Bolton NHS Foundation Trust – Board Meeting 25 January 2018

Location: Boardroom **Time: 0930**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story (acute adult division)	DoN		For the Board to hear a recent patient story to bring the patient into the room (Press and public to be excluded to preserve confidentiality)
09.30	1.	Welcome and Introductions	Chairman	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chairman	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 21st December 2017	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 17 January 2018	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	10.	Finance and Investment Committee – Chair Report - 23 January 2018	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 – 22nd December 2017 and 18th January 2018	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
10.00	12.	Urgent Care Delivery Board Chair Report – 9th January 2018	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.15	13.	Six monthly nurse staffing report	DoN	Report	To receive for assurance

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10.30	14.	RTT update	COO	Report	To receive an update on RTT performance
10.40	15.	Integrated Performance Report	Exec team	Report	To receive for information
Strategy					
11.00	16.	North West Sector Business Case	R Mundon	Report	To Note
Reports from Sub-Committees (for information)					
	17.	Any other business			
Questions from Members of the Public					
	18.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
11.20	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				

Coffee

Meeting	Board of Directors Meeting – Part One	
Time	09.00	
Date	22 December 2017	
Venue	Board Room 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
Mr S Hodgson	Medical Director	SH
Ms B Ismail	Non-Executive Director	BI
Mrs J Njoroge	Non-Executive Director	JN
Mr A Thornton	Non-Executive Director	AT
Mrs A Walker	Director of Finance	AW
In attendance:-		
Mrs E Steel	Trust Secretary	ES
Mr R Mundon	Director of Strategy WWL	RM
Mrs H Brearley	Interim HR Director	HB

Apologies

No apologies received.

Welcome and Introductions

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

1. Patient Story

K and P attended the Board meeting to share their story of the care provided for their son N. N who was born prematurely and received care in the NICU at Manchester Children's Hospital attended a scheduled appointment for jaundice

screening.

N and other members of the family had been ill prior to this appointment and had been seen in Salford on the previous day and discharged home.

When they attended for screening the family were greeted by Pauline (advanced paediatric nurse practitioner), bloods were taken but Pauline had concerns about N's appearance and was in the process of arranging a clinical review when N vomited and stopped breathing. Pauline remained calm and supported the family in a transfer to HDU where N was ventilated and waited for a transfer to an ICU cot.

A number of factors delayed the onward transfer to paediatric ICU in Manchester and during this time the family were given "amazing care". Several members of staff stayed with N and his family until the transfer finally took place. Pauline and Dr Sam San were named for providing incredible calm, professional support and going above and beyond what would normally be expected.

After a week in ICU, N was transferred back to Bolton by ambulance, they received a good welcome back on the ward which felt safe and comfortable and "like coming home"

The one negative aspect of the care provided was the transfer back to Bolton when the ambulance staff moved N through the main entrance rather than using the correct pathway of through A&E. This exposed the family to cigarette smokers at the main entrance and compromised privacy and dignity.

The Chairman thanked the family for sharing their story, Board members discussed the main points raised in the story:

The importance of good clear communication was recognised

The issue of being repatriated through the main entrance coupled with the continued issue of smokers on site – the Chief Operating Officer advised that this was not the correct route for patient transfer

The strategic issue of not having a paediatric A&E department – The CEO advised that the capital plan includes the expansion of paediatric HDU from three to six beds and additional parental accommodation.

FT/17/108	AE to discuss route for patient transfer with NWAS	AE

2. Welcome and Introductions

The Chairman welcomed all attendees and observers to the meeting.

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 30 November 2017

The minutes of the meetings held on 30 November 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.

FT/17/105 The chief Executive confirmed that the executive team had discussed the implications of a pause to the wave three transfer of services to iFM Bolton. The Director of Finance confirmed that there would be financial implications and discussions were ongoing.

FT/17/108 The Chairman confirmed that the agreed letter had been sent to the GM team; a response had been chased but had not been received.

6. Matters Arising

No matters arising

7. Chairman's Report

The Chairman recognised the ongoing efforts to meet the A&E performance challenge, on a recent visit to A&E he had observed that although staff were tired they remained buoyant and were working hard with good will and good humour.

A&E difficulties exist across Greater Manchester were performance is below the national average.

The Trust is one of five organisations to receive an invitation to attend a royal reception to recognise the work done through the "Step into Health" programme – a national initiative to support ex-service men and women into NHS employment.

The Chairman expressed his thanks to all staff for their ongoing work and achievements over the last 12 months.

8. CEO report

The Chief Executive presented her monthly report and highlighted the following areas within the written report:

Employee of the Month – Pauline Cunliffe one of the advanced paediatric nurse practitioners was recognised for her work to support children and families (recognised in the patient story).

Team of the Month – Patient Services and Bereavement - recognised for their work in supporting families

Several members of staff from across the Trust have received national recognition recently, Andrea Bennett, the Deputy Director of Finance was highly commended in the recent HFMA awards, Martine Bayliss has been shortlisted for a Royal College of Midwives award and a number of staff have been shortlisted for a national award recognising the unsung heroes of the NHS.

The **NHSI** quarter two assurance report provided positive assurance in terms of

partnership working.

Discussion across **Greater Manchester** with regard to further collaboration has continued. Alongside this, the Trust has continued to engage with partners in the NW Sector to identify areas for collaboration.

Health Education England has commenced consultation on a national workforce strategy, within Bolton there is a locality group focused on new models of workforce for health and social care. The cultural complexities of integrating different kinds of organisation are recognised.

Resolved: The Board noted the CEO report

9. **Quality Assurance Committee Chair Report**

The Chair of the Quality Assurance Committee gave a verbal update from the meeting held on 20 December 2017. (written report to be uploaded to Admincontrol after the meeting)

Key points were as follows:

- The family care division provided a patient story summarising the case of a lady who was diagnosed with cervical cancer. This was a rare type of cancer which was not identified through routine screening. The previous histology samples are now being used for learning.
- The Elective Care divisional report identified an issue of patients being discharged before TTOs are ready.
- The Family Care divisional report included an outlier alert with regard to neonatal unit length of stay. The Committee were assured that this is not a significant concern as the Trust is comparable with similar trusts. The Medical Director has been asked to discuss further with CHKS to ensure appropriate benchmarking.
- The Committee received reports from the national audits into dementia care and falls; these reports highlighted a mix of positive and negative metrics and identified a potential need for more falls prevention resource.
- The family division responded to a report that identified the Trust as an outlier for 3rd and 4th degree tears. The Committee were assured by the data provided which showed a spike followed by a return to within expected limits.
- At the request of the Audit Committee, the QA Committee received a response to a previous internal audit report providing assurance that a system is in place with audit and checks to ensure appropriate reporting of blood test results. In the absence of an EPR, human factors will remain a risk – this is mitigated by two weekly audits.
- The PEIP Committee Chair report provided some assurance that issues identified through patient stories are actioned – the PEIP Committee have requested further evidence to be fully assured.
- The IT and Informatics Chair report included an update on GDPR, the Trust are 80% compliant with work underway to address gaps. There are financial and resource implications of the new GDPR requirements and a number of factors which need to be considered including a person's right to be forgotten.

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 gave a verbal report from the meeting held on 20 December 2017. (written report to be uploaded to Admincontrol after the meeting)

Key points were as follows:

- the Trust has a year to date deficit of £1m including STF, which is £2.2m worse than plan at the end of Month 8;
- agency costs are at £6.8m against a year to date plan of £4.2m which now exceeds the full year plan of £6.2m;
- ICIPs at £8.4m are £0.7m worse than the year to date (note the full year target of £20.8m);
- cash at £4m is worse than plan by £1.5m this month;
- capital spend is £9.1m which is £9.4m below the capital plan; and,
- The overall financial performance to M8 remains disappointing. The Q3 forecast is now at risk due to A&E performance. Meeting the Q3 financial target will require balance sheet flexibilities to be released early as well as formal recognition of a pro rata share of the £2.9m income from the CCG.
- There is still no evidence of improved divisional performance/ICIP delivery or of reduced variable pay spend relative to targets. The underlying cash position also gives cause for concern.
- As previously agreed, forecasts will be reviewed again at the end of Quarter 3.
- The Committee received a paper which reported that further slippage of £2m from the Capital Programme is now anticipated, i.e. total slippage of £7.5m.
- The Committee received a paper that outlined a strategic approach to the delivery of efficiency through the annual ICIP programme, for information and discussion and for assurance in relation to the ICIP process. The paper outlined the context, principles and process Involved in order to provide assurance.
- The Committee received the Elior Business case for information only on the basis that iFM Bolton had already given approval for this to proceed. There was some debate as to whether this approval should have been sought via the Finance & Investment Committee rather than being granted by iFM Bolton directly. The Committee agreed to refer the governance issues arising from this matter to the Board for wider debate.

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

11. Workforce Assurance Committee Chair Report

The Chief Executive presented her report from the meeting held on 29 November

2017. A task and finish group has been established to focus on recruitment and retention.

At the next meeting (22nd December 2017) the Committee will focus on an in-depth review of workforce metrics and staffing levels.

The Terms of Reference for the Workforce Committee were approved by Committee members, it was agreed that these should be circulated to Board members for approval by email.

FT/17/109	Workforce Assurance Committee terms of reference to be circulated for approval	ES

12. **Urgent Care Delivery Board Chair Report**

The Chief Executive gave a verbal update from the meeting of the Urgent Care Delivery Board held on 19 December 2017.

The Urgent Care Board (UC Board) received an update on the plans for CDU and an update from the mental health trust on streaming of patients. The UC Board also reviewed the overall workplan and expressed concern that updates are not being provided by all workstreams. A timeout session is being arranged to connect workstreams and deliverables and provide an opportunity to refresh the programme and highlight the importance of delivery by all parties.

In response to a request for an update on the additional 100 beds called for when the winter plan was presented to Board, the CEO advised that 65 additional beds are now available plus a further 15 virtual beds created by the use of home first and admission avoidance. These 80 beds plus the capacity for 20 outliers created by stopping routine elective admissions has created the system capacity called for. Additional surge capacity can also be made available by spot purchase of social care beds. Arrangements have also been made to extend the window to restart existing packages of care from four to six days.

The Board spent some time discussing the availability of additional beds to seek assurance that the requested 100 beds were available; the Chief Executive confirmed that the call for additional beds had generated the desired response although responding to surges in activity could still present a challenge.

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

13 **A&E update**

The Chief Operating Officer confirmed that the additional capacity is proving effective with performance better than the same period in 2016/17. The additional trolley spaces in A&E are now being used to create capacity when the department is full but there is still room for improvement. Key challenges that need to be addressed and sustained are decision to admit, early bed availability and weekend discharges.

Bolton has seen an early surge in the presentation of patients with the flu virus, 50% of all flu cases tested in England have been in Bolton with outbreaks in 13 schools.

Orthopaedic elective work has been put on hold with the orthopaedic lists used for trauma patients and E4 will switch from surgical to medical to accommodate

medical outliers.

Staff recognise the national context and have responded well to the challenge, divisions and teams are working well together with a real sense of focus and teamwork.

In response to a question about patients who breach the target while waiting for a mental health assessment, the Chief Operating Officer advised that a mental health streaming service has now been established although for some patients there is still a need to stabilise clinically before transferring to mental health.

The Chief Operating Officer advised that he was unable to provide assurance that the target would be achieved but could confirm that was the ambition.

Board members discussed the challenge of responding to the increased demand for services and the need to ensure additional capacity was safely staffed. The Director of Nursing advised that there would be support from nurses employed in corporate roles with additional support from members of admin teams who had volunteered to act as runners.

After further debate the Board agreed that while performance was off trajectory there appeared to be good prioritisation of key areas with a clear clinically led plan.

Resolved: the Board noted the update on A&E performance.

14. Infection Control External Review Briefing

The Director of Nursing advised that as previously discussed both within the Board meeting and at Quality Assurance Committee an external review of C difficile had been commissioned with two experts invited to undertake a review to include a site visit and interviews with key personnel.

Initial feedback following the visit confirms there are no significant underling issues but has identified three initial recommendations which include a more focused role for divisions in the rca process and enhanced antibiotic stewardship.

The review will continue with further interviews scheduled for January with the full report to the QA Committee in March 2018.

The Director of Nursing advised that although the report does not identify any significant new actions it does provide assurance that the team are not missing obvious actions.

Resolved: the Board noted the update on the infection control internal review.

FT/17/110	full infection control report to QA Committee (March 2018)	TAC

15. Update on RTT

The Chief Operating Officer presented a verbal update on the impact of operational pressures on the 18 week RTT target. In line with national guidance, in-patient elective work scheduled for January 2018 has been postponed. This will reduce performance against the RTT target which is anticipated to be around 88% at the end of January (against a target of 92%)

Day case surgery and elective surgery for cancer will go ahead and the 62 day cancer target should be achieved throughout quarter three.

Discussions are ongoing with CCG colleagues and WWL with regard to transferring some elective orthopaedic activity to WWL

Board members discussed the impact of reduced performance against the RTT target reflecting on the impact this could have on patient experience and potential regulatory attention if the target was not achieved. The Chief Operating Officer confirmed that the action is in line with NHSI required actions to prioritise A&E performance during the peak winter pressures.

Resolved: The Board noted the update on RTT performance.

16 **Discharge Medication Briefing**

The Medical Director provided a verbal update on actions to improve the timeliness of discharge medication (action FT/17/89)

A senior pharmacist with a track record of improving performance in this area has been appointed to drive results in this area. Junior doctors confirm that they understand the importance of ensuring that discharge prescriptions are completed as soon as possible on Ascribe to enable timely dispensing of medication.

The Heads of Division will be working with the consultant workforce to ensure this is prioritised and becomes established as practice.

Board members discussed the importance of timely discharge medication and also recognised the importance of communicating with patients, families and carers as part of the discharge process.

Resolved: the Board noted the update and requested a progress update in March 2018

FT/17/111	report back in March 2018 to update on changes and progress	SH

18 **Audit Committee Chair Report**

The Chair of the Audit Committee presented her written report having previously highlighted the key elements and the concerns relating to the internal audit report on blood tests in a verbal update to the November 2017 Board meeting.

The Trust IG lead had attended the Audit Committee meeting to provide an update on GDPR readiness. The external audit team commented that the NHS as a whole are not yet ready for GDPR which has potential financial and governance implications particularly with regard to a person's right to be forgotten.

The Trust Secretary and Director of Finance advised that the action to ensure robust executive follow up to internal reports had been completed with a change to the format of the report and a process adopted for all reports to be reviewed through by the Executive team before presentation to the Audit Committee.

Resolved: The board noted the Chair of Audit Report.

19 **Estates Masterplan Board - terms of reference**

The Trust Secretary proposed the constitution of a new Board level committee to have oversight of all elements of the estates strategy/masterplan.

Chair of iFM suggested that consideration should be given to including the iFM Director of Finance in the membership of the new committee – Board members agreed to consider this during the facilitated debate on iFM governance arrangements. It was recognised that delegated authorities would also need to be reviewed.

Resolved: The Board approved the constitution of an Estates Masterplan Board

20. **Charitable Funds Chair Report**

Resolved: The Board noted the Charitable Funds Chair report.

21. **Looked after Children Report**

The Director of Nursing presented the Looked After Children Report and advised that the report was a CCG report presented to the FT Board for information. Action relating to the report will be discussed through the Safeguarding Board at which the FT is a partner.

Board members spent some time discussing the issues and challenges identified in the report recognising the impact looked after children can have on the case load of Trust staff.

Resolved: the Board noted the Looked After Children Report.

FT/112/17	TAC to raise question regarding consent with the CCG (12.3)	TAC
FT/113/17	AW to address question regarding PbR (11.2)	AW

22 **Any other business**

No other business.

23 **Questions From Members of the Public**

No questions raised

Date And Time of Next Meeting

25 January 2018

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.

December 2017 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/17/97	30/11/2017	Performance report	Report on sepsis screening to Jan QA Committee	SH	Jan-18	completed December QA committee
FT/17/98	30/11/2017	Performance report	Report back on actions to improve RTT performance	AE	Jan-18	agenda item
FT/17/108	21/12/2017	patient story	AE to discuss route for patient transfer with NWAS	AE	Jan-18	verbal update
FT/17/109	21/12/2017	Workforce assurance committee	Workforce Assurance Committee terms of reference to be ciruclated for approval	ES	Jan-18	complete
FT/17/112	21/12/2017	Looked after children report	TAC to raise question regarding consent with the CCG (12.3)	TAC	Jan-18	verbal update
FT/17/113	21/12/2017	Looked after children report	AW to address question regarding PbR (11.2)	AW	Jan-18	verbal update
FT/17/114	21/12/2017	iFM Governance	Deloitte facilitated session to be run as FT:iFM Board to Board	ES	Jan-18	agenda item
FT/17/115	21/12/2017	iFM financial performance	AW to share updated iFM financial position with MH	AW	Jan-18	verbal update
FT/17/116	21/12/2017	Equality and Diversity	Board sponsor for E, D and I	DW	Jan-18	verbal update
FT/17/99	30/11/2017	Performance report	Report through Workforce Assurance Committee on quality of appraisals	HB	Feb-18	
FT/17/100	30/11/2017	Performance report	Report back to provide further understanding and assurance that staff are getting the training they need	HB	Feb-18	
FT/17/96	30/11/2017	Performance report	TAC to provide update on trajectory to achieve recommended fill rate	TAC	Feb-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/17/117	21/12/2017	Equality and Diversity	update on E,D&I	TAC	Jun-18	

Key

NHS
Bolton
NHS Foundation Trust

Agenda Item No: 8

Meeting	Board of Directors

Date	25 January 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

1. Awards and recognition

Employee of the Month - Michelle Bentham, Housekeeper in Theatres.

Team of the Month - the Gastro and Bowel Cancer Screening Team

2. Stakeholders

2.1 NHSI/NHSE

In common with other stakeholders, the prime focus of communications received since the last Board meeting has been continuing the focus on flow. The next quarterly review meeting with NHSI is scheduled for January 29th, at the time of writing we have not received the agenda - a verbal update will be provided if there are any points of which the Board should be aware.

2.2 CQC

Following the government's 2017 Spring Budget announcement of additional funding for adult social care, the Secretaries of State for Health and for Communities and Local Government asked CQC to carry out a programme of targeted 'system' reviews in local authority areas.

In December 2017 CQC published an interim report detailing initial findings from the 20 local system reviews carried out so far.

The key themes emerging from the first six reviews include how systems work together and how capacity, market supply and workforce are managed. CQC found that system-level leadership accountability is difficult to identify and that the availability of social care, especially nursing homes, is a widespread challenge.

CQC concluded that focusing on delayed transfers of care (DTOCs) in isolation will not resolve the problems that local systems are facing; there needs to be a whole system approach to prevent people from reaching crisis point and address capacity issues across primary and social care.

In summer 2018, CQC will publish a national report which will draw on the findings of all 20 reviews, once these have been completed.

Sir David Behan has announced his intention to step down as Chief Executive of CQC. He will continue in the role until the summer to allow the appointment process for a successor to take place.

2.3 Healthier Together

The North West Sector Partnership (Final) Business Case for new models of care is included within Board papers for noting.

2.4 North West Sector

A paper expanding on plans for collaboration with WWL will be discussed in the part two Board meeting

2.5 NWAS

NWAS are working collaboratively with acute trusts to review the process for transfers between hospitals to ensure priority is given to the most critical inter hospital transfers. This will link in with a national review that seeks to align healthcare professional requests to the national Ambulance Response Programme.

3. Reportable Issues Log

Issues occurring between 15/12/17 and 16/01/2018

3.1 Serious Incidents and Never events

There have been two serious incidents, one relating to an injury sustained during a surgical procedure and the other to a category four pressure ulcer.

3.2 Red Complaints

No red rated complaints have been received during the reporting period

3.3 Whistleblowing

Nothing to report

3.4 Media issues

There was national coverage of a story concerning a patient who was transferred home from A&E in a taxi. In cases such as this there is a need to preserve patient confidentiality, this limits the response we can make when requested to comment.

Alongside the coverage of A&E pressures and cancelled elective work, we also received some very positive media coverage in the Bolton News following the successful delivery of triplets within our maternity services.

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 risks 1.1, 1.2.1, 1.4 and 2.1 will be subject to review by the Audit Committee.

	Trust Wide Objective	Lead	I	L		Dec	Nov	Oct	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	Lack of assurance relating to ANTT competence	ANTT policy and training across all wards commenced June 2017 Hand hygiene policy revision July17	IPC committee
1.2.1	For our patients to receive safe and effective care (pressure ulcers and falls) Reduced following debate at Board and QA	DON	5	3	-	15	15	15	Falls and pressure ulcers	Implementation of policies and training July 17 – Nov 17	QA Comm and harm free care panel
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	3	-	16	16	16	Escalation of ill patients, **Increase in HSMR/RAMI**	Divisional action plans Morality review process	Mortality reduction
1.4	Staff and staff levels are supported	DON	4	5	-	20	20	20	Recruitment, limited pool of staff Staffing for escalation areas Delay in international recruitment	Recruitment workplan Internal Audit sickness absence report actions New Workforce Assurance Comm	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	Late decisions in A/E Beds coming up late Lower discharges at weekends A&E flow and staffing Urgent Care pressure and increased demand on Elective work	Urgent Care programme plan SAFER ECIP support Capacity and Demand Planning	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	Sustainability fund CIPS for 2017/18	Finance plan and A&E improvement Mid-year fundamental finance review	IPM F&I comm
4.4	Compliance with NHS improvement agency rules	DSOD	4	4	-	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	DSOD	5	4	-	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	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Urgent Care action plan ECIST support	Urgent care prog board

All information provided in this written report was correct at the close of play 16/01/18/17 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:	17 Jan 2018	Date of next meeting:	21 February 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Apologies:		Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story - Acute adult division		The patient story presented by the Acute Adult Division illustrated the impact pressures and flow can have on patient experience. The story was in relation to a patient who after a long wait for an ambulance subsequently had a long wait in A&E. The family contacted the CQC with their concerns and have since met with the Director of Nursing to discuss the story.	The division have taken action in response to the story. Additional actions were requested in relation to sharing the story and need for action with partners. The bereavement team are contacting families following the death of a relative in A&E to provide support.
Pressure Ulcers quarterly report		Good progress made in the reduction of pressure ulcers due to a lapse in care. Discussed factors contributing to lapse in care ulcers including non-concordance and the documentation of non-concordance, the availability of equipment and delay in removing bandages. The CCG senior nurse present at the meeting confirmed that the CCG are assured by the robust process and value the support provided by the Trust for community pressure ulcers	Continue with planned actions including harm free care panel and actions to address specific concerns. Looking at different ways to demonstrate improvement and relate to activity
Falls Quarterly report		Improvement in rate of falls per 1000 bed days. Accepted that while not possible to eliminate falls it is still possible to reduce harm from falls and recognise the factors that contribute to calls	Continuing with falls action plan which is under review to ensure that actions are in line with national recommendations

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

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

Committee/Group Chair's Report

Patient track and hospital at night update		System successfully implemented in February 2016 and gives increased visibility of risks and issues at night. Recognised potential further benefit from the system and the good engagement with clinicians	Continue to provide assurance through quarterly reports to Clinical Governance Committee. Debated metrics to measure out of hours activity, acuity and response.
Organ donation and transplant		Received letter from NHS Blood and Tissue authority. Number of donations increased	Full report back in March 2018
Ophthalmic service action plan		Consolidated action plan for previous reviews being led by new OBM, clinical lead and matron. Previous issues recognised, committee assured with regard to focus and direction of travel	Two year plan, feedback and follow up through divisional governance structure
Quality Account Governance Arrangements		Introduced priority long list for selection of priorities for the Quality Account and outlined the arrangements and schedule for the production of the Quality Account.	Further debate required to support selection of priorities. Survey monkey to stakeholders to select priorities
Mortality committee		Reduction in SHMI and downward trend in RAMI	
Workforce Assurance Committee		Committee continuing to develop, initial reports received in accordance with the workplan. Report received from new Medical Workforce Group	

	No assurance – could have a significant impact on quality, operational or financial performance;
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	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

Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	23rd January 2018	Date of next meeting:	20th February 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Apologies:	A Ennis	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 9)		Director of Finance	Key points noted from the Finance & Activity Report: • the Trust has a year to date surplus of £1.0m including STF, which is £1.1m worse than plan at the end of Month 9; • 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 £2.9m when STF is excluded from the position; • Balance Sheet adjustments of £0.8m were released into the position; • agency costs are at £7.6m against a year to date plan of £4.7m which now exceeds the full year plan of £6.2m; • ICIPs at £9.6m are £1.0m worse than the year to date plan. Note the full year target of £20.8m; • the month end cash balance is £2.9m which is worse than plan by £4.0m this month; • year to date capital spend is £12.7m which is £9.8m below the capital plan; and, • the Trust Use of Resource Rating is 3 as at the end of Month 9, which is below plan. The Q3 financial trajectory was delivered (including release of Balance Sheet flexibilities etc.) with some performance improvements across key areas, including variable pay spend. Q4 remains challenging but mitigation plans are in place and further opportunities being sought. Discussions with NHSI remain ongoing.	Risks to delivery of full year control totals remain significant. The underlying cash position continues to give cause for concern and will be closely monitored. Successful delivery of Q3 and improved performance in key areas are positive indicators, but the challenge remains to sustain improvements and drive forward the tactical plan and existing ICIP schemes. Additional performance improvement opportunities will also be required if the control totals are to be delivered. Work is ongoing in this regard. NHSI is fully briefed and understands the significant risks to delivery. Notwithstanding this, NHSI "strongly advises" Bolton FT to maintain the current forecast. They have also offered further suggestions to bridge the gap. On the basis of the above the Committee has agreed to recommend that the Board maintains the control total target as its forecast subject to ongoing NHSI assurance of understanding and support.

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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

Capital Programme Update (Month 9)		Director of Finance	The Committee received a paper which reported that slippage is now expected to be £10.2m rather than £7.5m reported previously. It was noted that further slippage is considered likely.	Assurance received that slippage will not impact adversely on future performance and will be carefully managed. Report noted.
Minutes from the Capital, Revenue and Investment Group		Director of Finance	The Committee received the report from the meeting held on 12th December.	Report noted.
Progress Report on Identifying Efficiency Opportunities		Director of Finance	The Committee received a report on progress made against the identification and delivery of efficiency opportunities including Lord Carter, in readiness for the submission of the 2018/19 ICIP plan.	Report noted. It was agreed that the Committee will receive the 2018/19 ICIP proposals in February rather than March in order to enable full debate/challenge before plans are finalised.
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.	Report noted.
Devolution Manchester		Director of Finance	The Director of Finance gave a verbal update in relation to recent progress.	Update noted.
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				

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Committee/Group Chair's Report

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

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

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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:	18 Jan 2018	Date of next meeting:	15th February 2018
Chair:	Jackie Bene, Chief Executive	Parent Committee:	Board of Directors
Apologies:	Annette Walker, Carol Sheard, Lyndsey Darley	Quorate (Yes/No):	No (no representation from the Integrated Care Division)

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Organisational Development and Learning update		HB	Update provided on key OD&L projects. The progress with student nurse training using the Synergy model was noted. OD&L nurses have provided increased presence and support to ward based areas to help with winter pressures. Future options for paediatric and maternity students are being explored	Committee members discussed plans to ensure the best use of resources and the process by which assurance could be provided to the Board that there is oversight and action as required for key programmes.
Staff engagement update		HB	Vacancy in the staff engagement lead since October has reduced activities	Action to be taken by new Workforce Director
Staff survey action plan		HB	Embargoed results show a mixed picture with some areas of improvement but also a few areas where the Trust is performing less well than others	Full survey to March Board Ongoing discussions and engagement to formulate action plan
Workforce performance report		HB	Discussed key metrics including turnover and absence rates. Some positive changes with a slight reduction in vacancies and agency spend and indication of increased grip	
Job planning		SH	Update provided on progress with job planning	Trajectory to be set to complete all job plans
Whistleblowing and Freedom to speak up		AW	Update provided on Freedom to Speak up activity – minimal use of the service so far	Sessions planned to raise awareness of the role

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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

Medical Workforce Group		SH	Chair report received – no risks escalated	
Locality Workforce Group		TAC	Chair report received – no risks escalated	
Comments:				
Risks escalated:				

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Committee/Group Chair's Report

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Board of Directors
Date of Meeting:	22nd December 2017	Date of next meeting:	18th January 2018
Chair:	Jackie Bene, Chief Executive	Parent Committee:	Board of Directors
Apologies:	Annette Walker, Susan Ainsworth, Esther Steel, Lynne Barnes, Carol Sheard	Quorate (Yes/No):	No (no representation from the Adult Acute Division)

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Workforce Race Equality Standard Reporting		HB	The Committee received the template to be submitted annually and the action plan for discussion. Discussed unconscious bias and opportunities for progression for BAME nursing staff.	The action plan will be further developed following the session at the Board of Directors on the 21st December 2017. HR Teams to work closely with Divisions.
Workforce performance report		HB	Debate focused on accuracy of vacancy levels in Divisions.	Workforce Operational Committee to undertake a piece of work to establish vacancy levels on a couple of wards in each Division to ensure the wards are adequately staffed.
Deep Dive on Fill Rates		HB	The Committee received a snapshot of vacancies/fill rates/bank and agency use on D4 Ward to visualise the metrics and the challenge.	The analysis presented some requirement for further clarity on definitions and some checks were required on accuracy of data.
Medical Workforce Group		SH	The Committee noted that a separate group had been established to look at medical workforce productivity and reducing discretionary spend.	Chair's report to be submitted to future meetings.
Comments:				
Risks escalated:				

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Bolton NHS
NHS Foundation Trust

Committee/Group Chair's Report

Name of Committee/Group:	Bolton Urgent Care Delivery Board	Report to:	Bolton FT Trust Board
Date of Meeting:	9th January 2018	Date of next meeting:	13th February 2018
Chair:	Dr Jackie Bene	Parent Committee:	Bolton System Resilience Board
Apologies:		Quorate (Yes/No):	Y

Key Agenda Items:	Assurance Yes/No	Lead	Key Points	Action/decision
Presentation from NW Utilisation Management Team on ED attendances For the >65s July to October 2017	No	Debbie Atkinson (NWUMT)	Showed clearly that this group of self presenters call NWAS (60%), only 53% required admission and most were due to falls and musculoskeletal problems Only half the patients who rpresented via NWAS required admission and roughly half could and should have accessed their GP.	Will help direct the work of alternative pathways for NWAS to GP's and other community care facilities. Reinforced the need for Home First and a Frailty pathway from ED Both projects underway.
Exception reports : • Enhanced primary care support to care homes • ED flow and internal escalation • Discharge to assess work • Immedicare wotk in NH's • Home First initiative in ED	No Yes	BFT and CCG leads BFT	All falling behind plan and not delivering according to timeline – largely due to recruitment issues Established, embedded and activity surpassing original goals - >4 admissions a day avoided	Timelines extended where recruitment main issue.

Committee/Group Chair's Report

NHSI support	Yes	ECIP lead	Description of observations and work thus far described focusing on ED processes and more general operational flow	6 month programme with monthly progress reports
Performance Dashboard	Partial	BFT	Main issue of concern was the access to admissions avoidance and LOS on their caseload – relates to resources /sickness	Assured this is now addressed. Meeting on 12/01/18 to discuss quality and appropriateness of current metrics and their relationship to outcomes of workstreams

NHS
Bolton
NHS Foundation Trust

Agenda Item No 13

Meeting	Board of Directors

Date	25th January 2018

Title	Staffing Paper – Comprehensive Overview
Executive Summary • *Why is this paper going to the Board* • *To summarise the main points and key issues that the Board should focus on including risk, compliance priorities, cost and penalty implications, KPI's, Trends and Projections, conclusions and proposals*	This report provides the Board with a comprehensive update on nurse and midwifery staffing, mainly focusing within the bed base areas. An overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable is also outlined.

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

Next steps/future actions *Clearly identify what will follow a Board decision i.e. future KPI's, assurance requirements*	Staffing will continue to be presented on a monthly basis at board. A comprehensive update on progress of activity outlined within this report will be presented to board July 2018.			
	Discuss	✓	Receive	
	Approve	✓	Note	

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	Marie Forshaw, Deputy Director of Nursing Contributions from Divisional Nurse Directors, Acute Adult, Elective, Families and Integrated Community Services, Governance Team & Workforce	Presented by	Trish Armstrong-Child, Director of Nursing and Midwifery

Board of Directors – 25th January 2018

Comprehensive Staffing Paper Update

1 Purpose

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

2 Background

Since 2013 the Board has consistently reviewed its current staffing establishment and significant investment has been made into a variety of nursing establishments. The majority of investment has been made within our inpatient areas and has been based on NICE guidance (Inpatient staffing 2014 and Maternity services 2015), professional judgement, the enhanced care project and consideration of quality indicators. The Trust also participated in the Lord Carter Review in 2015.

This approach was reinforced by a joint communication from the Care Quality Commission, NHS England, Chief Nursing Officer and NHS Improvement that was sent to Trusts Chief Executives in October 2015. This letter outlined a shared view that providers should approach the need to ensure safe, quality care for patients on a sustained financially stable basis. Whilst reinforcing the need to use guidance and best practice. The importance of professional judgement, taking into account other disciplines contribution to providing direct care was advised. In response to this the organisation has continued to undertake systematic establishment reviews of areas and these will be highlighted later within the paper. In addition further staffing reviews have taken place.

However, despite the intense focus on staffing levels, nurse recruitment and retention remains a challenge and continues to be highlighted as a significant organisational risk on the Trusts Board Assurance Framework (BAF).

3 Current Position

The charts below (Table 1, Graph 1) provide a breakdown of our UNIFY fill rate data that we collect and submit externally on a monthly basis (July to December 2017 inclusive) for our inpatient areas. It shows a percentage of the Planned v Actual staffing levels for both the Day and Night shifts split by registered and unregistered.

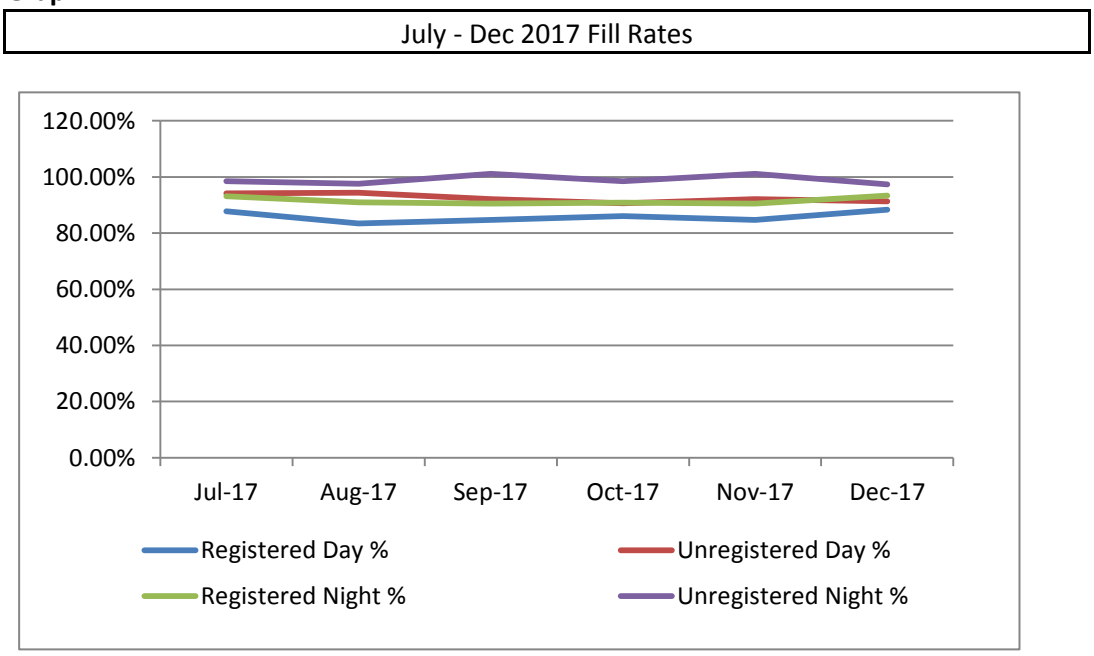
July to December 2017 has shown a slight decrease in the average fill rates for both registered & unregistered staff compared to the last staffing paper received at Trust Board in July 2017. One of the main contributors to this was the Trust opening additional capacity to manage winter pressures.

Table 1

Percentage fill rate – Unify Submission

Month	Registered Day %	Unregistered Day %	Registered Night %	Unregistered Night %
Jul-17	87.77%	94.18%	93.09%	98.49%
Aug-17	83.41%	94.34%	90.94%	97.59%
Sep-17	84.73%	92.12%	90.51%	101.11%
Oct-17	86.09%	90.58%	90.86%	98.55%
Nov-17	84.73%	92.12%	90.51%	101.11%
Dec-17	88.41%	91.28%	93.37%	97.30%
Average	88.20%	94.40%	99.40%	103.20%

Graph 1



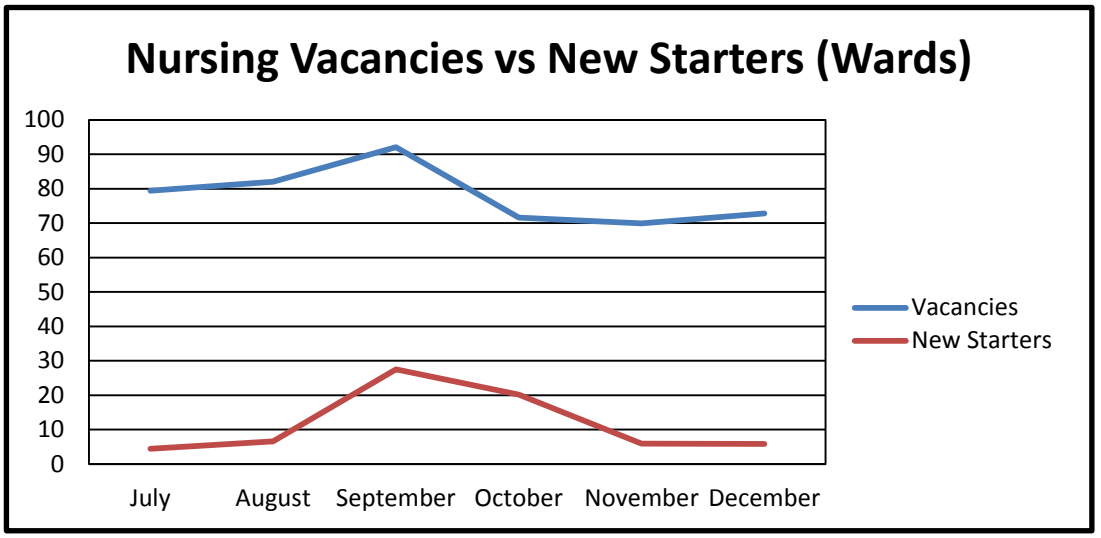
4 Vacancies

The graphs below (graph 2&3) illustrate the number of new starters for both Nurses and Health Care Assistants (HCAs) have remained consistent throughout the period, apart from September and October which saw a peak in recruitment. This is attributed to the recruitment of Newly Qualified Nurses (September cohort), and also a HCA recruitment open day which was held in September.

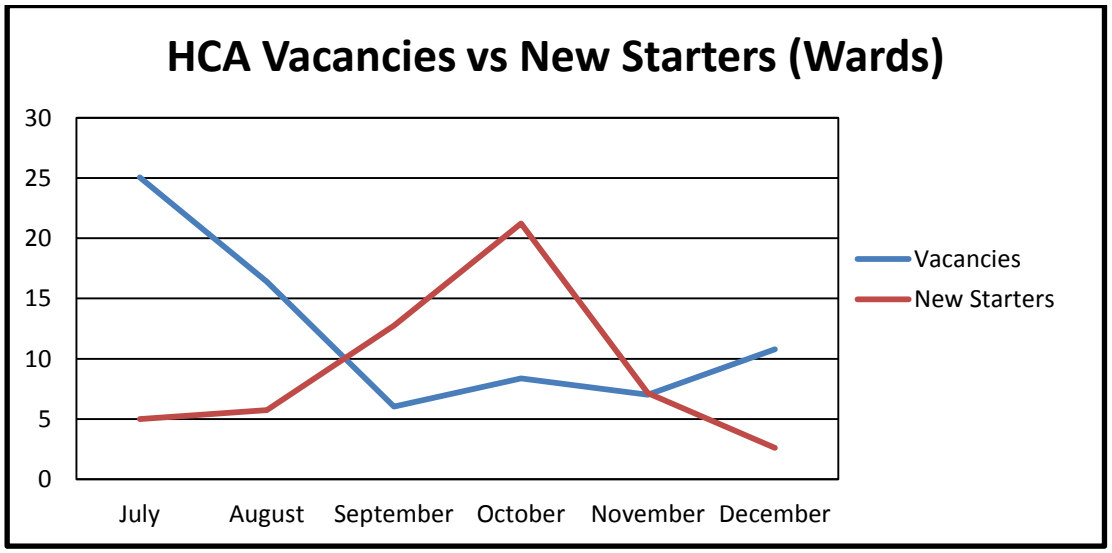
The figures show that from July to December 2017 there has been an average of 12 Nurses and 9 HCA new starters per month.

However despite successful recruitment events and continuous hard work to reduce vacancies across the Wards, the vacancy WTE at ward level as at December 2017 for nursing staff remains challenging at 73 WTE. In the last report (July 2017) the Trust was reporting 90 WTE registered nurse vacancies. The vacancy WTE for HCA has seen a greater reduction and as at December 2017 was 11 WTE (compared to 28 in July 2017).

Graph 2



Graph 3



5 Recruitment and Retention

The Professional Lead for Nursing Workforce continues to focus and work proactively between the Workforce team and the Divisional Nurse Directors (DNDs) to review and transform aspects of recruitment and retention across the Trust. The following are examples of progress since the last report.

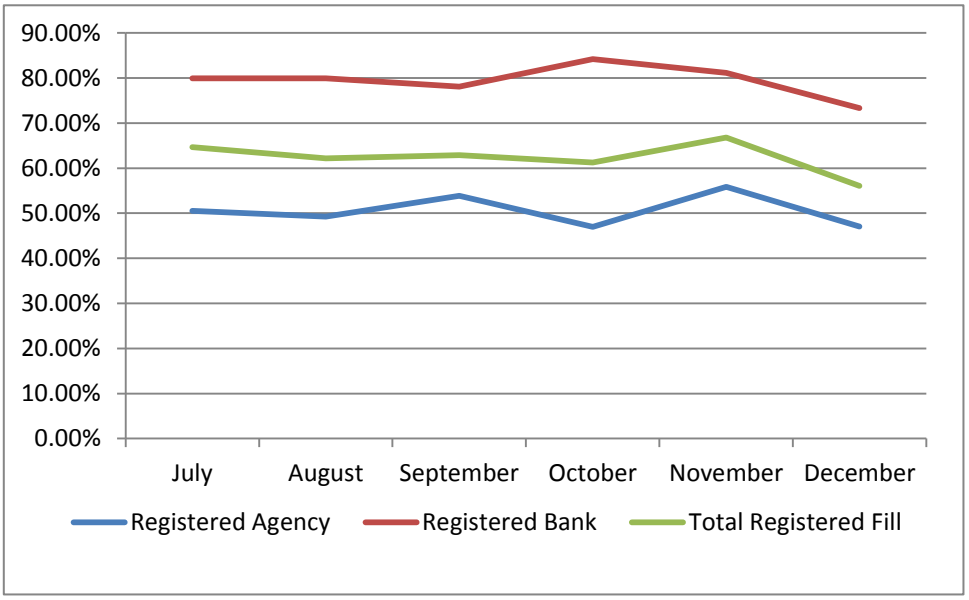
- 10 more international Nurses joined the Trust with a further 5 due to start on 5th February 2018
- **45 newly qualified** commenced in the Trust in September 2017 from our pre registration training cohorts
- **30 newly qualified** due to commence in March 2018
- **New initiatives have been implemented to retain student nurse workforce. This includes:**
  - Breakfast meeting held with Director of Nursing in December for student nurses due to qualify in March 2018, with further events planned for June and September 2018 students
  - Professional Lead for Nursing Workforce has met with all student nurses who qualified in September 2017 and those due to qualify this year and has kept in touch with them during recruitment process
  - Ward Information Booklets completed currently at medical Illustrations for roll out end of February 2018
  - Ward Profiles completed for job adverts
  - Recruitment Calendar completed for 2018
  - Recruitment open events planned for Theatres 13th January 2018
  - Four Trust wide open days are planned for 2018
  - Posts advertised as job of week on BOB
  - All Posts advertised on Twitter and Facebook
  - Rolling adverts for wards introduced
  - Professional lead for Nursing Workforce now meets weekly with Employee Service Manager to ensure all new starters are on track.

6 Temporary Staffing

When staffing numbers fall below agreed staffing levels there are systems and processes in place that allows Managers to fill gaps with temporary staffing. The Trust's Temporary Staffing is managed in house within the Human Resource Department. Graphs 4&5 demonstrate our current fill rates against requests.

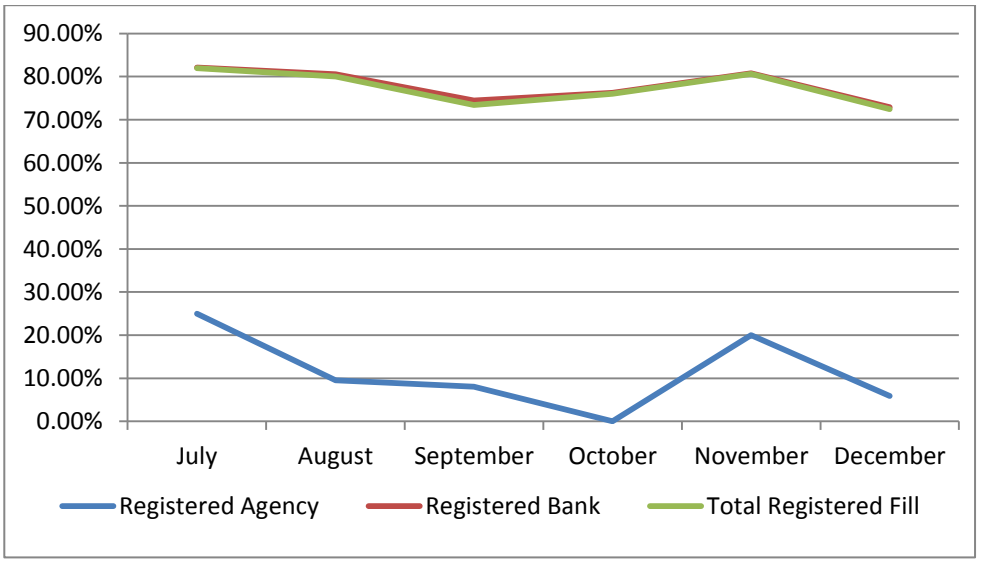
Graph 4

Bank and Agency Fill Rate - RN



Graph 5

Bank and Agency Fill Rate - HCA



7 Staffing & Skill Mix Reviews Update by Division

7.1 Acute Adult Division Nurse Staffing Update

Scheduled staffing requirements across the Division for this reporting period have been amended to a six monthly reporting period next due Jan 2018. This supports recommendations from the National Quality Board regarding regular review of establishments. The decision to change the workforce review schedule from quarterly to six monthly was made following reviews in April 17 and July 17 which identified the need to provide enough time to evaluate impact of staffing changes. This will allow for more accurate forecasts to be included in future reports. Establishment reviews are undertaken using a range of metrics including patient acuity (dependency) data, staff skill mix requirements (including multi-disciplinary staff provision), patient safety data and professional judgement.

Senior Ward Leadership

For this reporting period 8.25 WTE posts were converted from band 5 to band 6 following a review of leadership requirements as part of a skills and competency assessment. This was put in place in conjunction with a new band 6 development programme in order to provide senior leadership required to support junior staff and as part of supporting retention.

As part of winter planning, 2 additional Ward managers were appointed to lead teams in ward escalation areas.

Band 5 Recruitment

Vacancies have remained static at around 44 WTE for this reporting period, however this includes recruitment to Escalation wards B4 and B2 to 26 beds and 16 beds respectively. 18 month rotational posts across the division will be advertised in January 2018 in order to widen the offer of development opportunities in the Division.

Health Care Assistants

Wards D4 and C2 were uplifted for night cover for HCA as part of the July 2017 staffing review following presentation of evidence. No further uplifts were required.

Enhanced Care

Work is underway to evaluate the Enhanced Care Policy (introduced in April 2017) and to assess the impact of previous investment and current clinical need in Healthcare Assistant requirements to support those patients requiring Enhanced Care. It is expected that this will be completed in March 2018.

Acute Adult Emergency Department Review Update

Both establishment and skill mix requirements have been completed for this reporting period in preparation for the next phase of the Emergency Department expansion expected in spring 2018.

Emergency Department Skill Mix Review

The skill mix review is part of the wider workforce strategy for the division for 2017 – 2020. This identified that there is a requirement to further invest in clinical nursing leadership in order to futureproof Emergency Care requirements. For this reporting period there has been investment in a new role of Nurse Consultant, a further 2 Advanced Nurse Practitioner (ANP) trainees and 4 Emergency Nurse Practitioner (ENP) trainees which will support future requirements.

Emergency Department Establishment Review

Recruitment for new build requirements (outlined in appendix 1) are on track to be in place for spring 2018. For most posts, staff will be in post January 2018 in order to support pressures envisaged in the Emergency Department and new ways of working to support rapid assessment of patients.

Acute Adult Respiratory Care D3 /D4

Enhanced Respiratory Care Bay Pilot Update

The way that care is organised and delivered in wards D3 has been tested following approval of The Operational Policy for the High Care Respiratory Beds. A pilot of a Respiratory Enhanced Care bay which cohort's patients with higher care needs has been in place since September 2017. This will be formally evaluated in January 2018 and in planned to extend to D4. Initial findings from this pilot has Identified that new shift patterns and a slight increased establishment may be required, however the impact on quality, safety and patient experience has been positive.

B4 and B2 (Escalation wards)

Ward B4 has been open to capacity of 26 beds for this reporting period and Ward B2 opened in October 2017 with capacity for 16 beds. Divisional Winter Planning for B2 opening was accelerated from Jan 2018 to October 2017. As a result planned support from the Surgical Division has been put in place to support ward B2 in addition to a new ward manager and staff from within the division.

<u>Key Risks for the Division</u>

Escalation Areas

Escalation bed numbers and duration has resulted in a higher than expected use of reliance on Agency staff. This has been mitigated by daily skill mix reviews and development of an established senior leadership team and established trust staff. However the escalation wards at times rely on higher levels than expected of agency staff than other wards.

Retention

Data identifies that retention of staff remains static at 15%. A new Divisional Oversight Committee to support recruitment, retention and workforce planning is due to be launched in February 2018.

7.2 Elective Care Division Staffing Update

Critical Care Areas

Between October – December 2017 ITU has experienced 9 leavers which has caused considerable pressure on the workforce. This was anticipated with a variety of reasons cited for leaving (predominantly lack of career progression). However, whilst recruitment has been productive and posts are filled this leaves the profile of the unit with a junior workforce. This is further compounded by the retirement of an experienced band 7 nurse. The Division is looking to retain the skills of the current unit manager by offering a supervisory post to support the development of the new appointees and maintain our strong critical care network links.

F3

F3 has experienced challenges in recruitment for the last eighteen months. The ward runs with an average 8 WTE vacancies and despite focused recruitment campaigns we have been unable to recruit full establishment. In addition patient acuity has increased and the ward is going through a transitional process in order to become a more effective assessment unit. In December 2017, authorisation was granted to uplift 3.6 WTE band 5 posts to band 6s. This will allow a band 6 24 hours a day providing leadership and enhanced clinical skills. The recruitment for this has commenced.

ANPs

In November the Division had 4 new ANPs commence in post. Two within Orthopaedics have commenced a two year training programme and will be developing the roles to bring together the urgent and emergency care pathways. A further two were recruited for general surgery, both of whom only have one year of training left to complete. The ANPs will be focusing on the pathways between, ED, ACU and the assessment unit in order to streamline services, improve safety, efficiency and also the patient experience.

Forward Planning

A full staffing review will begin in February 2018 across the Division, commencing with the ward areas. It is the planned to undertake a review of all Out Patient areas, Specialist Nurses and therapy. These will be scheduled from April 2018.

7.3 Family Care Division Staffing Update

Maternity

The Board received a maternity staffing update in July 2017 and at that time it was highlighted that the staffing ratio was operating at a 1:29 ratio. One of the contributing factors to this was due to a reduction in the staffing budget in 16/17 based on the outturn from 15/16. This equated to 11 WTE midwifery posts. An additional 4 WTE were recruited into and this increased staffing against predicted births. The birth rate fluctuates each month and as a consequence maternity staffing levels need to be managed to respond accordingly. The development of a birth predictor tool has assisted in the effective management of staffing across the maternity unit. It is used proactively to support planned staffing requirements during busy and quiet periods. The table below (table 2) highlights the ratio compliance of 1:28 for the past 6 months

Table 2

Month	Birth Rate + actual in month
July	1:32
August	1:26.5
September	1:27
October	1:28.6
November	1:29.4
December	1:27.6

Nationally there is no indication that guidance will move away from the Birth Rate plus (BR+) tool and the recommended standard of 1:28, however, clinical outcomes and performance and skill mix should also be considered.

In December 2017 an exercise was undertaken in order to triangulate the 1:28 ratio/the current budgeted established and eroster. The staffing review was led by the Head of Midwifery and involved finance business partners, eroster colleagues and was supported by the project management office to explore greater efficiencies through the eroster system. This will support the Division to consider a future skill mix.

BR+ recommends a 90/10 staffing ratio split of midwives to midwifery support workers (MSWs). However, evidence and experience gained from a staffing ratio review completed at Portsmouth Hospital supports an 80/20 split using the “nurture” programme.

This model facilitates more postnatal work being undertaken by the midwifery support workers**.** This would in turn release midwives time to provide care only they are qualified to give.

We currently do not have a 90/10 skill mix, as recommended by Birth rate plus. Development of this specialist support workforce is underway and MSW’s have been introduced in community in order to support the Ingleside model. A full training and competency assessment has been developed in order to support the new role. A gradual, phased introduction will be undertaken across the rest of the service to ensure safety and quality is maintained.

Following a period of evaluation and consolidation it may be possible to adopt an 80/20 ratio in the future a phased implementation could be considered with impact being continuously assessed and reviewed at the 6 monthly Board reviews as per NICE guidance.

Maternity Quality and Safety metrics are considered as part of the triangulation of staffing requirements. With respect to staffing levels the following indicators remain the most relevant.

- 1:1 care - available to all labouring women as per NICE guidance - we have achieved this consistently above 98%.
- FFT recommended rates – have improved within this period, however response rates continue to be a challenge. The reporting of FFT has been amended to identify each of the 4 areas as recommended nationally this has demonstrated areas where targeted intervention has been required to improve the response rates.
- Incidents. - There has been 1 SI in the months July to December.
- Staff training and appraisals – Have remained fairly consistent from July to December. Appraisals have gradually increased and are currently at 83%. Mandatory and statutory training is gradually improving Mandatory training stood at 86%% in December 2017 and Statutory at 88%.

Acuity is also monitored on a monthly basis based on the following key indicators:

- Number of caesarean sections.
- Number of instrumental births
- Number of inductions.

The unit is not seen as an outlier in GM for performance but at midpoint of network data.

Other Staffing Considerations:

- *High Dependency Needs*

The unit operates an identified area equivalent to high dependency unit. The original model for this assumed that all the care will be provided by nursing rather than trained midwifery staff. Training of midwifery staff to support this area has been identified and will be facilitated by anesthetic colleagues, dates are booked for January and March a total of 11 midwives have expressed an interest and will be trained. The benefits of the midwifery staff being trained would be that they could provide flexibility in the workforce and a cohort of women could remain on CDS thus enabling the care of mother and baby together.

- *Outreach Midwives*

These midwives form part of the 1:28 ratio and work in community with a caseload focused on the safeguarding needs of women and their babies. Historically this has been developed from the Sure Start Midwifery role however the role and Job Description have not been reviewed for a number of years. A workshop is planned for February 2018 in order to understand the complexity of the role, a review and refresh of the referral criteria and pathways in place in order to support our most vulnerable clients.

- *Specialist Midwives*

Although we have a number of established Specialist Midwives we are not meeting all national guidance due to the size and complexity of care we offer. Some of the resource that sits within the specialist midwife provision is actually funded from the 1:28 ratio, this is utilised on a regular basis in the provision of general midwifery care, leading to gaps in provision in areas such as bereavement support, diabetes and screening. The Specialist Midwife provision has been reviewed as part of the overall staffing review and will be considered when finalising the eroster templates, the information to finalise has not yet been received from workforce and finance business partners. The budget will then be thoroughly reviewed, to fully utilise this workforce to support the increased ratio suggested by the BR+ reviews undertaken.

This will ensure that our women and the front line midwives are given the additional support they need. This alongside our band 2's and 3's with additional skills would largely mitigate the gap due to the acuity of our service users. However there remains a gap in Diabetes and Mental Health midwives.

There has been an exponential rise in the diabetic population and this has in turn led to a rise in demand on the diabetes service in both the obstetric team and the Trust diabetes team, who support the maternity service. We are currently working with colleagues in the CCG to establish what additional investment will be required to support the Maternity Diabetic pathway. The posts for diabetic specialist midwives are considered crucial to service delivery. This is shortfall in expertise is not sustainable as we cannot adopt the most recent NICE guidance as the current provision is over capacity and the new guidance would further impact on the capacity of the service. This is acknowledged by the Division and is a highly rated risk on the risk register.

The single most common cause of maternal death is suicide (MBRACE 2016). The CCG have recognised the gap in the Perinatal Mental Health Pathway and additional funding has been identified to support the recruitment of specialist midwives to support this pathway. The Perinatal Mental Health model and pathways are currently under development and the primary post of a Band 7 specialist Perinatal Mental Health Midwife will be recruited early in 2018 with additional posts being recruited to later in the year.

- *Continuity of Carer*

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalized; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of the vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. We are working with the Local Maternity System in order to consider how this will be implemented locally two models that meet the principles include Team continuity and also full caseloading. The Head of Midwifery has joined a task and finish group led by the LMS in order to engage with designing and delivering a model of continuity of carer for the local population.

7.4 *Children's Services*

Children's Unit

The national guidance for inpatient paediatric units from the Royal College of Nursing (RCN) suggests an aspirational standard of the following measures:

- Nurse to patient ratio of 1:3 for age 2 and under
- 1:4 for age 3 and over
- 1:2 for all children's requiring high dependency care
- Supernumerary nurse supervisor.

Bolton NHS Foundation Trust have an agreed internal standard, based on professional judgement, of 1:4 for all ages of ward patients, but maintain the ratio for high dependency and the nurse in charge status being supernumerary.

The staffing numbers, patient profile and acuity on the E5/F5 Children's Unit continue to be monitored by shift and via the monthly IPM. Ratios and supernumerary status is also reported via the Trust Heat map at Trust Board and Quality Assurance.

Since the last Board report, the average ratios and status of supernumerary supervisor is demonstrated in the table below:

Table 3

MONTH	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017 (to date of report)
AVERAGE RATIOS	1:3	1:2.6	1:3.6	1:3.4	1:5.8	1:37
SUPERNUMERARY NURSE IN CHARGE COMPLIANCE	87%	100%	90%	97%	96%	70%

The high dependency staffing position has been supported over the winter months with additional funding from Bolton CCG. Formal commissioning of Paediatric High Dependency is being addressed long term by the CYP network.

Neonatal Unit

The British Association of Perinatal Medicine (BAPM) provides nationally recognised standards for staff to patient ratios in Neonatal services. The gold standard is 1:1 for intensive care, 1:2 for high dependency and 1:4 for special care babies.

The compliance with BAPM since the previous report is illustrated in the table below:

Table 4

MONTH	JULY 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017 (to date of report)
BAPM COMPLIANCE	97.5%	101%	102.6%	91.3%	97.3%	96%

The local guideline and escalation policy provide clarity on the process for managing variation in staffing levels in order to ensure safe and appropriate care of infants. The Family Care Division continues to monitor this on a daily basis and the trends are monitored monthly via IPM, in addition to reporting monthly on the Heat Map. The Neonatal ODN also monitors and reports on staffing levels.

Staffing levels on both the Neonatal and Children's Units are reviewed twice weekly by the Matrons, the (DND) and Operational Business Manager (OBM). Nurses can either be transferred to alleviate staffing pressures where possible or bank/agency is used to fill the gaps.

The number of registered children's nurses is recognised as insufficient to meet the workforce requirements. This is being addressed locally by providing more placements to local Universities and full engagement with the regional and national direction via the network and Association of Chief Children's Nurses (ACCN).

The DND and Matrons responsible for the Children's Ward and NNU have reviewed the proposed improvement resources from the National Quality Board regarding safe, sustainable and productive staffing in paediatrics and neonatology.

7.5 Integrated Community Services Division Staffing Update

Darley Court

Darley Court has continued to flex staffing numbers to facilitate the refurbishment and the management of the additional beds to support winter pressures. Over the summer months the unit have intentionally held vacancies because of the temporary reduction in bed numbers during the refurbishment. In addition there was a proactive approach to managing capacity and demand by taking an annualised view of encouraging staff to take more annual leave in summer months to reduce annual leave in Q4 in order to support the additional winter beds.

The majority of vacancies have been successfully recruited to now that the refurbishment is completed and all beds are fully operational with increased capacity in winter pressure beds (5) open from January to March 2018.

Darley Court has been placing a significant amount of focus on staff development and multidisciplinary working which has had a stabilising effect on the substantive workforce and favourably assists with recruitment and retention. This includes active involvement in the Trainee Nurse Associate and with the Advanced Practitioner programme. In addition, the unit has piloted the Synergy infrastructure for mentoring pre-registration nursing students using a collaborative learning in practice model that enables a greater increase in training placements.

District Nursing

District Nursing continues to be an attractive area of nursing and currently has 7.9 WTE vacancies (this includes evening service). The service is exploring developing a flexible approach to shift patterns that may be trialed in the future.

8 Initiatives to Support Staffing Numbers

Training Nursing Associate (TNA)

Nationally the Nursing Associate Apprenticeship Standards have been finalised and agreed, any further cohorts of Nursing Associates will be supported through this route. The Department of Health (DoH) will look to support nationally, 5000 more Nursing Associates to commence training in 2018, with a further 7500 to commence training in 2019. Health Education England (HEE) will allocate £3,200 per trainee per programme as a support package to help employers with the expansion programme during 2018 only.

The NMC are working on the Standards for Proficiency for the Nursing Associate and are due to consult on these alongside Fees and The Code in April 2018, by July 2018 the NMC are expecting to become the regulator in Law and by September 2018 final approval of Standards for Proficiency. January 2019 the pilot site Nursing Associates should qualify and would then apply for registration.

Greater Manchester (GM) continue to work together to recruit Trainee Nursing Associates with a plan to recruit to a second cohort in April 2018. Bolton FT currently has 20 in training and 19 have progressed into the second year. Feedback continues to be positive from the TNAs and the current rotational programme offered has promoted interest across the organisation. The organisation is looking to recruit another 20-25 into training in the April 2018 recruitment programme.

Increase in Pre Registration Training Numbers

Work remains on going to proactively increase our pre registration nursing numbers year on year. In recent years we have increased our adult student nurse placements three fold with a further plan to increase by another 50 places this year. This is aligned to our recruitment strategy and supports changes to our current mentorship model.

9 Acuity and Dependency

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

Care hours per patient day (CHPPD)

The Trust continues to report nationally via the unify the care hours per patient day (CHPPD). CHPPD is a simple calculation by dividing the number of actual nursing (both registered and unregistered) hours by the number of patients. It therefore represents the number of nursing hours that are available to each patient. It is one part of the nursing workforce component of the model hospital, alongside other metrics. Table 5 (below) provides an overview of CHPPD for the ward areas in the past six months, the caveat to this is there is currently no set standard or benchmarking. Acuity and professional judgment must also be taken into consideration, therefore this metric has significant limitations. The previous staffing paper indicated that further national guidance was anticipated in order to further understand how CHPPD data could facilitate benchmarking with other similar Trusts.

The CHPPD implementation lead at NHSI has indicated the publication of guidance has been delayed and is now due to be published during Quarter 1.

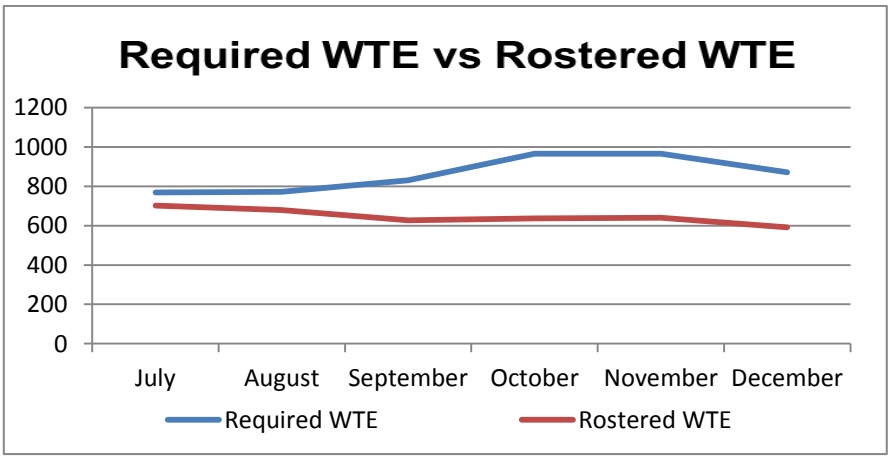
Table 5

	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
July	5.5	4.0	9.6
August	5.4	4.1	9.5
September	5.4	4.1	9.5
October	5.6	4.1	9.7
November	5.0	3.5	8.4
December	6.0	4.2	10.2
Average	5.49	3.99	9.48

SafeCare

SafeCare is an end-to-end software solution that is fully integrated with the current Healthroster system across the Trust. SafeCare provides the Trust with the ability to make just-in-time changes on the ground. The graph below provides a six month overview of the total hours required v worked.

Graph 6



The Deputy Director of Nursing and the Deputy Chief Operating Officer are working towards establishing the use of SafeCare in the Bed Meetings to inform decision making through the visualisation of the safecare wheel. Appendix 2 is an example of the visual reports that can now be produced on a daily basis to inform staffing decisions

10 Processes of Governance and Escalation for Safe Staffing

As previously highlighted, nurse staffing remains a significant risk within our wards, departments and community settings. To manage this risk effectively, the organisation has several assurance processes in place to enable appropriate daily oversight and is able to take appropriate action. Outlined below are several embedded processes to ensure tight operational grip.

Staffing Meetings

The Divisions hold a staffing meeting twice weekly to review rostered staffing levels for the week ahead, and the weekend to identify any areas of concern and solutions to address any concerns raised. The meeting is chaired by the Divisional Nurse Director and is supported by the Workforce team. The meeting also functions as a forum to review draft rotas for approval, and at review to highlight any suggestions for amendment before rosters are published. Registered Nurse shifts for the fortnight ahead are escalated to temporary staffing during these meetings. On a day to day basis, the Division identifies a Matron of the Day to review staffing levels for that day, and the 48hrs ahead to identify any staffing shortfalls and to move staff between clinical areas to address staffing concerns. As part of this daily review, Matrons refer to the electronic roster to review rostered staff, and the SafeCare system to identify the number of patients who require additional supervision. Following the review of electronic systems, the Matron of the Day visits all Ward areas to discuss patient acuity and dependency, and to review the level of care that patients who need additional supervision require, so that decisions about staff movement between areas is informed by this.

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

Incident Reporting

Work has continued across the organisation to encourage staff to feel confident and safe to report any incident or concern regarding staffing or training via the safeguard system. The Trust is in the top 25% of incident reporters nationally, as reported by the NRLS, and anecdotal assessments, based on reporting figures within the organisation, indicate that this position is likely to be held in the next published report. The ability of staff to report incidents, and their understanding of what to report is assessed as part of the Bolton Scheme of Care Accreditation (BoSCA). Appendix 3 provides an overview of all staffing incidences reported between July- December 2017

11 Conclusion

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

Trust-wide recruitment continues across all areas supported by the Professional Lead for Nursing Workforce.

There is a real need for a clear recruitment and retention strategy and it is anticipated that this will be implemented prior to the next comprehensive staffing review.

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

12 Recommendation

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

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

APPENDIX 1

Majors

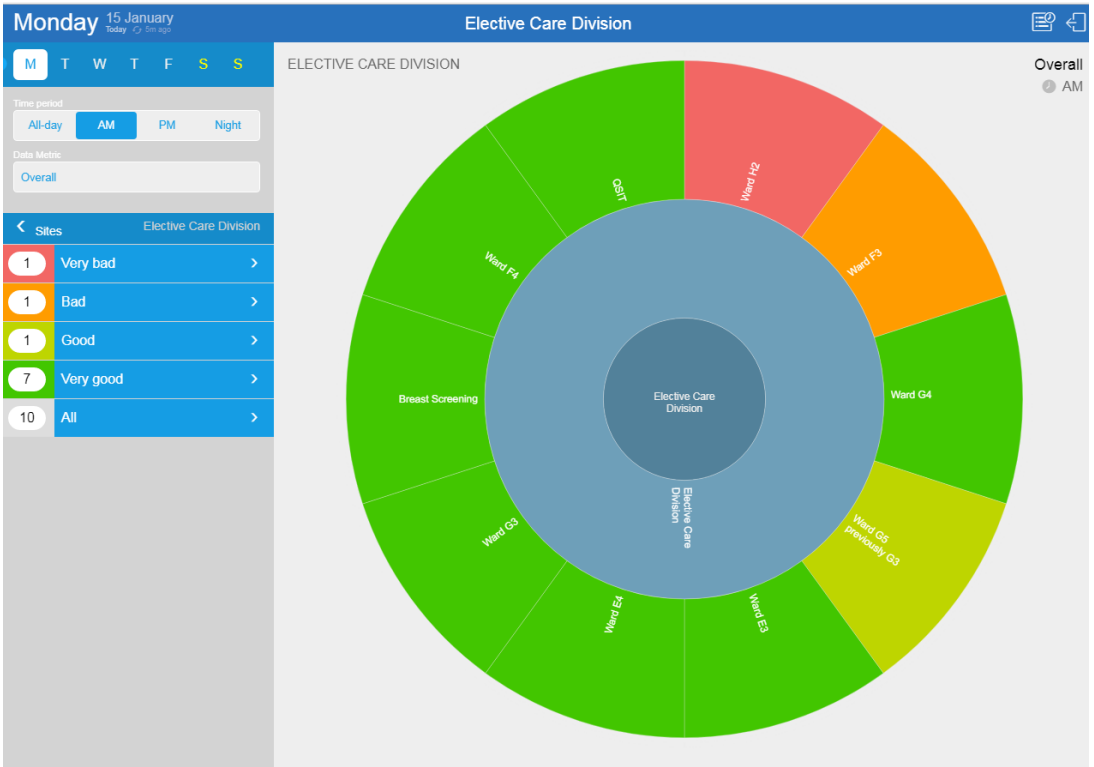
Staff grade	Establishment prior to upgrade	Establishment post build up grade	Current staff in post	Recruited staff not yet in post	Remaining gap to recruit by March
Band 6	20.04	25.54	25.08	0	0.46
Band 5	32.26	32.26	26.83	1.00	4.43
HCA (incl minors numbers)	14.49	24.19	22.50	3.00	0.00
Total	**66.79**	**81.99**	**74.41**	**4.00**	**4.89**

Minors

Staff grade	Establishment prior to upgrade	Establishment post build up grade	Current staff in post	Recruited staff not yet in post	Remaining gap to recruit by January
ENP	15.92	17.72	16.71	0.00	1.01
Total	**15.92**	**17.72**	**16.71**	**0.00**	**1.01**

APPENDIX 2


Monday 15 January
Today 2m ago
Acute Adult Care Division
M T W T F S S
Time period
All-day AM PM Night
Data Metric
Overall
Sites
Acute Adult Care Division
Bolton NHS Foundation Trust
Elective Care Division
Family Division
ACUTE ADULT CARE DIVISION
Overall
AM
Ward B2 (Contingency...
Ward B3
Ward C1
Ward D4
Ward D2
Acute Frailty Unit - B1
Contingency Beds (based on B4)
Ward D1
Ward B5 - Bluebell Unit
Ward C4
Ward H3
Ward A4
Ward C2
Ward C3
Clinical Decisions Unit
Coronary Care Unit
Acute Adult Care Division
Acute Adult Care Division


Monday 15 January
Today 5m ago
Elective Care Division
M T W T F S S
Time period
All-day AM PM Night
Data Metric
Overall
Sites
Elective Care Division
1 Very bad
1 Bad
1 Good
7 Very good
10 All
ELECTIVE CARE DIVISION
Overall
AM
Ward H2
Ward F3
Ward G4
Ward G5 (previously G3)
Ward E3
Ward E4
Ward G3
Breast Screening
Ward F4
GSST
Elective Care Division
Elective Care Division

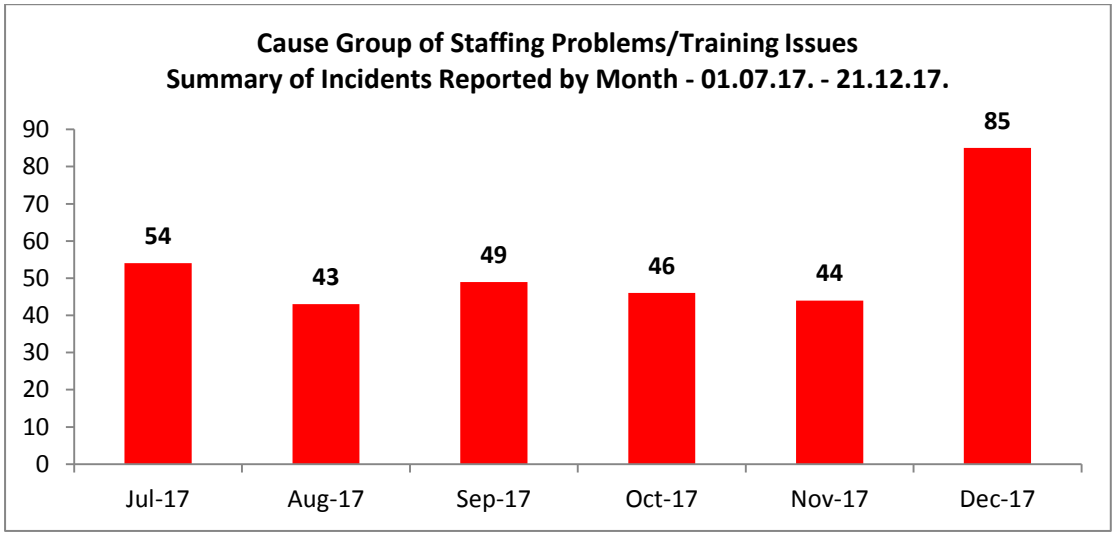
APPENDIX 3

Staffing Red Flags

Staffing Problems/Training Issues Incidents by Month

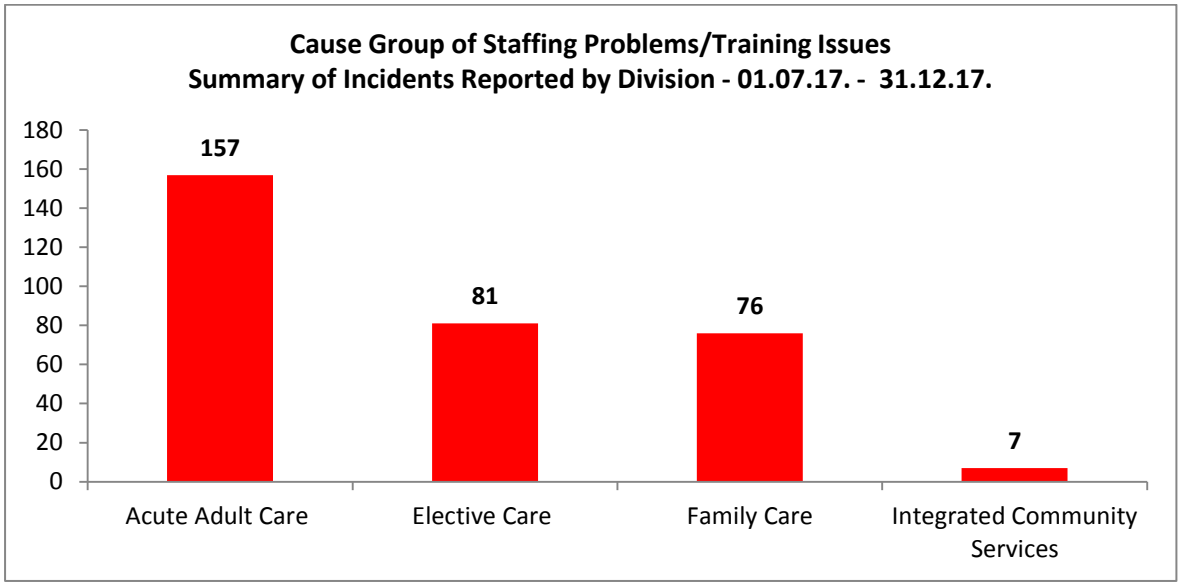
There were a total of 321 incidents reported under the 'Cause Group of Staffing Problems/Training Issues' on the Trust Safeguard Incident Reporting system during the 6 month period 1.7.17 to 31.7.17. For the purposes of this report which focuses mainly on nursing/midwifery staffing issues, only wards have been included.

A summary graph of incidents reported by month is shown below:-



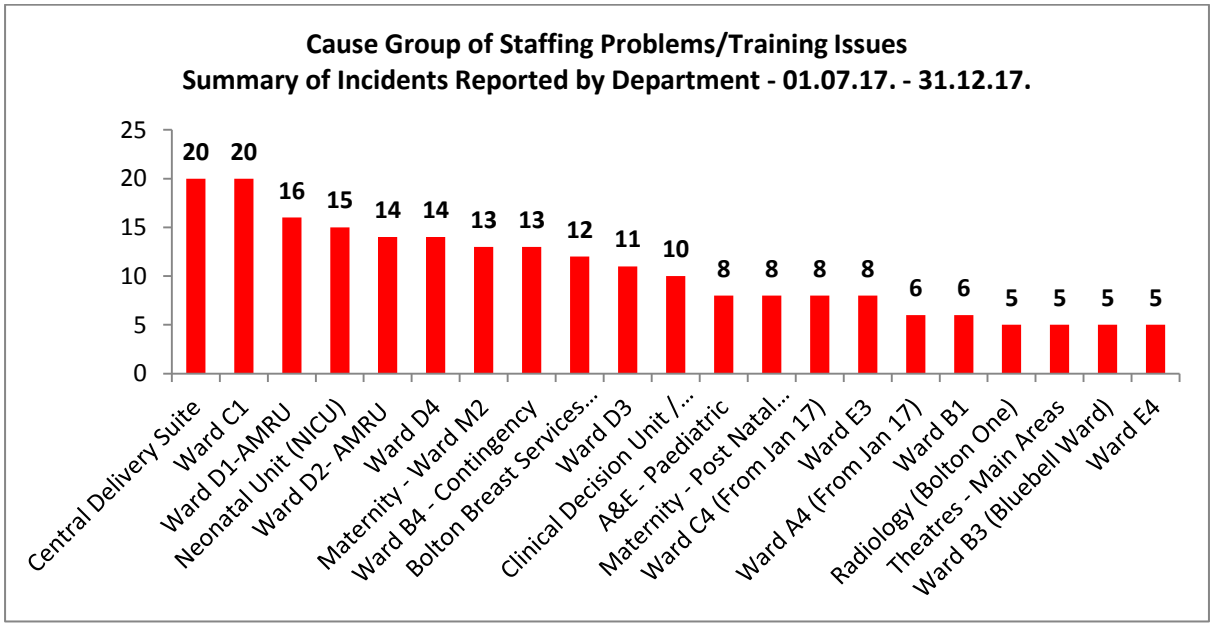
There is a sharp increase in December this year, compared to December 2016 when there were 58 incidents reported.

Staffing Problems/Training Issues by Division

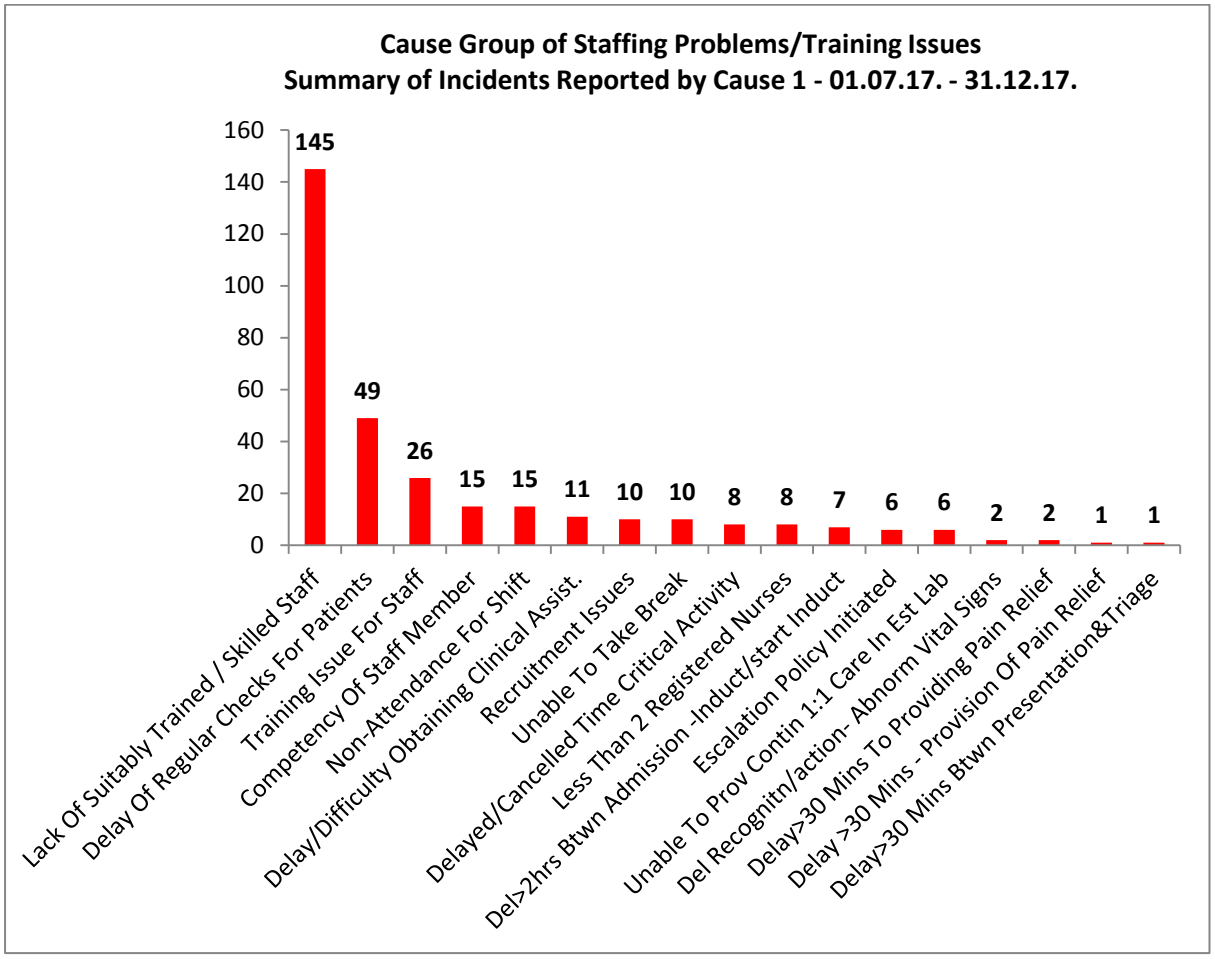


Acute Adult remains the highest reporting division for staffing related incidents – reporting 157 incidents during the period July to December 2017. This compares with a total of 178 incidents reported during the same period last year.

Staffing Problems/Training Issues by Department



Staffing Problems/Training Issues by Theme



Agenda Item No	

Meeting	Trust Board

Date	25th January 2018

Title	RTT – January Elective Inpatient Cancellations

Executive Summary	This paper outlines the impact of deferring inpatient elective activity during January 2018 to support non elective pressures. The paper describes the still considerable amount of elective activity carried out by the Trust during January despite the restrictions and notes the impact on the 18 week RTT standard.

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

Next steps/future actions	• Develop a recovery plan for the RTT standard • Agree next steps with CGG			
	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

RTT – January Elective Inpatient Cancellations

1. Background

On 2nd January 2018 NHS Improvement wrote to all health economies across the NHS instructing them to extend deferral of routine inpatient elective activity until the beginning of February 2018 to support non-elective pressures.

As part of the winter planning for 2017, Bolton FT had planned in advance to not schedule routine inpatient elective activity during the last week of December and the first 2 weeks of January to support non-elective pressures.

To mitigate some of the impact of not undertaking routine inpatient elective activity, between 26th December and 14th January, there was advance planning to focus on booking more day case procedures; this led to a proportion of the elective activity continuing during January.

2. Extending Elective Inpatient Activity Deferral

The extension to deferral of routine inpatient elective activity has resulted in patient cancellations and will have operational and performance impact on the RTT position. Table 1 below includes the number of patients cancelled broken down by specialty for the period 15-31st January 2018.

Table 1

Number of cancellations (15th – 31st January 2018)

Specialty	**Number of patients cancelled**
General Surgery	19
Trauma and Orthopaedics	60
ENT	38
Urology	6
Endoscopy	4
Breast	8
Gynae	2
Radiology	6
Oral Surgery	2
Total	**145**

3. Maintaining Elective Activity – Day case

Although the organisation has not undertaken any routine elective inpatient activity since December 26th, it has maintained a significant proportion of activity by targeting day case procedures, as demonstrated by information in Table 2 and 3. There has also been a continuation of inpatient activity for cancer, urgent and patients who would exceed 52 week wait.

Table 2

Activity undertaken (Day case / Elective) 1st January – 31st January 2018 – elective / urgent

Specialty/Month		January (Inc's TCI's booked 21/01/18 to 31/01/18)				
		Day Case		Elective		
Specialty Name		Total	Cancer	Total	Cancer	RTT %
100	General Surgery	429	14	58	7	
101	Urology	46	0	33	1	
110	Trauma & Orthopaedics	111	0	17	0	
120	Ent	54	0	18	0	
130	Ophthalmology	293	0	0	0	
140	Oral Surgery	129	0	23	0	
160	Plastic Surgery	54	6	0	0	
171	Paediatric Surgery	19	0	0	0	
180	Accident & Emergency	0	0	0	0	
190	ANAESTHETICS	38	0	0	0	
300	General Medicine	539	0	42	1	
301	Gastroenterology	7	0	0	0	
303	Clinical Haematology	85	0	0	0	
320	Cardiology	15	0	0	0	
340	Respiratory Medicine	4	0	1	0	
410	Rheumatology	5	0	0	0	
420	Paediatrics	18	0	0	0	
430	Geriatric Medicine	21	0	5	0	
502	Gynaecology	71	0	17	1	
810	RADIOLOGY	0	0	1	0	
Grand Total		**1938**	**20**	**215**	**10**	

4. Collaboration Work with CCG

The organisation is working with CCG colleagues on short term and long term plans to recover and manage RTT, the areas of focus include:

- Non-recurrent capacity requirements
    - Backlog analysis and clearance
- Recurrent capacity and productivity requirements
    - Review of core capacity to slow backlog growth
- Demand management
    - Meeting Demand Differently
    - Stopping Demand

5. Summary

The organisation had taken steps to plan in advance for the 3 weeks after Christmas by not scheduling any inpatient elective activity.

The extension of the deferral of routine elective activity that came from NHS Improvement on 2nd January led to a total of 145 patients being cancelled.

During the month of January the organisation carried 2183 elective procedures both day case (majority) and inpatient

In total 6% of potential elective activity was cancelled as a result of the NHSI guidance.

The biggest impact of the cancellations or not scheduling inpatient activity has been on Trauma & Orthopaedics, as G5 ward, which is a closed elective orthopaedic ward, has been open to non-elective patients to support the winter pressures.

RTT performance had already started to dip before the NHSI intervention, the cancellation although relatively small exacerbates the situation

Elective inpatient activity restarts from the beginning of February and the work continues with the CCG to establish plans to reduce the backlog of patients and look for long term solutions to some of the capacity and demand pressures.

Agenda Item No	
Meeting	Board of Directors
Date	
Title	Summary Performance Report – December 2017
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. A full pack of data against all indicators in the business plan and other monitoring information is provided.
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

Balanced Scorecard - Summary Performance

Trust Objective	Year to Date Performance	Forecast Year Performance
1: Quality of Care		
2: Operational Performance		
3: Leadership and Improvement		
4: Finance and Use of Resources		
5: Fit for the Future		

Trust Objective 1:

Quality of Care

Objective 1 - Quality of Care Summary

Year to date performance is rated as AMBER.

Areas of good performance to highlight are:

- Compliance with preventative measure for VTE % - 97.2% (Target 95.0%)
- All inpatient falls per 1000 bed days – 4.81 (Threshold 6.63)
- Total Pressure Damage due to lapses in care – 4 (Threshold 6)
- Staff completing Mandatory Training – 90.2% (Target 85.0%)

Areas where further work on performance is needed are:

- Total Hospital acquired infections
- Transfers between 11pm and 6am
- Same Sex Accommodation Breaches (MSA)
- Harms from falls
- Emergency patients screened for Sepsis (quarterly)

Total Hospital acquired Infections

C-Diff (CDT) infections

There were two Clostridium Difficile toxin positive cases in December 2017. One case has been reviewed at the harm free care panel and was determined to be a performance case. The second case has not yet been reviewed by the panel (planned date 22/01/18).

Year to date the Trust has reported 26 cases, of these, 13 in total had lapses in care and are considered as performance cases against the trust threshold of 19 cases. Given this level of performance at quarter two the Trust cannot achieve the NHSE assigned threshold of 19 CDT cases for 2017/18.

MRSA Bacteraemia Infections

There were one case apportioned to the Trust in December. A post infection review has been conducted and the final assignment will be to the Trust. This means there have been two Trust assigned MRSA cases for Bolton FT in 2017/18. The review identified that although the root cause of the infection may have been unavoidable and that the patient had been screened in line with Trust policy, the patient had acquired MRSA during the current admission.

Transfers between 11pm and 6am

Performance for December was the same as November (29). This issue is being scrutinised at IPM by the executive team. A dynamic portal report been put together and released to the DDOs to aid auditing of these transfers. This should help to ascertain if this is a recording or process issue or if they are transfers that should be clinically excluded from the denominator.

Objective 1 - Quality of Care Summary

Same Sex Accommodation Breaches (MSA)

In December 2017 there were 12 mixed sex accommodation breaches all related to patients from HDU/ICU and all related to capacity issues with the Trust bed base.

This issue remains a concern both internally and externally and the Trust remains focused on eliminating MSA.

Harms from Falls

The falls coordinator has now started in post and will undertake a full review of the current falls action plan for 2017/18 to ensure it remains robust.

On the basis that the actions outlined above are successful the objective of Quality of Care is forecast to be GREEN by the year end.

Objective 1 - Quality of Care

Key Performance Indicators

Trust Objective	Outcome Measure	Oversight Committee	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	14	29	1.6	3	2	1	2	5	4	5	3	4	4	1	3
			2017/18	19	14	26	1.6	4	2	1	6	3	5	2	1	2			
	Total Hospital acquired MRSA infections		2016/17	0	0	2	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			
	National Early Warning Scores to Gold standard		2016/17	85.0%	85.0%	89.0%	85.0%	72.0%	92.0%	91.0%	90.0%	91.0%	90.0%	92.0%	93.0%	90.0%	87.0%	89.0%	90.0%
			2017/18	85.0%	85.0%	96.0%	85.0%	95.0%	92.0%	95.0%	93.0%	93.0%	96.0%	94.0%	90.0%	96.0%			
Patients Receive safe and effective care	Compliance with preventative measure for VTE		2016/17	95.0%	95.0%	95.8%	95.0%	95.6%	96.7%	96.7%	94.9%	93.8%	95.2%	96.4%	95.9%	97.3%	97.7%	97.5%	95.7%
			2017/18	95.0%	95.0%	97.2%	95.0%	97.3%	98.5%	98.1%	98.4%	98.6%	97.6%	97.5%	96.0%	97.2%			
	Transfers between 11pm and 6am (excluding transfers from assessment wards)		2016/17	0	0	214	0	18	22	21	19	21	26	35	30	22	38	36	33
			2017/18	0	0	246	0	37	38	21	22	25	18	27	29	29			
	Same Sex accommodation		2016/17	0	0	77	0	3	6	3	4	9	15	12	18	7	18	16	24
			2017/18	0	0	98	0	21	10	11	10	6	18	4	6	12			
	Never Events		2016/17	0	0	2	0	1	0	0	1	0	0	0	0	0	0	0	0
			2017/18	0	0	1	0	1	0	0	0	0	0	0	0	0			
	Risk adjusted Mortality (ratio) (1 mth in arrears)		2016/17	90	90	91	90	86	87	89	88	89	90	91	91	102	105	105	105
			2017/18	90	90	87	90	102	100	98	96	93	88	87	87				
	Standardised Hospital Mortality (ratio) (quarterly in arrears)		2016/17	1.000	1.000	0.000	1.000		1.045			1.000			1.016			1.046	
			2017/18	1.000	1.000	1.070	1.000		1.043			1.080			1.070				
	Crude Mortality % (1 mths in arrears)		2016/17			1.8%		2.2%	2.1%	1.7%	1.6%	2.1%	1.9%	2.0%	1.8%	2.4%	3.1%	2.0%	1.9%
			2017/18			1.9%		2.1%	2.2%	1.6%	1.6%	2.2%	1.9%	2.1%	1.9%				
	All Inpatient Falls (Safeguard Per 1000 bed days)		2016/17	4.40	4.40	5.57	4.40	6.70	5.00	4.60	5.80	5.10	6.60	6.20	4.30	5.90	5.69	5.58	4.40
			2017/18	6.63	6.63	5.26	6.63	6.06	5.38	3.48	5.34	5.72	5.76	5.38	5.29	4.81			
	Inpatient falls resulting in Harm (Moderate +)		2016/17	No threshold set		1.8%		3.0%	1.3%	1.6%	1.3%	0.0%	3.3%	1.1%	1.5%	2.1%	1.9%	1.1%	7.5%
			2017/18			3.1%		4.0%	2.3%	0.0%	3.6%	4.5%	4.4%	2.4%	3.7%	1.3%			
	Acute Inpatients acquiring pressure damage (grd 2)		2016/17	No threshold set		64		11	8	7	4	14	2	4	2	12	7	7	4
			2017/18			45		3	4	5	7	2	5	3	3	13			
	Acute Inpatients acquiring pressure damage (grd 3)		2016/17	No threshold set		4		2	0	0	0	1	0	0	0	1	1	1	3
			2017/18			3		0	1	1	0	0	0	1	0	0			
	Acute Inpatients acquiring pressure damage (grd 4)		2016/17	No threshold set		0		0	0	0	0	0	0	0	0	0	0	0	0
			2017/18			0		0	0	0	0	0	0	0	0	0			
	Community patients acquiring pressure damage (grd 2)		2016/17	No threshold set		76		5	15	11	7	14	8	7	6	3	7	3	9
			2017/18			55		11	7	7	6	5	5	4	2	8			
	Community patients acquiring pressure damage (grd 3)		2016/17	No threshold set		35		1	7	2	2	5	6	2	6	4	10	4	2
			2017/18			31		0	9	2	0	7	5	1	5	2			
	Community patients acquiring pressure damage (grd 4)		2016/17	No threshold set		10		0	2	2	1	1	2	2	0	0	0	2	4
			2017/18			8		1	1	1	1	0	1	0	1	2			
	Total Pressure Damage due to lapses in care		2016/17	No threshold set		63		11	9	6	1	13	7	7	4	5	2	5	5
			2017/18	67	50	24	5.6	3	2	3	2	2	2	2	4	4			
	Maternity - Stillbirths		2016/17	48	36	22	4	0	2	3	3	3	3	2	1	5	2	1	4
			2017/18	48	36	20	4	6	1	2	4	0	0	2	2	3			
	Maternity -3rd/4th degree tears		2016/17	3.0%	3.0%	2.9%	3.0%	1.7%	3.2%	2.8%	3.0%	2.0%	2.5%	2.1%	3.8%	5.1%	1.6%	1.9%	1.2%
			2017/18	3.0%	3.0%	2.7%	3.0%	2.4%	3.4%	1.9%	2.4%	2.9%	2.4%	2.5%	2.9%	3.4%			
	Neonates - Infections per 1000 central line days		2016/17	12.5	12.5	7.7	12.5	6.8	7.8	0.0	16.5	8.3	7.5	8.0	7.2	7.2	0.0	18.9	0.0
			2017/18	12.5	12.5	10.0	12.5	9.5	9.3	35.0	0.0	15.4	0.0	11.0	9.9	0.0			
	CAMHS - Service user by session experience		2016/17	16.0	16.0	18.8	16.0	19.40	19.10	18.65	18.73	18.90	18.59	19.02	18.55	18.52	18.78	18.88	18.87
			2017/18	16.0	16.0	19.0	16.0	18.9	18.5	19.0	19.0	19.0	18.9	19.9	18.9	18.8			
	Patients going to theatre within 36 hours of a fractured Neck of Femur		2016/17	85.0%	85.0%	62.2%	85.0%	60.0%	59.0%	52.0%	57.0%	37.5%	58.0%	85.0%	68.0%	83.0%	72.0%	51.0%	72.0%
			2017/18	75.0%	75.0%	65.4%	75.0%	61.3%	77.4%	69.2%	57.1%	63.6%	56.4%	62.1%	74.3%	66.7%			
	TIA (Transient Ischaemic attack) patients seen <24hrs		2016/17	100.0%	100.0%	22.1%	100.0%	12.5%	46.7%	80.0%	33.3%	17.7%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			2017/18	100.0%	100.0%	31.9%	100.0%	0.0%	43.0%	50.0%	20.0%	60.0%	20.0%	26.0%	27.3%	41.2%			
	Emergency patients screened for Sepsis (quarterly, a month in arrears)		2016/17	90.0%	90.0%	84.5%	90.0%		83.0%			86.0%			94.0%			91.0%	
			2017/18	90.0%	90.0%	77.0%	90.0%		66.0%			77.0%							
	Patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly, a month in arrears)		2016/17	tbc	tbc	74.00%	tbc		80.0%			68.0%			57.0%			71.0%	
			2017/18	tbc	tbc	77.00%	tbc		89.0%			65.0%							
1.3 - Patients experience good care	Clinical Correspondence - Inpatients %<1 wk. day		2016/17	80.0%	80.0%	80.0%	80.0%	80.5%	79.6%	80.8%	80.3%	80.2%	77.2%	75.6%	78.5%	80.0%	79.2%	81.8%	80.0%
			2017/18	80.0%	80.0%	77.6%	80.0%	80.2%	77.8%	80.3%	82.2%	82.4%	80.9%	76.9%	75.3%	77.6%			
	Clinical Correspondence - Outpatients %<5 wk. days		2016/17	72.0%	72.0%	72.5%	72.0%	69.9%	75.9%	80.1%	82.9%	77.4%	66.8%	70.9%	77.2%	72.5%	73.2%	74.5%	76.4%
			2017/18	72.5%	72.5%	77.5%	72.5%	81.0%	81.0%	83.5%	82.6%	83.9%	88.6%	90.6%	89.3%	77.5%			

Objective 1 - Quality of Care

Trust Objective	Outcome Measure	Oversight Committee	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Both Staff and staffing levels are supported	Total Nursing Fill Rates - Minimum staffing rates achieved by employed / Agency staff		2016/17	100.0%	100.0%	95.8%	100.0%	99.1%	97.0%	96.8%	96.3%	96.3%	93.7%	95.1%	96.8%	95.8%	96.0%	97.3%	95.4%
			2017/18	100.0%	100.0%	89.6%	100.0%	95.4%	94.7%	93.3%	92.4%	74.4%	87.7%	86.4%	91.8%	89.6%			
	Registered Nurses fill rate		2016/17	100.0%	100.0%	90.8%	100.0%	93.2%	94.1%	95.5%	94.9%	92.7%	89.3%	90.5%	92.0%	90.8%	90.9%	93.0%	91.3%
			2017/18	100.0%	100.0%	88.7%	100.0%	91.3%	92.5%	90.0%	90.0%	73.3%	84.2%	84.2%	90.5%	88.7%			
	Unregistered Nurses fill rate		2016/17	100.0%	100.0%	103.9%	100.0%	109.1%	101.6%	98.8%	98.6%	101.9%	100.7%	102.8%	104.7%	103.9%	104.0%	104.0%	101.7%
			2017/18	100.0%	100.0%	90.8%	100.0%	101.7%	97.5%	98.0%	96.0%	76.4%	94.4%	90.7%	93.8%	90.8%			
	Total Bank shifts filled - Qualified Nurses		2016/17	66.0%	60.0%	74.4%	66.0%	78.8%	76.3%	71.7%	73.7%	71.7%	74.0%	76.5%	75.6%	74.4%	74.0%	78.4%	78.0%
			2017/18	66.0%	60.0%	74.4%	66.0%	79.2%	85.0%	79.3%	81.1%	87.4%	84.5%	81.4%	81.6%	74.4%			
	Total Agency Shifts filled		2016/17	70.0%	70.0%	45.2%	70.0%	52.2%	55.3%	57.3%	62.7%	63.3%	56.6%	56.9%	50.0%	45.2%	53.7%	55.7%	63.3%
			2017/18	70.0%	70.0%	57.6%	70.0%	64.4%	66.9%	61.7%	60.2%	58.6%	63.8%	57.0%	64.9%	57.6%			
	Staff completing Statutory Training		2016/17	95.0%	95.0%	92.6%	95.0%	95.4%	94.9%	94.1%	93.2%	92.9%	92.5%	93.0%	92.5%	92.6%	93.0%	92.7%	92.5%
			2017/18	95.0%	95.0%	92.9%	95.0%	92.4%	92.8%	93.1%	93.8%	92.9%	92.2%	92.4%	91.9%	92.9%			
	Staff completing Mandatory Training		2016/17	85.0%	85.0%	89.0%	85.0%	91.1%	91.3%	91.3%	90.1%	88.7%	88.0%	88.9%	88.8%	89.0%	89.2%	88.7%	89.1%
			2017/18	85.0%	85.0%	90.2%	85.0%	88.9%	89.3%	89.6%	90.7%	89.0%	88.7%	89.3%	89.2%	90.2%			
	Staff completing Safeguarding Training		2016/17	95.0%	95.0%	92.8%	95.0%	96.6%	95.8%	93.3%	92.2%	91.4%	91.1%	91.9%	91.4%	92.0%	92.2%	92.7%	92.4%
			2017/18	95.0%	95.0%	93.2%	95.0%	92.3%	93.0%	93.4%	94.1%	92.8%	92.2%	92.6%	91.8%	93.2%			
	Local Induction		2016/17	85.0%	85.0%	72.9%	85.0%	81.3%	81.4%	82.6%	82.0%	82.8%	77.8%	77.8%	74.7%	72.9%	72.6%	71.8%	68.8%
			2017/18	85.0%	85.0%	75.6%	85.0%	69.4%	74.2%	78.2%	80.3%	81.0%	81.0%	73.9%	63.5%	75.6%			

See Key Performance Indicators Exceptions below.

Objective 1 - Quality of Care

Trust Wide Objectives	
1.1 - Reduce Healthcare acquired infections	Compliance with antibiotic prescribing standards
	Infection Control Champions in all clinical areas

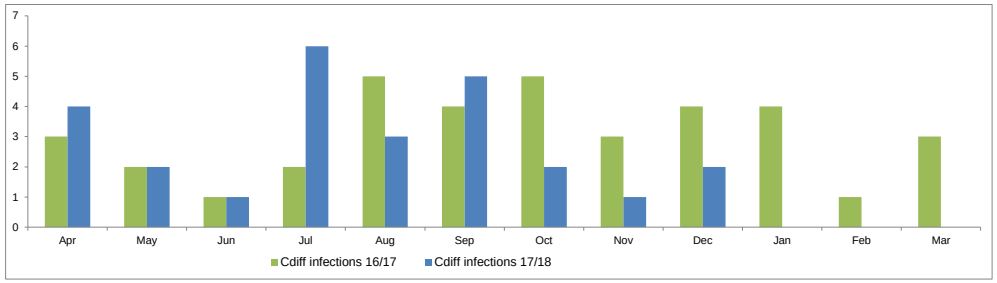
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Rag guide for Objectives
Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Objective 1 - Quality of Care

Key Performance Indicator Exceptions

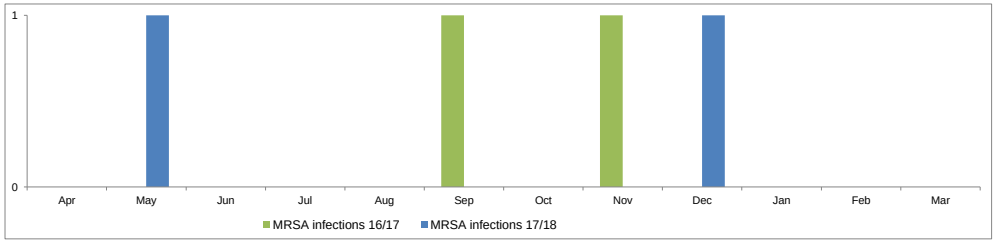
Total Hospital acquired C-Diff infections



Narrative:

Year to date the Trust has reported 26 cases, however as per the agreement with the CCG in relation to apportionment only 13 of these are classed as performance cases. This level of performance at quarter three means it will no longer be possible to achieve the 19 performance case yearly threshold applied to the Trust via NHSE.

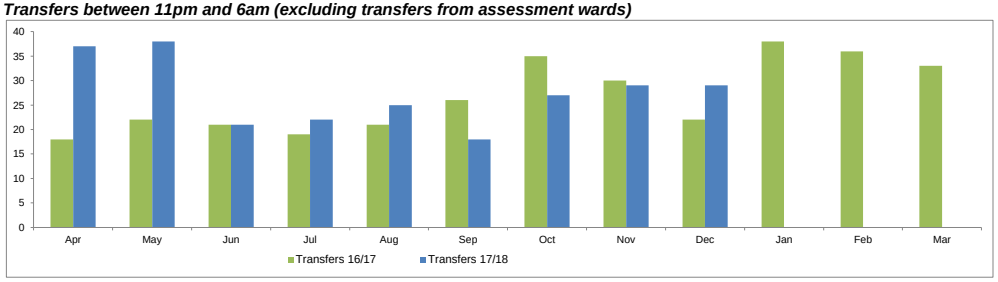
Total Hospital acquired MRSA infections



Narrative:

There was one new case assigned to the Trust in December. There are currently two cases assigned to the Trust.

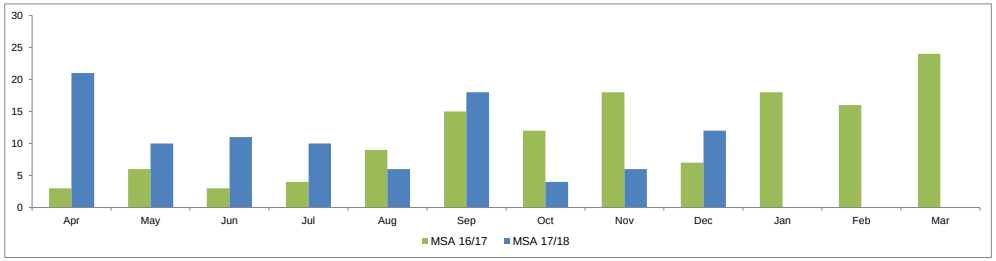
Transfers between 11pm and 6am (excluding transfers from assessment wards)



Narrative:

Performance for December was the same as November, with 29 transfers between 11pm and 6am (26 in October) and 32 more than the same point in time last year, year to date. These figures now exclude transfers to assessment wards and CCU, with this change being made retrospectively to aid comparison. This issue is being scrutinised at IPM by the executive team. A dynamic portal report has been put together and released to the DDOs to aid auditing of these transfers. This should help to ascertain if this is a recording or process issue or if they are transfers that should be clinically excluded from the denominator.

Same Sex accommodation



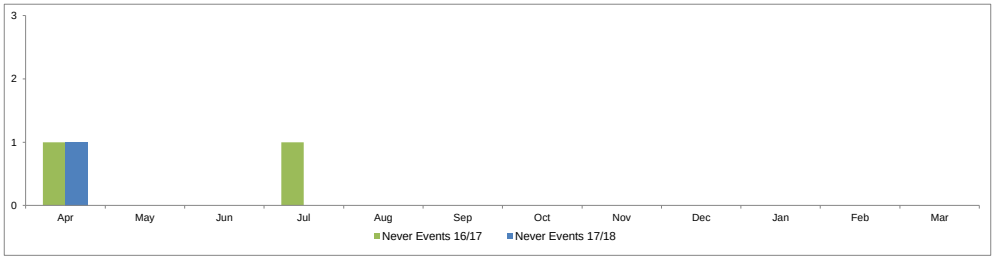
Narrative:

In December 2017 there were 12 mixed sex accommodation breaches related to patients from within HDU / ICU, all relating to capacity issues within the Trust bed base. Patient flow issues have impacted significantly on this patient quality / experience metric in month. Performance in month saw an increase of 6 breaches on that reported in the previous month, and cumulative performance shows 98 breaches compared to 77 at the same point last year. This issue remains a concern both internally and externally and the Trust remains focused on eliminating MSA.

Objective 1 - Quality of Care

Key Performance Indicator Exceptions

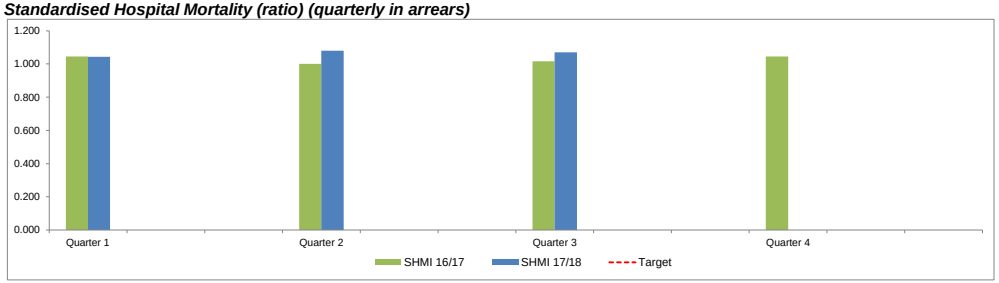
Never Events



Narrative:

There were no never events in December. Given one was reported in April this indicator will stay red throughout the year as the target is zero for the entire year.

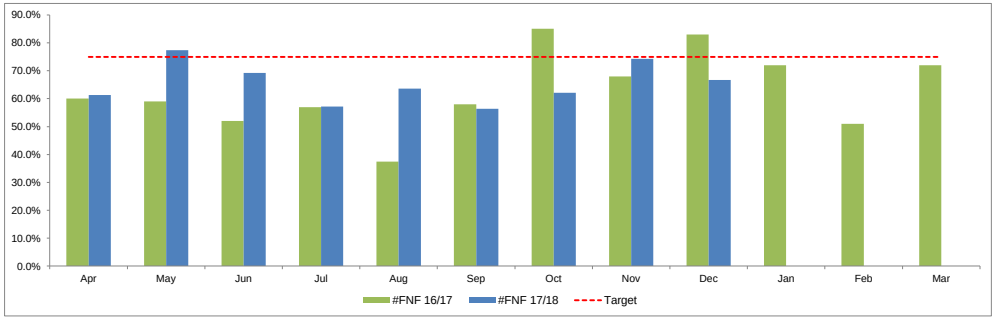
Standardised Hospital Mortality (ratio) (quarterly in arrears)



Narrative:

Standardised Hospital Mortality Index (SHMI) is the ratio of observed deaths for a given demographic catchment of a Trust compared with the expected volume. A mortality ratio of 1.000 is anticipated for each Trust which means that observed mortality is equal to that expected, variance to this is examined down to root diagnosis at the Trust (MRG) SHMI is showing a variance to the expected position with performance in the rolling twelve month period of July 2016 to June 2017 of 1.070 (7% - more deaths in the period than expected). The Trust Mortality Reduction Group (MRG) routinely focuses on issues relating to reducing overall mortality and improving patient outcomes on a monthly basis.

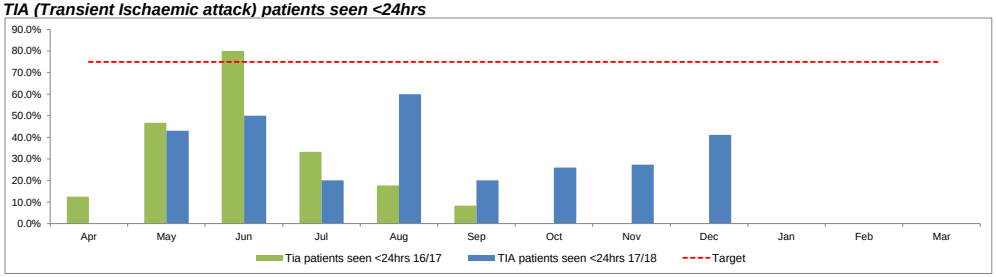
Patients going to theatre within 36 hours of a fractured Neck of Femur



Narrative:
33 patients admitted in December (3 patients admitted under 60 years)
30 patients eligible; 20 patients met 36 hours to theatre = 67%

Reasons for non compliance
4 – Lack of capacity
1 – On apixaban
3 – Needed hip surgeon
2 – Cancelled due to other emergency trauma

TIA (Transient Ischaemic attack) patients seen <24hrs



Narrative:

Validated performance for December has increased to 41.2% from the 27.3% reported in November in relation to high risk TIA patients being seen within 24 hours of referral when compared to the trust target of 75%. Historically there are two main contributory factors to Trust performance:

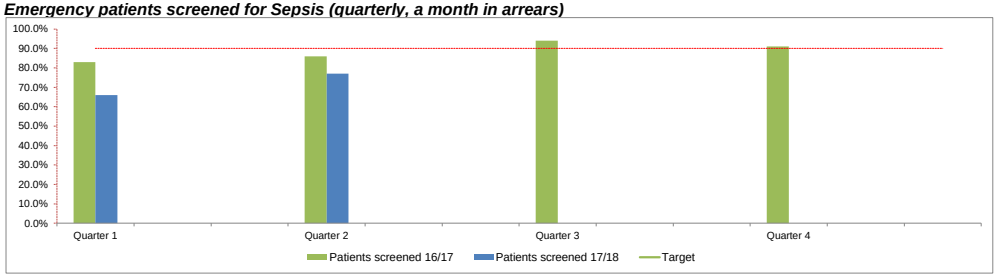
1) Capacity
2) Process of referral and booking

The Trust has provided the CCG with an action plan to address the issues and continues to monitor performance through Divisional and Executive IPMs.

Objective 1 - Quality of Care

Key Performance Indicator Exceptions

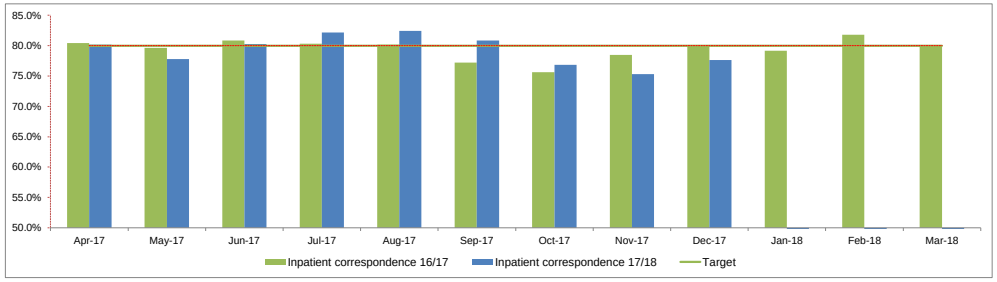
Emergency patients screened for Sepsis (quarterly, a month in arrears)



Narrative:

Performance in relation to emergency patients screened for sepsis increased in quarter two to 77% from 66% reported in quarter one, this is however still someway below the national target of 90%, although the numbers involved in this are relatively small. The quarter two audit was performed on schedule using existing methodology. Performance is driven and tracked as part of a national CQUIN. Performance for quarter two for CQUIN was a pass against a locally agreed CQUIN target of 70% with 90% being the target for quarter four.

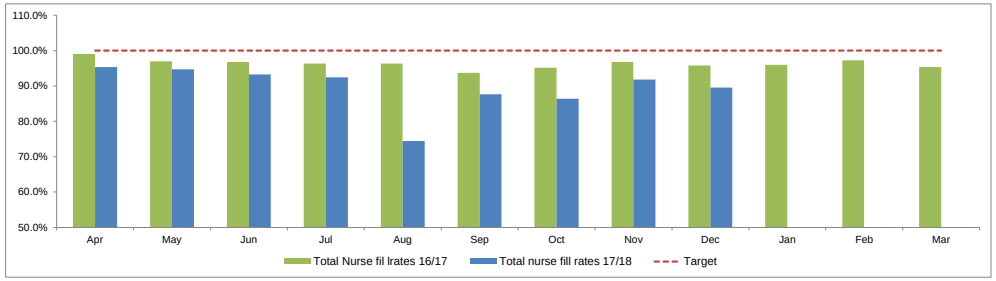
Clinical Correspondence - Inpatients %<1 wk. day



Narrative:

Correspondence performance for inpatients has shown a slight improvement on the previous month, though still below the trust target of 80%.

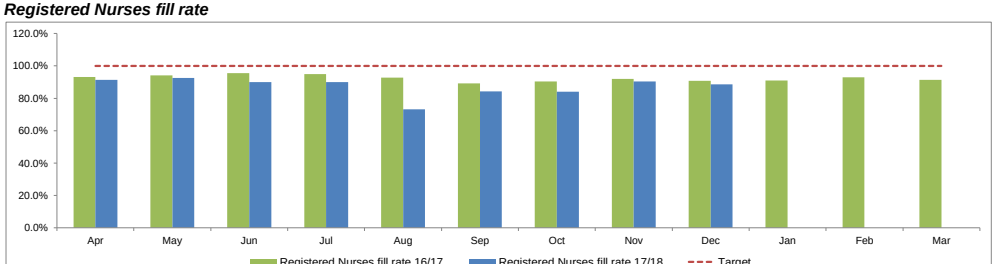
Total Nursing Fill Rates - Minimum staffing rates achieved by employed / Agency staff



Narrative:

Minimum staffing rates have not been achieved all year and are lower than last year.

Registered Nurses fill rate

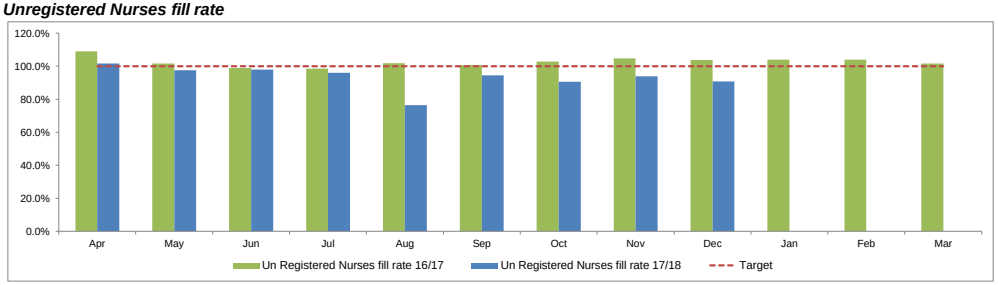


Narrative:

Registered Nurses fill rates have not been achieved all year and are marginally lower than last year.

Key Performance Indicator Exceptions

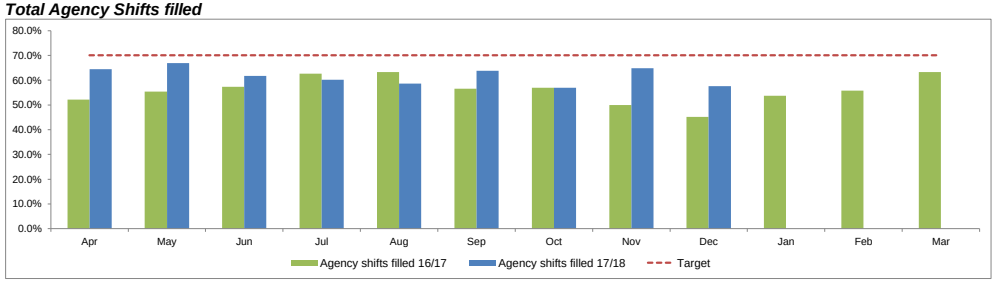
Unregistered Nurses fill rate



Narrative:

Unregistered Nurses fill rates although not achieved recently are higher than registered nurse fill rates and are marginally lower than last year.

Total Agency Shifts filled

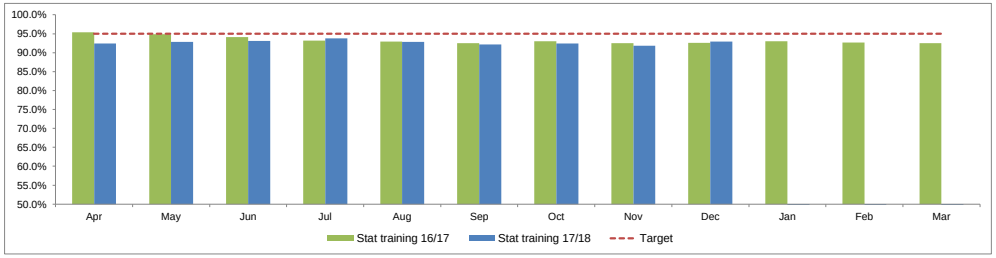


Narrative:

57.6% of agency shifts were filled in December against the planned threshold of 70%, a decline on previous month's performance (64.9%), though better than the same point last year (45.2%).

This measure is difficult to read in isolation given that one of the Trust objectives is to reduce agency use, and agency staff are therefore frequently requested late. It also needs to be reviewed alongside bank staff fill rates, which show that 74.4% of shifts offered out to bank staff are filled.

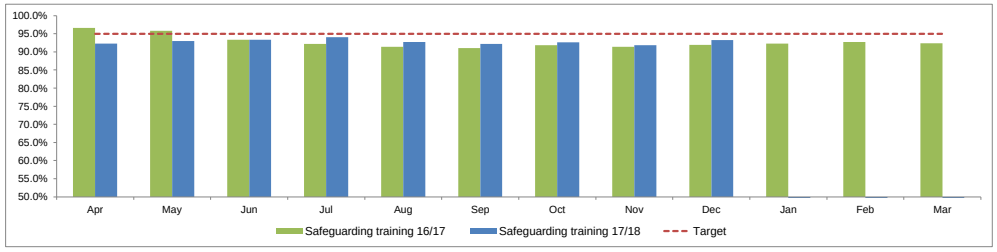
Staff completing Statutory Training



Narrative:

Statutory training compliance stood at 92.9% in December against the target set of 95% and was slightly up on last year's position (92.6%). By type, some training compliance is consistently high and above the 95% target for example safeguarding for non clinical staff. Other subjects score much less well for example fire safety. Staff generally cite difficulties in being released from their immediate responsibilities in explaining poor performance. In respect of clinical divisions, acute adults face the greatest challenges, elective and families division are generally very close to the 95% target.

Staff completing Safeguarding Training



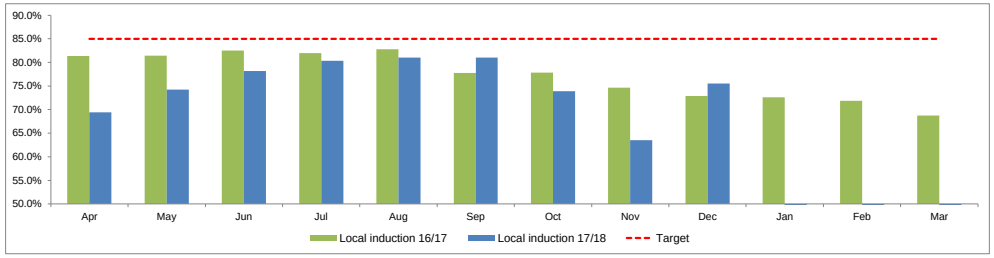
Narrative:

Safeguarding training for appropriate staff has been below the Trust target of 95% since May 2016, December 2017 performance was 93.2% which although below the target is above the position reported in December last year of 92%.

Objective 1 - Quality of Care

Key Performance Indicator Exceptions

Local Induction



Narrative:

Local induction performance has again shown a significant improvement in performance this month (75.6%), compared to November (63.5%), and is also better than the same month last year (72.9%), although is still some way from the 85% trust target.

Board Assurance Heat Map - Hospital - December 2017

	INDICATOR	Darley Court	AED-Adults	AED-Paeds	B1 (Frailty Unit)	A4	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	H3 (Stroke Unit)	HDU	ICU	E3	E4	F3	F4	G3/TSU	G4/TSU	G5	DCU (daycare)	EU (daycare)	H2 (daycare)	UU (daycare)	E5 (Paed HDU and Obs)	F5	M1 and Assessment	EPU	M2	CDS	M3 (Birth Suite)	M4/M5	NICU	Total
		Acute Division																		Elective Division													Families Division										
Beds	Total Beds (2017)	30			22	22	21	26	25	26	26	27	10	14	26	22	27	27	24	10	8	25	25	25	23	24	24	16	12	9	11	4	38	7	17	6	26	15	21	44	28	793
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	100.0%	100.0%	non return	95.0%	100.0%	80.0%	20.0%	90.0%	non return	non return	non return	80.0%	75.0%	non return	90.0%	75.0%	non return	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	95.0%	100.0%	95.0%	100.0%		70.0%		100.0%	70.0%	100.0%	100.0%	100.0%	91.4%
	Environment Audit Compliance %	89.0%			100.0%	100.0%	95.0%	67.0%	78.0%	89.0%	89.0%	84.0%	100.0%	84.0%	95.0%	95.0%	95.0%	100.0%	84.0%	100.0%	100.0%	100.0%	84.0%	95.0%	89.0%	95.0%	83.0%	95.0%	100.0%	100.0%	94.0%	100.0%	94.0%		89.0%		100.0%	89.0%	100.0%	89.0%	94.0%	92.6%
	Mattress Audit Compliance %	100.0%			non return	non return	non return	non return	non return	non return	non return	67%	100%	100%	100%	95%	83%	91%	non return	100%	100%	100%	100%	100%	67%	100%	100%	100%			100%		99%		100%		100%	100%	100%	100%	100%	96.1%
	C - Diff	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	MRSA acquisitions	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Harm Free Care	Safety Express Programme Harm Free Care (%)	96.7%			100.0%	95.5%	90.5%	96.2%	96.0%	90.0%	100.0%	100.0%	100.0%	90.0%	100.0%	95.0%	96.2%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	non return	non return	non return	non return	non return		100.0%	100.0%	100.0%	100.0%	non return	100.0%	100.0%	97.8%
	All Inpatient Falls (Safeguard)	7	4	0	3	8	6	6	3	7	4	7	3	3	0	3	3	4	2	0	0	2	4	0	0	1	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	83
	Harms related to falls (moderate and above)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VTE Assessment Compliance				100.0%	100.0%		28.6%	100.0%	100.0%	94.8%	0.0%	100.0%	97.6%	94.5%		81.0%	86.4%	83.3%	100.0%	100.0%	87.5%	100.0%	96.7%	78.3%	95.6%	97.3%	98.1%	100.0%	99.4%	100.0%	95.2%			97.1%	100.0%	99.6%	100.0%	96.9%	98.4%		97.2%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	4	0	0	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
	Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	PU due to lapses in care	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Audit	Monthly KPI Audit %	97.2%	77.0%		76.8%	88.9%	85.7%	69.0%	82.5%	82.6%	82.5%	78.9%	100.0%	68.2%	91.6%	91.3%	70.0%	76.3%	78.4%	100.0%	100.0%	98.2%	97.7%	93.2%	100.0%	93.0%	97.0%	95.7%					98.2%		98.4%		91.3%	98.4%	94.7%	90.6%	97.2%	89.1%
	Bolton System of Care Accreditation (BoSCA)	60.5%			61.7%	80.3%	70.9%		68.1%	60.1%	75.1%	57.7%	90.2%	80.7%	80.4%	50.6%	82.2%	61.8%	75.1%	90.2%	95.1%	82.6%	90.6%	79.2%	90.6%	85.9%	80.7%	90.7%					80.8%		76.0%		73.9%	86.9%	90.5%	79.7%		77.6%
Patient Experience	Friends and Family Response Rate	100.0%	15.6%	6.2%	32.1%	31.7%	36.4%	0.0%	27.2%	54.9%	38.9%	33.9%	38.5%	20.5%	23.8%	35.8%	41.1%	46.5%	48.1%	55.6%	12.5%	34.5%	32.6%	25.6%	34.6%	13.0%	34.3%	50.6%	37.4%	47.2%	34.0%	33.3%	14.8%		16.9%		15.3%	20.7%	36.8%	35.4%	0.0%	32.0%
	Friends and Family Recommended Rate	84.0%	84.0%	74.2%	94.1%	92.3%	100.0%	0.0%	92.0%	100.0%	100.0%	100.0%	100.0%	87.2%	86.1%	93.0%	100.0%	97.0%	84.6%	100.0%	100.0%	94.7%	100.0%	95.6%	100.0%	88.9%	87.5%	95.3%	96.7%	96.4%	95.5%	100.0%	97.9%		95.6%		98.6%	91.0%	100.0%	96.2%	0.0%	89.4%
	Number of complaints received	0	3	1	0	1	1	1	0	0	0	0	0	1	0	0	2	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	14
Governance	SIs in Month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Incidents	28	45	13	13	19	33	26	10	14	12	27	4	22	41	30	21	21	7	26	21	12	23	11	16	27	20	12	13	15	3	6	19	6	12	1	3	51	11	6	50	**750**
	Harms related to Incidents (Moderate and above)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	0	0	1	0	**8**
Staff Development	Appraisals	94.6%	70.4%	70.4%	50.0%	60.0%	81.8%		48.5%	94.9%	76.9%	51.3%	55.2%	50.0%	60.0%	56.8%	84.6%	35.3%	72.7%	82.9%	94.4%	60.0%	76.9%	77.5%	91.7%	74.5%	85.4%	88.9%	93.3%	86.6%	65.0%	82.4%	100.0%		73.9%		72.5%			83.5%	73.6%
	Statutory Training	96.23%	92.22%	92.22%	83.64%	89.90%	84.69%		81.78%	97.42%	84.39%	79.34%	93.03%	87.16%	83.38%	83.72%	92.51%	91.86%	90.31%	95.83%	95.66%	86.96%	85.23%	92.58%	89.94%	91.02%	84.14%	96.75%	97.55%	92.46%	94.65%	88.89%	97.7%		96.71%		91.9%			99.09%	90.6%
	Mandatory Training	94.4%	75.2%	75.2%	76.3%	75.7%	74.7%		76.0%	85.9%	77.0%	69.7%	81.8%	73.0%	68.9%	71.0%	78.2%	79.6%	74.4%	80.7%	80.4%	70.9%	65.8%	92.3%	80.6%	78.0%	71.7%	76.6%	83.2%	87.8%	77.3%	90.6%	98.1%		79.8%		74.3%			98.0%	79.2%
Staffing & Workforce	% Qualified Staff (Day)				78.3%	93.6%	79.3%		80.1%	87.3%	89.8%	88.2%	96.6%	106.3%	94.8%	95.2%	102.7%	93.3%	82.8%	88.9%	103.1%	95.4%	93.0%	71.6%	107.5%	100.0%	98.9%	93.7%					99.3%		75.1%		93.7%	84.5%	79.0%	86.9%	72.2%	90.4%
	% Qualified Staff (Night)				101.9%	99.6%	102.3%		98.3%	98.3%	100.1%	100.3%	100.0%	98.5%	98.3%	101.9%	111.2%	109.6%	100.0%	96.6%	82.8%	109.6%	101.1%	93.2%	106.3%	100.0%	86.5%	99.0%					87.3%		100.9%		97.8%	91.1%	74.2%	93.0%	82.6%	97.4%
	% un-Qualified Staff (Day)				93.9%	108.6%	93.8%		93.2%	98.1%	99.6%	95.8%	146.5%	111.3%	90.1%	79.2%	99.0%	99.3%	105.2%	73.4%	76.4%	99.8%	104.3%	96.5%	90.7%	103.4%	93.6%	99.7%					48.9%		76.7%		96.7%	84.1%	45.3%	61.5%	0.0%	88.8%
	% un-Qualified Staff (Night)				95.0%	134.5%	99.7%		98.7%	100.0%	100.1%	105.9%	100.0%	133.0%	85.1%	108.3%	108.9%	101.6%	97.8%	3.3%	36.7%	95.9%	105.3%	101.7%	82.2%	103.4%	141.7%	96.7%					80.7%		136.4%		100.0%	98.7%	53.0%	75.8%	0.0%	92.7%
	Current Budgeted WTE (From Ledger)	43.38	122.12		38.03	32.82	43.34		33.71	41.38	42.69	40.69	26.93	19.97	50.83	40.30	38.51	38.47	36.15	39.58	54.29	30.21	35.52	37.79	29.41	41.63	41.83	18.07	27.14	37.72	36.87	15.88	66.44		25.72		267.68			106.59	1,601.69
	Actual WTE In-Post (From Ledger)	38.60	130.69		36.09	31.09	41.44		29.39	37.81	35.20	38.85	26.41	19.12	46.65	37.56	35.69	37.17	31.79	38.43	50.60	29.63	36.32	36.31	28.80	42.45	38.11	16.79	25.68	45.74	41.20	14.55	58.92		20.00		254.15			95.94	1527.17
	Actual Worked (From Ledger)	44.17	136.86		40.56	37.48	45.48		36.07	40.12	40.54	43.91	25.56	21.33	51.58	39.86	41.59	41.26	35.73	37.43	50.96	32.01	41.08	39.86	34.74	46.06	42.86	19.21	26.88	46.83	40.88	14.88	62.33		22.12		251.40			91.39	1623.02
	Sickness (%) (Dec)	10.31%	5.91%	5.91%	12.21%	12.33%	13.33%		7.03%	6.68%	4.88%	10.63%	6.48%	6.46%	3.59%	3.16%	5.15%	14.76%	19.87%	3.72%	7.00%	3.25%	6.49%	2.76%	18.68%	5.64%	8.96%	12.76%	12.48%	3.31%	6.26%	0.83%	3.03%		5.17%		8.60%			6.42%	7.77%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)	4.78	-11.57	0.00	0.94	1.73	1.90		4.32	2.96	4.49	1.84	0.52	0.85	4.18	1.74	2.82	1.30	4.36	1.15	1.69	-1.42	-0.80	-0.52	0.61	-1.82	3.72	-2.72	0.82	-10.02	-4.33	1.33	4.52		3.72		5.61			10.65	39.35
	Pending Appointment		3		1					0.61	3					1					2	2		2		1		4	0.64	2			3		2		7.9				35.17
	Substantive Staff Turnover Headcount (rolling average 12 months)	13.6%	16.3%	16.3%	11.9%	17.1%	12.0%		16.7%	14.0%	16.7%	7.5%	8.8%	14.3%	13.5%	8.1%	15.8%	16.2%	5.1%	6.4%	14.8%	27.3%	20.0%	11.9%	12.1%	20.0%	6.8%	10.0%	12.1%	12.7%	7.5%	5.9%	16.9%		3.6%		6.9%			13.5%	12.7%

Data Legend

No data returned

No Eligible patients

Friends and Family (Staff) - Data during Q3 is not recorded due to the national survey
Monthly New pressure Ulcers (Grade 2+)
WTE data is for Nursing staff only. The figures do not include Admin, Therapists or Doctors.

Bolton NHS Foundation Trust

Bolton NHS Foundation Trust

Board Assurance Heat Map - District Nursing Domiciliary - December 2017

INDICATORS	Avondale and Chorley old Road	Breightmet & Little Lever	Crompton	Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Total
Safety Express Programme Harm Free Care (%)													
Total Monthly New pressure Ulcers (Grade 2+)(Lapse in Care + No Lapse in Care)	1	4	4	0	1	0	0	0	1	0	0	0	11
Total Monthly New pressure Ulcers (Grade 2+) *(No Lapse in Care only)*	1	4	4	0	1	0	0	0	1	0	0	0	11
High Dependency Patients (40 Minutes >)	186	278	173	267	415	183	270		359	251	97		2479
Medium Dependency Patients (21 Mins >)	984	850	1697	729	1094	631	912		1448	751	590		9686
Low Dependency Patients (< 20 mins)	426	418	944	218	951	562	744		802	369	726		6160
Number of Home Visits (from Lorenzo) **	123	50		124	131	365	253	135	191	131	181	1765	3449
Monthly KPI Audit % (Revised Buddy Assessed Audit)	96.40%	97.59%	92.41%	96.71%	88.22%	88.67%	95.94%	88.80%	93.71%	98.86%	94.69%	98.27%	94.19%
BoSCA - Bolton Safe Care Accreditation	92.00%	82.80%	81.42%	90.54%	85.89%	81.03%	92.30%	83.88%	83.88%	91.64%	77.64%	76.16%	84.93%
Current Budgeted WTE	11.64	12.92	16	8.13	18.24	7.11	13.12	16.13		9.13	12.09	19.96	144.47
Actual WTE In-Post	11.04	12.32	16.38	7.13	16.07	8.11	12.84	17.40		8.73	8.6	17.92	136.54
Actual WTE Worked	11.26	12.33	16.82	7.43	17.33	7.61	12.84	16.94		9.28	8.60	18.38	138.82
Pending Appointment	1	1	0.5	0.0	1.8	0.0	0.0		1	1	0.8	0	7.10
Current Budgeted Vacancies (WTE)	0.6	0.6	-0.38	1.00	2.17	-1.00	0.28	-1.27		0.40	3.49	2.04	7.93
Sickness (%) Nov 2017	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	6.18%	5.04%
Substantive Staff Turnover Headcount (rolling average 12 months) Dec 2017	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	6.94%	15.63%	8.52%
12 month Appraisal Dec 2017	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	89.4%	96.67%	90.7%
12 month Statutory Training Dec 2017	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.91%	95.83%	95.90%
Number of complaints received	0	0	0	1	0	0	0	0	0	0	0	0	1
Total Incidents reported on Safeguard (see end total column)	8	14	6	5	8	4	9	10	6	8	5	0	83

Trust Objective 2:

Operational Performance

Objective 2 - Operational Performance Summary

Year to date performance is rated as AMBER.

Areas of good performance to highlight are:

- Cancer Performance - All achieved except for first appointment from urgent cancer referral to be within 11 days (stretch target). 62 day standard and Breast 2 week waits (symptomatic)
- Readmissions within 30 days - 12.7% (Target 13.5%)
- Day case rates % - 84.5% (Target 80%)

Areas where further work on performance is needed are:

- RTT Incomplete pathways within 18 weeks %
- Breast 2 week waits symptomatic
- A&E 4 hour target and Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 minutes)

RTT Incomplete Performance

Performance of this constitutional indicator has remained below the target for the third month with performance in month of 88.8%. 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.

Breast 2 week waits symptomatic

Performance in November 2017 was 86.9% against the national target of 93%. Referral numbers for breast have continued to be at an elevated level overall. This is a significant improvement on past months and is on track to recover the position by the end of December 2017.

A&E 4 hour target and Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 minutes)

A&E performance in December 2017 was 76.9%; this was a further 3.5% reduction on the previous month and 2.3% worse than the same month last year. Performance in December 2017 was 13.1% worse than the improvement trajectory agreed with NHSI of 92.0%.

In December 2017, 117 patients waited more than 60 minutes for ambulance handover at the Trust compared to 259 for the same period last year and 212 in November 2017.

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

On the basis that the actions outlined above are successful the objective of Operational Performance is forecast to be AMBER by the year end.

Objective 2: Operational Performance

Key Performance Indicators

Trust Objective	Outcome Measure	Oversight Committee	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
To Deliver the NHS Constitution, achieve Monitor standards and contractual targets	RTT Incomplete pathways within 18 weeks %	DDO's Clinical Divisions	2016/17	92.0%	92.0%	92.5%	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%	88.8%	92.0%	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%			
	RTT 52 week waits (incomplete pathways)		2016/17	0	0	6	0	0	0	0	0	0	3	2	1	0	3	2	1
			2017/18	0	0	20	0	5	1	1	4	3	2	1	1	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	6	0	2	1	1	0	0	2	0	0	0			
	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	8	0	0	2	1	0	2	0	1	2	0			
	First appointment from urgent cancer referral to be within 11 days (1 mth in arrears)		2016/17	93.0%	93.0%	89.4%	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%	68.4%	93.0%	63.7%	84.1%	71.7%	69.3%	69.2%	63.3%	66.1%	68.4%				
	62 day standard % (1 mth in arrears)		2016/17	85.0%	85.0%	95.2%	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%	91.4%	85.0%	94.2%	93.0%	92.0%	92.7%	92.9%	91.1%	87.4%	87.6%				
	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%	83.3%	90.0%	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%				
	31 days to first treatment % (1 mth in arrears)		2016/17	96.0%	96.0%	96.0%	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%				
	31 days subsequent treatment (surgery) % (1 mth in arrears)		2016/17	94.0%	94.0%	94.1%	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%	98.0%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	92.9%	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%				
	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%				
	Patients 2 week wait (breast symptomatic) % (1 mth in arrears)		2016/17	93.0%	93.0%	96.0%	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%	58.3%	93.0%	89.1%	87.7%	45.1%	62.9%	21.8%	34.9%	38.1%	86.9%				
	A&E 4 hour target		2016/17	95.0%	95.0%	82.5%	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%	82.9%	95.0%	82.5%	86.4%	84.7%	84.8%	78.3%	84.5%	88.0%	80.4%	76.9%			
	AED time to decision to admit (minutes)		2016/17	120	120	142	120	152	147	145	149	136	132	154	155	142	144	130	130
			2017/18	120	120	155	120	129	127	132	132	147	134	128	150	155			
	Bed Request to Bed Availability (minutes)		2016/17	60	60	179	60	153	317	181	139	214	119	178	158	179	174	140	155
			2017/18	60	60	153	60	134	115	122	108	146	120	108	134	153			
	Stranded patients		2016/17			245		265	252	241	237	238	240	251	262	245	274	255	260
			2017/18			251		267	248	237	229	233	239	225	245	251			
	Discharges by Midday		2016/17	30.0%	30.0%	26.0%	30.0%	25.8%	21.9%	25.2%	28.0%	27.4%	26.0%	26.8%	25.6%	26.9%	25.3%	25.2%	26.0%
			2017/18	30.0%	30.0%	27.6%	30.0%	26.6%	28.1%	27.1%	27.8%	28.4%	27.7%	26.9%	29.5%	26.0%			
	Discharges by 4pm		2016/17	70.0%	70.0%	64.1%	70.0%	64.2%	61.5%	65.3%	65.6%	63.6%	64.0%	66.2%	62.0%	64.4%	62.9%	61.8%	63.8%
			2017/18	70.0%	70.0%	65.8%	70.0%	66.4%	66.6%	65.8%	65.8%	65.8%	63.2%	65.1%	68.8%	64.3%			
	Re-admission within 30 days of discharge (1 mth in arrears)		2016/17	13.5%	13.5%	11.6%	13.5%	12.5%	12.8%	11.6%	12.4%	11.7%	11.5%	10.4%	9.9%	11.5%	12.7%	12.2%	11.9%
			2017/18	13.5%	13.5%	13.0%	13.5%	13.0%	14.3%	13.3%	12.7%	12.3%	13.4%	12.2%	12.7%				
	Daycase Rates (1 mth in arrears)		2016/17	80.0%	80.0%	80.6%	80.0%	83.0%	83.0%	82.7%	79.9%	81.1%	75.9%	76.6%	82.3%	76.7%	83.4%	76.5%	78.8%
			2017/18	80.0%	80.0%	82.5%	80.0%	82.3%	83.0%	82.8%	81.7%	82.8%	77.2%	85.5%	84.5%				
	Operations cancelled on the day for Non clinical reasons		2016/17	0.8%	0.8%	2.0%	0.8%	1.2%	1.9%	2.5%	2.5%	2.4%	1.3%	2.2%	1.9%	1.8%	1.3%	0.8%	1.8%
			2017/18	0.8%	0.8%	1.4%	0.8%	1.5%	1.6%	1.3%	0.8%	0.9%	1.1%	1.5%	2.0%	2.1%			
	Cancelled operations re-booked within 28 days		2016/17	100.0%	100.0%	91.5%	100.0%	100.0%	88.2%	96.1%	91.3%	84.9%	97.3%	98.3%	88.1%	79.2%	50.0%	78.3%	94.6%
			2017/18	100.0%	100.0%	89.2%	100.0%	81.1%	93.2%	92.1%	85.7%	79.2%	96.6%	92.3%	94.1%	88.1%			
	Total Theatre Productivity		2016/17	85.0%	85.0%	82.3%	85.0%	80.3%	85.1%	82.4%	84.5%	84.9%	82.5%	80.8%	78.6%	81.7%	73.2%	81.6%	83.9%
			2017/18	85.0%	85.0%	83.1%	85.0%	79.8%	84.0%	88.1%	86.2%	82.5%	81.9%	85.1%	81.0%	79.3%			
	Delayed Transfers Of Care (% occupied bed days delayed - phased reduction)		2016/17	5.0%	5.0%	6.7%	5.0%	6.6%	6.2%	7.6%	5.5%	7.1%	8.5%	8.5%	5.8%	4.7%	6.1%	5.4%	5.4%
			2017/18	4.6%	4.6%	6.4%	4.6%	4.4%	5.3%	6.0%	4.0%	4.1%	5.3%	6.6%	4.4%	6.4%			
	Elective Length of Stay (Discharges in month)		2016/17	2.0	2.0	1.8	2.0	2.1	1.8	2.1	1.8	2.1	1.6	1.7	1.3	1.7	1.4	1.8	2.1
			2017/18	2.0	2.0	2.4	2.0	2.4	2.1	2.7	2.2	2.7	2.5	2.4	2.2	2.9			
	Non Elective Length of Stay (Discharges in month)		2016/17	3.7	3.7	3.7	3.7	3.9	3.7	3.8	3.4	3.7	3.7	3.8	3.8	3.9	3.9	3.8	3.9
			2017/18	3.7	3.7	3.9	3.7	4.2	4.0	4.1	3.8	4.1	3.9	3.7	3.8	3.9			
	Gynaecology - Returns to Theatre within 30 days		2016/17					1	0	3	0	0	0	2	0	0	0	1	2
			2017/18	24	18	7	2	0	0	0	0	2	3	0	0	2			
	Sexual Health - Patients offered an appointment <48hrs (%)		2016/17	100.0%	100.0%	98.1%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	93.3%	91.4%	100.0%	97.6%	97.0%	93.2%
			2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Sexual Health - patients attended appointment within 48hrs (%)		2016/17	90.0%	90.0%	99.7%	90.0%	99.4%	99.8%	99.7%	99.5%	99.7%	99.4%	99.8%	99.8%	99.9%	100.0%	100.0%	100.0%
			2017/18	90.0%	90.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%			

Objective 2: Operational Performance

Diagnostics and continued care of the services at BFT	Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)		2016/17	0	0	1942	0	215	198	161	218	173	172	274	276	255	293	267	221
			2017/18	0	0	2737	0	270	245	235	199	364	319	285	371	449			
	Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)		2016/17	0	0	1410	0	132	165	89	139	88	115	206	217	259	269	157	185
			2017/18	0	0	1206	0	133	64	83	82	226	183	106	212	117			
	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%	1.4%	1.0%	0.9%	0.7%	0.3%	0.5%	0.8%	0.8%	1.5%	1.7%	5.3%			
	% of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)		2016/17	80.0%	80.0%	83.3%	80.0%	78.3%	88.2%	92.6%	85.0%	69.2%	81.3%	81.8%	90.0%	60.6%	86.7%	72.1%	78.6%
			2017/18	80.0%	80.0%	85.1%	80.0%	87.5%	88.9%	87.5%	78.9%	88.9%	90.9%	83.3%	75.0%				

See Key Performance Indicators Exceptions below.

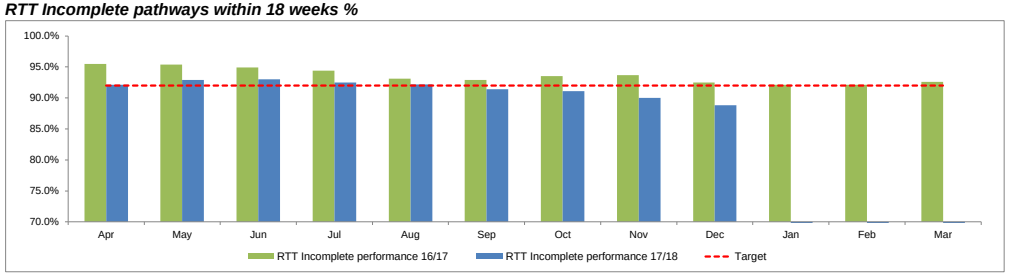
Objective 2: Operational Performance													
Trust Wide Objectives		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2.3 - To Have clear plans in place to ensure our IT systems are fit for the future	Electronic Patient Record												
	Shared Data across GM (BFT/SRFT/WWL)												
	Completion of Community Integration												
	Shared Services / Unified Communications												

Rag guide for Objectives
Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Objective 2: Operational Performance

Key Performance Indicator Exceptions

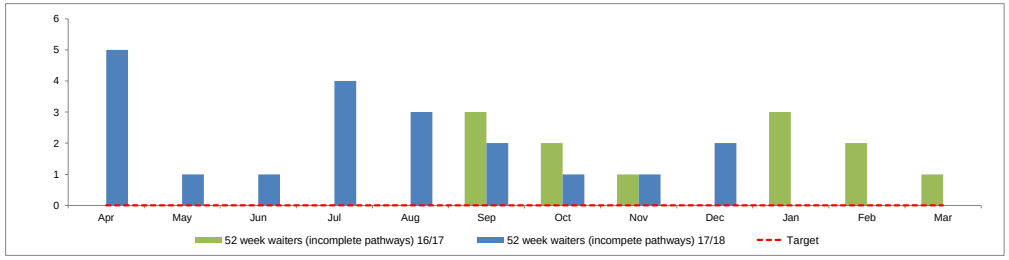
RTT Incomplete pathways within 18 weeks %



Narrative:

The Trust failed to achieve the RTT standard for the fourth month. Work is ongoing with the CCG around demand management and a proposal and trajectory for recovery is being drafted.

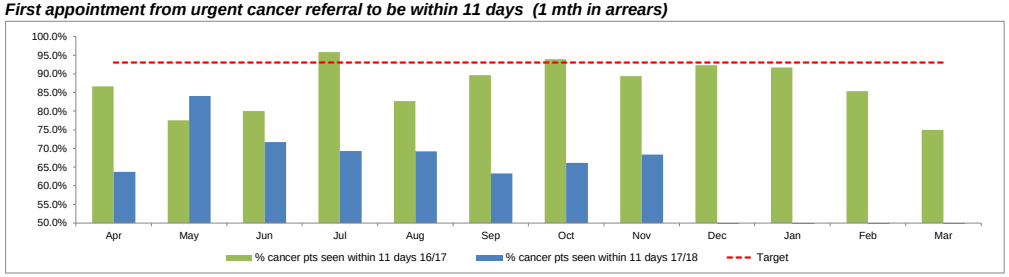
RTT 52 week waits (incomplete pathways)



Narrative:

There were two patients waiting longer than 52 weeks for treatment on an active pathway in December. This case brings the total number of incomplete breaches to 20 in the year to date.

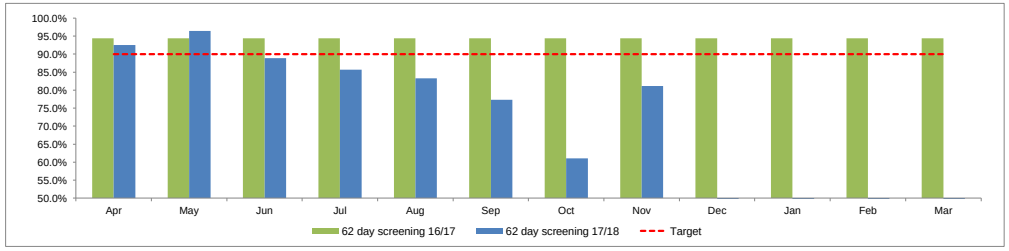
First appointment from urgent cancer referral to be within 11 days (1 mth in arrears)



Narrative:

Performance in November was 68.4% 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.

62 day screening % (1 mth in arrears)



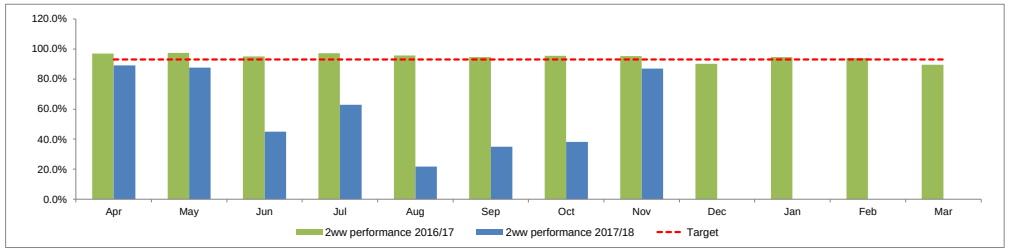
Narrative:

Cancer Screening remains a concern, though November marked a significant improvement on October's performance. 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.

Objective 2: Operational Performance

Kev Performance Indicator Exceptions

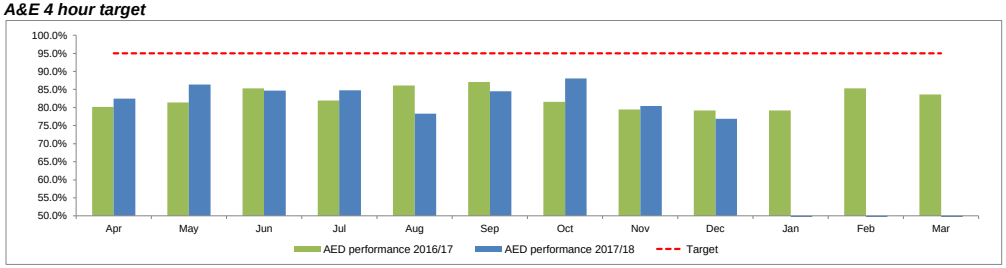
Patients 2 week wait (breast symptomatic) % (1 mth in arrears)



Narrative:

Work is ongoing to recover the breast symptomatic standard. A trajectory is in place and is currently on track to recover the position by the end of December 2017. November saw a significant improvement on recent performances.

A&E 4 hour target

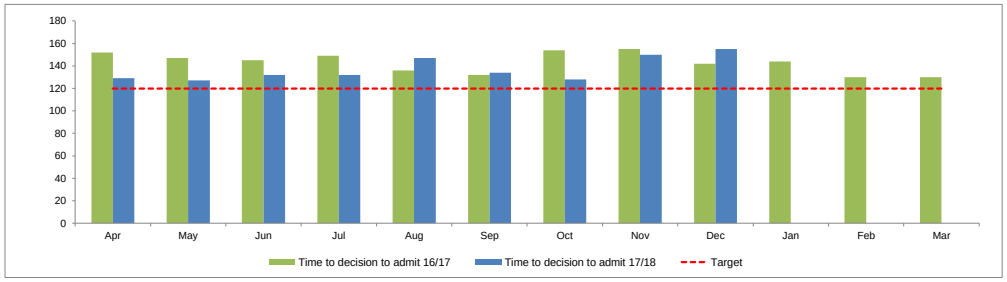


Narrative:

Performance in A&E against the national four hour standard continued to decline with performance of 76.9% which is still significantly below both the national target and and the trajectory of 92% set as per the Trust's STF plans, as well as December last year (79.2%).

The Trust keeps NHSI informed of operational pressures as well as its regional partners.

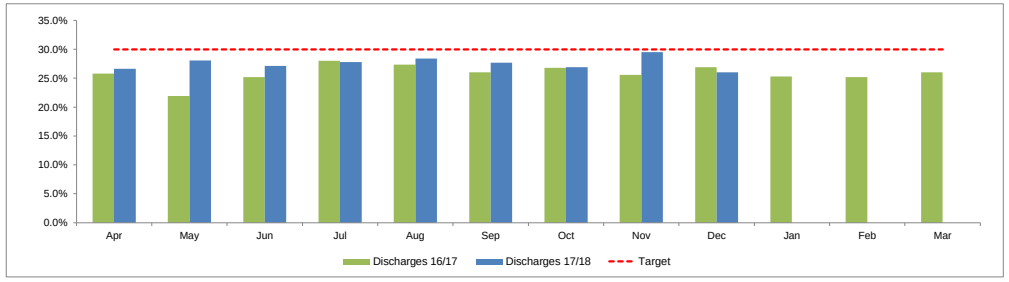
AED time to decision to admit (minutes)



Narrative:

Time to decision to admit increased to 155 minutes in December from 150 in November and 128 in October. This measure combined with bed occupancy, time to bed once decision made and the number of stranded patients are all key indicators which directly effect overall AED performance. The overall number of stranded patients (those patients with a length of stay greater than 6 days) has increased over recent months, this increase reflects the pressure felt in A&E.

Discharges by Midday



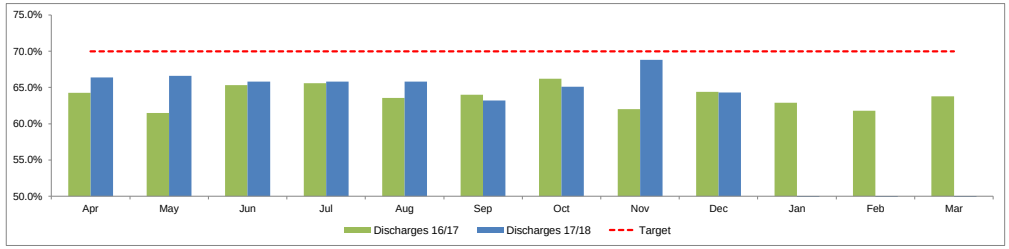
Narrative:

Discharges by midday were performing at 26% which although only marginally below the threshold of 30%, is the worst performing month of the year to date, and worse than December last year (26.9%).

Objective 2: Operational Performance

Key Performance Indicator Exceptions

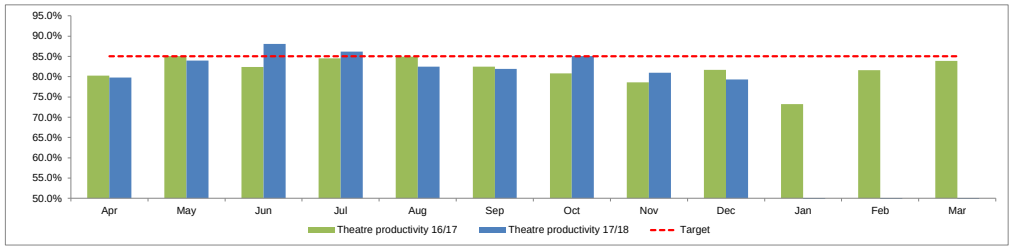
Discharges by 4pm



Narrative:

Performance in December of 64.3% was similar to the same period last year (64.4%) against the target of 70%, however it was significantly worse than November (68.8%).

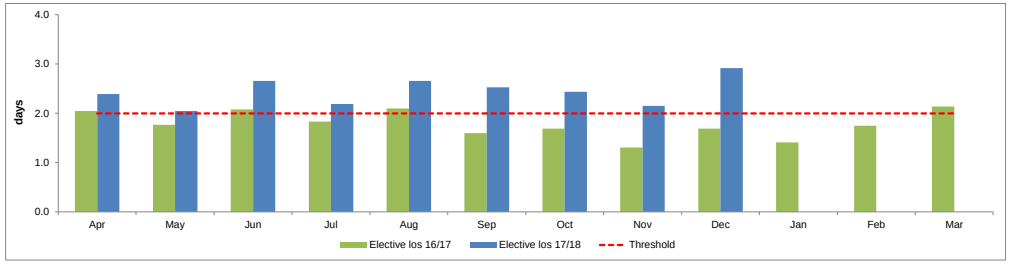
Total Theatre Productivity



Narrative:

Total theatre productivity (a ratio of the volume of theatre minutes utilised from those available) dipped slightly to 79.3% in December 2017 against a plan of 85% and is slightly below performance achieved in December last year of 81.7%.

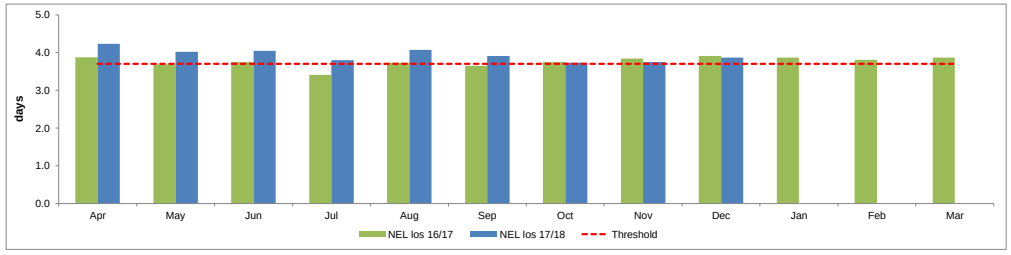
Elective Length of Stay (Discharges in month)



Narrative:

Elective length of stay increased to 2.9 days in December against the Trust plan of 2.0 days and is a significant spike, compared to a recent downwards trend. Elective length of stay was 1.2 days longer this month than at the same point last year.

Non Elective Length of Stay (Discharges in month)



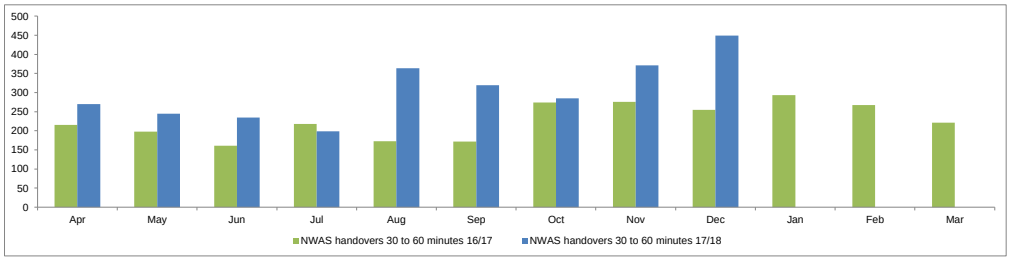
Narrative:

Non elective length of stay continues to be challenging and in month performance stands at an average of 3.9 days against the Trust plan of 3.7 days, although this is the same as the same period last year.

Objective 2: Operational Performance

Key Performance Indicator Exceptions

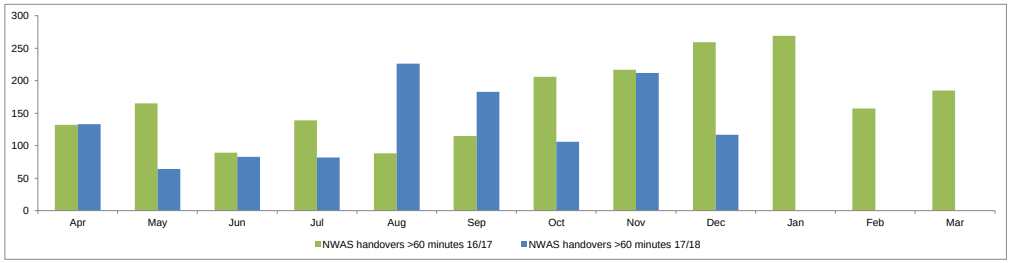
Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



Narrative:

There were 449 ambulance handovers between 30 and 60 minutes in December 2017, a reduction in performance on the 371 reported in November 2017 and worse than the same time last year.

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



Narrative:

There were 212 ambulance handovers over 60 minutes in December 2017, which is nearly half the 212 reported in November and less than the same point in time last year (259).

Trust Strategic Objective 3:

Leadership and Improvement

Objective 3 - Leadership and Improvement

Year to date performance is rated as GREEN.

Areas of good performance to highlight are:

- Bolton System of Care Improved Accreditation (BOSCA) KPI Audits – 88.0% (Target 70.0%)
- Complaints responded to within the period – 100.0% (Target 95.0%)
- Total Incidents resulting in Moderate, Severe harm – 0.0% (Target 1.2%)

Areas where further work on performance is needed are:

- Increased numbers of staff undertaking an appraisal
- BOSCA Rollout for all Hospital and Community settings

Increased numbers of staff undertaking an appraisal

Performance in December 2017 shows 82.3% of staff undertaking an appraisal which is an improvement in performance from that reported in November 2017 of 81.7% compared to the plan of 85%.

Performance has been patchy for a number of months, and only a few corporate functions are now achieving this target. The best performing clinical division is elective, with acute adults having the worst performance. A continuous focus on this target has been shown to be effective in improving performance. Elective distribute regular updates to their managers showing staff that are overdue for an appraisal.

BOSCA Rollout for all Hospital and Community settings

The ward accreditation programme continues to grow and embed. 120 audits have been undertaken across the Trust. We now have bespoke templates in use for all inpatient areas, District Nursing, Maternity and Paediatrics. A Theatre BoSCA will be available in the New Year. The aim is to have credible and transparent data to evidence the good patient care that is provided. It ensures all staff are aware of what is expected and also inform where support may be required from divisional, corporate & specialist teams. Latest District Nursing Teams Status - the District Nursing teams have now all moved out of bronze and we also have our first PLATINUM. Congratulations to Avondale. Grades range from 75.9% to 92.3%. Engagement has been excellent with a healthy level of peer competition. Latest Bed Based Status - this now also includes maternity and paediatrics. Grades range from 56.4% to 95.1%. GOLD BoSCAs have been awarded to CCU, F4 & M3. We now have 4 PLATINUM wards/ units as ICU, HDU, E4 and G5 have been awarded 2 consecutive golds. There has been great engagement in some areas clearly embracing the process and making BoSCA part of everyday business.

On the basis that the actions outlined above are successful the objective of Leadership and Improvement is forecast to be GREEN by the year end.

Objective 3: Leadership and Improvement

Key Performance Indicators

Trust objective	Outcome Measure	Oversight Committee	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Effective Boards and Governance	Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	Workforce Committee	2016/17	66.0%	66.0%	72.0%	62.0%		72.0%			72.0%			N/A			69.0%	
			2017/18	68.0%	68.0%	71.5%	66.0%		71.0%			72.0%			N/A				
	Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)		2016/17	80.0%	80.0%	82.0%	80.0%		82.0%			83.0%			N/A			82.0%	
			2017/18	80.0%	80.0%	85.0%	80.0%		86.0%			85.0%							
	Inpatient Friends and Family completion rates		2016/17	30.0%	30.0%	32.4%	30.0%	35.7%	38.1%	35.8%	34.8%	32.8%	25.2%	30.5%	29.7%	28.7%	30.0%	34.1%	32.8%
			2017/18	30.0%	30.0%	33.7%	30.0%	35.3%	33.9%	31.4%	35.3%	35.1%	29.4%	36.9%	34.9%	31.3%			
	Maternity Friends and Family completion rates		2016/17	15.0%	15.0%	11.1%	15.0%	24.4%	20.0%	20.0%	15.5%	16.1%	15.5%	14.5%	15.2%	11.1%	11.9%	11.8%	13.5%
			2017/18	15.0%	15.0%	22.3%	15.0%	26.1%	46.4%	23.7%	19.3%	30.9%	35.7%	18.7%	18.0%	22.3%			
	Antenatal - Friends and Family Response Rate		2016/17																
			2017/18					29.8%	19.1%	14.3%	28.8%	18.8%	12.2%	16.7%	14.4%	15.3%			
	Birth - Friends and Family Response Rate		2016/17																
			2017/18	15.0%	15.0%	26.8%	15.0%	16.7%	22.9%	32.4%	18.5%	21.8%	17.8%	18.3%	18.0%	26.8%			
	Hospital Postnatal - Friends and Family Response Rate		2016/17																
			2017/18					29.7%	33.6%	28.6%	18.9%	18.0%	23.3%	20.0%	34.9%	35.4%			
	Community Postnatal - Friend and Family Response Rate		2016/17																
			2017/18					11.6%	19.3%	16.7%	19.2%	20.0%	20.2%	20.0%	7.9%	12.9%			
	NHS Improvement Patient Safety Alerts (CAS) Compliance		2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
			2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Continuous Improvement Capability	Bolton System Of Care Improved Accreditation (BOSCA) KPI Audits	Quality and Safety Committee	2016/17	70.0%	70.0%	90.0%	70.0%	87.0%	89.0%	90.0%	90.0%	91.0%	91.0%	91.0%	87.0%	90.0%	89.0%	90.0%	90.0%
			2017/18	70.0%	70.0%	88.0%	70.0%	92.0%	92.0%	93.0%	93.0%	93.0%	94.0%	93.0%	89.0%	88.0%			
	Formal complaints acknowledged within 3 working days		2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
			2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Complaints responded to within the period		2016/17	95.0%	95.0%	90.9%	95.0%	96.1%	89.6%	96.0%	93.3%	100.0%	86.0%	100.0%	100.0%	90.9%	100.0%	88.5%	43.0%
			2017/18	95.0%	95.0%	100.0%	95.0%	91.0%	100.0%	96.0%	96.0%	100.0%	96.0%	100.0%	100.0%	100.0%			
	All Serious Incidents investigated and signed off within 90 days (sourcing data)		2016/17	100.0%	100.0%		100.0%												
			2017/18	100.0%	100.0%		100.0%												
	SAFEGUARD Incidents NOT signed off at month end. (Snapshot)		2017/18			400		178	266	230	229	370	431	292	273	400			
	Total Number of incidents reported on SAFEGUARD		2016/17	15348	11511	11309	1279	1137	1199	1235	1275	1227	1243	1348	1317	1328	1321	1299	1419
			2017/18	15348	11511	11885	1279	1378	1249	1232	1322	1266	1351	1357	1390	1340			
	% Incidents NOT signed off at Month end		2017/18			21.5%		12.9%	21.3%	18.7%	17.3%	29.2%	31.9%	21.5%	19.6%	29.9%			
	Total Incidents resulting in Moderate, Severe harm		2016/17	1.2%	1.2%	0.1%	1.2%	0.2%	0.2%	0.5%	0.2%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%	0.3%
			2017/18	1.2%	1.2%	0.0%	1.2%	0.2%	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.1%	0.0%			
Leaders are Visible and deal with issues effectively	I know who the Senior Managers are - 2016 survey	Workforce Committee	2016/17			84.00%		84.0%											
			2017/18	32.7%	32.7%		32.7%												
	Communication between managers and staff is effective' - 2016 survey		2016/17			40.0%		40.0%											
			2017/18	32.7%	32.7%		32.7%												
	Senior managers here try to involve staff in important decisions - 2016 survey		2016/17			32.0%		32.0%											
			2017/18	32.7%	32.7%		32.7%												
	Senior managers act on staff feedback - 2016 survey		2016/17			33.0%		33.0%											
			2017/18	32.7%	32.7%		32.7%												
	Increased numbers of staff undertaking an appraisal		2016/17	85.0%	85.0%	82.1%	85.0%	84.4%	85.6%	84.1%	83.7%	82.9%	80.4%	79.3%	82.6%	82.1%	82.2%	83.8%	81.6%
			2017/18	85.0%	85.0%	82.3%	85.0%	79.9%	80.3%	80.0%	82.7%	81.8%	80.3%	83.7%	81.7%	82.3%			
	Staff reporting a quality appraisal in the last year' - 2016 survey		2016/17	45.0%	45.0%		45.0%	74.0%											
			2017/18	45.0%	45.0%		45.0%												

Staff survey results from the 2017 survey will only be received in Quarter 4 17/18. 2016 results displayed were an improvement from the previous year

Objective 3: Leadership and Improvement

See Key Performance Indicator Exceptions below.

	Trust Wide Objective	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Effective Boards and Governance	To Address all actions identified from the Well Led Review												
Continuous Improvement Capability	BOSCA Rollout for all Hospital and Community settings												

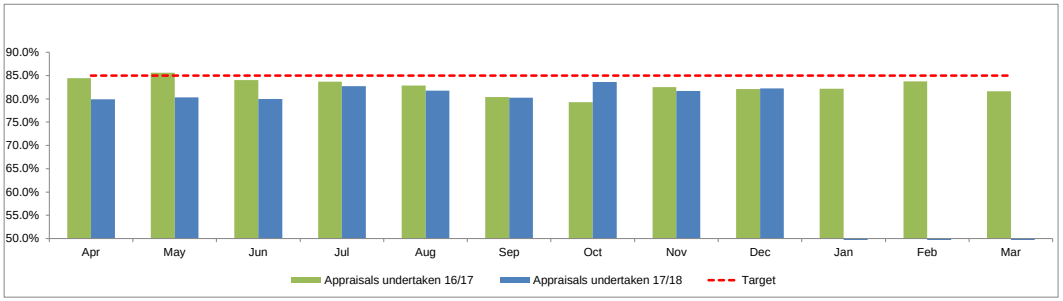
Rag guide for Objectives

Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Objective 3: Leadership and Improvement

Key Performance Indicators Exceptions

Increased numbers of staff undertaking an appraisal



Narrative:

Performance in December 2017 shows that 82.3% of staff undertook an appraisal which is an improvement in performance over that reported in the previous month of 81.7% against the Trust target of 85%. A continuous focus on the number of expired appraisals has been shown to be effective in improving performance.

Objective 3: Leadership and Improvement

Key Performance Indicators Exceptions

Trust Wide Objective		Year to Date
3.1 - Effective Boards and Governance	BOSCA Rollout for all Hospital and Community settings	

The ward accreditation programme continues to grow and embed. 120 audits have been undertaken across the Trust. We now have bespoke templates in use for all inpatient areas, District Nursing, Maternity and Paediatrics. A Theatre BoSCA will be available in the New Year. The aim is to have credible and transparent data to evidence the good patient care that is provided. It ensures all staff are aware of what is expected & also inform where support may be required from divisional, corporate and specialist teams. Latest District Nursing Teams Status - the District Nursing teams have now all moved out of bronze and we also have our first PLATINUM. Congratulations to Avondale. Grades range from 75.9% to 92.3%. Engagement has been excellent with a healthy level of peer competition. Latest Bed Based Status - this now also includes maternity and paediatrics. Grades range from 56.4% to 95.1%. GOLD BoSCAs have been awarded to CCU, F4 and M3. We now have four PLATINUM wards/units as ICU, HDU, E4 and G5 have been awarded two consecutive golds. There has been great engagement in some areas clearly embracing the process and making BoSCA part of everyday business.

Rag guide for Objectives

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Green - Actions required to deliver the plan are on track - On Plan

Trust Objective 4:

Finance and Use of Resources

Objective 4 - Finance and Use of Resources

Year to date performance is rated as AMBER (GREEN in May).

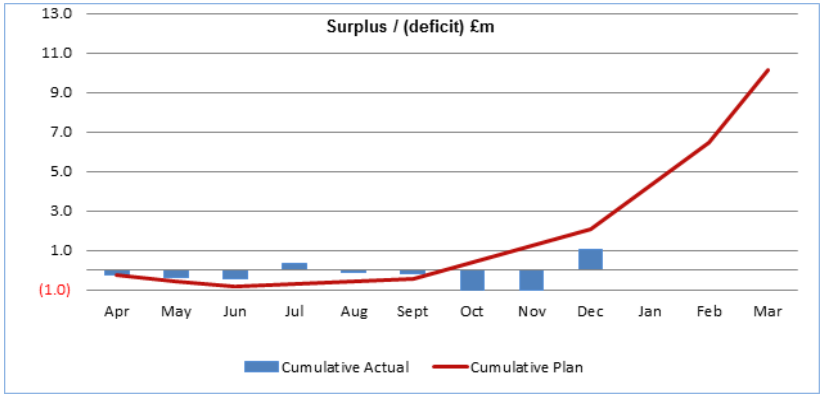
The values and narrative for I&E within this report are the consolidated values for the Group.

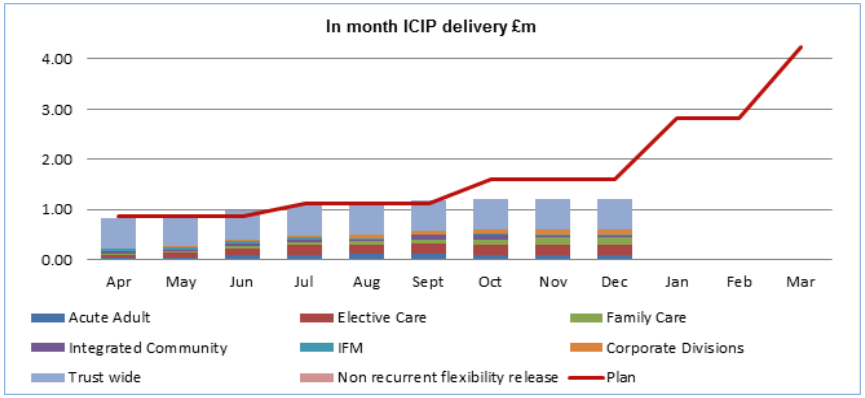
Key points to note are:

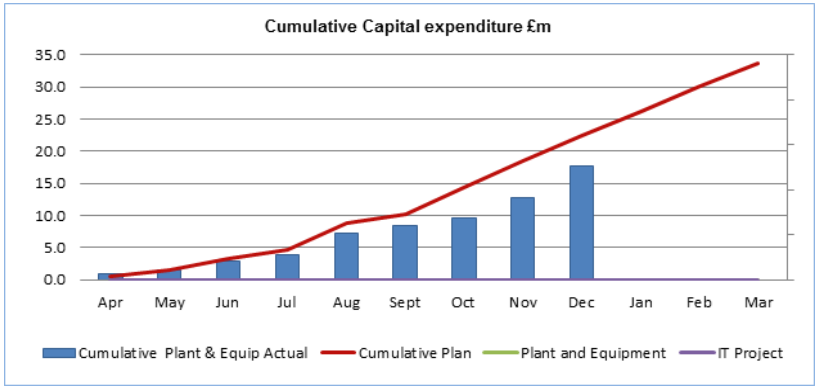
- The Trust has a year to date surplus of £1.0m including STF, which is £1.1m worse than plan at the end of Month nine.
- The NHSI plan is a surplus control total of £10.1m by the end of the year.
- The Trust has a year to date deficit of £2.9m when STF is excluded from the position.
- Agency costs are at £7.6m against a year to date plan of £4.7m which now exceeds the full year plan of £6.2m.
- ICIPs at £9.6m are £1.0m worse than the year to date plan. Note the full year target of £20.8m.
- The month end cash balance is £2.9m which is worse than plan by £4.0m this month.
- Year to date capital spend is £12.7m which is £9.8m below the capital plan.
- The Trust Use of Resource Rating is three as at the end of Month nine which is below plan.
- The implementation of the Lord Carter recommendations continues to be monitored.
- The Trust is currently forecasting to NHSI that it will achieve the plan surplus of £2.2m (excluding STF) based on the implementation of the Tactical Financial Plan taken to the Finance and Investment Committee. However it should be noted that this is subject to significant risk.
- The Trust is currently forecasting to NHSI that it will achieve the control total of £2.2m (plus STF of £6.4m; £8.6m total surplus) based on the implementation of the Tactical Financial Plan taken to the Finance and Investment Committee. However it should be noted that this is subject to significant risk.

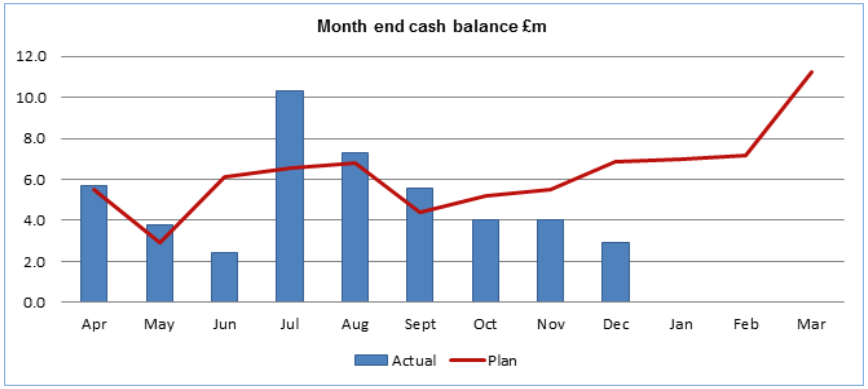
The year end forecast for Finance and Use of Resources is AMBER on the basis of the risk range for the year end outturn.

Objective 4 - Finance and Use of Resources









Surplus / (Deficit)
Year to date including STF the Trust has a surplus £1.0m, which is £1.1m worse than plan.
Year to date the Trust has a deficit of £2.9m excluding STF.
The Trust Use Of Resource Rating is 3 as at the end of December which is below plan for December and quarter 3. All individual metrics are below plan except I&E margin and I&E Variance from plan.

ICIPs
Year to date ICIPs delivered are £9.7m which is £1.0m below plan.

Cash
There was a cash balance of £2.9m at the end of the month which is £4.0m below plan. The underlying cash position is (£2.3)m.

Capital
The Capital budget for the year is £33.7m. At the end of December, £12.7m was spent on the Capital programme which is £9.8m underspent YTD.

Objective 4 - Finance and Use of Resources

Trust Summary	Annual budget £m	In month Budget £m	In month Actual £m	In month Var £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Var £m
Contract income	284.4	23.7	26.1	2.4	213.3	219.0	5.6
Education and Training Income	9.4	0.8	0.7	(0.1)	7.1	7.1	0.0
Other income	14.4	1.2	1.4	0.2	10.8	12.5	1.6
Total Income	***316.2***	***26.5***	***28.3***	***1.8***	***236.4***	***242.3***	***5.9***
Direct - Pay	(213.9)	(17.8)	(19.0)	(1.2)	(162.1)	(170.0)	(7.9)
Direct - Non Pay	(81.2)	(6.8)	(7.4)	(0.6)	(64.1)	(66.4)	(2.3)
Flexibilities	(1.0)	(0.1)	0.8	0.9	(0.6)	0.9	1.5
Total Operational Costs	***(296.1)***	***(24.8)***	***(25.6)***	***(0.8)***	***(226.8)***	***(235.6)***	***(8.8)***
EBITDA	***20.1***	***1.7***	***2.7***	***1.0***	***9.5***	***6.7***	***(2.8)***
Capital charges	(10.0)	(0.8)	(0.7)	0.2	(7.4)	(5.7)	1.7
Total Costs	***(306.1)***	***(25.6)***	***(26.3)***	***(0.6)***	***(234.3)***	***(241.3)***	***(7.0)***
Surplus / (Deficit)	***10.1***	***0.9***	***2.0***	***1.2***	***2.1***	***1.0***	***(1.1)***

Narrative:

In month income has over performed by £2.4m. Pay is £1.2m worse than plan and non pay is £0.6m worse than plan. Capital charges are £0.2m better than plan due to the technical changes in 2016/17.
Year to date agency expenditure is £7.6m against a plan of £4.7m. The annual target is £6.2m.
Balance sheet flexibilities of £0.8m have been released into the position.
The Trust is currently forecasting to NHSI that it will achieve the plan surplus of £2.2m (excluding STF) following mitigating actions and strategies. The Trust will not achieve full STF due to A&E performance.

Trust Statement of Financial Position

Trust Summary	Year to Date £m	Year to Date £m	Year to Date £m
Non-current assets	117.8	111.8	(6.0)
Current assets	24.0	29.9	5.9
Current liabilities	(29.2)	(39.2)	######
Non-current liabilities	(29.1)	(26.2)	2.9
Total assets employed	**83.4**	**76.2**	**(7.2)**
Taxpayers Equity	**83.4**	**76.2**	**(7.2)**

Narrative:

The Capital budget for the year is £33.7m. At the end of December, £12.7m was spent on the Capital programme which is £9.8m underspent YTD. The revised forecast for capital spend is £23.5m.
Cash is below plan at the end of December by £4.0m.
In December the Trust managed down payment runs by £3.3m. The underlying cash position was (£2.3)m.

Objective 4 - Finance and Use of Resources

Key Performance Indicators

Trust objective	Outcome Measure	Oversight Committee	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Teams are appropriately staffed and flexible	95% of recruitment completed to unconditional offer <8wks		2016/17	<8wks	<8wks	55.0%	<8wks	54.0%	43.0%	50.0%	36.0%	56.3%	30.0%	56.3%	62.0%	55.0%	56.8%	65.3%	85.7%
			2017/18	<8wks	<8wks	84.6%	<8wks	89.0%	85.3%	70.0%	91.7%	88.2%	93.1%	91.3%	93.7%	84.6%			
	Average time to recruit		2016/17	<15 wks.	<15 wks.	12.8	<15 wks.	14.7	15.6	14.4	14.7	15.5	17.3	16.8	12.5	12.8	13.7	13.5	13.4
			2017/18	<15 wks.	<15 wks.	12.2	<15 wks.	13.9	12.9	12.4	12.8	13.9	12.4	12.3	12.6	12.2			
	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%	5.6%	4.2%	4.4%	4.1%	4.2%	4.5%	4.5%	4.6%	4.8%	5.2%	5.6%			
	iFM sickness		2017/18			7.36%		5.3%	6.2%	6.4%	7.8%	8.1%	7.7%	8.0%	7.3%	7.4%			
	Ward sickness		2017/18			7.77%		5.9%	5.5%	5.2%	6.0%	6.5%	6.6%	6.3%	6.8%	7.8%			
4.4 - NHSI agency rules	Annual ceiling for Nursing Staff agency spend		2017/18	100.0%	100.0%	147.9%	100.0%	164.0%	144.7%	131.2%	138.4%	191.0%	302.1%	238.1%	169.5%	200.6%			
	Medical staffing agency spend		2017/18	100.00%	100.0%	193.5%	100.0%	119.0%	147.8%	155.6%	119.4%	144.7%	208.6%	142.3%	129.7%	159.6%			
	Compliance with hourly caps for all agency staff		2017/18	Pass	Pass	Fail	Pass	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail			

See Key Performance Indicator Exceptions below.

Trust Wide Objectives		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.1 - Use or Resources	Deliver control surplus of £2.239m and control surplus of £2.706m for 2018/19												
	Achieve a Use of Resource rating of one												
	Implement Lord Carter report recommendations												
4.2 - Financial Governance Improvements	Maintain an ALE score of Good												
	No increase in BGAF red flags												
	Basic process assurance remains green												
4.3 - Finance Skills Development	Implement next phase of Finance Directorate Development Plan												
	Provide training to the Divisions to enable the development of effective joint savings plans with Bolton CCG												
4.4 - NHSI agency rules	Frameworks for all nurse agency staff												

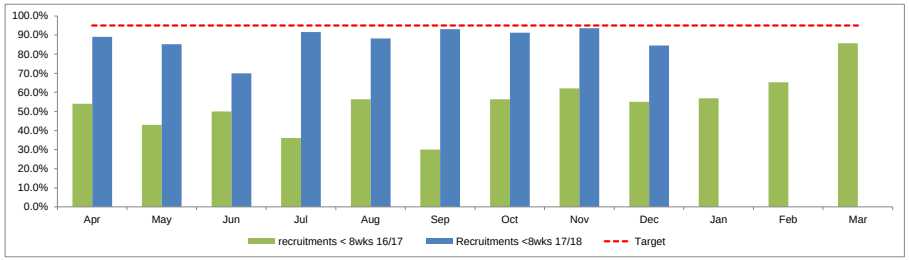
Rag guide for Objectives

Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Objective 4 - Finance and Use of Resources

Key Performance Indicators Exceptions

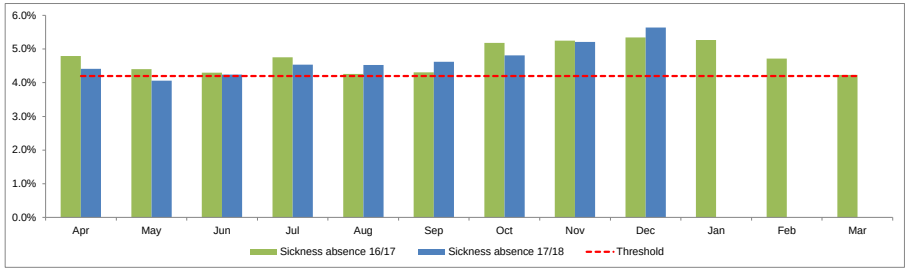
95% of recruitment completed to unconditional offer <8wks



Narrative:

Although significant progress has been made with this metric compared to last year, performance is still challenging, currently standing at 84.6% of recruitments being finished within 8 weeks compared to the 95% target which although a reduction on the previous month is still higher than at any single point last year.

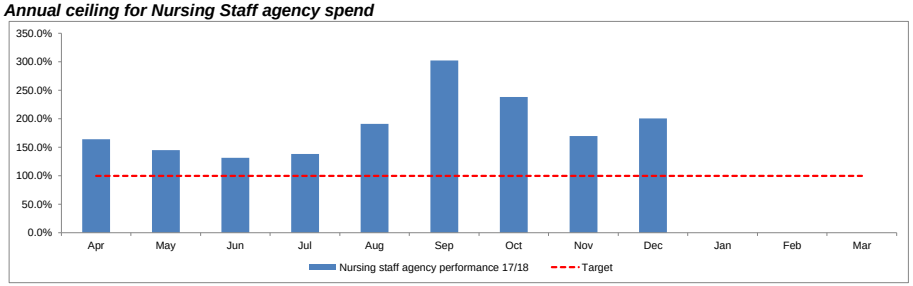
Sickness absence levels are appropriately managed



Narrative:

Sickness levels were 5.6% in December 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.

Annual ceiling for Nursing Staff agency spend

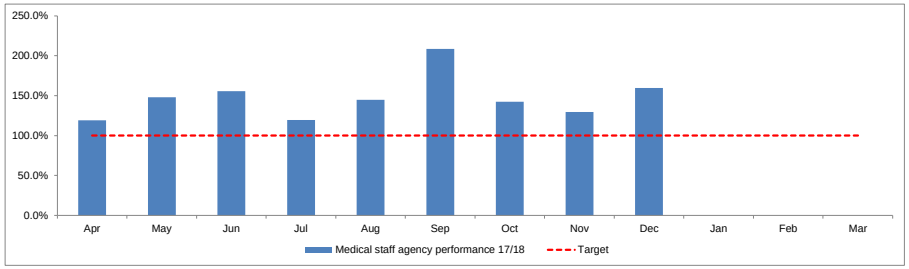


Narrative:

Cumulatively at the end of December the Trust was 200.6% compared to the ceiling for Nursing Staff agency spend.

There is a nursing agency plan in place which includes:
• International recruitment and re enforced recruitment process;
• roster good practice management linked to a project running with NHSI to ensure the Trust is working to good practice
• Enhanced care policy being rolled out

Medical staffing agency spend



Narrative:

Cumulatively at the end of December the Trust was 159.6% compared to the ceiling for Medical Staff agency spend.

Objective 4 - Finance and Use of Resources

Key Performance Indicators Exceptions

Trust Wide Objectives		Year to date	
4.4 - Teams are appropriately staffed and flexible	Deliver control surplus of £2.239m and control surplus of £2.706m for 2018/19		The Trust is currently forecasting to NHSI that it will achieve the plan surplus of £2.2m (excluding STF) based on the implementation of the Tactical Financial Plan taken to the Finance and Investment Committee. However it should be noted that this is subject to significant risk.
4.4 - Teams are appropriately staffed and flexible	Achieve a Use of Resource rating of one		The Trust Use Of Resource Rating is 3 as at the end of December which is below plan for December and quarter three. All individual metrics are below plan except I&E margin and I&E variance from plan.
4.4 - Teams are appropriately staffed and flexible	Frameworks for all nurse agency staff		There is a nursing agency plan in place which includes : International recruitment and re enforced recruitment process; roster good practice management linked to a project running with NHSI to ensure the Trust is working to good practice; enhanced care policy being rolled out.

Rag guide for Objectives

Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Trust Objective 5:

Fit for the Future

Objective 5 - Fit For The Future

Year to date performance is rated as AMBER.

Areas of good performance to highlight are:

- Total Vacancy Level - 2.0% (Target 6.0%)
- Co Location of GP OOH into AED
- Community Estates Rationalisation

Areas where further work on performance is needed are:

- Reduce emergency admissions from Nursing Homes by 5%
- Reduce AED attendances from Nursing Homes by 8%

Performance has deteriorated year to date in both attendance and admissions from Nursing homes. The CCG led schemes regarding GP support and Telemedicine in Nursing homes have only just begun to be rolled out in September, the impact of these schemes may not be felt until the fourth quarter of the year.

On the basis that the actions outlined above are successful the objective of Fit for the Future is forecast to be GREEN by the year end.

Objective 5: Fit for the Future

Key Performance Indicators

Trust objective	Outcome Measure	Oversight Committee	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5.1 - Planning and support of staffing levels	Vacancy level	Workforce Committee	2016/17	6.0%	6.0%	1.3%	6.0%	2.0%	2.0%	1.6%	3.2%	2.3%	2.2%	2.1%	1.5%	1.3%	1.7%	1.8%	1.3%
			2017/18	6.0%	6.0%	2.0%	6.0%	4.7%	4.8%	4.8%	4.7%	3.9%	3.4%	2.6%	2.0%	2.0%			
	Turnover		2016/17	8 - 10%	8 - 10%	10.6%	8 - 10%	9.2%	9.2%	9.5%	9.8%	9.8%	10.0%	10.2%	10.2%	10.6%	10.6%	11.1%	11.2%
			2017/18	8 - 10%	8 - 10%	10.2%	8 - 10%	12.3%	11.0%	11.3%	11.3%	10.7%	10.6%	10.6%	10.4%	10.2%			
5.6 - Shift of activity into the community	Reduce emergency admissions from Nursing / Care homes by 5%		2016/17	1127	845	812	94	106	102	91	103	81	68	85	82	94	124	106	85
			2017/18	1071	803	916	89	96	93	90	110	108	115	98	100	106			
	Reduce AED attendances from Nursing / Care homes by 8%		2016/17	1571	1178	1135	131	118	140	125	147	133	94	135	109	134	160	153	123
			2017/18	1445	1084	1339	120	146	139	138	149	160	145	149	148	165			

These are Bolton Local Health Economy Objectives and as such are not based solely on Bolton FT activity

Trust wide Objective		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5.2 - Transfer of High Risk Colorectal Surgery to Salford Royal Hospital	Appointment of a clinical lead for the single service												
	Establishment of Sector Multidisciplinary Team Meetings												
	Establishment of a shared out of hours on call arrangements												
	Approved business case for recurrent investment and required capital funds sourced												
5.3 - To Implement a model of care for Paediatric services that delivers to the related standards and is financially viable	Complete case for change for Paediatric services and public consultation												
	Complete business case												
5.4 - Achieving sustainable services through collaboration within the North West Sector of Manchester	Implement a sector model of provision for Urology services that fully aligns to GM requirements												
	Sector Model for the provision of Orthopaedic services												
	Sector Model for the provision of Breast services												

Rag guide for Objectives

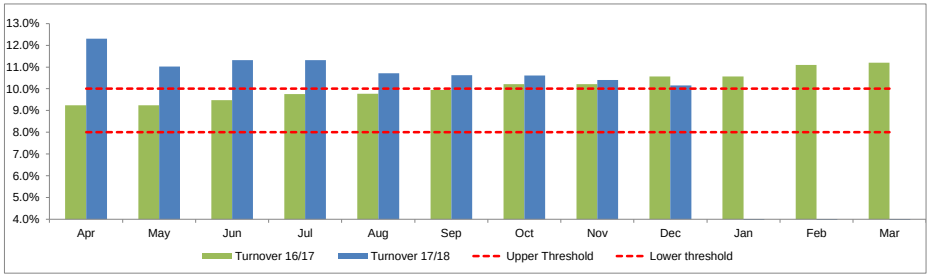
Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Trust wide Objective		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5.5 - Supporting the Urgent Care System	Co-Location of GP OOH into AED												
	Integrated Neighbourhood Teams to support Tier 4 (Acorn group 1) of the most at risk population												
	Admission Avoidance Team - reducing unnecessary admissions												
5.6 - Shift Activity into the Community	In collaboration with Bolton Council develop and commence an education package for care home staff												
	Provisions of virtual and rapid access clinics to support patients with long term respiratory conditions												
	Implementation of a Community Heart Failure team and rehabilitation service												
5.7 - Development of a Local Care Organisation	Governance in place to enable greater single management between health and social care providers												
	Development of wider roles to support practice neighbourhoods												
	Implementation of redesigned urgent care												
5.8 - Estates	Community Estates Rationalisation												
	Completion of Hospital Site Energy Scheme												
	Endoscopy unit expansion complete												

Rag guide for Objectives
Red - Actions required to deliver the plan are not on track - Off Plan
Amber - Varying off plan (some risk to delivery)
Green - Actions required to deliver the plan are on track - On Plan

Key Performance Indicator Exceptions

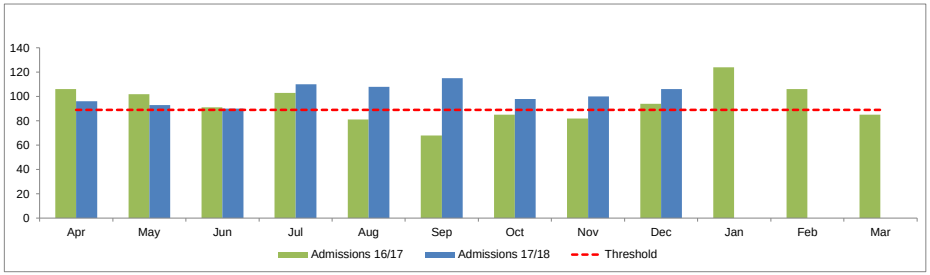
Turnover



Narrative:

Turnover steadily increased during the last financial year with sharp divisional differences and performance at 10.2% is currently marginally outside the threshold of 10%.The workforce team is working with nursing colleagues to address issues.

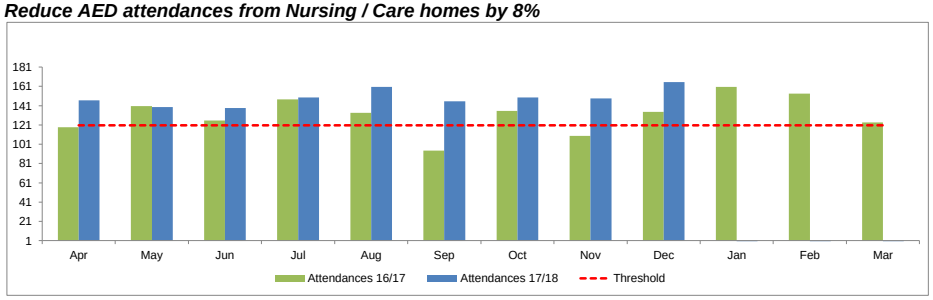
Reduce emergency admissions from Nursing / Care homes by 5%



Narrative:

The volume of emergency admissions to the Trust from Nursing homes in 2016/17 was 1127. As part of the Urgent Care Action Plan this demand was to be reduced by 5% in 2017/18 which would result in monthly admissions of around 89.
Performance in December 2017 showed 106 admissions, which is above the threshold set and above that of the same point in time last year. Cumulatively admissions were 916 at the end of December 2017 which is a 12.8% increase on the cumulative December 2016 position of 812 admissions. Given that we are about to enter the 'winter' period it is now going to be very challenging for the Trust to hit this locality plan target metric.

Reduce AED attendances from Nursing / Care homes by 8%



Narrative:

Reducing AED attendances from Nursing / Care homes forms part of the Urgent Care plan with attendances in 2017/18 to be 8% less than the year before.

Performance in December 2017 was 165 attendances against the threshold of 120, 37.5% over the monthly threshold. Cumulatively at the end of December 2017 performance stands at 1339 attendances which is 18% more than the cumulative position for the same period last year.

Key Performance Indicator Exceptions

Trust Wide Objectives		Year to date	
5.2 - Transfer of High Risk Colorectal Surgery to Salford Royal Hospital	Establishment of a shared out of hours on call arrangements		The surgical governance and implementation board now meets regularly to oversee changes to adult general surgical services. It is chaired by the newly appointed clinical lead for the shared service. The introduction of a shared on call service has been identified as an initial step prior to the transfer of patients to the high risk site. The definition of this objective is to have commenced a pilot of this new way of working during the current financial year. Progress has been slow to date and clinicians remain reluctant to work across sites.
	Approved business case for recurrent investment and required capital funds sourced		In the north west sector of Greater Manchester the implementation of healthier together for general surgery has always relied upon additional capital investment at Salford Royal, and to a much lesser extent on the two low risk sites in Bolton and Wigan. The capital funding proposals have been with Centre for several weeks now, any announcements were initially held up by purdah. At the time of writing, no confirmation has been received that capital funding will be made available. As reported previously, around two years will be needed to complete the capital scheme on the high risk site, meaning that full implementation of healthier together for general surgery can now not take place until 2020 at the earliest.
5.4 - Achieving sustainable services through collaboration within the North West Sector of Manchester	Implement a sector model of provision for Urology services that fully aligns to GM requirements		There is now a single clinical lead for a shared urology service across Wigan and Bolton, supported by a single operational manager. At a sector level, things are more complex. GM requirements of urology have not yet been fully clarified, and the implications for this sector are also dependent on a decision regarding Uro-oncology services. The CCG have pulled together an initial draft proposal on behalf of the three commissioners in the sector. The draft proposal suggests a single site between Bolton and Wigan, Salford will look to potentially work with Pennine. The plan has yet to be formally agreed but is scheduled for business in the next quarter.
	Sector Model for the provision of Breast services		Salford CCG are leading on discussions to a sector solution. The proposal would be for a single service in the sector jointly provided by Bolton and Wigan. The proposal includes the suggestion of capital investment on the Bolton site to create a single centre similar to the Nightingale unit in South Manchester, and the extension of the catchment area to include symptomatic services to cover the areas screened by the respective units. in Bolton's case this would mean taking patients from Bury and Rochdale. The proposal is in its first draft.
5.5 - Supporting the Urgent Care System	Integrated Neighbourhood Teams to support Tier 4 (Acorn group 1) of the most at risk population		This work is due to start in June.
5.6 - Shift Activity into the Community	Provisions of virtual and rapid access clinics to support patients with long term respiratory conditions		Transformation Funding has been approved for these clinics. Work has started on how to implement these changes.
	Implementation of a Community Heart Failure team and rehabilitation service		Transformation Funding has been approved for these services. Work has started on how to implement these changes.
5.7 - Development of a Local Care Organisation	Governance in place to enable greater single management between health and social care providers		There has been agreement on a joint way of working but as yet the formalising of joint accountability has not been decided upon.

Appendix 1

NHS Improvement Risk Oversight Framework

Theme	Information Used	Governance concern triggered by
Quality of Care	• CQC information • Other quality information to inform our view of a provider • 7-day services	• CQC 'inadequate' or 'requires improvement' assessment in one or more of safe, effective, caring, responsive • CQC warning notices • Any other material concerns identified through, or relevant to, CQC's monitoring process, e.g. civil or criminal cases raised, whistleblower information, etc. • Concerns arising from trends in our quality indicators • Delivering against an agreed trajectory for the four priority standards for 7-day hospital services
Finance	• Sustainability Capital service cover Liquidity • Efficiency I&E14 margin • Controls Performance against plan Agency spend • Value for money information	• Poor levels of overall financial performance (average score of 3 or 4) • Very poor performance (score of 4) in any individual metric • Potential value for money concerns
Operational Performance	NHS Constitution standards Other national targets and standards	• For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard. • For providers without STF trajectories: failure to meet any standard for at least two consecutive months
Strategic Change	Review of sustainability and transformation plans and other relevant matters	• Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution
Leadership and Improvement Capability	Findings of governance or well-led review undertaken against the current well-led framework. Third party information, e.g. Healthwatch, MPs, whistleblowers, coroners' reports. Organisational health indicators . Operational efficiency metrics. CQC well-led assessments.	• Material concerns • CQC 'inadequate' or 'requires improvement' assessment against 'well-led'.

*Framework revised September 2016

Appendix 2

NHS Improvement Risk Oversight Report 2016/17 and 2017/18

Indicator (All measured/reported Quarterly)	Threshold	Qtr1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Apr-17	May-17	Jun-17	Qtr1 17/18	Jul-17	Aug-17	Sep-17	Qtr2 17/18	Oct-17	Nov-17	Dec-17	Qtr3 17/18	Jan-18	Feb-18	Mar-18	Qtr4 17/18
Referral to treatment time - incomplete pathways	92%					92.1%	92.9%	93.0%	92.7%	92.5%	92.2%	91.4%	92.0%	91.1%	90.0%	88.8%					
Referral to treatment time - 52 week waits (incomplete pathways)	0	0	3	3	6	5	1	1	7	4	3	2	9	1	1	2					
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	82.3%	85.0%	80.1%	82.7%	82.5%	86.4%	84.7%	84.7%	84.8%	78.3%	84.5%	84.7%	88.0%	80.4%	76.9%					
All cancers: 62-day wait for first treatment from:																					
From urgent GP referral - post local breach re-allocation	85%	95.8%	93.5%	96.1%	94.5%	94.2%	93.0%	92.0%	93.1%	92.7%	92.9%	91.1%	92.2%	87.4%	87.6%						
From NHS Cancer Screening referral - post local breach re-allocation	90%	95.5%	98.4%	97.2%	96.0%	92.5%	96.4%	88.9%	92.6%	85.7%	83.3%	77.3%	82.1%	61.0%	81.1%						
From urgent GP referral - pre local breach re-allocation	No Threshold	96.1%	92.7%	95.8%	96.3%	90.7%	93.0%	94.8%	92.8%	92.7%	91.3%	87.2%	90.4%	90.0%	89.2%						
From NHS Cancer Screening Service referral) - pre local breach re-allocation	No Threshold	96.4%	98.4%	97.2%	96.0%	94.9%	96.4%	90.9%	94.1%	94.1%	87.0%	77.3%	86.1%	65.8%	83.3%						
All cancers: 31-day wait for second or subsequent treatment																					
Surgery	94%	98.1%	86.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	97.0%	92.9%	100.0%						
Drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
From diagnosis to first treatment	96%	97.7%	95.2%	96.4%	99.6%	100.0%	100.0%	99.0%	99.7%	97.8%	100.0%	98.9%	98.9%	100.0%	100.0%						
Cancer: two week wait from referral to date first seen, comprising:																					
Cancer 2 week (all cancers)	93%	98.7%	99.0%	98.8%	98.6%	93.9%	98.6%	98.6%	97.0%	97.2%	97.2%	98.0%	97.5%	98.3%	97.0%						
Cancer 2 week (breast symptoms)	93%	96.5%	95.9%	93.7%	92.7%	89.1%	87.7%	45.1%	74.0%	62.9%	21.8%	34.9%	39.9%	38.1%	86.9%						
C.Diff due to lapses in care (RAG Rated monthly)	19	5	3	6	6	1	2	1	4	0	3	4	7	2	0						
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	No Threshold	6	11	12	8	4	2	1	7	6	3	5	14	2	1	2					
C.Diff cases under review	No Threshold	2	4	2	1	3	0	0	3	0	0	0	0	0	0	1					
Certification against compliance with requirements regarding access to health care for people with a learning disability	No Threshold	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Risk of, or actual, failure to deliver Commissioner Requested Services	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
CQC compliance action outstanding (as at time of submission)	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
CQC enforcement action within last 12 months (as at time of submission)	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
CQC enforcement action (including notices) currently in effect (as at time of submission)	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					
Trust unable to declare ongoing compliance with minimum standards of CQC registration	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No					

* All Cancer data reported one month in arrears.

Appendix 3

62 day Cancer Performance by site

All tumour sites
National standard 85%
Figures are post-reallocation

Month	Breast	Gynaecology	Haematology	Head and Neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urology	All Sites
April	11.5/11.5	1/1.5	1/2	4/4	6/6	5/5			7/7	4/4.5	9/10	48.5/51.5
	100.0%	66.7%	50.0%	100.0%	100.0%	100.0%	N/A	N/A	100.0%	88.9%	90.0%	94.2%
May	4.5/5.5	2.5/2.5	2/2	1/1	9.5/9.5	2.5/3			15/15	3.5/4.5	6/7	46.5/50
	81.8%	100.0%	100.0%	100.0%	100.0%	83.3%	N/A	N/A	100.0%	77.8%	85.7%	93.0%
June	14/15	2/2	2/3	2.5/2.5	1.5/1.5	5.5/6.5		0.5/0.5	9/9	1.5/2.5	7.5/7.5	46/50
	93.3%	100.0%	66.7%	100.0%	100.0%	84.6%	N/A	100.0%	100.0%	60.0%	100.0%	92.0%
Q1 (April-June)	**30/32**	**5.5/6**	**5/7**	**7.5/7.5**	**17/17**	**13/15**		**0.5/0.5**	**31/31**	**9.5/12.5**	**23/24**	**142/152.5**
	93.8%	**91.7%**	**71.4%**	**100.0%**	**100.0%**	**86.7%**	**N/A**	**100.0%**	**100.0%**	**76.0%**	**95.8%**	**93.1%**
July	12/14	3/3	6.5/6.5	0.5/0.5	6.5/6.5	3/3			8/8	3/5	8.5/8.5	51/55
	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	N/A	100.0%	60.0%	100.0%	92.7%
August	7/9	2.5/2.5	5/6	3/3	10/10	5/5	1/1	0.5/0.5	8/8	3/4	7.5/7.5	52.5/56.5
	77.8%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	92.9%
September	4.5/5.5	0.5/1.5	4/4	2.5/2.5	5/6	3.5/4.5	1/1		8.5/8.5	1.5/1.5	10/10	41/45
	81.8%	33.3%	100.0%	100.0%	83.3%	77.8%	100.0%	N/A	100.0%	100.0%	100.0%	91.1%
Q2 (July-September)	**23.5/28.5**	**6/7**	**16.5/17.5**	**6/6**	**21.5/22.5**	**11.5/12.5**	**2/2**	**0.5/0.5**	**24.5/24.5**	**7.5/10.5**	**26/26**	**145.5/157.5**
	82.5%	**85.7%**	**94.3%**	**100.0%**	**95.6%**	**92.0%**	**100.0%**	**100.0%**	**100.0%**	**71.4%**	**100.0%**	**92.4%**
October	9.5/11.5	2/2	3/3	2.5/3.5	3/3	4/7			11.5/11.5	2.5/3	7/7	45/51.5
	82.6%	100.0%	100.0%	71.4%	100.0%	57.1%	N/A	N/A	100.0%	83.3%	100.0%	87.4%
November	9/10	1.5/1.5	5/7	2.5/2.5	4/4	2/3			10/10	3.5/5.5	12/13	49.5/56.5
	90.0%	100.0%	71.4%	100.0%	100.0%	66.7%	N/A	N/A	100.0%	63.6%	92.3%	87.6%
December												
Q3 (October-December)												
January												
February												
March												
Q4 (January-March)												
Year	**72/82**	**15/16.5**	**29.5/34.5**	**18.5/19.5**	**45.5/46.5**	**30.5/37.5**	**2/2**	**1/1**	**77/77**	**23/31.5**	**68/70**	**382/418**
	87.8%	**90.9%**	**85.5%**	**94.9%**	**97.8%**	**81.3%**	**100.0%**	**100.0%**	**100.0%**	**73.0%**	**97.1%**	**91.4%**

Source: Open Exeter

Appendix 3

62 day Cancer Performance by site

All tumour sites
National standard 85%
Figures are post-reallocation

62 Day Cancer Performance

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Bolton Reallocated Position	90.40%	85.50%	88.20%	91.40%	85.00%	90.00%	92.50%	88.70%	93.80%	87.20%	90.60%	93.50%
GM & C performance	90.20%	84.10%	82.60%	87.90%	85.50%	84.10%	86.40%	89.50%	90.00%	85.20%	86.00%	88.60%
National Performance	83.10%	81.20%	81.40%	81.90%	82.70%	81.50%	81.80%	83.50%	85.10%	81.00%	81.00%	84.00%
National Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Bolton Reallocated Position	94.00%	97.00%	96.40%	93.40%	93.40%	93.60%	96.90%	97.80%	94.80%	92.31%	92.2%	94.6%
GM & C performance	87.60%	88.00%	86.00%	87.60%	86.80%	85.70%	86.10%	88.30%	86.60%	86.90%	84.9%	85.8%
National Performance	82.80%	81.50%	82.70%	82.20%	82.80%	81.40%	81.10%	82.27%	83.05%	79.69%	79.8%	83.0%
National Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.0%	85.0%

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Bolton Reallocated Position	94.20%	93.07%	92.00%	92.73%	92.86%							
GM & C performance	87.70%	85.15%	83.40%	85.30%								
National Performance	82.91%	81.03%	80.55%	81.40%	82.63%							
National Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.0%	85.0%

	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18
Bolton Reallocated Position	88.50%	88.80%	91.70%	90.60%	95.80%	93.20%	96.20%	94.5%	93.11%			
GM & C performance	85.70%	85.90%	88.50%	86.80%	87.30%	86.70%	87.00%	86.3%	85.70%			
National Performance	81.80%	81.90%	83.40%	81.90%	82.40%	82.30%	82.25%	81.1%	81.55%			
National Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.0%	85.0%	85.0%	85.0%	85.0%

Narrative:

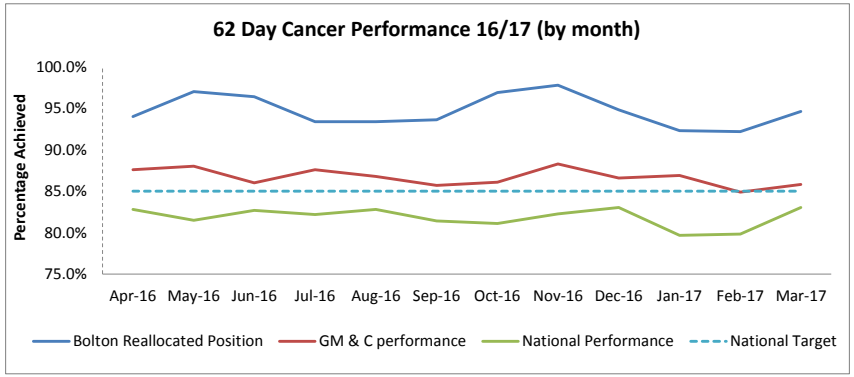
The main national cancer target is the 62 day (referral to treatment) standard. This is a quarterly target of 85% of patients commencing their cancer treatment within 62 days from referral.
The attached graphs demonstrate the Trust's performance against this standard, the England average, and the Greater Manchester and Cheshire (GM&C) average . Additionally, the graphs below demonstrate the performance by individual months.

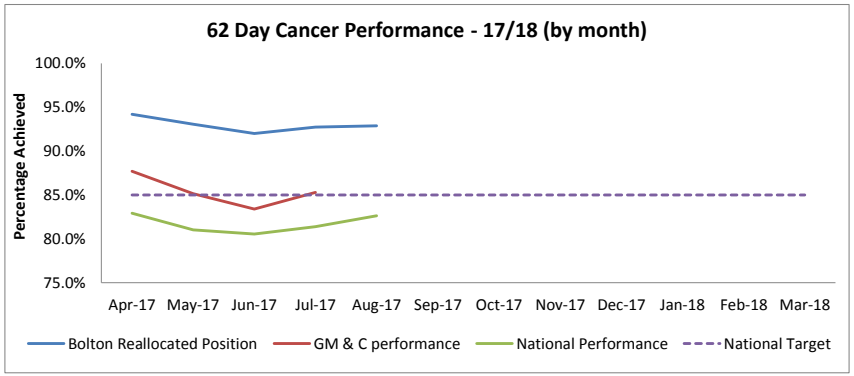
The Trust was the best performing provider in Greater Manchester & Cheshire against the main national cancer standard (the 62 day referral to treatment target) for Q1, Q2, Q3 and Q4 in 2016/17.

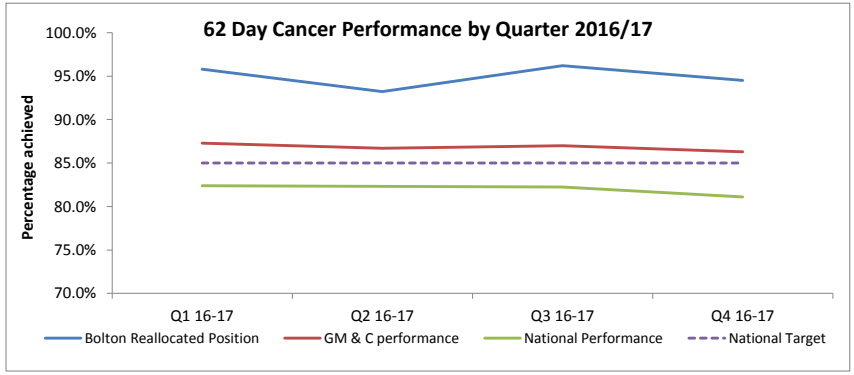
62 day Cancer Performance by site

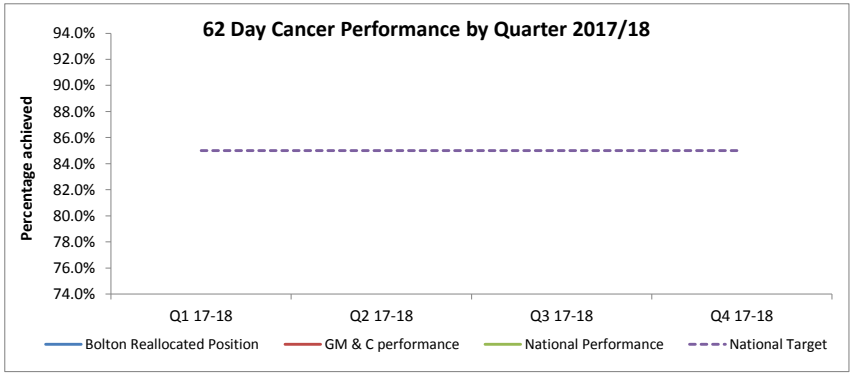
All tumour sites
National standard 85%
Figures are post-reallocation

62 Day Cancer Performance - Charts









Appendix 4

Acronyms/Terms used in Report

Acronym	Definition
AHP	Allied Health Professional
AHSN	Academic Health Science Networks
BADS	British Association of Day Surgery
BCF	Better Care Fund
C. Diff. / CDT	Clostridium Difficile
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CHKS	Comparative Health Knowledge System
CIP	Cost Improvement Programme
CNST	Clinical Negligence Scheme for Trusts
CPE	Carbapenemase producing Enterobacteriaceae - Carbapenem antibiotic resistant bacteria
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
GDH	Clostridium Difficile GDH (Glutamate Dehydrogenase)
GUM	Genito Urinary Medicine
HCAI	Health Care Associated Infections
HSCIC	Health and Social Care Information Centre - NHS Digital
HSMR	Hospital Standardised Mortality Ratio
ICIP	Income and Cost Improvement Programme
IPC	Infection Prevention and Control
LD	Learning Disability
LOS	Length of Stay
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NEL	Non Elective
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
PTL	Patient Target List
QAC	Quality Assurance Committee
QPG	Quality and Performance Group
RCA	Root Cause Analysis
RTT	Referral to Treatment
SAS	Specialty and Associate Specialist Doctors
SHMI	Standardised Hospital Mortality Indicator
SI	Serious Incident
STF	Sustainability and Transformation Fund
VTE	Venous Thromboembolism
WHO	World Health Organisation
YTD	Year to date

Appendix 5

Report Change log

Date	Indicator Description	Requested by	Change	Authorised by
18/05/2017	iFM sickness breakdown	Mark Wilkinson	Add metric	Exec Team
18/05/2017	Nurse Group sickness breakdown	Mark Wilkinson	Add metric	Exec Team
18/05/2017	Nurse Fill rates	Mark Wilkinson	Add metric	Exec Team
18/05/2017	Unregistered Nurse fill rate	Mark Wilkinson	Add metric	Exec Team
18/05/2017	Annual ceiling for Nursing staff agency spend	Mark Wilkinson	Add metric	Exec Team
19/05/2017	Compliance with hourly caps for all agency staff	Mark Wilkinson	Add metric	Exec Team
16/06/2017	Turnover of band 5 staff	Mark Wilkinson	Remove metric	
11/07/2017	Add in section summary sheet	Exec team	Added summary sheet	Exec team
11/07/2017	Stability index	Carol Sheard	Remove metric	Exec Team
18/07/2017	Aid time for decision to admit	Andy Ennis	Add metric	Exec Team
18/07/2017	Deb request to availability	Andy Ennis	Add metric	Exec Team
18/07/2017	Stranded patients (pts with a length of stay greater than 6 days - average No for the month)	Andy Ennis	Add metric	Exec Team
01/11/2017	RTT 52 week breaches (admitted pathways)	Exec team	Add metric	Exec Team
01/11/2017	RTT 52 week breaches (Non admitted pathways)	Exec team	Add metric	Exec Team
01/11/2017	Operations cancelled on the day for Non clinical reasons	Exec team	Add metric	Exec Team
01/11/2017	Cancelled operations re-booked within 28 days	Exec team	Add metric	Exec Team
01/11/2017	Total Number of incidents reported on SAFEGUARD	Exec team	Add metric	Exec Team
21/11/2017	Added in maternity split for Friends and Family indicators	Exec team	Added metrics	Exec Team

08/12/2017 Alligned Trust objectives with Operational Plan

Trust Objectives

NHS Bolton NHS Foundation Trust

Agenda Item No: 16

Meeting	Board of Directors

Date	25th January 2018

Title	North West Sector Partnership Healthier Together Business Case

Executive Summary	This paper shares the North West sector Business Case and is going simultaneously to all provider Boards and commissioner Governance Bodies in the Sector. The main focus of this Business Case is to capture progress made in developing new models that comply with Healthier Together requirements and will deliver high quality and sustainable services for the benefit of the 860,000 people in the North West Sector.

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	North West Sector Programme Office	Presented by	Richard Mundon, Director of Strategy

NHS
Bolton, Salford and Wigan Partnership
NHS organisations working together

North West Sector Partnership (Final)

Business Case for new models of care – Healthier Together In-scope Services:

- General Surgery
- Urgent, Emergency and Acute Medicine
- Radiology

November 2017

Revision history

Revision	Date	Summary of Changes	Author
Jo Goodfellow	13.2.17		
PMO	17.03.17		
Jo Goodfellow	4.6.17.	Review of whole document	
Jo Goodfellow Diane Morrison Mel Laskey	14.9.17.	Revision of UEAM, Radiology and Finance sections Paediatric Surgery section	JG/DM/ML
Jo Goodfellow added revised finance section	13.10.17.	Revised finance section	DM
Jo Goodfellow added comments from partner organisations and Assurance Statement	30.11.17	Best use of emergency theatres at hub site page 49 (SRFT). Update of section on sector shared services Page 86 Scope of the Business case does not cover locality plans. Page 6 Update on the GM NWAS Task and Finish Group Page 28 Refresh of section 1.3.4. following DoF agreement on Assurance Statement Page 10 Requirement to review use of estate to mitigate stranded costs Page 83 Updated Risk Register Page 103	JG

Approvals				
Version	**Name**	**Governance**	**Date of Approval**	**Date of Issue**

Table of contents

1. Executive summary

1.1 Purpose of the business case

1.1.1 This Business Case (BC) demonstrates how the North West Sector Partnership (NWSP, comprising the three NHS Foundation Trusts and three Clinical Commissioning Groups) will implement new clinical models for Healthier Together (HT) in-scope services. It will also reflect the wider work being carried out in the sector which will enable implementation of the HT model.

In this document we:

- Set out the context for the implementation phase of Greater Manchester Healthier Together (GM HT).
- Provide a summary of Sector new clinical models for General Surgery; Urgent, Emergency and Acute Medicine (UEAM); and Radiology.
- Explain the outputs of extensive, detailed activity modelling with the implications for patient flows, capacity and workforce.
- Review the financial implications, including capital and transition costs, and recurrent and non-recurrent revenue, and how they will be managed within the Sector.
- Describe Programme 3, the NWS approach to exploring and developing single sector services that will ensure future sustainability of services across all three localities.
- Demonstrate arrangements in place for leadership and governance, including risk management.
- Make recommendations for the NWS Partnership Board, in the context of governance processes and due diligence summarised in the box below.

Governance and due diligence processes for the sector business case – in brief

- The Sector has developed this Business Case to: present the clinically-led new models of care; outline the implications for patients, workforce and finance; explain how the changes will be implemented.
- It is set in the context of:
  - A set of prior decisions regarding the case for change and preferred model.
  - A GM-wide Financial Business Case (FBC), to which the Sector has contributed and is the route for capital and transitional support.
  - A broader process through which the six organisations in the Sector will agree management of recurrent revenue consequences.
- Due diligence is assured in two respects:
  - Commissioners, with the Joint Commissioning Board, have considered the case for change, anticipated benefits, value for money and affordability.
  - Clinicians within the Sector, with scrutiny and support from GM HT leads, have signed-off the clinical models, activity figures and will lead the phased implementation.

Further assurance is given at a Sector level through the NWS Partnership Board and the Boards of constituent organisations.

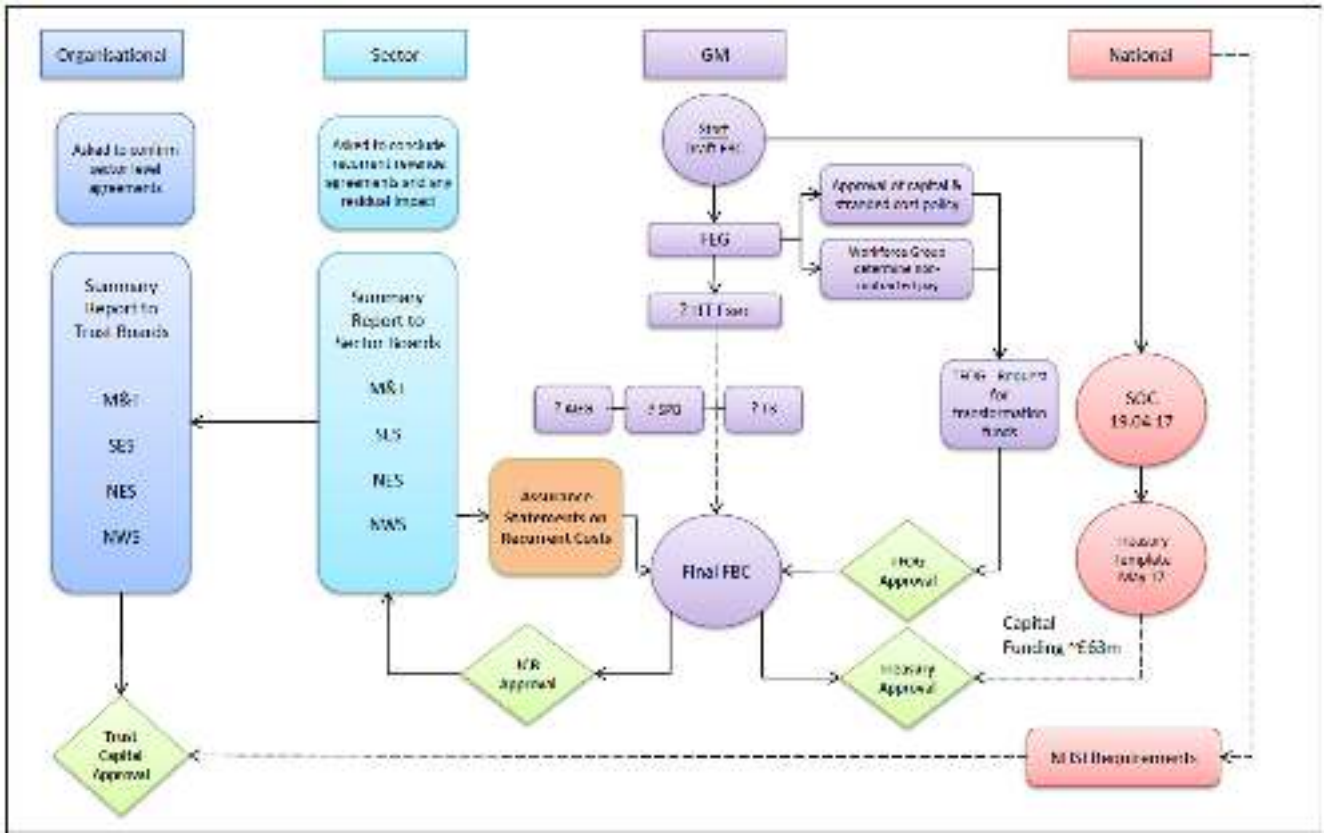
Alignment between Healthier Together FBC and NW Sector Business Case

As explained in a letter from Chief Executive Jon Rouse (8th May 2017, Appendix 1), the GM Health and Social Care Partnership agreed that the decision to progress the Healthier Together FBC will be approved through a single

collective governance route. The Joint Commissioning Board will act as the key commissioning decision-making forum, for GM-wide service configuration issues. As a consequence, it is not deemed necessary for the HT FBC to go to each Sector governance group for approval. It was agreed that a report in the form of an assurance paper will be taken through local governance routes, inclusive of the statement of assurance from the Directors of Finance in each Sector, for recurrent revenue agreements. The decision-making points, and request for each relevant body, are therefore:

- **Transformation Fund Oversight Group** – asked to assess and approve the transformation fund bid.
- **Joint Commissioning Board** – single point of approval for FBC and implementation decision, with DH **/ Treasury** asked to assess the strategic outline case and approve the release of capital.
- **Sector Boards** – asked to conclude and confirm the recurrent revenue agreements.
- **Trust Boards** – asked to confirm sector level agreements, and in the case of hub sites to approve capital investments and liaise with NHSI on the individual Trust capital business cases.

The governance map below illustrates the process and decision-making outlined above.



The main focus of this Business Case is to capture progress made in developing new models that comply with HT requirements and will deliver high quality and sustainable services for the benefit of the 860,000 people in the North West Sector. Aligned to and drawing on this document, the Sector will receive an assurance paper on financial implications and the requirement for new capital investment, as part of a GM HT Financial Business Case. The GM HT Decision Making Business Case (DMBC, Appendix 2) as approved by GM and Sector commissioners is taken as the Outline Business Case for the changes.

1.2 Scope

1.2.1 The Business Case has been commissioned by the NWS Partnership Board which comprises representatives of:

- Bolton NHS Foundation Trust (BFT)
- Salford Royal NHS Foundation Trust (SRFT)
- Wrightington, Wigan and Leigh NHS Foundation Trust (WWL)
- Bolton Clinical Commissioning Group
- Salford Clinical Commissioning Group
- Wigan Borough Clinical Commissioning Group

This Business Case will be received by the Partnership Board and six organisational Boards to support implementation of GM HT new models of care in the North West Sector, with formal governance provided through the process summarised above.

Members of the NWS Partnership Board at its meeting on 21st April 2017 discussed the process to finalise the implementation plan for HT in-scope services and the new models explained in this Business Case. It was noted that the Transformation Unit (TU) would develop a single Business Case for Healthier Together that would go to the Joint Commissioning Board. The NWS Partnership Board, based on GM-wide guidance and agreement, noted that adoption of GM HT models across GM is a commissioner decision, with provider Trust Boards in the Sector required to agree implementation plans, having been assured by the Partnership Board that due diligence has been followed – with all relevant issues scrutinised, risks identified and mitigated, and supporting governance arrangements in place.

This NWS Business Case is aligned with the GM HT Business Case, and provides much greater detail on the Sector response to delivering HT new models of care for relevant services. It summarises and reiterates the clinical case, and presents extensive work in the Sector on the clinical, financial and operational implications of implementing the new models of care for the areas below.

1.2.2 The scope of this Sector Business Case includes HT in-scope hospital services which are:

- General Surgery
- Urgent, Emergency and Acute Medicine (UEAM)
- Radiology

Given clinical interdependencies, we also summarise the Sector's approach to making changes in a range of other acute services through NWSP Programme 3. This work is assessing how wider strategic service transformation in the NWSP can deliver further improvement and resilience through collaboration. It includes developing single sector services and potential relocations to mitigate the consequences of implementing HT, such as handling stranded costs. Based on analysis and engagement, eight priority areas have been identified for Programme 3, including paediatrics. This work is also aligned to wider changes and emerging approaches as part of GM HT Theme 3.
This Business Case does not reflect other GM Themes or locality plans within Bolton, Salford or Wigan.

1.2.3 The objectives of this Business Case are to:

- Capture and report on progress made in the Sector in creating new clinical models.
- Clarify the implications for patient flows, the distribution of activity and capacity across the Sector, along with the impact on our workforce.
- Present financial analysis, including capital and transitional costs required to implement the new models and revenue implications, both for transition and longer term impact.
- Gain support from Boards in the partnership for the Sector's implementation plan.

Clinical Area	Brief summary – developments
General Surgery	• Creating a single shared service for general surgery, with a Sector hub for high-risk emergency and elective activity at Salford and low-risk sites at Bolton and Wigan, which will continue to assess all elective and non-elective GS cases, streaming patients to the most appropriate care pathway and providing care to low-risk elective and non-elective cases on site. • Detailed work and extensive analysis of high and low-risk, elective and non-elective activity – what will move, what remains at local sites – with related analysis of capacity and workforce. In summary: o As ***elective high-risk*** general surgical cases are moved to the Sector hub, around ***one in five of elective patients*** currently admitted to Bolton or Wigan will transfer to Salford (363 out of a total of 1,934). o As ***non-elective high-risk*** general surgical cases are moved to the Sector hub, around ***one in seven non-elective patients*** currently admitted to Bolton or Wigan will transfer to Salford (1,268 out of a total of 8,798). o The Sector hub will require capacity for an additional 53 inpatient general surgical beds (10 EL, 42 NEL), an additional 6 critical care beds and 617 theatre sessions per annum. • The new model of care emphasises the importance of: o Developing consistent, effective model of ambulatory care o Surgical triage, with senior clinical decision makers and diagnostics o Reducing unwarranted variation and spreading best practice • Extensive clinical engagement, led by a General Surgeon, with plans to support staff through the transition e.g. to maintain and develop skills.
Urgent, Emergency and Acute Medicine (UEAM)	• Given the volumes of activity and levels of demand, Emergency Department / A&E and full Acute Medicine services will continue at all three Sector sites. • A collaborative service model is being developed, aiming to: o Improve consistency, quality and efficiency in day-to-day working across all three sites, in part by improving patient flows. o Develop to meet HT standards that affect the longer-term running of each service, which include access to specialist input. o Collaborative working to achieve additional standards – as part of which, there will be an opportunity (not mandated) for staff to work across Trusts in the Sector. The Sector has the ambition to provide a minimum 16-hour consultant cover 7/7 at all three sites (which exceeds HT standards and is subject to discussion within the Sector). • The new model of care is being developed through clinical engagement and leadership,

	and emphasises the importance of: ○ Standardising what are currently different models and practices. ○ Responding to gaps in the senior medical workforce, as experienced in the Sector, GM and nationally. ○ Creating a 'blended workforce' which includes new roles and practitioners, in part to mitigate risks with the shortage of staff and to support innovation in clinical practice.
Radiology	• Work is underway to develop a new Radiology model of care, which is highly dependent on approaches in General Surgery and UEAM, given clinical co-dependencies. • Radiology faces significant challenges in recruiting appropriate senior workforce, in particular for interventional radiology, which will be a further driver of new practice and service innovation. • Much work is taking place at a GM-level, such as the development of a business case for seamless image sharing (PACS / VNA). This approach will continue and potentially broaden as it is only through transformation across a larger footprint that viable, robust services can be developed. • Current activities in the Sector include: mapping current activity, workforce and equipment; analysing models and capacity; identifying opportunities for collaboration and improvement in the NWS; and supporting GM-wide workstreams to identify wider solutions to workforce challenges.
NWS Programme 3	• The Sector has been forging ahead (led by a Task and Finish Group) in delivering service improvements by collaborating on a series of priority areas. • The initial eight services considered by the group in 'Wave 1' were: breast services; benign urology; elective orthopaedics; paediatrics; dermatology; sterile services; pathology; back office functions. • The NWS Partnership Board agreed in January 2017 to further develop workstreams for paediatrics, breast services, elective orthopaedics and benign urology, and to regularly review dermatology and sterile services. • Following review in April 2017, it was highlighted to NWS Partnership Board that resilience issues have increased in Dermatology services due to changes in consultant workforce. In response, the Board requested that a number of actions be taken, including collaboration between Sector services to support resilience at the Bolton FT site in the short term, and the longer-term development of a single sector service for Dermatology, hosted by SRFT. • For paediatrics, work is underway to develop a business case for a new model, given the prior approval of a case for change. This area has specific clinical interdependencies, such as with Emergency Medicine, General Surgery and Radiology. It is important to note that in the NWS paediatric high-risk surgery cannot be cannot be co-located with high-risk adult services because the Sector hub does not provide paediatrics. • A case for change is being developed for breast services, dermatology and elective orthopaedics. The case for change for breast and dermatology services will be presented to the NWS Partnership Board in September 2017. • We are currently assessing the benefits and risks of developing benign urology services at different scales, and will take account of the GM model of care for Urology services (a draft GM case for change was circulated in July 2017).

Further information and evidence to support the Business Case are given in a set of Appendices.

1.3 Summary

1.3.1 The Business Case

The business case is based on extensive and ongoing engagement, particularly with clinicians, and has been subject to detailed scrutiny within the Sector and by GM HT for compliance with the wider programme objectives and quality standards. Organisations in NWSP are working in close partnership to implement the HT programme by:

- Creating a single shared service for General Surgery (including Paediatric non-elective surgery) with a common model of care operating across three sites, with implications for ambulatory care, and high and low risk elective and non-elective General Surgery.
- Enabling all Urgent, Emergency and Acute Medicine (UEAM) services to provide consistent and improved patient care across the Sector which meets GM standards. This will be achieved by creating a more collaborative model of care, with a blended workforce and enhanced senior medical cover.
- Developing a new, transformed model of radiology that meets clinical standards and is aligned with the Sector changes in General Surgery and UEAM, as well as GM-wide developments in radiology. The work includes consideration of Sector and GM options for effective service delivery, given the particular workforce challenges faced in this specialty.
- Addressing critical issues including clinical-interdependencies between these services and wider models of care.

Clinical models

A short summary of developments for the main clinical areas is given in the table below. All the changes are designed to help the Sector meet GM HT Quality and Safety Standards, supported by the NWS Partnership, and implement the agreed new models of care through single shared services or greater collaboration across separate Sector services.

1.3.3 Implementation Plan

The overall implementation plan is given at the start of Section 4. In summary:

- A phased implementation approach is being taken, with no activity shifting until the capacity and workforce are in place to assure appropriate quality and safety standards, except for a small group of high-risk elective surgery patients which can be accommodated within SRFT's existing bed and clinical capacity. This early implementation will enable Sector clinicians to become familiar with working at the hub site and develop inter-organisational relationships in advance of the transfer of all high risk patients to the hub once the capital build is complete.
- General Surgery is leading by creating and implementing a single shared service, with the new model of care being implemented from Q1, 2017. Initial changes include more joint working, particularly to deliver greater benefits from Ambulatory Care, and collaborating in a Sector-wide colorectal MDT, though which a small volume of high-risk elective activity will shift to the Sector hub. More substantial changes in patient flows and activity (with all high-risk elective and high-risk non-elective General Surgery shifting to the Sector hub) are anticipated to occur in early 2020, given contingency on having the necessary infrastructure in place. We anticipate receiving the decision on capital by mid-June, after which we can make further progress on creating the additional capacity (beds, theatres, critical care) and workforce required to implement the new

model of care. In addition, the Sector will identify suitable smaller groups of high-risk elective cases that could be moved to the hub site from 2017, in advance of the capital build, when capacity becomes available.

- Changes in UEAM and Radiology are currently in development, with outline plans described later in this Business Case. Specific priorities include meeting the requirements of the GS work stream, creating a blended workforce, standardising ambulatory care models, developing pathways and supporting wider work across GM (particularly for Radiology). For all, our aim is to provide consistent, sustainable care that meets HT quality and safety standards.
- The wider implementation will be supported by enabling work including:
    - Governance and leadership for single shared services
    - Communications and engagement
    - Workforce development
    - IM&T – particularly for shared records to support standardised pathways

1.3.4 Financial implications, risks and mitigation

The sector approach is founded on the agreement and principles described in the Memorandum of Understanding (MOA, July 2016) which includes the shared vision of delivering:

- Clinically sustainable services, where care is standardised, ensuring the best possible outcomes, provided as local as possible.
- An affordable acute footprint, delivered within available resources.

During 2017, finance leaders from the sector partner organisations worked together to develop an assurance statement which outlines the North West Sector (NWS) Directors of Finance (DoFs) agreement, or proposed further work required to gain agreement, in relation to the finances related to implementing HT. This finance assurance statement is required as evidence for the capital business case and the submission for non recurrent funding through the Greater Manchester Transformation Fund. It is unlikely that either capital or non recurrent funding will be approved unless agreement has been reached- or a process to resolve any outstanding issues has been agreed- on the recurrent financial consequences of implementing the HT standards.

On 17th November 2017, sector DoFs agreed a funding assurance statement which they were happy to recommend for review and approval by their respective Boards. The statement was also sent to GM Health and Social Care Partnership Team

1.3.5 Governance and leadership

Well established governance arrangements are in place for the North West Sector, with clear reporting arrangements, shared aims and ways of working in collaboration. These are aligned to other structures, such as the recently reformed Shared Services Board which will better enable providers to collaborate in implementing the changes. (Appendix 3).

1.4 Recommendations

The recommendations of the Sector Business Case for the NWS Partnership Board, reflecting the governance and due diligence processes outlined above, are as follows:

Notes to the recommendations	**Decisions taken prior to this Business Case include:** • In 2014 Commissioners decided unanimously to approve the Healthier Together model of care across GM and for this to be implemented in the North West Sector, including the transfer of high risk general surgical patients to a single Sector hub site. (Committee in Common decisions in June and July 2015); HT Clarification Document (GS model of care, April 2016); reaffirmed by the NWS Partnership Board) • Agreement across the NWS to work together in implementing the decision in line with a set of principles and objectives (Partnership Board and Memorandum of Agreement, July 2016). • All partners decided to support the creation of a single shared service in General Surgery with a single Clinical Director and wider infrastructure support. The approach reflects the paper Development of NWS Shared Services Board, approved by the three NHS FT Boards in January 2017 (given in Appendix 3). Similar support is agreed for greater collaboration and common, consistent models in UEAM and Radiology, along with a wider set of services (Programme 3). **HT Commissioning intentions** Commissioners have affirmed their decision to commission services in line with HT models and this was included in all commissioning intentions letters to Trusts in GM. It states the intention to implement the first elements of HT framework as soon as possible, including the transfer of high risk elective general surgery patients to the hub sites from 1st April 2017. It included a 'variation' for the North West Sector recognising capacity constraints at the Sector hub and dependency on capital funding. (HT Commissioning Intentions 2016/17, Appendix 4). *At the Joint Committee on 19th September 2017, GM Commissioners approved the Greater Manchester Business Case for Healthier Together.* **Financial principles:** The financial impact of the new models (including risk share framework and balancing transitional costs with long-term revenue neutrality) will be handled in line with the Sector's Financial Principles, as approved by the Partnership Board (10th May 2016). **Value for Money:** Commissioners will continue to review and refresh the financial and investment case to ensure it continues to meet the required value for money indicators and is affordable.
Section	**Recommendations for approval**

Section 2 **Strategic case**	a) Note the updates to the clinical case for change and additional information on the strategic context.
Section 3 **Clinical models**	b) Support implementation of the new model of care for **General Surgery** and: i. Note the outcome of clinically-led work in the Sector to develop an appropriate Sector model of care to meet HT Standards, improve outcomes and reduce unwarranted variation. This includes pathways for high-risk and low-risk elective and non-elective activity at the Sector hub and non-hub sites. ii. Recognise the volume of high-risk elective and non-elective activity that will transfer to the Sector hub based on the model of care mandated at GM and refined by clinicians in the Sector. iii. Endorse the development of a common approach to Ambulatory Care and creation of a Sector colorectal MDT. c) Support development of a new model of care for **Urgent, Emergency and Acute Medicine** including: i. Greater collaboration across the Sector to deliver consistent patient care including the establishment of a UEAM Clinical Governance Forum which will be held 3 times per year, attended by sector Medical Directors. ii. Ongoing work on levels of cover, creation of a 'blended' workforce and innovative roles to help meet HT standards and support viability and affordability. iii. Support work to improve access to specialist input in acute care, aligned with locality plans to enable appropriate and timely flow of patients. d) Support development of a new model of care for **Radiology** that will improve diagnostic and interventional services through joint working across the Sector and beyond, including plans to meet clinical standards and support wider transformation. e) Endorse work to pursue wider opportunities for improvement through collaboration across the Sector through Programme 3 and recognise its interdependency with GM Theme 3.
Section 4 **Implementation plan**	f) Note the summary plan for a phased implementation of the new models of care from 2017 onwards including: i. A single shared General Surgery service implementing the new model of care including: initial transfer of selected high-risk elective cases to the Sector hub (dependent on capacity being available); establishment of sector Colorectal MDT; and implementation of 7-day consistent Ambulatory Care pathways. ii. Note that the most significant shifts affecting patient flows, activity and workforce will occur in early 2020 given dependency on a new capital development at the Sector hub. iii. Action to pursue priority improvements in UEAM and Radiology.

	g) Support ongoing work in key enablers including: workforce development, communications and engagement (with the public, patients and professionals) and IM&T.
Section 5 **Financial case**	h) Note the Sector's bid for Transitional Funding and the Transitional costs of implementation that will be funded by the GM Transformation Fund (£5.256m). i) Note the requirements for capital investment in the Sector hub, receipt of which is contingent on completion of an appropriate Full Business Case by GM for Healthier Together (£18,450m). j) Receive the Assurance Statement signed by NWS Directors of Finance / Chief Finance Officers describing a shared commitment and approach to capital costs, transitional costs, and the handling of non-recurrent and recurrent revenue implications (dated 23rd May 2017).
Section 6 **Governance and leadership**	k) Note the governance and leadership arrangements in place to support implementation of the clinical models and deliver benefits.

2. Strategic Case

2.1 Context

2.1.1 GM HT Programme

The GM HT Programme commenced in 2012 when the 12 CCG's in GM came together with the support of the wider system to initiate transformational change in A&E, Acute Medicine and General Surgery. A case for change was developed through 84 clinical congress/workshop sessions attended by over 370 clinicians including representatives of the North West Sector. Clinicians also described a consistent cohort of standards that, if adopted across the conurbation, would significantly reduce variation and improve performance and quality. Healthier Together is a key part of the wider programme of health and care reform across Greater Manchester and the GM Strategic Plan has five main themes, the third of which is Standardising Acute and Specialist Care (Dec 2015, see Appendix 5) summarised as:

The creation of "single shared services" for acute services and specialist services to deliver improvements in patient outcomes and productivity, through the establishment of consistent and best practice specifications that decrease variation in care; enabled by the standardisation of information management and technology.

Following extensive, long term development, the programme is now at the implementation phase focusing on three areas of 'in-scope hospital services' – general surgery, UEAM and radiology. Following public consultation (by CCGs, July to October 2014), the direction for the programme was articulated in the Decision-Making Business Case (DMBC, October 2015), approved by the Committees in Common (commissioners). The NWS Partnership is responsible for implementing the programme reflecting the context of the North West Sector.

2.1.2 Development of the sector response – clinical models

The then North West Sector Alliance developed a Strategic Outline Case (SOC) in July 2015, as a shared provider response to inform decision making by GM HT. The SOC provides extensive strategic context, including the development of GM HT, its aims and ambitions, and the local contexts for the Sector populations and providers. It reported on the outcome of extensive options appraisal of models for adult general surgery and emergency and acute medicine. The SOC, as the Sector's response to HT proposals, required Board approval by each of the three Foundation Trust Boards (Bolton, Salford and Wigan), which was given. Each Trust presented their specific perspective on the Sector response, including their Board's priorities and requirements (conditions) for the implementation of the approach, as summarised in the notes of the Partnership Board meeting held on 9th June 2015 (Appendix 6)

The North West Sector Partnership comprising all commissioners and providers was created to take forward the work of implementing HT and pursue other opportunities for improvement through collaboration, which are being progressed through Programme 3. A summary of governance arrangements is given in Section 6 of this Business Case. The SOC and other partnership documents give information on health and care in the Sector, which are not repeated here but for the following brief summary.

2.1.3 Health and social care in the North West Sector

The North West Sector of Greater Manchester covers a population of over 860,000. There are significant inequalities in health within Wigan, Bolton and Salford, with all three areas having 'higher than average' deprivation and 'generally worse' general health. Our population will grow in line with the national average leading to a higher prevalence of chronic disease. This means that the health and care needs of our total population will continue to be greater than the national average. Demand for acute services particularly

emergency care has been rising year on year. The financial challenge facing our local organisations requires joined up strategic action between local NHS partners and between health and social care.

Our sector comprises three Foundation Trusts who provide district general hospital services to the populations of Salford, Bolton and Wigan, with Bolton and Salford providing combined acute and community Services. All three Trusts provide some specialist services and SRFT provides Neurosciences for the whole of Greater Manchester.

In the North West sector we recognise the challenges facing our health and social care services now and into the future. No organisation in Greater Manchester or in the North West sector currently meets all of the agreed quality and safety standards. We will be unable to do so unless we work together to deliver reforms which take into account the following:

- The continued growth in demand for existing healthcare services is not sustainable
- The need to ensure a sustainable workforce where there is a national shortage of senior clinical staff in some specialities
- The financial climate and the need to ensure we have financially sustainable services and a viable health and social care sector

We believe that reforms are needed and that there is a moral imperative and urgency to ensure the standards of clinical care are met.

Our three CCGs, three Local Authorities and three Foundation Trusts have come together to create a new partnership and to design a new vision for healthcare across the sector. The aim is to deliver the objectives and standards of the Healthier Together programme, improving the quality and safety of care for patients, improving access to primary care and creating a radically different integrated care system which will see patients receiving much more care in the community or in their own home. More integrated community care will mean far fewer patients needing hospital intervention or admission and will support the planned contraction of hospital capacity. And when people need acute care this will be delivered through an affordable and sustainable service, delivering safe and high quality care that achieves the best possible outcomes.

2.2 Alignment with Healthier Together

2.2.1 Process for alignment with Decision Making Business Case (DMBC)

The GM NHS Transformation Unit is implementing the HT Assurance Framework to ensure that in delivering new models the Sectors meet the Implementation Conditions and Equalities Implementation Conditions set out by the Committees in Common (Appendix 7). The seven stages in the approach are:

1) Establish programme
2) Design of model of care and pathways
3) Modelling of activity, workforce and finance (completion of business case)
4) Detailed design including job plans, rotas, protocols
5) Preparation of estates
6) Planning for transition of patients
7) Post implementation review

In preparing the work captured in this Business Case, the focus has been on Stage 2 which has entailed multiple reviews and submissions of information (further detail available separately). Through this process GM HT have reviewed the Sector's local models of care and pathways to ensure they deliver the standards and principles of HT, through three phases:

- 2a (Clinical) – Presenting the model of care for general surgery (agenda and panel questions)
- 2b (Clinical) – Actions and follow up on the model of care for general surgery and presentation of the medical model of care (agenda and panel questions)
- 2c (SRO and Programme Director, Senior Executive membership, CCG) – Full review of all assurance criteria including management of risks regarding performance

The 2a and 2b reviews have involved extensive and ongoing engagement with clinical leaders in the Sector and in GM HT with detailed examination of models, patient activity and the impact of implementation. The Sector received a letter from Jane Eddleston, Chief Medical Advisor to the HT Programme, on 1st March 2017, following further meetings on 16th and 22nd February, which further clarified the final number of patients to be transferred to the hub sites. Final confirmation of GM assurance of the NWS clinical model is given in the paper *Healthier Together Clinical Model of Care Compliance* (Appendix 8), endorsed by the Association of Governing Groups (AGG – GM meeting of CCG Chief Officers and Chairs) at its meeting on 21st March 2017.

The next section briefly summarises the case for change which underpin the reforms explained in this Business Case.

2.3 The Case for Change

2.3.1 GM HT decisions, case for change and new models of care

The Key Decisions

The NWS Partnership is responsible for implementing GM Healthier Together and the set of clinical and support service improvements being pursued under Programme 3. The GM HT recommendations were approved by the 12 CCGs through the Committees in Common as follows:

January 2015 – decisions on:

- Confirmation of the Case for Change
- Support for the Model of Care
- Consideration of whether there are any Alternative Options
- Criteria to select an option for implementation

June and July 2015 – decisions on:

- The number of single services across GM
- The option to be implemented

Commissioners unanimously decided that implementing four single services would be the best way to improve standards of care and save more lives. The evidence demonstrated four single services would offer the same quality and benefits as five units, but would be quicker and easier to recruit the staff required and implement the changes and deliver improvements.

Before the public consultation (which took place from July to October 2014), commissioners decided that there should be at least three single services in Greater Manchester. Salford Royal, Central Manchester and Royal Oldham hospitals will each specialise in emergency abdominal surgery (general surgery) due to the existing clinical services they currently provide and to ensure all areas in Greater Manchester have equitable access to specialist services. Each of these hospitals will work in a single service with other neighbouring hospitals in Greater Manchester. In July 2015, the decision was taken for Stepping Hill Hospital in Stockport to be the fourth single service.

The Case for Change (clinical and financial) and Vision for the Future are given in the Pre-consultation Business Case (PCBC 2014, p27 – p 47) with a wide range of supporting evidence.

In summary:

A range of acute hospital services – Urgent, Emergency and Acute Medicine, General Surgery and Children's services – currently have highly variable standards and outcomes for patients, and are challenged with shortages of specialist staff and constrained resources. These services would benefit greatly from a new model of care, with the formation of shared, single services across larger geographical footprints, raising the standards in all hospitals, and concentrating the specialist workforce in delivery of the most specialised services into fewer places.

Factors highlighted in the detailed analysis include:

- Relatively poor performance on population health
- Ageing of the population
- Growing demand, such as in primary care and for urgent and emergency care
- Variation in models of care, standards of care and outcomes, such as in emergency care, acute medicine and in general surgery
- Difficulties in recruiting specialist clinical staff (reflected in vacancies for key posts)
- Difficulties in maintaining levels of clinical skills and experience due to the current model where services are spread over many sites
- Inefficient use of scarce, specialist resources, such as for consultants in emergency care and general surgery

For General surgery, a review by the Royal College of Surgeons cited in the PCBC stated:

"The delivery of emergency surgical care is currently sub-optimal. There has been a lack of investment in, and understanding of, the risks of this type of surgery and the associated workload. Mortality varies two-fold between units for surgical emergencies"

Supporting analysis by Dr Foster cited in the PCBC stated that:

If all trusts in Greater Manchester achieved the lowest relative risk nationally, the number of deaths could reduce by 289 per year.

The HT Full Business Case (2017) adds that:

In addition, greater emphasis has recently been placed on the need to provide equity through the provision of 7 day services in the NHS (Seven Day services in hospitals: clarification of priority clinical standards; NHS Improvement December 2016)

The **financial case** was summarised as:

In the light of future growth in demand and actual or relative reductions in budget, the current health and social care system is unaffordable. Current projections estimate a £742 million funding gap across Health and a further £333 million gap in social care, a total gap of more than £1 billion [by 2017/18] *out of a current spend of £6 billion across GM.*

The vision for the future is summarised as:

Hospital services delivered in accordance with best practice standards with quality and safety paramount – the right staff, doing the right things, at the right time

The In Hospital programme aims to achieve the following objectives to contribute to this vision:

- *Care delivered in the community where it is safe and appropriate to do so*

- *Provide consultant delivered care*
- *Deliver seven day services*
- *Provide consistent, high quality care across Greater Manchester*
- *Improve outcomes and experience of hospital care for patients*
- *Effective use of hospital resources – right staff, doing the right things, at the right time and place*
- *Provide a sustainable hospital workforce model for Greater Manchester*

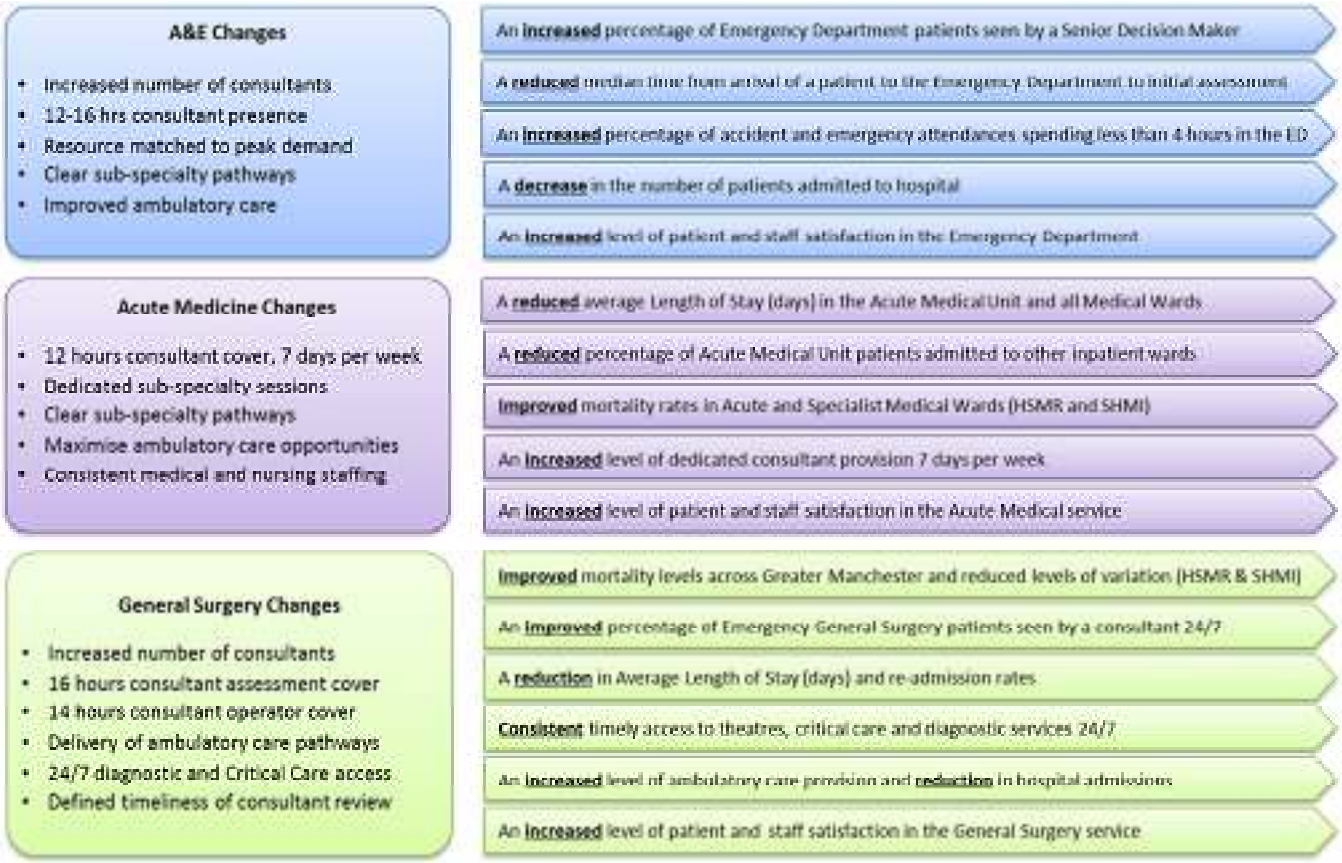
A central tenet of the Hospital vision is to provide reliable, consistent high quality care. To achieve this, a standard specification for services to be delivered against is required. Therefore, the GM Quality and Safety Standards provide the foundation for the hospital future model of care.

The new Model of Care described in the PCBC (p61) includes:

- *Deliver care locally for the majority of patients – Local Services;*
- *Upgrade Local Services so that all sites achieve Greater Manchester Quality and Safety standards;*
- *Care for the small number of patients with 'once in a lifetime' life threatening illnesses and injuries in a smaller number of Specialist Services delivered in line with best practice standards;*
- *To achieve this, create Single Services – multi-disciplinary teams responsible for the delivery of Specialist and Local Services across a sector of Greater Manchester;*
- *Consultant led services delivered to best practice standards*
- *Standardise and improve children's community care to treat as many children as is safe and appropriate to do so in the community;*
- *Work with the Ambulance Service to direct patients to the right place at the right time, including to Community and Primary Care if appropriate as well as to Local and Specialist services, and;*
- *Effective clinical leadership and decision making to ensure high quality, efficient care.*

In conclusion, the North West Sector is charged with enacting this model of care in accordance with the above vision and model of care, based on the previously agreed case for change.

The diagram below summarises the priority changes for the three clinical areas and how these drive benefits (as given in the GM HT Full Business Case).



HT Delivery Board update – clinical case for change

The HT Programme Team recently issued an update on the clinical case for change (Appendix 9 – March 2017) which provides new information confirming the unacceptable variations in care and lack of compliance with national standards that has driven the focus on General Surgery and UEAM, supported by Radiology. The short paper refers to the themes underlying non-compliance (e.g. the need for defined pathways and support from radiology) and expands on workforce issues including variation in the number of key staff (e.g. A&E consultants and middle grades) and gaps in meeting minimum national standards (e.g. number of consultants in urgent care, surgery and anaesthetics). For specific clinical areas, the issues highlighted include the following.

Specialty	***Issues raised and evidence provided – at a GM Level***
Urgent and Acute Medicine	• Unprecedented demand for urgent and emergency care (in common with the wider NHS) • Significant variation in meeting quality and safety standards • Differences in models of care, staffing models and variation in attaining clinical standards, contributing to variation in lengths of stay, readmission rates and patient outcomes.
General surgery	• Evidence of variation in practices between units and individual surgeons 'is overwhelming and significant' • Surgical morbidity and mortality compares unfavourably with international results and

	at a GM level services are characterised by variations in: the number of EM general surgical admissions; average length of stay; compliance with key standards in NELA; access to diagnostics and use of ambulatory care.
	• Quality Improvement themes include:
	  ○ Identification of risk patients, both elective and emergency
	  ○ Understanding by clinical teams of 'true' risk
	  ○ Standardising clinical pathways
	  ○ Making appropriate use of associated specialties e.g. radiology and critical care
	• The analysis also states the use of ambulatory care in surgery is not yet optimised and there are issues in accessing radiology and attracting trainees.
	• National priorities and initiatives from surgical bodies over the past two years reinforce the case for change in general surgery across GM.

Radiology	• Significant workforce challenges, meaning a major shortfall in appointing sufficient radiologists, leading to a reliance on outsourcing some or all of the emergency workload reporting (associated with raised risks of discrepancy in reporting, particularly for those having an urgent or emergency CT abdomen as part of NELA). • Major problems in delivering resilient seven-day basic and intermediate non-vascular interventional radiology (leading to non-compliance with NCEPOD 'Time to get Control' standards for gastrointestinal haemorrhage.

Once implemented, Greater Manchester will be at the forefront in providing high quality and safe care through collaborative, networked working as described in the NHS Five Year Forward View and the Keogh Review[1].

As part of the Full Business Case (FBC) for the GM HT programme a review of programme readiness has been completed as summarised below.

Readiness	Complete?
Counterfactual evidenced (scheme avoids operational/quality harm)	Yes – see case for change in outline business case ("Healthier Together Decision Making Business Case") and this full business case. The clinical case was developed through over 80 GM clinical congresses/workshops assured by the National Clinical Advisory Team (NCAT). The standards were recently re-tested for impact on 12 hour waits with NHSIs Emergency Care Improvement Programme Team (ECIP).
Support to national and GM strategic objectives	Healthier Together supports national strategic objectives: It stretches across primary care, integrated care and acute care, with the primary care element already increasing primary care access in order to reduce inappropriate acute attendances The acute workstream, for which capital funding is sought, ensures care is more cost effective and appropriate by: centralising high acuity care onto four specialist hub sites; and

[1] "Transforming urgent and emergency care services in England" http://www.nhs.uk/NHSEngland/keogh-review/Pages/about-the-review.aspx

	making improvements to the way that care is delivered, such as expansion of ambulatory care (with patients seen the same day in a clinic rather than being admitted for lengthy stays on a ward). This solution is in line with the networked models of care described in the Five Year Forward View and Keogh review. Locally, Healthier Together underpins the GM hospital based services strategy and merger of University Hospital South Manchester and Central Manchester Foundation Trust into a "Single Hospital Service"
Affordability evidenced	Yes – An Outline Business Case, describing "affordability and value for money" was assessed by the ten Greater Manchester CCGs on the 15th of July 2015. The CCGs took a unanimous decision to implement the project. Over 2015, Trusts have worked together to develop the detailed design and refresh their financial estimates. These have not materially changed from the estimates described in the Outline Business Case and are presented in this Full Business Case. Greater Manchester will support transitional and recurrent revenue costs.
NHS England Assurance (inc. four tests)	Yes – Evidenced in the Outline Business Case
Financial return	Yes – Evidenced in the Outline Business Case using a "cost avoidance" approach and refreshed in this Full Business Case using an improved assessment of the benefits to length of stay, admissions and readmissions. Both approaches were tested with Greater Manchester CCG Chief Finance Officers
Outline Business Case ("Decision Making Business Case") signed off by GM	Yes – Agreed unanimously by all 10 CCGs as a "Committees in Common" in 2014
Can Demonstrate Best Possible Value	Yes - The decision to implement Healthier Together was taken in late 2014 and therefore preceded the Best Possible Value Framework. However, a coherent decision making process was undertaken. The programme was assessed on the factors that are included in the framework, for example, clinical effectiveness and safety, patient experience, revenue costs and capital costs. The decision-making process was thoroughly tested when a full judicial review was successfully defended in January 2015
Full Business Case ("Decision Making Business Case") signed off by GM	Yes – This full business case has been reviewed by CCGs, Trust Boards, cross-Trust Sector Boards and the Health and Social Care Partnership (via the Theme Three Delivery Board)[2]
Single Oversight Framework	Yes – The impact on revenue/income has been captured in this full business case. Trusts have modelled the impact on income and expenditure locally as part of the full business case process[3]

[2] This will be confirmed by the central PMO prior to submission
[3] This will be confirmed by the central PMO prior to submission

Ready to implement	Yes – Trusts are ready to start implementation in April 2017 (subject to resolution of funding streams).

2.3.2 Additional supporting evidence and sector analysis – in brief

More recent evidence and analysis further supports the implementation of new models of care in the North West Sector. The most recent annual data for the **National Emergency Laparotomy Audit** (NELA, December 2015 to November 2016) demonstrates variation in performance across the three sites in the Sector and several areas with 'Red' ratings on the NELA dashboard for at least one site, including:

- Final case ascertainment (SRFT and BFT rated Red)
- Proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist (if pre-operative p-possum mortality risk >=5%) (WWL rated Red)
- Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital (all three rated Red)
- Proportion of cases where interval from decision to operate (or time of booking) to arrival in theatre was appropriate to documented operative urgency (for cases with urgency <18 hours) (BFT rated Red)

Further information on the NELA audit, with relevant graphs and analysis at Sector and GM levels, is given in Appendix 10, and an explanation is given in Section 3.1.2, Description of the Clinical Model (for General Surgery).

Finally, analysis conducted to support the implementation of GM HT in the NW Sector has highlighted **significant variations in models of care, clinical pathways and their impact**.

For example, the **Ambulatory Care models** introduced for General Surgery differ markedly, and evidence to demonstrate their impact – on reducing low risk non-elective admissions to hospital and use of hospital beds – is mixed. National guidance points to the opportunities for improvement, such as Commissioning Guidance for Emergency General Surgery (acute abdominal pain) published by the Association of Surgeons of Great Britain and Ireland and the Royal College of Surgeons (2014) which states that:

> *Sub-acute conditions such as biliary colic, cholecystitis, and non-specific abdominal pain represent a substantial, expensive, inpatient burden. The development of acute ambulatory surgical services can reduce admissions within this basket of diagnoses by up to 30% and thereby reduce costs. The presence of a defined acute biliary pathway can help identify well organised services. Integrated and rapid access to imaging must be part of these services.*

The Ambulatory Care model in place in Salford since January 2016 is informed by this guidance and learnt from a model successfully implemented at Royal Blackburn Hospital. Data indicates this has improved patient flows, reduced admissions and resulted in a reduction of 10 general surgical beds. The model front-loads the process through access to diagnostics and consultant assessment. As part of developing the single shared service model, discussions are underway across the Sector to deliver similar benefits through use of a consistent approach across all three sites. At present, Ambulatory Care is not provided 7/7 across the NWS and variation in practice and in the availability of support (such as weekend 'hot clinics' and diagnostics) results in sub-optimal care pathways, particularly for low-risk non-elective cases where admission could be avoided by best practice ambulatory care. Detailed Sector analysis of NEL cases which do not meet either NELA or Critical Care criteria (explained further in section 3.1.3) further supports claims that there are significant opportunities for improvement (i.e. to reduce NEL admissions, target conditions amenable to Ambulatory Care and follow pathways that can improve patient experience and outcome and increase service efficiency).

In conclusion, the ambitions, objectives and case for GM HT are explained in detail elsewhere, and from a Sector perspective the benefits being pursued are, in brief:

- Improving patients' experience and outcomes
- Enhancing service efficiency
- Enabling more consistent models of care, 7 days a week, based on best practice, which reduce unwarranted variation
- Supporting and developing our workforce
- Ensuring resilient and viable services, able to provide sustainably high quality care and support our collective ambition of improving the health and wellbeing of our populations

Delivering these improvements requires new, enhanced Sector-wide models of care delivered as part of single shared services, as explained in the next section.

3. Clinical models

This Section presents the clinical models for General Surgery, UEAM and Radiology, and for each explains three main elements:

- The scope of services and quality standards to be met
- The clinical model as developed in the Sector
- Outcome of activity, capacity and workforce analysis on the impact of new models

The Healthier Together Business Case for the Transformation of A&E, Acute Medicine and General Surgery Services across Greater Manchester summarises the developments in acute care as below, and these themes are reflected in our Sector models of care. (HT BC given in Appendix 11)

Proposed acute developments

1. **All hospitals in Greater Manchester will make a series of improvements to the way that they deliver Acute Medicine, A&E and General Surgery in order to deliver a step change in performance…**all hospitals will introduce or expand:
    - **Senior decision making at the front door**, which can significantly reduce admissions and length of stay.
    - **Signposting to primary care and management of chronic attenders.**
    - **Use of alternatives to admission** – Ambulatory Care will be expanded, with A&E patients seen on the day by the appropriate specialism for issues such as extremity fractures, chest pain, shortness of breath and headaches.
    - **Management of frail elderly** – all hospitals will introduce, if it does not exist, a multidisciplinary frail elderly assessment team that reaches into the Emergency Department and AMU.
    - **Timely diagnostics** – all hospitals will set KPIs relating to timely availability of diagnostics, with processes to ensure a 60 minutes turnaround for standard emergency blood tests and the availability of a radiologist to review images 24/7.

2. ***The scheme will also centralise high risk elective and all emergency general surgery from 9 sites onto 4 "hub" sites:***
    - High acuity (very sick) patients requiring specialist care will be transferred and receive that care at a specialist centre.
    - This allows us to organise the overstretched workforce in a more effective way.
    - Each hub site will collaborate with at least one other hospital in a "single service", with staff working as one team. This means that if a patient is transferred between two hospitals, there are pathways and processes in place to do this seamlessly. Staff will also work across sites in the single service, ensuring they continue to build both low acuity and high acuity experience.

3.1 General surgery

3.1.1 Scope and quality standards

The scope of this section of the Business Case is to explain the revised clinical model for General Surgery including:

- **Elective and emergency, high and low risk, General Surgical inpatient services for adults**
- **Ambulatory Care** – advances in which will support the new model, and are already being implemented
- **Implications of new models for activity, capacity and workforce**

Within the new models, it is important to note that:

- **Daycase** and **outpatient activity**, new and follow-up, will remain largely as at present, with services delivered to people at their local hospital. We will continue to review opportunities to increase the proportion of activity carried out as a daycase, and for outpatients will review the appropriateness of attendances, engaging with colleagues in primary care. Pathways will be communicated and where appropriate co-designed with colleagues in primary care to ensure patients are referred appropriately and speedily to the appropriate service.

- **Paediatric surgery** – emergency Paediatric General Surgery is within scope but is part of a separate North West Sector Paediatric Review which, due to clinical interdependencies, has a wider remit of hospital services for children and forms part of NWS Programme 3. The approach being developed in the Sector is also linked to the emerging model for all paediatric care within GM Theme 3. Further detail on these elements is given later in this section.

Quality standards

The relevant GM HT standards for general surgery build on national evidence and compliance with professional and regulatory guidance. Originally described in June 2013 pre-consultation business case (Appendix 12: *GM Quality and Safety Standards Part 1, Appendix 2*), the standards have been refined over time. All Trusts have completed three separate self-assessments, most recently submitted in October 2016, for compliance with a sub-set of standards prioritised by GM HT for initial implementation, given in the table below.

ID	Standard
EGS013*	As a minimum, a specialty trainee (ST3 or above) or a clinician with equivalent ability (e.g. MRCS with ATLS® provider status), is available to see/ treat acutely unwell patients at all times within 30 minutes and is able to escalate concerns to a consultant.
EGS020*	Those considered at high risk (e.g. patients with a predicted mortality of >5% using the appropriate specialty risk scoring mechanism) are discussed with the consultant and reviewed by a consultant surgeon within four hours* (*excluding patients on a palliative pathway).
EGS021*	All patients considered as 'high risk' have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.
EGS025	If the patient is admitted but not taken to theatre (i.e. they are admitted for observation and conservative treatment), as a minimum they are seen by a consultant surgeon within a maximum of 14 hours of admission. Active and continued monitoring of the patient takes place.

ID	Standard
EGS059	The service submits data to prescribed national audits, including NELA, National Bowel Cancer Audit, National Oesophago-gastric Cancer Audit
EGS232*	There is 24-hour cover of Critical Care by a named consultant with appropriate experience and competences. Level 2 and 3 patients are cared for within a closed critical service in which admissions are agreed by Intensive Care Medicine consultants and primary responsibility for ongoing care lies with the critical care team, with input as required from parent specialty consultants/teams.
EGS233*	A consultant in intensive care medicine reviews all emergency surgical admissions to the ICU within 12 hours.
EGS235*	Level 2 and level 3 capacity is sufficient to support the emergency surgical workload, such that timely care is provided.
EGS257*	Best practice: The timescale of intervention is defined and achieved Patients with ongoing haemorrhage require immediate surgery.
EGS258*	Patients with septic shock who require immediate surgery are operated on within 2 hours of the decision to operate as delay increases mortality significantly.
EGS259*	Patients with severe sepsis (with organ dysfunction) who require surgery are operated on within a maximum of six hours to minimise deterioration into septic shock.
EGS260*	Patients with sepsis (but no organ dysfunction) who require surgery should have this within a maximum of 18 hours.
EGS261*	Patients with no features to indicate systemic sepsis can be managed with less urgency but in the absence of modern and structured systems of care, delay will result in unnecessary hospital stay, discomfort, illness and cost.
EGS280*	Each patient has his or her expected risk of death estimated and documented prior to surgical or interventional radiological intervention using recognised methods (see RCS2011b for examples) or an equivalent method; and due adjustments are made in urgency of care and seniority of staff involved.
EGS285*	Patients with an estimated risk of death of >5% are admitted to a Critical Care Unit (level 2 or 3), unless there is an active and documented decision that it is contraindicated (for example, the patient is on a palliative/end of life pathway).

A variety of data sources listed below indicate variation across the Sector and GM in meeting these and other standards for General Surgery (on which further detail is available).

- NELA
- NCEPOD (Time to Get Control and Treat the Cause)
- National Bowel Cancer Audit (NBOCA)
- National Clinical Advisory Team independent assessment of Trust compliance with national and GM General Surgery quality and safety standards (2013), and local self-assessment against standards (2016)
- 30-day risk-adjusted mortality (for patients between December 2013 to November 2016)

3.1.2 Description of the clinical model

We conducted an extensive options appraisal process, as explained in detail in the SOC, as our Sector response to GM HT and to support development of a new clinical model for General Surgery. The approach has been developed further with extensive clinical engagement, led by the Surgical Governance and Implementation Board (SGIB, previously Surgical Operational Group), as well as a variety of clinical congresses and other events. When fully implemented the model will result in SRFT becoming the Sector hub site and focus for high-risk activity,

working as part of a single shared surgical service with BFT and WWL FT. Full implementation is dependent on several conditions including: access to capacity at the hub site (beds, critical care, operating theatres); availability of relevant clinicians; support from diagnostics and ambulance services; and a wide range of communications and supporting work with patients, the public and other health and care professionals to ensure quality and safety during the transition. These conditions are themselves dependent in part on GM HT capital and transformation funding and Sector-level agreement on the management of recurrent revenue consequences from the new model of care.

The overall purpose is to improve outcomes, reduce variation, expand and standardise Ambulatory Care and make most effective use of resources for General Surgery in the Sector and those of associated services such as Radiology. As explained later in this Section, elements of the new clinical model are already being implemented, such as in developing common pathways and more consistent, extended use of ambulatory care. A summary of key components of the new model of care for general surgery is given below, followed by further explanation of each element.

Summary – on full implementation of the new model of care

- **High Risk Emergency General Surgery** – will be concentrated at the Sector hub in Salford, based on definitions and criteria explained below, and supported by senior clinical decision-makers at all provider sites.
- **Low Risk Emergency General Surgery** – will be provided at all three sites, for local activity.
- **High Risk Elective General Surgery** – will be delivered at the Sector hub, using the definitions explained below.
- **Ambulatory Care** – will be enhanced as a critical element of the new model, with a consistent, common approach across the Sector.
- **Related pathways** – will be in place for GI Bleeds and Non-Vascular Interventional Radiology (NVIR), potentially as part of a GM wide solution.
- Arrangements will remain as at present for: **Low Risk Elective**; **Daycase**; **Endoscopy**; and **Outpatient** activity, which continue to be delivered locally.

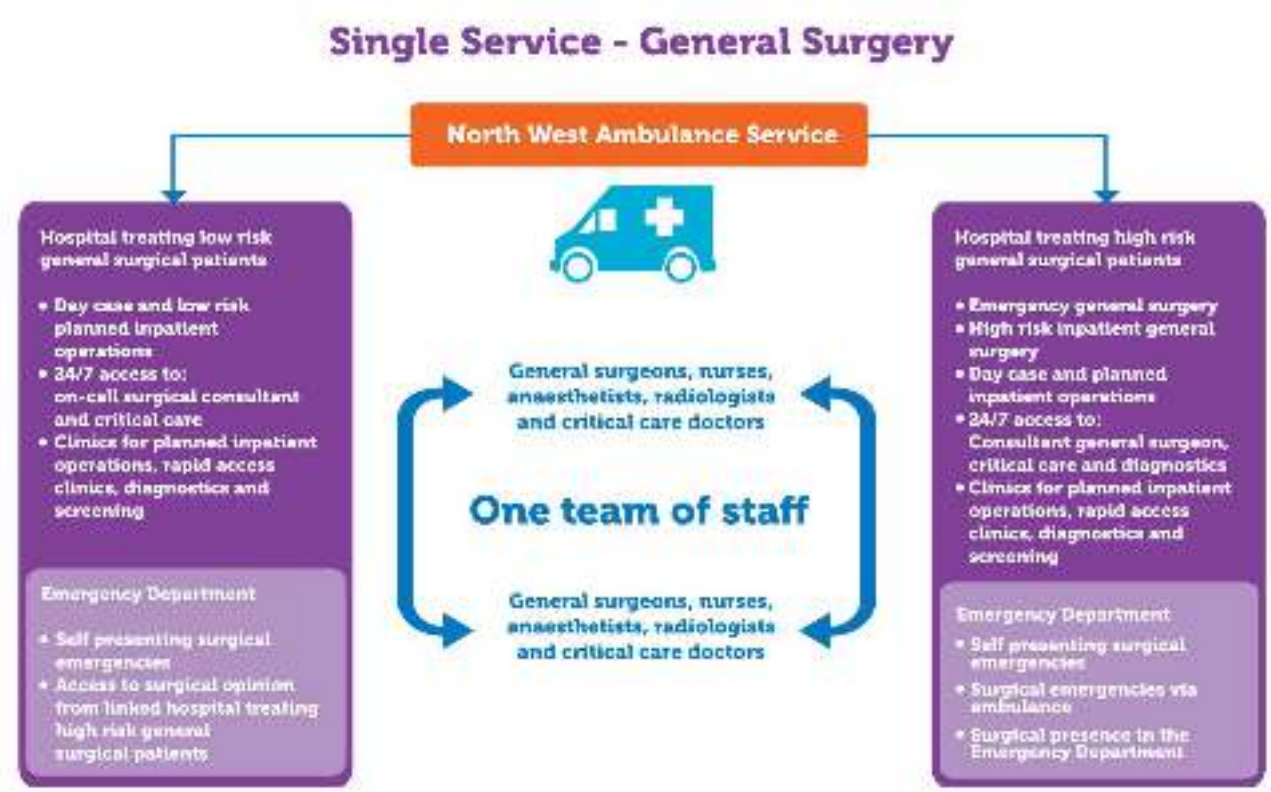
Creation of a single shared service for general surgery

In July 2015, the HT Committees in Common representing the commissioners of Greater Manchester agreed four 'single services' to provide new standards of care for Emergency Medicine and General Surgery in all hospitals across Greater Manchester. Further detail on the single shared service approach is given in Section 4, Implementation Plan.

General Surgery is leading in creating a Single Shared Service in the NW Sector, with a combined clinical team, single clinical lead (a General Surgeon), and network of linked services working in partnership to deliver better care for patients. The clinical team will provide care to local people at all three sites, including assessment and appropriate streaming of high-risk cases to the hub site. At the hub, expertise and resources from the Sector will be pooled to ensure patients have access to 24-hour consultant-led General Surgical care. Developing shared pathways that are consistently followed will reduce unwarranted variation in practice (variation that is not due to patient need or preference) and support best practice and the delivery of high quality, sustainable care. For example, plans are underway to create a single Sector MDT for colorectal cancers. With common leadership, a single team of General Surgeons will be responsible for meeting the needs of the combined population across

three localities, for high and low risk care. A critical aspect of the Single Shared Service will be rotation across sites to ensure clinicians maintain and develop their skills and provide supportive clinical governance.

The diagram below illustrates the Single Shared Service model for General Surgery, with details of the operational arrangements to be implemented in the NW Sector explained in the remainder of this section.



High-risk emergency general surgery

In line with GM HT new models of care, all high-risk (HR) emergency surgery will be provided at the Sector hub in Salford. All non-elective admissions will first present at their local hospital either by ambulance, via their GP or self-presenting. All patients assessed as HR will then be transferred by NWAS to the hub which will provide the services listed below. NWAS conducted a retrospective audit of relevant patients (200 per Sector, from the past year) which determined this approach and concluded – ***it is not possible to identify patients with a general surgical emergency from their presenting discriminating factors***. Following concerns raised within the North West Sector, a GM wide NWAS Task and Finish Group was established, to consider issues arising from the transfer of patients across sectors to the high risk site. This work included a review of the potential impact of a double ambulance journey upon patients who initially present by ambulance to their local site, and following clinical review are required to transfer by ambulance to the hub site. This work is due to conclude in December 2017 will publish a document to provide assurance of the quality and safety for the transfer of patients between sites within the Healthier Together model (Appendix 13).

At the **hub site**, the key elements of clinical provision to support the new model are below:

- On-site consultant surgical opinion to A&E, medicine, surgical assessment (including surgical ambulatory clinic), diagnostics, observations and admission of high risk patients, 24/7. This is also required to provide out of hours emergency surgery cover.
- On-site 14-hours a day, 7/7, consultant led emergency operating service. The remaining 10 hours per day will be covered by the on-site consultant (above) and with additional support available 7/7 from the clinicians at the non-hub sites.
- An additional six hours of consultant ward round provision to support Inpatient assessment and patient flow 7/7.

The above provision **at the Sector hub** will significantly increase the proportion of the time for which high-risk emergency patients have access to on-site consultant General Surgical input.

A Sector clinical consensus has been reached on the definition of HR emergency patients (which is not all emergency admissions). A summary of the HR emergency general surgical activity is given below.

- *HR NEL activity for all Code 100 excluding Breast, Vascular & Endoscopy (the scope of general surgery)*
- *All Non-Elective patients meeting the criteria of the laparotomy audit (as defined on the NELA website – National Emergency Laparotomy Audit) and using procedure codes in all 14 positions in the coding*
- *All Non-Elective patients having a procedure not in the above group who used critical care*
- *All Non-Elective patients admitted to surgery not having a procedure who used critical care*
- *Excludes any patient requiring a surgical opinion in ED and/or admitted under another specialty*

The impact of this definition as criteria for determining High Risk Emergency General Surgery activity is given in the section on activity modelling (Section 3.1.3).

Low-risk emergency general surgery

Low Risk Emergency General Surgery requiring admission will be provided at all three local sites. Patients with co-morbidities which result in them being classified as HR will be transferred to the hub site at Salford.

Low risk sites at Bolton and Wigan will provide:

- Consultant surgical assessment, diagnostics, observations 12-hours a day, 7/7, and access to consultant (off-site) on-call rota from 8pm to 8am, 7/7
- On-site surgical consultant opinion to A&E, medicine & dependencies 12/7
- Low risk emergency operations and surgical procedures will be undertaken from 8am to 8pm
- Low Risk Sites have a 3-hour ambulatory care clinic, 7/7, consultant-led
- Low risk site will have on site senior decision maker (Middle Grade) 24/7
- All low risk emergency cases will go through the General Surgery Ambulatory Care triage model, including diagnostics, using an ‘assess to admit’ approach.

In addition, low risk sites will support:

- Tests and diagnosis in the Emergency Department
- Tests and diagnosis under care of Acute Medicine
- Referral to a local hot clinic (via ED, GPs, Acute Medicine)
- Referral to local ambulatory care service (Via ED, GPs, Acute Medicine)
- Transfer to the general surgical high acuity hub site

The above allows for consultant-level cover for 12 hours per day at the Low Risk sites, which exceeds the minimum standard of 10 hours set by HT. The Sector proposes this marginally higher input to ensure cover is not reduced from current levels and provide additional assurance of patient safety and responsiveness.

As well as being the Sector hub, SRFT will continue to provide low-risk General Surgical emergency and elective services to local residents in Salford.

High-risk elective general surgery

Discussions within the Sector and with HT have refined and clarified the definition and scope of HR elective General Surgery. Patients requiring an elective procedure who are identified as high-risk at the point of assessment will be listed for surgery at the hub site. They will comprise two main groups: patients identified under a set of codes defined as high risk in the GM HT Clarification Document (Appendix 14) and those who require critical care.

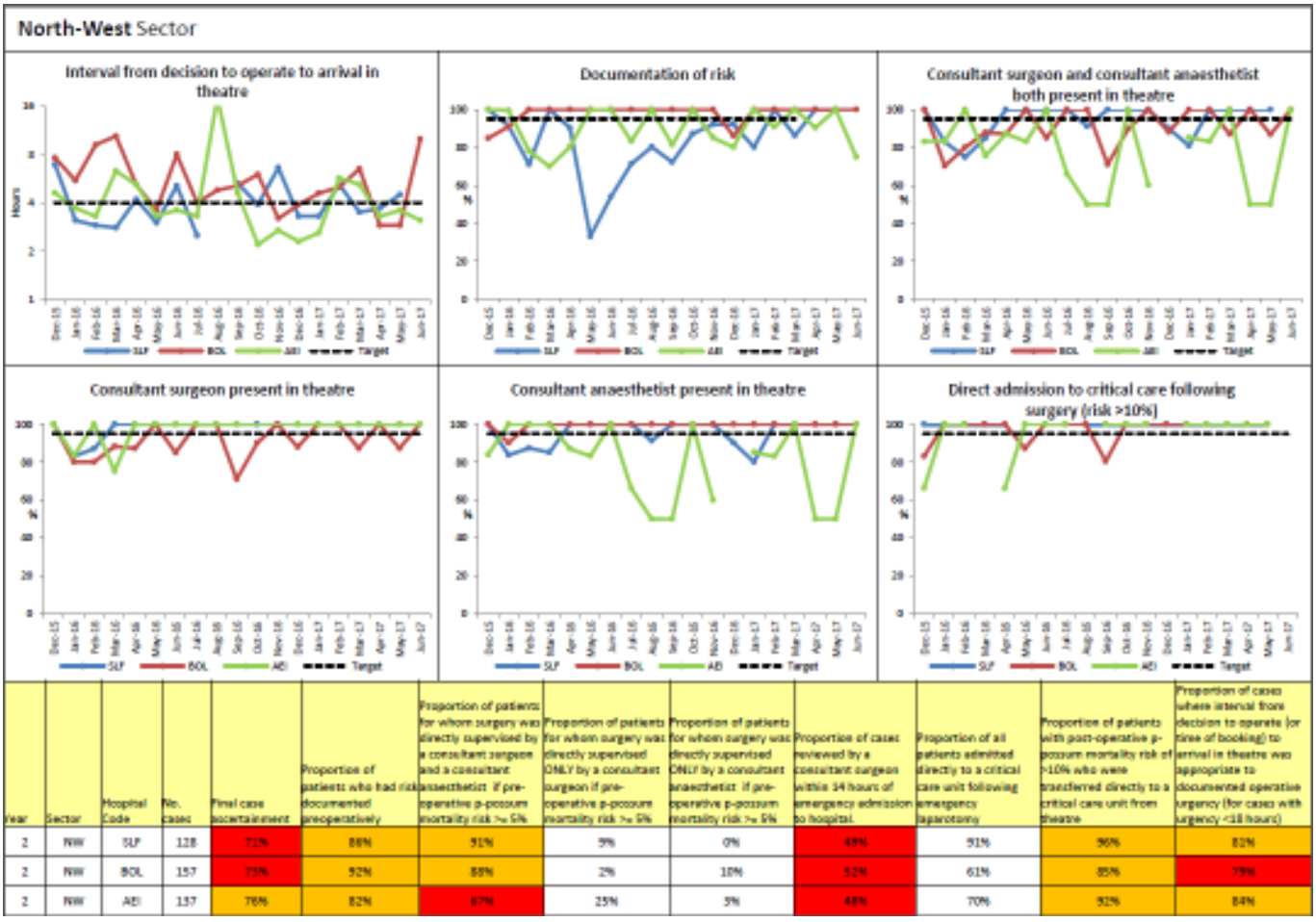
A summary of the HR elective general surgical activity definition is given below.

- *HR EL activity for all Code 100 excluding Breast, Vascular & Endoscopy (the scope of general surgery)*
- *All High Risk elective procedures identified in the GM HT Stage 2a review feedback have been classified as High Risk. Additions to the above list as agreed during a meeting with GM HT Chief Medical Advisor post stage 2a review (17.8.16).*
- *All Elective patients requiring critical care.*

Application of this definition to the activity involved is given later in this section.

Patients requiring non-elective laparotomy

Currently each site views its own NELA data, with previously only annual performance circulated across the Sector. In order to measure progress towards achieving GM HT and wider quality standards, the Sector is imminently moving to more frequent data sharing, with the NELA dashboard to be shared quarterly. A single Sector NELA coordinator has been identified to facilitate this process. As a result, NELA will be used to support improvement, as one of the two external sources helping to measure progress in meeting HT Priority One standards for General Surgery (the other being the GM Critical Care Peer Review report). In addition, NELA will continue to be part of the audit processes.
The following table illustrates the most recent (June 2017) North West Sector NELA data:



Year	Sector	Hospital Code	No. cases	Final case ascertainment	Proportion of patients who had risk documented preoperatively	Proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist if pre-operative p-possum mortality risk >= 5%	Proportion of patients for whom surgery was directly supervised ONLY by a consultant surgeon if pre-operative p-possum mortality risk >= 5%	Proportion of patients for whom surgery was directly supervised ONLY by a consultant anaesthetist if pre-operative p-possum mortality risk >= 5%	Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital	Proportion of all patients admitted directly to a critical care unit following emergency laparotomy	Proportion of patients with post-operative p-possum mortality risk of >10% who were transferred directly to a critical care unit from theatre	Proportion of cases where interval from decision to operate (or time of booking) to arrival in theatre was appropriate to documented operative urgency (for cases with urgency <18 hours)
2	NW	SLF	128	71%	88%	91%	9%	0%	49%	91%	96%	82%
2	NW	BOL	157	73%	92%	88%	2%	10%	52%	61%	85%	79%
2	NW	AEI	137	76%	82%	67%	25%	5%	48%	70%	52%	84%

Patients with colorectal cancer

As part of a Single Shared Service, the Sector is developing a joint colorectal service with agreed pathways and an MDT for colorectal cancer that convenes weekly (virtually) to review and support the most complex cases. This group of patients will include T4 disease, metastatic disease (may require synchronous resection) and disease recurrence. Video conferencing facilities will be made available at all three sites and there will be input from radiology, pathology and clinical oncology. Early benefits will include optimisation of resources, quicker decision making and increased compliance with peer reviewed standards.

Although the majority of HR cases cannot be transferred to the hub site until capital work is complete in early 2020, the Sector is planning to move a limited group of high risk elective patients in 2017-18. Members of SGIB are developing a pathway of care to enable the safe transfer of these patients and SRFT is identifying capacity. The development of a single Sector colorectal MDT for the most complex patients will support the patients identified for transfer.

Low-risk elective general surgery

Low risk elective General Surgery will continue to be provided locally at all three Sector sites.

In monitoring and supporting quality and service improvement, the Sector will adhere to the GM agreed benefits and measures detailed in the table below to enable tracking across GM and facilitate shared learning.

Data completeness for referral and outcomes of MDT
Quicker decision making and optimisation of resources
Proportion of palliative cases with obstruction treated with stent Proportion of emergency cases operated on by colorectal cancer surgeon
NBOCA Key measures: • Improved case ascertainment • Reduced 30-day emergency re-admission rate • Reduced 90-day re-admission rate • Reduced 90-day mortality • Reduced 2-year mortality • Reduced 18-month stoma rate
Reduced variation in clinical practice and outcomes across GM
Increased proportion of patients recruited to clinical trials (through monitoring of sector MDTs)
Improved patient experience
RO resection rates
Monitoring outliers and further action as agreed

Aligned with the changes to meet GM HT standards, the Sector is working to increase the proportion of elective patients entering ERAS+ pathway, as explained below.

Enhanced recovery after surgery – plus (ERAS+)

ERAS is a programme to optimise surgical outcomes by improving both patient experience and clinical outcomes. The ERAS programme was first developed in 2000 and enhanced recovery is now a standard of care for patients having elective major surgery. A quality improvement team at Central Manchester NHS FT developed and implemented ERAS+ as an innovative model of peri-operative care. The aim was to add specific measures to reduce pulmonary complications (a significant post-operative complication which occurred in nearly 20% of patients undergoing major elective surgery who were admitted to critical care, according to a prevalence audit in CMFT). The new model has been effective in reducing post postoperative pulmonary complication rates (initially from 19.3% to 10.5%, and further to 8.7% as the benefits were sustained 1 year after intervention) and lengths of stay (the median reduced from 12 days to 9 days). Although it is not a core element of Healthier Together, ERAS+ is being implemented across GM and the NW Sector alongside HT.

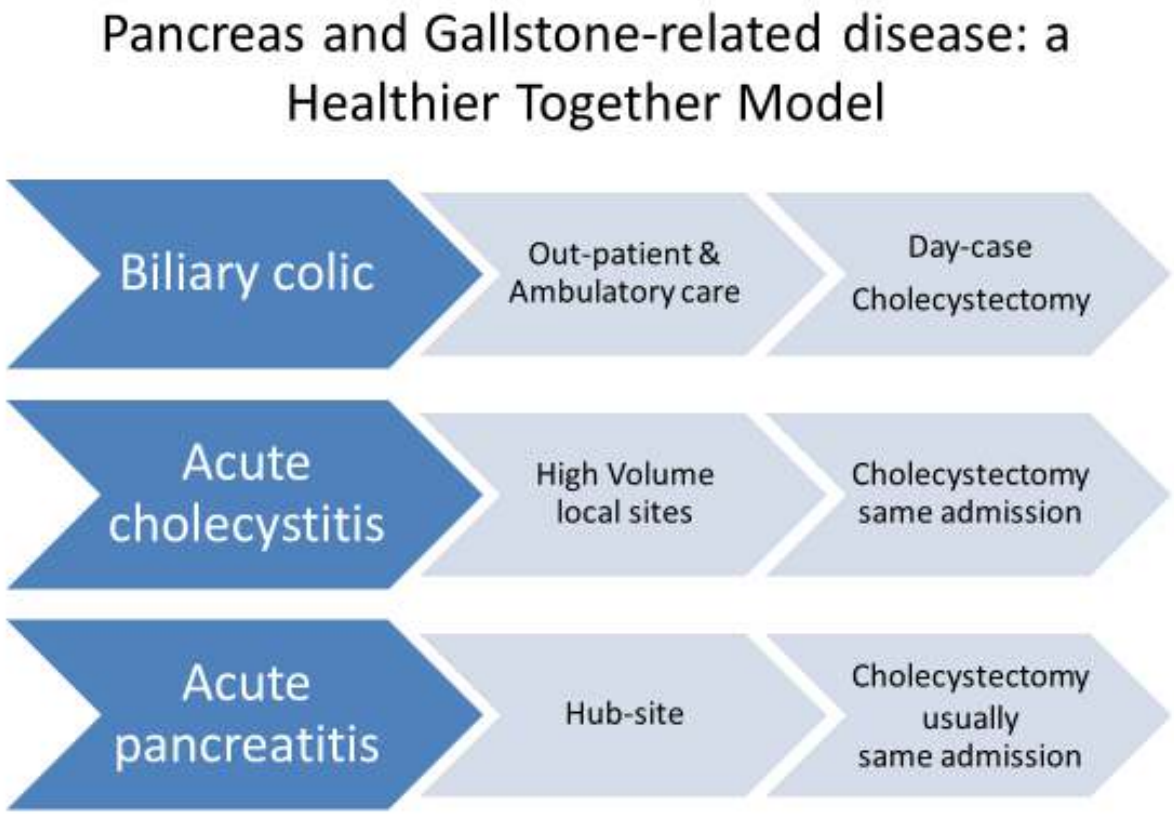
Pancreas and gallstone related disease

A further example of the detailed work underway to implement the GM HT standards-driven model of care is that for gallstone related disease. Informed by external independent clinical expertise a Sector clinical-consensus has been reached to segment such cases between three pathways:

- Biliary colic – to be managed through outpatient or Ambulatory Care, with elective cholecystectomy
- Acute cholecystitis – high volume activity, most of which will be managed at local sites, and for which a shared pathway is in development

- Acute pancreatitis – which is high-risk, so all cases will be managed at the Sector hub

The new model is reflected in the diagram below.



Ambulatory care and diagnostic service

Development of the new model of care for General Surgery and discussions with surgeons across the Sector has emphasised the pivotal role of ambulatory care (AC) in supporting the non-elective pathway. The three sites have implemented AC models though these vary in approach and impact. Detailed analysis of current non-elective activity has identified significant opportunities to manage more patients through AC interventions, which will provide a better experience and outcomes while reducing admissions and lengths of stay. This finding is in line with national guidance, such as from the Association of Surgeons and Royal College of Surgeons (2014) which suggests between 15% and 30% of acute admissions in general surgery could be managed without admission to a hospital bed. At present, the separate, parallel adoption of varied AC models in different contexts has resulted in:

- Adoption of different terms and definitions of AC (and interpretations can vary within as well as between hospital services).
- Difficulties in directly comparing impact of approaches, given varying data collection systems and criteria used to collect key metrics, such as 'deflections'.

- Varied levels of seniority in decision making and processes for liaison with inter-dependent services, both in hospital (e.g. ED and diagnostics) and outside (primary and community care).

The table below briefly summarises the existing arrangement for General Surgical AC in the Sector.

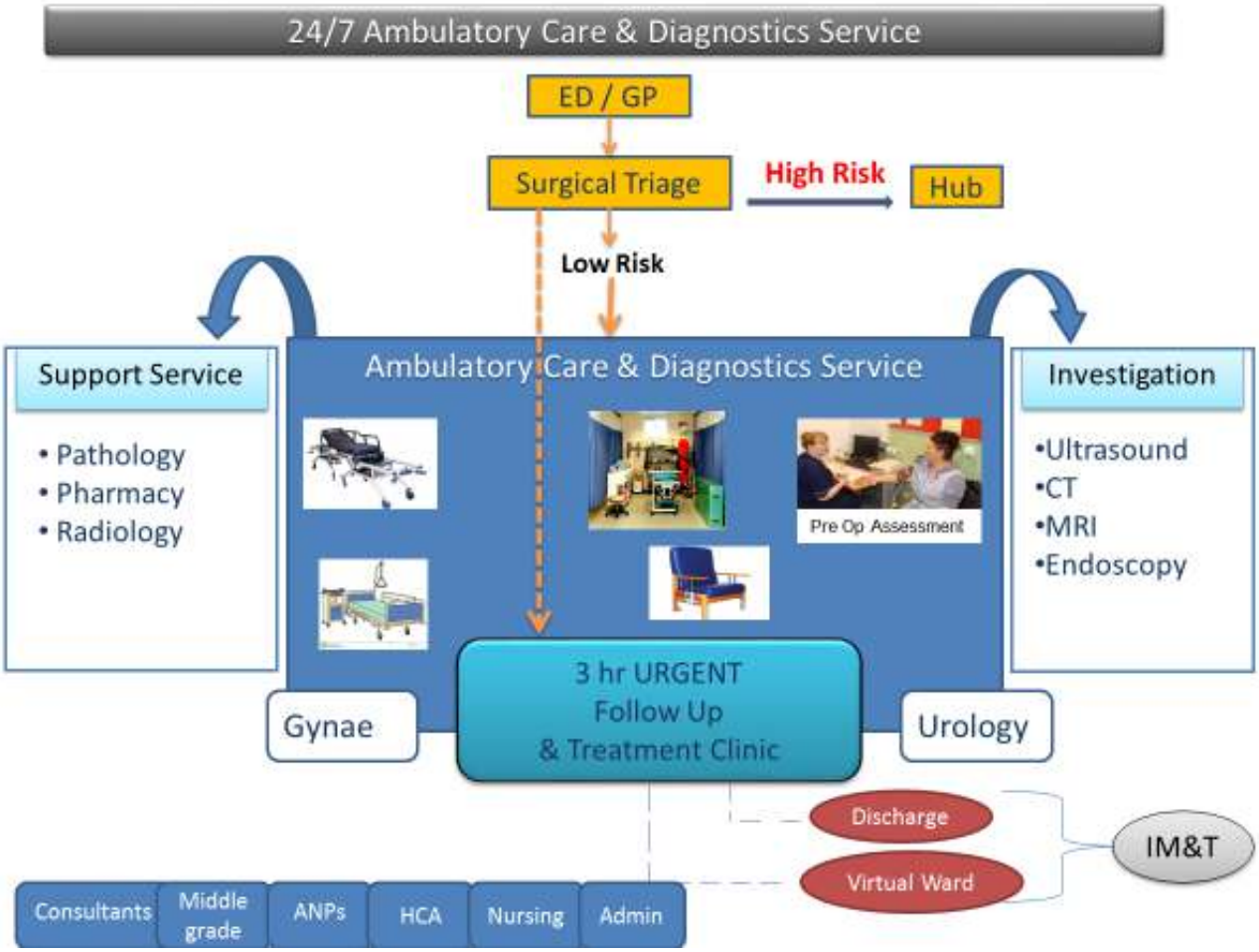
	Bolton	Salford	Wigan
Model and scope	Surgical Admission Unit (SAU), Surgical Acute Referral Clinic (SARC), Ambulatory Care Unit (ACU)	Surgical Triage Unit General surgery, urology, gynaecology, Hot clinics	Surgical Admission Unit (SAU) with Surgical Acute Referral Clinic (SARC) General surgery, urology, gynaecology
Structure and services	Admissions Unit SAU, 23 beds Hot clinics 5 days per week ACU enabled direct referral from Primary Care 10am to 8pm, Monday to Friday Access to diagnostics	8-12 bedded STU, 6 assessment rooms, 2 clinic rooms 7/7 Hot clinics Nurse led clinic slots Access to diagnostics	Admissions Unit SAU 4 male, 4 female beds SARC clinic 5 days per week, afternoons, middle grade run with consultant input Access to diagnostics

As a Single Shared Service, General Surgeons across the Sector are collaborating to enhance and align the approach to provide a consistent, high quality seven-day service that delivers GM HT standards and complies with AC commissioning standards (Appendix 15, Royal College of Surgeons (2014): Commissioning Guide: Emergency general surgery (acute abdominal pain)). The approach is being developed by the clinically-led Surgical Triage & Ambulatory Care Sub Group of SGIB. Core components of the proposed new model encompass surgical assessment, diagnosis, observation and treatment delivered through:

- Consultant-led decision making
- 24/7 surgical assessment
- Access to diagnostics
- Dedicated service and dedicated area for surgical patients
- Co-location with gynaecology and urology
- Access to clinics (3 hours, available 7 days a week) for rapid treatment and follow up

Progress is already being made, as illustrated by the outcome of a recent pilot of an enhanced AC clinic held on a Sunday afternoon (3pm to 5pm, consultant-led) in Bolton (March and April 2017), which identified around one or two patients per clinic as avoided admissions. Although small numbers, results so far suggest that more than half of the patients were appropriately seen in AC (24 of 42), more than a quarter were avoided admissions (12/42) and a few were inappropriate referrals or DNAs (6/42). Clinicians involved felt the pilot had improved communication between A&E / Emergency Department and General Surgical Ambulatory Care. The extended weekend AC approach will be developed further in Bolton and the Sector also aims to do similar in Wigan once Transitional funding can be accessed(Salford already has a seven day a week clinic). The impact of enhanced, consistent AC will primarily be on improving patient experience and flows, rather than significantly increasing efficiency.

The diagram below illustrates the emerging model of a 24/7 Ambulatory Care and Diagnostics service in the Sector.



The above is illustrative rather than comprehensive, but points to the critical importance of ***Surgical Triage*** in delivering a safe, effective and efficient service. The key is having senior clinical decision makers intervening early in the process to assess and direct patient pathways. With early senior input, supported by rapid access to diagnostics, patients can be accurately assessed and, based on modelling evidence, many may be suitable for interventions as alternatives to hospital admission. For example, at present some patients are admitted as surgical inpatients for conditions as diverse as constipation to end-of-life care, where alternative, more appropriate care pathways could improve outcomes, experience and efficiency. Senior input may also avoid two key risks highlighted by clinicians in the Sector and discussed at SGIB and GM HT reviews of the new models of care for non-elective activity:

- Inappropriate decisions to transfer patients from non-hub sites to the hub – which could result in too many people being moved and swamping the hub site with activity that could and should be delivered locally (referred to as 'over triage'), and conversely:
- Inappropriate decisions not to transfer patients from non-hub sites to the hub – which could result in HR cases being managed in environments which do not have the optimal levels of support.

Delivery of safe and effective surgical triage will be at the core of the new model and is a key condition for implementation with the beneficial impact on patient pathways illustrated in the example below.

Patient Profile: 1

NHS
in Bolton, Salford and Wigan

Ms Smith

Age: 54
Lives with Civil Partner and grown up children

Hometown: Bolton

Medical Conditions: High Blood Pressure

Time: Sunday - 2pm

Symptoms:
Extreme abdominal pain and constipation

Current Model

At presentation
Arrives at Bolton A& E via an ambulance.

Assessed by an A&E Dr and has initial tests (blood tests etc.)

A&E Dr suspects a surgical issue and beeps the **on call surgeon (middle grade).**

Surgical Intervention

Middle grade reviews medical history and test results and agrees to admit Ms Smith for observation and further tests are required (e.g. ultrasound scan)

Patient stay in hospital

Patient is admitted to surgical word at Bolton for 3 days where she is treated undergoes further tests and has treatment as surgery is not required.

Hospital discharge is supported through the Integrated Discharge team.

New Model

At presentation
Arrives at Bolton A&E via an ambulance.

Assessed by an A&E Dr and has initial tests (blood tests etc.)

A&E Dr suspects a surgical issue and contacts the **on site Sonsultant Surgeon.**

Surgical Intervention

Consultant reviews patient in the Surgical Assessment and diagnostic service, doesn't suspect anything sinister, prescribes medication to help and asks Ms Smith to come back the next day for an ultrasound scan followed by an appointment with a Consultant at 3pm the following day.

Ms Smith returns the next day, the Consultant reviews her in clinic, the medication has worked and the symptoms have now eased. No further intervention required

Patient stay in hospital

Work is ongoing to align and improve current models across the Sector, with a series of clinically-led events arranged to address critical issues, including:

- Develop pathways for common conditions and causes of admission, such as: gall bladder; abscesses; hernia; diverticulitis; constipation.
- Agree a standard service model and a trajectory for implementation across all three sites.
- Create a shared understanding of terminology and definitions, such as what is classed as an 'admission' (e.g. more than 12 hours, more than 24 hours, use of a bed etc.).
- Determine deflection criteria, to enable comparative analysis of deflection rates and impact.

As a working definition, emergency surgical ambulatory care is a personal health care consultation, treatment, or intervention delivered on an outpatient basis facilitating early review, senior decision-making and access to diagnostics. All three sites have developed models for AC in General Surgery which aim to provide:

- Consultant-led, 7-day services supported with timely diagnostics and consultant diagnosis, leading to greater use of elective admissions where patients are referred for a procedure in the following 24 to 72 hours.
- Designed to 'assess to admit' rather than 'admit to assess' – avoiding unnecessary non-elective admissions, reducing lengths of stay and improving patient experience.

The emerging Sector AC model includes the following.

- *Standard offer to combined population from all three sites, 7/7, which is consultant-led with ASP/Middle Grade support, facilitating rapid decision-making including discharge or management through a clinic*
- *Aiming to provide better outcomes for patients and improve patient flow within surgical services, increasing efficiency of the on-call team's management of non-elective care, avoiding unnecessary admissions and reducing pressure on emergency departments*
- *Provide an area where 'appropriate' surgical patients can be assessed and monitored; it will also provide treatment & minor procedures*
- *Accessed from GP and A&E, with surgical team acting as gatekeepers, diagnostics include:*
    - *Bloods – will be taken by teams on the relevant unit.*
    - *Abdominal x-ray, erect chest x-ray. Agreed slots will be available in each site.*
    - *USS abdomen/pelvis (same or next day). Agreed bookable slots will be available in each site*
    - *CT/Endoscopy*
- *Clinic appointments will be available 3-hours daily, 7/7 at each site.*

There are additional benefits to be gained by co-locating gynaecology and urology within surgical admissions units especially in the rapid diagnosis of acute abdominal pain, reduction in unnecessary tests and bed days as evidenced by the SRFT experience. In addition, these specialties are ideally suited to management through hot clinics, thereby reducing the pressures on surgical beds. BFT and WWL FT, both with pre-existing Surgical Admission Units have developed SARC clinics in line with direct support from local commissioners.

It is emphasised that while there remain opportunities for significant improvement through AC, many of the initial benefits have been delivered through the initiatives already implemented at each site. For example, as a result of a new AC model, the average lengths of stay in General Surgery for all emergency admissions at Salford reduced from c.4 days to 2.2 days between July 2015 and May 2016. Also, Bolton have included AC benefits in locality planning and also have a block contract with commissioners which includes acute medicine.

With new shared leadership across the Sector, work will continue to maximise the benefits from a consistent, advanced AC model which moves towards the aims of the model described above.

Paediatric general surgery

Paediatric General Surgical services were identified by the NW Sector Partnership Board as a priority service for review due to:

- Clinical resilience issues across the Sector
- Interdependency of services with the proposed changes to adult General Surgical services as part of HT, through which Salford will be the high-risk adult general surgical site but will not be a receiving site for Paediatric General Surgical emergencies
- Current provision of paediatric general surgical services 24/7 at both Wigan and Bolton

As the only GM Sector without a co-located paediatric and adult emergency surgical centre, the model of care for Paediatric General Surgical services in the NW Sector needs to be determined ahead of the implementation of the wider HT surgical model, taking into account workforce and rota implications of the current three site configuration (two sites Paediatric / one site Adult).

Due to clinical interdependencies, the Sector widened the scope of review to include:

- All paediatric surgical specialties (rather than solely General Surgery) and related Paediatric Anaesthesia
- General Acute Paediatric Inpatient Services
- Paediatric Critical Care

The review has also considered Paediatric A&E, Paediatric Observation & Assessment (O&A) Units, Children's Outpatients and Children's Community Nursing Teams (CCNTs). The aim of the ongoing process is to determine a model that provides safe and effective Paediatric General Surgical services, prevents avoidable paediatric admissions and enables care to be delivered wherever possible in community and primary care.

In January 2017, the NWS Partnership Board approved the outcome of the review to date, a Case for Change which proposes a series of steps to consider the options given below and select a preferred option which will be captured in a Business Case.

The **options for the clinical model** building on the case for change were as follows:

1. Do Nothing

2a. Centralise paediatric emergency general surgery only on one site. Retain elective surgery and paediatric inpatients on 2 sites (and HDU) and daycase surgery, O&A and Paediatric A&E on 3 sites

2b. Centralise all paediatric emergency surgery on one site. Retain elective surgery and paediatric inpatients on 2 sites (and HDU) and daycase surgery, O&A and Paediatric A&E on 3 sites

3a. Centralise all paediatric emergency surgery and some elective and daycase surgery on one site. Retain paediatric inpatients on 2 sites (and HDU) and O&A and Paediatric A&E on 3 sites

3b. Centralise all paediatric surgery (elective, emergency and daycase) on one site. Retain paediatric inpatients on 2 sites (and HDU) and O&A and Paediatric A&E on 3 sites

4. Centralise all paediatric surgery (elective, emergency and daycase) and paediatric inpatients (and HDU) on one site and retain O&A and Paediatric A&E on 3 sites

Much progress has been made with the development of the model for Paediatric General Surgery and wider services. Work to date has focused on refining and assessing the clinical model, led by a Clinical Working Group and facilitated through a series of seven workshops. These have reviewed the current services' ability to meet national standards, identified clinically interdependent services, considered activity (and the impact of shifts in this) and developed the proposed model of care (recognising the different needs of children in different age bands). Current priorities and next steps include more detailed work on clinical pathways and the impact on flows (including patient transfers for emergency care) as well as an options appraisal on the appropriate site for those Paediatric services that will be centralised (the scope of which will be determined by the new clinical model). A paper summarising the recommendations of the Clinical Working Group will be presented to the Partnership Board in September 2017.

The CWG has recognised that there is no clinical need to make changes to paediatric emergency surgery ahead of the transfer of adult emergency activity; CWG agreed that the sector work should now align to GM Theme 3 timescales, with a GM model of care agreed by end March 2018. This is supported by HT Clinical lead.

In addition, Bolton CCG has developed and is implementing a service specification for paediatric community services in line with the standards for community services – *Facing the Future: Together for Child Health*. Work is progressing to roll out the service specifications across the Sector and ensure standardised, high quality. The work is being directed within the Greater Manchester Children's and Maternity Consortium.

Based on the above detailed explanation of the new model of care for General Surgery for adults, the next section sets out the implications for activity, capacity and workforce.

3.1.3 Activity, capacity and workforce modelling

Summary:

- Extensive, detailed modelling of general surgery activity, both elective (EL) and non-elective (NEL) has been undertaken for data across the Sector (2015/16 full year, and forecast outcome 2016/17, based on nine months).
- The outputs have been repeatedly shared with and reviewed by surgeons in the Sector. Iterations have been approved by the Sector's Surgical Governance and Implementation Board (SGIB) and have been accepted by GM HT Chief Medical Advisor and Clinical Champion for surgery within the GM HT Gateway Review process.
- The results indicate that:
    - As ***elective high-risk*** general surgical cases are moved to the Sector hub, around ***one in five of elective patients*** currently admitted to Bolton or Wigan will transfer to Salford (363 out of a total of 1,934).
    - As ***non-elective high-risk*** general surgical cases are moved to the Sector hub, around ***one in seven non-elective patients*** currently admitted to Bolton or Wigan will transfer to Salford (1,268 out of a total of 8,798).
    - The Sector hub will require capacity for an additional 53 inpatient general surgical beds (10 EL, 42 NEL), an additional 6 critical care beds and 617 theatre sessions per annum.
    - The impact on the non-hub sites will, in summary, include:
        - 1,273 low-risk general surgical patients will have a procedure in theatre at either WWL or BFT sites, anticipated to occur between 8am and 8pm. Any patients requiring surgery overnight (8pm to 8am) will be transferred to the hub site.
        - 6,257 low-risk patients will be seen WWL/BFT who will not have a procedure, and it is

	anticipated many of these cases will go through an ambulatory care pathway (proportion to be determined based on model development).

Further detail is provided below summarising: the method and background; elective analysis and pathway; non-elective analysis and pathway; and data for rectal cancers and pouch procedures, identified for early transfer.

Method and background

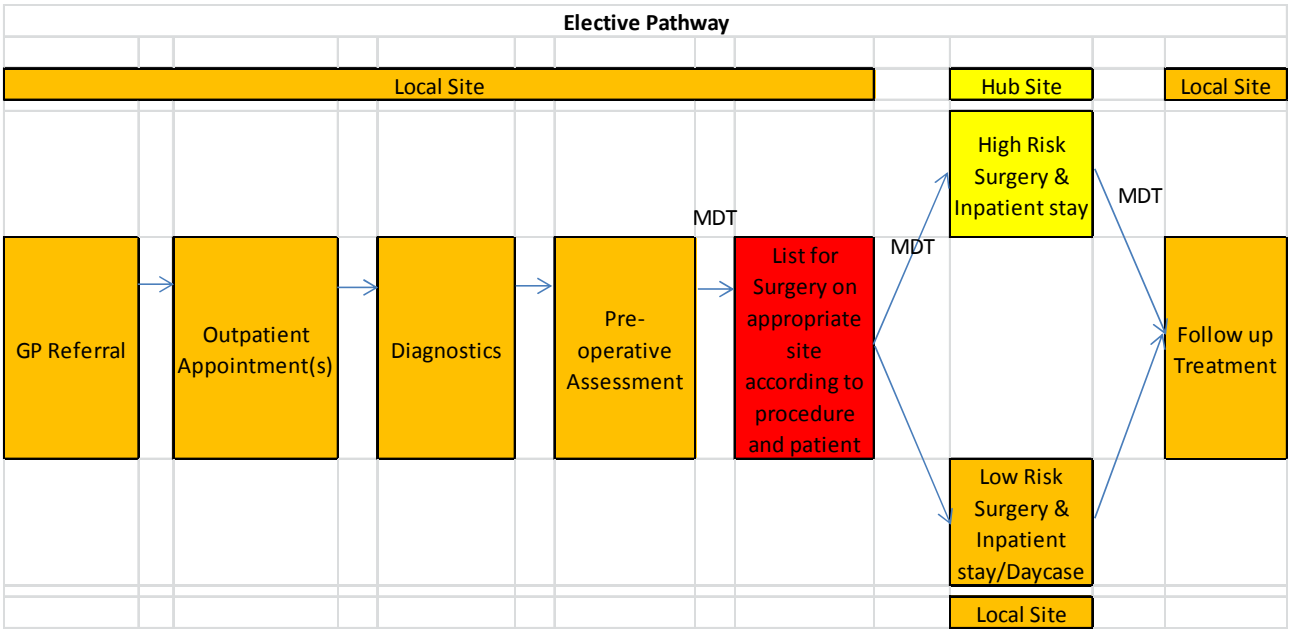
Analysis has been conducted by the NWS PMO Data Analyst, working closely with colleagues, particularly in provider organisations using the most recent full-year dataset for 2015/16 and forecasting based on part-year 2016/17 (April-December). The scope and content of activity that will be affected has changed over time, from the original GM DMBC (Decision Making Business Case) through a GM Clarification Document (April 2016) and a series of discussions and decisions through the GM HT gateway review process (2a and 2b reviews). The most recent amendments to the classification of high-risk NEL activity is based on the outcome of a meeting with the HT Chief Medical Advisor, Jane Eddleston, on 22nd February 2017 and follow up. Throughout the data have been tested with surgeons as appropriate and shared through surgical governance structures. The data are now being shared with operational teams to enable them to plan to operationalise the new model of care. Though all efforts have been made to confirm the accuracy and completeness of data, there may still be further revisions to the modelling outputs.

Analysis of elective general surgery activity

The NW Sector clinical model for elective general surgery assumes:

- Patients have their initial outpatients, diagnostics and pre-operative assessment pathway at their local hospital.
- At the point of listing for elective surgery, those meeting the agreed criteria for being designated high risk are listed for and have their surgery and inpatient stay at the Sector hub.
- Patients have their follow up pathway delivered locally.

A high-level summary of the elective pathway is given below.

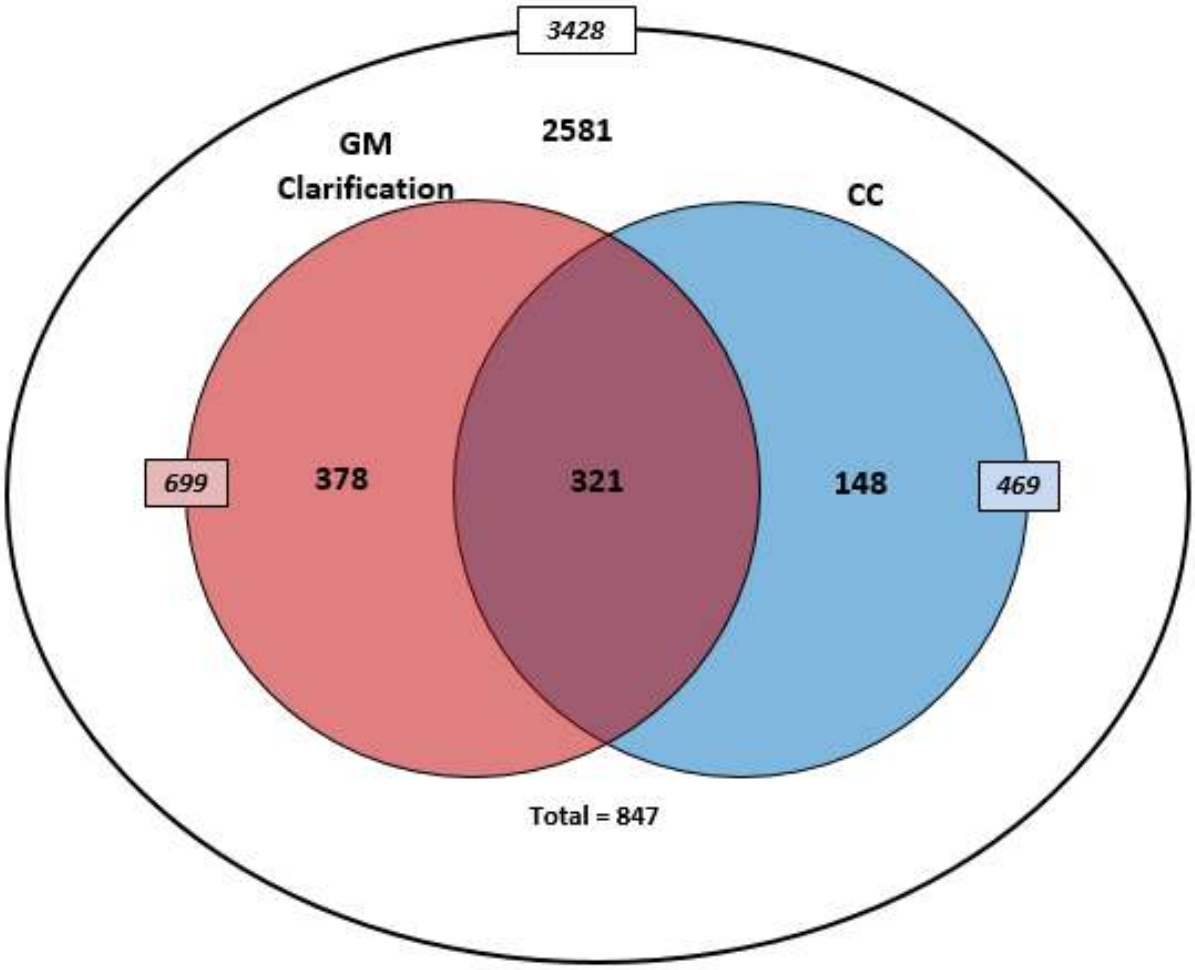


Following a series of iterations on the scope and definition of patients, those identified as high-risk, at the point of being listed for surgery, comprise two main groups:

- Patients identified under codes listed in *Appendix 3* of the GM HT Clarification Document (v.0.7 27/04/16) "*Elective general surgical identified as high risk using the Healthier Together modelled definition*". (Appendix 16)
- Patients identified as requiring critical care, many of whom will be having a low-risk procedure but due to their condition (e.g. co-morbidities) require critical care.

The diagrams below summarise the outputs of modelling.

Elective general surgical activity – North West Sector (all sites)

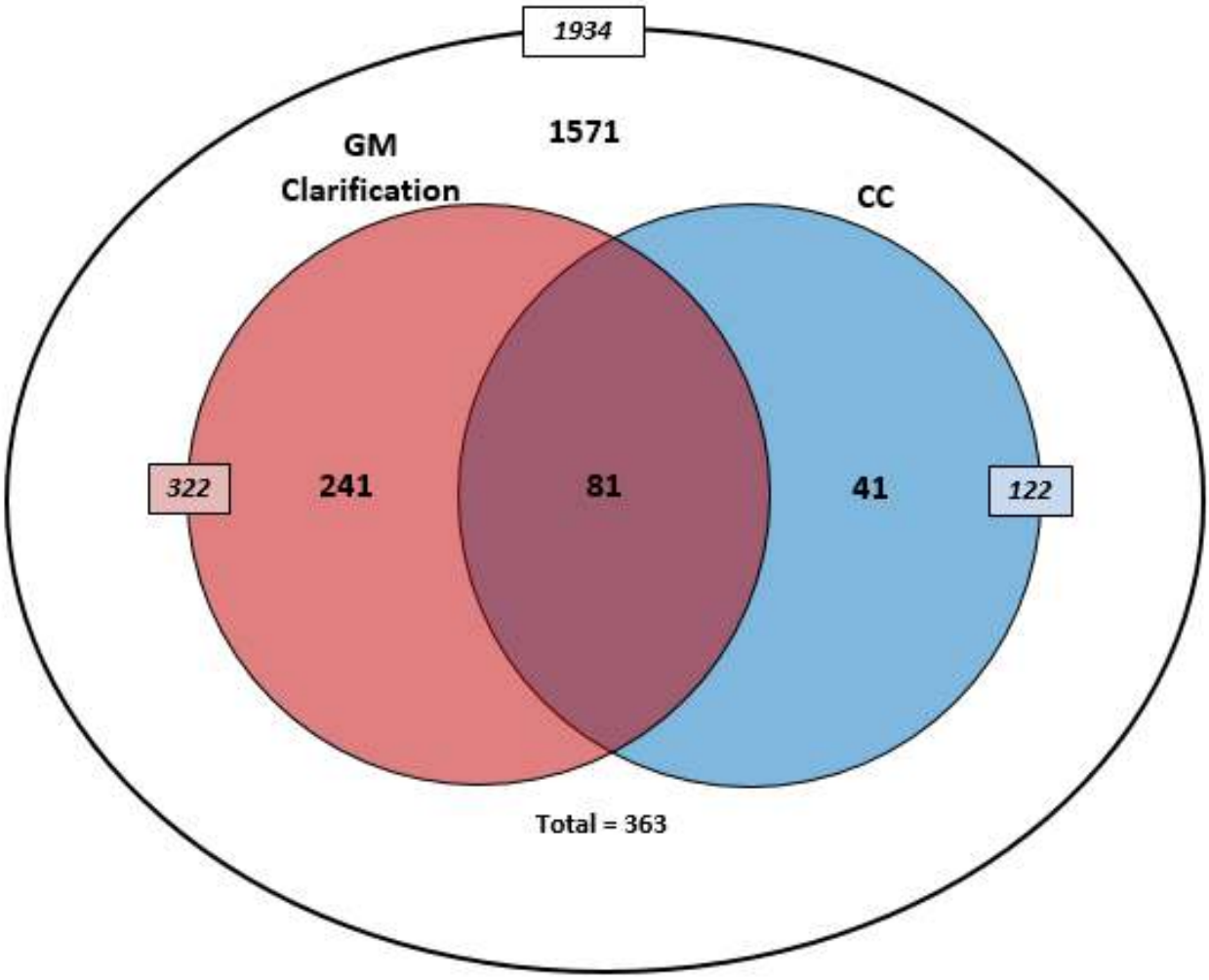


Explanation:

- *The diagram indicates that 3,428 EL GS spells were carried out across the Sector in 2015/16*
- *Of these, a total of 847 were high risk based on the two criteria*
    - *699 cases meet the GM Clarification, 469 met the Critical Care criterion, with 321 cases meeting both criteria*
- *The remainder of 2,581 cases were low risk*

The next diagram provides the same analysis for the Bolton and WWL sites only, which indicates number of elective spells that will move to the Sector hub with the full implementation of the new General Surgery model of care.

Elective general surgical activity – Bolton and Wrightington, Wigan and Leigh



Explanation:

- *The diagram indicates that 1,934 EL GS spells were carried out in Bolton and WWL combined, in 2015/16*
- *Of these, a total of 363 were high risk based on the two criteria*
    - *322 cases meet the GM Clarification, 122 met the Critical Care criterion, with 81 cases meeting both criteria*
- *The remainder of 1,571 cases were low risk*

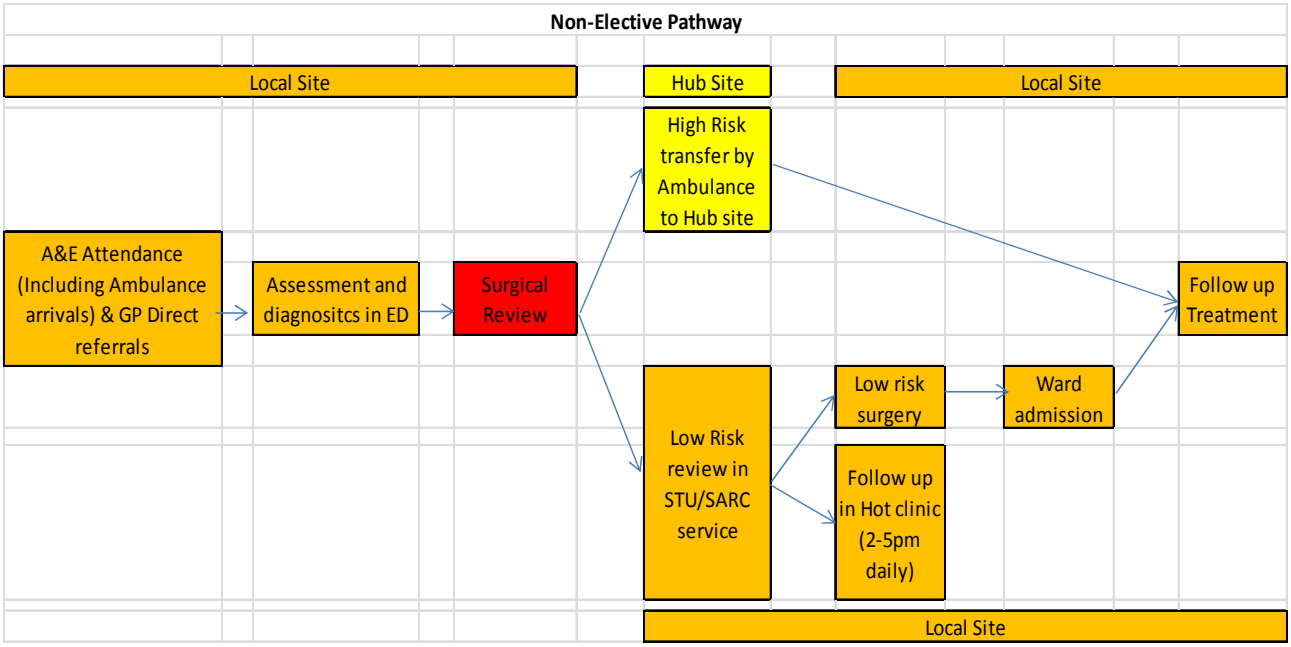
As a result, the analysis shows that the high risk elective general surgery activity that will transfer from non-hub sites to hub site in the Sector will be c.363 spells per year.

Analysis of non-elective general surgery activity

The NW Sector clinical model for non-elective admissions to general surgery assumes:

- Patients present to their local hospital, including those arriving by Ambulance (around one quarter of NEL admissions arrive by ambulance)
- Patients are assessed and diagnosed according to the GM HT Standards on all three sites
- Patients identified as high risk on the non-hub sites are transferred by ambulance to the hub site in a timely way and admitted to a surgical receiving service rather than via the Emergency Department
- Patients identified as low risk are treated in their local hospital and will be managed; this may include referral to a hot clinic (3 hours per day, 7 days per week) or admission to a STU / SARC or surgical ward, and will include some low risk emergency surgery.
- Patients have their follow up pathway delivered locally, including rehabilitation and reablement.

A high-level summary of the non-elective pathway is given below.



Following a series of iterations on the scope and definition of patients, those identified as high-risk non-elective patients comprise four main groups:

- Patients meeting the NELA Criteria – National Emergency Laparotomy Audit
- Patients identified under primary diagnosis codes listed in *Appendix 4* of the GM HT Clarification Document (v.0.7 27/04/16) "*Nuffield Trust, emergency general surgery: challenges and opportunities – definition of high-risk diagnoses*". (Appendix 17)
- Patients assessed as requiring critical care.
- An additional group of patients with diagnoses (five primary diagnosis codes) relating to acute pancreatitis and gallstone cholecystitis (in line with Clinical Alliance guidance, and as incorporated in other Sector models).

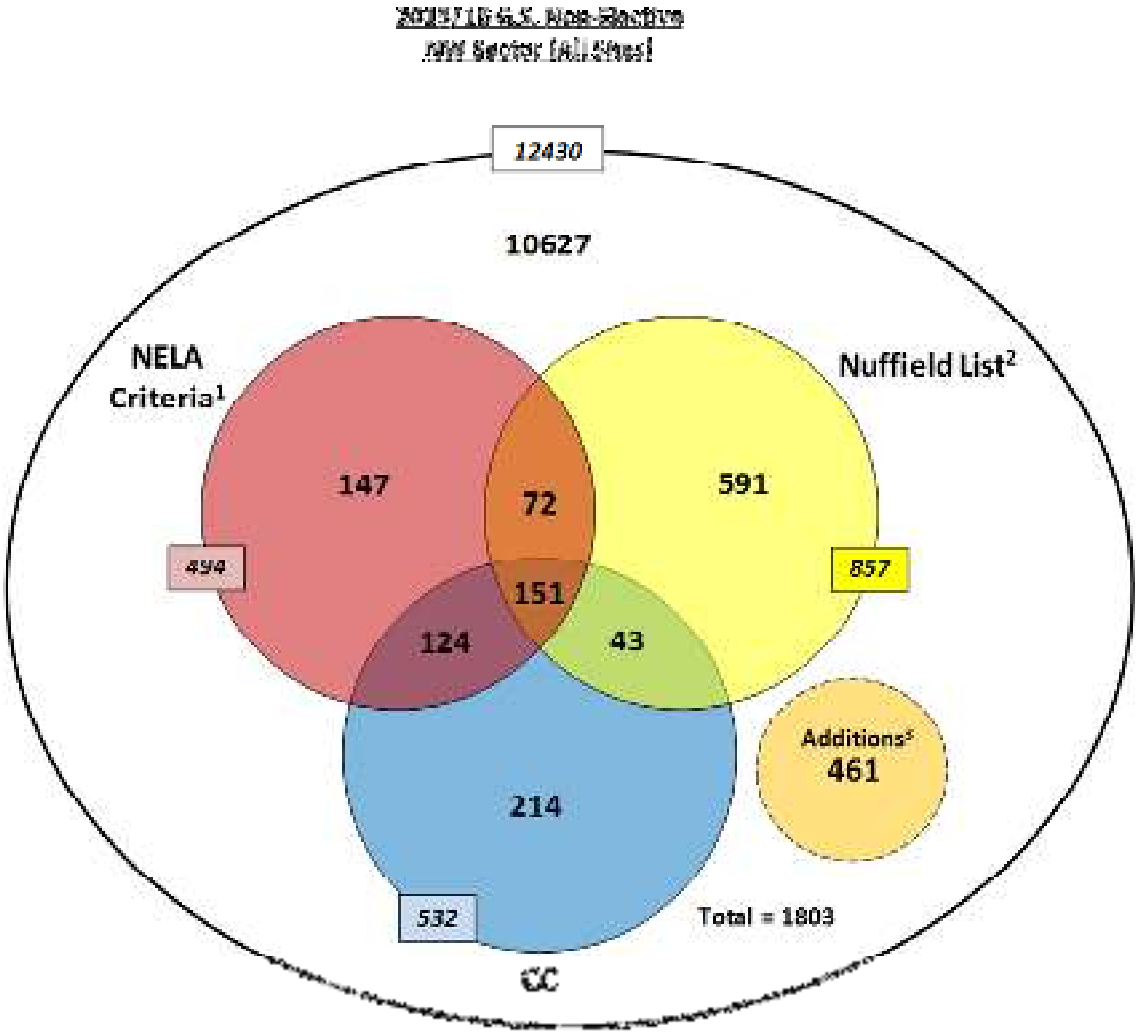
Note, this assumes that these patients are identified accurately through the Surgical Review stage of the non-elective pathway. Retrospective data has been used for this analysis, and it is assumed there is no 'over-triage', i.e. inappropriate transfer of patients to the high-risk hub (though this assumption has been varied, explained later in this section). The Chief Medical Advisor for HT has advised the NWS it should not assume any over triage due to senior assessment of cases before decision to transfer to hub.

The projections for NWS General Surgery high-risk activity transfers were discussed and agreed at a series of post-stage 2b review meeting with the HT Chief Medical Advisor in January and February 2017. It is noted that these figures are baseline and do not include projections for growth and activity (an approach agreed with GM TU) nor do they include the (small) number of patients with significant GI bleeds transferring to the hub. (A GM pathway for this group of patients is currently being developed by GM wide clinical group).

Extensive work has also been undertaken at a Sector level to review whether there are additional high-risk patients not identified through the four criteria above. Assessment by surgeons at the three Trusts identified three additional coding groups procedure codes (J182, J121, J241) where they considered patients would be high risk. In 2015/16 only one additional patient was coded to these groups and would have required transfer to the Sector hub**.**

The diagrams below present NEL activity for the NW Sector, followed by activity at the non-hub sites combined which will require transfer to the hub.

Non-elective general surgical activity – North West Sector (all sites)

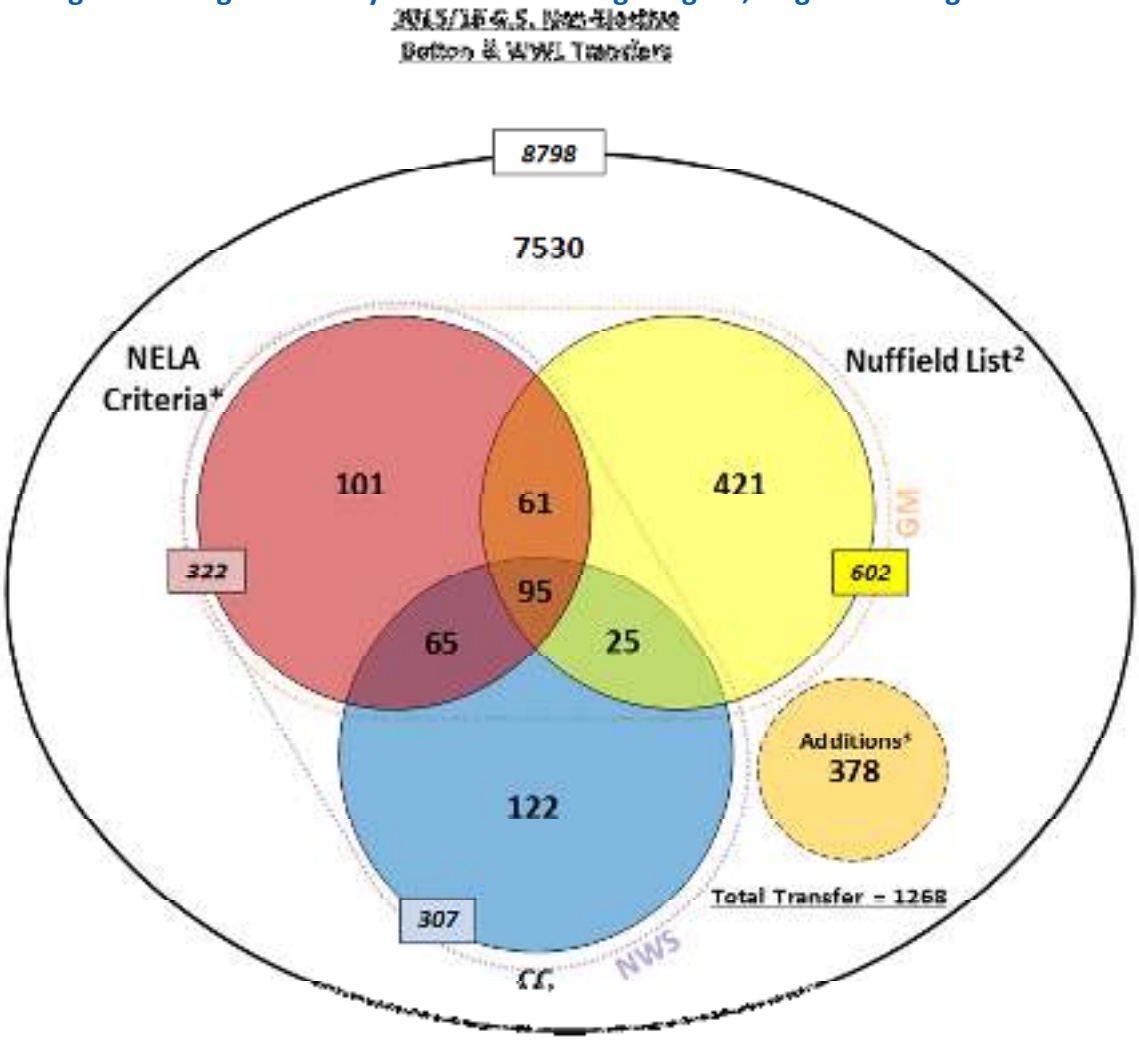


Explanation:

- *The diagram indicates that 12,430 NEL GS spells were carried out across the Sector in 2015/16*
- *Of these, a total of 1,803 were high-risk based on the four groups:*
    - *494 met NELA criteria; 857 were on the Nuffield List; 532 required critical care, with numbers above at the intersections of the Venn diagrams indicating those who meet two or three of these criteria.*
    - *The additional group (acute pancreatitis and gallstone cholecystitis) account for a further 461 patients.*
- *The remainder of 10,627 were low risk (i.e. 85% of the total)*

The next diagram provides the same analysis for the Bolton and WWL sites only, which indicates number of non-elective spells that will move to the Sector hub with the full implementation of the new General Surgery model of care.

Non-elective general surgical activity – Bolton and Wrightington, Wigan and Leigh



Explanation:

- *The diagram indicates that 8,798 NEL GS spells were carried out in Bolton and WWL combined, in 2015/16*
- *Of these, a total of 1,268 were high-risk (i.e. 14%, or around one-in-seven) based on the four groups:*
    - *322 met NELA criteria; 602 were on the Nuffield List; 307 required critical care, with numbers at the intersections of the Venn diagrams indicating those who meet two or three of these criteria.*
    - *The additional group (acute pancreatitis and gallstone cholecystitis) account for a further 378 patients.*
- *The remainder of 7,530 were low risk (i.e. 86% of the total)*

As a result, the analysis shows that the high risk non-elective general surgery activity that will transfer from the non-hub sites to the hub site in the Sector (including the one additional patient determined by a review of low-

risk activity) will be c.1269 spells per year. This is the figure used to determine capacity requirements, as explained further below.

Combined elective and non-elective analysis and implications for capacity at the three provider sites

Analysis has been conducted using the previous data on spells to identify the implications for capacity: acute hospital beds (assuming 85% occupancy); critical care beds (assuming 85% occupancy); and theatre sessions per annum (assumptions to be confirmed to reflect actual elective scheduling and sufficient availability of emergency theatres). Further detail is available (detailed modelling paper given in Appendix 18), **and a site-level summary pre- and post-implementation is given below.**

Bolton FT (non-hub site)	Pre-Implementation (2015/16)	Post-Implementation (forecast)	Difference
Elective			
Total spells	1,234	1,024	-210
Total beds	14.7	7.87	-6.83
Total Critical Care beds	1.04	0.24	-0.8
Total Theatre sessions	565	358.49	-206.84
Non-Elective			
Total spells	4,935	4,318	-617
Total beds	63.69	40.83	-22.86
Total Critical Care beds	2.69	0.16	-2.53
Total Theatre sessions	511	320	-191
Combined EL and NEL			
Total spells	6,169	5,342	-827
Total beds	78.39	48.7	-29.69
Total Critical Care beds	3.73	0.4	-3.33
Total Theatre sessions	1,077	679	-398

Salford Royal FT (hub site)	Pre-Implementation (2015/16)	Post-Implementation (forecast)	Difference
Elective			
Total spells	1,494	1,857	363
Total beds	21.14	31.12	9.98
Total Critical Care beds	5.69	6.9	1.21
Total Theatre sessions	855	1,182	327
Non-Elective			
Total spells	3,632	4,900	1,268
Total beds	62.59	105.4	42.81
Total Critical Care beds	6.1	10.45	4.35
Total Theatre sessions	308	597	290
Combined EL and NEL			
Total spells	5,126	6,757	1,631
Total beds	83.73	136.52	52.79
Total Critical Care beds	11.79	17.35	5.56
Total Theatre sessions	1,162	1,779	617

Wigan, Wrightington and Leigh FT (non-hub site)	Pre-Implementation (2015/16)	Post-Implementation (forecast)	Difference
Elective			
Total spells	700	547	-153
Total beds	6.28	3.13	-3.15
Total Critical Care beds	0.41	0	-0.41
Total Theatre sessions	272	151	-120
Non-Elective			
Total spells	3,863	3,212	-651
Total beds	52.48	32.54	-19.94
Total Critical Care beds	1.83	0.01	-1.82
Total Theatre sessions	205	106	-99
Combined EL and NEL			
Total spells	4,563	3,759	-804
Total beds	58.76	35.67	-23.09
Total Critical Care beds	2.24	0.01	-2.23
Total Theatre sessions	476	257	-219

Capacity and capital implications

Based on the above analysis, the hub site will require an additional:

- **53 acute hospital beds**
- **6 critical care beds**
- **617 theatre sessions per year**

Factors to be noted in determining the theatre requirements for HT, include:

- Modelling analysis (above) for theatres is a sum of elective and non-elective requirements.
- Capacity will be required to guarantee access standards are met after the transfer of activity from the non-hub sites and allow for peaks in demand.
- Implementation planning by Salford Royal has considered in detail how to deliver the emergency activity associated with Healthier Together on the Salford Royal site. The efficiency of the current Salford Royal emergency theatre has been significantly improved, in particular through morning huddles and start times, and the introduction of the Surgical Triage Unit has greatly improved turnaround times and planning. Despite these efficiency gains the capacity required to meet the transferring emergency activity would require a further three session theatre per day to absorb the additional highly complex colorectal and high risk general surgery activity. This should enable the existing emergency General Surgery patients at Salford Royal to be managed in a timely way, be in line with the service specification and without causing unintended delays to either patient group.

  The implication for capital was the need for an additional two 36-bedded wards at Salford, as the hub site, and this was included in the HT Financial Business Case, further details of which are given in Section 5 – Financial Case. The broader approach has been subject to 'stress testing' by the GM TU team, through sensitivity analysis (varying assumptions) on key parameters including:
- Efficiencies (lengths of stay)
- Repatriations (patients repatriated from hub to non-hub sites after 28 days)

- Over triage (inappropriate transfers from non-hub to hub site)

Best, Worst and Most Likely cases were developed, all of which confirmed the capital implication as two 36-bedded general surgical wards at the hub site.

As noted in section 1.3.2, work is ongoing to determine the potential for reducing the additional capacity required at the Sector hub through potential: efficiency gains (e.g. lengths of stay reductions); impact of ambulatory care; and mitigations through wider GM Theme 3 and Sector Programme 3 actions.

At this stage, the hub site cannot rule out that the delivery of future pathways for high risk patients will not incur increased costs of associated services; mapping of future pathways of care will enable identification of the cost implications of associated services and consideration of how these could be mitigated.

Both non-hub sites will see a reduction in activity and requirement for capacity, as indicated above. Discussions are ongoing regarding the operational implications (clinical interdependencies); funding (stranded costs); and links with other developments and activity shifts (e.g. from Programme 3).

The Sector has raised specific questions and concerns about potential quality and safety issues involved in double ambulance journeys for emergency surgical patients (i.e. to a non-hub site, then transfer to the hub). The issues are being addressed by the GM-wide NWAS Group, which includes Sector representation. (Appendix 13)

Workforce modelling

The following sets out the current baseline, pre- and post-implementation position on workforce requirements to deliver the new General Surgical model of care. In line with advice from GM HT and informed by extensive discussions within the Sector, in modelling future workforce requirements we focus on NEL activity and the impact (initially on consultant posts) of shifting high-risk NEL from non-hub to hub sites. A small proportion of elective activity will transfer from non-hub to hub sites and while the implications are significant, the resources in the Sector should be redeployed to meet the different location and working patterns. This is not to minimise the issues involved in operationally delivering the new model and the impact on workforce.

The summary output of the modelling is the Sector requirement for consultant surgeons will increase from the baseline of 32.8 to a forecast of 41.5, meaning an additional 8.7 WTE consultant posts. In part the growth is due to the Sector's proposed cover arrangements to implement the NWS model of care in General Surgery which differ from the HT standards in two respects, for which evidence is provided below and to demonstrate the case for local commissioner support:

- 12-hours consultant cover 7/7 at the non-hub sites (rather than the 10 hours HT standard)
- 6 hours of consultant ward-based activity to manage speed and flow of NEL activity at the hub site

The estimated requirements for increased consultant establishment is based on both the above requirements and the need to meet GM HT quality and safety standards. The following sets out the baseline, and summarises the pre- and post-implementation position in terms of required consultant PAs.

Baseline – current workforce

The current baseline of WTE staff across the Sector for General Surgery is as follows.

General Surgery Baseline -GS				
	Bolton	Salford	Wigan	Total
Consultants	9.1	16.7	7.0	32.8
Middle Grades	9.0	12.0	11.0	32.0
Core Trainees	8.0	9.0	2.0	19.0
FY1	9.0	13.0	9.2	31.2
Total	35.1	50.7	29.2	115.0

For information, the baseline for anaesthetics is given below, though this is best given as PAs per week, given the flexible use of a wider pool of anesthetists to support the number of sessions indicated below.

General Surgery Baseline - Anaesthetics (PAs per week)				
	Bolton*	Salford**	Wigan***	Total
Consultants GS	19.0	42.0	10.0	71.0
Consultants ET	29.0	69.5	17.5	116.0
Middle Grades	0.0	0.0	0.0	0.0
Core Trainees	0.0	0.0	0.0	0.0
FY1	0.0	0.0	0.0	0.0
Total	48.0	111.5	27.5	187.0
*Bolton	Emergency Theatre 8am to 6pm M-F On Call rota outside core hours			
**Salford	Emergency Theatres 7.30am to 7pm M-F 8am to 5pm W/End & BH On Call outside core hours			
***Wigan	Emergency Theatre 8am to 6pm 7 days a week plus On Call rota outside core hours			

In addition to describing the baseline, the table above also illustrates the variation in current models across the three sites, specifically for emergency theatres.

Analysis – impact of new model of care

The following summarises briefly the workforce model developed to support the new Single Shared Service approach to General Surgery, which will be operationalised through clinically-led implementation.

A detailed daily rota has been developed to model consultant workforce requirements in General Surgery at hub and non-hub sites, which balances the roles of: assessment; operating; ward based activity; ambulatory clinic; and on-call.

- Non-hub sites each needs a rota for one consultant General Surgeon available 24/7, 7 days a week and with balance of on-site (12-hours) and off-site (on-call, 12-hours).
- Hub site requires a rota for three consultant General Surgeons available with the following cover to meet patterns of activity from the new model of care:
    - 8am to 2pm – three consultants on-site (with one specifically on ward round activities, one operating and one assessing)
    - 2pm to 10pm – two consultants on-site (one assessment and one operating)
    - 10pm to 8am – one consultant on-site (covering all activities)

Based on the above requirements and a set of assumptions (such as 12 PA contract and agreed time commitments for different activities of PA, SPA, MDT etc.) the analysis indicates the following PA requirements across the Sector pre- and post-implementation given first as Annual PAs.

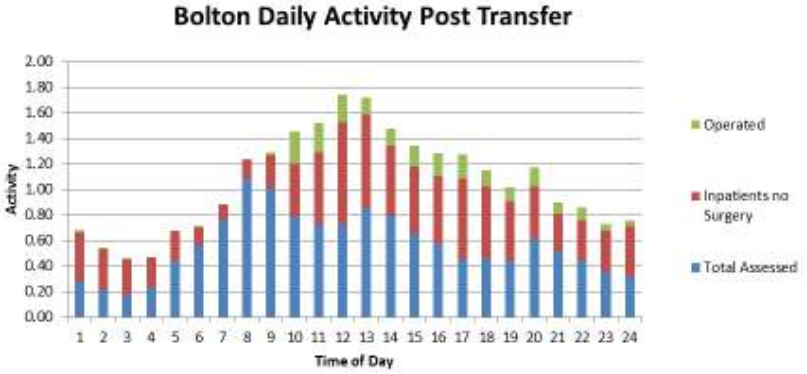
North West Sector Annual PA's	Pre-Implementation	Post-Implementation	Variance
Non Elective PA's			
Bolton	1,279	1,725	446
Salford	1,430	5,765	4,335
Wigan	1,279	1,725	446
North West Sector	3,988	9,215	5,227
SPA's and MDT			
Bolton	1,186	1,290	104
Salford	2,174	2,798	624
Wigan	910	1,014	104
North West Sector	4,269	5,101	832
Combined PA's			
Bolton	2,465	3,015	550
Salford	3,604	8,563	4,959
Wigan	2,189	2,739	550
North West Sector	8,258	14,316	6,059

Based on agreed assumptions the post-implementation requirement is for 41.5 (WTE) consultant General Surgeons in the Sector, which compares with a current total of 32.8 WTEs (a difference of 8.7).

The case for 12-hour consultant cover at non-hub sites is that:

- The volume of activity for NEL activity, including assessments, support to ED, unscheduled low-risk surgical procedures and admission avoidance all require consultant input across 12 hours (8am to 8pm) to support flow and reflect activity illustrated in the graphs below for Wigan and Bolton.

Bolton Site - Activity by time of day

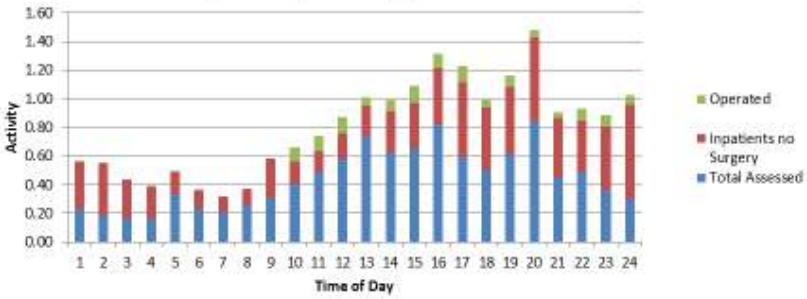


Assumptions

- Average Day = Annual activity/365
- Assumes transfer of HR to HR site (1.69 = 0.59 Surgery, 1.10 no surgery)
- Assessment takes place 4 hours prior to admission
- All admissions to be assessed by a Surgeon
- Excludes patients not admitted (surgical opinion to A&E and in patient medicine)

Total per Day	Assessments	LR surgery (remaining)	LR no surgery (remaining)	LR admission avoidance (Ambulatory)	LR no surgery (remaining)
13.52	13.52	2.24	9.59	1.40	8.19

Wigan Site - Activity by time of day



Assumptions

- Average Day = Annual activity/365
- Assumes transfer of HR to HR site (1.78 = 0.56 surgery, 1.22 no surgery)
- Assessment takes place 4 hours prior to admission
- All admissions to be assessed by a Surgeon
- Excludes patients not admitted (surgical opinion to A&E and in patient medicine)

Total per Day	Assessments	LR surgery (remaining)	LR no surgery (remaining)	LR admission avoidance (Ambulatory)	LR no surgery (remaining)
10.58	10.58	1.25	7.55	1.21	6.34

The above graphs clearly demonstrate peaks of activity at both non-hub sites from 8am to 8pm. Associated with a continuing high volume of admissions (c.14 per day at Bolton, c.11 per day at Wigan) and ongoing support for all remaining inpatient ward activity, the clinical leaders are clear that any less than 12 hours consultant cover result in a significant diminution of the service.

The case for 6 hours of consultant ward rounds to manage NEL activity at the hub site is that:

- The surgical team at Salford will be managing an increased volume of high-risk emergency activity of around one-third (from 3,632 to 4,900 spells, 35% increase) and inpatient wards modelled at c.137 beds, of which c.105 will be NEL activity.
- Consultant ward-based activity for 6 hours per day (scheduled for the peak, currently modelled as 8am to 2pm) is necessary to provide rapid access to senior decision making and support for discharge to enable the necessary patient flow.

Further work is being undertaken, with clinical engagement, to refine workforce modelling and extend its scope to include non-consultant medical staff and other professional groups. A Group has been established to clarify how the new workforce model and arrangements will be implemented, led by the General Surgery clinical lead, with operational management input from each site.
Recent analysis has indicated the impact of the new model in terms of consultants (PAs and WTE) as below.

NWS Consultant PAs Pre and Post Transfer		
Current PA's	**Future PAs**	**Variance**
4,804	**9,875**	**5,071**

NWS Consultant WTE Pre and Post Transfer		
Current Workforce Requirements	**Future Workforce Requirements**	**Variance**
10.3	**19.0**	**8.7**

In reviewing the developing clinical models and an earlier draft of this Sector Business Case at the Partnership Board meeting on 23rd March 2017, leaders identified the need to consider how the model could be provided if oesophageal-gastro (OG) surgeons were not included in the General Surgery on-call rota, with the results as below. The sector is working with the Manchester and Trafford Sector, the Transformation Unit to understand the impact of the GM development of a single-site OG model, which would be based at SRFT, with a dedicated on-call rota upon the single service General Surgery on-call rota in the NWS.

NWS Consultant PAs Pre and Post Transfer				
Current PA's	**OG Consultant PAs**	**Remaining PAs**	**Future PAs**	**Variance**
4,804	**624**	**4,180**	**9,875**	**5,071**

NWS Consultant WTE Pre and Post Transfer				
Current Workforce Available	**OG Consultant Workforce**	**Remaining Workforce**	**Future Workforce Requirements**	**Variance**
10.3	**1.0**	**9.3**	**19.0**	**9.7**

Supporting governance arrangements

Implementation of the new model of care for General Surgery will be governed by the new Sector-level arrangements as described in Section 6, led by the Shared Services Board. Specifically for General Surgery, SGIB will remain the leadership body and has established Operational and Clinical Pathway sub-groups.

In summary, the above section has set out the requirements to meet GM HT Standards, the revised model of care for a Single Shared Service in General Surgery, its basis and implications in terms of activity and shifts in patient flows, and the impact on workforce and requirements for implementation. Further information including the financial consequences and phased approach to delivering the new General Surgery model of care are given later in this Business Case. The next section presents the approach to meeting GM HT standards and emerging Sector model of care for Urgent, Emergency and Acute Medicine.

3.2 Urgent, Emergency and Acute Medicine (UEAM)

The Urgent, Emergency and Acute Medicine (UEAM) Project is driven by the need to deliver GM HT quality and safety standards supported by greater collaboration and a common Clinical Governance framework, as explained below. Leaders of UEAM across the NWS have identified and are pursuing opportunities for innovative service development and improvement, informed by the outcome of peer review of standards and other analysis of service delivery and practice.

Summary – UEAM new model of care

Urgent / Emergency Medicine

- Will continue to be provided at the three sector provider sites (A&E units at Bolton, Salford and Wigan).
- Patients will benefit from a more consistent model of care, learning from best practice in the sector and beyond, such as greater use of Ambulatory Care and condition specific pathways, including frail elderly.
- Enhanced in-hospital care will be complemented by improved communication and patient flow with colleagues in primary and community care, linking with work across the sector to better integrate health and social care.
- Delivering these improvements will require a 'blended workforce' with the development of new roles and spread of innovative practice, such as for advanced practitioners (AP).

Acute Medicine

- Will continue as a critical element of hospital services at the three sector providers and benefit from a more consistent, reliable model.
- Enhanced access to specialist care is critical to delivering standards, enabling more rapid access to senior clinical input and decision making for areas such as respiratory, Cardio Vascular Disease (CVD) and diabetes.
- An additional priority for acute medicine is to enhance ambulatory care, providing rapid access to diagnostics and specialist input, thus reducing the reliance upon inpatient based services.

The UEAM new model of care continues to be developed and will be implemented through a collaborative, cross-sector approach. A shared clinical governance framework will support the development of consistent pathways and monitoring of progress to collectively improve outcomes, experience and service efficiency.

3.2.1 UEAM overview

UEAM includes the following two, interrelated specialties;

- Emergency medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury.
- Acute medicine is that part of internal medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies.

The sector's vision for UEAM is to provide high quality and clinically sustainable Emergency Medicine and Acute Medicine services to the local population from each acute hospital site in the NWS. A small number of patients with specific specialist needs, such as GI bleeds will receive assessment and diagnostics at their local site before being transferred by ambulance to designated units (GM-wide clinical model has been agreed for GI bleeds, and reviewed by the GM Clinical Alliance which has representation from the NWS). All pathways are clinically-led and based on evidence, quality and safety standards.

The sector's three large and busy A&E Departments will continue to operate 24 hours a day, seven days a week, in line with the needs of their local population. They will be supported by full acute medicine and critical care services, which reflect the requirements for on-site services based on patient acuity and volumes.

The three services are working together to establish a single clinical governance arrangement for UEAM across the NWS. This will include a clinical governance forum led by the sector Medical Directors, where clinical pathways are agreed, incidents reviewed and issues managed or escalated. The new clinical governance structure will report through the partnerships governance structure and to the NWS Partnership Board if issues or risks cannot be resolved, and will be supported by quarterly monitoring of compliance against priority standards for UEAM.

The sector has an aspiration to provide 16-hours of on-site consultant cover in each A&E; the rationale for this is described later in this chapter.

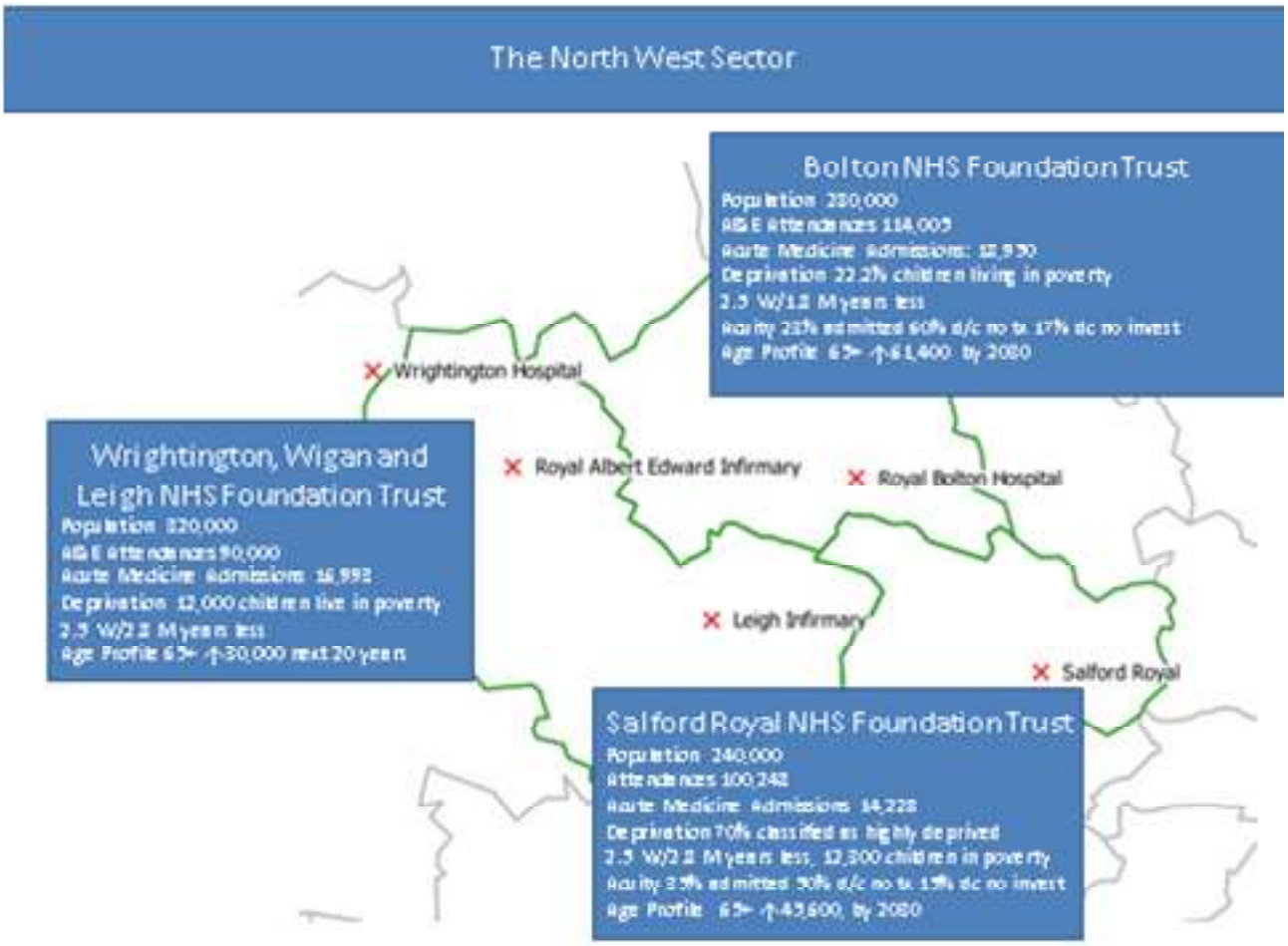
While changes to high risk emergency general surgical services are important to take into account, the numbers of patients deflected to the hub site are small (circa 2 per department per day), and the majority of A&E attendances and resultant admissions are medical patients.

As explained below, the priorities in developing a consistent sector approach to UEAM include:

- ***Improving patient flows***
- ***Sharing good practice***
- ***Enhancing specific pathways*** (including ambulatory care)
- ***Ensuring appropriate and timely access to specialist input*** e.g. cardiology, respiratory, gastroenterology and care of the elderly
- **Enabling consistent, safe and effective services by *developing a 'blended workforce'***
    - Agreeing a single sector service model with a flexible/mobile workforce supporting the needs of the population
    - Reviewing the skill mix
    - Strengthening existing roles
    - Developing new roles
    - Innovating the development of new ways of working.

A sector-wide UEAM model of care is being developed to better meet GM standards through clinically-led initiatives, commencing with the themes above.

The distribution of services and volumes are summarised below using 2015/16 trust data and CCG locality plans:



Based on an assessment of existing services in the sector, we have identified a range of opportunities to improve services and associated risks, as summarised below:

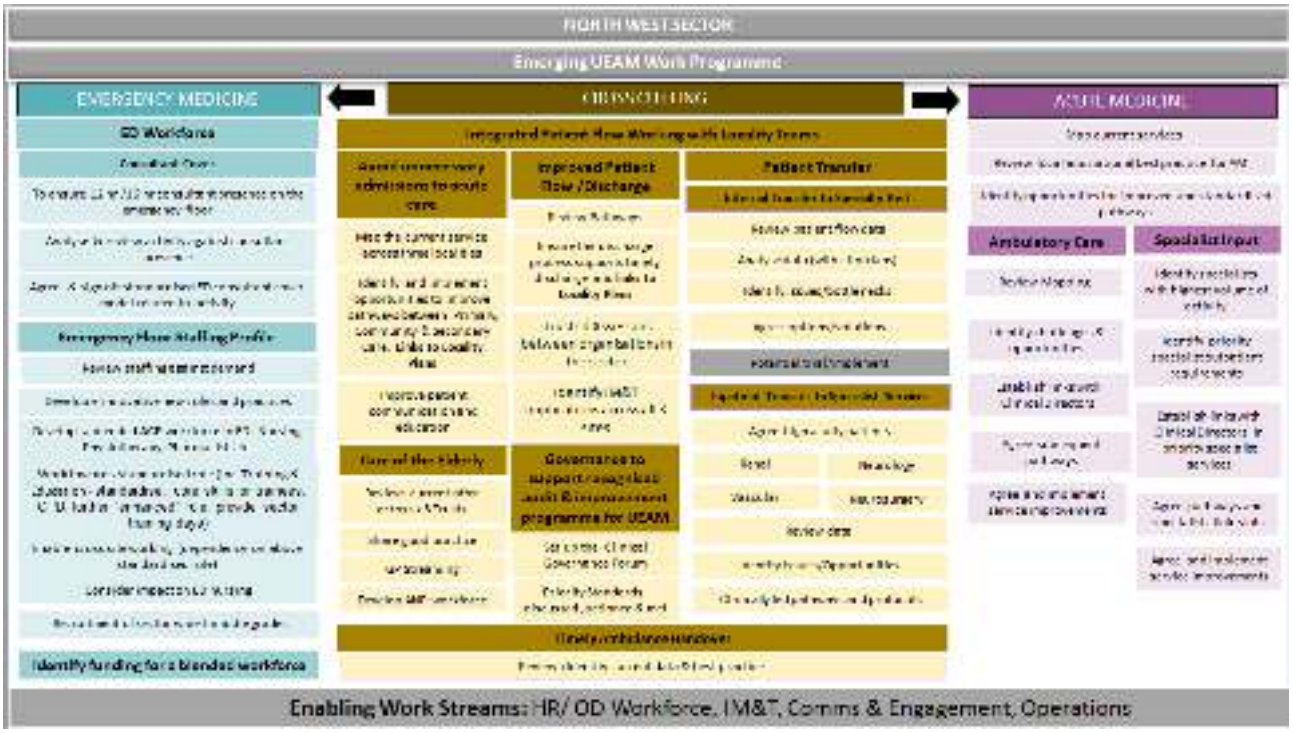
Risks and challenges – to be managed by UEAM workstreams:

- A national shortage of available staff at all levels
- Attracting sufficient applicants for vacant roles
- Achieving the required standards
- Ability to provide sufficient Consultant cover
- Impact of workforce development in some areas, e.g. ANP roles, leading to shortages in others e.g. ED nursing staff
- Managing clinical interdependencies, and collaborating with other work streams, such as General Surgery and Radiology

The table (Appendix 19 - Dashboard against Healthier Together Quality and Safety Standards - May 2017)

summarises the Healthier Together UEAM standards and the sector's RAG rating against each standard based on the final response to the Clinical baseline from GM Healthier Together in March 2017 . Further details are given in later sections relating to emergency medicine and then acute medicine, with aligned work plans.

The priorities for improvement indicated by this analysis are reflected in the structure of the sector UEAM activities summarised in the following Plan on a page; it is recognised that there will be interdependencies with Locality Plans, and the UEAM CSG will work with Locality Teams to align their work.

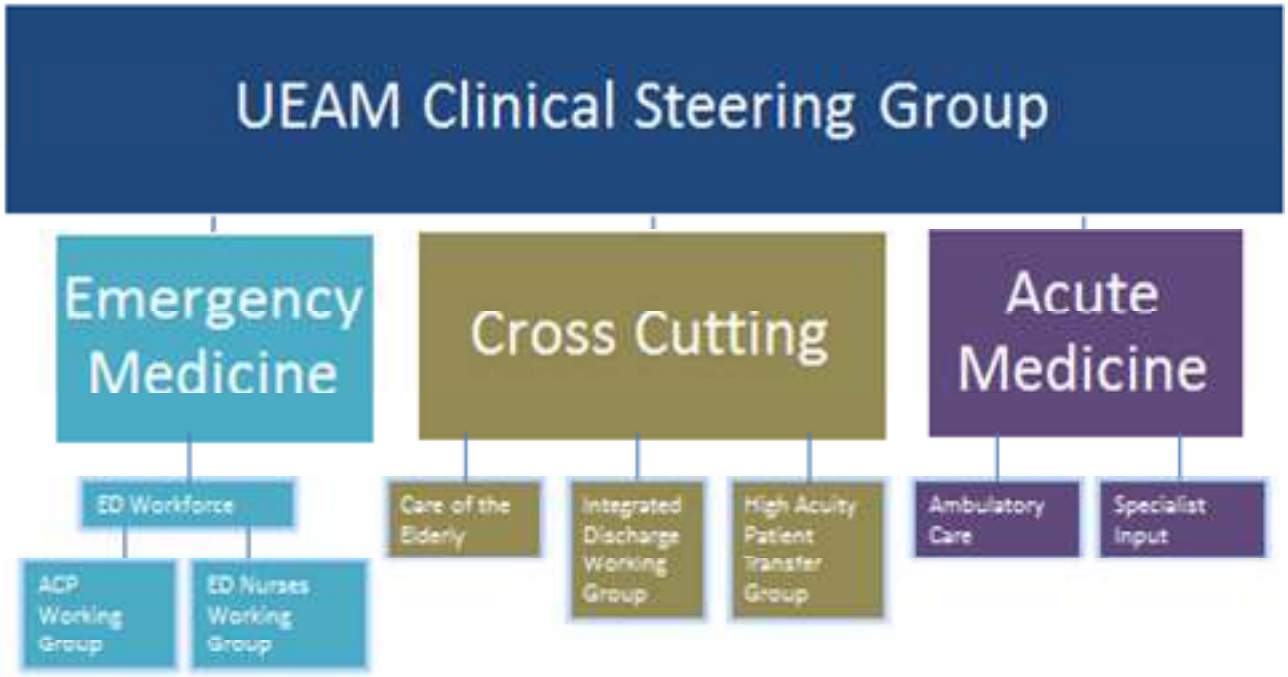


Leadership and structure of the UEAM project

Sector work on UEAM aims to ensure relevant GM HT quality and safety standards are fully met and to identify and exploit opportunities for innovative service development and improvement. The work is led by the sector's UEAM Clinical Steering Group (CSG) that comes together bi-monthly (every two months – 6 meetings a year) co-chaired by Dr Nasir (A&E Consultant WWL) and Dr Munshi (Consultant Acute Physician BFT) . Reporting to this overall leadership body are eight 'task and finish' work streams, as follows:

Subgroups	Aim
ED Workforce	To map capacity & demand; identify gaps in the ED workforce. To create a blended workforce facilitating innovative new roles and best use of the available workforce
ACP Working Group	This is a sub set group to ED Workforce; its aim is to standardise and develop Advanced Care Practitioner roles across the sector, to enable sharing of good practice across organisations and provide opportunities for cross site working
ED Nurses Working Group	This is a sub set group to ED Workforce; its aim is to standardise elements of nursing (e.g. induction, practice development and management arrangements) and to share good practice across organisations. The group will work with HR colleagues to explore a pathway to encourage nurses into Emergency Medicine.
Ambulatory Care	Standardise access and provision of service in ambulatory care. To provide clear, seamless pathways of care between GP's and ambulatory care 7 days per week.
Specialist Input	Ensuring timely, equitable and consistent access to specialist services across the sector (Care of the Elderly, Cardiology, Respiratory, Gastroenterology & DM & Endo). Input into A&E and Medical Assessment wards: 7-day service, provide specialist opinion to patients thereby preventing admission or facilitating early discharge.
Care of the Elderly Working Group	Spreading good practice, exploring possibility of sector working, provide a 7-day service, specialist opinion to patients in ED and on Medical Assessment wards and facilitate early discharge.
Integrated Care Working Group	Linking with Locality Teams to identify opportunities to reduce unnecessary admissions. To standardise the discharge process for patients leaving the urgent/emergency or acute medical services within the North West Sector To provide a 7-day service to facilitate discharge of medically fit patients.
High Acuity Patient Transfer Group	To provide a 7-day service (Renal, Neurology, Neuro-surgery and Vascular) to facilitate prompt transfer of patients from Bolton and Wigan to hub sites for specialist care.

The structure for delivering improvement in UEAM is given below:



The UEAM CSG provides the NWS's senior clinical leaders with authoritative clinical advice and priorities for action. Developing the vision for UEAM and setting a clinical specification for a single service model will ensure effective involvement and engagement of the wider clinical community in relation to the following issues;

- The increasing and changing demand for urgent, emergency and acute medicine
- The current variation in models of care, such as in the way acute medical units have been implemented
- Limited resources, particularly in the availability of ED doctors and nurses
- The opportunity to standardise approaches, e.g. ambulatory care, enhance patient experience and outcomes

The immediate priorities of the CSG are:

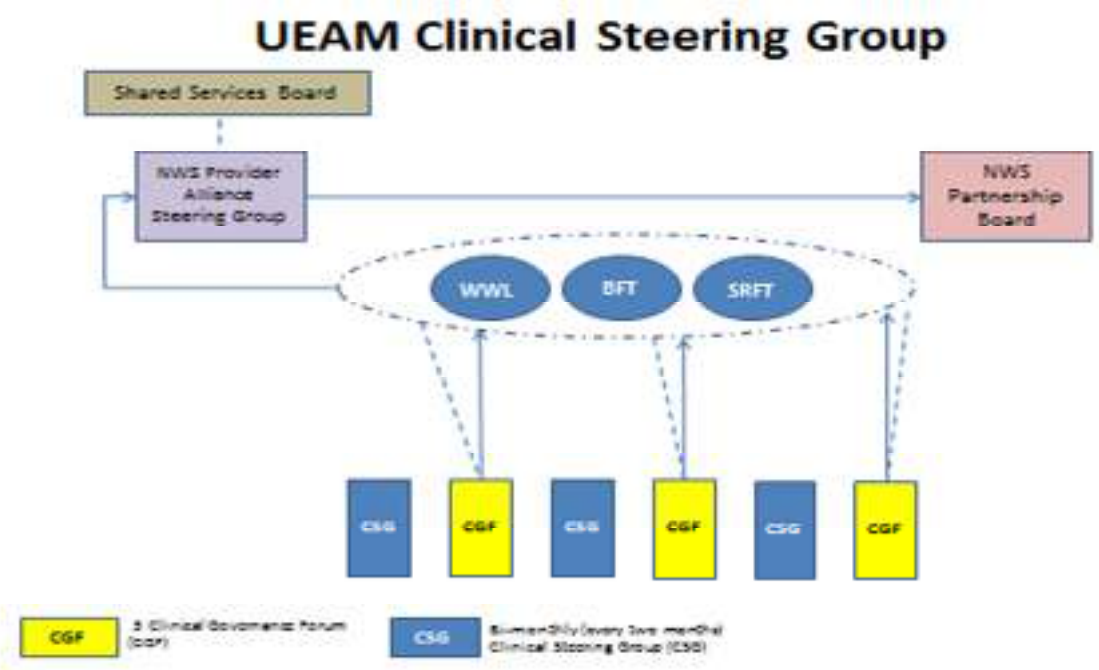
1. Identify and describe future standard model that can be delivered at local level and what is best achieved as a sector of care for Emergency Departments and AMU's in the NWS
2. Develop 2017-18 work plan to meet priority standards
3. Establish UEAM Clinical Governance Forum (CGF)
4. Ensure operational managers, including HR, join working groups.

The sector has stated its commitment to develop a shared Clinical Governance model for UEAM, with every other CSG meeting being dedicated to Clinical Governance Forum (3 times a year). These meetings will;

- Be led by the Medical Directors from each organisation
- Include GM HT Quality and Safety Standards in common sector policy aligned to individual Trust policy
- Measure performance against these standards at every CGF on progress
- Agree/approve common clinical pathways; conduct "deep dive", report on incidents, review, manage and escalate issues and document as part of sector policy.
- Analyse comparative performance and plan actions to address variances
- Inform discussion at the sector shared services board to review overall UEAM progress on standards and to give a provider based forum for collective intervention

- Report progress to Provider Alliance Steering Group which will escalate to NWS Partnership Board is necessary.
- Review job planning for relevant clinicians and include capability assessment as part of annual appraisal

The diagram below illustrates the proposed Clinical Governance Forum which is currently in development.



3.2.2 Urgent / Emergency Medicine

Each of the three sector providers has one A&E unit, based respectively at Bolton Royal Foundation Trust, Salford Royal Foundation Trust and the Royal Albert Edward Infirmary (WWL FT). Each site is currently experiencing unprecedented levels of activity with growth in A&E attendances and an increasing complexity given the ageing of the population and greater acuity such as multiple co-morbidities in the frail elderly.

Current levels of consultant cover are:

- Bolton provides 14-hour on site consultant cover, 7 days a week
- Salford provides 16-hour on site consultant cover, 7 days a week in the emergency department (24 hours for major trauma)
- Wigan provides a 13-hour on site consultant cover, 7 days a week

In line with trends seen both nationally and across GM, the growth and changing nature of demand is affecting the sector's performance against national waiting time targets, illustrated in the table below:

GM A&E performance against the 95% national standard (FY 15/16) vs (FY 16/17)

Organisation	Q1		Q2		Q3		Q4	
	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17
Bolton NHS Foundation Trust	95.4%	82.3%	95.0%	85.0%	90.9%	80.1%	80.0%	82.9%
Salford Royal NHS Foundation Trust	96.3%	92.2%	95.2%	87.8%	90.9%	83.9%	90.9%	79.8%
Wrightington, Wigan And Leigh NHS Foundation Trust	97.9%	92.3%	96.3%	91.2%	94.0%	83.6%	92.4%	83.0%
National Average	**94.1%**	**90.3%**	**94.2%**	**90.6%**	**91.5%**	**87.9%**	**87.9%**	**87.6%**

Emergency medicine priority standards and work programme

Led by CSG, a comprehensive, local self-assessment peer review of current performance against GM standards for UEAM was completed in January 2016. This was followed by an external GM HT assessment. While there were some differences (with GM HT reporting a lower level of compliance than the local results), an agreed set of priorities are being addressed, as given in the work programme below.

Emergency Medicine - Priority Standards & Work Programme

STANDARD	ACUTE (AM) or EMERGENCY (EM)	STANDARD SUMMERY	SALFORD	BOLTON	WIGAN	RESPONSIBLE LEAD/ACTION
UEAM01	**EM**	Consultant presence on the Emergency Floor of an accredited Consultant in Emergency Medicine [CCT holder] between 08:00 and 24:00, 7 days per week. Highest Acuity site: Minimum 8am - 12pm (16 hours) Best practice 24 hours Secondary Care Site: Minimum 8am - 8pm (12 hours).	FC	FC	FC	**CSG/Individual Sectors -** Analse activity mapped against comnsultant presence and use to decide how best to meet patent demand.
UEAM02	**EM**	Emergency Floor Clinical staffing profile should be aligned to demand throughout the 24 hour period evidenced by rotas and job plans.	FC	FC	FC	**ED Workforce Group** - To review ED staffing cover against demand, work collaboratively to review innovative new roles and practices. **ACP Working Group** -.To develop a blended ACP workforce in A&E: Nursing, physiotherapy, pharmacist etc. **ED Workforce Group** - Jointly recruiting sector-wide trainees
UEAM04	**EM**	Patient care in the ED should be directed by experienced senior ED doctors and nurses supported by junior staff.	FC	No ev	No ev	
UEAM06	**EM**	The Emergency Floor must have a clear and specific process for safe and effective assessment of incoming ambulance cases within 15 minutes of arrival and a documented escalation process to manage demand surge.	NC	NC	FC	**High Acuity Patient Transfer Group** - Review current data, identify good practice, make recommendations
UEAM30	**EM**	The ED and Primary Care must work together to design aligned services tailored for the local population. The ED must be able to direct suitable patients to timely primary care access. Acute care providers must provide a robust and clear mechanism for GPs to access timely specialist medical opinion.	FC	NC	FC	**All Groups (CSG / NWS / PMO)** - Links in with locality working through locality leads to share NWS and locality work programmes and ensure alignment of plans, programmes, project plans, whole MDT to become Trusted Assessor,s improved pathways, identify UEAM IT needs and link in with GM IM&T work.

It is noted that the standard given in GM HT for Emergency Medicine is for 16-hours consultant on site cover for the hub (Salford), and 12 hours for non-hub sites (Bolton and Wigan) (UEAM 01). This standard is fully met across the sector; however the NWS has a clear ambition for an enhanced Emergency Medicine model, which delivers 16 hours of consultant cover across all sites, given the levels of demand and activity in the sector. The Emergency Medicine Workforce Group is responsible for defining and delivering the new model.

ED Workforce

The critical starting point is the workforce, particularly levels of consultant cover, with the current situation given in the table below.

	Bolton	Salford	Wigan
Substantive Consultants	10.6	16	6
Locum Consultants	0	0	2 & 2 Associate Specialists
Consultant Vacancies	5.4	0	0
Daily Hours of Consultant Cover	14	16 – A&E 24 – Major Trauma Centre	13
Annual Attendances (2015/16)	114,006	100,248	90,081
(2016/17)	111,177	101,565	89,476

The above demonstrates variability across the sector in terms of:

- Hours of consultant cover
- Vacant posts
- Reliance on locum cover

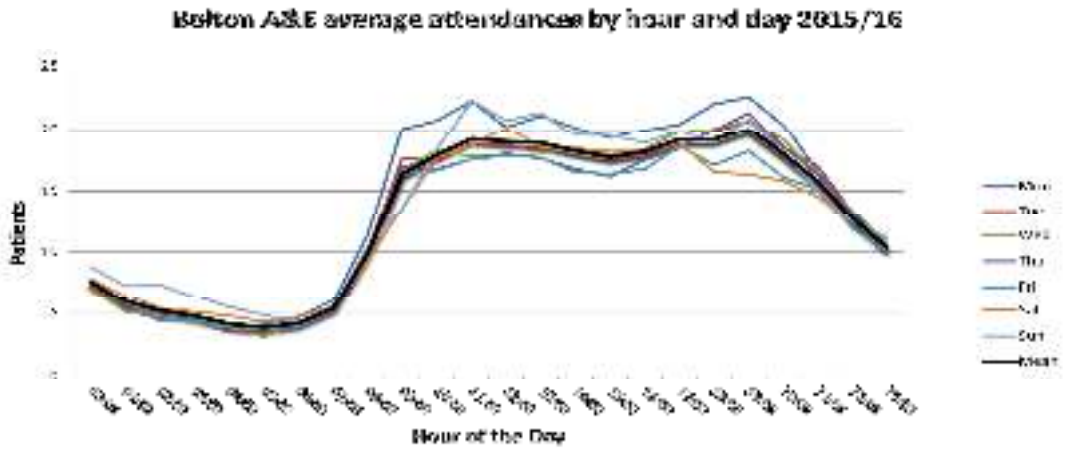
The aim of the UEAM work stream is to provide equitable levels of cover and consistent, high quality services in all settings. The College of Emergency Medicine recommends that every emergency department should have a minimum of 10 whole time equivalent consultants in Emergency Medicine, enabling a consultant to be present and supervising care for a minimum of 14 hours a day. Increased consultant-led/delivered services are expected to deliver:

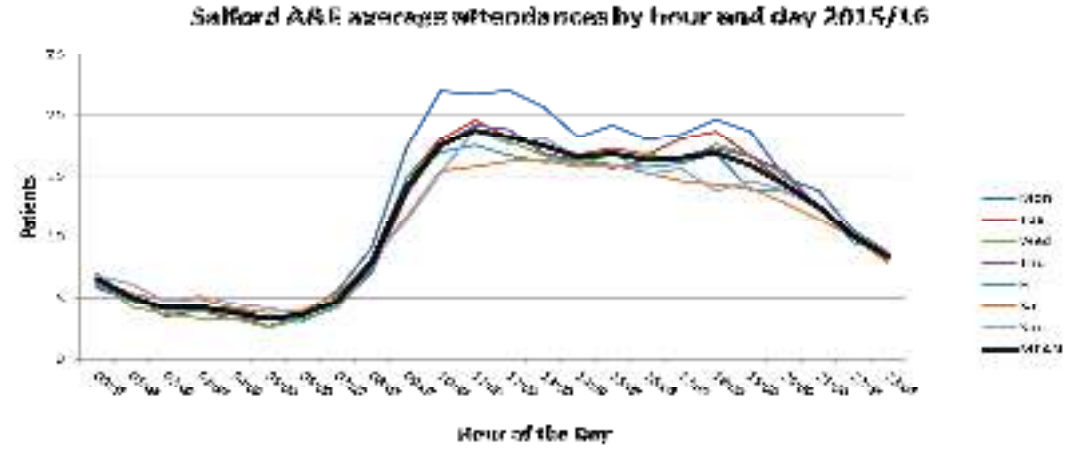
- Improved patient experience and outcomes,
- Improved recruitment and retention
- Improved training for doctors and other staff.

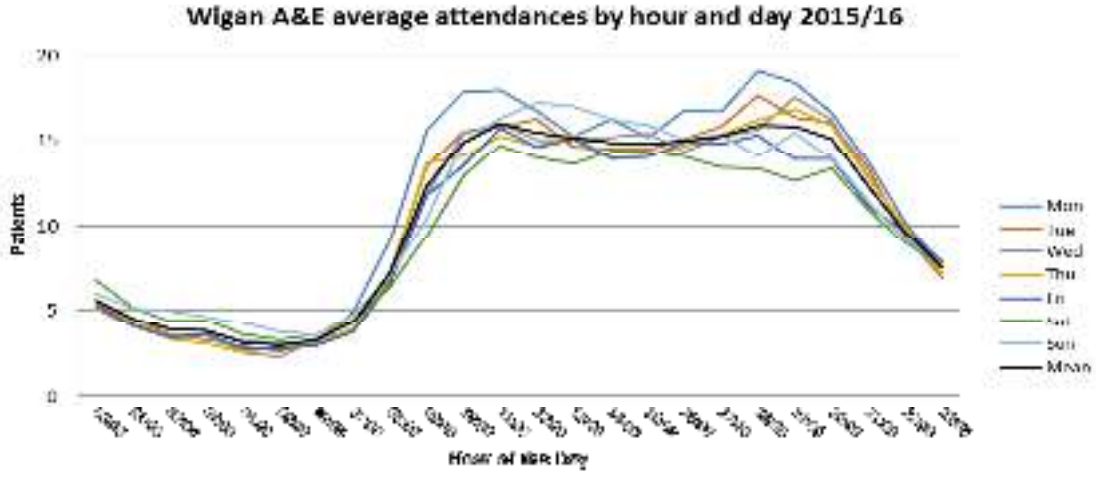
Sector view is that 16 hours is required to support the needs of the sector at the non-hub sites as indicated by the activity shown in the next section. To bridge the gap in current provision would equate to an additional 5 hours per day and consultant manpower would equal 1.5 WTE additional staff across the NWS.

Workforce and activity analysis

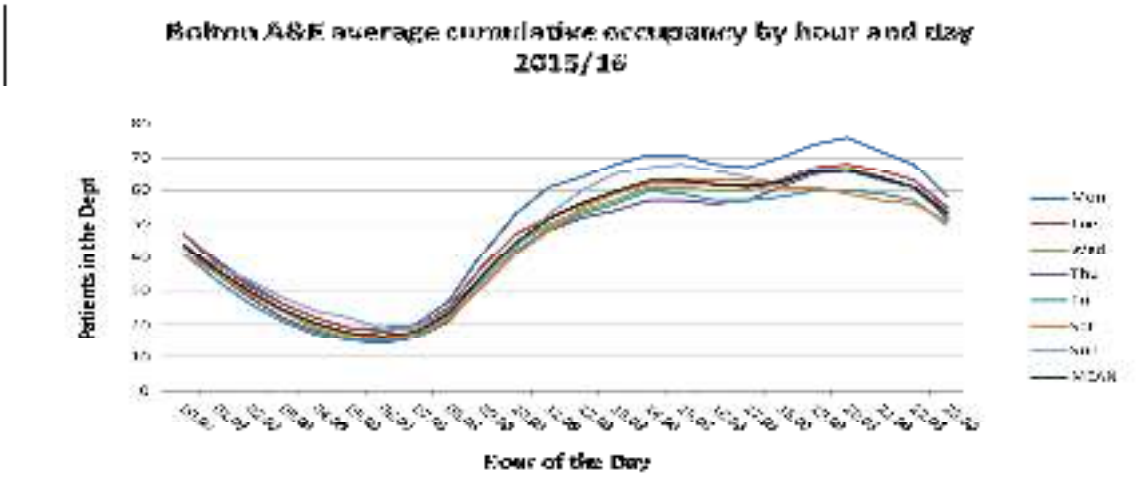
The sector has undertaken an extensive analysis of patient flow within its emergency departments; the following data shows 2015-16 levels of demand mapped against hours of consultant cover (by site) and highlights periods when available cover is sub-optimal given levels of activity.

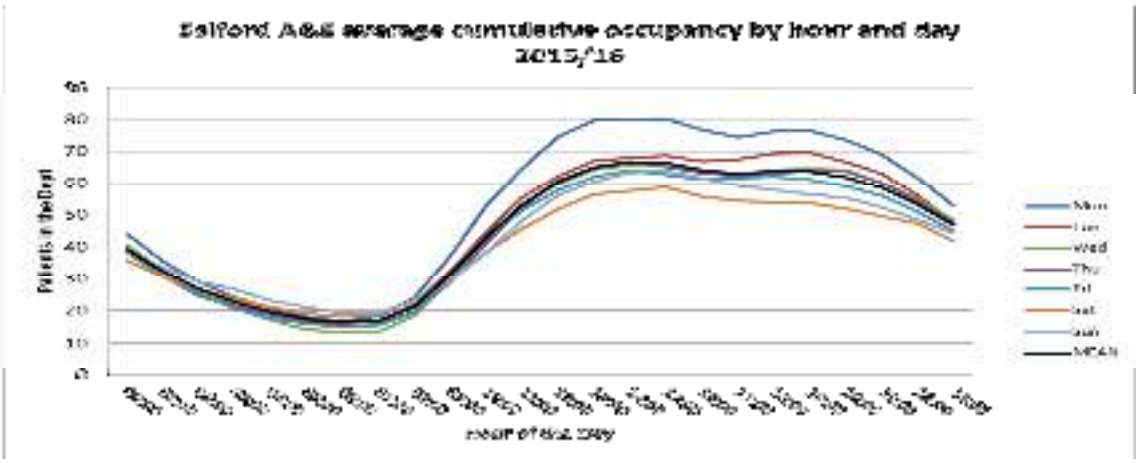

Bolton A&E average attendances by hour and day 2015/16
Patients
Hour of the Day

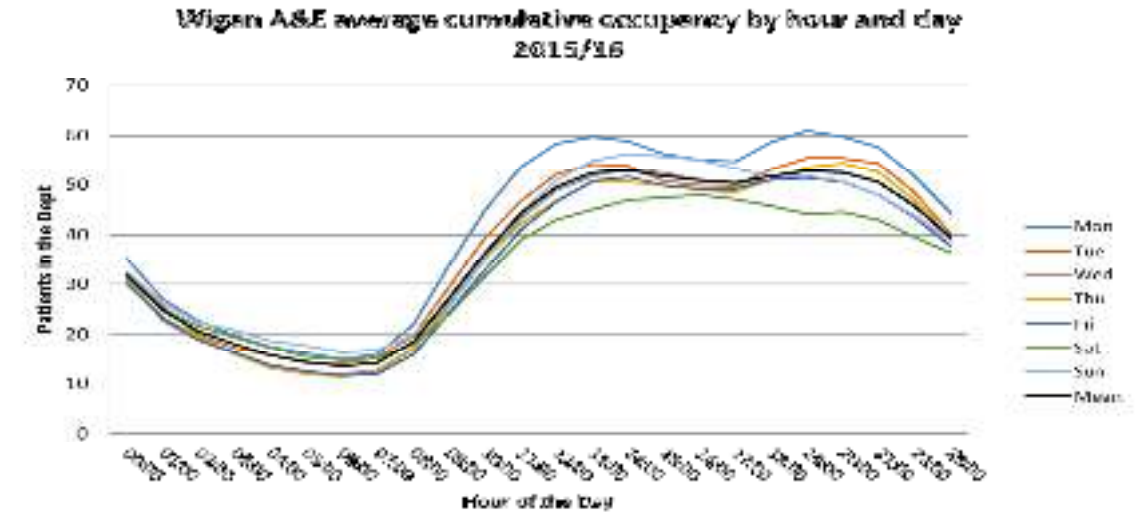

Salford A&E average attendances by hour and day 2015/16
Patients
Hour of the Day


Wigan A&E average attendances by hour and day 2015/16
Patients
10
Mon
Tue
Wed
Thu
Fri
Sat
Sun
Mean

The tables below show the average total number of patients in the NWS sector's three A&E departments for 2015/16 by hour of the day and day of the week. These identify that the activity over all the days of the week start to build up from 8am and increases throughout the day to a peak early afternoon and another peak into the evening, and not showing any reduction in demand until after midnight.



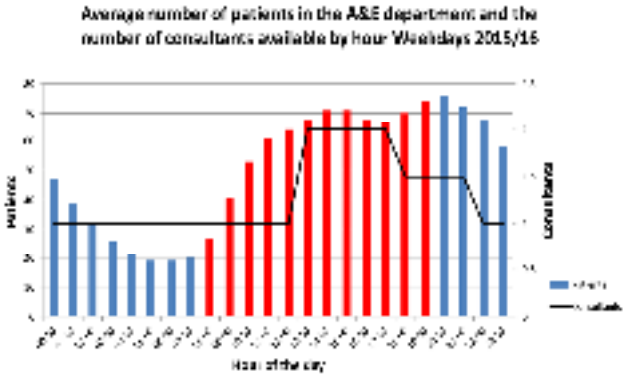


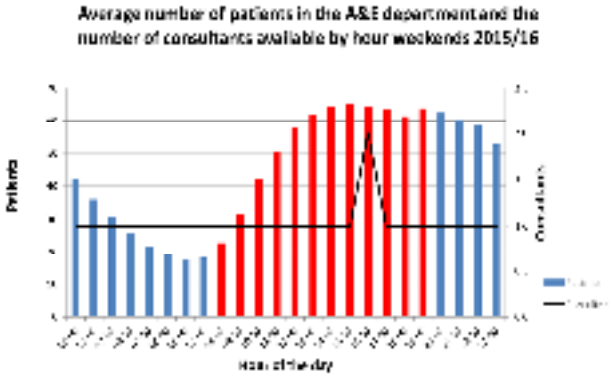


The tables below show the average total number of patients in the NWS sector's A&E departments for 2015/16 by hour and day of the week and the number of consultants available. The consultant presence includes both on site and on call availability. The HT standard for 12 hour presence is highlighted in red covering 8am to 8pm, for both weekdays and weekends.

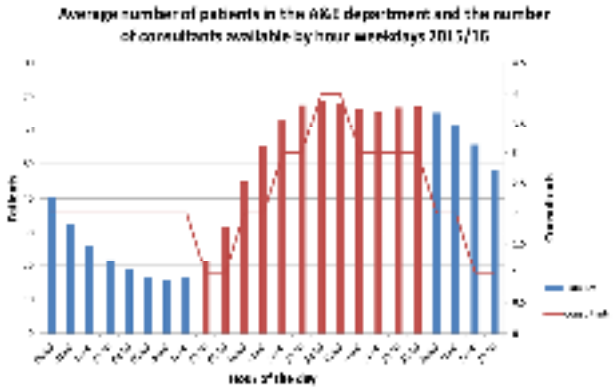
As indicated above the activity peaks at two points in the day and does not show any significant reduction until after midnight. The presence of consultant cover over the sectors requirement of 16 hours up to midnight ensures that there is a senior decision maker in the department when the patient activity is at its greatest. There is still an on-call provision available between 12 midnight and 8am to advise and if required attend the departments.

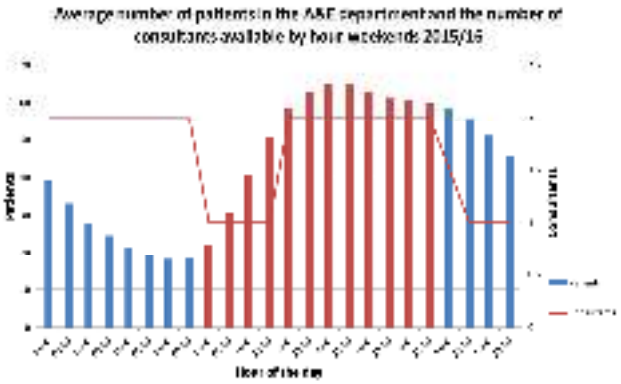
Bolton



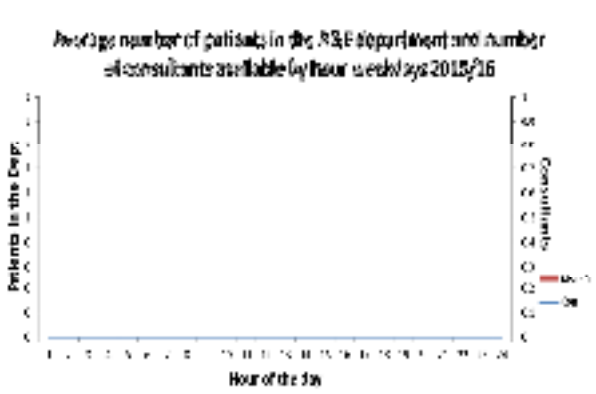


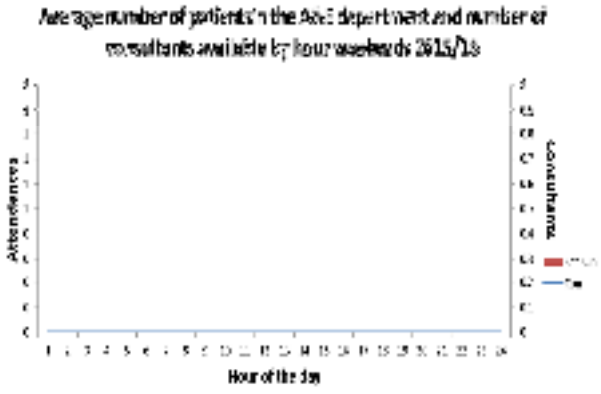
Salford





Wigan NB; WWL data required





Informed by this and related workforce analysis the UEAM emergency medicine sub-group is focusing on the following priorities:

1. Exploring the feasibility of providing an enhanced consultant presence in A&E to 16-hours a day at Bolton and Wigan and 24-hours a day at Salford (Inc. trauma).
2. Reviewing innovative uses of workforce in emergency medicine both locally and nationally and make a decision whether to adapt and adopt these across the sector.
3. Launching a second round of recruitment for joint rotational sector-wide middle grades and junior clinical fellows (the first attempt being unsuccessful in 2016 due to insufficient applicants).
4. Developing a single workforce strategy for emergency medicine within the sector.
5. Oversight of work to standardise the advanced care practitioner role in emergency medicine.

Advanced Care Practitioners (ACP) working group

Experience and innovation in the sector demonstrates the role ACPs can play in improving EM patient outcomes and experience. To ensure this was focused upon in the sector the CSG set up a working group to standardise the role and ensure:

- All new trainees undergo a standardised initial training programme enabling them to work across the sector, and to access the same level of support
- All existing ACPs in the sector have access to equitable training opportunities, including funding, with a collaborative training programme developed and made available to all
- The ACP role will be standardised and a joint approach taken to succession planning, workforce and career development
- If the group is able to present a case that the ACP workforce should be expanded, a case to fund this expansion would need to be developed and presented to the NWS Partnership Board
- All current ACPs have the choice to work within one individual department or rotate across the sector

The current AP workforce in the sector is as follows.

Current Workforce	ANP Adult	ANP Paed	ANP In-training (Adult)	ANP In-training (Paeds)	Other
Bolton	**4**	**3**			
Salford	**9.6**	**3.6**	**7.72**	**3**	**2.2 – Physiotherapists 2 – Nurse Consultants (Paeds)**
Wigan	**2.6**		**2**		**2 - Physiotherapist**

Salford made a decision to invest in this group of practitioners when they recognized that they could not consistently recruit to consultant posts. Over a 3-5 year period, the Trust has invested in these roles which have enabled them to look at the medical workforce and develop a work force strategy.

Benefits

- Increased clinical activity – PPD
- Increasing continuity and quality of care instead of using junior locums
- Reduction in locum spend
- AP led clinics instead of consultant (Ortho)
- Ward based AP – Standardising
- Supporting the medical rotes in ED
- Assessment of patient at the door across medical and Surgery hot-clinics, developing ambulatory care pathway.

Current work underway includes:

- A baseline survey to establish the current ACP workforce including education, training, banding etc.
- A trial of cross-sector working for ACP's
    - Initial orientation meetings have taken place and the practicalities that need to be in place to enable this such as governance, prescribing, requesting radiology are being addressed
- Linking in with the Royal College of Emergency Medicine's Pilot Credentialing Trial, this work will be localised so that the sector is able to offer:
    - A standardised set of core skills for trainee ACPs in emergency medicine
    - A standardised set of core skills for ACPs in emergency medicine so that those wishing to work at a more advanced level (e.g. on the middle grade rota) are accredited
    - A sector-wide continuing professional development (CPD) programme
- Improving communication across the workforce (ACP forum) and sharing education opportunities

ED nurses working group

This is a sub set group to ED Workforce; its aim is to standardise elements of nursing (e.g. induction, practice development and management arrangements) and to share good practice across organisations. The group will work with HR colleagues to explore a pathway to encourage nurses into Emergency Medicine.

3.2.3 Acute medicine

The sector has three Acute Medicine (AM) departments based at each of the three provider Trusts, each of which has:

- A dedicated acute medical unit (AMU)
- Dedicated acute medicine consultants and staff
- An established medical ambulatory care model (detailed below)
- All sites meet the GM HT safety and quality standard of 12-hour consultant cover 7/7 (UEAM 09) and are working to a standard pathway for the repatriation of stroke and MI for example

Acute medicine priority standards and work programme

A clinical peer review process was conducted for AM (December 2015) to determine compliance against GM HT quality and safety standards with priorities and associated actions given in the work programme below:

Acute Medicine - Priority Standards & Work Programme

STANDARD	ACUTE (AM) or EMERGENCY (EM)		STANDARD SUMMERY	SALFORD	BOLTON	WIGAN	RESPONSIBLE LEAD/ACTION
UEAM12	**AM**		Consultants from other specialties should commit sessions dedicated to Acute Medicine on the AMU with timely in reach to facilitate same day discharge. Including Respiratory, Cardiology, Gastroenterology, Geriatric Medicine, Diabetes & Endocrinology and Neurology.	FC	PC	PC	**Specialist Input** - Address gaps in specialist input provision and develop dedicated slots
UEAM26	**AM**	**EM**	Copies of discharge letters and summaries should be given to all patients being discharged (whether from ED, CDU, AMU or ward) and to those close to them if appropriate. Discharge letters and summaries should be shared with the patient's GP in a timely manner.	No ev	NC	NC	**Trust Patient Information Group** - Ensure patients receive a copy of their discharge letter
UEAM23	**AM**	**EM**	Robust systems must be in place for handover of patients between clinical teams with readily identifiable agreed protocol-based handover procedures (24/7).	FC	FC	FC	**Integrated Care Working Group/High Acuity Patient Transfer Group** - Address pateint length of stay issues and audit handover process.
UEAM27	**AM**		There must be a facility to deliver care for short-length-of-stay patients (up to 72 hours) with KPIs in place to uphold. All patients in short stay facilities should have a management plan on arrival.	PC	FC	PC	
UEAM28	**AM**	**EM**	The Emergency and Acute Floors must manage ambulatory emergency care (AEC) and have pathways in place for the management of chest pain, headache, PE, DVT, cellulitis and renal colic as a minimum. Pathways and conditions appropriate for AEC include those described in the Directory of Emergency Ambulatory Care, although this list is not exhaustive.	PC	FC	No ev	**Ambulatory Care** - Further standardise ambulatory care model (neurology and renal). Also standardise where possible medical ambulartory care.
UEAM29	**AM**		The Acute Medicine service should offer alternatives to admission including rapid-access outpatient clinics, ambulatory, rapid response community alternatives or intermediate care beds.	FC	FC	PC	
UEAM30	**EM**		The ED and Primary Care must work together to design aligned services tailored for the local population. The ED must be able to direct suitable patients to timely primary care access. Acute care providers must provide a robust and clear mechanism for GPs to access timely specialist medical opinion.	FC	NC	FC	**All Groups (CSG / NWS / PMO)** - Links in with locality working through locality leads to share NWS and locality work programmes and ensure alignment of plans, programmes, project plans, whole MDT to become Trusted Assessor,s improved pathways, identify UEAM IT needs and link in with GM IM&T work.
UEAM33	**AM**	**EM**	A multidisciplinary frail elderly assessment team must be available to in-reach into the Emergency Department and AMU, 7 days per week with availability mapped to clinical and social care demand.	FC	FC	NC	**Care of the Eledery Working Group** - Spread frail elderly MDT model across sector and share good practice.

Based on this agreed analysis, the sector is progressing work in acute medicine on areas of non-compliance reflected in the following themes:

- Input from specialist services
- Pathways for the transfer of acutely ill patients
- Integrated working initially concentrating on the discharge procedures including:
    - Cross sector 'trusted assessors'
    - Improved communication between sector teams
    - Optimising the appropriate use of intermediate care step up/step down facilities
- Improving communication to ensure all patients receive copies of their discharge letters and summaries
- Standardising and enhancing the availability of ambulatory care across the sector
- Developing alternatives to admission, linking to relevant locality plans
- Ensuring timely transfer of patients to specialty inpatient beds, as required

Based on local evidence and the views of clinical leaders, the sector is also prioritising the HT standard on the provision of an in-reach MDT for care of the elderly. To this end the care of the elderly subgroup has identified three priorities:

- Development of the ACP workforce, specifically the development of a sector-wide older falls advanced practitioner
- Sharing good practice around GP nursing home practice models and discharge processes
- Improving the role community services in GP deflection processes supporting the sector A&Es

A further specific action based on feedback from the GM HT clinical champion is to ensure all NWS Trusts submit data annually to comply with the Society for Acute Medicine Benchmarking Audit (SAMBA).
Currently both Bolton and Salford submit annually to the Society of Acute Medicine's KPI audit, but fall below national averages in two key areas:

- Real time senior review process within specified timescales
- The assessment of a patient's severity of illness made immediately on arrival

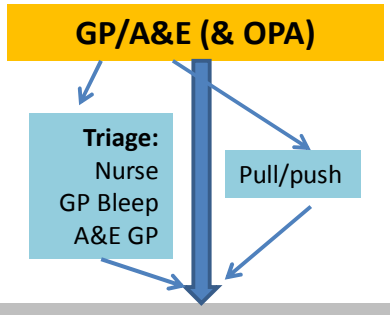
Wigan will commence submission to the National SAMBA audit during 2017.

To address the above gaps in compliance the sector's UEAM Clinical Steering Group it has set up two working groups for Acute Medicine with three Cross Cutting Groups (collaborative working), please refer back to page 5 of the eight "task and finish" work stream table to gain clarity of their aims.

Ambulatory care for acute medicine

As referenced above, the sector has identified ambulatory care as a critical element of meeting GM HT standards and in providing reliable, consistent and appropriate care. The aim is that all patients, barring exclusions, should be considered for AC in the first instance. The diagram below presents an overview of the **existing** model across the sector.

Average number of patients per day		
Bolton	**Salford**	**Wigan**
25 – 30	20	25 - 30

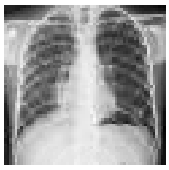


7 Day Working		
	Weekdays	***Weekends***
Bolton	7.30 am – 10 pm	11 am – 7 pm
Salford	8.00 am – 8.00 pm	9 am – 8 pm
Wigan	9 am – 10 pm	11 am – 7 pm

North West Sector Medical Ambulatory Care Model

(X 3 consultant acute medicine led dedicated units)

Average time in unit	
Bolton	4 – 6 hours
Salford	6 hours
Wigan	4 hrs



Investigations:
Priority as per A&E

Challenges:
- Mental Health
- Inappropriate patients
- Communication with GPs
- Robust access to specialist services

ADMISSION

DISCHARGE (Optimum)
- Home
- Back to GP

FOLLOW-UP
- In MAU
- Refer to specialist
- Dedicated clinic

To inform development of our model of care an initial mapping exercise has been completed and from this the ambulatory care subgroup is exploring the potential to standardise elements of the model including:

- Establishing turnaround times for radiology scanning and reporting for ambulatory care patients
- Exploring the possibility of a GP with a special interest being the first point of triage for referrals
- Prioritising ambulatory care patients for discharge

In addition, the acute medicine subgroup has prioritised renal and neurology as areas to standardise specialist in-reach into acute medicine. The anticipated benefits to patients of a standardised neurology and renal AC service are:

- Shortened length of stay
- Improved patient experience
- Specialist input into care earlier in the patient pathway
- Appropriate specialist tests earlier in the pathway

Workforce

A summary of the workforce at consultant level for Acute Medicine is as follows.

	Admissions (2015/16)	Consultant Workforce	
		In Post	**Vacant**
Bolton	18,950	5.8	0.2
Salford	14,228	12.0 (1.0 mat leave)	2.0
Wigan	16,993	4.0	3.0

The above illustrates a marked variation in the numbers of Acute Medicine consultants across the sector sites, which is linked to significant differences in models of care. For example, the larger number of consultants at Salford reflects high acuity of patients, the need to cover additional wards and the fact that there are no SPR's based in the service. The model in Salford is that the unit runs with no input Monday to Friday from the general physicians, weekends are covered by two acute physicians, two geriatricians and one general physician. The CSG and leaders of UEAM are responsible will explore and consider how differences could be managed to enable the achievement of relevant standards across the sector.

Summary - UEAM

Sector work on UEAM encompasses a range of coordinated workstreams and projects designed to ensure responsive, high quality services that are fully integrated, accessible and meet the expectations and needs of our patient populations. The changes in models of care in emergency and acute medicine and supporting sector-wide clinical governance will enable delivery of GM HT quality and safety standards.

The clinical teams in UEAM will work with clinicians and project managers for General Surgery and Radiology to understand the interdependencies between the 3 work streams and ensure that streamlined pathways are designed to ensure patients receive the right care at the right time from the right clinician.

3.3 Radiology

The following section describes the clinical model and current context for Radiology services, followed by an explanation of the Healthier Together quality and safety standards which impact upon Radiology services and resulting priorities for action. The work plan for Radiology is still in development and reflects the complexity of balancing Sector and GM-wide initiatives and responding to an emergent set of GM HT standards. The process of developing a new, more collaborative and consistent model of care for Radiology involves careful work to distinguish between solutions best delivered at sector level and those delivered across a wider footprint, for example, across GM.

Work to develop the sector's new model of care and collaborative approach to Radiology is led by the NWS Radiology Services Clinical Working Group (CWG) with a membership comprising:

- Two executive sponsors (Medical Director and Strategy Director)
- Radiology Clinical Directors
- Operational Managers
- A Radiology Strategy Lead
- NWS Programme Project Manager

The Radiology CWG recognises the need to be transformational in its approach in order to provide sustainable services at a time when demand for diagnostic and interventional radiology is growing, and emerging technology offers new ways of working; the North West Sector Partnership Board has urged the Radiology CWG to speak to industry partners and Vanguard sites which have focused in this area.

The Partnership Board has said it would like to see an approach that:

- Supports a collective managing of demand (assuming technology supports domiciliary working this could be offering work to any Radiologist across GM regardless of site).
- Further standardisation and the ability to create a single shared service. The Provider organisations should work collectively as three partners and develop a shared operating model.
- The set- up of pan - GM Interventional Radiology rotas where they are required.
- A work plan that maps a journey to a pan GM Radiology service rather than one for each organisation. It was acknowledged there will need to be arrangements put in place that support clinical dialogue with the development of procedures across each site dependent upon current clinical services, once Theme 3 work is complete.
- Take the opportunity to identify industry partners who should be able to accelerate the change.

The Radiology CWG has defined its aims as being to:

- Deliver the relevant GM HT quality and safety standards including diagnostic standards based on modality – X-ray, CT, ultrasound and MR – and for Non-vascular Interventional Radiology (NVIR).
- Work in close collaboration with the GM HT Radiology Clinical Advisory Group to create GM wide solutions where appropriate, such as for Vascular Interventional Radiology (VIR).
- Support delivery of clinically-interdependent pathways such as for General Surgery, UEAM, Pediatrics, Ambulatory Care and particular patient groups such as the radiology element of significant GI bleeds.
- Responsively meet the different needs and contexts of the three providers and in doing so increasingly drawing on the resources and expertise in Radiology across the Sector.

To this end two workshops have been arranged in the summer of 2017 with the aim of:

- Identifying the risks and issues for the service and identifying mitigating actions for these.
- Identifying and defining the ambition for the service.
- Planning how this ambition can be realised.

The first workshop held on 13th June 2017 was attended by Radiology Business Managers, the NWS SRO (Radiology work stream) and Medical Directors, the GM HT Radiology Clinical Champion, the NWS PMO and the GM Transformation Unit. The workshop identified the existing position of each service including challenges faced, and opportunities for moving towards a shared operating model. The second workshop is to be held on the 3rd October 2017, this will include a wider representation from across Radiology services in the NWS and it will focus on:

- Prioritising workstreams
- The organisational level at which decisions can be made
- Identify the 'quick wins' to be delivered in the NWS
- Development of a robust project plan

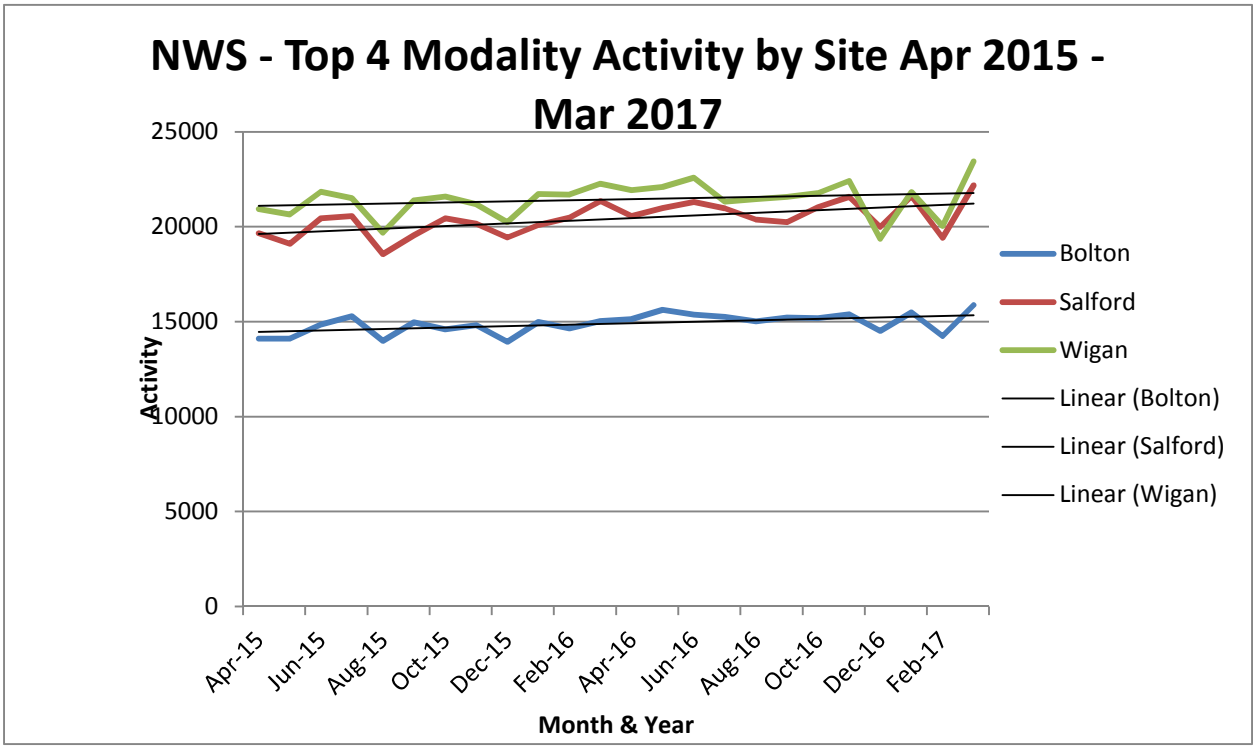
There will be close alignment between NWS and GM work to transform Radiology services.

3.3.1 Description of the current clinical model

The three NWS Radiology services currently provide the following services:

- Plain film (24/7)
- CT (24/7)
- MR
- Ultrasound

The collective demand for these modalities is modelled in the following table and demonstrates a steady growth in demand across all Trusts in the sector between 2015 and 2017.



There is a need for detailed capacity and demand modeling for Radiology services in the sector.

Current Clinical Model

Current Clinical Model

	Plain Film 24/7	CT 24/7	MR In-Hours	MR Out-of-Hours	Non - Vascular Interventional Radiology (NVIR)	Vascular Interventional Radiology (VIR)	UltraSound In Hours	UltraSound Out 0f Hours
Bolton (BFT)	Y	Y	Y	N	Provided inhouse on an ad hoc basis.	Provided by CMFT	Y	On Call
Salford (SRFT)	Y	Y	Y	Y	Provided inhouse on an ad hoc basis. Agreement for cover from CMFT if support cannot be offered by SRFT Radiologists. This would involve transfer to CMFT for intervention.	Available only for Major Trauma through GM Major Trauma Collaborative. CMFT have provided on site support at SRFT for non-trauma work but no formal arrangement is in place.	y	On Call until outsourcing commences at 8.30pm (M-F) and 9.00pm (S&S)
Wigan (WWL)	Y	Y	Y	Slots reserved during weekend O/P lists for urgent MSCC	Available for urgent/elective (Mon-Fri) Transered via surgeons as appropriate out of hours	Available for elective day cases (Mon-Fri) Complex or urgent cases done at Preston (Lancashire Teaching Hospital)	Y	On Call

The provision of services not 24/7 may differ slightly at each organisation during the week or day dependent on the availability of equipment and staff.

Current challenges and complexities faced by Radiology include the following:

- Difficulties in recruiting and retaining staff, particularly ultra-sonographers and radiologists. Work should be carried out in partnership with the GM Theme 3 workforce group as workforce resilience will be a challenge across GM. Workforce pressures have led to a reliance on the private sector which in turn has attracted some staff to work in the private sector in preference to the NHS.
- Some established pathways are outside of the NWS, such as the shared vascular pathway between WWL and Lancashire Teaching Hospitals NHS Foundation Trust.
- Operational pressures such as reporting backlogs and difficulties meeting turnaround times.
- Delivering, supporting and resourcing a 7-day diagnostic service.
- Balancing the provision of a day-to-day diagnostic service and providing sufficient sub-specialist cover to meet local population needs, particularly in neurology, MSK, breast and pediatrics.
- Working together to create a shared understanding of the sector's Radiology service, specifically as many solutions and initiatives require work GM wide and sometimes beyond.
- Repetition of diagnostic tests when patients clinical journey takes place in primary care or through a private provider

The NWS has already played a key role in the re-procurement of the Picture Archiving and Communication System (PACS) and Vendor Neutral Archive (VNA) system. The initiative developed by the Greater Manchester Collaborative Imaging Procurement Project (a partnership involving all GM acute trusts) has procured a PACS/VNA solution which will provide a digital imaging service which meets all agreed standards, provides system resilience and is clinically and financially sustainable for all providers. The new technology would open up a host of transformation opportunities, by enabling seamless image sharing across GM (which is currently problematic, with manual intervention required). For example, out-of-hours rotas for reading scans could be combined and more rapid access to specialist advice be given to clinicians providing emergency care. It is imperative that sector services are redesigned (within sector and across a wider footprint) to ensure the maximum benefits are realized from this technology.

+3.3.2 Scope and quality standards

GM HT quality and safety standards for Radiology specify requirements for the diagnostic modalities of X-ray, computerised tomography (CT), ultrasound and magnetic resonance (MR) imaging to support new models of care, and VIR within a wider GM context. Whether NVIR will require a sector or GM-wide solution has yet to be determined. The NWS Radiology Services Clinical Working Group is currently exploring the feasibility of providing a level 2, 7-day NVIR solution at the sector hub supported by radiologists from a group of 3 provider organisations.

The initial Radiology standards used in the GM HT review by National Clinical Audit Team (NCAT) in 2013 were based on Royal Colleges other than that for Radiologists, leading to a request from the sector for them to be revised as follows:

- To be based on standards produced by the Royal College of Radiologists and reflect a radiological perspective, for instance in being modality-specific
- Incorporate a range of other targets and data required of radiology departments
- Reduce duplication in the original standards that resulted from combining sources from several Royal Colleges
- Recognise the breadth of Radiology services and reflect input to other priority pathways such as major trauma and stroke

A new set of more pertinent standards were devised through the GM HT Radiology Clinical Advisory Group, were released to the sectors in November 2016 with a requirement for a rapid self-assessment response.

Diagnostic Standards Total = 6	Compliant	Partially Compliant	Non-compliant	Further Input from other teams needed
Bolton	2	2	2	0
Salford	1	4	1	0
Wigan	3	1	2	0
NVIR Standards Total = 13				
Bolton	3	1	5	4
Salford	5	0	4	4
Wigan	4	1	4	4
VIR Standards Total = 15				
Bolton	9	0	2	4
Salford	4	0	6	5
Wigan	7	0	2	6
TOTAL (Total 34 standards x 3 Trusts = 102)	38/102	9/102	28/102	27/102

The sector Radiology services CWG agreed that the following standards should be prioritized for action in 2017-18.

As part of

Standard	Project	Lead
R1 – c Ultrasound	Deliver the radiology elements of the General Surgery Ambulatory Care pathway	Rubeena Razzaq, Clinical Director, RBH
NVIR 1 – 13 Non-vascular Interventional Radiology	Explore the feasibility of providing a non-vascular interventional (NVIR) Radiology service at the Sector hub (Salford) to at least level 2: Intermediate – nephrostomy, cholecystectomy	Jill Carlin, Clinical Director, SRFT
R1 – d Magnetic Resonance Imaging	To provide a robust MR pathway for urgent spinal imaging e.g. suspected cauda equina, MSCC	Ismail Ahmed, Clinical Director, WWL
R1 – c Ultrasound	To provide a pathway and US solution as needed for the paediatric hub	TBC – confirmed model awaited.

The workshop being held in October 2017 will enable the CWG to identify other priority standards for action which will be built into the Project plan for the work stream.

Informed by progressing these specific priorities, the sector has developed the following initial vision for its future radiology model of care:

Clinically Interdependent Pathways

A number of other pathways are dependent on Radiology to deliver best practice. Members of the Clinical Working Group are working in collaboration with colleagues in other specialties to deliver specific Radiology elements of the clinical pathways in the following areas:

- **Non-Vascular Interventional Radiology** – as explained above, work is ongoing to determine whether a sector solution can be delivered for NVIR. The sector CSG will carry out work to appraise options for local provision of NVIR. It is noted that the numbers for this activity are small, for example currently circa 12 patients per year in Salford.
- **Vascular Interventional Radiology** will continue to be accessed via the hub in Salford for trauma patients only, but it seems likely that the vascular interventional radiology pathway for non-trauma patients who require interventional radiology if initial endoscopic intervention is unsuccessful can be managed solely in the NWS; WWL already have shared vascular pathway with Lancashire Teaching Hospitals NHS Foundation Trust.
- **Significant GI Bleeds** – will continue to be admitted directly to the nearest local hospital. A Greater Manchester GI bleeds group was established to support the required work for Healthier Together Programme going forward and has now developed proposed guidelines for the management of GI bleeds. The GM clinical lead for GI Bleeds, will be working closely with sectors to develop and strengthen the service across GM.
- **Ambulatory Care –** work will be undertaken on close collaboration with the NWS Surgical Governance and Implementation Board to deliver the Radiology elements of the General Surgery AC model and that being developed for UEAM, both of which are explained earlier in this business case.
- **Paediatrics –** a representative from the NWS Radiology Services Clinical Working Group is involved in discussions to develop the sector model for paediatric services and will bring the outcomes back to the group for review and response. Once agreed work will be undertaken by the RSCWG to deliver the new model, which is likely to require additional ultrasound.

Once clarified this will also need to determine any financial implications, particularly of actions required to ensure the sector meets GM HT quality and safety standards

3.4 North West Sector Programme 3

The Sector has taken a whole systems approach to determine priority areas for improvement through collaboration by first reviewing all 37 service lines / specialties which use inpatient hospital capacity. Externally supported analysis (MBI) in 2016, led to the establishment of a Priority Services Task and Finish Group working on the first tranche of eight areas. The process to select these specialties and areas has included:

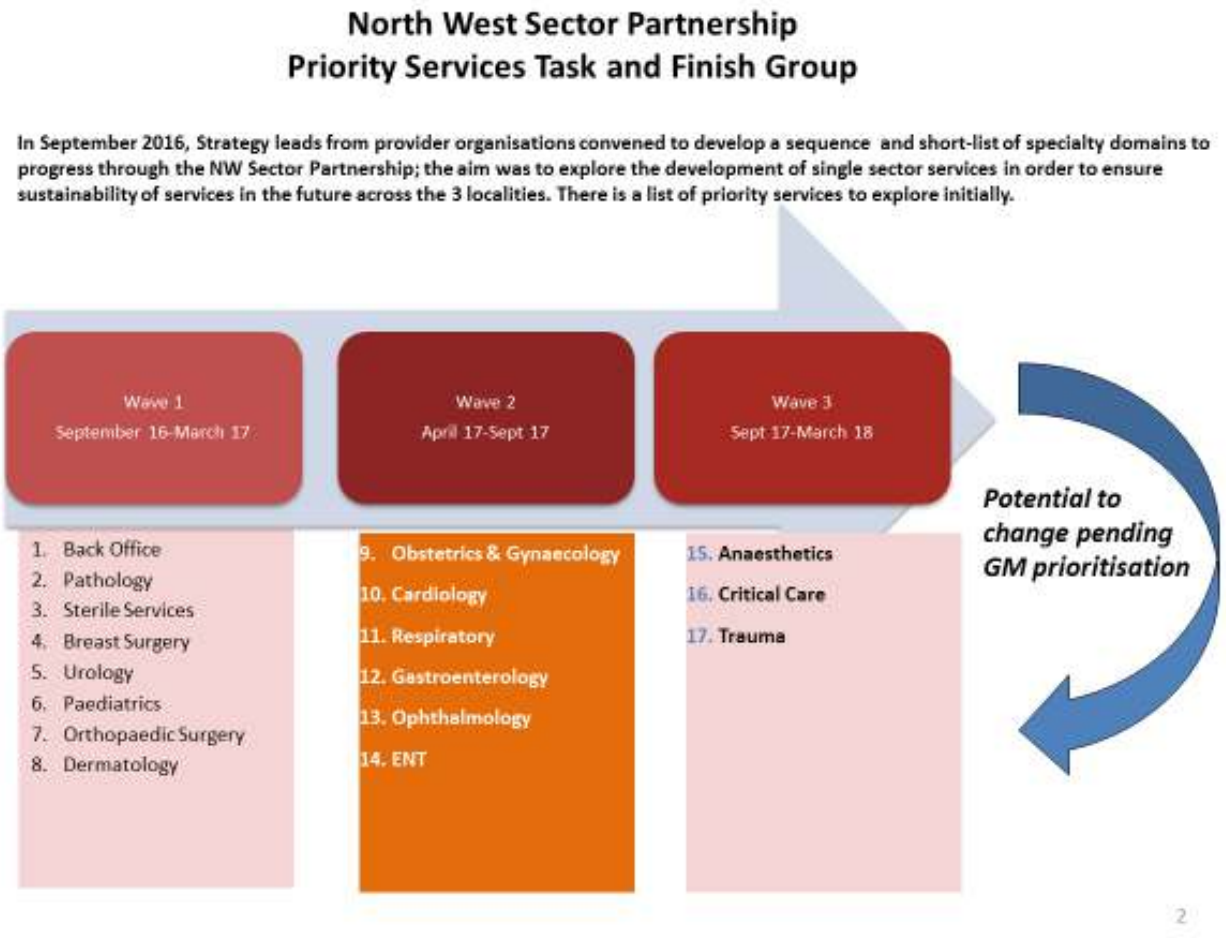
- Preparation of data (2015/16) including HES, Theatres and PAS (including admissions not outpatients), to assure completeness and accuracy of information.
- Benchmarking and comparative analysis.
- Engagement with clinical and managerial leads to explore opportunities, gain intelligence and identify resilience issues.
- Long-list and short-listing process to determine NWS priorities.
- Sector collaboration to review and develop an approach for each specialty or area, informed by recognition of multiple clinical inter-relationships and inter-dependencies.

A further element of this Programme is considering the implications of proposed changes particularly given clinical interdependencies.

Work on paediatrics in the Sector in the context of wider changes across GM is summarised earlier in this Business Case, at the end of Section 3.1.2. The other seven Programme Three priority areas reviewed in Wave 1 were:

- Breast services
- Benign urology (benign and Level 1 cancers)
- Elective orthopaedics
- Dermatology
- Sterile Services
- Pathology
- Back office function

The overall approach including three waves and 17 specialties is illustrated in the diagram below.



The following table presents a short summary of the issues, the recommendations made by the Task and Finish Group and the response from the NWS Partnership Board at its meeting on 10th January 2017. Further detail is available as required, including on the important process for prioritising which services to address first through Programme 3.

Service	**Summary of current position and recommendations of the Task and Finish Group**	**Response from the NWS Partnership Board and next steps**
Breast Services	All organisations in the NWS committed to develop a single shared service. Related work ongoing to develop a GM wide approach, NWS working in partnership with GM TU to align Sector plans. Salford CCG to resolve interim arrangement for provision for Salford Residents. WWL request for support from Salford in identifying community location.	NWS Partnership Board supported progress to develop a case for change, planning and decision-making paper. Noted interim arrangement for provision of Breast service for Salford residents from 1st April 2017.

Service	**Summary of current position and recommendations of the Task and Finish Group**	**Response from the NWS Partnership Board and next steps**
Benign Urology	Currently varied models of urology in place across the Sector. BFT and WWL are progressing a model to support local sustainability, with potential for single site for inpatient services. GM wide work also underway – awaiting decision on urology cancer contract and potential impact on GM and Sector plans. NWS clinicians attending GM workshops. Medical Directors, Clinical Leads for Urology and Directors of Strategy from NWS provider organisations to meet early February to agree a way forward.	Work to focus on what services have in common to propose a clinically-led, standards-based approach. Solution will need to ensure appropriate service access, quality and safety for benign urology, and take into account clinical requirements of the of high-risk site. Also, exploring potential for wider collaboration, e.g. with North East Sector.
Elective Orthopaedics	Developing options for the most appropriate model and service configuration in the Sector, with potential clinical and financial benefits. Wider interrelationships with MSK services and beyond, e.g. Orthopaedic Alliance. Clinical teams exploring standardising clinical pathways, including enhanced recovery for arthroplasty patients, standardised listing, pre-operative assessment protocols and the management of pre-operative assessment. All providers should consider use of the WWL bone bank service. Potential benefits being explored of: • A single service model for arthroplasty and revision surgery. The latter should include the identification of specialised work that should only be done on a single site. • Opportunities to consolidate estate or services across the NWS, which will consider the impact of existing patient flows and providers' strategic plans.	Work is ongoing to articulate current models, activity, clinical standards and performance. This will inform options appraisal and alignment with GM approach. Immediate steps include data validation and analysis. NWS approach is intrinsically linked to GM wide work, with potential for NWS to be used as a foundation for wider GM solution. Case being developed with emphasis on initial practical proposal. NWSP work to be aligned with the review of MSK/Orthopaedic services as part of the HT Theme 3 programme, and timelines.

Service	**Summary of current position and recommendations of the Task and Finish Group**	**Response from the NWS Partnership Board and next steps**
Dermatology	Range of resilience issues and some reliance on use of locums. Recognised GM wide issue on recruitment of consultant staff. Potential to explore Sector wide service at some point and opportunities to complement existing service model e.g. from use of GPs with specialist interest. Current restrictions to referrals remain in place at each Foundation Trust in order to maintain RTT performance. Quarterly updates to the Priority Services Task and Finish Group to maintain oversight and assurance.	Will be subject to regular, ongoing review via the Priority Services Group. Future approach will be aligned with GM wider work, being led by Salford CCG. Opportunities to improve patient pathways and manage demand are explored via the GM Dermatology Commissioners Group.
Sterile Services	WWL and SRFT currently in shared service model. BFT has internal provision. Following review, recommendation made that BFT sterile services are not reviewed further at this time, and will be considered within the wider estates strategy linked to clinical services. Plan for annual review by the Priority Services Group. SRFT and WWL considering if the turnaround time for instruments under the K61 agreement could be reduced through further efficiencies.	Currently subject to review of potential and approach for a Sector wide solution. Recommendations noted by the Partnership Board – while no case for change at present, the financial opportunities could improve over time. Also, recognised co-dependencies between several Priority Services and sterile services, which could form a bundle – to optimise use of estate.
Pathology	NWSP to consider the report and recommendations published by the GM Pathology workstream (anticipated end of January 2017).	Noted the GM-wide options appraisal work underway and anticipated report – to be presented to the Partnership Board once available.
Back Office	GM reported on corporate functions, focusing on payroll. SRFT have undertaken a benchmarking exercise. Providers exploring potential for Sector wide approach to: IT support, employee services (TRAC); occupational health; payroll – and will continue to regularly review opportunities. Further consideration being given to provider collaborative approach to IT, to ensure integrated development of EPR and support to new clinical models.	Noted that CCGs have no requirements of providers in relation to Back Office Functions – it is up to providers to decide on the approach. Agreement to share learning and support in relation to implementation of EPR (Allscripts). SRFT looking to connect to NES. GM workshop end of January.

Consequently, the Priority Services Task and Finish Group have been refreshed to form the NWS Programme 3 Priority Services Group. Attended by Heads of Planning / Strategy from provider organisations and CCG Heads of Commissioning, the group is overseeing the local development of the Breast services, Paediatrics, Elective Orthopaedics and Benign Urology services to establish single sector models which are aligned to the Healthier Together Theme 3 work. The group will also keep Dermatology, Pathology and Sterile Services under regular review as agreed at the NWS Partnership Board in January 2017. Finally, the group will identify if any additional services need to be highlighted to the NWS Programme Board if they provide an opportunity for a single sector approach to service provision.

The following table summarises the position of the Programme 3 key work streams reported to the NWS Partnership Board on 30th May 2017 and 29th September 2017

Service	Update May 2017	Update September 2017
Paediatrics	See section on Paediatric General Surgery at the end of Section 3.1.2.	See section on Paediatric General Surgery at the end of Section 3.1.2.
Elective Orthopaedics	NWS analysis indicates strong clinical interdependencies between paediatrics and elective orthopaedics, particularly related to the use of estate at BFT and WWL FT sites. The Partnership Board accepts the need to present together the business cases for changes in paediatrics and elective orthopaedics. Clinical leads from BFT and WWL FT are meeting in mid-June, with data collection underway and alignment being assured between GM and Sector level work.	• NWS Transformation Working Group to be established October 2017 • GM Theme 3 Case for Change due Q3 2017-18 which will be used as platform from which NWS model will be designed. • Working in close alignment with GM Theme 3 work stream.
Breast Services	Interim arrangements for provision of Breast Services for Salford residents were established from 1 April 2017. Work is underway to identify a location for local service provision of outpatients and diagnostics in Salford. A Clinical Reference Group is being established to advise on a single Sector model of care, again aligned to work at a GM level.	• Case for Change to be presented to the NWS Partnership Board 29th Sept 2017. • NWS Transformation Working Group established. • Working in close alignment with Theme 3 work stream.
Benign Urology	Wigan Borough CCG is leading work to identify the risks and benefits of working at different scales to provide services in the Sector	• Await GM model of care for Urology services (case for change developed Sept 2017). • Collaboration between BFT and WWL to support resilience issues related to on-call provision.
Dermatology	Resilience issues reported to NWS Partnership Board in April 2017. SRFT was asked to consider leading a NWS single sector Dermatology Service, with a paper gong to SRFT Management Board	• NWS Transformation Working Group established. • NWS Partnership Board to receive Case for Change on 29th Sept 2017. • SRFT to lead a single Sector service.

Service	Update May 2017	Update September 2017
	on 26th May. Interim arrangements to ensure service delivery at BFT have been agreed. The NWS Dermatology Group has established and met for the first time on 5th June. The Group will consider interim service provision and plans to develop a single Sector service and liaise with the GM workforce lead to support the work.	

The importance of this work stream has emerged as the Sector has modelled the impact of the HT General Surgery model upon the provider sites. The transfer of high risk inpatient work to the hub site will create capacity (stranded costs) on the low risk sites, whilst the hub site may have to consider the transfer of cases off site to create capacity to accommodate in-flowing work.

The Priority Services Group has identified interdependencies which exist between clinical services either because they are clinically interdependent, or in order to optimise the use of estate; the latter recognises the need to maximise the use of estate across the sector and minimise the need for additional capital. The group is therefore exploring key interdependencies between the clinical services in Programme 3. In order to be able to understand the impact of changes to the delivery of acute services across the sector a modelling tool has been developed (Jigsaw modelling tool) to allow instant calculation of the impact of any combination of potential changes upon inpatient bed capacity, Critical Care capacity and theatre capacity.

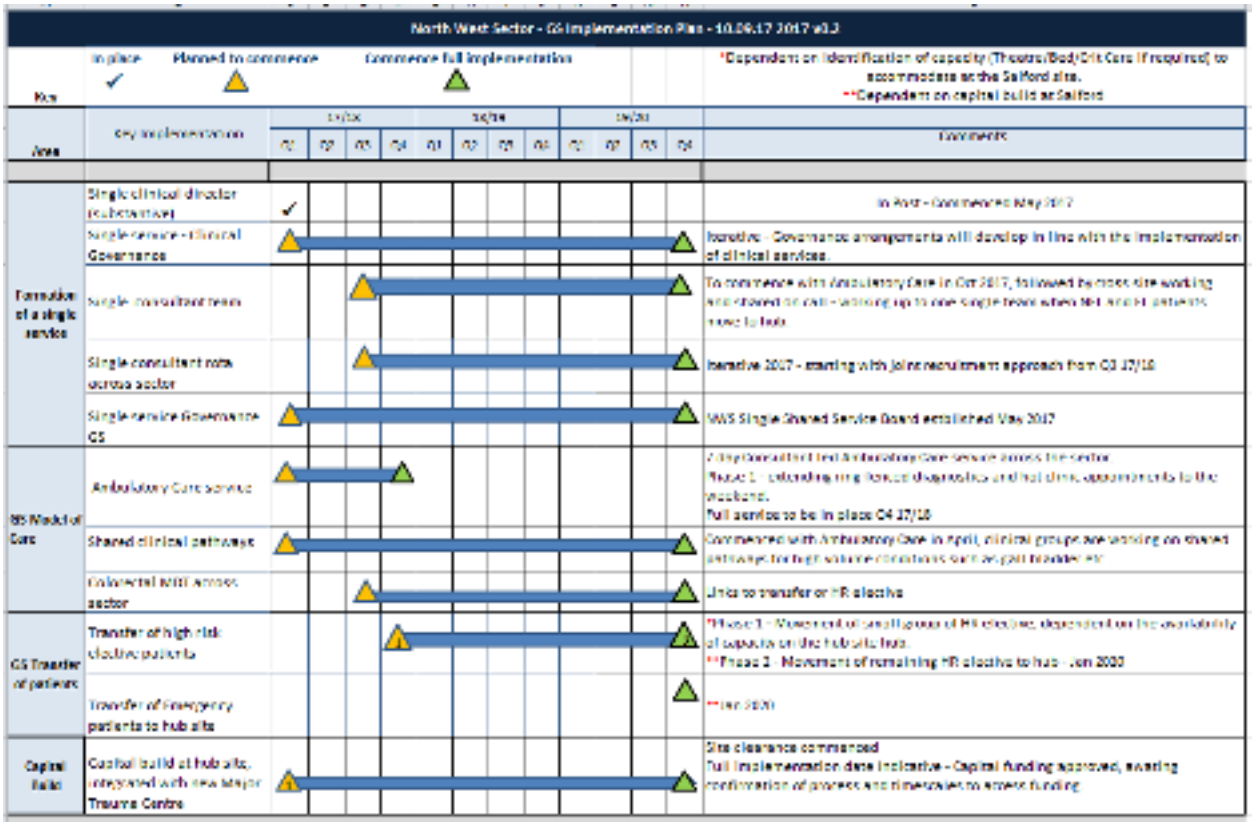
The workstreams being developed under Programme 3 will identify opportunities to redesign service delivery across the sector to mitigate the impact of changes that arise through Healthier Together. The Priority services group will explore these opportunities and present cases for change to the NWS Programme Board for consideration.

The Sector has liaised regularly with the GM HT team coordinating Theme 3 as several clinical services being progressed at a GM level are also the Sector's Programme 3, including: Breast Services, Paediatrics, Benign Urology and Elective Orthopaedics. Alignment between work in the Sector and in GM is critical to ensure clear, consistent messages and to support delivery of shared objectives. A range of clinical, commissioning and provider organisation leaders are actively involved in relevant GM working groups for these specialty areas.

4.0 Implementation plans for the new models of care

4.1 General Surgery, UEAM and Radiology

The overall implementation plan which takes a phased approach to delivering the new models of care in General Surgery can be seen below:



The PMO is responsible for the structure and support for the implementation plan, enabling clinical leaders and colleagues to drive forward the changes that deliver new models of care and meet GM HT quality and safety standards. Overall implementation plans for UEAM and Radiology Services will be published following the completion of scoping work that is currently underway. The detailed approach for each of the three key clinical areas will be led by the relevant clinical working group, and a consistent approach will be taken to present, monitor and support progress. A key element will be continually reviewing and revising the implementation plan and tracking key measures, to realise anticipated benefits and provide assurance to the NWS Partnership Board.

The approach will continue to be revised and updated to reflect further development work across all work streams including NWS Programme 3.

4.2 Sector Shared services

New arrangements are being established to enable the innovative creation of sector shared services across Bolton, Salford and Wigan Foundation Trusts. While commencing with General Surgery as described in the previous Section, the approach will support wider developments in line with HT and the Sector's Programme 3.

WWL and SRFT have previously operated a bi-lateral Shared Services Board for PAWS (Pathology) and SSDU (Sterile Services) which had responsibility to oversee the delivery of both services through monitoring of operational and financial performance.

BFT and SRFT have established an integrated Sexual Health services, in response to a tender by sector commissioners. This service is hosted by BFT.

Organisation and leadership of sector shared services – the Shared Services Board

The three FTs recognised the need to establish dedicated governance arrangements to oversee the operational, financial and clinical performance of all Shared Services across the sector, as these are implemented and extended.

The proposed governance arrangements were reviewed by the Provider Alliance Steering Group and WWL and SRFT's existing Shared Services Board in December, with both committees supporting the recommendation to establish a single Shared Services Board for the NW sector.

In January 2017, the **Board of Directors of BFT, SRFT and WWL** were asked to support the following recommendations:

- Support the establishment of a North West Sector Shared Services Board
- Approve the proposed draft Terms of Reference

In addition, **the Board of Directors of SRFT and WWL** were asked to the support the following recommendation:

- Approve the dis-establishment of the existing Shared Services Board (for SSDU and PAWS).

All the recommendations were supported and the new governance arrangements are being established, with the inaugural meeting of the NWS Shared Service Board held on 9th May 2017. Work is underway to establish the detailed governance arrangements for the sector single service for General Surgery including the following elements;

a) The scope of the service
b) The site / location where the service will be delivered
c) The workforce included in the single service
d) The costs / assets / income and liabilities associated with the single service
e) Targets and performance issues to be considered.

The rationale for the development of the new NW sector Shared Services Board is to provide a single governance arrangement that incorporates existing shared services, the HT programme of single service models and also any future shared services that arise from either Greater Manchester and/or sector discussions.

The arrangements will complement wider system-level partnership arrangements in the sector and those specific to commissioning. The arrangements will support various levels of integration, reflecting a continuum of models, such as those outlined for the three clinical areas in Section 3. These will enable critical elements of shared services to be created, reflecting the details of such models including:

- Integrated teams, with a single employer and consolidated provision.
- Dedicated, Sector-wide clinical leadership.
- Development of common pathways and clinical guidelines and standards to ensure consistent, efficient and high quality patient flows and outcomes.
- Joint working across the sector in areas such as recruitment, training and development, and flexible working across sites (such as to ensure clinicians maintain and further develop skills).

It has been recognised by the Shared Service Board that the development of governance arrangements to support a sector-wide single service for General Surgery requires a range of matters to be taken into account. The Shared Service Board has tasked the Provider Alliance Steering Group to describe in detail the governance arrangements for the single service. Consequently, task and finish groups have been established to consider the following areas;

- Governance
- Clinical
- Workforce
- Operational
- Finance

These groups are made up of subject matter expects and will work individually and together to develop proposals for the Provider Alliance Steering Group. From this, a range of options for the governance of the single service will be presented to Shared Service Board for consideration.

The governance pathways and reporting arrangements of the following Shared services are being reviewed to ensure a standard sector approach to the governance of sector shared services;

- Pathology
- Sexual Health
- Sterile Services

4.3 HR, OD and workforce

The Sector recognised at the outset the importance of workforce and organisational development in developing and implementing the new models of care required to meet GM HT quality and safety standards. In responding to the significant changes the Partnership established a Steering Group which is responsible for coordinating actions on HR, OD and Workforce to support delivery of NWS Programmes and Projects. The terms of reference recognise the breadth of issues and include the following.

- For the Single Shared Service in General Surgery – work to support a single team of Consultant Surgeons; other medical staff including in Anaesthetics and Critical Care; enhancing the approach to surgical ambulatory care; and future changes to emergency Paediatric General Surgery.

- For UEAM – work to support changes to consultant presence in A&E and wider workforce planning including ANPs, Middle Grades and Physician Associates
- Coordinate all strategic workforce analysis and confirm workforce requirements by staff group
- Ensure alignment with wider GM plans and developments
- Review recruitment and retention issues associated with the new models of care and the delivery of the GM HT quality and safety standards
- Review of the HR and contractual implications of a new governance arrangements

The Group includes workforce, planning and OD leads across the Sector and oversees areas including: linking activities to Programme objectives; managing risks and issues relating to HR, OD and Workforce; and ensure learning across the Sector. An HR framework is being developed to support implementation which could include the following:

- Stability of employment agreement
- Recruitment policy
- Cross boundary framework
- Education and training agreement
- New employment models to align with revised governance arrangements

Engaging and developing the Sector's workforce is an ongoing, long-term process and our initial priorities have been engagement with senior clinical leads, particularly consultant medical staff. It will be important to extend the scope of this work, which has already commenced with recent engagement events and other work, such as developing a 'blended' workforce and innovative new roles within UEAM. Given the scale and complexity of the changes affecting General Surgery, the Sector commissioned specific input to assess state of readiness and factors likely to enable implementation of the model of care. This had a direct impact, such as on refreshing and revising clinical leadership arrangements.

The Partnership recognises the complexity of change management and that creating successful large-scale change requires a structured approach, strong leadership, hard work and an understanding of what must actually take place to make the change happen. In responding to the significant cultural challenges the Sector has gained input from Trust OD teams who have a wealth of experience in successful change management and also external workforce, OD and improvement specialists (including AQuA – Advancing Quality Alliance).

Overall, the activities and milestones for OD are as follows:

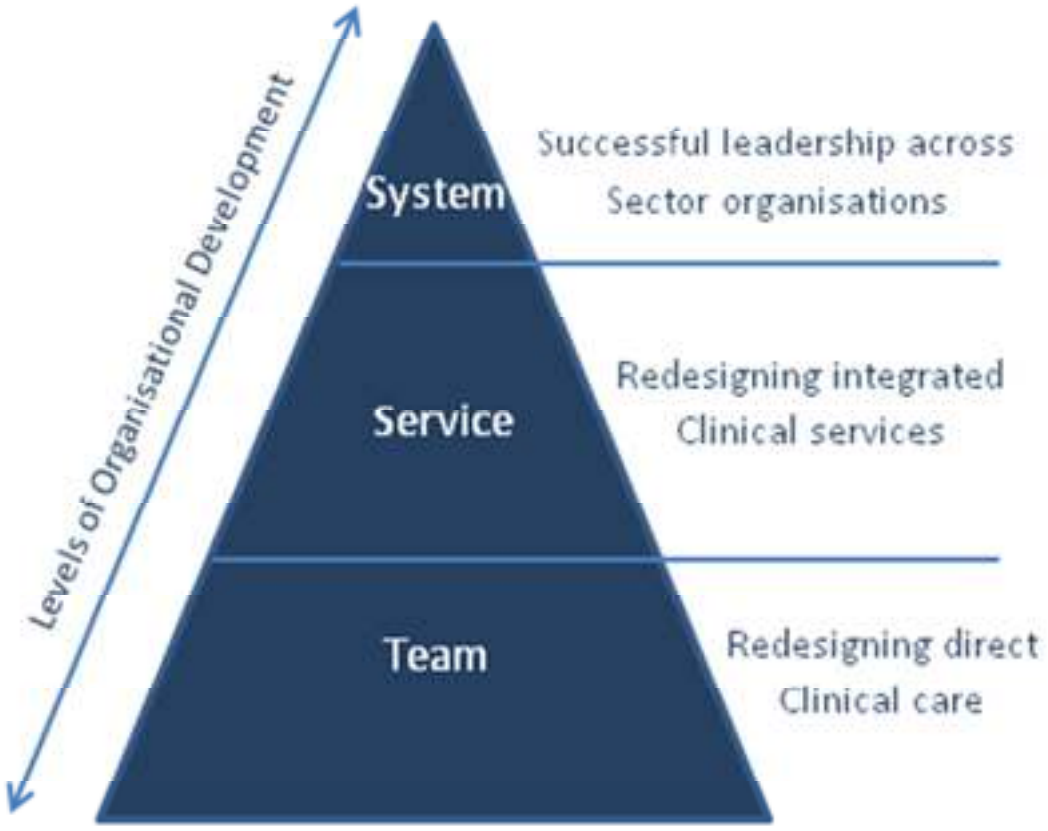
OD stages	*Key Interventions*	*Timescales*
OD Diagnostic	Contract awarded Undertake diagnostics using agreed methods Findings to PASG and Partnership Board	May 2016 May to August 2016 August 2016
OD Plan	Review recommendations and plan approach OD Sub-group formed, linked with GM OD leads and reviews Trust OD offers Staff engagement workshop	September 2016 October 2016 December 2016
OD Implementation	Confirmation of OD and Improvement Grant Support from AQuA for large scale change Develop draft patient stories	January 2017 January 2017 February 2017

	General Surgery Ambulatory Care workshop Update OD plan to support implementation, aligned to GM HT approach	March 2017 April 2017

The Sector Partnership has an OD sub-group responsible for leading workforce and organisational development, whose scope includes the Sector's collaborative approach to GM HT Theme 3 service changes (initially General Surgery, UEAM and Radiology) and the Sector's Programme 3 range of priority areas. The work of the OD leadership team, whose membership draws on the PMO and OD specialist leaders from partner organisations, includes the following.

- Development of an OD strategy to enable the implementation of Healthier Together and NWS Programme 3 within the North West sector.
- Creating an implementation plan to enable the OD strategy which is affordable and sustainable, and ensuring delivery against agreed milestones.
- Identifying resource to enable the successful implementation of the OD strategy and ensuring Sector skills and facilities are effectively deployed.
- Seek support from other organisations in the North West with expertise in OD & leadership.

To support the OD plan the Sector recognises the need to intervene at three levels – system, service, team – as illustrated in the diagram below.



Aligned to the role above, the Sector successfully applied for a grant from the North West Leadership Academy to support implementation of the new model of care for General Surgery. The resources are being used to develop materials, design and run workshops and procure specialist and analytical expertise for workforce modelling in

line with the new approach. In line with the extension of workforce development to all staff, the work includes developing a Systems Leadership Programme (for clinical leaders from multi-professions); supporting communications and engagement with all staff; and modelling of non-consultant medical staff, nursing and AHP workforce required to deliver the new model of care. Practical implications will include arrangements for staff to work across more than one Trust (e.g. for consultants in providing high risk Non-Elective General Surgery on full implementation of the model) and other collaboration, such as staff rotation.

The wider approach to workforce and organisational development draws both on the capacity and leadership in NWS organisations and the resources of AQuA, of which all three provider Trusts are members. As a specialist improvement organisation, AQuA provides a range of support including:

- One-to-one coaching for senior leaders.
- System integration framework and assessment – an evidence-based approach using the three levels of integrating teams, services and systems, against which the Sector can be assessed for eight key enablers (domains – such as leadership, governance and culture).
- Advice and expertise on delivering large scale change (informed by the work of Paul Plsek) with its emphasis on the ongoing cycle of change – repeatedly (re) framing the issues, engaging and connecting with others, and making pragmatic change in multiple processes.

Building on this framework for HR, workforce and organisational development, further information on communications and engagement is given in the next section.

4.4 Communications and engagement

The Sector recognises the importance of communications on a complex and wide ranging set of service changes and the need to engage with a broad set of stakeholders. The following presents a summary of actions to date and current plans, which whilst initially focusing on internal audiences to inform the clinical models, is increasingly being widened to a broader range of staff groups, patients and the public. The three key elements of this enabling workstream are: communications strategy and planning; engagement with professionals and partners; engagement with patients and the public.

4.4.1 Communications strategy and planning

The Sector's approach is led by a Communications and Engagement Working Group comprising representatives from all NWSP commissioners and providers. The scope includes the breadth of GM HT new models of care as described earlier in this Business Case. A draft communications and engagement strategy has been developed and shared with partners, as reported to the Partnership Board in October 2016. The purpose is to identify, determine and support actions required to deliver Programme objectives, recognising the changes are complex and at times contentious. While Sector level coordination is important, all partners have a key role given existing expertise and the importance of knowing local communities and contexts for successful engagement on such large-scale change. The overall approach includes the following elements.

- Agreeing and communicating the vision and developing appropriate narrative
- Using a variety of communications and engagement methods, such as:
    - Communicating: written, oral, face-to-face, online and digital
    - Engaging: open space events, focus groups, patient and advisory panels, surveys
- Existing mechanisms will be used where possible to support the process, complemented by the processes established to support development of new models of care (such as clinically-led workstream and project groups)
- Balancing local with Sector activity, and aligning (drawing upon) GM HT resources

- Use of frameworks such as a 'messaging matrix' and stakeholder mapping to support sharing consistent messages, seeking feedback and involving the appropriate groups and individuals
- Appointment of dedicated communications and engagement resource to the NWS PMO to provide capacity to deliver the communications and engagement strategy in partnership with NWS organisation's Communications and Engagement teams.

4.4.2 Engagement with professionals and partners

The core of engagement is clinically-led workstreams and a wide variety of project groups. Each organisation takes a lead in communicating within their organisation, and the approach was broadened with a large-scale engagement event held on 6th December 2016 with 100 clinical staff participating. Attendance was balanced across the three provider Trusts and drew on a range of professions and clinical leaders. The opportunity was taken to share and reconfirm messages and update people on progress made with the development of clinical models. The event then engaged clinicians on key issues for their specific services, including: repatriation of patients; skill mix and experience for clinicians; standardising approaches across the Sector; and supporting appropriate pathways and patient journeys.

As the Programme progresses to implementation the engagement will need to widen, in terms of staff groups within the services affected, in Partner organisations and beyond, such as with primary and community care, social care and Local Authorities. Engagement is a standard item on all of the clinically-led project groups and the need to extend the approach is being reflected in the Sector Communications and Engagement Plan that is currently being revised.

4.4.3 Engagement with the public and patients

Building on previous extensive engagement with the public and patients by GM HT, the Sector is developing its approach to communicate with local communities. A key element has been the commissioning of joint support from the three Health Watch organisations for Bolton, Salford and Wigan to develop Patient Participation Groups specifically for the Sector approach to implement HT related new models of care. In summary, the objectives are:

- To achieve a consistent, workable, engaging and accessible approach to Local Equalities Groups across the Sector.
- To ensure engagement at sector level from representatives who are able to confidently express the views of local communities.
- To create a mechanism for bringing representatives from each locality together at sector level to discuss service change, plan work in the localities and present findings.

Practical actions so far include a public engagement event on 5th December 2016 on the whole Programme and a meeting of the General Surgery specific PPG on 27th February 2017. The latter event was supported by the development of four Patient Profiles as stories to illustrate the current arrangements and impact of the new models of care on hypothetical, representative people who require General Surgical support. An annual programme of sector PPG events commences on 2nd October 2017.

Our approach to engagement with the public and patients builds on the GM HT framework, particularly for Equalities Benchmarking and PPG approach to the HT implementation phase. In part this is to ensure compliance with the ten equality implementation conditions, as given in the diagram below.

		Integrated Impact Assessment: Implementation Conditions
Transition	1	Clear and regular communication is provided to staff and patients
	2	Training and development of Single Service staff to better support patients with specific needs
Travel and Access	3	Coordinated transport planning and information on transport options is incorporated into Single Service implementation plans
	4	An appraisal of priority access to car parking facilities at each Single Service hospital site is completed and reviewed by commissioners
	5	An evaluation to appraise the extension of the volunteer driver scheme is completed
	6	A common policy for travel reimbursement/set tariffs for taxis is established within each Single Service
	7	Improved publicity of community transport schemes and travel voucher schemes to be provided
Service change	8	Patients are offered a choice of appointment times for elective care
	9	An appraisal of flexible visiting times within a Single Service is completed in advance of any changes taking place
Monitoring	10	Commissioners will establish a monitoring/evaluation process to assess the progress of all IIA Implementation conditions

The Sector and its commissioners must ensure through that due regard is given to the above equality conditions and that consideration is given to equality groups as highlighted in the Equality Act 2010 in order to ensure that services are based on fairness and inclusion.

4.5 Information management and technology

Information management and technology is well recognised as a critical enabler for the implementation of new models of care. The overall aim is to provide interoperable systems which help staff to access information quickly and efficiently, add to care records and support wider data capture. The development of IM&T systems is driven by the new operational models and key practical questions such as: who needs to access what records at which locations. It is also important to clarify the ownership of records to support quality assurance around accuracy and completeness.

A work programme is being developed and will be refined in the implementation period. A brief summary of issues and initiatives is given below.

4.5.1 Systems

Current systems reflect the organisational structure with different approaches at each provider. In brief, at a hospital level:

- Bolton – has a strategic plan to implement Allscripts by end 2019/early 2020.
- Salford – went live with its latest EPR system, provided by Allscripts, in June 2013.
- Wigan – has recently implemented the Allscripts EPR.

Each site is also involved in wider work reflecting their local context. For example, a shared care record is being created, with a single repository, across primary and secondary heath care, social care and mental health services in Bolton. Also, Salford has, since 2009, been developing and using the Salford Integrated Record which combines health records across primary and secondary care and is used to support delivery of care and research and development.

At an operational level, practice also reflects the context. For example, in General Surgery clinicians at each organisation keep their own records and follow local practices and procedures, such as accessing local (different) PAS systems to arrange appointments. The aim, with single shared services, will be to create a common electronic record that can be accessed from any of the three sites. Transition to this goal will be cumulative and may require interim solutions, such as a central booking team which would have interoperable access to make appointments at all three sites. These approaches will need to be aligned with Sector wide responses to shared services and extend to other clinical areas, as being developed within Programme 3.

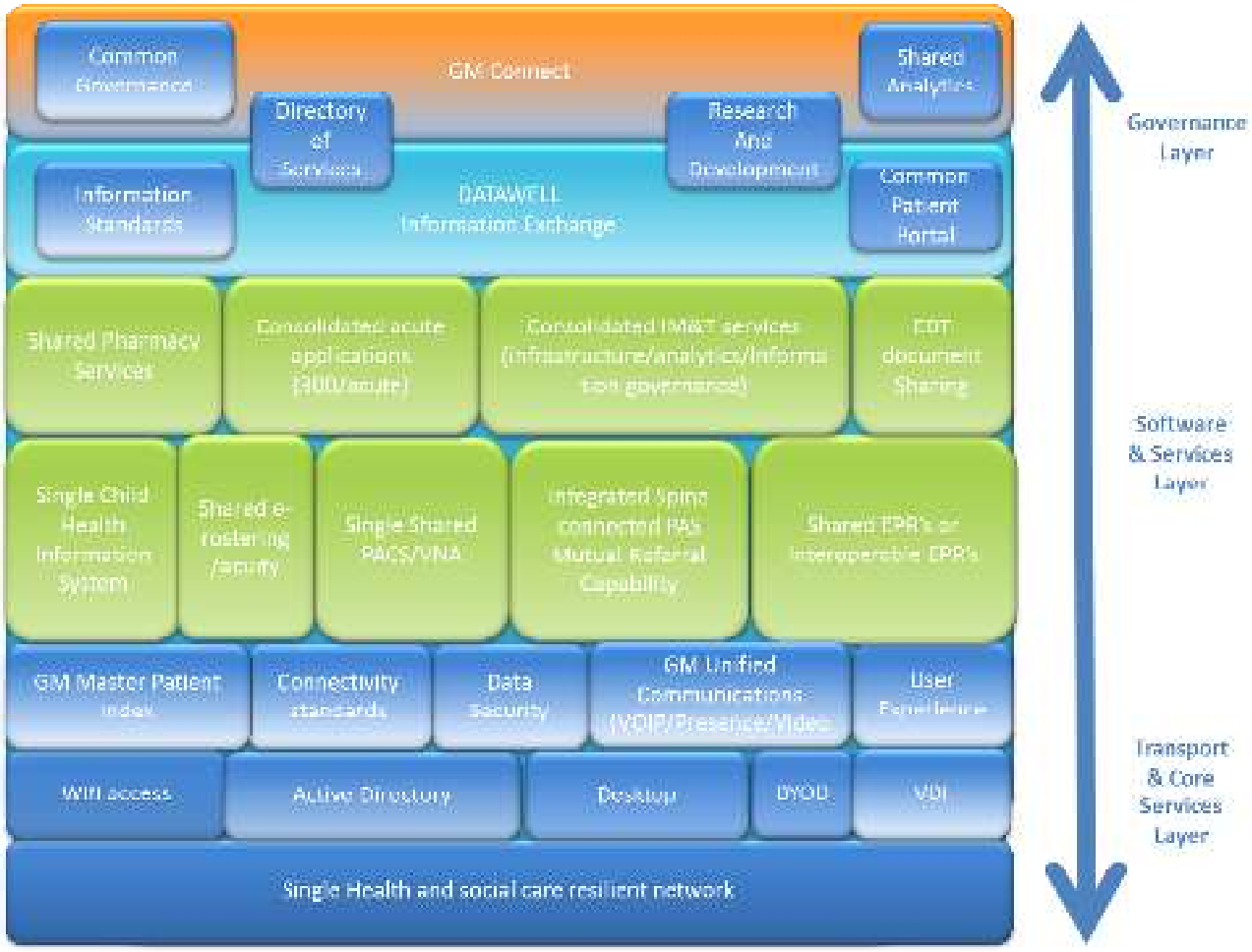
Developments are also underway at GM and HT levels as part of Transformation Programme 5 and through work to collaborate across wider sectors (e.g. from health and social care, into education and police). IM&T forms a critical part of all elements of the GM strategic plan, at three levels: GM approaches such as DataWell and GM Connect; Clusters, including Sectors; and initiatives driven by localities. The complexity and scope of the interaction and role of IM&T issues is illustrated by the diagram below which starts to look at the various layers to support system convergence and consistent user experiences, single services, standards and pathways.

4.5.2 Technology

IM&T leaders are already collaborating across the Sector. For example, the Technical Design Architecture group is already working on, and in some cases trialing initiatives such as:

- Creating a single desk top, so clinicians can log on and get access to their 'native' Trust systems wherever they are currently working.
- Federating Wi-Fi, so staff can pick up on the local site Wi-Fi, again to access their existing systems.
- Work to enhance cyber security, share information and explore the potential to host data 'in the cloud'.

The specification for IM&T support will be based on clinical workflows for relevant services, once available. For example, if a patient attends at one site, but needs to be seen for follow up or diagnostics at another site, a simple system is required to enable a booking to be made immediately. Over time, the ambition is also to provide access to a common EPR. Plans for IM&T will be developed further as the clinical models and resultant workflows are created in more detail



[*Reference: Appendix20 , Transformation Programme 5 IM&T Programme Definition and Implementation Plan, DRAFT. Could also reference GM Devolution IM&T Objectives and GM Digital Roadmap, June 2016*]

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5 Financial case

5.1 Revenue – income and expenditure

Below is a summary of recommendations made by the Finance Executive Group, and endorsed by the Healthier Together Executive, to ensure there was a consistent set of assumptions behind the costings across GM.

In relation to transitional funding and recurrent revenue costs the main recommendations from FEG, which are fully endorsed by the Healthier Together Executive, are detailed below. Discussions at FEG focused on ensuring we have a consistent set of assumptions behind the costings. They did not seek to make a final decision on an award or to pre-judge the TF assessment process.

- Stranded costs – The FEG will lead on establishing a GM-wide stranded costs policy. The amounts included in the FBC represent unmitigated costs and Sectors will need to work to mitigate these prior to any bid from the Transformation Fund.
- Non-contracted pay – Consistent GM-wide approach will be adopted to ensure that any request for transitional funds are associated solely with the additional requirements of meeting Healthier Together standards, and only where substantive recruitment is actively underway. Premium costs associated with non-contracted pay are not expected to be funded by the GM Transformation Fund.
- Recurrent costs – Sectors are required to confirm that appropriate arrangements are in place at sector level to address the recurrent cost implications.

5.1.1 Revenue consequences – income and expenditure

This section considers the recurrent revenue consequences of the transfer of high risk general surgery activity to SRFT.

The financial case needs to be underpinned by a set of principles agreed by all parties which are:

1. The figures in this section are draft and will be subject to change. For example, commissioners have requested the financial data presented in the case is reworked using 2017/18 national tariffs which is expected to have an impact on the overall financial position. All six organisations are committed to either safely reducing or mitigating the costs of implementing the Standards where possible.
2. Recurrent revenue consequences will managed through a number of sources which include:
    a. A provider risk share agreement
    b. The transferring activity will provide a tariff to SRFT within which it must deliver this same activity (excluding costs associated with the capital development and implementing the Standards).
    c. When agreement is reached that the net costs of meeting the Standards are as low as possible, CCGs will agree to fund any additional costs for a time limited period (three years from commencement of the full Healthier Together model).
    d. CCGs will agree funding for the revenue consequences of the capital investment

Table 5.1.1 sets out a summary of the forecast recurrent income and expenditure position when activity transfers to SRFT. The table is divided into three sections as follows:

Section 1 - Baseline

The income and expenditure position for BFT and WWL for the delivery of high risk general surgery activity that will transfer to SRFT (N.B this is not based on 2017/18 tariffs which is an exercise that is in progress). This shows the baseline income and expenditure position of the transferring activity is a net deficit.

Section 1 - funding the revenue consequences:

A provider risk share agreement will be developed and will describe how this net deficit position will be managed between the three Trusts.

Section 2 – Income and expenditure forecast when activity transfers to SRFT

The income and expenditure estimates in this section are based on a number of assumptions which include:

1. The income forecast to be earned by SRFT associated with elective and non-elective activity transferring from BFT and WWL will be based on national tariffs adjusted for SRFT's specific market forces factor rate.
2. All costs currently incurred by BFT and WWL in delivery of the transferring activity will become the cost envelope within which SRFT must also deliver this activity with the exception of:-
   - Critical care costs will be based on SRFT's costs
   - Revenue costs of capital investment required to implement the general surgery Healthier Together requirements at SRFT.
3. Section 2a contains an estimate of the value of overheads included in tariff, but also as stranded costs at WWL and BFT and therefore in aggregate are duplicated across the sector and therefore included as a contribution to the costs of implementing the Standards.

Section 2 - funding the revenue consequences:

Critical care income and expenditure are expected to be funded through local tariffs by commissioners.

Commissioners have agreed to fund the revenue consequences of capital investment associated with building a receiving centre, theatres, critical care, beds and diagnostic capacity with a capital value of up to £16 million on the SRFT site.

Section 3 – costs of delivering the standards

When the activity has transferred, the general surgery quality and safety standards will be required to be met. To meet the standards two key areas needing additional investment are:

1. Increasing the medical workforce, as described in the workforce modelling section.
2. Providing a dedicated emergency theatre with minimum 14 hour per day cover. The additional costs of providing a further 10 hours per day on-call to have a 24 hour per day service have been removed in order to reduce the overall cost to the sector. SRFT already has an on call service out of hours and it is currently assumed that any additional activity transferring out of hours can be absorbed within this service. If that proves unviable then additional costs of £0.6m per year would need to be met by the sector in order to provide a second on call service out of hours. The costs in table 5.1.1 are based on providing the cover required based on the current activity data from the three providers.

Section 3 - funding the revenue consequences:

Further discussions and agreement is required between providers and with commissioners with respect to opportunities to safely mitigate or reduce the recurrent revenue consequences of delivering the Standards. Subject to potential further reduction to costs, the three CCGs will fund the remaining revenue gap of implementing the Standards for three years from implementation i.e. when the new surgical centre is opened and activity transfers to the hub site.

Section 3a sets out the estimated cost of implementing a standardised ambulatory care in each of the three providers with the costs representing the additional resources required by BFT and WWL. The GM Transformation Fund will provide a source of revenue for the first year of running after which the recurrent revenue costs will need to be agreed between each provider and its local commissioner.

Some mitigation of the increase to costs is expected from growth and / or efficiencies as summarised in section 5.1.2 below.

Table 5.1.1

Table 5.1.1

		Section 1			Section 2	Section 2a	Section 3	Section 3a	
		Baseline income & cost associated with transferring activity			Additional cost to deliver on SRFT Site	Removal of estimated duplicated cost (between 3 providers)	Original Cost of meeting Standards	Add Cost of meeting Standards Ambulatory Care	Revised Total Cost
		BFT £000s	WWL £000s	Total £000s	SRFT £000s	Total All Sites £000s	Total All Sites £000s	BFT / WWL £000s	Total £000s
INCOME									
	Elective	1,075	792	1,867					1,867
	Non Elective	2,352	2,349	4,701					4,701
	Excess Bed Days	180	167	347					347
	Critical Care Income	1,269	870	2,139					2,139
	Education Income	451	230	680					680
INCOME Total		5,327	4,407	9,734	0	0	0	0	9,734
DIRECT EXPENDITURE									
	Consultant	-763	-564	-1,327			-1,455	0	-2,482
	Other Medical	-901	-459	-1,360				-213	-1,573
	Other Clinical Staff	-126	-29	-155					-155
	Nursing Staff	-1,188	-800	-2,088				36	-2,052
	Theatres	-889	-657	-1,546			-1,370		-3,016
	Drugs	-44	-135	-183				7	-176
	Non Clinical Staff	-68	-151	-209				1	-208
	Other Non Pay	-146	-177	-322				-41	-363
	Critical Care	-861	-813	-1,804	-74				-1,878
DIRECT Total		-5,206	-3,885	-9,885	-74	0	-2,825	-218	-12,884
INDIRECT EXPENDITURE									
	Radiology	-122	-75	-197				-69	-266
	Pathology	-190	-54	-249				-8	-257
	Sterile Services	-83	-49	-83				3	-80
	Pharmacy	-90	-89	-125				0	-125
	Hotel Services	-251	-263	-514				8	-506
	Other	-76	-218	-294				-64	-358
Indirect Total		-753	-719	-1,472	0	0	0	-130	-1,602
OVERHEADS									
	CNST	-229	0	-229		151			-78
	Corporate	-379	-400	-579		727			-252
	Site	0	-100	-100		0			-100
	Other Overheads	-327	-310	-637		270			-367
Overhead Total		-929	-1,082	-2,011	0	1,149	0	0	-862
NON EBITDA	Depr and Financing	-155	-70	-225	-1,700			-148	-2,073
Non EBITDA Total		-155	-70	-225	-1,700	0	0	-148	-2,073
EXPENDITURE Total		-7,043	-5,360	-12,603	-1,774	1,149	-2,825	-488	-16,541
Surplus / (Deficit) Total		-1,716	-1,153	-2,869	-1,774	1,149	-2,825	-488	-6,807

5.1.2 Growth and efficiency assumptions

Growth in demand has not been included in the recurrent revenue forecasts. If demand for high risk general surgery increases, SRFT will be able to generate additional income at 100% of national tariff (elective activity) and 70% of tariff (non-elective activity). Further discussions and agreement is required with commissioners to determine a tariff for growth in demand that recognises commissioner investment above national tariff to support high quality and safe service delivery. A proportion of additional income from any growth in activity may be required to offset recurrent revenue shortfall in delivering the Standards.

Three opportunities to deliver efficiencies have been identified:

Table 5.1.2

	Efficiency Opportunity	Potential Impact	Beneficiary
1	Reducing length of stay for general surgery patients to achieve national benchmarks of upper quartile performance. Assuming this equates to an average reduction equivalent to 0.5 days per spell for the transferring activity in the Sector.	Reduction of c. 2 in-patient beds. c. £40k variable cost reduction based on a 0.5 day reduction	Scope to reduce provider cost is expected to be limited to variable costs. Potential to agree variable costs contribute to fund above tariff revenue costs.
2.	Reducing the number of excess bed days currently reported for the transferring activity through implementation of the standards	Total estimated annual income from excess bed days is £347k	Commissioners.
3.	Reducing readmissions following general surgery in-patient spell through implementation of the standards	Based on 10% reduction to SRFT's current readmission performance which is 5% for general surgery – equates to a reduction of c. 33 patient spells with a variable cost of c. £10k.	Scope to reduce provider cost is expected to be limited to variable costs. Potential to agree variable costs contribute to fund above tariff revenue costs.

5.2 Investment required – capital and transition costs

5.2.1 Capital

Briefly, the new build at the Sector hub site includes:

Table 5.2.1

North West Sector	£16 million Estimated capital cost for Healthier Together activity	- in-patient beds - critical care beds - elective and emergency theatres	Salford Royal Foundation Trust, which manages one hospital in Salford, has been selected as both a hub site for Healthier Together and the single Major Trauma Centre for Greater Manchester. SRFT have already cleared space for the erection of a new building to allow for both the additional Healthier Together and Major Trauma activity. This includes an emergency receiving area, diagnostics, theatres, critical care capacity and in-patient beds.

In addition, capital investment of £2m is required in two developments (one at BFT and one at WWL) to provide suitable accommodation for ambulatory surgical activity services.

5.2.2 Transformation and Transitional Funding

Transformation funding has been requested by the sector to support non-recurrent costs of implementing the standards. The Sector bid and the maximum sums approved by the Transformation Fund are summarised in the table below.

Table 5.2.2 Five Year Transformation Fund bid (2017-18 to 2021-22)

	North West Sector (to 2021/22) £'000	Transformation Fund maximum funding (to 2020/21) £'000
Project Management costs	1,655	1,151
Transitional workforce costs (early recruitment of medical staff and establishment of standard surgical triage models in all three Trusts)	3,136	1,792
Residual stranded costs	8,294	4,498
Site preparatory works for capital scheme	1,250	1,250
Revenue consequences of capital during construction phase	1,063	1,063
Total bid	**15,397**	**9,754**

IM&T costs : request to consider funding from Digital Fund not Transformation Fund		
IM&T – Datawell implementation	*1,440*	*TBC*
IM&T – inter-EPR and clinical systems communications	*12,000*	*TBC*

5.3 Risks and mitigation

5.3.1 Financial risk identification and mitigation

The key financial risks and mitigations are:

Table 5.3.1

Risk	Mitigation
Transferring activity currently trades at a loss creating new budget pressures at the Sector hub	Provider Risk Share Agreement required
Estimated activity volumes transferring are not accurate.	Non-hub sites to access stranded costs funding via Transformation Fund to maintain capacity if fewer spells transfer. Hub site to access stranded costs funding to increase capacity if more spells transfer.
Scheme capital costs exceed estimates	SRFT to undertake value engineering of the scheme to remain within funding envelope

The sector Finance Assurance Statement is attached as Appendix 21.

6 Leadership and governance

6.1 North West Sector Partnership

The North West Sector Partnership was first established in April 2014 as a formal partnership comprising the 3 Clinical Commissioning Groups, 3 Councils and 3 Foundation Trust across the North West (NW) sector of Greater Manchester. The parties made an explicit commitment to work together to develop and implement a sector-based response to GM HT, which is consistent with the new model of care and meets the agreed quality and safety standards for the in-scope services. The partnership is going further than this, identifying further opportunities for collaboration, and agreeing a wider programme of work where this is in the best interests of patients and the population. Clinical engagement and leadership is at the core of the Partnership approach in pursuing these aims.

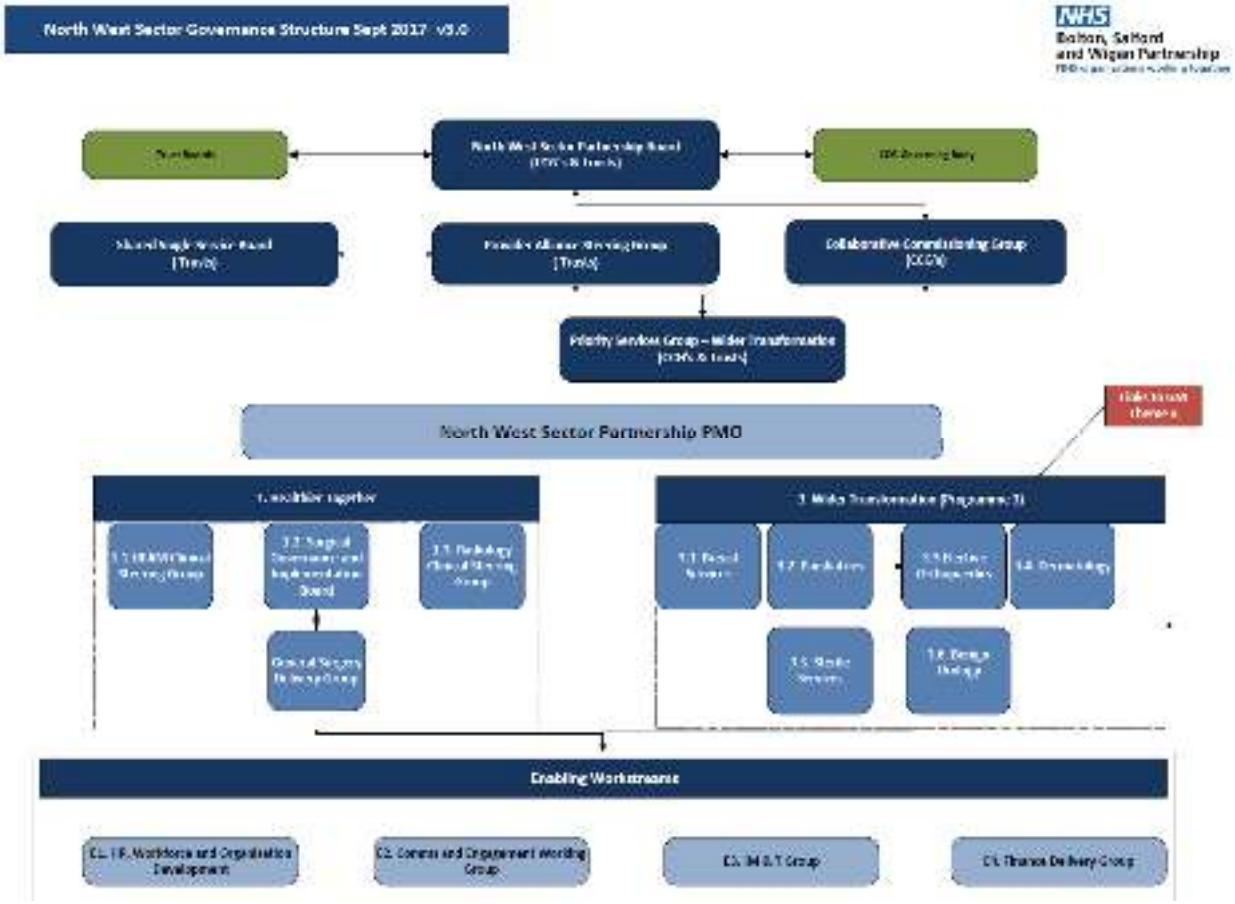
The objective of the North West Sector Project (for Healthier Together in-scope services) has been to ensure a robust process to identify, analyse and build organisational consensus on the preferred future configuration of relevant services that: delivers quality and safety standards; is clinically sustainable; and is affordable to providers and commissioners. The Memorandum of Understanding (July 2016) updated the approach and states:

This Partnership is focused on ensuring the delivery of high quality, safe and sustainable acute services to the combined population that we serve. In doing so we will take into account the locality plans and the related programmes of work to ensure alignment of plans. We will plan and deliver changes to acute services across the sector footprint to secure a range of benefits for patients and the wider system which cannot be secured or sustained by the efforts of an individual Trust or CCG. These benefits include clinically sustainable acute services; and affordable services within available resources.

In leading service change, the Partnership is underpinned by guiding principles including:

- To act in the best interests of service users and the public
- To work as a partnership of equals
- To seek to develop as a collaborative in order to achieve the full potential of the partnership on behalf of the populations we serve
- To involve and engage with clinicians, patients, carers and the public throughout
- Ensure no unwarranted variation in the quality of care
- Ensure that services provided to our patients offers the highest quality of care and achieves the best clinical outcomes
- Ensure that when considering service changes we take into account the views of local people, the access needs of patients, securing improved outcomes for patients and best value.

The MOU establishes the basis for how the Partnership operates and its aligned structures and processes, including the Partnership Board comprising the three CCGs and three NHS Foundation Trusts. The current governance arrangements and core Partnership Programmes are given in the following diagram.

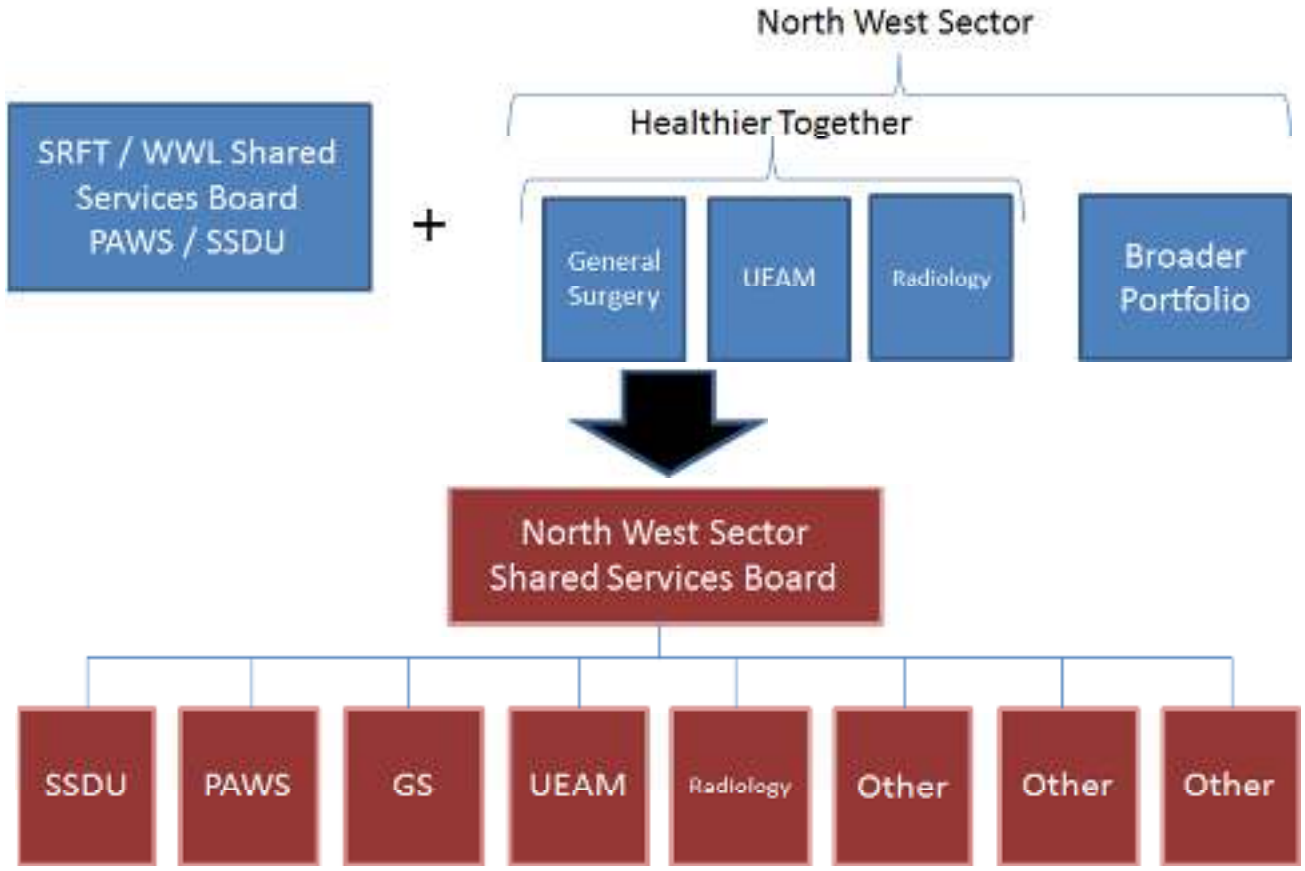

North West Sector Governance Structure Sept 2017 v3.0
NHS
Bolton, Salford
and Wigan Partnership
North West Sector Partnership PMO
Enabling Workstreams

6.2 Governance and risk management

6.2.1 Wider governance structure

Aligned to the Partnership Programme governance, providers are establishing a Shared Services Board (comprising BFT, WWL and SRFT) to oversee and govern shared services established as part of GM HT and through the NW Sector Partnership and Programme. It builds on services currently delivered on a bi-lateral basis including Pathology and Sterile Services (SRFT and WWL) and Sexual Health (BFT and SRFT). The Board replaces and subsumes the responsibilities of the existing Shared Services Board between WWL and SRFT. Further detail is given in Appendix 22 (Development of the North West Sector Shared Services Board, January 2017) and is summarised in the diagram below.

Current and proposed model for the Shared Services Board



6.2.2 Risk management

The Sector has adopted a best-practice approach to identify, assess and mitigate risks and issues involved in implementation of the Programme. A risk strategy has been developed and aligned to GM HT risk management approach, with a common rating and classifications system. We distinguish between risks (of an uncertain event or set of events that may happen and impact on achievement of objectives) and issues (unplanned events impacting on the Programme that must be resolved). The Sector's risk management approach includes the following elements.

- PMO leadership in making risks visible, understood, quantified and mitigated.
- Supporting better decision making through considering risks and issues, making risk management integral to all Programme activities.
- Consideration of risks and issues at the level of projects and work streams as well as the implementation of the Programme as a whole.

We follow a standard risk and issues management approach: Identify > Document > Evaluate > Mitigate > Monitor > Review > Close.

Risks are rated using a best-practice matrix assessing relative likelihood and impact on a five point scale, which when combined determines the overall rating (low to very high). Based on such analysis we have a process to escalate risks and issues to the appropriate level, from work stream sub-groups up to GM Level Programme Board. The high risks for escalation in November 2017 are seen in the tables below. Further information on the risk strategy and log of issues and risks is available if required.

DOC Risk Register(Programme)

7 Conclusions

The Sector Business Case for Healthier Together in-scope services is founded on decisions taken by commissioners in the NWS and across GM to implement new models of care to deliver an enhanced set of quality and safety standards for patients. The governance approach has been clarified by the GM Health and Social Care Partnership, with the NWS Partnership Board, as the leadership and governance body for the Sector, responsible for assuring and supporting implementation. Earlier drafts of the document have been shared with the Board and its content reflects the extensive, ongoing work to develop the NWS approach in implementing HT. Extensive engagement with and leadership by clinicians has mainly focussed on the impact on patients (experience and clinical outcomes) and the workforce, both directly in the specialties involved and with the many associated staff and services. We also provide an update on linked work, within the wider GM Theme 3 and the Sector-specific development of services through Programme 3, in part to address the impact of HT (such as stranded costs).

The Business Case details the current status of clinically-led developments in General Surgery, UEAM and Radiology, the headlines of which are that:

- General Surgery is progressing as a Single Shared Service to create the conditions to implement the new model of care which will see high-risk activity concentrated at the Sector hub.
- UEAM is establishing a common governance framework to provide more consistent, improved care at all three sites, driven by the need to better meet quality and safety standards, through initiatives including enhanced ambulatory care and a developing a blended workforce.
- Radiology is further developing its approach, in the Sector and across GM, to transform the current model, using the benefits of digital technologies in part to address significant workforce challenges.

The enabling workstreams are presented, along with how the financial implications have been assessed and will be managed by the Sector.

Recommendations are given in the Executive Summary.

Schedule of appendices

The following table presents key documents and sources, by Section, which collectively provide evidence to support the conclusions drawn and recommendations made in the Business Case.

Section 1: Executive summary			
Ref	Pg	Document	Date and status
Appendix 1	4	Letter from GM Health and Social Care Partnership Chief Executive John Rouse	8 May 2017
Appendix 2	5	GM HT Decision Making Business Case (DMBC)	Approved October 2015
Appendix 3	11	Development of NWS Shared Services Board	Approved (by NHS FT Boards) January 2017
Appendix 4	11	HT Commissioning Intentions 2016/17 (with text incorporated into all commissioning intentions letters to trusts in GM).	Approved by The Joint Committee of GM CCGs

Section 2: Strategic context			
Ref	Pg	Document	Date and status
Appendix 5	14	GM Strategic Plan – Taking Charge of our Health and Social Care in Greater Manchester	Approved, December 2015
Appendix 6	14	Presentations by each Trust of their perspectives on the Sector response	Summarised in notes of the PB Meeting, 9th June 2015
Appendix 7	15	Healthier Together (HT) Assurance Framework Approach Outline	Final (v0.5), 17th February 2016
Appendix 8	16	Healthier Together Clinical Model of Care Compliance	Endorsed by the AGG, 21st March 2017
Appendix 9	19	HT Delivery Board update – Clinical case for change	Final (v0.2), 2nd March 2017
Appendix 10	22	Sector level information on National Emergency Laparotomy Audit (NELA)	NELA Dashboard 2nd February 2017

Section 3: Clinical models			
Ref	Pg	Document	Date and status
Appendix 11	24	Healthier Together Financial Business Case (FBC) for the Transformation of A&E, Acute Medicine and General Surgery Services across Greater Manchester	Received from TU following Joint Committee on 19th September 2017
Appendix 12	25	Pre-consultation Business Case GM Quality and Safety Standards Part 1, Appendix 2	June 2013
Appendix 13	28	Assurance of the quality and safety for the transfer of patients between sites within the Healthier Together model.	NWAS Task and Finish Group 4th December 2017
Appendix 14	30	Healthier Together – Clarification of the model of care for sectors – General Surgical Model	v0.7 27 April 2016

Appendix 15	34	Royal College of Surgeons Commissioning Guide: Emergency general surgery (acute abdominal pain)	Published April 2014
Appendix 16	41	Appendix 3 of the GM HT Clarification Document "*Elective general surgical identified as high risk using the Healthier Together modelled definition*".	v0.7 27 April 2016
Appendix 17	44	Appendix 4 of the GM HT Clarification Document "*Nuffield Trust, emergency general surgery: challenges and opportunities – definition of high-risk diagnoses*"	v0.7 27 April 2016
Appendix 18	48	NWS PMO General Surgery Activity and Capacity Planning	v2 February 2017
Appendix 19	57	Dashboard against Healthier Together Quality and Safety Standards	May 2017

Section 4: Implementation plan and enabling work streams			
Ref	Pg	Document	Date and status
Appendix 20	93	Transformation Programme 5 IM&T Programme Definition and Implementation Plan	DRAFT 30th March 2016

Section 5: Financial case			
Ref	Pg	Document	Date and status
Appendix 21	99	North West Sector (NWS) Finance Assurance Statement	17th November 2017 Recommended to sector Boards and Governing Bodies by sector DoFs.

Section 6: Leadership and governance			
Ref	Pg	Document	Date and status
Appendix	102	Development of the NWS Shared Services Board	Approved (by NHS FT Boards) January 2017