Bolton NHS Foundation Trust – Board Meeting 25 October 2018

Location: Boardroom **Time: 0900 – 1600**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story – Integrated Care	CEO	Presentation	To note
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 27th September 2018	Chairman	Minutes	To approve the previous minutes
	5.	Action sheet	Chairman	Action log	To note progress on agreed actions
	6.	Matters arising	Chairman	Verbal	To address any matters arising not covered on the agenda
	7.	Chairman's Report	Chairman	Verbal	To receive a report on current issues
	8.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09:50	9.	Quality Assurance Committee Chair Report	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
10:00	10.	Finance and Investment Committee – Chair Report (meeting 23rd October 2018)	FC – Chair	To follow	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
10:10	11.	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
10:20	12.	Urgent Care Delivery Board Chair Report	CEO	Report	To receive a report on the Urgent Care Delivery Board
10:30	13.	Seasonal Plan update	COO	Report	To note
10:40	14.	Infection control Annual Report	Director of Nursing	Report	To note

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10:50	15.	Safeguarding Annual Report	Director of Nursing	Report	To note

Coffee

11:15	16.	Performance Report	Chief Executive	Report	To receive
11:35	17.	Use of Resources update	Director of Nursing	Verbal/ presentation	To note
Governance					
	18.	Board Assurance Framework and Corporate Risk Register	Trust Secretary	Report	To note
Strategy					
	19.	Update on EPR implementation	COO	Report	To receive the update on the implementation of EPR
Reports from Sub-Committees (for information)					
	20.	Any other business			
Questions from Members of the Public					
	21.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted				

12:30pm Lunch

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	27 September 2018
Venue	Boardroom RBH

Present:-

Mr D Wakefield	Chairman	DW
Dr J Bene	Chief Executive	JB
Dr F Andrews	Medical Director	
Mrs T Armstrong-Child	Director of Nursing	TAC
Mr A Duckworth	Non-Executive Director	
Mr A Ennis	Chief Operating Officer	AE
Mr M North	Non-Executive Director	MN
Mrs S Martin	Director of Strategic Transformation	SM
Mr J Mawrey	Director of Workforce	JM
Mr A Thornton	Non-Executive Director/Deputy Chair	AT
Mrs A Walker	Director of Finance	AW

In attendance:-

Mrs E Steel	Trust Secretary	ES

Apologies

Ms B Ismail, Mrs J Njoroge

Patient Story

L attended to share her experience of inpatient care from her perspective as carer of her 19 year old son D who has complex needs and autism.

L described excellent nursing care and great support from the Learning Disabilities nurse. However the transition from children's services to an adult ward came as a shock and was difficult for all concerned. D was initially admitted to D2 and given a bed on the main ward before later being transferred to C2 where he was allocated a side ward.

L needed to stay with her son to provide 24 hour support, although staff were happy to accommodate this, the facilities provided for carers are very limited, there are no shower facilities, no kitchen facilities and although a "Z bed" was provided on C2, whilst on D2 she had to sleep in an armchair. Storage for carers' belongings if staying overnight is also limited.

Board members thanked L for sharing her story and reflected on the challenges

of transition services and the need to provide acceptable facilities for carers.

Resolved: The Board noted the story and delegated a response to actions to the PEIP Committee.

FT/18/79	PEIP to consider actions to address issues raised with regard to carer accommodation and transition services

Welcome and Introductions

The Chairman welcomed Board members and attendees to the meeting.

Introductions were made

3. Declarations of Interest

Mr J Mawrey	Non-Executive Director iFM Bolton
Mrs E Steel	Company Secretary iFM Bolton

4. Minutes of The Board Of Directors Meetings Held 30 August 2018

The minutes of the meetings held on 30 August 2018 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

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

6. Matters Arising

There were no matters arising.

7. Chairman's Report

The Chairman welcomed Malcolm Brown, Francis Andrew and Sharon Martin to their first meeting as members of the Board.

The Chairman confirmed that he would now remain in post until the 12th November when the new Chairman would start, he thanked Board members and others for the gift and presentation made to him at the Annual Members Meeting.

CQC – The Trust received the initial PIR request from the CQC starting the process towards an unannounced inspection and a well led review before the end of the calendar year.

Accident and Emergency – latest results show an improvement in performance to 86%, while this is good progress there is still more to be done to achieve the

target of 95% by March 2019.

8. Chief Executive report

The Chief Executive highlighted key points from her written report:

In response to a question regarding the RTT target the CEO confirmed that the NHS constitution target of 92% still stands – guidance indicates that regulators priorities are to eradicate 52 week waits and not allow lists to increase, we are working with the CCG to ensure the guidance is met.

Resolved: the board noted the CEO update.

9. Quality Assurance Committee Chair Report

Mr Thornton presented his report as Chair of the Quality Assurance Committee and highlighted the discussion points from the meeting which provided assurance or highlighted risks:

The Acute Adult Division Assistant Divisional Nurse Director had been gathering real patient experience information in urgent and emergency care and provided three examples of feedback from patients and their comments on what a gold standard would represent.

The Clinical Governance and Quality Committee Chair Report escalated a concern with regard to low compliance for NBTC competency assessments. Assurance was provided that only fully trained staff will be expected to complete transfusions.

Comprehensive reports received from both the Family Care and Elective Care divisions, the committee were assured that the divisions have a good awareness of the challenges with actions in place to address these

The Assistant Director of Infection, Prevention and Control presented a briefing outlining the clinical implications of Gram negative infections and the emergence of new national mandatory reporting schemes.

A paper was presented following Board concern with regard to the performance against the TIA target. The Committee discussed the emerging risk of pressure within the stroke network and concerns regarding the number of stroke patients not accepted at the specialist stroke unit in Salford. The Committee have requested a further report to understand any implications of the challenges to capacity and specifically to determine if patients missed an opportunity for thrombolysis as a result.

The Family Care Divisional Medical Director presented the Antenatal New born screening – QA Visit Report and Action Plan report - the new Head of Midwifery has taken ownership of the action plan and the QA team are assured with the progress being made on the actions.

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

10. Finance and Investment Committee

Mr Duckworth presented his report as Chair of the Finance and Investment

Committee and highlighted the discussion points from the meeting which provided assurance or highlighted risks:

- The Trust has a year to date deficit of £2.5m, this is £0.4m behind plan
- ICIP performance is behind plan – although divisional forecasts have improved, the Committee remain concerned about ICIP delivery.
- Agency spend remains above target and the potential risk relating to medical staff and iFM pay award was noted.
- While the financial performance is currently rated amber committee members agreed the need to continue to monitor and potentially re forecast.
- A paper on cash management highlighted mitigations to address potential cash flow challenges in Q4.
- NHSI self-assessment checklists provided assurance that all relevant guidelines have been followed.
- The Committee received an update on reference cost processes and approved the costing process outlined in the paper.

Board members expressed disappointment that the Trust had not been successful in its joint proposal for the Greater Manchester Diabetic Eye Screening Programme. Concern was expressed that the exclusion of foot screening in the winning bid will impact on the quality of care for Bolton patients.

Resolved: the Board noted the update from the Chair of the Finance and Investment Committee and the escalated risks.

11. **Workforce Assurance Committee Chair Report**

The Chief Executive presented the Chair report from the August meeting of the Workforce Assurance Committee, a number of the reports and highlighted the following areas from within the report:

- The Committee received the annual report from the Freedom to Speak up Guardian – three concerns were reported to the Guardian, two relating to culture and one relating to low staff morale as a result of ward moves. The Workforce Assurance Committee discussed the comparatively low number of concerns raised and although the staff survey results indicate that staff feel able to raise concerns a re-energised approach was approved for launch in October 2018.
- The Committee received sickness absence data from the four clinical divisions and discussed the actions being taken to reduce absence – further actions are planned and an additional report was requested for the October meeting.
- The update on the Occupational Health service highlighted concerns with regard to Q1 performance and the governance arrangements for the shared service. These concerns will be followed up at the October Workforce Committee meeting.
- Agency expenditure and reliance remains a concern, the committee received an update on actions to recruit into hard to fill areas with forecasts that indicate a significant reduction in agency spend could be achieved when these key roles are filled.

- The committee received the report from the Guardian of Safe Working (GOSW) The Chief Executive and Medical Director had subsequent discussion with regard to supporting the Guardian and ensuring appropriate support and information was provided by divisions when requested.

Resolved: The Board noted the report from the Workforce Assurance Committee

12 **Audit Committee Chair Report**

The Trust Secretary presented the report from the Chair of the Audit Committee.

At its September meeting, the Audit Committee received four final reports from the internal auditors, two of these being high risk reports that had previously been escalated to the Board.

In response to a question about the Payroll Report, the Director of Workforce confirmed that he would be bringing a briefing back to the Audit Committee to provide assurance that appropriate actions were taken to close access to systems and facilities. A further action was agreed to request an internal audit review of IT security arrangements in relation to staff lists and staff access.

Resolved: The Board noted the Audit Committee Chair report.

FT/18/80	Report back through audit committee to provide assurance that robust arrangements in place to close employee access to systems at end of employment

FT/18/81	Internal Audit plan - review IT security arrangements - segregation of duties and reconciliation of staff list and email accounts

13 **Urgent Care Delivery Board Chair Report**

The Chief Operating Officer presented the report from the Urgent Care Delivery Board and highlighted the discussion points from the meeting which provided assurance or highlighted risks to delivery of the nine high impact workstreams.

Board members discussed the impact of the closure of Four Seasons Nursing Home and the potential impact on capacity at peak pressure. The CEO advised that the CCG recognise this challenge and are discussing potential surge capacity with the CCG.

Resolved: The Board noted the report from the Chair of the Urgent Care Delivery Board.

14. **Seasonal Plan Update**

The Chief Operating Officer presented a verbal update on plans to ensure capacity and processes are in place to mitigate for winter pressures.

The capital work in A&E for streaming and to increase resus capacity has been delayed, this is subject to regular discussions with iFM but at the time of reporting the Chief Operating Officer advised that he could not give assurance that the

revised dates for completion would be met. Other aspects of the seasonal plan however can be undertaken, staffing plans are more robust than in 2017/18 and the "winter ward" is complete. A&E streaming can be done without the physical build and ambulance turnaround has already improved.

Performance against the A&E target has also continued to improve and although still not at 90% performance is similar to others.

Board members discussed the delay to the A&E capital programme reflecting back on previous discussions when concerns about the capacity within iFM had been raised. The Chief Executive advised that these concerns had been discussed in detail within the Strategic Estates Committee and Capital Programme Board. It had been recognised that the capital programme was ambitious and the iFM team lacked the experience to manage a large complex programme. All new capital contracts now have penalties for late delivery and iFM has strengthened the senior team to ensure a more robust and proactive approach to future projects.

The Chair of iFM will be reporting back to the FT Chair and CEO in November 2018.

Board members discussed the continued challenge and the impact of seasonal pressures and requested a written update for the October Board meeting.

FT/18/82	written update to October meeting

15. **RTT update**

The Chief Operating Officer provided an update on Trust performance against the RTT target, the activity undertaken to recover performance and the challenges to deliver activity to meet the target.

Additional activity is being undertaken to recover performance against the target and to reduce the waiting list with a programme of back log reduction, this includes additional sessions and work with WWL to provide orthopaedic lists at Wrightington and some general surgery work at Leigh.

The four areas where capacity remains a challenge are endoscopy, ophthalmology, general surgery and orthopaedics. The CCG remain very supportive in addressing capacity to meet demand with a further meeting scheduled to discuss the commissioner support required. NHSI undertook a visit to review RTT processes and provided favourable feedback on the systems in place.

Board members discussed the continued challenge of providing capacity to meet increasing demand and the actions needed to ensure a reduction in the waiting list and to address 52 week waits with a further report requested to update on these key areas.

In discussion and in response to questions, the following points were noted:

- more cancers are being identified in some specialities
- The CCG has a clear policy to restrict procedures of limited clinical value, clinicians are actively engaged in identifying procedures that could be stopped or done elsewhere.

- Cancellations were higher than anticipated in the summer months due to an increase in surgical length of stay – this has been raised with the division through IPM.

Resolved: board members noted the update on RTT performance

FT/18/83	Update to October Board meeting

15. Performance Report

The Chief Executive presented the performance report.

Members of the Executive team responded to questions on the area of the report within their portfolio, the following key points were noted:

Quality and Safety

- Reduction seen in falls per 1000 bed days in both hospital and Darley Court inpatient areas.
- Although there has been an increase in E. coli infection rates overall rates remain low – E coli cases are apportioned to the Trust if symptoms start more than 48 hours after admission. An RCA process is being implemented as a health economy with recognition that although not a significant concern, further work is required to understand with some potential learning with regard to antibiotics and catheter care.
- All new litigation claims are reported through the WIICAM group and if necessary escalated to Board members the Clinical Governance Committee Chair report.
- Following discussion at the August Board meeting, maternity metrics are being reviewed for the October Board report.

Operational

- The QA Committee received a report on the challenge to achieve the stroke and TIA target and recognised that these are not metrics the Trust can achieve in isolation. The QA Committee Chair confirmed that a follow up report had been requested to provide assurance with regard to patient outcomes.
- Cancer performance in August was good and although September has been more of a challenge Q2 cancer performance targets will be achieved.

Finance

- In response to a question raised with regard to an ICIP recovery plan, the Director of Finance advised that all divisions other than community had been asked to submit recovery plans and were attending weekly escalation meetings to review these plans. The executive team confirmed that they were actively looking at capacity in divisions and the resource required to support divisions to undertake transformative actions.

Use of Resources

- The Trust Use of Resources review is scheduled for November 2018 – an update on the associated metrics and assessment process will be provided through the QA committee in October

A number of anomalies were identified in the report for escalation to BI

Resolved: Board members noted the Board Performance Report and agreed the following actions.

FT/18/84	FA to respond to MB query about prostatic biopsies by email
FT/18/85	Use of Resources update to October Board

17. Workforce and OD Strategy

The Director of Workforce presented the Workforce and OD strategy advising that the document which sets out the four key areas for action had been developed and shaped in collaboration with staff and stakeholders. The Director of Strategic Transformation confirmed that she would work with the Workforce Director to support the evolution of the Strategy alongside the development of the new five year strategic plan.

Board members commended the strategy and the ambition and endeavour to develop a strong and sustainable workforce. The Director of Workforce confirmed that an action plan had been developed to support the delivery of the strategy and that this would be overseen through the Workforce Assurance Committee.

Resolved: The Board approved the Workforce and OD Strategy.

18 Complaints Annual Report

The Director of Nursing presented the Complaints Annual Report and confirmed that the document which had previously been presented to the QA Committee would continue to evolve to increase focus and to ensure an accurate reflection of the diverse groups served by the Trust. The Director of Nursing stressed the importance of the report and the lasting impact a poor experience could have on a patient.

The Board discussed the data presented in the report – the following points were noted:

- The number of open cases has reduced and the target 95% response rate was achieved.
- There were no ombudsman investigations
- The overall quality of letters in response to complaints has improved with improved turnaround times and a more proactive response to accept and apologise for failings.
- Each division produces a patient experience strategy, key themes from these reports will be pulled together into a Trust Patient Experience report outlining the key themes and actions to help Board members understand the “so what” question and the key priorities.

Resolved: the Board approved the Annual Complaints Report.

19. WRES

The Director of Workforce presented the Workforce Race Equality Standard 2018 (WRES) report for Board members to review performance against the nine WRES indicators and to note the action plans to close the gap in workforce experience between white and BME staff.

Whilst some improvement has been made in WRES indicators Board members agreed that more actions were required to ensure fair recruitment and fair access to career progressions.

The Director of Workforce confirmed that the actions agreed would be overseen by the Workforce Assurance Committee and reported to the Board through the WAC Chair report.

Resolved: Board members discussed the metrics in the report and agreed the actions proposed

20. Freedom to Speak Up

The Director of Workforce presented the annual update from the Trust's Freedom to Speak up Guardian including the self-assessment undertaken against the NHSI and National Freedom to Speak up self-review tool.

In 2017/18 three concerns were raised by staff, this is low compared to other organisations but the Trust benchmark well on the staff survey questions on raising concerns. The low take up of raising concerns through the Guardian has been discussed with a number of actions including champions to support at a local level have been agreed. Monthly meetings are in place for the Freedom to Speak up champions and the Guardian to discuss concerns with the CEO and the Director of Workforce.

Board members discussed the self-assessment and the actions required to ensure staff feel they can speak up without any fear of reprisal.

Resolved: Board members recognised the need for a clear and accessible process to ensure all staff can speak up if they wish. Board members requested further assurance to be provided through the consolidation of related metrics in a report to be presented to the Workforce Assurance Committee and then to the Board in December.

report back in December

21. EPRR report

The Chief Operating Office presented the annual EPRR core standards self-assessment for approval.

Resolved: the Board approved the EPRR report and the signing of the statement of compliance.

22. **Revalidation**

The Medical Director presented the annual Revalidation report to support the annual statement of compliance for submission to NHS North.

Board members discussed the data presented in the report with some concern expressed with regard to the sampling process and the number of cases identified as having conduct concerns. The Medical Director and CEO confirmed that although the sample reviewed for the report is random a QA process is in place whereby the clinical lead reviews all appraisals, appraisers are given feedback and are provided with support to ensure the process can be completed.

The Medical Director confirmed that of the three cases reported as not being completed two are now complete and actions are underway to ensure the process is completed for the third doctor. A prescribed process is in place for doctors who do not complete the process; this includes a series of local warnings followed by a GMC referral.

The Medical Director and Director of Nursing agreed an action for an off line discussion regarding medical devices training.

In response to a question about the process in place for locum doctors and those on temporary contracts the Medical Director agreed to consider if any action was required to provide assurance with regard to revalidation for this group of staff.

Resolved: The Board approved the revalidation report and approved the signing of the Statement of Compliance.

FT/18/87	TAC and FA to discuss with regard to status of med devices training
FT/18/88	FA to consider what actions should be taken for doctors on short term contracts

13. **Any other business**

No other business.

19. **Questions from Members of the Public**

No questions submitted.

Date and Time of Next Meeting

25 October 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.

September 2018 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/18/84	27/09/2018	Performance report E Coli	FA to respond to MB query about prostatic biopsies by email	FA	Oct-18	complete email discussion
FT/18/31	26/04/2018	Data Security	update on plans for full implementation	AE	Oct-18	update on EPR implementation - agenda item
FT/18/82	27/09/2018	Seasonal plan	written update to October meeting	AE	Oct-18	agenda item
FT/18/83	27/09/2018	RTT	Update to October Board meeting	AE	Oct-18	agenda item
FT/18/85	27/09/2018	performance report	Use of Resources update to October Board	AW/TAC	Oct-18	agenda item
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	Oct-18	BAF agenda item at Oct Board and Nov Audit committee
FT/18/50	28/06/2018	Mortality Report	Update to Board on the application of technology for patient care within the Trust	FA	Oct-18	update on EPR implementation - agenda item
FT/18/76	30/08/2018	Performance report - turnover	report to Workforce Assurance Committee to benchmark turnover rates	JM	Oct-18	WAC chair report
FT/18/91	27/09/2018	Ward visits	AE to write formally to divisions with regard to the provision of food for carers	AE	Oct-18	verbal update
FT/18/88	27/09/2018	Revalidation	FA to consider what actions should be taken for doctors on short term contracts	FA	Oct-18	verbal update
FT/18/89	27/09/2018	Ward visits	Ensure robust process for ward to provide feedback to HR with regard to agency staff	JM	Oct-18	verbal update
FT/18/71	30/08/2018	Chief Exec Report	Check if there are VAT implications to shared services through an SLA	RH	Oct-18	verbal update
FT/18/87	27/09/2018	Revalidation	TAC and FA to discuss with regard to status of med devices training - ? If mandatory	TAC/FA	Oct-18	verbal update
FT/18/74	30/08/2018	Performance report - maternity targets	review target/threshold for interventions in labour	TAC/RH	Oct-18	verbal update
FT/18/68	26/07/2018	Performance report	update on fracture neck of femur - evidence of good outcome measures to QA Committee	FA	Nov-18	QA Committee Chair report
FT/18/38	31/05/2018	Patient Story	six month update on Patrick's story to QA committee	ES	Nov-18	
FT/18/80	27/09/2018	Audit Committee Chair report - Payroll audit	Report back through audit committee to provide assurance that robust arrangements in place to close employee access to systems at end of employment	JM	Nov-18	briefing to Audit Committee
FT/18/86	27/09/2018	Freedom to Speak up	report back in December	JM	Dec-18	
FT/18/79	27/09/2018	Patient Story	PEIP to consider actions to address issues raised with regard to carer accommodation and transition services	TAC	Dec-18	verbal update
FT/18/81	27/09/2018	Audit Committee Chair report - Payroll audit	Internal Audit plan - review IT security arrangements - segregation of duties and reconciliation of staff accounts	AW	Jan-19	
FT/18/90	27/09/2018	Ward visits	Execs to consider potential options to support wards with storage issues	Execs	Jan-19	

Key

complete	agenda item	due	overdue	not due

Agenda Item No: 8

Meeting	Board of Directors

Date	25 October 2018

Title	Chief Executive Update

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

Previously considered by	

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

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

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

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

All information provided in this written report was correct at the close of play 18/10/2018 a verbal update will be provided during the meeting if required

1. Awards and recognition

The annual staff awards are scheduled to take place on Friday 26th October, this year saw a record number of nominations all well deserving of recognition.

September:

Team – E5 Nursing and Medical Team - pilot ward for the introduction of EObs

Employee – Toni Smith, HR Advisor, Workforce Directorate Toni in a short period of time has supported managers to bring a number of comprehensive sickness cases to final formal review meetings

August:

Team – Family Care Divisional Management Team – for the compassion shown to a colleague newly diagnosed with a serious illness

Employee – Sandra Commons, Clerical Officer in Health Records – for her dedication to her role and execution of duties under considerable pressure

2. Stakeholders

2.1 CQC

As notified as our last meeting, we have submitted our response to the CQC PIR and subsequent follow up questions; we will receive notification of the dates for the formal Well Led inspection. In addition to this we can expect unannounced inspections of at least one core service.

2.2 NHSI

NHSI will be undertaking their Use of Resources inspection of the Trust on 27th November 2018. The outcome of this review will contribute to the CQC Well Led review.

NHSI have launched a consultation on proposals to change the way the approve the establishment of subsidiary companies and the way trust's report subsidiary companies the guidance is primarily for Trust's establishing new subsidiaries however, business cases that make a material change to an existing subsidiary will also be subject to this revised process

https://engage.improvement.nhs.uk/subsidiary-companies-review/extension-to-review-of-subsidiary-companies/

2.3 Greater Manchester

No significant developments to report.

2.4 North West Sector

Exec to Exec meetings with WWL have continued, the two teams are scheduled to meet on 29 October, a written update will be provided for consideration by both Boards

2.5 Bolton

Work to develop the partnership governance arrangements for the Integrated Care Partnership continues.

2.6 iFM Bolton

Staff from the Trust's wholly owned subsidiary and provider of Estates and Facilities services took industrial action in the form of a 48 hour strike from 07.00 am on 11th October to 07.00 am on 13th October. Contingency plans were put in place for the two day period to ensure services continued to function safely. As part of those plans assurance processes

were in place to monitor the levels of cleaning. This was discussed at the recent debrief session and assurance gained that standards within clinical areas were maintained during this period.

At the time of writing negotiations are ongoing to hopefully avert a further 72 hour strike.

Reportable Issues Log

Issues occurring between 25/09/18 and 18.10.18

3.1 Serious Incidents and Never events

We have reported two serious incidents since the last Board meeting, one a wrong site block (never event) and one relating to a fall.

3.2 Red Complaints

No red rated complaints were received in the reporting period

3.3 Regulation 28 Reports

No regulation 28 reports

3.3 Whistleblowing

Nothing to report

3.4 Media issues

There has been some adverse local media coverage relating to the potential industrial dispute amongst iFM staff.

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 full Board Assurance Framework is on the Board agenda for information and will be reviewed at the November Audit Committee

	Trust Wide Objective	Lead	I	L		Sept	Aug	June	May	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	16	Sub-optimal of robust clinical engagement with Antimicrobial Stewardship.	Implementation of all key actions from the IPC review – July 2018	IPC committee
1.2.1a	For our patients to receive safe and effective care (pressure ulcers)	DON	5	2	-	10	10	10	10	No identified risks, sharing, learning arrangements robust.	Maintain current governance arrangements and enhance ward based training (calibrated to releasing staff safely)	QAC and Harm Free Care
1.2.1b	For our patients to receive safe and effective care (falls)	DON	5	3	-	15	15	15	15	Sub-optimal adoption of all preventative falls measures consistently	Implemented updated Falls Action Plan	QAC and Harm Free Care
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	4	-	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Roll out mortality review process Drive further improvement in ward observation KPI's Ensure Patient Track Oversight Group delivers on action plan Deliver on Quality Account 2017/18 sepsis actions (March 2019)	Mortality reduction
1.4	Staff and staff levels are supported	DoW	4	5	-	20	20	16	20	Recruitment, limited pool of staff Staffing for escalation areas Sickness rates esp within AACD	Recruitment workplan in place overseen through Workforce Assurance Committee Targeted actions to reduce sickness absence New Workforce Strategy to be approved by the Board in September 2018	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	20	Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Urgent Care pressure and increased demand on Diagnostic and Elective work	Urgent Care programme plan SAFER ECIP support Enhanced pathways as part of the new streaming model commences Dec 2018	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	20	Healthier Together Access to Transformation Fund Delivery of cost improvement plans Lack of workforce leading to agency costs Impact of GM theme work Fragmentation of commissioning Organisational change NHS funding settlement Efficiency requirements	Develop Estates Master Planning Implement Capital planning process – RIBA implementation Develop strategic approach to cost improvement Locality plan delivery Joint system savings approach LCO Development Strategic financial planning for 5 year timeframe	IPM F&I comm System groups:-System Board Strategic Estates group HWBE
4.4	Compliance with NHS improvement agency rules	DoW	4	4	-	16	16	16	16	Sickness absence Workforce shortage Gaps in rotas	Additional admin support for wards. Ongoing recruitment Targeted actions to address sickness absence	IPM Workforce comm
5.4	Achieving sustainable services through collaboration within the NW sector	Dir Strat.	5	4	-	20	20	20	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing discussions with WWL – paper planned for future Board	Board F&I
5.5	Supporting the urgent care system	COO	4	4	-	16	16	16	20	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Estates improvements to A&E – Phase 2 (new resuscitation and ambulance triage) expected completion Nov 2018, Phase 3 (increased triage/consultation rooms and new reception/ wait area) expected Dec 2018 Further work with Community services on discharge to assess/home based care	Urgent care prog board

All information provided in this written report was correct at the close of play 17.10.18 a verbal update will be provided during the meeting if required

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	17 October 2018	Date of next meeting:	21 November 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Members present/attendees:	A Thornton, J Bene, J Mawrey. Representation from the four clinical divisions	Quorate (Yes/No):	No
		Key Members not present:	T Armstrong Child, M Brown, S Martin

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story – Integrated Care		Integrated Care Division presented a patient story illustrating the support available to keep patients in their own home with respite support for family carers. The support now available means patients who might previously have been admitted to long term care can now remain in their own home	Story noted
Clinical Governance and Quality Committee Chair Report		The Committee advised that completing SI actions had been noted as a challenge however action has now been taken to resolve this. Positive assurance from the Critical Care peer review action plan	COO reminded all attendees to ensure that all relevant committees consider the potential benefits/application of EPR
Quality Account priority –Reduction in Medication errors		Update provided with regard to progress made against the Quality Account goal to reduce omissions of critical medicines. Policy strengthened and medicines trollies reintroduced	Next steps include developing the message for patients to empower them to challenge/speak up with regard to the administration of medicines. The action plan will continue to be monitored through the medicines safety group.
BOSCA update		Update provided on the BOSCA process and current ratings of wards and departments – no areas rated white, 7 bronze, 19 silver, 8 gold and 7 platinum.	The Committee discussed the support to sustain and the importance of continued engagement with the BOSCA process

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Committee/Group Chair's Report

Use of Resources review		Update provided on the Use of Resources metric and the role of key committees in ensuring grip around each metric. Data and supporting narrative being collated for submission as part of UoR assessment in November	Update noted
Safeguarding Annual Report		The Deputy Director of Nursing reminded Committee members that Safeguarding is everyone's responsibility. Successes include implementation of paediatric information sharing and the development of safeguarding champions.	Annual Report approved for submission to the Board Committee members noted the increase in adult safeguarding referrals this was attributed to a combination of increased awareness and the impact of austerity
Infection Control Annual Report		Annual report on the surveillance of infection control, good progress made with assurance that attributable cases have not occurred as a result of cross contamination.	Report approved for submission to the Board
Human Tissue Authority Report		A routine on-site assessment of the department deemed the premises and practices to be suitable and in accordance the requirements of the legislation. A number of recommendations were made and some areas of good practice recognised	Progress to address the recommendations noted
Patient Experience, Inclusion and Partnership Committee		The Committee received a number of positive reports including a report from Healthwatch following an inspection of Ophthalmology	Report noted
Mortality Committee		SHMI 105.22 RAMI 92.48 The Medical Director advised that an analysis of pneumonia deaths is being undertaken with a review of 17 cases	Report noted

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Committee/Group Chair's Report

Risk Management Committee		Corporate Risk Register developed. Group Health and Safety committee escalated a concern with regard to violence and aggression towards staff – actions to address this and support staff will be taken forwards through the security group	Report noted
IT and Information Committee		Increase in volume of FOI requests noted Progress made with the removal of faxes	
Safeguarding Committee		Updates provided on adult and child safeguarding. Good assurance that the national requirements for looked after children are being met	
Comments			
Risks Escalated			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	23rd October 2018	Date of next meeting:	20th November 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Members Present:	A Duckworth, J Bene, A Walker, S Martin, B Ismail, A Ennis	Quorate (Yes/No):	Yes
		Key Members not present:	D Wakefield

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 6)		Director of Finance	Key points noted from the Finance & Activity Report: • the Trust has a year to date deficit of £2.3m when PSF and impairments are excluded from the position, which is £0.03m better than plan; • against the control total the Trust has a surplus of £0.4m, which is £1.2m less than plan; • there were no additional non-recurrent Balance Sheet adjustments released into the position; • agency costs are at £4.5m against a year to date NHSI target of £3.2m; • ICIPs at £3.2m are £2.3m below plan for the year; • the month end cash balance is £10.4m which is better than plan by £3.4m this month; • year to date capital spend is £7.4m which is £1.2m above the capital plan; and, • the Trust's Use of Resource Rating is 2 as at the end of Month 6, which is on plan. ICIP performance remains well below plan with the low level of risk adjusted schemes still a concern. Agency costs remain well above the NHSI target. Positive progress has been made with the CCG regarding additional income.	The key material risk for the year remains Divisional performance/ICIP delivery. Agency spend continues to be well above plan and NHSI targets. Some improvement is noted but the level and pace of this remains disappointing despite significant efforts reported. Concern was also expressed at the potential impact of slow progress on next year's planning. Divisional forecasts continue to improve but still exceed Trust plans by a significant amount, reflecting ongoing poor ICIP achievement. The risk remains high that forward PSF targets may be missed.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 6) continued			iFM pay still represents further potential risk.	Potential pay award risks remain, including the actual impact of the recent iFM pay settlement. Cash and UoR ratings are still regarded as key risks.
Chair Report from CRIG		Director of Finance	The Committee received the Chair report from the CRIG meeting held on 9th October. No risks were escalated although concerns over A&E overspends were noted.	Chair report noted.
Chair Report from the Strategic Estates Board		Chief Executive	The Committee received the Chair report from the Strategic Estates Board meeting held on 10th October. Concern was expressed regarding A&E overspend and delays due to poor contract management. Assurance was given that this situation is being addressed so, at this stage, no risks were escalated.	Chair report noted.
Chair Report from the Digital Transformation Board		Chief Executive	The Committee received the Chair's report from the Digital Transformation Board meeting held on 8th October. No risks were escalated.	Chair report noted.
Report on GM Developments		Director of Finance	There were no updates this month however further developments are expected in November.	Noted.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Use of Resources Assessment		Director of Finance	A briefing report setting out the arrangements for the forthcoming Use of Resources assessment was received. This provided useful information on the process involved, but it was agreed that a further paper would be prepared to aid understanding of the context and potential results. This will be based on the submitted data and will include appropriate commentary and interpretation.	Report noted. A follow-up paper to be prepared.
Procurement KPI Report		Director of Finance	The Committee received the quarterly KPI report which set out current performance against the key indicators in the Trust's strategy and the service specification between the Trust and iFM. The improved format of the report was welcomed: more focused on strategic issues and clearer links to financial plans/ICIP.	Report noted.
Top up Insurance		Director of Finance	The Committee received and debated an update on the Trust's "top up" insurance cover. Levels of excess were questioned and it was agreed to explore options to reduce levels and/or the impact of them on claims. It was also agreed to undertake a more strategic review of insurances ahead of the next term.	The Committee agreed it would be useful to consider options to reduce levels of excess and also in advance of the next renewal period a longer term strategic review should be undertaken.
Bolton College of Medical Sciences Development – Financial Case		Director of Finance	The Committee received details of the financial case to be incorporated into the business case which is to be considered by the Board at its meeting in October. It was agreed that the paper demonstrated a strong prima facia financial case based on the assumptions used. Sensitivity was considered verbally but a formal sensitivity analysis was requested to provide more assurance.	A formal sensitivity analysis will be prepared to provide further assurance.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Tender Update		Director of Strategic Transformation	The Committee received and noted an overview of the competitive tender exercises that the Trust is presently engaged in. It was noted that the Bolton 0-19 service was regarded as a strategic priority and strong efforts will be made to secure this service going forward.	Update noted.
Assurance report re Provision of IT Services to Bolton CCG		Director of Finance	An assurance paper was provided following a request from the Committee at its meeting in September. The paper provided greater assurance in regard to the Trust's ability to deliver, and the broader strategic benefits were well appreciated. The Committee, however, felt that further information was needed to demonstrate sustainable financial viability (including an adequate risk premium). Further assurance regarding contractual arrangements, including potential termination arrangements etc. was also requested. It was noted that the governance arrangements would be set out as an appendix to the paper and submitted to the Digital Transformation Board.	Further information and assurance was requested: • to demonstrate sustainable financial viability (including an adequate risk premium) • with regard to contractual arrangements
Comments				
Risks escalated for 2018/19 • Divisional Performance: Forecasts/ICIP identification and delivery/Pay Costs (agency) - key material risks for the year • PSF Achievement (A&E and Financial) • Pay Awards: (AfC) – potential funding shortfall; medical pay awards; the recent iFM settlement • Cash and UoR ratings (especially potential cash constraints under mid case forecasts) • CapEx delivery (in particular if cash constrained) • GM Integrated Care Control Total: risk for 18/19 capped at £263k, but longer term risks are more uncertain				

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Trust Board
Date of Meeting:	16th October, 2018	Date of next meeting:	
Chair:	Jackie Bene	Parent Committee:	Trust Board
Members present/attendees:	Jackie Bene, Trish Armstrong Child, James Mawrey, Andy Ennis, Francis Andrews, Sharon Martin, Lindsey Darley, Paul Settle, Lynne Barnes, Lianne Robinson, Chrisella Morgan, Carol Sheard, Esther Steel, Rachel Hemingway, Mayen Egbe	Quorate (Yes/No):	Yes
		Key Members not present:	Annette Walker

Key Agenda Items:	RAG	Key Points	Action/decision
Allied Health Professional – Deep Dive	Green	• In line with AHP day (15th October), the Committee received a report on the challenges and opportunities that were facing this diverse staffing group. • The group supported the need to have a sharpened focus on the following AHP matters: Leadership, Workforce Planning, Development of new roles and innovative approaches to recruitment.	Actions agreed:- • The Committee supported the proposal that a further paper would come back to the Committee in three months' time.
Workforce Dashboard	Amber	• Improvements have been made to the Workforce & OD Dashboard which have been well received at both Divisional and Trust level. • Following on from a Board action it was noted that the Trust turnover rate benchmarks as 10th out of 26 NHS organisations in the North West. Whilst this is a relatively positive position it was noted that a retention task group (reportable to Workforce Operational Committee) has been established to ensure all possible measures are being taken. • The Exit Interview response rates now form part of the dashboard. Given that new process has recently been introduced it was agreed that a full paper would come to the Committee in December on the findings / themes.	• The Workforce Assurance Committee fully supported the new dashboard and agreed that a report on the refreshed approach to Exit interviews would be discussed at the December Committee.

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Committee/Group Chair's Report

Sickness Absence (Standing item)	Amber	• It was noted that there has been a slight improvement in the sickness rate for September when compared to last month. • The Trust has launched the pilot Attendance Matters scheme in Adult Acute, ICS and IFM. Within the first 2 weeks the team have handled 1000 calls (450 inbound/550 outbound), the team have made fast track referral to the staff physio therapy team, signposted the mental health drop in sessions and provided direct advise in relation to reason for absence from our attendance matters nurse. The Committee were pleased to hear that the Trust has recently increased the number of mental well-being sessions being offered (from mid-September) and that the Resilience Programme (launched on 20th September with up to 400 places) was being well received. • A task & finish group had been established to review the reasons for the high sickness absence within the Additional Clinical Services Staffing group.	Agreed actions: • Feedback to the Committee on the findings of the HSCW Sickness absence task & finish group.
Occupational Health Update	Red	• Following the last meeting the Terms of Reference for the Joint Collaboration Board were reviewed. Amends have been made to ensure attendance by the Director of Workforce and Operational leadership. • An update was provided on the findings of the Customer Service survey – undertaken by the Occupational Health service. Given the low response rate it was agreed that the FT would undertake their own feedback and use this information to form part of the improvement plan that is required for the service.	Agreed actions: • The Trust to undertake their own customer survey on the Occupational Health Service and report back to the December Committee.

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Committee/Group Chair's Report

Recruitment Update	Green	• It was noted that there continues to be good progress on both nursing and medical recruitment. • The Committee felt that it is currently in the strongest position it has been in for nursing staff for a number of years - Elective have 1.78 WTE ward level nursing vacancies and Acute medicine have 24.37 WTE. • Medical recruitment remains strong – as previously noted a large number of Consultant and Middle Grade Doctors are due to commence between September and November, which include 'hard to fill' specialities such as Anaesthetics, Radiology, Histopathology, Surgery, and Obstetrics and Gynaecology. There does remain 'hard to fill' medical posts in Dermatology, and Accident and Emergency (albeit there has been some interest in the recent advert). • It was noted that significant improvements had been made in the way the Trust embraces social media and the pro-active recruitment calendar was well received by the Committee. • The Trust took part in a joint recruitment fair with colleagues from Bolton Council, Bolton CCG, and the third sector in Bolton at the beginning of October. The event was very well attended with over 240 visitors and is part of the locality strategy to market Bolton as a great place to live and which will support the work we do to ensure the Trust is seen as a great place to work.	Agreed actions: • Update on the 'Bolton Brand' work programme at the next meeting

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Committee/Group Chair's Report

Agency (Standing item)	**Amber**	• It was noted that there has been a significant decrease in Agency Spend when compared to previous months. The Trust is £270k behind the internally set Agency forecast (as per Annual Plan). • The majority of agency spend is due to vacancies (65%), with the main pressures being in nursing and medical agency usage. • Elective Care in particular are forecasting a significant reduction in agency spend in October when a number of key roles will be filled. • A meeting took place with NHSi colleagues (end of September, 2018) to further review the measures that Bolton are taking to reduce their reliance on Agency Spend. This meeting was very helpful and provided an opportunity for the Trust to embrace further 'best practice' ideas and to provided re-assurance to the Trust Executive Director that all appropriate steps were being taken.	Agreed actions: • Remain a standing item on the agenda with an update being provided on the enabling actions being taken at a Divisional and Trust level to drive down Agency rates.
GMC Survey	Amber	• Compared to other Trusts in the region, Bolton FT's performance was largely average, although there were areas of positive & negative feedback. • Our Paediatrics, Neonatology, Urology, ENT and A&E departments notably excelled in many areas of performance compared to other Trusts in the region. • It was noted that work programmes had commenced to look at the areas that had not reported positively – Obstetrics & Gynaecology and Respiratory Medicine	Agreed actions:- • The report was noted. Update to be provided to the Committee following the forthcoming re-visit.

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Committee/Group Chair's Report

Workforce Workstream - ICIP	Amber	• The Committee reviewed the following workforce related workstreams:- Medical Workforce, Nursing Workforce and Other Workforce • Given the position of the Medical Workforce workstream it was noted that steps have been put in place to re-vitalise this work. Focused Project Management support has been identified and work has commenced	Agreed actions:- • The report was noted. • Update on the Medical Workforce Workstream to be considered at a future Executive team
Audit Committee action	Green	• An audit review of the Trust payroll function was commissioned and undertaken in September, 2018. The audit report classified as 'low risk' but recommended that a number of action and controls should be introduced. The paper provided assurance that all of these actions have been undertaken in the manner identified in the report.	Agreed actions;- • The report was noted
Workforce Operational Committee – Chair report	Green	• The report was noted. • All matters escalated from this meeting were on the agenda.	None • The report was noted
Strategic Workforce Board	Green	• The report was noted. Particular discussion took place regarding the scale of the OD agenda required to support this significant agenda.	None • The report was noted
Risks escalated A. None			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Urgent and Emergency Care Board	Report to:	CCG/Trust Boards
Date of Meeting:	9th October 2018	Date of next meeting:	15th November 2018
Chair:	Su Long	Parent Committee:	
Members Present:	All partners represented	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
GM UEC winter planning request received		CCG	• Request from GM to review the system winter plan • Emphasis on system response and bed occupancy as key factor at Trust	• Paper to Next Boards
Social Care / reablement		LA	• Capacity & Demand work for Care Homes • Audit of long term care admissions • Initial feedback from Trusted Assessment Cases • Additional Community Bed Capacity Update • Red Bag Scheme	• Monitor schemes • Relaunch of red bag scheme
Safe and Sober unit			• Discussion initiated by Trust proposing the establishment of a safe and sober unit development off site	• Initial costs do not demonstrate VFM, further work required
NWAS update • Alternatives to transfer • 111			• Presentation of impact of pathways for alternatives to transfer demonstrate increased uptake • Paper received on 111 performance	• further on alternative pathways with community services • continue monitoring
Comments				
Risks escalated				

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Bolton Urgent & Emergency Care Board

System Self-Assessment for Winter 2018/19

Winter 2017/18 Review

- In March 2018 a review of Winter 2017/18 was undertaken in the form of a system wide workshop.

- The workshop heard from all parts of the system to understand the impact of winter 2017/18, including the increasing demand on all services as a result of increased activity and higher acuity linked.

- One of the key reasons for this increased demand was the extraordinary strain of Flu and the rapid testing capability at Bolton FT which is believed to have been beneficial in terms of containing spread but impacted on bed management and cohorting requirements. The flu also reduced capacity as the wider health and care workforce was affected.

Winter 2018/19 Predictions

- Building on the data analysis from previous years, Bolton FT has built a bespoke bed modelling tool throughout the summer period, to ensure accurate capacity planning for Winter 2018/19.

- The tool has been utilised to identify the key requirements of achieving 90% bed occupancy, which would be critical to the achievement of A&E 4hr performance.

- The key requirements are identified as reducing Length of Stay by 0.3 days, reducing emergency hospital admissions by 4 per day, and opening 22 escalation beds by December 2018.

Bolton FT Acute Bed Modelling Assurance

(Adult acute specialties only, excludes surgical specialties, T&O and gynaecology – as they are modelled separately)

- The bed modelling tool has be utilised for assurance using 3 scenarios:-
  - Best case – opening escalation beds, reducing LoS by 0.3 days & achieving a reduction in 4 admissions per day. (would result in achieving bed occupancy within a range of 84% and 92% across the winter months)
  - Median case – Opening escalation beds, reducing LoS by 0.2 days & achieving a reduction in 2 admissions per day (would increase the expected occupancy to around 97%)
  - Worst case – only opening the additional escalation beds and not achieving any reduction in LoS or admissions (would increase occupancy to almost 100%)

N.B. the model is in the process of being updated to reflect the recent improvements in a number of key metrics. All of the above is based on the assumption that the flu impact will be at "normal" levels. LoS reduction is all admissions.

Acute Bed Modelling Summary

- The bed modelling confirms that the acute bed stock is sufficient to meet demand with the addition of 22 escalation beds over the winter period.

- The model demonstrates that the focus needs to be on improving flow and reducing admissions and delays.

Intermediate Tier Capacity & Demand Modelling

- Utilising the same tools and principles of the Bolton FT acute bed modelling, work has also been done to model the capacity for the Intermediate tier Services.
- A number of assumptions have been built into the model to predict the amount of capacity needed in the IMT bed based and community services. These assumptions include the following:-

  - Target occupancy 98% in the community beds
  - Medically Optimised and Delayed Transfers of Care targets built in
  - Re-ablement scheduling system achieving a > 10% improvement on downtime
  - Increase in D2A Pathway 1 (Home based) to 10 per week from 6
  - 16% reduction in LoS at Lab Lodge and 10% at Wilfred Geere
  - 7 day domiciliary assessments being in place
  - An increase in Step up activity to 30%
  - Demographic growth has been built in

ITS Bed capacity modelling outcome

Current:

Darley: 30, + an additional 5 in winter months
Laburnum: 32
Wilfred Gere: 7

Projections - IMC Bed Base

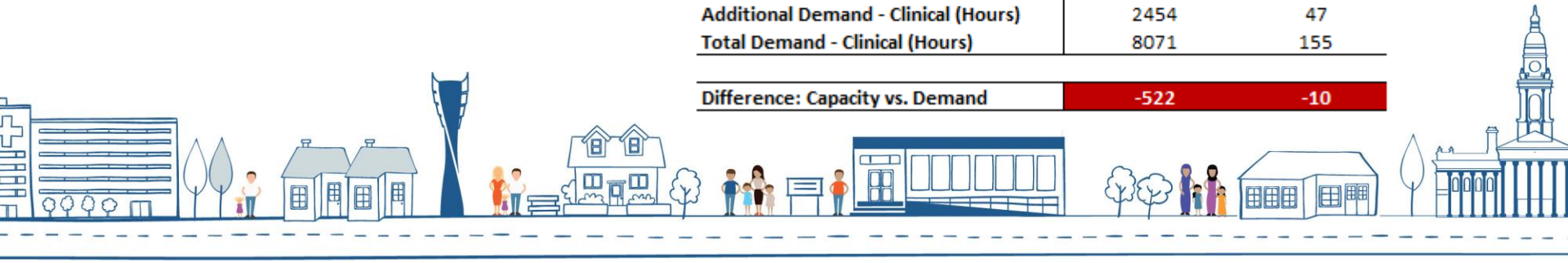
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Spring	Summer	Autumn	Winter	2018/19	2019/20	2020/21	2021/22	2022/23
No of Beds Required at Target Occupancy	88	86	74	66	73	72	75	79	77	83	83	76	83	71	75	81	78	78	79	79	79
Difference vs. Bed Base	-6	-3	-15	-19	-6	-2	6	10	8	9	9	2	-2	-13	5	9	-1	0	0	1	1

	2018/19			2019/20	2020/21	2021/22	2022/23
Required IMC Bed Base	Min	Avg	Max	Avg	Avg	Avg	Avg
	66	78	88	78	79	79	79

ITS community teams capacity modelling outcome

IMC@Home	2018/19 Overall	2018/19 Per Week (avg)
Base Capacity - Clinical (Hours)	23276	448
Additional Capacity - Clinical (Hours)	1488	29
Total Capacity - Clinical (Hours)	24764	476
Base Demand - Clinical (Hours)	19818	381
Additional Demand - Clinical (Hours)	4840	93
Total Demand - Clinical (Hours)	24657	474
Difference: Capacity vs. Demand (Hours)	107	2

Reablement	2018/19 Overall	2018/19 Per Week (avg)
Base Capacity - Clinical (Hours)	7451	143
Additional Capacity - Clinical (Hours)	98	2
Total Capacity - Clinical (Hours)	7549	145
Base Demand - Clinical (Hours)	5617	108
Additional Demand - Clinical (Hours)	2454	47
Total Demand - Clinical (Hours)	8071	155
Difference: Capacity vs. Demand	-522	-10



ITS Capacity Modelling Summary

- The bed modelling identified that there is a gap in the amount of available beds, compared to capacity, as follows:

Nov	Dec	Jan	Feb	Mar
5	2	9	9	2

- The following 3 high level actions have been undertaken to ensure sustainability of ITS capacity through the year with a specific focus on the winter period:
  1. Commissioning additional 9 “beds” from November to March.
  2. Ensuring the delivery of the service efficiencies in terms of reduced LoS, reduced delays and enhanced capacity.
  3. Commissioning of additional reablement capacity alongside service redesign to improve efficiency.

Winter 2018/19 Predictions

- In addition to the local work, the system has considered the Utilisation Management Teams report for Bolton with predictive activity based on historical data, that summarises to outcome for Bolton in a “do nothing” scenario.

- The report highlighted a prediction of 78% A&E performance for winter 2018/19 if everything remained the same as last winter.

- The Bolton locality believes that the system wide actions being undertaken will address this risk, as demonstrated in the following slides.

What is the system doing to ensure achievement of 90% A&E performance for winter 2018/19

Bolton Foundation Trust Seasonal Plan key actions

- Increase of 22 acute beds to manage acuity from December to May
- Additional respiratory nursing capacity for community and impatient care from November - March
- Dedicated ward pharmacists on assessment areas to speed discharge
- Increase in community based IV therapy to reduce admissions and LoS (Sept - March)
- Increase the number of admissions avoided by Home First from 6 – 10 a day
- Increase the numbers of patients streamed to primary care from 30-40 per day
- Mobilise of the full streaming model at the front door ensuring patients streamed straight to ACU, Home first etc.
- Completion of the capital works to create new ambulance handover bays and new increased capacity for resus.
- Increased day case activity to reduce the reliance on inpatients beds
- Step down elective activity from 23rd December to 14th January 2019.
- Increase bed capacity at Darley Court by 5 beds.
- Reduced Medically Optimised list size and LOS on list

Bolton FT Progress Tracking

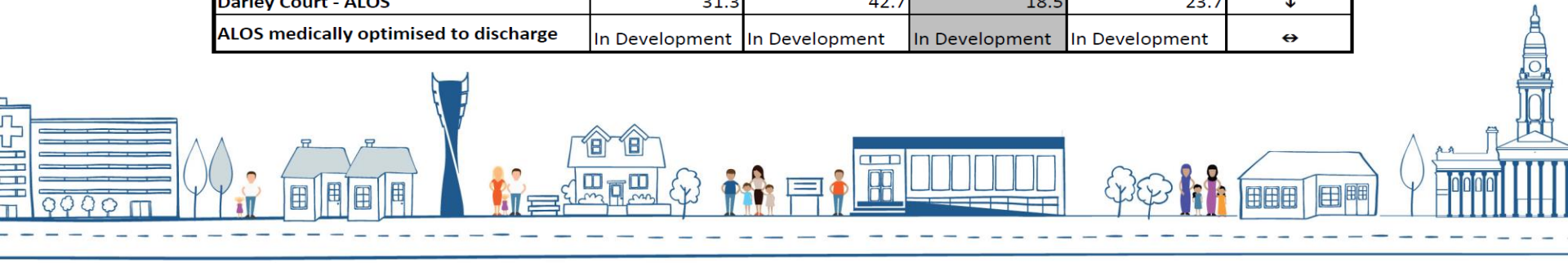
- An Example of Bolton FT's weekly tracker to align with their seasonal plan is shown below, which is , monitored through weekly SRG

Seasonal Dashboard

07/10/2018 ← Select date

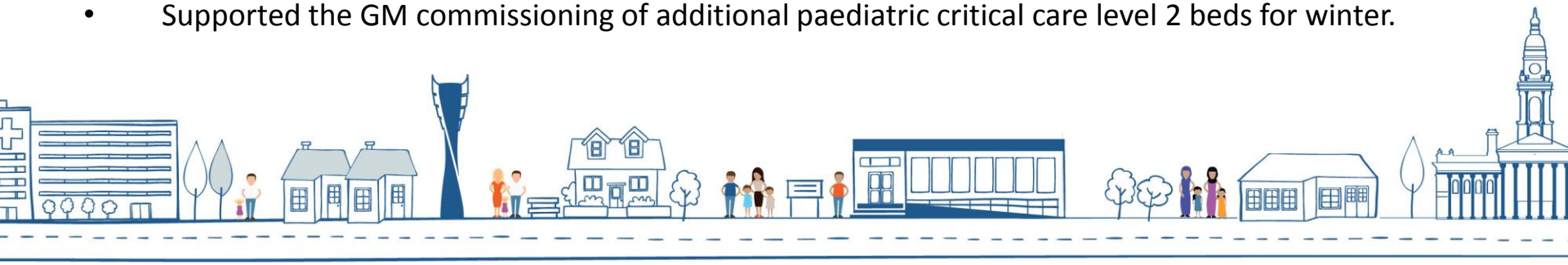
27 Week number

	Previous 4 week average	Previous week	Current week (27)	Week (27) in 2017/18	Weekly Direction of travel
A&E Performance	87.3%	88.1%	89.8%	89.1%	↑
A&E Attendances - Type 1	2006	2090	2085	2027	↓
A&E Attendances - Type 3	203	207	237	260	↑
Ambulance Attendances	552	582	592	655	↑
Home First Deflections	33	31	36	23	↑
Paediatric Non-Elective Admissions	146	153	153	184	↔
MAU (D1,D2) - number with LOS over 48 hours	42	46	41	30	↓
Long Stay Patients 7+	227	218	210	228	↓
Long Stay Patients 14+	131	125	124	132	↓
Long Stay Patients 21+	84	81	80	82	↓
Discharges by 12	28.7%	31.1%	31.8%	23.2%	↑
Discharges by 4	63.7%	62.7%	67.6%	61.9%	↑
IV Therapy contacts	154	147	68	182	↓
Day case patients in inpatient beds	3.4%	3.5%	3.8%	3.90%	↑
Discharge to assess at home	In Development	In Development	In Development	In Development	↔
Darley Court - Bed Occupancy	102%	99%	101%	80%	↑
Darley Court - ALOS	31.3	42.7	18.5	23.7	↓
ALOS medically optimised to discharge	In Development	In Development	In Development	In Development	↔



Bolton CCG

- Provided additional £1.5m of winter funding for agreed Bolton FT schemes (Acute & Community based).
- Provided GMMH with winter funding to increase capacity in CMHS and RAID capacity.
- Commissioned 5 additional beds from the care home sector to support the reduction of patients on the medically optimised list, with a focus of those in the process of choosing their preferred care home.
- Commissioned 2 “Extra Care Housing” beds to test a new model of working meeting a new demand in the system and supporting flow out of the hospital.
- Developed Trusted Assessments with a number of care homes for nursing beds through the support of the CHC team.
- Working with neighbouring CCGs to support timely discharge of out of area patients.
- Supported the GM commissioning of additional paediatric critical care level 2 beds for winter.



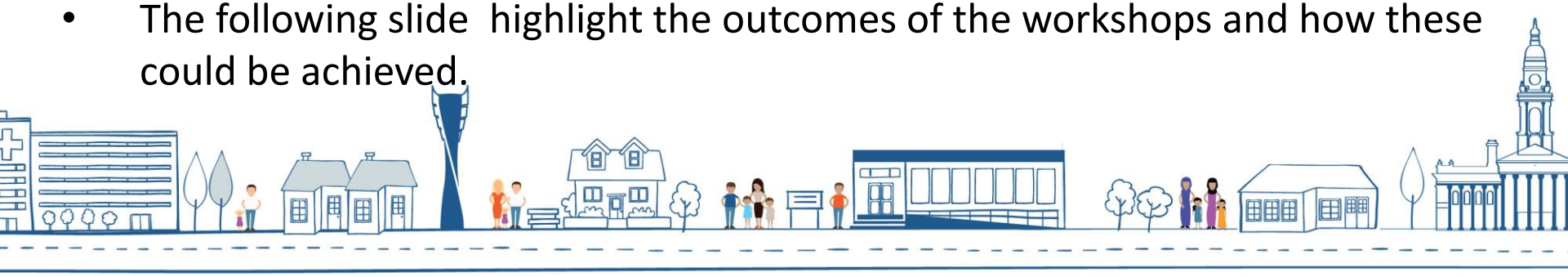
Primary Care

- The CCG Primary care team have worked with Neighbourhood GP Leads to carry out a winter planning exercise through a series of meetings in August and September.
- Practices were asked to :

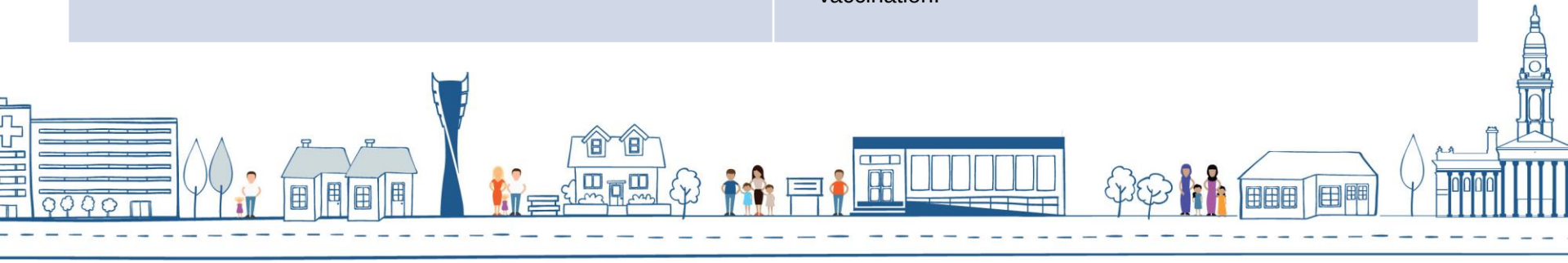
1. Discuss what your ‘core team’ might do differently to focus on patients
    - Winter planning appointment?
    - Better care plans?
    - Longer appointments?

2. Discuss what services you might need outside your ‘core team’ to support patients
    - Integrated Neighbourhood Team?
    - CVS services?
    - Specialist hospital staff?

- The following slide highlight the outcomes of the workshops and how these could be achieved.



Suggestions received	Addressed by…
Neighbourhood MDT meeting	This is part of the Bolton Quality Contract and practices are encouraged to ensure these happen. Farnworth / Kearsley have also submitted a TF bid to test out innovation in neighbourhood MDTs
Less staff holidays during winter	Practices will be organising this through business as usual.
More on the day appointments during winter	Practices will be organising this through business as usual.
Better relationships and knowledge of CVS	Darren Knight and Sue Longden invited to clinical leads meetings
Reducing Hospital Admissions and A&E attendances	• Following a review of practice data in October, all practices have been set a target to reduce hospital admissions by 3 and attendances by 3.
Proactive reviews: • Frequent fliers • COPD • Heart Failure • Moderate to Severe Rockwood Score	A work plan is being scoped to undertake the following: • All practices will be carrying out a full care plan review of all patients in these categories prior to winter. • These will be followed up by telephony reviews on a monthly basis. • There will be a work up of projects across primary care to support.
• Supporting the system to ensure minimal impact of Flu	• All practices support flu campaign and targets set for flu vaccination.



BARDOC (lead provider) – Primary Care Locality Service

- Extended Access in place across 3 hubs providing an addition 150hrs per week.
- Rotas planned to ensure capacity based on previous years demand.
- Call handling in place to support increased ATT activity.
- Supporting flu campaigns with developments for flu messages on call handling system.
- Working to develop direct booking into UTC from 111.
- Trialling near patient testing in 2 sites, including streaming service in A&E.

Bolton Council

Service area	Actions taken to date – Winter planning	Progress/Action
ICES **Equipment and minor adaptations**	Business case to increase establishment of store keeper and driver fitter to enable to respond to increased demand over 7 day week. Recruitment commenced to be in place by November 2018	Ongoing recruitment
Home care bookings **Packages of care**	Fundamental review of spot purchasing has identified a risk in the system, improved processes for bookings has been implemented. Bookings team to commence spot contracting role from September 2018. Escalation process in place as and when needed – daily huddle Main providers have over recruited to support holiday periods.	Discussions are taking place at an Exec level to develop a different approach to block book increased capacity through January for Home Care in the post Christmas response to avoid high levels of spot purchasing. Capacity monitoring underway
Restarts and tweaks to care packages	Home first team and D1 and D2 can do restarts from the assessment wards Agreement that over Bank holiday periods restart period extended to 6 days.	In place
Social Work	Social work resource and cover for Bank holidays will be in place in IDT and ITS. Over holiday and winter period minimum staffing levels agreed.	In place
Wilfred Geere D2A	Ability to flex up to 9 beds with prior agreement and commissioning of GP cover through GP Fed by CCG.	Agreement made for these to be in place from the 1st November 2018.
IMC/Reablement	Reablement implementing electronic systems September will deliver efficiencies and increase capacity 15%	ongoing

Greater Manchester Mental Health

Supporting Bed Occupancy and Patient Flow

GMMH have employed a Strategic Lead for Patient Flow, Development and Delivery to lead on all aspects of Patient Flow, reducing the use of OAP, identifying barriers to discharge to support flow through the Trust Inpatient services.

GMMH have twice-daily capacity reports and a daily 4pm teleconference identifying current demand and capacity which is shared with all Heads of Operations, on call managers across GMMH to ensure availability of beds.

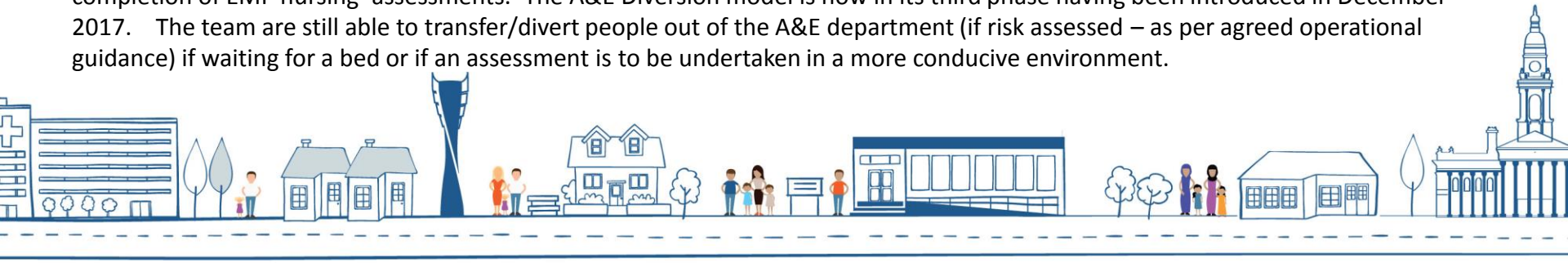
Detailed analysis has shown that there are unpredictable spikes in demand for mental health beds, there a bed Bureau model has been developed and is currently being consulted on across the organisation. This will be supported by an electronic inpatient flow management system to provide 24hr support, ensuring that inpatient beds are identified as they become available reducing the length of time service users wait for a bed.

Additional Capacity and Alternatives

- GMMH continue to work alongside the Local Authority in the development of the mental health respite facility, New Lane. A review of the model is being undertaken to enable increased capacity.
- An additional male acute mental health bed has been commissioned at Maryfield Court in Whalley Range, which again increases capacity in the system and reduces the likelihood of service users being placed out of area.

Bolton RAID/Mental Health Liaison Team

The team are nearing full establishment which will support both A&E and the acute hospital in respect of patient flow; including the completion of EMI 'nursing' assessments. The A&E Diversion model is now in its third phase having been introduced in December 2017. The team are still able to transfer/divert people out of the A&E department (if risk assessed – as per agreed operational guidance) if waiting for a bed or if an assessment is to be undertaken in a more conducive environment.



Greater Manchester Mental Health

- The Trust will participate in a program of vaccinations as outlined by the Department Of Health to ensure that a target of 75% of staff are vaccinated. Flu fighters have been identified locally and we have completed 4 training sessions already with a further 2 planned. Seasonal Flu clinics are available on the GMMH intranet site for staff to view across the Trust and attend on a drop in basis. The Seasonal Flu Campaign officially started on the 8th October 2018.

- Greater Manchester Mental Health Trust have a Trust Adverse Weather Resilience Plan which details how the trust will ensure service resilience during periods of adverse weather.

- The following Winter funded schemes have also been agreed with the CCG to provide additional capacity in the system.

Scheme	Evidence of need	Details of what will delivered	Operational date	End date	Overall UEC and MH system activity	Patient experience and outcomes
CMHT/Early Intervention Rapid Access	Complementary to the A&E Diversion Scheme allowing rapid access into CMHT for those individuals signposted. There is no current capacity within CMHT or Early Intervention given numbers on caseloads.	Additional Community Mental Health Practitioners, 1 for each Team (North, South and EIT)	1.10.18	31.3.19	Reduced pressure in the system	Improved access to CMHT for those presenting in crisis to A&E. Enabling the CMHT/EIT to be more responsive to escalated need in the winter period. Stress levels are exacerbated over the festive and post-Christmas winter period and so demand increases.
RAID – Improved access and working closely with IDT (and supporting home first) to quickly identify people who require assessment for potential EMI nursing care.	RAID service has significant pressures due to A&E and CYP demand.	Additional B6 Mental Health Practitioner to support RAID and to work closely with the IDT	1.10.18	31.3.19	Reduced pressure in system	Patients on medical wards can be seen in a more timely way, assessment could be completed quicker and potentially influencing reduced LOS and discharge.

NWAS

- Reconfiguration of the fleet to reduce number of RV's and increase DC ambulance to support achieving the ARP targets. 3 additional 12hr DCA's within the Bolton Group.
- Increasing referrals to the Admission Avoidance Community pathways, increasing overall ATT activity.
- Implementation of electronic devices in all vehicles to ensure crews have easy access to all alternative pathways and the Doc to avoid unnecessary conveyance to hospital.

Bolton System Communications Actions

- Worked with GMHSCP to develop robust winter comms to ensure the “Home First” messages are embedded with the public in an appropriate manner.

- Supported Flu planning and campaign to maximise the take up of the flu vaccination among the population of workforce.

System Risks

Category	Risk	Mitigation
Workforce	• Recruitment to additional posts identified across the system. • Retention of staff. • Impact of outbreak of infection in the workforce.	• Sickness management procedures in place. • Recruitment campaigns ongoing • Use of bank/agency where necessary. • Ensuring workforce are vaccinated against flu.
Demand	• Impact of flu will be greater than expected, causing increase in patients acuity and increased LoS • Infection outbreaks across the system • Impact of cancelling RTT • Rising prevalence of higher acuity mental health presentations.	• Bolton FT inflection control team closely monitoring flu trends as a proxy in line with public health England guidance. • Flu campaigns in place across the system, promoting vaccinations. • All age RAID in place and additional Mental Health capacity commissioning for the winter period.
Capacity	• Capital works not complete in time for opening of additional bed capacity on escalation wards. • Capital works in ED not complete in time, including Ambulance handover bays, resus capacity and streaming extension. • Infection outbreaks across the system • Impact of cancelling RTT	• Bolton FT have plans in place for some minimal • Close monitoring in place with service provider to ensure timely delivery
Finances	• Increased cost is if risks in capacity, demand and workforce are not fully mitigated, resulting in financial implications, such as additional spend on opening increase bed capacity or increase spend in agency etc.	• Close monitoring of all risks highlighted and tracking of spend.

Agenda Item No	

Meeting	Board of Directors

Date	25th October 2018

Title	Infection Prevention and Control Annual Report 2017-18

Executive Summary	This report provides a summary of the activities of the Infection Prevention and Control Team (IPCT) for the year 2017/18. It includes key issues such as; meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* figures, Carbapenemase Producing Enterobactericae (CPE) activity, audit activities and adverse incidents.

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

Next steps/future actions	Final approval at Trust Board			
	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	Richard Catlin, Assistant Director of Infection, Prevention and Control	Presented by	Trish Armstrong-Child, Director of Nursing

Infection Prevention and Control Annual Report

April 2017-March 2018

1. EXECUTIVE SUMMARY

This report is intended to give a concise overview of key activities in the Trust related to infection prevention and control (IPC), healthcare associated infections (HCAI) and antibiotic stewardship. IPC remains critical to the Trust as it is a core component in the delivery of clean, safe care; failures in IPC can lead to adverse outcomes for patients and a poor patient experience. Antimicrobial stewardship has increasingly been identified as a challenge for the UK and presents a legitimate risk of the widespread dissemination of multi-drug resistant organisms and is therefore reflected in this report and future plans.

The Trust has IPC and HCAI objectives set by NHS England related to *Clostridium difficile*[1] and meticillin resistant *Staphylococcus aureus* (MRSA)[2]. The Trust also has key IPC/HCAI objectives commissioned by Bolton CCG.

Fig. 1: Summary table of performance of 2017/18 HCAI cases as reported as part of the mandatory surveillance scheme

Organism	Cases Reported		
	All Cases	Trust Cases[3]	
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias	**8**	**2 Trust apportioned**	
***Clostridium difficile* toxin cases**	96	30 Trust apportioned	17 Performance cases[4]
Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias	101	15	
***Escherichia coli* (*E. coli*) bacteraemias**	290	44	
***Klebsiella spp.* bacteraemias**	54	9	
***Pseudomonas aeruginosa* bacteraemias**	12	2	

MRSA Bacteraemia

NHS England adopts a zero tolerance to MRSA bacteraemias with an expectation that acute providers will have no avoidable MRSA cases as determined by root cause analysis of the case.

There were two Trust assigned MRSA cases in 2017/18 compared with four cases in the previous year.

Clostridium difficile

NHS England sets the annual *Clostridium difficile* objectives. The objective for 2017/18 was no more than 19 Trust apportioned cases. There were 30 Trust apportioned cases in

[1] https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/
[2] https://www.england.nhs.uk/patientsafety/associated-infections/
[3] As determined by Department of Health definitions
[4] As agreed with Bolton CCG in line with agreed performance criteria

total. The Trust has an agreement with Bolton CCG that a decision regarding performance will be discussed at the CDT Harm Free Care Panels; if causal lapses in care are identified, then the case will be considered a performance case and so count against the target of 19 cases. Of the 30 Trust apportioned cases, there were no causal lapses in care in 13 instances meaning that there were 17 cases where lapses were noted.

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

There are no national objectives for MSSA cases but these are a good proxy for the delivery of safe care, in particular related to line and wound care which are frequently the root cause of these infections. In 2017/18, there were 15 Trust apportioned cases compared with 16 cases in the previous year.

Gram Negatives

In November 2016, the government announced an intention to reduce all Gram negative bloodstream infections by 50% by the end of 2020/21. As a consequence, two new organisms were added to the mandatory surveillance list: *Klebsiella* species and *Pseudomonas aeruginosa*.

***Escherichia coli* (*E. coli*) Bacteraemia**

E. coli bacteraemias were brought into line with MRSA and MSSA and reported as Trust and non-Trust apportioned based on the same criteria. The figures for these were applied retrospectively. In 20117/18 there were 290 cases in total compared to 284 in 2016/17. There were 44 Trust apportioned cases compared with 50 cases for the previous year.

***Pseudomonas aeruginosa* Bacteraemia**

There were 12 *Pseudomonas aeruginosa* bacteraemias in 2017/18 in comparison with eight cases in the previous year. Of these, two were Trust apportioned compared with two in 2016/17.

Klebsiella spp. Bacteraemia

This surveillance includes all species of *Klebsiella* – referred to as *Klebsiella spp.* There were 54 *Klebsiella spp.* bacteraemias in 2017/18 in comparison with 40 cases in the previous year. Of these, nine were Trust apportioned compared with 10 in 2016/17.

Carbapenemase Producing Enterobactericae (CPE)

In 2017/18 there were seven CPE cases identified at Bolton FT. Of these, six were colonised patients identified through screening and one case was as a result of a clinical infection. This compares with two cases in the previous year; both colonised patients from screening.

2. SYSTEMS TO MANAGE AND MONITOR THE PREVENTION AND CONTROL OF INFECTION PREVENTION AND CONTROL (IPC)

2.1 IPC Service Delivery

The IPCT remains unchanged from the structure in the previous year. The IPC functions continue to be split between the acute team who serve the Trust's acute services and the community team who serve the Trust's community functions as well as the Bolton Council. Bolton Council continues to commission Bolton Foundation Trust to provide community IPC services for their areas of accountability and the community services provided by Bolton FT.

The Director of Infection Prevention and Control (DIPC) retains overarching responsibility for IPC and reports directly to the Board. The Assistant DIPC (ADIPC) oversees the development and implementation of IPC strategy and policies for the acute and community teams, reporting directly to the DIPC. The ADIPC works in conjunction with the IPC doctor and the rest of the IPC team and key staff such as the antimicrobial pharmacist to develop strategy related to IPC and HCAI. The IPC matron has primary operational responsibility for day-to-day IPC management, management of the IPC team and oversight of key quality standards.

2.2 Microbiology Services

The provision of microbiology services also remains unchanged with three consultant microbiology posts (2.6 WTE).

The team continue to provide advice by phone, regular antimicrobial ward rounds for the review of patients with complex or prolonged antibiotic treatment and has recently established a weekly ward round to review *Clostridium difficile* toxin positive patients. The team also provide planned and prospective support for the critical care departments such as ICU and NICU.

Out of hours IPC advice continues to be provided by the microbiology service. The microbiology service also provides IPC advice Greater Manchester West Mental Health Trust under a service level agreement and a limited service for GPs.

The microbiology laboratory continues to provide a seven-day service for the diagnosis of *Clostridium difficile* toxin, Meticillin resistant *Staphylococcus aureus* (MRSA), and Norovirus infections.

2.3 Healthcare Associated Infection (HCAI) System

The IPCT makes use of ICNet; a proprietary system for the management of HCAI. The system extracts data from the Trust laboratory system and Patient Administration System. It uses this information to alert the IPCT to these results in real time and is also the electronic patient record for the IPCT. The system allows epidemiological information to be used from historical data. The system also allows the acute and community team to function collaboratively and independently with each able to access each other's notes and to alert the opposing team to new information e.g. a patient of interest can be flagged prior to or on discharge for follow-up in the community.

The system is operated on in a licensed fashion with an annual fee for licenses.

3. Healthcare Associated Infections (HCAI) performance

The Trust participates in the mandatory HCAI programmes. The following conditions are reported to the Department of Health (DH) via the Public Health England (PHE) Data Collection System (DCS):

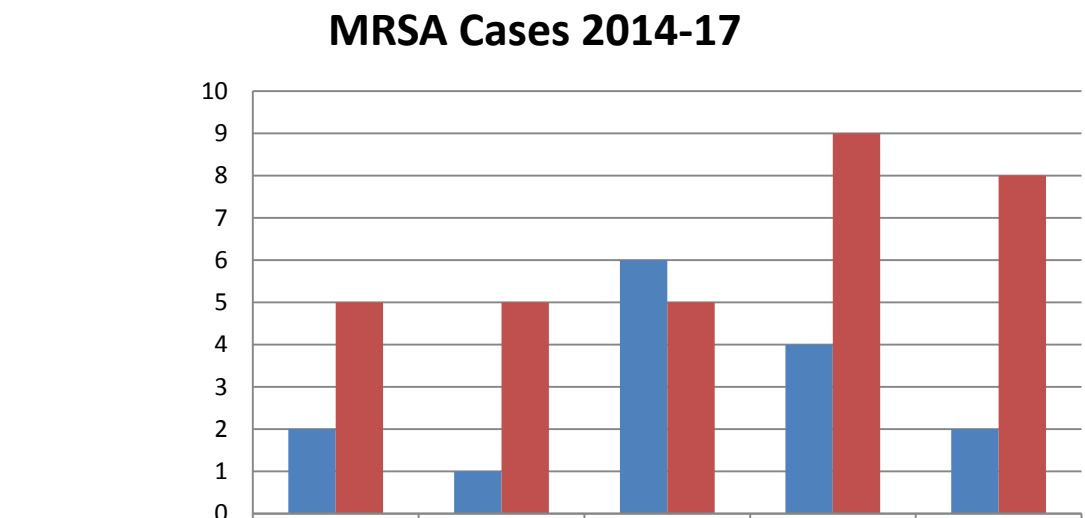
1. MRSA positive blood cultures
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures
4. *E. coli* positive blood cultures
5. *Klebsiella spp.* positive blood cultures
6. *Pseudomonas aeruginosa* blood cultures
7. Surgical Site Infections

3.1 MRSA Bacteraemia

The DH apportions cases to acute Trusts based on date of specimen collection. If blood cultures are collected on the day of admission or the following day then the case is automatically apportioned to the Clinical Commissioning Group (CCG). Specimens collected after this period are automatically apportioned to the Trust. These apportionments can be re-allocated following a post-infection review (PIR) in agreement with the CCG or NHS North if agreement cannot be reached with the CCG.

This surveillance only covers MRSA positive blood cultures and excludes results from screening and other clinical sites.

Fig. 2: MRSA cases



	2013/14	2014/15	2015/16	2016/17	2017/18
Trust Assigned	2	1	6	4	2
Non-Trust Assigned	5	5	5	9	8

3.1.1 Trust Apportioned Cases

NHS England has set a zero tolerance policy for MRSA bacteraemias so every acute provider has a trajectory of zero cases every year. During 2017/18 there were two Trust assigned MRSA bacteraemias.

The cases were reviewed using PIR methodology:

1. One case was related to a dialysis line in a known MRSA positive patient inserted and managed by Salford Royal Foundation Trust. This case was unsuccessfully appealed
2. One case related to a urinary tract infection in a patient who became colonised with MRSA following admission to Royal Bolton Hospital

The IPC team continues to work with the clinical divisions in developing the ANTT competence process.

3.1.2 Non-Trust Apportioned MRSA Cases

There were eight non-Trust assigned cases in 17/18. These cases have also been reviewed using PIR methodology. In year, the support by Bolton FT for the CCG to undertake these reviews has been strengthened to improve shared learning.

3.1.3 Post Infection Review (PIR) of MRSA Bacteraemia Cases

The Trust follows the mandated NHS England PIR process[5] in conjunction with the CCG. This requires for a case to be reviewed and fed back to a joint Trust/CCG group to agree apportionment.

3.1.4 MRSA Screening

The Trust has maintained a universal policy to MRSA screening with all elective and non-elective admissions being screened for MRSA on admission to the Trust. Additional screening is undertaken in the critical care departments of the Trust where patients are screened on admission to the relevant unit and on a weekly basis. Elective patients may also be screened as part of their pre-admission pathway to maximise safety prior to surgery or other invasive procedures.

Patients are re-screened for MRSA weekly once they have been an inpatient for 14 days or more.

Patients who have become colonised with MRSA after admission are now reviewed to determine measures to reduce future likelihood.

3.2 *Clostridium difficile*

The DH apportions cases to acute Trusts based on date of specimen collection. If a stool specimen is collected on the day of admission, the following day or the day after that, then the case is automatically apportioned to the Clinical Commissioning Group (CCG). Specimens collected after this period are automatically apportioned to the Trust. There is no agreed process for apportionment to be re-allocated, but there is now an agreement with the CCG on acceptable standards of care for patients with possible *Clostridium difficile* infection. If the Trust can demonstrate that there have been no lapses of care then the CCG has agreed to consider these cases as not counting to performance.

[5] http://www.england.nhs.uk/wp-content/uploads/2014/04/mrsa-pir-guid-april14.pdf

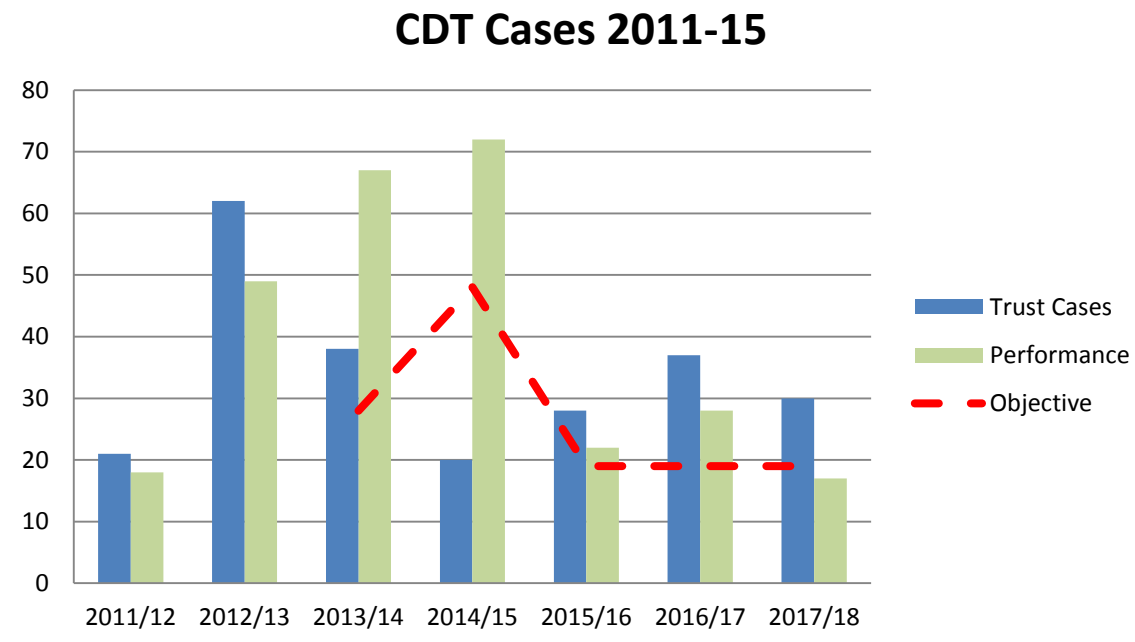
The Trust remains complaint follows the Department of Health guidelines for *C. difficile* testing[6]. These guidelines stipulate that all stool specimens type 5-7 on the Bristol Stool Chart (BSC) should be tested if there is no other clear cause of diarrhoea. All samples submitted to the lab from the acute services in patients older than two years that meet this definition should always be tested for CDT in the laboratory, additional to any other test request. Any sample in a patient over the age of 65 from community patients should be tested for CDT additional to any other tests requested.

The test should be undertaken using a two-step algorithm with a sensitive screening test; step one using glutamate dehydrogenase enzyme immunoassay (GDH EIA) or *Clostridium difficile* toxin polymerase chain reaction (CDT PCR). Step two using CDT EIA. It is only the CDT EIA positive cases that are mandated for reporting. Bolton FT uses GDH EIA followed by CDT EIA.

3.2.1 Trust Apportioned Cases

The objective for Bolton FT by NHS England was no more than 19 Trust apportioned cases. The Trust ended the year with 37 Trust apportioned cases in total. In agreement with Bolton CCG nine cases were considered to have no lapses in care and so were not considered to be performance cases contributing to the objective of 19 cases; the objective was still exceeded with 28 cases being considered performance cases.

Fig. 3: CDT cases



Trust apportioned cases are subject to a review which is undertaken using a guided root cause analysis approach. The purpose of these is to review the care provided and assess whether the care delivered was safe and appropriate. They are reviewed to establish whether care might have contributed to the risk of the patient developing a CDT infection and if this is the case, whether the corresponding policy was followed.

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf

The clinical teams are responsible for the review. On the day of the result, the ward/department management team (patient consultant, ward manager and matron) are notified and given a date for the case to be fed back. The review should be multidisciplinary and it has been agreed with the Divisional Heads of Division that the patient's consultant will be ultimately responsible for the review. The review should be undertaken using a multidisciplinary approach and should be fed back (as a minimum) by a senior doctor and a senior nurse from the department. The case is fed back to a Harm Free Care Panel consisting of:

- DIPC or ADIPC (chair)
- IPC Doctor or Consultant Microbiologist
- Medical Director
- Antimicrobial pharmacist

The themes that have emerged from reviews of cases in 2017/18 are:

- In 10 cases the panel identified a failure to collect a sample in a prompt fashion
- In three cases the patient did not have an altered bowel chart in use at the time of the result
- In three cases the patient's bowel habit was not documented using the Bristol Stool Chart definitions (see **Appendix 1**)
- In 10 cases, the panel concluded that there was a failure to isolate the patient in a prompt fashion

3.2.1.2 Outbreaks

There were no outbreaks *Clostridium difficile* infection in 2016/17.

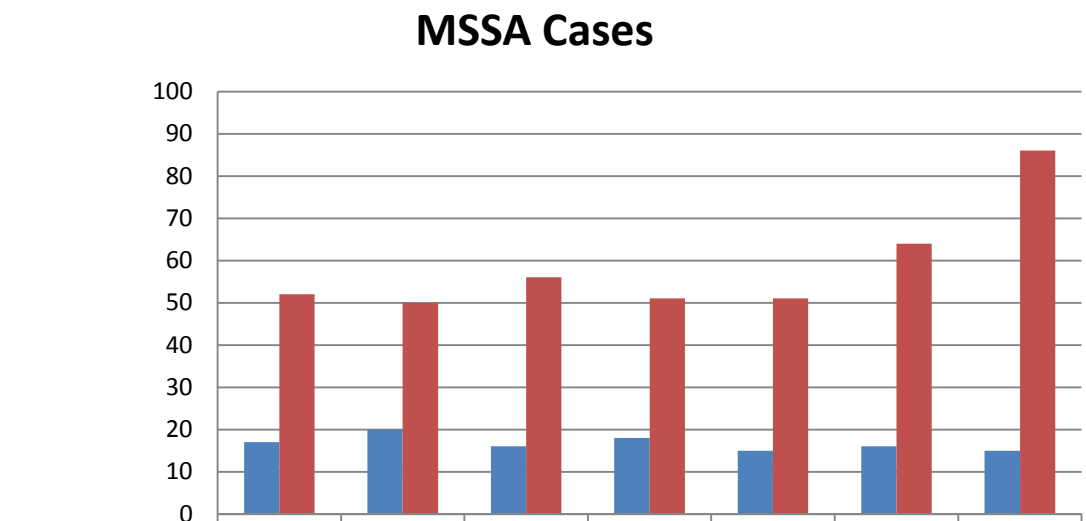
3.3 MSSA Bacteraemia

There are no national targets for MSSA cases. The DH apportions cases to acute Trusts based on date of specimen collection in the same way it does for MRSA. If blood cultures are collected on the day of admission or the following day then the case is automatically apportioned to the Clinical Commissioning Group (CCG). Specimens collected after this period are automatically apportioned to the Trust.

This surveillance only covers MSSA positive blood cultures and excludes results from screening and other clinical sites.

In summary, the cases apportioned to the Trust appear to be static whilst a rise in the non-Trust apportioned cases has been noted.

Fig. 4: MSSA cases



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Trust Cases	17	20	16	18	15	16	15
Non-Trust Cases	52	50	56	51	51	64	86

The risks associated with MRSA infections apply to MSSA cases; infections are predominantly linked to wound and line infections. Efforts to reduce the risk of MRSA infections will also reduce the likelihood of MSSA infections.

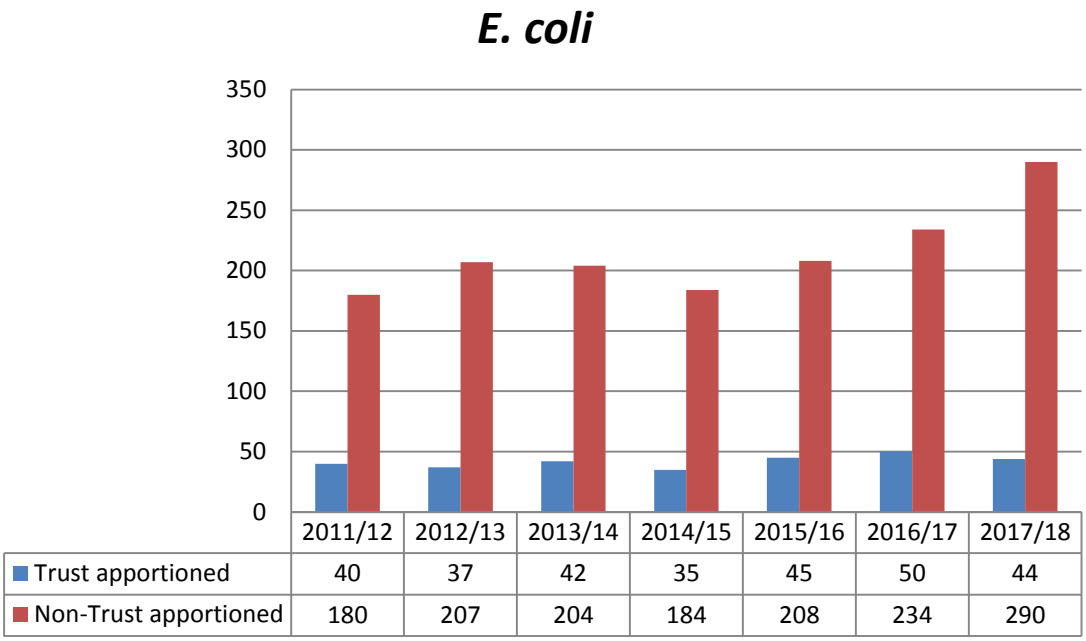
Gram Negatives

In November 2016, the government announced an intention to reduce all Gram negative bloodstream infections by 50% by the end of 2020/21. As a consequence, two new organisms were added to the mandatory surveillance list: *Klebsiella* species and *Pseudomonas aeruginosa*.

3.4 *E. coli* Bacteraemia

E. coli infections are much more complex than MRSA or MSSA infections and much less likely to attributed only to healthcare provision with personal hygiene and levels of hydration key risk factors for these infections.

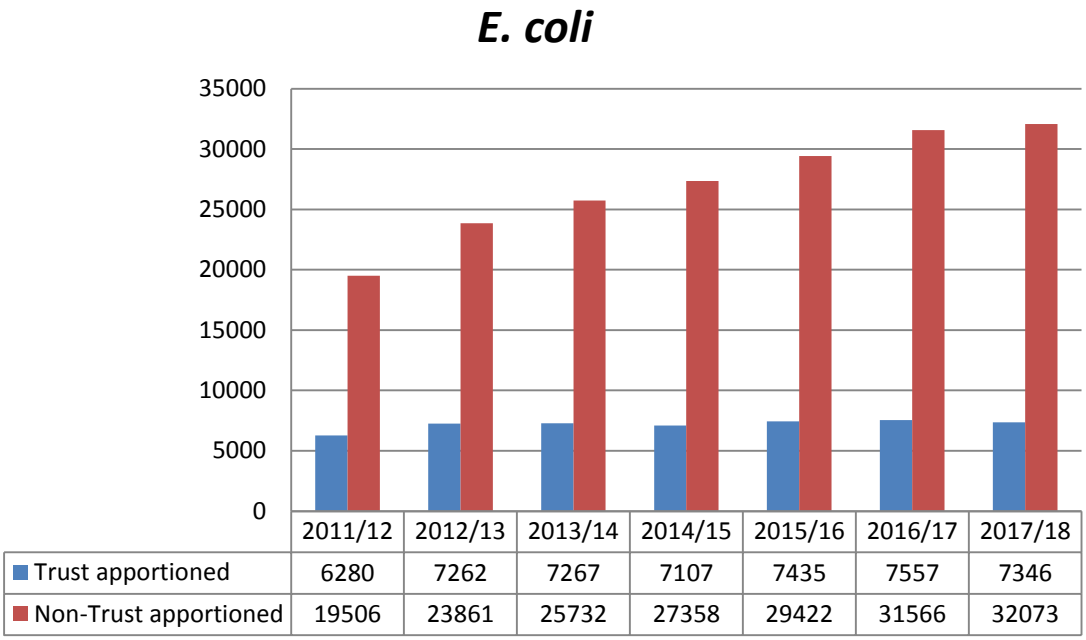
Fig. 5: *E. coli* cases



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Trust apportioned	40	37	42	35	45	50	44
Non-Trust apportioned	180	207	204	184	208	234	290

The trend locally is rising and this matched on a national level with the trajectories being broadly similar.

Fig. 6: *E. coli* cases – UK



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Trust apportioned	6280	7262	7267	7107	7435	7557	7346
Non-Trust apportioned	19506	23861	25732	27358	29422	31566	32073

There are *E. coli* cases that are directly related to the provision of healthcare – *E. coli* infections due to urinary tract infections in patients with indwelling urinary catheters – others are less clear although hydration and cleanliness are known to be important.

The Trust has seen a reduction in *E. coli* BSIs; the reasons for this are likely to be:

- Improved intentional rounding – patients are being encouraged to drink on a regular basis and are having their hygiene needs met in a more planned fashion

- Standardised fluid balance recording – the Sepsis team have focussed on staff recording as part of sepsis awareness and a new fluid balance chart has been approved

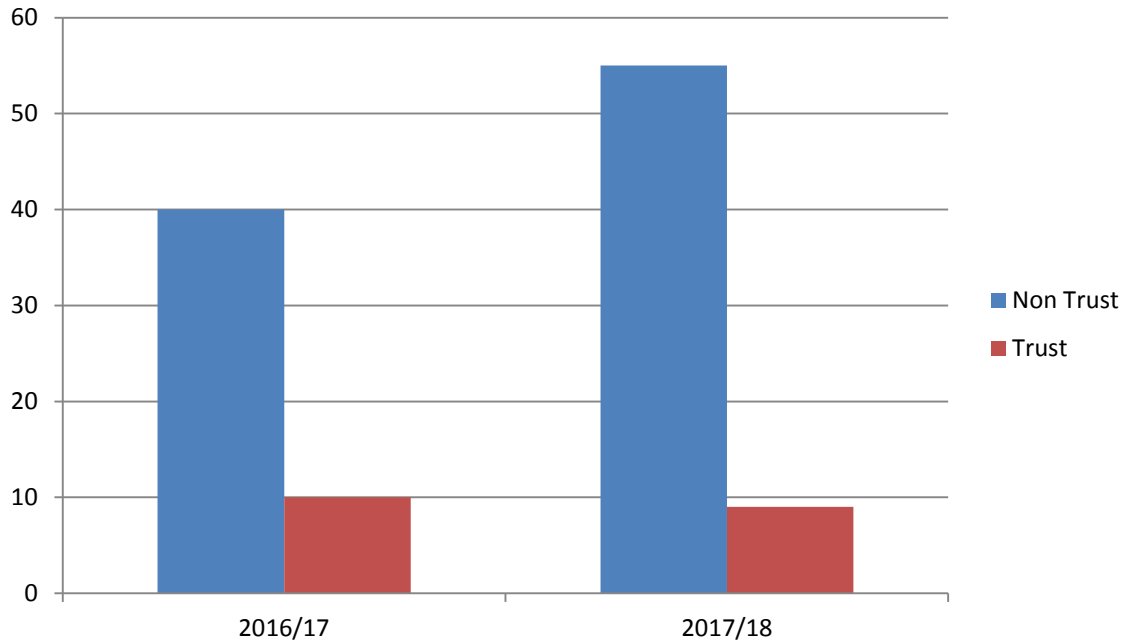
The Trust has been recognised by NHSi for the reductions made between calendar year 2016 and 2017 (see **Appendix 3**).

Detailed surveillance on the *E. coli* BSIs is now being undertaken. The IPCT continues to work closely with clinical staff to maintain best practice in regards to urinary catheter care.

3.5 *Klebsiella spp.* Bacteraemia

Mandatory surveillance of bloodstream infections caused by all species of *Klebsiella* started in 2017. There were 55 cases in total of which nine were apportioned to the Trust. This compares with 40 cases in total in 2016/17 of which 10 would have been apportioned to the Trust.

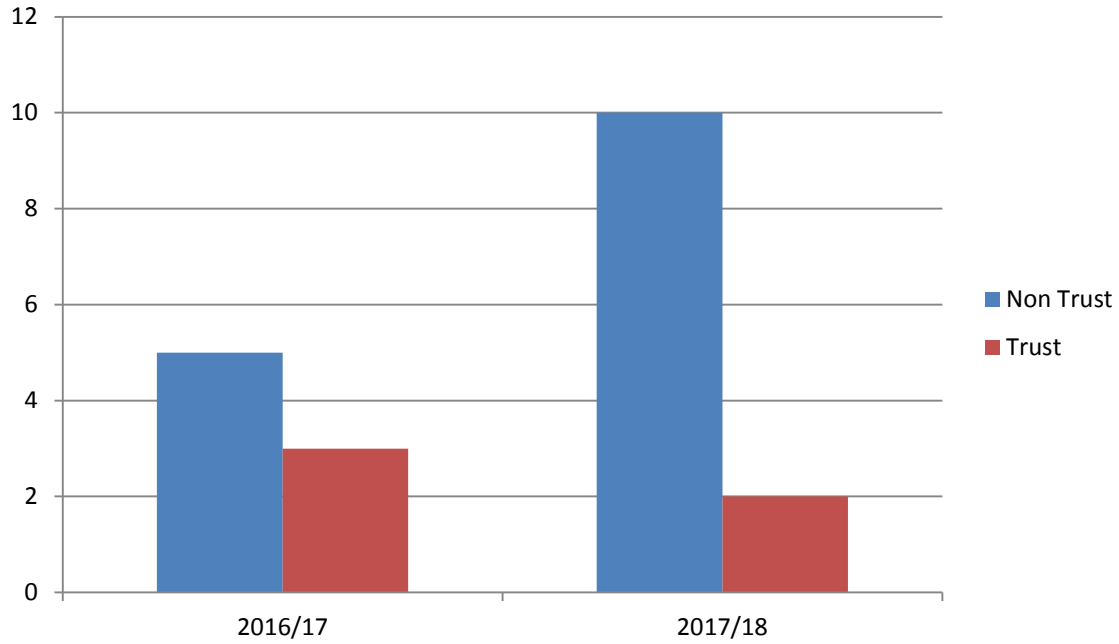
Fig. 7: *Klebsiella spp* Cases



3.6 *Pseudomonas aeruginosa* Bacteraemia

Mandatory surveillance of bloodstream infections caused by all species of *Pseudomonas aeruginosa* started in 2017. There were 12 cases of which two were Trust apportioned in 2017/18; this compares to eight and three respectively in 2016/17.

Fig. 8: *Pseudomonas aeruginosa* Cases



3.5 Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

There were no cases of GRE bacteraemia in the Trust in 2017/18.

3.6 Additional Surveillance

In addition to these HCAI, the IPC team undertakes active surveillance of other infections or conditions that are important because of the illness they cause and the impact or due to the antibiotic resistance they confer.

These organisms are reported to the IPC team either by the ICNet (the IPC team surveillance system and electronic patient record) or by the laboratory on suspicion or confirmation.

3.7 Surgical Site Infection Surveillance (SSIS)

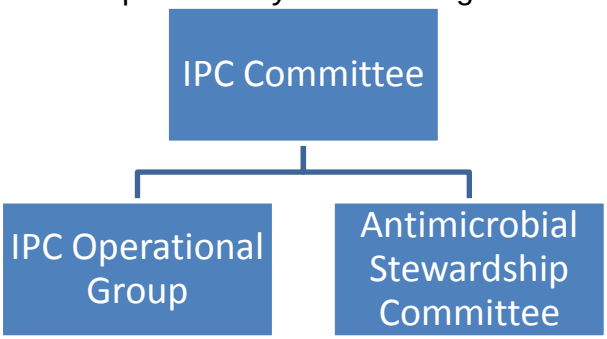
Every Trust that provides orthopaedic surgery is required by mandate to undertake SSIS. The minimum commitment for a Trust is one quarter of the year of at least total knee or hip replacements. At Bolton, the orthopaedic team ordinarily undertake ongoing surveillance (all quarters of every year) of total knee and total hip replacements as well as repairs of neck of femur resulting from fractures. This gives the Trust an excellent oversight of both elective and non-elective orthopaedic surgery. There were senior nursing capacity issues in year and the team were only able to undertake surveillance in the final quarter hence the small sample sizes. This has now been resolved, and the team intends to continue its commitment to continuous surveillance.

Fig. 9: Reported SSI

	Total Knee Replacement		Total Hip Replacement		Repair of Neck of Femur	
	RBH	National Average[7]	RBH	National Average	RBH	National Average
No. of procedures	202	328,585	162	305,108	315	95,968
No. of infections	1	4,355	0	2,903	1	1,207
Incidence of infection	0.5%	1.3%	0%	1%	0.3%	1.3%

4. Infection Prevention and Control Governance

IPC assurance continues to be provided by the following:



The IPC Committee was reviewed for 2016/17 and has strengthened the strategic role of the committee in line with other groups such as Clinical Governance and Quality. Accordingly, the IPC operational group has also been reviewed to take more of the developmental and operational role for IPC.

4.1 Infection Prevention Control Committee (IPCC)

The committee continues to meet bi-monthly and is chaired by the DIPC (the ADIPC in the DIPC's absence). This committee provides assurance to the DIPC to be reported to the Board where required and provides a strategic direction for the provision of IPC. The committee covers the following on a regular basis plus other topics by exception:

- HCAI surveillance
- Outbreaks/periods of increased incidence
- Antimicrobial stewardship
- Policy approval
- Emerging issues
- Divisional concerns
- Feedback from the whole health economy

The revised Terms of Reference are available on request.

[7] The national comparison is against reported figures without patient questionnaires completed for a like for like comparison

4.2 Infection Control Operational Group

This group also meets on a bi-monthly basis alternating with the IPC committee. The purpose of this group is much more operational and covers agenda items such as:

- IPC audits
- Operational impact of emerging issues
- HCAI performance and corresponding feedback from RCAs

The revised Terms of Reference are available on request.

4.3 Antibiotic Stewardship Committee (ASC)

The antimicrobial stewardship committee is chaired by the IPC doctor and includes representation from each of the clinical divisions. The remits of the group are to provide assurance on the following:

- Ensuring the relevant policies are in date and evidence based
- Provide assurance that key antibiotic prescribing policies are audited and that the audits are fed back
- The Trust has a strategy for providing safe and effective care related to antibiotic prescribing and use

The committee oversees the audit of antibiotic prescribing against the standards set out in the DH Start Smart Then Focus[8]. There are five auditable standard:

1. Compliance with Trust Antibiotic Guidelines (*including prescription in line with culture and sensitivity testing and/or microbiology recommendation).*
2. Indication for treatment written in the patient case notes at the point of antibiotic initiation.
3. Indication for treatment written in the antibiotic section of the prescription chart.
4. Stop date or a review clearly documented in the case notes by 48 hrs.
5. Stop or review date clearly documented on the prescription chart by 48 hrs.

Trustwide Compliance with Each Standard:

The set the Trust an objective of at least 85% compliance with all five standards for 2016/17.

Fig. 9: Antimicrobial stewardship compliance

Quarter	Compliance
Quarter 1	77.4%
Quarter 2	Audit not completed
Quarter 3	84.6%
Quarter 4	80.3%
Average	**80.8%**

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

This falls short of the stated objective of 85%, and demonstrates maintenance of the standards from the previous year (average 80.7%). The IPC committee has reviewed the audits and has agreed with the ASC recommendation that the objective for 2018/19 should be 85% again.

4.4 Representation at other Trust wide groups

Members of the IPCT represent the service at a number of Trust wide groups such as the medical devices group, Professional Advisory Group (PAG), Trust Health and Safety Committee and is invited into other Trustwide groups such as building projects as required.

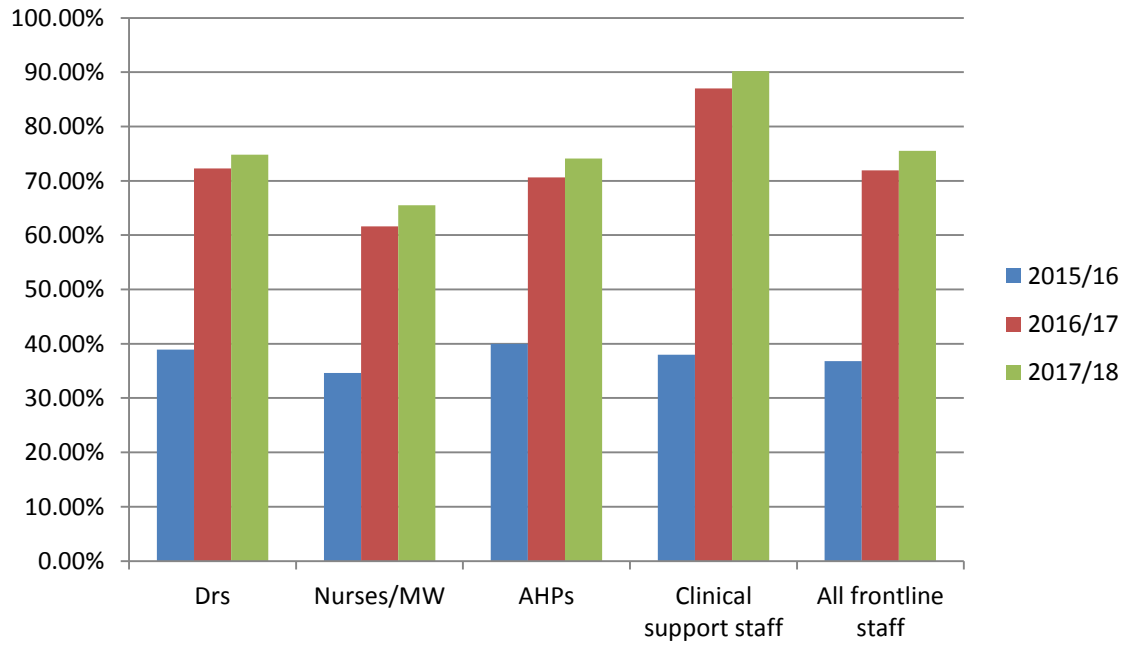
The IPCT also represent the Trust at external meetings including the Greater Manchester West Mental Health Trust IPCC, North West Infection Control (NORWIC) and the NHS North IPC collaborative group.

5. Flu

5.1 Staff Flu Vaccination Campaign

The IPCT led on a successful flu vaccination programme for frontline staff in 2017/18[9]. Uptake in all frontline staff groups increased based on the previous years. Overall uptake for the Trust for frontline healthcare staff was 75.47% representing 3446 frontline staff having the vaccine and up from 3005 in the previous year.

Fig. 10: Flu Vaccine Uptake



In total 4310 staff were vaccinated including non-frontline staff – again an increase on the 3743 staff vaccinated in the previous year.

[9] Frontline staff are classified by the DH as: doctors, GPs, qualified nurses/midwives, other registered healthcare professionals and support staff to clinical staff

5.1 Seasonal Flu

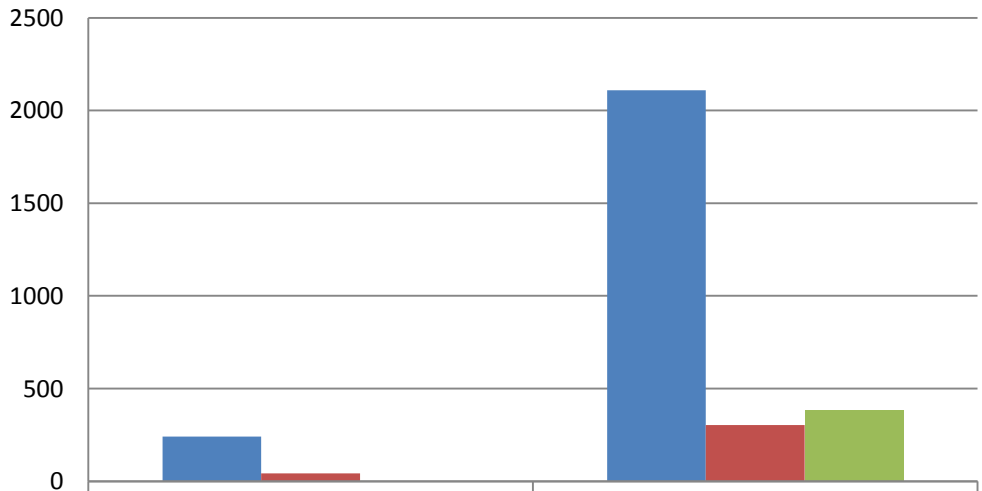
The 2017 flu season was a very severe one with Public Health England noting in their annual flu report (Surveillance of influenza and other respiratory viruses in the UK: Winter 2017 to 2018[10]) that there was:

> "…*moderate to high levels of influenza activity were observed in the UK with co-circulation of influenza B and influenza A (H3).*
>
> *The impact of this co-circulation was predominantly seen in older adults, with a consistent pattern of outbreaks in care homes noted. In addition, very high impact in terms of laboratory confirmed influenza hospital and ICU/HDU admissions particularly amongst older adults were observed*…"

The impact of flu was felt keenly across Bolton and the disease had a significant impact on patient admissions.

In the 2016 flu season there 242 samples submitted to the lab for flu tests and of these, 43 were positive for flu A and none were positive for flu B. In the 2017 the flu season started earlier than experience would suggest, with the first cases noted in September as opposed to mid to late October, finished later with cases still being detected in May as opposed to February as expected. There were 2109 requests for flu season in the 2017, with 304 patients positive for flu A and 382 samples positive for flu B.

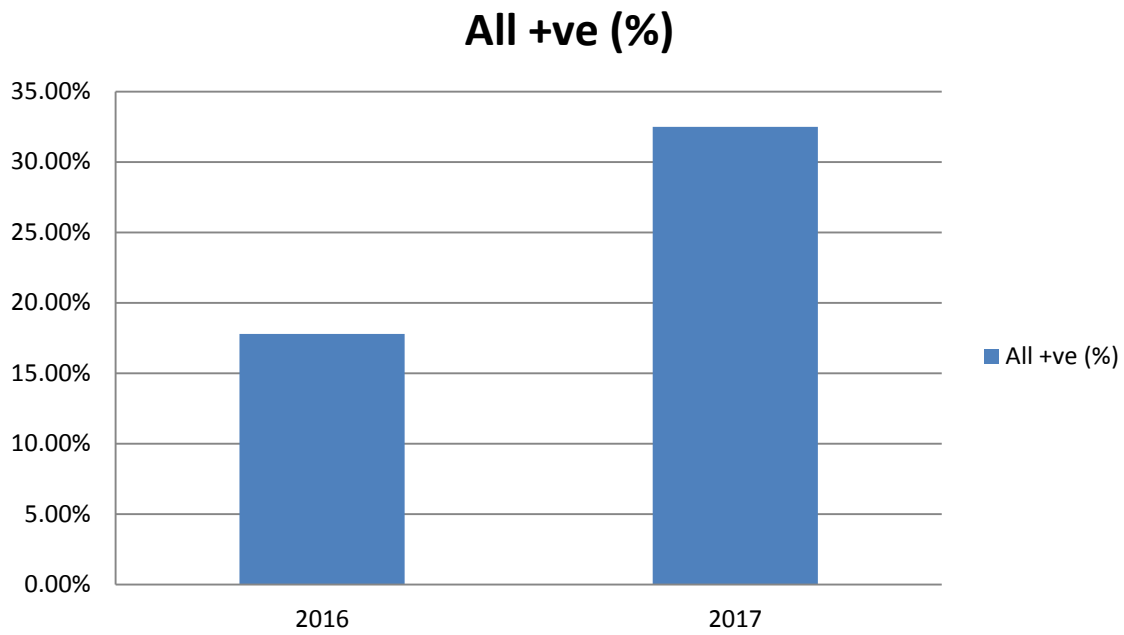
Fig. 11: Flu Testing



	2016	2017
Total Samples	242	2109
Flu A+ve	43	304
Flu B+ve	0	382

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/740606/Surveillance_of_influenza_and_other_respiratory_viruses_in_the_UK_2017_to_2018.pdf

Fig. 12: Proportion of Cases Positive



In addition to lab testing, Point of Care Testing (POCT) for flu was introduced to A&E as a live pilot. On top of the patients tested for flu in the laboratory, an additional 127 patients were tested in A&E. An additional 19 patients with flu A and 37 patients with flu B were diagnosed using the POCT.

This proved to be an essential tool in patient management as it meant that a fast, reliable test was available 24 hours/day whereas laboratory tests were available 8-5 each day. The test provided a result in 20 minutes and provided a positive result 80% and a negative result 94.5% as consistently as the laboratory test.

This was invaluable as 40% of patients were discharged safely home once a diagnosis of influenza was made.

The community IPC team managed 30 outbreaks of influenza like illness over the flu season affecting more than 390 residents. Flu was confirmed in 19 of these outbreaks (11 flu A and eight flu B) and other organisms in a further three; these outbreaks were caused by metapneuomovirus, rhinovirus and parainfluenza virus.

They also managed 15 outbreaks in nurseries, schools and colleges affecting scores of pupils. Flu was confirmed in 10 of these outbreaks; 10 flu A and one flu A and flu B.

6. Outbreaks

During 2017 there was an outbreak of *Pseudomonas aeruginosa* that affected the Neonatal Intensive Care Unit (NICU) and Special Care Baby Unit (SCBU). Three babies had *Pseudomonas aeruginosa* isolated from sputum specimens and a fourth baby was confirmed to be colonised with *Pseudomonas aeruginosa* as part of the screening actioned in response to the outbreak. All of the babies were discharged safely from NICU/SCBU with no appreciable harm caused by the incident. The three babies with *Pseudomonas aeruginosa* isolated from sputum were all given antibiotics but in two cases, this was precautionary rather than as clinical need.

The outbreak control team (OCT) concluded that the person to person and person to environment transmission had three key underlying causes:

1. **Clinical practices:** staff are likely to have contaminated the environment (sinks and taps most specifically) after contact with babies with *Pseudomonas aeruginosa* (Infection or colonisation). At the time of the outbreak, gelling hands after hand washing was not standard practice and it likely that taps and sinks that had become contaminated with *Pseudomonas aeruginosa* contaminated staff hands as part of hand washing. This in turn transferred to other babies on the hands of staff.
2. **Hygiene practices:** domestic staff working on these units regularly were unaware and therefore non-compliant with cleaning sinks and outlets in a standardised fashion. This in turn moved bacteria from one part of the sink/tap to another rather than removing it.
3. **Water outlets:** the OCT – with advice from environmental experts from Public Health England – concluded that the taps on the unit were contributing to the persistence of the bacteria in the environment. The taps in use were designed with water saving in mind and so were unlikely to be flushing with enough force or volume to flush bacteria from the outlets.

These three issues were addressed and resolved by a change in policy, training, education, audit and replacement of taps. The outbreak has now been officially closed as no further *Pseudomonas aeruginosa* positive babies with links to the outbreak have been identified for more than 12-months.

7. External Review

The IPC Committee commissioned a review of policies and practices related to the management of *Clostridium difficile*. This review took place over two dates: one in November 2017 and one in March 2018. The review was undertaken by Pauline Bradshaw: Senior Clinical Advisor Cheshire and Merseyside, HCAI Lead NORTH NHSI and Martin Kiernan: Visiting Clinical Fellow, Richard Wells Research Centre, University of West London.

The reviewers identified areas of good practice including:

- There is a clear structure of accountability from the DIPC with good relationships with the assistant DIPC and infection prevention and control team.
- The IPC team is committed, and motivated.
- The microbiologists and team are fully engaged with the AMR agenda. There are good relationships between the Microbiology team and the clinical teams.
- The antimicrobial pharmacist has a clear understanding of the agenda and actions required to improve compliance.
- The Divisional Nurse Director for the Acute Adult Care Division attended the lunchtime meeting with the reviewers on the day of the visit, and was able to demonstrate a clear understanding of the IPC agenda.

The reviewers also provided 14 recommendations for improvement:

1. The structure and terms of reference of the IPCC should be reviewed to ensure improved clinical commitment and ownership of agendas.
2. In line with national decontamination guidance the Trust is required to appoint a decontamination lead with overarching responsibility for all aspects of decontamination.

3. The remit and accountability of matrons in relation to IPC should be clear.
4. The infection prevention and control team would benefit from further development in IPC knowledge and areas of leadership.
5. The Trust should undertake more whole health economy reviews of RCAs with Bolton CCG and:
    a. a sample of CDI cases will undergo a deeper dive with an MDT approach to see if there is further untapped learning
    b. revision of CDI RCA process – actions to return to be discussed at Divisional Governance Board. There will be an expectation of formal divisional update papers at IPCC
6. There should be clear guidance in relation to the ownership of the antimicrobial data: consultants and clinical teams should be able to access their own patients audit data set and be accountable for delivering action plans for improvement. A clear escalation process should be described to monitor actions through the appropriate committee. Ownership should sit with Consultant and clinical teams and respective Division. The IPC committee should play an overarching role in advising and supporting.
7. The Trust should increase the capacity of dedicated antimicrobial pharmacist time
8. Explore alternatives to observational audit to improve hand hygiene compliance and assurance.
9. Revised assurance regarding hand hygiene compliance should be agreed with the CCG.
10. There should be some specific work in creating a clean and dirty flow for the processing of commodes.
11. Storage in the sluice of clean equipment or consumables must be avoided unless clear and robust segregation can be maintained.
12. A review of the decontamination element of any training delivered should be undertaken to ensure the key elements of clean to dirty flow and decontamination of reusable equipment are included.
13. Environmental issues that present an IPC risk should be highlighted, risk assessed and reported to estates by the ward staff and actioned in the appropriate timescales by the estates team.
14. The recommendations should be shared with the CCG and HCAI considered within the wider health and social care setting. Full engagement and support of commissioners and primary and community services will contribute to the trust's Trust's endeavours to reduce CDI in hospital and wider community settings.

These actions will be delivered by the IPC Operational Group and overseen by the IPC Committee.

8. Community IPC

The team covers such services as care, homes, Bolton hospice, schools, district nursing, podiatry and community loan stores as examples. The team provide an informative, open, and knowledgeable service working cross organisationally to promote safe and effective infection prevention and control practices.

The team have worked with care homes, schools and nurseries around the importance of reporting and appropriately managing outbreaks of infection - including diarrhoea and vomiting, and influenza. They have visited schools and carried out education sessions with the smallest of children, and also liaised with the local authority neighbourhood teams

to encourage the 'Making Every Contact Count' approach to infection prevention and control with a view to this message being shared with the wider community.

The team has also worked closely with community action groups in Bolton such as the Bolton Community of Mosques to discuss specific IPC and infection issues identified in their communities prevented or treated appropriately if identified and reported to GP without hesitation or embarrassment.

There are now separate bi-monthly link meetings for both FT community staff and care home staff which serve as an educational and informative forum for staff to feed back to their areas of work. The team also carries out mandatory training for our community staff, and have made time to visit several individual teams at their request, including podiatry and respiratory services, to carry out more 'tailor made' training for staff.

The team also liaise directly with patients where necessary to ensure they are receiving the correct treatment and have a good understanding of their infection. This might include an initial conversation (by phone or in person) and it often followed up by a home visit to ensure correct practices and treatment are in place. This usually involves communication and close liaison with other teams - including district nurses, Children's Community Nursing Team, tissue viability service, podiatry and GPs amongst others.

8.1 Care Homes

The team continue to work consultatively with care homes to ensure that they are safe and improving. The average compliance with an overarching audit of facilities and practice is now more than 85%.

8.2 Training

On top of delivering mandatory training for community staff related to IPC, the IPC team delivered training for more than 392 staff in care homes and other care settings alone across 32 sessions in the year.

The team has also supported clinical staff in primary care and care homes to improve their provision of ANTT by facilitating cascade trainer sessions for these two staff groups.

8.3 Outbreaks

As covered earlier, the 2017 flu season was more challenging than those for the last 7-8 years. Despite excellent uptake of resident flu vaccines, there were a number of outbreaks of flu in care homes across the borough. The IPC team were instrumental in ensuring that patients were safe and managed according to best practice. Above and beyond the scope of their role, the IPC nurses undertook swabbing of residents in care homes to test for flu and were key in avoiding a number of admissions to A&E for patients who had flu but could be managed in their home.

The team dealt with 51 outbreaks in care homes and 39 outbreaks in schools in 2016/17:

Fig. 13: Summary of care home outbreaks (note that some homes had more than one outbreak at the same time**)**

Setting	Cause	Number/Proportion
Care Home	Diarrhoea/Vomiting	28 (42%)
	Flu like illness	28 (42%)
	Scabies	10 (15%)
Schools	Flu like illness	16 (35.5%)
	Diarrhoea/Vomiting	13 (28.9%)
	Chicken Pox	7 (15.6%)
	Hand Foot and Mouth	5 (11%)
	Scarlet Fever	1 (2.2%)
	Hepatitis A	2 (4.4% - these were two incidences and not outbreaks per se. Pupils were contact traced)
	CPE	1 (2.2% - an individual case unrelated to the school where the school asked for advice and support)

8.4 Other Functions

The team also take queries by phone, contribute to RCAs of Trust and non-Trust related infections. The team have been involved in a cluster of Group A *Streptococcus* incidents in people who inject drugs. The IPC team has also been consulted by Bolton's Environmental Health team to assist in a criminal investigation concerning unlicensed use of Botox.

The IPC team were also critical in helping to provide the flu vaccine for staff in the Trust community services – providing much of the uptake in this division.

9. Environmental Sampling

The IPCT continues to monitor ongoing sampling such as weekly rinse water testing from the washer-disinfectors, settle plates from HSDU and water sampling from recommended points in the Trust. Any abnormal results are acted upon as soon as possible. There have been no specific issues in year.

Environmental screening was used as part of the investigation and assurance related to the NICU/SCBU outbreak (see **Section 6**). Equipment was extensively screened to see if *Pseudomonas aeruginosa* could be detected in the environment and near patient equipment. All samples were negative except for some of the hand wash basins and taps which were positive. These were resolved and rectified as part of the outbreak management.

Environmental sampling was used as part of the work following the external review (see **Section 7**). More than 50 toilets and commodes were tested and all were negative for *Clostridium difficile*.

9.1 Rinse Waters

Weekly testing of rinse waters from washer-disinfectors has continued for all baths in both Endoscopy and Urology. The IPCT monitor the results that have been put into a

spreadsheet along with subsequent advice given to staff in both units. As above, there has been nothing of note to report.

10. VRE/CPE Screening on ICU

Patients are screened for VRE and CPE on admission to ICU and on a weekly basis until stepped down to a ward. This is to guide effective antibiotic used primarily.

11. Cleaning and Decontamination

11.1 Decontamination across the Trust

The Infection Prevention and Control team is continues to provide decontamination advice throughout the Trust. The IPCT are available to give specialist advice on policies, procedures and the purchase of equipment in relation to decontamination.

11.2 Cleaning Service

Domestic services continues to be delivered by Bolton iFM. Bolton iFM continue to monitor cleaning standards as part of the service contract. Audits are undertaken using national standards. The audits are visual inspections incorporating 41 standards.

Departments are considered to be high-risk (for example, complex care) or very high-risk (for example, ICU). The same standards are monitored, but a successful audit in a high-risk area is 95% compliance with the audit whereas the required compliance in a very high-risk area is 98%.

All cleaning performance is reviewed and discussed at the Trust IPC Committee and the IPC Operational Group. Scores are reviewed monthly by the IPC team and area with consistently low scores or scores that generate a specific concern are discussed with the relevant managers.

At the intermediate care facilities there is local authority in-house cleaning staff. Darley Court's cleanliness is now assessed exactly the same as any other inpatient department in the Trust and reviewed with the same processes. All community healthcare facilities perform a 3 monthly audit which checks the standards of cleanliness and identifies any building fabric or building concerns. The audits are returned to the management team to progress any actions.

In the new build health centres the cleaning is performed by Eric Wright associates and is performed to a high standard they perform monthly environmental/cleaning audits which are reported to the relevant management teams.

9.3 Infection Control audits

The IPCT carry out audits of practice and adherence to key IPC standards on at least an annual basis. High risk areas (listed below) are audited at least twice yearly:

- ICU
- HDU
- A&E Dept
- Ward D1
- Ward D2
- CDU

- NICU
- Main Theatres

The audits are planned in advance and carried out by a member of the IPCT with a member of the ward staff; ideally the ward manager or IPC link nurse.

An action plans are completed by the ward staff and returned to the IPCT and the results are fed back at the IPC operational group. The group is attended by representatives from Bolton iFM facilities to assist if there are environmental issues that the ward staff cannot resolve them themselves.

If the initial audit is unsatisfactory then a re-audit is required and if there are significant concerns, the issue may be escalated to the senior management team for support.

9.7 Hand Hygiene Audits

Hand hygiene audits are completed by nominated departmental staff continue and are inputted into secure applications. All grades of all types of staff are included in the audit and up to five members of staff are observed to check that hand washing before and after patient contact is taking place. Managers are able to generate reports for feed back to their team/department.

10. Ongoing Developments

10.1 Updated Policies

The IPC team continues to review IPC policies in line with new or revised guidance. Revised policies are shared with key stakeholders for comment before being reviewed at the IPC committee. New policies follow the same route but require final review by the executive team.

10.2 Infection Control webpage

The IPC webpage is continually updated to ensure that the advice and supportive information is current and fit for purpose. Organism specific information and key documents are available here for staff to review and access. The website also links to key external sites such as Public Health England advice pages.

11. Education and Training Activities

The delivery of training remains a core component of the IPC service. The IPCT provides training for the Trust on the corporate induction and day 2 of the induction for clinical staff. There is now an e-learning module for clinical and non-clinical mandatory training for acute staff although this training is still face-to-face with community staff.

Fig. 13: IPC Mandatory Training Compliance

Division	Training Compliance
Acute Adult Care	88.6%
Elective Care	92%
Family Care	92.9%
Integrated Care Services	95%
Total	**92%**

Face to face training continues to community staff.

The IPCT increasingly deliver training on an ad hoc basis as required and in response to incidents. More time is being devoted to training on a one-to-one basis or in small groups in the work setting as this is known to be an effective way of training staff.

An example of such is the 'Germ Warfare' sessions undertaken by the band 6 nurses in the IPC team. This is a regular, planned in-reach programme where the IPC nurses for a month will engage with clinical and frontline staff on a one-to-one basis or in small groups on key topics such as MRSA, CDT, SIGHT, the appropriate use of personal protective equipment or hand hygiene. The feedback from staff is that this is a valuable approach and supports the e-learning well.

The IPC team provide core training for cascade trainers – for example for cascade trainers for fit testing or aseptic non-touch technique (ANTT). An important part of the development of the Trust IPC link nurses is also teaching, training and information sharing.

11.1 Student Nurse Placements

The IPCT is a spoke placement area for both student nurses and qualified staff. During their placement the student/staff are given an insight into the daily working of the team which includes ward and patient visits, training, audits, community aspects and reviewing microbiology results. Visiting staff are given an information package which includes the names and contact details of the IPCT/microbiology team and the key roles and responsibilities in relation to infection prevention and control of all staff within the Trust.
They are also given an opportunity to undergo a brief training session to discuss the fundamental aspects of infection control.

11.2 IPC Link Meetings

The link group meetings have now been split into two discreet groups: acute staff link nurses and community staff link nurses. Each group is held bi-monthly and held mid-afternoon to facilitate maximum attendance.

The meetings generally incorporate a short presentation or demonstration related to an aspect of IPC. This is followed by the team giving the group up to date information on recent events, new initiatives, key priorities and educational opportunities. The purpose of the meeting is for the attendees to disseminate the information to their clinical areas.

The 'Link Champion' trophy is presented to a link person who has shown initiative in their area. The link person is presented with a trophy and a certificate. A certificate is also given to the ward/department to display on their achievement board.

12. Objectives for 2018/19

During the next 12 months the IPCT aims to ensure a high quality and effective service across the whole Trust. The IPCT will adopt a zero tolerance approach to avoidable HCAI's and ensure that all staff in the Trust are aware of their responsibilities in relation to infection prevention and control.

These objectives will be driven through an annual IPC/HCAI reduction plan that will be monitored through the IPC Committee and IPC Operational Group. It will be matched against the 10 core standards in the Code of Practice and NICE guidance and will be much more action and outcome focussed than the previous plan.

Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated 2012)		**NICE (2011) Quality Improvement Guide for HCAI**
Criterion	**The registered Provider is required to demonstrate**	**Quality Improvement Statement**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them	1
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**2**
3	Provide suitable accurate information on infections to service users and their visitors	
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion	**4**
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people	**5**
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	**6**
7	Provide or secure adequate isolation facilities	**7**
8	Secure adequate access to laboratory support appropriate	**8**
9	Have and adhere to polices, designed for the individual's care and provider organisations. That will help to prevent and control infections	**9**
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with provision of health and social care	**10**

The trajectories set by NHS England remain challenging:

- **MRSA Bacteraemia**: zero, no avoidable cases of MRSA bacteraemia
- **CDT cases**: no more than 18 Trust apportioned cases

Although there are no national objectives at Trust level, the IPC Committee has agreed that there should be a continuous improvement path for the other surveilled organisms. As a consequence, the IPC Committee objectives are to reduce MSSA, *Klebsiella spp.* and *Pseudomonas aeruginosa* bacteraemias by 10%; this equates to:

- **MSSA Bacteraemia:** no more than 13 Trust apportioned cases
- ***Klebsiella spp.* Bacteraemia:** no more than eight Trust apportioned cases

- ***Pseudomonas aeruginosa* Bacteraemia:** no more than one Trust apportioned case

The national focus for HCAI is the ongoing reduction of Gram negative infections which will be the focus of the IPC service for the next 12-months. The IPC team will develop a case review process for these to see where lessons can be learnt where cases may be avoidable.

Appendix 1: Bristol Stool Chart

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Appendix 2: Compliance with Agreed Standards of Care Related to *Clostridium difficile* Infection

Agreed Care Standards	Compliance
Patients with no history of CDT	95%
Was a sample collected in a timely fashion	71.5%
Did the patient have a stool chart	85.7%
Were Bristol Stool Chart definitions used	85.7%
Was the patient isolated in a timely fashion – or escalated appropriately if isolation wasn't possible	71.5%
Was the use of appropriate personal protective equipment advised	76.2%
Was appropriate hand washing advised	76.2%
Was antibiotic prescribing appropriate	95.2%
Was there evidence of a review of antibiotics when symptoms started	95.2%
Was there evidence of a review of proton pump inhibitors when symptoms started	87.3%
There was no link to a known CDT case	100%
Were there any fails of cleaning audits during the patients admission	85.7%
Is IPC training compliance on the ward ≥85%	95.2%
Was hand hygiene audit compliance ≥85% during the patient's admission	81%
There was no delay in discharge prior to the CDT	100%

NHS Improvement

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To: Director of Infection Prevention and Control
Cc: Director of Nursing

Wednesday 21 March 2018

Dear Trish,

Reduction in *Escherichia coli* bloodstream infections 2017

I am really pleased to see the excellent contribution you have made to reducing *Escherichia coli* bloodstream infections, based on the Quality Premium 2017-18. This used the 2016 data as the baseline.

Although, this has been a difficult ambition to achieve, your Trust is one of 59 who have achieved a 10% or greater reduction in the hospital onset *Escherichia coli* bloodstream infections.

Bolton NHS Foundation Trust baseline numbers were 50 in 2016, 39 in 2017, equivalent to a 22% reduction in cases. As we have been saying at every opportunity, these are not just numbers, these are people/patients so this directly contributes to better outcomes.

Can I please ask you to share your improvement plans/work so we can provide others that have not yet made the reductions, with some key actions that will assist them in their improvement journey. These can be shared by contacting the NHSI team at: nhsi.improveipc@nhs.net

Please do pass on my thanks to the wider team.

Kind regards,

Ruth May

Ruth May

Executive Director of Nursing, Deputy CNO & National Director for Infection, Prevention and Control

Agenda Item No	

Meeting	Board of Directors

Date	25th October 2018

Title	Safeguarding Children and Adults and Looked After Children Annual Report 2017-18

Executive Summary	The report provides a summary and overview of activity and arrangements in place within children and adult safeguarding across Bolton NHS Foundation Trust

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

Next steps/future actions	Final approval at Trust Board			
	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	Fiona Farnworth, Named Nurse Safeguarding Children Sandra Crompton, Lead Nurse Safeguarding Adults	Presented by	Trish Armstrong-Child, Director of Nursing and Midwifery

Safeguarding Children and Adults and Looked after Children Annual Report 2017-2018

Everyone's Responsibility

Contents	Page No

Safeguarding Team
Introduction

The purpose of this report is to provide assurance that the Trust is fulfilling its duties and responsibilities in relation to safeguarding and Looked after Children, adults and families who come into contact with our services and also the staff who deliver those services.

Safeguarding encompasses prevention of harm; exploitation and abuse through provision of high quality care, effective response to allegations and ensuring staff have the appropriate skills, confidence and knowledge to address safeguarding concerns. Trust values are incorporated in all aspect of the Trust's safeguarding provision, ensuring both adults and children have a 'voice'

Since the implementation of the Care Act 2014, there is now a greater emphasis on 'making safeguarding personal', focusing on victim centred care, by giving them all their options and allowing them to make decisions in respect of achieving a positive outcome. This ethos has been embraced by the Trust.

Safeguarding Adults Achievements and Developments 2017-2018

The 'Care Act' informs us that Adult safeguarding duties apply to any person aged 18 years or over and:

- Has needs for care and support (whether or not the Local Authority is meeting any of those needs) and;
- Is experiencing, or at risk of abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either risk of or the experience of abuse and neglect.

The past year has seen a significant increase in the number of referrals Trust Staff are making not only to partner agencies in Bolton but also neighbouring Local Authorities such as Wigan, Salford and Bury.
The increase is multi-factorial;

- Excellent working relationship with the Bolton Adult Safeguarding Team, ease of process and the ability to make direct referrals in a timely manner.
- Development of a Safeguarding Champions Training Programme with 33 Champions in the Emergency Department and a further 25 Champions across the Divisions
- Multi- Agency training provision. Partner agencies are invited to attend Trust' safeguarding workshops
- Bespoke training for specific areas such as Breast Unit, Theatres, Radiology.

Other Achievements

1. The Trust's Safeguarding Team has continued to deliver and promote the Government's Prevent Agenda in line with section 26 of the Counter Terrorism and Security Act 2015 and achieve required target.

2. The Trust has developed a new policy in respect of Managing patients who present as being non-concordant with training to support this being rolled out across the Divisions. Community teams have been prioritised due to the number of complex cases that are currently being managed not just by District Nursing Teams but by Therapy Services and Outreach Team

3. The Trust continues to be compliant with the Lampard Action plan with evidence submitted to both the CCG and NHS England ensuring all Volunteers receive appropriate training in respect of safeguarding

4. As per the Care Act 2014, The Trust is a member of the Bolton Adult Safeguarding Board with the Board, Executive Board and its subgroups represented by the Trust by either the Deputy Director of Nursing or the Lead Nurse for Adult Safeguarding

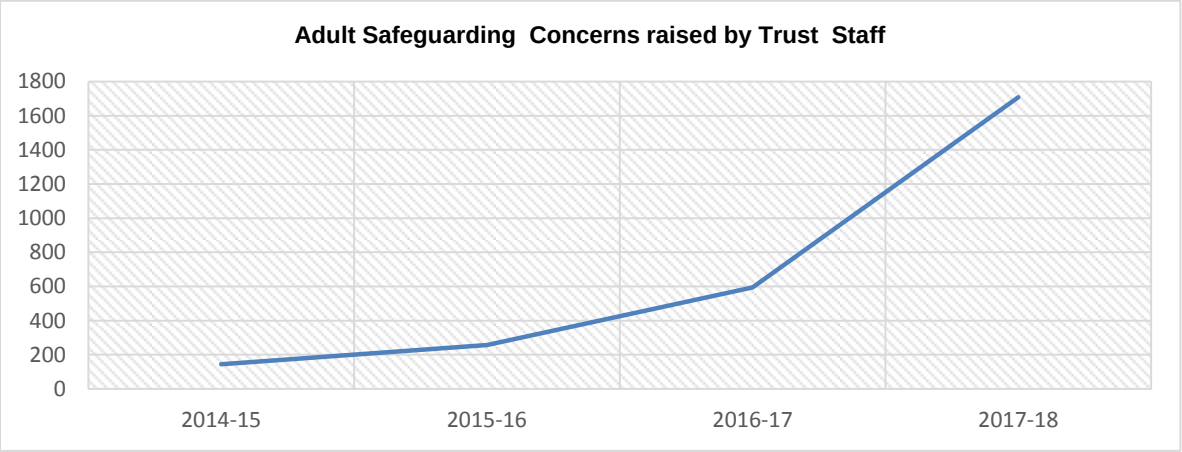
5. The Lead Nurse for Adult Safeguarding has contributed to training initiatives and delivered training for GP's in conjunction with the CCG and Local Authority, sharing new policy on management of non-concordance with all GP Clinical Leads

6. Has forged excellent partnership working with all partner agencies, especially the Local Authority Safeguarding Team with the Lead Nurse for Adult safeguarding and the Lead Nurse for the Tissue Viability Service being virtual members of that team

7. Developed better working relationships with independent Mental Health Care providers such as the Bolton Centre for Autism and the Cygnet Hospital

8. The Trust has adopted the Bolton Adult Safeguarding Board's policy on 'Making Safeguarding Personal' which will be incorporated in the Trust's Safeguarding Adults at Risk Policy

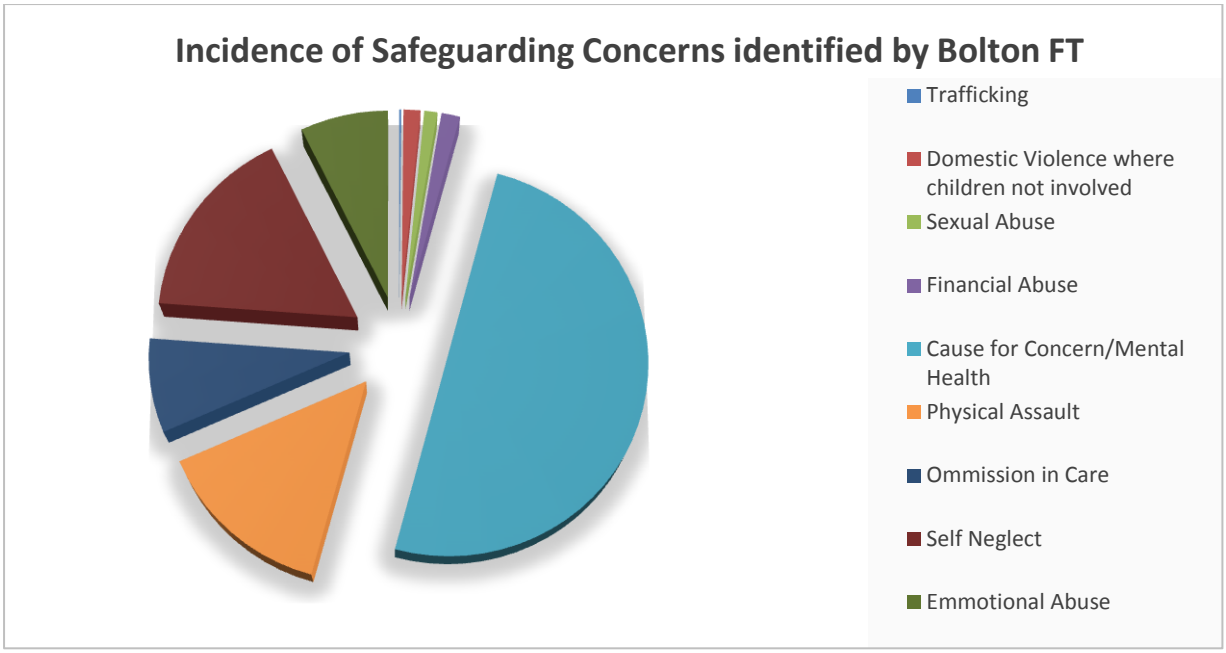
Adult Safeguarding Activity



In the past 12 months 1708 Adult safeguarding concerns have been made as opposed to 594 in the previous year a significant increase in the number of referrals Trust Staff are making not only to partner agencies in Bolton but also neighbouring Local Authorities such as Wigan, Salford and Bury. Approximately 95% of concerns are identified within the Emergency Department.

The increase is multi-factorial;

- Impact of 'system wide' challenges facing individuals and families
- Excellent working relationship with the Bolton Adult Safeguarding Team, ease of process and the ability to make direct referrals in a timely manner.
- Development of a Safeguarding Champions Training Programme with 33 Champions in the Emergency Department with a further Champions across all Divisions
- Multi- Agency training provision
- Bespoke training for specific areas such as Breast Unit, Theatres, Radiology, community services



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The increase in safeguarding referrals identified by Trust staff is also reflected in the Local Authority statistics below where Health Professionals raise the majority of concerns

				By Source
Source	Bolton 2014-15	Bolton 2015-16	Bolton 2016-17	Bolton 2017-18 Q4
	Percentage	Percentage	Percentage	Percentage
Anonymous	1%	1%	0%	0%
Care Quality Commission	2%	12%	1%	1%
Council professional	10%	8%	22%	27%
Education / Training / Workplace Establishment	0%	0%	0%	1%
Friend / Relative / Neighbour	13%	13%	15%	10%
Health professional	16%	15%	15%	35%
Housing	2%	1%	2%	2%
Member of the public	0%	0%	0%	0%
Other	5%	10%	35%	15%
Police or probation service	3%	3%	8%	8%
Provider Staff	45%	34%	0%	0%
Self Referral	2%	3%	2%	1%
Not Recorded	0%	0%	0%	0%
Grand Total	100%	100%	100%	100%

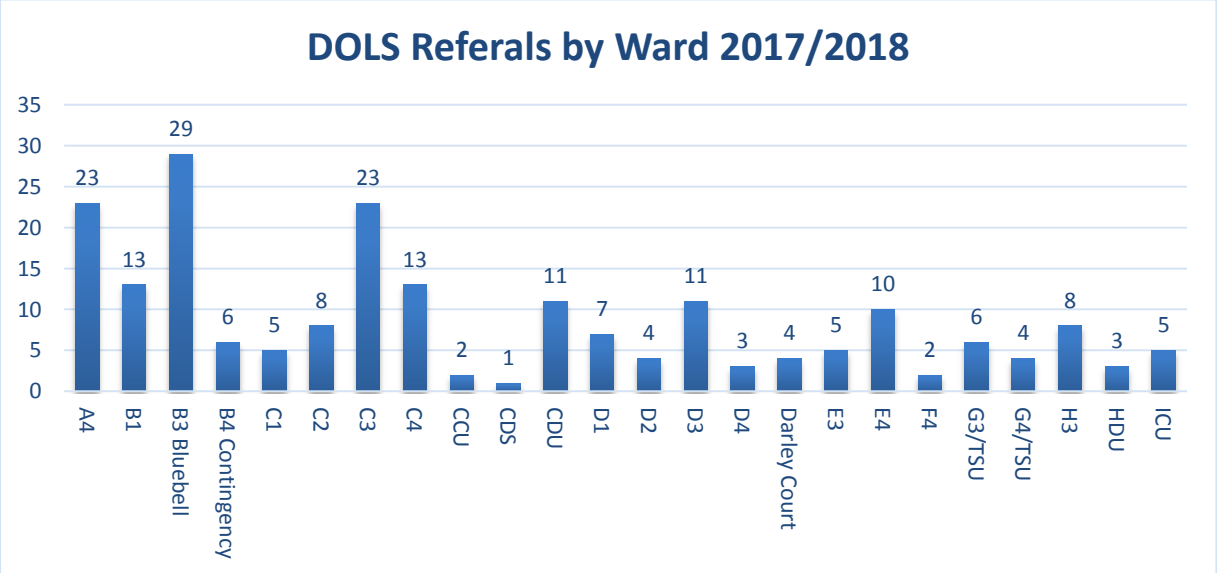
Bolton Safeguarding Board 2017-2018- Source of Safeguarding Adult Referrals

Deprivation of Liberty Safeguards (DoL's)

From the 3rd April 2017, the Chief Coroner for England has now directed local Coroners that they no longer need to routinely investigate the deaths of any person subject to a DoL's at the time of death.

New national guidance has also been introduced to reduce the number of DoL's that are imposed within the critical care environment as the majority of patients already have a number of restrictions in place as a result of the severity and debilitating effect of their physical illness and the care and treatment required to maintain their safety. The DoL's policy has been revised to reflect the changes in guidance and legislation

Throughout 2017-18, a rolling programme of Training for Deprivation of Liberty Safeguards has continued on a monthly basis for Ward Managers and Matrons and imposition activity has remained constant with 226 DoL's being imposed. The CQC is notified of all DoL's impositions by the Lead Nurse for Adult Safeguarding- a requirement of the Trust's CQC registration to detain patients.



It is expected that in 2019 there will be a complete review of the current legislation in respect of DoL's with the current framework being withdrawn and replaced with a new framework called 'Liberty Protection Safeguards' (LPS). The implications nationally are unclear and will be monitored by the Safeguarding Committee and the Adult Safeguarding Board.

Mental Capacity Act (MCA)

The Safeguarding Adult lead has continued a monthly rolling programme of training in respect of the Mental Capacity Act, the completion of mental capacity assessments and the promotion of the 'Best Interest Process'. There has been evidence of excellent practice across the Divisions, especially in respect of complex cases where there has been a need for a multi-disciplinary response. MCA standards are now included in the Trust's 'Bolton System of Accreditation (BoSCA)' process, as an audit measure of compliance in respect of the legislation. With the implementation of the new non-concordance policy, training to support this also includes the completion of mental capacity assessments.

Advocacy

In the past year, The Trust has cared for an increasing number of patients who have no family or representation at all. This has been a particular issue in the Intensive Care Unit.

Under the Mental Capacity Act 2005, all patients who are lacking the mental capacity to consent to care and treatment and have no next of kin or relevant representative are required to have an Independent Mental Capacity Advocate (IMCA) appointed to support the 'Best Interest' decision making process and ensure the Trust provides appropriate care.

'Rethink' advocacy service is the local provider commissioned by the Local Authority with service provision reviewed by the Adult Safeguarding Board. On average, the Trust applies for 3 advocates / month.

Prevent

Bolton NHS Foundation Trust (The Trust) is committed to delivering the highest standards of health, safety and welfare to its patients, visitors and employees. The aim of Prevent is to stop people becoming terrorists or supporting terrorism. Prevent is part of the Government's counter terrorism strategy known as CONTEST.
Under the strategy each NHS Trust is mandated to provide the Home Office training package to all clinical/frontline staff. The Trust has an identified cohort of 3700 staff who meet the requirement. As of March 31st 2018, 2241 designated staff (60.5%) had completed either the face to face or e-learning package. NHS England requires each Trust to achieve at least 85% compliance by the end of quarter 2 (2018-19). The Trust has an action plan, also submitted to NHS England, to ensure the target is achieved with all Divisions working diligently towards. Training compliance is

monitored by the Safeguarding Committee with quarterly training compliance data being submitted to NHS England.

The Trust's Prevent Trainers have had to ensure consideration is given to attendees of the face to face training who have been affected by the bombing at Manchester Arena on May 22nd 2017. The Safeguarding Lead Nurses have been involved in providing supervision and support for staff who cared for the victims or who were at the Arena.

The Trust has formally made 1 referral via the Prevent referral pathway in the past 12 months, although numerous concerns have been raised as potential referrals but these did not reach the required threshold.

The Trust works closely with Bolton Counter Terrorism Unit when any concerns are raised, as the majority to do reach the threshold for formal investigation.

Both the Lead Nurse for Adult Safeguarding and the Named Nurse for Safeguarding Children represent the Trust on the 'Bolton Channel Panel' which is led by the Police and is where Prevent referrals are considered and response action plans are implemented.

Quality and Improvement Measures

The quality of safeguarding provision is monitored by the Trust's Safeguarding Committee which meets on a bi-monthly basis, chaired by the Director of Nursing. All safeguarding standards are enacted via the committee to Quality Assurance. The Safeguarding lead is required to report activity as well as service developments and multi-agency working with members of the Adult Safeguarding Board.

To monitor the quality of the adult safeguarding provision at Ward Level there are a number of standards that each ward has to achieve on an annual basis as part of the Bolton System of Care and Assurance (BOSCA) inspection process. Members of the safeguarding team complete these assessments on a weekly basis covering all Divisions and supporting wards to make any necessary improvements. There are now a number of Wards achieving Gold and Platinum ratings

Bolton FT has also completed the NHS England /CCG Safeguarding Children and Adults assurance template for safeguarding which incorporates 31 standards including Lampard and Prevent responsibilities. This process will be repeated on an annual basis.

The implementation of the Safeguarding Champions programme is an additional resource that is improving the quality of the safeguarding provision and which will be extended in the forthcoming months.

Bolton Adult Safeguarding Adults Board

In accordance with the Care Act 2014, the core purpose of the board is to protect adults who are vulnerable, but to also have a key responsibility to promote the wider agendas of safeguarding and prevention through ensuring safeguarding is everybody's responsibility in Bolton organisations and communities.

The Trust is a partner member of the Bolton Adult Safeguarding Board. The Trust is represented on the Board by the Deputy Director of Nursing and the Executive Board by the Lead Nurse for Adult Safeguarding.

Bolton Safeguarding Adults Board mission and vision statements are to:-

- Prevent abuse and neglect happening within the community and in service settings.
- Promote the safeguarding interests of vulnerable adults to enable their wellbeing and safety.
- Respond effectively and consistently to instances of abuse and neglect

The Trust is also represented on 3 sub-groups of the Board-

A) Effective Practice Subgroup

Trust Representative- Lead Nurse, Adult Safeguarding

The Safeguarding Adults Board must develop clear policies and processes that have been agreed with other interested parties, and that reflect the local service arrangements, roles and responsibilities. They must be available to partner agencies and members of the public. The Effective Practice subgroup is responsible for the overseeing of policy development, procedure, guidance and governance.
In the past 12 months the group have developed and expedited a work plan, approved by the Board which includes-

- Serious Adult Reviews
- Management of complex safeguarding concerns
- Explore the need for a Designated Officer for Management of Allegations against Care Staff
- Reviewed new guidance on management of Hoarding

b) Workforce Development

Trust Representatives – Deputy Director OF Nursing (Chair) and Lead Nurse for Adult Safeguarding

This group is chaired by The Deputy Director of Nursing for Bolton NHS Foundation Trust. During the year there has been an emphasis on scoping out what partners are able to contribute to multi-agency training provision, and what levels of training are being offered. The group is also designing and drafting a Learning and Development strategy that can be adapted across the multiagency patch.

c) Safeguarding Intelligence Forum

Trust Representative – Lead Nurse, Adult Safeguarding

The Forum meets on a monthly basis to monitor independent care provision across Bolton with representation from the Trust, Local Authority, CCG, CQC and Health watch. The forum essentially provides a platform for the exploration of themes, trends and interdependencies that agencies can identify and experience which may require support from the Adult Safeguarding Board. Bolton has the largest percentage of Care Homes with a CQC rating of 'Good' or above in Greater Manchester. The group closely monitors performance and is able to offer expert support and guidance to Care Providers when particular concerns are identified.

The Board has 3 main priorities for 2018-2020 which the Trust will support:-

1. Ensure safeguarding processes are effective
2. Embed making safeguarding personal into all service delivery across the partnership
3. Improve Engagement

Adult Safeguarding Training

During the course of the year the Lead Nurse for Adult Safeguarding has continued to provide a monthly, rolling programme of training in respect of:-

- Deprivation of Liberty Safeguards
- Mental Capacity Act
- Corporate induction/ Trust Values
- Mental Health Act
- Prevent (delivered by all Safeguarding Team Members)

With additional bespoke and multi-agency training being provided for designated cohorts across the Divisions in respect of safeguarding and management of non-

concordance. Level 3 training has been provided for Safeguarding Champions with a number of workshops that have been supported by a number of partner agencies

As of 31st March 2018 the Trust's compliance for mandatory Adult Safeguarding is:-

Level 1 - 94.4 % (Target 95%)
Level 2 - 93.4% (Target 95%)

Training compliance is monitored by the Safeguarding Committee, with all Divisions striving to ensure targets are met. In addition, and compliance is a required standard as part of the B.O.S.C.A. system of accreditation.

Management of Patients with Learning Disabilities

Learning Disabilities Mortality Review (LeDeR)

The LeDeR programme supports local reviews of deaths of people with a learning disability, this supports greater scrutiny of deaths of people with a learning disability.
The hospital learning disability nurse is supporting the work of the reviewing officers a number of reviews have been completed and several others are work in progress and as we progress with the review process the aim is to devise an action plan to share good practice and to identify areas of learning across the organisation with the main objective of Improving the standard and quality of care for people with a learning disabilities.

Learning Disability Awareness training

The learning disability nurse engages in regular training throughout the hospital to raise awareness about the needs of people with a learning disability who access acute services at Royal Bolton hospital. Learning Disability awareness training is now a regular feature on the trust development days for newly qualified nurses in the elective and medicine divisions. Also Trust l staff have access to bespoke learning disability training pertinent to their speciality and area of work. Ward and department staffs also have access to support or advice specifically required for individual patient.

Learning Disability sub-Group

The learning disability sub group meet bi-monthly the membership of the group includes hospital staff representatives from the wards and departments throughout the hospital and people with a learning disability from a self-advocacy group.
Our aim is to promote and safeguard the rights and dignity of all patients with a learning disability and their carers who access acute health care at Royal Bolton hospital.

Safeguarding and support for patients with Dementia and their Carers

In 2015-16, there were 2,309 people with dementia in Bolton registered with their GP. In response to this in 2017-2018, Bolton FT as part of it's development of dementia awareness has included training on how patients with dementia can be exceptionally vulnerable and prone to abuse such as physical violence, neglect and financial abuse. Also, there has been an increase in the numbers of carers who are struggling to cope and provide care for loved ones with dementia and can subsequently develop 'carer's stress'. Integrated team working has proven on numerous occasions to improve support for patients and their carers.

In Addition, The Trust's Dementia Action Plan demonstrates the doing as a Trust around the subject area, aligns us to the national audit of dementia and ''fix dementia care: hospitals'' as well as providing oversight of other projects that will make a tangible difference to patients and relatives stay on the wards.

12. SAFEGUARDING CHILDREN

Safeguarding is a term which is broader than 'child protection' and relates to the action taken to promote the welfare of children and protect them from harm. Safeguarding is everyone's responsibility. Safeguarding is defined in statutory guidance as:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes

Safeguarding children across the Trust has proved a busy and productive year with the challenges of increasing numbers of children locally who are considered to be at risk of or suffering significant harm, children who are looked after and children below the threshold of significant harm requiring early intervention.

The Safeguarding Children team and Named Professionals support the Trust in meeting its statutory responsibility to safeguard children under section 11 of the Children Act 2004 by ongoing review and developing practice in areas well recognised to have a significant impact on children and to focus on new and emerging practice identified to pose a risk to children and young people.

Safeguarding achievements and developments 2017 -18

Changes in legislation and guidance

During the timeframe of the annual report the Department for Education consulted on revision of the guidance **Working together to safeguard children: guide to inter-agency working to safeguard and promote the welfare of children**, to include changes to support a new system of multi-agency safeguarding arrangements established by the Children and Social Work Act 2017. These changes relate to a number of practice areas including:

- replacement of Local Safeguarding Children Boards (LSCBs) with local safeguarding partners
- establishment of a new national Child Safeguarding Practice Review Panel
- the transfer of responsibility for child death reviews from LSCBs to new Child Death Review Partners.

Other changes and achievements

There have been a number of changes in roles and responsibilities of the safeguarding children team during 2017/18.

The Named Midwife now works 3 days a week as a Band 7 rather than the Named role being included within wider Matron responsibilities. This role is closely aligned to the safeguarding children team. Part of this role is to improve safeguarding processes within the maternity unit, enhance communication and visibility.

The Specialist Health Practitioner role in the multi-agency safeguarding team based at Castle Hill Centre (MASSS) is aligned with the Safeguarding Children team and directly managed by the Named Nurse for Safeguarding Children.

The Named Nurse Safeguarding Children has taken responsibility for Trust Looked after Children performance and assurance. This has aligned the governance arrangements for Safeguarding and LAC within the Trust with scrutiny and oversight from the Trust Safeguarding Committee.

Previous consideration of individual practice areas has provided a focus for the assessment and intervention of separate and distinct concerns about risks for children. Increasingly there is recognition of a number of safeguarding vulnerabilities under the umbrella of complex safeguarding. Greater Manchester Review of Children's Services (April 16) defined complex safeguarding as:

Criminal activity (often organised), or behaviour associated to criminality, involving often vulnerable children where there is exploitation and/or a clear or implied safeguarding concern".

This is a relatively new concept that encompasses a range of safeguarding vulnerabilities and may include one or a number of concerns including Child Sexual Exploitation (CSE), Missing from Home and Care, Modern Slavery and Trafficking, Prevent duty, so called Honour Based Violence and Abuse, Organised Crime Groups and gang activity. One of the key concerns highlighted from a recent Profile undertaken with Challenger, the Home Office and the Community Safety Partnership in Manchester were concerns about young people being exploited by organised crime groups to sell drugs. This phenomenon has been identified across the UK and is called 'County Lines' .This has been highlighted to staff within existing training and through circulation of the Home Office briefing.

Many forms of criminal activity or criminally associated behaviour results in children being harmed or placed at significant risk of harm. Some children and young people can be additionally vulnerable such as looked after children, young people involved in the criminal justice system and children with a range of additional needs who are not in education. The response of all agencies needs to be flexible to recognise the multiple vulnerabilities experienced by children and young people.

The Safeguarding Children team have contributed to working with the Police and partner agencies in relation to risks to children affected by serious and organised crime.

13. Achievements, developments and Progress 2017/18

Named Professionals continue to provide oversight of specific cases including complaints, incident reports, identified risks and internal reviews and investigations.

Named professionals have contributed to Serious Case Reviews and Domestic Homicide reviews as panel members or as contributors by agency reports for local and neighbouring areas where the child or adult in the family has had contact with Trust services. Learning and recommendations for practice are updated on a monthly basis and shared and reviewed at the Trust Safeguarding Committee.

Practice developments have been embedded for adult wards and services that have contact with 16 and 17 year olds resulting in evidence within the BOSCA that this age group receive age appropriate care and that carers are happy that their needs are considered and met.

Safeguarding and Looked after children training has been updated at all levels to include lessons learned from reviews.

Bespoke training is provided throughout the year to meet service specific training requirements or to respond to practice issues and themes and trends.

14. Child Protection Information System (CP-IS) was implemented from May 2017 in A&E, Paediatrics and Maternity. In recognition of effective collaborative working between the Trust, Local Authority, CCG and regional CP-IS team leading to implementation the Trust hosted a visit by the Children's Commissioner in March to meet with staff and to look at CP-IS in practice.

The use of CP-IS has increased Safeguarding Children team contact with allocated Social Workers when children attend A&E or access Paediatric services or pregnant women access maternity services.

The benefits of CP-IS include:

Improvements in the assessment of children presenting through access to better supporting information.

Deliver more focussed communication between social care and health concerning these children, leading to improved intervention to prevent the ongoing abuse or neglect of a child.

Building a stronger relationship with social care workers due to information being shared on the system.

15. Activity and referrals

The Trust Safeguarding Children team continue to offer advice and guidance daily by responding to telephone, secure email or written contact. The team have an established duty system each day so a nominated member of the team is responsible for key tasks. Where the volume of referrals is high the duty nurse is supported by other members of the team.

Written information sent to the Safeguarding children team includes information from Trust staff and from out of area or other agencies and information sent electronically includes reports from the Police, Probation or ambulance service.

In addition to daily contacts the safeguarding children team have established regular drop –in sessions for staff to access advice and support including CAMHS, A&E, Sexual Health.

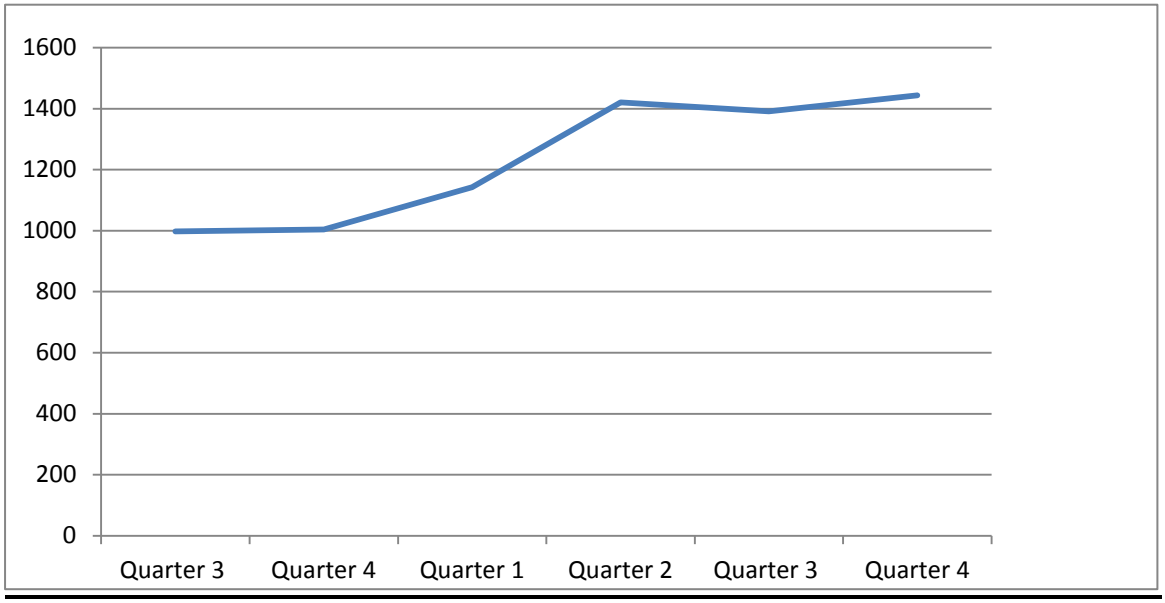
The Safeguarding Children Team continue to offer support to both adult and children's wards and departments based at the hospital and in community– for example attending Strategy Meetings, providing direct feedback to staff to identify good practice and where there is learning identified and on an ad hoc basis in response to complex practice issues.

Direct feedback is given to staff that have provided services or have had contact with a child or family subject to a safeguarding review through support and analysis of recommendations and identified learning.

Feedback is provided to managers and service leads where good practice has been identified or when lessons learned indicate the requirement for practice development.

The Trust Safeguarding Children team duty system is well established and is in place to respond to referrals from Trust and external services. Data collection has shown increasing numbers of safeguarding cases identified in A&E and RAID. This includes concerns when children attend, where 16 and 17 year olds are seen in Adult A&E and adult attendances where children are not seen but the adult may have caring responsibilities. The more complex cases identified are increasingly for adults who attend where there may be implications for children in the family. This may include adults who attend with mental health issues, substance use, physical health issues, or following an assault or domestic abuse. Concerns about parenting ability remain the main reason that adult workers raise concerns. This reflects work undertaken with staff in A&E to establish caring responsibilities when adults attend.

In total number of referrals from A&E and RAID Quarter 1 – 4 is 4115.



This represents a 26% increase from 2016-17.The are a number of reasons identified to have contributed to this increase including:

Increased staff awareness, knowledge, skills and confidence in identifying safeguarding concerns – examples of this include where adults attend and staff recognise there may be implications for parenting capacity, the positive impact of feedback process to staff about outcomes for children from their actions, excellent working relationships between the Trust Safeguarding Team and the RAID team

Recognition of the importance of early intervention to improve outcomes for children across services

Recognition of the impact on the child or family where there are multiple or complex issues including concerns about finances/benefits or housing, parental mental health, families where previous children have been subject to child protection or legal processes

Outcomes from the referrals include checking family details (in all cases) sharing information with health colleagues(16%), sharing information with other agencies(39%) referrals to Children's Social Care(27%) and some for no further action(18%).

16. Bolton Safeguarding Children Board and subgroups and Multi-agency working

The Safeguarding Children team have contributed to a number of board and community safety steering groups and events including:

- Quality and Performance group
- CSE/Missing Steering group and operational SEAM meetings
- FGM Steering Group
- MARAC steering group and operational MARAC
- Challenger meetings
- Staff Development Group
- Learning and Improvement Panel meetings and Serious Case Review panels
- Safeguarding Board Executive (Deputy Director of Nursing is the Safeguarding Board member)
- Safeguarding Children Board development session
- Safeguarding Board Multi-Agency Training and workshops
- Evaluation of Child Protection referral process

An example of response to recommendations from a Serious Case Review is the Safer Sleep Workshop that took place in March 2018 with attendees from both Trust services and partner agencies. This was part of an ongoing review of staff knowledge and skills from recommendations from a Serious Case Review and also a number of infant deaths where co-sleeping was identified as a risk factor. This was reported in Trust Talk.

17.Section 47 medicals service evaluation 2017-2018

Section 47 enquiries are carried out under specific guidance in legislation when Children's Social Care as the lead agency have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. All agencies have a responsibility to support Section 47 investigations including the medical assessment of a child.

The purpose of a medical assessment is:

- To diagnose any injury or harm to the child and to initiate treatment as required;
- To document the findings and to provide a medical report on the findings, including an opinion as to the probable cause of any injury or other harm reported;
- To assess the overall health and development of the child and to arrange for follow up and review of the child as required, noting new symptoms including psychological effects.
- Medical assessments must take into account the need for both specialist paediatric expertise and forensic requirements in relation to the gathering of evidence.
- Only approved Consultant Paediatricians, Police Surgeons or other suitably qualified specialists may undertake medical assessments carried out as part of a Section 47 Enquiry.
- The extent of any questioning of the child by the doctor will depend on the type of abuse and the age and understanding of the child.
- At the conclusion of the medical assessment, the doctor gives a brief report explaining the findings to the social worker/Police officer attending, followed by a detailed formal written report confirming the findings as soon as practicable.

The Section 47 Enquiry is concluded at the point when an informed decision is made taking account of all information available as to whether the child is at continuing risk of **Significant Harm** or not.

There is an agreed local process in place to arrange Section 47 medicals (also referred to as Child Protection medicals) .Referrals for section 47 medicals are made by a Social Worker in discussion with the Consultant Paediatrician on hot week. This follows the Social Worker being informed about a child where there are concerns (following contact from GP/HV/other agency) or A&E when concerns arise regarding neglect or physical abuse. An example may be a child who attends school with bruising and makes a disclosure of physical abuse or an immobile infant seen with bruising during a home visit by a Health Visitor.

Children up to the age of 16 are seen by senior Paediatric Medical Staff (mostly Consultant Paediatrician) on F5 (assessment unit).

The total number of medicals in 2017-2018 is 94

This represents a reduction in numbers compared with previous years - (145 in 2016-17)

65/94 (69%) were seen by a Consultant, the remainder by ST3-ST8 Paediatric trainees under supervision of Consultant. This represents a slight increase those seen by Consultant compared with previous years (2016-17 = 59%).

Section 47 medicals continue to place significant demands on the acute service, particularly out of hours and over the winter months. The nature of and variation in numbers and complexity of Section 47 medicals presents challenges to the hot week Consultant and wider Paediatric team. Whilst it is encouraging that overall numbers have decreased, it is unclear whether this represents a long term trend or normal variation in demand. A sustainable model with a separate clinic based rota needs to be established. This will require a significant increase in resource if not to impact adversely on general clinic capacity.

18. Looked after Children (LAC)

In England and Wales the term "looked after child" is defined in law under the Children Act 1989. A child is looked after by the local authority if he or she is in their care or is provided with accommodation for more than 24 hours .It includes unaccompanied asylum seeking children, children in friend and family placements and those children in the process of being placed for adoption.

There are four main groups of LAC:

- Children who are accommodated (including those who are compulsorily accommodated)
- Children under voluntary agreement with their parents (section 20)
- Children subject to a care order or interim care order (section 31 or 38)
- Children who are subject of emergency orders for their protection (section 44 and 46)

There has been a steady increase in the number of LAC across the UK and numbers are at their highest since 1985.The numbers of children in care fluctuates – some placements into care are short lived and some children move on into pre-adoptive or adoptive placements or return to care of parents or family. Most children in care from Bolton remain in local placements however there may be Bolton children placed out of borough and some children who are placed in Bolton from other local authorities.

Within the timeframe of the report the numbers of Looked after Children from Bolton have remained within a range from **580 to 615**.This is comparable with Local Authority data across the North West and demonstrates an ongoing upward trend.

The health and well -being of looked after children remains a national and local priority**.** Looked after children predominantly enter care due to abuse and neglect and as such can be described as a vulnerable group .Data shows they have poorer

health outcomes than other children with a corresponding adverse impact on their life opportunities and health in later life.

The legislation and guidance for Looked after Children guide the responsibilities of the Trust including "Promoting the Health and Wellbeing of Looked After Children Department of Education and Department of Health 2015" and "Looked after Children: knowledge, skills and competence of healthcare staff" (Intercollegiate Framework 2015) and NICE guidelines.

The Trust is responsible for ensuring the timely and effective delivery of health services to looked-after children. This includes specific services such as statutory health assessments with consideration of a child's looked after status for all services.

There are medical, nursing and administrative staff in the Trust have specific responsibilities for providing services to LAC. This includes Named Doctor, specialist nursing and administrative staff. In addition universal services undertake health assessments – for example Health Visitors.

Adverse Childhood Experiences (ACEs) also described within the work of FNP is an area recognised to contribute to the health and wellbeing of Looked after Children – this includes immediate consideration and for short and long term health outcomes. ACE's are traumatic, abusive or stressful experiences occurring in childhood which significantly increase the risk of profound negative health and social outcomes in adult life. Over recent years there have been large scale international studies and these have highlighted how children exposed to ACE's can suffer from 'toxic stress' which is harmful to physical and psychological bodily responses that occur during traumatic and abusive events. Studies also highlight the strong correlation between the number of ACE's suffered, the amount of exposure to toxic stress and the risk this has in terms of poor outcomes in later life this includes physical health, neurological functioning, emotional regulation, risk taking and harmful behaviours, violence, criminality and longevity of life. As a consequence this increases the likelihood of the sufferer's children also experiencing ACE's and toxic shock and increasing the chances of the cycle of disadvantage continuing.

This is included in staff training to promote analysis of the experience of every child throughout their journey into care and considered within their ongoing placement.

Strengths and Difficulties Questionnaire (SDQ) for children aged 4 to 17

SDQ scores contribute to the understanding of the emotional health of children and young people based on observed and reported behaviour. There is an agreed multi-agency process in place. The screening tool is completed by carers and when provided is used as part of the holistic assessment. The contribution of SDQ to a holistic assessment was discussed and endorsed at the Trust Safeguarding Committee.

Statutory Health Assessments

All children in care require health assessments –either on entering care (Initial Health Assessment) or as an ongoing process (Review Health Assessment).

The aim of the service is to ensure that the health needs of all children who are looked after resident in Bolton are addressed by ensuring quality health assessments are done on time and care plans are in place to achieve clearly defined outcomes.

The assessments should not be an isolated event but, rather, be part of the dynamic and continuous cycle of care planning (assessment, planning, intervention and review) and build on information already known from health professionals, parents and previous carers, and the child himself or herself. The assessments should be child centred and age appropriate and be undertaken with the child's informed consent, if he or she is 'competent' to give it.

The health practitioner carrying out the assessment has a duty of clinical care to the child. That includes making the necessary referrals for investigation and treatment of conditions identified at the assessment. Even if the placement is brief, the practitioner should follow up concerns and if the child returns home, every effort should be made to continue to implement the health plan

Initial Health Assessment (IHA)

A health assessment is undertaken with all children who enter care within the first 28 working days. From this Health Assessment a comprehensive Health Plan is formulated detailing all the individual health concerns and how these health concerns will be addressed going forward. The Health Plan is reviewed following every Health Review every 6 months if under the age of 5 years and every 12 months after the child reaches the age of 5 years. The plan when formulated is then shared with all corporate parents, G.P's and other relevant Health Professionals and with the relevant Social Worker.

The total number of IHA required within the timeframe of the annual report is 154.

The target is that 95% of Initial Health Assessments are completed within 20 working and this target has been met in 62% of health assessments. There is scrutiny and review of every breach to consider prevent future occurrences and to ensure that systems and processes are robust and efficient.

There are a number of reasons that health assessments have not been completed on time some of which are within the control of FT services and systems and other reasons outside the control of FT services. This includes delay in notification that a child is in care, appointment cancelled by carers or child not brought for the appointment, correct paperwork not provided and staffing/capacity issues. This data is reviewed every month to reduce modifiable factors internally and to raise issues

such as delays in the provision of paperwork from the Local Authority. This is reported within the Family Division and the Trust Safeguarding Committee.

The Review Health Assessment (RHA)

A review health assessment is to be undertaken with all children in care every six months up to the age of 5 and then annually thereafter. Pre-school RHA are provided by the Health Visiting service and children over the age of 5 are the responsibility of services provided by Bridgewater Community NHS Foundation Trust.

The completion of each Health Assessment is guided by GM framework and is then quality assessed by the relevant Health Visitor Team Leader.

The total number of RHA required within the timeframe of the annual report is 206.

RHA were completed on time for 69% of assessments required –the target is 95%. There is scrutiny and review of every breach to consider ways to prevent future occurrences and to ensure that systems and processes are robust and efficient.
There are a number of reasons that health assessments have not been completed on time with a significant number outside the control of FT services. This data is reviewed every month to reduce modifiable factors internally and to raise issues such as delays in the provision of paperwork from the Local Authority. This is reported within the Family Division and the Trust Safeguarding Committee

Service Developments 2017 -2018

There are a number of arrangements in now in place for LAC:

The Trust Safeguarding Committee reviews safeguarding and arrangements for LAC across the organisation bi-monthly. This enables mechanisms for reporting to the Trust Board, Quality and Risk committees if required.

The Director of Nursing is the Trust Board lead for safeguarding children and LAC

There are systems in place for completing Initial Health assessments (IHAs) and Review Health Assessments (RHAs) for Looked after Children and reporting compliance data.

Quality assurance process in place to ensure all completed health assessments are of a high quality.

Trust wide guidance is in place for Looked after Children.

There is an increasing focus on the Voice of the Child with work completed to implement audit activity to demonstrate that this is captured and contributes to the assessment and plan of care.

Combined Safeguarding and LAC training framework which identifies training levels in line with Intercollegiate Framework (March 2015).A training schedule is in place using an agreed training package for staff identified to require Level 3 LAC training.

The standard for the KPI that 95% of health assessments will be completed within timescales and is monitored at the Families Divisional Board and the Trust Safeguarding Committee.

There have been a number of practice developments for LAC within the Trust and there have been some challenges to the performance measures within the timeframe of the annual report requiring action. The quality of health assessments is reviewed for each health assessment and all now meet the standards required and are of good quality. Action has been taken to embed agreed systems and processes to ensure the timeliness and quality of assessments undertaken. Joint working with colleagues in other providers, the CCG and Local Authority continues to ensure that barriers to the effective and timely provision of health assessments and services in general are removed.

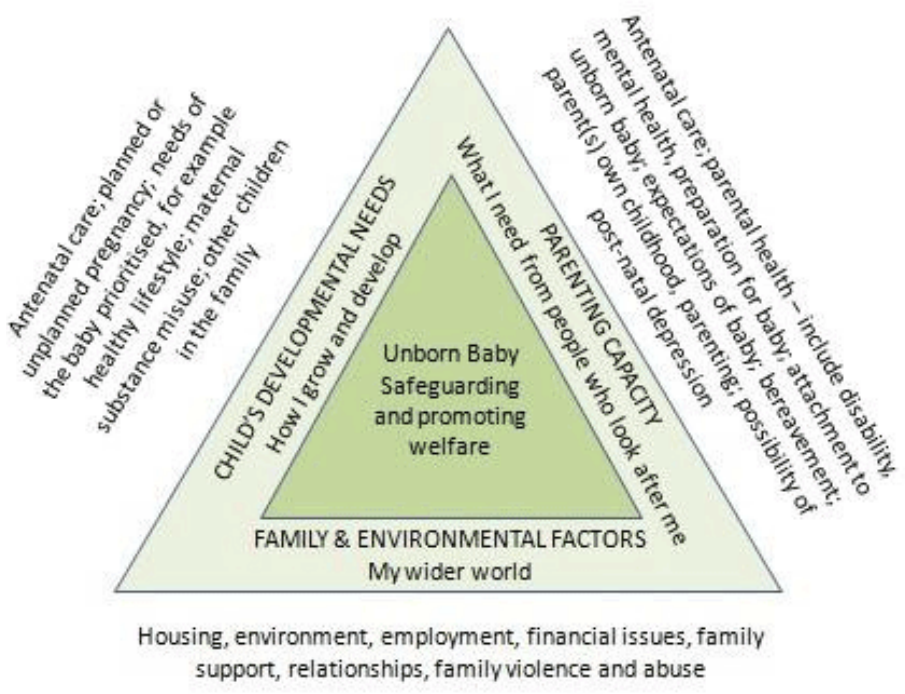
19. Maternity Update

In the vast majority of situations during a pregnancy, there will be no safeguarding concerns. However, in some cases it will be clear that a co-ordinated response is required by agencies to ensure that the appropriate support is in place during the pregnancy to best support and protect the baby before and following birth. It may also be necessary to consider the need for particular arrangements to be in place during and immediately following the baby's birth in order to do so.

In the early stages of the pregnancy, the Midwife must assess the strengths, risks and needs of the family and where there are concerns for the welfare of the unborn baby follow local multi-agency safeguarding procedures and thresholds within the Framework for Action. This includes a range of responses from early intervention /early help to supporting the Social Worker as Lead Professional as part of child protection procedures or providing to formal written reports within the family court arena.

There are a number of risk factors identified that may impact on the unborn or infant. Midwives contribute to the recognition of concerns in the ante-natal period and during and post -delivery. Recognition and response of risk factors is the responsibility of all midwives based at the hospital and in community teams.

The outreach midwives have caseloads that include families where there are known safeguarding concerns. Increasing numbers of families where there are concerns and increasing complexity has provided challenge to this specialist role. This has been recognised and the service including systems and processes is under review. The team are looking to put together a proposal which will consider the recommendations from Better Births and look at increasing continuity for the vulnerable women with complex needs.



Learning from Serious Case Reviews and Domestic Homicide Reviews provides the requirement to continuously develop practice based on lessons learned and recommendations. An example of this is routine enquiry about domestic abuse during pregnancy. This remains a focus throughout the ante-natal period with routine review of support, sources of stress and relationships.

Continuous developing practice across maternity on the hospital site is supported through the Named Midwife contributing to BOSCA.As part of a Trust wide process Safeguarding Champions for maternity will be identified and provided with additional training and support.

All midwives require Level 3 safeguarding children training .Training as a three year plan commenced in November 2016 and by the end of March 2018 compliance was 78%.This has enhanced the knowledge and skills of midwives in a range of practice issues and appropriate response to vulnerability and risks.

The Named Midwife continues to provide monthly safeguarding supervision for this group of midwives and compliance is recorded on the maternity dashboard.

The Named Midwife has completed a comprehensive guideline for caring for women who are undergoing surrogacy.

The Named Midwife has been working closely with Learning Disability lead in response to a recognised a gap in resources to enable effective provision of parent education to women with learning disability/difficulty. This has resulted in a joint proposal to secure the funding to purchase much needed resources.

20. Health Visiting

Health Visitors work to the national Healthy Child Programme and provide a minimum of 5 following mandated contacts to all families with children:-

Ante natal Visit, New Born Visit which is 10-14 days following birth, 6-8 week contact, 9-12 month contact and 2-2.5year contact. In addition to mandated visits there are additional contacts based on the needs of the child and family and where there are safeguarding concerns. Health Visitors work with children and families at each level of the Framework for Action from Early Help to children looked after or subject to a child protection plan. Health Visitors carry out Early Help assessments and act in the Lead Professional role where children and families need support or are at risk of harm.

The Heath visiting service in Bolton was redesigned into eight geographical teams based on demographic information in 2015. The deprivation index was used to allocate the number of health visitors per team with higher number in areas of high deprivation. This is to ensure that Health Visitors have the capacity to identify and support families that are in need of additional support and ultimately improve outcomes for children. This continues to be reviewed with colleagues from the Local Authority and Public Health.

The service is delivering to the Greater Manchester Early Years Delivery model and all Health Visitors are trained in delivering the following as standard:

The New born Behavioural Observation (NBO) which is a tool used to promote bonding and attachment and is carried out with all new babies and their parents / carers.

ASQ and ASQ-SE questionnaires to assess child development and gain population level data for the borough of Bolton.

Wellcomm which is an assessment and intervention tool that aims to support early speech and language development.

The Health Visiting service continues to have a focus on Postnatal and Parent Infant mental health to support mothers with low moods and depression which we know can have impact on children and their future outcome achievements.

Health Visitors have undertaken Solihull foundation training that facilitates a model based on the three concepts of Containment, Reciprocity and Behavioural management. Health Visiting will refer to these principles during their mandated and targeted contacts.

A small proportion of the service have recently undertook New born Behavioural Assessment Scale (NBAS) training, and are currently working towards their accreditation under the supervision and support of the Early Attachment Service in the neighbouring borough of Tameside. This assessment builds on the NBO tool and facilitates further assessment and support for families with high needs / risk factors with reference to bonding and attachment.

A separate small proportion of the service has completed Video Interactive Guidance (VIG) training. VIG aims to enhance communication within a relationship between a parent and their child using video clips to highlight positive interactions.

The Health Visiting service is 100% compliant with Level 3 Safeguarding and LAC Training. Health visitors also regularly access the multiagency safeguarding training.

Health visitor team leaders carry out managerial supervision for all staff working with families that have children subject to safeguarding plan and support staff with conference/ court reports. Team leaders are also responsible for supporting staff working with complex families and any escalation or where there are professional differences in case management.

Many heath visitors are trained safeguarding supervisors and there is a robust system in place to ensure all health visitors access supervision three monthly.

21. Family Nurse Partnership (FNP)

The Family Nurse Partnership Bolton is in its seventh year. This year FNP welcomed a new FNP Advisory Board Chair. The Advisory Board were pleased to report the excellent progress and achievements set out within the action plan from last year.

As identified in the last year's review, the clients recruited have very high levels of need, vulnerabilities and complexities, often suffering significant adversity during their life, and these levels are increasing year on year. Despite this, and staffing challenges, the team have continued to achieve excellent results and outcomes equal to, or better than the FNP National Average. Strategic support from senior managers and commissioners has also been really important. The team has also made a significant contribution and impact on the wider health economy, around safeguarding children, governance and quality.

The Annual review in January 2018 focused on the positive impact FNP has had on Adverse Childhood Experiences (ACE's). Research highlights the positive impact of routine enquiry re ACE's and 'Trauma Informed Care' with young people and parents as this helps to gain an understanding with early intervention and preventing negative outcomes associated with ACE's. It is positive that the Family Nurse

Partnership ethos and model of care has been recognised as also fitting with the principles of Trauma Informed Care and works to reduce the 'Unbearable State of Mind' which trauma suffers (including a high number of FNP clients) often face.

During this last year the FNP team has worked to help empower and enable clients and their families to realise some excellent health, growth, development and social outcomes. In addition, Bolton FNP has also made a positive impact and contribution to the wider Trust and social care partners including Safeguarding, Governance and Quality improvements and within the broader remit of Children's Community Health services. Despite year on year increases around client vulnerabilities, levels of need and complexity the data continues to demonstrate the excellent ongoing achievements of the clients, children and the FNP team in Bolton. Furthermore, the data and outcomes should be considered in terms of the immediate and long term impact for the children and families and also importantly in terms of the positive impact on the local economy in terms of health improvement, quality, productivity, engagement, social cohesion and cost savings.

FNP Outcomes and progress

This year the FNP team has worked with a total of 141 clients and delivered 1818 visits (average 1-1/2 hours) to help empower and enable clients and their families to realise some excellent health and social outcomes. Bolton FNP has also made a positive impact and contribution to the wider Trust and local area agendas and strategies, including those around Governance and Quality improvements, Safeguarding and within the broader remit of Children's Community Health services.

Caseload Management

It should be noted that the above successes have been achieved during a period of extra pressure, in relation to staffing and caseload management (during 2x maternity leaves and following a new member of the team starting). The FNP Advisory Board and Commissioners agreed that due to the known problems and limitations around utilising temporary staff for the delivery of a specialist therapeutic programme like FNP, that the caseload would reduce by 50 clients (each Family Nurses carries a maximum 25 clients - 2x staff on maternity leave = 50 clients) during the period of the maternity leaves. Ongoing updates and reviews have been provided to the FNP Advisory Board and at contract reporting meetings.

22. Domestic violence and abuse

The term "domestic violence and abuse "(DAV) is used to describe any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 and over who are family members or who are or have been, intimate partners. This includes psychological,

physical, sexual, financial and emotional abuse. It includes honour based violence and forced marriage.

DAV continues to be a focus of work to safeguard those over the age of 16 and to consider risks and needs of children who live in households where it is present.

The multi-agency risk assessment conference (MARAC) takes place fortnightly led by the detective inspector of the public protection investigation unit. MARAC victims are referred following completing a MARAC assessment that identifies high level domestic abuse concerns. To meet MARAC criteria victims are at high risk of homicide or serious injury. By association children within these households are also at high risk and vulnerable. The MARAC action plan for each case aims to reduce the risk and ensure vital information sharing.

The Trust safeguarding children's team attends each meeting as a necessary core agency. The Trust MARAC representative collates information from Trust services to contribute to assessing the full picture of risk. Relevant information plus actions set are fed back to Trust practitioners working with the families in order to contribute to safeguarding the children and supporting victims. On average between 15 and 28 cases are discussed per fortnightly meeting involving numbers of children ranging from 12 to 35 plus some unborn children. Trust services such as health visiting and midwifery also continue to contribute to referrals made to MARAC (20 during past year 2017/18).

The safeguarding children's team representative acts as a nominated gatekeeper able to upload referrals to the shared drive and to quality assure every referral. Any referral that does not appear to meet the threshold or lacks detail or suitable analysis is returned to the referrer with advice about resubmission and actions required to safeguard family members.

In an area of ongoing challenge, average Bolton district DAV crimes recorded per month is now 431 which is an increase of 134% against the previous average of 184 per month (GMP figures).

Domestic abuse is a significant factor for children and is reflected in data reviewed in March 2018 (in month data).

The number of open referrals to CSC Total 1675
Of which number where Domestic abuse is a factor 895 =53.4%

The number of children subject to a Child Protection Plan Total 299
Of which number of children where domestic abuse is a factor 181 =60.5%

The number of children subject to a Child in Need plan Total 587
Of which number of children where domestic abuse is a factor 408 =69.5%

The number of children who are Looked after (LAC) Total 626

Number of children where domestic abuse is a factor 360 =57.5%

Training about DAV is provided on a weekly basis to both medical and nursing staff via the A&E drop-in.

In response to recognition of an inconsistent response a domestic abuse pro-forma was devised and implemented in order to assist practitioners in helping victims of DAV within A&E. This commenced in December 2017.The pro-forma includes prompts to ensure that safety planning is enabled and vital details of children/perpetrator are captured providing the safeguarding team with improved quality of information for effective onward sharing.

The pro-forma has been shared with the Local Authority and well received at MARAC steering group. Where it is identified that the pro-forma has not been used to assess, provide interventions or support safety planning feedback is provided directly to the member of staff and escalated to managers within the department. The pro-forma has been shared with other Trust services with further agreement planned at Trust Safeguarding committee about wider use across the Trust.

Increasing staff knowledge and skills pertaining to domestic abuse remains a focus of training. This is also encompassed within Level 3 safeguarding children's training as part of the lessons learned discussions around a national SCR.

Further DAV awareness sessions for champions are arranged for 2018/19.

23. Female Genital Mutilation (FGM)

FGM is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls. Healthcare professionals play a significant role in the prevention and identification of FGM and supporting women and girls who have had FGM.

One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth through ante-natal care and delivery of the child. Recognised risk factors for FGM include where a mother or family members have had FGM and by country of origin.

FGM can be carried out at any age throughout childhood, meaning that identifying FGM at birth can have the consequence that any safeguarding measures adopted may have to be in place over the course of the girl's childhood. This is a significantly different timescale and profile compared with other risks to children or forms of abuse.

The Trust has procedures in place for services that come into contact with families where FGM is present or may be a risk. This includes both safeguarding and clinical

pathways .The Type of FGM identified is significant in relation to physical health outcomes and consideration of appropriate and safe clinical intervention.

Trust procedures for FGM have been agreed with partner agencies including the Police and Children's Social Care. There is regular review of individual cases to ensure that staff are able to recognise the specific characteristics of FGM and are able to use risk assessments to identify children who may be at risk of FGM.

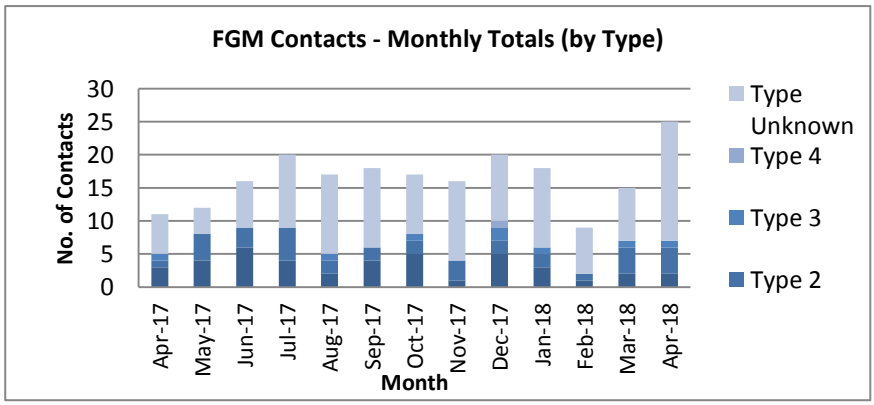
Trust staff are aware of their statutory duty (known as the Mandatory Reporting duty) to report cases of FGM to the police non-emergency number 101 in cases where a girl under 18 either discloses that she has had FGM or the professional observes physical signs of FGM. FGM is included in all levels of Safeguarding Children training.

Information sharing processes enable follow up for adults and children who have had FGM or may be at risk of FGM.

Partnership working for FGM is supported through sharing information, making referrals and attending multi-agency meetings. Strategic partnership working is supported by attendance and contribution to the Bolton FGM Steering Group chaired by Community Safety and as part of Bolton Domestic Abuse and Violence Partnership.

The Safeguarding team continue to raise awareness of FGM and lessons learned from local, regional and national data. This is shared at the Trust Safeguarding Committee. There has been a review of Trust procedures in preparation for adoption of the national FGM Information Sharing system

Monthly reporting data is shared at the Trust Safeguarding Committee



24. Child Sexual Exploitation

The new definition below includes a reference to online exploitation.

Child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point.

CSE remains a high profile area of practice where health professionals have a significant contribution to make in the identification of children and young people at risk.

There is a well-established SEAM (Sexual Exploitation and Missing) panel in Bolton which takes place every two weeks (this will move to monthly)and is in place to monitor the identification, support and protection of children at risk of CSE. This multi-agency panel is attended by a Specialist Nurse from the safeguarding children team who provides updates from contact with Trust services and to share information identified by Trust services and staff that may contribute to building intelligence about CSE. Examples include information directly shared about a child, risky adult or activity causing concern or locations identified that form an emerging picture of risk.

The Named Nurse attends the CSE/Missing Steering Group – a sub group of Bolton Safeguarding Children Board and has chaired meetings as deputy in place of the Chair.

25. Training

The purpose of safeguarding and LAC training is to achieve better outcomes for children.

Bolton NHS Foundation Trust has a responsibility to ensure all their staff have access to and receive training in safeguarding children so they can recognise children who may be at risk of abuse and be able to respond appropriately to promote their welfare. All staff must ensure they attend the safeguarding children training level appropriate to their role as defined in guidance.

The effectiveness of training is monitored by the safeguarding children team as part of supervision, multi-agency audits and during all review processes.

The Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document (Royal College of Paediatrics and Child Health 2014) and Intercollegiate Role Framework (RCN & RCPCH 2015) Knowledge skills and competencies for health care staff define the level of training and competencies' required. The safeguarding and LAC competences are the set of abilities that enable staff to effectively safeguard protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. Training compliance is monitored through service dashboards and safeguarding knowledge and skills reviewed as part of the BOSCA process and within each internal or external child review.

All staff must ensure they attend/access safeguarding/LAC training commensurate to their role as defined in the Safeguarding/LAC Children Training Strategy which includes a quick guide for staff.

Level 1: All staff including non-clinical managers and staff working in health care settings.

Level 2: This is the minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers.

Level 3: This includes clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

The strategy recognises the diversity of the organisation and that staff will have different training needs depending on their degree of contact time with children and families, as well as their level of responsibility. The emphasis is upon the importance of maximising flexible learning and a range of learning opportunities, drawing upon lessons learned from research, case studies and serious case reviews. Safeguarding Children training can be accessed through (but not exhaustive):

- Staff handbook
- E-learning
- Face to face training, staff workshops and briefings
- Annual updates
- External training
- Peer review
- Professional body training/events
- Local /Regional training
- Reflective practice

Safeguarding/LAC training compliance is monitored by reports to the Trust Safeguarding Committee, by Divisional managers and Divisional Boards by Named professionals and the Safeguarding Children Team.

Position March 2018

Level 1 – compliance 96.2% Level 2 – compliance 94.6%

The number of staff trained at Level 3 by end of March 2018 is 992 from 1110 staff identified in November 2016.

There has been an ongoing review of the staff identified to require level 3 safeguarding children training as intercollegiate guidance identifies staff groups that must have Level 3 training mostly within the Family Care division (midwives, Health Visitors, Paediatricians, Paediatric nurses for example) and also has suggested staff groups. For some areas/services senior or nominated staff only require Level 3 training to ensure there are a number of staff across Acute Adult division and Elective Care. This remains under review until the end of 3 year training plan which runs until November 2019.

Level 3 LAC training is split in to 2 groups (Level 3 and Level 3 Plus)

There is a training programme in place with priority for staff who complete LAC health assessments

26. Safeguarding Supervision

Effective safeguarding supervision can play a critical role in ensuring there is a clear focus on the welfare of a child.

Supervision can be defined as:

“An accountable process which supports assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed outcomes”.

Safeguarding supervision is separate from but complimentary to other forms of management or nursing supervision.

The Trust Safeguarding and Looked after Children Supervision Framework has the following components:

- Management/Child Protection Supervision
- Peer Supervision
- Specialist Supervision
- Advice and Guidance
- Restorative supervision
- Group Supervision
- Supervision for staff in specific safeguarding roles

Supervision for staff working with Looked after Children has been incorporated within the safeguarding supervision framework. Management supervision now includes LAC who have complex health or developmental concerns, where there is a risk of placement breakdown or where children remain at home with parents or family members on a Care Order.

Restorative supervision with groups of staff has been provided by the Safeguarding Children team in parallel with existing de-brief and clinical incident reviews. This approach is to provide staff with the opportunity to identify what helps when there is a serious incident and what practical support is required.

Staff groups who access formal and regular safeguarding supervision include Health Visitors, FNP and Outreach Midwives. This is reported internally to ensure compliance.

27. Learning from Reviews

Statutory guidance in Working Together to Safeguard Children (2015) sets out the required approach to learning and improvement for Safeguarding Children Boards and placed a duty on them to develop local learning and improvement frameworks. This includes a full range of case reviews and multi-agency audit activity and the review of cases that do not meet the threshold for a Serious Case Review but which may provide lessons about how organisations are working together to safeguard children. This includes contribution to reviews in Bolton and other areas where families may be resident but have had contact with Trust services or have moved out of area but information from contact with Trust services is requested.

The Safeguarding children team and Named professionals contribute to case reviews by attendance at panel meetings and preparing reports based on health records and direct contact with staff. The Named Nurse sits on the Learning and Improvement Panel. This provides the opportunity to identify areas of good practice and to provide objective analysis where concerns are identified. Recommendations/actions and challenges from reviews are shared in a number of ways including direct feedback to staff and managers ,staff briefings and training and updates provided within existing meetings.

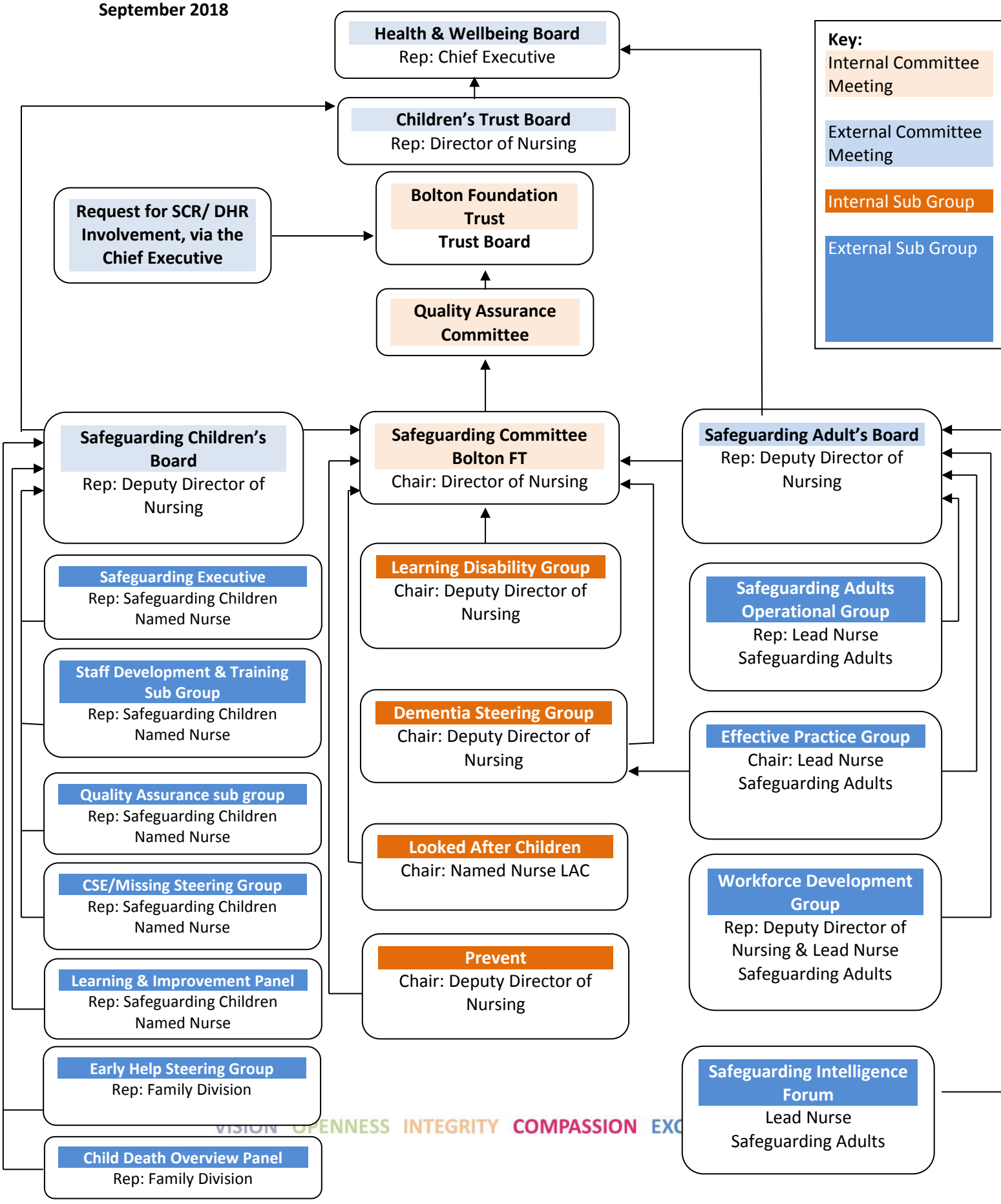
Learning from reviews is a standard agenda item at the Trust Safeguarding Committee.

April 2017 to March 2018

Case	Actions/Recommendations /Learning
Death of a child aged 11 weeks	Completed SCR. Reminder to staff about thresholds and significant harm. To update family circumstances at each contact. Strengthen support to practitioners when working with complex families. Safer sleep messages and assessment.
Child sustained serious injuries	SCR commenced – panel meetings and practitioner event have taken place.
Concealed pregnancy	Agreed that this met the criteria for SCR but not yet commenced. Maternity services review of previous learning and practice
Death of an infant	Out of area however maternity services provided prior to family moving .No specific recommendations for the Trust however learning from the review has been shared.
School age child not known to services/neglect	Out of area SCR has commenced but not completed. Adult who attended .Learning identified for A&E and adult wards
Domestic Homicide adult female	Out of area DHR ongoing. Short timeframe maternity services provided. Contribution to work of DH panel.
Domestic homicide adult female	DHR report provided –further enquiries to establish nature of contact with Trust services. Learning for adult services.

Bolton NHS
NHS Foundation Trust

GOVERNANCE STRUCTURES
SAFEGUARDING COMMITTEE
September 2018



References

- Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Saville 2014
- Care Act 2014
- Counter Terrorism and Security Act 2015
- Mental Capacity Act 2005 HMSO 2005
- Mental Capacity Act Code of Practice Department of Constitutional Affairs 2007
- Children Act 1989, 2004
- Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children (2015)
- Bolton Safeguarding Board Procedures – Framework for Action updated 2017
- Statutory Guidance on promoting the Health and well-being of Looked after Children (Department of Education and Department of Health ,2015)

Fiona Farnworth
Named Nurse, Safeguarding Children

Sandra Crompton
Lead Nurse, Safeguarding Adults

Integrated Summary Dashboard - September 2018

Executive Summary

Trust Objective	RAG Distribution	Total
Quality and Safety		
Harm Free Care		19
Infection Prevention and Control		9
Mortality		4
Patient Experience		16
Maternity		12
Operational Performance		
Access		10
Productivity		12
Cancer		7
Community		6
Workforce		
Sickness, Vacancy and Turnover		3
Organisational Development		6
Agency		4
Finance		
Finance		5
Use of Resources		
Clinical Services		4
People		6
Clinical Support Services		2
Corporate Services, Procurement, Estates & Facilities		5
Finance		5
Appendices		
Heat Maps		

NHS Bolton NHS Foundation Trust

Understanding the Report

This summary report shows the latest and previous position of selected indicators, as well as a year to date position, and a sparkline showing the trend over the last 12 months.

RAG Status

	Indicator is underperforming against the plan for the relevant period (latest, previous, year to date)
	Indicator is performing against the plan (including equal to the plan) for the relevant period (latest, previous, year to date)

Trend

	The direction of travel of the indicator value between the previous and latest period is downwards, and this is undesirable with respect to the plan
	The direction of travel of the indicator value between the previous and latest period is upwards, and this is undesirable with respect to the plan
	The indicator value has not changed between the previous and latest period
	The direction of travel of the indicator value between the previous and latest period is downwards, and this is desirable with respect to the plan
	The direction of travel of the indicator value between the previous and latest period is upwards, and this is desirable with respect to the plan

Integrated Summary Dashboard - September 2018

Quality and Safety

Harm Free Care

Falls
The quarterly falls report (Q2) will be presented at Novembers Quality Assurance Committee. Overall we have demonstrated achievement against our trajectory
Falls By Ward are improving across inpatient areas this quarter.

Pressure Ulcers
Hospital - There were 4 category 2 pressure ulcers in September with all recorded as lapses in care, a theme identified was a delay in escaltion. There were no reported category 3 or 4 pressure ulcers in hospital.
Community - There were 4 category 2 pressure ulcers in September, and 1 category 3 with all recorded as no lapses in care. There was one category 4 pressure ulcer recorded as a lapse in care.

Never Event – This involved a wrong site block. No harm occurred, however, a full report overseen by a NED will be presented to November Board.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
6 - Compliance with preventative measure for VTE	>= 95%	97.3%	Sep-18			>= 95%	97.8%	Aug-18		>= 95%	96.7%		95.4 - 97.8%	
9 - Never Events	= 0	1	Sep-18			= 0	0	Aug-18		= 0	2		0 - 1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	3.97	Sep-18			<= 5.30	3.72	Aug-18		<= 5.30	4.63		3.72 - 7.30	
14 - Inpatient falls resulting in Harm (Moderate +)	= 0	0	Sep-18			= 0	2	Aug-18		= 0	10		0 - 4	
15 - Acute Inpatients acquiring pressure damage (grd 2)	<= 6.0	4.0	Sep-18			<= 6.0	4.0	Aug-18		<= 36.0	43.0		3.0 - 15.0	
16 - Acute Inpatients acquiring pressure damage (grd 3)	<= 0.5	0.0	Sep-18			<= 0.5	1.0	Aug-18		<= 3.0	3.0		0.0 - 2.0	
17 - Acute Inpatients acquiring pressure damage (grd 4)	= 0.0	0.0	Sep-18			= 0.0	0.0	Aug-18		= 0.0	0.0		0.0 - 0.0	
18 - Community patients acquiring pressure damage (grd 2)	<= 7.0	4.0	Sep-18			<= 7.0	7.0	Aug-18		<= 42.0	47.0		2.0 - 12.0	

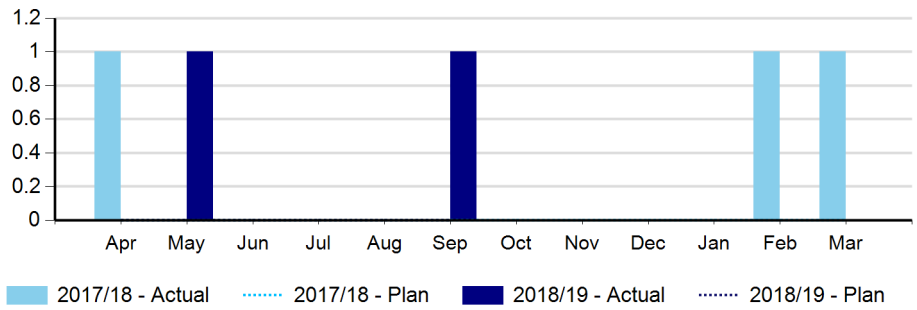
Integrated Summary Dashboard - September 2018

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
19 - Community patients acquiring pressure damage (grd 3)	<= 4.0	1.0	Sep-18			<= 4.0	3.0	Aug-18		<= 24.0	26.0		1.0 - 10.0	
20 - Community patients acquiring pressure damage (grd 4)	<= 1.0	1.0	Sep-18			<= 1.0	0.0	Aug-18		<= 6.0	5.0		0.0 - 3.0	
21 - Total Pressure Damage due to lapses in care	<= 6	5	Sep-18			<= 6	4	Aug-18		<= 34	34		2 - 13	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	91.8%	Q1 2018/19			>= 90%	88.7%	Q4 2017/18		>= 90%	91.8%		86.0 - 91.8%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	90.0%	Q1 2018/19			>= 90%	83.3%	Q4 2017/18		>= 90%	90.0%		83.3 - 100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	80.2%	Sep-18			>= 80%	78.1%	Aug-18		>= 80%	78.5%		76.7 - 82.2%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	73.4%	Sep-18			>= 72.5%	73.0%	Aug-18		>= 72.5%	79.6%		73.0 - 87.7%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	-	Sep-18			= 100%	90.0%	Aug-18		= 100%	98.0%		90.0 - 100.0%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	91.7%	Sep-18			>= 85%	91.7%	Aug-18		>= 85%	91.8%		89.7 - 92.9%	
91 - All Serious Incidents investigated and signed off by the Board of Directors within 60 days	= 100%	0.0%	Sep-18			= 100%	66.7%	Aug-18		= 100%	29.4%		0.0 - 100.0%	
312 - All Serious Incidents investigated and signed off by the Board of Directors within 60 days but within an agreed extension period	= 100%	100.0%	Sep-18			= 100%	100.0%	Aug-18		= 100%	94.1%		50.0 - 100.0%	

Integrated Summary Dashboard - September 2018

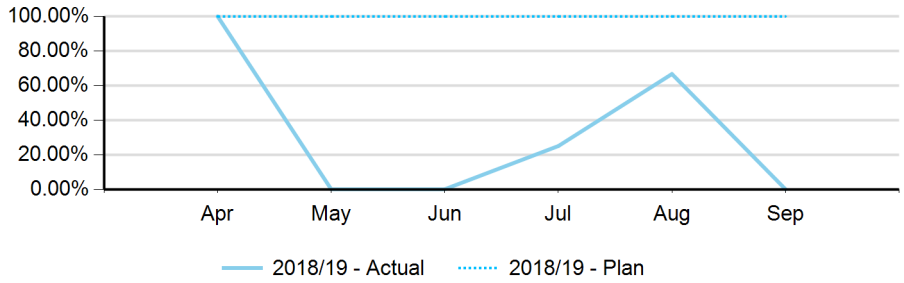
Exceptions

9 - Never Events



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	0	0	0	0	0	0	0	0	0	1	1
18/19	0	1	0	0	0	1						

91 - All Serious Incidents investigated and signed off by the Board of Directors within 60 days



	Apr	May	Jun	Jul	Aug	Sep
18/19	100.0%	0.0%	0.0%	25.0%	66.7%	0.0%

Integrated Summary Dashboard - September 2018

Infection Prevention and Control

A task and finish group has met to address the issue of blood culture contaminants. A&E is the outlier in this area accounting for 41 of the 57 (72%) blood culture sets contaminated in September while accounting for only 50% of the total number of blood cultures collected. A series of actions have been agreed and are now in progress, this will be monitored via the IPCC.

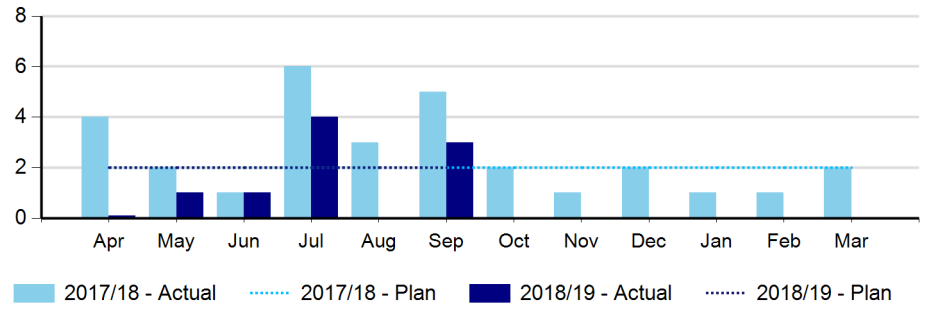
Root cause analysis is now being undertaken for MSSA bacteraemias.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
215 - Total Trust apportioned C. diff infections	<= 2	3	Sep-18			<= 2	0	Aug-18		<= 12	9		0 - 5	
216 - Total performance C. diff infections	<= 2	3	Sep-18			<= 2	0	Aug-18		<= 12	9		0 - 4	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Sep-18			= 0	0	Aug-18		= 0	1		0 - 1	
218 - Total Trust apportioned E. coli BSI	<= 3	2	Sep-18			<= 3	7	Aug-18		<= 19	17		0 - 7	
219 - Blood Culture Contaminants (rate)	<= 3%	6.8%	Sep-18			<= 3%	5.7%	Aug-18		<= 3%	4.8%		2.5 - 7.0%	
199 - Compliance with antibiotic prescribing standards	>= 95%	86.0%	Q1 2018/19			>= 90%	85.5%	Q4 2017/18		>= 95%	86.0%		84.8 - 86.0%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	1.0	Sep-18			<= 1.3	3.0	Aug-18		<= 7.8	11.0		0.0 - 4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 1	0	Sep-18			= 0	0	Aug-18		<= 5	5		0 - 2	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	0	Sep-18			= 0	1	Aug-18		<= 1	1		0 - 1	

Integrated Summary Dashboard - September 2018

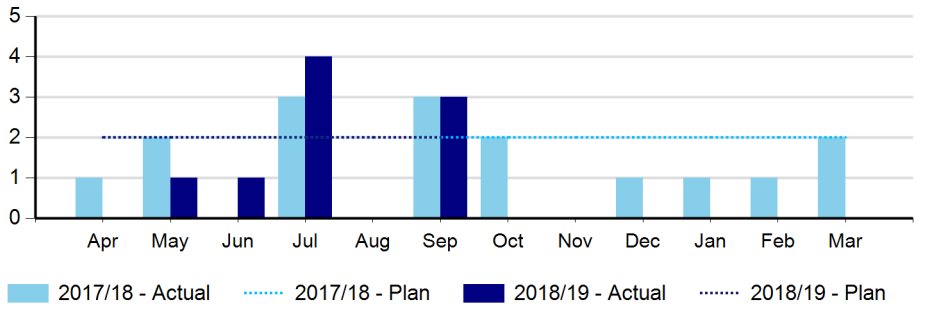
Exceptions

215 - Total Trust apportioned C. diff infections



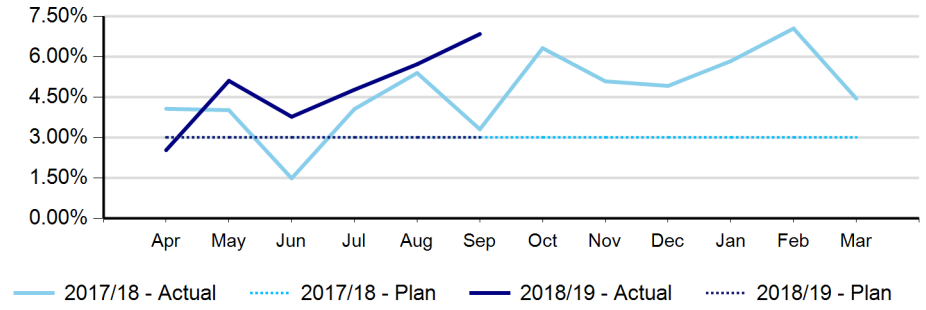
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4	2	1	6	3	5	2	1	2	1	1	2
18/19	0	1	1	4	0	3						

216 - Total performance C. diff infections



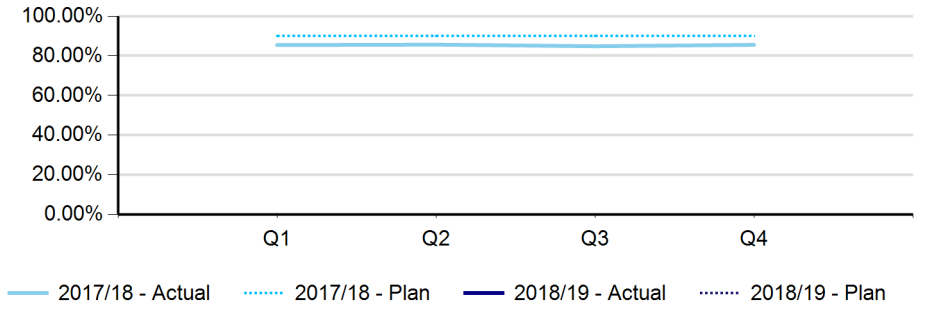
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	0	3	0	3	2	0	1	1	1	2
18/19	0	1	1	4	0	3						

219 - Blood Culture Contaminants (rate)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.1%	4.0%	1.5%	4.1%	5.4%	3.3%	6.3%	5.1%	4.9%	5.8%	7.0%	4.4%
18/19	2.5%	5.1%	3.8%	4.8%	5.7%	6.8%						

199 - Compliance with antibiotic prescribing standards



	Q1	Q2	Q3	Q4
17/18	85.4%	85.6%	84.8%	85.5%
18/19	86.0%			

Integrated Summary Dashboard - September 2018

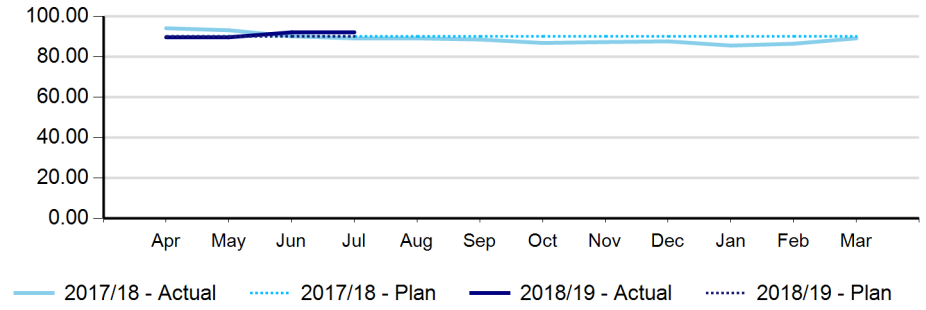
Mortality

The latest published SHMI data is for quarter 4 2017/18 and shows a rise compared to the previous quarter. The Mortality Board are aware of this rise and internal investigation is taking place in relation to SHMI groups, where deaths are above the expected levels. July 18 is the latest published data available in relation to RAMI.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
3 - National Early Warning Scores to Gold standard	>= 85%	87.1%	Sep-18			>= 85%	85.1%	Aug-18		>= 85%	91.1%		85.1 - 96.7%	
10 - Risk adjusted Mortality (ratio) (1 mth in arrears)	<= 90	92.0	Jul-18			<= 90	92.0	Jun-18		<= 90	92.0		85.4 - 92.0	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.000	108.700	Q4 2017/18			<= 100.000	105.220	Q3 2017/18		<= 100.000			105.220 - 108.700	
12 - Crude Mortality %	<= 2.9%	2.2%	Sep-18			<= 2.9%	1.9%	Aug-18		<= 2.9%	2.0%		1.9 - 3.1%	

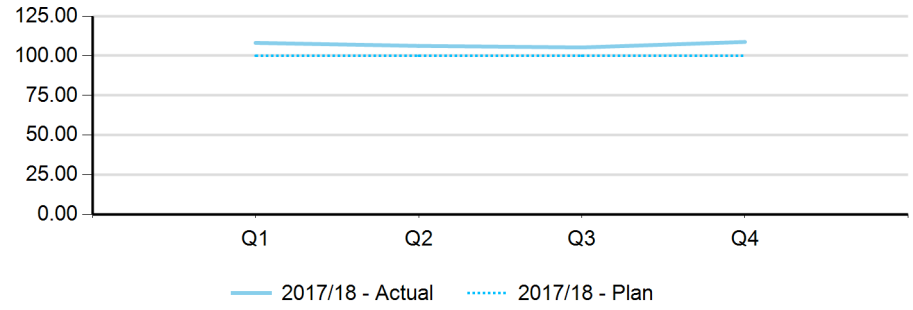
Exceptions

10 - Risk adjusted Mortality (ratio) (1 mth in arrears)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	94.0	93.0	90.0	89.0	89.0	88.4	86.7	87.2	87.5	85.4	86.3	89.0
18/19	89.5	89.5	92.0	92.0								

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



	Q1	Q2	Q3	Q4
17/18	108.100	106.200	105.220	108.700

Integrated Summary Dashboard - September 2018

Patient Experience

A&E Friends and Family
The response rates for September fell below the target at 16.6% and was as a result in a reduction in paediatric responses, a recovery plan is in place.

Maternity Friends and Family
The department is continuing to focus on sustaining the response rates.

Complaints response rates
We continue to meet the 25% response rate. Training for staff continues on a rolling basis.

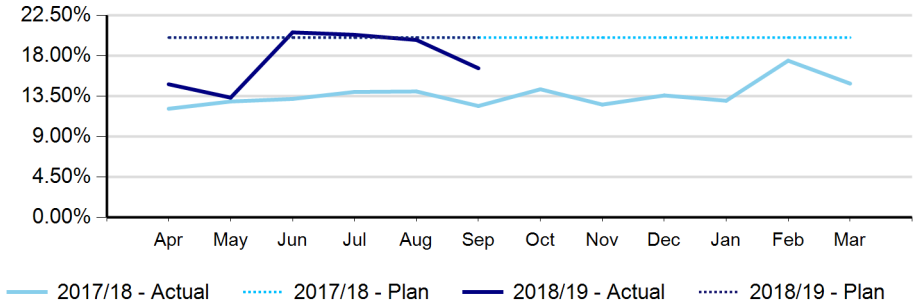
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
200 - A&E Friends and Family Response Rate	>= 20%	16.6%	Sep-18			>= 20%	19.7%	Aug-18		>= 20%	17.5%		12.4 - 20.6%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	90%	Sep-18			>= 90%	91%	Aug-18		>= 90%	89%		83 - 91%	
80 - Inpatient Friends and Family Response Rate	>= 30%	30.7%	Sep-18			>= 30%	30.9%	Aug-18		>= 30%	33.3%		29.3 - 37.5%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.3%	Sep-18			>= 90%	96.2%	Aug-18		>= 90%	96.6%		95.7 - 97.4%	
81 - Maternity Friends and Family Response Rate	>= 15%	32.7%	Sep-18			>= 15%	43.6%	Aug-18		>= 15%	28.3%		18.0 - 43.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	95.3%	Sep-18			>= 90%	97.1%	Aug-18		>= 90%	96.1%		93.4 - 97.9%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	20.6%	Sep-18			>= 15%	31.5%	Aug-18		>= 15%	12.0%		1.7 - 31.5%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	95.9%	Sep-18			>= 90%	97.0%	Aug-18		>= 90%	97.0%		88.9 - 100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	33.0%	Sep-18			>= 15%	29.9%	Aug-18		>= 15%	29.7%		17.8 - 34.7%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	90.9%	Sep-18			>= 90%	97.3%	Aug-18		>= 90%	93.8%		88.5 - 97.8%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	34.4%	Sep-18			>= 15%	44.5%	Aug-18		>= 15%	30.1%		18.0 - 44.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.4%	Sep-18			>= 90%	94.4%	Aug-18		>= 90%	95.3%		92.5 - 98.1%	

Integrated Summary Dashboard - September 2018

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	45.6%	Sep-18			>= 15%	75.1%	Aug-18		>= 15%	45.1%		7.9 - 75.1%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.3%	Sep-18			>= 90%	98.7%	Aug-18		>= 90%	98.2%		88.2 - 99.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Sep-18			= 100%	100.0%	Aug-18		= 100%	99.3%		96.6 - 100.0%	
90 - Complaints responded to within the period	>= 95%	95.2%	Sep-18			>= 95%	88.5%	Aug-18		>= 95%	93.8%		87.0 - 100.0%	

Exceptions

200 - A&E Friends and Family Response Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12.1%	12.9%	13.2%	13.9%	14.0%	12.4%	14.2%	12.5%	13.6%	13.0%	17.4%	14.9%
18/19	14.8%	13.3%	20.6%	20.3%	19.7%	16.6%						

Integrated Summary Dashboard - September 2018

Maternity

12+6 - 4 out of the 5 teams are performing this month at 92% . 1 of the teams underperforming achieved 87% as a result and issues identified are being acted upon.

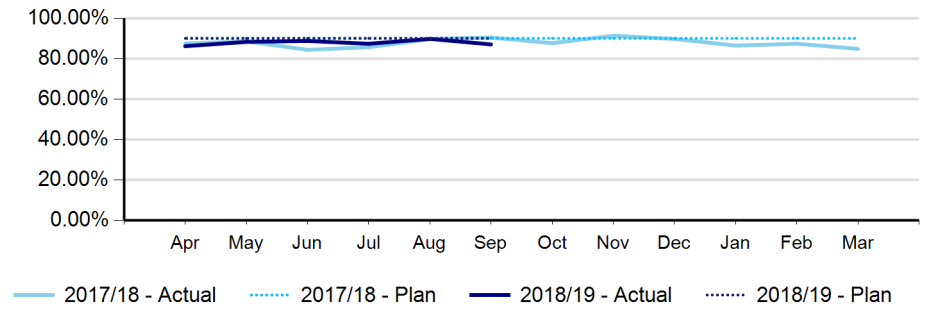
Inductions of labour - this is a reflection of increase in women presenting with diabetes, reduced fetal movements and suspected growth restriction. The drive to reduce still births has ultimately seen the induction rate increase. We are however not an outlier at GM level and these figures reflect the implications of saving babies lives. As previously stated a review of all current maternity metrics is underway.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
22 - Maternity - Stillbirths	<= 4	2	Sep-18			<= 4	1	Aug-18		<= 24	8		1 - 3	
23 - Maternity -3rd/4th degree tears	<= 3%	2.0%	Sep-18			<= 3%	2.2%	Aug-18		<= 3%	2.2%		1.6 - 4.2%	
201 - Total births	>= 500	502	Sep-18			>= 500	498	Aug-18		>= 3,000	2,936		386 - 519	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.8%	Sep-18			>= 95.0%	99.3%	Aug-18		>= 95.0%	99.2%		97.4 - 99.8%	
203 - Booked 12+6	>= 90%	87.0%	Sep-18			>= 90%	89.7%	Aug-18		>= 90%	75.3%		84.8 - 91.3%	
204 - Inductions of labour	<= 35%	40.3%	Sep-18			<= 35%	41.5%	Aug-18		<= 35%	40.3%		32.2 - 45.3%	
205 - Normal deliveries	>= 63.0%	59.6%	Sep-18			>= 63.0%	57.5%	Aug-18		>= 63.0%	58.7%		54.5 - 62.4%	
208 - Total C section	<= 25.5%	27.6%	Sep-18			<= 25.5%	29.5%	Aug-18		<= 25.5%	28.0%		25.7 - 30.4%	
210 - Initiation breast feeding	>= 65%	72.5%	Sep-18			>= 65%	68.6%	Aug-18		>= 65%	69.7%		64.5 - 72.5%	
211 - Maternal admissions to ICU	= 0	0	Sep-18			= 0	0	Aug-18		= 0	1		0 - 1	
213 - Maternity complaints	<= 5	3	Sep-18			<= 5	3	Aug-18		<= 30	17		2 - 3	
214 - New claims	= 0	0	Sep-18			= 0	2	Aug-18		= 0	5		0 - 2	

Integrated Summary Dashboard - September 2018

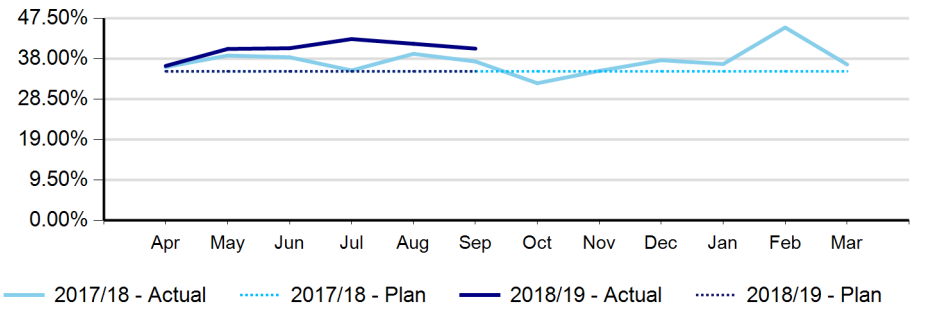
Exceptions

203 - Booked 12+6



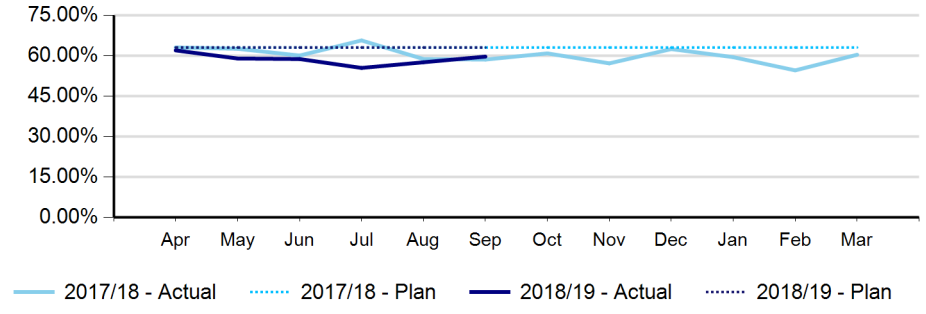
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	87.4%	88.5%	84.3%	85.6%	89.6%	90.4%	87.6%	91.3%	89.7%	86.4%	87.3%	84.8%
18/19	86.1%	88.2%	88.7%	87.3%	89.7%	87.0%						

204 - Inductions of labour



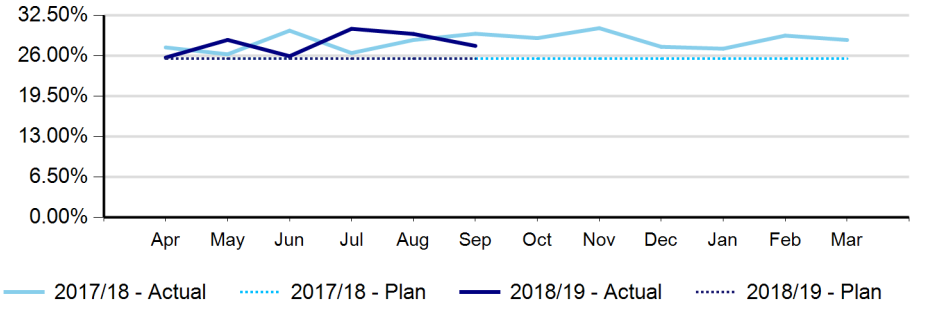
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	36.0%	38.7%	38.3%	35.2%	39.1%	37.3%	32.2%	35.1%	37.6%	36.7%	45.3%	36.6%
18/19	36.3%	40.3%	40.4%	42.6%	41.5%	40.3%						

205 - Normal deliveries



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	63.0%	62.5%	60.0%	65.6%	58.7%	58.5%	60.8%	57.1%	62.4%	59.4%	54.5%	60.3%
18/19	61.9%	58.9%	58.7%	55.4%	57.5%	59.6%						

208 - Total C section



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	27.3%	26.2%	30.0%	26.4%	28.5%	29.5%	28.8%	30.4%	27.4%	27.1%	29.2%	28.5%
18/19	25.7%	28.5%	25.9%	30.3%	29.5%	27.6%						

Integrated Summary Dashboard - September 2018

Operational Performance

Access

Transfers between 11pm and 6am has increased in September. A Task and Finish Groups is in the process of being created to gain greater traction on actions to improve performance.

Same sex accommodation breaches has reduced to 2 in September, the lowest number of breaches since April 18.

36 hours to theatre for fractured neck of femur patients has continued to be a challenge with 10 of the 30 patients failing the standard this month. The Trust is using the help of the Intensive Support Team to undertake a check and challenge of capacity and demand within orthopaedics and will continue to work with the CCG regarding the need for additional capacity.

RTT – the backlog reduction programme has continued, in all relevant specialities. The progress hasn't been as great as predicted due to a number of factors including; higher clinical risk patients being seen in ophthalmology, urgent care pressures continuing in the Summer months, and an increase in cancer referrals. The number of 52 week incomplete breaches has remained static and the Trust is in discussion with commissioners around the need to create additional capacity in Ophthalmology, Endoscopy, General Surgery and Orthopaedics in order to address this. In addition, the Trust is working with the Intensive Support Team to address some of the data quality issues which have resulted in 52 week breaches, through a training programme for all staff involved in RTT.

A&E 4 hour target – September saw a slight dip in performance to 89.1%, when compared to August's 89.6% On-going work within all the Divisions to improve patient flow continues with particular emphasis on discharges and reducing length of stay.

Diagnostics have remained under the 1% standard, however, there continues to be considerable pressure to achieve this standard particularly within Endoscopy. A business case has been developed to expand the service in order to cope with the increasing demand.

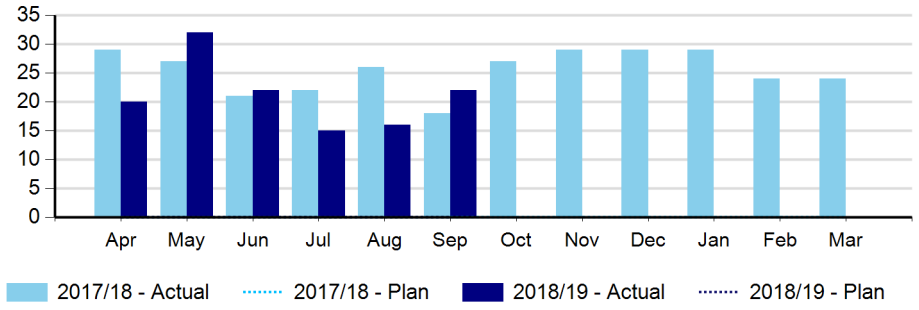
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	= 0	22	Sep-18			= 0	16	Aug-18		= 0	127		15 - 32	
8 - Same sex accommodation breaches	= 0	2	Sep-18			= 0	14	Aug-18		= 0	64		2 - 18	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	66.7%	Sep-18			>= 75%	59.4%	Aug-18		>= 75%	65.1%		55.6 - 88.6%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	89.1%	Sep-18			>= 92%	89.6%	Aug-18		>= 92%	89.5%		87.2 - 91.4%	
42 - RTT 52 week waits (incomplete pathways)	= 0	8	Sep-18			= 0	10	Aug-18		= 0	38		0 - 10	

Integrated Summary Dashboard - September 2018

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
53 - A&E 4 hour target	>= 95%	87.1%	Sep-18			>= 95%	88.2%	Aug-18		>= 95%	85.2%		76.9 - 88.2%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0%	6%	Sep-18			= 0%	5%	Aug-18		= 0%	9%		5 - 17%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	1.07%	Sep-18			= 0.00%	0.45%	Aug-18		= 0.00%	1.75%		0.45 - 13.54%	
72 - Diagnostic Waits >6 weeks %	<= 1%	0.9%	Sep-18			<= 1%	0.8%	Aug-18		<= 1%	0.7%		0.3 - 9.5%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	20.0%	Aug-18			= 100%	83.3%	Jul-18		= 100%	22.9%		0.0 - 83.3%	

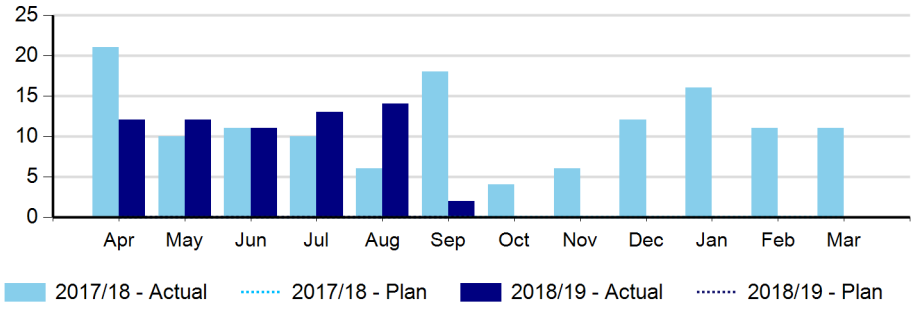
Exceptions

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	29	27	21	22	26	18	27	29	29	29	24	24
18/19	20	32	22	15	16	22						

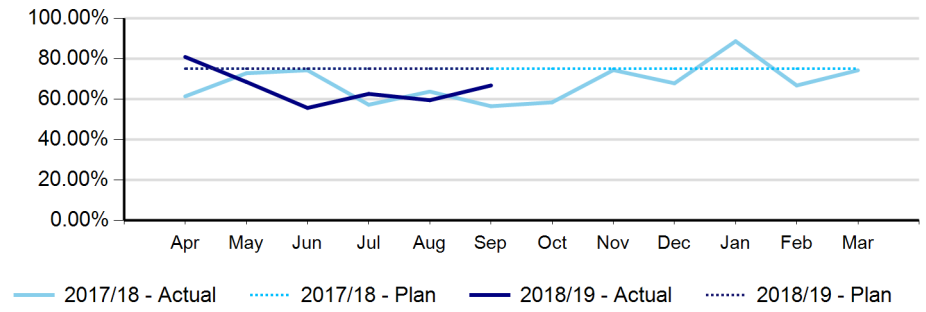
8 - Same sex accommodation breaches



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	21	10	11	10	6	18	4	6	12	16	11	11
18/19	12	12	11	13	14	2						

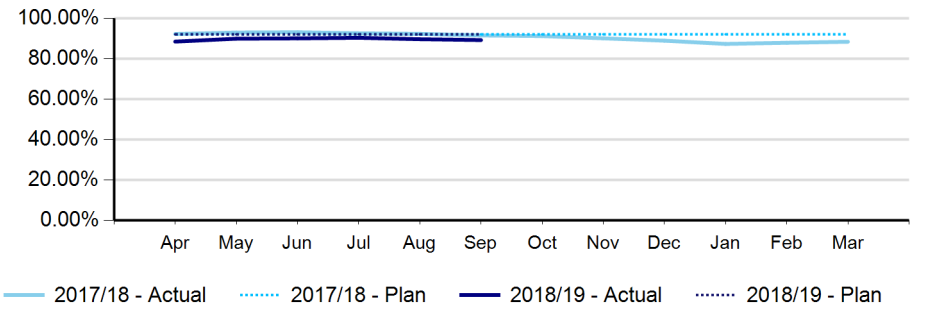
Integrated Summary Dashboard - September 2018

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



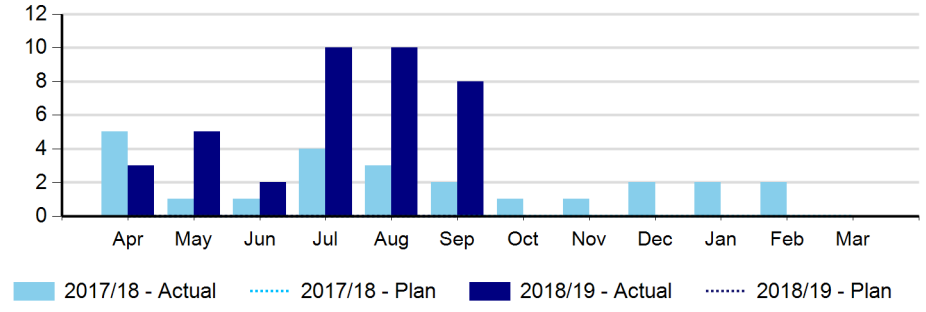
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	61.3%	72.7%	74.2%	57.1%	63.6%	56.4%	58.3%	74.3%	67.7%	88.6%	66.7%	74.2%
18/19	80.8%	68.4%	55.6%	62.5%	59.4%	66.7%						

41 - RTT Incomplete pathways within 18 weeks %



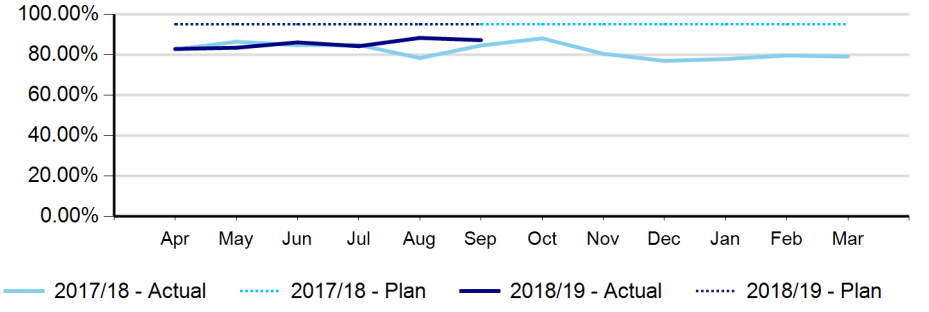
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.2%	87.8%	88.3%
18/19	88.4%	89.8%	90.0%	90.3%	89.6%	89.1%						

42 - RTT 52 week waits (incomplete pathways)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	5	1	1	4	3	2	1	1	2	2	2	0
18/19	3	5	2	10	10	8						

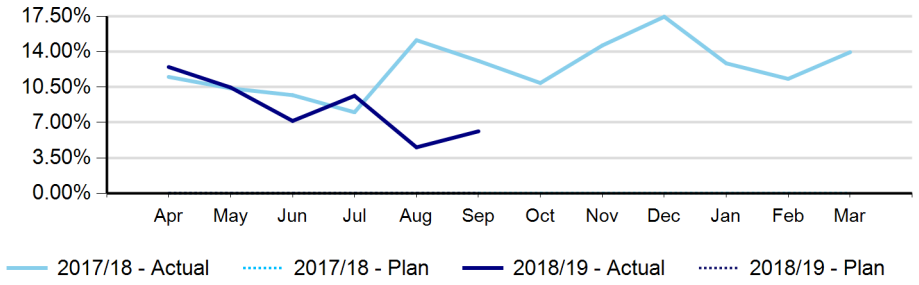
53 - A&E 4 hour target



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	82.5%	86.3%	84.6%	84.7%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%	79.5%	78.9%
18/19	82.7%	83.4%	86.0%	84.1%	88.2%	87.1%						

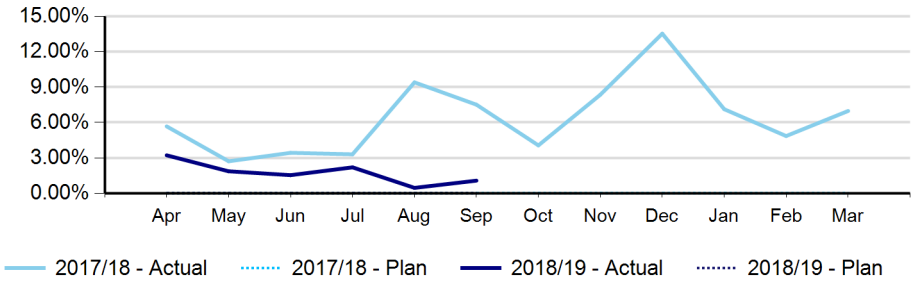
Integrated Summary Dashboard - September 2018

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



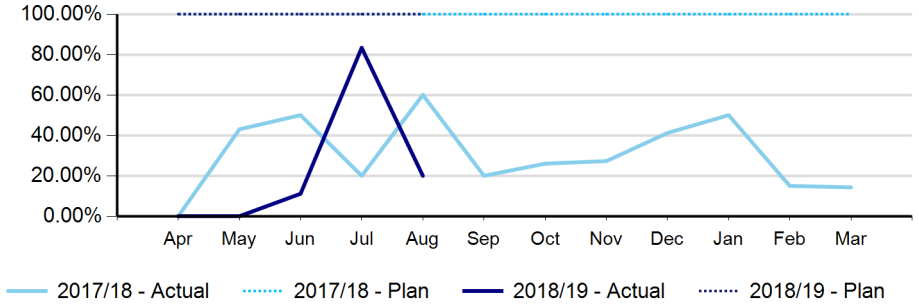
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12%	10%	10%	8%	15%	13%	11%	15%	17%	13%	11%	14%
18/19	12%	10%	7%	10%	5%	6%						

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	5.67%	2.71%	3.43%	3.30%	9.40%	7.51%	4.06%	8.36%	13.54%	7.13%	4.85%	6.98%
18/19	3.22%	1.86%	1.53%	2.19%	0.45%	1.07%						

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.0%	43.0%	50.0%	20.0%	60.0%	20.0%	26.0%	27.3%	41.2%	50.0%	15.0%	14.3%
18/19	0.0%	0.0%	11.1%	83.3%	20.0%							

Integrated Summary Dashboard - September 2018

Productivity

The Stranded and Super Stranded methodology has changed this month, to reflect the guidance issued by NHS Improvement. Work continues in the Divisions to ensure that clinicians are well sighted on their longest patients along with an escalation meeting to ensure there is robust challenge around the reasons for the longest staying patients.

DTOC has increased this month from 1.9% in August, to 2.8% in September, but remains under the target set by Greater Manchester of 3.3%.

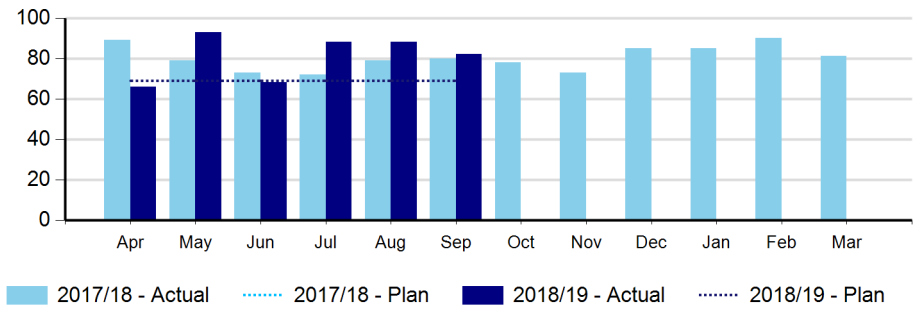
Length of stay shows a slight decrease this month of 0.1 day, this positive movement improves patient flow and assists the on-going demand for beds across the Trust.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
56 - Stranded patients	<= 200	199	Sep-18			<= 200	243	Aug-18		<= 200	199		199 - 281	
307 - Stranded Patients - LOS 21 days and over	<= 69	82	Sep-18			<= 69	88	Aug-18		<= 69	82		66 - 93	
57 - Discharges by Midday	>= 30%	28.5%	Sep-18			>= 30%	27.3%	Aug-18		>= 30%	29.0%		25.9 - 33.1%	
58 - Discharges by 4pm	>= 70%	64.3%	Sep-18			>= 70%	67.3%	Aug-18		>= 70%	67.6%		62.6 - 70.0%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	12.9%	Aug-18			<= 13.5%	12.6%	Jul-18		<= 13.5%	12.5%		11.7 - 13.4%	
60 - Daycase Rates	>= 80%	87.2%	Sep-18			>= 80%	88.3%	Aug-18		>= 80%	90.4%		77.2 - 100.0%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.8%	Sep-18			<= 1%	1.6%	Aug-18		<= 1%	1.6%		0.9 - 2.1%	
62 - Cancelled operations re-booked within 28 days	= 100%	88.1%	Sep-18			= 100%	100.0%	Aug-18		= 100%	85.8%		63.6 - 100.0%	
64 - Delayed Transfers Of Care - GM Methodology (% occupied bed days delayed - phased reduction)	<= 3.3%	2.8%	Sep-18			<= 3.3%	1.9%	Aug-18		<= 3.3%	2.5%		1.9 - 7.5%	
65 - Elective Length of Stay (Discharges in month)	<= 2.0	2.4	Sep-18			<= 2.0	2.5	Aug-18		<= 2.0	2.4		2.1 - 2.9	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.7	3.8	Sep-18			<= 3.7	3.9	Aug-18		<= 3.7	3.8		3.7 - 4.2	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	88.9%	Aug-18			>= 80%	75.0%	Jul-18		>= 80%	79.4%		53.3 - 91.3%	

Integrated Summary Dashboard - September 2018

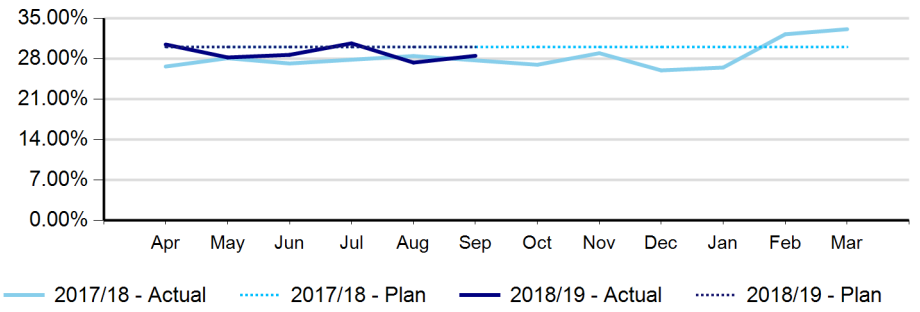
Exceptions

307 - Stranded Patients - LOS 21 days and over



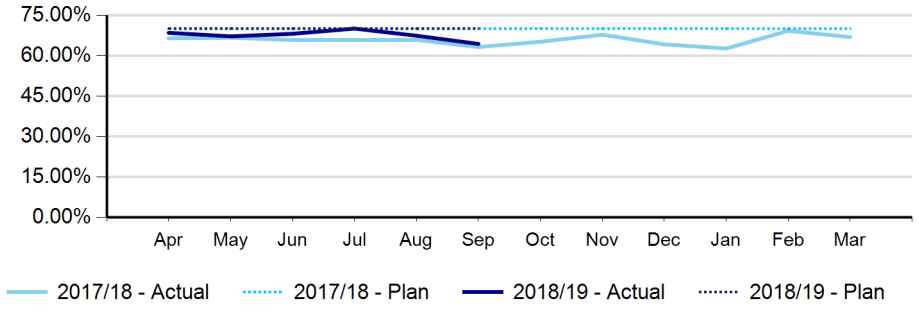
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89	79	73	72	79	80	78	73	85	85	90	81
18/19	66	93	68	88	88	82						

57 - Discharges by Midday



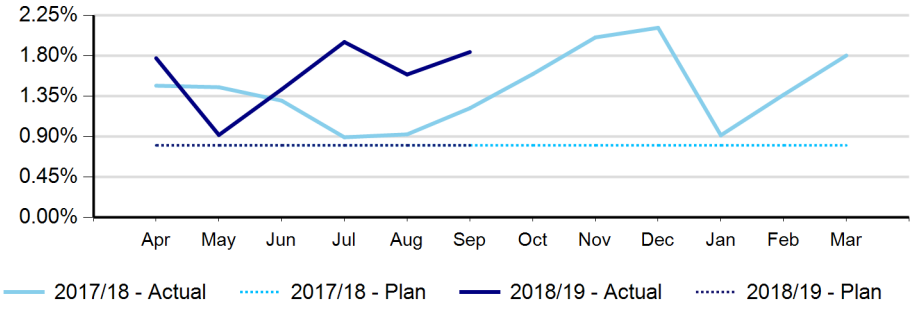
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	26.6%	28.1%	27.1%	27.8%	28.4%	27.7%	26.9%	28.9%	25.9%	26.4%	32.2%	33.1%
18/19	30.4%	28.2%	28.6%	30.6%	27.3%	28.5%						

58 - Discharges by 4pm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	66.4%	66.6%	65.8%	65.8%	65.8%	63.2%	65.1%	67.7%	64.1%	62.6%	69.2%	66.9%
18/19	68.4%	67.1%	68.1%	70.0%	67.3%	64.3%						

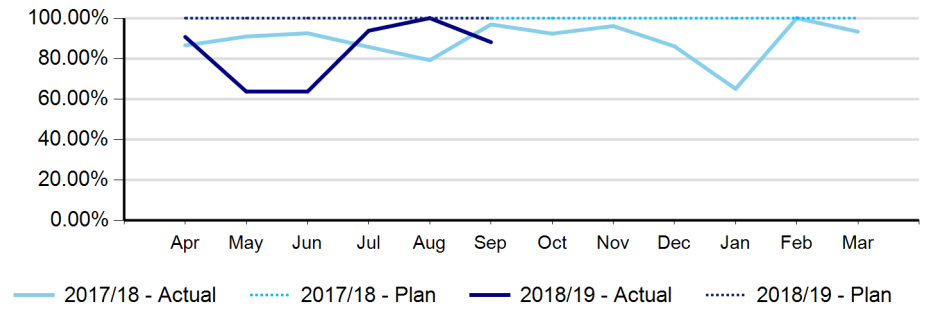
61 - Operations cancelled on the day for non-clinical reasons



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1.5%	1.4%	1.3%	0.9%	0.9%	1.2%	1.6%	2.0%	2.1%	0.9%	1.4%	1.8%
18/19	1.8%	0.9%	1.4%	2.0%	1.6%	1.8%						

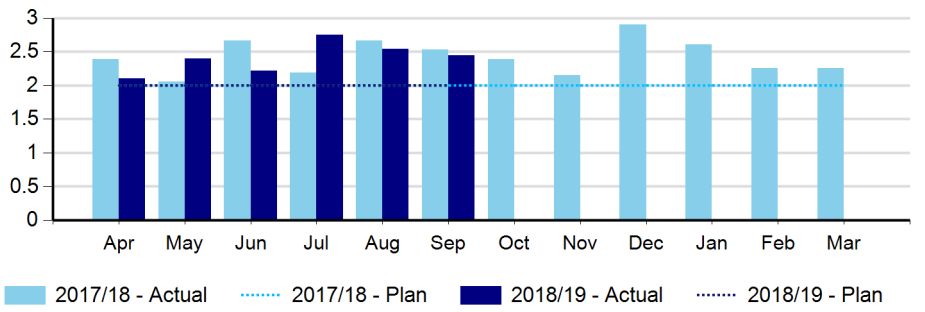
Integrated Summary Dashboard - September 2018

62 - Cancelled operations re-booked within 28 days



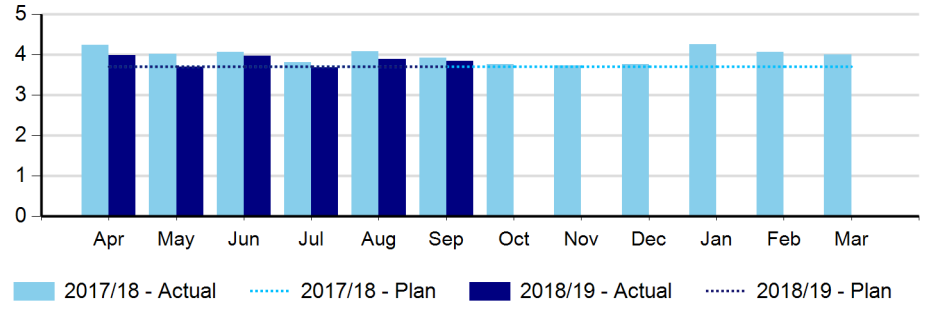
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86.5%	90.9%	92.5%	85.7%	79.2%	96.9%	92.3%	96.1%	86.0%	65.0%	100.0%	93.3%
18/19	90.7%	63.6%	63.6%	93.8%	100.0%	88.1%						

65 - Elective Length of Stay (Discharges in month)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2.4	2.0	2.7	2.2	2.7	2.5	2.4	2.1	2.9	2.6	2.3	2.3
18/19	2.1	2.4	2.2	2.8	2.5	2.4						

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.2	4.0	4.1	3.8	4.1	3.9	3.8	3.7	3.8	4.2	4.1	4.0
18/19	4.0	3.7	4.0	3.7	3.9	3.8						

Integrated Summary Dashboard - September 2018

Cancer

In August the Trust continued to deliver a high performance against the cancer standards, achieving 97.9% for patients waiting 2 weeks from referral for all cancers.

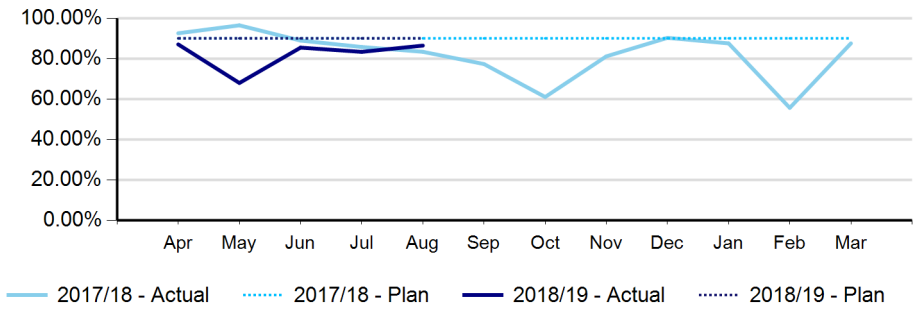
Patients starting cancer treatment with 62 days of urgent GP referral achieved 95.2%, and a ranking of 1 out of 131 trusts in August. (Source: BBC)

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
46 - 62 day standard % (1 mth in arrears)	>= 85%	92.1%	Aug-18			>= 85%	95.4%	Jul-18		>= 85%	92.2%		87.2 - 95.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	86.4%	Aug-18			>= 90%	83.3%	Jul-18		>= 90%	81.3%		55.6 - 90.2%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	100.0%	Aug-18			>= 96%	100.0%	Jul-18		>= 96%	99.8%		98.9 - 100.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Aug-18			>= 94%	100.0%	Jul-18		>= 94%	100.0%		90.9 - 100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Aug-18			>= 98%	100.0%	Jul-18		>= 98%	100.0%		100.0 - 100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	97.9%	Aug-18			>= 93%	96.3%	Jul-18		>= 93%	96.1%		93.6 - 98.3%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	93.7%	Aug-18			>= 93%	95.0%	Jul-18		>= 93%	71.6%		34.9 - 95.0%	

Integrated Summary Dashboard - September 2018

Exceptions

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%	90.2%	87.5%	55.6%	87.5%
18/19	87.0%	67.9%	85.4%	83.3%	86.4%							

Integrated Summary Dashboard - September 2018

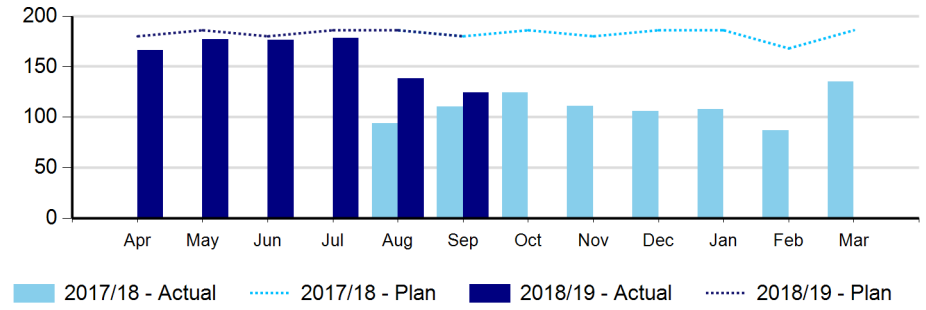
Community

Community performance against the metrics continues to be challenging. Admission avoidance remains above threshold in September.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
225 - Admission Avoidance	>= 166	192	Sep-18		↑	>= 166	175	Aug-18		>= 996	688		0 - 192	
226 - Home First (deflections from A&E)	>= 180	124	Sep-18		↓	>= 186	138	Aug-18		>= 1,098	959		87 - 178	
227 - Length of Stay - Darley Court	<= 28	35	Sep-18		↑	<= 28	23	Aug-18		<= 168	159		20 - 35	
228 - DTOC Numbers	<= 15	28	Sep-18		↑	<= 15	16	Aug-18		<= 15	28		16 - 28	
230 - Medically Optimised Numbers	<= 50	86	Sep-18		↑	<= 50	79	Aug-18		<= 300	415		52 - 86	
231 - Medically Optimised Days	<= 209	790	Sep-18		↑	<= 209	634	Aug-18		<= 1,254	3,057		344 - 790	

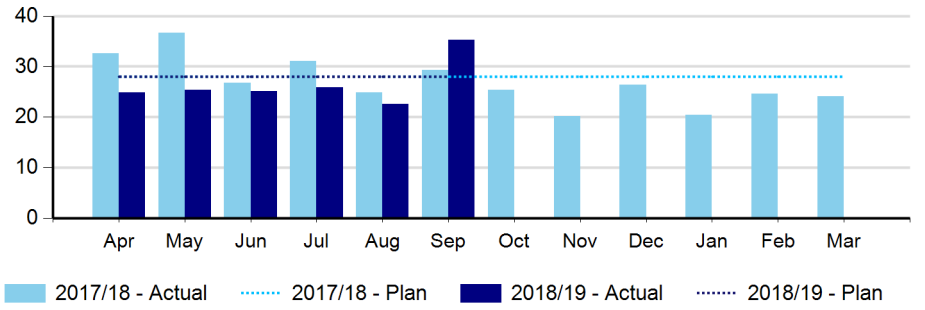
Exceptions

226 - Home First (deflections from A&E)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18					94	110	124	111	106	108	87	135
18/19	166	177	176	178	138	124						

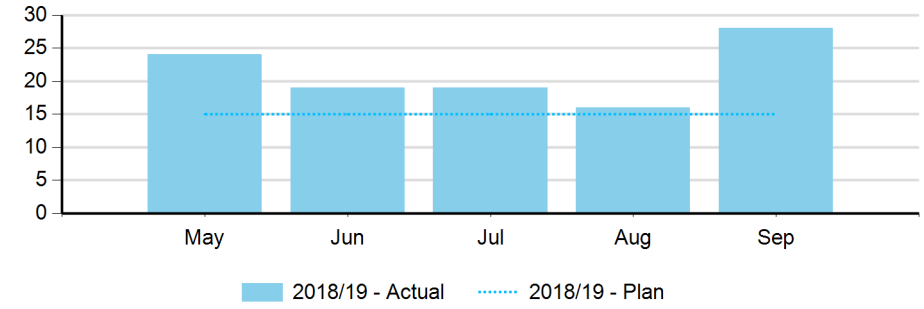
227 - Length of Stay - Darley Court



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	33	37	27	31	25	29	25	20	26	20	25	24
18/19	25	25	25	26	23	35						

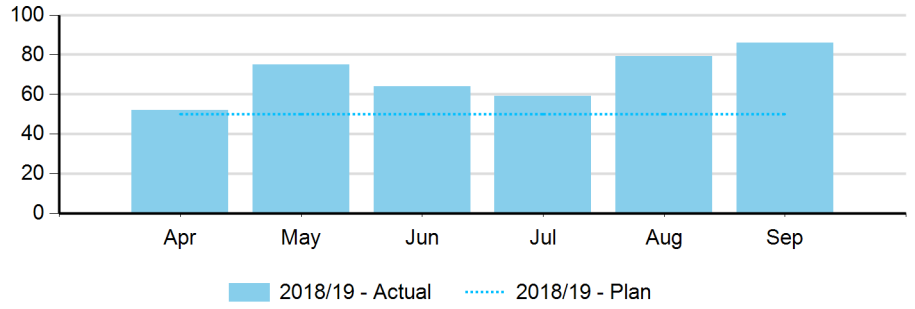
Integrated Summary Dashboard - September 2018

228 - DTOC Numbers



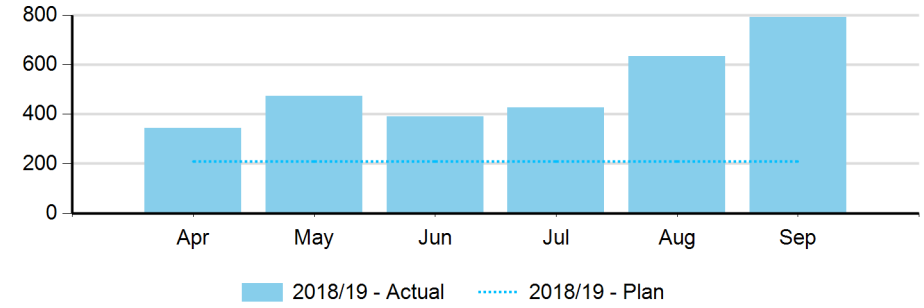
	May	Jun	Jul	Aug	Sep
18/19	24	19	19	16	28

230 - Medically Optimised Numbers



	Apr	May	Jun	Jul	Aug	Sep
18/19	52	75	64	59	79	86

231 - Medically Optimised Days



	Apr	May	Jun	Jul	Aug	Sep
18/19	344	472	391	426	634	790

Integrated Summary Dashboard - September 2018

Workforce

Sickness, Vacancy and Turnover

Recruitment
There continues to be good progress on both nursing and medical recruitment. The Trust is currently in the strongest position it has been in for nursing staff for a number of years - Elective have 1.78 WTE ward level nursing vacancies and Acute medicine have 24.37 WTE. Medical recruitment remains strong – the Divisions continue to work closely with the Workforce team to ensure a sharp focus is being taken on all vacancies – as previously noted a large number of Consultant and Middle Grade Doctors are due to commence between September and November, which include 'hard to fill' specialities such as Anaesthetics, Radiology, Histopathology, Surgery, and Obstetrics and Gynaecology. There does remain 'hard to fill' medical posts in Dermatology, and Accident and Emergency (albeit there has been some interest in the recent advert). Regrettable a Urology Consultant who was due to commence post in January 2019 has now withdrawn his appointment.

The Trust took part in a joint recruitment fair with colleagues from Bolton Council, Bolton CCG, and the third sector in Bolton at the beginning of October. The event was very well attended with over 240 visitors and is part of the locality strategy to market Bolton as a great place to live and which will support the work we do to ensure the Trust is seen as a great place to work.

Sickness
There has been a very slight improvement in the sickness rate September when compared to last month.

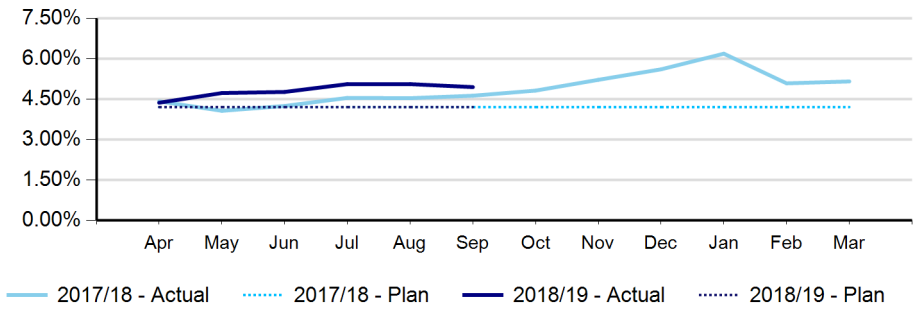
The HR Operational team have launched the pilot Attendance Matters scheme, which has a single reporting process and telephone line, 7 days a week for all absences for staff in the pilot areas (Adult Acute, ICS and IFM). Within the first 2 week the team have handled 1000 calls (450 inbound/550 outbound), the team have made fast track referral to the staff physio therapy team, signposted the mental health drop in sessions and provided direct advise in relation to reason for absence from our attendance matters nurse. Stress and anxiety remains the top absence reason in terms of calendar days lost and further work is being undertaken in this area, for example the Trust has recently increased the number of mental well-being sessions being offered (from mid-September); a Resilience Programme was launched on 20th September with up to 400 places being offered. A task & finish group has met to further review the reasons for the high sickness absence within the Additional Clinical Services Staffing group.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
117 - Sickness absence level - Trust	<= 4.2%	4.9%	Sep-18			<= 4.2%	5.1%	Aug-18		<= 4.2%	4.8%		4.4 - 6.2%	
120 - Vacancy level - Trust	<= 6%	3.5%	Sep-18			<= 6%	4.8%	Aug-18		<= 6%	4.6%		-0.2 - 5.3%	
121 - Turnover	8 - 10%	9.5%	Sep-18			8 - 10%	10.5%	Aug-18		8 - 10%	9.7%		9.4 - 10.6%	

Integrated Summary Dashboard - September 2018

Exceptions

117 - Sickness absence level - Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.4%	4.1%	4.2%	4.5%	4.5%	4.6%	4.8%	5.2%	5.6%	6.2%	5.1%	5.2%
18/19	4.4%	4.7%	4.8%	5.1%	5.1%	4.9%						

Integrated Summary Dashboard - September 2018

Organisational Development

Working in partnership with divisions, continued efforts have been made to ensure that statutory, mandatory and safeguarding training remains a priority. With the exception of statutory training (which remains at the same level) both mandatory and safeguarding training show a slight increase in activity levels. Managers across the Trust have been asked to plan ahead and identify staff that are due training in December and January and book them on courses in October and November. Disappointingly we have seen a slight decrease in our appraisal completion rate in September (85.5%) compared to the previous month which showed an all-time high at 87.1%. The Trust will continue to promote the new team appraisals and support managers to enable them to prioritise and complete appraisals.

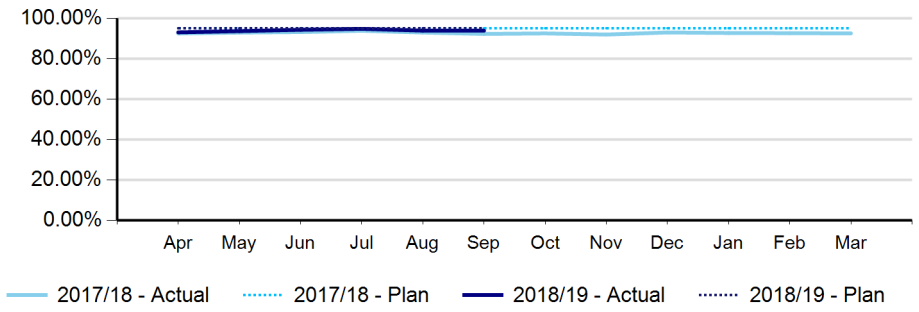
The National Staff Survey was launched on 24 September 2018. 1250 staff across the Trust, selected at random, have been invited to participate in the survey. At week 3 of the survey our overall response rate was 25% which is above the average response rate for combined trusts. Staff are continually being encouraged to take part in the survey as part of our new #SpeakUp internal communications campaign. The national survey closes on 30 November 2018 and we are working towards achieving a 50% overall response rate. Moving forward the Trust intends to use the Go Engage survey tool which will gather staff views and provide greater insights into staff engagement levels.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	**Plan**	**Actual**	**Period**	**RAG**		**Plan**	**Actual**	**Period**	**RAG**	**Plan**	**Actual**	**RAG**	**Range**	**Trend**
37 - Staff completing Statutory Training	>= 95%	93.8%	Sep-18			>= 95%	93.8%	Aug-18		>= 95%	93.8%		91.9 - 94.7%	
38 - Staff completing Mandatory Training	>= 85%	92.5%	Sep-18			>= 85%	91.4%	Aug-18		>= 85%	91.3%		88.7 - 92.5%	
39 - Staff completing Safeguarding Training	>= 95%	94.8%	Sep-18			>= 95%	94.7%	Aug-18		>= 95%	94.9%		91.8 - 95.6%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.5%	Sep-18			>= 85%	87.1%	Aug-18		>= 85%	85.0%		80.3 - 87.1%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	71.0%	Q1 2018/19			>= 66%	72.0%	Q4 2017/18		>= 66%			71.0 - 72.0%	
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	82.0%	Q1 2018/19			>= 80%	83.0%	Q4 2017/18		>= 80%			82.0 - 83.0%	

Integrated Summary Dashboard - September 2018

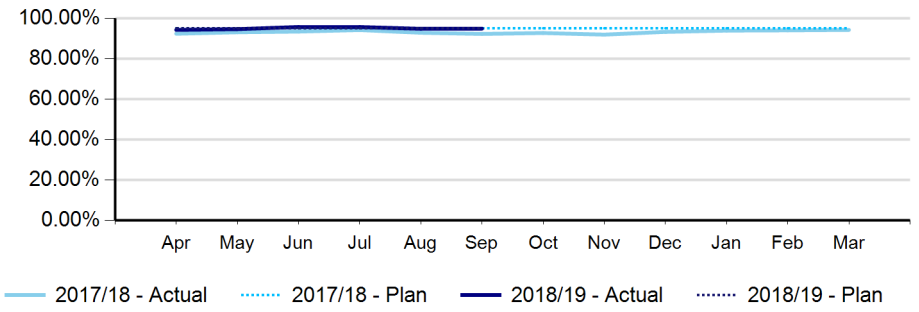
Exceptions

37 - Staff completing Statutory Training



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.4%	92.8%	93.1%	93.8%	92.9%	92.2%	92.4%	91.9%	92.9%	92.6%	92.6%	92.5%
18/19	93.0%	93.6%	94.2%	94.7%	93.8%	93.8%						

39 - Staff completing Safeguarding Training



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.3%	93.0%	93.4%	94.1%	92.8%	92.2%	92.6%	91.8%	93.2%	93.8%	93.9%	94.2%
18/19	94.2%	94.6%	95.6%	95.6%	94.7%	94.8%						

Integrated Summary Dashboard - September 2018

Agency

Colleagues will note there has been a significant decrease in Agency Spend when compared to previous months, with a significant reduction in month on medical agency spend which was in line with forecasted recruitment into ‘hard to fill’ medical vacancies; reductions in spending were also seen in relation to nursing, clerical, and AHP agency staffing. The Trust is just £270k behind the internally set Agency forecast (as per Annual Plan). There does remain an agency pressure in IFM (Senior Management - with this anticipated to remain until 1st November). Agency spend as a percentage of total spend for the Trust in 2017/18 was 4.4%; this is slightly above the regional average of 4% for the same year but is below both the national lower benchmark of 5.5% and the national upper benchmark of 8.0%. Achieving our forecast of £7.9million would move the Trust to 3.5% of total pay bill.

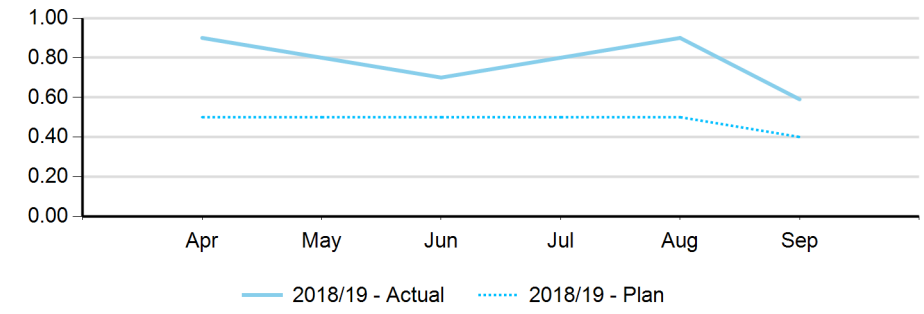
The majority of agency spend is due to vacancies (65%), with the main pressures being in nursing and medical agency usage. Elective Care in particular are forecasting a significant reduction in agency spend in October when a number of these key roles will be filled (albeit note earlier comments about Urology Consultant withdrawing his appointment which will therefore cause an on-going Agency pressure until that post is filled). A meeting took place with NHSi colleagues (end of September, 2018) to further review the measures that Bolton are taking to reduce their reliance on Agency Spend. This meeting was very helpful and provided an opportunity for the Trust to embrace further ‘best practice’ ideas and to provide re-assurance to the Trust Executive lead that all appropriate steps were being taken.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
198 - Trust Annual ceiling for agency spend (£m)	<= 0.40	0.59	Sep-18			<= 0.50	0.90	Aug-18		<= 2.90	4.69		0.59 - 0.90	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.10	0.28	Sep-18			<= 0.10	0.28	Aug-18		<= 0.60	1.86		0.28 - 0.40	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.20	0.30	Sep-18			<= 0.20	0.50	Aug-18		<= 1.20	2.30		0.30 - 0.50	
311 - Revised agency forecast plan (£m)	<= 0.57	0.59	Sep-18			<= 0.70	0.89	Aug-18		<= 4.25	4.52		0.59 - 0.89	

Integrated Summary Dashboard - September 2018

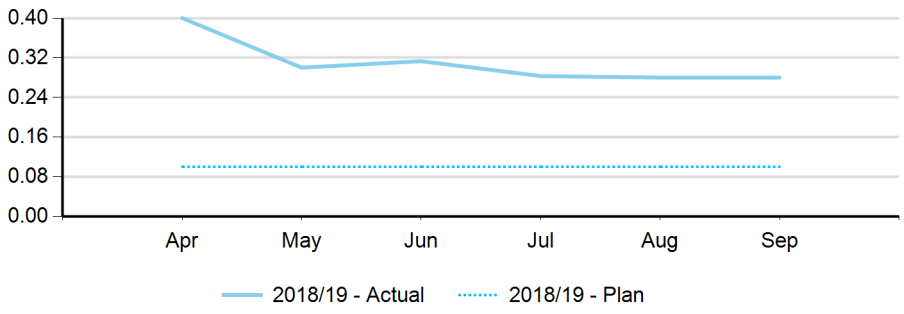
Exceptions

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



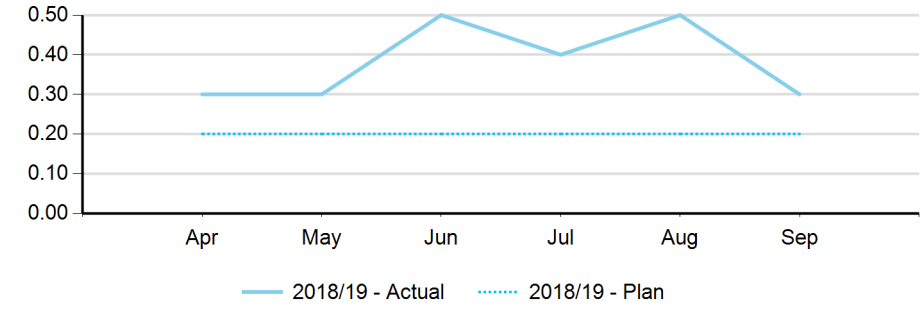
	Apr	May	Jun	Jul	Aug	Sep
18/19	0.90	0.80	0.70	0.80	0.90	0.59

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



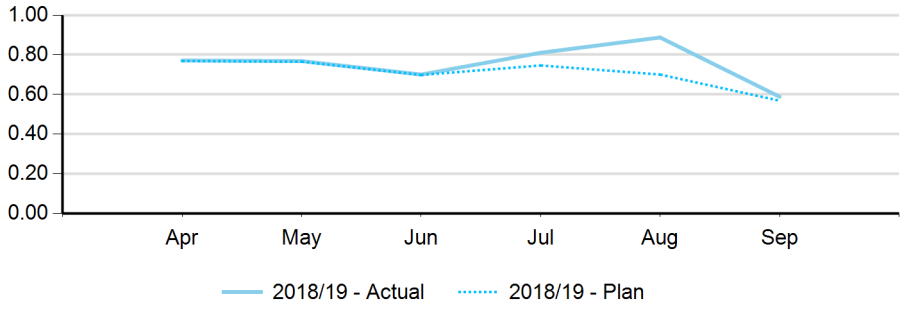
	Apr	May	Jun	Jul	Aug	Sep
18/19	0.40	0.30	0.31	0.28	0.28	0.28

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



	Apr	May	Jun	Jul	Aug	Sep
18/19	0.30	0.30	0.50	0.40	0.50	0.30

311 - Revised agency forecast plan (£m)



	Apr	May	Jun	Jul	Aug	Sep
18/19	0.77	0.77	0.70	0.81	0.89	0.59

Integrated Summary Dashboard - September 2018

Finance

Finance

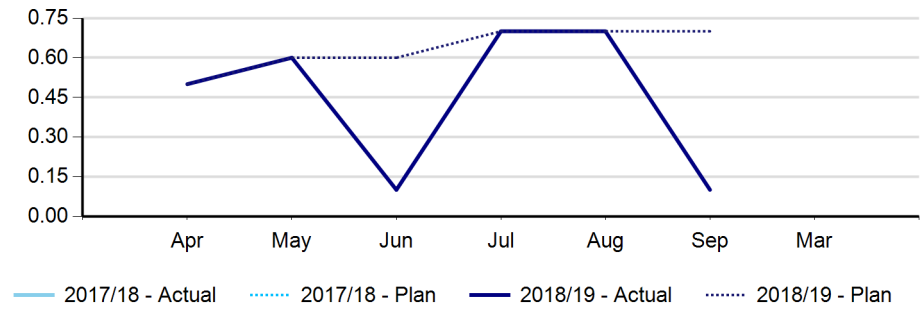
The Trust has a year to date deficit of £2.3m when PSF and impairments are excluded from the position; £0.03m better than plan.
Against the control total the Trust has a surplus of £0.4m; £1.2m less than plan.
There were no additional non-recurrent Balance Sheet adjustments released into the position.
Agency costs are at £4.5m against a year to date NHSI target of £3.2m.
ICIPs at £3.2m are £2.3m below plan for the year.
The month end cash balance is £10.4m which is better than plan by £3.4m this month.
Year to date capital spend is £7.4m which is £1.2m above the capital plan.
The Trust Use of Resource Rating is 2 as at the end of Month 6 which is on plan.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
220 - Control Total (£ millions)	>= -0.3	0.2	Sep-18			>= -0.3	-0.7	Aug-18		>= -2.4	-2.3		-1.2 - 2.3	
221 - Provider Sustainability Fund (£ millions)	>= 0.7	0.1	Sep-18			>= 0.7	0.7	Aug-18		>= 3.8	2.7		0.1 - 0.7	
222 - Capital (£ millions)	<= 1.7	1.7	Sep-18			<= 1.4	0.9	Aug-18		<= 6.5	7.5		0.5 - 2.9	
223 - Cash (£ millions)	>= 7.0	10.4	Sep-18			>= 7.4	12.4	Aug-18		>= 7.0	10.4		7.0 - 16.0	
224 - Use of Resources	<= 2	2	Sep-18			<= 2	2	Aug-18		<= 2	2		2 - 4	

Integrated Summary Dashboard - September 2018

Exceptions

221 - Provider Sustainability Fund (£ millions)



	Apr	May	Jun	Jul	Aug	Sep	Mar
17/18							0.6
18/19	0.5	0.6	0.1	0.7	0.7	0.1	

Integrated Summary Dashboard - September 2018

Use of Resources

Clinical Services

The Use of Resources information is derived from the model hospital data. The Board will note that the data is not always the most recent. Relevant committees have been tasked with providing assurance that metrics are being reviewed and exception reports produced for where the Trust is highlighted as red, this was agreed at QAC, the Associate Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager will meet to review in Q3 18/19 to ensure these arrangements are embedded.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
175 - Pre-procedure non-elective bed days	<= 1	1	Q1 2018/19			<= 1	2	Q4 2017/18		1 - 2	
176 - Pre-procedure elective bed days	<= 0.110	0.110	Q1 2018/19			<= 0.133	0.147	Q4 2017/18		0.110 - 0.167	
177 - Emergency readmissions (30 days)	<= 8%	8.2%	Q1 2018/19			<= 7%	7.5%	Q4 2017/18		7.5 - 8.6%	
178 - Did not attend (DNA) rate	<= 71%	8.7%	Q1 2018/19			<= 7%	8.9%	Q4 2017/18		8.7 - 8.9%	

Integrated Summary Dashboard - September 2018

People

The Use of Resources information is derived from the model hospital data. The Board will note that the data is not always the most recent. Relevant committees have been tasked with providing assurance that metrics are being reviewed and exception reports produced for where the Trust is highlighted as red, this was agreed at QAC, the Associate Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager will meet to review in Q3 18/19 to ensure these arrangements are embedded.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
179 - Staff retention rate	>= 85.50%	87.6%	May-18				89.3%	Apr-18		87.6 - 90.4%	
180 - Sickness absence rate	<= 3.99%	5.5%	Apr-18			<= 4.38%	5.5%	Mar-18		4.9 - 6.5%	
181 - Pay cost per weighted activity unit (WAU) - £	<= 2,157	2,348	Mar-17				2,268	Mar-16			
182 - Doctors cost per WAU - £	<= 526	424	Mar-17				412	Mar-16			
183 - Nurses cost per WAU - £	<= 718	961	Mar-17				920	Mar-16			
184 - Allied health professionals cost per WAU (community adjusted) - £	<= 845	1,144	Mar-17				1,095	Mar-16			

Integrated Summary Dashboard - September 2018

Clinical Support Services

The Use of Resources information is derived from the model hospital data. The Board will note that the data is not always the most recent. Relevant committees have been tasked with providing assurance that metrics are being reviewed and exception reports produced for where the Trust is highlighted as red, this was agreed at QAC, the Associate Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager will meet to review in Q3 18/19 to ensure these arrangements are embedded.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
185 - Top 10 medicines – percentage delivery of savings target	= 100.0%	72.6%	Nov-17			= 100.0%	83.0%	Oct-17		72.6 - 83.0%	
186 - Overall cost per test	<= 1.96	1.65	Mar-17			<= 2.12	2.48	Mar-16			

Integrated Summary Dashboard - September 2018

Corporate Services, Procurement, Estates & Facilities

The Use of Resources information is derived from the model hospital data. The Board will note that the data is not always the most recent. Relevant committees have been tasked with providing assurance that metrics are being reviewed and exception reports produced for where the Trust is highlighted as red, this was agreed at QAC, the Associate Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager will meet to review in Q3 18/19 to ensure these arrangements are embedded.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
187 - Non-pay cost per WAU	<= £1,301	£1,139.4	Mar-17			<= £1,320	£918.4	Mar-16			
188 - Finance cost per £100 million turnover	<= £670,512	£578,035.5	Mar-17								
189 - Human resources cost per £100 million turnover	<= £874,010	£790,402.9	Mar-17								
190 - Procurement Process Efficiency and Price Performance	<= 56.55	72.90	Q4 2016/17								
191 - Estates cost per square metre	<= £327	£273	Mar-17			<= £337	£269	Mar-16			

Integrated Summary Dashboard - September 2018

Finance

The Use of Resources information is derived from the model hospital data. The Board will note that the data is not always the most recent. Relevant committees have been tasked with providing assurance that metrics are being reviewed and exception reports produced for where the Trust is highlighted as red, this was agreed at QAC, the Associate Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager will meet to review in Q3 18/19 to ensure these arrangements are embedded.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
192 - Capital service capacity		2	Jul-18				1	Jun-18		1 - 2	
193 - Liquidity (days)		-3	Jul-18				-3	Jun-18		-15 - -3	
194 - Income and expenditure margin		0%	Jul-18				0%	Jun-18		-1 - 1%	
195 - Distance from financial plan		-1%	Jul-18				-1%	Jun-18		-1 - 0%	
196 - Distance from agency spend		34%	Jul-18				31%	Jun-18		31 - 65%	

Board Assurance Heat Map - Hospital - September 2018

	INDICATOR	Target	Darley Court	AED-Adults	AED-Paeds	B1 (Frailty Unit)	A4	B2	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)	Ingleside	M4/M5	NICU	Total
			Acute Division																			Elective Division														Families Division											
Beds	Total Beds (August 2018)		30			23	22	10	21	0	25	26	26	27	10	14	26	22	27	27	24	10	8	25	25	25	24	24	24	16	12	9	11	4	38	7	17	6	26	15	5		44	38	773
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R =	20.0%	90.0%	100.0%	95.0%	100.0%		100.0%		90.0%	100.0%	85.0%	85.0%	85.0%	90.0%	100.0%	95.0%	95.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	90.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	95.7%
	Environment Audit Compliance %	<80%=R, >80% <94.9%=A >95	96.0%	78.0%	96.0%		92.0%		83.0%		83.0%	96.0%	92.0%	79.0%	92.0%	87.0%	96.0%		92.0%	100.0%	70.0%	100.0%	100.0%		100.0%	88.0%	100.0%	83.0%	87.0%	92.0%	96.0%	96.0%	96.0%	100.0%		96.0%		87.0%		92.0%	96.0%	100.0%			100.0%	93.4%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%			99%	100%		100%		100%	100%	97%	97%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%			100%		100%		100%	100%	94%		100%	100%	99.6%
	C - Diff	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	3
	New MSSA BSIs	0	0	0	0	0	0		0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	1
	MRSA acquisitions	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	96.6%			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%	94.4%	100.0%	100.0%	87.5%	95.8%	100.0%	100.0%					100.0%		100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	98.4%
	All Inpatient Falls (Safeguard)	0	9	1	0	3	4		7		4	4	6	5	0	1	4	4	2	0	0	1	0	0	3	1	0	2	3	0	0	0	0	0	0	0	0	0	0	0	0		0	0	64
	Harms related to falls (moderate and above)		0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0
	VTE Assessment Compliance	95%				0.0%					100.0%	100.0%	96.2%	40.0%	94.0%	99.7%	95.9%	95.4%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%	100.0%	98.6%	39.4%	100.00%	100.00%	100.00%		99.9%	100.00%	76.0%			100.0%	100.0%	99.5%	95.9%	98.6%	66.7%	100.0%		97.3%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	0		0		0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0		0	0	0	0	0		0	0	4
	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	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0		0	0	0	0	0		0	0	4
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	96.7%	88.9%	93.7%	90.8%	97.0%		92.0%		74.2%	90.8%	81.4%	91.3%	98.3%	89.9%	95.1%	88.4%	94.9%	84.4%	90.3%	100.0%	100.0%	95.4%	98.1%	88.3%	91.6%	90.5%	91.6%	84.9%					98.5%		97.4%		91.8%	90.8%	93.3%		98.8%	97.0%	92.3%
	Bolton System of Care Accreditation (BoSCA)	R=<55%,A>55%<74.9%,S=>75%<89.9%,G >=90%	91.0%			63.3%	75.7%		70.3%		81.0%	72.7%	76.2%	59.6%	90.2%	72.1%	85.7%	73.0%	92.2%	90.4%	84.3%	92.0%	96.9%	76.1%	90.6%	85.2%	78.5%	90.3%	80.7%	90.7%					90.7%		79.6%		90.5%	78.1%	81.5%		83.5%		82.1%
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	19.0%	7.3%	14.0%	12.5%		61.1%		14.1%	23.1%	21.9%	37.5%	37.5%	29.7%	30.9%	17.4%	2.1%	58.7%	30.0%	20.0%	66.7%	28.9%	34.2%	19.5%	42.9%	39.8%	16.2%	72.1%	37.2%	28.2%	52.6%	48.0%	35.1%	4.8%	37.1%		20.6%	21.4%	46.7%		34.4%	63.9%	30.7%
	Friends and Family Recommended Rate	**97%**	90.5%	89.3%	94.4%	100.0%	100.0%		100.0%		100.0%	100.0%	93.8%	100.0%	100.0%	92.2%	88.9%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	89.3%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	96.1%	94.6%	95.4%	83.3%	100.0%	100.0%	90.1%		81.6%	86.8%	100.0%		73.6%	100.0%	96.3%
	Number of complaints received	**0**	0	10	0	0	0		0	0	0	5	2	0	0	2	2	0	0	2	0	0	0	0	5	0	0	0	2	0	0	0	0	0	2		0	1	0	2	0		3	0	38
Governance	SIs in Month	**0**	0	0	0	0	0	0	0	0.0%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0											
	Total Incidents		24	33	6	18	23		39		21	26	27	20	5	14	63	44	35	17	10	8	17	15	24	29	13	39	25	9	15	13	6	13	11	10	14	3	17	61	13		20	80	
	Harms related to Incidents (Moderate and above)		0	0	1	0	0		0		0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		0	0	**3**
Staff Development	Appraisals	85%	94.7%	84.5%		75.8%	79.4%		95.8%		87.5%	88.9%	77.8%	72.2%	87.1%	75.0%	86.5%	94.4%	91.4%	84.2%	89.5%	97.7%	91.4%	84.4%	89.2%	81.3%	58.1%	88.1%	97.4%	88.2%	75.0%	97.0%	95.8%	100.0%	94.9%		80.8%		78.2%				84.7%		86.3%
	Statutory Training	95%	99.10%	93.10%		80.89%	89.83%		90.96%		82.31%	93.84%	93.55%	84.62%	96.74%	86.61%	91.67%	91.39%	96.65%	93.50%	89.69%	98.31%	97.73%	95.93%	95.44%	96.94%	89.19%	92.12%	95.93%	99.09%	92.66%	96.64%	96.55%	100.00%	96.5%		92.97%		91.5%				98.66%		93.4%
	Mandatory Training	85%	97.3%	76.20%		69.1%	79.1%		81.3%		70.0%	84.3%	79.4%	76.9%	82.2%	74.2%	79.9%	77.6%	83.3%	80.8%	81.0%	83.8%	82.5%	82.2%	81.9%	91.2%	76.9%	81.0%	80.0%	81.5%	79.7%	96.3%	84.5%	95.2%	98.3%		79.8%		71.7%				99.2%		82.4%
Staffing & Workforce	% Qualified Staff (Day)					86.1%	101.3%		87.5%		66.1%	65.4%	87.2%	87.5%	104.1%	96.2%	79.7%	87.4%	95.9%	90.7%	90.0%	87.6%	87.0%	82.9%	96.9%	80.2%	97.9%	76.5%	77.6%	81.8%					80.1%		85.0%		81.2%	88.3%	91.4%		92.6%	100.1%	87.1%
	% Qualified Staff (Night)					99.9%	100.0%		99.1%		93.6%	98.8%	100.0%	97.0%	101.3%	100.0%	95.9%	96.6%	110.8%	101.9%	101.7%	83.4%	80.5%	101.9%	100.3%	96.0%	98.8%	95.6%	98.7%	90.0%					67.5%		99.3%		70.7%	87.8%	67.5%		97.2%	99.4%	94.4%
	% un-Qualified Staff (Day)					93.0%	110.7%		87.6%		94.1%	99.7%	89.9%	93.1%	113.4%	89.9%	76.0%	60.8%	86.1%	94.8%	94.6%	93.9%	44.8%	71.5%	73.5%	81.7%	109.0%	77.0%	106.4%	48.8%					72.2%		86.1%		78.6%	50.3%	94.9%		97.7%	-	85.2%
	% un-Qualified Staff (Night)					115.5%	128.7%		112.4%		96.9%	98.7%	105.7%	101.3%	96.7%	96.9%	72.6%	57.4%	94.2%	98.6%	94.4%	40.0%	0.0%	77.3%	70.0%	71.1%	121.6%	61.7%	93.4%	107.8%					61.4%		101.3%		96.5%	74.5%	95.0%		93.8%	-	87.4%
	Budgeted Nurse: Bed Ratio (WTE)		5.04	-5.19		4.09	2.61	6.84	1.23		-2.75	-0.06	6.50	4.84	1.18	-1.61	3.47	0.05	4.75	-0.69	0.78	3.54	-0.58	-1.55	-1.29	0.10	-3.68	-1.66	2.16	0.54	1.91	5.05	-3.79	1.50	-3.07										97.6%
	Current Budgeted WTE (From Ledger)		43.38	135.12		38.03	32.83	40.69	43.34		33.71	41.23	42.69	40.69	26.93	19.97	50.82	40.30	38.51	38.47	36.15	39.58	55.02	30.21	35.52	37.79	30.21	44.49	44.49	18.07	27.51	52.39	43.87	15.88	67.73		25.72							106.59	1,417.93
	Actual WTE In-Post (From Ledger)		38.34	137.31		32.02	30.22	33.85	42.11		33.54	40.68	33.19	33.85	25.75	20.58	46.35	37.25	33.76	38.16	35.37	36.04	53.60	31.76	35.81	36.69	31.89	41.15	36.33	16.53	25.60	47.34	46.66	14.38	66.80		22.61							99.03	1334.55
	Actual Worked (From Ledger)		42.75	142.05		40.90	36.25	38.86	46.13		34.91	43.08	39.89	38.86	26.01	22.86	50.59	40.22	40.30	41.96	39.48	37.67	55.12	32.92	39.11	42.76	37.57	49.47	43.94	17.46	27.72	47.72	44.94	14.64	66.05		23.54							93.85	1439.58
	Sickness (%) (September)	R = >4.75, A = 4.2 - 4.75, G = <4.2	8.60%	7.45%		10.21%	5.07%		5.70%		7.95%	14.43%	3.97%	7.21%	6.38%	4.75%	9.77%	12.64%	2.81%	10.19%	17.30%	4.96%	8.91%	8.00%	8.90%	12.68%	11.02%	16.38%	8.79%	12.98%	5.79%	5.68%	6.97%	4.40%	4.79%		4.68%							6.54%	8.31%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		5.04	-5.19		4.09	2.61	6.84	1.23		-2.75	-0.06	6.50	4.84	1.18	-1.61	3.47	0.05	4.75	-0.69	0.78	3.54	-0.58	-1.55	-1.29	0.10	-3.68	-1.66	2.16	0.54	1.91	5.05	-3.79	1.50	-3.07		3.11							7.56	#########
	Pending Appointment		0	3		2	0	0	0		2.92	0.61	3	2	0	1	1	3	0	1	0	0.0	2.0	0	1	1	2	5	6	1	0	0	1	0	4		0							0	42.45
	Substantive Staff Turnover Headcount (rolling average 12 months)	10%	11.5%	10.8%		21.2%	14.1%		10.2%		7.9%	6.6%	23.2%	11.5%	6.2%	31.3%	3.8%	10.3%	9.5%	14.8%	9.6%	7.0%	17.7%	5.9%	9.2%	9.8%	3.1%	12.3%	18.2%	9.7%	6.1%	11.2%	6.2%	0.0%	7.4%		10.8%		7.8%				13.4%		10.8%

Board Assurance Heat Map - District Nursing Domiciliary - September 2018

INDICATORS	Avondale and Chorley old Road	Breightmet & Little Lever	Crompton merged with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Total
Safety Express Programme Harm Free Care (%)	98.31%	98.15%	97.06%	97.37%	100.00%	100.00%	91.67%	96.97%	100.00%	93.75%		97.54%
Total Monthly New pressure Ulcers (Grade 2+)(Lapse in Care + No Lapse in Care)	0	0	4	2	0	0	0	0	0	0		6
Total Monthly New pressure Ulcers (Grade 2+) *(No Lapse in Care only)*	0	0	3	2	0	0	0	0	0	0		5
High Dependency Patients (40 Minutes >)												0
Medium Dependency Patients (21 Mins >)												0
Low Dependency Patients (< 20 mins)												0
Number of Home Visits (from Lorenzo) **	19	5	94	45	200	179	178	150	145	77	1673	2765
Monthly KPI Audit % (Revised Buddy Assessed Audit)	96.07%	99.36%	94.76%	96.93%	97.88%	97.88%	94.07%	98.52%	94.06%	95.86%	87.56%	95.72%
BoSCA - Bolton Safe Care Accreditation	92.00%		87.01%	70.04%	92.09%	94.57%	84.48%	84.48%		84.04%	84.42%	85.90%
Current Budgeted WTE	11.64	12.92	16	8.13	18.24	7.11	13.15	17.13	9.13	11.09	19.96	144.5
Actual WTE In-Post	12.04	13.52	15.1	5.533	15.2	8.107	13.907	20.033	9.613	6.6	18.99	138.643
Actual WTE Worked	12.04	13.85	16.078	6.169	14.459	8.181	12.674	19.002	8.394	6.6	20.25	137.697
Pending Appointment												
Current Budgeted Vacancies (WTE)												0.00
Sickness (%) August 2018	0.29%	0.36%	0.00%	16.12%	0.00%	0.00%	2.19%		6.84%	3.80%	3.23%	4.29%
Substantive Staff Turnover Headcount (rolling average 12 months)	0.00%	5.91%	5.50%	5.12%	0.00%	0.00%	4.82%		17.27%	34.74%	6.28%	6.92%
12 month Appraisal	100.0%	100.0%	80.0%	88.2%	77.8%	100.0%	87.0%		92.9%	88.9%	100.00%	92.1%
12 month Statutory Training	98.61%	100.00%	83.33%	92.16%	100.00%	100.00%	93.53%		98.72%	100.00%	98.53%	96.23%
Number of complaints received	0	0	0	0	1	0	0	0	0	0	0	1
Total Incidents reported on Safeguard (see end total column)	5	0	0	19	1	7	6	8	0	9	4	59

NHS Bolton NHS Foundation Trust

Agenda Item No	

Meeting	Board of Directors

Date	25 October 2018

Title	Board Assurance Framework and Corporate Risk Register

Executive Summary	Board members should be familiar with the BAF developed to provide assurance with regard to the management of the risks to achieving the objectives set out in the Strategic Plan 2017/19. A summary of the BAF is provided monthly within the CEO report, the full BAF is provided to the Board and Audit Committee twice a year. A new BAF will be developed alongside the new Strategic Plan for the Trust. The BAF is underpinned by the Trust risk management strategy of which risk registers form a key part with each division and each directorate holding a detailed risk register each of which is subject to scrutiny by the risk management committee in accordance with an agreed schedule. Between April 2018 and August 2018 consideration was given to the development of a Corporate Risk Register to sit alongside the Boars Assurance Framework.

Previously considered by	The attached report and summary corporate risk register were reviewed at the October meeting of the Risk Management Committee

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

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

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

Prepared by	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

1. Background

At the April 2018 meeting of the Risk Management Committee, the Trust Secretary and the Deputy Director of Governance undertook to give consideration to the introduction of a Corporate Risk Register.

The Trust Risk Management policy defines a "Corporate Risk" as "*A risk on the Trust Risk Register which is managed by the division in which it sits, but where the risk affects the entire organisation"*

In addition, there are also risks on Directorate risk registers which are defined as Corporate Risks.

A Corporate Risk Register should form part of the Trusts assurance framework as an articulation of the key risks impacting the Trust. It should be used to inform decision making, provide assurance over actions being taken to manage key risks and to inform risk management planning and mitigation activities

A risk register is a management tool that enables an organisation, directorate and or team to understand their comprehensive risk profile. It is a repository for all risk information. This repository is the hub of the internal control system, given that it should contain the objectives, risks and controls for the whole organisation. It is through this process that the Trust identifies, assesses and takes action to manage risks. Trust Risk registers are maintained on "Safeguard"

The **Board Assurance Framework** identifies and quantifies key risks that may potentially compromise the achievement of strategic objectives. These strategic risks to the organisation are identified and overseen by the Board. Gaps identified in controls or assurances, and the associated treatments to address them should contribute to the Trust's Corporate Risk Register.

2. Methodology

To provide the Board and the Risk Management Committee with clearer oversight of Corporate Risks a "Corporate Risk Register" should be reviewed by the Risk Management Committee on a quarterly basis. The Corporate Risk Register should be pulled from Divisional and Directorate risk registers and should include all risks deemed as corporate with a score of 15 or higher. The Corporate Risk Register should also be reviewed by the Audit Committee bi annually and be provided to all Board members for information at this time.

The table below summarises the corporate risk register (27th September 2018) produced in accordance with this proposal.

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Corporate Risk Register - summary		
Risk ref	Score	Summary description
Finance Directorate		
3127	20	STF funding
3125	16	ICIP failure
3126	16	Cost pressure/income risk
3128	16	Use of Resources
3189	16	Delivery of iFM Bolton financial plan
Nursing and Patient Experience		
1616	15	Shortage of registered nurse
3038	16	SI process
1230	16	Procedural documents out of date
3038	16	Delays in the process to investigate serious incidents
3087	16	Mortality review process
3095	15	Health and Safety support
3048	16	Safeguarding training compliance
3369	15	Achievement of clinical audit plan
Operational		
3202	15	Impact of late transfer of patients
1900	15	Recording of medical devices training
2964	15	GDPR – loss of income
2439	20	IT theft/damage
3021	16	Data centre resilience
3113	16	Data centre air conditioning
3170	16	Cancer performance – breach allocation
3282	16	Data warehouse server
2905	15	Implementation of urgent care plan
Workforce		
2641	15	Agency expenditure
3088	15	Sickness absence
2645	15	Failure to appoint to key roles
Acute Adult		
3152	20	A&E consultant cover
3105	16	Delay to delivery of A&E extension
2701	20	Delay in provision of mental health beds
1984	15	Documentation of DNACPR
2362	15	Substance misuse prescribing
3202	15	Late transfer of patients
3216	15	Lack high acuity respiratory area

3271	15	NIV/flu isolation
Elective		
3092	15	CT capacity
3170	16	Cancer waiting times
3158	20	Mobile X Ray – dose level

Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Board Assurance Framework 2017/19

Board Assurance Framework Explanatory Notes

- The objectives for the Trust are agreed in consultation with the Board and wider stakeholders and laid out within the Operational Plan
- For each objective the Executive team consider the risks and issues thatcould impact on the achievement of the objective, the BAF is then populated with these risks/issues, the controls in place and the assurance that the controls are having the desired impact. Actions to address gaps in controls and assurance are identified.
- Actions should be SMART and should include an expected date of completion.
- The "oversight" column is used to provide details of the key operational and assurance committee.
- The RAG column is used to indicate the level of assurance the Executive has that the risk is being managed.

	No or limited assurance– could have a significant impact on the achievement of the objective;
	Moderate assurance – potential moderate impact on the achievement of the objective
	Assured – no or minor impact on the achievement of the objective

- Where there is limited assurance the oversight column should also include detail of the most recent report to the Board or an assurance providing committee.
- The full BAF should be reviewed at least once a year at Board and twice a year at the Audit Committee, a summary BAF is also included in each Chief Executive Report
- Over the course of the year, the Audit Committee will conduct a series of deep dive reviews focusing on the risks within one or two Exec lead portfolios at each meeting.
- The Trust Secretary has ownership of the overall BAF including population of the summary BAF;
- Executive Leads are responsible for providing regular updates to the risks within their portfolio including if necessary the escalation of the risks to the achievement of objectives not previously included on the BAF

	Objective	I	L	Oct-18	Aug-18	Feb-18	Oct-17	Jun-17	Apr-17	lead
1.1	Reduce healthcare acquired infections	4	4	16	16	16	16	16	20	DON
1.2	Patients receive safe effective care (pressure ulcers)	5	2	10	10	20	15	20	20	DON
1.2	Patients receive safe effective care (falls)	5	3	15	15	20	15	20	20	DON
1.2	Patients receive safe effective care (mortality reduction)	4	4	16	16	16	12	12	20	MD
1.4	Staff and staff levels are supported	4	4	20	20	20	20	20	20	DoW
2.1	To deliver the NHS constitution, achieve NHSI and contractual targets	4	5	20	20	20	20	20	20	COO
4.1	Service and financial sustainability	5	4	20	20	20	20	20	20	DOF
4.4	NHSI agency rules	4	4	16	16	16	16	16	16	DOF
5.4	Achieving sustainable services though collaboration within the NW Sector of Manchester	5	4	20	20	20	16	20	20	CEO
5.5	Supporting the urgent care system	4	4	16	16	20	20	20	20	COO

Objective 1.1	Reduce healthcare acquired infections		Lead Director	Director of Nursing	
			Date updated	7 Sept 2018	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Failure to isolate patient(s) in a timely manner (Risk 1315)	In date evidence based Infection Prevention and Control policies Root cause analysis (RCA) process in place and conducted for 100% of appropriate cases Thematic reports at IPC Committee and IPC Operational Group to enable learning to be shared on a bi-monthly IPC service and Divisional reinforcement of SIGHT Local feedback from RCAs completed in 100% of cases SBARs produced following each HCAI Harm Free Care Panel for shared learning Shared RCA learning across the Trust via the IPC Operational Group Weekly SIGHT audits	Reduction in *Clostridium difficile* cases with identified and verified lapses in care Side ward utilisation now reviewed at every patient flow meeting Improved compliance with the audits of diarrhoea management	Action plan in response to external review commissioned by the Trust to examine c.diff management. Action plan remain on course with all actions as discussed at IPC 20/09/18 Action plan provided	IPC Operational Group/IPC Committee	
Delays in testing specimens (Risk 1313)	In date evidence based Infection Prevention and Control policies Root cause analysis (RCA) process in place and conducted for 100% of appropriate cases Thematic reports at IPC Committee and IPC Operational Group to enable learning to be shared on a bi-monthly/quarterly/annual basis IPC service and Divisional reinforcement of SIGHT Local feedback from RCAs completed in 100% of cases SBARs produced following each HCAI Harm Free Care Panel for shared learning Shared RCA learning across the Trust via the IPC Operational Group Audits of diarrhoea management and diarrhoea resulting from antibiotic use have commenced and reported to IPC Committee and IPC Operational Group	Reduction in Clostridium difficile cases with identified and verified lapses in care Improved compliance with the audits of diarrhoea management External review of CDI management	Action plan in response to external review commissioned by the Trust to examine c.diff management. Action plan remain on course with all actions as discussed at IPC 20/09/18	IPC Committee	
Inconsistent IV line care leading to potentially avoidable infections (Risk 1313)	New peripheral IV access device policy – with clear direction for visual inspection phlebitis (VIP) scoring New peripheral IV device care plan to encourage VIP documentation, prompt line	Audit schedule reviewing peripheral line care – feedback to departments, divisions and the IPC Operational Group	New peripheral IV care plan needs to be shared with stakeholders and ratified through PAG (November 2018)	IPC Committee	

	removal and audit in line with the relevant High Impact Intervention audits				
Risk of patient developing MRSA infections from colonisation acquired during their inpatient stay (Risk 1313)	New policy to screen long-stay patients (inpatient stays ≥10 days) at least weekly Emails identifying long-stay patients to relevant managers on a weekly basis Audit of compliance with re-screens undertaken by the IPC team at least quarterly – feedback to the IPC Operational Group Audits of compliance with MRSA management – undertaken by the IPC team and fed back to relevant managers	Audit data presented to IPC Committee at least quarterly with actions to address non-compliance	Data Warehouse data access challenges to be addressed and resolved by 30/09/18, which currently limit access to data MRSA screening compliance to be reported to divisional leadership teams on a monthly basis in addition to discussion at IPC (from 10/10/18)	IPC Committee	
Hand hygiene compliance	Robust scrutiny of hand hygiene intelligence to identify sub optimal practice conducted by the IPC team with the relevant department managers and matrons	Monthly audits in clinical departments Included in Divisional monthly reports and outcomes on secure Apps IPC Awareness raising posters replaced on a quarterly basis		IPC Operational Group/IPC Committee	
Environmental concerns - treatment rooms, capacity issues	Rapid improvement tool used in clinical departments on a monthly basis Robust scrutiny of rapid improvement tool intelligence to identify sub optimal practice conducted by the IPC team with the relevant department managers and matrons	(At least) annual departmental IPC audits Themes from the RIT audits to be taken to IPC Operational Group		IPC Operational Group/IPC Committee	
Lack of assurance related to clinical staff ANTT competence	Ongoing competency assessment programme in place	ANTT compliance reported by clinical department via IPC monthly reports		IPC Committee	
Adherence to policies	Review of practice against policy as part of post-infection RCAs Improved engagement with antimicrobial prescribing policies	Audits of key practices such as hand hygiene Improved compliance to standards 3, 4 and 5 of the quarterly antimicrobial audits Clear actions to improve compliance with these audits	Completion of a business case for additional antimicrobial pharmacy resource (in post: October 2018)	IPC Committee IPC Committee	

Objective 1.1	Reduce Healthcare acquired infections

Risk appetite

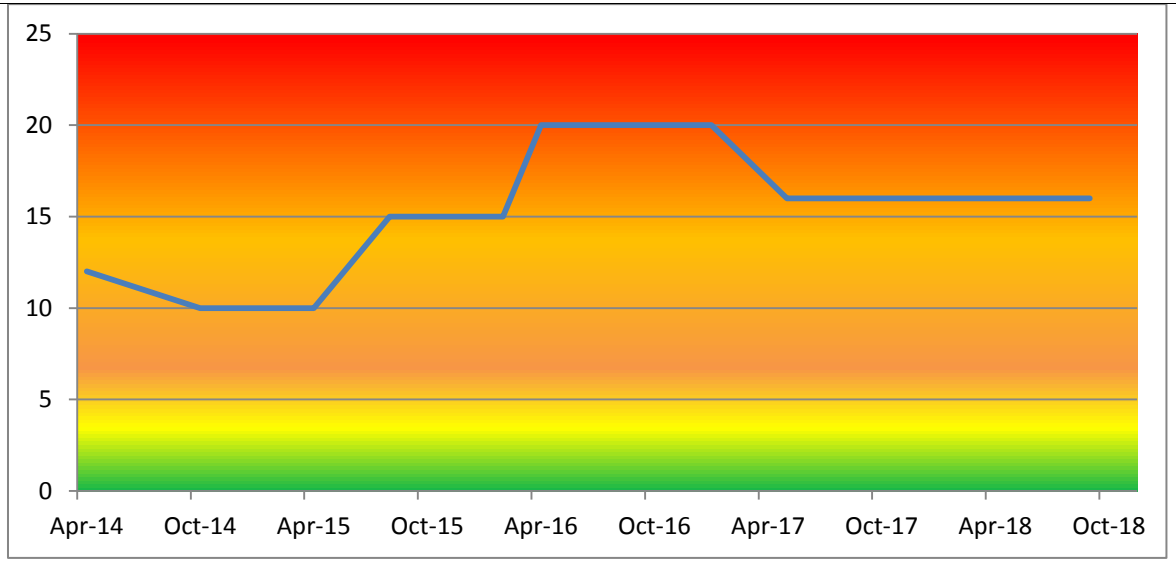
Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

There were six hospital onset CDT cases to the end of August. Of these three had lapses in care and are considered performance cases against a trajectory of no more than 19 cases. This compares with 16 hospital onset cases and six performance cases at the same point in 2017/18.

There has been one MRSA bacteraemias in 2018/19. Learning points have been identified which have been communicated to clinical teams across the Trust.

Risk tracking



date:	comments	Risk Score	I	L	
Sept 2017	Risk reviewed and updated – some actions remain outstanding therefore risk remains at 16		4	4	16
Feb 2018	Risk reviewed and updated – some actions remain outstanding therefore risk remains at 16		4	4	16
Sept 2018	Risk reviewed and updated – some actions remain outstanding therefore risk remains at 16		4	4	16

Objective 1.2 (1)	For our patients to receive safe effective care		Lead Director	Director of Nursing	
			Date updated	7 August 2018	

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Falls (Risk 1094)	Falls steering group (monthly) Falls collaborative (commencing Phase 3 re enhanced care) Incident reporting monitored daily by falls coordinator Regular completion of both local and national falls audit (RCP 15 & 17) – currently implementing actions from RCP17 Ward dashboards (KPIs in place) Falls policy Incident reporting and review process (in date until 2019) Weekly falls panel scheduled (Friday am) as required Report to Medical Devices Committee re timely provision of equipment Standard Operating Procedure regarding Falls data collection and reporting and SOP regarding 'falls with harm' and the governance arrangements Frequent Falls prevention and management training for clinical staff (monthly) Falls Co-ordinator tracking of patients who suffer more than one fall	Annual Trust work plan 18/19 Practice Educators ensuring that training and audit of equipment is regularly undertaken – audit results go to Medical Devices Committee Falls Nurse appointed July 2018	NAIF (National Audit Impatient Falls) rolling programme commencing December 2018 – led by the Falls Co-orindator & Falls Nurse	Harm Free Care Panel Annual Trust work plan 18/19 Falls steering group reporting through clinical governance committee Quarterly reporting to QA Committee	
Pressure Ulcers	Tissue viability working group in place to look at themes and to consider changes in practice where need is identified Incident reporting monitored daily by TVN, which supports timely assessment and review of patients Weekly PU panel, in both community (Thursday) and hospital (Friday) Education and training programme to continue Review of new NHSI recommendations to incorporate into policy and training	Monthly audit of ward level KPIs (specific to PU) Monthly monitoring of figures related to pressure ulcers Quarterly report on pressure ulcer numbers and themes provided to QA	Deliver annual pressure ulcer conference to raise awareness Continue ongoing pressure ulcer prevention and management training programme Continued attendance at GM Pressure Ulcer collaborative Await final ratification of Pressure Ulcer Prevention and Management Policy (November 2018) Await feedback on new Pressure Ulcer Prevention and Management care plans then implement (October 2018)	Harm Free Care Panel (Thursday and Friday) Learning , development and updates reported via PAG Quarterly reporting to QA Committee	
Never events	Arrangements in place for 72 hour scoping panels	Assurance from PwC that actions identified in RCS report have been completed (Feb 2017)	PwC Internal Audit review covering Serious Incidents/Complaints, Terms of Reference to	Clinical Governance Committee to QA Committee	

	New Serious Incident Policy (September 2018) All Serious Incidents including Never Events are subjected to scrutiny following thorough RCA investigation by the Board of Directors SBARS distributed on a monthly basis across the organisation to share learning gained from Serious Incidents to reduce repetition Sharing learning from HSIB (Stop before you block) September 2018		be drafted October 2018	Board of Directors	

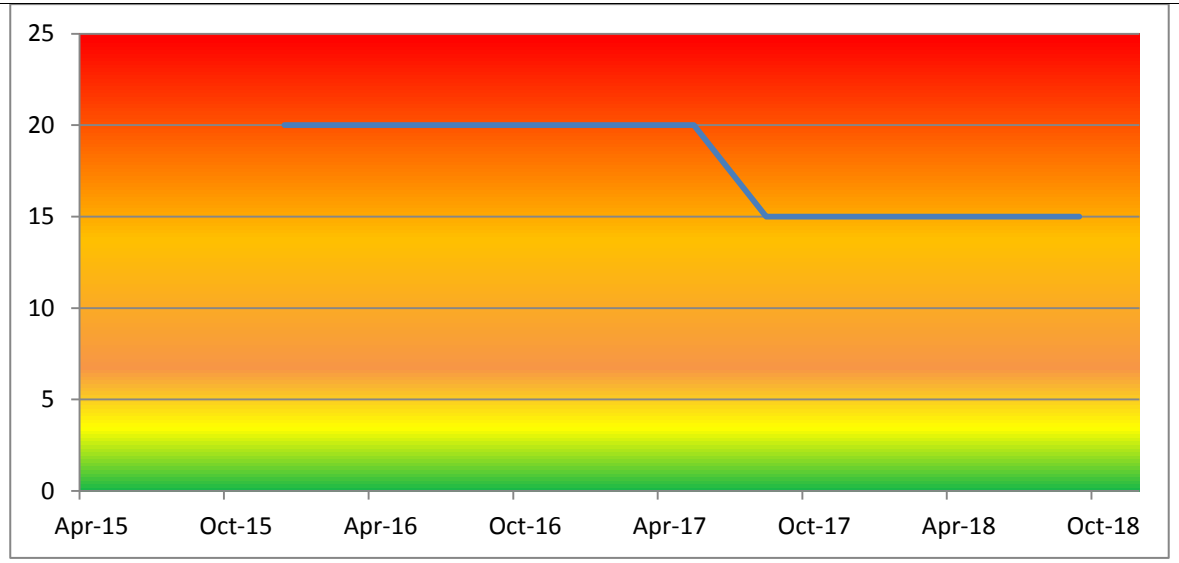
Objective 1.2	For our patients to receive safe effective care

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Risk tracking



date:	comments	Risk Score	I	L	
Sept 2017	Risk reviewed and remains at 15 due to actions not yet at due date and in progress		5	3	15
Feb 2018	Risk reviewed		5	3	15
Sept 2018	Risk reviewed		5	3	15

Objective 1.2 (2)	**For our patients to receive harm free care – (mortality reduction)**		**Lead Director**	**Medical Director**	
			Date updated	**8 August 2018**	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
SHMI and RAMI remain in the 'as expected' range	Monitored monthly at Trust Mortality Reduction Group (MRG)	Monthly RAMI (2 months in arrears) Quarterly SHMI (2 quarters in arrears)	Delivery of MRG workstream	Mortality Reduction Group Sub Committee Mortality Reduction Group Quality Assurance Committee	
Recording of diagnosis and co-morbidities not accurate Risk 2338	Mortality review process SHMI action plan	Monthly coding accuracy audits Monthly monitoring of co-morbidity recording	Continue roll out of mortality review process Effective ward round	Mortality Reduction Group Sub Committee Mortality Reduction Group Quality Assurance Committee	
Learning from deaths not actioned	Mortality review process	Quarterly reports	Share and demonstrate learning	Mortality Reduction Group Sub Committee Mortality Reduction Group Quality Assurance Committee	
NEWS compliance currently under 90%	Clinical incident reporting Root cause analysis Policies Monthly KPI's include sepsis screening tool Revised fluid balance charts	Monthly Audit via Nursing care Indicators. Patient Track audit of response	Divisional Action plans for aiding improvement in NEWS in place - for divisions to take appropriate ownership of the issues faced and report/update at the Trust Mortality Reduction Group	Mortality Reduction Group Mortality included in Divisional Quality reports	
Clear escalation of ill patients	Root cause analysis of cardiac arrests and critical care escalation Failure to recognise or respond to a deteriorating patient generates a clinical incident report Cardiac arrest reviews – data shows year on year reduction in avoidable cardiac arrests	Patient track monthly audit of response rates Sepsis CQUIN performance Quarterly cardiac arrest RCA reports	Root cause analysis of avoidable cardiac arrests On-going review of medical handover arrangements being monitored for improvement and eventual assurance Design and implement a robust monthly audit of response using patient track data	Mortality Reduction Group Clinical Governance & Quality Committee	
Documentation of DNACPR risk 1984	DNA CPR audits	Cardiac arrest RCA audits	Ensure EoL training plan is implemented	End of Life Steering Group Mortality Reduction Group	
Sepsis performance not at 100%	Sepsis improvement workstream	Sepsis CQUIN quarterly performance Mortality reports	Quality Account 2018/19 – sepsis action plan	Mortality Reduction Group - monthly Quality Assurance Committee - quarterly	

Objective 1.2	For our patients to receive harm free care – (mortality reduction)

Risk appetite

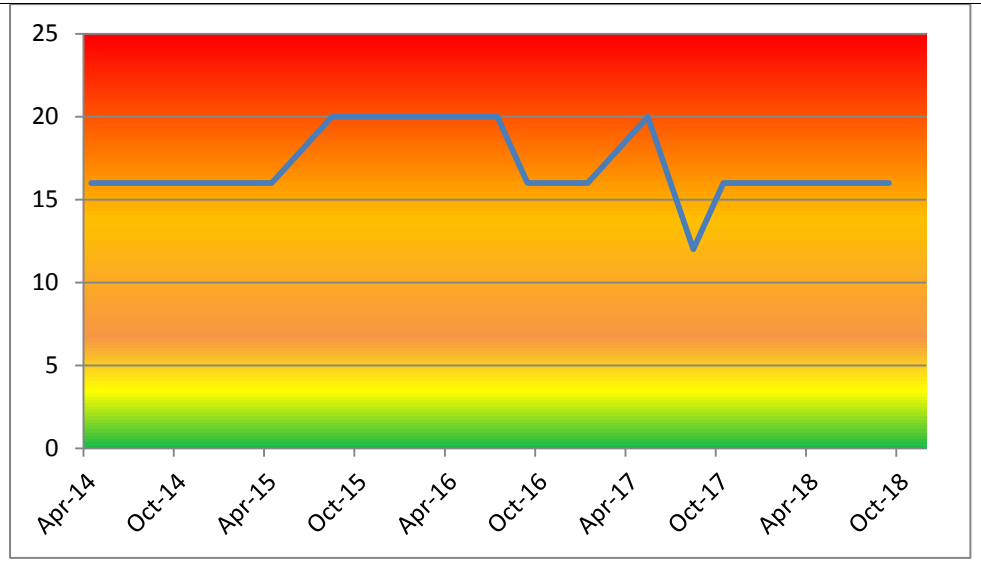
Risk levels / Key elements	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Mortality reduction remains a key strategic and operational objective for the Trust.

Over the years good progress has been made to reduce mortality rates and KPIs for mortality are now within the in expected range. There is however still work to do particularly with regard to the escalation and response to NEWS

Risk tracking



date:	comments	Risk Score	I	L	
May 2017	Score reviewed		4	3	12
Oct 2017	Score reviewed, SHMI 108.1 RAMI 95.8		4	4	16
Sept 2018	Reviewed		4	4	16

Objective 1.4	**Nurse Staff and staff levels are supported**		**Lead Director**	**Workforce Director**	
			Date updated	**8th August 2018**	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Recruitment – limited pool of staff with appropriate skills/experience/values	Staffing report, HR reports on vacancies Bank and agency staff use when required Recruitment calendar in place to provide an overview of the range of actions anyplace to recruit. Senior Nurse recruitment lead International recruitment programme ongoing Systems and processes in place to ensure retention of newly qualified staff nurses	Ward to Board heat map PMO in place Reports presented on exit interviews and recruitment QA Committee July 2017	Full recruitment workplan	IPM meetings Regular updates to workforce and QA committee	
Compliance with e-rostering policy	Ward staffing establishments agreed Rostering policy Incident reporting intelligence E Rostering team Daily staffing sitrep Rostering KPIs E rostering team monitor effective used of rostering with escalation mechanisms in place if required	Ward to Board heatmap Internal audit report findings and conclusions (date)	Develop forecasting tool Review of E Rostering Compliance with NHSI collaborative **Additional Workforce resource to project manage compliance until embedded**	Weekly e-rostering meetings	

Objective 1.4	Staff and staffing levels are supported

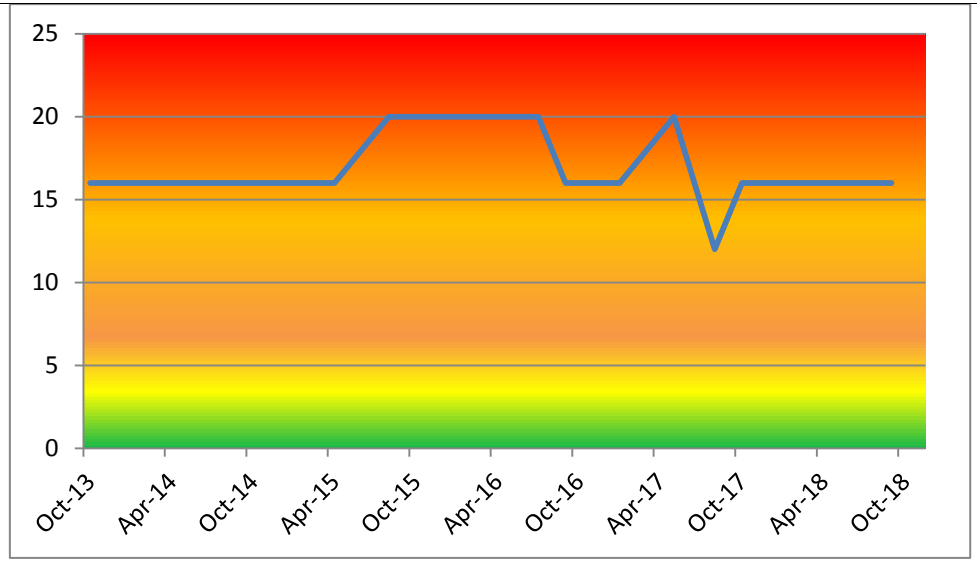
Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Narrative

Risk tracking



date:	comments	Risk Score	I	L	
May 2017	Updated – score unchanged, discussion at QA committee and Board with concerns expressed regarding pace of international recruitment		4	5	20
Sept 2017	Risk reviewed - unchanged		4	5	20
June 2017	Score reduced as sickness absence appears to be reducing and more assurance provided through Workforce Assurance Committee		4	4	16
Aug 2018	Score increased as sickness absence still a concern		4	5	20

Objective 2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets – A&E performance		Lead Director	Chief Operating Officer	
			Date updated	8th September 2018	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
failure to admit patients in a timely manner– risk register 191 Key causes • Late decision to admit from A/E • Failure to discharge patients in a timely manner • Failure to discharge enough patients at weekends	Escalation policy, flow meetings and reports(four a day) SAFER principles Joint working with CCG through Urgent Care Board Escalation beds opened in community Development of integrated discharge team Red2green/pj/paralysis programmes Streaming of patients away from A/E – Jan 19	Review by ECIP/NHSI August 2017 GMHSCP review qtrly Joint agreed programme with ECIP Jan 18 – Jun18	Urgent care programme plan Continued work through Divisions on SAFER – ongoing Work with ECIP on identified actions Focus on reducing LOS Revised streaming model to ensure patients go the appropriate service Revised CDU and ACU model as part of streaming	System Resilience Board - Trust Urgent Care Board- Locality -Board reports - GM reviews Weekly review by CEO of urgent care plan with Divisional senior teams and LA and CCG	
Lack of physical space in ED limits ability to ensure privacy and dignity and risks impeding flow at periods of peak demand – risk register 1329	Incident reporting	Phase 1 completed Feb 2017 (5 extra spaces)	Estates improvements to A&E – Phase 2 (new resuscitation and ambulance triage) expected completion July2018 Phase 3 (increased triage/consultation rooms and new reception/ wait area) expected Nov 2018	System Resilience Board iFM Estates committee	
primary care patients attending A&E	Primary care streaming 12hours per day	GP available 12 hours a day 7 days a week	Enhanced pathways as part of the new streaming model commences Oct 2018	System Resilience Board Urgent Care Board	
Staffing – risk of not having appropriate numbers and grades/roles of staff	Incident reporting Also refer to 1.4 and 3.4 Consultant recruited	Further recruitment and development of alternative roles	Recruit Nursing/ EMP –ongoing Review workforce plan for all staff –complete Developing teams for each for the specific areas within ED	IPM Workforce committee	
Human factors – impact of high pressure on A&E staff	Provide pastoral support through OH and management support	Staff survey	Support recruitment Regular meeting with staff Improve environment Work with ECIP on ownership	IPM Estate plan	

Objective 2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets – A&E performance

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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Background

The Trust has for some time, struggled to maintain the standard

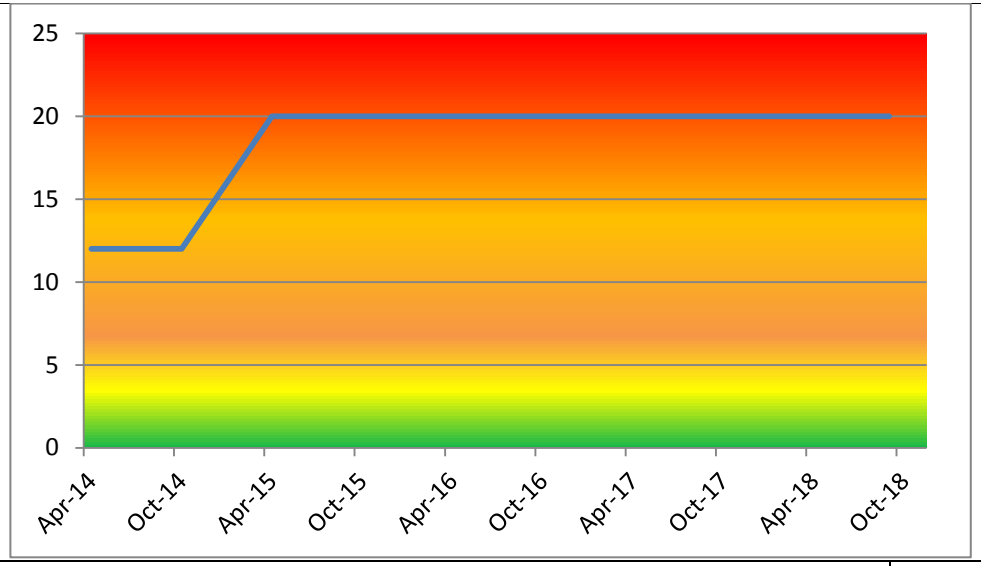
Failure on the 4 hour target was one of the reasons the Trust was placed in breach by Monitor. Interventions have led to successful performance but this has not been sustained.

There is now acceptance that this is an issue which needs to be addressed by the whole health economy, the Urgent Care Programme Board has been established to provide this oversight.

Achievement of A&E performance is likely to have an impact on funding through the sustainability fund

Nationally pressure in urgent care is resulting in vary few Trust achieving and maintaining the 4 hour standard

Risk tracking



date:	comments	Risk Score	I	L	
May 17	Risk evaluated by Exec team		4	5	20
Sept 2017	Risk remains high, additional Board meeting held to discuss urgent care action plan		4	5	20
May 2018	Risk score reviewed by exec team – remains 20		4	5	20
Aug 2018	Risk reviewed		4	5	20

Objective 4.1	Service and Financial Sustainability – delivery of control surplus of £10.1m		Lead Director	Annette Walker	
			Date updated	8th September 2018	

Risks/issues impacting on the achievement of the objective	Controls	Assurance	Actions required to improve controls/assurance	Oversight	Level of assurance
Breakdown of financial management process leading to loss of financial control	Finance Business Plans Monthly budget meeting and financial position meeting to triangulate data Close working between Senior team and DOF through weekly meetings Integrated Performance Management Framework – Finance Implementation of RIBA capital process	Reports to Executive, Finance Committee, Audit Committee, Board Internal Audit Reports External Audit Reports Scenario forecasting	Additional resource to triangulate workforce and finance metrics to improve understanding and drive management action.	Audit Committee Finance Committee Strategic Estates Board Workforce assurance committee ICIP escalation committee	
Failure to deliver the planned level of income and cost improvements Lack of workforce leading to agency cost pressures	Corporate cross cutting schemes programme Project Management Office process ICIP Escalation Meetings Integrated Performance Management Framework – Finance Locality plan / GM transformation fund	Reports to Executive, Finance Committee, Board Internal Audit Reports on ICIP Strategic approach to ICIP developed and approved by F&I	Agree risk management approach with partners Integrated care partnership development Joint system savings approach Additional capacity to drive transformation projects to improve cost	Finance Committee IPM ICIP escalation meeting Executive	
Contracting risk	CCG/FT Liaison through DoF and Finance Committees Aligned Incentive Contract Standard National Contract Local contracts Contracting procedures	Reports to Executive, Finance Committee, Board Reporting to NHSI and GM on contract alignment	Develop contracting models to support improved integration Secure additional resource through contracts for internal transformation projects	Finance Committee	
The contingent liability for ill health retirement crystalizes	Legal Advice has been taken confirming that Bolton FT is not the employer and there is no liability Treatment agreed with External audit over year end	Reports to Executive, Finance Committee, Audit Committee, Board	Invoices currently remain unsettled by the employer and there is a possibility of a provider to provider dispute.	Finance Committee Audit Committee	
Availability of sustainability and transformation funding Healthier Together Transformation funding	2018/19 Financial Plan New system governance being established NWS Partnership Board	Reports to Executive, Finance Committee, Board	Agreements around continuation of funding as schemes become BAU Clarity is required on national funding for HT Links between CCG and new Director of Transformation established and embedded	Finance Committee Board System governance	

Objective 4.1	Service and Financial Sustainability – delivery of control surplus of £10.1m, implement Lord Carter recommendations minimum Use of Resources of 3

Risk appetite

Risk levels / Key elements	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

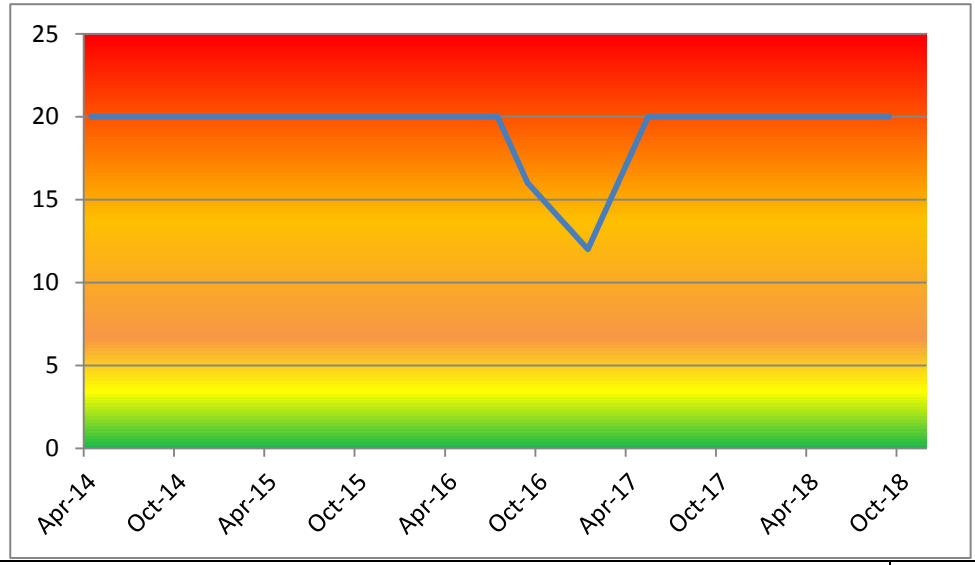
In order to achieve the full £12.7m surplus the Trust must achieve Income and Cost Improvements of £15.5m and delivery against the agreed urgent care trajectory

The mid case scenario at month 5 is a forecast deficit of £1.8m, an underachievement of plan by £14.0m.

Work continues to reduce this risk, on the best case scenario the Trust can achieve its plan in full

The Trust continues to forecast that it will achieve its plan, although this is high risk

Risk tracking



date:	Comments	Risk Score	I	L	
Sept 2017	Challenge to achieve remains a significant risk – score to be reviewed by Board after mid-year fundamental review		5	4	20
Feb 2018	Remains a significant risk		5	4	20
Aug 2018	Risk reviewed		5	4	20

Objective 4.4	**Compliance with NHS improvement agency rules**		**Lead Director**	**Director of Workforce**	
			Date updated	**8 September 2018**	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Achieving optimal recruitment to established posts.	Divisional workforce plans approved at Workforce Committee Workforce Turnaround meetings with AACD	Heatmaps and dashboards IPM	Ongoing recruitment events International recruitment Actions to bring in the nurses recruited	Executive Directors, IPM, Workforce Committee	
Utilisation of e rostering systems to manage workforce demand and supply.	E rostering policy	Reports from NHSI	Strengthen performance arrangements	Corporate IPM	
Rates of sickness absence	Workforce policies and performance reporting Workplace Health and Wellbeing Additional admin support for AACD and Elective	Heatmaps and dashboards IPM Survey of better performing trusts to June 2017 board	Sickness absence action plan monitored through Workforce Operational Committee and Workforce Assurance committee	Executive Directors, IPM, Workforce Assurance Committee	
Ongoing requirement for agency staff to support A&E Risk register 1193 and 1465	E rostering in the majority of clinical areas		New clinical lead in A&E discussing new working patterns with consultants	Executive Directors, IPM, Workforce Assurance Committee	
Gaps in medical staffing rota – risk 1852	Use of approved agencies when required	Weekly return to NHSI	Centralisation of medical staffing locum bookings Implementing e roster for medical staff	Workforce Assurance Committee	

Objective 4.4	Compliance with NHS improvement agency rules

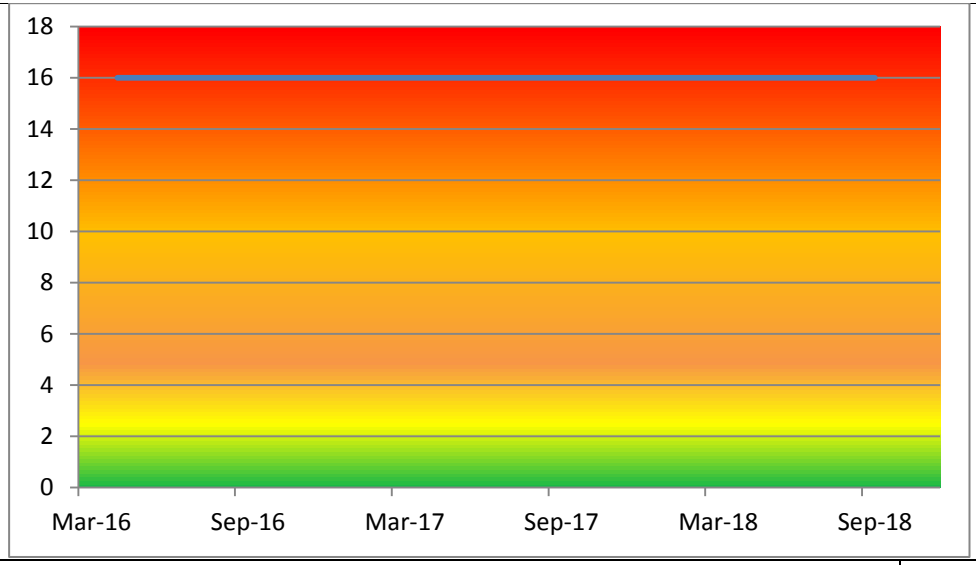
Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

NHSI introduced rules for the use of agency staffing and set trajectories for reducing the overall cost and use of agency staff.

Risk tracking



date:	comments	Risk Score	I	L	
Sept 2017	Risk score reviewed, remains unchanged		4	4	16
Feb 2018	Agency use remains high		4	4	16
Aug 2018			4	4	16

Objective 5.4	Achieving sustainable services though collaboration within the North West Sector of Manchester		Lead Director	CEO	
			Date updated	8 Sept 2018	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Implementation of Healthier Together for emergency and high risk general surgery	Provider Alliance Steering Group NW Sector Partnership	Minutes of sector meeting and NW shared services Board Financial risk share agreement	Financial mitigations for shared	Exec Directors NW Shared Services Board Ongoing debate with regard to scope of shared services and scope of Healthier Together implications	
Transformation plans for urgent, emergency and acute medicine	Provider Alliance Steering Group NW Sector Partnership	Minutes of sector meeting and NW shared services Board	Financial mitigations for shared services	Exec Directors NW Shared Services Board	
Radiology	Provider Alliance Steering Group NW Sector Partnership	GM wide support for collaborative image sharing project –Sept 2017		Exec Directors NW Shared Services Board	
Sector priority services: urology	Provider Alliance Steering Group NW Sector Partnership		Full implementation of single leadership –	Exec Directors NW Shared Services Board	
Sector priority services: Orthopaedics and paediatrics	Provider Alliance Steering Group NW Sector Partnership		Development of case/capital scheme	Exec Directors NW Shared Services Board	

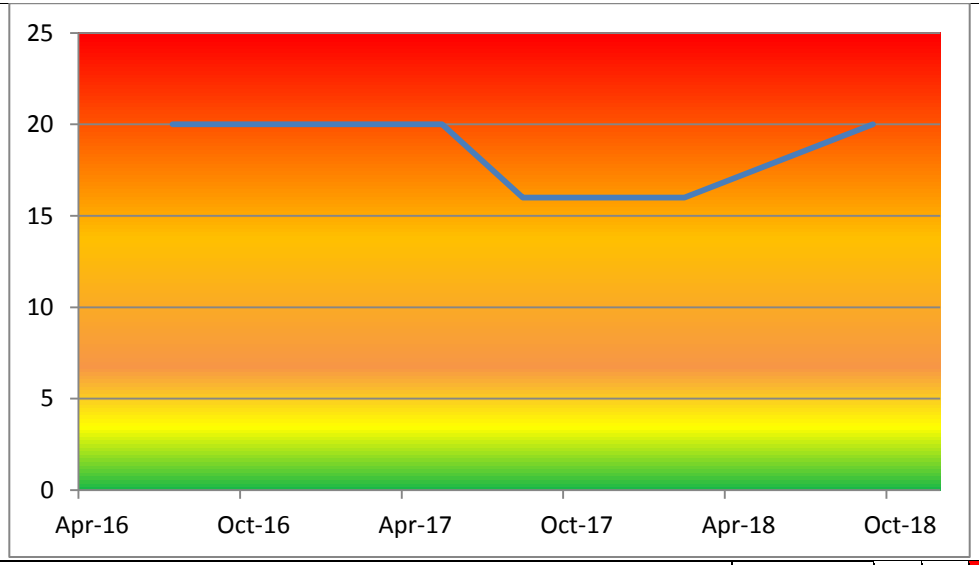
Objective 5.4	Achieving sustainable services though collaboration within the North West Sector of Manchester

Risk appetite

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Risk tracking



date:	comments	Risk Score	I	L	
Aug 2017	Score reduced following debate at Risk Management Committee		4	4	16
Sept 2017	Further update will be required after discussion in part two of implications of latest partnership board meeting		4	4	16
Feb 18	Uncertainty and ongoing debate on NW sector and Devo Manc implications		4	4	16
Sept 2018	Risk reviewed but remains ongoing – continue work to collaborate with local partners		4	4	16

Objective – 5.5	**Supporting the urgent care system**		**Lead Director**	**Chief Operating Officer**	
			Date updated	**8th September 2018**	
Risks/issues impacting on the achievement of the objective	**Controls**	**Assurance**	**Actions required to improve controls/assurance**	**Oversight**	**Level of assurance**
Co location of out of hours GP services on the Royal Bolton Hospital site	CCG have committed to starting public engagement on co location. National Mandate	GP Deflection scheme has provided some additional capacity. Number attending has reduced GP see 30+ on average daily	Work with CCG on updated plans – ongoing Work with CGG and GP Fed on Out of Hours Service based on hospital site Oct 18	Urgent Care Board Executive Directors	
Admissions Avoidance Team	Monitor numbers seen by team daily	Number seen rising, evidence of reduced admissions	Review make up of team and links with other community based teams Continue recruitment	IPM Urgent Care Board	
Intermediate Neighbourhood teams	Monitor numbers seen monthly	AQUA review	Model needs revision, not achieving expected gains. Actions by end q3 2018/19 to be reviewed Link to development of ICA	IPM Urgent Care Board	

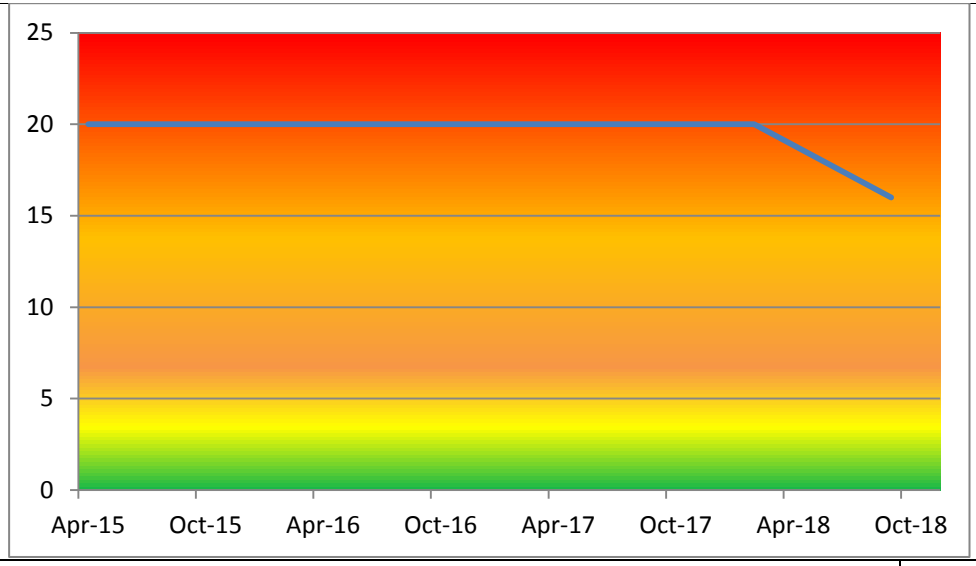
Objective 5.5	Supporting the urgent care system

Risk appetite

Risk levels / Key elements	0 Avoid	1 Minimal (ALARP)	2 Cautious	3 Open	4 Seek	5 Mature
	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.

Background

Risk tracking



date:	comments	Risk Score	I	L	
May 2017	Risk evaluated by Exec team		5	4	20
Sept 2017	Remains a significant challenge		5	4	20
May 2018	Remains a significant challenge		5	4	20
June 2018	Risk reduced, progress made with admissions avoidance and development of community services to support patients out of hospital		4	4	16

Change Log (risk scores) – introduced 01/08/17				
Date	**Objective risk**	**Score change from/to**	**Rationale**	**Approved at**
02/08/17	1.2 – Harm Free Care	20 to 15	Good progress made in reduction of harm from pressure ulcers, reports to QA Committee provided assurance to the Board who proposed debate on reduction of score	Risk Management Committee
02/08/17	5.4 – collaboration	20 to 16	Reduced following discussion at Risk Management Committee with regard to impact of issues and risks	Risk Management Committee
18/10/17	1.2.2 - Mortality	12 to 16	Risk increased following increase in HSMR	Board and QA Committee
26/02/18	1.2 - For our patients to receive safe effective care	15 to 20	Feb 2018 declaration of a wrong site surgical NE	Risk Management Committee March 2018
28/06/18	1.4 – staffing levels	20 to 16	Reduced as improved assurance through Workforce Assurance Committee	Board and WAC
28/06/18	5.5 – supporting the urgent care system	20 to 16	Reduced risk as improved admission avoidance/home first activity	Board and SRG
14/08/18	1.4 Staffing levels	16 to 20	Risk increased progress not as required to achieve reduction in sickness absence	WAC and Board

NHS Bolton NHS Foundation Trust

Agenda Item No : 19

Meeting	Board of Directors

Date	25th October 2018

Title	Digital Trust Update

Executive Summary	The Digital Trust programme is well underway with E-Observations live in half of the inpatient wards, Unified Communications providing improvements to underlying hardware and telephone infrastructure and the Electronic Patient Record (EPR) first phase due to be implemented in inpatient areas in Spring 2019 and a second phase in Spring 2020 for community and outpatient services. There is much preparatory and engagement work being undertaken by informatics staff to aid configuration and design of the EPR in order to maximise the benefits staff and patients will see from the systems .

Previously considered by	

Next steps/future actions	I. Note the significant progress made in IT Strategy implementation II. Consider how the Board would prefer to hear future updates about the programme			
	Discuss	Y	Receive	
	Approve		Note	
	For Information	Y	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	Phillipa Winter Chief Informatics Officer	Presented by	Phillipa Winter Chief Informatics Officer

BOARD – 25/10/2018

Digital Trust Progress Update

1. PURPOSE

The purpose of this paper is to update the Board on the progress of the Digital Trust programme.

2. BACKGROUND

The Trust Board approved the Informatics Strategy a 5 Year forwards View 2016-2021 in May 2016.The strategy set out the vision:

"To facilitate exceptional patient care through informatics that is innovative, reliable, resilient, agile and for informatics to become a valued corporate asset."

The high level aims of this strategy were:

Digital enablement: Providing clinical staff with the tools to use technology to support the delivery of patient care through the use of systems as the iBleep replacement and eOBS. Supporting the use of technology at the point of care.

EPR for hospital and community services: A key deliverable based on a revised approach to procurement and implementation of an electronic patient record and developing a supportive culture that enables clinicians to use and exchange information to improve the quality and safety pf patient care

Infrastructure: Upgrade our hardware to deliver leading edge technology enabling lower cost of ownership and better performance

Mobilising our workforce and empowering patients: Supporting patients to help in their own care through the use of telehealth and telecare

3. Strategy in Action

In order to deliver the strategy the Board approved a number of key projects, supported and underpinned by a major refresh of the IT Infrastructure aimed at providing a better user experience through single sign-on technology and enhanced levels of security.

In July 2017 the trust approved the Digital Trust programme to implement an Electronic Patient Record (EPR) and a range of associated technology and infrastructure improvements to firstly gain parity with other organisations in their digital maturity and then move to the position of being a digital leader by 2021. This includes; Task Management – which has already been implemented for Hospital at Night staff with additional alerting functions and devices to be added; the E-Observations system – recording patient vital signs electronically to automatically calculate risk scores and alerts to staff; EPR programme – moving from paper records to electronic documentation; Unified Communications – providing the infrastructure for telehealth, video

conferencing, messaging and more adaptable communication across the trust. The EPR programme is split into two main phases; implementation for inpatient areas in Spring 2019 and then in outpatient and community settings in Spring 2020.

The Trust is undertaking this in order to enable more effective and efficient working practices across the organisation, improving the quality of practice and the safety and outcomes for patients by utilising systems to identify when key tasks have yet to be completed or have been missed. There is also substantial potential to ease the administrative burden upon staff by improving the use and visibility of information whilst improving access to technology in order to facilitate this.

4. Achievements and Progress

4.1 Electronic Observations

Rollout of the system is now well underway with almost half of the inpatient areas now recording, viewing and monitoring patient observations digitally. The system has been designed and shown in other Trusts, to help support clinical staff in their identification of at risk and deteriorating patients and in their escalation and response to manage this. This is the first major step, clinically, towards implementation of the Electronic Patient Record (EPR), and once fully embedded, in line with research findings, the system should support significant quality and safety improvements and better outcomes for patients. The process implemented to deliver this project has involved close working relationships between the clinical and informatics teams which will be important for ongoing EPR work. The project team have also applied lessons learned from other Trusts such as Derby and Manchester who use the same system.

4.2 Task Management

The Task Management system has been implemented for the Hospital at Night team and the associated nursing and medical staff working on out of hours since February 2016. This has been operating on PCs with the support of Informatics staff since this point and has worked largely successfully, ironing out issues and fine-tuning the way it's set up to work best with Trust policies and processes.

The current stage of its development is to have specialist hand held phones integrated with the system and deployed in order that tasks can be raised on the go and staff can be called directly to further discuss any issues in relation to the patient. Ultimately it is envisaged that this can be used to replace the outdated pager system with these devices once rolled out.

Once the devices have been deployed, the next step will be to link the alerts being created within the E-Observations module to the task management so that alerts created as a result of a high Early Warning Score is sent directly to the relevant clinical staff to be able to see the patient's information and respond accordingly wherever they may be.

4.3 EPR Programme status

The programme is well underway with the team working closely with specialist stakeholder groups across the Trust to understand the detailed

elements of what paper or disparate systems that they use now. This includes ward doctor and nursing documentation, making referrals, ordering laboratory and diagnostic tests, prescribing and administering medication. The outline scope of inpatients in phase one and the rest of the organisation in phase two is being worked through in greater detail to ensure that services aren't unduly disrupted where outpatient and inpatient activities are intertwined once the system is implemented.

Whilst the system the Trust is implementing is used elsewhere it is very much a toolbox of functions that we can incorporate into our use of the system but many elements such as the makeup and design of a given clinical assessment need to be decided and built by a mixture of trust and supplier staff before they can be implemented. Therefore the current work of understanding what is needed in the system and then what that should look like are particularly important to the overall success of the programme.

4.3.1 Engagement

To complement this there is a lot of work being undertaken to ensure that the organisation understands where the Informatics team are up to with the programme through a varied communication strategy and plan to help answer questions, such as; when it is coming, what it will do when it arrives and how they can get involved in shaping it to make it work for them. This includes having a stronger presence and communication to and from Informatics in the organisation including providing updates at divisional board and management meetings, presence on wards and demonstrations in a variety of locations for any staff to attend.

The programme has held over 240 engagement events with groups of specialist staff to help with the understanding and refining of current processes and design of new ones in the system. This has involved Nurses, Midwives, Allied Health Professionals, Pharmacy, Radiology and Laboratory Medicine staff, but we have so far struggled to see the same consistent involvement and discussion from doctors, although a number of different avenues are being explored to improve this. In particular there have been consultations with the Medical Director to better understand potential barriers and of how to approach this better which as a result is seeing some time being freed up at occasional audit meetings but there is a need for more of this. Because of the nature of the system we are implementing and the degree to which is can be adapted locally, the need for engagement from all groups across all specialties is vitally important to ensure that the design of the system is appropriate for individual areas of the Trust.

To measure how effective these activities are the team have conducted a survey to Trust staff to understand how much they know about the Digital Trust and in particular the EPR programme as well as what further information and activities they would like to see. The feedback from this and other engagement activities have been used to refine the team's approach and will be repeated quarterly to continually monitor whether and where improvements can be made.

4.3.2 Learning lessons from elsewhere

The Informatics team partnered the Wigan team for their recent EPR 'Go-Live', which not only enhanced learning within the Bolton team, but Wigan plan to reciprocate this for our 'Go-Live' next Spring. Lessons have also been learned from a recent Radiology and Informatics team visit to Salford Royal's Radiology Department and the Chief Clinical and Nursing Informatics Officers visiting Wigan, further informing and helping enhance our ongoing developments.

4.3.3 Next Steps

The focus in the next couple of months will be finalising the creation of assessments and other clinical documentation in the system. Alongside this the training team will be creating lesson plans and e-learning packages, preparing to then commence training with clinical and operational staff in the New Year. Trust staff should see a further increased visible Informatics presence across the site with many more demonstration sessions; ward visits and online videos planned. In attempting to get the right technology available for staff to use there will be consultation events with staff where potential options are showcased and will be available to trial and give feedback on before they are purchased for the phase one go-live. A similar work stream will commence with the community services, initially focussing upon the Health Visitor teams in support of the 0-19 tender process but also because of their status as the phase two remote working pilot with a view to enabling a fully functioning mobile EPR to aid their activities.

be important for ongoing EPR work. The project team have also applied lessons learned from other Trusts such as Derby and Manchester who use the same system.

4.4 Governance and Quality Improvements

Governance and reporting processes for EPR and Electronic Observations are well embedded via the stakeholder groups to the Digital Transformation Board as shown in Appendix 1 – EPR Governance Structure.

Staff stakeholder groups are working to help design the system to ensure it fits our local needs. Whilst this approach has seen some challenges in attaining the correct and consistent membership, when this has been overcome there have been some major successes so far which will ensure quality and safety benefits are realised for both staff and patients, alike. These include the process to quality check, streamline and standardise patient care plans, and the development of the nursing assessment documents which prompt staff in line with Trust protocols and flag patient alerts.

4.5 Unified Communications

A system of to improve communications, including replacement of our telephony system is now well underway. The scope of the unified communications project brings together a range of services to aide communications and includes:

- Replacement and Unification of the Hospital Campus, GP's and Community Sites telephony services

- A robust, scalable and resilient VOIP (Voice over IT Network)
- Specialist Contact Centre's to expand existing services within IT Services, Estates (including ISS), Telephone Access Centre, Sexual Health and Single Point of Access
- A resilient system which provides up to 144 key areas 'red phones' using traditional telephony and working on a smaller scale as the phone system does now.
- 3000 Replacement IP Phone handsets across the organisation on top of resilience red phones.
- Unified Communications including Instant Messaging, Video Conferencing and One Number Reach be that from home, community or within the hospital.
- Webex Teams – Project Driven conversations to share files and have white board discussions in key project areas.

Progress to date has included hardware installation and configuration and IP phones have been rolled out within IT Services, Dowling House, N block and Medical and Gasto Secretaries.. This has involved We linking the new UC and legacy phone systems together. To undertake this work staff have been recruited to support both the GP and Trust UC Systems.

Cisco Jabber (Instant Messaging / Screen Sharing) has been rolled out as part of an updated desktop to trust staff.

Once fully deployed in April 2019 the following benefits are anticipated:

- Reduction in the Bolton FT and Community Offices and Accommodation (with your phone extension being available from anywhere and the benefits from remote access available via VDI we can have a truly mobile workforce enabled with I.T.)
- Bringing together the Bolton Locality including the 23 sites of the Foundation Trust as well as GP services.
- Travel reduction through the use of remote meetings
- Speaker Phones on all devices giving benefits to translation services. From a practical point of view this would allow more efficiently someone to dial into a meeting as opposed to attending face to face. Minimum of 50% savings from current annual charges.
- Reduced Telephony Call Costs between organisations.
- Messaging; instant messaging, Is a quick and effective way of contacting people when not on email application. This can be used for Screen Sharing and Video conferences.
- Future proofing for cross organisational working (interoperability across GM and Healthier Together).
- Enhanced integrated working between community and acute care which is enabled through technology

5. CONCLUSION

Significant and measurable progress has been made in all areas of strategy implementation. The progress made by the Trust has been recognised both locally and nationally and our work is now the focus of much attention.

The Trust is now well placed to realise the benefits from the substantial investment made in Information Technology in recent years, to bring our services up to modern standards and to underpin the wider transformation agenda.

The table below provides an assessment of each of the strategic aims facilitated by the programme of work highlighted in this report.

Strategic Aim	Summary	RAG
Digital Enablement	eOBS being implemented and on plan	Green
EPR	Design phase commenced and governance established and programme on plan	Green
Infrastructure	Desktop Infrastructure complete and Unified Communications on plan	Green
Mobilising Workforce	Limited deployment of mobile devices underway and on plan	Green

RECOMMENDATIONS

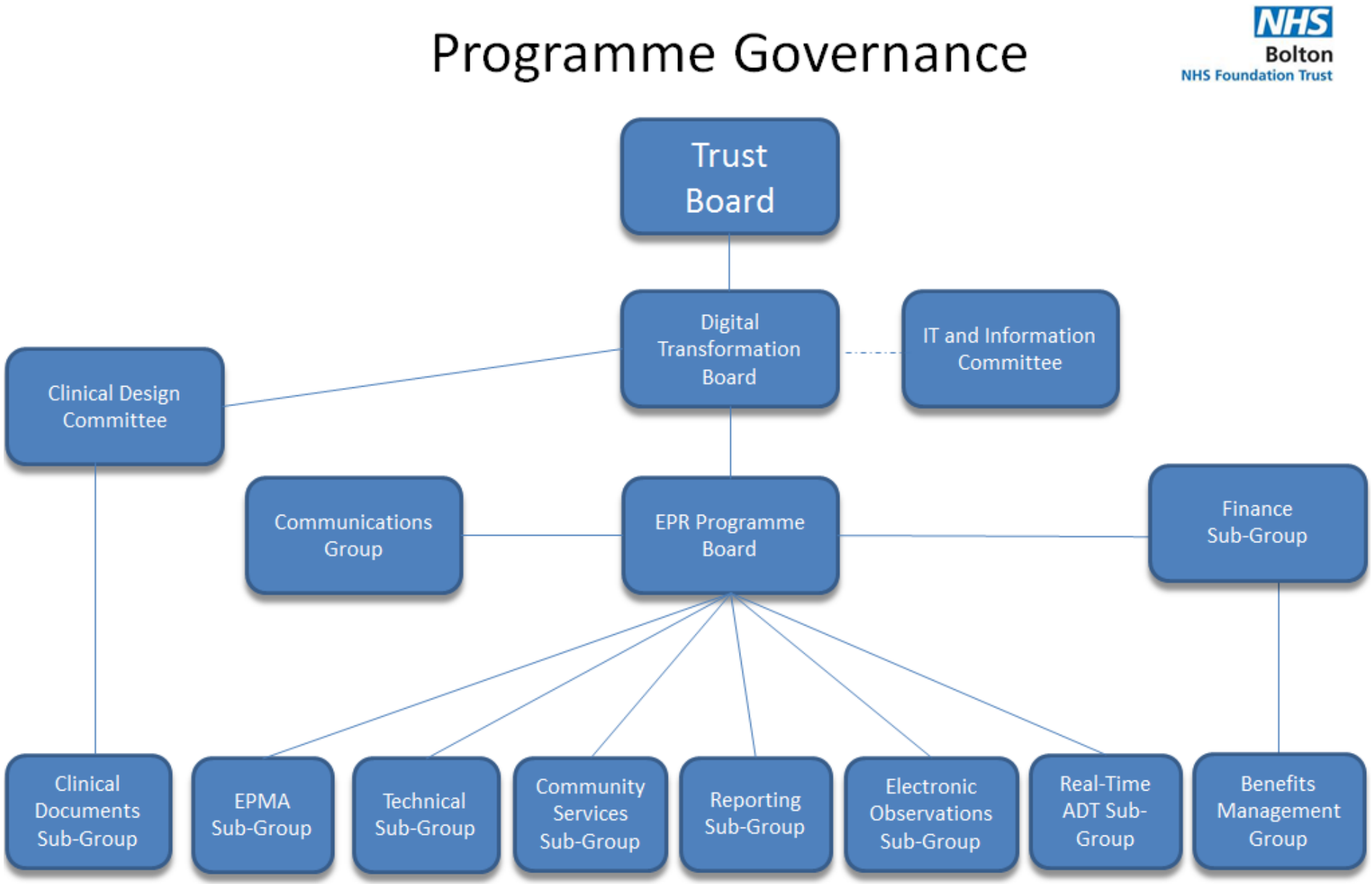
Board of Directors are asked to:

I. Note the significant progress made in IT Strategy implementation

II. Consider how further updates on strategy implementation should be reported to the Board of Directors

III.

6. Appendix 1 – EPR Governance Structure



7. Appendix 2 – Communications and Engagement Summary