas where further work on performance is needed are:

- Total Hospital acquired infections
- RTT Incomplete Pathways within 18 weeks
- Diagnostic waits
- Cancer
- A&E
- Sickness absence levels are appropriately managed
- Headline financial performance

Total Hospital acquired Infections

C-Diff (CDT) infections

There was one Clostridium Difficile toxin positive case in January 2018 which had a lapse in care. The panel concluded that there should have been more oversight for the antibiotic prescribing from admission.

Year to date the Trust has reported 27 cases, of these, 14 in total had lapses in care and are considered as performance cases against the trust threshold of 19 cases. Given this level of performance the Trust cannot achieve the NHSE assigned threshold of 19 CDT cases for 2017/18.

MRSA Bacteraemia Infections

There were no cases assigned to the Trust in January.

RTT

Performance of this constitutional indicator has remained below the target for the fifth month with performance in month of 87.2%. The largest challenges to this at a specialty level are observed in General Surgery, Trauma and Orthopaedics and Ophthalmology. A paper has been put together with a number of options open to the Trust to recover performance which is being reviewed by the executive team to determine the action required.

Cancer

First appointment from urgent cancer referral to be within 11 days (1 mth in arrears)

Performance in December was 72.1% although elevated levels of referrals and capacity issues are impacting on this metric significantly, the capacity within the division is used to protect and deliver the NHS constitutional standards. High performing areas are Colorectal, Head and Neck, Urology, Gynaecology and Lung. The main areas of underperformance are Skin, Upper GI, Breast and Haematology.

Performance Summary Exceptions

62 day screening % (1 mth in arrears)

Cancer Screening remains a concern on the year to date performance, although December was above threshold at 90.2%.Capacity issues in both breast treatment and endoscopy have impacted the breast and bowel cancer screening pathways. Performance is being managed through the twice weekly cancer performance meetings.

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

Work is ongoing to recover the breast symptomatic standard. The postion at the end of December was below the standard of 93% at 89.9% but this was a furtjher 3% improvement on November's performance.

A&E

A&E performance in January 2018 was 77.8%; an improvement of 0.9% on the previous month but 1.4% worse than the same month last year. Performance in January 2018 was 10.2% worse than the improvement trajectory agreed with NHSI of 88.0%.

Work continues on the urgent care plan with oversight from the Emergency and Urgent Care Delivery Board co-chaired by the Trust Chief Executive

Diagnostic Waits

There were 291 validated breaches at month end breaches have been validated, giving a final position of 9.5% of the Diagnostic Waiting List waiting more than 6 weeks at the end of January. Last month there were 165 patients waiting over 6 weeks (increase of 126 this month). The main areas of pressure continue to be Colonoscopy which accounts for 192 of the 291 patients who were waiting over six weeks and Gastroscopy with 73 patients.

A plan is in place to recover the Diagnostic 6 week performance standard (DMO1) by the end of March. The plan is made up of internal weekend support and Inhealth providing 14 day support onsite from March.

Sickness absence levels are appropriately managed

Sickness levels were 6.2% in January compared to the Trust target of 4.2% which is a further deterioration on last month's position and above the same time last year (5.3%). This is the highest it has been since January 2017. There is a report elsewhere on the Board agenda which provides further detail.

Headline financial performance

Performance Summary Exceptions

- The Trust has a year to date surplus of £1.7m including STF, which is £2.6m worse than plan at the end of Month 10
- The NHSI plan is a surplus control total of £10.1m by the end of the year.
- The Trust has a year to date deficit of £2.8m when STF is excluded from the position.
- Balance Sheet adjustments of £0.8m were released into the position.
- Agency costs are at £8.5m against a year to date plan of £5.2m which now exceeds the full year plan of £6.2m.
- ICIPs at £12.8m are £0.7m worse than the year to date plan. Note the full year target of £20.8m.
- The month end cash balance is £4.1m which is worse than plan by £2.9m this month.
- Year to date capital spend is £14.3m which is £12.0m below the capital plan.
- The Trust Use of Resource Rating is three as at the end of Month 10 which is below plan.

Summary Indicators

Key Performance Indicators

Trust Objective	Outcome Measure	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reduce healthcare acquired infections	Total Hospital acquired C-Diff infections	2016/17	19	16	33	1.6	3	2	1	2	5	4	5	3	4	4	1	3
		2017/18	19	16	27	1.6	4	2	1	6	3	5	2	1	2	1		
	Total Hospital acquired MRSA infections	2016/17	0	0	0.0%	0	0	0	0	0	0	1	0	1	0	0	0	0
		2017/18	0	0	2	0	0	1	0	0	0	0	0	0	1	0		
To Deliver the NHS Constitution, achieve Monitor standards and contractual targets	RTT Incomplete pathways within 18 weeks %	2016/17	92.0%			92.0%	95.5%	95.4%	94.9%	94.4%	93.1%	92.9%	93.5%	93.7%	92.5%	92.1%	92.1%	92.6%
		2017/18	92.0%	92.0%	87.2%	92.0%	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.2%		
	RTT 52 week waits (incomplete pathways)	2016/17	0	0	9	0	0	0	0	0	0	3	2	1	0	3	2	1
		2017/18	0	0	22	0	5	1	1	4	3	2	1	1	2	2		
	RTT 52 week waits (Admitted pathways)	2016/17	0	0	2	0	1	0	0	0	0	1	1	1	0	0	0	1
		2017/18	0	0	7	0	2	1	1	0	0	2	0	0	0	1		
	RTT 52 week waits (Non Admitted pathways)	2016/17	0	0	3	0	0	0	0	0	0	0	2	1	1	0	2	0
		2017/18	0	0	9	0	0	2	1	0	2	0	1	2	0	1		
	First appointment from urgent cancer referral to be within 11 days (1 mth in arrears)	2016/17	93.0%	93.0%	92.3%	93.0%	86.6%	77.6%	80.0%	95.8%	82.7%	89.6%	94.0%	89.4%	92.3%	91.7%	85.3%	75.0%
		2017/18	93.0%	93.0%	72.1%	93.0%	68.1%	83.4%	69.1%	63.4%	75.3%	71.9%	76.0%	69.3%	72.1%			
	62 day standard % (1 mth in arrears)	2016/17	85.0%	85.0%	95.1%	85.0%	94.0%	97.0%	96.4%	93.4%	93.4%	93.6%	95.7%	97.8%	94.8%	96.6%	92.2%	94.6%
		2017/18	85.0%	85.0%	91.2%	85.0%	94.2%	93.0%	92.0%	92.7%	92.9%	91.1%	87.4%	87.6%	90.4%			
	62 day screening % (1 mth in arrears)	2016/17	90.0%	90.0%	94.4%	90.0%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%
		2017/18	90.0%	90.0%	84.0%	90.0%	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%	90.2%			
	31 days to first treatment % (1 mth in arrears)	2016/17	96.0%	96.0%	96.4%	96.0%	96.8%	98.9%	97.3%	99.0%	93.8%	92.7%	93.4%	95.7%	100.0%	100.0%	98.9%	100.0%
		2017/18	96.0%	96.0%	99.5%	96.0%	100.0%	100.0%	99.0%	97.8%	100.0%	98.9%	100.0%	100.0%	100.0%			
	31 days subsequent treatment (surgery) % (1 mth in arrears)	2016/17	94.0%	94.0%	94.8%	94.0%	94.4%	100.0%	100.0%	100.0%	78.6%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		2017/18	94.0%	94.0%	98.2%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	92.9%	100.0%	100.0%			
	31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	2016/17	98.0%	98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		2017/18	98.0%	98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Patients 2 week wait (all cancers) % (1 mth in arrears)	2016/17	93.0%	93.0%	98.9%	93.0%	99.1%	99.1%	98.0%	99.6%	98.5%	99.0%	98.9%	99.0%	98.5%	98.4%	99.1%	98.4%
		2017/18	93.0%	93.0%	97.4%	93.0%	93.9%	98.6%	98.6%	97.2%	97.2%	98.0%	98.3%	97.0%	97.8%			
	Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	2016/17	93.0%	93.0%	95.4%	93.0%	97.0%	97.5%	95.0%	97.2%	95.8%	94.7%	95.5%	95.3%	90.2%	94.6%	94.0%	89.5%
		2017/18	93.0%	93.0%	61.8%	93.0%	89.1%	87.7%	45.1%	62.9%	21.8%	34.9%	38.1%	86.9%	89.9%			
	A&E 4 hour target	2016/17	95.0%	95.0%	82.1%	95.0%	80.2%	81.4%	85.3%	81.9%	86.1%	87.1%	81.5%	79.5%	79.2%	79.2%	85.3%	83.7%
		2017/18	95.0%	95.0%	82.4%	95.0%	82.5%	86.4%	84.7%	84.8%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%		
Diagnostics and continued care of the services at BFT	Diagnostic Waits >6 weeks %	2016/17	1.0%	1.0%	0.9%	1.0%	1.5%	0.9%	1.0%	0.5%	1.2%	1.0%	0.7%	0.7%	0.6%	1.0%	0.3%	0.4%
		2017/18	1.0%	1.0%	2.2%	1.0%	0.9%	0.7%	0.3%	0.5%	0.8%	0.8%	1.5%	1.7%	5.3%	9.5%		
Teams are appropriately staffed and flexible	Sickness absence levels are appropriately managed	2016/17	4.2%	4.2%	5.3%	4.2%	4.8%	4.4%	4.3%	4.8%	4.3%	4.3%	5.2%	5.3%	5.3%	5.3%	4.7%	4.2%
		2017/18	4.2%	4.2%	6.2%	4.2%	4.4%	4.1%	4.2%	4.5%	4.5%	4.6%	4.8%	5.2%	5.6%	6.2%		
	iFM sickness	2017/18			9.57%		5.3%	6.2%	6.4%	7.8%	8.1%	7.7%	8.0%	7.3%	7.4%	9.6%		
	Ward sickness	2017/18			8.36%		5.9%	5.5%	5.2%	6.0%	6.5%	6.6%	6.3%	6.8%	7.8%	8.4%		

Agenda Item No: 16.3

Bolton NHS Foundation Trust

Meeting	Board of Directors

Date	22nd February 2018

Title	Management of Antibiotics for Patients with Sepsis in A&E

Executive Summary	This is a brief note to inform the Board of Directors of actions agreed at Clinical Governance & Quality Committee on 7th February 2018 to address the issue of patients in our Sepsis CQUIN audit not meeting the standard of administration of intravenous antibiotics within 60 minutes of a sepsis diagnosis in our Accident and Emergency department.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	

Next steps/future actions				
	Discuss		Receive	
	Approve		Note	✓
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	
Valued Provider		To be financially viable and sustainable	
Great place to work		To be fit for the future	

Prepared by	Steve Hodgson, Medical Director	Presented by	Steve Hodgson, Medical Director

NHS
Bolton
NHS Foundation Trust

Clinical Governance and Quality Committee Meeting 7th February 2018

Management of Antibiotics for Patients with Sepsis

Issue:

NICE Guideline 51. Sepsis: recognition, diagnosis and early management recommends that patients receive intravenous antibiotics within 60 minutes of diagnosis.

We audit 30 patients per month in A&E to monitor our performance. Quarter 2 performance was median 50 minutes, average 64 minutes, range 8 – 220 minutes. The Trust Quality Assurance Committee wish to determine the outcome for patients not meeting the standard.

Agreed and Implemented Action:

To add to the monthly audit reason for not achieving 60 minutes and clinical outcome for all eligible patients. To share the information in the quarterly Sepsis Quality Account report to the Quality Assurance Committee. Audit results to be used to drive improved performance.

Agenda Item No : 16.3

Meeting	Trust Board

Date	22nd February 2018

Title	6 Week Diagnostic Wait (DMO1) Performance and Recovery Report

Executive Summary	This paper sets out the 6 week Diagnostics (DMO1) position at Bolton NHS Foundation Trust, some of the current challenges and action being taken to recover the standard.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	

Next steps/future actions				
	Discuss	X	Receive	X
	Approve		Note	
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	X	To be well governed	x
Valued Provider	X	To be financially viable and sustainable	X
Great place to work		To be fit for the future	X

Prepared by	Rayaz Chel, Divisional Director of Operations Elective Care	Presented by	Andy Ennis, Chief Operating Officer

NHS
Bolton
NHS Foundation Trust

6 Week Diagnostic Wait (DMO1) Performance and Recovery Report

1. Background / Chronology

- A number of diagnostic tests are encompassed within the DMO1 performance measure, including endoscopy. In recent months endoscopy has seen the volume of patients waiting over 6 weeks increase and this has led to deterioration in the DMO1 position, with the most recent performance for January being 9.5% against a 1% standard.

- The organisation undertakes an annual capacity and demand process to support the planning round for the following year. During the 16/17 capacity and demand process there was a shortfall in endoscopy capacity identified and there was acknowledgement by commissioners that there would be year on year growth within endoscopy. The growth this year is currently 13.2% made up of, 4.5% from general growth and the remainder from growth in national bowel cancer screening programme.

- The outcome of this year's capacity and demand process was to seek funding to resource all available sessions in the new endoscopy unit to meet demand. Recent capacity and demand identified a shortfall of 5 lists per week based on current demand.

- In addition to the growth in demand, there is significant growth in Urgent and 2ww priority referrals; resulting in routine patients waiting longer as a result, due to the clinical priority.

- Current capacity to deliver the activity is made up of core sessions within general surgeons and gastroenterologists job plans, and an additional 45 waiting lists per month in addition to the core sessions to meet rising demand.

- October 2017 saw the Trust fail to achieve the DM01 standard. Although there is growth across all areas of diagnostics, endoscopy related procedures resulted in the standard failing to achieve. The standard has failed each consecutive month since, with a steep decline in performance in December 17 and January 18.

- Although there has been acknowledgement of the growth in endoscopy, the significant increase in referrals was not apparent during the early part of this financial year. Table 1 below highlights that the increase has been seen most apparently in Q3.

- The new endoscopy unit will be opening in May 2018; the new unit will increase flexibility but will currently deliver the same volume of activity.

- Bolton CCG commission endoscopy services from Bolton FT and In-Health. The contract with In-Health is for direct referrals from Primary Care, and is on a cost per case contract. There is no pre-paid underutilised capacity with In Health. CCG confirm referrals to In Health are lower than expected.

- There is a backlog of patients to be cleared, as well as the requirement to deliver increased activity to meet the increased demand, and projected growth.

- A short term and a longer term plan are being developed.

- In the longer term the CCG have indicated that they would like to use all the available commissioned capacity with Bolton FT as a lead provider. Work has begun to look at the feasibility and the total capacity that would be available.

- In the short term, there is a plan to undertake a significant amount of additional activity during February and March to clear the backlog and return to DM01 compliance by April 2018.

2. Referrals / Demand

Table 1

Bolton NHS Foundation Trust
Endoscopy Demand
Based on Additions to the waiting Lists - 'NEW NURSE ENDOSCOPY','NEW-ENDOSCOPY','RE-ENDOSCOPY'

Demand ((Additions + Planned Due + Emergency) - Removals)

Type	Total Apr 16-Dec16	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total	Increase	Growth	Points Estimate 16/17	Points Core Capacity 16/17	Points Estimate 17/18	Points Core Capacity 16/17
Demand	**6525**	**698**	**716**	**731**	**735**	**730**	**768**	**848**	**938**	**657**	**6821**	**296**	**4.5%**	**9802**	**8144**	**10352**	**8144**
Routine	3140	336	311	347	324	309	363	372	476	324	3162	22	0.7%				
Two Week Wait	1462	175	167	175	192	188	179	219	206	162	1663	201	13.7%				
Urgent	1219	122	172	134	143	157	155	176	172	124	1355	136	11.2%				
Emergency	704	65	66	75	76	76	71	81	84	47	641	-63	-8.9%				

Bowel Screening	Total 16/17	Total 17/18	Increase	Growth
Demand	598	1245	943	13.2%

3. Plan for improvement

The Division has worked jointly with Bolton CCG to establish a plan to improve endoscopy waiting times as a short term measure, while a longer term plan is established.

The short term plan includes:

- To continue to deliver all core capacity – backfilling all available sessions.
- To continue to deliver the regular 45 waiting list initiatives each month.
- To deliver additional weekend activity through the current R1 endoscopy facility at Bolton FT.
- In addition the Trust will collaborate with In-Health to deliver 14 days of activity in March (2 x 7 day blocks WC 05.03 and WC 19.03). There is a significant cost implication in using In-Health but it is not possible to bring performance back in line without using a third party provider, given the limitations with space.
- The Trust is also exploring the ability to deliver evening sessions; and a feasibility assessment is under way.

The above plan produces enough capacity to clear the backlog, however, with the use of In-Health there are limitations on the acuity of patients they will see and therefore there will be regular weekly assessments on the volume of patients being seen and treated to mitigate any deviation to the recovery plan.

With the above plan, the Trust should return to compliance by 31.03.18 against the DM01 standard. However, without sustained increased activity the standard would re-fail in April, and therefore detailed discussions are taking place with the CCG to establish a longer term plan to mitigate the capacity deficit, but any long term plan will require additional funding.

Agenda Item No: 17

Meeting	Board of Directors

Date	22 February 2018

Title	NHS Planning Guidance 2018/19

Executive Summary	In 2016, NHS England and NHS Improvement set out planning guidance, including contracts and improvement priorities, for the period from 2017 to 2019. Refreshing NHS plans for 2018/19, published on 2 February 2018, reflects on the changes that have been made in the period since. It provides updated guidance on how commissioners and providers should refresh their plans for 2018/19. The guidance is intended to allow organisations to continue working together through STPs to deliver system-wide plans, with additional freedoms and flexibilities offered to the most advanced systems

Previously considered by	

Next steps/future actions	Board members are asked to read the attached guidance in preparation for a short preparation on the Trust's response to the attached guidance and guidance issued from GM			
	Discuss		Receive	
	Approve	✓	Note	
	For Information		Confidential y/n	

This Report Covers the following objectives(please tick relevant boxes)

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider	✓	To be financially viable and sustainable	✓
Great place to work	✓	To be fit for the future	✓

Prepared by	Esther Steel Trust Secretary	Presented by	Executive Team

Refreshing NHS Plans

for 2018/19

Published by NHS England and NHS Improvement

Refreshing NHS plans for 2018/19

Version number: 1.1

First published: 2 February 2018

Updated: 9 February 2018

Prepared by: NHS England and NHS Improvement

This document is for: Foundation Trusts, NHS Trusts, Direct Commissioners and CCGs and should be read in conjunction with the NHS Operational Planning and Contracting Guidance

Publications Gateway Reference: 07705 and 07706

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

Contents

1 Introduction

1.1 The NHS already has two-year contracts and improvement priorities set for the period 2017/19. These were based on the NHS Operational Planning and Contracting Guidance 2017-2019 published in September 2016 and reflected in the March 2017 document *Next Steps on the NHS Five Year Forward View*.

1.2 The November 2017 budget announced additional NHS revenue funding of £1.6 billion for 2018/19, which will increase funding for emergency & urgent care and elective surgery. In addition, for other core frontline services such as mental health and primary care, the Department of Health & Social Care (DHSC) is making a further £540 million available through the Mandate over the coming financial year. It is now our collective responsibility to ensure we deliver the best possible health service within the funds available. This joint NHS England and NHS Improvement updated guidance sets out how these funds will be distributed and the expectations for commissioners and providers in updating their operational plans for 2018/19.

1.3 In line with the priorities set out by the NHS England Board on 30 November 2017, for 2018/19 we will build on the progress made in 2017/18 and protect investment in mental health, cancer services and primary care in line with the available resources and agreed plans. Recognising the scale of unmet need in mental health, the importance of cancer services and the intense pressures on primary care we believe it would be unacceptable to compromise progress on these services. This means a continued commitment to deliver the cancer waiting time standards, achievement by each and every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce and General Practice Forward View commitments, consistent with the expectations already set out in the 2017-19 planning guidance.

1.4 Given that two-year contracts are in place, 2018/19 will be a refresh of plans already prepared. This will enable organisations to continue to work together through STPs to develop system-wide plans that reconcile and explain how providers and commissioners will collaborate to improve services and manage within their collective budgets. Additional freedoms and flexibilities, described in this guidance, will support the most advanced Integrated Care Systems to lead this process.

1.5 Our energies must remain focused on improving the quality of care for patients and maintaining financial balance, whilst working in partnership to strengthen the sustainability of services for the future.

2 Financial Framework

Financial Framework for CCGs

2.1 The resources available to CCGs will be increased by £1.4 billion, principally to fund realistic levels of emergency activity in plans, the additional elective activity

necessary to tackle waiting lists, universal adherence to the Mental Health Investment Standard and transformation commitments for cancer services and primary care. This additional investment will be made available in the following ways:

- the requirement for CCGs to underspend 0.5% of their allocations has been lifted for 2018/19, releasing £370 million of CCGs' resources to fund local pressures and transformation priorities. The requirement to use a further 0.5% of CCGs' allocations solely for non-recurrent purposes has also been lifted;
- £600 million will be added to CCG allocations for 2018/19 (which otherwise remain unchanged), distributed in proportion to CCGs' target allocations (which have been updated to reflect the latest population estimates and other data)[1]; and
- a new £400 million Commissioner Sustainability Fund (CSF) will be created, partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising CCGs to deliver against their financial control totals.

2.2 CCGs will be expected to plan against financial control totals communicated at the outset of the planning process[2] alongside revised allocations. CCGs collectively will be expected to deliver financial balance after the deployment of the Commissioner Sustainability Fund, and control totals will be set on this basis. Drawdown of cumulative underspends will be available subject to affordability, and where agreed with the relevant NHS England regional team.

2.3 CCGs' control totals will take into account each CCG's financial performance in 2017/18. Any CCG that is overspending in 2017/18 will be expected to improve its in-year financial performance by at least 1% of its overall allocation, and those with longer standing and/or larger cumulative deficits will be given a more accelerated recovery trajectory.

Commissioner Sustainability Fund

2.4 Where it is agreed that a CCG is unable to operate within its recurrent allocation for 2018/19 it will be required to commit to a credible plan, agreed and aligned at STP level, to deliver a stretching but realistic deficit control total set by NHS England and it will then qualify to access the Commissioner Sustainability Fund provided it delivers its financial control total.

2.5 All CCGs will be expected to achieve a minimum of financial balance with zero deficits, following deployment of any CSF allocations. Full details on the operation of the CSF will be published shortly.

[1] Revised CCG allocations have been published alongside this document on a provisional basis and for planning purposes, subject to confirmation at the NHS England public Board meeting on 8 February 2018.
[2] CCGs will be informed of their control total by NHS England in writing, shortly after this guidance is published.

Provider Sustainability Fund and Financial Framework for NHS Providers

2.6 £650 million will be added to the £1.8 billion Sustainability and Transformation Fund to create an enhanced £2.45 billion Provider Sustainability Fund, targeted at the same objectives as the existing Sustainability and Transformation Fund. The additional £650 million must deliver at least a pound-for-pound improvement in the aggregate provider financial position and will be reflected in 2018/19 provider control totals[3]. As in 2017/18, 30% of the total £2.45 billion fund will be linked to A&E performance. Full details will be published separately via an update to the existing Sustainability and Transformation Fund guidance. To access the performance element, each provider will need to achieve A&E performance in 2018/19 that is the better of either 90% or the equivalent quarter for 2017/18. The provider sector will plan and deliver a balanced income and expenditure position for 2018/19 after deployment of the £2.45 billion Provider Sustainability Fund.

2.7 Providers will be expected to plan on the basis of their 2018/19 control totals. Provider plans must make clear whether the Board has confirmed acceptance of its control total. NHS Improvement will use the completed financial planning template to capture this decision. If the control total has not been accepted, this is likely to trigger action under the Single Oversight Framework.

2.8 Providers who accept their control totals and so have access to the Provider Sustainability Fund for 2018/19 will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in the existing NHS Standard Contract. NHS England will shortly consult on changes to the Contract to extend this exemption to all national contractual performance sanctions except those relating to mixed sex accommodation, cancelled operations, Healthcare Associated Infections and the duty of candour, on the basis that continuing NHS Improvement oversight, including the NHS Improvement Single Oversight Framework, will ensure that NHS providers continue to perform to acceptable levels against all national standards. Neither providers nor commissioners should include the expected impact of contractual sanctions in their plans, whether or not the provider has accepted its control total and so has access to the Provider Sustainability Fund. Providers who accept control totals (and associated conditions) will also be eligible to be considered for any discretionary capital allocations.

Capital and Estates

2.9 The 2017 Autumn Budget provided an extra £354 million of public capital in 2018/19 and set out the Government's commitment to delivering its share of the NHS property and estates investment recommended in the Naylor review. NHS England and NHS Improvement are working together with DHSC and HMT to prioritise the allocation of additional STP capital. In updating 2018/19 operational plans, STPs and providers should not assume any capital resource

[3]Providers will receive a letter from NHS Improvement informing them of changes to their previously notified 2018/19 control totals shortly after this guidance is published

above the level in the current 2018/19 operating plans unless NHS England and NHS Improvement have given written confirmation of additional resource.

2.10 The approval of additional STP capital will be contingent on the STP having a compelling estates and capital plan. The STP plan must be fully aligned with the overarching strategy for service transformation and financial sustainability. This plan must set out how the individual organisations in the STP will work together to deploy capital funding to support integrated service models, maximise the sharing of assets and dispose of unused or underutilised estate. In addition, plans will need to demonstrate both value for money and savings to the STP over a reasonable payback period, taking full account of the life cycle costs associated with any new asset. STPs will also be expected to ensure that they maximise opportunities for self-funding of schemes using their own capital and receipts from land disposals and are fully considering the use of private finance where this provides value for money. Further information on the next steps regarding STP capital will be communicated separately.

2.11 Providers are asked to actively consider the requirement for funding critical estate backlog within their capital plan and explain their strategy for investment in backlog work and risk mitigation including how they will reduce operational expenditure relating to estate and facilities.

National Tariff

2.12 The two-year National Tariff Payment System which came into effect from 1 April 2017 remains in place for next year. Local systems are encouraged to consider local payment reform, in particular to complement the introduction of ‘advice and guidance’ services. Local systems are also encouraged to introduce appropriate local tariffs for emergency ambulatory care where they have not already done so, to replace the current A&E and non-elective tariffs for appropriate conditions. The next round of interventions eligible for direct reimbursement through the Innovation and Technology Payments, a programme designed to incentivise take-up of the latest innovations across the NHS, will be published by 31 March.

Underlying Assumptions

2.13 Local systems are expected to continue to implement the priority efficiency programmes within the 10 Point Efficiency Plan. This includes taking every opportunity to maximise provider operational productivity, guided by the Model Hospital portal, and to participate fully in associated programmes. It also includes the implementation of *Getting It Right First Time* recommendations; participation in networked arrangements for procurement, corporate services and diagnostic services; achieving best practice in clinical and other workforce productivity standards (including reducing agency staff usage); and improving the safety and efficiency of providers’ estate and facilities. Providers and STPs should also consider how to make best use of the digital and technological systems and innovations available to them. In addition to the moderation of emergency demand discussed below, the use of RightCare, elective care

redesign, urgent and emergency care reform, medicines optimisation, and more integrated primary and community services are also key areas of focus.

2.14 CCGs should assume that the current high level of discretionary prices for generic drugs in short supply will not persist in 2018/19. In 2018/19, CCGs will receive the remaining period of temporary benefit from changes made to Category M generic drug prices designed to recover excess community pharmacy margin from previous years (i.e. the Cat M clawback will not continue beyond 2017/18). Beyond this, no assessment has yet been made of whether upward or downward adjustments to generic drugs prices will be needed in 2018/19 to reflect under or over-delivery of community pharmacy margin delivered in 2016/17 and 2017/18. So no allowance for this should be included in CCG plans.

2.15 In December 2017, NHS England issued guidance on *Items that should not routinely be prescribed in primary care: Guidance for CCGs*. This guidance is aimed at reducing the routine prescribing of 18 ineffective and low clinical value medicines, such as some dietary supplements, herbal treatments and homeopathy. It is assumed CCGs will save up to £141 million a year from this programme. NHS England has also launched a public consultation (closing 20 March 2018) on reducing prescribing of over-the-counter medicines for 33 minor, short-term health concerns, as well as vitamins and probiotics. Depending on the outcome of the consultation, it is assumed this could save the NHS up to £136 million a year. CCGs should consider how to locally implement guidance on the 18 ineffective and low clinical value medicines and consider the potential impact of any developments concerning over the counter medications following the consultation.

2.16 It is assumed that all CCGs continue to work with the NHS England Continuing Healthcare strategic improvement and QIPP programmes to increase standardisation of processes and adopt best practice to deliver the targeted reduction in growth, thus mitigating cost and volume pressures, including the impact of any increases to Funded Nursing Care rates.

2.17 Where the activity, cost and efficiency assumptions made by an STP do not enable each of its organisations to meet the control totals set by NHS England and NHS Improvement, the STP will need to agree additional cost containment measures and highlight any implications. This includes potential impacts on the range or level of services to be provided, and where surpluses will be created to offset any unavoidable deficits within the STP. When considering options to deliver control totals, STPs must ensure the alignment of commissioner and provider assumptions. They must also ensure that plans continue to meet the requirements for A&E, RTT and cancer set out in this letter and that patients are able to exercise choice as set out in the NHS Constitution.

2.18 We are working through the implications of the Government's commitment on NHS pay described in the 2017 Autumn Budget and will publish further guidance in due course. Until this is available the impact of any changes to NHS pay beyond the 2017-19 published assumptions should be excluded from

plans. It is essential that the 2018/19 pay costs in financial planning returns are an accurate reflection of the cost of the current, published pay assumptions.

2.19 Further details about CQUIN, Quality Premium, national contract and winter planning are set out in section 6.

Specialised Commissioning

2.20 The contracting approach for specialised services continues into 2018/19, aligned to implementation of the Carter review. Specialised commissioners and providers will need to review the 2018/19 activity plans and agree any contract variations required in accordance with the contractual process and to the national timetable. Activity plans for 2018/19 will be reviewed as part of routine in-year contract management, incorporating delivery of QIPP planning and appropriate CQUIN benefit realisation. Locally priced services reform to reduce cost per weighted activity unit, multi-year medicines optimisation approach underpinned by CQUIN, and further reforms to the medical device supply chain, will continue. It remains a priority to have robust and high quality data flows to support accurate reimbursement, in particular of tariff-excluded high cost drugs and devices.

3 Planning Assumptions for Emergency Care and Referral to Treatment Times

Emergency Care

3.1 The combination of clarity on control totals for providers and commissioners, underpinned by the increased provider sustainability fund and the new commissioner sustainability fund, paid for using additional budget funding, should enable health systems to fund and plan for this year's activity in a way that enables improved A&E performance in 2018/19. In addition, the allocations for 2018/19 allow for 2.3% growth in non-elective admissions and ambulance activity and 1.1% growth in A&E attendances. This is in aggregate for England and reflects recent trends, but activity growth patterns to be reflected in plans will in practice vary by commissioner and provider.

3.2 Our expectation is that the Government will roll forward the goal of ensuring that aggregate performance against the four-hour A&E standard is above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019. STPs, commissioner and providers should review assumptions for levels of A&E attendances and non-elective admissions to ensure they reflect recent trends, adjusting as appropriate for demand management and other efficiency schemes that have been agreed between CCGs and providers. Given the differential implications for both bed capacity and cost, organisations will be required to plan and report non-elective admissions of less than one day separately from those of one day or more. Plans will also be collected on planned bed numbers to ensure

sufficient capacity is available throughout the year to meet anticipated demand for emergency and elective care.

3.3 Commissioner and provider plans will be expected to demonstrate how they will complete the implementation of the integrated urgent care strategy that was commenced this year, and how sufficient capacity will be available to meet planned activity growth through a combination of additional beds and/or:

- reductions in delayed transfers of care (DTOCs), both through reducing NHS-driven DTOCs and through continuing to work with local authorities to reduce social care DTOCs, with the aim of reducing the proportion of beds occupied by DTOC patients to 3.5%;
- reductions in average length of stay, including a focus on those patients with the longest length of stay as identified in the stranded patients metrics.

3.4 It is clear that there is significant variation in length of stay between providers, particularly in the number of patients with a length of stay over seven days (stranded patients) and a length of stay over 21 days (super stranded patients). We expect all providers and commissioners to work together to focus on reducing their length of stay, and particularly the very long lengths of stay, to release capacity for patients who are legitimately waiting for a hospital bed.

3.5 To further support progress in these areas and free-up capacity, providers of community services will be invited to participate in a new local incentive scheme in conjunction with their CCG whereby they will be able to reinvest savings from acute excess bed day costs to expand community and intermediate care services. This will benefit ‘stranded’ and ‘super-stranded’ patients in particular.

3.6 A total of £210 million of CCG Quality Premium incentive funding will be contingent on performance on moderating demand for emergency care. This payment will be conditional on the CCG meeting or improving on the levels jointly planned with providers. The principal metric for this purpose will be the level of growth in non-elective activity compared to the agreed plan.

Referral to Treatment Times

3.7 The 2018/19 allocations now allow for improvements in the volume of elective surgery being funded next year, and improvements in the number of patients waiting over 52 weeks. A more significant annual increase in the number of elective procedures compared with recent years means commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced. Numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible. The planning assumption for England as a whole is for 4.9% growth in total outpatient attendances (4.0% per working day) and up to 3.6% growth in elective admissions (2.7% per working day). It is also assumed that GP referrals will increase by 0.8% (i.e. no change per working day). The planned growth levels required will vary locally and therefore activity plans should be reviewed

to ensure delivery of these objectives, adjusting as appropriate for demand management and other efficiency schemes which have been jointly agreed between commissioners and providers. Systems will be expected to plan and report separately on day case and inpatient elective activity, based on their trend performance, the profile of expected referrals and the composition of their existing waiting list. Systems will be expected to demonstrate to regional teams that their RTT plans are robust and realistic, and that they make best and flexible use of available capacity across their STP footprint in order to optimise delivery against the objectives above.

3.8 Provider plans will need to consider the capacity required to deliver the growth in non-elective and elective activity and the impact on workforce, finance and productivity. Alongside these capacity considerations it remains essential that providers manage within their agency ceilings.

4 Delivery of Next Steps Priorities

4.1 The NHS is already working to two-year priorities as set out in last year's planning guidance and the March 2017 *Next Steps on the Five Year Forward View*. This document confirms the deliverables for 2018/19. These are set out in Annex 1, together with the progress made against 2017/18 deliverables.

5 Integrated System Working

5.1 In 2018/19, we expect all STPs to take an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs should:

- ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners which are credible in the round;
- work with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing primary care networks or increasing system-wide resilience ahead of next winter;
- identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
- undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate; and
- take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners, including where appropriate, local authorities. STPs should also take steps to resource their own 'infrastructure'. Although these should be mainly drawn from their constituent organisations, NHS England will be making a further non-recurrent allocation within each STP to support its leadership in 2018/19 on the same basis as last year.

Integrated Care Systems

5.2 We will reinforce the move towards system working in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems. Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations.

5.3 We are now using the term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.

5.4 We see Integrated Care Systems as key to sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

5.5 There are currently eight areas designated as 'shadow' accountable care systems, plus the two devolved health and care systems based on STP footprints (Greater Manchester and Surrey Heartlands). These systems should prepare a single system operating plan narrative that encompasses CCGs and NHS providers, rather than individual organisation plan narratives. The system operating plan should align key assumptions on income, expenditure, activity and workforce between commissioners and providers. System leaders should take an active role in this process, ensuring that organisational plans underpin and together express the system's priorities. All Integrated Care Systems are expected to produce together a credible plan that delivers the system control total, resolving any disputes themselves, and no 'shadow' Integrated Care System will be considered ready to go fully operational if it is unable to produce such a plan.

5.6 To reinforce this approach to system planning, NHS England and NHS Improvement will focus on the assurance of system plans for Integrated Care Systems rather than organisation-level plans. We expect that Integrated Care Systems will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.

NHS England and NHS Improvement will support system leaders in this task. We have developed a new approach to oversight and support for Integrated Care Systems, based on the principles of setting system-wide goals, streamlining the oversight and support provided by NHS England and NHS Improvement (supported by an integrated framework that brings together the separate frameworks for trusts and CCGs), and working with and through the local system leadership to provide any support or interventions in individual providers or localities.

5.7 Integrated Care Systems will be supported by new financial arrangements:

- all Integrated Care Systems will work within a system control total, the aggregate required income and expenditure position for trusts and CCGs within the system, as communicated by NHS England and NHS Improvement[4]. They will be given the flexibility, on a net neutral basis, and in agreement with NHS England and NHS Improvement, to vary individual control totals during the planning process and agree in-year offsets of financial over-performance in one organisation against financial under-performance in another;
- in 2018/19, systems are encouraged to adopt a fully system-based approach to the PSF and CSF under which no payment will be made unless the system as a whole has delivered against its system control total. If the system achieves its control total, but individual trusts or CCGs do not, the system will still retain its full share of the PSF (£2.45 billion in aggregate) and any applicable CSF awards, but NHS England and NHS Improvement will agree with the leadership how those trusts' and CCGs' shares will be apportioned between local organisations;
- systems adopting this full incentive structure will operate under a more autonomous regulatory relationship with NHS England and NHS Improvement. NHS England and NHS Improvement will also support fully authorised Integrated Care Systems by exercising their intervention powers alongside the system leadership. For example, where there is a case for regulatory intervention in a trust or CCG to address financial underperformance or issues of quality, the leadership of the Integrated Care System will play a key role in agreeing what remedial action needs to be taken; and
- all approved Integrated Care Systems will be required to operate under these fully-developed system control total incentive structures by 2019/20. However, in 2018/19 systems that are not ready to proceed with full system incentives and shared intervention arrangements will alternatively be allowed to adopt an interim approach under which only the additional funding that has been put into the PSF (£650 million in aggregate) will be linked to system financial performance. On this option, no payment will be made from this enhanced funding unless the system as a whole meets its control total. If individual trusts or CCGs miss their organisational control totals, but the system still achieves overall, their share will be apportioned in consultation with the system leadership. However, on this interim option

[4] Integrated Care Systems will be informed of their system control total by NHS England and NHS Improvement in writing, shortly after this this guidance is published

if the individual trusts or CCGs meet their organisational control totals, but the system does not overall, they will retain access to the relevant share of the existing £1.8 billion PSF and any applicable CSF awards.

New Integrated Care Systems

5.8 There is strong appetite amongst other systems to join the Integrated Care System development programme and we anticipate that additional systems will wish to join during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. STPs that can demonstrate their readiness to join the programme should speak to their regional teams to confirm expressions of interest from all organisations in the STP. We will aim to review any applications to join the programme by March 2018. We envisage that over time Integrated Care Systems will replace STPs.

5.9 The next cohort of Integrated Care Systems will be selected from STPs with:

- strong leadership, with mature relationships including with local government. The leadership team should have effective ways of involving clinicians and staff, the third sector, service users and the public. It should also have the right capability and infrastructure to execute on priorities;
- a track record of delivery, with evidence of tangible progress towards delivering the priorities in *Next Steps on the Five Year Forward View*. These systems should be meeting NHS Constitution standards or provide confidence that by working as an integrated system they are more likely to be recovered;
- strong financial management, with a collective commitment from CCGs and providers to system planning and shared financial risk management, supported by a system control total and system operating plan;
- a coherent and defined population that reflects patient flows and, where possible, is contiguous with local government boundaries; and
- compelling plans to integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. These models will necessarily require the widespread involvement of primary care, through incipient networks.

Public Engagement

5.10 As systems make shifts towards more integrated care, we expect them to involve and engage with patients and the public, their democratic representatives and other community partners. Engagement plans should reflect the five principles for public engagement identified by Healthwatch and highlighted in the *Next Steps on the Five Year Forward View*.

6 Process and Timetable

6.1 The task for commissioners and providers is to update the 2018/19 year of existing two-year plans to take account of the points set out above and to ensure that operating plans:

- are stretching and realistic, and show a bottom line position consistent with the control totals set by NHS England and NHS Improvement;
- are the product of partnership working across STPs, with clear triangulation between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions – and with assurance from STP leaders that this is the case whilst ensuring the updated plans and contracts are aligned between commissioners and providers. As a result of the activity moderation incentives in the new Commissioner Sustainability Fund and the revised Quality Premium scheme, it is now more critical than ever that activity and finance plans are aligned between commissioners and providers; and
- include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter, and ensuring efficiency savings are not back-loaded into the later part of the financial year.

Contract Variations

6.2 Where the 2018/19 plans have changed and these changes need to be reflected in the finance, activity or other schedules for the second year of two-year contracts, a contract variation should be agreed to this effect, and signed no later than 23 March 2018.

6.3 The NHS Standard Contract sets out clear rules relating to the updating of a contract for a second year, and our expectation is therefore that there should be no disputes between commissioners and providers about these variations.

6.4 Where commissioners and providers fail to reach timely agreement the dispute resolution process in the contract should be followed. Starting with escalated negotiation, the process then moves into mediation. Mediation may be undertaken within STPs if both parties are in agreement, or where this is not possible, it may be arranged with a third party. Where, exceptionally, agreement is not reached through mediation, organisations will be expected to follow the Expert Determination process set in the dispute resolution guidance, which will be published shortly. NHS England and NHS Improvement will view use of mediation, and in particular determination, as a failure of local system relationships and leadership. This guidance also provides detailed advice about the rules within the Contract on varying a contract for its second year.

6.5 On 3 January 2018, NHS England published a National Variation to the Standard Contract. This was principally to give effect to changes to the ambulance response standards, but took the opportunity to incorporate other national policy requirements which had been announced since the 2017-19 planning round. In particular, these related to: prohibiting the sale of sugary

drinks on NHS provider premises; prohibiting the provision or promotion of certain legal services from NHS provider premises; and mandating participation by NHS providers in the Nationally Contracted Products Programme. Commissioners and providers are legally bound to incorporate these changes into local contracts.

Plan Submissions

6.6 All commissioners (CCGs and direct commissioning including specialised) and all providers are required to submit a full suite of operating plan returns to the deadlines in the national timetable (see below); and also adhere to the contract variation deadlines and processes. We will update technical planning guidance to support the submission of templates to ensure plans are completed on a consistent basis and to a high standard. The data collected will be used to inform decision making and will also form the plan against which 2018/19 delivery is judged. All organisations must ensure submissions are accurate, detailed and consistent with their Board approved plans.

6.7 For providers the first and final plan submission will include finance, activity, workforce and triangulation returns alongside an update to the existing two-year plan narrative. For providers that are part of an Integrated Care System the provider plan narrative will be updated with a system plan narrative that describes the key changes to the existing plan, which will be assured jointly by NHS England and NHS Improvement.

6.8 Provider workforce plans will need to consider the significant workforce supply and retention challenges in the NHS. For 2018/19, providers are expected to update their workforce plans to reflect latest projections of supply and retention, taking into account the supply of staff from Europe and beyond, changes to NHS nursing and allied health professional bursaries, improvements expected in agency and locum use. Plans should also be updated to take account of the strengthening of bank arrangements and opportunities identified for improved productivity and workforce transformation through new roles and/or new ways of working. It is important that workforce plans are detailed and well-modelled – and align with both financial and service activity plans – to ensure the proposed workforce levels are affordable, efficient and sufficient to deliver safe care to patients. The workforce plans submitted will be used nationally for pay modelling during the year.

6.9 Commissioners will need to submit draft and final commissioner operating plan updates, using the financial, performance activity and milestone plan templates. These and the supporting guidance will be issued separately. Draft and final finance, performance and activity plans must be consistent, and triangulated with provider expectations.

6.10 For STPs, para 2.17 sets out the requirement to ensure alignment in activity, income and expenditure assumptions across STPs. Building on the 2017/18 in year contract alignment approach, we will be asking STP leaders to return a contract and plan alignment template to demonstrate that updated plans and contracts are aligned financially between commissioners and providers.

CQUIN and Quality Premium

6.11 NHS England will shortly be publishing an update to the 2017/19 CQUIN guidance. This update is required to provide indicator thresholds for some indicators for year 2 of the scheme. As part of the update, NHS England will clarify the requirements around the influenza vaccination indicator. In addition, NHS England has made some changes to the anti-microbial resistance indicator to take account of supply issues. The sepsis indicator will also be updated to require providers to replace locally devised protocols with a National Early Warning Score 2 (NEWS 2) by March 2019. In September 2017, the National Quality Board strongly endorsed NEWS 2 as a standardised system between clinicians in the acute setting to help early detection of deterioration/ identification of sepsis. Organisations will also be required to make a one-off data return in relation to the healthy food and drink indicator at the end of Q4.

6.12 In addition, in light of the specific challenges around delivering provider side balance, NHS England has agreed with NHS Improvement to offer a temporary relaxation of an element of the scheme for acute providers. Our shared position is that this concession is being made in 2018/19 only. On the basis that there are multiple initiatives supporting the discharge agenda, we have agreed to suspend the 'proactive and safe discharge' indicator for acute providers, with the remaining five indicators in the scheme increasing their weighting from 0.25% to 0.3% as a temporary measure for 2018/19.

6.13 This change will have implications for the linked indicators in Community and Care Home settings. We are issuing an updated indicator for Care Home providers. For Community providers, we expect CCGs to either take this opportunity to include a local CQUIN indicator in their contracts, or increase the weights of the remaining five indicators in the scheme to 0.3%.

6.14 The 0.5% risk reserve CQUIN will be withdrawn in 2018/19. The 0.5% will be added to the engagement CQUIN, which will increase as a result to 1%.

6.15 Our collective expectation is that the degree of conditionality in CQUIN will return to its 2017/18 levels from 2019/20. These temporary suspensions are not an indication of our future intentions for the CQUIN scheme, in respect of the quantum, the number of indicators, or their respective weightings.

6.16 In line with our policy intent that CQUIN is 'realistically earnable', NHS England and NHS Improvement will be trialling a new triangulated provider/ commissioner finance return, to confirm whether CQUIN awards have been earned during the year.

6.17 As previously indicated, the 2018/19 Quality Premium scheme will be restructured to include an incentive on non-elective demand management. Given the significant emphasis we wish CCGs to give to this issue, the non-elective measure will make up the majority of the Quality Premium scheme, with a potential award of £210 million nationally. We will retain a number of the existing quality measures, which will be linked to the remainder of the potential

Quality Premium funding, and we will continue to moderate payment through the operation of the existing Finance and Quality gateways. We will shortly publish updated guidance which will set out the full details of the revised scheme.

Winter Demand & Capacity Plans

6.18 There will be no additional winter funding in 2018/19. To ensure that winter preparation has been undertaken well in advance and using existing funds, systems will need to demonstrate that winter plans are embedded both in their system plans and in individual organisations' operating plans, including realistic phasing of non-elective and elective activity across the year.

6.19 To support this there is a requirement for each system to produce a separate winter demand and capacity plan, triangulating the finance and activity implications along with the actions and proposed outcomes. Guidance on submitting these winter plans will be available by March 2018.

Timetable

Item	Date
ICS system control total changes and assurance statement submitted	By 1 March 2018
Local decision to enter into mediation for 2018/19 contract variations	2 March 2018
Draft 2018/19 Organisational Operating Plans submitted	**8 March 2018**
Draft 2018/19 STP Contract and Plan Alignment template submitted	8 March 2018
National deadline for signing 2018/19 contract variations and contracts	23 March 2018
2018/19 Expert Determination paperwork completed and shared by all parties	27 April 2018
Final Board or Governing Body approved Organisation Operating Plans submitted	**30 April 2018**
2018/19 Winter Demand & Capacity Plans submitted	30 April 2018
Final 2018/19 STP Contract and Plan Alignment template submitted	30 April 2018
Final date for experts to notify outcome of determinations for 2018/19 update	8 June 2018

Annex 1: 2018/19 Deliverables

Reminder of 2018/19 deliverables – drawn from 'Next Steps on the NHS Five Year Forward View' published in March 2017

The NHS already has two-year priorities, set out in last year's Planning Guidance and the March 2017 publication of the *Next Steps on the NHS Five Year Forward View.* This Annex confirms these deliverables for 2018/19.

For national targets we will, where appropriate, provide disaggregated STP and CCG-level improvement targets and templates to ensure plans are completed on a consistent basis.

1. Mental Health

<table>
<tr><td colspan="2">Overall Goals for 2017-2019
We published Implementing the Mental Health Forward View in July 2016 to set out clear deliverables for putting the recommendations of the independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/21[5] in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this. Making parity a reality will take time, but this a major step on the journey towards providing equal status for mental and physical health. These ambitions are underpinned by significant additional funding for mental health care, which should not be used to supplant existing spend or balance reductions elsewhere.</td></tr>
<tr><td>Progress in 2017/18
On track to ensure an extra 35,000 children and young people are able to access services this year.
70 new or extended community eating disorder services funded and commissioned.
81 new beds for Children and Adolescent Mental Health Services (Tier 4) and at least another 50 beds will open by</td><td>Deliverables for 2018/19
Additional funding has now been built into CCG 2018/19 allocations to support the expansion of services outlined in this planning guidance and the specific trajectories set for 2018/19 to deliver the Five Year Forward View for Mental Health. Progress to be made against all deliverables in the Next Steps on the NHS Five Year Forward View and the Implementing the Mental</td></tr>
</table>

[5] Stepping Forward to 2020/21: Mental Health Workforce Plan for England (Health Education England).

end of March 2018. • Expanded **specialist perinatal care** with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. • Continued to meet the waiting time standard for **early intervention in psychosis.** • **Physical health checks and interventions** for patients with severe mental illness in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date. • Health Education England (HEE) expects to provide over 600 training places for Improving Access to Psychological Therapies (IAPT) practitioners. At least **800 practitioners in primary care** settings by March 2018. • 10 mental health **new care models** up and running and an additional 7 go live by April 2018. • CCGs have continued to meet the **dementia diagnosis standard**, which was at 68.3% by December 2017. • Seven **Global Digital Exemplar** Mental Health Trusts, funded to identify trusts which they will partner with as 'fast followers'.	*Health Forward View* in 2018/19 with all CCGs and STPs required to: • Each CCG must meet the **Mental Health Investment Standard** (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS. • Ensure that an additional 49,000 **children and young people** receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs. • Make further progress towards delivering the 2020/21 waiting time standards for **children and young people's eating disorder services** of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases. • Deliver against regional implementation plans to ensure that by 2020/21, **inpatient stays for children and young people** will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.

	• Continue to improve access to **psychology therapies** (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions. Do so by supporting HEE's commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid **long term physical health conditions** and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that access, waiting time and recovery standards are met. • Continue to work towards the 2020/21 ambition of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit. • Ensure that 53% of patients requiring **early intervention for psychosis** receive NICE concordant care within two weeks. • Support delivery of STP-level plans to reduce all inappropriate adult acute **out of area placements** by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21. Review all patients who are placed out of area to ensure that have appropriate packages of care.

	• Deliver annual **physical health checks** and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness. • Provide a 25% increase nationally on 2017/18 baseline in access to **Individual Placement and Support** services. • Maintain the **dementia** diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care. • Deliver their contribution to the **mental health workforce** expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people's workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21. • Deliver against multi-agency **suicide prevention** plans, working towards a national 10% reduction in suicide rate by 2020/21. • Deliver **liaison and diversion** services to 83% of the population. • Ensure all commissioned activity is recorded and reported through the Mental Health Services **Dataset**.

2. Cancer

Overall Goals for 2017-2019 Advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21.

Progress in 2017/18	Deliverables for 2018/19
• **Cancer survival** at its highest ever with latest figures showing that one-year cancer survival is up by over 2,000 people a year. • 95.1% of people seen by a specialist **within two weeks** of an urgent GP referral for suspected cancer, with 5.1% more patients being seen in the 12 months to November 2017 than in the previous 12 months. • Ten **multidisciplinary rapid diagnostic and assessment centres** in place across the country by March 2018, supporting patients with complex symptoms through to diagnosis. • We are on track to deliver the **largest radiotherapy upgrade programme in 15 years modern radiotherapy** have now funded 26 new machines in 21 trusts in 2017/18. • Half of the country's Cancer Alliances have begun to roll out **personalised follow-up** after cancer treatment. • Added 22 more drugs to the Cancer Drugs Fund, which have benefitted nearly 7,500 more patients, taking the total since the reformed CDF launched in July 2016 to 15,700 patients having benefited from 52 drugs treating 81 different cancers.	• Ensure all **eight waiting time standards** for cancer are met, including the 62 day referral-to-treatment cancer standard. The '10 high impact actions' for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances. The release of cancer transformation funding in 2018/19 will continue to be linked to delivery of the 62 day cancer standard. • Support the implementation of the new **radiotherapy** service specification, ensuring that the latest technologies, including the new and upgraded machines being funded through the £130 million Radiotherapy Modernisation Fund, are available for all patients across the country. • Ensure implementation of the nationally agreed **rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers**, ensuring that patients get timely access to the latest diagnosis and treatment. Accelerating the adoption of these innovations helps meet the 62 days standard ahead of the introduction of **the 28 day Faster Diagnosis Standard** in April 2020. • Progress towards the 2020/21 ambition for **62% of cancer patients to be diagnosed at stage 1 or 2**, and reduce the proportion of cancers diagnosed following an emergency admission. • Support the rollout of FIT in the **bowel cancer screening** programme during 2018/19 in line with the agreed national timescales following PHE's procurement of new FIT kit, ensuring that at least 10% of all bowel cancers diagnosed through the screening programme are detected at an early stage, increasing to 12% in 2019/20. • Participate in pilot programmes offering low dose CT scanning based on an assessment of lung cancer risk in

	CCGs with lowest **lung cancer** survival rates. • Progress towards the 2020/21 ambition for **all breast cancer patients to move to a stratified follow-up pathway** after treatment. Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs. All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring by the end of 2018/19. • Ensure implementation of the **new cancer waiting times system** in April 2018 and begin data collection in preparation for the introduction of the new 28 day Faster Diagnosis standard by 2020.

3. Primary Care

Overall Goals for 2017-2019 Stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering *General Practice Forward View* and *Next Steps on the NHS Five Year Forward View*.	
Progress in 2017/18 • 52% of the country now benefitting from **extended access** including appointments on evenings and weekends, beating the target of 40% for 2017/18. • **Primary care workforce**: o Over 770 additional GP trainees started specialist training since 2015 baseline (3,157 in total in 2017/18); o Begun GP international recruitment, with the first 100 GPs being recruited;	**Deliverables for 2018/19** Progress against all *Next Steps on the NHS Five Year Forward View* and *General Practice Forward View* commitments. This includes all CCGs: • Providing **extended access** to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods. • Delivering their contribution to the **workforce commitment**

o Launched the GP Retention Scheme; o Recruitment of an additional 505 clinical pharmacists, in addition to the 494 already in post. • **Investment in general practice** continues to increase on track to deliver the pledged additional £2.4 billion by 2021. • CCGs investing in line with expectations set out in the 2017/18 NHS's Planning Guidance, for **additional primary care transformation investment (£3/head)** over two years. • Invested in **upgrading primary care facilities**, with 844 schemes completed and a further 868 schemes in development.	to have an extra 5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19: o CCGs to recruit and retain their share of additional doctors via all available national and local initiatives; o 600 additional doctors recruited from overseas to work in general practice; o 500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase); o An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE); o Deliver increase to 1,500 mental health therapists working in primary care. • I**nvesting** the balance of the £3/head investment for general practice transformation support. • Actively encourage every practice to be part of a local **primary care network**, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000. • Investing in upgrading primary care facilities, ensuring completion of the pipeline of **Estates and Technology Transformation schemes**, and that the schemes are delivered within the timescales set out for each project. • Ensuring that 75% of 2018/19 **sustainability and resilience funding** allocated is spent by December 2018, with 100% of the allocation spent by March 2019.

	• Ensuring every practice implements at least two of the **high impact 'time to care' actions**. • In all practices, delivering primary care **provider development initiatives** for which CCGs will receive delegated budgets, including online consultations. • Where primary care commissioning has been **delegated**, providing assurance that statutory primary medical services functions are being discharged effectively. • Lead CCGs expected to commission, with support from NHS England Regional Independent Care Sector Programme Management Offices, **medicines optimisation** for care home residents with the deployment of 180 pharmacists and 60 pharmacy technician posts funded by the Pharmacy Integration Fund for two years.

4. Urgent and Emergency Care

Overall Goals for 2017-2019 Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time.	
Progress in 2017/18 • More patients able to **speak to a clinician** about their urgent and emergency care needs when calling NHS 111 – 40% of answered calls now receive clinical input, up from 22% last year. • Piloted and evaluated **NHS 111 Online** in a number of areas, with 27% of the population now able to access urgent and emergency care advice through this online portal.	**Deliverables for 2018/19** • Ensure that **aggregate performance against the four-hour A&E standard** is at or above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF payments.

• 110 **Urgent Treatment Centres (UTCs)** designated according to the revised standard specification. • **Ambulance Response Programme** implemented in all English mainland ambulance trusts. • 105 Trusts received capital funding of £96.7 million to implement **front-door clinical streaming**. Over 90% of Trusts now have this in place. • **1,491 beds have been freed up** as a result of **reducing delayed transfers of care (DTOC)**. • £30 million awarded to 74 areas to increase number of acute hospitals meeting the **'Core 24' standard for 24/7 mental health liaison teams**. • 97% of A&Es, 98% of the initial cohort of UTCs and 96% of e-prescribing pharmacies now have **access to primary care records** through either summary care records or local record sharing portals.	• Implementation of the **NHS 111 Online** service to 100% of the population by December 2018. • Access to enhanced **NHS 111** services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services. • By March 2019, CCGs should ensure technology is enabled and then ensure that **direct booking from IUC CAS into local GP systems** is delivered wherever technology allows. • Designate remaining **UTCs** in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care. • Work with local Ambulance Trusts to ensure that the new **ambulance response time standards** that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes. • Deliver a **safe reduction in ambulance conveyance** to emergency departments. • Continue to make progress on **reducing delayed transfers of care** (DTOC), reducing DTOC delayed days to around 4,000 during 2018/19, with the reduction to be split equally between health and social care. • Continue to improve patient flow inside hospitals through implementing the "Improving Patient Flow" guidance[6]. Focus specifically on **reducing inappropriate length of stay for admissions**, including specific attention on 'stranded' and

[6] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

	‘super stranded’ patients who have been in hospital for over 7 days and over 21 days respectively. • Continue to work towards the 2020/21 deliverable of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver **Core 24 mental health liaison standards for adults** in 50% of acute hospitals, subject to hospitals being able to successfully recruit. • Ensure that fewer than 15% of NHS **continuing healthcare full assessments** take place in an acute setting. • Continue to progress **implementation of the Emergency Care Data Set** in all A&Es (Type 1 and Type 2 by June 2018; and Type 3 by the end of 2018/19). • Increase the number of patients who have consented to share their additional information through the **extended summary care record** to 15% and improve the functionality of e-SCR by December 2018. • Implement a **proprietary appointment booking system** at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018. • Continue to rollout the **seven-day services four priority clinical standards to five specialist services** (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the **seven-day services four priority clinical standards in hospitals** to 50% of the population.

5. Transforming Care for People with Learning Disabilities

Overall Goals for 2017-2019
Our goal is to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

Progress in 2017/18

- 22% increase in the number of **annual health checks** delivered by GPs to improve access to community alternatives to hospital and tackle premature mortality.
- New and expanded **community teams** to support people with a learning disability at risk of admission to hospital, backed by £10 million transformation funding.
- **6% reduction in inappropriate hospitalisation** of people with a learning disability, autism or both, between March and November 2017, totalling a 14% reduction since March 2015. In addition, over 100 people previously in hospital for 5 years or more were discharged between March and November 2017.
- Tackling **premature mortality** by beginning to systematically review and learn from deaths of patients with learning disabilities by March 2018.

Deliverables for 2018/19
All Transforming Care Partnerships (TCPs), CCGs and STPs are expected to:

- Continue to **reduce inappropriate hospitalisation** of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. As part of achieving that reduction we expect CCGs and TCPs to place a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients).
- Continue to improve access to healthcare for people with a learning disability, so that the number of people receiving an **annual health check** from their GP is 64% higher than in 2016/17. CCGs should achieve this by both increasing the number of people with a learning disability recorded on the GP Learning Disability Register, and by improving the proportion of people on that register receiving a health check.
- Make further investment in **community teams** to avoid hospitalisation, including through use of the £10 million transformation fund.
- Ensure more **children with a learning disability**, autism or both get a community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital, such that 75% of under 18s admitted to hospital have either had a pre-admission CETR or a CETR immediately post admission.

	• Continue the work on tackling **premature mortality** by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance.

6. Maternity

Overall Goals for 2017-2019 Continue to make maternity services in England safer and more personal through the implementation of the *Better Births.*	
Progress in 2017/18 • Continuing the year on year **safety improvements** to maternity services including, since 2010, a 16% reduction in stillbirths, 10% reduction in neonatal mortality and 20% reduction in maternal deaths. • Seven maternity 'early adopters' established covering 125,000 births a year to implement specific elements of *Better Births* and service improvements. Pilots of **continuity of carer** established to over 3,000 women. • 44 **Local Maternity Systems** established bringing together commissioners, providers and service users to lead and deliver transformation of maternity services in every part of the country. • We will exceed the planned goal of 2,000 more women receiving **specialist perinatal care** in 2017/18, with over 5,000 additional women accessing these services between April and December 2017. Four new mother and baby units also funded.	**Deliverables for 2018/19** • Deliver improvements in **safety** towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019. • Increase the number of women receiving **continuity** of the person caring for them during pregnancy, birth and postnatally, so that by March 2019, 20% of women booking receive continuity. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. • By June 2018, agree trajectories to improve the **safety, choice and personalisation** of maternity.

N.B. This is not a comprehensive list of ‘Next Steps’ deliverables for 2018/19, simply an ‘aide memoire’ covering these service improvement areas. CCGs and STPs should also continue to work to reduce inequalities in access to services and in people’s experiences of care.

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Charitable Funds Committee	Report to:	Board of Directors
Date of Meeting:	6 Feb 2018	Date of next meeting:	08 May 2018
Chair:	David Wakefield	Parent Committee:	Board of Directors
Apologies:		Quorate (Yes/No):	Yes

Key Agenda Items:	Key Points	Action/decision
Fund balances	Total fund balance as at 31 December 2017 £1.2m £700k of total funds are within the Acute Adult Division	Fund balances noted, new DDO within Acute Adult will be ensuring appropriate use of funds for the benefit of patients
Update on funding previously approved	The Committee received a briefing on previously approved funding for assurance that funds continue to be used in line with the aims of the charity. Included an update on the success of the volunteer coordinator funded through the charity. 101 current volunteers; 14 volunteers have continued on into employment with the Trust	Report noted
Management charge to charitable fund	Proposal received from the Families Division to ask the Committee to consider waiving management fees for designated funds that are actively fundraising/fund of the year.	Committee voted and approved the proposal to waive management fees for charity of the year
John Briscoe Fund	Proposal received to seek to change the use of the fund in line with the bequest	Letter to be written to the solicitor to propose alternative use of the Capital bequest
Request for funding for 2018 Annual Nursing Midwifery and AHP Conference	Request for funding for the annual conference	Request approved – further decision will be required with regard to funding source – may need to be shared between divisions if other funds not available
Summer Fair	Fund to be created for administration of donations and expenditure. Some sponsorship now agreed which should cover the set up costs which the Trust had agreed to underwrite	Ongoing work to promote the Summer Fair and NHS 70th anniversary celebrations

	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

Staff Lottery/ Pennies from Heaven	Agreed that not possible to combine	Work required to increase awareness and promote for fundraising and use of funds
Special Care for Special Babies	Continues to gain momentum although not at the pace initially hoped for. Now agreed that an element of the work will be undertaken through the capital programme with fundraising to enhance the development	
Review of workstreams	Reviewed the workstreams and agreed a refresh required	Review of overall charitable funds governance and operation to be undertaken by Trust Secretary and Finance team during Q2
Report from the Trust Fundraiser	Update on continued engagement and fundraising	

	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